EXTERNAL TRANSFER SUMMARY

Catholic Health

Ioan Suiugan MRN: 286095347 Anoxic encephalopathy 5/11/2023 - 6/16/2023 BMH 5N MED SURG

Instructions

Your medications have changed

START taking:

amiodarone (Pacerone)
Start taking on: **June 17, 2023**

apixaban (Eliquis)

atorvastatin (Lipitor)
Start taking on: **June 17, 2023**

clopidogrel (Plavix)
Start taking on: **June 17, 2023**

insulin glargine (Lantus)

lansoprazole (Prevacid SoluTab)
Start taking on: **June 17, 2023**

metoprolol tartrate (Lopressor)

OLANZapine (Zyprexa)

QUEtiapine (Seroquel)

tamsulosin (Flomax)
Start taking on: **June 17, 2023**

Review your updated medication list below.

What's Next

You currently have no upcoming appointments scheduled.

Patient's Most Recent Vitals

Most recent update: 6/16/2023 7:53 AM

BP	Pulse	Temp	Resp	Height
124/91 (BP Location: Right arm, Patient Position: Lying)	97	36.2 °C (97.1 °F)	18	1.829 m (6' 0.01")

Weight	SpO2	BMI	Smoking Status
90.5 kg (199 lb 8.3 oz)	97%	27.05 kg/m^2	Every Day

Your Next Steps

Ask

☐ Ask how to get these medications
- amiodarone
- apixaban
- atorvastatin
- clopidogrel
- insulin glargine
- lansoprazole
- metoprolol tartrate
- OLANZapine
- tamsulosin

Do

☐ Pick up these medications from CVS/pharmacy #8066 - SOUTH LYON, MI - 22421 PONTIAC TRAIL AT CORNER OF 9 MILE ROAD
- QUEtiapine

MyChart

2 Day Vitals (last day)

Date/Time	Temp	Pulse	Resp	BP	SpO2	Weight
06/16/23 0700	36.2 °C (97.1 °F)	97	18	124/91	97 %	—
06/16/23 0652	—	—	19	—	—	—
06/16/23 0552	—	100	—	120/96 !	—	—
06/16/23 0017	—	88	—	132/68 !	—	—
06/15/23 1950	—	—	—	—	97 %	—
06/15/23 1929	36.3 °C (97.3 °F)	91	20	137/77 !	—	—
06/15/23 1500	36.6 °C (97.8 °F)	88	18	138/88 !	98 %	—
06/15/23 0700	36.7 °C (98 °F)	80	18	138/87 !	98 %	—
06/15/23 0524	—	91	—	143/94 !	—	—

Provider Notes

Discharge Summary by Prageet Kumar, MD at 6/16/2023 11:18 AM

Author: Prageet Kumar, MD
Service: Internal Medicine
Author Type: Physician
Filed: 6/16/2023 11:24 AM
Date of Service: 6/16/2023 11:18 AM
Status: Signed
Editor: Prageet Kumar, MD (Physician)

Hospitalist Discharge Summary
Sound Physicians

Admitting Provider: Valeri Kraskovsky, MD
Discharge Provider: Prageet Kumar, MD
Primary Care Physician at Discharge: PCP REQUIRES ASSIGNMENT None

Admission Date: 5/11/2023 Discharge Date: 6/16/2023

Discharge Condition: Guarded
Code Status at Discharge: Full Code

Hospital Course

62 y.o. male trucker from Michigan with reported history of diabetes mellitus and renal disorder who gets his care in Romania (does not speak English, only Romanian) but has not established care in USA. He was found down in the parking lot at the GM plant in Buffalo 2/2 VT cardiac arrest, CPR was started by bystanders, with placement of an AED with 3 shocks delivered prior to arrival of EMS, who subsequently defibrillated the patient an additional 3x and gave 5-6 amps of epinephrine + intubated, achieving ROSC after 60 minutes. Patient was originally taken to KMH and required norepinephrine and dobutamine for hemodynamic management. Patient was not able to be started on heparin ggt for suspected MI, as he had moderate amounts of blood coming from ET and NG tubes. He was then transferred to SBMH, admitted to the ICU on 5/11/2023. Patient began having SVT on 5/14/2023 with atrial flutter rhythm, requiring Lopressor, with diltiazem and then amiodarone ggt added on subsequent days. Patient was extubated on his 14th day of mechanical ventilation. He was also found to have right lower lobe streptococcal positive Serratia pneumonia. He completed a course of 10 days of antibiotics. With anoxic brain injury, he currently does not follow commands, but moves bilateral upper extremities spontaneously and withdraws to pain, but does not move or localize pain in his bilateral lower extremities, for which neurology has been consulted. MRI was done and it showed cortical ischemia. EEG showed no evidence of seizures. As per neurology recommendations, patient has anoxic brain injury secondary to cardiac arrest. Neurochecks were obtained every 4 hours. No further neurological intervention was recommended at this time. He had angiogram performed and it showed distal circumflex lesion that was 90% stenosed with 90% stenosed sidebranch and third marginal. Proximal LAD to mid LAD lesion was 30% stenosis. He was found to have occluded right coronary artery with well-developed left-to-right collaterals. Medical therapy was recommended, since no targets for revascularization existed. He will be continued on Plavix, Lipitor, Cardizem, and metoprolol. Eliquis was started for atrial flutter. As per cardiology and EP recommendations, patient is currently not a candidate for ICD placement secondary to altered mental status and unable to follow commands. Urology was consulted for urinary retention. Foley catheter was initially placed. He had bedside cystoscopy done yesterday and Foley catheter was removed. He is currently able to void on his own. He has been agitated throughout the hospital stay. For this reason, psychiatry and behavioral pharmacy were consulted. He was continued on Zyprexa twice daily and scheduled melatonin nightly. He was accepted at a rehab facility in Michigan. However, he cannot support his own weight and is unsafe for transfer to the patient's family's personal vehicle. Since this is not a wheelchair van, the patient's family signed AMA form indicating that they wish to transport patient on their own without any assistance of wheelchair van. They did not want the patient to be admitted to a rehab facility in the Buffalo area. He will be discharged at this time. He will follow-up with his primary care physician, cardiologist, and urologist as an outpatient.

Discharge Medications

New Medications at Discharge

- amiodarone (Pacerone) 200 mg tablet
- apixaban (Eliquis) 5 mg tablet
- atorvastatin (Lipitor) 40 mg tablet
- clopidogrel (Plavix) 75 mg tablet
- insulin glargine (Lantus) 100 unit/mL injection

Provider Notes (continued)

- lansoprazole (Prevacid SoluTab) 30 mg disintegrating tablet
- metoprolol tartrate (Lopressor) 50 mg tablet
- OLANZapine (Zyprexa) 5 mg tablet
- QUEtiapine (Seroquel) 25 mg tablet
- tamsulosin (Flomax) 0.4 mg 24 hr capsule

Physical Exam
Constitutional:
General: He is not in acute distress.
Appearance: He is obese. He is not ill-appearing or diaphoretic. **Confused, belligerent**
HENT:
Head: Normocephalic.
Cardiovascular:
Rate and Rhythm: Normal rate and regular rhythm.
Heart sounds: No murmur heard.
Pulmonary:
Effort: Pulmonary effort is normal. No accessory muscle usage or respiratory distress. He is not intubated.
Breath sounds: Normal breath sounds. No rhonchi.
Abdominal:
General: Abdomen is flat.
Palpations: Abdomen is soft.
Musculoskeletal:
Right lower leg: No edema.
Left lower leg: No edema.
In restraints.
Skin:
General: Skin is warm.
Neurological:
Comments: Alert and oriented to person only

Total time spent preparing discharge is 40 minutes.

Kumar, Prageet, MD

Consults by Courtney Jarka, PharmD at 6/14/2023 2:13 PM

Author: Courtney Jarka, PharmD | Service: Pharmacy | Author Type: Pharmacist
Filed: 6/14/2023 2:31 PM | Date of Service: 6/14/2023 2:13 PM | Status: Addendum
Editor: Courtney Jarka, PharmD (Pharmacist)

Consult Orders
1. Pharmacy Psychiatric/Behavioral Health Consult [95890570] ordered by Prageet Kumar, MD at 06/14/23 1129

Inpatient consult to Pharmacy
Consult performed by: Courtney Jarka, PharmD
Consult ordered by: Prageet Kumar, MD
Reason for consult: Psychiatric medication recommendations

Patient Name: Ioan Suiugan
DOB: 2/27/1961

MRN: 286095347
Today's Date: 6/14/23
Admission Date: 5/11/23
Length of Stay: 34

Chart review discussion performed.

Mr. Suiugan presented to MHB with cardiac arrest. He was admitted to the ICU for further evaluation and treatment. He has since been transferred out of ICU but has had ongoing periods of agitation, requiring one-time doses of lorazepam, midazolam, and haloperidol. Due to continued agitation, he has since been started on olanzapine.

Objective:

Current Facility-Administered Medications:
• acetaminophen (Tylenol) tablet 650 mg, 650 mg, oral, q6h PRN, Raj Thapar, MD, 650 mg at 06/01/23 2225
• [COMPLETED] amiodarone (Pacerone) tablet 400 mg, 400 mg, oral, Daily, 400 mg at 06/01/23 0949 **FOLLOWED BY** amiodarone (Pacerone) tablet 200 mg, 200 mg, oral, Daily, Chinyere Ezenwa, MD, 200 mg at 06/14/23 0913
• [COMPLETED] apixaban (Eliquis) tablet 10 mg, 10 mg, oral, BID, 10 mg at 06/02/23 0815 **FOLLOWED BY** apixaban (Eliquis) tablet 5 mg, 5 mg, oral, BID, Raj Thapar, MD, 5 mg at 06/14/23 0913
• arformoterol (Brovana) 15 mcg/2 mL nebulizer solution 15 mcg, 15 mcg, nebulization, BID, Raj Thapar, MD, 15 mcg at 06/13/23 1909
• atorvastatin (Lipitor) tablet 40 mg, 40 mg, oral, Daily, Raj Thapar, MD, 40 mg at 06/14/23 0913
• clopidogrel (Plavix) tablet 75 mg, 75 mg, oral, Daily, Raj Thapar, MD, 75 mg at 06/14/23 0913
• dextrose 50% (D50W) injection, 25 g, intravenous, q15 min PRN, Raj Thapar, MD, 25 g at 06/09/23 0142
• glucagon injection 1 mg, 1 mg, intramuscular, q15 min PRN, Raj Thapar, MD
• insulin glargine (Lantus) injection 100 units/mL, 30 Units, subcutaneous, Daily at 12 noon (glargine insulin), Raj Thapar, MD, 30 Units at 06/14/23 1149
• insulin lispro (HumaLOG) injection - CORRECTION DOSING, 0-12 Units, subcutaneous, TID AC insulin, Raj Thapar, MD, 6 Units at 06/14/23 1150
• insulin lispro (HumaLOG) injection - CORRECTION DOSING, 0-6 Units, subcutaneous, Nightly, Raj Thapar, MD
• lansoprazole (Prevacid SoluTab) disintegrating tablet 30 mg, 30 mg, oral, Daily, Raj Thapar, MD, 30 mg at 06/14/23 0913
• lidocaine 4 % topical patch 1 patch, 1 patch, topical (top), Daily, Raj Thapar, MD, 1 patch at 06/14/23 0914
• melatonin tablet 5 mg, 5 mg, oral, Nightly PRN, Muhammad B Cheema, MD, 5 mg at 06/13/23 2208
• metoprolol tartrate (Lopressor) tablet 50 mg, 50 mg, oral, q6h std, Raj Thapar, MD, 50 mg at 06/14/23 1143
• nicotine (Nicoderm CQ) 21 mg/24 hr patch 1 patch, 1 patch, transdermal, Daily, Eunkyung J Shin, 1 patch at 06/14/23 0918
• OLANZapine (Zyprexa) tablet 2.5 mg, 2.5 mg, oral, BID, Swati Bhargava, MD, 2.5 mg at 06/14/23 0913
• ondansetron (Zofran) injection 4 mg, 4 mg, intravenous, q6h PRN, Raj Thapar, MD
• revefenacin (Yupelri) 175 mcg/3 mL nebulizer solution 175 mcg, 175 mcg, nebulization, Daily, Raj Thapar, MD, 175 mcg at 06/13/23 0802
• sennosides-docusate sodium (Peri-Colace) 8.6-50 mg per tablet 1 tablet, 1 tablet, oral, Nightly PRN, Mohammad S Hussain Rumi, MBBS, 1 tablet at 06/13/23 2209
• sodium chloride 0.9 % IV line flushing using 250 ml bag, 25 mL, intravenous, PRN **OR** sodium chloride 0.9 % IV line flushing using 100 ml bag, 25 mL, intravenous, PRN **OR** sodium chloride 0.9 % IV line flushing using 50 ml bag, 25 mL, intravenous, PRN, Raj Thapar, MD
• sodium chloride 0.9% (flush) syringe 10 mL, 10 mL, intra-catheter, Daily PRN, Raj Thapar, MD

• Insert peripheral IV, , , Once **AND** IV site care, , , Until discontinued **AND** Saline lock IV, , , Once **AND** sodium chloride 0.9% (flush) syringe 3 mL, 3 mL, intravenous, q8h PRN, Raj Thapar, MD, 3 mL at 05/16/23 1351
• sodium chloride 0.9% (flush) syringe 3 mL, 3 mL, intravenous, q8h PRN, Raj Thapar, MD
• tamsulosin (Flomax) 24 hr capsule 0.4 mg, 0.4 mg, oral, Daily with breakfast, Phillip J Seereiter Jr., MD, 0.4 mg at 06/14/23 0807

No current facility-administered medications on file prior to encounter.

