Additional chronic and involutional findings as discussed.

Signed: Baskaran, Visveshwar MD
Report Verified Date/Time: 12/02/2017 12:46:41

Reading Location: SLH B1 C013V Neuro Reading Room
Electronically signed by: VISVESHWAR BASKARAN, M.D. on 12/02/2017 12:46 PM

ASSESSMENT/PLAN
93 y.o. with history of
Past Medical History:
Diagnosis Date

- Anxiety
- Depression
- Hip fracture (HCC)
- Hypertension
- Macular degeneration

presented with **Chief Complaint**
Patient presents with

- Fall
- Back Pain

93 y.o. F with dementia, HTN, anxiety, depression and h/o hip fx presents after being found down at NH.

Neuro -dementia-stable, fall precautions
Cardio -HTN-elevated, unknown home meds, prn hydralazine for now
Pulm -stable on RA
GI -reg diet
Heme -dvt ppx- hep sc
ID -abnormal UA- UTI POA- start rocephin and gentle fluids, f/u ucx
Renal -monitor crt and lytes
Psych -depression and anxiety- resume home meds once known
Ortho -new compression fx s/p fall- pain control, PT/OT
Dispo - SW consult for placement if pt does not want to return to current NH

Discussed this case with pt, RN

Notes since last seen reviewed.

Mahsa Abolfathian Massumi, MD
404-695-6151
12/2/2017

INDICATION: Head trauma, headache

TECHNIQUE: Axial noncontrast CT images through the head were obtained. This exam was performed according to our departmental dose optimization program which includes automated exposure control, adjustment of the mA and/or kV according to patient size and/or use of iterative reconstruction technique.

COMPARISON: CT head 5/23/2015

FINDINGS:
There is no focal scalp hematoma or calvarial fracture. No acute intra or extra-axial hemorrhage is seen.

A small left occipital lobe infarct is likely subacute to chronic. There are small chronic right parietal lobe and cerebellar infarcts. Other microvascular ischemic changes are similar and chronic appearing. There is no hydrocephalus, mass effect, or midline shift. Volume loss with temporal lobe predominance and vascular calcifications are noted. The visualized sinuses and mastoid air cells are well aerated. Cataract surgery changes and TMJ arthropathy are present.

IMPRESSION:

No acute intracranial hemorrhage or mass effect.

Progressed ischemic changes since 2015 without definitive acute features. Further characterization with MRI can be obtained as clinically warranted.

Additional chronic and involutional findings as discussed.

Signed: Baskaran, Visveshwar MD
Report Verified Date/Time: 12/02/2017 12:46:41

Reading Location: SLH B1 C013V Neuro Reading Room
Electronically signed by: VISVESHWAR BASKARAN, M.D. on 12/02/2017 12:46 PM

Meds:
Scheduled Meds:

• amiodarone	200 mg	Oral	Daily	200 mg at 12/04/17 0903
• aspirin	81 mg	Oral	Daily	81 mg at 12/04/17 0903
• cefTRIAXone	1 g	Intravenous	Q24H	1 g at 12/03/17 2023
• heparin	5,000 Units	Subcutaneous	Q12H	5,000 Units at 12/04/17 0903
• lisinopril	2.5 mg	Oral	Daily	2.5 mg at 12/04/17 0903

Inpatient consult to Social Work (Order 241779159)

Consult

Date: **12/3/2017**
Department: **BSLMC 24 Tower Nursing Service**
Ordering/Authorizing: **Massumi, Mahsa Abolfathian, MD**

Order Information

Order Date/Time	Release Date/Time	Start Date/Time	End Date/Time
12/03/17 10:52 AM	None	12/03/17 10:53 AM	12/03/17 10:53 AM

Order Details

Frequency	Duration	Priority	Order Class
Once	1 occurrence	Routine	Hospital Performed

Standing Order Information

Remaining Occurrences	Interval	Last Released
0/1	Once	12/3/2017

Released Orders

	Released On	Scheduled For	Released By
1.	12/3/2017 10:52 AM	12/3/2017 10:53 AM	Massumi, Mahsa Abolfathian, MD (auto-released)

Order Questions

Question	Answer	Comment
Post Acute Placement	**Skilled Nursing Facility Placement**	

Collection Information

Consult Order Info

ID	Description	Priority	Start Date	Start Time
241779159	Inpatient consult to Social Work	Routine	12/03/2017	10:53 AM

Provider Specialty	Referred to

Acknowledgement Info

For	At	Acknowledged By	Acknowledged On
Placing Order	12/03/17 1052	Ogwu, Nwaka U, RN	12/03/17 1645

