

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

ARMS#

13085



8 - OTHER

000001

Attachment 1

12/10-17/98 PJP

7/18/98

REGISTRATION
RECORD

PATIENT NO: [REDACTED] ADMIT DT/TIME: 7/18/98 15:21 M/R NO: [REDACTED]
 NS/ROOM/BED: [REDACTED] CLINICS: [REDACTED] FILING MR#: [REDACTED]
 BY: [REDACTED]
 PATIENT NAME: [REDACTED] TITLE: [REDACTED]
 LOCAL ADDRESS: [REDACTED] SOCIAL SECURITY: [REDACTED]
 CITY/STATE: [REDACTED] PHONE: [REDACTED]
 PERM ADDRESS: [REDACTED]
 CITY/STATE: [REDACTED] PHONE: ()
 OCCUPATION: [REDACTED] LANGUAGE: EN FC: 80
 POB: [REDACTED] ADMT PHYS: [REDACTED] HSV: 65
 DOB: [REDACTED] ADMT PHYS PHONE: () RLG: NP
 AGE: 31 Y ATTEND PHYS: [REDACTED] MS: M
 SEX: F REFER PHYS: [REDACTED] SMK:
 RACE: 1 FATHER'S DOB: [REDACTED] MOTHER'S DOB: [REDACTED] PT: 3
 REF SRC: [REDACTED] FLAG: [REDACTED] VAL:N

EMER CONTACT: [REDACTED] REL: SPOUSE
 ADDRESS: [REDACTED] PHONE: [REDACTED]
 CITY/STATE: [REDACTED]
 NEAREST RELT: [REDACTED] REL:
 ADDRESS: [REDACTED] PHONE: ()
 CITY/STATE: [REDACTED]

GUARANTOR: [REDACTED] REL: SELF
 ADDRESS 1: [REDACTED] PHONE: [REDACTED]
 ADDRESS 2: [REDACTED] SOCIAL SECURITY: [REDACTED]
 CTY/STE/CNTRY: [REDACTED] OCC:
 PAYOR NAME 1: [REDACTED] INS. PLAN ID: [REDACTED]
 PLAN NAME: [REDACTED] SRV/TYPE: [REDACTED]
 BILL C/O NAME: [REDACTED] AUTHORIZATION:
 BILL ADDRESS: [REDACTED] CERT-SSN-HIC-ID#: [REDACTED]
 CTY/STE/CNTRY: [REDACTED] BILL PHONE: [REDACTED]
 BILLING NAME: [REDACTED] -GP #: [REDACTED]
 INSURED: [REDACTED] SEX/REL: F SELF
 EMPLOYER: [REDACTED] MSP: N
 ADDRESS: [REDACTED] EMP PHONE: [REDACTED]
 CITY/STATE: [REDACTED] EID/ESC: [REDACTED]
 PAYOR NAME 2: [REDACTED] INS. PLAN ID:
 PLAN NAME: [REDACTED] CERT-SSN-HIC-ID#:
 BILL C/O NAME: [REDACTED] BILL PHONE: [REDACTED]
 BILL ADDRESS: [REDACTED] GP #: [REDACTED]
 CTY/STE/CNTRY: [REDACTED] SEX/REL:
 BILLING NAME: [REDACTED]
 INSURED: [REDACTED]
 EMPLOYER: [REDACTED]
 ADDRESS: [REDACTED] EMP PHONE: [REDACTED]
 CITY/STATE: [REDACTED] EID/ESC: [REDACTED]

SPAN CODE: [REDACTED] PRIOR HOSPITAL:
 FROM/TO DATE: [REDACTED]
 CONDITION CD CONDITION CD OCCURRENCE CD/DATE OCCURRENCE CD/DATE

11 7/11/98

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ADMIT DIAGNOSIS DESCRIPTION: ADMIT DIAGNOSIS CODE:

SEP 02 1998

ADMISSION RECORD

OUTPATIENT MEDICAL RECORD #: [REDACTED]

HOSPITAL #: [REDACTED]

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Patient name: [REDACTED]
Address: [REDACTED]
City/St: [REDACTED]
Room & bed: [REDACTED]
Pt type: [REDACTED]
Social security #: [REDACTED]
Financial class: [REDACTED]
Birthdate: [REDACTED]
Age: 31
Sex: F
Race: 1
Prev admit: [REDACTED]

Admitted: 08/05/98 09:37
Exp arrival dt/tm: [REDACTED]
Phone: [REDACTED] County: [REDACTED]
Admit source: [REDACTED]
Admit type: R Arrival means: [REDACTED]
Service: [REDACTED]
Discharged: [REDACTED]
Marital status: M
Spouse name: [REDACTED]
Maiden name: [REDACTED]
Religion: [REDACTED]
Advanced directive: [REDACTED]

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Employer: [REDACTED]
Address: [REDACTED]
City/St: [REDACTED]

