

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

ARMS#

13344



8 - OTHER

000001

EMERGENCY DEPARTMENT NURSING FLOW SHEET

Time	BP	P	R	T	O2 %	Medications	Comments (Initials)
1930	150/90	155	20				Received from _____
1943						Accucheck = 122 / Assessment done by _____	IV of NS started in (R) arm. Bloods drawn & sent: orders by Dr. _____
1955	160/77	95	20		100%		Ventilated w/ ambu bag - 100% O ₂
1956						* Succinylcholine 100mg IV given _____	
1957						* Etomidate 20mg IV given _____ #18g in (L)	
1959		107			100	(22 amp teeth.)	Oral ETT #8 placed by Dr. _____ TV = 900 100% O ₂ FIO ₂ = 12 PEEP = 5
2002	180/129	108			100		Ewall tube in (R) nare
2003						* Versed 4mg IV given _____	
2003			12			(on vent)	* Fentanyl 200 mcg IV given _____ * Vecuronium 10mg IV given _____ * Charcoal 50 Gm in Ewall (NG) tube 16FR Foley catheter in place. Ewall tube removed - _____ Salem Sump placed.
2010	146/62	89	12		100		Urine sent for U/A, tox screen
2016							12 lead EKG done
2025	142/70	71	12		100		To CT scan for head CT
2040	133/69	70	12		100		Returned to ED
2042						360 ³ (L)	* Vecuronium 5mg IV given _____ ABG's and Blood cultures x 2 drawn
2100	140/72	83	12		100		* Rocephin 2 Gm in 100cc NS hung _____ LP done → in progress
2115							* Vecuronium 15mg IV given _____
2116							* Versed 1mg IV given _____
2117							* Fentanyl 50mcg IV given _____
2125	154/66	67	12		100		LP complete, CSF samples sent by M.D.
2145	161/70	70	12		100		Dr. _____ in to examine pt. Pt. beginning to twitch
2155						000002	↳ move all extremities.
2200	144/99	110	12				1000cc NS absorbed. 2 nd 1000cc NS up

01/21/99 10:17

PAGE 001

DISCHARGE/FURLOUGH INSTRUCTIONS

PERMANENT CHART DOCUMENT

ADM: 01/18/99

WHAT YOU NEED TO KNOW TO TAKE CARE OF YOURSELF AT HOME.
 PLEASE BRING THIS FORM WHEN YOU RETURN FOR YOUR DOCTORS APPOINTMENT.
 ATTENDING PHYSICIAN: _____ DISCHARGE TODAY 01/21/99
 SERVICE: INT UNIT PHONE # _____ (ORDERED 01/21)
 DICTATING MD: _____ DESIGNATED RESIDENT: _____

DISCHARGE DIAGNOSIS: TOXIC INGESTION

ADDITIONAL DIAGNOSES/HOSP COURSE: _____

DRUG ALLERGIES: NONE KNOWN

DIET ALLERGIES: NONE KNOWN

MEDICINE INSTRUCTIONS:

PLEASE KEEP THESE AND ALL MEDICINES OUT OF THE REACH OF CHILDREN.

 --OTHER MEDICATION-RELATED INSTRUCTIONS:, --DISCONTINUE USE OF
 HYDROXYCUT, METABOLIC ENHANCERS, EXCESSIVE DOSES OF STIMULANT
 CONTAINING MEDICINES, ENTERED BY: _____

DISCHARGE DIET:

--RESUME PREVIOUS HOME DIET, ENTERED BY: _____

ACTIVITY (INCLUDES RESTRICTIONS, SCHEDULE OF PROGRESSION, ETC.):

--AS TOLERATED, ENTERED BY: _____

ADDITIONAL TREATMENTS:

--RETURN TO HOSPITAL/CALL MD FOR INCREASED CONFUSION, AGITATION,
 CHANGE IN MENTAL STATUS, SEVERE HA, ENTERED BY: _____

APPOINTMENT(S):

DATE	TIME	CLINIC	TO BE SEEN BY	PHONE NUMBER
PATIENT TO BE SEEN IN ONE WEEK	TO CALL LOCAL MD		DR. _____	_____
PHONE: _____				

CONTINUED

DISCHARGE/FURLOUGH INSTRUCTIONS

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[REDACTED]

ADM: 01/18/99

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DISCHARGE/FURLOUGH INSTRUCTIONS

PERMANENT CHART DOCUMENT

WHAT YOU NEED TO KNOW TO TAKE CARE OF YOURSELF AT HOME.
PLEASE BRING THIS FORM WHEN YOU RETURN FOR YOUR DOCTORS APPOINTMENT.

REMINDER: ALL VALUABLES/BELONGINGS TO BE RETURNED TO PATIENT OR FAMILY.

THE PATIENT'S SIGNATURE BELOW INDICATES THAT HE/SHE HAS RECEIVED AN EXPLANATION OF AND UNDERSTANDS THE INFORMATION ON THIS FORM.

[REDACTED] _____ *1/21/99* DATE
 (PATIENT'S SIGNATURE OR RESPONSIBLE PERSON)

[REDACTED] _____ R.N. *1/21/99* DATE

 * PATIENT AND NURSE TO SIGN BOTH COPIES. *

 * YOU MAY BE CONTACTED BY PHONE TO ANSWER PATIENT *
 * SATISFACTION QUESTIONS ABOUT YOUR STAY. *

LAST PAGE

CONDITIONS OF ADMISSION

Patient: [REDACTED]

History Number: [REDACTED]

Admission Date: 01/18/99

Consent to Admission: I consent to be admitted to the [REDACTED] [REDACTED]. No guarantees or promises have been made to me regarding the results of my examination and treatment at the [REDACTED].

Consent to Routine Treatment: I further consent to any routine diagnostic, and medical/surgical procedures which the physicians of the [REDACTED] may deem advisable during my hospitalization. I acknowledge that the [REDACTED] has the authority to dispose of specimens taken for laboratory examination.

Release of Information: I authorize the Medical Center, or its physicians, to release any and all information: 1) to my insurance company or any other agent which may be responsible for paying my medical bills; 2) to my referring and/or family physicians for continuity of care; 3) to any health care facility or agency to which I am transferred or referred by the [REDACTED] and 4) for the reporting of implanted devices to manufacturers as required by Federal law.

Patient Self-Determination Act: A representative of the [REDACTED] [REDACTED] has asked me whether I have an advance directive (such as a living will or durable power of attorney). I have been given written information regarding my rights under [REDACTED] to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to prepare an advanced directive, and also information about the [REDACTED] policies respecting the implementation of those rights.

Patient Rights Policies: I have been given information about the [REDACTED] patient rights policies. I certify that I have read this form, or that it has been read to me, and I understand and agree to its contents. If the signer is not the patient, the signer certifies that he or she is signing as the patient's authorized representative.

[REDACTED]
Witness

X

Patient

1.19.99

Date

If the patient is unable to sign:

Reason
X [REDACTED]

Signature of Next of Kin or other Representative

consenf5

FATHER

Relationship

000006

01/19/99 15:40

1/21/99

PATIENT: [REDACTED]
HISTORY: [REDACTED]
SVC: INT UNIT/BED: [REDACTED]
ATTENDING: [REDACTED]

D/C DATE: [REDACTED]
ADM DATE: 01/18/99
DOB: [REDACTED] AGE: 21
RACE: W SEX: M MMN:

CLERKS INITIALS: [REDACTED]

MARITAL STATUS: S OCC: EQUIPMENT INSTALLER
RELIGION: MET
SSN: [REDACTED]

DAYS SINCE LAST DSCHG:
PREV ADMIT DATE:
ADM TYPE: Z ADM SOURCE: EO
PRIOR STAY: TO

PT ADDR: [REDACTED]

NEAR RELATIVE REL TO PT: F

HOME PHONE: [REDACTED]
WORK PHONE: [REDACTED]

GUARANTOR: [REDACTED]

GUARANTOR: REL TO PT: [REDACTED]

FINANCIAL CLASS: C PRN: NO OF INS PLANS: 1
PAYRANGE : 7 RESP CODE [REDACTED] EXPIRATION DATE: 01/18/00

INS PLAN PRIORITY: 1

PLAN: [REDACTED] CODE: [REDACTED] POLICY #: [REDACTED]
GROUP: [REDACTED] GRP NO: [REDACTED] REL TO SUBC: [REDACTED]

INS PLAN PRIORITY:

PLAN: [REDACTED] CODE: [REDACTED] POLICY #:
GROUP: [REDACTED] GRP NO: [REDACTED] REL TO SUBC:

INS PLAN PRIORITY:

PLAN: [REDACTED] CODE: [REDACTED] POLICY #:
GROUP: [REDACTED] GRP NO: [REDACTED] REL TO SUBC:

INS PLAN PRIORITY:

PLAN: [REDACTED] CODE: [REDACTED] POLICY #:
GROUP: [REDACTED] GRP NO: [REDACTED] REL TO SUBC:

TRANSFERRED FROM:

ADMITTING DIAGNOSIS: COMA/POSS OD
ADVANCE DIRECTIVE DATA: NO AD ESTABLISHED

VISIT REFERRING
SELF REFERRAL

[REDACTED]
[REDACTED] O CONSENT: Y
PCP OB/GYN

CONSENT: N

1/2

STAT

RADIOLOGY ORDER REQUISITION

Name: [REDACTED] Hx: [REDACTED]

Sex: M DOB: [REDACTED] AGE: 98Y

Date of Service: 01/18/1999 07:48PM

Serv: [REDACTED] Floor: [REDACTED]

MIS ORD [REDACTED] MIS RE [REDACTED]

Pt Phone No: [REDACTED] Acct No: [REDACTED]

Adm Date: 01/18/1999 07:39PM Pt Class: EMERGENCY

D/T Entered: 01/18/1999 07:48PM BY: [REDACTED]

Transport: STRETCH IV: N [REDACTED]

Attn Phy: [REDACTED]

Ord Phy: [REDACTED]

Beeper/Pic: [REDACTED]

Diagnosis: [REDACTED]

Allergies: [REDACTED]

Exam(s):
Precautions:

LONG TERM ISOLATION:
Pregnant: LMP:

Clinical Data:
--S/P ? SEIZURE; INCONT TO URINE; DILATED PUPILS BIL

=====

IF ALL INDIVIDUAL
EXAMS ARE PRESENT
USE ONLY THIS
BARCODE FOR DICTATION

Physician Dictaphone Accession No:
[REDACTED]

INDIVIDUAL EXAMS

[REDACTED]
CNE 1 - CT HEAD W/OUT IV CONTRAST
GRANT:

WHO SPOKE TO: _____

EXT #: _____

TRAVELS BY: _____ W/C STR BED
HOOK UPS: YES NO
COOP: YES NO
ISOL: YES NO

OTHER: _____

ALLERGIES: _____

Diabetic _____ Meds: _____

BUN: _____ CR: _____

PT _____ PTT _____ PLAT _____

LEVEL OF CARE: _____

[REDACTED] T PERFORMED.BODY
[REDACTED] T PERFORMED.MSK
[REDACTED] T PERFORMED.NEURO

[REDACTED]

[REDACTED] TRANS NOTIFIED(U1) ENTER DEPT(ED) [REDACTED] PREP INCOMPLETE(U2)
[REDACTED] BEGIN PROC(BP) [REDACTED] END PROC(EP)
[REDACTED] LEAVE DEPT (LD) [REDACTED] ADD PROC [REDACTED] CHANGE PROC
[REDACTED] CANCEL PROC [REDACTED] REACTIONS
[REDACTED] QUIT [REDACTED] TRANS NOTIFIED (U4) [REDACTED] TRANS PICKUP (U5)

95 8V 9Z APR 26 95

APR 26 1995 8:56 PM

000008

RADIOLOGY ORDER REQUISITION

Name: [REDACTED] Hx: [REDACTED]
Sex: M DOB: [REDACTED] AGE: 98Y
Date of Service: 01/18/1999 08:04PM
Serv: [REDACTED] Floor: Bed:

MIS ORI [REDACTED] MIS REQ# [REDACTED]
Pt Phone No: [REDACTED] Acct No: [REDACTED]
Adm Date: 01/18/1999 07:39PM Pt Class: EMERGENCY
D/T Entered: 01/18/1999 08:04PM BY: [REDACTED]
Transport: STRETCH IV: N [REDACTED]
Attn Phy: [REDACTED]
Ord Phy: [REDACTED] Beeper/Pic: [REDACTED]
Diagnosis: [REDACTED]
Allergies: [REDACTED]

Exam(s):
Autions:

LONG TERM ISOLATION:
Pregnant: LMP:
Clinical Data:
--COMA

=====
IF ALL INDIVIDUAL
EXAMS ARE PRESENT
USE ONLY THIS
BARCODE FOR DICTATION

=====
INDIVIDUAL EXAMS

=====

[REDACTED]

[REDACTED]	[REDACTED]	[REDACTED]
	ENTER DEPT(ED)	BEGIN PROCEDURE(BP)
[REDACTED]	[REDACTED]	[REDACTED]
PROC ON HOLD	PROC OFF HOLD	LEAVE DEPT
[REDACTED]	[REDACTED]	
ADD PROC	CHANGE PROC	
[REDACTED]	[REDACTED]	[REDACTED]
CANCEL	COMPLETE	TRANSPORT NOTIFIED (U1)

