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

ARMS#

12843

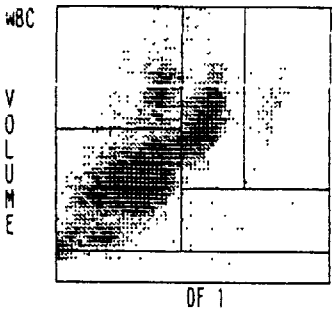
7 - PROCEDURES

HEM. .OLOGY

04/06/98 19:52:05 [redacted]

[redacted]

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



Patient Results	[redacted]	TIME 1945	TECH [redacted]

CBC+Diff [redacted] ----------

DATE: 04/06/98 TIME: 19:29:07

Name [redacted]

Room [redacted]
Physician [redacted]

Date & Time 04/06/98 19:20
Age 15
Patient ID#: [redacted]

Sex F

Abnormal WBC Pop			Normal RBC Pop			Normal PLT Pop		
WBC	7.9	10^3/uL	RBC	4.14	10^6/uL	PLT	292	10^3/uL
NE	26.1 L	%	HGB	11.3	g/dL	MPV	7.3	fL
LY	65.1 H	%	HCT	34.2	%			
MO	6.8	%	MCV	82.5	fL			
EO	0.8	%	MCH	27.4	pg			
BA	1.2	%	MCHC	33.2	g/dL			
NE	2.1	10^3/uL	RDW	12.3	%			
LY	5.1 H	10^3/uL	RET%		%			
MO	0.5	10^3/uL	RET#		10^6/uL			
EO	0.1	10^3/uL						
BA	0.1	10^3/uL						

☒ Manual Differential Performed - See Box Below

[redacted]

Reference Ranges

	MEN	WOMEN	UNIT
WBC	4.8 - 10.8		x 10^3
RBC	4.7 - 6.1	4.2 - 5.4	x 10^6
Hgb	14 - 18	12 - 16	g/dl
Hct	42 - 52	37 - 47	%
MCV	80 - 94	81 - 99	fl
MCH	27 - 31		pg
MCHC	32 - 36		g/dl
RDW	11.2 - 14.5		%
PLT	130 - 400		x 10^3
MPV	7.4 - 10.4		fl

DIFFERENTIAL COUNT	%	Absolute x 10^3
Neutrophil	43 - 65	2.2 - 4.8
Lyphocyte	20.5 - 45.5	1.3 - 2.9
Monocyte	5.5 - 11.7	0.3 - 0.8
Eosinophil	0.9 - 2.9	0 - 0.2
Basophil	0.2 - 1.0	0 - 0.1

NRBC/100WBC

CORRECTED WBC COUNT x 10^3

APR 6 7 54 PM '98

Manual Differential	
Segs	23 %
Bands	%
Lymphs	68 %
Monos	7 %
Eos	2 %
Basos	%
	%
	%
	%

RBC MORPHOLOGY

NORMAL		BURR [redacted]	+
MACRO	+	OVALO [redacted]	+
MICRO	+	SCHISTO [redacted]	+
ANISO [redacted]	+	HYPO	+
POIK [redacted]	+	POLY [redacted]	+

1 + Slight; 2 + Moderate; 3 + Marked

☐ Verified by Repeat Analysis

☐ Pathologist Review

Comments: _____

000002

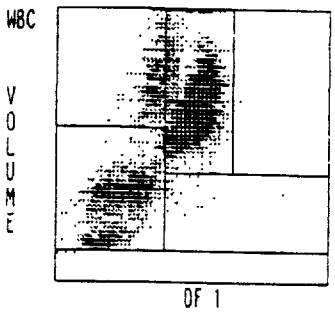
SIGNED TECHNOLOGIST [redacted]

HEMATOLOGY

04/07/98 15:37:47 [redacted]

[redacted]

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



Patient Results	REPORTED TO	TIME	TECH

CBC+Diff [redacted] ----------

DATE: 04/07/98 TIME: 15:37:42

Name [redacted]

Room
Physician [redacted]
Date of Birth Sex F
Comments:

Date & Time 04/07/98 15:24
Age 15
Patient ID#: [redacted]

Abnormal WBC Pop			Abnormal RBC Pop			Normal PLT Pop		
WBC	5.9	10^3/uL	RBC	4.02	10^6/uL	PLT	202	10^3/uL
			HGB	10.9	g/dL			
NE	76.3	%	HCT	32.1	%	MPV	7.1	fL
LY	17.3	%	MCV	79.9 L	fL			
MO	6.2	%	MCH	27.1	pg			
EO	0.1	%	MCHC	33.9	g/dL			
BA	0.1	%	RDW	12.5	%			
NE	4.5	10^3/uL						
LY	1.0	10^3/uL	RET%		%			
MO	0.4	10^3/uL	RET#		10^6/uL			
EO	0.0	10^3/uL						
BA	0.0	10^3/uL						

☒ Manual Differential Performed - See Box Below

Reference Ranges

	MEN	WOMEN	UNIT
WBC	4.8 - 10.8		x 10^3
RBC	4.7 - 6.1	4.2 - 5.4	x 10^6
Hgb	14 - 18	12 - 16	g/dl
Hct	42 - 52	37 - 47	%
MCV	80 - 94	81 - 99	fl
MCH	27 - 31		pg
MCHC	32 - 36		g/dl
RDW	11.2 - 14.5		%
PLT	130 - 400		x 10^3
MPV	7.4 - 10.4		fl

DIFFERENTIAL COUNT	%	Absolute x 10^3
Neutrophil	43 - 65	2.2 - 4.8
Lyphocyte	20.5 - 45.5	1.3 - 2.9
Monocyte	5.5 - 11.7	0.3 - 0.8
Eosinophil	0.9 - 2.9	0 - 0.2
Basophil	0.2 - 1.0	0 - 0.1

NRBC/100WBC

CORRECTED WBC COUNT x 10^3

Manual Differential		
Segs	37	%
Bands	*31	%
Lymphs	19	%
Monos	12	%
Eos	0	%
Basos	0	%
META	1	%
		%
		%

RBC MORPHOLOGY

NORMAL		BURR	+	2+ Moderate	1+ Slight
MACRO	+	OVALO	+		
MICRO	+	SCHISTO	+		
ANISO	+	HYPO	+		
POIK	+	POLY	+		3+ Marked

☐ Verified by Repeat Analysis

☐ Pathologist Review

Comments: _____

SIGNED TECHNOLOGIST [redacted]

APR 7 3 51 PM '98

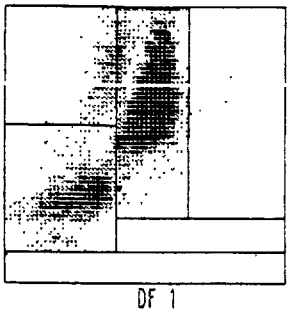
000003

HEM. .OLOGY

04/08/98 07:17:06 [redacted]

[redacted]

[redacted]



Patient Results	REPORTED TO	TIME	TECH
	ICU [redacted]	0715	[redacted]

CBC+Diff [redacted] ----------

DATE: 04/08/98 TIME: 07:17:01

Name [redacted]

Room
Physician [redacted]
Date of Birth Sex F
Comments:

Date & Time 04/08/98 06:30
Age 15
Patient ID#: [redacted]

Abnormal WBC Pop			Abnormal RBC Pop			Normal PLT Pop		
WBC	7.1	10^3/uL	RBC	3.56	10^6/uL	PLT	160	10^3/uL
			HGB	9.8 L	g/dL			
NE	81.7 H	%	HCT	28.7 L	%	MPV	7.6	fL
LY	14.9	%	MCV	80.5	fL			
MO	3.2	%	MCH	27.6	pg			
EO	0.1	%	MCHC	34.2	g/dL			
BA	0.1	%	RDW	12.2	%			
NE	5.8	10^3/uL						
LY	1.1	10^3/uL	RET%		%			
MO	0.2	10^3/uL	RET#		10^6/uL			
EO	0.0	10^3/uL						
BA	0.0	10^3/uL						

☐ Manual Differential Performed - See Box Below

[redacted]

Reference Ranges

	MEN	WOMEN	UNIT
WBC	4.8 - 10.8		x 10^3
RBC	4.7 - 6.1	4.2 - 5.4	x 10^6
Hgb	14 - 18	12 - 16	g/dl
Hct	42 - 52	37 - 47	%
MCV	80 - 94	81 - 99	fl
MCH	27 - 31		pg
MCHC	32 - 36		g/dl
RDW	11.2 - 14.5		%
PLT	130 - 400		x 10^3
MPV	7.4 - 10.4		fl

DIFFERENTIAL COUNT	%	Absolute x 10^3
Neutrophil	43 - 65	2.2 - 4.8
Lyphocyte	20.5 - 45.5	1.3 - 2.9
Monocyte	5.5 - 11.7	0.3 - 0.8
Eosinophil	0.9 - 2.9	0 - 0.2
Basophil	0.2 - 1.0	0 - 0.1

NRBC/100WBC -

CORRECTED WBC COUNT x 10^3

Manual Differential	
Segs	39 %
Bands	47 %
Lymphs	12 %
Monos	2 %
Eos	%
Basos	%
	%
	%
	%

RBC MORPHOLOGY

NORMAL		BURR	1 +	2 + Moderate	3 + Marked
MACRO	+	OVALO few	+		
MICRO	1 +	SCHISTO	+		
ANISO	+	HYPO	+		
POIK	1 +	POLY	+		

☐ Verified by Repeat Analysis

☐ Pathologist Review

Comments: No bands ↑↑

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

000004

SIGNED TECHNOLOGIST [redacted]

APR 8 8 34 AM '98 [redacted]

[redacted]

Name: [redacted]
MR# : [redacted]
Admt: 04/08/98

Loc: [redacted]
Age: 15Y
Sex: F

Dr.: [redacted]

BLOOD COUNT

DATE: 04/08/98
TIME: +1300

			NORMAL	UNITS
	Hemoglobin	**9.6***	12-16	gm/dl
	Hematocrit	**28.8***	37-47	%
	RBC	**3.61***	3.90-5.40	millions
	MCV	**79.9***	80.0-100.0	fl
	MCH	26.5	26-32	pg
	MCHC	33.2	31-36	gm/dl
	RDW	12.3	11.5-15.0	
	Platelet	168	150-450	K/mcl
	Mean Plt Vol	**7.1***	7.4-10.4	fl
	WBC	6.2	5.0-10.0	K/mcl
	Segmented Neut	**1.6***	1.8-6.7	K/mcl
		26%		
	Lymphocytes	**0.7***	1.5-5.0	K/mcl
		11%		
	Monocytes	**0.0****	0.1-1.0	K/mcl
		0%		
	Eosinophils	0.1	<0.7	K/mcl
		1%		
	Basophils	0.0	<0.2	K/mcl
		0%		
	Bands	**3.4****	0-0.7	K/mcl
		56%		
	Metamyelocytes	**0.4***	<0.1	K/mcl
		6%		
	RBC Morphology	(a)		
	WBC Morphology	(b)		
		(c)		

---FOOTNOTES---
(a) SLIGHT ANISOCYTOSIS
(b) TOXIC GRANULATION
(c) TOXIC VACUOLES

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

[redacted]

CONTINUED

Apr 6 8 01 PM

[redacted]

ID	[redacted]	DATE	04/06/98 19:51
S.NO.		OPERATOR ID	
S.TYPE		PATIENT NAME	[redacted]
AGE		PHYSICIAN	
SEX	F	LOCATION	
DRAW DATE	04/06/98		
DRAW TIME	19:20		

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	5.2 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]

lo [redacted]

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

APR 6 10 53 PM '98

[redacted]

ID	[redacted]	DATE	04/06/98 22:53
S.NO.		OPERATOR ID	[redacted]
S.TYPE		PATIENT NAME	
AGE	15 Y	PHYSICIAN	
SEX	F	LOCATION	
DRAW DATE	04/06/98		
DRAW TIME	22:30		

COMMENTS:

TEST	RESULT	UNIT	RANGE	REMARK
SODIUM	141	mmol/L	(135- 150)	
POTASSIUM	3.5 ↑	mmol/L	(3.5- 5.5)	
CHLORIDE	105	mmol/L	(98- 110)	
BICARBONATE	19 L	mmol/L	(22- 29)	
ANION GAP	17		(5- 20)	
BUN	13	mg/dL	(5- 25)	
CREATININE	0.9	mg/dL	(0.5- 1.5)	
BUN/CREAT	14.4		(10.0- 24.0)	
GLUCOSE	311 H	[redacted] mg/dL	(70- 115)	
MAGNESIUM	2.0	[redacted] mg/dL	(1.8- 2.4)	

[redacted]

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

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

[redacted]

ID	[redacted]	DATE	04/07/98 08:50
S.NO.		OPERATOR ID	[redacted]
S.TYPE		PATIENT NAME	
AGE	15 Y	PHYSICIAN	
SEX	F	LOCATION	
DRAW DATE	04/07/98		
DRAW TIME	08:00		

COMMENTS: FASTING

TEST	RESULT	UNIT	RANGE	REMARK
SODIUM	143	mmol/L	(135- 150)	
POTASSIUM	3.9	mmol/L	(3.5- 5.5)	
CHLORIDE	112 H	mmol/L	(98- 110)	
BICARBONATE	15 L	mmol/L	(22- 29)	
ANION GAP	16		(5- 20)	
BUN	23	mg/dL	(5- 25)	
CREATININE	1.5	mg/dL	(0.5- 1.5)	
BUN/CREAT	15.3		(10.0- 24.0)	
GLUCOSE	187 H	mg/dL	(70- 115)	
CALCIUM	7.4 L	mg/dL	(8.4- 10.2)	
PHOSPHORUS	1.9 L	mg/dL	(2.3- 4.7)	
URIC ACID	10.2 H	mg/dL	(2.8- 6.6)	
TOTAL PROTEIN	4.4 L	g/dL	(6.0- 8.0)	
ALBUMIN	2.9 L	g/dL	(3.5- 4.8)	
GLOBULIN	1.5	gm/dL	(1.5- 3.7)	
A/G RATIO	1.9		(1.1- 2.2)	
LDH	1595 H	U/L	(122- 220)	EDITED
AST (SGOT)	447 H	U/L	(0- 31)	
ALT (SGPT)	154 H	U/L	(0- 31)	
ALK PHOSPHATASE	60 L	U/L	(117- 390)	
TOTAL BILIRUBIN	0.4	mg/dL	(0.0- 1.0)	
CHOLESTEROL	65 L	mg/dL	(140- 200)	
CPK	14268 H	U/L	(24- 170)	EDITED
T4	5.7	µg/dL	(4.5- 12.0)	

[redacted]

[redacted]

ID	[redacted]	DATE	04/07/98 15:43
S.NO.		OPERATOR ID	[redacted]
S.TYPE		PATIENT NAME	
AGE	15 Y	PHYSICIAN	
SEX	F	LOCATION	
DRAW DATE	04/07/98		
DRAW TIME	15:22		

COMMENTS:

