

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

ARMS#

13021



8 - OTHER

000001

Department of Public Health

REPRINT IN PERMANENT INK FOR INSTRUCTIONS AND BOOK

1. DECEDENT'S NAME (First, Middle, Last) [REDACTED] 2. SEX **MALE** 3. DATE OF DEATH (Month, Day, Year) **NOVEMBER 1, 1997**

4. SOCIAL SECURITY NUMBER [REDACTED] 5. AGE AT BIRTH (Year) **43** 6. DATE OF BIRTH (Month, Day, Year) [REDACTED] 7. BIRTHPLACE (City and State or Foreign Country) [REDACTED]

8. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 Yes 2 No 9. PLACE OF DEATH (Check only one) 1 Hospital 2 Inpatient 3 ER/Outpatient 4 DOA 5 Nursing Home 6 Residence 7 Other (Specify)

10. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) **MARRIED** 11. SURVIVING SPOUSE (If wife, give maiden name) [REDACTED] 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) **SALESMAN** 12b. KIND OF BUSINESS/INDUSTRY [REDACTED]

13a. RESIDENCE-STATE [REDACTED] 13b. COUNTY [REDACTED] 13c. CITY, TOWN OR LOCATION [REDACTED] 13d. STREET AND NUMBER OR RURAL LOCATION [REDACTED]

13e. INSIDE CITY LIMITS? 1 Yes 2 No 13f. ZIP CODE [REDACTED] 14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes No 15. RACE - American Indian, Black, White, etc. (Specify) **WHITE** 16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) [REDACTED] College (1-4 or 5) **4**

17. FATHER'S NAME (First, Middle, Last) [REDACTED] 18. MOTHER'S NAME (First, Middle, Maiden Surname) [REDACTED]

19a. INFORMANT'S NAME (Type/Pprint) [REDACTED] 19b. RELATIONSHIP TO DECEASED **WIFE** 19c. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) [REDACTED]

20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) [REDACTED] 20c. LOCATION - City or Town, State [REDACTED]

21a. SIGNATURE OF FUNERAL DIRECTOR [REDACTED] 21b. LICENSE NUMBER OF FUNERAL DIRECTOR [REDACTED] 21c. SIGNATURE OF EMBALMER [REDACTED] 21d. LICENSE NUMBER OF EMBALMER [REDACTED]

22a. NAME AND ADDRESS OF FUNERAL HOME [REDACTED] 22b. LICENSE NUMBER OF FUNERAL HOME [REDACTED]

23. DATE FILED (Month, Day, Year) **November 18, 1997**

24. PHYSICIAN - To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. 1 SIGNATURE AND TITLE OF PHYSICIAN [REDACTED] 25b. LICENSE NUMBER [REDACTED] 25c. DATE SIGNED (Month, Day, Year) **11/17/97**

26a. MEDICAL EXAMINER - To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. 2 SIGNATURE AND TITLE OF MEDICAL EXAMINER [REDACTED] 26b. LICENSE NUMBER [REDACTED] 26c. DATE SIGNED (Month, Day, Year) [REDACTED]

27. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN OR MEDICAL EXAMINER) (Type/Pprint) [REDACTED]

DECEDENT

CENSUS TRACT

PARENTS

INFORMANT

DISPOSITION

REGISTRAR

CERTIFIER

PHYSICIAN OR MEDICAL EXAMINER EX-3 CERTIFICATE COMPLETE AND MEDICAL CERTIFICATE WITHIN 48

INSTRUCTIONS OTHER SIDE

CAUSE OF DEATH

Immediate Cause (Final disease or condition resulting in death) → a. **Acute Myocardial Infarction** **hau**
DUE TO (OR AS A CONSEQUENCE OF):

b. **Coronary Artery Thrombosis** **hau**
DUE TO (OR AS A CONSEQUENCE OF):

c. _____
DUE TO (OR AS A CONSEQUENCE OF):

d. _____
DUE TO (OR AS A CONSEQUENCE OF):

Approximate Interval Between Onset and Death

000002

PART II. Other significant conditions contributing to death but not resulting in the death as given in Part I.

CAUSE OF DEATH

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

29a. WAS AN AUTOPSY PERFORMED?

29b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 Yes 2 No

1 Yes 2 No

30. MANNER OF DEATH

- 1 Natural
- 2 Accidents
- 3 Suicide
- 4 Homicide
- 5 Pending Investigation
- 6 Could not be Determined

31a. DATE OF INJURY (Month, Day, Year)

31b. TIME OF INJURY

31c. INJURY AT WORK?

