

Caitlin Scholl

From: Klempay, Charles L <cklempay@latrobedistribution.com>
Sent: Tuesday, April 12, 2016 11:29 AM
To: Caitlin Scholl
Subject: FW: observation order for jeremy davis

1 of 3

From: Mosconi, Sharon A [mailto:SAMosconi@mercy.com]
Sent: Tuesday, April 12, 2016 1:21 PM
To: Klempay, Charles L
Subject: observation order for jeremy davis

**PATIENT STATUS (FROM ED OR
OR/PROCEDURAL) Observation (Order 478077819)
Transfer
Order: 478077819**

Date: **4/11/2016**
Department: **SEHC 5WE Ortho-Neuro**
Ordering/Authorizing: **Christopher G
Verdone, DO**

Order Information

Order Date/Time	Release Date/Time	Start Date/Time	End Date/Time
04/11/16 08:57 PM	None	04/11/16 09:00 PM	04/11/16 09:00 PM

Order Details

Frequency	Duration	Priority	Order Class
ONE TIME	1 occurrence	Routine	Hospital Performed

Standing Order Information

Remaining Occurrences	Interval	Last Released
0/1	ONE TIME	4/11/2016

Released Orders

	Released On	Scheduled For	Released By
1.	<u>4/11/2016 8:57 PM</u>	4/11/2016 9:00 PM	Christopher G Verdone, DO (auto- released)

ADT-Related Order Information

Transfer Order

Department: --	Service: Med/Surg
Level of care: --	Diagnosis: --
Condition: --	Expected length of stay: --
Expected discharge date: --	Attending provider: --

Order Questions

Question	Answer	Comment
Patient Class	Observation	
REQUIRED: Diagnosis	Facial fracture (HCC)	
Estimated LOS	Estimated stay of less than 2 midnights	
Future Attending Provider	MOUNT, MICHAEL G	

Process Instructions

The estimated time requirement will be met by the inpatient admission order written in accordance with the 2-midnight benchmark, supplemented by the physician notes and discharge planning instructions. The total estimated length of stay includes emergency department treatment, designated by first provider contact with the patient.

Collection Information

Acknowledgement Info

For	At	Acknowledged By	Acknowledged On
Placing Order	04/11/16 2057	Colleen A Courtney, RN	04/11/16 2057

Cosign Order Info

Action	Created on	Responsible Provider	Signed by	Signed on
Ordering	04/11/16 2057	Michael G Mount, DO	Michael G Mount, DO	04/11/16 2250

Cosign Info

Action	Created on	Responsible Provider	Signed by	Signed on
Ordering	04/11/16 2057	Michael G Mount, DO	Michael G Mount, DO	04/11/16 2250

Patient Information

Patient Name	Sex	DOB	SSN
Davis, Jeremy	Male	8/3/1979	xxx-xx-8375

Additional Information

- [Associated Reports](#)
- [View Encounter](#)
- [Priority and Order Details](#)
- [Click to Print Result](#)

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From: Klempay, Charles L <cklempay@latrobedistribution.com>
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2 of 3

From: Mosconi, Sharon A [mailto:SAMosconi@mercy.com]
Sent: Tuesday, April 12, 2016 1:20 PM
To: Klempay, Charles L
Subject: jeremy davis trauma notes

TRAUMA HISTORY & PHYSICAL
YOUNGSTOWN SURGICAL ASSOCIATES
TRAUMA ATTENDING

Attending Physician Statement:

I was present for the trauma team resuscitation. I agree with the assessment and plan as documented by the residents. The following summarizes my clinical findings and independent assessment.

CC: trauma alert

HISTORY

Mechanism of injury: Flying steel bar hit in face - unclear circumstances

Mode of arrival: ambulance

Prehospital interventions:

oxygen
peripheral IV
crystalloid infusion
cervical collar

Complaints:

Left facial pain
+ LOC

Past history/medications: as noted in resident/APN note

FHx: non - contributory

Review of Systems:

History obtained from the patient
Review of Systems - General ROS: negative
Psychological ROS: negative
Ophthalmic ROS: negative
ENT ROS: positive for - oral lesions and difficulty swallowing
Allergy and Immunology ROS: negative

Hematological and Lymphatic ROS: negative
Respiratory ROS: negative
Cardiovascular ROS: negative
Gastrointestinal ROS: negative
Genito-Urinary ROS: negative
Musculoskeletal ROS: negative
Neurological ROS: + LOC

PHYSICAL EXAM:

