

Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

12460



8 - OTHER

000001

MEDICAL RECORD

CONSULTATION SHEET

REQUEST

TO: 55 [REDACTED] DATE OF REQUEST 11/15/96

REASON FOR REQUEST (Complaints and findings)

support

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE

APPROVED

PLACE OF CONSULTATION

ROUTINE

TODAY

BEDSIDE

ON CALL

72 HOURS

EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED YES NO

PATIENT EXAMINED YES NO

S Pt. says she is getting better; she says she wants to go home next week because she has 2 different teleconferences + she [REDACTED] she acknowledged that Dr. [REDACTED] is working on her going to Rehab but she says she does not want to go.

O Pt. had CNA - live in [REDACTED], husband come in to talk re pt. dot. bills
I have known pt. for awhile - when she would e [REDACTED] + from Community activities I ~~have~~ explained to pt. dot. benefits of Rehab + encouraged her to go if it is set up.

P. I will be glad to assist pt. / family in d/c arrangements + assist in Rehab plans as needed

(Continue on reverse side)

SIGNATURE AND TITLE

[REDACTED SIGNATURE]

DATE

11/15/96

IDENTIFICATION NO.

ORGANIZATION

REGISTER NO.

WARD NO.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

[REDACTED PATIENT IDENTIFICATION]

CONSULTATION SHEET
Medical Record

000002

MEDICAL RECORD

CONSULTATION SHEET

REQUEST

TO:

RT

FROM: (Requesting physician or activity)

PC nursing

DATE OF REQUEST

11/20/96

REASON FOR REQUEST (Complaints and findings)

Pt. is unable to comprehend Incentive Spirometer. Please evaluate + advise

PROVISIONAL DIAGNOSIS

SP CVA

(had blood @ jugular aneurysm + clot @ carotid occlusion

DOCTOR'S SIGNATURE

APPROVED

PLACE OF CONSULTATION

ROUTINE

TODAY

BEDSIDE

ON CALL

72 HOURS

EMERGENCY

CONSULTATION REPORT

I.S. instruct done. Pt appears to be confused while doing inspiratory and expiratory maneuvers at appropriate times. She would blow into I.S. while being instructed to inhale. Pt. appears to need extra instruction.

RA SpO2 = 94%

(Continued on reverse side)

SIGNATURE AND TITLE

[Redacted Signature]

DATE

11/22/96

IDENTIFICATION NO

ORGANIZATION

REGISTER NO

WARD NO

CONSULTATION SHEET

000003

MEDICAL RECORD

CONSULTATION SHEET

REQUEST

TO: Physical Therapy FROM: [redacted] (M.D.) DATE OF REQUEST 11/11/96

REASON FOR REQUEST (Complaints and findings) CVA - (L) side

PROVISIONAL DIAGNOSIS [redacted]

DOCTOR'S SIGNATURE APPROVED PLACE OF CONSULTATION [X] BEDSIDE [] ON CALL [] ROUTINE [] TODAY [] 72 HOURS [] EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED [X] YES [] NO PATIENT EXAMINED [] YES [] NO

12/96 - Pt taken to X-ray: Clo fatigue - Echocardiogram this pm will Flt @ 4pm - or tomorrow, as per pt tolerance
1/13/96 - 5: 64 yo F admitted @ (L) CVA - (R) Hemiparesis, facial droop, slurred speech - brought in Sunday 10pm - fall from Bed. @ time of eval today - pt had fallen from toilet - pt insisted on being left alone, likely tried to stand OR each for TP - (A) (pt promised to notify when ready). Pt denies pain & is unable to explain fall - seemed disoriented upon transfer back to chair. recommend 101 as pt's judgement has been shown to be unsafe & pt's attempts to leave bed may ↑ therapeutic activity - Pt also seems very aware of deficits - when asked if she also spoke slower - she says it's her normal voice. When asked if she could move her arm or leg she says No - pt reportedly depends on them for transfers. Pt insists she is going home by Saturday to tend her table @ the Flea Market? Also flying to Jamaica Tuesday. Discussed realistic expectations - 4 month window of spontaneous recovery. 3: Pt denies loss of sensation @ (R) U/L - denies visual, swallowing difficulties, right touch intact - able to follow finger through all field. Palpate tone in