- 1 Yes
- 2 No

31d. DESCRIBE HOW INJURY OCCURRED

31e. PLACE OF INJURY-At home, farm, street, factory, office building, etc. (Specify)

31f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

4-1659
V. 2-93

BIRTH NO

NOV 18 1997

RDA 139

This is to certify that the above is a true and correct copy of the record filed with the [redacted] by the local Health Department.

This is valid only when the seal of the issuing local Health Department is affixed.



000003

POST-MORTEM EYE ENUCLEATION OPERATIVE NOTE

DONOR NAME: _____

HOSPITAL NAME: _____

HOSPITAL ID#: _____

DOD 11-2-97

DATE OF ENUCLEATION: 11-2-97

TIME OF ENUCLEATION: 0430

PROCEDURE:

Identification of donor was obtained according to toe tag and/or hospital arm band.

The donor's eyes were prepped beginning with bilateral irrigation of a sterile balanced saline solution (Dacriose, A-K Rinse). The face was then prepped over the eyelids, bridge of nose, eyebrows, and just below and temporal to eyelids with alcohol pads and then followed by a betadine swab. A sterile drape was placed over the face exposing the eyes only. Maintaining sterility, a lid speculum was inserted in the right eye and, using a fine tooth forcep and strabismus scissors, a peritomy of the conjunctiva was done. Tenon's capsule was pushed back by entering each of the four quadrants with the scissors and performing a blunt dissection. The four rectus muscles were isolated with the muscle hook and severed close to the insertion with the exception of the lateral rectus which was clamped with mosquito clamp and severed distal to clamp. The globe was then rotated and, with the blades apart, the enucleating scissors were inserted from the medial side of the globe. The optic nerve was located between the blades of the scissors, then severed. The globe was then lifted from the orbit and any excess tissue was excised using enucleation scissors. The orbit was then packed with cotton and the lid closed. The same procedure was then performed on the left eye.

Lastly, a blood sample (5-10 cc's) was obtained by locating a point 2/3 from the midline, right under the clavicle on the right/left side. A 30 cc syringe and 18 gauge needle were used to draw blood at the subclavian site for blood screening purposes.

TECHNICIAN _____

COMPLICATIONS/OTHER NOTES

011 - Before during and after eye enucleation
much bleeding.

000004

OF BODY TO MORTUARY

I, [redacted] give [redacted] permission to release the body of [redacted] to [redacted] Mortuary.

Signature: [redacted]

Relationship: *When she leaves the hospital* 0 wife

Address: [redacted]

Witness: [redacted] *M. Dew*

Date: 11/2/91

Phone: [redacted]

1. TO BE COMPLETED BY UNIT STAFF

a. Notify [redacted] Donor Services at [redacted] Time called: 12:35 AM ___ PM ___
 [redacted] will contact the physician and the family, if applicable)

b. Name of the [redacted] representative? [redacted]

c. Next-of-Kin approached by [redacted] Yes ___ No If no, Why? _____

d. Consent Obtained by [redacted] Yes ___ No ___
11-2-97 Date [redacted] Signature

2 Did patient have a suspected communicable, contagious or infectious disease or metastatic cancer? ___ yes no.

3. Is this a Medical Examiner case? ___ yes no Is cremation planned? ___ yes ___ no

4. Was Autopsy requested by MD? ___ yes no Requested by family? ___ yes ___ no

5. Family/next-of-kin agreed to autopsy? ___ yes ___ no Hold for Autopsy? Adult ___ Infant ___ Weight ___

Mortuary Release:

Date: _____ Time _____

_____ Mortuary received from [redacted] the

body of _____.

