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

ARMS#

12843

4 - ER URGENT

[redacted]

[redacted]

[redacted]

Date: 04/06/98

FR Agency: [redacted]

Unit Number: [redacted]

Agency Incident Number: [redacted]

Incident Location: ○ Home ○ Work ● Public Place ○ Other Location

[redacted]

City: [redacted]

Date of Birth: [redacted]

Pt Home ZIP Code: [redacted]

Sex: ○ Male ● Female

Age: 15 ● Year ○ Month ○ Day

Pt #: 01 of Pts: 01

Time Call Received by FR Agency: 18:49:35

Time FR Unit Dispatched: 18:50:12

Time FR Unit On Scene: 18:52:58

Time FR Unit Available: 19:08:20

Chief Complaint: Full Arrest

Estimated Time FR Personnel at Pt Side: 18:53

BP/Systolic: ○ Palp

BP / Diastolic:

Initial Pulse: ○ Regular ○ Irregular

Pt. Weight:

Resp Rate:

Past Medical History: ○ None ○ Unknown ○ Asthma ○ Cancer ○ Cardiac ○ CHF ○ COPD ○ CVA ○ Diabetes ○ HTN ○ Seizures ○ Other

Level of Consciousness: ○ Awake ○ Responds to Verbal ○ Responds to Pain ● Unresponsive ○ Disoriented

Orientation: ○ Person ○ Place ○ Time ○ Purpose

Skin Moisture: ○ Normal ○ Dry ○ Moist ○ Diaphoretic

Skin Color: ○ Normal ○ Pale ○ Cyanotic ○ Flushed ○ Jaundiced

Skin Temp: ○ Warm ○ Hot ○ Cool ○ Cold

Pupils: ○ PERL ○ Pinpoint ○ Midpoint ○ Fixed ○ Dilated ○ Unequal

Capillary Refill: ○ Normal ○ Delayed ○ None

Treatment: ● CPR ○ Oral Airway ○ Nasal Airway ● BVM ● Oxygen at 5 L/min ○ Mask ○ Cannula ● Suction ○ C-Spine ○ Splints ○ Traction Splint ○ Dressings ○ Extrication ○ OB Assistance ○ Other

Time	BP	Pulse	Resp	Narrative
				Pt Found Pulseless, Apnic upon Arrival, Sherriff Deputy Performing CPR bystander Advised Pt collapsed from a collision After complaint of Abdominal Pain [redacted]

Cardiac Arrest Prior to ALS Arrival: ● Yes ○ No

DNR Form Present: ○ Yes ● No

Time of Collapse Unknown: ○

Estimated Time of Collapse: 18:42

Witnessed: ○ No ○ EMS Personnel ● Bystander

CPR Initiated?: ○ No ○ EMS Personnel ● Bystander

Estimated Time CPR Started: 18:51

SAED Connected?: ● Yes ○ No

FR Defibrillation: ● Yes ○ No

Shocks: 2

Return of Pulses in Field?: ● Yes ○ No

Field Determination of Death: ○ Yes ● No

Transported To: ○ CMH ○ LRRMC ○ OVCH ○ PVH ○ SJRMC ● SPMH ○ SVH ○ VCMC ○ LAC ○ SBC ○ AMA Signed

Transport Agency: ○ Gold Coast ○ VCFD ● MedTrans ○ SAR ○ Ojai

Unit #: [redacted]

Est Time Care Transferred to Ambulance: 18:57

Other Agency on Scene: ● Yes ○ No

Agency Name: [redacted]

Incident Location Geo Ref:

FR Rider in Amb: ● Yes ○ No

[redacted] Printed Name

Crew1/SAED Operator: [redacted]

Crew Member 3: [redacted]

[redacted] Printed Name

[redacted] Printed Name

Crew Member 2: [redacted]

Crew Member 4: [redacted]

[redacted] Printed Name

[redacted]

000002

PATIENT CHART

[redacted] Best Quality FDA 3 [redacted] 5 [redacted]

INCIDENT INFORMATION

Date of Service: 04 / 06 / 98

ALS Provider: [redacted]

Code to Scene: ○ 1 ○ 2 ● 3

Code from Scene: ○ 1 ○ 2 ● 3

Unit Number: [redacted]

Transport Agency:

Dispatch Number:

Incident Location Geo Code:

Geo Code Assigned To:

Geo Code Responded From: [redacted]

Pt # 01 of 01 Pts

First Responder Form Number:

EMS Service Provider ID Number: [redacted]

Fire Department Incident Number:

Fire Department: [redacted]

Incident Address/City: [redacted]

Agency First on Scene: [redacted]

First Responder Care Given by: [redacted]

Incident Location

○ Residence ○ Pub Place
○ Surface St ○ EMS Rndzv
○ Frwy/Hwy ○ Hospital
○ Business ○ SNF
● School ○ Military Base [redacted]

Special Scene Conditions

○ Abused Patient ○ Form/DNR ○ Unsafe Scene
● Access Dly/EMS ○ HAZMAT ○ Use/Alcohol
○ Access Dly/Pt ○ Intentional Inj ○ Use/Drugs
○ Cmbtve/Uncoop ○ MCI ○ Weather
○ Crowds ○ Multi Amb Rspns ○ Work Related
○ Extrcatn>15 min ○ Poss Inf Dis Exper ○ Other
○ Form/CMO ● Terrain ○ Dr on Scene

Name/Title of Dr on Scene:

First Responder Care Given

○ Assess Pt ● CPR ○ Splinting
○ AED X ___ ○ Dressings ○ Vital Signs
○ AED NSI ○ Extrication ○ None
○ Airway ○ Immobilize ○ Other
○ Bkng Control ○ Oxygen

Safety Restraints Used

● None ○ Helmet
○ Lap Restraint ○ Prot Clothing
○ Shoulder ○ Other
○ Airbag ○ Unknown
○ Child Safety Seat

TIMES (Hr:Min:Sec)

Time Call Received: 18:45:38

Time Unit Dispatched: 18:46:27

Time Unit En Route: 18:46:56

Time Unit Arrives On Scene: 18:49:32

Depart Scene (Leave blank if pt not transported): 19:04:56

Arrv Destination (Leave blank if pt not transported): 19:20:09

Time Unit Available for Next Call: 19:46:18

PATIENT INFORMATION

Name: [redacted]

Address: [redacted]

City: [redacted]

Date of Birth: [redacted]

Gender: ○ Male ● Female

Age: 015 ● Yr ○ Mo ○ Day

Patient's Home ZIP Code: [redacted]

Social Security Number: ___ - __ - ____

Weight: 170 ● Lb ○ Kg

Past Medical History

● None ○ Cardiac ○ Diabetes
○ Unknown ○ CHF ○ HTN
○ Asthma ○ COPD ○ Seizures
○ Cancer ○ CVA ○ Other

ASSESSMENT INFORMATION

Level of Distress

○ Mild
○ Moderate
○ Severe
● Cardiac Arrest
○ None

Pt Chf Complaint: CAR

● Med ● Tra ● Blunt ○ Penetrating

Mech Injury (Trauma Only):

Location of Injury

○ Abd ● Chest ○ Hands ○ Neck
○ Arms ○ Face/Eye ○ Head ○ Pelvis
○ Back ○ Feet ○ Hip ○ Shoulders
○ Buttocks ○ Genitalia ○ Legs ○ Other

Pupils

○ PERL ○ Midpoint
○ Pinpoint ○ Unequal
● Dilated ○ Fixed

Airway: ● Patent ○ Obstructed

Resp Effort: ○ Normal (1) ○ Labored ○ Retractive (0) ● None

Chest Wall Mvmt: ● Equal ○ Unequal ○ None

Lung Sounds: ● Equal ○ Wheezes ○ Unequal ○ Rales ○ None ● Clear

Capillary Refill: ● 2 Normal ○ 1 Delayed ○ 0 None

Skin Moisture: ● Normal ○ Dry ○ Moist ○ Diaphoretic

Skin Color: ● Normal ● Pale / Ashen ○ Cyanotic ○ Flushed ○ Jaundiced

Skin Temp: ● Warm ○ Hot ○ Cool ○ Cold

Allergies to Medications: ● None

Current Medications ● None

Orientation

○ A&O x 4
○ Person
○ Place
○ Time
○ Purpose

Level of Consciousness

○ Conscious
● Unconscious
○ Disorientated - Normal State
○ Infant - Acting Appropriately

Neuro Evaluation (Document for Trauma/Altered Level of Consciousness)

Eye: ○ 4 Spontaneous ○ 3 To Voice ○ 2 To Pain ● 1 None

Verbal: ○ 5 Oriented ○ 4 Confused ○ 3 Inappropriate ○ 2 Garbled ● 1 None

Motor: ○ 6 Obeys command ○ 5 Localized Pain ○ 4 Withdraw pain ○ 3 Flexion (pain) ○ 2 Extension (pain) ● 1 None

Estimated Time to Pt Side: 18:52

NARRATIVE: Pt. was [redacted] witness states poss. collision c̄ other [redacted] witnessed cardiac arrest post short seizure activity. CPR started within 1-2 min. upon arrival pt pulseless / Apniec no obvious trauma to head or chest, two shocks delivered by F.D. prior to arrival of effect. at time of ET. pt. had gag reflex fr. short time had no effect on Et attempt - initial rhythm = st. PEA. pt has no medical Hx. post ET pt's skin color improved. throughout all pulses intermittent, enroute pt trying to [illegible] 6-8 per min [illegible] became more [illegible] [illegible]

EMS Pt Condition ID: CAR

[redacted] [redacted] Signature and Printed Name [redacted] Cert No.

