Inpatient Orders Patient 1– Pharmacist Information Week 1			
Setting	Emergency Department		
Scenario	Patient presents with a diabetic foot wound		
Patient Information	**Name: EC** **DOB: 6/30/1948** **Race**: White **Room #: ED 09** **Gender:** Male **Age:** 72 **Patient ID #:** 385027 **Allergies**: penicillin		
CC	"I have a sore on my foot that just keeps getting worse."		
HPI	EC is a 72-year-old male who presents to the ED with a non-healing wound to his right foot. Patient states that he has had this for several weeks and has tried topical OTC creams with no improvement. It looks worse and has started to smell bad. He couldn't get an appointment with his primary care physician for a couple of months, so he came to the ED. He denies pain.		
Family History	Mother- died of complications related to hip fracture Father- lived into his 90s and died of atherosclerotic disease Brothers—1 died of emphysema, 1 died from MI, 1 died from multiple MIs and related complications	**PMH**	Diabetes x 20 yrs, insulin dependent x 10 years Peripheral vascular disease (PVD) Glaucoma Diabetic retinopathy s/p bilat laser surgery Hx partial right foot amputation, well healed Possible stroke or TIA affecting left side; regained full function.
Social History	• Retired from construction work • Married 44 yr w/ grown children and grandchildren in area • Smokes 2-3 ppd, up from 1-2 ppd when working • Quit drinking alcohol 20 yr ago • Does not use illicit drugs • Drinks 1-2 cups coffee in morning • Unable to exercise due to wheelchair bound • Eats what wife cooks—meat & potatoes, some vegetables and fruits daily	**Vaccine History**	Tetanus 8 yr ago when oldest grandchild was born Shingles 9 yr ago Flu last fall COVID last fall w/booster 6 months ago Had measles, mumps, and chicken pox as a child

Physical Exam	• HEENT: Normocephalic, atraumatic. Right eye shows cloudy cataract. Oral mucosa is pink and patient is wearing dentures. Tobacco stains noted on lip margins. • Neck: positive bruit noted on left carotid high in neck. • Lungs: bilateral breath sounds +, no rales, rhonchi, or wheezes • Heart: RRR w/faint systolic ejection murmur at left sternal border • Abdomen: nontender, non-distended, + bowel sounds • Extremities: Dark brown tobacco stains noted on nails of right hand. Distal legs are dry, scaley, and show mild atrophic appearance to calves. Well healed amputation site to right foot. Right lateral foot shows discoid ulcerative wet lesion with odor. • Pulses: Femoral left 2, right 1. No distal pulses palpable distal to femoral arteries. Good capillary refill noted to left toes. • Neurological: A&O x3. Cranial nerves II-XII are grossly intact. Grips are 4/4 and muscle groups 4/4.
VS	BP: 145/56 HR: 69 RR: 18 T: 99 F O2 sat 97% Wt: 162 lb HT: 5'9"
Labs	Na: 144 mEq/L K: 4.8 mEq/L Cl: 108 mEq/L CO2: 24 mEq/L Ca: 8.5 mg/dL BUN: 29 mg/dL SCr: 1.1 mg/dL Glu: 138 mg/dL Phos: 2.1 mg/dL Mg 1.9 mg/dL Hgb: 14.4 g/dL Hct: 42.4 % RBC 4.29 X $10^3/mm^3$ WBC: 6.4 X $10^3/mm^3$ Plt: 197 X $10^3/mm^3$

ED orders written						
Medication	**Dose**	**Route**	**Frequency**	**Scheduled time**	**Last administered**	**Notes**
D5-1/4 NS	75 ml/hr	IV	continuous	1000		
Vancomycin	1 gram	IV	X1	1100		Pharmacy to dose
Piperacillin/ tazobactam	3.375 grams	IV	q6h	1200		
Lorazepam	1 mg tab	PO	On call to MRI		1030	

Home Medication List: Verified by pharmacy on admit	
Medication:	**Allergies:**
Insulin Lantus 50 units SC at HS	Penicillin—rash (within last 5 years)
Insulin Novolog 10 units ac breakfast & lunch, 30 units ac supper	
Metformin ER 1000 mg PO BID	
Lisinopril 5 mg PO daily	
Atorvastatin 40 mg PO daily	
Aspirin 325 mg PO daily	
Timoptic 0.5% ophthalmic sol. 1 drop OU BID	
Men's multivitamin 1 tablet PO daily	
OTC triple antibiotic cream applied TID-QID	

Student Name:

Jayhawk Medical Center Medication List and Instructions

Patient Name: EC		
Admission Date: 8/23/22	**Discharge Date: 8/25/22**	**Service: Med**
Principal Diagnosis This Admission: Infected diabetic foot ulcer		
Secondary Diagnosis: PAD, HTN		
Allergies (reactions): penicillin (rash)		

Medications added this visit: (begin taking these)
Ciprofloxacin 500 mg PO BID x 10 days Dakin's ½ strength solution to dressing; change daily Nicotine patch 21 mg applied topically daily
Medications changed this visit: (modify what you previously were taking)
Medications discontinued this visit: (stop taking these)
OTC triple antibiotic cream

Student Name:

FINAL DISCHARGE MEDICATION LIST					
MEDICATION/ROUTE/DOSAGE/FREQUENCY/DURATION	*Comments*	**Morning**	**Afternoon**	**Evening**	**Bedtime**
Insulin glargine (Lantus) 50 units SC					X
Insulin lispro 10 units SC	Before breakfast and lunch	X			
Insulin lispro 30 units SC	Before supper			X	
Metformin ER 1000 mg tablet		X		X	
Ciprofloxacin 500 mg tablet		X		X	
Lisinopril 5 mg tablet		X			
Atorvastatin 40 mg tablet		X			
Aspirin 325 mg tablet		X			
Timoptic 0.5% ophthalmic solution		1 drop in both eyes		1 drop in both eyes	
Men's multivitamin 1 tablet		X			
Nicotine patch 21 mg	Change at the same time each day and move patch to a different spot each time.				X
As needed medications					