



Number of pages:

16

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Home Medical Equipment

Durable medical equipment
Respiratory services
Orthotics and prosthetics

Traditional Home Healthcare

Nursing
Physical, occupational and speech language therapy
Other home care services

Home Infusion Services

Injectables
Acute infusion
Chronic infusion

HomeSTAR®

Readmission Prevention

Transitional Care Services
Interventions educate and build self-management skills post-discharge

Sleep Management Solutions (SMS)

Sleep testing & therapy utilization
On-going therapy support

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To	Carelink
Fax Number	18566917105
Date	Friday, November 06, 2015
From	Daniely, Lisa
Phone	
Fax	2

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Nov. 6. 2015 3:03PM

SMH 4H CD CARE 6099264721

No. 5049 P. 1

**SHORE**MEDICAL
CENTER**Care Management****FAX TRANSMISSION
COVER SHEET****Sender**Department Name: Case ManagementSender's Name: Steve HepdingPhone Number: 609-653-4685Fax Number: 609-926-4721**Recipient**Recipient Organization/Facility Name: CareCentrixRecipient Name: CHASSARecipient Phone Number: 888 999 2422Recipient Fax Number: 800 700 2085Steve Hepding, RN

Name of Person Releasing Information

11/6

Date

a.m. / p.m.

Time

Information faxed:

Patient # 5842005 HIGBEE, YNIAHOME RTI SCHED SCHED 11/9 MondayDIC PLAN HOME TEST 11/6-7

Total number of pages faxed (including this cover sheet): _____

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Nov. 6. 2015 3:03PM

SMH 4H CO CARE 6099264721

No. 5049 P. 2

State of New Jersey
PRESCRIPTION BLANK

MAE VARGAS, MSN, APN-C
SHORE MEDICAL CENTER
ONE EAST NEW YORK AVENUE
SOMERS POINT, NJ 08244
PH. (609) 926-4779 FAX (609) 926-4799
NPI #1396839361

CERTIFICATION # 26NN08195800 DEA # MV0692485

COLLABORATING PHYSICIAN

NAME CHARLES V. ROCHE II, MD LICENSE # 26MA08665700
(Enter Address and Phone Number only if different from above)

ADDRESS _____ PHONE # _____

PATIENT *Hesper YN12* D.O.B. _____
ADDRESS _____ DATE *11/6/15*

☐ *Home PT*
lure
dx
dx medicines
Bar

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____
DO NOT REFILL _____ SIGNATURE OF PRESCRIBER *[Signature]*
REFILL _____ TIMES _____

Use a separate form for each controlled substance prescription.
THEFT, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PUNISHABLE BY LAW.

AESMC1014000224

Nov. 6. 2015 3:03PM

SMH 4H CO CARE 6099264721

No. 5049 P. 3

SHORE MEDICAL CENTER
 SOMERS POINT, NJ 08244

INPATIENT REGISTRATION

Patient / FIN Number ▶

401031831

E/R NO. 601031831

Medical Record Number ▶

898815

E/R NO.