[redacted]

000003

PATIENT CHART PAGE 1

[redacted]

Best Quality FDA

[redacted]

TREATMENT DOCUMENTATION

Initial Vital Signs	Estimated Time	BP/Systolic	BP / Diastolic	Initial Pulse	Resp Rate	Initial EKG Rhythm
	18:57	0 ○ Palp		0 ● Regular ○ Irregular	0	5 ○ Ectopy ● PEA ● Monitor

[redacted]

Oxygen	IV	Fluids	Attempts	Route	Estimated Time Established	Crew Mbr
○ Cannula ○ Mask L/Min 15	○ Not Indicated ● Sucessful ○ Unsuccessful	● NS ○ D5W	● 1 ○ 2 ○ 3	○ Saline Lock ● Peripheral IV ○ Intraosseous ○ Ext Jugular ○ PVAD	18:56	● 1 ○ 2 ○ 3

ALS Airway	ET Atmpts	Alt Atmpts	Estimated Time Established	Crew Mbr
○ Not Indicated ● Successful ○ Unsuccessful	● 1 ○ 2 ○ 3	○ 1 ○ 2 ○ 3	18:54	● 1 ○ 2 ○ 3

Time	BP	Pulse	Resp	Rhythm	Treatment (Dosage/Route/Joules, etc)	Response/Comments	Crew Member
1858	0	0	0	PEA	epi. 1mg IV	0	[redacted]
1903	—	—	—	PEA	epi. " " " epi. 1mg @ 1905	+ Carotid pulse	
1912	0	0	0	VFib	shock 200 ws	+ > idio. PEA	
1913	↓	↓	↓	IR	epi. 1mg IV		
1916				VFib	shock 300 ws		
1917				" "	lido. 100 mg IV		
1918				VF.	shock 360 ws		
1919	↓	↓	↓	IR	epi. 1 mg IV	+ pulses and pt Attempting	
1920	unable	130	6	St.	Atropine 1 mg IV	to breath on own & 6 ventilations.	
					* Story received by paramedic: no [illegible] was found [illegible] + that seizure activity > [illegible] [illegible] [illegible]

CHECK ONE:

☑ EMERG. REC[illegible]

☐ OUT-PT. SUR[illegible] PT TYPE: [redacted]

[redacted]

REG BY: BK

CHART COPY [redacted]

PATIENT

PATIENT NO.	MEDICAL RECORDS NO.	EMERG. RM. NO.	FAMILY PHYSICIAN	BROUGHT BY
[redacted]	[redacted]		[redacted]	[redacted]

PATIENT NAME - LAST, FIRST, MIDDLE INITIAL: [redacted]

BIRTH DATE	AGE	SEX	MAR. STAT.	ETHNIC	RELIGION	SPOUSE
[redacted]	15Y	[illegible]	S	C	[redacted]	

DR. NO.	DOCTOR NAME	PAT. SOC. SEC. NO.	OCCUPATION	EMPL. PHONE
	[redacted]	[redacted]	MINOR	( )

PATIENT EMPLOYER/ADDRESS:

ADM	DATE	TIME
	04/06/98	19:29 M

RESPONSIBLE PARTY

RESPONSIBLE PARTY NAME	EMPLOYER	DISCH	DATE	TIME
[redacted]	[redacted]			M.

RESPONSIBLE PARTY ADDRESS		REL./FR. PHONE
[redacted]	[redacted]	( )

RESPONSIBLE PARTY CITY, STATE, ZIP	HOME PHONE	RELATIVE, FRIEND OR GUARDIAN	RESP. PARTY SOC. SEC. NO.
[redacted]	[redacted]		

INSURANCE

	PLAN NO.	INSURANCE CO. NAME	INS CO. CODE	POLICYHOLDER NAME	REL.	CERTIFICATE NO.	GROUP NO.
(A)	[redacted]	[redacted]	[redacted]	[redacted]	YN	[redacted]	[redacted]
(B)							
(C)							

	COMPANY ADDRESSES	ICD-9 CODES
(A)	[redacted]	
(B)	[redacted]	
(C)		

BX:
CODE BLUE

[redacted] AMBULANCE RADIO CALL PROCEDURE

Time: _____ Unit [redacted] route (or on scene)

~~50~~ 14 yr old (male/female) Patient of Dr_____

Complaining of Blunt Trauma

Involved in S.T. 120 Chest AA/Fall/Etc.

Level of Consciousness_____ Vital Signs:

B.P.____/___Pulse_____ Respirations PEA

Skin_____ Pupils_____

Code Blue PEA

5 Epi E.T.

E.T.A. _____ Minutes 100 Lido 1 Atropine

THE DOCTOR HAS REI[illegible] TIENT TO
ARRANGE WITH A PHY[illegible]

We will do everything we [illegible] hat we can do for
you - however, the basic [illegible]
Your insurance contract [illegible] t with your
insurance company. We [illegible] see what the
insurance will pay." A mu[illegible] s it with us.

When you have determin[illegible] m your insurance
company. Fill them out ar[illegible]
The hospital will not be lia[illegible] othe
property of unusual value[illegible] e hc

CONSENT TO TREATMENT: The p[illegible] nesia
treatment or hospital services render[illegible] med
to the patient, including the radiologis[illegible] pital,
contractors, and as such are the ager[illegible]

The undersigned has read the abo[illegible] hat m

RELEASE OF INFORMATION: The [illegible] ntrac
the patient or to a family member o[illegible] ce c
companies, worker's compensation ca[illegible], welfare funds, or the patient's employer.

FINANCIAL AGREEMENT: The undersigned agrees, whether he signs as agent or as patient, that in consideration of the services to be rendered to the patient, h
obligates himself to pay the account of the hospital in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorn
[redacted] fees and collection expense. All delinquent accounts bear interest at th[redacted]

[redacted] V Father RELATIONSHIP [redacted]

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to [redacted] me, plus the State Disability
Insurance which is applicable to my account, but not to exceed the hospital's regular charges [redacted] financially responsible to the hospital
for charges not covered by my hospitalization plan.

Date of signing: _____, 19____

WITNESS

V Father
RELATIONSHIP TO PATIENT

LOS 7710
4/14/98
WRB (390)
Medical records from Hospital.

000005

EMERGEN ROOM MEDICAL RECORD

[redacted]

PATIENT'S COMPLAINT: CODE BLUE

E.R. NO. [redacted]

(E LOS 7710
4/14/98
WRB (390)
Medical records from [redacted] Hospital.

MEDICAL RECORD NO. [redacted]

PATIENT NAME [redacted]

DATE OF SERVICE 4-06-98

ADDRESS [redacted]

PHONE [redacted]

ARRIVAL VIA: 4-6 19:22 '98

DEPARTURE 4-6-98 2140

DATE OF BIRTH [redacted]

AGE 15 SEX F SPANISH SPK. ONLY BED #

NURSING OBSERVATIONS: 1922 ← INITIAL ASSESSMENT TIME

Code Blue - Full Cardiac arrest - CPR in progress IV N/S 1000cc @ ALS - On scene - sinus rhythm but no pulses felt CPR continued - PEA ET tube in place - Bagged 100% O2 PX while [redacted] went down on knees on ground had seizure & went into full arrest - Has been taking Rapid Fuel

TEMP
PULSE 120's
RESP Bagged
B.P. 115/23
F.H.T.
WT.
O.D.

ALLERGIES: ☐ NKA

CURRENT MEDS: Metabolic Cocktail, Rapid Fuel

FAMILY DOCTOR [redacted]

LAST TET TOX

EXAM. BY Dr. [redacted] TIME: 1922 ? time period ☐ DIP TET 0.5cc IM TIME SITE

PHYSICIAN'S REP[redacted]

Px 15y/o ♀ BIB Paramedics - collapsed while [redacted]
Initial hx - blunt chest trauma, head vs. chest → collapse.
Later hx - no trauma, pt. collapsed [redacted]. Had been using energy supplements. Initial rhythm upon Paramedics arrival was V fib. Pt. defibrillated x 3, given Epi, Brief period of PEA. Bystander CPR was begun immediately.
Upon arrival - pt. intubated, occas. spontaneous respirations. Unconscious. Sinus tach @ 100. BP 110/60
Skin - no cyanosis or ecchymosis. HEENT - atraumatic. Pupils dilated. TMs intact
Neck - no jerspitus. Lungs - equal BS bilat. Heart - RR.
Abd - mild distension, ⊕BS. Neuro - unresponsive to verbal or painful stimuli.
ED course - BP decreased to 84 systolic, responded to fluids. Fluids. Occul. posturing. This pattern repeated itself several times. DOF Neg. unilat. PVCs - treated c̄ Lidocaine 75 mg ⇒ BP pulses 3 mm + reactive. Epi 1 amp given. Dr. [redacted] consulted - CVP placed - 15 V 20.

MEDICATIONS
CT 5055

DIAGNOSIS Full Arrest

PHYSICIANS ORDERS AND TREATMENT

LAB ✓	X-RAY ✓	PROCEDURES ✓	MEDS ✓
CBC, Chem 20,	P-CXR's for ET tube	No, Foley, EKG	Epi 1 mg IVP x1
UA	rCVP placement		Lidocaine 75 mg IVP
ABG's x2	CXR's → pulm. edema pattern.		No HCO3 ⅔ amp IVP
	CT head scan → neg		PVC's LR x3
			Dopamine drip - D/c'd.
Initial ET Tube failed - re-intubated c̄ succinylcholine			Succinylcholine 80 mg IVP

SPECIAL INSTRUCTIONS [redacted]

RX

AUTHORITIES NOTIFIED ☐ SPPD ☐ FPD ☐ CHP ☐ SHERIFF ☐ CORONER ☐ OTHER

DISPOSITION: ☐ HOME ☒ ADMIT ICU ☐ TRANS TO ☐ AMA ☐ OTHER

CONDITION: ☐ SATISFACTORY ☒ critical

DEPARTED VIA: ☐ WALK ☐ CAR ☐ WC ☐ POLICE ☐ AMB ☒ GUERNEY ☐ CARRIED

DISCHARGED TO

ADMISSION CRITERIA:
SYSTEM: Neuro
SI: unconscious
IS: ICU - Vent.

