

Medical Chronology/Summary

Confidential and privileged information

Usage guidelines/Instructions

Verbatim summary: All the medical details have been included “word by word” or “as it is” from the provided medical records to avoid alteration of the meaning and to maintain the validity of the medical records. The sentence available in the medical record will be taken as it is without any changes to the tense.

Case synopsis/Flow of events: For ease of reference and to know the glimpse of the case, we have provided a brief summary including the significant case details.

Injury report: Injury report outlining the significant medical events/injuries is provided which will give a general picture of the case.

Comments: We have included comments for any noteworthy communications, contradictory information, discrepancies, misinterpretation, missing records, clarifications, etc for your notification and understanding. The comments will appear in red italics as follows:
“**Comments*”.

Indecipherable notes/date: Illegible and missing dates are presented as “00/00/0000” (mm/dd/yyyy format). Illegible handwritten notes are left as a blank space “_____” with a note as “*Illegible Notes*” in heading reference.

Patient’s History: Pre-existing history of the patient has been included in the history section.

Snapshot inclusion: If the provider name is not decipherable, then the snapshot of the signature is included. Snapshots of significant examinations and pictorial representation have been included for reference.

De-Duplication: Duplicate records and repetitive details have been excluded.

General Instructions:

- *The medical summary focuses on labor and delivery, sustained fetal complications and it’s management in detail.*
- *All the records related to the above-mentioned case focus have been summarized in detail.*
- *Baby records have been presented in different font color for ease of reference.*
- *Therapy records have been presented briefly.*
- *Unrelated visits for other medical conditions have been included in brief for reference.*

Flow of Events

ABC Hospital

05/24/YYYY: ER visit for vaginal bleeding/6-weeks pregnant-Assessed with spotting in early pregnancy. Treated and discharged to home in stable condition.



Multiple Providers

05/28/YYYY-08/12/YYYY: Multiple prenatal visits.



ABC Hospital Pittsburgh, Inc

10/12/YYYY: ER visit for dizziness/shaky/passed out.



ABC Hospital Pittsburgh, Inc

12/02/YYYY: She presented for pre-term contractions-Assessed with IUP at 34 weeks/2 days-Resolved-Rx'd Tylenol 1g x 1 for pain.



ABC Hospital Pittsburgh, Inc

12/13/YYYY: She presented with IUP at 35w6d gestational age, who presented for contractions-Assessed with gestation hypertension and uterine contraction-Treated and discharged in stable condition.



ABC Hospital

12/31/YYYY: She was admitted for induction- Has had elevated BP the last few visits but PIH labs and PC ratio have been within normal limit. No severe BP and asymptomatic. She presented for spontaneous labor and was 4 to 5 cm dilated on admission. She was GBS positive so Ampicillin was started for Group B Strep prophylaxis. She was contracting irregularly and, due to multiparous status, augmentation was not started in order to allow for second dose of Ampicillin. She was 7 to 8 cm dilated with assisted rupture of membranes at approximately. Heart tones were very low. Returned to the room and the heart tones had recovered partially but then or decelerated into the 40s and did not return to baseline. We decided at this point to do a stat C-section and return to the other patient to her room. Delivered a viable male infant with APGAR 1-min 1, 5-mins 1, 10-mins 3. Cord blood gas obtained.



ABC Hospital

12/31/YYYY: Term newborn male delivered via emergency cesarean section following prolonged fetal deceleration during maternal pushing phase of delivery. With infant having fetal bradycardia extended a stat C-section was called. Upon delivery Infant had 0 APGAR. Full neonatal resuscitation performed. Patient required initially oxygen by positive pressure ventilation. His heart rate was not noted at the time of PPV. He was given chest compressions alternating with PPV. This resulted in fetal heart rate shortly after initiation chest compressions of greater than 100. Despite the heart rate of 100 his neurologic status was poor. He was not moving extremities. He did moan a few times during the course of resuscitation. His lungs were with crackles scattered throughout. Anesthesia was present and intubated along with continued respiratory support with bagging. Dr. XXXX has assembled a team from Freeman Neonatal and they should be arriving. Baby was transferred to Freeman Health for higher level of care.

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ACX Health System

01/01/YYYY-01/09/YYYY: A 9-days-old term Baby Boy transferred from OSH with hypoxic ischemic encephalopathy (Moderate), status post whole-body cooling, status post coagulopathy. Baby underwent cooling and rewarming without any complication. He did not have any seizure activity on multiple EEGs. Head ultrasound was normal and follow up brain MRI at 7 days of birth showed signs of HIE (Mild signal alteration of bilateral basal ganglia and brain stem). Baby had right sided undescended testis and a small VSD (Muscular). Mother has Covid and was in isolation. Baby tested negative for Covid x 2. Baby was a PO feeder and grower and doing well. He passed hearing test, passed car seat test, got Hepatitis B vaccine. Appropriate referral to the PCP, CMH Neurologist, Cardiologist and early intervention would be done on 01/08/YYYY as today was a weekend. Baby was directly discharged to parent.



ACB Hospitals and AB City

01/10/YYYY-12/20/YYYY: Multiple office/follow-up visits/hospitalization for hypoxic ischemic encephalopathy, other seizures, abnormal eye movements, acute bronchiolitis, undescended testis, hydrocele, fever, viral illness, fussiness in baby, breath-holding spell, constipation, acute asthma, hypoxia, respiratory distress, bronchiolitis, acute viral bronchiolitis, wheezing, reactive airway disease, normal cardiac examination, normal echocardiogram, stuffy and runny nose, cough, difficulty breathing, stomatitis, decreased oral intake.

Patient History-Mother

Past Medical History: Left foot fracture 2011, bipolar, depression (Ref: 963)

Surgical History: Not provided

Family History: Father: Anxiety, depression, Mother: Anxiety, bipolar, depression, PGM: Anxiety, depression, headache, MGM: Depression, migraine, migraine with aura, obsessive-compulsive disorder, MGF: Bipolar, depression (Ref: 2101)

Social History: Alcohol use: Denies use, smoking cessation: Former smoker (Ref: 63)

Allergy: Codeine (Unverified adverse reactions) (Ref: 61)

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Detailed Summary

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
05/24/YYYY	Hospital/ Provider Name	<p>ER visit:</p> <p>Priority: 5.</p> <p>Stated complaint: Vaginal bleeding/6-weeks pregnant</p> <p>Nursing triage note: Patient states that she is around 6-7 weeks pregnant and began bleeding tonight. Patient has a history of miscarriage and was concerned.</p> <p>History of present illness: The patient presents with some vaginal spotting. Patient is approximately 6-weeks 6-days pregnant. Patient's last menstrual period was 04/06/YYYY. Patient reports that she urinated and after she urinated she wiped and noticed some pink vaginal tenderness. Patient has a history of a previous miscarriage and was concerned. Patient has a little bit of pain in her back. No other systemic complaints</p> <p>Progress note: Patient with threatened miscarriage versus implantation bleeding. Discussed with her that we need to check an HCG level and then she will need to follow-up with her primary care provider for recheck.</p> <p>Primary impression: Spotting in early pregnancy</p> <p>Disposition: Home, self-care</p> <p>Condition: Stable.</p> <p>Discharge instructions: Follow-up with your Primary Care Provider/Ob in a couple days for recheck of your HCG blood levels.</p> <p><i>*Related records: Patient's information, assessment, patient education, orders, medication sheets, after visit summary.</i></p>	963-985, 945-946, 961-962
05/28/YYYY	Hospital/ Provider Name	<p>Initial Ob visit:</p> <p>Prenatal flow sheet: G6P3 here to establish. Has had some spotting. Taking Prenatal. Informal ultrasound shows singleton with cardiac activity. Prenatal lab work today.</p> <p>Assessment/plan: Routine antenatal care Encounter for supervision of normal pregnancy, unspecified, first trimester</p> <p>Ordered labs</p>	2-4, 5-6, 921-933

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		<i>*Related records: Orders, labs.</i>	
07/12/YYYY	Hospital/ Provider Name	Follow-up visit: Chief complaint: Follow-up: Pregnant. Prenatal flow sheet: 13weeks 6 days: Fundus 145, FHR 155, BP 122/76. Having some heart burn. No nausea. Reviewed lab work. Pelvic exam today. Pap and GC/Chlam. Informed ultrasound today shows singleton with cardiac activity. Assessment/plan: 1. Routine antenatal care Encounter for supervision of normal pregnancy, unspecified, first trimester 2. Pregnant Pregnant state, incidental Ordered labs and Pap. Pap: Negative for intraepithelial lesion or malignancy. <i>*Related records: Labs.</i>	7-10, 11-14
08/09/YYYY	Hospital/ Provider Name	Follow up visit: Chief complaint: Follow-up: Pregnant Prenatal flow sheet: 17weeks 6 days: FHR 155 Doing well. Quad screen and ultrasound ordered today Assessment/plan: 1. Routine antenatal care: Encounter for supervision of normal pregnancy, unspecified, first trimester -Quad screen, maternal, serum (With interpretation) -US, obstetric, 2nd or 3rd trimester, single gestation. <i>*Related records: Orders, labs.</i>	15-18, 886-887, 902-910
08/12/YYYY	Hospital/ Provider Name	Ultrasound of obstetric pregnancy late: Indication: Fetal survey Findings: There is a single live fetus in a transverse presentation, head to maternal right. Fetal heart rate was recorded at 132 bpm. Placenta is posterior and to the right. The amniotic fluid volume is normal. The fetal kidneys, bladder	888-891, 885

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		<p>and stomach are unremarkable. Fetal brain is unremarkable. There is a four-chamber heart. There is a three-vessel cord with normal insertion. Fetal spine is unremarkable.</p> <p>Biometrical measurements are as follows: Biparietal 4.33 cm, age 19 weeks 1 days. Head circumference 15.70 cm, age 18 weeks 5 days. Abdominal circumference 12.55 cm, age 18 weeks 2 days. Femur length 2.60 cm, age 18 weeks 0 days.</p> <p>Sonographic estimate age: 18 weeks 4 days. Sonographic estimated date of delivery: 01/09/22.</p> <p>Estimated Fetal Weight: 225 gm (+/- 33 gm). LMP percentile: 62%.</p> <p>Fetal heart rate: 132 beats per minute.</p> <p>Fetal number: 1 of 1.</p> <p>Impression: Single live IUP 18 weeks 4 days gestational age with estimated date of confinement sonographically of 01/09/YYYY. No complicating features are detected.</p>	
10/12/YYYY	Hospital/ Provider Name	<p>ER visit:</p> <p>Reason for visit: Dizziness/shaky/passed out</p> <p>Discharge disposition: Home, self-care.</p> <p>Toco flow sheet: UC mode: External Contraction frequency: None Monitor mode: External FHR: 140 bpm Accelerations: Present Fetal monitor decelerations: None Long term variability: Amplitude 6-25 bpm</p> <p>1735 hrs: She presented to unit via ambulatory from ER, accompanied by spouse, with complains of dizziness/shaky/passed out. She weighed, gowned, voided, and to bed. EFHM and TOCO applied, VS taken. Oriented to bed controls, call light, TV, heat, and A/C controls.</p> <p>1941 hrs: FHR 130s with average variability for pre-term and accelerations. Denies contractions. Difficult to maintain FHR due to frequent fetal movement. Patient states baby is always active. FHR 130rs with accelerations.</p>	844-847, 809-843, 867-874

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		<p>1925 hrs: Patient does not feel well-fainted at desk at school then went to sleep for 1 hour, complains of dizziness, vomiting since 2 p.m. today, and mild headache. States saw Dr. Burke yesterday in office with elevated BP and was "very anemic". Iron ordered for patient but has not picked up yet from pharmacy. Denies bleeding, fluid leakage, or contractions.</p> <p>2033 hrs: Discharge per Dr. Shaw, patient discharge instructions given verbally and written, patient educated on the possibility a call coming with results of culture and possible antibiotics ordered. All questions answered.</p> <p>2035 hrs: Patient ambulated to private vehicle with SO with no questions at this time.</p>	
10/13/YYYY	Hospital/ Provider Name	<p>Urine culture:</p> <p>Collection date: 10/12/YYYY.</p> <p>Result: Organism #1: Gram positive mixed bacterial flora >100,000/ml Consistent with usual urethral/vaginal flora, including</p> <p>Organism #2: Strep Agalactiae Group B <10,000 No further testing</p>	820-821
12/02/YYYY	Hospital/ Provider Name	<p>Standard progress notes:</p> <p>Progress/assessment & plan: Subjective: Patient is a 23-year-old G6P3023 with IUP at 34w2d who presents for contractions. Denies vaginal bleeding, abnormal vaginal discharge, LOF. Notes good fetal movements.</p> <p>Objective: General: Not in distress. Resting comfortably Heart: Normal rate and peripheral perfusion Lungs: Symmetric chest rise, non-labored respirations</p> <p>Toco: Contractions, Q3-5 mins</p> <p>FHR: 120bpm, mod variability, + accels, - decels</p> <p>SVE: 2/70/-3</p> <p>Final diagnosis: Preterm contractions</p> <p>Assessment and plan:</p>	751-752

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		A 23-year-old G6P3023 with IUP at 34 weeks/2 days who presents for contractions -Wet prep notable for clue cells and WBC: Will treat with Flagyl for BV -UA negative -UDS negative -SVE unchanged over period of stay in triage -Oral hydrate -Tylenol 1g per oral x 1 for pain.	
12/02/YYYY	Hospital/ Provider Name	Wet prep-Vaginal: Result: Numerous WBC's observed Moderate # clue cells observed No yeast observed, no trichomonas observed	755
12/02/YYYY	Hospital/ Provider Name	Short stay summary: Date of admission: 12/02/YYYY Date of discharge: 12/02/YYYY Family physician/provider: XXXX, M.D. Discharge diagnosis: Preterm contractions, preterm labor Hospital course: Problem list reviewed: Yes Final diagnosis: Preterm labor-Resolved, pregnancy Patient is a 23-years-old with IUP at 34-weeks 2-days who presented to triage for contractions. On evaluation maternal VS were within normal limit, SVE was 2/70/-3, and exam was negative for vaginal bleeding or range of motion. Fetal evaluation was also reassuring. A wet prep was notable for clue cells. She was instructed on per oral hydration while in triage, and she received Tylenol for her pain. Her pain improved with Tylenol, and although contractions were noted on toco, she did not make any cervical change over a 6-hours period of monitoring in triage. Maternal and fetal evaluation remained stable, and patient was discharged home with strict return precautions. Prescription for Flagyl provided for treatment of bacterial vaginosis, and instructions provided. Home meds: Metronidazole 500mg, every 12 hours x 7 days. Reported: Iron 100 plus (Iron, Carbonyl/Vitamin C/Vitamin B12/FA) 1 each tablet once. Prenatal Vitamins tablet (Prenatal Vitamin/Iron Fumarate/FA) 1 each tablet daily. Assessment/patient instructions:	742-745

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		<p>A 23-years-old with IUP at 34 weeks 2 days who presented to triage for contractions. Evaluation without evidence of active labor. Evaluation significant for bacterial vaginosis</p> <p>-Continue prenatal visits as scheduled -Call you doctor or present to triage for decreased fetal movement, leakage of fluid, vaginal bleeding, regular contractions every 5-10minute, temperature >100.4 degrees, intractable nausea or vomiting, headaches that don't go away with treatment, spots in your vision, chest pain/shortness of breath or other concerns. -Complete all prescribed antibiotic course -Keep all follow up appointments.</p> <p>Discharge instructions: Discharge diet: No restrictions Activity as tolerated.</p> <p><i>*Related records: Labs, medication administration, care plan, discharge instructions, nurses notes,</i></p> <p><i>Ref: 746-750, 753-782.</i></p>	
12/13/YYYY	Hospital/ Provider Name	<p>Standard progress notes:</p> <p>Date/time seen by a provider: 12/13/YYYY @ 22:20</p> <p>Expected date of delivery: Jan 11, YYYY</p> <p>Gestational age in weeks: 35</p> <p>Gestational age in days: 6</p> <p>LMP/EDD Comment: EDD: 01/11/YYYY</p> <p>Vitals: 1945 hrs: BP 136/96, Mean 109, PR 99 bpm, Temp 36.4, SpO2 99% on room air. 2200 hrs: BP 139/93, Mean 108, PR 94 bpm, RR 18 2245 hrs: BP 141/90, Mean 107, PR 93 bpm, RR 18, SpO2 100% on room air. 2300 hrs: BP 140/90, Mean 107, PR 94 bpm, RR 18. 2315 hrs: BP 141/92, Mean 108, PR 94, RR 18</p> <p>Progress/assessment & plan: Patient is a 23-year-old G6P3023 with IUP at 35w6d gestational age, who presented for contractions. SVE per RN was 3cm/thick/hi, and unchanged over the 3hr period of evaluation in triage. She denied any vaginal bleeding or abnormal vaginal discharge, and none was noted on exam. FHT was reactive.</p>	701

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		<p>Her pain resolved with Tylenol and Flexeril. Vital signs were however notable for mild range BPs over multiple checks while in triage, and patient denied any symptoms of end organ involvement including chest pain, shortness of breath, headache, vision abnormalities, or abdominal pain. CBC, CMP, and UPC were non-diagnostic for Pre-E. She was therefore diagnosed with gestational hypertension. FHT remained reactive.</p> <p>She has an OB prenatal appointment tomorrow with Shannon Duncan, APRN. Patient was encouraged to keep appointment, with plan to schedule IOL for 37 weeks gestational age secondary to gestation hypertension. Signs and symptoms of Pre-E were discussed with patient and return precautions were given.</p> <p>Evaluation and plan were discussed with patient's OB provider.</p> <p>Final diagnosis: Uterine contractions in third trimester Gestational hypertension</p> <p>Diagnosis/problems: Gestational hypertension Status: Acute</p> <p>Uterine contractions Status: Acute.</p> <p><i>*Related records: Patient information, orders, medication administration, care plan</i></p> <p><i>Ref: 694-700, 702-731, 2940-2947</i></p>	
12/31/YYYY	Hospital/ Provider Name	<p>Obstetrics and gynecology history and physical report:</p> <p>OB - chief complaint and history of present illness: Date/time seen by a provider: 12/13/YYYY @ 0945</p> <p>Chief complaint/history: OB-reason for admission/chief: Gestational diabetes AI, pregnancy induced hypertension History gravida: 4 History para: 3 Expected date of delivery: Jan 11, YYYY Gestational age in weeks: 38 Gestational age in days: 3 Indication for induction: Medical complication Admission nurse assessment rev: Yes</p> <p>Others: Fetal testing has been within normal limit. However, there is polyhydramnios.</p>	61-64

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		<p>She had been started on Metformin by Dr. Burke, but before she started it, she changed her diet (Her step daughter is a type I diabetic) and had controlled blood sugars so never did start. Has had elevated BP the last few visits but PIH labs and PC ratio have been within normal limit. No severe BP and asymptomatic. Plan was to induce 38-39 weeks (Scheduled 01/03/YYYY).</p> <p>OB – history: History of present pregnancy: Prenatal care: Yes Ultrasounds: Normal mid trimester ultrasounds Obstetrical complications: Gestational diabetes, gestational hypertension</p> <p>Obstetrical history: History gravida: 6 History para: 3 History term pregnancies: 3 History preterm pregnancies: 0 Number of living children: 3 History total of abortions (Spont): 2</p> <p>Physical examination: Vitals: First BP 160/94, repeat afebrile Abdomen: Gravid Extremities: Edema Cervical dilatation: 5cm Effacement: 100% Station: Ballotable (Vertex by bedside ultrasound) Fetal heart rate: 140's Accelerations: Accelerations present Short term variability: Present Long term variability: Average (6-25) Contractions on admission: 6-10 minutes apart</p> <p>Assessment/plan/diagnosis: Assessment: Active labor, group B positive strep, other (GDM1, PIH) Admission diagnosis: Labor Admission status: Inpatient order (Span 2 midnights) Reason for inpatient admission: Labor</p> <p>Plan: Plan: Expectant management Induction method: Other (Ampicillin for GBS prophylaxis. AROM (Artificial Rupture of Membrane) or Augment as needed, but not after 2 doses of Ampicillin. Burke-Peds).</p>	
12/31/YYYY	Hospital/ Provider Name	<p>Operative report: Pre/post-operative diagnosis: Gravida/para 6/3, gestational age 38 3/7 weeks,</p>	69-71

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		<p>fetal bradycardia. Gestational hypertension, gestational diabetes, GBS +</p> <p>Procedure: Primary low transverse cesarean section</p> <p>Indications: The patient is Gravida/para 6/3, gestational age 38 3/7 weeks, fetal bradycardia. Gestational hypertension, gestational diabetes presenting for emergency primary cesarean section.</p> <p>This patient presented in spontaneous labor and was 4 to 5 cm dilated on admission. She is GBS positive so Ampicillin was started for group B strep prophylaxis. She was contracting irregularly and, due to multiparous status, augmentation was not started in order to allow for second dose of Ampicillin. She was 7 to 8 cm dilated with assisted rupture of membranes at approximately.</p> <p>Procedure details: 20:10 p.m. Oxytocin had been started about 1600.</p> <p>She was thought to be nearly completely dilated and wanted to push so began pushing with the RN. But was not making progress and when I examined her she had a swollen cervix and I asked her to stop pushing and she was given 1 mg of Stadol. And allowed to labor. She was only 8 cm dilated at that time. She then tried to start pushing again and was again noted to be about 8 to 9 cm and her cervix was swollen so she was given 50 mg of Benadryl IV. This was to help with cervical swelling. During this time, she wanted to push on her hands and knees. And we were having difficulty with monitoring the baby. She did not have an epidural. A pudendal block was done with 1% Lidocaine. She continued to want to push on her side or hands and knees, but we were unable to monitor the baby. So she was turned to her back.</p> <p>At this point she was noted to be having variable decelerations but they did return to baseline.</p> <p>There was another patient that had been waiting for a cesarean section for failure to progress until this patient had delivered. Because she was not complete and would require some more laboring, we planned to proceed with the other patients C-section. However just as we got to the operating room, the nurse. Contacted me and stated that the heart tones were very low. I returned to the room and the heart tones had recovered partially but then or decelerated into the 40s and did not return to baseline. We decided at this point to do a stat C-section and return to the other patient to her room. And then proceeded with primary stat C-section for this particular patient.</p> <p>Foley catheter was placed by the nurse. And a Betadine splash was done on the abdomen. And, after general anesthesia was initiated by our anesthesia colleagues, the patient was placed in the dorsal supine with leftward tilt for uterine displacement. A Pfannenstiel skin incision was made at 2301 using a scalpel and carried down through the underlying fascia. The fascia was incised in the midline and extended laterally in a blunt fashion. The peritoneum was</p>	

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		<p>identified and entered bluntly in the midline. This was then stretched laterally using manual strength. After entering the abdominal cavity and confirming lack of intraperitoneal adhesions, an extra-large Alexis retractor was placed and the lower uterine segment was visualized. A scalpel was utilized to make a low transverse uterine incision. This was extended bluntly. The infant's head was grasped and brought to the level of the incision. Fundal pressure was applied and infant was delivered without difficulty. Delivery time 2301. The baby was minimally responsive. Mouth and nares were suctioned with bulb suction. After the umbilical cord was clamped and cut, the infant was handed off to the pediatric staff. A sample of cord blood was then obtained. Cord gases were sent.</p> <p>The placenta was delivered intact via uterine massage. The uterus was exteriorized and cleared of all clots and debris. Methergine was given due to uterine hypotonus. The uterine incision was closed using 0 Vicryl in a running locked fashion. A second imbricated layer was placed using 0 Vicryl in a running fashion as well. The uterus was flexed forward and the posterior rectouterine space was inspected and cleared of all clots and debris. Again the hysterotomy site was examined and hemostasis was observed. The bilateral tubes and ovaries appeared normal. The uterus was placed back into the abdominal cavity and abdominal gutters were cleared of all clots and debris. A final check of the uterine incision showed it to be hemostatic. The peritoneum was closed using 3-0 Vicryl in a running fashion. The fascia was closed with 0 PDS in a running fashion. The subcutaneous space was hemostatic and irrigated. The subcutaneous space was closed with 3-0 Vicryl in several single interrupted stitches. The skin was then closed using 4-0 Monocryl in a running subcuticular fashion. The skin edges were reapproximated together and were hemostatic. A pressure dressing was applied. All sponge, lap and needle counts were correct at the end of the procedure per nursing.</p> <p>Findings: Viable male infant, APGARs unknown at time of dictation, weight pending, intact placenta, 3VC, normal appearing uterus, tubes, and ovaries. Body cord x 1. Baby required resuscitation at time of delivery.</p> <p>Estimated blood loss: 700 ml</p> <p>Disposition: Stable and extubated.</p>	
12/31/YYYY	Hospital/ Provider Name	<p>Standard progress notes:</p> <p>Assessment and plan: Late entry from 12/31/YYYY at 2317 hrs: Involved in stat cesarean section with birth of viable baby boy at 2301. Mom under general anesthesia and stable on vent. Dr. Koehn and OB RN's attending to newborn in adjoining room to OR. Compressions and assistance with ventilation being provided by staff. At 2315 Dr Koehn requests my assistance with intubation of newborn. Mary Lou Keim, RN available to assist me with monitoring mom at the head of the table. I turned anesthesia monitors to allow both Mary Lou and my viewing during intubation of newborn, as newborn was in adjoining room.</p>	1107