TEST	RESULT	UNIT	RANGE	REMARK
SODIUM	143	mmol/L	(135- 150)	
POTASSIUM	3.7	mmol/L	(3.5- 5.5)	
CHLORIDE	113 H	mmol/L	(98- 110)	
BICARBONATE	13 L	mmol/L	(22- 29)	
ANION GAP	17		(5- 20)	
BUN	26 H	mg/dL	(5- 25)	
CREATININE	1.7 H	mg/dL	(0.5- 1.5)	
BUN/CREAT	15.3		(10.0- 24.0)	
GLUCOSE	188 H	mg/dL	(70- 115)	

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

[redacted]

ID	[redacted]	DATE	04/08/98 07:48
S.NO.		OPERATOR ID	[redacted]
S.TYPE		PATIENT NAME	
AGE	15 Y	PHYSICIAN	
SEX	F	LOCATION	
DRAW DATE	04/08/98		
DRAW TIME	06:30		

COMMENTS: FASTING

TEST	RESULT	UNIT	RANGE	REMARK
SODIUM	140	mmol/L	(135- 150)	
POTASSIUM	4.7	mmol/L	(3.5- 5.5)	
CHLORIDE	110	mmol/L	(98- 110)	
BICARBONATE	16 L	mmol/L	(22- 29)	
ANION GAP	14		(5- 20)	
BUN	21	mg/dL	(5- 25)	
CREATININE	1.1	mg/dL	(0.5- 1.5)	
BUN/CREAT	19.1		(10.0- 24.0)	
GLUCOSE	168 H	mg/dL	(70- 115)	
CALCIUM	7.2 L	mg/dL	(8.4- 10.2)	
PHOSPHORUS	3.4	mg/dL	(2.3- 4.7)	
URIC ACID	7.8 H	mg/dL	(2.8- 6.6)	
TOTAL PROTEIN	4.5 L	g/dL	(6.0- 8.0)	
ALBUMIN	2.9 L	g/dL	(3.5- 4.8)	
GLOBULIN	1.6	gm/dL	(1.5- 3.7)	
A/G RATIO	1.8		(1.1- 2.2)	
LDH	2373 H	U/L	(122- 220)	EDITED
AST (SGOT)	696 H	U/L	(0- 31)	
ALT (SGPT)	220 H	U/L	(0- 31)	
ALK PHOSPHATASE	62 L	U/L	(117- 390)	
TOTAL BILIRUBIN	0.8	mg/dL	(0.0- 1.0)	
CHOLESTEROL	55 L	mg/dL	(140- 200)	

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

Name: [redacted]
MR#: [redacted]
Admt: 04/08/98
Loc: [redacted]
Age: 15Y
Sex: F
Dr.: [redacted]

CHEMISTRY PANELS

DATE:	[----------04/08/98----------]				
TIME:	+1700	+1620	+1300	NORMAL	UNITS
*PLEASE NOTE:			(d)		
			(e)		
Sodium			138	135-147	meq/l
Potassium			3.8	3.5-5.2	meq/l
Chloride			**113***	98-110	meq/l
CO2			**19***	24-32	meq/l
BUN			17	8-25	mg/dl
Creatinine			1.2	0-1.5	mg/dl
Glucose			**128***	75-125	mg/dl
AGAP			6	5-15	meq/l
BUN/Creat			14.2	7.0-28.0	ratio
Calcium			**8.4***	9.0-11.5	mg/dl
Bilirubin,Total			0.8	0.2-1.5	mg/dl
Alkaline Phos			**62***	100-350	U/l
AST (SGOT)			**601****	0-41	U/l
			VER		
Protein			**5.3***	6.0-8.5	gm/dl
Albumin			**3.1***	3.7-5.1	gm/dl
Globulin			2.2	2.0-4.1	gm/dl
A/G Ratio			1.4	1.1-2.1	ratio
O2 Input	100	100			
pH, Whole Blood	**7.31***	**7.21***		7.350-7.450	
PCO2, Whole Blood	**62.9****	**68.6****		34-45	mmHg
PO2, Whole Blood	**73***	**58***		80-100	mmHg
Pt. Temperature	37.0	37.0			
pH, Corrected WB	7.31	7.21			
PCO2, Corrected WB	63.0	68.6			MMHG
PO2, Corrected WB	73	58			MMHG
Hematocrit, Calc	**24***	**26***		37-47	%
Sodium, WB	141	139		135-147	mmol/L
Potassium, WB	4.0	4.1		3.5-5.2	mmol/L

---FOOTNOTES---

VER VERIFIED BY REPEAT ANALYSIS

(d) Please note that the composition of this panel has been changed due to a HCFA mandate. The COMPREHENSIVE METABOLIC PANEL does not include CO2,ALT,MG,PHOS,LDH,GGT,URIC,Direct Bilirubin, or Cholesterol.

(e) The EXPANDED COMPREHENSIVE METABOLIC PROFILE does include CO2,ALT,MG,PHOS, and LDH, but not Cholesterol,URIC,GGT, or Direct Bilirubin. Tests not included in the panel or profile must be ordered separately.

Name: [redacted]
MR# : [redacted] *Admt:* 04/08/98

Loc: [redacted]
Age: 15Y
Sex: F

Dr.: [redacted]

CHEMISTRY PANELS

DATE: [----------04/08/98----------]
TIME: +1700 +1620 +1300

					NORMAL	UNITS
	Chloride, WB	109	**112***		98-110	mmol/L
	Calcium, Ionized	**4.0***	**4.3***		4.6-5.4	mg/dl
	Glucose, WB	**145***	**147***		75-125	mg/dl
	Lactic acid, WB	**2.8***	**2.3***		0.4-0.8	mmol/L
	Hgb, Calculated	**7.8***	**8.7***		12-16	g/dl
	Base Excess	5.7	0.5			MMOL/L
			NEGATIVE			
	Bicarbonate, Std	29.6	23.8			MMOL/L
	Bicarbonate	**32.1***	**27.4***		22-26	mmol/L
	CO2, Total	34.0	29.5			mmol/L
	O2 Saturation	**92.4****	**82.1****		>95	%
	Oxygen Content	**10.3***	**10.0***		16.0-21.5	ml/dl

CHEMISTRY TESTS--ALPHABETIC (A-COM)

DATE: 04/08/98
TIME: +1300

				NORMAL	UNITS
	ALT (SGPT)	**192***		5-45	U/l
		VER			
	Calcium, Ionize	**4.3***		4.6-5.4	mg/dl

---FOOTNOTES---
VER VERIFIED BY REPEAT ANALYSIS

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

[redacted]

CONTINUED

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

Result	Test (Normal Range)
mg dl	Alcohol Ethyl (None Detected)
20,900	CPK, Total (M 24-195 F 24-170)
ng ml	CKMB (≤ 5 ng ml)
%	Relative Index ≤ 4%)
[redacted]	NTERPRETATION CKMB > 5% with relative INDEX > 4% suggestive of acute myocardial infract.
mosm kg	Osmolality Serum (278-305)
mosm kg	Osmolality (Urine)
g dl	Total Protein (6.0-8.0)
	Protein Electrophoresis
g dl	Albumin (3.5-4.8)
	Acetone Serum (None Detected)
	Titer Positive dilution
	Negative dilution
ng ml	PSA (0.0-4.0 ng ml)
MIU ml	TSH (0.3-5.0 uIU/ml)
mcg dl	Iron (30-160)
mcg dl	T4 (5.0-12.0)
umol	Ammonia (11-35)

Reported To	Time	Tech
[redacted]	1600	[redacted]

TIME NEEDED 4-7-98 1500

TECH

REMARKS VERIFIED BY DIAZ-TON

APR 7 3 59 PM '98

REPORT RELEASED

[redacted]

CHEMISTRY II 86 PM 22 CHART COPY

[redacted]

MOUNT REPORT 2 HERE | MOUNT REPORT 3 HERE | MOUNT REPORT 4 HERE | MOUNT REPORT 5 HERE | MOUNT REPORT 6 HERE

[redacted]

[redacted]

[redacted]

MOUNT REPORT 2 HERE

MOUNT REPORT 3 HERE

MOUNT REPORT 4 HERE

MOUNT REPORT 5 HERE

MOUNT REPORT 6 HERE

Result	Test (Normal Range)
mg/dl	Alcohol Ethyl (None Detected)
39550 U/L	CPK Total (M 24-195 F:24-170)
ng/ml	~~CKMB (≤ 5 ng/ml)~~
%	Relative Index (≤ 4%)
	INTERPRETATION CKMB > 5% with relative INDEX > 4% suggestive of acute myocardial infract
mosm/kg	Osmolality Serum (278-305)
mosm/kg	Osmolality (Urine)
g/dl	Total Protein (6.0-8.0)
	Protein Electrophoresis
	Albumin (3.5-4.8)
	Acetone Serum (None Detected)
	Titer Positive dilution
	Negative dilution
ng/ml	PSA (0.0-4.0 ng/ml)
uU/ml	TSH (0.3-5.0 uU/ml)
mcg/dl	Iron (30-160)
mcg/dl	[illegible]
[redacted]	Ammonia (11-35)

Received [redacted] Time Z240 Tech [redacted]

TIME NOTIFIED 4/1/98 2000

REMARKS [redacted]

REPORT RELEASED 10 37 PM '98

APR 7 10 00 PM '98

TRY II [redacted] CHART COPY [redacted]

[redacted]

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

CHEMISTRY

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

Result	Test	Result	Test	Result	Test (Normal Range)
mg dl	Alcol (Non	mg dl	Alco Nor	mg dl	Alcohol Ethyl (None Detected)
20,900 U/L	CPK (M 2-	39550 U/L	CPK M 2	26680 U/L	CPK, Total (M 24-195 F 24-170)
ng ml	CKM (≤ 5	ng ml	CKM ≤ 5	259 ng ml	CKMB (≤ 5 ng/ml)
%		%		1.0 %	Relative Index (≤ 4%)
[redacted]	NTE CKMI NDE ot act		NTE CKM NDE ot ac		NTERPRETATION CKMB > 5% with re ative NDEX > 4% suggestive of acute myocardial infract
kg	Osm (278-	mosm kg	Osm 278	mosm kg	Osmolality Serum (278-305
mosm kg	Osm	mosm kg	Osm	mosm kg	Osmolality Urine
g dl	Total	g dl	Tota	g dl	Total Protein (6.0-8.0)
	Prote Elect		Prot Elec		Protein Electrophoresis
g dl	Albur	g dl	Albu	g dl	Albumin (3.5-4.8)
	Acet Non		Acet Nor		Acetone Serum (None Detected)
	Ter		Ter		Ter Positive dilution
	Nega		Neg		Negative dilution
ng ml	PSA	ng ml	PSA	ng ml	PSA (0.0-4.0 ng/ml)
MIU ml	TSH	MIU ml	TSH	MIU ml	TSH (0.3-5.0 uIU ml)
mcg dl	Iron (	mcg dl	Iron	mcg dl	Iron (30-160)
mcg dl	T (5	mcg dl	T_4 (5	mcg dl	T_4 (5.0-12.0)
umoyl	Amm	umoyl	Amr	umoyl	Ammonia (11-35)
			[redacted]		
Reported To		Reported To		Reported To	Time / Tech
[redacted]					

[redacted]

[redacted]

[redacted]

CHEMISTRY II CHEMISTRY II CHEMISTRY II CHART COPY [redacted]

[redacted]

[redacted]

[redacted]

MOUNT REPORT 4 HERE | MOUNT REPORT 5 HERE | MOUNT REPORT 6 HERE

REMARKS

APR 8 10 25 AM '98

REPORT REL

CHEMISTRY

000015

Name: [redacted]
MR# : [redacted]
Admt: 04/08/98

Loc: [redacted]
Age: 15Y
Sex: F

Dr.: [redacted]

========== CHEMISTRY TEST--ALPHABETIC (COP-F) ==========

DATE: 04/08/98
TIME: +1300

				NORMAL	UNITS
	CPK	25240**		25-180	IU/l
		VER			
		DIL			
		CALL			
		[redacted]			

========== CHEMISTRY TESTS--ALPHABETIC (G-L) ==========

DATE: 04/08/98
TIME: +1300

				NORMAL	UNITS
	LDH	1878**		65-190	U/l
		VER			

========== CHEMISTRY TESTS--ALPHABETIC (M-P) ==========

DATE: 04/08/98
TIME: +1300

				NORMAL	UNITS
	Magnesium	1.3*		1.5-2.0	meq/l
	Phosphorus	3.1		3.0-6.0	mg/dl

---FOOTNOTES---
CALL RESULTS CALLED
DIL RESULT OBTAINED ON DILUTION
VER VERIFIED BY REPEAT ANALYSIS

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

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

TEST DESIRED: (ONE PER SLIP)

TO BE FILLED IN BY NURSING STAFF

DRUG: ASA

TIME OF LAST DOSAGE unknown

DATE OF LAST DOSAGE

DOSAGE AMOUNT

METHOD OF ADMINISTRATION ☐ I.M ☐ I.V ☐ P.O

SIG

RESULTS: For Lab Use Only

SPECIMEN DRAWN AT 2230 HRS.

BY: [redacted]

LEVEL: < 2-8 mg/dl

THERAPEUTIC LEVEL: varies

REPORTED TO:	TIME	TECH

> 30 mg/dl toxic

REMARKS

APR 6 11 24 PM '98

THERAPEUTIC DRUG MONITORING

CHART COPY

APR 6 10 27 PM '98

TECH.

TEST DESIRED: (ONE PER SLIP)

TO BE FILLED IN BY NURSING STAFF

DRUG: Tylenol

TIME OF LAST DOSAGE unknown

DATE OF LAST DOSAGE

DOSAGE AMOUNT

METHOD OF ADMINISTRATION ☐ I.M. ☐ I.V. ☐ P.O.

SIG

RESULTS: For Lab Use Only

SPECIMEN DRAWN AT 2230 HRS.

BY: [redacted]

LEVEL: < 10 µg/ml

THERAPEUTIC LEVEL: 10-30 µg/ml

REPORTED TO.	TIME	TECH.

REMARKS

APR 6 11 24 PM '98

THERAPEUTIC DRUG MONITORING

CHART COPY

APR 6 10 27 PM '98

SPEC COLLECTED

TECH.

000017

MISCELLANEOUS

[redacted]

LABORATORY REPORT

[redacted]

[redacted]

PATIENT NAME	PATIENT ID	ROOM NO.	AGE	SEX	PHYSICIAN
[redacted]			15		[redacted]

RACE	REQUISITION NO.	ACCESSION NO.	LAB REF. #	COLLECTION DATE & TIME	LOG-IN-DATE	REPORT DATE	& TIME
[redacted]				04/06/98	04/08/98	04/09/98	1:14PM

REMARKS

[redacted]

REPORT STATUS: FINAL

TEST	RESULT (IN RANGE / OUT OF RANGE)	UNITS	REFERENCE RANGE	SITE CODE
SUBSTANCE ABUSE PANEL [redacted]				[redacted]
* CHAIN OF CUSTODY	NO			
* SPECIMEN ANALYSIS WAS PERFORMED WITHOUT CHAIN OF CUSTODY * HANDLING. THESE RESULTS SHOULD BE USED FOR MEDICAL * PURPOSES ONLY AND NOT FOR ANY LEGAL OR EMPLOYMENT * EVALUATIVE PURPOSES. *				
* AMPHETAMINES (1000 ng/mL SCREEN)	NEGATIVE			
* BARBITURATES	NEGATIVE			
* BENZODIAZEPINES	NEGATIVE			
* COCAINE METABOLITES	NEGATIVE			
* MARIJUANA METABOLITES (100 ng/mL SCREEN)	NEGATIVE			
* METHADONE	NEGATIVE			
* METHAQUALONE	NEGATIVE			
* OPIATES	NEGATIVE			
* PHENCYCLIDINE	NEGATIVE			
* PROPOXYPHENE	NEGATIVE			
* PLEASE NOTE: CREAT = 12 MG/DL				

THIS URINE HAS AN UNUSUALLY LOW CREATININE (LESS THAN 20 MG/DL) LOW URINE CREATININES MAY BE ENCOUNTERED IN SAMPLES COLLECTED FROM NORMAL INDIVIDUALS DEPENDING ON THEIR FLUID INTAKE; LOW URINE CREATININES MAY ALSO BE ENCOUNTERED IN DILUTED SAMPLES. A DILUTE URINE MAY PRODUCE A FALSE NEGATIVE URINE DRUG SCREEN. A REPEAT STUDY MAY BE INDICATED IF A FALSE NEGATIVE OR SAMPLE DILUTION IS SUSPECTED.

