SENSITIVE DOCUMENTS

Document Type: Child Protection Team IP Consult
Date/Time: 9/27/2017 16:00 EDT
Electronically Signed By: [redacted] (9/28/2017 15:01 EDT); [redacted] (9/28/2017 13:26 EDT); [redacted] (9/28/2017 11:14 EDT)

Child protection team note

Patient: **PETRO, BRANDEN** MRN: [redacted] FIN: [redacted]
Age: **15 years** Sex: **M** DOB: **02/17/2002**
Associated Diagnoses: None
Author: [redacted]

Child protection team note

Chief Complaint
altered mental status, malnutrition

History of Present Illness
Branden is a 15 year old male with history of intractable seizure disorder, developmental delay, and ulcerative colitis admitted for worsening of altered mental status and malnutrition. intractable seizure disorder began when 8 years old. he was diagnosed with FIRES (febrile infection-related epilepsy syndrome). branden was admitted to cumberland hospital for children on september 6 2017 for better control of seizures and ulcerative colitis. per mom on september 6 he was at baseline (he was able to walk, talk fluently, feed himself) and he weighed 88 pounds. on september 7 branden was asking nursing to see his mom. per mom this is the last time branden spoke. mom saw branden on september 11 and branden had an abrasion over his left eye and bruising on his arms and legs. mom was told changing story by nursing about how branden was injured. she was told he had a seizure and fell from his bed. she was also told he fell when no one was looking. when mom saw branden on september 11 he was not talking or eating. per mom on september 11 he weighed 78 pounds (he had lost 10 pounds). during his stay at cumberland branden began requiring diapers and began requiring an NG tube for feeds (he could use bathroom and feed himself at baseline). on september 22 mom initiated transfer of branden to VCU emergency department. mom has suspicion of physical abuse at cumberland given his injuries and inconsistent story from nursing. mom has suspicion of sexual abuse as branden becomes combative with bathing and with the genitourinary exam (which is not his baseline).

mom has pictures of branden from before his admission to cumberland which show him alert and interactive. branden is now not verbal and not interactive which mom believes is a result of his stay at cumberland.

on september 27 the medical director at cumberland (dr davidow) visited patient and mom at bedside. mom expressed concern that dr davidow was allowed to visit branden given that dr davidow is no longer his doctor and given mom's suspicions of abuse. mom would like to make it clear that dr davidow should not be allowed to visit branden.

Past Medical History

intractable seizure disorder

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developmental delay
ulcerative colitis

Past Surgical History

No Past Surgical History found. This information was current as of 09/27/17 @ 16:18:14.

Physical Examination

VS Range Over the Last 24 Hrs: This info was current as of 09/27/17 @ 16:18:00.

Last Measurements: HT 155.00 cm (61.02") (09/26) WT 35.400 kg (77.88lbs) (09/25) BMI 14.73 BSA 1.23

	Temp (C)	BP	HR	RR	SPO2	Pain/10
Last	36.9(09/27 12:00)	111/58(09/27 08:00)	101(09/27 12:00)	16(09/27 12:00)	98(09/27 12:00)	0(09/27 12:00)
Min	36.2(09/27 04:00)	101/55(09/27 00:00)	73(09/27 00:00)	14(09/26 20:00)	98(09/27 08:00)	0(09/26 20:00)
Max	36.9(09/27 12:00)	114/66(09/26 20:00)	101(09/27 12:00)	19(09/27 00:00)	100(09/26 20:00)	0(09/26 20:00)

General: altered mental status, agitated
Eye: pupils equal and reactive to light
HENT: normocephalic, oral mucosa is moist
Respiratory: lungs are clear to auscultation, respirations are non-labored
Cardiovascular: regular rate, regular rhythm, no murmurs, normal peripheral perfusion, normal cap refill
Gastrointestinal: soft, nontender, nondistended, normal bowel sounds
Genitourinary: normal genitalia for age, **no bruising of penis or scrotum**
Integumentary: warm, dry, **healing abrasion above left eye, bruising on arms bilaterally, bruising on legs bilaterally**
Neurologic: altered mental status, not verbal, not participating with exam

Allergies

Allergies as charted in the allergies profile as of 09/27/17 16:18:40.
NKA

Medications

Home Medications This information was current as OF 09/27/17 @ 16:18:00.

Prescriptions & Documented Meds By Hx:
-clonazepam (clonazePAM 1 mg oral tablet)*(Hx)*: mg, PO, bedtime
-hyoscyamine*(Hx)*:

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-mesalamine*(Hx)*:
-metronidazole (Flagyl)*(Hx)*: PO, three times a day
-perampanel (Fycompa 2 mg oral tablet)*(Hx)*: 2 mg, PO, bedtime

Labs and Studies

Subset of Labs from the (Last 72hrs.) as of 09/27/17 @ 16:18:00.