Patient Information

Patient Name	Sex	DOB	SSN
Mintz, Muriel Weiner	Female	9/5/1924	xxx-xx-8113

Additional Information

Associated Reports
Priority and Order Details

Order Transmittal Information

Inpatient consult to Social Work (Order #241779159) on 12/3/17

VITAL
HEART & VEIN

MINTZ, MURIEL

92 Y old Female, DOB: 09/05/1924
Account Number: 170780
1022 NORTHWICK DR, PEARLAND, TX-77584
Home: 713-824-6890
Guarantor: MINTZ, MURIEL Insurance: MEDICARE BTX
TRAILBLAZER HLTH Payer ID: 00097k
External Visit ID: 1826505
Appointment Facility: Cardiovascular Assoc (PL)

05/10/2017

Progress Notes: Rasheed Zaid, MD

Current Medications

Taking
- Eliquis 2.5mg PO 1 tab BID
- acetaminophen-codeine 300 mg-30 mg tablet 1 tab(s) orally every 6 hours
- amiodarone 200mg PO 1 tab daily
- Metoprolol Tartrate 50mg PO 1 tab BID
- potassium chloride 20 mEq tablet, extended release 1 tab(s) orally Daily
- Lasix 40mg PO 1 tab daily
- lisinopril 5 mg tablet 1/2 tab(s) orally once a day
- Aspirin Enteric Coated 81mg PO 1 tab daily
- Medication List reviewed and reconciled with the patient

Past Medical History

HTN
Systolic CHF - EF 30-35%
Atrial flutter
Dementia
Macular degeneration

Surgical History

Cataract removal
Basic Cell Carcinoma

Family History

Father: deceased, Old age
Mother: deceased

Social History

Tobacco Use Status: Never Smoker.
no Chewing tobacco.
no Recreational drug use.
Exercise: none.
no Caffeine.
no Alcohol.

Allergies

Haldol
antidepressents
Benadryl

Hospitalization/Major Diagnostic Procedure

Reason for Appointment

1. Established Patient
2. Lexiscan (sameday) follow up

History of Present Illness

HPI:

Patient is a 92 year old woman with dementia, HTN, recently dx'd systolic CHF (EF 30-35%), and persistent Atrial fib/flutter who presents for follow up. Sent to the ED after last visit b/c previous labs from PCP showed severe hyponatremia and hyperkalemia. Labs in the ED however showed acceptable e-lytes. She otherise dx'd with an left ankle fracture and sent home with a boot.

Pt now presents for same day nuclear stress test and follow up to investigate her systolic HF. Patient denies chest pain, SOB, palpitations, dizziness, presyncope, or syncope. EKG today shows an rate controlled A. fib/flutter.

Labs in the MHPL ED last week showed: Na 129, K 4.4, BUN/Cr of 17/1.22, Mg 2.3, and normal CBC.

Lexiscan nuclear stress test today shows normalization of LV function and normal myocardial perfusion.

Echocardiogram:

Date: 4/20/2017. Conclusion: LV is normal in size with moderate to severe reduction in systolic function. Est. LVEF is 30-35%.
RV is normal in size with mild reduction in systolic function.
Both atria are dilated.
Moderate mitral regurgiation.
Est. RVSP is 39 mmHg.
Normal aortic root dimensions.
No pericardial effusion.

Vital Signs

Ht (in) 59, Wt (lb) 107, BMI 21.61, HR (/min) 85, Left BP 116/68.

Examination

General examination:

General appearance: NAD, well nourished and hydrated, normal build. HEENT: NC/AT, EOMI. Oral cavity: MMM. Neck: no JVD, no carotid bruit. Heart: irregular rhythm, normal S1S2, no murmurs, gallops, or rubs. Lungs: CTAB, no wheezes or crackles. Abdomen: soft, non-tender, non-distended, normal BS, no rebound or

Memorial Hermann Pearland - shortness of breath, A. flutter, Systolic CHF 4/2017

Review of Systems

ZAID ROS:

no Weight Gain. no Weight Loss.
no Fever. no Chills. no Night Sweats.
no Cough. no Chest Pain. no Chest Pressure.
no Shortness of Breath. no DOE. no PND.
no Orthopnea. no Palpitations.
no Abdominal Pain. no Nausea.
no Vomiting. no Diarrhea. no Constipation.
no Abdominal Distension. no BRBPR.
no Melena. no LE Edema/Swelling.
no Extremity Numbness. no Extremity Weakness. no Rash. no Hives. no Dizziness.
no Syncope. no Seizures. no Changes in Vision. no Changes in Hearing.
no Depression. no Fatigue.
no Hallucinations. no Polyuria. no Nocturia.
no Dysuria. no Hematuria. no Joint Pain.
no Varicose Veins. no Leg Cramps.
no Claudication. no Leg Fatigue.
no Headache. no Anxiety.

guarding. Skin warm, dry, no rashes appreciated. Peripheral pulses: 2+ DP/PT and radial pulses bilaterally. Extremities: no clubbing, no cyanosis, LLE in a boot. Genitalia: not examined. Rectal not performed. Neurologic exam: alert, oriented x 3, non focal.