Admission Date 11/04/15	Admit Time 11:35	N. Sta. 1W	Room 002	Bed A	P. Type I	Serv. MED	Admitting Physician ADIGUN MD, JENNIFER	FC J	#In. 	Smk
Patient Name Last First HIGBEE, YNID J							Social Security 151-52-8210	Telephone No. 609-742-5425		Previous Adm.
Address Street City State Zip 401 OCEAN HEIGHTS AV SOMERS POINT NJ 08244							Birth Date 1/03/56	Church 		
Age 59Y	Sex F	Marital St. M	Rel. HE	Race 1	Employer Name RETIRED		Patient Employer Phone 			
Employer Address Street City State Zip 							Nearest Relative Name HIGBEE, CHRISTOPHER R			
Relative Address Street City State Zip 401 OCEAN HEIGHTS AV SOMERS POINT NJ 08244							Relationship HUSBAND	Relative Phone 609-742-5426		
Guarantor Name Last First HIGBEE, YNID J							No. 898815	Guarantor Phone 609-742-5425		Occupation DISABILITY
Guarantor Address Street City State Zip 401 OCEAN HEIGHTS AV SOMERS POINT NJ 08244							S. S. # 151-52-8210	Guarantor Employer Phone 		
Guarantor Employer RETIRED							Guarantor Employer Address Street City State Zip 			
Insurance Company CIGNA HEALTHCARE							Policy No. DAC326S011708800	Subscriber 22464 HIGBEE, CHRISTOPHER R		Relationship 02
Insurance #2 MEDICARE A INP.							151528210A	10356 HIGBEE, YNID J		01
Insurance #3 										
Admitting Diagnosis UPPER EXTREMITY WEAKNESS CVA								Admitting Diagnosis Code 		
Adm. Priority EM	R.I. Y	P.A.T. N	LAB # 	HIPAA RES-N R.ORG-M			Adv. Dir N	Organ Donor N	Admit By 	
Print Date/Time: 11/04/15 11:47:30										
FINAL DIAGNOSIS: DO NOT ABBREVIATE										
Principal Diagnosis: (Condition Established After Study to be Responsible for Hospitalization)										
Other Diagnosis or Complications (List All Diagnosis and Complications including Infection & Drug Reaction)										
Operations or Procedures with Dates										
RESULT ▶ ☐ Recovered ☐ Improved ☐ Not Improved ☐ Not Treated ☐ Diagnosis Only ☐ Exp ☐ Release Against Medical Advice DISPOSITION ▶ ☐ Follow-Up Office Visit in Days/Wks ☐ To Referring Physician ☐ Nursing Home ☐ Home Care ☐ AMA ☐ Other Institution I Have Examined and Approved this Complete Medical Record Date _____ Signature of Attending Physician _____										

8241.01 5/12

CHART COPY

CHART COPY
DO NOT REMOVE

Nov. 6. 2015 3:04PM

SMH 4H CO CARE 6099264721

No. 5049 P. 4

Shore Medical Center

History & Physical

HIGBEE, YNID J - 0898815

* Preliminary Report *

Result Type: History & Physical
Result Date: November 04, 2015 05:06
Result Status: Transcribed
Result Title: HP_DCMT
Performed By: ADIGUN, JENNIFER O on November 04, 2015 05:06
Encounter info: 401031831, SMH, Inpatient, 03-Nov-2015 -
Contributor system: MDITRANS

* Preliminary Report *

SHORE MEDICAL CENTER
Somers Point, NJ 08244

HISTORY AND PHYSICAL

PATIENT NAME: HIGBEE, YNID
MEDICAL RECORD NUMBER: 000898815
ACCOUNT NUMBER: 401031831
DATE OF BIRTH: 01/03/1956
LOCATION: 1W 0002
DATE OF ADMISSION: 11/03/2015
ATTENDING PHYSICIAN: JENNIFER ADIGUN, MD

HISTORY SOURCE: History is from the patient.

PRIMARY CARE PROVIDER: Primary Housecall Providers/Dr. Trumbauer.

CODE STATUS: Full code.

CHIEF COMPLAINT: Left upper extremity weakness and pain for the past 3 days.

HISTORY OF PRESENT ILLNESS: This is a 59-year-old Caucasian female whose past medical history is significant for fibromyalgia, COPD, hypothyroidism, diabetes, hypertension, depression, pneumonia, amongst others as will be detailed below.

The patient states that for the past 3 days she has been experiencing pain, weakness, tingling sensation, and numbness to her left upper extremity and left lower extremity. She states that she is unable to supinate her left upper extremity, has a sensation that

she has knot tied around her triceps region in her left upper arm. She states that due to

her fibromyalgia, she does get pain from time to time in her bilateral upper extremities,

but states that this is unusual for her usual pattern of fibromyalgia. She denies any history of recent falls. Her last fall was in 07/2015. She denies any recent falls. The

Printed by: HEPDING, STEVEN W-RN
Printed on: 06-Nov-2015 12:39

Page 1 of 4
(Continued)

Nov. 6. 2015 3:04PM

SMH 4H CO CARE 6099264721

No. 5049 P. 5

Shore Medical Center

History & Physical

HIGBEE, YNID J - 0898815

* Preliminary Report *

patient states that she also been experiencing pain, numbness, tingling sensation, also down her entire left leg, especially around her left shin As a result, she has been unable to stand. She also states she has been experiencing headaches for the past 1 month, diffuse, throbbing. No known aggravating or relieving factors, not associated or related to time of day. She states she had some subjective fevers on this day of presentation. Due to her fibromyalgia, she also states she has neck stiffness and is not sure if what she is experiencing is new or old. The patient also appeared to have generalized body aches and pains and numbness in other body parts as well.

