HB 1125

Chairwoman Pendergrass and Members of the Committee,

I would like to thank you for your time today, and Delegate Beitzel, thank you for inviting me to testify on HB 1125, the Prescription Drug Monitoring Program – Prescribers of Opioids – Notification Requirement. I am here on behalf of Strengthening the Mid-Atlantic Region for Tomorrow (SMART) as a member of the Health Working Group, and also as a concerned caregiver of a person who has undergone a number of surgeries from 2019-2020.

SMART's 15 working groups focused on veterans' issues, workforce development, and healthcare are comprised of community and industry leaders concentrated on identifying and supporting the implementation of best practices throughout the Mid-Atlantic. Their coordinated efforts across Maryland, Delaware, Pennsylvania, and New Jersey support consistent legislative and policy action across a wide range of issues which have been identified as having the most profound effect on the region- including actions to address the ongoing opioid epidemic across the four states SMART supports.

An analysis of Bureau of Labor and Statistics data conducted from 2011-2016 identified 3 industries where accidental overdose deaths on the job were most likely to occur: Transportation & Warehousing, Construction, and Healthcare & Social Assistance. These industries accounted for 43% of all overdose deaths at work during that time. On average, overdose deaths on the job increased by 25% per year between 2013-2017. That is an alarming statistic to keep in mind as numbers continue to trend upward. In December 2020, the CDC reported on data which included the early months of the on-set of COVID. The one-year period from May 2019-May 2020 saw over 80,000 overdose deaths- a 38.4% increase from the same period the year before. During that period, the construction industry experienced a significant increase in overdose deaths- up 3%. The high rate of injuries (77% higher than the national average) are commonly treated with prescription opioids, and laborers often return to job sites too early due to financial burdens, increasing the incidence of reinjury. This cycle puts workers at high risk of addiction. The Executive President of Skanska USA recently said "If you do simple math, you're 15 times more likely to die in construction from opioids than all the other hazards from a job site combined. That one statistic should really open everyone's eyes, but you never see it printed anywhere." We can speculate that industries deemed "essential", such as construction and healthcare & social services, will continue to be adversely affected.

Maryland is not exempt from the alarming trend sweeping across the nation- the Opioid Operational Command Center's September 2020 report outlining the first six months of 2020 showed opioids were involved in 89.5% of all unintentional intoxication deaths, up 9.4% from the same time period in 2019- including prescription opioid deaths increasing by 8.1%, which had been on a steady decline since 2016. The most significant increase in fatalities occurred in the Capital Region where I reside-nearly a 60% increase, followed by Western and Southern Maryland at 48.1% and 33.3% respectively.

Prior to COVID, Maryland was not experiencing the same rate of decline as other states where aggressive measures have been implemented in order to protect patients from the risk of addiction and overdose. The

state lacks the uniformity nearly a dozen other states have achieved through legislative and policy vehicles. For reference, on Monday New Jersey joined Arizona, Florida, New Mexico, Rhode Island, Vermont, Virginia, Washington, California, and Ohio in requiring co-prescription, or the offer of a naloxone prescription, when prescribing an opioid. Also, Medicaid has required co-prescription since 2017, however concerns remain policy hasn't been followed in Medicaid facilities. Included with my testimony submitted to the record is Table 3 from the OOCC's report- the Full Local Best Practices Matrix- which I implore you to review, as it highlights the explicit differences in how counties have implemented high priority programs - and how significantly access to life-saving resources varies for Maryland residents.

While a number of counties are practicing due diligence in bolstering patient safety, we need to acknowledge the existing gaps in care- and address the critical need for consistent, equitable practices. The purpose of HB 1125 is to address one facet of the inequity faced by Maryland residents.

As proposed, providers are required to check a box, one time, in the Prescription Drug Monitoring Program. Checking this box confirms that the prescriber complied with an existing mandate to educate the patient on the risks of opioids. It also confirms that the patient was educated on the existence of an overdose reversal drug, and an overdose reversal drug was dispensed or prescribed. While a check box may seem arbitrary, it serves as a reminder for prescribers to engage patients on the risks of their medication and to provide a potentially lifesaving resource- something an electronic health record cannot do.

Not only does this establish that the measures that have been put in place, with a patient's best interest in mind, are being followed by prescribers, but it also rapidly ensures that CDC Guidelines are being communicated to patients at risk. Further, this legislation provides key data to the State Department of Health and allows monitoring of best practices by providers.

I understand that many will point to recommendations made by the state as sufficient. My personal experience, as noted before, has confirmed that recommendations to entities to follow best practices as outlined by the CDC and CMS does not guarantee they will do the right thing, or that lapses will not occur. I was responsible as the caregiver for a person, a nurse, who had surgery months apart in 2019 that resulted in her being prescribed opioids, in addition to muscle relaxers. It is important to add that while in the hospital, her oxygen dropped to a dangerous level, leading to a doctor recommendation she be tested for sleep apnea. During her discharge, she was not educated on her prescriptions, nor offered an overdose reversal agent- even though the hospital recognized oxygen issues. After reviewing her discharge paperwork, submitted with my testimony, I found a section titled "Taking Your Pain Medication Safely." The section consisted of just over a dozen bullet points and included the statement "To learn about the risks of opioid abuse and overdose go to the website www.cdc.gov/drugoverdose." Other websites were provided in the event there was a concern of addiction. I thought about patients with limited access to internet, or different abilities otherwise- and how this is what they could be potentially be provided with in place of an actual conversation with a medical professional. It was shocking to experience first-hand.

COVID-19 has reiterated the importance of doctor-patient conversations. As the country looks to address a vaccine hesitancy issue, they are counting on doctors- boots on the ground- to educate and provide patients with the information and resources necessary to make educated decisions. The epidemic that existed prior to COVID, one that has wreaked havoc in every corner of this country, should be treated no

differently. It is imperative patients receive life-saving education and resources, just the same, from trusted professionals.

A study from October 2020 showed that states which have enacted mandates for education and co-prescription have seen an uptick in prescription claims for opioid reversal antidotes. We have known, as apparent through county actions, that expanded access to those antidotes correlates to a decrease in overdose deaths. Enacting legislation requiring the check of a box, and a co-prescription, only serves to ensure that providers are engaging patients on the dangers of opioids and exercising long-standing best practices across the state- instead of by jurisdiction.

Once again, resources made available to patients should not be dependent on where they reside.

I sincerely appreciate you taking the time to listen to my testimony, and I look forward to your questions.

OPIOID INTERVENTION TEAMS UPDATE – SECOND QUARTER, 2020

The OOCC consults routinely with the Opioid Intervention Teams (OITs) in each of Maryland's 24 local jurisdictions. OITs are multiagency coordinating bodies that seek to enhance multidisciplinary collaboration to combat the opioid crisis at the local level. Each OIT is chaired by the local health officer and the emergency manager. OITs are also required to have representatives from various agencies and organizations, including law enforcement, social services, education, and private community and faith-based groups. Each OIT is responsible for administering funds received through the OOCC's Block Grant Program, which is detailed beginning on page 19 of this report.

Since the beginning of the COVID-19 pandemic, OITs around the state have been working diligently to adapt their programming to the related public health challenges. For example, while some programs were suspended initially due to the risks associated with in-person activities, OITs have been working to resume certain functions virtually or with appropriate social distancing measures and with stringent safety precautions. This work is especially important now in light of the recent increases in opioid-related fatalities.

Local Best Practices

The OOCC has identified and tracks 129 high-priority programs and services supported by Maryland's OITs. The charts below illustrate the implementation of these activities by our local partners based on self-reported OIT data. Responses on implementation status range from "no programming planned" (red) to "substantial programming in place" (dark green).

