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

ARMS#

12483

4 - ER URGENT

[redacted]

FORM MUST BE FULLY COMPLETED AT TIME OF ACCIDENT

NAME: [redacted]	AGE: 35	DATE: 7/28/97	TIME: 8:30am
	911 ☒ YES	☐ NO	
ADDRESS OF INJURED: [redacted]		PHONE: [redacted]	
PLACE OF ACCIDENT: [redacted]			
PARENTS NAME (If under 18): —		PHONE: (W) —	
PARENTS ADDRESS: —		PHONE: (H) —	

DESCRIBE THE ACCIDENT: Stating unusual conditions contributing to the accident (Include Pertinent Remarks By Injured Person About Accident)

When necessary, was first aid protective equipment worn? ☐ Yes ☐ No

Paramedics called 7:59 A.M. Arrived 8:04 AM

THE VICTUM FELL TO THE FLOOR AFTER CARDIO COOL-DOWN (STEP). APPROX 7:57 AM I, AT ONCE, WENT TO HER AID, AS DID [redacted] (CLASS PARTICIPANT & ALSO A NURSE). VICTUM WAS BREATHING & HAD A PULSE, SO NO CPR WAS NECESSARY. [redacted] STAYED WITH VICTUM WHILE I TOLD [redacted] TO CALL "911". WHEN I WENT BACK TO VICTUM SHE WAS STILL BREATHING, BUT GASPING FOR BREATH, HER BODY WAS GOING INTO SPASMS (ARMS & LEGS TENSING AND FLEXING). HER EYES WERE OPEN. I ASKED MR. [redacted] FOR VICTUM'S MEMBERSHIP FILE TO FIND OUT ANY MEDICAL HISTORY. NONE THERE. I ALSO OBTAINED HER PHONE # & CALLED HER HUSBAND. PARAMEDICS ADMINISTERED O_2 & IV AT ONCE. VICTUM WAS TAKEN TO [redacted] EMERGENCY Room BY AMBULANCE (AT ABOUT 8:15 AM.

WITNESSES:

NAME: [redacted]	ADDRESS: [redacted]	PHONE: [redacted]
NAME: [redacted] (Nurse Member)	ADDRESS:	PHONE:
NAME: [redacted]	ADDRESS:	PHONE:

ACTION TAKEN: (Staff/Parent)

CALLED 911 IMMEDIATELY. CALLED [redacted] ALSO. PARAMEDICS ARRIVED AT 8:02 AM, 5 MINUTES AFTER CALL. CALLED HUSBAND WHEN PARAMEDICS ARRIVED.

STAFF SIGNATURE: [redacted] BRANCH: [redacted]

PARENTS SIGNATURE: SUPERVISOR SIGNATURE: [redacted]

ACCIDENT PROCEDURES: Branch Location Code:

1. Call 911 for an ambulance or for a complete investigation, if needed.
2. Call relative, friend or parent of victim in case of serious injury or if requested to do so. called [redacted]

[redacted] ice and retain a copy at the branch reporting the accident. Branch Executive or the Metropolitan Office and make

7-30/8-5-97 JAN(144)
Exhibit A Page 1 of 1

itan Office Phone: [redacted]

ACCOUNT # [redacted]
ADMISSION DATE 07/28/97
ATTENDING PHYSICIAN [redacted]
PATIENT LOCATION [redacted]

HISTORY OF PRESENT ILLNESS: The patient is a 34-year-old female who was doing aerobics this morning and had apparently been going for approximately an hour when she collapsed with a syncopal episode. The paramedics state that there was a retired physician there who said that the patient had stiffened and described a decerebrate-type posturing which lasted for a brief time. The patient was reportedly hyperventilating. The paramedics found the patient responsive and noted she was screaming, which I could hear in the background through the patch. Otherwise she would not follow commands.

Accu-Chek by the paramedics was greater than 80 and her vital signs have been stable. She was brought to the emergency room and her husband arrived. Further history was taken from him.

PAST MEDICAL HISTORY: The patient has no history of health problems. She has been taking no medications other than supposedly taking an herbal-type concoction for weight loss. She has been dieting, however her husband states that she still eats very healthily. She has been working out for approximately one month. He denies that she uses any drugs or has had any recent complaints.

PHYSICAL EXAMINATION: GENERAL: The patient was alert. She initially had some panic-type fear in her eyes and was drawing away, screaming in a high voice. She did not follow commands. NEUROLOGIC: It was noted that she had considerable facial grimacing, raising of eyebrows, eyes moving about, and she would not open her mouth on oral exam. The patient did not follow commands for hand grips. Reflexes were 2/4 in the upper and lower extremities. Negative extensor toe. HEENT: Funduscopic exam was attempted, however the patient's eye movement was considerable and optic grounds could not be well-visualized. Pupils equal, round, reactive to light and accommodation. HEART: Regular rate and rhythm. LUNGS: Clear. ABDOMEN: Soft.

DIAGNOSTIC STUDIES: CT scan revealed a subarachnoid hemorrhage per the radiologist.

DISPOSITION: This information was given to the husband and the patient was transported to [redacted] to accepting physician Dr. [redacted] She was transferred by helicopter with [redacted] The patient had received a total of 2 mg of Ativan IV to sedate her for CT scan as well as Compazine 5 mg IV for the vomiting. Other laboratory studies were pending at the time of transfer.

