1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME
Javier M. Castillo

DOB
01/09/1982

AGE/SEX
44 / Male

MRN / PATIENT ID
JMC-4410287

DATE OF SERVICE
11/03/2026

PROVIDER
Helena Voss

CREDENTIALS
MD, FCCM

VISIT TYPE
Daily ICU Progress Note — ICU day 5

CARE SETTING
MICU, bed 12

PRIMARY TEAM
Medical ICU (Team B)

CONSULTING SERVICES
General surgery, GI, nephrology, nutrition, social work

PRIMARY CARE PROVIDER, IF APPLICABLE
None established

REFERRING PROVIDER, IF APPLICABLE
Owen Patel, MD (Emergency Medicine)

CODE STATUS
Full code

DECISION-MAKER / HEALTHCARE PROXY, IF APPLICABLE
Lucia Castillo (wife) — surrogate

INTERPRETER USED, IF APPLICABLE
Spanish interpreter (in person, #2291) for family update

CC CHIEF COMPLAINT

2 REASON FOR ICU MANAGEMENT

Ongoing ICU management of acute hypoxemic respiratory failure from moderate ARDS on mechanical ventilation, with vasopressor-dependent distributive shock and stage 2 AKI, from severe alcohol-associated necrotizing pancreatitis.

S SUBJECTIVE

3 INTERVAL HISTORY & ICU COURSE

3a PRESENTATION & INTERVAL EVENTS

Reason for Critical Care Evaluation:

Ongoing ICU management of multi-organ failure (respiratory, cardiovascular, renal) from severe acute pancreatitis.

Interval Events / Overnight Events:

FiO2 weaned from 0.55 to 0.45 overnight; PEEP held at 12. Norepinephrine down from 0.12 to 0.05 mcg/kg/min. Tmax 38.4 °C at 02:00 — blood cultures repeated. Urine output 0.4 mL/kg/h. Bladder pressure 16 mmHg (was 19). Arterial line re-sited (R radial) after waveform dampening. No arrhythmias, bleeding, or transfusion.

History of Present Illness:

Daily heavy alcohol use (about 12 drinks/day). Presented 10/30 with 2 days of epigastric pain radiating to the back and vomiting. ED: HR 128, BP 84/50, SpO2 89% RA, lipase 4,820 U/L, lactate 4.1. Received 3 L LR, started norepinephrine, intubated on hospital day 2 for worsening hypoxemia. CT day 3: 40% pancreatic necrosis, no gas. Admitted to ICU for shock and respiratory failure.

3b ORGAN-SYSTEM STATUS

Respiratory Status:

Intubated (day 4), volume control. P/F improved from 128 to 182. Proned 16 h on days 2 and 3; supine since yesterday. Moderate thin white secretions. Synchronous on current sedation.

Hemodynamic Status:

Distributive shock (sterile inflammation) improving. Norepinephrine 0.05 mcg/kg/min, MAP 68–74. Lactate 4.1 → 2.6 → 1.4. Sinus tachycardia 104. Not fluid responsive on POCUS today.

Neurologic Status:

Lightly sedated, RASS –1; opens eyes to voice and squeezes hands on command. Pupils equal and reactive. No seizures. Cisatracurium stopped day 3.

Infectious / Sepsis History:

New fever overnight. Admission blood cultures negative. No antibiotics to date (sterile necrosis). Concern for infected necrosis, VAP, or line infection. Central line day 5. Not immunosuppressed.

Cardiac History and Symptoms:

No known cardiac history. Troponin peaked at 0.09 (demand). EKG: sinus tachycardia, no ischemic changes. TTE day 2: LVEF 60%, normal RV.

Renal / Fluid Status:

AKI stage 2 (Cr 0.9 baseline → 2.4 peak → 2.1 today). Net +9.8 L since admission. No CRRT yet. Potassium 4.6, bicarbonate 20.

Gastrointestinal / Nutrition Status:

Nasojejunal tube placed day 3; trophic feeds at 20 mL/h, tolerated. Abdomen distended. No bowel movement since admission. Mild transaminitis (AST 88, ALT 54); bilirubin 1.6. On pantoprazole.