* Reference footnote #1

>> REPORT CONTINUED ON NEXT PAGE <<

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

[redacted]

[redacted]

LABORATORY REPORT

[redacted]

MICROFILM# [redacted]

PATIENT NAME	PATIENT ID	ROOM NO.	AGE	SEX	PHYSICIAN
[redacted]			15		[redacted]

PAGE	LAB REF. #	COLLECTION DATE & TIME	LOG-IN DATE	REPORT DATE	& TIME
[redacted]		04/06/98	04/08/98	04/09/98	1:14PM

REMARKS

[redacted]

REPORT STATUS	TEST	RESULT IN RANGE	RESULT OUT OF RANGE	UNITS	REFERENCE RANGE	SITE CODE
FINAL						

Footnote 1

THE SUBMITTED URINE SPECIMEN WAS TESTED AT THE CUTOFFS LISTED BELOW.

DRUG CLASS	INITIAL TEST CUTOFF	CONFIRMATORY TEST CUTOFF	CONFIRMATORY METHOD
AMPHETAMINES	1000 ng/mL		
AMPHETAMINE		500 ng/mL	GC/MS
METHAMPHETAMINE		500 ng/mL	GC/MS
BARBITURATES	300 ng/mL		
AMOBARBITAL		200 ng/mL	GC/MS
BUTABARBITAL		200 ng/mL	GC/MS
BUTALBITAL		200 ng/mL	GC/MS
PENTOBARBITAL		200 ng/mL	GC/MS
PHENOBARBITAL		200 ng/mL	GC/MS
SECOBARBITAL		200 ng/mL	GC/MS
BENZODIAZEPINES	300 ng/mL	200 ng/mL	GC/MS
COCAINE METABOLITES	300 ng/mL	150 ng/mL	GC/MS
MARIJUANA METABOLITES	100 ng/mL	15 ng/mL	GC/MS
METHADONE	300 ng/mL	200 ng/mL	GC/MS
METHAQUALONE	300 ng/mL	200 ng/mL	GC/MS
OPIATES	300 ng/mL		
MORPHINE		300 ng/mL	GC/MS
CODEINE		300 ng/mL	GC/MS
PHENCYCLIDINE	25 ng/mL	25 ng/mL	GC/MS
PROPOXYPHENE	300 ng/mL	200 ng/mL	GC/MS

>> END OF REPORT <<

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

[redacted]

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

RESULT	TEST	X
	CBC WITH DIFF	X
	CBC WITHOUT DIFF	
g/dl	HEMOGLOBIN M: 14-18 F 12-16	
%	HEMATOCRIT M 42-52 F 37-47	
%	RETICS 0 5-2 0%	
mm	SED RATE M 0-10 mm F 0-20 mm	
12.7 sec	PROTHROMBIN TIME 11 4-13.4 sec	X
1.2	INR INTERNATIONAL NORMALIZED RATIO RECOMMENDED THERAPEUTIC RANGE 2.0-3.0	
PATIENT ON ANTICOAGULANT THERAPY?	YES / NO	
59 sec	PTT (< 34 sec)	X
mg/dl	FIBRINOGEN (200-400 mg.dl)	
mcg/ml	FDP (< 8 mcg/ml)	
min	TEMPLATE BLEEDING TIME (3-10 min)	

REPORTED TO [redacted]
DATE/TIME 4/16 [redacted]
REPORTED BY
REMARKS

TIME NEEDED

APR 6 8 05 PM '98

[redacted]

HEMATOLOGY CHART COPY

Drawn 1925

SPEC COLLECTED APR 6 7 49 PM '98

[redacted]

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[redacted]

[redacted]

[redacted]

000020

HEMATOLOGY

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

RESULT	TEST	X
	CBC WITH DIFF	X
	CBC WITHOUT DIFF	
g/dl	HEMOGLOBIN M 14-18 F 12-16	
%	HEMATOCRIT M 42-52 F 37-47	
%	RETICS 0.5-2.0%	
mm	SED RATE M 0-10 mm F 0-20 mm	
14.8 sec	PROTHROMBIN TIME 11.4-13.4 sec	X
1.7	INR INTERNATIONAL NORMALIZED RATIO RECOMMENDED THERAPEUTIC RANGE 2.0-3.0	
PATIENT ON ANTICOAGULANT THERAPY?	YES / NO	
49 sec	PTT (< 34 sec)	X
mg/dl	FIBRINOGEN (200-400 mg/dl)	
mcg/ml	FDP (< 8 mcg/ml)	
min	TEMPLATE BLEEDING TIME (3-10 min)	

REPORTED TO
DATE/TIME
REPORTED BY:
REMARKS

[redacted]

TECH

EASED

TIME NEEDED

4-7-98 1500

APR 7 3 47 PM '98

[redacted]

HEMATOLOGY CHART COPY

SPEC. COLLECTED APR 7 3 2 PM '98

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MOUNT REPORT 5 HERE

MOUNT REPORT 6 HERE

[redacted]

[redacted]

000021

HEMATOLOGY II

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

RESULT	RESULT	TEST	X
	C	CBC WITH DIFF	X
	C	CBC WITHOUT DIFF	
g/dl	H g/dl	HEMOGLOBIN M 14-18 F 12-16	
%	H %	HEMATOCRIT M 42-52 F 37-47	
%	R 0 %	RETICS 0 5-2.0%	
mm	S mm	SED RATE M 0-10 mm F 0-20 mm	
12.7 sec	Pl 14.8 sec	PROTHROMBIN TIME 11 4-13 4 sec	X
1.2	I RE TH 2 1.7	INR INTERNATIONAL NORMALIZED RATIO RECOMMENDED THERAPEUTIC RANGE 2.0-3.0	
PATIENT ON ANTICOAGUL THERAPY?	PATIENT ON ANTICOAGULANT THERAPY?	YES / NO	
59 sec	P 49 sec	PTT (< 34 sec)	X
mg/dl	F mg/dl	FIBRINOGEN (200-400 mg/dl)	
mcg/ml	F mcg/ml	FDP (< 8 mcg/ml)	
min	B min	TEMPLATE BLEEDING TIME (3-10 min)	
REPORTED TO	REPORTED TO:		
DATE/TIME. 4/1	DATE/TIME.		
REPORTED BY	REPORTED BY:		
REMARKS.	REMARKS		

[redacted]

TECH

RELEASED
TIME NEEDED 4-7-98 1500

APR 7 3 47 PM '98

[redacted]

HEMATOLOGY HEMATOLOGY CHART COPY

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APR 7 3 24 PM '98

MOUNT REPORT 3 HERE | MOUNT REPORT 4 HERE | MOUNT REPORT 5 HERE | MOUNT REPORT 6 HERE

[redacted]

[redacted]

HEMATOLOGY

Name: [redacted]
MR# : [redacted] *Admt:* 04/08/98

Loc: [redacted]
Age: 15Y
Sex: F

Dr.: [redacted]

PT AND PTT

DATE: 04/08/98
TIME: +1300

			NORMAL	UNITS
	PT	13.5	10.3-13.5	sec
	PT ratio	1.1		ratio
		PTRNL		
	INR	1.30		
		INRI0		
		INRI1		
	PTT	**38.0***	23.2-34.2	sec
	PTT ratio	1.3		ratio
		PTTRN		
	Anticoagulant	NONE		

DIC SCREEN--THROMBIN--FIBRINOGEN--DIMER

DATE: 04/08/98
TIME: +1300

			NORMAL	UNITS
	Fibrinogen	**>650***	200-400	mg/dl

---FOOTNOTES---

INRI0 Guidelines for monitoring PT using INR:

INRI1 Preop. oral anticoag. started 2 weeks before non-hip surgery: 1.50-2.50. Preop. oral anticoag. started 2 weeks before high risk surgery:2.00-3.00. Primary and secondary prevention of venous thrombosis and systemic embolism: 2.00-3.00. Acute myocardial infarction,atrial fibrillation,tissue heartvalves: 2.00-3.00. Mechanical prosthetic valves: 2.50-3.50.

PTRNL Reference ranges: Non-anticoagulated -- 0.9-1.1, Anticoagulated, venous thromboembolism -- 1.2-1.6, Anticoagulated, prosthetic valves -- 1.5-1.9

PTTRN Reference ranges: Non-anticoagulated -- 0.8-1.2, Anticoagulated (full dose heparin): 2.0-3.0.

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

[redacted]

CONTINUED

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

RESULT	TEST (NORM RANGE)	X
	HCG ENZYME IMMUNO	
	SERUM	
	URINE	X
	NEGATIVE	
	POSITIVE	
	URINE SP. GRAVITY 1-015	
	MONO SLIDE AGGL. (NEGATIVE)	
	NEGATIVE	
	POSITIVE	
	RHEUM. FACTOR SLIDE AGGL. (NEGATIVE)	
	NEGATIVE	
	POSITIVE	
	TITER	
	HIV ANTIBODY BY ELISA (NON REACTIVE)	
	NON REACTIVE	
	REACTIVE	
	RPR (NON REACTIVE)	
	NON REACTIVE	
	REACTIVE	
	COLD AGGLUTININ (NEGATIVE OR ≤ 1:32)	
	NEGATIVE	
	RAPID STREP Throat swab for Grp. A Streptococcal antigens by enzyme immunoassay (NEGATIVE)	
	NEGATIVE	
	POSITIVE	

REPORTED TO | DATE/TIME | Tech.

TIME NEEDED. REMARKS

APR 6 10 34 PM '98

REPORT RELEASED

[redacted]

IMMUNOLOGY CHART COPY

APR 6 10 27 PM '98

SPEC COLLECTED TECH

ROUTINE URINALYSIS ✓ CATH VOID

RESULT	TEST NORMAL RANGE
straw	COLOR (YELLOW/STRAW)
hazy	CHARACTER (CLEAR)
1.025	SP. GRAVITY (1.005-1.035)
5.0	PH (5-7.5)
e	Leukocyte Esterase (Negative)
e	NITRITE (Negative)
1+	PROTEIN (Negative)
2+	Sugar (Negative)
e	Ketones (Negative)
normal	Urobilinogen (0.1 - 1.0)
e	Bilirubin (Negative)
3+	Occult Blood (Negative)

[redacted]

MICROSCOPIC:

12-14	WBC / HPF 0 - 2 / HPF
10-12	RBC / HPF 0 - 2 / HPF
1+	EPITH. CELLS / LPF NONE TO 4+
2+	BACTERIA NONE TO FEW
e	TRICHOMONAS NONE
2+	AMORPHOUS DEP. NONE
e	CASTS / LPF NONE / HYALINE
occ	MUCUS THREADS NONE TO MOD
e	CRYSTALS NONE

TIME NEEDED: MISC COMMENTS DATE & TIME

APR 6 10 52 PM '98

[redacted]

URINALYSIS CHART COPY

APR 6 10 30 PM '98

SPEC COLLECTED TECH

[redacted]

[redacted]

000024

MISCELLANEOUS

[redacted]

Page : 1
Date : 04/06/1998
Time : 19:33:22

Med. Dir: [redacted]

BLOOD GAS REPORT [redacted]

Patient: ; ----------

Patient Id : [redacted]
Sex :
Note:

Department :
Physician :

Birthday : / /
Age :

Sample: [redacted] from [redacted] ----------

Date/time : 04/06/1998 19:29:00
Operator [redacted] *M*
Copy : No
Type : ARTERIAL
Sample Id :

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

Physician :
Department :
Sampling T.: 04/06/1998 19:29:00
Sample Site:

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 :

------ Blood Gas Values ------					--- Blood Oximetry Values ----			
pH	6.840			§				
pCO2	14.0	mmHg		§	sO2	100.0	%	§
pO2	684.0	mmHg		§				
------ Acid-Base Status ------								
HCO3-	2.26	mmol/L		§				
SBE	-28.51	mmol/L		§				

[redacted] Approved: Reported:

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

[redacted]

Page : 1
Date : 04/06/1998
Time : 22:29:43

Med. Dir: [redacted]

BLOOD GAS REPORT [redacted]

Patient: ; ----------

Patient Id : [redacted] Department : Birthday : / /
Sex : [redacted] Physician : Age :
Note:

Sample: [redacted] from [redacted] ----------

Date/time : 04/06/1998 22:25:00 Accepted : YES Physician :
Operator : [redacted] *M* Accepted by: [redacted] Department :
Copy : No Transmitted: No Sampling T.: 04/06/1998 22:25:00
Type : ARTERIAL Sample Site:
Sample Id :
Note: Calibration at: 04/06/1998 22:15:00 was accepted.

Information values ----------

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

------ Blood Gas Values ------					--- Blood Oximetry Values ----			
pH	7.260			§				
pCO2	38.0	mmHg		§	sO2	60.0	%	§
pO2	35.0	mmHg		§				
------ Acid-Base Status ------								
HCO3-	16.48	mmol/L		§				
SBE	-9.24	mmol/L		§				

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

[redacted] Approved: Reported:

[redacted]

Page : 1
Date : 04/07/1998
Time : 10:29:35

Med. Dir: [redacted]

BLOOD GAS REPORT

Patient: [redacted]

Patient Id : [redacted] Department : [redacted] Birthday : [redacted]
Sex : FEMALE Physician : [redacted] Age : 15 years
Note: ARREST; POSSIBLE ASPIRATION; POSS. DRUG OD

Sample: [redacted] from [redacted]

Date/time : 04/07/1998 10:23:00 Accepted : YES Physician : [redacted]
Operator : [redacted] *M* Accepted by: [redacted] Department : [redacted]
Copy : No Transmitted: No Sampling T.: 04/07/1998 10:23:00
Type : ARTERIAL Sample Site: RADIAL, RIGHT
Sample Id :
Note: Calibration at: 04/07/1998 10:15:00 was accepted.
RESULTS CALLELD TO DR. [redacted]

Information values

Temperature: 37.0 C tHb Enter: 15.0 g %
Ventilator : AC - 15; VT 650; PEEP 10; PRES SUP 10
Oxygen : 60%

------ Blood Gas Values ------				--- Blood Oximetry Values ----			
pH	7.440		'.....X..§				
pCO2	22.0	mmHg	' 32.0- 45.0§	sO2	97.0	%	'....X.....§
pO2	83.0	mmHg	'X.....§				
------ Acid-Base Status ------							
HCO3-	14.70	mmol/L	' 20.0- 24.0§				
SBE	-8.69	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	10:23:00	7.440	22.0*	83.0	14.70*	-8.69*	97.0	
Ventilator:	AC - 15; VT 650; PEEP 10; PRES SUP 10					Oxygen:	60%	
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]

000027

[redacted]

Page : 1
Date : 04/07/1998
Time : 15:16:02

Med. Dir: [redacted]

BLOOD GAS REPORT

Patient: [redacted]

Patient Id : [redacted] Department : [redacted] Birthday : [redacted]
Sex : FEMALE Physician : [redacted] Age : 15 years
Note: ARREST; POSSIBLE ASPIRATION; POSS. DRUG OD

Sample: [redacted] from [redacted]

Date/time : 04/07/1998 15:10:00 Accepted : YES Physician : [redacted]
Operator [redacted] *M* Accepted by: [redacted] Department : [redacted]
Copy : No Transmitted: No Sampling T.: 04/07/1998 15:10:00
Type : ARTERIAL Sample Site: BRACHIAL, RIGHT
Sample Id :
Note: Calibration at: 04/07/1998 14:15:00 was NOT accepted.