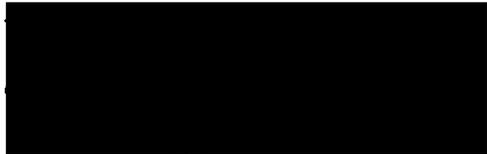
CONF # _____

2010 hrs

[REDACTED]
000009



PATIENT IDENTIFICATION



RADIOLOGY MRI PATIENT SCREENING

PATIENT NAME: _____ HEIGHT: _____ WEIGHT: 88.3kg

Because certain metallic objects may interfere with the strong magnetic field used for this imaging procedure, and to ensure a safe and satisfactory study, it is necessary that you answer the following questions.

Are you:

	YES	NO
Pregnant or breast-feeding	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Able to lay flat on your back	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Claustrophobic	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Allergic to any medication	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Please list and describe reaction: _____

Have you ever:

	YES	NO
Been a metal worker	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Been hit in the eye or face with metal pieces	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Had metal removed from your eyes	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Had an MRI examination	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Had surgery on your back	<input type="checkbox"/>	<input checked="" type="checkbox"/>

RADIOLOGY MRI PATIENT SCREENING

Do you have any of the following items in your body, or do any of the following conditions apply to you?

(please check yes or no):

	YES	NO		YES	NO
Pacemaker, wires, or defibrillator	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Orthopedic hardware (plates, pins, screws, rods, wires, etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Aneurysm clips	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Artificial limb or joint	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Ear implant (cochlear) or hearing aid	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Eyelid tattoo	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Eye implant	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Implanted catheter or tube	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Electrical stimulator for nerves or bone (TENS unit)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Artificial heart valve	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Bullets, BB's, or pellets	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Penile prosthesis	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Metal shrapnel or fragments	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Ventricular shunt	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Diaphragm or intrauterine device (IUD)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	False teeth, retainers or braces	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Infusion pump	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Magnetic implants anywhere	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Coil, filter, or wire in a blood vessel	<input type="checkbox"/>	<input type="checkbox"/>	Surgical clips, wires, staples or sutures ...	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Please explain any yes answers: _____

Music preference: Country Jazz Oldies Rock Classical Easy Listening Spiritual

X _____ 1/19/99 _____ X _____
 Signature (Patient or Guardian) Date Signature (Technologist) Date

Technologist Use Only:

Procedure: _____ Date: _____ Time: _____
 Venipuncture Site: _____ Type Needle / Cath: _____ # Sticks: _____
 Performed By: _____ Order by Rad Physician: _____
 Contrast Type and Amt: _____ Inj. By: _____
 Inj. rate: _____ Patient / Family Educated: YES NO
 Problems: _____



DIAGNOSIS AND PROCEDURE SUMMARY

USER ID: [REDACTED]

PT NAME:	[REDACTED]	ACCT TYPE:	ID
ADM DATE:	01/18/99	ACCT NUMBER:	[REDACTED]
AGE:	21	MED REC NO.:	[REDACTED]
		LEN. OF STAY:	3
		DSCH DATE:	01/21/99
		DSCH DISP:	[REDACTED]

=====

ATTENDING PHYSICIAN: [REDACTED] HOSP SVC: INT

ADMITTING DIAGNOSIS: [REDACTED] COMA

PRINCIPAL DIAGNOSIS: [REDACTED] POISON-MUSCLE AGENT NEC

SECONDARY DIAGNOSES: [REDACTED] TOXIC ENCEPHALOPATHY
 ACUTE DELIRIUM
 ACC POIS-MS/RESP AGNT
 HOME ACCIDENTS
 DISORDER PHOS METABOLISM
 HYPOCALCEMIA

PRINCIPAL PROCEDURE : [REDACTED] CAT SCAN HEAD

SECONDARY PROCEDURES: [REDACTED] SPINAL TAP
 INSERT ENDOTRACHEAL TUBE
 CONT MECH VENT-<96 HOURS
 ELECTROENCEPHALOGRAM
 MRI-BRAIN & BRAIN STEM
 INSERT GASTRIC TUBE NEC
 GASTRIC LAVAGE

CODEFINDER

SCHEME: [REDACTED]

DRG : [REDACTED]

DESC : POISONING AND TOXIC EFFECTS OF DRUGS, AGE 18+ with CC

SMS

SCHEME: [REDACTED]

DRG : [REDACTED]

DESC : [REDACTED] POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC