

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

ARMS#

12975



4 - ER URGENT

000001

ARMS # 12975



ROOM NO. [REDACTED]

EMERGENCY PATIENT RECORD 1

WR

PA [REDACTED]	AGE 23	SEX M	HEIGHT 5'11	WEIGHT 223	TIME	T 989	P 102	R 18	B/P 144/110
ARRIVED <input type="checkbox"/> HELICOPTER <input type="checkbox"/> AMBULATORY <input type="checkbox"/>	CARRIED <input type="checkbox"/> ALS <input type="checkbox"/> WHEELCHAIR <input type="checkbox"/>	LAST TETANUS <input type="checkbox"/> BLS <input type="checkbox"/> POLICE <input type="checkbox"/>	LNMP	G/P/A	VISUAL ACUITY	OS	OD	OU	
TIME 1325	DATE 1-3-97	PHYSICIAN [REDACTED]	CURRENT MEDICATIONS NONE	DOSE	FREQ.	MEDICAL HISTORY			
CATEGORY	CHIEF COMPLAINT			Diets Fuel		[REDACTED]			
Seizure activity @ home - alteration to @ head @ eye blurred speech amnesia x 2 da									
NEUROLOGIC			RESPIRATORY			MUSCULO-SKELETAL			
<input checked="" type="checkbox"/> Alert <input type="checkbox"/> Not Alert			<input checked="" type="checkbox"/> Normal			Location			
Responds to:			<input type="checkbox"/> Shallow			<input type="checkbox"/> Pain			
<input checked="" type="checkbox"/> Verbal Stimuli			<input type="checkbox"/> Labored			<input type="checkbox"/> Swelling			
<input type="checkbox"/> Painful Stimuli			Other			<input type="checkbox"/> Discoloration			
Oriented:			Other			<input type="checkbox"/> Deformity			
GCS:			Other			<input type="checkbox"/> Skin Broken			
IMMEDIATE INTERVENTION			Other			<input type="checkbox"/> Pulses Present			
<input type="checkbox"/> ICE <input type="checkbox"/> DRESSING <input type="checkbox"/> SPLINT			Other			<input type="checkbox"/> Distal To Injury			
<input type="checkbox"/> ELEVATION <input type="checkbox"/> COLLAR			Other			Pain 1 2 3 4 MAX			
TIME 1:25 pm			PHYSICIAN ASSESSMENT			SKIN COLOR			
HISTORY PRESENT ILLNESS			PHYSICIAN ASSESSMENT			TEMPERATURE			
up in room, found comatose, active seizure			PHYSICIAN ASSESSMENT			<input checked="" type="checkbox"/> Pink/Brown			
to @ home			PHYSICIAN ASSESSMENT			<input type="checkbox"/> Pale			
went back to sleep			PHYSICIAN ASSESSMENT			<input type="checkbox"/> Flushed			
Hx of Black out (zoning out); Absence x 2 eps			PHYSICIAN ASSESSMENT			<input type="checkbox"/> Jaundice			
Bite @ the tongue			PHYSICIAN ASSESSMENT			<input checked="" type="checkbox"/> Warm/Dry			
[Hand-drawn diagram of head and neck]			PHYSICIAN ASSESSMENT			<input type="checkbox"/> Hot			
REVIEW OF SYSTEMS:			HEENT:			<input type="checkbox"/> Cool			
CARDIO:			RESPIRATORY:			<input type="checkbox"/> Cold/Clammy			
GI:			NEURO:			<input type="checkbox"/> Diaphoretic			
MS:			All other systems negative			ALLERGIES			
SKIN:			All other systems negative			[REDACTED]			
PAST MED HISTORY:									
SOCIAL HX: Tobacco Alcohol Substance Abuse FAM HX: TB DM HTN HEART/LUNG KIDNEY									
Persistent Cough (> 2 wks) Bloody Sputum Night Sweats Unexplained Wt. Loss Anorexia Fever Malaise									
Recent close contact c̄ infectious TB Travel / Live in country c̄ high prevalence TB Previous Isoniazid- When- How long-									
PHYS. EXAM: loss of urine / loss B.L. Tongue									
<input type="checkbox"/> DICTATED									
ADMIT PER					TO:				
IMPRESSION: @ New Onset Generalized Seizure					DISCHARGE TIME				
					CONDITION ON DISCHARGE				
					<input type="checkbox"/> SATISFACTORY <input type="checkbox"/> IMPROVED				
					LEVEL: 400 401 402 403 404 405 406				
					TIME ADM. CALLED 1630 AM				
					TIME BED GIVEN: [REDACTED] AM				
					ROOM NO. [REDACTED] PM				
					DATE TO UNIT 1/3/98				
					TIME TO UNIT 1730 AM				
					<input type="checkbox"/> E <input type="checkbox"/> N				

MP # RM [REDACTED]

DR [REDACTED]

EMERGENCY PHYSICIAN: [REDACTED]

000002

EMERGENCY PATIENT MEDICAL RECORD

EMERGENCY PATIENT RECORD

DATE: 01/03/98

CHIEF COMPLAINT:

Possible new onset seizure.