NURSE'S SIGNATURE [redacted]

DATE 4-6-98

DO[redacted]

000006

DATE 4/6/98

M.D.

CHART COPY [redacted]

[redacted]

CARDIAC and/or RESPIRATORY RESUSCITATION RECORD

PATIENT NAME [redacted]

[redacted]

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]

000007

Resuscitation Team	Date & Time	Brief History:
Meds: [redacted]	4-6-98 1922	14yo ♂ Blunt trauma ♀ to chest Intubated Shocked X3 from V Fib
Scope [redacted]	Outcome: ICU	[redacted] → Seizures
EKG:	Pronounced at:	5 Epis 1 Atropine 100mg lidocaine in field
CPR: [redacted]	Pronounced by:	
Resp [redacted]		
MD: [redacted]		

ALLERGIES:

TIME	BP	P	R	IV	MEDICATIONS	PROCEDURES	CARDIAC RHYTHM	
1922						100% O2 to ET tube #7		Amber
			1000 #20	NS established		(L) antecubital —		Dr [redacted] notified
							ST 120s	lab work drawn
1926	115/73				Epi 1mg IVP			
						CXR done		
						CPR started — PEA		0 pulses
						CPR cont		Continues pulseless
1930								ABC's drawn —
				1000cc	NS to (L) ACBV		Amber to ET	100% O2 continuously
1935	108/91				NaHCO3 Amps ½ IVP			
1936								Good pulse - Attempts to breathe
1938					16 Fr	Foley cath inserted		0 urine return
1940	124/79				Lidocaine	100 mg IVP		Dr [redacted]

RN SIGNATURE: [redacted]

RECORDER'S SIGNATURE: [redacted]

[redacted]

CARDIAC and/or RESPIRATORY RESUSCITATION RECORD

[redacted]

PATIENT NAME [redacted]

Resuscitation Team	Date & Time
Meds:	4-6-98
Scope:	Outcome:
EKG:	
CPR:	Pronounced at:
Resp:	Pronounced by:
MD:	

Brief History:

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]

[redacted]

000008

ALLERGIES:

TIME	BP	P	R	IV	MEDICATIONS	PROCEDURES	CARDIAC RHYTHM	
1941					Dopamine	400mg/250cc NS IV @ 7cc/hr		
1943	103/82	130				100% O2	con't to ET tube — SaO2 100%	
								Dr [redacted]
							ST 120's	IV 20 Ga @ hand c LR
				1000cc LR	IV 20 Ga Rt hand			All IV's TKO
								SaO2 100%
1945	108/71	115			Dopamine off —		BP maintained	
							Attempting	Double lumen CVP
								inserted/Dr [redacted]
1948	96/58	111				16Fr NG inserted		Dr [redacted] consulting c
1950						Pupils reactive		Dr [redacted] /phone
1955	99/48	109					SaO2 100%	100% O2/Ambu/ET tube
1958	99/46							
2000	103/67	96					SaO2 100%	Con't to insert central line

RN SIGNATURE: [redacted] **RECORDER'S SIGNATURE:** [redacted]

[redacted]

CARDIAC and/or RESPIRATORY RESUSCITATION RECORD

PATIENT NAME [redacted]

[redacted]

600000

Resuscitation Team	Date & Time
Meds:	4-6-98
Scope:	Outcome:
EKG:	
CPR:	Pronounced at:
Resp:	Pronounced by:
MD:	

Brief History:

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]

ALLERGIES:

TIME	BP	P	R	IV	MEDICATIONS	PROCEDURES	CARDIAC RHYTHM	
2005	110/78	109					ST 110's	SaO2 100%
2008						ABG's drawn	—	
2010	108/47	108						Central line in NS TKO
								SaO2 100%
2012	98/63	98						pH 7.19 pCO2 20 pO2 192
								∅ urine output
								NG output small amt br fld.
2015							ST 109	SaO2 100%
2020	117/40					→	→	CVP 22
						CXR for placement of Central line		
2025	119/84	102				C Spine X-Ray done		100% O2 / Ambu to
								ET tube continuously —
								2200cc fluid intake
								∅ urine output

RN SIGNATURE: [redacted] **RECORDER'S SIGNATURE:** [redacted]

[redacted]

CARDIAC and/or RESPIRATORY RESUSCITATION RECORD

PATIENT NAME [redacted]

000010

Resuscitation Team	Date & Time
Meds:	4-6-98
Scope:	Outcome:
EKG:	
CPR:	Pronounced at:
Resp:	Pronounced by:
MD:	

Brief History: ? Drown c̄ Seizure

ALLERGIES:

TIME	BP	P	R	IV	MEDICATIONS	PROCEDURES	CARDIAC RHYTHM	
2030	119/52	105					ST	CT spine repeat –
2033	108/79	109				Suctioned for lg amt		Frothy bloody sputum
2035								Posturing noted c̄ suction
2040	118/74	105				CVP 18		Suctioned lge amt frothy
								bloody sputum – posturing
								cont c̄ noxious stimuli
2045				Anectine	60mg IVP	ET tube cuff inflation		ET tube pulled –
	130/44	117						Reintubated c̄ 7.5 ET tube
								Spont resp assisted
								continuously c̄ O2 100% Ambu
2048								
2050								
2055								

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted] To [redacted]

RN SIGNATURE: [redacted]

RECORDER'S SIGNATURE: [redacted]

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]

[redacted]

Resuscitation Team	Date & Time
Meds:	4-6-98
Scope:	Outcome:
EKG:	
CPR:	Pronounced at:
Resp:	
MD:	Pronounced by:

CARDIAC and/or RESPIRATORY RESUSCITATION RECORD

Brief History:

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]

PATIENT NAME

[redacted]

000011

ALLERGIES:

TIME	BP	P	R	IV	MEDICATIONS	PROCEDURES	CARDIAC RHYTHM	
2115	126/62	117			Atropin 1mg IVP		ST	Airway inserted –
								Suctioned freely for
								frothy pink sputum –
2118	99/50	115					ST	In CT scan –
					Lasix 40 mg IVP			100% O2 to ambu/ET
					MS 1mg IVP			continuously –
2120	100/55	113					ST	In Scanner –
2125	93/48	110					ST	Out of scanner –
								Preparing to transfer
2127	91/52	112					ST	Return to ER
2130	96/56	111		250cc D5W c 30mEq KCl piggybacked @ 158cc/hr –				
2135	118/67	122					ST	100% O2 to ET tube
2134								To ICU –

RN SIGNATURE: [redacted]

RECORDER'S SIGNATURE: [redacted]

APR 6 8 01 PM

[redacted]

ID [redacted]
S.NO.
S.TYPE
AGE
SEX F
DRAW DATE 04/06/98
DRAW TIME 19:20

DATE 04/06/98 19:51
OPERATOR ID [redacted]
PATIENT NAME
PHYSICIAN
LOCATION

COMMENTS: STAT

TEST	RESULT	UNIT	RANGE	REMARK
SODIUM	142	mmol/L	(135- 150)	
POTASSIUM	2.7 L	mmol/L	(3.5- 5.5)	
CHLORIDE	100	mmol/L	(98- 110)	
BICARBONATE	12 L	mmol/L	(22- 29)	
ANION GAP	30 H		(5- 20)	
BUN	8	mg/dL	(5- 25)	
CREATININE	1.0	mg/dL	(0.5- 1.5)	
BUN/CREAT	8.0 L		(10.0- 24.0)	
GLUCOSE	276 H	mg/dL	(70- 115)	
CALCIUM	7.9 L	mg/dL	(8.4- 10.2)	
PHOSPHORUS	10.3 H	mg/dL	(2.3- 4.7)	
URIC ACID	5.4	mg/dL	(2.8- 6.6)	
TOTAL PROTEIN	5.7 L	g/dL	(6.0- 8.0)	
ALBUMIN	3.5	g/dL	(3.5- 4.8)	
GLOBULIN	1.7	gm/dL	(1.5- 3.7)	
A/G RATIO	2.1		(1.1- 2.2)	
LDH	301 H	U/L	(122- 220)	
AST (SGOT)	90 H	U/L	(0- 31)	
ALT (SGPT)	85 H	U/L	(0- 31)	
ALK PHOSPHATASE	88	U/L	(39- 117)	
TOTAL BILIRUBIN	0.3	mg/dL	(0.0- 1.0)	
CHOLESTEROL	99 L	mg/dL	(140- 200)	

[redacted]

fo ER

[redacted]

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]

[redacted]

Page : 1
Date : 04/06/1998
Time : 23:48:35

Med. Dir: [redacted] MD

BLOOD GAS REPORT

Patient: [redacted]

Patient Id : [redacted]
Sex : FEMALE
Note:
Department : [redacted]
Physician : [redacted]
Birthday : [redacted]
Age : 15 years

Sample: [redacted] from [redacted]

Date/time : 04/06/1998 23:41:00
Operator : [redacted] *M*
Copy : No
Type : ARTERIAL
Sample Id :
Accepted : YES
Accepted by: [redacted]
Transmitted: No
Physician : [redacted]
Department : [redacted]
Sampling T.: 04/06/1998 23:41:00
Sample Site: FEMORAL, LEFT

Note: Calibration at: 04/06/1998 23:15:00 was accepted.

