



12 South Center Street
Bensenville, IL 60106

Office: 630.350.3404
Fax: 630.350.3438
www.bensenville.il.us

VILLAGE BOARD

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September 19, 2016

Mr. Maximilian Winters
1410 Belleau Woods Court
Wheaton, Illinois 60189

Re: August 28, 2016 FOIA Request

Dear Mr. Winters:

I am pleased to help you with your August 28, 2016 Freedom of Information Act ("FOIA"). Your request was received by the Village of Bensenville on August 29, 2016. You requested copies of the items indicated below:

"15-11580."

After a search of Village files, the following documents are enclosed to fulfill your request:

- 1) Village of Bensenville Crime Report No. BV15011580.1. (210 pgs.)

These are all of the documents that can be discovered responsive to your request.

Section 7(1)(b) of FOIA provided that "private information" is exempt from disclosure. "Private information" is defined in FOIA as, "unique identifiers, including a person's social security number, driver's license number, employee identification number, biometric identifiers, personal financial information, passwords or other access codes, medical records, home or personal telephone numbers, and personal email addresses. Private information also includes home address and personal license plates, except as otherwise provided by law or when complied without possibility of attribution to any person." 5ILCS 140/2(c-5). Consequently, certain unique identifiers have been redacted from the records being provided.

Section 7(1)(c) of FOIA provides that, "[p]ersonal information contained within public records, the disclosure of which would constitute a clearly unwarranted invasion per person privacy" is exempt from disclosure. Consequently, a birthdate and other personal information, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy, including a victim's name and identifying information, and the race of an individual, have been redacted from the records being provided.

Pursuant to Section 9 of the FOIA, 5 ILCS 140/9, I am required to advise you that I, the undersigned Freedom of Information Officer, reviewed and in consultation with an attorney for the Village, made the foregoing determination to deny a portion of your FOIA Request as indicated. Should you believe that this Response constitutes an improper denial of your request, you may appeal such by filing a request for review within sixty (60) days of the date of this letter with the Public Access Counselor of the Illinois Attorney General's Office, Public Access Bureau, 500 South Second Street, Springfield, Illinois 62706; telephone 1-887-299-FOIA; e-mail: publicaccess@atg.state.il.us. You may also have a right of judicial review of the denial under Section 11 of FOIA, 5 ILCS 140/11.

Do not hesitate to contact me if you have any questions or concerns in connection with this response.

Very truly yours,


Corey Williamsen
Freedom of Information Officer
Village of Bensenville

Bensenville Crime Report

Case No. **BV15011580**
Report No. **BV15011580.1**
Report Date: **12/15/2015**

Bensenville
345 E Green ST
Bensenville, IL 60106
630 350-3455

1

Page 1 of 3

Subject: **Criminal Abuse of long term care resident**

Case Report Status	V - Verified	Date Entered	12/15/2015 2:23:00 PM	Reporting Officer	523 - Larson, Michael
Occurred On (and Between)	10/31/2015 11:00:00 PM	Entered By	523 - Larson, Michael		
Location	[REDACTED]	Date Verified	8/7/2016 8:56:35 PM	Assisted By	
Jurisdiction	BV - Bensenville PD	Verified By	559 - Laporte, Richard		
Grid		Date Approved			
Sector		Approved By			
Map		Connecting Cases			
Census/Geo		Disposition	Inactive		
Call Source	Telephone - UDT	Clearance Reason			
		Date of Clearance			
		Reporting Agency	Bensenville		
		Division	Bensenville		
		Notified			
Vehicle Activity		Means			
Vehicle Traveling		Other Means			
Cross Street		Motive			
		Other Motives			

Report Narrative On 121515 I, Det. Michael Larson, met with the complainant, [REDACTED], in the conference room of the PD. [REDACTED] stated that he had fallen and broken bones in his back and that on Oct 1, 2015 he was admitted to the Bridgeway Christian Village located at [REDACTED] St, Bensenville, IL for rehabilitation.

[REDACTED] stated that during his stay that staff had repeatedly stole his pain medication and that on Oct 31, 2015 the staff injected him with an unknown medication that made him lose his memory for 2 weeks and that he was transported to Alexian Brothers Behavioral Health in Hoffman Estates for Psychiatric Treatment. [REDACTED] was also admitted to Alexian Brothers Hospital for chest pain while in the care of Behavioral Health. Winters stated that the unknown drug he was injected with caused him to become psychotic and he believes that the staff at Bridgeway Christian Village were trying to kill him.

I obtained forms for the release of [REDACTED] medical records from all of the facilities and [REDACTED] completed the forms for the release of his medical records.

I then met with the Director of the Bridgeway Christian Village, Biff Pfeiffer. Pfeiffer supplied me with all of [REDACTED] medical records. Pfeiffer went on to say that [REDACTED] had caused alot of problems while he was the facility. He stated that [REDACTED] had numerous episodes of becoming angry and throwing objects and being verbally abusive to staff. Pfeiffer also stated that the Illinois Department of Public Health had come into the facility and investigated [REDACTED] Claim. Pfeiffer also stated that the nurse who was in charge of [REDACTED] was Alejandro Leonardo and his phone number [REDACTED].

I called Leonardo and when I identified myself the subject on the line hung up the phone. Subsequent phone calls to the number went unanswered.

Records from the Bridgeway Christian Village show that [REDACTED] was admitted on Oct 1, 2015 and discharged Nov 1, 2015 to Alexian Brothers Behavioral Health.

In reviewing the records I noted that there were several documented incidents where [REDACTED] became abusive to the staff;

1. Oct 2, 2015 0808 hrs. Note by Nurse Jade Clark stating that [REDACTED] punched her in the left shoulder and became very combative and abusive while she was trying to reposition him in his chair.
2. Oct 3, 2015 0735 hrs. [REDACTED] calls Sheriff's Office on hospital because they would not let him go to the bathroom.
3. Oct 10, 2015 0730 hrs. Note by Alejandro Leonardo. [REDACTED] was verbally abusive and physically threatening Nurse
4. Oct 13, 2015 0741 hrs. Note by Alejandro Leonardo. [REDACTED] verbally abusive and threatening a CNA.
5. Oct 20, 2015 0900. Note by Elisa Wilsey. [REDACTED] calls 911 several times because he could not have anymore pain medication.
6. Nov 1, 2015 [REDACTED] transferred to Alexian Brothers after becoming aggressive towards staff.

I also observed a note by Dr. Ismael LeeChuy dated 10/15/15 at 1617 hrs stating that [REDACTED] has a long history of psychiatric problems as he was the oldest of 14 children and he was neglected since the age of 2 causing depression and complex PTSD. He has seen a psychiatrist and psychoanalyst for 18 years and therapists since he was a young man.

On 01/04/16 I spoke with Susan Medina from the Illinois Department of Public Health. Medina stated that she was assigned to investigate [REDACTED] claim that he was mistreated and injected with unknown drugs after he made a report with her office. Medina stated that the case was unfounded and she did not find any evidence to support [REDACTED] allegations.

On 01/05/16 I received [REDACTED] Medical Records from Alexian Brothers Hospital in Elk Grove.

Records state that [REDACTED] was admitted on Nov 12, 2015 from Behavioral Health due to Chest pains and that [REDACTED] had to

Bensenville Crime Report

Case No. **BV15011580**
Report No. **BV15011580.1**
Report Date: **12/15/2015**

Bensenville
345 E Green ST
Bensenville, IL 60106
630 350-3455

2

Page 2 of 3

physically restrained while in their care. [REDACTED] was discharged on Nov 17,2015 and returned to Behavioral Health.

On 03/17/16 I received [REDACTED] Medical Records from Alexian Brothers Behavioral Health.

Records from Behavioral Health state that Winters was admitted on 11/01/15 from Alexian Brothers emergency room and discharged on 11/25/15.

Records indicate that [REDACTED] has a risk of self harm and harm to others due to dementia, psychosis, confusion, poor insight and poor judgement. There were incidents noted during his stay where [REDACTED] became abusive and aggressive towards staff. [REDACTED] final diagnosis was bipolar disorder, mania with psychosis and dementia vascular with psychosis and behavioral disturbance.

Records also indicate that [REDACTED] was under the care of Dr. De los Santos while at behavioral health. I attempted several times to contact Dr. De Los Santos at his office and left messages with his staff. Dr. De Los Santos would not return any of my phone calls.

[REDACTED] then informed me that I should speak with Dr. Royal Priest, who was his doctor at the Bridgeway Christian Village. ON 6/16/16 at 1540 hrs I spoke with Dr. Royal Priest. The Doctor informed me that [REDACTED] has an extensive history of mental problems and that he was prescribed extensive doses of narcotics for pain by the physician that performed his surgery. I inquired about the incident on Oct 31, 2015 and Dr. Royal Priest stated that he was contacted by the staff because [REDACTED] was becoming aggressive. Dr. Royal Priest stated that it was determined to have him transferred to Alexian Brothers. Dr. Royal Priest stated that [REDACTED] was not injected with any drugs and that the order to do so would have had to be prescribed by him.

I then informed [REDACTED] of the interview of Dr. Royal Priest and [REDACTED] became upset stating that the doctor was lying. I also informed [REDACTED] that Dr. De Los Santos would not return any of my phone calls. [REDACTED] then advised me to contact nurse practitioner, Patricia Morgan, at Behavioral Health. I attempted several phone calls to her as well and Morgan would not return any of my phone calls.

With subsequent phone calls to [REDACTED] about the status of his case, [REDACTED] began to become more upset that the investigation was taking to long and not progressing. I explained to [REDACTED] the complications in the investigation starting with there was no lab report showing which narcotics were in his system when he was transferred to Alexian Brothers. [REDACTED] also stated that a toxicology was not performed. I also explained that Dr. De Los Santos or Dr. Morgan would not return my phone calls.

I then received a phone call from [REDACTED] stating that we should hire a forensic psychologist to prove that he was not insane. I advised him that we would not hire a forensic psychologist for this investigation. I attempted to explain that the psychologist would not be able to prove his state of mind back on October 31, 2015 nor would he be able to prove that [REDACTED] was injected with a drug to cause him to become insane. [REDACTED] became very irate and after yelling for quite a few minutes hung up on me.

On 08/05/16 I contacted Asst. States Attorney, Bridgette Carlson, of the Dupage County States Attorney's Office. I reviewed this case with her and she stated that there will be no charges approved against the Bridgeway Christian Village or its staff.

I then contacted [REDACTED] to explain that this case will be closed and [REDACTED] again became very irate and aggressive towards me. The phone call ended with [REDACTED] hanging up on me.

This case will be closed as unfounded.

Offense Detail: 0565 - CRIMINAL ABUSE OR NEGLECT OF ELDERLY, DISABLED, OR LONG TERM CARE RESIDENT

Offense Description	0565 - CRIMINAL ABUSE OR NEGLECT OF ELDERLY, DISABLED, OR LONG TERM CARE RESIDENT		
IBR Code	Location	233 - HOSPITAL	
IBR Group	Offense Completed?	No	No Prem. Entered
Crime Against	Offense Status	00 - Unfounded	Entry Method
Using	Hate/Bias	88 - None (No Bias)	Type Security
	Domestic Violence	No	Tools Used
Criminal Activity			
Weapons/Force			

Suspect S1: Village, Bridgeway Christian

Suspect Number	S1	DOB		Place of Birth	
Name	Village, Bridgeway Christian	Age	00	SSN	
AKA		Sex	U - Unknown	DLN	
Alert(s)		Race	U - Unknown	DLN State	
		Ethnicity	U - Unknown	DLN Country	
Address	111 E Washington	Ht.		Occupation/Grade	
CSZ	Bensenville, IL 60106	Wt.		Employer/School	
		Eye Color		Employer Address	

Bensenville Crime Report

Case No. **BV15011580**
Report No. **BV15011580.1**
Report Date: **12/15/2015**

Bensenville
345 E Green ST
Bensenville, IL 60106
630 350-3455

3

Page 3 of 3

Home Phone **630 787-4399**
Work Phone
Email Address

Hair Color
Hair Style
Hair Length
Facial Hair
Complexion
Build
Teeth

Employer CSZ
Res. County **dupage**
Res. Country
Resident Status **R - Resident**

Scars/Marks/Tattoos
Suspect MO
Other MO
Attire
Habitual Offender
Status
Suspect Notes

Victim V1: [REDACTED]

Victim Code **V1**
Victim Type **I - Individual**

Victim Of **0565 - CRIMINAL ABUSE OR NEGLECT OF ELDERLY, DISABLED, OR LONG TERM CARE RESIDENT**

Name [REDACTED]
AKA
Alert(s)
Address [REDACTED]
CSZ [REDACTED]
Home Phone [REDACTED]
Work Phone
Email Address
Attire
Injury
Circumstances

DOB [REDACTED]
Age **68**
Sex **M - Male**
Race **W - White**
Ethnicity **N - Not of Hispanic Origin**
HI
WI
Eye Color
Hair Color
Facial Hair
Complexion

Place of Birth
SSN
DLN [REDACTED]
DLN State
DLN Country
Occupation/Grade
Employer/School
Employer Address
Employer CSZ
Res. County **dupage**
Res. Country
Resident Status **R - Resident**
Testify

Law Enforcement Officer Killed or Assaulted Information	Type Assignment Activity Other ORI
--	---

Justifiable Homicide Circumstances

Victim Offender Relationships

Offender Relationship

Victim Notes

Printed Patient Name: _____ Date information Needed: 11/11/15 to 11/27/15
 Address: _____ Date of Birth: _____
 City: _____ State: IL Zip Code: _____ Telephone #: _____

I hereby authorize SAMC to release the protected health information indicated below on the above named individual to: (facility name)
Benseville Police Dept - Det. Mike Larson
 Provider Name/Organization/Individual
345 E. Green St
 Full address of Provider/Organization/Individual
 City: Benseville State: IL Zip Code: 60106 Fax #: (630) 350-0855
 Telephone #: _____
 For the following purpose: Physician or Health Care Facility Legal Purposes Personal Use At the request of the individual
 Other Ongoing Criminal Investigation
 For treatment date(s) or service Nov 1st to Nov 27, 2015
 Expiration Date or Expiration Event: 2015
 (If no prior notice of revocation is received, or expiration event/expiration date indicated, this authorization will expire 90 days from the date signed below.)

INFORMATION TO BE DISCLOSED:
 Abstract Chart (includes Face Sheet, Discharge Summary, History & Physical, Consultation Reports, Operative Reports, diagnostic tests)
 Entire medical record
 History and Physical Consultation Operative Report Discharge Summary
 Outpatient Services:
 Emergency Room Pathology Report(s) Laboratory Results Radiology Results Rehabilitation Services
 Other: _____

- I understand that:
- The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.
 - I have the right of access to inspect and obtain a copy of my protected health information.
 - I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the Health Information Management Department.
 - Revocation will not apply to information that has already been released in response to this authorization.
 - Once the above information is disclosed, there is the potential that it may be re-disclosed by the recipient, and therefore may not be protected by the federal privacy law regulations.
 - Failure to provide all required information will not constitute a proper authorization to disclose protected health information and that, therefore, my request may not be honored.
 - Authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment, payment or eligibility for benefits.

 (Signature of patient or legal representative) 12/30/015 Joseph Winter 12/30/15
 (Date) (Witness Signature) (Date)

(If signed by a legal representative, indicate the relationship to patient or authority to act for patient.)
 Fees/charges will comply with all laws and regulations applicable to release protected health information.

FOR FACILITY USE: Date received: _____ Date completed: _____ MR #: _____
 When applicable, the identity of the Legal Representative was verified by the following documentation and established that in his/her capacity, the above named legal representative is authorized to act on behalf of the patient: Driver's License Picture ID Legal guardian Court appointed legal guardian
 Power of Attorney Executor of Estate Other: _____
 Person/Department completing the request: _____

Authorization to Disclose Protected Health Information

will pick up



Alexian Brothers Medical Center
 800 Bicenterfield Road
 Elk Grove Village, IL 60007-3397
 847-437-5500
 Form # 76800 (3/03) Page 1 of 1
 12/30/2015 10:28AM FAX 8479565148

All () Areas must be Completed

Printed Patient Name: [REDACTED] Date of Birth: [REDACTED]
 Address: [REDACTED] Telephone Number: [REDACTED]
 City: [REDACTED] State: IL Zip Code: [REDACTED]

I hereby authorize Alexian Brothers Behavioral Health Hospital (facility name) to release and exchange written, oral or electronically transmitted protected health information indicated below on the above named individual to:
 Provider Name/Organization/Individual: MICHAEL LABORN DETECTIVE BENSenville POLICE
 Full address of Provider/Organization/Individual: 1650 NORTH LAUREL BLVD
 City: HOFFMAN State: IL Zip Code: 60140 Telephone #: 815.882.1600
 Including information related to: Psychiatric Care & Treatment Substance Abuse Care & Treatment Medical Care & Treatment
 For the following purpose: Physician or Health Care Facility Legal Purposes Personal Use Follow-up Care Tuition Payment School Staffing
 Placement Insurance Determination Vocational Service Referral Continuity of Care At Request of the Individual
 Primary Care Physician Other (Specify): DETECTIVE DEPT. OF SHERIFFS, ILL.
 Treatment date(s): 11/1/2015 to 11/2/2015 Date Authorization Expires: 11/1/2016
 (1 year maximum)

INFORMATION TO BE DISCLOSED:

<input checked="" type="checkbox"/> Dates of Admission & Discharge	<input checked="" type="checkbox"/> Discharge Summary	<input checked="" type="checkbox"/> Speech & Language Eval	<input checked="" type="checkbox"/> Attendance
<input checked="" type="checkbox"/> Pace Sheet	<input checked="" type="checkbox"/> Psychiatric Evaluation	<input checked="" type="checkbox"/> Laboratory Results	<input checked="" type="checkbox"/> Medication Information
<input checked="" type="checkbox"/> History and Physical	<input checked="" type="checkbox"/> Psychological Evaluation	<input checked="" type="checkbox"/> Radiology Reports	<input checked="" type="checkbox"/> Psychiatric Diagnosis
<input checked="" type="checkbox"/> Physical Health Screen	<input checked="" type="checkbox"/> Psychosocial Assessment	<input checked="" type="checkbox"/> Treatment Update	<input checked="" type="checkbox"/> Treatment Information
<input checked="" type="checkbox"/> Consultation	<input checked="" type="checkbox"/> Level of Care Screening	<input checked="" type="checkbox"/> Progress Notes	<input checked="" type="checkbox"/> Follow-up care
<input checked="" type="checkbox"/> Admission Assessment	Other (Specify): _____		<input checked="" type="checkbox"/> Chemical Dependency Diagnosis
HIV Documentation _____ (Must Initial)			<input checked="" type="checkbox"/> Medical Conditions and / or Diagnosis
Work Letter MAY Disclose Treatment Type and Facility _____ (Must Initial)			<input checked="" type="checkbox"/> Homework information
Work Letter MAY NOT Disclose Treatment Type and Facility _____ (Must Initial)			<input checked="" type="checkbox"/> IEP or 504 Plan Information
			<input checked="" type="checkbox"/> School Information Form

WORK LETTERS ARE NOT TO BE FAXED THEY MUST BE PICKED UP BY PATIENT

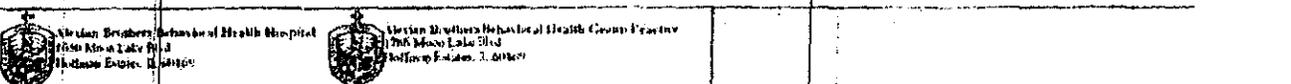
I understand that:

- The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).
- I have the right of access to inspect and obtain a copy of my protected health information.
- I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the Health Information Management Department.
- Revocation will not apply to information that has already been released in response to this authorization.
- Re-disclosure is prohibited unless the person who consented to the disclosure specifically consents to re-disclosure. However, once the above information is disclosed, there is the potential that it may be re-disclosed by the recipient, and therefore may not be protected by the federal privacy laws regulations.
- Failure to provide all required information will not constitute a proper authorization to disclose protected health information and that, therefore, my request may not be honored.
- Authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment, payment or eligibility for benefits.

Signature of patient: [REDACTED] (Date): 12/10/16
 Signature Parent or Legal Representative: [REDACTED] (Date): 12/2/16
 (Patients 12 to 17 years of age must sign in addition to the Parent or Legal/Personal Representative)
 Witness Signature: Joseph W. [REDACTED] (Date): 12/2/16
 (If signed by a legal representative, indicate the relationship to patient or authority to act for patient.)
 Fees/charges will comply with all laws and regulations applicable to release protected health information.

FOR FACILITY USE Date received: _____ Date completed: _____ MR #: _____
 When applicable, the identity of the Legal Representative was verified by the following documentation and established that in his/her capacity, the above named legal representative is authorized to act on behalf of the patient: Driver's License Picture ID Legal guardian Court appointed legal guardian
 Power of Attorney Executor of Estate Other _____
 Person/Department completing the request: _____

Authorization to Disclose Protected Health Information



*****AUTO**MIXED AADC 300

1396 2 MB 0.439

001396

BENSENVILLE POLICE DEPT

MICHAEL LARSON

5pgs

345 E GREEN ST

BENSENVILLE, IL 60106-2511



0005001396K01



ATTENTION

Confidential Information enclosed.
To be viewed by authorized persons only.

If you have questions regarding any information you have requested,
please call the phone number on the enclosed invoice.

Health information is reproduced by HealthPort, a health information management outsourcing service. Your healthcare provider contracts with HealthPort to process authorized requests for copies of health records.

Reproductions are made from the medical facility's original records. The confidentiality of these records is protected by federal and state laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

If you requested items that are not maintained in the medical record, your request for those items was forwarded to the appropriate department and will be sent under separate cover. Likewise, information that you asked to have delivered to another address is sent separately.

This package may or may not contain medical records, depending on what was requested and how it was processed.

You may not make any disclosure or use of these records without the permission of the individual who is the subject of the records.

This information *may or may not* contain records regarding drug and/or alcohol use or treatment. If this record contains any such information, it has been disclosed to you from records whose confidentiality is protected by federal regulation 42 CFR Part 2, which prohibits you from making any further disclosure of it without the *specific* written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of health or other information is not sufficient for this purpose. Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

If the enclosed record pertains to HIV/AIDS, it has been disclosed to you from records whose confidentiality is protected by federal and, perhaps, state law, which prohibits you from making any further disclosure of such information without the *specific* consent of the person to whom such information pertains or as otherwise permitted by state law. A general authorization for this release of health or other information is not sufficient for this purpose.

This is confidential and privileged information. If it contains mental health information, it is for professional use only.

HealthPort

P.O. Box 409822
Atlanta, GA 30384-9822
Fed Tax ID 58 - 2659941
(770) 754 - 6000

Date
2/12/2016
Request ID #
0186285991

Ship to:

MICHAEL LARSON
BENSENVILLE POLICE DEPT
345 E GREEN ST
BENSENVILLE, IL 60106-2511

Requested By: BENSENVILLE POLICE DEPT

Patient Name: [REDACTED]

DOB: 042047

Records from:

ALEXIAN BROS BEHAVIORAL HEALTH
1650 MOON LAKE BLVD
HOFFMAN ESTATES, IL 60169

HealthPort is the largest provider of release of information(ROI) services and technology. We ensure the compliant exchange of protected health information for over 10,000 healthcare facilities nationwide. To learn more about our flexible ROI solutions, go to www.healthport.com/facilityassist

From:

PT

Printed Patient Name: [Redacted]	Date Information Needed: ASAP
Address: [Redacted]	Date of Birth: [Redacted]
City: [Redacted] State: Illinois Zip Code: [Redacted]	Telephone Number: [Redacted]

I hereby authorize Alexian Brothers Behavioral Health Hospital to release the protected health information indicated below on the above named individual to: (facility name)

Bensenville Police Department Attention Detective Michael Larson
Provider Name/Organization/Individual

345 E Green Street
Full address of Provider/Organization/Individual

City: Bensenville State: Illinois Zip Code: 60108 Fax: (850) 355-0855
Telephone: [Redacted]

For the following purpose: Physician or Health Care Facility Legal Purposes Personal Use At the request of the individual
Other

For treatment date(s) or service: November 1 through November 26, 2015

Expiration Date or Expiration Event: March 31, 2016
(If no prior notice of revocation is received, or expiration event/expiration date indicated, this authorization will expire 90 days from the date signed below.)

INFORMATION TO BE DISCLOSED: All categories below plus doctor's notes

Abstract Chart (includes Face Sheet, Discharge Summary, History & Physical, Consultation Reports, Operative Reports, diagnostic tests)

Entire medical record

History and Physical Consultation Operative Report Discharge Summary

Outpatient Services:

Emergency Room Pathology Report(s) Laboratory Results Radiology Results Rehabilitation Services

Other: All other records without limitation including doctor's notes through February 1, 2016

I understand that:

- The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.
- I have the right of access to inspect and obtain a copy of my protected health information.
- I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the Health Information Management Department.
- Revocation will not apply to information that has already been released in response to this authorization.
- Once the above information is disclosed, there is the potential that it may be re-disclosed by the recipient, and therefore may not be protected by the federal privacy law regulations.
- Failure to provide all required information will not constitute a proper authorization to disclose protected health information and that, therefore, my request may not be honored.
- Authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment, payment or eligibility for benefits.

[Redacted Signature] 02/01/2015 (Date) [Redacted Signature] (Date)

(If signed by a legal representative, indicate the relationship to patient or authority to act for patient)
Fees/charges will comply with all laws and regulations applicable to release protected health information.

FOR FACILITY USE Date received: _____ Date completed: _____ MR #: _____

When applicable, the identity of the Legal Representative was verified by the following documentation and established that in his/her capacity, the above named legal representative is authorized to act on behalf of the patient: Driver's License Picture ID Legal guardian Court appointed legal guardian

Power of Attorney Executor of Estate Other: _____

Person/Department completing the request: _____

Authorization to Disclose Protected Health Information



Alexian Brothers Medical Center
800 Biessefield Road
Elk Grove Village, IL 60007-3397
847-437-5500

St Alexius Medical Center

Account #: [REDACTED]
 Patient: [REDACTED]

Unit #: [REDACTED]
 Patient Status: **DIS IN**

Admit Date: 11/12/15 Room/Bed : Y.3D Y.308-B
 Admit Time: 1503 Service/Location : TELE

DOB: [REDACTED] Age: 66 Sex: M Race: CA Ethnicity: NON Religion: [REDACTED]
 Address: [REDACTED]
 Home Ph: [REDACTED] Phone Message? Y

RETIRED
 X
 X, X X
 Work Phone:
 Occupation: NE

GUARANTOR
 Address: [REDACTED]
 Home Ph: [REDACTED]
 Relationship to Patient: Patient

GUARANTOR EMPLOYER
 RETIRED
 X
 X, X X
 Work Phone:
 Occupation: NE

PERSON TO NOTIFY
WINTERS, CHARLENE
 Home Phone: [REDACTED] Wk Phone:
 Relationship to Patient: Daughter

NEXT OF KIN
WINTERS, JOSEPH
 Home Phone: [REDACTED] Wk Phone:
 Relationship to Patient: Son

INSURANCE 1
 MCA
 MEDICARE PART A & B
 PO BOX 2348
 OMAHA, NE 68103-2348

Phone# [REDACTED]
 Policy# [REDACTED]
 Group# [REDACTED]
 Gr Name [REDACTED]

SUBSCRIBER
 Name: [REDACTED] DOB: [REDACTED]
 Address: [REDACTED]
 C/O/Z: [REDACTED]
 Phone: [REDACTED]

REL: Patient

INSURANCE 2
 BMOZOSUP
 BLUE CROSS MEDICARE SUPPLEMENT
 PO BOX 805107
 CHICAGO, IL 60600-4112

Phone# [REDACTED]
 Policy# [REDACTED]
 Group# [REDACTED]
 Gr Name [REDACTED]

SUBSCRIBER
 Name: [REDACTED] DOB: [REDACTED]
 Address: [REDACTED]
 C/O/Z: [REDACTED]
 Phone: [REDACTED]

REL: Patient

INSURANCE 3

Phone# [REDACTED]
 Policy# [REDACTED]
 Group# [REDACTED]
 Gr Name [REDACTED]

SUBSCRIBER
 Name :
 Address :
 C/O/Z :
 Phone :

DOB:

REL:



Last Hospitalization Admission Comment Allergy

PHYSICIAN
 Admitting Physician: MOHSIN, SAJDEH MD
 Attending Physician: MOHSIN, SAJDEH MD
 Emergency Room Physician: MOSWART, CHRISTOPHE
 Primary Care: NONE, NONE
 Non Staff/Other:

Source: ER - Self Referral Arrival: AMB Principal Admitting Diagnosis/Reason for Visit: CHEST PAIN-PNEUMONIA Language: ENG English

Registrar: YOCUS ENG / FPADEWJ Print Date/Time: 11/17/15 1252 Dis Date: 11/17/15 1251

St Alexius Medical Center

Account #: [REDACTED]
 Patient: [REDACTED]

Unit #: [REDACTED]
 Patient Status: **ADM In**

Admit Date: 11/21/15 Room/Bed : F.3N F.306-B
 Admit Time: 1544 Service/Location : OBSV3N

PATIENT INFORMATION

DOB: [REDACTED]	Age: 68	Sex: M	MD: D	Race: CA	Ethnicity: NON	Religion:	RETIRE
Address: [REDACTED]							X
Home Ph: [REDACTED]							X, X, X
Phone Message? Y							Work Phone:
							Occupation: NE

GUARANTOR

Address: [REDACTED]							GUARANTOR EMPLOYER
Home Ph: [REDACTED]							RETIRE
Relationship to Patient: Patient							X
							X, X, X
							Work Phone:
							Occupation: NE

PERSON TO NOTIFY

WINTERS, CHARLENE				WINTERS, JOSEPH			
[REDACTED]				[REDACTED]			
Wk Phone:				Wk Phone:			
Relationship to Patient: Daughter				Relationship to Patient: son			

INSURANCE #1

MCR	Phone# [REDACTED]	SUBSCRIBER	DOB: [REDACTED]
MEDICARE PART A & B	Policy# [REDACTED]	Name: [REDACTED]	
PO BOX 2348	Group# [REDACTED]	Address: [REDACTED]	
OMAHA, NE 68105-2348	Gr Name [REDACTED]	C/S/E: [REDACTED]	
		Phone: [REDACTED]	REL: Patient

INSURANCE #2

BCMEDSUP	Phone# [REDACTED]	SUBSCRIBER	DOB: [REDACTED]
ELVE CROSS MEDICARE SUPPLEMENT	Policy# [REDACTED]	Name: [REDACTED]	
PO BOX 805107	Group# [REDACTED]	Address: [REDACTED]	
CHICAGO, IL 60680-4112	Gr Name [REDACTED]	C/S/E: [REDACTED]	
		Phone: [REDACTED]	REL: Patient

INSURANCE #3

	Phone# [REDACTED]	SUBSCRIBER	DOB:
	Policy# [REDACTED]	Name:	
	Group# [REDACTED]	Address:	
	Gr Name [REDACTED]	C/S/E:	
		Phone:	REL:



Last Hospitalization	Admission Comment	Allergy
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PHYSICIAN INFORMATION

Admitting Physician	Attending Physician	Emergency Room Physician	Primary Care	Non Staff/Other
MOHSIN, SAJEDA MD	MOHSIN, SAJEDA MD	MCSWANE, CHRISTOPHER	NONE, NONE	

Source	Arrival	Principal Admitting Diagnosis/Reason for Visit	Language
EX - SELF Referral	AME	CHEST PAIN-PNEUMONIA	ENG English

Registrar: FOCUS BKG / TPADMBJ Print Date/Time: 11/21/15 0940

St Alexius Medical Center

Account #: [REDACTED]
 Patient: [REDACTED]

Unit #: [REDACTED]
 Patient Status: **REG ER**

Admit Date: 11/11/15 Room/Bed :
 Admit Time: 0822 Service/Location : F.XX

DOB: [REDACTED]	Age: 68	Sex: M	MS: D	Race: CA	Ethnicity: NON	Religion:	RETIREED X X, X X Work Phone: Occupation: NE
Address: [REDACTED]							X, X X
Home Ph: [REDACTED]							Work Phone:
Phone Message? I [REDACTED]							Occupation: NE

GUARANTOR	GUARANTOR EMPLOYER
Address: [REDACTED]	RETIREED
Home Ph: [REDACTED]	X
Relationship to Patient: Patient	X, X X
	Work Phone:
	Occupation: NE

PERSON TO NOTIFY	NEXT OF KIN
WINTERS, CHARLIE	WINTERS, JOSEPH
Address: [REDACTED]	Address: [REDACTED]
Home Ph: [REDACTED]	Home Ph: [REDACTED]
Relationship to Patient: Daughter	Relationship to Patient: SON

INSURANCE #1	Phone#	Policy#	Group#	Gr Name	SUBSCRIBER	DOB:
MCA MEDICARE PART A & B PO BOX 2348 OMAHA, NE 68103-2348	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	Name: [REDACTED] Address: [REDACTED] C/S/2 : [REDACTED] Phone : [REDACTED]	[REDACTED]
					REL: Patient	

INSURANCE #2	Phone#	Policy#	Group#	Gr Name	SUBSCRIBER	DOB:
BCHMOSUT BLUE CROSS MEDICARE SUPPLEMENT PO BOX 805107 CHICAGO, IL 60680-4112	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	Name: [REDACTED] Address: [REDACTED] C/S/2 : [REDACTED] Phone : [REDACTED]	[REDACTED]
					REL: Patient	

INSURANCE #3	Phone#	Policy#	Group#	Gr Name	SUBSCRIBER	DOB:
					Name : Address : C/S/2 : Phone :	
					REL:	

Account Number Bar Code	Medical Record Number Bar Code
	

Last Hospitalization	Admission Consent	Allergy
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Admitting Physician	Attending Physician	Emergency Room Physician	Primary Care	Non Staff/Other
		MCDONNELL, CHRISTOPHER	NONE, NONE	

Source	Arrival	Principal Admitting Diagnosis/Reason for Visit	Language
ER - Self Referral	AGE	CP	ENG English

Registrar: FOCUS ERG / MCDONNELL Print Date/Time: 11/11/15 1018

St Alexius Medical Center

Account #: [REDACTED]

Unit #: [REDACTED]

Patient: [REDACTED]

Patient Status: **PRE ER**

Admit Date: 11/11/15
Admit Time: 0922

Room/Bed :
Service/Location : Y.ER

PERSONAL INFORMATION

DOB: [REDACTED]	Age: 68	Sex: M	MR: D	Race: CR	Ethnicity: NON	Religion: X
Address: [REDACTED]						X X
Near Fb: [REDACTED]						X, X XX
Phone: 630-668-8966						Work Phone: 999-999-9999
Voter Message?						Occupation:

GUARANTOR	GUARANTOR EMPLOYER
Address: [REDACTED]	X
Near Fb: [REDACTED]	X X
Relationship to Patient: Patient	X, X XX
	Work Phone: 999-999-9999
	Occupation:

PERSON TO NOTIFY	NEXT OF KIN
	WINTERS, JOSEPH
Home Phone: [REDACTED]	Home Phone: [REDACTED]
Relationship to Patient:	Relationship to Patient: SON

INSURANCE #1	SUBSCRIBER
MCA MEDICARE PART A & B PO BOX 2346 OMAHA, NE 68103-2346	Name: [REDACTED] DOB: [REDACTED] Address: [REDACTED] C/S/2: [REDACTED] Phone: [REDACTED] REL: Patient
Phone: [REDACTED]	
Policy#: [REDACTED]	
Group#: [REDACTED]	
Gr Name: [REDACTED]	

INSURANCE #2	SUBSCRIBER
ECHEMSUP BLUE CROSS MEDICARE SUPPLEMENT PO BOX 805107 CHICAGO, IL 60680-4112	Name: [REDACTED] DOB: [REDACTED] Address: [REDACTED] C/S/2: [REDACTED] Phone: [REDACTED] REL: Patient
Phone: [REDACTED]	
Policy#: [REDACTED]	
Group#: [REDACTED]	
Gr Name: [REDACTED]	

INSURANCE #3	SUBSCRIBER
Phone: [REDACTED]	Name: [REDACTED] DOB: [REDACTED]
Policy#: [REDACTED]	Address: [REDACTED]
Group#: [REDACTED]	C/S/2: [REDACTED]
Gr Name: [REDACTED]	Phone: [REDACTED] REL: [REDACTED]



Last Hospitalization	Admission Comment	Allergy
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PHYSICIAN INFORMATION

Admitting Physician	Attending Physician	Emergency Room Physician	Primary Care	Non Staff/Other
		EMERGENCY, DEPT F.		

Source	Arrival	Principal Admitting Diagnosis/Reason for Visit	Language
	AMB	CF	ENG English

EMERGENCY DEPARTMENT SORT

ASBHH
 Date: _____ Time of arrival: *0920* Gender: M F Name: _____
 ESI: 1 2 3 4 5 Date of birth: _____

Mode of arrival: Walk-in Wheelchair Cart Carried Ambulance *HE*
 Reason for visit: *CP radiating to @ Shoulder* Physician: _____

Pertinent history: None Unknown Asthma CA Cardiac COPD CVA Diabetes
 HTN Psych Seizures Valid DNR/Advance directive Other: _____

NKDA Allergies: *amiodipine* *nonambulatory*

Responsiveness: <input type="checkbox"/> Alert <input type="checkbox"/> Verbal <input type="checkbox"/> Pain <input type="checkbox"/> Unresponsive Oriented to: <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time <input type="checkbox"/> Situation <hr/> Color: <input type="checkbox"/> Normal <input type="checkbox"/> Pale <input type="checkbox"/> Cyanotic <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced Temperature: <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Hot Moisture: <input type="checkbox"/> Dry <input type="checkbox"/> Moist <input type="checkbox"/> Diaphoretic <hr/> RESPIRATORY Effort: <input type="checkbox"/> Normal <input type="checkbox"/> Labored <input type="checkbox"/> Shallow <input type="checkbox"/> Stridorous

Isolation: <input type="checkbox"/> No <input type="checkbox"/> Yes → Type: <input type="checkbox"/> Mask <input type="checkbox"/> Contact <input type="checkbox"/> Negative airflow <input type="checkbox"/> Protective
--

Sort RN signature: _____ SAMC pneumatic: (_____) Date: _____ Time: _____
--

Interventions: EKG Urine Fingerstick glucose Blood IV
 Ice Dressing Sling Elevation Other: _____

Temperature: <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Tympanic <input type="checkbox"/> Axillary	Pulse: <i>83</i>	Respirations: <i>20</i>	Blood pressure: <i>95/44</i> <i>118/71</i>	Pain #: _____ <input type="checkbox"/> Faces <input type="checkbox"/> FLACC	SpO ₂ : <i>93 RA</i>
Height: _____ inches	Weight: _____ kgs	<input type="checkbox"/> Actual <input type="checkbox"/> Stated <input type="checkbox"/> Estimated	O ₂ at _____	liters per minute via: _____	at _____

ALEXIAN PROTECTORS
 1555 Barrington Road
 Hoffman Estates, IL 60169
 St. Alexius Medical Center

EMERGENCY DEPARTMENT SORT

ITEM # 0052158
 FORM # F36773 03/13
 (Emergency Department)



ED

Patient

[Redacted Patient Information]
 11/22/15
 M HERRIN, SANDEN MD
 WHITE - Chart CANARY - SUKIN N

St Alexius Medical Center

UNIT/MR#: [REDACTED]
 ACCOUNT#: [REDACTED]
 ROOM#: [REDACTED]
 SEX: M AGE: 68

PATIENT: [REDACTED]
 ATTENDING: [REDACTED]
 ADMIT DATE: [REDACTED]
 DOB: [REDACTED]
 Initialization Date: 11/11/15 0937

Signed

General Adult HPI

- Scribe Attestation

** Yes

Scribe Attestation:

Scribe documentation provided by, Mackenzie Cooper, acting as scribe for DEPT PHYSICIAN EMERGENCY on 11/11/15 at 09:37.

- General

Medical screening in progress: Yes (1000)

HPI Narrative:

68 Y/O M with h/o CHF, COPD, and mood disorder presents to ED via EMS from ABBHH for evaluation of an episode of CP which radiated to his left shoulder and has since resolved. Pt currently denies CP during exam. Pt is a poor historian due to AMS, so history is limited. Pt is allergic to Amlodipine.

Stated complaint: CP

Time Seen by Provider: 11/11/15 09:36

Source: Patient, EMS, Other

Mode of arrival: EMS

- Related Data

Home Medications

Medication	Instructions	Recorded	Confirmed
Acetaminophen	650 mg PO Q8HR PRN PRN	11/11/15	11/11/15
Albuterol Sulfate	2.5 mg IH Q6HR PRN PRN	11/11/15	11/11/15
Aspirin	325 mg PO DAILY	11/11/15	11/11/15
Bydureon Pen	0 SUB-Q Q7D	11/11/15	11/11/15
Calcium Carbonate	500 mg PO Q4HR PRN PRN	11/11/15	11/11/15
Cholecalciferol	2,000 unit PO DAILY	11/11/15	11/11/15
Fluticasone/Salmeterol	500 mcg IH Q12HR & PRN	11/11/15	11/11/15
Folic Acid	1 tab PO DAILY	11/11/15	11/11/15
Glucagon	1 mg IM PRN.P PRN	11/11/15	11/11/15
Glycerin	1 supp RECT PRN.P PRN	11/11/15	11/11/15
Hydromorphone HCl	2 mg PO Q4HWA	11/11/15	11/11/15

St Alexius Medical Center

Name: [REDACTED]

Unit/MR#: [REDACTED]

Insulin Aspart	0 units PRN,P PRN	11/11/15	11/11/15
Lactulose	10 gm PO TID	11/11/15	11/11/15
Lamotrigine	300 mg PO BID	11/11/15	11/11/15
Levothyroxine Sodium	100 mcg PO DAILY	11/11/15	11/11/15
Loratadine	10 mg PO DAILY	11/11/15	11/11/15
Lovenox	40 mg SUB-Q DAILY	11/11/15	11/11/15
Olanzapine	5 mg PO BID	11/11/15	11/11/15
Oxycodone	20 mg PO Q12HR PRN PRN	11/11/15	11/11/15
Pantoprazole Sodium	40 mg PO DAILY	11/11/15	11/11/15
Phenelzine Sulfate	15 mg PO DAILY	11/11/15	11/11/15
Polyethylene Glycol	17 gm PO DAILY	11/11/15	11/11/15
Potassium	40 meq PO BID	11/11/15	11/11/15
Pregabalin	150 mg PO BID	11/11/15	11/11/15
Senna	2 tab PO BID	11/11/15	11/11/15
Simethicone	80 mg PO Q4HR PRN PRN	11/11/15	11/11/15
Torsemide	40 mg PO BID	11/11/15	11/11/15

Allergies

Allergy/AdvReac	Type	Severity	Reaction	Status	Date / Time
amlodipine	Allergy			Verified	11/11/15 15:07

Review of Systems

All systems ED: reviewed and negative except as stated.

Constitutional: Denies: fever

Cardiovascular: Reports: chest pain

Past Medical History

Reviewed Information: I have reviewed and confirmed nurse's notes for patient's medications, allergies, medical history, family history, social history, and surgical history.

Reviewed Information Cont: EMS run sheet reviewed

- Past Medical History

Attestation: Yes The following information was validated with the patient.

PMFSH Narrative:

PSYCH: (+) mood disorder

Source: Patient, EMS, Other (ABBHH)

Medical history: States: CHF, COPD

- Social History

Smoking Status: Never smoker

Alcohol use: States: None

Report #: 1111-0061 Physician Documentation

Page: 2
Dept: ER

CC:

St Alexlus Medical Center

Name: [REDACTED]

Unit/MR#: [REDACTED] A#: [REDACTED]

Drug use: States: None
Living Arrangement: Other (ABBHH)

Physical Exam

CONSTITUTIONAL: Well-appearing; well-nourished; in no apparent distress. Nontoxic appearance; lethargic
HEAD: Normocephalic; atraumatic
EYES: PERRL; EOM intact
ENT: normal nose; no rhinorrhea; normal pharynx with no tonsillar hypertrophy
NECK: Supple; non-tender; no cervical lymphadenopathy
CARD: Normal S1, S2; no murmurs, rubs, or gallops
RESP: Normal chest excursion with respiration; breath sounds clear and equal bilaterally; no wheezes, rhonchi, or rales
ABD: Soft, normal bowel sounds; non-distended; non-tender x 4quadrants; no palpable organomegaly; no masses; no rebound; no guarding; no flank tenderness
EXT: Normal ROM in all four extremities; non-tender to palpation; distal pulses are normal; no edema
SKIN: Normal for age and race; warm; dry; good turgor; no apparent lesions or exudate
NEURO: lethargic. CN 2-12 grossly intact, motor/sensory grossly intact.

Course

- Consultations
Consultant #1: MOHSIN,SAFDER

Procedures

- Pulse Oximetry Interpretation
** Earlobe
Pulse Oximetry: 96
Pulse Oximetry Interpretation: Normal

Medical Decision Making

- Medical Decision Making
Medical decision making narrative:
The patient has been in the hospital at central dupage for surgery, followed by admission at ABBHH. He has some findings on CT consistent with pneumonia, possible aspiration. He has been in the hospital, so is susceptible for Hospital acquired pneumonia and needs treatment for this.

- Data Complexity
Data Complexity: Lab Ordered, X-ray Ordered, EKG Ordered
Data Complexity #2: Review and summary of old records and/or, obtaining hx from someone other
Report #: 1111-0061 Physician Documentation

Page: 3
Dept: ER

CC:

St Alexius Medical Center

Name: [REDACTED]

Unit/MR#: [REDACTED] A# [REDACTED]

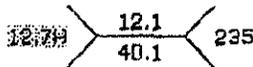
than the patient and/or, discussion with other healthcare provider.

- **Differential Diagnosis**
acs, pneumonia, pe

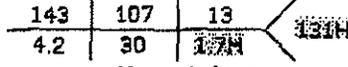
- **Medical Records**
Medical records reviewed: Yes Patient's past medical records reviewed.

- **Lab Data**
Result diagrams:

11/11/15 10:18



11/11/15 10:18



Hematology

	11/11/15 10:18
WBC	12.7 H
RBC	4.57
Hgb	12.1
Hct	40.1
MCV	87.7
MCH	26.5 L
MCHC	30.2 L
RDW	16.3 H
Plt Count	235
MPV	11.2
Differential Method	AUTOMATED
Immature Gran %	0.2
Neutrophils %	78.9
Lymphocytes %	12.2
Monocytes %	6.6
Eosinophils %	1.9
Basophils %	0.2
Immature Gran #	0.0
Neutrophils #	10.0 H
Lymphocytes #	1.5
Monocytes #	0.8
Eosinophils #	0.2
Basophils #	0.0

Report #: 1111-0061 Physician Documentation

Page: 4
Dept: ER

CC:

St Alexius Medical Center

Name: [REDACTED]

Unit/MR# [REDACTED] A#: [REDACTED]

Coagulation

	11/11/15 10:18
PT	14.1
INR	1.06
APTT	43.4 H
D-Dimer	2.38 H

Chemistry

	11/11/15 10:18
Sodium	143
Potassium	4.2
Chloride	107
Carbon Dioxide	30
Anion Gap	6
BUN	13
Creatinine	1.7 H
Estimated GFR	43
BUN/Creatinine Ratio	8
Glucose	131 H
Calcium	8.9
Magnesium	2.1
Total Bilirubin	0.4
AST	23
ALT	18
Total Alk Phosphatase	142 H
Troponin I	<0.39
B-Natriuretic Peptide	20
Total Protein	7.3
Albumin	2.9 L
Globulin	4.4
Albumin/Globulin Ratio	0.7 L

- Radiology Data

CT chest without contrast

IMPRESSION:

1. Cardiomegaly and coronary atherosclerosis.
2. Degree of aneurysmal dilatation of ascending thoracic aorta. This measures up to slightly under 5 cm diameter. No definite or indirect

Report #: 1111-0061 Physician Documentation

CC:

Page: 5
Dept: ER

St Alexius Medical Center

Name: [REDACTED]

Unit/MR#: [REDACTED] A# [REDACTED]

Portable AP chest 1025

IMPRESSION:

1. Prominence of right mediastinal margin as described. Recommend chest CT exam with IV contrast material, in particular to evaluate the proximal aorta, to exclude any possibility of aneurysm/dissection. This was communicated to ER physician Dr. McSwane.
2. Mild discoid left basilar atelectasis.

evidence of a dissection flap, although evaluation is suboptimal without IV contrast material.

3. Patchy/nodular right lower lobe infiltrates. May represent pneumonia. Atypical pneumonia? Lesser amount of left basilar atelectasis.
4. Gynecomastia.

Nuclear medicine lung scan ventilation and perfusion
History: Elevated d-dimer.

1. Low probability for pulmonary embolism.

- EKG Data

** EKG #1

EKG reviewed and interpreted:

11/11/15 14:18

nsr 76; pr normal; qrs normal; no acute sttwc

11/11/15 15:05

Rhythm: Normal sinus rhythm

Rate: 76

Disposition

Provider Attestation: I personally performed the services described in the documentation, reviewed documentation, as recorded by the scribe in my presence, and it accurately and completely records my words and actions.

Clinical Impression:

Chest Pain, Pneumonia

Condition: Stable

Referrals:

NONE, NONE [Primary Care Provider] -

Have the last set of vital signs been reviewed?: yes

Report #: 1111-0061 Physician Documentation

Page: 6
Dept: ER

CC:

St Alexius Medical Center

Name: [REDACTED]

Unit/MR#: [REDACTED] A#: [REDACTED]

Time of Disposition: 15:06

Electronically Entered By: CHRISTOPHE MCSWANE MD

<Electronically signed by CHRISTOPHE MCSWANE MD> 11/11/15 1524

MCSCH/ 1111-0061

Report #: 1111-0061 Physician Documentation

CC:

Page: 7
Dept: ER

St Alexius Medical Center
1555 BARRINGTON RD
HOFFMAN ESTATES IL 60169
1-847-843-2000

UNIT/MR#: [REDACTED]
ACCOUNT#: [REDACTED]
ROOM#: [REDACTED]
SEX: M AGE: 68

PATIENT: [REDACTED]
ATTENDING: SAFDER MOHSIN MD
ADMIT DATE: 11/12/15
DOB: [REDACTED]

Signed

JOB#: 317820

DATE OF ADMISSION: 11/12/2015

DATE OF DISCHARGE:

DISCHARGE DIAGNOSES:

1. Chest pain, no acute cardiac injury, negative stress test.
2. Pneumonia improved
2. Thoracic aneurysm, no further workup per patient and his family and POA.
3. Chronic obstructive pulmonary disease, advanced.
4. History of sleep apnea, on CPAP.
5. History of hypertension.
6. History of diabetes.
7. History of chronic kidney disease.
8. History of neuropathy.
9. History of hypothyroidism.
10. Chronic leg edema.
11. History of back pain status post kyphoplasty for fracture.
12. Nonambulatory for a prolonged period.
13. Chronic pain medication use as per family.

MEDICATIONS: See reconcile

DIET: Weight reduction ADA diet.

FOLLOWUP: Will be seen by the psychiatric services at the Behavioral Hospital and I will assist with any medical needs.

ADMITTING LABORATORY DATA: White count 12.7, hemoglobin 12.1, hematocrit 40. Chemistries: Sodium 143, potassium 4.2, chloride 107, bicarbonate 30, BUN 33, creatinine 1.7. Troponin x3 less than 0.39. Stress echo, no inducible ischemia, no suggestion of cardiac decompensation. CT scan of the chest revealed a thoracic aneurysm and also right lung infiltrate. A V/Q scan, low probability.

HOSPITAL COURSE: Patient basically was admitted with chest pain. He ruled out for acute MI. Stress test was negative. As regards to the thoracic aneurysm, the patient and the family, mainly his wife, requested no further intervention. He was also noted to have right-sided pneumonia that was treated with broad-spectrum antibiotics. He improved quite a bit while he was here. I also have tapered off significant amount of his pain medication and cut down Lyrica. Also, his psych meds were reduced secondary to severe lethargy. Now he is looking and feeling a lot better. He is alert, able to communicate. He will be transferred back to the Behavioral Hospital for further management of his mood issues and then subsequently he will need to be placed at a location of his and family's

Report #: 1116-0260 DISCHARGE SUMMARY

Additional copy
CC:

Page: 1
Dept: MR

end copies to-

St Alexius Medical Center

Name: [REDACTED] DOB: [REDACTED]
Unit/MR#: [REDACTED] A#: [REDACTED]

choice. Overall condition at the time of discharge from this facility is significantly improved from the time of admission.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature 97.9, blood pressure 104/57 and 126/____, heart rate is in 70s, O2 sat 96% on room air.

HEENT: Tongue is moist.

HEART: S1, S2 well heard.

LUNGS: Bilateral minimal wheeze.

ABDOMEN: Obese, nontender.

EXTREMITIES: Chronic stasis changes.

Overall, 40 minutes spent arranging his discharge, filling out the med rec and appropriate papers. I also communicated all the hospital details to the staff at the Behavioral Hospital and the receiving psychiatrist. Addendum; 11/17/15: finally they have bed available at abbhh, he will be transferred today, BP elevated secondary to anxiety but coming down, practically off pain meds, will further wean him off if possible at behavioral hospital, bp meds will be adjusted as well. Overall condition much improved from time of admission.

Dictated By: SAFDER MOHSIN MD

<Electronically signed by SAFDER MOHSIN MD> 11/18/15 0016

DD: 11/15/15 1400 DT: 11/15/15 2232
MOHSA/ES 1116-0260

Report #: 1116-0260 DISCHARGE SUMMARY
Additional copy
CC:

Page: 2
Dept: MR

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St Alexius Medical Center
1555 BARRINGTON RD
HOFFMAN ESTATES IL 60169
1-847-843-2000

UNIT/MR#: [REDACTED]
ACCOUNT#: [REDACTED]
ROOM#: [REDACTED]
SEX: M AGE: 68

PATIENT: [REDACTED]
ATTENDING: [REDACTED]
ADMIT DATE: 11/12/15
DOB: [REDACTED]

Signed

JOB#: 315779

DATE OF ADMISSION: 11/11/2015

CHIEF COMPLAINT: Chest pain.

