Bridjett Cooper, RN, APRN, MSN, FNP-CB

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# Objective

To Utilize my education and experience to provide care and educate as a Registered Nurse/Family Nurse Practitioner in both inpatient and outpatient settings.

# Education

## Master’s DEGREE OF NURSING | AUGUST 3RD, 2018 | PURDUE UNIVERSITY NORTHWEST|Hammond, IN

* Major: Family Nurse Practitioner

## BACHELOR’S DEGREE OF NURSING | MAY 20TH, 2012 | PURDUE UNVERISTY CALUMET|hAMMOND, in

* Major: Nursing

**CERTIFICATES**

* Certified Nursing Assistant -2004
* Certified Teaching Assistant -2004

# Experience

# REGISTERED NURSE|ACUMEN STAFFING|JUNE 2022-PRESENT

**AGENCY PRN STAFF**

**Kindred North, Chicago**

Document assessment, interventions, intake/output, tasks and medication in electronic health record.

·Assist with codes and bedside procedures

· Administer medication, change dressings, start IVs

· Provide critical care for 3-7 patients on Med/Tele and isolation units

· Collaborate with providers for referrals, consultations and outside community health resources

· Educate patients during hospital stay regarding health promotion and prevention; Ensure discharge planning meets the needs of individual patient

· Assess, report and document data related to direct patient care activities

· Utilize team leader skills and delegate to non-licensed staff

· Monitor patients on telemetry monitor; Report abnormalities to primary physician/specialist

**NURSE PRACTITIONER |OPTUM|JUNE 2022-PRESENT**

IN HOME HEALTH RISK ASSESSMENTS THROUGH JUDGE STAFFING AGENCY

-Conduct in home yearly health risk assessments for various United Health Care Members in Northwest Indiana.

-Review past medical history, current medication, fall risk, previous hospitalizations/surgeries, primary care provider and office visits.

-Head to toe assessment with blood pressure, temp, fecal occult stool, hep-C, A1C heart rate, foot exams, weight, pulse oximetry and other focus exams as needed.

-Identify any barriers or risk to client’s health in home or make recommendations of care, contact primary care doctor and/or refer to case management if needed.

-Visit assessment, referral, confirmation calls for each visit.

**REGISTERED NURSE|SUPPLEMENTAL HEALTHCARE|SEPTEMBER 2021-June 2022**

**AGENCY STAFF**

**Worked at Carle Foundation in Urbana and Kindred North Chicago**

·Document assessment, interventions, intake/output, tasks and medication in electronic health record.

·Assist with codes and bedside procedures

· Administer medication, change dressings, start IVs

· Provide critical care for 3-7 patients on Med/Tele, Rehab, Oncology, Renal, Pre op, Specialty and IMCU.

· Collaborate with providers for referrals, consultations and outside community health resources

· Educate patients during hospital stay regarding health promotion and prevention; Ensure discharge planning meets the needs of individual patient

· Assess, report and document data related to direct patient care activities

· Utilize team leader skills and delegate to non-licensed staff

· Monitor patients on telemetry monitor; Report abnormalities to primary physician/specialist

**NURSE PRACTITIONER |INOVALON|JUNE 2021-JULY 2022**

IN HOME HEALTH RISK ASSESSMENTS

-Conduct in home or virtual yearly health risk assessments for various Medicare clients in Northwest Indiana.

-Review past medical history, current medication, fall risk, previous hospitalizations/surgeries, primary care provider and office visits.

-Head to toe assessment with blood pressure, temp, heart rate, weight, pulse oximetry and other focus exams as needed.

-Identify any barriers or risk to client’s health in home or make recommendations of care, contact primary care doctor and/or refer to case management if needed.

-Log miles, visit assessment, referral, confirmation calls for each visit.

