Cayuga MEDICAL CENTER
A Member of Cayuga Health System

101 Dates Drive
Ithaca, New York 14850
(607) 274-4011

Highlighted text denotes items of interest;
Underlined text indicates errors.

ED Provider Documentation

Patient: BLAYK,BONZE ANNE ROSE
DOB/Age: 05/01/1956 62
Service Date: 09/19/18

Account Number: A00088518428
Medical Record#: M000597460
Location: 4 SOUTH - MEDICAL/TELEMETRY

Progress

- Progress Note
Progress Note:
This patient was signed out from Dr. Hinkley to Dr. Connor 0700 9/19/18 with CT reports pending. Pt is a transgender, now female, brought in on 941 status, who has been"sedated"with ketamine and lorazepam and geodon due to agitated delirium, in order to accomplish blood draws and CT scans for evaluation of trauma after alleged altercation with police. Arms reach 1:1 observation is in place. Pt has soft restraints in place per protocol. Pt is sleeping with mouth open, snoring respirations, lying supine on stretcher upon initial evaluation at 0700. Nose has dried blood is not bleeding. Cor S1 S2, lungs clear, abd soft, nondistended. Plan is for pt to be admitted to hospitalist service due to leukocytosis 28 K and elevated CK nearly 900. Dr. Hinkley presented pt's case to Dr. Caballes at change of shift 0700 9/19/18. Dr. Connor discussed pt with Dr. Politi, who called with re-read CXR at 0756 and states that the patient has a left nondisplaced 9th rib fracture. Re-eval at 0800: The patient cried out in the room. Exam is unchanged, resps unlabored. Lungs good BS bilat, Cor S1S2. No nasal bleeding. Dr. Caballes is in the room at 0800. Restraint protocol in place. Discussed with Dr. Ruparelia at 0940am (he was in OR prior to this) about the patient's case. Dr. Ruparelia reviewed pt's CT scans. He is aware of pt's pending admission to ICU and is available to consult if needed, otherwise suggests usual outpatient follow up of nasal fracture.

cf. "Briefly sedated with 4mg/kg Ketamine to induce agitated delirium" - Truth.

Re-Evaluation

- Re-Evaluation
** First Eval
Re-Evaluation Time: 07:00 - 9/19/18, Dr. Connor upon change of shift after sedation. See progress note.

** Second Eval
Re-Evaluation Time: 08:00 - 9/19/18, Dr. Connor
Change: Worse
Comment: Pt cried out in pain. Pt reassessed. See progress note. Dr. Caballes at bedside. Discussed pt care with Dr. Caballes and Dr. Politi. Dr. Ruparelia consulted, in the OR, will return call.

Course/Dx

- Course

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"Vitamin K" for KETAMINE is a DRUG OF ABUSE just like PCP:
"Brief sedation" with 24 hours of ferocious "in another world" hallucinations!

Course Of Treatment: Patient presents in florid psychosis having had an altercation with police. She is a transgender and known schizophrenic. Unknown if she is taking "her medication" or has used any substances. She has used synthetic marijuana in the past. There is bleeding from the nose and possible jaw deformity. The history is unreliable including a report of malocclusion. The patient is alert and "agitated" requiring sedation here for our own safety. Ketamine intramuscular was given at 4 mg/kg. This produced brief sedation and allowed us to get blood drawn. The patient awoke and HALLUCINATING was screaming and agitated and required repeat medication with Geodon, Ativan. This produced adequate sedation such that CT scans could be performed. No gross fracture was seen of the mandible which was a concern. Head and C-spine appeared negative. Tetanus was updated. IV fluids were hung for elevated CPK. WBC is also elevated likely due to altercation. These things also "could be" elevated in agitated delirium from synthetic marijuana or other synthetic drug abuse NOT VOLUNTARILY including methamphetamine. EKG is normal. Discussed the case with hospitalist, psychiatric crisis evaluator. Crisis does not feel that this patient could be easily medically cleared and thus hospitalist was asked to admit the patient. They likely will have to admit the patient to ICU given the need for close monitoring and likely treatment of agitation. Official reports of CT scans are pending.
CONNOR: 9/19/18 0730: Official CT reports show nasal fracture, no mandible fracture. Pt sedated, responds to tactile and verbal stimuli, soft restraint protocol in place, with 1:1 watch in place. Pt admitted to hospitalist. Care was discussed with Dr. Caballes, Dr. Politi and Dr. Ruparelia.

- Diagnoses
Provider Diagnoses:
Acute psychosis, Schizophrenia, Facial contusion, Nasal fracture, Rhabdomyolysis, Left rib fracture
KETAMINE /NORKETAMINE INTOXICATION AND AGITATION DUE TO "SEDATION"
"Zombified"

- Provider Notifications
Time Discussed With Above Provider: 06:16
Instructed by Provider To: Other - Does not want to admit pt if there is nobody available to fix his jaw. At 6:30 spoke to Dr. Monacelli, who said he does not fix jaw fractures. At 6:51 spoke with Dr. Caballes accepts pt for admission.

- Critical Care Time
Critical Care Time: 30-74 min - CCT is separately billable from other procedures.

<u>Discharge</u>

- Sign-Out/Discharge
Documenting (check all that apply): Patient Departure - admit

- Discharge Plan
Condition: Guarded
Disposition: ADMITTED TO CAYUGA MEDICAL

- Billing Disposition and Condition
Condition: GUARDED
Disposition: Admitted to Cayuga Medica

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- Attestation Statements
Document Initiated by Scribe: Yes
Documenting Scribe: Lee, Nikita
Provider For Whom Scribe is Documenting (Include Credential): Barbara J Connor, MD
Scribe Attestation:
I, Lee, Nikita, scribed for Barbara J Connor, MD on 09/20/18 at 0142.
Scribe Documentation Reviewed: Yes
Provider Attestation:
The documentation as recorded by the scribe, Lee, Nikita accurately reflects the service I personally performed and the decisions made by me, Barbara J Connor, MD

<Electronically signed by Barbara J Connor MD> 09/19/18 2331

<Electronically signed by Kirk Hinkley MD> 09/20/18 0152

Entered by: Nikita Lee Scribe
Entered Date/Time: 09/19/18 0759

Copy to: No Primary Care Phys,NOPCP

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