Patient name:	John Doe
Medical Record Number:	123456789
Date admitted:	July 1, 2050
Date discharged:	July 3, 2050
Attending Physician:	Dr. Will Teachwell
Resident Physician:	Dr. Bea Goodoc
Diagnosis:	Left-sided systolic congestive heart failure
	EF of 35% on echo performed 3 months ago
Other diagnoses:	Type 2 Diabetes
	Stage 2 Hypertension
	Osteoarthritis

History:

Mr. Doe is a 72 year old gentleman with a history of CHF who presented with a 3 day history of gradually worsening lower extremity edema, weight gain, and shortness of breath. Today while trying to mow his lawn he had to stop multiple times to catch his breath and developed some chest tightness leading him to come to the emergency room. He denies any other decrease in exercise tolerance or chest pain leading up to this event. He reports good understanding and adherence to his medications, but does report that when his daughter was visiting town 4 days prior to admission that he and his wife took her out for a special Mexican dinner and he indulged in several baskets of chips and salsa.

Problems:

1. CHF – On admission he had 3+ lower extremity pitting edema, rales from the bases to midlung bilaterally, elevated jugular venous pressure and a CXR consistent with volume overload. He was diuresed and was able to quickly wean off supplemental oxygen and exam revealed resolution of his edema and rales at discharge. Discharge weight is 202 lbs. Given that dietary indiscretion led to the exacerbation, it was not felt necessary to change his home diuretic regimen at this time. He was re-educated on diet and taking daily weights including information about weight gain that should trigger him to call his primary doctor. He will follow up with his doctor at the end of this week for volume reassessment and electrolyte labs.

2. Chest pain – due to chest pain while mowing, he was ruled out for an MI with serial EKGs and enzymes. His EKGs remained unchanged from previous and his enzyme curve remained normal. Chest pain was attributed to his hypoxia from his CHF and no further work-up was pursued at this time. On

follow-up, should readdress and make sure that he remains without change in his exercise tolerance and remains pain free now that he is back to euvolemia.

3. Type 2 Diabetes – His HgbA1C was 7.3 which is good control for him at this time. No changes were made to his diabetic regimen. On health maintenance questioning he revealed it has been 18 months since his last eye appointment and we recommended he make an appointment as soon as he can get in.

4. Hypertension – Though initially elevated at the time of admission, his BP came down nicely with diuresis and was 142/82 once euvolemic. In keeping with JNC-7 guidelines, we increased his lisinopril to 40 mg/day and his metoprolol to 50mg BID for optimal BP control given his diabetes. He resonded well to this without complications and was 126/72 at discharge.

5. Osteoarthritis – His knee pain was well controlled with Tylenol prn.

Medications:

New medications:	None
Medications discontinued:	None
Medications continued with dose changes:	Metorolol 50 mg PO BID
	Lisinopril 40 mg PO qd
Medications continued unchanged:	ASA 81 mg PO qd
	Furosemide 40 mg PO BID
	Spironolactone 50 mg PO qd
	Metformin 1000 mg PO BID
	Glipizide 10 mg PO BID
	Tylenol 325 mg PO q 4 hours as needed for pain

Functional status: He is at baseline, no assistance needed, independent ADLs .

Pending Results:	None
Follow up:	Dr. Primary Care - Friday, July 7 at 11:30
	Dr. Regular Cardiologist – Thursday, July 27 at 2:30
Cc:	Dr. Primary Care – fax 123-456-7890
	Dr. Regular Cardiologist – fax 123-098-7654

Patient name:	Mary Malloy
Medical Record Number:	123456789
Date admitted:	July 1, 2050
Date discharged:	July 3, 2050
Attending Physician:	Dr. Will Teachwell
Resident Physician:	Dr. Bea Goodoc
Diagnosis:	Left intertrochanteric hip fracture
Procedure:	Left hemiarthroplasty
Orthopedist:	Dr. Cal Seeyum
Other diagnoses:	Post-op atrial fibrillation
	Congestive heart failure – EF of 40% on echo May 2049
	Coronary artery disease
	Stage 2 Hypertension
	Osteoarthritis
	Osteoporosis

