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

ARMS#

13203

8 - OTHER

ISSUE DATE: 12/02/98 [redacted] PROGRAM-ID [redacted]
ISSUE TIME: 11.46.37 PHYSICIAN ATTESTATION REPORT

PATIENT NAME: [redacted] AGE: 46 Y SEX: F
ACCOUNT NUMBER: ROOM: [redacted]
MEDICAL RECORD NUMBER: [redacted] FIN. CLASS: 8 - COMMERCIAL
ADMISSION DATE: 11/13/98
DISCHARGE DATE/STATUS: 11/19/98 R - ROUTINE

MDC/DRG ASSIGNMENT
05 - DISEASES & DISORDERS OF THE CIRCULATORY SYSTEM
145 - OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC

PRINCIPAL DIAGNOSIS: 796.2 ELEV BL PRES W/O HYPERTN

SECONDARY DIAGNOSES

2.	784.0 HEADACHE	3.	368.2 DIPLOPIA
4.	780.6 FEVER	5.	
6.		7.	
8.		9.	
10.		11.	
12.		13.	
14.		15.	

PRINCIPAL SURGEON:

PROCEDURES DATE PHYSICIAN
HCPCS DATE PHYSICIAN

I CERTIFY THAT THE NARRATIVE DESCRIPTIONS OF THE PRINCIPAL AND SECONDARY DIAGNOSES AND THE MAJOR PROC[redacted] PERFORMED ARE ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

PHYS[redacted]STMENT: _____ _____
(SIGNATURE) (DATE)

ATTENDING PHYSICIAN: [redacted]

Best Quality FDA

[redacted]

D/C 11-19

MR#: [redacted] INPATIENT ADMISSION: 11/13/98 11:30 BY: [redacted] PT#: [redacted]

[redacted] AGE: 046Y [redacted] SEX: F RACE: C MAR: M
REL: EF SRC: [redacted] MSV: [redacted] FC: [redacted] AD.CAT: [redacted]
ROOM/BED: [redacted] AC: P SMOKER: N SPC HDL
SSN: [redacted] ATTENDING DOCTOR: [redacted]
PREVIOUS NAME: REFERRING DOCTOR: [redacted]
NEAREST RELATIVE: EMPLOYER NAME: EMERGENCY CONTACT:
[redacted] NO EMPLOYER [redacted]
[redacted] PT REL: [redacted] [redacted] PT REL: [redacted]

GUARANTOR#: [redacted] SSN: [redacted] GUARANTOR EMPLOYER: TREATMENT AUTH:
[redacted] NO EMPLOYER
[redacted] [redacted]
AD: OD:

ADMITTING DIAGNOSIS:
DOUBLE VISION ELEVATED BP FEVER DATE OF INJURY:

INS # 1 [redacted] PLAN: [redacted]
INS # 1 [redacted]
SUBSCRIBER: [redacted] REL: [redacted] GROUP: [redacted]
ID#: [redacted] CONTRACT: [redacted] TYPE: NA

INS # 2: CO: PLAN:
INS # 2 ADDRESS:
SUBSCRIBER: REL: GROUP:
ID#: CONTRACT: TYPE:

INS # 3: CO: PLAN:
SUBSCRIBER: REL: GROUP:
INS # 3 ADDRESS:
ID#: CONTRACT: TYPE:

COMMENTS: POWER OF ATTORNEY NO LIVING WILL NO
NO PRIOR VISIT/HAD ORDERS/IP 11-13-98/[redacted] PAPERS TO FLOOR WITH PT/[redacted]

[redacted] 1-24 [redacted]

000003

COPY 1

PT: [redacted] PT: [redacted]
MD: [redacted] MD: [redacted]