FRAUDSNIFFR

Medical Records Cover Page	
Client:	Lackey Bennett
Requester:	Deedra Bright
Claim #:	6863-01
Case #:	128115OT-02
Patient's Name:	Parker Phillips
Date of Birth:	2/8/2022

Our office was contacted and requested to secure records for the above-referenced patient from the following facility:

Dr./Facility:	Oklahoma Children's Hospital OU Health
Dr./Facility:	
Address:	
City/State/Zip:	
Telephone:	
Request Date:	Aug 25, 2025
Date Cleared:	Sept, 16, 2025

Special Instructions:

Obtain medical records based on canvass result.

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital

Visit Information

Admission Information

Arrival Date/Time:		Admit Date/Time:	12/16/2024 0658	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Nonhealthcare Facility Point Of Origin	Admit Category:	
Means of Arrival:		Primary Service:	Procedural	Secondary Service:	N/A
Transfer Source:		Service Area:	OU HEALTH SERVICE AREA	Unit:	Oklahoma Childrens Hospital
Admit Provider:	Vikram Ramjee, MD	Attending Provider:	Vikram Ramjee, MD	Referring Provider:	

Discharge Information

Date/Time: 12/16/2024 1216 | Disposition: Home Or Self Care | Destination: Home
Provider: Vikram Ramjee, MD | Unit: Oklahoma Childrens Hospital

Visit Account Information

Hospital Account

Name	Acct ID	Class	Status	Primary Coverage
Phillips, Parker L	601768344	Outpatient Surgery	Closed	OKLAHOMA COMPLETE HEALTH - OKLAHOMA COMPLETE HEALTH - SOONER SELECT

Guarantor Account (for Hospital Account #601768344)

Name	Relation to Pt	Service Area	Active?	Acct Type
Blue, Tatum	Mother	OUHSA	Yes	Personal/Family
Address	**Phone**			
102 PHILLIPS AVE MADILL, OK 73446-4006	580-257-9201(H)			

Coverage Information (for Hospital Account #601768344)

F/O Payor/Plan	Precert #
OKLAHOMA COMPLETE HEALTH/OKLAHOMA COMPLETE HEALTH - SOONER SELECT	
Subscriber	**Subscriber #**
Phillips, Parker L	B37271506
Address	**Phone**
PO BOX 8001 FARMINGTON, MO 63640-8001	833-752-1664

Reason for Visit

Visit Diagnosis

- **(primary)**

Hospital Problems

Name	Date Noted	Date Resolved	Present on Admission?
Developmental delay	12/13/2024	—	Unknown
Hypoxic-ischemic encephalopathy, unspecified severity (CMS-HCC)	12/13/2024	—	Unknown
Term birth of infant	12/13/2024	—	Exempt from POA reporting

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Patient Summary as-of Visit

Problem List as of 12/16/2024

Problems last reviewed by Lauren A Toft, PA on 12/16/2024 0710

Chronic rhinitis

Diagnosis: Chronic rhinitis | Noted on: 10/01/2024 | Priority: Medium
Chronic: No

Developmental delay

Diagnosis: Developmental delay | Noted on: 12/13/2024 | Priority: Medium
Chronic: No

Dysphagia

Diagnosis: Dysphagia | Noted on: 10/01/2024 | Priority: Medium
Chronic: No

Hypoxic-ischemic encephalopathy, unspecified severity (CMS-HCC)

Diagnosis: Hypoxic-ischemic encephalopathy, unspecified severity (CMS-HCC) | Noted on: 12/13/2024 | Priority: Medium
Chronic: No

Nasal obstruction

Diagnosis: Nasal obstruction | Noted on: 10/01/2024 | Priority: Medium
Chronic: No

Snoring

Diagnosis: Snoring | Noted on: 10/01/2024 | Priority: Medium
Chronic: No

Term birth of infant

Diagnosis: Term birth of infant | Noted on: 12/13/2024 | Priority: Medium
Chronic: No

Allergies as of 12/16/2024

Allergies last reviewed by Jessica Fritchie, RN on 12/16/2024 0727

OTHER

Reactions: Hives | Noted on: 12/16/2024
Comments: Ranch Dressing

Immunizations as of 12/16/2024

No documentation.

History as of 12/16/2024

Medical History as of 12/16/2024

Medical last reviewed by Lauren A Toft, PA on 12/16/2024

Past Medical History

Diagnosis	Date	Comments	Source
Chronic rhinitis	—	—	Provider
Development delay	—	—	Provider

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Patient Summary as-of Visit (continued)

Dysphagia	—	—	Provider
HIE (hypoxic-ischemic encephalopathy) (CMS-HCC)	—	—	Provider
Nasal obstruction	—	—	Provider
Neonatal seizures (CMS-HCC)	—	—	Provider
PFO (patent foramen ovale)	—	—	Provider
Snoring	—	—	Provider
Term birth of infant	—	—	Provider

Surgical History as of 12/16/2024

Surgical last reviewed by Lauren A Toft, PA on 12/16/2024

Past Surgical History

Procedure	Laterality	Date	Comments	Source
CIRCUMCISION, NON-NEWBORN	—	08/2022	—	Provider
brain MRI w GA - newborn [Other]	—	—	—	Provider

Family History as of 12/16/2024

Family History as of 12/16/2024

Neg Hx

Condition	Age of Onset	Comment
Anesthesia problems		

Socioeconomic History as of 12/16/2024

Socioeconomic as of 12/16/2024

Marital Status	Spouse Name	Number of Children	Years Education	Education Level	Preferred Language	Ethnicity	Race	Source
Single	—	—	—	—	English	Not Hispanic, Latino/a, or Spanish origin	White	—

Implants as of 12/16/2024

ENT Implant

Implant Laryn 1ml Gel H2o Base Inj Prolaryn - Log614131 - Implanted Throat

Inventory item:	Implant Laryngeal 1ml Gel Water Based Injectable Prolaryn	Model/Cat number:	8602M0K5
Manufacturer:	Merz Pharmaceuticals LLC	Lot number:	A00161400
Size:	1.0cc	Device identifier:	M2138602M0K52
Device identifier type:	HIBC		

GUDID Information

Request status	**Request failed - device not in GUDID**

As of 12/16/2024 (Log 614131)

Patient Summary as-of Visit (continued)

Status: **Implanted**

Medication List

Medication List

This report is for documentation purposes only. The patient should not follow medication instructions within. For accurate instructions regarding medications, the patient should instead consult their physician or after visit summary.

Prior To Admission

fluticasone (Flonase) 50 MCG/ACT nasal spray

Instructions: Administer 1 spray into each nostril in the morning. Shake gently. Before first use, prime pump. After use, clean tip and replace cap.
Authorized by: Stephanie Marie Noel, PA
Ordered on: 8/20/2024
Start date: 8/20/2024
Quantity: 16 g
Refill: 12 refills by 8/20/2025

ibuprofen (Childrens Motrin) 100 MG/5ML suspension

Instructions: Shake well. Take 6.4 mL by mouth every 6 hours. For use after surgery. Rotate with Tylenol every 3 hours.
Authorized by: Vikram Ramjee, MD
Ordered on: 12/9/2024
Start date: 12/16/2024
End date: 12/30/2024
Quantity: 120 mL
Refill: 1 refill by 12/9/2025

Discharge Medication List

fluticasone (Flonase) 50 MCG/ACT nasal spray

Instructions: Administer 1 spray into each nostril in the morning. Shake gently. Before first use, prime pump. After use, clean tip and replace cap.
Authorized by: Stephanie Marie Noel, PA
Ordered on: 8/20/2024
Start date: 8/20/2024
Quantity: 16 g
Refill: 12 refills by 8/20/2025

ibuprofen (Childrens Motrin) 100 MG/5ML suspension

Instructions: Shake well. Take 6.4 mL by mouth every 6 hours. For use after surgery. Rotate with Tylenol every 3 hours.
Authorized by: Vikram Ramjee, MD
Ordered on: 12/9/2024
Start date: 12/16/2024
End date: 12/30/2024
Quantity: 120 mL
Refill: 1 refill by 12/9/2025

Stopped in Visit

None

Clinical Notes

Discharge Instructions

Vikram Ramjee, MD at 12/16/2024 0900

Author: Vikram Ramjee, MD
Service: —
Author Type: Physician
Filed: 12/16/2024 9:00 AM
Date of Service: 12/16/2024 9:00 AM
Status: Written
Editor: Vikram Ramjee, MD (Physician)

Adenoidectomy and Microlaryngoscopy Discharge Instructions

Clinical Notes (continued)

Diet:
• There are no dietary restrictions.

Activity:
• There are no activity restrictions.
• Your child may return to school or daycare within a few days of surgery, based on whether your child needs to continue using pain medication.

Discharge Medications:
• Continue all medications on Medication Reconciliation form per original prescribing physician
• See Medication Reconciliation form for new or changed medications. The following medications except for saline have been called in to the OU Children's Pharmacy on the 2nd floor of the Children's Hospital near the main entrance.
• Use **saline spray** in both nostrils three times daily for 2 weeks.
• Take **acetaminophen (Tylenol)** and **ibuprofen (Motrin)** as needed for pain or fever. Both medications can be given every 6 hours. It is usually best for the first few days to alternate these and provide one or the other every 3 hours.
• Your discharge nurse should help you with weight-based dosing for both Tylenol and Motrin for your child before you discharge home.

Things to remember:
• Ear pain after surgery is common, and is likely to resolve as any throat pain gets better.
• Your child is likely to have foul smelling breath for 2-3 weeks.
• If you are worried about your child's fluid intake, monitor their urine output closely. Signs that your child is not taking enough fluids are a decreased frequency of urination, dark yellow or even brown colored urine, and dry mouth.
• Fever can occur after adenoidectomy. If so, continue treating with tylenol and ibuprofen, and encourage fluid intake. However, for fevers over 101.4F, go to the nearest emergency department.
• Call 911 or go to the nearest emergency department for: any bleeding from the mouth or nose, concern for dehydration, high fevers, significant difficulty breathing, neck stiffness, lethargy, or anything else you think may be an emergency.
• For any questions or concerns, you may call the pediatric ENT office at OU Children's at **405-271-2662** during business hours. For after hours or weekend concerns, you may call the main hospital phone number at **405-271-8001** and ask to speak to the ENT physician on call.

Follow-up:
• 1/22/2025 as scheduled

Electronically signed by Vikram Ramjee, MD at 12/16/2024 9:00 AM

Handoff

Jessica Fritchie, RN at 12/16/2024 0842

Author: Jessica Fritchie, RN
Filed: 12/16/2024 8:43 AM
Editor: Jessica Fritchie, RN (Registered Nurse)
Service: —
Date of Service: 12/16/2024 8:42 AM
Author Type: Registered Nurse
Status: Signed
Cosigner: Tierra M Sparks, RN at 12/16/2024 9:17 AM

I - Illness Severity

Severity: Stable
Code Status: No Order

P - Patient Summary

Allergies

Allergen	Reactions
• Other *Ranch Dressing*	Hives

Reason for Admission
ED - Chief Complaint: No chief complaint on file.

Patient Active Problem List

Diagnosis

- Dysphagia
- Nasal obstruction
- Snoring
- Chronic rhinitis
- Hypoxic-ischemic encephalopathy, unspecified severity
- Developmental delay
- Term birth of infant

Inpatient - Principal Problem: No Principal Problem: There is no principal problem currently on the Problem List. Please update the Problem List and refresh.
Significant Events by Date(free text):
Attending Provider: Vikram Ramjee, MD

Encounter Surgical Hx
Surgeries within this encounter: Procedure(s) (LRB):
ADENOIDECTOMY (N/A)
SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY WITH POSSIBLE INTERVENTION AND WITH INJECTION (N/A)

Focused Assessments
Surgical Dressings

Assessments needed following transfer (free text):

Vitals:

	12/16/24 0700
BP:	**(!) 94/79**
Pulse:	130
Resp:	22
Temp:	36.1 °C (97 °F)
SpO2:	98%

Pain

Pain Score

	12/16/24 0719
Pain Management Interventions:	pain management plan reviewed with patient/caregiver

Aldrete Score

Aldrete Score

	12/16/24 0718
Activity:	Able to move 4 extremities voluntarily or on command
Respiration:	Able to breathe deeply and cough freely
Circulation:	Blood pressure is plus or minus 20% of pre-anesthetic level
Consciousness:	Fully awake
Oxygen Saturation:	Able to maintain oxygen saturation greater than 92% on room air
Modified Aldrete Score:	10

I/O

No intake or output data in the 24 hours ending 12/16/24 0843

EBL

No data recorded

Orders Discussed(free text): preop meds

IV Access

Medications

Current infusions:

Currently Infusing

None

Pain meds last 12 hr:

Pain Meds (last 12 hours)

Date/Time	Action	Medication	Dose
12/16/24 0809	Given	acetaminophen (Tylenol) 32 MG/ML solution/suspension solution 188.9163 mg	188.9163 mg

Abnormal Results
Abnormal Labs results (free text):
Abnormal Imaging results (free text):

Mobility (free text) ambulatory

A - Action Items - To Do List
Has admitting provider seen the patient? has been seen by provider

S - Situation Awareness and Contingency Planning
Family
Family Present? patient, mother, and father
Family Special Requests?

Safety
Patient Hold? N/A
Suicide Risk?
Isolation? No active isolations

Fall Risk?
Low Fall Risk

S - Synthesis by Receiver/Teach Back

Handoff given by: Jessica Fritchie, RN
Handoff received by: Tierra, OR RN

Electronically signed by Jessica Fritchie, RN at 12/16/2024 8:43 AM
Electronically signed by Tierra M Sparks, RN at 12/16/2024 9:17 AM

Tierra M Sparks, RN at 12/16/2024 0908

Author: Tierra M Sparks, RN
Filed: 12/16/2024 9:51 AM
Editor: Tierra M Sparks, RN (Registered Nurse)
Service: —
Date of Service: 12/16/2024 9:08 AM
Author Type: Registered Nurse
Status: Signed
Cosigner: Kenzi E Griffin, RN at 12/16/2024 11:22 AM

I - Illness Severity
Severity: Stable
Code Status: No Order

P - Patient Summary
Allergies

Allergen	Reactions
• Other *Ranch Dressing*	Hives

Reason for Admission

ED - Chief Complaint: No chief complaint on file.

Patient Active Problem List

Diagnosis

- Dysphagia
- Nasal obstruction
- Snoring
- Chronic rhinitis
- Hypoxic-ischemic encephalopathy, unspecified severity
- Developmental delay
- Term birth of infant

Inpatient - Principal Problem: No Principal Problem: There is no principal problem currently on the Problem List. Please update the Problem List and refresh.

Significant Events by Date(free text):

Attending Provider: Vikram Ramjee, MD

Encounter Surgical Hx

Surgeries within this encounter: Procedure(s) (LRB):
ADENOIDECTOMY (N/A)
SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY (N/A)
INJECTION VOCAL CORDS (N/A)

Focused Assessments

Surgical Dressings

Assessments needed following transfer (free text):

Vitals:

	12/16/24 0700
BP:	**(!) 94/79**
Pulse:	130
Resp:	22
Temp:	36.1 °C (97 °F)
SpO2:	98%

Pain

Pain Score

	12/16/24 0719

Pain Management Interventions:	pain management plan reviewed with patient/caregiver

Aldrete Score

Aldrete Score

	12/16/24 0718
Activity:	Able to move 4 extremities voluntarily or on command
Respiration:	Able to breathe deeply and cough freely
Circulation:	Blood pressure is plus or minus 20% of pre-anesthetic level
Consciousness:	Fully awake
Oxygen Saturation:	Able to maintain oxygen saturation greater than 92% on room air
Modified Aldrete Score:	10

I/O

No intake or output data in the 24 hours ending 12/16/24 0908

EBL

No data recorded

Orders Discussed(free text):

IV Access

Peripheral IV 12/16/24 Left;Posterior (Active)

Placement Date: 12/16/24 Hand Hygiene Completed: Yes Size (Gauge): 24 G Orientation: Left;Posterior Location: Hand Site Prep: Alcohol Technique: Anatomical landmarks

Medications

Current infusions:

Currently Infusing

None

Pain meds last 12 hr:

Pain Meds (last 12 hours)

Date/Time	Action	Medication	Dose
12/16/24 0907	Given	lidocaine (Xylocaine) 1 % injection	3 mL
12/16/24 0809	Given	acetaminophen (Tylenol) 32 MG/ML solution/suspension solution 188.9163 mg	188.9163 mg

Abnormal Results
Abnormal Labs results (free text):
Abnormal Imaging results (free text):

Mobility (free text) WNL

A - Action Items - To Do List
Has admitting provider seen the patient? has been seen by provider

S - Situation Awareness and Contingency Planning
Family
Family Present? parents
Family Special Requests?

Safety
Patient Hold? N/A
Suicide Risk?
Isolation? No active isolations

Fall Risk?
Low Fall Risk

S - Synthesis by Receiver/Teach Back

Handoff given by: SPARKS, TIERRA OR RN
Handoff received by: GRIFFIN, KENZI PACU RN

Electronically signed by Tierra M Sparks, RN at 12/16/2024 9:51 AM
Electronically signed by Kenzi E Griffin, RN at 12/16/2024 11:22 AM

Kenzi E Griffin, RN at 12/16/2024 1141

Author: Kenzi E Griffin, RN
Filed: 12/16/2024 11:44 AM
Editor: Kenzi E Griffin, RN (Registered Nurse)
Service: —
Date of Service: 12/16/2024 11:41 AM
Author Type: Registered Nurse
Status: Signed
Cosigner: Sara Russell, RN at 12/16/2024 11:54 AM

I - Illness Severity
Severity: Stable
Code Status: No Order

P - Patient Summary
Allergies

Allergen	Reactions
• Other *Ranch Dressing*	Hives

Reason for Admission

ED - Chief Complaint: No chief complaint on file.

Patient Active Problem List

Diagnosis

- Dysphagia
- Nasal obstruction
- Snoring
- Chronic rhinitis
- Hypoxic-ischemic encephalopathy, unspecified severity
- Developmental delay
- Term birth of infant

Inpatient - Principal Problem: No Principal Problem: There is no principal problem currently on the Problem List. Please update the Problem List and refresh.

Significant Events by Date(free text):

Attending Provider: Vikram Ramjee, MD

Encounter Surgical Hx

Surgeries within this encounter: Procedure(s) (LRB):
ADENOIDECTOMY (N/A)
SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY (N/A)
INJECTION VOCAL CORDS-PROLARYN GEL (N/A)

Focused Assessments

Surgical Dressings

Wound 12/16/24 Other (comment) Throat (Active)

Site Assessment	Unable to assess	12/16/24 0954
Peri-Wound Assessment	Unable to assess	12/16/24 0954

Assessments needed following transfer (free text):

Vitals:

	12/16/24 1130
BP:	
Pulse:	140
Resp:	25
Temp:	36 °C (96.8 °F)
SpO2:	96%

Pain

Pain Score

	12/16/24 1049	12/16/24 1100	12/16/24 1115	12/16/24 1130
Pain Assessment:		FLACC	FLACC	FLACC
Pain Management Interventions:	pain management plan reviewed with patient/caregiver;pain medication given			

Aldrete Score

Aldrete Score

	12/16/24 0718	12/16/24 0954	12/16/24 1015
Activity:	Able to move 4 extremities voluntarily or on command	Able to move 4 extremities voluntarily or on command	Able to move 4 extremities voluntarily or on command
Respiration:	Able to breathe deeply and cough freely	Able to breathe deeply and cough freely	Able to breathe deeply and cough freely
Circulation:	Blood pressure is plus or minus 20% of pre-anesthetic level	Blood pressure is plus or minus 20% of pre-anesthetic level	Blood pressure is plus or minus 20% of pre-anesthetic level
Consciousness:	Fully awake	Arousable on calling	Fully awake
Oxygen Saturation:	Able to maintain oxygen saturation greater than 92% on room air	Needs oxygen inhalation to maintain oxygen saturation greater that 90%	Able to maintain oxygen saturation greater than 92% on room air
Modified Aldrete Score:	10	8	10

I/O

Intake/Output Summary (Last 24 hours) at 12/16/2024 1143
Last data filed at 12/16/2024 1100

	Gross per 24 hour
Intake	270.4 ml
Output	—
Net	**270.4 ml**

EBL

No data recorded

Orders Discussed(free text): reviewed with phase 2

IV Access

Medications

Current infusions:

Currently Infusing

None

Pain meds last 12 hr:

Pain Meds (last 12 hours)

Date/Time	Action	Medication	Dose
12/16/24 1045	Given	morphine PF 2 MG/ML 0.6 mg	0.6 mg
12/16/24 1022	Given	fentaNYL (PF) (Sublimaze) 10 mcg/mL injection 6.3 mcg	6.3 mcg
12/16/24 1004	Given	fentaNYL (PF) (Sublimaze) 10 mcg/mL injection 6.3 mcg	6.3 mcg
12/16/24 0907	Given	lidocaine (Xylocaine) 1 % injection	3 mL
12/16/24 0809	Given	acetaminophen (Tylenol) 32 MG/ML solution/suspension solution 188.9163 mg	188.9163 mg

Abnormal Results
Abnormal Labs results (free text):
Abnormal Imaging results (free text):

Mobility (free text) able to move all 4 extremities

A - Action Items - To Do List
Has admitting provider seen the patient? has been seen by provider Signed out by Dr. Padgett

S - Situation Awareness and Contingency Planning
Family
Family Present? mother and father
Family Special Requests?

Safety
Patient Hold? N/A
Suicide Risk?
Isolation? No active isolations

Fall Risk?
Low Fall Risk

S - Synthesis by Receiver/Teach Back

Handoff given by: Kenzi RN
Handoff received by: Sara RN

Electronically signed by Kenzi E Griffin, RN at 12/16/2024 11:44 AM
Electronically signed by Sara Russell, RN at 12/16/2024 11:54 AM

Op Note

Vikram Ramjee, MD at 12/16/2024 0851

Author: Vikram Ramjee, MD | Service: Otolaryngology | Author Type: Physician
Filed: 12/16/2024 9:25 AM | Date of Service: 12/16/2024 8:51 AM | Status: Signed
Editor: Vikram Ramjee, MD (Physician)

ADENOIDECTOMY, SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY WITH POSSIBLE INTERVENTION AND WITH INJECTION, INJECTION VOCAL CORDS Operative Note

Date: 12/16/2024 **Location:** OCH Main OR

Name: Parker L Phillips, **DOB:** 2/8/2022, **MRN:** 1001652520

Preprocedure Diagnosis
Pre-op Diagnosis
* Hypertrophy of adenoids [J35.2]
* Dysphagia [R13.10]
Silent aspiration

Posptprocedure Diagnosis
Post-op Diagnosis
* Hypertrophy of adenoids [J35.2]
* Dysphagia [R13.10]
Silent aspiration

Procedures
1. Microdirect laryngoscopy (CPT 31526)
2. Rigid bronchoscopy (CPT 31622)
3. Injection laryngoplasty for deep interarytenoid groove (CPT 31571)
4. Adenoidectomy <12 years of age (CPT 42830)

Surgeons
* Vikram Ramjee - Primary
* Raquel Querido - Resident - Assisting

Procedure Summary

Anesthesia: General
Estimated Blood Loss: Minimal
Total IV Fluids: 100 mL
Total Urine Output: None
Drains: * None in log *
Staff:
Circulator: Tierra M Sparks, RN
Scrub Person: Gregory Deon Brown

Indications: Parker L Phillips is an 2 y.o. male who is having surgery for Hypertrophy of adenoids [J35.2] Dysphagia [R13.10]. The risks and benefits of performing a microdirect laryngoscopy and bronchoscopy were discussed in detail and his family wished to proceed. Informed consent was obtained. The details of surgery and risks including pain, scarring, bleeding, infection, and velopharyngeal dysfunction were discussed with his family who agrees to proceed.

Procedure Details:
The patient was seen in the preoperative area. The risks, benefits, complications, treatment options, non-operative alternatives, expected recovery and outcomes were discussed with the patient. The possibilities of reaction to medication, pulmonary aspiration, injury to surrounding structures, bleeding, recurrent infection, the need for additional procedures, failure to diagnose a condition, and creating a complication requiring transfusion or operation were discussed with the patient. The patient concurred with the proposed plan, giving informed consent. The site of surgery was properly noted/marked if necessary per policy. The patient has been actively warmed in preoperative area. Preoperative antibiotics are not indicated. Venous thrombosis prophylaxis are not indicated.

Description of procedure: The patient was transported to the operating room. Patient identification and the procedure were confirmed according to institutional protocol. He was transferred to the operating table in the supine position. Care was transitioned to Anesthesiology for induction of general anesthesia, which occurred without incident. The eyes were taped and padded. A preoperative safety timeout was performed according to institutional protocol. The table was turned 90 degrees to the right and the patient was mask ventilated.

A tooth guard was placed to protect the maxillary dentition. A Parsons 2 laryngoscope was carefully inserted into the mouth and advanced into the vallecula, resulting in a Grade 1 view. 1% lidocaine was applied as topical laryngotracheal anesthesia by ENT. Microdirect laryngoscopy was performed including a microscopic examination of the oropharynx, hypopharynx, supraglottis, and glottis using a 4 mm 0-degree endoscope. Rigid bronchoscopy was then performed including a microscopic examination of the subglottis, trachea, mainstem bronchi, and secondary bronchi using a 4 mm 0-degree endoscope. This examination was significant for the below listed findings. The patient was placed into suspension and using a 90 degree probe a deep interarytenoid groove was noted and injected with 0.2 mL Prolaryn gel with good ablation noted. The patient was then intubated by the ENT team with a 4.0 cuffed ETT. Photodocumentation was obtained. The endoscope and tooth guard were carefully removed. The teeth were inspected and there was no evidence of dental injury.

The Crowe-Davis mouth retractor placed in the oral cavity. The palate was palpated with no evidence of a submucous cleft palate. A Foley catheter was placed for retraction of the palate and uvula. A laryngeal mirror was used to visualize the adenoids, and an adenoidectomy was performed using the Coblator. The nasopharynx and oropharynx were irrigated with saline, and an orogastric tube placed for removal of stomach and pharyngeal contents.

Care was transitioned to Anesthesiology for emergence from general anesthesia, which occurred in the operating room without incident. The patient tolerated the procedure well and there were no complications. He was transported to PACU in stable condition.

Dr. Vikram Ramjee was present and participated in the entirety of the procedure.

Findings:
Laryngeal Exposure:
1. Exposure of Larynx: Parsons 2, grade 1 view
2. Patient position and/or special maneuvers: shoulder roll

Findings:
1. Supraglottis: Normal
2. Glottis: Normal, deep interarytenoid groove noted and injected with 0.2 mL Prolaryn gel
3. Subglottis: Easily fit 4.0 cuffed ETT with leak present at 20 cm H2O
4. Upper trachea: Normal
5. Mid-trachea: Normal
6. Lower trachea: Normal
7. Right bronchus: Normal
8. Left bronchus: Normal
9. 75% adenoid obstruction

Emergency Airway Classification:
1. Bag / Mask from above: Yes
2. LMA from above: Yes
3. Able to intubate from above: Yes
4. Tracheostomy is only airway: N/A

Complications: None; patient tolerated the procedure well.
Disposition: PACU - hemodynamically stable.
Condition: stable

Vikram Ramjee
Phone Number: 405-271-5504

Electronically signed by Vikram Ramjee, MD at 12/16/2024 9:25 AM

PatientPass Instruction

Sara Russell, RN at 12/16/2024 1138

Author: Sara Russell, RN | Service: — | Author Type: Registered Nurse
Filed: 12/16/2024 11:38 AM | Date of Service: 12/16/2024 11:38 AM | Status: Signed
Editor: Sara Russell, RN (Registered Nurse)

Patient Education

Table of Contents

Flexible Bronchoscopy, Care After

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General Anesthesia, Pediatric, Care After

The following information offers guidance on how to care for your child after the procedure. Your child's health care provider may also give you more specific instructions. If you have problems or questions, contact your child's health care provider.

What can I expect after the procedure?

After the procedure, it is common for children to have:

- Pain or discomfort at the IV site.
- Nausea or vomiting.
- A sore throat or hoarse voice.
- Trouble sleeping.

Your child may also feel:

- Dizzy.
- Weak.
- Sleepy.
- Irritable.
- Cold.

Babies may briefly have trouble nursing or taking a bottle. Older children who are potty-trained may briefly wet the bed at night.

Follow these instructions at home:

Medicines

- Give over-the-counter and prescription medicines only as told by your child's health care provider. These include any sleeping pills or medicines that cause drowsiness.
- **Do not** give your child aspirin because of the association with Reye's syndrome.

Eating and drinking

Go back to your child's regular diet and feedings as told by your child's health care provider and as tolerated by your child. In general, it is best to:

- Start by giving your child only clear liquids.
- Give your child frequent small meals when your child starts to feel hungry.
- Have your child eat foods that are soft and easy to eat, such as toast. Slowly have your child return to their regular diet.
- Breastfeed or bottle-feed your baby or young child. Do this in small amounts. Slowly increase the amount.

Give your child enough fluid to keep their urine pale yellow.

If your child vomits, replace body fluid that has been lost (**rehydrate**) by giving water or clear juice.

Safety

Your child should rest as told by the health care provider.

For the time period you were told by the health care provider:

- **Do not** allow your child to participate in activities where they could fall or become injured.
- **Do not** allow an older child to drive or use machinery.
- **Do not** allow your child to drink alcohol.
- **Do not** allow your child to take sleeping pills or medicines that cause drowsiness.

Watch your child closely until your child is awake and alert.

Help your child with:

- Standing.
- Walking.
- Going to the bathroom.
- Supervise any play or activity.

General instructions

Your health care provider may check to make sure that your child can walk, drink, and urinate before your child will go home.

Have your child return to normal activities as told by the health care provider. Ask the health care provider what activities are safe for your child.

If your child has sleep apnea, surgery and certain medicines can increase the risk for breathing problems. If applicable, follow instructions from the health care provider about having your child use a sleep device:

- Anytime your child is sleeping, including during daytime naps.
- While your child is taking prescription pain medicines or medicines that make your child drowsy.

Do not allow your child to use any products that contain nicotine or tobacco. These can delay incision healing after surgery. These products include cigarettes, chewing tobacco, and vaping devices, such as e-cigarettes. If your child needs help quitting, ask a health care provider.

Do not smoke around your child.

Contact a health care provider if:

Your child has nausea or vomiting that does not get better with medicine.

Your child vomits every time they eat or drink.

Your child has pain that does not get better with medicine.

Your child cannot urinate or has bloody urine.

Your child develops a skin rash.

Your child has a fever.

Get help right away if:

Your child:

- Has trouble breathing or speaking.
- Makes high-pitched whistling sounds when they breathe, most often when they breathe out (**wheeze**).

Your child who is 3 months to 3 years old has a temperature of 102.2°F (39°C) or higher.

Your child who is younger than 3 months has a temperature of 100.4°F (38°C) or higher.

These symptoms may be an emergency. Do not wait to see if the symptoms will go away. Get help right away. Call 911.

Summary

After the procedure, it is common for a child to have nausea or a sore throat. It is also common for a child to feel sleepy.

Watch your child closely until your child is awake and alert.

Give your child enough fluid to keep their urine pale yellow.

Have your child return to normal activities as told by the health care provider. Ask the health care provider what activities are safe for your child.

This information is not intended to replace advice given to you by your health care provider. Make sure you discuss any questions you have with your health care provider.

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Flexible Bronchoscopy, Care After

After flexible bronchoscopy, it is common to have a cough that is worse than it was before the procedure for 24–48 hours. Also during this time it is common to have:

- A low-grade fever.
- A sore throat or hoarse voice.
- Some blood in the mucus from your lungs (**sputum**), if a biopsy was done.

Follow these instructions at home:

The instructions below may help you care for yourself at home. Your health care provider may give you more instructions. If you have questions, ask your health care provider.

Eating and drinking

- **Do not** eat or drink (not even water) for 2 hours after your test, or until your numbing medicine (**local anesthetic**) wears off. If you have a numb throat, the risk of burning yourself or choking is higher.
- Start eating soft foods and slowly drinking liquids after your numbness is gone and your cough and gag reflexes have returned.
- You may return to your normal diet the day after the procedure.

Driving

- If you were given a sedative during the procedure, it can affect you for several hours. **Do not** drive or operate machinery until your health care provider says that it is safe.
- Ask your health care provider if the medicine prescribed to you requires you to avoid driving or using machinery.

General instructions

- Take over-the-counter and prescription medicines only as told by your health care provider.
- Return to your normal activities as told by your health care provider. Ask your health care provider what activities are safe for you.
- **Do not** smoke or use any products that contain nicotine or tobacco. If you need help quitting, ask your health care provider.
- Keep all follow-up visits. This is important. It is very important if you had a tissue sample (**biopsy**) taken.

Contact a health care provider if:

- You have a fever.

Get help right away if:

You have shortness of breath that gets worse.

You get light-headed.

You feel like you are going to pass out (**faint**).

You have chest pain.

You cough up more than a small amount of blood.

These symptoms may be an emergency. Get help right away. Call 911.

Do not wait to see if the symptoms will go away.

Do not drive yourself to the hospital.

Summary

Do not eat or drink anything (not even water) for 2 hours after your test, or until your numbing medicine wears off.

Do not smoke or use any products that contain nicotine or tobacco. If you need help quitting, ask your health care provider.

Get help right away if you have chest pain.

This information is not intended to replace advice given to you by your health care provider. Make sure you discuss any questions you have with your health care provider.

Document Released: 2010-10-15 Document Updated: 2023-03-28 Document Reviewed: 2023-03-28
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Electronically signed by Sara Russell, RN at 12/16/2024 11:38 AM

Perioperative Nursing Note

Tierra M Sparks, RN at 12/16/2024 0907

Author: Tierra M Sparks, RN | Service: — | Author Type: Registered Nurse
Filed: 12/16/2024 9:55 AM | Date of Service: 12/16/2024 9:07 AM | Status: Signed
Editor: Tierra M Sparks, RN (Registered Nurse)

EASE APP UPDATES @:
0844/0903/0908/0939/0954

Electronically signed by Tierra M Sparks, RN at 12/16/2024 9:55 AM

H&P Notes

H&P by Theodore Dickinson Klug, MD at 12/16/2024 0709

Author: Theodore Dickinson Klug, MD | Service: Otolaryngology | Author Type: Resident
Filed: 12/16/2024 7:10 AM | Date of Service: 12/16/2024 7:09 AM | Status: Signed

Editor: Theodore Dickinson Klug, MD (Resident)

Cosigner: Vikram Ramjee, MD at 12/16/2024 7:48 AM

Chief Complaint
PCP **- Derek Landis, MD**
No chief complaint on file.

History Of Present Illness
Parker L Phillips is a 2 y.o. male presenting for SMLB with possible intervention and injection, adenoidectomy.

Past Medical History
He has no past medical history on file.

Surgical History
He has no past surgical history on file.

Family History
No family history on file.

Social History
He reports that he has never smoked. He has never used smokeless tobacco. He reports that he does not drink alcohol and does not use drugs.

Allergies
Patient has no known allergies.

Review of Systems
Negative except as above.

Physical Exam
Constitutional: Well-developed, well nourished
Communication: Normal vocal quality
Head: Normocephalic, atraumatic
Face: No sinus tenderness, salivary glands normal to palpation, normal facial strength
Eyes: Pupils equal, extraocular movements intact, normal alignment
Ears: external ears normal, hearing intact to conversational volume
Nose: No external evidence of trauma, external exam midline, No septal deviation, and No rhinorrhea
Mouth/Throat: tonsils 1+, dentition appropriate for age
Neck: no thyromegaly or neck mass
Lymphatic: no cervical lymphadenopathy
Respiratory: non-labored respirations, no stridor, no retractions
Cardiovascular: no peripheral edema or cyanosis
Neurologic: CNII-XII intact
Chest: Breath sounds clear

Last Recorded Vitals

H&P Notes (continued)

Blood pressure **(!) 94/79**, pulse 130, temperature 36.1 °C (97 °F), resp. rate 22, height 0.91 m (2' 11.83"), weight 12.5 kg (27 lb 10.7 oz), SpO2 98%.

Assessment/Plan

2 y.o. male presenting for SMLB with possible intervention and injection, adenoidectomy.

- Proceed to OR.

Electronically signed by Theodore Dickinson Klug, MD at 12/16/2024 7:10 AM
Electronically signed by Vikram Ramjee, MD at 12/16/2024 7:48 AM

Imaging

Respiratory Care

Pediatric Oxygen Therapy - Blow by (Discontinued)

Electronically signed by: **Susan Wittman, MD on 12/16/24 0837** Status: **Discontinued**
Ordering user: Susan Wittman, MD 12/16/24 0837 Ordering provider: Susan Wittman, MD
Authorized by: Susan Wittman, MD Ordering mode: Standard
Frequency: Routine PRN 12/16/24 0935 - Until Specified Class: Hospital Performed
Quantity: 1 Released by: Kenzi E Griffin, RN 12/16/24 0935
Discontinued by: Automatic Discharge Provider 12/16/24 1620 [Patient Discharge]
Acknowledged: Kenzi E Griffin, RN 12/16/24 0935 for Placing Order

Questionnaire

Question	Answer
Device:	Blow by
Keep O2 Sat Above:	95%

Order comments: Humidified O2

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Case 614131

Surgery Information

General Information

Date: 12/16/2024
Location: OCH Main OR
Patient class: Outpatient Surgery
Time: 0845
Room: OR 03
Case classification: G - Case to be done this admission
Status: Posted
Service: Otolaryngology

Diagnosis Information

Diagnosis	ICD Code
Hypertrophy of adenoids	J35.2
Dysphagia	R13.10

Panel Information

Panel 1

Surgeon	Role	Service	Start Time	End Time
Vikram Ramjee, MD	Primary	Otolaryngology	0903	0933
Raquel Querido, MD	Resident - Assisting	Otolaryngology		

Procedure: ADENOIDECTOMY [42830 (CPT®)]

Laterality	Wound Class	Incision Closure	Anesthesia	Op Region	Length
N/A	Class II/ Clean Contaminated	Deep and Superficial Layers	General	Throat	20

ADENOIDECTOMY (N/A) - Position 1

Body: **Supine** Sheet Draw, Strap Safety, Blanket
Left Arm: **Tucked at Side**
Right Arm: **Tucked at Side**
Head: **Aligned**
Left Leg: **Straight**
Right Leg: **Straight**

Procedure: SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY [31526 (CPT®) +1 more]

Laterality	Wound Class	Incision Closure	Anesthesia	Op Region	Length
N/A	Class II/ Clean Contaminated	No Incision / NA			20

SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY (N/A) - Position 1

Body: **Supine** Sheet Draw, Strap Safety, Blanket
Left Arm: **Tucked at Side**
Right Arm: **Tucked at Side**
Head: **Aligned**
Left Leg: **Straight**
Right Leg: **Straight**

Procedure: INJECTION VOCAL CORDS-PROLARYN GEL [31571 (CPT®)]

Laterality	Wound Class	Incision Closure	Anesthesia	Op Region	Length
N/A	Class II/ Clean Contaminated	Deep and Superficial Layers			

Surgeons

Name	Panel	Role	Time Period
Vikram Ramjee, MD	Panel 1	Primary	12/16/2024 0903 - 12/16/2024 0933
Raquel Querido, MD	Panel 1	Resident - Assisting	

Staff

Name	Type	Time Period

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Case 614131 (continued)

Tierra M Sparks, RN	Circulator	12/16/2024 0851 - 12/16/2024 0951
Gregory Deon Brown	Scrub Person	12/16/2024 0851 - 12/16/2024 0951

Anesthesia Staff

Name	Type	Time Period
Susan Wittman, MD	Anesthesiologist	
(Not assigned)	CRNA	
Garrett Michael Eakers, MD	Anesthesia Resident	

Case Completion - Additional Information

Pre-op diagnosis

Hypertrophy of adenoids [J35.2]
Dysphagia [R13.10]

Post-op diagnosis

None

Log Completed By

Sara Russell, RN	12/16/2024	1220

Verification Information

Staff Member	Date	Time
Tierra M Sparks, RN	12/16/2024	9:51 AM

Timeouts

Carley Raper, RN at Fri Dec 13, 2024 1222 CST

Timeout Details

Timeout type: Preprocedure Call

Procedures

Panel 1: ADENOIDECTOMY with Vikram Ramjee, MD
Panel 1: SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY WITH POSSIBLE INTERVENTION AND WITH INJECTION with Vikram Ramjee, MD

Comments

Arrival:0645
NPO:2300
Clears:0500

3/3k
2 adults
Illness: None
Meds: None

Signing History

Staff	Performed	Signed
Carley Raper, RN	Fri Dec 13, 2024 1222 CST	Fri Dec 13, 2024 1222 CST

Jessica Fritchie, RN at Mon Dec 16, 2024 0721 CST

Timeout Details

Timeout type: Preprocedure Checklist

Procedures

Panel 1: ADENOIDECTOMY with Vikram Ramjee, MD
Panel 1: SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY WITH POSSIBLE INTERVENTION AND WITH INJECTION with Vikram Ramjee, MD

Timeout Questions

Correct patient? Yes
Correct side? N/A
Site marked? N/A
H&P note completed? Yes
Consents verified? **No**
Allergies reviewed? Yes
Is there risk of high blood loss? No
Are there adequate fluids available to replenish high blood loss? N/A
Is documentation verified? Yes
Patient ID band on? Yes
Patient verification methods? Wristband, Family Confirmed
Methods used to verify the procedure that will be performed: Patient Chart, Parent confirmation

Signing History

Staff	Performed	Signed
Jessica Fritchie, RN	Mon Dec 16, 2024 0721 CST	Mon Dec 16, 2024 0721 CST

Tierra M Sparks, RN at Mon Dec 16, 2024 0903 CST

Timeout Details

Timeout type: Sign-In/Briefing

Procedures

Panel 1: ADENOIDECTOMY with Vikram Ramjee, MD
Panel 1: SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY WITH POSSIBLE INTERVENTION AND WITH INJECTION with Vikram Ramjee, MD

Timeout Questions

Correct patient? Yes
Correct site? Yes
Correct side? N/A
Correct position? Yes
Correct procedure? Yes
Site marked? N/A
Are all required blood products & devices for the procedure available? Yes
Have surgical team concerns been reviewed? Yes
Has the nursing team reviewed the sterility? Yes
Have all new equipment problems been addressed? Yes
Radiology images and results available? N/A
Has a sequential compression device been applied? N/A

Staff Present

Surgeons
Vikram Ramjee, MD
Raquel Querido, MD

Anesthesia Staff
Susan Wittman, MD
Garrett Michael Eakers, MD

Staff
Tierra M Sparks, RN
Gregory Deon Brown

Signing History

Staff	Performed	Signed

Tierra M Sparks, RN	Mon Dec 16, 2024 0903 CST	Mon Dec 16, 2024 0904 CST

Tierra M Sparks, RN at Mon Dec 16, 2024 0903 CST

Timeout Details

Timeout type: Fire Safety

Procedures

Panel 1: ADENOIDECTOMY with Vikram Ramjee, MD
Panel 1: SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY WITH POSSIBLE INTERVENTION AND WITH INJECTION with Vikram Ramjee, MD

Staff Present

Surgeons	Anesthesia Staff
Vikram Ramjee, MD	Susan Wittman, MD
Raquel Querido, MD	Garrett Michael Eakers, MD

Staff
Tierra M Sparks, RN
Gregory Deon Brown

Signing History

Staff	Performed	Signed
Tierra M Sparks, RN	Mon Dec 16, 2024 0903 CST	Mon Dec 16, 2024 0904 CST

Tierra M Sparks, RN at Mon Dec 16, 2024 0903 CST

Timeout Details

Timeout type: Pre-incision Timeout

Procedures

Panel 1: ADENOIDECTOMY with Vikram Ramjee, MD
Panel 1: SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY WITH POSSIBLE INTERVENTION AND WITH INJECTION with Vikram Ramjee, MD

Timeout Questions

Correct patient? Yes
Correct position? Yes
Correct procedure? Yes
Allergies reviewed? Yes
Is there risk of high blood loss? No
Have surgical team concerns been reviewed? Yes
Have all team members been introduced? Yes
Has the surgeon reviewed the critical steps? **No**

Staff Present

Surgeons	Anesthesia Staff
Vikram Ramjee, MD	Susan Wittman, MD
Raquel Querido, MD	Garrett Michael Eakers, MD

Staff
Tierra M Sparks, RN
Gregory Deon Brown

Signing History

Staff	Performed	Signed
Tierra M Sparks, RN	Mon Dec 16, 2024 0903 CST	Mon Dec 16, 2024 0904 CST

Tierra M Sparks, RN at Mon Dec 16, 2024 0933 CST

Timeout Details

Timeout type: Sign-out Debriefing

Procedures

Panel 1: ADENOIDECTOMY with Vikram Ramjee, MD
Panel 1: SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY with Vikram Ramjee, MD
Panel 1: INJECTION VOCAL CORDS-PROLARYN GEL with Vikram Ramjee, MD

Timeout Questions

Have surgical team concerns been reviewed? No
Are counts correct? N/A
Have specimens been labeled? N/A

Staff Present

Surgeons	Anesthesia Staff
Vikram Ramjee, MD	Susan Wittman, MD
Raquel Querido, MD	Garrett Michael Eakers, MD

Staff
Tierra M Sparks, RN
Gregory Deon Brown

Signing History

Staff	Performed	Signed
Tierra M Sparks, RN	Mon Dec 16, 2024 0933 CST	Mon Dec 16, 2024 0933 CST

Clinical Documentation

Case Tracking Events

Event	Time In
In Facility	0658
In Preprocedure	0659
Preprocedure Complete	0728
In Room	0851
Anesthesia Start	0851
Anesthesia Ready	0900
Case Start	0903
Case Finish	0933
Out of Room	0951
In Recovery	0954
Anesthesia Stop	0957
Recovery Care Complete	1141
Out of Recovery	1141
In Phase II	1141
Phase II Care Complete	1216
Out of Phase II	1216
Procedural Charting Complete	1216

Event Tracking

Panel 1

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Case 614131 (continued)

Event	Time In
Incision Start	
Incision Close	

Procedure : ADENOIDECTOMY

Event	Time In
Procedure Start	0903
Procedure End	

Procedure : SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY

Event	Time In
Procedure Start	
Procedure End	

Procedure : INJECTION VOCAL CORDS-PROLARYN GEL

Event	Time In
Procedure Start	
Procedure End	0933

Patient Preparation

Site Prep

Area	Laterality	Scrub	Paint	Hair Removal
	N/A			

Skin Condition

Skin Site	Condition	Comments
Overall	**Warm, Dry, Intact**	

Implants

Implants

IMPLANT LARYN 1ML GEL H2O BASE INJ PROLARYN - LOG614131

Inventory Item: Implant Laryngeal 1ml Gel Water Based Injectable Prolaryn
Serial no.:
Model/Cat no.: 8602M0K5
Implant name: IMPLANT LARYN 1ML GEL H2O BASE INJ PROLARYN - LOG614131
Laterality: N/A
Area: Throat
Manufacturer: Merz Pharmaceuticals LLC
Date of Manufacture:
Action: Implanted
Number Used: 1
Device Identifier: M2138602M0K52
Device Identifier Type: HIBC

Counts by Panel

No counts needed.

Panel 1 Combined Pick List

Medications	Amount	Open	PRN	Total
lidocaine (Xylocaine) injection 1 %	3 mL	1	0	1
oxymetazoline (Afrin) nasal spray 0.05 %	1 spray	0	1	1

Panel 1 Combined Pick List

Item Name	Tmp?	Type	Used	Wstd	Chrg?	Inv Location	Latex?
Catheter Urethral 10fr 3cc Foley 2 Way Silicone		Catheter	1	0	No	OCH OR Case Carts Basement	
Container Specimen 4oz Polypropylene Graduated Screw On Lid Leak Resistant For OR		Patient Care Supply	1	0	No	OCH OR Case Carts Basement	
Cover Mayo Stand 3 Layer		Other	1	0	No	OCH OR Case Carts	

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Case 614131 (continued)

SMS Reicofil Technology Disposable					Basement
Cover Table W44XL90in Polyethylene Universal Disposable	Drape	1	0	No	OCH OR Case Carts Basement
Glove Surgical Polyisoprene Size 7.5 Sterile Powder Free Chemo Biogel PI Ultratouch	Glove	1	0	No	OCH OR Case Carts Basement
Holder Instr Plas Dev 0 Pch Db 070	Instrument	1	0	No	OCH OR Case Carts Basement
Manifold Suction Standard 4 Port For Neptune 3 Waste Management System	Manifold	1	0	No	OCH OR Case Carts Basement
SODIUM CHL 0.9% IRRIG 1L	Solution	1	0	No	OCH OR Case Carts Basement
SYRINGE 10ML LL 200/BX 400/CA	Syringe	1	0	No	OCH OR Case Carts Basement
Solution Antifog Dropper Bottle Devon	Solution	1	0	No	OCH OR Case Carts Basement
Syringe Bulb Asepto 60ml Sterile	Syringe	1	0	No	OCH OR Case Carts Basement
Towel Surgical W17XL27in Standard Blue Cotton Prewashed Delinted Highly Absorbent Disposable	Towel	1	0	No	OCH OR Case Carts Basement
Tube Suction Standard Transparent Rigid With Bulb Tip Ribbed 5in1 Connector Nonvented Yankauer	Tip	1	0	No	OCH OR Case Carts Basement
Tubing Suction L12ft Dia0.25in Universal With Scalloped Female Connector	Tubing	1	0	No	OCH OR Case Carts Basement
Wand Ablation Coblation Triple Wire Active Electrode Malleable Shaft Integrated Saline Suction Port Evac 70XTra	Cautery	1	0	Yes	OCH OR Case Carts Basement

Additional Items

Item Name	Tmp?	Type	Used	Wstd	Chrg?	Inv Location	Latex?
Blanket Therapeutic Warming Pediatric W33XL36in Under Body Drape Full Access Model 55500 Bair Hugger		Patient Care Supply	1	0	No	OCH OR Case Carts Basement	

Notes

Anesthesia Postprocedure Evaluation

Hannah Padgett, MD at 12/16/2024 1138

Author: Hannah Padgett, MD
Filed: 12/16/2024 11:38 AM
Editor: Hannah Padgett, MD (Anesthesiologist)
Service: —
Date of Service: 12/16/2024 11:38 AM
Author Type: Anesthesiologist
Status: Signed

Patient: Parker L Phillips

Procedure Summary

Date: 12/16/24
Anesthesia Start: 0851
Procedures:
ADENOIDECTOMY (Throat)
SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY
INJECTION VOCAL CORDS-PROLARYN GEL
Surgeons: Vikram Ramjee, MD
Anesthesia Type: general

Room / Location: OCH OR 03 / OCH Main OR
Anesthesia Stop: 0957
Diagnosis:
Hypertrophy of adenoids
Dysphagia
(Hypertrophy of adenoids [J35.2])
(Dysphagia [R13.10])
Responsible Provider: Susan Wittman, MD
ASA Status: 2

Anesthesia Type: general

Vitals	Value	Taken Time
BP	93/50	12/16/24 0955
Temp	36.3 °C (97.3 °F)	12/16/24 0954
Pulse	140	12/16/24 1130
Resp	25	12/16/24 1130
SpO2	96 %	12/16/24 1130

POST ANESTHESIA EVALUATION

Perioperative course reviewed.

Patient evaluation in the PACU.

Airway: patent and clear
Hemodynamics: stable
Emergence: smooth
Mental Status: Awake and alert
Analgesia/Pain: Adequately controlled

Nausea/Vomiting: none
Postoperative Hydration: taking oral fluids

Disposition: phase 2 then home

No notable events documented.

Electronically signed by Hannah Padgett, MD at 12/16/2024 11:38 AM

Anesthesia Preprocedure Evaluation

Susan Wittman, MD at 12/16/2024 0835

Author: Susan Wittman, MD | Service: — | Author Type: Anesthesiologist
Filed: 12/16/2024 8:35 AM | Date of Service: 12/16/2024 8:35 AM | Status: Addendum
Editor: Susan Wittman, MD (Anesthesiologist)

Patient: Parker L Phillips

PROCEDURE INFORMATION:

Procedure Information

Date/Time: 12/16/24 0845
Procedures:
ADENOIDECTOMY (Throat)
SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY WITH POSSIBLE INTERVENTION AND WITH INJECTION
Location: OCH OR 03 / OCH Main OR
Surgeons: Vikram Ramjee, MD

NPO STATUS:

Date of Last Liquid: 12/15/24
Time of Last Liquid: 2200
Date of Last Solid: 12/15/24
Time of Last Solid: 2200

HEIGHT:

91cm

WEIGHT:

Current Weights for Phillips, Parker L

Recorded	Adjusted	Ideal
12.6 kg (27 lb 10.7 oz) 27 minutes ago	12.6 kg (27 lb 10.7 oz)	13.5 kg (29 lb 11.9 oz)

VITALS:
SpO2: 98 %

Visit Vitals

BP	**(!) 94/79**
Pulse	130
Temp	36.1 °C (97 °F)
Resp	22

BED:
OR Pool Room/OR Pool Bed

PROBLEMS:
Relevant Problems
Anesthesia (within normal limits)

Cardio (within normal limits)
ECHO on 2/16/22 showed structurally normal heart with small PFO.

Development
PT, OT, speech therapies
(+) Term birth of infant (NICU 12 days for HIE
Delivery was induced 2/8/22 due to prolonged labor with meconium stained amniotic fluid appreciated on delivery. He had low APGARs of 2, 6, and 7 and spells of apnea and leg twitching)

Endo (within normal limits)

GI/Hepatic
(+) Dysphagia (He had a dysphagiagram on 9/17/24 which showed trace silent aspiration of pudding bolus but was difficult attribute this to true dysphagia vs irritability. Per MOC, he aspirates daily on saliva but does not have induced apneic episodes.)

GU/Renal (within normal limits)

Hematology (within normal limits)

Pulmonary (within normal limits)
(-) Recent URI (denies)

Eyes, Ears, Nose, and Throat
5/2/24 sleep study No evidence of clinically significant sleep apnea on this polysomnography
(+) Snoring (nightly snoring and mouth-breathing)

Nervous
(+) Developmental delay
(+) Hypoxic-ischemic encephalopathy, unspecified severity (with neonatal seizures. He has had no further seizures since discharge.)

Infectious/Inflammatory
(+) Chronic rhinitis

Other
(+) Nasal obstruction

Clinical information reviewed:
Tobacco | Allergies | Meds | Problems | Med Hx | Surg Hx | Fam Hx |

2/16/22 ECHO
Summary:
1. Patent foramen ovale, small with a left to right interatrial shunt.
2. Trivial tricuspid valve insufficiency.
3. Trivial mitral valve insufficiency.
4. No patent ductus arteriosus.
5. Normal right ventricular cavity size and systolic function.
6. Normal left ventricular cavity size and systolic function.

PHYSICAL EXAM:
Physical Exam
Cardiovascular: Regular rhythm. Normal rate. No murmur heard.

Neurological:
He has alert, awake and developmentally delayed.
Pulmonary: He has transmitted upper airway sounds (coarse upper airway noise).

Airway: Mallampati class: II. Thyromental distance: TMD less than 6 cm. Mouth opening: Less than 3 cm mouth

opening. Neck range of motion: full.

Dental: unable to assess

ANESTHESIA PLAN:
Anesthesia Plan
ASA 2

general
(TIVA then ETT)
inhalational induction
Premedication planned: acetaminophen and midazolam
Anesthetic plan and risks discussed with father and mother.

EQUIPMENT REQUEST:
Additional Equipment Requests

Electronically signed by Susan Wittman, MD at 12/16/2024 8:35 AM

H&P

Theodore Dickinson Klug, MD at 12/16/2024 0709

Author: Theodore Dickinson Klug, MD
Filed: 12/16/2024 7:10 AM
Editor: Theodore Dickinson Klug, MD (Resident)
Service: Otolaryngology
Date of Service: 12/16/2024 7:09 AM
Author Type: Resident
Status: Signed
Cosigner: Vikram Ramjee, MD at 12/16/2024 7:48 AM

Chief Complaint
PCP **- Derek Landis, MD**
No chief complaint on file.

History Of Present Illness
Parker L Phillips is a 2 y.o. male presenting for SMLB with possible intervention and injection, adenoidectomy.

Past Medical History
He has no past medical history on file.

Surgical History
He has no past surgical history on file.

Family History
No family history on file.

Social History
He reports that he has never smoked. He has never used smokeless tobacco. He reports that he does not drink alcohol and does not use drugs.

Allergies
Patient has no known allergies.

Review of Systems
Negative except as above.

Physical Exam
Constitutional: Well-developed, well nourished
Communication: Normal vocal quality
Head: Normocephalic, atraumatic
Face: No sinus tenderness, salivary glands normal to palpation, normal facial strength
Eyes: Pupils equal, extraocular movements intact, normal alignment
Ears: external ears normal, hearing intact to conversational volume
Nose: No external evidence of trauma, external exam midline, No septal deviation, and No rhinorrhea
Mouth/Throat: tonsils 1+, dentition appropriate for age
Neck: no thyromegaly or neck mass
Lymphatic: no cervical lymphadenopathy
Respiratory: non-labored respirations, no stridor, no retractions
Cardiovascular: no peripheral edema or cyanosis
Neurologic: CNII-XII intact
Chest: Breath sounds clear

Last Recorded Vitals
Blood pressure **(!) 94/79**, pulse 130, temperature 36.1 °C (97 °F), resp. rate 22, height 0.91 m (2' 11.83"), weight 12.5 kg (27 lb 10.7 oz), SpO2 98%.

Assessment/Plan
2 y.o. male presenting for SMLB with possible intervention and injection, adenoidectomy.

- Proceed to OR.

Electronically signed by Theodore Dickinson Klug, MD at 12/16/2024 7:10 AM
Electronically signed by Vikram Ramjee, MD at 12/16/2024 7:48 AM

Handoff

Jessica Fritchie, RN at 12/16/2024 0842

Author: Jessica Fritchie, RN | Service: — | Author Type: Registered Nurse
Filed: 12/16/2024 8:43 AM | Date of Service: 12/16/2024 8:42 AM | Status: Signed

Editor: Jessica Fritchie, RN (Registered Nurse)

Cosigner: Tierra M Sparks, RN at 12/16/2024 9:17 AM

I - Illness Severity

Severity: Stable
Code Status: No Order

P - Patient Summary

Allergies

Allergen	Reactions
• Other *Ranch Dressing*	Hives

Reason for Admission

ED - Chief Complaint: No chief complaint on file.

Patient Active Problem List

Diagnosis

- Dysphagia
- Nasal obstruction
- Snoring
- Chronic rhinitis
- Hypoxic-ischemic encephalopathy, unspecified severity
- Developmental delay
- Term birth of infant

Inpatient - Principal Problem: No Principal Problem: There is no principal problem currently on the Problem List. Please update the Problem List and refresh.
Significant Events by Date(free text):
Attending Provider: Vikram Ramjee, MD

Encounter Surgical Hx

Surgeries within this encounter: Procedure(s) (LRB):
ADENOIDECTOMY (N/A)
SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY WITH POSSIBLE INTERVENTION AND WITH INJECTION (N/A)

Focused Assessments

Surgical Dressings

Assessments needed following transfer (free text):

Vitals:

	12/16/24 0700
BP:	**(!) 94/79**

Pulse:	130
Resp:	22
Temp:	36.1 °C (97 °F)
SpO2:	98%

Pain

Pain Score

	12/16/24 0719
Pain Management Interventions:	pain management plan reviewed with patient/caregiver

Aldrete Score

Aldrete Score

	12/16/24 0718
Activity:	Able to move 4 extremities voluntarily or on command
Respiration:	Able to breathe deeply and cough freely
Circulation:	Blood pressure is plus or minus 20% of pre-anesthetic level
Consciousness:	Fully awake
Oxygen Saturation:	Able to maintain oxygen saturation greater than 92% on room air
Modified Aldrete Score:	10

I/O

No intake or output data in the 24 hours ending 12/16/24 0843

EBL

No data recorded

Orders Discussed(free text): preop meds

IV Access

Medications

Current infusions:

Currently Infusing

None

Pain meds last 12 hr:

Pain Meds (last 12 hours)

Date/Time	Action	Medication	Dose
12/16/24 0809	Given	acetaminophen (Tylenol) 32 MG/ML solution/suspension solution 188.9163 mg	188.9163 mg

Abnormal Results
Abnormal Labs results (free text):
Abnormal Imaging results (free text):

Mobility (free text) ambulatory

A - Action Items - To Do List
Has admitting provider seen the patient? has been seen by provider

S - Situation Awareness and Contingency Planning
Family
Family Present? patient, mother, and father
Family Special Requests?

Safety
Patient Hold? N/A
Suicide Risk?
Isolation? No active isolations

Fall Risk?
Low Fall Risk

S - Synthesis by Receiver/Teach Back

Handoff given by: Jessica Fritchie, RN
Handoff received by: Tierra, OR RN

Electronically signed by Jessica Fritchie, RN at 12/16/2024 8:43 AM
Electronically signed by Tierra M Sparks, RN at 12/16/2024 9:17 AM

Tierra M Sparks, RN at 12/16/2024 0908

Author: Tierra M Sparks, RN
Filed: 12/16/2024 9:51 AM
Editor: Tierra M Sparks, RN (Registered Nurse)
Service: —
Date of Service: 12/16/2024 9:08 AM
Author Type: Registered Nurse
Status: Signed
Cosigner: Kenzi E Griffin, RN at 12/16/2024 11:22 AM

I - Illness Severity

Severity: Stable
Code Status: No Order

P - Patient Summary

Allergies

Allergen	Reactions
• Other *Ranch Dressing*	Hives

Reason for Admission
ED - Chief Complaint: No chief complaint on file.

Patient Active Problem List

Diagnosis

- Dysphagia
- Nasal obstruction
- Snoring
- Chronic rhinitis
- Hypoxic-ischemic encephalopathy, unspecified severity
- Developmental delay
- Term birth of infant

Inpatient - Principal Problem: No Principal Problem: There is no principal problem currently on the Problem List. Please update the Problem List and refresh.
Significant Events by Date(free text):
Attending Provider: Vikram Ramjee, MD

Encounter Surgical Hx
Surgeries within this encounter: Procedure(s) (LRB):
ADENOIDECTOMY (N/A)
SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY (N/A)
INJECTION VOCAL CORDS (N/A)

Focused Assessments
Surgical Dressings

Assessments needed following transfer (free text):

Vitals:

	12/16/24 0700
BP:	**(!) 94/79**
Pulse:	130
Resp:	22
Temp:	36.1 °C (97 °F)

SpO2:	98%

Pain

Pain Score

	12/16/24 0719
Pain Management Interventions:	pain management plan reviewed with patient/caregiver

Aldrete Score

Aldrete Score

	12/16/24 0718
Activity:	Able to move 4 extremities voluntarily or on command
Respiration:	Able to breathe deeply and cough freely
Circulation:	Blood pressure is plus or minus 20% of pre-anesthetic level
Consciousness:	Fully awake
Oxygen Saturation:	Able to maintain oxygen saturation greater than 92% on room air
Modified Aldrete Score:	10

I/O

No intake or output data in the 24 hours ending 12/16/24 0908

EBL

No data recorded

Orders Discussed(free text):

IV Access

Peripheral IV 12/16/24 Left;Posterior (Active)

Placement Date: 12/16/24 Hand Hygiene Completed: Yes Size (Gauge): 24 G Orientation: Left;Posterior Location: Hand Site Prep: Alcohol Technique: Anatomical landmarks

Medications

Current infusions:

Currently Infusing

None

Pain meds last 12 hr:

Pain Meds (last 12 hours)

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Case 614131 (continued)

Date/Time	Action	Medication	Dose
12/16/24 0907	Given	lidocaine (Xylocaine) 1 % injection	3 mL
12/16/24 0809	Given	acetaminophen (Tylenol) 32 MG/ML solution/suspension solution 188.9163 mg	188.9163 mg

Abnormal Results
Abnormal Labs results (free text):
Abnormal Imaging results (free text):

Mobility (free text) WNL

A - Action Items - To Do List
Has admitting provider seen the patient? has been seen by provider

S - Situation Awareness and Contingency Planning
Family
Family Present? parents
Family Special Requests?

Safety
Patient Hold? N/A
Suicide Risk?
Isolation? No active isolations

Fall Risk?
Low Fall Risk

S - Synthesis by Receiver/Teach Back

Handoff given by: SPARKS, TIERRA OR RN
Handoff received by: GRIFFIN, KENZI PACU RN

Electronically signed by Tierra M Sparks, RN at 12/16/2024 9:51 AM
Electronically signed by Kenzi E Griffin, RN at 12/16/2024 11:22 AM

Kenzi E Griffin, RN at 12/16/2024 1141

Author: Kenzi E Griffin, RN
Filed: 12/16/2024 11:44 AM
Editor: Kenzi E Griffin, RN (Registered Nurse)
Service: —
Date of Service: 12/16/2024 11:41 AM
Author Type: Registered Nurse
Status: Signed
Cosigner: Sara Russell, RN at 12/16/2024 11:54 AM

I - Illness Severity

Severity: Stable

Code Status: No Order

P - Patient Summary

Allergies

Allergen	Reactions
• Other *Ranch Dressing*	Hives

Reason for Admission

ED - Chief Complaint: No chief complaint on file.

Patient Active Problem List

Diagnosis

- Dysphagia
- Nasal obstruction
- Snoring
- Chronic rhinitis
- Hypoxic-ischemic encephalopathy, unspecified severity
- Developmental delay
- Term birth of infant

Inpatient - Principal Problem: No Principal Problem: There is no principal problem currently on the Problem List. Please update the Problem List and refresh.

Significant Events by Date(free text):

Attending Provider: Vikram Ramjee, MD

Encounter Surgical Hx

Surgeries within this encounter: Procedure(s) (LRB):
ADENOIDECTOMY (N/A)
SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY (N/A)
INJECTION VOCAL CORDS-PROLARYN GEL (N/A)

Focused Assessments

Surgical Dressings

Wound 12/16/24 Other (comment) Throat (Active)

Site Assessment	Unable to assess	12/16/24 0954
Peri-Wound Assessment	Unable to assess	12/16/24 0954

Assessments needed following transfer (free text):

Vitals:

	12/16/24 1130

BP:	
Pulse:	140
Resp:	25
Temp:	36 °C (96.8 °F)
SpO2:	96%

Pain

Pain Score

	12/16/24 1049	12/16/24 1100	12/16/24 1115	12/16/24 1130
Pain Assessment:		FLACC	FLACC	FLACC
Pain Management Interventions:	pain management plan reviewed with patient/caregiver;pain medication given			

Aldrete Score

Aldrete Score

	12/16/24 0718	12/16/24 0954	12/16/24 1015
Activity:	Able to move 4 extremities voluntarily or on command	Able to move 4 extremities voluntarily or on command	Able to move 4 extremities voluntarily or on command
Respiration:	Able to breathe deeply and cough freely	Able to breathe deeply and cough freely	Able to breathe deeply and cough freely
Circulation:	Blood pressure is plus or minus 20% of pre-anesthetic level	Blood pressure is plus or minus 20% of pre-anesthetic level	Blood pressure is plus or minus 20% of pre-anesthetic level
Consciousness:	Fully awake	Arousable on calling	Fully awake
Oxygen Saturation:	Able to maintain oxygen saturation greater than 92% on room air	Needs oxygen inhalation to maintain oxygen saturation greater that 90%	Able to maintain oxygen saturation greater than 92% on room air
Modified Aldrete Score:	10	8	10

I/O

Intake/Output Summary (Last 24 hours) at 12/16/2024 1143
Last data filed at 12/16/2024 1100

	Gross per 24 hour
Intake	270.4 ml
Output	—
Net	**270.4 ml**

EBL

No data recorded

Orders Discussed(free text): reviewed with phase 2

IV Access

Medications

Current infusions:

Currently Infusing

None

Pain meds last 12 hr:

Pain Meds (last 12 hours)

Date/Time	Action	Medication	Dose
12/16/24 1045	Given	morphine PF 2 MG/ML 0.6 mg	0.6 mg
12/16/24 1022	Given	fentaNYL (PF) (Sublimaze) 10 mcg/mL injection 6.3 mcg	6.3 mcg
12/16/24 1004	Given	fentaNYL (PF) (Sublimaze) 10 mcg/mL injection 6.3 mcg	6.3 mcg
12/16/24 0907	Given	lidocaine (Xylocaine) 1 % injection	3 mL
12/16/24 0809	Given	acetaminophen (Tylenol) 32 MG/ML solution/suspension solution 188.9163 mg	188.9163 mg

Abnormal Results

Abnormal Labs results (free text):

Abnormal Imaging results (free text):

Mobility (free text) able to move all 4 extremities

A - Action Items - To Do List

Has admitting provider seen the patient? has been seen by provider Signed out by Dr. Padgett

S - Situation Awareness and Contingency Planning

Family

Family Present? mother and father

Family Special Requests?

Safety

Patient Hold? N/A

Suicide Risk?
Isolation? No active isolations

Fall Risk?
Low Fall Risk

S - Synthesis by Receiver/Teach Back

Handoff given by: Kenzi RN
Handoff received by: Sara RN

Electronically signed by Kenzi E Griffin, RN at 12/16/2024 11:44 AM
Electronically signed by Sara Russell, RN at 12/16/2024 11:54 AM

Op Note

Vikram Ramjee, MD at 12/16/2024 0851

Author: Vikram Ramjee, MD | Service: Otolaryngology | Author Type: Physician
Filed: 12/16/2024 9:25 AM | Date of Service: 12/16/2024 8:51 AM | Status: Signed
Editor: Vikram Ramjee, MD (Physician)

ADENOIDECTOMY, SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY WITH POSSIBLE INTERVENTION AND WITH INJECTION, INJECTION VOCAL CORDS Operative Note

Date: 12/16/2024 **Location:** OCH Main OR

Name: Parker L Phillips, **DOB:** 2/8/2022, **MRN:** 1001652520

Preprocedure Diagnosis
Pre-op Diagnosis
* Hypertrophy of adenoids [J35.2]
* Dysphagia [R13.10]
Silent aspiration

Posptprocedure Diagnosis
Post-op Diagnosis
* Hypertrophy of adenoids [J35.2]
* Dysphagia [R13.10]
Silent aspiration

Procedures
1. Microdirect laryngoscopy (CPT 31526)
2. Rigid bronchoscopy (CPT 31622)
3. Injection laryngoplasty for deep interarytenoid groove (CPT 31571)
4. Adenoidectomy <12 years of age (CPT 42830)

Surgeons

* Vikram Ramjee - Primary
* Raquel Querido - Resident - Assisting

Procedure Summary

Anesthesia: General
Estimated Blood Loss: Minimal
Total IV Fluids: 100 mL
Total Urine Output: None
Drains: * None in log *
Staff:
Circulator: Tierra M Sparks, RN
Scrub Person: Gregory Deon Brown

Indications: Parker L Phillips is an 2 y.o. male who is having surgery for Hypertrophy of adenoids [J35.2] Dysphagia [R13.10]. The risks and benefits of performing a microdirect laryngoscopy and bronchoscopy were discussed in detail and his family wished to proceed. Informed consent was obtained. The details of surgery and risks including pain, scarring, bleeding, infection, and velopharyngeal dysfunction were discussed with his family who agrees to proceed.

Procedure Details:
The patient was seen in the preoperative area. The risks, benefits, complications, treatment options, non-operative alternatives, expected recovery and outcomes were discussed with the patient. The possibilities of reaction to medication, pulmonary aspiration, injury to surrounding structures, bleeding, recurrent infection, the need for additional procedures, failure to diagnose a condition, and creating a complication requiring transfusion or operation were discussed with the patient. The patient concurred with the proposed plan, giving informed consent. The site of surgery was properly noted/marked if necessary per policy. The patient has been actively warmed in preoperative area. Preoperative antibiotics are not indicated. Venous thrombosis prophylaxis are not indicated.

Description of procedure: The patient was transported to the operating room. Patient identification and the procedure were confirmed according to institutional protocol. He was transferred to the operating table in the supine position. Care was transitioned to Anesthesiology for induction of general anesthesia, which occurred without incident. The eyes were taped and padded. A preoperative safety timeout was performed according to institutional protocol. The table was turned 90 degrees to the right and the patient was mask ventilated.

A tooth guard was placed to protect the maxillary dentition. A Parsons 2 laryngoscope was carefully inserted into the mouth and advanced into the vallecula, resulting in a Grade 1 view. 1% lidocaine was applied as topical laryngotracheal anesthesia by ENT. Microdirect laryngoscopy was performed including a microscopic examination of the oropharynx, hypopharynx, supraglottis, and glottis using a 4 mm 0-degree endoscope. Rigid bronchoscopy was then performed including a microscopic examination of the subglottis, trachea, mainstem bronchi, and secondary bronchi using a 4 mm 0-degree endoscope. This examination was significant for the below listed findings. The patient was placed into suspension and using a 90 degree probe a deep interarytenoid groove was noted and injected with 0.2 mL Prolaryn gel with good ablation noted. The patient was then intubated by the ENT team with a 4.0 cuffed ETT. Photodocumentation was obtained. The endoscope and tooth guard were carefully removed. The teeth were inspected and there was no evidence of dental injury.

The Crowe-Davis mouth retractor placed in the oral cavity. The palate was palpated with no evidence of a submucous cleft palate. A Foley catheter was placed for retraction of the palate and uvula. A laryngeal mirror was used to visualize

the adenoids, and an adenoidectomy was performed using the Coblator. The nasopharynx and oropharynx were irrigated with saline, and an orogastric tube placed for removal of stomach and pharyngeal contents.

Care was transitioned to Anesthesiology for emergence from general anesthesia, which occurred in the operating room without incident. The patient tolerated the procedure well and there were no complications. He was transported to PACU in stable condition.

Dr. Vikram Ramjee was present and participated in the entirety of the procedure.

Findings:
Laryngeal Exposure:
1. Exposure of Larynx: Parsons 2, grade 1 view
2. Patient position and/or special maneuvers: shoulder roll

Findings:
1. Supraglottis: Normal
2. Glottis: Normal, deep interarytenoid groove noted and injected with 0.2 mL Prolaryn gel
3. Subglottis: Easily fit 4.0 cuffed ETT with leak present at 20 cm H2O
4. Upper trachea: Normal
5. Mid-trachea: Normal
6. Lower trachea: Normal
7. Right bronchus: Normal
8. Left bronchus: Normal
9. 75% adenoid obstruction

Emergency Airway Classification:
1. Bag / Mask from above: Yes
2. LMA from above: Yes
3. Able to intubate from above: Yes
4. Tracheostomy is only airway: N/A

Complications: None; patient tolerated the procedure well.
Disposition: PACU - hemodynamically stable.
Condition: stable

Vikram Ramjee
Phone Number: 405-271-5504

Electronically signed by Vikram Ramjee, MD at 12/16/2024 9:25 AM

Perioperative Nursing Note

Tierra M Sparks, RN at 12/16/2024 0907

Author: Tierra M Sparks, RN | Service: — | Author Type: Registered Nurse
Filed: 12/16/2024 9:55 AM | Date of Service: 12/16/2024 9:07 AM | Status: Signed
Editor: Tierra M Sparks, RN (Registered Nurse)

EASE APP UPDATES @:
0844/0903/0908/0939/0954

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Case 614131 (continued)

Electronically signed by Tierra M Sparks, RN at 12/16/2024 9:55 AM

SmartForms

PRE-OP: NURSES	POST-OP: NURSES
Jessica Fritchie, RN	Kenzi E Griffin, RN
	PHASE II: NURSES
	Sara Russell, RN

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Anesthesia on 12/16/24

Anesthesia Information

Anesthesia Summary - Phillips, Parker L [1001652520] Male 2 y.o. Current as of 12/16/24 0835

Height: 0.91 m (2' 11.83") (12/16/24)
Weight: 12.5 kg (27 lb 10.7 oz) (12/16/24)
BMI: 15.16 (12/16/24)
NPO Status: 2200
Allergies: OTHER

Procedure Summary

Date: 12/16/24
Anesthesia Start: 0851
Procedures:
ADENOIDECTOMY (Throat)
SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY
INJECTION VOCAL CORDS-PROLARYN GEL
Surgeons: Vikram Ramjee, MD
Anesthesia Type: general

Room / Location: OCH OR 03 / OCH Main OR
Anesthesia Stop: 0957
Diagnosis:
Hypertrophy of adenoids
Dysphagia
(Hypertrophy of adenoids [J35.2])
(Dysphagia [R13.10])
Responsible Provider: Susan Wittman, MD
ASA Status: 2

Responsible Staff

12/16/24

Name	Role	Begin	End
Susan Wittman, MD	ANESTH	0851	0957
Garrett Michael Eakers, MD	ARESD	0851	0957

Events

Date	Time	Event
12/16/2024	0835	Ready for Procedure
	0851	Anesthesia Start
	0851	Patient in Room
	0851	Start Data Collection Standard monitors placed.
	0854	Pediatric Induction Inhalation induction performed with Nitrous Oxide and Sevoflurane progressively increased.
	0854	Patient preoxygenated
	0857	Eyes taped prior to intubation
	0859	IV Placement
	0900	Anesthesia Ready
	0900	Positioning
	0903	Procedure Start
	0914	Intubation/Airway Placed
	0930	Memo ETT crimped a little at first and then more and more. Surgeon asked to stop and ETT uncrimped with immediate return to excellent oxygenation
	0933	Procedure Finish
	0946	Pharynx Suctioned
	0947	PED Extubation/Airway Removed Adequate neuromuscular recovery demonstrated. Patient stable and spontaneously ventilating.
	0949	Stop Data Collection
	0951	Patient Out of Room
	0956	Handoff to Receiving Clinician

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Anesthesia on 12/16/24 (continued)

I completed my handoff to the receiving clinician during which we:
1. Identified the patient
2. Identified the responsible provider
3. Reviewed the pertinent medical history
4. Discussed the surgical course
5. Reviewed intra-op anesthesia management and issues during anesthesia
6. Set expectations for post-procedure period
7. Allowed opportunity for questions and acknowledgement of understanding.

0957 Anesthesia Stop

Attestation Information

Staff Name	Date	Time	Type
Jessica Fritchie, RN	12/16/24	0728	Pre-Op
Tierra M Sparks, RN	12/16/24	0951	Intra-Op
Susan Wittman, MD	12/16/24	0957	Full Attestation
I was present for induction. I was present during the most demanding portions. I monitored the anesthetic course at intervals. I was immediately available for emergencies. I ensured that a qualified anesthesia provider was in attendance for the duration of the anesthetic. I reviewed the post anesthesia orders.			
Kenzi E Griffin, RN	12/16/24	1144	Phase I
Sara Russell, RN	12/16/24	1219	Phase II

Medications

propofol (Diprivan) infusion 10 mg/mL - OSM MED (mcg/kg/min) Dosing weight: 12.5

Date/Time	Rate/Dose/Volume	Action	Route	Admin User
12/16/24 0859	250 mcg/kg/min - 18.75 mL/hr	New Bag	Intravenous	Garrett Michael Eakers, MD
0905	300 mcg/kg/min - 22.5 mL/hr	Rate Change	Intravenous	Garrett Michael Eakers, MD
0907	12 mg	Given	Intravenous	Garrett Michael Eakers, MD
0908	6 mg	Given	Intravenous	Garrett Michael Eakers, MD
0911	250 mcg/kg/min - 18.75 mL/hr	Rate Change	Intravenous	Garrett Michael Eakers, MD
0914	6 mg	Given	Intravenous	Garrett Michael Eakers, MD
0919	9.2 mL	Stopped	Intravenous	Garrett Michael Eakers, MD
0950	12 mg - 1.2 mL	Given	Intravenous	Garrett Michael Eakers, MD

dexamethasone (Decadron) injection 4 mg/mL (mg)

Date/Time	Rate/Dose/Volume	Action	Route	Admin User
12/16/24 0903	6 mg	Given	Intravenous	Garrett Michael Eakers, MD

morphine PF injection 2 mg/mL (mg)

Date/Time	Rate/Dose/Volume	Action	Route	Admin User
12/16/24 0923	0.6 mg	Given	Intravenous	Garrett Michael Eakers, MD

ondansetron (Zofran) 2 mg/mL injection (mg)

Date/Time	Rate/Dose/Volume	Action	Route	Admin User
12/16/24 0923	1.8 mg	Given	Intravenous	Garrett Michael Eakers, MD

lactated Ringer's infusion (mL)

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Anesthesia on 12/16/24 (continued)

Date/Time	Rate/Dose/Volume	Action	Route	Admin User
12/16/24 0900		New Bag	Intravenous	Garrett Michael Eakers, MD
0951	250 mL	Stopped	Intravenous	Garrett Michael Eakers, MD

Preprocedure Signoff

Ready for Procedure: Susan Wittman, MD on 12/16/24 at 0835
Reviewed: Susan Wittman, MD on 12/16/24 at 0835
Reviewed: Susan Wittman, MD on 12/14/24 at 2336

Signoff Status

None

Notes

Anesthesia Postprocedure Evaluation

Hannah Padgett, MD at 12/16/2024 1138

Author: Hannah Padgett, MD | Service: — | Author Type: Anesthesiologist
Filed: 12/16/2024 11:38 AM | Date of Service: 12/16/2024 11:38 AM | Status: Signed
Editor: Hannah Padgett, MD (Anesthesiologist)

Patient: Parker L Phillips

Procedure Summary

Date: 12/16/24
Anesthesia Start: 0851
Procedures:
ADENOIDECTOMY (Throat)
SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY
INJECTION VOCAL CORDS-PROLARYN GEL
Surgeons: Vikram Ramjee, MD
Anesthesia Type: general

Room / Location: OCH OR 03 / OCH Main OR
Anesthesia Stop: 0957
Diagnosis:
Hypertrophy of adenoids
Dysphagia
(Hypertrophy of adenoids [J35.2])
(Dysphagia [R13.10])
Responsible Provider: Susan Wittman, MD
ASA Status: 2

Anesthesia Type: general

Vitals	Value	Taken Time
BP	93/50	12/16/24 0955
Temp	36.3 °C (97.3 °F)	12/16/24 0954
Pulse	140	12/16/24 1130
Resp	25	12/16/24 1130
SpO2	96 %	12/16/24 1130

POST ANESTHESIA EVALUATION

Perioperative course reviewed.

Patient evaluation in the PACU.

Airway: patent and clear
Hemodynamics: stable
Emergence: smooth
Mental Status: Awake and alert
Analgesia/Pain: Adequately controlled

Nausea/Vomiting: none
Postoperative Hydration: taking oral fluids

Disposition: phase 2 then home

No notable events documented.

Electronically signed by Hannah Padgett, MD at 12/16/2024 11:38 AM

Anesthesia Preprocedure Evaluation

Susan Wittman, MD at 12/16/2024 0835

Author: Susan Wittman, MD | Service: — | Author Type: Anesthesiologist
Filed: 12/16/2024 8:35 AM | Date of Service: 12/16/2024 8:35 AM | Status: Addendum
Editor: Susan Wittman, MD (Anesthesiologist)

Patient: Parker L Phillips

PROCEDURE INFORMATION:

Procedure Information

Date/Time: 12/16/24 0845
Procedures:
ADENOIDECTOMY (Throat)
SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY WITH POSSIBLE INTERVENTION AND WITH INJECTION
Location: OCH OR 03 / OCH Main OR
Surgeons: Vikram Ramjee, MD

NPO STATUS:
Date of Last Liquid: 12/15/24
Time of Last Liquid: 2200
Date of Last Solid: 12/15/24
Time of Last Solid: 2200

HEIGHT:
91cm

WEIGHT:
Current Weights for Phillips, Parker L

Recorded	Adjusted	Ideal
12.6 kg (27 lb 10.7 oz) 27 minutes ago	12.6 kg (27 lb 10.7 oz)	13.5 kg (29 lb 11.9 oz)

VITALS:
SpO2: 98 %

Visit Vitals

BP	**(!) 94/79**
Pulse	130
Temp	36.1 °C (97 °F)
Resp	22

BED:
OR Pool Room/OR Pool Bed

PROBLEMS:
Relevant Problems
Anesthesia (within normal limits)

Cardio (within normal limits)
ECHO on 2/16/22 showed structurally normal heart with small PFO.

Development
PT, OT, speech therapies
(+) Term birth of infant (NICU 12 days for HIE
Delivery was induced 2/8/22 due to prolonged labor with meconium stained amniotic fluid appreciated on delivery. He had low APGARs of 2, 6, and 7 and spells of apnea and leg twitching)

Endo (within normal limits)

GI/Hepatic
(+) Dysphagia (He had a dysphagiagram on 9/17/24 which showed trace silent aspiration of pudding bolus but was difficult attribute this to true dysphagia vs irritability. Per MOC, he aspirates daily on saliva but does not have induced apneic episodes.)

GU/Renal (within normal limits)

Hematology (within normal limits)

Pulmonary (within normal limits)
(-) Recent URI (denies)

Eyes, Ears, Nose, and Throat
5/2/24 sleep study No evidence of clinically significant sleep apnea on this polysomnography
(+) Snoring (nightly snoring and mouth-breathing)

Nervous
(+) Developmental delay
(+) Hypoxic-ischemic encephalopathy, unspecified severity (with neonatal seizures. He has had no further seizures since discharge.)

Infectious/Inflammatory
(+) Chronic rhinitis

Other
(+) Nasal obstruction

Clinical information reviewed:
Tobacco | Allergies | Meds | Problems | Med Hx | Surg Hx |

Fam Hx |

2/16/22 ECHO
Summary:
1. Patent foramen ovale, small with a left to right interatrial shunt.
2. Trivial tricuspid valve insufficiency.
3. Trivial mitral valve insufficiency.
4. No patent ductus arteriosus.
5. Normal right ventricular cavity size and systolic function.
6. Normal left ventricular cavity size and systolic function.

PHYSICAL EXAM:
Physical Exam
Cardiovascular: Regular rhythm. Normal rate. No murmur heard.

Neurological:
He has alert, awake and developmentally delayed.
Pulmonary: He has transmitted upper airway sounds (coarse upper airway noise).

Airway: Mallampati class: II. Thyromental distance: TMD less than 6 cm. Mouth opening: Less than 3 cm mouth opening. Neck range of motion: full.

Dental: unable to assess

ANESTHESIA PLAN:
Anesthesia Plan
ASA 2

general
(TIVA then ETT)
inhalational induction
Premedication planned: acetaminophen and midazolam
Anesthetic plan and risks discussed with father and mother.

EQUIPMENT REQUEST:
Additional Equipment Requests

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Anesthesia on 12/16/24 (continued)

Electronically signed by Susan Wittman, MD at 12/16/2024 8:35 AM

Flowsheets

Agents

Row Name	12/16/24 0949
Agents	
O2	0 L/min Simultaneous filing. User may not have seen previous data.
Inspired O2 Setting	0 %
Expired O2 Setting	0 %

Anesthesia Checklist

Row Name	Anesthesia from 12/16/2024 in Oklahoma Childrens Hospital with Susan Wittman, MD
Anesthesia Checklist	
Anesthesia Checklist	Anesthesia apparatus checked;Blood pressure cuff;Patient/guardian confirmed identity;Patient/guardian confirmed procedure, site and consent;Pulse oximeter;Reviewed allergies;Reviewed airway and blood loss risk
NIBP Site	Arm R
Cardiac	ECG
Leads	3

Anesthesia Device Data

Row Name	12/16/24 0853	12/16/24 0854	12/16/24 0855	12/16/24 0856	12/16/24 0857
Agents					
O2	5 L/min	5 L/min	5 L/min	4 L/min	4 L/min
N2O	5 L/min	5 L/min	5 L/min	0 L/min	—
Expired Sevoflurane	0 %	2.5 %	5.5 %	5.8 %	6 %
Expired N2O	49 %	34 %	43 %	14 %	4 %
Inspired Sevoflurane	0 %	4.2 %	6.2 %	5.9 %	6 %
Inspired N2O	49 %	44 %	46 %	6 %	2 %

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Anesthesia on 12/16/24 (continued)

Inspired O2 Setting	51 %	50 %	48 %	87 %	92 %
Expired O2 Setting	51 %	44 %	46 %	76 %	87 %
Respiratory					
Tidal (Observed)	—	87 mL	18 mL	84 mL	51 mL
Inspired Minute Volume	—	6.4 L/min	3.7 L/min	4.8 L/min	4.6 L/min
Expired Minute Volume	—	1.5 L/min	1.4 L/min	2.6 L/min	3.3 L/min
PIP Observed	1 cm H2O	4 cm H2O	2 cm H2O	15 cm H2O	14 cm H2O
PEEP/CPAP	5 cm H20	5 cm H20	5 cm H20	5 cm H20	5 cm H20
MAC	0.5	1.6	3.1	3	3
Core Vitals/Respiratory					
Pulse	155 bpm	148 bpm	149 bpm	159 bpm	159 bpm
SpO2	100 %	99 %	100 %	100 %	100 %
Resp Rate (Set)	16	16	16	16	16
Resp Observed	—	19	22	34	49
Anesthesia Monitoring					
Temp	**25.4 °C (77.7 °F)** !	34.1 °C (93.4 °F)	34.9 °C (94.8 °F)	36.5 °C (97.7 °F)	37.4 °C (99.3 °F)
ETCO2	**0 mmHg** !	31 mmHg	21 mmHg	25 mmHg	13 mmHg
FiO2 (%)	51 %	49 %	48 %	87 %	90 %
Other Vitals					
HR (ECG)	—	151 bpm	—	154 bpm	157 bpm
Cumulative Agents					
Cumulative Desflurane (mL of Liquid)	0 mL	0 mL	—	0 mL	—
Cumulative Isoflurane (mL of Liquid)	0 mL	0 mL	—	0 mL	—
Cumulative Sevoflurane (mL of Liquid)	0 mL	1 mL	—	8 mL	—
Cumulative N2O (L of Gas)	1 L	6 L	—	14 L	—
Cumulative Air (L of Gas)	0 L	0 L	—	0 L	—
Nitric Oxide					
iCO2	0	0	0	1	1
Row Name	**12/16/24 0858**	**12/16/24 0859**	**12/16/24 0900**	**12/16/24 0901**	**12/16/24 0902**
Agents					
O2	4 L/min	4 L/min	4 L/min	4 L/min	4 L/min
Expired Sevoflurane	4.5 %	4.1 %	4.3 %	4.3 %	4.6 %
Expired N2O	4 %	4 %	3 %	2 %	1 %
Inspired Sevoflurane	4.7 %	4.4 %	5 %	4.6 %	5 %
Inspired N2O	0 %	0 %	0 %	0 %	0 %
Inspired O2 Setting	95 %	95 %	95 %	96 %	96 %
Expired O2 Setting	89 %	82 %	88 %	88 %	91 %
Respiratory					
Tidal (Observed)	61 mL	27 mL	13 mL	27 mL	12 mL
Inspired Minute Volume	2.5 L/min	1.4 L/min	1.2 L/min	2.7 L/min	1.2 L/min

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Anesthesia on 12/16/24 (continued)

Expired Minute Volume	1.8 L/min	1.1 L/min	1 L/min	1 L/min	0.2 L/min
PIP Observed	7 cm H2O	5 cm H2O	7 cm H2O	7 cm H2O	1 cm H2O
PEEP/CPAP	5 cm H20	5 cm H20	5 cm H20	5 cm H20	5 cm H20
MAC	2.2	2	2.1	2.1	2.3
Core Vitals/Respiratory					
NIBP	—	—	—	—	**75/37** !
NIBP (Mean)	—	—	—	—	50 mmHg
Pulse	138 bpm	138 bpm	140 bpm	137 bpm	136 bpm
SpO2	100 %	100 %	100 %	100 %	100 %
Resp Rate (Set)	16	16	16	16	16
Resp Observed	50	41	31	27	6
Anesthesia Monitoring					
Temp	38 °C (100.4 °F)	38.2 °C (100.8 °F)	38.3 °C (100.9 °F)	38.4 °C (101.1 °F)	38.1 °C (100.6 °F)
ETCO2	21 mmHg	32 mmHg	28 mmHg	26 mmHg	19 mmHg
FiO2 (%)	95 %	95 %	96 %	96 %	96 %
Other Vitals					
HR (ECG)	141 bpm	136 bpm	134 bpm	136 bpm	135 bpm
Cumulative Agents					
Cumulative Desflurane (mL of Liquid)	0 mL	0 mL	—	0 mL	0 mL
Cumulative Isoflurane (mL of Liquid)	0 mL	0 mL	—	0 mL	0 mL
Cumulative Sevoflurane (mL of Liquid)	10 mL	11 mL	—	14 mL	15 mL
Cumulative N2O (L of Gas)	14 L	14 L	—	14 L	14 L
Cumulative Air (L of Gas)	0 L	0 L	—	0 L	0 L
Nitric Oxide					
iCO2	1	2	0	1	—
Row Name	**12/16/24 0903**	**12/16/24 0904**	**12/16/24 0905**	**12/16/24 0906**	**12/16/24 0907**
Agents					
O2	4 L/min	4 L/min	4 L/min	4 L/min	4 L/min
Expired Sevoflurane	4.5 %	1.3 %	0.8 %	0.8 %	0.6 %
Expired N2O	2 %	1 %	2 %	2 %	1 %
Inspired Sevoflurane	5 %	0.9 %	0.2 %	0.2 %	0.1 %
Inspired N2O	0 %	0 %	0 %	0 %	0 %
Inspired O2 Setting	96 %	100 %	—	—	—
Expired O2 Setting	91 %	95 %	93 %	93 %	89 %
Respiratory					
Tidal (Observed)	71 mL	10 mL	28 mL	48 mL	100 mL
Inspired Minute Volume	1.2 L/min	0.2 L/min	0.9 L/min	1.6 L/min	2.1 L/min
Expired Minute Volume	0.7 L/min	0.4 L/min	0.9 L/min	1.7 L/min	1.8 L/min
PIP Observed	9 cm H2O	1 cm H2O	2 cm H2O	2 cm H2O	3 cm H2O
PEEP/CPAP	5 cm H20	5 cm H20	5 cm H20	5 cm H20	5 cm H20
MAC	2.2	0.6	0.4	0.4	0.3
Core Vitals/Respiratory					

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Anesthesia on 12/16/24 (continued)

Pulse	133 bpm	132 bpm	132 bpm	130 bpm	170 bpm
SpO2	100 %	100 %	100 %	100 %	100 %
Resp Rate (Set)	16	16	16	16	16
Resp Observed	28	29	50	41	25
Anesthesia Monitoring					
Temp	37.8 °C (100 °F)	37.7 °C (99.9 °F)	37.6 °C (99.7 °F)	37.6 °C (99.7 °F)	37.7 °C (99.9 °F)
ETCO2	19 mmHg	17 mmHg	28 mmHg	35 mmHg	40 mmHg
FiO2 (%)	96 %	100 %	—	—	—
Other Vitals					
HR (ECG)	134 bpm	131 bpm	132 bpm	130 bpm	171 bpm
Cumulative Agents					
Cumulative Desflurane (mL of Liquid)	0 mL	—	0 mL	0 mL	0 mL
Cumulative Isoflurane (mL of Liquid)	0 mL	—	0 mL	0 mL	0 mL
Cumulative Sevoflurane (mL of Liquid)	16 mL	—	16 mL	16 mL	16 mL
Cumulative N2O (L of Gas)	14 L	—	14 L	14 L	14 L
Cumulative Air (L of Gas)	0 L	—	0 L	0 L	0 L
Nitric Oxide					
iCO2	0	1	1	1	0

Row Name	**12/16/24 0908**	**12/16/24 0909**	**12/16/24 0910**	**12/16/24 0911**	**12/16/24 0912**
Agents					
O2	4 L/min	4 L/min	4 L/min	4 L/min	4 L/min
Expired Sevoflurane	0.5 %	0 %	0 %	0 %	0 %
Expired N2O	1 %	0 %	0 %	0 %	0 %
Inspired Sevoflurane	0.1 %	0 %	0 %	0 %	0 %
Inspired N2O	0 %	0 %	0 %	0 %	0 %
Expired O2 Setting	93 %	—	—	—	—
Respiratory					
Tidal (Observed)	68 mL	—	—	—	—
Inspired Minute Volume	2.4 L/min	—	—	—	—
Expired Minute Volume	2.5 L/min	—	—	—	—
PIP Observed	1 cm H2O	0 cm H2O	1 cm H2O	1 cm H2O	1 cm H2O
PEEP/CPAP	5 cm H20	5 cm H20	5 cm H20	5 cm H20	5 cm H20
MAC	0.3	0	0	0	0
Core Vitals/Respiratory					
NIBP	—	—	—	—	**88/49** !
NIBP (Mean)	—	—	—	—	62 mmHg
Pulse	149 bpm	176 bpm	163 bpm	157 bpm	166 bpm
SpO2	100 %	96 %	96 %	96 %	97 %
Resp Rate (Set)	16	16	16	16	16
Resp Observed	33	—	—	—	—
Anesthesia Monitoring					
Temp	37.5 °C (99.5 °F)	37.6 °C (99.7 °F)	37.7 °C (99.9 °F)	37.6 °C (99.7 °F)	37.5 °C (99.5 °F)
ETCO2	37 mmHg	**0 mmHg** !	**0 mmHg** !	**0 mmHg** !	**0 mmHg** !

