02/18/2019 - ED to Hosp-Admission (Discharged) in Nursing Unit - High Point, Main Hospital

Reason for Visit

Chief complaint: Headache
Visit diagnoses:

- **Altered mental status, unspecified altered mental status type (primary)**
- Nonintractable headache, unspecified chronicity pattern, unspecified headache type
- Acute respiratory failure with hypercapnia
- Acute psychosis
- Hand pain, right
- Wrist pain, right
- Hand pain, left

Hospital problem: Acute psychosis

Visit Information

Admission Information

Arrival Date/Time:	02/18/2019 1006	Admit Date/Time:	02/18/2019 1016	IP Adm. Date/Time:	02/18/2019 2035
Admission Type:	Emergency (Medical Intervention For Severe, Life Threatening Or Disabling Condition.	Point of Origin:	Non-healthcare Facility Point Of Origin	Admit Category:	
Means of Arrival:	Ambulance, Guilford	Primary Service:	Icu-hp	Secondary Service:	N/A
Transfer Source:		Service Area:	WAKE FOREST BAPTIST MEDICAL CENTER	Unit:	Nursing Unit - High Point, Main Hospital
Admit Provider:	Leonard Alexander Stallings, MD	Attending Provider:	Charles Bryan Sheldon, MD	Referring Provider:	A Referral Self

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
02/22/2019 1610	Home Or Self Care	None	None	Nursing Unit - High Point Main Hospital

Follow-up Information

Follow-up With	Details	Why	Contact Info
Debra Anita Neblett, ANP	Follow up on 3/4/2019	8:30 am.	319 WESTWOOD AVENUE High Point NC 27262 336-878-6419

Verify Patient Has Pcp

Treatment Team

Provider	Service	Role	Specialty	From	To
Leonard Alexander Stallings, MD	General Medicine A	Admitting Provider	Internal Medicine	—	—
Milton Randall Dalbow, MD	Hospitalist	Attending Provider	HOSPITALIST	02/21/19 1554	02/22/19 1610
Leonard Alexander Stallings, MD	General Medicine A	Attending Provider	Internal Medicine	02/18/19 2222	02/21/19 1554
Barney Reece Jackson, MD	Emergency Medicine	Attending Provider	Family Medicine	02/18/19 1846	02/18/19 2222
Charles Bryan Sheldon, MD	Emergency Medicine	Attending Provider	Emergency Medicine	02/18/19 1146	02/18/19 1846
Divina Chorpening, CNA	—	Certified Nursing Assistant	—	02/22/19 1500	—
Psychiatry Consult	—	Consulting Physician	—	02/22/19 0907	—
Matthias Juchter, RN	—	Registered Nurse	Registered Nurse	02/22/19 0751	—
Mandy J Dehart, RRT	—	Respiratory Care	Respiratory Therapy	02/22/19 0738	—
Jakalia Cheek, CNA	—	Certified Nursing Assistant	—	02/22/19 0700	02/22/19 1611
Alicia K Travis, RN	—	Charge Nurse	Registered Nurse	02/22/19 0058	02/22/19 0959

02/18/2019 - ED to Hosp-Admission (Discharged) in Nursing Unit - High Point, Main Hospital (continued)

Discharge Summary (continued)

Author: Milton Randall Dalbow, MD
Filed: 2/22/2019 3:55 PM
Editor: Milton Randall Dalbow, MD (Physician)
Service: Hospitalist
Date of Service: 2/22/2019 3:49 PM
Author Type: Physician
Status: Signed

HPMC Hospitalist Discharge Summary

Identifying Information:
Brandon Embry
9/7/1986
4748498

Admit date: 2/18/2019

Discharge date: 2/22/2019

Discharge Service: HPMC Hospitalist

Discharge Attending Physician: Milton Randall Dalbow, MD

Discharge to: Home

Discharge Diagnoses:
Principal Problem:
Acute psychosis (HCC)
Resolved Problems:
* No resolved hospital problems. *

Hospital Course:
32 y/o M here with acute encephalopathy and agitation. Shortly after arrival in the ED his MS deteriorated further into a near comatose state necessitating intubation. He reportedly was acting strange at work and was sent for UDS which was negative. He was admitted to the ICU, sedated and remained on vent for several days. He was extubated earlier in his stay with hope that his encephalopathy had resolved. Shortly after extubation he became combative including spitting at staff, flailing his arms around wildly. He was re-intubated for airway protection and remained so until 2/21/19.

