Name: Zhao, Ryder K	**Home Phone:** (612)884-8276
Address: 500 N. 5th Street Minneapolis, MN 55401	**Office Phone:** (612)294-4441
Patient ID: 0000-3333	**Mobile Phone:** (763)406-4359
Birth Date: 05/21/2011	**Status:** Active
Gender: Male	**Martial Status:**
Contact By: Phone	**Race:** Asian
Soc Sec No: 777-88-9999	**MRN:** E0-123-4567
Email: ritn@nmdp.org	**External ID:** E0-123-4567

Vital Signs

Ht: 54 in. **Wt:** 70 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) 4 mg PO q 8h PRN
Acetaminophen 320 mg PO q 8h PRN
Filgrastim (Neupogen) 310mcg SC q daily

Review of Systems

General: Pt's mother states he has felt fatigued; started about 1 day after the incident. Mother 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's mother stated he vomited the evening of the incident, but stated she 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's mother 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

Tests

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
Disposition:

Notes

Patient’s mother stated he was inside the home when the explosion happened. They left Throughout the day he went outside multiple times to see what’s going on and estimates he was outside for 2 hours.