SIGNATURE AND TITLE DATE IDENTIFICATION NO. ORGANIZATION REGISTER NO. WARD NO.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; rank; rate; hospital or medical facility)

CONSULTATION SHEET Medical Record

000004

MEDICAL RECORD

CONSULTATION SHEET

REQUEST

TO: O.T. FROM: (Requesting physician or activity) [redacted] DATE OF REQUEST 11-12-96

REASON FOR REQUEST (Complaints and findings) Help w ADL's - Recent CVA @ sided - swallow reflex

PROVISIONAL DIAGNOSIS

@ CVA @ Hemiparesis

DOCTOR'S SIGNATURE APPROVED PLACE OF CONSULTATION ROUTINE TODAY BEDSIDE ON CALL 72 HOURS EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED YES NO PATIENT EXAMINED YES NO

11/12/96 S: 64 y/o ♀ referred w/ @ CVA @ hemiparesis, facial droop, slurred speech (dysarthria) some expressive/receptive aphasia, CVA on 11/11/96. disoriented to questions that are verbal only. oriented to Name, place, time in general.

O: Awake and alert to presence - low mood tone - No movement seen tonight on R arm/leg. facial droop present on @ side but only slight at rest. Did oral motor assessment. Results are sensory deficit on @ side of outside/inside of Mouth. Delayed Swallow 71 sec and is tipping head back, does not feel food in mouth or on lips in @ and uses a munching/mashing pattern over chewing - using tongue to push food around. No cough seen w/ aspiration of liquid - she can use straw for one swallow/sip at a time - but suck is stronger than her swallow is quick + she had 2 brief aspiration responses with choke but little cough seen. She could not voluntarily cough. Gag is present at back of tongue Left stronger than R side. Best food consistency is liquid or Cup + thicker foods like mashed potatoes, pudding, applesauce. She has good automatic conversation but receptive/expressive dysphasia seen when given verbal instruction + no visual cue. could not answer correctly to questions unframed. uses VISION to cue self. Did much better when there was visual modeling/imitation. Short term memory fair. Could repeat sentences of 4 numbers but NO if delayed over 10 seconds. Tongue function impaired which is main cause for slurred speech. palate and laryngeal function mixed. Cough main concern. Eyelid droop on left side noted.

Did a Visual Motor test - obvious Visual/Aphasic difficulty. may have R homonymous or R distortion. See test for specific difficulty. used L hand. good grip. + control. asked to write her name + wrote 0000 but when name is presented she could read it. + she could read words printed but when asked to write letters ABC + 123 she did 000 + perseverated is unaware of dysgraphia for this + dysgraphia for copying.

Overall ADL could not be done tonight. PT fatigued, left ADL Checklist + as it comes up staff can check it, will continue w/ADL tomorrow. over (Continue on reverse side)

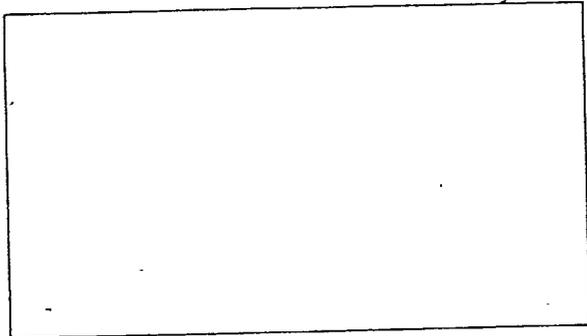
SIGNATURE AND TITLE: Occupational Therapist DATE: 11/13/96 IDENTIFICATION NO. ORGANIZATION REGISTER NO. WARD NO.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

OCCUPATIONAL THERAPY EVALUATION

Examination for swallowing disorder

Summary and Recommendations



NAME: [REDACTED]

DATE OF EVAL: 11/13/96

1. List history of patient's disorder: *LCVA R hemi.*
Diagnosis: *LCVA*

Date of onset:

