18

CLARK, PARTINGTON, HART, LARRY, BOND & STACKHOUSE
ATTORNEYS AT LAW
SUITE 800, ONE PENSACOLA PLAZA
125 WEST ROMANA STREET
PENSACOLA, FLORIDA 32501

PENSACOLA OFFICE

TELEPHONE (850) 434-9200
FAX (850) 432-7340
E-MAIL DLARRY@CPHLAW.COM

DENNIS K. LARRY

P.O. BOX 13010
PENSACOLA, FL 32591-3010

DESTIN OFFICE

SUITE 6 - A
151 REGIONS WAY
DESTIN, FLORIDA 32541
TELEPHONE (850) 650-3304
FAX (850) 650-3305

April 8, 2002

Mr. Thomas H. Perez
United States Food and Drug Administration
Center for Drug Evaluation and Research
5600 Fishers Lane
Rockville, MD 20857-0001

RE: [redacted] vs.
SmithKline Beecham Corporation and Glaxo Wellcome, Inc.

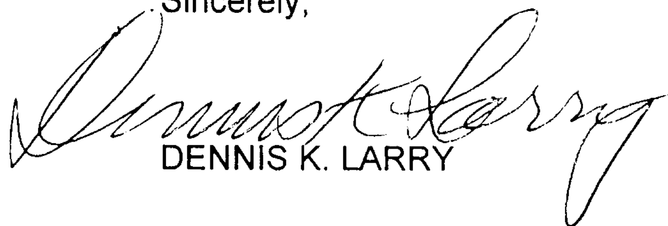
Dear Tom:

This letter follows our conversation concerning the April 23rd, 2002 FDA meeting before the Gastrointestinal Committee and the Risk Management Committee. You have confirmed, and I thank you, that there will be a television and a VCR available for our use during the public presentation portion of the meeting.

We also talked about [redacted] privacy, and I agreed to send you a set of redacted medical records. I believe these are exactly the same records I previously sent to you that were not redacted, and I ask that when you provide copies to the public and to the members of the Committees that you use copies made from the redacted set, so that we can assure [redacted] privacy.

Thank you very much for your help. I look forward to meeting you, in the event that that does occur, at the meeting on the 23rd of April.

Sincerely,



DENNIS K. LARRY

DKL:jdm
Enclosures

APTIST HOSPITAL
- INPATIENT

BAPTIST HEALTH CARE

VANCE DIRECTIVE: UNKNOWN

Organ Donor ___ Yes _X_ No 84-48-78

LED DATE	TIME	ADMIT/VISIT DATE	TIME	DISCHARGE DATE	TIME
		06/01/00	21:30	6-6-00	

PATIENT INFORMATION

TIENT NAME: [redacted]

HOME ADDRESS: [redacted]

HOME PHONE	SEX	RACE	AGE	MARITAL STATUS
[redacted]	F	CAUCA	39Y	MARRIED

DATE OF BIRTH	SOCIAL SECURITY NUMBER
01/23/1961	[redacted]

RELIGION	LOCAL CHURCH	NOTIFY
BAPTIST	NONE	

PATIENT EMPLOYER INFORMATION

EMPLOYER	EMPLOYMENT STATUS
UNEMPLOYED	NOT EMPLOYED

WORK PHONE	OCCUPATION

SPOUSE OR NEAREST RELATIVE

NAME: [redacted]

ADDRESS: [redacted]

RELATIONSHIP	EMPLOYER	STATUS
[redacted]	[redacted]	[redacted]

HOME PHONE NUMBER	WORK PHONE NUMBER
[redacted]	

FINANCIAL CLASS: HEALTH OPTIONS PCOLA

HOSPITAL LAST IN:

MEDICAL INFORMATION

ACCOUNT NUMBER	LOCATION
000844878-0153	1W 117 -01 B

SERVICE	ADMIT TYPE	MODE OF ARRIVAL
MEDICAL S	EMERGENCY	AMBULANCE

ACCIDENT TYPE	DATE

	NAME	NUMBER
ADMITTING PHYSICIAN	[redacted]	12709
ATTENDING PHYSICIAN	[redacted]	12709
REFERRING PHYSICIAN	[redacted]	12709
FAMILY PHYSICIAN	NO, REFERRING PHYSICIAN	96000

CHIEF COMPLAINT: ATYPICAL CP

GUARANTOR INFORMATION

NAME: [redacted]

ADDRESS: [redacted]

RELATIONSHIP	HOME PHONE
PATIENT	[redacted]

EMPLOYER	EMPLOYMENT STATUS
[redacted]	[redacted]

WORK PHONE	SOCIAL SECURITY NUMBER
	[redacted]

SOURCE OF INFORMATION

SOURCE	CLERK	DATE	TIME
PHYSICIAN REFERRAL	P P	060200	02:47

COMMENTS:

PT REG TO CORRECT ACCT/ DOWNTIME MANUALLY GIVEN WR

	INSURANCE COMPANY NAME 1	INSURANCE COMPANY NAME 2	INSURANCE COMPANY NAME 3	INSURANCE COMPANY NAME 4
NAME	N01 HEALTH OPTIONS			
ADDRESS	2190 AIRPORT BLVD SUITE 3000 PENSACOLA FL 32504			
PHONE				
POLICY	26621300702			
GROUP NAME	SANTA ROSA COUNTY			
CONTRACT HOLDER	[redacted]			
AUTHORIZATION NUMBER	333			
GROUP NUMBER	96107P			

FORM NO. 916-017 (REV 11/98)

BAPTIST HEALTH CARE

☐ BAPTIST HOSPITAL - PENSACOLA ☐ GULF BREEZE HOSPITAL ☐ JAY HOSPITAL
☐ ATMORE COMMUNITY HOSPITAL ☐ BAPTIST MANOR ☐ AZALEA TRACE
☐ D.W. MCMILLAN MEMORIAL HOSPITAL ☐ LAKEVIEW CENTER

000844878-0153 BH
12709

CONSENT FOR TREATMENT AND CONDITIONS OF ADMISSION

I hereby authorize the performance of any medical or surgical procedures under local, general or any other type of anesthesia, which may be advised or recommended by my attending physician or surgeon of ______

Witness ______ (X) Pt unable to sign — Signature of Patient

Date 6-1-08 ______ Signature of Spouse

1. **Medical and Surgical Consent:** The patient is under the control of his attending physicians/dentists and the hospital is not liable for any act or omission in following the instructions of said physicians/dentists and the undersigned consents to any x-ray examination, laboratory procedures, anesthesia, medical, surgical or dental treatment or hospital services rendered the patient under the general and special instructions of the physician/dentist. The undersigned recognizes that all doctors of medicine and dentistry furnishing services to the patient, including the radiologist, pathologist, anesthetist, and the like are independent contractors and are not employees or agents of the hospital. I understand that an explanation of the risks, benefits, and alternatives of any medical or surgical procedure performed by my physician will be explained to me except in an emergency situation.
2. **Release of Information:** The hospital may disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract to the hospital or the patient or to a family member or employer of the patient for all or part of the hospital's charge, including, but not limited to hospital or medical service companies, insurance companies, workers' compensation carriers, welfare funds, or the patient's employer. The hospital may also send a copy of the patient's record to his private physician.
3. **Personal Valuables:** It is understood that the hospital maintains a safe for the safekeeping of money and valuables and the hospital shall not be liable for the loss or damage to any money, jewelry, documents, furs, fur coats and fur garments, or other articles of unusual value and compass, unless placed therein, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for safekeeping.
4. **Assignment of Insurance Benefits:** In the event the patient is entitled to hospital benefits arising out of any policy of insurance insuring patient or any other party liable to patient, said benefits are hereby assigned to the hospital for application on patient's bill, and it is agreed that the hospital may receipt for any such payment and such payment shall discharge the said insurance company of any and all obligations under the policy to the extent of such payment, the undersigned and/or patient being responsible for charges not covered by this assignment. State disablity benefits are assigned where applicable.
5. **Financial Agreement:** The undersigned agrees, whether he signs as patient or as agent of the patient, that in consideration of services to be rendered to the patient, he hereby obligates the patient to pay the account of the hospital in accordance with the regular rates and terms of the hospital. Furthermore he obligates the patient to make payments, if requested, and upon discharge, on the uninsured portion of the account. Should the account be referred to an attorney for collection, the patient shall pay reasonable attorney's fees and collection expenses.
6. I understand that under hospital regulations the possession of weapons, including but not limited to, firearms, knives, explosives of any nature are prohibited. I declare that I have none in my possession.
7. I understand that, without proper prescription, the possession of narcotics, and narcotic appliances or apparatus, as well as dangerous drugs, is illegal. I declare that I have none in my possession.
8. In the event that any such contraband shall be found in my possession at any time during my stay in the hospital, I hereby authorize its removal and consent to its destruction.
9. I hereby consent to the disclosure of my medical records relating to this admission to hospital personnel only for internal administrative purposes associated with treatment.
10. **Medicare-Medicaid Patients Certification:** I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize the release of all records required to act on this request and that payment of authorized benefits be made directly to Baptist Hospital and the physicians involved in my care for any services furnished me by Baptist Hospital and said physicians. My Medicare # is ______.
11. **Accommodation Request:** I hereby request:

(Patient Initials) Private room accommodations. (Patient Initials) Semi-private room accommodations.

AGE OF CONSENT	**WHERE MINORS ARE INVOLVED THE FOLLOWING PREVAILS** 1. The parent's or guardian's consent is required if the patient is unmarried or has never been married and is under the age of 18. 2. If the patient is married or has been married and has not attained the age of 18, then the consent of the parent or guardian is not required.

The undersigned certifies that he has read the foregoing, receiving a copy thereof, and is the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

(X) Pt unable to sign — Patient or Patient's Representative, if Patient unable to sign — State Reason — Relationship

Date 6-1-08 Pt unable to sign — Witness — Date ______ Signature of Insured, if other than patient

Baptist Healt[illegible] [illegible]are ☐ Jay Hospi[illegible] ☐ D.W. Mc[illegible] ☐ Atmore Community Hospi[illegible] [illegible]Memorial Hospital

0002098[illegible]5-0153 JK 00002

UNASSIGNED, PHYSICI 99999

Emergency Physician Record

Chief Complaint: [illegible] Time: ______ A.M. P.M.

History of Present Illness Nurses Notes Reviewed & Agreed With: ☐Yes ☐No Emergency Medical Condition Exists: ☐Yes ☐No

(Location, Context, Quality, Severity, Duration, Timing, Modifying Factors, Associated Signs Symptoms)

[illegible handwritten history]

Past Medical History: [illegible]

Social History: Patient lives in: ☐ The Local Area ☐ Other: ______ ☑ Smoker 1 ppd ☐ ETOH Intake, 0 perday ☐ Old Records Reviewed

Review of Systems: Positive

GEN: ☐Weight Loss ☐Fevers ☐Anorexia
EYES: ☐Vision Loss ☐Pain ☐Redness
HEME: ☐Anemia ☐Abn Bleed ☐Nodes
RESP: ☐SOB ☐Cough ☐Wheezing ☐Sputum ☐Hemoptysis
CV: ☑CP ☐Palpitations ☐Edema
GI: ☑Abd Pain ☑Diarrhea ☑N ☑V ☐GI Bleed

GU: ☐Dysuria ☐Frequency ☐Hematuria
MUSC-SK: ☐Pain ☐Swelling ☐Deformity
NEURO/CNS: ☐Focal Weakness ☐Numbness ☐Impaired Gait
PSYCH: ☐Depression ☐Anxiety ☐Hallucinations
OTHER: ______

☐ Remainder of Systems Negative

Physical Exam Vital Signs Noted ☑Yes

Gen [illegible] ☐ Appears well ☐ In no acute distress
Skin [illegible] ☑ Warm and well hydrated w/normal turgor
Eyes ☑ PERL ☐ Eyelids are normal
ENMT ☐ TMs w/o blood ☑ OP w/o erythema
Neck ☑ Supple ☐ No mass or thyromegaly
Chest ☑ CTA bilaterally ☐ Resp. effort is normal
C[illegible] [illegible] ☐ RRR ☐ w/o murmur ☐ No Thrill
ABD [illegible] ☐ Soft ☐ Nontender ☐ No splenomegaly
Back/Spine (*) ☐ Nontender ☐ No CVA tenderness
EXT (*) ☐ Nontender ☐ No Edema ☐ No Cyanosis or Clubbing
Neurologic ☐ Light touch, motor strength, and CN 3 - 12 grossly intact
☐ Alert and oriented to person, place, and time
Psychiatric ☐ Judgement is normal
Pelvic Exam: —
Genitalia —
Rectal:(*) —

Procedure Note: ______

Laceration Repair:
Wound prepped with: ☐ Scrub-stat ☐ ______
Locally anesthetized with: ☐ 1%Lido w/Bicarb oDig. Block ☐ ______
Wound Irrigated: ☐ Thoroughly with normal saline ☐ ______
Wound Exploration ☐ No foreign body ☐ ______
Wound Closure ☐ Skin closed with ______ ☐ Subcutaneous tissue w/______ ☐ ______
Dressing ☐ Sterile with antibiotic ointment ☐ ______

Differential DX

Interpretations /Pertinent Test Results ☐By EDP

LAB: [illegible] HCG/UCG: ______ CK: ______ UA: ______
ECG: ______ c/w ______
Cardiac Monitor ______ Accucheck ______
ABG ______
PROFILES: ☐ 7 ☐ Cardiac ☐ Liver ☐ Met
X-RAY: ☐ By EDP ☐ By Radiologist ☐ CXR: ______ Amylase/Lipase ______ Pulse Ox ______

Re-Assessment/Emergency Department Course ☐ CT Head:

Follow Up Care by: ☐Ortho ☐PMD ☐EDP ☐Wound Check ☐Suture Removal Follow-up in ____ days.