Information values

Temperature: 37.0 C tHb Enter: 15.0 g %
Ventilator : VT 750 FIO2 100% PEEP +10 AçC 16 ACTUAL RATE 20- 37
Oxygen : 100% +10 PEEP

Blood Gas Values			
pH	7.290		7.350-7.450§
pCO2	30.0	mmHg	32.0- 45.0§
pO2	49.0	mmHg	83.0-108.0§
Acid-Base Status			
HCO3-	13.97	mmol/L	20.0- 24.0§
SBE	-11.30	mmol/L	-3.3- 1.2§

Blood Oximetry Values			
sO2	81.0	%	95.0- 99.0§

Compressed list

Date	Time	pH	pCO2 mmHg	pO2 mmHg	HCO3- mmol/L	SBE mmol/L	sO2 %	FIO2
04/06/1998	23:41:00	7.290	30.0*	49.0*	13.97*	-11.30*	81.0*	
Ventilator:VT 750 FIO2 100% PEEP +10 AçC 16 ACTUAL RATE 20-						Oxygen:100% +10 PEEP		
04/06/1998	20:08:00	7.190	20.0*	192.0*	7.34*	-19.44*	99.0	
Ventilator:						Oxygen:BAGGING 100%		
04/06/1998	19:29:00	6.840	14.0*	684.0*	2.26*	-28.51*	100.0*	
Ventilator:						Oxygen:BAGGING 100%		

LOS 7710
4/15/98
WRB (390)
Medical records from [redacted]

[redacted]

Approved: Reported:

RADIOLOGIC CONSULTATION

RADIOLOGISTS

PATIENT NAME:
DOB:
DOCTOR:
DATE: 4/6/98
X-RAY #:

CT OF THE BRAIN

HISTORY: Drug overdose. Comatose. Full arrest. Rule out bleed.

TECHNIQUE: Multiple contiguous 10 mm. scans were obtained through the brain without IV contrast material.

FINDINGS: Scans are suboptimal because of artifacts from motion, however, no ventricular dilatation or distortion is seen. No abnormal areas of increased or decreased density are seen. No intracerebral hemorrhage or mass effect is identified.

IMPRESSION: Negative examination.

M.D.

trans: 4/7/98
dict: 4/7/98

LOS 7710
4/14/98
WRB (390)
Medical records from

[redacted]

RADIOLOGIC CONSULTATION

RADIOLOGISTS
[redacted]

[redacted]

PATIENT NAME: [redacted]
DOB:
DOCTOR:
DATE. 4/6/98
X-RAY #: [redacted]

PORTABLE CHEST 2050 hours

HISTORY: New endotracheal tube.

AP portable supine view of the chest at 2050 hours shows no change in the position of the nasogastric tube. Endotracheal tube is in place with the tip now about 3 cm. above the carina. there is no change in position of the right subclavian CVP line. There is continued bilateral pulmonary infiltrate. The costophrenic angles are sharp.

IMPRESSION: New endotracheal tube now in place with the tip about 3 cm. above the carina. Continued bilateral interstitial infiltrates.

[redacted] M.D.
[redacted]
[redacted]
trans: 4/7/98
dict: 4/7/98

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]

[redacted]

[redacted]

RADIOLOGIC CONSULTATION

RADIOLOGISTS
[redacted]

[redacted]

PATIENT NAME: [redacted]
DOB:
DOCTOR:
DATE: 4/6/98
X-RAY #: [redacted]

PORTABLE CHEST 2020 hours

HISTORY: Post central line placement.

AP portable supine view of the chest at 2020 hours shows no change in the position of the nasogastric tube or endotracheal tube. The heart is within normal limits for size. There is a right subclavian central venous line in place with the tip in the area of the superior vena cava. No pneumothorax or pleural fluid is seen. There are now some bilateral perihilar interstitial infiltrates suggesting pulmonary edema. Aspiration is also a consideration.

IMPRESSION: Right subclavian CVP line in place with the tip in the area of the superior vena cava. Development of bilateral perihilar interstitial infiltrates suggesting pulmonary edema or possibly aspiration.

CROSS-TABLE LATERAL CERVICAL SPINE

HISTORY: Question of trauma.

Cross-table lateral views of the cervical spine show intervertebral disc spaces and vertebral alignment to be well maintained. The odontoid process is intact. No fracture or dislocation is seen. The prevertebral soft tissues are unremarkable. There is a nasogastric tube in place and an oral endotracheal tube in place.

IMPRESSION: No fracture is seen.

[redacted]M.D.
[redacted]
[redacted]
trans: 4/7/98
dict: 4/7/98

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]

[redacted]

[redacted]

RADIOLOGIC CONSULTATION

RADIOLOGISTS
[redacted]

[redacted]

PATIENT NAME. [redacted]
DOB·
DOCTOR:
DATE: 4/6/98
X-RAY #: [redacted]

PORTABLE CHEST 1925 hours

HISTORY: [redacted] Full arrest.

AP portable supine view of the chest at 1925 hours shows cardiac monitoring leads in place. There is a nasogastric tube in place with the distal end in the region of the antrum of the stomach. There is an endotracheal tube in place with the tip about 5 cm. above the carina. The heart and great vessels are within normal limits. There is no mediastinal widening. The lung fields and costophrenic angles are clear. Visualized bony structures are unremarkable.

IMPRESSION: No acute cardiopulmonary findings. Nasogastric tube and endotracheal tube in place.

[redacted] M.D.

[redacted]

trans: 4/7/98 [redacted]
dict: 4/7/98

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]

[redacted]

		SpO2 %	NIBP s / d (m) mmHg	Resp RPM	Temp °F	Time	HR BPM	SpO2 %	NIBP s / d (m)
20:00	119	100	106 / 71 (81)	---	---	19:48	[---]	---	110 / 70 (77)
19:59	125	95	117 / 73 (86)	---	---	19:47	[---]	---	124 / 79 (91)
19:58	114	96	106 / 80 (87)	---	---	19:45	[---]	---	126 / 67 (86)
19:57	121	95	102 / 68 (79)	---	---	19:42	[---]	---	108 / 91 (99)
19:56	71	91	102 / 71 (87)	---	---	19:36	[---]	---	115 / 73 (81)
19:55	69	100	110 / 65 (81)	---	---				
19:53	126	94	100 / 64 (76)	---	---				
19:53	127	100	104 / 63 (81)	---	---				
19:49	[---]	---	103 / 82 (89)	[redacted]				[redacted]	

Time	HR BPM	SpO2 %	NIBP s / d (m) mmHg	Resp RPM	Temp °F	Time	HR BPM	SpO2 %	NIBP s / d (m)
20:19	109	100	106 / 59 (76)	---	---	20:11	109	100	99 / 46 (68)
20:18	109	100	106 / 47 (77)	---	---	20:09	110	100	106 / 59 (80)
20:17	110	100	104 / 59 (77)	---	---	20:08	112	100	101 / 62 (76)
20:16	109	100	113 / 51 (76)	---	---	20:06	126	100	97 / 60 (76)
20:15	121	100	106 / 77 (87)	---	---	20:06	114	100	115 / 67 (77)
20:1	[illegible]	100	103 / 66 (80)	---	---	20:04	115	99	[illegible] / 68 (78)
20:1	[illegible]	0	110 / 88 (91)	---	---	20:03	121	100	[illegible] (73)
20:1	[illegible]	0	110 / 78 (92)	---	---	20:02	120	100	[illegible]
[illegible]	[illegible]	[illegible]	108 / 67 (84)	---	[redacted]	20:01	118	100	[redacted]

		SpO2 %	NIBP s / d (m) mmHg	Resp RPM	Temp °F	Time	HR BPM	SpO2 %	NIBP s / d (m) mmHg
20:40	[---]	---	103 / 79 (91)	---	---	20:29	102	100	115 / 51 (74)
20:39	117	96	113 / 49 (66)	---	---	20:28	74	98	117 / 40 (64)
20:37	92	88	123 / 65 (79)	---	---	20:28	98	100	101 / 75 (83)
20:35	101	96	119 / 52 (80)	---	---	20:26	90	100	98 / 63 (75)
20:35	100	94	110 / 77 (81)	---	---	20:24	101	100	103 / 58 (78)
20:34	99	100	107 / 61 (76)	---	---	20:23	102	100	101 / 66 (79)
20:33	101	100	106 / 76 (83)	---	---	20:22	108	98	102 / [illegible] (70)
20:31	[illegible]	100	119 / 87 (98)	---	---	20:21	113	98	103
20:30	[illegible]	[illegible]	110 / 58 (77)	[redacted]		20:20	109	[redacted]	107

EKG STRIP SHEET

[redacted]

[redacted]

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]

0000018

		O2	NIBP s / d (m) mmHg	Resp RPM	Temp °F	Time	HR BPM		/ d (m)
21:20	118	80]	116 / 69 (91)	97	----	20:51	102	96	101 / 58 (73)
21:19	123	[75]	126 / 85 (97)	34	----	20:50	107	87	93 / 73 (82)
20:58	109	[75]	121 / 54 (90)	---	----	20:49	103	88	105 / 60 (80)
20:57	117	[46]	126 / 62 (88)	---	----	20:48	101	88	101 / 63 (72)
20:56	115	[67]	130 / 44 (68)	---	----	20:46	104	[85]	116 / 61 (68)
20:55	115	[71]	137 / 64 (79)	---	----	20:45	118	[83]	118 / 74 (84)
20:		96	5 / 59 (76)	---	----	20:44	106	[85]	/ 72 (92)
20:		85]	60 (70)	---	----	20:43	[---]	---	91)
20:		34]	1 (75)	[redacted]	----		42	[--- [redacted]	

	HR BPM	SpO2 %	NIBP s mmHg
21:5	[---]	---	118 / 67 (90)
21:28	111	[62]	96 / 65 (74)
21:27	112	[62]	91 / 52 (64)
21:26	110	[25]	93 / 48 (63)
21:25	113	[71]	100 / 55 (72)
21:24	116	[63]	100 / 53 (69)
21:23	115	[73]	99 / 57 (69)
		---]	113 / 57
2	[redacted]		105 / 6

[redacted]

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]

000019

[redacted]

Page : 1
Date : 04/06/1998
Time : 23:37:38

Med. Dir: [redacted]

BLOOD GAS REPORT

Patient: [redacted]

Patient Id : [redacted]
Sex : FEMALE
Note:

Department : [redacted]
Physician : [redacted]

Birthday : [redacted]
Age : 15 years

Sample: [redacted] from [redacted]

Date/time : 04/06/1998 20:08:00
Operator : [redacted]
Copy : No
Type : ARTERIAL
Sample Id :

Accepted : YES
M Accepted by: [redacted]
Transmitted: No

Physician :
Department :
Sampling T.: 04/06/1998 20:08:00
Sample Site: FEMORAL, RIGHT

Note: Calibration at: 04/06/1998 20:00:00 was accepted.

