

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

ARMS#

13009



4 - ER URGENT

**000001**

**EMERGENCY SERVICES RECORD**

NAME \_\_\_\_\_ DATE \_\_\_\_\_ TIME \_\_\_\_\_

POLICE NOTIFICATION ADMITTED BY  AMBULANCE  STRETCHER  WHEELCHAIR  CARRIER  SELF  POLICE  AMBULATORY  CRUTCHES

BY: \_\_\_\_\_ TRIAGE PERSON \_\_\_\_\_

CONDITION ON ARRIVAL:  GOOD  FAIR  SERIOUS  CRITICAL TETANUS HISTORY \_\_\_\_\_ LMP \_\_\_\_\_

TIME 1706 TEMP 97.8 PULSE 84 RRR 8 BP 127/81 HEIGHT / WEIGHT \_\_\_\_\_

PRESENT MEDICATIONS

Zantac 300 mg

ALLERGIES MS, Cefazolin, Sulfaz

PHYS SHX IS GERD with basal reflux

CHIEF COMPLAINT **Chest Pain**

PHYSICIAN NOTIFICATION  PANEL \_\_\_\_\_ TIME PAGED \_\_\_\_\_ CALL RE-TURNED \_\_\_\_\_ TIME OF ARRIVAL \_\_\_\_\_

18:00  
19:15

TIME OF EXAM \_\_\_\_\_ **PHYSICIAN ASSESSMENT**  PAGE 1 OF 2

RE-EXAM AT \_\_\_\_\_

RE-EXAM AT \_\_\_\_\_

RE-EXAM AT \_\_\_\_\_

EKG INTERPRETATION **Acute Inf-Wall MI -**

X-RAY REPORT **CXR = ⊖**

DOCTOR ORDERS	TIME	NURSE	DOCTOR ORDERS	TIME	NURSE
Mentor			ATIVAN 1mg IV -	1716	
Suoz 100 500 02 4hr -> 1000			Heparin 8000 u bolus	1755	
Jen 25 1708			then 1600 u/hr	1758	
Note get 10mg min prn q 1713			1000cc 0.9NS stat	2006	
Ativan 1mg IV 1716			Ortho R wrist		
RETAVASE 1000 IV now	1717				
then 10 u in 30 min	1747		Amiod 12.5mg IVP	1747	
Aggron 5mg IVP	1720		MgSO4 2gmo stat	1739	

<input checked="" type="checkbox"/> CBC: WBC 7.3 Plat	<input type="checkbox"/> ETOH	260	<input checked="" type="checkbox"/> URINE PREG	<input type="checkbox"/> U/A: SG
Hgb 12.5 Segs	<input type="checkbox"/> DRUG LEVEL	mg 1.5	<input type="checkbox"/> SERUM PREGNANCY	WBC
Hct 37.3 Lymph	<input type="checkbox"/> WINE DRUG SCREEN		<input type="checkbox"/> URINE DIPSTICK	RBC
<input checked="" type="checkbox"/> LYTES Na+ K+ Cl- CO2	<input type="checkbox"/> TRAUMA LABS		<input checked="" type="checkbox"/> HEMOCULT ⊖	<input type="checkbox"/> URINE DIPSTICK
<input type="checkbox"/> GLU 122	<input checked="" type="checkbox"/> PT, PTT 12.1/24		<input type="checkbox"/> TYPE + CROSS	UNITS
<input checked="" type="checkbox"/> BUN 14	<input checked="" type="checkbox"/> CPK 66		<input type="checkbox"/> ABG # 1 AT F 10'2	PH PC O2 P O2 HCO3 % SAT
<input checked="" type="checkbox"/> CR 0.8	<input type="checkbox"/> CK-MB		<input type="checkbox"/> ABG # 2 AT F 10'2	PH PC O2 P O2 HCO3 % SAT
<input type="checkbox"/> AMYLASE	<input checked="" type="checkbox"/> LDH		<input type="checkbox"/> CULTURES: URINE SPUTUM BLOOD MISC.	
<input checked="" type="checkbox"/> X-RAY <b>PERR</b>			TO X-RAY	RETURN
<input checked="" type="checkbox"/> EKG	EKG INTERP		<input type="checkbox"/> REPEAT EKG	<input type="checkbox"/> REPEAT EKG