DIAGNOSIS: Acute subarachnoid hemorr[redacted]

CC:
DD:07/28/97 12:23 P **DT:**07/29/97 2:00 P [redacted] **Job:**[redacted] **Doc:**[redacted]

[redacted]

[redacted]

DATE	TIME	PARAMEDIC	UNIT	AGE	SEX	TAPE NO.
7/25/97	0816	[redacted]	[redacted]	30	F	

NAME: [redacted]

MEDICATIONS:

COMPLAINT: [redacted]

TRIAGE LEVEL

PMHX: ☐ GOOD HEALTH ☐ HTN ☐ DM ☐ MI Unknown -
☐ NO CARDIAC HX ☐ COPD ☐ ASTHMA

VS: BP	PULSE	RESP.	O2SAT	SKIN	CAP. REFILL	EYES	ALLERGIES:
108/p	164	30	RA	☐ WARM & DRY ☐ DIAPHORETIC ☐ COOL ☐ HOT	☐ NORMAL ☐ DELAYED	☐ PERRL ☐ DL ☐ CONST. R 2mm L	☐ NKA

PHYSICIAN:

MONITOR: ☐ NSR ☐ NO ECTOPY ☐ SINUS TACH ☐ PVC's ☐ AT. FIB

PHYSICAL EXAM: ☐ EXAM UNREMARKABLE

NEURO: ☐ A&O ☐ UNCONSC. ☐ MOVES ALL EXT. ☐ RESPONSE TO PAIN

CHEST: ☐ CLEAR & EQUAL ☐ GOOD BS BILAT ☐ WHEEZES ☐ RALES

ABD: ☐ SOFT ☐ RIGID ☐ NONTENDER ☐ TENDER

[redacted]

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PRE-PATCH TREATMENT:

O2: ____ L/NC ☐ MONITOR
____ L/MASK

IV: ☐ D5W ☒ NS ☐ LR ☐ 2 LINES ☐ C-SPINE/BACKBOARD
☐ TKO ____ cc / BOLUS ☐ MAST SUIT
____ cc HR. ☐ DEFLATED ☐ INFLATED

SVN: ☐ ALBUTEROL ☐ OTHER ____

ACLS: ☐ COMPRESSIONS ☐ INTUBATED ☐ BVM ☐ DEFIB ____ / ____ / ____

Attack 97

PHYSICIAN ORDERS: ☐ NONE ☐ SIGN AMA

TRANSPORT: ☐ ALS ☐ BLS ☐ POV

[redacted]

PHYSICIAN'S DEA NO. [redacted]

RECEIVING FACILITY: [redacted]	ETA: 10 min	TIME NOTIFIED:	PHYS [redacted]
PERSON NOTIFIED:	NOTIFIED BY:	TELEMETRY NURSE SIGNATURE:	

[redacted]

[redacted]

[redacted]

SERVICE [redacted] ALS [X] 901-H DNR [redacted] REFUSAL [redacted]

NAME [redacted] AGE ? SEX F WT/kg 70 D.O.B ? / /

ADDRESS SAA [redacted]

PMH DENIES ☐ UNK ☐ CARDIAC ☐ HBP ☐ CVA ☐ RESP. ☐ SEIZURES ☐

DIABETES ☐ CA ☐ PREGNANT ☐ G ____ P ____ ESTIMATED DUE DATE / /

UNKNOWN

Rx/S DENIES ☐ UNK ☒

ALLERGIES NKA ☐ UNK ☒

DR./GROUP NONE ☐ UNK ☒

CC/PT STATED NEEDS

APPROX. TIME	0805	0817	0827	
BP	108/P	106/C	90/P	/
PULSE	104	120	96	
RESP.	30	30 c̄ DEEP	RESP	
SKIN	COOL+M		COOL+M	
CAP REFILL	NORM	NORM	NORM	
PUPILS	[illegible]	[illegible]	(L) PUPIL 3	(R) @ 2
GCS	[illegible]	[illegible]	8	
S_aO_2	98/RA	98/RA	98/RA	/ RA O_2

ONSET TIME/DATE OF ILLNESS/INJURY ____ : ____ / /

HPI/MOI O/A PT LYING SUPINE ON FLOOR - BYSTANDERS ST PT WAS IN AEROBICS CLASS - DURING COOL DOWN PT SLUMPED TO FLOOR c̄ RAPID BREATH BYSTANDERS ST IT LOOKED LIKE SEIZURE - PT EXIBITED DEEP RAPID RESP c̄ EXP NOISES - NO C-SPINE INDICATED - PT UNRESPONSIVE

SEATBELTS WORN YES ☐ NO ☐ UNK ☐

HELMET WORN YES ☐ NO ☐ UNK ☐

AIRBAG DEPLOYED YES ☐ NO ☐

LOC O/A AWAKE ☐ ALERT ☐ ORIENTED PERSON ☐ PLACE ☐ TIME ☐ EVENTS ☐ LOSS OF CONSCIOUSNESS YES ☒ NO ☐ UNK ☐ NEAR SYNCOPE YES ☐ NO ☐ UNK ☐

LOC OTHER PT UNRESPONSIVE - NO REAC TO PX STIMULUS - PT COMBATIVE c̄ SCREAMING

NO FINDINGS FINDINGS

HEAD/FACE PATENT AIRWAY - LARNYX CLEAR p̄ SUCTIONING - NO DEFICITS NOTED

NECK NO GIBBUS PALPATED

CHEST = ↑+↓ O/A PAIN NONE ☐

LUNGS CONGESTION (L) SIDE-MID TO LOWER - CLEAR ON (R)