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		<p>At 2317 hrs, I intubated with 2.5 uncuffed ETT utilizing MAC 1 blade, easily; however, ETCO2 color indicator did not confirm. I removed ETT and reintubated immediately with grade 2 view. On second attempt, confirmed ETCO2 color change and breath sounds, thus I returned to head of bed with mom. Mom remained stable throughout the procedure and was awake without complications per Bryan Baxley, CRNA.</p>	
12/31/YYYY	Hospital/ Provider Name	<p>X-ray of chest AP/PA view:</p> <p>History: ET and OG tube placement</p> <p>Finding: There are mildly prominent perihilar interstitial markings.</p> <p>Impression: The endotracheal tube is in the left mainstem bronchus. This has been adjusted on subsequent radiographs. The OG tube projects over the stomach.</p> <p>Radiographic findings are suggestive of retained fetal lung fluid. Follow-up is suggested if symptoms do not improve as neonatal pneumonia may also have this appearance.</p>	1115
12/31/YYYY	Hospital/ Provider Name	<p>X-ray of chest AP/PA view:</p> <p>History: Follow-up ET tube and OG tube.</p> <p>Findings: The endotracheal tube has been retracted and is at the level of the clavicles. This has been adjusted on subsequent radiographs. The OG tube projects over the stomach. The thymic shadow is mildly prominent. There are mildly prominent perihilar interstitial markings.</p> <p>Impression: The endotracheal tube has been retracted with the tip at the level of the clavicles. This has been adjusted on subsequent radiograph.</p> <p>Radiographic findings are suggestive of retained fetal lung fluid. Follow- up is suggested if symptoms do not improve as neonatal pneumonia may also have this appearance.</p>	1116
12/31/YYYY	Hospital/ Provider Name	<p>Lab test:</p> <p>CBC: High: MCV 120, RDW 16.9, Eos# 0.4, Baso# 0.2, IG# 0.8 Low: RBC 3.89 Polychromasia: Moderate Macrocytosis: Marked Burr cells: Slight.</p> <p>Chemistry:</p>	1108- 1110

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		<p>Low: CO2 11 High: Anion gap 23, calcium 10.4</p> <p>Blood gas: High: PO2 221, O2 sat 100 Low: HCO3 10, BE -19.0, pH 7.03</p> <p>Cord arterial blood: pH: 6.71 (Low).</p>	
12/31/YYYY	Hospital/ Provider Name	<p>New born assessment:</p> <p>Vital signs new born: 2306 hrs: Rate: 96 bpm Oxygen delivered method: T-piece FIO2: 100% Pulse oximetry: 70%</p> <p>2313 hrs: Rate: 120 bpm Oxygen delivered method: T-piece FIO2: 100% Pulse oximetry: 91%</p> <p>2318 hrs: Rate: 147 bpm Oxygen delivered method: T-piece FIO2: 100% Pulse oximetry: 99%</p> <p>Apgar score assessment: 1 minute: HR Below 100 bpm Respiratory effort: No spontaneous effort Muscle tone: Limp Reflex response: No response Color: Pallor or cyanosis Total score: 1</p> <p>5 minutes: HR: Below 100 bpm Respiratory effort: No spontaneous effort Muscle tone: Limp Reflex response: No response Color: Pallor or cyanosis Total score: 1</p> <p>20 minutes:</p>	1133- 1137

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		<p>HR 100 bpm or greater Respiratory effort: low respiration/weak cry Muscle tone: Minimal flexion/extension Reflex response: No response Color: Pallor or cyanosis Total score: 4</p> <p>Newborn birth height/weight measurements: Height: 20 inches Weight: 6 pounds 11.0 oz Head: 14.00 inches Chest: 12.50 inches Abdomen: 10.75 inches.</p>	
12/31/YYYY	Hospital/ Provider Name	<p>Progress notes:</p> <p>General: Patient condition: Mental status/LOC: Same as pre-op Cardiovascular: Satisfactory Nausea/vomiting: Absent Respiratory: Satisfactory Pain: Controlled Complications: Absent</p> <p>Post-op complications: None</p> <p>Follow up care/instructions: Patient instructions None needed.</p> <p>Anesthesia/patient condition: Patient is doing well, no complaints, stable vital signs, no apparent adverse anesthesia problems. No complications reported per nursing.</p>	65
12/31/YYYY	Hospital/ Provider Name	<p>Short stay summary:</p> <p>Time seen by provider: 2340 hrs</p> <p>Reason for visit/history of resent illness: Term newborn male delivered via emergency cesarean section following prolonged fetal deceleration during maternal pushing phase of delivery. With infant having fetal bradycardia extended a stat C-section was called. Upon delivery Infant had 0 Apgar.</p> <p>Date of admission: 12/31/YYYY @ 23:03</p> <p>Date of discharge: 12/31/YYYY</p> <p>Attending physician: XXXX, M.D.</p>	1088- 1089

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		<p>Physical examination: General appearance: Other (At present some movement of extremities) Respiratory: Crackles (Scattered throughout both lungs), Other (Infant is currently intubated) Cardiovascular: Regular rate, rhythm (And with a rate of 120)</p> <p>Discharge diagnosis-short stay: Admission diagnosis: -Term newborn male delivered by emergency cesarean section following extended fetal bradycardia Cardiopulmonary arrest</p> <p>Final discharge diagnosis: Term newborn male delivered by emergency cesarean section following extended fetal bradycardia Cardiopulmonary arrest</p> <p>Conclusion/plan: Full neonatal resuscitation performed. Patient required initially oxygen by positive pressure ventilation. His heart rate was not noted at the time of PPV. He was given chest compressions alternating with PPV. This resulted in fetal heart rate shortly after initiation chest compressions of greater than 100. Despite the heart rate of 100 his neurologic status was poor. He was not moving extremities. He did moan a few times during the course of resuscitation. His lungs were with crackles scattered throughout. Anesthesia was present and intubated along with continued respiratory support with bagging.</p> <p>At the time of this dictation at 2350 hrs, Obstetrician informed me that the cord gas pH at time of delivery was 6.7. At this time chest X-ray was observed and tube was in the left mainstem. The tube was slightly pulled back with another X-ray pending. An IV is in process and D10W will be ran at 1 cc/hr. Dr. XXXX has assembled a team from Freeman Neonatal and they should be arriving.</p>	
12/31/YYYY	Hospital/ Provider Name	<p>Nurse notes:</p> <p>0906 hrs: Patient presented to unit via wheelchair from ED, accompanied by ER staff and S/O, with complaints of contractions. Patient weighed, gowned, voided, and to bed. EFHM and TOCO applied, vital signs taken. Patient oriented to bed controls, call light, TV, heat, and A/C controls.</p>	310
12/31/YYYY - 01/01/YYYY	Hospital/ Provider Name	<p>Nurses notes:</p> <p>12/31: 2303 hrs: Birth of viable male infant by emergent cesarean section by Dr. Shaw. Infant transported to preheated radiant warmer by Dr. Koehn.</p> <p>Delivery of viable male via stat C-section after failure to progress with fetal</p>	1143

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		<p>intolerance. FHR dropping to 60's, patient to OR and general anesthesia administered. Fetus delivered by Dr. Shaw and handed to Dr. Koehn. Infant to radiant warmer and D/S immediately. No respiratory effort and PPV started. 2305 no respiratory effort noted, HR questionable above 100, SpO2 placed and chest compression started with HR below 100. 2307 re-eval, change on chest compressor after HR remains in 80's. RT present and notes taken, second SPO2 monitor placed (Pre/post ductal). 2309 continue to perform chest compressions, bulb suction to remove mucus and PPV continues at 100% O2. Lung sounds to right and left with crackling noting in uppers.</p> <p>2311 hrs: FHR 120 chest compressions stopped, PPV continues, infant having some effort with agonal breathing noted, model color noted and CPAP attempted with infant attempting to breath. CRNA present to intubate. PPV continued with some skin color improvement noted. Dr Koehn present, suction to airway and attempt of ET tube at 2317. No change in carbon monoxide detector, tube removed and PPV continued.</p> <p>2318 hrs: ET in placed with change in color on CO2 probe.</p> <p>2320 hrs: Infant voiding and abduction arm movement noted. Dr Koehn to call Freeman NICU and rectal probe in place for cooling.</p> <p>2323 hrs: Infant moved to nursery with ET and 96% O2 sat. This RN to father to notify him of delivery and POC. Father to nursery</p> <p>2329 hrs: Infant in nursery and heater off, rectal probed set for 34°C. Infant opening eyes and moving extremities. IV attempted with no success</p> <p>2337 hrs: EES topical OU and Vitamin K IM RVL given</p> <p>2338 hrs: Footprints obtained.</p> <p>2341 hrs: Bands placed color remains dusky with 100% O2sat HR 126 respirations 50 infant breathing more than Ambu bag.</p> <p>2344 hrs: OG placed and 12ml of air and some fluid from stomach</p> <p>2345 hrs: X-ray obtained and ET told to pull back to 9cm suction of thick mucus removed</p> <p>2353 hrs: Lab arrived for labs and measurements obtained.</p> <p>2354 hrs: Second X-ray obtained to check placement and ET pulled to 10cm line. O2 sat remain good at this time. IV unsuccessful and Dr Koehn to attempt UVC line.</p> <p>01/01/22: 0001 hrs: BS obtained 65</p>	

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		<p>0003 hrs: Dr Koehn attempted to placed UVC line, unsuccessful at this time, X-ray taken</p> <p>0021 hrs: PKU completed and labs obtained.</p> <p>0025 hrs: Freeman NICU arrived on unit and reviewing information.</p> <p>0031 hrs: Freeman NICU obtained an IV and infant tube placement lost and infant extubated. Infant breathing independently.</p> <p>0050 hrs: NICU team to talk to mother and plan for departure, copies of mothers prenatals with NICU team.</p>	
01/01/YYYY	Hospital/ Provider Name	<p>New born discharge notes:</p> <p>Destination of infant: Other facility Transfer: Yes Date/time: 01/01/YYYY @ 0055 hrs Transfer location: Freeman Joplin Method of transfer: Emergency medical service Report given to: NICU team</p>	1137- 1138
01/01/YYYY	Hospital/ Provider Name	<p>NICU doctor/NNP transport notes: <i>(Illegible notes)</i></p> <p>Transport hospital: Via Christi</p> <p>Reason for transport: Higher level of care</p> <p>Arrival time: 0020 hrs</p> <p>Referring physician: Koehn</p> <p>Follow up physician: Burke</p> <p>Condition: On our arrival infant pale/cool hypotonic, VSS, _ via ETT by RN, _ sats _ on 100%. No IV access obtained, with second attempt to left hand. X-ray shows ETT above clavicles-extubated. Spontaneous breathing with increased _ and cry. ABGs-Metabolic acidosis, NS bolus. Proceed on CPAP-7, Apnea x 1 with desat _ with stable sats. Parents updated. Consents signed. Tolerate transport well. Vital signs stable, weaned.</p> <p>Physical examination: Temp 34.3, HR 133 bpm. RR 37. SaO2 96. Respiratory support: CPAP 7, 400-NIV</p> <p>General appearance: Lethargic Lungs: Intubated with PPV Neurology: Hypotonic Extremities: MAE with noxious stimuli</p>	1171

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		<p>Skin: Abnormal: Passive coding, pale Skin: Cool, pale, passive cooling</p> <p>Diagnosis: HIE, prenatal depression</p> <p>Procedure: PIV: Left hand D10 (60) Extubated at 0045 hrs</p> <p>Medication: NS 30ml at 0110 hrs</p> <p>Status: Critical</p> <p>Labs: CBC: WBC 16, Hgb 15.5, HCT 47, PLT 206, Segs 44, bands 0, Glucose 115 ABG/CBG/VBG: pH 7.05, pCo2 47, pO2 131, HCO3 13, BE -17</p> <p>X-ray chest: Clear expanded to 10-ETT above clavicles, OG tube in place.</p> <p>NC/CPAP/vent setting: Hand bagging via 2.5 ETT.</p> <p>Departure time: 0122 hrs</p> <p>Arrival at Freeman: 0205 hrs</p>	
01/01/YYYY	Hospital/ Provider Name	<p>Emergency/medical transfer form: <i>(Illegible notes)</i></p> <p>Reason for transfer: Fetal distress, cardiopulmonary artery</p> <p>Patient and/or patients representation informed of both risks and benefits of transfer: Yes Risk of transfer: Further cardiopulmonary compromise Benefits of transfer: Neonatal services</p> <p>Receiving facility/physician agree to accept patient: Yes Receiving facility: Freeman NICU Accepting physician: Dr. Oberio Date/time of transfer: 12/31/YYYY @2320 hrs</p> <p>Name of person contacting hospital/MD: XXXX, M.D.</p> <p>Method of transport: ACLS, BLS.</p> <p>Accompanying documentation: X-rays, labs, face sheet.</p>	1145- 1146
01/01/YYYY	Hospital/ Provider Name	<p>Pre-hospital care report:</p> <p>Times: Call received: 23:35:23 Dispatched: 23:37:53</p>	1158- 1160, 3101- 3104

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		<p>En route: 23:39:53 On scene: 00:21:01 Patient contact: 00:27:33 Left scene: 01:23:50 At destination: 02:06:23 Transfer of care: 02:07:23 In service: 02:12:06</p> <p>Call information: Disposition: Treated/transported Initial patient acuity: Lower acuity (Green) Unit#: M22 - METS 22. Grand-ambulance-BLS Trip type: Initial trip Run type to scene: Medical transport emergent (Immediate response) Incident facility: VIA Christi Hospital Pittsburg (Hospital) Incident location type: Facility</p> <p>Receiving facility: Freeman West Hospital (Hospital) Destination type: Hospital Emergency Department Destination reason: Hospital diversion Hospital capability: Neonatal center Condition of patient at destination: Unchanged Registration: N/A</p> <p>Jocelyn Honsinger : Gloves, mask-surgical (Non-fitted) Justin Smith: Gloves, mask-surgical (Non-faked) Personnel other non-nets: Gloves, mask-surgical (Non-fitted)</p> <p>Moved to ambulance by: Stretcher Transport position: Supine From ant by: Stair chair</p> <p>Call origin: N/A Lights/siren: Scene - Lights and sirens Destination - Lights and sirens</p> <p>Clinical: Onset date/time: 12/03/YYYY @ 23:03:00 Dispatch reason (EMD): 37A02S Inter-facility transfer, ready now</p> <p>Chief complaint (Primary): Respiratory failure Duration: 2 Hours Organ system: Global/general Anatomic location: General/global Provider impression: Monitoring required Protocol 1: General medical</p> <p>Assessment:</p>	

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		<p>0032 hrs: Type: ABC Summary: Skin color: Cyanotic: Yes</p> <p>0033 hrs: Type: Neurological Summary: Unresponsive: Yes, Unresponsive – Normal for patient: No</p> <p>0028 hrs: Summary: BP: 50/19, Pulse: 122, RR: 21, SpO2: 97, Temp: 93.2 F Glasgow coma score: (Unable to complete): N/A – child</p> <p>Narrative history text: Mets 22 dispatched for a NICU transfer from via Christi to Freeman West.</p> <p>Chief complaint is respiration failure.</p> <p>Patient was a 3-hour old new born with failure to thrive. assessment and treatment handled by NICU team</p> <p>Patient transported non-emergent to Freeman.</p> <p>Upon arrival, the NICU team took patient to NICU. Signatures obtained. M22 clear.</p>	
01/01/YYYY	Hospital/ Provider Name	<p>Urine culture report:</p> <p>Collection date: 12/31/YYYY.</p> <p>Final report: 40,000cfu/ml of Gram positive mixed bacterial flora Growth consistent with normal urethral flora and/or colonizing bacteria from the skin, vaginal, or rectal areas.</p>	110
01/01/YYYY	Hospital/ Provider Name	<p>Delivery record:</p> <p>Shoulder dystocia: No Delivery time: 2303 hrs Delivery location: C-section room Gestation age in weeks: 38 Gestational in days: 3 Labor: Induction Delivering provider: Dr. Shaw Deliver type: Primary C-section Reason for C-section: Fetal intolerance/labor Anesthesia type: General Gestation: Single Gender: Male</p>	283-284

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		Viability: Living APGAR at 1-min: 1 APGAR at 5-mins: 1 APGAR at 10-mins: 3 Placental delivery: Manual Placenta disposition: Sent to lab Date cord blood collected: 12/31/YYYY at 2303 hrs Name of person collecting: Dr. Shaw Prenatal events: Gestational diabetes, pregnancy induced HTN Estimated blood loss: 700ml.	
01/01/YYYY	Hospital/ Provider Name	Physical assessment admit newborn: Newborn APGAR score: Scoring interval: 10 minutes HR: 100 bpm or greater Respiratory effort: Slow respiration/weak cry Muscle tone: Limp Reflex response: No response Color: Pallor or cyanosis Total score: 3 Newborn delivery assessment: Delivery method: C-section emergency Operative indications: Fetal distress Anesthesia type: General Fetal cord description: 3 vessels Nuchal wrap: None Fetal cord comment: Body cord Resuscitation: Cardiac compressions CPAP CPT Intubation Oxygen blow by PPV Tracheal suction Resuscitation comments: Gestational age: 38 weeks 3 days Delivery date/time: 12/31/YYYY @ 2303 Gender: Male Single or multiple gestation: Single Muscle tone: Hypotonic Eyes, nose, mouth: Hard & soft palate intact Back: Anus patent, spine closed Genitalia: Testicles descended Skin: Vernix	1138- 1142

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		<p>Newborn offered breast within 1 hour of delivery: Nil per oral</p> <p>Newborn physical maturity: Skin: Cracking, rare veins Lanugo: Mostly bald Plantar surface: Creases ant 2/3 Breast: Raised areola; 3-4 mm bud Eye/ear: Form/firm; instant recoil Genitals male: Descending; few range Total score: 36.</p> <p>RT standby: Attended code blue: Yes Standby: C-section attended 1 minute APGAR score: 1 points 5 minutes APGAR score: 1 points Blow by: Yes Mask CPAP: Yes Intubated: Yes ET tube size: 2.5 cm Tube insertion: 10 cm Tube placement: Middle of mouth Manually ventilated: yes Manually ventilated @ FiO2 100% CPAP via ET tube: N</p> <p>TOD: 2303 2305: Mask PPV 2305: Compressions 2306: 70% O2 96 hr 2307: Resume 2309: Dr. Khane 2311: Assess HR 2312: O2 blow by 2313: Improved color 91% O2 2314: Khane assess HR >90% 2315: Retractions 2316: CPAP 2317: Intubation attempt 2318: ETT in 2321: X-ray 2318: HR 147, 99% Patient went to nursery Continue bagging until Freeman transport team came Freeman showed up and took over.</p>	
01/01/YYYY	Hospital/ Provider Name	<p>Lab test:</p> <p>Blood gas:</p>	1110

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		Low: HCO3 10; O2 sat 100; cap blood pH 7.03 High: pO2 221, O2 sat 100	
01/01/YYYY	Hospital/ Provider Name	<p>Pediatric history and physical examination report:</p> <p>Referring physician: Dr. Koehn</p> <p>Status: Critical (CPAP)</p> <p>Chief complaint: Neonatal encephalopathy/HIE</p> <p>History of present illness: Term neonate with neonatal encephalopathy/HIE</p> <p>Prenatal/delivery/neonatal history: Some information missing from outside available records at time of admission</p> <p>Baby boy Lewis was born at Pittsburg Via Christi Hospital on 12/31/YYYY at an estimated PMA of 38 weeks and 3days with a BW of 3034 g, to a 23 y/o, now G 6 P3 mother.</p> <p>Medications during pregnancy prenatal vitamins and iron, per records mother was prescribed Metformin however was able to control sugars with diet and never actually started taking.</p> <p>Prenatal labs: Mother blood type: A+ HBs AG: Negative Syphilis: Negative HIV: Negative GBS: Positive Rubella: Immune</p> <p>Pregnancy complications: Polyhydramnios, gestational hypertension, gestational diabetes</p> <p>C-section secondary to prolonged fetal D cells, emergency C-section</p> <p>An outside hospital record, initial Apgar noted as zero. Per transferring physician verbal, he had stated that “first few APGARs were zeros”.</p> <p>Infant was depressed at birth and received PPV and chest compressions. After stabilization patient was transferred to nursery.</p> <p>NICU physical examination: Mild decreased tone however active with exam On CPAP, intermittent retractions, bilaterally coarse 1 out of 6 left upper sternal border systolic ejection murmur Pupils bilaterally equal, mildly sluggish to light capillary refill 3 seconds</p>	1167- 1170

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		<p>General appearance: Pink Lungs: Breath sounds equal to auscultation bilaterally, diminished, subcostal retractions, coarse Neurology: Generalized mild hypotonia Skin: Pink</p> <p>Lab results: CBC: WBC 10.4, Hgb 13.0 (Low), HCT 35.7 (Low), PLT 186 Chemistry: Na 133, K 5.6, Cl 100, CO2 30 (High), BUN 39 (High), Creat 0.7 (High), Glu 58</p> <p>Assessment and plan: Current visit: Yes Category: Medical Status: Acute</p> <p>Problems: Term newborn, current hospitalization: Assessment and plan: Term neonate transferred from an outside hospital due to neonatal encephalopathy/HIE. Maternal history of gestational diabetes, gestational hypertension. Pregnancy complicated by polyhydramnios. Plan: Routine NICU management</p> <p>Hypoxic-ischemic encephalopathy: Emergency C-section due to prolonged fetal decelerations and fetal bradycardia. Child received PPV followed by chest compressions at outside hospital, per transferring physician no epinephrine given during resuscitation process. Cord arterial gas and records noted at 6.7. Baby capillary blood gas at outside hospital 7.03/-19. Transport NICU blood gas obtained at several hours of life 7.05/-17. Per transferring physician verbal, child was “no tone, completely out of it, no obvious seizures however obtunded”. Plan: Start HIE cooling protocol Monitor clinically</p> <p>Need for observation and evaluation of newborn for sepsis: Mother GBS positive, child with neonatal encephalopathy and respiratory distress. Plan: CBC and blood culture now Start amp and Ceftazidime Monitor clinically We will hold off on LP at this time, will obtain if clinically indicated</p>	

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		<p>Slow, feeding newborn: Unknown if mother plans to breast-feed IDM Birthweight 3034 g</p> <p>Plan: Nil per oral given clinical status IV fluids Sugar/labs as needed.</p>	
01/01/YYYY	Hospital/ Provider Name	<p>Post-partum notes:</p> <p>Post-partum day: #1</p> <p>Subjective: Patient is without complaints. Ambulating, voiding. Tolerating a regular diet without nausea or vomiting. Normal lochia. Pain is well controlled with oral pain medications.</p> <p>Assessment: POD 1 PLTCS Acute blood loss anemia- superimposed on anemia of pregnancy Peripartum hypertension- labile</p> <p>Plan: Routine postpartum care. Encourage breast feeding. Encourage ambulation. Ferrous sulfate supplementation. Plan for discharge tomorrow.</p>	66-68
01/01/YYYY	Hospital/ Provider Name	<p>Progress notes:</p> <p>General: Patient condition: Mental status/LOC: Same as pre-op Cardiovascular: Satisfactory Nausea/vomiting: Absent Respiratory: Satisfactory Pain: Controlled Complications: Absent</p> <p>Post-op complications: None</p> <p>Patient condition: Patient is doing well, no complaints, stable vital signs, no apparent adverse anesthesia problems. No complications reported per nursing.</p>	369
01/01/YYYY	Hospital/ Provider Name	<p>X-ray of chest AP/PA view:</p>	1117

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		<p>History: Evaluate ET and OG tube.</p> <p>Findings: The endotracheal tube is below the clavicles and above the carina. The OG tube tip projects over the stomach. The thymic shadow is mildly prominent. There are mildly prominent perihilar interstitial markings. There appears to be a skin fold at the left lung base.</p> <p>Impression: The endotracheal tube is below the clavicles and above the carina. The OG tube appears stable.</p> <p>Radiographic findings are suggestive of retained fetal lung fluid. Follow-up is suggested if symptoms do not improve as neonatal pneumonia may also have this appearance.</p>	
01/01/YYYY	Hospital/ Provider Name	<p>Brief provider note:</p> <p>Update note: At approximately 0230 a.m., I called and updated mother. I Emphasized to mother that child is critically ill, formal diagnosis is neonatal encephalopathy/HIE. Child's short-term outcomes as well as long term neuro developmental outcomes and or death are considerable at this time. I explained the process of cooling and subsequent rewarming as well as complications of cooling in detail with mother. Total conversation on phone approximately 15 minutes. Mother expressed understanding, agreeable with plan.</p>	1297
01/01/YYYY	Hospital/ Provider Name	<p>Brief provider note:</p> <p>Update note: At 4pm, I called and spoke to mother. I discussed all medical management at this time, discussed coagulopathy requiring cryo, discussed that child remains on resp support, IV antibiotics, and undergoing cooling. I discussed that child's neuro exam is better today vs at time of admission however I remain ___ regarding prognosis given degree of acidosis and since child is s/p CPR. I emphasized to mother that child is at high risk for short term mortality and long-term morbidity including neuro developmental impairments and CP. Mother expressed understanding and agreeable with plan.</p>	1298
01/01/YYYY	Hospital/ Provider Name	<p>NICU procedure report:</p> <p>Procedure was performed: After Admission</p> <p>Procedure: Umbilical catheter placement</p> <p>Universal protocol followed: Time out performed</p> <p>Indication: Whole body cooling</p> <p>Description: Area was prepped and draped in a sterile fashion. Then artery was identified.</p>	1349-1350