Hematology / Bleeding / Thrombosis:

Hb 9.4 (stable). Platelets 118. INR 1.3. No bleeding. Heparin 5,000 units SC every 8 h.

Endocrine / Metabolic Status:

Insulin infusion; glucose 140–180. Ionized calcium 1.02 (repleted). Triglycerides 210 (not causative). Magnesium and phosphate repleted.

Pain, Sedation, and Delirium:

Fentanyl 75 mcg/h plus propofol 20 mcg/kg/min. RASS goal 0 to –1. CPOT 1. CAM-ICU negative today. High alcohol-withdrawal risk (last drink 10/29) — phenobarbital load given day 1.

Lines, Tubes, Drains, and Devices:

ETT 8.0, 24 cm at lip (day 4). R IJ triple-lumen CVC (day 5). R radial arterial line (new, day 0). Foley (day 5). Nasojejunal tube (day 3). OGT to low suction.

3c MEDICATIONS & BACKGROUND

Medication and Infusion History:

Norepinephrine 0.05 mcg/kg/min, fentanyl 75 mcg/h, propofol 20 mcg/kg/min, insulin infusion, heparin SC, pantoprazole 40 mg IV daily, thiamine 500 mg IV TID, folate, multivitamin, chlorhexidine oral care. No home medications.

Past Medical History:

Alcohol use disorder (severe); one prior withdrawal seizure (2022). No prior pancreatitis or ICU stay. Ultrasound shows fatty liver, no cirrhosis. Smoker, 15 pack-years. Fully independent; works as a roofer.

Goals of Care / Family Communication:

Full code. Wife (Lucia) is surrogate; no advance directive. Family meeting yesterday with interpreter: discussed severity, prolonged ICU course, possible necrosectomy. Family wants full treatment. Palliative care not yet involved.

Pertinent Negatives:

No new neurologic deficit, seizure, active bleeding, arrhythmia, or abdominal rigidity. Shock is improving, not worsening.

ROS CRITICAL CARE REVIEW OF SYSTEMS

4 FROM NURSING, CHART & OBSERVATION

Dyspnea, cough, sputum, hypoxemia, ventilator intolerance, or increased work of breathing
Positive — hypoxemia (improving), moderate secretions. Ventilator synchronous.

Chest pain, palpitations, syncope, edema, hypotension, or arrhythmia symptoms
Positive — hypotension on low-dose norepinephrine; generalized edema. No arrhythmia.

Fever, chills, infection symptoms, wounds, device-related symptoms, or sepsis concern
Positive — new fever 38.4 °C. Line sites clean.

Altered mental status, agitation, delirium, seizure activity, weakness, or focal neurologic deficits
Sedated; CAM-ICU negative. No seizure or focal deficit.

Abdominal pain, vomiting, diarrhea, ileus, GI bleeding, jaundice, or nutrition intolerance
Positive — distension, ileus, CPOT 1 with abdominal palpation. No GI bleeding.

Oliguria, anuria, edema, electrolyte symptoms, or dialysis-related concerns
Positive — oliguria (0.4 mL/kg/h), edema.

Bleeding, bruising, thrombosis symptoms, transfusion reactions, or anticoagulation concerns
Negative.

Pain, anxiety, sedation effects, withdrawal symptoms, or sleep disturbance
No signs of withdrawal on current sedation; nursing notes poor night sleep.

O OBJECTIVE

5 MONITORING & ORGAN-SYSTEM EXAMINATION

5a VITALS AND MONITORING

TEMPERATURE	BLOOD PRESSURE	MEAN ARTERIAL PRESSURE
38.1 °C (Tmax 38.4)	**112/58 mmHg**	**72 mmHg**

HEART RATE	RESPIRATORY RATE	OXYGEN SATURATION
104 bpm, sinus	24 (set 24)	94%
OXYGEN DELIVERY / VENTILATOR MODE	**FIO2**	**PEEP**
ETT — volume control (AC/VC)	0.45	12 cmH2O
VASOPRESSOR / INOTROPE SUPPORT	**INTAKE / OUTPUT**	**NET FLUID BALANCE**
Norepinephrine 0.05 mcg/kg/min	3,120 / 1,840 mL (24 h)	+1.28 L (24 h); +9.8 L LOS
URINE OUTPUT	**WEIGHT**	**PAIN SCORE, IF APPLICABLE**
0.4 mL/kg/h (680 mL/24 h)	91.2 kg (admit 82.0)	CPOT 1
RASS SCORE, IF APPLICABLE	**CAM-ICU, IF APPLICABLE**	
–1	Negative	

5b EXAMINATION

General Appearance:

Intubated, lightly sedated, calm. Head of bed 30°. Diffusely edematous. Critically ill but improving.

