26 de abril del 2022

Comisión de Asuntos de Vida y Familia
Presidenta
Joanne Rodríguez Veve

"Ley para la protección del Concebido en su Etapa Gestacional de Viabilidad"; y para otros fines relacionados." Proyecto del Senado 693.

Lymari Ocasio Pérez (madre); Bachillerato en Artes, Justicia Criminal.

Luis A. Scharón Cruz (padre); Empleado de la AEP.

Padres de Lilianis A. Scharón Ocasio, de quien testificaremos nuestra experiencia personal de nuestro proceso de recuperación, ante un nacimiento prematuro de 27 semanas de gestación de nuestra hija. También adjuntamos documentos "Discharge Summary" provistos por Ashford Presbyterian Community Hospital.

Reciban nuestro cordial saludo honorables senadores, funcionarios y público presente.

Desde el comienzo de mi embarazo los exámenes médicos indicaban que tenía Diabetes Gestacional. Recibí cuidado prenatal de mi Ginecólogo-Obstetra y Nutricionista para controlar la condición. El 11 de septiembre de 2012, comencé a tener contracciones fuertes en mi hogar, por lo que mi esposo, Luis A. Scharón Cruz y yo, salimos al hospital. En el estacionamiento de sala de emergencia comenzó la labor de parto, expulsé abundante líquido amniótico y sentía a mi bebé en la canal vaginal. Mientras todo esto sucedía mi esposo, buscaba al personal médico para atender la situación.

Esa tarde a las 2:14 p.m., nació Lilianis A. Scharón Ocasio, en el estacionamiento de sala de emergencia del hospital. Inmediatamente la enfermera que logró llegar a tiempo observó que Lilianis salió en posición "Breech", o de nalgas, lo cual disminuye las probabilidades de sobrevivir para un bebé prematuro. Observé algo peculiar, y fue que al Lilianis inmediatamente nacer buscaba respirar abriendo su boca constantemente. Llegó la doctora de turno de Sala de Emergencia quien apresuradamente cortó el cordón umbilical y soplando su carita, se llevó a la bebé al interior del hospital.

Mientras yo era tratada en sala de recuperación en el área de maternidad, y se me informó que las primeras 24 horas de vida eran sumamente importantes; mi esposo Luis, estuvo presente con Lilianis, por lo cual doy gracias a Dios. Él presenció la siguiente escena: se abrieron las dos puertas de sala de emergencias

del hospital, tres enfermeros empujando rápidamente una cuna, la doctora que se había llevado a mi hija, estaba dentro de esa cuna, ventilando y asistiendo a mi hija, camino a la Unidad de Intensivo Neonatal. En un acto heroico, el personal le dió las atenciones cruciales a una niña prematura de 27 semanas, para superar las primeras 24 horas de vida, que se convirtieron en una estadía de 75 días en NICU.

Adjunto a este escrito, hay 11 (once) páginas del resumen del alta, donde se describen los 12 diagnósticos activos, que pasaron a ser 34 diagnósticos resueltos entre los cuales se evidencia anemia, leucemia, hemorragia cerebral, retinopatía, insuficiencia pulmonar entre otros. Verán las observaciones del equipo médico como enfermeros y doctores especialistas como neonatólogo, cardiólogo y oftalmólogo. Los tratamientos recibidos, incluyendo tecnología como incubadora, alimentación por sonda, entre otros medicamentos. Añadimos un método no explicado en el resúmen del alta: el Método Canguro el cuál fue, para nosotros, sumamente importante para la recuperación de Lilianis, y practicado por mamá y papá.

Dentro de nuestro testimonio queremos dejar claro que nuestra convicción no permite apoyar el aborto en ninguna etapa de gestación. Es nuestro ejemplo el como una vida prematura sobrevive cuando los cuidados inmediatos y adecuados, se imparten con la voluntad para que ocurra. Sin embargo, conscientes de que pueden ocurrir excepciones en casos médicos, donde un Ginecólogo- Obstetra lo certifique pertinente, teniendo en cuenta el bienestar y riesgos para ambas vidas, estamos de acuerdo con la PS 693.

Agradecidos de la oportunidad de llevar nuestro testimonio, quedamos disponibles para cualquier duda o pregunta.

