Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

12948

4 - ER URGENT

[redacted]

TYPE OF ADMISSION:
☐ DS
☑ Admit
☐ OBS
☐ Emergency
☐ Outpatient

[redacted]

PATIENT ADMISSION ASSESSMENT

CHIEF COMPLAINT: Seizures | PROCEDURE: | MODE OF ARRIVAL: ☑ WC ☐ Stretcher ☐ Walk ☐ Carry | ACCOMPANIED BY: Patient / Husband

REL. OF PERSON PROVIDING INFO: Husband | [redacted] | ARRIVED / TRANSFERRED FROM: ☐ Home ☐ Amb. ☐ Other: ☐ Nursing Home

VITAL SIGNS B/P CODES: SU = Supine SI = Sitting ST = Standing

TIME	UNIT	TEMP.	PULSE	RESP.	BLOOD PRES.	O2 SAT
0145	[redacted]	97	74	20	134/78 SU	98

Hospitalization past 12 months? [redacted] ☑ Yes ☐ No If Yes, When, Where? Sept 98

Skilled Nursing last 60 days? ☐ Yes ☑ No

HEIGHT	WEIGHT	HEAD CIRC.

ALLERGY — FOOD: NKA | DRUG: NKA | OTHER:

PERTINENT MEDICAL/SURGICAL HISTORY & DATE (If checked, explain)
☐ Hypertension ☐ Cardiac ☐ Diabetic ☐ Stroke ☐ Renal ☐ TB
☐ Emphysema/Asthma ☐ Hepatitis ☐ Jaundice ☐ Smoking ☐ Last Menstrual Period 3/2/98 ☐ Cancer ☐ EtOH ☐ Drug ☐ Other:

EXPLANATION:

Are you currently taking diet pills/appetite suppressants? ☐ Y ☑ N x 2 mths

Any complications with anesthesia or anesthetic agents? ☐ Y ☑ N Lidocaine/Prilocaine? ☐ Y ☑ N Recent use of steroids? ☐ Y ☑ N

MEDS TAKEN PAST 2 WEEKS DISP. CODES: A = Sent Home B = Not Brought C = At Bedside D = Other

DOSE & FREQUENCY	REASON	LAST DOSE	*DISP.	DOSE & FREQUENCY	REASON	LAST DOSE	*DISP.
[redacted] Adipex prn Diet pills?		3/28					

Do you have special request/restriction regarding your religion/culture? ☐ Y ☐ N

NX ASSESS. PHYS. EXAM

HEENT: ☑ WNL ☐ NA | GU: ☑ WNL ☐ NA | OTHER:
CHEST: ☑ WNL | NEUROLOGICAL: ☐ WNL Nl to GCS expressive aphasia
CARDIOVASCULAR: ☑ WNL | EXTREMITIES: ☑ WNL ☐ NA
ABDOMEN: ☑ WNL | PSYCHO/SOCIAL: ☐ WNL

PLAN OF CARE: Monitor for s/s seizures - provide safe & comfortable environment

NURSE'S NOTES: Pt had new onset Seizures x 2 1st approx 10 min and 3rd followed by memory loss - witnessed by husband [redacted] WNL = Meets Standard

NUTRITION HX / SCREEN

1 Is patient on a special diet? (i.e. cardiac, diab, low Na, etc.) ☐ Y ☑ N
Specify:
2 Does patient have chewing /swallowing problems? ☐ Y ☑ N
3 Has patient had unplanned wt loss of 10% or more in past 6 mo.? ☐ Y ☑ N
4. Has patient had problems w/vomiting for 48 hrs or longer? ☐ Y ☑ N
5 Has patient had problems w/diarrhea for past 48 hrs or longer? ☐ Y ☑ N
6. Is patient intolerant of foods for religious or cultural reasons? ☐ Y ☑ N
7 Has patient had a decrease in food intake of 50% or greater for the past 7-10 days? ☐ Y ☑ N
8. Does patient have decubitus – Stage 3 or multiple? ☐ Y ☑ N
9 Is the patient being tube fed? ☐ Y ☑ N

IF YES TO ANY OF THESE, ORDER DIETICIAN CONSULT.