Neurologic:

GCS E3 VT M6. Pupils 3 mm, equal, reactive. Moves all four limbs to command. No tremor or clonus. Off neuromuscular blockade (TOF 4/4).

Cardiovascular:

Tachycardic, regular, no murmur. Warm extremities; capillary refill 2–3 s. 2+ pitting edema. Crisp arterial waveform after re-siting.

Pulmonary:

Synchronous with ventilator. Bilateral crackles, decreased at both bases (L worse than R). No wheeze. Moderate white secretions; weak cough with suction.

Abdomen / Gastrointestinal:

Distended, tense but not rigid. Grimaces with epigastric palpation. Hypoactive bowel sounds. No peritonism. NJ tube secure. No surgical wounds.

Renal / Genitourinary:

Foley draining concentrated amber urine. No dialysis catheter. Bladder pressure 16 mmHg.

Extremities / Vascular:

2+ edema all four limbs. No mottling or cyanosis. Pulses palpable. Calves soft and symmetric. Braden 11 (high risk).

Skin / Wounds:

Warm. Faint left flank ecchymosis (Grey Turner sign), unchanged. Stage 1 sacral pressure injury noted overnight — offloading started. Line sites clean.

Lines / Tubes / Drains:

R IJ CVC (10/30): functioning, dressing intact, no erythema — still needed for norepinephrine. R radial A-line (11/03): functioning. ETT (10/31): secure, cuff 26 cmH2O. Foley (10/30): needed for strict output and bladder pressure. NJ tube (11/01): bridled.

RS RESPIRATORY SUPPORT / VENTILATOR ASSESSMENT

6 VENTILATOR SETTINGS & WEANING

OXYGEN DELIVERY DEVICE	VENTILATOR MODE AND SETTINGS

ETT 8.0 — mechanical ventilation

AC/VC, Vt 420 mL (6 mL/kg PBW), RR 24

FIO2 AND PEEP

0.45 / 12 cmH2O

TIDAL VOLUME AND RESPIRATORY RATE

Exhaled Vt 415 mL; total RR 25

PEAK AND PLATEAU PRESSURES WHEN AVAILABLE

Peak 33 / plateau 26 cmH2O

DRIVING PRESSURE WHEN AVAILABLE

14 cmH2O

MINUTE VENTILATION

10.4 L/min

ABG/VBG INTERPRETATION

7.36 / 44 / 82 / 24 — compensated; P/F 182

SPONTANEOUS BREATHING TRIAL STATUS

Not eligible (PEEP 12, FiO2 0.45, on pressor)

SEDATION AND SYNCHRONY

Light sedation; synchronous

SECRETIONS AND AIRWAY CLEARANCE

Moderate; suction every 2–3 h

CUFF LEAK OR AIRWAY CONCERNS

None

PRONING STATUS IF APPLICABLE

Stopped day 3 (P/F above 150 supine)