Lymari Ocasio Pérez y Luis A. Scharón Cruz

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Ashford Presbyterian Community Hospital (ASPC)

R/O Sepsis DOL > 28 Days	10/9/2012	
Sepsis-newborn	9/13/2012	
Sepsis-newborn	9/23/2012	
Thrombocytopenia	9/11/2012	Mild
Urinary Tract Infection-DOL>28 - unspecified	10/8/2012	

Maternal History

Mom's Age: 38 **Race:** Hispanic **Blood Type:** O Pos **G:** 3 **P:** 2 **A:** 0
RPR/Serology: Non-Reactive **HIV:** Negative **Rubella:** Immune **GBS:** Unknown **HBsAg:** Negative
EDC - OB: 12/9/2012 **Prenatal Care:** Yes
Mom's First Name: Lymari **Mom's Last Name:** Ocasio-Perez
Complications during Pregnancy, Labor or Delivery: Yes

Name	Comment
Breech presentation	
Precipitous delivery	
Delivery en route from home	in parking
Premature onset of labor	

Maternal Steroids: No

Delivery

Date of Birth: 9/11/2012 **Time of Birth:** 14:11 **Fluid at Delivery:**
Live Births: Single **Birth Order:** Single **Presentation:** Breech
Delivering OB: **Anesthesia:**
Birth Hospital: Ashford Presbyterian Community Hospital (ASPC) **Delivery Type:** Vaginal
ROM Prior to Delivery: **Reason for Attending:**

APGAR: 1 min: 3 10 min: 5
Labor and Delivery Comment:
1 minute Apgar was given by Dr. M Ramirez Pediatrician at ER. 10 Minute Apgar was given upon arrival to NICU by Dr. E Barreto.

Discharge Physical Exam

Temperature	Heart Rate	Resp Rate	O2 Sats
97.2	145	48	100

Bed Type: Open Crib
General: The infant is sleepy but easily aroused.
Head/Neck: Anterior fontanelle is soft and flat. No oral lesions.
Chest: Clear, equal breath sounds.
Heart: Regular rate and rhythm, without murmur. Pulses are normal.
Abdomen: Soft and flat. No hepatosplenomegaly. Normal bowel sounds.
Genitalia: Normal external genitalia are present.
Extremities No deformities noted. Normal range of motion for all extremities.
Neurologic: Normal tone and activity.
Skin: The skin is pink and well perfused. No rashes, vesicles, or other lesions are noted.

Nutritional Support

Diagnosis	Start Date	End Date
Nutritional Support	9/11/2012	
Ileus - non specific	9/20/2012	9/29/2012
Continuous Feedings	10/15/2012	11/2/2012

History

Upon admission infant was kept NPO and started on TPN. On 09/14 infant is tolerating trophic feeds.By 9/17 feeds continued to be advanced by continuous mode and TPN adjusted. On 09/20 infant was kept NPO on parenteral nutritional support secondary to non specific ileus. Follow up KUB showed decrease bowel gas pattern with no pneumatosis or free air. No air in rectum. Patient continues with ileus but less amount of bilious secretions and more air seen on abdominal XRAYS by 9/23. On 09/25 infant remains NPO on full parenteral nutrition secondary to ileus. On 09/28 infant remains with bilious secretions per OGT. Some bowel sound but no bowel movements. By 9/29 feeds with BM restarted by continuous mode. Patient arrived to full feeds by 10/7 and HMF added and IVF's discontinued.Patient continues with BM & HMF as well as Beneprotein on continuous mode with adequate tolerance by 10/16.Patient continues tolerating continuous feeds but with slow weight gain. Beneprotein increased. On 10/31 feeds were changed to bolus mode given over 1 hr. By 11/4 patient was tolerating well enteral feeds by bolus mode up to 35 ml/feed given over 1 hr with Good Start 24 cal/oz since there was no BM available. Patient continues tolerating feedings well with Good Start premature 24cal/oz and tolerates 35ml/feed by nipple. Nipple well. Patient continues tolerating feedings well and nipple 45-50ml/feed. On 11/24 at the time of discharge infant is nippling well all feeds ad lib.

Necrotizing enterocolitis medical

Diagnosis	Start Date	End Date
Blood in Stool	9/22/2012	9/29/2012
R/O Necrotizing enterocolitis medical	9/22/2012	9/23/2012
Necrotizing enterocolitis medical	9/25/2012	9/29/2012

History

Infant presented blood in the stools, gas less KUB , low platelets count,bandemia, all of these finding are compatible with NEC stage 1B. On 09/25 follow up KUB still shows decrease bowel gas pattern but no free air or pneumatosis. No bowel movements in the last 24hrs. OGT output remains low but bilious.

Hyperbilirubinemia-Prematurity

Diagnosis	Start Date	End Date
Hyperbilirubinemia-Prematurity	9/13/2012	9/18/2012

History

Progressive increase of bili levels noted, 7.8 mg/dl infant was placed under phototherapy, mother and baby are O+. On 09/14 bilirubin up to 10.12mg/dl for this reason second phototherapy was started and total IVF's adjusted.By 9/17 bilirubin levels decrease significantly and phototherapy discontinued.

Metabolic

Diagnosis	Start Date	End Date
Hypernatremia	9/14/2012	9/23/2012
Dehydration - newborn	9/14/2012	9/23/2012
Metabolic Acidosis	9/17/2012	9/18/2012
Hyperglycemia	9/20/2012	9/22/2012

History

On 09/14 serum sodium level up to 154mmol/l. For this reason current TPN was discontinued and new TPN requested without sodium supplementation. Infant had marked diuresis with a output of 7ml/kg/hr in the last 24hrs.By 9/18 patient Na decreased to 147 and serum osmolality reported at 301. On 09/20 am serum dextrose was adequate. Infant is now on supplemental IVF's with 0.45NS to complete intake since TPN rate was adjusted due to high serum dextrose.By 9/22 hypernatremia resolved.

Plan

Respiratory Syncytial Virus - at risk for

Diagnosis	Start Date	End Date
Respiratory Syncytial Virus - at risk for	9/11/2012	

History

Due to gestational age infant at risk for complications associated with RSV infection. Papers given to mother and case was send to Optima Infusion. Synagis already on Presby .First dose given on 11/12/2012

Plan

continue monthly Synagis prophylaxis during season, next dose December 21

Pulmonary Insufficiency of Prematurity

Diagnosis	Start Date	End Date
Respiratory Distress - newborn	9/11/2012	9/14/2012
Respiratory Distress Syndrome	9/11/2012	9/14/2012
Pulmonary Insufficiency of Prematurity	9/14/2012	10/29/2012

History

Infant was born at 27 weeks by dates and exam. Upon arrival to NICU was intubated with 2.5ETT and placed on mechanical ventilatory support. Survanta per ETT was given.Initial CXrays compatible with RDS. After Survanta patient had tolerated weaning from IMV and oxygen support.Although patient on minimal IMV settings and oxygen needs by 9/17 , extubation trial not done since patient with mild metabolic acidosis that maybe due to dehydration.By 9/18 patient extubated to NCPAP. By 2212 infant was intubated secondary to persistent apnea and desaturation later this evening. 09/21/2012 Patient continues on low ventilatory settings with adequate O2 sats. Patient remains intubated on low IMV settings by 9/23 with adequate ABG's on minimal IMV settings. On 09/25 infant was stable on minimal mechanical ventilatory support for this reason was extubated to NCPAP with adequate tolerance so far. By 9/29 placed on HFNC. On 10/06 infant was weaned off NCPAP to supplemental oxygen by HFNC with adequate tolerance so far. On 10/09 infant is now back on NCPAP secondary to frequent two days ago. By 10/11 patient was placed again on HFNC. Patient continues on HFNC with oxygen needs.Chlorothiazide begun.By 10/21 placed on NC at 0.5L/min .

Apnea of Prematurity

Diagnosis	Start Date	End Date
Apnea of Prematurity	9/14/2012	10/19/2012

History

Since 09/13 infant was started on prophylactic caffeine in anticipation for extubation trial.By 9/18 patient placed on NCPAP with Cafcit.Cafcit was placed in hold due to ileus.Patient remains apnea free on minimal IMV settings without Cafcit by 9/23.By 9/29 placed on HFNC and no A&B's reported.10/04/2012 No significant apneas or bradycardia have been reported. Infant remains on NCPAP.Infant on HFNC without A&B's, off Cafcit.