Dentures: ☐ N/A ☐ Upper ☐ Lower Partials: ☐ Upper ☐ Lower
Last time you ate Date: 3/29 Time: 1300
What did you eat? Sandwich
Reports of: ☐ Indigestion ☐ Sore Mouth ☐ Nausea
PEDIATRIC ☐ Breast ☐ Bottle ☐ Baby ☐ Junior ☐ Finger Food

RN

☐ Fluid volume ☐ Deficit ☐ Excess (CP)
☐ Swallowing, Impaired
☐ Nutrition alterations in, less than body req
☐ Oral mucous membrane, alterations in
☐ Skin integrity, impairment of
☐ Other:

PHYSICIAN ONLY — PHYSICAL EXAM

HEENT:
CHEST:
CARDIOVASCULAR:
ABDOMEN:
IMPRESSION.
PLAN:

RECTO-PELVIC.
NEUROLOGICAL:
EXTREMITIES:
OTHER:
SIGNATURE
_____, M D

IMMUNIZATIONS:

	1ST	2ND	3RD	BOOSTER	1ST	2ND
DPT/DT	2 Mo	4 Mo	6 Mo		18 Mo	4-6 Yr
Polio	2 Mo	4 Mo	6 Mo		18 Mo	4-6 Yr
MMR				15 Mo		4-6 Yr
HIB	2 Mo	4 Mo	6 Mo		18 Mo	
Hepatitis B	Birth	2 Mo	4 Mo			

UP TO DATE ☐ Yes ☐ No **If no, circle what is needed.**
TB Tine: _____ Other: _____
2nd PKU: ☐ Yes ☐ No ☐ N/A VERIFIED: ☐ Verbal ☐ Written

ADMITTING RN | **DATE** | **TIME**

PREADMISSIONS _____ AM PM
OP _____ AM PM
UNIT _____ AM PM
_____ AM PM
_____ AM PM

000002

[redacted] FAX TO PHARMACY [redacted]

Date: 5-28-98 [redacted] rea: Wan

PA[redacted] UN #: [redacted]

CH[redacted]

TIME OF CALL: _____

No Complaints

En Route _____ Arrive Scene _____ Depart Scene _____ Arrive Dest. _____

PAST MEDICAL HISTORY: No Hist

ALLERGIES: NKDA

PRESENT MEDS: Dilantin prescribed This morning Pt. has not Taken Med yet.

DESCRIPTION OF ILLNESS / INJURY: (ONSET, LOCATION, DURATION, QUALITY, QUANTITY, RADIATING, ALLEVIATING, AGGRAVATING, ETC.)

Called to Scene of Pt. C/O Nothing Find Pt Postectal / Post seizure Pt. Has No Hist. of seizures but Pt had a seizure This AM and was treated at [redacted] Pt was Prescribed dilantin but did not get script filled and Has taken No Meds Pt Alert X3 Initially would not answer questions Pt will answer questions Now. Pt Not very cooperative on scene Pt had to be persuaded to go to [redacted] Pt did not Remember going to Hos. This Morning Pt Refuses to answer Quest. properly Pt is More alert Now and will cooperate

PRIMARY SURVEY: (Description of Life Threatening Problems) LOC: A V P U: ☑ Appropriate ☐ Inappropriate

AIRWAY: Patent / Verbal BREATHING: Present / Non Labored CIRCULATION: pulses present / cap refill

SECONDARY SURVEY: (Document all findings - positive and pertinent negatives)

HEENT: PEARL

NECK: Track Midline No JVD Supple Strong Carotid Pulse

CHEST: B.S. Clear X4 Good Compliance equal rise & Fall

ABD: Soft, Non tender,

PELVIS: Stable

UPPER EXT: ROM (+) PMS (+) Pt has equal grips w/ cap Refill <2

LOWER EXT: Pt Ambulatory equal pulses, cap Refill <2

BACK: Stable

NEURO: Pt Alert X3 Pt Confused upon arrival

SKIN: Warm & Dry

ASSESSMENT (Presumptive Diagnosis): Poss seizure disorder

CARDIAC ARREST SURVEY: ☐ Witnessed ☐ Unwitnessed CPR BY: N/A EST. DOWN TIME: _____