PAST MEDICAL HISTORY:

1. Hypertension.
2. Hyperlipidemia.
3. Diabetes.
4. Diabetic neuropathy with Charcot foot, status post _____ fifth toe amputations.
5. Anxiety and depression.
6. Chronic lower extremity edema.
7. Sedentary lifestyle/wheelchair bound due to generalized body aches and pains.
8. Chronic obstructive pulmonary disease.
9. Hypothyroidism.

PAST SURGICAL HISTORY: Significant for

1. Amputation of her _____ small fifth toe secondary to diabetic osteomyelitis.
2. Gastric bypass due to obesity.
3. Appendectomy in 01/2010.
4. Bilateral cataract removal.
5. Right hip ORIF.
6. Multiple debridements of her feet.
7. Total abdominal hysterectomy.

FAMILY HISTORY: Significant for lung cancer, breast cancer in her mom. Renal cancer in her dad.

SOCIAL HISTORY: The patient is married. No smoking, alcohol, or illicit drug use.

REVIEW OF SYSTEMS: All systems reviewed by me and found to be negative, otherwise noted in HPI.

ALLERGIES:

1. Biaxin.
2. Bactrim.

MEDICATIONS:

1. Nifedipine 90 mg daily.
2. Lasix 40 mg b.i.d.

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Printed on: 06-Nov-2015 12:39

Page 2 of 4
(Continued)

Nov. 6. 2015 3:04PM SMH 4H CO CARE 6099264721

No. 5049 P. 6

Shore Medical Center

History & Physical

HIGBEE, YNID J - 0898815

* Preliminary Report *

3. Sertraline 100 mg b.i.d.
4. Oxycodone 30 mg q.6h p.r.n. and 80 mg q.12h.
5. Terazosin 1 mg at bedtime.
6. Levothyroxine 88 mcg daily in addition to 150 mcg daily.
7. Metformin 1000 mg daily.

PHYSICAL EXAMINATION: On examination in the emergency room, vital signs revealed a blood pressure of 143/71, respiratory rate of 17, heart rate was 68, temperature is 37.4. She weighed 93.2 kg. Saturating at 98% on 2 liters. General examination: Middle-aged female who is sitting upright in bed. She appears in distress, in no respiratory distress. She is afebrile to touch. HEENT: Normocephalic, atraumatic. She is not pale or jaundiced. Her pupils are equal, round, and reactive to light and accommodation. Extraocular muscles are intact. External ears and nose appear normal. Neck is supple, free range of motion. No JVD, thyroid nodes or midline masses. Respiratory: Clear to auscultation bilaterally with good respiratory effort. Cardiovascular: S1, S2, regular rate and rhythm. Abdomen is soft, nontender, nondistended. Bowel sounds are present. Extremities reveal chronic venostasis changes, mild edema, tenderness in her bilateral lower limbs, including her anterior shin and calf. Peripheral pulses are more diminished on the left than on the right. Both feet are warm. Neurologic: Awake, alert, oriented x3. The patient demonstrates weakness in her left upper extremity, 2 to 3/5 in her left upper extremity and 3 to 4/5 in her left lower extremity. Sensation is intact. Musculoskeletal examination: The patient demonstrates tender points in her left upper triceps region, her left shoulder, back of her neck, left hip, left shin.

INVESTIGATIONAL WORKUP: WBC is 8.8, hemoglobin is 11.7, platelet count is 316. INR is 1.0. Chemistry has a sodium of 139, potassium of 4.8, chloride of 102, bicarbonate 31, BUN is 24, creatinine 0.7, glucose level is 87. First set of troponin is negative at 0.084. CT of the head shows no acute intracranial process. Chest x-ray shows bibasilar infiltrates, right greater than left. Also, the presence of air in the stomach with increased perihilar and pulmonary vascular markings in her bilateral upper lobes, which appears unchanged since 09/2015.