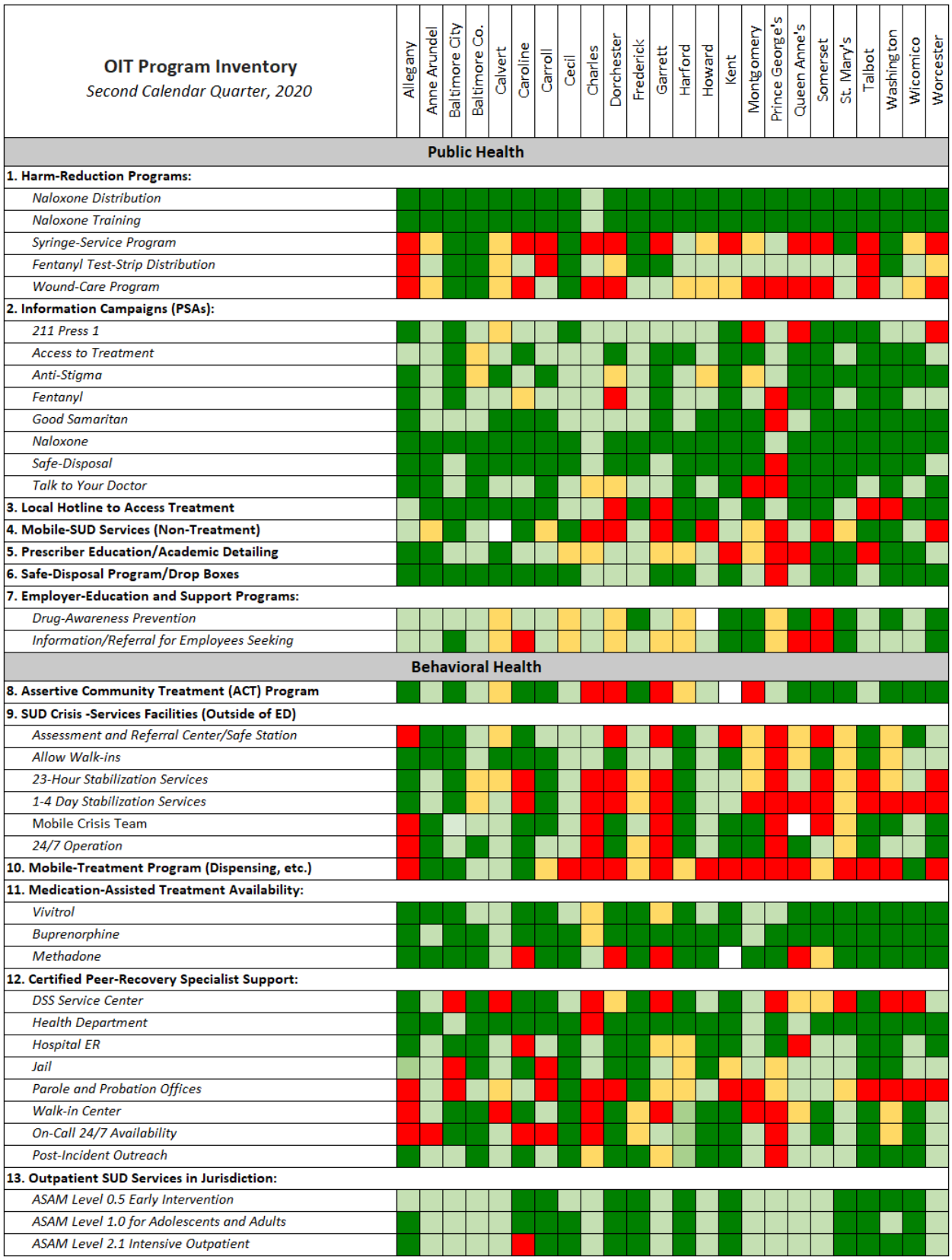
Table 2. Summary of Program Implementation by Jurisdiction

OIT Program Inventory - Totals *Second Calendar Quarter, 2020*	Allegany	Anne Arundel	Baltimore City	Baltimore Co.	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worcester
Total of Substantial Programming Implemented	65	46	65	71	30	65	64	42	3	38	51	28	90	56	69	34	38	44	46	57	78	81	47	39
Total of Some Programming Implemented	22	57	40	44	52	20	39	67	72	27	58	37	14	47	20	53	44	31	26	53	19	24	58	43
Subtotal of Substantial & Some Programming	87	103	105	115	82	85	103	109	75	65	109	65	104	103	89	87	82	75	72	110	97	105	105	82
Total Programming in Development	4	21	16	13	36	6	11	10	18	34	13	18	19	14	17	16	10	21	16	11	2	11	6	13
Total of Programs Not Planned	38	5	8	1	10	38	15	10	36	30	6	45	6	9	20	26	36	32	37	8	29	13	18	21

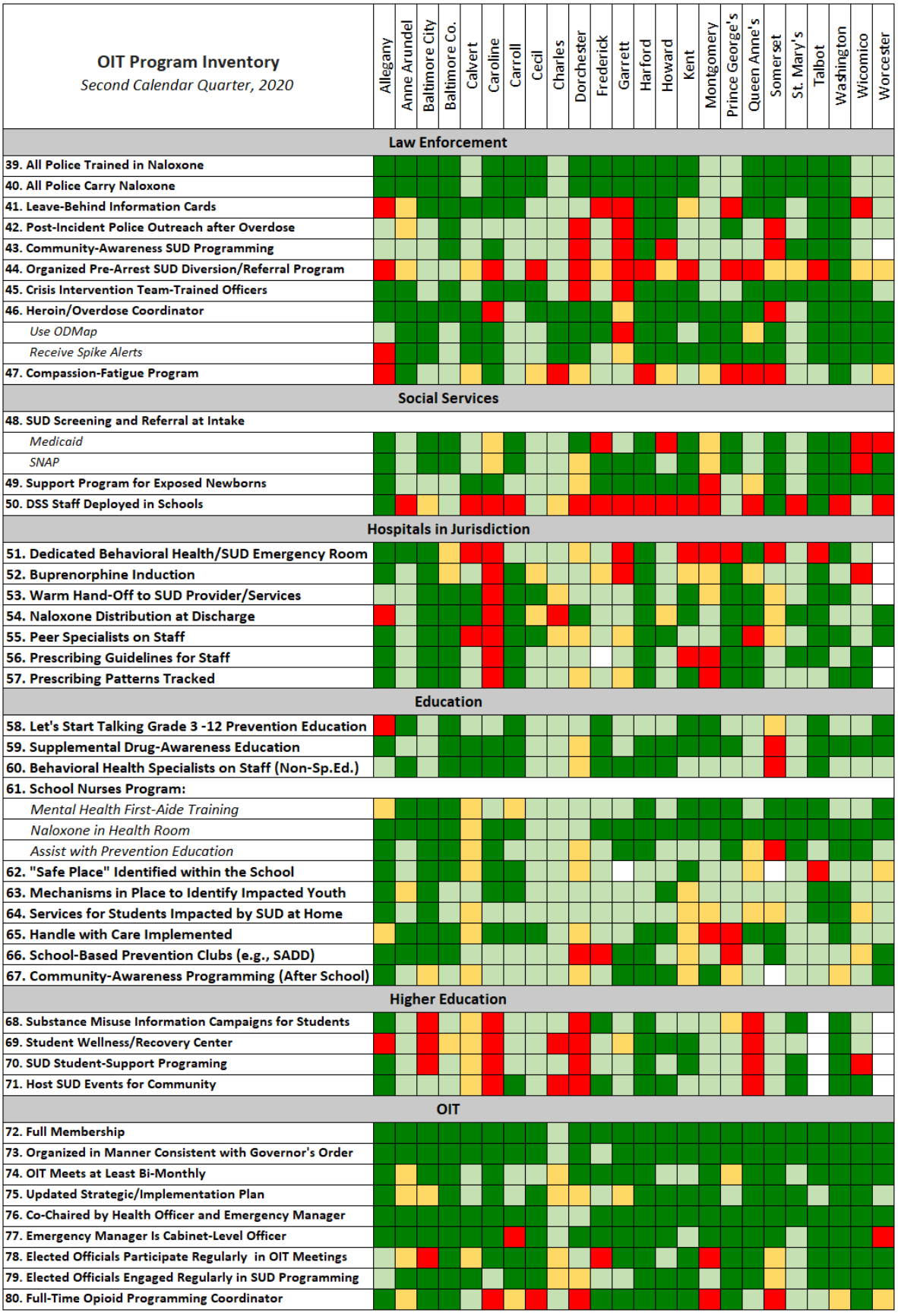
Since the beginning of this year, OITs have made substantial progress toward implementing high-priority programs. All jurisdictions (two more than in the first quarter) reported having at least 50 percent of the 129 high-priority programs either substantially or partially implemented as of the second quarter of 2020. Half of the 24 jurisdictions (two more than at the end of last year) reported having at least 75 percent of these programs substantially or partially implemented. There was a 7.5 percent increase in the number of programs that were substantially implemented and a 4.2 percent increase in the number of programs that were at least partially implanted across the board since the end of last year.