EKG MONITORING: Rhythm — HR — R - I — Ectopy Y / N —

TIME	MEDIC	TREATMENT / PROCEDURES / MEDS / IV / O2	RESULTS OF TREATMENT
	[redacted]	Initial Vitals Glucose ck Vitals en route O_2 4 Lpm [redacted]	— 96 mg/DL O2 Sat —

ENDOTRACHEAL INTUBATION: ☑ N/A Equal B/S: ☐ Yes ☐ No Good Compliance: ☐ Yes ☐ No ☐ Oral ☐ Nasal Cord Visualized: ☐ Yes ☐ No

MED CONTROL CONTACT & ORDERS REQUESTED, GIVEN AND/OR DENIED: [redacted]

REASSESSMENT EN ROUTE: yes

SAFETY DEVICES: ☑ N/A ☐ Airbag ☐ None ☐ Helmet ☐ Seatbelt/Shoulder Harness ☐ Child Restraints

MECH. OF INJURY: ☑ N/A ☐ AUTO – ☐ Driver ☐ Passenger ☐ Ejected ☐ Motorcycle ☐ Pedestrian ☐ Electrocution ☐ Burn ☐ GSW ☐ Stab (/P) ☐ Bicycle ☐ Crush ☐ Fall ___ ft ☐ Industry ☐ Home ☐ Farm ☐ Road / Highway ☐ Other _____

DAMAGE TO VEHICLE: ☑ N/A ☐ Steering Wheel Deformed ☐ Windshield Spider ☐ Rollover ☐ Intrusion Passenger Compart. ☐ DAS/Same Vehicle ☐ Major Damage Exterior

Care prior to arrival? ☐ Yes ☑ No ☐ N/A

Provided by: ☐ 1st Resp. ☐ Fire ☐ Police ☐ Citizen ☐ Hosp/ED

Type of Aid: ☐ CPR ☐ AED ☐ Splinting ☐ Bleed Control ☐ Airway/Breathing ☐ Shock Manage ☐ Other

GCS/TS: GCS ___ TS ___ Time ___ GCS ___ TS ___ Time ___ GCS ___ TS ___ Time ___

VITALS: BP: 142/78 P: 101 (RI) R: 17/96% Time: _____ BP: 130/60 P: 96 (RI) R: 17/96% Time: _____ BP: ___/___ P: ___ (RI) R: ___ Time: _____ BP: ___/___ P: ___ (RI) R: ___ Time: _____

SIGNATURES:

Primary Medic [redacted] Secondary Medic/EMT: [redacted]

Med. Control [redacted] Nurse / MD Rec. Patient: [redacted] Time Care Assumed: _____

HOSPITAL COPY

000003

[redacted]

Emergency Department Clinical Record

E.D. Room: [redacted]

Acct. No.: [redacted]

Date: 03-28-98 Time: 2005 [redacted] Med. Rec. No: [redacted]

NAME: [redacted] DOB: [redacted] AGE: 44 SEX: F RACE: W

ARRIVED: ☐ Amb. ☐ Wheelchair ☐ Alone ☐ Accomp. by: [redacted] TRANSFERRED FROM: ☐ PD ☐ DPS ☐ Notified-Time. ☐ SO ☐ JP ☐ Here-Time:

[redacted] REFERRED TO: PERSONAL PHYSICIAN: [redacted] ADMITTING PHYSICIAN: HOSP RM #:

CHIEF COMPLAINT: Seizure [redacted] WEIGHT: 150 TET. HX: [redacted] LMP: last week VA: Rt: Lt: LAST MEAL:

CURRENT MEDICATIONS: Ø ALLERGIES: NKDA [redacted]

HX: had a seizure 2 hrs ago witnessed by husband, went to [redacted] this am for seizure denies hx of seizures A. AAO x3, less lucid, skin WDP no seizure activity at this time [redacted]

Time	T	P	R	BP
2005	97.5	86	18	126/86

[redacted]