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Anesthesia on 12/16/24 (continued)

Other Vitals					
HR (ECG)	151 bpm	175 bpm	163 bpm	154 bpm	166 bpm
Cumulative Agents					
Cumulative Desflurane (mL of Liquid)	0 mL	0 mL	0 mL	0 mL	0 mL
Cumulative Isoflurane (mL of Liquid)	0 mL	0 mL	0 mL	0 mL	0 mL
Cumulative Sevoflurane (mL of Liquid)	16 mL	16 mL	16 mL	16 mL	16 mL
Cumulative N2O (L of Gas)	14 L	14 L	14 L	14 L	14 L
Cumulative Air (L of Gas)	0 L	0 L	0 L	0 L	0 L
Nitric Oxide					
iCO2	0	0	0	0	0
Row Name	**12/16/24 0913**	**12/16/24 0914**	**12/16/24 0915**	**12/16/24 0916**	**12/16/24 0917**
Agents					
O2	4 L/min	4 L/min	4 L/min	4 L/min	4 L/min
Expired Sevoflurane	0 %	0 %	0 %	0 %	0 %
Expired N2O	0 %	0 %	0 %	0 %	0 %
Inspired Sevoflurane	0 %	0 %	0 %	0 %	0 %
Inspired N2O	0 %	0 %	0 %	0 %	0 %
Inspired O2 Setting	—	—	—	—	100 %
Expired O2 Setting	—	—	—	—	68 %
Respiratory					
Tidal (Observed)	—	—	—	—	23 mL
Inspired Minute Volume	—	—	—	—	2.2 L/min
Expired Minute Volume	—	—	—	—	0.2 L/min
PIP Observed	1 cm H2O	1 cm H2O	1 cm H2O	1 cm H2O	14 cm H2O
PEEP/CPAP	5 cm H20	5 cm H20	5 cm H20	5 cm H20	5 cm H20
MAC	0	0	0	0	0
Core Vitals/Respiratory					
NIBP	—	—	—	—	**88/43** !
NIBP (Mean)	—	—	—	—	62 mmHg
Pulse	159 bpm	170 bpm	168 bpm	162 bpm	161 bpm
SpO2	97 %	99 %	98 %	99 %	94 %
Resp Rate (Set)	16	16	16	16	16
Resp Observed	—	—	—	—	8
Anesthesia Monitoring					
Temp	37.5 °C (99.5 °F)	37.4 °C (99.3 °F)	37.4 °C (99.3 °F)	37.4 °C (99.3 °F)	37.4 °C (99.3 °F)
ETCO2	**0 mmHg** !	**0 mmHg** !	**0 mmHg** !	**0 mmHg** !	34 mmHg
Other Vitals					
HR (ECG)	160 bpm	166 bpm	170 bpm	165 bpm	160 bpm
Cumulative Agents					
Cumulative Desflurane (mL of Liquid)	0 mL	0 mL	0 mL	—	0 mL
Cumulative	0 mL	0 mL	0 mL	—	0 mL

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Anesthesia on 12/16/24 (continued)

Isoflurane (mL of Liquid)					
Cumulative Sevoflurane (mL of Liquid)	16 mL	16 mL	16 mL	—	16 mL
Cumulative N2O (L of Gas)	14 L	14 L	14 L	—	14 L
Cumulative Air (L of Gas)	0 L	0 L	0 L	—	0 L
Nitric Oxide					
iCO2	0	0	0	0	1
Row Name	**12/16/24 0918**	**12/16/24 0919**	**12/16/24 0920**	**12/16/24 0921**	**12/16/24 0922**
Agents					
O2	4 L/min	4 L/min	0.3 L/min	0.3 L/min	0.3 L/min
Air	—	—	2.66 L/min	2.66 L/min	2.66 L/min
Expired Sevoflurane	0 %	0.2 %	0.9 %	1.9 %	1.7 %
Expired N2O	0 %	0 %	1 %	1 %	0 %
Inspired Sevoflurane	0 %	0 %	2.3 %	2.8 %	2.9 %
Inspired N2O	0 %	0 %	1 %	0 %	0 %
Inspired O2 Setting	—	—	51 %	36 %	30 %
Expired O2 Setting	98 %	94 %	81 %	34 %	22 %
Respiratory					
Vent Mode	—	Pressure support with apnea backup mode	Pressure support with apnea backup mode	Pressure support with apnea backup mode	Pressure support with apnea backup mode
Tidal (Observed)	95 mL	0 mL	22 mL	82 mL	49 mL
Inspired Minute Volume	2.8 L/min	2.1 L/min	3 L/min	1.3 L/min	1.7 L/min
Expired Minute Volume	1.8 L/min	1.9 L/min	0.9 L/min	1.4 L/min	1.7 L/min
PIP Observed	29 cm H2O	6 cm H2O	15 cm H2O	15 cm H2O	15 cm H2O
PEEP/CPAP	5 cm H20	5 cm H20	5 cm H20	5 cm H20	5 cm H20
MAC	0	0	0.4	0.9	0.8
Core Vitals/Respiratory					
NIBP	—	—	—	—	**79/37** !
NIBP (Mean)	—	—	—	—	54 mmHg
Pulse	151 bpm	147 bpm	147 bpm	152 bpm	156 bpm
SpO2	100 %	99 %	99 %	99 %	97 %
Resp Rate (Set)	16	—	—	—	—
Resp Observed	37	26	12	22	27
Anesthesia Monitoring					
Temp	37.3 °C (99.1 °F)	37.3 °C (99.1 °F)	37.3 °C (99.1 °F)	37.4 °C (99.3 °F)	37.4 °C (99.3 °F)
ETCO2	16 mmHg	37 mmHg	45 mmHg	48 mmHg	46 mmHg
FiO2 (%)	—	—	51 %	35 %	30 %
Other Vitals					
HR (ECG)	151 bpm	148 bpm	145 bpm	149 bpm	156 bpm
Cumulative Agents					
Cumulative Desflurane (mL of Liquid)	0 mL	0 mL	0 mL	0 mL	0 mL
Cumulative Isoflurane (mL of Liquid)	0 mL	0 mL	0 mL	0 mL	0 mL

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Anesthesia on 12/16/24 (continued)

Cumulative Sevoflurane (mL of Liquid)	16 mL	16 mL	16 mL	16 mL	17 mL
Cumulative N2O (L of Gas)	14 L	14 L	14 L	14 L	14 L
Cumulative Air (L of Gas)	0 L	0 L	0 L	3 L	5 L
Nitric Oxide					
iCO2	1	1	0	1	1
Row Name	**12/16/24 0923**	**12/16/24 0924**	**12/16/24 0925**	**12/16/24 0926**	**12/16/24 0927**
Agents					
O2	0.5 L/min	0.5 L/min	0.5 L/min	0.5 L/min	0.5 L/min
Air	3.54 L/min	3.54 L/min	3.54 L/min	3.54 L/min	3.54 L/min
Expired Sevoflurane	2.8 %	2.2 %	2.4 %	2.3 %	2.5 %
Expired N2O	0 %	0 %	0 %	0 %	0 %
Inspired Sevoflurane	3.5 %	3.6 %	3.6 %	3.4 %	3.5 %
Inspired N2O	0 %	0 %	0 %	0 %	0 %
Inspired O2 Setting	29 %	29 %	29 %	29 %	28 %
Expired O2 Setting	25 %	21 %	20 %	16 %	16 %
Respiratory					
Vent Mode	Pressure support with apnea backup mode	Pressure support with apnea backup mode	Pressure support with apnea backup mode	Pressure support with apnea backup mode	Pressure support with apnea backup mode
Tidal (Observed)	74 mL	42 mL	40 mL	39 mL	38 mL
Inspired Minute Volume	2.3 L/min	2.6 L/min	2.4 L/min	1.3 L/min	1.6 L/min
Expired Minute Volume	2.2 L/min	1.4 L/min	0.6 L/min	0.9 L/min	1.6 L/min
PIP Observed	15 cm H2O	15 cm H2O	15 cm H2O	15 cm H2O	15 cm H2O
PEEP/CPAP	5 cm H20	5 cm H20	5 cm H20	5 cm H20	5 cm H20
MAC	1.4	1.1	1.2	1.1	1.2
Core Vitals/Respiratory					
NIBP	—	—	—	—	**80/39** !
NIBP (Mean)	—	—	—	—	56 mmHg
Pulse	162 bpm	160 bpm	158 bpm	156 bpm	154 bpm
SpO2	94 %	97 %	97 %	95 %	94 %
Resp Observed	35	19	15	21	39
Anesthesia Monitoring					
Temp	37.4 °C (99.3 °F)	37.5 °C (99.5 °F)	37.6 °C (99.7 °F)	38 °C (100.4 °F)	38.1 °C (100.6 °F)
ETCO2	41 mmHg	48 mmHg	46 mmHg	52 mmHg	51 mmHg
FiO2 (%)	29 %	29 %	29 %	28 %	29 %
Other Vitals					
HR (ECG)	159 bpm	160 bpm	—	—	—
Cumulative Agents					
Cumulative Desflurane (mL of Liquid)	0 mL	0 mL	0 mL	0 mL	0 mL
Cumulative Isoflurane (mL of Liquid)	0 mL	0 mL	0 mL	0 mL	0 mL
Cumulative Sevoflurane (mL of Liquid)	17 mL	18 mL	19 mL	20 mL	21 mL

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Anesthesia on 12/16/24 (continued)

Cumulative N2O (L of Gas)	14 L	14 L	14 L	14 L	14 L
Cumulative Air (L of Gas)	8 L	12 L	16 L	19 L	23 L
Nitric Oxide					
iCO2	1	0	0	1	1
Row Name	**12/16/24 0928**	**12/16/24 0929**	**12/16/24 0930**	**12/16/24 0931**	**12/16/24 0932**
Agents					
O2	0.5 L/min	0.5 L/min	0.5 L/min	1 L/min	1 L/min
Air	3.54 L/min	3.54 L/min	3.54 L/min	3.04 L/min	3.04 L/min
Expired Sevoflurane	2.6 %	2.6 %	2.7 %	2.6 %	2.8 %
Expired N2O	0 %	0 %	0 %	0 %	0 %
Inspired Sevoflurane	3.5 %	3.5 %	3.5 %	3.7 %	3.6 %
Inspired N2O	0 %	0 %	0 %	0 %	0 %
Inspired O2 Setting	28 %	28 %	28 %	36 %	38 %
Expired O2 Setting	16 %	15 %	14 %	13 %	31 %
Respiratory					
Vent Mode	Pressure support with apnea backup mode	Pressure support with apnea backup mode	Pressure support with apnea backup mode	—	Pressure support with apnea backup mode
Tidal (Observed)	36 mL	21 mL	22 mL	18 mL	72 mL
Inspired Minute Volume	1.6 L/min	1.3 L/min	1 L/min	1.1 L/min	2.7 L/min
Expired Minute Volume	1.5 L/min	1.2 L/min	1 L/min	1.3 L/min	3.2 L/min
PIP Observed	15 cm H2O	14 cm H2O	14 cm H2O	5 cm H2O	15 cm H2O
PEEP/CPAP	5 cm H20	5 cm H20	5 cm H20	5 cm H20	5 cm H20
MAC	1.3	1.3	1.3	1.3	1.4
Core Vitals/Respiratory					
NIBP	—	—	—	—	**81/42** !
NIBP (Mean)	—	—	—	—	59 mmHg
Pulse	156 bpm	154 bpm	156 bpm	155 bpm	153 bpm
SpO2	94 %	92 %	**86 %** !	**85 %** !	99 %
Resp Observed	39	40	41	43	43
Anesthesia Monitoring					
Temp	37.8 °C (100 °F)	37 °C (98.6 °F)	36.4 °C (97.5 °F)	36 °C (96.8 °F)	35.7 °C (96.3 °F)
ETCO2	50 mmHg	47 mmHg	51 mmHg	58 mmHg	52 mmHg
FiO2 (%)	28 %	28 %	28 %	36 %	38 %
Other Vitals					
HR (ECG)	—	—	156 bpm	156 bpm	153 bpm
Cumulative Agents					
Cumulative Desflurane (mL of Liquid)	0 mL	0 mL	0 mL	—	0 mL
Cumulative Isoflurane (mL of Liquid)	0 mL	0 mL	0 mL	—	0 mL
Cumulative Sevoflurane (mL of Liquid)	21 mL	22 mL	23 mL	—	25 mL
Cumulative N2O (L of Gas)	14 L	14 L	14 L	—	14 L
Cumulative Air	26 L	30 L	33 L	—	40 L

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Anesthesia on 12/16/24 (continued)

(L of Gas)					
Nitric Oxide					
iCO2	1	1	1	1	1
Row Name	**12/16/24 0933**	**12/16/24 0934**	**12/16/24 0935**	**12/16/24 0936**	**12/16/24 0937**
Agents					
O2	1 L/min	4 L/min	10 L/min	10 L/min	10 L/min
Air	3.04 L/min	0 L/min	—	—	—
Expired Sevoflurane	2.8 %	1.7 %	0.9 %	0.7 %	0.5 %
Expired N2O	0 %	0 %	0 %	0 %	0 %
Inspired Sevoflurane	3.6 %	0.3 %	0.2 %	0.1 %	0.1 %
Inspired N2O	0 %	0 %	0 %	0 %	0 %
Inspired O2 Setting	38 %	100 %	—	—	—
Expired O2 Setting	31 %	60 %	91 %	94 %	94 %
Respiratory					
Vent Mode	Pressure support with apnea backup mode	Pressure support with apnea backup mode	Pressure support with apnea backup mode	Pressure support with apnea backup mode	Pressure support with apnea backup mode
Tidal (Observed)	107 mL	98 mL	104 mL	121 mL	116 mL
Inspired Minute Volume	2.5 L/min	1.4 L/min	2.3 L/min	2.8 L/min	2.8 L/min
Expired Minute Volume	2.6 L/min	1.5 L/min	2.5 L/min	3 L/min	2.9 L/min
PIP Observed	15 cm H2O	15 cm H2O	15 cm H2O	15 cm H2O	15 cm H2O
PEEP/CPAP	5 cm H20	5 cm H20	5 cm H20	5 cm H20	5 cm H20
MAC	1.4	0.8	0.4	0.3	0.2
Core Vitals/Respiratory					
NIBP	—	—	—	—	**77/37** !
NIBP (Mean)	—	—	—	—	53 mmHg
Pulse	154 bpm	149 bpm	141 bpm	137 bpm	133 bpm
SpO2	99 %	99 %	100 %	99 %	99 %
Resp Observed	33	14	27	26	24
Anesthesia Monitoring					
Temp	35.5 °C (95.9 °F)	35.3 °C (95.5 °F)	35.2 °C (95.4 °F)	35.1 °C (95.2 °F)	35.1 °C (95.2 °F)
ETCO2	52 mmHg	56 mmHg	49 mmHg	45 mmHg	43 mmHg
FiO2 (%)	38 %	100 %	—	—	—
Other Vitals					
HR (ECG)	153 bpm	—	144 bpm	135 bpm	133 bpm
Cumulative Agents					
Cumulative Desflurane (mL of Liquid)	0 mL	0 mL	0 mL	0 mL	0 mL
Cumulative Isoflurane (mL of Liquid)	0 mL	0 mL	0 mL	0 mL	0 mL
Cumulative Sevoflurane (mL of Liquid)	25 mL	26 mL	26 mL	26 mL	26 mL
Cumulative N2O (L of Gas)	14 L	14 L	14 L	14 L	14 L
Cumulative Air (L of Gas)	43 L	44 L	44 L	44 L	44 L
Nitric Oxide					
iCO2	1	1	1	1	1

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Anesthesia on 12/16/24 (continued)

Row Name	12/16/24 0938	12/16/24 0939	12/16/24 0940	12/16/24 0941	12/16/24 0942
Agents					
O2	10 L/min	10 L/min	10 L/min	10 L/min	10 L/min
Expired Sevoflurane	0.4 %	0.3 %	0.3 %	0.3 %	0.3 %
Expired N2O	0 %	0 %	0 %	0 %	0 %
Inspired Sevoflurane	0.1 %	0.1 %	0.1 %	0.1 %	0.1 %
Inspired N2O	0 %	0 %	0 %	0 %	0 %
Expired O2 Setting	95 %	95 %	95 %	95 %	96 %
Respiratory					
Vent Mode	—	Pressure support with apnea backup mode	Pressure support with apnea backup mode	Pressure support with apnea backup mode	—
Tidal (Observed)	7 mL	155 mL	115 mL	106 mL	23 mL
Inspired Minute Volume	2.6 L/min	1.6 L/min	2.1 L/min	2.9 L/min	2.4 L/min
Expired Minute Volume	2.7 L/min	2.1 L/min	2.1 L/min	3 L/min	2.7 L/min
PIP Observed	5 cm H2O	15 cm H2O	15 cm H2O	15 cm H2O	1 cm H2O
PEEP/CPAP	5 cm H20	5 cm H20	5 cm H20	5 cm H20	5 cm H20
MAC	0.2	0.1	0.1	0.1	0.1
Core Vitals/Respiratory					
NIBP	—	—	—	—	**78/39** !
NIBP (Mean)	—	—	—	—	55 mmHg
Pulse	132 bpm	156 bpm	138 bpm	136 bpm	134 bpm
SpO2	99 %	99 %	99 %	99 %	99 %
Resp Observed	25	23	18	27	27
Anesthesia Monitoring					
Temp	35 °C (95 °F)	35 °C (95 °F)	34.9 °C (94.8 °F)	34.9 °C (94.8 °F)	34.8 °C (94.6 °F)
ETCO2	41 mmHg	37 mmHg	42 mmHg	40 mmHg	37 mmHg
Other Vitals					
HR (ECG)	130 bpm	151 bpm	138 bpm	135 bpm	133 bpm
Cumulative Agents					
Cumulative Desflurane (mL of Liquid)	0 mL	0 mL	0 mL	0 mL	0 mL
Cumulative Isoflurane (mL of Liquid)	0 mL	0 mL	0 mL	0 mL	0 mL
Cumulative Sevoflurane (mL of Liquid)	26 mL	26 mL	26 mL	26 mL	26 mL
Cumulative N2O (L of Gas)	14 L	14 L	14 L	14 L	14 L
Cumulative Air (L of Gas)	44 L	44 L	44 L	44 L	44 L
Nitric Oxide					
iCO2	1	1	1	1	1

Row Name	12/16/24 0943	12/16/24 0944	12/16/24 0945	12/16/24 0946	12/16/24 0947
Agents					
O2	10 L/min	10 L/min	10 L/min	10 L/min	10 L/min
Expired Sevoflurane	0.2 %	0.3 %	0.3 %	0.2 %	0.2 %
Expired N2O	0 %	0 %	0 %	0 %	0 %
Inspired	0.1 %	0 %	0 %	0 %	0 %

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Anesthesia on 12/16/24 (continued)

Sevoflurane					
Inspired N2O	0 %	0 %	0 %	0 %	0 %
Expired O2 Setting	95 %	95 %	95 %	95 %	94 %
Respiratory					
Tidal (Observed)	76 mL	73 mL	75 mL	39 mL	327 mL
Inspired Minute Volume	1.9 L/min	1.8 L/min	1.9 L/min	1.5 L/min	1.8 L/min
Expired Minute Volume	2.1 L/min	2 L/min	2 L/min	1.7 L/min	1.8 L/min
PIP Observed	1 cm H2O	3 cm H2O	3 cm H2O	3 cm H2O	6 cm H2O
PEEP/CPAP	5 cm H20	5 cm H20	5 cm H20	5 cm H20	5 cm H20
MAC	0.1	0.1	0.1	0.1	0.1
Core Vitals/Respiratory					
NIBP	—	—	—	—	93/52
NIBP (Mean)	—	—	—	—	69 mmHg
Pulse	133 bpm	131 bpm	130 bpm	152 bpm	143 bpm
SpO2	99 %	99 %	99 %	100 %	100 %
Resp Observed	35	28	25	28	26
Anesthesia Monitoring					
Temp	34.8 °C (94.6 °F)	34.8 °C (94.6 °F)	34.7 °C (94.5 °F)	34.7 °C (94.5 °F)	34.8 °C (94.6 °F)
ETCO2	41 mmHg	42 mmHg	41 mmHg	41 mmHg	46 mmHg
Other Vitals					
HR (ECG)	132 bpm	130 bpm	129 bpm	146 bpm	144 bpm
Cumulative Agents					
Cumulative Desflurane (mL of Liquid)	0 mL	0 mL	0 mL	0 mL	0 mL
Cumulative Isoflurane (mL of Liquid)	0 mL	0 mL	0 mL	0 mL	0 mL
Cumulative Sevoflurane (mL of Liquid)	26 mL	26 mL	26 mL	26 mL	26 mL
Cumulative N2O (L of Gas)	14 L	14 L	14 L	14 L	14 L
Cumulative Air (L of Gas)	44 L	44 L	44 L	44 L	44 L
Nitric Oxide					
iCO2	1	1	1	1	1

Row Name	**12/16/24 0948**	**12/16/24 0949**
Agents		
O2	10 L/min	—
Expired Sevoflurane	0 %	0 %
Expired N2O	0 %	0 %
Inspired Sevoflurane	0 %	0 %
Inspired N2O	0 %	0 %
Respiratory		
Tidal (Observed)	0 mL	—
Inspired Minute Volume	1.5 L/min	—
Expired Minute Volume	1.1 L/min	—
PIP Observed	3 cm H2O	1 cm H2O
PEEP/CPAP	5 cm H20	5 cm H20

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Anesthesia on 12/16/24 (continued)

MAC	0	0
Core Vitals/Respiratory		
Pulse	144 bpm	145 bpm
SpO2	98 %	99 %
Resp Observed	13	—
Anesthesia Monitoring		
Temp	34.8 °C (94.6 °F)	34.9 °C (94.8 °F)
ETCO2	**0 mmHg** !	**0 mmHg** !
Other Vitals		
HR (ECG)	143 bpm	—
Cumulative Agents		
Cumulative Desflurane (mL of Liquid)	0 mL	0 mL
Cumulative Isoflurane (mL of Liquid)	0 mL	0 mL
Cumulative Sevoflurane (mL of Liquid)	26 mL	26 mL
Cumulative N2O (L of Gas)	14 L	14 L
Cumulative Air (L of Gas)	44 L	44 L
Nitric Oxide		
iCO2	0	0

I/O

Row Name	12/16/24 0810	12/16/24 0859	12/16/24 0900	12/16/24 0903	12/16/24 0905
propofol (Diprivan) 1000 MG/100ML infusion Start: 12/16/24 0859					
Dose	—	*250 mcg/kg/min	—	—	*300 mcg/kg/min
dexAMETHasone (Decadron) 4 MG/ML injection Start: 12/16/24 0903					
Dose	—	—	—	*6 mg	—
midazolam (PF) (Versed) 10 MG/2ML injection 6.25 mg Start: 12/16/24 0729					
Dose	*6.25 mg	—	—	—	—

Row Name	12/16/24 0907	12/16/24 0908	12/16/24 0911	12/16/24 0914	12/16/24 0919
propofol (Diprivan) 1000 MG/100ML infusion Start: 12/16/24 0859					
Dose	*12 mg	*6 mg	*250 mcg/kg/min	*6 mg	*0 mcg/kg/min
Volume (mL)	—	—	—	—	9.2

Row Name	12/16/24 0923	12/16/24 0950	12/16/24 0951	12/16/24 1004	12/16/24 1022
lactated Ringer's infusion Start: 12/16/24 0900					
Rate	—	—	0 mL/hr	—	—
Volume (mL)	—	—	250 mL	—	—
propofol (Diprivan) 1000 MG/100ML infusion Start: 12/16/24 0859					
Dose	—	*12 mg	—	—	—
Volume (mL)	—	1.2	—	—	—
morphine PF Start: 12/16/24 0923					
Dose	*0.6 mg	—	—	—	—
Fentanyl Drip					
Bolus (mcg) Fentanyl	—	—	—	6.3 mcg	6.3 mcg
Rate Fentanyl	—	—	—	—	—
Concentration Fentanyl	—	—	—	10 mcg/mL	10 mcg/mL

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Anesthesia on 12/16/24 (continued)

Row Name	12/16/24 1045
morphine PF 2 MG/ML 0.6 mg	Start: 12/16/24 0935
Dose	*0.6 mg

Medication Exclusion

Row Name	Anesthesia from 12/16/2024 in Oklahoma Childrens Hospital with Susan Wittman, MD
Antibiotic/Beta Blocker/Antiemetic Administration Exclusions	
Reason Antibiotic Not Administered	Surgeon requests no antibiotics

Positioning

Row Name	12/16/24 0900
Positioning	
Position	Supine;Pressure points checked;Pressure points padded;Patient turned 90 degrees
Arm Placement	tucked and pressure points padded
Eyes Checklist	Eyes taped;Neck in neutral position;Pressure points checked

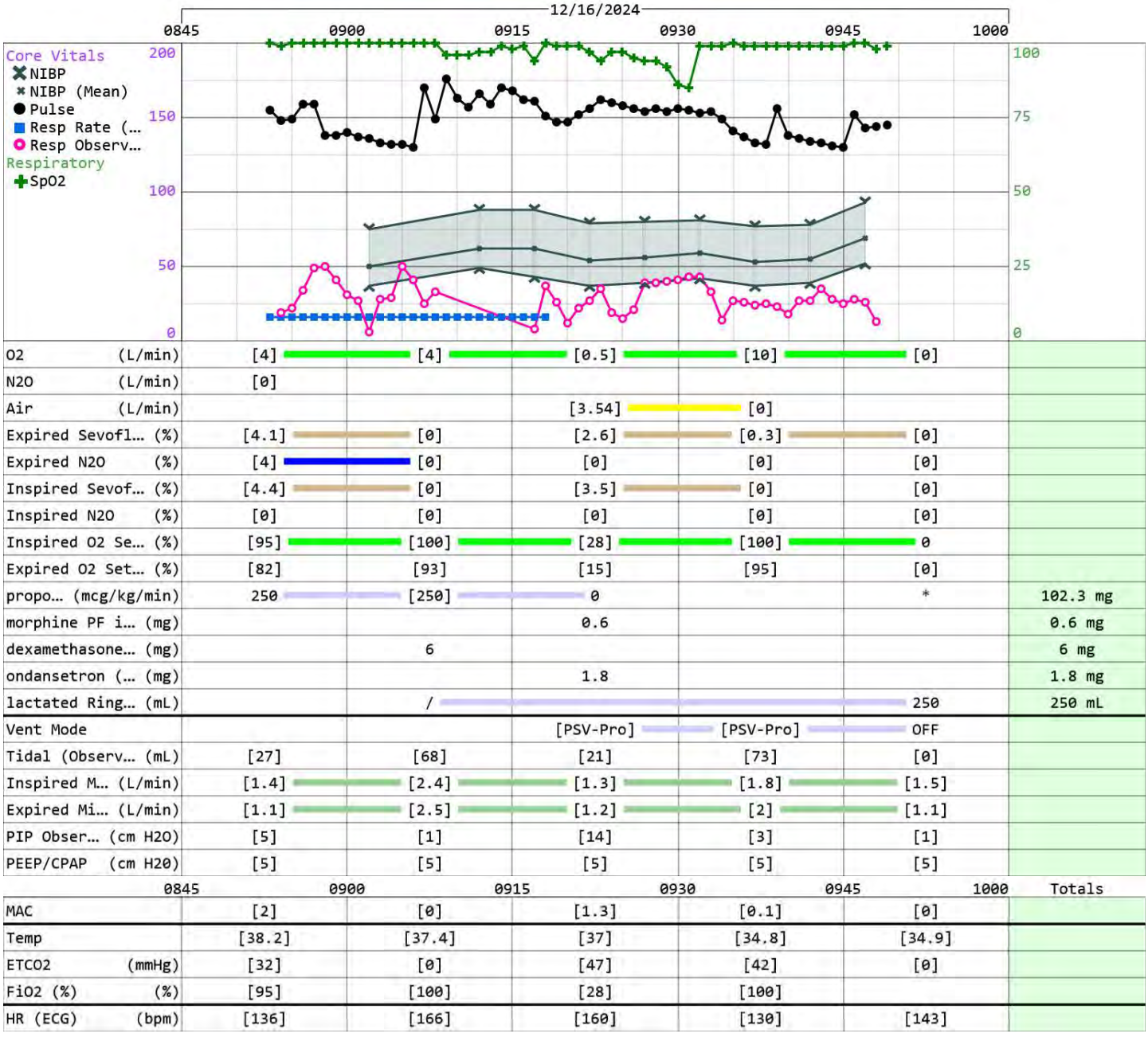
Vitals/Agents

Row Name	12/16/24 0949
Respiratory	
Vent Mode	Vent off

Anesthesia Graph

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Anesthesia on 12/16/24 (continued)



O2	(L/min)	[4]	[4]	[0.5]	[10]	[0]	
N2O	(L/min)	[0]					
Air	(L/min)			[3.54]	[0]		
Expired Sevofl...	(%)	[4.1]	[0]	[2.6]	[0.3]	[0]	
Expired N2O	(%)	[4]	[0]	[0]	[0]	[0]	
Inspired Sevof...	(%)	[4.4]	[0]	[3.5]	[0]	[0]	
Inspired N2O	(%)	[0]	[0]	[0]	[0]	[0]	
Inspired O2 Se...	(%)	[95]	[100]	[28]	[100]	0	
Expired O2 Set...	(%)	[82]	[93]	[15]	[95]	[0]	
propo...	(mcg/kg/min)	250	[250]	0		*	102.3 mg
morphine PF i...	(mg)			0.6			0.6 mg
dexamethasone...	(mg)		6				6 mg
ondansetron (...	(mg)			1.8			1.8 mg
lactated Ring...	(mL)		/			250	250 mL
Vent Mode				[PSV-Pro]	[PSV-Pro]	OFF	
Tidal (Observ...	(mL)	[27]	[68]	[21]	[73]	[0]	
Inspired M...	(L/min)	[1.4]	[2.4]	[1.3]	[1.8]	[1.5]	
Expired Mi...	(L/min)	[1.1]	[2.5]	[1.2]	[2]	[1.1]	
PIP Obser...	(cm H2O)	[5]	[1]	[14]	[3]	[1]	
PEEP/CPAP	(cm H20)	[5]	[5]	[5]	[5]	[5]	

	0845	0900	0915	0930	0945	1000	Totals
MAC	[2]	[0]	[1.3]	[0.1]	[0]		
Temp	[38.2]	[37.4]	[37]	[34.8]	[34.9]		
ETCO2 (mmHg)	[32]	[0]	[47]	[42]	[0]		
FiO2 (%) (%)	[95]	[100]	[28]	[100]			
HR (ECG) (bpm)	[136]	[166]	[160]	[130]	[143]		

Anesthesia Orders

propofol (Diprivan) 1000 MG/100ML infusion (Discontinued)

Electronically signed by: **Garrett Michael Eakers, MD on 12/16/24 0901** Status: **Discontinued**
Ordering user: Garrett Michael Eakers, MD 12/16/24 0901 Ordering provider: Garrett Michael Eakers, MD
Authorized by: Susan Wittman, MD Ordering mode: Standard
Frequency: Routine Continuous PRN 12/16/24 0859 - 12/16/24 0958 Class: Normal
Discontinued by: Garrett Michael Eakers, MD 12/16/24 0958 [Discontinued in Anesthesia] Package: 0409-4699-24

morphine PF (Discontinued)

Electronically signed by: **Garrett Michael Eakers, MD on 12/16/24 0923** Status: **Discontinued**
Ordering user: Garrett Michael Eakers, MD 12/16/24 0923 Ordering provider: Garrett Michael Eakers, MD

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Anesthesia on 12/16/24 (continued)

Authorized by: Susan Wittman, MD
Frequency: Routine PRN 12/16/24 0923 - 12/16/24 0958
Discontinued by: Garrett Michael Eakers, MD 12/16/24 0958 [Discontinued in Anesthesia]
Ordering mode: Standard
Class: Normal
Package: 0409-1890-01

ondansetron (Zofran) 4 MG/2ML injection (Discontinued)

Electronically signed by: **Garrett Michael Eakers, MD on 12/16/24 0924**
Status: **Discontinued**
Ordering user: Garrett Michael Eakers, MD 12/16/24 0924
Ordering provider: Garrett Michael Eakers, MD
Authorized by: Susan Wittman, MD
Ordering mode: Standard
Frequency: Routine PRN 12/16/24 0923 - 12/16/24 0958
Class: Normal
Discontinued by: Garrett Michael Eakers, MD 12/16/24 0958 [Discontinued in Anesthesia]
Package: 0641-6078-25

lactated Ringer's infusion (Discontinued)

Electronically signed by: **Garrett Michael Eakers, MD on 12/16/24 0924**
Status: **Discontinued**
Ordering user: Garrett Michael Eakers, MD 12/16/24 0924
Ordering provider: Garrett Michael Eakers, MD
Authorized by: Susan Wittman, MD
Ordering mode: Standard
Frequency: Routine Continuous PRN 12/16/24 0900 - 12/16/24 0958
Class: Normal
Discontinued by: Garrett Michael Eakers, MD 12/16/24 0958 [Discontinued in Anesthesia]
Package: 0409-7953-03

dexAMETHasone (Decadron) 4 MG/ML injection (Discontinued)

Electronically signed by: **Garrett Michael Eakers, MD on 12/16/24 0924**
Status: **Discontinued**
Ordering user: Garrett Michael Eakers, MD 12/16/24 0924
Ordering provider: Garrett Michael Eakers, MD
Authorized by: Susan Wittman, MD
Ordering mode: Standard
Frequency: Routine PRN 12/16/24 0903 - 12/16/24 0958
Class: Normal
Discontinued by: Garrett Michael Eakers, MD 12/16/24 0958 [Discontinued in Anesthesia]
Package: 67457-423-12

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Medication Administrations

acetaminophen (Tylenol) 32 MG/ML solution/suspension solution 188.9163 mg [45447337]

Ordering Provider: Lauren A Toft, PA
Ordered On: 12/16/24 0729
Ordered Dose (Remaining/Total): 15 mg/kg (0/1)
Frequency: Once
Admin Instructions: preop

Status: Completed (Past End Date/Time)
Starts/Ends: 12/16/24 0730 - 12/16/24 0809
Route: Oral
Ordered Rate/Order Duration: — / —

Timestamps	Action	Dose	Route	Other Information
Performed 12/16/24 0809 Documented: 12/16/24 0810	Given	188.9163 mg	Oral	Performed by: Shelby Davis, RN Scanned Package: 68094-330-59

albuterol (2.5 MG/3ML) 0.083% nebulizer solution 2.5 mg [45447350]

Ordering Provider: Susan Wittman, MD
Ordered On: 12/16/24 0935
Ordered Dose (Remaining/Total): 2.5 mg (0/1)
Frequency: Once as needed

Status: Completed (Past End Date/Time)
Starts/Ends: 12/16/24 0935 - 12/16/24 0954
Route: Nebulization
Ordered Rate/Order Duration: — / —

Timestamps	Action	Dose	Route	Other Information
Performed 12/16/24 0954 Documented: 12/16/24 1027	Given	2.5 mg	Nebulization	Performed by: Kenzi E Griffin, RN Scanned Package: 76204-200-01

fentaNYL (PF) (Sublimaze) 10 mcg/mL injection 6.3 mcg [114312878]

Ordering Provider: Susan Wittman, MD
Ordered On: 12/16/24 0935
Ordered Dose (Remaining/Total): 0.5 mcg/kg (Dosing Weight) (2/4)
Frequency: Every 5 min PRN

Status: Discontinued (Past End Date/Time), Reason: Patient Transfer
Starts/Ends: 12/16/24 0935 - 12/16/24 1145
Route: Intravenous
Ordered Rate/Order Duration: — / 1 Minutes

Line	Med Link Info	Comment
Peripheral IV 12/16/24 Left;Posterior	12/16/24 1004 by Kenzi E Griffin, RN	—

Timestamps	Action	Dose / Duration	Route	Other Information
Performed 12/16/24 1022 Documented: 12/16/24 1023	Given	6.3 mcg 1 Minutes	Intravenous	Performed by: Kenzi E Griffin, RN Scanned Package: 9999-7005-63
Performed 12/16/24 1004 Documented: 12/16/24 1004	Given	6.3 mcg 1 Minutes	Intravenous	Performed by: Kenzi E Griffin, RN Scanned Package: 9999-7005-63

Pharmacy Actions

Type	Date/Time	User	Extra Information
Waste	Mon Dec 16, 2024 1137	Kenzi E Griffin, RN	**fentaNYL 1000 MCG/20ML solution [131634]** Waste Amount: 36.4878 mcg Package: 20 mL Vial (0409-9094-16) Charge Failure Reason: Linked admin charge contains waste charge

Medication Administrations (continued)

Waste Reason: Discarded Drug Not Administered
Package From: MAR

sodium chloride 4 MEQ/ML solution [7322]

Waste Amount: 0.1149 mL (0.4596 mEq)
Package: 100 mL Vial (63323-095-02)
Charge Failure Reason: Linked admin charge contains waste charge

Waste Reason: Discarded Drug Not Administered
Package From: MAR

sterile water (PF) solution [7484]

Waste Amount: 2.8783 mL
Package: 1,000 mL Flex Cont (0990-7990-09)
Charge Failure Reason: Linked admin charge contains waste charge

Waste Reason: Discarded Drug Not Administered
Package From: MAR

lidocaine (Xylocaine) 1 % injection [114319835]

Ordering Provider: Vikram Ramjee, MD
Ordered On: 12/16/24 0907
Status: Discontinued (Past End Date/Time), Reason: Patient Discharge
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 12/16/24 0907 Documented: 12/16/24 0907	Given	3 mL	Other	Performed by: Raquel Querido, MD Documented by: Tierra M Sparks, RN Comments: topical airway local

midazolam (PF) (Versed) 10 MG/2ML injection 6.25 mg [45447338]

Ordering Provider: Lauren A Toft, PA
Ordered On: 12/16/24 0729
Ordered Dose (Remaining/Total): 0.5 mg/kg (Dosing Weight) (0/1)
Frequency: Once PRN Procedure
Admin Instructions: Usual total sedation dose maximum: 6 mg.
Status: Completed (Past End Date/Time)
Starts/Ends: 12/16/24 0729 - 12/16/24 0815
Route: Oral
Ordered Rate/Order Duration: — / 5 Minutes

Timestamps	Action	Dose / Duration	Route	Other Information
Performed 12/16/24 0810 Documented: 12/16/24 0810	Given	6.25 mg 5 Minutes	Oral	Performed by: Shelby Davis, RN Scanned Package: 0409-2308-22

Pharmacy Actions

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Medication Administrations (continued)

Type	Date/Time	User	Extra Information
Waste	Mon Dec 16, 2024 0753	Shelby Davis, RN	**midazolam (PF) 10 MG/2ML solution [168901]** Waste Amount: 0.75 mL (3.75 mg) Package: 2 mL Vial (0409-2308-22) Charge Dropped: 2.250 Billing Code Quantity: 3.00 Billing Code: J2250 Charge Modifiers: JW,TB Charge Method: Injection Standard (System picked) Charge Map: CHARGE MAP Charge Table: OUH STANDARD CHARGE Implied Quantity: 0.375 Implied Unit Type: Entire Package (2 mL Vial (0409-2308-02)) Waste Reason: Discarded Drug Not Administered Package From: MAR

morphine PF 2 MG/ML 0.6 mg [114312879]

Ordering Provider: Susan Wittman, MD
Status: Discontinued (Past End Date/Time), Reason: Patient Transfer
Ordered On: 12/16/24 0935
Starts/Ends: 12/16/24 0935 - 12/16/24 1145
Ordered Dose (Remaining/Total): 0.6 mg (3/4)
Route: Intravenous
Frequency: Every 5 min PRN
Ordered Rate/Order Duration: — / —

Line	Med Link Info	Comment
Peripheral IV 12/16/24 Left;Posterior	12/16/24 1045 by Kenzi E Griffin, RN	—

Timestamps	Action	Dose	Route	Other Information
Performed 12/16/24 1045 Documented: 12/16/24 1046	Given	0.6 mg	Intravenous	Performed by: Kenzi E Griffin, RN Scanned Package: 0409-1890-03

Pharmacy Actions

Type	Date/Time	User	Extra Information
Waste	Mon Dec 16, 2024 1137	Kenzi E Griffin, RN	**morphine PF 2 MG/ML solution [40800087]** Waste Amount: 0.7 mL (1.4 mg) Package: 1 mL Cartridge (0409-1890-03) Charge Failure Reason: Medication is not configured for waste Waste Reason: Discarded Drug Not Administered Package From: MAR

Other Orders

Consult

Anesthesia Follow-up (Cancel Held)

Electronically signed by: **Susan Wittman, MD on 12/16/24 0837**
Status: **Cancel Held**
Ordering user: Susan Wittman, MD 12/16/24 0837
Ordering provider: Susan Wittman, MD
Authorized by: Susan Wittman, MD
Ordering mode: Standard
Frequency: Routine Once 12/16/24 0836 - 1 occurrence
Class: Hospital Performed

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Other Orders (continued)

Quantity: 1
Canceled by: Automatic Order Context Provider 12/20/24 0002

Discharge

Discharge patient (Completed)

Electronically signed by: **Vikram Ramjee, MD on 12/16/24 0858** Status: **Completed**
Ordering user: Vikram Ramjee, MD 12/16/24 0858
Ordering provider: Vikram Ramjee, MD
Authorized by: Vikram Ramjee, MD
Ordering mode: Standard
Frequency: Routine Once 12/16/24 0859 - 1 occurrence
Class: Hospital Performed
Quantity: 1
Instance released by: Vikram Ramjee, MD (auto-released) 12/16/2024 8:58 AM

Updates

Accommodation reason: Ready for Discharge
Discharge date and time: 12/16/2024 Morning
Discharge disposition: Home or Self Care

Medications

ondansetron (Zofran) 4 MG/2ML injection - Pyxis Override Pull (Active)

Electronically signed by: **Garrett Michael Eakers, MD on 12/16/24 0921** Status: **Active**
Ordering user: Garrett Michael Eakers, MD 12/16/24 0921
Ordering mode: Standard
Frequency: 12/16/24 0921 - Until Discontinued
Admin instructions: Created by cabinet override
Medication comments: Created by cabinet override
Package: 0641-6078-25

dexAMETHasone (Decadron) 4 MG/ML injection - Pyxis Override Pull (Active)

Electronically signed by: **Garrett Michael Eakers, MD on 12/16/24 0921** Status: **Active**
Ordering user: Garrett Michael Eakers, MD 12/16/24 0921
Ordering mode: Standard
Frequency: 12/16/24 0921 - Until Discontinued
Admin instructions: Created by cabinet override
Medication comments: Created by cabinet override
Package: 67457-423-12

Propofol (Diprivan) 200 MG/20ML injection - Pyxis Override Pull (Active)

Electronically signed by: **Garrett Michael Eakers, MD on 12/16/24 0827** Status: **Active**
Ordering user: Garrett Michael Eakers, MD 12/16/24 0827
Ordering mode: Standard
Frequency: 12/16/24 0827 - Until Discontinued
Admin instructions: Created by cabinet override
General Anesthetic - do not give without appropriate ventilation support.
Medication comments: Created by cabinet override
Package: 0409-6010-25

morphine PF 2 MG/ML - Pyxis Override Pull (Active)

Electronically signed by: **Garrett Michael Eakers, MD on 12/16/24 0827** Status: **Active**
Ordering user: Garrett Michael Eakers, MD 12/16/24 0827
Ordering mode: Standard
Frequency: 12/16/24 0827 - Until Discontinued
Admin instructions: Created by cabinet override
Medication comments: Created by cabinet override
Package: 0409-1890-01

acetaminophen (Tylenol) 32 MG/ML solution/suspension solution 188.9163 mg (Completed)

Electronically signed by: **Lauren A Toft, PA on 12/16/24 0729** Status: **Completed**
Ordering user: Lauren A Toft, PA 12/16/24 0729
Ordering provider: Lauren A Toft, PA
Authorized by: Lauren A Toft, PA
Ordering mode: Standard
Frequency: Routine Once 12/16/24 0730 - 1 occurrence
Class: Normal
Admin instructions: preop

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Other Orders (continued)

Package: 68094-330-59

midazolam (PF) (Versed) 10 MG/2ML injection 6.25 mg (Completed)

Electronically signed by: **Lauren A Toft, PA on 12/16/24 0729** Status: **Completed**
Ordering user: Lauren A Toft, PA 12/16/24 0729 Ordering provider: Lauren A Toft, PA
Authorized by: Lauren A Toft, PA Ordering mode: Standard
PRN reasons: sedation anxiety
Frequency: Routine Once PRN 12/16/24 0729 - 1 occurrence Class: Normal
Admin instructions: Usual total sedation dose maximum: 6 mg.
Package: 0409-2308-22

lidocaine (Xylocaine) 1 % injection (Discontinued)

Electronically signed by: **Tierra M Sparks, RN on 12/16/24 0907** Status: **Discontinued**
Ordering user: Tierra M Sparks, RN 12/16/24 0907 Ordering provider: Vikram Ramjee, MD
Authorized by: Vikram Ramjee, MD Ordering mode: Per protocol: cosign required
Cosigning events
Electronically cosigned by Vikram Ramjee, MD 12/16/24 0923 for Ordering
Frequency: Routine PRN 12/16/24 0907 - 12/16/24 0951 Class: Normal
Discontinued by: Tierra M Sparks, RN 12/16/24 0951 [Patient Discharge]
Acknowledged: Tierra M Sparks, RN 12/16/24 0907 for Placing Order
Package: 63323-201-10

ondansetron (Zofran) 4 MG/2ML injection 1.89 mg (Discontinued)

Electronically signed by: **Susan Wittman, MD on 12/16/24 0837** Status: **Discontinued**
Ordering user: Susan Wittman, MD 12/16/24 0837 Ordering provider: Susan Wittman, MD
Authorized by: Susan Wittman, MD Ordering mode: Standard
PRN reasons: nausea
Frequency: Routine Once PRN 12/16/24 0935 - 1 occurrence Class: Normal
Released by: Kenzi E Griffin, RN 12/16/24 0935 Discontinued by: Automatic Transfer Provider 12/16/24 1145 [Patient Transfer]
Acknowledged: Kenzi E Griffin, RN 12/16/24 0935 for Placing Order
Package: 0641-6078-25

ibuprofen 100 MG/5ML suspension 126 mg (Discontinued)

Electronically signed by: **Susan Wittman, MD on 12/16/24 0837** Status: **Discontinued**
Ordering user: Susan Wittman, MD 12/16/24 0837 Ordering provider: Susan Wittman, MD
Authorized by: Susan Wittman, MD Ordering mode: Standard
PRN reasons: mild pain (pain scale 1-3)
Frequency: Routine Once PRN 12/16/24 0935 - 1 occurrence Class: Normal
Released by: Kenzi E Griffin, RN 12/16/24 0935 Discontinued by: Automatic Transfer Provider 12/16/24 1145 [Patient Transfer]
Acknowledged: Kenzi E Griffin, RN 12/16/24 0935 for Placing Order
Admin instructions: Shake well.
Package: 68094-494-59

fentaNYL (PF) (Sublimaze) 10 mcg/mL injection 6.3 mcg (Discontinued)

Electronically signed by: **Susan Wittman, MD on 12/16/24 0837** Status: **Discontinued**
Ordering user: Susan Wittman, MD 12/16/24 0837 Ordering provider: Susan Wittman, MD
Authorized by: Susan Wittman, MD Ordering mode: Standard
PRN reasons: moderate pain (pain scale 4-6)
Frequency: Routine q5 min PRN 12/16/24 0935 - 4 occurrences Class: Normal
Released by: Kenzi E Griffin, RN 12/16/24 0935 Discontinued by: Automatic Transfer Provider 12/16/24 1145 [Patient Transfer]
Acknowledged: Kenzi E Griffin, RN 12/16/24 0935 for Placing Order
Package: 0409-9094-16, 63323-095-02, 0990-7990-09

morphine PF 2 MG/ML 0.6 mg (Discontinued)

Electronically signed by: **Susan Wittman, MD on 12/16/24 0837** Status: **Discontinued**
Ordering user: Susan Wittman, MD 12/16/24 0837 Ordering provider: Susan Wittman, MD
Authorized by: Susan Wittman, MD Ordering mode: Standard

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Other Orders (continued)

PRN reasons: severe pain (pain scale 7-10)
Frequency: Routine q5 min PRN 12/16/24 0935 - 4 occurrences
Released by: Kenzi E Griffin, RN 12/16/24 0935
Class: Normal
Discontinued by: Automatic Transfer Provider 12/16/24 1145 [Patient Transfer]
Acknowledged: Kenzi E Griffin, RN 12/16/24 0935 for Placing Order
Package: 0409-1890-03

lactated Ringer's infusion (Discontinued)

Electronically signed by: **Susan Wittman, MD on 12/16/24 0837**
Status: **Discontinued**
Ordering user: Susan Wittman, MD 12/16/24 0837
Ordering provider: Susan Wittman, MD
Authorized by: Susan Wittman, MD
Ordering mode: Standard
Frequency: Routine Continuous 12/16/24 0945 - 12/16/24 1145
Class: Normal
Released by: Kenzi E Griffin, RN 12/16/24 0935
Discontinued by: Automatic Transfer Provider 12/16/24 1145 [Patient Transfer]
Acknowledged: Kenzi E Griffin, RN 12/16/24 0935 for Placing Order
Package: 0338-0117-02

racepinephrine (Asthmanefrin) 2.25 % nebulizer solution 0.5 mL (Discontinued)

Electronically signed by: **Susan Wittman, MD on 12/16/24 0837**
Status: **Discontinued**
Ordering user: Susan Wittman, MD 12/16/24 0837
Ordering provider: Susan Wittman, MD
Authorized by: Susan Wittman, MD
Ordering mode: Standard
PRN reasons: wheezing shortness of breath
Frequency: Routine Once PRN 12/16/24 0935 - 1 occurrence
Class: Normal
Released by: Kenzi E Griffin, RN 12/16/24 0935
Discontinued by: Automatic Transfer Provider 12/16/24 1145 [Patient Transfer]
Acknowledged: Kenzi E Griffin, RN 12/16/24 0935 for Placing Order
Admin instructions: If dose ordered in "inhalations", pour full neb contents into handheld nebulizer, then instruct pt to inhale the ordered number of inhalations.
Not to exceed 12 inhalations per 24 hour period
Package: 0487-5901-99

albuterol (2.5 MG/3ML) 0.083% nebulizer solution 2.5 mg (Completed)

Electronically signed by: **Susan Wittman, MD on 12/16/24 0837**
Status: **Completed**
Ordering user: Susan Wittman, MD 12/16/24 0837
Ordering provider: Susan Wittman, MD
Authorized by: Susan Wittman, MD
Ordering mode: Standard
PRN reasons: wheezing
Frequency: Routine Once PRN 12/16/24 0935 - 1 occurrence
Class: Normal
Released by: Kenzi E Griffin, RN 12/16/24 0935
Acknowledged: Kenzi E Griffin, RN 12/16/24 0935 for Placing Order
Package: 76204-200-01

Nursing

Notify Anesthesia (Discontinued)

Electronically signed by: **Susan Wittman, MD on 12/16/24 0837**
Status: **Discontinued**
Ordering user: Susan Wittman, MD 12/16/24 0837
Ordering provider: Susan Wittman, MD
Authorized by: Susan Wittman, MD
Ordering mode: Standard
Frequency: Routine Until discontinued 12/16/24 0936 - Until Specified
Class: Hospital Performed
Quantity: 1
Instance released by: Kenzi E Griffin, RN (auto-released) 12/16/2024 9:35 AM
Discontinued by: Automatic Transfer Provider 12/16/24 1145 [Patient Transfer]
Order comments: Notify attending anesthesiologist if patient continues to complain of pain.

Vital signs (per PACU protocol) (Discontinued)

Electronically signed by: **Susan Wittman, MD on 12/16/24 0837**
Status: **Discontinued**
Ordering user: Susan Wittman, MD 12/16/24 0837
Ordering provider: Susan Wittman, MD
Authorized by: Susan Wittman, MD
Ordering mode: Standard
Frequency: Routine Per unit protocol 12/16/24 0936 - Until Specified
Class: Hospital Performed

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Other Orders (continued)

Quantity: 1
Instance released by: Kenzi E Griffin, RN (auto-released) 12/16/2024 9:35 AM
Discontinued by: Automatic Transfer Provider 12/16/24 1145 [Patient Transfer]

Continuous Pulse Oximetry (Discontinued)

Electronically signed by: **Susan Wittman, MD on 12/16/24 0837**
Status: **Discontinued**
Ordering user: Susan Wittman, MD 12/16/24 0837
Ordering provider: Susan Wittman, MD
Authorized by: Susan Wittman, MD
Ordering mode: Standard
Frequency: Routine Until discontinued 12/16/24 0936 - Until Specified
Class: Hospital Performed
Quantity: 1
Instance released by: Kenzi E Griffin, RN (auto-released) 12/16/2024 9:35 AM
Discontinued by: Automatic Transfer Provider 12/16/24 1145 [Patient Transfer]

Cardiac monitoring (Discontinued)

Electronically signed by: **Susan Wittman, MD on 12/16/24 0837**
Status: **Discontinued**
Ordering user: Susan Wittman, MD 12/16/24 0837
Ordering provider: Susan Wittman, MD
Authorized by: Susan Wittman, MD
Ordering mode: Standard
Frequency: Routine Until discontinued 12/16/24 0936 - Until Specified
Class: Hospital Performed
Quantity: 1
Instance released by: Kenzi E Griffin, RN (auto-released) 12/16/2024 9:35 AM
Discontinued by: Automatic Transfer Provider 12/16/24 1145 [Patient Transfer]

May Return to Floor/Discharge from PACU (Discontinued)

Electronically signed by: **Susan Wittman, MD on 12/16/24 0837**
Status: **Discontinued**
Ordering user: Susan Wittman, MD 12/16/24 0837
Ordering provider: Susan Wittman, MD
Authorized by: Susan Wittman, MD
Ordering mode: Standard
Frequency: Routine Once 12/16/24 0936 - 1 occurrence
Class: Hospital Performed
Quantity: 1
Instance released by: Kenzi E Griffin, RN (auto-released) 12/16/2024 9:35 AM
Discontinued by: Automatic Transfer Provider 12/16/24 1145 [Patient Transfer]
Order comments: When patient meets criteria may return to floor/discharge from PACU.

Flowsheets

Activities of Daily Living Screening

Row Name	12/16/24 0718
ADL Screening	
Patient's Vision Adequate to Safely Complete Daily Activities	Yes
Patient's Judgment Adequate to Safely Complete Daily Activities	Yes
Patient's Memory Adequate to Safely Complete Daily Activities	Yes
Patient Able to Express Needs/Desires	Yes
Dressing	Dependent
Grooming	Dependent
Feeding	Dependent

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Flowsheets (continued)

Bathing	Dependent
Toileting	Dependent
In/Out Bed	Dependent
Walks in Home	Dependent
Weakness of Legs	None
Weakness of Arms/Hands	None
Hearing - Right Ear	Functional
Hearing - Left Ear	Functional
Assistive Devices	
Assistive Devices	None
Therapy Consults	
PT Evaluation Needed	No
OT Evaluation Needed	No
SLP Evaluation Needed	No

Care Plan (Perioperative/Perianesthesia)

Row Name	12/16/24 0720
Individualization	
Anxieties, Fears or Concerns	none stated att
Goal: Minimized Risk/Safety Maintenance	
Outcome Minimized Risk and Safety	progressing
Goal: Physiologic Homeostasis	
Outcome Physiologic Homeostasis	progressing
Goal: Optimal Comfort and Wellbeing	
Elevated Risk Identified	pain;situational anxiety
Outcome Optimal Comfort and Wellbeing	progressing
Outcome Summary	
Plan of Care Reviewed With	parent

Care Plan (Perioperative/Perianesthesia)

Row Name	12/16/24 1050	12/16/24 1216
Goal: Minimized Risk/Safety Maintenance		
Elevated Risk Identified	infection	—
Outcome Minimized Risk and Safety	progressing	met
Goal: Physiologic Homeostasis		
Elevated Risk	bleeding	—

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Flowsheets (continued)

Identified		
Outcome Physiologic Homeostasis	progressing	met

Goal: Optimal Comfort and Wellbeing

Elevated Risk Identified	pain	—
Outcome Optimal Comfort and Wellbeing	progressing	met

Goal: Anesthesia/Sedation Recovery

Outcome Anesthesia/Sedation Recovery	progressing	met

Outcome Summary

Plan of Care Reviewed With	parent	parent

Custom Formula Data

Row Name	12/16/24 0700	12/16/24 0718	12/16/24 0954	12/16/24 0955	12/16/24 1130
OTHER					
Percent Excess Weight Loss	70.86 Percent	—	—	—	—
IBW in lbs (Bariatric)	-39.04	—	—	—	—
Weight Change Since Last Visit	12.55 kg	—	—	—	—
IBW in kg (Bariatric)	-17.71	—	—	—	—
Weight Change since last visit	0	—	—	—	—
Percent Wt Change since Last Visit	0	—	—	—	—
IBW/kg (Calculated) Male	-5.6 kg	—	—	—	—
IBW in kg (Bariatric)	-17.71 kg	—	—	—	—
IBW in lb (Bariatric)	-39.04 lb	—	—	—	—
Weight Change Since Last Visit	12.55 kg	—	—	—	—
Weight Z-Score Current	-1.07	—	—	—	—
Length Z-Score Current	-0.75	—	—	—	—
Weight Growth Chart	CDC BOYS (2-20 YEARS)	—	—	—	—
Length Growth Chart	CDC BOYS (2-20 YEARS)	—	—	—	—
Measurements					
Total Weight Change Percent	2222 Percent	—	—	—	—
Weight Change Since Preop	12.55 kgs	—	—	—	—
Initial Excess Weight	17.71 kgs	—	—	—	—

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Flowsheets (continued)

Percent of IBW	0 Percent	—	—	—	—
EBW (kg)	443.18 kg	—	—	—	—
EBW (lbs)	445.12 lbs	—	—	—	—
Weight Change Since Preop	12.55 kg	—	—	—	—
Initial Excess Weight	17.71 kg	—	—	—	—
Percent of IBW	0 Percent	—	—	—	—
EBW (kg)	30.26 kg	—	—	—	—
EBW (lb)	66.71 lb	—	—	—	—
COPD Assessment					
BMI (Calculated)	15.16	—	—	—	—
Vital Signs					
BMI (Calculated)	15.16	—	—	—	—
Weight and Growth Recommendation					
IBW/kg (Calculated) Female	-10.1 kg	—	—	—	—
Vitals					
Boys Systolic BP Percentile	74 %	—	**96 %** !	71 %	—
Boys Diastolic BP Percentile	**99 %** !	—	85 %	74 %	—
Diastolic BP Percentile	—	—	85 %	74 %	—
Systolic BP Percentile	—	—	**96 %** !	71 %	—
Height and Weight					
Weight in (lb) to have BMI = 25	45.5	—	—	—	—
Measurements					
BMI (Calculated)	15.2	—	—	—	—
Percent Excess Weight Loss	70.86 Percent	—	—	—	—
Relevant Labs and Vitals					
Temp (in Celsius) for APACHE IV	36.1	—	36.3	—	36
Fall Risk Scale					
Fall Risk Calculated Score	—	Low Fall Risk	—	—	—
Fall Risk Calculated Score	—	8 (Humpty Dumpty)	—	—	—

Row Name	**12/16/24 1141**	**12/16/24 1200**
Relevant Labs and Vitals		
Temp (in Celsius) for APACHE IV	36	36.1

Discharge Planning

Row Name	**12/16/24 0719**	**12/16/24 1141**
Discharge Planning		
Living Arrangements	Parent	Parent
Support Systems	Parent	Parent
Assistance Needed	none at this time	none noted

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Flowsheets (continued)

Type of Residence	Private residence	Private residence
Patient expects to be discharged to:	HOME	home

Document Return of Belongings

Row Name	12/16/24 1149
Patient Belongings Sent Home	
Belongings Sent Home	None
Medications Sent Home	
Medications Sent Home	None to return

Education

Row Name	12/16/24 0719	12/16/24 1049	12/16/24 1141	12/16/24 1216
Education				
Person Taught	parent	parent	parent	parent
Learning Readiness and Ability	no barriers identified	no barriers identified	no barriers identified	no barriers identified
Teaching Focus	unit orientation;perioperative routine	unit orientation;discharge criteria	unit orientation;perioperative routine	discharge criteria;discharge instructions
Education Outcome Evaluation	eager to learn;verbalizes understanding	acceptance expressed;eager to learn	verbalizes understanding;eager to learn	eager to learn;verbalizes understanding
Discharge Instructions				
Discharge Readiness Evaluation	—	—	—	able to teach back
Patient Education Handouts	—	—	—	received AVS, OTC pain med sheet

Humpty Dumpty Pediatric Fall Assessment Scale

Row Name	12/16/24 0718
Humpty Dumpty Fall Risk Assessment	
Age	Less than 3 years old
Diagnosis	Other
Cognitive Impairment	Oriented to Own Ability
Environmental	Outpatient Area
Reponse to Surgery/Sedation /Anesthesia	No Sedation or More than 48 Hours
Total	8
Peds Fall Risk Category	Low Fall Risk
Fall Risk Interventions	
Humpty Dumpty Low Risk Fall	Orient to room;Lighting

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Flowsheets (continued)

Interventions	adequate;Call light in reach

Interventions

Row Name	12/16/24 0719	12/16/24 1049	12/16/24 1216
Interventions			
Fire Safety Risk Review	—	no elevated risk identified	no elevated risk identified
Fire Safety Interventions	—	—	safety protocol maintained
Warming Method	—	maintained	maintained
Safety Promotion/Fall Prevention	family at bedside;safety round/check completed	family at bedside	nonskid shoes/slippers when out of bed;family at bedside
Trust Relationship/Rapport	questions answered;care explained	care explained;choices provided;emotional support provided;empathic listening provided;questions answered;questions encouraged;reassurance provided;thoughts/feelings acknowledged	care explained;questions encouraged;questions answered;thoughts/feelings acknowledged;emotional support provided
Pain Management Interventions	pain management plan reviewed with patient/caregiver	pain management plan reviewed with patient/caregiver;pain medication given	care clustered;pain management plan reviewed with patient/caregiver;diversional activity provided;quiet environment facilitated

IV Assessment

Row Name	12/16/24 0954
[REMOVED] Peripheral IV 12/16/24 Left;Posterior	
IV Properties	Placement Date: 12/16/24 Hand Hygiene Completed: Yes Size (Gauge): 24 G Orientation: Left;Posterior Location: Hand Site Prep: Alcohol Technique: Anatomical landmarks Removal Date: 12/16/24 Removal Time: 1055
Site Assessment	Clean;Dry;Intact
Dressing Type	Transparent
Line Status	Saline locked
Dressing Status	Clean;Dry;Intact

LACE+ Score

Row Name	12/16/24 1220
LACE+	
LACE+ Score	11

Lines/Drains/Airways

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Flowsheets (continued)

Row Name	12/16/24 1141
[REMOVED] ETT 4 mm	
ETT Properties	Placement Date: 12/16/24 Placement Time: 0914 Placed by External Staff?: — , ENT Hand Hygiene Completed: Yes Mask Ventilation: Vent by mask Technique: Direct laryngoscopy;Stylet ETT Type: ETT - single Single Lumen Tube Size: 4 mm Cuffed: Yes Laryngoscope: — , suspension laryngoscope Location: Oral Grade View: Full view of the glottis Airway Insertion Attempts: 1 Placement Verification: Auscultation;Capnometry;Symmetrical chest wall movement Removal Date: 12/16/24 Removal Time: 0946
[REMOVED] Wound 12/16/24 Throat	
Wound Properties	Date First Assessed: 12/16/24 Hand Hygiene Completed: Yes Primary Wound Type: Other (comment) , ablation-coblator-adenoid site Location: Throat Final Assessment Date: 08/12/25 Final Assessment Time: 0603 Wound Outcome: Healed
Site Assessment	Intact
Peri-Wound Assessment	Intact
Closure	Unable to assess
Drainage Amount	None
Dressing	Open to air
Dressing Status	Intact
[REMOVED] Peripheral IV 12/16/24 Left;Posterior	
IV Properties	Placement Date: 12/16/24 Hand Hygiene Completed: Yes Size (Gauge): 24 G Orientation: Left;Posterior Location: Hand Site Prep: Alcohol Technique: Anatomical landmarks Removal Date: 12/16/24 Removal Time: 1055

Modified Aldrete Score

Row Name	12/16/24 0718	12/16/24 1141
Modified Aldrete		
Activity	Able to move 4 extremities voluntarily or on command	Able to move 4 extremities voluntarily or on command
Respiration	Able to breathe deeply and cough freely	Able to breathe deeply and cough freely
Circulation	Blood pressure is plus or minus 20% of pre-anesthetic level	Blood pressure is plus or minus 20% of pre-anesthetic level
Consciousness	Fully awake	Fully awake
Oxygen Saturation	Able to maintain oxygen saturation greater than 92% on room air	Able to maintain oxygen saturation greater than 92% on room air
Modified Aldrete Score	10	10

Normothermia Protocol

Row Name	12/16/24 0954
Postprocedure Normothermia Interventions	
Blanket Applied	No
Is the patient normothermic?	Yes

Nutrition Screen

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Flowsheets (continued)

Row Name	12/16/24 0727
Nutrition Screen	
Unplanned Weight Loss in Last Three Months	No
Poor Oral Intake for More Than Seven Days Prior to Admission	No
Difficulty Chewing or Swallowing	No
Pressure Injury or Non-Healing Wound	No
Home Tube Feeding or Total Parenteral Nutrition (TPN)	No
Dietitian Consult Needed	No

Pain Assessment

Row Name	12/16/24 0954	12/16/24 0955	12/16/24 1000	12/16/24 1005	12/16/24 1015
Pain Assessment Timer					
Restart Pain Assessment Timer	Yes	Yes	Yes	Yes	Yes

Row Name	12/16/24 1030	12/16/24 1045	12/16/24 1100	12/16/24 1115	12/16/24 1130
Pain Assessment Timer					
Restart Pain Assessment Timer	Yes	Yes	Yes	Yes	Yes

Row Name	12/16/24 1141	12/16/24 1200
Pain Assessment Timer		
Restart Pain Assessment Timer	Yes	Yes

Patient Belongings

Row Name	12/16/24 0710
Patient Belongings at Bedside	
Belongings at Bedside	Clothing
Clothing	Pants;Shirt
Patient Belongings Sent Home	
Belongings Sent Home	None
Patient Belongings Sent to Safe	
Belongings Sent to Safe	None

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Flowsheets (continued)

Peds Braden QD Scale Assessment

Row Name	12/16/24 0718
Braden QD Scale	
Mobility	No limitations
Sensory Perception	No Impairment
Friction and Shear	No problem
Nutrition	Adequate
Tissue Perfusion and Oxygenation	Adequate
Number of Medical Devices	0
Repositionability/ Skin Protection	No medical devices
Braden QD Score	0
Braden QD Skin Risk Level	Low Risk

Peds I/O

Row Name	12/16/24 0810	12/16/24 0859	12/16/24 0900	12/16/24 0903	12/16/24 0905
midazolam (PF) (Versed) 10 MG/2ML injection 6.25 mg Start: 12/16/24 0729					
Dose	*6.25 mg	—	—	—	—
propofol (Diprivan) 1000 MG/100ML infusion Start: 12/16/24 0859					
Dose	—	*250 mcg/kg/min	—	—	*300 mcg/kg/min
dexAMETHasone (Decadron) 4 MG/ML injection Start: 12/16/24 0903					
Dose	—	—	—	*6 mg	—

Row Name	12/16/24 0907	12/16/24 0908	12/16/24 0911	12/16/24 0914	12/16/24 0919
propofol (Diprivan) 1000 MG/100ML infusion Start: 12/16/24 0859					
Dose	*12 mg	*6 mg	*250 mcg/kg/min	*6 mg	*0 mcg/kg/min

Row Name	12/16/24 0923	12/16/24 0950	12/16/24 0951	12/16/24 1004	12/16/24 1022
lactated Ringer's infusion Start: 12/16/24 0900					
Rate	—	—	0 mL/hr	—	—
propofol (Diprivan) 1000 MG/100ML infusion Start: 12/16/24 0859					
Dose	—	*12 mg	—	—	—
morphine PF Start: 12/16/24 0923					
Dose	*0.6 mg	—	—	—	—
Fentanyl Drip					
Bolus (mcg) Fentanyl	—	—	—	6.3 mcg	6.3 mcg
Rate Fentanyl	—	—	—	—	—
Concentration Fentanyl	—	—	—	10 mcg/mL	10 mcg/mL

Row Name	12/16/24 1045	12/16/24 1100	12/16/24 1200
Intake			
P.O.	—	10 mL	30 mL
morphine PF 2 MG/ML 0.6 mg Start: 12/16/24 0935			
Dose	*0.6 mg	—	—

Peds PACU

Row Name	12/16/24 0954	12/16/24 0955	12/16/24 1000	12/16/24 1005	12/16/24 1015

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Flowsheets (continued)

Vital Signs					
Temp	36.3 °C (97.3 °F)	—	—	—	—
Temp src	Temporal	—	—	—	—
Pulse	131	128	**157** !	**165** !	**169** !
Heart Rate Source	Monitor	Monitor	Monitor	Monitor	Monitor
Resp	32	32	**52** !	**52** !	35
BP	107/54	93/50	— pt did not tolerate	— pt did not tolerate	—
MAP (mmHg)	75	69	—	—	—
BP Location	Right arm	Right arm	—	—	—
BP Method	Automatic	Automatic	—	—	—
Patient Position	Lying	Lying	—	—	—
Pain Assessment					
Pain Assessment	FLACC	FLACC	FLACC	FLACC	FLACC
FLACC (Face, Legs, Activity, Crying, Consolability)					
Pain Rating: FLACC (Activity) - Face	Occasional grimace or frown, withdrawn, disinterested	Occasional grimace or frown, withdrawn, disinterested	Occasional grimace or frown, withdrawn, disinterested	Occasional grimace or frown, withdrawn, disinterested	Occasional grimace or frown, withdrawn, disinterested
Pain Rating: FLACC (Activity) - Legs	Uneasy, restless, tense	Uneasy, restless, tense	Uneasy, restless, tense	Uneasy, restless, tense	Uneasy, restless, tense
Pain Rating: FLACC (Activity)	Squirming, shifting back and forth, tense	Squirming, shifting back and forth, tense	Squirming, shifting back and forth, tense	Squirming, shifting back and forth, tense	Squirming, shifting back and forth, tense
Pain Rating: FLACC (Activity) - Cry	Moans or whimpers, occasional complaint	Moans or whimpers, occasional complaint	Moans or whimpers, occasional complaint	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaint
Pain Rating: FLACC (Activity) - Consolability	Reassured by occasional touch, hug or being talked to	Reassured by occasional touch, hug or being talked to	Difficult to console or comfort	Difficult to console or comfort	Reassured by occasional touch, hug or being talked to
Score: FLACC (Activity)	5	5	6	6	6
Oxygen Therapy					
SpO2	99 %	98 %	93 %	93 %	95 %
Pulse Oximetry Type	Continuous	Continuous	Continuous	Continuous	Continuous
Oxygen Therapy	Supplemental oxygen	Supplemental oxygen	Supplemental oxygen	None (Room air)	None (Room air)
O2 Delivery Method	Simple mask	Blow-by neb treatment	Blow-by neb treatment	—	—
O2 Flow Rate (L/min)	6 L/min	6 L/min	6 L/min	—	—
Patient Observation					
Patient Observations	pt crying upset	—	—	—	parents at bedside
Modified Aldrete					
Activity	Able to move 4 extremities voluntarily or on command	—	—	—	Able to move 4 extremities voluntarily or on command
Respiration	Able to breathe deeply and cough freely	—	—	—	Able to breathe deeply and cough freely
Circulation	Blood pressure is plus or minus 20% of pre-anesthetic level	—	—	—	Blood pressure is plus or minus 20% of pre-anesthetic level

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Flowsheets (continued)

Consciousness	Arousable on calling	—	—	—	Fully awake
Oxygen Saturation	Needs oxygen inhalation to maintain oxygen saturation greater that 90%	—	—	—	Able to maintain oxygen saturation greater than 92% on room air
Modified Aldrete Score	8	—	—	—	10
Neurological					
Neurological (WDL)	**Exceptions to WDL** ! hx HIE, developmental delay, seizures	—	—	—	Within Defined Limits
Level of Consciousness	Responds to voice	—	—	—	—
Respiratory					
Respiratory (WDL)	Exceptions to WDL supplemental oxygen	—	—	—	Within Defined Limits
Respiratory Depth/Rhythm	Regular	—	—	—	Regular
Respiratory Effort	Unlabored	—	—	—	Unlabored
Chest Assessment	Symmetrical	—	—	—	Symmetrical
Bilateral Breath Sounds	Crackles	—	—	—	Crackles
[REMOVED] ETT 4 mm					
ETT Properties	Placement Date: 12/16/24 Placement Time: 0914 Placed by External Staff?: — , ENT Hand Hygiene Completed: Yes Mask Ventilation: Vent by mask Technique: Direct laryngoscopy;Stylet ETT Type: ETT - single Single Lumen Tube Size: 4 mm Cuffed: Yes Laryngoscope: — , suspension laryngoscope Location: Oral Grade View: Full view of the glottis Airway Insertion Attempts: 1 Placement Verification: Auscultation;Capnometry;Symmetrical chest wall movement Removal Date: 12/16/24 Removal Time: 0946				
Cardiac					
Cardiac (WDL)	Within Defined Limits hx pfo	—	—	—	—
Head, Ears, Eyes, Nose, and Throat (HEENT)					
Head, Ears, Eyes, Nose, and Throat (WDL)	Exceptions to WDL s/p adenoidectomy, suspended microlaryngoscopy/bronchoscopy, vocal cord injection	—	—	—	—
Nose	Congested or occluded;No drainage/discharge	—	—	—	—
Mouth	No bleeding	—	—	—	—
Peripheral Vascular					
Peripheral Vascular (WDL)	Within Defined Limits	—	—	—	—
Integumentary					
Integumentary (WDL)	Within Defined Limits	—	—	—	—
[REMOVED] Wound 12/16/24 Throat					
Wound Properties	Date First Assessed: 12/16/24 Hand Hygiene Completed: Yes Primary Wound Type: Other (comment) , ablation-coblator-adenoid site Location: Throat Final Assessment Date: 08/12/25 Final Assessment Time: 0603 Wound Outcome: Healed				
Site Assessment	Unable to assess internal wound	—	—	—	—
Peri-Wound	Unable to assess	—	—	—	—

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Flowsheets (continued)

Assessment					
Musculoskeletal					
Musculoskeletal (WDL)	Within Defined Limits	—	—	—	—
Gastrointestinal					
Gastrointestinal (WDL)	Within Defined Limits	—	—	—	—
Genitourinary					
Genitourinary (WDL)	Within Defined Limits	—	—	—	—
Row Name	**12/16/24 1030**	**12/16/24 1040**	**12/16/24 1045**	**12/16/24 1100**	**12/16/24 1115**
Vital Signs					
Pulse	**171** !	—	**155** !	**159** !	118
Heart Rate Source	Monitor	—	Monitor	Monitor	Monitor
Resp	30	—	35	20	21
Pain Assessment					
Pain Assessment	FLACC	—	FLACC	FLACC	FLACC
FLACC (Face, Legs, Activity, Crying, Consolability)					
Pain Rating: FLACC (Activity) - Face	Occasional grimace or frown, withdrawn, disinterested	—	Occasional grimace or frown, withdrawn, disinterested	No particular expression or smile	No particular expression or smile
Pain Rating: FLACC (Activity) - Legs	Uneasy, restless, tense	—	Uneasy, restless, tense	Normal position or relaxed	Normal position or relaxed
Pain Rating: FLACC (Activity)	Squirming, shifting back and forth, tense	—	Squirming, shifting back and forth, tense	Lying quietly, normal position, moves easily	Lying quietly, normal position, moves easily
Pain Rating: FLACC (Activity) - Cry	Crying steadily, screams or sobs, frequent complaint	—	Crying steadily, screams or sobs, frequent complaint	Moans or whimpers, occasional complaint	Moans or whimpers, occasional complaint
Pain Rating: FLACC (Activity) - Consolability	Reassured by occasional touch, hug or being talked to	—	Reassured by occasional touch, hug or being talked to	Reassured by occasional touch, hug or being talked to	Content, relaxed
Score: FLACC (Activity)	6	—	6	2	1
Oxygen Therapy					
SpO2	96 %	—	94 %	96 %	97 %
Pulse Oximetry Type	Continuous	—	Continuous	Continuous	Continuous
Oxygen Therapy	None (Room air)	—	None (Room air)	None (Room air)	None (Room air)
Patient Observation					
Patient Observations	—	—	—	—	pt asleep in moms arms
[REMOVED] Wound 12/16/24 Throat					
Wound Properties	Date First Assessed: 12/16/24 Hand Hygiene Completed: Yes Primary Wound Type: Other (comment) , ablation-coblator-adenoid site Location: Throat Final Assessment Date: 08/12/25 Final Assessment Time: 0603 Wound Outcome: Healed				
Provider Notification					
Reason for Communication	—	Evaluate pt inconsulable and pulling at IV	—	—	—
Provider Name	—	Dr. Wittman	—	—	—
Provider Role	—	Attending physician	—	—	—
Method of Communication	—	Face to face	—	—	—

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Flowsheets (continued)

Response	—	Other (Comment) give morphine and then remove IV	—	—	—
Notification Time	—	1041	—	—	—

Row Name	12/16/24 1130	12/16/24 1141	12/16/24 1200
Vital Signs			
Temp	36 °C (96.8 °F)	36 °C (96.8 °F)	36.1 °C (97 °F)
Temp src	Temporal	Temporal	Temporal
Pulse	140	135	129
Heart Rate Source	Monitor	Monitor	Monitor
Resp	25	24	24
BP	—	— pt irritable when RN nearby. unable to obtain BP.	—
Pain Assessment			
Pain Assessment	FLACC	FLACC	FLACC
FLACC (Face, Legs, Activity, Crying, Consolability)			
Pain Rating: FLACC (Rest) - Face	—	—	No particular expression or smile
Pain Rating: FLACC (Rest) - Legs	—	—	Normal position or relaxed
Pain Rating: FLACC (Rest) - Activity	—	—	Lying quietly, normal position, moves easily
Pain Rating: FLACC (Rest) - Cry	—	—	No cry (Awake or asleep)
Pain Rating: FLACC (Rest) - Consolability	—	—	Content, relaxed
Score: FLACC (Rest)	—	—	0
Pain Rating: FLACC (Activity) - Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	—
Pain Rating: FLACC (Activity) - Legs	Normal position or relaxed	Normal position or relaxed	—
Pain Rating: FLACC (Activity)	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	—
Pain Rating: FLACC (Activity) - Cry	Moans or whimpers, occasional complaint	Moans or whimpers, occasional complaint	—
Pain Rating: FLACC (Activity) - Consolability	Content, relaxed	Reassured by occasional touch, hug or being talked to	—
Score: FLACC (Activity)	1	4	—
Oxygen Therapy			
SpO2	96 %	97 %	95 %
Pulse Oximetry Type	Continuous	Continuous	—
Oxygen Therapy	None (Room air)	None (Room air)	None (Room air)
Patient Observation			

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Flowsheets (continued)

Patient Observations	—	Pt awake and alert. watching tv	—
Neurological			
Neurological (WDL)	—	Within Defined Limits hx: HIE, developmental delay, neonatal seizure.	—
Level of Consciousness	—	Alert	—
Cry	—	Strong	—
Respiratory			
Respiratory (WDL)	—	Within Defined Limits	—
Respiratory Depth/Rhythm	—	Regular	—
Respiratory Effort	—	Unlabored	—
Chest Assessment	—	Symmetrical;Trachea midline	—
Bilateral Breath Sounds	—	Coarse	—
Cardiac			
Cardiac (WDL)	—	Within Defined Limits hx: PFO	—
Head, Ears, Eyes, Nose, and Throat (HEENT)			
Head, Ears, Eyes, Nose, and Throat (WDL)	—	Exceptions to WDL s/p adenoidectomy, bronchoscopy, vocal cord injection.	—
Throat	—	Intact	—
Peripheral Vascular			
Peripheral Vascular (WDL)	—	Within Defined Limits	—
Integumentary			
Integumentary (WDL)	—	Within Defined Limits	—
[REMOVED] Wound 12/16/24 Throat			
Wound Properties	Date First Assessed: 12/16/24 Hand Hygiene Completed: Yes Primary Wound Type: Other (comment) , ablation-coblator-adenoid site Location: Throat Final Assessment Date: 08/12/25 Final Assessment Time: 0603 Wound Outcome: Healed		
Musculoskeletal			
Musculoskeletal (WDL)	—	Within Defined Limits	—
Gastrointestinal			
Gastrointestinal (WDL)	—	Within Defined Limits	—
Abdomen Inspection	—	Nondistended;Rounded	—
Abdominal Tenderness	—	Soft	—
Bowel Sounds	—	All quadrants	—
Bowel Sounds (All Quadrants)	—	Active	—
Genitourinary			
Genitourinary (WDL)	—	Within Defined Limits	—

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Flowsheets (continued)

Peds Vitals

Row Name	12/16/24 0700
Vital Signs	
Temp	36.1 °C (97 °F)
Pulse	130
Resp	22
BP	**94/79** !
Systolic BP Percentile	74 %
Diastolic BP Percentile	**99 %** !
Oxygen Therapy	
SpO2	98 %
Height and Weight	
Height	0.91 m (2' 11.83")
Weight	12.5 kg (27 lb 10.7 oz)
Dosing Weight	12.5 kg (27 lb 10.7 oz)
BSA (Calculated - sq m)	0.56 sq meters

Peds/PICU Assessment

Row Name	12/16/24 0716
Neurological	
Neurological (WDL)	Within Defined Limits
Head, Ears, Eyes, Nose, and Throat (HEENT)	
Head, Ears, Eyes, Nose, and Throat (WDL)	Exceptions to WDL hx: nasal obstruction/snoring
Respiratory	
Respiratory (WDL)	Within Defined Limits
[REMOVED] ETT 4 mm	
ETT Properties	Placement Date: 12/16/24 Placement Time: 0914 Placed by External Staff?: — , ENT Hand Hygiene Completed: Yes Mask Ventilation: Vent by mask Technique: Direct laryngoscopy;Stylet ETT Type: ETT - single Single Lumen Tube Size: 4 mm Cuffed: Yes Laryngoscope: — , suspension laryngoscope Location: Oral Grade View: Full view of the glottis Airway Insertion Attempts: 1 Placement Verification: Auscultation;Capnometry;Symmetrical chest wall movement Removal Date: 12/16/24 Removal Time: 0946
Cardiac	
Cardiac (WDL)	Within Defined Limits
Peripheral Vascular	
Peripheral Vascular (WDL)	Within Defined Limits
Integumentary	
Integumentary (WDL)	Within Defined Limits
[REMOVED] Wound 12/16/24 Throat	
Wound Properties	Date First Assessed: 12/16/24 Hand Hygiene Completed: Yes Primary Wound Type: Other (comment) , ablation-coblator-adenoid site Location: Throat Final Assessment Date: 08/12/25 Final Assessment Time: 0603 Wound Outcome: Healed
Musculoskeletal	

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Flowsheets (continued)

Musculoskeletal (WDL)	Within Defined Limits
Gastrointestinal	
Gastrointestinal (WDL)	Within Defined Limits
Genitourinary	
Genitourinary (WDL)	Within Defined Limits
Psychosocial	
Psychosocial (WDL)	Within Defined Limits
Charting Type	
Charting Type	Admission

Safety and Coping

Row Name	12/16/24 0718
Safety and Concerns	
Concern About Anyone in Family Being Harmed	Unable to screen due to no privacy
Caregiver Concerns and Issues	none at this time
Coping	
Ways to Help Child Cope	family support
Consults	
Child Life Consult Needed	No
Social Services Consult Needed	No

Screenings (A)

Row Name	12/16/24 0718
Trauma/Abuse Assessment	
Physical Abuse	Unable to assess
Verbal Abuse	Unable to assess
Values/Beliefs	
Cultural Requests During Hospitalization	none at this time
Spiritual Requests During Hospitalization	none at this time
Consults	
Spiritual Care Consult Needed	No
Palliative Care Consult Needed	No

Vital Signs

Row Name	12/16/24 0700	12/16/24 0954	12/16/24 0955	12/16/24 1000	12/16/24 1005

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Flowsheets (continued)

Vital Signs					
Restart Vitals Timer	Yes	Yes	Yes	Yes	Yes
Row Name	**12/16/24 1015**	**12/16/24 1030**	**12/16/24 1045**	**12/16/24 1100**	**12/16/24 1115**
Vital Signs					
Restart Vitals Timer	Yes	Yes	Yes	Yes	Yes
Row Name	**12/16/24 1130**	**12/16/24 1141**	**12/16/24 1200**		
Vital Signs					
Restart Vitals Timer	Yes	Yes	Yes		

Vitals Reassessment

Row Name	**12/16/24 0700**	**12/16/24 0954**	**12/16/24 0955**	**12/16/24 1000**	**12/16/24 1005**
Vitals Timer					
Restart Vitals Timer	Yes	Yes	Yes	Yes	Yes
Row Name	**12/16/24 1015**	**12/16/24 1030**	**12/16/24 1045**	**12/16/24 1100**	**12/16/24 1115**
Vitals Timer					
Restart Vitals Timer	Yes	Yes	Yes	Yes	Yes
Row Name	**12/16/24 1130**	**12/16/24 1141**	**12/16/24 1200**		
Vitals Timer					
Restart Vitals Timer	Yes	Yes	Yes		

VITALS/NPO STATUS

Row Name	**12/16/24 0709**
NPO/Void Status	
Date of Last Liquid	12/15/24
Time of Last Liquid	2200
Date of Last Solid	12/15/24
Time of Last Solid	2200

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Documents

Clinical Photo - Scan on 12/16/2024: AIDA HD CONNECT

Scan (below)

AIDA HD Connect

STORZ
KARL STORZ · ENDOSKOPE

Date Of Treatment: 12/16/2024
Surgeon: Ramjee
Hospital: OU Children's OR 3
Patient ID:
Last Name: PHILLIPS
First Name: PARKER
Date of Birth: 02/08/2022
Procedure: smlBONCH

Captures: Stills (7), Videos (0) 00:00:00

File Name: IMG007
File Remarks: IMG007

Phillips, Parker L
CSN: 1038914696
DOB: 2/8/2022 (2 yrs)
Sex: Male
MRN: 1001652520
Adm Date: 12/16/2024

Page 2 of 2

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Documents (continued)

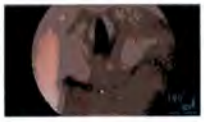
AIDA HD Connect

STORZ KARL STORZ ENDOSKOPE

Date Of Treatment: 12/16/2024
Surgeon: Ramjee
Hospital: OU Children's OR 3
Patient ID:
Last Name: PHILLIPS
First Name: PARKER
Date of Birth: 02/08/2022
Procedure: smlBONCH

Phillips, Parker L
URG CARE SITES POC USE ONLY
CSN: 1038914696
MRN: 1001652520
DOB: 2/8/2022 (2 yrs) / **Sex:** M

Captures: Stills: (7), Videos: (0) 00:00:00



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File Remarks: IMG001

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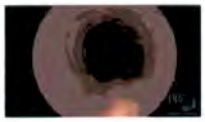
File Remarks: IMG002



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File Remarks: IMG003

File Name: IMG004
File Remarks: IMG004

File Name: IMG005
File Remarks: IMG005

File Name: IMG006
File Remarks: IMG006

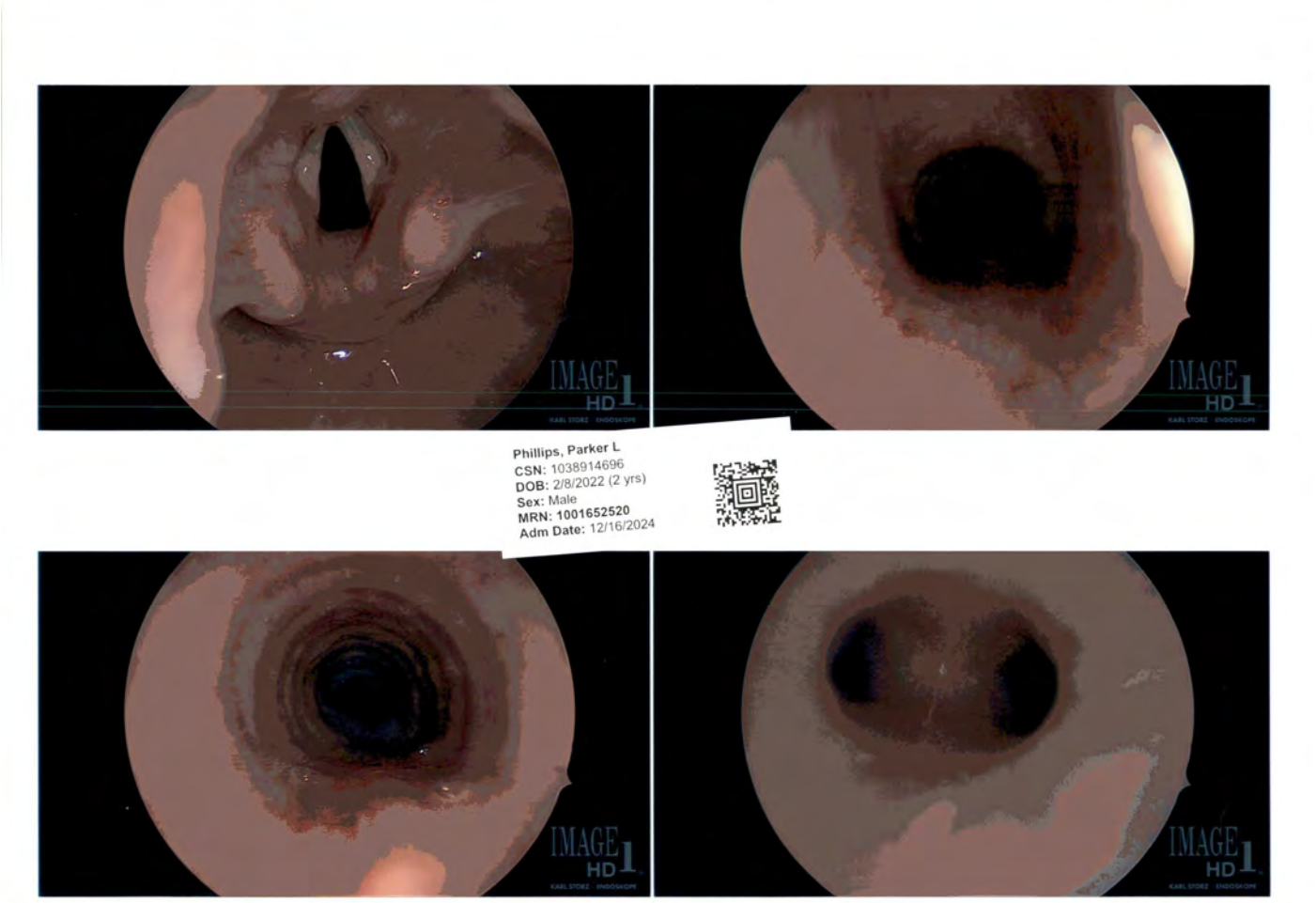
Page 1 of 2

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Documents (continued)

Clinical Photo - Scan on 12/16/2024

Scan (below)

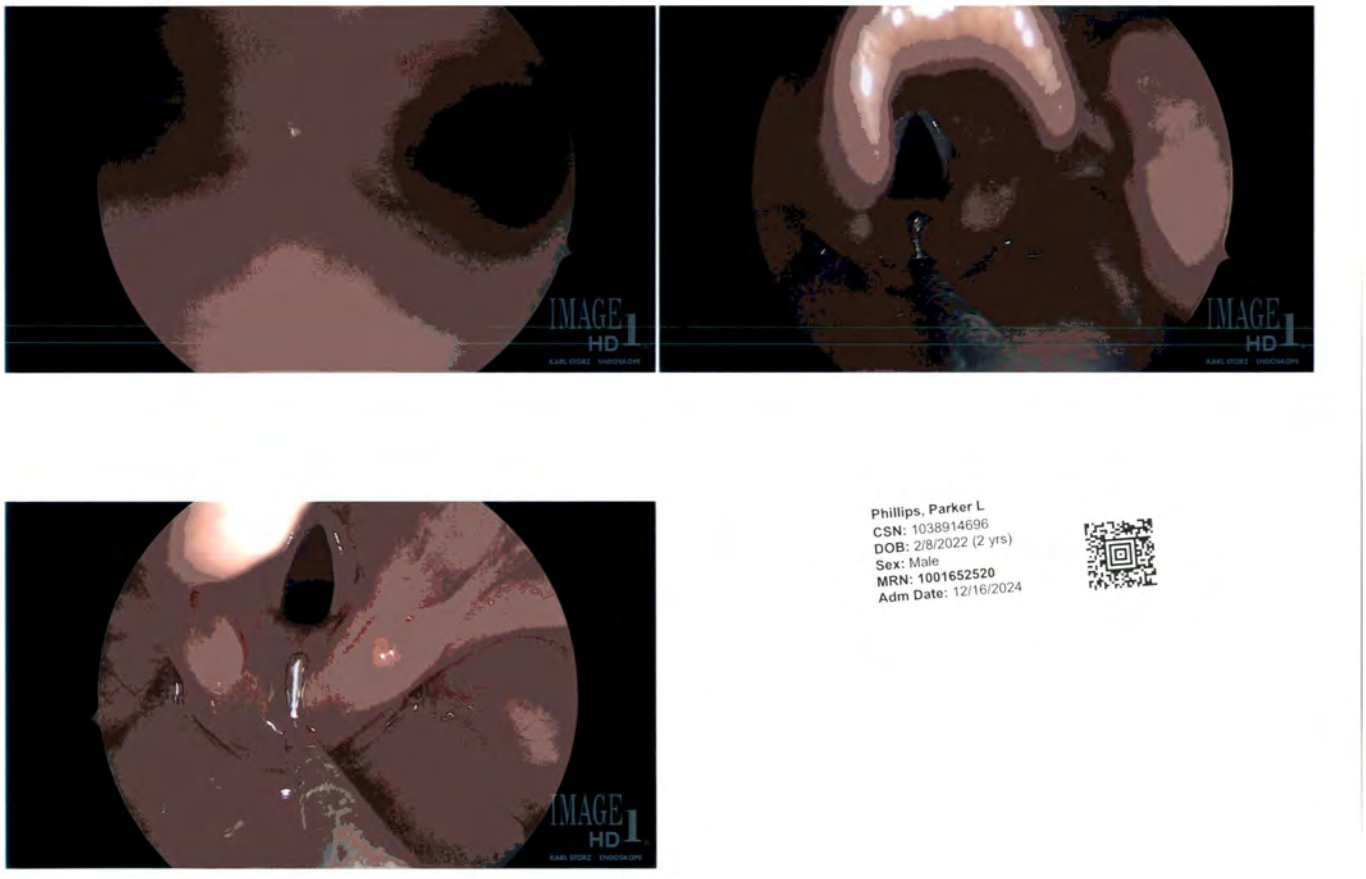


12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Documents (continued)

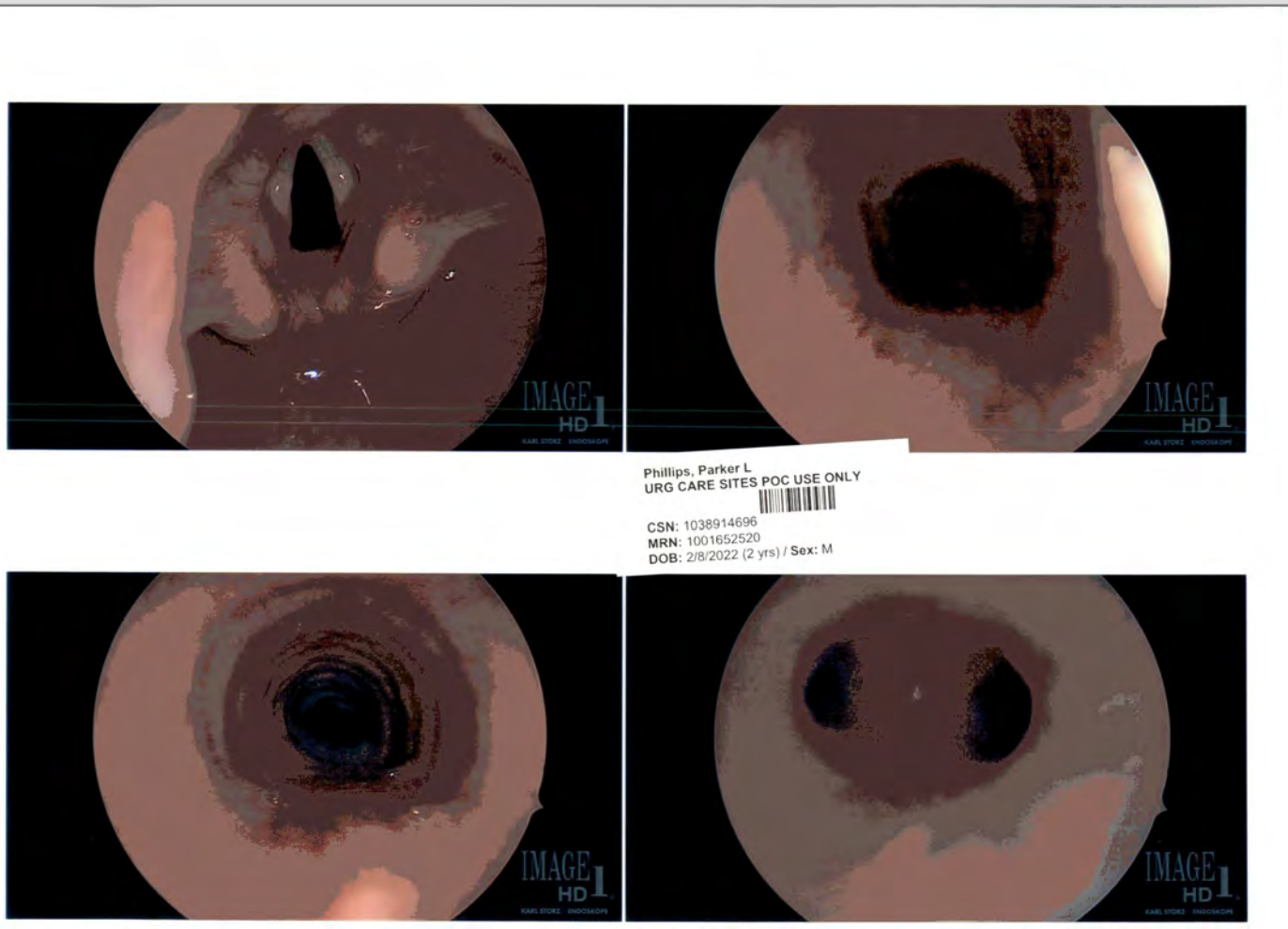
Clinical Photo - Scan on 12/16/2024

Scan (below)



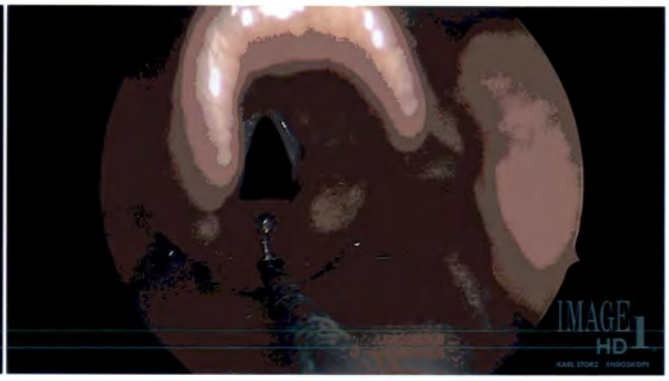
12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

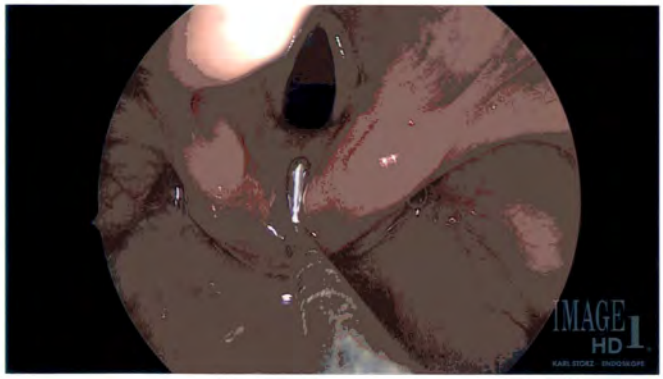
Documents (continued)



12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Documents (continued)





Phillips, Parker L
URG CARE SITES POC USE ONLY
CSN: 1038914696
MRN: 1001652520
DOB: 2/8/2022 (2 yrs) / Sex: M

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Documents (continued)

Consent Form - Scan on 12/16/2024 6:56 AM: Ease App (effective from 12/16/2024)

Scan (below)

EASE APPLICATIONS

CONSENT FOR ELECTRONIC ACCESS TO SURGICAL EVENTS

What it is: Electronic Access to Surgical Events (EASE) is provided by The Children's Hospital at OUMS as an optional way to update the patients' designated loved ones ("Designated Recipients") about the patient's progress during a medical procedure. EASE is a secure messaging system that is used to update the patient's designated loved ones ("Designated Recipients") about the progress of the patient undergoing medical procedures. Updates are sent to the patient's Designated Recipients via text message, photographs, and/or video/audio recording. The EASE application ("EASE app") allows the creation of a secure communications link with the patient's Designated Recipient's smart phone or other device for the transmission of that patient's updates via text message, photographs, and/or video/audio recording. EASE and the EASE app are the property of its creator, EASE Applications, LLC, a Florida limited liability company. The EASE app requires a minimum software requirement as designated in the Apple and Android App Stores.

How it works: The patient's Designated Recipients download the EASE app, called "EASE," to their smart phones or other mobile devices. In order to use the EASE app, the Designated Recipients must agree to specific terms and conditions. During the patient's procedure, updates will be sent to the patient's Designated Recipients' devices via the EASE app. The updates may include texts, pictures, or video/audio that detail the patient's procedure and medical progress. There may be service interruptions due to elements out of the control of The Children's Hospital at OUMS and EASE Applications, LLC such as Cellular service or Internet connectivity.

Confidentiality: Patient information is confidential. EASE is provided as an optional way for patients to share updates with their loved ones. You are not required to participate in EASE. If you choose to participate in EASE, you will designate the individuals who will receive information about your procedure (your "Designated Recipients") and decide whether your Designated Recipients will receive text updates, photographs, and/or video/audio. The medical information sent using the EASE app is encrypted to protect confidentiality. However, once your Designated Recipient receives the information, neither EASE Application, LLC nor The Children's Hospital at OUMS (are able to control how that information is used by your Designated Recipient.

If you want to participate in EASE, please complete this form consenting to the disclosure of information to your Designated Recipients.

CONSENT

I, Tatum Phillips (Parents/Legal Guardian) wish to participate in EASE (Electronic Access to Surgical Events) in connection with the following procedure(s) at The Children's Hospital at OUMS:

Procedure(s): Laparoscopy Date: 12/16/24

I understand that participation in EASE is optional and that if I choose to participate in EASE, confidential information about the patient will be provided to the individuals I designate to receive such information ("Designated Recipient(s)") within the EASE app.

I hereby authorize The Children's Hospital at OUMS, its medical staff, agents, and employees, to disclose information about the Procedure(s) and the patient's progress to Designated Recipients.

If I have selected Photographs and/or Video/Audio Recordings, I hereby authorize The Children's Hospital at OUMS, its medical staff, agents, and employees, to take photographs and/or video/audio recordings of the patient during the Procedure(s), and release EASE Applications, LLC, The Children's Hospital at OUMS, their medical staff, agents, officers, directors, and employees from any and all claims related to the taking of such photographs and video recordings within the EASE app.

I hereby release EASE Applications, LLC, The Children's Hospital at OUMS, their medical staff, agents, officers, directors, and employees from any and all claims related to the release of information concerning the patient to Designated Recipient(s) pursuant to this Consent.

I understand that the information released pursuant to this Consent is individually identifiable health information as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other laws and regulations. I understand that information that has been disclosed is subject to re-disclosure and is no longer protected. I understand that refusal to sign this Consent will not affect the patient's treatment.

I understand that I may revoke this Consent at any time, except to the extent that The Children's Hospital at OUMS has already taken action in reliance on this Consent.

Tatum Phillips — Patient/Legal Representative's Signature — Date: 12/16/24 — Time: 656

Witness Signature — Date: 12/16/24 — Time:

Phillips, Parker L
CSN: 1038914696
DOB: 2/8/2022 (2 yrs)
Sex: Male
MRN: 1001652520
Adm Date: 12/16/2024

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

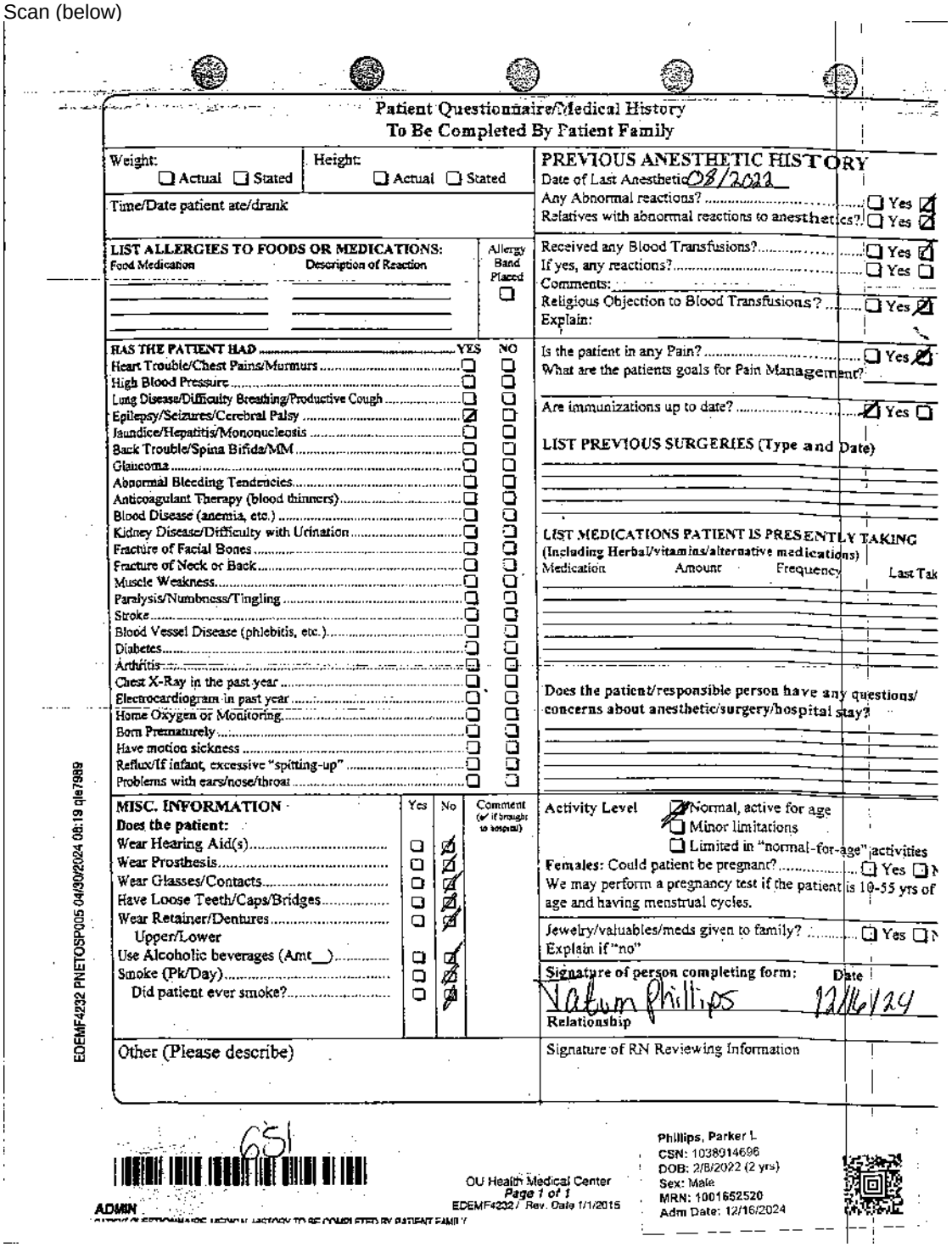
Documents (continued)

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Documents (continued)

Questionnaire - Scan on 12/16/2024 6:57 AM: patient questionnaire (effective from 12/16/2024)

Scan (below)



Patient Questionnaire/Medical History
To Be Completed By Patient Family

Weight: ☐ Actual ☐ Stated
Height: ☐ Actual ☐ Stated
Time/Date patient ate/drank

LIST ALLERGIES TO FOODS OR MEDICATIONS:
Food Medication — Description of Reaction — Allergy Band Placed ☐

HAS THE PATIENT HAD	YES	NO
Heart Trouble/Chest Pains/Murmurs	☐	☐
High Blood Pressure	☐	☐
Lung Disease/Difficulty Breathing/Productive Cough	☐	☐
Epilepsy/Seizures/Cerebral Palsy	☑	☐
Jaundice/Hepatitis/Mononucleosis	☐	☐
Back Trouble/Spina Bifida/MM	☐	☐
Glaucoma	☐	☐
Abnormal Bleeding Tendencies	☐	☐
Anticoagulant Therapy (blood thinners)	☐	☐
Blood Disease (anemia, etc.)	☐	☐
Kidney Disease/Difficulty with Urination	☐	☐
Fracture of Facial Bones	☐	☐
Fracture of Neck or Back	☐	☐
Muscle Weakness	☐	☐
Paralysis/Numbness/Tingling	☐	☐
Stroke	☐	☐
Blood Vessel Disease (phlebitis, etc.)	☐	☐
Diabetes	☐	☐
Arthritis	☐	☐
Chest X-Ray in the past year	☐	☐
Electrocardiogram in past year	☐	☐
Home Oxygen or Monitoring	☐	☐
Born Prematurely	☐	☐
Have motion sickness	☐	☐
Reflux/If infant, excessive "spitting-up"	☐	☐
Problems with ears/nose/throat	☐	☐

MISC. INFORMATION Does the patient:	Yes	No	Comment (✓ if brought to hospital)
Wear Hearing Aid(s)	☐	☑	
Wear Prosthesis	☐	☑	
Wear Glasses/Contacts	☐	☑	
Have Loose Teeth/Caps/Bridges	☐	☑	
Wear Retainer/Dentures Upper/Lower	☐	☑	
Use Alcoholic beverages (Amt__)	☐	☑	
Smoke (Pk/Day)	☐	☑	
Did patient ever smoke?	☐	☑	

Other (Please describe)

PREVIOUS ANESTHETIC HISTORY
Date of Last Anesthetic 08/2022
Any Abnormal reactions? ☐ Yes ☑
Relatives with abnormal reactions to anesthetics? ☐ Yes ☑
Received any Blood Transfusions? ☐ Yes ☑
If yes, any reactions? ☐ Yes ☐
Comments:
Religious Objection to Blood Transfusions? ☐ Yes ☑
Explain:
Is the patient in any Pain? ☐ Yes ☑
What are the patients goals for Pain Management?
Are immunizations up to date? ☑ Yes ☐

LIST PREVIOUS SURGERIES (Type and Date)

LIST MEDICATIONS PATIENT IS PRESENTLY TAKING
(Including Herbal/vitamins/alternative medications)
Medication — Amount — Frequency — Last Tak

Does the patient/responsible person have any questions/ concerns about anesthetic/surgery/hospital stay?

Activity Level ☑ Normal, active for age ☐ Minor limitations ☐ Limited in "normal-for-age" activities
Females: Could patient be pregnant? ☐ Yes ☐ N
We may perform a pregnancy test if the patient is 10-55 yrs of age and having menstrual cycles.
Jewelry/valuables/meds given to family? ☐ Yes ☐ N
Explain if "no"
Signature of person completing form: Date
Jatum Phillips 12/16/24
Relationship

Signature of RN Reviewing Information

EDEMF4232 PNETOSP005 04/30/2024 08:19 qle7989

651

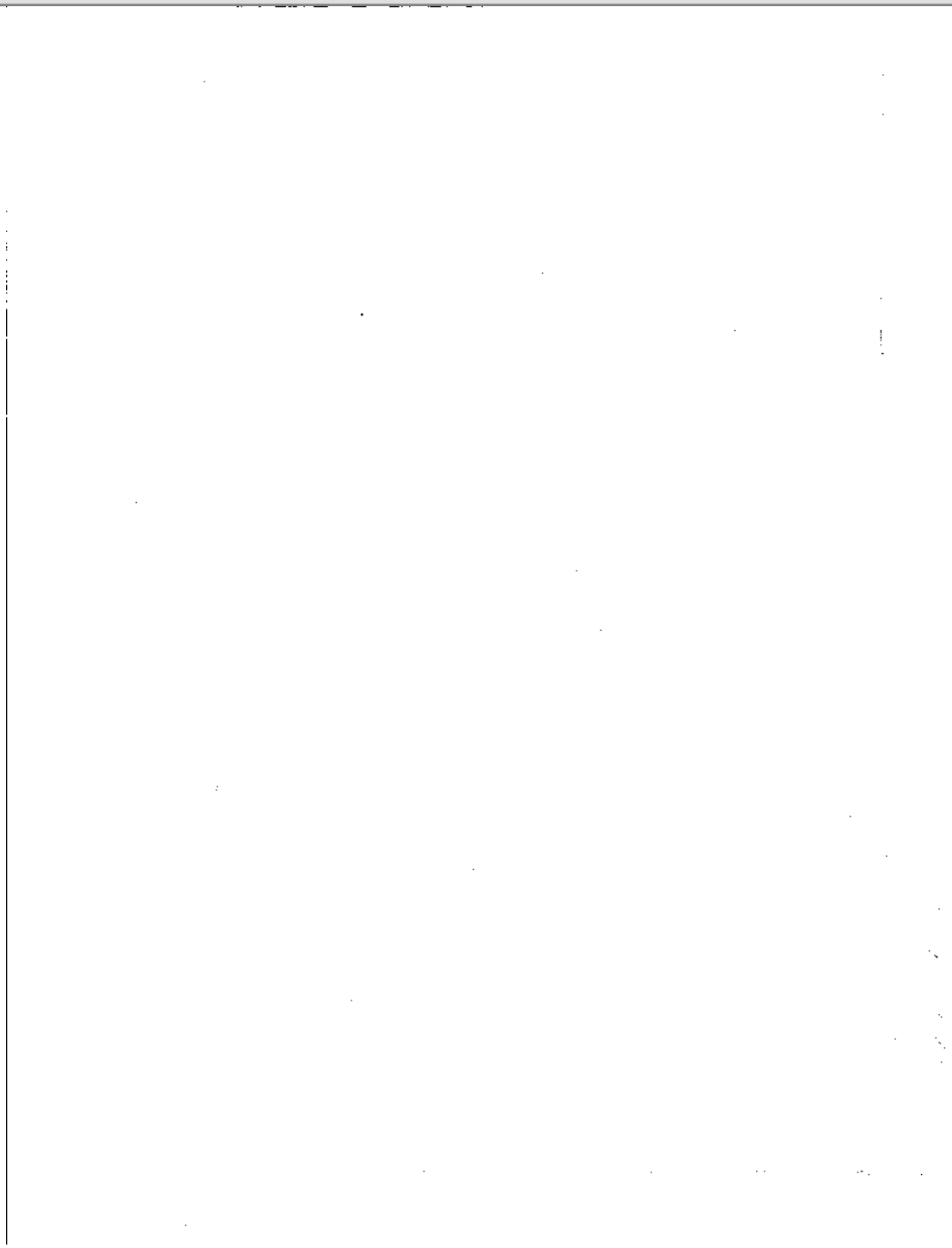
ADMIN

OU Health Medical Center
Page 1 of 1
EDEMF4232 / Rev. Date 1/1/2015

Phillips, Parker L
CSN: 1038914696
DOB: 2/8/2022 (2 yrs)
Sex: Male
MRN: 1001652520
Adm Date: 12/16/2024

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Documents (continued)

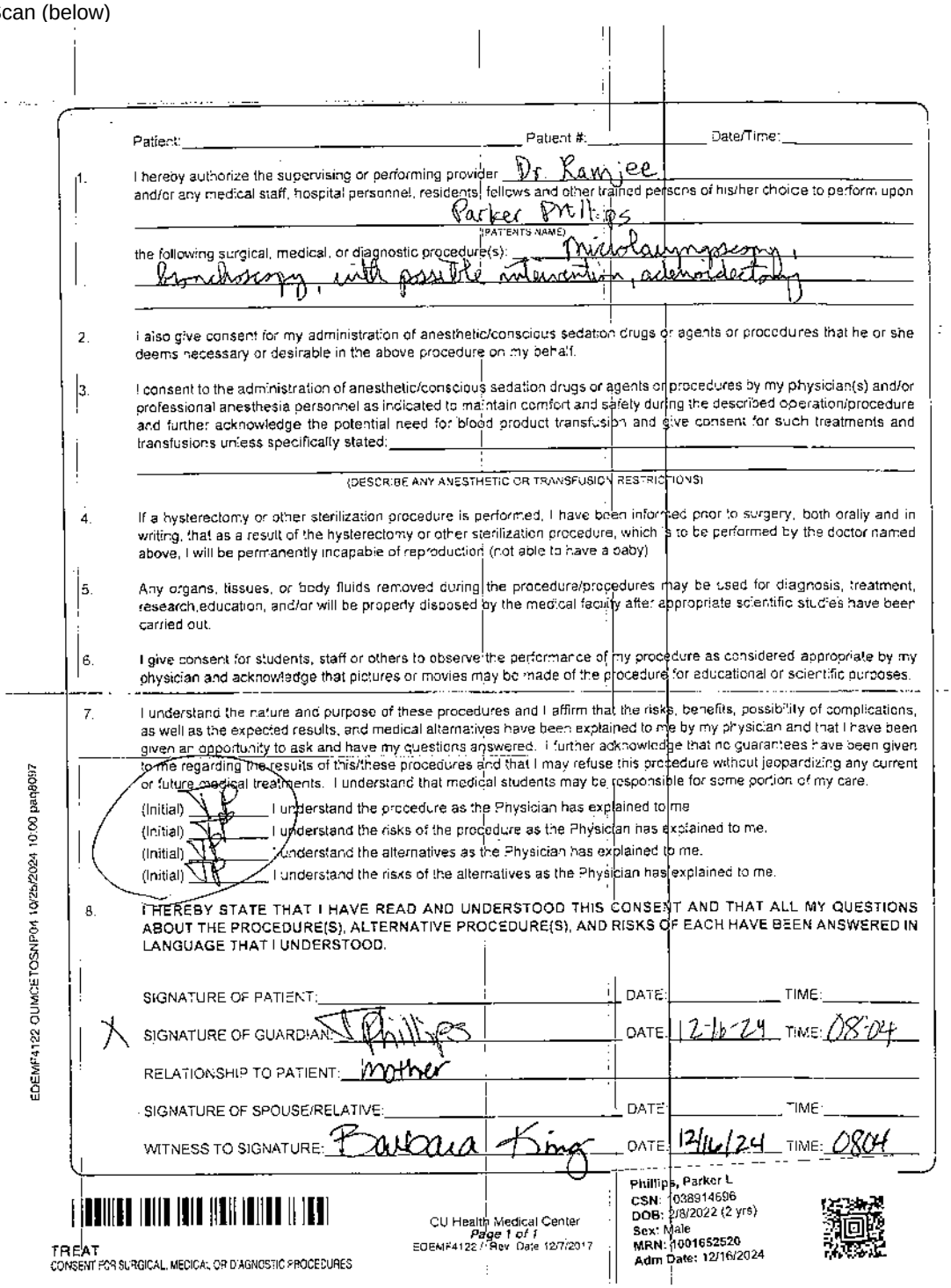


12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Documents (continued)

Consent Form - Scan on 12/16/2024 8:07 AM: ORL Surgery Consent (effective from 12/16/2024)

Scan (below)



Patient: _____ Patient #: _____ Date/Time: _____

1. I hereby authorize the supervising or performing provider Dr. Ranjee and/or any medical staff, hospital personnel, residents, fellows and other trained persons of his/her choice to perform upon Parker Phillips (PATIENT'S NAME) the following surgical, medical, or diagnostic procedure(s): Direct laryngoscopy, bronchoscopy, with possible intervention, adenoidectomy

2. I also give consent for my administration of anesthetic/conscious sedation drugs or agents or procedures that he or she deems necessary or desirable in the above procedure on my behalf.

3. I consent to the administration of anesthetic/conscious sedation drugs or agents or procedures by my physician(s) and/or professional anesthesia personnel as indicated to maintain comfort and safety during the described operation/procedure and further acknowledge the potential need for blood product transfusion and give consent for such treatments and transfusions unless specifically stated: _____ (DESCRIBE ANY ANESTHETIC OR TRANSFUSION RESTRICTIONS)

4. If a hysterectomy or other sterilization procedure is performed, I have been informed prior to surgery, both orally and in writing, that as a result of the hysterectomy or other sterilization procedure, which is to be performed by the doctor named above, I will be permanently incapable of reproduction (not able to have a baby)

5. Any organs, tissues, or body fluids removed during the procedure/procedures may be used for diagnosis, treatment, research,education, and/or will be properly disposed by the medical faculty after appropriate scientific studies have been carried out.

6. I give consent for students, staff or others to observe the performance of my procedure as considered appropriate by my physician and acknowledge that pictures or movies may be made of the procedure for educational or scientific purposes.

7. I understand the nature and purpose of these procedures and I affirm that the risks, benefits, possibility of complications, as well as the expected results, and medical alternatives have been explained to me by my physician and that I have been given an opportunity to ask and have my questions answered. I further acknowledge that no guarantees have been given to me regarding the results of this/these procedures and that I may refuse this procedure without jeopardizing any current or future medical treatments. I understand that medical students may be responsible for some portion of my care.

(Initial) BP I understand the procedure as the Physician has explained to me
(Initial) BP I understand the risks of the procedure as the Physician has explained to me.
(Initial) BP I understand the alternatives as the Physician has explained to me.
(Initial) BP I understand the risks of the alternatives as the Physician has explained to me.

8. I HEREBY STATE THAT I HAVE READ AND UNDERSTOOD THIS CONSENT AND THAT ALL MY QUESTIONS ABOUT THE PROCEDURE(S), ALTERNATIVE PROCEDURE(S), AND RISKS OF EACH HAVE BEEN ANSWERED IN LANGUAGE THAT I UNDERSTOOD.

SIGNATURE OF PATIENT: _____ DATE: _____ TIME: _____

X SIGNATURE OF GUARDIAN: J Phillips DATE: 12-16-24 TIME: 08:04

RELATIONSHIP TO PATIENT: mother

SIGNATURE OF SPOUSE/RELATIVE: _____ DATE: _____ TIME: _____

WITNESS TO SIGNATURE: Barbara King DATE: 12/16/24 TIME: 0804

EDEMF4122 OUMCETOSNP04 10/25/2024 10:00 pat#0697

TREAT
CONSENT FOR SURGICAL, MEDICAL, OR DIAGNOSTIC PROCEDURES

CU Health Medical Center
Page 1 of 1
EDEMF4122 / Rev. Date 12/7/2017

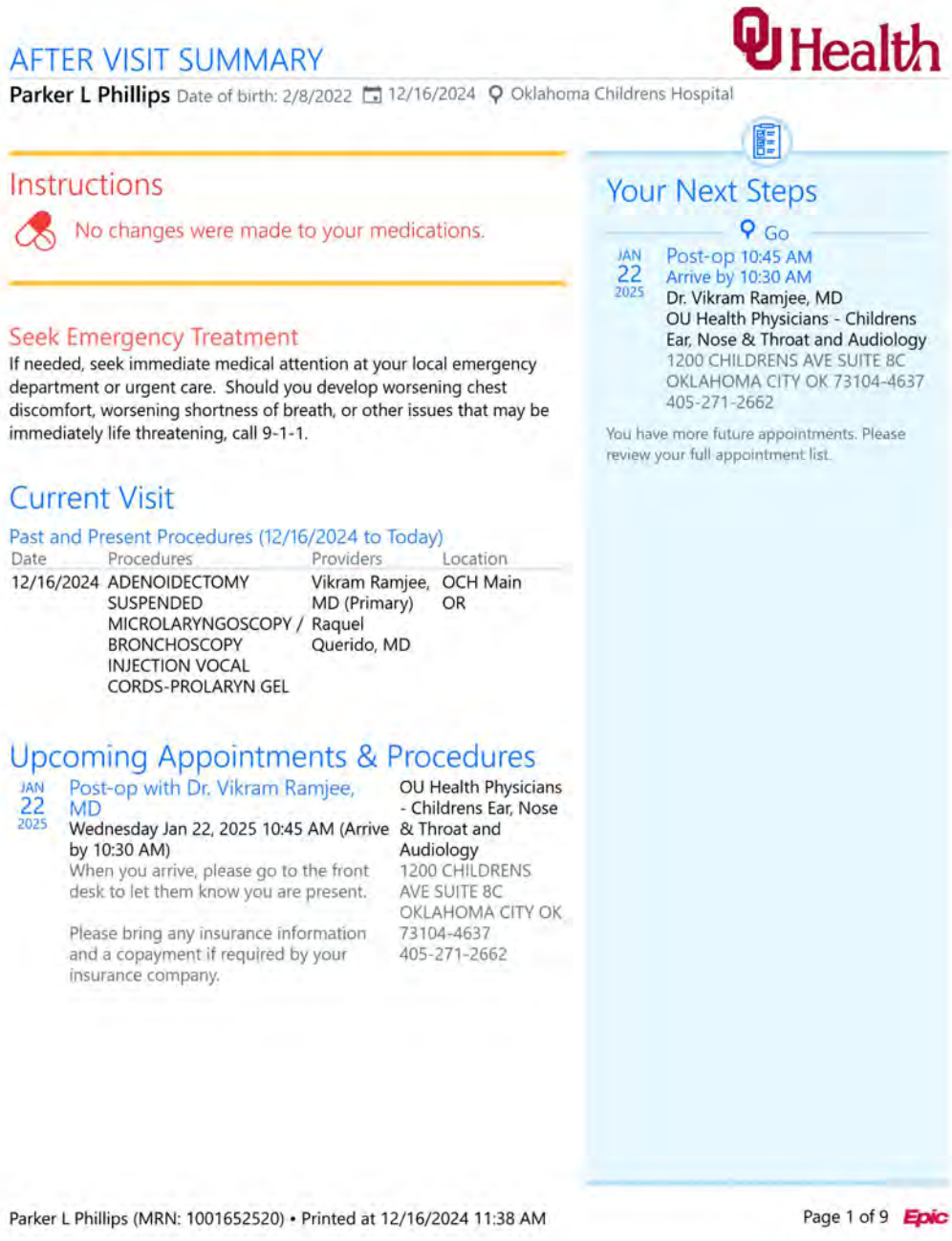
Phillips, Parker L
CSN: 038914696
DOB: 2/8/2022 (2 yrs)
Sex: Male
MRN: 1001652520
Adm Date: 12/16/2024

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Documents (continued)

After Visit Summary - Document on 12/16/2024 11:38 AM: AVS - Postprocedure Care

Document (below)



AFTER VISIT SUMMARY

Parker L Phillips Date of birth: 2/8/2022 12/16/2024 Oklahoma Childrens Hospital

Instructions

No changes were made to your medications.

Seek Emergency Treatment

If needed, seek immediate medical attention at your local emergency department or urgent care. Should you develop worsening chest discomfort, worsening shortness of breath, or other issues that may be immediately life threatening, call 9-1-1.

Current Visit

Past and Present Procedures (12/16/2024 to Today)

Date	Procedures	Providers	Location
12/16/2024	ADENOIDECTOMY SUSPENDED MICROLARYNGOSCOPY / BRONCHOSCOPY INJECTION VOCAL CORDS-PROLARYN GEL	Vikram Ramjee, MD (Primary) Raquel Querido, MD	OCH Main OR

Upcoming Appointments & Procedures

JAN 22 2025 — Post-op with Dr. Vikram Ramjee, MD
Wednesday Jan 22, 2025 10:45 AM (Arrive by 10:30 AM)
When you arrive, please go to the front desk to let them know you are present.

Please bring any insurance information and a copayment if required by your insurance company.

OU Health Physicians - Childrens Ear, Nose & Throat and Audiology
1200 CHILDRENS AVE SUITE 8C
OKLAHOMA CITY OK 73104-4637
405-271-2662

Your Next Steps

Go

JAN 22 2025 — Post-op 10:45 AM
Arrive by 10:30 AM
Dr. Vikram Ramjee, MD
OU Health Physicians - Childrens Ear, Nose & Throat and Audiology
1200 CHILDRENS AVE SUITE 8C
OKLAHOMA CITY OK 73104-4637
405-271-2662

You have more future appointments. Please review your full appointment list.

Parker L Phillips (MRN: 1001652520) • Printed at 12/16/2024 11:38 AM

Page 1 of 9 Epic

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Documents (continued)

Upcoming Appointments & Procedures (continued)

MAR 10 2025 — Eye New Patient with Dr. Maria Lim, MD
Monday Mar 10, 2025 12:45 PM (Arrive by 12:30 PM)

Dean McGee Eye Institute - Childrens Hospital
1200 CHILDRENS AVE STE 8A
OKLAHOMA CITY OK 73104-4637
405-271-7887

12/16/2024 - Admission (Discharged) in Oklahoma Childrens Hospital (continued)

Documents (continued)

Medication List

	Morning	Afternoon	Evening	Bedtime	As Needed
fluticasone 50 MCG/ACT nasal spray Commonly known as: Flonase Administer 1 spray into each nostril in the morning. Shake gently. Before first use, prime pump. After use, clean tip and replace cap.	✓ 1 spray				
ibuprofen 100 MG/5ML suspension Commonly known as: Childrens Motrin Shake well. Take 6.4 mL by mouth every 6 hours. For use after surgery. Rotate with Tylenol every 3 hours.	Shake well. Take 6.4 mL by mouth every 6 hours. For use after surgery. Rotate with Tylenol every 3 hours.				

If you have any questions about this medication list, please talk to your doctor at your next appointment. You may use this form to make notes about any medications that you have stopped or started taking, including over the counter medications. Bring the form with you to the appointment as a reminder to discuss with your doctor.

PatientPass Education
Patient Education

Table of Contents

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Access to this content will expire in one year.

General Anesthesia, Pediatric, Care After

The following information offers guidance on how to care for your child after the procedure. Your child's health care provider may also give you more specific instructions. If you have problems or questions, contact your child's health care provider.

What can I expect after the procedure?

After the procedure, it is common for children to have:

- Pain or discomfort at the IV site.
- Nausea or vomiting.
- A sore throat or hoarse voice.
- Trouble sleeping.

Your child may also feel:

- Dizzy.
- Weak.
- Sleepy.
- Irritable.
- Cold.

Babies may briefly have trouble nursing or taking a bottle. Older children who are potty-trained may briefly wet the bed at night.

Follow these instructions at home:

Medicines

- Give over-the-counter and prescription medicines only as told by your child's health care provider. These include any sleeping pills or medicines that cause drowsiness.
- **Do not** give your child aspirin because of the association with Reye's syndrome.

Eating and drinking

- Go back to your child's regular diet and feedings as told by your child's health care provider and as tolerated by your child. In general, it is best to:
  - Start by giving your child only clear liquids.

- Give your child frequent small meals when your child starts to feel hungry. Have your child eat foods that are soft and easy to eat, such as toast. Slowly have your child return to their regular diet.
- Breastfeed or bottle-feed your baby or young child. Do this in small amounts. Slowly increase the amount.

- Give your child enough fluid to keep their urine pale yellow.
- If your child vomits, replace body fluid that has been lost (**rehydrate**) by giving water or clear juice.

Safety

- Your child should rest as told by the health care provider.
- For the time period you were told by the health care provider:
  - **Do not** allow your child to participate in activities where they could fall or become injured.
  - **Do not** allow an older child to drive or use machinery.
  - **Do not** allow your child to drink alcohol.
  - **Do not** allow your child to take sleeping pills or medicines that cause drowsiness.
- Watch your child closely until your child is awake and alert.
- Help your child with:
  - Standing.
  - Walking.
  - Going to the bathroom.
  - Supervise any play or activity.

General instructions

- Your health care provider may check to make sure that your child can walk, drink, and urinate before your child will go home.
- Have your child return to normal activities as told by the health care provider. Ask the health care provider what activities are safe for your child.
- If your child has sleep apnea, surgery and certain medicines can increase the risk for breathing problems. If applicable, follow instructions from the health care provider about having your child use a sleep device:
  - Anytime your child is sleeping, including during daytime naps.
  - While your child is taking prescription pain medicines or medicines that make your child drowsy.
- **Do not** allow your child to use any products that contain nicotine or tobacco. These can delay incision healing after surgery. These products include cigarettes, chewing tobacco, and vaping devices, such as e-cigarettes. If your child needs help quitting, ask a health care provider.
- **Do not** smoke around your child.

Contact a health care provider if:

- Your child has nausea or vomiting that does not get better with medicine.
- Your child vomits every time they eat or drink.
- Your child has pain that does not get better with medicine.
- Your child cannot urinate or has bloody urine.
- Your child develops a skin rash.
- Your child has a fever.

Get help right away if:

- Your child:
  - Has trouble breathing or speaking.
  - Makes high-pitched whistling sounds when they breathe, most often when they breathe out (**wheeze**).
- Your child who is 3 months to 3 years old has a temperature of 102.2°F (39°C) or higher.

- Your child who is younger than 3 months has a temperature of 100.4°F (38°C) or higher.

These symptoms may be an emergency. Do not wait to see if the symptoms will go away. Get help right away. Call 911.

Summary

- After the procedure, it is common for a child to have nausea or a sore throat. It is also common for a child to feel sleepy.
- Watch your child closely until your child is awake and alert.
- Give your child enough fluid to keep their urine pale yellow.
- Have your child return to normal activities as told by the health care provider. Ask the health care provider what activities are safe for your child.

This information is not intended to replace advice given to you by your health care provider. Make sure you discuss any questions you have with your health care provider.

Document Released: 2014-10-08 Document Updated: 2023-03-17 Document Reviewed: 2023-03-17
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Flexible Bronchoscopy, Care After

After flexible bronchoscopy, it is common to have a cough that is worse than it was before the procedure for 24–48 hours. Also during this time it is common to have:

- A low-grade fever.
- A sore throat or hoarse voice.
- Some blood in the mucus from your lungs (**sputum**), if a biopsy was done.

Follow these instructions at home:
The instructions below may help you care for yourself at home. Your health care provider may give you more instructions. If you have questions, ask your health care provider.

Eating and drinking

- **Do not** eat or drink (not even water) for 2 hours after your test, or until your numbing medicine (**local anesthetic**) wears off. If you have a numb throat, the risk of burning yourself or choking is higher.
- Start eating soft foods and slowly drinking liquids after your numbness is gone and your cough and gag reflexes have returned.
- You may return to your normal diet the day after the procedure.

Driving

- If you were given a sedative during the procedure, it can affect you for several hours. **Do not** drive or operate machinery until your health care provider says that it is safe.
- Ask your health care provider if the medicine prescribed to you requires you to avoid driving or using machinery.

General instructions

- Take over-the-counter and prescription medicines only as told by your health care provider.
- Return to your normal activities as told by your health care provider. Ask your health care provider what activities are safe for you.
- **Do not** smoke or use any products that contain nicotine or tobacco. If you need help quitting, ask your health care provider.
- Keep all follow-up visits. This is important. It is very important if you had a tissue sample (**biopsy**) taken.

Contact a health care provider if:

- You have a fever.

Get help right away if:

- You have shortness of breath that gets worse.
- You get light-headed.
- You feel like you are going to pass out (**faint**).
- You have chest pain.
- You cough up more than a small amount of blood.

These symptoms may be an emergency. Get help right away. Call 911.

- **Do not wait to see if the symptoms will go away.**
- **Do not drive yourself to the hospital.**

Summary

- **Do not** eat or drink anything (not even water) for 2 hours after your test, or until your numbing medicine wears off.
- **Do not** smoke or use any products that contain nicotine or tobacco. If you need help quitting, ask your health care provider.
- Get help right away if you have chest pain.

This information is not intended to replace advice given to you by your health care provider. Make sure you discuss any questions you have with your health care provider.

Document Released: 2010-10-15 Document Updated: 2023-03-28 Document Reviewed: 2023-03-28
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COVID-19 Self Isolation

Please ensure you and those in your household follow CDC recommendations on social distancing following your procedure to reduce the likelihood of post-op complications due to COVID-19.

Instructions

Adenoidectomy and Microlaryngoscopy Discharge Instructions

Diet:
• There are no dietary restrictions.

Activity:
• There are no activity restrictions.
• Your child may return to school or daycare within a few days of surgery, based on whether your child needs to continue using pain medication.

Discharge Medications:
• Continue all medications on Medication Reconciliation form per original prescribing physician
• See Medication Reconciliation form for new or changed medications. The following medications except for saline have been called in to the OU Children's Pharmacy on the 2nd floor of the Children's Hospital near the main entrance.
• Use **saline spray** in both nostrils three times daily for 2 weeks.
• Take **acetaminophen (Tylenol)** and **ibuprofen (Motrin)** as needed for pain or fever. Both medications can be given every 6 hours. It is usually best for the first few days to alternate these and provide one or the other every 3 hours.
• Your discharge nurse should help you with weight-based dosing for both Tylenol and Motrin for your child before you discharge home.

Things to remember:
• Ear pain after surgery is common, and is likely to resolve as any throat pain gets better.
• Your child is likely to have foul smelling breath for 2-3 weeks.
• If you are worried about your child's fluid intake, monitor their urine output closely. Signs that your child is not taking enough fluids are a decreased frequency of urination, dark yellow or even brown colored urine, and dry mouth.
• Fever can occur after adenoidectomy. If so, continue treating with tylenol and ibuprofen, and encourage fluid intake. However, for fevers over 101.4F, go to the nearest emergency department.
• Call 911 or go to the nearest emergency department for: any bleeding from the mouth or nose, concern for dehydration, high fevers, significant difficulty breathing, neck stiffness, lethargy, or anything else you think may be an emergency.
• For any questions or concerns, you may call the pediatric ENT office at OU Children's at **405-271-2662** during business hours. For after hours or weekend concerns, you may call the main hospital phone number at **405-271-8001** and ask to speak to the ENT physician on call.

Follow-up:
• 1/22/2025 as scheduled

Age/Sex: 00M 16D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU.NICUF
Room/Bed: CU.7172-A

BLUE.BB-IAIUM

OU Medical Center NUR ***Live***
EVOLUTION PLAN OF CARE IIPF

Printed 02/24/22 at 0057

Diagnosis/Goal/Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Directions / Documented Comment	Documented Units	From Change
Activity Date: 02/08/22 Time: 2306											
Diagnosis: Developmental Age 0-1 year. Infant Related to our age specific Ploicy and Proceedure practice guidelines infant developmental need: Trust								A			
	Create	02/08/22	2306	BMP	02/08/22	2306	BMP				
Goal: Age Appropriate Guidelines will be met								A			
	Create	02/08/22	2306	BMP	02/08/22	2306	BMP				
Goal: Infant will participate in play exercises that are geared to stimulate cognitive development.								A			
	Create	02/08/22	2306	BMP	02/08/22	2306	BMP				
Diagnosis: Critical Care Neonate (Crib Notes) Care Area Practice Guidelines Guidelines focus on: Safety issues -- Psychosocial needs -- Nutritional needs ADI's Skin Integrity TV Lines -- Pain -- Respiratory function -- Cardiac function -- GI function -- Gu Function -- Monitoring lines -- Developmental needs								A			
	Create	02/08/22	2306	BMP	02/08/22	2306	BMP				
Goal: Care Area Practice Guidelines and Documentation Requirements are met. By discharge, the patient/caregiver will verbalize and/or demonstrate competence and confidence in providing safe, effective, care appropriate to their individual needs.								A			
	Create	02/08/22	2306	BMP	02/08/22	2306	BMP				
Activity Date: 02/11/22 Time: 1431											
Diagnosis: SI: PATIENT/CAREGIVER EDUCATION								A			
	Create	02/11/22	1431	ENL	02/11/22	1431	ENL				
Goal: RFHAB: PL/caregiver will verbalize and or demonstrate understanding, competence, and or confidence in providing safe, effective rehab techniques,appropriate to the patient's individual education needs as described documented in therapy eval & progress								A			
	Create	02/11/22	1431	ENL	02/11/22	1431	ENL				
Diagnosis: RFHAB:ORAL MOTOR DISORDERS/IMPAIRMENTS								A			
	Create	02/11/22	1431	ENL	02/11/22	1431	ENL				
Goal: RFHAB: With skilled Therapy intervention patient's oral motor skills will be improved to allow maximized function as described in the individualized treatment goals and interventions documented in Therapy eval & progress notes								A			
	Create	02/11/22	1431	ENL	02/11/22	1431	ENL				
Activity Date: 02/12/22 Time: 1715											
Diagnosis: Altered Respiratory Function Altered respiratory function/status related to disease process, physical limitations, surgical procedure and/or trauma.								A			
	Create	02/12/22	1715	CF	02/12/22	1715	CF				
Goal: Adequate air exchange with Oxygen sats >92%, clear and equal breath sounds, pink mucous membranes and nailbeds, respirations regular and unlabored prior to discharge.								A			
	Create	02/12/22	1715	CF	02/12/22	1715	CF				
Activity Date: 02/17/22 Time: 1734											
Diagnosis: OI: PATIENT/CAREGIVER EDUCATION								A			
	Create	02/17/22	1734	TLM	02/17/22	1734	TLM				
Goal: RFHAB: PL/caregiver will verbalize and or demonstrate understanding, competence, and or confidence in providing safe, effective rehab techniques,appropriate to the patient's individual education needs as described documented in therapy eval & progress								A			
	Create	02/17/22	1734	TLM	02/17/22	1734	TLM				
Diagnosis: OT: FEEDING DIFFICULTIES								A			
	Create	02/17/22	1734	TLM	02/17/22	1734	TLM				
Goal: REHAB: to ensure safe and adequate nutritional intake by discharge appropriate for patient's age and or disease process.								A			
	Create	02/17/22	1734	TLM	02/17/22	1734	TLM				
Diagnosis: REHAB: ROM & MM PERFORMANCE								A			
	Create	02/17/22	1734	TLM	02/17/22	1734	TLM				

Age/Sex: 00M 16D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU.NICUF
Room/Bed: FU.7172-A

BLUE,BB-IATUM

OU Medical Center NUR **Live**
EVOLUTION PLAN OF CARE IIPF

Printed 02/24/22 at 0057

Diagnosis/Goal/Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Directions Documented Units	From Change
Activity Date: 02/17/22 Time: 1734										
Goal: RFHAB: With skilled Therapy intervention patient's ROM and MM performance will be improved to allow maximized function as described in the individualized treatment goals and interventions documented in Theapy eval & progress notes								A		
-	Create	02/17/22	1734	TLM	02/17/22	1734	TLM			
Activity Date: 02/20/22 Time: 1103										
Diagnosis: Developmental Age 0-1 year. Infant Related to our age specific Ploicy and Proceedure practice guidelines infant developmental need: - Trust								D		
	Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
Goal: Age Appropriate Guidelines will be met								D		
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
Goal: Infant will participate in play exercises that are geared to stimulate cognitive development.								D		
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
Diagnosis: Critical Care - Neonate (Crib Notes) Care Area Practice Guidelines Guidelines focus on: Safety issues -- Psychosocial needs -- Nutritional needs -- ADL's -- Skin Integrity -- IV Lines Pain Respiratory Function Cardiac function -- GI function -- Gu function -- Monitoring lines -- Developmental needs								D		
	Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
Goal: Care Area Practice Guidelines and Documentation Requirements are met.								D		
By discharge, the patient/caregiver will verbalize and/or demonstrate competence and confidence in providing safe, effective, care appropriate to their individual needs.										
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
Diagnosis: SI: PATIENT/CAREGIVER EDUCATION								D		
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
Goal: RFHAB: PT/caregiver will verbalize and or demonstrate understanding, competence, and or confidence in providing safe, effective rehab								D		

Diagnosis/Goal/Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Directions Documented Units	From Change
Goal: REHAB: Pt/caregiver will verbalize (continued) techniques,appropriate to the patient's individual education needs as described documented in Therapy eval & progress										
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
Diagnosis: REHAB:ORAL MOTOR DISORDERS/IMPAIRMENTS								D		
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
Goal: RFHAB: With skilled Therapy intervention patient's oral motor skills will be improved to allow maximized function as described in the individualized treatment goals and interventions documented in Therapy eval & progress notes								D		
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
Diagnosis: Altered Respiratory Function Altered respiratory function/status related to disease process, physical limitations, surgical procedure and/or trauma.								D		
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
Goal: Adequate air exchange with Oxygen sats >92%, clear and equal breath sounds, pink mucous membranes and nailbeds, respirations regular and unlabored prior to discharge.								D		
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
Diagnosis: OT: PATIENT/CAREGIVER EDUCATION								D		
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
Goal: REHAB: Pt/caregiver will verbalize and or demonstrate understanding, competence, and or confidence in providing safe, effective rehab techniques,appropriate to the patient's individual education needs as described documented in Therapy eval & progress								D		
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
Diagnosis: OI: FEEDING DIFFICULTIES								D		
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
Goal: RFHAB: To ensure safe and adequate nutritional intake by discharge appropriate for patient's age and or disease process.								D		
	Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
Diagnosis: REHAB: ROM & MM PERFORMANCE								D		
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
Goal: REHAB: With skilled Therapy intervention patient's ROM and MM performance will be improved to allow maximized function as described in the individualized treatment goals and								D		

Age/Sex: 00M 16D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU.NICUF
Room/Bed: CU.7172-A

BLUE,BB-IATUM

OU Medical Center NUR ***Live***
EVOLUTION PLAN OF CARE IIPF

Printed 02/24/22 at 0057

Diagnosis/Goal/Intervention Description	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Directions Documented Units	From Change
Goal: REHAB: With skilled Therapy intervention (continued) interventions documented in Thearpy eval & progress notes	Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D

Monogram	Initials	Name	Nurse Type
BMP	FNUR,BMP6	PATRICK,BROOKE M	RN
CF	ERT,CF	FITZPATRICK,CHELSEA	RT
ENL	EPT,ENL	LEE,ERIKA N	SLP
TLM	EPT,TLM2	MACKEY,TARRYN L	OTR/L
his		automatic by program	

Age/Sex: 00M 16D M
Unit #: E003047593
Admitted: 02/08/22 at 2317
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU.NICUF
Room/Bed: FU.7172-A

BLUE,BB-IATUM

OU Medical Center NUR ***Live***
PLAN OF CARE RPT

Printed 02/24/22 at 0048

Diagnosis/Goal/Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Directions Documented Units	From Change
Activity Date: 02/08/22 Time: 2306										
Diagnosis: Developmental Age 0-1 year. Infant Related to our age specific Ploicy and Proceedure practice guidelines infant developmental need: Trust								A		
	Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
Goal: Age Appropriate Guidelines will be met								A		
	Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
Goal: Infant will participate in play exercises that are geared to stimulate cognitive development.								A		
	Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
Diagnosis: Critical Care Neonate (Crib Notes) Care Area Practice Guidelines Guidelines focus on: Safety issues -- Psychosocial needs -- Nutritional needs ADI's Skin Integrity TV Lines -- Pain -- Respiratory function -- Cardiac function -- GI function -- Gu Function -- Monitoring lines -- Developmental needs								A		
	Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
Goal: Care Area Practice Guidelines and Documentation Requirements are met. By discharge, the patient/caregiver will verbalize and/or demonstrate competence and confidence in providing safe, effective, care appropriate to their individual needs.								A		
	Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
Activity Date: 02/11/22 Time: 1431										
Diagnosis: SI: PATIENT/CAREGIVER EDUCATION								A		
	Create	02/11/22	1431	ENL	02/11/22	1431	ENL			
Goal: RFHAB: PL/caregiver will verbalize and or demonstrate understanding, competence, and or confidence in providing safe, effective rehab techniques,appropriate to the patient's individual education needs as described documented in therapy eval & progress								A		
	Create	02/11/22	1431	ENL	02/11/22	1431	ENL			
Diagnosis: RFHAB:ORAL MOTOR DISORDERS/IMPAIRMENTS								A		
	Create	02/11/22	1431	ENL	02/11/22	1431	ENL			
Goal: RFHAB: With skilled Therapy intervention patient's oral motor skills will be improved to allow maximized function as described in the individualized treatment goals and interventions documented in Therapy eval & progress notes								A		
	Create	02/11/22	1431	ENL	02/11/22	1431	ENL			
Activity Date: 02/12/22 Time: 1715										
Diagnosis: Altered Respiratory Function Altered respiratory function/status related to disease process, physical limitations, surgical procedure and/or trauma.								A		
	Create	02/12/22	1715	CF	02/12/22	1715	CF			
Goal: Adequate air exchange with Oxygen sats >92%, clear and equal breath sounds, pink mucous membranes and nailbeds, respirations regular and unlabored prior to discharge.								A		
	Create	02/12/22	1715	CF	02/12/22	1715	CF			
Activity Date: 02/17/22 Time: 1734										
Diagnosis: OI: PATIENT/CAREGIVER EDUCATION								A		
	Create	02/17/22	1734	TLM	02/17/22	1734	TLM			
Goal: RFHAB: PL/caregiver will verbalize and or demonstrate understanding, competence, and or confidence in providing safe, effective rehab techniques,appropriate to the patient's individual education needs as described documented in therapy eval & progress								A		
	Create	02/17/22	1734	TLM	02/17/22	1734	TLM			
Diagnosis: OT: FEEDING DIFFICULTIES								A		
	Create	02/17/22	1734	TLM	02/17/22	1734	TLM			
Goal: REHAB: to ensure safe and adequate nutritional intake by discharge appropriate for patient's age and or disease process.								A		
	Create	02/17/22	1734	TLM	02/17/22	1734	TLM			
Diagnosis: REHAB: ROM & MM PERFORMANCE								A		
	Create	02/17/22	1734	TLM	02/17/22	1734	TLM			

Age/Sex: 00M 16D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU.NICUF
Room/Bed: FU.7172-A

BLUE,BB-IATUM

OU Medical Center NUR **Live**
PLAN OF CARE RPT

Printed 02/24/22 at 0048

Diagnosis/Goal/Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Directions Documented Comment	Documented Units	From Change
Activity Date: 02/17/22 Time: 1734											
Goal: RFHAB: With skilled Therapy intervention patient's ROM and MM performance will be improved to allow maximized function as described in the individualized treatment goals and interventions documented in Therapy eval & progress notes								A			
-	Create	02/17/22	1734	TLM	02/17/22	1734	TLM				
Activity Date: 02/20/22 Time: 1103											
Diagnosis: Developmental Age 0-1 year. Infant Related to our age specific Ploicy and Proceedure practice guidelines infant developmental need: - Trust								D			
	Ed Status	02/20/22	1103	his	02/20/22	1103	his				A => D
Goal: Age Appropriate Guidelines will be met								D			
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his				A => D
Goal: Infant will participate in play exercises that are geared to stimulate cognitive development.								D			
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his				A => D
Diagnosis: Critical Care - Neonate (Crib Notes) Care Area Practice Guidelines Guidelines focus on: Safety issues -- Psychosocial needs -- Nutritional needs -- ADL's -- Skin Integrity -- IV Lines Pain Respiratory Function Cardiac Function -- GI Function -- Gu Function -- Monitoring lines -- Developmental needs								D			
	Ed Status	02/20/22	1103	his	02/20/22	1103	his				A => D
Goal: Care Area Practice Guidelines and Documentation Requirements are met. By discharge, the patient/caregiver will verbalize and/or demonstrate competence and confidence in providing safe, effective, care appropriate to their individual needs.								D			
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his				A => D
Diagnosis: SI: PATIENT/CAREGIVER EDUCATION								D			
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his				A => D
Goal: RFHAB: Pt/caregiver will verbalize and or demonstrate understanding, competence, and or confidence in providing safe, effective rehab								D			
Goal: REHAB: Pt/caregiver will verbalize (continued) techniques,appropriate to the patient's individual education needs as described documented in Therapy eval & progress											
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his				A => D
Diagnosis: REHAB:ORAL MOTOR DISORDERS/IMPAIRMENTS								D			
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his				A => D
Goal: RFHAB: With skilled Therapy intervention patient's oral motor skills will be improved to allow maximized function as described in the individualized treatment goals and interventions documented in Therapy eval & progress notes								D			
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his				A => D
Diagnosis: Altered Respiratory Function Altered respiratory function/status related to disease process, physical limitations, surgical procedure and/or trauma.								D			
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his				A => D
Goal: Adequate air exchange with Oxygen sats >92%, clear and equal breath sounds, pink mucous membranes and nailbeds, respirations regular and unlabored prior to discharge.								D			
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his				A => D
Diagnosis: OT: PATIENT/CAREGIVER EDUCATION								D			
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his				A => D
Goal: REHAB: Pt/caregiver will verbalize and or demonstrate understanding, competence, and or confidence in providing safe, effective rehab techniques,appropriate to the patient's individual education needs as described documented in Therapy eval & progress								D			
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his				A => D
Diagnosis: OI: FEEDING DIFFICULTIES								D			
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his				A => D
Goal: RFHAB: To ensure safe and adequate nutritional intake by discharge appropriate for patient's age and or disease process.								D			
	Ed Status	02/20/22	1103	his	02/20/22	1103	his				A => D
Diagnosis: REHAB: ROM & MM PERFORMANCE								D			
-	Ed Status	02/20/22	1103	his	02/20/22	1103	his				A => D
Goal: REHAB: With skilled Therapy intervention patient's ROM and MM performance will be improved to allow maximized function as described in the individualized treatment goals and								D			

Age/Sex: 00M 16D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU.NICUF
Room/Bed: CU.7172-A

BLUE,BB-IATUM

OU Medical Center NUR ***Interactive***
PLAN OF CARE UPT

Printed 02/24/22 at 0048

Diagnosis/Goal/Intervention Description	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Directions Documented Units	From Change
Goal: REHAB: With skilled Therapy intervention (continued) interventions documented in therapy eval & progress notes	Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D

Monogram	Initials	Name	Nurse Type
BMP	FNUR,BMP6	PATRICK,BROOKE M	RN
CF	ERT,CF	FITZPATRICK,CHELSEA	RT
ENL	EPT,ENL	LEE,ERIKA N	SLP
TLM	EPT,TLM2	MACKEY,TARRYN L	OTR/L
his		automatic by program	

OU Medical Center
700 NE 13th St
Oklahoma City, OK 73104

****Case Management Report****

**********Encounter Data**********

Patient Name: BLUE,BB-TATUM DOB: 02/08/22 Age: 00M 06D
Account # : E00677497957 MRN: E003047593
Admit Date : 02/08/22
Attending Dr: Bergner,Erynn MD

----------Discharge Planning----------

*CASE WORKERS :
Fruge,Kathy
Greenlee,Debora

UPDATED BY : Greenlee,Debora
COMMENTS :
--- 2/9/2022 01:18 PM by Debora Greenlee --- SW was contacted 2x stated that MGM was requesting to speak with SW. Pts nurse stated that dad was at the bedside and was needing to speak with SW. SW met with him in the Family Room. Mom was enroute to the hospital. He was told how to get her a wheelchair prior to her arrival. He and mom live together in Milburn (124 mi). This is the first child for both. They have named pt Parker Logan Phillips. Mom worked for a relative prior to being bedbound for blood pressure issues and he does not know if she will return to work. Her cell is 580-371-6882. Dad, Anthony Phillips, wks for PBR refrigeration repair. It is family owned and his time off is flexible. He also receives disability benefits through the VA. His cell is 580-919-4634. Additional contact is for MGM, Amanda Blue 580-371-8719. He states a large support system. SW handout and hospital resources were reviewed. He believes that Durant hospital added pt to the SoonerCare. He stated that mom has a doctor chosen for follow up care though he does not know the name. She is enrolled in WIC, is pumping and has a pump. Dad vapes and having a smoke free home was discussed. He uses THC occasionally and the importance of storing it safely was reviewed. Pt has a car seat, crib and supplies. Educational and support services were reviewed. He stated that mom does not have a hx of depression. SW encouraged him to have both of them read the March of Dimes and PPD handouts. Neither parent is vaccinated against COVID and would not be a candidate at this time at RMC. He requested a room at Holiday Inn. He was told that SW would contact Durant Hosp and see if pt had been added so that a lodging voucher could be done. SW and dad went to the waiting room and met with MGM. She had multiple questions that had prev. been explained to dad. SW told her about hosp. resources, wheelchairs, lodging, LC services and more. She stated that she is going to go home though would return and be staying. SW explained that she would not be able to see pt and she stated that she understood. Dad was given a visitation log for mom and it was explained how to complete it and the importance. Both understand to contact SW if they have any questions. Durant Hosp. had added pt and SoonerCare ID # is B37271506. Voucher was sent to Holiday Inn and confirmed received for the 9th through the 16th with check out on the 17th. Dad was updated. Will follow. --- 2/9/2022 10:08 AM by Kathy Fruge --- Day/Date: Wednesday 2/9/22 Anticipated discharge day/date: 2-3 weeks Reason for visit: Possible seizures Readmit: (yes/no) Any factors that may have contributed to readmission: Current family and support system (Caregiver/Guardian/DHS involvement): In utero drug exposure: No

Living arrangements: Parents Safe Sleep Plan: (crib, pack and play, bassinet) Pharmacy: Psychosocial issues that may affect transition (domestic violence, smoking): Insurance coverage for discharge needs: Medicaid pending. Financial Concerns: Medication Issues: (coverage, ability to afford, Meds to Beds at dc) Transportation at discharge and to appointments: (name, relationship, contact information, car seat available)

UTILIZATION SUPPORT SERVICES

DATE ENTERED : 2/9/2022
SERVICE TYPE : Resource Planning
CASE WORKER : CM,Childrens NICU
WORKLIST DATE : 2/14/2022
PAYER : MCAID PENDING
COMPLETED Y/N : N
UPDATED BY : Fruge,Kathy
COMMENTS :
--- 2/14/2022 08:54 AM by Kathy Fruge --- Pt now 41 weeks and 3410 grams. In radiant warmer. OG feeds with TPN, NIV support. --- 2/9/2022 10:07 AM by Kathy Fruge --- Pt admitted with possible seizures. Pt is 40.1 weeks and 3050 grams. In radiant warmer. NPO with Snap Dopamine drip. RA.

Patient Name: BLUE,BB-TATUM Account #: E00677497957

OU Medical Center
700 NE 13th St
Oklahoma City, OK 73104

****Case Management Report****

**********Encounter Data**********

Patient Name: BLUE,BB-TATUM DOB: 02/08/22 Age: 00M 08D
Account # : E00677497957 MRN: E003047593
Admit Date : 02/08/22
Attending Dr: Bergner,Erynn MD

----------Discharge Planning----------

*CASE WORKERS :
Fruge,Kathy
Greenlee,Debora

UPDATED BY : Greenlee,Debora
COMMENTS :
--- 2/16/2022 10:22 AM by Debora Greenlee --- Dad was contacted to confirm that they wanted to extend their stay at Holiday Inn. Logs were checked and voucher was sent through the 24th. These were confirmed received. Will follow. --- 2/9/2022 01:18 PM by Debora Greenlee --- SW was contacted 2x stated that MGM was requesting to speak with SW. Pts nurse stated that dad was at the bedside and was needing to speak with SW. SW met with him in the Family Room. Mom was enroute to the hospital. He was told how to get her a wheelchair prior to her arrival. He and mom live together in Milburn (124 mi). This is the first child for both. They have named pt Parker Logan Phillips. Mom worked for a relative prior to being bedbound for blood pressure issues and he does not know if she will return to work. Her cell is 580-371-6882. Dad, Anthony Phillips, wks for PBR refrigeration repair. It is family owned and his time off is flexible. He also receives disability benefits through the VA. His cell is 580-919-4634. Additional contact is for MGM, Amanda Blue 580-371-8719. He states a large support system. SW handout and hospital resources were reviewed. He believes that Durant hospital added pt to the SoonerCare. He stated that mom has a doctor chosen for follow up care though he does not know the name. She is enrolled in WIC, is pumping and has a pump. Dad vapes and having a smoke free home was discussed. He uses THC occasionally and the importance of storing it safely was reviewed. Pt has a car seat, crib and supplies. Educational and support services were reviewed. He stated that mom does not have a hx of depression. SW encouraged him to have both of them read the March of Dimes and PPD handouts. Neither parent is vaccinated against COVID and would not be a candidate at this time at RMC. He requested a room at Holiday Inn. He was told that SW would contact Durant Hosp and see if pt had been added so that a lodging voucher could be done. SW and dad went to the waiting room and met with MGM. She had multiple questions that had prev. been explained to dad. SW told her about hosp. resources, wheelchairs, lodging, LC services and more. She stated that she is going to go home though would return and be staying. SW explained that she would not be able to see pt and she stated that she understood. Dad was given a visitation log for mom and it was explained how to complete it and the importance. Both understand to contact SW if they have any questions. Durant Hosp. had added pt and SoonerCare ID # is B37271506. Voucher was sent to Holiday Inn and confirmed received for the 9th through the 16th with check out on the 17th. Dad was updated. Will follow. --- 2/9/2022 10:08 AM by Kathy Fruge --- Day/Date: Wednesday 2/9/22 Anticipated discharge

Patient Name: BLUE,BB-TATUM Account #: E00677497957

day/date: 2-3 weeks Reason for visit: Possible seizures Readmit: (yes/no) Any factors that may have contributed to readmission: Current family and support system (Caregiver/Guardian/DHS involvement): In utero drug exposure: No Living arrangements: Parents Safe Sleep Plan: (crib, pack and play, bassinet) Pharmacy: Psychosocial issues that may affect transition (domestic violence, smoking): Insurance coverage for discharge needs: Medicaid pending. Financial Concerns: Medication Issues: (coverage, ability to afford, Meds to Beds at dc) Transportation at discharge and to appointments: (name, relationship, contact information, car seat available)

UTILIZATION SUPPORT SERVICES

DATE ENTERED : 2/9/2022
SERVICE TYPE : Resource Planning
CASE WORKER : CM,Childrens NICU
WORKLIST DATE : 2/16/2022
PAYER : MCAID PENDING
COMPLETED Y/N : N
UPDATED BY : Fruge,Kathy
COMMENTS :
--- 2/14/2022 08:54 AM by Kathy Fruge --- Pt now 41 weeks and 3410 grams. In radiant warmer. OG feeds with TPN, NIV support. --- 2/9/2022 10:07 AM by Kathy Fruge --- Pt admitted with possible seizures. Pt is 40.1 weeks and 3050 grams. In radiant warmer. NPO with Snap Dopamine drip. RA.

Patient Name: BLUE,BB-TATUM Account #: E00677497957

RUN DATE: 02/22/22 — OU Medical Center ABS **LIVE** — PAGE 1
RUN TIME: 0431 — CODING SUMMARY
RUN USER: HPF.FEED

NAME: BLUE,BB-TATUM — ACCT#: E00677497957
FORM:
ADM DATE: 02/08/22 2217
ATTEND PHYS: Bergner,Erynn MD — UNIT#: E003047593
DIS DT/TM: 02/20/22 1101 — SEX: M
DIS DISP: Routine Home/Self Care — AGE: 00M 00D
LOS: : 12 — DOB: 02/08/22
PT CLASS: IN.OTH — FIN CLASS: 03
ABS STATUS: FINAL

DIAGNOSES			POA INDICATOR	CODESET
ADMIT DX	P90	CONVULSIONS OF NEWBORN		ICD10
REASON FOR VISIT DX				
PRIMARY CODESET				
PRINC DX	P91.63	SEVERE HYPOXIC ISCHEMIC ENCEPHALOPATHY [HIE]	Y	ICD10
OTHER DX	P90	CONVULSIONS OF NEWBORN	Y	ICD10
	P52.6	CEREBELLAR AND POSTERIOR FOSSA HEMORRHAGE OF NEWBORN	Y	ICD10
	Q21.1	ATRIAL SEPTAL DEFECT	E	ICD10
	P96.83	MECONIUM STAINING	Y	ICD10
	Z05.1	OBS & EVAL OF NB FOR SUSPECTED INFECT CONDITION RULED OUT	E	ICD10
	P29.89	OTH CARDIOVASC DISORDERS ORIGINATING IN THE PERINATAL PERIOD	Y	ICD10
	P22.9	RESPIRATORY DISTRESS OF NEWBORN, UNSPECIFIED	N	ICD10
OTHER CODESET				
PRINC DX				
OTHER DX				

PROCEDURE
PRIMARY CODESET

DATE	PROC CODE & NAME	SURGEON	ANESTHESIOLOGIST	
02/08/22	5A09557 ASSISTANCE WITH RESPIRATORY VE	Kassa,Netsanet		ICD10
02/09/22	009U3ZX DRAINAGE OF SPINAL CANAL, PERC	Dannaway,Dougla		ICD10
02/08/22	3E0436Z INTRODUCTION OF NUTRITIONAL IN	Kassa,Netsanet		ICD10

OTHER CODESET

PRIMARY CODESET
DRG I-10 793 FULL TERM NEONATE WITH MAJOR PROBLEMS
OTHER CODESET
DRG I-9

STATUS	$REIMB	MIN-LOS	STD-LOS	COST WT	GRP VERS	GRP FC
F	19738.46		4.7	3.9792	39	03

RUN DATE: 02/22/22
RUN TIME: 0431
RUN USER: HPF.FEED

OU Medical Center ABS **LIVE**
CODING SUMMARY

NAME: BLUE,BB-TATUM

ADM DATE: 02/08/22 2217
ATTEND PHYS: Bergner,Erynn MD
DIS DT/TM: 02/20/22 1101
DIS DISP: Routine Home/Self Care
LOS: : 12
PT CLASS: IN.OTH

ACCT#: E00677497957
FORM:

UNIT#: E003047593
SEX: M
AGE: 00M 00D
DOB: 02/08/22
FIN CLASS: 03
ABS STATUS: FINAL

DRG STATUS DATE: 02/21/22
CODER: ECODR.ML

ABS STATUS DATE: 02/21/22
ABSTRACTOR: ECODR.ML

This form will be maintained as a permanent part of the medical record

OUM Peripherally Inserted Central Catheter (PICC) or Midline Catheter Consent

1. I _____ hereby authorize the following OUM advanced practice provider, or vascular access nurse:_____
   to perform upon me a Peripherally Inserted Central Catheter (PICC) _____ (Initial)
   to perform upon me a Midline Catheter _____ (Initial)

2. **I understand the nature and purpose of this procedure, and I affirm that the risks, benefits, possibility of complications as well as the expected results, and medical alternatives have been explained to me. I have been given an opportunity to ask and have my questions answered. I further acknowledge that no guarantees have been given, and that I may refuse without jeopardizing any current or future medical treatments.**

   (Initial) _____ The catheter insertion procedure, care, maintenance, and possible complications have been explained to me and I understand them.

   (Initial) _____ I understand this is not the only way to receive my medication. I understand that my healthcare team has determined a PICC/Midline would be the safest and most effective means of giving my medication at this time.

   (Initial) _____ I understand the risks and alternatives of the procedure as explained by Advanced Practice provider or vascular access nurse.

   (Initial) _____ I understand this is an invasive and sterile procedure, and that the end of the PICC catheter will rest in a vein near my heart or Midline catheter tip in axilla.

Potential risks include, but are not limited to: infection, bleeding, thrombus, catheter or air embolism, arterial puncture, infiltration, nerve irritation or injury, and irregular heartbeat.

Phone consent from mother

Signature of Patient:_____ Date: 2/9/22 Time: 740

Signature of Patient Representative:_____ Date:_____ Time:_____

Relationship to Patient:_____

Witness to Signature: Krystal Miles, RN Date: 2/9/22 Time: 0740

I have explained the procedure(s), risk(s), benefit(s), and alternative(s), to the person or persons whose signature are affixed above:

Signature of OUM Advanced Practice provider or Vascular Access Nurse:

Billie Mathews RN Date: 2/9/22 Time: 740

EDEMF6699 PNET7WP004 02/09/2022 07:24 QJO8652

Patient: BLUE, BB - TATUM Patient #: _____ Date/Time: _____

1. I hereby authorize the supervising or performing provider Dr - Nalini Dasari and/or any medical staff, hospital personnel, residents, fellows and other trained persons of his/her choice to perform upon

_____
(PATIENTS NAME)

the following surgical, medical, or diagnostic procedure(s): _____

2. I also give consent for my administration of anesthetic/conscious sedation drugs or agents or procedures that he or she deems necessary or desirable in the above procedure on my behalf.

3. I consent to the administration of anesthetic/conscious sedation drugs or agents or procedures by my physician(s) and/or professional anesthesia personnel as indicated to maintain comfort and safety during the described operation/procedure and further acknowledge the potential need for blood product transfusion and give consent for such treatments and transfusions unless specifically stated: _____

(DESCRIBE ANY ANESTHETIC OR TRANSFUSION RESTRICTIONS)

4. If a hysterectomy or other sterilization procedure is performed, I have been informed prior to surgery, both orally and in writing, that as a result of the hysterectomy or other sterilization procedure, which is to be performed by the doctor named above, I will be permanently incapable of reproduction (not able to have a baby).

5. Any organs, tissues, or body fluids removed during the procedure/procedures may be used for diagnosis, treatment, research, education, and/or will be properly disposed by the medical facility after appropriate scientific studies have been carried out.

6. I give consent for students, staff or others to observe the performance of my procedure as considered appropriate by my physician and acknowledge that pictures or movies may be made of the procedure for educational or scientific purposes.

7. I understand the nature and purpose of these procedures and I affirm that the risks, benefits, possibility of complications, as well as the expected results, and medical alternatives have been explained to me by my physician and that I have been given an opportunity to ask and have my questions answered. I further acknowledge that no guarantees have been given to me regarding the results of this/these procedures and that I may refuse this procedure without jeopardizing any current or future medical treatments. I understand that medical students may be responsible for some portion of my care.

(Initial) _____ I understand the procedure as the Physician has explained to me.
(Initial) _____ I understand the risks of the procedure as the Physician has explained to me.
(Initial) _____ I understand the alternatives as the Physician has explained to me.
(Initial) _____ I understand the risks of the alternatives as the Physician has explained to me.

8. **I HEREBY STATE THAT I HAVE READ AND UNDERSTOOD THIS CONSENT AND THAT ALL MY QUESTIONS ABOUT THE PROCEDURE(S), ALTERNATIVE PROCEDURE(S), AND RISKS OF EACH HAVE BEEN ANSWERED IN LANGUAGE THAT I UNDERSTOOD.**
VERBAL CONSENT OVER PHONE FROM MOTHER.

SIGNATURE OF PATIENT: _____ DATE: _____ TIME: _____

SIGNATURE OF GUARDIAN: _____ DATE: _____ TIME: _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE OF SPOUSE/RELATIVE: _____ DATE: _____ TIME: _____

WITNESS TO SIGNATURE: Nalini Dasari DATE: 02/09/22 TIME: 4:00 AM

EDEMF4122 PNET7EP03 02/09/2022 01:20 JRI6472

TREAT
CONSENT FOR SURGICAL, MEDICAL OR DIAGNOSTIC PROCEDURES

BLUE,BB-TATUM
Acct # E00677497957 MR# E003047593
Loc: EU.7172-A DOB: 02/08/22 00M 00D M 02/08/22
Dannaway,Douglas MD

OU MEDICAL CENTER

The Children's Hospital **Oklahoma City, Oklahoma** **URN: E2368718**

Account No.	**E00677497957**	Adm Date 02/08/22	Med Rec No. E003047593
Room/Bed	EU.7172/A	Adm Time 2217	Fin Class 03
Type	DIS IN	Loc/Serv EU.NICUE - TCH NEONATAL ICU EAST 7E / NEONATAL IN	

PATIENT **BLUE,BB-TATUM**
Address : 9965 S BRUSHY RD
Address2 :
City/St/Zip: MILBURN,OK 73450
Phone : 580-371-6882
Other Phone:
PT EMPLOYER MINOR/CHILD
Address : MINOR/CHILD
City/St/Zip: OKLAHOMA CITY,OK 77777
Phone : 999-999-9999

COUNTY JOHNSTON

SS#: xxx-xx-0000
DOB: 02/08/22 Age: 00M 13D Sex: M
Mar St: S Race: U
Language: English
Religion: NON SPECIFIED
Legal Status:
EMAIL: TATUMBLUE2924@GMAIL.COM
Preferred Name:
Gender Identity:
Occupation: NEWBORN

NEXT OF KIN BLUE,TATUM
Address : 9965 S BRUSHY RD
City/St/Zip: MILBURN,OK 73450
Home Phone : 580-371-6882
Work Phone : 999-999-9999
Relation : MOTHER

NOTIFY BLU,BRANDON
Address : 9965 S BRUSHY RD
City/St/Zip: MILBURN,OK 73450
Home Phone : 580-371-6882
Work Phone : 999-999-9999
Relation : GRANDFATHER

GUARANTOR BLUE,TATUM
Birthdate : 07/25/01 Sex: F
Soc Sec # : xxx-xx-7777
Address : 9965 S BRUSHY RD
City/St/Zip: MILBURN,OK 73450
Phone : 580-371-6882
Relation : MOTHER

GUAR EMPLOYER UNKNOWN
Address : UNKNOWN
City/St/Zip: OKLAHOMA CITY,OK 77777
Phone : 999-999-9999

Occupation : UNK

	INSURANCE	POLICY NUMBER	GROUP NO.	SUBSCRIBER
1	MEDICAID PO BOX 18430	B37271506	999999	PHILLIPS,PARKER L OKLAHOMA CITY OK 73154
2				
3				

Insured Subscriber (If other than Patient) DOB: 06/13/97 SS#: xxx-xx-0688

ADM PHYS Dannaway,Douglas MD
PCP Does Not Know
REF PHYS Varughese,Paul John MD

ATTEND PHYS Bergner,Erynn MD
FAMILY PHYS
ER PHYS

Reason for Visit: APNEA
Comment:

	Occurrence	Date	Time		Condition Code
1	11	02/08/22		1	
2				2	
3				3	
4				4	

Last Hospitalization
Hospital : ALLIANCE HEALTH DURANT
From Date: 02/08/22
Thru Date:

ACCOUNT # E00677497957	PRE IN : EADM.KLJ	Reg by : EADM.KLJ

FACE

Page 1 of 1

OU MEDICAL CENTER
FACESHEET Printed on 02/21/22 at 1349

BLUE,BB-TATUM
Acct# E00677497957 MR# E003047593
Loc: EU.NICUE DOB: 02/08/22 M 02/08/22
Dannaway,Douglas MD

02/20/2022

OU MEDICAL CENTER

The Children's Hospital Oklahoma City, Oklahoma URN: E2368718

Account No.	E00677497957	Adm Date 02/08/22	Med Rec No. E003047593
Room/Bed	EU.7172/A	Adm Time 2217	Fin Class 03
Type	DIS IN	Loc/Serv EU.NICUE - TCH NEONATAL ICU EAST 7E / NEONATAL IN	

PATIENT BLUE,BB-TATUM
Address : 9965 S BRUSHY RD
Address2 :
City/St/Zip: MILBURN,OK 73450
Phone : 580-371-6882
Other Phone:
PT EMPLOYER MINOR/CHILD
Address : MINOR/CHILD
City/St/Zip: OKLAHOMA CITY,OK 77777
Phone : 999-999-9999

COUNTY JOHNSTON

SS#: xxx-xx-0000
DOB: 02/08/22 Age: 00M 12D Sex: M
Mar St: S Race: U
Language: English
Religion: NON SPECIFIED
Legal Status:
EMAIL: TATUMBLUE2924@GMAIL.COM
Preferred Name:
Gender Identity:
Occupation: NEWBORN

NEXT OF KIN BLUE,TATUM
Address : 9965 S BRUSHY RD
City/St/Zip: MILBURN,OK 73450
Home Phone : 580-371-6882
Work Phone : 999-999-9999
Relation : MOTHER

NOTIFY BLU,BRANDON
Address : 9965 S BRUSHY RD
City/St/Zip: MILBURN,OK 73450
Home Phone : 580-371-6882
Work Phone : 999-999-9999
Relation : GRANDFATHER

GUARANTOR BLUE,TATUM
Birthdate : 07/25/01 Sex: F
Soc Sec # : xxx-xx-7777
Address : 9965 S BRUSHY RD
City/St/Zip: MILBURN,OK 73450
Phone : 580-371-6882
Relation : MOTHER

GUAR EMPLOYER UNKNOWN
Address : UNKNOWN
City/St/Zip: OKLAHOMA CITY,OK 77777
Phone : 999-999-9999
Occupation : UNK

	INSURANCE	POLICY NUMBER	GROUP NO.	SUBSCRIBER
1	MEDICAID PO BOX 18430	B37271506	999999	PHILLIPS,PARKER L OKLAHOMA CITY OK 73154
2				
3				

Insured Subscriber (If other than Patient) DOB: 06/13/97 SS#: xxx-xx-0688

ADM PHYS Dannaway,Douglas MD
PCP Does Not Know
REF PHYS Varughese,Paul John MD
ATTEND PHYS Bergner,Erynn MD
FAMILY PHYS
ER PHYS
Reason for Visit: APNEA
Comment:

	Occurrence	Date	Time		Condition Code
1	11	02/08/22		1	
2				2	
3				3	
4				4	

Last Hospitalization
Hospital : ALLIANCE HEALTH DURANT
From Date: 02/08/22
Thru Date:

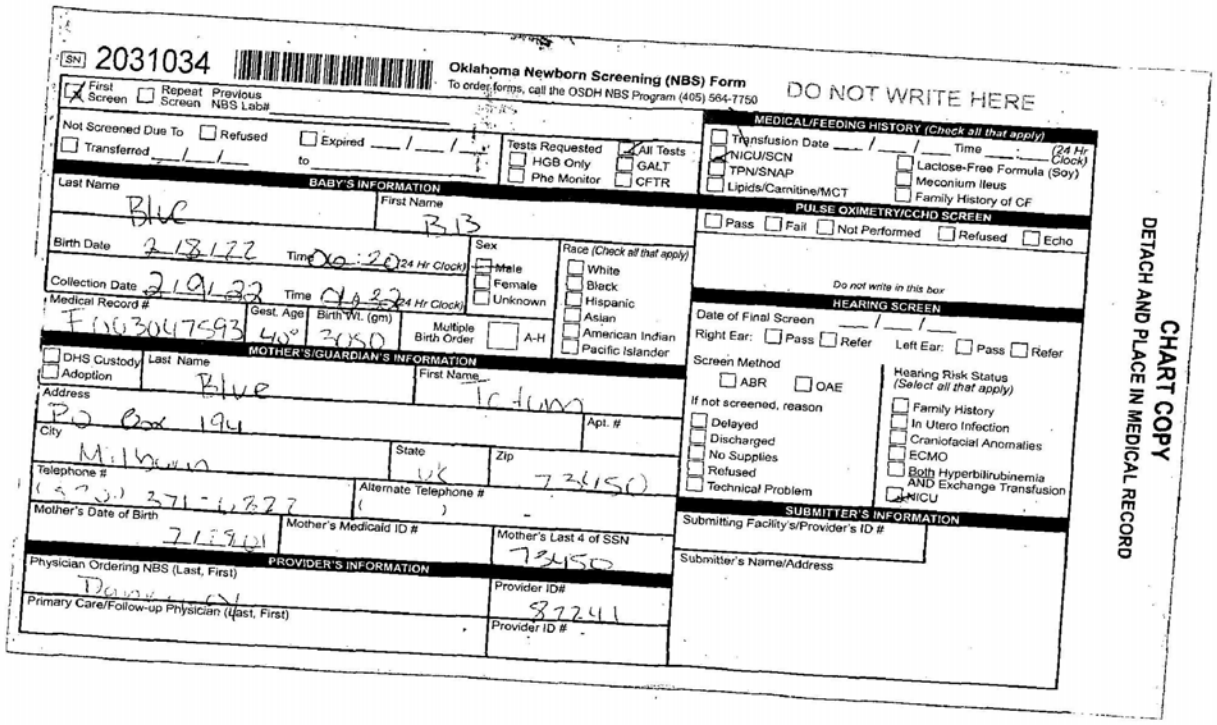
ACCOUNT # E00677497957 | PRE IN : EADM.KLJ | Reg by : EADM.KLJ

FACE

Page 1 of 1

BLUE,BB-TATUM
Acct# E00677497957 MR# E003047593
Loc: EU.NICUE DOB: 02/08/22 M 02/08/22
Dannaway,Douglas MD

OU MEDICAL CENTER
FACESHEET Printed on 02/20/22 at 2103



SN 2031034

Oklahoma Newborn Screening (NBS) Form
To order forms, call the OSDH NBS Program (405) 564-7750

DO NOT WRITE HERE

☒ First Screen ☐ Repeat Screen Previous NBS Lab#

Not Screened Due To ☐ Refused ☐ Expired ___/___/___ ☐ Transferred ___/___/___ to _____

Tests Requested ☐ HGB Only ☐ Phe Monitor ☒ All Tests ☐ GALT ☐ CFTR

BABY'S INFORMATION

Last Name: Blue
First Name: B13
Birth Date: 2/8/22 Time: 00:20 (24 Hr Clock)
Collection Date: 2/9/22 Time: 04:22 (24 Hr Clock)
Medical Record #: F003047593
Gest. Age: 40°
Birth Wt. (gm): 3480
Multiple Birth Order ☐ A-H
Sex ☐ Male ☐ Female ☐ Unknown
Race (Check all that apply) ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ American Indian ☐ Pacific Islander

MOTHER'S/GUARDIAN'S INFORMATION

☐ DHS Custody ☐ Adoption
Last Name: Blue
First Name: Victoria
Address: PO Box 194
Apt. #
City: Milburn
State: OK
Zip: 73450
Telephone #: (580) 371-4827
Alternate Telephone #
Mother's Date of Birth: 7/19/01
Mother's Medicaid ID #
Mother's Last 4 of SSN: 7345

PROVIDER'S INFORMATION

Physician Ordering NBS (Last, First): Downey, CY
Provider ID#: 87241
Primary Care/Follow-up Physician (Last, First)
Provider ID #

MEDICAL/FEEDING HISTORY (Check all that apply)

☐ Transfusion Date ___/___/___ Time ___:___ (24 Hr Clock)
☒ NICU/SCN
☐ TPN/SNAP
☐ Lipids/Carnitine/MCT
☐ Lactose-Free Formula (Soy)
☐ Meconium Ileus
☐ Family History of CF

PULSE OXIMETRY/CCHD SCREEN

☐ Pass ☐ Fail ☐ Not Performed ☐ Refused ☐ Echo

Do not write in this box

HEARING SCREEN

Date of Final Screen ___/___/___
Right Ear: ☐ Pass ☐ Refer Left Ear: ☐ Pass ☐ Refer
Screen Method ☐ ABR ☐ OAE
If not screened, reason ☐ Delayed ☐ Discharged ☐ No Supplies ☐ Refused ☐ Technical Problem
Hearing Risk Status (Select all that apply) ☐ Family History ☐ In Utero Infection ☐ Craniofacial Anomalies ☐ ECMO ☐ Both Hyperbilirubinemia AND Exchange Transfusion ☐ NICU

SUBMITTER'S INFORMATION

Submitting Facility's/Provider's ID #
Submitter's Name/Address

CHART COPY
DETACH AND PLACE IN MEDICAL RECORD

2022/02/14 13:41:54 4 /4

OKLAHOMA STATE DEPARTMENT OF HEALTH
Public Health Laboratory Service
4615 W. Lakeview Rd. Stillwater, OK 74075 (405) 564-7750

OKLAHOMA NEWBORN SCREENING REPORT

(Pending/Duplicate)

Date: 2/14/2022

Baby's Name	: BLUE, MALE	Lab Number	: 20220421066
Birth Date	: 2/8/2022@06:20	Serial Number	: 2031034
Collection Date	: 2/9/2022@06:32	Medical Record	: E003047593
Received Date	: 2/10/2022	Sex	: Male
Mother	: BLUE, TATUM	Birthweight	: 3050 gms
Address	: PO BOX 194	Multiple Birth Order	:
City/St/Zip	: MILBURN, OK 73450	Date Transfused^	:
Phone	: (580) 371-6882	Mother's DOB	: 7/25/2001
Submitter	: 91115 - EVERETT TOWER-OU MEDICAL CENTER	Specimen Type	: Initial
Physician	: 91115 - EVERETT TOWER-OU MEDICAL CENTER		

BLOOD SPOT SCREENING RESULT

DISORDER	RESULT	COMMENT	REFERENCE RANGE
Primary Congenital Hypothyroidism (CH)	Within Normal Limits	Not Consistent with CH	TSH < 27 µIU/mL
Galactosemia	Within Normal Limits	Not consistent with classic galactosemia	TG < 10 mg/dL
Congenital Adrenal Hyperplasia (CAH)	Within Normal Limits	Not Consistent with CAH	17-OHP < 25 ng/mL
Cystic Fibrosis (CF)	Within Normal Limits	Not Consistent with Cystic Fibrosis	IRT < 57 ng/mL
Hemoglobinopathy (HGB)	Hb: FA	No Abnormal Bands Detected	Hb = FA or AF
Fatty Acid Oxidation Disorders (FAOs)	Within Normal Limits	Not Consistent with MCAD or Other Fatty Acid Oxidation Disorders	C8 < 0.40 µmol/L and Other FAO Acylcarnitines WNL
Amino Acid Disorders (AAs)	**Met 77.97 µmol/L Arg 104.17 µmol/L**	**Outside Normal Limits See Comments (AA)**	**Met < 75 µmol/L Arg <100 µmol/L**
Organic Acid Disorders (OAs)	Within Normal Limits	Not Consistent with Organic Acid Disorders	C3 < 6.33 µmol/L and Other OA Acylcarnitines WNL
Biotinidase Deficiency (BIO)	Within Normal Limits	Not Consistent with Biotinidase Deficiency	BIO ≥ 57 U/dL
Severe Combined Immunodeficiency (SCID)	Within Normal Limits	Not Consistent with SCID	>768 copy/10^5 cells;GA>=37wks
Spinal Muscular Atrophy	Within Normal Limits	Not Consistent with SMA	Gene Present
Lysomal Storage Diseases	Pending		
X-Linked Adrenoleukodystrophy	Within Normal Limits	Not Consistent with with X-ALD	C26:0-LPC < 0.58 µmol/L C24:0-LPC < 1.60 µmol/L

Comments

AA - Pattern of Multiple Elevations, Consistent with TPN. Submit New Filter Paper Specimen at 14 Days of Age.

Oklahoma State Department of Health Public Health Laboratory (OSDH PHL) is a CLIA certified CAP accredited high-complexity laboratory. Tests are developed and performance characteristics determined by OSDH PHL. These tests have been US Food and Drug Administration (FDA) approved, cleared, or determined FDA approval is unnecessary (CFR 812.2(c)(3)(iv). Screening tests are not diagnostic and require confirmatory testing. False positives and false negatives may occur. Test methods, reference ranges, and limitations are available at http://nsp.health.ok.gov and http://phl.health.ok.gov . For follow-up call 405-426-8220.

NEWBORN HEARING SCREENING

PN:CG178R
02/17/22
BLUE,BB-TATUM
E00677497957

HEARING SCREENING: NO HEARING - BABY IN NCU

Information reported here is based on what was submitted on the Newborn Screening Form by EVERETT TOWER-OU MEDICAL CENTER. The Oklahoma State Department of Health, Public Hearing Screen. For more information about infant hearing screening and hearing testing, please call the newborn h)

LABS

0209 C730
E00677497957

OUHSC Biochemical Genetics Laboratory Test Report

Patient name: Blue, BB-Tatum Accession #: **22-133-AAQP**

DOB: 2/8/2022	Sex: Male	Referring Physician: Jennifer Fraysur	
Age at Collection: 1 day		Tel: -	Fax:
Sample Type: Plasma		Hospital/Institution: Oklahoma Health Science Center	
Sample Collected: 2/9/2022		Duplicate reports:	
Sample Received: 2/11/2022		Sample Condition: Good	
Final Report: 2/11/2022		Reason for referral: Apnea	
Medical record#: EM889286			
Client Accession #: 22-133-AAQP			
Sample ID #: E003047593			

Test Name: Amino Acids, Plasma - 1-31 days

Amino Acid	Result µmol/L	Ref Range µmol/L	Flag	Amino Acid	Result µmol/L	Ref Range µmol/L	Flag
Phosphoserine	8	7 - 47		Allo-isoleucine	0	0 - 1	
Taurine	220	46 - 492		Cystathionine	0	0 - 3	
Phosphoethanolamine	15	3 - 27		Isoleucine	182	26 - 91	H
Aspartic acid	54	20 - 129		Leucine	324	48 - 160	H
Hydroxyproline	32	0 - 91		Argininosuccinic acid	0	0 - 1	
Threonine	310	90 - 329		Tyrosine	68	55 - 147	
Serine	434	99 - 395	H	Phenylalanine	115	38 - 137	
Asparagine	42	29 - 132		b-Alanine	0	0 - 10	
Glutamic acid	180	62 - 620		b-Aminoisobutyric Acid	0	0 - 1	
Glutamine	840	376 - 709	H	Homocystine	0	0 - 1	
Sarcosine	0	0 - 625		Tryptophan	73	0 - 60	H
a-Aminoadipic Acid	0	0 - 1		Hydroxylysine	0	0 - 7	
Proline	560	110 - 417	H	Ornithine	434	48 - 211	H
Glycine	573	232 - 740		Lysine	374	92 - 325	H
Alanine	666	131 - 710		1-Methylhistidine	14	0 - 43	
Citrulline	33	10 - 45		Histidine	227	30 - 138	H
a-Amino-n-butyric Acid	37	8 - 24	H	3-Methylhistidine	7	0 - 5	H
Valine	372	86 - 190	H	Anserine	0	0 - 1	
Cystine	49	17 - 98		Carnosine	0	0 - 19	
Methionine	100	10 - 60	H	Arginine	168	6 – 140	H

Results and Interpretation

Interpretation: In this plasma amino acid profile, multiple species were mild to moderately elevated including leucine and ornithine. While not overly consistent with an inherited metabolic disorder and may be secondary to diet, illness, and/or medications, recommend repeat plasma amino acid profile if clinical symptoms persist.