Patent Ductus Arteriosus

Diagnosis	Start Date	End Date
Patent Ductus Arteriosus	9/21/2012	9/25/2012

History

09/21/2012 Patient evaluated by Dr Villavicencio. Dx Imp: small PDA, should be asymptomatic. By 9/23 no heart murmur heard.

Ashford Presbyterian Community Hospital (ASPC)

Sepsis-newborn

Diagnosis	Start Date	End Date
Sepsis-newborn	9/13/2012	9/20/2012
Maternal Fever	9/11/2012	9/20/2012
C-Reactive Protein - elevated	9/11/2012	9/20/2012
Sepsis-newborn	9/23/2012	9/29/2012
C-Reactive Protein - elevated	9/20/2012	10/3/2012
Cellulitis	9/23/2012	9/29/2012

History

Infant was born by precipitous delivery. Cord was cut sterile. Mother with reported high temperature upon arrival to maternity ward. Due to all this and clinical presentation sepsis to be ruled out.CRP increased further by 9/12. Due to high risk of sepsis and meningitis and since unable to do spinal tap secondary to marked thrombocytopenia 10 to14 days of antibiotic therapy considered. Blood cultures from admission were reported as negative on 09/14.By 9/17 spinal tap was done to r/o meningitis since platelet count>100K. By then CRP decreased significantly and patient on 7th day of antibiotic therapy.Spinal fluid results were not compatible with meningitis for which a total of 10days of antibiotics were planned. On 09/20 infant now on Vancomycin and Amikacin since antibiotics were change due to concerns for sepsis secondary to clinical findings with decrease activity, bilious OGT secretions and eventually abnormal CBC and CRP. By 9/23 patient with clinical improvement and area around umbilicus is mildly erythematous but not with increase heat and no suppuration. Amikin trough from 09/25 was adequate, peak was canceled. Infant completed 10 days of antibiotics on 09/29.

Anemia

Diagnosis	Start Date	End Date
Leukopenia - neonatal	9/11/2012	9/16/2012
Thrombocytopenia	9/11/2012	10/16/2012
Comment: Mild		
Leukemoid Reaction	9/13/2012	9/22/2012
Anemia	9/21/2012	
Bandemia	9/22/2012	9/29/2012
Leukemoid Reaction	10/7/2012	10/16/2012

History

Initial CBC showed low WBC's and platelets count.Follow up CBC with slight increase in WBC count and drop in platelet count. On 09/14 platelets dropped to 32K since at high risk for bleeding platelets transfusion will be given. 09/15/2012 Platelet transfusion requested. PLT count today 16/48. No evidence of bleeding.By 9/16 platelets increased to 181K after platelet transfusion and WBC count began to decrease. By 9/18 WBC count continues to decrease slowly and platelet count decrease also after last platelet transfusion.On 09/22/2012 3:41 CBC showed low platelets count and bandemia, Hg increase to 10.2 g , pt presenting active intestinal bleeding so platelets transfusion and FFP ordered, 09/24/2012 Platelet count today 76k/142k. No evidence of bleeding. On 10/03 infant remains with low Hct but hemodynamically stable therefore will hold transfusion unless becomes symptomatic. But platelets remains on the low side now manual count of only 56K. She was seen by hematologist and the possibility of immune mediated process is being considered. This morning new platelets count was discussed with Dr. Mejias and she recommended to obtain count on citrate before beginning IVIG therapy. Platelets in citrate from 1410 were reported as 22K. CBC was repeated and count of 22K was reported as well. For this reason platelets transfusion was ordered and IVIG started. Infant completed 3 days course of IVIG on 10/05. Infant remains hemodynamically stable. Infant completed 3 days course of IVIG on 10/05. Infant remains hemodynamically stable. Patient with history of significant thrombocytopenia that required platelet transfusion as well on 10/03. .HUS and abdominal US were reported as normal. Platelets remained mildly decreased but WBC count increase significantly although patient without signs of sepsis. On 10/09 infant with Hct up to 35.4% post PRBC's transfusion. Platelets count remains stable at 156K. CBC from 10/15 showed stable platelets up to 217K and Hct up to 34.4%. Most recent Hct of 30.7% on 10/30. Follow up CBC on 11/07 with Hgb/Hct of 9.2/27% with adequate retic on 6%.Last HG 9/26.3 retic 4.99. On 11/24 Hct of 25.7% with retic count of 5.9%. At this time no sings of symptoms of anemia.