HISTORY OF PRESENT ILLNESS: Taken from the nursing staff at Alexian Behavioral, I have spoken to the patient and I also spoke to the ER staff. In addition, I have been following this patient at the Behavioral Hospital. The patient is a 68-year-old gentleman that was admitted on the November 1st to Alexian Brothers Behavioral Hospital for severe mood and behavioral problems. The patient was transferred there from Bridgeway nursing facility. He was being managed by the psych services for ongoing behavioral problems, delirium, delusion and aggressive behavior. However, this morning, he complained of left-sided chest pain. At that time, he was transferred to the ER. He underwent extensive workup in the ER that included EKG, which was negative for any acute ST-T changes. Troponin was negative. D-dimer was mildly elevated; however, CT scan of the chest, V/Q scan was negative for PE, reportedly, low probability. He did have right-sided pneumonia that is being treated. In addition to that for this ongoing confusions, he underwent CT scan of the head that again was negative for any acute CVA bleed. He was given 2 doses of antibiotics, Zosyn and doxycycline following which cultures were obtained and he was admitted. When I saw him around noontime in the ER, he was sedated but easily arousable. He was not having any acute pain. He did look confused, which has been the case since he has been at the Behavioral Hospital.

PAST MEDICAL HISTORY:

1. Remarkable for congestive heart failure, ejection fraction unknown.
2. History of chronic obstructive pulmonary disease, advanced.
3. Reported history of sleep apnea, does not use CPAP.
4. History of hypertension.
5. History of diabetes with labile blood sugars.
6. History of chronic kidney disease.
7. History of neuropathy.
8. History of hypothyroidism.
9. History of chronic leg edema.
10. History of back pain status post recent kyphoplasty for fractures.

PAST SURGICAL HISTORY: Kyphoplasty.

MEDICATIONS: See reconcile.

FAMILY HISTORY: Noncontributory.

SOCIAL HISTORY: Prior to being transferred to the Bridgeway nursing home, he lived at home with wife and he also has a couple of disabled children that live at home. There is no current tobacco or alcohol use I have been informed. He does not work

Report #: 1112-0338 HISTORY AND PHYSICAL
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St Alexius Medical Center

Name: [REDACTED]

Unit/MR#: [REDACTED]

REVIEW OF SYSTEMS: HEENT: No headache, dizziness, blurring of vision. CARDIAC: He did complain of chest pain this morning, not at this time. He gets winded without much effort. RESPIRATORY: Admits to cough, wheeze. GASTROINTESTINAL: Fair appetite. No vomiting, diarrhea, blood in the stool. MUSCULOSKELETAL: Back pain. He wears a brace. NEUROLOGIC: Tingling, numbness in the lower extremities, which according to him is chronic. He cannot ambulate, mostly confined to a wheelchair. CIRCULATORY: Chronic leg edema and stasis changes. ENDOCRINE: He is diabetic and hypothyroid.

PHYSICAL EXAMINATION:

GENERAL: Alert, very argumentative, very focused on his pain medications, particularly narcotics.

VITAL SIGNS: Temperature 98.2; blood pressure 118/71, 147/72, 107/57; heart rate is in the 70s and regular; O2 sat 100% on room air.

HEENT: Eyes are anicteric.

NECK: Supple. Thyroid not enlarged. Carotids no bruits.

HEART: S1, S2 well heard. No S3 or S4. No murmurs. Rhythm is regular.

LUNGS: Diminished air entry bilateral mild wheeze. No rales.

ABDOMEN: Obese. No organomegaly, no tenderness. Bowel sounds well heard.

RECTAL: Decline lower extremities, massive pedal edema bilaterally. Also noted are multiple scabs, scaly skin.

There is also noted extensive thickening of the skin involving his feet and toes. Peripheral pulses, dorsalis, pedis, posterior tibial are felt but feeble.

JOINTS: Spine: No acute tenderness. He currently has a brace in place.

NEUROLOGIC: Cranial nerves are grossly intact. Motor: He moves all extremities. Gait: Unable to stand or walk independently.

LABORATORY DATA: White count 12.7, hemoglobin 12.1, hematocrit 40.1. Chemistries: Sodium 143, potassium 4.2, chloride 107, bicarbonate 30, BUN 13, creatinine 1.7. Troponin less than 0.39.

Chest x-ray: Prominence of mediastinal margin. No acute infiltrates. No evidence of CHF. CT scan of the chest: Cardiomegaly. Also noted is aneurysmal dilatation of the ascending aorta measures up to under 5 cm in diameter. No suggestion of dissection. A V/Q scan reported low probability. CT scan of the head: No acute CVA or bleed.

IMPRESSION:

1. Chest pain, no acute cardiac injury noted so far. However, he does have multiple risk factors for coronary artery disease.
2. History of diabetes with labile blood sugars. He did have a low sugar reaction yesterday at the Behavioral Hospital.
3. Advanced chronic obstructive pulmonary disease.
4. History of sleep apnea.
5. Hypertension, currently stable.
6. Chronic kidney disease, patient is aware of that.
7. Diabetic neuropathy.
8. Back pain, recent kyphoplasty.
9. Reported history of arrhythmia. The patient is unaware of what arrhythmia he has had.
10. Nonambulatory for quite sometime.
11. Morbid obesity.
12. Mood disorder with severe behavioral issues. The patient has been constantly complaining about staff abusing him. He made the allegation at the nursing home and he has been making this allegation on a daily basis at the Behavioral Hospital also which has been completely untrue.

PLAN: I will admit him to the monitor floor. I will check serial EKG enzymes and if these are negative, I am going to schedule him for Lexiscan scan to rule out any inducible ischemia. As regards to the pneumonia, I have started him

Report #: 1112-0338 HISTORY AND PHYSICAL

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Unit/MR#: [REDACTED]

on Zosyn, doxycycline and will also initiate DVT prophylaxis. Home meds were reviewed and adjusted. We will monitor his blood sugar and make further adjustments. I have also requested psych services Dr. De Los Santos' group to follow him while he is here. If patient has any further cardiovascular symptoms or the stress test is positive, I will have cardiology see him as well. I also advised the patient that we need to work on reducing his pain medications. He has been completely abscessed around round the clock use of Dilaudid, Lyrica and oxycodone, which could be contributing to some of his mood swings and sedation. I will also talk to his wife.

Dictated By: SAFDER MOHSIN MD

<Electronically signed by SAFDER MOHSIN MD> 11/12/15 2124

DD: 11/11/15 2222 DT: 11/12/15 0833
MOHSA/ES 1112-0338

Report #: 1112-0338 HISTORY AND PHYSICAL
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St Alexius Medical Center
1555 BARRINGTON RD
HOFFMAN ESTATES IL 60169
1-847-843-2000

UNIT/MR#: [REDACTED]
ACCOUNT#: [REDACTED]
ROOM#: F.308-B LOC: F.3N
SEX: M AGE: 68

PATIENT: [REDACTED]
ATTENDING: SAFDER MOHSIN MD
ADMIT DATE: 11/12/15
DOB: [REDACTED]

Signed

JOB#: 315920

DATE OF CONSULTATION: 11/12/15

CONSULTING PHYSICIAN: MONICA M ARGUMEDO MD

PSYCHIATRIC CONSULTATION

ATTENDING PHYSICIAN: Safder Mohsin, MD

REASON FOR CONSULTATION: The consult was ordered due to agitation.

HISTORY OF PRESENT ILLNESS: This patient is a 68-year-old, married, Caucasian male who has a history of an L4 fracture, congestive heart failure, hypertension, diabetes mellitus, chronic kidney disease, hypothyroidism, obesity, obstructive sleep apnea, atrial fibrillation, chronic leg edema, COPD, and GERD who was originally admitted to Alexian Brothers Behavioral Health Hospital on 11/01/2015 under the care of Dr. De Los Santos to address mood lability, agitation, and behavioral disturbance at the nursing facility where he had recently been residing. The patient's medications were in the process of being adjusted. It looks like the patient was recently started on Zyprexa for some periods of severe agitation and psychotic behavior. The patient did develop some complaints of chest pain and he seemed to be increasingly confused, so he was transferred to St. Alexius Medical Center. In the emergency room his EKG was negative. His troponins were negative. He had a mildly elevated D-dimer, but his VQ scans showed low probability of a PE. He did have a chest x-ray which showed some questionable right-sided pneumonia which is currently being treated. He did have a CAT scan of his head due to some increased confusion and that shows moderate diffuse atrophy but nothing acute.

PAST PSYCHIATRIC HISTORY: The patient is most recently under the care of Dr. De Los Santos. He had been on a combination of Lamictal and Nardil. The Nardil is currently not being taken. He had previously reported a lifelong history of depression with a history of previous inpatient psychiatric hospitalization back in 1999 for transcranial magnetic stimulation. He has never attempted suicide. His current psychotropic regimen includes Lamictal 300 mg twice a day. He had been having his Nardil slowly tapered down. According to review of records at the behavioral health hospital, he continued to struggle with a lot of mood lability and he would go from being very alert and oriented and able to engage to periods where he was absolutely not lucid and seemed incoherent.

PHYSICAL EXAMINATION:

VITAL SIGNS: Currently reveal a temperature of 101. His blood pressure is 123/71, his heart rate is 85, respiratory rate 20, and he is saturating 93% on 3 liters of oxygen.

SUBSTANCE ABUSE HISTORY: Per records is noncontributory.

MEDICATIONS: Currently being taken include senna, Mylicon, Bumex, Claritin, NovoLog, OxyContin, Lyrica, MiraLax, NovoLog, lactulose, Lamictal 300 b.i.d., Synthroid, Tylenol, aspirin, Tums, vitamin D, glucagon, heparin,

Report #: 1112-0840 CONSULTATION REPORT

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Name: [REDACTED]

Unit/MR#: [REDACTED]

and Difaudid 1 mg twice a day.

ALLERGIES: _____.

PAST MEDICAL HISTORY: Again, significant for congestive heart failure, hypertension, chronic kidney disease, diabetes mellitus, hypothyroidism, obesity, obstructive sleep apnea, atrial fibrillation, COPD, GERD, kyphoplasty, and a history of L4 fracture.

SOCIAL HISTORY: The patient apparently was born in Texas but was raised primarily in Illinois by his parents. He has 3 years of college. He has a history of being self employed as a software engineer. He is married. He apparently had been residing at home with his wife and some disabled children prior to admission to Bridgeway nursing facility. Per records, the patient has no history of abuse in his life. Unable to ascertain if there is any family history of psychiatric illness.

MENTAL STATUS EXAMINATION: Reveals an obese, 68-year-old Caucasian male. He is lying in the hospital bed. He is wearing a hospital gown. He presents as somewhat disheveled. He is noted to be in bilateral wrist restraints. He does not make any eye contact. The patient is talking, but he is incoherent. He seems confabulatory and quite confused. He is unable to answer questions appropriately. I am unable to assess his mood, affect, thought process, thought content, or suicidality or homicidality. He is alert and completely disoriented.

DIAGNOSTIC IMPRESSION:

AXIS I: Delirium related to underlying infection; rule out cognitive disorder; major depressive disorder, recurrent, severe without psychotic features per history, and unspecified anxiety disorder.

AXIS II: Deferred.

AXIS III: New diagnosis of pneumonia, history of congestive heart failure, hypertension, diabetes mellitus, chronic kidney disease, hypothyroidism, obesity, obstructive sleep apnea, atrial fibrillation, COPD, GERD, and L4 fracture.

PLAN OF CARE AND RECOMMENDATIONS: This case was discussed with nursing staff and with Dr. De Los Santos. I will start the patient on p.r.n. Zyprexa 5 mg IM or p.o. for agitation. The patient is likely delirious in the context of an infectious disease and some fever. He should be treated for his underlying medical conditions and then he should be transferred back to Alexian Brothers Behavioral Health Hospital under the care of Dr. De Los Santos once he is deemed medically cleared.

Thank you for the opportunity to participate in the care of this patient. Please do not hesitate to contact psychiatry with questions or concerns.

Dictated By: MARY DAVITT, APN

Dictated By: MARY E DAVITT APN

<Electronically signed by MARY E DAVITT APN> 11/13/15 1105

<Electronically signed by MONICA ARGUMEDO MD> 12/16/15 1245

DD: 11/12/15 0937 DT: 11/12/15 1112
DAVMAVES 1112-0840

Report #: 1112-0840 CONSULTATION REPORT
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1555 BARRINGTON RD
HOFFMAN ESTATES IL 60169
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DEPARTMENT OF CARDIOLOGY

UNIT/MR#: [REDACTED]
ACCOUNT#: [REDACTED]
ROOM#: LOC: F.ER
SEX: M AGE: 68
FAX#:

PATIENT: [REDACTED]
ATTENDING:
ORDERING: DEPT P. EMERGENCY
ADMIT DATE:
DOB: [REDACTED]

Signed

1111-0132 NIC/EKG (93005)

EKG

EXAM DATE/TIME: Nov 11 2015 09:31:51
Test Reason : CHEST PAIN
Blood Pressure : ***/** mmHG
Vent. Rate : 076 BPM Atrial Rate : 076 BPM
P-R Int : 192 ms QRS Dur : 106 ms
QT Int : 388 ms P-R-T Axes : 061 041 049 degrees
QTc Int : 436 ms

*** Poor data quality, interpretation may be adversely affected
Normal sinus rhythm
Normal ECG
No previous ECGs available
Confirmed by Wernick, Mark (12104) on 11/11/2015 10:31:57 AM

Referred By: DEPT EMERGENCY Confirmed By: Mark Wernick

Dictated By: MARK H WERNICK MD

<Electronically signed by MARK H WERNICK MD in OV> 11/11/15 1032

DD: 11/11/15 0931 DT: 11/11/15 1032
WERMA/ 1111-0047

Report #: 1111-0047 ELECTROCARDIOGRAM REPORT
CC: CHRISTOPHE MCSWANE MD; DEPT P. EMERGENCY
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St Alexius Medical Center
1555 BARRINGTON RD
HOFFMAN ESTATES IL 60169
1-847-843-2000

DEPARTMENT OF CARDIOLOGY

UNIT/MR#: [REDACTED]
ACCOUNT#: [REDACTED]
ROOM#: F.308-B LOC: F.3N
SEX: M AGE: 68
FAX#:

PATIENT: [REDACTED]
ATTENDING: SAFDER MOHSIN MD
ORDERING: SAFDER MOHSIN MD
ADMIT DATE: 11/12/15
DOB: [REDACTED]

Signed

1113-0238 NIC/STECDOCPWC (93351)

STRESS ECHOCARDIOGRAM REPORT
DOBUTAMINE

Account #: [REDACTED]
Accession #: [REDACTED]
Ht/Wt: 72 in 291 lb
Gender: M
BP: 136 / 77
Referring physician: Mohsin, Safder
Ordering physician: Mohsin, Safder
Performed by: Eric P Burseth, MD
Sonographer: Gustavo Felix, RDCS
Nurse: Jodi D'Ambrosia Beverly Wilk
Study Date: 11/13/2015

Ordering physician: Mohsin, Safder
Referring physician: Mohsin, Safder
Attending physician: Mohsin, Safder

Reading physician: Eric P Burseth, MD
Sonographer: Gustavo Felix, RDCS
Nurse: Jodi D'Ambrosia Beverly Wilk

Reason for Study: Chest pain. Chest pain.

STUDY DATA: Stress echocardiography. 2D. Study status: Routine. Location: St. Alexius Medical Center Patient status: Inpatient. Body surface area: BSA: 2.65 m². Consent: The risks, benefits, and alternatives to the procedure were explained to the patient and informed consent was obtained. Location: Echo laboratory. Procedure: initial setup. A baseline ECG was recorded. Intravenous access was obtained. Surface ECG leads and manual cuff blood pressure measurements were monitored. Transthoracic echocardiography. Image quality was adequate. The study was technically limited due to poor acoustic window availability. Dobutamine stress test. Stress testing was performed, with Report #: 1113-0281 STRESS ECHOCARDIOGRAM

CC: SAFDER MOHSIN MD

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Dept: CARD

St Alexius Medical Center

Name: [REDACTED]
Unit/MR: [REDACTED]

dobutamine infusion from 5 to 20 mcg/kg/min by 5 mcg/kg/min increments. Patient was also given atropine 1 mg IVP in divided doses to try to attain target heart rate. The infusion was terminated due to maximal dose administration. A pharmacologic approach was used because the patient was physically unable to exercise and because the patient failed to reach the target heart rate in a previous nondiagnostic exercise stress test. Exercise testing was performed. Post-stress images obtained within 90 seconds of peak stress. Transthoracic stress echocardiography. Image quality was adequate. The study was technically limited due to poor acoustic window availability. Images were captured at baseline, low dose, peak dose, and recovery. Intravenous contrast (Definity) was administered. Study completion: All catheters inserted during the procedure were removed. The patient tolerated the procedure well. There were no complications.

CONCLUSIONS

SUMMARY:

1. Stress: The patient experienced no chest pain during stress.
2. Stress ECG conclusions: Normal dobutamine stress EKG, however, the sensitivity is decreased since low maximal heart rate. Occasional PVC isolated PAC with aberrant conduction.
3. Stress echo: There is no echocardiographic evidence for stress-induced ischemia to the level of stress attained. The sensitivity is decreased since low maximal heart rate and images were technically suboptimal in the parasternal views but normal increase in contractility seen in the apical views which were of good quality.

OBSERVATIONS

BASELINE ECG: Nonspecific T wave changes.
STRESS PROTOCOL:

Stage	HR	BP (mmHg)
Baseline	163	136/77 (97)
Dobutamine 5 ug/kg/min		
Dobutamine 10 ug/kg/min		
Dobutamine 15 ug/kg/min		
Dobutamine 20 ug/kg/min		
Dobutamine 30 ug/kg/min		
Dobutamine 40 ug/kg/min		

Report #: 1113-0281 STRESS ECHOCARDIOGRAM

CC: SAFDER MOHSIN MD

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St Alexius Medical Center

Name: [REDACTED] DOB: [REDACTED]
Unit/MR: [REDACTED]

```
!Dobutamine 50 ug/kg/min! ! !
+-----+-----+
!Peak stress      |125|158/90 (113)!
+-----+-----+
!Immediate post stress | ! |
+-----+-----+
!Recovery; 1 min   | ! |
+-----+-----+
!Recovery; 2 min   | ! |
+-----+-----+
!Recovery; 3 min   | ! |
+-----+-----+
!Recovery; 4 min   | ! |
+-----+-----+
!Recovery; 5 min   | ! |
+-----+-----+
!Recovery; 6 min   | ! |
+-----+-----+
!Recovery; 7 min   | ! |
+-----+-----+
!Late recovery     | ! |
+-----+-----+
```

STRESS RESULTS: Maximal heart rate during stress was 125 bpm (82% of maximal predicted heart rate). The maximal predicted heart rate was 152 bpm. The target heart rate was not achieved. The heart rate response to stress is normal. There is a normal resting blood pressure with an appropriate response to stress. The rate-pressure product for the peak heart rate and blood pressure was 19750 mm Hg/min. The patient experienced no chest pain during stress.

STRESS ECG: Normal dobutamine stress EKG, however, the sensitivity is decreased since low maximal heart rate. Occasional PVC Isolated PAC with aberrant conduction.

STRESS ECHO RESULTS: Left ventricular ejection fraction was normal at rest and with stress. Resting LVEF of 60%. There is no echocardiographic evidence for stress-induced ischemia to the level of stress attained. The sensitivity is decreased since low maximal heart rate and images were technically suboptimal in the parasternal views but normal increase in contractility seen in the apical views which were of good quality.

Eric P Burseth, MD
11/13/2015 17:39

Dictated By: ERIC P BURSETH MD

<Electronically signed by ERIC P BURSETH MD in OV> 11/13/15 1739

DD: 11/13/15 1439 DT: 11/13/15 1739
BURER/ 1113-0281

Report #: 1113-0281 STRESS ECHOCARDIOGRAM

CC: SAFDER MOHSIN MD

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Dept: CARD



St. Alexius Medical Center
1555 Barrington Rd
Hoffman Estates, IL 60189

**STRESS ECHOCARDIOGRAM REPORT
DOBUTAMINE**

Patient: [REDACTED] Study Date: 11/13/2015 Gender: M
 DOB: [REDACTED] MRN: [REDACTED] Age: 68
 Account: [REDACTED] Ht/Wt: 72 in 291 lb BP: 136 / 77
 Access#: [REDACTED]

Ordering physician: Mohsin, Safder
 Referring physician: Mohsin, Safder
 Attending physician: Mohsin, Safder
 Reading physician: Eric P Burseth, MD
 Sonographer: Gustavo Felix, RDCS
 Nurse: Jodi D'Ambrosia Beverly Wilk

Reason for Study: Chest pain. Chest pain.

STUDY DATA: Stress echocardiography, 2D. Study status: Routine. Location: St. Alexius Medical Center Patient status: Inpatient. Body surface area: BSA: 2.65 m². Consent: The risks, benefits, and alternatives to the procedure were explained to the patient and informed consent was obtained. Location: Echo laboratory. Procedure: Initial setup. A baseline ECG was recorded. Intravenous access was obtained. Surface ECG leads and manual cuff blood pressure measurements were monitored. Transthoracic echocardiography. Image quality was adequate. The study was technically limited due to poor acoustic window availability. Dobutamine stress test. Stress testing was performed, with dobutamine infusion from 5 to 20 mcg/kg/min by 5 mcg/kg/min increments. Patient was also given atropine 1 mg IVP in divided doses to try to attain target heart rate. The infusion was terminated due to maximal dose administration. A pharmacologic approach was used because the patient was physically unable to exercise and because the patient failed to reach the target heart rate in a previous nondiagnostic exercise stress test. Exercise testing was performed. Post-stress images obtained within 90 seconds of peak stress. Transthoracic stress echocardiography. Image quality was adequate. The study was technically limited due to poor acoustic window availability. Images were captured at baseline, low dose, peak dose, and recovery. Intravenous contrast (Definity) was administered. Study completion: All catheters inserted during the procedure were removed. The patient tolerated the procedure well. There were no complications.

CONCLUSIONS

SUMMARY:

- Stress: The patient experienced no chest pain during stress.
- Stress ECG conclusions: Normal dobutamine stress EKG, however, the sensitivity is decreased since low maximal heart rate. Occasional PVC Isolated PAC with aberrant conduction.
- Stress echo: There is no echocardiographic evidence for stress-induced ischemia to the level of stress attained. The sensitivity is decreased since low maximal heart rate and images were technically suboptimal in the parasternal views but normal increase in contractility seen in the apical views which were of good quality.

OBSERVATIONS

BASELINE ECG: Nonspecific T wave changes.

STRESS PROTOCOL:

Stage	HR	BP (mmHg)
Baseline	63	136/77 (97)
Peak stress	125	158/90 (113)

STRESS RESULTS: Maximal heart rate during stress was 125 bpm (82% of maximal predicted heart rate). The maximal predicted heart rate was 152 bpm. The target heart rate was not achieved. The heart rate response to stress is normal.

[REDACTED] - 11/13/2015

There is a normal resting blood pressure with an appropriate response to stress. The rate-pressure product for the peak heart rate and blood pressure was 19750 mm Hg/mln. The patient experienced no chest pain during stress.

STRESS ECG: Normal dobutamine stress EKG, however, the sensitivity is decreased since low maximal heart rate. Occasional PVC Isolated PAC with aberrant conduction..

STRESS ECHO RESULTS: Left ventricular ejection fraction was normal at rest and with stress. Resting LVEF of 60%. There is no echocardiographic evidence for stress-induced ischemia to the level of stress attained. The sensitivity is decreased since low maximal heart rate and images were technically suboptimal in the parasternal views but normal increase in contractility seen in the apical views which were of good quality.

Prepared and electronically signed by
Eric P Burseth, MD
11/13/2015 17:39

ALEXIAN BROTHERS HOSPITAL NETWORK

Alexian Brothers Medical Center
 800 Biesterfield Road
 Elk Grove Village, IL 60007
 (847) 437-5500 Lab Ext. 4555

St. Alexius Medical Center
 1555 Barrington Road
 Hoffman Estates, IL 60169
 (847) 490-6934

LABORATORY DAILY SUMMARY REPORT

Name : ██████████ DOB: ██████████ Sex: M
 Acct#: ██████████ Unit#: ██████████ Location: F.3N

**** COAGULATION ****

Date	11/11/15			Reference	Units
Time	1018				
ProTime	14.1			(12.2-15.1)	SECONDS
INR	1.06(B)			(0.80-1.20)	
(B) INR Therapeutic Range:					
	Normal:	2.0 - 3.0			
	High Intensity:	2.5 - 3.5			
PTT	43.4(C) H			(24.6-36.9)	SECONDS
(C) Heparin Therapeutic Range: 73.0 - 110.0 seconds					
DDIMER QUANT	2.38(D) E			(<0.50)	ug/mlFEU
(D) The STA Liatest D-Dimer may be used as an aid in excluding DVT and PE when combined with clinical evaluation. Studies show levels < 0.50 ug/ml (FEU) have a negative predictive value of 95-100%. Levels 0.50 ug/ml (FEU) and greater have many causes and are not specific.					

**** CHEMISTRY ****

Date	11/12/15	11/11/15			Reference	Units
Time	0517	2234	1018			
SODIUM			143		(136-145)	mmol/L
POTASSIUM			4.2		(3.5-5.1)	mmol/L
CHLORIDE			107		(98-107)	mmol/L
CO2			30		(21-32)	mmol/L
ANION GAP			6		(5-16)	mmol/L
GLUCOSE			131(E) H		(70-99)	mg/dL
(E) Impaired 100 - 125 mg/dL Diabetic >125 mg/dL						
BUN			13		(7-23)	mg/dL
CREATININE			1.7 H		(0.6-1.3)	mg/dL
BUN/CREA RATIO			8		(7-23)	

I=Low, L=Critical Low, H=High, H=Critical High, D=Delta, A=Abnormal

Acct# ██████████ Loc: F.3N F.308-B

** CONTINUED ON NEXT PAGE **

ALEXIAN BROTHERS HOSPITAL NETWORK

Alexian Brothers Medical Center
 800 Bicasterfield Road
 Elk Grove Village, IL 60007
 (847) 437-5500 Lab Ext. 4555

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 1555 Barrington Road
 Hoffman Estates, IL 60169
 (847) 490-6934

LABORATORY DAILY SUMMARY REPORT

Name: [REDACTED] DOB: [REDACTED] Sex: M
 Acct#: [REDACTED] Unit#: [REDACTED] Location: F.3N

*** CHEMISTRY *** (continued)

Date	11/12/15	11/11/15		Reference	Units
Time	0517	2234	1018		
EGFR			43(F)		
(F) Reference Range in mL/min/1.73 squared >60 = Normal (Unless evidence of kidney damage exists) 59 - 30 = Chronic Kidney Disease Stage 3 29 - 15 = Chronic Kidney Disease Stage 4 <15 = Chronic Kidney Disease Stage 5 If patient is African-American, multiply result by 1.21.					
CALCIUM			8.9	(8.5-10.1)	ng/dL
PROTEIN TOT			7.3	(6.4-8.2)	g/dL
ALBUMIN			2.9 I	(3.4-5.0)	g/dL
GLOBULIN			4.4	(1.4-4.8)	g/dL
A/G RATIO			0.7 I	(1.0-1.9)	g/dL
AST (SGOT)			23	(<37)	U/L
ALT (SGPT)			18	(16-61)	U/L
ALKP TOTAL			142 H	(45-117)	U/L
BILI TOTAL			0.4	(<1.0)	mg/dL
MAGNESIUM			2.1	(1.8-2.4)	mg/dL
TROPONIN I	<0.39	<0.39	<0.39	(0.00-0.39)	ng/mL
BNP			20(G)	(7-67)	pg/mL

(G) Patients taking Natrecor may show elevated results, since Natrecor is a Natriuretic Peptide.

THE CLINICAL UTILITY OF SERIAL BNP MEASUREMENTS HAS NOT BEEN ESTABLISHED AND THE PRACTICE IS NOT SUPPORTED BY THE AMERICAN COLLEGE OF CARDIOLOGISTS.

BNP testing should be used during the initial evaluation of a patient with possible heart failure and to differentiate heart failure from other causes of dyspnea only when the diagnosis is uncertain. In addition, a pre-discharged BNP may be indicated for risk stratification to determine adequacy of therapy to develop a management plan.

L=Low, L*=Critical Low, H=High, H*=Critical High, D=Delta, A=Abnormal

Acct# [REDACTED] Loc: F.3N F.308-B

** CONTINUED ON NEXT PAGE **

ALEXIAN BROTHERS HOSPITAL NETWORK

Alexian Brothers Medical Center
808 Biesterfield Road
Elk Grove Village, IL 60007
(847) 437-5500 Lab Ext. 4555

St. Alsegius Medical Center
1555 Barrington Road
Hoffman Estates, IL 60169
(847) 490-6934

LABORATORY DAILY SUMMARY REPORT

Name : [REDACTED] DOB: [REDACTED] Sex: M
Acct#: [REDACTED] Unit#: [REDACTED] Location: F.3N

**** POINT OF CARE LAB TESTS ****

Date	11/17/15				Reference	Units
Time	2130	1215	1137	0641		
GLUCOSE POCT	89(H)	77(I)	69(J) L	83(K)	(70-99)	mg/dL
	(H) Perf By: NATH, LISA					
	(I) Perf By: NATH, LISA					
	(J) Perf By: MUNOZ, VANESSA					
	Notified RN					
	(K) Perf By: JORDAN, ROWENA					

Date	11/16/15				Reference	Units
Time	2112	1545	1142	0621		
GLUCOSE POCT	105(L) H	159(M) H	93(N)	112(O) H	(70-99)	mg/dL
	(L) Perf By: ZUNIGA, JENNIFER					
	(M) Perf By: D'ACQUISTO, ADRIANA A					
	(N) Perf By: MUNOZ, VANESSA					
	Notified RN					
	(O) Perf By: VELASQUEZ, PETER					

Date	11/15/15				Reference	Units
Time	2043	1639	1133	0659		
GLUCOSE POCT	118(P) H	115(Q) H	135(R) H	112(S) H	(70-99)	mg/dL
	(P) Perf By: AMIN, VITALBEN					
	Notified RN					
	(Q) Perf By: AMIN, VITALBEN					
	Notified RN					
	(R) Perf By: BULLER, VERNA					
	(S) Perf By: APOSTLE, SHANNON					

L=Low, L*=Critical Low, H=High, H*=Critical High, D=Delta, A=Abnormal

[REDACTED] Acct# [REDACTED] Loc: F.3N F.308-B

** CONTINUED ON NEXT PAGE **

ALEXIAN BROTHERS HOSPITAL NETWORK

Alexian Brothers Medical Center
 800 Biesterfield Road
 Elk Grove Village, IL 60007
 (847) 437-5500 Lab Ext. 4555

St. Alexius Medical Center
 1555 Barrington Road
 Hoffman Estates, IL 60169
 (847) 490-6934

LABORATORY DAILY SUMMARY REPORT

Name : [REDACTED] DOB: [REDACTED] Sex: M
 Acct#: [REDACTED] Unit#: [REDACTED] Location: F.3N

**** POINT OF CARE LAB TESTS **** (continued)

Date	11/14/15				Reference	Units
Time	2126	1628	1133	0613		
GLUCOSE POCT	137(T) H	114(U) H	94(V)	104(W) H	(70-99)	mg/dL
	(T) Perf By: BRAVATA, SAMANTHA					
	(U) Perf By: BRAVATA, SAMANTHA					
	(V) Perf By: BULLER, VERNA					
	(W) Perf By: JORDAN, ROWENA					

Date	11/13/15				Reference	Units
Time	2134	1823	1609	1221		
GLUCOSE POCT	146(X) H	65(Y) I	66(Z)	116(AA) H	(70-99)	mg/dL
	(X) Perf By: AMIN, VITALBEN					
	(Y) Perf By: SI, XIAO					
	(Z) Perf By: SI, XIAO					
	(AA) Perf By: ROMERO-DIAZ, MAYIRA					

Date	11/13/15	11/12/15		Reference	Units
Time	0525	2103	1633	1302	
GLUCOSE POCT	95(AB)	121(AC) H	93(AD)	163(AE) H	(70-99) mg/dL
	(AB) Perf By: VELASQUEZ, PETER				
	(AC) Perf By: SI, XIAO				
	(AD) Perf By: BRAVATA, SAMANTHA				
	(AE) Perf By: CORONA, AMANDA				

Date	11/12/15	11/11/15	Reference	Units
Time	0510	2054		
GLUCOSE POCT	101(AF) H	97(AG)		(70-99) mg/dL
	(AF) Perf By: VELASQUEZ, PETER			
	(AG) Perf By: AMIN, VITALBEN			
	Notified RN			

L=Low, L*=Critical Low, H=High, H*=Critical High, D=Delta, A=Abnormal

[REDACTED]

Acct# [REDACTED]

Loc: F.3N F.308-B

** CONTINUED ON NEXT PAGE **

ALEXIAN BROTHERS HOSPITAL NETWORK

Alexian Brothers Medical Center
800 Biesterfield Road
Elk Grove Village, IL 60007
(847) 437-5500 Lab Ext. 4555

St. Alexius Medical Center
1555 Barrington Road
Hoffman Estates, IL 60169
(847) 490-6934

LABORATORY DAILY SUMMARY REPORT

Name: [REDACTED] DOB: [REDACTED] Sex: M
Acct#: [REDACTED] Unit#: [REDACTED] Location: F.3N

Microbiology Specimen Summary

Col	Date	Time	Specimen #	Source	Sp Desc	P/F	Organisms
>	11/11/15	1454	15:BC0028257S	Blood	Peripheral	F	<none>
>	11/11/15	1456	15:BC0028258S	Blood	Peripheral	F	<none>

L=Low, L*=Critical Low, H=High, H*=Critical High, D=Delta, A=Abnormal

[REDACTED]

Acct# [REDACTED]

Loc: F.3N F.308-B

** CONTINUED ON NEXT PAGE **

ALEXIAN BROTHERS HOSPITAL NETWORK

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800 Biesterfield Road
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St. Alexius Medical Center
1555 Barrington Road
Hoffman Estates, IL 60169
(847) 490-6934

LABORATORY DAILY SUMMARY REPORT

Name: [REDACTED] DOB: [REDACTED] Sex: M
Acct#: [REDACTED] Unit#: [REDACTED] Location: F.3N

*** MICROBIOLOGY ***

Specimen: 15:BC0028257S _____ Collected: 11/11/15
Source/Description: Blood - Peripheral
CULTURE, BLOOD (*a) Final 11/16/15
No growth after 5 days incubation.

CULTURE, BLOOD (*a) Preliminary (changed)
No growth after 4 days incubation.
Culture will be held 1 more day.

CULTURE, BLOOD (*a) Preliminary (changed)
No growth after 3 days incubation.
Culture will be held 2 more days.

CULTURE, BLOOD (*a) Preliminary (changed)
No growth after 2 days incubation.
Culture will be held 3 more days.

CULTURE, BLOOD (*a) Preliminary (changed)
No growth after 1 day of incubation.
Culture will be held 4 more days.

Specimen: 15:BC0028258S _____ Collected: 11/11/15
Source/Description: Blood - Peripheral
CULTURE, BLOOD (*a) Final 11/16/15
No growth after 5 days incubation.

CULTURE, BLOOD (*a) Preliminary (changed)
No growth after 4 days incubation.
Culture will be held 1 more day.

CULTURE, BLOOD (*a) Preliminary (changed)
No growth after 3 days incubation.
Culture will be held 2 more days.

NOTES: (*a) ALEXIAN BROTHERS MED CTR
TEST PERFORMED AT ALEXIAN BROTHERS MEDICAL CENTER
800 W. BIESTERFIELD ROAD, ELK GROVE VILLAGE, IL 60007

L=Low, I=Critical Low, H=High, H=Critical High, D=Delta, A=Abnormal

Acct# [REDACTED] Loc: F.3N F.308-B

** CONTINUED ON NEXT PAGE **

ALEXIAN BROTHERS HOSPITAL NETWORK

Alexian Brothers Medical Center
800 Biesterfield Road
Elk Grove Village, IL 60007
(847) 437-5500 Lab Ext. 4555

St. Alexius Medical Center
1555 Barrington Road
Hoffman Estates, IL 60169
(847) 490-6934

LABORATORY DAILY SUMMARY REPORT

Name: [REDACTED] DOB: [REDACTED] Sex: M
Acct#: [REDACTED] Unit#: [REDACTED] Location: F.3N

*** MICROBIOLOGY *** (continued)

Specimen: 15:BC00282585 Collected: 11/11/15
Source/Description: Blood - Peripheral
CULTURE, BLOOD (*b) Preliminary (changed)
No growth after 2 days incubation.
Culture will be held 3 more days.

CULTURE, BLOOD (*b) Preliminary (changed)
No growth after 1 day of incubation.
Culture will be held 4 more days.

NOTES: (*b) ALEXIAN BROTHERS MED CTR
TEST PERFORMED AT ALEXIAN BROTHERS MEDICAL CENTER
800 W. BIESTERFIELD ROAD, ELK GROVE VILLAGE, IL 60007

I=Low, L*=Critical Low, H=High, H*=Critical High, D=Delta, A=Abnormal

[REDACTED]

Acct#: [REDACTED]

Loc: F.3N F.308-B

** END OF REPORT **

St Alexius Medical Center
1555 BARRINGTON RD
HOFFMAN ESTATES IL 60169
1-847-843-2000

DEPARTMENT OF DIAGNOSTIC IMAGING

UNIT/MR# [REDACTED]
ROOM#: F.ERAC2R14-A Sex: M
LOC: F.ERHOLD
DOB: [REDACTED] Age: 68
FAX#: [REDACTED]
DATE OF EXAM: 11/11/15

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ORDERING: CHRISTOPHE MCSWANE MD
ATTENDING: SAFDER MOHSIN MD
ADMIT DATE: 11/11/15

Signed

1111-0182/I00D002134583 CT/HD (70450) ;

CT brain without IV contrast.

Indication:
Altered mental status

Technique: Images are obtained of the brain without IV contrast.

Comparison: None.

FINDINGS:
Motion artifact limits the diagnostic utility of the images.

CT scan of the brain shows that there is no gross extra-axial fluid collection, midline shift, mass effect, acute intracranial hemorrhage or hydrocephalus. The visualized paranasal sinuses are clear bilaterally. No acute appearing calvarial fracture.
Moderate diffuse atrophy.

Impression:
Motion artifact limits the diagnostic utility of the images.
No gross acute intracranial abnormality is seen as described.

Report #: 1111-1066 CAT SCAN

CC: CHRISTOPHE MCSWANE MD, NONE NONE ; SAFDER MOHSIN MD

end copies to~

Page: 1
Dept: DI

St Alexius Medical Center

Name [REDACTED]
Unit/MR# [REDACTED] A# [REDACTED]

Dictated By: JEFFREY E CHUNG MD

Signed By: <Electronically signed by JEFFREY E CHUNG MD in OV> 11/11/15 1847

DD: 11/11/15 1841 DT: 11/11/15 1841
CHUJE/ 1111-1066

Report #: 1111-1066 CAT SCAN

CC: CHRISTOPHE MCSWANE MD; NONE NONE ; SAFDER MOHSIN MD

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Page: 2
Dept: DI

St Alexius Medical Center
1555 BARRINGTON RD
HOFFMAN ESTATES IL 60169
1-847-843-2000

DEPARTMENT OF DIAGNOSTIC IMAGING

UNIT/MR# [REDACTED]
ROOM#: Sex: M
LOC: F, ER
DOB [REDACTED] Age: 68
FAX#:
DATE OF EXAM: 11/11/15

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ORDERING: CHRISTOPHE MCSWANE MD
ATTENDING:
ADMIT DATE: 11/11/15

Signed

1111-0140/10000D2134211 CT/CXR (71250) ;

CT chest without contrast

Information: 68-year-old with chest pain. Preceding portable chest radiograph suggested right-sided mediastinal soft tissue prominence.

Technique: No IV contrast was administered; patient reportedly had evidence of a degree of renal insufficiency based on function tests. Axial images were obtained from level of thoracic inlet through upper abdomen, final meter slice thickness.

FINDINGS: The heart is moderately enlarged and there are left coronary artery calcifications. No significant atherosclerotic changes noted involving aorta with only minimal arch plaque there is, however, a degree of dilatation of the ascending thoracic aorta which measures up to 4.8 cm AP diameter. No definite findings to indirectly suggest presence of dissection (i.e., no displaced or any intimal calcification to suggest flap), although exam is limited for that evaluation. No evidence of mediastinal or hilar lymphadenopathy.

There are patchy and nodular appearing airspace infiltrates within the right lower lobe. Lesser amount of left basilar atelectasis, less likely infiltrate. No evidence of pleural effusion.

There is bilateral gynecomastia. Degenerative disc changes of spine.

IMPRESSION:

1. Cardiomegaly and coronary atherosclerosis.
 2. Degree of aneurysmal dilatation of ascending thoracic aorta. This measures up to slightly under 5 cm diameter. No definite or indirect
- Report #: 1111-0612 CAT SCAN

Page: 1
Dept: DI

CC: CHRISTOPHE MCSWANE MD; NONE NONE

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St Alexius Medical Center

Name

Unit/MR#

A#

evidence of a dissection flap, although evaluation is suboptimal without IV contrast material.

3. Patchy/nodular right lower lobe infiltrates. May represent pneumonia.

Atypical pneumonia? Lesser amount of left basilar atelectasis.

4. Gynecomastia.

Dictated By: JOHN F BOCHNIAK MD

Signed By: <Electronically signed by JOHN F BOCHNIAK MD in OV> 11/11/15 1326

DD: 11/11/15 1307 DT: 11/11/15 1307
BOCJO1/ 1111-0612

Report #: 1111-0612 CAT SCAN

CC: CHRISTOPHE MCSWANE MD; NONE NONE

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Page: 2
Dept: DI

St Alexius Medical Center
1555 BARRINGTON RD
HOFFMAN ESTATES IL 60169
1-847-843-2000

DEPARTMENT OF DIAGNOSTIC IMAGING

UNIT/MR# [REDACTED]
ROOM#: Sex:M
LOC: F,ER
DOB: [REDACTED] Age:68
FAX#:
DATE OF EXAM: 11/11/15

PATIENT: [REDACTED]
ACCT# [REDACTED]
ORDERING: CHRISTOPHE MCSWANE MD
ATTENDING:
ADMIT DATE: 11/11/15

Signed

1111-0050/1000002134212 NM/LUNGV (78582) ;

Nuclear medicine lung scan ventilation and perfusion

History: Elevated d-dimer.

Technique:

Ventilation portion of the lung scan was performed during which 9.70 mCi of xenon-133 xenon gas was inhaled. Images were obtained in the posterior projection. Rebreathing and washout images were obtained. Then, the perfusion portion of the lung scan was performed during which 3.50 mCi of Tc 99m MAA was administered intravenously. D to patient being combative, only anterior and posterior perfusion views were obtained.

Correlation was made with the chest x-ray performed on the same day.

Findings:

On the ventilation portion of the study, there is heterogeneous deposition of radiotracer seen within the periphery of both lungs. Symmetric washout was noted.

On the perfusion portion of the study, there is heterogeneous deposition of radiotracer seen within the periphery of both lungs corresponding to the abnormality visualized on the ventilation portion of the study. No mismatched defects were noted. There are no segmental wedge shaped defects that extend into the pleura.

Impression:

1. Low probability for pulmonary embolism.

Report #: 1111-0755 NUC MED

Page: 1
Dept: DI

CC: CHRISTOPHE MCSWANE MD; NONE NONE

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St Alexius Medical Center

Name: [REDACTED]

Unit/MR#: [REDACTED] A# [REDACTED]

Dictated By: UMESH C AMIN MD

Signed By: <Electronically signed by UMESH C AMIN MD in OV> 11/11/15 1439

DD: 11/11/15 1434 DT: 11/11/15 1434
AMIUM/ 1111-0755

Report #: 1111-0755 NUC MED

CC: CHRISTOPHE MCSWANE MD; NONE NONE

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Page: 2
Dept: DI

St Alexius Medical Center
1555 BARRINGTON RD
HOFFMAN ESTATES IL 60169
1-847-843-2000

DEPARTMENT OF DIAGNOSTIC IMAGING

UNIT/MR#: [REDACTED] PATIENT: [REDACTED]
ROOM#: Sex: M ACCT#: [REDACTED]
LOC: F, ER ORDERING: CHRISTOPHE MCSWANE MD
DOB: [REDACTED] Age: 68 ATTENDING:
FAX#: ADMIT DATE: 11/11/15
DATE OF EXAM: 11/11/15

Signed

1111-0052/000002133826 PORT/CXR1 (71010) ;

Portable AP chest 1025

Information: 68-year-old with chest pain

COMPARISON: 11/1/2015 (ABMC)

FINDINGS: Cardiac monitor leads applied. Heart appears mildly enlarged. Normal pulmonary vascularity. Now noted is rounded prominence of the right mediastinal contour. This appears to be present at the level of the proximal ascending thoracic aorta. Milder discoid atelectasis persists at the left lung base.

IMPRESSION:

1. Prominence of right mediastinal margin as described. Recommend chest CT exam with IV contrast material, in particular to evaluate the proximal aorta, to exclude any possibility of aneurysm/dissection. This was communicated to ER physician Dr. McSwane.
2. Mild discoid left basilar atelectasis.

Dictated By: JOHN F. BOCHNIAK, MD

Signed By: <Electronically signed by JOHN F. BOCHNIAK, MD in OV> 11/11/15 1145

DD: 11/11/15 1133 DT: 11/11/15 1133
BOCJO1/ 1111-0454

Report #: 1111-0454 RADIOLOGY

Page: 1
Dept: DI

CC: CHRISTOPHE MCSWANE MD; NONE NONE

end copies to-

St Alexius Medical Center

Name: [REDACTED]

Unit/MR#: [REDACTED]

A# [REDACTED]

Report #: 1111-0454 RADIOLOGY

CC: CHRISTOPHE MCSWANE MD; NONE NONE

end copies to~

Page: 2
Dept: Di

68 years
Male
65in

Caucasian
177lbs

Technician:
Test ind: baseline

Vent. rate 69 bpm
PR interval 192 ms
QRS duration 116 ms
QT/QTc 398/228 ms
P-R-T axes 51 36 81

Normal sinus rhythm
Normal ECG

4-INDV-AV13

1975074

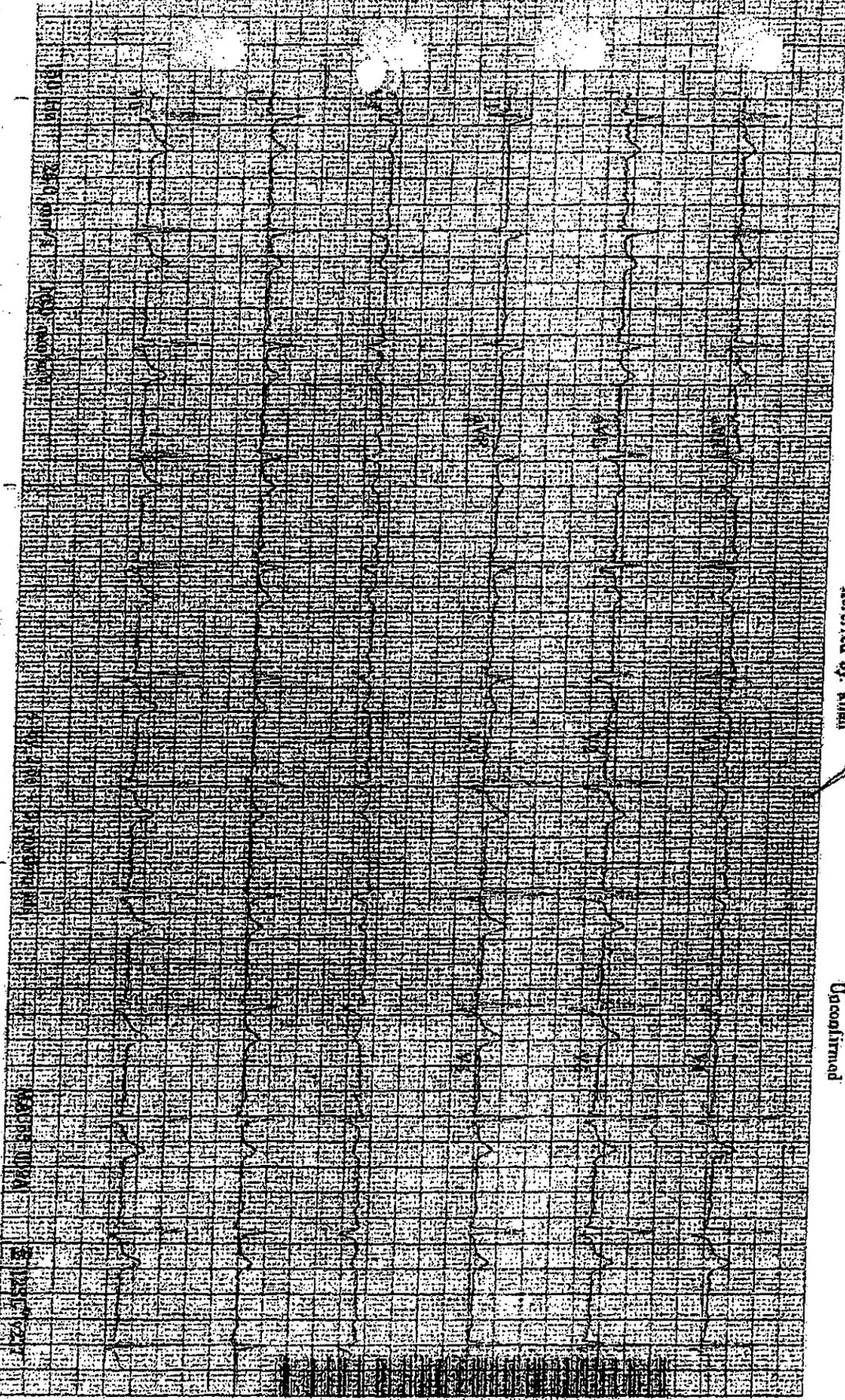
ALBERTA DEPARTMENT OF HEALTH SERVICES

68 M. ROBIN ROBERTS, F. MD
11/01/75
1975074

Referred by: Khan

Unconfirmed

RE
11/15/75
11/14/75



11-NOV-2015 09:31:51

ST. ALEXIUS MED. CTR.-ED ROUTINE RECORD

(68 yr)
Male Caucasian

Vent. rate	76	BPM
PR interval	192	ms
QRS duration	106	ms
QT/QTc	388/436	ms
P-R-T axes	61 41 49	

*** Poor data quality, interpretation may be adversely affected
 Normal sinus rhythm
 Normal ECG
 No previous ECGs available
 Confirmed by Wernick, Mark (12104) on 11/11/2015 10:31:57 AM