Information values

Temperature: 37.0 C tHb Enter: 15.0 g %
Ventilator :
Oxygen : BAGGING 100%

------ Blood Gas Values ------				--- Blood Oximetry Values ----			
pH	7.190		7.350-7.450§				
pCO2	20.0	mmHg	32.0- 45.0§	sO2	99.0	%	.....X.§
pO2	192.0	mmHg	83.0-108.0§				
------ Acid-Base Status ------							
HCO3-	7.34	mmol/L	20.0- 24.0§				
SBE	-19.44	mmol/L	-3.3- 1.2§				

Compressed list

Date	Time	pH	pCO2 mmHg	pO2 mmHg	HCO3- mmol/L	SBE mmol/L	sO2 %	FIO2
04/06/1998	20:08:00	7.190	20.0*	192.0*	7.34*	-19.44*	99.0	
Ventilator:						Oxygen:BAGGING 100%		
04/06/1998	19:29:00	6.840	14.0*	684.0*	2.26*	-28.51*	100.0*	
Ventilator:						Oxygen:BAGGING 100%		

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]

[redacted] Approved: Reported:

[redacted]

Page : 1
Date : 04/06/1998
Time : 23:34:26

Med. Dir: [redacted]

BLOOD GAS REPORT

Patient: [redacted]

Patient Id [redacted] Department : [redacted] Birthday : [redacted]
Sex : FEMALE Physician : [redacted] Age : 15 years
Note:

Sample: [redacted] from [redacted]

Date/time : 04/06/1998 19:29:00 Accepted : YES Physician : [redacted]
Operator : [redacted] *M* Accepted by: [redacted] Department : [redacted]
Copy : No Transmitted: No Sampling T.: 04/06/1998 19:29:00
Type : ARTERIAL Sample Site: FEMORAL, RIGHT
Sample Id :
Note: Calibration at: 04/06/1998 18:45:00 was NOT accepted.

Information values

Temperature: 37.0 C tHb Enter: 15.0 g %
Ventilator :
Oxygen : BAGGING 100%

------ Blood Gas Values ------				--- Blood Oximetry Values ----			
pH	6.840		'7.350-7.450§				
pCO2	14.0	mmHg	' 32.0- 45.0§	sO2	100.0	%	' 95.0- 99.0§
pO2	684.0	mmHg	' 83.0-108.0§				
------ Acid-Base Status ------							
HCO3-	2.26	mmol/L	' 20.0- 24.0§				
SBE	-28.51	mmol/L	' -3.3- 1.2§				

Compressed list

Date	Time	pH	pCO2	pO2	HCO3-	SBE	sO2	FIO2
			mmHg	mmHg	mmol/L	mmol/L	%	
04/06/1998	19:29:00	6.840	14.0*	684.0*	2.26*	-28.51*	100.0*	

Ventilator: Oxygen:BAGGING 100%

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]

[redacted] Approved: Reported:

[redacted]

Page : 1
Date : 04/06/1998
Time : 23:48:35

Med. Dir: [redacted] MD

BLOOD GAS REPORT

Patient: [redacted]

Patient Id [redacted] Department : [redacted] Birthday : [redacted]
Sex : FEMALE Physician : [redacted] Age : 15 years
Note:

Sample: [redacted] from [redacted]

Date/time : 04/06/1998 23:41:00 Accepted : YES Physician : [redacted]
Operator [redacted] *M* Accepted by: [redacted] Department : [redacted]
Copy : No Transmitted: No Sampling T.: 04/06/1998 23:41:00
Type : ARTERIAL Sample Site: FEMORAL, LEFT
Sample Id :
Note: Calibration at: 04/06/1998 23:15:00 was accepted.

Information values

Temperature: 37.0 C tHb Enter: 15.0 g %
Ventilator : VT 750 FIO2 100% PEEP +10 AçC 16 ACTUAL RATE 20- 37
Oxygen : 100% +10 PEEP

------ Blood Gas Values ------				--- Blood Oximetry Values ----			
pH	7.290		'7.350-7.450§				
pCO2	30.0	mmHg	' 32.0- 45.0§	sO2	81.0	%	' 95.0- 99.0§
pO2	49.0	mmHg	' 83.0-108.0§				
------ Acid-Base Status ------							
HCO3-	13.97	mmol/L	' 20.0- 24.0§				
SBE	-11.30	mmol/L	' -3.3- 1.2§				

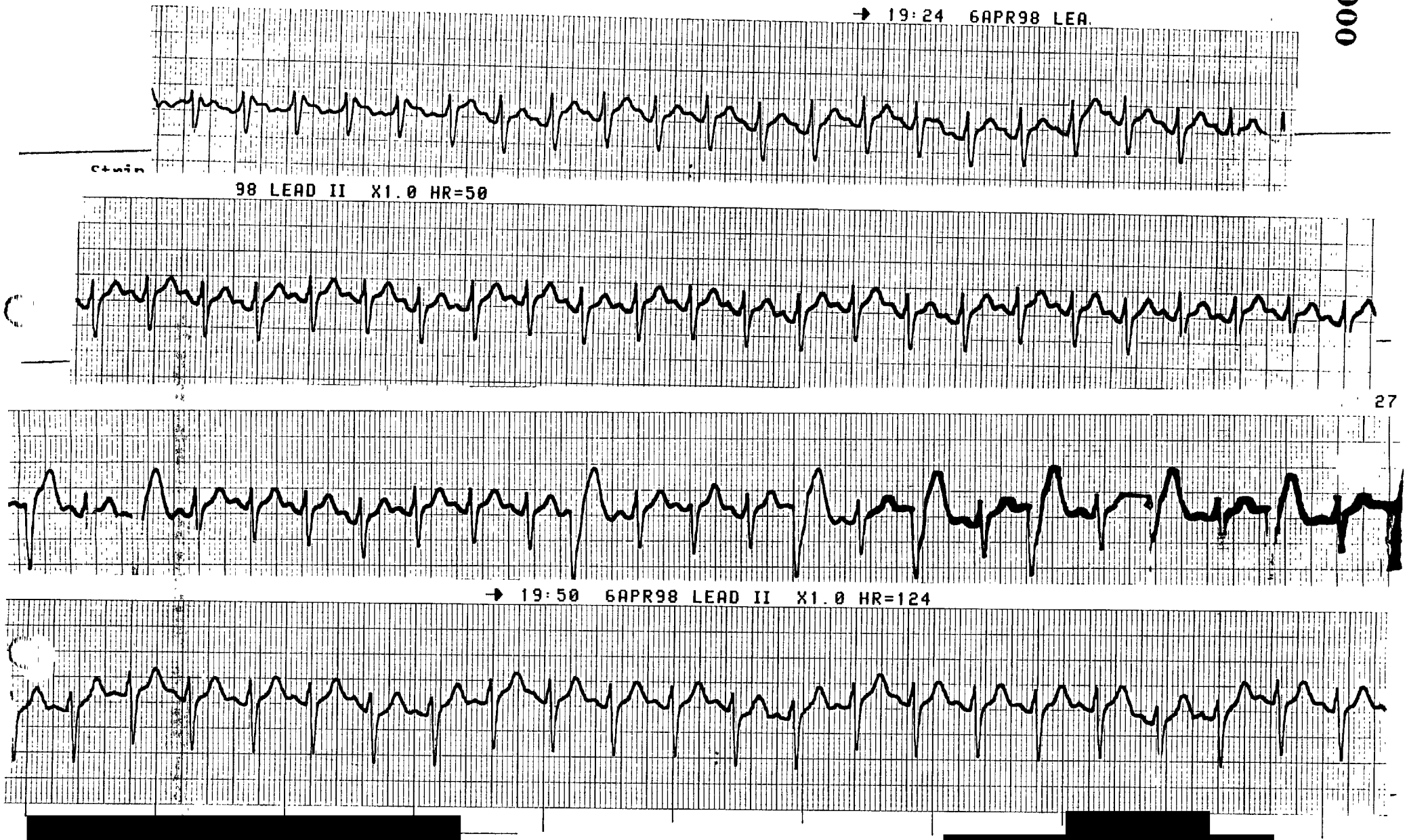
Compressed list

Date	Time	pH	pCO2 mmHg	pO2 mmHg	HCO3- mmol/L	SBE mmol/L	sO2 %	FIO2
04/06/1998	23:41:00	7.290	30.0*	49.0*	13.97*	-11.30*	81.0*	
Ventilator:VT 750 FIO2 100% PEEP +10 AçC 16 ACTUAL RATE 20-						Oxygen:100% +10 PEEP		
04/06/1998	20:08:00	7.190	20.0*	192.0*	7.34*	-19.44*	99.0	
Ventilator:						Oxygen:BAGGING 100%		
04/06/1998	19:29:00	6.840	14.0*	684.0*	2.26*	-28.51*	100.0*	
Ventilator:						Oxygen:BAGGING 100%		

