SH SUBURBAN HOSPITAL
8600 Old Georgetown Road
Bethesda MD 20814-1422

FOSHAY,KATHLEEN JOAN
MRN: SH2493734
DOB: 8/13/1955, Sex: F

JOHNS HOPKINS
MEDICINE

THIS IS YOUR AFTER VISIT SUMMARY (AVS)

Thank you for choosing Johns Hopkins Medicine for your health care. This summary contains important information about your hospitalization including your diagnoses, medications, tests ordered, post-hospital discharge follow-up and other instructions. Please read this document carefully and contact us if you have any questions.

Kathleen Joan Foshay

About your hospitalization

You were admitted on: November 19, 2015

You were discharged on: February 1, 2016

You last received care in the: Suburban Hospital Adult Surgical

Unit phone number: 301-896-3194

Why you were hospitalized

Your primary diagnosis was: Tbi (Traumatic Brain Injury), Without Loss Of Consciousness, Sequela

Your diagnoses also included: Sah (Subarachnoid Hemorrhage), Respiratory Failure Following Trauma And Surgery, Neck Pain, Hypokalemia, Hypophosphatemia, Mssa (Methicillin Susceptible Staphylococcus Aureus) Infection, Emphysema/Copd, Bacteremia Due To Staphylococcus Aureus, Schizophre

wrongful

Physicians who care [illegible] during your hospitalization

Provider	Role
Runa Sidhu, MD	Attending Provider
Surendra Kandel, MBBS	Consulting Physician
Elena Isenbergh, MD	Consulting Physician
David Nathan Greenblum, MD	Consulting Physician

You are allergic to the following

Date Reviewed: **11/20/2015**

No active allergies

Immunizations Administered for This Admission

None

Please review this information with your Primary Care Provider.

Medications

1056

How Do I Sign Up?

1. Visit **mychart.hopkinsmedicine.org** and click the yellow **Sign Up Now** button.
   - The AOL browser will not work with MyChart.
2. Enter your **Activation Code**, **Date of Birth**, **Zip Code**, and **Home Phone Number**
   - If you do not sign up before the expiration date, you must request a new code.
   - The phone number must match what we have on record as your home phone number.

   MyChart Activation Code: P799J-DCZHR (couldn't get through)
   Expires: 3/17/2016 4:02 PM
3. On the next screen, create a username and password.
   - Your username cannot be changed, so choose one that is easy to remember.
   - Your password must contain at least one letter and one number. You can change it at any time.
4. Select a Security Question and Answer.
   - This will be used if you forget your password.
5. Enter the e-mail address where you want to receive MyChart notifications.
6. Click **Sign In** and you're done! You can use MyChart on a computer, tablet or smartphone.
   - Download the MyChart app and pick Johns Hopkins Medicine.

Share Your MyChart Information (Proxy Access)

You can allow family members or others to access your medical information in MyChart using their own username and password. They don't need to be a Johns Hopkins Medicine patient. Please ask your clinical office or hospital unit staff for a Proxy Access authorization form.

Additional Information

Questions? Please view our FAQs at mychart.hopkinsmedicine.org.

Need help activating your account or using MyChart? Call 855-389-6928 for help. Please note that our support team can only assist with problems relating to MyChart.

- They cannot help with computer, Internet, or web browser issues.
- They cannot modify information contained in MyChart. Contact your provider's office to update your medical information.

MyChart should not be used for urgent needs. For medical emergencies, call 911.

3/16/16 letter postmarked 3/17/16, fm Gift of Peace, Emergency - mailed bc I never took out my papers to take a UK + recall to do tks on the 16th.

wrongful

Name FOSHAY, KATHLEEN J.

C. SERIOUS MENTAL ILLNESS (MI) (see definitions)

1. Diagnosis. Does the individual have a major mental disorder? wrongful
If yes, list diagnosis and DSM Code Schizophrenia 295.90 Yes ☒ No ☐

2. Level of Impairment. Has the disorder resulted in serious functional limitations in major life activities within the past 3 – 6 months (e.g., interpersonal functioning, concentration, persistence and pace; or adaptation to change? Yes ☐ No ☒

3. Recent treatment. In the past 2 years, has the individual had psychiatric treatment more intensive than outpatient care more than once (e.g., partial hospitalization) or inpatient hospitalization; or experienced an episode of significant disruption to the normal living situation for which supportive services were required to maintain functioning at home or in a residential treatment environment or which resulted in intervention by housing or law enforcement officials? Yes ☐ No ☒

Is the individual considered to have a SERIOUS MENTAL ILLNESS? If the answer is Yes to all 3 of the above, check "Yes." If the response is No to one or more of the above, check "No." Yes ☐ No ☒

If the individual is considered to have MI or ID or a related condition, complete Part D of this form. Otherwise, skip Part D and sign below.