Psych saw him on 2/22 and deemed him safe for d/c.

Discharge Day Services:
BP 115/49 | Pulse 68 | Temp 98.3 °F (36.8 °C) (Oral) | Resp 16 | Ht 1.778 m (5' 10") | Wt 119 kg (262 lb 4.8 oz) | SpO2 94% | BMI 37.64 kg/m²
Pt seen on the day of discharge and determined appropriate for discharge.
GEN: NAD, lying in bed
EYES: EOMI
ENT: MMM
CV: RRR, no murmurs appreciated
PULM: CTA B

Discharge Summary (continued)

ABD: soft, NT/ND, +BS
EXT: No edema
NEURO: No focal deficits
PSYCH: A+Ox3, appropriate
GU: No CVA tenderness
MSK: No spinal tenderness

Condition at Discharge: good

Length of Discharge: I spent 40 mins in the discharge of this patient.

Discharge Medications:
Patient Instructions:
There are no discharge medications for this patient.

Most Recent Labs:

Lab Results

Component	Value	Date/Time
WBC	7.9	02/22/2019 0350
RBC	4.31	02/22/2019 0350
HGB	13.9	02/22/2019 0350
HCT	39.1	02/22/2019 0350
PLT	208	02/22/2019 0350

Lab Results

Component	Value	Date
WBC	7.9	02/22/2019
HGB	13.9	02/22/2019
HCT	39.1	02/22/2019
PLT	208	02/22/2019

Lab Results

Component	Value	Date
CO2	25	02/22/2019
BUN	10	02/22/2019
CREATININE	0.73	02/22/2019
CALCIUM	9.0	02/22/2019
ALBUMIN	5.3 (H)	02/18/2019
AST	36	02/18/2019
ALT	50	02/18/2019

Lab Results

02/18/2019 - ED to Hosp-Admission (Discharged) in Nursing Unit - High Point, Main Hospital (continued)

Discharge Summary (continued)

Component	Value	Date
NA	140	02/22/2019
K	3.3 (L)	02/22/2019
CL	105	02/22/2019
CO2	25	02/22/2019
BUN	10	02/22/2019
CREATININE	0.73	02/22/2019
CALCIUM	9.0	02/22/2019
MG	1.8	02/21/2019
PHOS	3.1	02/21/2019

Lab Results

Component	Value	Date
ALKPHOS	40	02/18/2019
BILITOT	1.0	02/18/2019
PROT	8.0	02/18/2019
ALBUMIN	5.3 (H)	02/18/2019
ALT	50	02/18/2019
AST	36	02/18/2019

Lab Results

Component	Value	Date
INR	1.08	02/18/2019

Hospital Radiology:

Ct Head Wo Contrast

Result Date: 2/18/2019
CLINICAL DATA: Altered mental status. The patient is unresponsive today. EXAM: CT HEAD WITHOUT CONTRAST TECHNIQUE: Contiguous axial images were obtained from the base of the skull through the vertex without intravenous contrast. COMPARISON: None. FINDINGS: Brain: No evidence of acute infarction, hemorrhage, hydrocephalus, extra-axial collection or mass lesion/mass effect. Vascular: No hyperdense vessel or unexpected calcification. Skull: Intact. Sinuses/Orbits: Negative. Other: None. IMPRESSION: Normal head CT. Electronically Signed By: Thomas Dalessio M.D. On: 02/18/2019 12:30

Xr Chest Ap Portable

Result Date: 2/19/2019
CLINICAL DATA: Acute respiratory failure EXAM: PORTABLE CHEST 1 VIEW COMPARISON: 02/18/2019 FINDINGS: Endotracheal tube and NG tube are unchanged. Heart is borderline in size. No confluent airspace opacities or effusions. No acute bony abnormality. IMPRESSION: Stable support devices. No acute findings or active disease. Electronically Signed By: Kevin Dover M.D. On: 02/19/2019 07:55

Xr Chest Ap Portable

Result Date: 2/18/2019
CLINICAL DATA: Endotracheal tube placement. EXAM: PORTABLE CHEST 1 VIEW COMPARISON: Earlier film,

same date. FINDINGS: The cardiac silhouette, mediastinal and hilar contours are normal and stable. The NG tube is coursing down the esophagus and into the stomach. The endotracheal tube is in good position with the tip 4.6 cm above the carina. The lungs remain clear. IMPRESSION: Endotracheal tube in good position at the mid tracheal level. Electronically Signed By: P. Gallerani M.D. On: 02/18/2019 19:25