Filed Vitals:

04/11/16 2200
BP: 141/93
Pulse: 99
Temp: 99.2 °F (37.3 °C)
Resp: 17
SpO2:

Neuro:

GCS 15
Moving all extremities
Reactive, equal pupils

Psychiatric:

Affect normal, Judgement appropriate
Alert and oriented to self, place, time

Head/Face:

Left facial lacerations and bruising with TTP L,
no bony deformities

Eyes:

Vision/EOM grossly intact

Ears:

no otorrhagia

Nose:

no epistaxis

Mouth:

no intraoral lacerations/ecchymoses

Neck:

semi rigid collar present
no tracheal deviation
no soft tissue injury

Chest:

no deformities
non tender

Lungs:

equal and clear bilateral breath sounds
no use of accessory muscles

Heart:

normal sinus rhythm
warm, well perfused
strong femoral pulses bilaterally

Abdomen:

non distended
non tender
no soft tissue injury

Back:

no soft tissue injury

no deformities
nontender

Musculoskeletal:

Gait not inspected due to patient on trauma bed
RUE: no soft tissue injury, swelling, or deformity
RLE: no soft tissue injury, swelling, or deformity
LUE: no soft tissue injury, swelling, or deformity
LLE: no soft tissue injury, swelling, or deformity

TRAUMA BAY INTERVENTIONS:

Crystalloid infusion
PCXR: negative
PXR: negative

DIAGNOSTIC FINDINGS

I reviewed the available laboratory studies and diagnostic imaging.
UDS + opiates
CT head negative
CT face - oblique mandible fx with malocclusion, maxillary fx from midline to lateral nasal cavity
CT C-spine negative

ASSESSMENT:

Active Problems:
Concussion with LOC < 30 minutes
Mandible Fx
Maxillary Fx

PLAN:

- Admit to trauma service - observation
- Facial trauma consult - ancef and will eval in AM per discussion
- Sinus precautions
- Pain control
- Mild TBI precautions

Michael G Mount, DO
Pager: 330-229-1781
4/11/2016
10:41 PM

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TRAUMA HISTORY & PHYSICAL
Resident
4/11/2016
6:33 PM

PRIMARY SURVEY

CHIEF COMPLAINT: Trauma alert: 26 year old male hit by steel bar, unknown LOC, no anticoagulants.

AIRWAY:

Airway normal
EMS ETT Absent
Noisy respirations Absent

Retractions: Absent
Vomiting/bleeding: Absent

BREATHING:

Midaxillary breath sound left: Present
Midaxillary breath sound right: Present
Cough sound intensity: Fair
Respiratory rate: 16
FiO2: 15 liters/min via non-rebreather face mask
SMI: 2500

CIRCULATION:

Femoral pulse rate: normal
Femoral pulse intensity: present
Palpebral conjunctiva: Red Pink
Patient Vitals for the past 8 hrs:

BP

04/11/16 (l) 150/94 mmHg
1833

FAST EXAM: Not performed

Central Nervous System

GCS	Initial	15 minutes
Eye	4 - Opens eyes on own	4 - Opens eyes on own
Motor	6 - Follows simple motor commands	6 - Follows simple motor commands
Verbal	5 - Alert and oriented	5 - Alert and oriented

Neuromuscular blockade: No
Pupil size: Left 4 mm
Right 4 mm
Pupil reaction: Yes
Wiggles fingers: Left Yes Right Yes
Wiggles toes: Left Yes Right Yes

Hand grasp: Left normal
Right normal
Plantar flexion: Left normal
Right normal
Loss of consciousness: unknown

History Obtained From: patient
Private Medical Doctor: none

Pre-existing Medical History: no

Conditions: depression

Medications: cymaltta

Allergies: NKA

Social History:

Smoking: none
Alcohol: social drinker
Illicit Drug: no history of illicit drug use

Past Surgical History: none

NSAID use in last 72 hours: unknown

Taken PCN in past: yes

Last food/drink: earlier today- time unknown

Last tetanus: unknown to patient

Complaints:

Head/face: mild

Neck: none

Chest: none

Back: none

Abdomen: none

Extremities: none

Comments:

SECONDARY SURVEY

Head/scalp: left facial laceration X 2 -- transverse ~ 1cm, and ~2 cm , lateral to vermilion border and below it