Name of Representative _____ for _____ Mortuary Receiving Body

Address _____

White copy - Chart
Yellow copy - Mortuary

RELEASE OF BODY TO MORTUARY

000005

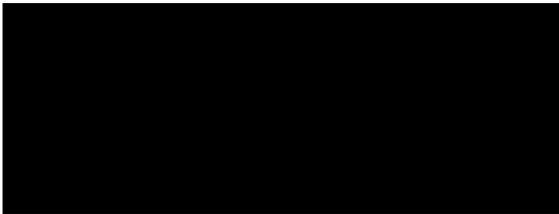
EMERGENCY ROOM RECORD

HEALTH SYSTEM

ACCOUNT NO	ADMISSION DATE / TIME	ROOM / BED	AC	SEX	M / S	RACE	SERVICE	PT	BIRTH DATE	AGE	ACCIDENT / WORK / DATE	MEDICAL RECORD NO	
	11/01/97 09:13pm	-		M	M	1				43Y	NO		
P A T I E N T	NAME AND ADDRESS		SOC SEC NO		DIAGNOSIS / COMPLAINT								
					CARDIAC ARREST CARDIAC ARREST								
	EMPLOYER NAME & ADDRESS		OCCUPATION		ADMITTING PHYSICIAN				SMK / PUB / VAL		AD BY		PAT C
					DOCTOR, ER								
G U A R A N T E E	NAME AND ADDRESS		EMPLOYER NAME & ADDRESS		ATTENDING PHYSICIAN		ADMIT TYPE		ROOM PREF				
					DOCTOR, ER		1						
					CHURCH		ADM SOURCE		DENOM		STATION		
				NON NO CHURCH									
I N S U R A N C E	INSURANCE 1 & 2				INSURANCE 3 & 4								
M I S C.	RELATIVE 1		SPOUSE		RELATIVE 2								
RENAL DIALYSIS	BLACK LUNG	RETIREMENT DATE		AMBULANCE									
APPROVAL NO	LOS	BEN		AD	ORGAN DONOR		EDA						
				NO	NO								
PRIMARY DIAGNOSIS:					CODE		ORIGINAL						
					410.91 427.5								
OTHER DIAGNOSIS:													
COMPLICATIONS:													
PRIMARY SURGICAL PROCEDURE:					CODE		ORIGINAL						
					99.60								
OTHER SURGICAL PROCEDURE:													
NON-OPERATIVE PROCEDURE:													
CONSULTANTS:													
RESULTS:													
<input type="checkbox"/> RECOVERED		<input type="checkbox"/> DIED UNDER 48 HOURS											
<input type="checkbox"/> NOT TREATED		<input type="checkbox"/> DIED OVER 48 HOURS											
<input type="checkbox"/> IMPROVED		<input type="checkbox"/> AUTOPSY											
<input type="checkbox"/> NOT IMPROVED													
CAUSE OF DEATH				UNITS OF BLOOD GIVEN									

PHYSICIANS SIGNATURE

000006



PATIENT INVENTORY LIST

Documentation and disposition of personal belongings will be filled out in duplicate with original to floor chart and duplicate filed in emergency room on all admissions to hospital, DOA's and DAA's.

When deemed appropriate, valuables may be put in a "Valuables Envelope" and placed in a locked area.

Date: 11-1-97 Patient's Name:  E.R. number _____

Check the applicable items. If more than one, list how many.

(A) CLOTHING

- 1. Bathrobe
- 2. Belt
- 3. Bra
- 4. Coat
- 5. Dress
- 6. Gown
- 7. Hat
- 8. Hose
- 9. Jacket
- 10. Pajamas
- 11. Panties
- 12. Shirt
- 13. Shoes
- 14. Shorts
- 15. Skirt
- 16. Slip
- 17. Socks
- 18. Sweater
- 19. Undershirt
- 20. Underwear
- 21. JGNS
- 22. Slacks

(C) VALUABLES AND MONEY

- 1. Checkbook
 - 2. Change Purse
 - 3. Pocketbook (un-inventoried)
 - 4. Wallet (un-inventoried)
 - 5. Currency
- \$ _____ 85

(B) JEWELRY

- 1. Bracelet
- 2. Earrings
- 3. Necklace
- 4. Rings yellow color band
- 5. Watch
- 6. RINGS

(D)

- 1. Contact Lens
- 2. Dentures
- 3. Glasses
- 4. Hearing Aid
- 5. Keys
- 6. Luggage (un-inventoried)
- 7. Pocket Knife
- 8. _____

Items locked up (i.e. B 5 & 6) gone ticket

Listed by: 

Witness: 

000007

CONFIDENTIAL



Consent for Organ and Tissue Donatlon

I, [redacted], do hereby certify that I am the (name of consenting party)

Durable Power of Attorney for Health Care Yes [] No [] Not Applicable [X]

I am the legal next-of-kin as follows (check appropriate box):

Table with 2 columns: Relationship and checkbox. Rows include Spouse, Adult Son/Daughter, Parent, Adult Brother/Sister, Guardian of decedent, and Other (specify).

of [redacted], a patient located at [redacted] (name of deceased) (location)

in [redacted] (city/state)

- 1. I understand that anatomical donation is an option to consider and I have reviewed this option. It has been explained to me in a language that is understandable. I have made an informed decision to voluntarily consent to anatomical donation. I have been given an opportunity to ask questions and have my concerns addressed.
2. I hereby give [redacted] and [redacted], after the pronouncement of death and in accordance with the [redacted] the authority to remove the following organs and/or tissues:

Table with columns: ORGANS, YES, NO, NA, TISSUES, YES, NO, NA. Rows list various organs and tissues for consent.