D. CATEGORICAL ADVANCE GROUP DETERMINATIONS

1. Is the individual being admitted for convalescent care not to exceed 120 days due to an acute physical illness which required hospitalization and does not meet all criteria for an exempt hospital discharge (described in Part A)? Yes ☐ No ☐

2. Does the individual have a terminal illness (life expectancy of less than six months) as certified by a physician? Yes ☐ No ☐

3. Does the individual have a severe physical illness, such as coma, ventilator dependence, functioning at a brain stem level or other diagnoses which result in a level of impairment so severe that the individual could not be expected to benefit from Specialized Services? Yes ☐ No ☐

4. Is this individual being provisionally admitted pending further assessment due to an emergency situation requiring protective services? The stay will not exceed 7 days. Yes ☐ No ☐

5. Is the individual being admitted for a stay not to exceed 14 days to provide respite? Yes ☐ No ☐

If any answer to Part D is Yes, complete the Categorical Advance Group Determination Evaluation Report and attach. Additionally, if questions 1, 2, or 3 are checked "Yes," or if all answers in Part D are "No," the individual must be referred to AERS for a Level II evaluation.

I certify that the above information is correct to the best of my knowledge. If the initial ID screen is positive and a Level II evaluation is required, a copy of the ID screen has been provided to the applicant/resident and legal representative.

Name [signature] Title LCSW, LCSW-C CAP Date 2/7/14

FOR POSITIVE ID SCREENS, NOT COVERED UNDER CATEGORICAL DETERMINATIONS, Check below.

☐ This applicant has been cleared by the Department for nursing facility admission.
☐ This resident has been assessed for a resident review.

Local AERS Office _____ Contact _____ Date _____

Patient Information

Patient Name	Sex	DOB	SSN
Foshay, Kathleen Joan	Female	8/13/1955	073-48-4061

Consults by David Nathan Greenblum, MD at 12/24/2015 11:09 AM

Author: David Nathan Greenblum, MD | Service: Psychiatry | Author Type: Physician
Filed: 12/24/2015 11:12 AM | Note Time: 12/24/2015 11:09 AM | Status: Signed
Editor: David Nathan Greenblum, MD (Physician)

Consult Orders:
1. Consult to Psychiatry [253489503] ordered by Kimberly Beth Zuzak, MD at 12/23/15 1615

CONSULT FOLLOWUP

Sneaky monster

Patient ID: Kathleen Joan Foshay is a 60 y.o. female.
2445/1
12/24/2015

Interm History:
Pt. continues to have the same symptomatology for which psychiatric consultation was sought.
Pt refuses admission to 7300
Pt is refusing to wear her nasal oxygen
Pt writes bizarre papers
Pt was homeless for years

**

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• acetaminophen (TYLENOL) 650 mg/20.3 mL oral solution 650 mg	650 mg	Oral	Q4H PRN	Theo Heller, MD		650 mg at 12/13/15 2124
• albuterol (PROVENTIL) 0.5 % nebulizer solution 2.5 mg	2.5 mg	Nebulization	Q6H PRN	Theo Heller, MD		2.5 mg at 12/14/15 0808
• albuterol (PROVENTIL) 0.5 % nebulizer solution 2.5 mg	2.5 mg	Nebulization	BID	Gita C Bakhshi, MD		2.5 mg at 12/24/15 0904
• budesonide (PULMICORT RESPULES) 0.5 mg/2 mL nebulizer solution 0.5 mg	0.5 mg	Nebulization	2 times daily	Theo Heller, MD		0.5 mg at 12/24/15 0904
•		Subcutaneous	Q8H SCH			

heparin (porcine) 5,000 unit/mL injection 5,000 Units	5,000 Units				Shanthi Murgesh Nadar, MD	5,000 Units at 12/24/15 0546
• QUEtiapine (SEROquel) tablet 100 mg	100 mg	Oral	Nightly		David Nathan Greenblum, MD	
• Saccharomyces boulardii (FLORASTOR) capsule 250 mg	250 mg	Oral	BID		Shanthi Murgesh Nadar, MD	250 mg at 12/24/15 0900
• tiotropium (SPIRIVA) inhalation capsule 18 mcg	18 mcg	Inhalation	Daily		Gita C Bakhshi, MD	18 mcg at 12/24/15 0905