No current outpatient medications on file prior to encounter.

Encounter Date: 05/11/23
ECG 12 lead

Narrative
BMH

Test Date: 2023-05-18
Pat Name: IOAN SUIUGAN Department:
Patient ID: 286095347 Room: 8114
Gender: Male Technician: LB
DOB: 1961-02-27 Requested By: RAJ THAPAR
Order Number: 94126602-70113862574 Reading MD: Dr. Mohan Madhusudanan
Measurements

Intervals		*Axis*	
Rate:	*81*	*P:*	*-74*
PR:	*132*	*QRS:*	*66*
QRSD:	*101*	*T:*	*70*
QT:	*384*		
QTc:	*448*		

Interpretive Statements
ECTOPIC ATRIAL RHYTHM WITH PAC, PVC
POSSIBLE INFERIOR MYOCARDIAL INFARCTION , PROBABLY OLD
ABNORMAL RHYTHM ECG
Compared to ECG 05
Ventricular premature complex(es) now present
Supraventricular tachycardia no longer present
ST (T wave) deviation no longer present
Myocardial infarct finding still present
Electronically Signed On 5-18-2023 16:18:57 EDT by Dr. Mohan Madhusudanan

	6/13/2023 7:13 PM	6/13/2023 7:18 PM	6/13/2023 7:20 PM	6/14/2023 5:43 AM	6/14/2023 7:47 AM	6/14/2023 7:58 AM	6/14/2023 11:43 AM
Vitals							
Systolic			128	131	**89** ⌄	102	108
Diastolic			64	76	**54** !	71	65
Pulse	80	80	79	75	66		92

	6/13/2023 7:13 PM	6/13/2023 7:18 PM	6/13/2023 7:20 PM	6/14/2023 5:43 AM	6/14/2023 7:47 AM	6/14/2023 7:58 AM	6/14/2023 11:43 AM
Temp			36.1 °C (97 °F)		**35.8 °C (96.4 °F)** !		
Resp	20	20	18		20		

Patient Active Problem List

Diagnosis

- Cardiac arrest (CMS/HCC)
- Acute renal failure with tubular necrosis (CMS/HCC)
- Transaminitis
- Acute respiratory failure with hypoxemia (CMS/HCC)
- Anoxic encephalopathy (CMS/HCC)
- Type 2 diabetes mellitus (CMS/HCC)
- Streptococcal pneumonia (CMS/HCC)
- Hyperlipidemia
- Tobacco use disorder
- Centrilobular emphysema (CMS/HCC)
- Hypomagnesemia

Recommendations:
Agitation:
-Continue olanzapine 2.5mg BID as this medication has been started <24 hours ago
--Continue to monitor for excessive sedation; if this occurs, consider change to 5mg at bedtime
--Noted patient difficulty with swallowing may consider change to ODT formulation of olanzapine for 5mg at bedtime dose
--May consider addition of olanzapine 5mg oral disintegrating tablet daily PRN periods of mild-moderate agitation
--Based on tolerability and response (need of PRN medication), may consider further increase in scheduled dose of olanzapine after one week if continued periods of agitation
--Monitor QTc/EKG at baseline and with each dose increase

-Consider change from PRN to scheduled melatonin to assist with sleep-wake cycle and limit periods of agitation over-night

-Continue to utilize non-pharmacologic intervention, including re-direction and re-orientation, as well as limiting the use of physical restraints as this may further contribute to agitation

Dragon voice-recognition was used to prepare this note. Although notes are reviewed for syntactic and/or grammatical errors, unintended but conspicuous translational errors can occur. Please call me if there are any questions about the contents of this note

Revision History

	Date/Time	User	Provider Type	Action
>	6/14/2023 2:31 PM	Courtney Jarka, PharmD	Pharmacist	Addend
	6/14/2023 2:30 PM	Courtney Jarka, PharmD	Pharmacist	Sign

Consults by Mohammad A Saeed, MD at 6/10/2023 7:53 PM

Provider Notes (continued)

Author: Mohammad A Saeed, MD | Service: Psychiatry | Author Type: Physician
Filed: 6/10/2023 7:56 PM | Date of Service: 6/10/2023 7:53 PM | Status: Signed
Editor: Mohammad A Saeed, MD (Physician)

Consult Orders

1. Inpatient consult to Psychiatry [95757315] ordered by Swati Bhargava, MD at 06/10/23 1248

It is a 62-year-old male who is admitted with anoxic brain injury after a cardiac arrest. I was told to evaluate him for capacity to make medical decisions.

Today when I saw the patient he was alert. He speaks Romanian. We tried to connect with the interpreter it did not work then his son came and he was helpful. Who reported that patient can understand and speak English. But patient was just talking and Romanian. Son reported that some of what he is saying makes sense and some does not. Reported that patient feels that he is like a prisoner here. He is very upset because he has mittens on his hands. Son denied any psych history. Denies any issues with alcohol or drugs. Reported that he was a truck driver by profession.

Past psych history as mentioned above

Social history. Patient is remaining speaking male who lives in Michigan. Family wants to take him back to Michigan.

Mental status examination. Patient is alert not cooperative with the interview. Could not assess the thought process.

Diagnosis. Evaluation for capacity to make medical decisions.

Assessment. Patient who suffers from anoxic brain injury after cardiac arrest. He presented irritable. He was not cooperative with the interview. Try to get help from patient's son who could translate. Son reported that most the time what patient says does not make sense. But reported that patient is pretty upset because of the mittens. Tried to explain to patient but he did not comprehend. It is difficult to assess capacity to make medical decisions at this time. It will be beneficial to involve family inpatient care. Family wants to know if patient can be transferred back to Michigan which will be helpful for patient and the family.

Consults by Annielaurie Goetz, NP at 6/9/2023 12:07 PM

Author: Annielaurie Goetz, NP | Service: Electrophysiology | Author Type: Nurse Practitioner
Filed: 6/9/2023 1:28 PM | Date of Service: 6/9/2023 12:07 PM | Status: Signed
Editor: Annielaurie Goetz, NP (Nurse Practitioner) | Cosigner: Mohamed L Metawee, MD at 6/13/2023 11:24 PM

ELECTROPHYSIOLOGY CONSULT

Chief Complaint:

I was asked to evaluate the patient for AICD implantation as secondary prevention due to history of ventricular fibrillation arrest.

HPI:

The patient is a 62 y.o. y/o male who brought to the emergency room on 5/11/23 after cardiac arrest. Patient is an out of town truck driver and he was found down in the parking lot of the GM plant. He was found by EMS with ventricular fibrillation and ACLS protocol was followed. Patient had extended cardiac arrest time with a reported total downtime of

> 60 minutes reported. MRI Brain 5/14/23 shows evidence of anoxic brain injury. He has significant cognitive impairment.

Coronary angiogram showed occluded RCA with well-developed left-to-right collaterals and severe disease in the distal circumflex. No indications for revascularization.

Echocardiogram on 5/11/23: EF 55%
Echocardiogram on 5/16/23 EF 50-55%
Echocardiogram on 5/22/23 Ef 55-60%

Electrophysiology was consulted to evaluate for AICD is recommended for the secondary prevention.

Patient also noted to have recurrent SVT and paroxysmal atrial flutter on telemetry monitor. He is currently on oral Eliquis 5 mg twice daily, amiodarone 200 mg daily, Cardizem 60 mg every 6 hours, metoprolol 50 mg every 6 hours.

Patient seen and examined at bedside today. He is oriented to self only and does not follow commands. He is confused to place and time and he does not appropriately follow commands. No family present at bedside on examination today.

PMH/PSH:

Patient Active Problem List

Diagnosis

- Cardiac arrest (CMS/HCC)
- Acute renal failure with tubular necrosis (CMS/HCC)
- Transaminitis
- Acute respiratory failure with hypoxemia (CMS/HCC)
- Anoxic encephalopathy (CMS/HCC)
- Type 2 diabetes mellitus (CMS/HCC)
- Streptococcal pneumonia (CMS/HCC)
- Hyperlipidemia
- Tobacco use disorder
- Centrilobular emphysema (CMS/HCC)

Medications:

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Admin
• acetaminophen (Tylenol) tablet 650 mg	650 mg	oral	q6h PRN	Raj Thapar, MD		650 mg at 06/01/23 2225
• amiodarone (Pacerone) tablet 200 mg	200 mg	oral	Daily	Chinyere Ezenwa, MD		200 mg at 06/09/23 0920

Provider Notes (continued)

• apixaban (Eliquis) tablet 5 mg	5 mg	oral	BID	Raj Thapar, MD	5 mg at 06/09/23 0920
• arformoterol (Brovana) 15 mcg/2 mL nebulizer solution 15 mcg	15 mcg	nebulization	BID	Raj Thapar, MD	15 mcg at 06/08/23 0658
• atorvastatin (Lipitor) tablet 40 mg	40 mg	oral	Daily	Raj Thapar, MD	40 mg at 06/09/23 0920
• clopidogrel (Plavix) tablet 75 mg	75 mg	oral	Daily	Raj Thapar, MD	75 mg at 06/09/23 0920
• dextrose 50% (D50W) injection	25 g	intravenous	q15 min PRN	Raj Thapar, MD	25 g at 06/09/23 0142
• dilTIAZem (Cardizem) immediate release tablet 60 mg	60 mg	oral	q6h std	Raj Thapar, MD	60 mg at 06/09/23 1154
• glucagon injection 1 mg	1 mg	intramuscular	q15 min PRN	Raj Thapar, MD	
• insulin glargine (Lantus) injection 100 units/mL	30 Units	subcutaneous	Daily at 12 noon (glargine insulin)	Raj Thapar, MD	30 Units at 06/09/23 1157
• insulin lispro (HumaLOG) injection - CORRECTION DOSING	0-12 Units	subcutaneous	TID AC insulin	Raj Thapar, MD	2 Units at 06/07/23 1152
• insulin lispro (HumaLOG) injection - CORRECTION DOSING	0-6 Units	subcutaneous	Nightly	Raj Thapar, MD	
• lansoprazole (Prevacid SoluTab) disintegrating tablet 30 mg	30 mg	oral	Daily	Raj Thapar, MD	30 mg at 06/09/23 0920
• lidocaine 4 % topical patch 1 patch	1 patch	topical (top)	Daily	Raj Thapar, MD	1 patch at 06/09/23 1155
• metoprolol tartrate (Lopressor) tablet 50 mg	50 mg	oral	q6h std	Raj Thapar, MD	50 mg at 06/09/23 1154

• nicotine (Nicoderm CQ) 21 mg/24 hr patch 1 patch	1 patch	transdermal	Daily	Eunkyung J Shin	1 patch at 06/09/23 0916
• ondansetron (Zofran) injection 4 mg	4 mg	intravenous	q6h PRN	Raj Thapar, MD	
• revefenacin (Yupelri) 175 mcg/3 mL nebulizer solution 175 mcg	175 mcg	nebulization	Daily	Raj Thapar, MD	175 mcg at 06/08/23 0658
• sodium chloride 0.9 % IV line flushing using 250 ml bag Or	25 mL	intravenous	PRN	Raj Thapar, MD	
• sodium chloride 0.9 % IV line flushing using 100 ml bag Or	25 mL	intravenous	PRN	Raj Thapar, MD	
• sodium chloride 0.9 % IV line flushing using 50 ml bag	25 mL	intravenous	PRN	Raj Thapar, MD	
• sodium chloride 0.9% (flush) syringe 10 mL	10 mL	intra-catheter	Daily PRN	Raj Thapar, MD	
• sodium chloride 0.9% (flush) syringe 3 mL	3 mL	intravenous	q8h PRN	Raj Thapar, MD	3 mL at 05/16/23 1351
• sodium chloride 0.9% (flush) syringe 3 mL	3 mL	intravenous	q8h PRN	Raj Thapar, MD	

Family Hx.:
No family history on file.

Surgical History
He has no past surgical history on file.

Social History
He reports that he has been smoking cigarettes. He has been smoking an average of 3 packs per day. He does not have any smokeless tobacco history on file. Drug use questions deferred to the physician. No history on file for alcohol use.

ROS:

Review of Systems
Reason unable to perform ROS: **Patient is confused and unable to cooperate with ROS**.