History:

Mrs. Malloy is a 83 year old woman who presented after slipping on the ice while trying to retrieve her morning newspaper. She landed on her left side and had immediate left leg pain upon trying to rise. Her neighbor noted her fall and called 911 when it was apparent she had been injured. She denied any head trauma or loss of consciousness and no other injuries were found on full body assessment.

Problems:

1. Left intertrochanteric femur fracture – Patient underwent a left hemiarthroplasty on hospital day 1. (Please see full Op note if further details desired.) Her post-p course was complicated by a two day period of atrial fibrillation and volume overload as detailed below, but otherwise she tolerated the procedure well. She started physical therapy POD #1 and has been progressing as expected. She will be discharged to the TLC Rehab Center to complete her course of rehab with the goal of returning to independent living. Her pain is currently well controlled on scheduled Tylenol as below with morphine sulfate 30mg tablet given 30 minutes prior to her morning and afternoon therapy sessions. She will remain on lovenox BID for DVT prohylaxis until she completes her therapy and is once again fully mobile. The surgical site should be evaluated daily for signs of infection, though currently this has not been a

problem. If she continues to heal well, the staples need to be removed on July 12. She is scheduled for follow-up with ortho A clinic as below.

2. Cardiovascular – At baseline she has fair exercise tolerance and has done well on her CHF regimen. POD #1 she developed atrial fibrillation with rapid ventricular response and a medicine consult was called. They adjusted her metoprolol dose and diuresed her with a resolution of her hypervolemia and A-fib in 2 days. Due to her CHF and A-fib she was ruled out for a peri-op MI with serial EKGs and enzymes. TSH was within normal limits. She is currently doing well and is considered to be euvolemic with a weight of 146 lbs.

3. Osteoporosis – Mrs. Malloy has never received a Dexa scan, but was taking vitamin D and calcium supplementation prior to admission, which was increased while here in keeping with new guidelines. She has been referred for ongoing treatment of her osteoporosis and is scheduled to have a Dexa scan on August 1 in the Bone and Mineral Metabolism clinic. We have deferred decisions re: bisphosphanate therapy choices to their expertise.

4. Rehab/Functional Status – At baseline, Mrs. Malloy lived independently and was independent in all ADLs. Her daughter assisted her with grocery shopping and transportation to events out of her immediate neighborhood as she has felt less and less comfortable driving longer distances. Her MMSE was 28/30 on this admission and she participated well in PT and OT – please see attached therapy progress notes for specifics. It is expected she will need 2 more weeks of inpatient therapy to be able to safely return home. At that time, we recommend a home safety evaluation by OT scheduled at a time her daughter can also be present to assist in making her home less of a fall risk.

Medications:

New medications:	Lovenox 30mg SC every 12 hours
	Morphine sulfate 30 mg PO twice daily, to be administered 30 minutes prior to her therapy sessions
	Tylenol 500 mg 2 tabs PO every 8 hours
	Colace 100 mg PO BID
Medications discontinued:	None
Medications continued with dose changes:	Metorolol 100 mg PO BID
	Calcium citrate with vitamin D – 500mg/400IU one tab PO BID
Medications continued unchanged:	ASA 81 mg PO qd
	Lisinopril 20 mg PO qd

Furosemide 40 mg PO BID

Spironolactone 50 mg PO qd

Pending Results: None

Follow up: Dr. Orthopedist – July 12 at 3:30 pm

Dr. Primary Care – July 28 at 10:00 am

Dr. Bone Mineral – August 1 at 9:00 am

Cc: Dr. Primary Care – fax 123-456-7890

Dr. Bone Mineral – fax 123-098-7654