Discharge Instructions ☐ See Discharge Instruction Sheet [illegible]

Diagnosis: 1. [illegible]
2. [illegible]
3. [illegible]

☐ Physician Chart Completed ☐ Dictated ☐ Priority

Case discussed with: Dr.______ at ______ ☐Family
Admitted:To Dr.: ______ Unit ______ Time Admitted: ______
Total Critical Care Time: ______
M.D. SIGNATURE

Baptist Health Care ☐ Baptist Hospital ☐ Gulf Breeze Hospital **Triage Sheet**

☐ Jay Hospital ☐ Atmore Community Hospital ☐ D.W. McMillan Memorial Hospital

Patient Name [redacted]

Room #____ Age 39 Sex F DOB 1/23/61

Date: 6/1/00 Sign In Time: 2024

Private Physician [redacted] Triage Time CA

E.M. Physician ____ D/C Time: ____

Arrived By: ☐ Car ☐ Law Enforcement ☑ Ambulance/LifeFlight ☐ Walk

Authority Notified: ☐ PD ☐ SO ☐ HP Name ____

☐ Emergent ☑ Urgent ☐ Non-Urgent ☐ Fast Track

Transfer from Jay Hospital

Chief Complaint: Racing heart beat x 3-4 wks, N+V since Tues

Vital Signs BP 126/64 P 125 R 18 T 99.2 SaO2 100 % on RA **Wt.** 160 **LMP**

Allergies ☐ NKDA Anti inflammatory, Sulfa, ASA

Last Tetanus: ☐ < 5 yrs. ☐ > 5 yrs.

Immunizations: ☐ Current ☐ Not Current

Current Medications: ☐ None

1. MS Contin
2. Elavil
3. Tricor
4. Buspar
5. Prilosec
6. Reglan
7. Ambien
8.

Past Medical History: ☐ No hx. Available

☐ No Significant PMH ☐ Asthma/COPD ☐ Cancer ☐ CVA ☐ HTN ☐ Diabetes ☐ Dialysis ☐ Smoker ☐ MI/Cardiac ☐ Migraine ☐ Seizures ☐ SickleCell ☐ TB ☐ Other

Fiber Myalgia

Time	Triage Intervention	Time
	Motrin	
	Tylenol	
	Visual Acuity:	
	___OS ___OD ___ Both Eyes	
	Dressing	
	Ice Pack	
	Splint	
	Accucheck	
	Other	
	To ETC tx. Area	
	Report To:	

Prior Treatments	
c-collar	
Back board	
CID	
Splint	Phenergan + Dilaudid
Dressing	~1800
O2	
Resp. Tx.	
IV. ga.: 22	Fluid ½NS
Site (R) H	Amt. Left: 500
Other:	

Pain Scale Assessment: 1 2 3 4 5 6 7 8 9 10 (None — Moderate — Worst) ☐ AMA ☐ LWT

Triage Assessment:

Triage Nurse's Signature K Sumner RN **Initials** CKS

MD Time	RN Time	Physician Orders
		12.5mg Phenergan IV 2050 KHS
		12.5mg Phenergan IV
		Nitro paste 1" — 2115 KHS
		Lovenox SQ 1mg/Kg

Emergency Condition Exists: ☐ Yes ☐ No

Physician Signature: [signature]

LAB	Time
CBC	
Retic Count	
T & S	
T & C x ___ u.	
Profiles	
Chem 7	
Metabolic	
Cardiac	
Liver	
CK w / MB	
Troponin	
Serum Ketones	
PT/INR	
PTT	
Amylase	
Lipase	
ETOH	
Serum DS	
Urine DS	
Drug Levels	
Tylenol	
ASA	
Dig	
Theo	
Dilantin	
Phenobarb	
Tegretol	
Depakote	
U/A cath / cc	
GYN	
UCG	
HCG	
Quant HCG	
Wet Prep	
GC & Chlam	
Cultures	
Urine C&S	
Blood Cx x1 x2	
Sputum C&S	
CSF	
CSF Cytococcal Antigen	
CSF TB Cx	
CSF	
CSF Panel: Tube #1: gluc. & protein, #2: Bact C & S & gram stain, #3: Hold, #4: Cell Ct. & Differential	

X-Ray	Time
CXR PA & Lat	
Portable	
ABD Series	
KUB	
AP Pelvis	
X-Table Lat. C-Spine	
LS Spine	
C-Spine, 3 View	
LS Spine 3 View	
5 View	
CT Head	
CT, Ureteral L/R	
CT Abd	
CT	
U/S Pelvic	
U/S Gallbaldder	
U/S Abd	
U/S	
R / L Thumb	
R / L ___ Digit	
R / L Hand	
R / L Wrist	
R / L Forearm	
R / L Elbow	
R / L Humerus	
R / L Shoulder	
R / L Clavicle	
R / L Scapula	
Sternum	
R / L Hip	
R / L Femur	
R / L Knee 2 View	
4 View with sunrise	
R / L Tib/Fib	
R / L Ankle	
R / L Foot	
R / L ___ Toe	
Nasal Bones	
Facial Series	
Mandible Series	
Sinus Series	

OTHER

Old Records

(EKG) — circled

Old EKG

ABG

-0100

Initial Assessment Time: 2024

Neurological:
- ☑ Alert
- ☐ Oriented x 3
- ☐ Disoriented
- ☐ Lethargic
- ☐ Unresponsive
- ☐ Combative

Limb Movement*: RA____ LA____ RL____ LL____

Pupils: L.____mm R____mm ☐ Reactive ☐ Nonreactive

GCS:____

*(N=Normal A=Absent W=Weak)

Cardiac: ☐ NA ☐ Denies Symptoms

Chest pain: racing
- ☐ Dull ☐ Sharp
- ☐ Radiating to____
- ☐ Non-radiating
- ☐ Epigastric ☐ Substernal

Time of onset:____
Activity of onset____
Intensity on 1-10 scale____

Respiratory: ☐ N/A ☑ Denies symptoms

R	L	Breath Sounds
		Clear
		Coarse
		Crackles
		Wheezes
		Diminished
		Absent

☐ Regular ☐ Equal ☐ Shallow ☐ Labored ☐ Cough ☐ Productive

Skin: ☐ Within normal limits
- ☐ Cyanotic ☐ Hot
- ☐ Pale ☐ Cool
- ☐ Jaundiced ☐ Diaphoretic
- ☐ Moist ☐ Dry
- ☐ Rash____

GI: ☐ N/A ☐ Denies Symptoms
- ☐ Bowel sounds+ ☐ Pain:____
- ☐ Nausea
- ☐ Vomiting ☐ Dysphagia
- ☐ Diarrhea ☐ Anorexia
- ☐ Constipation ☐ Distension
- ☐ Bleeding: ☐ Emesis ☐ Stool

Last po intake: time____

GYN: ☐ NA ☐ Denies Symptoms
- ☐ Vaginal Bleeding: amt.____
- ☐ Vaginal Discharge: type:____

Grav.:____Para:____ab____
FHT:____

URO: ☐ NA ☐ Denies Symptoms
- ☐ Frequency ☐ Hematuria
- ☐ Pain/burning ☐ Foley in place
- ☐ Other

Pediatrics: ☐ NA

Skin: ☐ Moist ☐ Dry pink ☐ Pale ☐ Cyanotic

Cap. Refill ☐ < 2 sec. ☐ > 2 sec.
- ☐ Playful ☐ Fussy ☐ Quiet
- ☐ Alert ☐ Retraction
- ☐ Grunting ☐ Nasal flaring
- ☐ Babbles ☐ Uses single words
- ☐ Uses sentences ☐ Speaks clearly

Extremities: ☐ N/A
C=Cold H=Hot W=Weak A=Absent
☐ WNL(Unless Indicated)

	Temp	Pulse	Cap Refill	Edema
RA				
LA				
RL				
LL				

Vital Signs ☑ See monitor printout for vital signs

Time	B/P	Pulse	Resp	Temp	O2 Sat	Intake	Output	Pupils L	Pupils R	GCS

IV Fluids:

Time	Type	Rate	IV cath size/site	Initials	Time D/C	Amt. Iinfused
PTA	1/2NS c 20mEq KCl	200cc/hr	(R) H	PTA	2155	800cc
2155	NS	125cc/hr	(R) H	KAS		

Medications (Effect codes: R=Relief P=Partial relief N=No relief O= No reaction)

Time	Medication	Dose	Route	Site	RN/RT	Effect Med Code	Sedation Level
2030	Phenergan	12.5mg	IV	—	KAS	P	1
2115	Phenergan	12.5mg	IV	—	KAS	P	1
2115	Nitro Paste	1"	Top	(L) chest	KAS	O	1
2115	Lovenox	1mg/kg	SQ	(L) abd	KAS	O	1
2155	Pepcid	20mg	IV	—	KAS	P	2
2155	Zocor	20mg	PO	—	KAS	O	2
2155	Lopressor	50mg	PO	—	KAS	O	2
0115	Phenergan	12.5mg	IV	-	KAS	—	—

Sedation Level: 1. Wide awake 2. Drowsy 3. Awakens only with arousal 4. Unarousable

Procedure/Treatment:

	Time	Initials		Time	Initials
Cardiac Monitor			Dressing		
Alarms On					
Pulse Ox			Splint (circ. check after)		
B/P Monitor			Warmed blankets		
O2: mask			Accucheck:		
Cannula			EKG		
L/min.			Pelvic Exam by:		
Foley Cath.			Orthostatic VS:		
Size:			Lying:		
Amt:			Standing:		
Sutures/staples					

Notes: 2024 Transfer from Jay Hospital. Pt c/o racing heartbeat 3-4 wks, N+V since Tues. KAS 2105 Dr Lees to see Pt. KAS 2115 Medications given. KAS 2115 PM medications given. Awaiting bed assignment KAS 2230 Room assigned not ready. Pt aware. Denies CP. KAS 2315 Repeat CK and isoenzymes drawn. Room still not ready. KAS 0000 Continue to wait on room. KAS

☐ See continuation note

Initial Nursing Assessment completed by: Signature	Initial	Signature	Initial	Signature	Initial	Signature	Initial
K Swanner RN	KAS						

Disposition: ☐ D/C:____Time ☐ Amb. ☐ W/C ☐ Other____ ☐ Verbalizes Understanding of Instructions

☐ Admitted: Report To ____Time____ Tx. to Room#____Time Tx.____ ☐ Old Chart Sent

Is this hospitalization a result of trauma? ☐ Yes ☐ No (If yes, notify Unit Coordinator) Valuables form completed: ☐ Yes ☐ No

Pt. Valuables: ☐ With Pt. ☐ To Home ☐ Safe ☐ None ☐ See List ☐ Transfer to:____Time____See Tx. Documents

D/C Nurse____ Condition at time of D/C: ☐ Good ☐ Fair ☐ Serious ☐ Critical

Baptist Health e ... ge Sheet

☐ Jay Hospital ☐ Atmore Community Hospital

PATIENT NAME [redacted]

DOM # ____ Age 38 Sex F DOB ____

Date: 6-1-00 Sign In Time: ____

Private Physician [redacted] Triage Time 1435

E.M. Physician [redacted] D/C Time: ____

☐ Emergent ☐ Urgent ☐ Non-Urgent ☐ Fast Track

Arrived By:
☑ Car
☐ Law Enforcement
☐ Ambulance/LifeFlight
☐ Walk

Authority Notified:
☐ PD ☐ SO ☐ HP
Name ____

[redacted] 0153 JH
00002

Chief Complaint: vomiting & diarrhea x 2 days

Vital Signs	BP 102/60	P 92	R 26	T 99.4	SaO2 % on	Wt.	Last dT	Visual Acuity: R ____ L ____

Allergies: Sulfa, ASA, anti-inflammatory

Current Medications: [illegible]
MS contin [illegible] 60
[illegible] 750 [illegible]
Elavil 100 [illegible]
[illegible] x days
[illegible]

Past Medical History: [illegible]

LMP

Nursing Assessment — Initial Assessment Time:

To ER c/o vomiting & diarrhea x 2 days. — [signature]

GCS: ____

Pediatric Assessment
Immunizations Current? ☐ Yes ☐ No
History of Communicable disease/recent exposure?
☐ Measles
☐ Chickenpox
☐ Mumps
☐ Rubella
Mentation
☐ Awake
☐ Alert
☐ Confused
☐ Lethargic
☐ Smiling
☐ Crying/Fussy
Respiratory Status
☐ Even, nonlabored
☐ Tachypneic
☐ Sternal retraction/grunting
☐ Wheezing
☐ Nasal Flaring
Skin
☐ Pink
☐ Pale
☐ Cyanotic
Turgor: ☐ Good ☐ Poor
Speech
☐ Babbles/coos
☐ Uses single words
☐ Uses sentences
☐ Speaks clearly
Other ____

CIRCLE ORDERS

LAB	Time	X-RAY	Time
(CBC)	[initials]	CXR	
Panels		PA & Lat	
Lytes		(Portable)	[initials]
BMP		ABD Series	
Hepatic		(KUB)	
(Metabolic)	[initials]	AP Pelvis	
Lipid		X-Table Lat.	
Renal		C-Spine	
(PT / INR)	[initials]	LS Spine	
(PTT)		C-Spine, 3View	
CK		LS Spine	
CK w / iso		CT Head	
Troponin I		CT	
(Amylase)	[initials]	U/S Pelvic	
(Lipase)		U/S RUQ	
ETHO		U/S ____	
Serum Tox			
Urine drug screen			
Tylenol			
Dig			
Theo			
Dilantin			
(U/A) (ccu-scu-foley)			
U/A w/culture		OTHER	
Urice HCG		Old Records	
Serum HCG		(ABG)	[initials]
Wet Prep		(EKG)	[initials]
Quant. HCG		Old EKG	
GC & Chlamidia		C. Monitor	
Urine C & S		Pulse Ox	
Blood Cult. x's ____			
Sputum C & S			
Acetone			

MD Time	Physician Orders	Nurse Time
	IV D5 1/2 NS at 200cc/hr	
	25 [illegible] IV	1505 [initials]
	[illegible]	
	Phenergan 12.5mg IV now	1635 [initials]
	MS Contin 60mg po now	1750 [initials]

MD Time	Physician Orders	Nurse Time
1700	22 RH	
	1) Add [illegible] Troponin I [illegible]	
	2) [illegible]	
	3) [illegible]	
	4) [illegible] now	
	5) Phenergan 12.5 IV [illegible]	

Disposition
☐ Home ☐ Expired
☐ Admit Rm. # ____
☐ Transfer to ____
☐ AMA ☐ Left w/o TX

Condition On Discharge
☐ Satisfactory ☐ Wheelchair
☐ Fair ☐ Ambulatory
☐ Stable ☐ Ambulance
Visit Level ____

Disposition of Valuables:

Emergency Condition Exists: ☐ Yes ☐ No PHYSICIAN SIGNATURE:

BAPTIST HOSPITAL
1000 WEST MORENO STREET
PENSACOLA, FLORIDA 32522-7500

HISTORY AND PHYSICAL EXAMINATION

PATIENT: [redacted]
DICTATING: [redacted]
ATTENDING: [redacted] MD

MR#: 00844878-0153
ROOM: 1W - 117 -
ADM DATE: 06/01/2000

Contacted by [redacted] in Jay about transfer of this 39-year-old white female with very atypical chest pain. The patient has a complex past medical history and I have no medical records. Apparently, she has had several weeks of palpitations with flip flop sensation in her chest but no definite substernal chest pain over the last 2 days. Her biggest complaint has been low grade fevers, some nausea, vomiting and diarrhea with difficulty taking in fluids. She presented with that complaint. ECG however, showed diffuse anterolateral ST changes and with this she was transferred down here for further evaluation and treatment. Again, she has not had any substernal chest pain. She has not complained of any at the present time.

