SAMPLE ADMISSION NOTE — CARDIOLOGY

1 Patient Information

1 ADMISSION DETAILS

Name
Raymond G. Fletcher

Date of Admission
05/06/2026

DOB / Age / Sex
09/05/1947 | 78M

Date of Service
05/06/2026

MRN
CARD-2024-5510

Admitting Provider
Dr. Olivia S. Park, MD

Attending
Dr. Marcus T. Hendricks, MD (Cardiology)

Source of Admission
Emergency Department — direct transfer to cardiology floor

CC Chief Complaint

2 PRIMARY REASON FOR ADMISSION

Patient presents with progressive dyspnea on exertion over 5 days, orthopnea requiring 3-pillow positioning, and 12 lb weight gain over the past 10 days, consistent with acute decompensated heart failure.

HPI History of Present Illness

3 HPI LEADING TO HOSPITALIZATION

Mr. Fletcher is a 78-year-old male with a well-established history of HFpEF (EF 55%, last echo 8 months ago), hypertension, atrial fibrillation on anticoagulation, and CKD stage 3a who presents via ED with a 5-day history of worsening dyspnea on exertion. Baseline he can walk one block without symptoms; over the past 5 days he has become dyspneic walking from his bedroom to the bathroom. He has slept upright in his recliner for the past 3 nights due to orthopnea. He notes bilateral ankle swelling that his wife describes as 'pitting.' He reports a weight gain of approximately 12 lbs over the past 10 days documented on his home scale. He denies fever, chills, or recent URI. He reports no chest pain or palpitations. He was seen in cardiology clinic 3 weeks ago with stable symptoms; his furosemide dose was reduced from 40 mg to 20 mg daily due to a creatinine bump of 0.3 mg/dL. He attributes the decompensation partly to dietary indiscretion over the holiday weekend — elevated sodium intake estimated at 4,000–5,000 mg/day. He is on furosemide 20 mg, carvedilol 6.25 mg BID, and lisinopril 5 mg daily. He had no prior hospitalizations for HF in the past 18 months.

ROS Review of Systems

4 SYSTEM REVIEW

Constitutional: Significant fatigue and weakness; no fever or chills. CV: Dyspnea, orthopnea, leg edema; no chest pain, palpitations. Respiratory: Dyspnea at rest and exertion; no hemoptysis; mild nocturnal cough. GI: Reduced appetite, mild nausea; denies abdominal pain. GU: Decreased urine output over past 3 days. MSK: Bilateral leg swelling and heaviness. Neuro: No dizziness, syncope, or focal deficits.

H Past History

5a PAST MEDICAL HISTORY

1. HFpEF — EF 55%, last echo 8 months ago. 2. Persistent atrial fibrillation — on apixaban. 3. Hypertension — long-standing. 4. CKD stage 3a — baseline Cr 1.4. 5. T2DM — controlled on metformin. 6. Hyperlipidemia — on statin. 7. History of left BKA repair 2019.

5b **PAST SURGICAL HISTORY**

CABG x3 (2008). Left femoral endarterectomy (2019). Cholecystectomy (1995).

5c **MEDICATIONS**

Furosemide 20 mg PO daily. Carvedilol 6.25 mg PO BID. Lisinopril 5 mg PO daily. Apixaban 5 mg PO BID. Atorvastatin 40 mg PO nightly. Metformin 500 mg PO BID. Aspirin 81 mg PO daily.

5d **ALLERGIES**

Penicillin — anaphylaxis. Contrast dye — urticaria (requires premedication).

5e **FAMILY & SOCIAL HISTORY**

Father: Coronary artery disease, died of MI at 65. Mother: Hypertension, stroke at 78. | Retired postal worker. Lives with wife of 54 years in rural Alabama. Nonsmoker for 20 years (60 pack-year history prior). Denies alcohol and illicit substances. Dietary sodium intake poorly controlled. Limited ambulation at baseline — walks with cane.

