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

ARMS#

13085

4 - ER URGENT

Attachment 1

[redacted]

12/10-17/98 PJP

[redacted]

No. [redacted]

[redacted]

RTV _____ Room No. [redacted]

TIME ADMIT

Family Physician. _____

HOW BROUGHT TO HOSPITAL						ADMISSION SOURCE											
AMBULATORY	CARRIED	WHEEL CHAIR	POLICE	AMBULANC[redacted]		X E M ROOM	2 OUT PT DEPT	1 PRIVATE PHYSICIAN	4 OTHER HOSP	5 SKILLED NURSE FACILITY	6 REHAB CENTER	PSYCH FACILITY	HOME HEALTH	NURSING HOME	COURT LAW ENFORCEMENT		

WHEN INJURED OR STRICKEN — WHERE

DATE 7/18/98 TIME AM PM — 05 HOME — 04 WORK — 01 AUTOMOBILE — 05 OTHER — 06 CRIME — R Knee injury 1510 [redacted]

AGE	WT	TEMP	PULSE	RESP	B P	ALLERGIES	LAST TET DATE	CONDITION ON ARRIVAL	
31	98	166	104	20	130/90	NKDA	UTD	X CONSCIOUS	UNCONSCIOUS

TIME 1510 NURSES NOTES 31 yr. old wt presents to ER per stretcher. C/C Pain R Knee - states she was pumping gas her knee gave way and she fell on knee. C/O pain posterior states sm. bruised to side of knee - knee immobilized on arrival to ER. Ice pack applied, elevated, pulse good.

LMP. 6/4/98 Med. Diet Pills

T.D N [redacted]

"X" LAB & X-RAY

CBC	LYTES	GLU
BUN	CREAT	CPK
LDH	EKG	ABG'S
C & S OF	UA	ISOENZYMES
L-S SP	C-SP	SKULL

[redacted]KR

R Knee

O: THERAPY

IV THERAPY

Written DCI given c good understanding

PHYSICIAN'S EXAMINATION SIGNATU[redacted]

DISCHARGE IMPRESSIONS Contusion R Knee

TREATMENT [redacted] Elastic support Ac Lidine XL 500 BCD-015

Elevate & ice pack

AFTERCARE INSTRUCTIONS See Orthopedic Dr [redacted]

DRIVING Family member

☐ CARDIAC MONITOR

Inter _____

☐ Tet-Toxoid _____

1) Wound Length _____ cm

2) No of Sutures _____

3) Inj c _____ c c

Police Notified

Time _____

Dept _____

On Scene _____

☒ Nurse s Notes Complete

☐ Castcare Instruction

☐ Casting Charged

☐ Narcotics Precautions

☐ Tetanus Follow-up

☐ Medicines Charged

000002

PHYSICIAN'S VISIT

X Minimal ___ Limited ___ Intermediate

___ Extended ___ Intensive

Discharge TX DISC _____ AMA _____ DOA _____ Expired _____ Transferred _____

☒ Ambulatory ☐ Stretcher ☐ Wheelchair Admit _____ ☐ Family Physician Notified ☐ Other _____ Time _____

X GOOD FAIR POOR

PATIENT'S SIGNATURE X [redacted]

PHYSICIAN'S [redacted]

D O Discharge 7/18/98 T O Discharg[redacted] 1620

attachment 1

[redacted]

12/10-17/98 PJP

[redacted]

Lower Extremity Injury (3)

TIME SEEN: 3 30 p ROOM: [redacted]

HISTORIAN: (patient) __family __paramedic __translator

HPI **chief complaint:**
__hip R / L
__thigh R / L
(knee) (R) / L
__leg R / L

injury to:
__ankle R / L
__foot R / L
__R great 2 3 4 little toe
__L great 2 3 4 little toe

occurred:
(just prior to arrival)
__today
__yesterday
_____ days PTA

location:
__home __school
__neighbor's __city park
__work __street
GAS STATION

mechanism / activity at time of injury:
(fell) __twisted __direct blow __incised wound __stab __burn

Knee gave away & pt fell - 5 hrs squatted to pump gas

foreign body: (n/a) __unlikely __unknown __likely

weight-bearing: __normal (painful) __unable

PAST HISTORY: __negative __see nurses note __peptic ulcer
Knee weak for past 1-2 weeks

Meds- __none / see nurses note

Allergies- __NKDA

☑ Nursing Assessment, Vital Signs Reviewed. ☐ Immunizations UTD

PHYSICAL EXAM

__Alert

Distress: __NAD __mild __moderate __severe

NEURO-VASCULAR-TENDON
__no vascular compromise
__see diagram
__abnml color / warmth / cap refill
__pulse deficit
__sensation intact
__sensory / motor deficit
__tendon injury
__ROM nml
__ROM limited by pain

SKIN
__intact
__see diagram

GAIT
__normal
__limited by pain / unable to bear weight
__antalgic gait
__gait not tested due to pain

[redacted]