96% O2 s RA

Orders: ☐ ASAP ☐ EMERGENC

TIME		TIME		TIME		TIME	X-RAYS
2035	☒ CBC [redacted]		☐ PT / PTT		☐ EKG	2035	[redacted]
	☐ UA		☐ C&S		☐ ABG		
2035	☒ SMA6		☐ TRANSGROW		☐ OTHER		
	☐ P_2		☐ HCG	2035	☒ RSDS Mg Ca.		
	☐ AMYLASE	2035	☒ ETOH				
	☐ CREAT.		☐ T&C #				

TIME: 2035 PHYSICIAN'S NOTES

[redacted]

DIAGNOSIS:

PHYSI [redacted] Date: Time:

Time	ORDERS	RACK TIME: 2015
	Proc. Exp ☒	
	PMH denies	
	~~Dilant 300~~	
00	[redacted] Cerebyx 750	
002	~~Ativan 0.5~~ po	
	Cerebyx	
	~~Ativan 0.5~~	
	~~Dilant 300~~	
	~~Rocephin~~	
	legal to [redacted]	

CONDITION ON DISCHARGE: ☐ Critical ☐ Improved ☐ Stable ☐ Unchanged ☐ Resolved

☐ CBC ☐ UA

HGB	COLOR	CHAR
HCT	SG	PH
WBC	RBC	PROTEIN
BASO	WBC	GLU
EOS	CASTS	ACE
MYELO	EPITH	OCC BLOOD
JUV	BACT	BILI
BAND		
SEG	☐ SMA 6	
LYM	NA	CO_2
MONO	K	BUN
[redacted]		GLU

Doctor	Called	Response

ASSESSMENT

☐ I ☐ II ☒ III ☐ T ☐ M ☐ S ☐ F/U

☐ DISM. WITH INSTR. ☐ TRANSFER ☒ ADMIT ☐ EXPIRED ☐ SURGERY TIME: 0110

[redacted]

MEDICAL RECORDS COPY

[redacted]

[redacted]

Seizure [redacted]

TIME SEEN: 2025 ROOM: [redacted]

HISTORIAN: ✓ patient

HPI

chief complaint- seizure x1 x2 x3 multiple
hx of seizure disorder

occurred- ✓ *just prior to arrival*

witnessed? __no ✓ yes, by: [illegible]

character of seizure(s)-

✓ lost consciousness
✓ unresponsive
completely partially unknown
did not regain between seizures

✓ motor activity
focal generalized
tonic tonic-clonic
other:

__bowel incontinence
__urinary incontinence
__stopped breathing
__lost pulse
__unknown

number and duration-

__unknown duration / number
✓ single isolated seizure
duration _____ *sec-min-hr*
__repeated seizures
x2 x3 x4 multiple
__status epilepticus
__continued on arrival in ED

post-ictal symptoms-

__none
__confusion
__lost power/feeling
arm / leg R / L
__speech difficulty
__visual disturbance

prior seizure of [redacted]

injury- head neck nose lip mouth bit tongue
chest abdomen back RUE RLE LUE LLE none
Contusion elbow

preceding symptoms /cause of seizure ✓ none
__missed recent doses of seizure meds
__changed medication or dosage
__recent alcohol intake
__sleep deprivation
__recent illness / see ROS
? diet pills

__Recently seen/treated by doctor

ROS

NEURO
✓ headache
✓ recent head injury

CVS & PULMONARY
✓ chest pain
✓ palpitations
✓ cough
__purulent sputum
✓ trouble breathing

CONST
✓ fever

EYES & ENT
✓ trouble with vision
__sore throat

GI & GU
✓ abdominal pain
__nausea / vomiting
✓ diarrhea
✓ black/bloody stools
✓ painful / frequent urination

SKIN & LYMPH & MS
✓ skin rash / swelling
__joint pain

☐ ROS limited due to:

PAST HISTORY __negative __see NAS.
__stroke
__craniotomy
__heart disease
__high blood pressure
__diabetes *insulin / oral / diet*
cervical
fusion lamoage.
__previous seizure / seizure disorder
recent onset / long-standing / since childhood
occasional / frequent / none for years last seizure:
2° to: idiopathic / head injury / prior stroke / ethanol abuse / unsure

Medications ✓ none __see NAS
__dilantin
__phenobarbital
__tegretol
__depakote

Allergies
✓ NKDA __see NAS

SOCIAL HX ✓ smoker ✓ drugs
alcohol (recent / heavy / occasional) denies

FAMILY HX

☑ Nursing Assessment Reviewed. ☑ [illegible], RR, Temp reviewed.