Pt occupation: CNA
Accident ind: N Job related:
Ph: [REDACTED] Date: [REDACTED]

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Guarantor: [REDACTED]
Address: [REDACTED]
City/St: [REDACTED]
Phone: [REDACTED] Ss#: [REDACTED]

Relationship: B SPOUSE
Guar employer: [REDACTED]
Guar emp addr: [REDACTED]
City/St: [REDACTED]

N
K

Next of kin/relative:
Emergency contact: [REDACTED]

Phone: [REDACTED]
Phone: [REDACTED]

EVAL CYSTIC LESION

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Diagnosis: US LIVER
Admit doctor: [REDACTED]

Attend doctor: [REDACTED]
PCP doctor: [REDACTED]

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1: Y13	[REDACTED]	COB: 1	Y	Pol#:	[REDACTED]	Gr#:	[REDACTED]
Address:	[REDACTED]		C	Subscr:	[REDACTED]		Rel: S
City/St:	[REDACTED]			Sub address:	[REDACTED]		
Phone #:	[REDACTED]	Auth#:		City/St:	[REDACTED]		
2:		COB:		Pol#:		Gr#:	
Address:				Subscr:			Rel:
City/St:				Sub address:			
Phone #:		Auth#:		City/St:			
3:		COB:		Pol#:		Gr#:	
Address:				Subscr:			Rel:
City/St:				Sub address:			
Phone #:		Auth#:		City/St:			
4:		COB:		Pol#:		Gr#:	
Address:				Subscr:			Rel:
City/St:				Sub address:			
Phone #:		Auth#:		City/St:			

Informa Attachment 4 [REDACTED]

nt by: [REDACTED]

12/10-17/98

PJP

000003

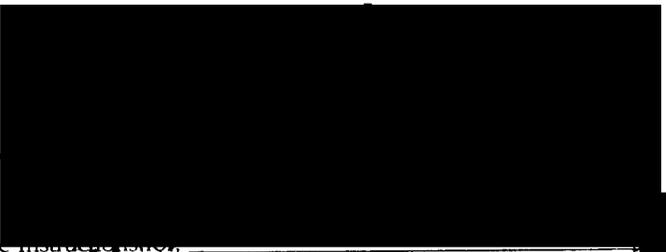


1

PATIENT DISCHARGE INSTRUCTION SHEET

DATE: 7/25/98 TIME: 1240 AM
Please (✓) the appropriate one:

Discharge instructions:



DIET:

No Restrictions Limited Restrictions _____ Special Diet _____ Dietary Instructions / Sheet _____
Dietary instructions by Dietician if applicable: _____

ACTIVITY:

No Restrictions Limited Restrictions _____ Bedrest _____ Crutches _____ Walker _____ Wheelchair _____
No heavy lifting until further instructed _____ No driving until further instructed _____
Other _____

MEDICATIONS:

Prescription(s) or Rx given: Yes No _____ Other Keflex 500mg. 1 by mouth
3x day for 14 days - Tylenol 325mg 5-6 as needed for pain

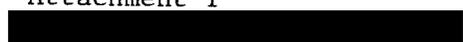
APPOINTMENT:

Appointment given: Yes _____ No _____ Other Call for app't - in [redacted]
early next week

ADDITIONAL DISCHARGE INSTRUCTIONS:

DRINK plenty fluids

Attachment 1



12/10-17/98 PJP

DISCHARGED VIA:

Ambulatory: Wheelchair _____ Crutches _____ Walker _____ Stretcher _____ Other _____

Discharged with and / or to care of self

Accompanied at time of discharge by hospital associate [redacted] (Name)

Nurse [redacted] Physician [redacted]

I understand the above instructions [redacted]

Signature of patient and / or other responsible person [redacted]

000004

Pretest

Iso/Result: 01 **Staphylococcus lugdunensis**
Heavy growth of a pure culture of a gram pos cocci

Attachment 1

12/10-17/98

DJP

Antimicrobial/Dose	MIC	Systemic		Urine		CC
		I	II	I	II	
Amox/K Clavate(c) PO 1-2 tablets Q8h	<=4/2					
Ampicillin PO 250-500 mg Q6h	<=0.12	+++				
IV 1.0-2.0 gm Q4h		+++				
Ancef IM 0.5-1.0 gm Q8h	<=2	+++				
IV 1.0-2.0 gm Q8h		+++				
Claforan IV 1.0-2.0 gm Q8-12h	<=8	S				
Keflin PO 250-500 mg Q6h	<=8	S				
IV 0.5-2.0 gm Q4-6h		S				
Cipro PO 250-750 mg Q12h	<=1	S				
IV 200-400 mg Q12h		S				
Cleccin PO 150-300 mg Q6h	<=0.25	+++				
IV 600-900 mg Q8h		+++				
Erythromycin PO 250-500 mg Q6h	<=0.25	+++				
Saramycin IM/IV 1.0-1.7 mg/Kg Q8h	<=1	+++				
Primaixin IV 0.5-1.0 gm Q6-8h	<=4	S				
Macrodantin PO 50-100 mg Q6h	<=32					
Norfloxacin PO 400 mg Q12h	<=4					
Oxacillin IV 0.5-2.0 gm Q4h	<=0.5	+++				
Penicillin PO 250-500 mg Q6h	<=0.07	+++				
IM 0.9-1.2 MIL U Q6-12h		+++				
IV 1.0-3.0 MIL U Q4h		+++				
Rifampin PO 300 mg Q12h	<=1	S				
Tetracycline PO 250-500 mg Q6h	8	R				
Bactrim PO 1-2 tablets Q12h	<=2/3B	TFB				
IV 3.3-6.6 mg/Kg Tmp Q8h						
Vancomycin IV 1.0 gm Q12h	<=2	+++				