FEET & ANKLES
__nml inspection
__see diagram
__swelling / tenderness / ecchymosis
__bony point-tenderness
__laxity of ligaments (ant. drawer)

LEGS
__nml inspection
__see diagram
__swelling / tenderness / ecchymosis
__bony point-tenderness

KNEES
__nml inspection
__see diagram
__swelling / (tenderness) / ecchymosis
__bony point-tenderness
__effusion
(limited ROM)

__stable
Ligaments-
__pain / laxity on anterior drawer
__pain / laxity on posterior drawer
__pain / laxity on medial stress
__pain / laxity on lateral stress

THIGHS & HIPS
__nml inspection
__see diagram
__tenderness / swelling
__limited hip ROM
__hip pain on leg movement (R / L)

XRAYS: (R) / L *ankle tib-fib* (knee) *femur hip*
(normal) / NAD
__DJD
__dislocation
__soft-tissue swelling
__fracture

PROGRESS AND PROCEDURE NOTES

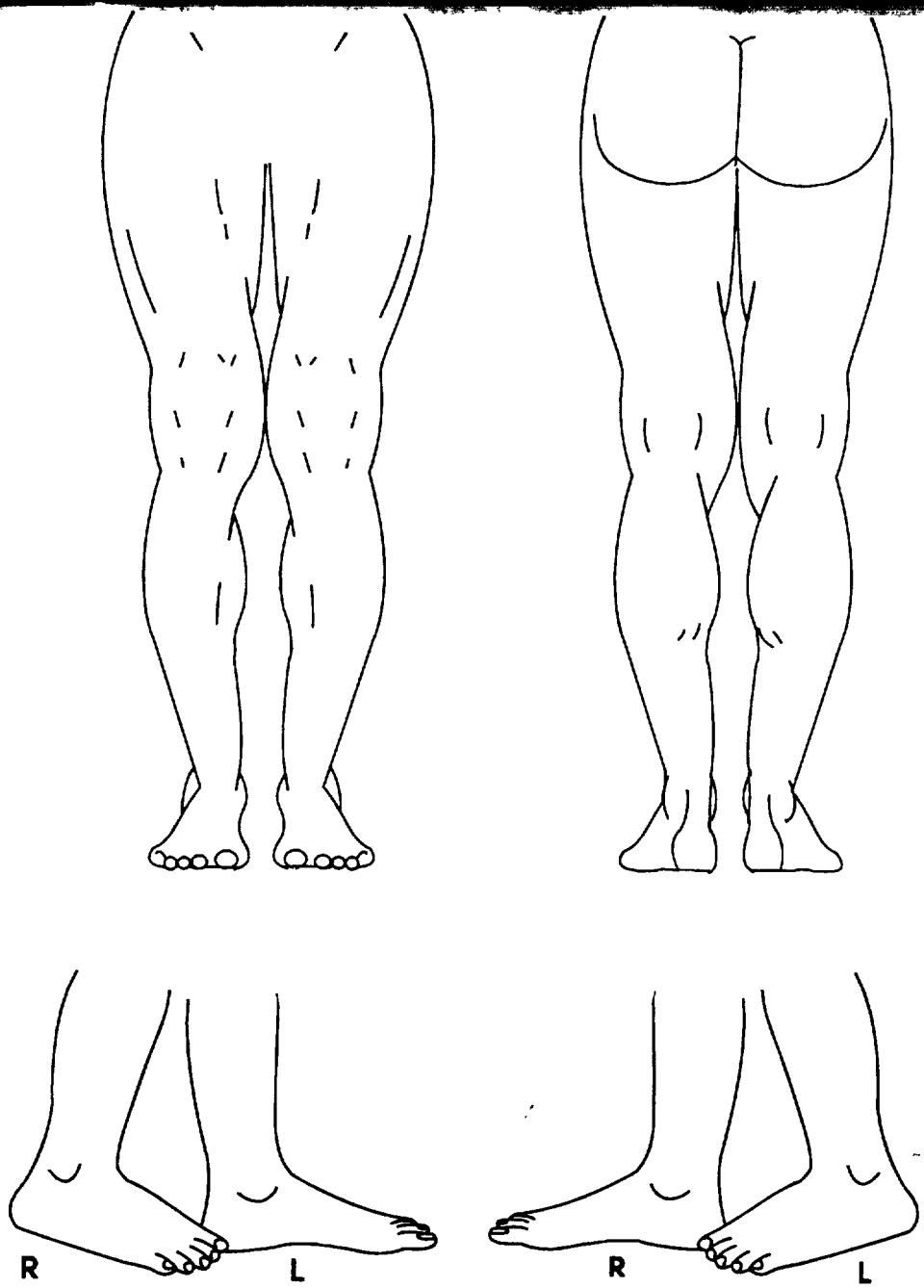
KNEE-
__knee immobilizer __crutches __neoprene sleeve
__arthrocentesis done after betadine prep; _____ cc
of __serous __serosanguinous __bloody fluid removed.

