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

ARMS#

12733

4 - ER URGENT

000001

[redacted]

Date 12/12/97

Name [redacted] Phone # [redacted] Age 47 Sex: (M) F

Address [redacted] Nearest Relative [redacted]

Referring Physician [redacted] Receiving Physician [redacted]

☐ Trauma ☐ HRI ☐ Cardiac ☐ Burn ☐ Behavioral ☐ Spinal ☐ Poison

Other (L) CVA (L) hemiplegic

Ambulance Service Priority

Unit [redacted] Driver [redacted] EMT [redacted]

Destination [redacted]

History: Allergies NKDA

Medications Ø

Medical Hx. HTN

Assessment: Patient's Condition: ☐ Good ☐ Fair ☒ Poor ☐ Critical

Chief Complaint ↓ LOC

B/P 186/98 Temp N/A Pulse 77 Resp 24 Weight N/A

TREATMENT RECORD

TIME	B/P	PULSE	RESP	NURSES NOTES
1149pm	196/94	76	24	Pt resting response to verbal stimuli. (L)
				side ~~paraplegia~~ Paraplegia noted. Pupil (L) ↓ reactive
				to light. [redacted]
				pt lying quietly responses to verbal
1205A	190/98	73	24	stimuli. Resp even & unlabored [redacted]
				IV's infusing ē difficulty. SR on
				monitor. O2 on 10 L/m mask [redacted]
1211Am	196/94	76	22	on arrival [redacted], pt Resp even
			~~22~~	unlabored. (L) Side hemiplegic
				responding to verbalized Denies any
				pain. IV infusing ē difficulty [redacted]

1215/Am [redacted]

Time Designation/Personnel Assuming Responsibility for Patient

000002

[redacted]

[redacted]

Addressograph: [redacted]

Physician's Emergency R[redacted]

Patient Name: _____ 22 yoM

Chief Complaint: onset of sx ~ 20304 - awakened wife - confused, weak

(Check appropriate box and /or add note:)	Review of Past, Family, & Social History:	Review of Systems: ☐ Confirmed
Past Hx: Confirmed: ☐ (Supplemental)	☐ NO additional information	Additional Review: Hx of HTN - no meds x "20 yrs"
Family Hx: Confirmed: ☐ (Supplemental) Father + DM, MI	☐ NO additional information	
Social Hx: Confirmed: ☐ (Supplemental) ⊕ tobacco, OETOH	☐ NO additional information	

Physical Exam: (Check N/I=not indicated or WNL=with-in-normal limits) ☐ Single organ/body area Exam ☐ General Multi-System Exam

Constitutional: ☐ N/I ☐ WNL diaphoretic - hold @ arm extended - no active nystagmus (horiz plane)

Neuro/Psych: ☐ N/I ☐ WNL ⊕ hemiplegia @ mid to PERRL, tongue deviates to ⊖ - week ⊕ memory

Skin: ☐ N/I ☐ WNL moist

GI/Abd: ☐ N/I ☒ WNL

HEENT: ☐ N/I ☐ WNL ⊖ papilledema, hem - anthyx in nostrils, ⊖ carotid bruits

GU: (rectal/pelvic) ☒ N/I ☐ WNL

CV/Cardio/Chest: ☐ N/I ☐ WNL regular ⊖

Musc/Skel/Extrem: ☐ N/I ☐ WNL ⊕ Babinski on ⊖ weakness & active arm ⊖ side

Resp/Lungs: ☐ N/I ☐ WNL Good bs bilat.

H/L/I: ☐ N/I ☐ WNL

Additional Notes: wife states pt stopped HBP meds ~ 20yrs ago - only meds - OTC appetite suppressant -

SaO2 over 90%, on 2L nc, ↑ to 94-95% on 6L, 97-98% on 10L FM (nonrebreather)

Old Chart Reviewed: Y N

Results of Review:

Laceration Repair: ☐ Simple ☐ Intermed ☐ Complex Length_____CM ☐ Debridment ☐ Exploration required ☐ Drains required

{ Initial to indicate all Lab reviewed_____} (Circle or check test ordered) [WNL =with-in-normal limits]

Time	Inital	Meds/ IV(s)	Time	Initial
		① ~~D5 @ TKO NS @ 30 cc/h~~		[redacted]
		② NTG drip to titrate BP ⊂ 160/90	10[illegible]	
		③ ASA GI now	10[illegible]	
		④ Tylenol 650 PR	10[illegible]	

PHYSICIAN ORDERS

CBC, Chem 24, PT/PTT, CK-MB

EKG ✓

pCXR ✓ O2 @ 10L nonrebreather

Head CT stat/urgent

IVC - nurse

Saline Lock, CM, BP q 5"

CBC: (WNL)
WBC 10.4
HGB 14.5 gm
HCT 41.9 %
Plt - 248 K

UA: WNL ☐ Clean Catch ☐ Cath

Hemat: WNL

EKG ☒ 12 Lead Rhythm Strip
EKG ☐
Results: NSR, ST ↓'s
Inverse inversion lat.

☒ BP Monitor (Continuous / Single)
☒ Cardiac Monitor
☐ Pulse Ox: Single / Multiple / Continuous
☐ Neb./Aresol Tx :

RENAL: WNL
Gluco 165
Bun 10
Creat 1.2
Na+ 142
K+ 3.4
CL- 102
CO2- 27

Patient CONT
PT 12.9
INR 1.0
PTT 22.9

ABG: WNL
pH O2 SAT
Pco2 Pulse OX
ACT HCO3

X-Ray:

Read by: ERP Radiologist

☐ O2 treatment 10 L/M 10 L/min nasal [redacted]

☒ Old Chart requested

000003

Final Dx: ① CVA c ② hemiplegia R/O in evolution

Rx: To [redacted] - Dr. [redacted] - Neurol.

____ I certify that this patient is felt to be stable for discharge & follow-up with private Physician.

____ I certify that this patient's condition requires further testing/treatment on a Inpatient basis.

Nurse Signature: | Nurse Signature: | Nurse Signature: [redacted]

ERP Signatur[redacted] | Attending/Consulting's Signature: | NP's Signature: | Date: 12/12/97

[redacted]

Addressograph:

[redacted]

Emergency Department Record

Review of Systems

(Fill in Blank, Circle, or Check to Indicate:) N/I = Not Indicated Neg. = Negative or within normal limits at time of review

Constitutional: ☐ (N/I) ☐ (Neg.)
General Appearance: Clean Neat Unkept Disheveled
Fever/chills: ☐ (Neg.)
Weakness: General: Specific:
Pt. able to communicate: Verbal Signs other: confused

HEENT: ☐ (N/I) ☐ (Neg.)
Hearing Loss: R L ☒ (Neg.)
Pain: ☒ (Neg.)
Visual Acuity: Visual Field:
Foreign body: ☒ (Neg.)
Bleeding: ☒ (Neg.)
Drainage: ☒ (Neg.)

Pupils	Left	Right
MM:		
Round:	Y (N)	Y (N)
RTL	Y (N)	Y N

CV/Chest: ☐ (N/I) ☐ (Neg.)
Pain: Sharp Dull Pressure Sudden Gradual Radiation ☒ (Neg.)
B/P: (HTN) HYPO WNL
Edema: ☐ (Neg.)
Palpitations: ☒ (Neg.)
S.O.B dt. labored ☐ (Neg.)

Respiratory: ☐ (N/I) ☐ (Neg.)
S.O.B. dt. labored ☐ (Neg.)
Productive cough ☐ (Neg.)
Wheezing ☐ (Neg.)
Pain with resp. ☒ (Neg.)
Sputum + - ☐ (Neg.)

	Left	Right
	☐	☐
Clear	☐	☐
Bilateral	☐	☐
Absent	☐	☐
Decreased	☐	☐

Neuro: ☐ (N/I) ☐ (Neg.)
Numbness: L Side ☐ (Neg.)
Tingling ☒ (Neg.)
Cooperative: (Y) N Combative: (Y) N Restless: Y (N)
Syncope: ? Volume ☐ (Neg.)
Dizziness ☐ (Neg.)
Gait
H/A ☐ (Neg.)

Psych: ☐ (N/I) ☒ (Neg.)
Anxiety ☒ (Neg.)
Affect
Paranoid ☒ (Neg.)
Mood ☒ (Neg.)
Anxious mildly ☐ (Neg.)

