

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

ARMS#

12975



8 - OTHER

000001

ER

ACCOUNT NUMBER

ADMISSION DATE TIME

DISCHARGE DATE TIME

1-03-98 18:15

1-5-98 1410

PATIENT

[REDACTED]

[REDACTED]

[REDACTED]

SEX M	RACE W	MARITAL STATUS S	AGE 23	BIRTH DATE [REDACTED]	ADM CLERK [REDACTED]
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ROOM NO SERVICE

MED

RELIGION - CTH
CHURCH - CATHOLIC

PATIENT EMPLOYER

LAST I.P. DISCHARGE DATE

LAST O.P. VISIT DATE

NAME THEN -

MAIDEN NAME -

NEXT OF KIN FATHER

OCCUPATION -

RESPONSIBLE PARTY FATHER

[REDACTED]

[REDACTED]

[REDACTED]

SOCIAL SECURITY NO - [REDACTED]
EMPLOYED BY - [REDACTED]

PHYSICIANS

[REDACTED]

ACCIDENT DATE

INJURY COMP

HOOR -

WHERE -

ADM
DIAG

SURGERY

NEW ONSET SEIZURES

PRINCIPAL DIAGNOSIS: (The condition established after study to be chiefly responsible for the patient's admission to the hospital)

New onset of grand mal seizure, epilepsy.

Service 10-19-98 Days 2

OTHER DIAGNOSES

Laceration of tongue with cellulitis due to biting during seizure.

PROCEDURES

Medical.

000003

DATE DICTATED

H & P _____
 O R _____
 C S _____

AUTOPSY YES NO

(ADDITIONAL TREATMENT and SUMMARY INFORMATION - Page 2)

SUMMARY 1 CONDITION AT DISCHARGE

2 PROGNOSIS

I CERTIFY THAT THE NARRATIVE DESCRIPTIONS OF THE PRINCIPAL AND SECONDARY DIAGNOSES AND THE MAJOR PROCEDURES PERFORMED ARE ACCU

RESIDENT

ATTENDING PHYSICIAN

DATE 1/29/98

MEDICAL RECORD NO

PATIENT

ROOM NO

DOCTOR

EMERGENCY RECORD

BIRTH DATE AGE SEX MAR STAT SMOK

[REDACTED] 23 M S

DISCH. DATE TIME

PATIENT
NEXT OF KIN
RESPIRATORY

PHONE

PREV ADMIT MAIDEN NAME

EMERGENCY
NOTIFY
URAI

FATHER

FATHER

FRIEND

PHONE

SOCIAL SECURITY

PHONE

SERVICE E.M.R.

MODE OF ARRIVAL --- **AMB** DATE OF ONSET **1-03-98**

AMBULANCE CO ---

IF ACCIDENT HOW DID IT HAPPEN? DATE TIME

AUTO OTHER

WHERE? POLICE NOTIFIED

WORK OTHER HERE BADGE NO

PHYSICIAN
PRI

**PRIOR APPROVAL
REQUIRED**

CONSENT FOR DIAGNOSIS AND TREATMENT/AUTHORIZATION TO RELEASE INFORMATION

- I, [REDACTED], HEREBY VOLUNTARILY REQUEST, CONSENT TO, AND AUTHORIZE MY ATTENDING PHYSICIAN (OR THE PHYSICIAN WHO MAY BE ASSIGNED BY THE HOSPITAL WHETHER A STAFF PHYSICIAN OR AN INDEPENDENT CONTRACTOR), HIS ASSOCIATES, ASSISTANTS, OR OTHER PRACTITIONERS UNDER HIS ORDERS TO ATTEND ME AT [REDACTED] AND TO PROVIDE MEDICAL AND SURGICAL TREATMENT AND HOSPITAL CARE, INCLUDING, BUT NOT LIMITED TO, DIAGNOSTIC PROCEDURES, X-RAYS, AND ADMINISTRATION OF MEDICATIONS, AS IS DEEMED NECESSARY AND ADVISABLE. I AM AWARE THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT SCIENCE, AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULTS OF THE CARE AND TREATMENT WHICH I HAVE HEREBY AUTHORIZED.
- I AUTHORIZE [REDACTED] TO RELEASE TO ANY THIRD PARTY PAYOR, OR ITS REPRESENTATIVE, WHICH MAY BE RESPONSIBLE FOR PAYMENT IN MY CASE, OR AS REQUIRED BY LAW, SUCH INFORMATION FROM MY PATIENT RECORDS AS IS NECESSARY IN ORDER TO RECEIVE REIMBURSEMENT FOR ANY BILLINGS RENDERED RELATING TO MY TREATMENT, INCLUDING ALCOHOL AND DRUG ABUSE RECORDS PROTECTED UNDER THE REGULATIONS IN 42 CFR, PART 2, IF ANY, AND SOCIAL SERVICES RECORDS, IF ANY, AND PSYCHOLOGICAL SERVICES RECORDS, IF ANY, INCLUDING COMMUNICATIONS MADE BY ME TO A SOCIAL WORKER OR PSYCHOLOGIST. THIS CONSENT SHALL BE EFFECTIVE ONLY SO LONG AS NECESSARY TO OBTAIN REIMBURSEMENT AND WILL EXPIRE WHEN REIMBURSEMENT IS OBTAINED OR UNTIL REQUIRED THIRD PARTY PAYOR REVIEW OF NECESSARY RECORDS IS COMPLETED. THIS CONSENT IS SUBJECT TO REVOCATION AT ANY TIME WITH RESPECT TO ANY ALCOHOL OR DRUG ABUSE RECORDS, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN RELIANCE THEREON.
- I UNDERSTAND THE CONTENT AND SIGNIFICANCE OF THIS FORM, AND MY QUESTIONS HAVE BEEN ANSWERED.
- I FURTHER UNDERSTAND THAT ACT NO 488, PUBLIC ACTS OF 1988, OF THE [REDACTED] PERMITS AN HIV ANTIBODY TEST TO BE PERFORMED UPON A PATIENT WITHOUT THE WRITTEN CONSENT GENERALLY REQUIRED FOR HIV ANTIBODY TESTS (AIDS) IF THE HIV ANTIBODY TEST IS PERFORMED AFTER A HEALTH PROFESSIONAL OR OTHER HEALTH FACILITY EMPLOYEE SUSTAINS A PERCUTANEOUS MUCOUS MEMBRANE OR OPEN WOUND EXPOSURE TO THE BLOOD OR OTHER BODY FLUIDS OF THE PATIENT.

DATE SIGNED **1-03-98**

SIGNATURE OF PATIENT

(IF PATIENT IS A MINOR OR UNABLE TO CONSENT, COMPLETE THE FOLLOWING.)

PATIENT IS A MINOR _____ YEARS OF AGE; IS UNABLE TO CONSENT BECAUSE _____

SIGNATURE OF LEGAL GUARDIAN OR CLOSEST AVAILABLE RELATIVE

SIGNATURE OF WITNESS

AGAINST MEDICAL ADVICE VERIFICATION

(I) (WE) REFUSE HOSPITAL ADMISSION OR TREATMENT RECOMMENDED BY THE PHYSICIAN(S) AT [REDACTED] AND ASSUME FULL RESPONSIBILITY FOR LEAVING

SIGNED

RELATIONSHIP

DATE

MEDICAL RECORD NO

PATIENT

ROOM NO

ATTENDING AND/OR CONSULTING PHYSICIAN

00003