Assessments

1. Acute systolic (congestive) heart failure - I50.21 (Primary), LV function has now normalized on Lexiscan stress testing. No ischemia detected. Initial low EF was likely tachy-induced related to A. fib/flutter. Compensated and euvolemic on exam. Stop scheduled lasix + K supplementation.
2. Essential (primary) hypertension - I10, BP controlled. Cont current meds.
3. Atypical atrial flutter - I48.4, Appears to have settled down into a rate controlled A. fib/flutter rhythm. Cont metoprolol + PO Amio + low dose Eliquis for anticoagulation.
4. Hypo-osmolality and hyponatremia - E87.1, Chronic. Na 128 on 4/24/17, then 119 on 4/28/17, then 129 on 5/3/17.
5. Hyperkalemia - E87.5, Resolved.

Treatment

1. Acute systolic (congestive) heart failure

Stop potassium chloride tablet, extended release, 20 mEq, 1 tab(s), orally, Daily
Stop Lasix PO, 40mg, 1 tab, daily

2. Essential (primary) hypertension

Continue Metoprolol Tartrate PO, 50mg, 1 tab, BID
Continue lisinopril tablet, 5 mg, 1/2 tab(s), orally, once a day
Continue Aspirin Enteric Coated PO, 81mg, 1 tab, daily

3. Atypical atrial flutter

Continue Eliquis PO, 2.5mg, 1 tab, BID
Continue amiodarone PO, 200mg, 1 tab, daily

Procedure Codes

G8427 LIST CUR MEDS W/DOSAGES DOC BY PROV
1036F TOBACCO NON-USER
G8783 BP SCR PRFRM RCMDD DEFIND SCR INTVL

Follow Up

3 Months (Reason: Follow up)

R Zaid MD

Electronically signed by Rasheed Zaid , MD on 08/15/2017 at 10:39 PM CDT

Sign off status: Completed

Cardiovascular Assoc (PL)
10907 Memorial Hermann Dr.
Pearland, TX 77584
Tel: 281-741-0280
Fax: 832-486-9953

Patient: MINTZ, MURIEL DOB: 09/05/1924 Progress Note: Rasheed Zaid, MD 05/10/2017

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Patient Name	MRN	DOB	Age
Mintz, Muriel Weiner	02225967	9/5/1924	93 y.o.

"Progress Notes by Hasan, Syed Ali Reza, MD at 12/4/2017 10:29 AM (Date of Service Note Date/Time)"

Author: Hasan, Syed Ali Reza, MD | Service: Internal Medicine | Author Type: Physician
Filed: 12/4/2017 10:40 AM | Note Type: Progress Notes | Status: Addendum
Editor: Hasan, Syed Ali Reza, MD (Physician)

MEDICAL CENTER ASSOCIATES OF HOUSTON, LLP
INTERNAL MEDICINE PROGRESS NOTE
713-790-8025

J.Daniel, R.Giveon, L.Kazim, C.Neason, M.Tran, R.Varughese
S.Hasan, F.Joudah, P.Kaldis, M.Massumi, A.Yoon

Muriel Weiner Mintz is a 93 y.o. female patient. Medical Record # 02225967.
Admit Date: 12/2/2017
Length of Stay: 1 days.

Subjective:
Afebrile
Some dysuria
Some lower back pain - mild
Had a BM day before yesterday
Otherwise rest of 10 pt ros negative

Brief run of rate controlled afib on tele, now in NSR (has history of chronic afib per PCP note in chart)

Objective:
Temp: [95.8 °F (35.4 °C)-96.8 °F (36 °C)] 95.8 °F (35.4 °C)
Heart Rate: [67-83] 83
Resp: [12-18] 18
BP: (126-186)/(59-99) 126/66

Intake/Output Summary (Last 24 hours) at 12/04/17 1029
Last data filed at 12/03/17 1930

	Gross per 24 hour
Intake	30 ml
Output	0 ml
Net	30 ml

Glucose Meter 24: No results for input(s): POCGLUC in the last 24 hours.