All counties reported plans to expand high-priority programming, no counties reported full or partial implementation of all programs, and no counties reported having plans to implement all programs. Thus, ample opportunities remain for program expansion across all jurisdictions.

Table 3. Full Local Best Practices Matrix



OIT Program Inventory *Second Calendar Quarter, 2020*	Allegany	Anne Arundel	Baltimore City	Baltimore Co.	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worcester
Behavioral Health (cont'd)																								
14. ASAM Level 2.5 Partial Hospitalization																								
15. Licensed SUD Residential-Treatment Programs:																								
3.1 Clinically Managed Low-Intensity																								
3.3 Clinically Managed High-Intensity, Adults Only																								
3.5 Clinically Managed High-Intensity, Adults & Adolescents																								
3.7 Medically Monitored Intensive Inpatient																								
3.7 Medically Monitored Inpatient Withdrawal Mgmt.																								
16. Recovery-Support Programs																								
Sober-Living/Recovery Housing																								
Wellness/Recovery Centers																								
17. Recovery Oriented Systems of Care (ROSC)																								
Judiciary/States Attorney																								
18. Specialized Courts:																								
Adult Drug Court																								
Adolescent Drug Court																								
19. Public-Messaging Program																								
20. Prosecute for Distribution Leading to Death																								
21. Pre-Trial Referral-to-Treatment Protocol																								
22. Information Cards Provided by Commissioners																								
Corrections																								
23. Universal Substance-Use Screening During Intake																								
24. Pre-Trial Referral to Treatment																								
25. Drug-Treatment Programs While Incarcerated:																								
Counseling																								
Methadone																								
Buprenorphine																								
Vivitrol																								
Outpatient (1.0)																								
Intensive Outpatient (2.1)																								
26. Day-Reporting Center																								
27. Facilitated Re-Entry Programs:																								
Employment-Transition Support																								
MAT Upon Release																								
Naloxone Provided at Release																								
Recovery-Housing Referral																								
Transportation Assistance																								
Treatment-Program Referral/Warm Hand-Off																								
28. Provide State Inmates Access to Local Re-Entry Programs																								
29. Organized Planning for HB 116																								
30. Compassion-Fatigue Program																								
Parole and Probation																								
31. Screening and Referral to Treatment																								
32. Treatment Monitoring Program																								
33. SUD Services On-Site at Parole and Probation Offices																								
Emergency Medical Services																								
34. Post-Incident EMS Outreach after Overdose																								
35. Leave-Behind Information Cards																								
36. Leave-Behind Naloxone																								
37. Transport to Alternative Destination (Non-ED)																								
38. Compassion-Fatigue Program																								


OIT Program Inventory
Second Calendar Quarter, 2020
Allegany
Anne Arundel
Baltimore City
Baltimore Co.
Calvert
Caroline
Carroll
Cecil
Charles
Dorchester
Frederick
Garrett
Harford
Howard
Kent
Montgomery
Prince George's
Queen Anne's
Somerset
St. Mary's
Talbot
Washington
Wicomico
Worcester
Law Enforcement
39. All Police Trained in Naloxone
40. All Police Carry Naloxone
41. Leave-Behind Information Cards
42. Post-Incident Police Outreach after Overdose
43. Community-Awareness SUD Programming
44. Organized Pre-Arrest SUD Diversion/Referral Program
45. Crisis Intervention Team-Trained Officers
46. Heroin/Overdose Coordinator
Use ODMap
Receive Spike Alerts
47. Compassion-Fatigue Program
Social Services
48. SUD Screening and Referral at Intake
Medicaid
SNAP
49. Support Program for Exposed Newborns
50. DSS Staff Deployed in Schools
Hospitals in Jurisdiction
51. Dedicated Behavioral Health/SUD Emergency Room
52. Buprenorphine Induction
53. Warm Hand-Off to SUD Provider/Services
54. Naloxone Distribution at Discharge
55. Peer Specialists on Staff
56. Prescribing Guidelines for Staff
57. Prescribing Patterns Tracked
Education
58. Let's Start Talking Grade 3 -12 Prevention Education
59. Supplemental Drug-Awareness Education
60. Behavioral Health Specialists on Staff (Non-Sp.Ed.)
61. School Nurses Program:
Mental Health First-Aide Training
Naloxone in Health Room
Assist with Prevention Education
62. "Safe Place" Identified within the School
63. Mechanisms in Place to Identify Impacted Youth
64. Services for Students Impacted by SUD at Home
65. Handle with Care Implemented
66. School-Based Prevention Clubs (e.g., SADD)
67. Community-Awareness Programming (After School)
Higher Education
68. Substance Misuse Information Campaigns for Students
69. Student Wellness/Recovery Center
70. SUD Student-Support Programing
71. Host SUD Events for Community
OIT
72. Full Membership
73. Organized in Manner Consistent with Governor's Order
74. OIT Meets at Least Bi-Monthly
75. Updated Strategic/Implementation Plan
76. Co-Chaired by Health Officer and Emergency Manager
77. Emergency Manager Is Cabinet-Level Officer
78. Elected Officials Participate Regularly in OIT Meetings
79. Elected Officials Engaged Regularly in SUD Programming
80. Full-Time Opioid Programming Coordinator

[redacted] Admin Sex: **Female** DOB: [redacted] **1963**

Continuity of Care Document

Summarization of Episode Note 04/25/2019 to 04/26/2019

Source: [redacted]

Created: 02/17/2020

Demographics

Contact Information:

[redacted]

Tel: [redacted]

Tel: [redacted]

Mail: [redacted]

Marital Status: [redacted]

Religion: [redacted]

Race: [redacted]

Previous Name(s):

Ethnic Group: Not Hispanic or Latino

Language: dn

ID: [redacted]

Care Team

Type	Name	Represented Organization	Address	Phone
primary care physician	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]			

Relationships

No Data to Display

Document Details

Source Contact Info

[redacted]

Author Contact Info

Recipient Contact Info

Healthcare Professionals

No Data to Display

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Document Template ID: 2.16.840.1.113883.10.20.22.1.1 : , 2.16.840.1.113883.10.20.22.1.1 : 2015 08 01, 2.16.840.1.113883.10.20.22.1.2 :

2015 08 01

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Document Type Code: 2.16.840.1.113883.6.1, 34133 9

Document Language Code: en US

Document Set ID:

Document Version Number:

Primary Encounter

Encounter Information

Registration Date: 04/25/2019

Discharge Date: 04/26/2019

Visit ID:

Location Information

[redacted]

Providers

Type	Name	Address	Phone
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

Encounter

4/25/19 - 4/26/19

[redacted]

Encounter Diagnosis

Arthritis of right hip (Discharge Diagnosis) 4/24/19
Unilateral primary osteoarthritis, right hip (Final) 4/26/19
Hypothyroidism, unspecified (Final) 4/26/19
Essential (primary) hypertension (Final) 4/26/19
Nicotine dependence, cigarettes, uncomplicated (Final) 4/26/19
Dysthymic disorder (Final) 4/26/19
Mixed hyperlipidemia (Final) 4/26/19
Gout, unspecified (Final) 4/26/19
Gastro esophageal reflux disease without esophagitis (Final) 4/26/19
Arthrodesis status (Final) 4/26/19
Other long term (current) drug therapy (Final) 4/26/19
Discharge Disposition: Disch to home or self care Routine

[redacted]

Reason for Visit

OSTEOARTHRITIS OF RIGHT HIP

Allergies, Adverse Reactions, Alerts

Substance	Reaction	Severity	Status
Latex	Rash		Active
Nickel	Rash		Active
predniSONE	Shaky		Active

Assessment and Plan

Extracted from:

Title: Progress Note	**Author:** [redacted]	**Date:** 4/26/19

1. Arthritis of right hip M16.11
Postoperative day 1 status post right anterior total hip
Pain control DVT prophylaxis
DC Hemovac drain
Oral pain medication physical therapy
Discharge planning

Extracted from:

Title: Progress Note POD #0	**Author:** [redacted]	**Date:** 4/25/19

A: This is a 55 year old female who is POD #0 s/p R THA anterior approach doing well post operatively P:
1. Pain Control continue PO Oxycodone PRN
2. DVT ppx: TEDs/SCDs/ASA
3. Labs/vitals/I&O, stable, patient due to void
4. Abx ppx: continue Ancef
5. PT/OT WBAT, anterior hip precautions
6. Monitor HV drain

Immunizations

No data available for this section

Medications

acetaminophen (acetaminophen 325 mg oral tablet) 2 Tablet(s) By Mouth every 4 hours as needed pain/fever/headache.	
acetaminophen (Tylenol 325 mg oral tablet) 2 Tablet(s) By Mouth every 6 hours. Please take 2 tabs every 6 hours in conjunction with oxycodone for better pain relief. Refills: 0. Ordering provider: [redacted]	[redacted]
acetaminophen-codeine (acetaminophen-codeine 300 mg-15 mg oral tablet) 1 Tablet(s) By Mouth every 6 hours as needed as needed for pain. Refills: 0. Ordering provider: [redacted]	**WALGREENS DRUG STORE** [redacted]
acetaminophen-HYDROcodone (Norco 5 mg-325 mg oral tablet) 1 Tablet(s) By Mouth every 6 hours. Refills: 0. Ordering provider: [redacted]	**WALGREENS DRUG STORE** [redacted]
amoxicillin (amoxicillin 500 mg oral tablet) 4 tabs By Mouth One Time. please take 4 tabs (2 grams) one hour prior to dental work for abx prophylaxis. Refills: 1. Ordering provider: [redacted]	[redacted]
aspirin (Adult Aspirin 325 mg oral tablet) 1 Tablet(s) By Mouth every 12 hours. Please take one tab in the morning, one in the evening for one month for blood clot prevention. Refills: 0. Ordering provider: [redacted]	[redacted]
cephalexin (Keflex 500 mg oral capsule) 1 Capsule(s) By Mouth One Time. Please take this antibiotic the night of surgery for infection prophylaxis. Refills: 0. Ordering provider: [redacted]	[redacted]
cholecalciferol (Vitamin D3 2000 intl units oral tablet) 1 Tablet(s) By Mouth every day.	
cyclobenzaprine (cyclobenzaprine 10 mg oral tablet) 1 Tablet(s) By Mouth 3 times a day. Refills: 0. Ordering provider: [redacted]	
cyclobenzaprine (cyclobenzaprine 10 mg oral tablet) 1 Tablet(s) By Mouth 3 times a day. Refills: 0. Ordering provider: [redacted]	**WALGREENS DRUG STORE** [redacted]

cyclobenzaprine (cyclobenzaprine 10 mg oral tablet) 1 Tablet(s) By Mouth 3 times a day as needed as needed for spasm. Refills: 0. Ordering provider: [redacted]	[redacted]
cyclobenzaprine (cyclobenzaprine 10 mg oral tablet) 1 Tablet(s) By Mouth 3 times a day as needed as needed for spasm. Refills: 0. Ordering provider: [redacted]	[redacted]
cyclobenzaprine (cyclobenzaprine 10 mg oral tablet) 1 Tablet(s) By Mouth every 8 hours as needed as needed for spasm. Refills: 0. Ordering provider: [redacted]	[redacted]
cyclobenzaprine (cyclobenzaprine 5 mg oral tablet) 1 Tablet(s) By Mouth every 8 hours as needed muscle spasm. Refills: 0. Ordering provider: [redacted]	[redacted]
cyclobenzaprine (cyclobenzaprine 5 mg oral tablet) 1 Tablet(s) By Mouth 3 times a day as needed muscle spasm. Refills: 0. Ordering provider: [redacted]	[redacted]
cyclobenzaprine (cyclobenzaprine 5 mg oral tablet) 1 Tablet(s) By Mouth every 8 hours as needed muscle spasm. Refills: 0. Ordering provider: [redacted]	[redacted]
cyclobenzaprine (cyclobenzaprine 5 mg oral tablet) 1 Tablet(s) By Mouth every 8 hours as needed muscle spasm. Refills: 0. Ordering provider: [redacted]	[redacted]
docusate-senna (docusate-senna 50 mg-8.6 mg oral tablet) 2 Tablet(s) By Mouth 2 times a day.	
hydrochlorothiazide-losartan (hydrochlorothiazide-losartan 25 mg-100 mg oral tablet) 1 Tablet(s) By Mouth every day.	
levothyroxine 150 Microgram once a day (in the morning).	
lidocaine topical (Salonpas Maximum Strength 4% topical film) 1 Patch Topical 3 times a day as needed pain. Refills: 0. Ordering provider: [redacted]	[redacted]
losartan By Mouth every day.	
meloxicam (meloxicam 15 mg oral tablet) TAKE 1 TABLET BY MOUTH DAILY. Refills: 0. Ordering provider: [redacted]	[redacted]
meloxicam (meloxicam 15 mg oral tablet) TAKE 1 TABLET BY MOUTH DAILY. Refills: 0. Ordering provider: [redacted]	[redacted]
meloxicam (meloxicam 15 mg oral tablet) TAKE 1 TABLET BY MOUTH DAILY. Refills: 0. Ordering provider: [redacted]	[redacted]
meloxicam (meloxicam 15 mg oral tablet) TAKE 1 TABLET BY MOUTH DAILY. Refills: 0. Ordering provider: [redacted]	[redacted]
meloxicam (meloxicam 15 mg oral tablet) TAKE 1 TABLET BY MOUTH DAILY. Refills: 0. Ordering provider: [redacted]	[redacted]

meloxicam (Mobic 15 mg oral tablet) 1 Tablet(s) By Mouth every day. Refills: 0. Ordering provider:	
metaxalone (metaxalone 800 mg oral tablet) 1 Tablet(s) By Mouth 3 times a day for 14 Day(s). Refills: 0. Ordering provider:	
metaxalone (metaxalone 800 mg oral tablet) 1 Tablet(s) By Mouth every 6 hours as needed muscle spasm. Refills: 0. Ordering provider:	
oxyCODONE (oxyCODONE 5 mg oral TABLET) 1 Tablet(s) By Mouth every 4 hours. Please take 1 2 tabs every 4 hours as needed for post operative pain. Refills: 0. Ordering provider:	**MedStar at Union Memorial Hospital**
oxyCODONE (oxyCODONE 5 mg oral TABLET) 1 Tablet(s) By Mouth every 4 hours for 3 Day(s). Refills: 0. Ordering provider:	
oxyCODONE (oxyCODONE 5 mg oral TABLET) 1 Tablet(s) By Mouth every 12 hours. Please take 1 2 tabs daily as needed for pain. Refills: 0. Ordering provider:	
oxyCODONE (oxyCODONE 5 mg oral TABLET) 1 Tablet(s) By Mouth every 6 hours. Refills: 0. Ordering provider:	
oxyCODONE (oxyCODONE 5 mg oral TABLET) 1 2 tab By Mouth every 4 hours as needed as needed for pain. Refills: 0. Ordering provider:	
traMADol (traMADol 50 mg oral tablet) 1 Tablet(s) By Mouth every 6 hours as needed as needed for pain. Refills: 0. Ordering provider:	**WALGREENS DRUG STORE**
traMADol (traMADol 50 mg oral tablet) 1 Tablet(s) By Mouth every 6 hours as needed as needed for pain. Refills: 0. Ordering provider:	
traMADol (traMADol 50 mg oral tablet) 1 Tablet(s) By Mouth every 4 hours as needed as needed for pain. Refills: 0. Ordering provider:	
traMADol (traMADol 50 mg oral tablet) 1 Tablet(s) By Mouth every 4 hours as needed as needed for pain. Refills: 0. Ordering provider:	
traMADol (traMADol 50 mg oral tablet) 1 Tablet(s) By Mouth every 6 hours as needed as needed for pain. Refills: 0. Ordering provider:	
traMADol (traMADol 50 mg oral tablet) 1 Tablet(s) By Mouth every 12 hours. please take 1 tab nightly as needed for pain. not to exceed 400 mg/day. Refills: 1. Ordering provider:	
traMADol (traMADol 50 mg oral tablet) 1 Tablet(s) By Mouth every 8 hours. Refills: 0. Ordering provider:	

traMADol (traMADol 50 mg oral tablet) 1 Tablet(s) By Mouth every 4 hours. Refills: 0. Ordering provider: [redacted]	
traMADol (traMADol 50 mg oral tablet) 1 Tablet(s) By Mouth every 4 hours as needed as needed for pain. Refills: 0. Ordering provider: [redacted]	[redacted]
traMADol (traMADol 50 mg oral tablet) 1 Tablet(s) By Mouth every 8 hours. Refills: 0. Ordering provider: [redacted]	[redacted]
traMADol (traMADol 50 mg oral tablet) 1 Tablet(s) By Mouth every 12 hours as needed as needed for pain. Refills: 1. Ordering provider: [redacted]	[redacted]
venlafaxine (Effexor) 225 Milligram By Mouth once a day (in the morning).	