PAST MEDICAL HISTORY
Quite complex and confusing. It appears she has some sort of rheumatologic disorder, has undergone extensive evaluation in Pensacola and Birmingham without a specific diagnosis. She gets intermittent cyanosis of her hands and especially her left leg. She has chronic pain syndrome, on chronic narcotics and her symptoms are so severe she is unable to walk. Other past history significant for borderline diabetes, elevated cholesterol.

PAST SURGICAL HISTORY
Includes 2 separate carpal tunnel releases. Surgery on her septum, hysterectomy partial x2.

ALLERGIES
Sulfa, possible aspirin and intolerance to nonsteroidal anti-inflammatory drugs.

OUTPATIENT MEDICATIONS
Buspar, MS Contin, Robaxin, Elavil, Tricor, Prilosec and Reglan.

SOCIAL HISTORY
She intermittently smokes, does not drink.

FAMILY HISTORY
Noncontributory.

REVIEW OF SYSTEMS
Negative, other than that states in history of present illness. HEAD, EYES, EARS, NOSE, AND THROAT: There is no jugular venous distention, carotid bruits, lungs are clear. CARDIOVASCULAR: Regular rate and rhythm without murmur, rubs, clicks or gallops. ABDOMEN: Soft; nontender. EXTREMITIES: Show no clubbing, cyanosis or edema. EKG from Jay Hospital demonstrates sinus tachycardia with anterolateral ST depression and other nonspecific ST-T wave changes.

Laboratory data is all pending.

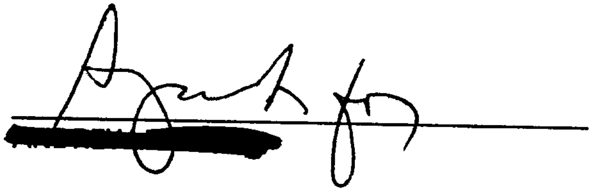
PATIENT:
MR#: 00-84-48-78
ROOM: 1W - 117
ADM DATE: 06/01/2000

IMPRESSION

Confusing consolation of symptoms that has apparently been going on for years with intermittent hand and left leg cyanosis, chronic pain syndrome and chronic habitual narcotic use. Now presents with a fairly benign sounding history of palpitations, a 2 day history of a gastroenteritis type picture and ECG showing diffuse ST-T wave changes without comparison tracings.

PLAN

We will rule out for myocardial infarction, add nitrates, Beta Blockade. I suspect clinically she is dry. We will gently hydrate and add Lovenox. Most importantly we will try to obtain old EKG. She thinks she had one at Santa Rosa Hospital. I will try to obtain that tonight and compare with the abnormal ECG at Jay and here. Further recommendations based on results of above.



T: 06/01/2000
D: 06/01/2000
504446/26677c/tmp/sc

cc: MD
DO
MD

117-01

BAPTIST HEALTH CARE

☐ [illegible]ST HOSPITAL - PENSACOLA ☐ ATMORE COMMUNITY HOSPITAL ☐ BAPTIST MANOR ☐ GULF BREEZE HOSPITAL ☐ JAY HOSPITAL ☐ AZALEA TRACE ☐ MIZELL MEMORIAL HOSPITAL ☐ D.W. MCMILLAN MEMORIAL HOSPITAL ☐ LAKEVIEW CENTER

[redacted] 00844818-0153 BH
[illegible], G RAMON 12709
F 117 - 1

Consultation Record

TO: Dr. Surgical

Will you accept transfer & treat? ____
Will you treat along with me? ____
Will you advise me on patient's care? ____

Is aware of consultation:

Family Yes____ No____
Patient Yes____ No____

Please see patient named above:
Reason: Abd Pain

My own opinion: ____

[signature, redacted]
Requesting Physician

6/2/00 1950 a Ans Son "Green"
Date/hour signed or requested

REPORT

Surgery - Pt transferred yest from Jay via consult of/ from Dr D Smith & cardiac assessment, ? of myocardial ischemia. Had been EGD'd by Dr Maddux, Milton, as w/u for reflux esophagitis, poss need for anti-reflux surgery. Has developed since N/V + diarrhea. Hurts in entire abd, worse in upper midabd + (R) side. Had had US to R/O stones but pt said Dr Maddux did not mentioned wether or not she had stones. No N/V or diarrhea written by Nurses. H+P was available & read. Agree c confusing picture and c PMH. PE - awake, alert, stable afebrile.

Abd obese, soft, no rebound or rigidity. Could be gastroenteritis, doubt perf viscus. Await GE consult. Also

DIAGNOSIS: await R/O cardiac & if not then re assess, ? of abd CT.

RECOMMENDATIONS: Await GE assessment, re✓ as needed, consider abd CT. Will follow. Thanks!

DATE: 6/2/00

SIGNATURE OF CONSULTANT [signature]

BAPTIST HOSPITAL
1000 WEST MORENO STREET
PENSACOLA, FLORIDA 32522-7500

CONSULTATION REPORT

PATIENT:	[redacted]	MR#:	00844878-0153
CONSULTING:	[redacted] MD	ROOM:	1W -117 -01
ATTENDING:	[redacted] MD	CONSULT DATE:	06/02/2000

REASON FOR CONSULTATION
Epigastric pain.

REVIEW OF PATIENT'S RECORD
The patient is a very perplexing 39-year-old white female who apparently has been wheelchair bound for the past 2 years. She was diagnosed with fibromyalgia about 2-3 years ago and has been to several physicians, including the University of South Alabama. She has had several tests done for rheumatological problems. In March 2000, she apparently had an upper esophagogastroduodenoscopy done which showed significant gastroesophageal reflux disease. She complains that since that time, she has been having abdominal pain, nausea, vomiting, and diarrhea, which persisted until about four days prior to admission when it got worse. She was seen at Jay Hospital Emergency Room and was transferred here because of abnormal changes in her EKG. She had ST-T wave changes in the anterolateral leads and was sent here for cardiac evaluation. She denies any history of now or in the past of chest pain. She has never had an MI. There is no history of fatty food intolerance, but she does admit to a slight amount of fever. There is no dysphagia, no anorexia, no weight loss. No history of jaundice, though she admits to significant flatulence dating back to the time of her upper endoscopy.

PAST MEDICAL HISTORY
1. Fibromyalgia for two to three years.
2. Gastroesophageal reflux disease.
3. Hysterectomy. Presently has no ovaries. The reason for hysterectomy was endometriosis.
4. History of breast biopsy. No history of breast cancer.
5. She has had two carpal tunnel surgeries and two operations for deviated nasal septum.
6. She also has a history of depression.

FAMILY HISTORY
Mother is diabetic. Brother has fibromyalgia. She has a sister with endometriosis and hypertension. She has two kids, of which one daughter is diabetes.

SOCIAL HISTORY
She smokes one pack a day and has been doing this for 20 years. She denies any history of ETOH or illicit drug use. She is a housewife.

HOME MEDICATIONS
1. Reglan 10 mg 1 p.o. a.c. and h.s.
2. Robaxin 1 p.o. q.i.d.
3. BuSpar 1 p.o. b.i.d.
4. MS Contin 30 mg p.o. b.i.d.

ontinued on next page

5. Prilosec 20 mg p.o. twice a day.
6. Elavil 100 mg 1 p.o. q.h.s.
7. Ambien 10 mg p.o. q.h.s.

ALLERGIES
NSAIDS, SULFA, AND ASPIRIN.

PHYSICAL EXAMINATION
GENERAL: This is a young lady, obese, lying flat in bed with depressed affect. Afebrile. No lymphadenopathy. Anicteric. Not in any obvious cardiopulmonary distress.
VITAL SIGNS: Blood pressure 138/83, pulse 69, respiratory rate 20, temperature 97.5°.
HEENT: Unremarkable.
CARDIOVASCULAR: First and second heart sounds are normal. No S3 or S4. No murmurs.
RESPIRATORY: Chest is clear to auscultation.
ABDOMEN: She is tender in the right upper quadrant and epigastrium. There is no abdominal distention. No guarding. There is no organ enlargement. Murphy's sign negative. Boas sign negative. She has normal bowel sounds.
EXTREMITIES: She has no pedal edema. No calf tenderness. She has +2 bilateral dorsalis pedis and posterior tibialis pulses.
CNS: Cranial nerves II-XII are grossly intact. She has diminished power in both upper extremities but there are no lateralizing signs. In her lower extremities, she has no movement in the left lower extremity but significantly grade 2 to grade 3 power in the right lower extremity. Plantars are downgoing.

SIGNIFICANT LABORATORY FINDINGS
Glucose 188. She had normal LFTs. Amylase was normal. CKs have all been negative, the first one was 109, the second 85. MB less than 1.

EKG - normal sinus rhythm at 77, initially with ST-T wave changes in the anterolateral leads.

IMPRESSION
1. Epigastric and right upper quadrant pain, cause undetermined at this time. Possible causes include gastroenteritis.
2. Chronic diarrhea.
3. Fibromyalgia.
4. Glucose intolerance, possible diabetes.
5. Gastroesophageal reflux disease.

Continued on next page

PATIENT:
MR#: 00-84-48-78
ROOM: 1W 117 01
CONSULT DATE: 06/02/2000

DISCUSSION AND PLAN

It is very unlikely that this lady has any ischemic cardiac disease. Her problem I would think is more gastrointestinal in nature. I concur with the gastroenterologist that she needs a CT scan of the abdomen and possibly a repeat EGD and stool studies. In the meantime, I would continue her home medication and anti-reflux therapy with Proton pump inhibitor. I must admit that this lady does present a very interesting array of symptoms and definitely a challenge.

At the same time, I would like to thank [redacted] for asking me to participate in the care of this patient.

T: 06/04/2000
D: 06/02/2000
504827/26972 /daf

[redacted] MD

cc: [redacted] MD
[redacted] MD

BAPTIST HOSPITAL
1000 WEST MORENO STREET
PENSACOLA, FLORIDA 32522-7500

CONSULTATION REPORT

PATIENT:		MR#:	00844878-0153
CONSULTING:	MD	ROOM:	1W -117 -01
ATTENDING:	, MD	CONSULT DATE:	06/02/2000

CHIEF COMPLAINT
Persistent epigastric pain and right upper quadrant abdominal pain.

HISTORY OF PRESENT ILLNESS
The patient presents with recurrent problems with abdominal pain and epigastric pain from Santa Rosa Medical Center. She was admitted for problems with atypical chest pain. To date, her cardiac workup has been negative. She has recently been evaluated with an upper endoscopy procedure b at Santa Rosa Medical Center that was essentially negative. It was suggested that she probably had some gastroesophageal reflux symptoms and was placed on Prilosec and had initial relief of symptoms but then required increasing doses of Prilosec and had little relief of symptoms. Since that time, she has had an abdominal ultrasound that was unremarkable and she was scheduled with for further evaluation with esophageal manometry and pH probe, which she has not yet had performed.

PAST MEDICAL HISTORY
Significant for chronic pain syndrome, hypercholesterolemia, fibromyalgia, gastroesophageal reflux disease.

PAST SURGICAL HISTORY
Deviated septum, hysterectomy, carpal tunnel syndrome, bladder tack.

PRESENT MEDICATIONS
MS Contin, Robaxin, Elavil, Ambien, Prilosec, Reglan, BuSpar.

ALLERGIES
Sulfa, aspirin, anti-inflammatories.

FAMILY HISTORY
Positive for heart disease, diabetes, anemia, hypertension. Denies any GI malignancies.

SOCIAL HISTORY
The patient is married, smokes a pack of cigarettes a day, denies alcohol use.

REVIEW OF SYSTEMS
Some chronic problems with headaches as she relates it to sinusitis, has significant problems with joint pain and joint arthralgias. She has significant problems with epigastric discomfort and right upper quadrant abdominal pain. Some associated nausea and diarrhea symptoms. Denies any melenic stools. No hematochezia. She states that she is unable to move her left leg, which is a chronic problem for her.

PATIENT: [redacted]
MR#: 00-84-48-78
ROOM: 1W 117 01
CONSULT DATE: 06/02/2000

PHYSICAL EXAMINATION
VITAL SIGNS: Blood pressure 108/65, weight 160, pulse 82, respiratory rate 18 per minute, temperature 98.3.
GENERAL: This is a cooperative female who is in moderate distress, lying supine in bed.
HEAD, EYES, EARS, NOSE, AND THROAT: Neck is supple, no jugular venous distention. CHEST: Clear to auscultation, although breath sounds are somewhat diminished in the bases. CARDIOVASCULAR: Heart regular rate and rhythm without murmurs or gallops auscultated. ABDOMEN: Soft and obese. Diffusely tender in the epigastric area and somewhat in the right upper quadrant as well, but mildly tender throughout the whole abdomen. There is no organomegaly appreciated. Bowel sounds are active x 4 quadrants. SKIN: Without masses or lesions. EXTREMITIES: No edema.

LABORATORY DATA
Basic metabolic panel is within normal limits except for an elevated glucose of 188. Liver enzymes are normal. CPK is normal.

IMPRESSION
1. Persistent epigastric pain and right upper quadrant pain.
2. Diarrhea.

PLAN
1. We will schedule her for a CT scan of the abdomen since she has been evaluated recently by an EGD as well as an ultrasound.
2. Will repeat hepatic panel, amylase and lipase. Rule out any pancreatitis.
3. If CT scan is negative, may need to repeat her esophagogastroduodenoscopy. We will base this on further evaluation of her symptoms.
4. Will check routine stool studies regarding C. difficile, ova and parasites and culture and sensitivity.