PHYSICAL EXAM: *Rx PTA-* __IV

Distress- ✓ NAD __Alert __convulsing __confused (post-ictal)

HEENT:
✓ scalp/face atraumatic
✓ pharynx clear
__eyes normal
__hemotympanum
__TM obscured by cerumen (R/L)
__tongue abrasion / laceration

NECK:
✓ supple
✓ non-tender
__meningismus
__vertebral point tenderness

CHEST:
✓ non-tender
✓ normal excursions
__breath sounds nml
__rales
__rhonchi
__wheezing

CVS:
__regular rate, rhythm
✓ heart sounds nml
__tachycardia / bradycardia
__irregularly irregular rhythm
__extrasystoles (occasional / frequent)
__murmur grade ___/6 sys / dias

ABDOMEN:
✓ non-tender
__tenderness
__organomegaly

BACK:
✓ normal inspection
__CVA tenderness (R / L)

SKIN & EXTREMS:
✓ no apparent trauma
✓ no apparent rash
__skin rash
__tenderness

OBSERVED SEIZURE ACTIVITY IN E.D. _____ duration _____
focal / generalized awake / unresponsive
head turned R / L eyes deviated R / L

NEURO:

alertness & orientation
✓ alert
✓ oriented x3
__slow / confused / combative
__disoriented to *time / place / person*
__aphasic *expressive / receptive*

cranial nerves-
✓ normal (as tested)
✓ pupils equal, round & reactive to light
__facial droop (R / L)
__tongue deviation (to R / L)
__abnormal accommodation
__pupils unequal
R pupil ___mm L pupil ___mm
__EOM palsy
__abnml fundi *papilledema / hemorrhages*

cerebellar-
✓ normal as tested
__abnormal Romberg test
__abnormal finger-nose-finger
__abnormal gait

sensorimotor-
✓ no motor deficit
✓ no sensory deficit
✓ reflexes nml
sysmmetrical
__weakness
__sensory deficit
__hyperreflexia / hyporeflexia
__Babinski
__abnormal reflexes

LABS, XRAYS, [illegible] PROGRESS:

CBC		Chemistries	
normal		*normal*	
nml except		*nml except*	
WBC 11 300	segs	Na	Gluc
Hgb 14	bands	K	Bun
Hct 40	lymphs	Ci	Creat
Platelets	monos	CO2	

Drug Levels dilantin_____ phenobarb_____ tegretol_____

Head CT ✓ nml

CXR __nml / NAD RSD6 ⊖

EKG- __nml __abnormal: Ca 9.1
EtOH Ø

Comparison w/ prior EKG- Mg 2.3

Cardiac Monitor- __NSR

*Time*_____ __unchanged __improved __re-examined_____

Pt lost 1 bro son almost exactly 7 yrs ago - pts behavior unusual - does not seem concerned about seizure or memory loss - indifferent smiling

[redacted]

✓ Discussed with Dr [redacted]
will see patient in: office / ED / hospital
__Counseled patient / family regarding:
lab results diagnosis need for follow-up
__Admission orders written

__Prior records obtained
__Additional history from:
[redacted]
__EKG / X-ray examined
__Discussed with radiologist

CLINICAL IMPRESSION: *EMS Arrival*

Seizure
New-Onset Epileptic
Generalized Focal
Grand Mal

Status Epilepticus
Cardiac Dysrhythmia
Cerebrovascular Accident

DISPOSITION- ☑ home ☐ admitted
CONDITION- ☐ unchanged ☐ improved ☑ stable

PHYSICIAN SIGNATURE- [redacted]

[redacted]

[redacted]

[redacted]