HISTORY OF PRESENT ILLNESS:

This is a 23-year-old male who presents to the emergency department complaining of having a possible seizure. His mother states that he was up in bed sleeping. She heard a ruckus noise upstairs. She states she went up to see him. He was laying on the floor confused and combative. She states he has never had a history of seizure. She states there was a scrape on his head and he was talking funny like he had bitten his tongue and his clothes were wet from urine. He states he does not remember any of this happening. He states he has had a few episodes where he is sitting and all of a sudden he sort of blacks out though he doesn't faint, he just feels like he can't remember anything for awhile. He states he has had those over the last couple of months. He has not sought treatment for this. He states otherwise he feels good. He denies any headache, loss of consciousness, dizziness, vertigo, syncope, seizure, nausea or vomiting, neck pain, chest pain, abdominal pain, upper or lower extremity pain. He denies any dizziness, vertigo, syncope.

PAST MEDICAL HISTORY:

None.

MEDICATION(S):

None except for over-the-counter diet fuel.

ALLERGIES:

None.

SOCIAL HISTORY:

He is here with his mother and father.

FAMILY HISTORY:

Denied except for cancer in grandparents.

REVIEW OF SYSTEMS:

All other systems have been reviewed and were negative.

PHYSICAL EXAMINATION:

GENERAL: This is a cooperative, alert, non-toxic appearing 23-year-old male in no distress.

VITAL SIGNS: Temperature 98.9, pulse 100, respirations 18, and blood pressure initially 144/105.

PSYCHIATRIC: Shows good judgement and insight. He is not anxious, depressed

99 MAY 24 AS:01

RECEIVED
CLINICAL RESEARCH
& REVIEW/OSN HFS-450

PT. [REDACTED]

M.R.#/RM. [REDACTED]

DR. [REDACTED]

000003

MEDICAL RECORD

EMERGENCY ROOM ADMIT

EMERGENCY PATIENT RECORD

EMERGENCY PATIENT RECORD 3

or agitated. He is alert and oriented to person, place and time. Memory is intact to remote. Some recent memory is not completely intact. He could not initially remember who had won the football game two days ago that he watched.

HEAD, EYES, EARS, NOSE AND THROAT: Normocephalic and atraumatic. Pupils were equal, round. Extraocular movements were intact. Fundi unremarkable. There is some edema noted in the right upper lid with ecchymosis. Conjunctiva are not injected nor icteric. Tympanic membranes within normal limits and external canals clear. Nasal mucosa without erythema, edema or exudate. Posterior pharyngeal mucosa without erythema, edema or exudate. Mucous membranes moist. Tongue extends to the midline. There is moist bite marks noted.

NECK: Supple, without rigidity. No lymphadenopathy noted. No thyromegaly. No masses.

CHEST: Chest wall nontender.

LUNGS: Good respiratory effort. Clear.

HEART: Regular rhythm without murmurs, rubs or gallop. There are equal pulses in all extremities. Good refill. No edema.

ABDOMEN: Soft, flat and without masses or tenderness. No guarding, rigidity or rebound noted. Bowel sounds normoactive and normal pitch.

BACK: Without deformity or tenderness.

EXTREMITIES: Without cyanosis, clubbing or edema. Range of motion full.

NEUROLOGICAL: The patient is awake, alert and oriented to person, place and time. Cranial nerves II through XII were grossly intact. Equal reflexes. Equal grip strength. Good sensation.

DERMATOLOGICAL: Without rashes or lesions.

LYMPHATIC: There is no neck, axillary or groin nodes noted.

MEDICAL DECISION MAKING:

This patient is managed in consultation with Dr. [REDACTED] After the patient was examined, appropriate studies were ordered including a CT scan of the head which was read as negative. CBC - WBC 12.7, hemoglobin 15, hematocrit 44. Urinalysis is negative except for a trace of blood, 2+ protein. Sodium 140, potassium 3.6, chloride 106, CO2 26, BUN 22, creatinine 1.2, glucose 115, calcium 2.33, magnesium 1.0. With the above finding, a gram of Dilantin is loaded IV slowly. Dr. [REDACTED] was contacted. The case was discussed. She is covering for Dr. [REDACTED] The patient will be admitted for further evaluation and treatment of the above complaints.

PT. [REDACTED]

EMERGENCY ROOM ADMIT

000004

M.R.#/RM. [REDACTED]

MEDICAL RECORD

DR. [REDACTED], M.D. [REDACTED]

EMERGENCY PATIENT RECORD [REDACTED]

EMERGENCY PATIENT RECORD

IMPRESSION:

1. New onset seizure.

DISPOSITION:

Admitted in stable condition.

D 01/03/98

T 01/04/98

cc: [REDACTED] M.D.

PT. [REDACTED]

000005

EMERGENCY ROOM ADMIT

M.R.#/RM. [REDACTED]

MEDICAL RECORD

DR. [REDACTED] M.D.