Information values

Temperature: 37.0 C tHb Enter: 15.0 g %
Ventilator : VT 650 FIO2 60% AçC12 PEEP +8 P.S. 20
Oxygen : 60% PEEP 8

------ Blood Gas Values ------				--- Blood Oximetry Values ----			
pH	7.410		'.....X.....§				
pCO2	23.0	mmHg	' 32.0- 45.0§	sO2	97.0	%	'....X.....§
pO2	85.0	mmHg	'X.....§				
------ Acid-Base Status ------							
HCO3-	14.29	mmol/L	' 20.0- 24.0§				
SBE	-9.47	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	15:10:00	7.410	23.0*	85.0	14.29*	-9.47*	97.0	
Ventilator:VT 650 FIO2 60% AçC12 PEEP +8 P.S. 20						Oxygen:60% PEEP 8		
04/07/1998	10:23:00	7.440	22.0*	83.0	14.70*	-8.69*	97.0	
Ventilator: AC - 15; VT 650; PEEP 10; PRES SUP 10						Oxygen: 60%		
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:

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

[redacted]

Page : 1
Date : 04/08/1998
Time : 06:54:55

Med. Dir: [redacted]

BLOOD GAS REPORT

Patient: [redacted]

Patient Id [redacted] Department : [redacted] Birthday : [redacted]
Sex : FEMALE Physician : [redacted] Age : 15 years
Note: ARREST; POSSIBLE ASPIRATION; POSS. DRUG OD

Sample: [redacted] from [redacted]

Date/time : 04/08/1998 06:49:00 Accepted : YES Physician : [redacted]
Operator : [redacted] *M* Accepted by: [redacted] Department : [redacted]
Copy : No Transmitted: No Sampling T.: 04/08/1998 06:49:00
Type : ARTERIAL Sample Site: BRACHIAL, RIGHT
Sample Id : [redacted]
Note: Calibration at: 04/08/1998 06:45:00 was accepted.

Information values

Temperature: 37.0 C tHb Enter: 15.0 g %
Ventilator : AC 12 VT650 FIO2 80% PEEP10 PS 10
Oxygen :

------ Blood Gas Values ------				--- Blood Oximetry Values ----			
pH	7.370		'.X.....§				
pCO2	31.0	mmHg	' 32.0- 45.0§	sO2	100.0	%	' 95.0- 99.0§
pO2	302.0	mmHg	' 83.0-108.0§				
------ Acid-Base Status ------							
HCO3-	17.49	mmol/L	' 20.0- 24.0§				
SBE	-6.79	mmol/L	' -3.3- 1.2§				

Compressed list

Date	Time	pH	pCO2 mmHg	pO2 mmHg	HCO3- mmol/L	SBE mmol/L	sO2 %	FIO2
04/08/1998	06:49:00	7.370	31.0*	302.0*	17.49*	-6.79*	100.0*	
Ventilator:AC 12 VT650 FIO2 80% PEEP10 PS 10						Oxygen:		
04/07/1998	15:10:00	7.410	23.0*	85.0	14.29*	-9.47*	97.0	
Ventilator:VT 650 FIO2 60% AçC12 PEEP +8 P.S. 20						Oxygen:60% PEEP 8		
04/07/1998	10:23:00	7.440	22.0*	83.0	14.70*	-8.69*	97.0	
Ventilator: AC - 15; VT 650; PEEP 10; PRES SUP 10						Oxygen:	60%	
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%		

[redacted]

[redacted]. Approved: Reported: [redacted]

[redacted]

NEONATAL

DATE DRAWN: 04/08/1998
TIME DRAWN: 1300 HRS
DATE ANALYZED: 04/08/1998
TIME ANALYZED: 1300 HRS
SAMPLE: ARTERIAL
STUDY NO: [redacted]

NAME: [redacted]
HOSP NO: [redacted]
LOCATION: [redacted]
AGE: 5 [redacted] (F)
PHYSICIAN: [redacted]

	RESULTS	UNITS
PH	7.39	
CO2 TENSION (PCO2)	30.4	MMHG
O2 TENSION (PO2)	118	MMHG
BICARBONATE (HCO3)	18.5	MEQ/L
BASE EXCESS (BE)	-4.3	MEQ/L
APPROX. ALV-ART O2 GRAD (CALC)	551	MMHG
PUNCTURE SITE	PAL	
FIO2	1.00	
TIDAL VOLUME	450	
PIP	30	
ITIME	0.90	
RATE (Set/Actual)	12/30	
PEEP	6	
MODE	SIMV PS: 20 FC: 22	
1 POINT CAL.	PH=7.354 PCO2=34.9 PO2=125	

SUMMARY OF MOST RECENT BLOOD GASES

DRAW DATE	DRAW TIME	STDY NO.	PH	PCO2	PO2	HCO3	BE	AaDO2	TEMP	SAMP	FIO2	COMMENTS
04/08	1300	[redacted]	7.39	30.4	118	18.6	-4.3	551	37.0	ART	100	[redacted]
04/08	1300		7.26	49.5	102	22.4	-4.6	543	37.0	ART	100	

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

000030

[redacted] [redacted] [redacted]

[redacted]

NEONATAL

DATE DRAWN: 04/08/1998
TIME DRAWN: 1800 HRS
DATE ANALYZED: 04/08/1998
TIME ANALYZED: 1800 HRS
SAMPLE: ARTERIAL
STUDY NO: [redacted]

NAME: [redacted]
HOSP NO: [redacted]
LOCATION: [redacted]
AGE: 5 [redacted] (F)
PHYSICIAN: [redacted]

	RESULTS	UNITS
PH	* 7.23	
CO2 TENSION (PCO2)	52.5	MMHG
O2 TENSION (PO2)	67	MMHG
BICARBONATE (HCO3)	22.2	MEQ/L
BASE EXCESS (BE)	-5.5	MEQ/L
APPROX. ALV-ART O2 GRAD (CALC)	574	MMHG
PUNCTURE SITE	PAL	
FIO2	1.00	
TIDAL VOLUME	570	
PIP	40	
ITIME	0.90	
RATE (Set/Actual)	16/16	
PEEP	9	
MODE	SIMV PS: 20 PC: 30	
1 POINT CAL.	PH=7.384 PCO2=35.0 PO2=133	

SUMMARY OF MOST RECENT BLOOD GASES

DRAW DATE	DRAW TIME	STDY NO.	PH	PCO2	PO2	HCO3	BE	AaDO2	TEMP	SAMP	FIO2	COMMENTS
04/08	1800	[redacted]	*7.23	52.5	67	22.2	-5.5	574	37.0	ART	100	[redacted]
04/08	1200		7.39	30.4	118	18.6	-4.3	551	37.0	ART	100	
04/08	1200		7.26	45.5	102	22.4	-4.6	543	37.0	ART	100	

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

[redacted] [redacted] [redacted]

[redacted]

NEONATAL

DATE DRAWN: 04/08/1998
TIME DRAWN: 1900 HRS
DATE ANALYZED: 04/08/1998
TIME ANALYZED: 1900 HRS
SAMPLE: ARTERIAL
STUDY NO: [redacted]

NAME: [redacted]
HOSP NO: [redacted]
LOCATION: [redacted]
AGE: 5 [redacted] (F)
PHYSICIAN: [redacted]

	RESULTS	UNITS
PH	7.26	
CO2 TENSION (PCO2)	49.5	MMHG
O2 TENSION (PO2)	102	MMHG
BICARBONATE (HCO3)	22.4	MEQ/L
BASE EXCESS (BE)	-4.6	MEQ/L
APPROX. ALV-ART O2 GRAD (CALC)	543	MMHG
PUNCTURE SITE	PAL	
FIO2	1.00	
TIDAL VOLUME	450	
PIP	30	
ITIME	0.30	
RATE (Set/Actual)	12/30	
PEEP	5	
MODE	SIMV PS: 20 PC: 22	
1 POINT CAL.	PH=7.384 PCO2=35.1 PO2=135	

SUMMARY OF MOST RECENT BLOOD GASES

DRAW DATE	DRAW TIME	STDY NO.	PH	PCO2	PO2	HCO3	BE	AaDO2	TEMP	SAMP	FIO2	COMMENTS
04/08	1900	[redacted]	7.26	49.5	102	22.4	-4.6	543	37.0	ART	100	[redacted]
04/08	1800	[redacted]	7.23	52.5	67	22.2	-5.5	574	37.0	ART	100	[redacted]
04/06	1300	[redacted]	7.39	30.4	118	18.6	-4.3	551	37.0	ART	100	[redacted]

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

[redacted] [redacted] [redacted]

[redacted]

NEONATAL

DATE DRAWN: 04/09/1998
TIME DRAWN: 0020 HRS
DATE ANALYZED: 04/09/1998
TIME ANALYZED: 0022 HRS
SAMPLE: ARTERIAL
STUDY NO: [redacted]

NAME: [redacted]
HOSP NO: [redacted]
LOCATION: [redacted]
AGE: 5 [redacted] (F)
PHYSICIAN: [redacted]

	RESULTS	UNITS
PH	7.53	
CO2 TENSION (PCO2)	29.5	MMHG
O2 TENSION (PO2)	* 267	MMHG
BICARBONATE [HCO3]	25.1	MEQ/L
BASE EXCESS (BE)	4.1	MEQ/L
APPROX. ALV-ART O2 GRAD (CALC)	191	MMHG
PUNCTURE SITE	RAL	
FIO2	.70	
TIDAL VOLUME	436	
PIP	38	
ITIME	0.76	
RATE (Set,Actual)	22/29	
PEEP	10	
MODE	SIMV PS: 20 PC: 26	↓ / C
1 POINT CAL.	PH=7.384 PCO2=35.1 PO2=133	

SUMMARY OF MOST RECENT BLOOD GASES

DRAW DATE	DRAW TIME	STDY NO.	PH	PCO2	PO2	HCO3	BE	AaDO2	TEMP	SAMP	FIO2	COMMENTS
4/09	0020	[redacted]	7.53	29.5	*267	25.1	4.1	191	37.0	ART	70	[redacted]
04/08	1900	[redacted]	7.26	49.5	102	22.4	-4.6	543	37.0	ART	100	[redacted]
04/08	1500	[redacted]	*7.23	52.5	67	22.2	-5.5	574	37.0	ART	100	[redacted]
04/08	1300	[redacted]	7.39	30.4	118	18.6	-4.3	551	37.0	ART	100	[redacted]

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

[redacted] [redacted] [redacted]

[redacted]

NEONATAL

DATE DRAWN: 04/09/1998
TIME DRAWN: 0430 HRS
DATE ANALYZED: 04/09/1998
TIME ANALYZED: 0431 HRS
SAMPLE: ARTERIAL
STUDY NO: [redacted]

NAME: [redacted]
HOSP NO: [redacted]
LOCATION: [redacted]
AGE: 5 [redacted] (F)
PHYSICIAN: [redacted]

	RESULTS	UNITS
PH	7.53	
CO2 TENSION (PCO2)	29.0	MMHG
O2 TENSION (PO2)	126	MMHG
BICARBONATE (HCO3)	24.6	MEQ/L
BASE EXCESS (BE)	3.7	MEQ/L
APPROX. ALV-ART O2 GRAD (CALC)	191	MMHG
PUNCTURE SITE	RAL	
FIO2	.50	
TIDAL VOLUME	477	
PIP	38	
ITIME	0.76	
RATE (Set/Actual)	16/26	
PEEP	10	
MODE	SIMV PS: 20 PC: 36	
1 POINT CAL.	PH=7.384 PCO2=34.9 PO2=135	

SUMMARY OF MOST RECENT BLOOD GASES

DRAW DATE	DRAW TIME	STDY NO.	PH	PCO2	PO2	HCO3	BE	AaDO2	TEMP	SAMP	FIO2	COMMENTS
04/09	0430	[redacted]	7.53	29.0	126	24.6	3.7	191	37.0	ART	50	[redacted]
04/09	0020	[redacted]	7.53	29.5	*267	25.1	4.1	191	37.0	ART	70	[redacted]
04/08	1900	[redacted]	7.26	49.5	102	22.4	-4.6	543	37.0	ART	100	[redacted]
04/08	1800	[redacted]	*7.23	52.5	67	22.2	-5.5	574	37.0	ART	100	[redacted]
04/08	1300	[redacted]	7.39	30.4	118	18.6	-4.3	551	37.0	ART	100	[redacted]

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

[redacted] [redacted] [redacted]

[redacted]

NEONATAL

DATE DRAWN: 04/09/1998
TIME DRAWN: 1445 HRS
DATE ANALYZED: 04/09/1998
TIME ANALYZED: 1445 HRS
SAMPLE: ARTERIAL
STUDY NO: [redacted]

NAME: [redacted]
HOSP NO: [redacted]
LOCATION: [redacted]
AGE: 5 [redacted] (F)
PHYSICIAN: [redacted]

	RESULTS	UNITS
PH	7.46	
CO2 TENSION (PCO2)	42.1	MMHG
O2 TENSION (PO2)	96	MMHG
BICARBONATE (HCO3)	30.2	MEQ/L
BASE EXCESS (BE)	6.2	MEQ/L
APPROX. ALV-ART O2 GRAD (CALC)	134	MMHG
PUNCTURE SITE	RAL	
FIO2	.40	
TIDAL VOLUME	477	
PIP	34	
ITIME	0.90	
RATE (Set/Actual)	12/12	
PEEP	8	
MODE	SIMV PS: 20 PC: 26	
1 POINT CAL.	PH=7.384 PCO2=34.5 PO2=135	

SUMMARY OF MOST RECENT BLOOD GASES

DRAW DATE	DRAW TIME	STDY NO.	PH	PCO2	PO2	HCO3	BE	AaDO2	TEMP	SAMP	FIO2	COMMENTS
04/09	1445	[redacted]	7.46	42.1	96	30.2	6.2	134	37.0	ART	40	[redacted]
04/09	0430	[redacted]	7.53	29.0	126	24.6	3.7	191	37.0	ART	50	[redacted]
04/09	0020	[redacted]	7.53	29.5	*267	25.1	4.1	131	37.0	ART	70	[redacted]
04/08	1300	[redacted]	7.26	49.5	102	22.4	-4.6	543	37.0	ART	100	[redacted]
04/08	1800	[redacted]	*7.22	52.5	67	22.2	-5.5	574	37.0	ART	100	[redacted]