Objective:
Temp: [98.4 °F (36.9 °C)-98.6 °F (37 °C)] 98.4 °F (36.9 °C)
Heart Rate: [84-99] 84
Resp: [18-20] 18
BP: (108-123)/(56-70) 113/67 mmHg
SpO2: [80 %-84 %] 80 %

On examination:
Normal gait & station
No tremors
No involuntary movements

Mental Status Exam:

Appearance: appropriate
Behavior:uncooperative
Speech: normal
Mood: depressed
Affect: constricted
Thought Process: disorganized
Hallucinations none
Delusions: persecutory
Suicidal/Homicidal Ideation: denied
Judgment/Insight: impaired minimal
Consciousness alert
Orientation: person, place, time
Memory: WNL
Intellectual Functioning: average

Admission on 11/19/2015
No results displayed because visit has over 200 results.

Patient Information

Patient Name	Sex	DOB	SSN
Foshay, Kathleen Joan	Female	8/13/1955	073-48-4061

Progress Notes by Kimberly Beth Zuzak, MD at 12/28/2015 2:08 PM

Author: Kimberly Beth Zuzak, MD | Service: General Medicine | Author Type: Physician
Filed: 12/28/2015 2:12 PM | Note Time: 12/28/2015 2:08 PM | Status: Signed
Editor: Kimberly Beth Zuzak, MD (Physician)

HOSPITALIST PROGRESS NOTE

Date/Time: 12/28/2015 2:09 PM
Patient Name: Kathleen Joan Foshay
DoB: 8/13/1955
MRN: SH2493734
CSN: 1114155968

Subjective :

Continues to work diligently on her papers. Documenting things that she remembers and is trying to make sure the word gets out.

Patient is comfortable. No complaints.

Denies fever, chills, N/V, diarrhea, CP, SOB, dizziness, HA, presyncope or syncope.

All other systems reviewed and are negative. Although, patient is delusional.

Objective:

Filed Vitals:

	12/28/15 1349
BP:	107/61
Pulse:	88
Temp:	98.2 °F (36.8 °C)
Resp:	18
SpO2:	99%

PE:

General Appearance:	Alert, cooperative, no distress, appears stated age
Head:	Normocephalic, without obvious abnormality, atraumatic
Eyes:	PERRL, conjunctiva/corneas clear, EOMI
Ears:	Normal external ear canals, both ears
Back:	Symmetric, no curvature, ROM normal, no CVA tenderness
Lungs:	Clear to auscultation bilaterally, respirations unlabored
Chest Wall:	No tenderness or deformity
Heart:	Regular rate and rhythm, S1 and S2 normal, no murmur, rub or gallop
Abdomen:	Soft, non-tender, bowel sounds active all four quadrants, no masses, no organomegaly

Extremities: Extremities normal, atraumatic, no cyanosis or edema
Skin: Skin color, texture, turgor normal, no rashes or lesions
Neurologic: CNII-XII intact, normal strength, sensation and reflexes throughout

Activity level: Activity: Walks occasionally
Mobility: No limitation

Medications, Laboratory Results, and Imaging Results were reviewed in the EMR as of 12/28/2015 2:09 PM.

Recent Labs

Lab	12/27/15 0615
WBC	4.64
RBC	4.10
HGB	12.6
HCT	39.6
MCV	96.6
MCHC	31.8
MCH	30.7
RDW	19.7*
PLT	224
NRBC	0.00

Recent Labs

Lab	12/27/15 0615
NA	137
K	4.7
CL	97*
CO2	26
BUN	22
CREATININE	0.4*
GLU	79
CALCIUM	9.6

• albuterol	2.5 mg	Nebulization	BID
• budesonide	0.5 mg	Nebulization	2 times daily
• heparin (porcine)	5,000 Units	Subcutaneous	Q8H SCH
• QUEtiapine	100 mg	Oral	Nightly
• Saccharomyces boulardii	250 mg	Oral	BID
• tiotropium	18 mcg	Inhalation	Daily