Problem List

Condition	Effective Dates	Status	Health Status	Informant
Depression(Confirmed)		Active		patient
High cholesterol(Confirmed)		Active		patient
Hip replacement(Confirmed) [1]		Active		
s/p MIS PSF L3 5 & Left L3 5 decompression, DOS 10/22/19(Confirmed)		Active		
HTN (hypertension) (Confirmed)		Active		patient
Lumbar radiculopathy(Confirmed)		Active		
Osteoarthritis of right hip(Confirmed)		Active		
Osteoporosis(Confirmed) [2]		Active		patient
PONV (postoperative nausea and vomiting) (Confirmed)		Active		patient
Thyroid disease(Confirmed)		Active		patient
Tobacco use(Confirmed)		Active		

[1] Problem added automatically by system based on initiation of the Hip Replacement Plan of Care.

[2] Pt Denies having

Procedures

Procedure	Date	Related Diagnosis	Body Site	Status
MIS PSF L3 5 & Left L3 5 decompression	10/22/19			Completed
COLLECTION VENOUS BLOOD VENIPUNCTURE	4/26/19			Completed
COLLECTION VENOUS BLOOD VENIPUNCTURE	4/26/19			Completed
COLLECTION VENOUS BLOOD VENIPUNCTURE	4/26/19			Completed
[redacted]				[redacted]
[redacted]				[redacted]
[redacted]				[redacted]
[redacted]				[redacted]
[redacted]				[redacted]

Results

Laboratory List

Name	Date
.GFR	4/26/19
Basic Metabolic Panel	4/26/19
Complete Blood Count w/ Differential	4/26/19
Dosing Height Weight	4/25/19

4/26/19

Test	Result	Reference Range	Specimen Source	Laboratory
WBC	7.6 k/uL	(Normal is 4.0 10.8 k/uL)	Blood	UMH Lab
Hgb	11.5 gm/dL	(Normal is 11.0 14.5 gm/dL)	Blood	UMH Lab
Hct	35.4 %	(Normal is 34.5 44.0 %)	Blood	UMH Lab
Platelet	237 k/uL	(Normal is 145 400 k/uL)	Blood	UMH Lab
MCV	94.7 FL	(Normal is 81.0 100.0 FL)	Blood	UMH Lab
MCH	30.7 pg	(Normal is 27.0 31.0 pg)	Blood	UMH Lab
MCHC	32.5 gm/dL	(Normal is 31.0 36.0 gm/dL)	Blood	UMH Lab
RDW	12.9 %	(Normal is 11.5 15.5 %)	Blood	UMH Lab
RBC	3.74 million/uL	(Normal is 3.60 5.00 million/uL)	Blood	UMH Lab
Neutro %	61.6 %	(Normal is 43.0 75.0 %)	Blood	UMH Lab
Lymph %	26.4 %	(Normal is 15.0 45.0 %)	Blood	UMH Lab
Mono %	9.4 %	(Normal is 3.0 12.0 %)	Blood	UMH Lab
Eos %	2.2 %	(Normal is 0.0 6.0 %)	Blood	UMH Lab
Basophil %	0.3 %	(Normal is 0.0 2.0 %)	Blood	UMH Lab
Neutro Absolute	4.7 k/uL	(Normal is 1.7 8.1 k/uL)	Blood	UMH Lab
Lymph Absolute	2.0 k/uL	(Normal is 0.6 4.9 k/uL)	Blood	UMH Lab
Monocyte Abs	0.7 k/uL	(Normal is 0.1 1.3 k/uL)	Blood	UMH Lab
Eosinophil Abs	0.2 k/uL	(Normal is 0.0 0.7 k/uL)	Blood	UMH Lab
Basophil Abs	0.0 k/uL	(Normal is 0.0 0.2 k/uL)	Blood	UMH Lab

Imm Gran %	0.1 %	(Normal is 0.1 0.3 %)	Blood	UMH Lab
Imm Gran Absolute	0.01 k/uL	(Normal is 0.01 0.03 k/uL)	Blood	UMH Lab
MPV	9.9 FL	(Normal is 7.5 10.4 FL)	Blood	UMH Lab
NRBC auto	0 /100 wbcs	(Normal is 0 2 /100 wbcs)	Blood	UMH Lab
NRBC Abs	0.0 k/uL	(Normal is 0.0 0.1 k/uL)	Blood	UMH Lab
Imm Platelet %	1.0 %	(Normal is 1.1 6.7 %)	Blood	UMH Lab
Temperature Oral	37.2 DegC	(Normal is 36 37.8 DegC)		
Temperature Oral	36.9 DegC	(Normal is 36 37.8 DegC)		
Temperature Oral	36.7 DegC	(Normal is 36 37.8 DegC)		
Peripheral Pulse Rate	92 bpm	(Normal is 60 100 bpm)		
Peripheral Pulse Rate	77 bpm	(Normal is 60 100 bpm)		
Peripheral Pulse Rate	78 bpm	(Normal is 60 100 bpm)		
Respiratory Rate	15 BR/min	(Normal is 12 20 BR/min)		
Respiratory Rate	17 BR/min	(Normal is 12 20 BR/min)		
Respiratory Rate	20 BR/min	(Normal is 12 20 BR/min)		
Systolic BP, Automated	117 mmHg	(Normal is 90 140 mmHg)		
Systolic BP, Automated	117 mmHg	(Normal is 90 140 mmHg)		
Systolic BP, Automated	111 mmHg	(Normal is 90 140 mmHg)		
Diastolic BP, Automated	75 mmHg	(Normal is 60 90 mmHg)		
Diastolic BP, Automated	80 mmHg	(Normal is 60 90 mmHg)		
Diastolic BP, Automated	77 mmHg	(Normal is 60 90 mmHg)		
BP Extremity, Automated	Right upper			
BP Extremity, Automated	Right upper			
MAP, Automated	89 mmHg			
MAP, Automated	93 mmHg			
Sodium Lvl	144 mmol/L	(Normal is 137 145 mmol/L)	Blood	UMH Lab
Potassium Lvl	3.6 mmol/L	(Normal is 3.5 5.1 mmol/L)	Blood	UMH Lab
Chloride	109 mmol/L	(Normal is 98 107 mmol/L)	Blood	UMH Lab
CO2	29 mmol/L	(Normal is 21 32 mmol/L)	Blood	UMH Lab
BUN	13 mg/dL	(Normal is 7 17 mg/dL)	Blood	UMH Lab
Creatinine	0.54 mg/dL	(Normal is 0.52 1.04 mg/dL)	Blood	UMH Lab
est. CrCl	105.75 mL/min 1			
Glucose Lvl Random	105 mg/dL	(Normal is 65 140 mg/dL)	Blood	UMH Lab
Calcium Lvl	8.5 mg/dL	(Normal is 8.5 10.1 mg/dL)	Blood	UMH Lab
AGAP	6 mmol/L	(Normal is 5 15 mmol/L)	Blood	UMH Lab
GFR African American	>60 mL/min/1.73 m2		Blood	
GFR Non African American	>60 mL/min/1.73 m2		Blood	