[redacted] Approved: Reported: [redacted]

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]

000023



[redacted]

[redacted]

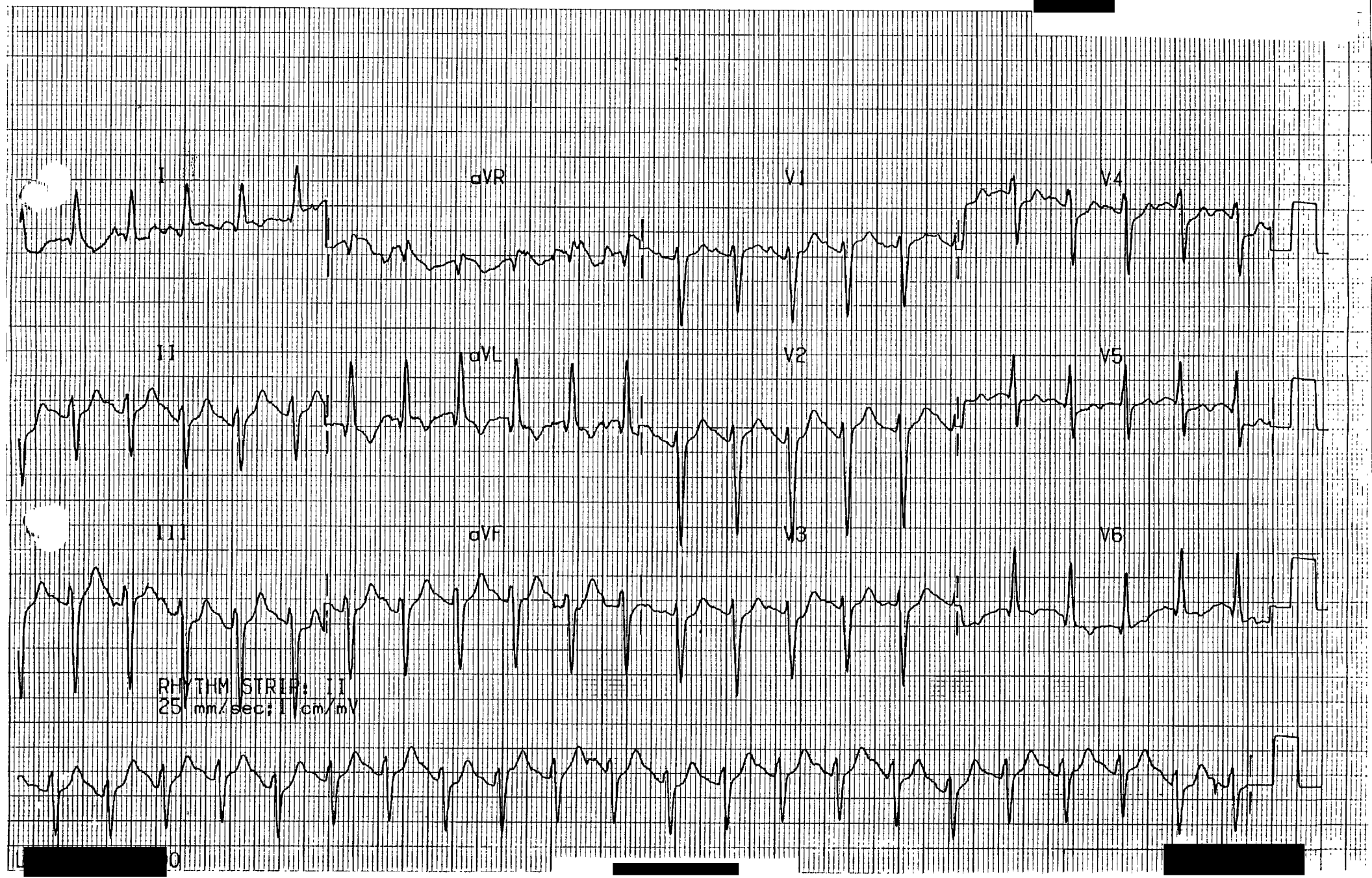
LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]

[redacted]

6 APR 98 18:46:17

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]

000024



[redacted]

[redacted]

[redacted]

[redacted]

ELECTROCARDIOGRAPHIC REPORT

Last Name	First Name	Initial	Room #	Hospital #
			[redacted]	

Birthdate	Age	Attending Physician	

Date and Time		EKG #	Emergency Room #
4-6-98	19:40	[redacted]	

Atrial Rate	Rhythm
—	MFAT
Ventricular Rate 130-150's	

Intervals	P.R.	QRS	Q-T	QRS Axis
	0.18 sec.	0.10 sec.	0.32 sec.	-60°

Clinical Interpretations or Remarks:

ST ↓ in I. AVL. V3-V6

Electrocardiographic Diagnosis:

MFAT

LAD

ST ↓ in lat. leads.

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]

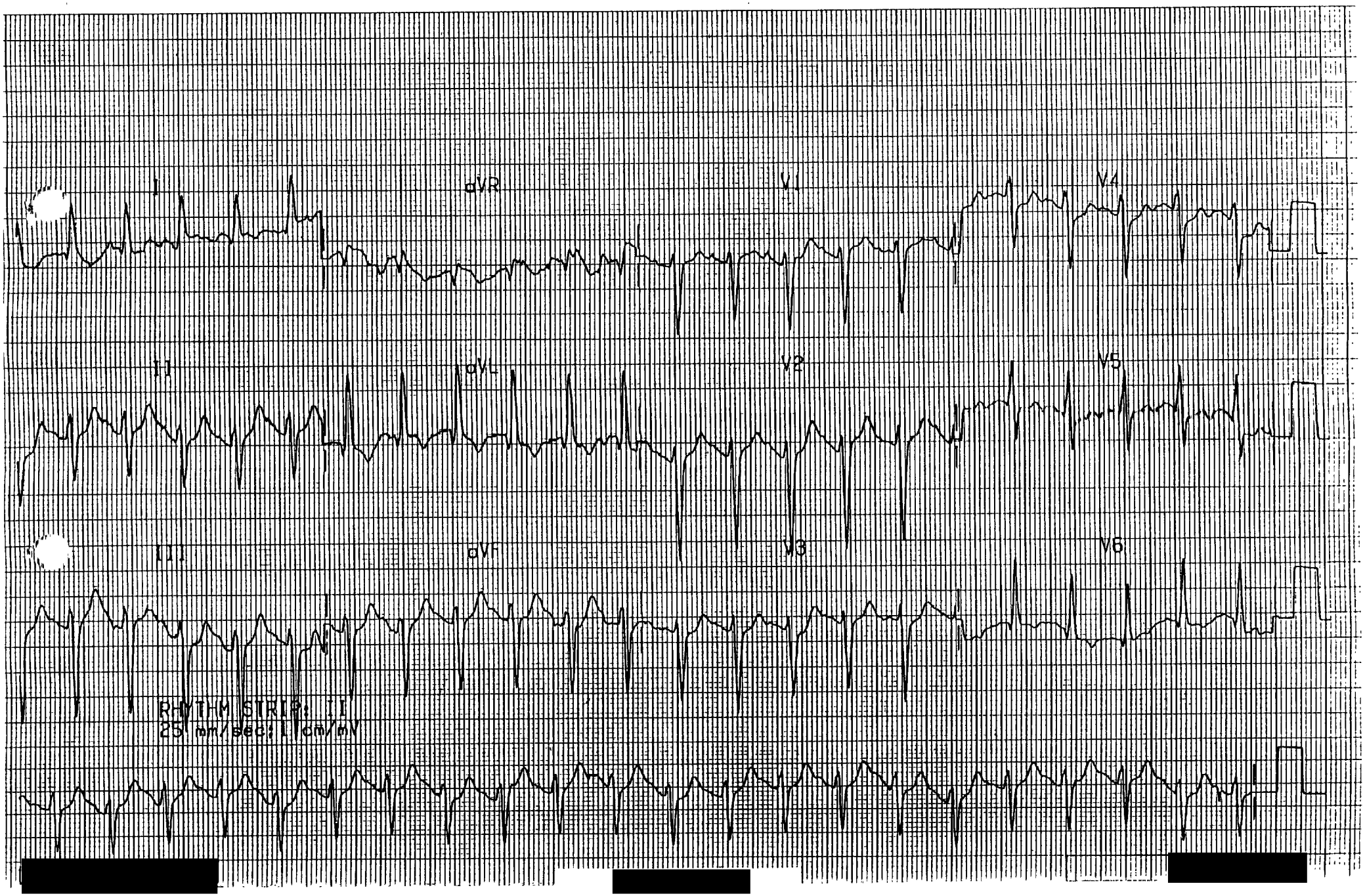
[redacted]

[redacted]

[redacted]

6 APR 98 18:46:17 LOS 7710
4/20/98
WRB (390)
Medical records from Dr. [redacted]

000026



[redacted] [redacted] [redacted]

[redacted]

ELECTROCARDIOGRAPHIC REPORT

Last Name	First Name	Initial	Room #	Hospital #
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Birthdate	Age	Attending Physician
[redacted]	15	[redacted]

Date and Time		EKG #	Billing #
04-06-98	1940	[redacted]	[redacted]

Atrial Rate	Rhythm
-	Multifocal atrial tachycardia.
Ventricular Rate	
130-150's	

Intervals	P.R.	QRS	Q-T	QRS Axis
	0.18 sec.	0.10 sec.	0.32 sec.	-60

Clinical Interpretations or Remarks:

ST depression in I, aVL and V3-V6.