Assessment:
Kathleen Joan Foshay is a 60 y.o. female, HD #39 with the following problems:

Principal Problem:
TBI (traumatic brain injury), without loss of consciousness, sequela

(page 33 is identical)

Patient Information

Patient Name	Sex	DOB	SSN
Foshay, Kathleen Joan	Female	8/13/1955	073-48-4061

Progress Notes by Vikas Kapoor, MD at 12/27/2015 4:39 PM

Author: Vikas Kapoor, MD | Service: Infectious Disease | Author Type: Physician
Filed: 12/28/2015 1:50 AM | Note Time: 12/27/2015 4:39 PM | Status: Signed
Editor: Vikas Kapoor, MD (Physician)

INFECTIOUS DISEASES PROGRESS NOTE

Date/Time: 12/27/2015 4:39 PM
Patient Name: Kathleen Joan Foshay
DOB: 8/13/1955
MRN: SH2493734
Length of Stay: Day #38

Subjective :
Pt seen and examined. Sitting up and writing. No complaints offered.
Objective:
Vitals:
Temp: [98.2 °F (36.8 °C)-99.1 °F (37.3 °C)] 98.7 °F (37.1 °C)
Heart Rate: [76-99] 95
Resp: [18] 18
BP: (100-109)/(58-63) 100/58 mmHg
SpO2: [80 %-97 %] 94 %

Physical Exam:
GENERAL: NAD, conversant
HEENT: No icterus, oral mucosa moist, no oral thrush
CARDIOVASCULAR: RRR +S1/S2, no murmur heard
LUNGS: clear to auscultation b/l but overall diminished
ABDOMEN: positive bowel sounds, soft, non tender, non distended
NEURO: Alert, responsive
EXTREMITIES: no edema LE
SKIN: no lesions or rashes seen

IV access site: none

Current Medications:

• albuterol	2.5 mg	Nebulization	BID
• budesonide	0.5 mg	Nebulization	2 times daily
• heparin (porcine)	5,000 Units	Subcutaneous	Q8H SCH
• QUEtiapine	100 mg	Oral	Nightly
• Saccharomyces boulardii	250 mg	Oral	BID
• tiotropium	18 mcg	Inhalation	Daily

acetaminophen, albuterol

Lab Data:
Recent Labs

Lab	12/27/15 0615
WBC	4.64
RBC	4.10
HGB	12.6
HCT	39.6
MCV	96.6
MCHC	31.8
MCH	30.7
RDW	19.7*
PLT	224
MPV	10.0
NRBC	0.00

Recent Labs

Lab	12/27/15 0615
NA	137
K	4.7
CL	97*
CO2	26
GLU	79
BUN	22
CREATININE	0.4*
CALCIUM	9.6
PROT	7.1
ALBUMIN	3.7
BILITOT	0.3
ALKPHOS	105
AST	14
ALT	12

No results for input(s): SEDRATE in the last 168 hours.

No results for input(s): CRP in the last 168 hours.

Micro Data:
BCS 12/8, 12/19 negative
MRSA negative
C Diff negative
BCS 12/2, 11/29 Staph aureus
Sputum CS Enterobacter aerogenes

Radiology Data:
CT chest:
Impression:

No identifiable cause for the patient's sepsis.

Elliptical collection along the right major fissure which is unchanged and presumptively reflects trapped fluid

Persistent underlying emphysema

No results found.

Imaging (Last 72 hours)
None

?!

Assessment:
Principal Problem:
TBI (traumatic brain injury), without loss of consciousness, sequela
Active Problems:
SAH (subarachnoid hemorrhage)
Respiratory failure following trauma and surgery
TBI (traumatic brain injury)
Hypokalemia
Hypophosphatemia
MSSA (methicillin susceptible Staphylococcus aureus) infection
Emphysema/COPD
Bacteremia due to Staphylococcus aureus

Recommendations:
1.Pt with delusions and paranoia
2.Clinically stable and remains afebrile
3.Will monitor off antibiotics
4.Follow CT chest in about 3 more weeks (total 4 weeks from prior scan)

D/W RN. D/W patient. Will D/W Dr Zuzak

Vikas Kapoor, MD
Date/Time: 12/27/2015 4:39 PM

[ ] Patient goals evaluated and plan of care reviewed at multi-disciplinary rounds today.