ANKLE-
__ace wrap / tape __boot orthosis __crutches __post-op shoe
__air cast __neoprene
__splint *stirrup / posterior* OCL / Ortho-glass / plaster
__applied by ED Physician / Orthopedist / Tech

000003

OTHER-
__laceration (procedure note on reverse)
__referred to / discussed with Dr.
will see patient in: office / ED / hospital in _____ days

[redacted]



WOUND DESCRIPTION

Wound:_____

Size: _____-cm

Distal NVT: __sensation intact
__vascular. intact __tendon intact

Depth/shape/contamination:
__superficial __linear __flap
__SQ __stellate __irregular
__muscle __skieved __nail avulsed
__clean
__contaminated with_____
__contused surrounding tissue

ANESTHESIA
__local __digital / metacarpal block
_____cc .25% .5% 1% 2%
__lidocaine __marcaine w/epi w/o epi

WOUND PREP
__Betadine / hibiclens
__irrigated / washed with saline
__wound explored
__foreign material noted / removed
minimal / moderate / extensive
__wound debrided

WOUND REPAIR
SKIN #____ ____-0
material- nylon prolene vicryl _____
__interrupted __running
__simple __mattress (h / v)

SUBCUTAN #____ ____-0
*material- vicryl chromic*_____
__interrupted __running
__simple __mattress (h / v)

*OTHER*_____
*material-*_____
__interrupted __running
__simple __mattress (h / v)

T=Tenderness S=Swelling E=Ecchymosis
B=Burn C=Contusion Lac=Laceration
A=Abrasion M=Muscle spasm
PW=puncture wound
(Ø=without m=mild mod=moderate sv=severe)
Example- Tsv, A = Tenderness on palpation (severe) and Abrasion

CLINICAL IMPRESSION

Fall Alleged Assault

~~Contusion /~~ Hematoma / Laceration / Sprain *1° 2° 3°* Fracture R / L

~~R / L~~ hip thigh leg
~~knee~~ ankle foot

nav

Attachment 1

[redacted]

12/10-17/98 PJP

DISPOSITION- ☒ ~~home~~ ☐ admitted _____
☒ Rx given

CONDITION- ☐ unchanged ☒ ~~improved~~ ☐ stable _____

PHYSICIAN SIGNATURE- [redacted]

Lower Extremity -11

attachment 1

12/10-17/98 PJP

D BY DOCTOR			DATE TO BE DONE
ALKING	X WHEELCHAIR	PORTABLE	CART
STAT	PREOP	O_2 GOING	IV GOING

RIGHT KNEE WITH SUNRISE VIEW: 7-18-98. Patient fell on knee.

Joint appears to be well maintained. No fracture identified.

IMPRESSION:

1. Unremarkable exam.

M.D. typed 7-19-98 at 12:09 pm

TIME	FIO2 / FLOW	DEVICE	HOURS	COMMENTS	SIGNATURE

[redacted]

Attachment 1

[redacted]

12/10-17/98 PJP

[redacted]

RTV _____ Room No. [redacted]

TIME ADMIT

Family Physician. [redacted]

[redacted]

HOW BROUGHT TO HOSPITAL: AMBULATORY | CARRIED | WHEEL CHAIR | POLICE | [redacted]

ADMISSION SOURCE: [X] 7 E M ROOM | 2 OUT PT DEPT | 1 PRIVATE PHYSICIAN | 4 OTHER HOSP | 5 SKILLED NURSE FACILITY | 6 REHAB CENTER – PSYCH FACILITY – HOME HEALTH – NURSING HOME | COURT LAW ENFORCEMENT

0925

WHEN INJURED OR STRICKEN [redacted] HERE

DATE 7 TIME AM PM | 05 HOME | 04 WORK | 01 AUTOMOBILE | 05 OTHER | 06 CRIME | General Weakness

LAST TET DATE | CONDITION ON ARRIVAL: [X] CONSCIOUS | UNCONSCIOUS

AGE	WT	TEMP	PULSE	RESP	B P	ALLERGIES
31	166	99.2	88	20	135/71	NKDA

TIME 0925 NURSES NOTES 31 yr. old WF presents to ER per stretcher c/c General Weakness onset Saturday c/o pain @ rib cage area (L) flank pain Was seen here Saturday for injury to @ knee

1225 B/P 116/73 P.75

T D N. [redacted]

"X" LAB & X-RAY

CBC X	LYTES X	GLU X
BUN X	CREAT X	CPK [redacted]
LDH	EKG X	[redacted]
C & S OF	NA X	ISOENZYMES
L-S SP	C-SP	SKULL

[redacted] AAS- Amylase, lipase, calcium, albumin, CBC, diff, platelets, PT, PTT, UA

Stool guaiac - positive

O2 THERAPY

Pulse ox 98%

IV THERAPY [redacted] on left hand

IV Started w/ (R) 20 gauge, after fluid bolus & rate 150 c/h

PHYSICIAN'S EXAMINATION SIGN [redacted]

Report called to [redacted]

Spoke to [redacted] to [redacted]

Spoke to [redacted] → coming

DISCHARGE IMPRESSIONS hypokalemia

TREATMENT 1015 [redacted] Gavicon/xylocaine 30cc po 1015 [redacted] Pepcid 20mg po 40 meq K Dur po stat 1130 BF

[X] CARDIAC MONITOR NSR

Inter

[ ] Tet-Toxoid

AFTERCARE INSTRUCTIONS.