Face: as above

Eyes/ears/nose: EOMI, PEERL, frontal teeth missing - left upper and lower

Pharynx/mouth: As above

Neck: No Soft Tissue Injuries

Cervical sine tenderness: none

ROM: Not indicated; Cervical Collar in place

Chest wall: CTAB, no crepitus appreciated, No Soft Tissue Injuries

Heart: RRR, S1, S2, No M/R/G

Abdomen: Soft, non-distended, No Soft Tissue Injuries

Tenderness: none

Pelvis: No Soft Tissue Injuries

Tenderness: none

Thoracolumbar spine: No Soft Tissue Injuries, No step-offs appreciated

Tenderness: none

Genitourinary: no traumatic injuries

Rectum: no traumatic injuries

Perineum: no traumatic injuries

Extremities:

Sensory normal

Motor normal

Distal Pulses

Left arm Normal
Right arm Normal
Left leg Normal
Right leg Normal

Capillary refill
Left arm normal
Right arm normal
Left leg normal
Right leg normal

Procedures in ED: None
Lacerations sutured by: -
Description of repair: -

Radiology: pending

Consultations: none

Admission/Diagnosis:
26 year old male hit by steel bar, amnestic to events

Plan of Treatment:
Will observe in ED. Follow up CT scans. Will re-evaluate in the next few hours to determine disposition.

Plan discussed with Dr. Mount on 4/11/2016 at 6:33 PM

Workup pending: as stated
Official Reads
Labs

Rema J Malik on 4/11/2016 at 6:33 PM

Cosigned by: Michael G Mount, DO at 4/11/2016 10:48 PM

Revision History

Date/Time	User	Provider Type	Action
4/11/2016 10:48 PM	Michael G Mount, DO	Physician	Cosign
4/11/2016 6:44 PM	Rema J Malik, MD	Resident	Sign

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Caitlin Scholl

From: Klempay, Charles L <cklempay@latrobedistribution.com>
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3 of 3.

Caitlin, Thank you for all your help. I will be sure to let you know how we handle this later today. - Chuck

From: Mosconi, Sharon A [mailto:SAMosconi@mercy.com]
Sent: Tuesday, April 12, 2016 1:19 PM
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Department of Plastic Surgery - Adult Attending Facial Trauma Consult Note

CHIEF COMPLAINT: Left facial trauma

History Obtained From: Patient, EMR

HISTORY OF PRESENT ILLNESS:

The patient is a 36 y.o. male who presents with left sided facial trauma. The pt states they obtained their injury yesterday as a result of a steel beam to the left face while at work. He does not remember the injury but states his foreman at work relayed the events that happened. The pt states their pain is currently mild. The patient denies any blurred vision, double vision or changes in vision. They state that their teeth are not coming together in their normal occlusion.

Past Medical History:

Past Medical History
History reviewed. No pertinent past medical history.

Past Surgical History:

Past Surgical History
History reviewed. No pertinent past surgical history.

Current Medications:

Current Hospital Medications
Current facility-administered medications: 0.9 % sodium chloride infusion, , Intravenous, Continuous
hydrALAZINE (APRESOLINE) injection 10 mg, 10 mg, Intravenous, Q30 Min PRN
sodium chloride flush 0.9 % injection 10 mL, 10 mL, Intravenous, 2 times per day
sodium chloride flush 0.9 % injection 10 mL, 10 mL, Intravenous, PRN
acetaminophen (TYLENOL) tablet 650 mg, 650 mg, Oral, Q4H PRN
magnesium hydroxide (MILK OF MAGNESIA) 400 MG/5ML suspension 30 mL, 30 mL, Oral, Daily PRN

ondansetron (ZOFTRAN) injection 4 mg, 4 mg, Intravenous, Q6H PRN
ceFAZolin (ANCEF) IVPB 1 g, 1 g, Intravenous, Q8H
morphine (PF) injection 2 mg, 2 mg, Intravenous, Q3H PRN **OR** morphine (PF) injection 4 mg, 4 mg, Intravenous, Q3H PRN
HYDROcodone-acetaminophen (NORCO) 5-325 MG per tablet 1 tablet, 1 tablet, Oral, Q4H PRN **OR** HYDROcodone-acetaminophen (NORCO) 5-325 MG per tablet 2 tablet, 2 tablet, Oral, Q4H PRN
diphenhydrAMINE (BENADRYL) injection 25 mg, 25 mg, Intravenous, Q6H PRN

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

Social History:

Social History

History

Social History

- Marital Status: Single
- Spouse Name: N/A
- Number of Children: N/A
- Years of Education: N/A

Occupational History

- Not on file.