Note: I have reviewed and updated, if indicated, any information recalled into this document from a prior document.

Patient's care discussed with:
[X] Patient/Family [X] Nursing [ ] ED Attending
[ ] Consultant [ ] PCP [X] Attending
[ ] Other

Patient Information

Patient Name	Sex	DOB	SSN
Foshay, Kathleen Joan	Female	8/13/1955	073-48-4061

Progress Notes by Kimberly Beth Zuzak, MD at 12/27/2015 9:07 AM

Author: Kimberly Beth Zuzak, MD | Service: General Medicine | Author Type: Physician
Filed: 12/27/2015 9:16 PM | Note Time: 12/27/2015 9:07 AM | Status: Signed
Editor: Kimberly Beth Zuzak, MD (Physician)

HOSPITALIST PROGRESS NOTE

Date/Time: 12/27/2015 9:07 AM
Patient Name: Kathleen Joan Foshay
DoB: 8/13/1955
MRN: SH2493734
CSN: 1114155968

Subjective :

States that she is working on documenting everything that is going on in the world. States that she doesn't know that much about NIH, but will write what she knows.

Patient is comfortable. No complaints.

Denies fever, chills, N/V, diarrhea, CP, SOB, dizziness, HA, presyncope or syncope.

All other systems reviewed and are negative. Although, patient is delusional.

Objective:

Filed Vitals:

	12/27/15 0602
BP:	109/62
Pulse:	79
Temp:	98.2 °F (36.8 °C)
Resp:	18
SpO2:	97%

PE:

General Appearance:	Alert, cooperative, no distress, appears stated age
Head:	Normocephalic, without obvious abnormality, atraumatic
Eyes:	PERRL, conjunctiva/corneas clear, EOMI
Ears:	Normal external ear canals, both ears
Back:	Symmetric, no curvature, ROM normal, no CVA tenderness
Lungs:	Clear to auscultation bilaterally, respirations unlabored
Chest Wall:	No tenderness or deformity
Heart:	Regular rate and rhythm, S1 and S2 normal, no murmur, rub or gallop
Abdomen:	Soft, non-tender, bowel sounds active all four quadrants, no masses, no organomegaly

Active Problems:
SAH (subarachnoid hemorrhage)
Respiratory failure following trauma and surgery
TBI (traumatic brain injury)
Hypokalemia
Hypophosphatemia
MSSA (methicillin susceptible Staphylococcus aureus) infection
Emphysema/COPD
Bacteremia due to Staphylococcus aureus

Plan :

Traumatic brain injury, s/p pedestrian struck w/ SDH/SAH; ??Possibly she jumped in front of the vehicle, possible suicide attempt (refer to earlier notes 12/2 and 12/3)
- Completed 14 days of seizure ppx per NSU
- D/W Dr. Greenblum seroquel uptitrated
- Monitor behavior
- Needs likely to return to a group home setting, however her previous home will not take her back; SW working on medical shelter that will accept oxygen

MSSA Bacteremia
- Repeat BCLx negative
- CT chest in 3 weeks
- Dr. Kapoor, ID following

Chronic schizophrenia w/ intermittent paranoid delusions all untrue
- Uptitrate seroquel, now 100mg po nightly
- Reconsulted psych
- Behavior has not improved, continues to write copious papers on conspiracy, French Connection, Armageddon, NIH and the "detractors"
- Continue to monitor, but will likely need involuntary placement ← horri-fying

also all untrue **Chronic Emphysema**
- O2 recommended due to hypoxia, she states that she is now amenable to keeping the oxygen on
- Continue to redirect as needed

Prophylaxis: Heparin

Reason for continued hospitalization: Placement, psych re-eval completed, SW seeking medical shelter, d/w Grace today

Kimberly B. Zuzak, MD, MHS, FACP
Service: Internal Medicine
Date/Time: 12/27/2015 9:07 AM

[ ] Patient goals evaluated and plan of care reviewed at multi-disciplinary rounds today.

Note: I have reviewed and updated, if indicated, any information recalled into this document from a prior document.