DRIVING

1) Wound Length _____ cm

2) No of Sutures _____

3) Inj c _____ cc

Police Notified

Time 145/95/94

Dept 40/16

On Scene 9.6

[ ] Nurse's Notes Complete

[ ] Castcare Instruction

[ ] Casting Charged

WBC 8.5 Hct 35.3

[ ] Narcotics Precautions

[ ] Tetanus Follow-up

[ ] Medicines Charged

000006

PHYSICIAN'S VISIT. ___ Minimal ___ Limited ___ Intermediate [✓] Extended ___ Intensive

Discharge TX DISC [redacted] DOA _____ Expired _____ Transferred _____ GOO FAIR

[ ] Ambulatory [ ] Stretcher [ ] W [redacted] [ ] Family Physician Notified [ ] Other _____ [redacted]

PATIENT'S SIGNATURE PHYSICIAN'S [redacted]

[redacted]

[redacted]

[redacted]

General Adult

TIME SEEN: 9 40 ROOM: [redacted]

HISTORIAN: X patient X family husband __paramedic __translator

Chief complaint: weakness

Started: x 2d.

time course:	severity:	modifying factors:
✓ still present	__mild	✓ none
__better	moderate	
__gone now	__severe	
__worse		

Patient c/o general weakness
Vomiting x 3 this am, epigastric
+ LUQ pain, + malaise.
Hurt (L) knee saturday - here
+ received Lodic Rx.
No cough or cold. No known
fever.

Attachment 1

[redacted]

12/10-17/98 PJP

__Similar symptoms previously

No

__Recently seen/treated by doctor

yes - here

ROS

CONST.
__fever
subjective / to ____ °F
__chills

ENT
__sore throat
__nasal drainage / congestion

CHEST / CVS
__cough
sputum
__trouble breathing
__chest pain

GI
✓ abdominal pain
✓ nausea / vomiting
__diarrhea
__black / bloody stools

URINARY
__problems urinating
__frequent urination
dark urine

__abnormal bleeding / discharge

LMP
postmenopausal / hysterectomy

SKIN / Musculoskeletal
__skin rash
__back pain
__leg pain
__foot swelling

NEURO / EYES
__headache
__blackout
__lost feeling / power
in arm leg face R / L
__difficulty walking
__difficulty with speech
__double vision
__confusion

☐ all systems neg. except as marked

PAST HISTORY

__neurological problems
CVA seizure disorder

__cardiac disease
heart attack (MI) angina
heart failure

__high blood pressure

__lung disease
asthma emphysema

__diabetes
insulin-dependent diet-controlled
oral hypoglycemic

__high cholesterol
__other problems

Medications __none see nurses note
__ASA __NSAID __acetaminophen

Allergies NKDA
__see nurses note

SOCIAL HX smoker ____ drugs ____
alcohol occasional / frequent / recent

000007

FAMILY HX

PHYSICAL EXAM __Alert __Anxious __IV _____

General Appearance- Distress- __no acute __moderate __severe

mild distress

HEENT
__ENT inspection nml
__no dental injury

__scleral icterus / pale conjunctivae
__purulent nasal drainage
__pharyngeal erythema / exudate
mouth dry

NECK
__nml inspection
__thyroid nml

__thyromegaly
__lymphadenopathy (R / L)

RESPIRATORY
__no resp. distress
__breath sounds nml
__chest non-tender

__see diagram
__wheezing
__rales
__rhonchi

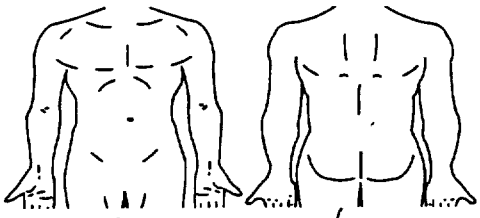
CVS
__regular rate, rhythm
__no murmur
__no gallop

__irregularly irregular rhythm
__extrasystoles (occasional / frequent)
__tachycardia / bradycardia
__PMI displaced laterally
__JVD present
__murmur grade ___ /6 *sys / dias*

__gallop (S3 / S4)
__friction rub

__decreased pulse(s)
*R carotd*___ *fem*___ *dors ped*___
*L carotd*___ *fem*___ *dors ped*___

T=tenderness
R=rebound
m=mild
mod=moderate
sv=severe
Example- Tsv indicates severe tenderness.