+, ++, +++, or S = Susceptible
I = Intermediate
R = Resistant
N/R = Not Reported
CC = Cost Code
MIC = mcg/ml (ug/L)
BLac = Beta Lactamase Positive
TFS = Thymidine-dependent Strain
Blank = Data not available, or drug not advisable or tested

For Blood and CSF Isolates, a Beta-Lactamase test is recommended for Enterococcus species.
IB appears in place of S, I, S, +, ++, or +++ with species known to possess inducible B-lactamases; potentially they may become resistant to all B-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined B-lactam drugs.
(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
(b) Breakpoints based on parenteral dose. For cefuroxime Axetil (PO) use 8-8, 8-16-1, 16-8.
(c) For non-enterococcal streptococci, Micrococcus species, and Listeria species, refer to the Ampicillin interpretation.

* Interpretations based on approx. adult attainable systemic/urine levels, except drugs with <3 dilutions, which print NCCLS. Doses are guidelines; consider weight and renal/hepatic function. Urine interpretation for lower UTI only.
** Interpretations based on NCCLS M7-A2. Ticar/Clavate for gram positives based on manufacturer's breakpoints.

Tech :
Report # 10732

Source :
Collected : 07/25/98 **:**

Name :
ID #

000005** FINAL **

Patient Name: [redacted] Date of Birth: [redacted] Sex () M (X) F

Address: [redacted]

Routine Physical Exam: Yes () No () Preadmission Testing: Yes () No ()

Service Desired:

* (X) Radiology	* () EKG	* () Peripheral Vascular	() OP Surgery
() Lab	* () EEG	* () Cardiopulmonary	() Inpatient
* () Physical Therapy	* () G.I. Lab	* () Respiratory Therapy	() Observation

* Please phone for appointment *() Outpatient

Test Desired: Ultrasound of Liver Date 8/5/98

Special Instructions (Preps) 9300

Do you wish a phoned report: Yes () No ()

Diagnosis/Chief Complaint and/or Symptom: Cystic lesion [redacted]

Physician [redacted] Signature [redacted]

Attachment 4
[redacted]
12/10-17/98
PJP

PATIENT INFORMATION

SPECIMEN/TECHNICAL INFORMATION

BILLING INFORMATION

Form fields for patient information including name, address, and contact details.

Billing information fields including account type, insurance details, and responsible party name.

ADVANCE BENEFICIARY NOTICE

Notice text regarding Medicare coverage and patient responsibility for the indicated tests.

DIAGNOSIS CODES

Enter All That Apply

Authorization text for the release of medical information necessary to process a claim.

Instructional text for ordering tests for Medicare and Medicaid patients.

- PROFILES: Chem-Screen* Panel (Basic Panel), Chem-Screen* Panel + HDL*, Chem-Screen* Panel + HDL*, TIBC*, Ferritin*, Reflex, etc.

INDIVIDUAL TESTS

- ALT(SGPT), Amylase, ANA (Hep 2), AST (SGOT), Beta HCG Quant, Blood Urea Nitrogen (BUN), CA 125*, Carbamazepine (Tegretol), Hemogram*, etc.

- Hepatitis B Surface Antibody, Hepatitis B Surface Antigen, Hepatitis C Antibody, HIV-1 Antibody Screen, HIV Ab w/Western Blot Reflex, etc.

- Urogram, Urinalysis, Complete, Valproic Acid (Depakene), Vitamin B12, Vitamin B12 and Folate

OBIOLGY(r = Sensitivities & ID if indicated)

- Beta Strep Group A Direct (Throat), Chlamydia (DNA Probe), GC (DNA Probe), Chlamydia and GC (DNA Probe), Culture, Acid Fast, Sputum†, etc.

ADDITIONAL TESTS List Test Code and Name

- PANELS: Arthritis Panel*, Hepatic Function Panel*, Hepatitis Panel*, Lipid Panel*, Thyroid Panel* (T3U, T4, T7)

Attachment 2

12/10-17/98

Handwritten initials 'PJP'

000007

Adhere to Specimen Container(s).