

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

ARMS#

12888



4 - ER URGENT

000001

RUN INFO

PATIENT INFO

COMMENTS

HX

MEDICAL

TRAUMA

PHYSICAL

VITALS

D/E

ET INTUBATION

TYPE OF SITUATIONS FOUND

NO PATIENT PAGE 2

DOA* IFT PT# **L OF L** DATE **12-25-97** JUR. STA. **ROP USE** EMS EMTD

ASSIST ONLY

INCIDENT LOC. _____ STREET NUMBER _____ STREET NAME _____ ST TYPE _____ APT # _____ CITY CODE _____

TEAM MEMBER #1 _____ CERT # _____ TEAM MEMBER #2 _____ CERT # _____ TEAM MEMBER #3 _____ CERT # _____ TEAM MEMBER #4 _____ CERT # _____ TEAM MEMBER #5 _____ CERT # _____

BLS _____ ALS _____ AMB/REL _____

NAME _____ SEQ NO. _____

ADDRESS _____ Street _____ Apt _____ City _____ State _____ Zip _____

AGE **41** D.O.B. _____ M F **ETH** TEL. (____) _____

SEVERITY OF ILLNESS/INJURY None Mild Mod. Severe Approx. Wt. **150** Kg | lbs.

Allergies* Suspected: ETOH* Family/Violence/Neglect* Inquiry Requested*

Hx of left sided weakness / "numbness"
Slight left sided weakness / symmetrical
facial movement - Slurred speech

TRANSPORT No Transport Heli.

Amb Fire Pvt. Veh

Amb. & Med REC. HOSP. _____ (1 only)

Most Access. EDAP Req by pt

Trauma PeriNatal Other*

PCCC Diversion

UNCONTROLLABLE IN FIELD

Ext. Hemorrhage Cardiac Arrest

Airway Other _____

Unavailable Diabetes Pos Pregnancy _____ Mo. COPD Hypertension

No Sig. Hist. Heart Dis HX. Current Complaint Seizure Other*

Abd/Pelvic Pain Behavioral Foreign Body Obs. Head Pain OBstetrics SEizure

Allergic Reaction Cardiac Arrest Ext. Bleeding Local Neuro Signs* Labor Newborn Short of Breath

(Suspected) Chest Pain PleUritic GI Nausea/Vomiting OD/POisoning SYNcope

Altered LOC DYsrhy./PalpitationS VAginal Near Drowning Respiratory Arrest Weak/Dizzy

Apnea Episode FEver NOsebleed Neck/Back Pain OTHER _____

No Apparent Injuries Bums/Shock

B P _____ **B P** _____ **B P** _____

Minor Lac./ Head Abdomen

Fall Chest Facial/Dental Diffuse Tend

T. Pneumo Neck Genital/Buttocks

Trauma Chest Extremities

Arrest Bat. Mid Clav FRactures

Back Amputations _____

Enc. Veh Seat Belt Airbag Assault Fall

Pass. Space Intrusion With Blunt Inst > 15Ft. - Ched M.O.T.

Surv. of Fatal Acc. GSW Electric Shock

Ejected from Vehicle TRunk Hazmat Exposure

EXtrication Required STabbing Thermal Burn

Ped/Bike vs. Vehicle S. I. Accidental SPorts

Motorcycle/Moped S. I. Intentional Work Related

Vs. Veh. HelMet OTHER _____ UNKNOWN

Alert Oriented x4 PERL

Not Alert Disoriented Unequal*

Combative NorMal for pt. Pinpoint

Responds to Verbal Eye **4**

Responds to Pain Motor **6**

Purposefully Verbal **8**

Non-Purposefully

No Response

SPON EYE OPENING? N Y

Normal Clear Appears Normal

Tidal Volume ↑ ↓ N Abnorm. Cap. Refill

Wheezes Rales Jaundiced

RHonchi BasiLar Cyanotic Hot

Unequal Stridor Pale CoLd

Other Apnea Flushed Diaphoretic

JVD Other _____

Not Taken* TIME	6 & Under BP<70	B/P	7 & Over BP<90	PULSE RATE	(R) (l)	RESP. RATE
0230		170/108		116	R	18

DRUGS	EKG	TIME	DEFIB /DRUG	DOSE	TM#	ROUTE	EFFECT ↑↓N
		0240		MSTKO	2		U

(Indicate Team Member # in Space)

Attempt #1 _____ #2 _____ #3 _____

Were Cords Visualized? Y N

BS after ET/EOA

Patient Resisted Intubation

Vomitus/Secretions in Airway

Solid Foreign Body in Airway

Blood in Airway

Anatomical Abnormality

Success? Y N

Tube Size _____

OTHER _____

Loxy **15** NC or M

Naso/oro Airway

Esophageal Airway

Back Blows/Thrust

F.B. Removal

Suction

B/V/M T.M. # _____

D. Valve/ATV _____

Mouth to Mouth _____

THoracostomy _____

Witnessed Arrest _____

CPR: Citizen MEdic _____ min. to CPR

SHock Position

Direct Pressure

Anti-Shock Suit

Vagal Maneuvers **80**

Chemstrip **80**

DRessing

SPInt

Traction Splint

Spinal Immobilization

Restoration of Pulse ChildBirth Refused: Treatment Transport

NO Treatment Restraints* _____

DNR OTHER _____

Reviewed by: _____

000002

RECEIVING HOSPITAL

TRIAGE

TIME IN 0200

LEVEL: 1 (2) 3

VISIT TO ED WITHIN 48 HR YES NO

MECHANISM OF INJURY

Auto: Driver Passenger
 Seat Belt Yes No
 Safety Seat Yes No
 Ejected Yes No
 Motorcycle/Bicycle:
 Helmet Yes No
 Pedestrian Yes No
 Fall Yes No

CHIEF COMPLAINT (TIME - ONSET - DURATION) *Awoken from Sleep c/o numbness & tingling in (C) side - slight weakness (C) upper extremities extreme weakness in (C) foot.*

MODE OF ARRIVAL: SQUAD AMBULANCE GURNEY WC AMBULATORY CARRIED

TREATMENT PRIOR TO ARRIVAL: C-COLLAR LONG BOARD IMMOBILIZER

O2 IV ETT/EOA MEDS: _____ MEDICATIONS YES NO UNKNOWN

MEDICAL HISTORY:

NO CHRONIC ILLNESS
 CARDIAC DISEASE
 HYPERTENSION
 COPD ASTHMA DIABETES *Family Hx Strong CIA*
 SEIZURE DISORDER MENTAL HEALTH
 NATAL
 UNCOMPLICATED COMPLICATED
 PREMATURE GESTATION
 OTHER *EDH several glasses earlier*
 SURGERIES

MEDICATIONS YES NO UNKNOWN

ALLERGIES (REACTION) YES NO UNKNOWN

VITAL SIGNS

TIME	B/P	PULSE	RESP	TEMP	O2 SAT	INITIAL
0230	158/99	95	18	97.2		

HEAD CIRCUMFERENCE *NA* (UNDER 1yr & IF APPL) LAST TETANUS < 5 YRS > 5 YRS UNKNOWN
 HEIGHT *5'6"* WEIGHT *160#* LMP *12-1-97* PED IMMUNIZATION UTD YES NO UNKNOWN

POLICE: TIME CALLED: _____ TIME ARRIVED: _____ OFFICER & BADGE #: _____

INFORMANT: _____ PRIMARY LANGUAGE: *English* TRANSLATOR: _____ DISPOSITION: WAITING ROOM TREATMENT ROOM INIT

TREATMENT ROOM: TIME IN: *0230*

VITAL SIGNS

TIME	B/P	PULSE	RESP	TEMP	MONITOR	O2 SAT	INITIAL	TIME	B/P	PULSE	RESP	TEMP	MONITOR	O2 SAT	INITIAL
<i>see Trends</i>															

PHYSICIAN LOG

ED PHYSICIAN	NOTIFIED	EXAM	COMMENTS - INIT
<i>Dr. [redacted]</i>			
PHYSICIAN	TIME CALLED	TIME RESPONDED	COMMENTS - INIT
<i>Dr. [redacted]</i>		<i>0730</i>	<i>Returned call orders received & hold transfer to [redacted] until 0730. [redacted] MD will assume care of client & [redacted]</i>

PSYCHO SOCIAL ASSESSMENT

ANXIOUS HOSTILE RESTLESS CALM COMBATIVE IRRITABLE COOPERATIVE WITHDRAWN QUIET BEHAVIOR APPROPRIATE FOR AGE INAPPROPRIATE NORMAL AFFECT POOR HYGIENE LETHARGIC FLAT AFFECT HALLUCINATIONS
 SPIRITUAL NEEDS: _____
 CULTURAL NEEDS: _____
 RESIDENTIAL STATUS: PRIVATE HOME NONE ECF B & C
 VICTIM OF ABUSE YES NO

ADDRESSOGRAPH | BED

000003

DATE 12/29/97	TIME IN 0300	LAST NAME [REDACTED]	FIRST [REDACTED]	MI [REDACTED]	AGE 41	SEX M	PRIMARY CARE PHYSICIAN [REDACTED]	TIME OUT 0740	
TIME 0300	T 97	P 95	R 18	BP 158/99	HT 5'6"	WT 160	MP 12-1-97	LAST DT TOX. [REDACTED]	
MEDICATIONS None				ALLERGIES NKA			NURSE SIGNATURE [REDACTED]		
CHIEF COMPLAINT New onset numbness & tingling + weakness (L) arm							ORDERS hem		
TIME M D H&P							TIME ORDERED		
<p>PT states that she awaked early this AM with numbness in (L) eye. She then noted numbness in "most of left side" & found she self unable to walk in a straight line. Denies headache, nausea, vomiting, syncope, falls.</p> <p>Known hypertension - self did not recall when numbness started. Well going, remainder of - of trees in screen seem a bit slant off trees.</p> <p>Denies NCAT, PAM, double vision, upper extremities weakness.</p> <p>Denies - in 3rd day of sedation, 1 call to ER from home. (with - stroke, stroke, stroke)</p>							<input type="checkbox"/> Long Panel <input type="checkbox"/> Chem 20 <input type="checkbox"/> Abd. Panel <input checked="" type="checkbox"/> CBC Hgb Hct 41 WBC 11.1 SEG BND LYM PLT <input checked="" type="checkbox"/> PT 11.7 14.1 4.1 <input checked="" type="checkbox"/> PTT 106 1.1 2.7 <input type="checkbox"/> Chem 7 <input type="checkbox"/> Creat 1.1 <input type="checkbox"/> BUN 1.9 <input type="checkbox"/> Creat 1.1 <input type="checkbox"/> TOX SCREEN <input type="checkbox"/> AMYLASE <input checked="" type="checkbox"/> CPK 62 mb <input type="checkbox"/> CARDIAC ENZYMES <input type="checkbox"/> UA WBC <input type="checkbox"/> RBC <input type="checkbox"/> PREG (U) (B) <input checked="" type="checkbox"/> EKG N/A <input type="checkbox"/> ABG <input checked="" type="checkbox"/> Pulse Ox 100% ON O2 <input type="checkbox"/> O2 l/min <input type="checkbox"/> Cardiac Monitor <input type="checkbox"/> X RAY <input type="checkbox"/> CXR <input type="checkbox"/> CIS <input type="checkbox"/> ABD SERIES <input type="checkbox"/> KUB <input type="checkbox"/> CT <input type="checkbox"/> UIS <input type="checkbox"/> ADDITIONAL ORDERS <input checked="" type="checkbox"/> CT Brain No contrast		
RE-EVALUATION CONDITION TIME							INITIAL WHEN COMPLETED		
CONDITION AT DISCHARGE <input type="checkbox"/> UNCHANGED <input type="checkbox"/> CHANGED (HOW?)							<input type="checkbox"/> SEE CONTINUATION SHEET <input checked="" type="checkbox"/> OLD CHART		
PLAN <input type="checkbox"/> DISCHARGE <input checked="" type="checkbox"/> ADMIT <input checked="" type="checkbox"/> TRANSFER <input type="checkbox"/> EXPIRATION				MEDICATION ORDERS					
[REDACTED]				TIME ORDERED					
[REDACTED]				<input type="checkbox"/> S/L <input checked="" type="checkbox"/> IV NS-TRD					
IMPRESSION Severe gain distal paresis-hypertension							ADDRESSOGRAPH		
PHYSICIAN SIGNATURE F [REDACTED]				PHYSICIAN SIGNATURE SECOND MD [REDACTED]				[REDACTED]	