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CSF	9/17/2012	No Growth	
Blood	9/19/2012	No Growth	
Urine	9/19/2012	No Growth	
Catheter tip	9/21/2012	No Growth	
Blood	10/7/2012	No Growth	
Blood	10/7/2012	No Growth	
Urine	10/7/2012	Positive	Escherichia Coli
Comment: >100,000 colonies			
Urine	10/10/2012	Positive	Escherichia Coli
Comment: 1000 colonies			
Urine	10/14/2012	No Growth	
Comment: 48 hrs			

Intake/Output

Actual Intake

Fluid Type	Cal/oz Dex %	Prot g/kg	Prot g/100mL	Amount	Comment
Good Start Premature 24	24			375	

Route: PO Feeding Comment: dxt = 117

Actual Fluid Calculations

Total mL/kg	Total cal/kg	Ent mL/kg	IVF mL/kg	IV Gluc mg/kg/min	Total Prot g/kg	Total Fat g/kg
189	151	189	0	0	4.53	7.73

Planned Intake

Fluid Type	Cal/oz Dex %	Prot g/kg	Prot g/100mL	Amt	mL/feed	feeds/ day	mL/hr	mL/kg/day	Comment
Good Start Premature 24	24			400	50	8		201	ad lib

Planned Fluid Calculations

Total mL/kg	Total cal/kg	Ent mL/kg	IVF mL/kg	IV Gluc mg/kg/min	Total Prot g/kg	Total Fat g/kg	Total Na mEq/kg	Total K mEq/kg	Total Elem Ca mg/kg	Total Elem Phos mg/kg
201	161	201			4.83	8.25	4.8		528	

Output

Urine Amount: 214 mL 4.5 mL/kg/hr Calculation: 24 hrs

Total Output:

214 mL 4.5 mL/kg/hr 107.6 mL/kg/day Calculation: 24 hrs

Stools: 6 Last Stool: 11/20/2012

Medications

Active	Start Date	Start Time	Stop Date	Dur(d)	Comment
Multivitamins with Iron	10/15/2012			41	0.5ml PO Q 12hrs
Folic Acid	10/15/2012			41	50mcg PO Q 24hrs
Inactive	**Start Date**	**Start Time**	**Stop Date**	**Dur(d)**	**Comment**
Ampicillin	9/11/2012		9/19/2012	9	87mg IV Q 12hrs

Ashford Presbyterian Community Hospital (ASPC)

Respiratory Support

Respiratory Support	Start Date	Stop Date	Dur(d)	Comment
Ventilator	9/11/2012	9/18/2012	8	
Nasal CPAP	9/18/2012	9/20/2012	3	
Ventilator	9/21/2012	9/25/2012	5	
Nasal CPAP	9/25/2012	9/29/2012	5	
High Flow Nasal Cannula delivering CPAP	9/29/2012	9/29/2012	1	
Nasal CPAP	9/29/2012	10/6/2012	8	
High Flow Nasal Cannula delivering CPAP	10/6/2012	10/8/2012	3	
Nasal CPAP	10/8/2012	10/11/2012	4	
High Flow Nasal Cannula delivering CPAP	10/11/2012	10/21/2012	11	
Nasal Cannula	10/21/2012	10/26/2012	6	
Room Air	10/26/2012		30	