TRACHEOSTOMY STATUS IF APPLICABLE

Not indicated now; reassess day 10

WEANING READINESS AND BARRIERS

Barriers: PEEP need, abdominal pressure, fluid overload

EXTUBATION PLAN OR ESCALATION PLAN

Wean PEEP by 2 every 12 h if SpO2 ≥92%; re-prone if P/F below 150

HS HEMODYNAMIC / SHOCK ASSESSMENT

7 PERFUSION & RESPONSE

SHOCK TYPE SUSPECTED

Distributive (SIRS from pancreatitis); rule out new septic component

MAP GOAL

≥65 mmHg

VASOPRESSOR AND INOTROPE DOSES

Norepinephrine 0.05 mcg/kg/min; no inotrope

FLUID RESUSCITATION RECEIVED

6.5 L crystalloid days 1–2; none in last 48 h

FLUID RESPONSIVENESS ASSESSMENT

Not responsive — IVC 2.4 cm, minimal variation; passive leg raise negative

LACTATE TREND

4.1 → 2.6 → 1.4 mmol/L

URINE OUTPUT

0.4 mL/kg/h

EXTREMITY PERFUSION

Warm; capillary refill 2–3 s

CENTRAL VENOUS PRESSURE OR ADVANCED MONITORING IF USED

CVP 14 mmHg; ScvO2 72%

BEDSIDE ULTRASOUND OR ECHOCARDIOGRAM FINDINGS IF AVAILABLE

Hyperdynamic LV, normal RV, small L pleural effusion, B-lines bilaterally

SOURCE CONTROL OR BLEEDING CONTROL STATUS

HEMODYNAMIC RESPONSE TO INTERVENTIONS

Sterile necrosis to date; no drainage yet

Pressor need falling over 48 h

IB ICU BUNDLE / SAFETY ASSESSMENT

8 PREVENTION & SAFETY MEASURES

DVT PROPHYLAXIS

Heparin 5,000 units SC every 8 h + SCDs

STRESS ULCER PROPHYLAXIS

Pantoprazole 40 mg IV daily

VENTILATOR-ASSOCIATED PNEUMONIA PREVENTION

Subglottic suction ETT; VAP bundle

HEAD-OF-BED ELEVATION

30°

ORAL CARE

Chlorhexidine every 12 h; toothbrushing

SEDATION INTERRUPTION / AWAKENING TRIAL WHEN APPROPRIATE

SAT passed this morning

SPONTANEOUS BREATHING TRIAL

Not eligible (see above)

DELIRIUM PREVENTION

Day–night cycle, glasses, family presence

EARLY MOBILITY

Passive ROM; PT to start in-bed cycling

NUTRITION PLAN

NJ trophic feeds, advance to goal

BOWEL REGIMEN

Senna + PEG (start today)

GLYCEMIC CONTROL

Insulin infusion; target 140–180

PRESSURE INJURY PREVENTION

Turns every 2 h, air mattress, sacral foam

FOLEY AND CENTRAL LINE NECESSITY REVIEW

Both still needed (pressor, bladder pressure)

RESTRAINT NECESSITY AND ALTERNATIVES WHEN APPLICABLE

Soft wrist restraints — ETT safety; reviewed

FAMILY COMMUNICATION AND GOALS-OF-CARE REVIEW

Daily update; meeting 11/02 with interpreter

PR PROCEDURES PERFORMED, IF APPLICABLE

9 CRITICAL CARE PROCEDURES

1) Arterial line placement, R radial, 04:40. Indication: dampened L radial line on vasopressor. Consent by phone from wife, with interpreter. Timeout done. Full sterile technique. Ultrasound-guided. 1% lidocaine. 20G catheter, one attempt. Confirmed by waveform. No complications. Old L line removed. 2) Point-of-care ultrasound (heart, lungs, IVC) at 08:15 — findings in Shock Assessment. 3) Ventilator management — settings adjusted as above.

L LABORATORY AND DIAGNOSTIC RESULTS

10 REVIEWED & ORDERED

Laboratory Testing:

WBC 17.8 (was 14.2). Hb 9.4. Platelets 118. Na 138, K 4.6, HCO3 20, BUN 48, Cr 2.1. AST 88, ALT 54, bilirubin 1.6. Lactate 1.4. INR 1.3. CRP 312 (was 286). Procalcitonin 2.9 (was 1.1). Ionized Ca 1.02. Mg 1.9. Phosphate 2.4. Triglycerides 210.

Microbiology:

Admission blood cultures ×2: no growth at 5 days. Repeat blood cultures ×2 (02:00) pending. Mini-BAL sent today. Urine culture sent. MRSA nares negative. Respiratory viral panel negative.

Imaging:

CXR today: bilateral airspace disease, slightly improved; new L lower lobe opacity versus atelectasis; ETT and CVC in good position. CT A/P day 3: 40% necrosis of pancreatic body and tail, acute necrotic collection 9 × 6 cm, no gas. Repeat contrast CT A/P ordered today.