V Vitals (Admission)

V **VITAL SIGNS**

Temperature
97.9°F

Blood Pressure
162/96 mmHg (right arm, supine)

Heart Rate
88 bpm (irregularly irregular)

Respiratory Rate
22 breaths/min

SpO_2
91% on room air → 96% on 4L NC

Weight

PE Physical Examination

6 **COMPREHENSIVE ADMISSION EXAM**

General: Elderly male in moderate respiratory distress, diaphoretic, sitting upright. HEENT: JVD estimated 14 cm at 45°. Oropharynx clear. CV: Irregularly irregular rhythm; S3 gallop present at apex; 2/6 systolic murmur at RUSB. Respiratory: Bilateral basilar crackles extending to mid-lung fields; dullness to percussion at bilateral bases; mild accessory muscle use. Abdomen: Mild RUQ tenderness consistent with hepatic congestion; hepatomegaly 2–3 cm below costal margin; ascites suspected but not confirmed. MSK: 3+ bilateral pitting edema to the mid-thigh. Skin: Cool, mottled extremities distally; no ulcerations.

L Lab & Imaging

7a **LABORATORY STUDIES**

BNP: 1,840 pg/mL (markedly elevated). BMP: Na 132, K 5.1, Cl 96, CO2 18, BUN 44, Cr 1.9 (baseline 1.4), Glucose 164. CBC: WBC 9.8, Hgb 10.4 (mild anemia), Plt 188. LFTs: AST 58, ALT 46 (mildly elevated, consistent with hepatic congestion). PT/INR: 2.1 (therapeutic on apixaban per bridging calculation). Troponin I: 0.06 ng/mL (mildly elevated, demand ischemia vs chronic elevation).

7b **IMAGING / ECG**

CXR (portable): Marked cardiomegaly. Bilateral interstitial and alveolar infiltrates consistent with pulmonary edema. Bilateral pleural effusions, moderate on the right, small on the left. Kerley B lines noted at bilateral bases. Mediastinum unremarkable.

A Assessment

8 **ADMISSION ASSESSMENT**

Mr. Fletcher is a 78-year-old male with HFpEF presenting with acute decompensated heart failure (ADHF) precipitated by dietary sodium indiscretion and recent furosemide dose reduction. His presentation meets criteria for ADHF with evidence of volume overload: elevated JVP, pulmonary edema

on CXR, BNP 1,840, 12 lb weight gain, and bilateral pleural effusions. Worsening renal function (Cr 1.9 from baseline 1.4) indicates cardiorenal syndrome type 1. Inpatient admission is warranted for IV diuresis, hemodynamic monitoring, and optimization of outpatient medical therapy. Risk stratification is high given age, CKD, and degree of decompensation.

P Plan

9 INITIAL INPATIENT MANAGEMENT

1. IV furosemide 80 mg bolus x1, then 20 mg/hr continuous infusion; target UOP >200 mL/hr. 2. Strict I&O and daily weights. 3. 2g sodium, fluid restriction 1.5L/day diet. 4. Hold lisinopril and metformin during acute kidney injury. 5. Continue carvedilol at current dose if HR and BP tolerated. 6. Continue apixaban — no dose adjustment at this creatinine level. 7. Repeat BMP and BNP Q12h during IV diuresis. 8. Cardiology to review echo — repeat TTE in AM to assess current EF and new wall motion abnormalities. 9. Supplemental O2 to maintain SpO2 ≥95%. 10. DVT prophylaxis not indicated on therapeutic anticoagulation. 11. Telemetry monitoring for AF with RVR.

D Disposition & Code Status

10 LEVEL OF CARE & DIRECTIVES

Disposition
Admission to telemetry unit (stepdown). ICU not required at this time. Reassess in AM.

Code Status
DNR/DNI — confirmed with patient and wife. POLST on file from previous admission (2024). Advance directive naming wife as healthcare proxy.

TIME DOCUMENTATION & BILLING

Total Time
65 minutes

E/M Level
99223 — Initial Hospital Care, High Complexity

Counseling Time
18 minutes

Basis
Medical Decision Making — High Complexity

Primary Dx Code
I50.31 — Acute on chronic diastolic heart failure

Secondary Dx Code(s)
N17.9 — Acute kidney injury; I48.19 — Persistent AFib; I10 — HTN; E11.65 — T2DM with hyperglycemia

PROVIDER NAME
Dr. Olivia S. Park, MD

CREDENTIALS
MD — Cardiology

DATE & TIME
05/06/2026