Xr Chest Ap Portable

Result Date: 2/18/2019
CLINICAL DATA: Post intubation. EXAM: PORTABLE CHEST 1 VIEW COMPARISON: None. FINDINGS. Endotracheal tube in place with the tip approximately 3.8 cm above the level of the carina. Enteric tube within the stomach. The heart size and mediastinal contours are within normal limits. Normal pulmonary vascularity. Low lung volumes. No focal consolidation, pleural effusion, or pneumothorax. No acute osseous abnormality. IMPRESSION: 1. Appropriately positioned endotracheal and enteric tubes. 2. No active disease. Electronically Signed By: William T Derry M.D. On: 02/18/2019 14:02

Xr Wrist Right (routine: Ap,lat,obl)

Result Date: 2/21/2019
CLINICAL DATA: Hand and wrist pain. EXAM: RIGHT HAND - COMPLETE 3+ VIEW; RIGHT WRIST - COMPLETE 3+ VIEW COMPARISON: None. FINDINGS: Right hand and wrist: There is no evidence of fracture or dislocation. There is no evidence of arthropathy or other focal bone abnormality. Soft tissues are unremarkable. IMPRESSION: No acute osseous abnormality of the right hand and wrist. Electronically Signed By: William T Derry M.D. On: 02/21/2019 17:10

Xr Hand Left (routine: Ap,lat,obl)

Result Date: 2/21/2019
CLINICAL DATA: Acute left hand pain without known injury. EXAM: LEFT HAND - COMPLETE 3+ VIEW COMPARISON: None. FINDINGS: There is no evidence of fracture or dislocation. There is no evidence of arthropathy or other focal bone abnormality. Soft tissues are unremarkable. IMPRESSION: No significant abnormality seen in the left hand. Electronically Signed By: James Green Jr, M.D. On: 02/21/2019 17:12

Xr Hand Right (routine: Ap,lat,obl)

Result Date: 2/21/2019
CLINICAL DATA: Hand and wrist pain. EXAM: RIGHT HAND - COMPLETE 3+ VIEW; RIGHT WRIST - COMPLETE 3+ VIEW COMPARISON: None. FINDINGS: Right hand and wrist: There is no evidence of fracture or dislocation. There is no evidence of arthropathy or other focal bone abnormality. Soft tissues are unremarkable. IMPRESSION: No acute osseous abnormality of the right hand and wrist. Electronically Signed By: William T Derry M.D. On: 02/21/2019 17:10

Us Abdomen Complete

Result Date: 2/19/2019
CLINICAL DATA: Sepsis EXAM: ABDOMEN ULTRASOUND COMPLETE COMPARISON: CT 10/05/2018 FINDINGS: Gallbladder: No gallstones or wall thickening visualized. No sonographic Murphy sign noted by sonographer. Common bile duct: Diameter: Normal caliber, 3 mm Liver: No focal lesion identified. Within normal limits in parenchymal echogenicity. Portal vein is patent on color Doppler imaging with normal direction of blood flow towards the liver. IVC: No abnormality visualized. Pancreas: Visualized portion unremarkable. Spleen: Size and appearance within normal limits. Right Kidney: Length: 12.8 cm. Echogenicity within normal limits. No mass or hydronephrosis visualized. Left Kidney: Length: 13.8 cm. Echogenicity within normal limits. No mass or

02/18/2019 - ED to Hosp-Admission (Discharged) in Nursing Unit - High Point, Main Hospital (continued)

Discharge Summary (continued)

hydronephrosis visualized. Abdominal aorta: No aneurysm visualized. Other findings: None. IMPRESSION: Unremarkable abdominal ultrasound. Electronically Signed By: Kevin Dover M.D. On: 02/19/2019 08:44

Discharge Instructions:

Discharge Orders and Instructions

Diet At Discharge Complete by: As directed

Recommended diet at discharge: Regular diet

Activity At Discharge Complete by: As directed

Recommended activity at discharge: Activity as tolerated

UPCOMING WAKE FOREST BAPTIST HEALTH APPOINTMENTS

Appointment Date and Time	Provider	Department	Dept Phone	Address
3/4/2019 8:30 AM	Debra Anita Neblett, ANP	Wake Forest Health Network Transitional Care - Westwood	336-878-6419	319 WESTWOOD AVEHIGH POINT NC 27262-4323