GI/ABD: ☐ (N/I) ☒ (Neg.)
Abd. Pain ☐ (Neg.)
Cramps ☐ (Neg.)
Constipation ☐ (Neg.)
Diarrhea ☐ (Neg.)
N/V ☐ (Neg.)
BS: + - Hyper Hypo
Bleeding ☐ (Neg.)
Distended ☐ (Neg.)
ABD: Soft Rigid Obese ☐ (Neg.)
Tender Guarding

GU: ☒ (N/I) ☒ (Neg.)
Dysuria: Y N
Discharge: Y N
Pain ☐ (Neg.)
Hx. of Kidney Stones: Y N Date: ☐ (Neg.)
Hematuria: Y N
Frequency: Y N
L.M.P.
G. P. A.
E.D.C.

Endo: ☒ (N/I) ☒ (Neg.)
Thirst ☐ (Neg.)
Thyroid ☐ (Neg.)
Appetite
Diabetes ☐ (Neg.)
Other:
Other:

Hemata/Lymph: ☒ (N/I) ☒ (Neg.)
Glands ☐ (Neg.)
Bleeding ☐ (Neg.)
Sickle Cell Hx: Y N
Other:
Other:
Other:

Skin: ☒ (N/I) ☒ (Neg.)
Rash ☐ (Neg.)
Itching ☐ (Neg.)
Burn ☐ (Neg.)
Lesion(s) ☐ (Neg.)
Abrasion(s) ☐ (Neg.)

Musculoskeletal ☒ (N/I) ☒ (Neg.)
Contusion(S) ☐ (Neg.)
Injury ☐ (Neg.)
Pain ☐ (Neg.)
Stiffness ☐ (Neg.)
Deformity ☐ (Neg.)

Plan of Care:

Initials:

[redacted]

[redacted]

Emergency Department Record

Addres[illegible]ograph:

[redacted]

Date: 12-[redacted]-97 Patient Name: [redacted] M F Age: 47 Arrival Time: 2200 A.M. P.M.

(Circle or Check to INDICATE choice)

Triage Assessment:

Time: 2200 | Triage Class: Non-Urgent (Urgent) Emergency Code Status

Means of Arrival: Walk-in self Relative Friend W/C (Ambulance) Police Other

Chief Complaint: "Unresponsive @ home"

Interventions PTA: IV by EMS, O2, Cm NTG -

Allergies: NKDA

Current Meds: ?

Date last seen by MD: _____ MD Name _____ Phone: _____

Primary / Attending Physician	Time called:	Time Replied	Time arrived ER	Initials
[redacted]				

Time:	Temp.	Pulse	Resp.	B/P	Weight	Height	Nurse Signature :
2200	97°	73	22	150/107	/	/	

Valuables/Disposition: 0

Immunization status ☐ UP to date ☐ Other:

Triage Nurse Signatur[redacted]

Time to ER Room: 2200

Past, Family, & Social History: (Circle to indicate as a positive History of:)

Information obtained from: Patient Family member Wife Other:

Past History: Not Indicated — PUD (HTN) Diabetes CAD AMI Angina Seizures Psychiatric Urolithiasis Migraine H/A COPD Asthma CVA CA

(circle to indicate positive Hx) — (Operations, Injuries, Treatments) Other:

Family History: ✓ Not Indicated — DM CAD Asthma Seizures HTN CA Psychiatric COPD Migraine H/A Obesity Other:

(circle to indicate positive Hx) — Other:

Social History: ✓ Not Indicated — Single (Married) Employed Unemployed Disabled Lives alone Present living arrangements

(circle to indicate positive Hx) — Other:

Smoker: Y N Packs/Day: _____ How Long: _____ ETOH: Y N Type: _____ Amt./day: _____ Date Last use: _____

☐ Unable to Obtain History due to:

Notes: 2200 to Room [redacted] per amb. stretcher, c/o unresponsive @ home on arrival - confused, disoriented, chin pad of tongue bitten, slurred speech, pupils reactive to light, PERRL, Oriented to self, Nursing Hx: difficulty SaO_2 - 94% O_2 2L NC

11/15/pm Cobra completed by

Time:	B/P	Pulse	Resp.	Initials
	See Monitor Strip for VS, SaO2			

Assessment of Learning Needs	Readiness to Learn	Barriers to Learning
medications, equipment, rehab techniques, illness/condition, food/drug interactions, Self Care, Community resources, academic education, procedure preparation, safety, modified diet/nutritional issues	Non-Receptive, Written Instructions- ability to understand Y N, Verbal Instructions- ability to understand Y N	language, reading, hearing, visual, cultural, religious, speaking, age related, emotional, motivational, cognitive, financial concerns, none