**NURSE PRACTITIONER| FAMILY URGENTCARE| OCTOBER 2019-SEPTEMBER 2020**

PROVIDER

-See patients for urgent care/primary care needs and follow up as needed. (Tele-visits, COVID testing)

-Perform procedures: suturing, incision & drainage of cysts/abscess, IV fluids, injections, EKG, xrays, PAPs/STI testing, order and interpret labs and scans

-PCP visits, post hospital, workman’s comp, return to work and pre-op clearance visits

-DOT certifications, work/school physicals, FMLA paperwork.

**CEO| SOLUTION TELEHEALTH/WELLNESS| DECEMBER 2020-PRESENT**

WEIGHT LOSS CONSULTANT

-Pre-operative surgical clearance, work/school/sports physicals, IV hydration therapy.

-Conduct initial wellness assessment, labs to obtain baseline function, follow ups with weigh-ins.

-Review labs with client, discuss 123GO meal plan, set small goals for healthier lifestyle.

-Recommend vitamin injections and/or all natural supplements based on clients’ needs/goals.

-Prescribe appetite suppressants if the clients qualifies or if weight loss is minimal with diet and exercise alone.

**NURSE PRACTITIONER | ADVANCED REHABILITATION CARE| AUGUST 2019-MARCH 2021**

PHYSIATRY

-Round at facilities on Medicare A/B beds 1-2 times weekly and identify any barriers with rehab.

-Attend Weekly Medicare meetings and discuss discharge planning.

-Collaborate with staff and PCPs on inventions to help prevent complications or treat common medical barriers while in rehab.

-See 20-30 patients per day, document new consults and follow up visits in EMR

## NURSE PRACTITIONER| GREAT LAKES HOMECARE| January 2019-JUNE 2020

VISITING PRIMARY CARE PROVIDER/PULMONARY

-Conduct monthly home visits to home-bound patients and provide medical care. (Tele-visits during COVID)

-See 6 to 10 patients per day in their homes and document in Epic.

-Conduct assessments, annual wellness visits, home health certification, wound care and referrals. Order and review labs and scans.

-Credentialed at Methodist Hospitals in Gary/Merrillville campuses under Pulmonary.

-See 15 to 25 patients per day from ICU to inpatient rehab units.

-Assess and review labs, ABGs, scans, H&P and document new consults and progress notes under the direction of the pulmonary doctor.

## REGISTERED NURSE | METHODIST HOSPITALS | AUGUST 2016-april 2019

FLOAT POOL

- Float to various departments in the organization within scope to assist work/case load

-Assist with Transitional Care in the Quality Improvement Department with preventing readmissions by educating, sending referrals for high risk patients [Stroke, COPD, CHF, and pneumonia] and follow up phone calls up to 30 days after discharge.

· Assist with codes and bedside procedures

· Administer medication, change dressings, start IVs

· Provide critical care for 3-7 patients on Med/Tele, Rehab, Oncology, Renal, Pre op, Neurological and Cardiac IMCU.

· Collaborate with providers for referrals, consultations and outside community health resources

· Educate patients during hospital stay regarding health promotion and prevention; Ensure discharge planning meets the needs of individual patient

· Assess, report and document data related to direct patient care activities

· Utilize team leader skills and delegate to non-licensed staff

· Monitor patients on telemetry monitor; Report abnormalities to primary physician/specialist

**CREDENTIALS/ LICENSURES**

- AANP IN. and IL. States Family Nurse Practitioner exp Sept 2023

- Licensed IN. State Registered Nurse exp Oct 2023

- Licensed IL. State Registered Nurse exp May 2022

- DOT Certification exp Jan 2030

- ACLS Certified exp Jan 2023

- BLS Certified exp Jan 2023

# Activities

# NURSE PRATITIONER-PHYSCIAN ASSISTANT UNITE (NP-PA Unite) MAY 2019-PRESENT

# Director of Fundraiser and Development

# -Coordinate fundraising events

# -Preceptorship

# -Networking

# -Community Outreach

# -Assist with Educational In-services