Social History Main Topics

- Smoking status: Never Smoker
- Smokeless tobacco: Not on file
- Alcohol Use: Not on file
- Drug Use: Not on file
- Sexual Activity: Not on file

Other Topics Concern

- Not on file

Social History Narrative

- No narrative on file

Family History:

Family History

History reviewed. No pertinent family history.

REVIEW OF SYSTEMS:

CONSTITUTIONAL: negative for fevers, chills, sweats and fatigue

EYES: negative for diplopia or acute vision loss.

RESPIRATORY: negative for dry cough, cough with sputum, dyspnea, wheezing and chest pain

CARDIOVASCULAR: negative for chest pain, dyspnea, palpitations, syncope

GASTROINTESTINAL: negative for nausea, vomiting, change in bowel habits, diarrhea, constipation and abdominal pain

EXTREMITIES: negative for edema

MUSCULOSKELETAL: negative for muscle weakness

SKIN: negative for itching or rashes.

BEHAVIOR/PSYCH: negative for poor appetite, increased appetite, decreased sleep and poor concentration

NEURO: negative for agitated mood

PHYSICAL EXAM:

Physical Exam

Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished.

Neck: Normal range of motion. Neck supple.

Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses. No murmur heard.

Pulmonary/Chest: Effort normal and breath sounds normal.

Abdominal: Soft. Bowel sounds are normal. He exhibits no mass. No tenderness.

Musculoskeletal: Normal range of motion. He exhibits no edema.

Lymphadenopathy: He has no cervical adenopathy.

Neurological: He is alert and oriented to person, place, and time. He has normal reflexes.

Skin: Warm and dry.

Neuro: Cranial nerves II-XII grossly intact.

FACE

Head: Normocephalic, left facial laceration noted and repaired. Left lower third of face facial edema noted.

Right Ear: External ear normal.

Left Ear: External ear normal.

Nose: Nose normal. No Septal Hematoma. No Deviation

Mouth/Throat: Malocclusion noted to dentition. V1-V3 distribution intact bilaterally

Eyes: Conjunctivae and extraocular motions are normal. Pupils are equal, round, and reactive to light.

No Stepoffs palpated

DATA:

Radiology Review:

Patient MRN: 01821982
DOB: 8/3/1979
Age: 36 years
Gender: Male
Order Date: 4/11/2016 7:06 PM
EXAM: CT FACIAL BONES WO CONTRAST
NUMBER OF IMAGES: 671.
INDICATION: Facial trauma and pain.
COMPARISON: None.
FINDINGS:
There is an oblique slightly displaced fracture of the left side of the mandible running through the ramus to reach the midline.
Associated malocclusion is noted.
In addition there is a fracture through the maxilla with minimal displacement running from the midline anteriorly and to the left to reach the left lateral wall of the nasal cavity. Some comminution is evident at the level of the nasal cavity. Fracture line also extends to the alveolar ridge of the maxilla.
The mandibular condyles articulate normally at the TMJ fossa. The orbital margins and floors are intact. There is no evidence of orbital emphysema or other acute traumatic orbital pathology. Mucosal thickening is noted in the paranasal sinuses. Other intact structures include the left and right zygomatic arch, the pterygoid plates, and

the visualized base of the skull.

IMPRESSION:
1. Oblique fracture with displacement running through the left side of the mandible involving the ramus with extension to the midline. Malocclusion noted.
2. Fracture of the maxilla running from the midline and passing anteriorly and to the left to reach the left lateral margin of the nasal cavity. At this point there is some comminution. Malocclusion is noted.

IMPRESSION/RECOMMENDATIONS:

Diagnosis
-)Left parasymphseal mandible fracture

Keflex for 5 days
HOB Elevated 30 degrees
No Nose Blowing
Soft Diet
Peridex Oral Rinse TID
Continue dental care as directed.

Will plan for Open Reduction Internal Fixation of left parasymphseal mandible fracture with plates screws and maxillomandibular fixation. Thursday 4-14-16

OK for discharge from plastic surgery standpoint

Adam Daniel Cash

Revision History

Date/Time	User	Provider Type	Action
4/12/2016 9:30 AM	Adam Daniel Cash, MD	Physician	Sign
4/12/2016 9:14 AM	Christopher F Jonda, PA	Physician Assistant	Share
4/12/2016 9:05 AM	Christopher F Jonda, PA	Physician Assistant	Share
4/12/2016 9:03 AM	Christopher F Jonda, PA	Physician Assistant	Share
View Details Report			

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