Physical Exam:

Vitals: **Visit Vitals**

BP	96/70 (BP Location: Left arm, Patient Position: Lying)
Pulse	70
Temp	36.2 °C (97.2 °F) (Temporal)
Resp	18
Ht	1.829 m (6' 0.01")
Wt	90.5 kg (199 lb 8.3 oz)
SpO2	**(!) 94%**
BMI	27.05 kg/m²
Smoking Status	Every Day
BSA	2.14 m²

General: Well developed, well nourished male in no apparent distress.
Eyes: sclerae anicteric, no redness
Neck: Supple, No thyromegaly
Cardiac: RRR, nml S1 and S2, no M/R/G, no carotid bruits
Lungs: Clear, good air entry, no wheezes or rales
Abdomen: Soft, NT/ND No hepatospenomegaly
Musculoskeletal: Normal tone, no deformities
Skin: Warm and dry, no rash
Ext: +trace pedal edema, No cyanosis.
Psychiatric: Alert, oriented to self only.

Laboratory values:

Lab Results

Component	Value	Date
INR	1.3 (H)	05/19/2023
INR	1.4 (H)	05/11/2023
PROTIME	14.7 (H)	05/19/2023
PROTIME	16.2 (H)	05/11/2023

Lab Results

Component	Value	Date
WBC	10.8	06/07/2023
RBC	4.11 (L)	06/07/2023
HGB	12.4 (L)	06/07/2023
HCT	36.5 (L)	06/07/2023
MCV	88.8	06/07/2023
MCH	30.1	06/07/2023
MCHC	33.9	06/07/2023
RDW	13.6	06/07/2023
PLT	366	06/07/2023

Lab Results

Component	Value	Date

BUN	16	06/08/2023
GFR	>90.0	06/08/2023
MG	1.8	06/07/2023

6/9/23: K+ = 3.8
6/2/23:
-AST 35
-ALT 64

Cardiology Tests

Electrocardiogram:

Encounter Date: 05/11/23
ECG 12 lead

Narrative
BMH

Test Date: 2023-05-18
Pat Name: IOAN SUIUGAN Department:
Patient ID: 286095347 Room: 8114
Gender: Male Technician: LB
DOB: 1961-02-27 Requested By: RAJ THAPAR
Order Number: 94126602-70113862574 Reading MD: Dr. Mohan Madhusudanan
Measurements

Intervals		*Axis*	
Rate:	*81*	*P:*	*-74*
PR:	*132*	*QRS:*	*66*
QRSD:	*101*	*T:*	*70*
QT:	*384*		
QTc:	*448*		

Interpretive Statements
ECTOPIC ATRIAL RHYTHM WITH PAC, PVC
POSSIBLE INFERIOR MYOCARDIAL INFARCTION , PROBABLY OLD
ABNORMAL RHYTHM ECG
Compared to ECG 05
Ventricular premature complex(es) now present
Supraventricular tachycardia no longer present
ST (T wave) deviation no longer present
Myocardial infarct finding still present
Electronically Signed On 5-18-2023 16:18:57 EDT by Dr. Mohan Madhusudanan

Echocardiogram: Transthoracic echo (TTE) limited

Result Date: 5/22/2023
- Technically difficult study
- Limited study, definity contrast was used

• Left ventricular systolic function is normal with an ejection fraction of 55-60%.
• Left Ventricle: Regional wall motion cannot be accurately assessed.

Transthoracic echo (TTE) limited

Result Date: 5/16/2023
• Left ventricular systolic function is low normal with an ejection fraction of 50-55%.
• The following segments are hypokinetic: basal inferoseptal, basal inferior and basal inferolateral. All other segments are normal.
• Right ventricular systolic function is normal.
• Left ventricle shows mild concentric hypertrophy.
• When compared to the prior study on 5/11/23 (very difficult study on my review), the segmental wall motion abnormalities may have been possibly present on the prior study.

Transthoracic echo (Transthoracic Echo) complete

Result Date: 5/11/2023
• Technically very difficult study
• Left Ventricle: Left ventricular systolic function appears to be normal with an ejection fraction of approx 55 +/- 5 %.
• Right ventricular systolic function is normal.
• There is a trivial pericardial effusion.

Telemetry: Patient is currently not being monitored on telemetry. Discontinued as per medicine.

Assessment:
VT/VF cardiac arrest
Recurrent supraventricular tachycardia, atrial flutter

Plan:
EP initially evaluated patient for possible AICD and seen by Dr. Metawee on 6/1/23. At this time Dr. Metawee discussed plan with patient's son at bedside and the son requested to have time to talk with the family prior to proceeding. EP recalled today as family would like to proceed with AICD placement. Detailed discussion with patient's daughter today via telephone and family would like to proceed with AICD placement at this time. His daughter expressed wishes to move forward with this plan in hopes patient will have cognitive recovery in the future. His daughter indicated family is in agreement and they are agreeable and consent to moving forward with AICD implant.
-Recommend ICD implant as secondary prevention. Risks/benefits previously discussed with patient's son on 6/1/23 (See prior EP note). We will plan to implant next week as per Dr. Metawee's schedule (date/time pending).
-CHAD2DS2-VASc > 2
-Continue Eliquis 5 mg BID as AC for stroke prevention d/t paroxysmal Aflutter.
-Continue amiodarone 200 mg daily. AST/ALT monitored. Will need monitoring at minimum every 3 months while on amiodarone therapy.
-Consider PFT's in future if amiodarone is long term therapy.
-Continue metoprolol tartrate 50 mg every 6 hours - recommend changing dosing to metoprolol succinate 200 mg daily.

Attending: Dr. Metawee
Case discussed in detail with Dr. Metawee.

Revision History

	Date/Time	User	Provider Type	Action
>	6/9/2023 1:28 PM	Annielaurie Goetz, NP	Nurse Practitioner	Sign
	6/9/2023 1:26 PM	Annielaurie Goetz, NP	Nurse Practitioner	Sign

Consults by Talia A Calabro, PA at 6/9/2023 11:06 AM

Author: Talia A Calabro, PA Service: Urology Author Type: Physician Assistant
Filed: 6/9/2023 12:32 PM Date of Service: 6/9/2023 11:06 AM Status: Signed
Editor: Talia A Calabro, PA (Physician Assistant)

Consult Orders
1. Inpatient consult to Urology [95595875] ordered by Chinyere Ezenwa, MD at 06/09/23 0819

Urology Consult Note
WNY Urology

Ioan Suiugan 2/27/1961
286095347
6/9/2023 11:06 AM

Reason for Consult: Urinary Retention

HPI:
62-year-old male who was found down in the parking lot at GM plant and received CPR at the scene started by bystanders with placement of an AED which delivered 3 shocks prior to the arrival of EMS. EMS defibrillated an additional 3 times and gave 5-6 amps of epinephrine. He was started on dobutamine and norepinephrine for shock and transferred to SVM for further care. He has anoxic encephalopathy. He has had a Foley catheter during this admission and his catheter was removed for voiding trial. Unfortunately, he was unable to urinate and required straight catheterization x2. Ultimately, his Foley catheter was replaced and urology was consulted for urinary retention. History was obtained from the chart as patient has significant cognitive impairment from his anoxic brain injury. It is unclear if he has had any urologic issues in the past and/or if he has seen a urologist previously. He has no prior records with our practice.

Past Medical History:

Diagnosis	Date

- Diabetes mellitus (CMS/HCC)
- Renal disorder

History reviewed. No pertinent surgical history.

Social Connections: Not on file

No current facility-administered medications on file prior to encounter.

No current outpatient medications on file prior to encounter.

No Known Allergies

Review of Systems:

Unable to obtain due to cognitive impairment

Physical Exam:

Constitutional: No apparent distress. Patient is not ill-appearing or toxic-appearing.
HENT: Head normocephalic and atraumatic.
Eyes: No scleral icterus. Conjunctiva/sclera: Conjunctivae normal.
Neck: Normal range of motion and neck supple.
Cardiovascular: No obvious JVD
Pulmonary: Breathing comfortable
Abdominal: General: Abdomen is soft, non-distended, non-tender
Musculoskeletal: Normal range of motion.
Skin: Warm and dry.
Neurological: Cognitive impairment secondary to anoxic brain injury
Psychiatric: Mood and Affect normal.
GU: No grimacing with palpation of abdomen and/or flanks, phallus with no lesions/rash/discharge, testicles downgoing BL, Foley catheter in place and draining clear yellow urine

Labs:

Lab Results

Component	Value	Date
WBC	10.8	06/07/2023
HGB	12.4 (L)	06/07/2023
HCT	36.5 (L)	06/07/2023
MCV	88.8	06/07/2023
PLT	366	06/07/2023

Lab Results

Component	Value	Date
GLUCOSE	95	06/08/2023
CALCIUM	8.1 (L)	06/08/2023
NA	139	06/08/2023
K	3.5	06/08/2023
CO2	27	06/08/2023
CL	104	06/08/2023
BUN	16	06/08/2023
CREATININE	0.64 (L)	06/08/2023

Impression:
62-year-old male with an anoxic brain injury secondary to cardiac arrest and prolonged downtime [~60 min]
Urology consult for urinary retention likely secondary to NGB and decreased mobility
Plan:
Maintain Foley catheter; routine catheter care; monthly catheter exchanges
Would recommend maintaining Foley catheter until he is able to undergo outpatient urodynamic studies

Provider Notes (continued)

Will discuss with Dr. Seereiter
Please call with any questions or concerns (716) 677–2273

Talia Calabro, PA-C

Consults by Shannon M Bunch, PA at 6/1/2023 2:05 PM

Author: Shannon M Bunch, PA | Service: Electrophysiology | Author Type: Physician Assistant
Filed: 6/1/2023 2:16 PM | Date of Service: 6/1/2023 2:05 PM | Status: Attested
Editor: Shannon M Bunch, PA (Physician Assistant) | Cosigner: Mohamed L Metawee, MD at 6/3/2023 2:18 PM

Consult Orders
1. Inpatient consult to Electrophysiology [94797463] ordered by Jonathan C Zirna, PA at 05/27/23 1016

Attestation signed by Mohamed L Metawee, MD at 6/3/2023 2:18 PM

Mr. Suiugan was admitted with VT arrest, he had a spontaneous rate turn of circulation, his downtime was 60 minutes, the patient had an angiogram that showed coronary artery disease but no indication for revascularization, his echocardiogram showed ejection fraction 50-55%, he still has significant cognitive impairment from anoxic brain injury. His son was by the bedside. I had a discussion with his son about the patient condition, I discussed with him the ICD, discussed the role of ICD in him and the effect that may impose on the patient given the cognitive impairment, I discussed the risks and benefits of ICD, discussed complications, the son will think about it and talk to his family, he thinks that the patient is not ready now for anything and he is hoping that his cognitive impairment will improve with time. For now we will follow from a distance, please contact us close to the patient discharge so we can revisit the issue with the family.

Brief EP Consult

Reason for consult: consideration of ICD placement s/p VF arrest; paroxysmal A-flutter

Chart reviewed, events noted
Discussed with Cardiology, RN at bedside and Dr. Metawee

Patient's cognitive status is poor, had prolonged downtime per chart with anoxic brain injury
MRI of brain obtained on 5/15 which revealed " cortical ischemic bilaterally, compatible with anoxic brain injury".
Patient also not moving BL LE and has urinary retention, concern for spinal cord infarct in setting of cardiac arrest and systemic hypoperfusion. MRI thoracic spine: limited no significant acute lesion was visible

Patient only speaks Romanian
No family at bedside
Attempted to communicate with patient with translator computer however patient not interacting at all

Patient on PO amiodarone for Paroxysmal A-flutter, currently in sinus rhythm
On Eliquis

At this time the patient is not a good candidate for ICD implantation due to cognitive impairment

Recommend further discussion with family to establish goals of care and wishes going forward
Further EP recs pending clinical course

Bunch, Shannon M, PA
Attending: Dr. Metawee

Consults by Prashant Pendyala, MD at 6/2/2023 9:16 AM

Author: Prashant Pendyala, MD | Service: Nephrology | Author Type: Physician
Filed: 6/2/2023 9:26 AM | Date of Service: 6/2/2023 9:16 AM | Status: Signed
Editor: Prashant Pendyala, MD (Physician)

Consult Orders
1. Inpatient consult to Nephrology [95080445] ordered by Praqeet Kumar, MD at 06/02/23 0854

Catholic Health

Consult Notes

Patient Name: Ioan Suiugan
Date of Birth: 2/27/1961
Medical Record #: 286095347

Reason For Consult
hypernatremia

History Of Present Illness
Loan Suiugan is a 62 y.o. male found down in the parking lot at the GM plant. Per notes, patient is a trucker from Michigan and initial downtime was not known. CPR was started by bystanders with placement of an AED with 3 shocks delivered prior to arrival of EMS. EMS defibrillated an additional 3 times and gave 5-6 amps of epinephrine. He was started on dobutamine and norepinephrine for shock and transferred to SBM for further treatment.
He has anoxic enceph
His sodium is running high and renal consult obtained for the same.
Past Medical History
He has a past medical history of Diabetes mellitus (CMS/HCC) and Renal disorder.

Surgical History
He has no past surgical history on file.

Social History
He reports that he has been smoking cigarettes. He has been smoking an average of 3 packs per day. He does not have any smokeless tobacco history on file. Drug use questions deferred to the physician. No history on file for alcohol use.