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		<p>The umbilical artery was dilated. A 5 French single lumen catheter was attempted but would not advance. Then, a double lumen umbilical catheter was placed into the umbilical vein to 9 cm. The line flushed/drew easily. The lines were sutured in place. An X-ray confirmed the placement of the UVC within the liver; The line was readjusted out to 7cm. The line was then secured further.</p> <p>Complications: Minimal < 1 ml.</p>	
01/01/YYYY	Hospital/ Provider Name	<p>X-ray of chest:</p> <p>Clinical history: Line placement</p> <p>Findings: NG tube terminates in the stomach. UVC project over the right hepatic lobe, likely within the portal vein, recommend readjustment. Lungs are slightly hypoinflated with mild granular opacities.</p> <p>Impression: Abnormally placed UVC, recommend readjustment.</p>	1376- 1377
01/01/YYYY	Hospital/ Provider Name	<p>Pediatric transthoracic echocardiogram:</p> <p>Limitation reason: Patient crying Patient status: Urgent</p> <p>Summary: Small moderately restrictive left right anterior muscular defect at the ventricular septum PFO with left- to- right shunt Small to moderate left right PDA Otherwise normal echocardiogram with normal function.</p>	1386- 1388
01/01/YYYY	Hospital/ Provider Name	<p>Ultrasound of neonatal head:</p> <p>Clinical indication: Screening exam; Patient history: Term neonate, HIE 38.3 weeks gets gestation at birth</p> <p>Findings: Germinal matrix: Normal. No germinal matrix/caudothalamic groove hemorrhage. Ventricles: Normal. No ventriculomegaly. No hemorrhage. Brain: Normal. No abnormal periventricular echogenicity. No bleed. Extra-axial space: Subarachnoid space is normal for patient's age.</p> <p>Impression: No germinal matrix bleed.</p>	1378- 1379
01/01/YYYY	Hospital/ Provider Name	<p>Ultrasound of echoencephalogram:</p> <p>Clinical indication: Screening exam; patient history neonate, HIE 38.3 weeks gestation at birth</p>	1384

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		<p>Findings: Germinal matrix: Normal. No germinal matrix/caudothalamic groove hemorrhage. Ventricles: Normal. No ventriculomegaly. No hemorrhage. Brain: Normal. No abnormal periventricular echogenicity. No bleed. Extra-axial space: Subarachnoid space is normal for patient's age.</p> <p>Impression: No germinal matrix bleed.</p>	
01/01/YYYY	Hospital/ Provider Name	<p>EKG:</p> <p>Result: HR 101 bpm Normal sinus rhythm Possible left ventricular hypertrophy No previous EKGs available.</p>	1391
01/01/YYYY	Hospital/ Provider Name	<p>Patient discharge instructions:</p> <p>Instructions: Nothing in vagina for 6 weeks No lifting over 25 lbs No driving for 1 week</p> <p>Final diagnosis: Labor Gestational hypertension Gestational diabetes Fetal bradycardia Emergency cesarean section Antepartum anemia</p> <p>Problems reviewed: Yes</p> <p>Consults/follow up: Additional follow up: Yes (1 week with Dr. Shaw for incision check; 6 weeks with Dr. Burke)</p> <p>Activity: Activity: Activity as tolerated Driving instructions: No driving for 1 week No smoking: No smoking Nothing inside vagina: No douching, no intercourse, no tampons</p> <p>Diet: Discharge diet: No restrictions Symptoms to report to Dr: Bleeding excessive, pain increased, fever over 101°F, vaginal bleeding Increase, cramps in feet or legs, vaginal discharge foul For any problems or questions: Contact your physician</p>	312-313

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		Skin/wound care: Infection signs and symptoms: Increased redness, foul odor of wound, increased drainage, skin itchy or has a rash, increased swelling, temperature above 101°F Operative area clean and dry: Keep incision clean/dry Stitches/staples/Dermabond: Dermabond Bathing instructions: Shower.	
01/01/YYYY - 01/02/YYYY	Hospital/ Provider Name	Nurse notes: 01/01: 0145 hrs: Patient taking on cell phone, Dr. Shaw at bedside. 0235 hrs: Approximately time, right present for IS 0255 hrs: Patient requests Sandwich tray, house supervisor called for supply of trays and will bring up shortly. 0340 hrs: Scheduled Motrin and Tylenol administered. Patient has rested very well but has woken up in pain. Wishes to just try scheduled meds at this time and will call if Oxycodone is needed. 1143 hrs: This RN to bedside for rounding, patient tearful, on the phone, denies any needs, S/O at bedside 1442 hrs: Patient up to the bathroom with assistance per this RN and S/O. Positive void, positive peri-care. 400 cc of urine output noted. New V-Pad and panties on. Fresh gown. Patient back to bed with assistance. No further needs or concerns voiced 2155 hrs: Complete shift assessment done. Vital signs stable. Motrin and Colace administered. Patient denies any further needs. 01/02: Patient discharged by wheelchair to private car with S/O and this staff RN at side, denies questions or concerns at this time.	310-311
01/02/YYYY	Hospital/ Provider Name	Patient health summary: Plan of care: Reason for visit: Labor & delivery Instructions/education provided: Postpartum discharge Cesarean section discharge	20-29

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		<p>General anesthesia Anemia caused by low iron, Adult (DC) Anemia, possibly from low iron, adult ED</p> <p>Discharge instructions: Nothing in vagina for 6 weeks No lifting over 25 lbs No driving for 1 week Additional follow up: Yes (1 week with Dr. Shaw for incision check; 6 weeks with Dr. Burke) Activity: Activity as tolerated Driving instructions: No driving for 1 week No smoking: No smoking Nothing inside vagina: No douching, no intercourse, no tampons Discharge diet: No restrictions</p> <p>Symptoms to report to Dr: Bleeding excessive Pain increased Fever over 101°F Vaginal bleeding increase Cramps in feet or legs Vaginal discharge foul</p> <p>For any problems or questions: Contact your physician Infection signs and symptoms: Increased redness, foul odor of wound, increased drainage, skin itchy or has a rash, increased swelling, temperature above 101°F Operative area clean and dry: Keep incision clean/dry Stitches/staples/derma-bond: Dermabond Bathing instructions: Shower.</p> <p>Functional/cognitive status: Pasero Opioid-induced Sedation Scale (POSS): Response: Awake and alert</p> <p>Current home medications: Oxycodone HCL 5 mg every 4 hours as needed for pain breakthrough Ibuprofen 600 mg every 6 hours Docusate Sodium 100 mg twice a day Acetaminophen 500 mg every 8 hours on schedule Iron, Carbonyl/Vitamin C/Vitamin B12/FA (Iron 100 plus tablet) Prenatal Vitamin/Iron Fumarate/FA (Prenatal vitamins tablet) Metronidazole 500 mg every 12 hours</p> <p><i>Reviewed results of labs.</i></p> <p>Encounter diagnosis: Proteinuria, unspecified</p>	

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		Abnormality of forces of labor, unspecified Decreased fetal movements, third trimester, unspecified Gestational hypertension without significant proteinuria, third trimester 35 weeks gestation of pregnancy.																																																																																																																																					
01/02/YYYY	Hospital/ Provider Name	<p>NICU progress notes:</p> <p>Subjective: Gestational age 38.3 Day of life two Corrected gestational age 38.5</p> <p>Child remains on cooling protocol, day 2/3 Remains on IV antibiotics and Morphine drip Remains on noninvasive ventilation Remains nil per oral and on TPN Morning CBC with down trending hemoglobin, thrombocytopenia, coagulation stable, blood gas stable, electrolytes will be adjusted in TPN based off the morning labs</p> <p>Patient status: Critical (Non-invasive ventilation)</p> <p>Vitals:</p> <table border="1" data-bbox="488 1014 1328 1879"> <thead> <tr> <th>Time (Hrs)</th> <th>Temp (°C)</th> <th>Pulse (BPM)</th> <th>RR</th> <th>BP</th> <th>Pulse ox (%)</th> </tr> </thead> <tbody> <tr><td>01/01 @ 1600</td><td>33.3</td><td>100</td><td>35</td><td>67/36</td><td>100</td></tr> <tr><td>1700</td><td>33.5</td><td>111</td><td>20</td><td>59/34</td><td>100</td></tr> <tr><td>1800</td><td>33.6</td><td>127</td><td>18</td><td>54/33</td><td>99</td></tr> <tr><td>1900</td><td>33.6</td><td>119</td><td>34</td><td>57/31</td><td>100</td></tr> <tr><td>2000</td><td>33.6</td><td>116</td><td>27</td><td>53/33</td><td>100</td></tr> <tr><td>2100</td><td>33.4</td><td>109</td><td>33</td><td>50/36</td><td>100</td></tr> <tr><td>2200</td><td>33.5</td><td>108</td><td>29</td><td>54/35</td><td>100</td></tr> <tr><td>2300</td><td>33.6</td><td>109</td><td>29</td><td>52/32</td><td>100</td></tr> <tr><td>01/02 @ 0000</td><td>33.5</td><td>111</td><td>35</td><td>54/38</td><td>100</td></tr> <tr><td>0100</td><td>33.4</td><td>108</td><td>29</td><td>53/37</td><td>100</td></tr> <tr><td>0200</td><td>33.5</td><td>113</td><td>32</td><td>56/33</td><td>100</td></tr> <tr><td>0300</td><td>33.4</td><td>108</td><td>32</td><td>54/33</td><td>100</td></tr> <tr><td>0400</td><td>33.5</td><td>114</td><td>29</td><td>58/36</td><td>100</td></tr> <tr><td>0500</td><td>33.7</td><td>114</td><td>30</td><td>53/37</td><td>100</td></tr> <tr><td>0600</td><td>33.4</td><td>114</td><td>34</td><td>54/44</td><td>100</td></tr> <tr><td>0700</td><td>33.6</td><td>111</td><td>27</td><td>54/40</td><td>100</td></tr> <tr><td>0800</td><td>33.6</td><td>114</td><td>28</td><td>57/37</td><td>100</td></tr> <tr><td>0900</td><td>33.6</td><td>112</td><td>23</td><td>59/34</td><td>100</td></tr> <tr><td>1000</td><td>33.5</td><td>109</td><td>23</td><td>47/26</td><td>100</td></tr> <tr><td>1100</td><td>33.4</td><td>112</td><td>29</td><td>57/33</td><td>100</td></tr> <tr><td>1200</td><td>33.4</td><td>115</td><td>23</td><td>60/27</td><td>100</td></tr> </tbody> </table>	Time (Hrs)	Temp (°C)	Pulse (BPM)	RR	BP	Pulse ox (%)	01/01 @ 1600	33.3	100	35	67/36	100	1700	33.5	111	20	59/34	100	1800	33.6	127	18	54/33	99	1900	33.6	119	34	57/31	100	2000	33.6	116	27	53/33	100	2100	33.4	109	33	50/36	100	2200	33.5	108	29	54/35	100	2300	33.6	109	29	52/32	100	01/02 @ 0000	33.5	111	35	54/38	100	0100	33.4	108	29	53/37	100	0200	33.5	113	32	56/33	100	0300	33.4	108	32	54/33	100	0400	33.5	114	29	58/36	100	0500	33.7	114	30	53/37	100	0600	33.4	114	34	54/44	100	0700	33.6	111	27	54/40	100	0800	33.6	114	28	57/37	100	0900	33.6	112	23	59/34	100	1000	33.5	109	23	47/26	100	1100	33.4	112	29	57/33	100	1200	33.4	115	23	60/27	100	1299-1306
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		<p>Assessment: Observation evaluation for sepsis, on IV antibiotics, remains critically ill however clinically improving</p> <p>Plan: Continue IV antibiotics Follow-up blood culture till final Monitor clinically We will hold off on LP at this time, will obtain if clinically indicated</p> <p>Slow, feeding newborn: Mother plans to breast-feed IDM Birth weight 3034 g Daily weight 3180 g, down 154 g NPO, N at 70 mils per KG per day</p> <p>Plan: NPO given clinical status Continue TPN, adjust as needed Sugar/labs as needed.</p>	
01/02/YYYY	Hospital/ Provider Name	<p>Brief provider notes:</p> <p>During the daytime, I spoke with parents in person in my office. Grandmother was on speaker phone. Total conversation lasted approximately 20 minutes. I discussed in detail about neonatal encephalopathy, discussed that my prognosis for child at this time remains guarded however child is clinically improving on clinical exam as well as overall labs are remaining relatively stable. I went in detail describing current imaging results. All questions answered, parents and grandmother expressed understanding and agreeable plan.</p> <p>During the conversation, grandmother stated that she had lost an earlier child years ago to the "same condition". During the conversation, family stated that they have spoken to a malpractice lawyer and have already "opened a case". Parents for several minutes discussed that they are "very unhappy with the delivery process and with Pittsburgh Hospital". Mother stated that she felt that C-section should have happened approximately 2 hours prior. Mother stated that she was "yelling for somebody to listen to her because she did not feel things were okay with the baby". Mother stated that at some point fetal monitoring was removed despite concerns about the baby at the time, mother states that a Pediatric nurse came in and placed the fetal monitoring back on after hearing "me yelling and shouting that something was not right". I explained to family that since I was not there at the time, I cannot comment on what was happening however if family has concerns regarding the delivery process, they should speak to their delivering OB. Family stated that they plan on doing that as well.</p>	1307- 1308
01/02/YYYY	Hospital/ Provider Name	<p>X-ray of chest:</p> <p>Clinical history: Follow-up UVC positioning</p>	1380

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		<p>Findings: NG tube is in place. UVC tip terminates at T10-11. Interval placement of a pelvic catheter. Lungs demonstrate mild granular opacities. No pleural effusion or pneumothorax. Normal cardiothymic silhouette. Bowel gas pattern is non obstructive. No evident pneumatosis. No acute osseous findings.</p>																																																																																																							
01/03/YYYY	Hospital/ Provider Name	<p>NICU progress notes:</p> <p>Subjective: Gestational age 38.3 Day of life 3 Corrected gestational age 38.6</p> <p>Child remains on cooling protocol, day 3/3 Remains on IV antibiotics and Morphine drip Remains on noninvasive ventilation Remains NPO and on TPN No significant overnight events reported by nursing Overnight sugars in the 50s, will increase dextrose in TPN and continue monitoring closely</p> <p>Patient status: Critical (Noninvasive ventilation)</p> <p>Vitals:</p> <table border="1" data-bbox="488 1045 1328 1745"> <thead> <tr> <th>Time (Hrs)</th> <th>Temp (°C)</th> <th>Pulse (BPM)</th> <th>RR</th> <th>BP</th> <th>Pulse ox (%)</th> </tr> </thead> <tbody> <tr><td>01/02 @ 2000</td><td>33.7</td><td>114</td><td>30</td><td>43/34</td><td>100</td></tr> <tr><td>2100</td><td>33.3</td><td>111</td><td>37</td><td>59/46</td><td>98</td></tr> <tr><td>2200</td><td>33.3</td><td>107</td><td>29</td><td>66/44</td><td>99</td></tr> <tr><td>2300</td><td>33.4</td><td>104</td><td>30</td><td>65/39</td><td>99</td></tr> <tr><td>01/03 @ 0000</td><td>33.4</td><td>106</td><td>27</td><td>58/43</td><td>99</td></tr> <tr><td>0100</td><td>33.5</td><td>105</td><td>29</td><td>61/34</td><td>98</td></tr> <tr><td>0200</td><td>33.6</td><td>108</td><td>28</td><td>57/45</td><td>100</td></tr> <tr><td>0300</td><td>33.6</td><td>110</td><td>32</td><td>56/40</td><td>98</td></tr> <tr><td>0400</td><td>33.6</td><td>112</td><td>31</td><td>47/37</td><td>100</td></tr> <tr><td>0500</td><td>33.6</td><td>108</td><td>30</td><td>57/37</td><td>100</td></tr> <tr><td>0600</td><td>33.5</td><td>105</td><td>27</td><td>48/31</td><td>100</td></tr> <tr><td>0700</td><td>33.7</td><td>105</td><td>25</td><td>58/40</td><td>100</td></tr> <tr><td>0800</td><td>32.5</td><td>110</td><td>25</td><td></td><td>100</td></tr> <tr><td>0900</td><td>33.5</td><td>112</td><td>30</td><td>69/42</td><td>98</td></tr> <tr><td>1500</td><td>32</td><td>102</td><td>22</td><td>56/39</td><td>100</td></tr> <tr><td>1900</td><td>33.2</td><td>96</td><td>27</td><td>64/39</td><td>98</td></tr> </tbody> </table> <p>Assessment and plan: Term newborn, current hospitalization: Term neonate transferred from an outside hospital due to neonatal</p>	Time (Hrs)	Temp (°C)	Pulse (BPM)	RR	BP	Pulse ox (%)	01/02 @ 2000	33.7	114	30	43/34	100	2100	33.3	111	37	59/46	98	2200	33.3	107	29	66/44	99	2300	33.4	104	30	65/39	99	01/03 @ 0000	33.4	106	27	58/43	99	0100	33.5	105	29	61/34	98	0200	33.6	108	28	57/45	100	0300	33.6	110	32	56/40	98	0400	33.6	112	31	47/37	100	0500	33.6	108	30	57/37	100	0600	33.5	105	27	48/31	100	0700	33.7	105	25	58/40	100	0800	32.5	110	25		100	0900	33.5	112	30	69/42	98	1500	32	102	22	56/39	100	1900	33.2	96	27	64/39	98	1309-1316
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		<p>encephalopathy/HIE. Maternal history of gestational diabetes, gestational hypertension. Pregnancy complicated by polyhydramnios.</p> <p>Studies: 1/2-EEG verbally reported as no seizures, few sharps noted 1/2-Head ultrasound with no IVH 1/2-Echo with PFO, PDA, muscular VSD 1/2-EKG with prolonged QTC</p> <p>Plan: Routine NICU management Repeat echo prior to discharge Repeat EKG once rewarmed Repeat EEG once rewarmed Brain MRI once rewarmed at 5 to 7 days of life</p> <p>Hypoxic-ischemic encephalopathy: Emergency C-section due to prolonged fetal decelerations and fetal bradycardia. Child received PPV followed by chest compressions at outside hospital, per transferring physician no epinephrine given during resuscitation process. Cord arterial gas and records noted at 6.7. Baby capillary blood gas at outside hospital 7.03/-19. Transport NICU blood gas obtained at several hours of life 7.05/-17. Per transferring physician verbal, child was “no tone, completely out of it, no obvious seizures however obtunded”.</p> <p>1/2-Morning coags reassuring, status post xl dose cryoprecipitate following admission. No overnight significant events, remains on cooling</p> <p>Assessment: Neonatal encephalopathy/HIE, on day 3/3 cooling protocol, gross neuro exam improving</p> <p>Plan: Continue HIE cooling protocol, rewarming to start approximately 4 am on 1/4 Monitor clinically Physical therapy consult for right hand contracture</p> <p>Need for observation and evaluation of newborn for sepsis: Mother GBS positive, child with neonatal encephalopathy and respiratory distress. 1/2 WBC 10 K, one band</p> <p>Assessment: Observation evaluation for sepsis, status post 48 hours IV antibiotics, blood culture no growth to date, clinically improving</p> <p>Plan: Follow-up blood culture till final Monitor clinically</p>	

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		<p>Slow, feeding newborn: Mother plans to breast-feed IDM Birth weight 303 4 g Daily weight 320 0 g, gained 20 g NPO, TPN at 80 mils per kg per day</p> <p>Plan: NPO given clinical status Continue TPN, adjust as needed Sugar/labs as needed.</p>																																																	
01/03/YYYY	Hospital/ Provider Name	<p>Electroencephalography:</p> <p>History: 0 day old 38 week undergoing therapeutic hypothermia for suspected HIE</p> <p>Impression: This patient's routine electroencephalogram is within the range of normal variation for age. No clinical or electrographic seizures were recorded during the study. No epileptiform discharges were seen. It should be noted a normal electroencephalogram does not rule out the possibility of seizures. Clinical correlation is advised.</p>	1924- 1925																																																
01/04/YYYY	Hospital/ Provider Name	<p>NICU progress notes:</p> <p>Subjective: Gestational age 38.3 Day of life 4 Corrected gestational age 39.0 Status post 72 hrs of cooling, completed rewarming at 10 am Morphine drip stopped Weaning NIPPV Feeding started this evening</p> <p>Patient status: Critical</p> <p>Vitals:</p> <table border="1" data-bbox="488 1518 1328 1894"> <thead> <tr> <th>Time (Hrs)</th> <th>Temp (°C)</th> <th>Pulse (BPM)</th> <th>RR</th> <th>BP</th> <th>Pulse ox (%)</th> </tr> </thead> <tbody> <tr> <td>01/03 @ 1800</td> <td>33.3</td> <td>109</td> <td>22</td> <td></td> <td>98</td> </tr> <tr> <td>1900</td> <td>33.2</td> <td>96</td> <td>27</td> <td>64/39</td> <td>98</td> </tr> <tr> <td>2000</td> <td>33.6</td> <td>103</td> <td>30</td> <td></td> <td>100</td> </tr> <tr> <td>2100</td> <td>33.3</td> <td>98</td> <td>28</td> <td>62/42</td> <td>100</td> </tr> <tr> <td>2200</td> <td>33.3</td> <td>96</td> <td>30</td> <td></td> <td>100</td> </tr> <tr> <td>2300</td> <td>33.2</td> <td>99</td> <td>24</td> <td>67/44</td> <td>100</td> </tr> <tr> <td>01/04 @ 0000</td> <td>33.7</td> <td>107</td> <td>29</td> <td></td> <td>97</td> </tr> </tbody> </table>	Time (Hrs)	Temp (°C)	Pulse (BPM)	RR	BP	Pulse ox (%)	01/03 @ 1800	33.3	109	22		98	1900	33.2	96	27	64/39	98	2000	33.6	103	30		100	2100	33.3	98	28	62/42	100	2200	33.3	96	30		100	2300	33.2	99	24	67/44	100	01/04 @ 0000	33.7	107	29		97	1317- 1324
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		0600	34.9	114	32	67/43	100	
		0700	34.0	115	30	63/40	98	
		0800	34.7	119	28	61/32	95	
		0900	34.4	121	14	64/36	96	
		1000	34.8	143	23	69/39	97	
		1100	36.5	136	30	62/36	96	
		1120	37.1					
		1200	36.2	140	30	65/41	96	
		1300	36.8	142	21	64/37	93	
		1400	37.0	155	35	59/28	94	
		1500	36.6	131	27	63/32	94	
		1600	36.6	140	48	71/35	92	
		<p>Assessment and plan: Hypoxic-ischemic encephalopathy: Emergency C-section due to prolonged fetal decelerations and fetal bradycardia. Child received PPV followed by chest compressions at outside hospital, per transferring physician no Epinephrine given during resuscitation process. Cord arterial gas and records noted at 6.7. Baby capillary blood gas at outside hospital 7.03/-19. Transport NICU blood gas obtained at several hours of life 7.05/-17. Per transferring physician verbal, child was “no tone, completely out of it, no obvious seizures however obtunded”.</p> <p>1/2 morning coags reassuring, status post xl dose cryoprecipitate following admission. No overnight significant events, remains on cooling</p> <p>Assessment: Neonatal encephalopathy/HIE, status post whole-body cooling and rewarming (Rewarmed by 1000 today), on NIPPV</p> <p>Currently on NIPPV 20/6 rate of 30</p> <p>01/04/YYYY: Blood pressure normal, good urine output, rewarming labs normal, morphine stopped, feeding starting late this evening. CBG reassuring</p> <p>1/4: Physical therapy saw the baby and not concerned about the right-hand contracture</p> <p>Plan: Wean NIPPV rate with plans to switch to HFNC this evening EEG after completely rewarmed Brain MRI on day 7</p>						

Patient Name
Patient Name

DOB: MM/DD/YYYY
DOB: MM/DD/YYYY

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		<p>Need for observation and evaluation of newborn for sepsis: Mother CBS positive, child with neonatal encephalopathy and respiratory distress. 1/2 WBC 10K, one band</p> <p>Assessment: Observation evaluation for sepsis, status post 48 hours IV antibiotics, blood culture no growth to date, clinically improving</p> <p>Plan: Follow-up blood culture till final Monitor clinically</p> <p>Slow, feeding newborn: Mother plans to breast-feed IDM Birth weight 303 4 g Daily weight 323 0 g, gained 30 g</p> <p>Currently NPO on TPN, got foleys on 1/3 due to decreased UO Urine output is normal this morning</p> <p>Abdomen soft NTND, bowel sound present. CMP normal Plan: start feeding 10 ml EBM/Similac this evening after completely rewarmed Continue TPN, (TFV 120 ml/kg/day) Sugar/labs as needed</p> <p>Term newborn, current hospitalization: Term neonate transferred from an outside hospital due to neonatal encephalopathy/HIE. Maternal history of gestational diabetes, gestational hypertension. Pregnancy complicated by polyhydramnios.</p> <p>Studies: 1/2 EEG verbally reported as no seizures, few sharps noted 1/2 head ultrasound with no IVH 1/2 echo with PFO, PDA, muscular VSD 1/2 EKG with prolonged QTC</p> <p>Plan: Routine NICU management Repeat echo prior to discharge Repeat EKG once rewarmed Repeat EEG once rewarmed Brain MRI once rewarmed at 7 days of life.</p>	
01/04/YYYY	Hospital/ Provider Name	EKG:	1393