Cardiac Testing:

Telemetry: sinus tachycardia, no arrhythmia. TTE day 2 as above. QTc 462 ms.

Respiratory Testing:

P/F 128 → 156 → 182. Plateau 28 → 26. Driving pressure 16 → 14. EtCO2 38–41.

Neurologic Testing:

None indicated.

Prior Records Reviewed:

ED and ICU notes, surgery and GI consult notes (11/02), nephrology note, 2022 ED visit for withdrawal seizure. No advance directive on file.

A ASSESSMENT

11 CRITICAL CARE CLINICAL INTERPRETATION

44-year-old man, ICU day 5, with severe alcohol-associated necrotizing pancreatitis (40% necrosis) complicated by persistent three-organ failure (SOFA 9, down from 11). Overall improving, but a new fever and rising inflammatory markers need an answer. 1) Respiratory: acute hypoxemic respiratory failure from moderate ARDS — improving (P/F 182, driving pressure 14); not ready for SBT. Added load from abdominal pressure and fluid overload. 2) Shock: distributive, resolving (norepinephrine 0.05, lactate normal). 3) New fever, WBC 17.8, procalcitonin 2.9: concern for infected necrosis (day 5 is early) versus VAP (new LLL opacity) versus CLABSI. Cultures sent. Start empiric antibiotics after cultures. 4) Intra-abdominal hypertension grade I (16 mmHg) — no abdominal compartment syndrome. 5) AKI stage 2 with +9.8 L fluid balance — trial of diuresis now that pressor need is low; CRRT if oliguria or overload worsens. 6) Neuro: no delirium; high withdrawal risk, covered. 7) Nutrition: tolerating trophic NJ feeds. 8) Stage 1 sacral pressure injury. 9) Full code; family engaged. Remains appropriate for ongoing ICU care.

P PLAN

12 MANAGEMENT BY ORGAN SYSTEM

Neurologic Plan:

RASS goal 0 to −1. Analgesia first with fentanyl; lower propofol as tolerated. Daily SAT. CAM-ICU every shift. CIWA not usable while intubated — watch for autonomic signs. Continue high-dose thiamine ×5 days.

Respiratory Plan:

Keep Vt 6 mL/kg PBW, plateau ≤30, driving pressure ≤15. Wean PEEP by 2 every 12 h to 8 if SpO2 ≥92% on FiO2 ≤0.5. Re-prone if P/F below 150. ABG every 12 h and after changes. Daily SBT screen. Chest physiotherapy.

Cardiovascular / Shock Plan:

MAP ≥65; wean norepinephrine off as tolerated. No further fluid boluses unless POCUS shows fluid responsiveness. Lactate if pressor need rises.

Infectious Disease / Sepsis Plan:

Cultures sent (blood ×2, mini-BAL, urine). Start meropenem 1 g IV every 8 h (renally adjusted) — covers infected necrosis and VAP. Add vancomycin only if gram-positive cultures. Contrast CT A/P today to look for gas in the collection. Reassess antibiotics at 48–72 h. Surgery/IR: step-up approach — percutaneous drain if infected; delay necrosectomy to ≥4 weeks if possible.

Renal / Fluid / Electrolyte Plan:

Furosemide 40 mg IV ×1, then infusion 5 mg/h; target net –1 L/day. BMP every 12 h. Replete K, Mg, Ca, and phosphate per protocol. Nephrology following — CRRT if refractory overload, K above 6, or worsening acidosis. Renally dose all medications.

Gastrointestinal / Nutrition Plan:

Advance NJ feeds (peptide-based) by 10 mL/h every 8 h to goal 60 mL/h (25 kcal/kg). No parenteral nutrition. Bladder pressure every 6 h — call if above 20. Bowel regimen. Continue PPI. LFTs daily.

Hematology / Anticoagulation Plan:

Continue SC heparin + SCDs. Transfuse if Hb below 7. Monitor platelets. Watch for splenic vein thrombosis on CT.