Procedures

	Start Date	Stop Date	Dur(d)	Clinician	Comment
Phototherapy	09/12/2012	9/17/2012	6	Awilda Rivera, MD	
Peripherally Inserted Central Catheter	09/19/2012	9/21/2012	3	Rosa Bonilla, MD	
Abdominal X-ray	09/19/2012	9/19/2012	1	Amaury Velez, MD	MILDLY DISTENDED BOWEL LOOPS NO BOWEL OBSTRUCTION
Chest X-ray	09/19/2012	9/19/2012	1	Rosa Bonilla, MD	PICC has been placed with the tip in the superior venae venae
Intubation	09/20/2012	9/25/2012	6	Edwin Barreto, MD	
Abdominal X-ray	09/26/2012	9/26/2012	1		
Blood Transfusion-Packed	10/08/2012	10/8/2012	1		
UAC	09/11/2012	9/19/2012	9	Edwin Barreto, MD	
Chest X-ray	09/13/2012	9/13/2012	1		
Suprapubic Aspiration	10/12/2012	10/12/2012	1	Awilda Rivera, MD	dry tap
Lumbar Puncture	09/17/2012	9/17/2012	1	Awilda Rivera, MD	
Blood Transfusion-Packed	09/30/2012	9/30/2012	1	Rosa Bonilla, MD	
Fresh Frozen Plasma	09/22/2012	9/22/2012	1	Rosa Bonilla, MD	q 12 hrs x 3
Platelet Transfusion	09/22/2012	9/22/2012	1	Rosa Bonilla, MD	
Intubation	09/11/2012	9/18/2012	8	Edwin Barreto, MD	
UVC	09/11/2012	9/19/2012	9	Edwin Barreto, MD	

Labs

CBC	Time	WBC	Hgb	Hct	Plts	Segs	Bands	Lymph	Mono	Eos	Baso	Imm	nRBC	Retic
11/24/12		9.30	8.6	25.7	416	13.30		81	3.1	3.1				5.94

Chem2	Time	iCa	Osm	Phos	Mg	TG	Alk Phos	T Prot	Alb	Pre Alb
11/24/2012							712			

Cultures

Inactive

Type	Date	Results	Organism
Blood	9/11/2012	No Growth	
Blood	9/11/2012	No Growth	

Ashford Presbyterian Community Hospital (ASPC)

Retinopathy of Prematurity stage 1

Diagnosis	Start Date	End Date
At risk for Retinopathy of Prematurity	9/11/2012	10/16/2012
Retinopathy of Prematurity stage 1	10/12/2012	

Retinal Exam

Date	Stage - L	Zone - L	Stage - R	Zone - R
11/2/2012	Immature Retina		Immature Retina	
11/17/2012	Immature Retina		Immature Retina	
Comment: blurred peripheral				
10/19/2012	1	2	3	2
Comment: follow up in one week.				
10/26/2012	2	2	2	2
Comment: no plus nor pre plus ,RetCam in 1 week.				
10/12/2012	1	2	1	2
Comment: repeat 10/19				

History

Due to gestational age infant at risk for ROP. By 10/12 reported with Stage 1 Zone 2. RetCam done on 10/26 was reported with probable ROP stage 2, zone 2-3. No plus nor pre plus.On 11/2 was done and reported w Immature peripheral retina and the recommendation was repeat in 2 wks.On 11/17 follow Retcam was done.

Plan

minimize oxygen exposure
follow Retcam from 11/ 27
outpatient follow up have been schedule with Victor Maldonado for 12/14/12 at 7:30 am

Ecchymoses

Diagnosis	Start Date	End Date
Ecchymoses	9/12/2012	9/18/2012

History

Patient with ecchymosis and clinical jaundice for which phototherapy begun.Ecchymosis areas resolved by 1 week of age.

Urinary Tract Infection-DOL>28 - unspecified

Diagnosis	Start Date	End Date
Infectious Screen	10/7/2012	10/8/2012
Urinary Tract Infection-DOL>28 - unspecified	10/8/2012	10/18/2012
R/O Sepsis DOL > 28 Days	10/9/2012	10/12/2012

History

Since patient with leukocytosis infectious screen with blood and urine culture done.No signs of sepsis at this time. On 10/09 blood cultures were reported as negative in 24hrs. Urine culture with E. Coli. Abdominal ultrasound from 10/06 showed normal kidneys without hydronephrosis.By 10/16 follow up urine culture reported negative in 48 hrs.Patient received combined therapy with Tobramycin and Cefepime by 10/18.