3. I [redacted] and these organs and [redacted] tissues will be used for a [redacted] purpose including transplantation [redacted], education [YES/NO] and/or research [YES/NO]. The organs and/or tissues are not deemed [redacted] for transplantation and consent has not been given for education or research; I understand that the organs and/or tissues will be taken to the appropriate facility for disposition in accordance with state law.



CONFIDENTIAL

Donor Name [REDACTED]

- 4. I understand the recovery, allocation, and determination of the use of these gifts, will be coordinated by [REDACTED] and [REDACTED] in accordance with their professional standards and regulatory recognition policies.
- 5. I authorize [REDACTED] and [REDACTED] to obtain, photocopy, and release any information pertinent to the evaluation, billing, use, and follow-up of the donated organs and/or tissues. I further authorize any and all health care institutions and or providers to release to [REDACTED] and/or [REDACTED] any information relevant to the evaluation, use and follow-up of the donated organs and/or tissues.
- 6. I authorize [REDACTED] and [REDACTED] to perform those tests necessary to evaluate the safety of the organs and/or tissues for transplantation, including but not limited to those for communicable diseases such as, hepatitis and HIV (AIDS). These test results or medical information will be kept confidential in accordance with applicable laws and policy.
- 7. I understand that the costs relating to the evaluation, maintenance and recovery of donated organs and/or tissues will be paid by [REDACTED] and [REDACTED]. All other costs, including funeral and burial arrangements are the responsibility of the family.
- 8. The estimated period of time required for the evaluation, allocation and recovery of organs and/or tissues has been explained to me.
- 9. If necessary to facilitate the recovery of organs and/or tissues, I consent to the transfer of the deceased to another institution [YES/NO/NAI]
- 10. I hereby acknowledge that this authorization is freely given without obligation to any individual or organization authorized by law to receive this gift and that this authorization is motivated exclusively by humanitarian instincts without hope or expectation of reward or compensation of any kind.

if Taped telephone consent on F.1e

Signature: [REDACTED] Date: 11/2/97 Time: 0256
 Address: [REDACTED] Phone: [REDACTED]
 City: [REDACTED] State: [REDACTED] Zip Code: [REDACTED]

Witness: _____ Date: _____ Witness: _____ Date: _____
 Address: _____ Address: _____
 City: _____ State: _____ City: _____ State: _____
 Zip Code: _____ Phone: _____ Zip Code: _____ Phone: _____

Coordinator: [REDACTED] Date: 11/2/97 Time: 0256

Bereavement Program	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
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000009



To: Medical Examiner/Pathologist/Funeral Director/Operating Room

Subject: Bone/Tissue Procurement Operative Summary

After obtaining appropriate legal consent, bone and tissue was procured by [redacted] from:

[redacted] on 11-2-97 at [redacted] (Donor Name) (Date) (Hospital)

Depending upon the tissues recovered and following routine prepping and draping, skin incisions can be made from the iliac crest region down to the heel bilaterally, as well as from the shoulders to the wrists. A sternal incision or an inverted Y incision is used to gain access to the thoracic cavity. A linear incision along the lumbar spine is used to gain access to the lumbar vertebrae. Soft tissue is then dissected to expose all bone and tissue to be retrieved. Once all tissue is procured, the donor body is reconstructed using LIMBZ System Prosthesis and lap sponges to restore skeletal rigidity and cosmetic appearance. All skin incisions are then closed via running suture.