LABS

PN:CG178R
02/17/22
BLUE,BB-TATUM
E00677497957

Department of Pediatrics Section of Genetics – 1200 N Phillips Avenue, Suite 12010, Oklahoma City, OK 73104 Page 1/2

0209 C9875

OUHSC Biochemical Genetics Laboratory Test Report

Patient name: Blue, BB-Tatum Accession #: **22-133-AAQP**

Shibo Li, MD

Chelsea Zimmerman, PhD
Director, Biochemical Genetics Laboratory

These results and interpretations are made within the limits of sample collection, methodology and our current knowledge. They should be correlated by the referring physician with respect to the ongoing clinical situation of the patient.

eurofins | Viracor

LABORATORY REPORT

Patient Name: BLUE, BB-TATUM
Sex: M **DOB:** 02/08/2022 **Age:** 3d
Eurofins Viracor Patient ID: 541834
Physician: Caines, Macie N.
Received: 02/10/2022 08:15
Report Delivered: 02/11/2022 12:06

Client MRN: E003047593

Client:
OU Medical Center Laboratory
1200 Everett Drive
Room EB400
Oklahoma City, OK 73104

Comments:
TESTING PERFORMED AT LOW VOLUME ON PLASMA SPECIMEN FOR HSV 1 & 2, MAY AFFECT RESULTS.

RESULTS

HSV 1 & 2 qPCR (plasma) 8500
Client Accession ID: 0208:PN:VP00095R
Eurofins Viracor Accession ID: 2204004150
Collected: 02/08/2022 22:11
Final - Approved 02/11/2022 12:05
Performed at: Eurofins Viracor - 1001 NW Technology Dr., Lee's Summit, MO | CLIA# 26D-0983643

TEST	RESULT	FLAG	UNIT	REF RANGE
HSV 1	Not Detected		copies/mL	Not Detected
HSV 2	Not Detected		copies/mL	Not Detected

Assay Range for HSV 1 is 37 copies/mL to 1.00E+08 copies/mL

Assay Range for HSV 2 is 73 copies/mL to 1.00E+08 copies/mL

The limit of quantitation (LOQ) is 37 (HSV 1) and 73 (HSV 2) copies/mL. HSV DNA detected below the LOQ will be reported as Detected:<37 copies/mL (HSV 1) or Detected:<73 copies/mL (HSV 2).

This test was developed and its performance characteristics determined by Eurofins Viracor. It has not been cleared or approved by the U.S. Food and Drug Administration. Results should be used in conjunction with clinical findings, and should not form the sole basis for a diagnosis or treatment decision.

PN:CG178R
02/17/22
BLUE,BB-TATUM
E00677497957

Blue, Bb-tatum
Patient ID: **E003047593**
Specimen ID: **041-874-6202-0**

DOB: **02/08/2022**
Age: **1 day**
Sex: **Male**

Patient Report
Account Number: **35874545**
Ordering Physician: **J Fraysur**

labcorp

Ordered Items: **Pyruvic Acid, Blood**

Date Collected: **02/09/2022** Date Received: **02/10/2022** Date Reported: **02/15/2022** Fasting: **Not Given**

General Comments & Additional Information

Clinical Info: APNEA

Pyruvic Acid, Blood

Test	Current Result and Flag	Previous Result and Date	Units	Reference Interval
Pyruvic Acid, Blood [01]	0.4		mg/dL	0.3-0.7
Disclaimer: [01]	This test was developed and its performance characteristics determined by Labcorp. It has not been cleared or approved by the Food and Drug Administration.			

Disclaimer
The Previous Result is listed for the most recent test performed by Labcorp in the past 5 years where there is sufficient patient demographic data to match the result to the patient. Results from certain tests are excluded from the Previous Result display.

Icon Legend
△ Out of Reference Range ■ Critical or Alert

Performing Labs
01: BN - Labcorp Burlington 1447 York Court, Burlington, NC, 27215-3361 Dir: Sanjai Nagendra, MD
For Inquiries, the physician can contact Branch: 800-733-5221 Lab: 972-598-6000

PatientDetails
Blue, Bb-tatum
9965 S BRUSHY RD, MILBURN, OK, 73450

Phone: **580-371-6882**
Date of Birth: **02/08/2022**
Age: **1 day**
Sex: **Male**
Patient ID: **E003047593**
Alternate Patient ID: **E00677497957**

Physician Details
J Fraysur
Ou Medical Center
1200 Everett Drive, Rm# Eb400, Oklahoma City, OK, 73126

Phone: **405-272-0323**
Account Number: **35874545**
Physician ID: **FRAJE**
NPI:

Specimen Details
Specimen ID: **041-874-6202-0**
Control ID: **L58611501**
Alternate Control Number: **0209:PN:C02874R**
Date Collected: **02/09/2022 1715 Local**
Date Received: **02/10/2022 0000 ET**
Date Entered: **02/10/2022 1637 ET**
Date Reported: **02/15/2022 0406 ET**
Rte: **13**

LABS

PN:C2874R
02/09/22
BLUE,BB-TATUM
E00677497957

labcorp

Date Created and Stored 02/15/22 0408 ET **Final Report** Page 1 of 1

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This document contains private and confidential health information protected by state and federal law.
If you have received this document in error please call 972-598-6000

E00677497957

OUHSC Biochemical Genetics Laboratory Test Report

Patient name: Blue, BB-Tatum Accession #: **22-003-OAQL**

DOB: 2/8/2022	Sex: Male	Referring Physician: Jennifer Fraysur	
Age at Collection: 1 day		Tel:	Fax:
Sample Type: Urine		Hospital/Institution: Oklahoma Health Science Center	
Sample Collected: 2/9/2022		Duplicate reports:	
Sample Received: 2/11/2022		Sample Condition: Good	
Final Report: 2/15/2022		Reason for referral: Apnea	
Medical record#: EM889286			
Client Accession #: 22-003-OAQL			
Sample ID #: E003047593			

Test Name: Urine Organic Acids, Qualitative

Results and Interpretation

In this urine organic acid profile, no species overly consistent with an inherited metabolic disorder were observed. However, a large peak of N-acetyltyrosine was observed and is likely secondary to diet (total parenteral nutrition).

DISCLAIMER
The organic solvent extraction method used may produce sub-optimal extraction of some metabolites. These include, but are not limited to: orotic acid, succinylacetone and n-acetylaspartic acid, which may be ordered as specific tests. Metabolites observed in urine organic acids may reflect the recent clinical and nutritional status, special diets or dietary supplementation, of the patient at the time of sample collection. A test result that is non-diagnostic does not eliminate the possibility of the presence of a metabolic disease. Inborn errors of metabolism characterized by minute or intermittent excretion of the relevant metabolites may mean that these are missed especially if the patient is well or asymptomatic at the time of sample analysis.

Chelsea Zimmerman, PhD.
Director, Biochemical Genetics Laboratory

PN:U298R
02/09/22
BLUE,BB-TATUM
E00677497957

Department of Pediatrics Section of Genetics – 1200 N Phillips Avenue, Suite 12010, Oklahoma City, OK 73104

LABS

0209 U298
E00677497957

OUHSC Biochemical Genetics Laboratory Test Report

Patient name: Blue, BB-Tatum Accession #: **22-003-OAQL**

Chelsea Zimmerman

Shibo Li, MD

Chelsea Zimmerman, PhD Director Biochemical Genetics Laboratory

Department of Pediatrics Section of Genetics – 1200 N Phillips Avenue, Suite 12010, Oklahoma City, OK 73104

OKLAHOMA STATE DEPARTMENT OF HEALTH
Public Health Laboratory Service
4615 W. Lakeview Rd. Stillwater, OK 74075 (405) 564-7750

OKLAHOMA NEWBORN SCREENING REPORT

Date: 2/28/2022

Baby's Name	: BLUE, MALE	Lab Number	: 20220541007
Birth Date	: 2/8/2022@06:20	Serial Number	: 1997897
Collection Date	: 2/20/2022@08:45	Medical Record	: E003047593
Received Date	: 2/21/2022	Sex	: Male
Mother	: BLUE, TATUM	Birthweight	: 3050 gms
Address	: 9965 S BRUS	Multiple Birth Order	:
City/St/Zip	: MILBURN, OK 73450	Date Transfused^	:
Phone	: (580) 371-6882	Mother's DOB	: 7/25/2001
Submitter	: 91115 - EVERETT TOWER-OU MEDICAL CENTER	Specimen Type	: Repeat
Physician	: 91115 - EVERETT TOWER-OU MEDICAL CENTER		

BLOOD SPOT SCREENING RESULT

276

DISORDER	RESULT	COMMENT	REFERENCE RANGE
Primary Congenital Hypothyroidism (CH)	Within Normal Limits	Not Consistent with CH	TSH < 27 µIU/mL
Galactosemia	Within Normal Limits	Not consistent with classic galactosemia	TG < 10 mg/dL
Congenital Adrenal Hyperplasia (CAH)	Within Normal Limits	Not Consistent with CAH	17-OHP < 28 ng/mL
Cystic Fibrosis (CF)	Within Normal Limits	Not Consistent with Cystic Fibrosis	IRT < 57 ng/mL
Hemoglobinopathy (HGB)	Hb: FA	No Abnormal Bands Detected	Hb = FA or AF
Fatty Acid Oxidation Disorders (FAOs)	Within Normal Limits	Not Consistent with MCAD or Other Fatty Acid Oxidation Disorders	C8 < 0.40 µmol/L and Other FAO Acylcarnitines WNL
Amino Acid Disorders (AAs)	Within Normal Limits	Not Consistent with PKU or Other Amino Acid Disorders	Phe < 150 µmol/L and Other Amino Acids in Range
Organic Acid Disorders (OAs)	Within Normal Limits	Not Consistent with Organic Acid Disorders	C3 < 6.33 µmol/L and Other OA Acylcarnitines WNL
Biotinidase Deficiency (BIO)	Within Normal Limits	Not Consistent with Biotinidase Deficiency	BIO ≥ 57 U/dL
Severe Combined Immunodeficiency (SCID)	Within Normal Limits	Not Consistent with SCID	>768 copy/10^5 cells;GA>=37wks
Spinal Muscular Atrophy	Within Normal Limits	Not Consistent with SMA	Gene Present
Lysomal Storage Diseases	Within Normal Limits	Not Consistent with POMPE or MPS I	IDUA >= 1.3 µmol/hr/L GAA >=2.5 µmol/hr/L
X-Linked Adrenoleukodystrophy	Within Normal Limits	Not Consistent with with X-ALD	C26:0-LPC < 0.58 µmol/L C24:0-LPC < 1.60 µmol/L

Oklahoma State Department of Health Public Health Laboratory (OSDH PHL) is a CLIA certified CAP accredited high-complexity laboratory. Tests are developed and performance characteristics determined by OSDH PHL. These tests have been US Food and Drug Administration (FDA) approved, cleared, or determined FDA approval is unnecessary (CFR 812.2(c)(3)(iv). Screening tests are not diagnostic and require confirmatory testing. False positives and false negatives may occur. Test methods, reference ranges, and limitations are available at http://nsp.health.ok.gov and http://phl.health.ok.gov . For follow-up call 405-426-8220.

NEWBORN HEARING SCREENING

PN:CG178R
02/17/22
BLUE,BB-TATUM
E00677497957

HEARING SCREE *LABS* ed

Information reported here is based on what was submitted on the Newborn Screening Form by EVERETT TOWER-OU MEDICAL CENTER. The Oklahoma State Department of Health, Public Health Laboratory did not conduct the Hearing Screen. For more information about infant hearing screening and hearing testing, please call the newborn hearing screening program at 405-426-8220

PN:C730R
02/09/22
BLUE,BB-TATUM
E00677497957

OKLAHOMA STATE DEPARTMENT OF HEALTH

Public Health Laboratory Service
4615 W. Lakeview Rd. Stillwater, OK 74075 (405) 564-7750

OKLAHOMA NEWBORN SCREENING REPORT

(Pending/Duplicate)

Date: 02/15/2022

Baby's Name	: BLUE, MALE	Lab Number	: 20220421066
Birth Date	: 02/08/2022@06:20	Serial Number	: 2031034
Collection Date	: 02/09/2022@06:32	Medical Record	: E003047593
Received Date	: 02/10/2022	Sex	: Male
Mother	: BLUE, TATUM	Birthweight	: 3050 gms
Address	: PO BOX 194	Multiple Birth Order	:
City/St/Zip	: MILBURN, OK 73450	Date Transfused^	:
Phone	: (580) 371-6882	Mother's DOB	: 07/25/2001
Submitter	: 91115 - EVERETT TOWER-OU MEDICAL CENTER	Specimen Type	: Initial
Physician	: 91115 - EVERETT TOWER-OU MEDICAL CENTER		

BLOOD SPOT SCREENING RESULT

1

DISORDER	RESULT	COMMENT	REFERENCE RANGE
Primary Congenital Hypothyroidism (CH)	Within Normal Limits	Not Consistent with CH	TSH < 27 µIU/mL
Galactosemia	Within Normal Limits	Not consistent with classic galactosemia	TG < 10 mg/dL TG < 10 mg/dL
Congenital Adrenal Hyperplasia (CAH)	Within Normal Limits	Not Consistent with CAH	17-OHP < 28 ng/mL
Cystic Fibrosis (CF)	Within Normal Limits	Not Consistent with Cystic Fibrosis	IRT < 57 ng/mL
Hemoglobinopathy (HGB)	Hb: FA	No Abnormal Bands Detected	Hb = FA or AF
Fatty Acid Oxidation Disorders (FAOs)	Within Normal Limits	Not Consistent with MCAD or Other Fatty Acid Oxidation Disorders	C8 < 0.40 µmol/L and Other FAO Acylcarnitines WNL
Amino Acid Disorders (AAs)	**Met 77.97 µmol/L Arg 104.17 µmol/L**	**Outside Normal Limits See Comments (AA)**	**Met < 75 µmol/L Arg <100 µmol/L**
Organic Acid Disorders (OAs)	Within Normal Limits	Not Consistent with Organic Acid Disorders	C3 < 6.33 µmol/L and Other OA Acylcarnitines WNL
Biotinidase Deficiency (BIO)	Within Normal Limits	Not Consistent with Biotinidase Deficiency	BIO ≥ 57 U/dL
Severe Combined Immunodeficiency (SCID)	Within Normal Limits	Not Consistent with SCID	TREC > 26 Copies
Spinal Muscular Atrophy	Within Normal Limits	Not Consistent with SMA	Gene Present
Lysomal Storage Diseases	Within Normal Limits	Not Consistent with POMPE or MPS I	IDUA >= 1.3 µmol/hr/L GAA >=2.5 µmol/hr/L
X-Linked Adrenoleukodystrophy	Within Normal Limits	Not Consistent with with X-ALD	C26:0-LPC < 0.58 µmol/L C24:0-LPC < 1.60 µmol/L

Comments

AA - Pattern of Multiple Elevations, Consistent with TPN. Submit New Filter Paper Specimen at 14 Days of Age.

Oklahoma State Department of Health Public Health Laboratory (OSDH PHL) is a CLIA certified CAP accredited high-complexity laboratory. Tests are developed and performance characteristics determined by OSDH PHL. These tests have been US Food and Drug Administration (FDA) approved, cleared, or determined FDA approval is unnecessary (CFR 812.2(c)(3)(iv). Screening tests are not diagnostic and require confirmatory testing. False positives and false negatives may occur. Test methods, reference ranges, and limitations are available at http://nsp.health.ok.gov and http://phl.health.ok.gov . For follow-up call 405-426-8220.

LABS

NEWBORN HEARING SCREENING

UPDATED HEARING RESULTS

HEARING SCREENING: Left ear: Pass: Right ear: Pass. Risk factor present. Screen hearing at 6 months.

Information reported here is based on what was submitted on the Newborn Screening Form by EVERETT TOWER - OU CHILDRENS MEDICAL CENTER.

Oklahoma State Department of Health
PUBLIC HEALTH LABORATORY SERVICE
4615 W. Lakeview Rd., Stillwater, OK 74075

EVERETT TOWER-OU MEDICAL CENTER
ATTN: VALERIE RAWLINGS, CENTRAL REC & P
PO BOX 26307
OKLAHOMA CITY, OK 73126

The Oklahoma State Department of Health, Public Health Laboratory did not conduct the Hearing Screen. For more information about infant hearing screening and hearing testing, please call the newborn hearing screening program at 405-426-8220

PN:C730R
02/09/22
BLUE.BB-TATUM
E00677497957

02/21/22 0151 MEDICATION DISCHARGE SUMMARY PAGE: 1

NAME: BLUE,BB-TATUM ADMIT DATE: 02/08/22 AGE: 00M 13D
UNIT #: E003047593 DISCHARGE DATE: 02/20/22 SEX: M
ACCT #: E00677497957 STATUS: DIS IN
CODED ALLERGIES No Known Allergies
CODED ADRs
UNCODED ALLERGIES
UNCODED ADRs

ADMINISTRATION PERIOD: 0700 02/08/22 to 0659 02/09/22	START/ STOP	
SYRINGE MED 1 EACH **(SYRINGE MED - SEE ADDITIVE)** **ACYCLOVIR 7MG/1ML 60 MG** **(ACYCLOVIR 7 MG/ML)** 8.57 MLS/HR IV Every 8 hours Spec Ins: Mixed in NS Comments: *****IV ROUTE***** Administer over 60 minutes RX #: 38693696	02/08/22 02/15/22	2153 Order Entry EAP.MNC1 2159 Pharmacy Edit or Verification EPHA.CM 2159 Pharmacy Edit or Verification FPHA.CM 2237 Nursing Acknowledged Order ENUR.RMP6 2330 ENUR.LY2 at 2356 SITE: PIV - PERIPHERAL IV GAVE: 8.57 MLS 02/08/22-2356 File Document by ENUR.LY2
SYRINGE MED 1 EACH **(SYRINGE MED - SEE ADDITIVE)** **AMPICILLIN 40 MG/1 ML IN 1/2NS 300 MG** **(AMPICILLIN SODIUM 40 MG/ML)** 15 MLS/HR IV Every 12 hours Total Bags: 3 (3 of 3 Given) Comments: Administer over 30 minutes ***REFRIGERATE*** RX #: 38693795	02/09/22 02/10/22	2228 Order Entry EAP.MNC1 2232 Pharmacy Edit or Verification EPHA.MN2 2237 Nursing Acknowledged Order ENUR.RMP6 0630 ENUR.LY2 at 0641 SITE: PIV - PERIPHERAL IV GAVE: 7.5 MLS 02/09/22-0641 File Document by ENUR.LY2
SYRINGE MED 1 EACH **(SYRINGE MED - SEE ADDITIVE)** **AMIKACIN 10MG/1ML 37 MG** **(AMIKACIN SULFATE 10 MG/ML 1 ML)** 7.4 MLS/HR IV Every 24 hours Total Bags: 1 (1 of 1 Given) Spec Ins: Mixed in NS Comments: Administer over 30 minutes - Mixed in NS RX #: 38693797	02/09/22 02/09/22	2228 Order Entry EAP.MNC1 2232 Pharmacy Edit or Verification EPHA.MN2 2237 Nursing Acknowledged Order ENUR.RMP6

*** CONTINUED ON PAGE 2 ***
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02/21/22 0151 MEDICATION DISCHARGE SUMMARY PAGE: 2

NAME: BLUE,BB-TATUM UNIT #: E003047593 ACCT #: E00677497957

ADMINISTRATION PERIOD: 0700 02/08/22 to 0659 02/09/22 (Continued)	START/ STOP	
SNAP 10% (SHORT-TERM AMINO ACID PREP) 250 ML **(SNAP 10% [SHORT TERM AA PREP] 250 ML BAG)** 10 ML/HR IV CONTINUOUS Spec Ins: Contains: DeXtrose 10% Trophamine 4% Calcium Gluconate 2 mEq/100ml Heparin 0.12 units/ml RX #: 38693798	02/08/22 03/10/22	2229 Order Entry EAP.MNC1 2232 Pharmacy Edit or Verification EPHA.MN2 2232 Pharmacy Edit or Verification EPHA.MN2 2237 Nursing Acknowledged Order FNUR.RMP6 2355 ENUR.LY2 at 2355 SITE: PIV - PERIPHERAL IV GAVE: 250 MLS 02/08/22-2356 File Document by ENUR.LY2
D10-W 250ML 250 ML **(DEXTROSE 10%-WATER 250 ML BAG)** **HEPARIN SODIUM 125 UNITS** **(HEPARIN SODIUM 1000 UNITS/ML 10 ML VIAL)** 1 ML/HR IV .Q24H RX #: 38693794	02/08/22 03/10/22	2229 Order Entry EAP.MNC1 2230 2231 Pharmacy Edit or Verification EPHA.MN2 2237 Nursing Acknowledged Order FNUR.RMP6
PHENobarbitaL sodium (PHENobarbitaL sodium 65 MG/ML VIAL) **15.25 MG** IV Every 24 hours Comments: Administer "straight" or dilute to 10 mg/ml by adding 1 ml from vial to 5.5 ml NS --> 6.5 ml with 65 mg RX #: 38693926	02/09/22 03/11/22	2320 Order Entry FPHA.CM 2356 Nursing Acknowledged Order FNUR.LY2
LMX4 (formerly ELA-MAX) 5 GM CREAM (LIDOCAINE HYDROCHLORIDE 4% 5 GM CREAM) **1 APPLIC** TOPICAL NOW/STA Spec Ins: to LP area one time RX #: 386940/1	02/09/22 02/09/22	0030 FNUR.LY2 at 0055 GAVE: 1 APPLTC NDC/DIN: (SOURCE: eMAR) 2435770105 ELAMAX - Lidocaine Hydrochloride 4% 5 ... 02/09/22-0055 File Document by ENUR.LY2 0031 Admin Criterion Entered RES.NKD 0031 Order Entry RFS.NKD 0031 Pharmacy Edit or Verification EPHA.CM 0031 Pharmacy DisconLinue SCHEDULER 0055 Nursing Acknowledged Order ENUR.LY2

*** CONTINUED ON PAGE 3 ***
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ADMINISTRATION PERIOD: 0700 02/08/22 to 0659 02/09/22 (Continued)	START/ STOP	
PHENobarbitaL sodium (PHENobarbitaL sodium 65 MG/ML VIAL) **61 MG** IV ONE TIME ONLY/ONE Comments: Administer "straight" or dilute to 10 mg/ml by adding 1 ml from vial to 5.5 ml NS > 6.5 ml with 65 mg RX #: 38694102	02/09/22 02/09/22	0049 Order Entry EPHA.CM 0052 Nursing Acknowledged Order ENUR.LS2O 0100 ENUR.LS2O at 0052 SITE: PIV - PERIPHERAL IV GAVE: 61 MG NDC/DIN: (SOURCE: eMAR) 0641047621 PHENIV651 - PHENobarbitaL sodium 65 MG/ML... Sedation medication purpose? Sedation RASS score? State Behavior Scale Score: 0 POSS? Result? Comment- 02/09/22-0052 File Document by ENUR.LS2O 0101 Pharmacy Discontinue SCHEDULER 0152 Nursing Reassessment by ENUR.LY2 at 1921
NS (SODIUM CHLORIDE 0.9% 250 ML BAG) **30 ML** IV ONE TIME ONLY/ONE RX #: 38694301	02/09/22 02/09/22	0250 Order Entry EAP.MNC1 0252 Pharmacy Edit or Verification EPHA.CM 0252 Pharmacy Edit or Verification FPHA.CM 0256 Nursing Acknowledged Order ENUR.RMP6 0300 ENUR.JP17 at 0322 SITE: PIV - PERIPHERAL IV GAVE: 30 ML NDC/DIN: (SOURCE: eMAR) 0338004902 SODIIL.936 - Sodium Chloride 0.9% 250 Ml Bag 02/09/22-0322 File Document by ENUR.JP17 0301 Pharmacy Discontinue SCHEDULER
DOPamine 3.2 MG/ML DRIP 25 ML **(DOPamine HCl 3.2 MG/ML DRIP)** 0.286 MLS/HR IV CONTINUOUS Spec Ins: please hold at bedside. RX #: 38694300	02/09/22 03/11/22	0250 Order Entry EAP.MNC1 0252 Pharmacy Edit or Verification EPHA.CM 0252 Pharmacy Edit or Verification EPHA.CM 0256 Nursing Acknowledged Order ENUR.RMP6 0323 ENUR.JP17 at 0323 SITE: PIV - PERIPHERAL IV GAVE: 25 MLS 02/09/22-0324 File Document by ENUR.JP17
KEPPRA (levETIRAcetam Inj 500 mg/5 ml Vial) **60 MG** IV ONE TIME ONLY/ONE Comments: Push over 2-5 minutes for doses 1500 mg or less. Pharmacy must mix for doses over 1500 mg. RX #: 38694371	02/09/22 02/09/22	0317 Order Entry RFS.NKD 0320 Pharmacy Edit or Verification FPHA.MN2 0327 Nursing Acknowledged Order ENUR.JP17 0330 ENUR.LY2 at 0331 SITE: PIV - PERIPHERAL IV GAVE: 60 MG NDC/DIN: (SOURCE: eMAR) 63323400005 KEPPRAIV - levETIRAcetam Inj 500 mg/5 ml... 02/09/22 0331 File Document by ENUR.LY2 0331 Pharmacy Discontinue SCHEDULER

*** CONTINUED ON PAGE 4 ***
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02/21/22 0151 MEDICATION DISCHARGE SUMMARY PAGE: 4

NAME: BLUE,BB-TATUM UNIT #: E003047593 ACCT #: E00677497957

ADMINISTRATION PERIOD: 0700 02/09/22 to 0659 02/10/22	START/ STOP	
SYRINGE MED 1 EACH **(SYRINGE MED - SEE ADDITIVE)** **ACYCLOVIR 7MG/1ML 60 MG** **(ACYCLOVIR 7 MG/ML)** 8.57 MLS/HR IV Every 8 hours Spec Ins: Mixed in NS Comments: *****IV ROUTE***** Administer over 60 minutes RX #: 38693696	02/08/22 02/16/22	0730 ENUR.AEM4 at 0747 SITE: PIV - PERIPHERAL IV GAVE: 8.57 MLS 02/09/22-0747 File Document by ENUR.AEM4 1530 ENUR.AEM4 at 1541 SITE: UVC - UMBILICAL VEIN CATH GAVE: 8.57 MLS 02/09/22 1541 File Document by ENUR.AEM4 2330 ENUR.LY2 at 02/10/22 - 0022 SITE: PICC - PICC LINE GAVE: 8.57 MLS 02/10/22-0022 File Document by ENUR.LY2
SYRINGE MED 1 EACH **(SYRINGE MED - SEE ADDITIVE)** **AMPICILLIN 40 MG/1 ML IN 1/2NS 300 MG** **(AMPICILLIN SODIUM 40 MG/ML)** 15 MLS/HR IV Every 12 hours Total Bags: 3 (3 of 3 Given) Comments: Administer over 30 minutes ***REFRIGERATE*** RX #: 38693795	02/09/22 02/10/22	1830 ENUR.AEM4 at 1757 SITE: PICC - PICC LINE GAVE: 7.5 MLS 02/09/22-1758 File Document by ENUR.AEM4 0630 ENUR.LY2 at 0624 SITE: PICC - PICC LINE GAVE: 7.5 MLS 02/10/22 0624 File Document by ENUR.LY2 0659 Pharmacy Discontinue SCHEDULER
SYRINGE MED 1 EACH **(SYRINGE MED - SEE ADDITIVE)** **AMIKACIN 10MG/1ML 37 MG** **(AMIKACIN SULFATE 10 MG/ML 1 ML)** 7.4 MLS/HR IV Every 24 hours Total Bags: 1 (1 of 1 Given) Spec Ins: Mixed in NS Comments: Administer over 30 minutes - Mixed in NS RX #: 38693797	02/09/22 02/09/22	1830 ENUR.AEM4 at 1754 SITE: PICC - PICC LINE GAVE: 3.7 MLS 02/09/22-1755 File Document by ENUR.AEM4 1859 Pharmacy Discontinue SCHEDULER

*** CONTINUED ON PAGE 5 ***
This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0700 02/09/22 to 0659 02/10/22 (Continued)	START/ STOP	
SNAP 10% (SHORT-TERM AMINO ACID PREP) 250 ML **(SNAP 10% [SHORT TERM AA PREP] 250 ML BAG)** 10 ML/HR IV CONTINUOUS Spec Ins: Contains: DeXtrose 10% Trophamine 4% Calcium Gluconate 2 mEq/100ml Heparin 0.12 units/ml RX #: 38693798	02/08/22 03/10/22	0950 ENUR,AEM4 at 0950 SITE: PICC - PICC LINE GAVE: 250 MLS 02/09/22-0951 File Document by ENUR,AEM4 1127 Pharmacy Edit or Verification EAP,JDF 1127 Pharmacy Edit or Verification EAP,JDF FROM: LAST BAG: 1 RATE: 9 ML/HR DURATION: 27 HR 47 MIN TO: LAST BAG: 0 RATE: 10 ML/HR DURATION: 25 HR 1305 Nursing Acknowledged Order ENUR,AEM4
D10-W 250ML 250 ML **(DEXTROSE 10%-WATER 250 ML BAG)** **HEPARIN SODIUM 125 UNITS** **(HEPARIN SODIUM 1000 UNITS/ML 10 ML VIAL)** 1 ML/HR IV .Q24H RX #: 38693794	02/08/22 03/10/22	1127 Pharmacy Discontinue EAP,JDF 1305 Nursing Acknowledged Order ENUR,AEM4
PHENobarbitaL sodium (PHENobarbitaL sodium 65 MG/ML VIAL) **15.25 MG** IV Every 24 hours Comments: Administer "straight" or dilute to 10 mg/ml by adding 1 ml from vial to 5.5 ml NS > 6.5 ml with 65 mg RX #: 38693926	02/09/22 03/11/22	1446 Pharmacy All Adjust Times EPHA,QXP 1502 Nursing Acknowledged Order ENUR,AEM4
DOPamine 3.2 MG/ML DRIP 25 ML **(DOPamine HCl 3.2 MG/ML DRIP)** 0.286 MLS/HR IV CONTINUOUS Spec Ins: please hold at bedside. RX #: 38694300	02/09/22 03/11/22	0951 ENUR,AEM4 at 0951 SITE: PICC - PICC LINE GAVE: 25 MLS 02/09/22 0951 File Document by ENUR,AEM4 1538 Pharmacy Edit or Verification EAP,JDF 1544 Pharmacy Deactivate EPHA,PE 1601 Nursing Acknowledged Order ENUR,AEM4
HEPARIN * PRESERVATIVE FREE * (HEPARIN NA (PRESERVATIVE-FREE) 10 UNITS/ML 1 ML SYR) **10 UNITS** IV Every 12 hours RX #: 38695179	02/09/22 03/11/22	0715 Order Entry EAP,JDF 0723 Pharmacy Edit or Verification EPHA,QXP 0723 Pharmacy Edit or Verification EPHA,QXP 0800 0806 Nursing Acknowledged Order ENUR,AEM4 2000

*** CONTINUED ON PAGE 6 ***
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02/21/22 0151 MEDICATION DISCHARGE SUMMARY PAGE: 6

NAME: BLUE,BB-TATUM UNIT #: E003047593 ACCT #: E00677497957

ADMINISTRATION PERIOD: 0700 02/09/22 to 0659 02/10/22 (Continued)	START/ STOP	
PHENobarbitaL sodium (PHENobarbitaL sodium 65 MG/ML VIAL) **30.5 MG** IV ONE TIME ONLY/ONE Comments: Administer "straight" or dilute to 10 mg/ml by adding 1 ml from vial to 5.5 ml NS > 6.5 ml with 65 mg RX #: 38698914	02/09/22 02/09/22	1446 Order Entry EPHA.QXP 1456 Nursing Acknowledged Order ENUR.AEM4 1500 ENUR.AEM4 at 1456 SITE: PICC - PICC LINE GAVE: 30.5 MG NDC/DIN: (SOURCE: eMAR) 0641047621 PHENIV651 - PHENobarbitaL sodium 65 MG/ML... 02/09/22-1455 File Document by ENUR.AEM4 1501 Pharmacy Discontinue SCHEDULER
CEREBYX (50 MG/ML PHENYTOIN EQUIVALENTS) (FOSPHENYTOIN 100 MG/2 ML VIAL) **60 MG** IV ONE TIME ONLY/ONE Comments: Concentration is calculated in PHENYTOIN EQUIVALENTS ** REFRIGERATE ** Dilute in 10 ml NS and administer slowly (0.5 3 mg PF/kg/min. Max 150 mg PF/min) ***LOW RISK MED*** RX #: 38701048	02/09/22 02/09/22	2317 Order Entry FAP.MNC1 2324 Nursing Acknowledged Order ENUR.LY2 2326 Pharmacy Edit or Verification EPHA.JS3 2330 ENUR.LY2 at 2330 SITE: PICC - PICC LINE GAVE: 60 MG 02/10/22-0024 File Document by ENUR.LY2 2331 Pharmacy Discontinue SCHEDULER

ADMINISTRATION PERIOD: 0700 02/10/22 to 0659 02/11/22	START/ STOP	
SYRINGE MED 1 EACH **(SYRINGE MED - SEE ADDITIVE)** **ACYCLOVIR 7MG/1ML 60 MG** **(ACYCLOVIR 7 MG/ML)** 8.57 MLS/HR IV Every 8 hours Spec Ins: Mixed in NS Comments: *****IV ROUTE***** Administer over 60 minutes RX #: 38693696	02/08/22 02/15/22	0704 Pharmacy Edit or Verification EAP.JDF 0704 Pharmacy Edit or Verification EAP.JDF FROM: DISPENSE: 1 LAST BAG: 8 DURATION: 60 MIN TO: DISPENSE: 6 LAST BAG: 6 DURATION: 1 HR 0704 Pharmacy Edit or Verification EAP.JDF 0730 ENUR.AEM4 at 0801 SITE: PICC - PICC LINE GAVE: 8.57 MLS 02/10/22 0801 File Document by ENUR.AEM4 0801 Nursing Acknowledged Order ENUR.AEM4 1530 ENUR.AEM4 at 1530 SITE: PICC - PICC LINE GAVE: 8.57 MLS 02/10/22-1532 File Document by ENUR.AEM4 2330 E.DDS at 2314 SITE: PICC - PICC LINE GAVE: 8.57 MLS 02/10/22-2315 File Document by E.DDS

*** CONTINUED ON PAGE 7 ***
This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0700 02/10/22 to 0659 02/11/22 (Continued)	START/ STOP	
SNAP 10% (SHORT-TERM AMINO ACID PREP) 250 ML **(SNAP 10% [SHORT TERM AA PREP] 250 ML BAG)** 10 ML/HR IV CONTINUOUS Spec Ins: Contains: DexLrose 10% Trophamine 4% Calcium Gluconate 2 mEq/100ml Heparin 0.12 units/ml RX #: 38693798	02/08/22 03/10/22	0653 Pharmacy Discontinue EAP.JDF
PHENobarbitaL sodium (PHENobarbitaL sodium 65 MG/ML VIAL) **15.25 MG IV Every 24 hours** Comments: Administer "straight" or dilute to 10 mg/ml by adding 1 ml from vial to 5.5 ml NS > 6.5 ml with 65 mg RX #: 38693926	02/09/22 03/11/22	1011 Pharmacy Discontinue EAP.JDF 1139 Nursing Acknowledged Order ENUR.AEM4
DOPamine 3.2 MG/ML DRIP 25 ML **(DOPamine HCl 3.2 MG/ML DRIP)** 0.286 MLS/HR IV CONTINUOUS Spec Ins: please hold aL bedside. RX #: 38694300	02/09/22 03/11/22	1446 Pharmacy Discontinue EAP.JDF 1529 Nursing Acknowledged Order ENUR.AEM4
HEPARIN * PRESERVATIVE FREE * (HEPARIN NA (PRESERVATIVE-FREE) 10 UNITS/ML 1 ML SYR) **10 UNITS IV Every 12 hours** RX #: 38695179	02/09/22 03/11/22	0800 2000 Not Administered F.DDS at 2145 FIUTDS 02/10/22-2145 File Document by E.DDS
SYRINGE MED 1 EACH **(SYRINGE MED - SEE ADDITIVE)** **AMPICILLIN 40 MG/1 ML IN 1/2NS 300 MG** **(AMPICILLIN SODIUM 40 MG/ML)** 15 MLS/HR IV Every 12 hours Total Bags: 10 (5 of 10 Given) Comments: Administer over 30 minutes ***RFFRIGFRATF*** RX #: 38702685	02/10/22 02/14/22	0704 Order Entry EAP.JDF 0738 Pharmacy Edit or Verification FPHA.ATI 0738 Pharmacy Edit or Verification EPHA.ATI 0800 ENUR.AEM4 aL 0917 SITE: PICC - PICC LINE GAVE: 7.5 MLS 02/10/22-0918 File Document by ENUR.AEM4 0801 Nursing Acknowledged Order ENUR.AEM4 2000 F.DDS at 2003 SITE: PICC PICC LINE GAVE: 7.5 MLS 02/10/22 2004 File Document by F.DDS

*** CONTINUED ON PAGE 8 ***
This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0700 02/10/22 to 0659 02/11/22 (Continued)	START/ STOP	
SYRINGE MED 1 EACH **(SYRINGE MED - SEE ADDITIVE)** **AMIKACIN 10MG/1ML 37 MG** **(AMIKACIN SULFATE 10 MG/ML 1 ML)** 7.4 MLS/HR IV Every 24 hours Total Bags: 5 (2 of 5 Given) Spec Ins: Mixed in NS Comments: Administer over 30 minutes - Mixed in NS RX #: 38702695	02/10/22 02/14/22	0704 Order Entry EAP,JDF 0738 Pharmacy Edit or Verification EPHA,AT1 0801 Nursing Acknowledged Order ENUR,AEM4 1800 ENUR,AFM4 at 1731 SITE: PICC - PICC LINE GAVE: 3.7 MLS 02/10/22-1731 File Document by ENUR,AEM4
PHENobarbitaL sodium (PHENobarbitaL sodium 65 MG/ML VIAL) 7.5 MG IV Every 12 hours Comments: Administer "straight" or dilute to 10 mg/ml by adding 1 ml from vial to 5.5 ml NS > 6.5 ml with 65 mg RX #: 38704318	02/10/22 03/12/22	1022 Order Entry EPHA,AT1 1139 Nursing Acknowledged Order ENUR,AEM4 1700 ENUR,AEM4 at 1638 SITE: PICC - PICC LINE GAVE: 7.5 MG NDC/DIN: (SOURCE: eMAR) 0641047621 PHENIV651 - PHENobarbitaL sodium 65 MG/ML... 02/10/22-1638 File Document by ENUR,AEM4 0500 E,DDS at 0554 SITE: PICC - PICC LINE GAVE: 7.5 MG NDC/DIN: (SOURCE: eMAR) 0641047621 PHENIV651 PHENobarbital sodium 65 MG/ML ... 02/11/22 0554 File Document by E,DDS 0654 Nursing Reassessment by ENUR,EBB at 0829
TPN (NEONATAL FORMULATION) 1 EA **(TPN (NEONATAL FORMULATION) 1 BAG)** UD IV 1800 Comments: To re-order without changes from the previous day, the prescriber should change the STOP DATE to be the next day. To edit TPN orders, prescriber should edit in Admin Criteria. RX #: 38705517	02/10/22 02/14/22	1224 Admin Criterion Entered EPHA,AT1 1224 Order Entry EPHA,AT1 1256 Nursing Acknowledged Order ENUR,AFM4 1800 ENUR,AEM4 at 1531 SITE: PICC - PICC LINE GAVE: 1 MLS Rate verified by? A RN 02/10/22-1532 File Document by ENUR,AEM4
SMOFOLIPID 20% IV FAT EMULSION 16 ML **(FAT EMUL/SOY/MCT/OLIV/FISH OIL 1 ML EMULSION)** 0.8 MLS/HR IV 1800 Total Bags: 1 (1 of 1 Given) RX #: 38705518	02/10/22 02/11/22	1224 Order Entry EPHA,AT1 1256 Nursing Acknowledged Order ENUR,AEM4 1800 ENUR,AFM4 at 1532 SITE: PICC - PICC LINE GAVE: 16 MLS 02/10/22 1532 File Document by ENUR,AFM4

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ADMINISTRATION PERIOD: 0700 02/10/22 to 0659 02/11/22 (Continued)	START/ STOP	
KEPPRA (levETIRAcetam Inj 500 mg/5 ml Vial) **60 MG IV ONE TIME ONLY/ONE** Comments: Push over 2-5 minutes for doses 1500 mg or less. Pharmacy must mix for doses over 1500 mg. RX #: 38709051	02/11/22 02/11/22	0123 Order Entry EAP.LXD 0127 Pharmacy Edit or Verification EPHA.JS3 0130 E.DDS at 0135 SITE: PICC - PICC LINE GAVE: 60 MG NDC/DIN: (SOURCE: eMAR) 0409188622 KEPPRAIV - levETIRAcetam Inj 500 mg/5 ml... 02/11/22-0135 File Document by E.DDS 0131 Pharmacy Discontinue SCHEDULER 0132 Nursing Acknowledged Order E.DDS

ADMINISTRATION PERIOD: 0700 02/11/22 to 0659 02/12/22	START/ STOP	
SYRINGE MED 1 EACH **(SYRINGE MED - SEE ADDITIVE)** **ACYCLOVIR 7MG/1ML 60 MG** **(ACYCLOVIR 7 MG/ML)** 8.57 MLS/HR IV Every 8 hours Spec Ins: Mixed in NS Comments: *****IV ROUTE***** Administer over 60 minutes RX #: 38693696	02/08/22 02/15/22	0730 FNUR.FBB at 0734 SITE: PICC PICC LINE GAVE: 8.57 MLS 02/11/22-0735 File Document by FNUR.FBB 1530 FNUR.DBB at 1515 SITE: PICC - PICC LINE GAVE: 8.57 MLS 02/11/22-1515 File Document by FNUR.FBB 2330 E.BJB at 2341 SITE: PICC - PICC LINE GAVE: 8.57 MLS 02/11/22 2341 File Document by E.BJB
SNAP 10% (SHORT-TERM AMINO ACID PREP) 250 ML **(SNAP 10% [SHORT TERM AA PREP] 250 ML BAG)** 10 ML/HR IV CONTINUOUS Spec Ins: Contains: Dextrose 10% Trophamine 4% Calcium Gluconate 2 mEq/100ml Heparin 0.12 units/ml RX #: 38693798	02/08/22 03/10/22	0703 Nursing Acknowledged Order F.DDS
HEPARIN * PRESERVATIVE FREE * (HEPARIN NA (PRESERVATIVE-FREE) 10 UNITS/ML 1 ML SYR) **10 UNITS IV Every 12 hours** RX #: 38695179	02/09/22 03/11/22	0800 Not Administered FNUR.FBB at 0734 FLUIDS 02/11/22 0735 File Document by FNUR.FBB 2000 Not Administered E.BJB at 2015 FLUIDS 02/11/22-2016 File Document by E.BJB

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02/21/22 0151 MEDICATION DISCHARGE SUMMARY PAGE: 10

NAME: BLUE,BB-TATUM UNIT #: E003047593 ACCT #: E00677497957

ADMINISTRATION PERIOD: 0700 02/11/22 to 0659 02/12/22 (Continued)	START/ STOP	
SYRINGE MED 1 EACH **(SYRINGE MED - SEE ADDITIVE)** **AMPICILLIN 40 MG/1 ML IN 1/2NS 300 MG** **(AMPICILLIN SODIUM 40 MG/ML)** 15 MLS/HR IV Every 12 hours Total Bags: 10 (5 of 10 Given) Comments: Administer over 30 minutes ***REFRIGERATE*** RX #: 38702685	02/10/22 02/14/22	0800 ENUR.EB8 at 0829 SITE: PICC - PICC LINE GAVE: 7.5 MLS 02/11/22-0829 File Document by ENUR.EB8 2000 E.BJB at 2015 SITE: PICC - PICC LINE GAVE: 7.5 MLS 02/11/22 2016 File Document by E.BJB
SYRINGE MED 1 EACH **(SYRINGE MED - SEE ADDITIVE)** **AMIKACIN 10MG/1ML 37 MG** **(AMIKACIN SULFATE 10 MG/ML 1 ML)** 7.4 MLS/HR IV Every 24 hours Total Bags: 5 (2 of 5 Given) Spec Ins: Mixed in NS Comments: Administer over 30 minutes - Mixed in NS RX #: 38702695	02/10/22 02/14/22	1800 ENUR.EB8 at 1745 SITE: PICC - PICC LINE GAVE: 3.7 MLS 02/11/22-1746 File Document by ENUR.EB8
PHENobarbitaL sodium (PHENobarbitaL sodium 65 MG/ML VIAL) **7.5 MG** IV Every 12 hours Comments: Administer "straight" or dilute to 10 mg/ml by adding 1 ml from vial to 5.5 ml NS > 6.5 ml with 65 mg RX #: 38704318	02/10/22 03/12/22	1700 ENUR.EB8 at 1743 SITE: PICC - PICC LINE GAVE: 7.5 MG NDC/DIN: (SOURCE: eMAR) 0641047621 PHENIV651 - PHENobarbitaL sodium 65 MG/ML... 02/11/22 1746 File Document by ENUR.EB8 0500 E.BJB at 0447 SITE: PICC - PICC LINE GAVE: 7.5 MG NDC/DIN: (SOURCE: eMAR) 0641047621 PHENIV651 - PHENobarbitaL sodium 65 MG/ML... 02/12/22-0449 File Document by E.BJB
TPN (NEONATAL FORMULATION) 1 EA **(TPN (NEONATAL FORMULATION) 1 BAG)** UD IV 1800 Comments: To re-order without changes from the previous day, the prescriber should change the STOP DATE to be the next day. To edit TPN orders, prescriber should edit in Admin Criteria. RX #: 38705617	02/10/22 02/14/22	1147 Pharmacy Edit or Verification CPHA.CR 1155 Nursing Acknowledged Order ENUR.EB8 1800 ENUR.EB8 at 1746 SITE: PICC - PICC LINE GAVE: 1 MLS Rate verified by? RN 02/11/22 1746 File Document by ENUR.EB8

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02/21/22 0151 MEDICATION DISCHARGE SUMMARY PAGE: 11

NAME: BLUE,BB-TATUM UNIT #: E003047593 ACCT #: E00677497957

ADMINISTRATION PERIOD: 0700 02/11/22 to 0659 02/12/22 (Continued)	START/ STOP	
SMOFOLIPID 20% IV FAT EMULSION 16 ML **(FAT EMUL/SOY/MCT/OLIV/FISH OIL 1 ML EMULSION)** 0.8 MLS/HR IV 1800 Total Bags: 1 (1 of 1 Given) RX #: 38705518	02/10/22 02/11/22	1359 Pharmacy Discontinue SCHEDULER
NS 100 ML **(SODIUM CHLORIDE 0.9% 100 ML BAG)** **KEPPRA 40 MG** **(levETIRAcetam Inj 500 mg/5 ml Vial)** 400 MLS/HR IV Every 12 hours Comments: Push over 2-5 minutes for doses 1500 mg or less. Pharmacy must mix for doses over 1500 mg. RX #: 01378055	02/11/22 03/13/22	1105 Order Entry EAP.JDF 1112 Nursing Acknowledged Order ENUR.EB8 1200 Canceled Order FPHA.JGB1
SMOFOLIPID 20% IV FAT EMULSION 30 ML **(FAT EMUL/SOY/MCT/OLIV/FISH OIL 1 ML EMULSION)** 1.5 MLS/HR IV 1800 Total Bags: 1 (1 of 1 Given) RX #: 38712354	02/11/22 02/12/22	1146 Order Entry EPHA.CR 1156 Nursing Acknowledged Order ENUR.EB8 1800 ENUR.EB8 at 1746 SITE: PICC PICC LINE GAVE: 30 MLS 02/11/22 1746 File Document by ENUR.EB8
KEPPRA (levETIRAcetam Inj 500 mg/5 ml Vial) **40 MG** IV Every 12 hours Comments: Push over 2-5 minutes for doses 1500 mg or less. Pharmacy must mix for doses over 1500 mg. RX #: 38712476	02/11/22 03/13/22	1159 Order Entry EPHA.JGB1 1200 Nursing Acknowledged Order ENUR.EB8 1200 ENUR.EB8 at 1512 SITE: PICC PICC LINE GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0409188622 KEPPRAIV - levETIRAcetam Inj 500 mg/5 ml... 02/11/22-1515 File Document by ENUR.EB8 1512 Nursing Adjust Admin ENUR.EB8 1516 Nursing Request Removed FPHA.PF 1516 Pharmacy All Adjust Times EPHA.PC 1602 Nursing Acknowledged Order ENUR.EB8 0300 E.BJB at 0302 SITE: PICC - PICC LINE GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0409188622 KEPPRAIV levETIRAcetam Inj 500 mg/5 ml... 02/12/22 0304 File Document by E.BJB

ADMINISTRATION PERIOD: 0700 02/12/22 to 0659 02/13/22	START/ STOP	

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NAME: BLUE,BB-TATUM UNIT #: E003047593 ACCT #: E00677497957

ADMINISTRATION PERIOD: 0700 02/12/22 to 0659 02/13/22 (Continued)	START/ STOP	
SYRINGE MED 1 EACH **(SYRINGE MED - SEE ADDITIVE)** **ACYCLOVIR 7MG/1ML 60 MG** **(ACYCLOVIR 7 MG/ML)** 8.57 ML/HR IV Every 8 hours Spec Ins: Mixed in NS Comments: *****IV ROUTE***** Administer over 60 minutes RX #: 38693696	02/08/22 02/15/22	0730 ENUR,KSW9 at 0726 SITE: PICC - PICC LINE GAVE: 8.57 ML 02/12/22-0726 File Document by ENUR,KSW9 1331 Pharmacy Discontinue EAP,KMC 1332 Nursing Acknowledged Order ENUR,KSW9
HEPARIN * PRESERVATIVE FREE * (HEPARIN NA (PRESERVATIVE-FREE) 10 UNITS/ML 1 ML SYR) **10 UNITS** IV Every 12 hours RX #: 38695179	02/09/22 03/11/22	0725 Pharmacy Discontinue EAP,KMC 0731 Nursing Acknowledged Order ENUR,KSW9
SYRINGE MED 1 EACH **(SYRINGE MED - SEE ADDITIVE)** **AMPICILLIN 40 MG/1 ML IN 1/2NS 300 MG** **(AMPICILLIN SODIUM 40 MG/ML)** 15 ML/HR IV Every 12 hours Total Bags: 10 (5 of 10 Given) Comments: Administer over 30 minutes ***REFRIGERATE*** RX #: 38702685	02/10/22 02/14/22	0800 ENUR,KSW9 at 1006 SITE: PICC - PICC LINE GAVE: 7.5 ML dose late from pharmacy 02/12/22-1006 File Document by ENUR,KSW9 1006 Nursing Adjust Admin ENUR,KSW9 1014 Pharmacy All Adjust Times FPHA,JT 1014 Nursing Adjust Admin FPHA,JT 1025 Nursing Acknowledged Order ENUR,KSW9 1202 Pharmacy Discontinue EAP,KMC 1240 Nursing Acknowledged Order ENUR,KSW9
SYRINGE MED 1 EACH **(SYRINGE MED - SEE ADDITIVE)** **AMIKACIN 10MG/1ML 37 MG** **(AMIKACIN SULFATE 10 MG/ML 1 ML)** 7.4 ML/HR IV Every 24 hours Total Bags: 5 (2 of 5 Given) Spec Ins: Mixed in NS Comments: Administer over 30 minutes - Mixed in NS RX #: 38702695	02/10/22 02/14/22	1202 Pharmacy DisconLinue EAP,KMC 1240 Nursing Acknowledged Order ENUR,KSW9

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02/21/22 0151 MEDICATION DISCHARGE SUMMARY PAGE: 13

NAME: BLUE,BB-TATUM UNIT #: E003047593 ACCT #: E00677497957

ADMINISTRATION PERIOD: 0700 02/12/22 to 0659 02/13/22 (Continued)	START/ STOP	
PHENobarbitaL sodium (PHENobarbitaL sodium 65 MG/ML VIAL) **7.5 MG** IV Every 12 hours Comments: Administer "straight" or dilute to 10 mg/ml by adding 1 ml from vial to 5.5 ml NS > 6.5 ml with 65 mg RX #: 38704318	02/10/22 03/12/22	1700 ENUR,KSW9 at 1712 SITE: PICC - PICC LINE GAVE: 7.5 MG Sedation medication purpose? Sedation RASS score? State Behavior Scale Score: 0 POSS? Result? Comment- item not able to scan. 02/12/22 1712 File Document by ENUR,KSW9 1812 Nursing Reassessment by ENUR,KSW9 at 1745 Sedation medication purpose? Sedation RASS score? State Behavior Scale Score: 0 POSS? Result? Comment- 0500 E.BJB at 0446 SITE: PICC - PICC LINE GAVE: 7.5 MG NDC/DIN: (SOURCE: eMAR) 0641047621 PHENY651 PHENobarbital sodium 65 MG/ML ... 02/13/22-0446 File Document by E.BJB
TPN (NEONATAL FORMULATION) 1 EA **(TPN (NEONATAL FORMULATION) 1 BAG)** UD IV 1800 Comments: To re-order without changes from the previous day, the prescriber should change the STOP DATE to be the next day. To edit TPN orders, prescriber should edit in Admin Criteria. RX #: 38705617	02/10/22 02/14/22	1239 Pharmacy Edit or Verification EPHA,BAB 1240 Nursing Acknowledged Order ENUR,KSW9 1800 ENUR,KSW9 at 1755 SITE: PICC - PICC LINE GAVE: 1 MLS Rate verified by? ENUR,KSW9 02/12/22-1756 File Document by ENUR,KSW9
SMOFOLIPID 20% IV FAT EMULSION 30 ML **(FAT EMUL/SOY/MCT/OLIV/FISH OIL 1 ML EMULSION)** 1.5 MLS/HR IV 1800 Total Bags: 1 (1 of 1 Given) RX #: 38712354	02/11/22 02/12/22	1359 Pharmacy Discontinue SCHEDULER

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ADMINISTRATION PERIOD: 0700 02/12/22 to 0659 02/13/22 (Continued)	START/ STOP	
KEPPRA (levETIRAcetam Inj 500 mg/5 ml Vial) **40 MG** IV Every 12 hours Comments: Push over 2-5 minutes for doses 1500 mg or less. Pharmacy must mix for doses over 1500 mg. RX #: 38712476	02/11/22 03/13/22	1500 ENUR,KSW9 at 1436 SITE: PICC - PICC LINE GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0409188622 KEPPRAIV - levETIRAcetam Inj 500 mg/5 ml... 02/12/22 1436 File Document by ENUR,KSW9 0300 E,BJB at 0233 SITE: PICC - PICC LINE GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0409188622 KEPPRAIV - levETIRAcetam Inj 500 mg/5 ml... 02/13/22-0234 File Document by E,BJB
CEREBYX (50 MG/ML PHENYTOIN EQUIVALENTS) 31 MG (FOSPHENYTOIN 500 MG/10 ML VIAL) IV ONE TIME ONLY/ONE Comments: Concentration is calculated in PHENYTOIN EQUIVALENTS ** REFRIGERATE ** ***LOW RISK MED*** RX #: U13284901	02/12/22 02/12/22	1017 Order Entry EAP,KMC 1024 Canceled Order EPHA,BAB 1025 Nursing Acknowledged Order ENUR,KSW9
CEREBYX (50 MG/ML PHENYTOIN EQUIVALENTS) (FOSPHENYTOIN 100 MG/2 ML VIAL) **31 MG** IV ONE TIME ONLY/ONE Comments: Concentration is calculated in PHENYTOIN EQUIVALENTS ** REFRIGERATE ** Dilute in 10 ml NS and administer slowly (0.5-3 mg PE/kg/min. Max 150 mg PE/min) ***LOW RISK MED*** RX #: 38717194	02/12/22 02/12/22	1025 Nursing Acknowledged Order ENUR,KSW9 1025 Order Entry EPHA,BAB 1100 ENUR,KSW9 at 1056 SITE: PICC - PICC LINE GAVE: 31 MG 02/12/22-1056 File Document by ENUR,KSW9 1101 Pharmacy Discontinue SCHEDULER
SMOFLIPID 20% IV FAT EMULSION 22 ML (FAT EMUL/SOY/MCT/OLIV/FISH OIL 1 ML EMULSION) 1.1 MLS/HR IV 1800 Total Bags: 1 (1 of 1 Given) RX #: 38717761	02/12/22 02/13/22	1239 Order Entry EPHA,BAB 1240 Nursing Acknowledged Order ENUR,KSW9 1800 ENUR,KSW9 at 1756 SITE: PICC - PICC LINE GAVE: 22 MLS 02/12/22-1756 File Document by ENUR,KSW9
HEPARIN * PRESERVATIVE FREE * (HEPARIN NA (PRESERVATIVE-FREE) 10 UNITS/ML 5 ML SYR) **10 UNITS** IV AS DIRECTED/PRN PRN Reason: IV line flush orders RX #: 38716466	02/12/22 03/14/22	0725 Order Entry EAP,KMC 0728 Pharmacy Edit or Verification EPHA,JGB1 0731 Nursing Acknowledged Order ENUR,KSW9

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ADMINISTRATION PERIOD: 0700 02/13/22 to 0659 02/14/22	START/ STOP	
PHENobarbitaL sodium (PHENobarbitaL sodium 65 MG/ML VIAL) 7.5 MG IV Every 12 hours Comments: Administer "straight" or dilute to 10 mg/ml by adding 1 ml from vial to 5.5 ml NS > 6.5 ml with 65 mg RX #: 38704318	02/10/22 03/12/22	1700 ENUR.AG37 at 1649 SITE: PICC - PICC LINE GAVE: 7.5 MG NDC/DIN: (SOURCE: eMAR) 0641047621 PHENIV651 - PHENobarbitaL sodium 65 MG/ML... 02/13/22 1650 File Document by ENUR.AG37 0500 ENUR.LJR2 at 0442 SITE: PICC - PICC LINE GAVE: 7.5 MG NDC/DIN: (SOURCE: eMAR) 0641047621 PHENIV651 - PHENobarbitaL sodium 65 MG/ML... Sedation medication purpose? Sedation RASS score? State Behavior Scale Score: POSS? Result? Comment- 02/14/22 0442 File Document by ENUR.LJR2 0542 Nursing Reassessment by ENUR.LJR2 at 0548 MD ORDER
TPN (NEONATAL FORMULATION) 1 EA **(TPN (NEONATAL FORMULATION) 1 BAG)** UD IV 1800 Comments: To re-order without changes from the previous day, the prescriber should change the STOP DATE to be the next day. To edit TPN orders, prescriber should edit in Admin Criteria. RX #: 38705517	02/10/22 02/14/22	1109 Pharmacy Edit or Verification EPHA.BAB 1204 Nursing Acknowledged Order ENUR.AG37 1800 ENUR.AG37 at 1756 SITE: PICC PICC LINE GAVE: 1 ML Rate verified by? AG37 02/13/22-1756 File Document by ENUR.AG37
KEPPRA (levETIRAcetam Inj 500 mg/5 ml Vial) 40 MG IV Every 12 hours Comments: Push over 2-5 minutes for doses 1500 mg or less. Pharmacy must mix for doses over 1500 mg. RX #: 38712476	02/11/22 03/13/22	1500 ENUR.AG37 at 1502 SITE: PICC - PICC LINE GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0409188622 KEPPRAIV - levETIRAcetam Inj 500 mg/5 ml... 02/13/22 1503 File Document by ENUR.AG37 0300 ENUR.LJR2 at 0256 SITE: PICC - PICC LINE GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0409188622 KEPPRAIV - levETIRAcetam Inj 500 mg/5 ml... 02/14/22-0256 File Document by ENUR.LJR2
SMOFOLIPID 20% IV FAT EMULSION 22 ML **(FAT EMUL/SOY/MCT/OLIV/FISH OIL 1 ML EMULSION)** 1.1 MLS/HR IV 1800 Total Bags: 1 (1 of 1 Given) RX #: 38717761	02/12/22 02/13/22	1359 Pharmacy Discontinue SCHEDULER

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ADMINISTRATION PERIOD: 0700 02/14/22 to 0659 02/15/22	START/ STOP	
PHENobarbitaL sodium (PHENobarbitaL sodium 65 MG/ML VIAL) **7.5 MG** IV Every 12 hours Comments: Administer "straight" or dilute to 10 mg/ml by adding 1 ml from vial to 5.5 ml NS > 6.5 ml with 65 mg RX #: 38704318	02/10/22 03/12/22	1102 Pharmacy Discontinue EAP.KMC 1140 Nursing Acknowledged Order ENUR.PXN1
TPN (NEONATAL FORMULATION) 1 EA **(TPN (NEONATAL FORMULATION) 1 BAG)** UD IV 1800 Comments: To re-order without changes from the previous day, the prescriber should change the STOP DATE to be the next day. To edit TPN orders, prescriber should edit in Admin Criteria. RX #: 38705617	02/10/22 02/14/22	1759 Pharmacy Discontinue SCHEDULER
KEPPRA (levETIRAcetam Inj 500 mg/5 ml Vial) **40 MG** IV Every 12 hours Comments: Push over 2 5 minutes for doses 1500 mg or less. Pharmacy must mix for doses over 1500 mg. RX #: 38712476	02/11/22 03/13/22	1102 Pharmacy Discontinue EAP.KMC 1140 Nursing Acknowledged Order ENUR.PXN1
D10-W 250ML 250 ML **(DEXTROSE 10%-WATER 250 ML BAG)** **HEPARIN SODIUM 125 UNITS** **(HEPARIN SODIUM 1000 UNITS/ML 10 ML VIAL)** 4.3 ML/HR IV CONTINUOUS RX #: 38/2381/	02/14/22 03/16/22	0/39 Order Entry EAP.KMC 0744 Pharmacy Edit or Verification FPHA.QXP 0744 Pharmacy Edit or Verification FPHA.QXP 0816 Nursing Acknowledged Order ENUR.PXN1 1528 ENUR.PXN1 at 1528 SITE: PICC - PICC LINE GAVE: 250.13 MLS 02/14/22-1528 File Document by ENUR.PXN1
KEPPRA ORAL SUSPENSION (levETIRAcetam Oral Liq 100 MG/ML ML) **40 MG** ENTERAL Every 12 hours RX #: 38725815	02/14/22 03/16/22	1132 Order Entry EPHA.CR 1140 Nursing Acknowledged Order ENUR.PXN1 1500 ENUR.PXN1 at 1432 GAVE: 40 MG Administer med via: Nasogastric tube If 'OTHER' please specify: 02/14/22-1432 File Document by ENUR.PXN1 0300 ENUR.LJR2 at 0253 GAVE: 40 MG Administer med via: Nasogastric tube If 'OTHER' please specify: 02/15/22-0253 File Document by ENUR.LJR2

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ADMINISTRATION PERIOD: 0700 02/14/22 to 0659 02/15/22 (Continued)	START/ STOP	
PHENobarbitaL (PHENobarbitaL 20 MG/5 ML UDBOT) **7.5 MG** PO Every 12 hours RX #: 38/25816	02/14/22 03/16/22	1132 Order Entry EPHA.CR 1140 Nursing Acknowledged Order ENUR.PXN1 1/00 ENUR.PXN1 at 1/10 GAVE: 7.5 MG NDC/DIN: (SOURCE: eMAR) 6068744840 PHENOL20 - PHENobarbitaL 20 MG/5 ML UDBOT 02/14/22-1710 File Document by ENUR.PXN1 0500 ENUR.LJR2 at 0507 GAVE: 7.5 MG NDC/DIN: (SOURCE: eMAR) 6068744840 PHFNOL20 PHFNobarbital 20 MG/5 ML UDBOT Sedation medication purpose? Sedation RASS score? State Behavior Scale Score: POSS? Result? Comment 02/15/22-0507 File DocumenL by ENUR.LJR2 0607 Nursing Reassessment by ENUR.LJR2 at 0606 MD ORDER Sedation medication purpose? Sedation RASS score? State Behavior Scale Score: POSS? Result? Comment-
HEPARIN * PRESERVATIVE FREE * (HEPARIN NA (PRESERVATIVE-FREE) 10 UNITS/ML 5 ML SYR) **10 UNITS** IV AS DIRECTED/PRN PRN Reason: IV line flush orders RX #: 38/16466	02/12/22 03/14/22	1432 ENUR.PXN1 at 1432 SITE: PICC - PICC LINE GAVE: 10 UNITS NDC/DIN: (SOURCE: eMAR) 8290306413 HEP-IV103 - Heparin Na (Preservative-free... Difference between amount dispensed and amount administered was discarded. 02/14/22-1432 File Document by ENUR.PXN1

ADMINISTRATION PERIOD: 0700 02/15/22 to 0659 02/16/22	START/ STOP	

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ADMINISTRATION PERIOD: 0700 02/15/22 to 0659 02/16/22 (Continued)	START/ STOP	
D10-W 250ML 250 ML **(DEXTROSE 10%-WATER 250 ML BAG)** **HEPARIN SODIUM 125 UNITS** **(HEPARIN SODIUM 1000 UNITS/ML 10 ML VIAL)** 4.3 ML/HR IV CONTINUOUS RX #: 38723817	02/14/22 03/16/22	1102 Pharmacy Edit or Verification EAP.JDF 1102 Pharmacy Edit or Verification EAP.JDF FROM: LAST BAG: 1 RATE: 5.6 ML/HR DURATION: 44 HR 40 MIN TO: LAST BAG: 0 RATE: 4.3 ML/HR DURATION: 58 HR 11 MIN 1136 Nursing Acknowledged Order ENUR.KR19 1740 ENUR.KR19 at 1740 SITE: PICC - PICC LINE GAVE: 250.13 MLS NDC/DIN: (SOURCE: eMAR) 0990/93002 DEXIIL1025 - Dextrose 10%-Water 250 Ml Bag 02/15/22 1740 File Document by ENUR.KR19
KEPPRA ORAL SUSPENSION (levETIRAcetam Oral Liq 100 MG/ML ML) **40 MG** ENTERAL Every 12 hours RX #: 38725815	02/14/22 03/16/22	1500 ENUR.KR19 at 1512 GAVE: 40 MG Administer med via: Nasogastric tube If 'OTHER' please specify: 02/15/22-1512 File Document by ENUR.KR19 0300 ENUR.CSG at 0231 GAVE: 40 MG Administer med via: Nasogastric tube If 'OTHER' please specify: 02/16/22 0231 File Document by ENUR.CSG

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NAME: BLUE,BB-TATUM UNIT #: E003047593 ACCT #: E00677497957

ADMINISTRATION PERIOD: 0700 02/15/22 to 0659 02/16/22 (Continued)	START/ STOP	
PHENobarbitaL (PHENobarbitaL 20 MG/5 ML UDBOT) **7.5 MG** PO Every 12 hours RX #: 38725816	02/14/22 03/16/22	1700 ENUR.KRI9 at 1724 GAVE: 7.5 MG NDC/DIN: (SOURCE: eMAR) 6068744840 PHENOL20 - PHENobarbitaL 20 MG/5 ML UDBOT Sedation medication purpose? Sedation RASS score? State Behavior Scale Score: 0 POSS? Result? Comment 02/15/22-1724 File Document by ENUR.KRI9 0500 ENUR.CSG at 0537 GAVE: 7.5 MG NDC/DIN: (SOURCE: eMAR) 6068744840 PHENOL20 - PHENobarbitaL 20 MG/5 ML UDBOT 02/16/22 0537 File Document by ENUR.CSG 0637 Nursing Reassessment by ENUR.CB36 at 1904
HEPARIN * PRESERVATIVE FREE * (HEPARIN NA (PRESERVATIVE-FREE) 10 UNITS/ML 5 ML SYR) **10 UNITS** IV AS DIRECTED/PRN PRN Reason: IV line flush orders RX #: 38716466	02/12/22 03/14/22	1229 Pharmacy Discontinue EPHA.RI1 1511 Nursing Acknowledged Order ENUR.KRI9
VERSED (MIDAZOLAM HCL 10 MG/5 ML SYRUP UDBOT) **0.305 MG** PO ONE TIME ONLY/PRN PRN Reason: MRI RX #: 38732885	02/16/22 03/17/22	1121 Order Entry EPHA.PE 1136 Nursing Acknowledged Order ENUR.KRI9 1221 ENUR.KRI9 at 1221 GAVE: 0.305 MG NDC/DIN: (SOURCE: eMAR) 68094764S9 VERSEDSUSP - Midazolam HCl 10 MG/5 Ml Syru... Sedation medication purpose? Sedation RASS score? State Behavior Scale Score: 0 POSS? Result? Comment- 02/15/22 1222 File Document by ENUR.KRI9 0634 Pharmacy Discontinue EAP.JDF

*** CONTINUED ON PAGE 20 ***
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02/21/22 0151 MEDICATION DISCHARGE SUMMARY PAGE: 20

NAME: BLUE,BB-TATUM UNIT #: E003047593 ACCT #: E00677497957

ADMINISTRATION PERIOD: 0700 02/15/22 to 0659 02/16/22 (Continued)	START/ STOP	
HEPARIN * PRESERVATIVE FREE * (HEPARIN NA (PRESERVATIVE-FREE) 10 UNITS/ML 1 ML SYR) **10 UNITS** IV AS DIRECTED/PRN PRN Reason: IV line flush orders RX #: 38733505	02/15/22 03/17/22	1229 Order Entry EPHA.RT1 1232 Nursing Acknowledged Order ENUR.KR19 1232 ENUR.KR19 at 1232 SITE: PICC - PICC LINE GAVE: 10 UNITS NDC/DIN: (SOURCE: eMAR) 6425322221 HEP 10 1ML - Heparin Na (Preservative-Free... Difference between amount dispensed and amount administered was discarded. 02/15/22-1232 File Document by ENUR.KR19

ADMINISTRATION PERIOD: 0700 02/16/22 to 0659 02/17/22	START/ STOP	
KEPPRA ORAL SUSPENSION (levETIRAcetam Oral Liq 100 MG/ML ML) **40 MG** ENTERAL Every 12 hours RX #: 38725815	02/14/22 03/16/22	1500 ENUR.CB36 at 1444 GAVE: 40 MG Administer med via: Nasogastric tube If 'OTHER' please specify: 02/16/22-1444 File Document by ENUR.CB36 0300 ENUR.KM47 at 0253 GAVE: 40 MG Administer med via: Nasogastric tube If 'OTHER' please specify: 02/17/22-0253 File Document by ENUR.KM47

*** CONTINUED ON PAGE 21 ***
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ADMINISTRATION PERIOD: 0700 02/16/22 to 0659 02/17/22 (Continued)	START/ STOP	
PHENobarbitaL (PHENobarbitaL 20 MG/5 ML UDBOT) **7.5 MG** PO Every 12 hours RX #: 38/25816	02/14/22 03/16/22	1700 ENUR.CB36 at 1744 GAVE: 7.5 MG NDC/DIN: (SOURCE: eMAR) 60687448 40 PHENOL20 - PHENobarbitaL 20 MG/5 ML UDBOT Sedation medication purpose? Pain/Anxiety RASS score? State Behavior Scale Score: POSS? Result? Comment 02/16/22-1744 File Document by ENUR.CB36 0500 ENUR.KM47 at 0434 GAVE: 7.5 MG NDC/DIN: (SOURCE: eMAR) 60687448 40 PHENOL20 - PHENobarbitaL 20 MG/5 ML UDBOT Sedation medication purpose? Pain/Anxiety RASS score? State Behavior Scale Score: POSS? S Sleep, easy to arouse Result? Acceptable Comment 02/17/22-0435 File Document by ENUR.KM47 0534 Nursing Reassessment by ENUR.KM47 at 0619 Sedation medication purpose? Pain/Anxiety RASS score? State Behavior Scale Score: POSS? 1 Awake and alert Result? Acceptable Comment-
VERSED (MIDAZOLAM HCL 10 MG/5 ML SYRUP UDBOT) **0.305 MG** PO ONC TIMC ONLY/PRN PRN Reason: MRI RX #: 38/32885	02/15/22 03/17/22	0724 Nursing Acknowledged Order ENUR.CSG
HEPARIN * PRESERVATIVE FREE * (HEPARIN NA (PRESERVATIVE-FREE) 10 UNITS/ML 1 ML SYR) **10 UNITS** IV AS DIRECTED/PRN PRN Reason: IV line flush orders RX #: 38/33805	02/15/22 03/17/22	1031 ENUR.CB36 at 1031 SITE: PICC - PICC LINE GAVE: 10 UNITS NDC/DIN: (SOURCE: eMAR) 6425322221 HEP 10 IML - Heparin Na (Preservative-Free... Difference between amount dispensed and amount administered was discarded. 02/16/22-1032 File Document by ENUR.CB36

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02/21/22 0151 MEDICATION DISCHARGE SUMMARY PAGE: 22

NAME: BLUE,BB-TATUM UNIT #: E003047593 ACCT #: E00677497957

ADMINISTRATION PERIOD: 0700 02/17/22 to 0659 02/18/22	START/ STOP	
D10-W 250ML 250 ML **(DEXTROSE 10%-WATER 250 ML BAG)** **HEPARIN SODIUM 125 UNITS** **(HEPARIN SODIUM 1000 UNITS/ML 10 ML VIAL)** 4.3 ML/HR IV CONTINUOUS RX #: 38723817	02/14/22 03/16/22	1221 Pharmacy Discontinue DR.THICA 1222 Nursing Acknowledged Order ENUR.PXN1
KEPPRA ORAL SUSPENSION (levETIRAcetam Oral Liq 100 MG/ML ML) **40 MG** ENTERAL Every 12 hours RX #: 38725815	02/14/22 03/16/22	1500 ENUR.PXN1 at 1427 GAVE: 40 MG Administer med via: Nasogastric Tube If 'OTHER' please specify: 02/17/22-1427 File Document by ENUR.PXN1 0300 ENUR.KM47 at 0228 GAVE: 40 MG Administer med via: Nasogastric Tube If 'OTHER' please specify: 02/18/22-0228 File Document by ENUR.KM47
PHENobarbitaL (PHENobarbitaL 20 MG/5 ML UDBOT) **7.5 MG** PO Every 12 hours RX #: 38725816	02/14/22 03/16/22	1354 Pharmacy Discontinue DR.MAKMA 1427 Nursing Acknowledged Order ENUR.PXN1
PHENobarbitaL (PHENobarbitaL 20 MG/5 ML UDBOT) **7.2 MG** PO Every 12 hours Dose Ins: **this is to round up dose to 1.8ml thanks** RX #: 38746322	02/17/22 03/19/22	1354 Order Entry DR.MAKMA 1359 Pharmacy Edit or Verification FPHA.KKI 1427 Nursing Acknowledged Order ENUR.PXN1 1700 ENUR.PXN1 at 1632 GAVE: 7.2 MG NDC/DIN: (SOURCE: eMAR) 6068744840 PHENOL20 - PHENobarbitaL 20 MG/5 ML UDBOT 02/17/22 1632 File Document by ENUR.PXN1 0500 ENUR.KM47 at 0429 GAVE: 7.2 MG NDC/DIN: (SOURCE: eMAR) 6068744840 PHENOL20 - PHENobarbitaL 20 MG/5 ML UDBOT 02/18/22-0429 File Document by ENUR.KM47 0529 Nursing Reassessment by ENUR.KM47 at 0648

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02/21/22 0151 MEDICATION DISCHARGE SUMMARY PAGE: 23

NAME: BLUE,BB-TATUM UNIT #: E003047593 ACCT #: E00677497957

ADMINISTRATION PERIOD: 0700 02/17/22 to 0659 02/18/22 (Continued)	START/ STOP	
HEPARIN * PRESERVATIVE FREE * (HEPARIN NA (PRESERVATIVE-FREE) 10 UNITS/ML 1 ML SYR) **10 UNITS** IV AS DIRECTED/PRN PRN Reason: IV line flush orders RX #: 38733505	02/15/22 03/17/22	1216 ENUR.PXN1 at 1216 SITE: PICC - PICC LINE GAVE: 10 UNITS NDC/DIN: (SOURCE: eMAR) 6425322221 HEP 10 1ML - Heparin Na (Preservative-Free... Difference between amount dispensed and amount administered was discarded. 02/17/22-1216 File Document by ENUR.PXN1 1221 Pharmacy Discontinue DR.THICA 1222 Nursing Acknowledged Order ENUR.PXN1
HEPARIN * PRESERVATIVE FREE * (HEPARIN NA (PRESERVATIVE-FREE) 10 UNITS/ML 5 ML SYR) **10 UNITS** IV AS DIRECTED/PRN PRN Reason: IV line flush orders RX #: 38/4/666	02/18/22 03/19/22	1223 Order Entry DR.THICA 1223 Pharmacy Edit or Verification DR.THICA 1225 Pharmacy Edit or Verification EPHA.RIR 1253 Nursing Acknowledged Order ENUR.PXN1

ADMINISTRATION PERIOD: 0700 02/18/22 to 0659 02/19/22	START/ STOP	
KEPPRA ORAL SUSPENSION (levETIRAcetam Oral Liq 100 MG/ML ML) **40 MG** ENTERAL Every 12 hours RX #: 38725815	02/14/22 03/16/22	1500 ENUR.BV2 at 1457 GAVF: 40 MG Administer med via: Oral If 'OTHER' please specify: 02/18/22-1459 File Document by ENUR.BV2 0300 ENUR.KM47 at 0221 GAVF: 40 MG Administer med via: Nasogastric Tube If 'OTHER' please specify: 02/19/22-0221 File Document by ENUR.KM47

*** CONTINUED ON PAGE 24 ***
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ADMINISTRATION PERIOD: 0700 02/18/22 to 0659 02/19/22 (Continued)	START/ STOP	
PHENobarbitaL (PHENobarbitaL 20 MG/5 ML UDBOT) **7.2 MG** PO Every 12 hours Dose Ins: **this is to round up dose to 1.8ml thanks** RX #: 38748322	02/17/22 03/19/22	1700 ENUR.BV2 at 1737 GAVE: 7.2 MG NDC/DIN: (SOURCE: eMAR) 6068744840 PHENOL20 - PHENobarbitaL 20 MG/5 ML UDBOT Sedation medication purpose? Sedation RASS score? State Behavior Scale Score: POSS? Result? Comment 02/18/22-1737 File Document by ENUR.BV2 1837 Nursing Reassessment by ENUR.BV2 at 1828 0500 ENUR.KM47 at 0420 GAVE: 7.2 MG NDC/DIN: (SOURCE: eMAR) 6068744840 PHENOL20 PHENobarbitaL 20 MG/5 ML UDBOT 02/19/22-0420 File Document by ENUR.KM47

ADMINISTRATION PERIOD: 0700 02/19/22 to 0659 02/20/22	START/ STOP	
KEPPRA ORAL SUSPENSION (levETIRAcetam Oral Liq 100 MG/ML ML) **40 MG** ENTERAL Every 12 hours RX #: 38725815	02/14/22 03/16/22	1500 ENUR.MM58 at 1439 GAVE: 40 MG Administer med via: Oral If 'OTHER' please specify: 02/19/22 1439 File Document by ENUR.MM58 0300 ENUR.OG2 at 0231 GAVE: 40 MG Administer med via: Oral If 'OTHER' please specify: 02/20/22 0231 File Document by ENUR.OG2

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ADMINISTRATION PERIOD: 0700 02/19/22 to 0659 02/20/22 (Continued)	START/ STOP	
PHENobarbitaL (PHENobarbitaL 20 MG/5 ML UDBOT) **7.2 MG** PO Every 12 hours Dose Ins: **this is to round up dose to 1.8ml thanks** RX #: 38748322	02/17/22 03/19/22	1700 ENUR.MM58 at 1650 GAVE: 7.2 MG NDC/DIN: (SOURCE: eMAR) 6068744840 PHENOL20 - PHENobarbitaL 20 MG/5 ML UDBOT 02/19/22 1650 File Document by ENUR.MM58 0500 ENUR.OG2 at 0442 GAVE: 7.2 MG NDC/DIN: (SOURCE: eMAR) 6068744840 PHENOL20 - PHENobarbitaL 20 MG/5 ML UDBOT Sedation medication purpose? Pain/Anxiety RASS score? State Behavior Scale Score: POSS? 1 Awake and alert Result? Acceptable Comment- 02/20/22 0442 File Document by ENUR.OG2

ADMINISTRATION PERIOD: 0700 02/20/22 to 0659 02/21/22	START/ STOP	
KEPPRA ORAL SUSPENSION (levETIRAcetam Oral Liq 100 MG/ML ML) **40 MG** ENTERAL Every 12 hours RX #: 38725815	02/14/22 03/16/22	1104 Pharmacy Discontinue DISCHARGE
PHENobarbitaL (PHENobarbitaL 20 MG/5 ML UDBOT) **7.2 MG** PO Every 12 hours Dose Ins: **this is to round up dose to 1.8ml thanks** RX #: 38748322	02/17/22 03/19/22	1104 Pharmacy Discontinue DISCHARGE
HEPARIN * PRESERVATIVE FREE * (HEPARIN NA (PRESERVATIVE-FREE) 10 UNITS/ML 5 ML SYR) **10 UNITS** IV AS DIRECTED/PRN PRN Reason: IV line flush orders RX #: 38747666	02/18/22 03/19/22	1104 Pharmacy Discontinue DISCHARGE

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LEGENDS

REASON CODES
FLUIDS - FLUIDS INFUSING
MD ORDER - PER MD ORDER

SITE CODES
PICC - PICC LINE
PIV - PERIPHERAL IV
UVC - UMBILICAL VEIN CATH

ELECTRONICALLY SIGNED BY

USER	USER NAME/TYPE	USER	USER NAME/TYPE	USER	USER NAME/TYPE	USER	USER NAME/TYPE
F.RJR	BFIT,RAYLOR J RN	F.DDS	SCHMIDT,DESTINY D RN	FNUR.AFM4	MACKEY,AMY F RN	FNUR.AG37	GILLIS,ANNA RN
ENUR.DMP6	PATRICK,BROOKE M RN	ENUR.BV2	VANSTORY,BREANNE RN	ENUR.CB36	BULLER,CARLEY RN	ENUR.CSG	CLARK,CARLA S RN
ENUR.EB8	BRALY,ELIZABETH RN	ENUR.JP17	PARSONS,JESSICA RN	ENUR.KM47	JONES,KATELYN RN	ENUR.KR19	ROSWELL,KATHERINE RN
ENUR.KSW9	WILLIAMS,KATIE S RN	ENUR.LJR2	RAMIREZ,LAURETTA J RN	ENUR.LS20	SLOAN,LAUREN RN	ENUR.LY2	YOUNG,LAUREN RN
ENUR.MM88	MCCANN,MELISSA RN	ENUR.OG2	GUYER,OLIVIA RN	ENUR.PXN1	NGUYEN,PHUONG RN		

OTHER USERS

USER	USER NAME	USER	USER NAME	USER	USER NAME	USER	USER NAME
DR.MAKMA	MAKONI,MARJORIE M MD	DR.THICA	LIENG,CAITLIN APRN C	EAP.JDF	FRAYSUR,JENNIFER D	EAP.KMC	CHRISTENSON,KAHLENE*
FAP.LXD	Donaldson,Lauren APN	FAP.MNCI	CAINES,MACIE N DHP	FNUR.FR8	BRALY,ELIZABETH	FNUR.KSW9	WILLIAMS,KATIE S
FPHA.ATI	TANG,ALLAN	FPHA.BAB	BRITCFK,BRANDT A	FPHA.CM	MATHEW,CHARLES	FPHA.CR	ROBERTS,CASSIE
EPHA.JGB1	BRAND,JOHN G	EPHA.JS3	SCHIBI,JOHN	EPHA.JT	THATCHER,JACQUELINE	EPHA.KK1	KIM,KYU
EPHA.MN2	NGUYEN,MICHELLE	EPHA.PE	ENERIO,PATRICIA RENE	EPHA.QXP	PHUNG,QUENTIN	EPHA.RT1	TRUEBLOOD,RUI
EPHA.RTR	RIDENOUR,ROBERT T	RES.NKD	Dasari,Nalini K Md				

PHA ALLERGY HISTORY

DATE	PHA	USER	ALLERGY DETAILS	
02/08/22 2158	Y	EPHA.CM - MATHEW,CHARLES	ADDED No Known Allergies OLD: NEW: No Known Allergies added.	by EPHA.CM

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NEWBORN HEARING SCR
PEDIATRIX
an affiliate of MEDNAX

Newborn Hearing Screen Results

BLUE,BB-TATUM
EU.7172-A AGE(00M 00D) E003047593
02/08/22 580-371-6882
Does Not Know SEX(M)
EU.NICUE
02/08/22 2217 IN E00677497957
MCD.PND

natus

ALGO® 5 HEARING SCREENING RESULT

BLUE, PARKER
E003047593

Date of Birth:	2/8/2022
Gender:	Male
Screen date:	2/18/2022
Screen time:	11:48 AM
Method:	L/R Simult.
Application:	35 dB nHL
Duration:	2:43
% Myogenic:	0%
Left ear:	Pass
Left sweeps:	3505
Right ear:	Pass
Right sweeps:	4507

RECOMMENDATIONS

☑ **PASS**: No further evaluation required at this time. Primary Care Physician to manage further audiological evaluation based on risk factors and child development.

☐ **FOLLOW UP REQUIRED**:

- ☐ **RESCREEN**: Baby requires rescreen prior to discharge due to Refer or incomplete/NA results.
- ☐ **REFER**: Passing result not achieved in one or both ears or testing was not performed due to atresia/microtia. Schedule further hearing testing 2-4 weeks from discharge. Your state may require cCMV screening.

Screener: Makeylyn Bawyer **Date** 02/18/22

The following are auditory risk indicators for use as a resource by Primary Care Physician from the Joint Committee on Infant Hearing. (2019). Year 2019 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs. *Journal of Early Hearing Detection and Intervention*, 4(4). DOI: 10.15142/fptk-b748

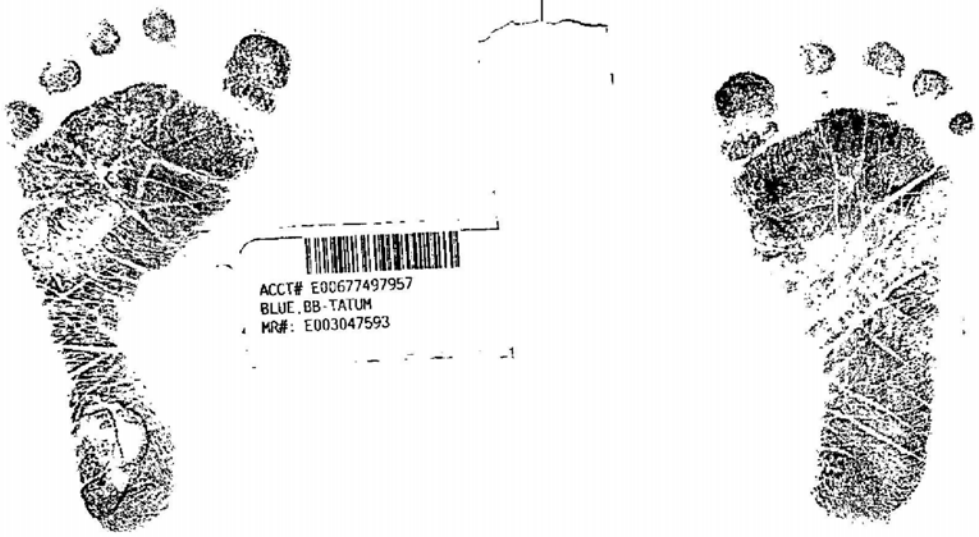
Risk Factors for Early Childhood Hearing Loss: Guidelines for Infants who Pass the Newborn Hearing Screen.
Please review state specific EHDI guidelines for further delineation of risk factor classification classes.

- Caregiver concern regarding hearing, speech, language, developmental delay, and/or developmental regression.
- Family history of permanent childhood hearing loss.
- Neonatal intensive care of more than 5 days or any of the following regardless of length of stay: Extracorporeal Membrane Oxygenation (ECMO), hyperbilirubinemia that requires exchange transfusion.
- Aminoglycoside administration of more than 5 days; if less than 5 days, aminoglycoside administration remains a risk factor if toxic blood levels are identified or if a family history of mitochondrial genetic mutation associated with aminoglycoside sensitivity exists.
- Asphyxia or Hypoxic Ischemic Encephalopathy (HIE).
- In utero infections, such as Cytomegalovirus (CMV), herpes, rubella, syphilis, toxoplasmosis, and/or Mother confirmed Zika and infant with or without laboratory finding.
- Craniofacial malformations, including microtia/atresia, ear dysplasia, oral facial clefting, microphthalmia, congenital microcephaly, congenital or acquired hydrocephalus, and temporal bone abnormalities.
- Physical findings, such as white forelock, that are associated with a syndrome known to include a sensorineural or permanent conductive hearing loss.
- Perinatal or postnatal culture-positive infections associated with sensorineural hearing loss, including confirmed bacterial and viral (especially herpes viruses and varicella) meningitis or encephalitis.
- Perinatal or Postnatal head trauma, especially basal skull/temporal bone fracture that requires hospitalization.
- Perinatal or postnatal chemotherapy.

Outpatient Appointment Information	Date:	Time:
	Location:	
Appointment Scheduled: ☐ YES ☐ NO	Coordinator Name:	
	Coordinator Phone:	

Rev.4/20/2020

Infant Account Number on ID Band:	Signature of Person Applying Identification Band and Transponder:		
E00677497957	Barbara Blue, RN		
Signature of Verifying Nurse # 1	Signature of Verifying Nurse # 2	Armband Number	Transponder Number
Signature of Verifying Nurse # 1	Signature of Verifying Nurse # 2	Armband Number	Transponder Number
Signature of Verifying Nurse # 1	Signature of Verifying Nurse # 2	Armband Number	Transponder Number
Signature of Verifying Nurse # 1	Signature of Verifying Nurse # 2	Armband Number	Transponder Number



Comments:

Upon Discharge Affix Infant's Identification band below and have statement signed and witnessed.

Date 2/20/2022

I Certify that during the discharge procedure I received my baby, examined it and determined that it was mine. I checked the identification parts sealed on the baby and on me and found that they were identically numbered _____ and contained correct identifying information.

Signed Tatum Blue Mother

Witness

RN

Hospital Representatives

EDEMF5459 PNET7EP04 02/08/2022 23:34 PCN0147

NB
INFANT ID BAND-TRANSPONDER SHEET

BLUE,BB-TATUM
Acct # E00677497957 MR# E003047593
Loc: EU.7172-A DOB: 02/08/22 00M 00D M 02/08/22
Dannaway,Douglas MD

OU MEDICAL CENTER
1200 Everett Drive
Oklahoma City, OK 73104

Name: BLUE,BB-TATUM
Account Number: E00677497957
Unit Number: E003047593
Room: EU.7172
Date Of Birth: 02/08/22
Attending Doctor: Dannaway,Douglas MD
Date: 02/08/22

Neonatology Inpatient Admit Note

Born: 2/8/22 6:20 (Tuesday); Admitted: 2/8/22
Mother: TATUM Blue
Father: Blue
Phone: 580-371-6882
Medical Record# E003047593; Account# E00677497957

OB:
Delivering OB: Whittington DO, Kinion (580)920-2122

CHIEF COMPLAINT: 3050 gram male transferred from Durant Medical Center of Southeastern Oklahoma and admitted for possible seizure activity, r/o sepsis.

MOTHER'S HISTORY: 20 year-old G1P0000 unknown race female.
Blood type B Positive; Syphilis test - negative; rubella - positive (immune); Hepatitis B studies - negative; HIV - negative; herpes history - no history of prior infection; hepatitis history - no known history.

PREGNANCY HISTORY: EDC 2/7/22 => 40 + 1/7 weeks.
Uncomplicated pregnancy.
GBS Status: negative.
Prenatal tests: Normal prenatal testing.
Medications: Omeprazole. Steroids: No antenatal steroids were given.
No tobacco, alcohol, or drug use during pregnancy.

LABOR and DELIVERY: Induced labor, AROM with thick meconium.
Artificial rupture of membranes 2/7/22 at 18:45 (11.6 hours prior to delivery); vaginal delivery with epidural anesthesia. Born on 2/8/22 at 6:20.

INFANT: Male, birthweight 3050 grams (6 lbs 11.6 oz).
Apgars: 2 @1 min (HR-2, Resp-0, Tone-0, Reflex-0, Color-0)
6 @5 min (HR-2, Resp-1, Tone-1, Reflex-1, Color-1)
7 @10 min (HR-2, Resp-2, Tone-1, Reflex-1, Color-1)
Resuscitation steps: oxygen, face mask ventilation.
Per reports from RH: Infant was deep suctioned by delivering provider immediately after delivery. Taken to warmer, continued to deep suction. HR >100bpm from birth. Infant showed no respiratory effort, PPV was given for approximately 3minutes and continued to have irregular respirations. Infant taken to nursery and CPAP was initiated. Grunting subsided and infant was weaned to RA by approximately 4HOL Oral feedings were started and infant continued to do well. At approximately 10HOL infant noted to have apnea spells with color change and possible twitching of extremities. D/t concerns for seizure activity

referral was initiated to transport infant to TCH. Infant again with seizure activity approximately 12HOL and was given loading dose of phenobarbital. NF team arrived to take over care, noted infant to be borderline lethargic following phenobarbital dose. NS bolus given in route for soft blood pressures. No seizure activity noted by NF team on transport. Infant admitted to NICU in room air with relatively normal neurological exam.

ADMISSION PHYSICAL EXAM (at 2/8/22 22:53)
Weight - 3050 grams (6 lbs 11.6 oz) - 11%ile; Z-score = -1.21
General: 40+1/7 weeks AGA male -- exam compatible with dates. Infant in room air and in no distress. Skin pink, warm, and dry. Petechia to back and sides.
HEENT: Anterior fontanelle open, soft, and flat with sutures approximated. Moulding and caput with redness to scalp from presentation. Eyes clear. Red reflex present bilaterally. Pupils equally round and reactive to light. Oral mucosa pink and moist, palate intact. Ears in normal shape and position.
Chest: Chest rise symmetrical with clear breath sounds bilaterally.
Heart: Normal sinus rhythm, normal perfusion and pulses, no murmur.
Abdomen: Soft and non-distended, non-tender with active bowel sounds.
Genitals: Normal male genitalia. tests descended bilaterally. Anus: Patent anus in normal position.
Skeletal: No abnormalities noted. Extremities: Moving all extremities equally.
Neuro: Alert, active, responsive, normal tone for gestational age, normal primitive reflexes. Infant appropriately reactive to exam.
Jittery/jerking movements seen at RH. none appreciated on exam.
Exam by L. Donaldson, NNP.