- Patient awake and anticipatory
 Patient asleep
 Patient comatose or in coma
 Patient awake but not oriented

2. Patient's Respiratory status: good fair poor respirator
is patient receiving O2? yes Nasal no

3. Patient's nutritional status: good fair poor IV fed

4. Patient's oral anatomy: intact minor anomaly grossly deformed

comments;

5. Patient's labial control as it affects keeping food in mouth: intact Impaired or absent
comments: *more control on L - can't move tongue to R + can't wipe lips & tongue*

5. Patient's tongue control: intact impaired Deviation; Left Right *slight*

comments:

6. Patient's palatal function: intact impaired food or liquid comes out nose

comments;

7. Patient's pharyngeal control: intact impaired aspiration present absent

comments;

*IV - DACL - NPO -
after
midnight*

*for lunch had
1/2 chicken salad sand.
Soyz. tea cream of mushroom*

000006

8. Patient's laryngeal control; intact impaired aspiration during swallow
comments;

9. Patient's ability to follow directions: intact impaired unable

10. Describe patients symptoms during attempts to swallow: *Delayed swallow - had trouble with artificial swallow (asked to swallow) but has automatic once food is at very back of tongue*

Recommendations: Paragraph that pertains will be indicated in box. Additional comments may follow.

Posture:

patient has poor tongue control with difficulty maneuvering the bolus in his or her mouth, or the bolus is trickling over the base of the tongue and into the pharynx before the voluntary swallow is initiated. Best to ask patient to tilt his or her head downward as food is introduced in the mouth and then throw his or her head backward to drain material from the mouth when the patient is ready to initiate the swallow.

asked her to do this but she is not moving food back to tongue w/o tipping back

Tilting the head backward is an entirely safe technique if the patient has normal pharyngeal and laryngeal control.

If patient has had a hemilaryngectomy or any reason for a delay in triggering of the swallowing reflex, it may be helpful to tilt head downward so that the vallecular space is widened. With this position, material will rest in the valleculae long enough to facilitate triggering of the reflex and the valleculae will divert material away from the airway.

If patient has a slightly inadequate laryngeal closure, the forward tilting of the head may result in greater protection of the airway by the overhanging epiglottis.

→ If the patient exhibits a pharyngeal paralysis, it may be helpful to turn the patient's head toward the affected side to close the pyriform sinus on that side, directing material down the more functional side.

good idea for [redacted] →

If the patient has a lingual hemiparesis or reduction in oral function on one side in addition to involvement of the pharynx on that side, tilting the head toward the stronger side may result in directing the material down that side, in both the oral and pharyngeal stages of the swallow. If that technique is necessary the patient will generally need to tilt his or her head before food is placed in the mouth. Otherwise with the head in the normal position material will tend to fall toward the affected side.

Positioning of food in mouth

Depends on oral sensitivity, food should be positioned on the ^{side} ~~side~~ of greater function and greater sensitivity. If liquid must be placed posteriorly in the oral cavity, a straw used as a pipette, or a syringe may be used. A tongue blade is often helpful in positioning thicker foods in particular places on the tongue.

Best food consistency

Patient's with poor oral control will do best with liquids or materials of thin consistency.

* → Patients with a delayed swallow will do best with materials of a thicker consistency, such as applesauce or mashed potatoes.

Patients with reduced pharyngeal peristalsis will do best with liquids.

Patients with reduced functioning of the cricopharyngeus muscles will do better with liquids

Patients with reduced laryngeal closure will do best with materials of a thicker consistency.

Combinations of disorders make selection more difficult..

She did better with cup & no straw to avoid aspiration because suck is strong enough + swallow is slower

If the patient has been found to have swallowing difficulty with the likelihood of aspiration then it may be appropriate for further evaluation by video fluoroscopy .