T: 06/03/2000
D: 06/02/2000
504783/26944 /lac

[redacted], MD
dictated by [redacted] ARNP/C

cc: [redacted], MD
[redacted], MD

BAPTIST HOSPITAL
1000 WEST MORENO STREET
PENSACOLA, FLORIDA 32522-7500

GASTROENTEROLOGY PROCEDURE REPORT

PATIENT: [redacted]
DICTATING: [redacted]
ATTENDING: [redacted], MD

MR#: 00844878-0153
ROOM: 1W -117 -01
PROC DATE: 06/04/2000

PROCEDURE
Esophagogastroduodenoscopy plus biopsy.

INSTRUMENT
Olympus video gastroscope.

PREMEDICATION
Sublimaze 4 cc and Versed 10 mg.

CLINICAL HISTORY
This is a 39-year-old white female admitted by [redacted] with atypical chest pain. She has also had a 10-year history of intermittent abdominal pain and probably a 10-year history of intermittent nausea and vomiting which seems to come in cycles. She does have an underlying history of recently elevated blood sugars but not a long history of diabetes suggestive of diabetic gastroparesis. An EGD was requested for further evaluation of an upper GI source of her symptoms.

PHYSICAL EXAMINATION
VITAL SIGNS: Temperature 97°, blood pressure 172/95, pulse 65, respirations 16, and O_2 saturation 100%.

DESCRIPTION OF PROCEDURE
The patient was placed in the left lateral decubitus position and after the above premedication, her conscious sedation was monitored by myself and the nurses. The flexible video gastroscope was placed without difficulty. The esophagus was normal. The scope was advanced into the stomach where there was some retained fluid. There was minimal prepyloric antral gastritis. A biopsy was taken of the prepyloric antrum for CLOtest to rule out Helicobacter pylori. The duodenal bulb, second and proximal third portions of the duodenum were all normal. Two random biopsies were taken at the second and proximal third portions of the duodenum as part of the diarrhea workup. The scope was then withdrawn back into the stomach and retroflexed as the angularis, fundus and cardia were inspected. No additional abnormalities were seen.

PATIENT: [redacted] A
MR#: 00-84-48-78
ROOM: 1W 117 01
PROC DATE: 06/04/2000

IMPRESSION

1. Retained fluid.
2. Minimal antral gastritis, status post biopsy for CLOtest.

PLAN

Will proceed to colonoscopy followed by gastric emptying study looking for evidence of gastroparesis.

T: 06/06/2000
D: 06/04/2000
505372/27153 /qt

cc: [redacted] MD
[redacted], MD

BAPTIST HOSPITAL
1000 WEST MORENO STREET
PENSACOLA, FLORIDA 32522-7500

GASTROENTEROLOGY PROCEDURE REPORT

PATIENT:		MR#:	00844878-0153
DICTATING:	MD	ROOM:	1W -117 -01
ATTENDING:	, MD	PROC DATE:	06/04/2000

PROCEDURE
Esophagogastroduodenoscopy plus biopsy.

INSTRUMENT
Olympus video gastroscope.

PREMEDICATION
Sublimaze 4 cc and Versed 10 mg.

CLINICAL HISTORY
This is a 39-year-old white female admitted by with atypical chest pain. She has also had a 10-year history of intermittent abdominal pain and probably a 10-year history of intermittent nausea and vomiting which seems to come in cycles. She does have an underlying history of recently elevated blood sugars but not a long history of diabetes suggestive of diabetic gastroparesis. An EGD was requested for further evaluation of an upper GI source of her symptoms.

PHYSICAL EXAMINATION
VITAL SIGNS: Temperature 97°, blood pressure 172/95, pulse 65, respirations 16, and O_2 saturation 100%.

DESCRIPTION OF PROCEDURE
The patient was placed in the left lateral decubitus position and after the above premedication, her conscious sedation was monitored by myself and the nurses. The flexible video gastroscope was placed without difficulty. The esophagus was normal. The scope was advanced into the stomach where there was some retained fluid. There was minimal prepyloric antral gastritis. A biopsy was taken of the prepyloric antrum for CLOtest to rule out Helicobacter pylori. The duodenal bulb, second and proximal third portions of the duodenum were all normal. Two random biopsies were taken at the second and proximal third portions of the duodenum as part of the diarrhea workup. The scope was then withdrawn back into the stomach and retroflexed as the angularis, fundus and cardia were inspected. No additional abnormalities were seen.

PATIENT: [redacted]
MR#: 00-84-48-78
ROOM: 1W 117 01
PROC DATE: 06/04/2000

IMPRESSION

1. Retained fluid.
2. Minimal antral gastritis, status post biopsy for CLOtest.

PLAN

Will proceed to colonoscopy followed by gastric emptying study looking for evidence of gastroparesis.

T: 06/06/2000
D: 06/04/2000
505372/27153 /qt

[redacted], MD

cc: [redacted] MD
[redacted], MD

BAPTIST HOSPITAL
1000 WEST MORENO STREET
PENSACOLA, FLORIDA 32522-7500

GASTROENTEROLOGY PROCEDURE REPORT

PATIENT:	[redacted]	MR#:	00844878-0153
DICTATING:	[redacted] MD	ROOM:	1W -117 -01
ATTENDING:	[redacted] MD	PROC DATE:	06/05/2000

PROCEDURE PERFORMED
Colonoscopy plus biopsy plus polypectomy.

INSTRUMENT
Olympus video colonoscope.

PREMEDICATION
Sublimaze 5 cc and Versed 17 mg.

DOCUMENTATION
By still photography.

CLINICAL HISTORY
This is a 39-year-old white female admitted by [redacted] with a 10-year history of epigastric abdominal pain and a one-week history of diarrhea consisting of four to six stools a day. Colonoscopy was requested for further evaluation of a colonic source of her diarrhea and abdominal pain.

PHYSICAL EXAMINATION
VITAL SIGNS: Temperature 99°, blood pressure 165/91, pulse 65, respirations 18, O_2 saturation 96%.

DESCRIPTION OF PROCEDURE
The patient was placed in the left lateral decubitus position and after the above premedication, her conscious sedation was monitored by myself and the nurses. Digital examination revealed small external hemorrhoids. The flexible video colonoscope was inserted and advanced to the cecum. The ileocecal valve appeared normal. The mucosa was inspected as the scope was slowly withdrawn. Unfortunately, the prep was very poor throughout. The portions of the ascending, transverse, descending and sigmoid colons appeared normal. In the rectum was a 2-3 mm sessile polyp removed with cold biopsy forceps. Two rectal biopsies were taken of a normal-appearing rectum as part of the diarrhea workup. The scope was retroflexed in the rectum; no additional abnormalities were seen. On slow withdrawal, it was noted that the patient had small external hemorrhoids.

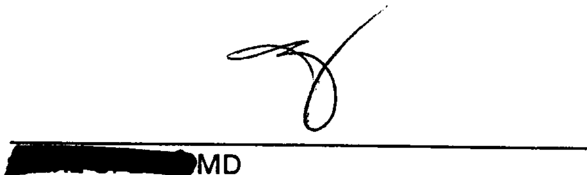
IMPRESSION
1. Poor prep.
2. One rectal polyp removed.
3. Small external hemorrhoids.

PATIENT:
MR#: 00-84-48-78
ROOM: 1W 117 01
PROC DATE: 06/05/2000

Of note is the fact that she seemed to have a significant amount of discomfort to colonic distention raising the possibility of irritable bowel syndrome.

PLAN
1. Would await stool studies and would obtain a small bowel series, either as an inpatient or outpatient.
2. May consider Bentyl or Lotronex.

I would like to thank for asking me to participate in this patient's care.



MD

T: 06/06/2000
D: 06/05/2000
505416/27438 /qt

cc: MD
MD

PATIENT:	[redacted]	**MR#:**	00844878-0153
DOB:	01/23/1961	**DATE:**	06/04/2000
SS#:	[redacted]	**ROOM:**	1W -117-01
AGE:	39	**PATH#:**	S00-3788
SEX:	F		
REFERRING:	[redacted] MD		

Rm 117

EXAMINATION: Small bowel bx
PREOPERATIVE Abd pain
POSTOPERATIVE: Pending

The specimen is labeled "small bowel biopsy" and consists of three pieces of tannish tissue measuring .2 x .2cm. All blocked.

JMPbb 6/5/00

DIAGNOSIS
Small bowel biopsy with no abnormality.

JMPbb 6/5/00

cc: [redacted] MD
MD

MD Pathologist

BAPTIST HOSPITAL
1000 WEST MORENO STREET
PENSACOLA, FL 32522-7500

CHART COPY HAS BEEN REVIEWED AND SIGNED BY THE PATHOLOGIST

BAPTIST HOSPITAL SURGICAL PATHOLOGY REPORT

BAPTIST HOSPITAL
1000 WEST MORENO STREET
PENSACOLA, FLORIDA 32522-7500

DISCHARGE SUMMARY

PATIENT:	[redacted]	**MR#:**	00844878-0153
DICTATING:	[redacted] MD	**ADM DATE:**	06/01/2000
ATTENDING:	[redacted], MD	**D/C DATE:**	06/06/2000

HOSPITAL COURSE

The patient was admitted initially for evaluation of chest pain; however, upon my questioning the patient really denied any chest pain symptoms and primarily complained of some epigastric right upper and right lower quadrant pain. No evidence of myocardial injury or damage was present during the admission and the patient developed no significant cardiac symptoms. She was seen in consultation by [redacted] and [redacted] for evaluation. EGD was performed revealing a normal esophagus, stomach with retained fluid and gastritis, normal small bowel. Colonoscopy was also performed due to the persistent diarrhea. A sessile polyp was noted which was removed, no significant additional findings were noted.

LABORATORY DATA

The laboratory data was remarkable for a cholesterol of 312, triglycerides of 632 and HDL of 25. ANA was negative. Urine porphyrin screen was negative. Anti-smooth muscle body antibody was negative. Stool culture was negative.

CT scan of the abdomen revealed fatty infiltration of the liver and was only equivocal finding. Echocardiograms performed revealing a normal left ventricle with ejection fraction of 55% and no significant valvular abnormality.

HOSPITAL COURSE

The patient continued to slightly improve during the course of the admission and by 06/05/00 was felt to be ready for discharge. Additional small bowel study and urine tests which were already outlined were to be completed as an outpatient. Gastric emptying study was also to be performed. Follow-up for this with Dr. Speer was recommended. Home medications were to be continued with the addition of Lotronex 1 mg b.i.d. Cardiac follow-up was not felt to be indicated at the present time as the patient did exhibit any evidence of ischemic disease.

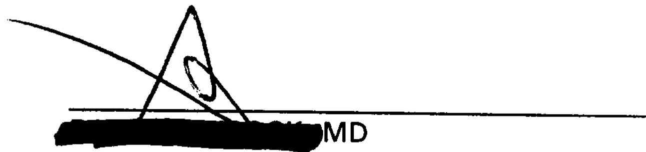
DISCHARGE DIAGNOSES

1. Persistent abdominal pain and diarrhea of uncertain origin, possibly irritable bowel disorder.
2. Fibromyalgia.
3. Obesity.
4. Glucose intolerance.
5. Depression.
6. Gastroesophageal reflux disease.
7. Hyperlipidemia.

PATIENT: [redacted]
MR#: 00-84-48-78
ADM DATE: 06/01/2000
D/C DATE: 06/06/2000

CONDITION AT DISCHARGE
Improved.

Diet and exercise discussed with the patient prior to discharge.



MD

T: 07/04/2000
D: 06/30/2000
512448/04070 /qt

cc: , MD

INITIAL ASSESSMENT FORM

Pt#: [redacted]

PRIORITY: 1

Patient: [redacted]

MR#: 258033

Emergent

DOB: 01/23/1961 AGE: 39YRS Sex: F

ED PHYS: [redacted]

DATE: 06/18/2000

PRIV MD: *UNKNOWN, PHYSICIAN

Presentation Time: 16:01 Triage Time: 16:01 Arrival Mode: WALK/TRIAGE

Weight: lbs. kgs. LMP: Last Tetanus:

Chief Complaint: ABD PAIN--GENERALIZED

Brief Assessment: COMPLAINS OF ABD PAINS RECENT HOSPITAL ADMISSION FOR IRRITABLE BOWELL SYNDROME

NIGHT SWEATS	UNK
WEIGHT LOSS	UNK
ANOREXIA	UNK
HEMOPTYSIS	UNK
FEVER	UNK
PREGNANCY POSSIBLE	UNK
NAUSEA AND/OR VOMITING	UNK
CHANGE IN BOWEL HABITS	UNK
DARK TARRY OR BLOODY STOOI	UNK

Vital Signs

T.	96.1	PO
P.	99	Regular
R.	20	Unlabored
BP.	126/073	
O2SAT.	97 %	

Plan

WR LA

ER XR

Sudden Onset:

Pre-Hospital Treatment:

Pediatric Assesment: N/A

Past Medical History: ABD PROBLEMS, IRREGULAR HEART BEAT

Allergies: ANTINFLAMATORY, ASA, SULFA

Medicines: LOPRESSOR, LOTRENEX, NEURONTIN, SERAZONE

Nurse Signature: _______________ BGG

Additional Notes

SANTA ROSA MEDICAL CENTER
1450 BERRYHILL ROAD
MILTON, FLORIDA 32570

NAME:
PATIENT MRN: 400079395
DATE: 06/19/2000
ATTENDING:

EMERGENCY DEPARTMENT HISTORY & PHYSICAL

The patient is a 39-year-old white female who was admitted by Dr. . The patient was diagnosed with abdominal pain and fecal impaction. There was a large amount of stool in the colon. The patient returned home with three enemas and analgesics. When the patient was ready to leave her home, she developed hypotension with her blood pressure going down to 80/50. She required fluid resuscitation of three liters lactose ringers. Her abdomen remained very soft. We performed a CT of the abdomen which showed bilateral small basilar interstitial infiltrates are identified, vascular distention, small bowel distended dilated proximal small amount of fluid on the ramp pre-colic gutter cecal region probably small bowel obstruction - unknown etiology.

I placed an NG after that report to improve her symptoms. The patient was continued with IV fluids. The case was discussed with primary care physician, Dr. who advised admission to Intensive Care Unit with IV fluids. We also consulted a surgeon. Dr. and she advised to admit the patient also and she explained that she was on her way to the hospital to see the patient right away.

M.D.
gs/dns
DD: 06/18/2000
DT: 06/21/2000

CC:

ICU

SANTA ROSA MEDICAL CENTER
1450 BERRYHILL ROAD
MILTON, FLORIDA 32570

NAME: [redacted]
PATIENT MRN: 400080305
DATE: 06/18/2000

HISTORY & PHYSICAL

REASON FOR ADMISSION: Hypotension.

HISTORY OF PRESENT ILLNESS: This is a 39 year old white female who presented to the Emergency Department with complaint of abdominal pain. She was undergoing evaluation for her abdominal pain and became acutely hypotensive with blood pressure of 90. She underwent a CAT scan during this time frame. Blood pressure went down into the 70's. CAT scan revealed dilatation of the stomach and proximal small bowel, and fluid collection in the region of the cecum. She continued to have profound hypotension, required intubation in the Emergency Department. Anesthesia was called for evaluation for operative risk and Dr. Browning stabilized the patient in the recovery room placing Swan-Ganz catheter and arterial lines. [redacted] and Dr [redacted] were also called for evaluation. It was felt that her abdominal pain was the source of her hypotension, probably intraabdominal sepsis. She had recently been seen at Baptist Hospital approximately 2 weeks ago with atypical chest pain. She underwent evaluation there without diagnosis of her symptoms.

PAST MEDICAL HISTORY: Significant for diabetes and an unknown neurologic disorder of the left lower extremity which produced cyanosis and weakness of the left leg. She has been wheelchair bound for approximately one year secondary to this. She has seen neurologists in Mobile and Birmingham for this.

PAST SURGICAL HISTORY: Positive for hysterectomy and carpal tunnel.

MEDICATIONS: Possibly Lopressor, Lotronex.

ALLERGIES: Anti-inflammatories and possibly sulfa.

PHYSICAL EXAM:
HEAD, EARS, EYES, NOSE AND THROAT: She has mild facial edema. Agonal respirations upon initial evaluation. She does respond to questions appropriately.
HEART: Regular rate and rhythm. No ectopy. She is somewhat tachycardic at about 140.
LUNGS: Relatively clear to auscultation with decreased respiratory effort due to abdominal pain.
ABDOMEN: Absent bowel sounds. It is soft, reportedly tender throughout. No masses palpated. Fullness in the epigastric region suggestive of gastrectasis. Diastasis recti noted on CAT scan.

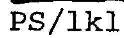
NAME:
PATIENT MRN: 400080305

HISTORY & PHYSICAL

EXTREMITIES: Full range of motion of the upper extremities. Right leg does move freely. Left leg only with severe pain. She has atrophy of the calf bilaterally, left greater than right.

IMPRESSION: 1. Hypotension secondary to intraabdominal sepsis.

PLAN: Abdominal exploration. The patient has already been stabilized by anesthesia department. However, she maintains blood pressure of 80. She has had cursory cardiac evaluation and this is not felt to be secondary to a catastrophic cardiac event. Risks have been explained to the husband, as well as the extremely grave prognosis.

 D.O.

PS/lkl
DD: 06/21/2000
DT: 06/21/2000

CC:

SANTA ROSA MEDICAL CENTER
1450 BERRYHILL ROAD
MILTON, FLORIDA 32570

NAME:
PATIENT MRN:
ATTENDING:
DATE OF CONSULT: 06/18/2000
DATE OF ADMISSION:

CONSULTATION REPORT

CHIEF COMPLAINT: Abdominal pain and hypotension.

HISTORY OF PRESENT ILLNESS: The patient is a 39-year-old woman who is an office patient of mine, who on the day of admission had abdominal pain and felt weak. She also reported having a history of a small amount of fresh blood per rectum earlier in the day. While in the Emergency Room, she became hypotensive with original blood pressure of 126/73 dropping down to systolic in the 90's and then into the 40's. The patient required fluid resuscitation with three liters of IV fluid as well as Dopamine drip to get the systolic back into the 60-80's. Subsequently ABG's showed a P02 of 30.2 and the patient was ventilated until she could be intubated in the Emergency Room.

The patient has been hospitalized at Baptist Hospital on 6/1/00 for similar symptoms. At the time they had done specific ST and T wave changes. Myocardial infarction was ruled out and the patient received gastroscopy and abdominal CT.

Immediate consultation was obtained with who operated on her and found rupture of sigmoid colon and found stool in the abdomen.

PAST MEDICAL HISTORY: Obtained mostly from my office record. She had a history of diabetes mellitus with recent diagnosis. Also a long history of fibromyalgia with chronic pain secondary to the fibromyalgia. The patient also had hyperlipidemia with triglyceride being found at one time of 6180 and on verification study showed a triglyceride of 4015 and cholesterol on the first study was 1020 with a subsequent check of 563. SGOT in February of 2000 was 713 at the time of the 6180 triglyceride.

The patient had irritable bowel syndrome and was recently worked up at Baptist Hospital, also tachycardia treated with Toprol and another doctor had found hematuria on her.

PAST SURGICAL HISTORY: Surgery for this hospitalization. Also partial hysterectomy in 1990 and a completion in 1994. Carpal tunnel surgery 1996. Sinus surgery at some point.

NAME: [redacted]
PATIENT MRN:

CONSULTATION REPORT

ALLERGIES: Sulfa and also reports gets GI upset from aspirin. Additionally she reports being allergic to Estratest and Premarin.

MEDICATIONS: Self administered vitamin B12, Ambien 10 mg at h.s., Elavil 100 to 150 mg at h.s., Robaxin 750 mg four times a day, and she also is on Serzone 200 mg four times a day, Lipitor 20 mg every day, Prilosec 20 mg twice a day, and Buspar 50 mg twice a day, MS-Contin 60 mg twice a day, Midrin prn for headaches and recently started on Lotrinex 1 mg capsules. She had been also using Compazine or Phenergan for nausea as well as TriCor 67 mg three times a day. This is the complete list obtained from my office record. On arrival to the Emergency Room, stated that she had been taking Lopressor and Lotrinex, Neurontin and Serzone.

SOCIAL HISTORY: One pack per day cigarette smoker and nondrinker. Lives with husband.

REVIEW OF SYSTEMS: Unable to obtain.

PHYSICAL EXAM: When seen this is a moderately obese woman in extremist in the Emergency Room. She was being bagged and she was in Trendelenburg position with systolic pressure in the 60's. Multiple IV's were in place. Temperature on arrival to the Emergency Room showed 96.1, pulse 152 and blood pressure systolic in the 60's and the patient was being bagged and not breathing on her own. The skin was sallow in color.
HEAD, EARS, EYES, NOSE AND THROAT: Pupils equal, round and reactive to light. Nose, mouth and throat were grossly unremarkable.
NECK: Without thyromegaly and no jugular venous distention was present.
LUNGS: Clear.
HEART: S1 and S2 without murmurs.
ABDOMEN: Distended and firm.
GENITALIA: Female, pelvic and rectal deferred.
Emergency Room doctor stated no stool or blood in rectum.
EXTREMITIES: Good range of motion of all four extremities. Poor muscle mass of the left leg but she was capable of moving the left leg when in pain.
NEURO: Awake and alert when she was oxygenated adequately and had an adequate systolic pulse and blood pressure. She was able to move all four extremities at this time.

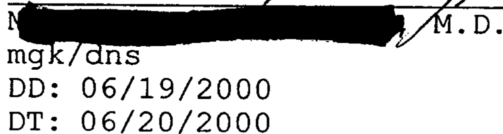
NAME:
PATIENT MRN:

CONSULTATION REPORT

LABORATORY/X-RAY: Electrocardiogram showed nonspecific ST and T wave changes and sinus tachycardia. CT of the abdomen showed some abnormalities reported near the cecum. Chest x-ray showed patchy interstitial infiltrates. CBC at 14,100 white blood cells with an hemoglobin and hematocrit of 16.4 and 49.3 and 417,000 platelets. There was a left shift with 78.8% segs. Electrolytes were unremarkable. BUN was 9. Creatinine 1.0 and calcium 9.3. LFT's showed slight elevation of AST and ALT. Amylase was normal and Sed rate was also normal.

IMPRESSION: The patient suffered catastrophic abdominal emergency which was shown at surgery to be a ruptured viscus with peritonitis. Hypovolemic versus septic shock. Respiratory failure. History of diabetes mellitus. History of fibromyalgia. Chronic pain and narcotic use for pain. History of irritable bowel syndrome. History of hyperlipidemia. History of hematuria. History of chronic weakness of left lower extremity. History of suggestion of underlying Addison's disease per another doctor. Polypharmacy.

PLAN: The patient went to surgery and subsequently was transported to Intensive Care Unit. She will receive inotropic support, ventilation and consults as appropriate.



M.D.
mgk/dns
DD: 06/19/2000
DT: 06/20/2000

CC:

SANTA ROSA MEDICAL CENTER
1450 BERRYHILL ROAD
MILTON, FLORIDA 32570

NAME:
PATIENT MRN: 400080305
DATE OF OPERATION: 06/19/2000

OPERATIVE REPORT

PRE-OPERATIVE DIAGNOSIS: Hypotension. Intraabdominal sepsis.

POST-OPERATIVE DIAGNOSIS: Perforated colon.

PROCEDURE: Abdominal exploration with Hartmann procedure/colostomy.

SURGEON: Schurman.

ANESTHESIA: General.

WOUND CLASSIFICATION: Dirty.

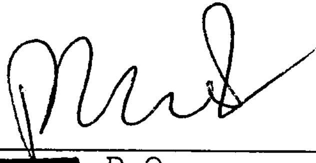
OPERATIVE INDICATIONS: This is a 39 year old white female who presents to the Emergency Department complaining of abdominal pain who, while in the Emergency Room department, developed profound hypotension. She was evaluated, stabilized and taken to the operating room for intraabdominal sepsis.

DESCRIPTION OF OPERATION: The patient was taken to the operating room, placed supine on the table, delivered general anesthesia via the anesthesia department. The abdomen was prepped and draped in a sterile fashion. Using the scalpel, a midline incision was made. Dissection was carried down to the fascia. The fascia was sharply incised and opened throughout the length of the incision. Peritoneum was grasped, elevated, sharply incised, and also opened to adequate length incision. Upon entering the abdomen, there was a large amount of fluid encountered, as well as fecal material. The abdomen was explored. Small bowel was noted to have mild degree of inflammatory adhesions. The sigmoid colon was followed and then the distal sigmoid colon has a large perforation with hard stool freely floating within the pelvis. This was removed. An area distal to the perforation was selected for transection. This was transected using GIA stapler. At that point, the mesentery was taken down in a sequential fashion using 2-0 Silk ties to an area distal to the perforation within the proximal sigmoid colon region. This was also selected for transection and the area was transected and the specimen was passed from the field. At that point, the abdomen was copiously irrigated and inspected for any other areas of perforation or interloop abscesses. None were noted. An area along the rectus muscle on the left lower abdominal wall was selected for colostomy site. Skin incision was made for this in a circular manner. Dissection was carried down through the subcutaneous

NAME: [redacted]
PATIENT MRN: **400080305**
DATE OF OPERATION: **06/19/2000**

OPERATIVE REPORT

tissue through the fascia. A cruciate incision was made in the fascia and incision was made in the posterior fascia. The pericolic fat was dissected free from the distal segment of the colon in order to facilitate movement of the colostomy through the anterior abdominal wall. The colostomy was brought up through the anterior abdominal wall, tacked into place using 2-0 Silk suture. At that point, the abdomen was again copiously irrigated. Drains were placed within each pelvic gutter and brought out through separate stab incisions. The fascia was then closed using running #1 Prolene sutures. Subcutaneous tissues were packed using normal saline soaked gauze. The colostomy staple line was then cut free and the colostomy was everted on itself to mature it, securing it to the skin level using 4-0 chromic suture and 2-0 chromic sutures. With that completed, the colostomy bag was placed and the patient was returned to the Intensive Care Unit in extremely unstable condition.



[redacted] D.O.
PS/IKI
DD: 08/16/2000
DT: 08/18/2000

CC:

SANTA ROSA MEDICAL CENTER
1450 BERRYHILL ROAD
MILTON, FLORIDA 32570

NAME: [redacted]
PATIENT MRN: **400080305**
DATE OF OPERATION: **06/27/2000**

OPERATIVE REPORT

PRE-OPERATIVE DIAGNOSIS: Necrotic colostomy

POST-OPERATIVE DIAGNOSIS: Same

PROCEDURE: Colostomy revision

SURGEON: [redacted]
ANESTHESIA: General
WOUND CLASS Contaminated

OPERATIVE INDICATIONS: This is a 39-year-old white female who approximately 18 days earlier had undergone colostomy placement for bowel perforation. She presents at this time with a necrosis of a distal segment of the colostomy. Procedure and surgical indications were discussed with the family and they elected to proceed with colostomy revision.

DESCRIPTION OF OPERATION: The patient was taken to the operating room and placed supine on the table and delivered the general anesthesia by the Anesthesia Dept. The area was prepped and draped in a sterile fashion. Using scissors the previous fascial closure was taken down and peritoneum again. The abdomen had only mild degree of inflammatory adhesions at this point. Left lower quadrant site of colostomy was immediately addressed and extremely large amounts of stool was noted to be within the left lower quadrant. This was removed and the area was copiously irrigated and the necrotic end of the colostomy was secured using a TA-55 blue stapler. The old colostomy was removed from its site and passed from the field. Using sharp dissection, the White line of Toldt was taken down off the left side of the abdomen mobilizing the colon towards the right. The proximal segment of the sigmoid colon was then resected back to the level of the left colic artery. At that point an area of viability was selected and the colon was transected using GIA stapler. The mesentery of the sigmoid colon was taken down in sequential fashion using 2-0 silk sutures. The colostomy was then brought out through a separate site on the right anterior abdominal wall and circular incision was made in the skin. Dissection was carried down to the fascia and the fascia was incised in a cruciate manner. The peritoneum was also incised. The colostomy was brought out through this site with easy mobilization. The abdomen was copiously irrigated and inspected for hemostasis. No other contaminates were found within the abdomen. A papillary dray was placed within the left gutter and

TCM

NAME:
PATIENT MRN: 400080305
DATE OF OPERATION: 06/27/2000

OPERATIVE REPORT

two capillary drains were placed out the right anterior abdominal wall; in the pelvis and one in the right gutter. The fascia was then closed using a running #1 prolene suture. Subcutaneous tissues were packed using normal saline gauze. The incision was closed and the colostomy was matured cutting free the staple line and everting the colostomy on itself using 2-0 chromic sutures. The free edge of the colostomy did bleed readily assuring viability. The colostomy bag was then attached and the patient was returned to the Intensive Care Unit in stable but guarded condition.

D.O.
PS/dns
DD: 08/16/2000
DT: 08/18/2000

CC:

SANTA ROSA MEDICAL CENTER
1450 BERRYHILL ROAD
MILTON, FLORIDA 32570

NAME: [redacted]
PATIENT MRN: **400080305**
DATE OF OPERATION: **07/07/2000**

OPERATIVE REPORT

PRE-OPERATIVE DIAGNOSIS: Prolonged ventilation
Decubitus wound on the back

POST-OPERATIVE DIAGNOSIS: Same

PROCEDURE: Tracheostomy
Debridement of decubitus wound on the back

SURGEON: [redacted]
ANESTHESIA: General
WOUND CLASS: Contaminated for tracheostomy
Dirty for debridement

OPERATIVE INDICATIONS: The patient is a 39-year-old white female who has been on a ventilator for approximately 2 weeks and anticipate prolonged ventilation. She also has a decubitus wound on her back felt to be secondary to CPR and hypotension. She presents at this time for tracheostomy and debridement.

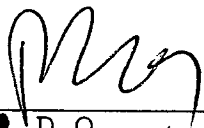
DESCRIPTION OF OPERATION: The patient was taken to the operating room and placed supine on the table and delivered anesthesia by the Anesthesia Dept. The neck was prepped and draped in a sterile fashion. Using a scalpel, incision was made approximately 2 finger breadths above the sternal notch in a horizontal fashion. Dissection was carried down to the strap muscle and dissection was carried vertically between the strap muscles to the thyroid. The isthmus was divided using electrocautery. The tracheal rings were identified and incision was made resecting a small amount of cartilage. AT that point a #8 Shiley tube was placed into the trachea without difficulty. The patient has maintained adequate oxygenation throughout the entire procedure. The skin was re-approximated using 3-0 nylon suture and a tracheostomy was placed with 3-0 nylon sutures. At that point the patient was returned to a left lateral position and using scalpel necrotic skin was dissected free from the subcutaneous fat down to

ICU

NAME:
PATIENT MRN: **400080305**
DATE OF OPERATION: **07/07/2000**

OPERATIVE REPORT

level of viable fatty tissue. The wound was packed with normal saline wet to dry dressings and she was returned to the Intensive Care Unit in stable condition.



D.O.

PS/dns
DD: 08/16/2000
DT: 08/18/2000

CC:

SANTA ROSA MEDICAL CENTER
1450 BERRYHILL ROAD
MILTON, FLORIDA 32570

NAME:
PATIENT MRN: 400080305
DATE OF OPERATION: 09/01/00

OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS:
1. Inanition.
2. Chronic abdominal wound.

POSTOPERATIVE DIAGNOSIS:
1. Inanition.
2. Chronic abdominal wound.

PROCEDURE:
1. PEG tube.
2. Wound closure.

SURGEON: , D.O.

ANESTHESIA: General.

OPERATIVE INDICATIONS:
The patient was taken to the OR, placed supine on the OR table, delivered general anesthesia via her tracheostomy. At that point, the endoscope was passed under direct visualization into the stomach. The stomach was insufflated and decompressed normally. The scope was then easily passed into the duodenum. She was noted to have a mild amount of prepyloric edema, otherwise no abnormalities, no ulcerations. An area on her anterior abdominal wall was identified for PEG tube placement and cleaned with Betadine. This was anesthetized with 1% Xylocaine local. A small incision was made, a spinal needle was introduced into the incision and directly into the anterior gastric wall. A guidewire was placed through this, grasped with a snare and brought out through the mouth. The PEG tube was fed over the guidewire and brought out through the abdominal incision. At that point, the endoscope was again placed to confirm adequate placement and a feeding adapter was placed on the end of the feeding tube. At that point, the abdomen was prepped and draped in a sterile fashion. The previously open abdominal wound was reapproximated using 2-0 nylon suture along the length of the wound. With that completed, sterile dressing was applied. Dressing change was made on her back. The patient was returned to PACU in stable condition.

D.O.
PS/ecta-kjp
DD: 09/14/00
DT: 09/20/00
Job: 49767

ICU

SANTA ROSA MEDICAL CENTER
1450 BERRYHILL ROAD
MILTON, FLORIDA 32570

NAME:
PATIENT MRN: 400080305
ATTENDING:
DATE OF CONSULT: 6-21-00
DATE OF ADMISSION:

CONSULTATION REPORT

This is a 39-year-old white lady who apparently has been wheelchair bound as I understand it and had been seen by a neurologist in the past but I am uncertain as to exactly why. She had been having severe abdominal pains and upon admission here because of syncope, subsequently found to have fluid in her abdomen and the probability of a ruptured bowel. She has coded twice, the last time of which she was severely acidotic and hypoxic. It is thought now that she may be septic and volume depleted. She has been on small amounts of pressure agents at this point including Ativan for sedation and Demerol. She has been using little Pavulon at recent time. The patient was brought to Dr. [redacted] who then consulted me for survivability. She also is on ARDS at this time and has been breathing on a respirator at about 30-40 times a time. Her chest x-ray shows patchy infiltrates in the right base. She has not had a CT of the head. At best will she show some decorticate movements and some grimacing to pain occasionally but does not open her eyes or show any evidence of response. Her temperature had spiked up to nearly 108. She has shown some degree of electrolyte imbalance. Her antibiotic coverage at this point - Clindamycin and Diflucan.

PHYSICAL EXAM: Shows her at a ventilatory rate of about 33. Her pulse rate is 130 and her blood pressure is 127/65. She is responsive only to deep sternal massage and shows a bit of increased tonus in the extremities. No clear decorticate or decerebric posturing is seen. Pupils are mid position, down gaze and poorly responsive. Dolls are negative. Corneals are not tested. ~~At this point were not done~~. There is no nuchal rigidity. She is hyperventilatory as noted above.

IMPRESSION: Suspected is severe anoxic encephalopathy, metabolic encephalopathy related to severe acidosis in addition. She also may be septic. She had been running a temperature probably suspicious for a central fever. Her condition is compatible then with severe encephalopathy. Brain scan might be helpful to determine evidence of hemorrhage and infarct. This may add to the determination of the prognosis. I would feel that she should be monitored and supported for the next couple of days. Discussion will have to be held with the

ICU

NAME:
PATIENT MRN: 400080305

CONSULTATION REPORT

patient's family as to quality of life issues and termination wishes. EEG will be done to help determine subclinical seizure and encephalopathy. Lumbar puncture might need to be considered for meningitis and encephalitis. Prognosis I feel is quite grave.

I will continue to follow the patient as well.

Thank you for this consultation.

M.D.

ms/dns
DD: 06/21/2000
DT: 06/26/2000

CC:

SANTA ROSA MEDICAL CENTER
1450 BERRYHILL ROAD
MILTON, FLORIDA 32570

NAME: [redacted]
PATIENT MRN: 400269338
ADMISSION DATE: 06/19/2000
DISCHARGE DATE: 09/30/2000

25-80-33
9/30

DISCHARGE SUMMARY

JOB ID#: 53926

PRIMARY DIAGNOSIS: Abdominal sepsis from colon perforation.

SECONDARY DIAGNOSES:
1. Septicemia.
2. Hypoxic encephalopathy.
3. Quadriplegia.
4. Necrotizing fasciitis.
5. Respiratory failure.
6. Colostomy revision.
7. Pneumonia.
8. Thrombocytopenia.
9. Pulmonary insufficiency.
10. Gastrointestinal hemorrhage.
11. Atelectasis.
12. Diabetes.

PROCEDURES: Sigmoidectomy with colostomy. Lung debridement. Revision of stoma. Bronchoscopy. PEG tube placement. Tracheostomy placement.

ADMISSION HISTORY: This is a 39-year-old white female who was admitted to the emergency department with acute abdominal sepsis secondary to bowel perforation. She underwent a surgical resection of this and approximately ten days later was noted to have necrosis of the colostomy. She had revision of this. She was critically ill the majority of her hospital stay requiring prolonged ventilation and multiple episodes of resuscitative measures.

CONSULTATIONS: Pulmonology, cardiology, infectious disease, neurology, orthopedics and rehab medicine.

She developed necrotizing fasciitis of the back felt to be secondary to bruising from CPR. This was debrided multiple times. Rehab evaluation was performed several times for possible placement in a rehab facility; however, nobody felt she was strong enough to tolerate their particular facility. At that point, preparations were made for discharge to home with home health.

NAME: [redacted]
PATIENT MRN: **400269338**

DISCHARGE SUMMARY

DISPOSITION: The patient was discharged to home with home health. She is still on tracheostomy with oxygen supplementation, IBBP treatment b.i.d., tube feed, wound care daily, trachea suctioning p.r.n.

For details of this protracted hospital stay, please see the chart.

[redacted] D.O.
PS/wv
DD: 11/08/2000
DT: 11/08/2000

CC:

ICU1

N ** PATHOLOGY REPORT 06/20/2000

, MD
SANTA ROSA MEDICAL CENTER
1450 BERRYHILL RD, MILTON, FL 32570

MR#: SRMC-43708 HOSP#:00095035903
DOB: 01/23/1961 AGE/SEX:39Y F
PATH#:00DN-994 DATE: 06/19/2000
LOCATION: SANTA ROSA TISSUES

00DN-994

ORDERING PHYSICIAN:
, DO
1544 BERRYHILL MEDICAL PK
MILTON, FL
MILTON, FL 32570

COPY TO:

SOURCE OF SPECIMEN: 1: SEGMENT OF SIGMOID COLON

PRE-OPERATIVE DIAGNOSIS: HYPOTENSION
POST-OPERATIVE DIAGNOSIS: SAME AS PRE-OPERATIVE DIAGNOSIS
PERFORATED BOWEL

PREVIOUS CASES:
00DN-585 98SR-469 97SR-2086 89-CG-03277

GROSS DESCRIPTION
RIF "segment of sigmoid colon" consists of two pieces of tissue which consist of open fragments of bowel and attached adipose tissue. One of them is 5 cm in length, 2-1/2 cm in width, and 2 cm in thickness. The other is 4 x 2-1/2 and is 1 cm in thickness, with attached adipose tissue measuring x 2 x 1 cm. The surfaces are granular and gray and are free of ulceration neoplasia. One piece has a wrinkled area with a linear appearance, thout any deep ulcers or evidence of neoplasm. The other piece has a segment of linear tissue and wrinkled area which is 2 x 0.5 cm. There is some hemorrhage in the adipose tissue adjacent to the wrinkled area. On the piece with the longer linear wrinkled area, a depressed area adjacent to the wrinkled area is 0.8 cm in diameter. On examining this, a perforated area is identified extending from the mucosa. I will attempt to demonstrate this perforation on slide A1. Sections of the wrinkled mucosa are A2. Sections of the mucosa on the other piece of bowel are submitted as A3, with a section taken through the wrinkled area.
DPN/PT/sd 06/19/2000

MICROSCOPIC DESCRIPTION
"A" demonstrates a perforated area extending the full thickness of the bowel with adjacent peritonitis and cellulitis of the peritoneal fat. A small amount of foreign material is present outside the bowel wall. Other sections demonstrate an epithelial invagination with no inflammatory or neoplastic changes of the mucosa. There is focal peritonitis.

PATHOLOGIC DIAGNOSIS
SIGMOID COLON:
- **TWO SEGMENTS OF COLON SHOWING FOCAL AREAS OF PERFORATION AND PERITONITIS ASSOCIATED WITH AREAS OF EPITHELIAL INVAGINATION.**

/PT/tmj 06/20/2000
END OF REPORT
******VERIFICATION SIGNATURE: MD, PATHOLOGIST (17368)******
te Finalled: 06/20/2000

CORPORATION ** PATHOLOGY REPORT 06/29/2000

ICD1

MD
SANTA ROSA MEDICAL CENTER
1450 BERRYHILL RD, MILTON, FL 32570

NAME:
MR#: SRMC-50770 HOSP#:00095035903
DOB: 01/23/1961 AGE/SEX:39Y F
PATH#:00DN-1059 DATE: 06/28/2000
LOCATION: SANTA ROSA TISSUES

00DN-1059

ORDERING PHYSICIAN:
, DO
1544 BERRYHILL MEDICAL PK
MILTON, FL
MILTON, FL 32570

COPY TO:

SOURCE OF SPECIMEN: 1: PORTION OF COLON

PRE-OPERATIVE DIAGNOSIS: NOT STATED
POST-OPERATIVE DIAGNOSIS: NOT STATED
PREVIOUS CASES:
00CN-1476 00DN-994 00DN-585 98SR-469 97SR-2086
89-CG-03277

GROSS DESCRIPTION

RIF "portion of colon - " consists of three segments of colon, one measuring 22 cm in length and 4 cm in diameter. Another is 11 cm in length and 4 cm in diameter. The third is 10 cm in length and 4 cm in diameter. The outer surfaces are partially covered by greenish exudate. The two smaller pieces are largely made of non-viable-appearing bowel. One piece consists of greenish, necrotic bowel along its entire length. A section is submitted as A1. The other smaller piece has a sharply demarcated area of necrosis located 5 cm from the end, but the remainder of the bowel appears viable. No tumor is present. A section of the viable-appearing bowel is A2 and the non-viable-appearing portion is A3. The longest segment has relatively unremarkable mucosa without any ulceration or tumor masses. The outer wall does show some exudate on the fatty tissue. The mucosal surface is stained yellowish-brown. Representative sections of the long segment of bowel are A4 and A5.
/PT/sd 06/28/2000

MICROSCOPIC DESCRIPTION

Areas of complete necrosis are present in two of the segments of bowel. The remaining bowel shows an entirely viable appearing mucosa and wall focally covered by granulation tissue and organizing fibrinous exudate containing foreign material.

PATHOLOGIC DIAGNOSIS
COLON RESECTION:

- **THREE SEGMENTS OF COLON WITH ONE PIECE SHOWING COMPLETE ISCHEMIC NECROSIS, ONE PIECE SHOWING PARTIAL ISCHEMIC NECROSIS WITH VIABLE MARGIN, AND THE THIRD PIECE SHOWING VIABLE BOWEL WITH ORGANIZING GRANULATION TISSUE AND ORGANIZING FIBRINOUS EXUDATE ON SEROSA.**
- **PERITONITIS.**
- **FOREIGN BODY REACTION ON PERITONEUM.**

DPN/PT/tmj 06/29/2000
END OF REPORT
******VERIFICATION SIGNATURE: D MD, PATHOLOGIST (17368)******
Date Finalled: 06/29/2000

CORPORATION PATHOLOGY REPORT 07/31/2000 ICLL

MD
SANTA ROSA MEDICAL CENTER
1450 BERRYHILL RD, MILTON, FL 32570

MR#: SRMC-43708 HOSP#:00095036885
DOB: 01/23/1961 AGE/SEX:39Y F
PATH#:00DN-1221 DATE: 07/28/2000
LOCATION: SANTA ROSA TISSUES

COPY TO:

00DN-1221

ORDERING PHYSICIAN:
DO
1544 BERRYHILL MEDICAL PK
MILTON, FL
MILTON, FL 32570

SOURCE OF SPECIMEN: 1: MUSCLE FROM BACK

PRE-OPERATIVE DIAGNOSIS: NECROTIZING FASCIITIS
POST-OPERATIVE DIAGNOSIS: SAME AS PRE-OPERATIVE DIAGNOSIS
PREVIOUS CASES:
00DN-1059 00CN-1476 00DN-994 00DN-585 98SR-469
97SR-2086 89-CG-03277

GROSS DESCRIPTION
Received in the fresh state labeled back tissue" consists of multiple irregular, reddish fragments of apparent muscle tissue which are 2 x 1-1/2 x 1.8 cm. They are received in a sterile container. The specimens will be sent for fungus culture. The specimen consists of muscle tissue having a tan discoloration. A portion will be submitted for frozen section examination and Gram's stain. The remainder will be entirely processed for permanent section examination. Tissue for frozen section and permanent section submitted in block A.
PT/sd 07/28/2000

FROZEN SECTION DIAGNOSIS
TISSUE FROM BACK:
- **CHANGES CONSISTENT WITH NECROTIZING FASCIITIS.**
- **GRAM STAIN SHOWS NUMEROUS BACTERIA.**

MICROSCOPIC DESCRIPTION
Complete necrosis of all muscle fibers is seen with a scanty acute inflammatory infiltrate and clouds of coccal bacteria many of which stain gram positively, but others gram negatively. The PAS stain is negative for fungal organisms.

PATHOLOGIC DIAGNOSIS
TISSUE FROM BACK:
- **NECROTIZING FASCIITIS WITH EXTENSIVE BACTERIAL GROWTH OF GRAM POSITIVE AND GRAM NEGATIVE ORGANISMS.**
- **FUNGUS STAINS NEGATIVE.**

PT/tmj 07/31/2000
END OF REPORT
******VERIFICATION SIGNATURE: MD, PATHOLOGIST (17368)******
Date Finalled: 07/31/2000

P[redacted] PATHOLOGISTS, .A. ** PATHOLOGY REPORT 06/21/2000

ICU

[redacted] P.A.
5151 N 9th AVE, [redacted]

NON-GYN CYTOLOGY REPORT

NAME: [redacted]
PATH #: 00CN-1476
DOB: 01/23/1961 AGE/SEX: 39Y F
MR#: SRMC-50770 HSP# [redacted]

ORDERING PHYSICIAN:
[redacted]
1551 BERRYHILL ROAD
MILTON, FL
32570

LOCATION: SANTA ROSA TISSUES
DATE COLLECTED: 06/19/2000
DATE RECEIVED : 06/19/2000
DATE REPORTED :
COPY TO:
[redacted]

00CN-1476

TYPE AND SOURCE OF SPECIMEN:
BRONCHIAL WASHING RT AND LEFT

CLINICAL IMPRESSION:
ASPIRATION

PREVIOUS CASES:
00DN-994 00DN-585 98SR-469 97SR-2086 89-CG-03277

GROSS DESCRIPTION
20 cc tan fluid. Two smeared slides.

PATHOLOGIC DIAGNOSIS:

BRONCHIAL WASHING RT AND LEFT:
- NO EVIDENCE FOR MALIGNANCY IDENTIFIED IN THIS SPECIMEN.
- FUNGAL ORGANISMS MORPHOLOGICALLY CONSISTENT WITH CANDIDA SPECIES
- TWO SLIDES REVIEWED

CEF/saf/jmh 6/20/2000

END OF REPORT
****VERIFICATION SIGNATURE: [redacted] MD, PATHOLOGIST (25817)****
Date Finalled: 06/20/2000

SANTA ROSA MEDICAL CENTER
1450 BERRYHILL ROAD
MILTON, FLORIDA 32570

NAME:
PATIENT MRN: 400080305
ATTENDING:
DATE OF CONSULT: 08/14/2000
DATE OF ADMISSION:

CONSULTATION REPORT

REASON FOR CONSULTATION: Communication deficits.

HISTORY OF PRESENT ILLNESS: This 39 year old white female is examined in the Intensive Care Unit bed. She communicates by nods and looking at word signs posted around the room. The history is obtained from the old records, as well as from discussions with the staff and Dr. Schurman. Reportedly, the patient was admitted on 6-19-00, following a deterioration in status while she was in the Emergency Room. She reportedly had come to the Emergency Department for abdominal pain. While undergoing evaluation for this, she reportedly became hypotensive. She received acute treatment for the hypotension. She underwent a CT scan which indicated dilatation of the stomach and proximal small bowel. She required placement of a Swann-Ganz catheter and arterial lines. She subsequently underwent abdominal surgery with apparent infarction of bowel. The patient underwent a colostomy. She later had a deterioration of her status requiring repeat surgery, take down of the colostomy for repeat perforation, and placement of a new colostomy. Her course has been complicated by multiple respiratory arrests requiring multiple episodes of resuscitation. She has developed an infection in the back requiring debridement with cultures indicating necrotizing fasciitis. The patient is undergoing maintenance physical therapy including range of motion techniques to maintain her flexibility. She is being turned routinely and is wearing Multi-Podus boots for skin protection.

PAST MEDICAL HISTORY: Diabetes. Left lower extremity monoparesis, undiagnosed. Necrotizing fasciitis of the back, multiple respiratory arrests. Possible anoxic encephalopathy vs metabolic encephalopathy.

PAST SURGICAL HISTORY: Hysterectomy. Carpal tunnel release. Colostomy x 2. Debridement of necrotizing fasciitis.

MEDICATIONS: Elavil. Norvasc. Unasyn. Dialose. Vasotec. Intralipid. Diflucan. Lasix. Heparin flush. Humulin-R scale. Trandate. Levaquin. Reglan. Lopressor. Nitroglycerin. Nutri-Flo. Prednisone. Accupril. Dopamine prn. Phenylephrine prn hypotension. Carafate. Acetaminophen prn. Alpha-Keri prn. Mylanta prn.

JLM

NAME: [redacted]
PATIENT MRN: 400080305

CONSULTATION REPORT

Artificial Tears prn. Atropine prn hypotension. Valium prn sedation. Dramamine prn nausea. Benadryl prn. Dilaudid prn pain. Ibuprofen prn elevated temperature. Lidocaine prn ventricular irritability. Ativan prn sedation. Demerol prn pain. Morphine prn pain. Nitroglycerin prn chest pain. Darvocet N-100 prn pain. Petrolatum prn. Amosan prn.

ALLERGIES: Anti-inflammatories. Possible sulfa.

FUNCTIONAL STATUS: The patient is non-ambulatory. She is dependent in all mobility, hygiene, bathing and dressing.

SOCIAL HISTORY: Prior to admission, the patient lived with her husband.

PHYSICAL EXAM: Well developed, poorly nourished, white, 39 year old female, in no acute distress. Vital signs: 127/52, 131, 26, 98.0.
HEAD, EARS, EYES, NOSE AND THROAT: Eyes - sclera are clear. Perrla. Extraocular movements are full and intact. Nose - nasal septum is midline. Membranes are moist. Mouth - oral mucosa is moist. The patient is unable to close her mouth. She approximates closure lacking 1 ½ inches. The patient's lower teeth are intact. Her upper teeth are missing. She has dentures but has not worn them since being hospitalized. Temporomandibular joints are intact, but there is minimal to no movement actively. There is swelling of the tissues of the next extending into the jaw line bilaterally. There is a #4 Shiley trachea with inter canula in place with a humidification mask over the trachea. No anterior or posterior cervical lymphadenopathy is noted. There is decreased fine joint mobility in the cervical spine.
HEART: Regular rate and rhythm. No murmur.
LUNGS: Clear to auscultation in the upper anterior fields. The lower posterior fields have a marked decrease in bilateral breath sounds.
ABDOMEN: Soft. Bowel sounds are decreased. Abdominal muscle tone is poor.
NEURO: Cranial nerves were tested. Cranial nerves 3, 4, 6 show direct and consensual constriction of the pupils. Extraocular movements are full and intact. No nystagmus. Cranial nerve 5 shows no active jaw movement. Cranial nerve 7 shows minimal to no facial movement in the upper and lower face. Cranial nerve 8 is intact with the patient responding appropriately to questions and instructions to look around the room. Cranial nerves 9, 10 show upward palatal

NAME: [redacted]
PATIENT MRN: **400080305**

CONSULTATION REPORT

movement. Cranial nerve 12 shows lack of tongue protrusion, however, the patient is able to extend her tongue slightly. No fasciculations are noted. Cranial nerves 1, 2, and 11 were not tested. Muscle stretch reflexes on a scale of 1-5 are one and equal bilaterally in the biceps, triceps, brachioradialis, pronator teres, patellar and hamstring tendons. Achilles tendons were not tested due to the patient's Multi-Podus boots. No Babinski is noted bilaterally. No clonus is noted bilaterally.
MUSCULOSKELETAL: The patient has markedly poor muscle tone in all extremities and in the abdominal musculature. Passive range of motion of the upper and lower extremities is grossly within normal with the exception of decreased abduction and external rotation at both shoulders. Manual muscle testing is on a scale of 1-5, and is +3 and equal bilaterally at the shoulder elevators and forward flexors. It is 0 and equal bilaterally in the remainder of the major and minor muscle groups of the upper and lower extremities.

ASSESSMENT:

1. Encephalopathy with cognitive deficits and quadriplegia.
2. Deficits in functional activities, especially communication, active range of motion, self care skills, hygiene, gross and fine motor control. The patient appears to be accurate ~~and he has~~ with yes-no questions, and directing some needs by looking towards communication sheets hung around the room.
3. History of diabetes.
4. Status-post colostomy x 2.
5. Status-post debridement of the back for necrotizing fasciitis.

RECOMMENDATIONS:

1. Continue with the communication sheets posted around the room. At the present time, the patient can respond to yes/no questions and look towards approximately half a dozen sheets posted on the walls. Though this is still a severe restriction in the patient's communication ability, it is much better than many patients with various encephalopathies or restricted to only yes/no responses.
2. The patient may benefit from communication technology devices. However, the availability or the patient's ability to use them is severely limited. For instance, due to the lack of voluntary activity in the upper extremities, the patient will not be able to use a Handy Talk device, which requires the patient to type out responses. Due to the inability to achieve mouth closure, the

NAME: [redacted]
PATIENT MRN: 400080305

CONSULTATION REPORT

patient, at this time, is unable to use a mouth splint with stick to either activate a Handy Talk or to point to more communication charts.

3. X-ray of mouth to evaluate temporomandibular joints for possible mobilization to improve jaw closure. If this is possible, the patient may be able to use a mouth stick and thereby increase her communication abilities.
4. Speech and language pathology to aid with oral stimulation in an effort to improve lip closure and tongue movement in preparation for speech, as well as stimulation of oral motor mechanism to aid jaw closure. The nurses should be present during the speech and language pathology sessions due to the patient's tendency for respiratory distress.

Thank you for allowing me to assist you with this very interesting patient. I will continue to assist you and her anyway possible. I will deal with the therapists as needed.

Time of evaluation, review of records, dictation and discussing case with staff: 1 ½ hours.

FAAPM&R, FAOC

LP/IKI
DD: 08/14/2000
DT: 08/15/2000

CC: Dr.
Dr.
Dr.

[redacted] M.D.
4288 Woodbine Rd., Ste. A
Pace, FL 32571

HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability. If you need assistance with this form, please feel free to ask the receptionist.

PATIENT NAME: [redacted] BIRTHDATE: 1/23/61

CHIEF COMPLAINT TODAY: Need Med Refilled & Need ~~Brest~~ Breast check Got A Knot in left Breast

ALLERGIES:

Are you allergic to any medications? (Yes) No If yes, please list: Sulfur, Asprin, Anti inflamator
~~Do you have any food or other allergies? Yes (No) If yes, please list~~ estrogen

MEDICATIONS: Are you currently taking any medications? Yes No If yes, please list below:

NAME OF MEDICATION	DOSAGE	HOW OFTEN DO YOU TAKE THIS?
B-12 Shots	1cc	every 2 weeks
Ambien	10mg	1 At Night
Elavil	25mg	~~1 X A Day~~ 4 tab at Night
Darvect	150mg	4 X A Day
Robaxin	750mg	4 X A Day

Please list additional medications on a separate sheet of paper if necessary.