The tissues obtained correspond to the following checked deposits:

- | | |
|--|--|
| Bilateral Fascia <input checked="" type="checkbox"/> | Heart for Valves <input checked="" type="checkbox"/> |
| Bilateral Femurs <input checked="" type="checkbox"/> | Saphenous Veins <input checked="" type="checkbox"/> |
| Bilateral Tibias <input checked="" type="checkbox"/> | Pericardium <input type="checkbox"/> |
| Bilateral Patellar Tendons <input checked="" type="checkbox"/> | Ribs <input type="checkbox"/> |
| Bilateral Achilles Tendons <input checked="" type="checkbox"/> | Costal Cartilage <input type="checkbox"/> |
| Bilateral Fibulas <input checked="" type="checkbox"/> | Vertebral Bodies <input type="checkbox"/> |
| Bilateral Hemi-Pelvis/Ilia <input checked="" type="checkbox"/> | Mandible <input type="checkbox"/> |
| Bilateral Humerus/Humeral Heads with Rotator Cuffs <input checked="" type="checkbox"/> | |
| Miscellaneous <input type="checkbox"/> | |

Comments: _____

If you have any questions or concerns, please contact the coordinator on call at [redacted]



[REDACTED]

1. **CONSENT FOR TREATMENT:** Authorization is hereby given to [REDACTED] to perform such treatments, services, procedures, diagnostic studies, nursing care, minor surgery, invasive procedures and medical treatment that my attending physician and/or his/her designee consider to be necessary. I understand that medicine is not an exact science and that diagnosis and treatment may involve risk of injury or even death. I acknowledge that no guarantees have been made to me regarding the outcome of this treatment. I understand that I have the right to accept or refuse consent of any proposed procedure or therapeutic course, and that I will not be involved in any research or experimental procedure without my knowledge and consent. Obtaining consent for special procedures and treatments is the responsibility of my physician.

2. **LIVING WILL & DURABLE POWER OF ATTORNEY FOR HEALTH CARE:** I have been provided written materials explaining my right to prepare a living will and/or a Durable Power of Attorney for Healthcare decisions. I understand that [REDACTED] cannot honor any such document unless & until it has been given to Physician and made a part of my chart.

I HAVE A LIVING WILL YES NO**ATTACHED TO CHART YES NO**FAMILY TO BRING YES NO
I HAVE A DURABLE POWER OF ATTORNEY YES NO**ATTACHED TO CHART YES NO**FAMILY TO BRING YES NO

COMMENT: _____

3. **RELEASE OF INFORMATION:** I authorize [REDACTED] and/or my attending physicians to disclose any and all information in my medical record to any person, insurance company or other party which is or may be liable for all or part of the charges associated with this admission. I further authorize [REDACTED] to furnish information contained in my medical record to other healthcare providers in order to facilitate my continued care and treatment. [REDACTED] is authorized to release this information even though the confidentiality of the information may be protected by Federal or State laws and regulations. The hospital, its agents and employees, are hereby relieved of any liability that may arise from the release or reproduction of such records or information.

4. **FINANCIAL AGREEMENT:** For and in consideration of all services rendered by [REDACTED] I understand that I am responsible for the payment of any and all charges for services rendered which are not covered by Medicare, Medicaid, [REDACTED], private insurance or other third party payor. I accept responsibility for any services deemed medically unnecessary by any third party payor. I understand that if more than one person signs this agreement their liability shall be joining and several. If I or my insurance fail to make payment for these services when due, the hospital may at any time, without notice or demand, declare the entire unpaid balance to be immediately due and payable. I further agree to pay reasonable attorney and collection fees of not less than 20% if this account is placed for collection. I authorize and direct my insurance company to pay directly to [REDACTED] any and all benefits up to the amount of my bill. I understand that all physician services, including specifically services of radiologists, pathologists, anesthesiologists, emergency room physicians, attending physicians and others will be billed independently by the physicians providing the services and I accept responsibility for paying such charges, and hereby grant assignment of insurance benefits for this admission.

5. **NON-COVERED SERVICES:** I agree to be financially responsible for any charges associated with Services which are not reasonable or necessary for the diagnosis or treatment of the patient, but are provided for the convenience of the patient, his/her family, or physician regardless of payor source.

6. **PERSONAL VALUABLES:** I understand that the hospital maintains a safe for money/valuables and that the hospital will not be responsible for loss or damage to any money, jewelry, eyeglasses, clothing, hearing aids, dentures or personal property not deposited with the hospital for safekeeping, and for which a receipt has been issued.