ABDOMEN
__non-tender
__no organomegaly
__nml bowel sounds

__tenderness - epigastric
__guarding
__rebound
__abnormal bowel sounds
increased / decreased / absent
__hepatomegaly /splenomegaly / mass

RECTAL
__non-tender
__heme neg stool

__black / bloody / heme pos. stool
__tenderness / mass / nodule

BACK
__nml inspection

__CVA tenderness (R / L)

SKIN
__color nml, no rash
__warm, dry

__cyanosis / diaphoresis / pallor
__skin rash

EXTREMITIES
__non-tender
__full ROM
__no pedal edema

__pedal edema
__calf tenderness

NEURO/PSYCH
__oriented x3
__mood/affect nml
CN's nml *(2-12)*

__disoriented *to person / place / time*
__depressed affect
__facial droop/EOM palsy/anisocoria
__weakness / sensory loss

[redacted]

EKG- __nml __abnormal:

Comparison w/ prior EKG-
Repeat EKG- __unchanged

Cardiac Monitor- __NSR

CBC	Chemistries		UA
normal	*normal*	CK	*normal*
nml except	*nml except*	CKMB	*nml except*
WBC	BUN	Troponin	WBC
Hgb	Na		RBC's
Hct	K		bacteria
Platelets	Cl	PT	dip:
segs	CO2	PTT	
bands	Gluc		
lymphs	Creat		
monos		Amylase	
eos		Lipase	

X-rays

*Time*_____ __unchanged __improved __re-examined

Attachment 1
[redacted]
12/10-17/98
PJP

__Hx / Exam limited by_____ __Crit Care- ____ min

__Discussed with Dr._____
will see patient in: office / ED / hospital
__Counseled patient / family regarding:
lab results diagnosis need for follow-up
__Rx given __Admit orders written

__Prior records ordered
__Additional history from:
family caretaker paramedics
__EKG / X-ray examined
__Discussed with radiologist

CLINICAL IMPRESSION:

DISPOSITION- ☐ home ☐ admitted ☐ transferred_____
CONDITION- ☐ unchanged ☐ improved ☐ stable_____

000008

PHYSICIAN SIGNATURE-_____

Best Quality FDA

[redacted]

Repeat

[redacted]

ALERT 1-13

TIME 1130	DATE 7-20-98	T[redacted]
DATE OF REQUEST	DATE TO BE DONE	
REQUESTED BY	DOCTOR	

CODE	X	TEST	RESULT	NORMAL
[redacted]		BUN		5-25 MG DL
		SODIUM		135-153 MMOL/L
	X	POTASSIUM	1.5	3 5-5 3 MMOL L
		CHLORIDE		101-111 MMOL L
		CO2		24-31 MMOL L
		GLUCOSE (FASTING)		70-110 MG DL
		GLUCOSE (RANDOM)		
		GLUCOSE (2HRPP)		
		CREATININE		0 5-1 4 MG DL
		TOTAL PROTEIN		6 0-8 0 GM DL
		ALBUMIN		3 5-5 0 GM DL
		CALCIUM		8 5-10 5 MG/DL
		CPK - TOTAL		22-269 IU/L
		CPK ISOENZYMES		SEE REPORT
		LDH - TOTAL		91-180 IU L
		LDH ISOENZYMES		SEE REPORT
		AMYLASE		44-128 U L
		MAGNESIUM		1 8-2 5 MG DL
		URIC ACID		2 3-7 5 MG DL
		VENIP[redacted]UTPT		

CODE	TEST	RESULT	NORMAL
[redacted]	BILIRUBIN		0 2-1 0 MG DL
	DIRECT BILIRUBIN		0 0-0 2 MG DL
	NEONATAL BILIRUBIN		2-12 MG DL
	SGOT		10-42 IU L
	SGPT		10-60 IU L
	GGT		7-64 IU L
	ALK PHOS		26-88 IU L
	PHOSPHORUS		2 5-4 6 MG DL
	LACTIC ACID		0 67-2 47 MMOL L
	CHEM [redacted]		SEE REPORT

Attachment 1

[redacted]

12/10-17/98

PJP

CHART COPY

CODE	X	TEST	RESULT	NORMAL
[redacted]	✓	BUN	14	5-25 MG DL
	✓	SODIUM	145	135-153 MMOL/L
	✓	POTASSIUM	1.6	3 5-5 3 MMOL L
	✓	CHLORIDE	95	101-111 MMOL L
	✓	CO2	40	24-31 MMOL L
		GLUCOSE (FASTING)		70-110 MG DL
	✓	GLUCOSE (RANDOM)	94	
		GLUCOSE (2HRPP)		
	✓	CREATININE	1.3	0 5-1 4 MG DL
		TOTAL PROTEIN		6.0-8.0 GM DL
		ALBUMIN		3 5-5 0 GM DL
		CALCIUM		8 5-10 5 MG/DL
		CPK - TOTAL		22-269 IU/L
		CPK ISOENZYMES		SEE REPORT
		LDH - TOTAL		91-180 IU/L
		LDH ISOENZYMES	45	SEE REPORT
	✓	AMYLASE		~~44-128 U~~ 109
		MAGNESIUM		1 8-2 5 MG DL
		URIC ACID		2 3-7 5 MG DL
		VENIPUNCTURE OUTPT		