LABS
Glucose:
* 2/8 23:09: 80 (Accuchek).

STABILIZATION
Infant admitted to the NICU in room air. Routine newborn assessment and protocols initiated.

MEDICATIONS
Acyclovir, 60 mg IV q8h (19.7 mg/kg/dose, 59 mg/kg/day) started on 2/8/22
Amikacin, 37 mg IV q24h (12.1 mg/kg/day) started on 2/8/22
Ampicillin, 300 mg IV q12h (98.4 mg/kg/dose, 197 mg/kg/day) started on 2/8/22
PHENObarbital, 15 mg IV q24h (4.9 mg/kg/day) started on 2/9/22

ALLERGIES and ADVERSE REACTIONS
No known allergies.

APPRAISAL
1. 40 week AGA male
2. r/o sepsis
3. r/o seizures

PLAN
Provide routine NICU care with CR monitor, neutral thermal environment, and routine screening procedures.
--RESPIRATORY: RA (required CPAP briefly after delivery, weaned to RA approximately 2HOL). THICK MEC
--Weaning parameters/gases: prn

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

--CV: needs CCHD at 24 hrs or when in room air. soft BPs reported in transport, NS bolus x1.
--FEN/GI: PO fed well at RH. currently NPO with SNAP10 approximately 80mL/kg/day. blood sugar stable. restart PO feeds and adjust IVF as indicated.
--HEME: MBT B+. Petecchial rash noted, although platelets WNL.
--ID: BCx sent at RH x2. Repeated on admission. ID labs on admission. HSV workup sent d/t questionable seizure activity. Will attempt LP for HSV CSF PCR and send serum PCR. Amp/Ami/Acyclovir. No known maternal hx. adequate prenatal care, all other labs negative.
--NEURO: needs ABR when in crib and 34 weeks. possible seizure activity (apnea and twitching) noted approximately 10HOL and again approximately 12HOL). loaded w/ Qbarb and maintenance ordered. consider CFM if any more seizure activity. Neurology consulted; they recommended Keppra for breakthrough seizure activty. HUS ordered and pending. Will need MRI in next couple of days.
--GEM/ORTHO/SKIN: NBS #1 ___, NBS #2 ___
--GU: strict I and O.
--EYE: monitoring for need
--IMMUNIZATIONS: HBV given at RH.
--HOMETOWN/SOCIAL: Durant. 20yo G1.

I personally examined the patient, reviewed and updated the history and assessment, and developed the plan of care with the multidisciplinary team as documented in this note. Macie Caines, NNP assisted me in the care of the patient and preparation of this note.

The patient requires intensive monitoring of cardiorespiratory stability, growth, nutrition, and I and O.
I provided 30 minutes of care.

E-signed by Doug Dannaway, MD; completed 2/9/22 4:16

Electronically Signed by Douglas Dannaway, MD on 02/09/22 at 0416

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: FU,7172-A

BLUE,BB-IAIUM

OU Medical Center NUR **Live**
CLINICAL DOCUMENTATION RECORD IIPI

Printed 02/21/22 at 0212

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Directions / Documented Comment	Documented Units	From Change
Activity Date: 02/08/22 Time: 2110										
?200004	Allergies NKDA Latex precautions for any neurosurgical or GI surgical patient.						A			OF
- Create	02/08/22	2110	MNC	02/08/22	2110	MNC				
2200031	Cardiac Monitoring Continuous monitoring of heart rate & respiratory rate						A			OE
- Create	02/08/22	2110	MNC	02/08/22	2110	MNC				
2200044	Daily Weight Obtain weight, length, head circumference, and physical exam assessment within 1 hour of admission. Repeat weights daily and length and head circumference measurements on Tuesdays.						A			OE
- Create	02/08/22	2110	MNC	02/08/22	2110	MNC				
2200059	Finger Stick Blood Sugar Glucometer measurements Q1 hr x 2 then Q4 hrs for first 24 hrs. For infants on IVF/TPN, obtain measurements 1-2 hrs after hanging new fluids or after discontinuance of fluids.						A	.[q 4 hrs then...]		OE
Create	02/08/22	2110	MNC	02/08/22	2110	MNC				
2200070	Intake and Output Monitoring Strict intake and output measurements, including blood						A			OC
Create	02/08/22	2110	MNC	02/08/22	2110	MNC				
2200085	Notify MD i. Notify clinician of the following: i. Heart rate: less than 100 or greater than 200. ii. Respiratory rate: less than 20 or greater than 80. iii. Blood pressure mean less than below 1. 25 for infants <600 grams 2. 35 for infants 600-999 grams 3. 40 for infants 1000-1999 grams 4. 45 for infants 2000-2999 grams 5. 50 for infants >3000 grams iv. Temperature: less than 36.5C or greater than 37.5C. v. SpO2: outside limits per oxygen management protocol (see 11.1) or if FiO2 needs are increased by 10% for longer than 15 minutes. vi. Urine output: less than 0.5 ml/kg/hr						A			OC

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Directions / Documented Comment	Documented Units	From Change
2200085	Notify MD (continued) or greater than 5 ml/kg/hr vii. Blood sugar: less than 40 or greater than 200									
- Create	02/08/22	2110	MNC	02/08/22	2110	MNC				
2200088	O2SAI Monitoring Continuous monitoring of pulse oximetry According to oxygen management protocol, maintain SpO2 by altering FiO2 concentration if on supplemental oxygen. i. For infants less than 32 weeks: 88-93%, at 32 weeks change to 90-95% ii. For infants born at 32-34 weeks: 90-95% iii. For infants born at 35 weeks or more: 95-98% iv. For infants with chronic lung disease (O2 at >36 wks): 92-97% v. For infants in room air: alarm limits should be set at 89% and 100% vi. Custom limits (cardiac or special circumstances only): Maintain SpO2 between _____% and _____% by altering FiO2 concentration if on supplemental oxygen.						A			OE
- Create	02/08/22	2110	MNC	02/08/22	2110	MNC				
?200090	Obtain Consent Ensure admission consent is signed and in chart within 24 hours of admission or before administering any blood products or assisting with any invasive procedures. For mothers who consent to using donor milk, ensure donor milk consent is in chart before administering donor milk or formula.						A			OF
- Create	02/08/22	2110	MNC	02/08/22	2110	MNC				
?200154	Vital Signs Vital signs on admission and hourly x 24 hours then Q2-4 hours per unit protocol, to include heart rate, respiratory rate, temperature, SpO2, and EDIN pain score. Four extremity blood pressures on admission then single extremity BP Q12 hrs (hourly if on pressors; Q___ hours if on cardiac team).						A			OF
- Create	02/08/22	2110	MNC	02/08/22	2110	MNC				

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Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Directions Documented Units	From Change
Activity Date: 02/08/22		**Time: 2110**							
?200???	Kangaroo care appropriate Kangaroo care per protocol.						A		OF
- Create	02/08/22	2110	MNC	02/08/22	2110	MNC			
2200234	Rewarm Infant Admit to Omni bed if <1800 grams, otherwise admit to radiant warmer. Follow temperature control policy for weaning incubator.						A		OE
Create	02/08/22	2110	MNC	02/08/22	2110	MNC			
2200249	Congenital Heart Dz Screen Critical Congenital Heart Disease (CCHD) screen for all infants between 24 hrs and 14 days old who are in room air and have not had an echocardiogram. Follow CCHD pulse oximetry screening protocol.						A		OE
- Create	02/08/22	2110	MNC	02/08/22	2110	MNC			
Activity Date: 02/08/22		**Time: 2305**							
1001095	ADM/Transfer: Quick Start Form +						A		AS
Create	02/08/22	2305	BMP	02/08/22	2306	BMP			
- Document	02/08/22	2305	BMP	02/08/22	2306	BMP			
Patient Type? CRITICAL CARE - NEONATE Patient Age Group? 0 - 1 yr									
Activity Date: 02/08/22		**Time: 2306**							
Diagnosis: Developmental Age 0-1 year. Infant Related to our age specific Ploicy and Proceedure practice guidelines infant developmental need: - Trust							A		
Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
Goal: Age Appropriate Guidelines will be met							A		
- Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
3200000	Age Appropriate Guidelines May Address via End of Shift Summary						A		CP
- Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
Goal: Infant will participate in play exercises that are geared to stimulate cognitive development.							A		
- Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
Diagnosis: Critical Care - Neonate (Crib Notes) Care Area Practice Guidelines Guidelines focus on: Safety issues Psychosocial needs -- Nutritional needs -- ADL's -- Skin Integrity -- IV Lines -- Pain -- Respiratory Function --							A		

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Directions Documented Units	From Change
Diagnosis: Critical Care - Neonate (Crib Notes) (continued) Cardiac Function -- GI Function -- Gu Function -- Monitoring lines -- Developmental needs									
- Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
Goal: Care Area Practice Guidelines and Documentation Requirements are met. By discharge, the patient/caregiver will verbalize and/or demonstrate competence and confidence in providing safe, effective, care appropriate to their individual needs.							A		
- Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
1000033	NICU Admission Data +						A	.Every admission	CP
Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
1701275	Weight +						A	Q14DX1,T	CP
- Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
1701325	Height +						A		CP
Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
1710105	End of Shift: NICU (Level of Care) + CritCare documents on paper except for POC, End of Shift Summary, and Education.						A	BID 6A 6P	CP
- Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
1900100	HOC: Measure +						A		CP
- Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
2500000	Fall Prevention & Post Fall +						A	.PRN Fall Score/Post Fall Documentation	CP
- Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
4101601	Medication Reconciliation +						A		CP
Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
4132203	Central & Foley Line Check +						A	0005	CP
- Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
4750218	Education: Interdisciplinary+						A		CP
Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
5060001	Handover/Transfer						A		CP
- Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
9900002	BCTA: Suspected Transfusion Reaction +						A		CP
Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
9900003	BCTA: Pre-Issue Checklist +						A		CP
- Create	02/08/22	2306	BMP	02/08/22	2306	BMP			
Activity Date: 02/09/22		**Time: 0715**							
2200043	Dressing Change A) Occlusive dressing changed 24 hours after insertion per PICC trained nurse. B) Then, occlusive dressing changed PRN (when dressing is soiled, saturated, or no longer intact)						A		OE

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Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Directions / Documented Comment	Units	From / Change

Activity Date: 02/09/22 Time: 0715 (continued)

2200043 Dressing Change (continued)
- Create 02/09/22 0715 JDF 02/09/22 0715 JDF
2200107 Procedure A OE
Implement care based on established protocols.

Use 1.9 french catheter for all infants

Place PICC line per policy

Verify central position with Radiologist/Attending/Neonatal Nurse Practitioner prior to use, with no more than 3 x-ray attempts.

Document procedure in Crib Notes.
- Create 02/09/22 0715 JDF 02/09/22 0715 JDF
2200213 Nursing Miscellaneous Order A OC
goal MAP 35-45
- Create 02/09/22 0715 JDF 02/09/22 0715 JDF
1710105 End of Shift: NICU (Level of Care) + A BID 6A 6P CP
CritCare documents on paper except for POC. End of Shift Summary, and Education.
- Document 02/09/22 0715 IY 02/09/22 0715 IY
Newborn level of care? Day 1
===Episode Day 1===
*** NICU Level 4 ***
*** NICU Level 3 ***
Hemodynamic stability: Y
Binding/intervention? IV med admin *
*** Special Care Level 2 ***
*** Newborn Level 1 ***
=== Episode Day 2-DC ===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
*** Newborn Level 1 ***
*** Transitional Care ***
Level of care: 3
Expected accomodation code: NB

Activity Date: 02/09/22 Time: 1247

5005020 Chaplain Spiritual Assessment + A PS
- Create 02/09/22 1247 TG 02/09/22 1247 TG
- Document 02/09/22 1247 TG 02/09/22 1247 TG
Type of Contact? I

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Directions / Documented Comment	Units	From / Change

Activity Date: 02/09/22 Time: 1247 (continued)

5005020 Chaplain Spiritual Assessment + (continued)
Status? PT/FAMILY PRESENT
Comment- Pastoral care offered and card left
=== SPIRITUAL ASSESSMENT ===
Emotions Expressed:
Received

Activity Date: 02/09/22 Time: 1536

Patient Notes: LACTATION CONSULT
- Create 02/09/22 1536 MO 02/09/22 1542 MO

Reason for Consult: Infant Admit to SCN/NICU
Consult time: 30 min
Lactation Acuity: Level III
LATCH Score: Unable to assess
Mom's Goal: Not sure

S: Mother states she wishes to provide EBM for her infant. Started pumping session and fitted for flange size 24. Mom voices understanding of pumping q 2 3 hrs 15 20 and at least once during the night with hands on pumping. Also discussed engorgement management. States has manual pump and hands free pump at home. Encouraged to use symphony pump at bedside while at bedside.

O: Education provided:
1. Benefits of Breastfeeding for Mom/Baby
2. Pump set-up and operation
3. Pumping frequency and duration, including hand expression after pumping
4. Cleaning Equipment
5. Milk Collection and Storage
6. Hand Expression, especially in 1st 3 days
7. Availability of hospital-grade pumps for use after mom is discharged
8. Kangaroo Care
9. Call TLC if she is having difficulty obtaining a pump
10. Benefits and risks of PDM and formula

A: Maternal knowledge deficit: establishing milk supply w/ a breast pump: Risk for delayed lactogenisis II and/or low milk supply r/t:induced labor,separation of mom/baby

P: Use breast pump at least 8x/24 hr, obtain breast pump for home use, begin KC & breastfeed when infant is able, LC f/u w/in 7 days.

Mariana Orozco LPN/IBCLC
Note Type Description
No Type None

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Diagnosis/Goal/Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Directions / Documented Comment	Documented Units	From Change
Activity Date: 02/09/22 Time: 1733											
	1710105	End of Shift: NICU (Level of Care) + CritCare documents on paper except for POC, End of Shift Summary, and Education.						A	BID 6A 6P		CP
	Document	02/09/22 1733 AFM			02/09/22 1734 AFM						
Newborn level of care? Day 2 ^ Discharge ===Episode Day 1=== *** NICU Level 4 *** *** NICU Level 3 *** *** Special Care Level 2 *** *** Newborn Level 1 *** === Episode Day 2-DC === *** NICU Level 4 *** *** NICU Level 3 *** Hemodynamic stability: Y Finding/intervention? Neuro assess >= q2h *** Special Care Level 2 *** *** Newborn Level 1 *** *** Transitional Care *** Level of care: 3 Expected accomodation code: N3											
Activity Date: 02/10/22 Time: 0618											
	1710105	End of Shift: NICU (Level of Care) + CritCare documents on paper except for POC, End of Shift Summary, and Education.						A	BID 6A 6P		CP
	Document	02/10/22 0618 LY			02/10/22 0619 LY						
Newborn level of care? Day 2 ^ Discharge ===Episode Day 1=== *** NICU Level 4 *** *** NICU Level 3 *** *** Special Care Level 2 *** *** Newborn Level 1 *** === Episode Day 2-DC === *** NICU Level 4 *** *** NICU Level 3 *** Hemodynamic stability: Y Finding/intervention? Anti-infective * *** Special Care Level 2 *** *** Newborn Level 1 *** *** Transitional Care *** Level of care: 3 Expected accomodation code: N3											

Diagnosis/Goal/Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Directions / Documented Comment	Documented Units	From Change
Activity Date: 02/10/22 Time: 1644											
	1710105	End of Shift: NICU (Level of Care) + CritCare documents on paper except for POC, End of Shift Summary, and Education.						A	BID 6A 6P		CP
	Document	02/10/22 1644 AFM			02/10/22 1645 AFM						
Newborn level of care? Day 2 ^ Discharge ===Episode Day 1=== *** NICU Level 4 *** *** NICU Level 3 *** *** Special Care Level 2 *** *** Newborn Level 1 *** === Episode Day 2-DC === *** NICU Level 4 *** *** NICU Level 3 *** Hemodynamic stability: Y Finding/intervention? IVF/TPN >=50mL/kg/24h *** Special Care Level 2 *** *** Newborn Level 1 *** *** Transitional Care *** Level of care: 3 Expected accomodation code: N3											
Activity Date: 02/11/22 Time: 0452											
	1710105	End of Shift: NICU (Level of Care) + CritCare documents on paper except for POC, End of Shift Summary, and Education.						A	BID 6A 6P		CP
	Document	02/11/22 0452 DDS			02/11/22 0452 DDS						
Newborn level of care? Day 2 ^ Discharge ===Episode Day 1=== *** NICU Level 4 *** *** NICU Level 3 *** *** Special Care Level 2 *** *** Newborn Level 1 *** === Episode Day 2-DC === *** NICU Level 4 *** *** NICU Level 3 *** Hemodynamic stability: Y *** Special Care Level 2 *** Hemodynamic stability: Y Finding/intervention? Isolation * *** Newborn Level 1 *** *** Transitional Care *** Level of care: 2 Expected accomodation code: N2											

Age/Sex: 00M 13D M
Unit #: E003047593
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Status: DIS IN

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Room/Bed: CU,7172-A

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Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Directions Documented Comment	Documented Units	From Change

Activity Date: 02/11/22 Time: 1105

2200184 Speech Therapy A OF

New onset Dysphagia: N New onset Cognitive deficits: N Intubated: N
New onset communication deficits: N
Comment: please evaluate for safe PO feeding
: thank you
:
:
Patient will discharge today,pending Therapy Evaluation. N Campus? C
Create 02/11/22 1105 JDF 02/11/22 1105 JDF

Activity Date: 02/11/22 Time: 1418

5186454 ST: NICU Evaluation A AS

- Create 02/11/22 1418 ENL 02/11/22 1430 ENL
- Document 02/11/22 1418 ENL 02/11/22 1430 ENL

SPEECH AND LANGUAGE PATHOLOGY
Date: 02/11/22
Time: 1418
By: EPT.ENL LEE,ERIKA N
Primary Therapist: EPT.ENL LEE,ERIKA N
Okay to reassign: Y
Physician's Orders: FEEDING CONSULT
Isolation? STANDARD
Isolation? STANDARD
as per Nursing
Resuscitation Directive: CPR/Full Resuscitation
Treatment Precautions: CONTACT
Treatment Units: EVALSWALFU, SWATX, 97533
Religious/Cultural Concerns Integrated Into Patient's Treatment Plan: Y
Mental Status? Alert
Previous Functional Status: INFANT
Understands English: Yes
as per Nursing
Current Medical Status: R/O SEPSIS, SEIZURES
Previous Medical History? NEWBORN
===PATIENT/CAREGIVER/INPUT/GOALS/CONCERNS===
Patient/Caregiver Comment PARENTS PRESENT AND AGREEABLE TO SLP EVAL OF SWALLOW
Patient/Caregiver Goal: FOR INFANT TO BE OK
Pt/Caregiver Discharge Destination Goal: Home
==== PAIN ====
Pain Intensity: 0
===Outcome Measure===
Date
Score
===COGNITION/LANGUAGE===
Addressed Today: N
===SPEECH/ORAL MOTOR===
Addressed Today? Y

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Directions Documented Comment	Documented Units	From Change

Activity Date: 02/11/22 Time: 1418 (continued)

5186454 ST: NICU Evaluation (continued)
- INFANT WAS IN HIS WARMER, UNDERGOING AN ECG. HE WAS HAND
- SWADDLED TO INTRO CARE. HE WAS NOTED TO BE SOMEWHAT IRRITABL
- BUT ABLE TO BE CONSOLED WITH HAND SWADDLING. HE WAS OFFERED
GLOVED FINGER TO ASSESS ORAL CAVITY AND SUCK. ORAL CAVITY
- WAS INTACT. HE HAD A HYPOTONIC TONGUE INITIALLY, BUT ONCE
- FINGER IN GOOD POSITION AND WITH FIRM STROKES TO TONGUE AND
- PALATE, HE WAS ABLE TO PRODUCE A SUCK ON GLOVED FINGER.
SUCK WAS STRONG. HE WAS TURNED TO SIDELYING IN HIS WARMER.
- AND MILK WAS OFFERED VIA SLOW FLOW NIPPLE. HE WAS GIVEN A
- DRY NIPPLE INITIALLY, WHICH INITIALLY MADE HIM IRRITABLE.
- BUT AFTER SEVERAL MINUTES OF CALMING AND ATTEMPTING TO
PRODUCE A SUCK ON THE NIPPLE, HE WAS ABLE TO LATCH. HE THEN
- PRODUCED A VERY STRONG NUTRITIVE SUCK. HE ATE WELL WITH
- BREAKS THAT WERE LONG, BUT HE WAS ALLOWED TO CONTINUE
- WITH THE FEED WITHOUT PRODDING. HE WAS ABLE TO COMPLETE HIS
40CC BOTTLE IN ABOUT 20 MINUTES FROM START TO FINISH.
Goal: SAFE, EFFICIENT PO FEEDING.
Target Date: 02/18/22
===IMPRESSIONS===
INFANT WAS ABLE TO PRODUCE A NUTRITIVE SUCK, HOWEVER HE
- REQUIRED EXTRA TIME AND PATIENCE TO LATCH AND PRODUCE A
- SUCK.
===RECOMMENDATIONS===
1. FEED 1X PER SHIFT OR WITH CUES
- 2. SLP WILL FOLLOW
Therapist Recommendation for discharge: Home
===Education===
Preferred Learning Method? ALL
Educational Needs(s)? FEEDING TECHNIQUES
- SPEECH PATHOLOGY
Patient/Support Person Ready to Learn: Y
Identified Barriers to Learning? NONE
Instructions Given Regarding- OUTCOME OF EVAL
Person Taught? PARENTS
Method Used? VERBAL
Evaluation? VERBALIZED UNDERSTANDING
===TREATMENT PLAN===
Type of feeder: Sick term
SLP only feeding? N
Plan to see patient M/TU/W/TH/F/SU
Until 02/18/22
when re-assessment is due, for
- Feeding Skills
Priority: (A)
===PHYSICIAN NOTIFICATION===
Physician Name- IVAVA Ivanov,Vadim A MD
Reason Notified? (free text if needed)

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Activity Date: 02/11/22 Time: 1418 (continued)									
5186454 ST: NICU Evaluation (continued) OUTCOME OF EVAL, PLAN OF CARE AND RECS									
Treatment Communications: TERM, SEIZURES. HAS A GOOD SUCK BUT TAKES A LOT OF PATIENCE - TO GET HIM TO LATCH									
Goal Prognosis? Good									
Rx Time In: 1140									
Time Out: 1210									
Report needs to be reviewed and co-Signed? N									
Functional Communication Measures (FCMs) choose one									
Functional Communication Measures (FCMs)									
Activity Date: 02/11/22 Time: 1431									
2200184 Speech Therapy							A		OC
- Feeding Skills							-	-	
-							-	-	
Plan to see patient M/TU/W/TH/F/SU Until 02/18/22 Campus? C									
- Create	02/11/22	1431	ENL	02/11/22	1431	ENL			
Diagnosis: ST: PATIENT/CAREGIVER EDUCATION							A		
Create	02/11/22	1431	FNI	02/11/22	1431	FNI			
Goal: REHAB: Pt/caregiver will verbalize and or demonstrate understanding, competence, and or confidence in providing safe, effective rehab techniques,appropriate to the patient's individual education needs as described documented in Therapy eval & progress							A		
Create	02/11/22	1431	FNI	02/11/22	1431	FNI			
1002067 ST: Speech Initial Segment +							A		CP
- Create	02/11/22	1431	ENL	02/11/22	1431	ENL			
5186365 ST: Patient/Family Education							A		CP
Create	02/11/22	1431	FNI	02/11/22	1431	FNI			
6280007 ST: Progress Note +							A		CP
- Create	02/11/22	1431	ENL	02/11/22	1431	ENL			
Diagnosis: REHAB:ORAL MOTOR DISORDERS/IMPAIRMENTS							A		
Create	02/11/22	1431	FNI	02/11/22	1431	FNI			
Goal: REHAB: With skilled Therapy intervention patient's oral motor skills will be improved to allow maximized function as described in the individualized treatment goals and interventions documented in therapy eval & progress notes							A		
Create	02/11/22	1431	FNI	02/11/22	1431	FNI			

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Documented Units	From Change
Activity Date: 02/11/22 Time: 1909									
1710105 End of Shift: NICU (Level of Care) + CritCare documents on paper except for POC, End of Shift Summary, and Education.							A	BID 6A 6P	CP
Document	02/11/22	1909	FB	02/11/22	1909	FB			
Newborn level of care? Day 2 ^ Discharge									
===Episode Day 1===									
*** NICU Level 4 ***									
*** NICU Level 3 ***									
*** Special Care Level 2 ***									
*** Newborn Level 1 ***									
=== Episode Day 2-DC ===									
*** NICU Level 4 ***									
*** NICU Level 3 ***									
*** Special Care Level 2 ***									
*** Newborn Level 1 ***									
*** Transitional Care ***									
Level of care: 2									
Expected accomodation code: N2									
Activity Date: 02/12/22 Time: 0713									
1710105 End of Shift: NICU (Level of Care) + CritCare documents on paper except for POC, End of Shift Summary, and Education.							A	BID 6A 6P	CP
- Document	02/12/22	0713	BJB	02/12/22	0714	BJB			
Newborn level of care? Day 2 ^ Discharge									
===Episode Day 1===									
*** NICU Level 4 ***									
*** NICU Level 3 ***									
*** Special Care Level 2 ***									
*** Newborn Level 1 ***									
=== Episode Day 2-DC ===									
*** NICU Level 4 ***									
*** NICU Level 3 ***									
Hemodynamic stability: Y									
*** Special Care Level 2 ***									
Hemodynamic stability: Y									
Finding/intervention? IVF/TPN <50mL/kg/24h *									
*** Newborn Level 1 ***									
*** Transitional Care ***									
Level of care: 2									
Expected accomodation code: N2									

Age/Sex: 00M 13D M
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Location: FU,NICUF
Room/Bed: FU,7172-A

BLUE,BB-IAIUM

OU Medical Center NUR **Live**
CLINICAL DOCUMENTATION RECORD IIPI

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Units	From Change
Activity Date: 02/12/22 Time: 1539									
2201135 RT:Ventilator NICU							A		OF
Campus? C									
Ventilation Mode: NIV									
Set Respiratory Rate: Tidal Vol (VC): Pressure Control (above PEEP):									
FIO2: Pressure Support: PEEP: 7.0 Inspiratory Time / I Time %:									
Please indicate any additional settings: CPAP									
- Create	02/12/22	1539	AEK	02/12/22	1539	AEK			
Activity Date: 02/12/22 Time: 1715									
2110202 RI: Noninvasive Ventilation +							A		CP
- Create	02/12/22	1715	CF	02/12/22	1715	CF			
Document	02/12/22	1715	CF	02/12/22	1716	CF			
Was this a new NIV set-up? Y									
Patient refused and physician notified? N									
Patient Status: Awake, Alert									
Breath sounds: CLEAR									
Cough: No cough effort									
Suctioned: N									
Patients home unit with home settings? N									
Modality: SERVO NIV CPAP									
FIO2: 21									
CPAP: 7									
Ambu bag at bedside: Y									
Vent hrs.: 3									
Bio-med control number: Rental									
Education provided? N									
Daily Review Complete? N									
===Education===									
Educational Needs(s)? NO NEEDS IDENTIFIED									
Patient/Support Person Ready to Learn: N									
Identified Barriers to Learning? NO FAMILY AVAILABLE									
TOP 12 PT. PROBLEMS AS PRIORITIZED ON POC:(see POC for all)									
Problem(s) Identified:									
STATUS									
PROBLEM EVALUATED									
===Adverse Medication Reaction===									
2110330 RT: Ventilator Circuit Change +							A		CP
- Create	02/12/22	1715	CF	02/12/22	1715	CF			
2110350 RT: Humidifier Water, Provide/Change +							A		CP
Create	02/12/22	1715	CF	02/12/22	1715	CF			
2110550 RT: Assist for 15 minutes +							A		CP
- Create	02/12/22	1715	CF	02/12/22	1715	CF			
1710105 End of Shift: NICU (Level of Care) + Critical Care documents on paper except for POC, End of Shift Summary, and Education. . .							A	BID 6A 6P	CP
- Document	02/12/22	1715	KSW	02/12/22	1716	KSW			

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Units	From Change
Activity Date: 02/12/22 Time: 1715 (continued)									
1710105 End of Shift: NICU (Level of Care) + (continued)									
Newborn level of care? Day 2 ^ Discharge									
===Episode Day 1===									
*** NICU Level 4 ***									
*** NICU Level 3 ***									
*** Special Care Level 2 ***									
*** Newborn Level 1 ***									
=== Episode Day 2-DC ===									
*** NICU Level 4 ***									
*** NICU Level 3 ***									
*** Special Care Level 2 ***									
Hemodynamic stability: Y									
Finding/Intervention? Oxygen therapy *									
*** Newborn Level 1 ***									
*** Transitional Care ***									
Level of care: 2									
Expected accomodation code: N2									
Diagnosis: Altered Respiratory function related to disease process, physical limitations, surgical procedure and/or trauma.							A		
- Create	02/12/22	1715	CF	02/12/22	1715	CF			
Goal: Adequate air exchange with Oxygen sats >92%, clear and equal breath sounds, pink mucous membranes and nailbeds, respirations regular and unlabored prior to discharge.							A		
Create	02/12/22	1715	CF	02/12/22	1715	CF			
1900700 Evaluate: Respiratory +							A	.As needed	CP
- Create	02/12/22	1715	CF	02/12/22	1715	CF			
Activity Date: 02/12/22 Time: 1716									
2110202 RI: Noninvasive Ventilation + NIV/CPAP PEEP7 21%							A		CP
Ed Text	02/12/22	1716	CF	02/12/22	1716	CF			
Activity Date: 02/13/22 Time: 0330									
2110202 RT: Noninvasive Ventilation + NIV/CPAP PEEP7 21%							A		CP
- Document	02/13/22	0330	JA	02/13/22	0331	JA			
Was this a new NIV set-up? N									
Shift: NIGHTS									
Patient refused and physician notified? N									
Patient Status: Cooperative									
Breath sounds: CLEAR									

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN
Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: CU,7172-A

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OU Medical Center NUR **Live**
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Printed 02/21/22 at 0212

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Documented Units	From Change

Activity Date: 02/13/22 Time: 0330 (continued)

2110202 RT: Noninvasive Ventilation + (continued)
Cough: No cough effort
Suctioned: N
Patients home unit with home settings? N
Modality: SFRYO NIV CPAP
FIO2: 23
CPAP: 7
Ambu bag at bedside: Y
Vent hrs.: 12
Bio-med control number: Rental
Education provided? N
Daily Review Complete? Y
===Education===
Educational Needs(s)? NO NEEDS IDENTIFIED
Patient/Support Person Ready to Learn: N
Identified Barriers to Learning? NO FAMILY AVAILABLE
TOP 12 PT. PROBLEMS AS PRIORITIZED ON POC:(see POC for all)
Problem(s) Identified:
STATUS
PROBLEM EVALUATED
1: Developmental Age 0 1 year. Infant
: A
2: Critical Care - Neonate (Crib Notes)
: A
3: ST: PATIENT/CAREGIVER EDUCATION
: A
4: REHAB:ORAL MOTOR DISORDERS/IMPAIRMENTS
: A
5: Altered Respiratory Function
: A
- ONGOING
Patient's POC Was Reviewed & Updated? Y
===Adverse Medication Reaction===
Has the patient received new medications this shift: N
If yes, did they have adverse reaction/s: N

Activity Date: 02/13/22 Time: 0719

1710105 End of Shift: NICU (Level of Care) + A BID 6A 6P CP
CritCare documents on paper except for POC, End of Shift Summary, and Education.
- Document 02/13/22 0719 BJB 02/13/22 0719 BJB
Newborn level of care? Day 2 ^ Discharge
===Episode Day 1===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Documented Units	From Change

Activity Date: 02/13/22 Time: 0719 (continued)

1710105 End of Shift: NICU (Level of Care) + (continued)
*** Newborn Level 1 ***
=== Episode Day 2-DC ===
*** NICU Level 4 ***
*** NICU Level 3 ***
Hemodynamic stability: Y
Finding/intervention? IVF/IPN >=50mL/kg/24h
*** Special Care Level 2 ***
*** Newborn Level 1 ***
*** Transitional Care ***
Level of care: 3
Expected accomodation code: N3

Activity Date: 02/13/22 Time: 1028

5186200 ST: NICU INITIAL SEGMENT A AS
Create 02/13/22 1028 ENL 02/13/22 1028 ENL
- Document 02/13/22 1028 CNL 02/13/22 1028 CNL
SPEECH AND LANGUAGE PATHOLOGY
Date: 02/13/22
Time: 1028
By: CPT,CNL LEE,ERIKA N
Primary Therapist: CPT,CNL LEE,ERIKA N
Okay to reassign: Y
Physician's Orders: FEEDING CONSULT
Treatment Precautions: CONTACT
Treatment Communications: TERM, SEIZURES. HAS A GOOD SUCK BUT TAKES A LOT OF PATIENCE
- TO GET HIM TO LATCH **ON NIV 2/13
Did not treat patient due to: due to medical status
- ON NIV
Current Medical Status: R/O SEPSIS, SEIZURES
Previous Medical History? NEWBORN
===SPEECH RECOMMENDATIONS FOR DIET===
Instructions
===TREATMENT PLAN===
Plan to see patient M/TU/W/TH/F/SU
Until 02/18/22
when re-assessment is due, for
- Feeding Skills
===PHYSICIAN NOTIFICATION===

Activity Date: 02/13/22 Time: 1336

2110202 RT: Noninvasive Ventilation + A CP
NIV/CPAP PFFP7 21%
- Document 02/13/22 1336 KTB 02/13/22 1336 KTB
Was this a new NIV set-up? N
Shift: DAYS

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: CU,7172-A

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Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Documented Units	From Change

Activity Date: 02/13/22 Time: 1335 (continued)

2110202 RT: Noninvasive Ventilation + (continued)
Patient refused and physician notified? N
Patient Status: Cooperative
Breath sounds: EQUAL
Cough: No cough effort
Suctioned: N
Patients home unit with home settings? N
Modality: SERVO NIV CPAP
FIO2: .23
CPAP: 7
Ambu bag at bedside: Y
Vent hrs.: 12
Bio med control number: Rental
Education provided? N
Daily Review Complete? N
==Education==
Educational Needs(s)? NA
Patient/Support Person Ready to Learn: N
Identified Barriers to Learning? NONE
TOP 12 PT. PROBLEMS AS PRIORITIZED ON POC:(see POC for all)
Problem(s) Identified:
STATUS
PROBLEM EVALUATED
==Adverse Medication Reaction==

Activity Date: 02/13/22 Time: 1440

4255001 I&O: Monitor + A MD
Create 02/13/22 1440 AG 02/13/22 1440 AG
- Document 02/13/22 1440 AG 02/13/22 1440 AG
---Intake---
Type- EBM
Output
I&O Comment- Calories: 20

---Non-BCTA documented blood products---
(if on weight based drip)
Fluid Type
Drip Dose
At
IV Site
Amount
(ml)
<> COMPLEX OUTPUT <>
New
Total for
Cannister
Cannister

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Documented Units	From Change

Activity Date: 02/13/22 Time: 1604

4255001 I&O: Monitor + A MD
- Document 02/13/22 1604 AG 02/13/22 1604 AG
---Intake---
Type- EBM
Output
I&O Comment- Calories: 20

---Non-BCTA documented blood products---
(if on weight based drip)
Fluid Type
Drip Dose
At
IV Site
Amount
(ml)
<> COMPLEX OUTPUT <>
New
Total for
Cannister
Cannister

Activity Date: 02/13/22 Time: 1815

4255001 I&O: Monitor + A MD
Document 02/13/22 1815 AG 02/13/22 1815 AG
---Intake---
Type- EBM
---Output---
I&O Comment- Calories: 20

---Non-BCTA documented blood products---
(if on weight-based drip)
Fluid Type
Drip Dose
At
IV Site
Amount
(ml)
<> COMPLEX OUTPUT <>
New
Total for
Cannister
Cannister
- Document 02/13/22 1815 AG 02/13/22 1815 AG
Intake
Type- EBM
---Output---
I&O Comment- Calories: 20

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: EU,NICUF
Room/Bed: EU,7172-A

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Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Directions Documented Units	From Change

Activity Date: 02/13/22 Time: 1815 (continued)

4255001 I&O: Monitor + (continued)

---Non-BCIA documented blood products---
(if on weight-based drip)
Fluid Type
Drip Dose
At
IV Site
Amount
(ml)
<> COMPLEX OUTPUT <>
New
Total for
Canister
Canister

Activity Date: 02/13/22 Time: 1840

1710105 End of Shift: NICU (Level of Care) + A BID 6A 6P CP
CritCare documents on paper except for POC, End of Shift Summary, and Education.
- Document 02/13/22 1840 AG 02/13/22 1849 AG
Newborn level of care? Day 2 ^ Discharge
===Episode Day 1===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
*** Newborn Level 1 ***
=== Episode Day 2-DC ===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
Hemodynamic stability: Y
Finding/intervention? Neuro assessments q3-4h
*** Newborn Level 1 ***
*** Transitional Care ***
Level of care: 2
Expected accomodation code: N2

Activity Date: 02/14/22 Time: 0016

4132203 Central & Foley Line Check + A 0005 CP
- Document 02/14/22 0016 LJR 02/14/22 0016 LJR
Lines present TODAY at 0001:
Urethral Catheter: N
Central Line: Y
Comment: RA PICC

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Directions Documented Units	From Change

Activity Date: 02/14/22 Time: 0016 (continued)

4132203 Central & Foley Line Check + (continued)
Not sure? Consult the charge nurse or Infection Control.

Activity Date: 02/14/22 Time: 0519

2110202 RT: Noninvasive Ventilation + A CP
NIV/CPAP PEEP/ 21%
- Document 02/14/22 0519 JA 02/14/22 0520 JA
Was this a new NIV set up? N
Shift: NIGHTS
Patient refused and physician notified? N
Patient Status: Cooperative
Breath sounds: COARSE
Cough: No cough effort
Suctioned: N
Patients home unit with home settings? N
Modality: SERVO NIV CPAP
FIO2: 30
CPAP: 7
Ambu bag at bedside: Y
Vent hrs.: 12
Bio-med control number: Rental
Education provided? N
Daily Review Complete? Y
===Education===
Educational Needs(s)? NO NEEDS IDENTIFIED
Patient/Support Person Ready to Learn: N
Identified Barriers to Learning? NO FAMILY AVAILABLE
TOP 12 PT. PROBLEMS AS PRIORITIZED ON POC:(see POC for all)
Problem(s) Identified:
STATUS
PROBLEM EVALUATED
1: Developmental Age 0 1 year. Infant
: A
2: Critical Care - Neonate (Crib Notes)
: A
3: ST: PATIENT/CAREGIVER EDUCATION
: A
4: REHAB:ORAL MOTOR DISORDERS/IMPAIRMENTS
: A
5: Altered Respiratory Function
: A
- ONGOING
Patient's POC Was Reviewed & Updated? Y
===Adverse Medication Reaction===
Has the patient received new medications this shift: N

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN
Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: CU,7172-A

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Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Directions Documented Comment	Units	From Change
Activity Date: 02/14/22 Time: 0608										
1710105	End of Shift: NICU (Level of Care) + CritCare documents on paper except for POC, End of Shift Summary, and Education.						A	BID 6A 6P		CP
Document	02/14/22	0608	LJR	02/14/22	0609	LJR				
Newborn level of care? Day 2 ^ Discharge										
===Episode Day 1===										
*** NICU Level 4 ***										
*** NICU Level 3 ***										
*** Special Care Level 2 ***										
*** Newborn Level 1 ***										
=== Episode Day 2-DC ===										
*** NICU Level 4 ***										
*** NICU Level 3 ***										
Hemodynamic stability: Y										
Finding/intervention? Oxygen therapy *										
*** Special Care Level 2 ***										
*** Newborn Level 1 ***										
*** Transitional Care ***										
Level of care: 3										
Expected accomodation code: N3										
Activity Date: 02/14/22 Time: 0848										
4255001	I&O: Monitor +						A			MD
- Document	02/14/22	0848	PXN	02/14/22	0848	PXN				
---Intake---										
Type- EBM										
Output										
I&O Comment- Calories: 20										
---Non-BCTA documented blood products---										
(if on weight based drip)										
Fluid Type										
Drip Dose										
At										
IV Site										
Amount										
(ml)										
<> COMPLEX OUTPUT <>										
New										
Total for										
Cannister										
Cannister										

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Directions Documented Comment	Units	From Change
Activity Date: 02/14/22 Time: 1102										
2200503	RT: High Flow O2						A			OF
Campus? C										
Flow (LPM): 3 FiO2: 21 Wean FiO2 (Y/N): Y										
Comments: Wean flow as tolerated										
Create	02/14/22	1102	AFK	02/14/22	1102	AFK				
2201135	RT:Ventilator NICU						C			OC
Campus? C										
Ventilation Mode: NIV										
Set Respiratory Rate: Tidal Vol (VC): Pressure Control (above PFFP):										
FIO2: Pressure Support: PEEP: 7.0 Inspiratory Time / I Time %:										
Please indicate any additional settings: CPAP										
- Ed Status	02/14/22	1102	KMC	02/14/22	1102	KMC				A => C
Activity Date: 02/14/22 Time: 1522										
5186200	ST: NICU INITIAL SEGMENT						A			AS
Document	02/14/22	1522	FI	02/14/22	1525	FI				
SPEECH AND LANGUAGE PATHOLOGY										
Date: 02/14/22										
Time: 1522										
By: FPT,FI IF,FI I7ABETH										
Primary Therapist: CPT,ENL LCC,ERIKA N										
Okay to reassign: Y										
Physician's Orders: FEEDING CONSULT										
Treatment Precautions: CONTACT										
Treatment Communications: TERM, SEIZURES, HAS A GOOD SUCK BUT TAKES A LOT OF PATIENCE										
- IO GET HIM TO LATCH **ON NIV 2/13										
Did not treat patient due to: scheduling conflict										
UNABLE TO COORDINATE CARE										
Current Medical Status: R/O SEPSIS, SEIUZURES										
Previous Medical History? NEWBORN										
===SPEECH RECOMMENDATIONS FOR DIET===										
Instructions										
===TREATMENT PLAN===										
Type of feeder: Sick term										
SLP only feeding? N										
Plan to see patient M/TU/W/TH/F/SU										
Until 02/18/22										
when re-assessment is due, for										
- Feeding Skills										
===PHYSICIAN NOTIFICATION===										
Activity Date: 02/14/22 Time: 1557										
2110202	RT: Noninvasive Ventilation + NIV/CPAP PEEP7 21%						A			CP
- Document	02/14/22	1557	NAG	02/14/22	1557	NAG				
Was this a new NIV set-up? N										

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN
Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: FU,7172-A

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Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Directions Documented Comment	Documented Units	From Change

Activity Date: 02/14/22 Time: 1557 (continued)

2110202 RT: Noninvasive Ventilation + (continued)
Shift: DAYS
Patient refused and physician notified? N
Patient Status: Cooperative
Breath sounds: EQUAL
Cough: No cough effort
Suctioned: N
Patients home unit with home settings? N
Modality: SERVO NIV CPAP
FIO2: 28
CPAP: 7
Ambu bag at bedside: Y
Vent hrs.: 3
Bio-med control number: Rental
Education provided? N
Daily Review Complete? N
===Education===
Educational Needs(s)? NO NEEDS IDENTIFIED
Patient/Support Person Ready to Learn: N
Identified Barriers to Learning? NONE
TOP 12 PT. PROBLEMS AS PRIORITIZED ON POC:(see POC for all)
Problem(s) Identified:
STATUS
PROBLEM EVALUATED
===Adverse Medication Reaction===

Activity Date: 02/14/22 Time: 1558

2110202 RT: Noninvasive Ventilation + C CP
NIV/CPAP PEEP7 21%
- Ed Status 02/14/22 1558 NAG 02/14/22 1558 NAG A => C
2110330 RT: Ventilator Circuit Change + C CP
Ed Status 02/14/22 1558 NAG 02/14/22 1558 NAG A => C
2110350 RT: Humidifier Water, Provide/Change + C CP
- Ed Status 02/14/22 1558 NAG 02/14/22 1558 NAG A => C
2110550 RT: Assist for 15 minutes + C CP
Ed Status 02/14/22 1558 NAG 02/14/22 1558 NAG A => C

Activity Date: 02/14/22 Time: 1710

1710105 End of Shift: NICU (Level of Care) + A BID 6A 6P CP
CritCare documents on paper except for POC, End of Shift Summary, and Education.
Document 02/14/22 1710 PXN 02/14/22 1711 PXN
Newborn level of care? Day 2 ^ Discharge
===Episode Day 1===
*** NICU Level 4 ***

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Directions Documented Comment	Documented Units	From Change

Activity Date: 02/14/22 Time: 1710 (continued)

1710105 End of Shift: NICU (Level of Care) + (continued)
*** NICU Level 3 ***
*** Special Care Level 2 ***
*** Newborn Level 1 ***
=== Episode Day 2 DC ===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
Hemodynamic stability: Y
Finding/intervention? Oxygen therapy *
*** Newborn Level 1 ***
*** Transitional Care ***
Level of care: 2
Expected accomodation code: N2

Activity Date: 02/15/22 Time: 0043

4132203 Central & Foley Line Check + A 0005 CP
- Document 02/15/22 0043 LJR 02/15/22 0043 LJR
Lines present TODAY at 0001:
Urethral Catheter: N
Central Line: Y
Comment: RA PICC
Not sure? Consult the charge nurse or Infection Control.

Activity Date: 02/15/22 Time: 0605

1710105 End of Shift: NICU (Level of Care) + A BID 6A 6P CP
CritCare documents on paper except for POC, End of Shift Summary, and Education.
- Document 02/15/22 0605 LJR 02/15/22 0605 LJR
Newborn level of care? Day 2 ^ Discharge
===Episode Day 1===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
*** Newborn Level 1 ***
=== Episode Day 2-DC ===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
Hemodynamic stability: Y
Finding/intervention? Tube feeding *
*** Newborn Level 1 ***
*** Transitional Care ***
Level of care: 2
Expected accomodation code: N2

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: CU,7172-A

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Printed 02/21/22 at 0212

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Documented Units	From Change

Activity Date: 02/15/22 Time: 1145

4255001 I&O: Monitor + A MD
- Document 02/15/22 1145 KR 02/15/22 1145 KR
---Intake---
Type- EBM
Output
I&O Comment- Calories: 20

---Non-BCTA documented blood products---
(if on weight based drip)
Fluid Type
Drip Dose
At
IV Site
Amount
(ml)
<> COMPLEX OUTPUT <>
New
Total for
Cannister
Cannister
Document 02/15/22 1145 KR 02/15/22 1145 KR
---Intake---
Type- EBM
---Output---
I&O Comment Calories: 20

---Non-BCIA documented blood products---
(if on weight-based drip)
Fluid Type
Drip Dose
At
IV Site
Amount
(ml)
<> COMPLEX OUTPUT <>
New
Total for
Cannister
Cannister

Activity Date: 02/15/22 Time: 1745

4255001 I&O: Monitor + A MD
- Document 02/15/22 1745 KR 02/15/22 1745 KR
IntLake
Type- EBM
---Output---
I&O Comment- Calories: 20

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Documented Units	From Change

Activity Date: 02/15/22 Time: 1145 (continued)

4255001 I&O: Monitor + (continued)

---Non-BCIA documented blood products---
(if on weight-based drip)
Fluid Type
Drip Dose
At
IV Site
Amount
(ml)
<> COMPLEX OUTPUT <>
New
Total for
Cannister
Cannister

Activity Date: 02/15/22 Time: 1802

1/10105 End of Shift: NICU (Level of Care) + A BID 6A 6P CP
CritCare documents on paper except for POC, End of Shift Summary, and Education.
- Document 02/15/22 1802 KR 02/15/22 1802 KR
Newborn level of care? Day 2 ^ Discharge
===Episode Day 1===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
*** Newborn Level 1 ***
=== Episode Day 2-DC ===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
Hemodynamic stability: Y
Finding/intervention? Oxygen therapy *
*** Newborn Level 1 ***
*** Transitional Care ***
Level of care: 2
Expected accomodation code: N2

Activity Date: 02/15/22 Time: 1954

4255001 I&O: Monitor + A MD
- Document 02/15/22 1954 CSC 02/15/22 1954 CSC
IntLake
Type- EBM
---Output---
I&O Comment- Calories: 20

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: FU,7172-A

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Printed 02/21/22 at 0212

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Documented Units	From Change

Activity Date: 02/15/22 Time: 1954 (continued)

4255001 I&O: Monitor + (continued)

---Non-BCIA documented blood products---
(if on weight-based drip)
Fluid Type
Drip Dose
At
IV Site
Amount
(ml)
<> COMPLEX OUTPUT <>
New
Total for
Canister
Canister

Activity Date: 02/16/22 Time: 0232

4132203 Central & Foley Line Check + A 0005 CP
- Document 02/16/22 0232 CSC 02/16/22 0232 CSC
Lines present TODAY at 0001:
Urethral Catheter: N
Central Line: Y
Comment: PICC
Not sure? Consult the charge nurse or Infection Control.

Activity Date: 02/16/22 Time: 0633

1710105 End of Shift: NICU (Level of Care) + A BID 6A 6P CP
CritCare documents on paper except for POC. End of Shift Summary, and Education.
- Document 02/16/22 0633 CSC 02/16/22 0633 CSC
Newborn level of care? Day 2 ^ Discharge
===Episode Day 1===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
*** Newborn Level 1 ***
=== Episode Day 2-DC ===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
Hemodynamic stability: Y
Finding/intervention? Tube feeding *
*** Newborn Level 1 ***
*** Transitional Care ***
Level of care: 2

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Documented Units	From Change

Activity Date: 02/16/22 Time: 0633 (continued)

1710105 End of Shift: NICU (Level of Care) + (continued)
Expected accomodation code: N2

Activity Date: 02/16/22 Time: 0957

2200213 Nursing Miscellaneous Order A OC
Please heplock PICC. Thanks
- Create 02/16/22 0957 OAO 02/16/22 0957 OAO
2200503 RT: High Flow O2 C OF
Campus? C
Flow (LPM): 3 FiO2: 21 Wean FiO2 (Y/N): Y
Comments: Wean flow as tolerated
Fd Status 02/16/22 0957 JDF 02/16/22 0957 JDF A => C

Activity Date: 02/16/22 Time: 0958

5186455 ST: NICU PROGRESS NOTE+ A AS
- Create 02/16/22 0958 ENL 02/16/22 1022 ENL
- Document 02/16/22 0958 ENL 02/16/22 1022 ENL
SPEECH AND LANGUAGE PATHOLOGY
Date: 02/16/22
Time: 0958
By: EPI.ENL LEE.ERIKA N
Primary Therapist: EPT.ENL LEE.ERIKA N
Okay to reassign: Y
Physician's Orders: FEEDING CONSULT
Isolation? STANDARD
Isolation? STANDARD
as per Nursing
Resuscitation Directive: CPR/Full Resuscitation
Treatment Communications: HERM, SEIZURES. HAS A GOOD SUCK BUT TAKES A LOT OF PATIENCE
- TO GET HIM TO LATCH **ON NIV 2/13
Treatment Precautions: CONTACT
Treatment Units: SWATX, 97533
===TREATMENT PLAN===
Patient reassessed this visit? N
Type of feeder: Sick term
SLP only feeding? N
Plan to see patient M/TU/W/TH/F/SU
Until 02/18/22
when re assessment is due, for
- Feeding Skills
as per Nursing
===RECOMMENDATIONS===
1. PFFD 1X PER SHIFT OR WITH CUES
- 2. SLP WILL FOLLOW
Rx Time In: 0830
Time Out: 0900

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU.NICUF
Room/Bed: CU.7172-A

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Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Units	From Change

Activity Date: 02/16/22 Time: 0958 (continued)

5186455 ST: NICU PROGRESS NOTE+ (continued)
Current Medical Status: R/O SEPSIS. SEIZURES
Previous Medical History? NEWBORN
===PATIENT/CAREGIVER/INPUT/GOALS/CONCERNS===
Patient/Caregiver Comment rn agreeable to slp tx
Patient/Caregiver Goal: FOR INFANT TO BE OK
Pt/Caregiver Discharge Destination Goal: Home
=== PAIN ===
Pain Intensity: 0
===Outcome Measure===
Date
Score
===COGNITION/LANGUAGE===
Addressed Today: N
===SPEECH/ORAL MOTOR===
Addressed Today? Y
INFANT WAS IN HIS WARMER. SWADDLED AND ON RA. HE WAS HAND
- SWADDLED TO INTRO CARE. HE WAS NOTED TO BE SOMEWHAT IRRITABL
- BUT ABLE TO BE CONSOLED WITH HAND SWADDLING. HE WAS OFFERED
- GLOVED FINGER TO ASSESS ORAL CAVITY AND SUCK. ORAL CAVITY
WAS INTACT. HE WAS ABLE TO PRODUCE A STRONG SUCK ALMOST
- IMMEDIATELY.
- HE WAS ABLE TO PRODUCE A SUCK ON GLOVED FINGER.
- SUCK WAS STRONG. HE WAS TRANSITIONED TO SLP LAP IN UPRIGHT
AND MILK WAS OFFERED VIA SLOW FLOW NIPPLE. HE ROOTED AND
- LATCHED AND ESTABLISHED A STRONG NUTRITIVE SUCK. HE WAS ABLE
- TO TAKE 60CC IN ABOUT 20 MIN. HE HAD COUGHING X2.
Goal: SAFE, EFFICIENT PO FEEDING.
Target Date: 02/18/22
Progress Towards Goal: PROGRESSING
===DEGLUTITION===
Addressed Today: N
===SPEECH RECOMMENDATIONS FOR DIET===
Instructions
of nutrition and hydration needs without s/s of aspiration.
cueing in order for increase deglutition function.
cueing in order to reduce risk of aspiration.
===IMPRESSIONS===
- INFANT TOOK 60CC IN ABOUT 20 MIN. HE HAD MILD UPPER AIRWAY
- CONGESTION AND COUGHING X2.
Therapist Recommendation for discharge: Home
===Education===
Addressed Today: N
===PHYSICIAN NOTIFICATION===
Physician Name .DNK Does Not Know
Reason Notified? (free text if needed)
SPOKE WITH NNP REGARDING PLAN OF CARE
Medicare Patient that requires Certification form: N

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Units	From Change

Activity Date: 02/16/22 Time: 0958 (continued)

5186455 ST: NICU PROGRESS NOTE+ (continued)
Report needs to be reviewed and co-Signed? N

Activity Date: 02/16/22 Time: 1238

2200270 Neonatal Therapy (OT,PT) A OC
Neonatal Therapy-Occupational Therapy (OT), Physical Therapy (PT)
Precautions:
Other:
Gestational Age at Birth: 40
Evaluate and Treat? Y
Comments:
Anticipated discharge within 48 hours? N
- Create 02/16/22 1238 JDF 02/16/22 1238 JDF

Activity Date: 02/16/22 Time: 1801

1710105 End of Shift: NICU (Level of Care) + A BID 6A 6P CP
CritCare documents on paper except for
POC, End of Shift Summary, and
Education.
- Document 02/16/22 1801 CB 02/16/22 1801 CB
Newborn level of care? Day 2 ^ Discharge
===Episode Day 1===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
*** Newborn Level 1 ***
=== Episode Day 2 DC ===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
Hemodynamic stability: N
*** Newborn Level 1 ***
*** Transitional Care ***
- Document 02/16/22 1801 CB 02/16/22 1802 CB
Newborn level of care? Day 2 ^ Discharge
===Episode Day 1===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
*** Newborn Level 1 ***
=== Episode Day 2-DC ===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
Hemodynamic stability: Y
Finding/intervention? Tube feeding *

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN
Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: CU,7172-A

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Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Directions Documented Comment	Units	From Change

Activity Date: 02/16/22 Time: 1801 (continued)

1710105 End of Shift: NICU (Level of Care) + (continued)
*** Newborn Level 1 ***
*** Transitional Care ***
Level of care: 2
Expected accomodation code: N2

Activity Date: 02/16/22 Time: 2255

4132703 Central & Foley Line Check + A 0005 CP
- Document 02/16/22 2255 KJ 02/16/22 2255 KJ
Lines present TODAY at 0001:
Urethral Catheter: N
Central Line: N
Not sure? Consult the charge nurse or Infection Control.

Activity Date: 02/17/22 Time: 0436

1710105 End of Shift: NICU (Level of Care) + A BID 6A 6P CP
CritCare documents on paper except for POC, End of Shift Summary, and Education.
- Document 02/17/22 0436 KJ 02/17/22 0436 KJ
Newborn level of care? Day 2 ^ Discharge
===Episode Day 1===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
*** Newborn Level 1 ***
=== Episode Day 2 DC ===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
Hemodynamic stability: Y
Finding/intervention? Tube feeding *
*** Newborn Level 1 ***
*** Transitional Care ***
Level of care: 2
Expected accomodation code: N2

Activity Date: 02/17/22 Time: 0943

1001124 OT: NEONATE Evaluation + A AS
- Create 02/17/22 0943 TLM 02/17/22 1013 TLM
- Document Unve 02/17/22 0943 TLM 02/17/22 1013 TLM
===OCCUPATIONAL THERAPY===
Date: 02/17/22
Time: 0943
By: EPT.TLM2 MACKEY,TARRYN L

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Directions Documented Comment	Units	From Change

Activity Date: 02/1//22 Time: 0943 (continued)

1001124 OT: NEONATE Evaluation + (continued)
Physician's Orders: NICU OT/PT
Isolation? STANDARD
Resuscitation Directive: CPR/Full Resuscitation
Treatment Precautions: SEIZURE
Treatment Session: 0900
- 0945
Treatment Units: 97167
Religious/Cultural Concerns Integrated Into Patient's Treatment Plan: Y
Previous Functional Status? Dependent
Previous Home Environment? In Utero
Understands English: Yes
as per Nursing
Current Medical Status: 40WEEK AGA.SEIZURE DISODER(2/8),NEONATAL ENCEPHALOPATHY
- (2/16)
Previous Medical History? 20Y/O MOM.MECONIUM ASPIRATION.VAGINAL DELIVERY.
- .
- .
- APGARS 2/6//
Date of Birth 02/08/22
Gestational Age weeks: 40
Chronological Age weeks: 1
Postmenstrual Age weeks: 41
Birth Wt (grams): 3050
===PATIENT/CAREGIVER/INPUT/GOALS/CONCERNS===
Patient/Caregiver Comment- BETTY,RN OK'd OT EVAL.
Patient/Caregiver Goal- UNKNOWN-PARENTS NOT PRESENT
Pt/Caregiver Discharge Destination Goal: Home
==RESTRAINTS==Temporary release of restraints for therapeutic intervention: N
====PAIN====
Pain intensity: 0
Pain Scale Used? NIPS
Type of intervention containment
- SOOTHING VOICE
===ENVIRONMENT===
Bedspace: warmer
Respiratory support: room air
% of O2
Nutrition: NG
- PO(2X W/SLP)
Lines PICC
Location RUE
Positioning Aids nest
- DANDLEPAL
===DEVELOPMENTAL SKILLS===
Addressed Today? Y
Arousal Response: DELAYED AROUSAL RESPONSE
Behavioral State: Drowsy

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN
Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: CU,7172-A

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Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Directions Documented Units	From Change

Activity Date: 02/1//22 Time: 0943 (continued)

1001124 OT: NFONATF Fvaluation + (continued)
- Light Sleep
State transition: smooth
Attempts self regulation: Y
Comment: STRESS CUES W/ASSESSMENT/HANDLING
O: BABY DROWSY,SUPINE,IN SWADDLE SACK W/NEST BOUNDARY,IN WARMER,R HEAD
- TURN.RN STATES BABY AWOKE FOR FEEDING.RN COMPLETED ROC/PO FEED.RN
- STATES BABY COMPLETED ML GOAL.UNSWADDLED POSITION:BUE;B SHLDRS ADD'd
TRUNK,HANDS TOWARDS MIDLINE,FLEW's FLEXED~90*,B WRISTS REST IN FLEX.
- SLIGHT PALMAR THUMB,BLE;B HIPS ABD^GRAVITY,KNEES 90-110* FLEX,NEUTRAL
- ANKLES,STATE:BABY PRESENTED W/LOW ALERTING STATE DESPITE NEONATOLOGY
- ENTERING&HANDLING BABY,BABY CONT'd*PRESENT W/LOW ALERTING STATE UNTIL
GALLANT REFLEX,VISION:BABY DID OPEN EYES W/TIMF/AUDITORY STIM&HANDING
- .FORWARD GAZE,SUPP SIT:TOL SITTING WELL W/MAX A FOR HEAD/TRUNK SUPP.
- GOOD WOB,VSS,IOL~3MIN,AT END OF OT EVAL BABY SLEEPING,SUPINE....
Pre Therapy
During Therapy
Post Therapy
HR 115
: Stable
: 134
Respirations 55
: Stable
: 60
% 02 sat: 98
: Stable
: 99
===MOVEMENTS & REFLEXES===
Addressed Today? Y
MOVEMENTS
Spontaneous Movement- MINIMAL BUE/BLE MVMT WHEN AGAINST GRAVITY
Abnormal hand/toe postures- B WRIST FLEX^GRAVITY
Startle ~3STARTLES
PRIMITIVE REFLEXES
Root Y
Suck Y
Palmar grasp R Y
L Y
Plantar grasp R Y
L Y
Babinski R Y
L Y
Galant R Y
L Y
Comment ALL REFLEXES WERE DELAYED&WEAK.
ORIENTATION AND BEHAVIOR
Eyes: EYES OPENED S/P PROLONGED ALERTING TECH.
Auditory Orientation: MIN ALERTING TOWARD AUDITORY STIM NOTED

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Directions Documented Units	From Change

Activity Date: 02/1//22 Time: 0943 (continued)

1001124 OT: NFONATF Fvaluation + (continued)
Peak of excitement: REMAINED LOW ALERTING DESPITE HANDLING/POSITION CHANGES/
Consolability: AUDITORY STIM. EASILY CONSOLED W/CONTAINMENT.
O: ...
===NEURO===
===COORDINATION===
===ORAL MOTOR===
====MUSCULOSKELETAL====
cm
cm
cm
cm
cm
===ROM===
===SKIN INSPECTION===
===SPLINTING===
Straps should be loose enough for you to put one finger under.
Precautions: look for skin breakdown. remove splint if redness noted
if redness still present after 15 minutes leave splint off and
Keep splint away from high heat
to don/doff appropriately.
Splint used to protect, immobilize or facilitate use body part.
===Orthotics===
===CAR SEAT===
Current
Height -
Family will verbalize & demonstrate understanding of securing baby in seat
Family will verbalize & demonstrate understanding of installing base in
===ASSESSMENT===
smooth state changes from deep sleep through quiet alert
by 40 weeks post menstrual age.
Autonomic stability to allow further eval of neuromuscular maturation.
head turn to L & R with age appropriate ROM
head deformity through conservative management
skin to skin holding to facilitate/prepare for
skin to skin holding to facilitate/prepare for
===Education===
===TREATMENT PLAN===
when re-assessment is due, for
===SPLINTING TREATMENT PLAN===
when re assessment is due for
===PHYSICIAN NOTIFICATION===
Communication:
- Document Ver 02/17/22 0943 TLM 02/17/22 1734 TLM
====OCCUPATIONAL THERAPY====
Date: 02/17/22
Time: 0943
By: EPT,TLM2 MACKEY,TARRYN L

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN
Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: CU,7172-A

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Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Units	From Change

Activity Date: 02/1/22 Time: 0943 (continued)

1001124 OT: NEONATF Evaluation + (continued)
Physician's Orders: NICU OT/PT
Isolation? STANDARD
Resuscitation Directive: CPR/Full Resuscitation
Treatment Precautions: SEIZURE
Treatment Session: 0900
- 094b
Treatment Units: 97167
Religious/Cultural Concerns Integrated Into Patient's Treatment Plan: Y
Previous Functional Status? Dependent
Previous Home Environment? In Utero
Understands English: Yes
as per Nursing
Current Medical Status: 40WEEK AGA,SEIZURE DISORDER(2/8),NEONATAL ENCEPHALOPATHY
- (2/16)
Previous Medical History? 20Y/O MOM,MECONIUM ASPIRATION,VAGINAL DELIVERY.
- .
- .
- APGARS 2/6/7
Date of Birth 02/08/22
Gestational Age weeks: 40
Chronological Age weeks: 1
Postmenstrual Age weeks: 41
Birth Wt (grams): 3050
===PATIENT/CAREGIVER/INPUT/GOALS/CONCERNS===
Patient/Caregiver Comment- BETTY,RN OK'd OT EVAL.
Patient/Caregiver Goal- UNKNOWN-PARENTS NOT PRESENT
Pt/Caregiver Discharge Destination Goal: Home
==RESTRAINTS==Temporary release of restraints for therapeutic intervention: N
====PAIN====
Pain Intensity: 0
Pain Scale Used? NIPS
Type of intervention comfainment
- SOOTHING VOICE
===ENVIRONMENT===
Bedspace: warmer
Respiratory support: room air
% of O2
Nutrition: NG
- PO(2X W/SLP)
Lines PICC
Location RUE
Positioning Aids nest
- DANDLEPAL
===DEVELOPMENTAL SKILLS===
Addressed Today? Y
Arousal Response: DELAYED AROUSAL RESPONSE
Behavioral State: Drowsy

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Units	From Change

Activity Date: 02/1/22 Time: 0943 (continued)

1001124 OT: NEONATF Evaluation + (continued)
- Light Sleep
State transition: smooth
Attempts self regulation: Y
Comment: STRESS CUES W/ASSESSMENT/HANDLING
O: BABY DROWSY,SUPINE,IN SWADDLE SACK W/NEST BOUNDARY,IN WARMER,R HEAD
- TURN,RN STATES BABY AWOKE FOR FEEDING,RN COMPLETED HOC/PO FEED,RN
- STATES BABY COMPLETED ML GOAL,UNSWADDLED POSITION:BUE;B SHLDRS ADD'd
TRUNK,HANDS TOWARDS MIDLINE,FLEW's FLEXED~90*,B WRISTS REST IN FLEX.
- SLIGHT PALMAR THUMB,BLE;B HIPS ABD*GRAVITY,KNEES 90-110* FLEX,NEUTRAL
- ANKLES,STATE;BABY PRESENTED W/LOW ALERTING STATE DESPITE NEONATOLOGY
- ENTERING&HANDLING BABY,BABY CONT'd*PRESENT W/LOW ALERTING STATE UNTIL
GALLANT REFLEX,VISION:BABY DID OPEN EYES W/TIME/AUDITORY STIM&HANDING
- .FORWARD GAZE,SUPP SIT:TOL SITTING WELL W/MAX A FOR HEAD/TRUNK SUPP.
- GOOD WOB,VSS,TOL~3MIN,AT END OF OT EVAL BABY SLEEPING,SUPINE....
Pre Therapy
During Therapy
Post Therapy
HR 115
: Stable
: 134
Respirations 55
: Stable
: 60
% O2 sat: 98
: Stable
: 99
===MOVEMENTS & REFLEXES===
Addressed Today? Y
MOVEMENTS
Spontaneous Movement- MINIMAL BUE/BLE MVMT WHEN AGAINST GRAVITY
Abnormal hand/toe postures- B WRIST FLEX*GRAVITY
Startle ~3STARTLES
PRIMITIVE REFLEXES
Root Y
Suck Y
Palmar grasp R Y
L Y
Plantar grasp R Y
L Y
Babinski R Y
L Y
Galant R Y
L Y
Comment ALL REFLEXES WERE DELAYED&WEAK.
ORIENTATION AND BEHAVIOR
Eyes: EYES OPENED S/P PROLONGED ALERTING TECH.
Auditory Orientation: MIN ALERTING TOWARD AUDITORY STIM NOTED

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: FU,7172-A

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Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Directions Documented Units	From Change

Activity Date: 02/1/22 Time: 0943 (continued)

1001124 OT: NFONATF Evaluation + (continued)
Peak of excitement: REMAINED LOW ALERTING DESPITE HANDLING/POSITION CHANGES/
Consolability: AUDITORY STIM. EASILY CONSOLED W/CONTAINMENT.
O: ...IN SWADDLE SACK&NEST.RN PRESENT.VSS.
===NEURO===
Addressed Today? Y
POSTURE: SEE O
ARM RECOIL: ARMS FLEX SLOWLY.NOT ALWAYS:NOT COMPLETELY
ARM TRACTION: ARMS FLEX SLIGHTLY OR SOME RESISTANCE FELT
LEG RECOIL: INCOMPLETE FLEX/STARTLES
LEG TRACTION: LEGS FLEX SLIGHTLY OR SOME RESISTANCE FELT
POPLITEAL ANGLE: ~110*
HEAD CONTROL (1): INFANT TRIES:EFFORT BETTER FELT THAN SEEN
===COORDINATION===
Addressed Today? N
===ORAL MOTOR===
Addressed Today? Y
Oral Motor: Sucking non nutritive: Continuous Cues
Oral Reflexes: + root
- + suck
O: BABY DID NOT ROOT TO GLOVED FINGER HOWEVER ROOTED^PACI/OTHER
- OM STIM.BABY DID NOT DEMO COMPLETE LATCH;BABY DID PRESENT
- W/BILLING ON PACI.
====MUSCULOSKELETAL====
Addressed Today? Y
cm
cm
cm
cm
cm
O: MIN R POSTERIOR FLATTENING NOTED.
===ROM===
GENERAL LOW TONE NOTED.
===SKIN INSPECTION===
Addressed Today? N
===SPLINTING===
Addressed Today? N
Straps should be loose enough for you to put one finger under.
Precautions: look for skin breakdown, remove splint if redness noted
If redness still present after 15 minutes leave splint off and
Keep splint away from high heat
to don/doff appropriately.
Splint used to protect, immobilize or facilitate use body part.
===Orthotics===
Orthotic Device In Use? N
===CAR SEAT===
Addressed Today? N
Current

1001124 OT: NFONATF Evaluation + (continued)
Height -
Family will verbalize & demonstrate understanding of securing baby in seat
Family will verbalize & demonstrate understanding of installing base in
===ASSESSMENT===
- BABY TOL OT EVAL WELL.REMAINED LOW ALERTING/W/LOW TONE.REC CONT OT TO
- ADDRESS STRESS IN BABY.DEV.PARENT EDU.OM SKILLS.HANDLING TOL.GENERAL
- STRENGTHENING,HEAD SHAPE&POSITIONING.
State & Self Regulation Goals Addressed Today: Y
* Baby will demonstrate
quiet alert state x 5 min while being held
To facilitate/prepare for developmental growth
Target Date: 02/24/22
* Baby will demonstrate
smooth state changes from deep sleep through quiet alert
To facilitate/prepare for developmental growth
by 40 weeks post menstrual age.
* Baby will demonstrate
- 3
- SELF SOOTHING SKILLS
To facilitate/prepare for developmental growth
Target Date: 02/24/22
* Parent will demonstrate
- ALERTING/CALMING TECH
APPROP^BABY's STATE
To facilitate/prepare for safe care at home
Target Date: 02/24/22
Sensory & Motor Development Goals Addressed Today: Y
* Baby will demonstrate
Autonomic stability to allow further eval of neuromuscular maturation.
Target Date: 02/24/22
* Baby will demonstrate
head turn to L & R with age appropriate ROM
to facilitate/prepare for developmental growth
Target Date: 02/24/22
* Baby will demonstrate
neutral alignment w/supp
- W/SUPP FROM CAREGIVERS/POSITIONERS
to facilitate/prepare for neurodevel/jnt alignment
Target Date: 02/24/22
* Baby will demonstrate
- SMOOTH STATE AROUSAL W/
- VESTIBULAR STIM W/O MOTOR STRESS CUES
to facilitate/prepare for developmental growth
Target Date: 02/24/22
* Baby will tolerate
- therapeutic handling
- W/AT LEAST 5MIN QUIET ALERT STATE

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN
Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: FU,7172-A

BLUE,BB-IAIUM

OU Medical Center NUR **Live**
CLINICAL DOCUMENTATION RECORD IPT

Printed 02/21/22 at 0212

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Documented Units	From Change

Activity Date: 02/1//22 Time: 0943 (continued)

1001124 OT: NFONATF FvaluaLion + (conLinued)
to facilitate/prepare for developmental growth
Target Date: 02/24/22
Baby to exhibit improved head shape to no
head deformity through conservative management
to facilitate/prepare for neurodevel/jnt alignment
Target Date: 02/24/22
Pre-Feeding & Feeding Goals Addressed Today: Y
* Baby will demonstrate
- ROOTˆSTIM 2/3 ATTEMPTS
- OF FACILLIATION
to facilitate/prepare for oral/motor development
Target Date: 02/24/22
* Baby will tolerate
- intra oral stim
- W/NO MORE THAN MIN INC IN STRESS CUES
to facilitate/prepare for oral/motor development
Target Date: 02/24/22
Skin to Skin Holding Addressed Today: Y
* Parent will demonstrate
Transfer techniques for
skin to skin holding to facilitate/prepare for
neurodevelopmental/parent bonding. Target Date 02/24/22
skin to skin holding to facilitate/prepare for
===Education===
Addressed Today? Y
Preferred Learning Method? ALL
Educational Needs(s)? DEVELOPMENTAL
FXERCISF
- SAFETY
- POSITIONING
Patient/Support Person Ready to Learn: Y
Identified Barriers to Learning? NO FAMILY AVAILABLE
Instructions Given Regarding- PROCESS OF EVAL
Person Taught? NURSE
Method Used? VERBAL
Evaluation? VERBALIZED UNDERSTANDING
===TREATMENT PLAN===
Plan to see patient NICU:3X/WK
Until 02/24/22
when re assessment is due, for
- ADL
- Activity tolerance
- Developmental Therapy
Exercise
- Neurodevelopment
- Patient/Family Education
- Positioning

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Documented Units	From Change

Activity Date: 02/1//22 Time: 0943 (continued)

1001124 OT: NFONATF FvaluaLion + (conLinued)
- Safety
This patient is appropriate for a COTA to work with at this time: N
===SPLINTING TREATMENT PLAN===
when re assessment is due for
===PHYSICIAN NOTIFICATION===
OT Communication: "PARKER" 8-11-2 41AGA
- ,
LOW ALERTING,LOW TONF,SFIZURF DISORDFR
- ,
- OT:1/
Communication:
Goal Prognosis? Good
Report needs to be reviewed and co-signed? N

Activity Date: 02/17/22 Time: 1523

5186455 ST: NICU PROGRESS NOTE+ A AS
- Document 02/17/22 1523 JKS 02/17/22 1541 JKS
SPEECH AND LANGUAGE PATHOLOGY
Date: 02/17/22
Time: 0958
By: EPM,JKS SIMON,JOHANNA K
Primary Therapist: EPT,ENL LEE,ERIKA N
Okay to reassign: Y
Physician's Orders: FEEDING CONSULT
Isolation? STANDARD
Isolation? STANDARD
as per Nursing
Resuscitation Directive: CPR/Full Resuscitation
Treatment Communications: FBRM. SEIZURES. HAS A GOOD SUCK BUT TAKES A LOT OF PATIENCE
- TO GET HIM TO LATCH **ON NIV 2/13
Treatment Precautions: CONTACT
Treatment Units: SWATX
===TREATMENT PLAN===
Patient reassessed this visit? N
Type of feeder: Sick Term
SLP only feeding? N
Plan to see patient M/TU/W/TH/F/SU
Until 02/18/22
when re assessment is due, for
- Feeding Skills
as per Nursing
===RECOMMENDATIONS===
1. FFFD 1X PFR SHIFT OR WITH CUFS
- 2. SLP WILL FOLLOW
Rx Time In: 1430
Time Out: 1500

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN
Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU.NICUF
Room/Bed: CU.7172-A

BLUE.BB-TAIUM

OU Medical Center NUR **Live**
CLINICAL DOCUMENTATION RECORD (IP)

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Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Directions Documented Units	From Change

Activity Date: 02/1//22 Time: 1523 (continued)

5186455 ST: NICU PROGRESS NOTE+ (continued)
Current Medical Status: R/O SEPSIS. SEIZURES
Previous Medical History? NEWBORN
==PATIENT/CAREGIVER/INPUT/GOALS/CONCERNS==
Patient/Caregiver Comment PARENTS AND RN AGREEABLE TO SLP TX.
Patient/Caregiver Goal: FOR INFANT TO EAT WELL
Pt/Caregiver Discharge Destination Goal: Home
=== PAIN ===
Pain Intensity: 0
==Outcome Measure==
Date
Score
==COGNITION/LANGUAGE==
Addressed Today: N
==SPEECH/ORAL MOTOR==
Addressed Today? Y
INFANT WAS QUIETLY ALERT LYING ON HIS WARMER SUCKING ON
- HIS PACIFIER. INFANT TRANSITIONED WELL TO MOTHER'S ARMS.
- MOTHER PLACED INFANT IN SLIGHTLY RECLINED POSITIONING.
- INFANT WAS OFFERED 67CC OF FORMULA VIA SLOW FLOW NIPPLE.
INFANT EASILY ROOTED TO THE NIPPLE. HE HAD UNORGANIZED SUCK
- BURSTS WITH POOR EXPRESSION. SLP ASSISTED MOTHER W/NIPPLE
- PLACEMENT (NIPPLE UNDER INFANT'S TONGUE). INFANT HAD STRONG
- LATCH ONCE RELATCHED TO THE NIPPLE. HE HAD STRONG EFFICIENT
SUCK BURSTS. INFANT HAD SOME GULPING WITH CONSECUTIVE SUCK
- BURSTS. SLP ASSISTED MOTHER W/ PLACING INFANT IN UPRIGHT
- POSITIONING AND OFFERING EXTERNAL PACING. INFANT HAD
- IMPROVED S/S/B COORDINATION. HE CONSUMED 67CC IN ~20 MIN.
INFANT HAD OCCASIONAL TACHYPNEA WITH JUMPS IN RR TO 70'S. HE
- WAS ABLE TO SELF PACE DURING THESE TIMES. INFANT WAS LEFT
- IN MOTHER'S ARMS AND RN NOTIFIED.
Goal: SAFE, EFFICIENT PO FEEDING.
Target Date: 02/18/22
Progress Towards Goal: PROGRESSING
==DEGLUTITION==
Addressed Today: N
==SPEECH RECOMMENDATIONS FOR DIET==
Instructions
of nutrition and hydration needs without s/s of aspiration.
cueing in order for increase deglutition function.
cueing in order to reduce risk of aspiration.
==IMPRESSIONS==
- INFANT TOOK 67CC IN ABOUT 20 MIN. HE SOME GULPING AT
- BEGINNING OF FEEDING THAT IMPROVED W/POSITIONING CHANGE AND
PACING.
Therapist Recommendation for discharge: Home
==Education==
Addressed Today: Y

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Directions Documented Units	From Change

Activity Date: 02/1//22 Time: 1523 (continued)

5186455 ST: NICU PROGRESS NOTE+ (continued)
Preferred Learning Method? ALL
Educational Needs(s)? FEEDING TECHNIQUES
Patient/Support Person Ready to Learn: Y
Identified Barriers to Learning? NONE
Instructions Given Regarding- POSITIONING FOR PO FEEDING
- EXTERNAL PACING AS NEEDED
Person Taught? PARENTS
Method Used? VERBAL
Evaluation? VERBALIZED UNDERSTANDING
==RESTRAINTS==temporary release of restraints for therapeutic intervention: N
==PHYSICIAN NOTIFICATION==
Medicare Patient that requires Certification form: N
Report needs to be reviewed and co-Signed? N

Activity Date: 02/17/22 Time: 1524

Patient Notes: CHILD LIFE NOTES
- Create 02/17/22 1524 RB 02/17/22 1529 RB

LATE ENTRY FROM 2/16/22

Child Life Note:

PL recently admitted to NICU with need for cooling. Per team, pt arrived too late to begin cooling protocols.

CCLS introduced self and services to pt's father, Anthony, at bedside. FOP verbalized that they were settling in to routine and life as NICU parents. CCLS validated the transition period and asked FOP how MOP is doing. CCLS asked about other children which FOP denied. CCLS provided FOP with CCLS's work number for times FOP and MOP have needs or questions. CCLS to continue supporting family and pt throughout admission.

Later, CCLS received message from FOP regarding MOP's concern that CCLS was sent by team to meet parents because something had changed in "pt's condition" or that "patient would not make it". CCLS followed up with parents and validated the fear/concern but reassured family that Child Life Specialists support all NICU families in various ways. CCLS did pass this along to team so they could be aware of family's fear/apprehension towards pt's status.

This CCLS to continue following pt and family. Questions.
Rachel Burnett, MS, CCLS
Certified Child Life Specialist
405 436 2321

Note Type	Description
No Type	None

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: FU,7172-A

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Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Documented Units	From Change

Activity Date: 02/17/22 Time: 1631

1710105 End of Shift: NICU (Level of Care) + CritCare documents on paper except for POC, End of Shift Summary, and Education. — A BID 6A 6P — CP

Document 02/17/22 1631 PXN 02/17/22 1631 PXN

Newborn level of care? Day 2 ^ Discharge
===Episode Day 1===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
*** Newborn Level 1 ***
=== Episode Day 2-DC ===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
Hemodynamic stability: Y
Finding/intervention? Tube feeding *
*** Newborn Level 1 ***
*** Transitional Care ***
Level of care: 2
Expected accomodation code: N2

Activity Date: 02/17/22 Time: 1734

2700182 Occupational Therapy — A — OF
- ADL - Exercise - Positioning
- Activity tolerance - Neurodevelopment - Safety
- Developmental Therapy - Patient/Family Education
Plan to see patient NICU:3X/WK UnTil 02/24/22 Campus? C

- Create 02/17/22 1734 TLM 02/17/22 1735 TLM

Diagnosis: OI: PATIENT/CAREGIVER EDUCATION — A
- Create 02/17/22 1734 TLM 02/17/22 1734 TLM

Goal: REHAB: PL/caregiver will verbalize and or demonstrate understanding, competence, and or confidence in providing safe, effective rehab techniques,appropriate to the patient's individual education needs as described documented in therapy eval & progress — A
- Create 02/17/22 1734 TLM 02/17/22 1734 TLM

1002020 OT Initial Segment + — A — CP
- Create 02/17/22 1734 TLM 02/17/22 1734 TLM

6265150 OI: Progress Note+ — A — CP
- Create 02/17/22 1734 TLM 02/17/22 1734 TLM

6265178 OT: PL/Family Instruction — A — CP
- Create 02/17/22 1734 TLM 02/17/22 1734 TLM

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Documented Units	From Change

Activity Date: 02/1//22 Time: 1/34

Diagnosis: OT: FFFDING DIFFICULTIFS — A
- Create 02/17/22 1734 TLM 02/17/22 1734 TLM

Goal: REHAB: to ensure safe and adequate nutritional intake by discharge appropriate for patient's age and or disease process. — A
- Create 02/1//22 1/34 ILM 02/1//22 1/34 ILM

Diagnosis: REHAB: ROM & MM PERFORMANCE — A
Create 02/17/22 1734 TIM 02/17/22 1734 TIM

Goal: REHAB: With skilled Therapy intervention patient's ROM and MM performance will be improved to allow maximized function as described in the individualized treatment goals and interventions documented in therapy eval & progress notes — A
Create 02/17/22 1734 TLM 02/17/22 1734 TLM

Activity Date: 02/1//22 Time: 2231

4132203 Central & Foley line Check + — A 0005 — CP
- Document 02/17/22 2231 KJ 02/17/22 2231 KJ

Lines present TODAY at 0001:
Urethral Catheter: N
Central line: Y
Not sure? Consult the charge nurse or Infection Control.

Activity Date: 02/18/22 Time: 0431

1710105 End of Shift: NICU (Level of Care) + CritCare documents on paper except for POC, End of Shift Summary, and Education. — A BID 6A 6P — CP
- Document 02/18/22 0431 KJ 02/18/22 0431 KJ

Newborn level of care? Day 2 ^ Discharge
===Episode Day 1===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
*** Newborn Level 1 ***
=== Episode Day 2 DC ===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
Hemodynamic stability: Y
Finding/intervention? PO feeding initiated <=3d
*** Newborn Level 1 ***
*** Transitional Care ***

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN
Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: FU,7172-A

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Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Directions Documented Comment	Units	From Change
Activity Date: 02/18/22 Time: 0431 (continued)									
1710105 End of Shift: NICU (level of Care) + (continued)									
Level of care: 2									
Expected accomodation code: N2									
Activity Date: 02/18/22 Time: 1041									
2200213 Nursing Miscellaneous Order							C		OE
Please heplock PICC. Thanks									
Ed Status	02/18/22	1041	CMK	02/18/22	1041	CMK			A => C
Activity Date: 02/18/22 Time: 1056									
2200213 Nursing Miscellaneous Order							A		OF
please discontinue PICC line									
- Create	02/18/22	1056	CMK	02/18/22	1056	CMK			
Activity Date: 02/18/22 Time: 1202									
1904/50 NBN Hearing Screen Results +							A		AS
- Create	02/18/22	1202	MOB	02/18/22	1202	MOB			
Document	02/18/22	1202	MOB	02/18/22	1202	MOB			
Hearing Screen Type Discharge: Automated Auditory Brain									
Hearing Screen Discharge: Hearing Screen Left-Pass									
Hearing Screen Rght-Pass									
Hearing Screen Date: 02/18/22									
Hearing Screen Time: 1202									
Activity Date: 02/18/22 Time: 1221									
6265153 OT: Neonate Progress Note+							A		AS
- Create	02/18/22	1221	TLM	02/18/22	1230	TLM			
- Document Unve	02/18/22	1221	TLM	02/18/22	1230	TLM			
====OCCUPATIONAl THERAPY====									
Date: 02/18/22									
Time: 1221									
By: EPT,TLM2 MACKEY,TARRYN L									
Physician's Orders: NICU OT/PT									
Isolation? STANDARD									
Resuscitation Directive: CPR/Full Resuscitation									
Treatment Precautions: SEIZURE									
Treatment Session: 1200									
- 1217									
Treatment Units: ADLI 1									
Understands English: Yes									
as per Nursing									
Current Medical Status: R/O SEPSIS. SCIUZURES									
- (2/16)									
Previous Medical History? NEWBORN									

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Directions Documented Comment	Units	From Change
Activity Date: 02/18/22 Time: 1221 (continued)									
6265153 OT: Neonate Progress Note+ (continued)									
- .									
- .									
- APGARS 2/6/7									
Date of Birth 02/08/22									
Gestational Age weeks: 40									
Chronological Age weeks: 1									
Postmenstrual Age weeks: 41									
Birth WL (grams): 3050									
===PATIENT/CAREGIVER/INPUT/GOALS/CONCERNS===									
Patient/Caregiver Comment- BREANNA,RN&MOM OK'd OT IX.									
Patient/Caregiver Goal- UNKNOWN-PARENTS NOT PRESENT									
PL/Caregiver Discharge Destination Goal: Home									
==RESTRAINTS==Temporary release of restraints for therapeutic intervention: N									
====PAIN====									
Pain intensity: 0									
Pain Scale Used? NIPS									
Type of intervention- containment									
- SOOTHING VOICE									
===ENVIRONMENT===									
Bedspace: bassinet									
Respiratory support: room air									
% of O2									
Nutrition: NG									
PO									
Positioning Aids nest									
- DANDLEPAL									
===DEVELOPMENTAL SKILLS===									
Addressed Today? Y									
Arousal Response: DELAYED AROUSAL RESPONSE									
Behavioral State: Drowsy									
- Light Sleep									
State Transition: smooth									
Attempts self regulation: Y									
Pre Therapy									
During Therapy									
Post Therapy									
===NEURO===									
Addressed Today? N									
===COORDINATION===									
Addressed Today? N									
===ORAL MOTOR===									
Addressed Today? Y									
Oral Motor: Sucking non nutritive: With in normal limits									
Oral Reflexes: + rool									
- + suck									
====MUSCULOSKELETAL====									
Addressed Today? Y									

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN
Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: CU,7172-A

BLUE,BB-IAIUM

OU Medical Center NUR **Live**
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Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Directions Documented Units	From Change

Activity Date: 02/18/22 Time: 1221 (continued)

6265153 OT: Neonate Progress Note+ (continued)
Measurements: Length 12.00
cm
Width: 10.00
cm
cm
Lsci: 11.00
cm
Rsci: 11.50
cm
Date measured: 02/18/22
O: MILD R PLAGIO.DISCUSSED HEAD SHAPE&INTERVENTIONS^ENCOURAGE APPROP HEAD SHAPE W/MOM.
===ROM===
===SKIN INSPECTION===
Addressed Today? N
===SPLINTING===
Addressed Today? N
Straps should be loose enough for you to put one finger under.
Precautions: look for skin breakdown, remove splint if redness noted
If redness still present after 15 minutes leave splint off and
Keep splint away from high heat
to don/doff appropriately.
Splint used to protect, immobilize or facilitate use body part.
===Orthotics===
Orthotic Device In Use? N
===CAR SEAT===
Addressed Today? N
Current
Height -
Family will verbalize & demonstrate understanding of securing baby in seat
Family will verbalize & demonstrate understanding of installing base in
State & Self Regulation Goals Addressed Today: Y
* Baby will demonstrate
quiet alert state x 5 min while being held
To facilitate/prepare for developmental growth
Target Date: 02/24/22
Progress Towards Goal: PROGRESSING
* Baby will demonstrate
smooth state changes from deep sleep through quiet alert
To facilitate/prepare for developmental growth
by 40 weeks post menstrual age.
Progress Towards Goal: PROGRESSING
* Baby will demonstrate
3
- SELF SOOTHING SKILLS
to facilitate/prepare for developmental growth
Target Date: 02/24/22

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Directions Documented Units	From Change

Activity Date: 02/18/22 Time: 1221 (continued)

6265153 OT: Neonate Progress Note+ (continued)
Progress Towards Goal: PROGRESSING
* Parent will demonstrate
- ALERTING/CALMING TECH
APPROP^BABY's STATE
To facilitate/prepare for safe care at home
Target Date: 02/24/22
Progress Towards Goal: PROGRESSING
Sensory & Motor Development Goals Addressed Today: Y
* Baby will demonstrate
Autonomic stability to allow further eval of neuromuscular maturation.
Target Date: 02/24/22
Progress Towards Goal: PROGRESSING
* Baby will demonstrate
head turn to L & R with age appropriate ROM
to facilitate/prepare for developmental growth
Target Date: 02/24/22
Progress Towards Goal: PROGRESSING
* Baby will demonstrate
- neutral alignment w/supp
W/SUPP FROM CAREGIVERS/POSITIONERS
to facilitate/prepare for neurodevel/jnt alignment
Target Date: 02/24/22
Progress Towards Goal: PROGRESSING
* Baby will demonstrate
- SMOOTH STATE AROUSAL W/
- VESTIBULAR STIM W/O MOTOR STRESS CUES
to facilitate/prepare for developmental growth
Target Date: 02/24/22
Progress Towards Goal: PROGRESSING
* Baby will tolerate
- therapeutic handling
W/AT LEAST 5MIN QUIET ALERT STATE
to facilitate/prepare for developmental growth
Target Date: 02/24/22
Progress Towards Goal: PROGRESSING
Baby to exhibit improved head shape to no
head deformity through conservative management
to facilitate/prepare for neurodevel/jnt alignment
Target Date: 02/24/22
Progress Towards Goal: PROGRESSING
Pre-Feeding & Feeding Goals Addressed Today: Y
* Baby will demonstrate
- ROOT^STIM 2/3 ATTEMPTS
OF FACILITATION
to facilitate/prepare for oral/motor development
Target Date: 02/24/22
Progress Towards Goal: PROGRESSING

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN
Attending: Bergner,Erynn MD
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Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Directions Documented Units	From Change

Activity Date: 02/18/22 Time: 1221 (continued)

6265153 OT: Neonate Progress Note+ (continued)
* Baby will tolerate
- intra oral stim
- W/NO MORE THAN MIN INC IN STRESS CUES
to facilitate/prepare for oral/motor development
Target Date: 02/24/22
Progress towards Goal: PROGRESSING
Skin to Skin Holding Addressed Today: Y
* Parent will demonstrate
- transfer techniques for
skin to skin holding to facilitate/prepare for
neurodevelopmental/parent bonding. Target Date 02/24/22
Progress Towards Goal: PROGRESSING
skin to skin holding to facilitate/prepare for
===ASSESSMENT===
- BABY TOL OT TX WELL,REC CONT OT TO ADDRESS STRESS IN BABY,DEV,PARENT
FDU,OM SKILLS,HANDLING TOL,PARENT FDU,HEAD SHAPE
===Education===
Addressed today? Y
Preferred Learning Method? ALL
Educational Needs(s)? FEEDING TECHNIQUES
- EXERCISE
- SAFETY
- POSITIONING
Patient/Support Person Ready to Learn: Y
Identified Barriers to Learning? NO FAMILY AVAILABLE
Instructions Given Regarding- OT POC
- HEAD SHAPE
Person Taught? MOTHER
- NURSE
Method Used? VERBAL
- VERBAL
Evaluation? VERBALIZED UNDERSTANDING
- VERBALIZED UNDERSTANDING
===TREATMENT PLAN===
Plan to see patient NICU:3X/WK
Until 02/24/22
when re-assessment is due. for
- ADL
- Activity Tolerance
Developmental Therapy
- Exercise
- Neurodevelopment
- Patient/Family Education
Positioning
- Safety
this patient is appropriate for a COTA to work with at this time: N
===SPLINTING TREATMENT PLAN===

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Directions Documented Units	From Change

Activity Date: 02/18/22 Time: 1221 (continued)

6265153 OT: Neonate Progress Note+ (continued)
when re-assessment is due for
===PHYSICIAN NOTIFICATION===
OT Communication: "PARKER" 8-11-2 41AGA
- .
- LOW ALERTING,LOW TONE,SEIZURE DISORDER
- .
- OT:17, 18
Goal Prognosis? Good
Report needs to be reviewed and co-signed? N
- Document Ver 02/18/22 1221 ILM 02/18/22 1601 ILM
===OCCUPATIONAL THERAPY===
Date: 02/18/22
Time: 1221
By: EPI,ILM2 MACKEY,TARRYN L
Physician's Orders: NICU OT/PT
Isolation? STANDARD
Resuscitation Directive: CPR/Full Resuscitation
Treatment Precautions: SEIZURE
Treatment Session: 1200
1217
: 1230
- 1254
Treatment Units: ADLT 1, FUNCA 1, TE 1
Understands English: Yes
as per Nursing
Current Medical Status: R/O SEPSIS, SEIZURES
- (2/16)
Previous Medical History? NEWBORN
- .
- .
- APGARS 2/6/7
Date of Birth 02/08/22
Gestational Age weeks: 40
Chronological Age weeks: 1
Postmenstrual Age weeks: 41
Birth Wt (grams): 3050
===PATIENT/CAREGIVER/INPUT/GOALS/CONCERNS===
Patient/Caregiver Comment- BREANNA,RNMOM OK'd OT TX.
Patient/Caregiver Goal- UNKNOWN-PARENTS NOT PRESENT
PL/Caregiver Discharge Destination Goal: Home
==RESTRAINTS==Temporary release of restraints for therapeutic intervention: N
====PAIN====
Pain intensity: 0
Pain Scale Used? NIPS
Type of intervention- containment
- SOOTHING VOICE
===ENVIRONMENT===

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: CU,7172-A

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CLINICAL DOCUMENTATION RECORD IIPI

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Diagnosis/Goal/Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Units	From Change
Activity Date: 02/18/22 Time: 1221 (continued)										

6265153 OT: Neonate Progress Note+ (continued)
Bedspace: bassinet
Respiratory support: room air
% of O2
Nutrition: NG
- PO
Positioning Aids nest
- DANDLEPAL
===DEVELOPMENTAL SKILLS===
Addressed Today? Y
Arousal Response: WITHIN NORMAL LIMITS
Behavioral State: Quiet Alert
Drowsy
State transition: smooth
Attempts self regulation: Y
O: MOM HOLDING QUIET ALERT BABY UPON ROOM ENTRANCE.MOM GREETED.DISUSSED
PUPROSE OF OT,POC&INTERVNETION EXAMPLES.WHTIE MOM HOLDING BABY OT
- MEASURED HEAD.MILD R PLAGIO NOTED.DISCUSSED HEAD SHAPE W/MOM&
- INTERVENTIONS^ADDRESS HEAD SHAPE.CHANGED HOB^ENCOURAGE L HEAD TURN.
- BABY DEMO GOOD FEEDING CUES W/HANDS^FACE&FINGER IN MOUTH&CRY(SIG FOR
BABY).MOM OFFERED BABY SLOW FLOW NIPPLE.BABY QUICKLY LATCHED&DEMO'd
- SUCK.EVERY COUPLE OF SUCK BURSTS BABY WOULD DE-LATCH W/MOD DISORGANIZ-
- ATION.W/TIME BABY WOULD RE-LATCH.OT EXITED ROOM WHILE MOM BOTILE
- FED BABY.RN PRESENT.
OT RETURNED S/P FEEDING.MOM NO LONGER IN ROOM.BABY QUIET ALERT.BABY...
Pre Therapy
During Therapy
Post Therapy
HR 153
: Stable
: 149
Respirations 60
: Stable
: 50
% O2 sat: 98
: Stable
: 97
===NEURO===
Addressed Today? N
===COORDINATION===
Addressed Today? Y
O: ...TRANS^OT HOLDING.PROVIDED PROLONGED CSPINE ROM:FAVORS R
- CSPINE ROTATION/>RESISTANCE^STRETCHING OF R SCM.ACHIEVED
- WFL CSPINE ROM S/P STRETCHING.SUPP SIT:TOL~4-5MIN SITTING
W/MAX A FOR HEAD/TRUNK SUPP.SIG IMPROVEMENT W/QUIET ALERT
- STATE MAINTENANCE COMPARED^2/17EVAL.VISION:BABY DEMO OPEN
- EYES FOR MAJORITY OF OT TX W/SLIGHT R/L VISUAL SHIFT^AUDIT-
- ORY STIM.BABY TRANS^SUPINE ON OT's LAP.ROM:PROVIDED BUE/...