NURSING ASSESSMENT-PROCEDURES

TIME	PROCEDURE	INITIALS	ACTION	RESPONSE
	ABR/LAC PREP SOLUTION USED _____ AMOUNT _____			
	ACE WRAP			
	AMBULATION			
	COLD PACK			
	COOLING MEASURES			
	CRUTCHES/GAIT TRAINING			
	DRESSING(S)		<input type="checkbox"/> KLING <input type="checkbox"/> 4 X 4 <input type="checkbox"/> ADAPTIC <input type="checkbox"/> TELFA <input type="checkbox"/> OTHER <input type="checkbox"/> BAND AID	
	RINGS REMOVED			
	FOLEY <input type="checkbox"/> I/O <input type="checkbox"/> RET SIZE CATH _____ BALLOON _____			
	NG TUBE TYPE _____ SIZE _____			
	OXYGEN _____ L / M METHOD _____			
	SLING			
	SPLINTS TYPE _____			

INTRAVENOUS SOLUTIONS

TIME	SOLUTION / AMOUNT	GAUGE	# ATTEMPTS	SITE	PUMP	RATE	INITIALS	TIME	AMT ABSORBED
0300	.9NS 500cc		established route		TKO				400cc

MEDICATIONS

TIME	DRUG	DOSE	MODE	PLACE	INITIALS	TIME	RESPONSE

LAB

ORDERED 0300

DRAWN 0350

RETURNED 0413

U/A

C&S

HCG-URINE/SERUM

CBC

PT-PTT

LIVER

CHEM 7

CARDIAC ENZ

AMYLASE _____

ACCUCHECK

TIME: _____ RESULTS _____

TIME: _____ RESULTS _____

X-RAY

C.T. Head - 0335

U.S. _____

ORDERED _____

DONE 0400

RETURNED _____

SKULL _____

C-SPINE _____

CHEST _____

ABDOMEN _____

EXTREMITIES _____

PELVIS _____

GURNEY WHEELCHAIR

AMBULATED PORTABLE

CARRIED

ABG'S

ORDERED _____ TITLE _____

DRAWN _____ SITE _____

RETURNED _____

BREATHING TREATMENT

	# 1	# 2	# 3	# 4	MEDICATION
ORDERED					_____
STARTED					_____
COMPLETED					_____

EKG

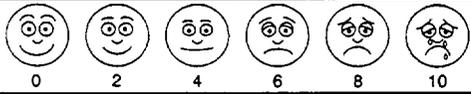
ORDERED _____ DONE _____

THROMBOLYTIC PROTOCOL TIME _____

000005

	WNL	ABN	NA	DETAIL OF ABN	QUALITIES
NEURO				Speech thickness & Surring, 0/0 X 4	Not facial droop
HEAD	✓				or drooling @ nigring in
NECK	✓				ears moving or
BACK/SPINE	✓				buzzing
CHEST	✓				
LUNG SOUNDS	✓				
ABDOMEN	✓				
PELVIS	✓				
EXTREM.			✓	0/0 (L arm) & (R leg) numbness & tingling.	
SKIN	X				

PAIN SCALE



EXPLAIN _____

NEUROLOGICAL EVALUATION-GLASCOW COMA SCALE

1 PUPIL REACTION S — SLUGGISH B — BRISK N — NON REACTIVE **2** PUPIL SIZE MM [Diagram of pupil sizes 1-9]

EYE OPENING			BEST MOTOR RESPONSE			VERBAL RESPONSE (TALKING)		
PATIENT'S RESPONSE	SCORE		PATIENT'S RESPONSE	SCORE		PATIENT'S RESPONSE	SCORE	
3 OPENS EYES ON OWN	4	4 PAIN	FOLLOWS SIMPLE COMMANDS	6	5 SPEECH	CARRIES ON CONVERSATION CORRECTLY TELLS WHERE THEY ARE, AND WHO THEY ARE, AND MONTH AND YEAR	5	
SPON-TANEOUS SPEECH OPENS EYES WHEN ASKED TO IN A LOUD VOICE	3		PULLS EXAMINERS HAND AWAY WHEN PINCHED	5		SEEMS CONFUSED OR DISORIENTED	4	
PAIN OPENS EYES WHEN PINCHED	2		PULLS PART OF BODY AWAY WHEN EXAMINER PINCHED PATIENT	4		TALKS SO EXAMINER CAN UNDERSTAND PATIENT, BUT MAKES NO SENSE	3	
			FLEXES BODY (INAPPROPRIATELY TO PAIN)	3		MAKES SOUNDS THAT EXAMINER CANNOT UNDERSTAND	2	
DOES NOT OPEN EYES	1		BODY BECOMES RIGID IN AN EXTENDED POSITION WHEN EXAMINER PINCHES PATIENT (DECEREBRATE POSTURING)	2		MAKES NO NOISE	1	
			HAS NO MOTOR RESPONSE TO PINCH	1				

NEUROLOGICAL OBSERVATIONS

TIME	R	1	L	R	2	L	3	4	5	GCS SCORE	TIME	R	1	L	R	2	L	3	4	5	GCS SCORE	
0300	B			0	3	3	4	5	6	15												

SKIN VITALS

TIME: 0300

COLOR
 NORMAL
 FLUSHED
 PALE
 CYANOTIC
 JAUNDICED

MOISTURE
 NORMAL
 MOIST
 DRY

TEMPERATURE
 NORMAL
 HOT
 COOL/COLD
 WARM

ABDOMINAL STATUS PAIN YES NO
 PRECIPITATING EVENT _____
 LOCATION _____
 DURATION _____
 TYPE CONSTANT INTERMITTENT DESCRIBE _____
 NAUSEA VOMITING _____
 COLOR/AMT _____
 DIARRHEA _____

RESPIRATORY STATUS DYSPNEA YES NO
 PRECIPITATING EVENT _____
 DURATION _____

GU HISTORY
 DYSURIA YES NO FREQUENCY YES NO
 URINARY RETENTION YES NO HEMATURIA YES NO
 URGENCY YES NO DURATION _____

ORTHOSTATIC VS

VISUAL ACUITY

TIME	POS	BP	PULSE	TIME	
	L				OD
	S				OS
	ST				OU

GYN HISTORY VAGINAL BLEEDING YES NO
 AMT/DURATION _____
 LMP _____ PELVIC EXAM TIME _____
 CONTRACEPTION USED YES NO KIND _____
 VAGINAL DISCHARGE NO YES, COLOR/AMT _____
 GRAVIDA _____ PARA _____ AB _____
 EDC _____ FHT _____
 BOW INTACT YES NO UNKNOWN

INTAKE		OUTPUT		SAFETY		TIME	TIME	TIME	TIME
ORAL		URINE	06:30 550cc	SIDE RAILS, UP / LOCKED					
PARENTERAL	1/2 400cc	EMESIS		ISOLATION					
OTHER		NG		RESTRAINTS: SOFT					
		OTHER		LEATHER					
				SEIZURE PRECAUTIONS					
				CALL BELL WITHIN REACH					
TOTAL	400cc	TOTAL	550cc	SECURITY WATCH					

TEACHING: PATIENT FAMILY CARE PROVIDER

discussed Head CT to R/O hemorrhagic stroke

TIME	NURSES NOTES
07:00	<p>noted difficulty in speaking, speech now slurred. (L) unable to raise (L) upper extremity, assistance of (R) arm. Reexamined by Dr. [redacted] clothing to (L) side. BP - 102/91 (0530) - attempted ambulation but unable to go profound weakness (L) side. Fearful mother @ 65 for emotional support. [redacted] 06:20 - speech still slurred still in room + trying to (L) side. voided 550cc - [redacted] 07:00 - family @ 65 for emotional support awaiting EMS transport.</p>
	<input type="checkbox"/> SEE ADDITIONAL NOTES

TRANSFER - DISCHARGE SUMMARY

FAMILY / FRIENDS NOTIFIED YES NO NAME OF INDIVIDUAL NOTIFIED _____

DISCHARGE W/ACI WO/ACI AMA OTHER _____

ADMITTED STRETCHER WC ROOM _____ @ _____ AM / PM

TRANSFERRED YES LOCATION _____ TIME 0740

CONDITION IMPROVED UNCHANGED IMPROVED UNCHANGED

CONDITION IMPROVED UNCHANGED UNSTABLE ACCOMPANIED BY _____

REPORT GIVEN TO _____

IV PATIENT YES NO SITE(S) _____

ACLS NO YES WITH DRUGS, MONITOR

PORTABLE SUCTION. O₂ YES NO

DEFIBRILLATOR - RHYTHM _____

TRANSPORTED BY AUTO EMT PM UNIT # _____ HELICOPTER ACLS

TRANSFER FORMS COMPLETED YES NO

X-RAYS: YES NO BELONGINGS: YES NO COPY OF CHART: YES NO LAB: YES NO

VALUABLES CHECKLIST:

PERSONAL PROPERTY DISPOSITION COMPLETED YES, BY WHOM. [redacted] INITIAL [redacted]

NO, EXPLAIN _____

SIGNATURES	NAME AND TITLE	INITIALS	NAME AND TITLE	INITIALS
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

000007

Time	01:32	03:13	04:05	04:12	04:27	04:49	05:04	05:19	06:10	06:25
Date	12/25	12/25	12/25	12/25	12/25	12/25	12/25	12/25	12/25	12/25
Rate	---	94	0	96	97	93	103	105	103	98
SpO2	--	100%	--	--	--	--	--	--	--	--
NIBP		158/ 99	162/ 91	161/ 102	143/ 87	158/ 97	157/ 98	138/ 90	151/ 85	142/ 81
Mean		(118)	(118)	(121)	(111)	(118)	(126)	(117)	(114)	(106)
Temp	---C									
IP1	---/ ---	---/ ---	---/ ---	---/ ---	---/ ---	---/ ---	---/ ---	---/ ---	---/ ---	---/ ---
Mean	(---)	(---)	(---)	(---)	(---)	(---)	(---)	(---)	(---)	(---)
IP2	---/ ---	---/ ---	---/ ---	---/ ---	---/ ---	---/ ---	---/ ---	---/ ---	---/ ---	---/ ---
Mean	(---)	(---)	(---)	(---)	(---)	(---)	(---)	(---)	(---)	(---)