GEN: NAD, sitting in bed
HEENT: AT/NC, PERRLA, patent nares, mmm
Neck: supple, no JVD, no LAD, no carotid bruit
CV: RRR, +S1/S2, no m/r/g, dorsalis pedis pulses 2+ B/L
RESP: CTAB
ABD: soft, NT/ND, +BS, no CVAT
EXT: no e/c/c; TTP mid back
Skin: warm, no rash
Neuro: AAO x 1, CN II-XII intact, strength 5/5 in UE and LE B/L, sensory intact
Mood: appropriate, calm

Foley: none

COMPARISON STUDY: None available.

FINDINGS: Two views of the left hip demonstrate no evidence of fracture or malalignment. Mild to moderate osteoarthritic changes are seen.

Signed: Stanietzky, Nir MD
Report Verified Date/Time: 12/02/2017 13:56:26

Reading Location: SLH B1 C013Y CT Body Reading Room
Electronically signed by: NIR STANIETZKY, M.D. on 12/02/2017 01:56 PM

XR chest 2 views [241768609]
Order Status: Completed
Collected: 12/02/17 1355
Updated: 12/02/17 1410
Narrative:
FINAL REPORT

PATIENT ID: 02225967

History: Status post fall, back pain

Comparison: Chest radiographs of 8/21/2016

Findings: Opacity at the left lateral costophrenic sulcus, which may represent a small pleural effusion or focus of atelectasis or pneumonitis. Lungs otherwise clear. Cardiac shadow normal in size. Thoracic aorta tortuous and calcified. No pneumothorax.

Moderate chronic compression fracture in the midthoracic spine. There is a suspected new compression fracture at the T12 level although evaluation is limited by the patient's osteopenia. No fracture was seen at this level on the prior radiographs.

Impression:

1. Small left pleural effusion versus focus of airspace consolidation at the left lateral costophrenic sulcus.

2. New compression fracture at the approximate T12 level.

Signed: Wells, David MD
Report Verified Date/Time: 12/02/2017 13:57:51

Reading Location: SLH B1 C013X Ortho Consult Reading Room
Electronically signed by: DAVID C WELLS, MD on 12/02/2017 01:57 PM

CT brain without IV contrast [241768606]
Order Status: Completed
Collected: 12/02/17 1238
Updated: 12/02/17 1248
Narrative:
FINAL REPORT

PATIENT ID: 02225967

• lisinopril	2.5 mg	Oral	Daily	2.5 mg at 12/04/17 0903
• metoprolol	50 mg	Oral	BID	50 mg at 12/04/17 0903
• sodium chloride 0.9% (NS)	5 mL	Intravenous	Q8H	5 mL at 12/04/17 0402

Continuous Infusions:
PRN Meds:.
- acetaminophen
- bisacodyl
- docusate sodium
- hydrALAZINE
- HYDROcodone-acetaminophen
- ondansetron
  Or
- ondansetron
- senna
- sodium chloride 0.9% (NS)

Assessment/Plan:
93 y.o. with history of
Past Medical History:
Diagnosis Date
- Anxiety
- Depression
- Hip fracture (HCC)
- Hypertension
- Macular degeneration

presented with
Chief Complaint
Patient presents with
- Fall
- Back Pain

93 y.o. F with dementia, HTN, anxiety, depression and h/o hip fx presents after being found down at NH.

Neuro -h/o senile dementia-stable, fall precautions
Cardio -h/o hypertensive heart disease without heart failure, HTN resume home meds
H/o chronic afib - resume amiodarone, metoprolol, aspirin
Dc tele
Pulm -stable on RA
GI -reg diet
Heme -dvt ppx- hep sc
ID -abnormal UA- UTI POA- start rocephin (on 12/2) today is day 3, f/u ucx
Renal -h/o hyponatremia POA - fluid restrict- stable
monitor crt and lytes
Psych -depression and anxiety- stable, not on meds
Ortho -h/o compression fx, falls, here with new compression fx s/p fall- pain control, PT/OT
Dispo - SW consult for SNF, will plan on dc once snf arranged

Patient Name	MRN	DOB	Age
Mintz, Muriel Weiner	02225967	9/5/1924	93 y.o.

"Consults by Kerr, Page E at 12/4/2017 10:18 AM (Date of Service Note Date/Time)"

Author: Kerr, Page E | Service: (none) | Author Type: Registered Dietitian
Filed: 12/4/2017 10:29 AM | Note Type: Consults | Status: Signed
Editor: Kerr, Page E (Registered Dietitian)
Consults

Nutrition Intervention Note

RD Recommendation(s) for Physician:
1) Consider multivitamin daily.