Diagnosis/Goal/Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Units	From Change
Activity Date: 02/18/22 Time: 1221 (continued)										

6265153 OT: Neonate Progress Note+ (continued)
===ORAL MOTOR===
Addressed Today? Y
Oral Motor: Sucking non nutritive: With in normal limits
Oral Reflexes: + rool
- + suck
O: ...BLE JOINT COMPRESSIONSX10&PROM.BABY DEMO MOD TIGHTNESS W/
- BUE/BLE JOINTS(SIG INC IN TIGHTNESS COMPARED TO 2/17EVAL WHEN
BABY DEMO'd GENERAL TOW TONE).PROVIDED BUE/BLE MILKING MASSAGE
- &ACHIEVED WFL PROM.PROVIDED HIP ROM^ENCOURAGE INTESTINAL
- MOTILITY.BABY TRANS^CHEST^CHEST W/OT.TOL~4MIN PRONE W/LULLABY.
- AT END OF OT TX BABY SLEEPING.SUPINE,IN SWADDLE SACK...
====MUSCULOSKELETAL====
Addressed Today? Y
Measurements: Length 12.00
cm
Width: 10.00
cm
cm
Lsci: 11.00
cm
Rsci: 11.50
cm
Date measured: 02/18/22
O: MILD R PLAGIO.DISCUSSED HEAD SHAPE&INTERVENTIONS^ENCOURAGE APPROP HEAD
- SHAPE W/MOM.
===ROM===
- &BASSINET.RN PRESNET.YSS.
===SKIN INSPECTION===
Addressed Today? N
===SPLINTING===
Addressed Today? N
Straps should be loose enough for you to put one finger under.
Precautions: look for skin breakdown. remove splint if redness noted
If redness still present after 15 minutes leave splint off and
Keep splint away from high heat
to don/doff appropriately.
Splint used to protect, immobilize or facilitate use body part.
===Orthotics===
Orthotic Device In Use? N
===CAR SEAT===
Addressed Today? N
Current
Height -
Family will verbalize & demonstrate understanding of securing baby in seat
family will verbalize & demonstrate understanding of installing base in
State & Self-Regulation Goals Addressed Today: Y
* Baby will demonstrate

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: CU,7172-A

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Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Directions Documented Comment	Units	From Change

Activity Date: 02/18/22 Time: 1221 (continued)

6265153 OT: Neonate Progress Note+ (continued)
quiet alert state x 5 min while being held
to facilitate/prepare for developmental growth
Target Date: 02/24/22
Progress Towards Goal: PROGRESSING
* Baby will demonstrate
smooth state changes from deep sleep through quiet alert
To facilitate/prepare for developmental growth
by 40 weeks post menstrual age.
Progress Towards Goal: PROGRESSING
* Baby will demonstrate
- 3
SELF SOOTHING SKILLS
To facilitate/prepare for developmental growth
Target Date: 02/24/22
Progress Towards Goal: PROGRESSING
* Parent will demonstrate
- ALERTING/CALMING TECH
- APPROP^BABY's STATE
To facilitate/prepare for safe care at home
Target Date: 02/24/22
Progress Towards Goal: PROGRESSING
Sensory & Motor Development Goals Addressed Today: Y
* Baby will demonstrate
Autonomic stability to allow further eval of neuromuscular maturation.
Target Date: 02/24/22
Progress Towards Goal: PROGRESSING
* Baby will demonstrate
head turn to l & R with age appropriate ROM
to facilitate/prepare for developmental growth
Target Date: 02/24/22
Progress Towards Goal: PROGRESSING
* Baby will demonstrate
- neutral alignment w/supp
- W/SUPP FROM CAREGIVERS/POSITIONERS
to facilitate/prepare for neurodevel/jnt alignment
Target Date: 02/24/22
Progress Towards Goal: PROGRESSING
* Baby will demonstrate
- SMOOTH STATE AROUSAL W/
VESTIBULAR STIM W/O MOTOR STRESS CUES
to facilitate/prepare for developmental growth
Target Date: 02/24/22
Progress Towards Goal: PROGRESSING
* Baby will tolerate
- therapeutic handling
- W/AT LEAST 5MIN QUIET ALERT STATE
to facilitate/prepare for developmental growth

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Directions Documented Comment	Units	From Change

Activity Date: 02/18/22 Time: 1221 (continued)

6265153 OT: Neonate Progress Note+ (continued)
Target Date: 02/24/22
Progress Towards Goal: PROGRESSING
Baby to exhibit improved head shape to no
head deformity through conservative management
to facilitate/prepare for neurodevel/jnt alignment
Target Date: 02/24/22
Progress Towards Goal: PROGRESSING
Pre Feeding & Feeding Goals Addressed Today: Y
* Baby will demonstrate
- ROOT^SUM 2/3 ATTEMPTS
- OF FACILITATION
to facilitate/prepare for oral/motor development
Target Date: 02/24/22
Progress Towards Goal: PROGRESSING
* Baby will tolerate
intra oral stim
- W/NO MORE THAN MIN INC IN STRESS CUES
to facilitate/prepare for oral/motor development
Target Date: 02/24/22
Progress Towards Goal: PROGRESSING
Skin to Skin Holding Addressed Today: Y
* Parent will demonstrate
- transfer techniques for
skin to skin holding to facilitate/prepare for
neurodevelopmental/parent bonding. Target Date 02/24/22
Progress Towards Goal: PROGRESSING
skin to skin holding to facilitate/prepare for
===ASSESSMENT===
- BABY TOL OT TX WELL.REC CONT OT TO ADDRESS STRESS IN BABY.DEV.PARENT
- EDU.OM SKILLS.HANDLING TOL.PARENT EDU.HEAD SHAPE
===Education===
Addressed Today? Y
Preferred Learning Method? ALL
Educational Needs(s)? FEEDING TECHINIQUES
- EXERCISE
SAFETY
- POSITIONING
Patient/Support Person Ready to Learn: Y
Identified Barriers to Learning? NO FAMILY AVAILABLE
Instructions Given Regarding OT POC
- HEAD SHAPE
Person Taught? MOTHER
- NURSE
Method Used? VERBAL
- VERBAL
Evaluation? VERBALIZED UNDERSTANDING
- VERBALIZED UNDERSTANDING

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: FU,7172-A

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Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Units	From Change

Activity Date: 02/18/22 Time: 1221 (continued)

6265153 OT: Neonate Progress Note+ (continued)
===TREATMENT PLAN===
Plan to see patient NICU:3X/WK
Until 02/24/22
when re-assessment is due, for
- ADL
- Activity tolerance
- Developmental Therapy
  Exercise
- Neurodevelopment
- Patient/Family Education
- Positioning
  Safety
This patient is appropriate for a COTA to work with at this time: N
===SPLINTING TREATMENT PLAN===
when re-assessment is due for
===PHYSICIAN NOTIFICATION===
OT Communication: "PARKER" 8-11-2 41/GA
- .
- SIG IMPROVEMENT W/AROUSAL,SEIZURE DISORDER
  IMPROVED INTEREST W/PO FFFDS, MILD R PLAGIO
- OT:17.18
Goal Prognosis? Good
Report needs to be reviewed and co-signed? N

Activity Date: 02/18/22 Time: 1243

Patient Notes: CHILD LIFE NOTES
Create 02/18/22 1243 RB 02/18/22 1247 RB

Child Life Note:

PL "Parker" continues NICU admission for HTF. CCLS met FOP, Anthony, at bedside earlier this week. MOP present and actively holding pt at this time.

CCLS introduced self and services to MOP. CCLS assessed how MOP has felt so far transitioning to life as a NICU mom. MOP stated that she is just happy on days like this when she gets to hold. CCLS talked with MOP about coping and provided MOP with a blank journal for any questions parents might think of when team members have left the room. CCLS offered a NICU journal for family to keep track of memories from the NICU with pt and MOP expressed interest. CCLS provided education regarding bonding and scent and provided MOP with scent cloths to utilize with pt when away from bedside.

Parents do not have other children. CCLS to continue following pt and family throughout admission. Questions.
Rachel Burnett, MS, CCLS
Certified Child Life Specialist

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Units	From Change

Activity Date: 02/18/22 Time: 1243 (continued)

Patient Notes: CHILD LIFE NOTES (continued)
405-436-2321
Note Type Description
No Type None

Activity Date: 02/18/22 Time: 1315

5186455 ST: NICU PROGRESS NOTE+ A AS
Document 02/18/22 1315 JKS 02/18/22 1323 JKS
SPEECH AND LANGUAGE PATHOLOGY
Date: 02/18/22
Time: 1315
By: FPM,JKS SIMON,JOHANNA K
Primary Therapist: CPT,CNL LCC,CRIKA N
Okay to reassign: Y
Physician's Orders: FEEDING CONSULT
Isolation? STANDARD
Isolation? STANDARD
as per Nursing
Resuscitation Directive: CPR/Full Resuscitation
Treatment Communications: TERM, SEIZURES, HAS A GOOD SUCK BUT TAKES A LOT OF PATIENCE
- TO GET HIM TO LATCH **ON NIV 2/13
Treatment Precautions: CONIACI
Treatment Units: SWATX, 97533
===TREATMENT PLAN===
Patient reassessed this visit? N
Type of feeder: Sick term
SLP only feeding? N
Plan to see patient M/TU/W/TH/F/SU
Until 02/18/22
when re-assessment is due, for
- Feeding Skills
as per Nursing
===RECOMMENDATIONS===
- 1. FEED 1X PER SHIFT OR WITH CUES
- 2. SLP WILL FOLLOW
Rx Time In: 0840
Time Out: 0905
Current Medical Status: R/O SEPSIS, SEIZURES
- (2/16)
Previous Medical History? NEWBORN
- .
- .
- APGARS 2/6/7
===PATIENT/CAREGIVER/INPUT/GOALS/CONCERNS===
Patient/Caregiver Comment- RN AGREEABLE TO SLP TX. NO FAMILY PRESENT
Patient/Caregiver Goal: FOR INFANT TO EAT WELL
Pt/Caregiver Discharge Destination Goal: Home

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: CU,7172-A

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Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Directions Documented Comment	Units	From Change

Activity Date: 02/18/22 Time: 1315 (continued)

5186455 ST: NICU PROGRESS NOTE+ (continued)
==== PAIN ====
Pain intensity: 0
===Outcome Measure===
Date
Score
===COGNITION/LANGUAGE===
Addressed Today: N
===SPEECH/ORAL MOTOR===
Addressed Today? Y
- INFANT WAS LIGHTLY SLEEPING IN HIS BASSINET UPON SLP'S
- ARRIVAL. SLP OFFERED HAND SWADDLING TO ALERT INFANT TO HOC.
  SLP COMPLETED BASIC HOC IN A NEUROPROTECTIVE MANNER. INFANT
- TOLERATED HOC WELL. INFANT WAS SWADDLED AND TRANSITIONED TO
- SLP'S ARMS. HE WAS PLACED IN SIDE-LYING POSITIONING. 70CC OF
- FORMULA WAS OFFERED VIA SLOW FLOW NIPPLE.INFANT EASILY
  ROOTED TO THE NIPPLE. HE HAD A STRONG LATCH WITH STEADY
- RYTHMIC SUCK BURSTS. MINIMAL EXTERNAL PACING OFFERED TO HELP
- COORDINATE S/S/B. HE HAD OCCASIONAL UNORGAINZED SUCK BURSTS
- BUT HE EASILY REORGANIZED WITH SHORT BREAKS. HE CONSUMED
  70CC IN ~20 MINUTES. VITAL STATS REMAINED STABLE THROUGHOUT
- FEEDING. INFANT WAS RETURNED TO HIS BASSINET AND RN NOTIFIED
Goal: SAFE, EFFICIENT PO FEEDING.
Target Date: 02/18/22
Progress Towards Goal: PROGRESSING
===DEGLUTITION===
Addressed Today: N
===SPEECH RECOMMENDATIONS FOR DIET===
Instructions
of nutrition and hydration needs without s/s of aspiration.
cueing in order for increase deglutition function.
cueing in order to reduce risk of aspiration.
===IMPRESSIONS===
- INFANT TOOK 70CC IN ABOUT 20 MIN. MINIMAL EXTERNAL PACING.
- OCCASIONAL UNORGAINZED SUCKS THAT IMPROVED W/BREAKS AND
- PACING.
Therapist Recommendation for discharge: Home
===Education===
Addressed Today: N
==RESTRAINTS==Temporary release of restraints for therapeutic intervention: N
===PHYSICIAN NOTIFICATION===
Medicare Patient that requires Certification form: N
Report needs to be reviewed and co-Signed? N

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Directions Documented Comment	Units	From Change

Activity Date: 02/18/22 Time: 1828

1710105 End of Shift: NICU (Level of Care) + CritCare documents on paper except for POC, End of Shift Summary, and Education. A BID 6A 6P CP
Document 02/18/22 1828 BV 02/18/22 1828 BV
Newborn level of care? Day 2 ^ Discharge
===Episode Day 1===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
*** Newborn Level 1 ***
=== Episode Day 2-DC ===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
Hemodynamic stability: Y
Finding/Intervention? PO feeding initiated <=3d
*** Newborn Level 1 ***
*** Transitional Care ***
Level of care: 2
Expected accomodation code: N2

Activity Date: 02/18/22 Time: 2337

4132203 Central & Foley Line Check + A 0005 CP
- Document 02/18/22 2337 KJ 02/18/22 2337 KJ
Lines present TODAY at 0001:
Urethral Catheter: N
Central Line: N
Not sure? Consult the charge nurse or Infection Control.

Activity Date: 02/19/22 Time: 0404

1710105 End of Shift: NICU (Level of Care) + CritCare documents on paper except for POC, End of Shift Summary, and Education. A BID 6A 6P CP
- Document 02/19/22 0404 KJ 02/19/22 0405 KJ
Newborn level of care? Day 2 ^ Discharge
===Episode Day 1===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
*** Newborn Level 1 ***
=== Episode Day 2 DC ===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: EU,NICUF
Room/Bed: EU,7172-A

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Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Documented Units	From Change

Activity Date: 02/19/22 Time: 0404 (continued)

1710105 End of Shift: NICU (Level of Care) + (continued)
Hemodynamic stability: Y
*** Newborn Level 1 ***
Gestational age >= 35 weeks: Y
Weight >= 2000g Y
Finding/intervention? Newborn care *
*** Transitional Care ***
Level of care: 1
Expected accomodation code: NI

Activity Date: 02/19/22 Time: 1616

1710105 End of Shift: NICU (Level of Care) + A BID 6A 6P CP
CritCare documents on paper except for
POC, End of Shift Summary, and
Education.
Document 02/19/22 1616 MM 02/19/22 1618 MM
Newborn level of care? Day 2 ^ Discharge
===Episode Day 1===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
*** Newborn Level 1 ***
=== Episode Day 2-DC ===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
Hemodynamic stability: Y
*** Newborn Level 1 ***
*** Transitional Care ***

Activity Date: 02/19/22 Time: 1618

1710105 End of Shift: NICU (Level of Care) + A BID 6A 6P CP
CritCare documents on paper except for
POC, End of Shift Summary, and
Education.
- Document 02/19/22 1618 MM 02/19/22 1618 MM
Newborn level of care? Day 2 ^ Discharge
===Episode Day 1===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
*** Newborn Level 1 ***
=== Episode Day 2-DC ===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Documented Units	From Change

Activity Date: 02/19/22 Time: 1618 (continued)

1710105 End of Shift: NICU (Level of Care) + (continued)
*** Newborn Level 1 ***
Gestational age >= 35 weeks: Y
Weight >= 2000g Y
Finding/intervention? Newborn care *
*** Transitional Care ***
Level of care: 1
Expected accomodation code: NI

Activity Date: 02/19/22 Time: 2208

4132203 Central & Foley Line Check + A 0005 CP
Document 02/19/22 2208 OG 02/19/22 2208 OG
Lines present TODAY at 0001:
Urethral Catheter: N
Central Line: N
Not sure? Consult the charge nurse or Infection Control.

Activity Date: 02/20/22 Time: 0404

1710105 End of Shift: NICU (Level of Care) + A BID 6A 6P CP
CritCare documents on paper except for
POC, End of Shift Summary, and
Education.
Document 02/20/22 0404 OG 02/20/22 0404 OG
Newborn level of care? Day 2 ^ Discharge
===Episode Day 1===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
*** Newborn Level 1 ***
=== Episode Day 2-DC ===
*** NICU Level 4 ***
*** NICU Level 3 ***
*** Special Care Level 2 ***
*** Newborn Level 1 ***
Gestational age >= 35 weeks: Y
Weight >= 2000g Y
Finding/intervention? Newborn care *
*** Transitional Care ***
Level of care: 1
Expected accomodation code: NI

Activity Date: 02/20/22 Time: 1009

5186455 ST: NICU PROGRESS NOTE+ A AS
- Document 02/20/22 1000 ENL 02/20/22 1005 ENL
SPEECH AND LANGUAGE PATHOLOGY

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: CU,7172-A

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Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Units	From Change

Activity Date: 02/20/22 Time: 1000 (continued)

5186455 ST: NICU PROGRESS NOTE+ (continued)
Date: 02/20/22
Time: 1000
By: EPT,ENL LEE,ERIKA N
Primary Therapist: EPT,ENL LEE,ERIKA N
Okay to reassign: Y
Physician's Orders: FEEDING CONSULT
Isolation? STANDARD
Isolation? STANDARD
as per Nursing
Resuscitation Directive: CPR/Full Resuscitation
Treatment Communications: TERM. SEIZURES. HAS A GOOD SUCK BUT TAKES A LOT OF PATIENCE TO GET HIM TO LATCH
Treatment Precautions: CONTACT
Treatment Units: SWAIX. 9/533
===TREATMENT PLAN===
Patient reassessed this visit? N
Type of feeder: Sick term
SLP only feeding? N
Plan to see patient CHECK EVERY 7 DAYS
Until 02/27/22
when re-assessment is due. for
- Feeding Skills
as per Nursing
===RECOMMENDATIONS===
- 1. FEED 1X PER SHIFT OR WITH CUES
- 2. SLP WILL FOLLOW
Rx Time In: 0845
Time Out: 0920
Current Medical Status: R/O SCPSIS. SEIZURES
- (2/16)
Previous Medical History? NEWBORN
- .
- .
- APGARS 2/6//
===PATIENT/CAREGIVER/INPUT/GOALS/CONCERNS===
Patient/Caregiver Comment RN AGREEABLE TO SLP TX. MOM ARRIVED AT END OF FEEDING
Patient/Caregiver Goal: FOR INFANT TO EAT WELL
Pt/Caregiver Discharge Destination Goal: Home
==== PAIN ====
Pain Intensity: 0
===Outcome Measure===
Date
Score
===COGNITION/LANGUAGE===
Addressed Today: N
===SPEECH/ORAL MOTOR===
Addressed Today? Y

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Documented Comment	Directions Units	From Change

Activity Date: 02/20/22 Time: 1000 (continued)

5186455 ST: NICU PROGRESS NOTE+ (continued)
- INFANT WAS LIGHTLY SLEEPING IN HIS BASSINET UPON SLP'S
- ARRIVAL. SLP OFFERED HAND SWADDLING TO ALERT INFANT TO ROC.
- SLP COMPLETED BASIC ROC IN A NEUROPROTECTIVE MANNER. INFANT TOLERATED ROC WELL. INFANT WAS SWADDLED AND TRANSITIONED TO
- SLP'S ARMS. HE WAS PLACED IN SIDE-TILT POSITIIONING.100CC OF
- FORMULA WAS OFFERED VIA SLOW FLOW NIPPLE.INFANT EASILY
- ROOTED TO THE NIPPLE. HE HAD A STRONG LATCH WITH STEADY RYTHMIC SUCK BURSTS. MINIMAL EXTERNAL PACING OFFERED TO HELP
- COORDINATE S/S/B. HE HAD OCCASIONAL UNORGANIZED SUCK BURSTS
- BUT HE EASILY REORGANIZED WITH SHORT BREAKS. HE CONSUMED
- ~90CC IN ~20 MINUTES. VITAL STATS REMAINED STABLE THROUGHOUT FEEDING. INFANT WAS RETURNED TO HIS BASSINET AND RN NOTIFIED
Goal: SAFE, EFFICIENT PO FEEDING.
Target Date: 02/27/22
Progress Towards Goal: PROGRESSING
===DEGLUTITION===
Addressed Today: N
===SPEECH RECOMMENDATIONS FOR DIET===
Instructions
of nutrition and hydration needs without s/s of aspiration.
cueing in order for increase deglutition function.
cueing in order to reduce risk of aspiration.
===IMPRESSIONS===
INFANT TOOK 90CC IN ABOUT 20 MIN. MINIMAL EXTERNAL PACING.
Therapist Recommendation for discharge: Home
===Education===
Addressed Today: N
===PHYSICIAN NOTIFICATION===
Physician Name- KASNE Kassa.Netsanet MD
Reason Notified? (free text if needed)
PROGRESSION OF FEEDING
Medicare Patient that requires Certification form: N
Report needs to be reviewed and co-Signed? N

Activity Date: 02/20/22 Time: 1103

1001095	ADM/Transfer: Quick Start Form +	D		AS
- Ed Status	02/20/22 1103 his 02/20/22 1103 his			A => D
1001124	OT: NEONATE Evaluation +	D		AS
Ed Status	02/20/22 1103 his 02/20/22 1103 his			A => D
1904750	NBN Hearing Screen Results +	D		AS
- Ed Status	02/20/22 1103 his 02/20/22 1103 his			A => D
2200004	Allergies	D		OE
	NKDA			
	Latex precautions for any neurosurgical or GI surgical patient.			

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: FU,7172-A

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Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Directions Documented Units	From Change
Activity Date: 02/20/22 Time: 1103 (continued)									
??00004	Allergies (continued)								
- Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
2200031	Cardiac Monitoring Continuous monitoring of heart rate & respiratory rate						D		OE
- Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
2200043	Dressing Change A) Occlusive dressing changed 24 hours after insertion per PICC trained nurse. B) Then, occlusive dressing changed PRN (when dressing is soiled, saturated, or no longer intact)						D		OE
Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
2200044	Daily Weight Obtain weight, length, head circumference, and physical exam assessment within 1 hour of admission. Repeat weights daily and length and head circumference measurements on Tuesdays.						D		OC
Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
2200059	Finger Stick Blood Sugar Glucometer measurements Q1 hr x 2 then Q4 hrs for first 24 hrs. For infants on IVF/TPN, obtain measurements 1-2 hrs after hanging new fluids or after discontinuance of fluids.						D	.[q 4 hrs then...]	OC
- Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
??00070	Intake and Output Monitoring Strict intake and output measurements, including blood						D		OF
- Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
??00085	Notify MD i. Notify clinician of the following: i. Heart rate: less than 100 or greater than 200. ii. Respiratory rate: less than 20 or greater than 80. iii. Blood pressure mean less than below 1. 25 for infants <600 grams 2. 35 for infants 600-999 grams 3. 40 for infants 1000-1999 grams 4. 45 for infants 2000-2999 grams 5. 50 for infants >3000 grams iv. Temperature: less than 36.5C or greater than 37.5C. v. SpO2: outside limits per oxygen management protocol (see 11.1) or if						D		OF
2200085	Notify MD (continued) FiO2 needs are increased by 10% for longer than 15 minutes. vi. Urine output: less than 0.5 ml/kg/hr or greater than 5 ml/kg/hr vii. Blood sugar: less than 40 or greater than 200								
Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
2200088	O2SAT Monitoring Continuous monitoring of pulse oximetry According to oxygen management protocol, maintain SpO2 by altering FiO2 concentration if on supplemental oxygen. i. For infants less than 32 weeks: 88 93%, at 32 weeks change to 90 95% ii. For infants born at 32-34 weeks: 90-95% iii. For infants born at 35 weeks or more: 95 98% iv. For infants with chronic lung disease (O2 at >36 wks): 92-97% v. For infants in room air: alarm limits should be set at 89% and 100% vi. Custom limits (cardiac or special circumstances only): Maintain SpO2 between _____% and _____% by altering FiO2 concentration if on supplemental oxygen.						D		OC
- Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
2200090	Obtain Consent Ensure admission consent is signed and in chart within 24 hours of admission or before administering any blood products or assisting with any invasive procedures. For mothers who consent to using donor milk, ensure donor milk consent is in chart before administering donor milk or formula.						D		OE
- Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
2200107	Procedure Implement care based on established protocols. Use 1.9 french catheter for all infants Place PICC line per policy Verify central position with						D		OE

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: FU,7172-A

BLUE,BB-IAIUM

OU Medical Center NUR **Live**
CLINICAL DOCUMENTATION RECORD IIPI

Printed 02/21/22 at 0212

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Directions Documented Units	From Change
2200107	Procedure (continued) Radiologist/Attending/Neonatal Nurse Practitioner prior to use, with no more than 3 x ray attempts. Document procedure in Crib Notes.								
- Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
2200154	Vital Signs						D		OF
	Vital signs on admission and hourly x 24 hours then Q2-4 hours per unit protocol, to include heart rate, respiratory rate, temperature, SpO2, and EDIN pain score. Four extremity blood pressures on admission then single extremity BP Q12 hrs (hourly if on pressors; Q___ hours if on cardiac team).								
- Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
2200182	Occupational Therapy						D		OE
	ADI Exercise Positioning - Activity Tolerance - Neurodevelopment - Safety - Developmental Therapy - Patient/Family Education Plan to see patient NICU:3X/WK Until 02/24/22 Campus? C								
Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
2200184	Speech Therapy						D		OC
	New onset Dysphagia: N New onset Cognitive deficits: N Intubated: N New onset communication deficits: N Comment: please evaluate for safe PO feeding : thank you : : Patient will discharge today,pending Therapy Evaluation. N Campus? C								
- Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
2200184	Speech Therapy						D		OE
	- Feeding Skills - - - - Plan to see patient M/TU/W/TH/F/SU Until 02/18/22 Campus? C								
- Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
2200213	Nursing Miscellaneous Order						D		OF
	goal MAP 35-45								
- Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
2200213	Nursing Miscellaneous Order						D		OE
	please discontinue PICC line								
- Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
2200222	Kangaroo care appropriate						D		OE
	Kangaroo care per protocol.								
Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D

Diagnosis/Goal/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Directions Documented Units	From Change
Activity Date: 02/20/22 Time: 1103									
2200234	Rowarm Infant Admit to Omni bed if <1800 grams, otherwise admit to radiant warmer. Follow temperature control policy for weaning incubator.						D		OF
- Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
2200249	Congenital Heart Dz Screen Critical Congenital Heart Disease (CCHD) screen for all infants between 24 hrs and 14 days old who are in room air and have not had an echocardiogram. Follow CCHD pulse oximetry screening protocol.						D		OE
Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
2200270	Neonatal Therapy (OT,PT) Neonatal Therapy-Occupational Therapy (OT), Physical Therapy (PT) Precautions: Other: Gestational Age at Birth: 40 Evaluate and Treat? Y Comments: Anticipated discharge within 48 hours? N						D		OC
- Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
4255001	I&O: Monitor +						D		MD
- Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
5005020	Chaplain Spiritual Assessment +						D		PS
- Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
5186200	SI: NICU INITIAL SEGMENT						D		AS
- Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
5186454	ST: NICU Evaluation						D		AS
- Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
5186456	SI: NICU PROGRESS NOTE+						D		AS
- Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
6265153	OT: Neonate Progress Note+						D		AS
- Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
Diagnosis: Developmental Age 0-1 year. Infant Related to our age specific Ploicy and Procedure practice guidelines infant developmental need: - trust							D		
- Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
Goal: Age Appropriate Guidelines will be met.							D		
- Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D
3200000	Age Appropriate Guidelines May Address via End of Shift Summary						D		CP
Ed Status	02/20/22	1103	his	02/20/22	1103	his			A => D

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN

Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU.NICUF
Room/Bed: FU.7172-A

BLUE.BB-IAIUM
OU Medical Center NUR **Live**
CLINICAL DOCUMENTATION RECORD IIPI

Printed 02/21/22 at 0210

Diagnosis/Goal/Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Directions Documented Units	From Change
Activity Date: 02/20/22 Time: 1103										
Goal: Infant will participate in play exercises that are geared to stimulate cognitive development.								D		
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
Diagnosis: Critical Care Neonate (Crib Notes) Care Area Practice Guidelines Guidelines focus on: Safety issues -- Psychosocial needs -- Nutritional needs ADI's Skin Integrity TV Lines -- Pain -- Respiratory Function -- Cardiac Function -- GI Function -- GU Function -- Monitoring Lines -- Developmental needs								D		
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
Goal: Care Area Practice Guidelines and Documentation Requirements are met. By discharge, the patient/caregiver will verbalize and/or demonstrate competence and confidence in providing safe, effective, care appropriate to their individual needs.								D		
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
1000033	NICU Admission Data +							D	.Every admission	CP
Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
1701275	Weight +							D	Q14DX1.T	CP
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
1701325	Height +							D		CP
Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
1710105	End of Shift: NICU (Level of Care) + CritCare documents on paper except for POC, End of Shift Summary, and Education.							D	BID 6A 6P	CP
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
1900100	POC: Measure +							D		CP
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
2500000	Fall Prevention & Post Fall +							D	.PRN Fall Score/Post Fall Documentation	CP
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
4101601	Medication Reconciliation +							D		CP
Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
4132203	Central & Foley Line Check +							D	0005	CP
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
4750218	Education: Interdisciplinary+							D		CP
Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D

Diagnosis/Goal/Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Directions Documented Units	From Change
Activity Date: 02/20/22 Time: 1103										
5060001	Handover/Transfer							D		CP
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
9900002	BCIA: Suspected Transfusion Reaction +							D		CP
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
9900003	BCTA: Pre Issue Checklist +							D		CP
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
Diagnosis: SI: PATIENT/CAREGIVER EDUCATION								D		
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
Goal: REHAB: PL/caregiver will verbalize and or demonstrate understanding, competence, and or confidence in providing safe, effective rehab techniques,appropriate to the patient's individual education needs as described documented in therapy eval & progress								D		
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
1002067	ST: Speech Initial Segment +							D		CP
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
5186366	SI: Patient/Family Education							D		CP
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
6280007	ST: Progress Note +							D		CP
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
Diagnosis: REHAB:ORAL MOTOR DISORDERS/IMPAIRMENTS								D		
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
Goal: RFHAB: With skilled Therapy intervention patient's oral motor skills will be improved to allow maximized function as described in the individualized treatment goals and interventions documented in Therapy eval & progress notes								D		
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
Diagnosis: Altered Respiratory Function Altered respiratory function/status related to disease process, physical limitations, surgical procedure and/or trauma.								D		
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
Goal: Adequate air exchange with Oxygen sats >92%, clear and equal breath sounds, pink mucous membranes and nailbeds, respirations regular and unlabored prior to discharge.								D		
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
1900700	Evaluate: Respiratory +							D	.As needed	CP
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D

Age/Sex: 00M 13D M
Unit #: E003047593
Admitted: 02/08/22 at 2217
Status: DIS IN
Attending: Bergner,Erynn MD
Account #: E00677497957
Location: FU,NICUF
Room/Bed: CU,7172-A

BLUE.BB-IAIUM

OU Medical Center NUR **Live**
CLINICAL DOCUMENTATION RECORD UPT

Printed 02/21/22 at 0212

Diagnosis/Goal/Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Directions Documented Units	From Change
Activity Date: 02/20/22 Time: 1103										
Diagnosis: OT: PATIENT/CAREGIVER EDUCATION								D		
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
Goal: REHAB: Pt/caregiver will verbalize and or demonstrate understanding, competence, and or confidence in providing safe, effective rehab techniques,appropriate to the patient's individual education needs as described documented in Therapy eval & progress								D		
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
1002020	OI Initial Segment +							D		CP
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
6765150	OT: Progress Note+							D		CP
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
526518	OI: Pt/Family Instruction							D		CP
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
Diagnosis: OT: FEEDING DIFFICULTIES								D		
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
Goal: REHAB: To ensure safe and adequate nutritional intake by discharge appropriate for patient's age and or disease process.								D		
- Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
Diagnosis: REHAB: ROM & MM PERFORMANCE								D		
Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D
Goal: REHAB: With skilled Therapy intervention patient's ROM and MM performance will be improved to allow maximized function as described in the individualized treatment goals and interventions documented in therapy eval & progress notes								D		
Ed Status		02/20/22	1103	his	02/20/22	1103	his			A => D

Monogram Initials	Name	Nurse Type
AFK	FAP.AFK	Kenmore,Allie F NNC	Provider
AEM	ENUR.AEM4	MACKEY,AMY E	RN
AG	ENUR.AG37	GILLIS,ANNA	RN
BJB	E.BJB	BELL,BAYLOR J	RN
BMP	ENUR.BMP6	PATRICK,BROOKE M	RN
BV	ENUR.BV2	VANSTORY,BRIANNE	RN
CB	ENUR.CB36	BULLER,CARLEY	RN
CF	ERT.CF	FITZPATRICK,CHELSEA	RT
CMK	FAP.CMK	KINSLOW,CLAUDIA M,AP	Provider
CSC	ENUR.CSG	CLARK,CARLA S	RN
DDS	E.DDS	SCHMIDT,DESTINY D	RN
EB	ENUR.EB8	BRALY,ELIZABETH	RN

Monogram Initials	Name	Nurse Type
EL	EPT.EL	LE,ELIZABETH	SLP
ENL	EPT.ENL	LEE,ERIKA N	SLP
JA	ERT.JA	AYESH,JENAN	RT
JDF	EAP.JDF	FRAYSUR,JENNIFER D	Provider
JKS	EPM.JKS	SIMON,JOHANNA K	SLP
KJ	ENUR.KM47	JONES,KATELYN	RN
KMC	FAP.KMC	CHRISTENSON,KAHLENE*	Provider
KR	ENUR.KR19	ROSWELL,KATHERINE	RN
KSW	ENUR.KSW9	WILLIAMS,KATIE S	RN
KTB	ERT.KTB	BUI,KATIE T	RT
LJR	ENUR.LJR2	RAMIREZ,LAURETTA J	RN
LY	ENUR.LY2	YOUNG,LAUREN	RN
MM	ENUR.MM58	MCCANN,MELISSA	RN
MNC	EAP.MNC1	CAINES,MACIE N DHP	Provider
MO	ENUR.MO14	OROZCO,MARIANA	RN
MOB	CHEAR.MOB	BARRINGTON,MAKAYLYNN	TECH
NAG	ERT.NAG	GIBSON,NATASHA A	RT
OAO	EAP.OAO	Ogunfolu,Olajumoke	Provider
OG	ENUR.OG2	GUYER,OLIVIA	RN
PXN	ENUR.PXN1	NGUYEN,PHUONG	RN
RB	ECL.RB	BURNETT,RACHEL	CLS
TG	EPC.TG	GODFREY,TAYLOR	PC
TLM	EPT.TLM2	MACKEY,TARRYN L	OTR/L
his		automatic by program	

OU Children's Hospital NICU Date of Birth **2/8/22**

Parker Blue Med Rec# **E003047593**

Discharge Instructions - Page 1

The Baby Care Book - The information in your Baby Care Book is considered as home care instructions. Your signature on the Discharge Instructions means that you understand and feel comfortable with each topic.

WARNING SIGNS - Call your baby's doctor for the following:
TEMPERATURE: Less than 97.° or greater than 100.4°.
BREATHING: Excessive crying, irritability or lethargy (sleepiness).
FEEDING: Difficulty waking up and refusing to eat for 2-3 feedings in a row.
SKIN: More yellow than at the time of discharge, or a blue or gray color.
VOMITING: After several feedings in a row, or bloody or green vomit.
URINATING: Less than 6 wet diapers in a 24 hour period.
STOOLING: Blood, black or dark purple, white/grey clay-like or chalky stools, large, frequent and watery stools, or no bowel movement for 2 days.
UMBILICAL CORD: Redness, swelling, tenderness, bleeding, foul odor, or yellow green discharge around the umbilical cord.
Feeding - Follow the feeding guidelines offered by your baby's discharging doctor:

Breastmilk or Similac Pro-Advance 20 calorie (100ml every 3 hours)
Temperature - Check the baby's temperature if he/she feels warm, cold or seems sick. If your baby's temperature is high, remove clothing and recheck in 30 minutes. If it is still high, your baby may be sick. If your baby's temperature is low, add clothing and recheck in 30 minutes. If the temperature is still low your baby may be sick. Call your doctor for any temperature issues.
A normal under arm temperature should be between 97.7 to 99.9 F (36.5-37.5 C).
Jaundice - Check your baby's skin color in the same lighting once a day. Yellowing of the skin that gets worse each day , or a blue or gray tone to your baby's skin color may need to be checked by your pediatrician.
Diapers - Bowel movements vary - some infants stool with each feeding and others every few days. Stools may be runny, seedy, mushy, pasty, green, yellow or brown. Babies should have at least 6 wet diapers in a 24 hour period. If your baby has not had a stool in 2-3 days and seems uncomfortable or is only having hard stool "pebbles", your baby may be constipated. Call your doctor for directions.
Activity Level - Limit activity outside the home to doctors visits only as much as possible. Avoid crowded areas like the mall, grocery store, church, or family gatherings with your baby. It is recommended that you avoid crowded areas for at least 6-8 weeks after discharge.
Sleeping - Always place your baby on his or her back to sleep, for naps and at night. Place your baby on a firm sleep surface, such as on a safety-approved crib mattress covered by a fitted sheet. Keep soft objects such as bumper pads, toys, and loose bedding out of your baby's sleep area. Keep your baby's sleep area close to, but separate from, where you and others sleep. Remember "tummy time" when your baby is awake and someone is watching him/her.
Car Seat Safety - Your baby should always ride in a rear-facing car safety seat, in the back seat of the vehicle, for as long as possible (weight and height with in range for that specific seat). This is safest. It protects babies from head and spinal cord injury. Make sure the seat belt or LATCH attachments hold the car seat in place tightly at the correct angel by following the angel indicator on the car safety seat. The base of the car seat, should not move more than 1 inch front to back, or side to side at the belt path once installed. Buckle and tighten the harness snugly over your baby's body, with the chest clip at armpit level. ALWAYS follow the car seats manufacturers instructions and the car manual to install and use the seat correctly.
NO SMOKING - Do not let anyone smoke around your baby.
Discharge Call Follow-up - Thank you for choosing OU Medicine. It is our highest priority you are very satisfied with the care we provided during your stay with us. To ensure continued excellent outcomes after your discharge, a nurse from our team will be contacting you in the next few days as a follow-up to your care to answer any questions you may have.Please let me know what number and time is best to reach you.
Thank you again for our privilege to serve you!
Is it okay for us to call you? (yes or no)
If yes, at what number can we call you? ( ) -
What time is best to reach you? (:)
Current Post Discharge Phone Number:

Printed: 2/20/22 9:29

OU Children's Hospital NICU Date of Birth **2/8/22**

Parker Blue Med Rec# **E003047593**

Discharge Instructions - Page 2

Medications
None

Appointments
Pediatrician - My Family Healthcare (580-924-5622), Durant, 1708 Delivery Lane - 2/24/22.

Immunizations & Procedures
Metabolic screening tests are pending from 2/9.
The infant passed the ABR test in both ears on 2/18/22.
The safe sleep survey was completed on 2/18/22.
The infant passed the critical congenital heart disease screening at 108.8 hours of age.
The Oklahoma Tobacco Helpline cessation referral does not apply for TATUM Blue

Signed: [signature]

Relationship: Father Date 2/20/2022

Nurse: Melissa Mccann, RN; (electronically signed 2/20/22 9:29)

Printed: 2/20/22 9:29

Children's Hospital
OUMC, Oklahoma City

Blue, BB-TATUM
Med Rec# | Accnt# E003047593 | E00677497957
Date of Birth: 2/8/22 Day of life: 2
Corrected GesAge: 40+3 weeks
Allergies: None

Orders from 2/10/22 12:05

Parenteral Nutrition Order Form

Custom Cl (TPN Order# 9E5T-TPN-02.10.22/1) - TPN Day# 1

Weight:	3050 grams
TPN to be received:	230 ml = 75 ml/kg/day
TPN Rate:	9.6 ml/hour by central line
SMOF 20%:	0.8 ml/hour for 20 hrs (Total of 16 ml; 1 gram/kg/day)

Additional IVs:	None
Estimated Feeds:	59 ml HM-Col and 1 ml HM-Col (included in TPN calcs) = 60 ml/day
Total Fluids:	305 ml/day (TPN+Feeds+Additional IVs+Lipids) = 100 ml/kg/day

Amount per 1000 ml			per kg/day TPN	Other*	Total
Dextrose	10	%	Gluc 7.5	-	7.5
Amino Acids	3.5	%	AA 2.6	0.6	3
NaCl			Na 1.2	0.4	1
NaAcetate			K 0.7	0.4	1
NaPhosphate	16	mEq	Cl 0.7	0.5	1
KCl	10	mEq	Ac 0	-	0
KAcetate			Phos 0.9	0	0
KPhosphate			Ca 1.5	0.2	1
CaGluconate	20	mEq	Mg 0.3	0	0
MgSO4	3	mEq			
Heparin	500	Units			
Zinc	2400	mcg			
Carnitine	80	mg			
Additions	MVI [5 mL max]: 27 mL/1000 ml (= 2 mL/				
	TE [1 mL max]: 4 mL/1000 ml (= 0.3 mL/k				
	Chromium [5...: 2.7 mcg/1000 ml (= 0.2 mc				
Osmolarity	919	mOsm			

Amount per 1000 ml		per kg/day TPN	~Feed*	Total
Famotidine	None			

Additional Instructions: MV:-Mon-Wed-Fri

Children's Hospital of Oklahoma
10-Feb-22 12:32:53
Acct : 3047593
BLUE, BB-TATUM Dosing Weight: 3.05 kg
Location: C NICUE/ Order No: 89623
Order Volume: 230 mL Compound Volume: 280 mL

Dextrose	10 %	Zinc Chloride	2,400 mcg/L
TrophAmine	3.5 %	Carnitine 20 MG/ML	80 mg/L
Sodium Phosphate	16 mEq/L	Multrys Trace Elements	0.3 ml/Kg
Potassium Chloride	10 mEq/L	Chromium 1mcg/ml	0.2 mcg/Kg
Calcium	20 mEq/L		
mag 0.325meq/ml	3 mEq/L		
Heparin (PF)	500 units/L		

(Final Amino Acid Concentration= 3.4 %)

** Approximate Electrolyte Totals **

Sodium	17.75 mEq/L	Phosphate	12 mM/L
Potassium	10 mEq/L	Acetate	33.95 mEq/L
Calcium	400.8 mg/L	Chloride	10 mEq/L
Magnesium	3 mEq/L		

Nitrogen	1.25 gm	Protein	31.23 KCal
Non-Protein	107 KCal	CHO KCal	78.2 KCal
Tota	138.23 KCal	Lipid	28.8 KCal

Flow Rate: 9.58 mL/hr X 24 hrs
Bag hung at: _____ by: _____ RN
Bag Expires: 02/11/2022 18:00
Total Osmolarity Concentration: 911 mOsm/L
****ADMINISTER VIA Central LINE ONLY***
If Lipids ordered, volume is: SMOF 16 mL
Prepared by: _____ Checked by: _____

72A

Children's Hospital
OUMC, Oklahoma City

Blue, BB-TATUM

Med Rec# | Acent#	E003047593 | E00677497957	
Date of Birth:	2/8/22	Day of life: 2
Corrected GesAge:	40+3 weeks	
Allergies:	None	

Ordered and e-signed by Jumoke A. Ogunfolu, NNP Student

*Others include Additional IVs and feeds.
Carbohydrate in feeds is not included in the glucose calculation.
*~Feed amounts are estimated based on the
percent of the fluid intake attributable to feeds.

Transcribed by: _____

Printed: 2/10/22 12:05

Children's Hospital
OUMC, Oklahoma City

Blue, BB-TATUM
Med Rec# | Accnt# E003047593 | E00677497957
Date of Birth: 2/8/22 Day of life: 3
Corrected GesAge: 40+4 weeks
Allergies: None

Orders from 2/11/22 10:58

Parenteral Nutrition Order Form

Custom Cl (TPN Order# 9E5T-TPN-02.11.22/2) - TPN Day# 2

Weight:	3050 grams
TPN to be received:	216 ml = 71 ml/kg/day
TPN Rate:	9 ml/hour by central line
SMOF 20%:	1.5 ml/hour for 20 hrs (Total of 30 ml: 2 grams/kg/day)

Additional IVs:	None
Estimated Feeds:	119 ml SAd v20 and 1 ml HM-PT (included in TPN calcs) = 120 ml/day
Total Fluids:	366 ml/day (TPN+Feeds+Additional IVs+Lipids) = 120 ml/kg/day

Amount per 1000 ml			per kg/day TPN	Others*	Total
Dextrose	12.5	%	Gluc 8.8	-	8.8
Amino Acids	4	%	AA 2.8	0.6	3.4
NaCl			Na 1.1	0.3	1.4
NaAcetate			K 0.4	0.7	1.1
NaPhosphate	16	mEq	Cl 0.3	0.5	0.8
KCl	5	mEq	Ac 0	-	0
KAcetate			Phos 0.9	0.1	1
KPhosphate			Ca 1.4	0.5	1.9
CaGluconate	20	mEq	Mg 0.2	0.1	0.3
MgSO4	3	mEq			
Heparin	500	Units			
Zinc	2400	mcg			
Carnitine	80	mg			
Additions	MVI [5 mL max]: 28 mL/1000 ml (= 2 mL/kg/d				
	TE [1 mL max]: 4.2 mL/1000 ml (= 0.3 mL/kg/d				
	Chromium [5...: 2.8 mcg/1000 ml (= 0.2 mcg/kg/				
Osmolarity	1087 mOsm				

Additional Instructions: MV:-Mon-Wed-Fri

Amount per 1000 ml — per kg/day

Children's Hospital of Oklahoma 11:50:28

11-Feb-22
Acct : 3047593
BLUE, BB-TATUM
Dosing Weight: 3.05 kg
Order No: 89832
Location: C NICUE/
Order Volume: 216 mL
Compound Volume: 266 mL

Dextrose	12.5 %	Zinc Chloride	2,400 mcg/L
TrophAmine	4 %	Carnitine 20 MG/ML	80 mg/L
Sodium Phosphate	16 mEq/L	Multivitamins-Pediatric	5 ml/day
Potassium Chloride	5 mEq/L	Multrys Trace Elements	0.3 ml/Kg
Calcium	20 mEq/L	Chromium 1mcg/ml	0.2 mcg/Kg
mag 0.325meq/ml	3 mEq/L		
Heparin (PF)	500 units/L		

(Final Amino Acid Concentration= 3.88 %)

** Approximate Electrolyte Totals **

Sodium	18 mEq/L	Phosphate	12 mM/L
Potassium	5 mEq/L	Acetate	38.8 mEq/L
Calcium	400.8 mg/L	Chloride	5 mEq/L
Magnesium	3 mEq/L		
Nitrogen	1.34 gm	Protein	33.52 KCal
Non-Protein	145.8 KCal	CHO KCal	91.8 KCal
Tota	179.32 KCal	Lipid	54 KCal

Flow Rate: 9.00 mL/hr X 24 hrs
Bag hung at: _____ by: _____ RN
Bag Expires: 02/12/2022 18:00
Total Osmolarity Concentration: 1,071 mOsm/L
Printed: ****ADMINISTER VIA Central LINE ONLY***
If Lipids ordered, volume is: SMOF 30 mL
Prepared by: _____ Checked by: _____

7172A

Children's Hospital
OUMC, Oklahoma City

Blue, BB-TATUM

Med Rec# | Acent#	E003047593 | E00677497957	
Date of Birth:	2/8/22	Day of life: 3
Corrected GesAge:	40+4 weeks	
Allergies:	None	

Ordered and e-signed by Jumoke A. Ogunfolu, NNP Student

*Others include Additional IVs and feeds.
Carbohydrate in feeds is not included in the glucose calculation.
*--Feed amounts are estimated based on the
percent of the fluid intake attributable to feeds.

Transcribed by: _____

Printed: 2/11/22 10:59

Children's Hospital
OUMC, Oklahoma City

Blue, Parker
Med Rec# | Accnt# E003047593 | E00677497957
Date of Birth: 2/8/22 Day of life: 4
Corrected GesAge: 40+5 weeks
Allergies: None

Orders from 2/12/22 12:11

Parenteral Nutrition Order Form

Custom Cl (TPN Order# 9E5T-TPN-02.12.22/2) - TPN Day# 2

Weight:	3050 grams
TPN to be received:	190 ml = 62 ml/kg/day
TPN Rate:	7.9 ml/hour by central line
SMOF 20%:	1.1 ml/hour for 20 hrs (Total of 22 ml; 1.4 grams/kg/day)

Additional IVs:	None
Estimated Feeds:	SAdv20 (included in TPN calcs) = 184 ml/day
Total Fluids:	397 ml/day (TPN+Feeds+Additional IVs+Lipids) = 130 ml/kg/day

Amount per 1000 ml			per kg/day TPN	Other*	Total
Dextrose	10	%	Gluc 6.2	-	6.2
Amino Acids	4.2	%	AA 2.7	0.8	3.5
NaCl			Na 1	0.4	1.4
NaAcetate			K 0.3	1.1	1.4
NaPhosphate	16	mEq	Cl 0.4	0.7	1.1
KCl	5	mEq	Ac 0	-	0
KAcetate			Phos 0.7	0.2	0.9
KPhosphate			Ca 1.2	0.8	2
CaGluconate	20	mEq	Mg 0.1	0.1	0.2
MgSO4	2	mEq			
Heparin	500	Units			
Zinc	2400	mcg			
Carnitine	80	mg			
Additions	MVI [5 mL max]: 32 mL/1000 ml (= 2 mL/kg/day				
	TE [1 mL max]: 4.8 mL/1000 ml (= 0.3 mL/kg/da				
	Chromium [5...: 3.2 mcg/1000 ml (= 0.2 mcg/kg/d				
Osmolarity	976	mOsm			

Additional Instructions: MV:-Mon-Wed-Fri

72A

Children's Hospital of Oklahoma

12-Feb-22 12:40:16
Acct : 3047593
BLUE, BB-TATUM
Location: C NICUE/
Order Volume: 190 mL
Dosing Weight: 3.05 kg
Order No: 90029
Compound Volume: 240 mL

Dextrose	10 %	Zinc Chloride	2,400 mcg/L
TrophAmine	4.2 %	Carnitine 20 MG/ML	80 mg/L
Sodium Phosphate	16 mEq/L	Multrys Trace Elements	0.3 ml/Kg
Potassium Chloride	5 mEq/L	Chromium 1mcg/ml	0.2 mcg/Kg
Calcium	20 mEq/L		
mag 0.325meq/ml	2 mEq/L		
Heparin (PF)	500 units/L		

(Final Amino Acid Concentration= 4.07 %)

** Approximate Electrolyte Totals **

Sodium	18.1 mEq/L	Phosphate	12 mM/L
Potassium	5 mEq/L	Acetate	40.74 mEq/L
Calcium	400.8 mg/L	Chloride	5 mEq/L
Magnesium	2 mEq/L		

Nitrogen	1.24 gm	Protein	30.96 KCal
Non-Protein	104.2 KCal	CHO KCal	64.6 KCal
Tota	135.16 KCal	Lipid	39.6 KCal

Flow Rate: 7.92 mL/hr X 24 hrs
Bag hung at: 1800 by: KSW RN
Bag Expires: 02/13/2022 18:00
Total Osmolarity Concentration: 961 mOsm/L
****ADMINISTER VIA Central LINE ONLY***
If Lipids ordered, volume is: SMOF 22 mL
Printed:
Prepared by: _____ Checked by: _____

Children's Hospital
OUMC, Oklahoma City

Blue, Parker
Med Rec# | Acent# E003047593 | E00677497957
Date of Birth: 2/8/22 Day of life: 4
Corrected GesAge: 40+5 weeks
Allergies: None

Ordered and e-signed by Allie Kenmore, Nurse Clinician

*Others include Additional IVs and feeds.
Carbohydrate in feeds is not included in the glucose calculation.
*~Feed amounts are estimated based on the
percent of the fluid intake attributable to feeds.

Transcribed by: _____

Printed: 2/12/22 12:12

Children's Hospital
OUMC, Oklahoma City

Blue, Parker
Med Rec# | Acent# E003047593 | E00677497957
Date of Birth: 2/8/22 Day of life: 5
Corrected GesAge: 40+6 weeks
Allergies: None

Orders from 2/13/22 10:57

Parenteral Nutrition Order Form

Custom CI (TPN Order# 9E5T-TPN-02.13.22/3) - TPN Day# 3

Weight:	3050 grams
TPN to be received:	163 ml = 53 ml/kg/day
TPN Rate:	6.8 ml/hour by central line
SMOF 20%:	No lipids
Additional IVs:	None
Estimated Feeds:	SAdv20 (included in TPN calcs) = 264 ml/day
Total Fluids:	427 ml/day (TPN+Feeds+Additional IVs+Lipids) = 140 ml/kg/day

Amount per 1000 ml			per kg/day TPN	Others*	Total	
Dextrose	10	%	Gluc	5.3	-	5.3	gram
Amino Acids	4.7	%	AA	2.5	1.2	3.7	gram
NaCl			Na	0.7	0.6	1.3	mEq
NaAcetate			K	0	1.6	1.6	mEq
NaPhosphate	12	mEq	Cl	0	1.1	1.1	mEq
KCl			Ac	0	-	0	mEq
KAcetate			Phos	0.4	0.3	0.7	mMol
KPhosphate			Ca	0.9	1.1	2	mEq
CaGluconate	17	mEq	Mg	0.2	0.1	0.3	mEq
MgSO4	2	mEq					
Heparin	500	Units					
Zinc	2400	mcg					
Carnitine	80	mg					
Additions	MVI [5 mL max]: 37 mL/1000 ml (= 2 mL/kg/day in TP						
	TE [1 mL max]: 5.6 mL/1000 ml (= 0.3 mL/kg/day in TI						
	Chromium [5...: 3.7 mcg/1000 ml (= 0.2 mcg/kg/day in T						
Osmolarity	994	mOsm					

Amount per 1000 ml		per kg/day TPN	-Feed*	Total
Famotidine	None			

Additional Instructions: MV:-Mon-Wed-Fri

7172A

Children's Hospital of Oklahoma
13-Feb-22 11:17:35
Acct: 3047593
BLUE, BB-TATUM
Location: C NICUE/
Dosing Weight: 3.05 kg
Order No: 90199
Order Volume: 163 mL
Compound Volume: 213 mL

Dextrose	10 %	Zinc Chloride	2,400 mcg/L
TrophAmine	4.7 %	Carnitine 20 MG/ML	80 mg/L
Sodium Phosphate	12 mEq/L	Multrys Trace Elements	0.3 ml/Kg
Calcium	17 mEq/L	Chromium 1mcg/ml	0.2 mcg/Kg
mag 0.325meq/ml	2 mEq/L		
Heparin (PF)	500 units/L		

(Final Amino Acid Concentration= 4.56 %)
** Approximate Electrolyte Totals **

Sodium	14.35	mEq/L	Phosphate	9	mM/L
Potassium	0	mEq/L	Acetate	45.59	mEq/L
Calcium	340.68	mg/L	Chloride	0	mEq/L
Magnesium	2	mEq/L			

Nitrogen	1.19 gm	Protein	29.72 KCal
Non-Protein	55.42 KCal	CHO KCal	55.42 KCal
Tota	85.14 KCal	Lipid	0 KCal

Flow Rate: 6.79 mL/hr X 24 hrs
Bag hung at: _____ **by:** _____ **RN**
Bag Expires: 02/14/2022 18:00
Total Osmolarity Concentration: 978 mOsm/L
Printed: 2/13. ****ADMINISTER VIA Central LINE ONLY***
If Lipids ordered, volume is: mL
Prepared by: _____ Checked by: _____

Children's Hospital
OUMC, Oklahoma City

Blue, Parker

Med Rec# | Acent#	E003047593 | E00677497957	
Date of Birth:	2/8/22	Day of life: 5
Corrected GesAge:	40+6 weeks	
Allergies:	None	

Ordered and e-signed by Allie Kenmore, Nurse Clinician

*Others include Additional IVs and feeds.
Carbohydrate in feeds is not included in the glucose calculation.
*~Feed amounts are estimated based on the
percent of the fluid intake attributable to feeds.

Transcribed by: _____

Room# 7172A

Printed: 2/13/22 10:57

Conditions of Admission and Consent for Outpatient Care

1. **Consent to Treatment.** I consent to the procedures, which may be performed during this hospitalization or during an outpatient episode of care, including, but not limited to, emergency treatment or services, and which may include laboratory procedures, x-ray examination, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services rendered as ordered by the Provider. I consent to allowing students as part of their training in health care education to participate in the delivery of my medical care and treatment or be observers while I receive medical care and treatment at the Hospital, and that instructors and/or hospital staff will supervise these students. I further consent to the hospital conducting blood-borne infectious disease testing, including but not limited to, testing for hepatitis, Acquired Immune Deficiency Syndrome ("AIDS"), and Human Immunodeficiency Virus ("HIV"), if a physician orders such tests or if ordered by protocol. I understand that the potential side effects and complications of this testing are generally minor and are comparable to the routine collection of blood specimens, including discomfort from the needle stick and/or slight burning, bleeding or soreness at the puncture site. The results of this test will become part of my confidential medical record.

2. **Consent to Treatment Using Telemedicine.** I consent to treatment involving the use of electronic communications ("Telemedicine") to enable health care providers at different locations to share my individual patient medical information for diagnosis, therapy, follow-up, and/or education purposes. I consent to forwarding my information to a third party as needed to receive Telemedicine services, and I understand that existing confidentiality protections apply. I acknowledge that while Telemedicine can be used to provide improved access to care, as with any medical procedure, there are potential risks and no results can be guaranteed or assured. These risks include, but are not limited to: technical problems with the information transmission or equipment failures that could result in lost information or delays in treatment. I understand that I have a right to withhold or withdraw my consent to the use of Telemedicine in the course of my care at any time, without affecting my right to future treatment and without risking the loss or withdrawal of any program benefit to which I would otherwise be entitled.

3. **Consent to Medication Not Yet FDA Approved and/or Medication Prepared/Repackaged by Outsourcing or Compounding Pharmacy**. As part of the services provided, you may be treated with a medication that has not received FDA approval. You may also receive a medication that has been prepared or repackaged by an outsourcing facility or compounding pharmacy. Certain medications, for which there are no alternatives or which your physician recommends, may be necessary for potentially life-saving treatment.

4. **Consent to Photographs, Videotapes and Audio Recordings.** I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the hospital's quality improvement and/or risk management activities. I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside of the facility without a specific written authorization from me or my legal representative unless otherwise required by law.

5. **Financial Agreement.** In consideration of the services to be rendered to Patient, Patient or Guarantor individually promises to pay the Patient's account at the rates stated in the hospital's price list (known as the "Charge Master") effective on the date the charge is processed for the service provided, which rates are hereby expressly incorporated by reference as the price term of this agreement to pay the Patient's

account. Some special items will be priced separately if there is no price listed on the Charge Master. An estimate of the anticipated charges for services to be provided to the Patient is available upon request from the hospital. Estimates may vary significantly from the final charges based on a variety of factors, including, but not limited to, the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services. Most or all of the physicians performing services in the hospital are independent and are not hospital agents or employees. Independent physicians are responsible for their own actions and the hospital shall not be liable for the acts or omissions of any such independent physicians. **Professional services rendered by independent contractors are not part of the hospital bill. These services will be billed to the Patient separately**. I understand that physicians or other health care professionals may be called upon to provide care or services to me or on my behalf, but that I may not actually see, or be examined by, all physicians or health care professionals participating in my care; for example, I may not see physicians providing radiology, pathology, EKG interpretation and anesthesiology services. I understand that, in most instances, there will be a separate charge for professional services rendered by physicians to me or on my behalf, and that I will receive a bill for these professional services that is separate from the bill for hospital services.

The hospital will provide a medical screening examination as required to all Patients who are seeking medical services to determine if there is an emergency medical condition without regard to the Patient's ability to pay. If there is an emergency medical condition, the hospital will provide stabilizing treatment within its capacity

If supplies and services are provided to Patient who has coverage through a governmental program or through certain private health insurance plans, the hospital may accept a discounted payment for those supplies and services. In this event any payment required from the Patient or Guarantor will be determined by the terms of the governmental program or private health insurance plan. If the Patient is uninsured and not covered by a governmental program, the Patient may be eligible to have his or her account discounted or forgiven under the hospital's uninsured discount or charity care programs in effect at the time of treatment. I understand that I may request information about these programs from the hospital. I also understand that, as a courtesy to me, the hospital may bill an insurance company offering coverage, but may not be obligated to do so. Regardless, I agree that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the Patient or Guarantor. I agree to pay for services that are not covered and covered charges not paid in full by insurance coverage including, but not limited to, coinsurance, deductibles, non-covered benefits due to policy limits or policy exclusions, or failure to comply with insurance plan requirements.

This hospital reserves the right not to submit a claim to a patient's insurance company. Upon written request, the hospital will provide the information necessary for the patient to file the insurance claim, except as prohibited by law.

6. **Third Party Collection**. I acknowledge that the Providers may utilize the services of a third party Business Associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing. During the time that the medical account is being serviced by the EBO Servicer, the account shall not be considered delinquent, past due or in default, and shall not be reported to a credit bureau or subject to collection legal proceedings. When the EBO Servicer's efforts to obtain payment have been exhausted due to a number of factors (for e.g., Patient or Guarantor's failure to pay or make a payment arrangement after insurance adjustments and payments have been credited, and/or the insurer's denial of claim(s) or benefits is received), the EBO Servicer will send a final notice letter which will include the date that the medical account may be returned from the EBO Servicer to the Provider. Upon return to the Provider by the EBO Servicer, the Provider may place the account back with the EBO

Servicer, or, at the option of the Provider, may determine the account to be delinquent, past due and in default. Once the medical account is determined to be delinquent it may be subject to late fees, interest as stated, referral to a collection agency for collection as a delinquent account, credit bureau reporting and enforcement by legal proceedings. I also agree that if the Provider initiates collection efforts to recover amounts owed by me or my Guarantor, then, in addition to amounts incurred for the services rendered, Patient or Guarantor will pay, to the extent permitted by law: (a) any and all costs incurred by the Provider in pursuing collection, including, but not limited to, reasonable attorneys' fees, and (b) any court costs or other costs of litigation incurred by the Provider.

7. **Assignment of Benefits.** Patient assigns all of his/her rights and benefits under existing policies of insurance providing coverage and payment for any and all expenses incurred as a result of services and treatment rendered by the Provider and authorizes direct payment to the Provider of any insurance benefits otherwise payable to or on behalf of Patient for the hospitalization or for outpatient services, including emergency services, if rendered. Patient understands that any payment received from these policies and/or plans will be applied to the amount that Patient or Guarantor has agreed to pay for services rendered during this admission and, that Provider will not retain benefits in excess of the amount owed to the Provider for the care and treatment rendered during the admission.

   I understand that any health insurance policies under which I am covered may be in addition to other coverage or benefits or recovery to which I may be entitled, and that Provider, by initially accepting health insurance coverage, does not waive its rights to collect or accept, as payment in full, any payment made under different coverage or benefits or any other sources of payment that may or will cover expenses incurred for services and treatment.

   I hereby **irrevocably appoint** the Provider as my authorized representative to pursue any claims, penalties, and administrative and/or legal remedies on my behalf for collection against any responsible payer, employer-sponsored medical benefit plans, third party liability carrier or, any other responsible third party ("Responsible Party") for any and all benefits due me for the payment of charges associated with my treatment. This assignment shall not be construed as an obligation of the Providers to pursue any such right of recovery. I acknowledge and understand that I maintain my right of recovery against my insurer or health benefit plan and the foregoing assignment does not divest me of such right.

   I agree to take all actions necessary to assist the Provider in collecting payment from any such Responsible Party should the Provider(s) elect to collect such payment, including allowing the Provider(s) to bring suit against the Responsible Party in my name. If I receive payment directly from any source for the medical charges associated with my treatment acknowledge that it is my duty and responsibility to immediately pay any such payments to the Provider(s). I assign and transfer to (1) the hospital and to (2) authorized and attending physicians of the hospital any and all benefits, monies, and sums payable to me for hospitalization, sickness, accident or bodily injury under any hospitalization, sickness, accident medical payments/PIP/bodily injury or uninsured/underinsured motorist policy providing for hospital, medical or physician payments.

8. **Medicare Patient Certification and Assignment of Benefit.** I certify that any information I provide in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the hospital or hospital-based physician by the Medicare or Medicaid program.

9. **Private Room.** I understand and agree that I am (or Guarantor is) responsible for any additional charges associated with the request and/or use of a private room.

10. **Outpatient Medicare Patients.** Medicare does not provide coverage for "self-administered drugs" or drugs that you normally take on your own, with only a few limited exceptions. If you get self-administered drugs that aren't covered by Medicare Part B, we may bill you for the drug. However, if you are enrolled in a Medicare Part D Drug Plan, these drugs may be covered in accordance with Medicare Part D Drug Plan enrollment materials. If you pay for these self-administered drugs, you can submit a claim to your Medicare Part D Drug Plan for a possible refund.

11. **Communications About My Healthcare.** I authorize my healthcare information to be disclosed for purposes of communicating results, findings, and care decisions to my family members and others I designate to be responsible for my care. I will provide those individuals with a password or other verification means specified by the hospital. I agree I may be contacted by the Provider or an agent of the Provider or an independent physician's office for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

12. **Consent to Telephone Calls for Financial Communications.** I agree that, in order for you, or your EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that you or your EBO Servicer and collection agents may contact me by telephone at any telephone number I have provided or you or your EBO Servicer and collection agents have obtained or, at any number forwarded or transferred from that number, regarding the hospitalization, the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

13. **Release of Information.** I hereby permit Providers to release healthcare information for purposes of treatment, payment or healthcare operations. Healthcare information regarding a prior admission(s) at other OUMI affiliated facilities may be made available to subsequent OUMI-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation. If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

14. Other Acknowledgements.

15. Personal Valuables. I understand that the hospital maintains a safe for the safekeeping of money and small personal valuables, and the hospital shall not be liable for the loss of or damage to any valuables or money. The liability of the hospital for loss of any personal property that is deposited with the hospital for safekeeping is limited to the greater of five hundred dollars ($500.00) or the maximum required by law, unless a written receipt for a greater amount has been obtained from the hospital by the Patient. The hospital is not responsible for the loss or damage of cell phones, glasses or dentures or personal valuables unless they are placed in the hospital safe in accordance with the terms as stated above.

16. Patient Visitation Rights. I understand that I have the right to receive the visitors whom I or my Patient Representative designates, without regard to my relationship to these visitors. I also have the right to withdraw or deny such consent at any time. I will not be denied visitation privileges on the basis of age, race, color, national origin, religion, gender, gender identity and gender expression, and sexual orientation or disability. All visitors I designate will enjoy full and equal visitation privileges that are no more restrictive than those that my immediate family members would enjoy.

17. Patient Self Determination Act. I have been furnished information regarding Advance Directives (such as durable power of attorney for healthcare and living wills). Please initial or place a mark next to **one** of the following applicable statements:

	I executed an Advance Directive and have been requested to supply a copy to the hospital		I have not executed an Advance Directive, wish to execute one and have received information on how to execute an Advance Directive		I have not executed an Advance Directive and do not wish to execute one at this time

18. Consent to Authorize Use of Email and Text for Patient Billing and Financial Obligations. By my consent below, I authorize the use of any email address or cellular telephone number I provide for receiving **information** relating to my financial obligations, including, but not limited to, payment reminders, delinquent notifications, instructions and links to hospital Patient billing information. I understand and acknowledge that my patient account number may appear in the email or test. I consent to receiving discharge instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained or, at any text number forwarded or transferred from that number.

Acknowledge:_____(Initial) I consent to use of email for Patient billings and financial obligation purposes.

Acknowledge:_____(Initial) I consent to use of text for Patient billings and financial obligation purposes.

19. Notice of Privacy Practices. I acknowledge that I have received the hospital's Notice of Privacy Practices, which describes the ways in which the hospital may use and disclose my healthcare information for its treatment, payment, healthcare operations and other prescribed and permitted uses and disclosures. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. I understand that I may contact the hospital Privacy Officer designated on the notice if I have a question or complaint.

Acknowledge:_____(Initial)

20. Acknowledgement of Notice of Patient Rights and Responsibilities. I have been furnished with a Statement of Patient Rights and Responsibilities ensuring that I am treated with respect and dignity and without discrimination or distinction based on age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law.

Acknowledge: AP (Initial)

21. Acknowledgement: I have been given the opportunity to read and ask questions about the information contained in this form, **specifically** including but not limited to the financial obligation's provisions and assignment of benefit provisions, and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction and that I have signed this document freely and without inducement other than the rendition of services by the Providers.

Acknowledge: AP (Initial)

This consent applies to services you receive from all healthcare providers listed above, occurring or commencing within one year from the date of this agreement.

Date: 2/9/2022	I, the undersigned, as the Patient or Patient Representative, or, for a minor/incapacitated Patient, as the legal guardian, hereby certify I have read, and fully and completely understand this Conditions of Admission and Authorization for Medical treatment, and that I have signed this Conditions of Admission and Authorization for Medical Treatment knowingly, freely, voluntarily and agree to be bound by its terms. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services. If insurance coverage is insufficient, denied altogether, or otherwise unavailable, the undersigned agrees to pay all charges not paid by the insurer.

Patient/Patient Representative Signature:

X A Phillips

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse
Parent
Legal Guardian
Sibling
Healthcare Power of Attorney
Guarantor
Other (please specify):

_____

Witness Signature and Title:

X _____

Additional Witness Signature and Title:
(required for Patients unable to sign without a representative or Patients who refuse to sign)

X _____

BLUE,BB-TATUM
Acct # E00677497957 MR# E003047593
Loc: EU.NICUE DOB: 02/08/22 00M 01DM 02/08/22
Varughese,Paul John MD

OU MEDICAL CENTER (COCPN)
Neurology Consult
REPORT#:0209-0044
DATE:02/09/22 Time: 0212

PATIENT: BLUE,BB-TATUM UNIT No: E003047593
ACCOUNT#: E00677497957 ROOM: EU.7172
REPORT AUTHOR: Siddiqui,Sameera MD

See Addendum

Siddiqui,Sameera 02/09/22 0212:

Neurology Consult Note

Consulting Service
Consulting Service
NICU
Responsible Faculty:
Dr. Chrusciel
Neurology Consult Note

REASON: Shaking, concerning for seizures 2/2 to suspected hypoxic ischemic event vs sepsis (etiology to be determined)

CC: "His legs were twitching and he wasn't taking breaths"

HPI:
1-day-old baby boy born at 40 weeks of gestation via artificial rupture of membranes, delivery significant for meconium stained amniotic fluid, transferred from Durant Medical Center 2/8/22 to OU Children's Center NICU for higher level of workup and care after presenting with low APGARs of 2, 6, and 7 and spells of apnea and leg twitching concerning for possible seizures due to a possible hypoxic ischemic event vs sepsis, etiology to be determined.

History was obtained mostly from the patient's father Brandon Blue as the patient's mother, Tatum is still at Durant Medical Center due to significant hemorrhaging from delivery. The pregnancy was overall uneventful with the mother being adherant to prenatal vitamins and checkups. She briefly had to be monitored for preeclampsia however workup was negative. Delivery was induced 2/8/22 due to prolonged labor with meconium stained amniotic fluid appreciated on delivery. The baby was not taking breaths or responding to nasal suctioning or stimulation and briefly required PPV which was provided for 3minutes however continued to have irregular respirations. The baby was then taken to nursery and CPAP was initiated. Grunting subsided and he was weaned to room air by approximately. Oral feedings were started and the baby continued to do well. However, at approximately 10am 2/8/22 the baby was noted to have apnea spells with color change and possible twitching of extremities concerning for seizures, which led to transfer to OU Children's Center.

En route to being transferred, the baby had another episode and was
was given loading dose of phenobarbital. NF team arrived to take over care, noted infant to be borderline lethargic following phenobarbital dose for which normal saline was given in route for soft blood pressures. The baby did not have further activity throughout transport and was transferred to NICU on room air.

However shortly before neurology was consulted, the patient exhibited another episode for

which he was provided another dose of phenobarbitol, thereby receiving a total of 40mg/kg of phenobarbital since arrival. Upon discussion with Dr. Chrusciel before my evaluation, phenobarbitol was advised to be held until a level is obtained and to not re-administer if the level is elevated.

On my evaluation, the patient was crying due to being touched and moved with IV access being obtained and did not have further episodes throughout my encounter, lasting approximately 40 minutes.

PMHx:
-Born at 40 weeks via artificial rupture of membranes
-No complications during pregnancy or abnormalities on ultrasound visits

PSHx:
-None

SOCHx:
-Lives with parents, Brandon and Tatum Blue. 1st baby and pregnancy for the parents.
-Smoke free environment; Brandon vapes away from Tatum

FAMHx:
-Brandon does not have any known medical conditions; grandfather had DM
-Tatum does not have medical diagnoses and he is not aware of medical conditions in her family
-He was able to confirm neither he nor Tatum have family history of seizures, strokes, or known clotting disorders, Tatum however is being treated for post partum hemorrhage at this time.

ALLERGIES:
NKDA

MEDICATIONS:

Current Medications

Medication	Dose	Sig/Sch Route	Start time Stop Time	Status	Last Admin
Phenobarbital Sodium	15.25 MG	Q24H IV	02/09 1900 03/11 1901	AC	
Amikacin Sulfate N/A	37 MG 1 EACH	Q24H IV	02/09 1830 02/09 1859	AC	
Ampicillin Sodium N/A	300 MG 1 EACH	Q12H IV	02/09 0630 02/10 0659	AC	
Dopamine HCl	25 ML	CONTINUOUS IV	02/09 0300 03/11 0301	AC	
Sodium Chloride	30 ML	ONCE ONE IV	02/09 0300 02/09 0301	DC	
Phenobarbital Sodium	61 MG	ONCE ONE IV	02/09 0100 02/09 0101	DC	02/09 0052

Patient: BLUE,BB-TATUM Unit#: E003047593
Date: 02/09/22 Acct#: E00677497957

Lidocaine HCl	1 APPLIC	NOW STA TOPICAL	02/09 0030 02/09 0031	DC	02/09 0055
Acyclovir N/A	60 MG 1 EACH	Q8H IV	02/08 2330 02/10 2201	AC	02/08 2356
Heparin Sodium (Porcine) Dextrose/Water	125 UNITS 250 ML	.Q24H IV	02/08 2230 03/10 2231	AC	
Nutrition (Parenteral)	250 ML	CONTINUOUS IV	02/08 2230 03/10 2231	AC	02/08 2355

REVIEW OF SYSTEMS:
-Negative except for what is outlined in HPI

VITALS:

	02/08 1500	02/08 2300	02/09 0700
Intake Total			
Output Total			
Balance			

EXAMINATION:
-General: pink complexion, on room air, crying while being moved with IV placement
-Cardio: RRR
-Pulm: on room air, no dyspnea or apnea appreciated
-Abd: soft, nondistended
-Skin: petechial looking rash along groin, back, and forehead, blanching to deep touch
Neuro:
Mental status: cries while being moved around however was consolable with stroking and pacifier
CN2-12: pupils equal and reactive, dolls eye intact, no fixed gaze, symmetric facial muscle movements when crying, palatte elevates, tongue appears midline
Motor: normal tone, moving all extremities spontaneously without signs of weakness/flaccidity
Sensory: withdraws toes to stroking
Reflexes: intermittent suck reflex, moro reflex intact, no rooting reflex appreciated, palmar reflex intact bilaterally, babinski intact bilaterally
Coord: no tremors appreciated on exam

LABS/IMAGING: reviewed in meditech/centricity

IMPRESSION:
-Seizures in the setting of hypoxic ischemic event vs sepsis, etiology to be determined

RECOMMENDATIONS:

Patient: BLUE,BB-TATUM Unit#: E003047593
Date: 02/09/22 Acct#: E00677497957

-Will advise no further doses of phenobarbitol as the patient received 40mg/kg total today
-Please obtain phenobarbitol levels in the meanwhile
-Continue infectious workup in the meanwhile including LP
-Will monitor for head ultrasound reading for now before proceeding with further imaging studies
-If seizure occurs again, please give 20mg/kg of keppra; will defer maintanence dosing based on how frequently seizures occur/if they re-occur
-If seizures do not settle after load of keppra, please call child neurology resident on call for the baby to be examined and then consider other options of treatment (fosphenytoin, phenobarbitol (depending on level))

Patient was discussed in detail with Dr. Chrusciel and will be staffed in the morning. Please page the child neurology resident for any further concerns.

Rabbani,Bahram X DO 02/09/22 0611:
Neurology Resident Addendum
Neurology Resident Addendum
Patient was personally seen and examined by me today. Please see the following addendum below for further details.

SUB:
1-day-old baby boy born at 40 weeks of gestation via artificial rupture of membranes, delivery significant for meconium stained amniotic fluid, transferred from Durant Medical Center 2/8/22 to OU Children's Center NICU for higher level of workup and care after presenting with low APGARs of 2, 6, and 7 and spells of apnea and leg twitching concerning for possible seizures due to a possible hypoxic ischemic event vs sepsis s/p phenobarbital loads (30 mg/kg in total).

02/09: Patient had 1-2 more seizures overnight. Given Keppra 20 mg/kg load once. No further events since 0700. PHB 29.4, CSF WBC 25, RBC ~50k, elevated neutrophils, glucose 62 (serum ~60-80), protein 113.

EXAM:
GEN: somnolent
HEENT: ant fontanelle soft, open, flat
ABD: soft

NEURO:
Lang/Ment: non-verbal, somnolent, arouses to touch
CN: pupils equally round and reactive to light; oculocephalic reflex present, symm face, responds

to touch, tongue midline on protrusion
Motor: normal tone, healthy flexed posture, moving all extremities
Sens: responds appropriately to touch/tickle
Coord: no abnormal movements
Reflexes: 2+, plantar extensor response bilaterally, +grasp, +rooting
Gait: deferred

IMPRESSION:
- Apnea episodes concerning for seizure in setting of r/o sepsis vs HIE (low suspicion for HIE?)

RECOMMENDATION:
- Neurochecks
- Seizure/aspiration precautions
- HUS negative for hemorrhage
- **MRI brain W/O can be performed on day 4 of life**
- Please start phenobarbital maintenance 5 mg/kg/day (PHB level 29 as of 02/09)
- For more seizures, can give another PHB 10 mg/kg load and check another PHB level

Discussed with attending physician of record during morning rounds.

CHRUSCIEL,DEEPTI G 02/09/22 1607:

Neurology Attending Note

Attending Note

I have interviewed and examined this patient and personally reviewed all labs and studies. I discussed the patient's management with the residents and reviewed the resident's note. I have discussed care with the patient and family who voiced understanding. I agree with the documented findings and plan of care unless amended below.

Parker is a first day of life baby boy born at 40 weeks with uncomplicated pregnancy with meconium stained fluid. APGARs of 2, 4, 7. He has spells of apnea and leg twitching concerning for seizures due to a possible hypoxic ischemic event vs metabolic or genetic etiology.

On exam:
On room air, AFSF
Reactive to light stimulation
Pupils equal, facies symmetric
Normal tone, flexed position
2/4 patellar reflex
Symmetric movement

I recommend EEG. Phenobarbital level was 29. If more seizures occur can load with 10 mg/kg otherwise start maintenance of 5 mg/kg/day. Would do MRI of the brain at 4 days life or older. Would consider metabolic workup. Will continue to follow.

99253: P90

Patient: BLUE,BB-TATUM Unit#: E003047593
Date: 02/09/22 Acct#: E00677497957

Electronically Signed by Siddiqui,Sameera MD on 02/09/22 at 0309
Electronically Signed by Rabbani,Bahram DO on 02/09/22 at 1411
Electronically Signed by Chrusciel,Deepti Ganti MD on 02/09/22 at 1610

Addendum 1: 02/09/22 1423 by Rabbani,Bahram DO

Metabolic work-up:
- Pyruvate
- Serum amino acids
- Urine organic acids
- Ammonia

EEG: frequent sharp rhythmic discharges at C4 and T5/O1 with one possible EEG-push button correlate. Spoke to NICU fellow, will change EEG to continuous (already discussed with EEG attending and peds neuro attending, and ordered) and give PHB 10 mg/kg load with PHB level after. Continue PHB 5 mg/kg/day 24 hours after the load (please do not exceed 10 mg/kg/day)

Electronically Signed by Rabbani,Bahram DO on 02/09/22 at 1432

RPT #: 0209-0044
END OF REPORT

OU MEDICAL CENTER
1200 Everett Drive
Oklahoma City, OK 73104

Name: BLUE,BB-TATUM
Account Number: E00677497957
Unit Number: E003047593
Room: EU.7172
Date Of Birth: 02/08/22
Attending Doctor: Dannaway,Douglas MD
Date: 02/09/22

FELLOW'S PROCEDURE NOTE

PROCEDURES AND TREATMENTS
2/9 5:30 (day 0) Lumbar puncture (N.Dasari, MD)
1. No contraindications were present: instability, increased ICP, coagulopathy
2. Patient's condition discussed with attending physician who was present for the procedure..
Exception: Dr.Dannaway was present on the unit at the time.
3. Written informed consent was obtained from the family.. Exception: Verbal consent
taken over the phone.
4. Time out taken: Patient's ID and procedure confirmed with bedside nurse.
5. Analgesic administered prior to procedure.. Exception: Applied EMLA cream at the site.
6. Procedure was performed as described below.
7. Orders were written for CSF studies.
8. Family was updated with infant's condition after procedure completed.

Indication: Seizures The infant was placed in the lateral decubitus position with spine flexed
and normal HR and oxygen saturation. The iliac crests were identified as the landmark for
L3 to L5. The lumbar region was swabbed with antiseptic and draped in sterile manner. The
puncture area was infiltrated with lidocaine. A 22-gauge, 1-inch spinal needle was inserted
with stylet in the midline towards the umbilicus. When the needle tip was felt to be in the
spinal canal, the stylet was removed. 4 ml of cerebral spinal fluid dripped by gravity into
various vials. The stylet was replaced and the needle removed. Hemostasis was obtained and
a dressing placed over the puncture site. The skin was cleaned of the antiseptic with water.
There were no complications, and the infant tolerated the procedure well. Estimated blood
loss was <1 ml. CSF specimens were obtained and sent to the lab as follows: Vial 1 was sent
for gram stain, culture, and sensitivities Vial 2 was sent for protein and glucose levels Vial 3
was sent for cell count and differential Vial 4 was sent for HSV PCR

Attending Physician: Doug Dannaway, MD.

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

E-signed by Nalini Dasari, MD; completed 2/9/22 5:45

Electronically Signed by Douglas Dannaway, MD on 02/10/22 at 1300

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

OU MEDICAL CENTER
1200 Everett Drive
Oklahoma City, OK 73104

Name: BLUE,BB-TATUM
Account Number: E00677497957
Unit Number: E003047593
Room: EU.7172
Date Of Birth: 02/08/22
Attending Doctor: Dannaway,Douglas MD
Date: 02/09/22

NEONATAL SERVICES DAILY PROGRESS NOTE
3050 gram, 40 + 1/7 week AGA male => 3070 grams; corrected gestational age 40 + 2/7 weeks.
Active Problems: r/o sepsis (identified 2/8/22)
Seizure disorder (identified 2/8/22)

PHYSICAL EXAM (at 2/9/22 8:15)
Weight - 3070 grams (+20 grams) - 11%ile ; Z-score = -1.23
Length - 52.0 cm - 60%ile ; Z-score = 0.26
Head circumference - 34.2 cm - 24%ile ; Z-score = -0.7
Vital Signs: HR - 156, RR - 40, BP - 61/36 (mean 45), O2 Sat - 96%, Temp - 36.8 degrees
General: Infant in room air and in no distress. Skin pink, warm, and dry.
HEENT: Anterior fontanelle open, soft, and flat with sutures approximated. Molding and caput with redness to scalp from presentation with petechiae noted. Eyes clear. Pupils equally round and reactive to light. Oral mucosa pink and moist, palate intact. Ears in normal shape and position.
Chest: Chest rise symmetrical with clear breath sounds bilaterally.
Heart: Normal sinus rhythm, normal perfusion and pulses, no murmur.
Abdomen: Soft and non-distended, non-tender with active bowel sounds.
Genitals: Normal male genitalia. Testes descended bilaterally.
Anus: Patent anus in normal position.
Skeletal: Normal clavicles and normal hip exam. Spine intact.
Extremities: Moving all extremities equally.
Neuro: Alert, hypotonic, normal tone for gestational age, normal primitive reflexes. Infant appropriately reactive to exam.

FLUIDS, ELECTROLYTES, NUTRITION
Objective: Weight today 3070 grams, up 20 grams from 2/8.
On a radiant warmer.
Input: 105 ml/9 hours = 92 ml/kg/day (all parenteral); 28 cal/kg/day.
Output: Urine - 45 ml/9 hrs (1.6 ml/kg/hr).
Stools - 0 (Last stool: none recorded).
The baby is on TPN which was started yesterday.
Protein - 2.2 gram/kg/day; Fat - 0.0 gram/kg/day; Carbohydrate - 5.6 gram/kg/day.
FEEDINGS: currently NPO; no residuals.
From 2/9 8:35: Na 139, K 3.5, Cl 103, Bicarb 18.0, Glucose 59, Ca 9.1, Phos 4.8, BUN 11.0, Creat 0.8.
From 2/8 22:11: Mg 1.5.
From 2/9 2:35: Accuchek - approximately 93.
Appraisal: Infant is NPO, receiving SNAP 10 @ 80 ml/kg/day. Electrolytes as listed. Voiding and meconium at birth.

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

Plan: Continue NPO, supplement with SNAP 10 for a TFG of 80 ml/kg/day, and gavage tube to gravity.
Will consider starting trophic feeds this evening.
Will continue to assess nutritional intake, output, and growth trend.

RESPIRATORY
Summary: Infant with meconium at delivery required PPV, suctioning and transitioned to CPAP. Eventually transitioned to RA.
Infant had apneic spell at 10 HOL concerning for seizures.
Objective: Respiratory rate for yesterday: average 48, range 37-66; for the past 8 hours: average 41, range 37-47.
O2 sats for yesterday: average 97, range 93-100; for the past 8 hours: average 98, range 96-100.
On no respiratory support.
A and B events yesterday - 4 (4 severe; none associated with feeding). No A and B events today.
Appraisal: Infant with meconium at delivery required PPV and transitioned to CPAP. Eventually transitioned to RA. Infant had apneic spell at 10 HOL concerning for seizures. Has been stable on room air.
Plan: Continue to monitor and obtain blood gas for metabolic component this evening.

HEMATOLOGY
Objective: From 2/9 8:35: Hgb 16.0, Hct 43.8, Plts 208,000, WBC 15,920 - 68 polys, 3 bands, 17 lymphs, 10 monos, 2 eos; AGC = 11,303, I:T = 0.04.
Appraisal: Heme Labs stable.
Plan: Continue to monitor.
Limit lab draws as able.

BILIRUBIN
Objective: Serum bili 5.1 (direct 0.3) on 2/9 8:35.
Mother's blood type B Positive.
The infant has not been treated with phototherapy.
The maximum total bilirubin was 5.1 (direct 0.3) on 2/9.
Appraisal: Mom's blood type is B+
Infant has not been treated with phototherapy and below threshold.
Plan: Repeat T. Bili in AM.

INFECTIOUS DISEASE
Objective: Temperature range over the past day: 36.8-37.2 degrees; temperature over the past 8 hours: 36.8-37.2 degrees.
From 2/9 8:35: CRP - <3.0.
From 2/9 5:20: CEREBRAL SPINAL FLUID
From 2/8 5:30: CSF 49,750 RBCs, 25 WBCs (87 polys, 10 lymphs, 3 monos), protein 113, glucose 62.
Appraisal: Infectious workup started due to concerns of seizures. Maternal labs reassuring. Blood and CSF cultures sent. CBC and CRP reassuring. HSV CSF 1/2 negative, HSV PCR blood pending. Infant started on Ampicillin, Amikacin and Acyclovir.
Plan: Continue to monitor
Follow cultures until final.
Continue antibiotics and trend labs in the am to determine treatment length.

CARDIOVASCULAR

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

Objective: Heart rate for the past 8 hours: average HR 141, range 120-156.
Blood pressure for the past 8 hours: average cuff BP - 55/37(43 mean), range - 44-62/28-48(35-53 mean).
Appraisal: Was hypotensive en route received NS bolus x1. Infant started on dopamine 5 mcg/kg/min. MAP have ranged from 31-44
Plan: Continue to monitor, will attempt to place dopamine on hold.
Goal MAPS 35-45

NEUROLOGY
Objective: Over the past 24 hours, Phenobarbital level: 2/9 at 8:35 - 29.4 No medications were given.
Appraisal: Infant admitted due to concern for seizure activity at RH, loaded with phenobarbital at RH at 12 HOL then transferred here for further evaluation. On admission, infant presented with seizure like activity given an additional phenobarb and Keppra. LP obtained, see ID. Neurology consulted, recommended EEG and infectious workup. EEG with frequent sharp rhythmic discharges at C4 and T5/O1. Given additional 10 mg/kg phenobarb with maintenance dosing ordered. HUS obtained normal. Neurology recommended continuing EEG and starting a metabolic workup.
Plan: Continue to monitor
Continue EEG
Continue phenobarb
Continue to follow neurology recommendations. MRI at 4 days of life.

IMMUNIZATIONS
Appraisal: Hepatitis B #1 given on 2/8 at RH.
Plan: Continue to follow AAP guidelines for vaccine schedule.

GENETICS, ENDOCRINE, METABOLIC
Summary: Family history of Galactosemia.
Objective: Metabolic screening tests are pending from 2/9.
Ca 9.1, Phos 4.8 (from 2/9), Alkaline phosphatase 123 (from 2/8).
From 2/9 11:55: AMMONIA - 83.
Specimen moderately hemolyzed.
Hemolyzed Specimen-Results may be affected.
Appraisal: State NB metabolic screen sent at 24 hours of life. Pending results.
Metabolic workup in progress due to seizures.
Workup includes: Ammonia level 83, pyruvic acid (pending), serum AA (pending), UA Organic acid and reducing substances (pending)
Plan: Continue to monitor.
Follow results of labs pending.
Follow results the NBS and repeat per protocol.

SOCIAL
Appraisal: Mom and Dad have been updated at bedside, questions answered.
Plan: Continue to update on plan of care.

IN-PATIENT DEVELOPMENTAL INTERVENTIONS
Appraisal: Infant at risk of developmental delays due hospitalization and seizures.
Plan: Continue to follow developmental needs while in the unit.

CURRENT MEDICATIONS
Acyclovir, 60 mg IV q8h (19.7 mg/kg/dose, 59 mg/kg/day) started on 2/8/22

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

Amikacin, 37 mg IV q24h (12.1 mg/kg/day) started on 2/8/22

Ampicillin, 300 mg IV q12h (98.4 mg/kg/dose, 197 mg/kg/day) started on 2/8/22
DOPamine, 3.2 mg in 1 ml @ 0.29 ml/hour IV (5 mcg/kg/minute) started on 2/9/22
PHENObarbital, 15 mg IV q24h (4.9 mg/kg/day) started on 2/9/22

I personally examined the patient, reviewed and updated the history and assessment, and developed the plan of care with the multidisciplinary team as documented in this note. Jumoke A. Ogunfolu, NNP Student assisted me in the care of the patient and preparation of this note.

The patient requires intensive monitoring of cardiorespiratory stability, growth, nutrition, and I and O.

E-signed by Vadim Ivanov, MD; completed 2/9/22 15:41

Electronically Signed by Vadim A Ivanov, MD on 02/10/22 at 2200

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

OU MEDICAL CENTER (COCPN)
Neuro Interim Note
REPORT#:0209-1258
DATE:02/09/22 Time: 1606

PATIENT: BLUE,BB-TATUM UNIT No: E003047593
ACCOUNT#: E00677497957 ROOM: EU.7172
REPORT AUTHOR: Sebasigari,Denise DO

See Addendum

Neurology Interim Note

Neurology Interim Note
continuous EEG reviewed until 16:11 pm

- Abnormal continous EEG with presence of frequent subclinical focal seizures; R central (frequent)> rare left posterior temporal occipital. Right central seizures were very frequent last one was at 16:05 pm. Most push button events corresponded to seizure (although on video it was not sure why button was push since no abnormal movement were see on video). The neurology consult team was informed of these findings at the time of review.
We will continue to monitor EEG periodically.

Electronically Signed by Sebasigari,Denise DO on 02/09/22 at 1617

Addendum 1: 02/09/22 2120 by Sebasigari,Denise DO

continuous EEG reviewed from 16:11 pm to 21:13 pm

- Abnormal continous EEG with presence of frequent subclinical focal seizures; R central (frequent)> rare left posterior temporal occipital. Right central seizures were very frequent. Seizure stopped from 16:05 pm to 19:49 pm and started again occuring every 5-10 minutes. Some push button events corresponded to seizure (although on video it was not sure why button was push since no abnormal movement were see on video) and some push button had no EEG correlate. The neurology consult team was informed of these findings at the time of review.
Official report tomorrow AM .