Condition on Discharge: Stable___ unstable___ NO change X Expired___

Disposition via: ___Walking ___Carried X Ambulance ___W/C ___Car

X Disposition: ___Home ___Dr. Office X Transfer Funeral Home ___Morgue Admit

Nurse Signature: [redacted]

Nurse Signature: [redacted]

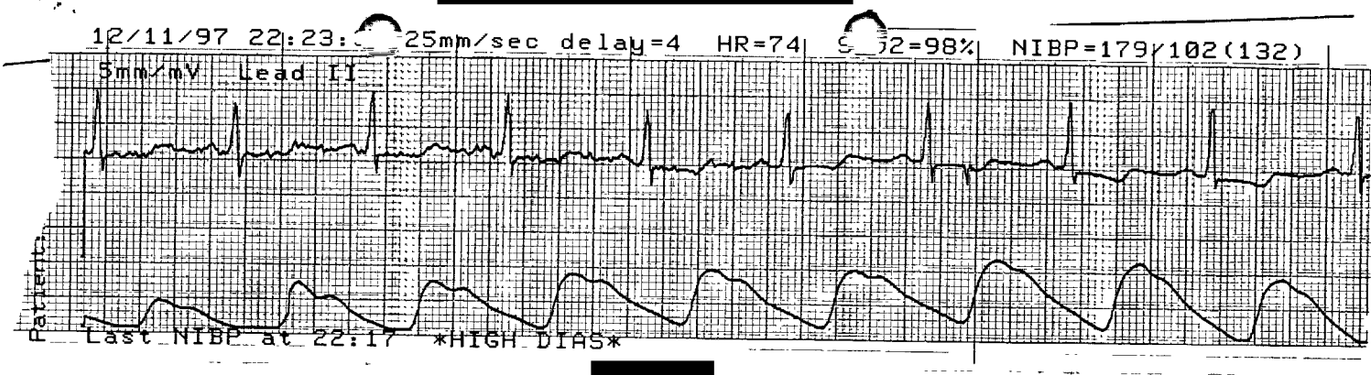
Nurse Signature: [redacted]

Nurse Signature: [redacted]