Family History
His family history is not on file.
Allergies
Patient has no known allergies.

Medications

No medications prior to admission.

Review of Systems
Could not be obtained

Physical Exam
HEENT: Pupils are equal, reacting to light. Oropharynx is normal. Neck: JVD is not elevated. Thyroid is not palpable. Lungs: Air entry is equal bilaterally, no rhonchi. Heart: First and second heart sounds are present, no rub. Abdomen is soft, nontender, bowel sounds are present. Extremities show 1 edema. Central nervous system: moves all limbs.

Last Recorded Vitals
Blood pressure **(!) 134/76**, pulse 65, temperature 36.2 °C (97.1 °F), temperature source Temporal, resp. rate 19, height 6' 0.01" (1.829 m), weight 198 lb 1.6 oz (89.9 kg), SpO2 97 %.

Relevant Results

ASSESSMENT

Hypernatremia
Na is 148
Has free water deficit

PLAN

Will do D5W at 80/hr
Will follow bmp

Consults by Divya Gumber, MD at 5/22/2023 5:06 PM

Author: Divya Gumber, MD
Filed: 5/22/2023 7:24 PM
Editor: Divya Gumber, MD (Physician)
Service: Cardiology
Date of Service: 5/22/2023 5:06 PM
Author Type: Physician
Status: Addendum

Catholic Health

Initial Cardiology Inpatient Consult Note

Patient Name: Ioan Suiugan
Reason for Consult: VT/Vfib arrest

Assessment

62 y/o M who was brought in after VT/Vfib arrest reported down time of 60 minutes, HS Trop elevation to a peak of 54 k on 5/11/23 likely in sp ischemic event. No Heparin gtt/full dose Lovenox was given at admission due to reported concern for GI bleed (none seen in the hospital). Pt had transaminitis and AKI which are resolving. Primary team nor proceeding with cath be pt has no insurance but prefer for us to be on board to monitor pt from a cardiac standpoint.

Also currently there is evidence of anoxic brain injury on brain MRI and ongoing encephalopthay, neurological prognosis unclear

VT/Vfib arrest on 5/11/23 reported ROSC after 60 mins likely 2/2 ischemic event
- TTE 5/16/23: EF 50-55%' HK in Basal IS, basal inf and basal IL segment
- TTE 5/22/23: EF 55-60%
- HS Trop peak 54 k on 5/11/23
- MRI Brain 5/14/23 shows evidence of anoxic brain injury
- CTH 5/18/23: No acute intracranial pathology

#New onset Atrial Flutter this admission
- CHADSVASc score 2? (HTN hx unknown? And DM2)
- Started on Amiodarone gtt 5/18/23 and transitioned from Heparin gtt to full dose Lovenox

#Encephalopathy 2/2 anoxic brain injury
Intubated on PSV not able to be extubated due to encephalopathy?
RLL PNA - Strep
Current smoker
DM2. Poorly controlled
AKI this admission which is now improving
Does not have insurance in US. Resident of Michigan. SW has applied fro Medicaid. For healthcare needs flies to Romania. Per sister was not on any medications at home?
#Full code

Recommendations

-We will proceed with LHC tomorrow for ischemic evaluation . I discussed with pt's daughter over the phone who is his healthcare proxy. She says she talked to SW today and is agreable with proceeding with LHC tom which is scheduled at 6:30 pm. Please keep NPO after MN

- I have held full dose Lovenox in anticipation of LHC tom

-In Atrial Flutter on tele , HR well controlled. After LHC tom long term may need to consider DCCV (plus or minus TEE) vs ablation but at this point his long term neurological prognosis is uncertain? Cannot be certain he never had paroxysmal Afib prior to this hospitalization since pt is non verbal at the moment and had poor follow up with physicians

- May need to be trached and PEGed long term

- Neurology will likely have to follo wup long term for prognostication

Interval Events

-Continues to be confused. Opens eyes and is agitated. Not following any commands
- Pt has been in new onset Atrial flutter since about 5/20/23. ICU team started Amiodarone gtt and transitioned him to full dose Lovenox

Pertinent Labs

- AKI resolving ; Pea Cr 1.8 --> Now 1.15
- Transaminitis resolving
- HS Trop peak 54 k (5/11/23) --> 454

History

Past Medical History:

Past Medical History:

Diagnosis	Date
• Diabetes mellitus (CMS/HCC)	
• Renal disorder	

Past Medical/Family/Surgical History:

I have reviewed, verified and personally updated the past medical, surgical, family, and social history.

Family History:

No family history on file.

Social History:

reports that he has been smoking cigarettes. He has been smoking an average of 3 packs per day. He does not have any smokeless tobacco history on file. Drug use questions deferred to the physician. No history on file for alcohol use.

Current Meds:

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Admin
• acetaminophen (Tylenol) 650 mg/ 20.3 mL oral solution 650 mg	650 mg	enteral tube	q6h PRN	Valeri Kraskovsky, MD		650 mg at 05/21/23 2324
• amiodarone (Nexterone) infusion 360 mg in 200 mL dextrose (1.8 mg/ mL) premix	0.5 mg/ min	intravenous	Continuous	Nirosshan Thiruchelvam, MD	16.67 mL/hr at 05/22/23 1500	0.5 mg/ min at 05/22/23 1500
• arformoterol (Brovana) 15 mcg/2 mL nebulizer solution 15 mcg	15 mcg	nebulization	BID	Christopher J Dowd, NP		15 mcg at 05/22/23 0753
• aspirin chewable tablet 81 mg	81 mg	enteral tube	Daily	Valeri Kraskovsky, MD		81 mg at 05/22/23 0916
• atorvastatin (Lipitor) tablet 40 mg	40 mg	oral	Daily	Raj Thapar, MD		40 mg at 05/22/23 0916
• cefepime (Maxipime) IVPB 2 g in 50 mL D5W (Duplex)	2 g	intravenous	q8h std	Marwan Saoud, MD	0 mL/hr at 05/21/23 2325	2 g at 05/22/23 1543
• clopidogrel (Plavix) tablet 75 mg	75 mg	enteral tube	Daily	Hannah E Gawlak		75 mg at 05/22/23 0917
• dextrose 50% (D50W) injection	25 g	intravenous	q15 min PRN	Alivia R Caldwell, NP		

Provider Notes (continued)

• dilTIAZem (Cardizem) immediate release tablet 60 mg	60 mg	enteral tube	q6h std	Marwan Saoud, MD		60 mg at 05/22/23 1143
• enoxaparin (Lovenox) syringe 110 mg	1 mg/kg	subcutaneous	q12h std	Marwan Saoud, MD		110 mg at 05/22/23 0916
• fentaNYL (Sublimaze) injection 100 mcg	100 mcg	intravenous	q2h PRN	Marwan Saoud, MD		100 mcg at 05/22/23 0344
• glucagon injection 1 mg	1 mg	intramuscular	q15 min PRN	Alivia R Caldwell, NP		
• insulin glargine (Lantus) injection 100 units/mL	40 Units	subcutaneous	Daily at 12 noon (glargine insulin)	Marwan Saoud, MD		40 Units at 05/22/23 1202
• insulin lispro (HumaLOG) injection - CORRECTION DOSING	0-12 Units	subcutaneous	q4h std	Alivia R Caldwell, NP		6 Units at 05/22/23 1207
• lansoprazole (Prevacid SoluTab) disintegrating tablet 30 mg	30 mg	enteral tube	Daily	Valeri Kraskovsky, MD		30 mg at 05/22/23 0916
• lidocaine 4 % topical patch 1 patch	1 patch	topical (top)	Daily	Zachary L Tomasik, PA		1 patch at 05/22/23 0917
• metoprolol tartrate (Lopressor) tablet 50 mg	50 mg	enteral tube	q6h std	Marwan Saoud, MD		50 mg at 05/22/23 1143
• ondansetron (Zofran) injection 4 mg	4 mg	intravenous	q6h PRN	Alivia R Caldwell, NP		
• propofol (Diprivan) 10 mg/mL infusion	5-50 mcg/kg/min	intravenous	Titrated	Nirosshan Thiruchelvam, MD	19.44 mL/hr at 05/22/23 1500	30 mcg/kg/min at 05/22/23 1500
• revefenacin (Yupelri) 175 mcg/3 mL nebulizer solution 175 mcg	175 mcg	nebulization	Daily	Christopher J Dowd, NP		175 mcg at 05/22/23 0753
• sodium chloride 0.9 % IV line flushing using 250 ml bag	25 mL	intravenous	PRN	Keira S McCarthy, NP		

Or					
• sodium chloride 0.9 % IV line flushing using 100 ml bag	25 mL	intravenous	PRN	Keira S McCarthy, NP	
Or					
• sodium chloride 0.9 % IV line flushing using 50 ml bag	25 mL	intravenous	PRN	Keira S McCarthy, NP	
• sodium chloride 0.9% (flush) syringe 10 mL	10 mL	intra-catheter	Daily PRN	Lisa M Hanavan, RA	
• sodium chloride 0.9% (flush) syringe 3 mL	3 mL	intravenous	q8h PRN	Keira S McCarthy, NP	3 mL at 05/16/23 1351

Allergies:
Patient has no known allergies.

Problem List
Problem List Items Addressed This Visit

Nervous
*** (Principal) Anoxic encephalopathy (CMS/HCC)**
Relevant Orders
Intubation (Completed)

Respiratory
Acute respiratory failure with hypoxemia (CMS/HCC)
Relevant Orders
Intubation (Completed)

Circulatory
Cardiac arrest (CMS/HCC) - Primary
Overview
VT VF arrest with 60 min downtime prior to ROSC (no TTM due to hemodynamic instability)

Relevant Medications
aspirin chewable tablet 81 mg
atorvastatin (Lipitor) tablet 40 mg
clopidogrel (Plavix) tablet 75 mg
enoxaparin (Lovenox) syringe 110 mg
metoprolol tartrate (Lopressor) tablet 50 mg
dilTIAZem (Cardizem) immediate release tablet 60 mg
digoxin (Lanoxin) injection 250 mcg (Completed)
amiodarone (Nexterone) infusion 360 mg in 200 mL dextrose (1.8 mg/mL) premix

Other Relevant Orders

Transthoracic echo (Transthoracic Echo) complete (Completed)
Transthoracic echo (TTE) limited (Completed)
Intubation (Completed)
Transthoracic echo (TTE) limited (Completed)
Case Request Cardiac Cath Procedure: CCA/LHC (Completed)
Cardiac Catheterization

Physical Exam

Visit Vitals

BP	104/73
Pulse	**(!) 116**
Temp	38.1 °C (100.6 °F) (Axillary)
Resp	**(!) 26**

General appearance: Intubated and sesated
HEENT: normocephalic and atraumatic
Cardiovascular: Irregular pulse. JVP not elevated
Pulmonary: clear to auscultation bilaterally, no wheezing, no rales
GI: soft and nontender
Musculoskeletal: no clubbing, no cyanosis
Neurologic; Not following commands purposefully

Gumber, Divya, MD
5/22/2023

Revision History

	Date/Time	User	Provider Type	Action
>	5/22/2023 7:24 PM	Divya Gumber, MD	Physician	Addend
	5/22/2023 5:12 PM	Divya Gumber, MD	Physician	Sign

Consults by Andrea N Perry, NP at 5/20/2023 12:38 PM

Author: Andrea N Perry, NP | Service: Critical Care | Author Type: Nurse Practitioner
Filed: 5/20/2023 1:11 PM | Date of Service: 5/20/2023 12:38 PM | Status: Signed
Editor: Andrea N Perry, NP (Nurse Practitioner)

Catholic Health

Neurocritical Care Service Consultation Note

Patient Name: Ioan Suiugan
Date of Birth: 2/27/1961
Medical Record #: 286095347

Reason for consult: Persistent encephalopathy after cardiac arrest

History Of Present Illness:

Per NCC consult on 5/11/23: "*Ioan Suiugan is a 62 y.o. male presenting with cardiac arrest from Kenmore Mercy Hospital. History was taken from staff and chart as patient is comatose, intubated and sedated. Patient is apparently from out of town and is a truck driver who was found down this morning in the parking lot of GM. Bystander CPR was started and patient did receive shocks upon EMS arrival. According to provider, patient said to have extended time of cardiac arrest, reportedly did achieve ROSC however did have another cardiac arrest. Total downtime said to be above 60 minutes in total. Patient was with shock after ROSC achieved requiring norepinephrine and dobutamine for hemodynamic management. Patient was not able to be started on heparin drip for suspected MI as he was with moderate amounts of blood coming from ET and NG tubes. Patient was subsequently transferred to Mercy Hospital for higher level of care and admitted to medical ICU team with neuro-critical care consult.*"

ICU Course: Patient was not a TTM candidate 2° suspected GIB, profound hemodynamic instability. He has had a complicated course with anoxic encephalopathy, ATN, Transaminitis, acute respiratory failure, streptococcal pneumonia and DVT. Patient is presently hospital day 9 post arrest and has remained encephalopathic, requiring sedation for safety and ventilator compliance. He had an MRI completed on 5/14/23 revealed cortical ischemia bilaterally, compatible with anoxic brain injury. Reportedly he has been waking up but not following commands, moving around and grabbing tubes/lines therefore he has been sedated with Propofol. Neurocritical care has been consulted at this time for further recommendations given his persistent encephalopathy related to anoxic brain injury.