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

[redacted] [redacted] [redacted]

[redacted]

NEONATAL

DATE DRAWN: 04/09/1998
TIME DRAWN: 2129 HRS
DATE ANALYZED: 04/09/1998
TIME ANALYZED: 2131 HRS
SAMPLE: ARTERIAL
STUDY NO: [redacted]

NAME: [redacted]
HOSP NO: [redacted]
LOCATION: [redacted]
AGE: 5 [redacted] (F)
PHYSICIAN: [redacted]

	RESULTS	UNITS
PH	7.42	
CO2 TENSION (PCO2)	39.7	MMHG
O2 TENSION (PO2)	79	MMHG
BICARBONATE [HCO3]	25.9	MEQ/L
BASE EXCESS (BE)	1.9	MEQ/L
APPROX. ALV-ART O2 GRAD (CALC)	154	MMHG
PUNCTURE SITE	RAL	
FIO2	.40	
TIDAL VOLUME	472	
PIP	35	
ITIME	0.90	
RATE (Set/Actual)	12/12	
PEEP	8	
MODE	SIMV PS: 20 PC: 26	
1 POINT CAL.	PH=7.384 PCO2=35.5 PO2=142	

SUMMARY OF MOST RECENT BLOOD GASES

DRAW DATE	DRAW TIME	STDY NO.	PH	PCO2	PO2	HCO3	BE	AaDO2	TEMP	SAMP	FIO2	COMMENTS
04/09	2129	[redacted]	7.42	39.7	79	25.9	1.9	154	37.0	ART	58 40	[redacted]
04/09	1445		7.46	42.1	96	30.2	6.2	134	37.0	ART	40	
04/09	0430		7.53	39.0	126	24.6	3.7	191	37.0	ART	50	
04/09	0020		7.53	39.5	*267	25.1	4.1	191	37.0	ART	70	
04/08	1900		7.26	43.5	102	22.4	-4.6	543	37.0	ART	100	

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

[redacted] [redacted] [redacted]

[redacted]

[redacted]

[redacted]

[redacted] ELECTROCARDIOGRAPHIC REPORT

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

Birthdate	Age	Attending Physician

Date and Time	EKG #	Emergency Room #
4-7-98 Am. 720	[redacted]	

Atrial Rate	Rhythm
150	Sinus tach
Ventricular Rate 150	

Intervals	P.R.	QRS	Q-T	QRS Axis
	.15 sec.	.08 sec.	.30 sec.	-50

Clinical Interpretations or Remarks:

Electrocardiographic Diagnosis: Sinus tach

(L) axis deviation

LOS 7710
4/14/98
WRB (390)
Medical records from [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 #
04-07-98	0720	[redacted]	[redacted]

Atrial Rate	Rhythm
150	Sinus tachycardia.
Ventricular Rate 150	

Intervals	P.R.	QRS	Q-T	QRS Axis
	.15 sec.	.08 sec.	.38 sec.	-50

Clinical Interpretations or Remarks:

Electrocardiographic Diagnosis:

1) Sinus tachycardia.
2) Left axis deviation.

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

[redacted]

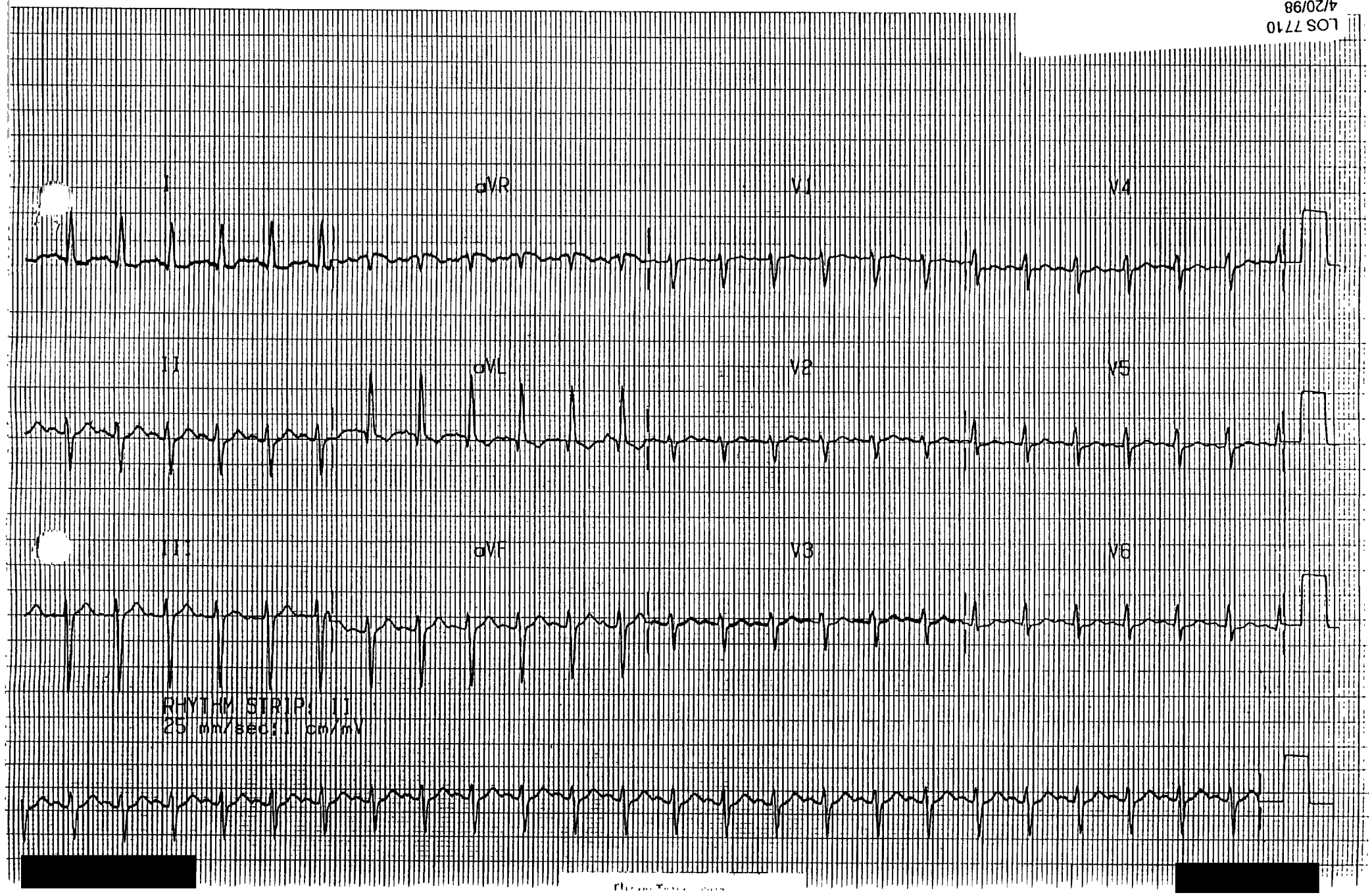
[redacted]

[redacted]

7 APR 98 ~~6:20:26~~
720

000039

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



[redacted]

000040

[redacted]
BED[redacted]
14:50 07APR98
II MON HR =138 A=0
RESP=25
SPO2=97% NIBP=14:30 94/ 48(61)mmHg
CO=NO DATA

Stri

[redacted] / [redacted] BE[redacted] 14:50 07APR98 II MON HR =138 A=0

2.0 MV

[redacted] / [redacted] BED[redacted] 21:11 07APR98 I MON HR =124 A=0

Strip #3

[redacted] [redacted] BE[redacted] 01:56 08APR98 NIBP=01:50 110/ 51(70)mmHg

Strip #4

[redacted] A=1 RESP=20 SPO2=100% CO=NO DATA T1=38.5CEL

[redacted] [redacted] BED[redacted] 08:13 08APR98 I MON HR =138 A=0

PATIE

SPEED=25 MM/SEC RESP=25 SPO2=98% NIBP=08:05 128/ 62(83)mmHg CO=NO DATA T1=38.5CEL

[redacted]

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

[redacted] ID: [redacted] 08-APR-98 20:31 [redacted]

000041

25mm/s
10mm/mV
40Hz
Pgm 005A
v206

Med: Unknown
[redacted] Ht: Wt:
Sex: F Race: Cauc
Loc: [redacted]

Vent. rate 154 BPM
PR interval 112 ms
QRS duration 84 ms
QT/QTc 268/428 ms
P-R-T axes 61 -50 89

** ** ** ** * PEDIATRIC ECG ANALYSIS * ** ** ** **
SINUS TACHYCARDIA
LEFT AXIS DEVIATION
NONSPECIFIC T WAVE ABNORMALITY

[redacted]

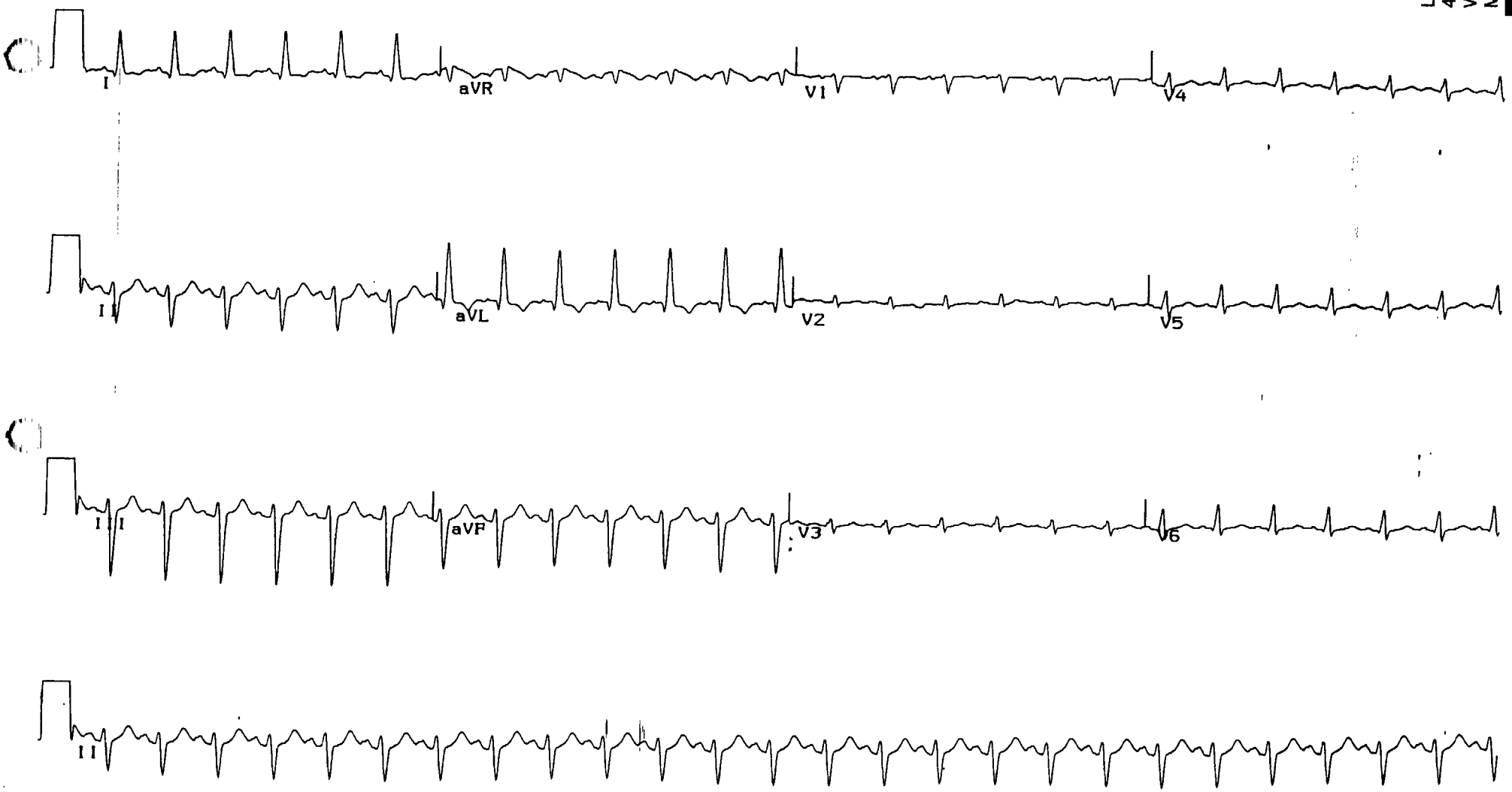
[redacted]

Order: [redacted]

Referred by: [redacted]

Reviewed by:

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



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

000042

[redacted]

ID: [redacted]

09-APR-98 14:07 [redacted]

25mm/s
10mm/mV
40Hz
Pgm 005A
v206

Med: Unknown
[redacted]: Wt:
Sex: F Race: Hisp
Loc: [redacted]

Vent. rate	111	BPM
PR interval	124	ms
QRS duration	96	ms
QT/QTc	292/394	ms
P-R-T axes	54 -45 103	