CODE	X	TEST	RESULT	NORMAL
[redacted]	✓	TOTAL BILIRUBIN	0.9	0 2-1 0 MG DL
		DIRECT BILIRUBIN		0 0-0 2 MG DL
		NEONATAL BILIRUBIN		2-12 MG DL
		SGOT		10-42 IU L
		SGPT		10-60 IU L
		GGT		7-64 IU L
		ALK PHOS		26-88 IU L
		PHOSPHORUS		2 5-4 6 MG DL
		LACTIC ACID		0 67-2 47 MMOL L
		CORTISOL (AM)		5-18 UG DL
		CORTISOL (PM)		3-13 UG DL
		CHOLESTEROL		[redacted] MG DL
		T3UPTAKE		35-[redacted]
		T4		5[redacted] L
		FTI		1 6[redacted]
		CHEM [redacted]		SE[redacted]

Repeated 2x Instrumentation

Critical Called

CHART COPY

[redacted]

Patient ID [redacted]
Physician MEYANTEL
Date/Time [redacted] 15:45

[redacted]

NE	55.0	H	[redacted]
LY	11.4	L	1.0
MO	3.5		0.3
EO	1.1		0.1
BA	0.2		0.0

HCT	[redacted]
HGB	[redacted]
MCV	93.1
MCH	28.0
MCHC	34.4
RDW	14.2
PLT	211
MPV	[redacted]

DATE 07/20/98
TIME 10:46:5[redacted]
Pos/Pos 06:955

[redacted]

MYELOCYTE	
MYELOCYTES	
PLTS	
NRBC	
ANISO	
HYPO	
MACRO	
MICRO	

000009

[redacted]

DATE OF REQUEST 7-20-98	[redacted]	X BLOOD GASES	[redacted]
DATE TO BE DONE		O2 SAT	
DOCTOR [redacted]		pH ONLY	
REQUESTED BY	FIO2		
COLLECTION TIME	O2 RATE		
COLLECTION DATE	TITLE VOLUME		
COLLECTED BY	PT TEMP		

HLNC

pH = 7.528
pCO2 = 48.0
pO2 = 151.9
HCO3 = 38.2
BE = 13
O2 Sat 99.4%
tCO2 = 40.5 %
CJBA-
(ORNING

NORMAL		
	ART	[redacted]
pH	7.35-7 45	7 32-7 42
pCO2	35-45	42-55
pO2	75-95	25-40
HCO3	22-26	24-28
CO2CT	23-27	25-29
ABE	-2.5-+2.5	-1-+5 0
O2SAT	95-97	40-70

CHART COPY

[redacted]

CODE	X	TEST			
[redacted]	X	URINALYSIS - VOIDED URINE			
	X	URINALYSIS - CATH URINE			
		COLOR Brownish Yellow	MICROSCOPIC EXAM (PER HPF)	X	SSA 100mg/dL
		APPEARANCE Clear			CLINITEST
		SPECIFIC GRAVITY 1.0150			ACETEST
		pH 5.0	WBC 4-8		ICTOTEST
		ALBUMIN 3+	RBC Ø		
		SUGAR —	CASTS Ø		
		KETONES —	CRYSTALS Ø		
		OCCULT BLOOD 3+	EPITHELIAL CELLS numerous		
		BILE —	AMORPHOUS trace		
		NITRITES —	BACTERIA 3+		
		UROBILINOGEN Normal	MUCUS Ø		
		LEUKOCYTE ESTERASE			

NORMAL RANGES	
SP GR 1 005-1 030	BLOOD NEG
pH 5 0-7 0	BILE NEG
ALBUMIN NEG	NITRITES NEG
SUGAR NEG	UROBILINOGEN NEG
KETONES NEG	LEUK EST NEG
URINE RBC 0-1	
URINE WBC 0-4	
BACTERIA 0-TRACE	

URINAL

CHART COPY

[redacted] 7-20-98 [redacted]

Attachment 1

[redacted]

12/10-17/98 PJP

[redacted]

[redacted]

SPECIMEN COLLECTED		
TIME 1310	DATE 7/20	[redacted]
DATE OF REQUEST 7/20	DATE TO BE DONE 7/20	
REQUESTED BY [redacted]	DOC[redacted]	