Receipt Number _____

7. **MEDICARE AND MEDICAID PATIENT CERTIFICATION/INFORMATION:** I certify that information given by me in application for payment under Title XVIII and Title XIX of the Social Security Act and Title XIX Medicaid is correct. I authorize any holder of information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I request payment of benefits be made on my behalf. I, as a Medicare beneficiary, have been informed in writing that the care for which Medicare payment is sought will be subject to review by the Peer Review Organization and some services may be denied as not medically necessary or appropriate. I am aware of my rights and responsibilities.

8. **INJECTION CONTROL:** If any employee of [REDACTED] or other health care worker is exposed to my blood or other body fluids, I hereby authorize [REDACTED] to test my blood for Hepatitis B and HIV (the virus that causes AIDS). I understand the tests will be done at the expense of [REDACTED]

I HAVE READ THE ABOVE INFORMATION, AND I CERTIFY AND ACKNOWLEDGE THAT I UNDERSTAND THE INFORMATION AND CONSEQUENCES.

[REDACTED] wife 11-1
Relationship to Patient 26/10/99

With _____ 2ND Witness needed for verbal consent

If patient is unable to execute above form for any reason, such as being a minor, explain:

FROM : [REDACTED]

PHONE NO. : [REDACTED]

Aug. 07 1998 03:21PM P02

11-1-97 [REDACTED]

[REDACTED]

12-5-97

[REDACTED]

Authorization for Release of Medical Information

To: [REDACTED]

Patient's Name: [REDACTED]

Telephone: [REDACTED]

Address: [REDACTED]

Zip: [REDACTED]

DOB: [REDACTED]

SS#: [REDACTED]

I authorize [REDACTED] to release to:

Dr. [REDACTED]

(Name and Address)

Family Physician

(Specify: Attorney, Insurance Co., etc.)

for the following purpose: to help and treat other family members who may have inherited the heart disease

I authorize release of information covering treatment from: 11-1-97

(Dates)

Specific reason for hospitalization (i.e. general medical, surgical, drug & alcohol diagnosis treatment and abuse, psychiatric, HIV Test, etc.): Cardiac arrest

Portions of records requested: All records which pertain to this hospitalization

This authorization expires ninety (90) days from the date below, if not previously revoked, and it covers only treatment prior to that date.

This consent is subject to revocation at any time except to the extent that [REDACTED] which is to make the disclosure has already taken action in reliance on it.

[REDACTED] is authorized to furnish this information even though the confidentiality of the information may be protected by Federal or State laws or regulations. The hospital is hereby released and discharged of any liability, and the undersigned shall hold [REDACTED] harmless for complying with this authorization.

Nov. 8, 1997 (Date)

PATIENT (or person authorized to consent for minor or patient who is unable to sign)

ID: [REDACTED]

wife Relationship to Patient

NOTICE TO PERSON OR AGENCY RECEIVING INFORMATION: Federal Laws and Regulations prohibit further disclosure of the alcohol and drug abuse records without a specific consent of the patient or a person authorized to consent for the patient.

[REDACTED]

TO [REDACTED] EW

From [REDACTED] EW

x copy of consent-for chrt

ADDRESSOGRAPH

ORDERS AND PROGRESS NOTES

AUTHORIZATION IS GRANTED FOR THE DISPENSING OF AN ALTERNATIVE GENERICALLY AND THERAPEUTICALLY EQUIVALENT BRAND AS APPROVED BY THE PHARMACY COMMITTEE UNLESS CHECKED HERE

DATE	PHYSICIAN'S ORDERS	DATE	PROGRESS NOTES
		11/1/97 2215	<p>Pastoral Care</p> <p>Responded to Cds 99 call. Family notified. Mother, 2 sister present 12 year old son being taken care of by family away from hospital. Wife 16 year old son notified by his sister of pt's falling at his mother. They were notified at 8:30 p.m. Contacted pt's minister in [redacted] Mother's sister present. Will follow [redacted]</p>
		11/2/97 0156	<p>Pastoral Care Note</p> <p>Wife & 15 year old son arrived at [redacted] Nine year old son arrived 1hr prior to their arrival. [redacted] Returned call to [redacted] Pt. will be at [redacted] or [redacted] Referred patient to [redacted] Psychological support to family. [redacted]</p>
		11/2/97 0156	<p>Pastoral Care Note</p> <p>[redacted] called back. They will contact family after they arrive at [redacted] They will call back to release [redacted] [redacted] M. Sw</p>

DO NOT WRITE BELOW THIS LINE

CHART COPY - DO NOT WRITE OF DEPS UNLESS RED NUMBER SHOWS IN THIS AREA



000014