Electronically Signed by Sebasigari,Denise DO on 02/09/22 at 2127

RPT #: 0209-1258
END OF REPORT

OU MEDICAL CENTER - THE CHILDREN'S HOSPITAL

1200 N. Phillips
Oklahoma City, OK 73104

ULTRASOUND
CONSULTATION REPORT

PHONE: (405) 271-5511
FAX: (405) 271-1718

LOC/RM: EU.NICUE/EU.7172 PACS ID: E2368718 MRN: E003047593
PT. TYPE: ADM IN CAMPUS: C PT: BLUE,BB-TATUM
ACCT#: E00677497957 DOB: 02/08/2022 AGE: 00M 01D SEX: M

ORD PROV: 1225611064 Caines,Macie N APRN EXAM START: 02/09/22 0113
ATT PROV: 1982672333 Dannaway,Douglas MD EXAM ENDED: 02/09/22 0113
ADMISSION CLINICAL DATA: APNEA

EXAMS:	CPT:
007122602 US ECHOENCEPHALOGRAPHY	76506

- US ECHOENCEPHALOGRAPHY February 9, 2022

HISTORY: One-day-old male, term infant, apnea, r/o IVH

COMPARISON: None

TECHNIQUE: Multiple axial, sagittal and coronal sonographic images of the brain were obtained.

FINDINGS:

Corpus callosum is formed. Midline structures are nondisplaced. Brain parenchyma shows no prominent mass effect. Sulcation pattern is symmetric. No prominent abnormal parenchymal echogenicity is demonstrated. Posterior fossa cerebellar hemispheres and vermis show no significant abnormality.

There are slitlike lateral ventricles. No large extra-axial fluid collection causing mass effect is identified.

IMPRESSION:

No acute intracranial process by ultrasound.

I have personally viewed the images and/or data and approve the report.

** Electronically Signed by 137 THERESA THAI MD **
** on 02/09/2022 at 1100 **
RESIDENT: QUINN BAKER, MD
Reported and signed by: THERESA THAI, MD 137

DICTATED: 02/09/2022 @ 0315 TRANSCRIBED: 02/09/22 @ 0320
TYPIST: RAD.VR PRINTED: 02/09/2022 @ 1102
E-SIGNATURE DATE/TIME: 02/09/2022 @ 1100 DR.THATH1 BATCH: N/A

PAGE 1 Signed Report

OU MEDICAL CENTER - THE CHILDREN'S HOSPITAL
1200 N. Phillips RADIOLOGY PHONE: (405) 271-5511
Oklahoma City, OK 73104 CONSULTATION REPORT FAX: (405) 271-1718

LOC/RM: EU.NICUE/EU.7172 PACS ID: E2368718 MRN: E003047593
PT. TYPE: ADM IN CAMPUS: C PT: BLUE,BB-TATUM
ACCT#: E00677497957 DOB: 02/08/2022 AGE: 00M 00D SEX: M

ORD PROV: 1225611064 Caines,Macie N APRN EXAM START: 02/08/22 2333
ATT PROV: 1982672333 Dannaway,Douglas MD EXAM ENDED: 02/08/22 2333
ADMISSION CLINICAL DATA: APNEA

EXAMS:	CPT:
007122562 RAD CHEST 1 VIEW	71045
007122563 RAD ABDOMEN 1 VIEW (KUB)	74018

- RAD CHEST 1 VIEW, - RAD ABDOMEN 1 VIEW (KUB) 007122562, 007122563
2/8/2022 11:33 PM

CLINICAL: APNEA
REASON FOR EXAM: line placement

COMPARISON: None

TECHNIQUE: Supine AP view of chest and abdomen

IMPRESSION:

1. UVC line distal portion is seen looped over right upper quadrant most likely in the right portal vein.

2. Lungs are clear with no focal consolidation, pleural effusion or pneumothorax.

3. Cardiomediastinal silhouette is within normal limits

4. Gas pattern is nonspecific. Visualized osseous structures and soft tissues do not show acute process.

** Electronically Signed by 247 SANDEEP PRABHU MD **
** on 02/09/2022 at 0942 **
Reported and signed by: SANDEEP PRABHU, MD 247

DICTATED: 02/09/2022 @ 0941 TRANSCRIBED: 02/09/22 @ 0941
TYPIST: RAD.VR PRINTED: 02/09/2022 @ 0944
E-SIGNATURE DATE/TIME: 02/09/2022 @ 0942 DR.PRASAN BATCH: N/A

PAGE 1 Signed Report

OU MEDICAL CENTER - THE CHILDREN'S HOSPITAL
1200 N. Phillips RADIOLOGY PHONE: (405) 271-5511
Oklahoma City, OK 73104 CONSULTATION REPORT FAX: (405) 271-1718

LOC/RM: EU.NICUE/EU.7172 PACS ID: E2368718 MRN: E003047593
PT. TYPE: ADM IN CAMPUS: C PT: BLUE,BB-TATUM
ACCT#: E00677497957 DOB: 02/08/2022 AGE: 00M 00D SEX: M

ORD PROV: 1437610375 Fox,Amber APRN EXAM START: 02/08/22 2334
ATT PROV: 1982672333 Dannaway,Douglas MD EXAM ENDED: 02/08/22 2334
ADMISSION CLINICAL DATA: APNEA

EXAMS:	CPT:
007122580 RAD CHEST 1 VIEW	71045
007122581 RAD ABDOMEN 1 VIEW (KUB)	74018

- RAD CHEST 1 VIEW, - RAD ABDOMEN 1 VIEW (KUB) 007122580, 007122581
2/8/2022 11:34 PM

CLINICAL: APNEA
REASON FOR EXAM: reposition line

COMPARISON: February 8, 2022

TECHNIQUE: Supine AP view of chest and abdomen

IMPRESSION:

1. UVC line distal portion is again seen looped over right upper quadrant, needs repositioning.

2. Shallow inspiration with groundglass haziness seen bilaterally. No pleural effusion or pneumothorax.

3. Cardiomediastinal silhouette is stable

4. Gas pattern is nonspecific. Visualized osseous structures and soft tissues do not show acute process.

** Electronically Signed by 247 SANDEEP PRABHU MD **
** on 02/09/2022 at 0943 **
Reported and signed by: SANDEEP PRABHU, MD 247

DICTATED: 02/09/2022 @ 0942 TRANSCRIBED: 02/09/22 @ 0942
TYPIST: RAD.VR PRINTED: 02/09/2022 @ 0946
E-SIGNATURE DATE/TIME: 02/09/2022 @ 0943 DR.PRASAN BATCH: N/A

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1200 N. Phillips RADIOLOGY PHONE: (405) 271-5511
Oklahoma City, OK 73104 CONSULTATION REPORT FAX: (405) 271-1718

LOC/RM: EU.NICUE/EU.7172 PACS ID: E2368718 MRN: E003047593
PT. TYPE: ADM IN CAMPUS: C PT: BLUE,BB-TATUM
ACCT#: E00677497957 DOB: 02/08/2022 AGE: 00M 00D SEX: M

ORD PROV: 1225611064 Caines,Macie N APRN EXAM START: 02/08/22 2333
ATT PROV: 1982672333 Dannaway,Douglas MD EXAM ENDED: 02/08/22 2333
ADMISSION CLINICAL DATA: APNEA

EXAMS:	CPT:
007122562 RAD CHEST 1 VIEW	71045
007122563 RAD ABDOMEN 1 VIEW (KUB)	74018

- RAD CHEST 1 VIEW, - RAD ABDOMEN 1 VIEW (KUB) 007122562, 007122563
2/8/2022 11:33 PM

CLINICAL: APNEA
REASON FOR EXAM: line placement

COMPARISON: None

TECHNIQUE: Supine AP view of chest and abdomen

IMPRESSION:

1. UVC line distal portion is seen looped over right upper quadrant most likely in the right portal vein.

2. Lungs are clear with no focal consolidation, pleural effusion or pneumothorax.

3. Cardiomediastinal silhouette is within normal limits

4. Gas pattern is nonspecific. Visualized osseous structures and soft tissues do not show acute process.

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** on 02/09/2022 at 0942 **
Reported and signed by: SANDEEP PRABHU, MD 247

DICTATED: 02/09/2022 @ 0941 TRANSCRIBED: 02/09/22 @ 0941
TYPIST: RAD.VR PRINTED: 02/09/2022 @ 0944
E-SIGNATURE DATE/TIME: 02/09/2022 @ 0942 DR.PRASAN BATCH: N/A

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OU MEDICAL CENTER - THE CHILDREN'S HOSPITAL
1200 N. Phillips RADIOLOGY PHONE: (405) 271-5511
Oklahoma City, OK 73104 CONSULTATION REPORT FAX: (405) 271-1718

LOC/RM: EU.NICUE/EU.7172 PACS ID: E2368718 MRN: E003047593
PT. TYPE: ADM IN CAMPUS: C PT: BLUE,BB-TATUM
ACCT#: E00677497957 DOB: 02/08/2022 AGE: 00M 00D SEX: M

ORD PROV: 1437610375 Fox,Amber APRN EXAM START: 02/08/22 2334
ATT PROV: 1982672333 Dannaway,Douglas MD EXAM ENDED: 02/08/22 2334
ADMISSION CLINICAL DATA: APNEA

EXAMS:	CPT:
007122580 RAD CHEST 1 VIEW	71045
007122581 RAD ABDOMEN 1 VIEW (KUB)	74018

- RAD CHEST 1 VIEW, - RAD ABDOMEN 1 VIEW (KUB) 007122580, 007122581
2/8/2022 11:34 PM

CLINICAL: APNEA
REASON FOR EXAM: reposition line

COMPARISON: February 8, 2022

TECHNIQUE: Supine AP view of chest and abdomen

IMPRESSION:

1. UVC line distal portion is again seen looped over right upper quadrant, needs repositioning.

2. Shallow inspiration with groundglass haziness seen bilaterally. No pleural effusion or pneumothorax.

3. Cardiomediastinal silhouette is stable

4. Gas pattern is nonspecific. Visualized osseous structures and soft tissues do not show acute process.

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** on 02/09/2022 at 0943 **
Reported and signed by: SANDEEP PRABHU, MD 247

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E-SIGNATURE DATE/TIME: 02/09/2022 @ 0943 DR.PRASAN BATCH: N/A

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OU MEDICAL CENTER - THE CHILDREN'S HOSPITAL
1200 N. Phillips RADIOLOGY PHONE: (405) 271-5511
Oklahoma City, OK 73104 CONSULTATION REPORT FAX: (405) 271-1718

LOC/RM: EU.NICUE/EU.7172 PACS ID: E2368718 MRN: E003047593
PT. TYPE: ADM IN CAMPUS: C PT: BLUE,BB-TATUM
ACCT#: E00677497957 DOB: 02/08/2022 AGE: 00M 01D SEX: M

ORD PROV: 1578940532 Fraysur,Jennifer D NP EXAM START: 02/09/22 0853
ATT PROV: 1982672333 Dannaway,Douglas MD EXAM ENDED: 02/09/22 0853
ADMISSION CLINICAL DATA: APNEA

EXAMS:	CPT:
007122848 RAD CHEST 1 VIEW	71045

- RAD CHEST 1 VIEW 007122848 2/9/2022 8:53 AM

CLINICAL: APNEA
REASON FOR EXAM: PICC PLACEMENT

COMPARISON: February 8, 2022

TECHNIQUE: Supine AP view of chest

IMPRESSION:

1. Right upper extremity PICC line distal tip is overlying proximal SVC. Enteric tube distal tip is in the region of GE junction.

2. Lungs shows minimal groundglass haziness with no focal consolidation, pleural effusion or pneumothorax

3. Cardiomediastinal silhouette is stable

4. Visualized osseous structures and soft tissues do not show acute process.

** Electronically Signed by 247 SANDEEP PRABHU MD **
** on 02/09/2022 at 0944 **
Reported and signed by: SANDEEP PRABHU, MD 247

DICTATED: 02/09/2022 @ 0943 TRANSCRIBED: 02/09/22 @ 0943
TYPIST: RAD.VR PRINTED: 02/09/2022 @ 0946
E-SIGNATURE DATE/TIME: 02/09/2022 @ 0944 DR.PRASAN BATCH: N/A

PAGE 1 Signed Report

OU MEDICAL CENTER
1200 Everett Drive
Oklahoma City, OK 73104

Name: BLUE,BB-TATUM
Account Number: E00677497957
Unit Number: E003047593
Room: EU.7172
Date Of Birth: 02/08/22
Attending Doctor: Dannaway,Douglas MD
Date: 02/10/22

NEONATAL SERVICES DAILY PROGRESS NOTE
3050 gram, 40 + 1/7 week AGA male => 3010 grams; corrected gestational age 40 + 3/7 weeks.
Active Problems: r/o sepsis (identified 2/8/22)
Seizure disorder (identified 2/8/22)

PHYSICAL EXAM (at 2/10/22 9:00)
Weight - 3010 grams (-60 grams) - 8%ile ; Z-score = -1.43
Vital Signs: HR - 153, RR - 32, BP - 57/30 (mean 36), O2 Sat - 93%, Temp - 37.0 degrees
General: Infant in room air and in no distress. Skin pink, warm, and dry.
HEENT: Anterior fontanelle open, soft, and flat with sutures approximated. Head covered with CFM elctrodes and gauze wrap. Eyes clear. Pupils equally round and reactive to light. Oral mucosa pink and moist, palate intact. Ears in normal shape and position.
Chest: Chest rise symmetrical with upper airway congestion bilaterally.
Heart: Normal sinus rhythm, normal perfusion and pulses, no murmur.
Abdomen: Soft and non-distended, non-tender with active bowel sounds.
Extremities: Moving all extremities equally.
Neuro: Resting, improving tone, normal primitive reflexes. Uncoordinated suck, little interest in a pacifier. Delayed gag on previous exam.

FLUIDS, ELECTROLYTES, NUTRITION
Objective: Weight today 3010 grams, down 60 grams from 2/9. Lost 20.0 grams/day/2 days. Down 1% below birthweight.
On a radiant warmer.
Input: 269 ml = 88 ml/kg/day (all parenteral); 39 cal/kg/day.
Output: Urine - 191 ml/day (2.6 ml/kg/hr).
Stools - 0 (Last stool: none recorded).
The baby has been on TPN for 2 days from 2/8. A PICC-Right arm was placed yesterday.
Protein - 3.1 gram/kg/day; Fat - 0.0 gram/kg/day; Carbohydrate - 7.9 gram/kg/day.
FEEDINGS: currently NPO; no residuals.
From 2/10 2:47: Na 139, K 4.5, Cl 104, Bicarb 20.0, Glucose 92, Ca 9.3, Phos 5.1, BUN 19.0, Creat 0.6.
From 2/8 22:11: Mg 1.5.
From 2/9 2:35: Accuchek - approximately 93.
Appraisal: Infant is NPO, receiving SNAP 10 @ 80 ml/kg/day. Electrolytes as listed. Voiding and meconium at birth. Infant is -1% below birthweight.
Plan: Start enteral feeds at 20 ml/kg of Human Milk or Similac term, supplement with TPN/SMOF for a TFG of 100 ml/kg/day.
Will continue to assess nutritional intake, output, and growth trend.

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

RESPIRATORY
Objective: Respiratory rate for yesterday: average 37, range 27-60; for the past 8 hours: average 31, range 27-34.
O2 sats for yesterday: average 97, range 93-100; for the past 8 hours: average 94, range 93-97.
On no respiratory support.
From 2/9 17:06: Capillary blood gases: pH 7.41, pCO2 37, pO2 42, base excess -0.9.
A and B events yesterday - 5 (5 mild; none associated with feeding). No A and B events today.
Appraisal: Infant with meconium at delivery required PPV and transitioned to CPAP. Eventually transitioned to RA. Infant had apneic spell at 10 HOL concerning for seizures. Has remained stable on room air. Infant had few events overnight that required no intervention.
Plan: Continue to monitor.

HEMATOLOGY
Objective: From 2/10 2:47: Hgb 16.7, Hct 45.7, Plts 239,000, WBC 15,600 - 71 polys, 14 lymphs, 9 monos, 4 eos; AGC = 11,076, I:T = 0.00.
Appraisal: Heme Labs stable.
Plan: Continue to monitor.
Limit lab draws as able.

BILIRUBIN
Objective: Serum bili 5.2 on 2/10 2:47.
Mother's blood type B Positive.
The infant has not been treated with phototherapy.
The maximum total bilirubin was 5.2 on 2/10 and the maximum direct bilirubin was 0.3 on 2/9.
Appraisal: Mom's blood type is B+. T bili remain below threshold of treatment.
Plan: Continue to monitor clinically.

INFECTIOUS DISEASE
Objective: Temperature range over the past day: 36.3-37.2 degrees; temperature over the past 8 hours: 36.3-37.0 degrees.
From 2/10 2:47: CRP - <3.0.
From 2/9 5:20: CEREBRAL SPINAL FLUID
From 2/8: CSF 49,750 RBCs, 25 WBCs (87 polys, 10 lymphs, 3 monos), protein 113, glucose 62.
Appraisal: Infectious workup started due to concerns of seizures. Maternal labs reassuring. Blood and CSF cultures sent. CBC and CRP reassuring. HSV CSF 1/2 negative, HSV PCR blood negative. Infant started on Ampicillin, Amikacin and Acyclovir. CSF and blood culture NGTD.
Plan: Continue to monitor
Follow cultures until final.
Continue antibiotics and attending to speak with Peds ID to determine treatment length.

CARDIOVASCULAR
Objective: Heart rate for yesterday: average HR 143, range 120-176; for the past 8 hours: average HR 147, range 137-157.
Blood pressure for yesterday: average cuff BP - 55/33(41 mean), range - 44-67/25-48(35-53 mean); for the past 8 hours: average cuff BP - 55/30(38 mean),

range - 52-58/28-32(36-41 mean).
Appraisal: Hemodynamically stable.
Plan: Continue to monitor clinically.

NEUROLOGY
Objective: Over the past 24 hours, Phenobarbital level: 2/9 at 17:15 - 39.1 No medications were given.
Appraisal: Infant admitted due to concern for seizure activity at RH, loaded with phenobarbital at RH at 12 HOL then transferred here for further evaluation. On admission, infant presented with seizure like activity given an additional phenobarb and Keppra. LP obtained, see ID. Neurology consulted, recommended EEG and infectious workup. EEG with frequent sharp rhythmic discharges at C4 and T5/O1. Given additional 10 mg/kg phenobarb with maintenance dosing ordered. HUS obtained normal. Neurology recommended continuing EEG and starting a metabolic workup.
Overnight, EEG concerning for more seizures, infant was given a one time loading dose of Fosphenytoin 20 mg/kg. If infant continues to have more seizures, consider genetic workup.
Plan: Continue to monitor
Continue EEG
Continue phenobarb, Change dose to 7.5 mg BID (2.5 mg/kg/dose)
Continue to follow neurology recommendations. MRI at 4 days of life.

IMMUNIZATIONS
Appraisal: Hepatitis B #1 given on 2/8 at RH.
Plan: Continue to follow AAP guidelines for vaccine schedule.

GENETICS, ENDOCRINE, METABOLIC
Objective: Metabolic screening tests are pending from 2/9.
Ca 9.3, Phos 5.1 (from 2/10), Alkaline phosphatase 123 (from 2/8).
From 2/9 11:55: AMMONIA - 83.
Specimen moderately hemolyzed.
Hemolyzed Specimen-Results may be affected.
Appraisal: State NB metabolic screen sent at 24 hours of life. Pending results.
Metabolic workup in progress due to seizures.
Workup includes: Ammonia level 83, pyruvic acid (pending), serum AA (pending), UA Organic acid and reducing substances (pending)
Plan: Continue to monitor.
Follow results of labs pending.
Follow results the NBS and repeat per protocol.

SOCIAL
Appraisal: Mom and Dad have been updated at bedside during rounds, questions answered.
Plan: Continue to update on plan of care.

IN-PATIENT DEVELOPMENTAL INTERVENTIONS
Appraisal: Infant at risk of developmental delays due hospitalization and seizures.
Plan: Continue to follow developmental needs while in the unit.

CURRENT MEDICATIONS
Acyclovir, 60 mg IV q8h (19.7 mg/kg/dose, 59 mg/kg/day) started on 2/8/22
Amikacin, 37 mg IV q24h (12.1 mg/kg/day) started on 2/8/22

Ampicillin, 300 mg IV q12h (98.4 mg/kg/dose, 197 mg/kg/day) started on 2/8/22

PHENObarbital, 15 mg IV q24h (4.9 mg/kg/day) started on 2/9/22

I personally examined the patient, reviewed and updated the history and assessment, and developed the plan of care with the multidisciplinary team as documented in this note. Jumoke A. Ogunfolu, NNP Student assisted me in the care of the patient and preparation of this note.

Intensive monitoring of cardiorespiratory stability, growth, nutrition, and I and O is needed.

E-signed by Vadim Ivanov, MD; completed 2/10/22 15:55

Electronically Signed by Vadim A Ivanov, MD on 02/11/22 at 1700

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

OU MEDICAL CENTER (COCPN)
Neurology Prog Note
REPORT#:0210-0337
DATE:02/10/22 Time: 0713

PATIENT: BLUE,BB-TATUM UNIT No: E003047593
ACCOUNT#: E00677497957 ROOM: EU.7172
REPORT AUTHOR: Rabbani,Bahram DO

Shroll,Ethan J 02/10/22 0713:
Neurology Progress Note

Subjective
MEDICAL STUDENT NOTE
2-day old male infant born at 40 wks via AROM with mecomnium stained amniotic fluid, transferred from Durant after APGAR of 2-6-7, spells of apnea and leg twitching concerning for possible seizures, hypoxic-ischemic event vs sepsis. Got phenobarbitol 30mg/kg at Durant.

EEG here showed focal seizures (frequently right central focus, rarely left posterior temporo-occipital) for which he got another phenobarbitol 10 mg/kg, then later fosphenytoin 20 mg/kg.

Problem List
1. Seizure

Physical Exam
Heart: RRR

Lungs: Coarse crackles, likely referred upper airway sounds

Abdomen: Soft, nontender, normal bowel sounds

Extremeties: Warm, well perfused

Neurological Exam: Sleepy, rousable, fussy. Pupils equal and reactive per nursing, face summetric, tongue midline, responds to touch in face and extremeties. Normal tone, patellar and Babinski reflexes intact, no abnormal spontaneous movements.

Current Medications
Current Medications

Medication	Dose	Sig/Sch Route	Start time Stop Time	Status	Last Admin
Amikacin Sulfate N/A	37 MG 1 EACH	Q24H IV	02/10 1800 02/14 1829	UNV	
Ampicillin Sodium N/A	300 MG 1 EACH	Q12H IV	02/10 0700 02/12 0701	UNV	
Fosphenytoin Sodium	60 MG	ONCE ONE	02/09 2330	DC	02/09

Patient: BLUE,BB-TATUM
Date: 02/10/22
Unit#: E003047593
Acct#: E00677497957

		IV	02/09 2331		2330
Phenobarbital Sodium	15.25 MG	Q24H IV	02/09 1900 03/11 1901	AC	
Amikacin Sulfate N/A	37 MG 1 EACH	Q24H IV	02/09 1830 02/09 1859	DC	02/09 1754
Phenobarbital Sodium	30.5 MG	ONCE ONE IV	02/09 1500 02/09 1501	DC	02/09 1455
Heparin Sodium (Porcine)	10 UNITS	Q12H IV	02/09 0800 03/11 0801	AC	
Ampicillin Sodium N/A	300 MG 1 EACH	Q12H IV	02/09 0630 02/10 0659	DC	02/10 0624
Dopamine HCl	25 ML	CONTINUOUS IV	02/09 0300 03/11 0301	DA	02/09 0951
Acyclovir N/A	60 MG 1 EACH	Q8H IV	02/08 2330 02/15 2201	r	02/10 0022
Heparin Sodium (Porcine) Dextrose/Water	125 UNITS 250 ML	.Q24H IV	02/08 2230 03/10 2231	DC	
Nutrition (Parenteral)	250 ML	CONTINUOUS IV	02/08 2230 03/10 2231	AC	02/09 0950

Diagnostic Studies
Laboratory Tests

	02/08 2211	02/08 2309	02/09 0028	02/09 0128
Chemistry				
Sodium (137 - 146 mmol/L)	135			
Potassium (3.7 - 6.1 mmol/L)	4.0			
Chloride (100 - 110 mmol/L)	100			
Carbon Dioxide (17 - 28 mmol/L)	16			
Anion Gap (4 - 14)	19			
BUN (2 - 19 mg/dL)	9.0			
Creatinine (0.20 - 0.41 mg/dL)	0.90			
Glucose (43 - 116 mg/dL)	80			
POC Glucose (40 - 110 mg/dL)		80	82	57
Calcium (7.7 - 10.5 mg/dL)	8.5			
Phosphorus (1.5 - 4.6 mg/dL)	4.4			
Magnesium (1.3 - 2.4 mg/dL)	1.5			
Total Bilirubin (0.9 - 8.8 mg/dL)	3.9			
AST (45 - 175 U/L)	65			
ALT (12 - 47 U/L)	27			
Total Alk Phosphatase (83 - 248 U/L)	123			
C-Reactive Protein (< 5.0 mg/L)	< 3.0			
Total Protein (None Established g/dL)	4.9			
Albumin (2.9 - 3.8 g/dL)	3.2			

Patient: BLUE,BB-TATUM
Date: 02/10/22
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Albumin/Globulin Ratio (1.0 - 2.2)	1.9			
Hematology				
WBC (5.00 - 25.00 K/mm3)	16.93			
RBC (4.10 - 6.10 M/mm3)	4.24			
Hgb (13.5 - 20.5 g/dL)	16.3			
Hct (41.0 - 65.0 %)	45.4			
MCV (88.0 - 122.0 fL)	107.1			
MCH (28.0 - 32.0 pg)	38.4			
MCHC (31.0 - 35.0 g/dL)	35.9			
RDW (11 - 15 %)	14.8			
Plt Count (150 - 400 K/mm3)	262			
MPV (9.3 - 12.2 fL)	9.6			
Seg Neutrophils % (32 - 62 %)	78			
Lymphocytes % (Manual) (26 - 36 %)	4			
Monocytes % (Manual) (2 - 10 %)	15			
Eosinophils % (Manual) (0 - 5 %)	1			
Myelocytes % (0 - 0 %)	2			
Seg Neutrophils # (1.6 - 15.5 K/mm3)	13.21			
Lymphocytes # (Manual) (1.3 - 9.0 K/mm3)	0.68			
Monocytes # (Manual) (0.1 - 2.5 K/mm3)	2.54			
Eosinophils # (Manual) (0 - 1.3 K/mm3)	0.17			
Myelocytes # (0 - 0 K/mm3)	0.34			
Nucleated RBCs # (0 - 0.012 K/mm3)	0.17			
Nucleated RBCs/100 WBC (0 - 0.2 /100 WBC)	1.00			
Platelet Estimate	APPEAR ADEQUATE			
Polychromasia	1+			
Poikilocytosis	1+			
Anisocytosis	1+			
Macrocytosis	1+			

	02/09 0235	02/09 0835	02/09 1127
Chemistry			
Sodium (137 - 146 mmol/L)		139	
Potassium (3.7 - 6.1 mmol/L)		3.5	
Chloride (100 - 110 mmol/L)		103	
Carbon Dioxide (17 - 28 mmol/L)		18	
Anion Gap (4 - 14)		18	
BUN (2 - 19 mg/dL)		11.0	
Creatinine (0.20 - 0.41 mg/dL)		0.76	
Glucose (43 - 116 mg/dL)		59	
POC Glucose (40 - 110 mg/dL)	93		
Calcium (7.7 - 10.5 mg/dL)		9.1	
Phosphorus (1.5 - 4.6 mg/dL)		4.8	
Total Bilirubin (0.9 - 8.8 mg/dL)		5.1	
Direct Bilirubin (0.2 - 0.4 mg/dL)		0.3	

Patient: BLUE,BB-TATUM
Date: 02/10/22
Unit#: E003047593
Acct#: E00677497957

Indirect Bilirubin (None establ. mg/dL)		4.8	
C-Reactive Protein (<5.0 mg/L)		<3.0	
Albumin (2.9 - 3.8 g/dL)		3.4	
Hematology			
WBC (5.00 - 25.00 K/mm3)		15.92	
RBC (4.10 - 6.10 M/mm3)		4.12	
Hgb (13.5 - 20.5 g/dL)		16.0	
Hct (41.0 - 65.0 %)		43.8	
MCV (88.0 - 122.0 fL)		106.3	
MCH (28.0 - 32.0 pg)		38.8	
MCHC (31.0 - 35.0 g/dL)		36.5	
RDW (11 - 15 %)		14.9	
Plt Count (150 - 400 K/mm3)		208	
MPV (9.3 - 12.2 fL)		8.7	
Seg Neutrophils % (32 - 62 %)		68	
Band Neutrophils % (0 - 12 %)		3	
Lymphocytes % (Manual) (26 - 36 %)		17	
Monocytes % (Manual) (2 - 10 %)		10	
Eosinophils % (Manual) (0 - 5 %)		2	
Seg Neutrophils # (1.6 - 15.5 K/mm3)		10.83	
Band Neutrophils # (0 - 3.0 K/mm3)		0.48	
Lymphocytes # (Manual) (1.3 - 9.0 K/mm3)		2.71	
Monocytes # (Manual) (0.1 - 2.5 K/mm3)		1.59	
Eosinophils # (Manual) (0 - 1.3 K/mm3)		0.32	
Nucleated RBCs # (0 - 0.012 K/mm3)		0.50	
Nucleated RBCs/100 WBC (0 - 0.2 /100 WBC)		3.10	
Platelet Estimate		APPEAR ADEQUATE	
Polychromasia		1+	
Poikilocytosis		1+	
Anisocytosis		1+	
Macrocytosis		1+	
Toxicology			
Phenobarbital (14 - 38 mg/L)		29.4	
Urines			
Urine Ketones (NEGATIVE)			NEGATIVE

	02/09 1155	02/09 1706	02/09 1715
Blood Gas			
Specimen Type		Capillary	
Patient Temperature (C or F)		36.5	
Capillary pH (7.30 - 7.45)		7.41	
Capillary pCO2 (35 - 45 mmHg)		37	
Capillary pO2 (40 - 50 mmHg)		42	
Capillary HCO3 (22 - 29 mEq/L)		23	
Capillary Base Excess (-4.0 - 4.0 mmol/L)		-0.9	

Patient: BLUE,BB-TATUM
Date: 02/10/22
Unit#: E003047593
Acct#: E00677497957

Capillary O2 Sat (%)		78	
POC FiO2 (% or L)		21	
Chemistry			
Ammonia (64 - 107 umol/L)	83		
Miscellaneous			
Specimen Comment			
Toxicology			
Phenobarbital (14 - 38 mg/L)			39.1

	02/10 0247
Chemistry	
Sodium (137 - 146 mmol/L)	139
Potassium (3.7 - 6.1 mmol/L)	4.5
Chloride (100 - 110 mmol/L)	104
Carbon Dioxide (17 - 28 mmol/L)	20
Anion Gap (4 - 14)	15
BUN (2 - 19 mg/dL)	19.0
Creatinine (0.20 - 0.41 mg/dL)	0.57
Glucose (43 - 116 mg/dL)	92
Calcium (7.7 - 10.5 mg/dL)	9.3
Phosphorus (1.5 - 4.6 mg/dL)	5.1
Total Bilirubin (0.9 - 8.8 mg/dL)	5.2
C-Reactive Protein (<5.0 mg/L)	<3.0
Albumin (2.9 - 3.8 g/dL)	3.1
Hematology	
WBC (5.00 - 25.00 K/mm3)	15.60
RBC (4.10 - 6.10 M/mm3)	4.24
Hgb (13.5 - 20.5 g/dL)	16.7
Hct (41.0 - 65.0 %)	45.7
MCV (88.0 - 122.0 fL)	107.8
MCH (28.0 - 32.0 pg)	39.4
MCHC (31.0 - 35.0 g/dL)	36.5
RDW (11 - 15 %)	15.3
Plt Count (150 - 400 K/mm3)	239
MPV (9.3 - 12.2 fL)	9.3
Seg Neutrophils % (32 - 62 %)	71
Lymphocytes % (Manual) (26 - 36 %)	14
Reactive Lymphs % (0 - 0 %)	2
Monocytes % (Manual) (2 - 10 %)	9
Eosinophils % (Manual) (0 - 5 %)	4
Seg Neutrophils # (1.6 - 15.5 K/mm3)	11.08
Lymphocytes # (Manual) (1.3 - 9.0 K/mm3)	2.18
Reactive Lymphs # (0 - 0 K/mm3)	0.31
Monocytes # (Manual) (0.1 - 2.5 K/mm3)	1.40
Eosinophils # (Manual) (0 - 1.3 K/mm3)	0.62

Patient: BLUE,BB-TATUM Unit#: E003047593
Date: 02/10/22 Acct#: E00677497957

Nucleated RBCs # (0 - 0.012 K/mm3)	0.24
Nucleated RBCs/100 WBC (0 - 0.2 /100 WBC)	1.50
Platelet Estimate	APPEAR ADEQUATE
Polychromasia	1+
Anisocytosis	1+
Macrocytosis	1+

Microbiology

Date/Time Source	Procedure - Status Growth
02/08 2234 NARES	MRSA Screen - COMP
02/08 2152 CSF	Herpes Simplex Virus II DNA (PCR) - COMP
02/08 2152 CSF	Herpes Simplex Virus I DNA (PCR) - COMP

Recent Impressions
RADIOLOGY - RAD ABDOMEN 1 VIEW (KUB) 02/08 2333
*** Report Impression - Status: SIGNED Entered: 02/09/2022 0944

IMPRESSION:

1. UVC line distal portion is seen looped over right upper quadrant most likely in the right portal vein.

2. Lungs are clear with no focal consolidation, pleural effusion or pneumothorax.

3. Cardiomediastinal silhouette is within normal limits

4. Gas pattern is nonspecific. Visualized osseous structures and soft tissues do not show acute process.
Impression By: DR.PRASAN - SANDEEP PRABHU, MD 247
RADIOLOGY - RAD CHEST 1 VIEW 02/08 2333
*** Report Impression - Status: SIGNED Entered: 02/09/2022 0944

IMPRESSION:

1. UVC line distal portion is seen looped over right upper quadrant most likely in the right portal vein.

2. Lungs are clear with no focal consolidation, pleural effusion or pneumothorax.

3. Cardiomediastinal silhouette is within normal limits

Patient: BLUE,BB-TATUM Unit#: E003047593
Date: 02/10/22 Acct#: E00677497957

4. Gas pattern is nonspecific. Visualized osseous structures and soft tissues do not show acute process.
Impression By: DR.PRASAN - SANDEEP PRABHU, MD 247

RADIOLOGY - RAD ABDOMEN 1 VIEW (KUB) 02/08 2334
*** Report Impression - Status: SIGNED Entered: 02/09/2022 0945

IMPRESSION:

1. UVC line distal portion is again seen looped over right upper quadrant, needs repositioning.

2. Shallow inspiration with groundglass haziness seen bilaterally. No pleural effusion or pneumothorax.

3. Cardiomediastinal silhouette is stable

4. Gas pattern is nonspecific. Visualized osseous structures and soft tissues do not show acute process.
Impression By: DR.PRASAN - SANDEEP PRABHU, MD 247

RADIOLOGY - RAD CHEST 1 VIEW 02/08 2334
*** Report Impression - Status: SIGNED Entered: 02/09/2022 0945

IMPRESSION:

1. UVC line distal portion is again seen looped over right upper quadrant, needs repositioning.

2. Shallow inspiration with groundglass haziness seen bilaterally. No pleural effusion or pneumothorax.

3. Cardiomediastinal silhouette is stable

4. Gas pattern is nonspecific. Visualized osseous structures and soft tissues do not show acute process.
Impression By: DR.PRASAN - SANDEEP PRABHU, MD 247

ULTRASOUND - US ECHOENCEPHALOGRAPHY 02/09 0113
*** Report Impression - Status: SIGNED Entered: 02/09/2022 1102

IMPRESSION:

No acute intracranial process by ultrasound.

I have personally viewed the images and/or data and approve the report.
Impression By: DR.THATH1 - THERESA THAI, MD 137

Patient: BLUE,BB-TATUM Unit#: E003047593
Date: 02/10/22 Acct#: E00677497957

RADIOLOGY - RAD CHEST 1 VIEW 02/09 0853
*** Report Impression - Status: SIGNED Entered: 02/09/2022 0946

IMPRESSION:

1. Right upper extremity PICC line distal tip is overlying proximal SVC. Enteric tube distal tip is in the region of GE junction.

2. Lungs shows minimal groundglass haziness with no focal consolidation, pleural effusion or pneumothorax

3. Cardiomediastinal silhouette is stable

4. Visualized osseous structures and soft tissues do not show acute process.
Impression By: DR.PRASAN - SANDEEP PRABHU, MD 247

Assessment
Newborn with focal seizures of unknown etiology, no further seizures after fos load, pending metabolic workup. No evidence of HIE, phenobarbitol levels at the high end of therapeutic. CSF concerning for infection.
Plan
Continue to monitor, if seizures recur, consider adding levotiracetam 10 mg/kg.
Other care per primary team.

Rabbani,Bahram X DO 02/10/22 0908:
Neurology Resident Addendum
Neurology Resident Addendum
Patient was personally seen and examined by me today. Please see the following addendum below for further details.

SUB:
1-day-old baby boy born at 40 weeks of gestation via artificial rupture of membranes, delivery significant for meconium stained amniotic fluid, transferred from Durant Medical Center 2/8/22 to OU Children's Center NICU for higher level of workup and care after presenting with low APGARs of 2, 6, and 7 and spells of apnea and leg twitching concerning for possible seizures due to a possible hypoxic ischemic event vs sepsis s/p phenobarbital loads (30 mg/kg in total).

02/09: Patient had 1-2 more seizures overnight. Given Keppra 20 mg/kg load once. No further events since 0700. PHB 29.4, CSF WBC 25, RBC ~50k, elevated neutrophils, glucose 62 (serum ~60-80), protein 113.

02/10: EEG demonstrated focal seizures from C4 and rarely T5/O1. Patient loaded with phenobarbital 10 mg/kg again with PHB level 39.1 today. Patient had another seizure later that

night and was given fosphenytoin 20 mg/kg once with resolution of spells the rest of the night (per EEG attending's verbal communication with me). Ammonia 83.

EXAM:
GEN: somnolent
HEENT: ant fontanelle soft, open, flat
ABD: soft

NEURO:
Lang/Ment: non-verbal, somnolent, arouses to touch; one apneic event during exam
CN: pupils equally round and reactive to light; oculocephalic reflex present, symm face, responds to touch, tongue midline on protrusion
Motor: normal tone, healthy flexed posture, moving all extremities
Sens: responds appropriately to touch/tickle
Coord: no abnormal movements
Reflexes: 2+, plantar extensor response bilaterally, +grasp, +rooting
Gait: deferred

IMPRESSION:
- Apnea episodes concerning for seizure in setting of r/o sepsis vs HIE (low suspicion for HIE?)

RECOMMENDATION:
- Neurochecks
- Seizure/aspiration precautions
- HUS negative for hemorrhage
- **MRI brain W/O can be performed on day 4 of life**
- **Change phenobarbital to 7.5 mg BID (2.5 mg/kg/dose)**
- For more seizures, can give fosphenytoin 10 mg/kg load
- Metabolic panel pending:
    - Pyruvate -
    - Serum amino acids - pending
    - Urine organic acids - not received yet
    - Ammonia - 83

Discussed with attending physician of record during morning rounds.

CHRUSCIEL,DEEPTI G 02/17/22 1214:

Neurology Attending Note

Attending Note

I have interviewed and examined this patient and personally reviewed all labs and studies. I discussed the patient's management with the residents and reviewed the resident's note. I have discussed care with the patient and family who voiced understanding. I agree with the documented findings and plan of care unless amended below.

Patient: BLUE,BB-TATUM Unit#: E003047593
Date: 02/10/22 Acct#: E00677497957

Patient seen on 2/10/22.

99232: P90 Neonatal seizures, G93.1 HIE

Electronically Signed by Shroll,Ethan James on 02/10/22 at 0820
Electronically Signed by Chrusciel,Deepti Ganti MD on 02/17/22 at 1215
Electronically Signed by Rabbani,Bahram DO on 02/20/22 at 1241

RPT #: 0210-0337
END OF REPORT

OU MEDICAL CENTER
1200 Everett Drive
Oklahoma City, OK 73104

Name: BLUE,BB-TATUM
Account Number: E00677497957
Unit Number: E003047593
Room: EU.7172
Date Of Birth: 02/08/22
Attending Doctor: Dannaway,Douglas MD
Date: 02/11/22

NEONATAL SERVICES DAILY PROGRESS NOTE
3050 gram, 40 + 1/7 week AGA male => 3090 grams; corrected gestational age 40 + 4/7 weeks.
Active Problems: r/o sepsis (identified 2/8/22)
Seizure disorder (identified 2/8/22)

PHYSICAL EXAM (at 2/11/22 7:15)
Weight - 3090 grams (+80 grams) - 10%ile ; Z-score = -1.31
Vital Signs: HR - 133, RR - 36, BP - 52/32 (mean 39), O2 Sat - 97%, Temp - 36.9 degrees
General: Term infant under radiant warmer, in room air and in no distress. Skin pink, warm, and dry.
HEENT: Anterior fontanelle open, soft, and flat with sutures approximated. Head covered with CFM elctrodes and gauze wrap. Eyes clear. Pupils equally round and reactive to light. Oral mucosa pink and moist, palate intact. Ears in normal shape and position.
Chest: Chest rise symmetrical with upper airway congestion bilaterally.
Heart: Normal sinus rhythm, normal perfusion and pulses, no murmur.
Abdomen: Soft and non-distended, non-tender with active bowel sounds.
Extremities: Moving all extremities equally.
Neuro: Resting, responsive to exam with improving tone. Uncoordinated suck, little interest in a pacifier.

FLUIDS, ELECTROLYTES, NUTRITION
Objective: Weight today 3090 grams, up 80 grams from 2/10. Gained 13.3 grams/day/3 days.
On a radiant warmer.
Input: 307 ml.
101 ml/kg/day (enteral - 11%/parenteral - 89%); 52 cal/kg/day (enteral - 15%/parenteral - 85%).
Output: Urine - 92 ml/day (1.3 ml/kg/hr).
Stools - 1 (Last stool: 6 AM 2/11).
The baby has been on TPN for 3 days from 2/8.
Protein - 3.0 gram/kg/day; Fat - 1.1 gram/kg/day; Carbohydrate - 8.5 gram/kg/day.
FEEDINGS: On SAdv20 (0.68 cals/ml) and HM-Col (0.6 cals/ml), 5.0-10 ml; last feed: 10 ml of SAdv20; no residuals. 4 feedings received; 3% nippled. Some gavage feeds given over 15 minutes.
From 2/11 4:10: Na 143, K 4.6, Cl 105, Bicarb 17.0, Glucose 54, Ca 9.7, Phos 6.0, BUN 15.0, Creat 0.4.
From 2/8: Mg 1.5.
Appraisal: Infant started enteral feeds and supplementing with HAL/SMOF @ 100 ml/kg/day. Electrolytes as listed. Voiding and stooling. Weight gain noted

overnight. Infant is 1% above birthweight. Speech consulted, recommended PO feeding attempts twice a day and with cues.
Plan: Advance enteral feeds at 40 ml/kg/d of Human Milk or Similac term, supplement with TPN/SMOF for a TFG of 120 ml/kg/day.
Will continue to assess nutritional intake, output, and growth trend.
Continue to follow speech pathology recommendations.

RESPIRATORY
Objective: Respiratory rate for yesterday: average 34, range 25-52; for the past 8 hours: average 35, range 25-44.
O2 sats for yesterday: average 96, range 92-100; for the past 8 hours: average 98, range 95-100.
On no respiratory support.
From 2/9 17:06: Capillary blood gases: pH 7.41, pCO2 37, pO2 42, base excess -0.9.
No A and B events since 2/10.
Appraisal: Infant has remained stable on room air. Infant had no events overnight.
Plan: Continue to monitor.

HEMATOLOGY
Objective: Blood out so far - 1.4 ml (never transfused).
From 2/10 2:47: Hgb 16.7, Hct 45.7, Plts 239,000, WBC 15,600 - 71 polys, 14 lymphs, 9 monos, 4 eos; AGC = 11,076, I:T = 0.00.
Appraisal: Heme Labs stable.
Plan: Continue to monitor.
Limit lab draws as able.

INFECTIOUS DISEASE
Objective: Temperature range over the past day: 36.5-37.3 degrees; temperature over the past 8 hours: 36.6-36.9 degrees.
From 2/10 2:47: CRP - <3.0.
From 2/9: CEREBRAL SPINAL FLUID
From 2/8: CSF 49,750 RBCs, 25 WBCs (87 polys, 10 lymphs, 3 monos), protein 113, glucose 62.
Appraisal: Infectious workup started due to concerns of seizures. Maternal labs reassuring. Blood and CSF cultures sent. CBC and CRP reassuring. HSV CSF 1/2 negative, HSV PCR blood negative. Infant started on Ampicillin, Amikacin and Acyclovir. CSF and blood culture NGTD.
Plan: Continue to monitor
Follow cultures until final.
Continue antibiotics, discussing length of treatment in rounds.
Per Peds ID recommendation, infant can come off Acyclovir after CSF cultures resulted.

CARDIOVASCULAR
Objective: Heart rate for yesterday: average HR 141, range 120-168; for the past 8 hours: average HR 134, range 126-144.
Blood pressure for yesterday: average cuff BP - 56/32(40 mean), range - 51-61/28-39(36-45 mean); for the past 8 hours: average cuff BP - 57/33(42 mean), range - 52-61/32-33(39-44 mean).
Appraisal: Hemodynamically stable.
Plan: Continue to monitor clinically.

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

NEUROLOGY
Objective: Over the past 24 hours, Phenobarbital level: 2/11 at 4:10 - 36.7 No medications were given.
Appraisal: Seizure workup continues, neurology consulting. Infant has received numerous loads of Phenobarb, Keppra and Fosphenytoin. Continuous EEG in progress. Is currently receiving Phenobarb and Keppra.
Plan: Continue to monitor
Discontinue EEG per neurology.
Continue phenobarb and add Levetiracetam 26 mg/kg/day
If infant continues to have more seizures, give Fosphenytoin 10 mg/kg load.
Continue to follow neurology recommendations. MRI on 2/14.
If infant continues to have seizures, Neurology will consider genetic workup.

IMMUNIZATIONS
Appraisal: Hepatitis B #1 given on 2/8 at RH.
Plan: Continue to follow AAP guidelines for vaccine schedule.

GENETICS, ENDOCRINE, METABOLIC
Objective: Metabolic screening tests are pending from 2/9.
Ca 9.7, Phos 6.0 (from 2/11), Alkaline phosphatase 123 (from 2/8).
From 2/9 11:55: AMMONIA - 83.
Specimen moderately hemolyzed.
Hemolyzed Specimen-Results may be affected.
Appraisal: State NB metabolic screen sent at 24 hours of life. Pending results.
Metabolic workup in progress due to seizures.
Workup includes: Ammonia level 83, pyruvic acid (pending), serum AA (pending), UA Organic acid and reducing substances (pending)
Plan: Continue to monitor.
Follow results of labs pending.
Follow results the NBS and repeat per protocol.

SOCIAL
Appraisal: Mom and Dad have been updated at bedside during rounds, questions answered.
Plan: Continue to update on plan of care.

IN-PATIENT DEVELOPMENTAL INTERVENTIONS
Appraisal: Infant at risk of developmental delays due hospitalization and seizures.
Plan: Continue to follow developmental needs while in the unit.
NICU PT/OT ordered.

CURRENT MEDICATIONS
Acyclovir, 60 mg IV q8h (19.7 mg/kg/dose, 59 mg/kg/day) started on 2/8/22
Amikacin, 37 mg IV q24h (12.1 mg/kg/day) started on 2/8/22
Ampicillin, 300 mg IV q12h (98.4 mg/kg/dose, 197 mg/kg/day) started on 2/8/22
Levetiracetam (Keppra), 40 mg IV q12h (13.1 mg/kg/dose, 26.2 mg/kg/day) started on 2/11/22
PHENObarbital, 15 mg IV q24h (4.9 mg/kg/day) started on 2/9/22

I personally examined the patient, reviewed and updated the history and assessment, and developed the plan of care with the multidisciplinary team as documented in this note. Jumoke A. Ogunfolu, NNP Student assisted me in the care of the patient and preparation of this note.

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

Intensive monitoring of cardiorespiratory stability, growth, nutrition, and I and O is needed.

E-signed by Vadim Ivanov, MD; completed 2/12/22 08:00

Electronically Signed by Vadim A Ivanov, MD on 02/12/22 at 1900

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

OU MEDICAL CENTER (COCPN)
Neuro Interim Note
REPORT#:0211-1366
DATE:02/11/22 Time: 1702

PATIENT: BLUE,BB-TATUM UNIT No: E003047593
ACCOUNT#: E00677497957 ROOM: EU.7172
REPORT AUTHOR: Sebasigari,Denise DO

Neurology Interim Note

Neurology Interim Note
continuos EEG reviewed from 06:00 am to 16:59 pm

- abnormal continuous video encephalogram for age due hemispheric asymmetry, presence of prominent left temporal sharp transients which are concerning for epileptiform discharges which could represent a seizures foci.
- This tracing is a significant improvement form the last tracing.
- No seizures captured
- rare brief rhythmic discharges (BRDs) recorded . These brief rhythmic discharges lie in the ictal-interictal continuum, and the last one was recorded at 10:02 am. T
-There were no push button events recorded.
Official report tomorrow

Electronically Signed by Sebasigari,Denise DO on 02/11/22 at 1705

RPT #: 0211-1366
END OF REPORT

OU MEDICAL CENTER (COCPN)
Neurology Prog Note
REPORT#:0211-0316
DATE:02/11/22 Time: 0715

PATIENT: BLUE,BB-TATUM UNIT No: E003047593
ACCOUNT#: E00677497957 ROOM: EU.7172
REPORT AUTHOR: Rabbani,Bahram DO

Shroll,Ethan J 02/11/22 0715:
Neurology Progress Note

Subjective
MEDICAL STUDENT NOTE
2-day old male infant born at 40 wks via AROM with mecomnium stained amniotic fluid, transferred from Durant after APGAR of 2-6-7, spells of apnea and leg twitching concerning for possible seizures, hypoxic-ischemic event vs sepsis. Got phenobarbitol 30mg/kg at Durant.

EEG here showed focal seizures (frequently right central focus, rarely left posterior temporo-occipital) for which he got another phenobarbitol 10 mg/kg, then later fosphenytoin 20 mg/kg.

Problem List
1. Seizure

Physical Exam
Physical Exam
Heart: RRR

Lungs: Coarse crackles, likely referred upper airway sounds

Abdomen: Soft, nontender, normal bowel sounds

Extremeties: Warm, well perfused

Neurological Exam: Sleepy, withdraws to noxious stimuli. Pupils equal and reactive, face summetric, tongue midline, responds to touch in face and extremeties. Normal tone, patellar and Babinski reflexes intact, no abnormal spontaneous movements.

Current Medications
Current Medications

Medication	Dose	Sig/Sch Route	Start time Stop Time	Status	Last Admin
Levetiracetam	60 MG	ONCE ONE IV	02/11 0130 02/11 0131	DC	02/11 0135
Amikacin Sulfate	37 MG	Q24H	02/10 1800	AC	02/10

Patient: BLUE,BB-TATUM Unit#: E003047593
Date: 02/11/22 Acct#: E00677497957

N/A	1 EACH	IV	02/14 1829		1731
Fat Emulsion-Soy/MCT/ Olive/Fish Oil	16 ML	1800 IV	02/10 1800 02/11 1359	AC	02/10 1532
Total Parenteral Nutrition	1 EA	1800 IV	02/10 1800 02/11 1759	AC	02/10 1531
Phenobarbital Sodium	7.5 MG	Q12H IV	02/10 1700 03/12 1701	AC	02/11 0554
Ampicillin Sodium N/A	300 MG 1 EACH	Q12H IV	02/10 0800 02/14 2029	AC	02/10 2003
Phenobarbital Sodium	15.25 MG	Q24H IV	02/09 1900 03/11 1901	DC	
Heparin Sodium (Porcine)	10 UNITS	Q12H IV	02/09 0800 03/11 0801	AC	
Dopamine HCl	25 ML	CONTINUOUS IV	02/09 0300 03/11 0301	DC	02/09 0951
Acyclovir N/A	60 MG 1 EACH	Q8H IV	02/08 2330 02/15 2201	AC	02/10 2314
Nutrition (Parenteral)	250 ML	CONTINUOUS IV	02/08 2230 03/10 2231	DC	02/09 0950

Diagnostic Studies

Laboratory Tests

	02/09 0835	02/09 1127	02/09 1155
Chemistry			
Sodium (137 - 146 mmol/L)	139		
Potassium (3.7 - 6.1 mmol/L)	3.5		
Chloride (100 - 110 mmol/L)	103		
Carbon Dioxide (17 - 28 mmol/L)	18		
Anion Gap (4 - 14)	18		
BUN (2 - 19 mg/dL)	11.0		
Creatinine (0.20 - 0.41 mg/dL)	0.76		
Glucose (43 - 116 mg/dL)	59		
Calcium (7.7 - 10.5 mg/dL)	9.1		
Phosphorus (1.5 - 4.6 mg/dL)	4.8		
Total Bilirubin (0.9 - 8.8 mg/dL)	5.1		
Direct Bilirubin (0.2 - 0.4 mg/dL)	0.3		
Indirect Bilirubin (None establ. mg/dL)	4.8		
Ammonia (64 - 107 umol/L)			83
C-Reactive Protein (<5.0 mg/L)	<3.0		
Albumin (2.9 - 3.8 g/dL)	3.4		
Hematology			
WBC (5.00 - 25.00 K/mm3)	15.92		
RBC (4.10 - 6.10 M/mm3)	4.12		
Hgb (13.5 - 20.5 g/dL)	16.0		

Patient: BLUE,BB-TATUM
Date: 02/11/22
Unit#: E003047593
Acct#: E00677497957

Hct (41.0 - 65.0 %)	43.8		
MCV (88.0 - 122.0 fL)	106.3		
MCH (28.0 - 32.0 pg)	38.8		
MCHC (31.0 - 35.0 g/dL)	36.5		
RDW (11 - 15 %)	14.9		
Plt Count (150 - 400 K/mm3)	208		
MPV (9.3 - 12.2 fL)	8.7		
Seg Neutrophils % (32 - 62 %)	68		
Band Neutrophils % (0 - 12 %)	3		
Lymphocytes % (Manual) (26 - 36 %)	17		
Monocytes % (Manual) (2 - 10 %)	10		
Eosinophils % (Manual) (0 - 5 %)	2		
Seg Neutrophils # (1.6 - 15.5 K/mm3)	10.83		
Band Neutrophils # (0 - 3.0 K/mm3)	0.48		
Lymphocytes # (Manual) (1.3 - 9.0 K/mm3)	2.71		
Monocytes # (Manual) (0.1 - 2.5 K/mm3)	1.59		
Eosinophils # (Manual) (0 - 1.3 K/mm3)	0.32		
Nucleated RBCs # (0 - 0.012 K/mm3)	0.50		
Nucleated RBCs/100 WBC (0 - 0.2 /100 WBC)	3.10		
Platelet Estimate	APPEAR ADEQUATE		
Polychromasia	1+		
Poikilocytosis	1+		
Anisocytosis	1+		
Macrocytosis	1+		
Toxicology			
Phenobarbital (14 - 38 mg/L)	29.4		
Urines			
Urine Ketones (NEGATIVE)		NEGATIVE	

	02/09 1706	02/09 1715	02/10 0247
Blood Gas			
Specimen Type	Capillary		
Patient Temperature (C or F)	36.5		
Capillary pH (7.30 - 7.45)	7.41		
Capillary pCO2 (35 - 45 mmHg)	37		
Capillary pO2 (40 - 50 mmHg)	42		
Capillary HCO3 (22 - 29 mEq/L)	23		
Capillary Base Excess (-4.0 - 4.0 mmol/L)	-0.9		
Capillary O2 Sat (%)	78		
POC FiO2 (% or L)	21		
Chemistry			
Sodium (137 - 146 mmol/L)			139
Potassium (3.7 - 6.1 mmol/L)			4.5
Chloride (100 - 110 mmol/L)			104
Carbon Dioxide (17 - 28 mmol/L)			20

Patient: BLUE,BB-TATUM
Date: 02/11/22
Unit#: E003047593
Acct#: E00677497957

Anion Gap (4 - 14)			15
BUN (2 - 19 mg/dL)			19.0
Creatinine (0.20 - 0.41 mg/dL)			0.57
Glucose (43 - 116 mg/dL)			92
Calcium (7.7 - 10.5 mg/dL)			9.3
Phosphorus (1.5 - 4.6 mg/dL)			5.1
Total Bilirubin (0.9 - 8.8 mg/dL)			5.2
C-Reactive Protein (<5.0 mg/L)			<3.0
Albumin (2.9 - 3.8 g/dL)			3.1
Hematology			
WBC (5.00 - 25.00 K/mm3)			15.60
RBC (4.10 - 6.10 M/mm3)			4.24
Hgb (13.5 - 20.5 g/dL)			16.7
Hct (41.0 - 65.0 %)			45.7
MCV (88.0 - 122.0 fL)			107.8
MCH (28.0 - 32.0 pg)			39.4
MCHC (31.0 - 35.0 g/dL)			36.5
RDW (11 - 15 %)			15.3
Plt Count (150 - 400 K/mm3)			239
MPV (9.3 - 12.2 fL)			9.3
Seg Neutrophils % (32 - 62 %)			71
Lymphocytes % (Manual) (26 - 36 %)			14
Reactive Lymphs % (0 - 0 %)			2
Monocytes % (Manual) (2 - 10 %)			9
Eosinophils % (Manual) (0 - 5 %)			4
Seg Neutrophils # (1.6 - 15.5 K/mm3)			11.08
Lymphocytes # (Manual) (1.3 - 9.0 K/mm3)			2.18
Reactive Lymphs # (0 - 0 K/mm3)			0.31
Monocytes # (Manual) (0.1 - 2.5 K/mm3)			1.40
Eosinophils # (Manual) (0 - 1.3 K/mm3)			0.62
Nucleated RBCs # (0 - 0.012 K/mm3)			0.24
Nucleated RBCs/100 WBC (0 - 0.2 /100 WBC)			1.50
Platelet Estimate			APPEAR ADEQUATE
Polychromasia			1+
Anisocytosis			1+
Macrocytosis			1+
Miscellaneous			
Specimen Comment			
Toxicology			
Phenobarbital (14 - 38 mg/L)		39.1	

Recent Impressions
RADIOLOGY - RAD CHEST 1 VIEW 02/09 0853
*** Report Impression - Status: SIGNED Entered: 02/09/2022 0946

IMPRESSION:

Patient: BLUE,BB-TATUM Unit#: E003047593
Date: 02/11/22 Acct#: E00677497957

1. Right upper extremity PICC line distal tip is overlying proximal SVC. Enteric tube distal tip is in the region of GE junction.

2. Lungs shows minimal groundglass haziness with no focal consolidation, pleural effusion or pneumothorax

3. Cardiomediastinal silhouette is stable

4. Visualized osseous structures and soft tissues do not show acute process.
Impression By: DR.PRASAN - SANDEEP PRABHU, MD 247

Assessment
Newborn with focal seizures of unknown etiology pending metabolic workup. No evidence of HIE.

Plan
Plan
Continue to monitor, if seizures recur, consider adding levotiracetam 10 mg/kg.
Other care per primary team.

Rabbani,Bahram X DO 02/11/22 1114:
Neurology Resident Addendum
Neurology Resident Addendum
Patient was personally seen and examined by me today. Please see the following addendum below for further details.

SUB:
3-day-old baby boy born at 40 weeks of gestation via artificial rupture of membranes, delivery significant for meconium stained amniotic fluid, transferred from Durant Medical Center 2/8/22 to OU Children's Center NICU for higher level of workup and care after presenting with low APGARs of 2, 6, and 7 and spells of apnea and leg twitching concerning for possible seizures due to a possible hypoxic ischemic event vs sepsis s/p phenobarbital loads (30 mg/kg in total).

02/09: Patient had 1-2 more seizures overnight. Given Keppra 20 mg/kg load once. No further events since 0700. PHB 29.4, CSF WBC 25, RBC ~50k, elevated neutrophils, glucose 62 (serum ~60-80), protein 113.

02/10: EEG demonstrated focal seizures from C4 and rarely T5/O1. Patient loaded with phenobarbital 10 mg/kg again with PHB level 39.1 today. Patient had another seizure later that night and was given fosphenytoin 20 mg/kg once with resolution of spells the rest of the night

Patient: BLUE,BB-TATUM Unit#: E003047593
Date: 02/11/22 Acct#: E00677497957

(per EEG attending's verbal communication with me). Ammonia 83.

02/11: One seizure at 1932. Loaded with levetiracetam 20 mg/kg once. No further seizures (more brief rhythmic discharges, last one 0106).

EXAM:
GEN: somnolent
HEENT: ant fontanelle soft, open, flat
ABD: soft

NEURO:
Lang/Ment: non-verbal, somnolent, arouses to touch; one apneic event during exam
CN: pupils equally round and reactive to light; oculocephalic reflex present, symm face, responds to touch, tongue midline on protrusion
Motor: normal tone, healthy flexed posture, moving all extremities
Sens: responds appropriately to touch/tickle
Coord: no abnormal movements
Reflexes: 2+, plantar extensor response bilaterally, +grasp, +rooting
Gait: deferred

IMPRESSION:
- Apnea episodes concerning for seizure in setting of r/o sepsis vs HIE (low suspicion for HIE?)

RECOMMENDATION:
- Neurochecks
- Seizure/aspiration precautions
- **Okay to discontinue EEG at this time**
- HUS negative for hemorrhage
- MRI brain W/O can be performed on day 4 of life **(may have to wait till Monday, which is OK)**
- Phenobarbital to 7.5 mg BID (2.5 mg/kg/dose)
- **Levetiracetam 40 mg BID (~26 mg/kg/day)**
- For more seizures, can give fosphenytoin 10 mg/kg load **(please check a free phenytoin level now)**
- Metabolic panel pending:
    - Pyruvate
    - Serum amino acids - pending
    - Urine organic acids - not received yet
    - Ammonia - 83

Discussed with attending physician of record during morning rounds.

CHRUSCIEL,DEEPTI G 02/17/22 1215:

Neurology Attending Note

Attending Note

I have interviewed and examined this patient and personally reviewed all labs and studies. I

Patient: BLUE,BB-TATUM Unit#: E003047593
Date: 02/11/22 Acct#: E00677497957

discussed the patient's management with the residents and reviewed the resident's note. I have discussed care with the patient and family who voiced understanding. I agree with the documented findings and plan of care unless amended below.

Patient seen on 2/11/22.

99232: P90 Neonatal seizures, G93.1 HIE

Electronically Signed by Shroll,Ethan James on 02/11/22 at 1122
Electronically Signed by Rabbani,Bahram DO on 02/11/22 at 1129
Electronically Signed by Chrusciel,Deepti Ganti MD on 02/17/22 at 1216

RPT #: 0211-0316
END OF REPORT

OU MEDICAL CENTER
1200 Everett Drive
Oklahoma City, OK 73104

Name: BLUE,BB-TATUM
Account Number: E00677497957
Unit Number: E003047593
Room: EU.7172
Date Of Birth: 02/08/22
Attending Doctor: Bergner,Erynn MD
Date: 02/12/22

NEONATAL SERVICES DAILY PROGRESS NOTE
3050 gram, 40 + 1/7 week AGA male => 3220 grams; corrected gestational age 40 + 5/7 weeks.
Active Problems: r/o sepsis (identified 2/8/22)
Seizure disorder (identified 2/8/22)

PHYSICAL EXAM (at 2/12/22 9:20)
Weight - 3220 grams (+130 grams) - 14%ile ; Z-score = -1.08
Vital Signs: HR - 129, RR - 35, BP - 49/22 (mean 33), O2 Sat - 98%, Temp - 36.8 degrees
General: Term infant under radiant warmer, in room air and in no distress. Skin pink, warm, and dry.
HEENT: Anterior fontanelle open, soft, and flat with sutures approximated. Head covered with CFM elctrodes and gauze wrap. Eyes clear. Oral mucosa pink and moist, palate intact. Ears in normal shape and position.
Chest: Chest rise symmetrical with upper airway congestion bilaterally.
Heart: Normal sinus rhythm, normal perfusion and pulses, no murmur.
Abdomen: Soft and non-distended, non-tender with active bowel sounds.
Genitals: Normal male genitalia.
Extremities: Moving all extremities equally.
Neuro: Resting, responsive to exam with mild hypotonia

FLUIDS, ELECTROLYTES, NUTRITION
Objective: Weight today 3220 grams, up 130 grams from 2/11. Gained 50.0 grams/day/3 days.
On a radiant warmer.
Input: 382 ml.
125 ml/kg/day (enteral - 30%/parenteral - 70%); 76 cal/kg/day (enteral - 33%/parenteral - 67%).
Output: Urine - 115 ml/day (1.6 ml/kg/hr) and 1.
Stools - 0 (Last stool: 6 AM 2/11).
The baby has been on TPN for 4 days from 2/8. A PICC-Right arm has been in place for 3 days from 2/9.
Protein - 3.1 gram/kg/day; Fat - 3.0 gram/kg/day; Carbohydrate - 10.1 gram/kg/day.
FEEDINGS: On SAdv20 (0.68 cals/ml), 10-15 ml; last feed: 15 ml; no residuals. 8 feedings received; 26% nippled. Gavage feeds given over 15-30 minutes.
From 2/11 4:10: Na 143, K 4.6, Cl 105, Bicarb 17.0, Glucose 54, Ca 9.7, Phos 6.0, BUN 15.0, Creat 0.4.
From 2/8: Mg 1.5.
Appraisal: Infant tolerating advancing enteral feeds of Sim Term with supplemental with HAL/SMOF @ 120 ml/kg/day. Electrolytes as listed. Voiding and stooling. Weight gain noted overnight. Speech consulted, recommended PO feeding

attempts twice a day and with cues.
Plan: Advance enteral feeds to 60 ml/kg/d of Similac term, supplement with TPN/SMOF for a TFG of 130 ml/kg/day.
Will continue to assess nutritional intake, output, and growth trend.
Continue to follow speech pathology recommendations.

RESPIRATORY
Objective: Respiratory rate for yesterday: average 40, range 27-59; for the past 8 hours: average 35, range 30-42.
O2 sats for yesterday: average 96, range 92-100; for the past 8 hours: average 95, range 92-100.
2/12 8:00: RA.
From 2/9 17:06: Capillary blood gases: pH 7.41, pCO2 37, pO2 42, base excess -0.9.
No A and B events since 2/10.
Appraisal: Infant has remained stable on room air.
Plan: Continue to monitor.

HEMATOLOGY
Objective: Blood out so far - 5.4 ml (never transfused).
From 2/10: Hgb 16.7, Hct 45.7, Plts 239,000, WBC 15,600 - 71 polys, 14 lymphs, 9 monos, 4 eos; AGC = 11,076, I:T = 0.00.
Appraisal: Heme Labs stable.
Plan: Continue to monitor.
Limit lab draws as able.

BILIRUBIN
Objective: Serum bili 5.2 on 2/10.
Mother's blood type B Positive.
The infant has not been treated with phototherapy.
The maximum total bilirubin was 5.2 on 2/10 and the maximum direct bilirubin was 0.3 on 2/9.
Appraisal: Mom's blood type is B+. T bili remains well below threshold of treatment.
Plan: Continue to monitor clinically.

INFECTIOUS DISEASE
Objective: Temperature range over the past day: 36.5-37.2 degrees; temperature over the past 8 hours: 36.8-37.1 degrees.
From 2/10: CRP - <3.0.
From 2/9: CEREBRAL SPINAL FLUID
From 2/8: CSF 49,750 RBCs, 25 WBCs (87 polys, 10 lymphs, 3 monos), protein 113, glucose 62.
Appraisal: Infectious workup started due to concerns of seizures. Maternal labs reassuring. Blood and CSF cultures sent. CBC and CRP reassuring. HSV CSF 1/2 negative, HSV PCR blood negative. Infant started on Ampicillin, Amikacin and Acyclovir. CSF negative and blood culture NGTD.
Plan: Continue to monitor
Follow cultures until final.
Discontinue antibiotics.
Discontinue acyclovir.

CARDIOVASCULAR
Objective: Heart rate for yesterday: average HR 142, range 124-168; for the past

8 hours: average HR 132, range 126-139.
Blood pressure for yesterday: average cuff BP - 53/33(40 mean), range - 52-54/32-34(39-41 mean); for the past 8 hours: average cuff BP - 49/22(33 mean), range - 49/22(33 mean).
Appraisal: Hemodynamically stable.
Plan: Continue to monitor clinically.
Obtain CCHD

NEUROLOGY
Objective: Over the past 24 hours, Phenobarbital level: 2/11 at 4:10 - 36.7 No medications were given.
Appraisal: Seizure workup continues, neurology consulting. Infant has received numerous loads of Phenobarb, Keppra and Fosphenytoin. Continuous EEG in progress. Is currently receiving Phenobarb and Keppra. EEG 2/12 showed subclinical seizures lasting 20-40 seconds, 3-7 times/hour.
Plan: Continue EEG
Load with 10mg/kg Fosphenytoin and follow a free phenytoin level.
Continue phenobarb and add Levetiracetam 26 mg/kg/day
Continue to follow neurology recommendations. MRI on 2/14.
If infant continues to have seizures, Neurology will consider genetic workup.

GASTROINTESTINAL
Objective: From 2/11: Alb 3.3.
Appraisal: Normal abdominal exam and stooling pattern. Tolerating advancing enteral feedings.
Plan: Continue to monitor stooling pattern and quantity.

IMMUNIZATIONS
Appraisal: Hepatitis B #1 given on 2/8 at RH.
Plan: Continue to follow AAP guidelines for vaccine schedule.

GENETICS, ENDOCRINE, METABOLIC
Objective: Metabolic screening tests are pending from 2/9.
Ca 9.7, Phos 6.0 (from 2/11), Alkaline phosphatase 123 (from 2/8).
From 2/9 11:55: AMMONIA - 83.
Specimen moderately hemolyzed.
Hemolyzed Specimen-Results may be affected.
Appraisal: State NB metabolic screen sent at 24 hours of life. Pending results.
Metabolic workup in progress due to seizures.
Workup includes: Ammonia level 83, pyruvic acid (pending), serum AA (pending), UA Organic acid and reducing substances (pending)
Plan: Continue to monitor.
Follow results of labs pending.
Follow results the NBS and repeat per protocol.

SOCIAL
Appraisal: Mom and Dad have been updated at bedside during rounds, questions answered.
Plan: Continue to update on plan of care.

CURRENT MEDICATIONS
Acyclovir, 60 mg IV q8h (19.7 mg/kg/dose, 59 mg/kg/day) started on 2/8/22
Amikacin, 37 mg IV q24h (12.1 mg/kg/day) started on 2/8/22
Ampicillin, 300 mg IV q12h (98.4 mg/kg/dose, 197 mg/kg/day) started on 2/8/22

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

Levetiracetam (Keppra), 40 mg IV q12h (13.1 mg/kg/dose, 26.2 mg/kg/day) started

on 2/11/22
PHENObarbital, 15 mg IV q24h (4.9 mg/kg/day) started on 2/9/22

I personally examined the patient, reviewed and updated the history and assessment, and developed the plan of care with the multidisciplinary team as documented in this note. Allie Kenmore, Nurse Clinician assisted me in the care of the patient and preparation of this note.

Intensive monitoring of cardiorespiratory stability, growth, nutrition, and I and O is needed.

E-signed by Vadim Ivanov, MD; completed 2/12/22 14:18

Electronically Signed by Vadim A Ivanov, MD on 02/13/22 at 2100

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

OU MEDICAL CENTER (COCPN)
Neuro Interim Note
REPORT#:0212-0934
DATE:02/12/22 Time: 1500

PATIENT: BLUE,BB-TATUM UNIT No: E003047593
ACCOUNT#: E00677497957 ROOM: EU.7172
REPORT AUTHOR: Durica,Sarah MD

****See Addendum****

Neurology Interim Note

Neurology Interim Note
This is a preliminary report.

EEG reviewed from 8:00-14:59.

There were continued frequent seizures until 11:24. The last seizure was at 11:24, following fosphenytoin load at 10:56. After 11:24, there were rare brief potentially ictal rhythmic discharges, but no definite seizures. Overall this is significantly improved from report earlier this morning (see full EEG report dated 2/12/22 for full details).

Results communicated with neurology team.

Electronically Signed by Durica,Sarah MD on 02/12/22 at 1505

Addendum 1: 02/12/22 1727 by Durica,Sarah MD

EEG reviewed from 14:59-17:20.

There were no seizures.

Results communicated with neurology team.

Electronically Signed by Durica,Sarah MD on 02/12/22 at 1728

Addendum 2: 02/12/22 2129 by Durica,Sarah MD

EEG reviewed from 17:20-21:28.

There were no seizures. There were occasional brief potentially ictal rhythmic discharges over the left central and centromidline regions (C3/Cz), but no definite seizures.

The EEG will continue running overnight. The next scheduled update will be tomorrow morning, unless otherwise requested. Please page on call EEG attending for any EEG-related concerns.

Results communicated with the neurology team.

Electronically Signed by Durica,Sarah MD on 02/12/22 at 2129

Patient: BLUE,BB-TATUM
Date: 02/12/22

Unit#: E003047593
Acct#: E00677497957

RPT #: 0212-0934
END OF REPORT

OU MEDICAL CENTER (COCPN)
Neurology Prog Note
REPORT#:0212-0203
DATE:02/12/22 Time: 0646

PATIENT: BLUE,BB-TATUM UNIT No: E003047593
ACCOUNT#: E00677497957 ROOM: EU.7172
REPORT AUTHOR: Rabbani,Bahram DO

Shroll,Ethan J 02/12/22 0646:
Neurology Progress Note

Subjective
MEDICAL STUDENT NOTE
2-day old male infant born at 40 wks via AROM with mecomnium stained amniotic fluid, transferred from Durant after APGAR of 2-6-7, spells of apnea and leg twitching concerning for possible seizures, hypoxic-ischemic event vs sepsis. Got phenobarbitol 30mg/kg at Durant.

EEG here showed focal seizures on 2/10 (frequently right central focus, rarely left posterior temporo-occipital) for which he got another phenobarbitol 10 mg/kg, then later fosphenytoin 20 mg/kg.

Update 2/12, EEG has had numerous seizures overnight despite therapeutic levels of phenytoin and phenobarbitol and 26 mg/kg/day levoteracetam.

Problem List
1. Seizure

Physical Exam
Heart: RRR

Lungs: Wheezing, likely referred upper airway sounds

Abdomen: Soft, nontender, normal bowel sounds

Extremeties: Warm, well perfused

Neurological Exam: Sleepy, withdraws to noxious stimuli. Pupils equal and reactive, face summetric, tongue midline, responds to touch in face and extremeties. Normal tone, patellar and Babinski reflexes intact, no abnormal spontaneous movements. Opened eyes spontaneously toward end of exam.

Current Medications
Current Medications

Medication	Dose	Sig/Sch Route	Start time Stop Time	Status	Last Admin
Fat Emulsion-Soy/MCT/	30 ML	1800	02/11 1800	AC	02/11

Patient: BLUE,BB-TATUM
Date: 02/12/22
Unit#: E003047593
Acct#: E00677497957

Olive/Fish Oil		IV	02/12 1359		1746
Levetiracetam	40 MG	Q12H IV	02/11 1200 03/13 1201	AC	02/12 0302
Levetiracetam Sodium Chloride	40 MG 100 ML	Q12H IV	02/11 1115 03/13 1116	CAN	
Amikacin Sulfate N/A	37 MG 1 EACH	Q24H IV	02/10 1800 02/14 1829	AC	02/11 1745
Fat Emulsion-Soy/MCT/ Olive/Fish Oil	16 ML	1800 IV	02/10 1800 02/11 1359	DC	02/10 1532
Total Parenteral Nutrition	1 EA	1800 IV	02/10 1800 02/12 1759	AC	02/11 1746
Phenobarbital Sodium	7.5 MG	Q12H IV	02/10 1700 03/12 1701	AC	02/12 0447
Ampicillin Sodium N/A	300 MG 1 EACH	Q12H IV	02/10 0800 02/14 2029	AC	02/11 2015
Heparin Sodium (Porcine)	10 UNITS	Q12H IV	02/09 0800 03/11 0801	AC	
Acyclovir N/A	60 MG 1 EACH	Q8H IV	02/08 2330 02/15 2201	AC	02/11 2341

Diagnostic Studies
Laboratory Tests

	02/11 0410	02/11 1400
Chemistry		
Sodium (137 - 146 mmol/L)	143	
Potassium (3.7 - 6.1 mmol/L)	4.6	
Chloride (100 - 110 mmol/L)	105	
Carbon Dioxide (17 - 28 mmol/L)	17	
Anion Gap (4 - 14)	21	
BUN (2 - 19 mg/dL)	15.0	
Creatinine (0.20 - 0.41 mg/dL)	0.43	
Glucose (43 - 116 mg/dL)	54	
Calcium (7.7 - 10.5 mg/dL)	9.7	
Phosphorus (1.5 - 4.6 mg/dL)	6.0	
Albumin (2.9 - 3.8 g/dL)	3.3	
Toxicology		
Free Phenytoin (0.80 - 2.20 mg/L)		1.41
Phenobarbital (14 - 38 mg/L)	36.7	

Assessment
Newborn with focal seizures of unknown etiology pending metabolic workup. No evidence of HIE.

Patient: BLUE,BB-TATUM Unit#: E003047593
Date: 02/12/22 Acct#: E00677497957

Plan
Fosphenytoin 10 mg/kg load with free phenytoin level check 2 hours after, MRI and genetic testing Monday. Frequent neurochecks, metabolic panel pending.
Remainder of care per primary team.

Rabbani,Bahram X DO 02/12/22 0703:
Neurology Resident Addendum
Neurology Resident Addendum
Patient was personally seen and examined by me today. Please see the following addendum below for further details.

SUB:
3-day-old baby boy born at 40 weeks of gestation via artificial rupture of membranes, delivery significant for meconium stained amniotic fluid, transferred from Durant Medical Center 2/8/22 to OU Children's Center NICU for higher level of workup and care after presenting with low APGARs of 2, 6, and 7 and spells of apnea and leg twitching concerning for possible seizures due to a possible hypoxic ischemic event vs sepsis s/p phenobarbital loads (30 mg/kg in total).

02/09: Patient had 1-2 more seizures overnight. Given Keppra 20 mg/kg load once. No further events since 0700. PHB 29.4, CSF WBC 25, RBC ~50k, elevated neutrophils, glucose 62 (serum ~60-80), protein 113.

02/10: EEG demonstrated focal seizures from C4 and rarely T5/O1. Patient loaded with phenobarbital 10 mg/kg again with PHB level 39.1 today. Patient had another seizure later that night and was given fosphenytoin 20 mg/kg once with resolution of spells the rest of the night (per EEG attending's verbal communication with me). Ammonia 83.

02/11: One seizure at 1932. Loaded with levetiracetam 20 mg/kg once. No further seizures (more brief rhythmic discharges, last one 0106).

02/12: EEG report up till 1700 demonstrated marked improvement from last tracing with prominent left temporal sharp transients and rare brief rhythmic discharges, but no seizures. However, overnight, EEG demonstrated numerous seizures (report still pending, given verbally).

EXAM:
GEN: awake
HEENT: ant fontanelle soft, open, flat
ABD: soft

NEURO:
Lang/Ment: non-verbal, arouses to touch; one apneic event during exam
CN: pupils equally round and reactive to light; oculocephalic reflex present, symm face, responds to touch, tongue midline on protrusion
Motor: normal tone, healthy flexed posture, moving all extremities
Sens: responds appropriately to touch/tickle

Patient: BLUE,BB-TATUM Unit#: E003047593
Date: 02/12/22 Acct#: E00677497957

Coord: no abnormal movements
Reflexes: 2+, plantar extensor response bilaterally, +grasp, +rooting
Gait: deferred

IMPRESSION:
- Apnea episodes concerning for seizure in setting of r/o sepsis vs HIE (low suspicion for HIE?)

Levels:
- Phenobarbital: 29.4 --> 39.1 --> 36.7
- Free phenytoin: 1.41 (02/11)

RECOMMENDATION:
- Please give a fosphenytoin 10 mg/kg load and check a free phenytoin level 2 hours after the load.
- Restarted continuous EEG for further monitoring

- Neurochecks
- Seizure/aspiration precautions
- HUS negative for hemorrhage
- MRI brain W/O can be performed on day 4 of life **(may have to wait till Monday, which is OK)**
- Phenobarbital to 7.5 mg BID (2.5 mg/kg/dose)
- Levetiracetam 40 mg BID (~26 mg/kg/day)
- For more seizures, can give fosphenytoin 10 mg/kg load with free phenytoin level check 2 hours after
- Metabolic panel pending:
    - Pyruvate
    - Serum amino acids - pending
    - Urine organic acids - not received yet
    - Ammonia - 83
- Epilepsy genetic testing -- will be swabbed on Monday 02/14/2022

Discussed with attending physician of record during morning rounds.

CHRUSCIEL,DEEPTI G 02/17/22 1216:

Neurology Attending Note

Attending Note

I have interviewed and examined this patient and personally reviewed all labs and studies. I discussed the patient's management with the residents and reviewed the resident's note. I have discussed care with the patient and family who voiced understanding. I agree with the documented findings and plan of care unless amended below.

Patient seen on 2/12/22.

Patient: BLUE,BB-TATUM
Date: 02/12/22

Unit#: E003047593
Acct#: E00677497957

99232: P90 Neonatal seizures, G93.1 HIE

Electronically Signed by Shroll,Ethan James on 02/12/22 at 0845
Electronically Signed by Rabbani,Bahram DO on 02/12/22 at 1110
Electronically Signed by Chrusciel,Deepti Ganti MD on 02/17/22 at 1216

RPT #: 0212-0203
END OF REPORT

OU MEDICAL CENTER - THE CHILDREN'S HOSPITAL
1200 N. Phillips RADIOLOGY PHONE: (405) 271-5511
Oklahoma City, OK 73104 CONSULTATION REPORT FAX: (405) 271-1718

LOC/RM: EU.NICUE/EU.7172 PACS ID: E2368718 MRN: E003047593
PT. TYPE: ADM IN CAMPUS: C PT: BLUE,BB-TATUM
ACCT#: E00677497957 DOB: 02/08/2022 AGE: 00M 04D SEX: M

ORD PROV: 1538404637 Christenson,Kahlene M AP EXAM START: 02/12/22 1515
ATT PROV: 1982672333 Dannaway,Douglas MD EXAM ENDED: 02/12/22 1520
ADMISSION CLINICAL DATA: APNEA

EXAMS:	CPT:
007127587 RAD CHEST 1 VIEW	71045

Chest single view February 12, 2022

COMPARISON: February 2022

HISTORY: 4-day-old male term infant, increased work of breathing.

IMPRESSION:

Enteric tube extends towards abdomen. Right upper extremity PICC line tip projects over SVC.

There is mild left lung atelectasis. There is no prominent effusion or pneumothorax in this semiupright exam.

Heart and mediastinum appear more prominent probably due to patient positioning, rotated to the left.

Soft tissue and bony structure show no acute process.

** Electronically Signed by 137 THERESA THAI MD **
** on 02/12/2022 at 1544 **
Reported and signed by: THERESA THAI, MD 137

DICTATED: 02/12/2022 @ 1538 TRANSCRIBED: 02/12/22 @ 1539
TYPIST: RAD.VR PRINTED: 02/12/2022 @ 1549
E-SIGNATURE DATE/TIME: 02/12/2022 @ 1544 DR.THATH1 BATCH: N/A

PAGE 1 Signed Report

OU MEDICAL CENTER
1200 Everett Drive
Oklahoma City, OK 73104

Name: BLUE,BB-TATUM
Account Number: E00677497957
Unit Number: E003047593
Room: EU.7172
Date Of Birth: 02/08/22
Attending Doctor: Bergner,Erynn MD
Date: 02/13/22

NEONATAL SERVICES DAILY PROGRESS NOTE
3050 gram, 40 + 1/7 week AGA male => 3370 grams; corrected gestational age 40 + 6/7 weeks.
Active Problems: Seizure disorder (identified 2/8/22)
respiratory distress (identified 2/12/22)

PHYSICAL EXAM (at 2/13/22 6:40)
Weight - 3370 grams (+150 grams) - 21%ile ; Z-score = -0.81
Vital Signs: HR - 113, RR - 48, BP - 60/28 (mean 40), O2 Sat - 92%, Temp - 36.7 degrees
General: Term infant under radiant warmer, on CPAP and in no acute distress. Skin pink, warm, and dry.
HEENT: Anterior fontanelle open, soft, and flat with sutures approximated. Head covered with CFM elctrodes and gauze wrap. Eyes clear. Oral mucosa pink and moist, palate intact. Ears in normal shape and position.
Chest: Chest rise symmetrical with upper airway congestion bilaterally. Mild suprasternal retractions.
Heart: Normal sinus rhythm, normal perfusion and pulses, no murmur.
Abdomen: Soft and non-distended, non-tender with active bowel sounds.
Genitals: Normal male genitalia.
Anus: Patent anus.
Skeletal: Spine intact.
Extremities: Moving all extremities equally.
Neuro: Resting, responsive to exam with mild hypotonia

FLUIDS, ELECTROLYTES, NUTRITION
Objective: Weight today 3370 grams, up 150 grams from 2/12. Gained 120.0 grams/day/3 days.
On a radiant warmer.
Input: 413 ml.
136 ml/kg/day (enteral - 41%/parenteral - 59%); 84 cal/kg/day (enteral - 44%/parenteral - 56%).
Output: Urine - 215 ml/day (2.9 ml/kg/hr).
Stools - 1 (Last stool: 9 PM 2/12).
The baby has been on TPN for 5 days from 2/8. A PICC-Right arm has been in place for 4 days from 2/9.
Protein - 3.1 gram/kg/day; Fat - 3.7 gram/kg/day; Carbohydrate - 10.1 gram/kg/day.
FEEDINGS: On SAdv20 (0.68 cals/ml), 15-23 ml; last feed: 23 ml; no residuals. 8 feedings received; 3% nippled. Some gavage feeds given over 20-30 minutes.
From 2/13 3:06: Na 140, K 4.3, Cl 102, Bicarb 22.0, Glucose 62, Ca 9.6, Phos 6.0, BUN 13.0, Creat 0.5, Mg 1.9, Triglycerides 206.
From 2/12 17:53: Glucose bld-75, Ca (ionized) 1.31, Lactate 1.4.

Appraisal: Infant tolerating advancing enteral feeds of Sim Term with supplemental with HAL/SMOF @ 130 ml/kg/day. Electrolytes as listed. Voiding and stooling. Weight gain noted overnight. Speech consulted, holding PO feeds due to concern for aspiration and respiratory status.
Plan: Advance enteral feeds to 80 ml/kg/d of Similac term, supplement with TPN/SMOF for a TFG of 140 ml/kg/day.
Will continue to assess nutritional intake, output, and growth trend.
Continue to follow speech pathology recommendations.

RESPIRATORY
Objective: Respiratory rate for yesterday: average 35, range 22-47; for the past 8 hours: average 33, range 22-48.
O2 sats for yesterday: average 96, range 91-99; for the past 8 hours: average 95, range 92-98.
2/13 9:30: Non-inv CPAP-23% O2, PEEP/CPAP - 7.0.
From 2/12 17:53: Capillary blood gases: pH 7.41, pCO2 44, pO2 41, base excess 2.4.
No A and B events since 2/10.
Appraisal: Infant was placed on CPAP on 2/12 for increased work of breathing/stridor with bottle feeding and crackles. Infant was previously stable in room air.
Plan: Continue to monitor.
CXR/CBG in PRN.

HEMATOLOGY
Objective: Blood out so far - 9.0 ml (never transfused).
From 2/12 17:53: Hgb 14.5, Hct 43.0.
From 2/10: Platelets 239,000.
Appraisal: Heme Labs stable.
Plan: Continue to monitor.
Limit lab draws as able.

BILIRUBIN
Objective: Serum bili 1.0 on 2/13 3:06.
Mother's blood type B Positive.
The infant has not been treated with phototherapy.
The maximum total bilirubin was 5.2 on 2/10 and the maximum direct bilirubin was 0.3 on 2/9.
Appraisal: Mom's blood type is B+. T bili remains well below threshold of treatment.
Plan: Continue to monitor clinically.

INFECTIOUS DISEASE
Objective: Temperature range over the past day: 36.6-37.3 degrees; temperature over the past 8 hours: 36.7-36.9 degrees.
From 2/10: CRP - <3.0.
From 2/9: CEREBRAL SPINAL FLUID
From 2/8: CSF 49,750 RBCs, 25 WBCs (87 polys, 10 lymphs, 3 monos), protein 113, glucose 62.
Appraisal: Infectious workup started due to concerns of seizures. Maternal labs reassuring. Blood and CSF cultures sent. CBC and CRP reassuring. HSV CSF 1/2 negative, HSV PCR blood negative. Infant started on Ampicillin, Amikacin and Acyclovir dc'd on 2/13. CSF negative and blood culture NGTD.
Plan: Continue to monitor

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

Follow cultures until final.

CARDIOVASCULAR
Objective: Heart rate for yesterday: average HR 130, range 118-157; for the past 8 hours: average HR 122, range 113-133.
Blood pressure for yesterday: average cuff BP - 53/28(38 mean), range - 49-56/22-34(33-43 mean); for the past 8 hours: average cuff BP - 60/28(40 mean), range - 60/28(40 mean).
The infant passed the critical congenital heart disease screening at 108.8 hours of age.
Appraisal: Hemodynamically stable.
Plan: Continue to monitor clinically.
Obtain CCHD

NEUROLOGY
Objective: Over the past 24 hours, Phenobarbital level: 2/11 - 36.7 No medications were given.
Appraisal: Seizure workup continues, neurology consulting. Infant has received numerous loads of Phenobarb, Keppra and Fosphenytoin. Continuous EEG in progress. Is currently receiving Phenobarb and Keppra. EEG 2/12 showed subclinical seizures lasting 20-40 seconds, 3-7 times/hour. Loaded with 10mg/kg Fosphenytoin on 2/13 and free phenytoin level (2.1)
Plan: Continue EEG
Continue phenobarb and Levetiracetam
Continue to follow neurology recommendations. Obtain MRI 2/14 per neuro's recs.
Obtain random phenobarb level
Neurology requested genetic workup on 2/14.

GASTROINTESTINAL
Objective: From 2/13: T Prot 4.8, Alb 3.1, AST(SGOT) 39, ALT(SGPT) 23.
Appraisal: Normal abdominal exam and stooling pattern. Tolerating advancing enteral feedings.
Plan: Continue to monitor stooling pattern and quantity.

IMMUNIZATIONS
Appraisal: Hepatitis B #1 given on 2/8 at RH.
Plan: Continue to follow AAP guidelines for vaccine schedule.

GENETICS, ENDOCRINE, METABOLIC
Objective: Metabolic screening tests are pending from 2/9.
Ca 9.6, Phos 6.0, Alkaline phosphatase 111 (from 2/13).
From 2/9 11:55: AMMONIA - 83.
Specimen moderately hemolyzed.
Hemolyzed Specimen-Results may be affected.
Appraisal: State NB metabolic screen sent at 24 hours of life. Pending results.
Metabolic workup in progress due to seizures.
Workup includes: Ammonia level 83, pyruvic acid (pending), serum AA (pending), UA Organic acid and reducing substances (pending)
Plan: Continue to monitor.
Follow results of labs pending.
Follow results the NBS and repeat per protocol.

IN-PATIENT DEVELOPMENTAL INTERVENTIONS
Appraisal: Infant at risk of developmental delays due hospitalization and

seizures.

Plan: Continue to follow developmental needs while in the unit.
NICU PT/OT ordered.

CURRENT MEDICATIONS
Levetiracetam (Keppra), 40 mg IV q12h (13.1 mg/kg/dose, 26.2 mg/kg/day) started on 2/11/22
PHENObarbital, 15 mg IV q24h (4.9 mg/kg/day) started on 2/9/22

I personally examined the patient, reviewed and updated the history and assessment, and developed the plan of care with the multidisciplinary team as documented in this note. Allie Kenmore, Nurse Clinician assisted me in the care of the patient and preparation of this note.

The patient needs critical care.

E-signed by Vadim Ivanov, MD; completed 2/13/22 13:22

Electronically Signed by Vadim A Ivanov, MD on 02/14/22 at 2000

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

OU MEDICAL CENTER (COCPN)
Neuro Interim Note
REPORT#:0213-0534
DATE:02/13/22 Time: 0907

PATIENT: BLUE,BB-TATUM UNIT No: E003047593
ACCOUNT#: E00677497957 ROOM: EU.7172
REPORT AUTHOR: Durica,Sarah MD

See Addendum

Neurology Interim Note

Neurology Interim Note
this is a preliminary report. Full report to follow.

EEG reviewed from 21:28 on 2/12/22-09:13 on 2/13/22.

There were no seizures. There was one pushbutton event at 23:49 for nonspecific movements and alarm sounding, but no clear epileptiform EEG changes.

Results communicated with neurology team.

Electronically Signed by Durica,Sarah MD on 02/13/22 at 0914

Addendum 1: 02/13/22 1311 by Durica,Sarah MD

EEG reviewed from 09:13-13:02.

There were no seizures.

Electronically Signed by Durica,Sarah MD on 02/13/22 at 1311

Addendum 2: 02/13/22 2032 by Durica,Sarah MD

EEG reviewed from 13:02-20:30.

There were no seizures. There was one pusbutton event at 18:19 for uncertain reason other than the alarm sounding. There was no associated epileptiform activity.

Results communicated with neurology team.

The EEG will continue recording overnight. The next update will be tomorrow morning, unless otherwise requested.

Electronically Signed by Durica,Sarah MD on 02/13/22 at 2033

RPT #: 0213-0534
END OF REPORT

OU MEDICAL CENTER (COCPN)
Neurology Prog Note
REPORT#:0213-0126
DATE:02/13/22 Time: 0625

PATIENT: BLUE,BB-TATUM UNIT No: E003047593
ACCOUNT#: E00677497957 ROOM: EU.7172
REPORT AUTHOR: Rabbani,Bahram DO

Mcnaughton,Jeffrey M 02/13/22 0625:
Neurology Progress Note

Subjective
Medical Student Note

Parker is a 5-day-old baby boy born at 40 weeks of gestation via artificial rupture of membranes, delivery for significant prolonged labor and meconium stained amniotic fluid, transferred from Durant Medical Center 2/8/22 to OU Children's Center NICU for higher level of workup and care after presenting with concern for seizure manifested by spells of apnea and leg twitching due to a possible hypoxic ischemic event vs sepsis s/p phenobarbital loads (30 mg/kg in total).

Physical Exam

Language/Mental Status non-verbal, arouses to touch and tickle
CN: pupils equally round and reactive to light; oculocephalic reflex present, symmetrical face, responds to touch, tongue midline on protrusion
Motor: normal tone, healthy flexed posture, moving all extremities
Sensory: responds appropriately to touch/tickle
Coordination: no abnormal movements
Reflexes: 2+, plantar extensor response bilaterally, +grasp, +rooting
Gait: deferred

Assessment
****Medical Student Note****

Impression: Parker is a 5-day-old baby boy born at 40 weeks of gestation via artificial rupture of membranes, delivery for significant prolonged labor and meconium stained amniotic fluid, transferred from Durant Medical Center 2/8/22 to OU Children's Center NICU for higher level of workup and care after presenting with concern for seizure manifested by spells of apnea and leg twitching due to a possible hypoxic ischemic event vs sepsis s/p phenobarbital loads (30 mg/kg in total).