[Redacted Signature]

11/13/96

Consulting Therapist

Date

000008

Examination of oral anatomy...oral motor control examination

Lip configuration: even *slight droop on L*
 Palatal configuration: height: *arch narrow high* width: *average*
 soft palate and uvular area (posterior pharyngeal wall) *slight deviation*
 Intact faucial arches anterior posterior
 lingual configuration: *flat & even slight dev. to R*
 adequacy of sulci at sides *less on L* at front *on L only*
 any scarring in oral cavity yes no on neck yes no
 any asymmetries in structures? yes no if yes ..where:

Labial function:

able to spread lips as wide as possible on the vowel /i/: yes no
 able to round them as much as possible on the vowel /u/: yes *Some slack on R* no
 able to rapidly alternating these two postures (/i/ and /u/) approximately 10 times; yes no *Confused*
 able to rapidly repeat the syllable *pa* to determine diadochokinetic rate: *20 in 10 sec Visual* yes no *Can imitate*
 able to close mouth tightly: yes no *some chattering but not in last 10 - Verbal*
 labial closure at rest yes no
 during saliva swallowing yes no
 able to maintain lip closure despite changes in head posture: yes no
Problems able to maintain lip closure while chewing food: yes *pa & while* no not able to chew
 able to suck through a straw: yes no able to suck consecutively yes no
 able to drink from a glass or cup: yes no unable to drink

Lingual function

anterior tongue

able to extend the tongue tip as far forward as possible: yes no *no tongue tip*
 able to retract as far backward as possible: yes no
 able to touch each corner of his or her mouth: yes no *NOT to corner L > R*
 able to laterally alternate lateral movements yes no *to R only*
 able to open the mouth widely and with mouth in this position elevate tongue tip to the alveolar ridge and rapidly alternate elevation and depression of the tongue while maintaining an open mouth: yes no *beginning can imitate visual*
 able to rapidly repeat the syllable /ta/ to determine *make sound but tongue flat on palate* yes no

000010

the diadochokinetic rate can't keep up e ta wka Da Pa
La
10/10 Sec -
able to repeat the sentence; Tom is able to tip toe to the television. (Is it clear with the /t/ sound): yes no

Is the patient able to pretend to clear the palate of food that is stuck (peanut butter on the roof of the mouth, can they move tongue in a fashion that would clear it): yes no can't get tongue tip to form

Posterior tongue :

able to lift back of tongue as if saying a /k/ and holding the tongue back for several seconds: yes no

able to repeat the syllable /ka/ as rapidly as possible to assess diadochokinetic rate: 14/10 Sec.

repeat this sentence; Can you come and play kick less clear (the can with us.

Is it clear and complete: yes no

Soft palate function and oral reflexes

able to produce a strong, loud /a/ and to sustain it for several seconds: yes no

able to rapidly repeat the /a/: yes no ah eh ah eh - only -

Laryngeal function

voice quality: good hoarse no voice soft voice breathy

able to rapidly repeat the syllable /ha/, able to clearly produce sound: yes no say Ah!

Not on command

able to cough; yes strength of cough: strong fair weak none

able to produce sound up and down scale (la, la, la, la) yes no

able to keep phonation going for period of time, take a breath and say z for as long as possible. (this also tests respiration): more than 10 sec. more than 5 sec.

less than 5 sec. unable

Laryngeal control: good fair poor no control

if control is less than good teach supraglottic swallow to protect patient's airway prior to initiating any swallows.

Swallowing:

able to successfully swallow food: yes no

partial swallow but food remains in mouth because they cannot form single bolus

transit time slow, resulting in aspiration

needs to tip head to transit food back in mouth

little movement in muscles of neck with swallow

normal length of time for swallow (1 second)

gargling noted after swallow

4sec

Some ~ 2x aspirated liquid -

patient asked to pant for several seconds after swallowing, if material is in pharyngeal recesses (valleculae or pyriform sinus) it will be shaken loose and fall into airway

resulting in cough (aspiration): cough produced

yes

no

Could not imitate

Other comments:

main areas of concern Sensory awareness of food

Cough, lack of

no repeat swallow

delayed swallow

Aphasia/dysphasia -

Using left hand well to spoon -
able to compensate for some deficits
by using vision for cues.

[Redacted]

11/13/96

Consulting Therapist

Date

Physical Therapy Inpatient Functional Assessment

Diagnosis: ① CVA ② Hemi.

