Ahsip, Tommy

MRN: 1000014397

Robert Stanley Arthur Hayward, MD
Physician
General Internal Medicine

Transfer Note
Signed

Creation Time: 16/08/21 1153

General Internal Medicine Interfacility Transfer Summary

Encounter dates:	Admitted 01 Aug 2019; Transferred 12 Aug 2021 (746 hospital days)
Disposition:	Transferred to acute care facility with planned repatriation
Goals of care:	GCD-M1 (Source: Patient;Alternate Decision Maker; Clarification: Family conference outcome)
Isolation status:	Contact and Droplet COVID-19 NAT (last in 1y): no result in 1Y
MyAHS Connect:	Pending

Overview

This 82 y.o. year old man was brought from home (family care) to the EDM WMC University of Alberta Hospital because of 1 week worsening ertional dyspnea, was admitted for respiratory support, and is transferred to Camrose hospital for further convalescence.

Most Responsible Diagnosis

Respiratory failure with hypoxia

Hospital Problems

Principal Problem:
Respiratory failure with hypoxia
Active Problems:
Type 2 diabetes mellitus
CKD (chronic kidney disease)
COPD (chronic obstructive pulmonary disease)
HFrEF (heart failure with reduced ejection fraction)
Hypertension
GERD (gastroesophageal reflux disease)
Resolved Problems:
Stroke
Diabetes mellitus

Hospital Course

This 82 y.o. man was brought from home (family care) to the EDM WMC University of Alberta Hospital because of 1 week worsening ertional dyspnea and was admitted for respiratory support. Key hospital milestones include:

- Stabilized with fluid, electrolyte and glucose management (brief ketoacidosis), coupled with short term speculative antibiotics

- Recovered baseline organ function within 48 hours while mild delirium cleared within 72 hours
- Remainder of hospitalization focused on re-calibration of medications and reactivation for deconditioning

Transfer Assessment & Plan

*** Respiratory failure with hypoxia**
Multifactorial acute respiratory failure on baseline borderline exercise tolerance related to COPD, HFrEF and increasing pulmonary hypertension.

HFrEF (heart failure with reduced ejection fraction)
Followed by: Heart function clinic, Dr. Wirzba
Status: key CHF (HFrEF <41%) events include prior MI; causes include hypertension; and complications include serosal effusions.
Function: NYHA class III-A, with last ejection fraction of 28% (noted on 2020) classified as Severely reduced (< 31%)
Interventions: ICD
Therapies: ACE, Loop diruetics
Course: improving

COPD (chronic obstructive pulmonary disease)
Followed by: Ron Damant
Status: key risks include never intubated, 2 hosp/yr; causes include 50 py smoking; complications include pulmonary hypertension
Function: outcome markers include FEV1 0.8L, follows own peak flow
Interventions: has attended pulmonary rehabilitation
Therapies: triple puffers, compliant
Course: stable

Stable without evidence of exacerbation. At baseline.
- No new interventions or investigations and no change in physical findings

CKD (chronic kidney disease)
Followed by: Nephrology (KEC)
Function: outcome markers include baseline creatinine ~150
Course: stable

Worsening renal failure indicators likely transient with expectation of return to baseline.
- ACE inhibitor held till Cr within 10% of baseline

Type 2 diabetes mellitus
Followed by: internal medicine
Status: key problem-related risks/events include 3 prior admissions for hypoglycemia, brittle control; causes include metabolic syndrome and history of pancreatitis; and complications include vasculopathy, retinopathy and gastroparesis.

Function: problem-associated functional impacts include medication and diet supervision.
- Edmonton Frailty Score (1 Y look-back) 12 (Severe Frailty)
- ADL/IADLs moderate assistance

Interventions: cannot manage more than daily cap glucose check
Therapies: insulin dependent
Course: stable

Hyperglycemia with mild ketoacicosis likely multifactorial triggered by stress, medication (short term steroid) and hydration.
- Fluid and metabolic resuscitation, with improvement apparent while temp hold of metformin.
- Resume home hypoglycemic/insulin regimin.

GERD (gastroesophageal reflux disease)
Post prandial retrosternal burning sensation has worsened while acutely stressed, motivating temporary increase in PPI dosing to twice daily.
- Considering osteoporosis and hypomagnesemia, taper and discontinue PPI when asymptomatic 2 weeks
- Consider follow-up with dietician

Hypertension
Transiently hypotensive with volume depletion.
- Resume outpatient meds when pressure and creatinine normalized

Transfer Medications

Adverse Reactions: Avocado and Penicillin g

Medications recommended at transfer:

Discharge Medications

Scheduled:
• cetirizine 5 mg tablet; 5 mg, oral, daily
• flu vacc qs 2019-20 (6mos up)(PF) 60 mcg (15 mcg x 4)/0.5 mL syringe injection; 0.5 mL, intramuscular, during hospitalization
• furosemide 20 mg tablet; 20 mg, oral, 2 times per day
• insulin aspart-aspart protamin 100 unit/mL (30-70) cartridge; Commonly known as: NovoMix 30 Penfill U-100 Insul; 15 mg, subcutaneous, 2 times per day
• insulin lispro-insulin lispro protamine (HumaLOG Mix 25) injection 100 unit/mL cartridge injection cartridge; Commonly known as: Humalog Mix25 U-100 Insulin; 4 units, subcutaneous, 2 times per day
• metFORMIN 500 mg tablet; 1,000 mg, oral, 2 times per day, with breakfast and supper

Changes and rationale: vigorous deprescribing heeding Beers criteria

Follow Up Arrangements

- *Primary care provider:* Aidevo Sandra Adebo
- *Attending provider at discharge:* Fraser W. Armstrong
- *Attending provider at transfer*: to be received by Frank Sterns (CGH)
- *Other follow up provider(s):* Robert Hayward (internal medicine econsult service)
- *Follow-up acccountabilities:* Any tests ordered in the sending hospital encounter but resulted post-transfer are copied to the discharge attending. Medications listed for transfer consideration will be followed, prescribed and refilled by the receiving site.
- *Follow-up appointments:* Frank Sterns to check with Robert Hayward vis eConsult for review of convalescence

Social Supports

Social History
Social History Narrative
Needs walker to ambulate

Transition from:

- *Residence type:* virtual hospital
- *Living arrangement:* Child(ren);Spouse/significant other
- *Assistance:* ADLs
- *Personal supports:* Family members
- *Community supports:* Antenatal Care;Community Rehabilitation Services

Transition to:

- *Patient transition goals:* learn to love
- *Destination type:* Group home
- *Other needs and supports:* virtual hospital may be an alternative, review in 3 weeks

Interventions

No clinically significant procedural interventions occurred during this admission.

Other History

Pertinent medical, surgical, family, social, device and immunization history is included in the admitting history and physical report of 11 August 2021.

Electronically signed by Robert Stanley Arthur Hayward, MD at 16/08/21 1156

Admission (Current) on 1/8/2019