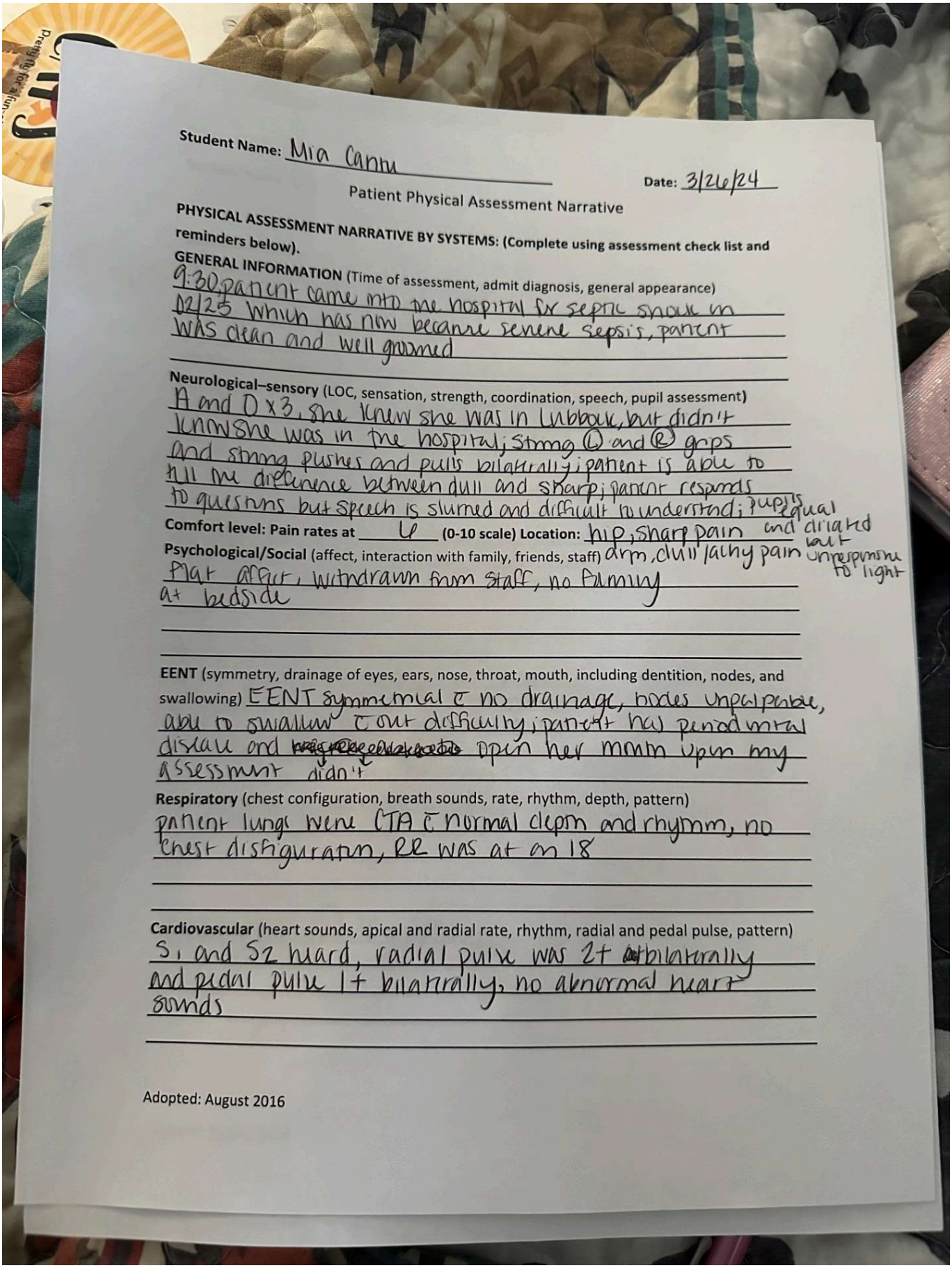


Student Name: Mia Cantu **Date:** 3/26/24

Patient Physical Assessment Narrative

PHYSICAL ASSESSMENT NARRATIVE BY SYSTEMS: (Complete using assessment check list and reminders below).

GENERAL INFORMATION (Time of assessment, admit diagnosis, general appearance)
9:30 patient came into the hospital for septic shock on 3/25 which has now became severe sepsis, patient was clean and well groomed

Neurological–sensory (LOC, sensation, strength, coordination, speech, pupil assessment)
A and O x3, she knew she was in Lubbock, but didn't know she was in the hospital; Stmg (L) and (R) grips and stmg pushes and pulls bilaterally; patient is able to tell me difference between dull and sharp; patient responds to questions but speech is slurred and difficult to understand; pupils equal dilated but unresponsive to light

Comfort level: Pain rates at 4 **(0-10 scale) Location:** hip, sharp pain and arm, dull/achy pain