CODE	X	TEST	RESULT	NORMAL	CODE	X	TEST	RESU[redacted]	NORMAL
[redacted]		BUN		5-25 MG DL	[redacted]		TOTAL BILIRUBIN		0 2-1 0 MG DL
		SODIUM		135-153 MMOL L			DIRECT BILIRUBIN		0 0-0 2 MG DL
	X	POTASSIUM	1.9	3 5-5 3 MMOL L			NEONATAL BILIRUBIN		2-12 MG DL
		CHLORIDE		101-111 MMOL/L			SGOT		10-42 IU L
		CO2		24-31 MMOL L			SGPT		10-60 IU L
		GLUCOSE (FASTING)		70-110 MG DL			GGT		7-64 IU L
		GLUCOSE (RANDOM)					ALK PHOS		26-88 IU L
		GLUCOSE (2HRPP)					PHOSPHORUS		2 5-4 6 MG DL
		CREATININE		0 5-1 4 MG DL			[illegible]		0 67-2 47 MMOL L
		TOTAL PROTEIN		6 0-8 0 GM DL			[illegible]		5 18 UG DL
		ALBUMIN		3 5-5 0 GM DL			CORTISO[redacted]		2-13 UG DL
		CALCIUM		8 5-10 5 MG DL			CHOLEST[redacted]		<200 MG DL
		CPK - TOTAL		22 269 IU L			T3UPTAK[redacted]		35-45%
		CPK ISOENZYMES		SEE REPORT			T4		4 5 12 0 UG DL
		LDH - TOTAL		[illegible]			FT		1 6-5 4
		LDH ISOENZYMES		SEE REPORT			CHEM 18		SEE REPORT
		AMYLASE		44-128 U L					
		MAGNESIUM		1 8-2 5 MG DL					
		URIC ACID		2 3-7 5 MG DL					
		VENIPUNCTURE OUTPT							

[redacted]

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LABORATORY REPORTS

[redacted]

Best Quality FDA

[redacted]

SPECIMEN COLLECTED

TIME 1200 DATE 1/20/98 [redacted]

DATE OF REQUEST 1/20/98 DATE TO B[redacted]

REQUES[redacted]

1800

CODE	X	TEST	RESULT	NORMAL
[redacted]		BUN	8	5-25 MG/DL
		SODIUM	144	135-153 MMOL/L
		POTASSIUM	2.0	3 5-5 3 MMOL/L
		CHLORIDE	109	101-111 MMOL/L
		CO2	34	24-31 MMOL/L
		GLUCOSE (FASTING)		70-110 MG/DL
		GLUCOSE (RANDOM)	99	
		GLUCOSE (2HRPP)		
		CREATININE	1.4	0 5-1 4 MG/DL
		TOTAL PROTEIN		6 0-8 0 GM/DL
		ALBUMIN		3 5-5 0 GM/DL
		CALCIUM		8 5-10.5 MG/DL
		CPK - TOTAL		22-269 IU/L
		CPK ISOENZYMES		SEE REPORT
		LDH - TOTAL		91-180 IU/L
		LDH ISOENZYMES		SEE REPORT
		AMYLASE		44-128 U/L
		MAGNESIUM		1 8-2 5 MG/DL
		URIC ACID		2 3-7 5 MG/DL

CODE	X	[redacted]	RESULT	NORMAL
[redacted]		TOTAL BILIRUBIN		0 2-1.0 MG/DL
		DIRECT BILIRUBIN		0 0-0 2 MG/DL
		NEONATAL BILIRUBIN		2-12 MG/DL
		SGOT		10-42 IU/L
		SGPT		10-60 IU/L
		GGT		7-64 IU/L
		ALK PHOS		26-88 IU/L
		PHOSPHORUS		2 5-4.6 MG/DL
		LACTIC ACID		0 67-2 47 MMOL/L
		CORTISOL (AM)		5-18 UG/DL
		CORTISOL (PM)		2-13 UG/DL
		CHOLESTEROL		<200 MG DL
		[redacted]		35-45%
		[redacted]		4 5-12 0 UG/DL
		FT[redacted]		1 6-5 4
		CH[redacted]		SEE REPORT

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pH = 7.516
PCO2 = 37.9
PO2 = 13.4
HCO3 = 30.6
ABE = 7.1
TCO2 = 31.2
O2 SAT = 96.1

	NORMAL	
	ART	VEN
pH	7 35-7 45	7.32-7 42
pCO2	35-45	42-55
pO2	75-95	25-40
HCO3	22-26	24-28
CO2CT	23-27	25-29
ABE	-2.5-+2.5	-1-+5 0
O2SAT	95-97	40-70

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[redacted]

CODE	X	TEST	RESULT	NORMAL
[redacted]		BUN		5-25 MG DL
		SODIUM		135-153 MMOL L
		POTASSIUM	1.8	3 5-5 3 MMOL/L
		CHLORIDE		101-111 MMOL L
		CO2		24-31 MMOL L
		GLUCOSE (FASTING)		70-110 MG DL
		GLUCOSE (RANDOM)		
		GLUCOSE (2HRPP)		
		CREATININE		0 5-1 4 MG DL
		TOTAL PROTEIN		6 0-8 0 GM DL
		ALBUMIN		3 5-5 0 GM DL
		CALCIUM		8 5-10 5 MG DL
		CPK - TOTAL		22-269 IU L
		CPK ISOENZYMES		SEE REPORT
		LDH - TOTAL		91-180 IU L
		LDH ISOENZYMES		SEE REPORT
		AMYLASE		44-128 U L
		MAGNESIUM		1 8-2 5 MG DL
		URIC ACID		2 3-7 5 MG DL
		VENIPUNCTURE OUTPT		