Past Medical History
He has a past medical history of Diabetes mellitus (CMS/HCC) and Renal disorder.

Surgical History
Unable to obtain as patient intubated and comatose.

Social History
He reports that he has been smoking cigarettes. He has been smoking an average of 3 packs per day. He does not have any smokeless tobacco history on file. Drug use questions deferred to the physician. No history on file for alcohol use.

Family History
Unable to obtain as patient intubated and comatose.

Allergies
Patient has no known allergies.

Review of Systems
Review of Systems
Unable to perform ROS: Intubated

Physical Exam
Vitals: Blood pressure 101/76, pulse **(!) 159**, temperature 37.7 °C (99.9 °F), temperature source Esophageal, resp. rate **(!) 22**, height 1.829 m (6' 0.01"), weight 108 kg (238 lb 1.6 oz), SpO2 100 %.
Physical Exam
Vitals and nursing note reviewed.
Constitutional:
Appearance: He is ill-appearing.
Comments: **Patient laying in bed, intubated**
HENT:
Head: Normocephalic and atraumatic.
Mouth/Throat:

Mouth: Mucous membranes are moist.
Comments: **ETT/OGT present with blood noted to**
Eyes:
Pupils: Pupils are equal, round, and reactive to light.
Comments: **Pupils ~3mm round with sluggish reaction to light, gaze midline currently**
Pulmonary:
Comments: **Intubated, mechanical ventilation**
Abdominal:
Palpations: Abdomen is soft.
Skin:
General: Skin is warm and dry.
Neurological:
Comments: **PERRL. Gaze midline. +Cough/gag with suctioning. Withdraws BUE to pain. No movement BLE.**

Patient was evaluated on propofol infusion @ 50mcg.

Relevant laboratory data and imaging studies were reviewed.

ASSESSMENT/PLAN:

NEURO
Anoxic brain injury 2° cardiac arrest and prolonged downtime ~60 min
- Discontinue sedation, get best neuro exam
- Consider EEG if he continues to not following commands
- No further imaging needed at this time
- Management per MICU, we will continue to follow along and assist with patients neuro status

CCT 45 min. Patient seen and examined with Dr. Coplin all plans made and discussed with him. Plans relayed to medical team and nurse.

Consults by Divya Gumber, MD at 5/19/2023 3:10 PM

Author: Divya Gumber, MD | Service: Cardiology | Author Type: Physician
Filed: 5/19/2023 3:12 PM | Date of Service: 5/19/2023 3:10 PM | Status: Signed
Editor: Divya Gumber, MD (Physician)

Brief Cardiology Note

Still not following any commands. Per nursing staff here yesterday and even when being spoken to in Romanian he is not following commands appropriately. I am told that there is supposed to be a family meeting tomorrow and neurology will decide on prognostication soon. Shows no significant ventricular arrhythmias. Continue current baby aspirin Plavix, atorvastatin 40 Mg daily and Lopressor 25 mg BID

Remains intubated and was agitated when I went in to see him.

Gumber, Divya, MD

Consults by Divya Gumber, MD at 5/17/2023 2:07 PM

Author: Divya Gumber, MD | Service: Cardiology | Author Type: Physician
Filed: 5/17/2023 2:23 PM | Date of Service: 5/17/2023 2:07 PM | Status: Signed
Editor: Divya Gumber, MD (Physician)

Catholic Health

Initial Cardiology Inpatient Consult Note

Patient Name: Ioan Suiugan
Reason for Consult: VT/Vfib arrest

Assessment

62 y/o M who was brought in after VT/Vfib arrest reported down time of 60 minutes, HS Trop elevation to a peak of 54 k on 5/11/23 likely in sp ischemic event. No Heparin gtt/full dose Lovenox was given at admission due to reported concern for GI bleed (none seen in the hospital). Pt had transaminitis and AKI which are resolving. Primary team nor proceeding with cath be pt has no insurance but prefer for us to be on board to monitor pt from a cardiac standpoint. Also currently there is evidence of anoxic brain injury on brain MRI and ongoing encephalopthay, neurological prognosis unclear

VT/Vfib arrest on 5/11/23 reported ROSC after 60 mins likely 2/2 ischemic event
- TTE 5/16/23: EF 50-55%' HK in Basal IS, basal inf and basal IL segmetn
- HS Trop peak 54 k on 5/11/23
- MRI Brain 5/14/23 shows evidence of anoxic brain injury

#Encephalopathy 2/2 anoxic brain injury
Intubated on PSV not able to be extubated due to encephalopathy?
RLL PNA - Strep
Current smoker
DM2. Poorly controlled
AKI this admission which is now improving
Does not have insurance in US. Resident of Michigan. SW has applied fro Medicaid. For healthcare needs flies to Romania. Per sister was not on any medications at home?

Recommendations

-From a cardiac standpoint patient did have VT arrest as well as possibly an ischemic event given high troponin level on admission with peak of 54 K and wall motion abnormality TTE and he warrants a left heart catheterization for ischemic evaluation. He also has several risk factors for CAD including uncontrolled diabetes, current smoker and poor follow-up with physicians. He was not on any medications prior to admission. However the primary team we will hold off on angiogram from a psychosocial standpoint. Patient seems to have no insurance in the US. He lives out of state in Michigan. Social work has recently applied for Michigan Medicaid. He used to fly out to Romania for healthcare needs. Also not entirely sure what his neurological prognosis. His previous brain MRI on 5/14/2023 showed anoxic brain injury and he has had ongoing encephalopathy which has made extubation challenging.

-Telemetry he does not have significant VT. His study from today shows no VT whatsoever. Currently on Lopressor and 25 Mg twice daily. If he develops VT

- I have ordered a repeat EKG for him tom, one form yesterday showed very poor BL

- Also ordered repeat HS trop for him tonight

- Too late to do Heparin gtt for him he has likely completed his infarct. Cont baby ASA. If LHC is definitely off the table for insurance reason, low threshold to initiate Plavix for him. . On Lipitor 40 mg every day which can be continues , transaminitis is improving

Interval Events

-Continues to be confused. He speaks Romanian but nursing staff is not really following any commands, sometimes with grip and but this is likely not purposeful.
-Patient has a fecal management system in place, has been having diarrhea.
-She shows normal sinus rhythm. No significant ventricular ectopy.
- HS Trop 454 yesterday, downtrended from prior

Pertinent Labs

- AKI resolving
- Transaminitis resolving

History

Past Medical History:

Past Medical History:

Diagnosis	Date

- Diabetes mellitus (CMS/HCC)
- Renal disorder

Past Medical/Family/Surgical History:

I have reviewed, verified and personally updated the past medical, surgical, family, and social history.

Family History:

No family history on file.

Social History:

reports that he has been smoking cigarettes. He has been smoking an average of 3 packs per day. He does not have any smokeless tobacco history on file. Drug use questions deferred to the physician. No history on file for alcohol use.

Current Meds:

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Admin
• acetaminophen (Tylenol) 650 mg/ 20.3 mL oral solution 650 mg	650 mg	enteral tube	q6h PRN	Valeri Kraskovsky, MD		650 mg at 05/17/23 1014
• arformoterol (Brovana) 15 mcg/2 mL nebulizer solution 15 mcg	15 mcg	nebulization	BID	Christopher J Dowd, NP		15 mcg at 05/17/23 0727

Provider Notes (continued)

• aspirin chewable tablet 81 mg	81 mg	enteral tube	Daily	Valeri Kraskovsky, MD	81 mg at 05/17/23 0953
• atorvastatin (Lipitor) tablet 40 mg	40 mg	oral	Daily	Raj Thapar, MD	40 mg at 05/17/23 0953
• cefepime (Maxipime) IVPB 2 g in 50 mL D5W (Duplex)	2 g	intravenous	Once	Marwan Saoud, MD	
• cefepime (Maxipime) IVPB 2 g in 50 mL D5W (Duplex)	2 g	intravenous	q8h std	Marwan Saoud, MD	
• clopidogrel (Plavix) tablet 75 mg	75 mg	enteral tube	Daily	Hannah E Gawlak	75 mg at 05/17/23 1241
• dextrose 50% (D50W) injection	25 g	intravenous	q15 min PRN	Valeri Kraskovsky, MD	
• dextrose 50% (D50W) injection	25 g	intravenous	q15 min PRN	Marwan Saoud, MD	
• enoxaparin (Lovenox) syringe 40 mg	40 mg	subcutaneous	q24h std	Valeri Kraskovsky, MD	40 mg at 05/17/23 0954
• fentaNYL (Sublimaze) injection 100 mcg	100 mcg	intravenous	q2h PRN	Valeri Kraskovsky, MD	100 mcg at 05/17/23 0108
• glucagon injection 1 mg	1 mg	intramuscular	q15 min PRN	Valeri Kraskovsky, MD	
• glucagon injection 1 mg	1 mg	intramuscular	q15 min PRN	Marwan Saoud, MD	
• insulin glargine (Lantus) injection 100 units/mL	15 Units	subcutaneous	Daily at 12 noon (glargine insulin)	Marwan Saoud, MD	15 Units at 05/17/23 1237
• insulin lispro (HumaLOG) injection - CORRECTION DOSING	0-12 Units	subcutaneous	q6h std	Marwan Saoud, MD	4 Units at 05/17/23 1238
• lansoprazole (Prevacid SoluTab) disintegrating tablet 30 mg	30 mg	enteral tube	Daily	Valeri Kraskovsky, MD	30 mg at 05/17/23 0953
• lidocaine 4 % topical patch 1 patch	1 patch	topical (top)	Daily	Zachary L Tomasik, PA	1 patch at 05/17/23 0953

• metoprolol tartrate (Lopressor) tablet 25 mg	25 mg	enteral tube	BID	Marwan Saoud, MD	25 mg at 05/17/23 0953
• revefenacin (Yupelri) 175 mcg/3 mL nebulizer solution 175 mcg	175 mcg	nebulization	Daily	Christopher J Dowd, NP	175 mcg at 05/17/23 0727
• senna (Senokot) syrup 10 mL	10 mL	enteral tube	BID	Marwan Saoud, MD	10 mL at 05/16/23 2158
• sodium chloride 0.9 % IV line flushing using 250 ml bag Or	25 mL	intravenous	PRN	Keira S McCarthy, NP	
• sodium chloride 0.9 % IV line flushing using 100 ml bag Or	25 mL	intravenous	PRN	Keira S McCarthy, NP	
• sodium chloride 0.9 % IV line flushing using 50 ml bag	25 mL	intravenous	PRN	Keira S McCarthy, NP	
• sodium chloride 0.9% (flush) syringe 3 mL	3 mL	intravenous	q8h PRN	Keira S McCarthy, NP	3 mL at 05/16/23 1351

Allergies:
Patient has no known allergies.

Problem List
Problem List Items Addressed This Visit

Circulatory

Cardiac arrest (CMS/HCC) - Primary

Overview

VT VF arrest with 60 min downtime prior to ROSC (no TTM due to hemodynamic instability)

Relevant Medications

enoxaparin (Lovenox) syringe 40 mg
aspirin chewable tablet 81 mg
atorvastatin (Lipitor) tablet 40 mg
metoprolol tartrate (Lopressor) tablet 25 mg
clopidogrel (Plavix) tablet 75 mg

Other Relevant Orders

Transthoracic echo (Transthoracic Echo) complete (Completed)
Transthoracic echo (TTE) limited (Completed)

Physical Exam

Visit Vitals

BP	**(!) 149/83 (BP Location: Left arm, Patient Position: Sitting)**
Pulse	98
Temp	**(!) 38.6 °C (101.5 °F) (Esophageal)**
Resp	**(!) 22**

General appearance: Intubated. Opening eyes. Moving extremities
HEENT: normocephalic and atraumatic
Cardiovascular: regular rate and rhythm, normal S1, normal S2, no murmurs, no rubs or gallops, preserved pedal pulses, no carotid bruits, no pitting edema lower extremities
Pulmonary: clear to auscultation bilaterally, no wheezing, no rales
GI: soft and nontender
Musculoskeletal: no clubbing, no cyanosis
Integ: no rashes
Psych: appropriate affect
Neurologic; Not following commands purposefully

Gumber, Divya, MD
5/17/2023

Consults by Divya Gumber, MD at 5/16/2023 4:01 PM

Author: Divya Gumber, MD | Service: Cardiology | Author Type: Physician
Filed: 5/16/2023 4:56 PM | Date of Service: 5/16/2023 4:01 PM | Status: Signed
Editor: Divya Gumber, MD (Physician)

Consult Orders
1. Inpatient consult to Cardiology [93928694] ordered by Christopher J Dowd, NP at 05/16/23 1022

Catholic Health

Initial Cardiology Inpatient Consult Note

Patient Name: Ioan Suiugan
Reason for Consult: VT/Vfib arrest

Assessment

62 y/o M who was brought in after VT/Vfib arrest reported down time of 60 minutes, HS Trop elevation to a peak of 54 k on 5/11/23 likely in sp ischemic event. No Heparin gtt/full dose Lovenox was given at admission due to reported concern for GI bleed (none seen in the hospital). Pt had transaminitis and AKI which are resolving. Primary team nor proceeding with cath be pt has no insurance but prefer for us to be on board to monitor pt from a cardiac standpoint. Also currently there is evidence of anoxic brain injury on brain MRI and ongoing encephalopthay, neurological prognosis unclear

VT/Vfib arrest on 5/11/23 reported ROSC after 60 mins likely 2/2 ischemic event

- TTE 5/16/23: EF 50-55%' HK in Basal IS, basal inf and basal IL segmetn
- HS Trop peak 54 k on 5/11/23
- MRI Brain 5/14/23 shows evidence of anoxic brain injury

#Encephalopathy 2/2 anoxic brain injury
Intubated on PSV not able to be extubated due to encephalopathy?
RLL PNA - Strep
Current smoker
DM2. Poorly controlled
AKI this admission which is now improving
Does not have insurance in US. Resident of Michigan. SW has applied fro Medicaid. For healthcare needs flies to Romania. Per sister was not on any medications at home?