[redacted]

Electrocardiographic Diagnosis:

1) Multifocal atrial tachycardia.
2) Left axis deviation.
3) ST depression in lateral leads.

LOS 7710
4/20/98
WRB (390)
Medical records from [redacted]

[redacted]

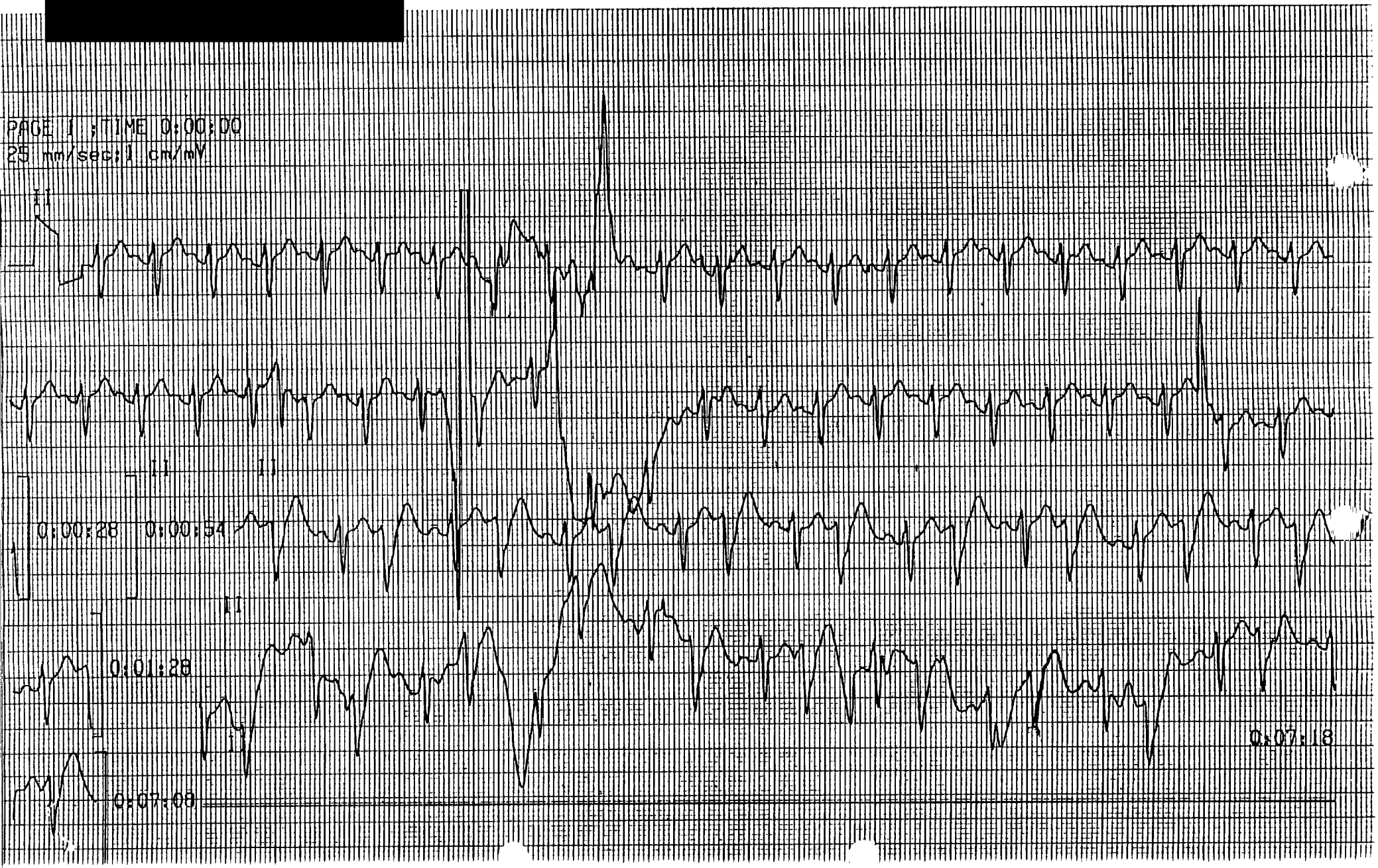
[redacted]

6 APR 98 18:27:47

LOS 7710
4/20/98
WRB (390)
Medical records from Dr. [redacted]

000028

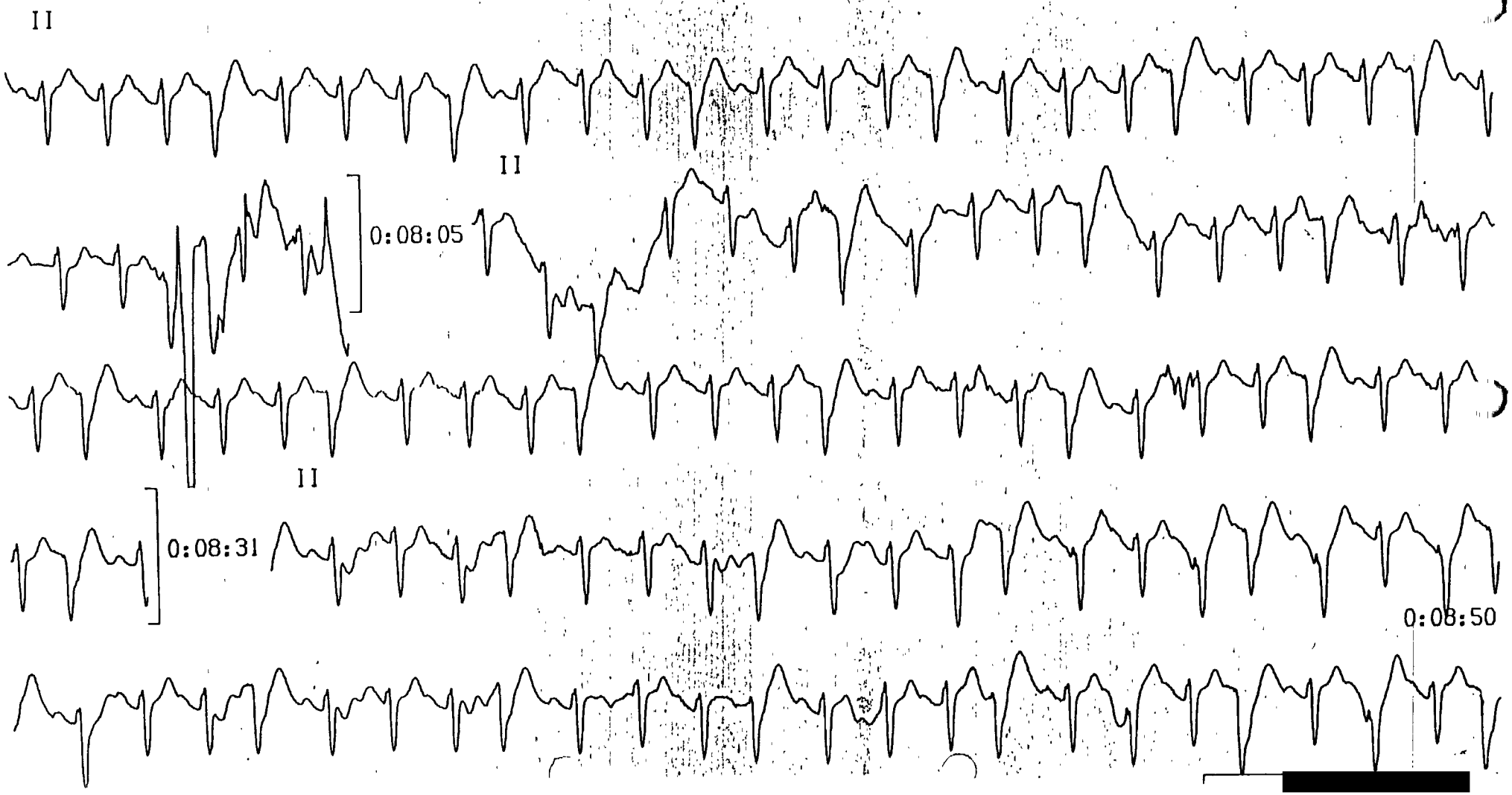
Code Blue



LOS 7710
4/20/98
WRB (390)
Medical records from Dr [redacted]

000029

PAGE 2 ;TIME 0:07:46
25 mm/sec;1 cm/mV



[redacted]

ELECTROCARDIOGRAPHIC REPORT CODE BLUE

Last Name	First Name	Initial	Room #	Hospital #
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Birthdate	Age	Attending Physician
[redacted]	15	[redacted]

Date and Time		EKG #	Billing #
04-06-98	1920	[redacted]	[redacted]

Atrial Rate	Rhythm
130	Sinus tachycardia.
Ventricular Rate 130	

Intervals	P.R.	QRS	Q-T	QRS Axis
	0.14 sec.	0.12 sec.	0.36 sec.	-

Clinical Interpretations or Remarks:

[redacted]

Electrocardiographic Diagnosis:

Rhythm strip: Sinus tachycardia with frequent premature atrial contractions.