ABD SNT - NO GUARDING

PELVIS PT INCONTINENT TO URINE

EXT NROM - MAE - NO DEFICITS NOTED - NO POSTURING NOTED

BACK NOT VISUALIZED

[redacted]

UNIT/EMT/PM #	APPROX. TIME	TX/PROCEDURE	RESPONSE TO TREATMENT	BLOOD GLU[redacted]
[redacted]	0803	O_2 15 L/M NASAL ☐ MASK ☐ NRB ☒ BLOW BY ☐ BVM ☐ ____ /MIN.		TIME 0805 / READING 87 TIM[redacted]NG
		SPINAL STABILIZATION ☐ CC ☐ HEAD BLOCK ☐ BB ☐ TAPE/STRAPS ☐ VACUUM MATTRESS ☐	M&S INTACT x 4 ā & p̄ SPINAL STABILIZATION ☐	
		IV ☒ SOLUTION NS 250 ☐ 1000 ☒ GTTS/ML 10 ☒ 60 ☐ GAUGE 18 SITE (L) HAND ATTEMPTS 3	TOTAL FLUIDS INFUSED ____	TOTAL FLUIDS WASTED 900cc
	0812	MONITOR ☒ NSR ☐ RATE: 104 OTHER: ST ⊖ ECTOPY		
	0808	SUCTION OUT GURGLING IN BACK OF MOUTH - PT TURNED ON SIDE		
	0820	PT COMBATIVE c̄ SCREAMING - UNRESPONSIVE		
		BLOOD GLUCOSE @ HOSP 217		
	0815	PATCH ☒ NFO ☒ ORDERS:		

[redacted]

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STATUS ENROUTE/AT HOSP. NO CHANGE ☒ OTHER ☐

(PRINT) EMT ☒ [redacted] CEP ☒ [redacted]

PATCH DR/RN [redacted] TSL ☒ DSH ☐ OTHER: [redacted]

EQUIP. LEFT ON PT [redacted]

[redacted]

* ALL TIMES APPROXIMATE *

TO PATIENT RECORDS

000005

[redacted]

EMERGENCY DEPARTMENT RECORD

[redacted]

ED BED # [redacted]

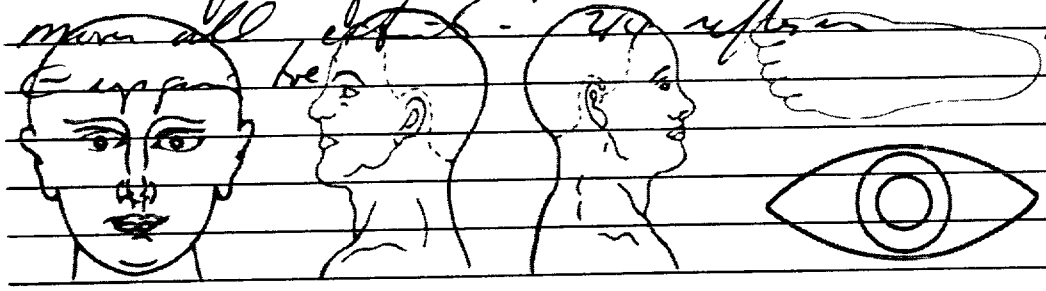
[redacted]		[redacted]	DATE 1/28/97	TIME ORDERED	TIME COMPLETED
ED PHYSICIAN	EXAM TIME 0840	FAMILY [redacted]		[redacted]	[redacted]

ALLERGIES NKA

CHIEF COMPLAINT
arechic x 1 h. - collapsed - Doc on scene
disorded decreased posturing
AMA ⊖

HISTORY
taking - no meds other than herbal extract

PHYSICAL EXAM
Alert - doesn't follow
E - commands - wax + wanes - sometimes
answer questions
Eg - [illegible] - [illegible] (not moved)
EXT ⊖ [illegible]
[illegible]
[illegible] L-C [illegible]
nerve: full facial expression -
moves all extr - 2/4 reflexes
⊖ upgoing toe



IMPRESSIONS OR DIAGNOSIS (1) Subachroid Hemorrhage

CONDITION AT DISCHARGE: ☐ STABLE ☒ SERIOUS ☐ AMA ☐ DECEASED ☐ OTHER

DICTATED ☐ YES [redacted]

TRANSFERRED ☒ TO [redacted]

EMERGENCY PHYSICIAN SIGNATURE X [redacted]

EMERGENCY PHYSICIAN SIGNATURE X [redacted]

POLICE SIGNATURE [redacted]

TIME ORDERED	TIME COMPLETED	PHYSICIAN'S ORDERS
[redacted]	[redacted]	TEST ORDERED: Accucheck 87
0832	[redacted]	CM, pulse ox
0835	[redacted]	Accucheck 217
		ELT
2	08	Chem - 20
		AT, ATT
[redacted]		DAS, [illegible]
		EKG
[redacted]		CT Head
010	[redacted]	MEDICATION, IV'S, RX: NS infuse solns TL 2nd I.V. 250cc [illegible] Compazine 5mg I.V. Ativan 1mg I.V. 10mg Vit R S-Q.