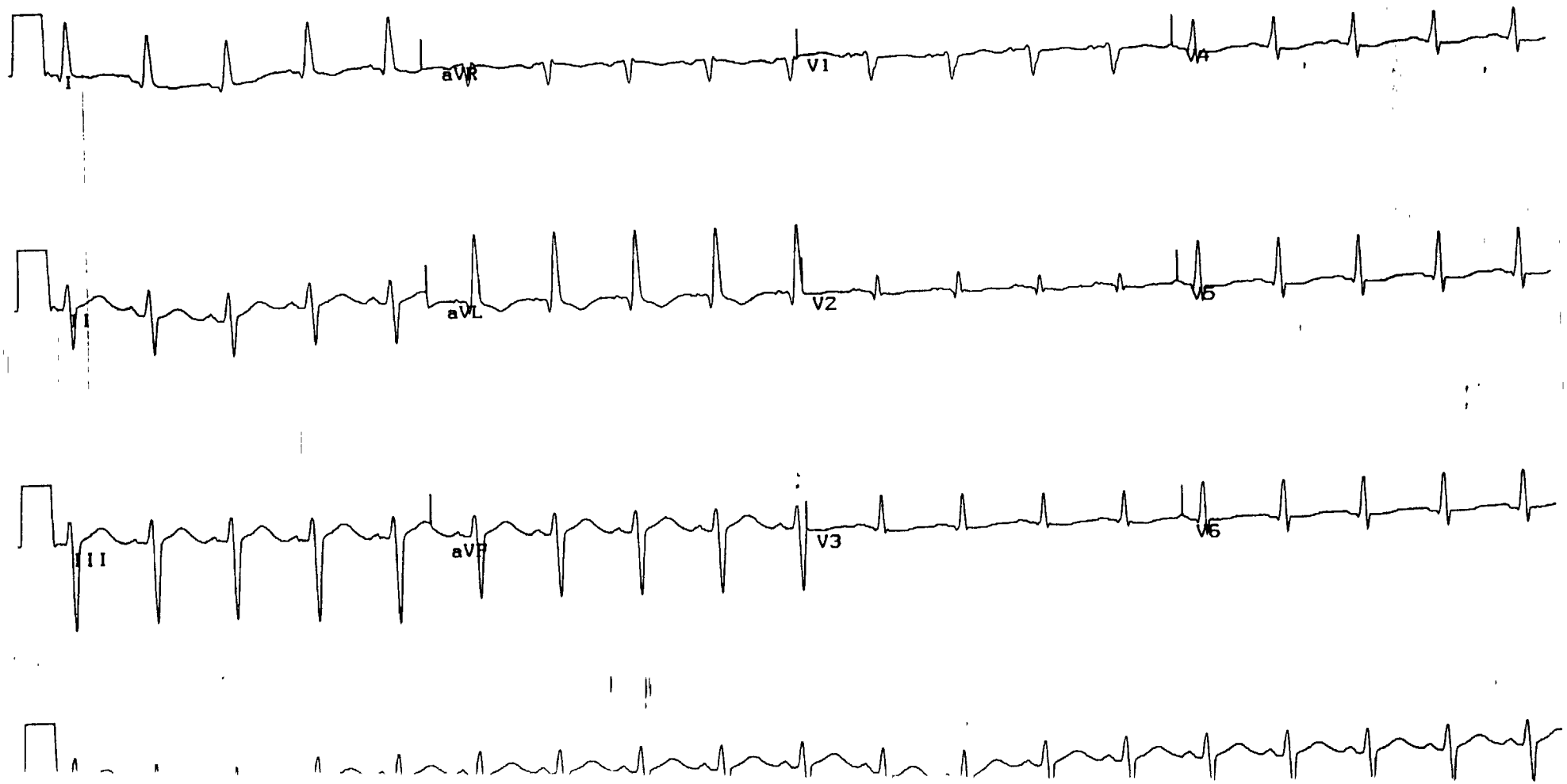
** ** ** ** * PEDIATRIC ECG ANALYSIS * ** ** ** **
NORMAL SINUS RHYTHM
LEFT AXIS DEVIATION
NONSPECIFIC ST AND T WAVE ABNORMALITY

[redacted]

Order: [redacted]

Referred by: [redacted]

Reviewed by:



NEURO CHILDREN'S COMA SCALE

REACTION

B - BRISK
S - SLUGGISH
N - NON-REACTIVE

FONTANELLE

S - SOFT
F - FULL
FL - FLAT
T - TENSE
B - BULGING
D - DEPRESSED

EYES

SPONTANEOUS 4
REACT TO SPEECH 3
REACT TO PAIN 2
NO RESPONSE 1
PARALYZED P

BEST MOTOR RESPONSE

OBEYS-SPONTANEOUS 6
LOCALIZE PAIN 5
WITHDRAW TO PAIN 4
DECORTICATE 3
DECEREBRATE 2
NO RESPONSE 1
PARALYZED P

PUPILS

1 2 3 4 5 6 7 8

BEST VERBAL

INFANT

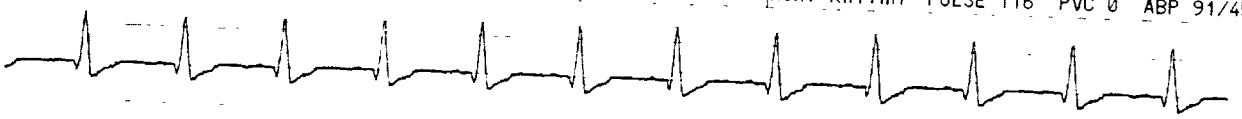
SMILES, INTERACTS, FOLLOWS OBJECTS, ORIENTED TO SOUND 5
CONSOLABLE 4
INCONSISTENTLY CONSOLABLE 3
INCONSOLABLE 2
NO RESPONSE 1
INTUBATED 0

CHILD/ADULT

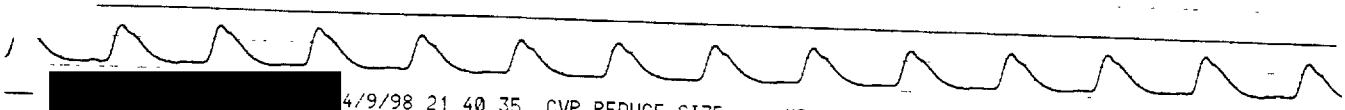
ORIENTED & CONVERSE 5
DISORIENTED & CONVERSE 4
INAPPROPRIATE WORDS 3
INCOMPREHENSIBLE 2
NO RESPONSE 1
INTUBATED 0

EKG STRIPS

[redacted] 4/9/98 7 56 15 ALARMS SUSPENDED HR 115 SV TACHY RHYTHM PULSE 116 PVC 0 ABP 91/45 (59



/80 0 /120 0)



[redacted] 4/9/98 21 40 35 CVP REDUCE SIZE HR 105 SV TACHY RHYTHM PULSE 104 PVC 0 ABP 11-

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

ADDRESSOGRAPH

APR 09 1998

[redacted]

[redacted]

PICU FLOWSHEET

000043

[redacted]

[redacted]

RADIOLOGIC CONSULTATION

RADIOLOGISTS

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

PORTABLE CHEST 2245 hours

HISTORY: Full arrest. Overdose.

AP portable supine view of the chest at 2245 hours shows no change in the position of the endotracheal tube or nasogastric tube or CVP line. There is marked increase in the bilateral pulmonary infiltrates with alveolar consolidation with the infiltrates becoming more extensive as well with almost complete involvement of the right lung. This most likely represents pulmonary edema. There is now a small to moderate sized right pneumothorax of 20-30%.

IMPRESSION: Considerable increase in the pulmonary edema since the last film. Also, development of a right pneumothorax.

M.D.

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

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

RADIOLOGIC CONSULTATION

RADIOLOGISTS

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

PORTABLE CHEST 2315 hours

HISTORY: Post chest tube placement for right pneumothorax.

AP portable supine view of the chest at 2315 hours shows no change in the position of the nasogastric tube or central venous line. The endotracheal tube is about 2 cm. above the carina. There is now a right chest tube in place with the tip in the right medial apex. The right pneumothorax is markedly decreased with very small right apical pneumothorax remaining. There are continued extensive bilateral alveolar infiltrates, which have become somewhat more extensive on the left since earlier examination and, again, most likely represents pulmonary edema.

IMPRESSION: Right chest tube now in place. Marked decrease in the right pneumothorax with only a very small residual right apical pneumothorax remaining. Continued bilateral pulmonary edema with some increase on the left since the last film.

M.D.

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

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

RADIOLOGIC CONSULTATION

RADIOLOGISTS

PATIENT NAME:
DOB:
DOCTOR:
DATE. 4/7/98
X-RAY #:

CHEST

HISTORY: Status post full arrest.

Single frontal portable chest was obtained at 0745 hours and compared to previous study from 4/6/98. There is an endotracheal tube with the tip in the mid trachea. There is a chest tube in the right chest. There is no residual pneumothorax seen. There is a nasogastric tube with the tip directed to the pyloric region of the stomach, below the level of the film. Cardiac size remains within normal limits. There is bilateral pulmonary edema, which is slightly improved when compared to previous 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: 4/7/98
X-RAY #: [redacted]

PORTABLE CHEST AT 1850 HOURS

AP portable upright view of the chest at 1850 hours shows the endotracheal tube tip to be about 2 cm. above the carina. The nasogastric tube remains in place. The CVP line appears to have been removed. Right chest tube remains in place. The right pneumothorax has returned and is now about 20%. There is subcutaneous emphysema at both supraclavicular areas and along the left chest wall. There is also probably some pneumomediastinum. Bilateral pulmonary infiltrates are again noted and appear slightly increased on the right. There is also now left apical pneumothorax of about 5%. Also noted is some air over the lateral upper outer quadrant. This could be related to the subcutaneous emphysema, however, intraperitoneal air cannot be ruled out.

IMPRESSION: Development of bilateral pneumothoraces. Bilateral subcutaneous emphysema and probably mediastinal emphysema. Continued bilateral infiltrates which have increased somewhat on the right. Some air seen over the left upper quadrant of the abdomen and some free intraperitoneal air cannot be ruled out.

[redacted] M.D.

[redacted]
trans: 4/8/98
dict: 4/8/98 [redacted]

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

[redacted]

RADIOLOGIC CONSULTATION

RADIOLOGISTS

PATIENT NAME:
DOB:
DOCTOR:
DATE: 4/7/98
X-RAY #:

PORTABLE CHEST AT 1935 HOURS

AP portable upright view of the chest at 1935 hours shows no change in the nasogastric tube, endotracheal tube or right chest tube. The right pneumothorax appears to have resolved since the last examination. There is essentially no change in the left pneumothorax. Again is noted subcutaneous emphysema and some pneumomediastinum. Bilateral pulmonary infiltrates appear improved. Again, this likely represents pulmonary edema and developing adult respiratory distress syndrome. Again, there is a question of some free intraperitoneal air in the left upper quadrant laterally, although again this could represent subcutaneous emphysema superimposed on the upper outer quadrant. This could be from the pneumomediastinum if this is air within the abdomen. This appears less in amount.

M.D.

trans: 4/8/98
dict: 4/8/98

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

[redacted]

RADIOLOGIC CONSULTATION

RADIOLOGISTS
[redacted]

[redacted]

PATIENT NAME: [redacted]
DOB:
DOCTOR:
DATE: 4/8/98
X-RAY #: [redacted]

PORTABLE CHEST AT 0815 HOURS

HISTORY: Intubated. Question of adult respiratory distress syndrome.

AP portable upright view of the chest at 0815 hours shows no change in the heart size since previous examinations. There is no change in the position of the endotracheal tube and nasogastric tube and right chest tube. No right pneumothorax is seen. The left pneumothorax is almost completely resolved with very tiny residual in the left apex laterally. Subcutaneous emphysema is considerably decreased. There is no evidence of free air in the left upper quadrant as on the previous examinations. There is considerable improvement in the bilateral pulmonary infiltrates. Again, the pulmonary changes could be secondary to adult respiratory distress syndrome.

IMPRESSION: Marked improvement in the bilateral pulmonary infiltrates, as well as marked improvement in the mediastinal and subcutaneous emphysema. Apparent resolution of the probable small amount of pneumoperitoneum.

[redacted] M.D.

[redacted]

trans: 4/8/98
dict: 4/8/98

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

[redacted]

Loc:
Status:
MRN:
Visit number:

DOB:
MRN:
SEX: F

Attending Physician:

Patient Name:

Requesting Physician:

8-Apr-1998 CHEST 1 VIEW (PORT)-----

CHEST 1 VIEW 4/8/98 @ 1320 HOURS

CLINICAL HISTORY: Assess line placement. Prior history of cardiac arrest and anoxic injury.

There are no prior comparison films. The endotracheal tube ends somewhat low and the tip is at the carina. An NG tube is present and I am really not certain as to where this tube ends. There is some other type of tubing projected over the right heart border and right diaphragm. A chest tube is present in the right apical pleural space and a central line enters the right subclavian vein and the tip terminates in the superior vena cava. There is streaky density in the right paraspinal area consistent with mediastinal emphysema. Subcutaneous emphysema is noted as well but a definite pneumothorax is not visualized. Bilateral alveolar infiltrates consistent with edema and presumably ARDS are noted.

IMPRESSIONS:

1) Low positioning of endotracheal tube and uncertain position of NG tube.

2) Findings consistent with ARDS with pulmonary edema, mediastinal emphysema, and subcutaneous air.

Dictated by: M.D. /signed by/ , M.D

Finalized on: 8-Apr-1998 19:53 by M.D.
Authenticated on: 9-Apr-1998 10:30 by M.D.
Transcribed on: 8-Apr-1998 16:30 by

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

Loc:
Status:
MRN:
Visit number:

DOB:
MRN:
SEX: F

Attending Physician:

Patient Name:

Requesting Physician:

9-Apr-1998 CHEST SINGLE VIEW---

CHEST 4-9-98 0500 HR.

HISTORY: Respiratory arrest.

Nasogastric tube is in place as well an endotracheal tube. Compared with yesterday an additional right chest tube has been added. There is decrease in retroperitoneal and mediastinal air when compared with yesterday. The bilateral infiltrate persists but this too is slightly improved. It is on the outside of the patient. There is diffuse infiltrate throughout both lungs perhaps minimally improved when compared with yesterday. Less mediastinal air is seen as well.

Dictated by: M.D. /signed by/

Finalized on: 9-Apr-1998 10:33 by M.D.
Authenticated on: 9-Apr-1998 10:36 by
Transcribed on: 9-Apr-1998 09:25 by

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

Loc: [redacted]
Status: [redacted]
MRN: [redacted]
Visit number: [redacted]

DOB: [redacted] SEX: F
MRN: [redacted]

[redacted]

Patient Name:

[redacted]

Attending Physician:

[redacted]

Requesting Physician: [redacted]

8-Apr-1998 CT [redacted] FOSSA W/O- [redacted]

CT HEAD 4-8-98 1400 HR.

HISTORY: Status post arrest.

PROCEDURE: Using the GE CT HiSpeed Advantage scanner computed tomography of the head was performed. Intravenous contrast was not administered.

FINDINGS: There is diffuse cerebral edema present with loss of the gray/white matter differentiation, diffuse sulcal effacement, effacement of the basal cisterns and sylvian fissures. Cerebellar herniation of the foramen magnum is also noted.

There is no evidence of extra-axial or intra-axial hemorrhage.

The bony calvarium is intact. Evaluation of the paranasal sinuses reveals diffuse mucosal thickening of the ethmoid air cells and sphenoid sinus.

IMPRESSION: Diffuse cerebral edema with complete effacement of the basal cisterns and sylvian fissures. Herniation through the foramen magnum is present.

The staff radiologist (whose name appears below the resident's name) has personally reviewed this exam and agrees with the report.

Dictated by: [redacted] signed by/ [redacted] M.D.
Staffed by : [redacted]. /signed by/ [redacted] M.D

Finalized on: 8-Apr-1998 19:53 by [redacted] M.D.
Authenticated on: 9-Apr-1998 10:30 by [redacted] M.D.
Transcribed on: 8-Apr-1998 16:29 by [redacted]

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

DATE: April 7, 1998
1800 hours

PREOPERATIVE DIAGNOSIS: RIGHT FOOT ISCHEMIA, POSSIBLE RIGHT SUPERFICIAL ARTERY OCCLUSION/INTIMAL TEAR.

POSTOPERATIVE DIAGNOSIS: MINOR INTIMAL DISRUPTION, RIGHT SUPERFICIAL FEMORAL ARTERY WITH NON-OCCLUSIVE DEBRIS.

PROCEDURE PERFORMED: 1. RIGHT SUPERFICIAL FEMORAL ARTERY EXPLORATION WITH REPAIR OF INTIMAL RENT. 2. FOGERTY CATHETER EMBOLECTOMY OF RIGHT SUPERFICIAL FEMORAL, POPLITEAL AND POSTERIOR TIBIAL ARTERY.

SURGEON: M.D.

ANESTHESIA: O2 only with respiratory support M.D.

ESTIMATED BLOOD LOSS: Approximately 50 cc.

FLUIDS: Approximately 200 cc of crystaloid.

TUBES: Endotracheal tube. Foley catheter.

DRAINS: None.