Recommendations

-From a cardiac standpoint patient did have VT arrest as well as possibly an ischemic event given high troponin level on admission with peak of 54 K and wall motion abnormality TTE and he warrants a left heart catheterization for ischemic evaluation. He also has several risk factors for CAD including uncontrolled diabetes, current smoker and poor follow-up with physicians. He was not on any medications prior to admission. However the primary team we will hold off on angiogram from a psychosocial standpoint. Patient seems to have no insurance in the US. He lives out of state in Michigan. Social work has recently applied for Michigan Medicaid. He used to fly out to Romania for healthcare needs. Also not entirely sure what his neurological prognosis. His previous brain MRI on 5/14/2023 showed anoxic brain injury and he has had ongoing encephalopathy which has made extubation challenging.

-Telemetry he does not have significant VT. His study from today shows no VT whatsoever. Currently on Lopressor and 25 Mg twice daily. If he develops VT

- I have ordered a repeat EKG for him tom, one form yesterday showed very poor BL

- Also ordered repeat HS trop for him tonight

- Too late to do Heparin gtt for him he has likely completed his infarct. Cont baby ASA. If LHC is definitely off the table for insurance reason, low threshold to initiate Plavix for him. . On Lipitor 40 mg every day which can be continues , transaminitis is improving

HPI

Ioan is a 62 y.o. male with past medical history of uncontrolled DM2 who was brought in after VT arrest, reported downtime 60 minutes. High-sensitivity troponin peaked at around 54 K, likely had an ischemic event. No known cardiac history before. Patient had poor follow-up with physicians and was reportedly not on any medications prior to admission per sister. His echocardiogram does show wall motion abnormality. He has been intubated since his cardiac arrest. Brain MRI on 5/14/2023 shows anoxic brain injury and he has ongoing encephalopathy which also is making extubation difficult and he is currently on pressure support ventilation. We are being consulted just to monitor him from a cardiac standpoint. His telemetry shows mostly normal sinus rhythm, no significant ventricular arrhythmias. Currently he is on presently 5 Mg twice daily, no amiodarone. When I saw him he was opening his eyes and moving around, not very well sedated but I am not sure if he was following any purposeful commands. I did discuss the case with his primary team. I am told that patient does not have any insurance in the US and he is a resident of Michigan. Social work is applied for Medicaid for him. Not sure if a left heart catheterization would be covered for him. Plan right now is to not proceed with a left heart catheterization unless absolutely necessary.

Pertinent Labs

- AKI resolving

- Transaminitis resolving

History

Past Medical History:

Past Medical History:

Diagnosis	Date

- Diabetes mellitus (CMS/HCC)
- Renal disorder

Past Medical/Family/Surgical History:

I have reviewed, verified and personally updated the past medical, surgical, family, and social history.

Family History:

No family history on file.

Social History:

reports that he has been smoking cigarettes. He does not have any smokeless tobacco history on file. Drug use questions deferred to the physician. No history on file for alcohol use.

Current Meds:

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Admin
• acetaminophen (Tylenol) 650 mg/ 20.3 mL oral solution 650 mg	650 mg	enteral tube	q6h PRN	Valeri Kraskovsky, MD		650 mg at 05/16/23 0828
• arformoterol (Brovana) 15 mcg/2 mL nebulizer solution 15 mcg	15 mcg	nebulization	BID	Christopher J Dowd, NP		15 mcg at 05/16/23 1036
• aspirin chewable tablet 81 mg	81 mg	enteral tube	Daily	Valeri Kraskovsky, MD		81 mg at 05/16/23 0827
• atorvastatin (Lipitor) tablet 40 mg	40 mg	oral	Daily	Raj Thapar, MD		40 mg at 05/16/23 1129
• dextrose 50% (D50W) injection	25 g	intravenous	q15 min PRN	Valeri Kraskovsky, MD		
• dextrose 50% (D50W) injection	25 g	intravenous	q15 min PRN	Marwan Saoud, MD		
• enoxaparin (Lovenox) syringe 40 mg	40 mg	subcutaneous	q24h std	Valeri Kraskovsky, MD		40 mg at 05/16/23 0827
• fentaNYL (Sublimaze) injection 100 mcg	100 mcg	intravenous	q2h PRN	Valeri Kraskovsky, MD		100 mcg at 05/16/23 0234

Provider Notes (continued)

• glucagon injection 1 mg	1 mg	intramuscular	q15 min PRN	Valeri Kraskovsky, MD	
• glucagon injection 1 mg	1 mg	intramuscular	q15 min PRN	Marwan Saoud, MD	
• [START ON 5/17/2023] insulin glargine (Lantus) injection 100 units/mL	10 Units	subcutaneous	Daily at 12 noon (glargine insulin)	Marwan Saoud, MD	
• insulin lispro (HumaLOG) injection - CORRECTION DOSING	0-12 Units	subcutaneous	q6h std	Marwan Saoud, MD	2 Units at 05/16/23 1254
• lansoprazole (Prevacid SoluTab) disintegrating tablet 30 mg	30 mg	enteral tube	Daily	Valeri Kraskovsky, MD	30 mg at 05/16/23 0827
• lidocaine 4 % topical patch 1 patch	1 patch	topical (top)	Daily	Zachary L Tomasik, PA	1 patch at 05/16/23 0828
• metoprolol tartrate (Lopressor) tablet 25 mg	25 mg	enteral tube	BID	Marwan Saoud, MD	
• piperacillin-tazobactam (Zosyn) IVPB 3.375 g mini bag plus in 100 mL NS	3.375 g	intravenous	Q8H Zosyn	Raj Thapar, MD	
• revefenacin (Yupelri) 175 mcg/3 mL nebulizer solution 175 mcg	175 mcg	nebulization	Daily	Christopher J Dowd, NP	175 mcg at 05/16/23 1036
• senna (Senokot) syrup 10 mL	10 mL	enteral tube	BID	Marwan Saoud, MD	
• sodium chloride 0.9 % IV line flushing using 250 ml bag Or	25 mL	intravenous	PRN	Keira S McCarthy, NP	
• sodium chloride 0.9 % IV line flushing using 100 ml bag Or	25 mL	intravenous	PRN	Keira S McCarthy, NP	
• sodium chloride 0.9 % IV line flushing using 50 ml bag	25 mL	intravenous	PRN	Keira S McCarthy, NP	

• sodium chloride 0.9% (flush) syringe 3 mL	3 mL	intravenous	q8h PRN	Keira S McCarthy, NP	3 mL at 05/16/23 1351

Allergies:
Patient has no known allergies.

Problem List
Problem List Items Addressed This Visit

Circulatory
Cardiac arrest (CMS/HCC) - Primary
Overview
VT VF arrest with 60 min downtime prior to ROSC (no TTM due to hemodynamic instability)

Relevant Medications
enoxaparin (Lovenox) syringe 40 mg
aspirin chewable tablet 81 mg
atorvastatin (Lipitor) tablet 40 mg
metoprolol tartrate (Lopressor) tablet 25 mg (Start on 5/16/2023 9:00 PM)

Other Relevant Orders
Transthoracic echo (Transthoracic Echo) complete (Completed)
Transthoracic echo (TTE) limited (Completed)

Review of system
Constitution: Negative for fever, chills, weight gain and weight loss.
HENT: Negative for hearing loss, nosebleeds and sore throat, hemoptysis.
Eyes: Negative for blurred vision and visual disturbance.
Cardiovascular: As described above.
Respiratory: No cough
Endocrine: Negative for cold intolerance, heat intolerance, polydipsia and polyuria.
Hematologic/Lymphatic: Negative for bleeding problem. Does not bruise/bleed easily.
Skin: Negative for poor wound healing and rash.
Musculoskeletal: negative for joint pain and myalgias.
Gastrointestinal: Negative for bloating, diarrhea, constipation, dysphagia, hematochezia, melena, and heartburn.
Genitourinary: Negative for dysuria, hematuria and nocturia.
Neurological: Negative for focal weakness, light-headedness and loss of balance.
Psychiatric/Behavioral: Negative for depression. The patient is not nervous/anxious.

Physical Exam
Visit Vitals

BP	**(!) 159/97**
Pulse	**(!) 102**
Temp	38 °C (100.4 °F) (Esophageal)
Resp	18

General appearance: Intubated. Opening eyes. Moving extremities
HEENT: normocephalic and atraumatic
Cardiovascular: regular rate and rhythm, normal S1, normal S2, no murmurs, no rubs or gallops, preserved pedal pulses, no carotid bruits, no pitting edema lower extremities
Pulmonary: clear to auscultation bilaterally, no wheezing, no rales
GI: soft and nontender
Musculoskeletal: no clubbing, no cyanosis
Integ: no rashes
Psych: appropriate affect
Neurologic; alert, oriented *3

Gumber, Divya, MD
5/16/2023

H&P by Keira S McCarthy, NP at 5/11/2023 10:45 AM

Author: Keira S McCarthy, NP | Service: Critical Care | Author Type: Nurse Practitioner
Filed: 5/11/2023 11:50 AM | Date of Service: 5/11/2023 10:45 AM | Status: Signed
Editor: Keira S McCarthy, NP (Nurse Practitioner)

Catholic Health

MERCY HOSPITAL OF BUFFALO MEDICAL / SURGICAL CRITICAL CARE SERVICE
ADMISSION HISTORY AND PHYSICAL EXAMINATION

Patient Name: Ioan Suiugan
Date of Birth: 2/27/1961
Medical Record #: 286095347

Chief Complaint
Cardiac Arrest

History Of Present Illness
Ioan Suiugan is a 62 y.o. male found down in the parking lot at the GM plant early this morning. Per notes, patient is a trucker from Michigan and initial downtime was not known. CPR was started by bystanders with placement of an AED with 3 shocks delivered prior to arrival of EMS. EMS defibrillated an additional 3 times and gave 5-6 amps of epinephrine. Case discussed with Dr Meltser by ER physician and declined for intervention. He was started on dobutamine and norepinephrine for shock and transferred to SBM for further treatment. Limited history available due to patient being from out of town, there is a note from 2020 in Epic detailing an admission for fross hematuria/renal and ureteral calculous obstruction. Family is currently en route from Michigan to see patient. Admitting to MICU for further evaluation and treatment.

Past Medical History
He has a past medical history of Diabetes mellitus (CMS/HCC) and Renal disorder.

Surgical History
He has no past surgical history on file.

Social History
He reports that he has been smoking cigarettes. He does not have any smokeless tobacco history on file. Drug use questions deferred to the physician. No history on file for alcohol use.Travels for work . Trucker

Family History
His family history is not on file. Family history not obtainable.

Allergies
Patient has no known allergies.

Medications
Prior to Admission medications
Not on File

Review of Systems
Review of Systems
Unable to perform ROS: Patient unresponsive

Physical Exam
Vitals: Blood pressure **(!) 73/61**, pulse **(!) 108**, temperature 37 °C (98.6 °F), resp. rate **(!) 29**, SpO2 98 %.
Physical Exam
Constitutional:
  Appearance: He is ill-appearing.
HENT:
  Head: Normocephalic and atraumatic.
  Mouth/Throat:
  Mouth: Mucous membranes are moist.
  Pharynx: Oropharynx is clear.
Eyes:
  Conjunctiva/sclera: Conjunctivae normal.
  Pupils: Pupils are equal, round, and reactive to light.
Neck:
  Comments: **No JVD, trachea in midline**
Cardiovascular:
  Rate and Rhythm: Regular rhythm. Tachycardia present.
Pulmonary:
  Comments: **Diffusely diminished**
Abdominal:
  Comments: **NG tube with bloody output, hypoactive bowel sounds**
Musculoskeletal:
  Right lower leg: No edema.
  Left lower leg: No edema.
Skin:
  General: Skin is warm.
  Comments: **Feet pale, toes slightly dusky**
Neurological:
  Comments: **Does not follow commands, upper extremities with clonic movements**

Relevant laboratory data, imaging studies, microbiology results were all reviewed.