Room: 14
Loc: 31

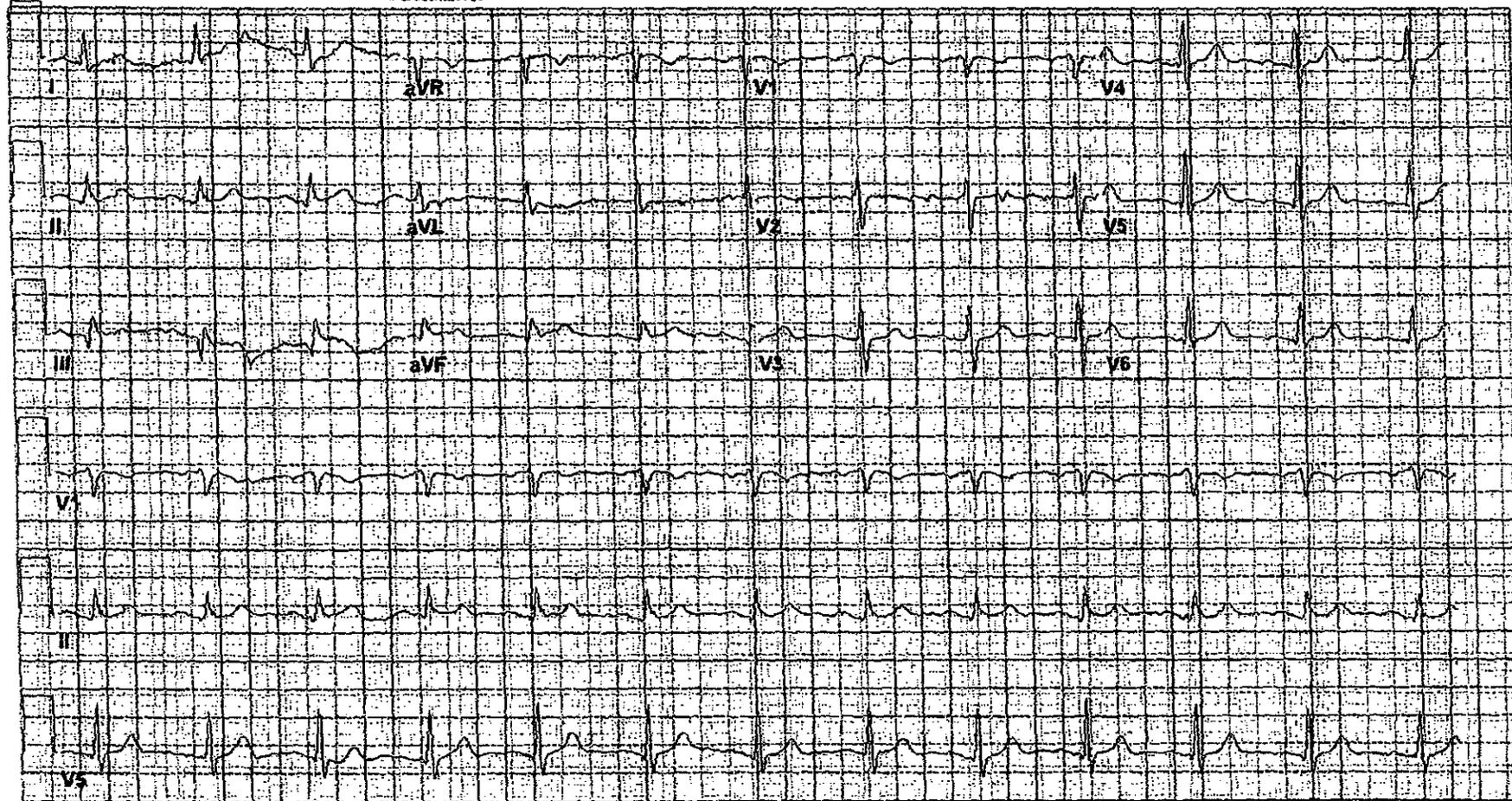
Technician: K LW
Test ind: CHEST PAIN

Referred by: DEPT EMERGENCY

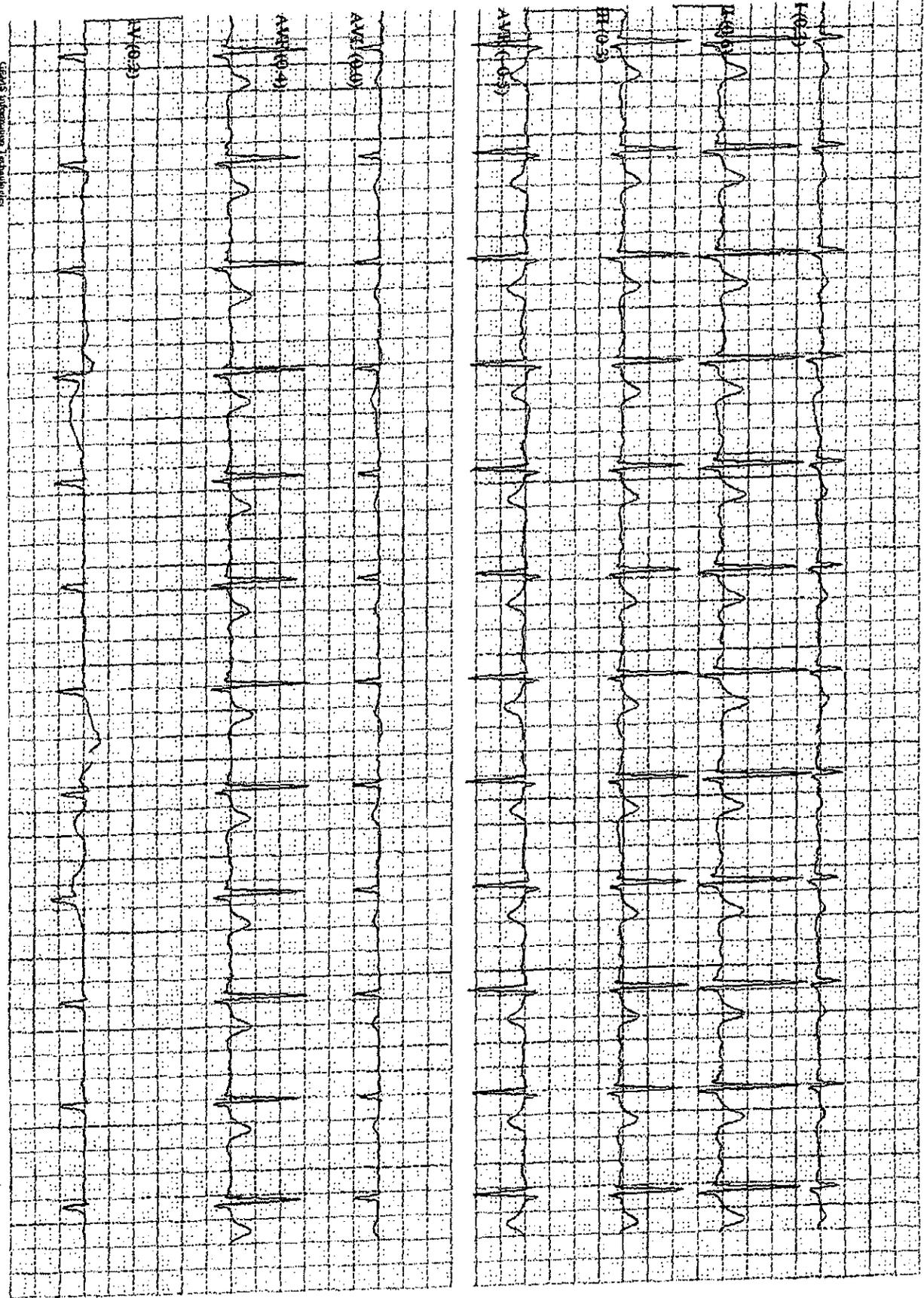
Confirmed By: Mark Wernick

STAT: Yes

COMMENT:



50/100



GEAR'S Subcontractor Technical Support

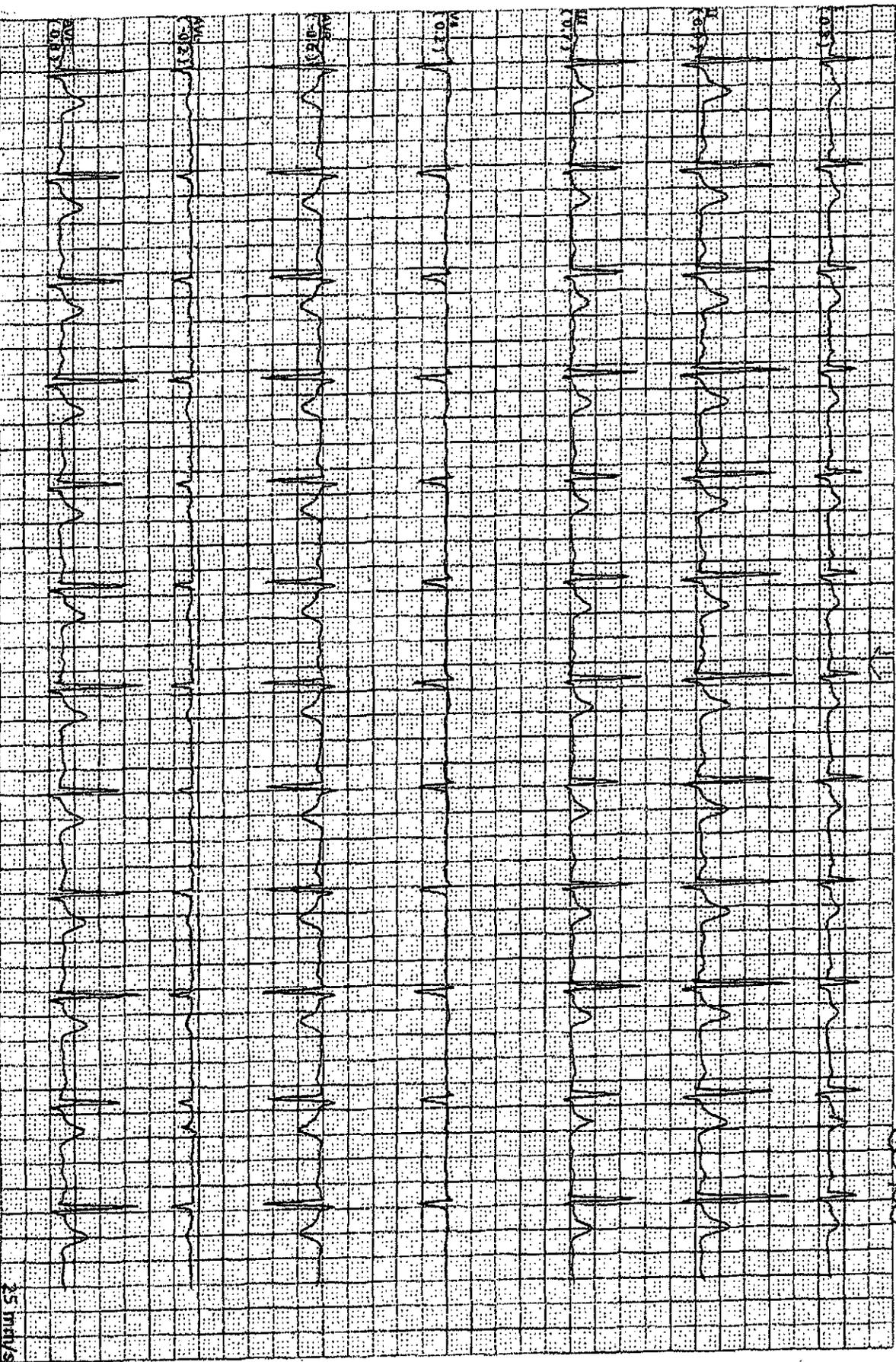
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TTX# 8619AP

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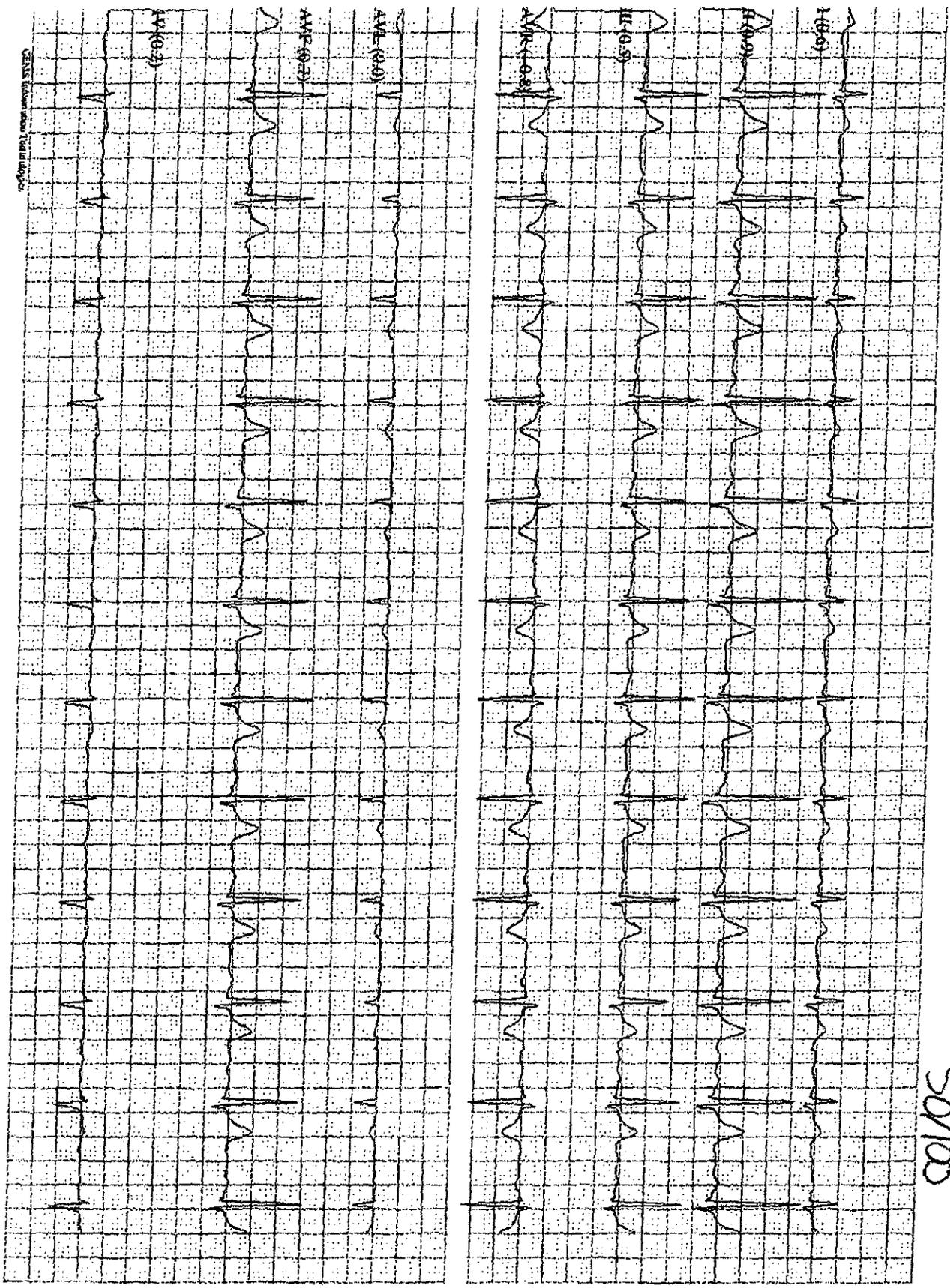
Full Disclosure

TELE 308-B*TTX# 8619AP

EG-100

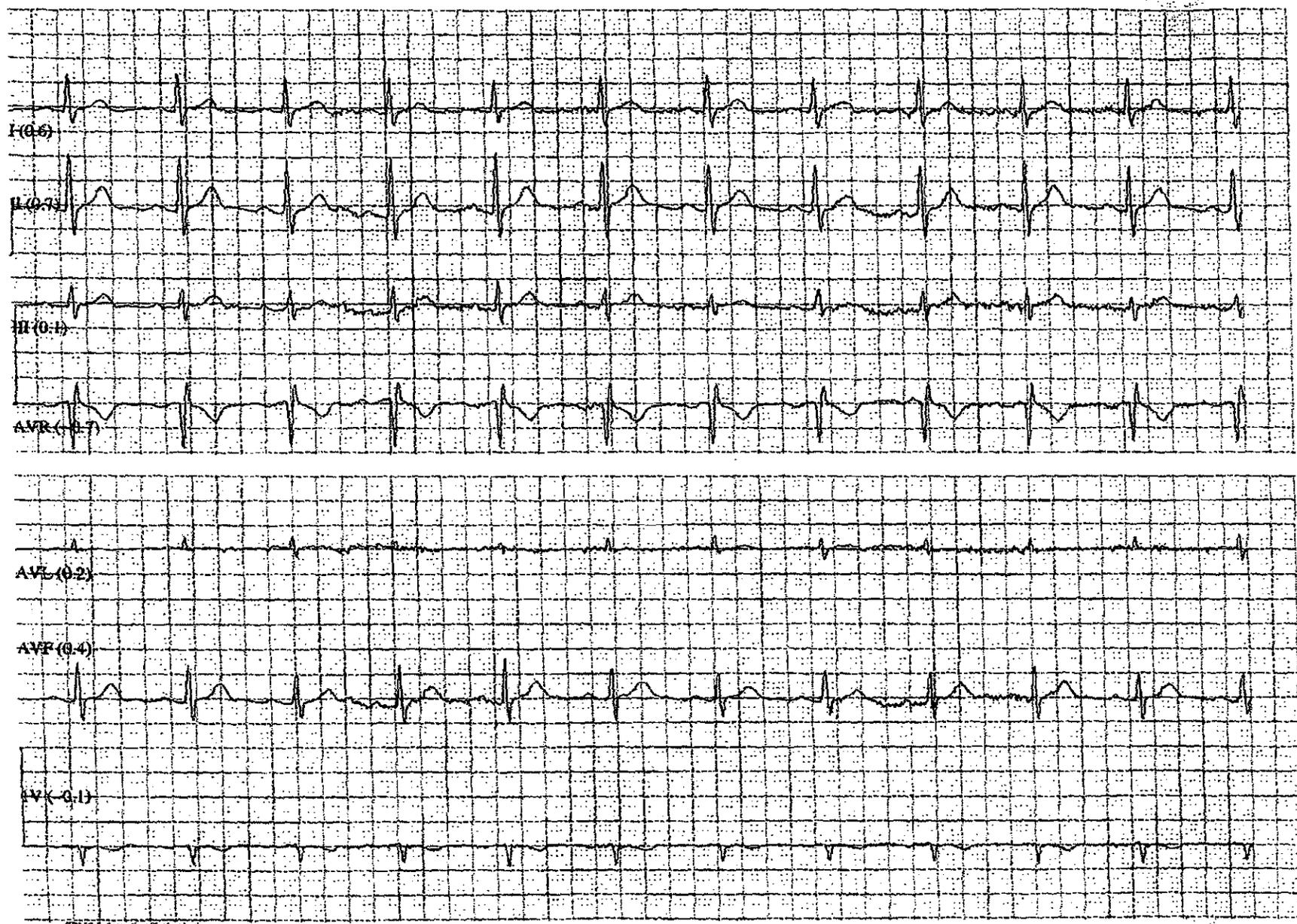


50/100

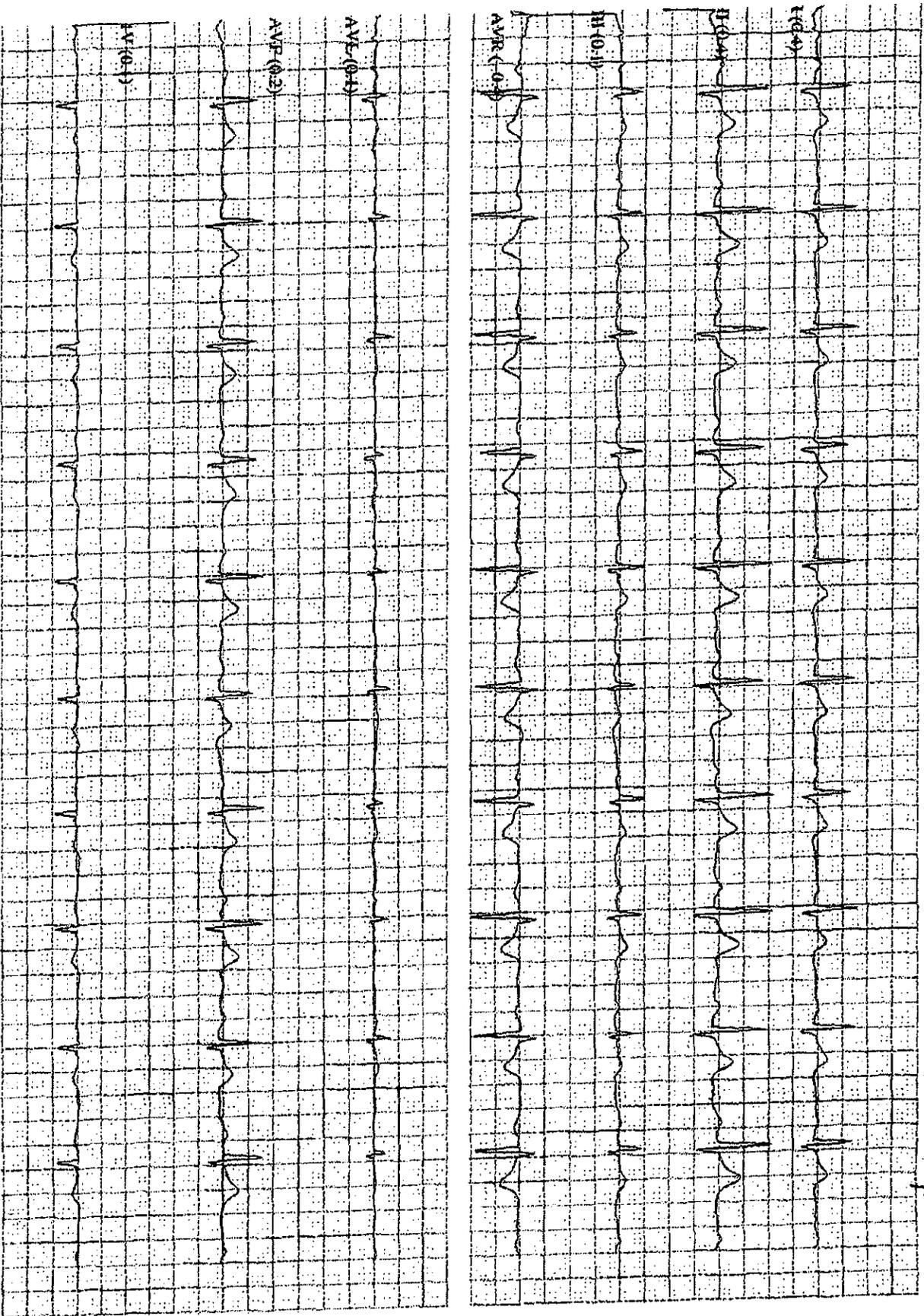


GEVSS (0.000000) T1000 (0.000000)

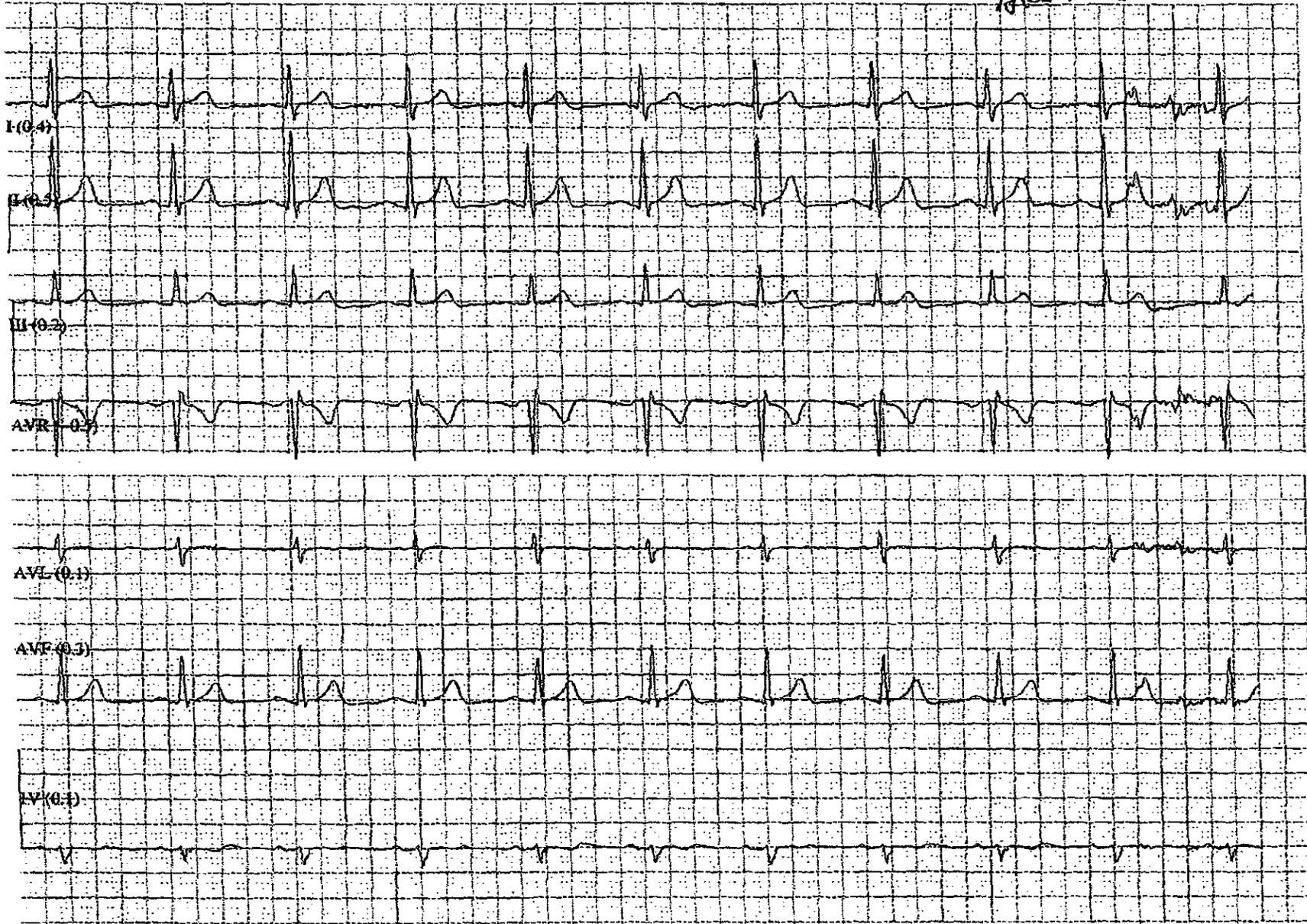
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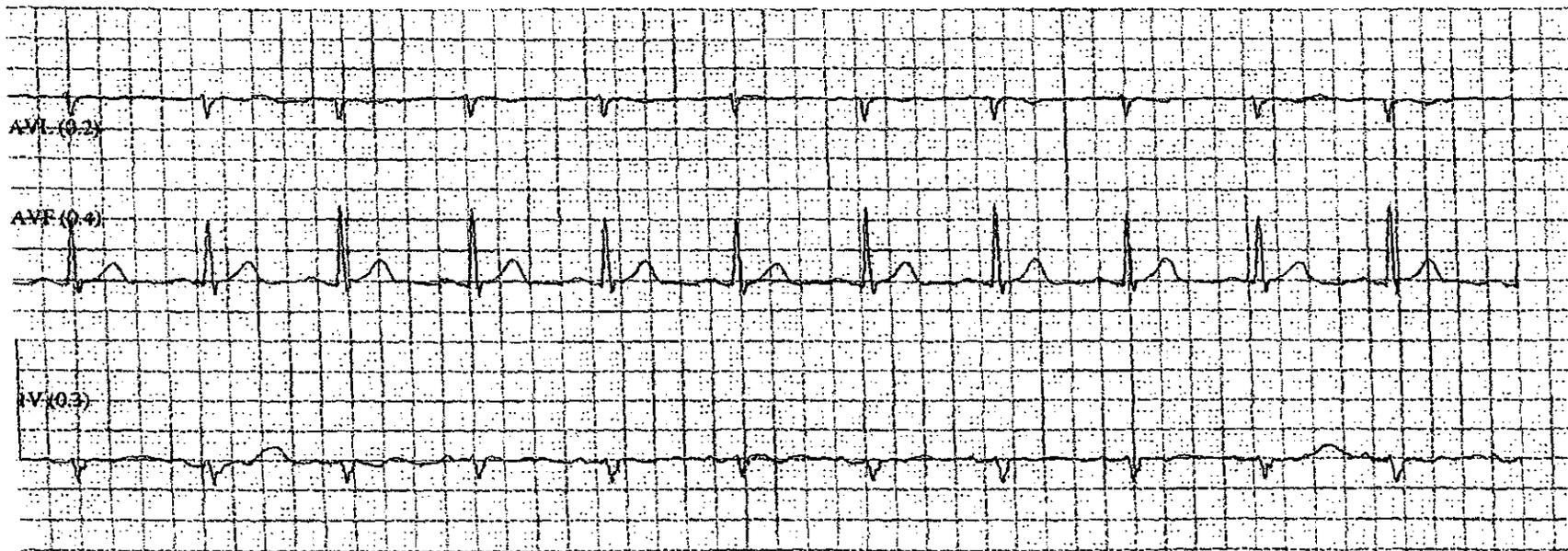
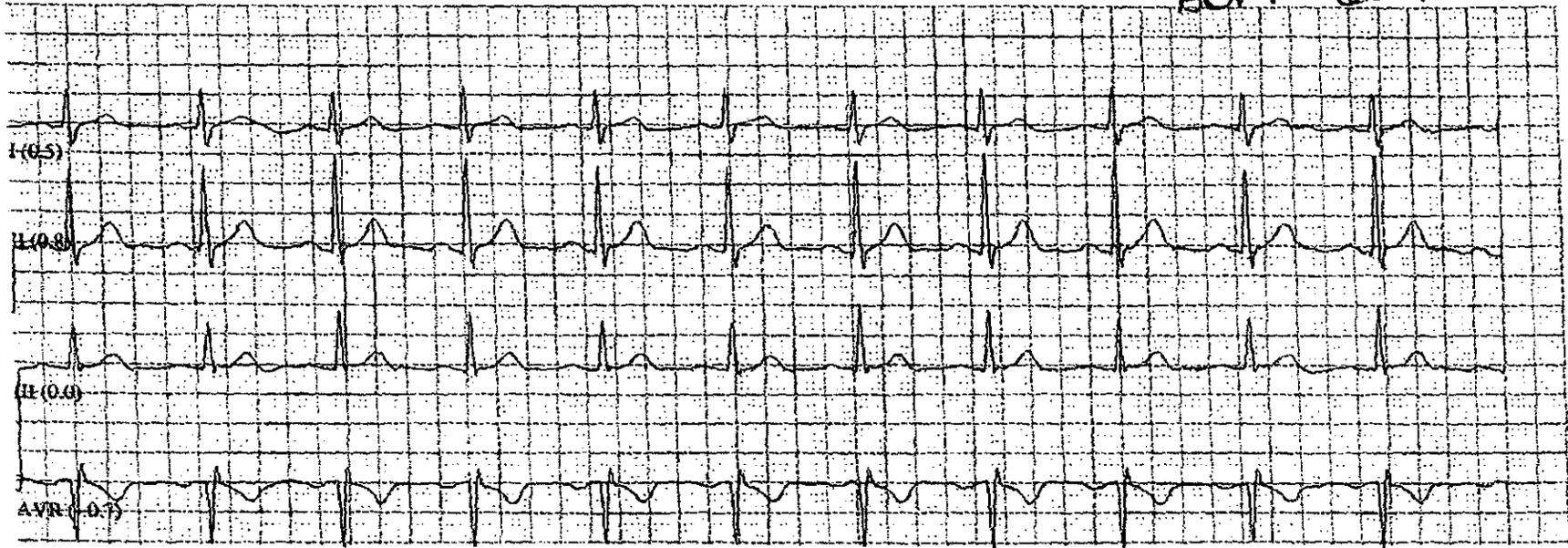
abrm sd/100



Alarm 60-110



Abn (60-100)



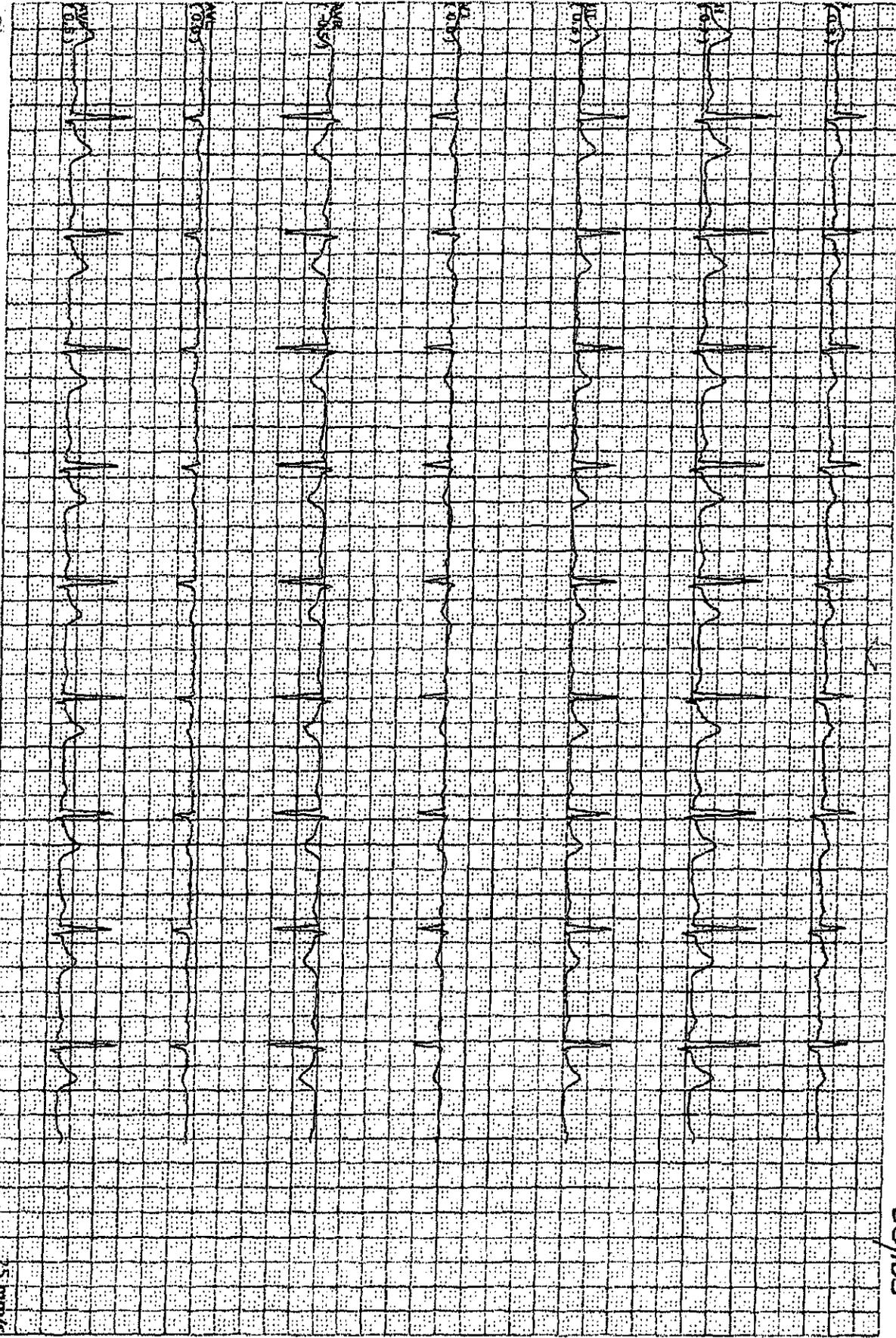
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TTX# 8619AP

14-Nov-2015 22:09:45

Full Disclosure

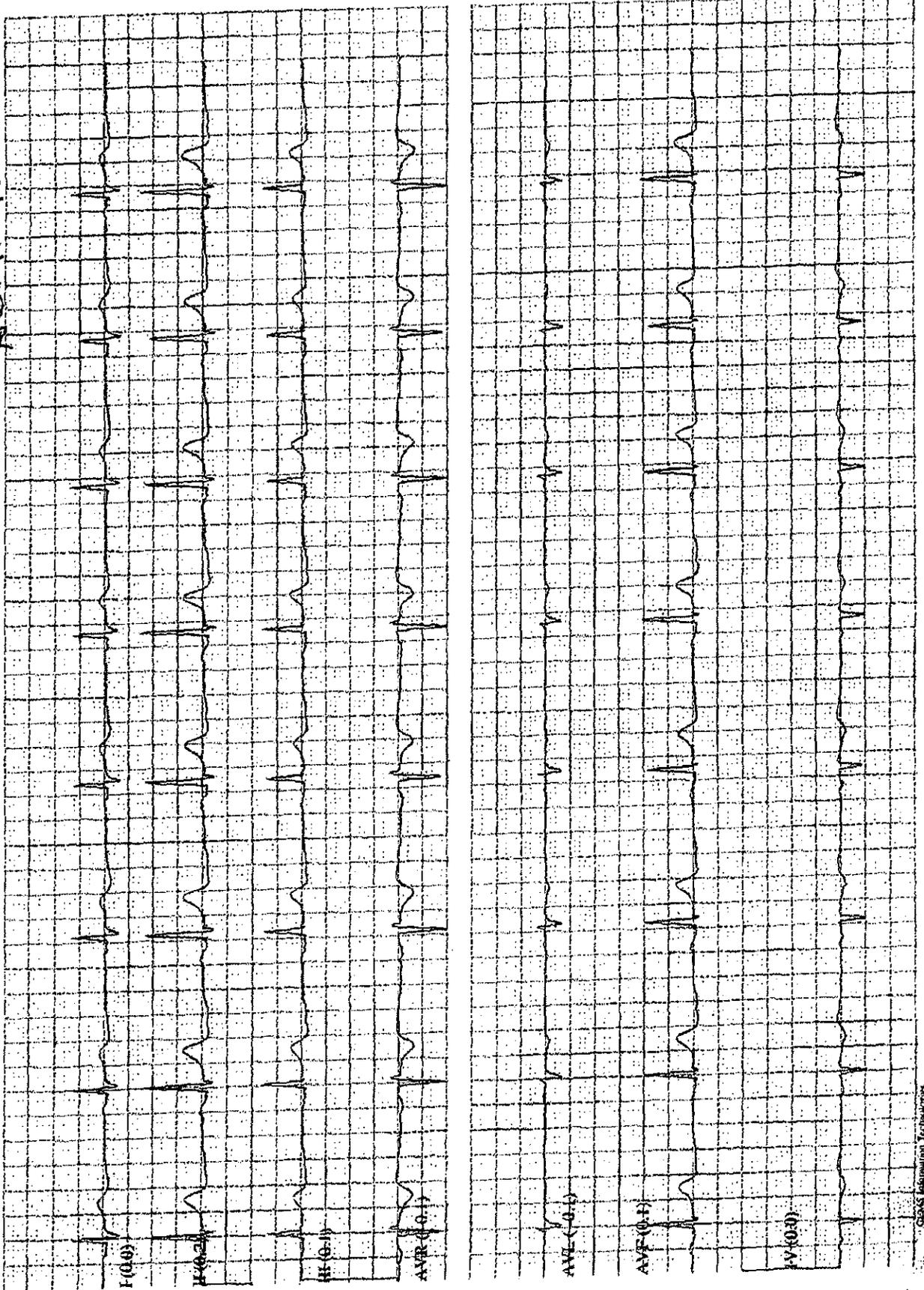
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60/105

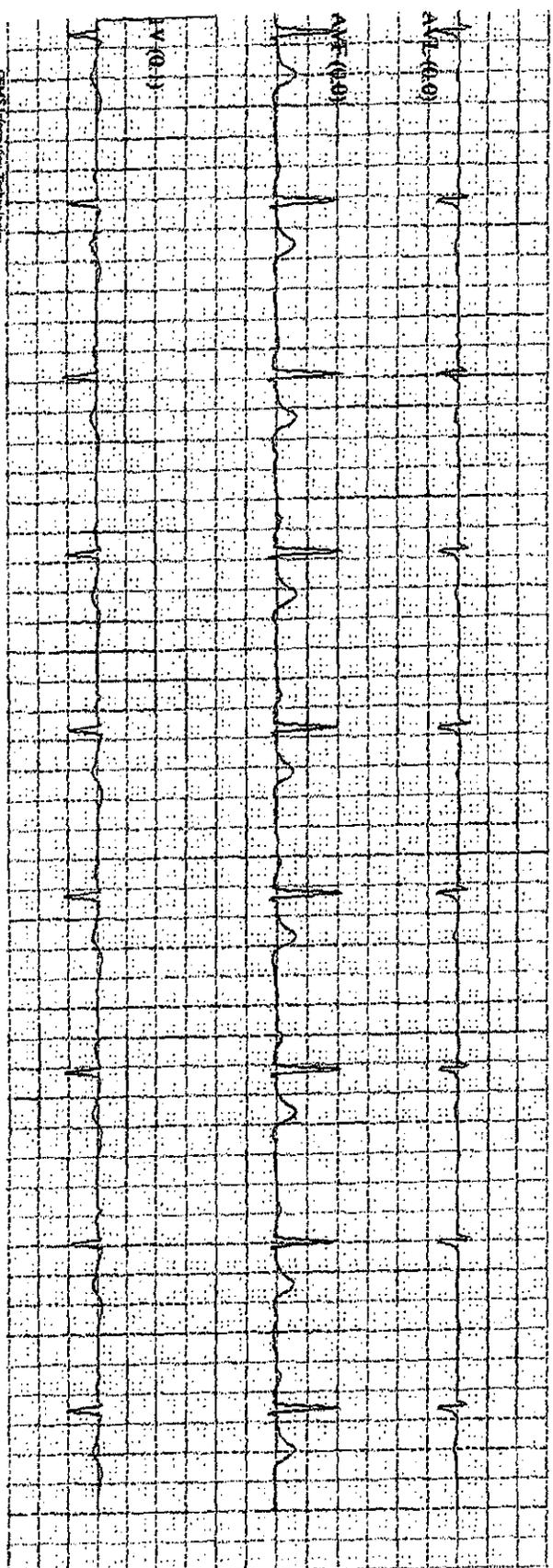
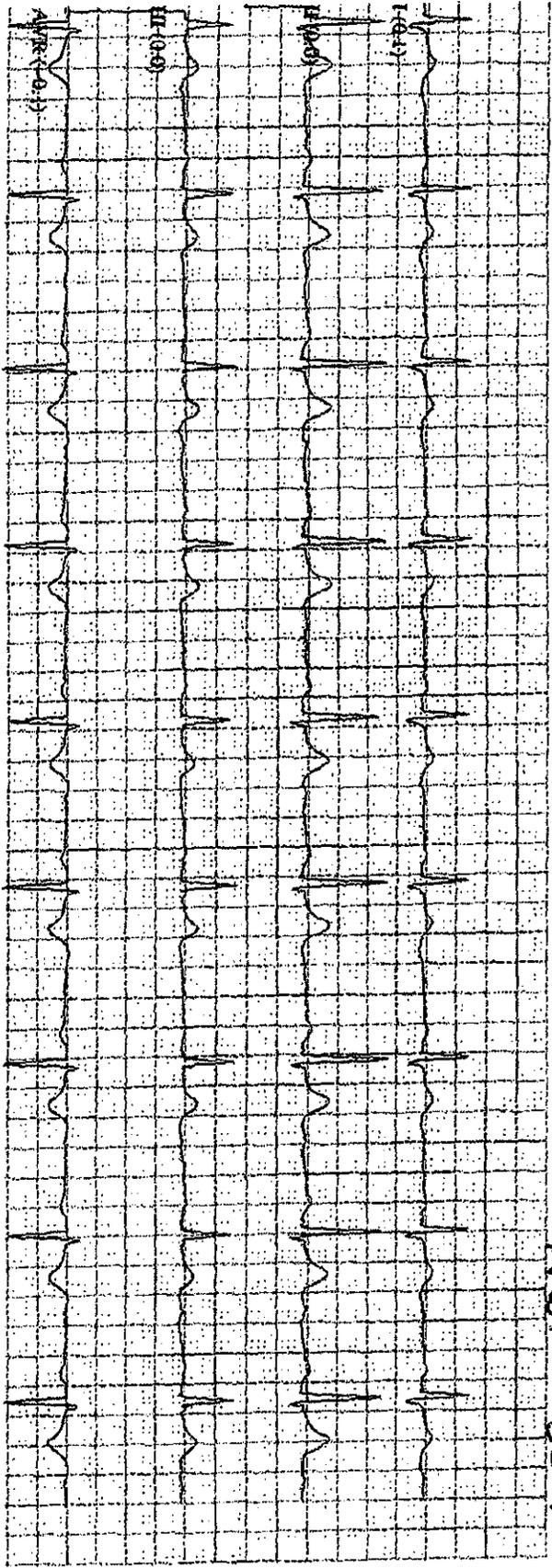


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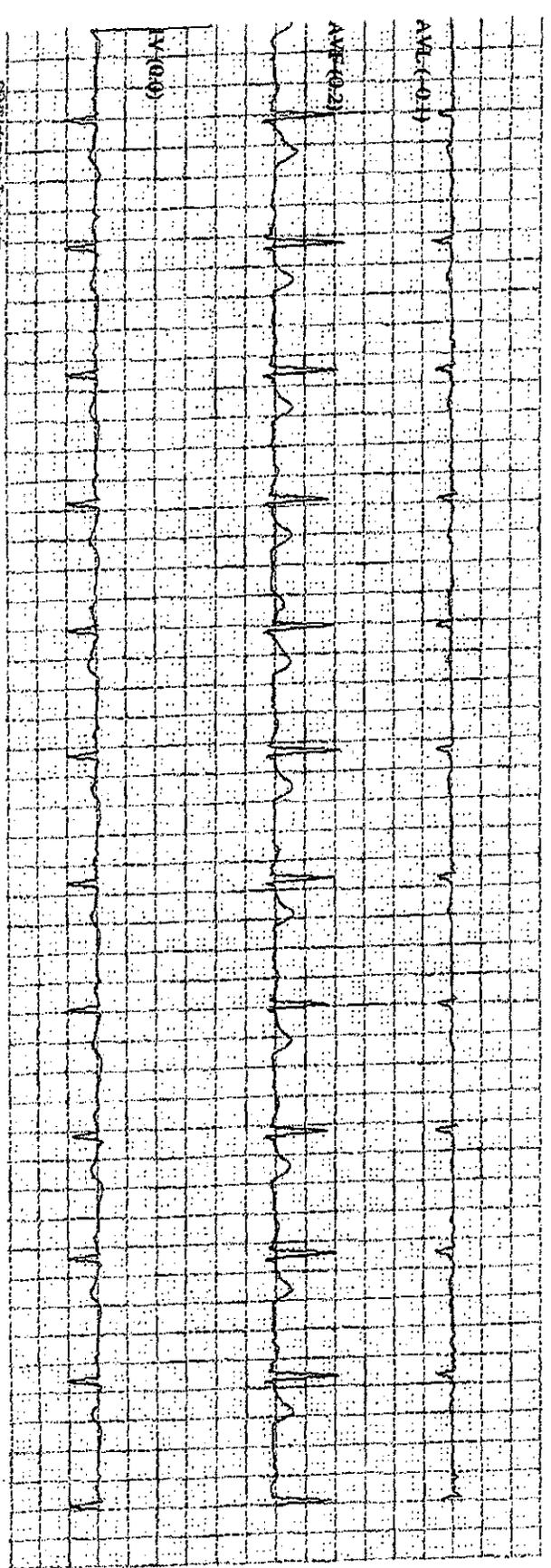
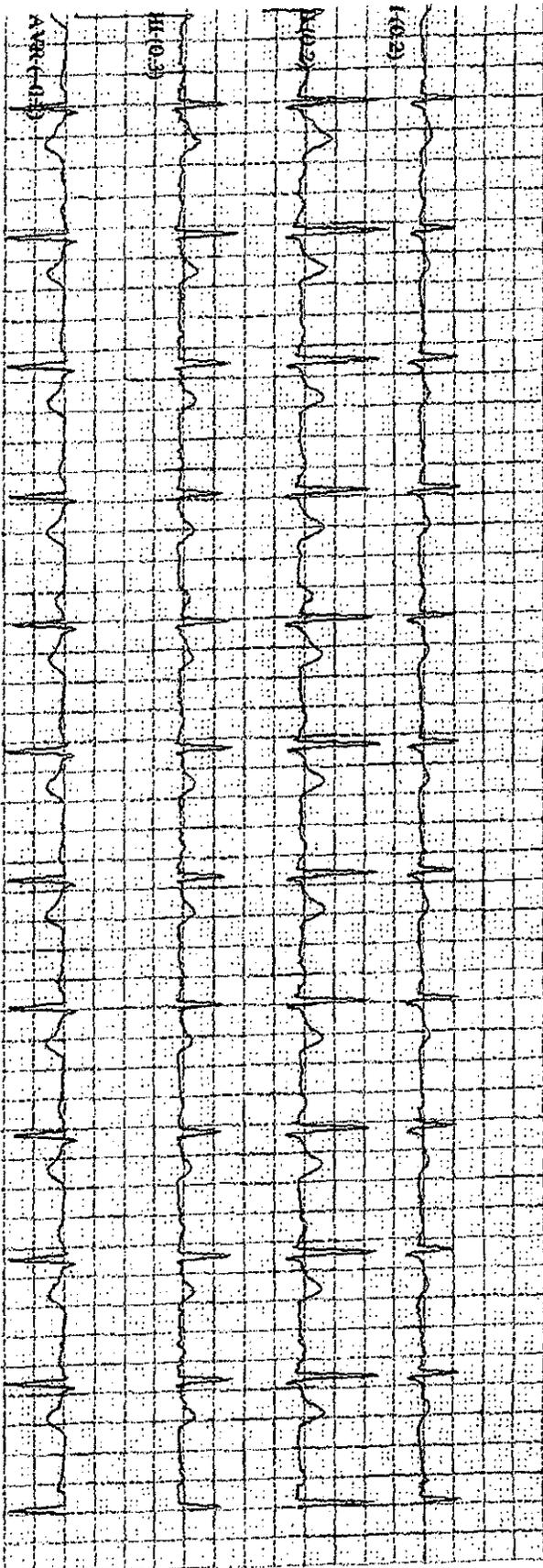
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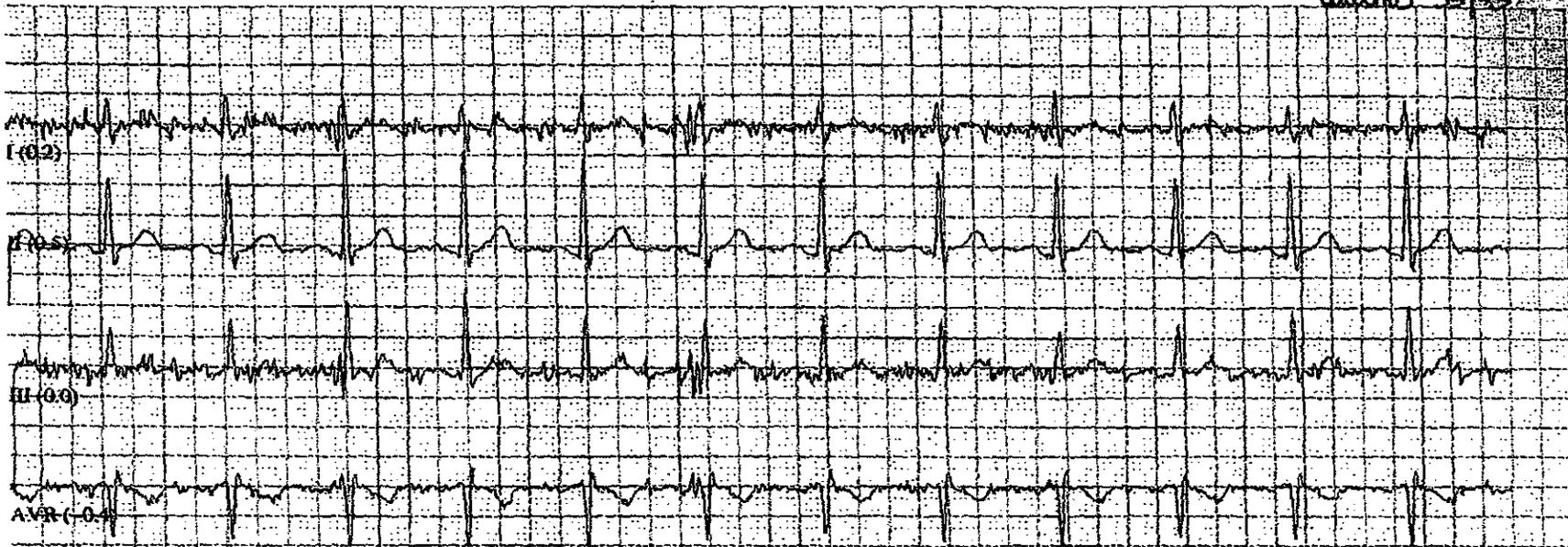
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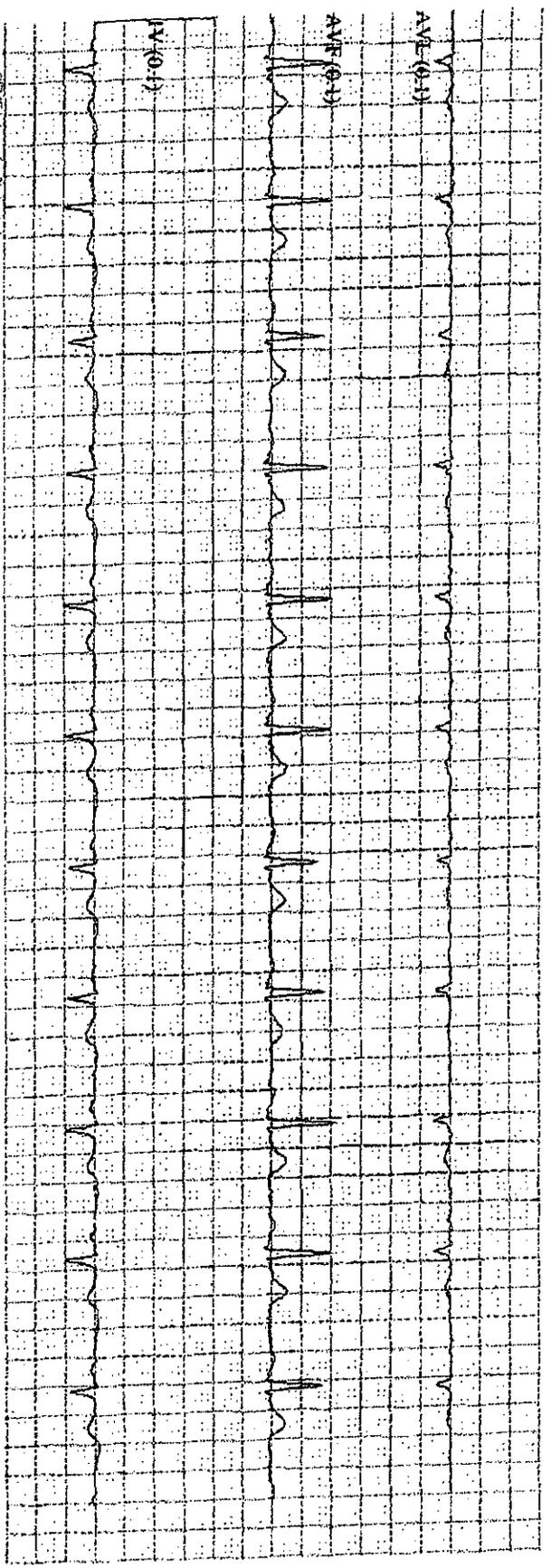
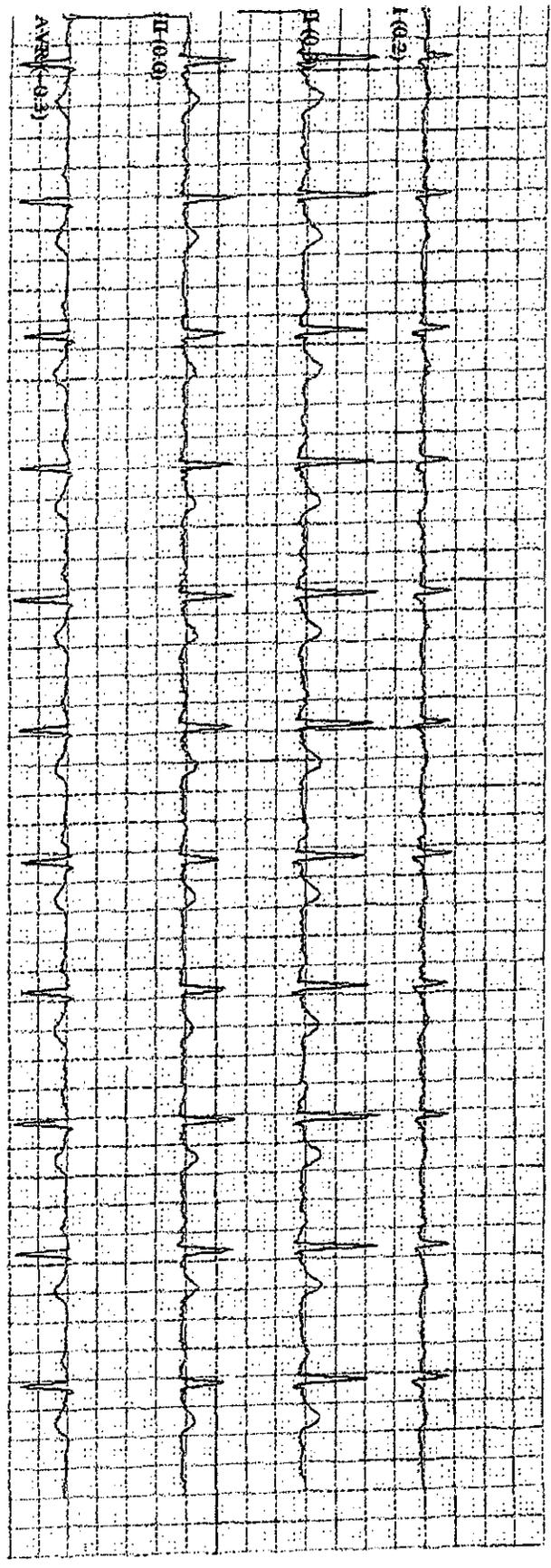
Olivero Edo/90