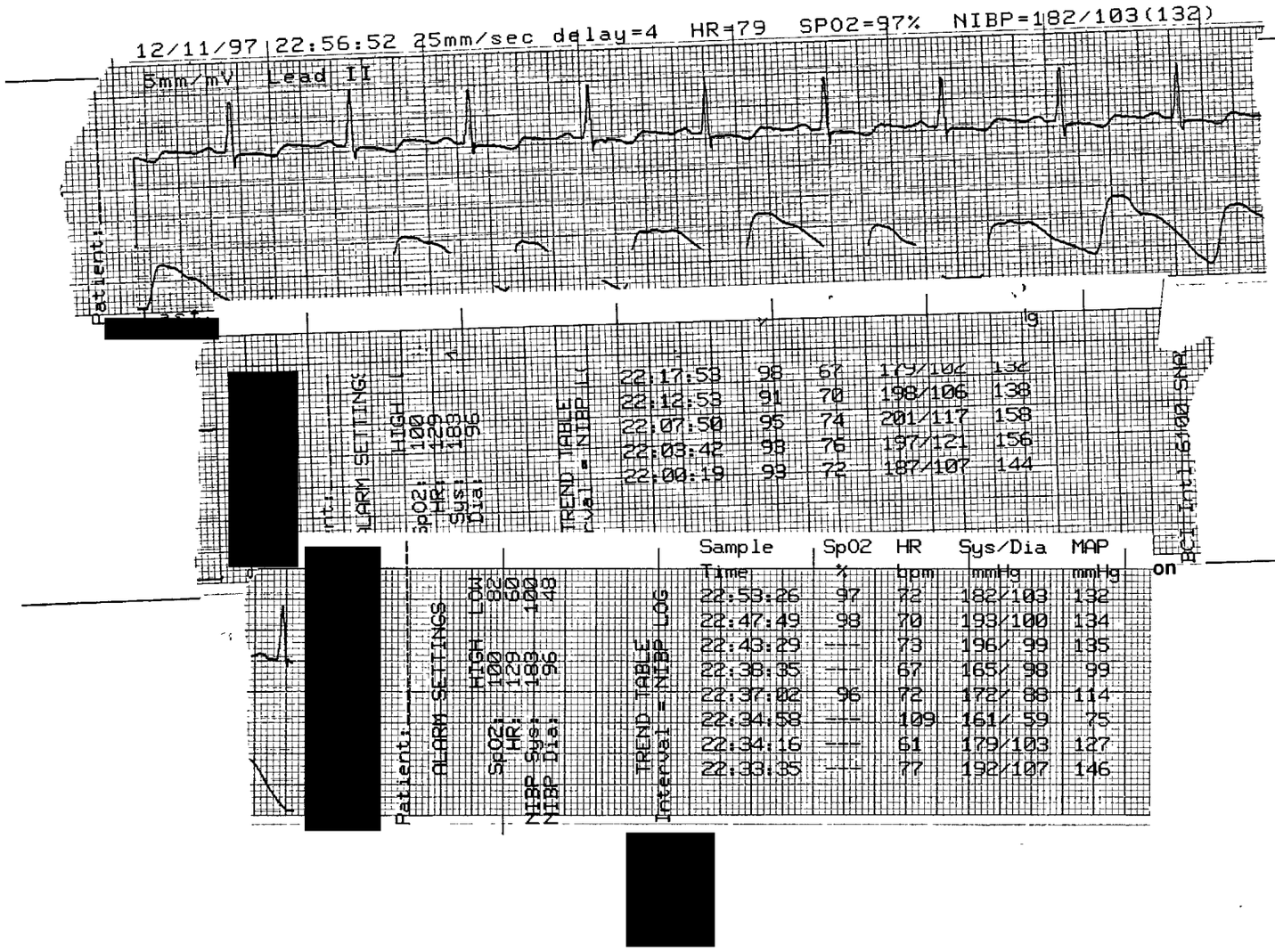
Date: 12/12/97 Time: [redacted] 1150

000005

[redacted]



[redacted]



[redacted]

INSTRUCTIONS: REMOVE TAPE ON NO. 1 AND PRESS REPORT TO GUM STRIP.

[redacted]

[redacted]

000006

[redacted] [redacted] [redacted] 12/12/97 10:14pm 2 [redacted]

12/12/97 [redacted] NOW 12/12/97 10:1 [redacted]

[redacted] 47Y M

ELEVATED BP
COMMENT BED [redacted]

2005 CBC W/AUTOMATED 3 PART DIFF Order

COLLECTED BY [redacted] TIME 2200 DATE 12/12

CBC (COMPLETE BLOOD COUNT) WITH 3 PART AUTOMATED DIFF

REPORT FROM COULTER JT AUTOMATED HEMATOLOGY INSTRUMENT

[redacted]

☐ CBC ☐ HGB/HCT ☐ WBC ☐ DIFF ☐ RBC ☐ PLATELETS ☐ HGB ☐ HCT

REQ. BY [redacted] TIME AM PM DATE

COLL. BY [redacted] TIME AM PM DATE 12/12

REPT. BY [redacted] TIME AM PM DATE 2210

12/13/97 TEST NO. [redacted]

COULTER JT		NORMAL VALUES
WBC x 10³	10.4	M 4.8-10.8 F
RBC x 10⁶	5.00	M 4.7-6.1 F 4.2-5.4
Hgb g/dL	14.5	M 14-18 F 12-16
Hct %	41.9	M 42-52 F 37-47
MCV fL	83.8	M 80-94 F 81-99
MCH pg	29.0	M 27-31 F
MCHC g/dL	34.6	M 33-37 F
RDW %	13.4	M 11.5-14.5 F
PLT x 10³	248.	M 130-400 F
MPV fL	8.6	M 7.4-10.4 F
LYMPH %	31.9	M 20.5-51.1 F
MONO %	5.0	M 1.7-9.3 F
GRAN %	63.1	M 42.2-75.2 F
LYMPH x 10³	3.3	M 1.2-3.4 F
MONO x 10³	.5	M 0.11-0.59 F
GRAN x 10³	6.6	M 1.4-6.5 F

☐ THIS A.M. ☐ TODAY ☐ PRE-OP ☐ STAT

MORPH 1 2 3 4

POLYCHROM

HYPOCHROM

POIK

TARGET

SPHERO

ANISO

MICRO

MACRO

SICKLE CELLS

BASO STIP

VACUOLES

TOXIC GRAN

MORPHOLOGY SYMBOLS 1-SLIGHT 2-MODERATE 3-MOD TO MARKED 4-MARKED

PLATELETS NO. ☐ ADEQUATE ☐ INCREASED ☐ DECREASED MORPH ☐ NORMAL ☐ ATYPICAL

☐ DIFFERENTIAL

SEG %

BAND %

LYMPH %

MONO %

EOSIN %

BASO %

ATYP LYMPH %

META %

MYELO %

PRO MYELO %

BLAST %

COMMENTS:

HEMATOLOGY I

[redacted] [redacted] [redacted] 12/12/97 10:14pm 2 [redacted]

12/12/97 [redacted] NOW 12/12/97 10:14P [redacted]

[redacted] 47Y M

ELEVATED BP
COMMENT [redacted]

2709 PT/PTT Order

COLLECTED BY [redacted] TIME 2200 DATE 12/12/97

PT/PROTHROMBIN TIME 12.9 SECONDS

REFERENCE RANGE (11.2 - 13.2 SECONDS) MEAN VALUE (12.4 SEC)

PATIENT INR VALUE 1.0 (REPORTED ON ANTICOAGULATED PATIENTS)
RECOMMENDED THERAPEUTIC INR FOR ORAL ANTICOAGULATION:
STANDARD INTENSITY: 2.0-3.0 HIGHER INTENSITY: 2.5-3.5

PTT/PARTIAL THROMBOPLASTIN TIME 22.9 SECONDS
CONTROL 27.8 SECONDS

REPORTED BY [redacted] TIME 2230 DATE 12/12/97

[redacted]

LABORATORY

[redacted]

PATIENT NAME: [redacted]
HOSPITAL #:
AGE: SEX: M ROOM: [redacted]
PHYSICIAN: [redacted]

COLLECTED DATE: 12/12/97
COLLECTED TIME: 2200
FLUID: SERUM
COMMENT:
SAMPLE ID: [redacted]

PROFILE: CHEM 24 & CK-MB

TEST		RESULT		NORMAL RANGE
GLUCOSE	HI	165.	mg/dL	65. - 110.
UREA NITROGEN		10.	mg/dL	6. - 22.
CREATININE		1.2	mg/dL	.5 - 1.5
SODIUM		142.	mmol/L	135. - 145.
POTASSIUM	LO	3.4	mmol/L	3.5 - 5.5
CHLORIDE		102.	mmol/L	95. - 110.
CARBON DIOXIDE		27.	mmol/L	20. - 29.
ANION GAP		13.	mmol/L	
CALCIUM		8.8	mg/dL	8.5 - 10.5
MAGNESIUM		2.0	mg/dL	1.6 - 2.3
PHOSPHORUS		2.9	mg/dL	2.5 - 4.9
CHOLESTEROL		198.	mg/dL	107. - 200.
TRIGLYCERIDES	HI	364.	mg/dL	35. - 160.
URIC ACID		7.2	mg/dL	2.2 - 9.0
TOTAL PROTEIN		7.5	g/dL	6.3 - 8.2
ALBUMIN		3.9	g/dL	3.9 - 5.0
SGOT/AST		23.	U/L	5. - 35.
SGPT/ALT		43.	U/L	5. - 56.
LDH		556.	U/L	310. - 618.
CK		109.	U/L	25. - 225.
CK-MB		0.	U/L	0. - 10.
ALKP		90.	U/L	30. - 150.
G-GTP		41.	U/L	8. - 78.
TOTAL BILI		1.1	mg/dL	.2 - 1.5
% CK-MB		0.	%	

REPORT DATE/TIME: 12/12/97 22:39:04
SR=CRITICAL VALUE

REPORTED BY [redacted]

[redacted]

ID: [redacted]

12-Dec-1997 22:18:33

47years
Male

Room: [redacted]

Vent. rate	66 bpm
PR interval	172 ms
QRS duration	106 ms
QT/QTc	442/463 ms
P-R-T axes	32 7 132

1)Normal sinus rhythm
2)Left atrial enlargement
3)ST & T wave abnormality, consider lateral ischemia and/or left ventricular overload
4)Prolonged QT
Abnormal ECG

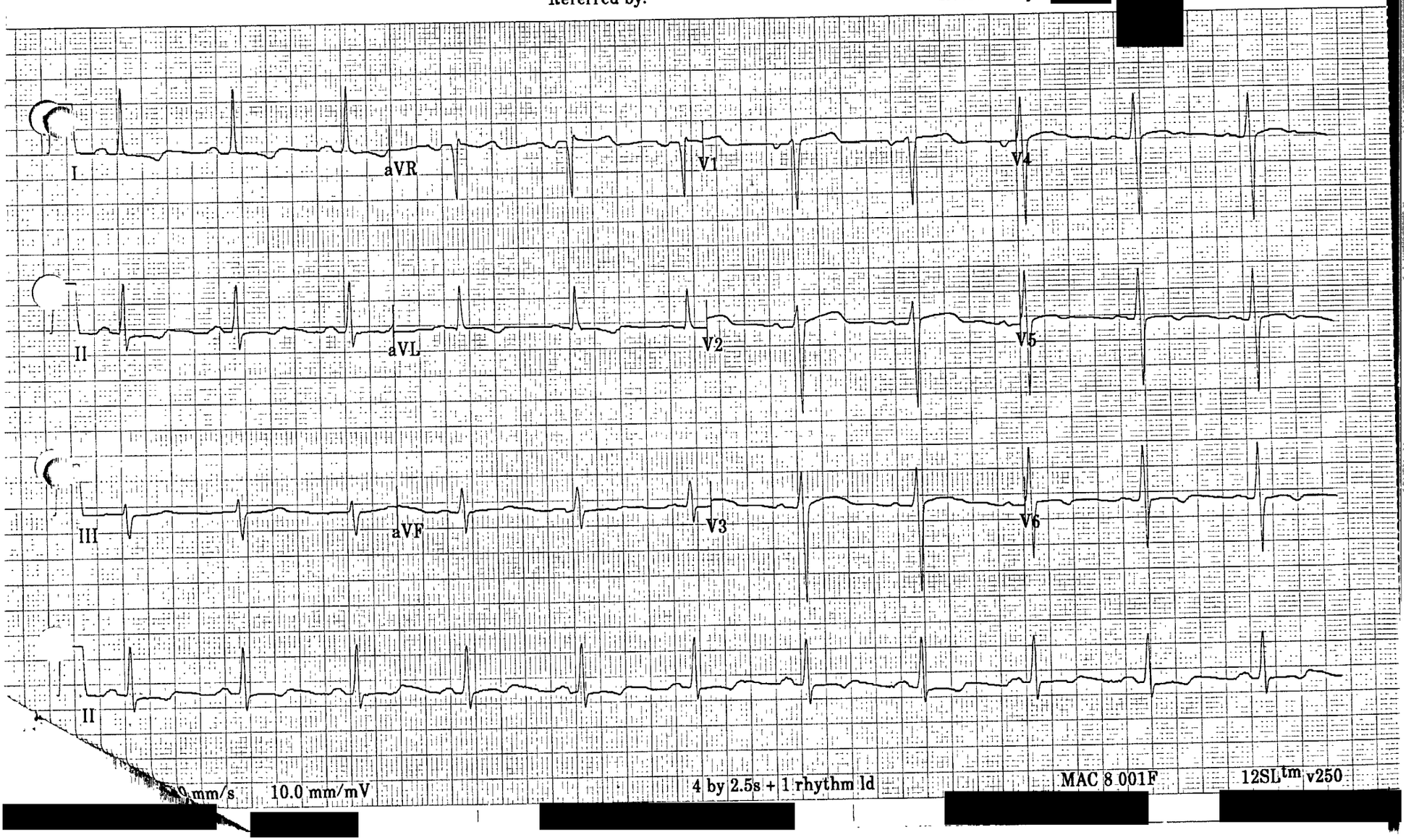
000009

Technician: [redacted]
Test ind:

previous trAcing not available

Referred by:

Reviewed by: [redacted]



[redacted]

[redacted]

RADIOLOGY REPORT

Name: [redacted]
Doctor:
X-Ray Number:
Room Number:
Date: 12/12/1997

[redacted]

CHEST: AP Portable - 12/12/97

No previous films available.

The heart is magnified in this projection, but is judged to be mildly enlarged.

The lungs are well expanded and clear.

UNENHANCED CT SCAN OF THE HEAD:

Multiple 10 millimeter axial images. No IV contrast.

There is a large, acute, intracranial hemorrhage in the mid portion of the right cerebral hemisphere. There is considerable associated cerebral edema causing effacement of the right lateral ventricle and early displacement of the midline structures to the left.

[redacted]
D: 12/15/1997
T: 12/15/1997

[redacted] M.D.

000010