Plan
- Conitue EEG for further monitoring
- Neurochecks
- Seizure/aspiration precautions
- MRI brain W/O can be performed on or after day 4 of life (Planning on Monday)
- Phenobarbital 7.5 mg BID (2.5 mg/kg/dose)
- Levetiracetam 40 mg BID (~26 mg/kg/day)

Patient: BLUE,BB-TATUM Unit#: E003047593
Date: 02/13/22 Acct#: E00677497957

- For more seizures, can give fosphenytoin 10 mg/kg load with free phenytoin level check 2 hours after
- Metabolic panel pending:
  - Serum amino acids - pending
  - Ammonia - 83
- Epilepsy genetic testing -- will be swabbed on Monday 02/14/2022

Rabbani,Bahram X DO 02/13/22 0713:
Neurology Resident Addendum
Neurology Resident Addendum
Patient was personally seen and examined by me today. Please see the following addendum below for further details.

SUB:
5-day-old baby boy born at 40 weeks of gestation via artificial rupture of membranes, delivery significant for meconium stained amniotic fluid, transferred from Durant Medical Center 2/8/22 to OU Children's Center NICU for higher level of workup and care after presenting with low APGARs of 2, 6, and 7 and spells of apnea and leg twitching concerning for possible seizures due to a possible hypoxic ischemic event vs sepsis s/p phenobarbital loads (30 mg/kg in total).

02/09: Patient had 1-2 more seizures overnight. Given Keppra 20 mg/kg load once. No further events since 0700. PHB 29.4, CSF WBC 25, RBC ~50k, elevated neutrophils, glucose 62 (serum ~60-80), protein 113.

02/10: EEG demonstrated focal seizures from C4 and rarely T5/O1. Patient loaded with phenobarbital 10 mg/kg again with PHB level 39.1 today. Patient had another seizure later that night and was given fosphenytoin 20 mg/kg once with resolution of spells the rest of the night (per EEG attending's verbal communication with me). Ammonia 83.

02/11: One seizure at 1932. Loaded with levetiracetam 20 mg/kg once. No further seizures (more brief rhythmic discharges, last one 0106).

02/12: EEG report up till 1700 demonstrated marked improvement from last tracing with prominent left temporal sharp transients and rare brief rhythmic discharges, but no seizures. However, overnight, EEG demonstrated numerous seizures (report still pending, given verbally).

02/13: Seizures until 1124 yesterday (following fosphenytoin load @ 1056). Afterward, rare BRDs over left central and centromidline regions (C3/Cz) but no definite seizures. Remained seizure-free for the rest of 02/12 until 2128 (end of EEG attending's review, next review this morning still pending).

EXAM:
GEN: awake
HEENT: ant fontanelle soft, open, flat

Patient: BLUE,BB-TATUM Unit#: E003047593
Date: 02/13/22 Acct#: E00677497957

ABD: soft

NEURO:
Lang/Ment: non-verbal, arouses to touch; one apneic event during exam
CN: pupils equally round and reactive to light; oculocephalic reflex present, symm face, responds to touch, tongue midline on protrusion
Motor: normal tone, healthy flexed posture, moving all extremities
Sens: responds appropriately to touch/tickle
Coord: no abnormal movements
Reflexes: 2+, plantar extensor response bilaterally, +grasp, +rooting
Gait: deferred

IMPRESSION:
- Apnea episodes concerning for seizure in setting of r/o sepsis vs HIE (low suspicion for HIE?)

Levels:
- Phenobarbital: 29.4 --> 39.1 --> 36.7
- Free phenytoin: 1.41 --> 2.12

RECOMMENDATION:
- Restarted continuous EEG for further monitoring
- Neurochecks
- Seizure/aspiration precautions
- HUS negative for hemorrhage
- MRI brain W/O can be performed on or after day 4 of life **(may have to wait till Monday, which is OK)**
- Phenobarbital 7.5 mg BID (2.5 mg/kg/dose) - **please check a phenobarbital level today**
- Levetiracetam 40 mg BID (~26 mg/kg/day)
- For more seizures, can give fosphenytoin 10 mg/kg load with free phenytoin level check 2 hours after
- Metabolic panel pending:
    - Serum amino acids - pending
    - Ammonia - 83
- Epilepsy genetic testing -- will be swabbed on Monday 02/14/2022

Discussed with attending physician of record during morning rounds.

CHRUSCIEL,DEEPTI G 02/17/22 1216:

Neurology Attending Note

Attending Note

I have interviewed and examined this patient and personally reviewed all labs and studies. I discussed the patient's management with the residents and reviewed the resident's note. I have discussed care with the patient and family who voiced understanding. I agree with the

Patient: BLUE,BB-TATUM Unit#: E003047593
Date: 02/13/22 Acct#: E00677497957

documented findings and plan of care unless amended below.

Patient seen on 2/13/22.

99232: P90 Neonatal seizures, G93.1 HIE

Electronically Signed by McNaughton,Jeffrey on 02/13/22 at 1138
Electronically Signed by Rabbani,Bahram DO on 02/13/22 at 1141
Electronically Signed by Chrusciel,Deepti Ganti MD on 02/17/22 at 1216

RPT #: 0213-0126
END OF REPORT

OU MEDICAL CENTER
1200 Everett Drive
Oklahoma City, OK 73104

Name: BLUE,BB-TATUM
Account Number: E00677497957
Unit Number: E003047593
Room: EU.7172
Date Of Birth: 02/08/22
Attending Doctor: Bergner,Erynn MD
Date: 02/14/22

NEONATAL SERVICES DAILY PROGRESS NOTE
3050 gram, 40 + 1/7 week AGA male => 3410 grams; corrected gestational age 41 + 0/7 weeks.
Active Problems: Seizure disorder (identified 2/8/22)
respiratory distress (identified 2/12/22)

PHYSICAL EXAM (at 2/14/22 6:47)
Weight - 3410 grams (+40 grams) - 21%ile ; Z-score = -0.79
Vital Signs: HR - 115, RR - 26, BP - 54/33 (mean 40), O2 Sat - 97%, Temp - 36.9 degrees
General: Term infant under radiant warmer, on CPAP and in no acute distress. Skin pink, warm, and dry.
HEENT: Anterior fontanelle open, soft, and flat with sutures approximated. Head covered with CFM elctrodes and gauze wrap. Eyes clear. Oral mucosa pink and moist, palate intact. Ears in normal shape and position.
Chest: Chest rise symmetrical with upper airway congestion bilaterally. Mild suprasternal retractions.
Heart: Normal sinus rhythm, normal perfusion and pulses, no murmur.
Abdomen: Soft and non-distended, non-tender with active bowel sounds.
Genitals: Normal male genitalia.
Anus: Patent anus.
Skeletal: Spine intact.
Extremities: Moving all extremities equally.
Neuro: Asleep, responsive to exam. Hypotonic.

FLUIDS, ELECTROLYTES, NUTRITION
Objective: Weight today 3410 grams, up 40 grams from 2/13. Gained 106.7 grams/day/3 days.
On a radiant warmer with a set temperature of 36.0 degrees.
Input: 441 ml.
145 ml/kg/day (enteral - 58%/parenteral - 42%); 91 cal/kg/day (enteral - 61%/parenteral - 39%).
Output: Urine - 316 ml/day (4.3 ml/kg/hr).
Stools - 2 (Last stool: 9 AM 2/14).
The baby has been on TPN for 6 days from 2/8. A PICC-Right arm has been in place for 5 days from 2/9.
Protein - 3.7 gram/kg/day; Fat - 3.5 gram/kg/day; Carbohydrate - 11.7 gram/kg/day.
FEEDINGS: On SAdv20 (0.68 cals/ml) and HM-T (0.64 cals/ml), 23-33 ml; last feed: 42 ml of SAdv20; one 3 ml residual - refed. 8 feedings received; none nippled. Gavage feeds given over 30-40 minutes.
From 2/13 3:06: Na 140, K 4.3, Cl 102, Bicarb 22.0, Glucose 62, Ca 9.6, Phos 6.0, BUN 13.0, Creat 0.5, Mg 1.9, Triglycerides 206.

From 2/12 17:53: Glucose bld-75, Ca (ionized) 1.31, Lactate 1.4.
Appraisal: Infant tolerating advancing enteral feeds of Sim Term with supplemental with HAL/SMOF @ 140 ml/kg/day. Electrolytes as listed. Voiding and stooling. Weight gain noted overnight. Speech consulted, holding PO feeds due to concern for aspiration and respiratory status.
Plan: Advance enteral feeds to 100 ml/kg/d and supplement with D10W for a TFG of 140 ml/kg/day via PICC.
Will continue to assess nutritional intake, output, and growth trend.
Continue to follow speech pathology recommendations.

RESPIRATORY
Objective: Respiratory rate for yesterday: average 41, range 22-65; for the past 8 hours: average 37, range 26-49.
O2 sats for yesterday: average 96, range 92-98; for the past 8 hours: average 97, range 95-99.
2/14 10:15: NC-21% O2 @ 3.00 L/min.
From 2/12 17:53: Capillary blood gases: pH 7.41, pCO2 44, pO2 41, base excess 2.4.
A and B events yesterday - 2 (2 mild; 1 associated with feeding). No A and B events today.
Appraisal: Infant was placed on CPAP on 2/12 for increased work of breathing/stridor with bottle feeding and crackles. Infant was previously stable in room air.
Plan: Wean to HFNC and wean as tolerated.
Continue to monitor.
CXR/CBG in PRN.

HEMATOLOGY
Objective: Blood out so far - 9.6 ml (never transfused).
From 2/12 17:53: Hgb 14.5, Hct 43.0.
From 2/10: Platelets 239,000.
Appraisal: Heme Labs stable.
Plan: Continue to monitor.
Limit lab draws as able.

BILIRUBIN
Objective: Serum bili 1.0 on 2/13 3:06.
Mother's blood type B Positive.
The infant has not been treated with phototherapy.
The maximum total bilirubin was 5.2 on 2/10 and the maximum direct bilirubin was 0.3 on 2/9.
Appraisal: Mom's blood type is B+. T bili remains well below threshold of treatment.
Plan: Continue to monitor clinically.

INFECTIOUS DISEASE
Objective: Temperature range over the past day: 36.7-37.2 degrees; temperature over the past 8 hours: 36.9-37.0 degrees.
From 2/10: CRP - <3.0.
From 2/9: CEREBRAL SPINAL FLUID
From 2/8: CSF 49,750 RBCs, 25 WBCs (87 polys, 10 lymphs, 3 monos), protein 113, glucose 62.
Appraisal: Infectious workup started due to concerns of seizures. Maternal labs reassuring. Blood and CSF cultures sent. CBC and CRP reassuring. HSV CSF 1/2

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

negative, HSV PCR blood negative. Infant started on Ampicillin, Amikacin and Acyclovir dc'd on 2/13. CSF negative and blood culture negative.
Plan: Continue to monitor

CARDIOVASCULAR
Objective: Heart rate for yesterday: average HR 120, range 108-137; for the past 8 hours: average HR 115, range 105-124.
Blood pressure for yesterday: average cuff BP - 60/28(40 mean), range - 60/28(40 mean); for the past 8 hours: average cuff BP - 54/33(40 mean), range - 54/33(40 mean).
The infant passed the critical congenital heart disease screening at 108.8 hours of age.
Appraisal: Hemodynamically stable.
Plan: Continue to monitor clinically.

NEUROLOGY
Objective: Over the past 24 hours, Phenobarbital level: 2/13 at 15:30 - 39.9 No medications were given.
Appraisal: Seizure workup continues, neurology consulting. Infant has received numerous loads of Phenobarb, Keppra and Fosphenytoin. Continuous EEG in progress. Is currently receiving Phenobarb and Keppra. EEG 2/12 showed subclinical seizures lasting 20-40 seconds, 3-7 times/hour. Loaded with 10mg/kg Fosphenytoin on 2/13 and free phenytoin level (2.1) Phenobarb level 2/13 39.9 WNL
Plan: Continue EEG per neurology.
Continue phenobarb and Levetiracetam, change to PO route
Continue to follow neurology recommendations. Obtain MRI 2/14 per neuro's recs.
Neurology requested epilepsy genetic workup on 2/14.

GASTROINTESTINAL
Objective: From 2/13: T Prot 4.8, Alb 3.1, AST(SGOT) 39, ALT(SGPT) 23.
Appraisal: Normal abdominal exam and stooling pattern. Tolerating advancing enteral feedings.
Plan: Continue to monitor stooling pattern and quantity.

GENITOURINARY
Objective: Urine output: 79 ml (3.2 ml/kg/hr) over the past 8 hours and 4.3 ml/kg/hr over the past 24 hours. On 2/13 3:06, BUN 13.0 and creatinine 0.4.
Appraisal: Normal renal function for age.
Plan: Continue to monitor clinically. Monitor UOP.

IMMUNIZATIONS
Appraisal: Hepatitis B #1 given on 2/8 at RH.
Plan: Continue to follow AAP guidelines for vaccine schedule.

GENETICS, ENDOCRINE, METABOLIC
Objective: Metabolic screening tests are pending from 2/9.
Ca 9.6, Phos 6.0, Alkaline phosphatase 111 (from 2/13).
From 2/9 11:55: AMMONIA - 83.
Specimen moderately hemolyzed.
Hemolyzed Specimen-Results may be affected.
Appraisal: State NB metabolic screen sent at 24 hours of life. Pending results.
Metabolic workup in progress due to seizures.
Workup includes: Ammonia level 83, pyruvic acid (pending), serum AA elevated

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

levels but not consistent with inherited metabolic disease, UA Organic acid and

reducing substances (pending)
Plan: Continue to monitor.
Follow results of labs pending.
Follow results the NBS and repeat per protocol.

SOCIAL
Appraisal: Mom and Dad have been updated at bedside during rounds, questions answered.
Plan: Continue to update on plan of care.

IN-PATIENT DEVELOPMENTAL INTERVENTIONS
Appraisal: Infant at risk of developmental delays due hospitalization and seizures.
Plan: Continue to follow developmental needs while in the unit.
NICU PT/OT ordered.

CURRENT MEDICATIONS
Levetiracetam (Keppra), 40 mg enterally q12h (13.1 mg/kg/dose, 26.2 mg/kg/day) started on 2/14/22
PHENObarbital, 15 mg enterally q24h (4.9 mg/kg/day) started on 2/14/22

I personally examined the patient, reviewed and updated the history and assessment, and developed the plan of care with the multidisciplinary team as documented in this note. Allie Kenmore, Nurse Clinician assisted me in the care of the patient and preparation of this note.

The patient requires critical care.

E-signed by Marjorie Makoni, MD; completed 2/14/22 18:12

Electronically Signed by Marjorie Mercy Makoni, MD on 02/15/22 at 2300

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

OU MEDICAL CENTER (COCPN)
Neuro Interim Note
REPORT#:0214-0618
DATE:02/14/22 Time: 0902

PATIENT: BLUE,BB-TATUM UNIT No: E003047593
ACCOUNT#: E00677497957 ROOM: EU.7172
REPORT AUTHOR: Durica,Sarah MD

Neurology Interim Note

Neurology Interim Note
This is a preliminary report.

EEG reviewed until 08:45.

There were no seizures.

Results communicated with neurology team.

Electronically Signed by Durica,Sarah MD on 02/14/22 at 0902

RPT #: 0214-0618
END OF REPORT

OU MEDICAL CENTER (COCPN)
Neurology Prog Note
REPORT#:0214-0190
DATE:02/14/22 Time: 0628

PATIENT: BLUE,BB-TATUM UNIT No: E003047593
ACCOUNT#: E00677497957 ROOM: EU.7172
REPORT AUTHOR: Rabbani,Bahram DO

Rabbani,Bahram X DO 02/14/22 0628:
Neurology Progress Note

Subjective
5-day-old baby boy born at 40 weeks of gestation via artificial rupture of membranes, delivery significant for meconium stained amniotic fluid, transferred from Durant Medical Center 2/8/22 to OU Children's Center NICU for higher level of workup and care after presenting with low APGARs of 2, 6, and 7 and spells of apnea and leg twitching concerning for possible seizures due to a possible hypoxic ischemic event vs sepsis s/p phenobarbital loads (30 mg/kg in total).

UPDATES:
02/12: EEG report up till 1700 demonstrated marked improvement from last tracing with prominent left temporal sharp transients and rare brief rhythmic discharges, but no seizures. However, overnight, EEG demonstrated numerous seizures.

02/13: Seizures until 1124 on 02/12 (following fosphenytoin load @ 1056). Afterward, rare BRDs over left central and centromidline regions (C3/Cz) but no definite seizures. Remained seizure-free for the rest of 02/12 until 2128 (end of EEG attending's review, next review this morning still pending).

02/14: No seizures overnight (one push-button event at 1819 with no electrographic evidence of seizures) or in the last 24 hours. Will obtain epilepsy gene panel swab today or tomorrow. Possibly going for MRI brain today.

Physical Exam
GEN: awake
HEENT: ant fontanelle soft, open, flat
ABD: soft

NEURO:
Lang/Ment: non-verbal, arouses to touch; one apneic event during exam
CN: pupils equally round and reactive to light; oculocephalic reflex present, symm face, responds to touch, tongue midline on protrusion
Motor: normal tone, healthy flexed posture, moving all extremities
Sens: responds appropriately to touch/tickle
Coord: no abnormal movements
Reflexes: 2+, plantar extensor response bilaterally, +grasp, +rooting
Gait: deferred

Assessment

Patient: BLUE,BB-TATUM Unit#: E003047593
Date: 02/14/22 Acct#: E00677497957

- Apnea episodes concerning for seizure in setting of r/o sepsis vs HIE (low suspicion for HIE?)

Levels:
- Phenobarbital: 29.4 --> 39.1 --> 36.7 --> 39.9
- Free phenytoin: 1.41 --> 2.12

RECOMMENDATION:
- Restarted continuous EEG for further monitoring
- Neurochecks
- Seizure/aspiration precautions
- HUS negative for hemorrhage
- MRI brain W/O can be performed on or after day 4 of life **(may have to wait till Monday, which is OK)**
- Phenobarbital 7.5 mg BID (2.5 mg/kg/dose)
- Levetiracetam 40 mg BID (~26 mg/kg/day)
- For more seizures, can give fosphenytoin 10 mg/kg load with free phenytoin level check 2 hours after
- Metabolic panel pending:
    - Serum amino acids - pending
    - Ammonia - 83
- Epilepsy genetic testing -- will be swabbed on Monday 02/14/2022
- **D/c EEG**

Discussed with attending physician of record during morning rounds.

PURCARIN,GABRIELA 03/16/22 0727:

Neurology Attending Note

Attending Note

I have examined this patient on 2/14/22 and personally reviewed all labs and studies. I discussed the patient's management with the residents and reviewed the resident's note. I have discussed care with the family who voiced understanding. I agree with the documented findings and plan of care unless amended below.

24hr EEG didn't show any seizures. There were bilateral epileptiform discharges, but no seizures. The 3 push-button events were not seizures.

CPT 99232
Neonatal seizures P90
Neonatal encephalopathy P91.81

Electronically Signed by Rabbani,Bahram DO on 02/14/22 at 1318
Electronically Signed by Purcarin,Gabriela MD on 03/16/22 at 0730

Patient: BLUE,BB-TATUM
Date: 02/14/22

Unit#: E003047593
Acct#: E00677497957

RPT #: 0214-0190
END OF REPORT

OU MEDICAL CENTER
1200 Everett Drive
Oklahoma City, OK 73104

Name: BLUE,BB-TATUM
Account Number: E00677497957
Unit Number: E003047593
Room: EU.7172
Date Of Birth: 02/08/22
Attending Doctor: Bergner,Erynn MD
Date: 02/15/22

NEONATAL SERVICES DAILY PROGRESS NOTE
3050 gram, 40 + 1/7 week AGA male => 3470 grams; corrected gestational age 41 + 1/7 weeks.
Active Problems: Seizure disorder (identified 2/8/22)
respiratory distress (identified 2/12/22)

PHYSICAL EXAM (at 2/15/22 8:15)
Weight - 3470 grams (+60 grams) - 23%ile ; Z-score = -0.73
Length - 53.0 cm - 64%ile ; Z-score = 0.37
Head circumference - 36.0 cm - 61%ile ; Z-score = 0.27
Vital Signs: HR - 134, RR - 74, BP - 51/25 (mean 32), O2 Sat - 97%, Temp - 37.0 degrees
General: Term infant under radiant warmer, on LFNC and in no acute distress.
Skin pale, pink, warm, and dry.
HEENT: Anterior fontanelle open, soft, and flat with sutures approximated. Eyes clear. Ears in normal shape and position. Oral mucosa pink and moist, palate intact.
Chest: Chest rise symmetrical with clear breath sounds bilaterally.
Heart: Normal sinus rhythm, normal perfusion and pulses, no murmur.
Abdomen: Soft and non-distended, non-tender with active bowel sounds.
Extremities: Moving all extremities equally.
Neuro: Active, responsive, normal tone for gestational age.

FLUIDS, ELECTROLYTES, NUTRITION
Objective: Weight today 3470 grams, up 60 grams from 2/14. Gained 83.3 grams/day/3 days.
On a radiant warmer with a set temperature of 36.5 degrees.
Input: 482 ml.
158 ml/kg/day (enteral - 70%/parenteral - 30%); 95 cal/kg/day (enteral - 78%/parenteral - 22%).
Output: Urine - 336 ml/day (4.6 ml/kg/hr).
Stools - 4 (Last stool: 9 AM 2/15).
The baby was on TPN for 7 days from 2/8 to 2/14. A PICC-Right arm has been in place for 6 days from 2/9.
Protein - 2.7 gram/kg/day; Fat - 3.9 gram/kg/day; Carbohydrate - 12.8 gram/kg/day.
FEEDINGS: On SAdv20 (0.68 cals/ml) and HM-PT (0.66 cals/ml), 42 ml; last feed: 52 ml of SAdv20; no residuals. 8 feedings received; none nippled. Gavage feeds given over 35-40 minutes.
From 2/13: Na 140, K 4.3, Cl 102, Bicarb 22.0, Glucose 62, Ca 9.6, Phos 6.0, BUN 13.0, Creat 0.5, Mg 1.9, Triglycerides 206.
From 2/12: Glucose bld-75, Ca (ionized) 1.31, Lactate 1.4.
Appraisal: Infant tolerating advancing enteral feeds of Sim Term with

supplemental with clears @ 140 ml/kg/day. Electrolytes as listed. Voiding and stooling. Weight gain noted overnight. Speech consulted, holding PO feeds due to concern for aspiration and respiratory status.
Plan: Advance enteral feeds to 120 ml/kg/d and supplement with D10W for a TFG of 150 ml/kg/day via PICC.
Will continue to assess nutritional intake, output, and growth trend.
Continue to follow speech pathology recommendations.

RESPIRATORY
Objective: Respiratory rate for yesterday: average 34, range 26-49; for the past 8 hours: average 46, range 29-74.
O2 sats for yesterday: average 97, range 94-100; for the past 8 hours: average 96, range 92-100.
2/15 9:32: NC-21% O2 @ 1.00 L/min.
From 2/12 17:53: Capillary blood gases: pH 7.41, pCO2 44, pO2 41, base excess 2.4.
No A and B events since 2/14.
Appraisal: Infant was placed on CPAP on 2/12 for increased work of breathing/stridor with bottle feeding and crackles; transitioned to LFNC 2/14.
Plan: Continue LFNC and wean as tolerated.
Continue to monitor.
CXR/CBG in PRN.

HEMATOLOGY
Objective: Blood out so far - 9.6 ml (never transfused).
From 2/12: Hgb 14.5, Hct 43.0.
From 2/10: Platelets 239,000.
Appraisal: Heme Labs stable.
Plan: Continue to monitor.
Limit lab draws as able.

INFECTIOUS DISEASE
Objective: Temperature range over the past day: 36.4-37.0 degrees; temperature over the past 8 hours: 36.7-37.0 degrees.
From 2/10: CRP - <3.0.
From 2/9: CEREBRAL SPINAL FLUID.
Appraisal: NO current concern for infection.
Plan: Continue to monitor

CARDIOVASCULAR
Objective: Heart rate for yesterday: average HR 116, range 102-138; for the past 8 hours: average HR 128, range 108-144.
Blood pressure for yesterday: average cuff BP - 57/33(42 mean), range - 54-60/33(40-43 mean); for the past 8 hours: average cuff BP - 55/25(35 mean), range - 51-58/24-26(32-37 mean).
The infant passed the critical congenital heart disease screening at 108.8 hours of age.
Appraisal: Hemodynamically stable.
Plan: Continue to monitor clinically.

NEUROLOGY
Objective: Over the past 24 hours, Phenobarbital level: 2/13 at 15:30 - 39.9 No medications were given.
Appraisal: Seizure workup continues, neurology consulting. Infant has received

numerous loads of Phenobarb, Keppra and Fosphenytoin. Continuous EEG in progress. Is currently receiving Phenobarb and Keppra. EEG 2/12 showed subclinical seizures lasting 20-40 seconds, 3-7 times/hour. Loaded with 10mg/kg Fosphenytoin on 2/13 and free phenytoin level (2.1) Phenobarb level 2/13 39.9 WNL. Epilepsy genetic workup pending.
Plan: Continue EEG per neurology.
Continue phenobarb and Levetiracetam
Continue to follow neurology recommendations. Obtain MRI 2/15 per neuro's recs.

IMMUNIZATIONS
Appraisal: Hepatitis B #1 given on 2/8 at RH.
Plan: Continue to follow AAP guidelines for vaccine schedule.

GENETICS, ENDOCRINE, METABOLIC
Objective: Metabolic screening tests are pending from 2/9.
Ca 9.6, Phos 6.0, Alkaline phosphatase 111 (from 2/13).
From 2/9 11:55: AMMONIA - 83.
Specimen moderately hemolyzed.
Hemolyzed Specimen-Results may be affected.
Appraisal: State NB metabolic screen sent at 24 hours of life, consistent with TPN.
Metabolic workup in progress due to seizures.
Workup includes: Ammonia level 83, pyruvic acid (0.4 normal), serum AA elevated levels but not consistent with inherited metabolic disease, UA Organic acid and reducing substances (pending)
Plan: Continue to monitor.
Follow results of labs pending.
Repeat NBS at 14 days of life.

SOCIAL
Appraisal: Mom and Dad have been updated at bedside during rounds, questions answered.
Plan: Continue to update on plan of care.

IN-PATIENT DEVELOPMENTAL INTERVENTIONS
Appraisal: Infant at risk of developmental delays due hospitalization and seizures.
Plan: Continue to follow developmental needs while in the unit.
NICU PT/OT ordered.

CURRENT MEDICATIONS
Levetiracetam (Keppra), 40 mg enterally q12h (13.1 mg/kg/dose, 26.2 mg/kg/day) started on 2/14/22
PHENObarbital, 15 mg enterally q24h (4.9 mg/kg/day) started on 2/14/22

I personally examined the patient, reviewed and updated the history and assessment, and developed the plan of care with the multidisciplinary team as documented in this note. Jumoke A. Ogunfolu, NNP Student assisted me in the care of the patient and preparation of this note.

The patient needs intensive monitoring of nutrition, I and O, growth, and cardiorespiratory stability.

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

E-signed by Marjorie Makoni, MD; completed 2/15/22 16:18

Electronically Signed by Marjorie Mercy Makoni, MD on 02/16/22 at 2000

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

OU MEDICAL CENTER (COCPN)
Neurology Prog Note
REPORT#:0215-0180
DATE:02/15/22 Time: 0628

PATIENT: BLUE,BB-TATUM UNIT No: E003047593
ACCOUNT#: E00677497957 ROOM: EU.7172
REPORT AUTHOR: Rabbani,Bahram DO

See Addendum

Rabbani,Bahram X DO 02/15/22 0628:

Neurology Progress Note

Subjective

5-day-old baby boy born at 40 weeks of gestation via artificial rupture of membranes, delivery significant for meconium stained amniotic fluid, transferred from Durant Medical Center 2/8/22 to OU Children's Center NICU for higher level of workup and care after presenting with low APGARs of 2, 6, and 7 and spells of apnea and leg twitching concerning for possible seizures due to a possible hypoxic ischemic event vs sepsis s/p phenobarbital loads (30 mg/kg in total).

UPDATES:
02/12: EEG report up till 1700 demonstrated marked improvement from last tracing with prominent left temporal sharp transients and rare brief rhythmic discharges, but no seizures. However, overnight, EEG demonstrated numerous seizures.

02/13: Seizures until 1124 on 02/12 (following fosphenytoin load @ 1056). Afterward, rare BRDs over left central and centromidline regions (C3/Cz) but no definite seizures. Remained seizure-free for the rest of 02/12 until 2128 (end of EEG attending's review, next review this morning still pending).

02/14: No seizures overnight (one push-button event at 1819 with no electrographic evidence of seizures) or in the last 24 hours. Will obtain epilepsy gene panel swab today or tomorrow. Possibly going for MRI brain today.

02/15: Serum AA profile not overly consistent with an inherited metabolic disorder, but several species elevated. No MRI was obtained yesterday.

Physical Exam

GEN: awake
HEENT: ant fontanelle soft, open, flat
ABD: soft

NEURO:
Lang/Ment: non-verbal, arouses to touch; one apneic event during exam
CN: pupils equally round and reactive to light; oculocephalic reflex present, symm face, responds to touch, tongue midline on protrusion
Motor: normal tone, healthy flexed posture, moving all extremities
Sens: responds appropriately to touch/tickle
Coord: no abnormal movements
Reflexes: 2+, plantar extensor response bilaterally, +grasp, +rooting

Patient: BLUE,BB-TATUM Unit#: E003047593
Date: 02/15/22 Acct#: E00677497957

Gait: deferred

Assessment
- Apnea episodes concerning for seizure
  - Seizures resolved on 02/12/2022 @ 1124

Levels:
- Phenobarbital: 29.4 --> 39.1 --> 36.7 --> 39.9
- Free phenytoin: 1.41 --> 2.12

RECOMMENDATION:
- Restarted continuous EEG for further monitoring
- Neurochecks
- Seizure/aspiration precautions
- HUS negative for hemorrhage
- **MRI brain W/O can be performed on or after day 4 of life when able**
- **Phenobarbital level tomorrow (02/16)**
- Phenobarbital 7.5 mg BID (2.5 mg/kg/dose)
- Levetiracetam 40 mg BID (~26 mg/kg/day)
- For more seizures, can give fosphenytoin 10 mg/kg load with free phenytoin level check 2 hours after
- Metabolic panel pending:
  - Serum amino acids - not
  - Ammonia - 83
- Epilepsy genetic testing -- will be swabbed on Monday 02/14/2022

Discussed with attending physician of record during morning rounds.

PURCARIN,GABRIELA 03/16/22 0733:

Neurology Attending Note

Attending Note

I have examined this patient on 2/15/22 and personally reviewed all labs and studies. I discussed the patient's management with the residents and reviewed the resident's note. I have discussed care with the mother who voiced understanding. I agree with the documented findings and plan of care unless amended below: He has been off EEG monitoring since 2/14 because no seizures were recorded and the recorded events were non-epileptic).
Seizure medication doses: phenobarbital 7.2mg (1.8ml) BID and Keppra 40mg BID
MRI showed DWI changes in R>L white matter in the periventricular areas and corpus callosum, suggestive of HIE and a right cerebellar intraparenchymal hemorrhage. Rec. a f/up head CT to make sure the hemorrhage is not expanded. Clinically, he is reactive, AFSOF, moves all extremities to light stimulation.

Patient: BLUE,BB-TATUM
Date: 02/15/22

Unit#: E003047593
Acct#: E00677497957

CPT 99232
Neonatal seizures P90
Neonatal HIE G93.1

Electronically Signed by Rabbani,Bahram DO on 02/15/22 at 1023
Electronically Signed by Purcarin,Gabriela MD on 03/16/22 at 0737

Addendum 1: 02/15/22 1226 by Rabbani,Bahram DO

- Phenobarbital 4.7 mg BID (7.2 mg/kg/dose = 1.8 mL BID)
- Levetiracetam 40 mg BID (~26 mg/kg/day = 0.4 mL BID)

Electronically Signed by Rabbani,Bahram DO on 02/15/22 at 1228

RPT #: 0215-0180
END OF REPORT

OU MEDICAL CENTER - THE CHILDREN'S HOSPITAL

1200 N. Phillips
Oklahoma City, OK 73104

MAGNETIC RESONANCE IMAGING
CONSULTATION REPORT

PHONE: (405) 271-7454
FAX: (405) 271-2674

LOC/RM: EU.NICUE/EU.7172 PACS ID: E2368718 MRN: E003047593
PT. TYPE: ADM IN CAMPUS: C PT: BLUE,BB-TATUM
ACCT#: E00677497957 DOB: 02/08/2022 AGE: 00M 07D SEX: M

ORD PROV: 1538404637 Christenson,Kahlene M AP EXAM START: 02/15/22 1250
ATT PROV: 1962762948 Bergner,Erynn MD EXAM ENDED: 02/15/22 1335
ADMISSION CLINICAL DATA: APNEA

EXAMS:	CPT:
007129448 MR BRAIN WO INF	70551

MRI brain without contrast dated 2/14/2022 .

Comparison: Ultrasound study on 2/9/2022.

History: Seizures

Technique: Multiplanar imaging of the brain was performed without contrast.

Findings:
Restricted diffusion involving multiple areas of right greater than left cortical/subcortical supratentorial region as well as the periventricular region, external and internal capsule along with the corpus callosum. Associated more diffuse intrinsic T1 signal involving the bilateral cerebral cortices. Findings likely related to HIE.

Intrinsic T1 signal, low T2 signal and susceptibility artifact with fluid-fluid level in the region of the right cerebellar hemisphere which may represent parenchymal hemorrhage. Mild scattered susceptibility artifact with intrinsic T1 signal likely representing blood products along the cerebellar tentorium and dorsal aspect of the posterior fossa as well as along the convexities of the right middle cranial fossa as well as the dorsomedial left occipital lobe, some likely representing birth-related sequela. Scattered supratentorial punctate susceptibility artifacts, also representing blood products, in the bilateral cerebral hemispheres.

Otherwise normal myelination. No midline shift. No hydrocephalus. The basal cisterns are patent. The cerebellar tonsils are normal in position. The pituitary bright spot is preserved. Intracranial arterial flow voids are patent. Mild subgaleal collection at the posterior scalp. The orbits are unremarkable. Mild paranasal sinus disease. Mild effusion of the right greater than left mastoid air cells.

Impression:
Changes related to severe HIE, as described above.

Right cerebellar hemisphere parenchymal hemorrhage.

OU MEDICAL CENTER - THE CHILDREN'S HOSPITAL

1200 N. Phillips
Oklahoma City, OK 73104

MAGNETIC RESONANCE IMAGING
CONSULTATION REPORT

PHONE: (405) 271-7454
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LOC/RM: EU.NICUE/EU.7172 PACS ID: E2368718 MRN: E003047593
PT. TYPE: ADM IN CAMPUS: C PT: BLUE,BB-TATUM
ACCT#: E00677497957 DOB: 02/08/2022 AGE: 00M 07D SEX: M

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ADMISSION CLINICAL DATA: APNEA

EXAMS:	CPT:
007129448 MR BRAIN WO INF	70551

<Continued>

** Electronically Signed by 384 ANJALI LAL MD on 02/15/2022 at 1505 **
Reported and signed by: ANJALI LAL, MD 384

DICTATED: 02/15/2022 @ 1426 TRANSCRIBED: 02/15/22 @ 1426
TYPIST: RAD.VR PRINTED: 02/15/2022 @ 1507
E-SIGNATURE DATE/TIME: 02/15/2022 @ 1505 DR.LALAN BATCH: N/A

The Children's Hospital at OU Medicine
Pediatric Echo Lab
1200 Children's Avenue
Oklahoma City, OK 73104

Transthoracic Echocardiogram Report

NAME:	BB-TATUM BLUE	DOB: 2/8/2022	Ht: 53.0 cm
PT ID#:	E003047593	Age: 8 days	Wt: 3.0 kg
STUDY DATE:	2/16/2022 3:12:31 PM	Sex: M	BSA: 0.21 m
Acc N:	202202160157CVIS		BP: 66/32 mmHg

Ordering Physician: BERER1 Erynn Bergner
Sonographer: Megan Hix
Diagnosing Physician: Umakumaran Ponniah, MD.

Procedure(s) Performed: Transthoracic Echocardiogram: Congenital complete (2D, Spectral Doppler, Color Flow) - 93303; -93320; -93325

Indication: SIGNS/SYMPTOMS: MURMUR NOS-R01.1
Diagnosis: SIGNS/SYMPTOMS: MURMUR NOS-R01.1
Study Info: The images were of adequate diagnostic quality.
Location: NICU

Summary:
1. Patent foramen ovale, small with a left to right interatrial shunt.
2. Trivial tricuspid valve insufficiency.
3. Trivial mitral valve insufficiency.
4. No patent ductus arteriosus.
5. Normal right ventricular cavity size and systolic function.
6. Normal left ventricular cavity size and systolic function.

Segmental Cardiotype, Cardiac Position, and Situs:
S,D,S. The heart position is within the left hemithorax. The cardiac apex is oriented leftward. The aorta is to the right of the pulmonary artery. There is visceral situs solitus.
Systemic Veins:
The superior vena cava is right-sided and drains normally to the right atrium. The superior vena cava flow profile is normally phasic. The innominate vein is present and of normal caliber. The inferior vena cava is right-sided and inserts into the right atrium normally.
Pulmonary Veins:
At least one pulmonary vein on each side drains to the left atrium.
Atria:

No atrial septal defect is detected. There is a small patent foramen ovale. Predominantly left to right flow across the interatrial septum. The right atrium is normal in size. The left atrium is normal in size.
Mitral Valve:
The mitral valve is normal. Mitral inflow is laminar, with normal Doppler velocity pattern. There is no evidence of mitral valve stenosis. The papillary muscle configuration appears normal. There is trivial mitral valve

insufficiency.

Tricuspid Valve:
The tricuspid valve is normal.
Tricuspid inflow is laminar, with normal Doppler velocity pattern. There is trivial (physiologic) tricuspid valve insufficiency. There is no evidence of tricuspid valve stenosis.
AV Canal/Complex Inlet/Single Ventricle:
The crux of the heart is normal.
Left Ventricle:

Left ventricular cavity size and systolic function are normal. Left Ventricle diastolic dimension is 1.93 cm, Z score of -0.29. Left Ventricle systolic dimension is 1.37 cm, Z score of 0.87. The fractional shortening of the left ventricle is 29.0 %.
Right Ventricle:
Right ventricular cavity size and systolic function are normal. TR peak gradient is 27.2 mmHg.
VSD:

There is no evidence of ventricular septal defect.
Conotruncal Anatomy:
Normal conotruncal anatomy.
Left Ventricular Outflow Tract and Aortic Valve:
There is no evidence of left ventricular outflow obstruction. The aortic valve is normal. Transaortic flow is laminar, with normal Doppler velocity pattern. Based on Doppler velocities, there is no aortic transvalvular flow obstruction. There is no evidence of aortic valve insufficiency.
Right Ventricular Outflow Tract and Pulmonary Valve:
There is no evidence of right ventricular outflow obstruction. The pulmonary valve is normal.
Transpulmonary flow is laminar, with normal Doppler velocity pattern. Based on Doppler velocities, there is no pulmonary transvalvular flow obstruction. Trivial pulmonary valve insufficiency.
Aorta:
The (aortic) sinuses of Valsalva segment is normal. The ascending aorta is normal. The transverse aortic arch segment is normal. There is a left aortic arch with normal branching pattern of the brachiocephalic arteries. The flow pattern in the aorta is normal. There is no evidence of coarctation of the aorta.
Pulmonary Arteries:

There is no evidence of supravalvular pulmonary artery stenosis. The main pulmonary artery is normal. The left branch pulmonary artery is normal. The right branch pulmonary artery is normal.
Ductus Arteriosus:
There is no evidence of a patent ductus arteriosus.
Coronary Arteries:
Left main and right coronary artery structures are normal.
Pericardium:
There is no evidence ofpericardial effusion.

M-mode		Z-score
IVSd:	0.26 cm	-3.01
IVSs:	0.37 cm	-3.79
LVIDd:	1.93 cm	-0.29
LVIDs:	1.37 cm	0.87

NAME: BLUE,BB-TATUM ROOM: EU.7172

LVPWd:	0.26 cm	-2.60
LVPWs:	0.34	-5.24

LV mass (corr.): 6.73 g -3.74
LV mass index: 37.39 g/m 2.7

LV Systolic Function
LV SF (M-mode): 29 %
LV EF (M-mode): 59 %

LV Diastolic Function
MV E/A (mitral inflow): 1.65

Right Ventricle
RVIDd (M-mode): 1.09 cm

LVOT Doppler
Peak velocity: 0.58 m/s
Peak gradient: 1.02 mmHg

Aortic Valve Doppler
Peak velocity: 0.92 m/sec
Peak gradient 3 mmHg

Mitral Valve Doppler
Peak E: 0.69 m/s
Peak A: 0.42 m/s

Pulmonary Valve Doppler
Peak velocity: 0.94 m/sec
Peak gradient: 3.56 mmHg

Tricuspid Valve Doppler
Regurg peak velocity: 2.61 m/s
Regurg peak gradient 27.2 mmHg

Umakumaran Ponniah
Electronically signed: 2/16/2022 4:46:35 PM

*** Final ***

Electronically Signed by Umakumaran Ponniah, MD on 02/16/22 at 1646

NAME: BLUE,BB-TATUM ROOM: EU.7172

OU MEDICAL CENTER
1200 Everett Drive
Oklahoma City, OK 73104

Name: BLUE,BB-TATUM
Account Number: E00677497957
Unit Number: E003047593
Room: EU.7172
Date Of Birth: 02/08/22
Attending Doctor: Bergner,Erynn MD
Date: 02/16/22

NEONATAL SERVICES DAILY PROGRESS NOTE
3050 gram, 40 + 1/7 week AGA male => 3490 grams; corrected gestational age 41 + 2/7 weeks.
Active Problems: Seizure disorder (identified 2/8/22)
neonatal encephalopathy (identified 2/16/22)

PHYSICAL EXAM (at 2/16/22 7:52)
Weight - 3490 grams (+20 grams) - 23%ile ; Z-score = -0.75
Vital Signs: HR - 110, RR - 42, O2 Sat - 97%, Temp - 36.6 degrees
General: Term infant under radiant warmer, on LFNC and in no acute distress. Skin pale pink, warm, and dry.
HEENT: Anterior fontanelle open, soft, and flat with sutures approximated. Eyes clear. Ears in normal shape and position. Oral mucosa pink and moist, palate intact.
Chest: Chest rise symmetrical with clear breath sounds bilaterally.
Heart: Normal sinus rhythm, normal perfusion and pulses, no murmur.
Abdomen: Soft and non-distended, non-tender with active bowel sounds.
Extremities: Moving all extremities equally.
Neuro: Active, responsive, normal tone for gestational age.

FLUIDS, ELECTROLYTES, NUTRITION
Objective: Weight today 3490 grams, up 20 grams from 2/15. Gained 40.0 grams/day/3 days.
On a radiant warmer with a set temperature of 35.8 degrees.
Input: 513 ml.
147 ml/kg/day (enteral - 79%/parenteral - 21%); 88 cal/kg/day (enteral - 88%/parenteral - 12%).
Output: Urine - 326 ml/day (3.9 ml/kg/hr).
Stools - 6 (Last stool: 8 AM 2/16).
The baby was on TPN for 7 days from 2/8 to 2/14.
Protein - 1.6 gram/kg/day; Fat - 4.2 gram/kg/day; Carbohydrate - 11.5 gram/kg/day.
FEEDINGS: On SAdv20 (0.68 cals/ml) and HM-T (0.64 cals/ml), 42-52 ml; last feed: 58 ml of SAdv20; no residuals. 8 feedings received; none nippled. Gavage feeds given over 40-45 minutes.
From 2/13: Na 140, K 4.3, Cl 102, Bicarb 22.0, Glucose 62, Ca 9.6, Phos 6.0, BUN 13.0, Creat 0.5, Mg 1.9, Triglycerides 206.
From 2/12: Glucose bld-75, Ca (ionized) 1.31, Lactate 1.4.
Appraisal: Infant tolerating advancing enteral feeds of Sim Term with supplemental with clears @ 140 ml/kg/day. Electrolytes as listed. Voiding and stooling. Weight gain noted overnight. Speech consulted, holding PO feeds due to concern for aspiration and respiratory status.
Plan: Advance enteral feeds to 150 ml/kg/d

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

Discontinue D10W and heplock PICC.
Speech Pathologist recommends PO feeds twice a day
Continue to follow speech pathology recommendations.
Will continue to assess nutritional intake, output, and growth trend.

RESPIRATORY
Objective: Respiratory rate for yesterday: average 47, range 29-74; for the past 8 hours: average 47, range 34-56.
O2 sats for yesterday: average 97, range 92-100; for the past 8 hours: average 97, range 95-100.
2/16 7:50: RA.
From 2/12 17:53: Capillary blood gases: pH 7.41, pCO2 44, pO2 41, base excess 2.4.
No A and B events since 2/14.
Appraisal: Infant weaned to RA this morning.
Plan: Continue to monitor.

HEMATOLOGY
Objective: Blood out so far - 9.6 ml (never transfused).
From 2/12: Hgb 14.5, Hct 43.0.
From 2/10: Platelets 239,000.
Appraisal: Heme Labs stable.
Plan: Continue to monitor.
Limit lab draws as able.

INFECTIOUS DISEASE
Objective: Temperature range over the past day: 36.5-37.4 degrees; temperature over the past 8 hours: 36.6 degrees.
From 2/10: CRP - <3.0.
Appraisal: NO current concern for infection.
Plan: Continue to monitor

CARDIOVASCULAR
Objective: Heart rate for yesterday: average HR 120, range 100-144; for the past 8 hours: average HR 116, range 100-135.
Blood pressure for yesterday: average cuff BP - 56/28(37 mean), range - 51-60/24-35(32-42 mean).
The infant passed the critical congenital heart disease screening at 108.8 hours of age.
Appraisal: Hemodynamically stable.
Plan: Continue to monitor clinically.
Obtain Echo to rule out congenital anomalies.

NEUROLOGY
Objective: Over the past 24 hours, Phenobarbital level: 2/13 - 39.9 No medications were given.
Appraisal: Seizures. Currently receiving Keppra and Phenobarbital. Last noted seizures was on 2/12. Epilepsy genetic workup pending. MRI (2/15) showed changes related to severe HIE.
Plan: Continue phenobarb and Levetiracetam
Continue to follow neurology recommendations.

IMMUNIZATIONS
Appraisal: Hepatitis B #1 given on 2/8 at RH.

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

Plan: Continue to follow AAP guidelines for vaccine schedule.

GENETICS, ENDOCRINE, METABOLIC
Objective: Ca 9.6, Phos 6.0, Alkaline phosphatase 111 (from 2/13).
Appraisal: State NB metabolic screen sent at 24 hours of life, consistent with TPN.
Metabolic workup in progress due to seizures.
Workup includes: Ammonia level 83, pyruvic acid (0.4 normal), serum AA elevated levels but not consistent with inherited metabolic disease, UA Organic acid and reducing substances (pending)
Plan: Continue to monitor.
Follow results of labs pending.
Repeat NBS at 14 days of life.

SOCIAL
Appraisal: Mom and Dad have been updated at bedside during rounds, questions answered.
Plan: Continue to update on plan of care.

IN-PATIENT DEVELOPMENTAL INTERVENTIONS
Appraisal: Infant at risk of developmental delays due hospitalization and seizures.
Plan: Continue to follow developmental needs while in the unit.
NICU PT/OT ordered.

CURRENT MEDICATIONS
Levetiracetam (Keppra), 40 mg enterally q12h (11.5 mg/kg/dose, 22.9 mg/kg/day) started on 2/14/22
PHENObarbital, 15 mg enterally q24h (4.3 mg/kg/day) started on 2/14/22

I personally examined the patient, reviewed and updated the history and assessment, and developed the plan of care with the multidisciplinary team as documented in this note. Jumoke A. Ogunfolu, NNP Student assisted me in the care of the patient and preparation of this note.

The patient requires intensive monitoring of cardiorespiratory stability, growth, nutrition, and I and O.

E-signed by Marjorie Makoni, MD; completed 2/16/22 18:52

Electronically Signed by Marjorie Mercy Makoni, MD on 02/17/22 at 1700

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

OU MEDICAL CENTER (COCPN)
Neurology Prog Note
REPORT#:0216-0197
DATE:02/16/22 Time: 0625

PATIENT: BLUE,BB-TATUM UNIT No: E003047593
ACCOUNT#: E00677497957 ROOM: EU.7172
REPORT AUTHOR: Rabbani,Bahram DO

See Addendum

Rabbani,Bahram X DO 02/16/22 0625:

Neurology Progress Note

Subjective

5-day-old baby boy born at 40 weeks of gestation via artificial rupture of membranes, delivery significant for meconium stained amniotic fluid, transferred from Durant Medical Center 2/8/22 to OU Children's Center NICU for higher level of workup and care after presenting with low APGARs of 2, 6, and 7 and spells of apnea and leg twitching concerning for possible seizures due to a possible hypoxic ischemic event vs sepsis s/p phenobarbital loads (30 mg/kg in total).

UPDATES:
02/12: EEG report up till 1700 demonstrated marked improvement from last tracing with prominent left temporal sharp transients and rare brief rhythmic discharges, but no seizures. However, overnight, EEG demonstrated numerous seizures.

02/13: Seizures until 1124 on 02/12 (following fosphenytoin load @ 1056). Afterward, rare BRDs over left central and centromidline regions (C3/Cz) but no definite seizures. Remained seizure-free for the rest of 02/12 until 2128 (end of EEG attending's review, next review this morning still pending).

02/14: No seizures overnight (one push-button event at 1819 with no electrographic evidence of seizures) or in the last 24 hours. Will obtain epilepsy gene panel swab today or tomorrow. Possibly going for MRI brain today.

02/15: Serum AA profile not overly consistent with an inherited metabolic disorder, but several species elevated. No MRI was obtained yesterday.

02/16: NAEON, exam stable. Will discuss imaging findings with mother of patient today if she's at bedside.

Physical Exam

GEN: awake
HEENT: ant fontanelle soft, open, flat
ABD: soft

NEURO:
Lang/Ment: non-verbal, arouses to touch; one apneic event during exam
CN: pupils equally round and reactive to light; oculocephalic reflex present, symm face, responds to touch, tongue midline on protrusion
Motor: normal tone, healthy flexed posture, moving all extremities

Patient: BLUE,BB-TATUM Unit#: E003047593
Date: 02/16/22 Acct#: E00677497957

Sens: responds appropriately to touch/tickle
Coord: no abnormal movements
Reflexes: 2+, plantar extensor response bilaterally, +grasp, +rooting
Gait: deferred

Assessment
- Apnea episodes concerning for seizure, resolved
  - Seizures resolved on 02/12/2022 @ 1124
- Hypoxic ischemic encephalopathy (previously did not appear clinically to be HIE, but metabolic w/up negative)

Levels:
- Phenobarbital: 29.4 --> 39.1 --> 36.7 --> 39.9
- Free phenytoin: 1.41 --> 2.12

RECOMMENDATION:
- Restarted continuous EEG for further monitoring
- Neurochecks
- Seizure/aspiration precautions
- Phenobarbital 4.7 mg BID (7.2 mg/kg/dose = 1.8 mL BID)
- Levetiracetam 40 mg BID (~26 mg/kg/day = 0.4 mL BID)
- For more seizures, can give fosphenytoin 10 mg/kg load with free phenytoin level check 2 hours after
- Metabolic panel:
  - Serum amino acids - not overly consistent with inherited metabolic disorder
  - Ammonia - 83
  - Pyruvate - 0.4
- Epilepsy genetic testing -- swabbed on 02/15, pending (to be follow up in outpatient setting)

Outpatient follow-up with Dr. Chrusciel at neurology clinic 3 months after discharge. Parents will have to call 405-271-2244 to schedule appointment.

Discussed with attending physician of record during morning rounds.

PURCARIN,GABRIELA 03/16/22 0738:
Neurology Attending Note
Attending Note
I have examined this patient on 2/16/22 and personally reviewed all labs and studies. I discussed the patient's management with the residents and reviewed the resident's note. I have discussed care with the mother who voiced understanding. I agree with the documented findings and plan of care unless amended below:
Seizure medication doses: phenobarbital 7.2mg (1.8ml) BID and Keppra 40mg BID

Patient: BLUE,BB-TATUM
Date: 02/16/22

Unit#: E003047593
Acct#: E00677497957

CPT 99232
Neonatal seizures P90
Neonatal HIE G93.1

Electronically Signed by Rabbani,Bahram DO on 02/16/22 at 1235
Electronically Signed by Purcarin,Gabriela MD on 03/16/22 at 0739

Addendum 1: 02/17/22 0638 by Rabbani,Bahram DO

Pardon the error, EEG has been discontinued.

Electronically Signed by Rabbani,Bahram DO on 02/17/22 at 0638

RPT #: 0216-0197
END OF REPORT

OU MEDICAL CENTER
1200 Everett Drive
Oklahoma City, OK 73104

Name: BLUE,BB-TATUM
Account Number: E00677497957
Unit Number: E003047593
Room: EU.7172
Date Of Birth: 02/08/22
Attending Doctor: Bergner,Erynn MD
Date: 02/17/22

NEONATAL SERVICES DAILY PROGRESS NOTE
3050 gram, 40 + 1/7 week AGA male => 3550 grams; corrected gestational age 41 + 3/7 weeks.
Active Problems: Seizure disorder (identified 2/8/22)
neonatal encephalopathy (identified 2/16/22)

PHYSICAL EXAM (at 2/17/22 9:20)
Weight - 3550 grams (+60 grams) - 25%ile ; Z-score = -0.69
Vital Signs: HR - 129, RR - 45, BP - 68/44 (mean 53), O2 Sat - 98%, Temp - 36.6 degrees
General: Term infant under radiant warmer (no heat), stable room air and in no acute distress. Skin pale pink, warm, and dry.
HEENT: Anterior fontanelle open, soft, and flat with sutures approximated. Eyes clear. Oral mucosa pink and moist. NGT secure.
Chest: Chest rise symmetrical with clear breath sounds bilaterally.
Heart: Normal sinus rhythm, normal perfusion and pulses, no murmur.
Abdomen: Soft and non-distended, non-tender with active bowel sounds.
Extremities: Moving all extremities equally.
Neuro: Active, responsive, normal tone for gestational age.

FLUIDS, ELECTROLYTES, NUTRITION
Objective: Weight today 3550 grams, up 60 grams from 2/16. Gained 46.7 grams/day/3 days. In an open crib.
Input: 521 ml.
147 ml/kg/day (enteral - 98%/parenteral - 2%); 98 cal/kg/day (enteral - 99%/parenteral - 1%).
Output: Urine - 401 ml/day (4.7 ml/kg/hr) and 1.
Stools - 4 (Last stool: 9 AM 2/17).
The baby was on TPN for 7 days from 2/8 to 2/14.
Protein - 2.0 gram/kg/day; Fat - 5.2 gram/kg/day; Carbohydrate - 11.0 gram/kg/day.
FEEDINGS: On SAdv20 (0.68 cals/ml) and HM-T (0.64 cals/ml), 58-65 ml; last feed: 65 ml of SAdv20; no residuals. 8 feedings received; 25% nippled. Some gavage feeds given over 40-45 minutes.
From 2/13: Na 140, K 4.3, Cl 102, Bicarb 22.0, Glucose 62, Ca 9.6, Phos 6.0, BUN 13.0, Creat 0.5, Mg 1.9, Triglycerides 206.
From 2/12: Glucose bld-75, Ca (ionized) 1.31, Lactate 1.4.
Appraisal: Infant tolerating full enteral feeds of Sim Term, PO fed x2 (took all); ST consulting. Good UOP and stooling. Weight gain noted.
Plan: Continue on full enteral feeds of SimTerm formula for 150 ml/kg/day, PO BID per ST recs.
Will continue to assess nutritional intake, output, and growth trend.
Heparin lock PICC.

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

RESPIRATORY
Objective: Respiratory rate for yesterday: average 51, range 31-62; for the past 8 hours: average 54, range 44-65.
O2 sats for yesterday: average 97, range 91-100; for the past 8 hours: average 98, range 95-100.
2/17 1:06: RA.
From 2/12 17:53: Capillary blood gases: pH 7.41, pCO2 44, pO2 41, base excess 2.4.
No A and B events since 2/14.
Appraisal: Stable in room air.
Plan: Monitor respiratory status.

HEMATOLOGY
Objective: Blood out so far - 9.6 ml (never transfused).
From 2/12: Hgb 14.5, Hct 43.0.
Appraisal: Heme Labs stable.
Plan: Continue to monitor.
Limit lab draws as able.

INFECTIOUS DISEASE
Objective: Temperature range over the past day: 36.5-37.5 degrees; temperature over the past 8 hours: 36.6-37.5 degrees.
Appraisal: No current concern for infection.
Plan: Continue to monitor

CARDIOVASCULAR
Objective: Heart rate for yesterday: average HR 120, range 103-139; for the past 8 hours: average HR 136, range 115-153.
Blood pressure for yesterday: average cuff BP - 69/37(48 mean), range - 66-72/32-41(44-51 mean); for the past 8 hours: average cuff BP - 68/44(53 mean), range - 68/44(53 mean).
The infant passed the critical congenital heart disease screening at 108.8 hours of age.
Appraisal: Hemodynamically stable.
ECHO on 2/16 d/t congenital anomalies; small PFO and no PDA.
Plan: Continue to monitor clinically.

NEUROLOGY
Objective: Over the past 24 hours, Phenobarbital level: 2/13 - 39.9 No medications were given.
Appraisal: Seizures on Keppra and Phenobarbital. Last noted seizures was on 2/12. Epilepsy genetic workup pending. MRI (2/15) showed changes related to severe HIE. Also has R cerebellar hemorrhage; neurology rec to obtain CT and coags (ordered on 2/17 with pending results).
Plan: Continue phenobarb and Levetiracetam
Continue to follow neurology recommendations.
Monitor result of head CT d/t R cerebellar hemorrhage and coags per neurology recs.

IMMUNIZATIONS
Appraisal: Hepatitis B #1 given on 2/8 at RH.
Plan: Continue to follow AAP guidelines for vaccine schedule.

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

GENETICS, ENDOCRINE, METABOLIC
Objective: Ca 9.6, Phos 6.0, Alkaline phosphatase 111 (from 2/13).
Appraisal: State NB metabolic screen sent at 24 hours of life, consistent with TPN.
Metabolic workup in progress due to seizures. Workup includes: Ammonia level 83, pyruvic acid (0.4 normal), serum AA elevated levels but not consistent with inherited metabolic disease, UA Organic acid and reducing substances (pending).
Plan: Continue to monitor.
Follow results of labs pending.
Repeat NBS at 14 days of life.

SOCIAL
Appraisal: Mom and Dad have been updated when able.
Plan: Continue to update on plan of care.

IN-PATIENT DEVELOPMENTAL INTERVENTIONS
Appraisal: Infant at risk of developmental delays due hospitalization and seizures.
Plan: Continue to follow developmental needs while in the unit.
NICU PT/OT ordered.

CURRENT MEDICATIONS
Levetiracetam (Keppra), 40 mg enterally q12h (11.3 mg/kg/dose, 22.5 mg/kg/day) started on 2/14/22
PHENObarbital, 15 mg enterally q24h (4.2 mg/kg/day) started on 2/14/22

I personally examined the patient, reviewed and updated the history and assessment, and developed the plan of care with the multidisciplinary team as documented in this note. Caitlin Lieng, NNP assisted me in the care of the patient and preparation of this note.

The patient needs intensive monitoring of nutrition, I and O, growth, and cardiorespiratory stability.

E-signed by Marjorie Makoni, MD; completed 2/17/22 16:05

Electronically Signed by Marjorie Mercy Makoni, MD on 02/18/22 at 2000

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

OU MEDICAL CENTER (COCPN)
Neurology Prog Note
REPORT#:0217-0272
DATE:02/17/22 Time: 0649

PATIENT: BLUE,BB-TATUM UNIT No: E003047593
ACCOUNT#: E00677497957 ROOM: EU.7172
REPORT AUTHOR: Rabbani,Bahram DO

Rabbani,Bahram X DO 02/17/22 0649:
Neurology Progress Note

Subjective

9-day-old baby boy born at 40 weeks of gestation via artificial rupture of membranes, delivery significant for meconium stained amniotic fluid, transferred from Durant Medical Center 2/8/22 to OU Children's Center NICU for higher level of workup and care after presenting with low APGARs of 2, 6, and 7 and spells of apnea and leg twitching concerning for possible seizures due to a possible hypoxic ischemic event vs sepsis s/p phenobarbital loads (30 mg/kg in total).

UPDATES:
02/12: EEG report up till 1700 demonstrated marked improvement from last tracing with prominent left temporal sharp transients and rare brief rhythmic discharges, but no seizures. However, overnight, EEG demonstrated numerous seizures.

02/13: Seizures until 1124 on 02/12 (following fosphenytoin load @ 1056). Afterward, rare BRDs over left central and centromidline regions (C3/Cz) but no definite seizures. Remained seizure-free for the rest of 02/12 until 2128 (end of EEG attending's review, next review this morning still pending).

02/14: No seizures overnight (one push-button event at 1819 with no electrographic evidence of seizures) or in the last 24 hours. Will obtain epilepsy gene panel swab today or tomorrow. Possibly going for MRI brain today.

02/15: Serum AA profile not overly consistent with an inherited metabolic disorder, but several species elevated. No MRI was obtained yesterday.

02/16: NAEON, exam stable. Will discuss imaging findings with mother of patient today if she's at bedside (diffuse HIE, right cerebellar IPH).

02/17: Spoke with NICU provider yesterday about repeating CTH to monitor R cerebellar IPH which can be done today when able. Exam remains stable.

Objective

Per NICU charting

Physical Exam

GEN: asleep but easily arousable
HEENT: ant fontanelle soft, open, flat
ABD: soft

Patient: BLUE,BB-TATUM Unit#: E003047593
Date: 02/17/22 Acct#: E00677497957

NEURO:
Lang/Ment: non-verbal, arouses to touch
CN: pupils equally round and reactive to light; oculocephalic reflex present, symm face, responds to touch, tongue midline on protrusion
Motor: normal tone, healthy flexed posture, moving all extremities
Sens: responds appropriately to touch/tickle
Coord: no abnormal movements
Reflexes: 2+, plantar extensor response bilaterally, +grasp, +rooting
Gait: deferred

Assessment
- Apnea episodes concerning for seizure, resolved
  - Seizures resolved on 02/12/2022 @ 1124
- Hypoxic ischemic encephalopathy (previously did not appear clinically to be HIE, but metabolic w/up negative)

Levels:
- Phenobarbital: 29.4 --> 39.1 --> 36.7 --> 39.9
- Free phenytoin: 1.41 --> 2.12

RECOMMENDATION:
- Neurochecks
- Seizure/aspiration precautions
- **Please check a PT/INR today**
- **Please check CT head to follow up on the right cerebellar IPH (communicated verbally to NICU team on 02/16)**
- Phenobarbital 4.7 mg BID (7.2 mg/kg/dose = 1.8 mL BID)
- Levetiracetam 40 mg BID (~26 mg/kg/day = 0.4 mL BID)
- For more seizures, can give fosphenytoin 10 mg/kg load with free phenytoin level check 2 hours after
- Metabolic panel:
  - Serum amino acids - not overly consistent with inherited metabolic disorder
  - Ammonia - 83
  - Pyruvate - 0.4
- Epilepsy genetic testing -- swabbed on 02/15, pending (to be follow up in outpatient setting)

Outpatient follow-up with Dr. Chrusciel at neurology clinic 3 months after discharge. Parents will have to call 405-271-2244 to schedule appointment.

Discussed with attending physician of record during morning rounds.

PURCARIN,GABRIELA 03/16/22 0741:
Neurology Attending Note

Patient: BLUE,BB-TATUM
Date: 02/17/22
Unit#: E003047593
Acct#: E00677497957

Attending Note
I have examined this patient on 2/17/22 and personally reviewed all labs and studies. I discussed the patient's management with the residents and reviewed the resident's note. I agree with the documented findings and plan of care unless amended below: phenobarbital dose is 7.2mg(1.8ml) BID.

Coags are normal and head CT showed stable size of the cerebellar hematoma. Neuro exam continues to be reassuring

CPT 99232
Neonatal seizures P90
Neonatal HIE G93.1
ICH -I61.8

Electronically Signed by Rabbani,Bahram DO on 02/17/22 at 1301
Electronically Signed by Purcarin,Gabriela MD on 03/16/22 at 0743

RPT #: 0217-0272
END OF REPORT

OU MEDICAL CENTER - THE CHILDREN'S HOSPITAL
1200 N. Phillips CT SCAN PHONE: (405) 271-5511
Oklahoma City, OK 73104 CONSULTATION REPORT FAX: (405) 271-1718

LOC/RM: EU.NICUE/EU.7172 PACS ID: E2368718 MRN: E003047593
PT. TYPE: ADM IN CAMPUS: C PT: BLUE,BB-TATUM
ACCT#: E00677497957 DOB: 02/08/2022 AGE: 00M 09D SEX: M

ORD PROV: 1174677314 Lieng,Caitlin Thi APRN C EXAM START: 02/17/22 1612
ATT PROV: 1962762948 Bergner,Erynn MD EXAM ENDED: 02/17/22 1612
ADMISSION CLINICAL DATA: APNEA

EXAMS:	CPT:
007133822 CT BRAIN WO CONTRAST	70450

REASON FOR EXAM: R cerebellar hemorrhage on MRI

EXAM PERFORMED: - CT BRAIN WO CONTRAST

TECHNIQUE:
Routine noncontrast CT brain imaging in bone and soft tissue algorithm. Coronal and sagittal reformats were obtained.

CONTRAST:
None

COMPARISON:
MR brain on 2/14/2022.

FINDINGS:
Changes related to hypoxic ischemic injury are better evaluated on the recent MR study on 2/14/2022. Areas of loss of gray-white matter differentiation within the bilateral frontal lobes correspond to the known areas of hypoxic ischemic injury. The ventricles are mildly decreased in size when compared to the previous MR, which may be related to edema associated with hypoxic ischemic injury. The right cerebellar parenchymal hematoma is unchanged.

No extra axial axial collection. No definite additional acute hemorrhage. No midline shift. The basal cisterns are patent. The cerebellar tonsils are normal in position. The orbits are unremarkable. The mastoid air cells and middle ear cavities are clear. The paranasal sinuses are clear. Partially visualized nasogastric tube. No acute osseous abnormalities.

IMPRESSION:
Changes related to hypoxic ischemic injury are better evaluated on the recent MR study on 2/14/2022.

The ventricles are mildly decreased in size when compared to the previous MR, which may be related to edema associated with hypoxic ischemic injury.

The right cerebellar parenchymal hematoma is unchanged.

OU MEDICAL CENTER - THE CHILDREN'S HOSPITAL

1200 N. Phillips
Oklahoma City, OK 73104

CT SCAN
CONSULTATION REPORT

PHONE: (405) 271-5511
FAX: (405) 271-1718

LOC/RM: EU.NICUE/EU.7172 PACS ID: E2368718 MRN: E003047593
PT. TYPE: ADM IN CAMPUS: C PT: BLUE,BB-TATUM
ACCT#: E00677497957 DOB: 02/08/2022 AGE: 00M 09D SEX: M

ORD PROV: 1174677314 Lieng,Caitlin Thi APRN C EXAM START: 02/17/22 1612
ATT PROV: 1962762948 Bergner,Erynn MD EXAM ENDED: 02/17/22 1612
ADMISSION CLINICAL DATA: APNEA

EXAMS:	CPT:
007133822 CT BRAIN WO CONTRAST	70450

<Continued>

** Electronically Signed by 384 ANJALI LAL MD on 02/17/2022 at 1638 **
Reported and signed by: ANJALI LAL, MD 384

DICTATED: 02/17/2022 @ 1617 TRANSCRIBED: 02/17/22 @ 1624
TYPIST: RAD.VR PRINTED: 02/17/2022 @ 1640
E-SIGNATURE DATE/TIME: 02/17/2022 @ 1638 DR.LALAN BATCH: N/A

PAGE 2 Signed Report

OU MEDICAL CENTER
1200 Everett Drive
Oklahoma City, OK 73104

Name: BLUE,BB-TATUM
Account Number: E00677497957
Unit Number: E003047593
Room: EU.7172
Date Of Birth: 02/08/22
Attending Doctor: Bergner,Erynn MD
Date: 02/18/22

NEONATAL SERVICES DAILY PROGRESS NOTE
3050 gram, 40 + 1/7 week AGA male => 3505 grams; corrected gestational age 41 + 4/7 weeks.
Active Problems: Seizure disorder (identified 2/8/22)
neonatal encephalopathy (identified 2/16/22)

PHYSICAL EXAM (at 2/18/22 7:03)
Weight - 3505 grams (-45 grams) - 20%ile ; Z-score = -0.85
Vital Signs: HR - 120, RR - 44, BP - 62/44 (mean 49), O2 Sat - 96%, Temp - 36.8 degrees
General: Term infant under radiant warmer (no heat), stable room air and in no acute distress. Skin pale pink, warm, and dry.
HEENT: Anterior fontanelle open, soft, and flat with sutures approximated. Eyes clear. Oral mucosa pink and moist. NGT secure.
Chest: Chest rise symmetrical with clear breath sounds bilaterally.
Heart: Normal sinus rhythm, normal perfusion and pulses, no murmur.
Abdomen: Soft and non-distended, non-tender with active bowel sounds.
Extremities: Moving all extremities equally.
Neuro: Active, responsive, normal tone for gestational age.

FLUIDS, ELECTROLYTES, NUTRITION
Objective: Weight today 3505 grams, down 45 grams from 2/17. Gained 11.7 grams/day/3 days. In an open crib.
Input: 525 ml = 150 ml/kg/day (all enteral); 101 cal/kg/day.
Output: Urine - 336 ml/day (4.0 ml/kg/hr) and 1.
Stools - 4 (Last stool: 6 AM 2/18).
The baby was on TPN for 7 days from 2/8 to 2/14.
Protein - 2.1 gram/kg/day; Fat - 5.5 gram/kg/day; Carbohydrate - 11.1 gram/kg/day.
FEEDINGS: On SAdv20 (0.68 cals/ml), 65-70 ml; last feed: 70 ml; no residuals. 8 feedings received; 63% nippled. Gavage feeds given over 45 minutes.
From 2/13: Na 140, K 4.3, Cl 102, Bicarb 22.0, Glucose 62, Ca 9.6, Phos 6.0, BUN 13.0, Creat 0.5, Mg 1.9, Triglycerides 206.
From 2/12: Glucose bld-75, Ca (ionized) 1.31, Lactate 1.4.
Appraisal: Infant tolerating full enteral feeds of Sim Term, PO fed x2 (took all); ST consulting. Good UOP and stooling. Small weight loss noted.
Plan: Continue on full enteral feeds of SimTerm formula for 150 ml/kg/day, PO BID per ST recs.
Will continue to assess nutritional intake, output, and growth trend.
Discontinue PICC line

RESPIRATORY
Objective: Respiratory rate for yesterday: average 43, range 28-65; for the past

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

8 hours: average 38, range 28-45.
O2 sats for yesterday: average 98, range 95-100; for the past 8 hours: average 99, range 96-100.
2/18 9:00: RA.
From 2/12 17:53: Capillary blood gases: pH 7.41, pCO2 44, pO2 41, base excess 2.4.
No A and B events since 2/14.
Appraisal: Stable in room air.
Plan: Monitor respiratory status.

HEMATOLOGY
Objective: Blood out so far - 9.6 ml (never transfused).
From 2/12: Hgb 14.5, Hct 43.0.

2/17/22 12:35: Coags: PT - 10.9, PTT - 35.2.
Appraisal: Heme Labs stable.
Plan: Continue to monitor.
Limit lab draws as able.

BILIRUBIN

Objective: Serum bili 1.0 on 2/13.
Mother's blood type B Positive.
The infant was not treated with phototherapy.
The maximum total bilirubin was 5.2 on 2/10 and the maximum direct bilirubin was 0.3 on 2/9.
Appraisal: Mom's blood type is B+. T bili remains well below threshold of treatment.
Plan: Continue to monitor clinically.

INFECTIOUS DISEASE
Objective: Temperature range over the past day: 36.5-37.5 degrees; temperature over the past 8 hours: 36.8-37.0 degrees.
Appraisal: No current concern for infection.
Plan: Continue to monitor

CARDIOVASCULAR
Objective: Heart rate for yesterday: average HR 132, range 105-166; for the past 8 hours: average HR 126, range 107-166.
Blood pressure for yesterday: average cuff BP - 65/44(51 mean), range - 62-68/44(49-53 mean); for the past 8 hours: average cuff BP - 62/44(49 mean), range - 62/44(49 mean).
The infant passed the critical congenital heart disease screening at 108.8 hours of age.
Appraisal: Hemodynamically stable.
ECHO on 2/16 d/t congenital anomalies; small PFO and no PDA.
Plan: Continue to monitor clinically.

NEUROLOGY
Objective: Over the past 24 hours, Phenobarbital level: 2/13 - 39.9 No medications were given.
Appraisal: Seizures on Keppra and Phenobarbital. Last noted seizures was on 2/12. Epilepsy genetic workup pending. MRI (2/15) showed changes related to severe HIE. Also has R cerebellar hemorrhage; neurology rec to obtain CT (done 2/17)-->The ventricles are mildly decreased in size when compared to the

previous MR, which may be related to edema associated with hypoxic ischemic injury. The right cerebellar parenchymal hematoma is unchanged). Coags (are wnl)
Plan: Continue phenobarb and Levetiracetam
Continue to follow neurology recommendations.

GASTROINTESTINAL
Objective: From 2/13: T Prot 4.8, Alb 3.1, AST(SGOT) 39, ALT(SGPT) 23.
Appraisal: Normal abdominal exam and stooling pattern. Tolerating advancing enteral feedings.
Plan: Continue to monitor stooling pattern and quantity.

GENITOURINARY
Objective: Urine output: 137 ml (4.9 ml/kg/hr) and 1 over the past 8 hours and 4.0 ml/kg/hr and 1 over the past 24 hours. On 2/13, BUN 13.0 and creatinine 0.4.
Appraisal: Normal renal function for age.
Plan: Continue to monitor clinically. Monitor UOP.

IMMUNIZATIONS
Appraisal: Hepatitis B #1 given on 2/8 at RH.
Plan: Continue to follow AAP guidelines for vaccine schedule.

GENETICS, ENDOCRINE, METABOLIC
Objective: Ca 9.6, Phos 6.0, Alkaline phosphatase 111 (from 2/13).
Appraisal: State NB metabolic screen sent at 24 hours of life, consistent with TPN.
Metabolic workup in progress due to seizures. Workup includes: Ammonia level 83, pyruvic acid (0.4 normal), serum AA elevated levels but not consistent with inherited metabolic disease, UA Organic acid and reducing substances (pending).
Plan: Continue to monitor.
Follow results of labs pending.
Repeat NBS at 14 days of life.

SOCIAL
Appraisal: Mom and Dad have been updated when able.
Plan: Continue to update on plan of care.

IN-PATIENT DEVELOPMENTAL INTERVENTIONS
Appraisal: Infant at risk of developmental delays due hospitalization and seizures.
Plan: Continue to follow developmental needs while in the unit.

NICU PT/OT ordered.

CURRENT MEDICATIONS
Levetiracetam (Keppra), 40 mg enterally q12h (11.4 mg/kg/dose, 22.8 mg/kg/day) started on 2/14/22
PHENObarbital, 15 mg enterally q24h (4.3 mg/kg/day) started on 2/14/22

I personally examined the patient, reviewed and updated the history and assessment, and developed the plan of care with the multidisciplinary team as documented in this note. Claudia M. Kinslow, APRN, NNP - BC assisted me in the care of the patient and preparation of this note.

The patient requires intensive monitoring of cardiorespiratory stability,

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

growth, nutrition, and I and O.
I provided 30 minutes of care.

E-signed by Netsanet Kassa, MD; completed 2/18/22 21:59

Electronically Signed by Netsanet Kassa, MD on 02/19/22 at 1500

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

OU MEDICAL CENTER
1200 Everett Drive
Oklahoma City, OK 73104

Name: BLUE,BB-TATUM
Account Number: E00677497957
Unit Number: E003047593
Room: EU.7172
Date Of Birth: 02/08/22
Attending Doctor: Bergner,Erynn MD
Date: 02/19/22

NEONATAL SERVICES DAILY PROGRESS NOTE
3050 gram, 40 + 1/7 week AGA male => 3505 grams; corrected gestational age 41 + 5/7 weeks.
Active Problems: Seizure disorder (identified 2/8/22)
neonatal encephalopathy (identified 2/16/22)

PHYSICAL EXAM (at 2/19/22 6:35)
Weight - 3505 grams (0 grams) - 18%ile ; Z-score = -0.91
Vital Signs: HR - 131, RR - 51, O2 Sat - 99%, Temp - 37.0 degrees
General: Term infant under radiant warmer (no heat), stable room air and in no acute distress. Skin pale pink, warm, and dry.
HEENT: Anterior fontanelle open, soft, and flat with sutures approximated. Eyes clear. Oral mucosa pink and moist. NGT secure.
Chest: Chest rise symmetrical with clear breath sounds bilaterally.
Heart: Normal sinus rhythm, normal perfusion and pulses, no murmur.
Abdomen: Soft and non-distended, non-tender with active bowel sounds.
Extremities: Moving all extremities equally.
Neuro: Active, responsive, normal tone for gestational age.

FLUIDS, ELECTROLYTES, NUTRITION
Objective: Weight today 3505 grams, unchanged from 2/18. Gained 40.7 grams/day/7 days. In an open crib.
Input: 590 ml = 168 ml/kg/day (all enteral); 114 cal/kg/day.
Output: Urine - 469 ml/day (5.6 ml/kg/hr).
Stools - 5 (Last stool: 6 AM 2/19).
The baby was on TPN for 7 days from 2/8 to 2/14.
Protein - 2.4 gram/kg/day; Fat - 6.1 gram/kg/day; Carbohydrate - 12.5 gram/kg/day.
FEEDINGS: On SAdv20 (0.68 cals/ml), 40-75 ml; last feed: 50 ml; no residuals. 9 feedings received; 100% nippled.
From 2/13: Na 140, K 4.3, Cl 102, Bicarb 22.0, Glucose 62, Ca 9.6, Phos 6.0, BUN 13.0, Creat 0.5, Mg 1.9, Triglycerides 206.
Appraisal: Infant tolerating full enteral feeds of Enfamil PO fed x2 (took all); ST consulting. Good UOP and stooling well.
Plan: Continue on full enteral feeds of Enfamil formula for 150 ml/kg/day, PO BID per ST recs.
Will continue to assess nutritional intake, output, and growth trend.

RESPIRATORY
Objective: Respiratory rate for yesterday: average 45, range 27-65; for the past 8 hours: average 40, range 27-58.
O2 sats for yesterday: average 98, range 95-100; for the past 8 hours: average 98, range 96-100.

2/18 21:57: RA.
No A and B events since 2/14.
Appraisal: Stable in room air.
Plan: Continue to monitor respiratory status.

HEMATOLOGY
Objective: Blood out so far - 9.6 ml (never transfused).
2/17/22 12:35: Coags: PT - 10.9, PTT - 35.2.
Appraisal: Heme Labs stable.
Plan: Continue to monitor.
Limit lab draws as able.

BILIRUBIN
Objective: Serum bili 1.0 on 2/13.
Mother's blood type B Positive.
The infant was not treated with phototherapy.
The maximum total bilirubin was 5.2 on 2/10 and the maximum direct bilirubin was 0.3 on 2/9.
Appraisal: Mom's blood type is B+. T bili remains well below threshold of treatment.

Plan: Continue to monitor clinically.

INFECTIOUS DISEASE
Objective: Temperature range over the past day: 36.6-37.0 degrees; temperature over the past 8 hours: 36.7-37.0 degrees.
Appraisal: No current concern for infection.
Plan: Continue to monitor

CARDIOVASCULAR
Objective: Heart rate for yesterday: average HR 131, range 104-180; for the past 8 hours: average HR 128, range 104-158.
Blood pressure for yesterday: average cuff BP - 81/49(60 mean), range - 73-89/39-59(51-68 mean).
Appraisal: Hemodynamically stable.
ECHO on 2/16 d/t congenital anomalies; small PFO and no PDA.
Plan: Continue to monitor clinically.

NEUROLOGY
Objective: Over the past 24 hours, Phenobarbital level: 2/13 - 39.9
The infant passed the ABR test in both ears on 2/18. No medications were given.
Appraisal: Seizures on Keppra and Phenobarbital. Last noted seizures was on 2/12. Epilepsy genetic workup pending. MRI (2/15) showed changes related to severe HIE. Also has R cerebellar hemorrhage; neurology rec to obtain CT (done 2/17)-->The ventricles are mildly decreased in size when compared to the previous MR, which may be related to edema associated with hypoxic ischemic injury. The right cerebellar parenchymal hematoma is unchanged). Coags (are wnl)
Plan: Continue phenobarb and Levetiracetam
Continue to follow neurology recommendations.

GASTROINTESTINAL
Objective: From 2/13: T Prot 4.8, Alb 3.1, AST(SGOT) 39, ALT(SGPT) 23.
Appraisal: Normal abdominal exam and stooling pattern. Tolerating advancing enteral feedings.

Plan: Continue to monitor stooling pattern and quantity.

GENITOURINARY
Objective: Urine output: 179 ml (6.4 ml/kg/hr) over the past 8 hours and 5.6 ml/kg/hr over the past 24 hours. On 2/13, BUN 13.0 and creatinine 0.4.
Appraisal: Normal renal function for age.
Plan: Continue to monitor clinically. Monitor UOP.

IMMUNIZATIONS
Appraisal: Hepatitis B #1 given on 2/8 at RH.
Plan: Continue to follow AAP guidelines for vaccine schedule.

GENETICS, ENDOCRINE, METABOLIC
Objective: Ca 9.6, Phos 6.0, Alkaline phosphatase 111 (from 2/13).
Appraisal: State NB metabolic screen sent at 24 hours of life, consistent with TPN.
Metabolic workup in progress due to seizures. Workup includes: Ammonia level 83, pyruvic acid (0.4 normal), serum AA elevated levels but not consistent with inherited metabolic disease, UA Organic acid and reducing substances (pending).
Plan: Continue to monitor.
Follow results of labs pending.
Repeat NBS at 14 days of life.

SOCIAL
Objective: The Oklahoma Tobacco Helpline cessation referral does not apply for TATUM Blue on 02/18/2022.
Appraisal: Mom at bedside yesterday 2/18/discussed rooming in possible discharge soon.
Plan: Continue to update on plan of care.

IN-PATIENT DEVELOPMENTAL INTERVENTIONS
Appraisal: Infant at risk of developmental delays due hospitalization and seizures.
Plan: Continue to follow developmental needs while in the unit.
NICU PT/OT ordered.

CURRENT MEDICATIONS
Levetiracetam (Keppra), 40 mg enterally q12h (11.4 mg/kg/dose, 22.8 mg/kg/day) started on 2/14/22
PHENObarbital, 15 mg enterally q24h (4.3 mg/kg/day) started on 2/14/22

I personally examined the patient, reviewed and updated the history and assessment, and developed the plan of care with the multidisciplinary team as documented in this note. Claudia M. Kinslow, APRN, NNP - BC assisted me in the care of the patient and preparation of this note.

The patient needs intensive monitoring of nutrition, I and O, growth, and cardiorespiratory stability.
I provided 30 minutes of care.

E-signed by Netsanet Kassa, MD; completed 2/19/22 22:27

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

Electronically Signed by Netsanet Kassa, MD on 02/20/22 at 1400

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

OU MEDICAL CENTER
1200 Everett Drive
Oklahoma City, OK 73104

Name: BLUE,BB-TATUM
Account Number: E00677497957
Unit Number: E003047593
Room: EU.7172
Date Of Birth: 02/08/22
Attending Doctor: Bergner,Erynn MD
Date: 02/20/22

*** DISCHARGE SUMMARY ***
Baby: Parker Blue
Born: 2/8/22 6:20 (Tuesday)
Admitted: 2/8/22; Discharged: 2/20/22; LOS: 12 days
Mother: TATUM Blue
Phone: 580-371-6882

CHIEF COMPLAINT: 3050 gram male transferred from Durant Medical Center of Southeastern Oklahoma and admitted for possible seizure activity, r/o sepsis.

MOTHER'S HISTORY: 20 year-old G1P0000 unknown race female.
Blood type B Positive; Syphilis test - negative; rubella - positive (immune); Hepatitis B studies - negative; HIV - negative; herpes history - no history of prior infection; hepatitis history - no known history.

PREGNANCY HISTORY: EDC 2/7/22 => 40 + 1/7 weeks.
Uncomplicated pregnancy.
GBS Status: negative.
Prenatal tests: Normal prenatal testing.
Medications: Omeprazole. Steroids: No antenatal steroids were given.
No tobacco, alcohol, or drug use during pregnancy.

LABOR and DELIVERY: Induced labor, AROM with thick meconium.
Artificial rupture of membranes 2/7/22 at 18:45 (11.6 hours prior to delivery); vaginal delivery with epidural anesthesia. Born on 2/8/22 at 6:20.

INFANT: Male, birthweight 3050 grams (6 lbs 11.6 oz).
Apgars: 2 @1 min (HR-2, Resp-0, Tone-0, Reflex-0, Color-0)
6 @5 min (HR-2, Resp-1, Tone-1, Reflex-1, Color-1)
7 @10 min (HR-2, Resp-2, Tone-1, Reflex-1, Color-1)
Resuscitation steps: oxygen, face mask ventilation.
Per reports from RH: Infant was deep suctioned by delivering provider immediately after delivery. Taken to warmer, continued to deep suction. HR >100bpm from birth. Infant showed no respiratory effort, PPV was given for approximately 3minutes and continued to have irregular respirations. Infant taken to nursery and CPAP was initiated. Grunting subsided and infant was weaned to RA by approximately 4HOL Oral feedings were started and infant continued to do well. At approximately 10HOL infant noted to have apnea spells with color change and possible twitching of extremities. D/t concerns for seizure activity referral was initiated to transport infant to TCH. Infant again with seizure activity approximately 12HOL and was given loading dose of phenobarbital. NF team arrived to take over care, noted infant to be borderline lethargic following phenobarbital dose. NS bolus given in route for soft blood pressures.

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

No seizure activity noted by NF team on transport. Infant admitted to NICU in room air with relatively normal neurological exam.

ADMISSION PHYSICAL EXAM (at 2/8/22 22:53)
Weight - 3050 grams (6 lbs 11.6 oz) - 11%ile; Z-score = -1.21
General: 40+1/7 weeks AGA male -- exam compatible with dates. Infant in room air and in no distress. Skin pink, warm, and dry. Petechia to back and sides.
HEENT: Anterior fontanelle open, soft, and flat with sutures approximated. Moulding and caput with redness to scalp from presentation. Eyes clear. Red reflex present bilaterally. Pupils equally round and reactive to light. Oral mucosa pink and moist, palate intact. Ears in normal shape and position.
Chest: Chest rise symmetrical with clear breath sounds bilaterally.
Heart: Normal sinus rhythm, normal perfusion and pulses, no murmur.
Abdomen: Soft and non-distended, non-tender with active bowel sounds.
Genitals: Normal male genitalia. tests descended bilaterally. Anus: Patent anus in normal position.
Skeletal: No abnormalities noted. Extremities: Moving all extremities equally.
Neuro: Alert, active, responsive, normal tone for gestational age, normal primitive reflexes. Infant appropriately reactive to exam.
Jittery/jerking movements seen at RH. none appreciated on exam.

Exam by L. Donaldson, NNP.

LABS
Glucose:
* 2/8 23:09: 80 (Accuchek).

STABILIZATION
Infant admitted to the NICU in room air. Routine newborn assessment and protocols initiated.

MEDICATIONS
Acyclovir, 60 mg IV q8h (19.7 mg/kg/dose, 59 mg/kg/day) started on 2/8/22
Amikacin, 37 mg IV q24h (12.1 mg/kg/day) started on 2/8/22
Ampicillin, 300 mg IV q12h (98.4 mg/kg/dose, 197 mg/kg/day) started on 2/8/22
PHENObarbital, 15 mg IV q24h (4.9 mg/kg/day) started on 2/9/22

ALLERGIES and ADVERSE REACTIONS
No known allergies.

Status at discharge: 3050 gram, 40 + 1/7 week AGA male; now 3590 grams; corrected gestational age 41 + 6/7 weeks.

Hospital Course

FLUIDS, ELECTROLYTES, NUTRITION
Summary: -->NUTRITIONAL SUPPORT: Parenteral fluid with protein was started upon admission. The baby was on TPN for 6 days, lastly on 2/14. Enteral feeds were started on 2/10/22. The infant is currently receiving Sim Advance 20 cal.
-->ELECTROLYTES: Electrolytes stable thus far
-->LINES: PICC from 02/09 to 02/18.
Objective: Weight today 3590 grams, up 85 grams from 2/19. Gained 31.4 grams/day/7 days. In an open crib.
Input: 645 ml = 180 ml/kg/day (all enteral); 121 cal/kg/day.
Output: Urine - 523 ml/day (6.1 ml/kg/hr).

Stools - 8 (Last stool: 6 AM 2/20).
The baby was on TPN for 7 days from 2/8 to 2/14.
Protein - 2.5 gram/kg/day; Fat - 6.5 gram/kg/day; Carbohydrate - 13.3 gram/kg/day.
FEEDINGS: On SAdv20 (0.68 cals/ml) and HM-T (0.64 cals/ml), 50-105 ml; last feed: 105 ml of SAdv20; no residuals. 8 feedings received; 100% nippled.
Plan: Continue ad lib po feeding with standard formula
PCP will monitor growth

RESPIRATORY
Summary: Infant with meconium at delivery required PPV, suctioning and transitioned to CPAP. Eventually transitioned to RA.
Infant had apneic spell at 10 HOL concerning for seizures and was placed on CPAP. Weaned to NC on 2/15.
Stable to room air since 2/16 with no sign of respiratory distress

HEMATOLOGY
Summary: Stable CBC. Never transfused.

BILIRUBIN
Summary: Mother's blood type B Positive.
The infant was not treated with phototherapy.
The maximum total bilirubin was 5.2 on 2/10 and the maximum direct bilirubin was 0.3 on 2/9.
Serum bili 1.0 on 2/13.

INFECTIOUS DISEASE
Summary: Infectious workup started due to concerns of seizures. Maternal labs reassuring. Blood and CSF cultures sent. CBC and CRP reassuring. HSV CSF 1/2 negative, HSV PCR blood negative. Infant started on Ampicillin, Amikacin and Acyclovir. CSF negative and blood culture negative and final. Antibiotics and Acyclovir discontinued on 02/12.
Currently no clinical sign or symptom of infection.

CARDIOVASCULAR
Summary: Was hypotensive during transfer received NS bolus x1.
ECHO on 2/16 showed structurally normal heart with small PFO.

NEUROLOGY
Summary: -Infant admitted due to concern for seizure activity at RH, loaded with phenobarbital at RH at 12 HOL then transferred here for further evaluation. On

admission, infant presented with seizure like activity given an additional phenobarb and Keppra. LP obtained, see ID. Neurology consulted, recommended EEG and infectious workup. EEG with frequent sharp rhythmic discharges at C4 and T5/O1. Given additional 10 mg/kg phenobarb and continued on maintenance. HUS obtained normal. Last noted seizures was on 2/12.
-MRI (2/15) showed changes related to severe HIE involving multiple areas of right greater than left cortical/subcortical supratentroial region as the periventricular region, external and internal capsule along with the corpus callosum and associated more diffuse intrinsic T1 signal involving the bilateral cerebral cortices. Also has R cerebellar hemorrhage. Neurology rec to obtain CT (done 2/17)-->The ventricles are mildly decreased in size when compared to the previous MR, which may be related to edema associated with hypoxic ischemic injury. The right cerebellar parenchymal hematoma is unchanged).

-Epilepsy genetic workup pending.
Objective: Over the past 24 hours, The infant passed the ABR test in both ears on 2/18. No medications were given.
Plan: Continue phenobarb 7.2 mg po every 12 hours.
Continue Keppra 40mg po every 12 hours
Follow up with Child neurology in 3 month

GASTROINTESTINAL
Summary: No GI issues during hospital admission.

GENITOURINARY
Summary: Normal renal function and UOP

IMMUNIZATIONS
Summary: Hepatitis B #1 given on 2/8 at RH
Plan: Continue to follow AAP guidelines for vaccine schedule.

GENETICS, ENDOCRINE, METABOLIC
Summary: Family history of Galactosemia.
State NB metabolic screen sent at 24 hours of life, consistent with TPN. Repeat sent on 02/20 and is pending
Metabolic workup in progress due to seizures. Workup includes: Ammonia level 83, pyruvic acid (0.4 normal), serum AA elevated levels but not consistent with inherited metabolic disease, UA Organic acid and reducing substances (pending).
Epilepsy genetic work up done and is pending
Plan: Follow result of repeat NBS
Follow results of Urine organic acid and the epilepsy genetic work up.

SOCIAL
Summary: Parents were involved in infant's care and were regularly updated by Neonatal and Child neurology team.

OTHER
Summary: PCP: My Family Health Care on 02/24/22
Child Neurology with Dr. Chrusciel in 3 month after discharge. (Clinic number: 405-271-2244)

DISCHARGE EXAM (at 2/20/22 6:47)
Weight - 3590 grams (7 lb 14.6 oz) - 21%ile ; Z-score = -0.79
Length - 53.0 cm (20.9 in) - 53%ile ; Z-score = 0.08 (2/15/22)
Head circumference - 36.0 cm (14.2 in) - 51%ile ; Z-score = 0.02 (2/15/22)
Vital Signs: HR - 121, RR - 41, O2 Sat - 100%, Temp - 36.8 degrees
General: Term infant in crib, stable room air and in no acute distress. Skin pale pink, warm, and dry.
HEENT: Anterior fontanelle open, soft, and flat with sutures approximated. Eyes clear. Oral mucosa pink and moist.
Chest: Chest rise symmetrical with clear breath sounds bilaterally.
Heart: Normal sinus rhythm, normal perfusion and pulses, no murmur.
Abdomen: Soft and non-distended, non-tender with active bowel sounds.
Extremities: Moving all extremities equally.
Neuro: Active, responsive, normal tone for gestational age.

CLINICAL PROBLEMS AND FUNCTIONAL STATUS
Active Problems: Seizure disorder (identified 2/8/22)

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957

neonatal encephalopathy (identified 2/16/22)
Resolved Problems: r/o sepsis (2/8/22-2/13/22)
respiratory distress (2/12/22-2/16/22)

Functional Status: At increased risk for neurodevelopmental delays

CURRENT MEDICATIONS
Levetiracetam (Keppra), 40 mg enterally q12h (11.1 mg/kg/dose, 22.3 mg/kg/day) started on 2/14/22
PHENObarbital, 15 mg enterally q24h (4.2 mg/kg/day) started on 2/14/22

ALLERGIES and ADVERSE REACTIONS
None.

DISCHARGE DIAGNOSES
1. 40 week AGA male

Peds - My Family Healthcare (My Family, Healthcare) - Durant office

I provided 45 minutes of care.
Discharge planning completed, patient examined, family instructed, and discharge summary created for communication of history and plan to PCP.
I provided 45 minutes of care.

E-signed by Netsanet Kassa, MD; completed 2/20/22 08:52

Electronically Signed by Netsanet Kassa, MD on 02/21/22 at 1400

PATIENT NAME: BLUE,BB-TATUM ACCOUNT #: E00677497957