IMPRESSION: **1) Acute Inf-Wall MI**  
**2) Hypomagnesemia**

TREATMENT: \_\_\_\_\_

CONDITION ON DISCHARGE  GOOD  FAIR  SERIOUS  CRITICAL  EXPIRED  
PT. DISPOSITION  ROOM  HOME  OTHER  
ESCORT BY:  S.O.  OTHER **Staff**  
ADM # **2191** VIA **CARFO**  
RM # \_\_\_\_\_  
REPO # \_\_\_\_\_  
NUR # \_\_\_\_\_  
NUR # \_\_\_\_\_ INITIAL \_\_\_\_\_  
 COBRA

PHYSICIAN'S SIGNATURE \_\_\_\_\_ 13009 000002

T. NURSING NOTES

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SAFETY.			
BED SIDE RAILS	YES	NO	N/A
BED LOW AND LOCKED	YES	NO	N/A
RESTRAINTS	YES	NO	N/A
WHEEL CHAIR LOCKED	YES	NO	N/A

INITIAL ASSESSMENT FINDINGS (SEE REVERSE SIDE FOR CODES)

RESP ASSESS	CV	NEURO	SKIN	MUSC /SKEL	N V	GI	GU	PSYCH /SOC	PAIN	INITIALS

TIME BP P R NURSING INTERVENTIONS/ OBSERVATIONS

9:00 midstemel C. P started 1/2° PTH radiates  
 Dam diaphoretic + SOB pt appears mod distress  
 rates pain "10" 1/10 scale + dressing light  
 headed 12 lead EKG done

1716 99-18 136/80 9.5 T pain - Ativan 8mg po rd. -  
 Ketorolac 10mg IV given over 2-3 min

1720 Voiced 2000 bed pain Ativan given  
 as ordered PCKIT done

1725 106/74 82-18 Lopressor 5mg IV given  
 Pain about 8.5 1/10 scale Ntz 30mg

1735 Pain about 7.5 1/10 scale

1747 118/78 78-18 Ketorolac 10mg IV given  
 Heparin 800u IV bolus followed E  
 get @ 1600u/32cc

1755 106/72 97-28 Pain about the same  
 Pt C/O chest pain - getting worse

1803 Pt C/O chest pain + heaviness rates about "10"  
 N. to T 12a/40mg... 12 lead

1805 117/72 97-28 pain + heaviness rates about "10"  
 N. to T 12a/40mg... 12 lead

1807 117/72 97-28 pain + heaviness rates about "10"  
 N. to T 12a/40mg... 12 lead

1810 119/75-DEK 6 repeated Lopressor 5mg IV given

TOTAL INTAKE		TOTAL OUTPUT
I.V	ORAL	URINE 200
BLOOD		
SIGN /INIT		
SIGN /INIT		
SIGN /INIT		

PT/S O RECEIVED DISCHARGE INSTRUCTIONS *Admit*

TEACHING NEEDS

ENVIRONMENTAL CONCERNS

**SUPPLEMENTAL E.R. NURSING NOTES**

DATE 1/28/98

TIME	BP	P	R	NURSING INTERVENTIONS/OBSERVATIONS
1815				Dr. [redacted] consulted. Dr. [redacted]
1820	100/66	76	18	pain cont to be @ 10 Magnesium 20m / 50u NS IV PB given
1825	100/61	77	20	pain ↓ rates @ "4" 1/10 scale
1830				Dr. [redacted] in to see pt
1835				pain down to "3" 1/10 scale 12 lead EKG repeated
1840	104/56	76	20	pain still about "3"
1855	104/56	69	20	med
1910	95/60	71	20	Resting @ this time denies any pain
1930	109/61	80	18	Report called to ICU.
1940				Pt transferred to 219-1 via CAT C Tech & RN.

000004

SIGN: [redacted] INITIAL: [redacted] SIGN: [redacted] INITIAL: [redacted]

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MEDICAL RECORD DEPARTMENT

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EMERGENCY ROOM REPORT

PATIENT NAME: [REDACTED]

MR#: [REDACTED]  
ACCT#: [REDACTED]

DATE OF EVALUATION: 01/28/98  
TIME OF EVALUATION: 1706 hrs.

FAMILY PHYSICIAN: [REDACTED]

PATIENT COMPLAINT: Chest pain.

ALLERGIES: MORPHINE, COMPAZINE AND SULFA.