Time	06:40	06:56	07:10
Date	12/25	12/25	12/25
Rate	96	95	93
SpO2	--	--	--
NIBP	155/ 90	145/ 88	138/ 84
Mean	(109)	(108)	(111)
Temp	---C	---C	---C
IP1	---/ ---	---/ ---	---/ ---
Mean	(---)	(---)	(---)
IP2	---/ ---	---/ ---	---/ ---
Mean	(---)	(---)	(---)

PATIENT: [REDACTED]



[REDACTED]

PAGE: 2
12/26/97
12:04

MR#: [REDACTED]
ID#: [REDACTED]
DOB: [REDACTED]
LOC: [REDACTED]
ADM PHYS: [REDACTED]
ATTN PHYS: [REDACTED]
COMMENTS: [REDACTED]

LABORATORY DIRECTOR: [REDACTED]

*** FINAL DISCHARGE ***

** CUMULATIVE REPORT **

HEMATOLOGY

12/25/97
03:50
[REDACTED]

TEST NAME		UNITS	RANGE
COMPLETE BLOOD COUNT			
WBC	8.10	10 ³	4.8-10.8
RBC	4.50	10 ⁶	4.00-6.20
HEMOGLOBIN	14.1	g/dl	12.0-16.0
HEMATOCRIT	40.7	%	36.0-48.0
MCV	90.5	fl	80.0-99.0
MCH	31.3 H	pg	27.0-31.0
MCHC	34.6	g/dl	32.0-36.0
NEUT%	ND	%	42.0-70.0
LYMPHS%	ND	%	20.0-44.0
MONO%	ND	%	2.0-11.0
EOS%	ND	%	0-5.0
BASO%	ND	%	0-2.0
PLATELET COUNT	364	10 ³	130-430

DIFFERENTIAL, MANUAL COUNTS

BASO	1	%	0-2 %
EOS	2	%	0-5 %
PLAT	4	%	0-6 %
POLY	50	%	42-70 %
LYMPH	38	%	20-44 %
MONO	5	%	2-11 %
TOTAL	100		0-0 %

MORPHOLOGY

PLATELET ADICQ

DIFFERENTIAL REMARK

[REDACTED] 12/25/97 03:50

RBC MORPHOLOGY APPEARS NORMAL

PT, PROTHROMBIN TIME

PROTHROMBIN TIME, 11.2 seconds 10.0-13.0

RECOMMENDED THERAPEUTIC DOSE IS 1.5 - 2.5 TIMES THE CONTROL TIME.

PROTIME CONTROL 12.3 seconds 10.9-12.9

PROTIME RATIO 0.97 0.85-1.00

INR 1.0 I.

THE REFERENCE RANGE:
LOWER INTENSITY ANTICOAGULATION: (2.0 - 3.0)
HIGHER INTENSITY ANTICOAGULATION: (2.5 - 3.5)

APTT, PARTIAL THROMBOPLASTIN

APTT 27.0 seconds 26.0-35.0

APTT, CONTROL 29.0 seconds 26.0-35.0

000009

PATIENT: [REDACTED]

[REDACTED]

PAGE: 3
12/26/97
12:04

MR#: [REDACTED]

ID#: [REDACTED]

DOB: [REDACTED]

LOC: [REDACTED]

LABORATORY DIRECTOR: [REDACTED]

ADM PHYS: [REDACTED]

GIN PHYS: [REDACTED]

COMMENTS:

*** FINAL DISCHARGE ***

** CUMULATIVE REPORT **

=====

HEMATOLOGY

=====

12/25/7
03:50

[REDACTED]

TEST NAME [REDACTED] UNITS RANGE
SAMPLE COMMENTS: [REDACTED] REPORT PRINTED TO FR/COL AT 0428.

000010

PATIENT: [REDACTED]

PAGE: 1
12/26/97
12:04

MR #: [REDACTED]
TO #: [REDACTED]
DOB: [REDACTED]
LDC: [REDACTED]
ADM PHYS: [REDACTED]
DIS PHYS: [REDACTED]
COMMENTS: [REDACTED]

LABORATORY DIRECTOR: [REDACTED]

*** FINAL DISCHARGE ***

** CUMULATIVE REPORT **

===== CHEMISTRY =====

12/25/7
03:50
[REDACTED]

TEST NAME		UNITS	RANGE
DNG PROFILE			
GLUCOSE	114 H	mg/dl	65-105
SODIUM	141	mEq/L	137-145
POTASSIUM	4.1	mEq/L	3.6-5.0
CHLORIDE	106	mEq/L	98-107
CO2	27	mEq/L	22-30
ANION GAP	8		5-18
BUN, BLOOD UREA NIT	18.0	mg/dl	7-18
CREATININE	1.0	mg/dl	0.8-1.5
CFR	60	U/L	30-135

SAMPLE COMMENTS: [REDACTED] REPORT PRINTED TO [REDACTED] AT 0428.

000011

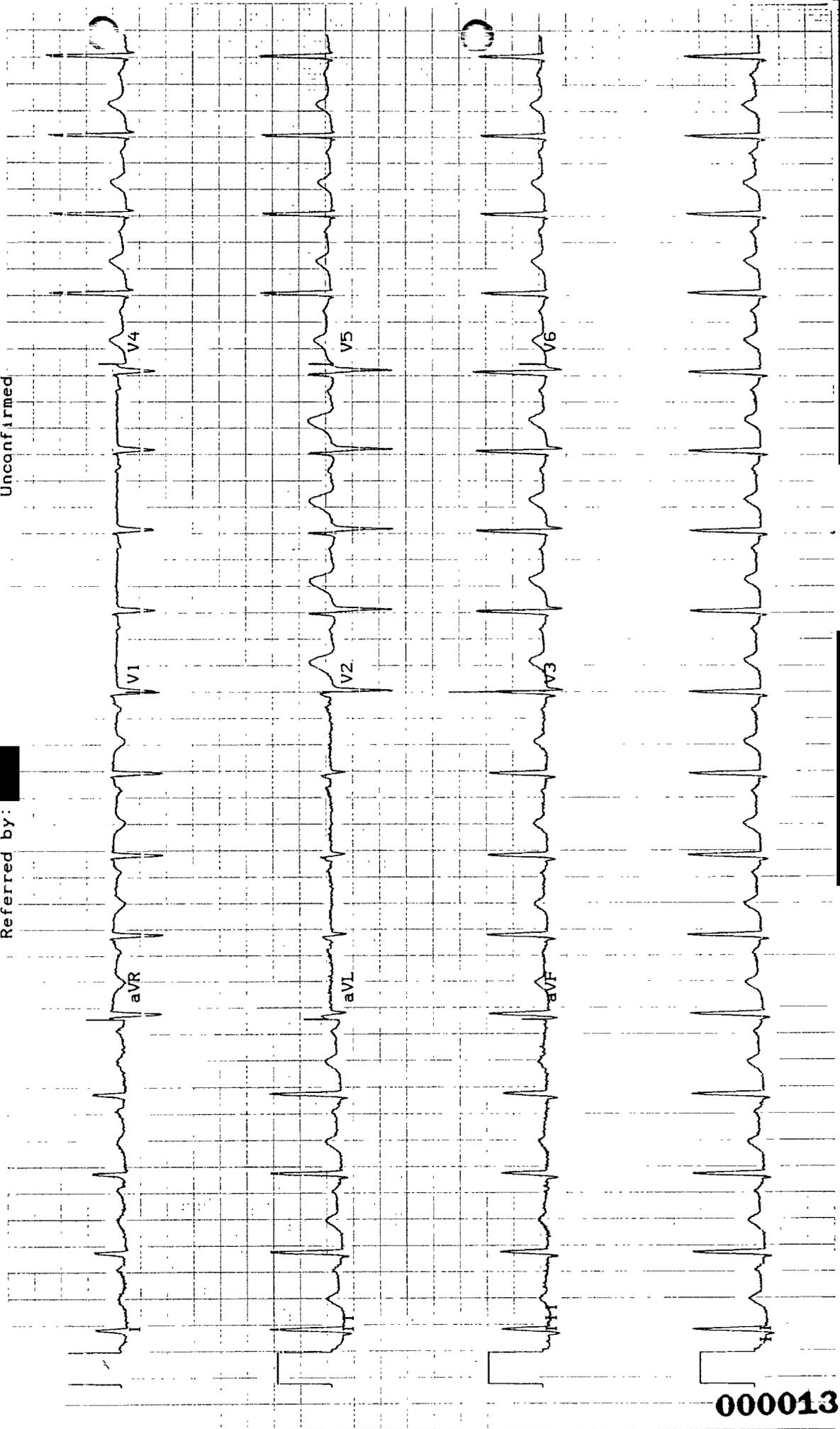
25mm/s
 10mm/mV
 100Hz
 Pgm 007A
 v206
 S

Med: [REDACTED]
 41yr
 Sex: F
 Loc: [REDACTED]
 Ht: [REDACTED]
 Race: Cauc
 Room: [REDACTED]
 Vent. rate 98 BPM
 PR interval 132 ms
 QRS duration 80 ms
 QT/QTc 364/461 ms
 P-R-T axes 26 64 58

NORMAL SINUS RHYTHM
 NORMAL ECG

Referred by: [REDACTED]

Unconfirmed



NAME: [REDACTED]
REF. PHYS.: Dr. [REDACTED]
SEX: F
AGE: 41
HOSPITAL NO.: [REDACTED]

ROOM NO.: [REDACTED]
REQUEST NO.: [REDACTED]
EXAM DATE: 12/25/97
X-RAY NO.: [REDACTED]

REPORT OF ROENTGENOLOGICAL CONSULTATION: [REDACTED]

HEAD CT 12/25/97:

History of new onset left sided numbness and weakness.

TECHNIQUE AND FINDINGS:

3.0 mm. axial slices were acquired through the posterior fossa followed by 10.0 mm. axial slices through the remainder of the calvarium. The cerebral density is normal throughout. There are no masses, mass effect, midline shift, evidence of intracranial hemorrhage, subdural collections, or evidence of recent or remote cerebral infarction. The ventricular system and the subarachnoid space over the sulci are within normal limits. Visualized paranasal sinuses are clear.

IMPRESSION: Normal cranial CT.

[REDACTED]

MD

[REDACTED], M.D.

[REDACTED]
D: 12/25/97
T: 12/26/97 8:39 am

[REDACTED] PATIENT: [REDACTED]
MR#: [REDACTED]
ROOM: [REDACTED]

ROENTGENOLOGICAL CONSULTATION: [REDACTED]

[REDACTED]

M.R. UNIT #: [REDACTED]

DATE OF ED EXAMINATION: 02/05/98

HISTORY OF PRESENT ILLNESS: This is a 41-year-old, white female who comes into the Emergency Department complaining of increasing weakness on the left side of her body. The patient has a history of cerebrovascular accident in December of 1997 and she had been improving. The patient had been able to ambulate and use the left side of her body well after going through neurologic rehabilitation. The patient started having some weakness in the left arm and now today it progressed to the left leg. She is unable to ambulate now. She denies any headache. The patient takes Coumadin and Colace. She denies any history of diabetes, hypertension or heart disease.