4/25/19

Test	Result	Reference Range	Specimen Source	Laboratory

Temperature Temporal	36.2 DegC	(Normal is 36.3 37.8 DegC)		
Temperature Temporal	36.6 DegC	(Normal is 36.3 37.8 DegC)		
Temperature Temporal	36 DegC	(Normal is 36.3 37.8 DegC)		
Heart Rate Monitored	65 bpm	(Normal is 60 100 bpm)		
Heart Rate Monitored	63 bpm	(Normal is 60 100 bpm)		
Heart Rate Monitored	62 bpm	(Normal is 60 100 bpm)		
BP Extremity, Automated	Left upper			
MAP, Automated	88 mmHg			
Weight Measured (Non Dosing)	80 kg			
Height/Length Measured (Non Dosing)	165 cm			
Dosing Weight Method	Estimated			
Dosing Weight Method	Measured			
Dosing Height Method	Measured			
Dosing Height Method	Measured			
BSA Dosing	1.87 m2			
BSA Dosing	1.87 m2			
Weight Dosing	80 kg			
Weight Dosing	80 kg			
Height/Length Dosing	165 cm	(Normal is 129 213 cm)		
Height/Length Dosing	165 cm	(Normal is 129 213 cm)		
Body Mass Index Dosing	29.38 kg/m2			
Body Mass Index Dosing	29.38 kg/m2			

[1] Result Comment: Resulted by Rule: PHA CrCl CALCULATION CPOE The documented "Ideal Body Weight" was used for this Calculation

Ideal body weight < Weight dosing

The estimated creatinine clearance is calculated based on the following Cockcroft Gault formulas:

Male: ((140 Age) / SerumCreat) * (Weight / 72)

Female: ((140 Age) / SerumCreat) * (Weight / 72) * 0.85

As with any estimated result, discretion should be applied before clinical decisions are made.

Laboratory Information

[redacted]

[redacted]

[redacted]

Vital Signs

4/26/19

Temperature Oral	37.2 DegC	(Normal is 36 37.8 DegC)
Temperature Oral	36.9 DegC	(Normal is 36 37.8 DegC)
Peripheral Pulse Rate	92 bpm	(Normal is 60 100 bpm)
Peripheral Pulse Rate	77 bpm	(Normal is 60 100 bpm)
Respiratory Rate	15 BR/min	(Normal is 12 20 BR/min)
Respiratory Rate	17 BR/min	(Normal is 12 20 BR/min)
Blood Pressure	117/75 mmHg	(Normal is 90 140/60 90 mmHg)
Blood Pressure	117/80 mmHg	(Normal is 90 140/60 90 mmHg)
BP Extremity, Automated	Right upper	
BP Extremity, Automated	Right upper	
MAP, Automated	89 mmHg	
MAP, Automated	93 mmHg	

4/25/19

Temperature Temporal	36.2 DegC*LOW*	(Normal is 36.3 37.8 DegC)
Temperature Temporal	36.6 DegC	(Normal is 36.3 37.8 DegC)
Heart Rate Monitored	65 bpm	(Normal is 60 100 bpm)
Heart Rate Monitored	63 bpm	(Normal is 60 100 bpm)
Height/Length Dosing	165 cm	(Normal is 129 213 cm)
Height/Length Dosing	165 cm	(Normal is 129 213 cm)
Body Mass Index Dosing	29.38 kg/m2	
Body Mass Index Dosing	29.38 kg/m2	
Weight Dosing	80 kg	
Weight Dosing	80 kg	

Social History

Social History Type	Response
Smoking Status	Former smoker
Birth Sex	

Goals

No data available for this section

Hospital Discharge Instructions

Patient Education

05/10/2019 09:01:27

You've Been Prescribed an Antibiotic - Now What

You've Been Prescribed an Antibiotic Now What?

Your healthcare team thinks that you or your loved one might have an infection. Some infections can be treated with antibiotics, which are powerful, life saving drugs. Like all medications, antibiotics have side effects and should only be used when necessary. There are some important things you should know about your antibiotic treatment.

A. Your healthcare team may run tests before you start taking an antibiotic.

• Your team may take samples (e.g., from your blood, urine or other areas) to run tests to look for bacteria. These tests can be important to determine if you need an antibiotic at all and, if you do, which antibiotic will work best.

B. Within a few days, your healthcare team might change or even stop your antibiotic.

• Your team may start you on an antibiotic while they are working to find out what is making you sick.
• Your team might change your antibiotic because test results show that a different antibiotic would be better to treat your infection.
• In some cases, once your team has more information, they learn that you do not need an antibiotic at all. They may find out that you don't have an infection, or that the antibiotic you're taking won't work against your infection. For example, an infection caused by a virus can't be treated with antibiotics. Staying on an antibiotic when you don't need it is more likely to be harmful than helpful.

C. You may experience side effects from your antibiotic.

• Like all medications, antibiotics have side effects. Some of these can be serious.
• Let your healthcare team know if you have any known allergies when you are admitted to the hospital.
• One significant side effect of nearly all antibiotics is the risk of severe and sometimes deadly diarrhea caused by Clostridium difficile (C. difficile). This occurs when a person takes antibiotics because some good germs are destroyed. Antibiotic use allows C. difficile to take over, putting patients at high risk for this serious infection.
• Diarrhea caused by C. difficile can be serious and must be recognized and treated quickly. When you are taking an antibiotic and you develop diarrhea, let your healthcare team know immediately.
• The risk of getting C. difficile diarrhea can last for up to a few weeks even after you are no longer getting antibiotics. You should let your healthcare team know if you develop diarrhea even after you are no longer getting an antibiotic.

D. Another serious side effect of taking antibiotics is the risk of getting an antibiotic resistant infection later. Infections caused by antibiotic resistant bacteria are often more difficult to treat. In some cases, the antibiotic resistant infections can lead to serious disability or even death.

04/24/2019 16:37:52

Venous Thromboembolism Prevention

Venous Thromboembolism Prevention

Venous thromboembolism (VTE) is a condition in which a blood clot (thrombus) develops in the body. A thrombus usually occurs in a deep vein in the leg or the pelvis (DVT), but it can also occur in the arm. Sometimes, pieces of a thrombus can break off from its original

place of development and travel through the bloodstream to other parts of the body. When that happens, the thrombus is called an embolus. An embolus that travels to one or both lungs is called a pulmonary embolism. An embolism can block the blood flow in the blood vessels of other organs as well.

VTE is a serious health condition that can cause disability or death. It is very important to get help right away and to not ignore symptoms.

How can a VTE be prevented?

• Exercise regularly. Take a brisk 30 minute walk every day. Staying active and moving around can help you to prevent blood clots.

• Avoid sitting or lying in bed for long periods of time without moving your legs. Change your position often, especially during long distance travel (over 4 hours).

• If you are a woman who is over 35 years of age, avoid unnecessary use of medicines that contain estrogen. These include birth control pills and hormone replacement therapy.

• Do not smoke, especially if you take estrogen medicines. If you need help quitting, ask your health care provider.

• Eat plenty of fruits and vegetables. Ask your health care provider or dietitian if there are foods that you should avoid.

• Maintain a weight that is appropriate for your height. Ask your health care provider what weight is healthy for you.

• Wear loose fitting clothing. Avoid constrictive or tight clothing around your legs or waist.

• Try not to bump or injure your legs. Avoid crossing your legs when you are sitting.

• Do not use pillows under your knees while lying down unless told by your health care provider.

• Wear support hose (compression stockings or TED hose) as told by your health care provider Compression stockings increase blood flow in your legs and can help prevent blood clots. Do not let them bunch up when you are wearing them.

How can I prevent VTE when I travel?

Long distance travel (over 4 hours) can increase the risk of a VTE. To prevent VTE when traveling:

• Exercise your legs every hour by standing, stretching, and bending and straightening your legs. If you are traveling by airplane, train, or bus, walk up and down the aisle as often as possible to get your blood moving. If you are traveling by car, stop and get out of the car every hour to exercise your legs and stretch. Other types of exercise might include:

Keeping your feet flat on the ground and raising your toes.

Switching from tightening the muscles in your calves and thighs to relaxing those same muscles while you are sitting.

Pointing and flexing your feet at the ankle joints while you are sitting.

• Stay well hydrated while traveling. Drink enough water to keep your urine clear or pale yellow.

• Avoid drinking alcohol during long travel.

Generally, it is not recommended that you take medicines to prevent DVT during routine travel.

How can VTE be prevented if I am hospitalized?