Endocrine / Metabolic Plan:

Insulin infusion, target 140–180; switch to basal-bolus once feeds at goal. Acetaminophen for temperature above 38.5 °C (max 2 g/day given liver). Triglycerides weekly.

Lines / Tubes / Devices Plan:

CVC (10/30) — remove once off norepinephrine; culture tip if removed. Foley needed for bladder pressure. A-line (11/03) new. ETT day 4. Dates on whiteboard.

Skin / Wound / Mobility Plan:

Wound care nurse for stage 1 sacral injury. Turns every 2 h, air mattress. PT/OT for in-bed mobility. Reassess restraints every shift.

Medication Plan:

Start meropenem and furosemide. Continue thiamine, folate, PPI, SC heparin, insulin. Pharmacy to dose meropenem for AKI. Track propofol triglycerides. No home medications.

Procedural Plan:

IR-guided percutaneous drain if CT shows gas or FNA is positive — consent from wife with interpreter. Hold heparin 12 h before procedure.

Goals of Care / Communication Plan:

Full code confirmed. Daily update to wife with Spanish interpreter. Discussed new fever and possible drain today. Offer palliative care for symptom and family support given expected long stay.

Disposition Plan:

Remain in MICU. No isolation. Expect prolonged ICU stay. Alcohol use disorder treatment and social work involvement before discharge.

F FOLLOW-UP

13 ICU REASSESSMENT

Reassess at 16:00 after CT A/P and diuretic response. ABG and BMP at 18:00. Culture review at 24 and 48 h; antibiotic timeout 11/05. Surgery and IR huddle after CT. Family update this evening. Daily SBT screen.

TB TIME DOCUMENTATION & BILLING

14 CRITICAL CARE TIME DOCUMENTATION

TOTAL CRITICAL CARE TIME

110 minutes

TIME EXCLUDES SEPARATELY BILLABLE PROCEDURES

Yes

FAMILY MEETING / GOALS-OF-CARE TIME, IF APPLICABLE

20 minutes (with interpreter)

PROCEDURE TIME, IF SEPARATELY DOCUMENTED

15 minutes (arterial line)

VENTILATOR MANAGEMENT TIME, IF APPLICABLE

included in critical care time

CARE COORDINATION TIME

15 minutes (surgery, IR, nephrology)

RECORDS REVIEW TIME, IF APPLICABLE

10 minutes

Document that critical care time was spent in direct management of life-threatening organ dysfunction when applicable.

I personally spent 110 minutes of critical care time, not counting separately billable procedures, managing life-threatening respiratory, circulatory, and renal failure. This included ventilator and vasopressor titration, review of data, bedside exam, and decisions on empiric antibiotics and source control.

14a BILLING CONSIDERATIONS — CRITICAL CARE / ICU CODING

CRITICAL CARE CODE(S)

99291 ×1, 99292 ×1

E/M LEVEL, IF APPLICABLE AND NOT BILLED AS CRITICAL CARE

Not applicable

PROCEDURE CODE(S), IF APPLICABLE

36620 (arterial line); 76604 (chest ultrasound)

VENTILATOR MANAGEMENT CODE(S), IF APPLICABLE

Bundled into critical care

CENTRAL LINE / ARTERIAL LINE / INTUBATION / CHEST TUBE CODE(S), IF APPLICABLE

36620

BASIS FOR BILLING

Critical care time + Procedure-based

ICD-10 DIAGNOSIS CODES

K85.21 — Alcohol-induced acute pancreatitis with uninfected necrosis

[SECONDARY ORGAN FAILURE / SHOCK / SEPSIS / RESPIRATORY / METABOLIC DIAGNOSIS CODE(S), IF APPLICABLE]

J80 — ARDS; J96.01 — Acute respiratory failure with hypoxia; R65.11 — SIRS of non-infectious origin with acute organ dysfunction; N17.9 — Acute kidney failure; F10.20 — Alcohol dependence; L89.151 — Pressure ulcer of sacral region, stage 1

SO

SIGNATURE

15 PROVIDER SIGN-OFF

PROVIDER NAME	CREDENTIALS	SPECIALTY
Helena Voss	MD, FCCM	Critical Care Medicine

DATE	TIME
11/03/2026	13:45

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