Electronically signed by: Milton Randall Dalbow, MD
02/22/19 1555

Electronically signed by Milton Randall Dalbow, MD at 2/22/2019 3:55 PM

ED Provider Note

ED Provider Notes by Charles Bryan Sheldon, MD at 2/18/2019 11:47 AM

Author: Charles Bryan Sheldon, MD
Filed: 2/25/2019 7:08 AM
Service: Emergency Medicine
Date of Service: 2/18/2019 11:47 AM
Author Type: Physician
Status: Addendum
Editor: Charles Bryan Sheldon, MD (Physician)

Procedure Orders
1. Intubation [508258373] ordered by Charles Bryan Sheldon, MD
2. Critical Care [508763211] ordered by Charles Bryan Sheldon, MD

High Point Medical Center Emergency Department
Emergency Department Provider Note

02/18/2019 - ED to Hosp-Admission (Discharged) in Nursing Unit - High Point, Main Hospital (continued)

ED Provider Note (continued)

Provider at bedside: 02/18/2019 11:47 AM

History obtained from the: patient

History

Chief Complaint

Patient presents with
- Headache

HPI
Brandon Embry is a 32 y.o. male who presents to the ED via EMS. All history is provided by EMS and the patient is unresponsive making further history and ROS unattainable. The patient was apparently at work earlier this morning and was told to go have a drug screen performed because he was acting unusual. The patient left to go do this but stopped at a McDonalds on the way. He got food and started eating it in the parking lot and then witnesses saw him vomiting and called EMS. The patient apparently told EMS he wasn't vomiting but rather spitting the food out because it was bad. Police were on the scene as well and they encouraged him to go to the hospital as he seemed altered, but they did not perform a field sobriety test. The patient was apparently combative on the way to the hospital with EMS and refused testing when initially greeted by ED staff. However, the patient has since fallen asleep and is now unresponsive to verbal as well as noxious stimuli.

LMP: No LMP for male patient.

Past Medical History

Past Medical History:

Diagnosis	Date
• Migraines	

Past Surgical History

Past Surgical History:

Procedure	Laterality	Date
• SHOULDER ARTHROSCOPY W/ ROTATOR CUFF REPAIR		

Medications

These were reviewed. See nursing note for details.

Allergies

Patient has no known allergies.

Family History

No family history on file.

Social History

Social History

Substance Use Topics

02/18/2019 - ED to Hosp-Admission (Discharged) in Nursing Unit - High Point, Main Hospital (continued)

ED Provider Note (continued)

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used
- Alcohol use: Yes
  Comment: ONCE A MONTH

Review of Systems

Review of Systems
Unable to perform ROS: Patient unresponsive

Physical Exam

BP (!) 151/117 | Pulse 82 | Temp 98.4 °F (36.9 °C) (Oral) | Resp 20 | Ht 1.829 m (6') | Wt 124.7 kg (275 lb) | SpO2 98% | BMI 37.30 kg/m²

Physical Exam
Constitutional: He appears well-developed and well-nourished.
HENT:
Head: Normocephalic and atraumatic.
Eyes:
Pupils small but not pin-point. Minimally reactive
Neck: Neck supple.
No meningismus
Cardiovascular: Regular rhythm.
Pulmonary/Chest:
Sonorous respirations
Abdominal: Soft. There is no tenderness.
Musculoskeletal: He exhibits no edema.
Neurological:
Cannot assess due to mental status
Skin: Skin is warm and dry. No rash noted.
Psychiatric:
Cannot assess due to mental status
Nursing note and vitals reviewed.

Results

LABS

Recent Results (from the past 72 hour(s))

Urinalysis With Microscopic

Result	Value	Ref Range
Urine Color	Yellow	Yellow
Urine Appearance	Hazy (A)	Clear
Urine Specific Gravity	1.020	1.005 - 1.030
Urine pH	5.0	5.0 - 8.0
Urine Leukocyte Esterase	Negative	Negative
Urine Nitrite	Negative	Negative
Urine Protein	Negative	Negative MG/DL
Urine Glucose	Negative	Negative MG/DL
Urine Ketone	Negative	Negative MG/DL

02/18/2019 - ED to Hosp-Admission (Discharged) in Nursing Unit - High Point, Main Hospital (continued)

ED Provider Note (continued)

Urine Urobilinogen	Negative	Negative EU/DL
Urine Bilirubin	Negative	Negative
Urine Blood/Hb	Small (A)	Negative
Urine WBC	1	0 - 3 /HPF
Urine Calcium Oxalate Crystals	Few (A)	None seen /HPF
UMUC	Rare (A)	None seen /HPF

CBC and Differential

Result	Value	Ref Range
WBC	17.1 (H)	4.0 - 10.5 x 10*3/uL
RBC	5.07	4.22 - 5.81 x 10*6/uL
Hemoglobin	16.2	13.0 - 17.0 G/DL
Hematocrit	46.8	39.0 - 52.0 %
MCV	92.2	78.0 - 100.0 FL
MCH	31.9	26.0 - 34.0 PG
MCHC	34.6	30.0 - 36.0 G/DL
RDW	13.4	11.5 - 15.5 %
Platelets	274	150 - 400 X 10*3/uL
MPV	7.3	7.2 - 11.0 FL
Neutrophil %	87	%
Lymphocyte %	9	%
Monocyte %	4	%
Eosinophil %	0	%
Basophil %	0	%
Neutrophil Absolute	14.8 (H)	1.7 - 7.7 x 10*3/uL
Lymphocyte Absolute	1.5	0.7 - 4.0 x 10*3/uL
Monocyte Absolute	0.7	0.1 - 1.0 x 10*3/uL
Eosinophil Absolute	0.0	0.0 - 0.7 x 10*3/uL
Basophil Absolute	0.0	0.0 - 0.1 x 10*3/uL

Ammonia

Result	Value	Ref Range
Ammonia	81 (H)	16 - 60 UMOL/L

Comprehensive Metabolic Panel

Result	Value	Ref Range
Sodium	137	135 - 146 MMOL/L
Potassium	5.4 (H)	3.5 - 5.3 MMOL/L
Chloride	108	98 - 110 MMOL/L
CO2	21 (L)	23 - 30 MMOL/L
BUN	27 (H)	8 - 24 MG/DL
Glucose	90	70 - 99 MG/DL
Creatinine	1.34	0.50 - 1.35 MG/DL
Calcium	9.6	8.5 - 10.5 MG/DL
Total Protein	8.0	6.0 - 8.3 G/DL
Albumin	5.3 (H)	3.5 - 5.0 G/DL
Total Bilirubin	1.0	0.1 - 1.2 MG/DL
Alkaline Phosphatase	40	25 - 125 IU/L
AST (SGOT)	36	5 - 40 IU/L
ALT (SGPT)	50	5 - 50 IU/L
Anion Gap	8	4 - 14 MMOL/L
Est. GFR Non-African American	70	>=60 ML/MIN/1.73 M*2
Est. GFR African American	80	>=60 ML/MIN/1.73 M*2

PT/PTT

02/18/2019 - ED to Hosp-Admission (Discharged) in Nursing Unit - High Point, Main Hospital (continued)

ED Provider Note (continued)

Result	Value	Ref Range
Prothrombin Time	14.1	11.6 - 15.2 SEC
INR	1.08	0.00 - 1.49
PTT	28.6	24.0 - 37.0 SEC

CBC and Differential

Narrative

The following orders were created for panel order CBC and Differential.

Procedure	Abnormality	Status
CBC and Differential[508256370]	Abnormal	Final result

Please view results for these tests on the individual orders.

Ethanol

Result	Value	Ref Range
Alcohol	<10	<=10 MG/DL

Urine Drug Screen

Result	Value	Ref Range
Amphetamines	Negative	Negative
Barbiturates	Negative	Negative
Benzodiazepines	Negative	Negative
Cocaine	Negative	Negative
Opiates	Negative	Negative
Oxycodone	Negative	Negative
THC	Negative	Negative
Methadone	Negative	Negative
Tricyclic antidepressants	Negative	Negative

Narrative

Drug detection involves initial screening of samples for drugs, and in medical applications the screening tests results are directly used for medical evaluation. The screening procedure essentially eliminates all negatives, and positive results are regarded as presumptive and require confirmation using confirmatory methods such as high performance liquid chromatography and mass spectrometry. Confirmatory methods offer an accurate detection of drugs, but due to cost and labor requirements their application to routine and large-scale analysis is limited.

Screening methods are employed to enable rapid routine analysis of multiple sample. The samples are assigned as positive if the value is above a defined cut-off concentration.

POCT Glucose

Result	Value	Ref Range
GLUCOSE, POC, NOVA	107 (H)	70 - 99 mg/dL

RADIOLOGY

Results for orders placed or performed during the hospital encounter of 02/18/19

CT HEAD WO CONTRAST

Narrative

CLINICAL DATA: Altered mental status. The patient is unresponsive today.

EXAM:

02/18/2019 - ED to Hosp-Admission (Discharged) in Nursing Unit - High Point, Main Hospital (continued)

ED Provider Note (continued)

CT HEAD WITHOUT CONTRAST

TECHNIQUE:
Contiguous axial images were obtained from the base of the skull through the vertex without intravenous contrast.

COMPARISON: None.

FINDINGS:
Brain: No evidence of acute infarction, hemorrhage, hydrocephalus, extra-axial collection or mass lesion/mass effect.

Vascular: No hyperdense vessel or unexpected calcification.

Skull: Intact.

Sinuses/Orbits: Negative.

Other: None.

IMPRESSION:
Normal head CT.

Electronically Signed
By: Thomas Dalessio M.D.
On: 02/18/2019 12:30

EKG
Rate: 83
Rhythm: Normal Sinus Rhythm
Axis: normal
Intervals: Normal
ST-T Waves: Nonspecific T wave abnormality
Comparison with Old: none available

Procedure Note

Intubation
Date/Time: **2/18/2019 12:34 PM**
Performed by: **SHELDON, CHARLES BRYAN**
Authorized by: **SHELDON, CHARLES BRYAN**
Consent: **The procedure was performed in an emergent situation.**
Patient identity confirmed: **arm band**
Time out: **Immediately prior to procedure a "time out" was called to verify the correct patient, procedure, equipment, support staff and site/side marked as required.**
Indications: airway protection

02/18/2019 - ED to Hosp-Admission (Discharged) in Nursing Unit - High Point, Main Hospital (continued)

ED Provider Note (continued)

Intubation method: video-assisted
Patient status: paralyzed (RSI)
Preoxygenation: nonrebreather mask
Sedatives: etomidate
Paralytic: succinylcholine
Laryngoscope size: Mac 3
Tube size: 7.5 mm
Tube type: cuffed
Number of attempts: 1
Cords visualized: yes
Post-procedure assessment: chest rise and CO2 detector
Breath sounds: equal
ETT to lip: 24 cm
Tube secured with: ETT holder
Patient tolerance: Patient tolerated the procedure well with no immediate complications

Critical Care

Performed by: **SHELDON, CHARLES BRYAN**
Authorized by: **DALBOW, MILTON RANDALL**
Total critical care time: 50 minutes
Critical care time was exclusive of separately billable procedures and treating other patients.
Critical care was necessary to treat or prevent imminent or life-threatening deterioration of the following conditions: CNS failure or compromise.
Critical care was time spent personally by me on the following activities: discussions with consultants, evaluation of patient's response to treatment, ordering and review of laboratory studies, obtaining history from patient or surrogate, pulse oximetry, review of old charts, development of treatment plan with patient or surrogate, examination of patient, ordering and performing treatments and interventions, ordering and review of radiographic studies and re-evaluation of patient's condition.

ED Course/ED Assessment/Plan

ED Course as of Feb 18 1352

Mon Feb 18, 2019

1300 Patient initially presented with headache and confusion, progressed to unresponsive by the time of my evaluation. He did not respond to verbal or noxious stimuli. No obvious abnormality on head CT to account for his mental status. He was returned to the ED and given Narcan 2mg without change.Continues to have sonorous respirations and concern for impending airway compromise. He was intubated in the ED as above. Labs still pending at the time, Dr. Stallings with ICU in the ED at bedside to evaluate. After RSI meds had worn off, the patient became more awake, following commands and Dr. Stallings decided to extubate him in the ED. He became

02/18/2019 - ED to Hosp-Admission (Discharged) in Nursing Unit - High Point, Main Hospital (continued)

ED Provider Note (continued)

agitated, trying to sit up in bed and not cooperative. He was given a dose of Versed and Haldol per Dr. Stallings recommendations and he calmed down. He ultimately became unresponsive again, with sonorous respirations and no gag reflex. At this time, Dr. Stallings is planning re-intubation. [CS]

1351 Labs and imaging in the ED unremarkable, still not clear indication for his AMS. He is now re-intubated and will be admitted to the ICU. [CS]