COMPLICATIONS: None.

DISPOSITION: Patient tolerated the procedure well, remains in critical condition to Intensive Care Unit.

INDICATIONS FOR PROCEDURE: This is an unfortunate 15 year old Latina female who was admitted to the hospital post-cardiac arrest yesterday while and apparently she had been taking some "over-the-counter pep-up pills". She was resuscitated, has been comatose with ARDS type findings in her lungs and at the time of admission attempts were made to get arterial lines in that were unsuccessful, in the wrists, and attempt was made of the right superficial femoral artery site using Seldinger technique that did not result in a permanent arterial line in place and the site was abandoned.

continued.....

This morning the patient was noted to have cool though vascularized right foot although throughout the day the right foot has become pale, pulseless and evidence of significant ischemia to the level of the right ankle with absent dorsalis pedis, posterior tibial pulses. Question centered around whether or not there was a full occlusion of the right superficial femoral artery although there was evidence of a pulse at this level but no popliteal pulse. The other issue centered around peripheral embolization of intimal material.

I had discussed the matter in detail with both parents and advised them of the need for urgent exploration of the right superficial femoral artery.

FINDINGS AT PROCEDURE: A non-occluded right superficial femoral artery with a small intimal rent where a needle had passed in with some intimal debris and thrombotic material around the intimal rent but no real lifting up of an intimal flap to occlude the artery. #3 and 4 Fogerty catheters were passed down to the ankle and only a minimal amount of clot material brought up. There was good back flow and good irrigation of the artery.

DESCRIPTION OF PROCEDURE: The patient was placed on the operating room table, prepped and draped from the costal margins to the sole of right foot including the perineum. A right inguinal incision was made in a vertical fashion overlying the right femoral artery, dissecting down and through the subcutaneous tissue to expose the right common femoral artery up to it's junction with the external iliac below the inguinal ligament and distally down to normal appearing superficial femoral artery that did not show any evidence of blood staining or subcutaneous clot around the artery from previous cannulation of the artery. Small branches were looped with Vesi-Loop as well as proximally and distally, looping with Vesi-Loops and then clamping the junction of the external iliac and common femoral artery proximally and distally of the superficial femoral artery. A longitudinal arteriotomy in length of 3 cm overlying an obvious anterior puncture site was made entering into the artery and noting no completely occluding thrombotic material. There was, however, what appeared to be a mild amount of thrombotic material around several intimal puncture sites, one measuring about 2 mm in transverse diameter. This was on the right lateral common femoral artery. Fogerty balloon catheters were advanced distally down to the ankle level bringing back only a scant amount of clot material, raising the issue that this most likely represented some peripheral embolization of material at the time of manipulation of the artery for insertion of arterial line. The artery was irrigated multiple times with Heparinized Saline solution, 100 units per cc with good back flow return noted afterwhich the small intimal rent on the right side was repaired with 6-0 cardiovascular Prolene and then the arteriotomy closed with a running 6-0 cardiovascular Prolene, releasing the distal clamp to purge the air and opening up the proximal clamp and finishing the closure of the arteriotomy with no bleeding from the suture line noted.

continued.....

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

The area was irrigated out with warm Saline solution and closed in three layers with 3-0 Vicryl and a 4-0 subcuticular Vicryl, applying tincture of Benzoin and steri-strips to the wound margins followed by Op-Site dressing.

Reinspection of the right foot was carried out, there was still no evidence of pulses but patient is quite clamped down. There was no arterial change in the right foot,however, and no Doppler pulses although the Doppler available in the operating room is not of a vascular surgery quality Doppler apparatus. It is difficult to hear even normal arterial sounds with the Doppler.

[redacted] [redacted] M.D.

Trans: 4-8-98
Dict: 4-7-98

cc: Dr. [redacted]
Dr.
Dr.

DATE 4-7-98 | OR NUM [redacted] | IN OR [redacted] | SURGERY START PM 1635 | SURGERY FINISH AM PM 1245 | AM PM 1805

ALLERGIES ☒ NONE KNOWN. [redacted]

PRE-OP OF STATUS ☐ RESPONSIVE ☐ DROWSY ☐ APPREHENSIVE ☐ ALERT | PRE-OP SKIN INTEGRITY ☐ NO ABNORMAL SIGNS ☐ OTHER

OTHER Non Responsive

PRE-OP DIAGNOSIS PER SURGEON/CHRONIC ILLNESS Full Code S/p - Cold + Blue Rt leg

IC INDEX 1 2 3 4

POST-OP DIAGNOSIS PER SURGEON

OPERATIVE PROCEDURE Explor Right Femoral Artery

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

SPECIMEN/CULTURE —

IMPLANTS GRAFTS | TYPE AND INFORMATION

☐ IMPLANT BOOK

SURGEON [redacted] | ASSISTANT [redacted]

ANESTHESIA [redacted] ☐ GENERAL ☐ SPINAL ☐ BIER BLOCK ☐ [redacted] ☐ EPIDURAL [redacted] RELIEF On Ventilator [redacted]

CIRCU [redacted] RELIEF

POSITION AND PRECAUTIONS
☐ LATERAL
☒ SUPINE
☐ LITHOTOMY
☐ PRONE
☒ THIGH STRAP
☐ HELD
☐ TAPED
☒ ARMS ADDED
☐ R ☒ OUT ☐ R ☐ L IN
☐ HEELS PADDED

SKIN PREP
☐ SHAVE
☐ HIBICLENS
☒ IODOPHOR SCRUB
☒ IODOPHOR PAINT
☐ OTHER

ESU/L [redacted]
ESU # [redacted]
PLATE Pt Right
CUT 3 COAG 3
BIPOLAR SETTING
LASER UNIT
SETTING
K-THERM # TEMP

☐ TOURNIQUET
SITE
PRESSURE
TIMES
UP
DOWN

COMMENTS Cooling Blanket under Pt on

DRAINS	SIZE	LOCATION	DESCRIPTION OF DRAINAGE	DRAINS	SIZE	LOCATION	DESCRIPTION OF DRAINAGE
☐ FOLEY (by)	Existing			☐ PENROSE			
☐ RED RUBBER (by)				☐ HEMOVAC/DAVOL			
☐ JACKSON PRATT				☒ CHEST TUBE	Existing		
☐ NG				☐ OTHER			

DRESSINGS
☐ ABD
☐ ACE
☐ ADAPTIC
☐ BANDAID
☐ CAST
☐ CAST PADDING
☐ COLLODIAN
☐ EYEPAD
☐ NUGAUZE
☐ KLING
☐ SPLINT
☐ STERISTRIP
☐ STOCKINETTE
☐ TELFA
☐ TNC BENZOIN
☐ VAG PACK
☐ VASELINE GAUZE
☐ XEROFORM
OTHER
PACKING SITE

TAPE
☐ SILK
☐ PAPER
☐ ELASTROPLAST
☐ FOAM
OTHER

IRRIGATION/RINSE
NGX ✓
H20X Lactated
DABX
LRX
OTHER

DRUGS	DOSAGE	ROUTE	TIME	INITIALS
Heparin	10,000 / 100 NS			

COUNTS
SCRUB INITIALS [redacted]
CIRCULATOR INITIALS [redacted]

COUNT STATUS
☒ MD NOTIFIED
☐ X-RAY

NEEDLE ☒ CORRECT ☐ INCORRECT
SPONGE ☒ CORRECT ☐ INCORRECT
INSTRUMENT ☒ CORRECT ☐ INCORRECT

INTRA OPERATIVE NURSING NOTES:
ID checked Consent signed on. Bagged on transfer to OR Bed Cooling Blanket on Prepped Draped Proc Started [redacted]

PATIENT TO ☐ RR ☒ ICU ☐ OTHER [redacted] | BY ☐ STRETCHER ☒ BED ☐ WHEELCHAIR | POST-OP EQUIPMENT NEEDED

[redacted] DS POST-OP SKIN INTEGRITY ☐ NO ABNORMAL SIGNS ☐ OTHER

[redacted]

[redacted] 000056

OPERATIVE RECORD

[redacted]

[redacted]

ANESTHESIA RECORD

Date 4/4/18

Surgeon [redacted] Assistant

Preoperative Diagnosis arterial occlusion RLE - ischemic R foot

Operation Proposed Brain exploration

Operation Performed

ASA: 4E ARDS CVS CHF

AM 1610 PM 1700 1800

Premed: Time:

Oxygen 3 5 10 100%
N_2O
Agent
Sux
Pentothal
Relaxant

ADEQ. SEDATED
LIGHT INADEQ

Remarks: 5'4" 120#

N/H/O 8.9/32.1
PT INR 1.7 PTT 4
143 113 1.7 135
3.7 23 26
admission 3.7
CXR CHF
CT Brain neg

B.P. °C. Pulse Start Anes. X Start Op. End Anes.

N-M STIMULATOR ANALYZER

TEMP E R

Resp. Spon. Asst. Cont.

Position

IV D5/2 Ringer

IV

Electrocardioscope

Respirator

Transport
Arrival
Tocky
controlled
PEEP 10 intubated

Fluids in OR:
LR
D5LR
D5NS
D5½NS (700)
WHOLE BLOOD
PACKED CELLS

Comments: O2 ambu transfer - cooling blanket continued - initial BP low - unable to maintain SpO2 - Inhalation therapy for PEEP - suction control - BP ok - no anesthesia required Hyperventilate continued RR 40 - less suctioning c̄ PEEP - Take frequent settings of PEEP for safety SpO2 - less suctioning c̄ PEEP - [redacted] O2 for cell return of PEEP & decreased immediately c̄ ↑ secretions

Technique: GET → continued monitored

Lacrimbe
ET Tube #..... Cuff..... Difficult Yes / No
Tourniquet

EBL: Minimal
URINE OUTPUT 200

Patient [redacted]
Hospital No.
Doctor
Date
Room

000057

AM PM	START	FINISH
ANESTHESIA	1610	1805
SURGERY	1635	1845

[redacted] M.D.

Anesthesiologist's Signature:

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

ANESTHESIA RECORD

[redacted] POST ANESTHESIA CARE RECORD

ADMISSION: D[redacted] /7/98 ALLERGIES NKA

SURGEON [redacted] ANESTHESIOLOGIST [redacted]

SURGICAL NURSE [redacted] PROCEDURE

N/C Check: [redacted] ern: [redacted] Preop V/S:

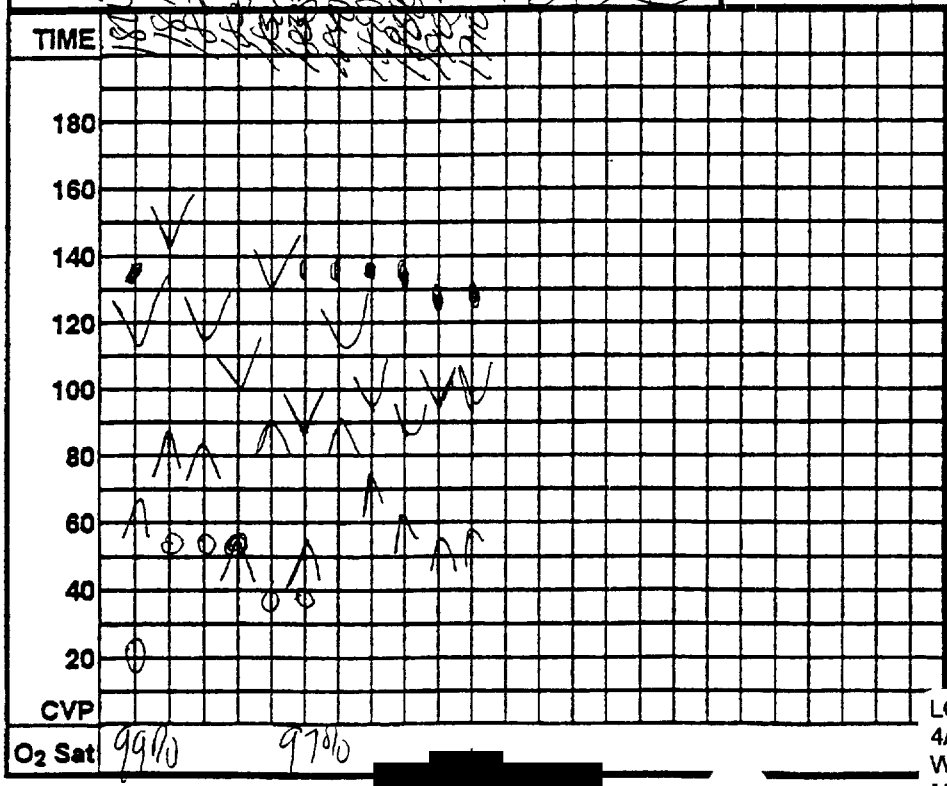
ANESTHESIA	AIRWAY	OXYGEN	DRAINS	TUBE	DRESSINGS on Arrival	POSITION	SKIN
___General	___Oral	___Nasal	___CT	___Thigh	X D/I	X Supine	X W/D
___Spinal	___Nasal	___Mask	X F/C	___Knee	___Drainage	___Lateral:L/R	___C/M
___Level	X ET Tube	___TMist	___NG	___Flowtrons	___Reinforced	X HOB Up	___Other
___Local	___Trach	___Rx	___J/P	NA	___Replaced	___HOB Flat	BLANKETS
X None	___None	___L/Min	___T-Tube		NO		~~NO~~ Warm
		___Time Off 100	X Other CT				___B.Hugg'r

Fluids in OR		Fluids in PACU	Output in OR		Output in PACU
	LR		0	EBL	
	D5LR		0	Urine	
200	D51/2NS	100	0	J/P	
	Blood		0	Other	
	Other				

POST ANESTHESIA RECOVERY SCORE		In	1/2°	Out
moves 4 extremities = 2 moves 2 extremities = 1 moves 0 extremities = 0	ACTIVITY	0	0	0
deep breathe & cough = 2 dyspnea or limited = 1 apnea = 0	RESPIRATION	vent	vent	vent
b/p 20 pre-op = 2 b/p 20-50 pre-op = 1 b/p 50 pre-op = 0	CIRCULATION	1	2	2
fully awake = 2 arousable = 1 nonresponsive = 0	CONSCIOUSNESS	0	0	0
pink = 2 pale, dusky, jaundiced = 1 cyanotic = 0	COLOR	1	1	1
	TOTALS	2	3	3

MEDICATIONS

Time	Drug/Dose	Route	RN
1830	Atropin 2mg IVP	IVP	[redacted]
1930	MS 4mg IVP		



NURSES NOTES:

Received from OR c̄ Lap. D
HR → ↓ @ pupil ↑ to
5mm - c̄ diff ventilating pt
Dr [redacted] notified - orders
received NO gm Ga Dr [redacted]
held @ 1845 - pupils now 2mm
reactive - Cheyne Stokes pattern improved
BP stable - vent AC 12 70%
80% - IV 150 70% O2
SAT 99% [redacted]

Report to: Init [redacted]

EKG STRIP

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

000058

Signature [redacted]

[redacted]

Date 1/98

Diagnosis: Comatose - L cire R frost -

Operation proposed: Grain application

Pt. agrees to All forms ..... or .....

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

See other form

RIPPED for mass reduction & body building taken
Precordial thump on fwd.
Defib x3
WNL ō PEEP 15 now 6 for SpO2 > 90
CHF improving
Chest tube for pneumothorax

Signature ..... M.D.

