

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

ARMS#

13344



4 - ER URGENT

000001

Hours _____

Gas _____

AGE: 21

1/18/99

Ident # _____

Agency # _____

TIME (24 HOUR) _____ DATE 1/19/99 SQUAD _____ UNIT _____

Incident Occurred _____	Mileage In _____	CREW (Name & Title) _____
Call Received <u>1830</u>	Mileage Out <u>66555</u>	_____
Unit Enroute _____	Total Mileage _____	_____
Arrive/Scene <u>1810</u>	PATIENT _____	Med. Com. Hospital _____
Left Scene _____	Address _____	Receiving Hospital _____
Arrive/Destination _____	Phone # _____	Police Officer at Scene _____
Clear _____	History # _____	Activated For <u>Disoriented dt.</u>
Time In _____	Patient's Physician _____	Chief Complaint <u>Disoriented</u>
AGE <u>22</u> DOB _____		
<input checked="" type="checkbox"/> M <input type="checkbox"/> B <input type="checkbox"/> Other		
<input type="checkbox"/> F <input checked="" type="checkbox"/> W Weight _____ lbs.		

TIME	B.P.	PULSE	RESP.	BREATH SOUNDS	SKIN	PUPILS	LOSS OF CONSC.	CAP. REFILL
		_____/min. Regular Irreg. Strong Weak	_____/min. Normal Shallow Labored Abdominal	Clear Rales Ronchi Wheezes Diminished	L, R L, R L, R L, R L, R Moist Dry Jaundiced Hot Cold Cyanotic Pale Flushed Cool	Normal R > L L > R <u>Dilated</u> Constricted	YES NO ? Duration	Normal 2 sec Delayed > 2 sec None

NEUROLOGICAL				GLASGOW COMA SCALE				MEDICAL HISTORY						
S	Normal	M	Normal	E	Open	4	V	Oriented	5	M	Obey Command	6	<input type="checkbox"/> Allergies	<input type="checkbox"/> Psych.
E	Deficit	T	Deficit	Y	To Voice	3	E	Disoriented	4	O	Localize Pain	5	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures
N	Arm L, R	O	Arm L, R	E	To Pain	2	R	Inappropriate	3	T	Withdraw	4	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke
S	Leg L, R	T	Leg L, R	S	Not Open	1	A	<u>Incomprehensible</u>	1	O	Flexion	3	<input type="checkbox"/> High B.P.	<input type="checkbox"/> Cancer
O	<u>Unknown</u>	R	<u>med</u>				L	None		R	Extension	2	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Other
R											None	1		

HISTORY PRESENT ILLNESS / PHYSICAL EXAM

No vitals were taken -> Pt. combative
 Unresponsive to commands - No verbalization
 UnKnown Medical History
 Pt was on a ski trip all day - ate only a hot dog? A friend stated he had not acted like himself today - complained of stomach ache earlier today -

DENIES/NOT FOUND

TIME	B.P.	PULSE	RESP.	COMA SCALE	COMMENTS	AID GIVEN TO PATIENT
				E V M	(O ₂ flow, Mask, Splinting, Bandaging, MAST, I.V., Meds, EKG, Defib, etc.)	
				E V M	Oz NFB 15LA	
				E V M	1 entire tube of glucose administered	
				E V M		
				E V M		
				E V M		
				E V M		
				E V M		

CONDITION ON ARRIVAL AT E.R. unchanged APPROX. MILES TO E.R. _____ TOTAL I.V. FLUID GIVEN 000002

Physician's Signature: _____ Technician's Signature: _____

EMERGENCY DEPARTMENT RECORD

Name: [REDACTED]
Med Rec: [REDACTED]
Date of Service: 01/18/99
Log#: [REDACTED]

Attending Physician: [REDACTED] M.D.
Nurse Practitioner or Resident: [REDACTED] M.D.

DATE OF BIRTH: Unknown.

TIME OF INITIAL CONTACT: 19:30

CHIEF COMPLAINT: Unresponsive.

HISTORY OF PRESENT ILLNESS: The patient is a 22-year-old white male who was traveling home to [REDACTED] on a charter bus after a day of skiing at [REDACTED]. According to bus riders, the patient had a loss of consciousness with questionable seizure activity described as eyes rolling back in head, frothing at the mouth. Friends riding with the gentleman today say that he had not had any trauma or falls while at the ski resort today. A friend did report that the patient was not acting himself and was quite quiet and withdrawn today. Friend reports eating lunch with no other p.o. intake since then. The patient's friend described no ingestion of any toxic substance to their knowledge. The patient is otherwise reportedly with no medical history. No further information was gatherable secondary to the patient's mental status.

PAST MEDICAL HISTORY: Unknown.

PAST SURGICAL HISTORY: Unknown.

CURRENT MEDICATIONS: Unknown.

ALLERGIES: Unknown.

REVIEW OF SYSTEMS: Unobtainable.

SOCIAL HISTORY: Unknown.

PHYSICAL EXAMINATION: Blood pressure 160/90, pulse 120, respirations 12 to 16, temperature afebrile. In general, patient on a backboard with spider straps present, handcuffs and flailing all extremities about. He was very combative, not following commands and not directable. HEENT: Head is normocephalic, atraumatic with no focal evidence of trauma. Pupils are dilated to approximately 6 mm, minimally reactive bilaterally. Extraocular movements are roving in nature with no gaze preference noted. Tympanic membranes clear bilaterally. Oropharynx: Oral cavity is clear with moist mucous membranes. Neck: Trachea midline. No step-offs posteriorly. The patient thrashing about. Chest: No evidence of trauma. Breath sounds are clear bilaterally. Cardiovascular: Regular rate and rhythm. Significantly tachycardic. Abdomen soft, nontender and active bowel sounds. Pelvis is stable. Extremities with no evidence of trauma. Neuro: The patient is awake with a blank gaze. He is flailing all extremities and moving all extremities spontaneously and withdrawing to painful stimulus. The patient is nonverbal and not responding to simple questions. No focal deficits appreciated.

ORIGINAL COPY

000003

Continued...

DO NOT REMOVE FROM RECORD

Page: 1 of 3

EMERGENCY DEPARTMENT RECORD

Name: [REDACTED]
Med Rec: [REDACTED]
Date of Service: 01/18/99
Log#: [REDACTED]

Attending Physician: [REDACTED] M.D.
Nurse Practitioner or Resident: [REDACTED] M.D.

EMERGENCY DEPARTMENT MANAGEMENT: This is a 22-year-old male with unknown past medical history with questionable seizure episode on a bus. The patient reportedly has no history of trauma. There was no focal evidence of trauma. Dilated pupils with nonreactiveness suggestive of possible postictal state which is significant in duration at this time. The patient was otherwise unable to follow commands and severely combative hindering workup of the patient. The patient was electively intubated via rapid sequence induction. The patient was initially preoxygenated with 100% oxygen. Rapid sequence induction was performed utilizing 20 mg of etomidate and 100 mg of succinylcholine. The patient was intubated under direct visualization with a Mack 4 blade with cords easily visualized and an 8-0 tube passed without difficulty, noted to be at 22 cm at the teeth. Bilateral breath sounds were auscultated post intubation with good calorimetric change on end tidal CO2 monitoring. Chest x-ray pending at time of dictation. The possibility of possible toxidrome considered and, hence, the patient received a large Ewalt nasogastric tube with gastric lavage performed. The patient had clear effluent with some small food products, but no pill fragments were noted. The patient received 50 grams of activated charcoal with Sorbitol down the Ewalt tube prior to being removed. The patient was en route to head CT for emergent head CT to rule out intracranial process.

CBC, Chem-10, alcohol, Tylenol, aspirin, LFT's, PT, PTT and serum um and urine drug screen are pending at time of dictation.

The patient will be admitted to the MICU unless an intracranial process is found and, hence, neurosurgery will become involved.

PROCEDURES PERFORMED: 1. Endotracheal intubation. 2. Gastric lavage via large Ewalt tube. 3. Nasogastric tube placement.

DISCHARGE DIAGNOSIS: Acute mental status change - possible overdose/toxidrome.

As further information becomes available, it will be documented in the emergency department record.

The patient was seen with Dr. [REDACTED] who agrees with diagnosis and disposition.

000004

[REDACTED]
EMERGENCY DEPARTMENT RECORD

Name: [REDACTED]
Med Rec: [REDACTED]
Date of Service: 01/18/99
Log#: [REDACTED]

Attending Physician: [REDACTED] M.D.
Nurse Practitioner or Resident: [REDACTED] M.D.

TIME OF ENDING CONTACT: 20:20

Dictated by:

Signed by:

[REDACTED]

[REDACTED] M.D.
RESIDENT
DEPT OF EMERGENCY MEDICINE

[REDACTED] M.D.
ATTENDING
DEPT OF INTERNAL MEDICINE

[REDACTED] Job: [REDACTED] D: 01/18/99 T: 01/18/99

000005

EMERGENCY DEPARTMENT RECORD
Physician/NP Reassessment/Procedure Flow Sheet

T E AGE: 98 01/18/99 ISO: M.R. #: SEX:

Reassessment #1 Date: Time:
EM Attending Note (cont)
Plan: head CT
Intubation / gastric lavage / charcoal
VECG / T-SPIC SCREEN

Reassessment #2 Date: Cultures, (Ideed, urine) Time:
App coverage
Tella, Na
Ice adm / may need ECG

Reassessment #3 Date: Consider LP Time:
9:15 pm: Mother contacted (soc serv)
I spoke with her at length → call re/topic
mgmt on ticket

Procedure Note Date: 1/18/99 Time: 2:10 Provider Name:
Procedure: R L Intubation
Device (Size): ind. endotracheal, attached to ventilator, post intubated
at presentation ~ 100% O₂, RSI ~ 100%
succ. intubation; dist ventilation, BT tube
placed thru cords, tube @ 22cm @ till
@ RS @ ventilator & BT O₂ mch; cap @

Procedure Note Date: 1/18 Time: Provider Name:
Procedure: R L Edlich No tube
Device (Size): Placed via RN nas
lavage ~ NS until
clear (500cc)
No pill fragments
50 gm Charcoal given

Procedure Note Date: 1/18 Time: 9:00 Provider Name:
Procedure: R L Lumbar Puncture
Device (Size): 22G spinal
needle
Clear fluid

Procedure Note Date: Time: Provider Name:
Location: Total Length (cm's):
Skin Prep: Irrigation:
Anesthetic / Route:
Explored:
Skin Suture:
Deep Suture:
Dressing:
Comments:

Additional Comments:

000006

EMERGENCY DEPARTMENT RECORD

PATIENT NAME [REDACTED]		ISOLATION INDICATOR	
M.R. # [REDACTED]	PRE-CERTIFICATION # [REDACTED]	MARITAL STATUS [REDACTED]	RACE [REDACTED]
ACCOUNT # [REDACTED]	AGE [REDACTED]	TRANSFER FROM [REDACTED]	

DATE 01/18/99	TIME IN 19:39	LOG # 139	PATIENT ADDRESS - STREET, CITY, STATE, ZIP CODE		HOME PHONE #
NEXT OF KIN		NEXT OF KIN ADDRESS - STREET, CITY, STATE, ZIP CODE			NEXT OF KIN PHONE
FAX CONSENT [REDACTED]	REFERRING MD	PAYOR STATUS		LAST ED VISIT / LOG #	
COMPLAINT UNRESPONSIVE	ACCIDENT DATE & TIME	ISOLATION INDICATOR	PRIMARY MD / CLINIC	MD / CLINIC PHONE #	LAST HOSPITAL DISCHARGE

BP 150/p	P 155	R 28	T. PO / TM / BT	WT	FAMILY: <input type="checkbox"/> PRESENT <input type="checkbox"/> EN ROUTE <input type="checkbox"/> UNKNOWN	MEANS OF ARRIVAL
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CHIEF COMPLAINT:		NURSING INTERVENTIONS:	
SIGNATURE: _____		<input type="checkbox"/> CARDIAC MONITOR	<input checked="" type="checkbox"/> WBC
		<input checked="" type="checkbox"/> O2 SAT @ _____	HCT
		<input checked="" type="checkbox"/> IV <input type="checkbox"/> SALINE LOCK	HGB
		<input type="checkbox"/> PFR L/MIN	PLTS
		<input checked="" type="checkbox"/> GLUCOSE 122	DIFF
		<input type="checkbox"/> DENIES	GLU
ALLERGIES:	CURRENT MEDS & DOSE: <input type="checkbox"/> DENIES	NA	
		K	
		CL	
		CO ₂	
		BUN	
		CR	
		<input checked="" type="checkbox"/> CA	

MEDICATIONS / DIAGNOSTIC / TREATMENT ORDERS				X-RAYS ORDERED	
TIME	ORDER	ORDERED BY/SIGNED BY	TIME / GIVEN BY		
1950	Etomidate 2mg IV	[REDACTED]	[REDACTED]	<input checked="" type="checkbox"/> CHEST	<input checked="" type="checkbox"/> MG
1950	Succinylcholine 10mg IV	[REDACTED]	[REDACTED]	<input type="checkbox"/> ABDOMEN	<input checked="" type="checkbox"/> PHOS
1950	Fentanyl 70mcg IV	[REDACTED]	[REDACTED]	<input type="checkbox"/> WRIST / HAND L/R L/R	<input type="checkbox"/> CK-MB
1950	Versed 4mg IV	[REDACTED]	[REDACTED]	<input type="checkbox"/> FOOT / ANKLE L/R L/R	<input checked="" type="checkbox"/> AMY
1950	Vecuronium 10mg IV	[REDACTED]	[REDACTED]	<input type="checkbox"/> HIP / PELVIS L/R	<input checked="" type="checkbox"/> BILI
1950	Charcoal 50gms NG	[REDACTED]	[REDACTED]	<input type="checkbox"/> CT ABDOMEN	<input type="checkbox"/> LIPASE
				<input type="checkbox"/> C-SPINE	<input checked="" type="checkbox"/> LFTs
				<input type="checkbox"/> L-SPINE	<input checked="" type="checkbox"/> PT / PTT
				<input type="checkbox"/> T-SPINE	<input type="checkbox"/> INR
				<input type="checkbox"/> TRAUMA SERIES	<input type="checkbox"/> HCG URINE
				<input type="checkbox"/> ULTRASOUND	<input type="checkbox"/> ETOH
				<input type="checkbox"/> OTHER	<input type="checkbox"/> TRAUMA LABS
					<input type="checkbox"/> T & S
					<input type="checkbox"/> T & C x units
					<input type="checkbox"/> pH
					<input type="checkbox"/> PCO ₂
					<input type="checkbox"/> PO ₂
					<input type="checkbox"/> UA Sent / Saved
					<input checked="" type="checkbox"/> C & S: URINE / BLOOD
					<input checked="" type="checkbox"/> Drug Screen
					<input checked="" type="checkbox"/> ECG → NSR

DISCHARGE DIAGNOSES & PLAN		X-RAY & ECG RESULTS:
1.	AMS - possible GO/toxicchem	head ct: (E)
2.	COMA / Toxic Ingestion	CPR: ETOH NGAK
3.		NO infiltrates

PRIMARY MD NAME: _____	<input type="checkbox"/> CONTACTED <input type="checkbox"/> FOLLOW-UP	<input type="checkbox"/> REFERRED TO UVA CLINIC	<input type="checkbox"/> SOCIAL WORK SCREEN	TIME OF DC
DISPOSITION: <input type="checkbox"/> HOME <input type="checkbox"/> CLINIC <input checked="" type="checkbox"/> WARD <input checked="" type="checkbox"/> ICU <input type="checkbox"/> OR <input type="checkbox"/> OTHER	<input type="checkbox"/> LEFT WOBs <input type="checkbox"/> LEFT WOBd <input type="checkbox"/> LEFT AMA <input type="checkbox"/> ECO <input type="checkbox"/> TOD	CONDITION ON DC: <input type="checkbox"/> IMPROVED <input type="checkbox"/> STABLE <input checked="" type="checkbox"/> GUARDED <input type="checkbox"/> CRITICAL		<input type="checkbox"/> EXPIRED
ADMIT SERVICE MICU	<input type="checkbox"/> SSP <input type="checkbox"/> REGULAR	ADMITTING SERVICE RESIDENT / ATTENDING	ADMIT UNIT	TIME ADMIT PROCESSED
CONSULT SERVICE	CONSULTING MD	TIME CALLED 000007	TIME ARRIVED	
ED RESIDENT	NURSE PRACTITIONER	ED ATTEN	<input type="checkbox"/> DNB	

RESUME
LIVELY

EMERGENCY DEPARTMENT RECORD

EMERGENCY DEPARTMENT RECORD
History & Physical

Name: [Redacted] Age: [Redacted]
M.R. #: [Redacted] Sex: [Redacted]

Time of initial contact: _____

CC:

HPI:

ROS:

PMH:

SOCIAL HX:

PE:

Old chart reviewed

ASSESSMENT:

ADMIT

000008

Further hx + exam limited by coma + combative

ED RESIDENT:

Dictated Job # _____

ED NURSE PRACTITIONER:

MD Critical Care Time 9pm

EM ATTENDING USE ONLY ATTENDING NOTE:

The young ♂ became unresponsive/combative on bus returning from ski trip. "foaming at mouth" No further hx available
 Exam Combative, obtunded ♂ dilated reactive pupils
 Moves all 4 extremities purposefully. diaphoretic pale
 No verbal response NC/AT Neck supple BS=13L CONSISTENT
 ABD soft ext. abdomen N/V/O US as above good strength bilat
 By checking this box I certify that:
 I have seen and examined this patient
 I have confirmed and concur with the resident's Hx, PE, A & P.
 I was present for the procedures performed on this patient
 EM ATTENDING: [Redacted] Meningitis, Encephalitis
 ET intubation/NaFolex cath (Hox) cep mont 5000

PATIENT CARE SERVICES

Emergency Department Adult Nursing Assessment

NAME: [REDACTED]

AGE: 22y

T
E

Time in: 1930	BP	P
1	2	3
R		T: PO / TM / R

Triage / Receiving Note:

- Collar
- Splint
- Ice
-
-

Signature: _____

Primary Nurse Objective: Time in: 1930 Room: [REDACTED] Ambulatory W/C Stretcher

PATIENT PROBLEM

NEURO: A & O x 3 DISORIENTED LETHARGIC FOLLOWS COMMANDS: Y / N MAE EQUALLY: Y / N
 SPEECH: CLEAR: Y / N SLURRED PUPILS: L 6 R 6 GCS: E 4 V 1 M 3
 COMMENTS: *muscles rigid, clenched jaws, salivating non-verbal. Pupils dilated & sluggish to react*

1 Altered LOC
2
3

CV: S1/S2: CLEAR DISTANT MUFFLED MURMUR
 RHYTHM: _____ ECTOPY: _____
 IV SIZE/SITE: _____ SALINE LOCK: _____
 SKIN: WARM DRY COOL DIAPHORETIC PALE RINK MOTTLED FLUSHED CYANOTIC
 COMMENTS: _____

PULSES	RADIAL	FEMORAL	PEDAL
RIGHT	✓		✓
LEFT	✓		✓

ED PLAN OF CARE STANDARD FOR:

RESP: SPONTANEOUS RAPID SHALLOW DEEP UNLABORED LABORED SYMMETRICAL: Y N
 02 @ _____ VIA _____
 02 SAT % 98 Room Air PUGH: Y / N
 PRODUCTIVE: Y / N _____
 COMMENTS: _____

BREATH SOUNDS	CLEAR	RALES	RHONCHI	WHEEZES	DECREASED
RIGHT	✓				
LEFT	✓				

GI/GU: ABD. SOFT FIRM FLAT DISTENDED GUARDED NON-TENDER TENDER WHERE: _____
 BOWEL SOUNDS: NONE ACTIVE HYPO HYPER SPONTANEOUS VOID FOLEY CONTINENT INCONTINENT of urine
 COMMENTS: _____

INTEG/EXT: INTACT ECCHYMOSIS BREAKDOWN PRESSURE SORE SCARS: _____
 COMMENTS: _____

PSYCH/SOCIAL: APPROPRIATE: ANXIOUS FEARFUL FLAT DEFENSIVE COMBATIVE IDEATION: HALLUCINATIONS DELUSIONS
 COMMENTS: *Unresponsive*
 LATEX ALLERGY: Y / N ?

COMMENTS: *unknown allergies*

000009

Signature: [REDACTED]

DISCHARGE INFORMATION

BELONGINGS LIST

Time: 2230

Discharged
 Admitted to: [REDACTED] ICU
 Transferred to: _____
 O. R.
 Self
 Family
 Police

MODE:
 Ambulatory
 W/C
 Stretcher
 Walker
 Crutches

Blouse Bra Coat Dress Gloves Gown Pajamas Pants
 Robe Shirt Shoes Shorts Skirt Slip Slippers Socks
 Sweater T-shirt Underpants Cane Prosthesis Walker Wheelchair
 Dentures: Upper Lower Partial Glasses Contacts Hearing Aid
 Bracelet Earrings Necklace Ring Watch Purse Wallet
 Medications Money \$41.00 Other _____
 Comments: *watch & wallet locked in safe*
 Disposition: With Patient Valuables to Safe
 With Family

Discharging RN: [REDACTED]

Date: 1/18/99

ED ADULT ASSESSMENT SHEET

NAME: [REDACTED]
MED REC NO: [REDACTED]
SEX: M
DOB: [REDACTED] AGE: 98Y
ATTENDING MD: [REDACTED]
ORDERING MD: [REDACTED]
LOCATION: [REDACTED]
PT ACCT NO: [REDACTED]

[REDACTED]
**DIAGNOSTIC RADIOLOGY
CONSULTATION REPORT PAGE 1 OF 1**

[REDACTED] **PHYSICIAN**

ORDER NO: [REDACTED]

CLINICAL DATA:

--COMA

EXAMINATION:

DIA-22 CHEST, PORTABLE 1 VIEW EXAM DT/TIME: 01/18/1999 08:10PM
[REDACTED] [REDACTED]

CHEST, PORTABLE 1 VIEW

FULL RESULT:

CHEST, PORTABLE ONE VIEW: THE HEART SIZE, MEDIASTINUM, AND HILUM ARE WITHIN NORMAL LIMITS. THE LUNGS SHOW NO CONGESTION, EFFUSION, OR INFILTRATE. THERE IS AN ENDOTRACHEAL TUBE WITHIN THE THORAX, JUST ABOVE THE CLAVICLES. THERE IS AN NG TUBE THAT PASSES BELOW THE DIAPHRAGM AND BEYOND THE FIELD OF VIEW.

IMPRESSION:

1. SLIGHTLY HIGH ET TUBE POSITION, OTHERWISE NORMAL CHEST X-RAY.

[REDACTED] M.D.
[REDACTED] M.D.

TECHNOLOGIST:	[REDACTED]	DATE/TIME: 01/18/1999 08:10PM	SIGNED
TRANSCRIBED BY:	[REDACTED]	DATE/TIME: 01/19/1999 05:24AM	
READING MD:	[REDACTED]	DATE/TIME: 01/18/1999 09:07PM	
RESIDENT MD:	[REDACTED]	DATE/TIME: 01/19/1999 09:14AM	
SIGNING MD:	[REDACTED]	DATE/TIME: 01/19/1999 12:52PM	

**THIS DOCUMENT WAS SIGNED ELECTRONICALLY
A COPY OF THIS DOCUMENT IS ON FILE IN MEDICAL RECORDS**

BY ELECTRONICALLY SIGNING THIS REPORT, I THE SIGNING PHYSICIAN ATTEST THAT I HAVE PERSONALLY REVIEWED THE FILMS FOR THE ABOVE EXAMINATION(S) AND AGREE WITH THE FINDING(S) AS DOCUMENTED ABOVE.

NAME: [REDACTED]
MED REC NO: [REDACTED]
SEX: M
DOB: [REDACTED] AGE: 21Y
ATTENDING MD: [REDACTED]
ORDERING MD: [REDACTED]
LOCATION: [REDACTED]
PT ACCT NO: [REDACTED]

COMPUTED TOMOGRAPHY
CONSULTATION REPORT PAGE 1 OF 1

[REDACTED] PHYSICIAN

ORDER NO: [REDACTED]

CLINICAL DATA: S/P ? SEIZURE; INCONT TO URINE; DILATED PUPILS BIL.

EXAMINATION:

CNE-1 CT HEAD W/OUT IV CONTRAST EXAM DATE: 01/18/1999
[REDACTED] [REDACTED]

FULL RESULT:

CT HEAD: CONTIGUOUS AXIAL IMAGES WERE OBTAINED FROM THE SKULL BASE TO THE VERTEX WITHOUT IV CONTRAST. BRAIN AND BLOOD WINDOWS WERE PRINTED.

BRAIN PARENCHYMA SHOWS NO ABNORMAL LESIONS. THERE ARE NO MASS LESIONS, MIDLINE SHIFT. THE VENTRICLES ARE WITHIN NORMAL LIMITS. THERE ARE NO EXTRA-AXIAL FLUID COLLECTIONS. THERE IS NO SOFT TISSUE SWELLING OF THE SCALP. THE SINUSES SHOW NO MUCOSAL DISEASE.

IMPRESSION:

NORMAL HEAD CT.

[REDACTED] M.D.

[REDACTED] M.D.

TECHNOLOGIST:	[REDACTED]	DATE/TIME:	01/18/1999 08:34PM	SIGNED
TRANSCRIBED BY:	[REDACTED]	DATE/TIME:	01/20/1999 09:28AM	
READING MD:	[REDACTED]	DATE/TIME:	01/18/1999 10:28PM	
RESIDENT MD:	[REDACTED]	DATE/TIME:		
SIGNING MD:	[REDACTED]	DATE/TIME:	01/20/1999 11:32AM	

THIS DOCUMENT WAS SIGNED ELECTRONICALLY
A COPY OF THIS DOCUMENT IS ON FILE IN MEDICAL RECORDS

BY ELECTRONICALLY SIGNING THIS REPORT, I THE SIGNING PHYSICIAN ATTEST
THAT I HAVE PERSONALLY REVIEWED THE FILMS FOR THE ABOVE EXAMINATION(S)
AND AGREE WITH THE FINDING(S) AS DOCUMENTED ABOVE.