

CL# 1192987
 26 MD# 00801 FAY, NANCY E
 A# 70784968 DOB [REDACTED]

Carle Foundation Hospital
 Urbana, Illinois
Obstetrical
PATIENT CARE DATABASE

X5594-090:

Essential Elements

Standardized Screens / Outcome / Referrals: the box preceding each screen to indicate it has been completed.
 Circle any applicable items and make referrals as directed for any + responses.



Immunization?

- Yes No Is the patient a candidate for Influenza or pneumococcal vaccination? (refer to immunization protocol)
 If Yes, and requested, order Influenza pneumococcal vaccine per printed orders/protocol.

Pain Screen - is the patient in pain? Y N

- If Yes, **Chronic?** (> 3 months) **Acute?**
- Location: _____
 - Frequency: Continuous Intermittent Continuous Intermittent
 - Duration: Minutes Hours ≥Days Minutes Hours ≥Days
 - Relief/Improves with: Meds _____ Meds _____
 - Heat Cold Rest Position Heat Cold Rest Position
 - Effects on ADL's None Moderate Severe None Moderate Severe

Educational Needs - What questions/concerns do you have about hospitalization/illness? (tests, surgery, diagnosis, etc.)

- Has no questions
 • How do you learn new information? Reading Watching TV / Video Touching / Doing Listening

Gift of Hope Yes NA Gift of Hope # _____ Date: _____ Time: _____
 (Indicated if stillborn • 20 weeks @ 800-545-4438)

Advanced Directives / Care Preferences Addressed

- Yes No Do you have any cultural/religious practices that we can support while you are here? Specify: _____
 Yes No Do you have any emotional/spiritual needs that we can help you with? If so, tell us how we can help.
 Yes Advanced Directives Form completed and placed behind Advanced Directives tab in chart. MD notified and braceleted if applicable.

Advanced Directives - All patients/legal guardians are informed of their right to be involved in the care provided. If the pt/guardian has care preference regarding rights about end of life care, organ donation, healthcare power of attorney, blood directives and/or mental health treatment, we provide them with the opportunity to document these. The purpose of asking our pts is twofold: 1) to help our pts proactively make informed decisions if the need should arise and 2) educate them regarding choices they have for future care. (Carle Foundation reviews these standard questions with all in-pts, emergency dept. and out pts receiving invasive procedures). If pt. indicates a desire to have their preferences documented, it is critical this be accomplished by the attending MD as soon as possible.

Hx of Isolation? None, TB, MRSA, Antibiotic Resistant Bacteria, Other: _____

Infectious Disease History - Identify those pts at risk of transferring a communicable disease and assure that they have the appropriate room and / or Isolation precautions initiated.

Order _____ Isolation/Precautions _____

Recent exposure to infection Yes No Type _____ Tx Date _____

Communication Barriers (specify) Physical: _____ Language: _____ Literacy: _____ Cognition: _____

Translator available: _____ If not, use ATT Hotline 1-800-874-9426. (CFH Policy #123)

Communication Barriers - Barriers are identified and measures to address the deficits include: family presence to interpret, ATT Interpreter service, House Officer for sign language access; case mgmt for correcting or adapting to the physical barrier....(ie, bring in the pt's glasses or hearing aid; consult with Rehab/Speech Therapy for aphasic communication tools, etc.)

Nutritional Screen

- | | | | |
|------------------|--|---|--|
| Points | <input type="checkbox"/> TPN/PPN | <input type="checkbox"/> Tube Feeding | <input type="checkbox"/> Lactating woman |
| _____ 4pts. each | <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes (new diagnosis) | <input checked="" type="checkbox"/> Pregnant (Admit Dx = Childbirth) |
| _____ 3pts. each | <input type="checkbox"/> CHF (acute) | <input type="checkbox"/> DKA | <input type="checkbox"/> Renal failure |
| | <input type="checkbox"/> Decubitus ulcer | <input type="checkbox"/> Malnutrition (diagnosis) | |
| _____ 1pt. each | <input type="checkbox"/> > 5# unexpected weight gain/loss in one month Actual change: _____ # in _____ wks/mos.) | | |
| | <input type="checkbox"/> Nausea, vomiting or diarrhea > 3 consecutive days | | |

3 Total Points

If any (+) response, order Dietician Consult on Invision Date/Time: 3/11 / _____ Guidelines for Response/ Dietician Assessment is based on Risk Level **Low** (1-4 pts.) - within 72 hours • **Moderate** (5-7 pts.) - within 48 hours • **High** (> 7 pts.) - within 24 hours

Behavioral / Alcohol / Substance Abuse Screen and Identify Developmental Stage

Behavioral / Developmental Stage identified: Adolescent Adult

Behavioral / Alcohol / Substance Abuse Screening - The pt is asked the following questions with the associated referrals made based on the answers and documented below:

- Is anxiety / nervousness / depression or hostility negatively affecting their life? If yes, refer to Primary Provider
- Is their alcohol/substance use having negative consequences (DUI, problems with job or family, etc.)?
 If yes, order **New Choice assessment consult. (9-373-1700- ask for assessment)**
- Is nicotine use creating negative effects on their body or life (ie, heart disease, high blood pressure, slowed wound and bone healing, etc)?
 If yes, order nicotine educational packet (Storeroom #245365) and consider nicotine replacement medication patch, and CCTV #1128
Smoking: Getting Ready to Quit.