Plan of Care: RD following. Encouraging intake. Added Ensure Enlive BID.

Nutrition reason for involvement: nutrition risk trigger-poor oral intake

---

RD Assessment
12/4- Pt with hx of dementia , compression fx of verterbra found down at NH. No family at bedside. RN reports pt only ate a few bites with AM.

Principal Problems: compression fx, s/p fall with hx of dementia, HTN, anxiety, depression

PMH:

Past Medical History:

Diagnosis	Date
• Anxiety	
• Depression	
• Hip fracture (HCC)	
• Hypertension	
• Macular degeneration	

Past Surgical History:

Procedure	Laterality	Date
• EYE SURGERY *cataract*		

I/O: 12/03 0700 - 12/04 0659
In: 30 [P.O.:30]
Out: -

IVF: -

GI: WDL; LBM 12/2

Skin: abrasion right arm

Labs: Reviewed

Meds: Reviewed

Malnutrition Evaluation (12/4/2017)
Unable to complete malnutrition evaluation at this time.
Energy Intake: estimated energy requirements unable to assess; pt not oriented and with hx of dementia; no family at bedside.
Weight loss: unable to evaluate; pt not oriented and with hx of dementia and no family at bedside.
Fat loss: Unable to evaluate
Muscle loss: Unable to evaluate

Supporting Evidence:
Fluid accumulation: No accumulation identified
Functional Status: Unable to evaluate

Ht:1.499 m (4' 11")
Wt: **(!) 44.9 kg (98 lb 14.4 oz)**
Body mass index is 19.98 kg/(m^2).
IBW (kg): 43.2

Estimated Nutritional Needs
1130-1350 calories/day (25-30 kcal/kgCurrent BW)
55-60 g protein/day (1.2-1.3 pro/kg Current BW)

Nutrition Prescription

Diet Order(s):
Diet Diet type: Regular-NO Restrictions

Allergies

Allergen	Reactions
• Benadryl [Diphenhydramine Hcl] *Confusion, delerium*	Other (See Comments)
• Ciprofloxacin	Nausea And Vomiting
• Other *SSRI lowers sodium*	Other (See Comments)

Diet Education Needs Assessment:Diet education not indicated; patient on regular diet

Adequacy: Not meeting calorie needs and Not meeting protein needs

Tolerance: Tolerating PO

Nutrition Care Level Moderate

Nutrition Diagnosis:Inadequate energy intake related to poor appetite as evidenced by ot not meeting estimated caloric and protein needs.

Goal: Patient will meet 75-100% of estimated needs by follow up
N/A

Interventions: General/healthful diet, Commercial beverage and Multivitamin/mineral supplement therapy

OT Problem List: Decreased ADLs, Decreased Cognition, Decreased Balance, Decreased Strength, Decreased Transfers, Decreased Ambulation, Decreased Functional Mobility, Decreased Activity Tolerance, Decreased Safety and Pain

Patient Comments: 'I was married to a lawyer from Houston'.

OT History: History Reviewed. Pertinent history includes: Pt is a 93 y/o F admitted 12/2 s/p fall at NH with back pain and new T10-T11 compression fractures.

Past Medical History:

Diagnosis	Date
• Anxiety	
• Chronic a-fib (HCC)	
• Depression	
• Hip fracture (HCC)	
• Hypertension	
• Macular degeneration	

Past Surgical History:

Procedure	Laterality	Date
• EYE SURGERY *cataract*		

Prior Level of Functioning: Assist needed w/ADL's, Assist needed w/ambulation, Right hand dominant
Home Equipment: Patient has Gait device(s) - Rolling walker and Single point cane

Living Situation:
Lives: at an assisted living center (for only one day before being brought to BSLMC s/p fall)
Assistance Available at Home:Yes: with staff as needed
Type of Dwelling Upon Discharge: Skilled Nursing Facility
Number of Steps to Enter Dwelling: None
Bedroom: 1st Floor
Bathroom: 1st Floor

Lines/Tubes: Peripheral IV

Pain Assessment: Pt stated increased back pain as a result of compression fractures; however, did not quantify at this time.

Vitals: Vital signs stable throughout therapy treatment.

Communication Status:
Primary language is English
Communication Deficits: None
Mental/Cognitive Status: Cooperative, Follows commands and Confused

Precautions: Safety, Fall and History of Falls

Vision: OU/Both Eyes Acuity/Reading intact Right and Left

ROM: Patient's ROM was WFL in right UE and left UE