A VTE may be prevented by taking medicines that are prescribed to prevent blood clots (anticoagulants). You can also help to prevent VTE while in the hospital by taking these actions:

• Get out of bed and walk. Ask your health care provider if this is safe for you to do.

• Request the use of a sequential compression device (SCD). This is a machine that pumps air into compression sleeves that are wrapped around your legs.

• Request the use of compression stockings, which are tight, elastic stockings that apply pressure to the lower legs. Compression stockings are sometimes used with SCDs.

How can I prevent VTE after surgery?

Understand that there is an increased risk for VTE for the first 4 6 weeks after surgery. During this time:

• Avoid long distance travel (over 4 hours). If you must travel during this time, ask your health care provider about additional preventive actions that you can take. These might include exercising your arms and legs every hour while you travel.

• Avoid sitting or lying still for too long. If possible, get up and walk around one time every hour. Ask your health care provider when this is safe for you to do.

Get help right away if:

• You have new or increased pain, swelling, or redness in an arm or leg.

• You have numbness or tingling in an arm or leg.

• You have shortness of breath while active or at rest.
• You have chest pain.
• You have a rapid or irregular heartbeat.
• You feel light headed or dizzy.
• You cough up blood.
• You notice blood in your vomit, bowel movement, or urine.
These symptoms may represent a serious problem that is an emergency. Do not wait to see if the symptoms will go away. Get medical help right away. Call your local emergency services (911 in the U.S.). Do not drive yourself to the hospital.
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: 12/06/2010 Document Revised: 05/25/2017 Document Reviewed: 04/13/2016

04/24/2019 16:37:51

Taking Your Pain Medications Safely (CUSTOM)

Taking Your Pain Medicines Safely
You are going home with a prescription for an opioid pain medicine to help you as you heal.
What do I need to know?
• Pain medicines may not take away all your pain.
• Your goal is to control your pain to safely heal and stop anything from getting worse.
• It is normal to still feel pain when moving around while you are getting better.
How much medicine should I take?
Follow the directions on the bottle It is not safe to take any more than your doctor prescribed for you.
This medicine can have serious side effects and can cause you to become addicted. Taking any medicine in a bigger amount (dose) or more often could cause you to overdose or die.
• You may take your opioid medicines for moderate to severe pain. You can try other things, like using heat or ice, which may also help your pain. Talk to your doctor about what will work best for you.
• You should notice that you need less and less opioid medicine as you start to feel less pain. Take less and less of your opioid medicines each day as your pain gets better. This may mean taking a smaller dose each time, or waiting for a longer amount of time between each dose you take. This is called tapering.
• If you feel like your pain is not at a comfortable level, or is getting worse, call your doctor.
Where should I keep my medicines?
• Keep these medicines in a safe and secure place, away from other people in your family, children, visitors and pets.
• Do not let other people take or use your medicines. This is very unsafe and against the law.
How do I stay safe while taking these medicines?
• Do not drive, operate machinery, or drink alcohol while taking opioid pain medicines.
• Check with your doctor before taking any other medicines that you did not talk about at discharge.
• Tell a friend or family member that you are taking these medicines and to call 911 if they are worried you are more sleepy than normal and it is hard to wake you up.
• Your doctor may give you naloxone (Narcan), which is a medicine that can quickly reverse an overdose of opioid pain medicines. Tell a friend or family member that you have this and to be ready to give it to you after calling 911.
What should I do with my opioid medicines after I stop using them?
If you are no longer using your opioid medicines, get rid of any that is leftover.
Here are some safe ways to do this:
Ÿ Find your local drug take back program or your pharmacy mail back program
• Go to FDA.gov/Drugs/ResourcesForYou and follow the instructions from the FDA.
• Flush prescription drugs down the toilet following the instructions that came with your medicine or if it is listed at the FDA website above.
To learn about the risks of opioid abuse and overdose go to the website www.cdc.gov/drugoverdose
If you think you may have a problem with addiction, tell your doctor and ask for help, or call the national helpline at 1 800 662 HELP.
Visit https://www.samhsa.gov to find treatment programs in our area.

04/24/2019 16:37:48

ORTHO DISCHARGE ANTERIOR THA - [redacted]

Total Hip Arthroplasty Discharge Instructions

Activity

Elevate operative leg as much as possible. Avoid extending or externally rotating your hip.

Wear your leg stockings on both legs for 4 weeks. Remove only when bathing.

Weight bear as tolerated with assistive devices as required (walker, crutches, or cane). No heavy lifting, twisting, or bending.

You may or may not have been prescribed outpatient physical therapy, home physical therapy, or a stay in a rehabilitation facility. This varies from patient to patient. Your physician may also wait to prescribe physical therapy at the first followup visit. Every day, you should work on your own doing the exercises shown to you in the hospital. You should work to get your knee completely straight.

You may drive a car when approved by your physician which generally occurs when the following have been met:

You are fully weight bearing and

Not using a walker to bear weight

You are not on pain medication

You may or may not need visits from a home nurse. If so, before you leave the hospital, information will be provided regarding the visiting nurse.

Post Surgical Problems

Slight drainage from the incision is expected within the first 5 days after surgery.

Numbness and swelling around the incision is expected.

Some muscle tightness will occur, movement will help prevent this.

GO TO THE EMERGENCY DEPARTMENT FOR ANY OF THE FOLLOWING:

Temperature >38.5 Celsius (101.2 Fahrenheit), uncontrolled/increased pain, moderate or persistent bleeding or drainage from surgical site, calf pain, chest pain, shortness of breath, nausea/vomiting, or any other medical concerns.

Blood Clot Prevention

You will be given a prescription for either Aspirin or Coumadin (Warfarin) & instructed on the dose to be taken daily.

If given COUMADIN: You will take Coumadin for 4 weeks after your surgery. Coumadin has many drug interactions. Do NOT start or stop any prescription or over the counter medications or herbal supplements without consulting your healthcare provider. The dose of Coumadin WILL CHANGE based on blood levels that need to be checked you will either go to a clinic for blood draws or they will be drawn by a home nurse service, and the result will be faxed to Union. The Union Memorial Hospital Joint Replacement Center Anticoagulation Services will notify you within a day or two to let you know your results and if you need to change your dose.

Avoid non steroidal medications such as Ibuprofen/Motrin/Naproxen/Aleve/etc. Do not take Aspirin unless otherwise prescribed by your healthcare provider.

If given ASPIRIN: You will take Aspirin twice a day for 4 weeks after your surgery. Do not take any other blood thinners unless prescribed by your doctor.

Pain Medicine

Take pain medicine at the start of pain. DO NOT WAIT until the pain is unbearable. If you are taking Percocet (Oxycodone/Acetaminophen) do NOT take additional Tylenol (Acetaminophen).

You should take over the counter stool softeners such as Senokot S or Miralax ito avoid constipation. You may discontinue them when you are no longer on prescription pain medication or if you develop loose or frequent stools.

Antibiotics

Because your have metal implants, you must receive prophylactic antibiotics with any dental work (including routine cleaning) or any invasive procedure for at least 2 years following surgery.

Wound Care

If you have STAPLES: A home nurse will remove your staples at home.

Swelling around the thigh and down the leg to the knee region is to be expected. Elevate the leg and apply ice to the knee to help minimize the swelling and discomfort. Apply ice 20 minutes 3 4 times a day.
You may shower after discharge with the waterproof dressing in place. Once removed,if the incision site is clean, dry, and non draining, you may shower. DO NOT soak/submerge the wound in a tub/pool.
Numbness over the hip and surgical wound is to be expected. This will last for an extended period of time. Generally the numb area gets smaller over time.
Your dressing should stay on a total of 10 days after your date of surgery. You may then remove it at home, and if there is no drainage you can leave it uncovered. If there is mild drainage, you may cover it with gauze and paper tape. Once 3 days have passed with no drainage, you may shower. After removing the dressing keep the wound clean and dry. You may have little tapes (Steri Strips) across the wound. These little tapes will fall off on their own, usually around one week. You may remove them yourself if they are still in place on post operative day 14.

Diet
No new dietary restrictions, follow a heart healthy diet.

Smoking Cessation
Avoid smoking and using tobacco products. Smoking is harmful to your health. If you smoke, STOP.

Followup
Follow up with your surgeon in 4 weeks for your post operative visit.