Emergency Dept.
NURSES RECORD

DATE/TIME	V.S./MEDS./PROCEDURES	NURSING CARE AND RESULTS
2005		here per EMS see assessment - [redacted]
2110		lab in to draw blood. - [redacted]
2125		to CT per cart c̄ side rails ↑x2 — [redacted]
2140	76 18 139/87	Back from CT per cart urine obtained to sent to lab - [redacted]
2200		pt. asleep easily aroused, family at bedside - [redacted]
2350	79 18 129/83	pt awake, resp even unlabored, family at bedside - [redacted]
0020		20g Heplock + 1 attempt c̄ [illegible] - [redacted]
0023	.5 ms Ativan po	[redacted]
0025		report to [redacted] RN - [redacted]
0025	↑ Cerebryx 750 mg	IVPB. Heplock started to (L) hand c̄ 18g X1 stick per protocol - [redacted]
0100	Cerebryx infused	
0110		Rec. admission orders - [redacted]
0115		Report called to unit Spoke c̄ [redacted] RN per [redacted] RN. Transporting to unit via w/c. Voiced no %. Heplock intact [redacted]

20:10	126/ 86(103) mmHg	HR= 82 (NIBP)	INTERV
22:48	139/ 87(106) mmHg	HR= 76 (NIBP)	q 30 m
23:57	129/ 83(95) mmHg	HR= 79 (NIBP)	LAST BI
00:53	139/ 83(102) mmHg	HR= 74 (NIBP)	00:55
00:55	142/ 90(106) mmHg	HR= 75 (NIBP)	03/29

[redacted]

[redacted] IMPRINT BELOW THIS LINE

[redacted]

[redacted]

Physician's Orders

ADMISSION ORDERS

EMERGENCY DEPARTMENT

[redacted]

DIAGNOSIS: New onset Seizure

ALLERGIES:

NCR PAPER REQUIRES A BALL POINT PEN - FELT TIP / SOFT PEN MAY DELAY YOUR ORDER
PLEASE PRESS FIRMLY AND WRITE LEGIBLY

DATE / TIME	ORDERS: ANOTHER BRAND OF GENERICALLY EQUIVALENT PRODUCT IDENTICAL IN DOSAGE FORM AND CONTENT OF ACTIVE INGREDIENT MAY BE ADMINISTERED.
	1. Admission / Observation ✓ ICU/Telemetry with monitor/floor.
3/29/98	Consult to:
	2. Place patient on Dr. [redacted] service. ✓
DLC	3. Notify attending MD of room number on arrival to floor / 7:00 AM
	4. Activity: ☐ Bedrest ☐ Ad Lib ☐ Only with assistance Seizure precautions ✓
	5. Diet: ☐ Regular ☐ NPO ☐ Ice Chips ☑ Clears ☐ As Usual ☐ Cardiac ☐ Other
	6. Old medical records to floor. ✓
	7. Vital signs of 4 hours. Neuro checks q 4 hours. Pulse oximetry checks q _____ hours. ✓
	8. Intake and output? ☑ Yes ☐ No ✓
	9. IV orders: Heplock ☐ NS ☐ D5½NS with _____ mEq KCL at _____ cc/hr.
	10. Oxygen orders: ☐ 2L NC ☐ Simple ☐ NRBM at _____ L/min. ✓
	11. Notify attending MD for: a) Temp. greater than 100.5;
	b) Systolic BP greater than 180 or less than 90; ✓
	c) Pulse greater than 125 or less than 50.
	12. Code status: ☑ Full ☐ DNR ☐ Unknown ✓
	13. Notify attending MD for any changes and for further orders. ✓
	14. All care transferred to attending MD. ✓
	15. Medication orders: Home medications? ☐ Yes ☑ No ✓
	Tylenol _____ mg po / pr q _____ ° PRN Comfort/Fever
	Dilantin 100 mg po tid
	Ativan 0.5 mg po q 1-8° pm anxiety
	16. Additional orders: Foley / Foley PRN
	NGT
	[redacted]
	[redacted] MD

3/29/98 DC home [redacted]

000008 [redacted]

3/28/98 20:34 [redacted] Rslt Ent:
[redacted] ********** RESULTS ********** Rslt Vfy:

LAB CHEMISTRY

OrderNo, Description... [redacted] MAGNESIUM (MG)
Number, Name, Room/Bed: [redacted]

Collection Date/Time	03/28/98 21:10		
MG	2.3	mg/dL	(1.6-2.6

3/28/98 20:34 [redacted] Rslt Ent:
[redacted] ********** RESULTS ********** Rslt Vfy:

LAB CHEMISTRY

OrderNo, Description... [redacted] ALCOHOL BLOOD (ETOH) [redacted]
Number, Name, Room/Bed: [redacted]

Collection Date/Time	03/28/98 21:10	
ALCOHOL, SERUM	0	(0

. For emergency toxicology use:
. Alcohol levels greater than 400 mg/dL have been associated
. with fatalities.
. LEGAL LIMIT OF INTOXICATION: 100 mg/dL

3/28/98 20:34 [redacted] Rslt Ent:
[redacted] ********** RESULTS ********** Rslt Vfy:

LAB CHEMISTRY

OrderNo, Description... [redacted] CALCIUM BLOOD [redacted]
Number, Name, Room/Bed: [redacted]

Collection Date/Time	03/28/98 21:10		
CALCIUM	9.1	mg/dL	(8.4-10.2

3/28/98 20:34 [redacted] Rslt Ent:
[redacted] ********** RESULTS ********** Rslt Vfy:

LAB CHEMISTRY

OrderNo, Description... [redacted] DIALYSIS PROFILE [redacted]
Number, Name, Room/Bed: [redacted]

Collection Date/Time	03/28/98 21:10		
SODIUM	142	mEq/L	(133-145
POTASSIUM	4.2	mEq/L	(3.3-5.1
CHLORIDE	105	mEq/L	(96-108
CARBON DIOXIDE	24.9	mEq/L	(22.0-29.0
GLUCOSE	104	mg/dL	(70-105
BLOOD UREA NITROGEN	15	mg/dL	(6-19
CREATININE	0.7	mg/dL	(0.4-1.2

3/28/98 20:34 [redacted] Rslt Ent:
[redacted] ********** RESULTS ********** Rslt Vfy:

LAB HEMATOLOGY

OrderNo, Description... [redacted] COMPLETE BLOOD COUNT (CBC) [redacted]
Number, Name, Room/Bed: [redacted]

Collection Date/Time		03/28/98 21:10		
WBC	H	12.3	K/mm3	(5.0-10.0
RBC		4.32	M/mm3	(3.60-5.50
HGB		14.2	g/dL	(12.0-18.0
HCT		40.8	%	(32.0-54.0
MCV	H	94.4	fL	(80.0-94.0
MCH		32.9	pg/mL	(27.0-33.0
MCHC		34.8	%	(32.0-38.0
RDW		11.7	%	(11.5-14.5
PLT		241	K/mm3	(130-400
MPV		8.8	fL	(7.4-10.4
SEGS	H	88.0	%	(50-65
LYMPHOCYTES	L	7.8	%	(25-40
MONOCYTES		3.0	%	(0-10
EOSINOPHILS		0.9	%	(0-5
BASOPHILS		0.3	%	(0-3

[redacted]

[redacted]

PRELIMINARY REPORT
RAPID STAT DRUG SCREEN

Patient's Name: [redacted] ID#: [redacted]

Tech: [redacted] Date: 3-28-98 Time: 2210

	None Detected	Detected To be Confirmed
1. Amines	✓	
2. PCP-Phencyclidine	✓	
3. Barbiturates	✓	
4. Benzodiazepines	✓	
5. Cannabinoids-THC	✓	
6. Cocaine	✓	
7. Opiates	✓	

THIS IS A PRELIMINARY REPORT ONLY. THIS DOES NOT CONSTITUTE A FINAL REPORT.

All Rapid Stat Drug Screens are confirmed (positives and negatives) Monday through Friday on the 3-11 p.m. shift.

A final report will be issued after all confirmations are complete.

[redacted]

[redacted]
RADIOLOGY DEPARTMENT

PATIENT NAME: [redacted] DOB [redacted] X-RAY NO. [redacted]

REFERRED BY DR. [redacted] RAD [redacted]

ROOM NO: [redacted]

CT HEAD 03/28/1998

INDICATIONS: Possible seizure.

The 3rd, 4th and lateral ventricles are of normal size and configuration. There is no evidence of mass effect, midline shift or extra-axial fluid collection. No abnormal areas of high or low density are seen to suggest hemorrhage or infarction.

IMPRESSION:Normal unenhanced head CT.