Name: Sellers, Larry J	**Home Phone:** (612)884-8276
Address: 500 N. 5th Street Minneapolis, MN 55401	**Office Phone:** (612)294-4441
Patient ID: 0000-6666	**Mobile Phone:** (763)406-4359
Birth Date: 05/21/1991	**Status:** Active
Gender: Male	**Martial Status:** Single
Contact By: Phone	**Race:** White
Soc Sec No: 111-22-3333	**MRN:** E0-123-1234
Email: ritn@nmdp.org	**External ID:** E0-123-1234

Vital Signs

Ht: 72 in. **Wt:** 181 lbs. **T:** 100.6 degF. **T site:** oral **P:** 70 **Rhythm:** regular **R:** 16 **BP:** 118/70

Allergies

NKDA

Past Medical History

None

Medications

Ondansetron (Zofran) 8 mg PO q 8h PRN
Acetaminophen 650 mg PO q 8h PRN
Filgrastim (Neupogen) 820mcg SC q daily

Review of Systems

General: pt states he has felt fatigued; started about 1 day after the incident. Pt states he has had a fever; started the evening of the incident.
Eyes: denies blurring, diplopia, irritation, discharge
Ear/Nose/Throat: denies ear pain or discharge, nasal obstruction or discharge, sore throat
Cardiovascular: denies chest pain, palpitations, paroxysmal nocturnal dyspnea, orthopnea, edema Respiratory: denies coughing, wheezing, dyspnea, hemoptysis
Gastrointestinal: pt stated he vomited the evening of the incident, but stated he thought it was due to nerves; vomiting has continued once per day since the incident.
Genitourinary: denies hematuria, frequency, urgency, dysuria, discharge, impotence, incontinence
Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain
Skin: denies rashes, itching, lumps, sores, lesions, color change
Neurologic: Pt states he has had headaches (moderate) since the night of the incident.
Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping, suicidal ideation, hallucinations, paranoia
Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance

Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats
Allergic/Immunologic: denies urticaria, hay fever, frequent UTIs; denies HIV high risk behaviors

Physical Exam

General Appearance: no acute distress
Eyes: conjunctiva and lids normal, PERRLA, EOMI, fundi WNL
Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL
Respiratory: clear to auscultation and percussion, respiratory effort normal
Cardiovascular: regular rate and rhythm, S1-S2, no murmur, rub or gallop, no bruits, peripheral pulses normal and symmetric, no cyanosis, clubbing, edema or varicosities
Skin: clear, good turgor, color WNL, no rashes, lesions, or ulcerations

Labs

CBC #1 [for time/date use yesterday's date and 10:00 AM]
WBC: 3.0
HGB: 0.9
Platelets: 78
Lymphs (absolute): 1.00

CBC #2 [for time/date use today's date and 10:00 AM]
WBC: 2.7
HGB: 0.8
Platelets: 73
Lymphs (absolute): 0.70

Radiation dose assessment method: Lymphocyte depletion kinetics
Estimated whole body dose from exposure: 2.3 Gy

Plan

Admission Status: Outpatient

Orders:
CBC w/diff and platelets 24 hours, x 10 days, until further orders
Comprehensive Metabolic Panel (CMP) / Chem 14 24 hours, x 5 days, until further orders

Education/Conseling (time): 15 minutes
Coordination of Care (time): 45 minutes
Follow-up/Return Visit: 1 day

Notes

Patient stated he was outside of his home when the explosion happened and spent approximately 30min watching the mushroom cloud and talking with his neighbor. Throughout

the day he went outside multiple times to see what's going on and estimates he was outside for 2 hours.