CODE	X	[redacted]	RESULT	NORMAL
[redacted]		TOTAL BILIRUBIN		0 2-1 0 MG DL
		DIRECT BILIRUBIN		0 0-0 2 MG DL
		NEONATAL BILIRUBIN		2-12 MG DL
		SGOT		10-42 IU L
		SGPT		10-60 IU L
		GGT		7-64 IU L
		ALK PHOS		26-88 IU L
		PHOSPHORUS		2 5-4 6 MG DL
		[redacted]		0 67-2 47 MMOL L
		CHEM 18		SEE REPORT

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Attachment 1

[redacted]

12/10-17/98

PJP

A-3

000011

LABORATORY REPORTS

OUT				
		150		8
11-7	7-3	3-11	24h total	

[redacted]

[redacted]	[redacted]	O2 BAY
		pH ONLY
REQUESTED BY	FIO2	
COLLECTION TIME	O2 RATE	
COLLECTION DATE	TITLE VOLUME	
COLLECTED BY	PT TEMP	

[redacted]

NORMAL		
	ART	VEN
pH	7.35-7.45	7 32-7 42

COPY

Attachment 1

[redacted]

12/10-17/98

PJP

[redacted]

[redacted]

[redacted]

SPECIMEN COLLECTED		
TIME	DATE	TECH
DATE OF REQUEST	DATE TO BE DONE	
REQUESTED BY	DOCTOR	

CODE	X	TEST	RESULT	NORMAL
[redacted]		BUN		5-25 MG DL
		SODIUM		135-153 MMOL L
		POTASSIUM		3 5-5 3 MMOL L
		CHLORIDE		101-111 MMOL L
		CO2		24-31 MMOL L
		GLUCOSE (FASTING)		70-110 MG DL
		GLUCOSE (RANDOM)		
		GLUCOSE (2HRPP)		
		CREATININE		0 5-1 4 MG DL
		TOTAL PROTEIN		6 0-8 0 GM DL
		ALBUMIN		3 5-5 0 GM DL
		CALCIUM	7.0	8 5-10 5 MG DL
		CPK - TOTAL		22-269 IU L
		CPK ISOENZYMES		SEE REPORT
		LDH - TOTAL		91-180 IU L
		LDH ISOENZYMES		SEE REPORT
		AMYLASE		44-128 U L
		MAGNESIUM	2.4	1 8-2 5 MG DL
		URIC ACID		2 3-7 5 MG DL
		VENIPUNCTURE OUTPT		

CODE	X	TEST	RESULT	NORMAL
[redacted]		TOTAL BILIRUBIN		0 2-1 0 MG DL
		DIRECT BILIRUBIN		0 0-0 2 MG DL
		NEONATAL BILIRUBIN		2-12 MG DL
		SGOT		10-42 IU L
		SGPT		10-60 IU L
		GGT		7-64 IU L
		ALK PHOS		26-88 IU L
		PHOSPHORUS		2 5-4 6 MG DL
		LACTIC ACID		0 67-2.47 MMOL L
		CORTISOL (AM)		5-18 UG DL
		CORTISOL (PM)		2-13 UG DL
		CHOLESTEROL		<200 MG DL
		T3UPTAKE		35-45%
		T4		4 5-12 0 UG DL
		FTI		1 6-5 4
		CHEM 18		SEE REPORT
		[redacted]		

[redacted]

ALBUMIN		3 5-5 0 GM DL
CALCIUM		8 5-10 5 MG DL
CPK - TOTAL		22 269 IU L
CPK ISOENZYMES		SEE REPORT
LDH - TOTAL		91 180 IU L
LDH ISOENZYMES		SEE REPORT
AMYLASE		44-128 U L
MAGNESIUM		1 8-2 5 MG DL
URIC ACID		2 3-7 5 MG DL
VENIPUNCTURE OUTPT		

[redacted]

		2-13 UG DL
		<200 MG DL
		35-45%
		4 5-12 0 UG DL
FTI		1 6 5 4
CHEM 18		SEE REPORT

[redacted]

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000012

LABORATORY REPORTS

ORDERED BY DOCTOR				DATE TO BE DONE		
	WALKING		WHEELCHAIR	PORTABLE		CART
	STAT		PREOP	O_2 GOING		IV GOING

Attachment 1

12/10-17/98 AJP

ACUTE ABDOMEN SERIES: 7-20-98

HISTORY: Left flank pain, general weakness. No previous exams.

No acute cardiac or pulmonary abnormalities.

Gas is noted within the large and small bowel without disproportionate distention. No free abdominal air. There is a small calcification in each side of the pelvis consistent with phleboliths or distal ureteral stones.

, M.D.: typed 7-20-98 11:24 a.m.