ASSESSMENT AND PLAN:

1. Elderly female with history and presentation as noted above. She has been admitted for upper extremity weakness, rule out cerebrovascular accident with atypical presentation. Differentials include fibromyalgia exacerbation, especially given her recent hospitalization for bilateral pneumonia in 09/2015. At this time, she does

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Printed on: 06-Nov-2015 12:39

Page 3 of 4
(Continued)

Nov. 6. 2015 3:05PM SMH 4H CO CARE 6099264/21

No. 5049 P. 1

Shore Medical Center

History & Physical

HIGBEE, YNID J - 0898815

* Preliminary Report *

not

demonstrate any cough or fever. Her symptoms are mainly centered around generalized

aches and pains. We will consult infectious disease to reassess need for antibiotic

treatment. She also does not show any leukocytosis. Since her chest x-ray is still showing bilateral infiltrates, which I believe from previous in September for which

she had been treated, and we will continue to follow for resolution. We will get an

MRI of her head and neck, as well as MRA, obtain a neurologist consultation.

2. The patient also complained about progressively worsening dysphagia to both solids and liquids. We will consult gastroenterology for a possible esophagogastroduodenoscopy and other upper GI series workup for dysphagia.

3. Diabetes. We will monitor weight-based insulin protocol.

4. Hypertension.

5. Anxiety and depression.

6. Chronic pain syndrome. We will continue the patients home narcotics and refrain and

discourage use of IV while she is here.

7. Condition is guarded. Investigational workup and management plan discussed with the

patient. She expresses understanding and she is in agreement.

DICTATED BY: JENNIFER ADIGUN, MD [3106]

DD: Wed Nov 04 05:06:58 2015

DT: Wed Nov 04 06:11:51 2015

94948288 / 96926

CC:

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Page 4 of 4
(End of Report)

Nov. 6. 2015 3:05PM

SMH 4H CO CARE 6099264721

No. 5049 P. 8

Shore Medical Center**Consultation****HIGBEE, YNID J - 0898815***** Final Report ***

Result Type: Consultation
Result Date: November 04, 2015 13:54
Result Status: Auth (Verified)
Result Title: CO DCMT
Performed By: ROELTGEN, DAVID P on November 04, 2015 13:54
Verified By: ROELTGEN, DAVID P on November 04, 2015 16:51
Encounter Info: 401031831, SMH, Inpatient, 03-Nov-2015 -
Contributor system: MDITRANS

*** Final Report ***

SHORE MEDICAL CENTER
Somers Point, NJ 08244

CONSULTATION

PATIENT NAME: HIGBEE , YNID
MEDICAL RECORD NUMBER: 000898815
ACCOUNT NUMBER: 401031831
DATE OF BIRTH: 01/03/1956
LOCATION: NH 0479
DATE OF ADMISSION: 11/04/2015
DATE OF CONSULTATION: 11/04/2015
REQUESTING PHYSICIAN:
CONSULTING PHYSICIAN: DAVID ROELTGEN, MD

HISTORY OF PRESENT ILLNESS: This is a 59-year-old lady with fibromyalgia, COPD, hypothyroidism, diabetes, hypertension, depression, pneumonia, sedentary lifestyle with wheelchair bound due to generalized body pain, chronic lower extremity edema, anxiety and depression, diabetic neuropathy with Charcot foot, previous toe amputation, hyperlipidemia, hypertension, and hypothyroidism.

She has had a gastric bypass due to obesity, multiple debridements of her feet, total hysterectomy, right hip ORIF, and an appendectomy. She had the abrupt onset of weakness in her hand. She also notes numbness. She has been unable to use her hand since the onset yesterday. With this, she indicates she has her chronic headache, but it is without change. She has had no change in vision. She has had no change in speech or trouble swallowing. She has had no numbness or tingling on her face. She has the usual tingling and numbness in her feet, but no change with the present illness. She has no lateralized symptoms in her legs. She has pain in her arm, which is difficult to distinguish from her chronic pain, but she has had no pain in her shoulder or

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Printed on: 06-Nov-2015 12:39

Page 1 of 4
(Continued)

Nov. 6. 2015 3:05PM SMH 4H CO CARE 6099264721

No. 5049 P. 9

Shore Medical Center

Consultation

HIGBEE, YNID J - 0898815

* Final Report *

preceding
pain behind her shoulder. She has no neck pain.