BMP (09/25 03:30) Na **138** K **4.4** Cl **103** CO2 **32** AG **3** BUN **14** Cr **0.45** Glu **165** Ca **8.4**
BMP (09/25 03:30) Mg **2.3**
BMP (09/25 03:30) PO4 **3.9**
BMP (09/26 05:30) Na **134** K **4.1** Cl **99** CO2 **30** AG **5** BUN **11** Cr **0.40** Glu **133** Ca **8.5**
BMP (09/26 05:30) Mg **2.0**
BMP (09/26 05:30) PO4 **2.7**
BMP (09/27 03:00) Na **133** K **4.5** Cl **98** CO2 **29** AG **6** BUN **11** Cr **0.44** Glu **121** Ca **8.9**
BMP (09/27 03:00) Mg **2.1**
BMP (09/27 03:00) PO4 **3.4**

Assessment and Plan:
Branden is a 15 year old male with history of intractable seizure disorder, developmental delay, and ulcerative colitis admitted for worsening of altered mental status and malnutrition. on exam he appears emaciated which is consistent with malnutrition. per mom he has lost 10 pounds since his admission to cumberland. we will need to get records from cumberland to confirm weight loss. on exam branden had a healing abrasion above left eye, bruising on arms bilaterally, bruising on legs bilaterally. he had no bruising of his penis or scrotum. the abrasion and bruising together with the inconsistent story told to mom raise the suspicion for physical abuse. the genitourinary exam was normal but this cannot be used to exclude the possibility of sexual abuse. it is concerning that dr. davidow was able to visit branden and mom would like to make it clear that this should not be allowed.

seen and discussed with [redacted]

[redacted]
Pediatric Resident [redacted]
[redacted]

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BEGIN ATTENDING DOCUMENTATION

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Teaching physician note: I was NOT present with the resident during the interview & examination of the patient. I personally interviewed the patient & repeated the critical or key portions of the exam. I confirmed/amended the history, exam, assessment and plan as noted.

Hx: 15 yo male who presents with acute weight loss after three week hospitalization at Cumberland that started on September 6. Pt is from Tampa and had been hospitalized at St Josephs there for his diagnosis for one month in August and then Tricare and mom had facilitated this admission to Cumberland._Weight was 88 lbs on admission which was

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verified by the chart sent from Cumberland. Weight on admission here was 78 lbs. Mom reports that he was eating by mouth at the time of admission and had not been on tube feeds except for a brief period of time in the beginning of admission to St Josephs when he was first diagnosed with UC. Pt was originally admitted to the nonacute floor at Cumberland. Mom met with staff and patient was transferred to the acute unit and started on tube feeds. Mom ultimately requested transfer by ambulance from Cumberland to here on the night of September 22. Pt was noted to have abrasions and bruising present by mom thruout his stay. There was no clear consistent history offered to mom regarding etiology. Pt does still have scabbing lesions over left eyebrow and faint abrasion over the right eyebrow and bruising of the left arm at the wrist. Mom very concerned about patients current condition. Mom did verbalize concerns for sexual abuse secondary to his reaction to bathing and because of something said to her by staff at the long term care facility but there is no direct history or symptoms associated with that concern.

Exam: 15 yo male who is nonverbal and does not make eye contact. Rarely he will arouse to sounds and open his eyes and rotate his head but not tracking. Pt is thin. Pt has scab in left eyebrow and abrasion under right eyebrow. CHest CTA CV RRR ABD soft nontender Neuro pt is non verbal not tracking no ambulating. Pt is combative when examining his gu area with good purposeful strength and grasp. Pt does not have bruising or injury to his penis or scrotal region. Pt has bruising on the volar aspect of the right wrist and some linear bruising over the left lateral upper arm. Pt has bruising at the elbow on the left. Pt has bruising of the left ankle _

Assessment/Plan: Records obtained from Cumberland and weight confirmed. I spoke to Dr [redacted] and would request records from St Josephs in Tampa to get an objective assessment of his pre admission status. Do not think this burden should be on the mother in terms of what has effectively changed since his long term care hospitalization. Mom has reported her concerns to Tricare and VDH and JCAHO. Photographs taken by me of his soft tissue injuries.
Significant weight loss of more than 10% body weight during long term care hospitalization in the face of progressive neurologic disease seizure disorder and ulcerative colitis.
Awaiting outside records from previous acute care hospital_

Date of Service (if different from date of note): _

In addition to the above statement, the attending must add at least one element from each of the required components of the service. For example, if a new patient visit, the attending must add one element of each from history, exam, and plan.

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END ATTENDING DOCUMENTATION

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Electronically signed by
[redacted] MD [redacted]