Admit Date: 11/11/90

Precautions: Judgement / safety / Unaware of Deficits / Swallowing

Key	General Impressions:
I - Independent	severely involved (R) Hemi & Facial droop, slurred speech some judgement Deficits Flacid @ Admit - Tone ↑ Dysgraphia - uncertain re: leading Ability - Trouble word/name finding Some dysphagia - choking precautions. Has improved Daily since Admit.
SBA - Stand by Assist	
CG - Contact Guard	
Min A - Minimal Assist	
Mod A - Moderate Assist	
Max A - Max Assist	
Dep - Dependent	
NT - Not Tested	
NA - Not Applicable	

Functional Activity	@ Eval	Goal	Status	@ D/C	Comments, Equipment, Distance
B Rolling Right				I	
E Rolling Left				min (A)	(A) & (R) LE - VC to Bring (R) UE
D Bridging				min	(A) & (R) LE
Supine ↔ sit				SBA	VC to Bring / Hook (R) LE
I Bed ↔ WC/Commoae				Mod (A)	standing pivot
R sit ↔ stand				Mod (A)	
N WC ↔ car				Mod/Max (A)	
B Static sitting				(I)	
A dynamic sitting				(I)	trouble & extreme (R) Leaning
L static stand				Mod (A)	
dynamic stand				Max (A)	
W Level				SBA (A)	Mobile & (R) UE & LE - some trouble negotiating (re elevator)
C incline/decline/outdoor curbs				NT	
A Level				Max (A)	@ # Bars
M uneven				NT	
B stairs				NT	
A Dressing				Mod (A)	
D toileting				Mod (A)	
L eating				SBA	- some choking
O					
T					
H					

Movement-Motor Control: ROM/Strength/Endurance/Posture/Balance/Tone/Coordination/Goals achieved/Status Date/Other

PROM - WNL, Strength (L) 4/5 gross, (R) Hip 1-2/5 all others 0/5
Tone ↑ in (R) UE - especially Biceps - over last week (Now Hypertonic)
Flacid (R) Hand.
Fair → Good trunk control - excellent sitting Balance

Movement/Motor Control/Goals
1 CG WC → Mat transfer
2
3
4

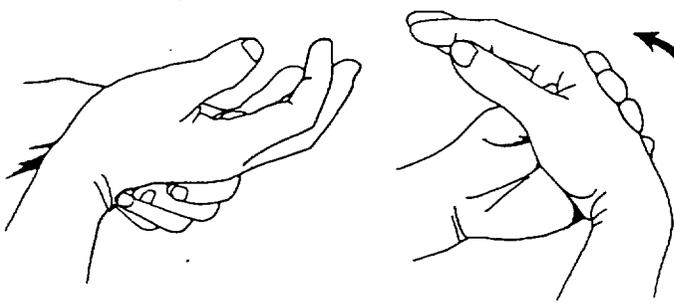
Treatment Plan/Frequency
Dynamic Sitting - Reaching, Cones, Transfer training, Standing Activities, Ambin # Bars,
(R) UE ROM, (R) UE Neuromusc. re-ed

Addressograph: _____

Provider signature: _____

Date: 11/22/90

HAND - 12 Passive Range of Motion
Wrist Flexion/Extension



Using other hand, grasp involved hand and slowly bend wrist until a stretch is felt. Relax. Then stretch as far as you can in the opposite direction. Be sure to keep elbow bent.
Repeat ___ times. Do ___ sessions per day. Copyright VHI 1990

HAND - 38 Elbow Flexion and Extension: Passive Range of Motion

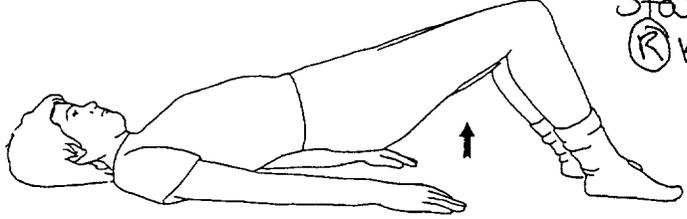
is doing self-mobility & auto massage to Right Hand By Herself - @ fingers, wrist, elbow & overhead