04/24/2019 16:37:33

Mepilex dressing Rob's [redacted]

Information and Home Care Regarding Your Surgical Dressing
Please note that you have been sent home with a surgical dressing being used by MedStar Good Samaritan Hospital's Orthopedic Team to prevent post operative skin tears and blisters, help prevent infection, and decrease the need for bulky daily dressing changes.
Please wash your hands with soap and water prior to touching your dressing Information Regarding your Mepilex Dressing:
• The dressing is water proof
• You may shower at the time of discharge unless their wound is actively draining. Do not submerge dressing (No swimming, hot tubs or baths).
• Please Remove the Mepilex Dressing in 5 days
• This dressing should only be removed sooner if drainage from your surgical incision extends beyond the border of the dressing or the dressing is 80% saturated.
• The adhesive on the dressing prevents tension from being applied to the skin and therefore should not be painful upon removal or cause pulling of hair or tearing of skin.
• Should you need to remove the dressing to reposition it or pull the dressing down to inspect your incision, please note that you do not need to throw it away. The dressing was designed so that it can be removed and re adhered to the skin so that the incision may be visualized. It is also made to wick away drainage, so even if there is drainage on the wound, the drainage itself is not going to affect the wound if it is left on.
When to call your surgeon's office:
• If your dressing becomes saturated from incisional drainage
• You notice any of the following:
Redness around the incision
Skin blisters along the operative site
Excessive warmth to the touch
What to do if your incision is still draining after removal of the dressing:
• Continue to keep your incision clean and dry by placing gauze over the surgical site.
• Do not shower while your incision is draining. Wait until 3 days after no drainage is noted from your incision.
Should your incision continue to drain past 1 week, please call your surgeon's office for further follow up.

04/24/2019 16:37:31

[redacted] Dermabond Prineo Skin Closure System August 2017 (CUSTOM)

Dermabond Prineo Skin Closure System

Dermabond Prineo is the combination of a mesh and a liquid adhesive that allows the incision or wound to be held together during the healing process. Dermabond Prineo should remain in place between 7 14 days. In the event that you notice that Dermabond Prineo is beginning to loosen or may be coming off, allow it to do so. This is normal.

Bathing and Showering:

You may occasionally and briefly wet your incision or wound that was treated with Dermabond Prineo in the shower or bath.

Do not soak or scrub your incision or wound.

Do not swim or soak your incision or wound in water.

After showering or bathing, gently blot your incision/wound with a soft towel.

Care should also be taken so that any tape that may be part of the dry Mepilex protective dressing does not come into contact with Dermabond Prineo because when the tape is removed, it may also remove Dermabond Prineo.

Wound Healing:

If you experience any redness, swelling, discomfort, warmth or pus, contact your healthcare professional and he or she will determine how your incision/wound is healing and take the necessary steps to address any issues.

Exercise:

Do not engage in strenuous exercise, that may cause additional stress on your incision/wound, other than what is guided by your Physical Therapist.

Follow your healthcare professional's guidance about when you can return to your normal activities.

Removing Dermabond Prineo:

On Day 14 following surgery, you may carefully peel off the Dermabond Prineo, starting at one of the ends, if it has not already come off. If it is still adhering you can use and antibiotic ointment to help remove it.

Prior to removal, do not scratch, rub or pick at the mesh. This may loosen the adhesive and mesh before the skin is healed.

If you do not feel comfortable removing the Prineo, please make an appointment to have it removed 2 weeks following surgery.

Ointments or Liquids:

Topical ointments, liquids or any other product (other than dry bandages) should not be applied to the incision while Dermabond Prineo is in place.

This may loosen Dermabond Prineo from the skin before it has completely healed.

04/24/2019 16:37:25

General Anesthesia, Adult, Care After

General Anesthesia, Adult, Care After

These instructions provide you with information about caring for yourself after your procedure. Your health care provider may also give you more specific instructions. Your treatment has been planned according to current medical practices, but problems sometimes occur. Call your health care provider if you have any problems or questions after your procedure.

What can I expect after the procedure?

After the procedure, it is common to have:

• Vomiting.

• A sore throat.

• Mental slowness.

It is common to feel:

• Nauseous.

• Cold or shivery.

• Sleepy.
• Tired.
• Sore or achy, even in parts of your body where you did not have surgery.

Follow these instructions at home:
For at least 24 hours after the procedure:
• Do not:
Participate in activities where you could fall or become injured.
Drive.
Use heavy machinery.
Drink alcohol.
Take sleeping pills or medicines that cause drowsiness.
Make important decisions or sign legal documents.
Take care of children on your own.

• Rest.
Eating and drinking
• If you vomit, drink water, juice, or soup when you can drink without vomiting.
• Drink enough fluid to keep your urine clear or pale yellow.
• Make sure you have little or no nausea before eating solid foods.
• Follow the diet recommended by your health care provider.
General instructions
• Have a responsible adult stay with you until you are awake and alert.
• Return to your normal activities as told by your health care provider. Ask your health care provider what activities are safe for you.
• Take over the counter and prescription medicines only as told by your health care provider.
• If you smoke, do not smoke without supervision.
• Keep all follow up visits as told by your health care provider. This is important.
Contact a health care provider if:
• You continue to have nausea or vomiting at home, and medicines are not helpful.
• You cannot drink fluids or start eating again.
• You cannot urinate after 8 12 hours.
• You develop a skin rash.
• You have fever.
• You have increasing redness at the site of your procedure.
Get help right away if:
• You have difficulty breathing.
• You have chest pain.
• You have unexpected bleeding.
• You feel that you are having a life threatening or urgent problem.
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: 03/26/2002 Document Revised: 05/22/2017 Document Reviewed: 12/01/2016

Follow Up Care
02/14/2019 09:18:07
With: [redacted]
Address:
[redacted]
[redacted]
[redacted]

[redacted]

When: 1 month

Comments: If symptoms worsen, call Provider Call for followup appointment

Reason for Referral

No data available for this section

Health Concerns

No data available for this section

Medical Equipment

Implanted Date: 10/22/19 **Target Site:** Spine Lumbar

Description	Quantity	MRI	Company	Model
SCR ORTF S MODU CANN 7.5X40 FIREBIRD	3		ORTHOFIX SPINAL IMPLANTS	Unknown
UDI: No Information		**Assigning Authority:** FDA		
SCR SYS POST PEDL PHOENIX	3		ORTHOFIX SPINAL IMPLANTS	Unknown
UDI: No Information		**Assigning Authority:** FDA		
BODY SCR TOP LOADING FIREBIRD	3		ORTHOFIX SPINAL IMPLANTS	Unknown
UDI: No Information		**Assigning Authority:** FDA		
SET SCR FIREBIRD	6		ORTHOFIX SPINAL IMPLANTS	Unknown
UDI: No Information		**Assigning Authority:** FDA		
SCR FIREBIRD CANN ST 7.5X45MM	3		ORTHOFIX SPINAL IMPLANTS	Unknown
UDI: No Information		**Assigning Authority:** FDA		
ROD S PHOENIX PLROD W/HEX 70MM	1		ORTHOFIX SPINAL IMPLANTS	Unknown
UDI: No Information		**Assigning Authority:** FDA		

Implanted Date: 10/22/19 **Target Site:** Spine Cervical

Description	Quantity	MRI	Company	Model
ROD PRE LORDOSED W/HEX TPR 75MM PHOENIX	1		ORTHOFIX SPINAL IMPLANTS	Unknown
UDI: No Information		**Assigning Authority:** FDA		

Implanted Date: 4/25/19 **Target Site:** Hip Right

Description	Quantity	MRI	Company	Model
CUP ACET PINN SECTOR II 50	1		DEPUY ACE	Unknown
UDI: No Information		**Assigning Authority:** FDA		
CMPNT NEU PINN ALTRIX 28X50MM	1		DEPUY ORTHOPEDICS	Unknown
UDI: No Information		**Assigning Authority:** FDA		

Description	Quantity	MRI	Company	Model
STEM FEM STD COLLARED SZ8	1		SYNTHES TRAUMA	Unknown
UDI: No Information		**Assigning Authority:** FDA		
HEAD FEM 12/14 CERAMIC 28MM P1.5MM	1		DEPUY ORTHOPEDICS	Unknown
UDI: No Information		**Assigning Authority:** FDA		