EMERGENCY PATIENT RECORD 3

EMERGENCY ROOM PHYSICIAN'S ORDER SHEET

RM. #

PRESS FIRMLY WITH BALLPOINT PEN ONLY

DATE	TIME	MEDICATIONS / OTHER ORDERS

RESIDENT/P.A.:

EMERGENCY PHYSICIAN:

PRESS FIRMLY WITH BALLPOINT PEN ONLY

DATE	TIME	NOTIFICATIONS:	TIME INITIATED:	TIME RESPONDED:
1/31/98		2 Cnt H / Magnesium		
		① From Careb hold needs for now		
	3:00 PM	① Dilantin + some I.V.		Done
		② or For Admission 10:00		
				TIME 1:25

RESIDENT/P.A.:

EMERGENCY PHYSICIAN:

LABS: ACETAMINOPHEN AMYLASE/LIPASE BIPR ~~CPK~~ CPK DIG LEVEL DILANTIN
 DRUG SCREEN (URINE) ETOH EZPR GC / C+S ~~GLUCOMETER~~ 88 Mg T & S / XM ^{sent} UNITS
 PT / PTT RHOGAM SCREEN SALICYLATE TRAUMA PANEL TRICYCLIC LEVEL PREG (URINE) ~~URINE~~ URINE DIPSTIX

X-RAY: ABDOMEN 3 VIEWS C-SPINE, FULL C-SPINE, X-TAB LAT CHEST 2 VIEWS/ PORTABLE SKULL

OTHER: _____ CT: HEAD ABDOMEN CHEST OTHER: _____

ULTRASOUND: PELVIS OTHER _____ VENOUS DOPPLER: _____ CLINICAL DATA: new or set stage

IV'S: D5W D5LR D5 2NS D5.3NS D5.45NS

LR ~~NS~~ SALINE LOCK @ i cc/hr

OTHER: _____

RESPIRATORY: ALUPENT PROVENTIL
 AIRWAY: NC / MASK / ET (TUBE SIZE _____)
 @ _____ L% PULSE OX _____

ABG'S _____ VENT SETTINGS: _____

MONITOR EKG OLD CHART: _____

RESIDENT/P.A.

EMERGENCY PHYSICIAN:

DATE
1/31/98
TIME

000006



TIME	1425	1515	1730							ER PROCESS EXPLAINED	YES
B/P	21/58	14/15	29/60	/	/	/	/	/	/	SIDE RAILS UP → # _____	<input type="checkbox"/>
P	80	83	80							CALL LIGHT IN REACH	<input type="checkbox"/>
RESP RATE		16	16							PARENT/GUARDIAN/S.O. AT BEDSIDE	<input type="checkbox"/>
T										Tuberculosis Control Screening Questionnaire	
MONITOR										If Yes To Any, Refer To Airborne Transmission Precautions Policy	
PULSE OX										Yes	No
I/O	/	/	/	/	/	/	/	/	/	Have you recently had an exposure to TB?	
INITIALS	[Redacted]									Have you ever had a positive TB skin test?	

TIME	BOTTLE NO.	AMOUNT IN BOTTLE	TYPE OF SOLUTION	MEDICATIONS ADDED	NEEDLE SIZE	SITE	IV RATE	AMOUNT ABSORBED	NURS. INITIA.
1415				Paramedic	20	② AC	200		
1630	1	100	NS	Dilator 1 gm					

TIME	MEDICATION, SITE, DOSE, ROUTE	INIT	TIME	MEDICATION, SITE, DOSE, ROUTE	INIT

TIME NARRATIVE NOTES

1335 @ seizure activity since adm to ER. Seizure precautions implemented [Redacted]

1415 Labs drawn & sent. Glucometers 88. Urine specimen obtained (UA sent) @ seizure activity

1425 to CT [Redacted]

1515 Assumed care. PT presently in CT. [Redacted]

1510 ADT returned from CT [Redacted]

1525 APO x 3. SK w IP. No generalized a/c. Respirat. unlabored. Monitor → SK. A nurse waiting lab results [Redacted]

1730 Alert. Denies discomfort. SK w IP. Respirations unlabored. A nurse being admitted 1 gm dilator completely induced by pump thru filter over 10 [Redacted]

ADMISSION TRANSFER SUMMARY **DISCHARGE**

TIME 1740 TO: Home Work Rm 807 B/P 129/69 P 80 R 16 MONITOR PATTERN _____

TRANSFERRED TO _____ PRESCRIPTION _____

LOC: alvt

INSTRUCTIONS GIVEN TO:

PT PARENT S.O. OTHER _____

VERBALLY INDICATES UNDERSTANDING OF INSTRUCTIONS _____

BY: STRETCHER W/C AMB RN _____ ERT _____

PROBLEM: Seizure activity

INTERACTION: labs, CT, IV, mgds

RESPONSE: admit

SIGNATURE: [Redacted] **600007**

DISTRIBUTION: Med Records _____ Business Office _____
ER Physician _____ Attending Physician _____