ED Course User Index
[CS] Charles Bryan Sheldon, MD

ED Clinical Impression

1. **Altered mental status, unspecified altered mental status type**
2. Nonintractable headache, unspecified chronicity pattern, unspecified headache type

Scribe's Attestation: Charles Sheldon, MD obtained and performed the history, physical exam and medical decision making elements that were entered into the chart. Documentation assistance was provided by me personally, a scribe.
Signed by *Michael Hoffman*, Scribe on 2/18/2019 11:47 AM

Documentation assistance provided by the scribe. I was present during the time the encounter was recorded. The information recorded by the scribe was done at my direction and has been reviewed and validated by me.
Charles Sheldon, MD
2/18/2019
11:47 AM

Electronically signed by: Charles Bryan Sheldon, MD
02/18/19 1422

Electronically signed by: Charles Bryan Sheldon, MD
02/25/19 0708

Electronically signed by Charles Bryan Sheldon, MD at 2/25/2019 7:08 AM

ED Notes

ED Triage Notes by Terra Coward Myers, RN at 2/18/2019 10:07 AM

Author: Terra Coward Myers, RN | Service: Emergency Medicine | Author Type: Registered Nurse

02/18/2019 - ED to Hosp-Admission (Discharged) in Nursing Unit - High Point, Main Hospital (continued)

ED Notes (continued)

Filed: 2/18/2019 10:10 AM
Editor: Terra Coward Myers, RN (Registered Nurse)
Date of Service: 2/18/2019 10:07 AM
Status: Signed

Patient was at work, complaining of headache and seemed altered per EMS. Patient states job sent patient in POV for drug screen. Patient stopped and McDonalds before going to get drug screen, and became sick/unresponsive in parking lot. EMS states patient was "strongly encouraged" to come to ED by police department. PD refused to let patient leave in vehicle. Patient did not receive field sobriety test.

Electronically signed by Terra Coward Myers, RN at 2/18/2019 10:10 AM

ED Notes by Terra Coward Myers, RN at 2/18/2019 10:18 AM

Author: Terra Coward Myers, RN
Filed: 2/18/2019 10:49 AM
Editor: Terra Coward Myers, RN (Registered Nurse)
Service: Emergency Medicine
Date of Service: 2/18/2019 10:18 AM
Author Type: Registered Nurse
Status: Signed

Patient refused work up, only consented to drug screen.

Electronically signed by Terra Coward Myers, RN at 2/18/2019 10:49 AM

ED Notes by Shanna Younts, RN at 2/18/2019 10:23 AM

Author: Shanna Younts, RN
Filed: 2/18/2019 10:24 AM
Editor: Shanna Younts, RN (Registered Nurse)
Service: Emergency Medicine
Date of Service: 2/18/2019 10:23 AM
Author Type: Registered Nurse
Status: Signed

Knife removed from pts pocket by EMS, labeled and given to security

Electronically signed by Shanna Younts, RN at 2/18/2019 10:24 AM

ED Notes by Catherine A Green, RN at 2/18/2019 12:46 PM

Author: Catherine A Green, RN
Filed: 2/18/2019 12:46 PM
Editor: Catherine A Green, RN (Registered Nurse)
Service: Emergency Medicine
Date of Service: 2/18/2019 12:46 PM
Author Type: Registered Nurse
Status: Signed

MD at bedside- Dr Stallings into examine patient

Electronically signed by Catherine A Green, RN at 2/18/2019 12:46 PM

ED Notes by Catherine A Green, RN at 2/18/2019 12:57 PM

Author: Catherine A Green, RN
Filed: 2/18/2019 12:58 PM
Editor: Catherine A Green, RN (Registered Nurse)
Service: Emergency Medicine
Date of Service: 2/18/2019 12:57 PM
Author Type: Registered Nurse
Status: Signed

Patient awakened during attempting to place OG; extubated by Stallings and became combative; 2L nC applied; attempted to place NPA became combative; ENT suctioned; snoring respirations

Electronically signed by Catherine A Green, RN at 2/18/2019 12:58 PM

ED Notes by Catherine A Green, RN at 2/18/2019 5:05 PM

Author: Catherine A Green, RN
Filed: 2/18/2019 5:36 PM
Editor: Catherine A Green, RN (Registered Nurse)
Service: Emergency Medicine
Date of Service: 2/18/2019 5:05 PM
Author Type: Registered Nurse
Status: Signed