HISTORY: This 38 year old white female who works as a nurse for Dr. [REDACTED] presented to the Emergency Department after she developed chest and left arm pain associated with diaphoresis, slight shortness of breath while wheeling a patient out of the office. This patient was brought back into the office and had a rhythm strip taken which showed elevated ST segments. She was given 2 nitroglycerin and aspirin and transported to the Emergency Department by ambulance. En-route to the hospital the patient received an additional 2 nitroglycerins for a total of 4. She continued to have pain and was given IV Demerol due to an ALLERGY TO MORPHINE.

PAST MEDICAL HISTORY: This patient has a PMH of gastroesophageal reflux disease and irritable bowel syndrome.

PAST SURGICAL HISTORY: Positive for back surgery and knee surgery.

FAMILY HISTORY: There is no family history of coronary artery disease in either of her parents or siblings.

SOCIAL HISTORY: Patient does not smoke or use alcohol products.

REVIEW OF SYSTEMS: Ten point system review is done on the patient and is essentially unremarkable other than the PMH as noted above.

PHYSICAL EXAMINATION:

CONSTITUTIONAL: On arrival into the ER the patient's vital signs were stable. She is a well developed, well nourished female, somewhat obese, normotensive, afebrile, non-toxic appearing.

PSYCHIATRIC: The patient was mildly anxious, affect appropriate, alert and oriented x 3, judgment intact.

SKIN: Warm and dry without evidence of rash or lesions.

HEAD: Normocephalic.

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EMERGENCY ROOM REPORT

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PATIENT NAME: [REDACTED]

MR#: [REDACTED]

ACCT#: [REDACTED]

EYES: Sclera white, conjunctiva pink, pupils symmetrical.

EARS: Patent.

MOUTH AND THROAT: Throat is clear. Mucous membranes are well hydrated.

NECK: No thyromegaly or lymphadenopathy.

LUNGS: Clear, equal air entry bilaterally, no rales, rhonchi or wheezes are heard. Patient does not splint with inspiration. She has no chest wall tenderness.

CARDIAC: Normal S-1 and S-2 without appreciable adventitial sound, murmur or rub. Carotid upstrokes are normal, no bruits are heard, no abdominal pulsations are present.

ABDOMEN: Obese, soft, non-distended, non-tender, no palpable organomegaly, no flank tenderness laterally or posteriorly.

EXTREMITIES: Without calf tenderness, peripheral cyanosis or pitting edema.

MUSCULOSKELETAL: There is no gross joint deformity, erythema or obvious effusion, major joints have a normal range of motion.

NEUROLOGIC: Cranial nerves 2 through 12 are grossly intact, no focal findings present, no facial droop or asymmetry, no slurring or garbled speech. The remainder of the exam is non-contributory.

The remainder of exam is non-contributory.

**ER TREATMENT:** An EKG was done on the patient immediately upon arrival in the ER. A rectal exam was also done and she was found to be heme negative. EKG was reviewed and showed acute inferior wall myocardial infarction with reciprocal changes. Heart rate was in the 80's. Portable chest x-ray was done, also reviewed and found to be unremarkable.

The risks and benefits of thrombolytic therapy were then explained to the patient including the risk of bleeding and even death. She has agreed to proceed and was given Retevase in 2 boluses - first 10 units and 30 minutes later a second 10 units. Patient was given IV Ativan for her anxiety. She has previously had aspirin. She also was given IV Demerol in 25 and 12.5 mg aliquots to help relieve her pain.

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EMERGENCY ROOM REPORT

PATIENT NAME: [REDACTED]

MR#: [REDACTED]  
ACCT#: [REDACTED]

One dose of 5 mg IV Lopressor was given. The patient was also heparinized with 8,000 units of heparin given as a bolus and started on a drip at 1600 units per hour. Dr. [REDACTED] was contacted and notified of the patient's impending admission. Referral is made to [REDACTED] however, the patient has refused to see Dr. [REDACTED] who was on call for that service. Therefore, referral is given to [REDACTED] and Dr. [REDACTED] will be in to see the patient. Cardiology consultation is also anticipated for a possible interventional maneuver if the patient's pain does not subside. She is in guarded condition at the time of this dictation, still complaining of pain in the 7-8 out of 10 range.

PROVISIONAL DIAGNOSIS: Acute inferior wall myocardial infarction.

[REDACTED] MD

R: 01/28/98 6:02 P  
T: 01/28/98 7:28 P  
J: [REDACTED]  
D: [REDACTED]

cc: [REDACTED] MD  
[REDACTED] MD

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