LOS 7710
4/20/98
WRB (390)
Medical records from Dr. [redacted]

000030

[redacted]

[redacted]

[redacted]

ELECTROCARDIOGRAPHIC REPORT

Last Name	First Name	Initial	Room #	Hospital #
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Birthdate	Age	Attending Physician
[redacted]	15	[redacted]

Date and Time		EKG #	Billing #
04-06-98	1940	[redacted]	[redacted]

Atrial Rate	Rhythm
-	Multifocal atrial tachycardia.
Ventricular Rate	
130-150's	

Intervals	P.R.	QRS	Q-T	QRS Axis
	0.18 sec.	0.10 sec.	0.32 sec.	-60

Clinical Interpretations or Remarks:

ST depression in I, aVL and V3-V6.

Electrocardiographic Diagnosis:

1) Multifocal atrial tachycardia.
2) Left axis deviation.
3) ST depression in lateral leads.

000031

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]
[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]ELECTROCARDIOGRAPHIC REPORT

Last Name	First Name	Initial	Room # [redacted]	Hospital #
Birthdate	Age	Attending Physician		
Date and Time 4-6-98 @ 19:20		EKG # Code Blue [redacted]	Emergency Room #	
Atrial Rate 130.	Rhythm ST.			
Ventricular Rate 130				
Intervals	P.R. 0.14 sec.	QRS 0.12 sec.	Q-T 0.36 sec.	QRS Axis —

Clinical Interpretations or Remarks:

Electrocardiographic Diagnosis:

(1.) Rhythm strip: ST c PAC's freq.

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]

[redacted]

[redacted]

Page : 1
Date : 04/07/1998
Time : 07:10:34

Med. Dir: [redacted]

BLOOD GAS REPORT

Patient: [redacted]

Patient Id : [redacted] Department : [redacted] Birthday : [redacted]
Sex : FEMALE Physician : [redacted] Age : 15 years
Note:

Sample: [redacted] from [redacted]

Date/time : 04/06/1998 20:08:00 Accepted : YES Physician :
Operator : [redacted] *M* Accepted by: [redacted] Department :
Copy : No Transmitted: No Sampling T.: 04/06/1998 20:08:00
Type : ARTERIAL Sample Site: FEMORAL, RIGHT
Sample Id :
Note: Calibration at: 04/06/1998 20:00:00 was accepted.

Information values

Temperature: 37.0 C tHb Enter: 15.0 g %
Ventilator :
Oxygen : BAGGING 100%

------ Blood Gas Values ------				--- Blood Oximetry Values ----			
pH	7.190		'7.350-7.450§				
pCO2	20.0	mmHg	' 32.0- 45.0§	sO2	99.0	%	'.....X.§
pO2	192.0	mmHg	' 83.0-108.0§				
------ Acid-Base Status ------							
HCO3-	7.34	mmol/L	' 20.0- 24.0§				
SBE	-19.44	mmol/L	' -3.3- 1.2§				

Compressed list

Date	Time	pH	pCO2 mmHg	pO2 mmHg	HCO3- mmol/L	SBE mmol/L	sO2 %	FIO2
04/06/1998	20:08:00	7.190	20.0*	192.0*	7.34*	-19.44*	99.0	
Ventilator:						Oxygen:BAGGING 100%		
04/06/1998	19:29:00	6.840	14.0*	684.0*	2.26*	-28.51*	100.0*	
Ventilator:						Oxygen:BAGGING 100%		

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]

[redacted] Approved: Reported:

[redacted]

Page : 1
Date : 04/07/1998
Time : 07:10:48

Med. Dir: [redacted]

BLOOD GAS REPORT

Patient: [redacted]

Patient Id : [redacted] Department : [redacted] Birthday : [redacted]
Sex : FEMALE Physician : [redacted] Age : 15 years
Note:

Sample: [redacted] from [redacted]

Date/time : 04/06/1998 23:41:00 Accepted : YES Physician : [redacted]
Operator : [redacted] *M* Accepted by: [redacted] Department : [redacted]
Copy : No Transmitted: No Sampling T.: 04/06/1998 23:41:00
Type : ARTERIAL Sample Site: FEMORAL, LEFT
Sample Id :
Note: Calibration at: 04/06/1998 23:15:00 was accepted.

Information values

Temperature: 37.0 C tHb Enter: 15.0 g %
Ventilator : VT 750 FIO2 100% PEEP +10 AçC 16 ACTUAL RATE 20- 37
Oxygen : 100% +10 PEEP

------ Blood Gas Values ------				--- Blood Oximetry Values ----			
pH	7.290		7.350-7.450§				
pCO2	30.0	mmHg	32.0- 45.0§	sO2	81.0	%	95.0- 99.0§
pO2	49.0	mmHg	83.0-108.0§				
------ Acid-Base Status ------							
HCO3-	13.97	mmol/L	20.0- 24.0§				
SBE	-11.30	mmol/L	-3.3- 1.2§				

Compressed list

Date	Time	pH	pCO2 mmHg	pO2 mmHg	HCO3- mmol/L	SBE mmol/L	sO2 %	FIO2
04/06/1998	23:41:00	7.290	30.0*	49.0*	13.97*	-11.30*	81.0*	
Ventilator:VT 750 FIO2 100% PEEP +10 AçC 16 ACTUAL RATE 20-						Oxygen:100% +10 PEEP		
04/06/1998	20:08:00	7.190	20.0*	192.0*	7.34*	-19.44*	99.0	
Ventilator:						Oxygen:BAGGING 100%		
04/06/1998	19:29:00	6.840	14.0*	684.0*	2.26*	-28.51*	100.0*	
Ventilator:						Oxygen:BAGGING 100%		

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]

[redacted] Approved: Reported:

[redacted]

Page : 1
Date : 04/07/1998
Time : 07:11:02

Med. Dir: [redacted]

BLOOD GAS REPORT

Patient: [redacted]

Patient Id : [redacted] Department : [redacted] Birthday : [redacted]
Sex : FEMALE Physician : [redacted] Age : 15 years
Note:

Sample: [redacted] from [redacted]

Date/time : 04/07/1998 07:04:00 Accepted : YES Physician : [redacted]
Operator : [redacted] *M* Accepted by: [redacted] Department : [redacted]
Copy : No Transmitted: No Sampling T.: 04/07/1998 07:04:00
Type : ARTERIAL Sample Site: BRACHIAL, RIGHT
Sample Id :
Note: Calibration at: 04/07/1998 06:45:00 was accepted.

Information values

Temperature: 37.0 C tHb Enter: 15.0 g %
Ventilator : AC - 20; VT - 750; PEEP +10
Oxygen : 100%

------ Blood Gas Values ------				--- Blood Oximetry Values ----			
pH	7.430		'.....X...§				
pCO2	23.0	mmHg	' 32.0- 45.0§	sO2	99.0	%	'.....X.§
pO2	149.0	mmHg	' 83.0-108.0§				
------ Acid-Base Status ------							
HCO3-	15.00	mmol/L	' 20.0- 24.0§				
SBE	-8.51	mmol/L	' -3.3- 1.2§				

Compressed list

Date	Time	pH	pCO2 mmHg	pO2 mmHg	HCO3- mmol/L	SBE mmol/L	sO2 %	FIO2
04/07/1998	07:04:00	7.430	23.0*	149.0*	15.00*	-8.51*	99.0	
Ventilator:	AC - 20; VT - 750; PEEP +10					Oxygen:	100%	
04/06/1998	23:41:00	7.290	30.0*	49.0*	13.97*	-11.30*	81.0*	
Ventilator:	VT 750 FIO2 100% PEEP +10 AçC 16 ACTUAL RATE 20-					Oxygen:	100% +10 PEEP	
04/06/1998	20:08:00	7.190	20.0*	192.0*	7.34*	-19.44*	99.0	
Ventilator:						Oxygen:	BAGGING 100%	
04/06/1998	19:29:00	6.840	14.0*	684.0*	2.26*	-28.51*	100.0*	
Ventilator:						Oxygen:	BAGGING 100%	

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]

[redacted] Approved: Reported [redacted]

[redacted]

Page : 1
Date : 04/07/1998
Time : 07:10:26

Med. Dir: [redacted]

BLOOD GAS REPORT

Patient: [redacted]

Patient Id : [redacted] Department : [redacted] Birthday : [redacted]
Sex : FEMALE Physician : [redacted] Age : 15 years
Note:

Sample: [redacted] from [redacted]

Date/time : 04/06/1998 19:29:00 Accepted : YES Physician : [redacted]
Operator : [redacted] *M* Accepted by: [redacted] Department : [redacted]
Copy : No Transmitted: No Sampling T.: 04/06/1998 19:29:00
Type : ARTERIAL Sample Site: FEMORAL, RIGHT
Sample Id :
Note: Calibration at: 04/06/1998 18:45:00 was NOT accepted.

Information values

Temperature: 37.0 C tHb Enter: 15.0 g %
Ventilator :
Oxygen : BAGGING 100%

------ Blood Gas Values ------				--- Blood Oximetry Values ----			
pH	6.840		'7.350-7.450§				
pCO2	14.0	mmHg	' 32.0- 45.0§	sO2	100.0	%	' 95.0- 99.0§
pO2	684.0	mmHg	' 83.0-108.0§				
------ Acid-Base Status ------							
HCO3-	2.26	mmol/L	' 20.0- 24.0§				
SBE	-28.51	mmol/L	' -3.3- 1.2§				

Compressed list

Date	Time	pH	pCO2 mmHg	pO2 mmHg	HCO3- mmol/L	SBE mmol/L	sO2 %	FIO2
04/06/1998	19:29:00	6.840	14.0*	684.0*	2.26*	-28.51*	100.0*	

Ventilator: Oxygen:BAGGING 100%

LOS 7710
4/14/98
WRB (390)
Medical records from [redacted]
Hospital.

[redacted] Approved: Reported: