ICE Case Study

ICE LEARNING CENTER Skilled Nursing Facility / Rehabilitation Unit Medical Record			Name: Dr. T Age: 83 Gender: Male Patient ID: 028
Admit Date 8/23	Admitting Physician *Dr. Medical	Family / Caregiver Lives with wife, adult daughter who lives nearby is involved in care	Admitting Diagnosis Severe spinal stenosis with spinal cord compression
Date of Onset 7/13	Employment Status Full-time	Employer / Occupation M.D. (Pathologist)	Treatment Diagnosis C3-C7 laminectomy and fusion (7/13); post-op incomplete quadriplegia
Medications *Gabapentin; pain meds prn		Insurance Medicare A	Secondary Diagnosis Neurogenic bowel and bladder, post-op anemia

History of Current Condition / Surgery

History of worsening spinal stenosis and spinal cord compression for at least 2 years, with symptoms of paresthesia and decreasing strength. Patient declined surgery and continued to work until condition had significant impact on function. C3-C7 laminectomy and fusion (7/13) followed by in-patient rehabilitation (2 weeks) and return home. Admitted to SNF rehab unit following decline in function and fall at home.

Precautions

*Cervical precautions and Miami J use discontinued upon admission to SNF/rehab by M.D. (approx. 6 weeks post-op). Fall precautions.

Past Medical / Surgical History

HTN, R shoulder rotator cuff tear, R adhesive capsulitis, R shoulder tendinitis; falls

Prior Level of Function

Before worsening spinal cord compression, was working as pathologist with control over work tasks and environment. Had been using folding wheeled walker. Performed most ADLs independently, with assist for bathing.

Since returning home after rehabilitation, function has declined. Patient became non-ambulatory and needed significant assistance with transfers and ADLs.

Home Situation / DME

*Walker (folding, wheeled), 3-in-1 commode (used over toilet), tub transfer bench

*Background information created to complete medical history.

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