Assessment:

Patient is a critically ill 62 y/o man who was found down in the parking lot of the GM plant by bystanders. CPR initiated, AED applied with 3 shocks delivered. EMS arrived and transported to KMH ER with an additional 3-4 shocks given as well as 5-6 amps of epinephrine per notes. Patient has been unresponsive since arrival to KMH, declined for cath lab. Transferred to SBM MICU for further evaluation and treatment. Currently requiring vasopressin, norepinephrine and dobutamine for blood pressure support. Family en route from Michigan, expected to arrive in the next 2 hours.

Principal Problem:
  Cardiac arrest (CMS/HCC)
Active Problems:
  Cerebral ischemia
  Coma (CMS/HCC)
  Lactic acidosis
  Hematochezia
  Hypokalemia
  Hyperglycemia
  High anion gap metabolic acidosis
  Acute renal failure with tubular necrosis (CMS/HCC)
  Shock liver

Plan:

PULMONARY: Maintain full vent support, VAP prophylaxis. Will treat for likely aspiration. Started on Propofol for vent synchony. CTA chest ordered and pending to r/o PE
CARDIOVASCULAR: Maintain MAP > 65, currently on norepinephrine/vasopressin/dobutamine. Arterial line placed for continuous blood pressure monitoring. 2D echo ordered and pending. Not currently a candidate for intervention by Cardiology. Trend troponin for peak. Not started on heparin gtt given bloody output from NG tube. Keep K+ > 4, Mag > 2. Trend lactic until wnl
RENAL: Foley catheter for strict I&Os. Trend renal indices. Monitor lytes and replace as needed
INFECTIOUS DISEASE: Esophageal probe for continuous temp monitoring. Trend WBCs. Treating with Unasyn for likely aspiration. Sending pan cultures
GI: Pantoprazole BID given blood NG output. Maintain NPO status
HEME: Trend CBC. Transfuse as needed for hgb < 7
ENDO: Hyperglycemic, starting of insulin gtt. Goal blood glucose 100-180
NEURO: Serial neurochecks. Continuous EEG ordered and pending
Nutrition: NPO
DVT Prophyx: Pneumatic Compression Devices

Care plan discussed with interdisciplinary critical care team.

Critical care time (not including billable procedures) spent addressing organ failure in the cardiovascular, respiratory, gastrointestinal / hepatobiliary, hematologic, neurologic , renal, and endocrinologic systems :30 min

Consults by Maria M White, NP at 5/11/2023 10:45 AM

Author: Maria M White, NP Service: Critical Care Author Type: Nurse Practitioner
Filed: 5/11/2023 11:33 AM Date of Service: 5/11/2023 10:45 AM Status: Addendum
Editor: Maria M White, NP (Nurse Practitioner)

Neurocritical Care Service ConsultationNote

Patient Name: Ioan Suiugan
Date of Birth: 2/27/1961
Medical Record #: 286095347

Reason for consult: cardiac arrest

History Of Present Illness
Ioan Suiugan is a 62 y.o. male presenting with cardiac arrest from Kenmore Mercy Hospital. History was taken from staff and chart as patient is comatose, intubated and sedated. Patient is apparently from out of town and is a truck driver who was found down this morning in the parking lot of GM. Bystander CPR was started and patient did receive shocks upon EMS arrival. According to provider, patient said to have extended time of cardiac arrest, reportedly did achieve ROSC however did have another cardiac arrest. Total downtime said to be above 60 minutes in total. Patient was with shock after ROSC achieved requiring norepinephrine and dobutamine for hemodynamic management. Patient was not able to be started on heparin drip for suspected MI as he was with moderate amounts of blood coming from ET and NG tubes. Patient was subsequently transferred to Mercy Hospital for higher level of care and admitted to medical ICU team with neuro-critical care consult.

Past Medical History
He has a past medical history of Diabetes mellitus (CMS/HCC) and Renal disorder.

Surgical History
Unable to obtain as patient intubated and comatose.

Social History
He reports that he has been smoking cigarettes. He does not have any smokeless tobacco history on file. Drug use questions deferred to the physician. No history on file for alcohol use.

Family History
Unable to obtain as patient intubated and comatose.

Allergies
Patient has no known allergies.

Review of Systems
Review of Systems
Unable to perform ROS: Intubated

Physical Exam
Vitals: Blood pressure 109/65, pulse **(!) 118**, temperature 36.5 °C (97.7 °F), resp. rate **(!) 33**, SpO2 **(!) 94 %**.
Physical Exam
Vitals and nursing note reviewed.
Constitutional:

Appearance: He is ill-appearing.
Comments: **Patient laying in bed, intubated**
HENT:
Head: Normocephalic and atraumatic.
Mouth/Throat:
Mouth: Mucous membranes are moist.
Comments: **ETT/OGT present with blood noted to**
Eyes:
Pupils: Pupils are equal, round, and reactive to light.
Comments: **Pupils ~3mm round with sluggish reaction to light, gaze midline currently**
Pulmonary:
Comments: **Intubated, mechanical ventilation**
Abdominal:
Palpations: Abdomen is soft.
Genitourinary:
Comments: **Foley catheter with dark yellow urine present**
Musculoskeletal:
Cervical back: Neck supple.
Skin:
General: Skin is warm and dry.
Neurological:
Comments: **GCS E1 Vt M1, no response to verbal/tactile/noxious stimuli, pupils ~3mm round with sluggish reaction to light, gaze currently midline, trace spontaneous movement noted to extremities, no involuntary or seizure like movements noted.**

Patient was evaluated on propofol infusion, said to have been previously moving arms against gravity however not following commands or purposeful.

Relevant laboratory data and imaging studies were reviewed.

ASSESSMENT/PLAN:

NEURO
Global cerebral ischemia s/p cardiac arrest
Coma
Shock
- Patient with extended cardiac arrest this morning, reported arrest x2 with total downtime said to be above 60 minutes and was subsequently transferred from Kenmore to Mercy Hospital for higher level of care. At this time, patient not a candidate for targeted temperature management post cardiac arrest due to his hemodynamic instability (currently with SBP in 70-80mmHg range on two vasopressors), also with active bleeding with noted moderate amount of blood noted around nose and mouth. Would continue neuro checks q 1 hour and report acute changes. Plan to obtain CT of head at this time to r/o acute intracranial pathology. Also will place on cEEG to r/o seizures or epileptiform activity. Would avoid fevers, would recommend from neuro standpoint to treat temperature > 99.4°F with acetaminophen as needed. Would avoid hypotension, MAP goal 70-100mmHg as tolerated to ensure cerebral perfusion post cardiac arrest. Would try to wean sedation as safely able to be able to fully evaluate neuro examination.

Provider Notes (continued)

Patient seen and examined with Dr. Alnaji, all plans made and discussed with him. See above for full NCC plan. Discussed with medical ICU team, would continue medical and ventilation management per their discretion. Plan of care also discussed with bedside and charge nurses. CCT spent reviewing labs and imaging, formulating plan of care, and examining patient.

CCT = 35 minutes.

Revision History

	Date/Time	User	Provider Type	Action
>	5/11/2023 11:33 AM	Maria M White, NP	Nurse Practitioner	Addend
	5/11/2023 11:32 AM	Maria M White, NP	Nurse Practitioner	Sign

2 Day Medication Administration Report for Suiugan, Ioan as of 06/16/23 1155

Medications	06/15/23	06/16/23
acetaminophen (Tylenol) tablet 650 mg Dose: 650 mg Freq: Every 6 hours PRN Route: oral PRN Reason: fever Start: 05/26/23 0937 End: 08/24/23 0936 Admin Instructions: Acetaminophen Max Daily Dose Total from all sources Age <30 days 500 mg, Age </= 14 years 3000 mg, Age > 14 years 4000 mg		
amiodarone (Pacerone) tablet 200 mg Dose: 200 mg Freq: Daily Route: oral Start: 06/08/23 0900 End: 07/08/23 0859	1136- Given	(0822)- Not Given 1146- Given [C]
apixaban (Eliquis) tablet 10 mg Dose: 10 mg Freq: 2 times daily Route: oral Start: 05/26/23 2100 End: 06/02/23 0815 Order specific questions: Specify the indication for DOAC use: History of DVT/PE		
Followed by **apixaban (Eliquis) tablet 5 mg** Dose: 5 mg Freq: 2 times daily Route: oral Start: 06/02/23 2100 End: 08/31/23 2059 Order specific questions: Specify the indication for DOAC use: History of DVT/PE	1136- Given 2251- Given	(0822)- Not Given 1148- Given [C] 2100
arformoterol (Brovana) 15 mcg/2 mL nebulizer solution 15 mcg Dose: 15 mcg Freq: 2 times daily respiratory Route: nebu Start: 05/16/23 1045 End: 08/14/23 0659	(0646)- Not Given 1929- Given	0651- Given 1900

atorvastatin (Lipitor) tablet 40 mg Dose: 40 mg Freq: Daily Route: oral Start: 05/16/23 1030 End: 08/14/23 0859	1136- Given	(0822)- Not Given 1148- Given [C]
clopidogrel (Plavix) tablet 75 mg Dose: 75 mg Freq: Daily Route: oral Start: 05/26/23 0900 End: 08/15/23 0859	1137- Given	(0822)- Not Given 1147- Given [C]
dextrose 50% (D50W) injection Dose: 25 g Freq: Every 15 min PRN Route: IV PRN Reason: low blood sugar PRN Comment: severe hypoglycemia Start: 05/26/23 1441 End: 08/24/23 1440 Admin Instructions: Give for blood glucose value less than 70 mg/dL if patient unconscious or not alert. Repeat as ordered until blood glucose above 70 mg/dL.		
glucagon injection 1 mg Dose: 1 mg Freq: Every 15 min PRN Route: IM PRN Reason: low blood sugar PRN Comment: severe hypoglycemia Start: 05/26/23 1441 End: 08/24/23 1440 Admin Instructions: May give IM or SQ if no IV access, give for blood glucose value less than 45 mg/dL if patient unconscious or not alert. Caution: glucagon can cause nausea and vomiting. Roll patient on their side when administering to prevent aspiration.		
insulin glargine (Lantus) injection 100 units/mL Dose: 30 Units Freq: Daily at 12 Noon Route: subQ Start: 05/26/23 1200 End: 08/12/23 1159 Admin Instructions: Before holding basal insulin, contact provider for approval to hold. BKC-(Black dispose) Dispose of leftover medication in black waste container	1229- Given	1200

insulin lispro (HumaLOG) injection - CORRECTION DOSING Dose: 0-6 Units Freq: Nightly Route: subQ Start: 05/26/23 2200 End: 08/24/23 2159 Admin Instructions: Moderate Intensity regimen BKC-(Black dispose) Dose of leftover medication in black waste container Order specific questions: BG 140-180: 0 BG 181-220: 0 BG 221-260: 2 BG 261-300: 4 BG 301-350: 6 BG > 350: 6 BG > 350 instructions: Call provider	**(2250)-** **Not Given**	2200
insulin lispro (HumaLOG) injection - CORRECTION DOSING Dose: 0-12 Units Freq: 3 times daily before meals insulin Route: subQ Start: 05/26/23 1630 End: 08/24/23 1629 Admin Instructions: Moderate Intensity regimen BKC-(Black dispose) Dose of leftover medication in black waste container Order specific questions: BG 140-180: 2 BG 181-220: 4 BG 221-260: 6 BG 261-300: 8 BG 301-350: 10 BG > 350: 12 BG > 350 instructions: call provider	**(0811)-** **Not Given** **(1228)-** **Not Given** **(1657)-** **Not Given**	**(0735)-** **Not Given** 1130 1630
lansoprazole (Prevacid SoluTab) disintegrating tablet 30 mg Dose: 30 mg Freq: Daily Route: oral Start: 05/26/23 0900 End: 08/12/23 0859 Admin Instructions: For NG tube administration, place tablet in oral syringe, draw up 4 mL water, and administer within 15 minutes of dissolving. Refill syringe with 5mL water, shake gently, and use to flush the NG tube.	**1137-** **Given**	**(0822)-** **Not Given**
lidocaine 4 % topical patch 1 patch Dose: 1 patch Freq: Daily Route: top Start: 05/14/23 0900 End: 08/12/23 0859 Admin Instructions: Apply to chest. Remove current patch before administering new patch.	**(1235)-** **Not Given**	**(0828)-** **Not Given**
melatonin tablet 5 mg Dose: 5 mg Freq: Nightly Route: oral Start: 06/14/23 2200 End: 06/21/23 2159	**2251-** **Given**	2200