8-5
 2000 →

State of Illinois
Department of Public Aid
CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ **CONSENT TO STERILIZATION** ■

I have asked for and received information about sterilization from Cathy PB/GYN (doctor or clinic). When I first asked for

the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a Tubal Ligation. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on 05 09 78
Month Day Year

I, [Redacted], hereby consent of my own free will to be sterilized by Cathy PB/GYN (doctor)

by a method called Tubal Ligation. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health, Education, and Welfare or
- Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received this form on 5 12 85
Date: Month Day Year
[Redacted Signature]
Signature

You are requested to supply the following information, but it is not required:

- Race and ethnicity designation (please check)
- | | |
|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Black (not of Hispanic origin) |
| <input type="checkbox"/> Asian or Pacific Islander | <input type="checkbox"/> Hispanic |
| | <input type="checkbox"/> White (not of Hispanic origin) |

■ **INTERPRETER'S STATEMENT** ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter Date

■ **STATEMENT OF PERSON OBTAINING CONSENT** ■

Before [Redacted] signed the consent form, I explained to him/her the nature of the sterilization operation Tubal Ligation, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

[Redacted Signature] 5/12/85
Signature of person obtaining consent Date
[Redacted]
Facility
6011 W. State Parkway
Address
CHL USCA

■ **PHYSICIAN'S STATEMENT** ■

Shortly before I performed a sterilization operation upon [Redacted] on 5 12 85
Name of individual to be sterilized Date of sterilization

I explained to him/her the nature of the sterilization operation Tubal Ligation, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- Premature delivery
 - Individual's expected date of delivery:
 - Emergency abdominal surgery;
- (describe circumstances):

Physician Date

3/11/05

It would not work as an open eye
eye when awake. No pain

T: 101.4
HR: 97, NT
RR: 17, NT
FHR:

baseline Tachycardia, acceleration
present
HR: 100

Sp: 98%
Plan: (PR, R/hold on)

3/12/05

11A

A febrile, USS
FHTs reactive - still in crisis; not eating
Pt still not acknowledging our presence
other than grunting responses to ?'s
Plan to have CMS consult - see if
there is anything we need to be aware
of as pt becomes more lucid when
drugs wear off
Pt will need to flu with prog if we
can get her to for the removal of AFE
although no current evidence of
FHR - same

Handwritten signature

3/12/05
11:30
AM

- Drug abuse -> social work consult
- NIV -> ✓ Army late, ligase, most probably 20
to Gastroenteritis, try to keep rhy chats,
use Zofran 2mg q3hr or
- ✓ Hpc Antibody.
- ?UTI -> awaiting culture. Urine culture.

Handwritten signature

PROGRESS NOTES

CL# 1192987
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286-1186

DATE

5/13/05 @ 24° Nursing Summary - pt currently @ 33wks c.
gastroenteritis. Vital signs et assessment WNL. Reactine
strips obtained C (+) acels, (+) fetal movement and average
CTV. No decels. No contractions noted per toc. Pt
denies feeling contractions. Pt's IV infiltrated at night.
Dr. Takowski notified. Ondans received to d/c infiltrated
IV and d/c IV declon. Preliminary GBS results were
negative. Pt uncooperative at times. Frequently requires
repeated instructions. MW, RW

3/13/05 A female US FHT's reactive
of S/S labor

Pt finally "waking up" - now more agitated
as drugs wearing off; using ctivan per
discussion getting pt into New Chance - she knows
more about these programs than I do! - was in
program in Chicago apparently for 9 mos!

Will ↑ diet - pt now 'spitting' - no real emesis
currently

Funds soft - explained again pt will need to
file for prenatal care to close file as

AFFI law re - may be referred to
Finances Nelson at discharge (no service at clinic per notes)
in all hrs

03/14/05 24° Nursing Summary - VSS et RN Assessments WNL.
@ 0600 Reassuring FHT. Pt. Uncooperative. Tossing and turning
and yelling during monitoring attempts. NO CTX per
toc or pt. [REDACTED] to be pt's power of
attorney. Social service contacted. Pt. signed paper
revoking IPA tubal ligation consent papers. Pt. had
emesis after drinking or eating very quickly. Pt. denies
gag - used to induce vomit. Significant other in room. Will