Patient Information

Patient Name	Sex	DOB	SSN
Foshay, Kathleen Joan	Female	8/13/1955	073-48-4061

H&P by Adam J Schechner, MD at 11/19/2015 6:31 PM

Author: Adam J Schechner, MD | Service: Trauma | Author Type: Physician
Filed: 11/20/2015 11:20 AM | Note Time: 11/19/2015 6:31 PM | Status: Signed
Editor: Adam J Schechner, MD (Physician)

ADULT TRAUMA H&P

Trauma,Oscar
MRN: SH2493734
DOB: 1/1/1871
Acct #: 1114155968
Adm: 11/19/2015

Admitting Provider: Adam J Schechner
Primary Care Physician: No primary care provider on file.

Allergies:
Review of patient's allergies indicates no known allergies.

Arrived by: EMS

Chief Complaint:
Oscar Thirty Four Trauma is an 60y.o. female presenting with a complaint of: Other pedestrian struck

HPI:
60yo female was a pedestrian struck by a car at relatively low velocity while crossing the street. +LOC. She was initially responsive and oriented when EMS arrived on the scene, but en route she became unresponsive. The patient arrived as level 1 trauma about 10 minutes later on a backboard with cervical collar in place. She was awake and alert on arrive, and she complained mainly of mild sharp facial pain which was made worse with palpation.

Onset: today
Locale: Street
Activity during Injury: Walking
Mechanism of Injury: pedestrian struck
Description of Injury (Quality): Blunt trauma

Location of Pain/Injuries: face

Severity of Pain/Injury:
Flowsheet Rows

	Most Recent Value

Pain Score **Zero** File time: 11/19/2015 1823

Associated Symptoms: Loss of consciousness and Transient confusion
Possible Contributing Factors: unknown

Review of Systems:
Review of Systems
All other systems reviewed and are negative.
Objective:

Medical History:
Past medical history: schizophre 1989 lie-set
Past surgical history: none
Home medications: none
Allergies: NKDA

Family History:
Noncontributory

Social History:
Tobacco use: denies smoking cigarettes
Alcohol use: denies
Illicit drug use: denies

Physical Exam:
Physical Exam
Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished. No distress.
HENT:
Head: Normocephalic.
Right Ear: External ear normal.
Left Ear: External ear normal.
Blood in nares, no active bleeding
Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light.
Neck: Normal range of motion. Neck supple. No JVD present. No tracheal deviation present. No thyromegaly present.
Cardiovascular: Normal rate, regular rhythm and normal heart sounds.
No murmur heard.
Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress. He has no wheezes. He has no rales. He exhibits no tenderness.
Abdominal: Soft. Bowel sounds are normal. He exhibits no distension and no mass. There is no tenderness. There is no rebound and no guarding.
Musculoskeletal: Normal range of motion. He exhibits no edema or tenderness.
Neurological: He is alert and oriented to person, place, and time. No cranial nerve deficit.
Skin: Skin is warm and dry. No erythema.
Psychiatric: He has a normal mood and affect.

