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Respect Patient Privacy

This is NOT a part of the patient's permanent record.
Shred this sheet at end of shift.

Room #: 482 Name: Jane Doe 87F Date: adm 8/25 POD #3

MD	Diagnosis	Allergies
Smith 555-5555	Rt Total Knee	Codeine, PCN, strawberries

BP	P	R	T	O_2%
0800 156/95	95	20	97.5	98%2L
1200 116/72	72	18	97.7	98% 1L
1600 136/83	75	20	98.5	96% RA

I	O
IV: 800	UO: 600
PO: 1200	incont. x2
	BM x1

Report

Slept well
CPM 0-90 4 hrs last night
Hemovac removed 0600
up to BSC
Steady w/walker + 1 assist
Pain meds: 2 perc @ 0100, 0600

2 units PRBCs for Hct 25 yest.

Staples CDI & OTA

Confused at night

Likely discharge to rehab today

Fall yesterday am

Medical History

Dementia, Lt knee in 2006
Fall in hospital
Osteoarthritis
HTN

IV: Lt AC D5NS @ 100/hr

Pain: Rt knee 5/10 2 Percocet = 2/10

Neuro: A&Ox1 denies N/T

Heart: RRR, denies CP/pressure

Lungs: Dim to bases

GI: BM yesterday

GU: BSC + Depends

MS: PT/OT walked pt to door
CPM 0-100 2 hours am 2 hours pm

EENT: Glasses + bilateral hearing aids

Endocrine: WNL

Circ: PPP, 1+ edema RLE

Skin: Rt knee - staples intact. Some bruising. OTA

Psych: Pleasantly confused

Labs & Tests

Hct: 25→31
WBC: 11.2→8.5
CXR r/o pneumonia: NML

Yesterday f/u fall:
Rt knee x-ray: normal
Head CT: degen. changes, nothing acute
Hip/pelvis: nothing acute
C-spine: old fractures

8	9	10	11	12	13	14	15	16	17	18	19	Diet	Activity
Ancef galantamine	Protonix Lopressor		Percocet X-ray					Ancef Percocet				reg	↑x1 assist

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