ACCEPTING DOCTOR [redacted]

HOW CALLED	ANSWER	PRESCRIPTIONS
1005		

000006

[redacted]

MEDICAL RECORDS

[redacted]

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[redacted]

CHIEF COMPLAINT: Pt presents screaming, unaware of surroundings. Combative with only 1 yr/m. Unassisted. Pt was exercising & went staff.

ONSET OF SX:

PMH: ☐ HEART ☐ MI (DATE) _____ ☐ CHF ☐ HIV + ☐ HYPERTENSION ☐ PULM. DISEASE ☐ DM ☐ SEIZURES

☐ OTHER: _____ ☐ SURGERIES: _____

CURRENT MEDS

Name	Freq.	Last Dose	Name	Freq.	Last Dose
NKA					

IMMUNIZATIONS / LAST TETANUS

HEAD CIRCUMFERENCE / BIRTH WEIGHT

TIME OF ARRIVAL _____

☐ TIME OF TRIAGE _____

☐ REGISTRATION @ 0845

☒ ER BED @ [redacted]

ARRIVED BY:

☐ WALK

☐ CARRIED

☐ WHEELCHAIR

☒ AMBULANCE [redacted]

☐ OTHER

TRIAGE CLASSIFICATION:

☐ Life Threatening

☐ Emergent

☒ Urgent

NURSING ASSESSMENT / DATA BASE

FILL IN OR CIRCLE WHERE APPROPRIATE TO CHIEF COMPLAINT

VENTILATION

RESPIRATIONS: (Regular) Shallow Labored Retractions Flaring

BREATH SOUNDS: Clear Crackles Coarse Wheezes Expr - Inspir

Grunting Describe _____

COUGH: Y - N Non-Productive Y - N Sputum _____

DEFERRED

CIRCULATION

SKIN TYPE: (Warm) Cool Dry (Moist) Other _____

SKIN COLOR Normal Cyanotic Jaundiced Other Pale

NAILBEDS: (Pink) Cyanotic Capillary Refill _____ Other _____

EDEMA: Absent Pedal Other _____ PULSES: Radial RIGHT Y - N LEFT Y - N

SKIN INTEGRITY: Pedal Y - N Y - N

DEFERRED Other _____ Y - N Y - N

COGNITIVE COMMUNICATION

NEUROLOGICAL: Glasgow Coma Scale E 4 M 4 V 2 Total 10

PUPILS: Dilated R 2 L 2 Constricted R L Sneller

SPEECH: Slurred Silent Coherent Garbled

BEHAVIOR: Cooperative Uncooperative Confused Unresponsive

Restless (Combative) Crying Anxious Other _____

DEFERRED _____

FOREIGN LANGUAGE _____ / TRANSLATOR NAME: _____

MOBILITY COMFORT

PAIN: Location Denies

Scale 1 2 3 4 5 6 7 8 9 10

OB / GYN

VAG BLEEDING / DISCHARGE _____ LMP _____

GR / PARA: _____ AB / MISC.: _____

EDC _____ FHT _____ ACTIVE LABOR ☐ Y ☐ N

DESCRIPTION _____

DEFERRED _____

NUTRITION FLUID STATUS

[redacted]

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NEURO MOTOR GAIT

☐ SYMMETRICAL

EXTREMITY DEFICIT L R

FACIAL DROOP L R

NUMBNESS L R

C-SPINE PRECAUTION Yes ☐ No ☐

Removed by: _____

Time _____

NECK PAIN Yes ☐ No ☐

DEFERRED

NURSING PROBLEMS

#	
	INEFFECTIVE AIRWAY EXCHANGE
	ALTERED CARDIAC OUTPUT
	ALTERED TISSUE PERFUSION
	ALTERATION IN COMFORT
	SENSORY / PERCEPTUAL ALTERATIONS
	IMPAIRED TISSUE INTEGRITY
	IMPAIRED PHYSICAL MOBILITY
	ALTERATION IN ELIMINATION
	HYPOTHERMIA / HYPERTHERMIA
	FLUID VOLUME DEFICIT / EXCESS
X	POTENTIAL FOR Injury
	OTHER

GLASGOW COMA SCALE

EYE OPENING
(4 - Spontaneous) 2 - To Pain
3 - To Speech 1 - None

MOTOR RESPONSE
6 - Obeys Commands 3 - Flexion
5 - Localizes Pain 2 - Extension
(4 - Withdraws) 1 - None

VERBAL RESPONSE
5 - Oriented 3 - Inappropriate Word
4 - Confused (2 - Incomprehensible)
Conversation Words
1 - None

[redacted]

VITALS

BP: 110/38

HR: 104

RR: 32 OXI:

TEMP: 94.1 (T)

WT: HT /LMP

PSYCHOSOCIAL

OBSERVED BEHAVIOR

☐ Relaxed/At Ease ☐ Agitated

☐ Angry ☐ Depressed

☒ Anxious ☐ Flat Affect

☐ Withdrawn

Religious Preference/Culture Beliefs Which May Affect Treatment or Care ☐ Y ☐ N

SIGNS OF ABUSE

SEXUAL ☐ Y ☒ N

EMOTIONAL ☐ Y ☒ N

PHYSICAL ☐ Y ☒ N

RECV. TREATMENT ☐ Y ☒ N

RESOURCE INFO PROVIDED ☐ Y ☒ N

PRE-HOSPITAL CARE

☐ CPR ☐ Monitor

☐ ET Tube ☐ Spineboard

☐ Airway ☐ C-Collar

☐ Splint _____ RA LA RL LL

☐ O2 _____ Min. NC or Mask _____

☒ Accucheck 87

Medication _____

☒ Field IV Solution #1 LNS

☐ Amt. Infused _____

Site _____

CONSENT TO TREAT

CONSENT FROM: _____

WITNESS. _____

WITNESS: _____

TIME: _____

[redacted]

TIME & INITIALS	MEDICATIONS/PROCEDURES	DOSE	ROUTE	SITE	RESPONSE	TIME & INITIALS	UNIT GLUCOSE	UNIT O2 SAT
900 [redacted]	Compazine 5 mg		IV		↓ vomiting			
910	Ativan 1 mg		IV		↓ agitation			
10[redacted]	Vitamin K	10 mg	pill		↓ Dulcolax			

[redacted]

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INTAKE TIME & INITIALS	SITE	SIZE CATH	IV FLUIDS	AMOUNT
Jello	IV			1000cc
Hosp [redacted]	#2	1000	cc 9 am	
				TOTAL

OUTPUT TIME & INITIALS	SOURCE/DESCRIPTION	AMOUNT
		TOTAL

[redacted]

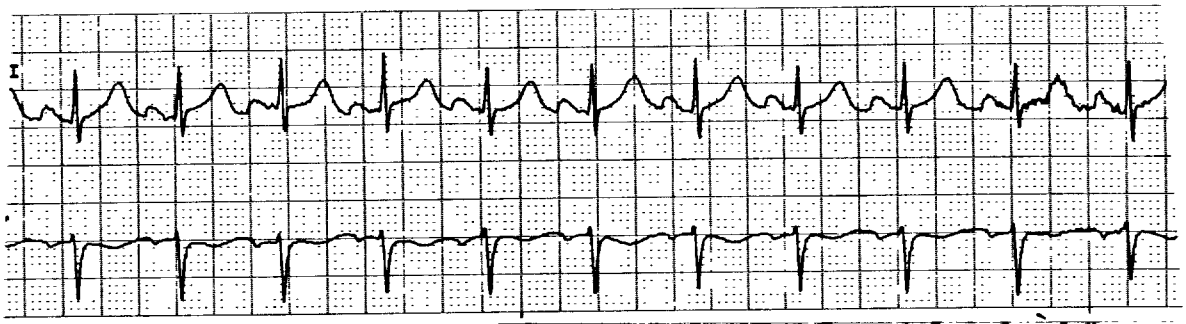
INITIALS	SIGNATURE/TITLE

INITIALS	SIGNATURE/TITLE

CONTINUING ASSESSMENT AND INTERVENTIONS

TIME	T	P	R	B/P	NSG DX #	ACTION	RESPONSE

JAL SAVED EMER [redacted] 28-JUL-1997 08:54:06 ALM VOL 20X @25 MM/S
107 ARR FULL PVC 0 NBP 110/38 (92 X08:34 SPO2 91 RATE 101



855 Monitor: RSR - RST 5 Utopia
wretching - sm amt liquid + residue
#18 Fr Foley inserted - very sm amt
dk amber urine

DISCHARGE / TRANSFER / ADMISSION

VITAL SIGNS _____
RESPIRATIONS: Regular Shallow Labored Retractions
BREATH SOUNDS: _____
NEUROLOGICAL: Glasgow Coma Scale E __ M __ V __ Total ____
BEHAVIOR: Cooperative Uncooperative Confused Unresponsive
Restless Combative Crying Other
PAIN: [redacted]
SKIN: Warm Dry [redacted]
SKIN INTEGRITY:
ASSESSMENT UN

ADMITTED TO HOSPITAL # [redacted] TIME _____
TRANSFERRED T [redacted] TIME 1035
EXPIRED ☐
RELEASED TO _____ TIME _____

DISCHARGE INSTRUCTIONS ☐ WRITTEN ☐ VERBAL
EXPRESSES UNDERSTANDING ☐ YES ☐ NO
HOME WITH: ☐ SELF ☐ FAMILY/FRIEND/CARE-TAKER
VIA ☐ POV ☐ TAXI ☐ AMBULANCE
DISCHARGE ☐ AMB ☐ W/C ☐ STRETCHER ☐ CARRIED
DISCHARGE TIME _____
NURSES SIGNATURE [redacted]

[redacted]

[redacted]

[illegible] in CT per care

940 Return from CT per cart

[redacted]

[illegible] @ bedside - Dr [redacted] discussed

results of CT

condition unchg'd - moaning but

in other wise not verbal

skin cool & pl moist

pt's parents @ bedside - spoke c Dr

[redacted] regarding pt's condition

1010 [redacted] & notified -

1015 COBRA form signed by pt's spouse

1035 transferred to [redacted] Dr [redacted]

JUL- EMER [redacted] 28-JUL-1997 10:20

VITAL SIGNS	28-JUL 09:15	28-JUL 09:30	28-JUL 09:45	28-JUL 10:00	28-JUL 10 15
HR	118		100	108	102
PVC	1		0	0	0
NBP-S	102	97	102	102	101
NBP-D	52	58	59	64	59
NBP-M	74	78	81	85	76
NBP-R	120	107	98	118	104
SPO2-%	91		100	92	99
SPO2-R	116		100	98	102

ALARMS NBP (MMHG)

[redacted]

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[redacted]

[redacted]

7

[redacted]

Service: [redacted]

****

In: 07/28/97 0916
Out: 07/28/97 0922
Coll Time: 07/28/97 0915
Order Phys: [redacted]

HEMOGRAM

Spec: Blood
Techs: [redacted]

*STAT*STAT*STAT*

Result Name	Result	Normal Range
WBC(K/cmm):	10.4	4.8-11.0
RBC(M/cmm):	4.14	4.00-4.90
Hgb(gm/dl):	13.2	12.0-15.0
Hct(%):	37.8	36.0-46.0
MCV(fl):	91	80.0-100.0
MCH(pg):	32.0	27.0-32.0
MCHC(%):	35.0	32.0-36.0
PLT(K/cmm):	224	150-450

In: 07/28/97 0921
Out: 07/28/97 0922
Coll Time: 07/28/97 0915
Order Phys: [redacted]

DIFFERENTIAL

Spec: Blood
Techs: [redacted]

*STAT*STAT*STAT*

Result Name	Result	Normal Range
Segs(%):	79 H	46-66
Lymphs(%):	13 L	24-44
Monos(%):	5	0-10
Eos(%):	1	0-7
Basos(%):	1	0-2
RBC Morph:	Normal	Normal

In: 07/28/97 0916
Out: 07/28/97 0949
Coll Time: 07/28/97 0915
Order Phys: [redacted]

PROTHROMBIN TIME

Spec: Blood
Techs: [redacted]

*STAT*STAT*STAT*

Result Name	Result	Normal Range
Pro Time(seconds):	14.7 H	11.1-13.3
INR:	1.4 L	1.5-3.0

[redacted], M.D.

Outpatient Summary Report

[redacted]
07/28/97
Dr. [redacted]

[redacted]

[redacted]

[redacted]

****

In: 07/28/97 0916
Out: 07/28/97 1013
Coll Time: 07/28/97 0915
Order Phys: [redacted]

| CHEM 7 PROFILE |

Spec: Blood
Techs: [redacted]

*STAT*STAT*STAT*

Result Name	Result	Normal Range
Sodium(mmol/L):	140	138-148
Potassium(mmol/L):	4.2	3.5-5.3
Chloride(mmol/L):	108	95-110
CO2(mmol/L):	16 L	21-33
Glucose(mg/dl):	192 H	65-110
BUN(mg/dl):	13	6-25
Creatinine(mg/dl):	1.1	0.5-1.3

In: 07/28/97 1038
Out: 07/28/97 1039
Coll Time: 07/28/97 0915
Order Phys: [redacted]

| CHEMISTRY PROFILE |

Spec: Blood
Techs: [redacted]

*STAT*STAT*STAT*

Result Name	Result	Normal Range
Sodium(mmol/L):	140	138-148
Potassium(mmol/L):	4.2	3.5-5.3
Chloride(mmol/L):	108	95-110
CO2(mmol/L):	16 L	21-33
Glucose(mg/dl):	192 H	65-110
BUN(mg/dl):	13	6-25
Creatinine(mg/dl):	1.1	0.5-1.3
CK(U/L):	157	21-215
LD(U/L):	129	95-180
AST(U/L):	19	12-45
Alk Phos(U/L):	55	50-136
Gamma GT(U/L):	11	5-55
Uric Acid(mg/dl):	4.8	2.5-7.8
Bilirubin(mg/dl):	0.5	0-1.5
Prot Total(gm/dl):	6.3 L	6.5-8.2
Albumin(gm/dl):	3.6	3.5-5.5
Globulins, Total(gm/dl):	2.7	2.3-3.5
Calcium(mg/dl):	8.5 L	8.7-10.7
Phosphorus(mg/dl):	3.1	2.5-4.9
Cholesterol(mg/dl):	175	140-200
Triglycerides(mg/dl):	77	20-150

[redacted] M.D.

[redacted] 07/28/97

Dr. [redacted]

Outpatient Summary Report

[redacted]

7-30/8-5-97 JAN(144)

[redacted]

[redacted]

****

In: 07/28/97 0950
Out: 07/28/97 1008
Coll Time: 07/28/97 0945
Order Phys: [redacted]

Spec: Urine
Techs: [redacted]

DRUG ABUSE SCREEN, URINE

*STAT*STAT*STAT*

Result Name	Result	Normal Range
PCP:	Negative	Neg
Benzodiazepine:	Negative	Neg
Cocaine:	Negative	Neg
Amphetamine:	Pos	Neg
THC:	Negative	Neg
Opiates:	Negative	Neg
Barbiturate:	Pos	Neg
Tricyclics:	Negative	Neg

End of Report - 07/29/97 06:28

[redacted]

7-30/8-5-97 JAN(144)
Exhibit B Page 12 of 13

[redacted] M.D.

Outpatient Summary Report

[redacted] 07/28/97 [redacted]

000012

[redacted]

[redacted]

****

In: 07/28/97 0916
Out: 07/28/97 0949
Coll Time: 07/28/97 0915
Order Phys: [redacted]

Spec: Blood
Techs: [redacted]

[redacted]

PARTIAL THROMBOPLASTIN TIME

*STAT*STAT*STAT*

Result Name	Result	Normal Range
aPTT(seconds):	31	22-32

In: 07/28/97 0950
Out: 07/28/97 1054
Coll Time: 07/28/97 0945
Order Phys: [redacted]

Spec: Urine
Techs: [redacted]

[redacted]

URINALYSIS COMPLETE

*STAT*STAT*STAT*

Result Name	Result	Normal Range
Color:	Yellow	Yellow
Appears:	Cloudy	Clear
Glucose, Ur(mg/dl):	Neg	Neg
Bili Urine:	Neg	Neg
Ketone(mg/dl):	1+	Neg
Spec Gravity:	> 1.030	1.005-1.030
pH(pH Units):	6.0	5.0-9.0
Protein(mg/dl):	3+	Neg
Urobilinogen(EU/dl):	Norm	0.2-1.0
Nitrite:	Neg	Neg
Occ Bld-Urine:	1+	Neg
Leukocyte Est:	Neg	Neg
WBCs(/HPF):	0-3	0-3
RBCs(/HPF):	5-10 H	0-3
Epithelial Cell(/HPF):	10-20 H	0-3
Bacteria:	2+	
Microscopic Exam:	Few Yeast	
Casts(/LPF):	>50 Hyaline Casts/LPF Finely Granular casts	

[redacted]

[redacted] M.D.

Outpatient Summary Report

[redacted] 07/28/97

Dr. [redacted]

[redacted] ID: [redacted] 28-JUL-1997 09:16 [redacted] ROUTINE RECORD

	Vent. rate	120	BPM
	PR interval	160	ms
	QRS duration	76	ms
	QT/QTc	324/458	ms
5	P-R-T axes	58 -42	84

SINUS TACHYCARDIA
LEFT AXIS DEVIATION
ANTERIOR INFARCT, AGE UNDETERMINED
ABNORMAL ECG

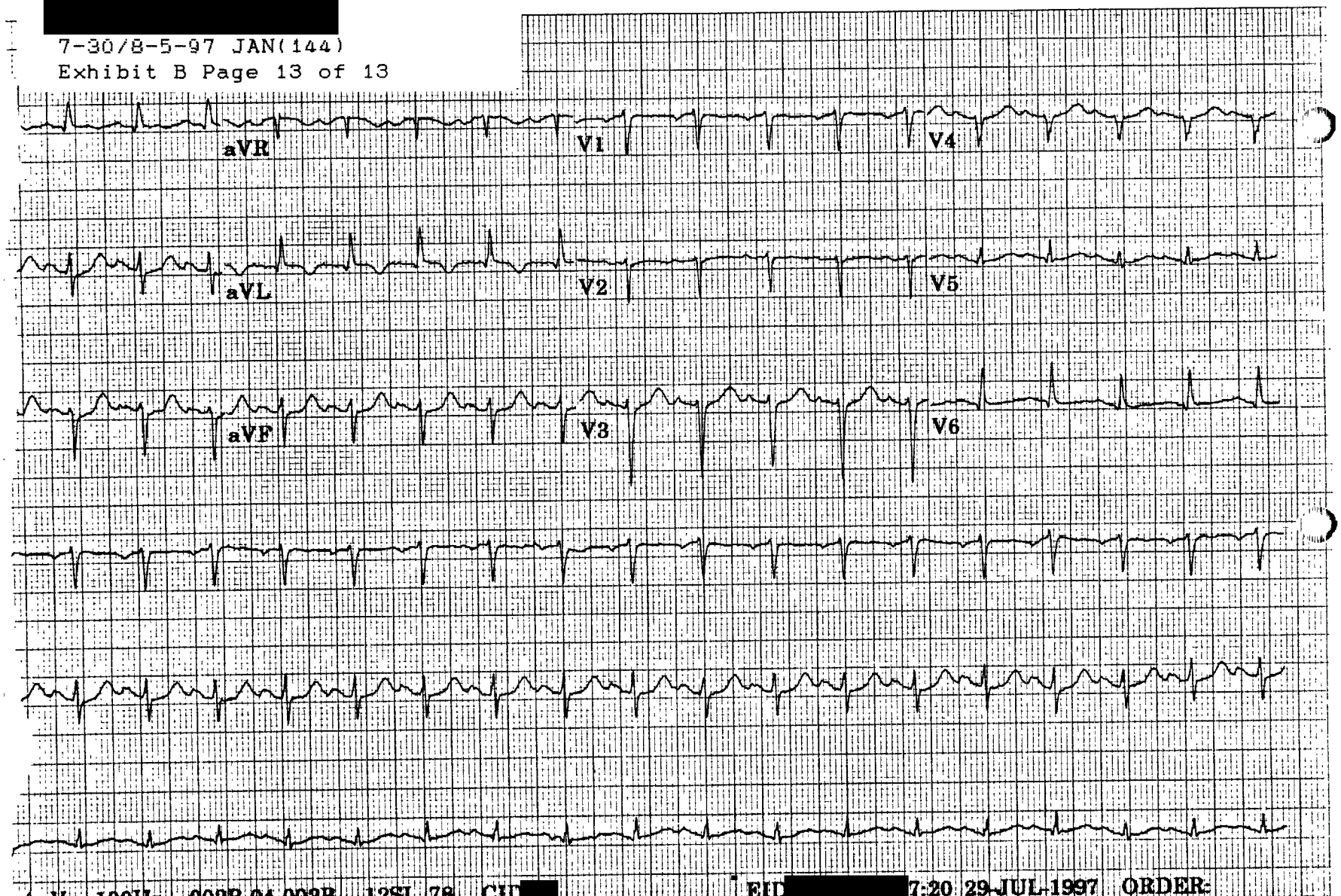
echnician ID: [redacted]

erred by: [redacted]

Confirmed by: [redacted]

[redacted]

7-30/8-5-97 JAN(144)
Exhibit B Page 13 of 13



mV 100Hz 002B-04-002B 12SL 78 CID [redacted] EID [redacted] 7:20 29-JUL-1997 ORDER:

[redacted]

000014

PATIENT NAME [redacted]
MEDICAL REC #
ACCOUNT #
ADMISSION DATE 07/28/97
ADMITTING PHYSICIAN
PRIMARY CARE PHYSICIAN
PATIENT LOCATION

CHECK-IN#: [redacted]

CT OF THE HEAD

DATE: 7/28/97

CPT CODE: [redacted]

INDICATION: The patient is a 34-year-old with syncope and decreased level of consciousness.

PROCEDURE: Soft tissues, subdural, and bone windows were obtained. No contrast was given.

FINDINGS: Hemorrhage is seen in the third and fourth ventricles. Hemorrhage is identified in the cistern of lamina terminalis. Subarachnoid hemorrhage is identified in the basilar cisterns including on the left side of the mid brain. Subarachnoid hemorrhage is identified in the sylvian fissures. The hemorrhage is fairly symmetric. There is borderline dilatation of the lateral ventricles for the age of the patient. No fracture are identified.

CONCLUSION:

1. Findings are consistent with subarachnoid and intraventricular hemorrhage consistent with ruptured anterior communicating artery aneurysm. This case was discussed with Dr. [redacted]

/Read By/ [redacted] M.D.
/Released By/ M.D.
/Transcribed By/ [redacted] 07/28/97 1022

COMPLETE

[redacted]
7-30/8-5-97 JAN(144)

[redacted]

PATCH ☐
FROM
PRIOR

[redacted]

EMERGENCY DEPARTMENT

LEVEL I

Doctor _____ Date: 1-28-97

Patient's Name: [redacted] Age: 36 F Time: 1020

Problem or Diagnosis: SAH

[redacted]

☐ Call on Arrival ☐ Check & Call ☐ [redacted] ☐ X-Ray - Lab Call ☐ Treat & Release

☐ Dr.; Coming ☐ Dr.; In-House ☐ Refer to: _____

B.P. _____ P. _____ R. _____

I.V. _____

O_2 _____

Medications Given: _____

C-Spine Precautions

Mast Suit: ☐ On ☐ Inflated

Cardiac Rhythm: _____

Injuries: _____

Doctor's Orders: _____

Patient's Medications: _____

Allergies: _____

[redacted]

7-30/8-5-97 JAN(144)
Exhibit K Page 2 of 6

ETA From: [redacted]

☐ Air ☐ Ambul [redacted]

Orders Taken BY: [redacted]

PRIOR ORDERS

000016

THIS FORM IS A PORTION OF THE MEDICAL RECORD; PLEASE ATTACH TO CHART.

[redacted]

[redacted] 3 [redacted]

LABORATORY
- ☐ ABG
- ☐ AMYLASE
- ☐ BLOOD CULT x 1 x 2
- ☐ CARDIAC ENZ
- ☐ CHEM 15
- ☐ CREATININE
- ☐ DIG LEVEL
- ☐ DILANTIN LEVEL
- ☐ ETOH
- ☐ LIPASE
- ☐ MAG
- ☐ PELVIC BATTERY
- ☐ PT. PTT
- ☐ QUANT. HCG
- ☐ SED RATE
- ☐ TEGRETOL LEVEL
- ☐ TOX, ED
- ☐ TRAUMA PROFILE
- ☐ TRAUMA PROFILE (PED)
- ☐ TYPE & SCREEN
- ☐ URINE
- ☐ URINE C & S

ER STAT LAB
- ☐ CHEM 5
- ☐ EKG
- ☐ HEME - 8
- ☐ MED PROFILE (ABG, CHEM 5, HEME - 8)
- ☐ UA DIP
- ☐ URINE PREG (+) (-)

X-RAY
- ☐ AAS
- ☐ ANKLE L R
- ☐ C-SPINE
- ☐ PCXR
- ☐ ELBOW L R
- ☐ FOOT L R
- ☐ FOREARM L R
- ☐ HAND L R
- ☐ HIP L R
- ☐ IVP
- ☐ KNEE L R
- ☐ KUB
- ☐ SHOULDER L R
- ☐ SHUNT SERIES
- ☐ T-SPINE
- ☐ WRIST
- ☐ US _____
- ☐ VQ SCAN

[redacted]

Date Ordered	TIME LAB DONE	UNIT SEC SIGNATURE	✓	Time Done	Signature
7/28	PCXR stat		✓	1110	[redacted]
	TFC 4 units		✓		
	A-line		✓		
	CBC, CP, PT/PTT/INR		✓		
	BHCG		✓	↓	↓
	Lasix 40mg IV x 1 now		✓	1110	[redacted]
	Consult for ventriculostomy		✓	↓	↓
	4 Vessel cerebral [redacted]				
	[redacted]				
	[redacted]				
	Zinacef 1.5 gm IV	not given - pt to			[redacted]
	Prep for ventric	Ventric to be done on			[redacted]

Authorization is given for dispensing non-proprietary name unless checked here. ☐

[redacted]

7-30/8-5-97 JAN(144)
Exhibit K Page 1 of 6

TIME	RESIDEN[redacted]	DR. SIGNATURE

000017

[redacted]

EMERGENCY DEPARTMENT ORDERS

[redacted]