IMPRESSION: Multifocal intracranial hemorrhage including a left subdural hemorrhage, small right subdural hemorrhage adjacent to the anterior falx, subarachnoid hemorrhage and small bifrontal parenchymal hemorrhages. Scalp swelling along the vertex. PROCEDURE: Face CT. TECHNIQUE: Axial noncontrast CT imaging which forms the basis for coronal and sagittal reformats. FINDINGS: There is some motion on the study. There is suspicion of a nondisplaced right nasal bone fracture. This appearance could be produced by patient motion. There does appear to be nasal soft tissue swelling greater on the right side. There also appears to be soft tissue air within the anterior soft tissues of the nose centrally. The remainder of the study demonstrates no definite fracture .The globes and intra-and extraconal contents are symmetric. The paranasal sinuses are essentially clear. There is a concha bullosa within each middle turbinate. **IMPRESSION: Study limited by patient motion. Possible nondisplaced fracture of the right nasal bone. Evidence of nasal soft tissue swelling with associated soft tissue air suggesting a component of laceration.** PROCEDURE: Cervical spine CT. TECHNIQUE: Helical CT scanning which forms the basis for coronal and sagittal reformatted images. FINDINGS: The study is limited due to patient motion. Vertebral body heights appear maintained. No acute fracture is detected. There is incomplete bony union along the anterior and posterior arch of C1 which appears developmental. There appears to be slight retrolisthesis of C4 over C5 there are severe disc space loss at this level with prominent degenerative endplate changes. The prevertebral soft tissues are within normal limits. IMPRESSION: Limited study due to patient motion. No acute fracture detected. Slight retrolisthesis at C4-5. Clinical clearance of the cervical spine is recommended. PROCEDURE: Chest, abdomen and pelvis CT with contrast. TECHNIQUE: Helical scanning was performed during uneventful infusion of 140 cc Omnipaque 300. FINDINGS: There are emphysematous changes within the lungs most marked in the upper lobes. There is reticular coarsening concentrated within the mid to lower lungs. There is a broad opacity along the minor fissure which measures 13 Hounsfield units in density. There is a prominent reticular coarsening adjacent to this density extending to the lung periphery extending more anteriorly within the lung at this level. There are are no dependent pleural fluid collections. No pneumothorax. No pericardial effusion. No mediastinal hematoma. There are multiple rounded low-density lesions within the liver. There is a 2.4 cm lesion in the left lobe measuring 10 Hounsfield units in density compatible with a cyst. There is a 1.9 severe lesion at the lateral aspect of the right lobe measuring 2 Hounsfield units in density compatible with a cyst. There are multiple smaller hepatic lesions having low density, likely additional cysts. Normal appearance of the spleen, pancreas, gallbladder, adrenal glands and right kidney. There is a left renal cortical cyst. There is mural thickening and hyperenhancement involving the duodenum, jejunum and proximal to mid ileal loops. No abnormal bowel distention. No free fluid or free air. No acute displaced fractures are seen. **IMPRESSION: 1. Mural thickening and hyperenhancement involving small bowel concerning for shock bowel. 2. Emphysema with pulmonary fibrosis. 3. Broad low-density opacity along the minor fissure. The differential would include a low-density mass and fluid along the fissure. No fluid is seen more dependently within the chest. 4. Multiple hepatic cysts.** PROCEDURE: Recon thoracic spine CT. TECHNIQUE: The axial source data was reconstructed which forms the basis for coronal and sagittal reformats. FINDINGS: Vertebral body heights and alignment are maintained without acute fracture seen. **IMPRESSION: No acute osseous abnormality is seen.** PROCEDURE: Recon lumbar spine CT. TECHNIQUE: The axial source data was reconstructed which forms the basis for coronal and sagittal reformats. FINDINGS: Vertebral body heights and alignment are maintained without acute fracture seen. **IMPRESSION: No acute osseous abnormality is seen.** PROCEDURE: CT angiogram of the head with IV contrast. HISTORY: Trauma. Intracranial hemorrhage. TECHNIQUE: Axial imaging was initially performed through the head without contrast. Postcontrast imaging performed after the administration of 140 cc of Omnipaque 300 intravenously which was given for today's CT of the chest abdomen and pelvis. Three-dimensional MIP reconstructions were performed. FINDINGS: The internal carotid arteries are patent bilaterally as they course through the skull base to the circle of Willis. There is flow seen within the anterior, middle and posterior cerebral arteries bilaterally as well as the basilar artery. There is flow in both vertebral arteries. No vascular malformation or aneurysm is identified. No significant occlusive changes are

seen. Again seen is scalp swelling over the vertex. **IMPRESSION: No occlusive changes seen. No evidence of aneurysm or vascular malformation.** Signed by Bryan A Defranco M.D on 11/19/2015 7:51 PM

Treatment/Management/Course:

Vitals:

First set:
BP: 186/88 mmHg
Heart Rate: 96
Resp: 18
SpO2: 97 %
Temp: 98 °F (36.7 °C)
Temp src: Oral
Weight: 49.896 kg (110 lb)
Weight Method: Estimated

Most recent:
Filed Vitals:

	11/19/15 1824	11/19/15 1825	11/19/15 1825
BP:		178/94	183/98
Pulse:	97	90	95
Temp:	98 °F (36.7 °C)		
TempSrc:			
Resp:		19	
SpO2:		94%	

IV Lines:
Lines and Catheters

No matching active lines, drains, or airways

Medications:

• levETIRAcetam (KEPPRA) IVPB	1,000 mg	Intravenous	Once

Procedures:
PROCEDURE NOTE

A FAST exam and limited real-time 2-D transthoracic echocardiogram were performed under my direction and supervision to rule out intra-abdominal and intra-thoracic injury in this blunt trauma patient with chest and abdominal wall contusions.

Starting in the chest, there was no free fluid seen in the pericardium and no evidence of pneumothorax or hemothorax bilaterally.