FAMILY HISTORY: Significant for lung cancer and breast cancer, as well as renal cancer.

SOCIAL HISTORY: She does not smoke, drink alcohol, or use recreational drugs.

REVIEW OF SYSTEMS: A 12 point system review, with the exception of the present illness and the diagnoses noted therein, is unremarkable.

ALLERGIES: She has allergies to Biaxin and Bactrim.

MEDICATIONS: At the time of admission included nifedipine, Lasix, sertraline, oxycodone, terazosin, levothyroxine, and metformin.

PHYSICAL EXAMINATION: Blood pressure is 147/72. She is afebrile. Pulse is 61, respirations are 18. Her pulse has been in the 50s through much of the hospitalization. She has bilateral pitting edema of both legs. She has stasis dermatitis in both legs. I could not feel her peripheral pulses.

On mental status examination, she is awake, alert and attentive. She is very anxious. She is somewhat tangential in her thinking and in her speech. Comprehension of conversational language and commands is intact. She is well oriented.

On cranial nerve assessment, pupils are equal and reactive to light. The fundi are not well visualized. The fields are full, though she has some difficulty cooperating. The extraocular movements are intact. Facial sensation is intact to pin and touch. Facial movement is normal. Hearing is intact to voice. The uvula elevates in midline and the tongue protrudes in the midline. The shoulder shrug is symmetrical.

On motor examination, she has 2/5 strength of the intrinsic muscles of the hand on the left, as well as wrist flexion and extension. She has 4/5 at the elbow and 5/5 at the shoulder. Tone is diminished at the wrist.

The remainder of her motor examination shows no focal weakness or abnormality to tone in the other 3 extremities. She has no focal atrophy. There are no abnormal involuntary movements.

Sensory examination shows a distal decrease to all modalities, pin, touch, position, and vibration. Additionally, temperature is symmetrical in her hands and pin is relatively

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Page 2 of 4
(Continued)

Nov. 6. 2015 3:05PM SMH 4H CO CARE 6099264721

No. 5049 P. 10

Shore Medical Center**Consultation****HIGBEE, YNID J - 0898815***** Final Report ***

symmetrical, but touch, position, and vibration are diminished in the left hand.

Her reflexes are symmetrical at 1+ throughout at the biceps, brachialis, triceps, knees, and ankles. Because of sore feet she refused Babinski testing.

Finger-to-nose on the right is without dysmetria and toe-to-finger without dysmetria.

Because this lady does not walk on a regular basis, station and gait were not tested.

An MRI scan of the brain is pending, as is carotid duplex. A CT scan of the head showed no definite abnormalities.

This presentation is highly suggestive of a cortical stroke in the right hemisphere given that motor and sensory findings are equally affected and it appears to be more cortical sensations than primary sensation, such as pin and temperature. A lesion in the white matter of the internal capsule is also in the differential diagnosis.

RECOMMENDATIONS: For an aggressive stroke workup and treatment, and in particular, starting the patient on an antiplatelet agent, as I can find no clear contraindication to such management and apparently she has not been on an antiplatelet agent in the past.

I think it is also reasonable to add a statin to her treatment because as best I can determine she has not been on a statin in the past, either.

Thank you for this consultation.

Dictated by: DAVID ROELTGEN, MD [3164]

DD: Wed Nov 04 13:54:19 2015
DT: Wed Nov 04 16:22:50 2015
94958948 / 95434

CC:

Signature Line

Electronically Signed On: 04-Nov-15 04:51 PM

ROELTGEN, DAVID P MD

(Electronically Signed)

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Printed on: 06-Nov-2015 12:39

Page 3 of 4
(Continued)

Nov. 6. 2015 3:06PM SMH 4H CO CARE 6099264721

No. 5049 P. 11

PT Initial Evaluation

11/04/15 02:08 pm Performed by RODRIGUEZ-VENTURA, MARIA-PT

Entered on 11/04/15 02:41 pm

~~PT Inpatient Assessment~~

PT PERFORMED / VERIFIED BY: Maria S. Rodriguez Ventura, PT 40QA00780600

PT TIME IN: 13:25

PT TIME OUT: 13:40

PT EVALUATION: In Patient Initial Evaluation

~~Subjective~~

PT INFORMATION REVIEWED: Patient information form, Physician H&P

PT GENERAL APPEARANCE: Patient agreeable to participate with PT, Other: greeted sitting EOB

PT EQUIPMENT PRESENT: Telemonitoring

PT SUBJECTIVE COMMENT: Pt is admitted for CVA with RUE weakness in SMC 11/3/15

~~Social Status~~

PT PATIENT LIVES WITH: Spouse, Other: son

PT CAREGIVER AVAILABILITY: Intermittent

Levels of Home: One level, Two levels / Split level

Type of Home: House

Steps to Enter: Other: 4 steps

PT RAILING TO ENTER HOME: Bilateral ascending railings

PT SOCIAL STATUS COMMENT: Pt is retired, Home maker

~~Prior Level of Function~~

PT PRIOR TRANSFERS: Independent

PT PRIOR AMBULATION: Independent

PT PRIOR ASSISTIVE DEVICE: Other: Pt states that she furniture walks at home vs RW

PT PRIOR HYGIENE ASSISTANCE: Other: Independent

PT PRIOR FEEDING ASSISTANCE: Other: Independent

PT PRIOR MEAL PREP ASSISTANCE: Other: light

PT PRIOR ADL'S ASSISTANCE: Shopping, Housework

PT HAND DOMINANCE: Right

PT ASSISTIVE DEVICE AT HOME: Rolling walker, Straight cane, Power Wheelchair, Commode, Shower chair/Tub bench, Other: rollator

PT PRIOR LEVEL OF FUNCTION COMMENT: Pt does not drive

~~Musculoskeletal~~

PT ROM - GENERAL: BUE/LE= WFL/AROM, sitting

PT STRENGTH - GENERAL: BUE/LE= 3+/5 grossly graded

PT MUSCULOSKELETAL COMMENT: appropriate for age/needs, Pt states that R hand/wrist/Arm, feels like the same, no improvement of symptoms felt upon admission.

~~Neurological~~

PT MENTATION: Alert, Oriented to person, place, date, Follows multi-step directions, Needs cues to complete directions, Concrete

PT PSYCHOLOGICAL: Cooperative, Calm, Pleasant, Flat affect

PT HAND TO NOSE COORDINATION: Decreased speed - bilaterally

PT RECIPROCAL FOOT TAPS: Intact

PT TONE: No abnormalities identified

PT NEUROLOGICAL COMMENTS: sensation grossly intact in all 4's, denies any tingling and numbness to BUE/LE

~~Integumentary~~

PT INTEGUMENTARY: No abnormalities identified

PT INTEGUMENTARY COMMENT: flexed posture

~~Function~~

PT FUNCTIONAL ASSESSMENT

ROLL IN BED: CS

SUPINE <-> SIT: CS

EDGE OF BED: CS

REACHING IN SITTING: CS

SIT <-> STAND: CS

TRANSFERS: CS

PT TYPE OF CHAIR: Bed side

PT AMBULATION ASSESSMENT

PT AMBULATION CS

PT ASSISTIVE DEVICE Rolling walker

PT DISTANCE 100 feet x2

PT WEIGHT BEARING

STATUS WBAT

PT EXTREMITIES BLE

SMH(Location:NH ; 0479 ; B)

Patient Name: HIGBEE, YNID J DOB / AGE / SEX: 01/03/56 59 Years Female

Admitting Physician: ADIGUN, JENNIFER O

Admission Date / MRN / Financial Num: 11/03/15 898815 401031831

Page 1 of 3

Print Date: 11/06/15

Print Time: 12:31

Printed by: HEDDING, STEVEN W-RN

Nov. 6. 2015 3:06PM SMH 4H CO CARE 6099264721

No. 5049 P. 12

PT Initial Evaluation
 11/04/15 02:08 pm Performed by RODRIGUEZ-VENTURA, MARIA-PT
 Entered on 11/04/15 02:41 pm

Function (cont.)

PT GAIT DEVIATIONS Decreased stride
 length - right,
 Decreased stride
 length - left,
 Decreased cadence,
 Flexed posture,
 Narrow base of
 support, Other: inc
 time, cues for
 safety awareness

PT STAIR/CURB NEGOTIATION

PT STAIR/CURB
 NEGOTIATION
 ASSISTANCE CS
 PT NUMBER OF STEPS 4
 PT RAILINGS Left ascending
 railing
 PT STEP PATTERN Step to step

PT FUNCTIONAL COMMENT: inc time and effort

Cardiopulmonary

PT ENDURANCE: Fair
 PT RESPIRATORY: No abnormalities identified
 PT CARDIAC: Asymptomatic
 PT CARDIOPULMONARY ASSESSMENT: BP= 145/79, HR= 57

Pain

PT PAIN INQUIRY: Yes
 PT PAIN AT REST: Denies pain
 PT PAIN WITH ACTIVITY: Denies pain
 PT PAIN POST ACTIVITY: Denies pain
 PT PAIN COMMENT: some minor aches to joints.

Interdisciplinary Communication

PT INTERDISCIPLINARY COMMUNICATION RE: Clearance obtained from nurse prior to evaluation, Primary nurse aware of PT eval, Charge nurse aware of PT eval, Primary nurse aware of patient status, Case discussed with discharge planner, Case discussed with MSW

Interventions

PT INTERVENTIONS: Education performed - Refer to interdisc Ed Form, Gait training, Initial Evaluation, OOB to chair

PT PATIENT EDUCATION

PT INTERDISC PT ED
 TOPIC Ambulation with
 assistive device,
 Other: discharge
 recommendation
 PT INTERDISC ED
 IMPACTORS ON LEARNING Motivation, Physical
 limitations
 PT INTERDISC ED
 METHOD USED Verbal,
 Demonstration given
 PT INTERDISC ED
 EVALUATION Verbalizes
 understanding,
 Demonstrates
 understanding,
 Requires further
 practice, Needs
 reinforcement
 PT INTERDISC ED
 LEARNER Patient

Patient Name: HIGBEE, YNID J SMH(Location:NH ; 0479 ; B)
 Admitting Physician: ADIGUN, JENNIFER O DOB / AGE / SEX: 01/03/56 59 Years Female
 Admission Date / MRN / Financial Num: 11/03/15 898815 401031831

Page 2 of 3
 Print Date: 11/06/15
 Print Time: 12:31
 Printed by: HEDDING, STEVEN W-RN

Nov. 6. 2015 3:07 PM

SMH 4H CO CARE 6099264/21

No. 5049 P. 13

PT Initial Evaluation

11/04/15 02:08 pm Performed by RODRIGUEZ-VENTURA, MARIA-PT

Entered on 11/04/15 02:41 pm

Problems/Goals/Plans**PT PROBLEMS/GOALS/PLANS****PT PROBLEMS**Decreased bed
mobilityDecreased sitting
balanceDecreased standing
balance**PT GOALS**Good safety
awareness, Able to
sit, Able to perform
exercises,
IndependentGood safety
awareness, Able to
sit, Able to perform
exercises,
IndependentGood safety
awareness, Able to
stand, Independent,
Appropriate
assistive device,
Tolerate above plan
with minimal pain
Standing balance
activities**PT PLANS**Sitting balance
activitiesSitting balance
activities**PT PROBLEMS**

Decreased transfers

Decreased ambulation

Decreased elevation
negotiation**PT GOALS**Good safety
awareness, Able to
transfer bed to
chair/commode,
Independent,
Appropriate
assistive deviceGood safety
awareness, Able to
ambulate, 100 feet
x3, Independent,
Rolling walkerGood safety
awareness, Able to
ascend/descend 3-5
steps, Close
supervision**PT PLANS**

Transfer training

Ambulation training

Stair negotiation

Recommendations**PT DIAGNOSIS FOR PT:** Acute neuromuscular deficits**PT POTENTIAL:** Good**PT LIMITATIONS IE:** Co-morbidities**PT DISCHARGE RECOMMENDATIONS:** Home PT**PT STANDARDIZED TEST SCORES****Initial Modified Rankin Date:** 11/04/15**Initial Modified Rankin Scale Score:** 4

Patient Name: HIGBEE, YNID J SMH(Location:NH ; 0479 ; B)
Admitting Physician: ADIGUN, JENNIFER O DOB / AGE / SEX: 01/03/56 59 Years Female
Admission Date / MRN / Financial Num: 11/03/15 898815 401031831

Page 3 of 3
Print Date: 11/06/15
Print Time: 12:31
Printed by: HERRING, STEVEN W-RN

Nov. 6. 2015 3:07PM SMH 4H CO CARE 6099264721

No. 5049 P. 14

PT Progress Note

11/05/15 05:55 pm Performed by RODRIGUEZ-VENTURA, MARIA-PT
Entered on 11/05/15 05:58 pm~~PT Inpt Progress Note~~

PT PERFORMED / VERIFIED BY: Maria S. Rodriguez Ventura, PT 40QA00780600

PT TIME IN: 14:50

PT TIME OUT: 15:05

PT GAIT TRAINING / ELEVATIONS: 15 Minutes

~~Subjective~~

PT GENERAL APPEARANCE: Patient agreeable to participate with PT, Greeted in bedside chair

PT SUBJECTIVE COMMENT: Pt s/o pain all over " I' m very achy"

~~Neurological~~

PT MENTATION: Alert, Oriented to person, place, date, Follows multi-step directions, Needs cues to complete directions

PT NEUROLOGICAL COMMENTS: pleasant and cooperative

~~Therapeutic Exercise~~

PT BALANCE ACTIVITIES: Standing, Standing weight shifts

~~Function~~

PT FUNCTION

ROLL IN BED: DS

SUPINE <-> SIT: DS

SIT <-> STAND: DS

TRANSFERS: DS

SITTING STATIC: I

SITTING DYNAMIC: I

STANDING STATIC: DS

STANDING DYNAMIC: DS

PT TYPE OF CHAIR: Bed side

PT AMBULATION

PT AMBULATION

DS

PT ASSISTIVE DEVICE Rolling walker

PT DISTANCE Other: 150'

PT GAIT DEVIATIONS
Decreased stride
length - right,
Decreased stride
length - left,
Decreased cadence,
Flexed posture

PT FUNCTIONAL COMMENT: inc time

~~Pain/Endurance~~

PT PAIN INQUIRY: Yes

PT PAIN LOCATION: Unable to quantify pain all over, states pain is constant

PT ENDURANCE: Good

~~Patient Education~~

PT PATIENT EDUCATION

PT INTERDISC PT ED

TOPIC

Exercise, Ambulation
with assistive device

PT INTERDISC ED

IMPACTORS ON LEARNING Pain

PT INTERDISC ED

METHOD USED

Verbal,
Demonstration given

PT INTERDISC ED

EVALUATION

Verbalizes
understanding,
Performs skill
independently,
Requires further
practice, Needs
reinforcement

PT INTERDISC ED

LEARNER

Patient

Patient Name: HIGBEE, YNID J SMH (Location: NH ; 0479 ; B)
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Page 1 of 2

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No. 5049 P. 15

PT Progress Note

11/05/15 05:55 pm Performed by RODRIGUEZ-VENTURA, MARIA-PT

Entered on 11/05/15 05:58 pm

Patient Education (cont.)

PT EDUCATION PROVIDED Treatment plan/goals
discussed with
patient/family

Interdisc Communication

PT INTERDISCIPLINARY COMMUNICATION: Therapy coordinated with nurse, Therapy coordinated with pain medication, Prior clearance obtained from nurse, Primary nurse aware of patient status, Charge nurse aware of patient status, Case discussed with MSW

Progress/Goals/Plans

PT PROGRESS TOWARDS GOALS: 50% met

PT PLAN: Continue with current treatment plan, Progress as able

PT FREQUENCY: 7x /week

Recommendations

PT DISCHARGE RECOMMENDATIONS: Home PT

Patient Name: HIGBEE, YNID J SMH(Location:NH ; 0479 ; B)
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