metoprolol tartrate (Lopressor) tablet 50 mg Dose: 50 mg Freq: Every 6 hours standard Route: oral Start: 05/26/23 0000 End: 06/19/23 1159	0111- Given 0524- Given 1137- Given 1657- Given	0017- Given 0552- Given 1136- Given 1800
nicotine (Nicoderm CQ) 21 mg/24 hr patch 1 patch Dose: 1 patch Freq: Daily Route: TD Start: 05/27/23 1330 End: 08/25/23 0859 Admin Instructions: Remove current patch before administering new patch. Order specific questions: Time to remove patch: 9:00 PM	1140- Medication Applied 2252- Medication Removal	0822- Medication Applied 2100 (Medication Removal)
OLANZapine (Zyprexa) tablet 5 mg Dose: 5 mg Freq: 2 times daily Route: oral Start: 06/14/23 2100 End: 09/11/23 2059 Admin Instructions: AM and HS	1137- Given 2251- Given	(0822)- Not Given 2100
ondansetron (Zofran) injection 4 mg Dose: 4 mg Freq: Every 6 hours PRN Route: IV PRN Reasons: nausea,vomiting Start: 05/21/23 0426 End: 08/19/23 0425 Admin Instructions: First choice antiemetic		
revefenacin (Yupelri) 175 mcg/3 mL nebulizer solution 175 mcg Dose: 175 mcg Freq: Daily respiratory Route: nebu Start: 05/16/23 1045 End: 08/14/23 0659	(0647)- Not Given	0651- Given

sodium chloride 0.9 % IV line flushing using 250 ml bag Dose: 25 mL Freq: As needed Route: IV PRN Reason: secondary IV line flush Start: 05/11/23 1009 End: 08/09/23 1008 Admin Instructions: This fluid is to be used as a temporary "primary" fluid to clear the IV tubing of remaining medication when a patient requires a secondary piggyback infusion and is without a current primary fluid infusing. 1) Look up the rate of the secondary infusion (PB to be administered). This rate can be found in the EPIC MAR. 2) Select line flush NS in Alaris. This is the primary, NS 250ml bag. 3) Program the rate for the primary which needs to be the same rate as the infusion rate of the secondary. 4) Primary volume to be infused = 25ml. This amount will clear the tubing of remaining medication. 5) Select secondary, search for the medication in the Alaris library & program the pump. 6) Begin infusion.		
Or **sodium chloride 0.9 % IV line flushing using 100 ml bag** Dose: 25 mL Freq: As needed Route: IV PRN Reason: Line flush for secondary IV Start: 05/11/23 1009 End: 08/09/23 1008 Admin Instructions: This fluid is to be used as a temporary "primary" fluid to clear the IV tubing of remaining medication when a patient requires a secondary piggyback infusion and is without a current primary fluid infusing. 1) Look up the rate of the secondary infusion (PB to be administered). This rate can be found in the EPIC MAR. 2) Select line flush NS in Alaris. This is the primary, NS 250ml bag. 3) Program the rate for the primary which needs to be the same rate as the infusion rate of the secondary. 4) Primary volume to be infused = 25ml. This amount will clear the tubing of remaining medication. 5) Select secondary, search for the medication in the Alaris library & program the pump. 6) Begin infusion.		

Or **sodium chloride 0.9 % IV line flushing using 50 ml bag** Dose: 25 mL Freq: As needed Route: IV PRN Reason: Flush for secondary IV line Start: 05/11/23 1009 End: 08/09/23 1008 Admin Instructions: This fluid is to be used as a temporary "primary" fluid to clear the IV tubing of remaining medication when a patient requires a secondary piggyback infusion and is without a current primary fluid infusing. 1) Look up the rate of the secondary infusion (PB to be administered). This rate can be found in the EPIC MAR. 2) Select line flush NS in Alaris. This is the primary, NS 250ml bag. 3) Program the rate for the primary which needs to be the same rate as the infusion rate of the secondary. 4) Primary volume to be infused = 25ml. This amount will clear the tubing of remaining medication. 5) Select secondary, search for the medication in the Alaris library & program the pump. 6) Begin infusion.		
sodium chloride 0.9% (flush) syringe 10 mL Dose: 10 mL Freq: Daily PRN Route: cath PRN Reason: line care Start: 05/22/23 1537 End: 08/20/23 1536 Admin Instructions: Flush line after each use- at least q 12h		
sodium chloride 0.9% (flush) syringe 3 mL Dose: 3 mL Freq: Every 8 hours PRN Route: IV PRN Reason: line care PRN Comment: Intermittent IV trap should be flushed a minimum of every 12 hours with 3ml or more of normal saline Start: 05/23/23 1950 End: 08/21/23 1949 Admin Instructions: Flush line after each use- at least q 12h		
sodium chloride 0.9% (flush) syringe 3 mL Dose: 3 mL Freq: Every 8 hours PRN Route: IV PRN Reason: line care Start: 05/11/23 1009 End: 08/09/23 1008 Admin Instructions: Flush line after each use- at least q 12h		

tamsulosin (Flomax) 24 hr capsule 0.4 mg Dose: 0.4 mg Freq: Daily with breakfast Route: oral Start: 06/10/23 1000 End: 09/08/23 0759 Admin Instructions: Do not crush, chew, or split.	1136- Given	(0822)- Not Given

Completed Medications

Medications	06/15/23	06/16/23
LORazepam (Ativan) injection 1 mg Dose: 1 mg Freq: Once Route: IV Start: 06/15/23 1315 End: 06/15/23 1300 Admin Instructions: Dilute drug volume with an equal amount of sterile water or normal saline. Give at no faster than 2 mg/min.	1300- Given	
OLANZapine (Zyprexa) injection 5 mg Dose: 5 mg Freq: Once Route: IM Start: 06/16/23 1145 End: 06/16/23 1135 Admin Instructions: IM injection: Inject deeply into the gluteal muscle to minimize tissue irritation. Do not inject more than 5 mL into any one site. Use solution within 1 hour; discard any unused portion. Do not administer intra-arterially. Intravenous for off label use, administer by rapid IV push. Immediately after use, dispose of syringe in approved sharps box. (*Dissolve the contents of the vial using 2.1 mL of Sterile Water for Injection to provide a solution containing approximately 5 mg/ml; refer to manufacturer table for injection volumes and corresponding doses*) Dissolve completely; resulting solution should be clear and yellow.		1135- Given

Discontinued Medications

Medications	06/15/23	06/16/23
sennosides-docusate sodium (Peri-Colace) 8.6-50 mg per tablet 1 tablet Dose: 1 tablet Freq: Nightly PRN Route: oral PRN Reason: constipation Start: 06/13/23 0111 End: 06/16/23 0110 Admin Instructions: Hold for loose stools.		

24 Hour Results

ID	Description	Status	Collection Date/Time
96084460	CBC (Abnormal)	Final result	06/15/23 0624

Result	Value	Flag	Comment
WBC	13.0	High	
RBC	4.30	Low	
Hemoglobin	12.8	Low	
Hematocrit	38.4	Low	
MCV	89.2		

24 Hour Results (continued)

ID	Description		Status		Collection Date/Time
	MCH	29.7			
	MCHC	33.3			
	RDW	13.6			
	Platelets	323			
	MPV	7.5			
96084461	**Basic metabolic panel (Abnormal)**		Final result		06/15/23 0624
	Result	Value	Flag	Comment	
	Glucose	**113**	**High**		
	BUN	10			
	Creatinine, Serum	**0.75**	**Low**		
	Bun/Creatinine Ratio	13.3			
	Sodium	139			
	Potassium	4.1			
	Chloride	101			
	CO2	28			
	Anion Gap	10			
	Calcium	**8.5**	**Low**		
	GFR	>90.0		Effective 5/11/2022, Calculation based on the Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) equation refit without adjustment for race	
96084462	**Magnesium** ()		Final result		06/15/23 0624
	Result	Value	Flag	Comment	
	Magnesium	1.9			
96084481	**CBC**		Canceled		--
96084482	**Basic metabolic panel (Abnormal)**		Final result		06/16/23 0749
	Result	Value	Flag	Comment	
	Glucose	**151**	**High**		
	BUN	18			
	Creatinine, Serum	1.01			
	Bun/Creatinine Ratio	17.8			
	Sodium	**134**	**Low**		
	Potassium	4.4		Sample is slightly hemolyzed, result may be affected.	
	Chloride	103			
	CO2	**19**	**Low**		
	Anion Gap	**12**	**High**		
	Calcium	**8.1**	**Low**		
	GFR	**84.1**	**Low**	Effective 5/11/2022, Calculation based on the Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) equation refit without adjustment for race	
96084483	**Magnesium** ()		Final result		06/16/23 0749
	Result	Value	Flag	Comment	
	Magnesium	1.8			
95890574	**POCT glucose meter (Abnormal)**		Final result		06/14/23 1553
	Result	Value	Flag	Comment	
	Glucose, Poc	**156**	**High**		

24 Hour Results (continued)

ID	Description		Status		Collection Date/Time
96084466	**POCT glucose meter (Abnormal)**		Final result		06/14/23 2116
	Result	Value	Flag	Comment	
	Glucose, Poc	**194**	**High**		
96084475	**POCT glucose meter (Abnormal)**		Final result		06/15/23 1129
	Result	Value	Flag	Comment	
	Glucose, Poc	**103**	**High**		
96084478	**POCT glucose meter (Abnormal)**		Final result		06/15/23 1650
	Result	Value	Flag	Comment	
	Glucose, Poc	**162**	**High**		
96084489	**POCT glucose meter (Abnormal)**		Final result		06/15/23 2249
	Result	Value	Flag	Comment	
	Glucose, Poc	**146**	**High**		
96084491	**POCT glucose meter (Abnormal)**		Final result		06/16/23 0723
	Result	Value	Flag	Comment	
	Glucose, Poc	**159**	**High**		

Intake/Output

None

Recent Lines/Drains/Airways/Wounds

Active LDAs

Name	Placement date	Placement time	Site	Days
Midline Single Lumen 05/31/23 Right Basilic	05/31/23	0844	Basilic	16
Rash 06/06/23 1700 other (see comments) perineum other (see comments)	06/06/23	1700	—	9
Rash 06/06/23 1700 other (see comments) groin	06/06/23	1700	—	9
Wound 06/06/23 Skin Tear Buttocks Right	06/06/23	1700	Buttocks	9

Inactive LDAs

Name	Placement date	Placement time	Removal date	Removal time	Site	Days
[REMOVED] Urethral Catheter 16 Fr.	06/09/23	0157	06/15/23	1330	—	6

Medication List

	Morning	Afternoon	Evening	Bedtime	As Needed
START **amiodarone** 200 mg tablet Commonly known as: Pacerone Start taking on: June 17, 2023 Take 1 tablet (200 mg total) by mouth 1 (one) time each day.					
START **apixaban** 5 mg tablet Commonly known as: Eliquis Take 1 tablet (5 mg total) by mouth in the morning and 1 tablet (5 mg total) before bedtime.					
START **atorvastatin** 40 mg tablet Commonly known as: Lipitor Start taking on: June 17, 2023 Take 1 tablet (40 mg total) by mouth 1 (one) time each day.					
START **clopidogrel** 75 mg tablet Commonly known as: Plavix Start taking on: June 17, 2023 Take 1 tablet (75 mg total) by mouth 1 (one) time each day.					
START **insulin glargine** 100 unit/mL injection Commonly known as: Lantus Inject 0.3 mL (30 Units total) under the skin 1 (one) time each day at 12 Noon.					
START **lansoprazole** 30 mg disintegrating tablet Commonly known as: Prevacid SoluTab Start taking on: June 17, 2023 Take 1 tablet (30 mg total) by mouth 1 (one) time each day. Dissolve on tongue before swallowing particles; do not chew, cut, break, or swallow whole.					
START **metoprolol tartrate** 50 mg tablet Commonly known as: Lopressor Take 1 tablet (50 mg total) by mouth every 6 (six) hours.					
START **OLANZapine** 5 mg tablet Commonly known as: Zyprexa Take 1 tablet (5 mg total) by mouth in the morning and 1 tablet (5 mg total) before bedtime.					
START **QUEtiapine** 25 mg tablet Commonly known as: Seroquel Take 1 tablet (25 mg total) by mouth every night.					

Medication List (continued)

	Morning	Afternoon	Evening	Bedtime	As Needed
START **tamsulosin** 0.4 mg 24 hr capsule Commonly known as: Flomax Start taking on: **June 17, 2023** Take 1 capsule (0.4 mg total) by mouth 1 (one) time each day with breakfast.					

Where to pick up your medications

Pick up these medications at CVS/pharmacy #8066 - SOUTH LYON, MI - 22421 PONTIAC TRAIL AT CORNER OF 9 MILE ROAD

- QUEtiapine 25 mg tablet

Address: 22421 PONTIAC TRAIL, SOUTH LYON MI 48178
Phone: 248-437-8131

Ask your doctor where to pick up these medications

- amiodarone 200 mg tablet
- apixaban 5 mg tablet
- atorvastatin 40 mg tablet
- clopidogrel 75 mg tablet
- insulin glargine 100 unit/mL injection
- lansoprazole 30 mg disintegrating tablet
- metoprolol tartrate 50 mg tablet
- OLANZapine 5 mg tablet
- tamsulosin 0.4 mg 24 hr capsule

Instructions

Follow-up with primary care physician within 1 to 2 weeks.
Follow-up with cardiology within 1 to 2 weeks.
Follow-up with urology within 1 to 2 weeks.