HomeCentris Healthcare LLC memo...

Patient: Yvonne Miller
DOB: 11/04/1949

Subject: Discharge Summary - SN

Submitted By: Karen Hill Campbell

Date: 08/20/2025

Agency Rep: Karen Hill Campbell **Rep Phone:** 410-321-8448

Memo:

Admitted on: 06/28/2025

Emergency Contact: Damien, 443-468-1426

Diagnoses:
Hypertensive heart disease with heart failure (I11.0),Unspecified diastolic (congestive) heart failure (I50.30),Type 2 diabetes mellitus without complications (E11.9),Pain in right knee (M25.561),Other chronic pain (G89.29),Unspecified atrial fibrillation (I48.91),Obstructive sleep apnea (adult) (pediatric) (G47.33),Depression, unspecified (F32.A),Hyperlipidemia, unspecified (E78.5),Long term (current) use of anticoagulants (Z79.01)

Medications:
Acetaminophen - Acetaminophen 325 mg 325 Mg,Give 2 tablet by mouth every 6 hours
Atorvastatin Calcium - Atorvastatin Calcium 10 Mg, Give 1 tablet by mouth at bedtime
Citalopram Hydrobromide - Citalopram Hydrobromide eq 10 mg base 10 Mg, Give 1 tablet by mouth once a day
Furosemide - Furosemide 40 mg 40 Mg, Give 1 tablet by mouth once a day
Gabapentin - Gabapentin 600 mg 600 Mg, Give 1 tablet by mouth three times a day
Ipratropium - Ipratropium Bromide 0.5-2.5 Mg/3Ml, 1 Unit inhale inhalant every 6 hours
Lidocaine - Lidocaine 4 % Patch, Apply to right knee topical once a day
Loperamide Hydrochloride - Loperamide Hydrochloride 1 mg/5ml 1 Mg/7.5 Ml, Give 15 ml by mouth every 8 hours
Metoprolol Tartrate - Metoprolol Tartrate 25 mg 25 Mg, Give 1 tablet

by mouth twice a day
Pradaxa - Dabigatran Etexilate Mesylate 150 mg 150mg; 1 cap by mouth twice a day
Vitamin D3 - Alpha-Tocopherol Acetate; Ascorbic Acid; Biotin; Cholecalciferol; Cyanocobalamin; Dexpanthenol; Folic Acid; Niacinamide; Pyridox 1.25 Mg(50000 UT), Give 1 capsule by mouth once a week

Services Provided:
cough/deep breathing exercises,physician-ordered wound care

lifestyle modifications to manage cardiac condition including symptom management, diet changes, regular exercise, getting enough sleep,lifestyle modifications to manage cardio-respiratory condition including diet changes and regular exercise; strategies to control shortness of breath and home remedies to keep lungs healthy,lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings, physical exercise plan and diet,how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain, teach relaxation skills and diversional activities,depression-prevention strategies including avoidance of isolation, healthy eating and sleeping habits, identification of activities that bring pleasure, preventive care,strategies to minimize fatigue and exhaustion including work simplification, energy conservation, lifestyle changes and diet,teach patient how to self-administer medications as prescribed,related medication(s) purpose and schedule,symptoms requiring physician notification,how to take the patient's blood pressure and record the reading

Follow-up Action:

Follow-up Memo: SN discharge

Patient at max goals with HH. Patient is obese requiring assistive device for ambulatory safety. Patient continues to report Family issues. Patient ambulating with rollator. Patient reports last BM was today. Sleep reported is good. Blood pressure stable. Patient denies chest pain. Random BS= 132. Patient instructed on diabetes management and monitoring. Patient reports right leg pain 3. Patient lying in the bed. Patient instructed to report weight gain of 2-5 within 24 hours period to nurse and provider. No weights recorded. hydration noted. Patient reports she had video tele visit with provider last week. Medications reviewed. Patient verbalized understanding of action of each medication. Patient able to read label of medications for directions. No abnormal bleeding reported. No falls reported. Patient instructed on incentive spirometer and demonstrated proper use. Tylenol for pain. Cough resolved. Lungs on auscultation clear. Patient able to speak in complete sentences without shortness of breath. Prescription for inhalation therapy for nebulizer. No falls. No wounds

noted. No pain with urination. Patient reports appetite is okay due to family issues. No abnormal bleeding reported.

This memo is for your records.