Grasp involved arm at wrist and gently bend elbow as far as possible. Hold ___ seconds then straighten arm as far as possible.
Repeat ___ Repetitions/set. Do ___ Sets/session.
Do ___ Sessions/day. Copyright VHI 1992

EXERCISE - 30
Therapeutic - Bridging

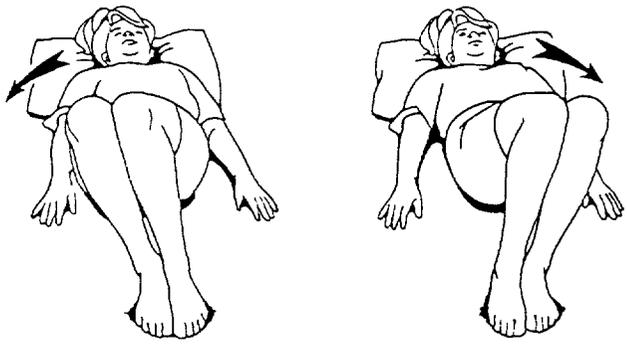
Doing exercises in Bed & needs assist to stabilize knee



Lift buttock, keeping back straight and arms on floor.
Hold 3 seconds.
Repeat 10 times.

Copyright VHI 1995

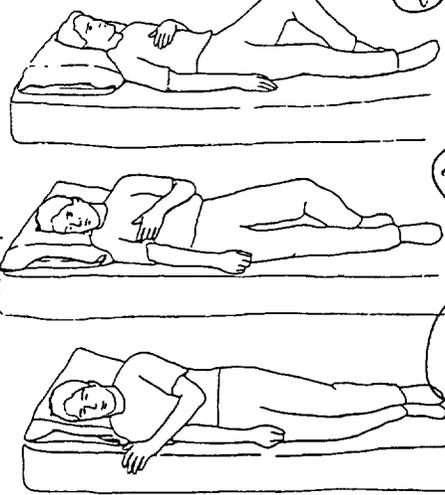
BACK - 35 Lumbar Rotation in Non-weightbearing



Slowly rock knees from side to side in a small, painfree range of motion. Allow low back to rotate slightly.
Repeat 10 Repetitions/set. Do ~~5~~ Sessions/day.
Do 2 Sessions/day. Copyright VHI 1992

MOVEMENT - 3
Log Roll

Rolling onto Left side

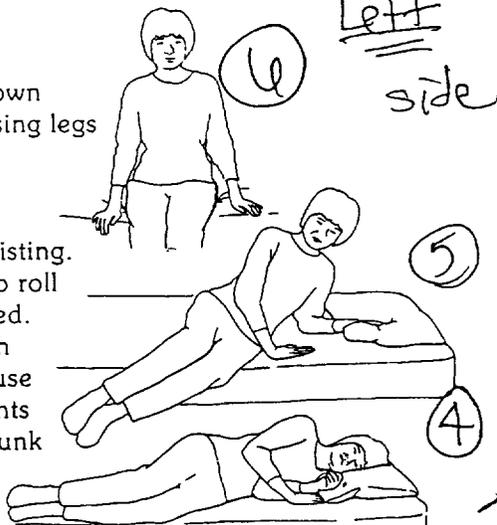


Lying on back, bend left knee and place left arm across chest. Roll all in one movement to right. Reverse for rolling to left. Always move as one unit.

MOVEMENT - 4
In/Out of Bed

000014

Left side



Lower self to lie down on one side by raising legs and lowering head at the same time. Use arms to assist moving without twisting. Bend both knees to roll on to back if desired. To sit up, start with lying on side and use the same movements in reverse. Keep trunk aligned with legs.

Copyright VHI 1995

Copyright VHI 1995

Msg: please encourage/allow [redacted] to do as much as possible by herself - May need verbal cues to bring R Arm Along - Remind her to reposition. (R) Leg BV Ankura & Heboina - (R) Leg to align with head