FAMILY HISTORY: The patient has a family history of heart disease and cerebrovascular accident as well as hypertension.

SOCIAL HISTORY: The patient denies drinking alcohol or smoking cigarettes.

REVIEW OF SYSTEMS: Negative and noncontributory. No pertinent positives.

PHYSICAL EXAMINATION: VITAL SIGNS: Temperature 98.3, pulse 107, respirations 20, blood pressure 150/90. GENERAL APPEARANCE: A well-developed, well-nourished female in no acute distress. HEAD: Normocephalic, atraumatic. EYES: Pupils are equal, round and reactive to light. EARS: Within normal limits. NOSE AND THROAT: Clear. Mucosa is moist. NECK: Supple. CHEST: Clear to auscultation and percussion. CARDIAC EXAM: Regular rate and rhythm without murmur. ABDOMEN: The abdomen is soft and nontender. Normal bowel sounds. NEUROLOGICAL: The patient is alert, awake, oriented times four. The patient has a slightly slurred speech. She is very weak on the left side of the body. She is able to move her extremities against gravity.

EMERGENCY DEPARTMENT COURSE AND TREATMENT: The patient had CBC which reveals hemoglobin of 15.1, hematocrit of 43.9, white blood count of 7,600. Prothrombin time 18.7 with a control of 12.0, partial thromboplastin time 50.8. The patient had CT scan of the head which was

Page 1 of 2
ORIGINAL

PATIENT: [REDACTED]

MRU#: [REDACTED]

ROOM: [REDACTED]

ACCT#: [REDACTED]

PHYSICIAN: [REDACTED]
M.D.

EMERGENCY DEPARTMENT SUMMARY

000015



read by the radiologist as negative. SMA-ED is pending at the time of dictation and will be reviewed by the Emergency Department physician.

I thought the patient should be evaluated by a neurologist for possible admission.

Dr. [REDACTED] who is covering for Dr. [REDACTED] patient's private physician, was notified, case was discussed and he will come in and evaluate the patient. Dr. [REDACTED] will make the final disposition on the patient.

IMPRESSION:

1. Acute left-sided weakness, rule out cerebrovascular accident.

CONDITION: Stable.

[REDACTED]
D: 02/05/98 17:55
T: 02/06/98 14:10

[REDACTED]
[REDACTED] M.D.

PATIENT: [REDACTED]

MRU#: [REDACTED]

ROOM: [REDACTED]

ACCT#: [REDACTED]

PHYSICIAN: [REDACTED]
M.D.

EMERGENCY DEPARTMENT RECORD

NAME [REDACTED] AGE 41 SEX F DATE 02/05/98 TIME 1313 MR. # [REDACTED]

TRIAGE RECORD

LAST VISIT 02/04/98 BED # [REDACTED]

CHIEF COMPLAINT INCREASING WEAKNESS ON LEFT SIDE, HX OF CVA - unk IN DEC. 97. STARTED HAVING VISUAL DISTURBANCE YESTERDAY. Sent here by RA [REDACTED]

VITALS: T 98.3 P 107 R 20 B/P 120/90 IMMUNIZATIONS/TET [REDACTED] UTD [REDACTED]

MEDS: [] None COUMADIN, COLACE ALLERGIES: [] None NKA

PMD [] None [REDACTED] Notified by [REDACTED] @

EMERGENCY PHYSICIAN RECORD

TIME 1426
Hx as above
WOUND OF NAD
HEENT - WNL
Chest, clear AP
Lungs RLLS
All soft NT
A

PMH (-)
Family Hx
Soc Hx (-)

LABORATORY & DIAGNOSTIC TESTS ORDERED

- T & C
- PT PTT
- CBC WBC
- POLYS BANDS L PL P
- LYTES SMA SMA-20
- Na K
- Cl CO₂
- GLU BUN Cr
- Mg Ca
- Serum Amylase Urine Amylase
- CPK Liver Profile
- Preg Test DRUG Screen
- UA Dip CC Cath
- WBC RBC Bact
- CHEM ED PNL
- ASA Acetaminophen
- Dilantn Phenobarb
- Dig Theo
- Head CT Infusion
- C-spine Limited
- CXR Port Upright
- Abdomen
- Pelvis
- Ultrasound
- DIPH TET 0.5 cc im
- O₂ L N/C MASK
- ABG pH PO₂ PCO₂
- Monitor
- EKG
- IV
- PULSEOXI ___ cont ___
- SALINE LOCK
- GLUCOSCAN ___ nl ___ abnl
- FOLEY CATH
- NG TUBE
- ORTHOSTATICS
- PEAK FLOWS ___ nl ___ abnl
- HHN

ORDERS & TREATMENT

TIME [] SEE INITIAL ORDERS [] SEE TRAUMA ORDERS

PHYSICIAN IMPRESSION: Acute Left Sided Weakness
No CVA

DISCHARGE: [] ADMIT [] ACC [] AMA [] LWBS [] ELOPED [] TRANSFERRED TO

[] PMD in ___ days
DISCHARGE: [] IMPROVED [] UNCHANGED [] WORSE DOCTOR'S SIGNATURE [] SERIOUS [] CRITICAL [] EXPIRED X

ADMIT DR. 000017
[] TRANSLATOR
[] DICTATED [] SUPPL FORM USED

NURSING RECORDS

TIME ARRIVED: **1335** DATE: **01/5/98** AGE: **4 1/2** SEX: **F** VISION IMPAIRED: YES NO HEARING IMPAIRED: YES NO SPANISH SPEAKING ONLY: YES OTHER

INFORMANT: SELF PARENT OTHER HOW ARRIVED: CARRIED AUTO W/C WALKED AMB/EMT: NAME/NO AMB/PARAMEDIC: NAME/NO JURISDICTION: _____

CHIEF COMPLAINT: **side weakness**
 TRIAGE NOTE: **↑ (R)**

MEDICAL HISTORY

PULMONARY HYPERTENSION
 CARDIAC NEURO **CVA**
 DIABETES RENAL
 OTHER NONE

ALLERGIES: **NKA**

POSTURAL VITAL SIGNS

TIME: _____

CARDIAC STATUS

Pain: NO YES
 Severity: Mild Mod Severe
 Type: Constant Intermittent Other
 Location: _____ Duration: _____

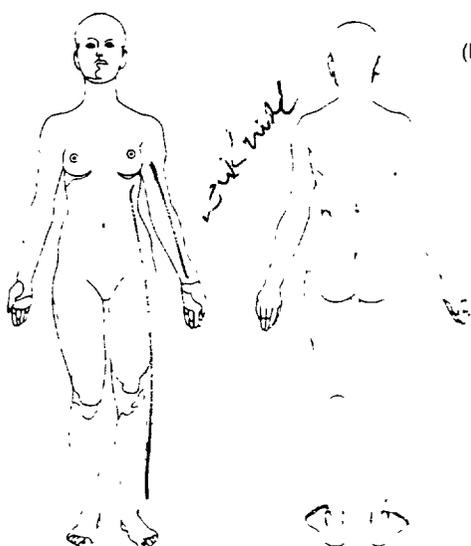
RESPIRATORY	SKIN	GI	ABD
<input checked="" type="checkbox"/> BREATH SOUNDS CLEAR <input type="checkbox"/> CRACKLES/RHONCHI <input type="checkbox"/> WHEEZES <input type="checkbox"/> DIMINISHED <input type="checkbox"/> ABSENT <input type="checkbox"/> DYSPNEA <input type="checkbox"/> RETRACTION <input type="checkbox"/> NASAL FLARING <input type="checkbox"/> COUGH <input type="checkbox"/> PRODUCTIVE <input type="checkbox"/> NON-PRODUCTIVE	<input checked="" type="checkbox"/> WNL <input type="checkbox"/> CYANOTIC <input type="checkbox"/> PALE <input type="checkbox"/> FLUSHED <input type="checkbox"/> HOT <input type="checkbox"/> COOL <input type="checkbox"/> MOIST <input type="checkbox"/> DRY <input type="checkbox"/> EDEMA <input type="checkbox"/> JAUNDICE <input type="checkbox"/> SITE	<input checked="" type="checkbox"/> WNL <input type="checkbox"/> NAUSEA <input type="checkbox"/> VOMITING <input type="checkbox"/> CONSTIPATION <input type="checkbox"/> DIARRHEA <input type="checkbox"/> SPECIAL DIET	<input checked="" type="checkbox"/> WNL <input type="checkbox"/> TENDER <input type="checkbox"/> RIGID <input type="checkbox"/> DISTENDED <input type="checkbox"/> PAIN BOWEL SOUNDS <input type="checkbox"/> ABSENT <input checked="" type="checkbox"/> PRESENT <input type="checkbox"/> N/A

NEUROLOGICAL ASSESSMENT

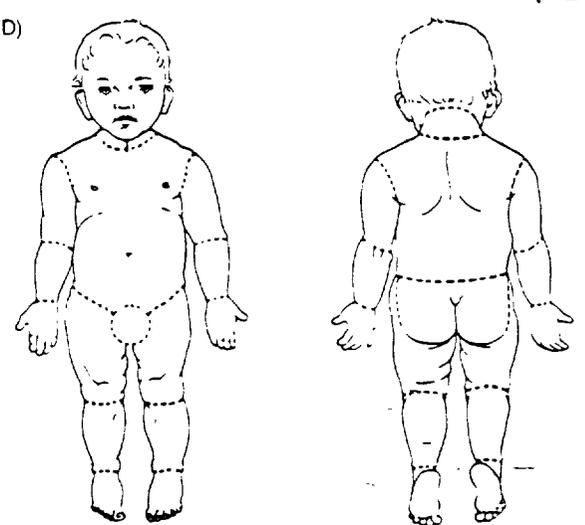
	INFANT	CHILD	ADULT	SCORE
EYE	OPENS SPONTANEOUSLY			4
	OPENS TO SPEECH			3
	OPENS TO PAIN			2
MOTOR	NIL			1
	SPON MOVEMENTS	OBEYS COMM	OBEYS COMM	8
	WITHDRAWS TO TOUCH	LOCALIZES	LOCALIZES	5
	WITHDRAWS TO PAIN	WITHDRAWS	WITHDRAWS TO PAIN	4
	FLEXION	FLEXION	FLEXION	3
	EXTENSION	EXTENSION	EXTENSION	2
VERBAL	NIL			1
	COOS & BABBLES	ORIENTED	ORIENTED	8
	IRRITABLE CRY	CONFUSED	DISORIENTED	4
	CRIES TO PAIN	INAPPROPRIATE	INAPPROPRIATE	3
	MOANS TO PAIN	INCOMPREHENSIBLE	INCOMPREHENSIBLE	2
NIL			1	
TOTAL 3-15				15

PUPILS

2 3 4 5 6 7 8 9



- INJURY/LACERATION (LABEL AND SHADE AREAS INVOLVED)**
- A - ABRASIONS
 - B - BRUISE
 - C - BURNS 1° 2° 3°
 - D - FOREIGN BODY
 - E - LACERATION
 - F - PUNCTURE
 - G - POSSIBLE FX
 - H - C/O PAIN
 - I - REDDENED
 - J - PRESSURE SORE
 - K - SWELLING
 - L - SHUNT
 - M - HEMATOMA



MEDICATIONS: *Comradon, Colace*

INITIAL ASSES: _____ R N: _____ NS SIGNATURE/INITIAL: _____
 PRIMARY NS SIGNATURE/INITIAL: _____ SIGNATURE/INITIAL: _____

PATIENT FLOWSHEET
DEPARTMENT EMERGENCY
MEDICINE

000018

OTHER ER VISITS

MEDICAL RECORDS

NAME [REDACTED] AGE 37 SEX F DATE 04/21/93 TIME 1121 LAST VISIT [REDACTED] BED# [REDACTED]

TRIAGE RECORD

CHIEF COMPLAINT

HA, DIZZINESS, VOMITING SINCE MON NOC. STARTED ON MEDS YESTERDAY BUT CAN'T RETAIN.

PMD: [REDACTED] INS: [REDACTED]

VITALS: T 97.7 P 93 R 16 B/P 170/92 WGT: [REDACTED] VA: [REDACTED]

MEDS: None AMOXIL, ANTIVERT

ALLERGIES: None NO

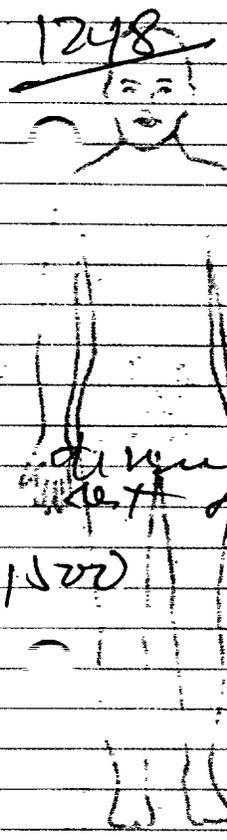
Authorization Rec'd

PMD None

Notified by [REDACTED]

Signature [REDACTED]

EMERGENCY PHYSICIAN RECORD



1248 He is alive. 3rd line of NY + dizziness, healed a abn not 19, minimal frontal headache
N R. A + A
neck sore
open eye
dizziness + neck + headache
A dx in NL

1500 LMA OK, CPK 31
not as anxious
frontal pressure, eye thro sore
open neck

<input type="checkbox"/> O2	PH	PO2	PCO2
<input type="checkbox"/> ABG			
<input type="checkbox"/> Monitor			
<input type="checkbox"/> EKG			
<input type="checkbox"/> IV			
<input type="checkbox"/> Hgb/Hct			
<input checked="" type="checkbox"/> Blood			
<input checked="" type="checkbox"/> CBC			
<input type="checkbox"/> POLYS			
<input type="checkbox"/> LYTES			
Na			
Cl			
<input type="checkbox"/> GLU	<input type="checkbox"/> BUN	<input type="checkbox"/> Cr	
<input type="checkbox"/> Serum Amylase	<input type="checkbox"/> Urine Amylase		
<input type="checkbox"/> CPK	<input type="checkbox"/> Liver Profile		
<input type="checkbox"/> Preg Test			
<input type="checkbox"/> UA	<input type="checkbox"/> Dip	<input type="checkbox"/> CC	<input type="checkbox"/> Cath
WBC	RBC	Bact	
<input type="checkbox"/> Skull			
<input type="checkbox"/> Head CT	<input type="checkbox"/> Infusion		
<input type="checkbox"/> C-spine	<input type="checkbox"/> Limited		
<input type="checkbox"/> CXR	<input type="checkbox"/> Port Upright		
<input type="checkbox"/> Abdomen			
<input type="checkbox"/> Pelvis			
<input type="checkbox"/> Ultrasound			

SEE INITIAL ORDERS SEE TRAUMA ORDERS
7:19 AM vital S/M 200
pr
1455 J/C
Stop Amoxicillin

DISCHARGE CONDITION: Stable

DISPOSITION: D/C HOME ADMIT TRANSFER CONSULT ACU

Discharge Impression: Acute Arterial Venous Thrombosis
Probable Viral Infection

MD Signature: [REDACTED] 000020

TIME ARRIVED: 1225 DATE: 4/21/93 AGE: 37 SEX: F VISION IMPAIRED: YES NO HEARING IMPAIRED: YES NO SPANISH SPEAKING ONLY: YES OTHER: OTHER

INFORMANT: SELF PARENT OTHER: CARRIED AUTO W/C WALKED EMT AMB/ PARAMEDIC IN CUSTODY IN CUSTODY

CHIEF COMPLAINT: TRIAGE NOTE

MEDICAL HISTORY

PULMONARY HYPERTENSION
 CARDIAC NEURO
 DIABETES RENAL
 OTHER NONE

ALLERGIES: NKDA

Gr.	PARA	AB	FHT	LMP
RESPIRATORY				
R	L BREATH SOUNDS	<input type="checkbox"/> W.N.L	<input type="checkbox"/> W.N.L	<input type="checkbox"/> W.N.L
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> CLEAR	<input type="checkbox"/> CYANOTIC	<input checked="" type="checkbox"/> NAUSEA	<input type="checkbox"/> TENDER
<input type="checkbox"/>	<input type="checkbox"/> CRACKLES/RHONCHI	<input checked="" type="checkbox"/> PALE	<input type="checkbox"/> VOMITING	<input type="checkbox"/> RIGID
<input type="checkbox"/>	<input type="checkbox"/> WHEEZES	<input type="checkbox"/> FLUSHED	<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> DISTENDED
<input type="checkbox"/>	<input type="checkbox"/> DIMINISHED	<input type="checkbox"/> HOT <input type="checkbox"/> COOL	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> PAIN
<input type="checkbox"/>	<input type="checkbox"/> ABSENT	<input type="checkbox"/> MOIST <input type="checkbox"/> DRY	<input type="checkbox"/> SPECIAL DIET	BOWEL SOUNDS
<input type="checkbox"/>	<input type="checkbox"/> DYSPNEA	<input type="checkbox"/> EDEMA		<input type="checkbox"/> ABSENT
<input type="checkbox"/>	<input type="checkbox"/> RETRACTION	<input type="checkbox"/> JAUNDICE		<input type="checkbox"/> PRESENT
<input checked="" type="checkbox"/>	<input type="checkbox"/> NASAL FLARING	SITE:		<input type="checkbox"/> N/A
<input type="checkbox"/>	<input type="checkbox"/> COUGH			
<input type="checkbox"/>	<input type="checkbox"/> PRODUCTIVE <input type="checkbox"/> NON-PRODUCTIVE			

PUPILS

② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

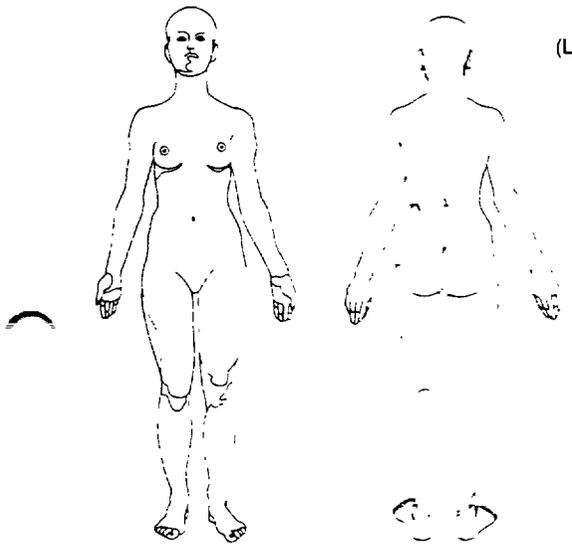
POSTURAL VITAL SIGNS

TIME: _____

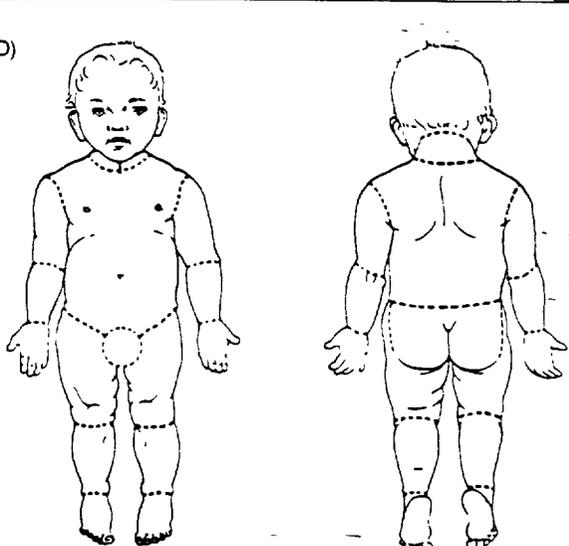
CARDIAC STATUS

Pain: NO YES
 Severity: Mild Mod Severe
 Type: Constant Intermittent Other
 Location: _____ Duration: _____

NEUROLOGICAL ASSESSMENT				
	INFANT	CHILD	ADULT	SCORE
EYE	OPENS SPONTANEOUSLY			4
	OPENS TO SPEECH			3
	OPENS TO PAIN			2
MOTOR	NIL			1
	SPON MOVEMENTS	OBEYS COMM	OBEYS COMM	6
	WITHDRAWS TO TOUCH	LOCALIZES	LOCALIZES	5
	WITHDRAWS TO PAIN	WITHDRAWS	WITHDRAWS TO PAIN	4
	FLEXION	FLEXION	FLEXION	3
	EXTENSION	EXTENSION	EXTENSION	2
VERBAL	NIL			1
	COOS & BABBLING	ORIENTED	ORIENTED	5
	IRRITABLE CRY	CONFUSED	DISORIENTED	4
	CRIES TO PAIN	INAPPROPRIATE	INAPPROPRIATE	3
	MOANS TO PAIN	INCOMPREHENSIBLE	INCOMPREHENSIBLE	2
NIL				1
TOTAL 3-15				15



- INJURY/LACERATION (LABEL AND SHADE AREAS INVOLVED)**
- A - ABRASIONS
 - B - BRUISE
 - C - BURNS 1° 2° 3°
 - D - FOREIGN BODY
 - E - LACERATION
 - F - PUNCTURE
 - G - POSSIBLE FX
 - H - C/O PAIN
 - I - REDDENED
 - J - PRESSURE SORE
 - K - SWELLING
 - L - SHUNT
 - M - HEMATOMA



MEDICATIONS: Amoxil, fentives

INITIAL ASSESSMENT: _____ R N NS SIGNATURE/INITIAL

PRIMARY NS SIGNATURE/INITIAL: _____ SIGNATURE/INITIAL

**PATIENT FLOWSHEET
DEPARTMENT EMERGENCY
MEDICINE**

000021

AFTERCARE INSTRUCTIONS FOLLOWING EMERGENCY TREATMENT

Thank you for letting us serve you today. Be sure that you read and understand all instructions before signing below. You should follow the physician's advice and these instructions closely as a safeguard against complications. The medical care you have received in the emergency facility is not intended to be a substitute for or an effort to provide complete medical care. It is important that you let your personal/referral physician check you again and that you report to the physician any new/continuing problems, because it is impossible to recognize and treat all elements of injury or illness in a single emergency visit. When you visit your physician, please take along this instruction sheet and any prescribed medication. *Your X-rays have been reviewed on a preliminary basis only. Attempts will be made to notify you when final interpretation of your X-rays by a radiologist differs significantly from the initial reading of your X-rays. Additionally, attempts will be made to notify you whenever culture or other test results such as EKG indicate the need to change your treatment.* Your physician may call the hospital for the results of any of your tests. Culture results usually take 24-72 hours.

PRINTED AFTERCARE INSTRUCTIONS

- WOUND CARE FRACTURES SPRAINS & STRAINS GI HEAD INJURY
- PEDIATRICS
- FEVER CONTROL VOMITING & DIARRHEA RESPIRATORY DPT

TREATMENT PROVIDED AT THIS FACILITY

- LAB TESTS CULTURE X-RAY EKG SUTURED
- MEDICATION/S DT DPT TETANUS HYPERTET

THE PHYSICIAN/S WHO SAW YOU

PRELIMINARY DIAGNOSIS (This is not your final diagnosis)

*Dizziness & Vomiting
Viral infection*

MEDICATION

Until you see your physician you should follow the label instructions for any prescription. Most illnesses and many medications affect your alertness. If you are not as alert as usual, you must avoid dangerous activities such as driving a car, working with machinery or working in high or unprotected places.

FOLLOW-UP WITH THE FOLLOWING PHYSICIAN/S

CARD/S PROVIDED

Dr

IN 1-2 DAYS FOR RE-EXAM & RE-EVALUATION/WOUND CHECK

RETURN TO THIS FACILITY AT ANY TIME IF YOU DO NOT GET BETTER OR YOUR CONDITION BECOMES WORSE.

Call this physician/clinic/hospital promptly to make an appointment. Arrange an earlier appointment if you or your physician think it is necessary and take your instructions and medications with you. Immediately contact this emergency facility if you have difficulty in obtaining follow-up with your personal/referral physician.

I hereby acknowledge that I have received and understand these aftercare instructions and I acknowledge that I have all my belongings and valuables.

PATIENT/
RESPONSIBLE PARTY
SIGNATURE _____

NURSE'S
SIGNATURE _____

DATE 4-21-93

OTHER AFTERCARE INSTRUCTIONS

Use suppositories as directed for Nausea

Stop taking Amoxil

DIET

- REGULAR DIET INCREASE FLUID INTAKE LIQUID DIET
- FOLLOW PEDIATRIC VOMITING & DIARRHEA INSTRUCTIONS
- SOFT DIET NOTHING BY MOUTH

ACTIVITY

- NO RESTRICTIONS NO WORK/SCHOOL NO PE
- LIMITED DUTY* BED REST EASY ACTIVITY
- CRUTCH WALKING

*Work Release must be obtained from Referral M.D.

AFTERCARE INSTRUCTIONS

000022

NURSING RECORDS

TIME	BP	T/P/R	INPUT		OUTPUT		SaO ₂	SIDE RAILS (L/T)	PATIENT CARE NOTES	INIT.
			PO	IV	GI	URINE				
1240									pt to [redacted] unsteady gait pt states can't keep anything down	
1250									Exam by Dr [redacted]	
1335									Blood drawn from arm + sent to lab	
1415									Medicated R for N/V...	
1500	142/80	92				214			Re-eval by [redacted] pt advised comfortable. remains dizzy Home - mother Rx given NAD	
TOTAL I/O										

000023

DATE OF EMERGENCY DEPARTMENT EXAMINATION: 4/21/93

This 37-year-old female arrived at this facility at 1121 and was seen by me at 1248. The patient apparently has had an abrupt onset of nausea and vomiting and dizziness, especially with any motion, since Monday. She apparently saw Dr. [REDACTED] on Tuesday and was placed on Antivert and Amoxil. She continues to have significant problems including vomiting. She also has a minimal frontal headache. She denies pregnancy. She feels like she is seasick. She has had no chills. Apparently she is unable to retain any fluids.

PHYSICAL EXAMINATION:

GENERAL: Alert and awake female.

VITAL SIGNS: Temperature 97.7°; pulse 93; respiratory rate 16; blood pressure 170/92.

HYDRATION: Normal.

NEUROLOGICAL: She is alert and awake, oriented. PERL. No definite focal signs. Gait not tested at present. Eye examination shows no significant nystagmus. Motion leads to dizziness symptoms.

NECK: Supple.

CHEST: Equal breath sounds, clear.

HEART: Regular rhythm. No murmurs.

ABDOMEN: Benign.

CBC came back with a white count of 8400, H&H 15/42. SMA came back normal. Tigan rectal suppository 200 mg per rectum was given.

At 1500 hours lab is checked and is okay. Patient feeling better. Friend is present. There is also a slight eruptive rash of the face and neck which she states she gets when she is under stress. I have advised both the patient and her friend regarding diagnostic possibilities. Patient discharged home. Advised to stop Amoxil. She is to take Antivert two tid (apparently they are 25 mg), prescription for Tigan written, bedrest, clear fluids, re-check if worse, referral to Dr. [REDACTED] within two days.

DIAGNOSIS:

1. Acute dizziness with vomiting, probable viral process.

SIGNED _____

M.D.

M.D.

DD: 4/21/93

DT: 4/23/93

CC: _____ M.D.

PATIENT _____

HOSPITAL# _____

PHYSICIAN _____

ROOM ED

M.D.

EMERGENCY DEPARTMENT SUMMARY

000025

NAME :
H# :
R# :

NS: [REDACTED] DR: [REDACTED]
ROOM: [REDACTED] SEX: F P#: [REDACTED]
DOB: [REDACTED]

***** B L O O D C E L L P R O F I L E *****

TEST:	RBC	HGB	HCT	MCV	MCH	MCHC	RDW-SD
LO-HI:	4.2-5.4	12-16	37-47	82-100	27-32	32-36	37.0-47.0
UNITS:	MILL/CMM	GM/DL	%	CU.MIC.	PG	%	FL
\C04/21/93	4.76	15.1	42.5	89.3	31.7	35.5	42.3
\ 1332HR							

TEST:	PLT COUNT	MPV	WBC
LO-HI:	150-350	7.4-10.4	4.3-10.8
UNITS:	THS/CMM	FL	THS/CMM
\C04/21/93	280	10.0	8.4
\ 1332HR			

***** D I F F E R E N T I A L *****

TEST:	POLYS	LYMPHS	MONOS	EOS	BASOS
UNITS:	%	%	%	%	%
\C04/21/93	78	16	4	.2	1.1
\ 1332HR					

***** R O U T I N E C H E M I S T R Y *****

TEST:	NA	K	CL	CO2	BUN	CREATININ
LO-HI:	137-145	3.6-5.0	101-111	22-31	7-18	.7-1.2
UNITS:	MEQ/L	MEQ/L	MEQ/L	MEQ/L	MG/DL	MG/DL
\C04/21/93	141	4.0	99	27	9	.8
\ 1332HR						

***** N O N - F A S T I N G G L U C O S E *****

TEST:	GLUCOSE
UNITS:	MG/DL
\C04/21/93	97
\ 1332HR	

***** C H E M I S T R Y *****

TEST:	CALCIUM	MAGNESIUM	BILI TOT	ALT/SGPT	AMYLASE	LIPASE	ALK PTASE
LO-HI:	9.1-10.6	1.7-2.2	.2-1.3	7-56	30-110	23-203	38-126
UNITS:	MG/DL	MG/DL	MG/DL	UNITS/L	UNITS/L	UNITS/L	UNITS/L
\C04/21/93	9.3	2.1	.6	16	70	74	61
\ 1332HR							

***** C A R D I A C E N Z Y M E S *****

TEST:	CPK
LO-HI:	35-230
UNITS:	UNITS/L
\C04/21/93	31
\ 1332HR	

000026

INITIAL

EMERGENCY DEPARTMENT VALUABLES CHECKLIST

- | | | | |
|---|-------|--|-------|
| <input type="checkbox"/> BELT | A B C | <input type="checkbox"/> PURSE/WALLET | A B C |
| <input type="checkbox"/> BRA | A B C | <input type="checkbox"/> RINGS # _____ | A B C |
| <input type="checkbox"/> BRACELET # _____ | A B C | <input type="checkbox"/> ROBE | A B C |
| <input type="checkbox"/> CANE/WALKER | A B C | <input type="checkbox"/> SCARF | A B C |
| <input type="checkbox"/> COAT | A B C | <input type="checkbox"/> SHIRT/BLOUSE | A B C |
| <input type="checkbox"/> CONTACTS | A B C | <input type="checkbox"/> SHOES | A B C |
| <input type="checkbox"/> DENTURES/PLATE | A B C | <input type="checkbox"/> SKIRT | A B C |
| <input type="checkbox"/> DRESS | A B C | <input type="checkbox"/> SLACKS | A B C |
| <input type="checkbox"/> EARRINGS # _____ | A B C | <input type="checkbox"/> SLIP | A B C |
| <input type="checkbox"/> GLASSES | A B C | <input type="checkbox"/> SLIPPERS | A B C |
| <input type="checkbox"/> HAT | A B C | <input type="checkbox"/> SOCKS | A B C |
| <input type="checkbox"/> JEANS | A B C | <input type="checkbox"/> SUITCASE | A B C |
| <input type="checkbox"/> KEYS | A B C | <input type="checkbox"/> SWEAT PANTS | A B C |
| <input type="checkbox"/> NECKLACE | A B C | <input type="checkbox"/> SWEATER | A B C |
| <input type="checkbox"/> NIGHTGOWN | A B C | <input type="checkbox"/> VEST | A B C |
| <input type="checkbox"/> PAJAMAS | A B C | <input type="checkbox"/> WATCH | A B C |

MONEY:

AMOUNT:

MEDICATION: _____

OTHER: _____

SIGNATURE: _____

WITNESS: _____

A — WITH PATIENT B — FAMILY/FRIEND C — OTHER

DISPOSITION SUMMARY

TIME	CONDITION			
	<input type="checkbox"/> IMPROVED <input type="checkbox"/> UNCHANGED <input type="checkbox"/> UNSTABLE <input type="checkbox"/> EXPIRED			
DISCHARGED		<input type="checkbox"/> W/ACI <input type="checkbox"/> W/O ACI <input type="checkbox"/> AMA <input type="checkbox"/> ELOPED <input type="checkbox"/> IN CUSTODY/JAIL WARD		TRANSFERRED: LOCATION: _____
ADMITTED:		ROOM		PHYSICIAN ACCEPTING: _____ MODE: _____
<input type="checkbox"/> STRETCHER <input type="checkbox"/> W/C <input type="checkbox"/> CRIB				<input type="checkbox"/> AUTO/TAXI <input type="checkbox"/> EMT. AMB <input type="checkbox"/> PM. AMB <input type="checkbox"/> CCT <input type="checkbox"/> HELICOPTER
OXYGEN	IV IN PLACE	MONITOR/DEFIB.	RHYTHM	SENT WITH PATIENT:
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> TEST RESULTS <input type="checkbox"/> X-RAYS <input type="checkbox"/> BELONGINGS <input type="checkbox"/> COPY OF CHART
ACLS DRUGS	SUCTION	ACCOMPANIED BY		DEATH:
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO			CORONERS: <input type="checkbox"/> YES # _____ <input type="checkbox"/> NO
REPORT GIVEN TO:				BODY TO: <input type="checkbox"/> MORGUE

000027

EMERGENCY DEPARTMENT ADMISSION

MEDICAL RECORD NO	PT	FC	ADMIT DATE	ADMIT TIME	DISCH DATE	DISCH TIME	ROOM BED	AC	MED SERV	SEX	ACCOUNT ID
[REDACTED]	[REDACTED]	[REDACTED]	04/21/73	1152	1-21-73	1500	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

PATIENT NAME: LAST [REDACTED] FIRST [REDACTED] MI [REDACTED]

ADDRESS [REDACTED] APT [REDACTED]

CITY/STATE [REDACTED]

ZIP CODE [REDACTED] PHONE [REDACTED]

PREADMIT DATE [REDACTED]

OB/OR DATE [REDACTED]

EMPLOYER [REDACTED]

ADDRESS [REDACTED]

CITY/STATE [REDACTED]

ZIP CODE [REDACTED] PHONE [REDACTED]

ADM TYPE [REDACTED] ADM SOLB [REDACTED]

AGE 57 BIRTHDAY [REDACTED]

ALLERGY N CDL [REDACTED]

SMOKER [REDACTED] ADMIT BY [REDACTED]

RELIGION LU CHURCH [REDACTED]

VALUABLES [REDACTED] POLICE [REDACTED]

NEW EST [REDACTED] MODE ARR WALK-IN

SOCIAL SEC# [REDACTED] EMP ID# [REDACTED]

UNION NAME [REDACTED] LOCAL# [REDACTED]

EMERGENCY CONTACT [REDACTED]

ADDRESS [REDACTED]

CITY/STATE [REDACTED]

ZIP [REDACTED] REL FO

DAY PHONE [REDACTED] NIGHT PHONE [REDACTED]

EMPLOYER [REDACTED]

ADDRESS [REDACTED]

PHONE [REDACTED]

OCCUPATION PROGRAM MANAGER

NAME [REDACTED]

ADDRESS [REDACTED]

CITY/STATE [REDACTED]

ZIP CODE [REDACTED] REL SP

DAY PHONE [REDACTED] NIGHT PHONE [REDACTED]

EMPLOYER [REDACTED]

ADDRESS [REDACTED]

CITY/STATE [REDACTED]

ZIP CODE [REDACTED] PHONE [REDACTED]

SOCIAL SEC# [REDACTED]

OCCUPATION TEACHER

CD INSURANCE CO	SUBSCRIBER	REL	ASSIG AUTH NO	CERT NO.	GROUP NO.
[REDACTED]	[REDACTED]	SP	[REDACTED]	[REDACTED]	[REDACTED]

NAME [REDACTED] PHONE [REDACTED] FAMILY M [REDACTED]

TIME [REDACTED] PLACE OF ACCIDENT [REDACTED]

CRIP F ACCIDENT [REDACTED]

PLAINT HA. DIZZINESS, VOMITING SINCE MON NOC. STARTED ON [REDACTED]

1. **CONSENT FOR TREATMENT:** Having been admitted to the Emergency Department of the [REDACTED] I hereby consent to and authorize the administration of all emergency, diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the attending physician. The undersigned further consents to, and authorizes, demonstration, and/or observation and/or treatment of patient during administration of medical treatment or surgical procedures, by physicians, dentists and physician residents and any other physician whose presence is deemed appropriate by the attending physician. Consent also enables physicians, dentists and physician residents to follow the medical management of the undersigned throughout the hospital system such as observing surgical procedures in the operating suites, observing procedures in the critical care units, and reviewing the daily management of the undersigned while in [REDACTED]. Consent also enables physicians, dentists and resident physicians to review all hospital clinical records that the undersigned accumulates during hospitalization at [REDACTED].
2. **AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize [REDACTED] and all my attending physicians to release the information to complete my hospital claim forms
3. **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby instruct my insurance carrier to make payment directly to [REDACTED] for the hospital expense benefits, otherwise payable to me, but not to exceed the hospital's regular charges for the services rendered. Fees for private practicing physicians will be billed separately. Furthermore, I instruct and authorize my insurance carrier to make payment for radiological service rendered directly to: Drs [REDACTED] or emergency physician service rendered directly to: [REDACTED]
4. **FINANCIAL RESPONSIBILITY:** I understand I am financially responsible to the above named hospital and doctors for charges
5. **RECEIPT OF INSTRUCTIONS:** I acknowledge and understand that I have received emergency first care only. This is intended to take care of any immediate emergency problem and not complete definitive diagnosis, medical care and treatment. I have been instructed and am personally responsible to immediately contact a physician, including my family physician or a physician assigned to me, or other medical facilities for continued and complete medical diagnosis, care and treatment if X-ray, EKG or studies have been interpreted on a preliminary basis, final interpretation will be [REDACTED] by the appropriate physician
6. If I should leave the hospital without the written consent of my attending physician, I hereby relieve said physician and the hospital of a [REDACTED] liability for my action

SIGNATURE (Responsible Party) [REDACTED] X

MEDICAL RECORDS BUSINESS OFFICE

000028

MEDICAL RECORDS

NAME

AGE

SEX

DATE

TIME

LAST VISIT

BED#

TRIAGE RECORD

CHIEF COMPLAINT

(L) KNEE PAIN
SKIN ACCIDENT

VITALS: T

98.2 P 100 R 18 BP 190

WGT: 145

VA: 10

TET

MEDS: None

ELAVIL, LOESTRINTZ

ALLERGIES: None

Authorization Rec'd

PMD None

Notified by

Signature:

EMERGENCY PHYSICIAN RECORD

2105

AC on above

Swollen left knee - severely
Anterior pain
SI effusion
near to pain
MM without
MC + CC L OK

0800

WJ ? medial plateau fr

2230

probable tibial plateau
pt + male perid amed

- O2
- ABG pH PO2 PCO2
- Monitor
- EKG
- IV
- Hgb/Hct
- Blood
- CBC WBC

POLYS	BANDS	LYMPHS	M	E
-------	-------	--------	---	---
- LYTES SMA-6 SMA-20
- Na K
- Cl CO2
- GLU BUN Cr
- Serum Amylase Urine Amylase
- CPK Liver Profile
- Preg Test
- UA Dip CC Cath
- WBC RBC Bact
- Skull
- Head CT Infusion
- C-spine Limited
- CXR Port Upright
- Abdomen
- Pelvis
- Ultrasound

000029

AC to trial
plateau fr

DISCHARGE CONDITION

- SEE INITIAL ORDERS
- SEE TRAUMA ORDERS

XR left knee - shelf
obvious

Repeat Q/P 104/104

no tx in 800 i po

Get tibial plateau
2230 knee instability
Anterior
DIC 55.9.5
401.9

Stable

DISPOSITION

- HOME
- ADMIT
- TRANSFER
- CONSULT
- AC

Went home, elevate and ice
Get R/P checked
AC noted + motion
IMD. REFERRAL RMD + ORT 10 w/ 720 in days

DISCHARGE IMPRESSION

Acute left knee pain
probable tibial
plateau vs Acute
ligamentary

MD Signature

DEPARTMENT OF EMERGENCY MEDICINE
Nursing Record

DATE 2/12/93

AGE 36

HOW ARRIVED WALKED WHEELCHAIR AMBULANCE CRUTCHES CARRIED FROM HOME SNF OTHER

CHIEF COMPLAINT (4) Knee Pain TIME 0855 INFORMANT SELF PARENT OTHER
ARRIVED WITH: Self Parent Spouse
 Friend Police Paramedic
 Other

LEVEL OF CONSCIOUSNESS:
 Awake Alert
 Oriented X 4
 Purposeful response to pain
 Non-purposeful response to pain
 Unresponsive to pain
 Odor of alcohol on breath
 Lethargic
 Disoriented
 Combative

MENTAL ASSESSMENT:
PHYSICAL APPEARANCE
GAIT Normal Unstable
HYGIENE Normal Other
OVERALL PE Normal Frail Robust

VISUAL OS ACUITY: OD _____ OS _____
 Glasses Contact Lens

MEDICAL HISTORY: Blind Deaf/hard of hearing
 Asthma COPD Hypertension No previous med
 Cardiac Seizures None available
 Diabetes PUD
 Other

RESPIRATORY: N/A
CHEST SYMMETRICAL Y/N
Breath sounds
 Clear
 Rales
 Wheezes
 Diminished
 Absent
Dyspnea
Retraction
Nasal flaring
Cough
 Productive
 Non-productive

MOOD/AFFECT
 Appropriate Cooperative
 Inappropriate Fearful
 Blunted/flat Hopelessness
 Defensive

ALLERGIES: NKA

MEDS: NONE See trays

MEMORY - RECENT THOUGHTS
 Intact Impaired
 Clear
 Vague/disconnected
 Spontaneous
 Slow to answer questions

LAST TETANUS: _____

SPEECH
 Normal Clear
 Silent Mumbling/Garbled
 Talkative Monotone
 Loud Slurred
 Deliberate

CARDIAC STATUS N/A
Pain NO YES
Severity Mild Mod Severe
Type Constant Intermittent Other
Location _____
Duration _____

BLEEDING:
 None Controlled
 Uncontrolled Unobservable
SITE: _____

SKIN: COLOR: NORMAL
 Pale/ashen Dry Moist Profuse
 Cyanotic SKIN TEMP: Warm
 Flushed Hot Cold
 Cool

Pedal Edema NO YES
JVD NO YES

GU:
 Incontinent
 Frequency
 Urgency
 Retention
 Foley
 N/A

GI:
 Diarrhea
 Constipation
 Nausea
 Vomiting
 Other
 N/A

ABDOMINAL STATUS N/A
Pain NO YES
Location _____
Duration _____

GYN STATUS N/A
LNMP _____ G _____ P _____ Ab _____
Vagina Bleeding NO YES
Pregnant NO YES _____ MOS _____ FHT
 Refer to triage notes EDC _____

GLASGOW COMA SCALE		INITIAL	5 MIN	30 MIN	60 MIN
1 EYE OPENING	Spontaneous	4			
	To Voice	3			
	To Pain	2	<u>4</u>		
	None	1			
2 VERBAL RESPONSE	Oriented	5			
	Confused	4			
	Inappropriate Words	3			
	Incomprehensible Words	2	<u>5</u>		
3 MOTOR RESPONSE	None	1			
	Obeys Commands	6			
	Purposeful Movement (Pain)	5			
	Withdraw (Pain)	4	<u>6</u>		
	Flexion (Pain)	3			
EXTENSION (Pain)	None	1			
	Extension (Pain)	2			
	None	1			
GLASGOW COMA SCALE TOTAL					

KEY

- A Abrasion
- B Burn
- C Contusion
- D Amputation
- E Paralysis
- F Fracture
- G Gunshot Wd
- H Open fracture
- I Stab Wd
- J Pain
- K Paresthesia
- L Laceration

PUPILARY RESPONSE

- C Constricted
- D Dilated
- E Equal
- F Fixed
- N/R Nonreactive
- R Reactive
- S Sluggish
- U Unequal

GLASGOW COMA SCALE TOTAL		INITIAL	5 MIN	30 MIN	60 MIN
RIGHT PUPILS	SIZE:				
	RESPONSE:				
LEFT PUPILS	SIZE:				
	RESPONSE:				

Signatures _____ Date 2/12/93 Time 0855
Initial Assess _____ Signature _____
Primary Nurse (RN only) _____ Signature _____

Department of Emergency Medicine
Nursing Record

Name [REDACTED]

TIME	TEMP	B.P.	PULSE	R.R.	P/OX	SIDE RAILS	EKG
2155		104/109	100	16		↑ ↓	

Time Initial

2055 By w/c 7
Prepared for exam -
(L) Knee (red, swollen)
& tender to touch.
Also fair E movement

TIME	ORTHOSTATIC VITALS	BP	PULSE	INIT
	LYING			
	SIT			
	STAND			

2130 PT to X-ray
2155 Returned to ER
2210 Back to X-ray
2230 Returned to ER
2245 OC'd in NAD E

TIME	MEDICATIONS	MODE	PLACE	RESPONSE	INIT
	Morun 800mg po			improved.	

(L) knee immobilizer
intact. Ambulatory
on crutches,
displays proper
crutch walking
technique.

TIME	IV SOLUTIONS	GAUGE	PLACE	TIME	AMOUNT ABSORBED	INIT

TIME	OUTPUT/SOURCE	ORAL	URINE	NG	OTHER	OUTPUT	INIT

TIME	INTAKE TOTAL	OUTPUT TOTAL	INIT

Transfer/Discharge Summary

Condition Improved Unchanged Stable Expired Other _____

Discharged W/ACI WO/ACI AMA Other _____

Discharged with Self Family Friend _____

Admitted Room Gurney WC Time _____

Accompanied by _____

O2 No Yes Cardiac Monitor No Yes Cardiac Drugs No Yes

Transferred Location _____ Time _____ Report to _____

Transported by Pvt. Auto EMT PM Helicopter

Copies Sent X-rays Chart Belongings Sent

Family/Friend Notified Yes (Name: _____) No Unable

SIGNATURES

[REDACTED] INIT [REDACTED] NAME AND TITLE [REDACTED]

AFTERCARE INSTRUCTIONS FOLLOWING EMERGENCY TREATMENT

Thank you for letting us serve you today. Be sure that you read and understand all instructions before signing below. You should follow the physician's advice and these instructions closely as a safeguard against complications. The medical care you have received in the emergency facility is not intended to be a substitute for or an effort to provide complete medical care. It is important that you let your personal/referral physician check you again and that you report to the physician any new/continuing problems, because it is impossible to recognize and treat all elements of injury or illness in a single emergency visit. When you visit your physician, please take along this instruction sheet and any prescribed medication. *Your X-rays have been reviewed on a preliminary basis only. Attempts will be made to notify you when final interpretation of your X-rays by a radiologist differs significantly from the initial reading of your X-rays. Additionally, attempts will be made to notify you whenever culture or other test results such as EKG indicate the need to change your treatment.* Your physician may call the hospital for the results of any of your tests. Culture results usually take 24-72 hours.

PRINTED AFTERCARE INSTRUCTIONS

- WOUND CARE FRACTURES SPRAINS & STRAINS G.I HEAD INJURY
- PEDIATRICS
- FEVER CONTROL VOMITING & DIARRHEA RESPIRATORY DPT

TREATMENT PROVIDED AT THIS FACILITY

- LAB TESTS CULTURE X-RAY EKG SUTURED
- MEDICATION/S DT DPT TETANUS HYPERTET

THE PHYSICIAN/S WHO SAW YOU

Dr. [REDACTED]

OTHER AFTERCARE INSTRUCTIONS

Take your medications as directed.
 wear knee immobilizer
 Use crutches
 Get your blood pressure rechecked.
 Elevate @ leg & use cold compresses.
 No weight bearing on @ leg.

PRELIMINARY DIAGNOSIS (This is not your final diagnosis)

Acute Tibial Plateau Fracture
 Hypertension

MEDICATION

Until you see your physician you should follow the label instructions for any prescription. Most illnesses and many medications affect your alertness. If you are not as alert as usual, you must avoid dangerous activities such as driving a car, working with machinery or working in high or unprotected places.

FOLLOW-UP WITH THE FOLLOWING PHYSICIAN/S

Dr. [REDACTED] and [REDACTED] ortho doctor ([REDACTED]) CARD/S PROVIDED

IN 3 DAYS FOR RE-EXAM & RE-EVALUATION/WOUND CHECK

RETURN TO THIS FACILITY AT ANY TIME IF YOU DO NOT GET BETTER OR YOUR CONDITION BECOMES WORSE.

Call this physician/clinic/hospital promptly to make an appointment. Arrange an earlier appointment if you or your physician think it is necessary and take your instructions and medications with you. Immediately contact this emergency facility if you have difficulty in obtaining follow-up with your personal/referral physician.

I hereby acknowledge that I have received and understand these aftercare instructions and I acknowledge that I have all my belongings and valuables.

DIET

- REGULAR DIET INCREASE FLUID INTAKE LIQUID DIET
- FOLLOW PEDIATRIC VOMITING & DIARRHEA INSTRUCTIONS
- SOFT DIET NOTHING BY MOUTH

ACTIVITY

- NO RESTRICTIONS NO WORK*/SCHOO. NO P.E.
- LIMITED DUTY* BED REST EASY ACTIVITY
- CRUTCH WALKING

PATIENT/RESPONSIBLE PARTY SIGNATURE [REDACTED]

NURSE'S SIGNATURE [REDACTED]

DATE 2/12/93

*Work Release must be obtained from Referral M.D.



AFTERCARE INSTRUCTIONS



F 36
 MRUN: [REDACTED]
 Loc: [REDACTED]
 IC: [REDACTED]
000032

RADIOLOGISTS

RADIOLOGISTS

LAST NAME	FIRST NAME	MIDDLE NAME	SEX	ACCOUNT NO.
			F	
ORDERING PHYSICIAN			LOCATION	MEDICAL RECORD NO.
REFERRING PHYSICIAN	DOB	AGE	DATE OF EXAM	RADIOLOGY NO.
		36	02/12/93	

REPORT

EXAMS: LEFT KNEE

LEFT KNEE:

There is a nondisplaced fracture through the lateral tibial plateau. There is a joint effusion. There are no other fractures identified.

IMPRESSION:

THERE IS A FRACTURE INVOLVING THE LATERAL TIBIAL PLATEAU.

CC:

CODE:
 TRANSCRIBED DATE/TIME: 02/13/93 1045
 TRANSCRIPTIONIST:
 PRINTED DATE/TIME: 02/13/93 1054

PAGE 1

CHART COPY

M.D.

000033

[Redacted]

Address _____ Date 2/12/92

R Acetaminophen 600mg / 5HTA x 5 d

R Vuoden 960 mg severe pain

R _____ as a prescription.

Copy for information only.
Federal Law prohibits

TOTAL R 2 3

LABEL WITH APPROPRIATE WARNINGS

- TAKE WITH MEALS/FOOD/LIQUIDS
- NO DAIRY PRODUCTS
- DO NOT SUBSTITUTE

[Redacted]

PRINT NAME

NO REFILLS

[Redacted] 1 [Redacted] [Redacted] [Redacted]

[Redacted]

000034

EMERGENCY DEPARTMENT ADMISSION

MEDICAL RECORD NO	PT	FC	ADM DATE 02/12/93	ADM TIME 2106	DISCH DATE 2/12/93	DISCH TIME 2245	ROOM BED	AC	MED SERV	SEX	ACCOUNT
PATIENT NAME [REDACTED]			ADDRESS [REDACTED]			CITY/STATE [REDACTED]			ZIP CODE [REDACTED]		
PREADMIT DATE [REDACTED]			OB/OR DATE [REDACTED]			ADM TYPE [REDACTED]			ADM SOURCE EMERGENCY DEPARTMENT		
EMPLOYER [REDACTED]			ADDRESS [REDACTED]			CITY/STATE [REDACTED]			ZIP CODE [REDACTED]		
PHONE [REDACTED]			SOCIAL SEC# [REDACTED]			EMP ID# [REDACTED]			UNION NAME [REDACTED]		
LOCAL# [REDACTED]			EMERGENCY CONTACT [REDACTED]			ADDRESS [REDACTED]			CITY/STATE [REDACTED]		
PHONE [REDACTED]			DAY PHONE [REDACTED]			GHT PHONE [REDACTED]			OCCUPATION [REDACTED]		
NAME [REDACTED]			ADDRESS [REDACTED]			CITY/STATE [REDACTED]			ZIP CODE [REDACTED]		
DAY PHONE [REDACTED]			PHONE [REDACTED]			SOCIAL SEC# [REDACTED]			OCCUPATION [REDACTED]		
CD INSURANCE CO. [REDACTED]			SUBSCRIBER [REDACTED]			REL ASSIG AUTH NO [REDACTED]			CERT NO [REDACTED]		
GROUP NO [REDACTED]			NAME [REDACTED]			PHONE [REDACTED]			FAMILY M [REDACTED]		
DATE 02/12/93			TIME 0930			PLACE OF ACCIDENT [REDACTED]			SC [REDACTED]		
N OF ACCIDENT [REDACTED]			OTHER ACCIDENT [REDACTED]			CHIEF COMPLAINT TRIPES: KNEE PAIN SKIING ACCIDENT					

1. **CONSENT FOR TREATMENT:** Having been admitted to the Emergency Department of the [REDACTED], I hereby consent to and authorize the administration of all emergency, diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the attending physician. The undersigned further consents to, and authorizes, demonstration, and/or observation and/or treatment of patient during administration of medical treatment or surgical procedures, by physicians, dentists and physician residents and any other physician whose presence is deemed appropriate by the attending physician. Consent also enables physicians, dentists and physician residents to follow the medical management of the undersigned throughout the hospital system such as observing surgical procedures in the operating suites, observing procedures in the critical care units, and reviewing the daily management of the undersigned while in [REDACTED]. Consent also enables physicians, dentists and resident physicians to review all hospital clinical records that the undersigned accumulates during hospitalization at [REDACTED].
2. **AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize [REDACTED] and all my attending physicians to release the information to complete my hospital claim forms.
3. **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby instruct my insurance carrier to make payment directly to [REDACTED] for the hospital expense benefits, otherwise payable to me, but not to exceed the hospital's regular charges for the services rendered. Fees for private practicing physicians will be billed separately. Furthermore, I instruct and authorize my insurance carrier to make payment for radiological service rendered directly to: Drs. [REDACTED] or emergency physician service rendered directly to: [REDACTED].
4. **FINANCIAL RESPONSIBILITY:** I understand I am financially responsible to the above named hospital and doctors for charges.
5. **RECEIPT OF INSTRUCTIONS:** I acknowledge and understand that I have received emergency first care only. This is intended to take care of any immediate emergency problem and not complete definitive diagnosis, medical care and treatment. I have been instructed and am personally responsible to immediately contact a physician including my family physician or a physician assigned to me, or other medical facilities for continued and complete medical diagnosis, care and treatment. If X-Ray, E.K.G., or studies have been interpreted on a preliminary basis, final interpretation will be performed by the appropriate physician.
6. If I should leave the hospital without the written consent of my attending physician, I hereby relieve said physician and the hospital of all responsibility for my action.

SIGNATURE (Responsible Party) [REDACTED] X	SIGNATURE [REDACTED] X
<input checked="" type="checkbox"/> MEDICAL RECORDS <input type="checkbox"/> BUSINESS OFFICE	000035