POST ANESTHETIC STATE

Date 4/7/98

Recovery Room ..... ICU [redacted] Ward .....

Reactivity: Unreactive Reactive Drowsy Awake

BP 119 / 63 P 122 Res 30-50 SpO2 52-9%

Amber O2 for transfer
Well saturated
Immed. PEEP reinstituted & stabilized
Temp 38.9 (102°)

Time	Orders	Doctor
	CXR Resume ventilator care & dietitian / Dr [redacted]	[redacted]

Recovery Discharge State

Critical

Signature [redacted] M.D.

000059

MR#:
AC#:
RM#:
DC:
PT:

NAME:
D.P.: M.D.
A.P.: M.D.

DOB:

SEX: F

PROCEDURE NOTE

DATE OF PROCEDURE: 04/08/98

PROCEDURE PERFORMED: Arterial line placement.

PHYSICIAN: M.D.

INDICATIONS: The patient is on a ventilator and requires arterial blood gas monitoring.

PROCEDURE: Attempt was made to place a right radial A-line without success. Her left radial area was then cleaned with Betadine. Approximately 0.2 cc of 1% lidocaine was infiltrated locally. A #20 guage angiocatheter was inserted percutaneously with good return of arterial flow on the first pass. The catheter was easily inserted into the left radial artery. The catheter was flushed and secured into place. It showed excellent arterial wave form. Distal perfusion unchanged.

No complications.

M.D.

\:
/:
JOB
ID:
DD: 04/08/98
DT: 04/09/98

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

PRE-PROCEDURE

DATE 4-8-98 | ARRIVAL T 1430 | RADIOLO [redacted]

OUT.PT. ☐ IN PT. ☒ Unit/Rm# ________

CONSENT Y/N by MD | ALLERGIES Y/N NKA

MODE OF ARRIVAL: Walk ☐ Wheelchair ☐ Gurney ☐

NURSE [redacted] TECH [redacted]

DIGITAL PULSE	PRE CATH	
	Right	Left
[redacted]		2+
		2+

RHYTHM: ST

CONDITIONS OF ADMISSION: Y/N

PATIENT EDUCATION: ☐

PROCEDURE RLE angio

LAB DATE. | BUN·
H & H:
PT/PTT | CREATININE

PROCEDURE RECORD

PROCEDURE START TIME. 1450 | FLOURO TIME 1 min | BETADINE PREP ☑ STERILE DRAPE [redacted] ANESTHETIC TOPICAL AGENT ☐ | APPROACH [redacted] CONTRAST MEDIA TYPE AND AMOUNT GIVEN [redacted]

TIME 1445 1457

BP ∨ ∧ | PULSE ● | RESP ○

200 180 160 140 120 100 80 60 40

O2 SAT 96

OBSERVATIONS

1430 Arrived Rad Rm via Bed from CT. on vent - unresponsive [illegible]

[redacted]

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[redacted]

DRUGS

TIME, ROUTE

INTRAVENOUS

IV SOLUTION	SITE	CC Amt	INITIAL
NS [illegible]	[illegible]	[illegible]	[redacted]

Opaque Injections

	TIME	CATHETER TIP LOCATION	CATHETER TYPE	MEDIA	VOLUME	CC / SEC	PRESSURE / MANUAL
1.	1457	[illegible]	[illegible]	[illegible]			[illegible]
2.							
3.							
4							
5							
6.							
7.							
8							

POST PROCEDURE

COMPLETION TIME: 1504 | **POST PROCEDURE INSTRUCTIONS GIVEN:**

Signature:

Physicians # ____________ **MD**

DIGITAL PULSE	POST CATH	
	Right	Left

DEPARTURE TIME. 5 [illegible] [redacted]

Pt to Home ☐ Pt to Unit/Rm # [redacted]

MODE OF DEPARTURE Walked ☐ Wheelchair ☐ Gurney ☒

HEMATOMA [redacted] FORM COMPLETED BY

ADDRESSOGRAPH

[redacted]

Best Quality FDA

[redacted]

RADIOLOGY PROCEDURE RECORD

000061 20

[redacted]

[redacted]

[redacted]

HOSPITAL ROOM # [redacted]

[redacted]

OPERATING ROOM RECORD

- ☐ Emergency
- ☐ Laminar Flow
- ☐ Pump Run
- ☐ Pump Stand-By
- ☐ Pump Stand-By No Set-Up
- ☐ Case Set-Up and Cancelled
- ☐ Double Set
- ☐ Laser
- ☐ IABP Run
- ☐ IABP Stand-By
- ☐ Cell Saver
- ☐ Other

-98

SURGERY

FIN: 46

STAT: [redacted]

TOT:

ALLERGIES NONE ☒

ANESTHESIA TYPE/AGENT: Sevoflurane

- ☒ General
- ☐ Regional Block
- ☐ M.A.C.

ANESTHESIA CLASSIFICATION: ☐ I ☐ II ☐ III ☐ IV

PRE-OPERATIVE DIAGNOSIS: Femoral artery clot Rt.

SURGERY PERFORMED: Right femoral artery Thrombectomy [redacted] - 2 hrs

Rt femoral arteriogram Four Compartment fasciotomy - 1 hr

POST-OPERATIVE DIAGNOSIS: Same

Placement of 28 chest - 15 min

Surgeon: [redacted] MD [redacted]

Second Assistant: [redacted]

Anesthesiologist: [redacted]

[redacted]

Relief/Time: [redacted]

Scrub Nurse: [redacted]

PREP:

- ✓ Betadine Scrub By: [redacted] R.N.
- ___ Betadine Solution Per [redacted] M.D.
- ___ Other

PREP SITE: Entire Rt leg - mid third L leg

ELECTROCAUTERY MACHINE NUMBER: [redacted] None ☐

LOCATION OF GEL ON PATIENT: R & L outsides

MEDICATION: None ☒

Papaverine 60mg/20ml + 20 ml Lactated Ringers.

IRRIGATION: Bacitracin 25 000 U > 250 CCNS None ☐

Polymixin 1250 000 U

Heparin 5 000 U E 500 cc L.R.

Urokinase 500 000 IU + Lactated Ringers 50 ml

DRAINS/PACKING: (Kind/Site,Size) Chest tubes None ☐

F28 to atrium water seal chest drainage X 2.

URINARY CATH in Bath None ☐

By: [illegible] Per: [illegible] M.D.

SPECIMEN: ☐ None ☒ Pathology ☐ Microbiology

Thrombus

IMPLANTS: (Include company name, all model #, serial #'s, batch #'s, lots, etc.)

UNUSUAL INCIDENTS: None

COUNT:	CORRECT OR INCORRECT	CIRCULATING RN	COUNT SIGNATURE	SCRUB NURSE
Organ/Cavity/Uterus	N/A	[redacted]	[redacted]	
Peritoneum/Fascia	Correct			
Skin	Correct			

POST-OPERATIVE: Transfer To: Pre ICU

Via: Gurney/ ✓ Bed/ ___ Surgi Lift/ ___ Other [redacted]

BLOOD ADMINISTERED ☒ None | [redacted] ☒ None

# of Units ___

[redacted]

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Medical records from [redacted]

000062

ANESTHESIOLOGIST'S RECORD

[redacted]

SURGEON(S) [redacted]

ANESTHESIOLOGIST(S) [redacted]

PROP. SURG. (R) FEMORAL EMBOLECTOMY, FASCIOTOMY

SURG. PERFORMED

O.R. # [redacted]

PAGE 1 OF

HX + PE: BP ____ P ____ T ____ P.S. 1 2 3 4 (5) (E) · M · (F) ____ LBS/KG

ALLERGY

PRE OP MEDICATION	DOSE	TIME	EFFECT (circle one)
			ALERT
			DROWSY
			UNCONSCIOUS

MASK NP NT W/O CUFF OP OT W/ CUFF

TUBE SIZE IN SITU

DIFFICULTY

PC SCOPE: BP RA LA, EKG, EYES O O C, TEMP E R AX, VENTILATOR, O2 SAT MONITOR, ET CO2

ESOSCOPE: O2 ANALYZER, GASES VENTED, NERV STIM, ETT TUBE, FLUID WARMER, WARMING BLANKET, HUMIDIFIER

Hb. U/A

CHEM.

CXR

EKG

PERIPHERAL IV SITE/SIZE (L) ALF / 18

PERIPHERAL IV SITE/SIZE (L) HAND / 18

CENTRAL IV SITE/SIZE (R) SC / 3-L

ART LINE SITE/SIZE (L) RAD / 18

PA CATH SITE OF ENTRY

ALSO (L) FEM ART SHEATH

O_2 / Air	60	—	1/	— 2/6	—	2/6	—			
Sevoflur		1-.7	—	X		.5	—	X		
Sufenta	10	10						10		
Rocuron	50									
Vecuron						8		2		
TIME	X		1600		X		1700	X	1800	X 1900
CVP	4	8	9	10	12	11	7	10	10	
ECG	SR	SR	SR	SR	SR	ST	ST	ST	ST	ST
$EtCO_2$	44	43	40	42	41	41	44	35	32	32
SaO_2	91	99	93	90	84	87	91	96	99	99 99

OPER. ⊙ INTUB ⊕ ANES × RESP ○ PULSE ● BP >< 220 200 180 160 140 120 100 80 60 40 20

To PICU Propofol maintained 100% O_2

NOTES

MACHINE CHECKED
1511 PT INTO OR INTUBATED, VENTILATED, LINES IN SITU
SpO2 85-88 ON ARRIVAL BS R=L
1530 MANNITOL 25g } VIA CVP
1546 HEPARIN 5K UNITS }
1602 NaHCO3 50MEQ VIA CVP
1607 - SpO2 DOWN - BS [redacted] 10 CM PEEP ADDED - BILAT - ?CT WORKING - PLEURevac CHANGED - O AIR LEAK
16[25] Crackles in chest removed
16[35] SAT ↓ 80's — chest tube replaced. SAT 91% RR ↑ 10
16[40] $NaHCO_3$ x 2 Amps
16[55] Mannitol 12.5gm IV slowly
CXR → good lung expansion
17[00] Heparin 1,000 IU via CVL
17[05] RR ↑ 12

POSITION										
LEGEND	X	O								
FLUIDS NS	[redacted]									
4.5% NS LR	[redacted]									
URINE					360					
EBL										

TOTALS: 600 / 150

000063

CONDITION ON ARRIVAL IN [redacted]
UNCONSCIOUS DROWSY/REACTING ALERT

BP P R T % SAT

SIGNATURE [redacted] DATE 04-08-98

	ANES	SURG
FINISH	17[55]	17[40]
START	1515	1535
TOTAL		

TIME	FiO_2	pH	$PaCO_2$	PaO_2	BE	Hct	K	Glu	Ca++
15[37]	1.0	7.21	67	58	-5	26	4.1	147	4.3
17[00]	1.0	7.31	63	73	57	24	4.0	145	4.0

[redacted]

[redacted]

MR#: [redacted]
AC#:
RM#:
DC:
PT:

NAME: [redacted] DOB: [redacted] SEX: F
D.P.: [redacted] M.D.
A.P.: [redacted] M.D.

PROCEDURE NOTE

DATE OF PROCEDURE: 04/09/98.

PROCEDURE PERFORMED: Central line placement.

PHYSICIAN: [redacted] M.D.

INDICATIONS: Patient requires central venous access to measure central pressures and for medications.

PROCEDURE: The patient's right subclavian area was cleaned copiously with Betadine. The area was then prepped and draped in the usual sterile manner. Approximately 3 ml of 1% lidocaine was infiltrated locally. A 19-gauge needle was inserted percutaneously. There was subclavian artery hit x 1. Pressure was applied for 5 minutes. Landmarks were then again identified. The needle was then inserted into the region percutaneously with good return of venous flow on the 1st pass. The guidewire was introduced and passed easily. The vein was then dilated with a venous dilator. The 7-French 15 cm catheter was then placed over the guidewire into the right subclavian vein. The catheter passed easily. all ports aspirated venous blood easily. The catheter was transduced and showed an excellent central venous pressure (CVP) waveform. Chest x-ray showed catheter tip to be in good position in the superior vena cava (SVC). There was no reoccurrence of pneumothorax. The patient tolerated the procedure well. There were no complications.

[redacted] M.D.

\: [redacted]
/:
JOB:
ID:
DD: 04/09/98
DT: 04/09/98
cc: [redacted] M.D.

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

ANESTHESIOLOGIST'S RECORD

[redacted]

SURGEON(S) / /

ANESTHESIOLOGIST(S) [redacted]

PROP. SURG. [redacted]

SURG. PERFORMED

O.R. # [redacted]

PAGE ____ OF ____

HX + PE: BP ____ P ____ T ____ PS 1 2 3 4 5 E - M - F ____ LBS/KG

ALLERGY Nkda

ASA 6 15yic ♀ for organ donation

PRE OP MEDICATION	DOSE	TIME	EFFECT (circle one)
			ALERT
			DROWSY
			UNCONSCIOUS

MASK NP NT W/O CUFF
OP OT W/ CUFF

TUBE SIZE ____

DIFFICULTY

PS SCOPE
BP/ RA LA
EKG
EYES X O OX
TEMP E R AX
VENTILATOR
O_2 SAT MONITOR
ET CO_2

ESOSCOPE
O2 ANALYZER
GASES VENTED
NERV STIM
NG TUBE
FLUID WARMER
WARMING BLANKET
HUMIDIFIER

Hb. U/A

CHEM.

CXR

EKG

PERIPHERAL IV SITE/SIZE ____/____
PERIPHERAL IV SITE/SIZE ____/____
CENTRAL IV SITE/SIZE ____/____
ART LINE SITE/SIZE ____/____
PA CATH SITE OF ENTRY ____

O_2 L/L		4	2	→	2	→	2	→	→						
Paw						10									
Dyn		5	→	5	→	5	→	5	→						
TIME	0200		*		0300		*		0400		*	0500			
ECG		ST	ST	ST	ST	ST	ST	ST	NSR						
$EtCO_2$		34	32	32	30	27	25	25	25						
SaO_2		100	100	100	99	100	100	100	100						

OPER ⊙ INTUB ⊕ ANES × RESP ○ PULSE ● BP >< 220 200 180 160 140 120 100 80 60 40 20

0400

POSITION															
LEGEND															
FLUIDS															
[redacted]															
URINE						400		350/hr							
EBL															

NOTES

Id client received
O - Digoxin 5 mg/min
FiO2 & PEEP 10
Pavulon 10 mg IV
Ancuron/PEEP/monitored
Mercu
Solumedrol 1 gm IV 0220
Methylpred 2 gm IV 0230
Betadine 250 cc no NPT
Heparin 30,000 in IV soln
Mix 100 mg IV ...
Nimbex 2 mg IV ...
Admin Vented ACC

TOTALS

[redacted]

000065

CONDITION ON ARRIVAL IN PACU		
UNCONSCIOUS	DROWSY/REACTING	ALERT
BP	P R T	% SAT
[redacted]		4/min

	ANES	SURG
FINISH	0400	
START	0155	0222
TOTAL		

TIME	FiO_2	pH	$PaCO_2$	PaO_2	BE	Hgb	K	Glu		