Patient Name
Patient Name

DOB: MM/DD/YYYY
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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		<p>Result: Normal sinus rhythm Possible left ventricular hypertrophy No previous EKGs available.</p>	
01/04/YYYY	Hospital/ Provider Name	<p>Physical therapy initial evaluation report:</p> <p>Birth history: Induction for PIH, crash C/S with APGARs 1/1/3/ questionable, intubation at referral hospital, EKG prolonged QT, EEG no seizures, rewarming complete this am at 10am. Morphine just discontinued this morning. Encephalopathy with whole body cooling</p> <p>NICU assessment: Infant 39.0 PCA male born at 38.3 via crash c/section after induction, whole body cooling just completed with rewarming this am, morphine DC this am. There were concerns of right-hand fisting during cooling process with possibility of contracture. There is no range of motion deficits currently on right and, there is active right finger extension equal to the left, there is active wrist extension on right equal to the left, there is active thumb abduction on right equal to the left. Infant is alerting this pm and getting hands to mouth and rooting, he has appropriate flexion tone for age. There is symmetrical active range of motion of right upper extremities compared to left at this time so no further physical therapy recommended.</p> <p>Treatment: Gait training Therapeutic exercise Therapeutic activity Neuromuscular re-education Wheelchair management Positioning Manual therapy Functional assessment E-stim (Attended) Ultrasound.</p>	1399-1402
01/05/YYYY	Hospital/ Provider Name	<p>NICU progress notes:</p> <p>Subjective: Gestational age 38.3 Day of life 5 Corrected gestational age 39.1 Status post 72 hrs of cooling and rewarming Tolerating PO HFNC EEG and EKG done Foley catheter and UVC removed Patient status: Non critical</p> <p>Vitals:</p>	1325-1330

Patient Name
Patient Name

DOB: MM/DD/YYYY
DOB: MM/DD/YYYY

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS						PDF REF
		Time (Hrs)	Temp (°C)	Pulse (BPM)	RR	BP	Pulse ox (%)	
		01/04 @ 1600	36.6	140	48	71/35	92	
		1700		133	25		91	
		1800		134	18		92	
		1900		135	30		93	
		2000	37.3	145	55	54/31	93	
		2100		147	32		98	
		2200		146	41		96	
		2300	37.2	132	52		92	
		01/05 @ 0000		154	52		96	
		0100		155	46		93	
		0200	36.8	133	29		95	
		0300		138	28		100	
		0400		174	53		100	
		0500	37.3	133	42		98	
		0600		163	36		95	
		0700		124	32		99	
		0800	36.7	134	50	67/41	96	
		0900		128	44		98	
		1000		105	23		100	
		1100	36.7	120	38		99	
		1200		128	36		100	
		1300		133	37		96	
		<p>Assessment and plan: Current visit: Yes Category: Medical Status: Acute</p> <p>Problems: Hypoxic-ischemic encephalopathy: Emergency C-section due to prolonged fetal decelerations and fetal bradycardia. Child received PPV followed by chest compressions at outside hospital, per transferring physician no epinephrine given during resuscitation process. Cord arterial gas and records noted at 6.7. Baby capillary blood gas at outside hospital 7.03/-19. Transport NICU blood gas obtained at several hours of life 7.057-17. Per transferring physician verbal, child was “no tone, completely out of it, no obvious seizures however obtunded”.</p> <p>1/2 morning coags reassuring, status post xl dose cryoprecipitate following admission. No overnight significant events, remains on cooling</p> <p>Assessment: Neonatal encephalopathy/HIE, status post whole-body cooling and rewarming</p>						

Patient Name
Patient Name

DOB: MM/DD/YYYY
DOB: MM/DD/YYYY

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		<p>(Rewarmed by 1000 today), status post morphine drip, comfortable on HFNC</p> <p>01/04/YYYY: Blood pressure normal, good urine output, rewarming labs normal, morphine stopped, feeding starting late this evening. CBG reassuring</p> <p>1/4: Physical therapy saw the baby and not concerned about the right-hand contracture</p> <p>Plan: Wean to room air EEG and EKG done today, reading awaited Brain MRI on day 7</p> <p>Need for observation and evaluation of newborn for sepsis: Mother GBS positive, child with neonatal encephalopathy and respiratory distress. 1/2 WBC 10 K, one band</p> <p>Assessment: Observation evaluation for sepsis, status post 48 hours IV antibiotics, blood culture no growth to date, clinically improving</p> <p>Plan: Follow-up blood culture till final Monitor clinically</p> <p>Slow, feeding newborn: Mother plans to breast-feed IDM Birth weight 3034 g Daily weight 3209 g, lost 21 g Tolerating enteral feeds Has foleys catheter</p> <p>Abdomen soft NTND, bowel sound present. CMP normal</p> <p>Plan: PO ad lib Remove UVC if good PO intake Remove foleys catheter Sugar/labs as needed</p> <p>Term newborn, current hospitalization: Term neonate transferred from an outside hospital due to neonatal encephalopathy/HIE. Maternal history of gestational diabetes, gestational hypertension. Pregnancy complicated by polyhydramnios.</p> <p>Studies:</p>	

Patient Name
Patient Name

DOB: MM/DD/YYYY
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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		1/2 EEG verbally reported as no seizures, few sharps noted 1/2 head ultrasound with no IVH 1/2 echo with PFO, PDA, muscular VSD 1/2 EKG with prolonged QTC Plan: Routine NICU management Repeat echo prior to discharge Follow up on EKG and EEG Brain MRI at 7 days of life.	
01/05/YYYY	Hospital/ Provider Name	EKG: Result: Normal sinus rhythm Normal EKG Pediatric analysis. Manual comparison required When compared with EKG of 01/01/YYYY. Previous EKG is present.	1392
01/05/YYYY	Hospital/ Provider Name	Electroencephalography: Patient history: This is a 5-day male born at 38 weeks with history of HIE. EEG has been done to look for underlying epileptic activity. Impression: This patient's electroencephalogram is within the range of normal variation for age. No clinical or electrographic seizures were recorded during the study. It should be noted a normal electroencephalogram does not rule out the possibility of seizures. Clinical correlation is advised.	1926
01/06/YYYY	Hospital/ Provider Name	Pathology report: Collected date and time: 12/31/YYYY Diagnosis: Placenta, delivery-Third trimester placenta with increased intervillous fibrin; negative for acute chorioamnionitis, funisitis or chronic. Specimen: Placenta, third trimester Pertinent history: Fetal bradycardia Previous cesarean section Gestation: 39 weeks one day; Apgar score: unavailable at current time; fetal distress: Yes.	406-407
01/06/YYYY	Hospital/ Provider Name	NICU progress notes: Subjective: Gestational age 38.3 Day of life #6	1331- 1336

Patient Name
Patient Name

DOB: MM/DD/YYYY
DOB: MM/DD/YYYY

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF																																																
		<p>Corrected gestational age 39.2</p> <p>Status post whole-body cooling and rewarming Tolerating PO well Comfortable in room air</p> <p>Patient status: Non-critical</p> <p>Vitals:</p> <table border="1"><thead><tr><th>Time (Hrs)</th><th>Temp (°C)</th><th>Pulse (BPM)</th><th>RR</th><th>BP</th><th>Pulse ox (%)</th></tr></thead><tbody><tr><td>01/05 @ 1730</td><td>37.2</td><td>148</td><td>49</td><td></td><td>99</td></tr><tr><td>2030</td><td>36.8</td><td>124</td><td>30</td><td></td><td>100</td></tr><tr><td>2330</td><td>36.7</td><td>130</td><td>28</td><td>75/48</td><td>100</td></tr><tr><td>01/06 @ 0230</td><td>36.7</td><td>112</td><td>38</td><td></td><td>99</td></tr><tr><td>0530</td><td>36.9</td><td>152</td><td>30</td><td></td><td>99</td></tr><tr><td>0830</td><td>36.6</td><td>119</td><td>38</td><td>60/24</td><td>98</td></tr><tr><td>1130</td><td>36.8</td><td>99</td><td>48</td><td></td><td>100</td></tr></tbody></table> <p>Assessment and plan: Current visit: Yes Category: Medical Status: Acute</p> <p>Problems: Hypoxic-ischemic encephalopathy: Emergency C-section due to prolonged fetal decelerations and fetal bradycardia. Child received PPV followed by chest compressions at outside hospital, per transferring physician no epinephrine given during resuscitation process. Cord arterial gas and records noted at 6.7. Baby capillary blood gas at outside hospital 7.03/-19. Transport NICU blood gas obtained at several hours of life 7.05/-17. Per transferring physician verbal, child was “no tone, completely out of it, no obvious seizures however obtunded”.</p> <p>1/2 morning coags reassuring, status post xl dose cryoprecipitate following admission. No overnight significant events, remains on cooling</p> <p>1/4: Physical therapy saw the baby and not concerned about the right-hand contracture 1/5: Normal EEG (Post rewarming) 1/5: EKG normal</p> <p>Assessment: Neonatal encephalopathy/HIE, status post whole-body cooling 1/6: Neuro exam: good movement, tone</p>	Time (Hrs)	Temp (°C)	Pulse (BPM)	RR	BP	Pulse ox (%)	01/05 @ 1730	37.2	148	49		99	2030	36.8	124	30		100	2330	36.7	130	28	75/48	100	01/06 @ 0230	36.7	112	38		99	0530	36.9	152	30		99	0830	36.6	119	38	60/24	98	1130	36.8	99	48		100	
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Patient Name
Patient Name

DOB: MM/DD/YYYY
DOB: MM/DD/YYYY

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		<p>Plan: Continue to observe in room air Brain MRI tomorrow</p> <p>Need for observation and evaluation of newborn for sepsis: Mother GBS positive, child with neonatal encephalopathy and respiratory distress. 1/2 WBC 10 K, one band</p> <p>Assessment: Observation evaluation for sepsis, status post 48 hours IV antibiotics, blood culture negative final</p> <p>Plan: Monitor clinically</p> <p>Slow, feeding newborn: Mother plans to breast-feed IDM Birth weight 3034 g</p> <p>Daily weight 3080 g, lost 129 g Adequate voids and stools tolerating enteral feeds status post IVF and UVC removed yesterday 1/6: POC glucose normal 1/7: POC glucose normal</p> <p>Plan: PO ad lib with a minimum of 30 ml per feed Sugar/labs as needed</p> <p>Term newborn, current hospitalization: Term neonate transferred from an outside hospital due to neonatal encephalopathy/HIE. Maternal history of gestational diabetes, gestational hypertension. Pregnancy complicated by polyhydramnios.</p> <p>Studies: 1/2: EEG verbally reported as no seizures, few shams noted 1/2: head ultrasound with no IVH 1/2: echo with PFO, PDA, muscular VSD 1/2: EKG with prolonged QTC 1/5: EEG and EKG normal</p> <p>Plan: Routine NICU management Repeat echo prior to discharge Brain MRI tomorrow.</p>	
01/07/YYYY	Hospital/ Provider	NICU progress notes:	1337-

Patient Name
Patient Name

DOB: MM/DD/YYYY
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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF																																																
	Name	<p>Subjective: Gestational age 38.3 Day of life 7 Corrected gestational age 39.3</p> <p>HIE status post whole-body cooling and rewarming RA, working on PO, improving daily MRI brain today On isolation due to Covid exposure</p> <p>PS: Mother is Covid positive, she has to undergo isolation for 5 days and wear mask after that. Can visit after 5 days if asymptomatic and has to be fully gowned Patient status: Non critical</p> <table border="1" data-bbox="490 810 1328 1192"><thead><tr><th>Time (Hrs)</th><th>Temp (°C)</th><th>Pulse (BPM)</th><th>RR</th><th>BP</th><th>Pulse ox (%)</th></tr></thead><tbody><tr><td>01/06 @ 1730</td><td>37.0</td><td>172</td><td>43</td><td></td><td>100</td></tr><tr><td>2030</td><td>36.6</td><td>157</td><td>48</td><td></td><td>100</td></tr><tr><td>2330</td><td>36.7</td><td>112</td><td>34</td><td>81/41</td><td>100</td></tr><tr><td>01/07 @ 0230</td><td>36.5</td><td>114</td><td>32</td><td></td><td>100</td></tr><tr><td>0530</td><td>36.5</td><td>177</td><td>45</td><td></td><td>93</td></tr><tr><td>0830</td><td>36.5</td><td>104</td><td>56</td><td>78/38</td><td>100</td></tr><tr><td>1130</td><td>36.7</td><td>109</td><td>55</td><td></td><td>100</td></tr></tbody></table> <p>Assessment and plan: Current visit: Yes Category: Medical Status: Acute</p> <p>Problems: Hypoxic-ischemic encephalopathy: Emergency C-section due to prolonged fetal decelerations and fetal bradycardia. Child received PPV followed by chest compressions at outside hospital, per transferring physician no epinephrine given during resuscitation process. Cord arterial gas and records noted at 6.7. Baby capillary blood gas at outside hospital 7.03/-19. Transport NICU blood gas obtained at several hours of life 7.05/-17. Per transferring physician verbal, child was “no tone, completely out of it, no obvious seizures however obtunded”.</p> <p>1/2 morning coags reassuring, status post xl dose cryoprecipitate following admission. No overnight significant events, remains on cooling</p> <p>1/4: Physical therapy saw the baby and not concerned about the right-hand contracture</p>	Time (Hrs)	Temp (°C)	Pulse (BPM)	RR	BP	Pulse ox (%)	01/06 @ 1730	37.0	172	43		100	2030	36.6	157	48		100	2330	36.7	112	34	81/41	100	01/07 @ 0230	36.5	114	32		100	0530	36.5	177	45		93	0830	36.5	104	56	78/38	100	1130	36.7	109	55		100	1342
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Patient Name

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		<p>1/5: Normal EEG (Post rewarming) 1/5: EKG normal</p> <p>Assessment: Neonatal encephalopathy/HIE, status post whole-body cooling 1/6: Neuro exam: Good movement, tone</p> <p>Plan: Continue to observe in room air Follow up MRI result (Done today)</p> <p>Need for observation and evaluation of newborn for sepsis: Mother GBS positive, child with neonatal encephalopathy and respiratory distress. 1/2 WBC 10 K, one band</p> <p>Assessment: Observation evaluation for sepsis, status post 48 hours IV antibiotics, blood culture negative final</p> <p>Plan: Monitor clinically</p> <p>Slow, feeding newborn: Mother plans to breast-feed IDM</p> <p>Birth weight 3034 g Daily weight 3045 g, -35g overnight Adequate voids and stools Tolerating enteral feeds, working on PO</p> <p>1/7: POC glucose normal</p> <p>Plan: PO ad lib with a minimum of 45 ml per feed Sugar/labs as needed</p> <p>Term newborn, current hospitalization: Term neonate transferred from an outside hospital due to neonatal encephalopathy/HIE: Maternal history of gestational diabetes, gestational hypertension. Pregnancy complicated by polyhydramnios.</p> <p>Studies: 1/2: EEG verbally reported as no seizures, few shams noted 1/2: head ultrasound with no IVH 1/2: echo with PFO, PDA, muscular VSD 1/2: EKG with prolonged QTC</p>	

Patient Name
Patient Name

DOB: MM/DD/YYYY
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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		<p>1/5: EEG and EKG normal</p> <p>Plan: Routine NICU management Repeat echo prior to discharge Brain MRI today</p> <p>Exposure to Covid-19 virus: Mother tested positive for Covid on 1/6, father exposed to Covid, baby exposed on 1/5 when parent visited. Mother unvaccinated.</p> <p>Plan made in consultation in infection control in line with current CDC guideline</p> <p>Plan: Isolate baby for 5 days and do Covid testing on Day 5 Mother and father to have isolation for 5 days followed by visit fully gowned and masked and only if they are asymptomatic Baby will be considered Covid negative if day 5 test is negative.</p>	
01/07/YYYY	Hospital/ Provider Name	<p>MRI of brain without contrast:</p> <p>History: Encephalopathy</p> <p>Findings: Diffusion weighted images demonstrate no acute ischemia. Sulcation pattern is symmetric bilaterally. Mild periventricular signal alteration of bilateral basal ganglia and brainstem nonspecific at this time.</p> <p>Impression: Very mild signal alteration of bilateral basal ganglia and brainstem, cannot exclude inflammatory changes or mild ischemic process, recommend short-term follow-up.</p> <p>No acute hemorrhage, midline shift, hydrocephalus or acute ischemia.</p>	1381
01/07/YYYY	Hospital/ Provider Name	<p>EKG:</p> <p>Results: Normal sinus rhythm Normal EKG Pediatric analysis-Manual comparison required When compared with EKG of 01/01/YYYY, Previous EKG is present</p>	1394
01/08/YYYY	Hospital/ Provider Name	<p>Progress note:</p> <p>NICU subjective: Gestational age 38.3 Day of life 8 Corrected gestational age 39.4</p>	1343- 1348

Patient Name
Patient Name

DOB: MM/DD/YYYY
DOB: MM/DD/YYYY

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF																																																						
		<p>Baby is PUI due to maternal Covid, in isolation but baby doing well PO feeding much improved MRI shows signs of HIE Neuro exam normal Rooming in tonight</p> <p>Patient status: Non-critical</p> <p>Vitals:</p> <table border="1"><thead><tr><th>Time (Hrs)</th><th>Temp (°C)</th><th>Pulse (BPM)</th><th>RR</th><th>BP</th><th>Pulse ox (%)</th></tr></thead><tbody><tr><td>01/07 @ 1430</td><td>36.8</td><td>107</td><td>45</td><td></td><td>100</td></tr><tr><td>1730</td><td>36.9</td><td>138</td><td>48</td><td></td><td>100</td></tr><tr><td>2000</td><td>36.1</td><td>123</td><td>37</td><td>78/44</td><td>100</td></tr><tr><td>2330</td><td>36.7</td><td>109</td><td>51</td><td></td><td>100</td></tr><tr><td>01/08 @ 0200</td><td>36.4</td><td>106</td><td>43</td><td></td><td>99</td></tr><tr><td>0500</td><td>36.7</td><td>136</td><td>44</td><td></td><td>100</td></tr><tr><td>0830</td><td>36.6</td><td>151</td><td>46</td><td>81/44</td><td>100</td></tr><tr><td>1130</td><td>36.9</td><td>135</td><td>50</td><td></td><td>95</td></tr></tbody></table> <p>Assessment and plan: Current visit: Yes Category: Medical Status: Acute</p> <p>Hypoxic-ischemic encephalopathy: Emergency C-section due to prolonged fetal decelerations and fetal bradycardia. Child received PPV followed by chest compressions at outside hospital, per transferring physician no epinephrine given during resuscitation process. Cord arterial gas and records noted at 6.7. Baby capillary blood gas at outside hospital 7.03/-19. Transport NICU blood gas obtained at several hours of life 7.05/-17. Per transferring physician verbal, child was “no tone, completely out of it, no obvious seizures however obtunded”.</p> <p>1/2 morning coags reassuring, status post xl dose cryoprecipitate following admission. No overnight significant events, remains on cooling</p> <p>1/4: Physical therapy saw the baby and not concerned about the right-hand contracture 1/5: Normal EEG (Post rewarming) 1/5: EKG normal</p> <p>Assessment: Neonatal encephalopathy/HIE, status post whole-body cooling MRI shows signs of HIE</p>	Time (Hrs)	Temp (°C)	Pulse (BPM)	RR	BP	Pulse ox (%)	01/07 @ 1430	36.8	107	45		100	1730	36.9	138	48		100	2000	36.1	123	37	78/44	100	2330	36.7	109	51		100	01/08 @ 0200	36.4	106	43		99	0500	36.7	136	44		100	0830	36.6	151	46	81/44	100	1130	36.9	135	50		95	
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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		<p>1/7: Neuro exam: good movement, tone normal, slight head lag</p> <p>Plan: Continue to observe in room air HGB tomorrow Neuro clinic referral Early intervention referral</p> <p>Slow, feeding newborn: Mother plans to breast-feed IDM</p> <p>Birth weight 3034 g Daily weight 3036 g, -9g overnight Adequate voids and stools Tolerating enteral feeds, took 100% PO overnight</p> <p>1/7: POC glucose normal</p> <p>Plan: PO ad lib with shift minimum of 200 ml Sugar/labs as needed</p> <p>Term newborn, current hospitalization: Term neonate transferred from an outside hospital due to neonatal encephalopathy/HIE. Maternal history of gestational diabetes, gestational hypertension. Pregnancy complicated by polyhydramnios</p> <p>Studies: 1/2: EEG verbally reported as no seizures, few shams noted 1/2: head ultrasound with no IVH 1/2: echo with PFO, PDA, muscular VSD 1/2: EKG with prolonged QTC 1/5: EEG and EKG normal 1/6: Brain MR1 shows signs of HIE</p> <p>Plan: Routine NICU management follow up with cardiology in one month for PDA and VSD</p> <p>Exposure to Covid-19 virus: Mother tested positive for Covid on 1/6, father exposed to Covid, baby exposed on 1/5 when parent visited. Mother unvaccinated</p> <p>Plan made in consultation in infection control in line with current CDC guideline</p> <p>Plan: Isolate baby for 5 days</p>	

Patient Name
Patient Name

DOB: MM/DD/YYYY
DOB: MM/DD/YYYY

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		<p>Will do Covid testing today and tomorrow as baby is likely to be discharged home tomorrow Mother and father to have isolation for 5 days followed by visit fully gowned and masked and only if they are asymptomatic Baby will be considered Covid negative if day 5 test is negative</p> <p>Ventricular septal defect, muscular: Term baby with moderate PDA and small muscular VSD in initial echocardiogram done just after birth Exam: No murmur</p> <p>Plan: Echocardiogram prior to discharge</p> <p>Undescended right testicle: Right testis not palpable in exam Plan: Testicular US prior to discharge.</p> <p>Addendum: Direct discharge tomorrow, no rooming in as mother has Covid.</p>	
01/08/YYYY	Hospital/ Provider Name	<p>Ultrasound of testicular:</p> <p>Clinical statement: Undescended right testicle.</p> <p>Findings: There is an abnormal position of the right testicle high within the right inguinal canal, at the level of the urinary bladder dome, consistent with right cryptorchidism.</p> <p>Impression: Right cryptorchidism. The right testicle is undescended. No evidence of significant testicular atrophy at this time. Normal testicular color doppler flow. Small hydrocele on the left.</p>	1382- 1383
01/08/YYYY	Hospital/ Provider Name	<p>Pediatric transthoracic echocardiogram report:</p> <p>Indication: Patent ductus arteriosus (PDA) and VSD</p> <p>Findings: Ventricular system: Trivial mid-muscular ventricular septal defect with left to right shunting.</p> <p>Summary: Trivial muscular VSD, no PDA.</p>	1389- 1390
01/09/YYYY	Hospital/ Provider Name	<p>Hearing screening report:</p> <p>Test results: Left ear: Pass POVR score: 3.56</p>	1921- 1922

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		<p>Stimuli averaged: 4608 Number of artifact: 2664 Test time: 10 mins 07 sec</p> <p>Right ear: Pass POVR score: 3.50 Stimuli averaged: 6144 Number of artifact: 2037 Test time: 04 mins 21 sec.</p> <p>Interpretation: No interpretation.</p>	
01/09/YYYY	Hospital/ Provider Name	<p>Discharge summary:</p> <p>Admit date: 01/01/YYYY</p> <p>Discharge date: 01/09/YYYY</p> <p>Hospital course (Not required if < 48 HR): A 9-days old term baby boy transferred from OSH with hypoxic ischemic encephalopathy (Moderate), status post whole-body cooling, status post coagulopathy. Baby underwent cooling and rewarming without any complication. He did not have any seizure activity on multiple EEGs. Head ultrasound was normal and follow up brain MRI at 7 days of birth showed signs of HIE (Mild signal alteration of bilateral basal ganglia and brain stem). Baby has right sided undescended testis and a small VSD (Muscular). Mother has Covid and is in isolation. Baby tested negative for Covid x2. Baby is a PO feeder and grower and doing well. He passed hearing test, passed car seat test, got Hepatitis B vaccine. Appropriate referral to the PCP, CMH neurologist, cardiologist and early intervention will be done on 01/08/YYYY as today is a weekend. Baby is directly discharged to parent. Appropriate Covid precaution advise has been provided over the phone by me.</p> <p>Reason for admission: Term with hypoxic ischemic encephalopathy for whole body cooling</p> <p>Pertinent lab and imaging: 1/2: EEG verbally reported as no seizures, few sharps noted 1/2: Head ultrasound with no IVH 1/5: EEG and EKG normal 1/6: Brain MRI: Mild signal alteration of bilateral basal ganglia and brain stem</p> <p>1/2: Echo with PFO, PDA, muscular VSD 1/8: Echocardiogram small VSD, no PDA 1/8: Ultrasound testis: Undescended right testis (Inguinal canal)</p> <p>NICU physical examination: HEENT: Anterior fontanelle open, red reflex present bilaterally. Lungs: Respirations unlabored</p>	1161- 1166

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		<p>Abdomen: Active bowel sounds Neurology: Comment: Slight head lag while pulling to sit Skin: Pink</p> <p>NICU discharge assessment and plan: Problems: Hypoxic ischemic encephalopathy severity: Moderate Moderate hypoxic ischemic encephalopathy Category: Medical Status: Resolved</p> <p>Discharge assessment and plan: 9 days old term baby boy with hypoxic ischemic encephalopathy (Moderate), status post whole-body cooling, status post coagulopathy. Baby underwent cooling and rewarming without any complication. He did not have any seizure activity on multiple EEGs. Head ultrasound was normal and follow up brain MRI at 7-days of birth showed signs of HIE (Mild signal alteration of bilateral basal ganglia and brain stem).</p> <p>1/5: Normal EEG (Post-re-warming) 1/5: EKG normal 1/7: Brain MRI: Mild signal alteration of bilateral basal ganglia and brain stem 1/8: Neurology exam; Active alert, good movement, tone normal, slight head lag</p> <p>Plan: Follow up with PCP on 01/12/YYYY (Will make appointment on 1/10 as it is weekend today) CMH neurology clinic referral (Will be made on 1/10) Early intervention referral</p> <p>Slow, feeding newborn: Category: Medical Status: Resolved DC assessment and plan: Term baby, status post HIE (Underwent cooling). Baby is a PO feeder and grower at this time. Taking EBM/Similac ad lib. Mother's milk has come in</p> <p>Birth weight 3034 g Daily weight 3125 g (Gained 86 gm overnight) Adequate voids and stools</p> <p>Plan: Similac/EBM PO ad lib Di-Visol 400 units PO once daily Follow up with PCP on 1/11 for weight and feeding check</p> <p>Term newborn, current hospitalization:</p>	

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		<p>Category: Medical Status: Resolved</p> <p>Discharge assessment and plan: 9 days old term baby boy transferred from OSH with hypoxic ischemic encephalopathy (Moderate), status post whole-body cooling, status post coagulopathy. Baby underwent cooling and rewarming without any complication. He did not have any seizure activity on multiple EEGs. Head ultrasound was normal and follow up brain MRI at 7 days of birth showed signs of HIE (Mild signal alteration of bilateral basal ganglia and brain stem). Baby has right sided undescended testis and a small VSD (Muscular). Mother has COVID and is in isolation. Baby tested negative for COVID x2. Baby is a PO feeder and grower and doing well. Baby was circumcised on 01/08/YYYY.</p> <p>Impression: FT with moderate HIE status post whole-body cooling, abnormal MRI, undescended right testis, small muscular VSD, Covid exposed (Test negative x2)</p> <p>Studies: 1/2: EEG verbally reported as no seizures, few sharps noted 1/2: Head ultrasound with no IVH 1/5: EEG and EKG normal 1/6: Brain MRI: mild signal alteration of bilateral basal ganglia and brain stem</p> <p>1/2: Echo with PFO, PDA, muscular VSD 1/8: Echocardiogram Small VSD, no PDA 1/8: Ultrasound testis: Undescended right testis (Inguinal canal)</p> <p>Plan: Follow up with PCP on 01/12/YYYY (Appointment has to be made) Follow up with CMH neurology in one month follow up with cardiology in 2 months for VSD (PCP to kindly make the appointment) Missouri first step referral (Will be done on 01/10/YYYY)</p> <p>Exposure to COVID-19 virus: Category: Medical Status: Acute DC assessment and plan: Mother tested positive for COVID on 1/6, father exposed to COVID, baby exposed on 1/5 when parent visited. Mother unvaccinated. Baby is doing fine (Two COVID tests done 24 hrs apart is negative). PS: I talked with mother over the phone this morning. As per mom Health department has taken her off isolation and has advised use of mask and hand hygiene when around the baby. COVID precaution was re-emphasized on the phone by me.</p>	

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		<p>Plan: Discharge the baby home Mother to take COVID precaution Father to take COVID precaution as well</p> <p>Ventricular septal defect, muscular: Category: Medical Status: Acute</p> <p>Discharge assessment and plan: Term baby with moderate PDA and small muscular VSD in initial echocardiogram done just after birth. Repeat echocardiogram done on 1/8 showed small VSD without any PDA.</p> <p>1/2: Echo with PFO, PDA, muscular VSD 1/8: Echocardiogram Small VSD, no PDA Exam: No murmur</p> <p>Plan: Follow up with cardiologist in 2 months</p> <p>Undescended right testicle: Category: Medical Status: Acute</p> <p>Discharge assessment and plan: Right testis not palpable in exam 1/8: Testicular ultrasound: Right testis in inguinal canal</p> <p>Plan: PCP to kindly follow up clinically during visits Refer to urologist if it fails to descend in 6 months</p> <p>NICU routine health maintenance: Neonatal hearing screen:</p> <p>Vaccines: Hepatitis B: 01/05/YYYY Newborn screen #1: 01/01/YYYY (PCP to kindly follow up on the result) Result #1: Pending</p> <p>Newborn screen #2: 01/08/YYYY (PCP to kindly follow up on the result) Result #2: Pending</p> <p>Car seat test: Passed (60 minute minimum of continuous cardiopulmonary data was recorded by the bedside RN while child was in the car seat. I have reviewed this information, it is safe at this time to discharge)</p> <p>CHD screening:</p>	

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		<p>Result of screening: Pass Not screened due to: Requiring respiratory sup</p> <p>Discharge planning and follow up: - Follow up Parents last updated on: 01/09/22 (Mother) Last update given: By phone</p> <p>NICU discharge: Discharge diagnosis: Final diagnosis: Exposure to COVID-19 virus (Acute) Undescended right testicle (Acute) ventricular septal defect, muscular (Acute) Hypoxic ischemic encephalopathy (Resolved) Need for observation and evaluation of newborn for sepsis (Resolved) Slow, feeding newborn (Resolved) Term newborn, current hospitalization (Resolved)</p> <p>Activity on discharge: Normal Problem: RDS</p> <p>Instructions: Refer to the detailed instructions in your discharge packet related to your injury or illness. Follow up with your primary care provider as directed. Keep a list of your home medications with you at all times.</p> <p>Muti-vitamins as prescribed</p> <p>Vaseline gauze to circumcision until fully healed</p> <p>Sponge bath until the umbilical cord falls off</p> <p>Continue to wear a mask around the baby until you are cleared by your doctor. Good hand washing by you or anyone else caring for the baby</p> <p>We will fax information to KC Children’s Mercy regarding follow up Neurology appointment. Expect a call from them regarding one month appointment.</p> <p>Condition on discharge: Stable</p> <p>Discharge disposition: Home</p> <p>Referral and follow up request: David Anthony (Allied Health)- (Call for six-month appointment) XXXX, MD (For referral purposes only) - (We will make appointment for you for Tuesday. Expect a call from us tomorrow regarding this).</p>	

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		<p><i>*Related records: Instructions, patient information, consent, orders, labs, respiratory therapy, medications, discharge instructions, medications, nursing notes, medication administration, fax cover sheet</i></p> <p>PDF Ref: 1536-1538, 2255, 2995-2997, 1351-1355, 2256, 2258, 1487, 1385, 3086-3090, 1172-1292, 1356-1375, 1406-1479, 1480-1486, 1488-1535, 1539-1920, 3004-3006, 3055-3070, 1396-1398, 2257, 3022-3024, 1293-1296</p>	
01/10/YYYY	Hospital/ Provider Name	<p>Referral form:</p> <p>Specialty: Neurology</p> <p>Reason for consultation: Hypoxic ischemic encephalopathy.</p>	2276- 2278
02/01/YYYY	Hospital/ Provider Name	<p>Triage call report:</p> <p>Call time: 2036 hrs</p> <p>History of present illness: Per mom- mom is pretty sure child is having seizures today. He is getting still and stiff. His eyes move back and forth/shake. Mom was feeding him his bottle and he got tense, and his eyes are making rapid movements. It lasts over a minute. He is breathing normal. His color is good. No blueish lips or face. His arms and legs are not shaking. He is stiff right now and making a tight fist with one hand and his eyes are moving back and forth rapidly. His back is arched. He is breathing normal and he is awake. He has done this several times today. Child has not been seen in neuro clinic.</p> <p>Guideline title: Seizure without fever</p> <p>Recommended disposition: Go to emergency department now</p> <p>Reason for disposition: Second seizure occurs on the same day (Exception: Petit mal)</p> <p>After call notes: Mom will bring child to the emergency department to be seen.</p>	3098
02/01/YYYY	Hospital/ Provider Name	<p>Neurology consultation notes:</p> <p>Received call from Dr. Parker at CMK ER regarding patient, a 4-week-old baby presenting after 10 episodes concerning for seizures today.</p> <p>Baby was born at Via Christi hospital via stat C-section. Baby coded after birth for 45 minutes. He was transferred to the NICU at Freeman Hospital in Joplin. He completed cooling protocol and was there for 11 days. Apparently had some subclinical seizures but was not started on maintenance ASD. He was referred to CMH neuro but hasn't had appointment yet.</p> <p>Today, he had 10 episodes all lasting about 1 minute involving left gaze deviation, left beating nystagmus, and left arm stiffening. PCP saw video and</p>	1929

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		<p>referred to the ER. Before today, parents had not seen any abnormal movements concerning for seizures at home.</p> <p>Baby is alert and at baseline currently</p> <p>Although he may have epilepsy resulting from perinatal insult, at his age he will need an infectious work-up. It may be that infection is provoking seizures. Recommend LP with HSV testing. Recommend Keppra load and starting maintenance ASAP due to multiple seizures in 24-hour period. Recommend admission to general pediatrics, will monitor on EEG overnight. Neurology will follow along as consult.</p> <p>By Marcie Files, M.D.: I agree with the above recommendations provided by the resident.</p>	
02/02/YYYY	Hospital/ Provider Name	<p>Emergency medical service report:</p> <p>Service: Children's Mercy Base: CMH ground Unit: Ambulance 8 Shift: Team 8 Dispatched as: Pediatric – medical Mass casualty: No Type of service: Hospital-to-hospital transfer Unscheduled Dispatch priority: RN-RT-EMT Response mode: Emergent (Immediate response) Mode descriptors: No lights or sirens Moved via: Stretcher Position: Semi fowlers Disposition: Treated and transported by CCT</p> <p>Location: Children's Mercy Hospital Kansas Emergency Department Ref. MD: XXXX Ref. RN: Kirsten RN</p> <p>Specific equipment: Neo Mate Transport mode: Emergent (Immediate response) Mode descriptors: No lights or sirens Moved from: Structure Finally acuity: Emergent (Yellow) Receiving: Children's Mercy Hospital Rec. MD: Jennifer Flint (FLJE) Destination basis: Specialty Resource Center</p> <p>Chief complaint: Seizures</p> <p>Anatomic location: General/global</p>	3091- 3093

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		<p>History of present illness: Transport requested for a 1-month-old male with seizure like activity. Per referral report, patient has a history of mild HIE following low APGAR scores and prolonged cardiopulmonary resuscitation after birth. Tonight patient presented to the referring hospital with parents for multiple episodes of abnormal movements throughout the day. Parents describe each episode as left arm tightening, and left eye deviation with nystagmus, each episode lasted approximately one minute and self-resolved. Parents deny skin color change or breathing issues with events. A full septic work up was completed at the referral including a CBC, BMP, CRP, UA, and LP. UA, BMP, CRP and LP were all reported as within normal limits. CBC: WBC-7.6, Hgb-8.4, Hct-24.1, Plt-408. Head CT reported concern for mild bifrontal encephalomalacia, possibly biparietal. Patient was given Keppra, Acyclovir and Ceftriaxone. Patient will be transported to CMH for specialty pediatric services not available at referring facility.</p> <p>Fluids before and during transport: Intake: Before during: 10 ml</p> <p>IVs prior to assessment: Gauge: 24 Site: Left scalp</p> <p>Impression/diagnosis: System: CNS/neuro Symptoms: Convulsions/seizure Impression: Seizure Initial patient acuity: Emergent (Yellow) Working diagnosis: Seizures</p> <p>Activity: 0225 hrs: HR: 140, BP: 83/35, MAP: 51, SpO2: 98, RR: 32, GCS: 15, Temp: 36.7°C</p> <p>0230 hrs: Medical consult: Chantal Williams consulted with Flint Jennifer # from Children's Mercy Hospital via Cellular. CMH pediatric interfacility general stabilization protocol utilized for the duration of transport under Dr. Flint.</p> <p>Med calc weight 3.7kg Transport to CMH Attempts: 1, Successful</p> <p>0240 hrs: HR: 143, BP: 98/60, MAP: 73, SpO2: 100, RR: 34.</p> <p>0255 hrs:</p>	

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		<p>HR: 146, BP: 89/51, MAP: 64, SpO2: 100, RR: 35.</p> <p>0310 hrs: HR: 133, BP: 88/51, MAP: 63, SpO2: 100, RR: 40.</p> <p>0320 hrs: CMCCT arrived to 6Henson. Patient tolerated transport without adverse event. PIV remains secure and patent. Report given to MD and RN, all questions answered, patient care transferred.</p>	
02/02/YYYY	Hospital/ Provider Name	<p>ER visit:</p> <p>Chief complaint: Seizure activity- possible</p> <p>History of present illness: Patient is a 4-week-old male presenting to Kansas emergency department tonight with parents due to concern for new onset seizures. Mom reports that patient was born at 38 weeks via difficult delivery and newborn course. She states she had spontaneous onset of labor, however had failure to progress with nuchal cord and ultimately required stat C-section at Via Christi Hospital. Mom reports patient was born without a pulse and required him to be coded for about 45 minutes. Return of pulse was obtained, and patient was transferred to Freeman Hospital West NICU in Joplin Missouri for cooling protocol. Mom reports patient was rewarmed, with subsequent MRI brain and EEG which was consistent with HIE but no subclinical or clinical seizures to date. Mom reports that starting today patient began having "episodes" concerning for seizures. She describes the events as each lasting about 1 minute in length, the patient had about 10 total episodes today, where his eyes were deviated to the left, with left lateral beating nystagmus, and left arm stiffening. Afterwards patient would return to normal activity level. Mom denies any recent fever or sick symptoms, he has been eating, voiding, and growing well since NICU discharge at 11 days old. He is followed by a family practice physician in Pleasantville Kansas, he has been referred to Children's Mercy neurology for follow-up but has not had an appointment yet.</p> <p><i>Reviewed results of CT of head or brain without contrast dated on 02/02/YYYY</i></p> <p>Review of systems: Neurological: Positive seizure</p> <p>Physical examination: Skin: Warm, dry</p> <p>Assessment/plan: In summary, this patient presented with new onset seizure Diagnosis likely consistent with new onset seizure based off presentation, testing and exam.</p> <p>Plan includes:</p>	2123- 2127

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		<p>We completed a full sepsis work-up including blood work, urine, cultures, HSV testing and lumbar puncture</p> <ul style="list-style-type: none"> -We ordered a CT head to rule out bleed or mass was negative -We started Keppra load 40 mg/kg, and Vancomycin/Ceftriaxone/Acyclovir during sepsis rule out -Transfer to Adele Hall for admission to general peds, for long-term EEG with neuro consult -NICU discharge paperwork faxed to your location, it will be scanned into the system prior to transfer -Parents agree with plan <p>Re-examination/re-evaluation:</p> <p>02/01/YYYY 2302 hrs: I spoke with Julie with neurology who recommends full sepsis work-up including lumbar puncture and HSV testing, CT head, Keppra load 40 mg/kg, and continue Keppra maintenance after admission, then transfer to Adele Hall for admission to general peds with neuro consulting, for long-term EEG.</p> <p>02/02/YYYY 0055 hrs: CT shows no acute abnormality, mild bifrontal encephalomalacia. CBC shows normal white count with differential of mild neutropenia/ANC 1318, mild anemia with hemoglobin 8.4. Normal electrolytes with borderline low protein level at 5, normal urinalysis, Covid negative.</p> <p>0125 hrs: Patient tolerated LP well, clear fluid obtained and sent to lab, see separate procedure note. Spoke with general peds team hospitalist Dr. Schmidt, will admit to general peds service, transfer to Adele Hall via EMS transport, recommend starting antibiotics to cover during sepsis rule out, will start Ceftriaxone, Vancomycin, Acyclovir.</p> <p>Diagnosis/disposition Diagnosis: Hypoxic ischemic encephalopathy, unspecified Other seizures</p> <p>Admit request – Ordered</p> <p>02/01/22 23:31:00 hrs, General pediatrics, mode of transport CMH transport (x53329), other seizures, hypoxic ischemic encephalopathy, unspecified patient tested for Covid: Yes - pre-procedure, 27169</p> <p>Condition: Select one.</p>	
02/02/YYYY	Hospital/ Provider Name	<p>CT of head or brain without contrast:</p> <p>Indication: Seizure</p> <p>Findings:</p>	1927-1928

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		<p>Subtle low attenuation in the high parasagittal frontal lobes bilaterally i.e. image 16/2. Concomitant volume loss, mild.</p> <p>Suggestion of mild volume loss at the posterior parasagittal parietal convexities images 19-20/2.</p> <p>Mild prominence of the extra-axial subarachnoid fluid spaces intracranially</p> <p>Impression: Concern for mild bifrontal encephalomalacia and possibly biparietal. No acute intracranial abnormality.</p>	
02/02/YYYY	Hospital/ Provider Name	<p>Pediatric history and physical report:</p> <p>Chief complaint: Seizure</p> <p>History of present illness: Quincy is a 4-week-old male with history of HIE after traumatic delivery who presents with concern of seizure activity. He is accompanied by his parents who provide the history.</p> <p>Parents state that the patient was born at 38-weeks' gestation at Via Christi Hospital. Mother went into spontaneous labor but had failure to progress. Patient was found to have nuchal cord and an emergent C-section was performed. Pregnancy was complicated by polyhydramnios, hypertension, gestational diabetes, and Covid infection during pregnancy. Mother was also GBS positive at delivery but received 2 doses of Penicillin greater than 4 hours from delivery. Mother did not have a fever during delivery. Mother denies any history of gonorrhea, chlamydia, HIV, syphilis. Both parents agree that there are no known HSV exposures in family or friends who have seen Quincy. Patient received vitamin K and hepatitis B vaccine at delivery.</p> <p>After delivery, patient had APGARS of zero, and resuscitation was performed for 45 minutes. Patient was transferred to Freeman Hospital and admitted to the NICU. Cooling protocol was performed for concern of HIE. During 10-day NICU stay, EEG was performed that showed a few spikes, but was otherwise normal. MRI was performed that showed moderate HIE, and echo was performed that showed a VSD. Patient was discharged home on day of life 11 with CMH neuro follow up.</p> <p>Parents state that the patient was in his regular state of health until 4 days ago when they noticed abnormal movements. Mother states that the episodes have increased in frequency, and yesterday he had 10 episodes described as left arm tightening, left hand in a fist, and nystagmus of both eyes towards the left. Episodes lasted 1-minute each. Mother states that there was no change in color during the episodes, however notes pausing respirations with rapid gasping. Mother states that patient will return to baseline within 10 to 15 seconds after the episode stops. Mother also states that the episodes tend to happen most often while eating. Mother notes that the patient had 2 episodes within 30 minutes on</p>	1944- 1948

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		<p>the way to the hospital, for a total of 12 episodes prior to presentation to the hospital. Parents deny any sick contacts.</p> <p>On arrival to the CMH Kansas emergency department, Temp 37.0, HR 133, RR 52, SPO2 99% in RA. Neurology was consulted who recommended full infectious work-up, head CT, and lumbar puncture. CBCD, BMP, UA were all obtained and within normal limits other than decreased H/H. Blood culture and urine culture were obtained. COVID swab was obtained and negative. CT head was obtained and showed mild bifrontal encephalomalacia and possibly biparietal. LP was obtained and CSF studies showed glucose 42, protein 80, 6 nucleated cells with 0% neutrophil, 68% lymphocyte, 32% monocytes/macrophage. Patient received IV Keppra load, IV Ceftriaxone (50 mg/kg), and IV acyclovir. Patient was transported to CMH Adele Hall via CMH transport.</p> <p>Mother states that patient is breast-fed and usually eats 6 ounces every 2 hours via bottle. Mom notes that he has had increased number of spit ups tonight, but no projectile vomiting. Mother states that he normally has a wet diaper with every feed and this is continued today. He has had regular bowel movements. She does note that he has been sleepier since arriving to the hospital.</p> <p><i>Reviewed results of CT head or brain without contract dated on 02/02/YYYY.</i></p> <p>Review of systems: Neurological: Positive seizure activity</p> <p>Physical examination: General: Crying but consolable HEAD: NCAT, AFOSF Eyes: Red reflex present bilaterally. Light reflex symmetric GU: Left testicle descended, right testicle not descended (In inguinal canal) Access: PIV in left scalp</p> <p>Assessment/plan: Quincy is a 4-week-old male with history of HIE after traumatic delivery who presents with concerns for seizure activity. Due to patient's age, full infectious work-up was indicated. Patient's labs from the emergency department are all within normal limits. CSF glucose is a little low at 42, protein elevated to 80, 6 nucleated cells with 68% lymphocytes and 0% neutrophils, but overall low concern for bacterial meningitis. CSF cultures and PCR studies pending. HSV PCR pending. Patient is currently being treated for bacterial and HSV meningitis and on prolonged EEG to monitor seizure activity. Patient's history of HIE could be potential source of seizures if CSF cultures are negative. CT at outside hospital not concerning for mass or hemorrhage. Plan as follows:</p> <p>Neurology: Concern for seizures, history HIE Acetaminophen as needed for fever</p>	

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		<p>Prolonged EEG Status post Keppra load in CMH KS emergency department Continue Keppra twice daily Lorazepam 0.1 mg/kg as needed for seizure activity > 5 minutes Consult neurology Anticipate the need for MRI brain</p> <p>CV/respiration: Hemodynamically stable on RA Vitals per floor protocol CR monitors, oxygen monitors</p> <p>Fen/GI: Regular diet for age, breastfed MIVF with D5 1/2NS Monitor I and Os Patient not currently taking Vitamin D, discuss with parents</p> <p>ID/Heme: Afebrile; low hemoglobin, low hematocrit, CSF: Low glucose, high protein, 6 nucleated cells - concern for bacterial or viral meningitis, COVID negative Consider repeat H/H. Continue IV Ceftriaxone (50 mg/kg), Vancomycin (50 mg/kg), Acyclovir (16 mg/kg) Obtained HSV swabs of eyes, nose, mouth, and anus on admission Follow-up CSF PCR Follow-up CSF cultures Follow-up blood cultures Follow-up urine cultures Consider ID consult pending CSF or fevers</p> <p>Dispo: Admit to general pediatrics, purple team, for further management of seizures and infectious workup.</p> <p>Senior resident attestation: I have personally evaluated the patient and reviewed critical portions of the history, physical exam, and pertinent laboratory/radiology results. I assisted in the formulation of the assessment and plan and am in agreement with the above documentation by Dr. Rebholz.</p> <p>In brief, this is a 4-week-old boy with a history of HIE who presents with first-time Seizures.</p> <p>Differential at this time includes focal seizure due to HIE versus bacterial or viral meningitis versus tumor. Patient most likely has epilepsy due to HIE given the significant birth trauma history. Meningitis is less likely in this patient given</p>	

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		<p>reassuring initial laboratory findings, but CSF studies show mildly decreased glucose and elevated protein. Head CT shows no evidence of tumor. Overall the patient is well appearing on exam. Will treat for meningitis with Ceftriaxone, Vancomycin, and Acyclovir. We will continue Keppra twice daily. Patient will have prolonged EEG to monitor for further seizures.</p> <p>Attending attestation: I saw and examined the patient on 02/02/YYYY. I reviewed any new laboratory or radiographic data as well as consultant recommendations. I discussed the management with the resident and directly supervised the formulation of the plan. I agree with the findings and plan as written in the resident's note.</p>	
02/02/YYYY	Hospital/ Provider Name	<p>Neurology initial consultation report:</p> <p>Reason for consultation: Seizures</p> <p>History of present illness: Quincy is a 4-week-old infant with history of HIE admitted with concern for seizures.</p> <p>For approximately the past 5 days, he has had intermittent left beating nystagmus occurring at least once per day. Yesterday, he had several episodes, at least 4, in which he had flexion of the left arm along with the eye movements. His mother shows a video of him feeding (Unclear if actively sucking and swallowing) with the left beating nystagmus. All episodes last around a minute. The eyes always beat to the left, never to the right. Prior to the past week, he had never had any abnormal movements concerning for seizures. He has not been febrile, no cough, congestion or other ill symptoms.</p> <p>Neurology was called and recommended sepsis work-up, prolonged EEG, Keppra load, and maintenance Keppra.</p> <p>Sepsis work up was completed including LP. LP was benign showing 6 WBC (11 RBC), with normal glucose and protein, culture pending. CT was done showing bifrontal encephalomalacia.</p> <p>He was born at term via emergent c-section due to failure to progress. He coded at birth and required 45 minutes of resuscitation efforts. He was transferred from birth hospital to Freeman in Joplin for cooling protocol. EEG showed spikes but no seizures. He has never been on any ASDs. He was referred to CMH but has not had appointment yet. He had an MRI at Joplin, which his mother recalls showed some occipital abnormalities.</p> <p>He did not have any events overnight but had mostly been sleeping. This afternoon, he had a typical event of leftward nystagmus, which had no EEG correlate</p> <p>Physical examination: Constitutional: Awake, alert, fussy but consolable</p>	1939- 1943

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		<p>Neurology: Mental status: Awake, fussy, crying when examined, calm with mother CN: Squeezes eyes shut tight against resistance, squints with light Sensation: Withdraws to touch in all four extremities Reflexes: 2/4 reflexes noted in biceps and patella</p> <p>Impression and recommendations: Quincy is a 4-week-old with history of HIE who presented with concern for seizures. He was placed on Keppra overnight with concern for status, but EEG has not shown any seizures. Indicates diffuse neuronal dysfunction/dysmaturity, which is consistent with his past history. EEG captured event of leftward beating nystagmus, which was non-epileptic. CT head shows bifrontal encephalomalacia, no previous imaging currently available for comparison, but he did have MRI done after completing cooling protocol at birth. Though he remains at risk for future seizures, the events of concern are non-epileptic, and therefore he may discontinue Keppra.</p> <p>Recommendations: Discontinue Keppra Continue EEG at least 24 hours Request that MRI be clouded over from Joplin</p> <p>Neurology will continue to follow</p> <p>Neurology attending note by Marcie Files, M.D.: I have seen and examined the patient. I have reviewed the note and made changes to the documentation as needed. I have supervised the formulation of the impression and plan.</p> <p>Will review MRI from Joplin and determine if repeat MRI is indicated.</p>	
02/02/YYYY	Hospital/ Provider Name	<p>Lactation note: Chart reviewed: Yes Spoke with: Mother Communication site: Phone EBM feeding method: PO Feeding/NPO comments: EBM by bottle Lactation team note: Encouraged to contact lactation team as needed, Will continue to follow, Caregiver verbalizes understanding Comments: Quincy is a 4-week-old with history of HIE who is currently inpatient for evaluation of possible seizure activity. He has remained on RA and is taking EBM by bottle.</p> <p>Lactation spoke with mother via phone. Mother reports that she has pump and supplies at bedside. Mother requesting lanolin for sore nipples. Reviewed where to obtain lanolin in hospital. Mother also reports that husband is bringing some from home. Mother aware of meal tray availability and how to order. Mother denies further lactation needs at this time. Lactation will continue to follow and</p>	2875- 2876

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02/02/YYYY	Hospital/ Provider Name	<p>provide support as needed.</p> <p>Progress notes:</p> <p>Subjective/reason for ongoing admission: Quincy had no acute events overnight- he has been sleeping comfortably per dad.</p> <p>Physical examination: Head: EEG cap on.</p> <p>Assessment/plan: Quincy is a 4-week-old male with HIE after traumatic delivery who presents with concerns for seizure activity. Patient is currently being treated empirically for bacterial and HSV meningitis following LP while awaiting CSF cultures and HSV PCR. On prolonged EEG to monitor seizure activity. Neurology following. History of HIE is likely source of seizures if CSF cultures are negative. Plan as follows:</p> <p>Neuro: Concern for seizures, history HIE -CT at OSH not concerning for mass or hemorrhage -Acetaminophen as needed for fever -Prolonged EEG for 24 hrs -Continue Keppra twice daily -Lorazepam 0.1 mg/kg as needed for seizure activity > 5 minutes -Neurology consulted, appreciate their recs -He will need MRI brain, but unsure if it will be inpatient or outpatient</p> <p>CV/resp: Hemodynamically stable on RA -Vitals per floor protocol -Pulse oximetry</p> <p>FEN/GI: -Regular diet for age, breastfed -IVF discontinued -Monitor I and Os -Patient not currently taking Vitamin D, discuss with parents</p> <p>ID/heme: Afebrile; low hemoglobin, low hematocrit, CSF: Low glucose, high protein, 6 nucleated cells -Continue IV Ceftriaxone (50 mg/kg), Vancomycin (50 mg/kg) -HSV negative; discontinuing acyclovir -Follow up CSF PCR -Follow up CSF cultures -Follow up blood cultures -Follow up urine cultures -Consider ID consult pending CSF or fevers</p>	1955- 1958

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		<p>Dispo: Admit to general pediatrics, purple team, for further management of seizures and infectious workup.</p> <p>Attending attestation: I saw and examined the patient on 02/02/YYYY. I reviewed any new laboratory or radiographic data as well as consultant recommendations. I discussed the management with the resident and directly supervised the formulation of the plan. I agree with the findings and plan as written in the resident's note.</p>	
02/02/YYYY	Hospital/ Provider Name	<p>Electroencephalography:</p> <p>Total duration of study: 27 hrs 57 mins</p> <p>Recording started at: 02/02/YYYY Recording ended at: 02/03/YYYY</p> <p>History of present illness: 1 month male that was born at 38 weeks (Now 42weeks) via C-section presented for seizures. Coded @ birth for 45 minutes with subclinical seizure with cooling protocol with no maintenance ASD. No noted seizure at home until 2/1 with rapid eye flutter to the left and left arm flexion (~10 episodes at home) Given Keppra load in ER prior to EEG hook up.</p> <p>Impression: This is an abnormal EEG which shows presence of mild diffuse neuronal dysfunction due to low voltage background activity. There were excessive multifocal sharp transients for age which is indicative of cortical dysmaturity. The background rhythms displayed shifting asymmetries, but there were no persistent asymmetries. No clinical or electrographic seizures were captured, but multiple events as describe above had no EEG correlate. Clinical and neuroimaging correlation is indicated.</p>	1966- 1968
02/02/YYYY	Hospital/ Provider Name	<p>Procedure notes:</p> <p>Lumbar puncture: Time: 02/02/YYYY @ 01:42:00 Confirmed: Patient, procedure, side, and site correct. Time-out taken prior to procedure. Exam type: Point of care procedural assistance. Consent: Parent, has given verbal consent. Performed by: XXXX, MD. Indication: Seizure. Procedural sedation: None. Location: L4-L5. Technique: Real-time guidance: 2 attempts, fluid volume: 6 ml. Patient position: Right, Lateral decubitus. Outcome: A successful CSF aspiration. Complications: None. Provider attestation: I performed the procedure.</p>	2179- 2180

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		Sterile field and preparation was used including gown, gloves, mask, hand washing, betadine, sterile field LP needle size: 1cm.	
02/02/YYYY	Hospital/ Provider Name	CT of head or brain without contrast: Indication: Seizure Findings: Subtle low attenuation in the high parasagittal frontal lobes bilaterally i.e. image 16/2. Concomitant volume loss, mild. Suggestion of mild volume loss at the posterior parasagittal parietal convexities images 19-20/2. Mild prominence of the extra-axial subarachnoid fluid spaces intracranially. The parenchymal attenuation and morphology are otherwise normal without intracranial mass or hemorrhage. Wide sutures. Left scalp IV. Impression: Concern for mild bifrontal encephalomalacia and possibly biparietal. No acute intracranial abnormality	2856- 2857
02/03/YYYY	Hospital/ Provider Name	MRI of brain without contrast: Indication: Seizures Findings: The bilateral lateral and third ventricles are minimally enlarged. There is mild enlargement of the supratentorial subarachnoid spaces and prominence of the sulci. There is mild scattered mucosal thickening/fluid signal within the paranasal sinuses. Impression: Mild supratentorial volume loss. Otherwise normal brain MRI	1937- 1938
02/03/YYYY	Hospital/ Provider Name	Progress note: Subjective/reason for ongoing admission: No acute events overnight. Parents agreeable to MRI recommended by neurology. They live in Kansas and would like Infant and toddler services to come into their home to provide services. Assessment/plan: Quincy is a 4-week-old male with HIE after traumatic delivery who presents with concerns for seizure activity. Initially treated empirically for bacterial and HSV meningitis following LP while awaiting CSF cultures and HSV PCR, but infectious work-up has been reassuring and will discontinue antimicrobials.	1959- 1961

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		<p>Neurology following. EEG taken off after 24 hrs total monitoring showed no epileptic discharges. His HIE is likely source of abnormal eye movements and he remains at risk for seizures. Plan as follows:</p> <p>Neurologic: Concern for seizures, history HIE CT at OSH not concerning for mass or hemorrhage, but showed encephalomalacia Discontinue Keppra per neurology with no seizure activity captured on EEG Lorazepam 0.1 mg/kg as needed for seizure activity > 5 minutes Neurology consulted MRI brain while inpatient Infant and Toddler Services to be requested by SW</p> <p>CV/respiration: Hemodynamically stable on RA -Vitals per floor protocol</p> <p>FEN/GI: Regular diet for age, breastfed Monitor I and Os Patient not currently taking Vitamin D, discuss with parents.</p> <p>ID/Heme: Afebrile; low hemoglobin, low hematocrit, CSF: low glucose, high protein, 6 nucleated cells Ceftriaxone (50 mg/kg) discontinued as CSF cx NGTD for approximately 36 hrs HSV negative CSF culture NGTD Blood culture NGTD Urine culture NGTD</p> <p>Dispo: Admit to general pediatrics, purple team, for further management of seizures and infectious workup.</p> <p>Attending attestation: I saw and examined the patient on 02/03/YYYY. I reviewed any new laboratory or radiographic data as well as consultant recommendations. I discussed the management with the resident and directly supervised the formulation of the plan. I agree with the findings and plan as written in the resident's note. Anticipate discharge home tomorrow.</p>	
02/04/YYYY	Hospital/ Provider Name	<p>Neurology progress notes:</p> <p>Subjective/reason for ongoing admission: Quincy has not had further events off Keppra</p> <p>Physical examination: Constitutional: Fussy but consolable Skin: Warm, dry Mental status: sleeping, calm with mother</p>	1953- 1954

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		<p>Diagnostic results: MRI: Impression: Mild supratentorial volume loss. Otherwise normal brain MRI.</p> <p>Assessment/plan: Quincy is a 5-week-old with history of HIE who presented with concern for seizures. He was placed on Keppra overnight with concern for status, but EEG captured events in question, consisting of left beating nystagmus, and found that this was non-epileptic. Keppra was discontinued. EEG indicated diffuse neuronal dysfunction/dysmaturity, which is consistent with his past history. Due to CT head showing bifrontal encephalomalacia, we recommended MRI, which shows mild supra-tentorial volume loss. We went over results with patient's parents. Discussed that baby had no seizures on EEG, but that given his history he may have seizures in the future, along with developmental delays, but that we cannot predict these things for certain based on MRI.</p> <p>Recommendations: OK from neurology standpoint for discharge Will need follow up with neurology outpatient</p> <p>Patient seen and discussed with Dr. Files.</p> <p>Neurology attending note: I have seen and examined the patient. I have reviewed the note and made changes to the documentation as needed. I have supervised the formulation of the impression and plan.</p>	
02/04/YYYY	Hospital/ Provider Name	<p>Discharge summary:</p> <p>Referring physician: XXXX, M.D.</p> <p>Admit date: 02/02/YYYY</p> <p>Discharge date: 02/04/YYYY</p> <p>Discharge condition: Stable</p> <p>Discharge disposition: Home</p> <p>Discharge diagnosis: Hypoxic ischemic encephalopathy, at risk for seizures, abnormal eye movements</p> <p>Consultants: Neurology</p> <p>Indication for admission: Seizure like activity</p> <p>Hospital course:</p>	1962- 1965, 2189- 2193

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		<p>Quincy is a 4-week-old male with HIE after traumatic delivery who was admitted for concern of seizure activity. Patient was born at 38 weeks gestation at Via Christi Hospital and was found to have nuchal cord and so an emergent C-section was performed. Pregnancy was complicated by polyhydramnios, hypertension, gestational diabetes, and Covid infection during pregnancy. Mother was also GBS positive at delivery but received 2 doses of penicillin greater than 4 hours from delivery. Patient received vitamin K and hepatitis B vaccine at delivery.</p> <p>After delivery, patient had APGARS of zero, and resuscitation was performed for 45 minutes. Patient was transferred to Freeman Hospital and admitted to the NICU. Cooling protocol was performed for concern of HIE. During 10-day NICU stay, EEG was performed that showed a few spikes, but was otherwise normal. MRI was performed that showed moderate HIE, and echo was performed that showed a VSD. Patient was discharged home on day of life 11 with CMH neuro follow up.</p> <p>Patient was in his regular state of health until 01/29/YYYY when parents noticed abnormal movements. Mother stated that the episodes increased in frequency and he had 10 episodes on 2/1/22 described as left arm tightening, left hand in a fist, and nystagmus of both eyes towards the left. He had two additional episodes en route to the CMH emergency department. Episodes lasted 1 minute each. There was no change in color during the episodes, however pausing respirations with rapid gasping noted. Patient noted return to baseline was 10 to 15 seconds after the episodes stopped.</p> <p>On arrival to the CMH Kansas emergency department, Temp 37.0, HR 133, RR 52, SPO2 99% in RA. He underwent infectious work-up including LP. CBCD, BMP, UA were within normal limits other than decreased H/H consistent with this physiologic nadir. Blood, urine, and CSF cultures were obtained. Covid swab was negative. CT head showed mild bifrontal and possibly biparietal encephalomalacia. CSF studies showed Glucose 42, protein 80, 6 nucleated cells with 0% Neutrophil, 68% lymphocyte, 32% monocytes/macrophage. Patient received IV Keppra load, IV Ceftriaxone (50 mg/kg), and IV acyclovir. Patient was transported to CMH Adele Hall via CMH transport.</p> <p>At CMH Adele, Neurology was consulted and patient was put on a prolonged EEG for 24 hours. Patient was kept on Acyclovir until HSV resulted negative. Ceftriaxone was discontinued after cultures negative at approximately 36 hrs. An MRI brain showed supratentorial volume loss.</p> <p>EEG did not show any epileptic seizures so Keppra that was originally initiated was discontinued. Patient was stable, well-appearing and at neurological baseline at the time of discharge. Neurology will follow up with patient within 3 months outpatient. We discussed that he is at increased risk for seizures, but with reassuring EEG antiepileptic medication was not recommended at this time. This may change in the future. A referral was placed to infants and Toddlers Kansas for developmental monitoring and therapy. A follow up</p>	

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		<p>appointment was arranged with the patient's PCP, Dr. XXXX on 2/7 at 11:20 am. A referral was placed and appointment arranged with CMH cardiology for follow up on patient's VSD.</p> <p><i>Reviewed results of MRI of brain without contrast dated on 02/03/YYYY</i></p> <p>Physical examination: Head: EEG cap on Integumentary: Warm, dry</p> <p>Discharge medications: Nystatin topical 100,000 units/g cream 1 application affected areas with diaper changes as needed for rash</p> <p>Attending attestation: I saw and examined the patient on 02/04/YYYY. I discussed the discharge plans with the resident physician and family. I directly supervised the formulation of the plan of care. I agree with the discharge documentation.</p> <p><i>*Related records: Medication administration, work sheet, nursing notes, growth chart, discharge plan, check list, acknowledgement, discharge instructions</i></p> <p><i>Ref: 1930-1936, 3022-3024, 2245-2248, 2916-2920, 2925-2936, 3097, 2860, 2873-2874, 2958-2986, 1949-1952, 2216-2218, 2914-2916.</i></p>	
<p>02/02/YYYY - 02/05/YYYY</p>	<p>Hospital/ Provider Name</p>	<p>Culture cerebrospinal fluid & stain:</p> <p>Date of collection: 02/02/YYYY.</p> <p>Stains/preparations: Verified date/time: 02/02/YYYY @ 02:12 No organisms seen No white blood cells noted Few RBCs noted</p> <p>Verified date/time: 2/5/YYYY @ 07:35 No growth at 3 days</p>	<p>2871</p>
<p>02/25/YYYY</p>	<p>Hospital/ Provider Name</p>	<p>ER visit:</p> <p>Chief complaint: Fever - respiratory complaint</p> <p>History of present illness: Quincy is a 8-week-old male with HIE after traumatic delivery presenting with a few days of cough, congestion, daily fevers (T-max 103), and development of roughly 20 episodes of 10 - 30 second pauses in breathing with associated flushed red facial color overnight. Mom notes that patient is arching his back during these events. No history of reflux. No reported problems with spit up. Mom endorses intermittent trouble breathing overnight with tachypnea and</p>	<p>2119- 2123, 1969- 1980, 2910- 2913</p>

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		<p>retractions.</p> <p>No vomiting, rash, non-bloody looser stools. Older sibling has viral URI symptoms. Has not received our 2-month vaccinations yet.</p> <p>After delivery, patient had APGARS of zero, and resuscitation was performed for 45 minutes. Patient was transferred to Freeman Hospital and admitted to the NICU.</p> <p>Cooling protocol was performed for concern of HIE. During 10-day NICU stay, EEG was performed that showed a few spikes, but was otherwise normal. MRI was performed that showed moderate HIE, and echo was performed that showed a VSD. Patient was discharged home on day of life 11 with CMH neuro follow-up.</p> <p>Pain score: 0/10.</p> <p>Assessment/plan: Quincy is a 8-week-old male with HIE after traumatic delivery presenting with fever in setting of a viral bronchiolitis. He is currently hemodynamically stable and oxygenating well on room air. Patient had moderate work of breathing that significantly improved following suctioning. Labs were obtained to evaluate fever in a well appearing newborn given his age of 56 days and his previous hospitalization and chronic medical history and were reassuring. CXR notable for a viral process. Covid, flu, RSV were negative. Discussed supportive care with family who were comfortable discharging home. Addressed all questions and concerns. Provided return precautions. At time of discharge, patient was breathing comfortably on room air with good aeration throughout and tolerating feeds without any documented apneic events.</p> <p>Diagnosis: Bronchiolitis, acute</p> <p>Discharge patient - Ordered 02/25/YYYY at 11:41 hrs, Discharge home</p> <p>Condition: Good.</p> <p><i>*Related records: Discharge instructions, transition of care.</i></p>	
02/25/YYYY	Hospital/ Provider Name	<p>X-ray of chest:</p> <p>Indication: Cough</p> <p>Findings: Patch perihilar airspace opacities and peribronchial cuffing are present.</p> <p>Impression: Small airways disease versus viral process.</p>	1981- 1982
03/04/YYYY	Hospital/ Provider Name	<p>Office visit:</p>	2284- 2291

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		<p>Reason for visit: Well baby, intermittent exotropia of left eye, undescended testicle</p> <p>History of present illness: Formula sensitive. 3- 4 ounces every 2-3 hours. Dark green BM's. Soft BM's. Sleeping and waking up to eat every 2 hours. Sleeps in parent's room. No concerns per mother.</p> <p>Physical examination: Head: Anterior fontanelle/sutures: soft, open, flat, and normal sutures. Eyes: Red reflex: Equal bilaterally ENT: Oral cavity: Oropharynx without lesion and palate intact Cardiovascular: PMI at mid clavicular line Abdomen: Umbilicus: Fallen off. Bowel sounds: positive bowel sounds Neurological: Deep tendon reflexes 2+ bilaterally</p> <p>Assessment: Well- appearing infant presents for 2-month WCC. Growing and developing well. Assessed vision and hearing risk factors. Vitamin D supplementation, iron supplementation. Will give 2- month immunizations as below. Anticipatory guidance discussed and provided as below, including SIDS prevention, sleeping, feeding, supervised tummy time, no smoke around baby, car safety, and infection control measures. Follow up as scheduled for 4- month WCC. sooner if any new concerns or symptoms</p> <p>Plan of treatment: Referral: Pediatric urologist referral – Children's Mercy Hospital- pediatric urology.</p>	
03/10/YYYY	Hospital/ Provider Name	<p>New patient visit:</p> <p>Chief complaint: Undescended testicle</p> <p>History of present illness: Quincy is a 2-month-old male we are seeing in the CMK surgery clinic today with his parents in consultation for a right UDT. Mom reports he's always been missing his right testis. She states over the last few weeks, she's now noting that the right microtome will get very large and bluish in the color and this will come and go. He's not been in any pain and she's not noticed a bulge in the right groin.</p> <p>Review of systems: Comment: Testicle hasn't descended</p> <p>Physical examination: Respiration: Respirations even and unlabored GI: Positive BS in all 4 quadrants GU: Circumcised phallus, orthotopic meatus, left testis normally descended and sits in proper position in the left hemi-scrotum; right testis possibly palpable in</p>	1991- 1992, 1983- 1990, 2235- 2242, 2908- 2909

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		<p>the right groin, currently no right hydrocele Skin: PWD</p> <p>Assessment/plan: Undescended testis Hydrocele</p> <p>Since Quincy is just 2 months old, we will continue with observation and will see him back around 6 months of age at which time we will likely get him scheduled for a right orchiopexy. In the interim, he will have visits with cardiology to r/o a VSD and neurology to evaluate potential seizure activity. Parents were given anticipatory guidance about a UDT as well as an IH and they verbalize understanding of when to seek care urgently.</p> <p><i>*Related records: Discharge instructions, transition of care.</i></p>	
03/15/YYYY	Hospital/ Provider Name	<p>Follow up visit:</p> <p>Chief complaint: Seizures</p> <p>History of present illness: Visit type- new patient Quincy is a 2-month-old male who was seen today in the neurology clinic at CM Kansas with a chief complaint of HIE and seizures. Quincy is accompanied by parents who reported the patient's history.</p> <p>Quincy is a 2-month-old baby boy with a history of HIE who is being seen in neurology clinic for hospital follow up of episodes concerning for seizure. He is accompanied to his appointment by his parents who provide history. Additional history is obtained from review of EMR.</p> <p>He was born via emergent C-section due to failure progress on time. His APGARS were 0 and he required 45 minutes of resuscitation. He was transferred from the birth hospital to Freeman in Joplin for cooling protocol for about 3 days. After cooling was over he had feeding difficulties and at the end of his hospital admission mom found out she had Covid. EEG during this process was normal for age in review of EMR and he did not require any AEDs. MRI was completed which noted some abnormalities.</p> <p>He was admitted at 4 weeks of life after a 5-days history of episodes of gaze deviation and nystagmus that occurred at least once per day. He had several episodes the day prior to hospital admission also involving flexion of left arm as well as the eye movements and was subsequently admitted for seizure work up. All episodes would last about 1 minute in length and eyes always would beat to the left. He was loaded with Keppra and started on maintenance Keppra for presumed seizures, connected to long-term EEG and completed a sepsis work up for infectious etiology. He had multiple events of abnormal eye movements lasting briefly on EEG which did not have any electrical correlate and therefore were deemed nonepileptic. EEG and Keppra were discontinued. MRI brain was completed which showed volume loss. He was discharged from the hospital in</p>	2008- 2011, 1993- 1995, 2906- 2907

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		<p>stable condition.</p> <p>He has therapies in place with early intervention and he is noted to be delayed. His therapists have expressed concern about a delay in vision. She comes once per week. He does fixate on items and sometimes he tracks depending on how much light is in the room. If it is dim in the room he does not pick up on seeing things. The gaze deviation episodes have continued but it seems to occur only when he is doing other things such as eating, focusing on other things. He hears well and will respond to sound with any slight noise. Head control is not great and they are working on it.</p> <p>Review of systems: Eye: Eye crossing, eye drifting in or out Neurological: Seizures, shakes or shaking</p> <p>Comment: We do not have confirmation that he is actively having seizures, but it is something we are continuously watching for due to the extent of his brain injury. We were told when we had the last 24-hour EEG that he is not having seizures but is showing seizure activity, and he is prone to having seizures because of his brain injury from birth.</p> <p>Physical examination: Abdomen: Positive bowel sounds Skin: Pink, dry</p> <p>Neurologic examination: Cranial nerves: Tracks inconsistently. Gag reflex present Motor assessment: Deep tendon reflexes 2+ and symmetric at biceps, brachioradialis, knees and ankles. Babinski present bilaterally Sensory: Sensation grossly intact to light touch throughout as noted by withdrawal to exam</p> <p>With eating he is noted to have left gaze and nystagmus movements that quickly aborts</p> <p>Assessment/plan: Quincy is a 2-month-old baby boy with a history of HIE who continues to have epilepsy and eye deviation and nystagmus which are most likely related to vision and less likely seizure. His prior work up was reviewed today which caught episodes and were found to be nonepileptic. Reviewed that he is at increased risk for seizure due to his history of HIE. I have asked to be notified if he has further episodes of concern or a change in episodes. Continue plan of care with therapies in place. Notify us if there are any developmental plateaus or regression. It is unclear what his progress will be like but we will continue to monitor his development and how he does. He will likely need a vision evaluation and should consider the need for CCVI in the future. I would like to see him back in 6 months or sooner if needed. All questions and concerns addressed. Parents verbalized understanding of all instructions and agreement</p>	

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		<p>with plan.</p> <p>Discharge instructions: -Video episodes of concern and notify me if there are any more episodes of concern -Notify us if there are any developmental slowing or loss of skills -Continue therapies in place for now -Follow-up in 6 months, or sooner if needed.</p> <p><i>*Related records: Discharge instructions, transition of care.</i></p>	
03/17/YYYY	Hospital/ Provider Name	<p>Emergency medical service communication data: <i>(Illegible notes)</i></p> <p>Call date: 03/17/YYYY. ETA: 15 minutes</p> <p>Pulse: 123 bpm</p> <p>Narrative history and physical: Shortness of breath RSV positive .</p>	2957
03/17/YYYY	Hospital/ Provider Name	<p>Patient care report:</p> <p>Service model agency AMR: From: 11155 Tucker RD (Medical - clinic/office)</p> <p>To: Children's Mercy Hospital South (Hospital - Emergency department) Room/department: Hospital Emergency Department Destination decision: Patient/family request</p> <p>History of present illness: Chief complaint category: Shortness of breath</p> <p>Narrative: Subjective: PA stated that the patient was brought into the clinic by mom who stated that the patient was having SOA, SpO2 was in the low 80s. Tested positive for RSV. Negative for Covid19 and flu, was given a breathing treatment which improved patient's breathing and SpO2 in the high 90s. Congestion in all lobes, no cyanosis. Retraction in the intercostal with some nasal flaring, wants patient transported to CMSO, history of TBI. Mom stated that the pt has been having trouble breathing today and seemed to be getting worse, has vomited 2-3x, fever of 101. Tylenol given and improvement noted, normal amount of wet diapers with normal eating.</p>	3008- 3011

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		<p>Objective: Patient was found sitting in car seat and appeared to be sleeping, pink in color, mild retraction noted with nasal flaring. ALS assessment and PE findings noted in the assessment portion of this report.</p> <p>Plan: Event history obtained from PA and 800. Helicopter cancelled. Patient contact. Vs obtained. Patient was secured to the cot with patient remaining in the car seat. Once en route to CMSO patient appeared to be sleeping, SpO2 was noted to be in the low 90's, O2 blow by was provided via O2 tubing, improvement noted and maintained in SpO2 at 99%, 4 lead attached. Patient would responded to touch at the bottom of the feet. Radio report given to CMSO. Bulb syringe had to be used on the patient's nose while the patient had a crying fit. Bright green mucus was noted. ALS assessment. Vs, 4 lead and SpO2 monitored throughout patient care. Once at CMSO patient was taken to RM14, unsecured from the cot. Patient while still in the car seat was placed on the bed with mom holding car seat. Patient report was given to the RM. Patient care was then transferred over to the ER staff at CMSO. EMS cleared.</p>	
03/17/YYYY	Hospital/ Provider Name	<p>ER visit:</p> <p>Chief complaint: Fever - respiratory complaint</p> <p>History of present illness: Mode of transport: POV Quincy is a 2-month-old male born at 38 weeks via c-section due to abruptio placenta, born stillbirth requiring 45 mins of resuscitation followed by a 10-day NICU stay, resulting in anoxic injury to the brainstem and frontal lobe; presenting for evaluation of difficulty breathing, cough and wheezing. He was seen at an outside clinic and was diagnosed with hypoxia O2 sats in the 80s. He was also diagnosed with RSV. Mom states that he was suctioned at the clinic, however they were unsuccessful at getting much out. He has also had fever for the last 2 days, T-max 103f. Mom denies color changes. She states that brought him to clinic evaluation because he was using his abdominal muscles while breathing.</p> <p>Mom states that he is formula fed and he has continued to feed well, today he did have one large NBNB emesis after coughing. He has had 4 wet diapers today. He had a dose of Tylenol 4 hours ago.</p> <p>Assessment/plan: 2-month-old male with a complex birth history resulting in anoxic brain injury, presenting tonight for evaluation of respiratory distress. On exam he is tachypneic with moderate intercostal retractions oxygen sat 96%. NA suction done with improved work of breathing. Crackles noted on exam with fever, CXR ordered to r/o pneumonia.</p> <p>Diagnosis: Bronchiolitis</p>	2116- 2118, 1996- 2005, 2903- 2905

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		<p>Fever</p> <p>Discharge patient – Ordered</p> <p>03/17/22 2053 hrs, discharge home, print discharge paperwork, non-confidential discharge</p> <p>Condition: Good.</p> <p><i>*Related records: Discharge instructions, transition of care, blank page.</i></p>	
03/17/YYYY	Hospital/ Provider Name	<p>X-ray of chest:</p> <p>Reason for exam: Pneumonia</p> <p>Impression: Normal chest</p>	2006- 2007
06/06/YYYY	Hospital/ Provider Name	<p>ER visit:</p> <p>Chief complaint: Inconsolable</p> <p>History of present illness: Quincy is a 5 month with past medical history of HIE and small VSD who comes to the emergency department for fussiness. Mom says he's had 2 days of fever, Tmax of 103. No rhinorrhea, cough, congestion, vomiting, diarrhea, or new rashes. He's had decreased appetite. Good wet diapers. No stools. Today he was seen by NP in their town, evaluated and advised to come to the emergency department. Mom describes an episode of him crying in the car on the way to the emergency department where he was crying, his body went limp, he turned blue around the lips. The episode lasted about 30 seconds. Mom shook him and blew in his face and patient started crying again. EMS arrived and per mom pt had a fever, his body stiffened, he had jerking of all extremities, his eye rolled back, episode lasted 6 seconds and then patient started crying again. Patient was taken to OPR, Tylenol given, his eye was stained and mom was told he had a stomach bug. Mom says he continues to be fussy and brought him to the emergency department for further evaluation. His last BM was today, it was soft, no straining.</p> <p>Assessment/plan: 5 month with past medical history of HIE and small VSD who comes to the emergency department 2 days of fever x 2 days, episode that sounds like a BRUE v possible seizure v other. Will start with flu, Covid, UA, KUB, CXR, and EKG.</p> <p>Diagnosis: Fever Viral illness Fussiness in baby Breath-holding spell Constipation</p>	2112- 2116, 2901- 2903

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		<p>Discharge patient - Ordered 06/06/YYYY 1901 hrs, Discharge home, print discharge paperwork, non-confidential discharge</p> <p>Condition: Good.</p> <p><i>*Related records: Discharge instructions, transition of care.</i></p>	
06/06/YYYY	Hospital/ Provider Name	<p>X-ray of abdomen:</p> <p>Indication: Fever; constipation.</p> <p>Findings: There is a peribronchial cuffing. The bowel gas pattern is non-obstructive with moderate colonic gas and stool.</p> <p>Impression: Peribronchial cuffing. No focal pneumonia. Moderate colonic gas and stool with non-obstructive bowel gas pattern.</p>	2017- 2018
06/06/YYYY	Hospital/ Provider Name	<p>EKG:</p> <p>Result: Normal sinus rhythm Normal EKG.</p>	2987
07/13/YYYY	Hospital/ Provider Name	<p>Follow up visit:</p> <p>Chief complaint: Follow up right UDT</p> <p>History of present illness: Quincy is a 6-months old being re-evaluated for UDT. He has not had any changes per parents.</p> <p>Review of systems: General: Very sensitive to heat or cold Ear, nose, mouth, throat: Ear infections, ear pain</p> <p>Comment: His testicle still hasn't dropped; He has a sinus infection (Diagnosed)</p> <p>Assessment/plan: We will plan lap orchiopexy as an outpatient when able.</p>	YYYY- YYYY
08/13/YYYY	Hospital/ Provider Name	<p>Patient care report:</p> <p>Service model agency: From: 604 Kansas St (Home/Residence) To: Children's Mercy Hospital South Destination/decision: Patient/family request</p> <p>Destination: Children's Mercy Hospital South</p>	3017- 3021

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		<p>Chief complaint category: Breathing problem</p> <p>Narrative: Unit 823 responded to the above address for a reported patient with shortness of breath. On scene patient found being held by his mother. Patient is alert and acting appropriate according to the mother. Patient's mother states he has had increased work of breathing since midnight and has had a fever since. Patient lung sounds have rales noted in the lower quadrants. Patient placed into his car. Seat and secured. Patient secured to EMS cot. Patient transported non-emergent to Children's Mercy South. Albuterol nebulized breathing treatment administered by blow by oxygen blow by continued after nebulized treatment given. Patient continues the transport resting with his eyes closed. Patient report radioed to the receiving facility prior to EMS arrival. At children's south patient moved to emergency department bed #19. Patient care given to ER staff. Patient's mother signs EMS authorization form, unit 823 returns to the county and to service.</p>	
08/13/YYYY	Hospital/ Provider Name	<p>ER visit:</p> <p>Chief complaint: Difficulty breathing.</p> <p>History of present illness: Positive cough/congestion started last night, positive fever, mom gave Ibuprofen at 4 a.m., no V/D, fed ok yesterday, UOP ok, Imm not UTD delayed due to HIE, positive history of HIE, positive history of bronchiolitis x 2, no hospitalization, has used Albuterol with bronchiolitis, no diagnosis asthma.</p> <p>Diagnosis: Acute asthma Hypoxia Respiratory distress Bronchiolitis</p> <p>Admit request – Completed</p> <p>08/13/YYYY 1201 hrs, General pediatrics, mode of transport CMH transport, hypoxia patient tested for Covid: Yes - symptomatic, #</p> <p>Condition: Select one</p> <p>Medication reconciliation: Unchanged: Acetaminophen (Tylenol) Ibuprofen (Ibuprofen 100 mg/5 ml oral suspension) 25 Milligram.</p>	2110- 2112, YYYY- 2026, 2898- 2900
08/13/YYYY	Hospital/ Provider Name	<p>Ambulance report:</p> <p>Service: Children's Mercy</p>	3094- 3096

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		<p>Type of service: Hospital to Hospital Transfer Disposition: Treated and transported by CCT Referring/scene: Children's Mercy Hospital Kansas – Emergency Receiving/destination: Hospital Children's Mercy Hospital</p> <p>Chief complaint (Category: Pediatric - pulmonary): Respiratory distress with hypoxia</p> <p>Duration: 1 days</p> <p>Anatomic location: General/global</p> <p>History of present illness: CMCCT requested for transport of 7-month male, 10 kg for respiratory distress. Patient is previously healthy male patient with history of NICU admission for HIE and previous bronchiolitis without admissions. The patient began cough/congestion/fever yesterday and went to the emergency department this morning for increasing distress. In the emergency department, IV access was obtained, 2 hours of continuous was administered. 4 Albuterol nebulizers given every 2 hrs, Ibuprofen for fever, magnesium sulfate IV, normal saline bolus, and IVF administered. Patient was placed on HFNC at 12 lpm/21 % FiO2. CMCCT established pt care after RN-RN handoff. Patient transported to CMH for services unavailable at referral facility.</p> <p>Neurological examination: Respiratory: Effort: Tachypnea Sounds right and left: Coarse Oxygen: 12 lpm via High Flow Nasal Cannula, FiO2: 21 Respiration exam: Coarse, equal right to left, tachypnea</p> <p>Initial physical findings: Assessment: Head findings: Anterior fontanelle soft and flat, small (Approximate 1 cm) bruise noted to right temporal area of forehead. Generalized Ab findings: Positive bowel sounds</p> <p>IVs prior to assessment: Right hand: 24 gauge</p> <p>Impression/diagnosis: System: Pulmonary Symptoms: Respiratory distress Impression: Respiratory distress Initial patient acuity: Emergent (Yellow) Working diagnosis: Respiratory distress</p> <p>Vitals:</p>	

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		<p>#1945 hrs: HR 174, BP 113/78, MAP 90, SpO2 97, RR 60, GCS 15, Temp 36.6°C</p> <p>Pain scale scores: FLACC score values are activity: normal, legs: normal/relaxed, face: no expression, cry: no cry, consolability: content/relaxed. Arrived at CMK emergency department. Patient being held by staff in exam room with family present. Report received from RN and RT. Patient assessed and care assumed by transport team.</p> <p>#1955 hrs: Medical consult: Casey McMillan consulted with Pfeiffer Stephen # from Children's Mercy Hospital via Cellular Dr. Pfeiffer/C. McMillan Med calc 10 kg Transport CMH by ground D5NS 40 ml/hr IV continuous HFNC 12 Lpm (Titrated for WOB) FiO2 titrate SpO2 >94%. Attempts: 1, successful.</p> <p>#2000 hrs: HR 166, BP 116/77, MAP 90, SpO2 98, RR 66, Temp: 19.8</p> <p>Airway: Oxygen initiated at 10:1pm via high flow nasal cannula by Charlene Cochran, role performing: respiratory therapist, flow set at 10 LPM on air flow meter in ambulance, no change in patient status. FiO2: 21, air temperature: 35 Complications: None, None. Authorization: Pfeiffer Stephen #. Patient response: not known.</p> <p>#2005 hrs: Dextrose 5%, 0.9 Nacl, 40 ML/HR via IV pump, rate: 40 ML/HR, given by Casey McMillan. Complication: None. Authorization: other on-line (Radio or telephone). Patient response: Unchanged. D5NS IVF 40 ml/hr continued from referral facility.</p> <p>#2015 hrs: HR 154, BP 121/80, MAP 94, SpO2 98, RR 70</p> <p>#2030 hrs: HR 142, BP 102/66, MAP 78, SpO2 96, RR 58, Temp 2</p> <p>#2035 hrs: HR 147, BP 102/65, MAP 77, SpO2 96, RR 64</p> <p>Patient care transferred to CMH after RN-RN handoff. Patient tolerated transport without complication. PIV remains patent.</p>	
08/13/YYYY	Hospital/ Provider Name	<p>Pediatric hospital medicine visit:</p> <p>History of present illness: Quincy Brown is a 7-month-old male who presents via transport to CMH with increased work of breathing, fever, cough and congestion</p> <p>Report given by transport. Patient had presented to the emergency department in</p>	2144-2146

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		<p>the morning with a 1-day history of illness including cough, congestion and runny nose. In the emergency department patient was treated with Decadron/Albuterol/Atrovent and was given high flow oxygen. There was a good response to Albuterol with minimal retractions and continuous was stopped and observed without oxygen. Around 1000 patient was given normal saline bolus and put on 1 hour Albuterol. At 1200 sats were in the 80s without oxygen. Patient was put on high flow 35% 10L and attempted to space out Albuterol to every 2 hours. Patient was less responsive to and more responsive to suctioning. The decision was made to transfer the patient to CMH</p> <p>During transit patient was on 10L and weaned to 3L on 100%.</p> <p>Mother was in the room to confirm the story. Patient was born at 39 weeks with pregnancy complicated by gestational diabetes and hypertension. Delivery itself was an emergent C-section which resulted in an extended NICU stay and a cooling blanket. Patient has previously been hospitalized 2–3 times for bronchiolitis. And 1 previous admission for seizure-like activity. Mom confirmed most of the story around midnight she noticed that the patient had a fever around 101 (Rectal). She gave 1 25 Ibuprofen and the fever broke. Patient later woke up early this morning and was read and crying. She tried suctioning him with nose Freda provided no relief. She noticed he was red, hot, and had a dry cough with congestion before going to the emergency room.</p> <p>Patient has a family history of allergies and asthma in the dad and siblings with allergies. She also states that several people in the family have hypothyroidism. Of note the patient does not have any past surgical history but does have a future surgery scheduled in 1 month for Cryptorchidism on the right side. Patient has had vaccines up to 3 months and is due for 6-month vaccines. She states that they had to delay vaccine schedules due to NICU stay, which delayed getting the 1-month vaccines.</p> <p>Physical examination: Head/neck: Normocephalic, 1 cm light brown brushing over right temple ENT: Congestion Abdomen: Bowel sound GU: Right testes has not descended</p> <p>Assessment/plan: Quincy Brown is a 3-year-old male with past medical history of 2-3x hospitalizations for bronchiolitis and 1x hospitalization for seizure like activity who presents with fever, cough, congestion, and hypoxemia. Symptoms reportedly had some improvement after Albuterol treatment. Exam findings and symptoms are consistent with bronchiolitis. Patient was admitted for bronchiolitis. Respiratory Syncytial Virus (RSV) is most likely, though other causes include Rhinovirus, Parainfluenza Virus, Human Metapneumovirus, Influenza Virus, Adenovirus, Coronavirus, and Human Bocavirus. (Lower respiratory tract infection and wheezing episodes in infants infrequently are associated with Mycoplasma pneumoniae and Bordetella pertussis.) He is</p>	

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		<p>clinically stable and well-appearing today.</p> <p>Neurologic: Stable and at baseline Meds: -Tylenol as needed for fever for fever -Ibuprofen as needed every 6 for fever/mild pain not responsive to Tylenol</p> <p>CV: Hemodynamically stable -CR monitors -Vitals per floor protocol</p> <p>Respiratory: # Bronchiolitis Currently on RA -Wean O2 as tolerated to keep saturations >92% -RT care plan > NA/NP suctioning as needed > Hypertonic saline per protocol -Continuous O2 sat monitors -Routine vitals</p> <p>FEN/GI: Good per oral intake, well hydrated on exam -Regular diet for age -Monitor I&Os</p> <p>GU: # Right sided cryptorchidism Plan: -Patient has surgery scheduled 09/16/YYYY at CMH</p> <p>ID: Afebrile, likely viral etiology -No antibiotics indicated at this time</p> <p>Social: Parents at bedside and updated on plan of care. Team remains to answer questions. Concerns regarding care at home. There was a reported incident that a sibling was removed from the home 12 years ago, with concerns for sexual abuse and ingestion. This was per transport from the nurse. Plan: -Social work consult in the morning.</p> <p>Disposition: Admit to general pediatrics for further management of bronchiolitis. Consider discharge when: no longer requiring supplemental oxygen while awake or sleeping, has good per oral intake, and adequate urine output</p> <p>Attending attestation: I personally examined the patient at 2300 on 08/13/22. I actively participated in the formulation of the plan of care. I agree with the above documentation including the physical exam, assessment and plan.</p>	
08/14/YYYY	Hospital/ Provider	Lactation note:	2875

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	Name	Chart reviewed: Yes Spoke with: Nurse Communication site: Phone Comments: MPTL notification due to breast milk diet. Per admission database, Quincy is exclusively formula fed. I-views shows only feeds as formula by bottle. Confirmed with RN that mom is not pumping. RN to have medical team discontinue breast milk order.	
08/14/YYYY	Hospital/ Provider Name	Discharge summary: Admit date: 08/13/YYYY Discharge date: 08/14/YYYY Referring physician: Lance Shipman Discharge diagnosis: Acute viral bronchiolitis Discharge disposition/condition: Discharge home/condition: Good Consultants last 7 days: Consult to social work Indication for admission: Increased work of breathing, hypoxia, bronchiolitis Hospital course: Quincy is a 7-month-old that was admitted for concerns of increased work of breathing and hypoxia in the setting of bronchiolitis, likely secondary to viral infection. Upon presentation to the emergency department was desatting in the 80's. Was given Decadron/Albuterol/ Atrovent/Mag and placed on high flow 35% 10L. Started on MIVF and admitted to the floor for further observation. Was able to wean to RA and tolerated PO intake. Sating mid 90s prior to discharge. Sent home with Albuterol inhaler will follow up with PCP this week. Physical examination: Head/neck: 1 cm light brown brushing over right temple Discharge medications: Albuterol HFA 90 mcg/inhalation Aerosol 4 puff Inhaled per protocol as needed for wheezing or cough Ibuprofen 100 mg/5 ml oral suspension 25 mg Tylenol Feeding regimen: Discharge home diet: Regular age appropriate Follow up appointments: CMH surgery on 09/16/YYYY	2027- 2029, 2210- 2215

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		<p>Neuro follow up on 09/16/YYYY</p> <p>Attending attestation: On 8/14, I have taken the history, examined the patient, reviewed the available lab data and discussed this information with the team thereby directing formation of the assessment and plans. My history, exam findings and assessments and plans confirm those documented by the resident.</p> <p><i>*Related records: Discharge instructions.</i></p>	
08/23/YYYY	Hospital/ Provider Name	<p>EMU admission criteria:</p> <p>EMU admission criteria: To quantify seizure frequency, to develop or modify treatment, or to establish the diagnosis of epilepsy in young children with clinical symptoms consistent with epilepsy, but who present with diagnostic difficulties after clinical assessment and interictal EEG, Suspicion of non-epileptic events or mixed epilepsy and non-epileptic, Episodes sufficiently frequent for a significant chance of capturing one during monitoring daily or weekly versus monthly, Patient has poor awareness or ability to communicate with indistinct seizure events (eg, absence seizures); hampered ability to communicate (eg, patients with autism, infants, young children) or encephalopathy, Patient has continued symptoms, and test results of interictal EEG are inconclusive/non-diagnostic.</p>	2279
08/23/YYYY	Hospital/ Provider Name	<p>Follow up visit:</p> <p>Chief complaint: HIE, abnormal eye movements</p> <p>History of present illness: Visit type- Follow up Quincy is a 7-month-old male who was seen today in the Neurology Clinic at CM Kansas with a chief complaint of hypoxic ischemic encephalopathy. Quincy is accompanied by parents who reported the patient's history</p> <p>PCP: Rhonda Kellstadt, ARNP</p> <p>Referring provider: XXXX, M.D.</p> <p>Quincy is a 7-month-old baby boy with a history of hypoxic ischemic encephalopathy who is being seen in neurology clinic for follow up. He is accompanied to his appointment by his parents who provide history. Additional history is obtained from review of EMR. He was last seen in neurology in March.</p> <p>He was born via emergent C-section due to failure progress on time. His APGARS were 0 and he required 45 minutes of resuscitation. He was transferred from the birth hospital to Freeman in Joplin for cooling protocol for about 3 days. After cooling was over he had feeding difficulties and at the end of his hospital admission mom found out she had Covid. EEG during this process was normal for age in review of EMR and he did not require any AEDs.</p>	2033- 2036, 2030- 2032

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		<p>MRI was completed which noted some abnormalities.</p> <p>He was admitted at 4 weeks of life after a 5-day history of episodes of gaze deviation and nystagmus that occurred at least once per day. He had several episodes the day prior to hospital admission also involving flexion of left arm as well as the eye movements and was subsequently admitted for seizure work up. All episodes would last about 1 minute in length and eyes always would beat to the left. He was loaded with Keppra and started on maintenance Keppra for presumed seizures, connected to long-term EEG and completed a sepsis work up for infectious etiology. He had multiple events of abnormal eye movements lasting briefly on EEG which did not have any electrical correlate and therefore were deemed nonepileptic. EEG and Keppra were discontinued. MRI brain was completed which showed volume loss. He was discharged from the hospital in stable condition.</p> <p>He has therapies in place with early intervention and he is noted to be delayed. His therapists have expressed concern about a delay in vision. She comes once per week. He does fixate on items and sometimes he tracks depending on how much light is in the room. If it is dim in the room he does not pick up on seeing things. The gaze deviation episodes have continued but it seems to occur only when he is doing other things such as eating, focusing on other things. He hears well and will respond to sound with any slight noise. Head control is not great and they are working on it. He had nystagmus but was making progress with a plan for early intervention.</p> <p>He has started having episodes described as a full body shake, his arms are tense and mom puts her hands in his palm and sometimes he calms down. Usually happens if he was outside, fever, upset. They occur every 2-3 days lasting longer than others 20 seconds or longer. They have seen a correlation with being hot even being outside and it happens when he coughs a lot. Usually he is stuck on whatever he is looking at. His hands get tight and she pulls his arms out and she focuses on mom and a bit later he calms down. It is more like a tremor side to side movements and whole body and not a rhythmic hard jerk. He is alert sometimes when it occurs and mom feels like he responds to her. She always goes to stimulate him with the episodes because they scare her and she feels she can get him out of them. Afterwards he is calm sometimes he goes to sleep afterwards. They have tried keeping him out of the heat. When he is on the floor playing with toys he tries to crawl and he does not use his left leg. He will grab with his left arm for toys but that is it. He will not put any weight on his arm or leg. He continues to have nystagmus. His lazy eye is bad when he gets tired. He will sit up and requires support and if unsupported he always falls to the left. They see slow gradual progress with therapy. He continues getting early intervention.</p> <p>Physical examination: Abdomen: Bowel sounds.</p> <p>Neurologic exam:</p>	

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		<p>Cranial nerves: PERRL. Tracking much improved from prior exam, no nystagmus noted on exam today. Facial movements symmetric bilaterally. Motor assessment: Moves all extremities, left arm and leg appear weaker compared to right. Raising all extremities against gravity</p> <p>Assessment/plan: Quincy is a 7-month-old baby boy with a history of HIE who continues to have nystagmus and has new episodes of shaking of unclear etiology. His prior work up was reviewed today. Based on description of episodes and that mom is able to abort them, they sound less concerning for seizure. I have recommended they stop intervening a few times to see what happens and verify that their intervention resolves episodes which would be less suggestive of seizure. Because the episode occur fairly frequently in an infant who has elevated risk for seizure and HIE I have ordered an EMU to capture and characterize episodes. He is at increased risk for seizure due to his history of HIE. I have asked to be notified if these episodes change or he has new ones of concern. If family is able to get a video of them it would be helpful but I understand their being very brief. Continue plan of care with therapies in place. Notify us if there are any developmental plateaus or regression. It remains unclear what his progress will be like but we will continue to monitor his development and how he does. He has been referred to Ophthalmology and CCVI for further evaluation of vision concerns. His exam shows focal weakness on the left side. I would like to see him back in 6 months or sooner if needed. All questions and concerns addressed. Parents verbalized understanding of all instructions and agreement with plan.</p> <p>Discharge instructions: Workup: EMU Referral for Ophthalmology Referral to CCVI Continue therapies as planned Notify me of any new concerns Follow-up in 6 months, or sooner if needed</p>	
09/07/YYYY - 09/08/YYYY	Hospital/ Provider Name	<p>Pre-anesthesia communication notes:</p> <p>09/07: 1554 hrs: Date of surgery: 09/16/YYYY Procedure: Lap right orchiopexy Surgeon: St. Peter</p> <p>Question/concern: History of Hypoxic Ischemic Encephalopathy, Developmental Delay, Shaking of unknown etiology, VSD- has missed the appointment with Cardiology on 3/31 and then on 9/6, Mom was in the hospital on 9/6, he is now scheduled for 9/30. Quincy was admitted 8/13/22-8/14/22 with increased work of breathing, hypoxia, desats down to 80's and diagnosed with Bronchiolitis, he was sent home with Albuterol. Please advise.</p>	2332- 2335

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		<p>1630 hrs: Prior to proceeding with his surgery, he needs to be seen by cardiology. Can you please contact the cardiac clinic schedulers to see if that is possible to coordinate questionable. He also should be scheduled for a TH PAT.</p> <p>09/08: 0833 hrs: See ANES recommendations below. Is there any appointment with any provider this PT could be squeezed into before 9/16 questionable.</p> <p>0846 hrs: I called each number listed in the chart and there was no answer. I left a voicemail with our number for callback to hopefully get them scheduled before the 16th. I will keep you posted.</p> <p>0849 hrs: If you have an appointment, go ahead and schedule family and let us know what the date and time is. I will continue to try to contact family as we need to schedule a PAT appointment as well, so I can inform family of cardiology appointment time, if/when I reach them.</p> <p>0903 hrs: We were able to squeeze them in on 9/14 @ 10:15 arrival time. This is going to be at our College Boulevard location. With Julie Martin. Please let me know if you need anything else.</p> <p>0928 hrs: Spoke to mom, advised of Cardiology follow up 9/14, mother agreeable. PAT scheduled 9/14 at 1330. Mother provided with both addresses, reiterated that appointments were at different locations, mom voiced understanding.</p>	
09/08/YYYY	Hospital/ Provider Name	<p>ER visit:</p> <p>Chief complaint: Difficulty breathing</p> <p>History of present illness: Quincy Brown is a 8-month-old male with past medical history of HIE as newborn and asthma/reactive airway that presents to the ER with mom at bedside complaint of wheezing and worsening trouble breathing since this morning. Mom says that patient was doing well yesterday and this morning started to feel wheezy and having trouble breathing. Mom ran out of his inhaler last night and he has not gotten any treatment today. Mom says that patient was admitted a few months ago for this and has been using his inhalers maybe x2/week since. Patient denies any fever, chills, leg swelling, sore throat, congestion, rhinorrhea, NVD, abdomen pain, urinary symptoms, back pain, headache, vision changes, dizziness, or weakness/numbness to extremities. Patient denies ever being intubated for an asthma attack. Patient is UTD with immunizations and routine medical care. Patient has no other complaints at this</p>	2108- 2110, 2037- 2044, 2891- 2894

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		<p>time.</p> <p>Assessment/plan: Patient presents with wheezing and respiration problems. Has been out of inhalers at home. Physical examination shows wheezing and mild respiratory distress. Will start Hr-long breathing treatment, give steroids and reassess.</p> <p>Diagnosis: Wheezing Reactive airway disease</p> <p>Discharge patient – Ordered</p> <p>09/08/22 2131 hrs, discharge home, print discharge paperwork, non-confidential discharge</p> <p>Condition: Good.</p> <p><i>*Related records: Discharge instructions, transition of care.</i></p>	
09/09/YYYY	Hospital/ Provider Name	<p>Pre-anesthesia communication notes:</p> <p>0925 hrs: Date of surgery: 09/16/YYYY Procedure: Lap orchiopexy Surgeon: ST Peter Question/concern: Was admitted for asthma exacerbation on 8/13/YYYY with steroids and seen again in the ER on 09/08/YYYY for asthma with another dose of oral steroids for 4 days.</p> <p>Please review for upcoming or procedure scheduled on 9/16/YYYY.</p> <p>0941 hrs: Patient will need to be rescheduled for 10/11 or after (4 weeks after completing 5-day course of oral steroids). Please make sure mom follow up with PCP per ED recommendations.</p> <p>1240 hrs: I spoke with mom and advised her of the cancellation of the OR and the pat. I encouraged mom to keep the cardiology appointment at the college BLVD location. Mom is planning on keeping appointment. I advised her of the rescheduling date of 10/11/YYYY or after. I asked her to call the surgery clinic to reschedule.</p>	2331- 2332
09/14/YYYY	Hospital/ Provider Name	<p>Cardiology visit:</p> <p>Chief complaint: VSD</p> <p>History of present illness: I saw Quincy for evaluation of a possible ventricular septal defect in</p>	2057- 2060, 2045- 2052, 2292- 2294,

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		<p>consultation at the request of Rhonda Kellstadt, in the Children's Mercy College boulevard cardiology clinic on September 14, YYYY, Quincy was accompanied by the parents and brother.</p> <p>Quincy is an 8-month-old male referred to the cardiology clinic for evaluation. According to the medical records Quincy had ventricular septal defect noted shortly after birth. According to the mother she believed Quincy and abnormalities within his valves. I did not have access to the echocardiogram report or echocardiogram images</p> <p>Today I obtain additional information from the parents. Quincy had a significant hypoxic event during the labor and delivery process. According to the mother he received resuscitation for 48 minutes postdelivery. Secondary to this insult he has developed seizures and developmental delays. Quincy tends to use his left leg less frequently than his right leg. He receives therapy in the home through the birth to 3 program.</p> <p>From a cardiac standpoint the parents have not observed any significant color changes cyanosis or pallor. Quincy's upper and lower extremities are equal in color and temperature. The parents have not felt an increased cardiac impulse when they have placed the hands onto Quincy chest wall. Quincy in general has easy respiratory pattern. During times of illnesses he has more frequent episodes of increased work of breathing and louder breathing. He has an Albuterol inhaler prescribed which helps relieve the symptoms. Quincy has been hospitalized on several occasions secondary to respiratory symptoms and for management of RSV.</p> <p>The mother reports Quincy is an undescended testicle which has not been surgically corrected. Quincy has extra buildup of earwax noted on a regular basis.</p> <p>Quincy receives Similac pro advance formula. He drinks between 6 and 8 ounces every 2-3 hours. He also eats baby 3. There is no increased work of breathing or color changes with the feedings. He has a normal urination and a normal stooling pattern. He has shown good weight gain</p> <p>Quincy has been healthy and afebrile.</p> <p>Birth history: Parents state that the patient was born at 38 weeks gestation at Via Christi Hospital. Mother went into spontaneous labor but had failure to progress. Patient was found to have nuchal cord and an emergent C-section was performed. Pregnancy was complicated by polyhydramnios, hypertension, gestational diabetes, and Covid infection during pregnancy. Mother was also GBS positive at delivery but received 2 doses of Penicillin greater than 4 hours from delivery. Mother did not have a fever during delivery. Mother denies any history of gonorrhea, chlamydia, HIV, syphilis. Both parents agree that there are no known HSV exposures in family or friends who have seen Quincy. Patient</p>	2889-2891

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		<p>received vitamin K and hepatitis B vaccine at delivery.</p> <p>After delivery, patient had APGARS of zero, and resuscitation was performed for 45 minutes. Patient was transferred to Freeman Hospital and admitted to the NICU. Cooling protocol was performed for concern of HIE. During 10-day NICU stay, EEG was performed that showed a few spikes, but was otherwise normal. MRI was performed that showed moderate HIE, and echo was performed that showed a VSD. Patient was discharged home on day of life 11 with CMH neuro follow-up.</p> <p><i>Reviewed results on echocardiogram and EKG dated on 09/14/YYYY, 06/06/YYYY</i></p> <p>Review of systems: General: Often sick, very sensitive to heat or cold Lung: Cough Comment: Assuming this is for his cardio appointment today, he's here to have his heart looked at to see if his valves have closed.</p> <p>Assessment/plan: Diagnosis: Normal cardiac examination Normal echocardiogram</p> <p>Quincy was seen in cardiology clinic today for evaluation of a possible ventricular septal defect versus cardiac valve abnormality.</p> <p>Today for further cardiac assessment an echocardiogram was completed. The echocardiogram was normal. There were no cardiac structure abnormalities. There is normal biventricular function.</p> <p>I discussed the echocardiogram findings with the parents. The family was informed Quincy does not have evidence of a cardiac disease process. Without prior echocardiogram results it is difficult to determine if he actually had a ventricular septal defect or other cardiac findings which have self-resolved.</p> <p>As anticipatory guidance I informed the family innocent heart murmurs can be noted during times of growth spurts, illnesses, fevers, or anemia. If a murmur is noted in the future with Quincy I instructed the family to reassure the healthcare provider of Quincy's normal echocardiogram results.</p> <p>Recommendations: Quincy does not require any activity restrictions. Quincy does not require subacute bacterial endocarditis prophylaxis. I recommend Quincy receives the annual flu shot and immunizations per the recommended schedule. I do not believe any additional cardiology follow-up appointment is necessary at this time.</p>	

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		<p>The family was instructed to contact cardiology with new questions or concerns.</p> <p><i>*Related records: Discharge instructions, transition of care, assessment.</i></p>	
09/14/YYYY	Hospital/ Provider Name	<p>Transthoracic echocardiogram:</p> <p>Reason for study: History of SVD</p> <p>Interpretation summary: Uncooperative patient. Technically difficult, suboptimal study. History of ventricular septal defect.</p> <p>No evidence of a ventricular septal defect Normal left ventricular size and systolic function Normal right ventricular size and systolic function No pericardial effusion</p>	2948- 2950
10/26/YYYY	Hospital/ Provider Name	<p>Triage call report:</p> <p>History of present illness: Per mom: Caller is not with patient. Grandmother is caring for patient today and called mother. Patient was standing in front of the couch, holding on, and his feet slipped out from underneath him. Patient fell backwards hitting his head "really hard". Patient cried appropriately but then abruptly quit crying and "fell asleep". Grandmother tells mom that he is difficult to wake up and only stays awake for a second or so and then goes back to sleep. Mother on Facetime with grandmother and child. Mother advised to have grandma call 911 now. Understanding verbalized. Guideline title: Head Injury Recommended disposition: Call EMS 911 Now</p> <p>Reason for disposition: Acute neuro symptom Symptom persists (Definition: Difficult to awaken or keep awake or altered mental status with confused thinking and talking or slurred speech or weakness of arms or unsteady walking).</p>	3099- 3100
11/16/YYYY	Hospital/ Provider Name	<p>ER visit:</p> <p>Chief complaint: Difficulty breathing</p> <p>History of present illness: Quincy Brown is a 10-month-old male with past medical history of HIE as newborn and asthma that presents to the ER with mom at bedside complaint of wheezing and difficulty breathing. Symptoms started 2 days ago with fever (T-max 102.9 F), nasal congestion and cough. Yesterday, patient started to have difficulty breathing and wheezing. He also started to have post-tussive emesis and does not tolerate PO as before. He urinated 3 times in last 24 hours. Mom gave him Albuterol by Nebulizer 3 times yesterday and once this morning, without improvement. Patient also received Tylenol with his fever (Lasts dose was around noon). Mom does not suction his secretions frequently at home. Of</p>	2105- 2107, 2886- 2889

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		<p>note, patient was admitted a few months ago for same symptoms and has been using his inhalers maybe x2/week since that time. Patient is UTD with immunizations and routine medical care. Patient has no other complaints at this time.</p> <p>Assessment/plan: A 10-month-old male with past medical history of HIE and asthma presents with wheezing and difficulty breathing preceded by URI symptoms. Has been using inhalers at home without improvement. Physical examination shows bilateral coarse breathing sound with diffuse wheezing. Patient sitting at low 90s.</p> <ul style="list-style-type: none"> - Will test him for Covid19, FLU and RSV. - Deep suctioning of secretions. - Will start 1 hour of continues Albuterol. - Will give a dose of Dexamethasone - Encouraged giving oral fluids to assess his PO tolerance. - Reassess after an hour. 	
12/31/YYYY	Hospital/ Provider Name	<p>SEK birth to three referral form:</p> <p>Reason for referral to birth to 3 program: Identified condition or diagnosis: Neonatal encephalopathy</p>	1395
05/26/YYYY	Hospital/ Provider Name	<p>Pediatric surgery history and physical examination report:</p> <p>History of present illness: Now 16-month-old male seen July last year for undescended testicle and the plan for surgery at that time however he has not been scheduled until now. He is presenting for elective right orchiopexy. The right testicle is now palpable in the inguinal area. No recent fever or illness. Does have a history of hypoxic ischemic encephalopathy as well as reactive airway disease.</p> <p>Physical examination: Respiratory: Bilateral chest rise, respirations even and unlabored Left testicle palpable in the scrotum. Right testicle palpable in the inguinal area</p> <p>Assessment/plan: We will plan for open right orchiopexy using either a scrotal or inguinal approach.</p>	2131- 2132
05/26/YYYY	Hospital/ Provider Name	<p>Operative report:</p> <p>Indication for surgery: Right orchiopexy</p> <p>Pre/post operative diagnosis: Right undescended testicle</p> <p>Operation: Inguinal exploration, right orchiopexy</p> <p>Indication for operation: The patient was a 16mo male with a history of right undescended testicle. Testicular exam under anesthesia, possible diagnostic laparoscopy, orchiopexy,</p>	2161- 2162

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		<p>possible excision of testicular remnants was recommended. The risks, benefits, and alternatives were discussed in detail with the patient's parents and they agreed to proceed.</p> <p>Description of procedure: All the instruments, needle, sponges counts were correct at the end of the procedure. The patient tolerated the procedure well, was extubated without complications and transported to the PACU in good conditions.</p> <p>Dr. St peter participated and directed the entire procedure.</p> <p>Estimated blood loss: 1cc</p> <p>Findings: Undescended right testicle</p> <p><i>*Related records: Pre-op notes, intra-op records, discharge instructions, anesthesia records</i></p> <p><i>Ref: 2162-2165, 2168-2175, 2199-2209, 2320-2327, 2330, 2882-2884</i></p>	
05/26/YYYY	Hospital/ Provider Name	<p>Pediatric surgery notes:</p> <p>The patient underwent an uncomplicated orchiopexy today after which he was transferred to the recovery area. Here he experienced episodes of oxygen desaturation requiring supplemental oxygen throughout the day. This occurred mostly while the patient fell asleep and was as severe as an O2 saturation of 84%, requiring as much as 10L O2 by a face mask. Due to this oxygen requirement, the recommendation was made to have the patient admitted for observation with the intention of having the general pediatrics team evaluate him. The parent's however felt that these episodes of hypoxia were normal for him in the context of his history of asthma. Anesthesia did attempt albuterol treatments and it is unclear if this significantly improved his status. Ultimately, the parents decided they did not want to stay in the hospital to receive further cares and discharged themselves against medical advice. The risks of doing so including further desaturation, with associated morbidity and mortality were thoroughly discussed with the parents and they expressed understanding. The patient was ultimately taken home by family 5/26/YYYY at around 20:00. This was discussed with charge nurse and pediatric surgery fellow.</p> <p>Pediatric surgery staff note: Patient was seen by the house staff and pediatric surgical fellow and discharged. I did not directly participate in this patient's care but did review the encounter.</p>	2309
12/19/YYYY	Hospital/ Provider Name	<p>ER visit:</p> <p>Chief complaint: Difficulty breathing</p> <p>History of present illness: The patient with a history of asthma and HIE who presents to Children's Mercy Hospital's Adele Hall Emergency Department due to concern for cough.</p>	2100-2105

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		<p>According to parents, low-grade fever, runny nose/nasal congestion, and cough began 4 days ago. T-max < 100.4 Fahrenheit. Cough is described as “wet”. Endorses difficulty breathing. Endorses 3 episodes of non-bloody, nonbilious, post-tussive emesis yesterday; No emesis reported today. Endorses “off and on” diarrhea since onset of illness; Endorses approximately 1 episode of non-bloody diarrhea daily. Endorses mouth sores; Denies additional rash. Endorses 1 episode of urine output today; endorses poor fluid intake. For relief, no Tylenol or Ibuprofen given today. Quincy was evaluated at Outside Healthcare Clinic and given 1 Albuterol treatment (Last dose: 12/19/YYYY 1:30 pm). Quincy was noted to have low SpO2 at outside clinic, so family was advised to seek further care at Children’s Mercy Hospital. Endorses history of asthma exacerbation requiring hospitalization (Last CMH hospitalization in 8/YYYY); No oral steroids administered since onset of illness. Denies recent travel in the past 2 weeks. Endorses exposure to brother with illness symptoms. No exposure to contacts with cold sores. Upon review of CMH medical record, Quincy underwent an Orchiopexy on 05/26/YYYY; post-surgery, Quincy had an episode of desaturation requiring supplemental oxygen; surgical team recommended admission for ongoing observation post-anesthesia; however, family preferred discharge home. Mother reports that Quincy’s SpO2 at baseline is around 90-94%. Quincy was evaluated by CMH cardiology team and had a negative echocardiogram on 05/14/YYYY.</p> <p>Birth history: Patient was born at 39 weeks with pregnancy complicated by gestational diabetes and hypertension. Delivery itself was an emergent C-section which resulted in an extended NICU stay and a cooling blanket.</p> <p>Pain score: 0.</p> <p>Assessment/plan: Quincy is a 23-month-old male with a history of asthma who presents to children’s Mercy’s emergency department for low-grade fever, runny nose/nasal congestion, and cough. In the emergency department, Quincy is mildly dehydrated but non-toxic appearing. Mild acute respiratory distress. Given history of asthma, Dexamethasone, Ipratropium and 1 hour of continuous Albuterol administered. Chest X-ray obtained which showed findings consistent with reactive airway disease vs. Viral process. RSV (Respiratory syncytial virus), flu test and rapid Covid-19 test negative. After 1st hour of continuous Albuterol, physical exam improved; however, tachypnea persisted with expiratory wheezing; 2nd hour of continuous Albuterol administered. Quincy monitored for 45 minutes post-2nd hour of continuous Albuterol and was able to eat/drink without difficulty. However, upon re-examination, Quincy continues to be Tachypneic with expiratory wheezing. Plan to place iv and administer 20 ml/kg normal saline fluid bolus. Will obtain bmp to check hydration status due to reported decreased oral intake. Will admit for ongoing observation and Albuterol spacing. At this time, symptoms likely related to a viral process. Patient’s parents verbalized understanding with no further</p>	

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		<p>questions/concern.</p> <p>Diagnoses: Stuffy and runny nose Cough Difficulty breathing Stomatitis Decreased oral intake</p> <p>Radiology: X-ray chest 2 view</p> <p>Admit request – Ordered</p> <p>Condition: Good.</p>	
12/19/YYYY	Hospital/ Provider Name	<p>History and physical examination report:</p> <p>Chief complaint: Difficulty breathing</p> <p>History of present illness: History obtained from: Mother, chart review Quincy is 23-month-old male with history of HIE, developmental delay, intermittent asthma who presents with respiratory distress.</p> <p>Patient has had 4 days of URI symptoms, intermittent fevers with Tmax “touch below 101”, and yesterday had NBNB post-tussive emesis x3 who presented initially to OSH ER where he got 1 alb treatment and had a reported desat to 70s. They were advised to come to CMH for further evaluation and came via POV. In the CMH emergency department he was found to be tachypneic 44-50s, subcostal retractions and diminished in bases and after an hour of continuous treatment had wheezing that improved with subsequent treatments. He received Decadron in the emergency department, IV fluid bolus and admitted after 3hr of continuous treatment. Chest X-ray was obtained and not concerning for pneumonia, IV bolus was given, BMP obtained that showed hyperglycemia and metabolic acidosis. Obtained A1c and blood gas.</p> <p>Per mom, patient was not responsive for 47 minutes at birth, underwent cooling and MRI afterwards showed severe brain damage and mom also notes “lung damage”. He has speech delay and even though able to walk, trips/falls very often. Not currently getting PT/ST.</p> <p>Assessment/plan: Quincy is a 23 Months Male with intermittent asthma who presents with status asthmaticus secondary to viral illness. Requires admission for continued frequent bronchodilator treatments.</p> <p>Neurology: - Tylenol, ibuprofen as needed</p>	2128- 2130

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		<p>CV: Tachycardia 2/2 Albuterol, will monitor</p> <p>Resp: Intermittent asthma exacerbation - Provide supplemental O2 as needed, goal saturations >89% - Wean Albuterol as tolerated per RT protocol - Continue steroid: Dexamethasone x 1 more dose prior to discharge - Started on Flovent twice a day - PEP/IS</p> <p>FEN/GI: - Regular diet ad lib - Well hydrated with good oral intake, no need for IVF at this time - Monitor I/Os - A1c normal. Ph near normal. likely steroid and stress induced hyperglycemia, will obtain every 3 while awake.</p> <p>ID: Likely viral URI - Fluvid negative</p> <p>Caregivers updated at bedside, in agreement with current plan of care. Patient will remain hospitalized until breathing comfortably in room air and Albuterol spaced to at least every 4hrs. Mom interested in establishing new PCP with CMH.</p> <p>Discharge planning: Patient requires ongoing admission due to need for frequent bronchodilator treatment Patient is anticipated to be medically ready for discharge in: Next 24 hours. Discharge planning/follow up needs: New PCP.</p>	
12/19/YYYY	Hospital/ Provider Name	<p>X-ray of chest:</p> <p>Indication: Cough</p> <p>Findings: Peribronchial cuffing. The upper abdomen demonstrate mild gaseous distention of loops of bowel in the left upper quadrant.</p> <p>Impression: Findings can be seen with reactive airway disease versus viral process.</p>	2849- 2850
12/20/YYYY	Hospital/ Provider Name	<p>Discharge summary:</p> <p>Admit date: 12/19/YYYY</p> <p>Discharge date: 12/20/YYYY</p>	2185- 2187

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		<p>Discharge diagnosis: Decreased oral intake Stomatitis Difficulty breathing Cough Stuffy and runny nose</p> <p>Discharge disposition/condition: Home in stable condition</p> <p>Indication for admission: Asthma exacerbation</p> <p>Hospital course: Quincy is a 23-month-old male with history of HIE, developmental delay, intermittent asthma who was admitted with asthma exacerbation secondary to viral URI. Patient required 3 hours continuous Albuterol, Dex and fluid bolus in the emergency department. Patient was admitted to the floor and initially requiring supplemental oxygen but was able to quickly be weaned off and Albuterol was spaced to every 4hrs. Patient was also started on Flovent twice a day. Discussed with parents who report that patient has daily night time cough even when well, patient discharged with Flovent twice a day as daily controller medication in his green zone. Asthma action plan and asthma education completed.</p> <p><i>Reviewed results of X-ray of chest dated on 12/19/YYYY</i></p> <p>Discharge medications: Albuterol HFA 90 mcg/inhalation Aerosol 2 puff one for home and one for school inhaled every 4 hours as needed for wheezing Fluticasone 110 mcg/inhalation Aerosol 220 mcg (2 puff) inhaled 2 times a day</p> <p>Feeding regimen: Discharge home diet: Regular age appropriate</p> <p>Follow up appointments: Follow up with: Rhonda Kellstadt – 12/22/YYYY</p> <p>Additional Instructions: Quincy is scheduled for his PCP hospital follow up on Friday 12/22/YYYY 2:20pm with Rhonda Kellstadt APRN at Community Health Center #. Parent: If there is a conflict with this appointment date and time please call Community Health Center to reschedule.</p>	
<p>*Other related records:</p> <p><i>Labs, rhythm strips, discharge instructions, medication administration, patient information, care plan</i></p> <p>PDF Ref: 1, 104-109, 111, 667-683, 793-798, 809-847, 858-866, 944, 947-950, 2230-2232</p> <p>*Reviewer's comment: All the significant details are included in the chronology. These records have been reviewed and do not contain any significant information. Hence not elaborated.</p>			

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<p><i>*Other related records:</i></p> <p><i>Request, discharge plan, anesthesia records, message notes, labs and cultures, orders, care plan, nursing notes, flow sheets, assessment, medications</i></p> <p><i>PDF ref: 1147, 1148, 1130-1142, 2193-2194, 2197-2199, 2219, 2336-2337, 2282, 2219-2222, 2896-2898, 2921-2924, 2951-2956, 2137-2143, 2327-2330, 2338-2848, 2879-2886, 2310-2319, 2063-2100, 2877-2878, 2937-2939, 3007, 3017, 2165-2168, 2861-2872</i></p> <p><i>*Reviewer's comment: All the significant details are included in the chronology. These records have been reviewed and do not contain any significant information. Hence not elaborated.</i></p>			

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