Hearing Screen - abnormal

Diagnosis	Start Date	End Date
Hearing Screen - abnormal	11/24/2012	

History

Infant has not passed AABR hearing tests while in hospital. For this reason will be referred for outpatient evaluation.

Plan
continue hematinics

Choroid Plexus Cyst

Diagnosis	Start Date	End Date
At risk for Intraventricular Hemorrhage	9/11/2012	11/11/2012
Choroid Plexus Cyst	11/11/2012	

Neuroimaging

Date	Type	Grade-L	Grade-R
10/2/2012	Cranial Ultrasound	Normal	Normal
11/5/2012	Cranial Ultrasound	Normal	Normal
Comment:	tiny choroid plexus cyst		
9/17/2012	Cranial Ultrasound	No Bleed	No Bleed

History
Due to clinical presentation infant at risk for IVH.By 9/17 HUS ordered and reported as normal. Follow up HUS from 10/02 was normal.Head sono done on 11/5 w tiny choroid plexus cyst in the left lateral ventricle. Examination is otherwise unremarkable. No evidence of an IVH is noted. Outpatient follow up advised.

Prematurity

Diagnosis	Start Date	End Date
Prematurity 750-999 gm	9/11/2012	
At risk for Anemia of Prematurity	9/11/2012	9/29/2012
At risk for Developmental Delay	9/11/2012	
At risk for Fungal Disease	9/11/2012	10/7/2012
At risk for White Matter Disease	9/11/2012	
At risk for Hearing Loss	10/16/2012	
At risk for Osteopenia of Prematurity	10/16/2012	

History
Due to gestational age infant at risk for many complications associated with prematurity.By 9/12 patient changed to closed isolette for temperature control. On 09/14 renal function and urine output were adequate.Patient continues in closed isolette for temperature control by 9/17.AlK PO4 on 11/12 reported at 682.On 11/19 patient was place in bassinet, with adequate temperature control.

Plan
continue to monitor closely
follow Alk PO4 two weeks from last (12/08) as outpatient and begin supplemental Ca and PO4 if greater than 800u/l

Psychosocial Intervention

Diagnosis	Start Date	End Date
Psychosocial Intervention	9/11/2012	

History
Infant condition, plan of care and morbidity / mortality associated with 27 weeks premature was discussed with father at bedside.Mother informed about CRP course

Gentamicin	9/11/2012		9/19/2012	9	2mg IV Q 24hrs
Survanta	9/11/2012	Once	9/11/2012	1	3.5ml per ETT
Vitamin K	9/11/2012	Once	9/11/2012	1	0.5mg IM
Erythromycin Eye Ointment	9/11/2012	Once	9/11/2012	1	OU
Fluconazole	9/12/2012	Once	9/12/2012	1	10mg IV loading dose
Fluconazole	9/12/2012		9/20/2012	9	5mg IV Q 72hrs
Caffeine Citrate	9/12/2012	Once	9/12/2012	1	17 mg iv to run over 30 min
Caffeine Citrate	9/13/2012		9/22/2012	10	5mg IV Q 24hrs
Midazolam	9/19/2012	Once	9/19/2012	1	0.1 before procedure
Vancomycin	9/19/2012		9/29/2012	11	8mg IV Q 12hrs
Amikacin	9/19/2012		9/29/2012	11	12mg IV Q 48hrs
Amphotericin B	9/20/2012		9/20/2012	1	4mg IV Q 24hrs
Mupirocin	9/18/2012		9/28/2012	11	to affected area Q 6hrs
Fluconazole	9/30/2012		10/7/2012	8	5.2mg IV Q 72hrs
IVIG	10/3/2012		10/5/2012	3	500mg IV to run over 6hrs
Vancomycin	10/8/2012		10/9/2012	2	10mg IV Q 8hrs
Tobramycin	10/8/2012		10/12/2012	5	4mg IV Q 24hrs
Cefepime	10/12/2012		10/18/2012	7	53mg IV Q 12hrs
Chlorothiazide	10/16/2012		10/29/2012	14	20mg PO Q 12hrs

Parental Contact

Parents will be updated during visiting hours.

Time spent preparing and implementing Discharge: > 30 min

Edwin Barreto, MD