Patient Report

SBAR Hand-Off	Current day and time:	Tuesday 0100					Admission day and time:	Monday 2200					
Situation	Name:	Jessie Hernandez											
	Age:	26	Sex:	Female		Ethnicity:	Hispanic		Religion:	Catholic			
	Provider:	Debra Warden, MD											
	Admission diagnosis:	Posttraumatic stress disorder											
Background	Pertinent medical history:	None											
	Pertinent social history:	The patient is single and lives with her parents and three younger siblings.											
	Allergies:	No known allergies											
	Code status:	Full status											
	Vital signs (most recent):	Time:	2000	T:	98.6 F (37.0 C)	BP:	131/88	P:	118	RR:	24	O_2 Sat:	98%
	Oxygen therapy:	Mode:		Room air		LPM:	Not applicable						
	Pain:	Rating:	0	Most recent pain medication:			Not applicable			Time:			

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	Other recent medication:	Paroxetine 10 mg daily, to start in AM							
	IVs:	Site:	None	Type:	Not applicable	Assessment:	Not applicable	Fluid:	Not applicable
	Drains and tubes:	Site:	None	Type:	Not applicable	Assessment:	Not applicable		
	Wounds:	Site:	None	Type:	Not applicable	Assessment:	Not applicable		
	ADLs:	Diet:	Regular				Activity:	No restrictions	
	Restrictions:	Isolation:	Standard precautions				Fall risk:	Low	
	Assessments:	Neurologic:	Alert and oriented to person, place, time, and situation						
		Cardiac:	Regular rate and rhythm.						
		Respiratory:	Lungs clear bilaterally						
		GI/GU:	Last bowel movement Monday. Voiding independently.						
		Integumentary:	Pink, warm, dry, and intact.						
		Ortho/Mobility:	Steady gait. Ambulates independently						
		Psychosocial:	Hypervigilant with exaggerated startle response since return from second deployment in the Middle East 3 months ago. Jessie has had several recent episodes of flashbacks and panic. Family reports that they can no longer deal with Jessie's strange behavior.						
		Other:	Patient was involved in a bombing during last deployment and witnessed several fellow soldiers injured or killed during both deployments. Victim of sexual assault during first deployment and did not report assault out of fear of reprisal.						

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	Labs and diagnostics:	Substance Use Toxicology (urine) - Negative
Assessment	Nurse's assessment:	Patient is oriented in all 4 spheres. Has been watchful and anxious since admission with exaggerated startle response. Has been able to follow concrete directions. Easily distracted and has difficulty answering questions. Becomes agitated if too many questions are asked at once or if she is unable to check the room. Jessie has had difficulty falling asleep and staying asleep.
Recommendation	Plan of care:	Continue to monitor closely for safety. Assess level of anxiety, teach coping skills as tolerated. Discharge planning per social-worker beginning Wednesday.
	Tests/results pending:	None
	Orders pending completion:	None
	Other:	On last round, patient was lying in bed quietly but awake. I told her we would be checking on her throughout the night and she is expecting to see you soon. She keeps asking for coffee or an energy drink to stay awake. I keep reinforcing to her that this will make her anxiety worse.