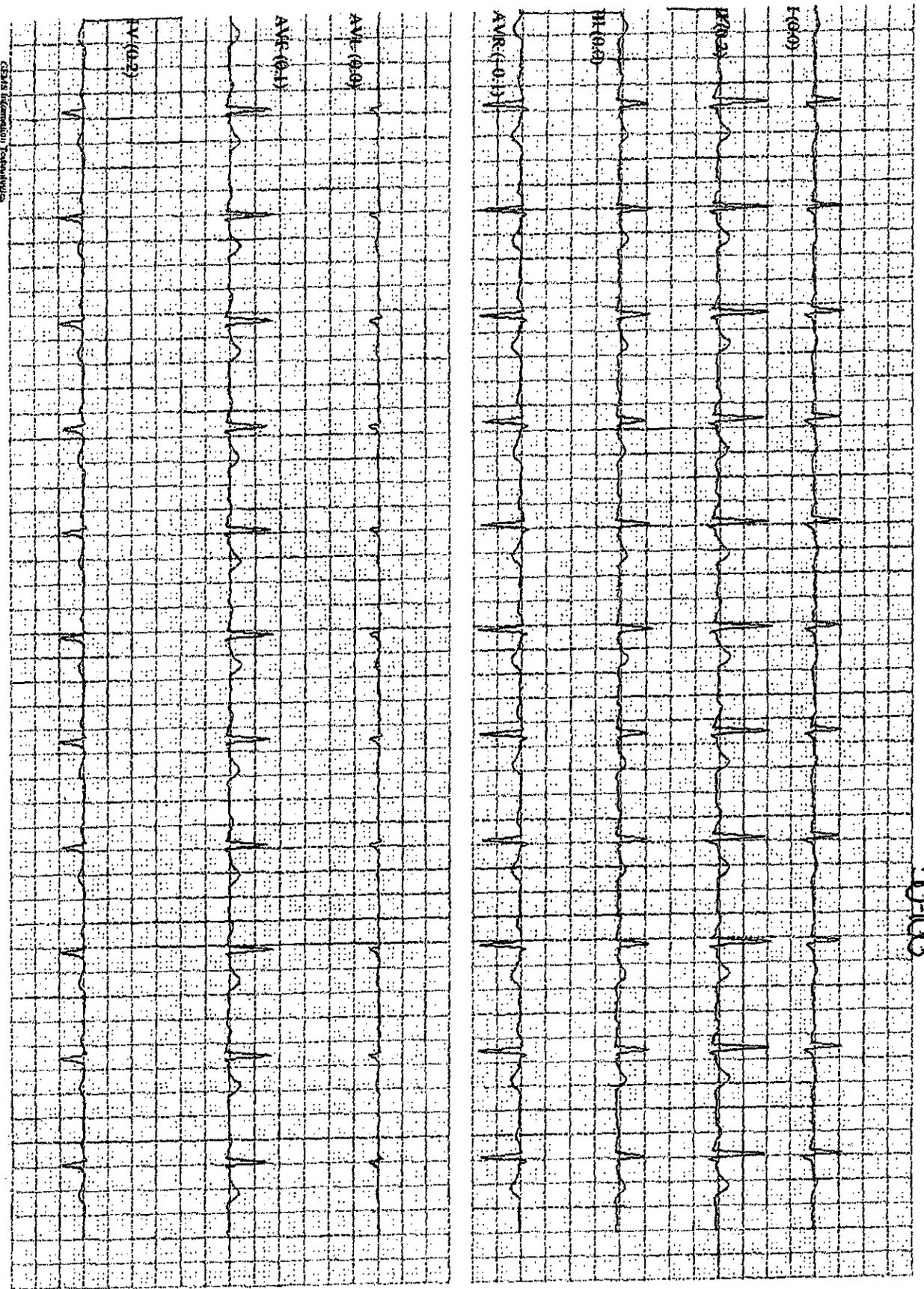
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50-100



50-100



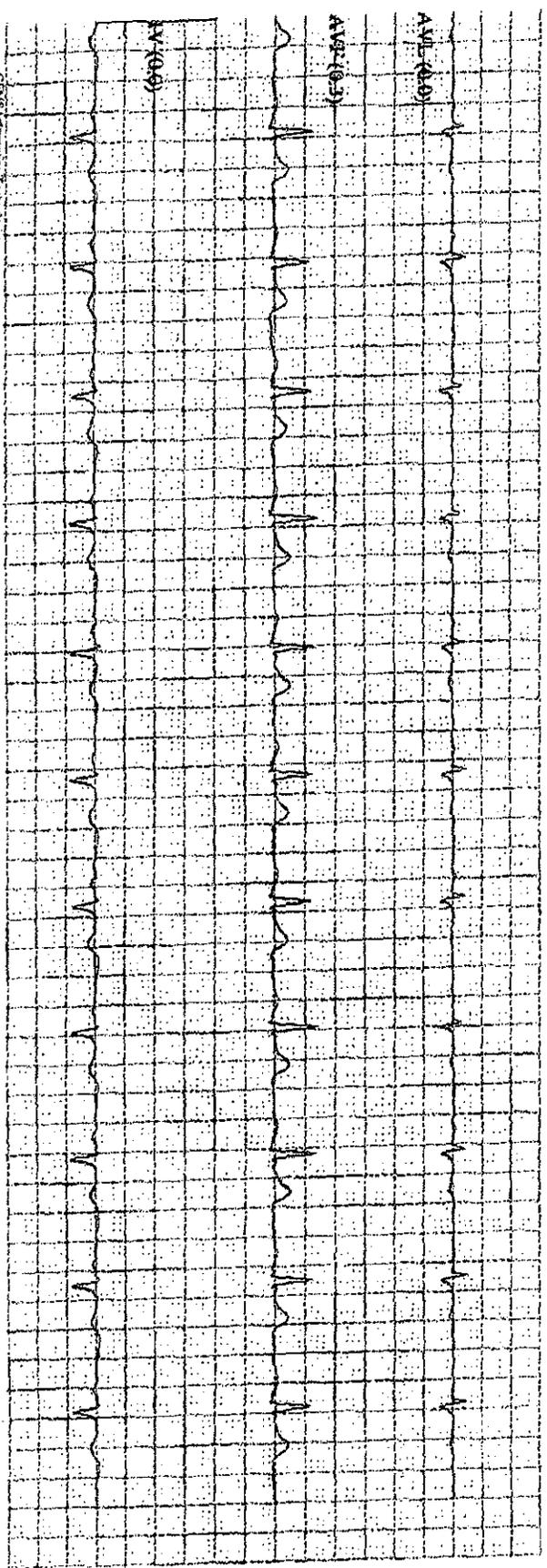
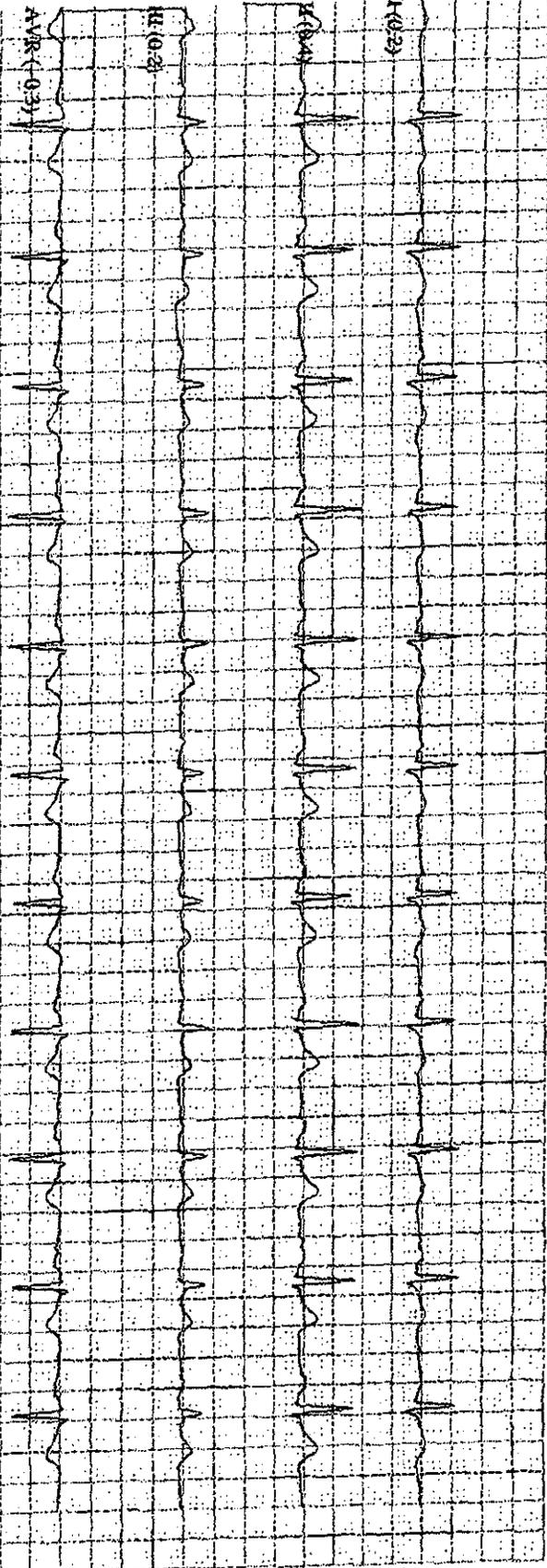
GE Healthcare Technologies

TELEPHONE: B*PID
@25 MM/5 HR 69 PACE 2 PACE %: X% PVC 0 ST II.0.4

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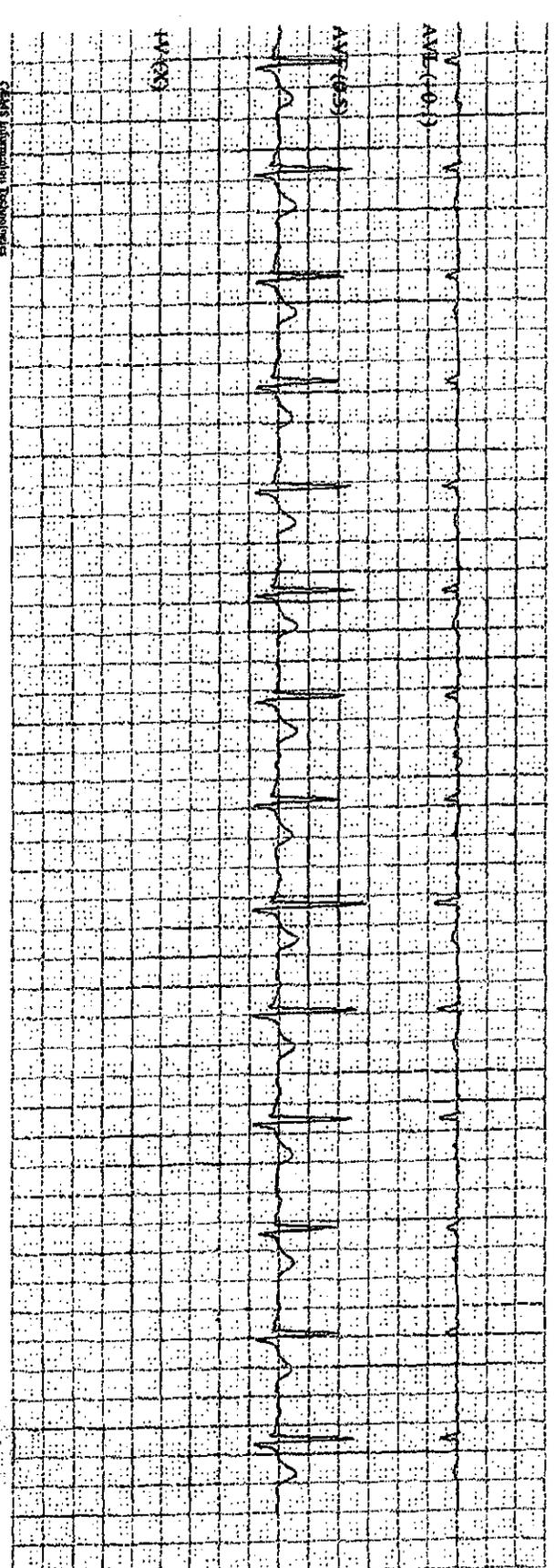
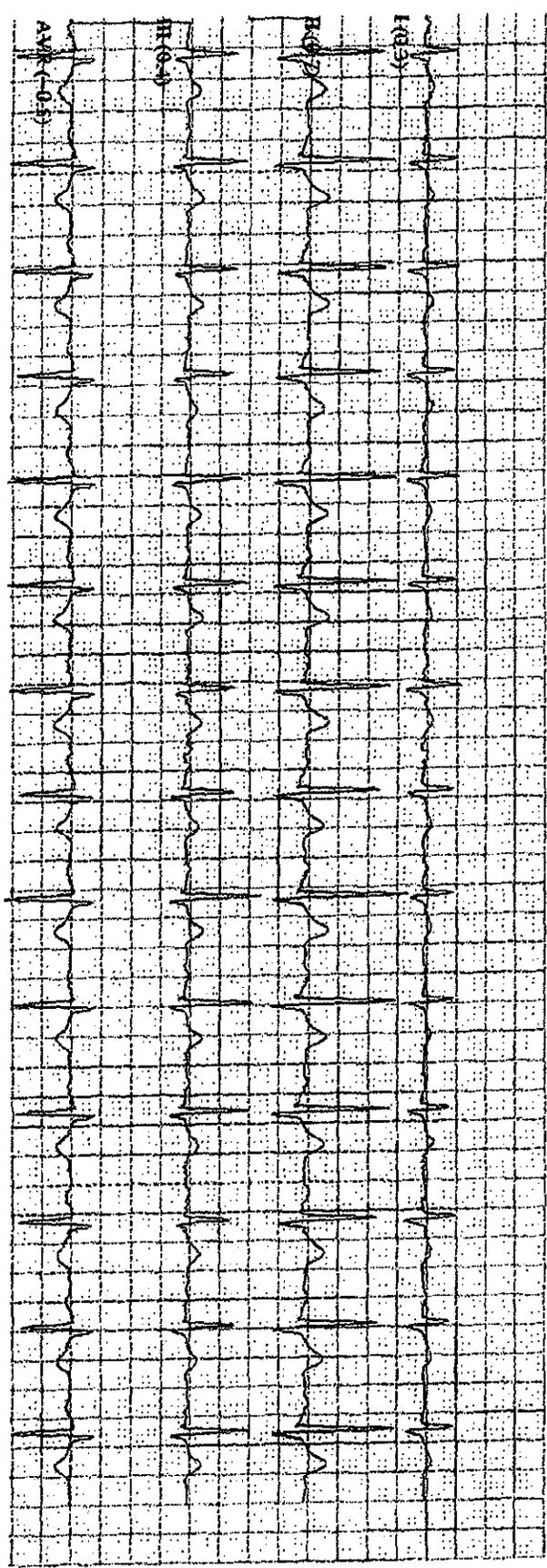
Page 1

5/2/100



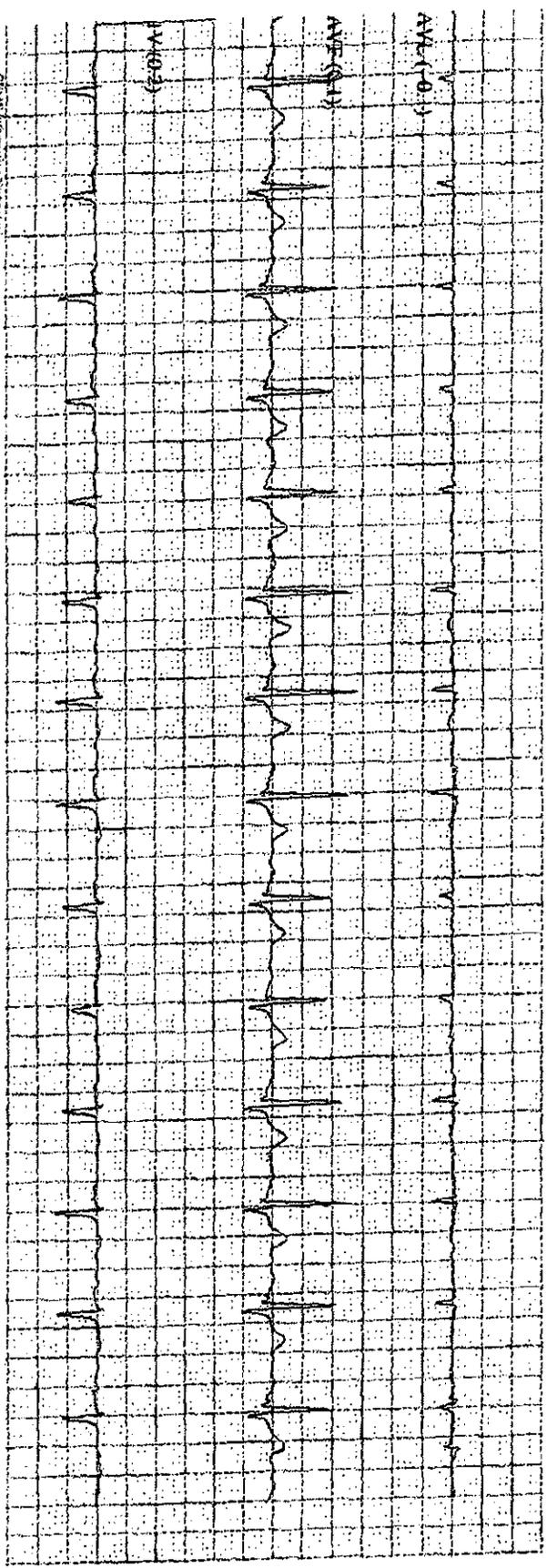
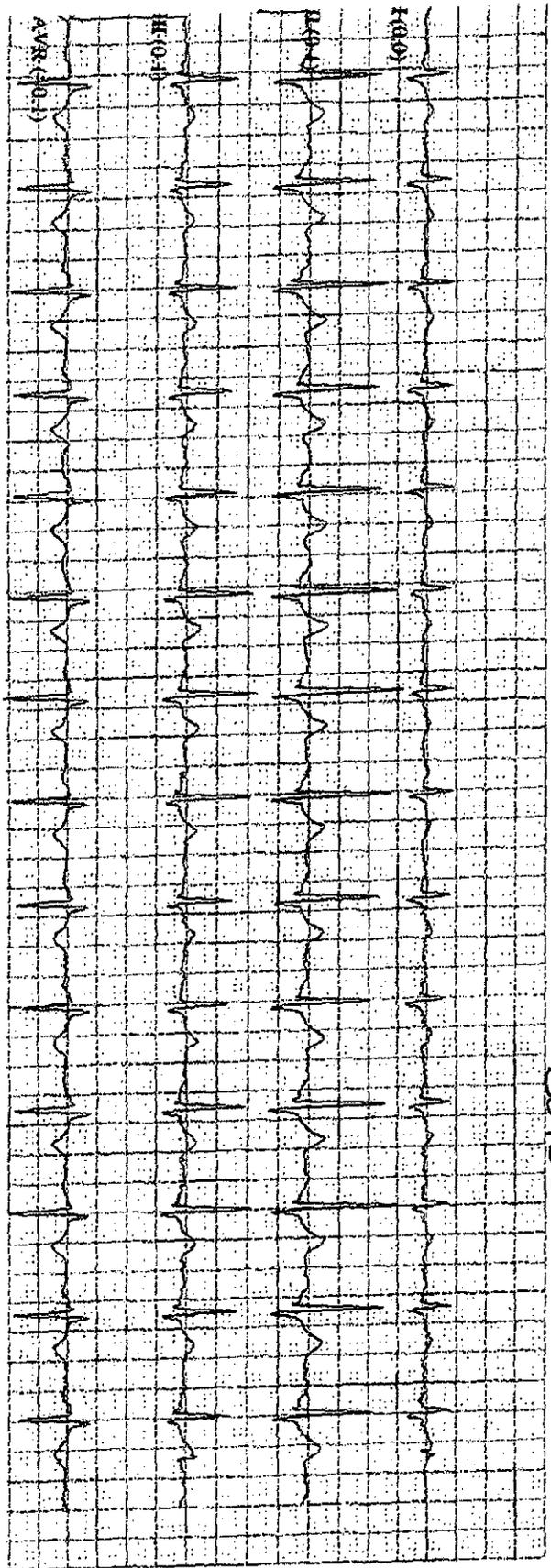
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@23 MM/5 V FAIL HR 85 PACE 2 Pace %; X% PVC 0 SF II 07

Page 1
50-100



Cardiac Information Technologies

SB-105



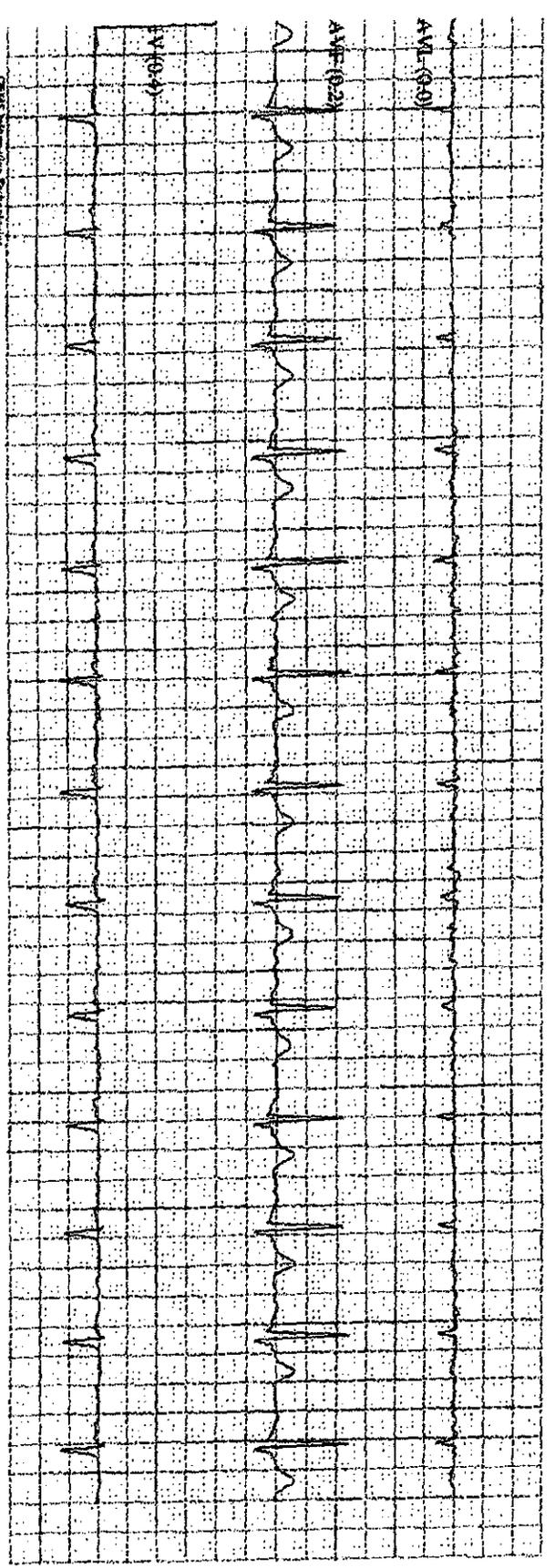
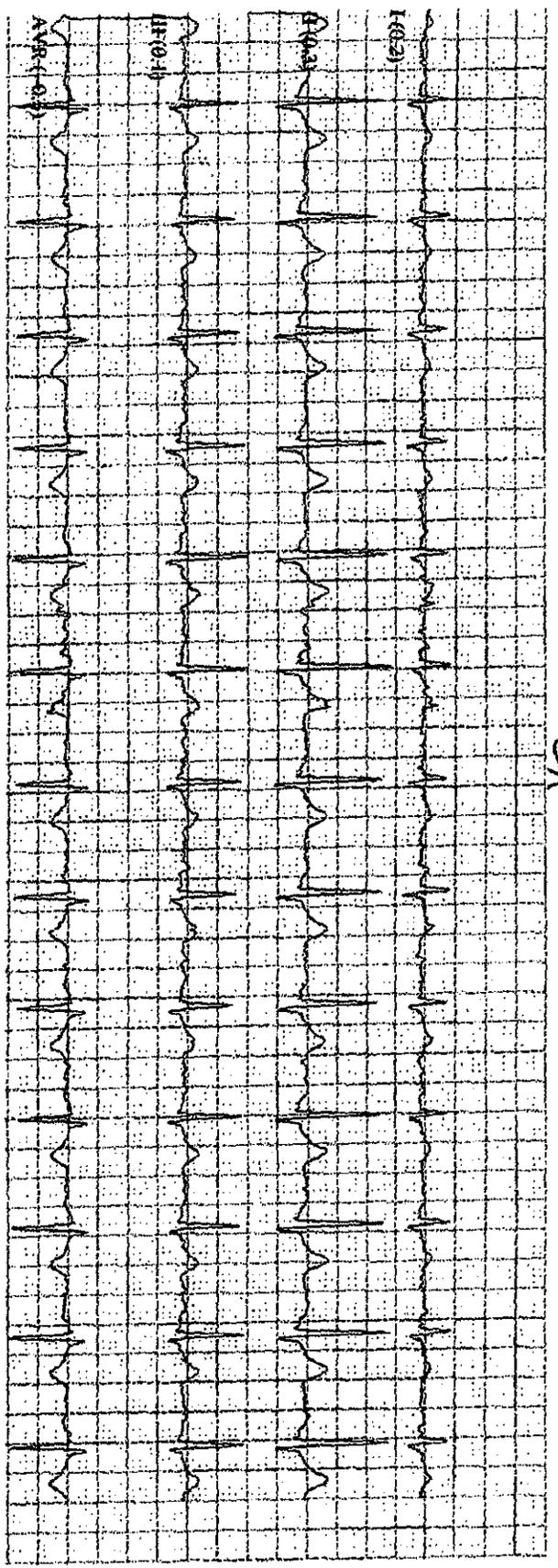
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25 MM/MS HR 79 PACE 2 Pace %: X% PVC 0 ST V1 0.4

SR

RA .18
601 .08

Page 1

UT/OT



GE Healthcare Technologies

Page: 4
 Date: 11/14/15 10:13
 User: F3N7LLA

Discharge Medication Reconciliation
 Physician Orders



St. Alexius Medical Center
 847-843-2000



Patient: [REDACTED] Acct: [REDACTED] Age/Sex: 68 M
 Location: F.3N Room: F.308-B MRN: [REDACTED] Ht: 1.83 m
 Physician: SAJDER MOHSIN Admit Date: 11/12/15 DOB: [REDACTED] (182.88 cm)
 Diagnosis: CHEST PAIN-PNEUMONIA Wt: 132.63 kg (132.630 kg)

Adverse Reactions/Allergies: amlodipine

Drug	Dose	Route	Freq	Attending/Primary		Consultant		Rx/Ref
				Order	Stop	Consult To Review	Order	
Inpt Acetaminophen[Tylenol 325 MG TAB] PRN Reason: *Pain, Mild 1-3 Out Of 10	650 MG	PO	Every 8 Hours as Needed					
Inpt Lorazepam Inj[Aivan Inj 2 MG/ML SYRINGE] PRN Reason: For Anxiety/Agitation Label Comments: **IVP Dilute with Equal Volume of Normal Saline Preceded by & Followed with Saline Flush Per Protocol If Via Heparin Lock or Incompatible IV Fluid*** **Fall Risk Potential** **REFRIGERATE**	0.5 MG	IVP	Every 4 Hours as needed					
Home Pregabalin[Lyrica 150 mg Cap]	150 MG	PO	Twice Daily		✓			
Inpt Pregabalin[Lyrica 25 MG CAP] Label Comments: *** FALL RISK POTENTIAL ***	25 MG	PO	Twice Daily	✓				
Home Phenelzine[Nardil 15 mg Tab]	15 MG	PO	Twice Daily		✓			
Home Olanzapine[Zyprexa 5 mg Tablet] PRN Reason: Agitation	5 MG	PO	Every 4 Hours As Needed		✓			

Telephone Order Read Back: _____ Date/Time: _____ Physician Signature:  Date/Time: 11/14/15 10A

Discharge Nurse: _____ Date/Time: _____

Page: 5
 Date: 11/14/15 10:13
 User: F3NTLR

Discharge Medication Reconciliation
 Physician Orders



St. Alexius Medical Center
 847-843-2000



Patient: [REDACTED] Acct: [REDACTED] Age/Sex: 68 M
 Location: F.3N Room: F.308-B MRN: [REDACTED] Ht: 1.83 m
 Physician: SAFDER MOHSIN Admit Date: 11/12/15 DOB: [REDACTED] (182.88 cm)
 Diagnosis: CHEST PAIN-PNEUMONIA Wt: 132.63 kg (132.630 kg)

Adverse Reactions/Allergies: amlodipine

	Drug	Dose	Route	Freq	Attending/Primary		Consultant		Rx/ E-Rx
					Order	Stop	Consult To Review	Order	
Home	Olanzapine[ZYPREXA 10 mg Vial]	5 MG	IM	Every 4 Hours As Needed					
	PRN Reason: Agitation					✓			
Home	Olanzapine[Zyprexa 5 mg Tab]	5 MG	PO	Twice Daily					
	PRN Reason: Agitation					✓			
Inpt	Olanzapine[ZYPREXA 10 MG VIAL]	5 MG	IM	Every 6 Hours as Needed					
	PRN Reason: Agitation Label Comments: MAXIMUM 30MG/24 HOURS - IF NOT TOLERATING ORALS DILUTE WITH 2.1 ML STERILE WATER = 5MG/ML USE IMMEDIATELY (WITHIN 1 HR) AFTER RECONSTITUTION				✓				
Inpt	Olanzapine[ZYPREXA 5 MG TAB]	5 MG	PO	Every 6 Hours as Needed					
	PRN Reason: Agitation Label Comments: ** FALL RISK POTENTIAL ** PRN IF TOLERATING ORALS					✓			
Home	Lactulose [Lactulose 10 gm/15 ml Solution]	10 GM	PO	Three Times Daily					
Inpt	Lactulose [Chronulac 30 ML UDC]	30 ML	PO	Three Times Daily					
	Label Comments: Hold if more than 2 BM				✓				

Telephone Order Read Back: _____ Date/Time: _____ Physician Signature: _____ Date/Time: 11/14/15 10:13

Discharge Nurse: _____ Date/Time: _____

Page: 7
 Date: 11/14/15 10:13
 User: F3NTLR

Discharge Medication Reconciliation
 Physician Orders



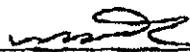
St. Alexius Medical Center
 847-843-2000



Patient: [REDACTED] Acct: [REDACTED] Age/Sex: 68 M
 Location: F.3N Room: F.308-B MRN: [REDACTED] Ht: 1.83 m
 Physician: SAFDER MOHSIN Admit Date: 11/12/15 DOB: [REDACTED] (182.88 cm)
 Diagnosis: CHEST PAIN-PNEUMONIA Wt: 132.63 kg (132.630 kg)

Adverse Reactions/Allergies: amlodipine

Drug	Dose	Route	Freq	Attending/Primary		Consultant		Rx/e-Rx
				Order	Stop	To Review	Order	
Inpt Torsemide [Demadex 20 MG TAB]	40 MG	PO	Twice Daily					
Inpt Glycerin [Glycerin Adult 1 SUPP SUPP] PRN Reason: Constipation	1 SUPP	RECT	As Needed					
Home Simethicone [Mylkon 80 mg Chewtab] PRN Reason: Gas Pain	80 MG	PO	Every 4 Hours As Needed					
Inpt Simethicone [Mylkon 80 MG CHEWTAB] PRN Reason: Gas Pain	80 MG	PO	Every 4 Hours As Needed					
Home Polyethylene Glycol 3350 [Miralax 17 gm Pkt]	17 GM	PO	Daily					
Inpt Polyethylene Glycol 3350 [Miralax 17 GM PKT] Label Comments: MIX IN 8OZ WATER UNTIL DISSOLVED THIS MEDICATION THINS NECTAR OR HONEY THICK LIQUIDS	17 GM	PO	Daily					
Inpt Sennosides [Senokot 8.6 MG TAB]	17.2 MG	PO	Twice Daily					

Telephone Order Read Back: _____ Date/Time: _____ Physician Signature:  Date/Time: 11/14/15 10:13

Discharge Nurse: _____ Date/Time: _____

Page: 10
 Date: 11/14/15 10:13
 User: F3NTLLR

Discharge Medication Reconciliation
 Physician Orders



St. Alexius Medical Center
 847-843-2000



Patient: ██████████ Acct: ██████████ Age/Sex: 68 M
 Location: F.3N Room: F.308-B MRN: ██████████ Ht: 1.83 m
 Physician: SAFDER MOHSIN Admit Date: 11/12/15 DOB: ██████████ (182.88 cm)
 Diagnosis: CHEST PAIN-PNEUMONIA Wt: 132.63 kg (132.630 kg)

Adverse Reactions/Allergies: amlodipine

Drug	Dose	Route	Freq	Attending/Primary		Consultant		Rx/ e-Rx
				Order	Stop	To Review	Order	
Home Folic Acid(Folic Acid 1 mg Tab)	1 MG	PO	Daily	✓				
Inpt Cholecalciferol(Vitamin D 1,000 UNIT TAB)	2000 UNIT	PO	Daily					
Home Cholecalciferol (Vitamin D3)[Vitamin D 2,000 unit Capsule]	2000 UNITS	PO	Daily	✓				

Discharge O2 orders (if Applicable):

O2 Device (Circle Device): N/C Simple Mask Ventmask Trach Collar

Bi-Pap ___/___ with O2 Yes No C-Pap ___ with O2 Yes No

O2 Flow Order (Enter Amounts): [Single Order] _____ Liters/Minute or _____ %

[Day Time Order] _____ Liters/Minute or _____ %

[With Exertion Order] _____ Liters/Minute or _____ %

[Night Time Order] _____ Liters/Minute or _____ %

Telephone Order Read Back:

Date/Time:

Physician Signatures:

Date/Time:

[Signature] 11/14/15 10:13

Discharge Nurse:

Date/Time:

Page: 11
Date: 11/14/15 10:13
User: FSNTLLR

Discharge Medication Reconciliation
Physician Orders



St. Alexius Medical Center
847-843-2000



Patient: [REDACTED] Acct: [REDACTED] Age/Sex: 68 M
Location: F.3N Room: F.308-B MRN: [REDACTED] Ht: 1.89 m
Physician: SAFDER MOHSIN Admit Date: 11/12/15 DOB: [REDACTED] (182.88 cm)
Diagnosis: CHEST PAIN-PNEUMONIA Wt: 132.63 kg
 (132.630 kg)

Adverse Reactions/Allergies: amlodipine

Drug	Dose	Route	Freq	Attending/Primary		Consultant		Rx/ e-Rx
				Order	Stop	To Review	Order	
New Discharge Medications								
Script Given	Ceftriaxone 500 mg BID x 8 days							
	Doxycycline 100 mg BID x 8 days							
	Fentanyl patch 250 mcg BID x 10 days							

Influenza Date:

*** FINAL PAGE ***

Telephone Order Read Back Date/Time: Physician Signatures: Date/Time: 11/14/15 10:09

Discharge Nurse: [Signature] Date/Time: 11/17/15 11:30

BENSENVILLE POLICE DEPT
100 N CHURCH RD
BENSENVILLE, IL 60106-2010

000045

98 pgs



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Confidential Information enclosed.
To be viewed by authorized persons only.

If you have questions regarding any information you have requested,
please call the phone number on the enclosed invoice.

Health information is reproduced by HealthPort, a health information management outsourcing service. Your healthcare provider contracts with HealthPort to process authorized requests for copies of health records.

Reproductions are made from the medical facility's original records. The confidentiality of these records is protected by federal and state laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

If you requested items that are not maintained in the medical record, your request for those items was forwarded to the appropriate department and will be sent under separate cover. Likewise, information that you asked to have delivered to another address is sent separately.

This package may or may not contain medical records, depending on what was requested and how it was processed.

You may not make any disclosure or use of these records without the permission of the individual who is the subject of the records.

This information *may or may not* contain records regarding drug and/or alcohol use or treatment. If this record contains any such information, it has been disclosed to you from records whose confidentiality is protected by federal regulation 42 CFR Part 2, which prohibits you from making any further disclosure of it without the *specific* written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of health or other information is not sufficient for this purpose. Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

If the enclosed record pertains to HIV/AIDS, it has been disclosed to you from records whose confidentiality is protected by federal and, perhaps, state law, which prohibits you from making any further disclosure of such information without the *specific* consent of the person to whom such information pertains or as otherwise permitted by state law. A general authorization for this release of health or other information is not sufficient for this purpose.

This is confidential and privileged information. If it contains mental health information, it is for professional use only.

Date: Jan 7, 2016
Time: 10:43:41 CT
User: Stan Sakinis

Bridgeway Senior Living, LLC
Progress Notes

Facility #

Page # 1

Resident Name: [REDACTED]

Location: .

Admission Date: 10/23/2015

Medical Record #: [REDACTED]

Gender: M

Date of Birth: [REDACTED]

Physician: Abdo, Wa'el

Pharmacy: Senior Care Pharmacy

Allergies: Amlodipine

Diagnoses: LUMBAGO WITH SCIATICA, LEFT SIDE, DIFFICULTY IN WALKING, NOT ELSEWHERE CLASSIFIED, ACUTE ON CHRONIC DIASTOLIC (CONGESTIVE) HEART FAILURE, HYPOTHYROIDISM, UNSPECIFIED, GASTRO-ESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS, ATTENTION-DEFICIT HYPERACTIVITY DISORDER, UNSPECIFIED TYPE, MUSCLE WEAKNESS (GENERALIZED), MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED, POST-TRAUMATIC STRESS DISORDER, UNSPECIFIED, ANXIETY DISORDER, UNSPECIFIED, OBESITY, UNSPECIFIED, TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY, OBSTRUCTIVE SLEEP APNEA (ADULT) (PEDIATRIC), VENTRICULAR FLUTTER, ESSENTIAL (PRIMARY) HYPERTENSION, CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED, HISTORY OF FALLING, NARCISSISTIC PERSONALITY DISORDER, METABOLIC SYNDROME, CHRONIC KIDNEY DISEASE, STAGE 3 (MODERATE), LUMBAGO WITH SCIATICA, RIGHT SIDE, UNSPECIFIED FRACTURE OF FOURTH LUMBAR VERTEBRA, SEQUELA, INCOMPLETE ROTATOR CUFF TEAR OR RUPTURE OF LEFT SHOULDER, NOT SPECIFIED AS TRAUMATIC, PERSONAL HISTORY OF (HEALED) TRAUMATIC FRACTURE

11/1/2015 03:30 Type: Nursing Note

Note Text:

Note Text : Elite ambulance was called at 11:30pm ETA 30min. resident started to become aggressive again and escalated e.g. accusing staff of lying, not doing their job right and stealing his medications, ambulance arrived at 12:20am but resident refused to go, threa (Draft)tening to sue, requested for a copy of the petition, spent 1 hr, reading it and then he called 911 (police and paramedics arrived) resident is refusing to go but finally calm down and left per stretcher to ABMC ER at 1:30am, son Joe was called and made aware at 1:35am. At 6am, residents admission to Alexian Bros. Behavioral unit was confirmed .

Transcriber: Alejandro S. Leonardo - RN

10/31/2015 17:41 Type: Physician Progress Note

Note Text:

- Incorrect Documentation -
- Incorrect Documentation - ~~Note Text : called by pt I have severe pain inthe back and my rightknee hurts and I can not move the knee~~
- Incorrect Documentation - ~~HPI~~
- Incorrect Documentation ~~[REDACTED] here for sar s/p kyphoplasti and pain managment and disposition planing~~
- Incorrect Documentation - ~~pt requested to be sent home and to talk to his NS as there is severe pain inthe area of the procedure.~~
- Incorrect Documentation - ~~NS was called, left note:~~
- Incorrect Documentation -
- Incorrect Documentation - ~~pt stated that he can not be here any more and he wants to be home and sleep home in his lazy boy chair. he demented to be discharge and stated that he is fine and will be able to take care for him self and has help he already arranged.~~
- Incorrect Documentation -
- Incorrect Documentation - ~~He also, mentioned that he spoke with NS and noted no new rees~~
- Incorrect Documentation - ~~he stated that he will seek SAR at the MARIAN JOY Rehabilitation on monday from his home.~~
- Incorrect Documentation -

1/7/2016

Progress Notes

Date: Jan 7, 2016
Time: 10:43:41 CT
User: Stan Sakinis

Bridgeway Senior Living, LLC
Progress Notes

Facility #

Page # 2

Resident Name [REDACTED] Location: - Admission Date: 10/23/2015

~~Incorrect Documentation - pt was educated over and over again regarding his health situation and it is unsafe to go home. Pt stated that he understands risk including death and severe worsening of his health which not limited to any particular organ or system.~~

~~Incorrect Documentation - pt stated "I will be fine I have help and don't worry, I am in the jail."~~

~~Incorrect Documentation - pt stated I am hurting in the back and R knee denies chills fever, no cough no sob.~~

~~Incorrect Documentation -~~

~~Incorrect Documentation - total time spent including on counseling and coordination of care with NR magnager admission manager and floor nurse~~

~~Incorrect Documentation - pt's son and pt him self was 55 mins~~

~~Incorrect Documentation - ff 44 mins~~

~~Incorrect Documentation -~~

~~Incorrect Documentation - ff~~

Strike Out Date: 10/31/2015 20:03

Author: Paul R Priest - Doctor [ESOF]

10/30/2015 21:00 Type: Physician Progress Note

Note Text:

Note Text : called by pt I have severe pain in the back and my right knee hurts and I can not move the knee HPI

[REDACTED] here for sar s/p kyphoplasty and pain management and disposition planning

pt requested to be sent home and to talk to his NS as there is severe pain in the area of the procedure.

NS was called, left note.

pt stated that he can not be here any more and he wants to be home and sleep home in his lazy boy chair. he demented to be discharge and stated that he is fine and will be able to take care for him self and has help he already arranged.

He also, mentioned that he spoke with NS and noted no new recs he stated that he will seek SAR at the MARIAN JOY Rehabilitation on monday from his home.

pt was educated over and over again regarding his health situation and it is unsafe to go home. Pt stated that he understands risk including death and severe worsening of his health which not limited to any particular organ or system.

pt stated "I will be fine I have help and don't worry, I am in the jail."

pt stated I am hurting in the back and R knee denies chills fever, no cough no sob.

pmh
copd bipolar depression opioid dependence

a/p
back, knee pain
deblility
s/p kyphoplasty
worsening

Date: Jan 7, 2016
Time: 10:43:41 CT
User: Stan Sakinis

Bridgeway Senior Living, LLC
Progress Notes

Facility #

Page # 3

Resident Name [REDACTED] Location: - Admission Date: 10/23/2015

total time spent including on counseling and coordination of care with NR magnager admission manager and floor nurse
pt's son and pt him self was 55 mins
ff 44 mins

Author: Paul R Priest - Doctor [ESOF]

10/30/2015 20:19 Type: Nursing Note

Note Text:

Note Text : Resident's son came to visit when resient began shouting and swearing at his son to take him home. He demanded that his son take him home immediately. His son came to writer with resident screaming to be let to go home. Manager Rizza was contacted and Dr. Priest came to unit. Dr. Priest said he could go home but it would be against medical advice. Paperwork to leave Against Medical Advice was given to [REDACTED] who did sign document. Family was contacted, but asked that resident remain her as no one would be able to care for him.

Resident took his night meds and began sleeping in his chair. Resident later awoke and began swearing at staff again to be sent home. Staff suggested he wait till the morning as resident's wife would have a difficult time if d/c late at night.

Author: Patricia Murray - RN [ESOF]

10/30/2015 19:37 Type: Nursing Note

Note Text:

Note Text : Resident is alert oriented x3. At around 7:40pm Anxious and Agitated. Resident was screaming to the staff, refusing care and meds. Insisted to go ' stated I want to go home and I don't want to stay here' Son was present and explained to the resident for safety purposes he cant go home. Resident insisted and very argumentative to the son. Dr. Priest educated resident for safety and health its unsafe to go home with no help. Resident stated ' I have help I called NCS agency and starting tomorrow their coming to my house for 12hrs a day to help me out, I pay them \$25hr' I Spoke to the wife and verbalized concerned and did not want resident to be home. MD stated 'resident may leave against medical advise. Wife stated 'I don't want him to be home, I have our son here at home that is paralyzed and needed full time care and I am weak also' Wife stated I cant handle him with his condition, our house is not even set up for him to come home'.I spoke and made aware of his wife concerned and encourage to stay for his safety and health condition. At 9:30pm resident calm down and took his meds. Ate his snacks. Called the wife and updated. Nurse on duty made aware to closely monitor resident.

Author: Riza Hernandez - ADON [ESOF]

10/30/2015 15:49 Type: Social Service Note

Note Text:

Note Text : Resident with anxiety calling out stating he wants to leave this facility. This writer met with resident and he states that he wants to go back home and do outpatient therapy at Marianjoy. Resident states that he will have his children help him at home and be at Marianjoy rehab center during day. Referral sent to Marianjoy per residents request. Intake coordinator states that liason will review and let this writer know if he is accepted. Resident made aware that the transfer will not happen immediately as his records will need to be reviewed and Liason at Marianjoy is gone for the day. He verbalized understanding. Social services will follow up.

Author: Elizabeth Castenada - Social Worker [ESOF]

10/29/2015 23:17 Type: Nursing Note

Date: Jan 7, 2016
 Time: 10:43:41 CT
 User: Stan Sakinis

Bridgeway Senior Living, LLC
 Progress Notes

Facility #

Page # 4

Resident Name: [REDACTED] Location: - Admission Date: 10/23/2015

Note Text: Resident alert, oriented x 2-3. medicated with prn pain meds as ordered with relief stated. Was up in dining area till 7 pm. C-Pap on. Call light within reach. Monitored closely.

Author: Huda Kaleel - RN [ESOF]

10/29/2015 07:34 Type: Nursing Note

Note Text:

Note Text : During initial rounds at 11:15pm, resident was asleep on his recliner on his room. Woke up screaming at 12:15am saying, " I can not breath, send me to the hospital ", 142/84 97.6 94 20 SPO-84-94%RA, Accu check "Hi", O2-started at 3L/min, 911 was called at 12:18am and arrived 8min later, resident remains alert and verbally responsive when he left per stretcher to EMH, message left sons voice mail, and Dr. Felix Funch on call for IPC was called and made aware, (left a message on his voice mail) At 4:15am, EMH ER called and said resident is coming back, as all test are normal, and their impression was COPD exacerbation. Resident arrived per superior ambulance at 5am, very sleepy but easy to arose, alert and verbally responsive, 130/84 97.8 78 20 SPO-94%RA, Accu check-225mg/dl.

Author: Alejandro S. Leonardo - RN [ESOF]

10/28/2015 22:37 Type: Physician Progress Note

Note Text:

Note Text : acceptance note as pt was out in hospital for 1 days

Pt was seen and examined

HPI: [REDACTED] 68 yo wm

with multiple medical problems listed below, here for sar, he has complex problems and stated that he is okay noted that his meds has been adjusted to him and has no problem now.

collateral hx positive for refusiog cpap and ms contine prefers only diladud for his pains.

also it was reported that his k level low

In the hospital his diladdid was change to q 8 hr and q 8 hr prn and kcl was added

PMH
 L 4 fx compression
 Debility
 DM
 OA
 depression
 chf
 copd

Surgical Hx
 kyphoplasty x2

Social Hx
 former smoker

1/7/2016

Progress Notes

Date: Jan 7, 2016
Time: 10:43:41 CT
User: Stan Sakinis

Bridgeway Senior Living, LLC
Progress Notes

Facility #

Page # 5

Resident Name [REDACTED] Location: - Admission Date: 10/23/2015

+ etoh in the pass

FamilyHx
no hx of dementia

ROS:all reviewed and negative except in hpi

MEDICATIONS:

reviewed
apap
oxy 20 er bid
diazepam 10 mg
torosemid
40 bid

PE

GEN: nad

vs; 138/68 p 72 r 18

HEENT: a/nc pupils reactive

LUNG: diminished bil no w a few wet rales

CV: regular sem 2/6 with hoisystolic split

ABD:distended, no bs +

EXT: + 3 edema + 1 edema in ue

NEURO: speech and language preserved but confused at times, R hand light tremor

Psychiatric: mood and affect flat

skin warm and dry there is redness in le b/l

m/sk; from in ue L >R at shoulder

LABS

k 3.4

A/P

medical domain

back pain due to L 4 fx

s/p kyphoplasty

continue meds

pt/ot

depression

severe

requires MOA and lamictal

cmp

LE edema

improved

will continue cmp

Date: Jan 7, 2016
Time: 10:43:41 CT
User: Stan Sakinis

Bridgeway Senior Living, LLC
Progress Notes

Facility #

Page # 6

Resident Name: [REDACTED] Location: - Admission Date: 10/23/2015

hypo K will replcace with 40 MEq bid bmp in 1 wk
with Mg

copd
resume advair
duoneb prn

OSA
cpap every night

cor pulmonaler

daily weight

hypogonadism
pt will f/u with his endo

hypopituatarism
primary most likiley due to no skin changes

dm
continue monitor
diet diabetic

obesity
dietician consult

blurred vision
family to make ophthalmomogy apt.

social support
good
discuss with his drt at the table

pt is dnr
discussed advance directive as pt stated above.

Author: Paul R Priest - Doctor [ESOF]

10/28/2015 21:39 Type: Nursing Note

Note Text:

Note Text : pt recd alert and verbal. pt tolerated all due medications , pt refused oxycotin as scheduled and perferred Duidid 4mg po prn with good results. pt refused to eat dinner at BWSL and son brough in fast food. pt consumed a large hotdog ,large fries with added salt and extra large chocolate shake. pt educated on diabetic teaching, diet, medication . pt and son verbalized understanding. will continue to be monitored.

1/7/2016

Progress Notes

Date: Jan 7, 2016
Time: 10:43:41 CT
User: Stan Sakinis

Bridgeway Senior Living, LLC
Progress Notes

Facility #

Page # 7

Resident Name: [REDACTED] Location: - Admission Date: 10/23/2015

Author: Mary Muhammad - LPN [ESOF]

10/28/2015 03:56 Type: Daily Skilled Note

Note Text:

Note Text [REDACTED] is receiving skilled care related to: Management / Evaluation of Resident Care Plan, Observation / Assessment of Resident's Condition, Teaching / Training to Manage Resident's Treatment Regimen, Diabetic Care (diet, foot care, etc.), PT, OT.

Current Vital Signs

T 98.1 - 10/28/2015 01:28 Route: Tympanic
P 67 - 10/28/2015 01:28 Pulse Type: Regular
R 20.0 - 10/28/2015 01:28
BP 143/71 - 10/28/2015 01:28 Position: Lying r/arm+

Pain is relayed as 5 on a scale of 0-10. legs/ shoulders

ADL Status:

Bed Mobility: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

Transfers: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

Eating: Activity did not occur. with

Toilet Use: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

There are no cardiovascular concerns at this time. .

There are no respiratory concerns at this time. . The following respiratory treatments are received: BiPap/CPap, .

Maximilian has unsteady gait, balance problems, ,no paralysis or weakness , ,

Skin is intact.

There are no GI issues at this time. Active .

There are no urinary concerns at this time. Maximilian is Continent of urine.

Maximilian is alert.

There are no mood problems at this time.

Date: Jan 7, 2016
 Time: 10:43:41 CT
 User: Stan Sakinis

Bridgeway Senior Living, LLC
 Progress Notes

Facility #

Page # 8

Resident Name [REDACTED] Location: - Admission Date: 10/23/2015

Author: Alejandro S. Leonardo - RN [ESOF]

10/27/2015 13:45 Type: Nursing Note

Note Text: Labs received with no abnormalities. Placed in IPC book. Resident alert and verbally responsive with no distress. Sitting in wheelchair under supervision at nurses station. Extensive assts with ADLs.

Author: Elissa Wilsey - Licensed Practical Nurse [ESOF]

10/26/2015 12:35 Type: Physician Progress Note

Note Text:

Note Text : GEROPSYCH

PATIENT IS ON
 NARDIL 30MG QAM
 NARDIL 45MG QHS
 LAMICTAL 300MG BID
 ADDERALL 30MG QAM
 PRN VALIUM

PATIENT HOSPITALIZED LAST WEEK DUE TO PATIENT DEMANDING HE BE SENT OUT. PER STAFF, HE IS DIFFICULT AND HAS CATASTROPHIC REACTIONS.

PATIENT IS UP AT TABLE IN DAYROOM, WORKING ON COMPUTER. WEARING BODY BRACE. GROOMING FAIR; NEEDS SHAVE. SPEECH COHERENT AND TP QUESTIONABLE.
 NO TREMOR.

MOOD IRRITABLE. ATTENTION GOOD.

PATIENT READMITTED FROM EMH ON DIFFERENT PSYCHOTROPIC REGIMEN. MAY NEED TO REVISE ANTIDEPRESSANT IF MOOD DOESN'T IMPROVE.

CPM FOR NOW.

MONITOR MOOD, BEHAVIOR, SLEEP AND APPETITE.

Author: Ismael LeeChuy - Physician [ESOF]

10/26/2015 07:30 Type: Nursing Note

Note Text: Resident woke up at 2am and unable to get back to sleep, with occasional screaming and yelling but able to calm down and responding well to cues, spent the rest of the night in TV room, 137/74 98.0 64 20 SPO-92%RA.

Author: Alejandro S. Leonardo - RN [ESOF]

10/25/2015 21:49 Type: Daily Skilled Note

Note Text:

Note Text [REDACTED] is receiving skilled care related to: Management / Evaluation of Resident Care Plan, Observation / Assessment of Resident's Condition, PT, OT.

Current Vital Signs

Date: Jan 7, 2016
Time: 10:43:41 CT
User: Stan Sakinis

Bridgeway Senior Living, LLC
Progress Notes

Facility #

Page # 9

Resident Name: [REDACTED] Location: - Admission Date: 10/23/2015

T 97.0 - 10/25/2015 20:29 Route: Tympanic
P 76 - 10/25/2015 20:29 Pulse Type: Regular
R 18.0 - 10/25/2015 20:29
BP 134/67 - 10/25/2015 20:29 Position: Sitting l/arm+

Pain is relayed as 0 on a scale of 0-10.

ADL Status:

Bed Mobility: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

Transfers: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

Eating: Independent - No help or staff oversight at any time. with Setup help only.

Toilet Use: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

There are no cardiovascular concerns at this time. .

There are no respiratory concerns at this time. . .

[REDACTED] has unsteady gait, balance problems, no paralysis or weakness, .

The following skin conditions exist:

There are no GI issues at this time. Active .

There are no urinary concerns at this time. Maximilian is Continent of urine.

[REDACTED] is alert.

There are no mood probelms at this time.

Author: Miranda Ekenjock - Licensed Practical Nurse [ESOF]

10/25/2015 06:05 Type: Nursing Note

Note Text: Observed to slept on and off thru the night, alert and verbally responsive, appears in control and No signs of aggressive behavior at this time, 153/81 96.7 84 20 SPO-96%RA.

Author: Alejandro S. Leonardo - RN [ESOF]

10/24/2015 06:38 Type: Nursing Note

Note Text:

Date: Jan 7, 2016
 Time: 10:43:41 CT
 User: Stan Sakinis

Bridgeway Senior Living, LLC
 Progress Notes

Facility #

Page # 10

Resident Name:	Location: -	Admission Date: 10/23/2015
<p>Note Text : Resident woke up at 2am screaming and yelling because he can not sleep anymore and on his request was transferred on his wheel chair and taken to the TV room wherein he stays the rest of the shift dozing on and off, very calm and quiet and appears in better control, 145/68 98.6 72 20 SPO-94%RA.</p> <p>Author: Alejandro S. Leonardo - RN [ESOF]</p>		
<p>10/23/2015 17:52 Type: Nursing Admission/Readmission Note</p> <p>Note Text: Resident admitted with Lumbago Sciatica weakness both extremities. Alert and oriented x 3. Lung sounds clear upon auscultation. Bowel sounds present in all four quadrants. All orders verified by Dr. Royal Priest</p> <p>Author: Joan B. Cadavez - RN [ESOF]</p>		
<p>10/23/2015 17:48 Type: Elopement Risk</p> <p>Note Text: [REDACTED] was admitted on 10/23/2015, is currently in room 1105-1 and scored 0.0. A score 5 or greater indicates high risk for elopement.</p> <p>Author: Joan B. Cadavez - RN [ESOF]</p>		
<p>10/21/2015 19:29 Type: Nursing Note</p> <p>Note Text: Called CDH Hospital, resident was Admitted into unit B-436. Spoke to nurse Caria. Resident was admitted for BLE weakness.</p> <p>Author: Zenaida Dimallig - 11-7 Supervisor [ESOF]</p>		
<p>10/21/2015 16:28 Type: Social Service Note</p> <p>Note Text:</p> <p>Note Text : Resident anxious and was demanding to be sent to the hospital today. He was calling attending physician and hospital stating that he is not able to move his arms and legs and believes its secondary to his spine. Resident was assessed and was able to move arms and feel toes. Resident continued to insist on being discharged, attending physician was notified of residents request to be sent to hospital. Resident was sent to Central Dupage hospital.</p> <p>Author: Elizabeth Castenada - Social Worker [ESOF]</p>		
<p>10/21/2015 14:35 Type: Nursing Note</p> <p>Note Text:</p> <p>Note Text : Resident is alert oriented and responsive. MD seen the resident this early morning D/C to home. Resident complaint of numbness and tingling sensation. Assess the resident able to move the toes, bilateral legs cellulitis and edematous above 4. Resident request to go in the Central Dupage Hospital. Report given to ER CDH. Advance ambulance transported the resident via stretcher.</p> <p>Author: Maria Manlapaz - Licensed Practical Nurse [ESOF]</p>		
<p>10/21/2015 05:23 Type: Daily Skilled Note</p> <p>Note Text:</p> <p>Note Text : [REDACTED] is receiving skilled care related to: Management / Evaluation of Resident Care Plan, Observation / Assessment of Resident's Condition, Teaching / Training to Manage Resident's Treatment Regimen., Diabetic Care (diet, foot care, etc.), PT, OT.</p> <p>Current Vital Signs</p>		

Date: Jan 7, 2016
Time: 10:43:41 CT
User: Stan Sakinis

Bridgeway Senior Living, LLC
Progress Notes

Facility #

Page # 11

Resident Name: [REDACTED] Location: - Admission Date: 10/23/2015

T 98.0 - 10/21/2015 02:07 Route: Tympanic
P 76 - 10/21/2015 02:07 Pulse Type: Regular
R 20.0 - 10/21/2015 02:07
BP 142/78 - 10/21/2015 02:07 Position: Sitting r/arm+

Pain is relayed as 6 on a scale of 0-10. right leg

ADL Status:

Bed Mobility: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

Transfers: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

Eating: Activity did not occur. with

Toilet Use: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

There are no cardiovascular concerns at this time. .

There are no respiratory concerns at this time. . .

[REDACTED] has unsteady gait, balance problems, ,no paralysis or weakness , ,

The following skin conditions exist:

There are no GI issues at this time. Active .

There are no urinary concerns at this time. Maximilian is Continent of urine.

[REDACTED] is alert.

There are no mood probelms at this time.

Author: Alejandro S. Leonardo - RN [ESOF]

10/20/2015 23:37 Type: Order Note

Note Text: Per Dr. Preist:

Hydromorphine 2mg tablet prn every 6 hours to prn every 4 hours.

Diazepam 10 mg tablet prn every 12 hours to prn every 4 hours.

Author: Diane Murray - Licensed Practical Nurse [ESOF]

Date: Jan 7, 2016

Bridgeway Senior Living, LLC

Facility #

Time: 10:43:41 CT

Progress Notes

User: Stan Sakinis

Page # 12

Resident Name [REDACTED]

Location: -

Admission Date: 10/23/2015

Late Entry

10/20/2015 19:04 Type: Physician Progress Note

Note Text:

Note Text : called by nurse supervisor pt wants to leave ama
HPI

[REDACTED] here for sar s/p kyphoplasti stated that he is not happy with services here and already set up all his services at home on his own and wants to go home. He requested wc rx as well and changes his pain meds to q 2 hrs prn due to severe pain.

Pt was explained the concerns regarding ama and increasing frequency of such potent opioid and it put him in risks.

pt was agreed to stay over night after 45 mins of discussions, to have sw arrange all above and provide safe discharge

soc
pt lives with wife and debilitated child
former ETOH and tobacco user

a/p
pain syndrome
opioid dependency
will increase hydromorphone to q 4 hrs prn as pt refused to have long acting oxycontin to be increased
will keep diazepam at the same dose

debility
due to osteoporosis and l4 fx
continue pt/ot
may have services as out patient
may have wc and need to have home eval for wc. safety.

total time 56 mins
counseling and education 47m ins

ff 40 mins

Author: Paul R Priest - Doctor [ESOF]

10/20/2015 14:48 Type: Nursing Note

Note Text: Patient stable, sleeping in wheelchair in common area. No distress. Will continue to monitor.

Author: Elissa Wilsey - Licensed Practical Nurse [ESOF]

10/20/2015 12:40 Type: Nursing Note

Note Text: Patient sleeping in wheelchair in common area after receiving PRN dilauded. No distress.

Author: Elissa Wilsey - Licensed Practical Nurse [ESOF]

10/20/2015 09:30 Type: Nursing Note

Date: Jan 7, 2016
 Time: 10:43:41 CT
 User: Stan Sakinis

Bridgeway Senior Living, LLC
 Progress Notes

Facility #

Page # 13

Resident Name [REDACTED] Location: - Admission Date: 10/23/2015

Note Text:

Note Text : Administered Diazepam for anxiety - patient complaint to receiving meds. Verbally abusive with staff. V/S: 147/63, P85, R18, T98.2, O2 94% R/A. C/O 10/10 pain - stated, "I refuse to take anything other than dilauded." Agreed to attend therapy. Will continue to monitor.

Author: Elissa Wilsey - Licensed Practical Nurse [ESOF]

10/20/2015 09:00 **Type:** Nursing Note

Note Text:

Note Text : Patient extremely agitated complaining of 10/10 general pain, yelling at staff stating, "I want my dilauded." Hydromorphone administered at 0540 per night shift documentation and report. Explained to patient that medication is PRN every 6 hours, but is he due for Oxycontin 15mg ER tablet. Patient stated, "nothing else works except for hydromorphone, I don't want it." Refused all scheduled medication. Paged MD reporting 10/10 pain and refusal of meds. New order to increase Oxycontin to 30mg ER every 12 hours. Reported to patient increase of pain medication and he stated, "I don't want it." Noted refusal of medication. Attempted to use distraction and offer other means of pain management. Patient verbally aggressive stating, "you're all liars." Refused vital signs. Allowing patient space to calm down, seated in front of nurses station, will continue to monitor.

Author: Elissa Wilsey - Licensed Practical Nurse [ESOF]

10/20/2015 07:17 **Type:** Nursing Note

Note Text:

Note Text : Resident woke up at 11:15pm and started c/o generalized pain, Tylenol 650mg. was Offered(Only pain medication available to give at the time), but he refused and keep on saying it is the wrong medications, resident then started calling 911 and and I talked to the village police 2x and let them know what was going on, and because he was calling non stop, the village sent 3 officer to investigate, they arrived at 4:20am, and after interviewing the resident and the RN, they left at 4:55am, resident finally get tired and sleepy and slept thru the night, wife was called and made aware, a message left to Dr. Priest.

Author: Alejandro S. Leonardo - RN [ESOF]

10/19/2015 23:51 **Type:** Nursing Note

Note Text:

Note Text : Received resident up in chair having recently returned from a doctor appt. per am nurse Helen. Given card with doctors office from am nurse to call and confirm appt. as resident stated that office said he did not have appt.

Called Endocrinologist office @ 630-532-5821; spoke to Maricelle who stated that appt had been cancelled by a relative of resident stating that appt. would be rescheduled after [REDACTED] was finished with his rehab at the rehab facility. Maricelle stated that she explained this thoroughly to [REDACTED]

Relayed this to resident who became very upset. He stated that no relative called and that it had to be one of the nurses here. Relayed to night nurse Rollie, Endocrinologist card in nursing care with resident's meds.

Author: Patricia Murray - RN [ESOF]

10/19/2015 23:37 **Type:** Daily Skilled Note

Note Text:

Note Text : [REDACTED]'s receiving skilled care related to: Management / Evaluation of Resident Care Plan, Observation / Assessment of Resident's Condition, PT, OT.

Date: Jan 7, 2016
 Time: 10:43:41 CT
 User: Stan Sakinis

Bridgeway Senior Living, LLC
 Progress Notes

Facility #

Page # 14

Resident Name: [REDACTED]

Location: -

Admission Date: 10/23/2015

Current Vital Signs

T 97.9 - 10/19/2015 21:08 Route: Tympanic
 P 65 - 10/19/2015 21:08 Pulse Type: Regular
 R 18.0 - 10/19/2015 21:08
 BP 129/76 - 10/19/2015 21:08 Position: Sitting r/arm+

Pain is relayed as 5 on a scale of 0-10. shoulder, back and legs

ADL Status:

Bed Mobility: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

Transfers: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

Eating: Independent - No help or staff oversight at any time. with One person physical assist

Toilet Use: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

There are no cardiovascular concerns at this time. .

There are no respiratory concerns at this time. . .

[REDACTED] has unsteady gait, balance problems, ,no paralysis or weakness , ,

Skin is intact.

There are no GI issues at this time. Active .

There are no urinary concerns at this time. Maximilian is Continent of urine.

[REDACTED] is alert.

There are no mood problems at this time.

The following behaviors have been exhibited: Verbal behaviors,

Author: Patricia Murray - RN [ESOF]

10/19/2015 23:03 Type: Nursing Note

Note Text: Resident complained about needing an MRI for his shoulder, was told Dr. Priest wants x-ray first. Informed order given for x-ray of right arm. Called US Diagnostics, spoke with Matt, informed x-ray will be done tonight.

Author: Patricia Murray - RN [ESOF]

Date: Jan 7, 2016
Time: 10:43:41 CT
User: Stan Sakinis

Bridgeway Senior Living, LLC
Progress Notes

Facility #

Page # 15

Resident Name: [REDACTED] Location: - Admission Date: 10/23/2015

10/19/2015 14:10 Type: Nursing Note

Note Text: Resident came back from a doctor's appointment to this unit alert and coherent.No apparent distress observed.No new skin issues observed.

Author: Clodualdo P. Cadavez - RN [ESOF]

10/18/2015 10:26 Type: Daily Skilled Note

Note Text:

Note Text : [REDACTED] is receiving skilled care related to: Management / Evaluation of Resident Care Plan, Observation / Assessment of Resident's Condition, Therapy, PT, OT.

Current Vital Signs

T 97.6 - 10/18/2015 02:08 Route: Tympanic
P 78 - 10/18/2015 02:08 Pulse Type: Regular
R 20.0 - 10/18/2015 02:08
BP 134/76 - 10/18/2015 02:08 Position: Lying r/arm+

Pain is relayed as 0 on a scale of 0-10.

ADL Status:

Bed Mobility: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

Transfers: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

Eating: Supervision - Oversight, encouragement or cueing with Setup help only.

Toilet Use: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

There are no cardiovascular concerns at this time. .

There are no respiratory concerns at this time. . .

[REDACTED] has unsteady gait, balance problems, ,no paralysis or weakness , ,

Skin is intact.

There are no GI issues at this time. Active .

There are no urinary concerns at this time. Maximilian is incontinent of urine.

[REDACTED] alert.

There are no mood probelms at this time.

Date: Jan 7, 2016
 Time: 10:43:41 CT
 User: Stan Sakinis

Bridgeway Senior Living, LLC
 Progress Notes

Facility #

Page # 16

Resident Name: [REDACTED] Location: - Admission Date: 10/23/2015

Author: Tamiwe Helen Sichinga - LPN [ESOF]

10/17/2015 15:18 Type: Physician Progress Note

Note Text:

Note Text : called by pt for the pain in the back
 stated that he had therapy sessions yesterday and noted that his pain was severe once he got back to the bed.
 noted that the pain was at the spot where the kyphoplasty done.
 he denies any new numbness in the leg no bb incontinence
 also, he stated that he wants to take diladid every 2 h as needed due to pain.
 he believes that it is the best for him as it was given at the hospital.
 now pt was educated that this is no a hospital and due to his habitus and location he is in risk for apnea and death
 as we have no means to monitor him every 2 hs in nursing home and he has copd obesity and osa.

pe nad sleepy
 close his et times
 crispy voice, obese in the wc
 back there is no skin changes no local tenderness at the l/s area. no visual deformetis

a/p
 chornic pain syndrome
 opioid dependence
 will shortening to q 6 h 2 mg of hypdromoprphone monitor vs and spo2
 pt will see NS for evaluation of worsening his pain as it suppost to improve once kyphoplasly is completed.
 continue pt.ot
 total time spen 55 mins
 ff49mins
 counseling and coordination of care 40 mins

Author: Paul R Priest - Doctor [ESOF]

10/15/2015 20:59 Type: Physician Progress Note

Note Text:

Note Text : called by pt for excruciated pain inthe knee and back
 hoi
 [REDACTED] here for sar s/p kyphoplasty
 noted above during pt/ot
 stated that he has oa and was give hydromorphon for the pain with good result

denies any new neurological signs or symprtoms
 noetd that his edema subside
 bnp 16

pe nad inthe wc working on laptom
 bp 131/78 t 97.9 p 74
 heent at nc pupils reactive

Date: Jan 7, 2016

Bridgeway Senior Living, LLC
Progress Notes

Facility #

Time: 10:43:41 CT

User: Stan Sakinis

Page # 17

Resident Name: [REDACTED]

Location: -

Admission Date: 10/23/2015

lung now r/r
 cv regular distant
 abd obese
 mks; in TLSO, no edema at the knees from with mild crepitus
 skin significant erythema over the R shin
 +3 edema b/l
 neuro sensation preserve
 R side facial drop/asymetry
 mood okay affect anxious.

bnp 16

a/p
 pain syndrome
 complex due to dm and oa and recent l4 fx
 will ask for hydromorphone 2 mg prior p/ot
 and may have ibuprofen 400 mg daily prn for severe knee pain.

cellulitis
 continue abt
 diuretics
 and mupirocin

Author: Paul R Priest - Doctor [ESOF]

10/15/2015 07:44 Type: Nursing Note

Note Text: Received call from Dr. Priest RE: Testosterone Inj. *Pharmacy will not deliver without a valid script. Endorsed to 7-3 nurse to notify Dr. Priest. Also endorsed that resident is requesting to see Dr. Priest this a.m.

Author: Patricia Martinez - Licensed Practical Nurse [ESOF]

10/14/2015 16:29 Type: Social Service Note

Note Text: Resident has verbalized a desire to sleep in recliner chair and prefers that his bed be removed from his room. Resident states that he feels more comfortable in the chair and works best for him when getting up to transfer to wheelchair.

Author: Elizabeth Castenada - Social Worker [ESOF]

10/14/2015 15:39 Type: Social Service Note

Note Text:

Note Text : Care plan meeting held this date to discuss residents progress and goals in therapy as well as discharge planning. Resident is very happy with goals therapy has for him and became tearful to hear that he has good potential to become independent and be able to return home. Resident stated that his wife is not able to care for him as she is caring for their disabled son. Resident has plans to return home once he completes his therapy

Author: Elizabeth Castenada - Social Worker [ESOF]

10/14/2015 13:44 Type: Nursing Note

Note Text:

Date: Jan 7, 2016

Bridgeway Senior Living, LLC
Progress Notes

Facility #

Time: 10:43:41 CT

User: Stan Sakinis

Page # 18

Resident Name [REDACTED]

Location: -

Admission Date: 10/23/2015

Note Text : Called Senior Care pharmacy regarding resident's testosterone injection. Regan stated that the pharmacy could not dispense the medication without a prescription. Called Dr. Preist to request an script for this medication and doctor states he will write one when he comes to the facility today. Resident notified.

Author: Sharelle Mershon - Assistant Director of Nursing [ESOF]

10/14/2015 06:55 **Type:** Infection Note

Note Text: Dicloxacillin continuous for cellulitis of both legs and tolerating it well without any side effects, both legs remains very red, swollen and warm to touch, 140/78 98.1 86 20 SPO-96%RA.

Author: Alejandro S. Leonardo - RN [ESOF]

10/14/2015 02:56 **Type:** Daily Skilled Note

Note Text:

Note Text [REDACTED] is receiving skilled care related to: Management / Evaluation of Resident Care Plan, Observation / Assessment of Resident's Condition, Teaching / Training to Manage Resident's Treatment Regimen, Diabetic Care (diet, foot care, etc.), PT, OT.

Current Vital Signs

T 98.1 - 10/14/2015 02:53 Route: Tympanic
P 86 - 10/14/2015 02:53 Pulse Type: Regular
R 20.0 - 10/14/2015 02:53
BP 140/78 - 10/14/2015 02:53 Position: Lying r/arm+

Pain is relayed as 0 on a scale of 0-10.

ADL Status:

Bed Mobility: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

Transfers: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

Eating: Activity did not occur. with

Toilet Use: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

There are no cardiovascular concerns at this time. .

There are no respiratory concerns at this time. . The following respiratory treatments are received: nebulizer treatments, BiPap/CPap, .

[REDACTED] has unsteady gait, no issues with balance, ,no paralysis or weakness , ,

Skin is intact.

Date: Jan 7, 2016

Bridgeway Senior Living, LLC
Progress Notes

Facility #

Time: 10:43:41 CT

User: Stan Sakinis

Page # 19

Resident Name [REDACTED]

Location: -

Admission Date: 10/23/2015

There are no GI issues at this time. Active .

There are no urinary concerns at this time [REDACTED] is Continent of urine.

[REDACTED] is alert.

There are no mood problems at this time.

Author: Alejandro S. Leonardo - RN [ESOF]

10/13/2015 07:41 Type: Infection Note

Note Text:

Note Text : At 1am, resident woke up and then started to become verbally abusive e.g. screaming and threatening the CNA and yet he is saying he will talk to the head nurse that the CNA is very abusive towards him, resident was up in the TV room until 3am, and although he calm down a little still with occasional screaming and yelling, finally settled and slept at 4am, 138/76 96.0 78 20 SPO-96%RA.

Author: Alejandro S. Leonardo - RN [ESOF]

10/12/2015 17:03 Type: Orders Note

Note Text:

Note Text : please do
increase torosemide to 80 mg
bydureon 2 mg wkly
it is okay, for Pt to go to all outside apt with specialist.
restart testosterone 200 mcg IM every other week.
pt/o/v/st
dietician consult
daily weight
start on advair 500/50 bid
mupirocin ointment daily to the le daily
lamictal 300 mg bid
change adderal to 6 am
pt is DNR
cbc cmp bnp
vs, spO2
duoneb prn q shift for whizing

enodrse to RN PAT

Author: Paul R Priest - Doctor [ESOF]

10/12/2015 16:47 Type: Physician Progress Note

Note Text:

Note Text : C/C I have low T level with low cortisone as well.
MD note

Date: Jan 7, 2016
Time: 10:43:41 CT
User: Stan Sakinls

Bridgeway Senior Living, LLC
Progress Notes

Facility #

Page # 20

Resident Name: [REDACTED] Location: - Admission Date: 10/23/2015

Pt was seen and examined
HPI [REDACTED] 68 yo wm
with multiple medical problems listed below, here for sar, he has complex problems and stated that some of his chronic medications were d/c while he was transfer from the hosptial
he stated that he is depressed and takes lamictal 300 mg bid deneis any si.hi
stated that he takes byderoun for his DM
takes testosterone for his pituatry insuficiency
takes advair for his copd and noted some doe
take 80 mg of torosemide for his chf and now he stated that he swollen up.
deneis any chills no fever,
now c/o pf his back pain s/u kyphoplasty and knees pain chronic oa

also, noted blurred vision which slowly getting worse, over the last few months hx of DM

PMH
L 4 fx compression
Debility
DM
OA
depression
chf
copd

Surgical Hx
kyphoplasty x2

Social Hx
former smoker
+ etoh in the pass

FamilyHx
no hx of dementia

ROS:all reviewed and negative except in hpi

MEDICATIONS:
reviewed
apap
oxy 20 er bid
diazepam 10 mg
torosemid
40 bid

PE
GEN: nad
VS 129/65 t 9.4 p 65 r 18

Date: Jan 7, 2016

Bridgeway Senior Living, LLC
Progress Notes

Facility #

Time: 10:43:41 CT

User: Stan Sakinis

Page # 21

Resident Name

Location: -

Admission Date: 10/23/2015

HEENT: at/nc pupils reactive

LUNG: diminished bl no w a few wet ralas

CV: regular sem 2/6 with hoisystolic split

ABD:distended, no bs +

EXT: + 3 edema + 2 edema in ue

NEURO: speech and language preserved but confused at times, R hand light tremor

Psychiatric: mood and affect flat

skin there is extensive erythema onthe L shin with some vesicular elements,pt has difficulties to pull pants up due to edema

msk; from in ue L >R at shoulder

LABS

no hospital labs available

A/P

medical domain

back pain due to L 4 fx

s/p kyphoplasia

cotninue meds

will as for pt/ot

local pain treatment

depression

severe

requites MOA and lamictal

will resume

cellulitis on top of chf exacerbationand le edema

bl

acute

will continue dicloxacin and topical mupirosic

copd

resume advair

duoneb prn

hypogonadism

will resume testosterone injection for his pt/ot session as well

pt will f/u with his endo

hypopituatirism

primary most likiley due to no skin changes

willask for adderall in 6 am

dm

will resume byderon accucheck qac and q hs

obesity

Date: Jan 7, 2016
Time: 10:43:41 CT
User: Stan Sakinis

Bridgeway Senior Living, LLC
Progress Notes

Facility #

Page # 22

Resident Name: [REDACTED] Location: - Admission Date: 10/23/2015

dietician consult

blurred vision
family to make ophthalmology apt.

social support
good
discuss with his drt at the table

pt is dnr
discussed advance directive as pt slated above.

endorsed to RN PAT

Author: Paul R Priest - Doctor [ESOF]

10/11/2015 13:10 Type: Daily Skilled Note

Note Text:

Note Text : [REDACTED] is receiving skilled care related to: Management / Evaluation of Resident Care Plan, Observation / Assessment of Resident's Condition, PT, OT.

Current Vital Signs

T 98.2 - 10/11/2015 12:59 Route: Oral
P 88 - 10/11/2015 12:59 Pulse Type: Regular
R 20.0 - 10/11/2015 12:59
BP 130/80 - 10/11/2015 12:59 Position: Sitting l/arm+

Pain is relayed as 0 on a scale of 0-10.

ADL Status:

Bed Mobility: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

Transfers: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

Eating: Supervision - Oversight, encouragement or cueing with Setup help only.

Toilet Use: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

There are no cardiovascular concerns at this time. . .

There are no respiratory concerns at this time. . .

[REDACTED] has unsteady gait, balance problems, ,no paralysis or weakness , ,

Date: Jan 7, 2016
Time: 10:43:41 CT
User: Stan Sakinis

Bridgeway Senior Living, LLC
Progress Notes

Facility #

Page # 23

Resident Name: [REDACTED] Location: - Admission Date: 10/23/2015

Skin is intact.

There are no GI issues at this time. Active .

There are no urinary concerns at this time. Maximilian is Continent of urine.

[REDACTED] is alert.

There are no mood problems at this time.

Author: Joan B. Cadavez - RN [ESOF]

10/10/2015 15:01 Type: Daily Skilled Note

Note Text:

Note Text : [REDACTED] is receiving skilled care related to: Observation / Assessment of Resident's Condition, Therapy, PT, OT.

Current Vital Signs

T 98.3 - 10/10/2015 10:31 Route: Tympanic
P 83 - 10/10/2015 10:31 Pulse Type: UTD - Unable to Determine
R 18.0 - 10/10/2015 10:31
BP 145/82 - 10/10/2015 10:31 Position: Sitting /arm+

Pain is relayed as 8 on a scale of 0-10. BLE

ADL Status:

Bed Mobility: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with One person physical assist

Transfers: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with One person physical assist

Eating: Independent - No help or staff oversight at any time. with Setup help only.

Toilet Use: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with One person physical assist

There are no cardiovascular concerns at this time. .

There are no respiratory concerns at this time. . .

[REDACTED] has unsteady gait, balance problems, ,no paralysis or weakness . .

Skin is intact.

Date: Jan 7, 2016
 Time: 10:43:41 CT
 User: Stan Sakinis

Bridgeway Senior Living, LLC
 Progress Notes

Facility #

Page # 24

Resident Name: [REDACTED] Location: - Admission Date: 10/23/2015

There are no GI issues at this time. Active .

There are no urinary concerns at this time. Maximilian is Continent of urine.

[REDACTED] is alert.

There are no mood problems at this time.

Author: Hyanease Ruffin - Licensed Practical Nurse [ESOF]

10/10/2015 14:17 Type: Nursing Note

Note Text:

Note Text : Received up in chair. A&O x3 breathing easy & unlabored no SOB. Good appetite. Continent of B&B. Meds taken as order PO ABT for BLE cellulitis no s/s of adverse reaction BLE swollen & red warm to touch. VSS. Dr. Priest paged for orders testosterone injection. Dr. Felix on-call MD call said no he can not give order for that medication & pt need to follow up with endocrinologist educated pt to what Dr. Felix orders was. Pt is upset stating that Dr. Priest was to come in to see him today but has not showed up. Pt stated that if Dr. Priest doesn't come in today by 4pm to see him he will leave the facility. Nursing supervisor made aware & came to talk with pt. Pt is now calm. Sitting dining room n his personal lap top pc. Will continue to monitor.

Author: Hyanease Ruffin - Licensed Practical Nurse [ESOF]

10/10/2015 07:30 Type: Infection Note

Note Text:

Note Text : 11:15pm, resident was very calm and quiet and working on his computer in the TV room, at 12am, he started demanding for a Valium which he already received at 10pm, resident refused RN's explanation that he just received it at 10pm and he got angrier when the book was showed to her, " It is all lies", screaming and yelling and was verbally and physically threatening to RN, resident able to calm down but remains very angry and refusing the RN to come closer, finally settled/ sleepy and was put back to bed at 1:45am. Both legs remains very red and swollen, but warm to touch with (+) pedal pulses, Dicloxacillin continuous and tolerating it well. 140/78 98.0 78 20 SPO-97%RA. woke up at 5:30am, very restless and agitated, Valium 10mg. given with good results.

Author: Alejandro S. Leonardo - RN [ESOF]

10/10/2015 03:18 Type: Daily Skilled Note

Note Text:

Note Text : [REDACTED] is receiving skilled care related to: Management / Evaluation of Resident Care Plan, Observation / Assessment of Resident's Condition, Teaching / Training to Manage Resident's Treatment Regimen., Diabetic Care (diet, foot care, etc.), PT, OT.

Current Vital Signs

T 98.0 - 10/10/2015 02:19 Route: Tympanic
 P 78 - 10/10/2015 02:19 Pulse Type: Regular
 R 20.0 - 10/10/2015 02:19
 BP 140/78 - 10/10/2015 02:19 Position: Sitting r/arm+

Date: Jan 7, 2016
 Time: 10:43:41 CT
 User: Stan Sakinis

Bridgeway Senior Living, LLC
 Progress Notes

Facility #

Page # 25

Resident Name: [REDACTED] Location: - Admission Date: 10/23/2015

Pain is relayed as 0 on a scale of 0-10.

ADL Status:

Bed Mobility: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

Transfers: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

Eating: Activity did not occur, with

Toilet Use: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

There are no cardiovascular concerns at this time. .

There are no respiratory concerns at this time. . .

[REDACTED] has unsteady gait, balance problems, ,no paralysis or weakness , .

Skin is intact.

There are no GI issues at this time. Active .

There are no urinary concerns at this time. Maximilian is Continent of urine.

[REDACTED] is alert.

The following mood problems are exhibited:

Author: Alejandro S. Leonardo - RN [ESOF]

10/9/2015 16:17 Type: Social Service Note

Note Text:

Note Text : Resident very upset and demanding to see his doctor. Resident states he has a lot of questions he need to discuss with his doctor and demanding that the physician come to see him today. Charge nurse called and spoke with Dr. Haebich to inform of residents request and he stated he is not able to come and see resident today. Resident very irrational and demanding to change physician. Resident signed change of physician form and chose Dr. Royal-Priest as his primary. Dr. Royal-Priest was called and he spoke with resident over the phone. Resident still not satisfied and continues to be very upset and disruptive in nurses station. Attempting to calm resident down but not very successful. Nurse supervisor made aware of residents behavior and will speak with him.

Author: Elizabeth Castenada - Social Worker [ESOF]

10/9/2015 15:37 Type: Nursing Note

Date: Jan 7, 2016

Bridgeway Senior Living, LLC
Progress Notes

Facility #

Time: 10:43:41 CT

User: Stan Sakinis

Page # 26

Resident Name: [REDACTED] Location: - Admission Date: 10/23/2015

Note Text: Resident was sitting in the dinning room all day with his lap top computer. Notice his lower extremities is edematous and red. Per NP resident has cellulitis in his lower extremities. Will monitor.

Author: Maria Manlapaz - Licensed Practical Nurse [ESOF]

10/9/2015 11:12 Type: Nursing Note

Note Text: Caleed MD to verify order for Bydureon inj. and MD refused to give order. MD was made aware that resident wants to see him today but stated he cannot come and is uncertain what day he could see the resident. Resident was made aware.

Author: Joan B. Cadavez - RN [ESOF]

10/9/2015 07:30 Type: Infection Note

Note Text:

Note Text : Resident woke up at 12:30am and unable to get back to sleep and on request was up in the TV room where he stays working on his computer, Dicloxacillin continuous for cellulitis on both legs and tolerating it well, legs remains very red and swollen, 125/63 98.4 80 20 SPO-94%RA. At 4am, resident finally get bored and was put back to bed on request, Slept for a couple of hours and woke up and was up on request at 6:45am.

Author: Alejandro S. Leonardo - RN [ESOF]

10/8/2015 11:20 Type: Infection Note

Note Text: Afebrile with a Temp. of 98F. Redness, swelling and warmth sensation still noted on BLE. On Dicloxacillin for cellulitis on BLE with no adverse reactions.

Author: Clodualdo P. Cadavez - RN [ESOF]

10/8/2015 07:28 Type: Infection Note

Note Text: Observed to slept most of the night, Dicloxacillin continuous for cellulitis of both legs and tolerating it well without any side effects, both legs remains red and slightly swollen and warm to touch, v/s stable.

Author: Alejandro S. Leonardo - RN [ESOF]

10/7/2015 12:50 Type: Daily Skilled Note

Note Text:

Note Text [REDACTED] is receiving skilled care related to: Observation / Assessment of Resident's Condition, Use and Care of Braces, Splints, Orthotics, Therapy, PT, OT.

Current Vital Signs

T 98.4 - 10/7/2015 09:54 Route: Tympanic
P 81 - 10/7/2015 09:54 Pulse Type: Regular
R 20.0 - 10/7/2015 09:54
BP 134/70 - 10/7/2015 09:54 Position: Sitting l/arm+

Pain is relayed as 5 on a scale of 0-10. Back

ADL Status:

Bed Mobility: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

Date: Jan 7, 2016
 Time: 10:43:41 CT
 User: Stan Sakinis

Bridgeway Senior Living, LLC
 Progress Notes

Facility #

Page # 27

Resident Name: [REDACTED] Location: - Admission Date: 10/23/2015

Transfers: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

Eating: Independent - No help or staff oversight at any time. with Setup help only.

Toilet Use: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

There are no cardiovascular concerns at this time. .

There are no respiratory concerns at this time. . The following respiratory treatments are received: BiPap/CPap, .

[REDACTED] has unsteady gait, balance problems, ,no paralysis or weakness , ,

The following skin conditions exist:

There are no GI issues at this time. Active .

There are no urinary concerns at this time. Maximilian is Continent of urine.

[REDACTED] is alert. Staff names and faces,

There are no mood problems at this time.

Author: Clodualdo P. Cadavez - RN [ESOF]

10/7/2015 07:56 Type: Infection Note

Note Text:

Note Text : Woke up at 3am and unable to get back to sleep, was up in the TV request and just use his computer the rest of the night, Diclxacillin continuous for cellulitis of both legs and tolerating it well without any side effects, No c/o made. 128/77 98.0 78 20 SPO-97%.

Author: Alejandro S. Leonardo - RN [ESOF]

10/5/2015 16:25 Type: Social Service Note

Note Text:

Note Text : Initial Admit Note:

Admitted this 68 year old married white male on 10/1/15 from Central Dupage hospital with a diagnosis of left lumbago with sciatica, hypothyroidism, attention deficit disorder, major depressive disorder, anxiety disorder, PTSD. Resident is alert and oriented x3, BIMS score 15/15. He is able to verbalize needs and understands others. Resident was previously living with his wife in a house and has plans to return home once he completes his rehabilitation. Resident is hopeful that he will be walking again and return home with his wife. He appears calm and cooperative today. Resident has history of becoming agitated, resistive to care and physically aggressive towards staff. Referral made to psychiatry. Resident wishes to be full code. He does not have any existing advance directives and may consider doing a POA for healthcare. Social services will follow up and assist with POA completion.

Date: Jan 7, 2016
Time: 10:43:41 CT
User: Stan Sakinis

Bridgeway Senior Living, LLC
Progress Notes

Facility #

Page # 28

Resident Name [REDACTED] Location: - Admission Date: 10/23/2015

Author: Elizabeth Castenada - Social Worker [ESOF]

10/5/2015 16:17 Type: Consultation Note

Note Text:

Note Text : GEROPSYCH EVALUATION

PATIENT IS A 68 YEAR OLD MALE ADMITTED 10-1-15 FROM CENTRAL DUPAGE HOSPITAL.

CC: REFERRED FOR EVALUATION DUE TO AGGRESSIVE BEHAVIOR, PSYCH DIAGNOSIS AND NEED FOR MED MANAGEMENT.

VITALS: BP 120/74 TEMP 97.3 HR 70
WEIGHT:320 LBS

PMH

LUMBAGO WITH SCIATICA
HYPOTHYROID
ADHD
GERD
CHF
MORBID OBESITY
DM
METABOLIC SYNDROME
MAJOR DEPRESSIVE DIS
ANXIETY DISORDER
POST TRAUMATIC STRESS DIS
NARCISSISTIC PERSONALITY DIS
OSA
HTN
VENTRICULAR FLUTTER
COPD
LEFT SHOULDER ROTATOR CUFF TEAR
CKD
LUMBAR VERTEBRAL FX
FALL
CELLULITIS

CURRENT MEDS

**NARDIL 30MG QAM
**NARDIL 45MG QHS
**PRN VALIUM 10MG Q 12 HOURS
DICLOXACILLIN
VIT D
ASA

Date: Jan 7, 2016
Time: 10:43:41 CT
User: Stan Sakinis

Bridgeway Senior Living, LLC
Progress Notes

Facility #

Page # 29

Resident Name: [REDACTED]

Location: -

Admission Date: 10/23/2015

PREGABALIN
PROTONIX
OMEGA 3
LOVENOX
METANX
INSULIN
LORATADINE
TORSEMIDE
LEVOTHYROXINE
SENNA

SH/FH/PSYCH

MARRIED, 3 CHILDREN, WORKS ON AND OFF AS COMPUTER SOFTWARE DESIGNER.

LONG HISTORY OF PSYCHIATRIC PROBLEMS. REPORTS HE WAS OLDEST OF 14 CHILDREN AND HE WAS NEGLECTED SINCE AGE 2 CAUSING DEPRESSION AND COMPLEX PTSD. HAS SEEN PSYCHIATRIST AND PSYCHOANALYST FOR 18 YEARS AND THERAPISTS SINCE HE WAS YOUNG MAN.

QUIT SMOKING IN 1980 AND HAD PERIOD OF HEAVY DRINKING FROM 1985 TO 1996 "WHEN A MAN ROBBED ME OF \$15 MILLION". NOW ABSTINENT.

FAMILY HISTORY OF DEPRESSION IN SEVERAL SIBLINGS AND ONE OF HIS SONS. SON WITH MULTIPLE SUICIDE ATTEMPTS NOW WITH HEMIPLEGIA AND BRAIN DAMAGE AND LIVING WITH HIM, BEING TAKEN CARE OF BY HIS WIFE AT HOME.

MSE

PATIENT IS OBESE WM IN BODY BRACE. UNSHAVEN
DISHEVELLED HAIR. GROOMING IS POOR. MILD TREMOR OF HANDS. POSTURE UPRIGHT IN BRACE IN W/C.

SPEECH WAS COHERENT AND TP WAS LOGICAL. VERY WILLING TO TALK AT LENGTH ABOUT HIMSELF.
LANGUAGE AND ASSOCIATIONS INTACT. ORIENTED TO SELF, PLACE WAS CALLED BAYVIEW. KNEW OCT 5TH, 2015 AND PRESIDENTS OBAMA, BUSH AND CLINTON. ATTENTION WAS GOOD BUT EYE CONTACT WAS NOT ALWAYS GOOD; I.E. SCANNING THE ROOM THROUGHOUT THE INTERVIEW.
MEMORY INTACT.

MOOD WAS ANXIOUS AND DYSPHORIC. NOT PSYCHOTIC.
JUDGMENT IS FAIR. INSIGHT IS FAIR. NO SI/HI.

PATIENT WAS ALERT AND COOPERATIVE WITH INTERVIEW.

Date: Jan 7, 2016
 Time: 10:43:41 CT
 User: Stan Sakinis

Bridgeway Senior Living, LLC
 Progress Notes

Facility #

Page # 30

Resident Name: [REDACTED] Location: - Admission Date: 10/23/2015

REPORTED PAIN IN LEFT SHOULDER AND RIGHT LEG AND BILATERAL KNEES. ACKNOWLEDGES A LONG HISTORY OF DEPRESSION AND TREATMENT AND BELIEVES THE BEST MEDICATION HAS BEEN A COMBINATION OF NARDIL AND LAMICTAL. SAYS HE'S DEPRESSED AS "I CAN BE" AND CRIES A BIT BUT IS MOTIVATED TO DO WELL IN THERAPY AND RETURN HOME. SLEEPS OK, EATS OK NOW THAT HE KNOWS THE PLAN OF THERAPY AND IS NOW HOPEFUL. WAS AFRAID HE WOULD NOT WALK AGAIN. ENERGY STILL LOW.
 PLANS TO RETURN TO WHEATON TO LIVE WITH WIFE AND DISABLED SON.

IMPRESSION

1. MAJOR DEPRESSION
2. PTSD PER HISTORY
3. PERSONALITY DISORDER
4. R/O ADJUSTMENT DISORDER
5. RECENT CALL TO 911--WONDER IF PART OF A CONFUSION/DELIRIUM?

SUGGEST

1. CONTINUE CURRENT MEDICATION
 2. MONITOR MOOD, APPETITE, SLEEP, BEHAVIOR AND COGNITIVE FUNCTIONS
 3. STRONGLY ENCOURAGED TO FIND ANOTHER PSYCHOTHERAPIST
 4. CONT TO FOLLOW WITH PRIVATE PSYCHIATRIST AFTER DISCHARGE
- WILL FOLLOW THANK YOU.

Author: Ismael LeeChuy - Physician [ESOF]

10/5/2015 09:54 Type: Nursing Note

Note Text:

Note Text : Alert and responsive.No manifestations of pain or discomfort.No complaints of dyspnea.Cooperative with nursing staff.No inappropriate behavior noted.Redness still apparent on BLE.On Dicloxacillin for BLE cellulitis with no adverse reactions.V/S checked BP-120/74 mmHg,pulse-70 beats/min.,RR-20 cycles/min.,and Temp.97.3F.

Author: Clodualdo P. Cadavez - RN [ESOF]

10/5/2015 07:00 Type: Infection Note

Note Text:

Note Text : Resident was very anxious and needy early in shift but able to calm down once his needs are met e.g. took him to bathroom when requested and made him comfortable in bed, both lower legs remains red and slightly swollen but warm to touch with (+) pulses, Dicloxacillin continuous and tolerating it well without any side effects, No c/o made this shift 124/68 97.9 68 18 SPO-95%RA, finally settled and slept at 2am until 5am, very compliant with meds.and care. encouraged to verbalized for his needs and concerns.

Author: Alejandro S. Leonardo - RN [ESOF]

10/4/2015 10:29 Type: Daily Skilled Note

Note Text:

Note Text [REDACTED] is receiving skilled care related to: Observation / Assessment of Resident's Condition, Use and Care of Braces, Splints, Orthotics, Therapy, PT, OT.

Current Vital Signs

Date: Jan 7, 2016
Time: 10:43:41 CT
User: Stan Sakinis

Bridgeway Senior Living, LLC
Progress Notes

Facility #

Page # 31

Resident Name: [REDACTED] Location: - Admission Date: 10/23/2015

T 97.6 - 10/4/2015 09:12 Route: Tympanic
P 68 - 10/4/2015 09:12 Pulse Type: Regular
R 20.0 - 10/4/2015 09:12
BP 138/74 - 10/4/2015 09:12 Position: Sitting l/arm+

Pain is relayed as 0 on a scale of 0-10.

ADL Status:

Bed Mobility: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

Transfers: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

Eating: Independent - No help or staff oversight at any time. with Setup help only.

Toilet Use: Extensive Assistance - Resident involved in activity, staff provide weight-bearing support with Two+ persons physical assist

There are no cardiovascular concerns at this time. .

There are no respiratory concerns at this time. . The following respiratory treatments are received: BiPap/CPap, .

[REDACTED] has unsteady gait, balance problems, ,no paralysis or weakness , ,

The following skin conditions exist:

There are no GI issues at this time. Active .

There are no urinary concerns at this time. [REDACTED] is Continent of urine.

[REDACTED] is alert. Staff names and faces.

There are no mood problems at this time.

Author: Clodualdo P. Cadavez - RN [ESOF]

10/4/2015 07:08 Type: Infection Note

Note Text:

Note Text : Observed to slept most of the night, woke up a couple of times but very calm and appears in control, verbalized for his needs without any agitation, both legs remains red and swollen and warm to touch, kept elevated on a pillow, Dicloxacillin continuous and tolerating it well without any side effects, 144/65 96.8 60 20 SPO-94%RA.

Author: Alejandro S. Leonardo - RN [ESOF]

Date: Jan 7, 2016

Bridgeway Senior Living, LLC
Progress Notes

Facility #

Time: 10:43:41 CT

User: Stan Sakinis

Page # 32

Resident Name: [REDACTED]

Location: -

Admission Date: 10/23/2015

10/3/2015 09:21 Type: Social Service Note

Note Text:

Note Text : One on one with resident to discuss events of lasdt night. When asked why he had called Sheriff and 911 resident stated because no one would take him to bathroom. Writer reminded resident when staff had tried to help him he would not allow them to touch him. Resident denied this. Resident also stated it was because he did not receive therapy. Resident reminded when therapy came to assess for transfer he refused. Resident also denies this. Resident present with angry, agitated mood. Resident still had breakfast tray in front of him and when asked why he hadn't eaten by writer resident raised voice to writer and told writer he did not want to eat and to take tray away. Resident than recheck by writer after tray was removed and resident was sleeping comfortably in bed. Nursing informed of conversation.

Author: Maggie M Kueking - Social Services [ESOF]

10/3/2015 08:05 Type: Nursing Note

Note Text:

Note Text : Resident came back from Alexian Bros. Medical Center via stretcher with 2 paramedics. Resident is alert and verbally responsive. No complaints of dyspnea nor pain. No signs or symptoms of hypo or hyperglycemia. V/S taken BP-130/80 mmHg, pulse-76 beats/min, RR-20 cycles/min. and Temp. 97.8F. Skin check done with no new skin issues noted. Dr. Haebich notified.

Author: Clodualdo P. Cadavez - RN [ESOF]

10/3/2015 07:35 Type: Nursing Note

Note Text:

Note Text : Resident woke up at 11:50pm, calm, quiet and in control and compliant with v/s=109/76 97.1 75 20 SPO-96%RA, 15min. later he started screaming said he needs to go to the bathroom, it took 3-4min. to gather 5 CNA that will help him but when CNAs arrived he does not want to be touch or be helped said "Nobody here knows what to do" then he said he needs a special bed, a big boy bed was offered but he refuses and just continue screaming, at 12:30am, Sheriffs office called but said he will not going to send anybody once the situation was explained to him and then Norcom Public safety called and then a few min. later Paramedics arrived escorted by 2 Policeman, Paramedics was given report of what was going on and then spent time interviewing the resident alone, resident left per stretcher to ABMC at 1:05am, wife was called and was made aware of the situation, Lydia, RN/NP was notified and Rizza ADON was also made aware of the problem. At 3:45am, received a call from Ruth at ABMC and that resident is coming back, and DVT was R/O. At 7am, ER called and said that resident just left the premise.

Author: Alejandro S. Leonardo - RN [ESOF]

10/2/2015 18:08 Type: Nursing Note

Note Text:

Note Text : Resident seen sleeping in the chair. Therapist came to do assessment on transfer. Refused to be transferred. Responded to pain stimuli. Refused to eat dinner. Family came and talked to nurse. Stated not to bother the resident when he is sleeping and to honor whatever is his decision about the care. Resident refused all his pm medications. MD made aware. Sleeping in the chair calmly and not on any kind of distress.

Author: Joan B. Cadavez - RN [ESOF]

10/2/2015 17:13 Type: Nursing Note

Note Text: Nurse Practitioner came and examined resident with orders for lab and antibiotics for both leg Cellulitis. All orders carried out.

Date: Jan 7, 2016
 Time: 10:43:41 CT
 User: Stan Sakinis

Bridgeway Senior Living, LLC
 Progress Notes

Facility #

Page # 33

Resident Name: [REDACTED] Location: - Admission Date: 10/23/2015

Author: Joan B. Cadavez - RN [ESOF]

10/2/2015 12:03 Type: Skin/Wound Note

Note Text:

Note Text : Admitted a 68 year old male w/ dx of Chronic CHF, Pain/t trauma, Hypothyroidism, DM Insipidus, PTSD, Asthma, Atrial flutter, Gastro-esophageal Reflux disease. Resident is A&OX2-3 with periods of confusion, incontinent of bowel and bladder, ambulatory via w/c. Res at risk for skin breakdown r/t impaired mobility, incontinence of bowel and bladder. During skin assessment the following was observe: Res is Morbidly Obese. Bilateral lower extremities very edematous, pitting edema +4, reddened, with hemosedirin , staining, warm touch, +CMS, able to wiggle toes.

Author: Susan Echevarria - Wound Care Coordinator [ESOF]

10/2/2015 09:01 Type: Nursing Note

Note Text:

Note Text : Received resident sitting on the chair in his room , calmed and is able to answer questions coherently. Morning pills taken without any hesitation. Therapist made aware for assessment on transfer. Medications verified by Dr. Haebich , reminded on script for Lyrica. Resident refused to sign consent for Haldol . Resident wants all medications in a packet with names before giving it to him . Psyche personnel came and assess the resident. No combative behavior noted. Refused to eat breakfast. Kept comfortable in the chair. Urinal offered.

Author: Joan B. Cadavez - RN [ESOF]

10/2/2015 08:08 Type: Nursing Note

Note Text:

Note Text : Upon evening round CNA was noted trying to assist resident in repositioning in chair. When CNA touched residents arm. Resident balled up fist and swung at aid and punch landed on left shoulder. Writer tried to calm resident down. Resident became very combative and verbally abusive. Resident screamed entire shift. Resident was accusing staff of lying and was noted becoming increasingly confused. Resident was not compliant with medications. Will continue to monitor and follow current plan of care.

Author: Jade Clark - Licensed Practical Nurse [ESOF]

10/2/2015 08:08 Type: Nursing Note

Note Text: Resident refused TB testing endorsed to next shift to try when combative behavior subsided.

Author: Jade Clark - Licensed Practical Nurse [ESOF]

10/2/2015 04:30 Type: Elopement Risk

Note Text: [REDACTED] was admitted on 10/1/2015, is currently in room 1106-1 and scored 4.0. A score 5 or greater indicates high risk for elopement.

Author: Jade Clark - Licensed Practical Nurse [ESOF]

10/1/2015 19:34 Type: Nursing Note

Note Text: Received resident via stretcher. Escorted by 3 staff members. No signs of distress noted. Slightly lethargic when asked questions.

Author: Jade Clark - Licensed Practical Nurse [ESOF]

PT

All (*) Areas must be Completed

* Printed Patient Name: [Redacted]
 * Address: [Redacted]
 * City: [Redacted] * Zip Code: [Redacted]
 * Date of Birth: [Redacted]
 * Telephone Number: [Redacted]

I hereby authorize Alexian Brothers Behavioral Health Hospital to release and exchange written, oral or electronically transmitted protected health information indicated below on the above named individual to:
 (facility name)
 * Provider Name/Organization/Individual: MICHAEL LABRINI DETECTIVE BENSenville POLICE
 Full address of Provider/Organization/Individual: 1651 NEW LAUREL RD
 * City: HAFFMAN * State: IL * Zip Code: 60148 * Telephone #: 815.882.1600
 * Including information pertained to: Psychiatric Care & Treatment Substance Abuse Care & Treatment Medical Care & Treatment
 * For the following purpose: Physician or Health Care Facility Legal Purposes Personal Use Follow-up Care Tuition Payment School Staffing
 Placement Insurance Determination Vocational Service Referral Continuity of Care At Request of the Individual
 Primary Care Physician (Identify): DR. KENNETH DE LUSSANETTO
 * Treatment date(s): 11/1/2015 to 11/1/2015 Date Authorization Expires: 11/1/2016
 Treatment Date(s) must include month and year. (1 year maximum)

INFORMATION TO BE DISCLOSED:
 Dates of Admission & Discharge
 Face Sheet
 History and Physical
 Physical Health Services
 Consultation
 Admission Assessment
 Discharge Summary
 Psychiatric Evaluation
 Psychological Evaluation
 Psychosocial Assessment
 Level of Care Screening
 Other (Specify):
 Speech & Language Eval
 Laboratory Results
 Radiology Reports
 Treatment Update
 Progress Notes
 Attendance
 Medication Information
 Psychiatric Diagnosis
 Treatment Information
 Follow-up care
 Chemical Dependency Diagnosis
 Medical Conditions and / or Diagnosis
 Homecare Information
 IEP or 504 Plan Information
 School Information Form
 HIV Documentation (Must Initial) _____
 Work Letter MAY Disclose Treatment Type and Facility (Must Initial)
 Work Letter MAY NOT Disclose Treatment Type and Facility (Must Initial)

WORK LETTERS ARE NOT TO BE FAXED THEY MUST BE PICKED UP BY PATIENT
 I understand that:
 • The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).
 • I have the right of access to inspect and obtain a copy of my protected health information.
 • I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the Health Information Management Department.
 • Revocation will not apply to information that has already been released in response to this authorization.
 • Re-disclosure is prohibited unless the person who consented to the disclosure specifically consents to re-disclosure. However, once the above information is disclosed, there is the potential that it may be re-disclosed by the recipient, and therefore may not be protected by the federal privacy laws regulations.
 • Failure to provide all required information will not constitute a proper authorization to disclose protected health information and that, therefore, my request may not be honored.
 • Authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment, payment or eligibility for benefits.
 * (Signature of Patient) [Redacted] * (Date) 12/16 * (Signature Parent or Legal Representative) [Redacted] * (Date) 12/16
 (Patient 17 years of age must sign in addition to the Parent or Legal Representative)
 * (Witness Signature) [Redacted] * (Date) 12/16
 (If signed by a legal representative, indicate the relationship to patient or authority to act for patient.)
 Fees/charges will comply with all laws and regulations applicable to release protected health information.