Do you take nutritional supplements? Yes No If yes, please list:
Do you use alternative medicine therapies? Yes No If yes, please list:

SPECIALISTS: Are you currently under the care of any specialists? (Yes) No If yes, please list below:

Physician Name	Speciality
Dr. Kimbrell	Fibromyalgia

PATIENT SOCIAL HISTORY:

Marital status: Single: ✓ Married: ✓ Separated: ___ Divorced: ___ Widowed: ___
Use of Alcohol: Never: ✓ Rarely: ___ Moderate: ___ Daily: ___
Use of Tobacco: Never: ✓ Previously, but quit: ___ Current packs/day: 1pK
Use of Drugs: Never: ✓ Type/Frequency: ___
Excessive exposure At home or work to: Fumes: ___ Dust: ___ Solvents: ___ Airborne Particles: ___ Noise: ___

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Not sure

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
Measles	no yes	Anemia	no yes	Back trouble	(yes)	Hepatitis	(no)
Mumps	no yes	Bladder Infections	no yes	High Blood Pressure	no yes	Ulcer	(yes)
Chickenpox	no yes	Epilepsy	no yes	Low Blood Pressure	no yes	Kidney Disease	(no)
Whooping Cough	no yes	Migraine Headaches	(yes)	Hemorrhoids	(yes)	Thyroid Disease	(no)
Scarlet Fever	no yes	Tuberculosis	no yes	Date of last chest x-ray		Bleeding Tendency	(no)
Diphtheria	no yes	Diabetes Not Sure	no yes	Asthma	(no)	Any other disease (please list):	no yes
Smallpox	no yes	Cancer	(no)	Hives or Eczema	(no)		
Pneumonia	no yes	Polio	(no)	AIDS or HIV+	(no)		
Rheumatic Fever	no yes	Glaucoma	(no)	Infectious Mono	(no)		
Heart Disease	no yes	Hernia Hiatal	(yes)	Bronchitis	(no)		
Arthritis	(yes)	Blood or Plasma Transfusions	no yes	Mitral Valve Prolapse	(no)		
Venereal Disease	no yes			Stroke	(no)		

Previous Hospitalizations/(Surgeries)/Serious Illnesses

	When?	Hospital, City, State
partial ~~[scribbled]~~ Hyst	1990	West Florida
Hyst	1994	Milton Hos
Both hand C.T.S.	1996	
(2) Sinus Surgery		

Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father		Hole in his heart)	ANUrism
Mother		Diabetes,	
Siblings		Nerves, Back problem	
S[illegible]		Sinus, Back problems, HeartBurn	
Children		Mytro Valve prolapse	
		DIABetes	

ITEM 16786 © 1998 COLWELL SYSTEMS 1.800.637.1140

Review of Systems: Please indicate any personal history below:

(Circled answer shown in brackets.)

☐ **Constitutional Symptoms**
- Good general health lately ..... No Yes
- Recent weight change .... No Yes [Yes]
- Fever .... No Yes [Yes]
- Fatigue .... No Yes [Yes]
- Headaches .... No Yes [Yes]

☐ **Eyes**
- Eye disease or injury .... No Yes
- Wear glasses/contact lenses .... No Yes
- Blurred or double vision .... No Yes [Yes]

☐ **Ears/Nose/Mouth/Throat**
- Hearing loss or ringing .... No Yes [Yes]
- Earaches or drainage .... No Yes [No]
- Chronic sinus problem or rhinitis . No Yes [Yes]
- Nose bleeds .... No Yes [No]
- Mouth sores .... No Yes [No]
- Bleeding gums .... No Yes [No]
- Bad breath or bad taste .... No Yes [Yes]
- Sore throat or voice change .... No Yes [Yes]
- Swollen glands in neck .... No Yes [Yes]

☐ **Cardiovascular**
- Heart trouble .... No Yes [No]
- Chest pain or angina pectoris .. No Yes [No]
- Palpitation .... No Yes [Yes]
- Shortness of breath w/walking or lying flat .... No Yes [No]
- Swelling of feet, ankles or hands. No Yes [Yes]

☐ **Respiratory**
- Chronic or frequent coughs .... No Yes [No]
- Spitting up blood .... No Yes [No]
- Shortness of breath .... No Yes [No]
- Wheezing .... No Yes [No]

☐ **Gastrointestinal**
- Loss of appetite .... No Yes [No]
- Change in bowel movements ... No Yes [Yes]
- Nausea or vomiting .... No Yes [No]
- Frequent diarrhea .... No Yes [Yes]
- Painful bowel movements or constipation .... No Yes
- Rectal bleeding or blood in stool No Yes [No]
- Abdominal pain .... No Yes [No]

☐ **Genitourinary**
- Frequent urination .... No Yes [No]
- Burning or painful urination ... No Yes [No]
- Blood in urine .... No Yes [No]
- Change in force of strain when urinating .... No Yes [No]
- Incontinence or dribbling .... No Yes [Yes]
- Kidney stones .... No Yes [No]
- Sexual difficulty .... No Yes [No]
- Male - testicle pain .... No Yes [No]
- Female - pain with periods .... No Yes [No]
- Female - irregular periods .... No Yes [No]
- Female - vaginal discharge .... No Yes [Yes]
- Female - # of pregnancies ... 3
- Female - # of miscarriages ...
- Female - date of last pap smear 1999

☐ **Musculoskeletal**
- Joint pain .... No Yes [Yes]
- Joint stiffness or swelling ...... No Yes [Yes]
- Weakness of muscles or joints .. No Yes [Yes]
- Muscle pain or cramps .... No Yes [Yes]
- Back pain .... No Yes [Yes]
- Cold extremities .... No Yes [Yes]
- Difficulty in walking .... No Yes [Yes]

☐ **Integumentary (skin, breast)**
- Rash or itching .... No Yes [No]
- Change in skin color .... No Yes [No]
- Change in hair or nails .... No Yes [Yes] Hair is getting thiner
- Varicose veins .... No Yes [Yes]
- Breast pain .... No Yes [Yes]
- Breast lump .... No Yes [Yes]
- Breast discharge .... No Yes [No]

☐ **Neurological**
- Frequent or recurring headaches No Yes [Yes]
- Light headed or dizzy .... No Yes [Yes]
- Convulsions or seizures .... No Yes [No]
- Numbness or tingling sensations No Yes [Yes]
- Tremors .... No Yes [Yes]
- Paralysis .... No Yes [No]
- Head injury .... No Yes [No]

☐ **Psychiatric**
- Memory loss or confusion ..... No Yes [Yes]
- Nervousness .... No Yes [Yes]
- Depression .... No Yes [Yes]
- Insomnia .... No Yes [Yes]

☐ **Endocrine**
- Glandular or hormone problem . No Yes [Yes]
- Excessive thirst or urination .... No Yes [Yes]
- Heat or cold intolerance .... No Yes [Yes]
- Skin becoming dryer .... No Yes [Yes]
- Change in hat or glove size ..... No Yes [Yes]

☐ **Hematologic/Lymphatic**
- Slow to heal after cuts .... No Yes
- Bleeding or bruising tendency .. No Yes [Yes]
- Anemia .... Dontno No Yes
- Phlebitis .... No Yes [No]
- Past transfusion .... No Yes [No]
- Enlarged glands .... No Yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibilty to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

[redacted]
Signature of Patient, Parent or Guardian

Date: Dec. 9, 1999

Doctor's Review

Signature of Doctor

Date

[redacted] M.D.
4288 Woodbine Rd., Ste. A
Pace, FL 32571

PROGRESS NOTES

LAST NAME	FIRST	MIDDLE	DOB:
[redacted]			1/23/61

6/6/00 Spoke c̄ Sharon Purdue, Nurse case mgr. @ BH. Hosp. records & D/C Summary will be sent to us. Pt. will attend diabetes classes ("New dx. of Borderline diabetes"). Pt. to call & sch. post hospital F/U. Will discuss need for bedside commode @ OV. Pts. husband called. Requests Rx for Compazine (nausea). Also, would like Dr. [redacted] to call Dr. [redacted] @ 436-4630 regarding pts. condition. —— SR, RN

6/8/00 Wt: 163 - Hosp. wt. BP: 104/64 P: 80 CC: Hosp.
F/U: (SR)

C.P — No MI. Recs Pending Baptist. Lots of tests.
— Dx DM. FBS 188..
— Fibromyalgia
— Hyperlipidemia
— IBS.

New Meds Lotensin & Toprol 50 q BID.
Notes [illegible].

F/U appt. 6/23/00 2:45 (SR)

6/8/00 Called BCBS H.O. @ pts. request to authorize diabetes supplies (pt. to receive monitor through their pt. education assistance program. Auth. #060800000181 phoned to SH H.C. - spoke c̄ Hughette. Order faxed to 432-2996 for supplies. SHHC to dispense supplies. —— SR, RN

(M)

[redacted] M.D.
?88 Woodbine Rd., Ste. A
Pace, FL 32571

PROGRESS NOTES

LAST NAME	FIRST	MIDDLE	DOB:
[redacted]		A.	1/23/61

6/8/2000 OFFICE NOTES (Please see previous page for Nurse's Notes).

S: Ms. [redacted] is here to follow-up for her hospital visit. She was seen at Jay Hospital and found to have an abnormal EKG and was referred to Baptist Hospital where she was admitted to the hospital and multiple tests of all kinds were taken. She was found not to have myocardial infarction and the records are pending from Baptist Hospital. Apparently, they did discover that she was mild diabetes. The patient has also talked with [redacted] and wants me to discuss with him because he has a computer program that takes list of symptoms and provides diagnoses. They stated was some kind of bleeding in spinal cord condition that would cause weakness. The patient is in a wheelchair and states she really can't use her left leg at all. The right leg is what she uses to maneuver herself around. She was given trials of physical therapy in the past with no response because of significant pain presumably on the basis of some fibromyalgia. Patient states she contacted Dr. [redacted]'s office and Dr. [redacted] nurse stated that she didn't know why [redacted] should go back to Dr. [redacted] if all we needed to do was talk. I will be more than happy to talk with Dr. [redacted] should he give me a call and I will try to call his office. In the interim, all Dr. [redacted] could offer was management with pain medications so I will continue her on the MS Contin and may try Oramorph since it is less expensive for about the same thing.

Also, because patient is complaining of some breakthrough pain and sometimes she has to take the MS Contin 3 times a day will add in a smaller amount of Lortab with 2.5 mg. so that she has something of use for breakthrough pain.

She has significant hyperlipidemia. Last cholesterol we have on her is greater than 500. Triglycerides was greater than 4,000 and her initial SGOT was 713. This was back in February. On February 11, 2000, she had another hepatic panel that showed normalization of her liver functions. Also, at that time, PT and PTT were normal. T4 was in the normal range with FTI normal, TSH also normal and T3 uptake normal.

A:
1. Diabetes mellitus.
2. Fibromyalgia.
3. Chronic pain secondary to #2.
3. Hyperlipidemia, uncertain control.
4. Irritable bowel syndrome, recently started on Lotrinex.
5. Tachycardia which was treated with Toprol at 50 mg. b.i.d. The patient has a bottle with the medication.

O: Examination shows WT: 163 lbs. which is what they weighed her at the hospital. BP: 104/64. P: 80. She is sitting in a wheelchair and she does have atrophy of muscles of the legs though it is not so bad to be consistent with denervation type atrophy.

EXTREMITIES: Examination of the legs shows 2+ and symmetric deep tendon reflexes for the knees. 0 and 0 reflexes on the ankles. Examination of the deep tendon reflexes shows that she has 2-3+ and symmetric reflexes for the biceps and triceps as well as brachial radialus reflexes on the upper extremities. On the lower extremities, they are also symmetric. Sensory evaluation was done of lower extremities showing the patient stating there is a difference of entire left leg compared to the right leg. She reports also that the lateral left leg feels different than the medial left leg a little bit. She has more sensation on the lateral portion of the left leg compared to the medial portion of the left leg. She is capable of feeling

continued

M.D.
8 Woodbine Rd., Ste A
Pace, FL 32571

PROGRESS NOTES

LAST NAME	FIRST	MIDDLE	DOB:
[redacted]	[redacted]	[redacted]	1/23/61

6/8/2000 continued

all up and down the leg but just states there is a bid difference between the entire left leg and the entire right leg.

A: 1. Chest pain with myocardial infarction ruled out.
2. Tachycardia treated with Toprol 50 mg. b.i.d.
3. Irritable bowel syndrome treated with Lotrinex and she has a prescription for it.
4. Diabetes and has been referred for getting a blood glucose monitor as well as some classes for diabetes.
5. Hyperlipidemia. I am still waiting for lab results from Baptist Hospital.
6. Chronic pain. Will give refill of narcotic in form of OxyCodone IR 7.5 mg., #120. She may take 1 p.o. q.i.d. prn for pain. This is for diagnosis of chronic pain and she has a narcotic contract.
7. On further examination of the legs, I find that when I ask her to lift her leg up I feel no heel pressure on either side when she attempts to lift up the leg (left leg) The right leg she is capable of lifting on her own.

P: 1. Follow-up 2 weeks.
2. I will call [redacted] regarding the nausea medicine and about his computer program. Also have given a refill of Reglan 10 mg., #90, 1 p.o. 1 hour a.c.
3. Patient is advised to check glucoses, fasting and at bedtime. Her toal is 80-120 for fasting and 100-140 for bedtime.

[signature] M.D.

MGK/djk
D: 6/8/2000
T: 6/12/2000

6/9/2000 NOTE
Ms. [redacted] is having nausea and it is not responding to p.o. Compazine. Will call in to pharmacy for Compazine suppositories 25 mg. p.o. q. 12 hours prn.

[signature] M.D.

MGK/djk
D: 6/9/2000
T: 6/13/2000

6/14/00 Pts. Husband called. Requests Δ in nausea medication from Compazine Suppositories to Phenergan Supp. Rx phoned to Jay Pharmacy 675-6666 per [redacted] Phenergan Supp #30.

SK, RN
[signature]

[redacted] M.D.
38 Woodbine Rd., Ste. A
Pace, FL 32571

PROGRESS NOTES

LAST NAME	FIRST	MIDDLE	DOB:
[redacted]			1/23/61

PHONE CALL

For: Sue
M: [redacted]
Date: 6-15-00 Time: 4:00 A.M. P.M.
Phone: [redacted] Fax:
Remarks: Wants Rx for sleep other than Ambien or Elavil. Call to Bucklew

- Telephoned
- Returned Your Call
- Please Call
- Will Call Again
- Came to See You
- Wants to See You

Signed: Restoril 30mg #30 q hs.

Sparco BRAND SPR02301

6/15/00 above Rx phoned to pharmacy. —— SRN

6/16/00 Husband called requesting RF on Buspar 15mg.
Refill Authorized for Buspar 15 p BID #60 refill x 3.
Called in to Jay Pharmacy 6/16/00 @ 3:10 pm. C RN

6/~~10~~ 19 error djk /2000 NOTE

S: On evening of 6/17/2000, I got a call about [redacted] who was in the Emergency Room. Approximately 2 weeks ago she was having nausea and vomiting and was sent to Jay Hospital where she was subsequently trandferred to Baptist Hospital for evaluation. The other night she had been having abdominal pain and went in to Santa Rosa Emergency Room. In the Emergency Room she developed acute hypotension and hypoxemia. The patient was fluid rescusitated and provided Dopamine drip, Swan-Ganz catheterization and multiple consults and subsequently was operated on for perforated sigmoid colon with stool in the abdomen. Subsequently, she apparently managed to pull the tube out of her throat with her tongue, vomited and aspirated and currently has ARDS.

MGK/djk D: 6/20/2000 T: 6/21/2000

[redacted] M.D.