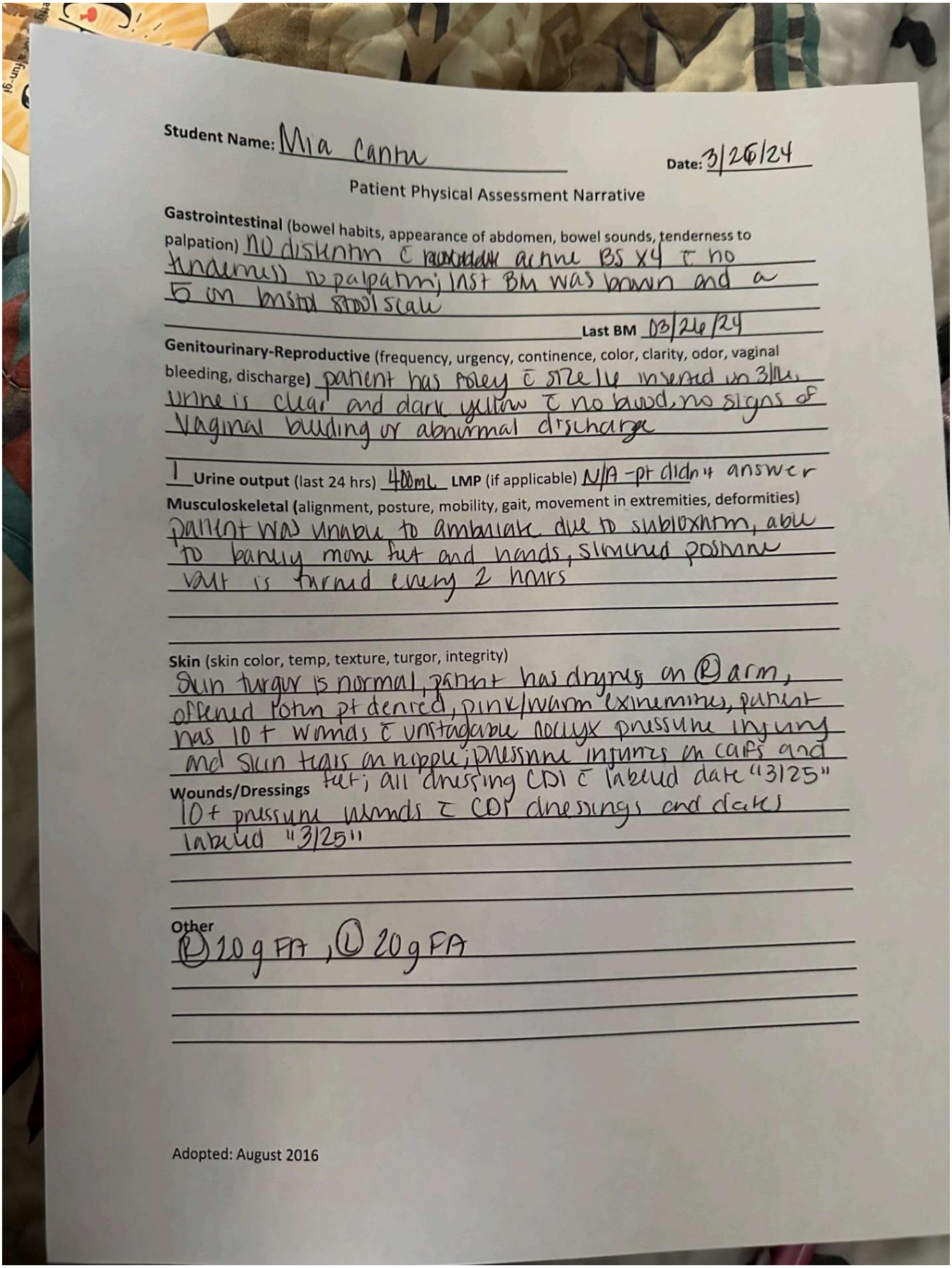
Psychological/Social (affect, interaction with family, friends, staff)
Flat affect, withdrawn from staff, no family at bedside

EENT (symmetry, drainage of eyes, ears, nose, throat, mouth, including dentition, nodes, and swallowing) EENT symmetrical & no drainage, bodies unpalpable, able to swallow & out difficulty; patient has periodontal disease and ~~[illegible]~~ open her mouth upon my assessment didn't

Respiratory (chest configuration, breath sounds, rate, rhythm, depth, pattern)
patient lungs were CTA & normal depth and rhythm, no chest disfiguration, RR was at an 18

Cardiovascular (heart sounds, apical and radial rate, rhythm, radial and pedal pulse, pattern)
S1 and S2 heard, radial pulse was 2+ bilaterally and pedal pulse 1+ bilaterally, no abnormal heart sounds

Adopted: August 2016



Student Name: Mia Cantu **Date:** 3/26/24

Patient Physical Assessment Narrative

Gastrointestinal (bowel habits, appearance of abdomen, bowel sounds, tenderness to palpation) NO distention c normoactive active BS x4 c no tenderness to palpation; last BM was brown and a 5 on bristol stool scale

Last BM 03/26/24

Genitourinary-Reproductive (frequency, urgency, continence, color, clarity, odor, vaginal bleeding, discharge) patient has foley c size 16 inserted on 3/26, urine is clear and dark yellow c no blood, no signs of vaginal buding or abnormal discharge

I **Urine output** (last 24 hrs) 400mL **LMP** (if applicable) N/A - pt didn't answer

Musculoskeletal (alignment, posture, mobility, gait, movement in extremities, deformities) patient was unable to ambulate due to subluxation, able to barely move feet and hands, situated position and is turned every 2 hours

Skin (skin color, temp, texture, turgor, integrity) Skin turgor is normal, patient has dryness on (R) arm, offered lotion pt denied, pink/warm extremities, patient has 10+ wounds c unstageable coccyx pressure injury and skin tears on nipple; pressure injuries on calfs and feet; all dressing CDI c labeled date "3/25"

Wounds/Dressings 10+ pressure wounds c CDI dressings and date labeled "3/25"

Other (R) 20g FA, (L) 20g FA

Adopted: August 2016

Diagnostic Worksheet

Admit Day 2/25/24

Mark high / low values with (↑ or ↓)		Covenant Normal Values *Diagnostic values vary from laboratory to laboratory.	Dates: Admit day	Dates: Most Recent	↑ ↓
CBC	WBC	3.6-10.8 k/uL	15.64	14.83	↓
	HGB	14-18 g/dL	14.2	9.3	↓
	HCT	42% - 52%	40.5	28.4	↓
	RBC	4.7-6.1 m/uL	4.64	3.09	↓
	PLT	150 - 400 k/uL	111	448	↑
CMP	Glucose	70-110 mg/dL	307	172	↓
	Sodium	134 - 145 mmol/L	133	139	↑
	Potassium	3.5 - 5.3 mmol/L	3.9	3.9	—
	BUN	9-21 mg/dL	64	61	↓
	Creatinine	0.8-1.5 mg/dL	3.30	1.10	↓
	Chloride	98 - 108 mmol/L	100	112	↑
	Calcium	8.4 - 11.0 mg/dL	9	10	↑
	Mg++	1.6 - 2.3 mg/dL	—	1.7	—
	Total Protein	5.5 - 7.8 g/dL	7.6	8	↑
	Albumin	3.4 - 5 g/dL	2	1.5	↓
	Total Bilirubin	0.1 - 1.3	1.9	0.6	↓
	AST(SGOT)	5 - 45 u/L	120	31	↓
	ALT (SGPT)	7-72 u/L	42	17	↓
	Alk Phos (ALP)	38 - 126 u/L	187	66	↓
Lipid Panel (NA)	Cholesterol	200mg/dL			
	TRIG	0-150 mb/dL			
	HDL	>60mg/dL			
	LDL	0-100 mg/dL			
Common (NA)	GFR	Refer to lab specific data			
	TSH	0.35 - 5.5 ULU/L			
	Digoxin	0.8 - 2 ng/dL			
	PT	10.0 - 12.9 secs			
	INR	Therapeutic 2 - 3			
	PTT	25.3 - 36.9 secs			
	BNP	5 - 100 pg/dL			
	CKMB	0 - 5 ng/dL			
	Troponin	neg = < 0.07 ng/mL			

Mark high / low values with (↑ or ↓)		Covenant Normal Values *Diagnostic values vary from laboratory to laboratory.	Dates: Admit day	Dates: Most Recent	↑ ↓
UA	Sp Gravity	1.005-1.030	1.015	NA	
	Protein	(-) to trace	30	NA	
	Glucose	(-) to trace	100	NA	
	Ketone	(-) to trace	trace	NA	
	Nitrite	(-)	(-)	NA	
	Leukocytes	(-)	small	NA	
	Bilirubin	(-)	(-)	NA	
	Blood	(-)	large	NA	
	pH	5-7	5	NA	
Other Labs					

Date	Culture	Site	Result
2/25	Blood	peripheral	(+) for staph aureus
	Urine		
	Wound		
	Wound		

Other Diagnositic / Procedures

Examples: CT/Xray/MRI/Paracentesis

Date	Type	Result
2/26	XR chest portable	(L) basilar atelectasis
2/29	XR Chest portable	possibility of Pedema
3/2	XR chest portable	sm atelectasis in lower lungs
3/3	XR chest portable	sm (R) pleural effusion
3/15	XR panorex	maybe periodontal disease
2/26	MRI thoracic/cervical spine w/o contrast	multilevel degenerative changes

Point of Care Glucose Results

Date	Time	Result	Date	Time	Result
2/25	2104	197	3/25	2028	247
2/25	2318	289	3/26	0537	176
2/26	01017	177	3/26	1054	170