FOR FACILITY USE: Date received: _____ Date completed: _____ MR #: _____
 When applicable, the identity of the legal representative was verified by the following documentation and established that he/she has capacity. The above named legal representative is authorized to act on behalf of the patient: Driver's License, Picture ID, Legal guardian, Court appointed legal guardian
 Power of Attorney, Executor of Estate, Other: _____
 Person/Department completing the request: _____
 Authorization to Disclose Protected Health Information

WINTERS, MAXIMILIAN

Fac: AB Behavioral Health Hospital

Loc: 3 North

Bed: 3304-1

68 M

Med Rec Num: H000129172

Visit:

Attending: AQEEL A KHAN

Reg Date: 11/01/15

Reason:

Transfer Assessment

10/31/15 22:14

Transfer Assessment

Start: 10/31/15 20:49

Status: Active

Freq:

Document TLP (Rec: 10/31/15 22:35 TLP BHINT1PC06)

Transfer Assessment

Transfer Assessment

Date of Assessment

11/01/15

Time of Assessment

03:15

Transferred From

BRIDGEWAY SENIOR LIVING

Mode of Arrival

Ambulance

Source of Information

Clinical Record

Symptoms That Require Psy Adm

Risk of Self-Harm and/or Harm to Others Yes

Query Text: Risk of Self-Harm and/or Harm to Others Due to Dementia, Psychosis, Confusion, Poor Insight or Poor Judgment

Provide details regarding any boxes checked above

PER PETITION: ON OCTOBER 31, 2015 [REDACTED] CALLED 911 AT AROUND 2:30AM TO THE BRIDGWAY SENIOR LIVING FACILITY.

[REDACTED] INFORMED THE POLICE THE NURSING STAFF WAS ABUSING HIM AND HITTING HIM. HE WAS YELLING AT THE STAFF AND CALLING THE NURSING STAFF, BITCHES AND TO GET OUT OF HIS FUCKING ROOM. THE POLICE DEPARTMENT WANTED TO TAKE HIM TO THE POLICE DEPARTMENT FOR ABUSING THE 911 SYSTEM AS HE HAS CALLED THE 911 SYSTEM MANY TIMES IN THE PAST. THEY ELECTED NOT TO DUE TO HIS FRAIL HEALTH STATUS.

[REDACTED] WAS AGGRESSIVE AND SCREAMED AT THE STAFF AS HE ACCUSED THE NURSING STAFF OF NOT GIVING HIM IS HYDROMCRPHONE MEDICATION.

[REDACTED] SIGNED AN "AGAINST MEDICAL ADVICE" MEDICAL FORM STATING HE WANTED TO BE DISCHARGED.

THIS AFTERNOON [REDACTED] BECAME INCREASINGLY AGITATED AND HE COULD NOT BE REDIRECTED. HE THREATENED THE STAFF BY THROWING OBJECTS SUCH AS HIS

11/01/15
M KHAN, AQEEL A, MD
MR# H000129172 RFG
ACCT# [REDACTED]

Fac: AB Behavioral Health Hospital

Loc: 3 North

Bed: 3304-1

68 M

Med Rec Num: H000129172

Visit: [REDACTED]

BEDSIDE COMMODE, HIS CLOTHES AND SHOES. HE THREW HIS HARD PLASTIC BRACE FOR HIS BACK AND HIS SMALL PERSONAL REFRIGERATOR TO THE GROUND BUT THE STAFF CAUGHT THIS BEFORE IT FELL. HE THREW HIS PERSONAL CARE ITEMS AT THIS BEDSIDE ONTO THE GROUND. HE SAT IN HIS ROOM ALONE AND WANTED THE DOOR SHUT. WHEN NURSING STAFF WOULD GO TO CHECK ON HIM HE WOULD YELL AT THEM AND SHOUT PROFANITY AT THEM. [REDACTED] WOULD SIT IN HIS WHEELCHAIR WITH THE TV ON. HIS UNDERWEAR WERE HALF OFF AND HE WAS SITTING LOWER IN THE WHEELCHAIR. THE STAFF BROUGHT IN HIS DINNER AROUND 5:00PM [REDACTED] THREW THIS ACROSS THE ROOM AND ONTO THE FLOOR. HIS MOOD DYSREGULATED WITH LOWS AND HIGHS AS HE WOULD BECOME INCREASINGLY AGITATED AND THEN BEGIN TO WHIMPER AND CRY AT OTHER TIMES. [REDACTED] HAS EXHIBIT BIZARRE BEHAVIORS TODAY THAT ARE SHOWING AN INCREASE AND DECREASE IN HIS MOOD OVER THE PAST TWENTY FOUR HOURS. TODAY [REDACTED] HAS SHOWN TO BE A DANGER TO HIMSELF AND OTHERS WITH THROWING OF OBJECTS, SCREAMING OUT OF HIS ROOM AND UPSETTING THE RESIDENTS WHO SHARE THE UNIT THAT HE RESIDES IN. SEVERAL OF THE RESIDENTS ARE AFRAID TO GO TO THEIR ROOMS AND ARE SITTING OUT OF THE RESIDENT'S EATING AREA. SOME RESIDENTS HAVE CLOSED THEIR DOORS. DR. ABDO WAS THE PHYSICIAN ON CALL AND HE WAS NOTIFIED OF THE BEHAVIORS [REDACTED] WAS EXHIBITING TODAY. DR. ABDO GAVE ORDERS FOR [REDACTED] TO BE SENT TO THE EMERGENCY ROOM FOR AN EVALUATION DUE TO BEING A DANGER TO SELF AND TO OTHERS. [REDACTED] WAS

11/01/15
 68 M KEAN, AQSEL A, MD
 HR# 8000129172 RFG
 ACCT [REDACTED]

Fac: AB Behavioral Health Hospital

Loc:3 North

Bed:3304-1

68 M

Med Rec Num:H000129172

Visit

Case Dispcision

Level of Care Recommended
 Patient Accept/Decline
 Accepting MD
 Admitting MD
 Inpatient Service Selected by Physician
 Inpatient Bed #

Inpatient
 Accepted
 KHAN,AQEEL A
 KHAN,AQEEL A
 GERO
 3304-1

User Key

Monogram	Mnemonic	Name	Provider Type
TLP	HAIDTLP	Pearson,Terri L	Access Staff

11/01/15

68 M KHAN,AQEEL A , MD

MR# H000129172 HFG

ACCT#

**ALEXIAN BROTHERS BEHAVIORAL HEALTH HOSPITAL
INPATIENT PSYCHOSOCIAL ASSESSMENT**

Patient Name: [REDACTED]

I. SYMPTOM CHECKLIST

CURRENT PAST

A. MOOD DISORDERS Pt denies

- | | | |
|--------------------------|-------------------------------------|---|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | Depressed mood |
| <input type="checkbox"/> | <input type="checkbox"/> | Daily irritability |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | Lack of interest/pleasure in activities |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | Increase in appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty sleeping |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor sleeping |
| <input type="checkbox"/> | <input type="checkbox"/> | Increased need for sleep |
| <input type="checkbox"/> | <input type="checkbox"/> | Decreased need for sleep |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | Restlessness |
| <input type="checkbox"/> | <input type="checkbox"/> | Inability to concentrate |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty making decisions |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | Fatigue/loss of energy |
| <input type="checkbox"/> | <input type="checkbox"/> | Feelings of worthlessness |
| <input type="checkbox"/> | <input type="checkbox"/> | Feelings of guilt |
| <input type="checkbox"/> | <input type="checkbox"/> | Feelings of hopelessness |
| <input type="checkbox"/> | <input type="checkbox"/> | Recurrent thoughts of death |

Comments: denying current depressive sx. "its under control." reports that he was crying because of intense pain and "thye took that as a sign of mental problems." s/t "i have been depressed all my life."

Pt denies

- | | | |
|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Elevated mood |
| <input type="checkbox"/> | <input type="checkbox"/> | Euphoric Mood |
| <input type="checkbox"/> | <input type="checkbox"/> | Increase in pleasurable activities |
| <input type="checkbox"/> | <input type="checkbox"/> | Increased energy |
| <input type="checkbox"/> | <input type="checkbox"/> | Rapid Mood Swings |
| <input type="checkbox"/> | <input type="checkbox"/> | Racing thoughts or ideas |
| <input type="checkbox"/> | <input type="checkbox"/> | Distractibility |
| <input type="checkbox"/> | <input type="checkbox"/> | Agitation |
| <input type="checkbox"/> | <input type="checkbox"/> | Grandiosity |
| <input type="checkbox"/> | <input type="checkbox"/> | Hyperactivity |
| <input type="checkbox"/> | <input type="checkbox"/> | Hyper verbal speech |
| <input type="checkbox"/> | <input type="checkbox"/> | Impulsivity |
| <input type="checkbox"/> | <input type="checkbox"/> | Violent Behavior |

Comments:

B. RISK OF HARM Pt denies

- | | | |
|-------------------------------------|-------------------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Suicidal ideation |
| <input type="checkbox"/> | <input type="checkbox"/> | Suicide attempt |
| <input type="checkbox"/> | <input type="checkbox"/> | Homicidal ideation |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Violence towards person |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Violence towards property |
| <input type="checkbox"/> | <input type="checkbox"/> | Self injury behaviors |

CURRENT PAST

C. ANXIETY DISORDERS Pt denies

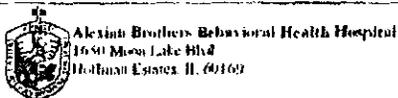
- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Accelerated heart rate |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Trembling/shaking |
| <input type="checkbox"/> | <input type="checkbox"/> | Sweating |
| <input type="checkbox"/> | <input type="checkbox"/> | Feeling flushed |
| <input type="checkbox"/> | <input type="checkbox"/> | Choking |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Distress |
| <input type="checkbox"/> | <input type="checkbox"/> | Feeling Unreal |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness |
| <input type="checkbox"/> | <input type="checkbox"/> | Tingling Sensations |
| <input type="checkbox"/> | <input type="checkbox"/> | Fear of dying or going crazy |
| <input type="checkbox"/> | <input type="checkbox"/> | Fear of persons/places/objects/situations |
| <input type="checkbox"/> | <input type="checkbox"/> | Recurrent/persistent thoughts/behaviors |
| <input type="checkbox"/> | <input type="checkbox"/> | Constant worries |
| <input type="checkbox"/> | <input type="checkbox"/> | Obsessive or intrusive thoughts |
| <input type="checkbox"/> | <input type="checkbox"/> | Compulsive behaviors/rituals |
| <input type="checkbox"/> | <input type="checkbox"/> | Hoarding items or animals |
| <input type="checkbox"/> | <input type="checkbox"/> | Phobias |
| <input type="checkbox"/> | <input type="checkbox"/> | Fears of embarrassment/public speaking |

Comments: "not really."

D. POST TRAUMATIC STRESS DISORDERS Pt denies

- | | | |
|--------------------------|-------------------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Psychological abuse |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | Physical abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexual abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Distressing memories that reoccur/intrude |
| <input type="checkbox"/> | <input type="checkbox"/> | Recurrent distressing dreams |
| <input type="checkbox"/> | <input type="checkbox"/> | Sense of reliving traumatic events |
| <input type="checkbox"/> | <input type="checkbox"/> | Periods of time you can't remember |
| <input type="checkbox"/> | <input type="checkbox"/> | Intense reactions to certain events/anniv. |
| <input type="checkbox"/> | <input type="checkbox"/> | Avoidance of thoughts/feelings of trauma |
| <input type="checkbox"/> | <input type="checkbox"/> | Detachment from feelings, people, places |
| <input type="checkbox"/> | <input type="checkbox"/> | Missing periods of time |
| <input type="checkbox"/> | <input type="checkbox"/> | Witnessing violence/crime |
| <input type="checkbox"/> | <input type="checkbox"/> | Military related trauma |
| <input type="checkbox"/> | <input type="checkbox"/> | War related trauma |

Comments: "my mother use to hit us all the time." c/o neglected



Alexian Brothers Behavioral Health Hospital
1650 Moon Lake Blvd
Hoffman Estates, IL 60169

Inpatient Psychosocial Assessment
Form #6010-082 12/10



[REDACTED] 11/01/15
68 M KRAN, AQREL A, MD
MR# R000129172 RFG
ACCT [REDACTED]

Comments: denying current and past si. per petition + outbursts - yelling, striking out. pt is denying. "i was swinging the phone cord to keep them away from me when they attacked me." pt reports lvo "early in life" of arguing and getting physical with wife

E. PSYCHOTIC DISORDERS Pt denies

- Auditory hallucinations
- Visual hallucinations
- Tactile hallucinations
- Olfactory hallucinations
- Grandiose delusions
- Paranoid delusions
- Persecutory delusions

Comments:

F. DEMENTIA/DELIRIUM N/A

- Paranoia
- Increase in forgetfulness
- Gait changes
- ADL changes
- Increase in somatic complaints
- Agitation/Aggression
- Fluctuations in mental status
- Anxiety
- Non-responsiveness
- Elopement
- Disrobing
- Recent falls
- Sexually inappropriate behavior

Comments: moca=14/30

G. EATING DISORDERS Pt denies

- Bingeing/compulsive overeating
- Intentional vomiting
- Diuretics/laxative misuse
- Excessive dieting
- Excessive exercising
- Fear of weight gain
- Poor body image

Comments:

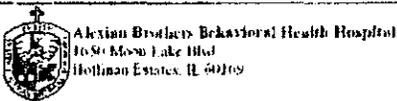
H. CONDUCT DISORDERS N/A

- Poor anger management
- Impulsivity
- Stealing
- Lying
- Uncooperativeness
- Defiant behaviors
- Poor grades
- Cruelty to animals
- Fire setting
- Bullying
- Intimidation
- Threatening
- Running away
- Truancy

Comments:

II. SUBSTANCE ABUSE/ADDICTIVE BEHAVIORS

- A. Past Use i smoked some pot in the past..never a really a problem Pt denies
- B. Current Use Pt denies
- C. Is the patient experiencing any withdrawal symptoms YES NO
If yes, please describe N/A
- D. Has substance abuse (alcohol, drugs, nicotine) and/or addictive behaviors interfered with work, school, family, or relationships? (If so, how?) Pt denies
- E. Has anyone ever told the patient they are concerned about his/her chemical use? Pt denies
- F. How often do you have a drink containing alcohol? Never Monthly or Less 2-4 times per month 2-3 times per week 4 or more times per week Patient Refused/Unable to Assess



Inpatient Psychosocial Assessment
Form #6010-082 12/10

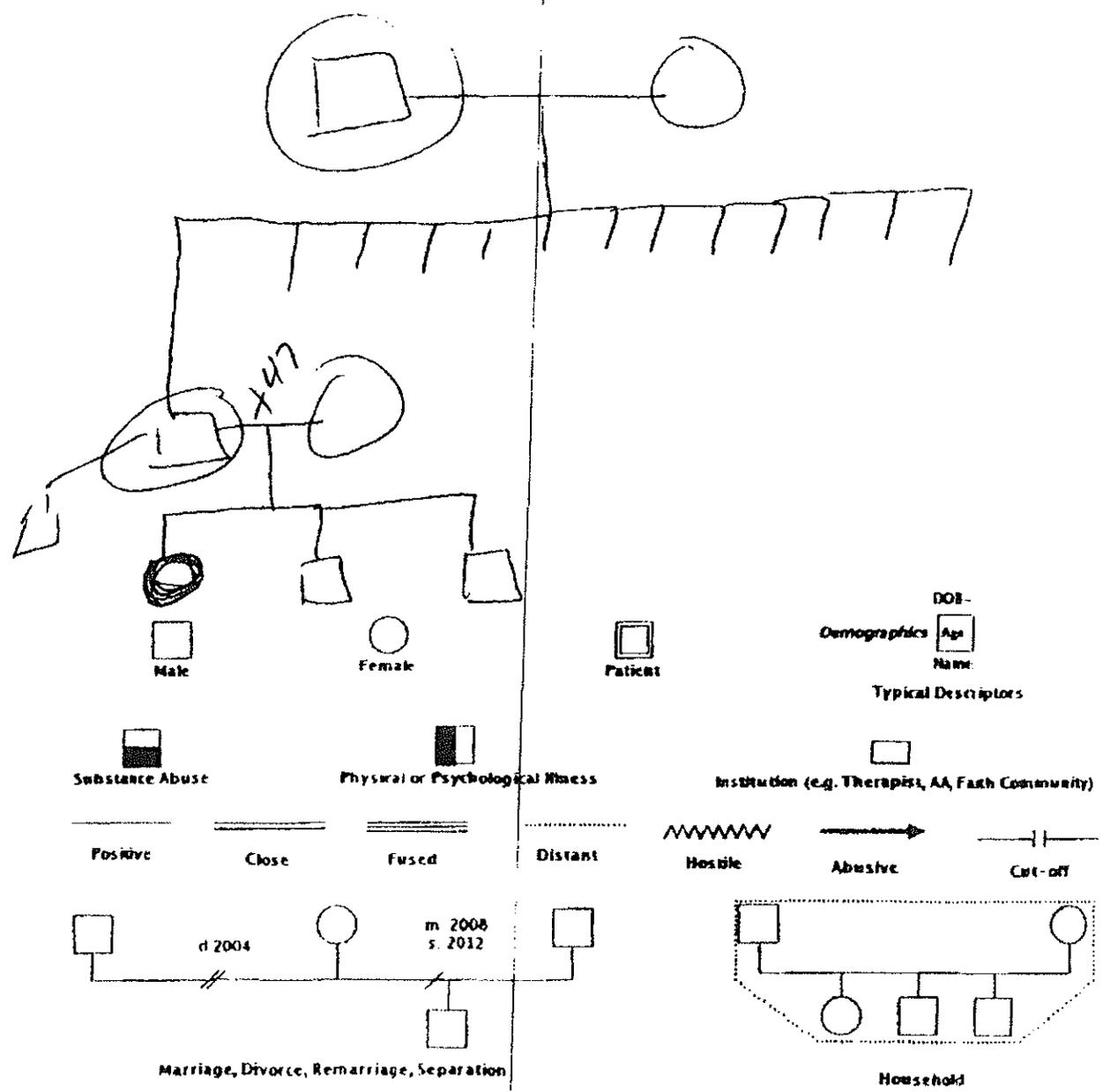


11/01/15
B M KHAN, AQEEL A, MD
MR# H000129172 BFG
ACCT#

ALEXIAN BROTHERS BEHAVIORAL HEALTH HOSPITAL
 INPATIENT PSYCHOSOCIAL ASSESSMENT

*14 siblings
 Contact 8/8/08*

~~GENOGRAM~~



Alexian Brothers Behavioral Health Hospital
 1650 Moon Lake Blvd
 Hoffman Estates, IL 60169

Inpatient Psychosocial Assessment (Attachment A)
 Form #6010-082 8/12



11/01/15
 DR. KEAN, AQEEL A., MD
 MR# 8000129172
 ACCT

AB Behavioral Health Hospital

1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR# H000129172
ROOM#: 3304-1 Sex: M
LOC. H 3N
DOB: [REDACTED] Age 68
Initialization Date: 11/01/15 1316

PATIENT [REDACTED]
ACCT#: [REDACTED]
ATT PHY AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/01/15

Signed

HISTORY AND PHYSICAL EXAMINATION

Date of Admission 11/1/15

HISTORY OF PRESENT ILLNESS:

Chief complaint: Severe mood and behavioral issues. History of present illness taken from the patient and also the transferring facility. Mr. [REDACTED] is a 68 year old gentleman that appears to have numerous medical problems. He basically was declining at home. He apparently had a fall sustaining compression fracture of his lumbar spine. He was seen at Central DuPage Hospital where he underwent spinal procedure, apparently kyphoplasty. He was seen by the neurosurgeon there, Dr. Dennis Ross. After the procedure, he was transferred to Bridgeway Nursing Facility for rehab. He states he has been there for about the last six to eight weeks. The patient apparently has been having frequent negative interactions with the staff. He ended up calling the police for some reported abusive issues. He did not go into any details, following which he was transferred out of there to the Emergency Room and then they transferred him here. He states he has been non-ambulatory for quite some time. Even prior to the spinal procedures, he was having gait and balance issues and he fell at home, following which he ended up at the Central DuPage Hospital. The patient also has had problems with chronic leg edema, peripheral vascular issues, and has been seen by different subspecialists. He again did not go into any details.

PAST MEDICAL HISTORY:

Past medical history remarkable for a reported history of CHF, apparently diastolic dysfunction, the details of the ejection fraction is unavailable, history of COPD, history of sleep apnea, history of hypertension, history of diabetes, history of gait and balance issues, recurrent falls, history of narcissistic personality disorder, history of chronic kidney disease, history of anemia, hypothyroid on replacement, chronic back pain, obesity, type 2 diabetes with neuropathy, reported history of ventricular arrhythmia, again no details available.

PAST SURGICAL HISTORY:

He has had kyphoplasty

MEDICATIONS:

See the med reconcile list.

SOCIAL HISTORY:

He states prior to going into the nursing home he was residing with his wife and three children. Two of his children have significant disability.

FAMILY HISTORY:

Report # 1101-0063 HISTORY AND PHYSICAL
Additional copy
CC:

Page: 1
Dept: MR

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]
Unit/MR#: [REDACTED] #: [REDACTED]

Family history noncontributory.

ALLERGIES:

Amlodipine.

REVIEW OF SYSTEMS:

HEENT: No headache, dizziness, blurring of vision. Cardiac: He denies chest pain, palpitations, shortness of breath. Respiratory: No reported cough, congestion, wheeze. GI: Fair appetite. No vomiting, diarrhea, blood in the stool. Musculoskeletal: Back and bilateral leg pain. He cannot ambulate independently. GU: No bladder disturbance. No dysuria. Circulatory: He has chronic erythema, dry skin, swelling involving both the legs. Neurologic: Tingling and numbness in both the legs.

PHYSICAL EXAMINATION: He is alert, anxious, very easily gets upset. O2 sat 95% on room air.

Vital signs: Blood Pressure 125/63, Pulse in the mid 60s, Respirations, Height 6'0", Weight 309.5 pounds, Temperature 97.0.

HEENT: Eyes are anicteric. Extraocular muscles are intact.
Neck: Supple. Thyroid not enlarged. Carotids, no bruits.
Heart: S1, S2 well heard. No S3, S4. No murmurs.
Lungs: Diminished air entry bilaterally. No rales or wheeze.
Abdomen: Obese. Nontender. No organomegaly. Bowel sounds are well heard.
Lymph Nodes:
Extremities: Lower extremities with 3+ edema. Severe scaling. Also noted are dry scabs and calluses involving both the feet. There is no evidence of cellulitis or infection. Joints: Spine with diffuse lumbosacral discomfort. Shoulders with limited range of motion, particularly the right shoulder.
Skin: For details, see body inspection.

NEUROLOGIC SCREEN: He is alert.

i. CRANIAL NERVES:

- Cranial Nerve 1: Olfactory with normal sense of smell.
- Cranial Nerve 2: Optic with normal visual acuity.
- Cranial Nerves 3, 4 & 6: Intact lateral and vertical gaze.
- Cranial Nerve 5: Normal blink.
- Cranial Nerve 7: Normal facial movements.
- Cranial Nerve 8: Normal hearing.
- Cranial Nerves 9 & 10: Able to cough.
- Cranial Nerve 11: Intact shoulder movements.
- Cranial Nerve 12: Normal tongue movements.

ii. MOTOR: He is diffusely weak both upper and lower extremities at 4/5 at the best.

iii. SENSORY:

iv. COORDINATION: Gait, he cannot ambulate without assist.

v. REFLEXES: Reflexes very sluggish, but symmetrical.

LABORATORY DATA:

Lab data reviewed.

IMPRESSION/TREATMENT PLAN:

1. Mood disorder with behavioral problems. Need further psych intervention.
2. History of recent back surgery. He still has quite a bit of back pain.

Report #: 1101-0063 HISTORY AND PHYSICAL
Additional copy
CC:

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]

Unit/MR#: [REDACTED] A#: [REDACTED]

- 3 History of hypertension
- 4 History of chronic obstructive pulmonary disease and sleep apnea.
- 5 History of diabetes.
- 6 History of chronic kidney disease.
- 7 History of hypothyroid. On replacement.
- 8 Severe leg edema and peripheral vascular changes that appear chronic.
- 9 Reported low testosterone levels on replacement.
- 10 Reported history of congestive heart failure and diastolic dysfunction
11. At risk for complications of immobility
12. Musculoskeletal pain. Currently on stiff dose of pain meds, including Oxycodone, Dilaudid, and Lyrica

PLAN:

- 1 I have reviewed his labs and meds. I will continue his medical meds
- 2 Requested PT evaluation.
- 3 Skincare will be done as needed
- 4 Depending on his progress, will make further recommendations.
- 5 The patient needs to follow with his primary M.D. upon discharge along with the subspecialists
- 6 Goals of treatment at this facility were reviewed with the patient
- 7 He also is noted to have a ventral hernia, which is easily reducible at this time
8. Psych management per Dr. Khan and team.

Thank you

1101-028

Dictated By: SAFDER MOHSIN MD 11/02/15 1938

<Electronically signed by SAFDER MOHSIN MD> 11/02/15 1938

DD 11/01/15 1139 DT 11/01/15 1252
MOHSA/NJK 1101-0063

AB Behavioral Health Hospital

1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR# H000129172
ROOM#: 3239 2 Sex:M
LOC: H 3E
DOB: [REDACTED] Age: 68
Initialization Date: 01/10/16 1159

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/17/15

Draft

DISCHARGE SUMMARY

Admission Date: 11/17/15
Discharge Date: 11/25/15

REASON FOR ADMISSION AND HISTORY OF PRESENT ILLNESS:

This is a 68 year old, married, Caucasian male who came in initially 11/1/15 through 11/11/15 before being transferred to St. Alexius Medical Center for chest pain. He had come to us from Central DuPage Hospital. He had been sent there by the Bridgeway Senior Rehab Center when he was having very aggressive agitated behavior, mood swings, tearful, accusing staff of mistreating him, calling the police, and saying he was being abused. He got agitated and threw dinner across the room. He was screaming, he was tearful, and he was sent for evaluation here. When he went to St. Alexius Medical Center he was cleared cardiac wise, but they did rule him in with right upper lobe pneumonia. Now, he is readmitted here for his stabilization.

His psych eval was done by Dr. De Los Santos. He states again the patient was initially admitted here for severe depression, agitation, and a risk to harm self and others. He was not able to function at his nursing home. He went to SAMC, was admitted, and then medically cleared. His past psychiatric history is he has a history of depression and a diagnosis of dementia with severe anxiety and behavioral disturbance. He has a history of psychiatric hospitalization for transcranial magnetic stimulation.

PERTINENT HISTORY AND PHYSICAL FINDINGS:

Appearance: He is wearing a hospital gown. He is disheveled with poor hygiene. Fair eye contact. Motor: He is mostly bound to the geriatric chair. His behavior is aggressive. His orientation is to person and place, not fully to situation. His speech is not aphasic. He is able to respond coherently. His mood is labile and agitated. His affect is anxious and angry. His thought process is circumstantial with no loosening of associations. Thought content: He does not appear to hallucinate. He denies any delusions. He denies any suicidal or homicidal ideations, but he has been aggressive, violent, and combative towards staff. His insight, judgment, attention, and concentration are all impaired. He is very distractible and not able to do Serial 7's. His immediate memory: He is able to repeat three words, but cannot recall after three or five minutes. Recent memory: He is not able to give a coherent account of why he ended up at the medical/surgical hospital and then came back to the Behavioral Health Hospital. Long term memory fair, but does not have full details of his past. His intellectual capacity is impaired. There are periods of increased confusion and cognitive decline.

The patient will be admitted to 3 East where we will do psychiatric med stabilization and evaluation. Dr. Mohsin will be consulted for medical management. The plan is to continue the patient's Lamictal 300 mg bid and the Zyprexa 2.5 mg three times a day. While he was here previously, he had a trial of Nardil, but that has now been successfully discontinued. We will look at use of Nuedexta for the emotional lability secondary to the patient's underlying

Report # 0110-0044 DISCHARGE SUMMARY
Draft copy
CC:

Page: 1
Dept: MR

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]
Unit/MR#: [REDACTED] A#: [REDACTED]

neurologic condition of vascular dementia. Case management will be consulted for discharge planning. The patient will participate in all appropriate psychosocial and psychotherapeutic programs. Objectives for discharge are there will be a significant alleviation or resolution of the patient's psychosis, behavioral disturbance agitation, and aggression, the patient will be at risk of harm to self or others, and he will be calm, cooperative, and allow treatment in a less restrictive environment. Aftercare is discharge back to Bridgeway or find alternative placement that can provide him supervision and monitoring for his healthcare needs in a therapeutic environment

His H&P was done by Dr. Safder Mohsin. He states that the patient's past medical history is significant for hypertension, chronic obstructive pulmonary disease and sleep apnea, diabetes, chronic kidney disease, hypothyroidism on replacement, leg edema severe from peripheral vascular changes that appear chronic low testosterone levels on replacement, congestive heart failure and diastolic dysfunction, musculoskeletal pain on stiff doses of pain medications, a remote history of cerebrovascular incident

HOSPITAL COURSE.

The patient came to 3 East. He had labs drawn, CBC and chemistry, which were unremarkable. He was oriented x2 but not to his situation. He was confused and forgetful. He was refusing all groups. When he would sit in the group room, he would just sleep. He was aggressive with staff, hitting, yelling loudly, cursing, very easily agitated, angry, and delusional. He could escalate at the drop of a hat. He was irritable, restless, isolative. His affect was labile and blunted. He needed frequent redirection and he kept perseverating about going home. He also was eating very poorly and refusing most meals, many days eating just breakfast. Dr. De Los Santos did start him on Nuedexta initially one capsule daily and as the patient was able to tolerate that and became less emotionally reactive he increased him to a discharge dose of Nuedexta one capsule twice a day for the pseudobulbar affect secondary to the underlying condition of the vascular dementia. The patient stayed on the Zyprexa 2.5 mg three times a day, but Dr. De Los Santos did get rid of the prn dose because the patient really had not been using but two times during his hospital stay. The Lamictal 300 mg twice a day remained the same. With the medication changes and additions, there was no EPS or any tardive dyskinesia.

DISCHARGE DIAGNOSIS

- Axis I: Major Depression, Recurrent, Severe Without Psychosis
Vascular Dementia Secondary to the Underlying Condition of Cerebrovascular Disease and Hypertension With Psychosis and Behavioral Disturbance
- Axis II: Deferred
- Axis III: No Delirium
- Axis IV: Relapse, severe
- Axis V: 45/65

CONDITION ON DISCHARGE AND AFTERCARE PLANS

The patient remains oriented just x2 not to his situation. Minimal participation in groups but the patient is calmer and more cooperative. He is actually pleasant upon discharge and thanks the staff for putting up with him. His eating is still very poor, mostly just breakfast. He wanted to go home to live with his ex-wife and she said she cannot handle him, so the patient will be going to new placement. It will be to the Elm Brook Nursing Home. The treatments to be addressed in aftercare are medication management and mood stabilization. He will follow a cardiac diet.

Dictated by Janine Stewart, R.N.

0109-081

Dictated By: RENATO DE LOS SANTOS MD

AB Behavioral Health Hospital

Name: [REDACTED] / DOB [REDACTED]
Unit/MR# [REDACTED] A# [REDACTED]

DD: 01/09/16 1401 DT: 01/10/16 1123
DELRE1/NJK 0110-0044

AB Behavioral Health Hospital

1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR#: H000129172
ROOM#: 3239-2 Sex: M
LOC: H.3E
DOB: [REDACTED] Age: 68
Initialization Date: 11/18/15 2025

PATIENT: [REDACTED]
ACCT#: H0000 [REDACTED]
ATT. PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/17/15

Signed

PSYCHIATRIC EVALUATION

IDENTIFYING DATA:

Patient is a 68 year old Caucasian who was referred back from St. Alexius Medical Center for admission to Alexian Brothers Behavioral Health Hospital.

CHIEF COMPLAINT:

Combative.

HISTORY OF PRESENT ILLNESS:

The patient was initially admitted to Alexian Brothers Behavioral Health Hospital for severe depression, agitation, and risk to harm self and others. Not able to function at the nursing home, but because of chest pain, he was referred to St. Alexius Medical Center emergency room, admitted, and then medically cleared.

PAST PSYCHIATRIC HISTORY:

History of depression and diagnosis of dementia with severe anxiety and behavioral disturbance. The patient had history of psychiatric hospitalization for transcranial magnetic stimulation.

PAST MEDICAL HISTORY:

History of L4 fracture, hypothyroidism, congestive heart failure, recent chest pain, history of diabetes with labile blood pressures, sleep apnea, hypertension, chronic kidney disease, diabetic neuropathy, back pain with recent kyphoplasty, reported history of arrhythmia. Non-ambulatory for quite some time. Morbid obesity.

The patient's CT scan of the head showed no evidence of acute findings indicative of any hydrocephalus or intracranial hemorrhage. There is consults done at the hospital indicated the patient had exacerbation of the cardiac problems, congestive heart failure, and then became

Report # 1118-0244 PSYCHIATRIC EVALUATION
Additional copy
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Page: 1
Dept: MR

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]
Unit/MR#: [REDACTED] A#: [REDACTED]

increasingly confused. EKG was negative. He had no evidence of pulmonary embolism. Questionable right-sided pneumonia, which he was treated. CT scan of the head due to some increased confusion that shows moderate diffuse atrophy, but nothing acute.

The patient is allergic to Amlodipine. There is no alcohol or drug history.

He was afebrile. Temperature of 97.2, pulse rate of 72, blood pressure of 133/92, respiratory rate of 20, and oxygen saturation of 98%. He had scabs and abrasions over his legs, but no edema. Patient was recently treated for pneumonia and increased confusion, which seems to be assessed as delirium then but that has medically cleared. The patient is not complaining of any chest pains. No respiratory distress. No abdominal pain. No physical complaints.

Review of Systems & Active Medical Problems:

**Constitutional: Eyes: Ears/ Nose/ Mouth/ Throat: Cardiovascular: Respiratory:
Gastrointestinal: Genitourinary: Musculoskeletal: Integumentary: Neurological:
Endocrine: Hematologic/ Lymphatic: Allergies/ Immune:**

SOCIAL HISTORY:

Patient worked as a software engineer, and has recently been placed at nursing home, at Bridgeway facility. The recent return to Alexian Brothers Behavioral Health Hospital from St. Alexis Medical Center didn't show any evidence of delirium.

FAMILY HISTORY:

History of depression and anxiety with his siblings, and currently with situation.

MENTAL STATUS EXAM:

- A. Appearance:** Patient is a 68 year old Caucasian male wearing hospital gown, disheveled. Poor hygiene. Fair eye contact.
- B. Behavior/Motor:** Motor Mostly bound to the geriatric chair. Behavior aggression.
- C. Orientation:** Orientation to person and place, not fully the situation. Not time.
- D. Speech:** Not aphasic. Patient is able to respond coherently.
- E. Mood/Affect:** Affect anxious, angry. Mood labile, agitated.
- F. Thought Process:** Circumstantial, but no loosening of association.
- G. Thought Content:** Did not appear to hallucinate. Denies any delusions.
- H. Suicidal/Assaultive/Violent Thought:** Denies any suicidal or homicidal ideation, although he has been aggressive and violent; combative towards staff.
- I. Insight/Judgment:** Impaired.
- J. Attention/Concentration:** Impaired. Very distractible. Not able to do Serials of 7s.
- K. Immediate Memory:** Able to repeat three words, but cannot recall after 3 or 5 minutes.
- 1. Recent Memory:** Not able to give coherent account of why he ended up at the medical surgical hospital, and then coming back to behavioral health hospital.
- 2. Long Term Memory:** Fair, but not full details of his past.

Report # 1118-0244 PSYCHIATRIC EVALUATION

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Page: 2
Dept: MR

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]

Unit/MR#: [REDACTED] A#: [REDACTED]

L. Intellectual Capacity: Impaired. Periods of increased confusion and cognitive decline.

ASSETS/STRENGTHS:

Access to care. Presence of Power of Attorney.

WEAKNESSES/LIABILITIES:

Impaired coping skills. Cognitive decline.

PROVISIONAL DIAGNOSIS:

- AXIS I** Major Depression, Recurrent, Severe, No Psychosis
Vascular Dementia with Psychosis and Behavioral Disturbance
- AXIS II** Deferred
- AXIS III** No Delirium
Recent Treatment of Pneumonia
- AXIS IV** Relapse severe
- AXIS V** 10

SYMPTOMS REQUIRING THIS LEVEL OF CARE:

His aggressive behavior, increased periods of confusion, not able to function in a less restrictive environment, and not able to care for self. Patient is a risk to harm others.

INITIAL TREATMENT PLAN:

Admit the patient to Alexian Brothers Behavioral Health Hospital. Dr. Mohsin for medical management. Patient will continue to take the prn Zyprexa and the Lamictal 300 mg twice daily, which I will find the lowest possible dose. There has also been, in the past, trial of the Nardil, which we have successfully discontinued. Then, will look into the use of the Nuedexta for the emotional lability secondary to the underlying neurologic condition of the vascular dementia. Will adjust the dose of the Zyprexa. Instead of doing the prn dose, we'll look into a low-scheduled dose of the medication as we gradually decrease the Lamictal. Case management for discharge planning. Participation in all appropriate psychosocial and psychotherapeutic program.

OBJECTIVES FOR DISCHARGE AND AFTERCARE PLAN:

Significant alleviation or resolution of the psychosis, behavioral disturbance, agitation, aggression. Patient will not be a risk to harm self and others. Calm, cooperative, and allow treatment in a less restrictive environment.

Aftercare is discharge to Bridgeway or find alternative placement that will provide him supervision, monitoring of his healthcare needs in a therapeutic environment. Continue medical and psychiatric services, and all support psychosocial and psychotherapeutic program.

AB Behavioral Health Hospital

Name [REDACTED] DOB: [REDACTED]

Unit/MR# [REDACTED] A#: [REDACTED]

ESTIMATED LENGTH OF STAY (ELOS): Seven to ten days.

1118-166

Dictated By: RENATO DE LOS SANTOS MD 11/27/15 1528

<Electronically signed by RENATO DE LOS SANTOS MD> 11/27/15 1528

DD 11/18/15 1713 DT 11/18/15 2005
DELRE1/HBH 1118-0244

AB Behavioral Health Hospital

1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR# [REDACTED]
ROOM#: 3239-2 Sex: M
LOC: H3E
DOB: [REDACTED] Age: 68
Initialization Date: 11/18/15 2151

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ATT. PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/17/15

Signed

HISTORY AND PHYSICAL EXAMINATION UPDATE

Date of Admission: 11/17/15

HISTORY OF PRESENT ILLNESS:

Chief complaint: Mood and behavioral issues. This an H&P Update. Patient was originally admitted here 11/1 and transferred to the St. Alexius Medical Center for chest pain. His cardiac workup there was negative for any inducible ischemia; however, he was noted to have right sided pneumonia and has been treated for that. Besides that, his other multiple other medical issues remained stable. His back pain particularly has been very stable and he's practically off of the narcotics. The main problem while he was there continued to be mood and behavioral issues, unpredictable anger. Psych services were monitoring and after he was medically stabilized, he's being transferred back here.

PAST MEDICAL HISTORY:

See my H&P 11/2/15 and also my H&P from St. Alexius Hospital.

PAST SURGICAL HISTORY:

See my H&P 11/2/15.

MEDICATIONS:

See reconcile.

SOCIAL HISTORY:

As per my H&P 11/2/15.

FAMILY HISTORY:

Report # 1118-0257 HISTORY AND PHYSICAL UPDATE

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Page: 1
Dept: MR

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]
Unit/MR#: [REDACTED] A#: [REDACTED]

ALLERGIES:

Amlodipine.

REVIEW OF SYSTEMS:

HEENT: No headache, dizziness, blurring of vision. Cardiac: He denies any further chest pains. He does get winded easily. Respiratory: No cough, congestion, discolored secretions. GI: Good appetite. No vomiting, diarrhea. No blood in the stool. Musculoskeletal: Minimal back discomfort. Does not appear to be in any distress. He is non-ambulatory. GU: No dysuria, incontinence. Circulatory: Chronic leg edema and stasis changes. Neurologic: Tingling, numbness, generalized leg weakness. Non-ambulatory.

PHYSICAL EXAMINATION: He's resting comfortably. He's quite friendly this afternoon.

Vital signs: Blood Pressure 110/74, 110/72, 128/84, Temperature: 97.2, 98.8, 97.6, O2 sat 93 to 98 percent, reportedly on 2L, but patient does not wear any oxygen.

HEENT:

Neck:

Heart: S1 and S2 well heard. No murmurs.

Lungs: Bilateral minimal wheeze. No rales.

Abdomen: Obese. Non-tender. Bowel sounds well heard.

Lymph Nodes:

Extremities: Chronic stasis changes.

Skin:

Joints:

NEUROLOGIC SCREEN: As per my H&P 11/2/15, no new changes

i. CRANIAL NERVES:

Cranial Nerve 1:

Cranial Nerve 2:

Cranial Nerves 3, 4 & 6:

Cranial Nerve 5:

Cranial Nerve 7:

Cranial Nerve 8:

Cranial Nerves 9 & 10:

Cranial Nerve 11:

Cranial Nerve 12:

ii. MOTOR:

iii. SENSORY:

iv. COORDINATION:

REFLEXES:

LABORATORY DATA:

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]
Unit/MR# [REDACTED] A#: [REDACTED]

IMPRESSION/TREATMENT PLAN:

1. Mood disorder, with severe behavioral problems. This has been the case according to the wife who had multiple discussions with me while he was at the other hospital and according to her, he has been like this over a number of years.
2. History of back surgery, excessive opiate use over a number of years; however, he has been successfully weaned off of the Dilaudid without any problems.
3. Advanced COPD, sleep apnea, on nebulizers and a CPAP.
4. History of hypertension, stable readings.
5. Diabetes, no further hypoglycemic episodes. He's been off bydureon, currently only on sliding scale.
6. History of chronic kidney disease.
7. History of hypothyroid, on replacement.
8. History of severe chronic leg edema, peripheral vascular disease with no further workup requested by patient and the family. They do understand that this is likely to get worse even resulting in amputations.
9. History of hypergonadism.
10. History of neuropathy. He's been non-ambulatory for at least some years.
11. Thoracic aneurysm. Patient and wife decline any further interventions. They do understand that this could result in a life threatening emergency.

PLAN:

1. I have reviewed his medications, progress.
2. We'll continue to arrange his medications as needed. Patient is very happy that he is off the narcotics to a great extent and also wife is very glad about it as well.
3. I will assist with his medical needs. According to the wife, he should be DNR, but i do not have the appropriate papers.

1118-211

Dictated By: SAFDER MOHSIN MD 11/20/15 1444

<Electronically signed by SAFDER MOHSIN MD> 11/20/15 1444

DD: 11/18/15 2048 DT: 11/18/15 2151
MOHSA/MMP 1118-0257

Fac: AB Behavioral Health Hospital

Loc: 3 East

Bed: 3239-2

68 M

Med Rec Num: H000129172

Visit:

Attending: AQEEL A KHAN

Reg Date: 11/17/15

Reason: F23

Level of Care Screening

12/02/15 00:12

Level of Care Screening

Start: 11/13/15 01:00

Freq:

Status: Discharge

Edit Status: BKG DAEMON (Rec: 12/02/15 00:12 ENG DAEMON ADE-BC11)

Active=>Discharge

Staff Signature

Date

User Key

Monogram	Mnemonic	Name	Provider Type
	BKG DAEMON	Daemon, Background	

AB Behavioral Health Hospital
1650 Moon Lake Blvd
Hoffman Estates, IL 60169

Date: 11/01/15
Acct Num: [REDACTED]
Med Rec Num: [REDACTED]
Name: [REDACTED]
Location: 3 North
Primary Provider: NIAN, ACEEL A

Continued Care Instructions

CONTINUED CARE INSTRUCTIONS AFTERCARE TREATMENT/FOLLOW UP INSTRUCTIONS

Treatment to be Addressed in Aftercare:

Discharge Patient to: Acute Care Hospital

Case Manager: Date: Time:

ADDITIONAL INFORMATION

Psychiatric Discharge Diagnosis: Major Depressive Disorder
Unspecified Anxiety Disorder

Diet: Diabetic

Exercise:

Medication Follow Up:

- Medications are listed on the Patient Discharge Medication List.
- Medication Doses may have changed, follow the instructions on the outpatient prescriptions.
- Avoid alcohol, alcohol containing substances, and mood altering drugs if taking psychiatric medications.

Medical Follow Up:

Discharge Date: 11/1/15 Time: 0900 RN Signature: [Signature]

By signing below, the patient/guardian attest they reviewed and agree to the D/C instructions and have received a copy.
Bring these instructions to all physician and therapist visits as a treatment reference.

Patient Signature: pt unable to sign

Guardian/Significant Other Signature: [Signature] / [Signature] RN

**IF FEELING SUICIDAL OR EXPERIENCING A PSYCHIATRIC EMERGENCY,
CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM**

DISCHARGE FORMS

Discharge Forms - Please check applicable box

Faxed

- Sent with patient transporter
- Sent to PHP/IOP/Group Practice
- Patient refused transmittal
- Patient will manage care plan

AB Behavioral Health Hospital
1650 Moon Lake Blvd
Hoffman Estates, IL 60169

Date: 11/01/15

Acct Num: [REDACTED]

Med Rec Num: [REDACTED]

Name: [REDACTED]

Location: 3 North

Primary Provider: KHAN, AQEEL A

By: Unit Secretary/Designee

[Handwritten Signature]

Date: 11/11/15

Time: 2:10

Page: 2
 Date: 11/11/15 20:54
 User: H3NGLFF

Patient Discharge Med List
 Alexian Brothers Behavioral Health Hospital
 847-682-1600

Patient: [REDACTED] Acct: [REDACTED] Age/Sex: 68 M
 Location: H.3N Room: 3304-1 MRN: [REDACTED] Ht: 6 ft
 Physician: AQEEL A KHAN Admit Date: 11/01/15 DOB: [REDACTED] (182.88 cm)
 Wt: 316 lb 7 oz (143.534 kg)

Adverse Reactions/Allergies: amlodipine

Home Medications

Drug	Dose	Method	Frequency	Prescription Given
✓ Lactulose[Lactulose 10 gm/15 ml Solution] Indication: hepatic encephalopathy	10 GM	BY MOUTH	Three Times Daily	No
✓ Lamotrigine[Lamictal 150 mg Tab] Indication: Bipolar	300 MG	BY MOUTH	Twice Daily	No
✓ Levothyroxine Sodium[Synthroid 100 mcg Tab] Indication: Thyroid	100 MCG	BY MOUTH	Daily	No
✓ Non-Formulary Medication[Non-Formulary Medication 1 ea Ea] <i>Oxyduron pen 2mg / 0.65 ml</i>	0.25 2mg	SUB-Q	Every 7 Days	No
✓ Olanzapine[Zyprexa 10 mg Vial] As Needed For: Agitation/Psychosis	5 MG	IN THE MUSCLE	Every 4 Hours as Needed	No
✓ Olanzapine[Zyprexa 5 mg Tab] As Needed For: Agitation/Psychosis	5 MG	BY MOUTH	Every 4 Hours as Needed	No
✓ Olanzapine[Zyprexa 5 mg Tab] Indication: Psychosis	5 MG	BY MOUTH	Twice Daily	No
✓ Oxycodone HCl[Oxycodone HCl 20 mg Tablet] Indication: Pain - Severe	20 MG	BY MOUTH	Twice Daily	No
✓ Pantoprazole[Protonix 40 mg Tab] Indication: acid reflux	40 MG	BY MOUTH	Daily	No
✓ Phenelzine Sulfate[Nardil 15 mg Tab]	15 MG	BY MOUTH	At Bedtime	No
✓ Phenelzine Sulfate[Nardil 15 mg Tab]	15 MG	BY MOUTH	Daily	No
✓ Polyethylene Glycol 3350[Miralax 17 gm Powd.Pack] Indication: Dietary Supplement	17 GM	BY MOUTH	Daily	No

Date: 11/11/15 20:54

Alexian Brothers Behavioral Health Hospital

User: H3NGLFF

847-882-1600

Patient: [REDACTED]	Acct: [REDACTED]	Age/Sex: 68 M
Location: H.3N	Room: 3304-1	MRN: [REDACTED]
Physician: AQEEL A KHAN	Admit Date: 11/01/15	DOB: [REDACTED]
		Ht: 6 ft (182.88 cm)
		Wt: 316 lb 7 oz (143.534 kg)

Adverse Reactions/Allergies: amlodipine

Home Medications

Drug	Dose	Method	Frequency	Prescription Given
Potassium Bicarbonate/Cit AC [Potassium 25 Meq Tablet Eff 25 meq Tablet Eff] Indication: edema	40 MEQ	BY MOUTH	Twice Daily	No
Pregabalin [Lyrica 150 mg Cap] Indication: Pain - Moderate	150 MG	BY MOUTH	Twice Daily	No
Sennosides/Docusate Sodium [Senna-Docusate Sodium Tab 1 each Tablet] Indication: Stool softner	2 TAB	BY MOUTH	Twice Daily	
Furosemide [Demadex 20 mg Tab] Indication: Blood Pressure High	40 MG	BY MOUTH	Twice Daily	No

Influenza Date:

Pneumococcal Date:

Stop taking any medication not listed above. If necessary, contact your primary physician with any questions. Update any records with your provider(s) and pharmacy.

I have reviewed and understand my Discharge Medication List:

Patient/Significant Other: _____

Date: _____

RN Signature: *Zhefstan RN / [Signature]*

Date: 11/11/15

Time: 2100

*** FINAL PAGE ***

AB Behavioral Health Hospital

1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR#: [REDACTED]
ROOM#: 3304-1 Sex: M
LOC: H.3N
DOB: [REDACTED] Age: 68
Initialization Date: 11/12/15 1056

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/01/15

Signed

Date: 11/11/15

Patient is discharged today because of chest pain. Diagnosis medical, chest pain and did the discharge order, transfer to St. Alexius Medical Center for further medical evaluation. Final diagnosis bipolar disorder, mania with psychosis and dementia vascular with psychosis and behavioral disturbance. Renewing the medication reconciliation Zyprexa 5 mg twice a day and the Lamictal 300 mg twice a day. Decreased the Nardil to 15 mg twice a day with the intent to discontinue that medication. I talked to Mary David the psychiatric nurse practitioner for further psychiatric management at St. Alexius Medical Center.

1111-211

Dictated By: RENATO DE LOS SANTOS MD 11/27/15 1526

<Electronically signed by RENATO DE LOS SANTOS MD> 11/27/15 1526

DD: 11/11/15 2031 DT: 11/12/15 1055
DELRE1/LH 1112-0091

AB Behavioral Health Hospital

1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR#: [REDACTED]
ROOM#: 3304-1 Sex: M
LOC: H.3N
DOB: [REDACTED] Age: 68
Initialization Date: 11/11/15 0726

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/01/15

Signed

Date: 11/10/15

Blood sugar of 115 this morning. No evidence of acute physical distress. There is no evidence of acute pain. However, the patient seems to be more confused and per Dr. Mohsin's assessment as of yesterday his medications have been reviewed. Blood sugar had been mostly stable but he seems to be more confused today and the labs other than the blood sugar which was slightly elevated did not show any other abnormalities. I have given him a stat dose of the olanzapine today and have started him on olanzapine 5 mg twice a day. I have decreased the phenelzine to 45 mg which I will decrease further to a total of 30 mg per day with the plan to discontinue this medication, maintaining the Lamictal as the antidepressant medication and minimizing the use of other psychotropic medication. However, the patient is at this time very psychotic, agitated, hyperverbal, and very labile and unpredictable. Will contact medical to review the medical status of this patient given his increased confusional state.

1110-044

Dictated By: RENATO DE LOS SANTOS MD 11/27/15 1525

<Electronically signed by RENATO DE LOS SANTOS MD> 11/27/15 1525

DD: 11/10/15 1245 DT: 11/11/15 0722
DELRE1/BAB 1111-0060

Report #: 1111-0060 PROGRESS NOTE
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Page: 1
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AB Behavioral Health Hospital

1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR#: [REDACTED]
ROOM#: 3304-1 Sex: M
LOC: H.3N
DOB: [REDACTED] Age: 68
Initialization Date: 11/09/15 2252

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/01/15

Signed

Date: 11/9/15

Patient is alert, oriented to person and place, but not to situation. The patient earlier was very psychotic, paranoid, kicking at the staff, and one of the nurses being the head-conspirator and claiming that his son is dying, which was a confabulation according to the wife. Patient has been very disorganized. One of his recent episodes prior to hospitalization was the periods of agitation, paranoia, and calling 911. Historically, the patient has major depressive or unipolar disorder, and trials of different medications have been tried with no positive response until the combination of Lamictal and Nardil. However, in the past few months prior to admission, questionable CVA / TIA or cerebral vascular events contributed by the patient's multiple medical problems, which seems to be contributing to a possible cerebrovascular event with recent anesthesia from back surgery have caused a dementing disease.

The neuropsychological testing did show the appreciation of the risk factors, which are mostly cerebrovascular in nature, and combinations of history of congestive heart failure, diastolic dysfunction, ejection fraction problems, COPD, hypertension, history of diabetes, recent recurrent falls, chronic kidney disease, anemia, hypothyroidism on replacement, chronic back pain, obesity, and ventricular arrhythmia. The wife did understand that what appeared to be a recent manic-like episode may be related to an underlying neurologic condition. So the patient was given several stat doses of Ativan, because of the agitation. But because of the psychotic, manic-like nature of the symptoms, I opted ___ the use of the Zyprexa. Indication, benefits, side-effects reviewed with the wife. The wife, who is Power of Attorney, gave consent. Nurse, Marta, witnessed the consent. I'm starting the patient on the Zyprexa 5 mg twice a day with a backup 5 mg po or IM every four hours prn for agitation and psychosis. With the wife's consent, I am also tapering down the Nardil from 60 mg down to 45 mg. Using the Lamictal as a mood stabilizing antidepressant medication primarily. Because of the many contraindications of using monoamine oxidase inhibitor, it will give us more psychopharmacologic flexibility for prescription that would be most appropriate for this patient's clinical state at this time.

1109-123

Dictated By: RENATO DE LOS SANTOS MD 11/27/15 1524

<Electronically signed by RENATO DE LOS SANTOS MD> 11/27/15 1524

Report #: 1109-0270 PROGRESS NOTE
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Page: 1
Dept: MR

AB Behavioral Health Hospital

1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR# [REDACTED]
ROOM#: 3304-1 Sex: M
LOC: H 3N
DOB: [REDACTED] Age: 68
Initialization Date: 01/09/16 1629

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/01/15

Draft

DISCHARGE SUMMARY

Admission Date: 11/1/15
Discharge Date: 11/11/15

REASON FOR ADMISSION AND HISTORY OF PRESENT ILLNESS:

This is a 68-year-old male who came from Alexian Brothers Medical Center, where he was sent by the Bridgeway Senior Rehab. The patient had some increased symptoms and safety concerns. He had called the police. He had accused staff of abusing and hitting him. He was swearing, calling names, and throwing things. He is obese and unkempt. He presents with a decreased affect. He is crying on admission because of intense pain, and states, nobody is giving him his pills.

His psych eval is done by Dr. Zafeer Berki. He states that the patient gives a history of feeling depressed on-and-off for as long as he can remember. In July of 2015, he fractured his L4, and was admitted to Central DuPage Hospital. After surgery, and medical stabilization, he was transferred to the Bridgeway Senior living facility for rehab. The nursing facility notes him to be aggressive and agitated with mood swings, tearful and accusing staff of mistreating him. Yesterday, he was agitated to the extent that he threw his dinner across the room. He was screaming out in his room, getting tearful and crying. The patient says he was not getting his pain medication and as a result, he was in terrible pain. He denies any hallucinatory experiences. No delusional thinking was expressed or elicited. No history of hypomanic or manic episodes.

Past psychiatric history: The patient has taken multiple psychotropic meds in the past. He denies any history of suicide attempts. He states he was admitted to a psychiatric facility in 1999, for transcranial magnetic stimulation.

PERTINENT HISTORY AND PHYSICAL FINDINGS:

His appearance, he looks his stated age. His behavior and motor, he was calm and cooperative

Report # 0109-0123 DISCHARGE SUMMARY
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Page. 1
Dept: MR

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]
Unit/MR#: [REDACTED] A#: [REDACTED]

with the exam, and made good eye contact. His orientation was to time, person and place. His speech was spontaneous with a regular rate and rhythm. His mood was depressed. His affect was sad and tearful. His thought process, coherent and goal directed. His thought content, no hallucinations. There were no overt delusions. The patient denies suicidal or homicidal ideations. His insight and judgment are limited. His attention and concentration is intact, as he was able to maintain attention during the exam. His immediate, recent, and long-term memory were all intact, and the patient was able to give accurate details. His intellectual capacity was estimated to be average.

The plan is to admit the patient to 3 East, level III nursing.

Dr. Safder Mohsin will be consulted for medical management. We will adjust the patient's psychotropic meds as tolerated and indicated. The patient came into the hospital on Valium 10 mg twice a day, Lamictal 300 mg twice a day, Nardil 30 mg in the morning and 45 mg at night.

Objectives for discharge and aftercare is there will be a significant improvement in the patient's behavior.

His H&P is done by Dr. Safder Mohsin. He states that the patient's past medical history is significant for hypertension, COPD with sleep apnea, diabetes, chronic kidney disease, hypothyroid on replacement, severe leg edema, and peripheral vascular changes that appear chronic, low testosterone levels on replacement, CHF with diastolic dysfunction, at risk for complications of immobility and musculoskeletal pain, on stiff doses of pain meds, oxycodone, Dilaudid, and Lyrica.

HOSPITAL COURSE:

The patient came to 3 East. He had labs drawn. They were basically unremarkable. He did have a normal BUN, but his creatinine was elevated at 1.6. The patient was only a fair eater, 25 to 50% of his meals, and some days he wouldn't eat at all. He was alert and oriented x 2 to 3, but not to his situation. He was forgetful. He was quite agitated. He was resistive to ADLs. He would be kicking and hitting at staff. He was psychotic, he was hypervocal, he was grandiose. He had very paranoid thinking. He was disorganized. His affect was labile, blunted, flat. He was emotionally crying, and was very unpredictable. He was supposed to wear CPAP at night, but he was refusing to use his machine.

Dr. De Los Santos did enact the power-of-attorney. The patient agreed to have his daughter be the power-of-attorney.

The medication changes that Dr. De Los Santos made: He maintained the Lamictal 300 mg twice a day, he started the patient on Zyprexa 5 mg twice a day, with p.r.n. doses of 5 mg every 4 hours, and his intent was to wean down the Nardil, and eventually discontinue, so the Nardil has been weaned down from 30 mg in the morning and 45 mg at night to 15 mg in the morning and 15 mg at night.

While the patient was in the hospital for his disruptiveness and his agitation, he received three

Report # 0109-0123 DISCHARGE SUMMARY

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Page: 2

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AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]
Unit/MR# [REDACTED] A#: [REDACTED]

dose of stat Ativan, a dose of stat Zyprexa, and about five or six doses of the p.r.n. Zyprexa 5 mg. The patient had a neuropsychological consult with Theresa Campbell. Her impression was that [REDACTED] has cognitive impairment of a quality and severity that is approaching, but in her opinion not yet meeting criteria for dementia. He has multiple risk factors for cerebrovascular disease, which is the most likely cause of his cognitive decline. Complicating his condition, [REDACTED] has psychiatric factors that affect his ability to reliably reflect on his limitations.

[REDACTED] would benefit from having regular supervision and assistance in some aspects of his daily routines. His physical limitations are deferred to his medical teams. He can contribute to decisions regarding healthcare matters when he is properly informed, and tracking the information correctly. However, due to his cognitive deficiency, he should utilize his POA, when facing major decisions. His psychiatric care should continue under Dr. De Los Santos. The patient will function best in an environment with a good level of structure, and minimizing the demands on his memory and executive function. He should have his meds managed for him and his meals provided to him. He would also benefit from having his finances managed for him. He should be encouraged to engage in structured activities offering cognitive stimulation, social interaction and physician approved physical exercise. The patient also had one-to-one psychotherapy with Serge Sorokin for anxiety and depression.

DISCHARGE DIAGNOSIS:

- AXIS I** Bipolar Disorder, Mania With Psychosis
 Dementia, Vascular
 Secondary to the Underlying Condition of Cerebrovascular Disease
 and Hypertension With Psychosis and Behavioral Disturbance
- AXIS II** Deferred
- AXIS III** No Delirium, But The Patient With Chest Pain, Admitted to Acute Facility,
 St. Alexius Medical Center
- AXIS IV** Relapse, severe
- AXIS V** 10 of 65 percent

CONDITION ON DISCHARGE AND AFTERCARE PLANS:

The patient is still oriented x2, and not to his situation, virtually no participation in groups, and not much improvement in his psychosis and paranoia. He was still disruptive. He was still unpredictable, labile, resistive to ADLs.

He complained of chest pain to the left side of his chest with radiation to his left arm. His vital signs were stable, 91 heart rate, 121/72, and sat of 90, and the patient afebrile. It was decided that 9-1-1 would be called, and the patient would be transferred to St. Alexius Medical Center for emergency treatment.

Dictated by Janine Stewart, RN

0108-194

AB Behavioral Health Hospital

1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR# [REDACTED]
ROOM#: 3304-1 Sex: M
LOC. H 3N
DOB: [REDACTED] Age: 68
Initialization Date: 11/01/15 1625

PATIENT [REDACTED]
ACCT# [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/01/15

Signed

PSYCHIATRIC EVALUATION

IDENTIFYING DATA:

The patient is a 68 year old married Caucasian male who was admitted through Alexian Brothers Medical Center Emergency Room.

CHIEF COMPLAINT:

Aggressive behavior.

HISTORY OF PRESENT ILLNESS:

The patient gives history of feeling depressed on and off as long as he can remember. In July he fractured L4 and he was admitted to Central DuPage Hospital. After surgery and medical stabilization he was transferred to Bridgeway Senior Living Facility for rehabilitation. The nursing facility noted him to be aggressive and agitated with mood swings, tearful and accusing staff of mistreating him. Yesterday, he was agitated to an extent where he threw his dinner across the room. He was screaming out in room, got tearful and was crying. The patient said that he was not getting his pain medication and as a result, he was in pain the pain control was inadequate. His sleep tends vary. His appetite is good. He denies suicidal or homicidal ideations. He denies thoughts of wanting to harm others. He denies hallucinatory experiences and no delusional thinking was expressed or elicited. No history of hypomanic or manic episodes.

PAST PSYCHIATRIC HISTORY:

The patient has taken multiple psychotropic medications in the past. He denies any history of suicide attempts. He says that he was admitted to a psychiatric facility in 1999 for transcranial magnetic stimulation.

PAST MEDICAL HISTORY:

History of L4 fracture, hypothyroidism, congestive heart failure, gastroesophageal reflux disease,

Report # 1101-0098 PSYCHIATRIC EVALUATION
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Page: 1
Dept: MR

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]

Unit/MR# [REDACTED] A# [REDACTED]

history of diabetes mellitus type 2, obesity, obstructive sleep apnea, hypertension, atrial fibrillation, COPB, chronic kidney disease.

SOCIAL HISTORY:

The patient was born in Texas, but raised in Illinois since he was about 6 or 8 months. He was raised by his parents, no history of abuse. He has three years of college education. He is self employed as a software engineer. He denies use of tobacco, street drugs or alcohol. He was married prior to the L4 fracture and he was living at home with his wife.

FAMILY HISTORY:

Psychiatrist history: The patient reports history of depression and anxiety in his siblings.

MENTAL STATUS EXAM:

- A. Appearance:** The patient appeared his stated age.
- B. Behavior/Motor:** He was calm and cooperative with exam and made good eye contact.
- C. Orientation:** He was oriented to time, place and person.
- D. Speech:** His speech was spontaneous with a regular rate and rhythm.
- E. Mood/Affect:** He described his mood as being depressed. His affect was sad and tearful.
- F. Thought Process:** Coherent and goal directed.
- G. Thought Content:** No hallucinations. There were no overt delusions.
- H. Suicidal/Assaultive/Violent Thought:** The patient denies suicidal or homicidal ideations.
- I. Insight/Judgment:** Limited.
- J. Attention/Concentration:** Intact as he was able to maintain attention during the exam.
- K. Immediate Memory:** Intact as patient was able to give accurate details of HPI and past psychiatric history.
- 1. Recent Memory:** Intact as patient was able to give accurate details of HPI and past psychiatric history.
- 2. Long Term Memory:** Intact as patient was able to give accurate details of HPI and past psychiatric history.
- L. Intellectual Capacity:** Estimated to be average.

ASSETS/STRENGTHS:

Current therapeutic environment.

WEAKNESSES/LIABILITIES:

Poor coping skills.

PROVISIONAL DIAGNOSIS:

AXIS I Major Depressive Disorder, Recurrent, Severe Without Psychotic Features
Unspecified Anxiety Disorder

AXIS II Deferred

Report # 1101-0098 PSYCHIATRIC EVALUATION

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Dept: MR

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]

Unit/MR #: [REDACTED] # : [REDACTED]

AXIS III No Acute Medical Problems

AXIS IV Severe

AXIS V 34

SYMPTOMS REQUIRING THIS LEVEL OF CARE:

Agitated behavior.

INITIAL TREATMENT PLAN:

Admit the patient to 3E. Consult Dr. Mohsin for medical management. Adjust patient's psychotropic medications as tolerated and indicated. Monitor for safety and compliance.

OBJECTIVES FOR DISCHARGE AND AFTERCARE PLAN:

Significant improvement in patient's behavior.

ESTIMATED LENGTH OF STAY (ELOS): 5 to 7 days.

1001-078

Dictated By: ZAFEER H BERKI MD 11/01/15 2215

<Electronically signed by ZAFEER H BERKI MD> 11/01/15 2215

DD: 11/01/15 1437 DT: 11/01/15 1624
BERZA/KNP 1101-0098

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]

Unit/MR #: [REDACTED] #: [REDACTED]

Dictated By: RENATO DE LOS SANTOS MD

DD: 01/08/16 1856 DT: 01/09/16 1629
DEI RE1/MRR 0109-0123

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]
Unit/MR#: [REDACTED]

DD: 11/09/15 1532 DT: 11/09/15 2239
DELRE1/HBH 1109-0270

Report #: 1109-0270 PROGRESS NOTE
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Page: 2
Dept: MR

G. How many drinks containing alcohol do you have on a typical day when you are drinking? N/A 1-2 3-4
 5-6 7-8 10 or more Patient Refused/Unable to Assess

H. How often do you have six or more drinks on one occasion? Never Less than monthly Monthly
 Weekly Daily or almost daily Patient Refused/Unable to Assess

I. For patients 18 years of age or older: N/A

During the past 30 days, has the patient smoked cigarettes, cigars, or pipes daily on average: 4 or less (<1/4 pack) Five or more (>1/4 pack) Patient did not use any forms of tobacco Patient refused to provide information Patient unable to provide information due to clinical condition

III. FAMILY HISTORY OF MENTAL ILLNESS, SUBSTANCE ABUSE, AND ADDICTIVE BEHAVIORS:

(Past and current, age of onset, types of treatment and response to treatment) some brothers and sisters struggle with depression Pt denies

IV. PERSONAL AND SOCIAL HISTORY:

A. Residential status (Include who the patient is living with, in what type of environment, and if this is a stable living arrangement) resident of bridgeway senior living after fall prior was living with wife and oldest son (he is paralyzed after car accident and requires 24 hour care)

B. Are there any transportation issues that might affect discharge aftercare planning? Pt denies

C. Military history Pt denies

D. Are there any financial concerns retired/fixed income Pt denies

E. Legal problems pending or in the past (Probation, court dates, charges) reports h/o suing partner for stealing money from him, called 911 several times to report abuse remote past of arrest for "smoking pot" Pt denies

F. DCFS involvement at present or in the past Pt denies

G. History of sexual abuse, physical abuse or neglect as a victim or a perpetrator reports that his mother hit and neglected him and he was dx with ptsd Pt denies

H. Any exceptional events (trauma, illness, divorce, adoption, deaths, etc.) born in TX, oldest of 14 siblings, trauma hx, married and divorced and remarried his wife, together for 47 years, son's accident, limited contact with siblings, c/o partner stole 2 million dollars from him after he invented a software program Pt denies

I. Social behaviors (include # of friends, regularity of social contact) few friends, stopped being social after the money was stolen

J. What does the patient do for social activity? time with family



Alexian Brothers Behavioral Health Hospital
1650 Moon Lake Blvd
Hoffman Estates, IL 60169

Inpatient Psychosocial Assessment
Form #6010-082 12/10



ASMT

11/01/15
M KHAN, AQEEL A. MD
MR# B000129172 RFG
ACCT# [REDACTED]

- K. What does the patient do for regular physical activity? i was trying to learn to walk
- L. What hobbies does the patient have? nothing right now
- M. What does the patient do to relax? TM
- N. Family relationships (amount and quality of contact, describe relationships with immediate family members)
See Genogram (Attachment A) for additional information. wife-married x 47 years-good. reports close relationship with children and 7 grandchildren
- O. Does patient have a support network (either family or friends) that can help with needs outside hospital-with meds., appointments, etc. family Pt denies
- P. Are there any physical, educational, spiritual, and/or cultural belief/value needs impacting treatment here?
 YES NO If so, how would patient like us to address that need? concurrent medical N/A
- Q. What is patient's religious affiliation, if any? christian Do your spiritual beliefs cause you any conflicts or problems that might impact your treatment? YES NO
If yes, explain: N/A
- R. Previous treatment (including community resources/self-help groups) one previous inpt tx "i got anxious during tms session and they sent me to the hospital for a couple days but i did not need to be there." reports long h/o outpt med mgmt. "i was seeing the head of the dept of psy at rush before." Pt denies
- S. Current treatment (including community resources/self-help groups) dr leechuy per bridgeway Pt denies
- T. Current stressors per petition. pt called police and accused staff of abusing and hitting him. he requested to be d/c'd ama. +outbursts -swearing, throwing things. difficul to redirect. per pt: "i wanted to leave. we had a meeting and they (nurses) said i could not leave. the doctor said it could and after he left they (nurses) started tom attcke me... i was swinging the phone cord to keep they away. i told them i was going to file a civil suit and that why i am here ..it s all lies."

V. DEVELOPMENTAL INFORMATION (Child/adolescent patients only) N/A See Attachment B

VI. EMPLOYMENT/SCHOOL STATUS:

- A. What is your employment status (Full-time, part-time, unemployed, retired, seasonal) unemployed
- B. Has patient worked in the last 5 years? YES NO
If patient is still not working, why not? retired/software designer N/A
- C. Any vocational training (Please describe) Pt denies
- D. Highest grade completed high school graduate/3 years of college



Alexian Brothers Behavioral Health Hospital
1650 Moon Lake Blvd
Hoffman Estates, IL 60169

Inpatient Psychosocial Assessment
Form #6010-082 12/10



ASMT



VII. TREATMENT POTENTIAL

- A. Describe patient strengths i am a good husband
- B. Describe patient limitations i don't know
- C. Patient's perceptions of the benefits/function of the problem behavior pt is denying need for tx
- D. Patient/family expectation of treatment to leave

VIII. DIAGNOSTIC PROBLEM AREAS:

Additional assessments needed: moca gds

Preliminary discharge plan to include: assess and assist with transition to assisted living med mgmt per md

Genogram: See Attachment A

IX. Integrated Assessment Summary (Include information from all available assessments)

68 y/o male to abmc er via ambulance on petition from bridgeway senior living for eval and tx of increased sx and safety concerns. staff reports that pt called police and accused staff of abusing/hitting him. he was swearing, calling names and throwing things. he was medically cleared and transitioned to abbhh on petition for continued care. this is 2nd inpt tx and pt has + current outpt psy providers at bridgeway. (dr leechuy). pt is a&ox3/obese/unkempt. presents with decreased affect, fair eye contact, normal rate and volume of speaking voice. strenghts-current tx environment. signed roi for wife. weakness-d/c'd from assisted living ama. denying need for tx and focused on d/c. concurrent medical-fall risk, htn, ckd, dm, sleep apnea, hypothyroidism, chronic pain. s/p fx back. dx ptsd-mom hit and neglected him. limited contact with family of origin. sx include-labile mood, reports any sleep or appetite disruption is r/t pain. minimizing current depression, refused gds, c/o tired, admits to h/o depression his "whole life." reports that he was crying prior to admission "because of intense pain and they were not giving me my pills." per med rec +outbursts-yelling, swearing, threatening, throwing things, pt is denying outbursts. pt has called police on several occassions to report abuse. denying current and past si. based on an analysis of all available data pt's care plan will address

- dm
- fall risk
- pain
- risk of skin breakdown

Integrated Assessment Summary Completed By: pmcnultyrn



Alexian Brothers Behavioral Health Hospital
1150 Moon Lake Blvd
Bolingbrook, IL 60109

Inpatient Psychosocial Assessment
Form #6010-082 12/10



ASMT

11/01/15
M KHAN, AQEEL A. MD
MHA H000129172 HPG

Date: 11/2/15 Time: 1215 Informant: med rec/pt

Signature: [Handwritten Signature]

Date: _____ Time: _____ Informant: _____

Signature: _____

MD Signature: [Handwritten Signature]

Date: 11/2/15 Time: 3

 Alexian Brothers Behavioral Health Hospital
1650 Mason Lake Blvd.
Hoffman Estates, IL 60169

Inpatient Psychosocial Assessment
Form #6010-082 12/10



ASMT

[Redacted] 11/01/15
[Redacted] KRAN, AQEEL A, MD
MR# R000129172 BFG
ACCT# [Redacted] je 6 of 6

AB Behavioral Health Hospital

1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR#: H000129172
ROOM#: 3304-1 Sex: M
LOC: H.3N
DOB: [REDACTED] Age: 68
Initialization Date: 11/09/15 1741

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/01/15

Signed

Date: 11/9/15

Subjective: Mood-wise, he still has quite a bit of lability. At times, he is aggressive, paranoid. At times, emotional and crying. The pain, according to him, is adequately controlled. He does not ambulate. Intake has been mostly good.

Vital signs: Temperature 97.8, Blood pressure 143/63, Heart rate in the 70s.

HEENT: Tongue is moist.

Heart: S1, S2 well heard.

Lungs: Clear.

Abdomen: Obese, nontender.

Lower Extremities: Chronic massive edema and chronic skin changes.

Spine: No acute tenderness.

IMPRESSION/SUMMARY/TREATMENT PLAN:

Diagnosis:

1. Back pain, currently on stiff doses of opiates.
2. History of COPD, stable.
3. Chronic leg edema with no acute changes.
4. Reported chronic kidney disease.
5. Mood disorder with emotional instability.

Plan:

1. I have reviewed his meds, progress, available labs. Will continue to assist with his medical needs.
2. Psych management per Dr. Khan and team.
3. Multiple blood sugars since he has been here have been stable.

1109-089

Dictated By: SAFDER MOHSIN MD 11/20/15 1443

Report #: 1109-0222 PROGRESS NOTE
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AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]

Unit/MR#: [REDACTED] #: [REDACTED]

<Electronically signed by SAFDER MOHSIN MD> 11/20/15 1443

DD: 11/09/15 1428 DT: 11/09/15 1741
MOHSA/KNP 1109-0222

Report #: 1109-0222 PROGRESS NOTE
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Page: 2
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AB Behavioral Health Hospital

1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR#: H000129172
ROOM#: 3304-1 Sex: M
LOC: H.3N
DOB: [REDACTED] Age: 68
Initialization Date: 11/09/15 0738

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/01/15

Signed

Date: 11/8/15

This is a 68 year old white male who is followed up at 3 North on November 8th. Discussed with nursing staff regarding his progress. He was admitted on November 1st. He still has been having labile mood swings, escalates easily, irritable, needed Ativan IM to calm down, has been having irritable and angry attack, demanding, take his medication.

Mental status examination: He is awake, alert, and oriented. Affect labile. Insight impaired. Judgment impaired.

Diagnosis: Mood Disorder
Rule Out Bipolar Affective Disorder

Plan: Continue his current treatment. Continue supportive therapy. Continue internal milieu therapy.

1108-134

Dictated By: AQEEL A KHAN MD 11/09/15 1949

<Electronically signed by AQEEL A KHAN MD> 11/09/15 1949

DD: 11/09/15 0015 DT: 11/09/15 0734
KHAAQ/MH 1109-0031

Report #: 1109-0031 PROGRESS NOTE
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Page: 1
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AB Behavioral Health Hospital
1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR#: H000129172
ROOM#: 3304-1 Sex:M
LOC: H.3N
DOB: [REDACTED] Age:68
Initialization Date: 11/08/15 1422

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/01/15

Signed

Date: 11/7/15

This is a 68 year old white male who is followed up at 3N on November 7th. Discussed with nursing staff regarding his progress. He was admitted for mood disorder. He has been impulsive, demanding. If his demands are not fulfilled immediately then he starts to become loud. At this time he is watching TV but later one became agitated and needed prn medication. He takes medication. He has no acute medical problems.

Mental status exam: He is awake, alert and oriented. Affect blunted. Insight and judgment impaired.

Assessment: Mood Disorder

Plan: Continue current treatment. Continue supportive therapy. Continue interval milieu therapy.

1107-160

Dictated By: AQEEL A KHAN MD 11/08/15 1956

<Electronically signed by AQEEL A KHAN MD> 11/08/15 1956

DD: 11/07/15 2329 DT: 11/08/15 1405
KHAHQ/MT 1108-0089

AB Behavioral Health Hospital
1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR#: H000129172
ROOM#: 3304-1 Sex: M
LOC: H.3N
DOB: [REDACTED] ge: 68
Initialization Date: 11/07/15 1137

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/01/15

Signed

Date: 11/6/15

Blood sugar 89 to 156. The patient is alert, oriented to person, place and situation but does have periods of confusion. The patient cannot be prescribed Nuedexta at this time for the emotional lability because of the prescription of the Nardil and Lamictal high dose of 600 mg total dose per day and the patient did get a stat dose of lorazepam yesterday. No stat dose of any medication today. The patient seems calmed down and no evidence of increased confusion today. We will plan to discharge the patient tomorrow. Vital signs within normal limits. No evidence of systemic infection and intake averaging about 75%.

1106-202

Dictated By: RENATO DE LOS SANTOS MD 11/27/15 1523

<Electronically signed by RENATO DE LOS SANTOS MD> 11/27/15 1523

DD: 11/06/15 1810 DT: 11/07/15 1132
DELRE1/MT 1107-0085

AB Behavioral Health Hospital
1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR#: H000129172
ROOM#: 3304-1 Sex: M
LOC: H.3N
DOB: [REDACTED] Age: 68
Initialization Date: 11/05/15 2129

PATIENT / [REDACTED]
ACCT#: [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/01/15

Signed

Date: 11/5/15

I enacted the power of attorney. At this time, he has had periods of confusion and periods of lucid moments. I reviewed the current clinical status and treatment status with case management citing the significant medical history of this patient including the diagnosis of congestive heart failure, diastolic dysfunction and severe COPD, hypertension and anemia, and ventricular arrhythmia all significant contributors to the possible cerebrovascular insult in the form of transient ischemic attack or anoxia to the brain. Given his forgetfulness, repeating himself and periods of confusion, I suspect the patient to have vascular dementing disease. He does have a significant history of bipolar disorder according to the family; but, the patient denies any history of mania. Most of the medications that I have reviewed, provided by the family, includes medications pointing to a unipolar disorder, which is major depression on the nardil, which is a monoamine oxidate inhibitor which has been augmented with Adderall as a stimulant and the Lamictal as a mood stabilizer medication, but used for its antidepressant property. The Lamictal was reportedly used at 300 mg twice a day which is a significantly high dose. We are going to confer with the pharmacy, because if there is any maneuver to deal with his agitation and irritability other than the prescription for Nuedexta for the emotional lability secondary to underlying neurologic condition what I suspect to be a dementing disease, I would maintain Lamictal 300 mg twice a day and keep the nardil at 60 mg every day. I do not see any need for the Adderall prescription at this time, but will reevaluate that. In the terms of the history of positive response, I requested for neuropsychological testing from Dr. Campbell. The report indicated cognitive impairment. Neuropsychological testing revealed intact basic auditory attention capacity, intact problem solving ability, although the potential to demonstrate deficient reasoning skills which has been displaced and there is significant impairment of the executive dysfunction in the area of mental flexibility, abstraction ability and conceptualization and planning skills. The memory skills are quite variable, but in clinical presentation there have been significant periods of confusion and memory impairment. The diagnosis: Implications of the testing at this time is indicating that he may not be meeting criteria for dementia and that there are multiple medical risk factors for cerebrovascular disease which is the most likely cause of his acute cognitive decline and I will have to assess, based on my clinical assessment, if the patient has a vascular dementing disease in early stage at this time and that would be a comorbidity to the major depressive disorder, recurrent type. So that should be managed accordingly as two comorbid major psychiatric conditions as well with significant multiple medical problems contributing to the fluctuation of his mental state. So I will start the patient on the Nuedexta at this time.

1105-150

Report #: 1105-0188 PROGRESS NOTE
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Page: 1
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AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]

Unit/MR#: [REDACTED] #: [REDACTED]

Dictated By: RENATO DE LOS SANTOS MD 11/27/15 1523

<Electronically signed by RENATO DE LOS SANTOS MD> 11/27/15 1523

DD: 11/05/15 1511 DT: 11/05/15 2128
DELRE1/KNP 1105-0188

Report #: 1105-0188 PROGRESS NOTE
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AB Behavioral Health Hospital

1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR# [REDACTED]
ROOM#: 3304-1 Sex: M
LOC: H.3N
DOB: 04/20/1947 Age: 68
Initialization Date: 11/05/15 1432

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/01/15

Signed

Date: 11/5/15

Subjective: Very irritable, full of complaints. States staff abused him last night and they roughed him up. He wants a list of people that he has that need to be fired right away. Also, states his sleep has been very disturbed. Food intake most of the time has been moderate. He cannot ambulate without assist. Pain is well controlled on current medications.

Vital signs: Temperature 96.9. Blood pressure 137/59. O2 sat 95% on room air.

Heart: S1, S2 is well heard.

Lungs: Clear. No rales or wheeze.

Abdomen: Obese, nontender.

Lower extremities: Chronic stasis changes. No acute open areas. He does have multiple scabs.

Spine: No acute tenderness. He has a brace in place.

IMPRESSION/SUMMARY/TREATMENT PLAN:

Diagnosis:

1. Mood disorder with severe behavioral changes needs further stabilization.
2. Back surgery, pain adequately controlled on current meds.
3. History of COPD, sleep apnea. Stable on current meds.
4. Chronic leg edema. Some of it could be related to poor mobility and medications. Pregabalin may be playing a role as well.
5. Hypothyroid on replacement.
6. Reported history of chronic kidney disease.

Plan:

1. I have reviewed his meds, blood sugars, progress.
2. I have reassured the patient that the staff here is to help make him feel well. They will assist him with all needs and will monitor from medical standpoint.
3. Psych recommendations per Dr. Khan, Dr. De Los Santos and team.

1105-108

Report #: 1105-0114 PROGRESS NOTE

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AB Behavioral Health Hospital

Name [REDACTED] DOB: [REDACTED]

Unit/MR# [REDACTED] A# [REDACTED]

Dictated By: SAFDER MOHSIN MD 11/09/15 1632

<Electronically signed by SAFDER MOHSIN MD> 11/09/15 1632

DD: 11/05/15 1253 DT: 11/05/15 1431
MOHSA/LH 1105-0114

Report #: 1105-0114 PROGRESS NOTE
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Page: 2
Dept: MR

AB Behavioral Health Hospital

1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR# [REDACTED]
ROOM#: 3304-1 Sex: M
LOC: H.3N
DOE [REDACTED] Age: 68
Initialization Date: 11/03/15 1956

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/01/15

Signed

Date: 11/3/15

Patient is alert, oriented to person, place, and situation. No evidence of confusion. The blood sugar ranged from 105 to 152. Otherwise, vital signs unremarkable. No evidence of systemic infection. No respiratory distress. No hypotension. The patient ate 50% of breakfast, 75% lunch, and he was articulate, appropriate with his interaction. There is no evidence of confusion. He did give the social worker verbal consent to have the daughter be the designated Power of Attorney for health. Will ~~do~~^{discontinue} the Valium 10 mg twice a day prn, which has not been used since the time of admission. Will discontinue this order. I did talk to the patient regarding access to subacute skilled rehab given his multiple falls. The combination of Lamictal and 300 mg twice a day and the Nardil has been giving him the best response. I will keep the Nardil at a lower dose of a total of 60 mg per day in combination with the Lamictal. He denies any manic episode, contrary to report of the family. There is no evidence of psychosis at this time. Will confer with case management to finalize the discharge plan in four to six days.

1103-168

Dictated By: RENATO DE LOS SANTOS MD 11/05/15 1417

<Electronically signed by RENATO DE LOS SANTOS MD> 11/05/15 1417

DD: 11/03/15 1734 DT: 11/03/15 1953
DELRE1/HBH 1103-0266

Report #: 1103-0266 PROGRESS NOTE
Additional copy
CC:

Page: 1
Dept: MR

AB Behavioral Health Hospital

1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR# [REDACTED]
ROOM#: 3304-1 Sex: M
LOC: H.3N
DOB [REDACTED] Age: 68
Initialization Date: 11/02/15 2154

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/01/15

Signed

Date: 11/02/15

Blood sugar today ranged from 103 to 151. Vital signs 140/68 blood pressure, pulse rate of 72, afebrile. No respiratory distress. Intake, no breakfast, but had 50% lunch. The patient did not present with any acute physical distress. No evidence of delirium. No acute pain. He seemed calmer today. The patient was not given any stat dose of any psychotropic medication. The prn Valium was not given today. The patient is taking Phenezine, which is Nardil, and antidepressant medication; a total of 75 mg. Will confer as an antidepressant medication. Will confer with pharmacy regarding the dosing of this medication, maximum dose. There is no evidence of adverse reaction at this time. The Lamictal at 300 mg twice a day. No evidence of seizures. The medical evaluation by Dr. Mohsin. Appreciated history of congestive heart failure. Apparently diastolic dysfunction. The details of ejection fraction is unavailable at the time of examination. History of COPD. History of sleep apnea, history of hypertension, history of gait imbalance issues, recurrent falls. The patient apparently has been falling for the last three years. History of narcissistic personality disorder, history of chronic kidney disease. History of questionable bipolar disorder. Obesity, diabetes mellitus type 2 with neuropathy. History of ventricular arrhythmia. At the time of medical examination there was no evidence of delirium. There is reported low testosterone levels, on replacement. Severe leg edema and peripheral vascular changes that appear chronic, at risk of complications for immobility. Report history of congestive heart failure and diastolic dysfunction, as I mentioned. The initial psychiatric evaluation was done by Dr. Berki, and patient came from Central DuPage Hospital. Patient gave a history of depression on and off. In July he fractured L4, and was admitted to the hospital. After surgery and medical stabilization, he was transferred to Bridgeway Senior Living Facility for rehabilitation. Patient has been aggressive and combative recently, which escalated. Patient claimed that he was not given his pain medication. There is questionable history of bipolar disorder, prior psychiatric hospitalization. It was also reported he was admitted to a psychiatric facility in 1999 for his transcranial magnetic stimulation. The patient was diagnosed with Major Depression, Recurrent, Severe Without Psychosis. Also there is questionable diagnosis of Bipolar Disorder, Depressive Episode. Patient seems more alert, less lethargic. His memory appears to be intact, but he seems to repeat himself and become forgetful. Will request neuropsychological testing from Michelle Sanfilippo. Continue the Lamictal and lower the dose of the Nardil, if in fact, the patient has a Bipolar Disorder, per family's report.

1102-220

Dictated By: RENATO DE LOS SANTOS MD 11/05/15 1416

<Electronically signed by RENATO DE LOS SANTOS MD> 11/05/15 1416

Report #: 1102-0189 PROGRESS NOTE
Additional copy
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Page: 1
Dept: MR

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]
Unit/MR# [REDACTED] A#: [REDACTED]

DD: 11/02/15 1828 DT: 11/02/15 2144
DELRE1/HBH 1102-0189

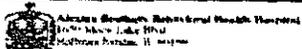
Report #: 1102-0189 PROGRESS NOTE
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Page: 2
Dept: MR

**ALEXIAN BROTHERS BEHAVIORAL HEALTH HOSPITAL
INPATIENT INTEGRATED PROBLEM SUMMARY AND MASTER TREATMENT PLAN OF CARE**

• Note: Upon Discharge, all problems/interventions are considered closed.

Problems Identified from Assessment Review (Include Patient/Caretaker's words/ideas about problem areas)		Date Initiated	Action Code	Reason Code	Staff Initiating Plan	Date	
ACTION CODE	REASON CODE					C = Continued	R = Revised
<p>Problem #1: Fall Risk - Physical Mobility Impaired</p> <p>Symptoms: wheelchair bound, impaired use of lower extremities</p> <p>Long Term Goal: Pt. will demonstrate measures to ^{use of a walker} minimize risk of fall</p> <p>Specific Short Term Goals/Objectives: (See Individualized Intervention List for Objective-Specific Interventions)</p> <ol style="list-style-type: none"> Pt. will be free from falls during hospitalization Pt. will use call light & w/c to minimize risk of fall. 		11/1/15	A	1	AKW	0-11/5	
<p>Problem #2: Moderate Risk for Skin Breakdown</p> <p>Symptoms: excoriation to perineal area, w/c bound, impaired mobility</p> <p>Long Term Goal: To prevent any further skin breakdown</p> <p>Specific Short Term Goals/Objectives: (See Individualized Intervention List for Objective-Specific Interventions)</p> <ol style="list-style-type: none"> Pt. will demonstrate & verbalize understanding of measures to prevent skin breakdown. Pt. will be turned every 2 hours while in bed & shift wt. in w/c 		11/1/15	A	1	AKW	0-11/5	
<p>Problem #3: Pain Issues - chronic, alteration in comfort</p> <p>Symptoms: Verbalizes complaints of chronic back pain, hx of compression fracture.</p> <p>Long Term Goal: Pt. will engage in regular daily activities with interruptions</p> <p>Specific Short Term Goals/Objectives: (See Individualized Intervention List for Objective-Specific Interventions)</p> <ol style="list-style-type: none"> Pt. will report pain & utilize prescribed pain manag. program. Pt. will not exhibit overt signs & symptoms of pain ^{using Baker Scale.} 		11/1/15	A	1	AKW	0-11/5	



Inpatient Integrated Problem Summary/Master Treatment Plan Of Care

Form # 6010-081 2/15
Chart copy - Patient copy



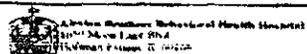
TX

11/01/15
68 M KHAN, AQEEL A. MD
MR# R000129172 HFG
A [REDACTED]

**ALEXIAN BROTHERS BEHAVIORAL HEALTH HOSPITAL
INPATIENT INTEGRATED PROBLEM SUMMARY AND MASTER TREATMENT PLAN OF CARE**

Note: Upon Discharge, all problems/interventions are considered closed.

Problems Identified from Assessment Review (Include Patient/Caretaker's words/ideas about problem areas)		Date Initiated	Action Code	Reason Code	Staff Initiating Plan	Date
ACTION CODE	REASON CODE					
<p>A. Active - Use in current Treatment Plan B. Monitor - Initiate plan if condition changes C. Refer - Include recommendations in Continued Care Plan D. Defer - Problem is stable or non-priority</p>	<p>1. Priority treatment focus - address now 2. Condition currently stable 3. Patient unready to pursue or declines services 4. Other problems currently more pressing</p>					<p>C = Continued R = Revised A = Achieved</p>
<p>Problem #4: <u>Diabetes mellitus</u> Symptoms: <u>Acute dx Ac/H/S, elevated BG + injectable insulin</u> Long Term Goal: <u>Pt will maintain optimal health & minimize complication of disease through good mgmt.</u> Specific Short Term Goals/Objectives: (See Individualized Intervention List for Objective-Specific Interventions) 1. <u>Pt will verbalize understanding of dx and tx of management.</u> 2. <u>Pt will comply w/ medication management, diet and glucose monitoring.</u></p>		11/15	A	10/15		11/15
<p>Problem #5: <u>depression with agitated</u> Symptoms: <u>labile, irritable, outbursts - yelling, chewing things, increased</u> Long Term Goal: <u>lean</u> Specific Short Term Goals/Objectives: (See Individualized Intervention List for Objective-Specific Interventions) 1. <u>nothing</u> 2. <u>pt will respond to redirection/reassurance → no outbursts</u></p>		11/15	A	1		11/15
<p>Problem #6: _____ Symptoms: _____ Long Term Goal: _____ Specific Short Term Goals/Objectives: (See Individualized Intervention List for Objective-Specific Interventions) 1. _____ 2. _____</p>						



Inpatient Integrated Problem Summary/Master Treatment Plan Of Care

Form # 6010-081 2/15
Chart copy - Patient copy



TX

11/01/15
ALEXIAN, AQUEL A., MD
MR# K000129172 HFG

**ALEXIAN BROTHERS BEHAVIORAL HEALTH HOSPITAL
INPATIENT INTEGRATED PROBLEM SUMMARY AND MASTER TREATMENT PLAN OF CARE**

- Note: Upon Discharge, all problems/interventions are considered closed.

EVIDENCE TO SUBSTANTIATE DIAGNOSIS:

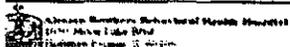
To substantiate the treatment focus, the following data sources were consulted: Psychiatric Evaluation, History and Physical Exam, Nursing Assessment, Psychosocial Assessment, Laboratory findings (if applicable), and reports from sending facility/agency.

Primary Treatment Focus	Psychiatric Diagnoses: <u>MDD recurrent severe without psychotic features, hmg unspecified Anxiety DD</u>
	Medical Diagnoses: <u>HTN, COPD, DM, Chronic kidney disease, severe leg edema, low testosterone</u>

TREATMENT TEAM MEMBERS:

The following represents specific staff responsible for ensuring compliance with the patient's individualized Plan of Care. Disciplines listed on specific Treatment Plan interventions refer to the assigned team member listed. NOTE: disciplines marked with an * are only identified if actively involved in the plan of care.

Discipline	Printed Name	Signature	Initials	Date	Time
Psychiatrist	<i>[Handwritten Name]</i>	<i>[Handwritten Signature]</i>	MB	11/2/15	12
Case Manager	<i>[Handwritten Name]</i>	<i>[Handwritten Signature]</i>	MM	11/1/15	0905
CM Initiating Care Plan	<i>[Handwritten Name]</i>	<i>[Handwritten Signature]</i>	<i>[Handwritten Initials]</i>	11/2/15	1130
Nurse	Karla DeMauro	<i>[Handwritten Signature]</i>	<i>[Handwritten Initials]</i>	11/1/15	0600
Mental Health Counselor					
Expressive Therapist	Lani Takaki	<i>[Handwritten Signature]</i>	LT	11/2/15	2000
*Therapist					
*Physical Therapist	Taylor Haultz, PT, DPT	<i>[Handwritten Signature]</i>	TH	11/4/15	1110
*Medical Physician / RNP					
*Dietitian					
*Chaplain					



Inpatient Integrated Problem Summary/Master Treatment Plan Of Care

Form # 6010-081 2/15
Printed copy - Patient copy



TX

11/02/15
H. KHAN, AQEEL A., MD
MR# H000129172 BFG

**ALEXIAN BROTHERS BEHAVIORAL HEALTH HOSPITAL
INPATIENT INTEGRATED PROBLEM SUMMARY AND MASTER TREATMENT PLAN OF CARE**

• Note: Upon Discharge, all problems/interventions are considered closed.

Discipline	Printed Name	Signature	Initials	Date	Time
Guest					

I have participated in and reviewed this treatment plan of care. It has been explained to me in a language that I understand.

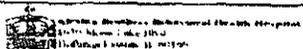
Decline

Patient Signature

Date/Time

Parent / Guardian Signature

Date/Time



Inpatient Integrated Problem Summary/Master Treatment Plan Of Care

Form # 6010-081 2/15

Chart copy - Patient copy



TX

11/01/15
 DR. KEVIN ADSEL, MD
 MRS HG00129172 SFG

AB Behavioral Health Hospital
1650 Moon Lake Blvd
Hoffman Estates, IL 60169

Date: 11/17/15
Acct Num: [REDACTED]
Med Rec Num: [REDACTED]
Name: [REDACTED]
Location: 3 East
Primary Provider: KHAN, AQEEL A

Continued Care Instructions

CONTINUED CARE INSTRUCTIONS AFTERCARE TREATMENT/FOLLOW UP INSTRUCTIONS

Treatment to be Addressed in Aftercare: Medication management, mood stabilization.

Discharge Patient to: Home/Self Care

Pt will return home with family once d/c from hospital and then will go to Elmhurst NH (on Friday 11/27)- 127 West Diversy Ave., Elmhurst, IL 60126 (630-530-5225/F: 630-530-7775). Pt will be under the care of Dr. De Los Santos at NH.

Case Manager: Neelu Nehls MA LCPC Date: 11/25/15 Time: 17:00

ADDITIONAL INFORMATION

Psychiatric Discharge Diagnosis: Major Depressive Disorder, Recurrent, in Partial Remission.
Dementia in OTH Diseases Classd Elsewhr w Behavioral disturbance.

Diet: Other
Cardiac diet

Exercise:
as tolerated

Medication Follow Up:

- Medications are listed on the Patient Discharge Medication List.
- Medication Doses may have changed, follow the instructions on the outpatient prescriptions.
- Avoid alcohol, alcohol containing substances, and mood altering drugs if taking psychiatric medications.

Medical Follow Up:

follow up with primary care physician

Discharge Date: 11/25/15 Time: 1715 RN Signature: [Signature]

By signing below, the patient/guardian attest they reviewed and agree to the D/C instructions and have received a copy.
Bring these instructions to all physician and therapist visits as a treatment reference.

Patient Signature: [Signature]

Guardian/Significant Other Signature: _____

IF FEELING SUICIDAL OR EXPERIENCING A PSYCHIATRIC EMERGENCY,
CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM

DISCHARGE FORMS

Discharge Forms - Please check applicable box

- Faxed
- Sent with patient transporter
- Sent to PHP/IOP/Group Practice
- Patient refused transmittal

AB Behavioral Health Hospital
1650 Moon Lake Blvd
Hoffman Estates, IL 60169

Date: 11/17/15

Acct Num: [REDACTED]

Med Rec Num: [REDACTED]

Name: [REDACTED]

Location: 3 East

Primary Provider: KHAN, AQEEL A

Patient will manage care plan

By: Unit Secretary/Designee

DM

Date:

11/25/15

Time:

@ 1715

Page: 1

Patient Discharge Med List

Date: 11/25/15 15:34

Alexian Brothers Behavioral Health Hospital

User: MRAIZ

847-882-1600

Patient: [REDACTED] Acct: [REDACTED] Age/Sex: 68 M
 Location: H.3E Room: 3239-2 MRN: [REDACTED] Ht: 6 ft
 Physician: AQEEL A KHAN Admit Date: 11/17/15 DOB: [REDACTED] (182.88 cm)
 Wt: 274 lb 6.4 oz (124.466 kg)

Adverse Reactions/Allergies: amlodipine

Home Medications

Drug	Dose	Method	Frequency	Prescription Given
Acetaminophen[Tylenol 325 mg Tab] As Needed For: Pain, Mild	650 MG	BY MOUTH	EVERY 8 HOURS AS NEEDED	No
Albuterol Sulfate/Ipratropium[Duoneb 3MI Nebule 3 ml Neb] As Needed For: Shortness Of Breath/Wheezing	3 ML	BY INHALER	Every 6 Hours as Needed	No
Aspirin[Aspirin 325 mg Tab] Indication: anticoagulant	325 MG	BY MOUTH	Daily	No
Calcium Carbonate[Tums Chew Tab 500 mg Chewtab] As Needed For: GI Upset	500 MG	BY MOUTH	Every 4 Hours as Needed	No
Cholecalciferol (Vitamin D3)[Vitamin D-3 2,000 unit Tablet] Indication: Vitamin Supplement	2000 UNIT	BY MOUTH	Daily	No
Dextromethorphan HBr/Quinidine[Nuedexta 1 each Cap] Indication: Mood Stabilization	1 EACH	BY MOUTH	Twice Daily	Yes
Fluticasone/Salmeterol[Advair 250Mcg/50Mcg Diskus 1 inh Disk.W.Dev] Indication: copd	1 INH	BY INHALER	Every 12 Hours (9A-9P)	Yes
Folic Acid[Folic Acid 1 mg Tab] Indication: Vitamin Supplement	1 MG	BY MOUTH	Daily	No
Insulin Aspart.[Novolog Sliding Scale 1 unit Vial] Indication: DM Protocol:	0 UNIT	SUB-Q	Three Times Daily	Yes
Blood Glucose 150-180mg/dl, 2 units subcutaneously, Blood Glucose 181-210mg/dl, 4 units subcutaneously, Blood Glucose 211-240mg/dl, 6 units subcutaneously, Blood Glucose 241-270 mg/dl, 8 units subcutaneously, Blood Glucose 271-300mg/dl, 10 units subcutaneously, Blood Glucose >300 mg/dl (Days), 10 units subcutaneously, Ca Blood Glucose <60 mg/dl, , Call Physician				

Page: 2
Date: 11/25/15 15:34
User: MRAIZ

Patient Discharge Med List
Alexian Brothers Behavioral Health Hospital
847-882-1600

Patient: [REDACTED] Acct: [REDACTED] Age/Sex: 68 M
Location: H.3E Room: 3239-2 MRN: [REDACTED] Ht: 6 ft
Physician: AQEEL A KHAN Admit Date: 11/17/15 DOB: [REDACTED] (182.88 cm)
Wt: 274 lb 6.4 oz (124.466 kg)

Adverse Reactions/Allergies: amlodipine

Home Medications

Drug	Dose	Method	Frequency	Prescription Given
Lamotrigine[Lamictal 150 mg Tab] Indication: Bipolar	300 MG	BY MOUTH	Twice Daily	Yes
Levothyroxine Sodium[Synthroid 100 mcg Tab] Indication: Thyroid	100 MCG	BY MOUTH	Daily	Yes
Loratadine[Claritin 10 mg Tab] Indication: Antihistamine	10 MG	BY MOUTH	Daily	No
Olanzapine[Zyprexa 2.5 mg Tab] Indication: Bipolar	2.5 MG	BY MOUTH	Three Times Daily	Yes
Pantoprazole[Protonix 40 mg Tab] Indication: acid reflux	40 MG	BY MOUTH	Daily	No
Polyethylene Glycol 3350[Miralax 17 gm Powd.Pack] Indication: Dietary Supplement	17 GM	BY MOUTH	Daily	No
Potassium Chloride[K-Dur 20 meq Tab] Indication: Vitamin Supplement	40 MEQ	BY MOUTH	Twice Daily	Yes
Pregabalin[Lyrica 25 mg Cap] Indication: Pain - Moderate	25 MG	BY MOUTH	Twice Daily	Yes
Torsemide[Demadex 20 mg Tab] Indication: Blood Pressure High	40 MG	BY MOUTH	Twice Daily	Yes

Influenza Date:

Pneumococcal Date:

Stop taking any medication not listed above. If necessary, contact your primary physician with any questions. Update any records with your provider(s) and pharmacy.

I have reviewed and understand my Discharge Medication List:

Patient/Significant Other: unable to sign Date: _____

RN Signature: [Signature] Date: 11-25-15 Time: 15:40

*** FINAL PAGE ***

AB Behavioral Health Hospital

1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR# [REDACTED]
ROOM#: 3239-2 Sex: M
LOC: H 3E
DOB: [REDACTED] age: 68
Initialization Date: 01/10/16 1159

PATIENT: [REDACTED]
ACCT# [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/17/15

Draft

DISCHARGE SUMMARY

Admission Date 11/17/15
Discharge Date 11/25/15

REASON FOR ADMISSION AND HISTORY OF PRESENT ILLNESS:

This is a 68 year old, married, Caucasian male who came in initially 11/1/15 through 11/11/15 before being transferred to St. Alexius Medical Center for chest pain. He had come to us from Central DuPage Hospital. He had been sent there by the Bridgeway Senior Rehab Center when he was having very aggressive agitated behavior, mood swings, tearful, accusing staff of mistreating him, calling the police, and saying he was being abused. He got agitated and threw dinner across the room. He was screaming, he was tearful, and he was sent for evaluation here. When he went to St. Alexius Medical Center, he was cleared cardiac wise, but they did rule him in with right upper lobe pneumonia. Now, he is readmitted here for his stabilization.

His psych eval was done by Dr. De Los Santos. He states again the patient was initially admitted here for severe depression, agitation, and a risk to harm self and others. He was not able to function at his nursing home. He went to SAMC, was admitted, and then medically cleared. His past psychiatric history is he has a history of depression and a diagnosis of dementia with severe anxiety and behavioral disturbance. He has a history of psychiatric hospitalization for transcranial magnetic stimulation.

PERTINENT HISTORY AND PHYSICAL FINDINGS:

Appearance. He is wearing a hospital gown. He is disheveled with poor hygiene. Fair eye contact. Motor: He is mostly bound to the geriatric chair. His behavior is aggressive. His orientation is to person and place, not fully to situation. His speech is not aphasic. He is able to respond coherently. His mood is labile and agitated. His affect is anxious and angry. His thought process is circumstantial with no loosening of associations. Thought content: He does not appear to hallucinate. He denies any delusions. He denies any suicidal or homicidal ideations, but he has been aggressive, violent, and combative towards staff. His insight, judgment, attention, and concentration are all impaired. He is very distractible and not able to do Serial 7's. His immediate memory. He is able to repeat three words, but cannot recall after three or five minutes. Recent memory. He is not able to give a coherent account of why he ended up at the medical/surgical hospital and then came back to the Behavioral Health Hospital. Long term memory fair, but does not have full details of his past. His intellectual capacity is impaired. There are periods of increased confusion and cognitive decline.

The patient will be admitted to 3 East where we will do psychiatric med stabilization and evaluation. Dr. Mohsin will be consulted for medical management. The plan is to continue the patient's Lamictal 300 mg bid and the Zyprexa 2.5 mg three times a day. While he was here previously, he had a trial of Nardil, but that has now been successfully discontinued. We will look at use of Nuedexta for the emotional lability secondary to the patient's underlying

Report # 0110-0044 DISCHARGE SUMMARY

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Page 1
Dept: MR

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]
Unit/MR#: [REDACTED] #: [REDACTED]

neurologic condition of vascular dementia. Case management will be consulted for discharge planning. The patient will participate in all appropriate psychosocial and psychotherapeutic programs. Objectives for discharge are there will be a significant alleviation or resolution of the patient's psychosis, behavioral disturbance, agitation, and aggression, the patient will be at risk of harm to self or others, and he will be calm, cooperative, and allow treatment in a less restrictive environment. Aftercare is discharge back to Bridgeway or find alternative placement that can provide him supervision and monitoring for his healthcare needs in a therapeutic environment.

His H&P was done by Dr. Safdar Mohsin. He states that the patient's past medical history is significant for hypertension, chronic obstructive pulmonary disease and sleep apnea, diabetes, chronic kidney disease, hypothyroidism on replacement, leg edema severe from peripheral vascular changes that appear chronic, low testosterone levels on replacement, congestive heart failure and diastolic dysfunction, musculoskeletal pain on stiff doses of pain medications, a remote history of cerebrovascular incident.

HOSPITAL COURSE.

The patient came to 3 East. He had labs drawn, CBC and chemistry, which were unremarkable. He was oriented x2 but not to his situation. He was confused and forgetful. He was refusing all groups. When he would sit in the group room, he would just sleep. He was aggressive with staff, hitting, yelling loudly, cursing, very easily agitated, angry, and delusional. He could escalate at the drop of a hat. He was irritable, restless, isolative. His affect was labile and blunted. He needed frequent redirection and he kept perseverating about going home. He also was eating very poorly and refusing most meals, many days eating just breakfast. Dr. De Los Santos did start him on Nuedexta initially one capsule daily and as the patient was able to tolerate that and became less emotionally reactive he increased him to a discharge dose of Nuedexta one capsule twice a day for the pseudobulbar affect secondary to the underlying condition of the vascular dementia. The patient stayed on the Zyprexa 2.5 mg three times a day, but Dr. De Los Santos did get rid of the prn dose because the patient really had not been using but two times during his hospital stay. The Lamictal 300 mg twice a day remained the same. With the medication changes and additions, there was no EPS or any tardive dyskinesia.

DISCHARGE DIAGNOSIS:

- Axis I: Major Depression, Recurrent, Severe Without Psychosis
Vascular Dementia Secondary to the Underlying Condition of Cerebrovascular Disease and Hypertension With Psychosis and Behavioral Disturbance
- Axis II: Deferred
- Axis III: No Delirium
- Axis IV: Relapse, severe
- Axis V: 45/65

CONDITION ON DISCHARGE AND AFTERCARE PLANS

The patient remains oriented just x2, not to his situation. Minimal participation in groups, but the patient is calmer and more cooperative. He is actually pleasant upon discharge and thanks the staff for putting up with him. His eating is still very poor, mostly just breakfast. He wanted to go home to live with his ex-wife and she said she cannot handle him, so the patient will be going to new placement. It will be to the Elm Brook Nursing Home. The treatments to be addressed in aftercare are medication management and mood stabilization. He will follow a cardiac diet.

Dictated by Janine Stewart, R.N.

0109-081

Dictated By: RENATO DE LOS SANTOS MD

AB Behavioral Health Hospital

Name: [REDACTED] N DOB: [REDACTED]
Unit/MR #: [REDACTED] A# [REDACTED]

DD: 01/09/16 1401 DT: 01/10/16 1123
DELRE1/NJK 0110-0044

AB Behavioral Health Hospital

1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR#: [REDACTED]
ROOM#: 3239-2 Sex:M
LOC: H 3E
DOB: [REDACTED] Age:68
Initialization Date: 11/18/15 2025

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/17/15

Signed

PSYCHIATRIC EVALUATION

IDENTIFYING DATA:

Patient is a 68 year old Caucasian who was referred back from St. Alexius Medical Center for admission to Alexian Brothers Behavioral Health Hospital.

CHIEF COMPLAINT:

Combative.

HISTORY OF PRESENT ILLNESS:

The patient was initially admitted to Alexian Brothers Behavioral Health Hospital for severe depression, agitation, and risk to harm self and others. Not able to function at the nursing home, but because of chest pain, he was referred to St. Alexius Medical Center emergency room, admitted, and then medically cleared.

PAST PSYCHIATRIC HISTORY:

History of depression and diagnosis of dementia with severe anxiety and behavioral disturbance. The patient had history of psychiatric hospitalization for transcranial magnetic stimulation.

PAST MEDICAL HISTORY:

History of L4 fracture, hypothyroidism, congestive heart failure, recent chest pain, history of diabetes with labile blood pressures, sleep apnea, hypertension, chronic kidney disease, diabetic neuropathy, back pain with recent kyphoplasty, reported history of arrhythmia. Non-ambulatory for quite some time. Morbid obesity.

The patient's CT scan of the head showed no evidence of acute findings indicative of any hydrocephalus or intracranial hemorrhage. There is consults done at the hospital indicated the patient had exacerbation of the cardiac problems, congestive heart failure, and then became

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]
Unit/MR# [REDACTED] A# [REDACTED]

increasingly confused. EKG was negative. He had no evidence of pulmonary embolism. Questionable right-sided pneumonia, which he was treated. CT scan of the head due to some increased confusion that shows moderate diffuse atrophy, but nothing acute.

The patient is allergic to Amlodipine. There is no alcohol or drug history.

He was afebrile. Temperature of 97.2, pulse rate of 72, blood pressure of 133/92, respiratory rate of 20, and oxygen saturation of 98%. He had scabs and abrasions over his legs, but no edema. Patient was recently treated for pneumonia and increased confusion, which seems to be assessed as delirium then but that has medically cleared. The patient is not complaining of any chest pains. No respiratory distress. No abdominal pain. No physical complaints.

Review of Systems & Active Medical Problems:

**Constitutional: Eyes: Ears/ Nose/ Mouth/ Throat: Cardiovascular: Respiratory:
Gastrointestinal: Genitourinary: Musculoskeletal: Integumentary: Neurological:
Endocrine: Hematologic/ Lymphatic: Allergies/ Immune:**

SOCIAL HISTORY:

Patient worked as a software engineer, and has recently been placed at nursing home, at Bridgeway facility. The recent return to Alexian Brothers Behavioral Health Hospital from St. Alexis Medical Center didn't show any evidence of delirium.

FAMILY HISTORY:

History of depression and anxiety with his siblings, and currently with situation.

MENTAL STATUS EXAM:

- A. Appearance:** Patient is a 68 year old Caucasian male wearing hospital gown, disheveled. Poor hygiene. Fair eye contact.
- B. Behavior/Motor:** Motor Mostly bound to the geriatric chair. Behavior aggression.
- C. Orientation:** Orientation to person and place, not fully the situation. Not time.
- D. Speech:** Not aphasic. Patient is able to respond coherently.
- E. Mood/Affect:** Affect anxious, angry. Mood labile, agitated.
- F. Thought Process:** Circumstantial, but no loosening of association.
- G. Thought Content:** Did not appear to hallucinate. Denies any delusions.
- H. Suicidal/Assaultive/Violent Thought:** Denies any suicidal or homicidal ideation, although he has been aggressive and violent: combative towards staff.
- I. Insight/Judgment:** Impaired.
- J. Attention/Concentration:** Impaired. Very distractible. Not able to do Serials of 7s.
- K. Immediate Memory:** Able to repeat three words, but cannot recall after 3 or 5 minutes.
- 1. Recent Memory:** Not able to give coherent account of why he ended up at the medical surgical hospital, and then coming back to behavioral health hospital.
- 2. Long Term Memory:** Fair, but not full details of his past.

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]
Unit/MR#: [REDACTED] A#: [REDACTED]

L. Intellectual Capacity: Impaired. Periods of increased confusion and cognitive decline.

ASSETS/STRENGTHS:

Access to care. Presence of Power of Attorney.

WEAKNESSES/LIABILITIES:

Impaired coping skills. Cognitive decline.

PROVISIONAL DIAGNOSIS:

AXIS I Major Depression, Recurrent, Severe, No Psychosis
Vascular Dementia with Psychosis and Behavioral Disturbance
AXIS II Deferred
AXIS III No Delirium
Recent Treatment of Pneumonia
AXIS IV Relapse severe
AXIS V 10

SYMPTOMS REQUIRING THIS LEVEL OF CARE:

His aggressive behavior, increased periods of confusion, not able to function in a less restrictive environment, and not able to care for self. Patient is a risk to harm others.

INITIAL TREATMENT PLAN:

Admit the patient to Alexian Brothers Behavioral Health Hospital. Dr. Mohsin for medical management. Patient will continue to take the prn Zyprexa and the Lamictal 300 mg twice daily, which I will find the lowest possible dose. There has also been, in the past, trial of the Nardil, which we have successfully discontinued. Then, will look into the use of the Nuedexta for the emotional lability secondary to the underlying neurologic condition of the vascular dementia. Will adjust the dose of the Zyprexa. Instead of doing the prn dose, we'll look into a low-scheduled dose of the medication as we gradually decrease the Lamictal. Case management for discharge planning. Participation in all appropriate psychosocial and psychotherapeutic program.

OBJECTIVES FOR DISCHARGE AND AFTERCARE PLAN:

Significant alleviation or resolution of the psychosis, behavioral disturbance, agitation, aggression. Patient will not be a risk to harm self and others. Calm, cooperative, and allow treatment in a less restrictive environment.

Aftercare is discharge to Bridgeway or find alternative placement that will provide him supervision, monitoring of his healthcare needs in a therapeutic environment. Continue medical and psychiatric services, and all support psychosocial and psychotherapeutic program.

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]

Unit/MR#: [REDACTED] #: [REDACTED]

ESTIMATED LENGTH OF STAY (ELOS): Seven to ten days.

1118-166

Dictated By: RENATO DE LOS SANTOS MD 11/27/15 1528

<Electronically signed by RENATO DE LOS SANTOS MD> 11/27/15 1528

DD 11/18/15 1713 DT 11/18/15 2005
DELRE1/HBH 1118-0244

AB Behavioral Health Hospital

1650 MOON LAKE BLVD
HOFFMAN ESTATES IL 60169

UNIT/MR# [REDACTED]
ROOM#: 3239-2 Sex:M
LOC: H 3E
DOB: [REDACTED] Age:68
Initialization Date: 11/18/15 2151

PATIENT: [REDACTED]
ACCT# [REDACTED]
ATT PHY. AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/17/15

Signed

HISTORY AND PHYSICAL EXAMINATION UPDATE

Date of Admission: 11/17/15

HISTORY OF PRESENT ILLNESS:

Chief complaint: Mood and behavioral issues. This an H&P Update. Patient was originally admitted here 11/1 and transferred to the St. Alexius Medical Center for chest pain. His cardiac workup there was negative for any inducible ischemia; however, he was noted to have right sided pneumonia and has been treated for that. Besides that, his other multiple other medical issues remained stable. His back pain particularly has been very stable and he's practically off of the narcotics. The main problem while he was there continued to be mood and behavioral issues, unpredictable anger. Psych services were monitoring and after he was medically stabilized, he's being transferred back here.

PAST MEDICAL HISTORY:

See my H&P 11/2/15 and also my H&P from St. Alexius Hospital.

PAST SURGICAL HISTORY:

See my H&P 11/2/15.

MEDICATIONS:

See reconcile.

SOCIAL HISTORY:

As per my H&P 11/2/15.

FAMILY HISTORY:

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]
Unit/MR#: [REDACTED] A#: [REDACTED]

ALLERGIES:

Amlodipine.

REVIEW OF SYSTEMS:

HEENT: No headache, dizziness, blurring of vision. Cardiac: He denies any further chest pains. He does get winded easily. Respiratory: No cough, congestion, discolored secretions. GI: Good appetite. No vomiting, diarrhea. No blood in the stool. Musculoskeletal: Minimal back discomfort. Does not appear to be in any distress. He is non-ambulatory. GU: No dysuria, incontinence. Circulatory: Chronic leg edema and stasis changes. Neurologic: Tingling, numbness, generalized leg weakness. Non-ambulatory.

PHYSICAL EXAMINATION: He's resting comfortably. He's quite friendly this afternoon.

Vital signs: Blood Pressure 110/74, 110/72, 128/84, Temperature: 97.2, 98.8, 97.6, O2 sat 93 to 98 percent, reportedly on 2L, but patient does not wear any oxygen.

HEENT:

Neck:

Heart: S1 and S2 well heard. No murmurs.

Lungs: Bilateral minimal wheeze. No rales.

Abdomen: Obese. Non-tender. Bowel sounds well heard.

Lymph Nodes:

Extremities: Chronic stasis changes.

Skin:

Joints:

NEUROLOGIC SCREEN: As per my H&P 11/2/15, no new changes.

i. CRANIAL NERVES:

Cranial Nerve 1:

Cranial Nerve 2:

Cranial Nerves 3, 4 & 6:

Cranial Nerve 5:

Cranial Nerve 7:

Cranial Nerve 8:

Cranial Nerves 9 & 10:

Cranial Nerve 11:

Cranial Nerve 12:

ii. MOTOR:

iii. SENSORY:

iv. COORDINATION:

REFLEXES:

LABORATORY DATA:

Report # 1118-0257 HISTORY AND PHYSICAL UPDATE
Additional copy
CC:

Page: 2
Dept: MR

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]

Unit/MR#: [REDACTED] A#: [REDACTED]

IMPRESSION/TREATMENT PLAN:

1. Mood disorder, with severe behavioral problems. This has been the case according to the wife who had multiple discussions with me while he was at the other hospital and according to her, he has been like this over a number of years.
2. History of back surgery, excessive opiate use over a number of years; however, he has been successfully weaned off of the Dilaudid without any problems.
3. Advanced COPD, sleep apnea, on nebulizers and a CPAP.
4. History of hypertension, stable readings.
5. Diabetes, no further hypoglycemic episodes. He's been off bydureon, currently only on sliding scale.
6. History of chronic kidney disease.
7. History of hypothyroid, on replacement.
8. History of severe chronic leg edema, peripheral vascular disease with no further workup requested by patient and the family. They do understand that this is likely to get worse even resulting in amputations.
9. History of hypergonadism.
10. History of neuropathy. He's been non-ambulatory for at least some years.
11. Thoracic aneurysm. Patient and wife decline any further interventions. They do understand that this could result in a life threatening emergency.

PLAN:

1. I have reviewed his medications, progress.
2. We'll continue to arrange his medications as needed. Patient is very happy that he is off the narcotics to a great extent and also wife is very glad about it as well.
3. I will assist with his medical needs. According to the wife, he should be DNR, but I do not have the appropriate papers.

1118-211

Dictated By: SAFDER MOHSIN MD 11/20/15 1444

<Electronically signed by SAFDER MOHSIN MD> 11/20/15 1444

DD 11/18/15 2048 DT 11/18/15 2151
MOHSA/MP 1118-0257

Fac: AB Behavioral Health Hospital

Loc: 3 East

Bed: 3239-2

68 M

Med Rec Num

Visit: H08002900234

Attending: AQEEL A KHAN

Reg Date: 11/17/15

Reason: F23

Transfer Assessment

11/17/15 13:57

Transfer Assessment

Start: 11/13/15 21:20

Freq:

Status: Active

Document AS (Rec: 11/17/15 14:00 AS BHINT1PC05)

Transfer Assessment

Transfer Assessment

Date of Assessment	11/17/15
Transferred From	SAMC
Mode of Arrival	Ambulance
Source of Information	Patient Clinical Record

Symptoms That Require Psy Adm

Unable to Care for Self	Yes
Risk of Self-Harm and/or Harm to Others	Yes

Query Text: Risk of Self-Harm and/or Harm to Others Due to Dementia, Psychosis, Confusion, Poor Insight or Poor Judgment
Provide details regarding any boxes checked above

PER PETITION: IN AN INTERVIEW IN HIS ROOM AT ST. ALEXIUS MEDICAL CENTER, OT CONTINUES TO BE SEVERLY CONFUSED AND AGGITATED. HE IS DELUSIONAL. KEEPS TALKING WITH NO ONE IN ROOM. HE NEEDS INPATIENT PSYCH ADMIT, HE IS UNABEL TO CARE FOR HIMSELF.

List of patient's current medication

SEE ATTACHED MED LIST

Mental Status

Exam

Grooming	Gown
Hygiene	Gown
Facial Expression	Stares
Motor Activity	Restless
Attention / Concentration	Poor
Alertness	Unremarkable
Orientation	Disoriented to Person
Speech Rate	Stressed
Speech Rhythm	Garbled
Speech Volume	Soft
Affect	Unable to Assess
Mood	Unable to Assess
Thought Process	Confused Digressive Flight of Ideas Rambling
Thought Content	Delusional
Perceptual Disturbance	None
Judgment	Poor

Fac: AB Behavioral Health Hospital
68 M

Loc:3 East
Med Rec Num

Bed:3239-2
Visit:H08002900234

Insight	Poor
Intellectual Functioning	Average
Sleep	UNKNOWN AT TIME OF ADMISSION
Appetite	UNKNOWN AT TIME OF ADMISSION
Mental Status Exam Cont'd	
Rapport with Clinician	Unable to Assess
Motivation for Treatment	Unable to Assess
Diagnostic Impressions	
Provisional Diagnostic Impression	
AXIS I	F23 - BRIEF PSYCHOTIC DISORDER
AXIS II	DEFERRED
AXIS III	OBESITY, KIDNEY DISEASE, COPD, GERD, DIABETES MELLITUS, HYPERTENSION
AXIS IV	Primary Support Group Social Environment
AXIS V Current	25
Case Disposition	
Case Disposition	
Level of Care Recommended	Inpatient
Patient Accept/Decline	Accepted
Service Type-Primary	Geriatric
Accepting MD	KHAN,AQEEL A
Admitting MD	KHAN,AQEEL A
Inpatient Service Selected by Physician	GERO
Inpatient Bed #	3239-2

User Key

Monogram	Mnemonic	Name	Provider Type
AS	ASMIT194	Smith,Ashley	Access Staff

AB Behavioral Health Hospital

1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR# [REDACTED]
ROOM#: 3239-2 Sex: M
LOC: H 3E
DOB: [REDACTED] age: 68
Initialization Date: 11/25/15 1631

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/17/15

Signed

Date: 11/25/15

The patient is discharged today, temporarily to home for a couple of days before he goes to subacute skilled rehab. The patient promised today that he will comply with the agreement. He was also praising the staff for having dealt with his very difficult episodes, tantrums because of his severe frustration. He has no physical complaints at this time. He is looking forward to being with family. He will continue to comply with the medication. I completed the medical reconciliation with prescription orders of the Zyprexa 2.5 mg three times a day, Nuedexta 1 capsule twice a day, Lamictal 300 mg twice a day. No evidence of delirium. Denies suicidal or homicidal ideation. He is calm, pleasant and cooperative.

Final diagnosis: Major depression, recurrent, severe without psychosis; vascular dementia with psychosis and behavioral disturbance; pseudobulbar affect secondary to underlying neurologic conditions of the vascular dementia.

1125-079

Dictated By: RENATO DE LOS SANTOS MD 11/27/15 1532

<Electronically signed by RENATO DE LOS SANTOS MD> 11/27/15 1532

DD: 11/25/15 1507 DT: 11/25/15 1631
DELRE1/KNP 1125-0147

AB Behavioral Health Hospital

1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR# [REDACTED]
ROOM#: 3239-2 Sex: M
LOC: H.3E
DOB [REDACTED] Age: 68
Initialization Date: 11/25/15 1713

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/17/15

Signed

Date: 11/25/15

Subjective: He looks and feels a lot better. Very cooperative. Tolerating medications. He has not asked for pain medications for a number of days. He's been off Dilaudid for a while and prn OxyContin also is never used. Blood sugars are stable on sliding scale. His bydureon has been on hold. No respiratory issues either. On examination, resting comfortably.

Vital signs: Temperature 98.0, blood pressure 148/86, O2 sat 96 percent on room air.

HEENT: Tongue is moist.

Heart: S1, S2 are well heard.

Lungs: Clear bilaterally with minimal wheeze, no rales.

Abdomen: Soft and nontender.

Extremities: Again, chronic changes that appear to be improving.

IMPRESSION/SUMMARY/TREATMENT PLAN:

Diagnosis:

1. Mood disorder, with behavioral issues, improved.
2. Chronic opiate use that also seems to have resolved.
3. Diabetes, stable on sliding scale.
4. Chronic stasis dermatitis, appears to be improving.
5. History of recent pneumonia that is resolved.
6. Hypothyroid, on replacement.
7. Sleep apnea, stable on CPAP.

Plan:

1. I have reviewed his medications.
2. Patient is apparently going to go and spend a couple of days with the family and will move into a nursing home on Friday.
3. I gave him scripts for a week.

Report #: 1125-0156 PROGRESS NOTE

Additional copy

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Page: 1
Dept: MR

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]
Unit/MR#: [REDACTED] A#: [REDACTED]

- 4. He will follow with his regular providers once he gets into the nursing home.
- 5. Psych recommendations per Dr. De Los Santos.

1125-096

Dictated By: SAFDER MOHSIN MD 11/29/15 2230

<Electronically signed by SAFDER MOHSIN MD> 11/29/15 2230

DD: 11/25/15 1611 DT: 11/25/15 1713
MOHSA/MP 1125-0156

AB Behavioral Health Hospital
1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR# [REDACTED]
ROOM#: 3239-2 Sex: M
LOC: H.3E
DOB: [REDACTED] Age: 68
Initialization Date: 11/24/15 1647

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/17/15

Signed

Date: 11/24/15

I had a phone conference with the ex-wife, case manager, patient, and myself. Patient is agreeing to go home. The ex-wife agreed to spend two days for Thanksgiving with the family and then go to subacute skilled rehab. Patient requires assistance with activities of daily living and they will hire a caregiver and patient has mood disorder, chronic pain, off opioids, doing well, diabetes, off medication and only on sliding scale, chronic stasis dermatitis, peripheral vascular disease, history of recent pneumonia with no further respiratory symptoms, and patient is physically better, mood wise better, calmer, less agitated, cooperative, coherent, not confused, and blood sugar ranged from 103 to 118, and doing very well with the Nuedexta one capsule q day, which I will be increasing to one capsule twice a day starting tomorrow and anticipating discharge temporarily to home and then to subacute skilled rehab, and continuing the Lamictal 300 mg twice a day and the Zyprexa 2.5 mg three times a day. No evidence of EPS or tardive dyskinesia. We'll finalize the discharge order tomorrow morning when we have everything in place.

1124-093

Dictated By: RENATO DE LOS SANTOS MD 11/27/15 1531

<Electronically signed by RENATO DE LOS SANTOS MD> 11/27/15 1531

DD: 11/24/15 1418 DT: 11/24/15 1647
DELRE1/MP 1124-0163

AB Behavioral Health Hospital

1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR#: [REDACTED]
ROOM#: 3239-2 Sex: M
LOC: H.3E
DOB: [REDACTED] Age: 68
Initialization Date: 11/24/15 1356

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/17/15

Signed

Date: 11/24/15

Subjective: Mood-wise he is better. He still argues, but not as much as before. Pain-wise he is remarkably stabilized. He is off Dilaudid. Not using oxycodone either. No reported pain. No distress noted by the staff during care. No further fever or other lung issues. His COPD is stable; Intake is moderate.

Vital signs: Temperature 96.5. Blood pressure 127/75. O2 sat 96% on room air.

Accu-Cheks: 103, 108, 135.

HEENT: Tongue is moist.

Heart: S1, S2 is well heard.

Lungs: Bilateral minimal wheeze. No rales.

Abdomen: Soft and nontender.

Extremities: Chronic stasis changes.

IMPRESSION/SUMMARY/TREATMENT PLAN:

Diagnosis:

1. Mood disorder with behavioral issues, improved.
2. Chronic pain, off opiates and doing well.
3. Diabetes, off Bydureon and doing well on sliding scale.
4. Chronic stasis dermatitis, peripheral vascular disease.
5. History of recent pneumonia with no further respiratory symptoms.
6. Hypothyroid on replacement.
7. Thoracic aneurysm, no further workup or investigations per patient's request and family.
8. Sleep apnea on CPAP.

Plan:

1. I have reviewed his meds, progress.
2. I have encouraged him to participate in activities.
3. Patient is stable from medical standpoint for discharge to nursing home.

Report #: 1124-0114 PROGRESS NOTE
Additional copy
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Page: 1
Dept: MR

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]

Unit/MR# [REDACTED] #: [REDACTED]

1124-087

Dictated By: SAFDER MOHSIN MD 11/29/15 2230

<Electronically signed by SAFDER MOHSIN MD> 11/29/15 2230

DD: 11/24/15 1330 DT: 11/24/15 1355
MOHSA/LH 1124-0114

Report #: 1124-0114 PROGRESS NOTE
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Page: 2
Dept: MR

AB Behavioral Health Hospital

1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR#: [REDACTED]
ROOM#: 3239-2 Sex: M
LOC: H.3E
DC [REDACTED] Age: 68
Initialization Date: 11/24/15 0659

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/17/15

Signed

Date: 11/23/15

The Legacy liaison did evaluate the patient today and the patient was belligerent and they are not going to accept him at this time. Patient is very labile. Patient is easily agitated and then escalates to be very angry. He has difficulty with his frustration. He wants to go home. He believes that he can spend Thanksgiving with his ex-wife and his children but case manager has talked to the ex-wife who is not able to take care of him and nobody can take care of him at home. He needs a structured, supervised, therapeutic environment. He has very labile mood and we just started him on the Nuedexta which we will have to maximize for the affective instability. We did the testing. Assessment: He does have a diagnosis of dementia. We have been successful in taking him off the Nardil and he does not show any vegetative symptoms of depression. He is on Lamictal, significantly high dose 300 mg twice a day, and we have as a backup the Zyprexa which has been given to him that he is able to tolerate. I am going to keep the backup Zyprexa 5 mg q.6h p.r.n. and then start him on scheduled Zyprexa 2.5 mg three times a day and use stat doses of Ativan if necessary. He does fluctuate in terms of his alertness and his awareness. He is not aphasic but he is forgetful and he is perseverative in his request to leave and be with family and then will beg to spend Thanksgiving there. I did talk to the case manager so that hopefully the ex-wife can keep reminding him that he needs to be transitioned to subacute rehab, that his expectation to spend time with the family for Thanksgiving is not going to happen.

His vital signs: Blood pressure 153/87, pulse rate of 59 to 63, afebrile. No respiratory distress. Intake very erratic. He can eat 75 to 100% and then he can refuse his meals as well when he gets agitated. Today he had breakfast, no lunch, and will encourage pushing oral fluids. No evidence of delirium at this time. Estimated length of stay 5 to 7 days.

1123-216

Dictated By: RENATO DE LOS SANTOS MD 11/27/15 1530

<Electronically signed by RENATO DE LOS SANTOS MD> 11/27/15 1530

Report #: 1124-0029 PROGRESS NOTE
Additional copy
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Page: 1
Dept: MR

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]

Unit/MR#: [REDACTED] A#: [REDACTED]

DD: 11/23/15 1835 DT: 11/24/15 0651

DELRE1/BAB 1124-0029

Report #: 1124-0029 PROGRESS NOTE
Additional copy
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Page: 2
Dept. MR

AB Behavioral Health Hospital
1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR# [REDACTED]
ROOM#: 3239-2 Sex: M
LOC: H.3E
DOE [REDACTED] Age: 68
Initialization Date: 11/23/15 0441

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/17/15

Signed

Date: 11/22/15

Subjective: He was seen this morning. His mood is much better. Pain wise he is remarkably stable and has not complained of any pain. He has been practically off the Dilaudid and also not using the Norco. No major breathing issues. Intake is moderate. On examination, alert, sitting comfortably.

Vital signs: Temperature 98.5. Blood pressure 150/84. Heart rate is in the 70s. O2 sat 95% on room air.

HEENT: Tongue is moist.

Heart: S1, S2 is well heard.

Lungs: Bilateral minimal wheeze. No rales.

Abdomen: Obese, non-tender.

Extremities: Severe chronic changes. No new lesions.

IMPRESSION/SUMMARY/TREATMENT PLAN:

Diagnosis:

1. Mood disorder with behavioral changes, have remarkably improved.
2. Chronic pain. Used to be on heavy doses of opiates. Currently he is off and still doing well.
3. History of recent back surgery.
4. History of COPD, sleep apnea, advanced, uses oxygen as needed.
5. History of hypertension mostly stable.
6. Diabetes, currently on sliding scale. His long-acting Bydureon has been held secondary to low sugar reactions.

Plan:

1. I have reviewed his meds, progress, labs.
2. He is stable from medical standpoint to be discharged to the nursing home.
3. Wife who is the POA wants conservative care and she fully understands that given his multiple comorbidity his overall prognosis is poor.

Report #: 1123-0005 PROGRESS NOTE
Additional copy
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Page: 1
Dept: MR

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]
Unit/MR #: [REDACTED] A#: [REDACTED]

1122-076

Dictated By: SAFDER MOHSIN MD 11/29/15 2230

<Electronically signed by SAFDER MOHSIN MD> 11/29/15 2230

DD: 11/22/15 2247 DT: 11/23/15 0436
MOHSA/MT 1123-0005

AB Behavioral Health Hospital
 1650 MOON LAKE BLVD
 HOFFMAN, ESTATES IL 60169

UNIT/MR# [REDACTED]
 ROOM#: 3239-2 Sex: M
 LOC: H.3E
 DOB: [REDACTED] Age: 68

PATIENT: [REDACTED]
 ACCT#: [REDACTED]
 ATT PHY: AQEEL A KHAN, MD
 ADMIT/SERVICE DATE: 11/17/15

Signed

PSYCHIATRY Progress Note

INTERVAL HISTORY: Record reviewed and patient discussed with staff. Staff reports that patient's behavior is generally appropriate. Occasional irritability. No physical aggression. Patient reports feeling "alright." Sleep is good and appetite fluctuates.

No med AEs.

Temp	Pulse	Resp	BP	Pulse Ox
97.6 F	63	18	155/73	97
11/21/15 16:41	11/21/15 16:41	11/21/15 16:41	11/21/15 16:41	11/21/15 16:41

24 Hour Range

Period	Temp	Pulse	Resp	BP Sys/Dias	Pulse Ox
Last 24 Hr	97.6 F-97.6 F	63-74	18-18	122-155/69-73	97-98

I&O/Weight Detailed - 3 days

	11/20/15 07:59	11/21/15 07:59
Intake:		
Milk	120	360
Juice	240	480
Other:		
Intake, Oral Amount	240	120
% Breakfast Eaten	0%	50%
Breakfast Comment	[Pt. refused to eat breakfast.]	
% Lunch Eaten	0%	0%
Lunch Comment	[Pt. refused to eat lunch.]	pt refused
% Dinner Eaten	0%	25%
Dinner Comment	pt refused	Yogurt
Total, Intake Amount	240	120

Report #: 1121-0189 Psychiatry Progress Note
 Additional copy
 CC:

Page: 1
 Dept: MR

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]

Unit/MR#: [REDACTED]

Voiding Method	Diaper	Toilet
Urine Color		Yellow
# of Times Urinated	2	2
Number of Bowel Movements	1	1
Stool Color	Brown	Brown
Stool Appearance	Soft	Soft
Stool Size	Large	Moderate
Comment		pt used the toilet to passed bowel

Active medications

- Acetaminophen (Tylenol) 650 mg PO Q8HPRN PRN
PRN Reason: PAIN, MILD
Stop: 01/16/16 19:28
- Albuterol/Ipratropium (Duoneb 3ml Nebule) 3 ml NEB Q6HPRN PRN
PRN Reason: SHORTNESS OF BREATH/ WHEEZING
Stop: 01/16/16 17:35
- Aspirin (Aspirin) 325 mg PO QAM SCH
Stop: 01/17/16 08:59
Last Admin: 11/21/15 08:13 Dose: 325 mg
- Bacitracin (Bacitracin Oint) 0 appl TOP DAILY SCH
Stop: 01/17/16 08:59
Last Admin: 11/21/15 08:14 Dose: 1 appl
- Calcium Carbonate (Tums Chew Tab) 500 mg PO Q4HPRN PRN
PRN Reason: HEARTBURN
Stop: 01/16/16 16:52
- Cefuroxime Axetil (Ceftin) 500 mg PO Q12H9 SCH
Stop: 11/25/15 09:01
Last Admin: 11/21/15 20:08 Dose: 500 mg
- Cholecalciferol (Vitamin D) 2,000 unit PO QAM SCH
Stop: 01/17/16 08:59
Last Admin: 11/21/15 08:16 Dose: 2,000 unit
- Dextromethorphan/Quinidine (Nuedexta) 1 each PO QPM SCH
Stop: 01/19/16 17:59
Last Admin: 11/21/15 17:20 Dose: 1 each
- Doxycycline Hyclate (Vibramycin) 100 mg PO Q12H9 SCH
Stop: 11/25/15 09:01
Last Admin: 11/21/15 20:08 Dose: 100 mg
- Enoxaparin Sodium (Lovenox) 40 mg SUB-Q QHS SCH
Stop: 01/17/16 08:59
Last Admin: 11/21/15 20:08 Dose: 40 mg
- Folic Acid (Folic Acid) 1 mg PO QAM SCH
Stop: 01/17/16 08:59
Last Admin: 11/21/15 08:15 Dose: 1 mg
- Glucagon (Glucagon) 1 mg IM PRN PRN
PRN Reason: HYPOGLYCEMIA
Stop: 01/16/16 17:43
- Glucose (Glucose-15 Tube) 0 gm PO PRN PRN
PRN Reason: HYPOGLYCEMIA
Stop: 01/16/16 17:40

Report #: 1121-0189 Psychiatry Progress Note
Additional copy
CC:

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]
Unit/MR#: [REDACTED] A#: [REDACTED]

Glycerin (Glycerin Supp) 1 supp RECT QDAYPRN PRN
PRN Reason: CONSTIPATION
Stop: 01/16/16 16:52
Insulin Aspart (Novolog Sliding Scale) 0 unit SUB-Q AC SCH
Stop: 01/17/16 07:29
Last Admin: 11/21/15 17:20 Dose: Not Given
Lactulose (Chronulac) 20 gm PO TID SCH
Stop: 01/16/16 17:59
Last Admin: 11/21/15 17:24 Dose: 20 gm
Lamotrigine (Lamictal) 300 mg PO BID SCH
Stop: 01/16/16 17:59
Last Admin: 11/21/15 17:20 Dose: 300 mg
Levothyroxine Sodium (Synthroid) 100 mcg PO DAILY@0600 SCH
Stop: 01/17/16 05:59
Last Admin: 11/21/15 05:56 Dose: 100 mcg
Loratadine (Claritin) 10 mg PO QAM SCH
Stop: 01/17/16 08:59
Last Admin: 11/21/15 08:15 Dose: 10 mg
Olanzapine (Zyprexa) 5 mg IM Q6HPRN PRN
PRN Reason: AGITATION
Stop: 01/16/16 17:50
Last Admin: 11/18/15 19:15 Dose: 5 mg
Oxycodone HCl (Oxycontin XI) 10 mg PO Q12HPRN PRN
PRN Reason: PAIN, MODERATE
Stop: 12/17/15 17:50
Last Admin: 11/21/15 01:48 Dose: 10 mg
Pantoprazole Sodium (Protonix) 40 mg PO QDAY@0630 SCH
Stop: 01/17/16 06:29
Last Admin: 11/21/15 05:56 Dose: 40 mg
Polyethylene Glycol (Miralax) 17 gm PO QAM SCH
Stop: 01/17/16 08:59
Last Admin: 11/21/15 08:16 Dose: 17 gm
Potassium Chloride (K-Dur) 40 meq PO BID SCH
Stop: 01/16/16 17:59
Last Admin: 11/21/15 17:20 Dose: 40 meq
Pregabalin (Lyrica) 25 mg PO BID SCH
Stop: 12/17/15 17:59
Last Admin: 11/21/15 17:20 Dose: 25 mg
Saccharomyces Boulardii (Florastor) 250 mg PO BID SCH
Stop: 01/16/16 17:59
Last Admin: 11/21/15 17:20 Dose: 250 mg
Fluticasone/Salmeterol (Advair 250mcg/50mcg Diskus) 0 inh IH Q12H9 SCH
Stop: 01/16/16 20:59
Last Admin: 11/21/15 20:09 Dose: 1 inh
Simethicone (Mylicon) 80 mg PO Q4H PRN
PRN Reason: Gas pains
Stop: 01/16/16 16:52
Torsemide (Demadex) 40 mg PO BID SCH
Stop: 01/16/16 17:59
Last Admin: 11/21/15 17:20 Dose: 40 mg

Report #: 1121-0189 Psychiatry Progress Note
Additional copy
CC:

Page: 3
Dept: MR

AB Behavioral Health Hospital

Name: [REDACTED] DOB: [REDACTED]

Unit/MR#: [REDACTED] A#: [REDACTED]

MENTAL STATUS EXAM: The patient appeared stated age. Patient was calm and cooperative with exam. Fair eye contact. Speech was non-spontaneous and soft. Patient described mood as being alright. Affect was constricted. No thoughts of wanting to harm self/others. Patient was not hallucinating. No overt delusions. Thought process was confused. Patient was alert and oriented x 3. Memory, attention and concentration, insight, and judgment is fair.

DIAGNOSIS

- (1) Minor/Major Neurocognitive disorder, due to multiple etiologies, with behavioral disturbance
- (2) Depression

PLAN

Continue and adjust psychotropic medications as tolerated and indicated. Monitor for safety and compliance. Medical management per internist.

ELOS: 5-7 days.

Electronically Entered By: ZAFEER H BERKI MD 11/22/15 1916

<Electronically signed by ZAFEER H BERKI MD> 11/22/15 1916

BERZA/ 1121-0189

AB Behavioral Health Hospital
1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR#: [REDACTED]
ROOM#: 3239-2 Sex: M
LOC: H 3E
DOB: [REDACTED] Age: 68
Initialization Date: 11/20/15 1641

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/17/15

Signed

Date: 11/20/15

Blood sugar 147. Patient did not present with any acute pain. No physical complaints. Patient had an outburst of crying, saying that he wants to go home. Patient has been maintained on the Lamictal 300 mg twice a day, and then the backup Zyprexa. Patient is diagnosed with history of major depression, according to the wife. He was never diagnosed to have any bipolar disorder. Patient was talking about his son, who has Asperger's, who has studied successfully to get two masters, and then has had this outburst of crying. Patient is more alert, more aware. Less lethargic and perseverating on wanting to go home and be with the family for the weekend. I talked to the case manager, who reported the wife does not want him home; that he needs to be transitioned to subacute skilled rehab, which is what we are going to do at this time. He does have a comorbid diagnosis of Vascular Dementia. Patient has been off the Nardil. We'll determine the prescription of the Zyprexa on a scheduled basis for mood stabilization or lability of mood, if we have to prescribe that medication. Try the patient on the Nuedexta for the emotional lability secondary to the underlying neurologic condition, which is the vascular dementia. Anticipating discharge next week.

1120-155

Dictated By: RENATO DE LOS SANTOS MD 11/27/15 1530

<Electronically signed by RENATO DE LOS SANTOS MD> 11/27/15 1530

DD: 11/20/15 1645 DT: 11/20/15 1633
DELRE1/HBH 1120-0221

Report #: 1120-0221 PROGRESS NOTE
Additional copy
CC:

Page: 1
Dept: MR

AB Behavioral Health Hospital

1650 MOON LAKE BLVD
HOFFMAN, ESTATES IL 60169

UNIT/MR# [REDACTED]
ROOM#: 3239-2 Sex: M
LOC: H.3E
DOB: [REDACTED] Age: 68
Initialization Date: 11/19/15 1903

PATIENT: [REDACTED]
ACCT#: [REDACTED]
ATT PHY: AQEEL A KHAN, MD
ADMIT/SERVICE DATE: 11/17/15

Signed

Date: 11/19/15

The patient was given a stat dose of medication later yesterday because he started to become agitated and restless. He became very irrational, loud, hostile. The patient did not present with any delirium post medical examination. The patient has advanced COPD and chronic kidney disease, severe chronic leg edema, hypergonadism, neuropathy, thoracic aneurysm.

Vital signs: Blood pressure within normal limits, afebrile. No respiratory distress. The patient has very poor appetite today and refused breakfast and lunch. The blood sugar was 162. The patient is on backup olanzapine 5 mg p.o. IM every 6 hours p.r.n. and Lamictal 300 mg twice a day. I did not see any evidence of vegetative symptoms of depression post discontinuation of the nardil. The patient's Lamictal will be maintained and I will evaluate the appropriateness of translating the p.r.n. Zyprexa as an antimanic medication because he appears loud and hyperverbal, then has racing thoughts and then become very illogical and agitated. I will also monitor with Dr. Mohsin the medical status. We have not given any stat doses of the Zyprexa at this time. One other option that we may have as a mood stabilizer given that he has had more depressive episodes in the past would be Abilify as well. The estimated length of stay is five to seven days. There is no evidence of delirium at this time.

1119-172

Dictated By: RENATO DE LOS SANTOS MD 11/27/15 1529

<Electronically signed by RENATO DE LOS SANTOS MD> 11/27/15 1529

DD: 11/19/15 1557 DT: 11/19/15 1903
DELRE1/KNP 1119-0219

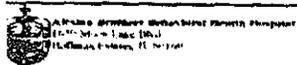
Report #: 1119-0219 PROGRESS NOTE
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Page: 1
Dept: MR

**ALEXIAN BROTHERS BEHAVIORAL HEALTH HOSPITAL
INPATIENT INTEGRATED PROBLEM SUMMARY AND MASTER TREATMENT PLAN OF CARE**

Note: Upon Discharge, all problems/interventions are considered closed.

Problems Identified from Assessment Review (Include Patient/Caretaker's words/ideas about problem areas)		Date Initiated	Action Code	Reason Code	Staff Initiating Plan	Date	
ACTION CODE	REASON CODE					C = Continued R = Revised A = Achieved	
<p>A. Active - Use in current Treatment Plan B. Monitor - Initiate plan if condition changes C. Refer - Include recommendations in Continued Care Plan D. Defer - Problem is stable or non-priority</p>	<p>1. Priority treatment focus - address now 2. Condition currently stable 3. Patient unready to pursue or declines services 4. Other problems currently more pressing</p>						
<p>Problem #1: <u>DM</u> Symptoms: <u>increased blood glucose</u> Long Term Goal: <u>The patient will maintain optimal health</u> Specific Short Term Goals/Objectives: (See Individualized Intervention List for Objective-Specific Interventions) 1. <u>provide medical management of diabetes</u> 2. <u>educate pt on diabetic care</u></p>		11/17/15	A	1	ZH		P-11/24 A-11/25
<p>Problem #2: <u>Fall risk</u> Symptoms: <u>Unsteady gait</u> Long Term Goal: <u>pt will maintain or improve functional level</u> Specific Short Term Goals/Objectives: (See Individualized Intervention List for Objective-Specific Interventions) 1. <u>clear hallway of spills and clutter</u> 2. <u>initiate medication review for potential interactions</u></p>		11/17/15	A	1	ZH		P-11/24 A-11/25
<p>Problem #3: <u>Pain - alteration in comfort</u> Symptoms: <u>pt c/o pain to low back</u> Long Term Goal: <u>The patient will engage in regular daily activities</u> Specific Short Term Goals/Objectives: (See Individualized Intervention List for Objective-Specific Interventions) 1. <u>provide medical management for pain</u> 2. <u>assess patient's pain and administer medications</u></p>		11/17/15	A	1	ZH		Cilia A-11/25



Inpatient Integrated Problem Summary/Master Treatment Plan Of Care

Form # 6010-081 2/15

Chart copy - Patient copy



TX

MRN: [REDACTED] GEN
 ACC: [REDACTED]
 11/17/15
 M. KURN, AQEEL A., MD

ACEELIAN BROTHERS BEHAVIORAL HEALTH HOSPITAL
INPATIENT INTEGRATED PROBLEM SUMMARY AND MASTER TREATMENT PLAN OF CARE

Note: Upon Discharge, all problems/interventions are considered closed.

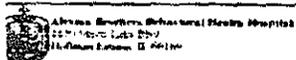
Problems Identified from Assessment Review (Include Patient/Caretaker's words/ideas about problem areas)		Date Initiated	Action Code	Reason Code	Staff Initiating Plan	Date	
ACTION CODE	REASON CODE					C = Continued R = Revised A = Achieved	
<p>A. Active - Use in current Treatment Plan B. Monitor - Initiate plan if condition changes C. Refer - Include recommendations in Continued Care Plan D. Defer - Problem is stable or non-priority</p>	<p>1. Priority treatment focus - address now 2. Condition currently stable 3. Patient unready to pursue or declines services 4. Other problems currently more pressing</p>						
<p>Problem #4: <u>Cardiac function impaired (CHF)</u> Symptoms: <u>low extremities edema</u> Long Term Goal: <u>The pt will maintain optimal cardiac functioning</u> Specific Short Term Goals/Objectives: (See Individualized Intervention List for Objective-Specific Interventions) 1. <u>provide medical management and assessment</u> 2. <u>pt will monitor signs/symptoms of ↓ cardiac output</u></p>		11/17/15	D	2	Z	C-11/24 A-11/25	
<p>Problem #5: <u>COPD PNEUMONIA COPD</u> Symptoms: <u>low O₂ saturation; pt on 2L O₂</u> Long Term Goal: <u>Maintain effective breathing and gas exchange</u> Specific Short Term Goals/Objectives: (See Individualized Intervention List for Objective-Specific Interventions) 1. <u>provide medical management and educate patient</u> 2. <u>educate pt on symptoms: SOB, pain, wheezing</u></p>		11/17/15	D	2	Z	C-11/24 A-11/25	
<p>Problem #6: <u>Pneumonia</u> Symptoms: <u>low O₂ saturation, shortness of breath</u> Long Term Goal: <u>Maintain effective breathing and gas exchange without respiratory infection</u> Specific Short Term Goals/Objectives: (See Individualized Intervention List for Objective-Specific Interventions) 1. <u>pt will have minimal to no episodes of respiratory difficulty within 7-10 days</u></p>		11/17/15	A	1	B	C-11/24 A-11/25	

MRSA [REDACTED]
 MACT [REDACTED] 11/17/15
 KHAN, ACEEL A., MD
 11/17/15

**ALEXIAN BROTHERS BEHAVIORAL HEALTH HOSPITAL
INPATIENT INTEGRATED PROBLEM SUMMARY AND MASTER TREATMENT PLAN OF CARE**

Note: Upon Discharge, all problems/interventions are considered closed.

Problems Identified from Assessment Review (Include Patient/Caretaker's words/ideas about problem areas)		Date Initiated	Action Code	Reason Code	Staff Initiating Plan	Date	
ACTION CODE	REASON CODE					C = Continued	R = Revised
<p>Problem #1: <u>Altered skin integrity</u> Symptoms: <u>abrasions to the leg</u> Long Term Goal: <u>to promote optimal wound healing + restore skin integrity</u> Specific Short Term Goals/Objectives: (See Individualized Intervention List for Objective-Specific Interventions) 1. <u>The patient will verbalize understanding of the condition</u> 2. <u>patient will verbalize desire to abstain from smoking</u></p>							C-11/04 A-11/25
<p>Problem #2: <u>dementia with behavioral disruption</u> Symptoms: <u>labile, argumentative, demanding, hallucinations</u> Long Term Goal: <u>to assist transition to a less acute care setting</u> Specific Short Term Goals/Objectives: (See Individualized Intervention List for Objective-Specific Interventions) 1. <u>no response</u> 2. <u>to respond to redirection/reassurance</u></p>		11/9/15	A	1			C-11/04 A-11/25 not aware of condition difficult to redirect
<p>Problem #3: _____ Symptoms: _____ Long Term Goal: _____ Specific Short Term Goals/Objectives: (See Individualized Intervention List for Objective-Specific Interventions) 1. _____ 2. _____</p>							



Inpatient Integrated Problem Summary/Master Treatment Plan Of Care

Form # 6010-081 2/15

Chart copy - Patient copy



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[Redacted]
 [Redacted]
 JAN. ROEL A. MD
 [Redacted]

**ALCANTARA BROTHERS BEHAVIORAL HEALTH HOSPITAL
INPATIENT INTEGRATED PROBLEM SUMMARY AND MASTER TREATMENT PLAN OF CARE**

Note: Upon Discharge, all problems/interventions are considered closed.

EVIDENCE TO SUBSTANTIATE DIAGNOSIS:

To substantiate the treatment focus, the following data sources were consulted: Psychiatric Evaluation, History and Physical Exam, Nursing Assessment, Psychosocial Assessment, Laboratory findings (if applicable), and reports from sending facility/agency.

Primary Treatment Focus	Psychiatric Diagnoses: <u>MDD recurrent, Anxiety & psychosis, Vascular Dementia</u>
	Medical Diagnoses: <u>DM, Pneumonia, CHF</u>

TREATMENT TEAM MEMBERS:

The following represents specific staff responsible for ensuring compliance with the patient's individualized Plan of Care. Disciplines listed on specific Treatment Plan interventions refer to the assigned team member listed. NOTE: disciplines marked with an * are only identified if actively involved in the plan of care.

Discipline	Printed Name	Signature	Initials	Date	Time
Psychiatrist	<i>[Signature]</i>	<i>[Signature]</i>	KS	11/19/15	1:00
Case Manager	Neha Nehra	<i>[Signature]</i>	nn	11/19/15	08:00
CM Initiating Care Plan	<i>[Signature]</i>	<i>[Signature]</i>	DM	11/19/15	08:00
Nurse	Wendy L. Smith, RN	<i>[Signature]</i>	wn	11/18/15	02:30
Mental Health Counselor	MERLE SOLIS	<i>[Signature]</i>	MS	11/18/15	06:00
Expressive Therapist	Ryan Kohler	<i>[Signature]</i>	RA	11/10/15	09:45
*Therapist					
*Physical Therapist	Taylor Hawthorn, PT, DPT	<i>[Signature]</i>	TH	11/19/15	14:00
*Medical Physician / RNP					
*Dietitian					
*Chaplain					

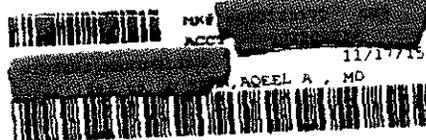
Alcantara Brothers Behavioral Health Hospital
1000 West Lake Park
Tomball, TX 77375

atient Integrated Problem Summary/Master Treatment
n Of Care

n # 6010-081 2/15
rt copy - Patient copy



TX



From:

1124293

Printed Patient Name: [REDACTED] Date Information Needed: 11/11/15 to 11/23/15
 Date of Birth: [REDACTED]
 City: [REDACTED] State: [REDACTED] Zip Code: [REDACTED]

I hereby authorize S.A.M.C. to release the protected health information indicated below on the above named individual to: (facility name)
Bensenville Police Dept. Det. Mike Larson
 Provider Name/Organization/Individual
345 E. Crown St.
 Full address of Provider/Organization/Individual
 City: Bensenville State: IL Zip Code: 60106 Fax #: (630) 350-0855
 Telephone #: (630) 594-1048
 For the following purpose: Physician or Health Care Facility Legal Purpose Personal Use At the request of the individual
 Other: Ongoing Criminal Investigation
 For treatment date(s) or service: Nov 1st to Nov 22, 2015
 Expiration Date or Expiration Event: 2015
 (If no prior notice of revocation is received, or expiration over/expiration date indicated, this authorization will expire 90 days from the date signed below.)

INFORMATION TO BE DISCLOSED:
 Abstract Chart (Includes Face Sheet, Discharge Summary, History & Physical, Coordination Reports, Operative Reports, Diagnostic tests)
 Entire medical record
 History and Physical Consultation Operative Report Discharge Summary
 Outpatient Services:
 Emergency Room Pathology Report(s) Laboratory Results Radiology Results Rehabilitation Services
 Other: _____

I understand that:
 • The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.
 • I have the right of access to inspect and obtain a copy of my protected health information.
 • I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the Health Information Management Department.
 • Revocation will not apply to information that has already been released in response to this authorization.
 • Once the above information is disclosed, there is the potential that it may be re-disclosed by the recipient, and therefore may not be protected by the federal privacy law regulations.
 • Failure to provide all required information will not constitute a proper authorization to disclose protected health information and that, therefore, my request may not be honored.
 • Authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment, payment or eligibility for benefits.

(Signature of patient or legal representative) [Signature] (Date) 12/30/15
 (If signed by a legal representative, indicate the relationship to patient or authority to act for patient.)
 Fees/charges will comply with all laws and regulations applicable to release protected health information.

FOR FACILITY USE: Date received: _____ Date completed: _____ MR #: _____
 When applicable, the identity of the Legal Representative was verified by the following documentation and established that in his/her capacity, the above named legal representative is authorized to act on behalf of the patient: Driver's License Picture ID Legal guardian Court appointed legal guardian
 Power of Attorney Executor of Estate Other: _____
 Person/Department completed the request: _____

Authorization to Disclose Protected Health Information

will pick up

2000/2000 D



RIR ORBY

Alcan Breast Medical Center
800 Blufffield Road
Six Creeks Village, IL 60007-2247
647-437-8300
Form # 763001 (0/0) Page 1 of 1
8F159981R YX MWZ:01 1102/02/21

73

Printed Patient Name: [REDACTED]		Date Information Needed: ASAP
[REDACTED]		Date of Birth: [REDACTED]
City: [REDACTED]	State: [REDACTED]	Zip Code: [REDACTED]
Telephone Number: [REDACTED]		

I hereby authorize Alexian Brothers Behavioral Health Hospital to release the protected health information indicated below on the above named individual to: (facility name)

Bensenville Police Department Attention Detective Michael Larson
 Provider Name/Organization/Individual

345 E Green Street
 Full address of Provider/Organization/Individual

City: Bensenville State: Illinois Zip Code: 60106 Fax # (890) 355-0855
 Telephone #: (630) 355-3455

For the following purpose: Physician or Health Care Facility Legal Purposes Personal Use At the request of the individual
 Other _____

For treatment date(s) or service November 1 through November 26, 2015

Expiration Date or Expiration Event: March 31, 2016
 (If no prior notice of revocation is received, or expiration event/expiration date indicated, this authorization will expire 90 days from the date signed below.)

- INFORMATION TO BE DISCLOSED: All categories below plus doctor's notes**
- Abstract Chart (includes Face Sheet, Discharge Summary, History & Physical, Consultation Reports, Operative Reports, diagnostic tests)
 - Entire medical record
 - History and Physical Consultation Operative Report Discharge Summary
 - Outpatient Services:**
 - Emergency Room Pathology Report(s) Laboratory Results Radiology Results Rehabilitation Services
 - Other: All other records without limitation including doctor's notes through February 1, 2016

I understand that:

- The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.
- I have the right of access to inspect and obtain a copy of my protected health information.
- I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the Health Information Management Department.
- Revocation will not apply to information that has already been released in response to this authorization.
- Once the above information is disclosed, there is the potential that it may be re-disclosed by the recipient, and therefore may not be protected by the federal privacy law regulations.
- Failure to provide all required information will not constitute a proper authorization to disclose protected health information and that, therefore, my request may not be honored.
- Authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment, payment or eligibility for benefits.

[REDACTED] 02/01/2015 _____
 (Signature of patient or legal representative) (Date) (Witness Signature) (Date)

(If signed by a legal representative, indicate the relationship to patient or authority to act for patient _____)
 Fees/charges will comply with all laws and regulations applicable to release protected health information.

FOR FACILITY USE: Date received: _____ Date completed: _____ MR #: _____

When applicable, the identity of the Legal Representative was verified by the following documentation and established that in his/her capacity, the above named legal representative is authorized to act on behalf of the patient: Driver's License Picture ID Legal guardian Court appointed legal guardian

Power of Attorney Executor of Estate Other: _____

Person/Department completing the request: _____

Authorization to Disclose Protected Health Information



Alexian Brothers Medical Center
 800 Biesterfeld Road
 Elk Grove Village, IL 60007-3397
 847-437-5500