EL CAMINO HOSPITAL
2500 GRANT ROAD, P.O. BOX 7025
MOUNTAIN VIEW, CA 94039-7025

828049

Patient Name 2/04
Medical Rec. # LABEL
Physician

Authorization to Release Protected Health Information

PATIENT'S NAME (print): STEVEN R. FALK **DATE OF BIRTH:** 04/29/1965

I, STEVEN FALK phone: 6503806707
(Patient or Legal Healthcare Representative)
hereby authorize use or release of the above named patient's health information as described below.

The following individual or organization is authorized to release the information:
EL CAMINO HOSPITAL

The information may be released to and used by the following individual or organization:
STEVEN FALK, 50 WOODSIDE PLZ #504, REDWOOD CITY CA 94061
(Name and Address)

INFORMATION TO BE RELEASED:

The information to be released is required for the following purpose:
X Continued medical care ___ Legal Counsel
___ Insurance (for payment) ___ Worker's Compensation (for payment)
___ Other (specify): ___

The type of information to be released includes (please initial):
SF General medical/surgical care
SF Behavioral health care (including mental health or chemical dependency)
SF HIV test results

Please note if there are specific uses & limitations on use of the information by the recipient:
NONE / N/A

Check only the desired records to be released. Dates of visit: 2/7/04 - 2/21/04

✓ Pertinent information (includes history & physical, laboratory (excluding HIV) reports, x-rays, pathology reports, consultations, procedure reports, discharge summary)

✓ History & physical exam	✓ Laboratory reports	✓ Doctors' orders
✓ Consultations	✓ Pathology reports	✓ Progress notes
✓ Procedure reports	✓ EKG reports	✓ Nurses' notes
✓ Discharge summary	✓ X-ray reports	✓ Emergency records

X Other (specify): PLANNED MOVE/RELOCATION FOR EMPLOYMENT PROMOTION, ~~FOR~~ SO I WANT TO HAVE ALL MEDICAL RECORDS TO HAND TO NEW G.P. SORRY FOR ALL THE WORK!

296A
10232/

EL CAMINO HOSPITAL
2500 GRANT ROAD, P.O. BOX 7025
MOUNTAIN VIEW, CA 94039-7025

Patient Name	
Medical Rec. #	LABEL
Physician	

Authorization to Release Protected Health Information

PATIENT'S NAME: STEVEN R. FALK

EXPIRATION OF AUTHORIZATION:

This authorization will expire upon completion of the specified disclosure, unless otherwise specified as follows: PROVIDED ~~AS~~ ALL MATERIALS REQUESTED ARE AVAILABLE TO EL CAMINO HOSPITAL & DELIVERED TO ME. I SEE NO SPECIFIC REASON TO NOT EXPIRE THIS PARTICULAR REQUEST.

Requestor's Initials: RF

NOTICE OF RIGHTS AND OTHER INFORMATION:

- I understand that authorizing release of this information is voluntary. If I refuse to sign this authorization, the requested information will not be released.
- Treatment, payment, enrollment, or eligibility for benefits will not be conditional upon this authorization being signed. However, if this authorization is needed for participation in a research study, I may be denied enrollment in the research study.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me (or a legal representative), and delivered to:
  El Camino Hospital - HIMS (ECHG23)
  2500 Grant Road
  Mountain View, CA 94040
- I understand that the revocation will not apply to information that has already been released based on this authorization.
- Information released based on this authorization could be re-released by the recipient and might no longer be protected by federal law. However, California law prohibits the person receiving health information from further release without authorization unless required or permitted by law.
- I may inspect or obtain a copy of the information for which I am authorizing release.
- I will be given a copy of this authorization form if I request it.

SIGNATURE:

Signature: _____ Date: 9/29/05

(Patient or Legal Healthcare Representative)

If signed by someone other than the patient, state your legal relationship to the patient:

_____

Witness: _____

_____ Initial here if you have received a copy of this authorization.

HOSPITAL USE ONLY

Requested information [_] MAILED [_] FAXED [_] DELIVERED to: _____

Date: _____ Time: _____ am / pm By: _____

XXXX X XXXX X X
X X X X X XX XX
X X XXX X X X X X X X X
X X XXXXX X X X X X
X X X XXXX X X

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S:
LEE,JANE MD

CARE COORDINATOR: JOAN SANTANA D-ADM SUMMARY

PREVIOUS ADMISSION NAME: SOCIAL SEC NO: F/C:
PATIENT ADDRESS: 1090 MAIN ST #407, REDWOOD CITY, CA., 94063
PH: 650/556-9891 BIRTHPLACE: BD: 04/29/65 RACE: W RELIG: UNKN
OCCUPATION:

BILL TO: KANTER BRIAN S PHONE: 650/556-9891
ADDRESS: 1090 MAIN ST #407 ,REDWOOD CITY ,CA.,94063
PRIMARY INS: UNITED HLTHCARE PPO 305 INSURED: FALK BOB
ID #: 811720357 GROUP: 702521 ,APPLERA CORP
AUTH #: 280054094 LOS: WK PH: 650/
SECOND INS: INSURED:
ID #: GROUP:
AUTH #: LOS: WK PH:
EMERG CONT: FALK BOB HO PH: 615/352-4080 WK PH: 650/638-6765
ADDRESS: REL: FA

ADMIT DATE: 02/07 TIME: 08:57PM PRIOR DISCHARGE DATE:
DISCHARGE DATE: 02/22 TIME: 12:00NN LAST DISCHARGE DATE: 02/22/04
EXPIRATION DATE: TIME: PRIOR EMERG DATE:
PHONE ORDER BY: GREENWALD,RON MD LAST EMERG DATE: 02/07/04 CD 3/3
MRF:

ADMIT DIAGNOSIS: SUBDURAL BLEED

DISCHARGE DIAGNOSIS: PRINCIPAL DX-.
EPIDURAL HEMATOMA 852.40

SECONDARY DIAGNOSES:

PROCEDURES: PROCEDURE: CRANIOTOMY WITH EVACUATION OF HEMATOMA: EPIDURAL
..61310 01.24

SUMMARY INFORMATION: SUMMARY DICTATED AT DISCHARGE BY....
GREENWALD,RON MD

DISCHARGE INSTRUCTIONS GIVEN TO PATIENT:
ACTIVITY: WALKING AS TOLERATED. ACTIVITY: NO HEAVY LIFTING.
ACTIVITY: MAY NOT DRIVE CAR. CALL GREENWALD,RON MD FOR APPOINTMENT
TWO WEEKS. CALL MD IF FEVER OVER 101.5. CHANGE DRESSINGS DAILY.
MAY SHOWER. DIET: REGULAR.

READMISSION POTENTIAL: READMISSION NOT ANTICIPATED

ATTENDING PHYSICIAN THIS ADMISSION: GREENWALD,RON MD.

CONTINUED

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S:
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

D-ADM SUMMARY

CONSULTING PHYSICIANS:
GREENWALD,RON MD RG
LI,JIAYI MD MLAF

CONTINUED

EL CAMINO HOSPITAL

MOUNTAIN VIEW, CA

Inpatient Coding Summary

Patient Name	Sex	Birthdate	Age	Medical Record Number	Financial Number
FALK, STEVEN	Male	04/29/1965	38	0828049	0403800216

Admit Date	Discharge Date	LOS	Disposition
02/07/04 08:57 PM	02/22/04 12:00 PM	15	Home

Financial Class
PPO

Attending Physician	Coder Initials
GREENWALD,RON	CCD

DRG Code	DRG Text
001	CRANIOTOMY AGE > 17 W CC

Admit DX	*Admit Diagnosis Text*
80023	CLOSED FRACTURE, SKULL VAULT WITH SUBARACHNOID/SUBDURAL/EXTRADURAL

Prin. DX	*Principal Diagnosis Text*
80023	CLOSED FRACTURE, SKULL VAULT WITH SUBARACHNOID/SUBDURAL/EXTRADURAL

DX Code	*Secondary Diagnosis Text*
78039	CONVULSIONS
3314	OBSTRUCTIVE HYDROCEPHALUS
30390	UNSPECIFIED ALCOHOL DEPENDENCE, UNSPECIFIED USE
30401	OPIOID TYPE DEPENDENCE, CONTINUOUS USE
E8889	UNSPECIFIED FALL
E8494	Injury or Poisoning occurring at/in place for recreation and sport
7948	NONSPECIFIC ABNORMAL RESULTS OF FUNCTION STUDY OF LIVER
7242	LUMBAGO (LOW BACK PAIN)
34690	UNSPECIFIED MIGRAINE WITHOUT INTRACTABLE MIGRAINE

PX Code	*Procedure Text*	*Date*	*Surgeon*
0124	CRANIOTOMY	02/08/04	GREENWALD,RON
022	VENTRICULOSTOMY	02/08/04	GREENWALD,RON

CPT Code & Modifier(s)	*CPT Text*	*Date*	*Surgeon*

Date Printed: 02/26/04

Printed By: Craig_Downing

S23A

EL CAMINO HOSPITAL
MOUNTAIN VIEW, CALIFORNIA
RONALD GREENWALD, M.D.

Falk, Steven
MR#: 828049
DOB: 04/29/1965
DISCHARGE SUMMARY

cc: DAN FOX, M.D.
RONALD GREENWALD, M.D.
JANE I. LEE, M.D.
JIAYI LI, MD
SCOTT WACHHORST, M.D.

ADMISSION DATE: 02/07/2004

DISCHARGE DATE: 02/21/2004

FINAL DIAGNOSIS(ES):
1. Craniocerebral trauma secondary to seizure.
2. History of seizure disorder.
3. History of drug abuse.
4. Acute suboccipital epidural hematoma with acute hydrocephalus.
5. Abnormal liver functions secondary to probably Ultram abuse.

OPERATIVE PROCEDURES: On February 8, 2004, he had a right external ventricular drain and a left suboccipital craniotomy and evacuation of epidural hematoma.

HISTORY: A 38-year-old, right-handed, white male who _____ at Rinconada Park in Palo Alto, had a seizure, struck the back of his head, and came to the Emergency Room lethargic but awake and alert. He became more unresponsive over 24 hours, and a CT scan showed an increasing epidural hematoma with 4th ventricular compression and obstructive hydrocephalus. He was immediately taken to the operating room on the second hospital day for an external ventricular drain on the right side and a left suboccipital craniotomy and evacuation of epidural hematoma. Postoperatively, he was slow to recover resolution of his hydrocephalus. Eventually he was able to get his tube out. He had developed elevated liver functions, probably secondary to Ultram abuse, and the liver functions improved. Preoperatively he developed a left 6th nerve palsy and diplopia which completely resolved. Upon discharge, he was neurologically intact, no complaints. Incisions were clean and dry. He was discharged on Norco for pain and his seizure medication. He is to return to the office in 2 weeks for followup.

RONALD GREENWALD, M.D.

RG:hs674170/29828/
D000674170 C409584
D: 02/21/2004 3:31 P
T: 02/21/2004 7:41 P

XXXXX XXXXX XXX XXXXX
X X X X
X XXX XXX X
X X X X
X XXXXX XXX X

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

REPORT PERIOD: ALL RESULTS IN MIS AS OF 11:59 PM 02/22/04

* = NEW RESULTS. OUT-OF-RANGE RESULTS ARE HIGHLIGHTED.

02/23/04 12:20 AM JOHN V. COLLIN, M.D., PATHOLOGIST

HEMOGRAM

	HCT	HGB	RBC	MCV	MCH
LO-HI:	39-55	13.9-16.3	4.3-5.9	80-100	25.4-34.
UNIT:	%	G/DL	M/MM3	U3	PG
FRI 02/20/04 06AM	38.3 L	12.7 L	4.06 L	94.2	31.3
TUE 02/17/04 06AM	40.5	13.6 L	4.36	92.7	31.3
MON 02/16/04 06AM	40.1	13.6 L	4.29 L	93.4	31.6
SUN 02/15/04 06AM	37.0 L	12.6 L	4.00 L	92.5	31.4
FRI 02/13/04 08AM	33.8 L	11.4 L	3.60 L	93.6	31.7
THU 02/12/04 07PM	36.0 L	11.8 L	3.79 L	95.0	31.1
SAT 02/07/04 06PM	46.3	15.0	4.78	96.8	31.5

	MCHC	RDW	WBC	NEUTROPHILS
LO-HI:	32-36	11.5-14.5	4.5-11.0	36-71
UNIT:	%	%	T/MM3	%
FRI 02/20/04 06AM	33.2	12.6	10.3	64.6
TUE 02/17/04 06AM	33.7	12.9	12.2 H	
MON 02/16/04 06AM	33.8	12.8	12.0 H	
SUN 02/15/04 06AM	33.9	12.8	12.4 H	
FRI 02/13/04 08AM	33.8	13.0	11.5 H	
THU 02/12/04 07PM	32.8	13.4	11.6 H	
SAT 02/07/04 06PM	32.5	13.2	15.6 H	

CONTINUED

XXXXX XXXXX XXX XXXXX
X X X X
X XXX XXX X
X X X X
X XXXXX XXX X

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

HEMOGRAM

	PMN	BAND	LYMPHS	MONOCYTE	EOS
LO-HI:	36-66	0-5	24-44	0-9	0-3
UNIT:	%	%	%	%	%
FRI 02/20/04 06AM			23.4 L	8.8	2.6
TUE 02/17/04 06AM	65	2	20 L	11 H	1
MON 02/16/04 06AM	47	8 H	19 L	14 H	7 H
SUN 02/15/04 06AM	41	12 H	29	17 H	1
FRI 02/13/04 07AM	71 H	1	13 L	13 H	2
THU 02/12/04 07PM	78 H	1	6 L	14 H	
SAT 02/07/04 06PM	39	2	29	17 H	2

	BASOS	ATYP LYMPHS	MYELO
LO-HI:	0-1		
UNIT:	%	%	%
FRI 02/20/04 06AM	0.6		
TUE 02/17/04 06AM	1		
MON 02/16/04 06AM	1		4
THU 02/12/04 07PM		1	
SAT 02/07/04 06PM		9	2

	MORPH
LO-HI:	
UNIT:	
TUE 02/17/04 06AM	NORMAL RBC MORPHOLOGY.
MON 02/16/04 06AM	TOXIC GRANULATION, 1+
SUN 02/15/04 06AM	TOXIC GRANULATION, 1+
FRI 02/13/04 07AM	NORMAL RBC MORPHOLOGY.
THU 02/12/04 07PM	NORMAL RBC MORPHOLOGY.
SAT 02/07/04 06PM	NORMAL RBC MORPHOLOGY.

CONTINUED

XXXXX XXXXX XXX XXXXX
X X X X
X XXX XXX X
X X X X
X XXXXX XXX X

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

HEMOGRAM

	PLT
LO-HI:	150-450
UNIT:	K/UL
FRI 02/20/04 06AM	595 H
TUE 02/17/04 06AM	532 H
MON 02/16/04 06AM	500 H
SUN 02/15/04 06AM	453 H
FRI 02/13/04 08AM	311
THU 02/12/04 07PM	290
SAT 02/07/04 06PM	352

COAGULATION

	INR-COUMAD	PROTHROMBIN TM	PRO TM CONTRO
LO-HI:	2.0-3.0	11.5-14.0	12.7-12.7
UNIT:		SEC	SEC
TUE 02/17/04 06AM	1.2 L	14.2 H	12.3

	PTT
LO-HI:	21.0-36.
UNIT:	SEC
TUE 02/17/04 06AM	27.7

CONTINUED

XXXXX XXXXX XXX XXXXX
X X X X
X XXX XXX X
X X X X
X XXXXX XXX X

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

ELECTROLYTES

	NA	K	CL	CO2
LO-HI:	135-145	3.5-5.0	101-111	22-32
UNIT:	MMOL/L	MMOL/L	MMOL/L	MMOL/L
FRI 02/20/04 06AM	138	3.7	100 L	33 H
TUE 02/17/04 06AM	135	3.9	96 L	32
MON 02/16/04 06AM	132 L	3.9	95 L	30
SUN 02/15/04 06AM	133 L	4.2	96 L	29
FRI 02/13/04 08AM	135	4.0	100 L	25
FRI 02/13/04 07AM		4.0		
THU 02/12/04 07PM	135	3.6	92 L	27
SAT 02/07/04 06PM	144	3.6	94 L	11 L

BL CHEMISTRY

	FBS	NON-FBS	CREAT	BUN	CA
LO-HI:	70-110	70-170	0.7-1.2	8-20	8.5-10.5
UNIT:	MG/DL	MG/DL	MG/DL	MG/DL	MG/DL
FRI 02/20/04 06AM		98	0.8	12	9.5
TUE 02/17/04 06AM		110	0.8	14	9.6
MON 02/16/04 06AM		107	0.8	15	9.4
SUN 02/15/04 06AM	108		0.8	11	8.9
FRI 02/13/04 08AM		104	0.8	11	8.5
THU 02/12/04 07PM		123	0.8	7 L	8.2 L
SAT 02/07/04 06PM		145	1.5 H	18	10.8 H

CONTINUED

XXXXX XXXXX XXX XXXXX
X X X X
X XXX XXX X
X X X X
X XXXXX XXX X

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

BL CHEMISTRY

	ALB	T.PROT	D.BILI	T.BILI	LIPASE
LO-HI:	3.0-5.0	6.0-8.5	0-0.2	0.2-1.2	22-51
UNIT:	G/DL	G/DL	MG/DL	MG/DL	U/L
FRI 02/20/04 06AM	3.1	7.0		0.6	
THU 02/19/04 07AM	3.0	6.8	0.0	0.3	
WED 02/18/04 06AM	3.0	7.1	0.1	0.6	
TUE 02/17/04 06AM	3.1	7.5	0.0	0.5	20 L
	3.1	7.5		0.5	
MON 02/16/04 06AM	3.0	7.4		0.6	
SAT 02/07/04 06PM	4.9	8.1		0.3	

	AMYLASE	COMMENT
LO-HI:	36-128	
UNIT:	IU/L	
TUE 02/17/04 06AM	68	
SUN 02/08/04 06AM		N/A
SAT 02/07/04 12MN		N/A
SAT 02/07/04 06PM		N/A

CONTINUED

XXXXX XXXXX XXX XXXXX
X X X X
X XXX XXX X
X X X X
X XXXXX XXX X

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

BL CHEMISTRY

	CHOL/HDL
LO-HI:	
UNIT:	
SAT 02/07/04 10PM	(1)
	(2)
	(3)
	(4)
	(5)
	(6)
	(7)
	(8)
	(9)
	(10)
	3.13
	(11)

(1) 7.05 2X AVERAGE (MODERATE)
(2) 4.44 AVERAGE (NORMAL)
(3) FEMALES: 3.27 HALF AVERAGE
(4) 23.99 3X AVERAGE (HIGH)
(5) 9.55 2X AVERAGE (MODERATE)
(6) 4.97 AVERAGE (NORMAL)
(7) MALES: 3.43 HALF AVERAGE
(8) CHOL/HDL RISK
(9) RELATIVE RISK OF CORONARY HEART DISEASE
(10) CHOLESTEROL/HDL RATIO INTERPRETATION:
(11) 11.04 3X AVERAGE (HIGH)

CONTINUED

XXXXX XXXXX XXX XXXXX
X X X X
X XXX XXX X
X X X X
X XXXXX XXX X

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

BL CHEMISTRY

	HEP B SUR ANTIG	HEP A IGM ANTIB
LO-HI:		NEG
UNIT:		
MON 02/16/04 06AM	NEGATIVE	NEGATIVE

	HEP BC ABY IGM	HCVABY
LO-HI:		
UNIT:		
MON 02/16/04 06AM	NEGATIVE	NEGATIVE

BL ENZYMES

	SGOT	SGPT	ALK PTASE	CPK
LO-HI:	15-41	11-63	38-126	22-269
UNIT:	IU/L	IU/L	U/L	U/L
FRI 02/20/04 06AM	45 H	134 H	136 H	
THU 02/19/04 07AM	54 H	143 H	149 H	
WED 02/18/04 06AM	50 H	148 H	148 H	
TUE 02/17/04 06AM	53 H	180 H	157 H	
	53 H	180 H	157 H	
MON 02/16/04 06AM	61 H	213 H	152 H	
SUN 02/08/04 06AM				3659 H
SAT 02/07/04 12MN				1646 H
SAT 02/07/04 06PM	41	27	122	342 H

CONTINUED

XXXXX XXXXX XXX XXXXX
X X X X
X XXX XXX X
X X X X
X XXXXX XXX X

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

BL ENZYMES

	CKMB	CKMB/CK REL IND	TROPONIN I
LO-HI:	0.3-4.0	0-4	-<0.04
UNIT:	NG/ML	%	NG/ML
SUN 02/08/04 06AM	4.7 H	0	(1)
			(2)
			(3)
			(4)
			(5)
			<0.03
SAT 02/07/04 12MN	4.2 H	0	(6)
			(7)
			(8)
			(9)
			(10)
			<0.03
SAT 02/07/04 06PM	5.5 H	2	(11)
			(12)
			(13)
			(14)
			(15)
			<0.03

(1) MYOCARDIAL INJURY.
(2) (>=0.50 NG/ML):CONSISTANT WITH
(3) (0.04-0.49 NG/ML):INDETERMINATE
(4) (<0.04 NG/ML):NORMAL
(5) TROPONIN-I INTERPRETATION:
(6) MYOCARDIAL INJURY.
(7) (>=0.50 NG/ML):CONSISTANT WITH
(8) (0.04-0.49 NG/ML):INDETERMINATE
(9) (<0.04 NG/ML):NORMAL
(10) TROPONIN-I INTERPRETATION:
(11) MYOCARDIAL INJURY.
(12) (>=0.50 NG/ML):CONSISTANT WITH
(13) (0.04-0.49 NG/ML):INDETERMINATE
(14) (<0.04 NG/ML):NORMAL
(15) TROPONIN-I INTERPRETATION:

CONTINUED

```
                                                    XXXXX XXXXX  XXX  XXXXX
                                                      X     X    X       X
====================================                  X     XXX   XXX     X
FALK STEVEN                    M 38 523A              X     X        X    X
 828049   F0403800216 ADM: 02/07/04 M.S: X           X    XXXXX  XXX     X
   LEE,JANE MD                                      ========================
CARE COORDINATOR: JOAN SANTANA                        TEST RESULTS SUMMARY
=============================================================================
                                                                MEDS + TOXICOL.


SAT 02/07/04 12MN  TEGRETOL
                L  CARBAMAZEPINE     2.5     MG/L            (4-12)
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CONTINUED

XXXXX XXXXX XXX XXXXX
X X X X
X XXX XXX X
X X X X
X XXXXX XXX X

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

ROUTINE UA

	WBC/HPF	RBC/HPF	PROT
LO-HI:			
UNIT:			MG/DL
SUN 02/15/04 08AM	NONE	1-2 /HPF	NEGATIVE
SAT 02/07/04 11PM	3-4 /HPF	1-2 /HPF	30 MG/DL

	GLUC	SP GR	PH	KETONE
LO-HI:			5-8	
UNIT:	MG/DL			MG/DL
SUN 02/15/04 08AM	NEGATIVE	1.010	5.5	NEGATIVE
SAT 02/07/04 11PM	NEGATIVE	1.025	5.0	TRACE

	OCC BLD	UROBIL	BILI
LO-HI:		0.1-1.0	
UNIT:		EU/DL	
SUN 02/15/04 08AM	NEGATIVE	0.2 EU/DL	NEGATIVE
SAT 02/07/04 11PM	MODERATE	0.2 EU/DL	NEGATIVE

	NITRITE	ESTERASE	COLOR
LO-HI:			
UNIT:			
SUN 02/15/04 08AM	NEGATIVE	NEGATIVE	YELLOW
SAT 02/07/04 11PM	NEGATIVE	NEGATIVE	YELLOW

CONTINUED

XXXXX XXXXX XXX XXXXX
X X X X
X XXX XXX X
X X X X
X XXXXX XXX X

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

ROUTINE UA

	TURB	BACT
LO-HI:		
UNIT:		
SUN 02/15/04 08AM	CLEAR	
SAT 02/07/04 11PM	CLOUDY	NONE

	EPITH/LPF	MUCUS
LO-HI:		
UNIT:		
SUN 02/15/04 08AM	NONE	
SAT 02/07/04 11PM	FEW	FEW

	COMMENT	GRAN CAST
LO-HI:		
UNIT:		
SUN 02/15/04 08AM	SAMPLE. (1)	
SAT 02/07/04 11PM	SPERM, MODERATE /HPF	TNTC

(1) SPECIMEN VOLUME LESS THAN 10ML, MAY NOT BE A REPRESENTATIVE

CONTINUED

XXXXX XXXXX XXX XXXXX
X X X X
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FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

SEROLOGY

	ANA
LO-HI:	
UNIT:	
TUE 02/17/04 06AM	(1)
	(2)
	(3)
	(4)

(1) TEST COMPLETE
(2) NEGATIVE
(3) FINAL 02/18 1345 BY WWA
(4) BLOOD MICRO ID#: 04004795

CONTINUED

XXXXX XXXXX XXX XXXXX
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X XXXXX XXX X

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

OTHER TESTS

	APPEARANCE	RBC	% CRENATED
LO-HI:			
UNIT:		/CUMM	%
SUN 02/15/04 08AM	CLEAR	694	0

	WBC	PMN	LYMPHS
LO-HI:			
UNIT:	/CUMM	%	%
SUN 02/15/04 08AM	3	N/A	N/A

	LG MONONUCLEAR
LO-HI:	
UNIT:	%
SUN 02/15/04 08AM	N/A

	OTHER
LO-HI:	
UNIT:	
SUN 02/15/04 08AM	N/A

CONTINUED

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X X X X
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FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

OTHER TESTS

SUN 02/15/04 08AM		GLUCOSE-CSF		
		GLUCOSE-CSF	CSF GLUCOSE NORMAL 60% OF SERUM GLUCOSE VALUE. MG/DL (50-65)	
		GLUCOSE-CSF	73 MG/DL	(50-65)
SUN 02/15/04 08AM		PROTEIN-CSF		
	L	PROTEIN-CSF	9 MG/DL	(15-45)

OTHER TESTS -CS CSF

SUN 02/15/04 08AM CULTURE CSF

SPINAL FLUID MICRO ID#: 04004606

FINAL 02/17 0927
BY KGAB
NO GROWTH
TEST COMPLETE

SUN 02/15/04 08AM GRAM STAIN:

SPINAL FLUID MICRO ID#: 04004604

GRAM STAIN 02/15 0918
BY LAM
NO ORGANISMS SEEN
TEST COMPLETE

OTHER TESTS -BC LEFT ARM AL

SUN 02/15/04 08AM CULTURE, BLOOD:

* LT. ARM MICRO ID#: 04004609

* PRELIMINARY 01 02/17 0925
BY LLB

CONTINUED

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FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

* NO GROWTH AT 48 HOURS

* FINAL 02/22 0808
BY LWAC
* NO GROWTH IN 1 WEEKS
* TEST COMPLETE

OTHER TESTS -BC RIGHT ARM AR

SUN 02/15/04 08AM CULTURE, BLOOD:
* RT. ARM MICRO ID#: 04004610

* PRELIMINARY 01 02/17 0925
BY LLB
* NO GROWTH AT 48 HOURS

* FINAL 02/22 0808
BY LWAC
* NO GROWTH IN 1 WEEKS
* TEST COMPLETE

OTHER TESTS -US URINE

SUN 02/15/04 08AM CULTURE,URINE:
URINE (VOIDED) MICRO ID#:
04004611
FINAL 02/16 1353
BY LLAA
NO GROWTH
TEST COMPLETE

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FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

OTHER TESTS

SAT 02/07/04 06PM		DRUGSCREEN BL ED			
	L	SALICYLATES	<4	MG/DL	
	L	ACETAMINOPHENS	<10.0	MG/L	
		ALCOHOL	<5	MG/DL	
SUN 02/08/04 06AM		MYOGLOBIN			
	H	MYOGLOBIN	466	NG/ML	(0-70)
SAT 02/07/04 12MN		MYOGLOBIN			
	H	MYOGLOBIN	957	NG/ML	(0-70)
SAT 02/07/04 11PM		DRUGSCREEN UR ED			
		BARBITURATES	NEGATIVE		
		BENZODIAZEPINES	POSITIVE		
		COCAINE METAB	NEGATIVE		
		OPIATE METAB	NEGATIVE		
		PHENCYCLIDINE	NEGATIVE		
		AMPHETAMINES	NEGATIVE		
SAT 02/07/04 10PM		LIPIDS NONFAST			
	H	CHOL NONFASTING	210	MG/DL	
		TRIG NONFASTING	61	MG/DL	
	H	LDL CHOL,CALC	131	MG/DL	(00-130)
		HDL NONFASTING	67	MG/DL	
SUN 02/15/04 08AM		CELL COUNT			
		COLOR	COLORLESS		
		TUBE	CSF TUBE #2		
		COMMENT	N/A		

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FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

OTHER TESTS

TUE 02/17/04 06AM ANTIGLIADIN ABYS

(800) 859-6046
SAN DIEGO, CA 92121
5601 OBERLIN DR.
LABCORP
SPECIMEN SENT TO:
GLIADIN ANTIBODY IGG REFERENCE:
(NEGATIVE: <20 UNITS)

GLIADIN ANTIBODY IGA REFERENCE:
(NEGATIVE: <20 UNITS)

NEGATIVE
NEGATIVE

TUE 02/17/04 06AM ANTIMITOCHOND AB

(800) 859-6046
SAN DIEGO, CA 92121
5601 OBERLIN DR.
LABCORP
SPECIMEN SENT TO:
SUGGESTIVE OF LIVER DISEASE: (>
1:80)
POSITIVE: (>
1:40; REPEAT IN 2 WEEKS TO NOTE ANY
TITER CHANGE)
NEGATIVE: (<1:20)
ANTIMITOCHONDRIAL ABY REFERENCE:

NEGATIVE

TUE 02/17/04 06AM ANTI-SMOOTH MUSC

(800) 859-6046
SAN DIEGO, CA 92121
5601 OBERLIN DR.

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FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

OTHER TESTS

TUE 02/17/04 06AM ANTI-SMOOTH MUSC

LABCORP
SPECIMEN SENT TO:
HEALTHY CONTROLS MAY BE POSITIVE.)

<1:80 DO NOT CORRELATE WELL WITH
DISEASE. ABOUT 3% OF NORMAL

POSITIVE: (>
1:80 STRONGLY SUGGESTIVE OF LIVER
DISEASE; TITERS
NEGATIVE: (<1:20)
ANTISMOOTH MUSCLE ANTIBODIES
REFERENCE:
NEGATIVE

TUE 02/17/04 06AM CERULOPLASMIN

(800) 859-6046
SAN DIEGO, CA 92121
5601 OBERLIN DR.
LABCORP
SPECIMEN SENT TO:
FEMALE: (17.9-53.3 MG/DL)

MALE: (16.2-35.6 MG/DL)

CERULOPLASMIN REFERENCE:

27.6

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FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

RADIOLOGY RESULTS: FILE #828049

R038-0096 11:50 AM 02/08/04 RADIOLOGIST: CHIN,DAVID,M.D. -
8.01 CT HEAD WITHOUT, 02/07/2004:

CT SCAN OF THE BRAIN: 2/7/04.

COMPARISON: NONE.

CLINICAL DATA: WITNESSED SEIZURE AND FALL.

TECHNIQUE: 5 MM HELICAL IMAGES WERE OBTAINED THROUGH THE BRAIN.

FINDINGS: THERE IS A 1.3 (THICK) BY ABOUT 6 CM LENTIFORM BICONVEX HIGH ATTENUATION EXTRA-AXIAL COLLECTION IN THE LEFT OCCIPITAL REGION, JUST DEEP TO A MINIMALLY DEPRESSED LEFT OCCIPITAL SKULL FRACTURE. THERE MAY BE A SMALL AMOUNT OF BLOOD LAYERING ALONG THE TENTORIUM. NO INTRA-AXIAL HEMORRHAGE IS DETECTED. NO INTRA-AXIAL MASS IS SEEN. EXCEPT THAT NOTED ABOVE, THE VENTRICLES AND SULCI ARE SYMMETRIC AND WITHIN NORMAL LIMITS FOR AGE. THERE ALSO APPEARS TO BE MILD DIASTASIS OF THE LEFT LAMBDOID SUTURE. AN AIR FLUID LEVEL IS PRESENT IN THE SPHENOID SINUS. NO DEFINITE FACIAL BONE FRACTURE IS VISUALIZED. THE ORBITS AND PARANASAL SINUSES ARE OTHERWISEUNREMARKABLE.

IMPRESSION: 1. SMALL ACUTE LEFT OCCIPITAL EXTRA-AXIAL (PROBABLY EPIDURAL) HEMATOMA SUBJACENT TO A LEFT OCCIPITAL SKULL FRACTURE. THERE MAY A SMALL AMOUNT OF BLOOD LAYERING AROUND THE TENTORIUM.
2. AIR FLUID LEVEL IN THE SPHENOID SINUS, ? SINUSITIS VERSUS OCCULT FRACTURE.
3. DISCUSSED WITH DR. FOX CONTEMPORANEOUSLY ON 2/07/04.

END OF IMPRESSION:

R038-0097 08:55 PM 02/08/04 RADIOLOGIST: VAN DALSEM,VOLNEY F III,M.D. -
13.01 C-SPINE, 2-3V, 02/07/2004:

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FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

CERVICAL SPINE: 2/07/04.

NO PRIOR EXAMINATIONS.

HISTORY: TRAUMA.

EXAMINATION CONSISTS OF TWO CROSS TABLE LATERAL VIEWS OF THE CERVICAL SPINE.

BONY ALIGNMENT IS WITHIN NORMAL LIMITS. DISC SPACES ARE OF NORMAL STATURE. NO FRACTURE OR DISLOCATION IS SEEN. PREVERTEBRAL SOFT TISSUES HAVE A NORMAL APPEARANCE. THE ODONTOID IS INTACT ON LATERAL VIEW. NASAL AIRWAY IS NOTED IN PLACE.

IMPRESSION: NO ABNORMALITY IDENTIFIED IN THIS LIMITED EXAMINATION.

END OF IMPRESSION:

R038-0105 08:53 PM 02/08/04 RADIOLOGIST: VAN DALSEM,VOLNEY F III,M.D. -
21.01 CHEST-PORTABLE, 02/07/2004:

AP CHEST, 2/7/04, 8:20 P.M.:

NO PRIOR EXAMINATION.

HISTORY: SEIZURE.

THE LUNGS ARE CLEAR. PULMONARY VASCULARITY IS NORMAL. CARDIOMEDIASTINUM IS WITHIN NORMAL LIMITS. NO OSSEOUS ABNORMALITY IS SEEN.

IMPRESSION: WITHIN NORMAL LIMITS.

END OF IMPRESSION:

R038-0112 04:30 PM 02/09/04 RADIOLOGIST: VAN DALSEM,VOLNEY F III,M.D. -
58.01 CT HEAD WITHOUT, 02/07/2004:

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FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

CRANIAL CT, 02/08/04.

COMPARE: 02/07/04.

HISTORY: WITNESSED SEIZURE. FALL.

EXAMINATION WAS PERFORMED WITHOUT THE USE OF INTRAVENOUS CONTRAST MATERIAL.

MODERATE INTERVAL INCREASE IN SIZE OF PREVIOUSLY NOTED LENTIFORM, PROBABLY EPIDURAL HEMATOMA IN THE LEFT OCCIPITAL REGION EXTENDING INFERIORLY INTO THE LEFT POSTERIOR FOSSA IS NOTED, MEASURING 2.5 TO 3 CM IN MAXIMAL DEPTH, 5.5 TO 6 CM IN MAXIMAL TRANSVERSE EXTENT (PREVIOUSLY 1.3 X 6 CM), AND 7 TO 8 CM IN CEPHALOCAUDAL EXTENT. THERE IS MODERATE MASS AFFECT IDENTIFIED PRIMARILY ON THE STRUCTURES OF THE POSTERIOR FOSSA, WITH MILD TO MODERATE DECREASE IN SIZE AND MODERATE RIGHTWARD SHIFT OF THE FOURTH VENTRICLE NOTED.

PROBABLE EXTRAAXIAL/SUBDURAL HEMATOMA EXTENDING DIFFUSELY ALONG THE TENTORIUM IS NOTED, MILDLY INCREASED. A 2.5 TO 3 CM INTRAAXIAL HEMATOMA IS NOW IDENTIFIED IN THE ANTEROINFERIOR ASPECT OF THE LEFT TEMPORAL LOBE. A 2.5 TO 3 CM ILL-DEFINED OVOID AREA OF MILDLY DIMINISHED DENSITY IN THE ANTEROINFERIOR ASPECT OF THE LEFT FRONTALAL LOBE CONTAINING 1 TO 1.5 CM PATCHY PARTIALLY CONFLUENT HEMORRHAGES IS ALSO SEEN, CONSISTENT WITH ADDITIONAL CONTUSION AT THIS SITE. INTRACRANIAL DENSITY PATTERN IS OTHERWISE UNREMARKABLE.

THERE IS MODERATE DILATATION OF THE TEMPORAL HORNS OF THE LATERAL VENTRICLES NOW SEEN, WITH MILD DILATATION OF THE REMAINDER OF THE LATERAL VENTRICLES AS WELL AS THE THIRD VENTRICLE NOW APPARENT. DIFFUSE PARTIAL EFFACEMENT OF CORTICAL SULCI IS NOTED, CONSISTENT WITH GENERALIZED INTRACRANIAL MASS AFFECT.

PREVIOUSLY NOTED LEFT OCCIPITAL FRACTURE WITH POSSIBLE ASSOCIATED DIASTASIS OF THE LEFT LAMBDOID SUTURE IS AGAIN APPARENT. NO ADDITIONAL ACUTE OSSEOUS ABNORMALITY IS SEEN. LIMITED FLUID ACCUMULATION IN THE DEPENDENT ASPECT OF THE SPHENOID SINUS IS AGAIN NOTED.

IMPRESSION: 1. MODERATE INTERVAL INCREASE OF PREVIOUSLY NOTED

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X X X X
X XXXXX XXX X

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FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

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LEFT OCCIPITAL/ POSTERIOR FOSSA APPARENT EPIDURAL HEMATOMA, MEASURING 2.5 TO 3 X 5.5 TO 6 X 7 TO 8 CM IN MAXIMAL DIAMETERS, WITH MODERATE INTERVAL INCREASE IN ASSOCIATED LEFT POSTERIOR FOSSA MASS AFFECT, WITH RIGHTWARD DISPLACEMENT/PARTIAL COMPRESSION OF THE FOURTH VENTRICLE AND RESULTANT MILD TO MODERATE DILATATION OF THE LATERAL AND THIRD VENTRICLES NOW SEEN.

2. 2.5 TO 3 CM ANTEROINFERIOR LEFT TEMPORAL CORTICAL HEMATOMA, WITH 2.5 TO 3 CM APPARENT CONTUSION CONTAINING 1 TO 1.5 CM PATCHY HEMORRHAGE IN THE ANTEROINFEROMEDIAL LEFT FRONTAL CORTEX.

3. DIFFUSE EFFACEMENT OF CORTICAL SULCI, CONSISTENT WITH GENERALIZED INTRACRANIAL MASS AFFECT/EDEMA.

4. SUSPECTED LIMITED SUBDURAL BLOOD LAYERING ALONG THE TENTORIUM, MILDLY INCREASED.

5. LEFT OCCIPITAL SKULL FRACTURE AGAIN IDENTIFIED.

6. PERSISTENT FLUID ACCUMULATION IN THE DEPENDENT ASPECT OF THE SPHENOID SINUS, NOT SIGNIFICANTLY CHANGED, POSSIBLY RELATING TO OCCULT SKULL BASE FRACTURE.

7. FINDINGS WERE DISCUSSED CONTEMPORANEOUSLY BY TELEPHONE WITH DR. RONALD GREENWALD.

END OF IMPRESSION:

R039-0053 11:45 AM 02/09/04 RADIOLOGIST: SCHNEIDER,E.,M.D. -
108.01 CT HEAD WITHOUT, 02/08/2004:

CRANIAL CT: 2/09/04.

HISTORY: POSTOPERATIVE.

5 MM SCANS WERE PERFORMED AND COMPARED TO 2/08/04.

THERE HAS BEEN INTERVAL LEFT OCCIPITAL CRANIOTOMY, WITH SURGICAL EVACUATION OF THE PREVIOUSLY NOTED LEFT OCCIPITAL/POSTERIOR FOSSA EPIDURAL OR SUBDURAL HEMATOMA. A SMALL AMOUNT OF RESIDUAL BLOOD AND AIR IS NOW SEEN IN THE SUBDURAL SPACE. A SMALL AMOUNT OF BLOOD IS ALSO NOTED TO LAYER ALONG THE TENTORIUM, LESS APPARENT RELATIVE TO THE PRIOR EXAM. A 2 CM HEMATOMA IS AGAIN NOTED IN THE ANTERIOR ASPECT OF THE LEFT MIDDLE CRANIAL FOSSA, PROBABLY INTRA-AXIAL AND LIKELY CONTUSION. A LOCALIZED HEMORRHAGIC FOCUS IS AGAIN SEEN IN THE LEFT FRONTAL LOBE, WITH SURROUNDING EDEMA SIMILAR TO PRIOR

CONTINUED

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FALK STEVEN M 38 523A X X X X
828049 F0403800216 ADM: 02/07/04 M.S: X X XXXXX XXX X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA TEST RESULTS SUMMARY

EXAM. THERE HAS BEEN INTERVAL PLACEMENT OF A VENTRICULAR SHUNT CATHETER VIA A RIGHT FRONTAL BURR HOLE, THE TIP POSITIONED IN THE THIRD VENTRICLE. PREVIOUSLY NOTED HYDROCEPHALUS HAS RESOLVED. NEW FLUID LEVELS HAVE DEVELOPED IN THE SPHENOID AND RIGHT MAXILLARY SINUSES.

IMPRESSION: 1. INTERVAL SURGICAL EVACUATION OF PREVIOUSLY NOTED LEFT OCCIPITAL/POSTERIOR FOSSA EXTRA-AXIAL HEMATOMA, WITH MILD RESIDUAL AIR AND BLOOD IN THE SUBDURAL SPACE.
2. SMALL AMOUNT OF BLOOD ALONG THE TENTORIUM, DECREASED IN CONSPICUITY.
3. STABLE AREAS OF HEMORRHAGE IN THE ANTERIOR LEFT TEMPORAL LOBE AND LEFT FRONTAL LOBE.
4. INTERVAL PLACEMENT OF VENTRICULAR SHUNT CATHETER, WITH RESOLUTION OF HYDROCEPHALUS.
5. NEW FLUID LEVELS INVOLVING THE SPHENOID AND RIGHT MAXILLARY SINUSES.

END OF IMPRESSION:

R042-0167 06:54 PM 02/12/04 RADIOLOGIST: MURAO,JOHN D.,M.D. -
128.01 CT HEAD WITHOUT, 02/12/2004:

CT BRAIN, 02/12/04.

COMPARE: 02/09/04.

HISTORY: EVACUATION OF A LEFT POSTERIOR FOSSA EPIDURAL HEMATOMA.

SERIAL AXIAL TOMOGRAMS OF THE BRAIN FROM BASE OF VERTEX WERE OBTAINED WITHOUT CONTRAST.

NO CHANGE IN THE APPEARANCE OF THE LEFT SUBOCCIPITAL CRANIOTOMY DEFECT AND INTERVENTRICULAR OSTOMY DEVICE VIA SUPERIOR RIGHT FRONTAL CALVARIAL ACCESS TIP RESIDING IN THE THIRD VENTRICLE. A FEW MORE AIR BUBBLES IN THE SUBCRANIOTOMY EXTRAAXIAL SPACE HAS RESORBED IN THE LEFT POSTERIOR INTRACRANIAL FOSSA. THERE IS SOME RESIDUAL HYPERDENSE MATERIAL AND BUBBLES EXTENDING INTO THE EXTRAAXIAL SPACE IN THE SUPRATENTORIAL LEFT OCCIPITAL REGION.

THE INTRINSIC HYPERDENSE GEOGRAPHIC AREAS IN THE LEFT FRONTAL

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FALK STEVEN M 38 523A X X X X
828049 F0403800216 ADM: 02/07/04 M.S: X X XXXXX XXX X
LEE,JANE MD

CARE COORDINATOR: JOAN SANTANA TEST RESULTS SUMMARY

AND ANTERIOR LEFT TEMPORAL LOBES ARE UNCHANGED. EACH OF THESE AREAS ARE SURROUNDED BY A HALO OF DIMINISHED ATTENUATION EDEMA. THERE IS NO SHIFT OF THE MIDLINE STRUCTURES. NO CHANGE IN APPEARANCE OF THE CORTICAL SULCI, VENTRICLES AND BASILAR CISTERN ANATOMY. NO HYDRONEPHROSIS HAS RECURRED. THE INCLUDED PARANASAL SINUSES AND MASTOID AIR CELLS AGAIN SHOW SOME SOFT TISSUE IN THE ETHMOID SINUSES.

IMPRESSION: 1. POST LEFT OCCIPITAL CRANIOTOMY SURGICAL CHANGES AND RIGHT FRONTAL VENTRICULOSTOMY TIP IN THE THIRD VENTRICLE.
2. NO NEW RECURRENT EXTRAAXIAL FLUID COLLECTIONS IN THE LEFT POSTERIOR INTRACRANIAL FOSSA.
3. NO SIGNIFICANT CHANGE IN THE SMALL AMOUNT OF RESIDUAL BLOOD AND AIR SURROUNDING THE SUPERFICIAL LEFT OCCIPITAL LOBE.
4. NO CHANGE IN THE CONTRECOUP INJURIES INVOLVING THE LEFT FRONTAL AND ANTERIOR TEMPORAL LOBES WITH PARENCHYMAL HEMATOMAS AND SURROUNDING EDEMA.
5. MINIMAL ETHMOID SINUS DISEASE.

END OF IMPRESSION:

R046-0015 06:19 PM 02/15/04 RADIOLOGIST: CHIN,DAVID,M.D. -
170.01 CT HEAD WITHOUT, 02/15/2004:

CT SCAN OF BRAIN: 2/15/04.

COMPARISON: 2/12/04, 2/9/04, AND 2/8/04.

CLINICAL DATA: TRAUMA. STATUS POST EVACUATION OF LEFT POSTERIOR FOSSA EPIDURAL HEMATOMA. FOLLOW-UP.

TECHNIQUE: 5 MM AXIAL IMAGES OF THE BRAIN WERE OBTAINED.

FINDINGS: THE PATIENT IS STATUS POST LEFT OCCIPITAL/SUB-OCCIPITAL CRANIOTOMY, WITH EXPECTED RECENT POSTOPERATIVE CHANGES, INCLUDING A SMALL AMOUNT OF LOCAL EXTRA-AXIAL AIR, OVERLYING SOFT TISSUE SWELLING, AND OVERLYING CUTANEOUS STAPLES. THERE IS A SMALL AMOUNT OF RESIDUAL SUBACUTE EXTRA-AXIAL HEMORRHAGE IN THE LEFT OCCIPITAL AND POSTERIOR TEMPORAL REGIONS, MEASURING UP TO 8 MM IN THICKNESS, SIMILAR TO 2/12/04. A SMALL AMOUNT OF BLOOD PROBABLY LAYERS ALONG THE TENTORIUM, UNCHANGED. THERE IS A

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FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

SMALL (ABOUT 1 CM) AREA OF DIMINISHED ATTENUATION JUST ABOVE THE TENTORIUM AT THE INFERIOR ASPECT OF THE LEFT TEMPORO-OCCIPITAL REGION (IMAGE 10), NOT DEFINITELY EVIDENT ON PREVIOUS EXAMS.

A RIGHT FRONTAL VENTRICULOSTOMY CATHETER IS PRESENT, ITS TIP IN THE ANTERIOR ASPECT OF THE THIRD VENTRICLE, UNCHANGED. AREAS OF DIMINISHED ATTENUATION ARE AGAIN NOTED IN THE ANTEROMEDIAL LEFT FRONTAL LOBE AND ANTEROINFERIOR LEFT TEMPORAL LOBE, WITH A SMALL AMOUNT OF RESIDUAL HIGH ATTENUATION MATERIAL IN THE LEFT ANTERIOR MIDDLE CRANIAL FOSSA, SLIGHTLY DECREASED SINCE 2/12/04. THE PREVIOUSLY NOTED SMALL AMOUNT OF HEMORRHAGE IN THE LEFT ANTERIOR FRONTAL REGION IS NO LONGER EVIDENT. THE VENTRICLES ARE SYMMETRIC AND NONDILATED, BUT SLIGHTLY INCREASED IN SIZE COMPARED WITH 2/12/04. THERE IS MILD MUCOSAL THICKENING IN THE SPHENOID SINUS, THE PREVIOUSLY NOTED AIR FLUID LEVEL HAVING RESOLVED SINCE 2/12/04. A LEFT OCCIPITAL SKULL FRACTURE IS AGAIN SEEN.

IMPRESSION: 1. STATUS POST LEFT OCCIPITAL/SUB-OCCIPITAL CRANIOTOMY AND EVACUATION OF PREVIOUSLY NOTED EPIDURAL HEMATOMA, WITH A SMALL AMOUNT OF RESIDUAL EXTRA-AXIAL BLOOD, SIMILAR TO 2/12/04.
2. RIGHT FRONTAL VENTRICULOSTOMY TUBE IN PLACE, TIP IN THE ANTERIOR THIRD VENTRICLE. THE VENTRICLES ARE NONDILATED, BUT SLIGHTLY INCREASED IN SIZE SINCE 2/12/04.
3. SMALL AMOUNT OF RESIDUAL BLOOD LAYERING ALONG THE TENTORIUM.
4. EVOLVING CONTUSIONS OF THE ANTEROMEDIAL LEFT FRONTAL AND ANTEROINFERIOR LEFT TEMPORAL LOBES.
5. POSSIBLE NEW SMALL NONHEMORRHAGIC INFARCT AT THE INFEROMEDIAL ASPECT OF THE LEFT TEMPOROPARIETAL REGION.
6. LEFT OCCIPITAL SKULL FRACTURE.
7. MILD SPHENOID SINUS DISEASE, WITH RESOLUTION OF THE PREVIOUSLY NOTED AIR-FLUID LEVEL.
8. DISCUSSED WITH DR. WACCHORST AT 1010 HOURS ON 2/15/04.

END OF IMPRESSION:

R046-0016 06:06 PM 02/15/04 RADIOLOGIST: CHIN,DAVID,M.D. -
172.01 CHEST-PORTABLE, 02/15/2004:

CHEST: 2/15/04.

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FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

COMPARISON: 2/7/04.

CLINICAL DATA: SUBDURAL HEMATOMA. PNEUMONIA.

TECHNIQUE: A SINGLE PORTABLE FRONTAL VIEW OF THE CHEST WAS OBTAINED.

FINDINGS: THE CARDIOMEDIASTINAL SILHOUETTE AND PULMONARY VASCULARITY ARE STABLE AND WITHIN NORMAL LIMITS. THE LUNGS ARE CLEAR. NO PLEURAL EFFUSION OR THICKENING OR PNEUMOTHORAX IS EVIDENT. THE APPEARANCE OF THE CHEST IS NOT SIGNIFICANTLY CHANGED COMPARED WITH 2/7/04.

IMPRESSION: STABLE CHEST, WITHOUT EVIDENCE OF ACUTE CARDIOPULMONARY DISEASE.

END OF IMPRESSION:

R049-0022 11:45 PM 02/19/04 RADIOLOGIST: PERINI,SEAN,M.D. -
205.01 CT HEAD WITHOUT, 02/18/2004:

CT HEAD, 2/18/04:

CLINICAL DATA: 38-YEAR-OLD STATUS POST EVACUATION OF LEFT POSTERIOR FOSSA EPIDURAL HEMATOMA, FOLLOW-UP.

COMPARISON: 2/15/04 AND 2/7/04.

TECHNIQUE: 5 MM IMAGES OBTAINED WITHOUT CONTRAST.

FINDINGS: CHANGES COMPATIBLE WITH A PRIOR LEFT OCCIPITAL/SUBOCCIPITAL CRANIOTOMY ARE AGAIN SEEN. THERE IS A SMALL EXTRA-AXIAL COLLECTION DEEP TO AND EXTENDING SLIGHTLY ABOVE TO THE CRANIOTOMY SITE. THE COLLECTION IS NOW MAXIMALLY 7 MM IN THICKNESS AND REDUCED IN OVERALL DENSITY COMPARED WITH PRIOR. THE AMOUNT OF GAS ASSOCIATED WITH THIS COLLECTION IS REDUCED IN QUANTITY.

A SMALL, APPROXIMATELY 1 CM REGION OF DIMINISHED ATTENUATION IS AGAIN SEEN ALONG THE LEFT TENTORIUM (IMAGE 12), UNCHANGED COMPARED WITH PRIOR. A SMALL AMOUNT OF HIGH DENSITY HEMORRHAGE IS AGAIN SEEN LAYERING ON THE TENTORIUM. AREAS OF

CONTINUED

XXXXX XXXXX XXX XXXXX
X X X X
X XXX XXX X
X X X X
X XXXXX XXX X

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

DIMINISHED ATTENUATION ARE AGAIN SEEN IN THE LEFT FRONTAL AND TEMPORAL LOBES. A SMALL AMOUNT OF RESIDUAL HIGH DENSITY HEMORRHAGE IS AGAIN SEEN INSEPARABLE FROM THE ANTERIOR PORTION OF THE LEFT TEMPORAL LOBE.

A RIGHT FRONTAL VENTRICULOSTOMY CATHETER REMAINS IN PLACE, ITS TIP NEAR THE ANTERIOR ASPECT OF THE THIRD VENTRICLE. SMALL POLYPS OR RETENTION CYSTS ARE AGAIN NOTED WITHIN THE SPHENOID SINUSES. THERE IS PARTIAL OPACIFICATION OF AIR CELLS WITHIN THE CAUDAL PORTION OF THE LEFT MASTOID BONE. CUTANEOUS STAPLES ARE AGAIN NOTED IN THE LEFT OCCIPITAL SCALP. A LEFT OCCIPITAL BONE SKULL FRACTURE AND ASSOCIATED DIASTASIS OF THE CAUDAL LEFT LAMBDOID SUTURE IS AGAIN NOTED NOW OBSCURED BY POSTOPERATIVE CHANGES IN REGION.

IMPRESSION: 1. CHANGES COMPATIBLE WITH PRIOR LEFT OCCIPITAL/SUBOCCIPITAL CRANIOTOMY AND EVACUATION OF HEMATOMA IN REGION. SMALL AMOUNT OF RESIDUAL EXTRA-AXIAL BLOOD, DECREASED IN DENSITY COMPARED WITH 2/15/04.
2. RIGHT FRONTAL VENTRICULOSTOMY TUBE IN PLACE, TIP IN THE REGION OF THE THIRD VENTRICLE. VENTRICLES REMAIN NORMAL IN SIZE.
3. SMALL AMOUNT OF RESIDUAL BLOOD LAYERING ALONG TENTORIUM.
4. EVOLVING CONTUSIONS WITHIN LEFT FRONTAL AND TEMPORAL LOBES.
5. POSSIBLE CONTUSION OR SMALL INFARCT ALONG LEFT ASPECT OF TENTORIUM, AS NOTED ON 2/15/04.
6. MILD SPHENOID SINUS DISEASE.
7. SMALL AMOUNT OF FLUID WITHIN CAUDAL PORTION OF LEFT MASTOID BONE NEAR CRANIOTOMY AND FRACTURE.

END OF IMPRESSION:

R050-0026 01:40 PM 02/19/04 RADIOLOGIST: CHU,GEORGE D.,M.D. -
210.01 CT HEAD WITHOUT, 02/19/2004:

CT HEAD WITHOUT CONTRAST, 2/19/04:

COMPARISON: 2/18 AND 2/15/04.

HISTORY: TRAUMA WITH SKULL FRACTURE AND INTRACRANIAL HEMORRHAGE STATUS POST EVACUATION.

CONTINUED

XXXXX XXXXX XXX XXXXX
X X X X
X XXX XXX X
X X X X
X XXXXX XXX X

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

TEST RESULTS SUMMARY

TECHNIQUE: SERIAL AXIAL NON CONTRAST CT IMAGES OF THE HEAD WERE OBTAINED.

FINDINGS: THERE HAS BEEN NO INTERVAL CHANGE IN THE APPEARANCE OF THE LEFT OCCIPITAL AND SUBOCCIPITAL CRANIOTOMY SITE. A SMALL LEFT OCCIPITAL EXTRA-AXIAL FLUID COLLECTION REMAINS STABLE WITH SCATTERED FOCI OF AIR. THE MAXIMUM THICKNESS MEASURES APPROXIMATELY 7 MM. A SMALL EXTRA-AXIAL HEMORRHAGE IN THE ANTERIOR AND LEFT MIDDLE CRANIAL FOSSA IS FAINTLY VISUALIZED AND IS LIKELY UNCHANGED. EVALUATION IS LIMITED BY STREAK ARTIFACT. MILD HIGH ATTENUATION PERSISTS ALONG THE TENTORIUM SUGGESTIVE OF RESIDUAL HEMORRHAGE. NO NEW AREAS OF HEMORRHAGE OR ABNORMAL EXTRA- AXIAL FLUID COLLECTIONS ARE IDENTIFIED. PERSISTENT REGIONS OF LOW ATTENUATION INVOLVE THE LEFT FRONTAL, LEFT TEMPORAL, AND LIKELY THE LEFT LATERAL CEREBELLUM SUGGESTIVE OF AREAS OF CONTUSION AND/OR INFARCT.

A RIGHT FRONTAL VENTRICULOSTOMY SHUNT CATHETER DEVICE REMAINS UNCHANGED WITH THE TIP LOCATED IN THE THIRD VENTRICLE. NO HYDROCEPHALUS OR MIDLINE SHIFT IS APPRECIATED. THE VISUALIZED ORBITS AND MASTOID AIR CELLS ARE UNREMARKABLE. SMALL POLYPS OR RETENTION CYSTS OF THE SPHENOID SINUS REMAIN STABLE. REMAINING VISUALIZED PARANASAL SINUSES ARE UNREMARKABLE. THERE IS PERSISTENT DIASTASIS OF THE LEFT LAMBDOID SUTURE SIMILAR TO THE PRIOR EXAMINATION. SMALL AMOUNT OF SCALP AIR IS SEEN AT THE SITE OF CRANIOTOMY. SKIN STAPLES ARE NOTED.

IMPRESSION: OVERALL THERE HAS BEEN NO INTERVAL CHANGE SINCE THE PRIOR EXAMINATION.

EXTRA-AXIAL LEFT OCCIPITAL FLUID COLLECTION REMAINS STABLE.

SMALL LEFT ANTERIOR MIDDLE CRANIAL FOSSA EXTRA-AXIAL HEMORRHAGE IS UNCHANGED.

MILD RESIDUAL HEMORRHAGE ALONG THE TENTORIUM REMAINS STABLE.

NO NEW AREAS OF HEMORRHAGE ARE IDENTIFIED.

AREAS OF LOW ATTENUATION INVOLVING THE LEFT FRONTAL, LEFT TEMPORAL, AND LEFT CEREBELLUM REMAIN STABLE SUGGESTIVE OF AREAS OF CONTUSION.

CONTINUED

XXXXX XXXXX XXX XXXXX
X X X X
X XXX XXX X
FALK STEVEN M 38 523A X X X X
828049 F0403800216 ADM: 02/07/04 M.S: X X XXXXX XXX X
LEE,JANE MD

CARE COORDINATOR: JOAN SANTANA TEST RESULTS SUMMARY

NO HYDROCEPHALUS.

LEFT OCCIPITAL AND SUBOCCIPITAL CRANIOTOMY WITH DIASTASIS OF THE LEFT LAMBDOID SUTURE REMAINS STABLE.

END OF IMPRESSION:

R050-0132 01:08 AM 02/21/04 RADIOLOGIST: PERINI,SEAN,M.D. -
214.01 CT HEAD WITHOUT, 02/19/2004:

CT HEAD, 02/20/04.

CLINICAL DATA: 38-YEAR-OLD WITH SKULL FRACTURE AND INTRACRANIAL HEMORRHAGE POST-EVACUATION, FOLLOW-UP.

TECHNIQUE: 5 MM IMAGES OBTAINED WITHOUT CONTRAST.

FINDING: THE LEFT OCCIPITAL/SUBOCCIPITAL CRANIOTOMY AND ADJACENT SKULL FRACTURE ARE STABLE IN APPEARANCE. THE SMALL EXTRAAXIAL FLUID COLLECTION CONTAINING A FEW GAS BUBBLES SEEN IN THIS REGION IS NOT SIGNIFICANTLY CHANGED IN APPEARANCE. AS NOTED ON 02/19/04 THE COLLECTION HAS A MAXIMUM THICKNESS OF APPROXIMATELY 5 TO 7 MM.

THE SMALL HEMORRHAGE WITHIN THE ANTERIOR LEFT MIDDLE CRANIAL FOSSA IS AGAIN FAINTLY VISUALIZED. DENSITY ALONG THE LEFT TENTORIUM SUGGESTIVE OF RESIDUAL HEMORRHAGE IS LESS CONSPICUOUS.

SMALL REGIONS OF LOW DENSITY WITHIN THE CAUDAL LEFT FRONTAL LOBE AND LEFT TEMPORAL LOBE COMPATIBLE WITH CONTUSIONS OR INFARCTS ARE AGAIN NOTED. SUBTLE LOW DENSITY ASSOCIATED WITH THE LEFT LATERAL CEREBELLUM IS AGAIN NOTED.

THE RIGHT FRONTAL VENTRICULOSTOMY CATHETER HAS BEEN REMOVED. THE VENTRICLES ARE NOT SIGNIFICANTLY CHANGED IN SIZE.

IMPRESSION: 1. INTERVAL REMOVAL OF RIGHT FRONTAL VENTRICULOSTOMY CATHETER. VENTRICLES NOT SIGNIFICANTLY CHANGED IN SIZE.
2. EXTRAAXIAL HEMORRHAGE CENTERED IN LEFT OCCIPITAL REGION NEAR PREVIOUSLY IDENTIFIED SKULL FRACTURE AND SUBSEQUENT CRANIOTOMY UNCHANGED.

CONTINUED

XXXXX XXXXX XXX XXXXX
X X X X
X XXX XXX X
FALK STEVEN M 38 523A X X X X
828049 F0403800216 ADM: 02/07/04 M.S: X X XXXXX XXX X
LEE,JANE MD

CARE COORDINATOR: JOAN SANTANA TEST RESULTS SUMMARY

3. SMALL AMOUNT OF RESIDUAL HEMORRHAGE ALONG TENTORIUM AND AT ANTERIOR ASPECT OF LEFT MIDDLE CRANIAL FOSSA NOT SIGNIFICANTLY CHANGED.
4. SMALL CONTUSIONS OR INFARCTS LEFT FRONTAL LOBE, LEFT TEMPORAL LOBE, AND ALONG LATERAL ASPECT OF LEFT CEREBELLUM AGAIN NOTED.

END OF IMPRESSION:

NUCLEAR MED RESULTS: FILE #828049

N047-0021 11:33 AM 02/17/04 RADIOLOGIST: CHIN,DAVID,M.D. -
202.01 ABDOMINAL SCAN, 02/16/2004:

ABDOMINAL SONOGRAM, 2/17/04:

COMPARISON: NONE.

CLINICAL DATA: INTRACRANIAL HEMORRHAGE. ABNORMAL LIVER FUNCTION TEST.

TECHNIQUE: MULTIPLE HIGH RESOLUTION REAL-TIME TRANSVERSE AND LONGITUDINAL TRANSABDOMINAL SONOGRAMS WERE OBTAINED PORTABLY IN THE ICU.

FINDINGS: THE LIVER AND SPLEEN ARE NORMAL IN SIZE AND CONTOUR AND DEMONSTRATE HOMOGENEOUS ECHOGENICITY, WITHOUT FOCAL OR DIFFUSE ABNORMALITY. NO INTRA- OR EXTRAHEPATIC BILIARY DUCTAL DILATATION IS APPRECIATED. THERE IS A SMALL AMOUNT OF GALLBLADDER SLUDGE. NO GALLSTONES ARE VISUALIZED. NO FOCAL GALLBLADDER TENDERNESS IS ELICITED. NO GALLBLADDER WALL THICKENING OR PERICHOLECYSTIC FLUID IS EVIDENT. NO INTRA- OR EXTRAHEPATIC BILIARY DUCTAL DILATATION IS SEEN. THE PANCREAS DISPLAYS NO FOCAL OR DIFFUSE ENLARGEMENT. NO ANEURYSM OR FREE FLUID IN THE ABDOMEN IS APPARENT. THE KIDNEYS ARE UNREMARKABLE, MEASURING 12.1 CM IN LENGTH ON THE RIGHT AND 12.0 CM ON THE LEFT. THERE IS A TRACE LEFT PLEURAL EFFUSION.

IMPRESSION: 1. GALLBLADDER SLUDGE.
2. TRACE LEFT PLEURAL EFFUSION.

CONTINUED

XXXXX XXXXX XXX XXXXX
X X X X
X XXX XXX X
FALK STEVEN M 38 523A X X X X
828049 F0403800216 ADM: 02/07/04 M.S: X X XXXXX XXX X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA TEST RESULTS SUMMARY

3. ABDOMINAL SONOGRAM OTHERWISE WITHIN NORMAL LIMITS.

END OF IMPRESSION:

ALL CURRENT TEST AND DISCHARGE ORDERS

03:16 PM 02/08/04
85. PHYSICAL THERAPY: EVALUATE & TREAT--POD 1, <02/08/04>, (RG).
86. OCCUPATIONAL THERAPY: -EVALUATION/TREATMENT IN AREAS OF NEED , <02/08/04>, (RG).
87. OCCUPATIONAL THERAPY: -ORAL-BULBAR EVALUATION--IF APPROPRIATE POD 1, <02/08/04>, (RG).
03:17 PM 02/08/04
102. OXYGEN THERAPY: INDICATIONS- POST OP; OXYGEN THERAPY ORDER- NASAL CANNULAE 2L/M, PRN, KEEP O2 SAT >94, <02/08/04>, (RG).
07:36 AM 02/14/04
159. OCCUPATIONAL THERAPY: -EVALUATION/TREATMENT IN AREAS OF NEED , <02/14/04>, (SMW).
07:49 AM 02/15/04
INPR 179. CULT(SENS, IF IND), CS, CSF, TUBE#1, <02/15/04>, (SMW).
05:01 PM 02/21/04
235. DISCHARGE PATIENT TOMORROW, <02/22/04>, (RG).

LAST PAGE

X X XXX X X XXX XXXXX
XX XX X X XX X X X
X X X X X X X X X X X X X
X X X X X X X X X X X
X X X X XXX X X XXX X

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA CLINICAL MONITOR

PHYSICIAN DISCHARGE DOCUMENTATION

02/08/04

ENTERED BY: UPADHYAYA,MASKELL RN MMND

LAST PAGE

EL CAMINO HOSPITAL
EMERGENCY DEPARTMENT - CHARGE SHEET
REVENUE CENTER 4010

FALK STEVEN
828049
LEE, JANE MD
F0403800216 02/07/04 M 48
CC11

RN/Tech Signature Required _____

PROCEDURES

SIM #	QTY	Service
ED SERVICES		
01020		Level 1
01225		Level 2
01227		Level 3
01230		Level 4
01235		Level 5
01240		Level 6
01245	X	Level 7
01015		Extended Care Hours-Regular
01001		Extended Care Hours-Critical
01023		Clinic Visit
01215		No Charge
01019		Triage Only (RN)
CARDIOVASCULAR PROCEDURES		
10105		Arterial Catheterization
10110		Arterial Puncture
10001		Cardioversion
10140		Cut Down
10850		CPR
10145		CVP Line Insertion
10270		Pericardiocentesis
20011		Pacemaker External
EYE/EAR/NOSE PROCEDURES		
20020		Cerumen removal
20021		Ear-F/B Removal
10155		Eye F/B Removal
10240		Nasal-Removal F/B
10245		Nasal Hemorrhage-Ant Simple
10250		Nasal Hemorrhage-Ant Complex
10255		Nasal Hemorrhage-Posterior
10260		Nasal Hem-Post Tonsillectomy
INJECTIONS/INFUSIONS PROCEDURES		
10190	X	IV Infusion w/o Thrombolytic
10191		IV Infusion with Thrombolytic

SIM #	QTY	Service
GASTROINTESTINAL PROCEDURES		
26103		Anoscopy
10280		Endoscopy-Lower
10281		Endoscopy-Upper
47330		Gastric Lavage
10175		Gastrostomy Tube Change
10171		NG insertion-MD
10170		NG insertion-RN
10275		Paracentesis, Abd.
GU/GYN PROCEDURES		
10115		Bladder Irrigation, Simple
10300		Urinary Cath - Simple
10301		Urinary Cath for UA/US
10305		Urinary Cath-Complex
20018		Suction Curettage
10311		Vaginal Exam w/IUD Removal
10310		Vaginal Exam
INTEGUMENTARY (SKIN) PROCEDURES		
10120		Debridement/Burn - small
10125		Debridement/Burn - medium
10130		Debridement/Burn - large
10160		F/B - removal simple, subQ
10165		F/B - removal Comp w/ Lac. Repair
10180		I&D abcess-simple
10185		I&D abcess-Comp/multiple
10195		Laceration Repair-**simple**
10200		Laceration Repair-**intermediate**
10205		Laceration Repair-**complex**

SIM #	QTY	Service
NAIL PROCEDURES		
10235		Subungual Hematoma Evacuation
10231		Nail/Nail Bed Repair
10225		Nail Removal-Partial
10232		Nail Removal-Complete
ORTHOPEDIC PROCEDURES		
10560		Cast Removal
10565		Cast Windowing
10570		Fracture/Dislocation Reduction
SPLINT WITH CAST MATERIAL		
10575		Finger with out Reduction
10580		Long Arm with out Reduction
10585		Short Arm with out Reduction
10590		Long Leg with out Reduction
10595		Short Leg with out Reduction
OTHER PROCEDURES		
10100		Arthrocentesis-small joint
10101		Arthrocentesis -medium joint
10102		Arthrocentesis-large joint
10220		Lumbar Puncture
10335		Procedure-ER, Simple
10336		Procedure-ER, Complex
RESPIRATORY PROCEDURES		
10135		Chest Tube Insertion
10150		Endotracheal Intubation
10210		Laryngoscopy-to view throat
10215		Laryngoscopy-Removal F/B
10290		Thoracentesis
10295		Tracheostomy
10296		Trach Tube Replacement

SUPPLIES

INJECTIONS/INFUSIONS SUPPLIES		
10700		Additional Angiocath
10705		Blood Tubing
10610		Catheter 3 Lumen
10735		Epidural Tray
10710		IV Pump Tubing
10410		Groshong Cath Kit (Dual)
10405		Groshong Cath Kit (Single)
26112		Intraosseous Needle
10400		IV Extension Set
10325		Additional IV Solution
10326	X	IV Start Supplies
10425		Needle Huber
10415		Percutaneous Sheath Kit
10420		Pic Catheter w/Kit
10285		Saline Lock
WOUND CARE SUPPLIES		
26057		Bartholin Cyst Catheter
47340		Dermabond
10740		Dressing - Small
10745		Dressing - Large
10445		Penrose Drain
10520		Scalpel
10525		Solution Irrigation
10530		Staple Remover
10535		Steri Strips
10540		Suture Removal Kit

WOUND CARE SUPPLIES CONTINUED		
20003		Suture Tray-Additional
20019		Wound Prep
ORTHOPEDIC-SUPPLIES		
10490		Ace Bandage
10495		Air Cast
27150		Arm Sling
10500		Cane
27165		Cast Shoe
10505		Cervical Collar
27000		Clavicle Strap
10510		Crutches
42860		Ice Bag
27114		Knee Immobilizer
27105		Metal Leg Splint
26106		Philadelphia Collar
10515		Post Op Shoe
27144		Rib Belt
27177		Riordan Fix Pin
27188		Shoulder Immobilizer
20007		Steinman Pin Tray
27183		Thomas Splint
10555		Walker
27066		Wrist Splint

OTHER SUPPLIES		
10465		Airway Oral
10430		Bair Warmer Blanket
10330		Easy Cap CO2 Monitor
10435		Enema Fleets
47327		Gastric Lavage Solution-Additional
10461		Leg Bag
10470		Mask Oxygen
10440		Morgue Pack
10475	X	Nasal Cannula
10800		Pulse Oximetry
10725		Rectal Probe-Disposable
10450	X	Restraint - Limb
10455		Restraint - Vest
40480		Suction Catheter (Balard)
10715		Suction Catheter
10485	X	Suction Catheter(Yankeur)
10720	X	Suction Set-up
10605		Suction Trap
10615		Urine Bag - Newborn/Pedi
10550		Urine Strainer

Rev 1/15/2004
TIK4

DOE JOHN

EL CAMINO HOSPITAL

FALK STEVEN
828049 M123
FOX, DAN E MD
F0403800216 02/07/04

EMERGENCY DEPARTMENT
NURSING CARE RECORD

TRIAGE TIME: AM PM | MODE OF ARRIVAL ☐ AMBULATORY ☒ AMBULANCE ☐ CRUTCHES ☐ IN ARMS ☐ WHEELCHAIR

CHIEF COMPLAINT: Grand mal Seizure, unknown time, 2nd Seizure X 2 minutes, Post dictal, then combative; Code 3

ALLERGIES: ?

MEDS: ?

WT: LMP:

TRIAGE NURSE:

PRE HOSPITAL: ☐ PARAMEDIC ☐ EMT
V.S.: 140/10, 129
MEDS:
BS 111
☐ C-SPINE PREC. ☐ BACKBOARD

TETANUS
☐ >5 YEARS
☐ <5 YEARS
☐ >25 YEARS
PRIMARY LANGUAGE
TRANSLATOR

PAST MEDICAL HISTORY
☐ NONE UNKNOWN
☐ CVD
☐ DIABETES
☐ HEPATITIS TYPE
☐ HYPERTENSION
☐ CVA
☐ SEIZURES
☐ MIGRAINE HEADACHES
☐ RENAL
☐ PULM. DISEASE
☐ SUBSTANCE ABUSE

PRIMARY NURSE ASSESSMENT TIME: 607 AM PM Heidi Hayden

AIRWAY
☐ CLEAR
☐ QUIET
☐ PATENT
☒ NOISY
☐ NASAL FLARE

MENTAL STATUS
☒ AWAKE
☐ ALERT
☐ LETHARGIC
☐ RESTLESS
☐ AGITATED
☒ COMBATIVE
☐ UNCOOPERATIVE
☐ UNCONSCIOUS
☐ ETOH ODOR
☐ _____

ORIENTED
☐ TIME
☐ PERSON
☐ PLACE
☐ EVENT

SPEECH
☐ COHERENT
☐ INCOHERENT
☐ SILENT
☐ SLURRED
☐ PREVERBAL
☒ UNABLE talk
☐ NON-ENGLISH
☐ INTUBATED

HEAD/NECK
☐ N/A
☐ _____
☐ _____

VISUAL ACUITY
☐ N/A

PUPILS W/WO CORRECTION
OD _____/_____
OS _____/_____

SKIN MOISTURE & COLOR / TEMP
☒ DRY
☒ MOIST
☐ DIAPHORETIC
☐ PINK
☐ PALE
☐ ASHEN
☒ FLUSHED
☐ CYANOTIC
☐ JAUNDICED
☐ MOTTLED
☐ HOT
☐ WARM
☐ COOL
☐ COLD
☐ _____
Face moist

CHEST ☐ N/A
☐ RETRACTIONS
R L
☐ ☐ _____
☒ ☒ CLEAR Equal bilateral
☐ ☐ CRACKLES _____
☐ ☐ GURGLES _____
☐ ☐ WHEEZES _____
☐ ☐ DECREASED _____
☐ ☐ ABSENT _____

ABDOMEN R L
☐ N/A
☐ SOFT
☐ FIRM
☐ DISTENDED
☐ NONTENDER
☐ TENDER _____
☐ BOWEL SOUNDS (+) ALL
☐ OBESE

1	2	3
4	5	6
7	8	9

G.U.
☐ N/A
☐ DIAPERED
☐ _____
☐ VAGINAL BLEED
AMT: _____
☐ _____

EXTREMITIES ☐ N/A ☐ CSM INTACT ☐ BLEED CNTRL
☐ AREA OF DEFICIT
☒ LAC SIZE cm 2 to occipital
☐ ECCHYMOSIS
☐ DISTAL PULSES + –
☐ RADIAL
☐ PEDAL
☐ EDEMA
☐ SWELLING
☐ DEFORMITY

TIME	610 pm	620 p	1845	1900									
BLOOD PRESSURE	171/71	149/83	157/66	120/61									
TEMP	98.6												
PULSE	147	128	124	130									
RESP RATE/ PATTERN	16	17	24	20									
EKG			ST	ST									
PAIN SCALE (0 – 10)	8												
O_2 SAT	100%	100%	100%	100%									
PUPILS	RBB LB		BB	BB									
EYE OPENING	4		4	4									
VERBAL	8		4	4									
MOTOR	6		6	6									
INITIALS	TH		SV	SV									

PUPIL GUIDE
B = BRISK
S = SLUGGISH
F = FIXED

7mm 6mm 5mm 4mm 3mm 2mm

RESP PATTERN
N = NONLABORED S = SHALLOW
L = LABORED I = IRREGULAR

Best Verbal Response	SPONTANEOUSLY	4
	TO VERBAL COMMAND	3
	TO PAIN	2
	NO RESPONSE	1
	ORIENTED AND CONVERSES	5
	DISORIENTED AND CONVERSES	4
	INAPPROPRIATE WORDS	3
	INCOMPREHENSIBLE SOUNDS	2
	NO RESPONSE	1
Best Motor Response	TO VERBAL COMMAND: OBEYS	6
	TO PAINFUL STIMULI: LOCALIZES PAIN	5
	FLEXION WITHDRAWAL	4
	FLEXION ABNORMAL	3
	EXTENSION	2
	NO RESPONSE	1

FORM 3065 (3/01)

MEDICATIONS

TIME	DRUG	DOSE	ROUTE / SITE	REASON	INITIALS	TIME	RESPONSE	INITIALS
	O2							
6:09A	Valium	2.5mg	IV		HH			
6:10A	Valium	2.5mg	IV		HH			
1847	Valium	2.5mg IV	for [illegible]					
1912	[illegible]	1 [illegible]	IV	[illegible] 30"	[illegible]			
1930	Tetanus	.5ml	(R) deltoid		HH			
1931	Phenergan	12.5mg IV	for [illegible]				LOT # MFG	

INTAKE

INTRAVENOUS									OTHER
START TIME	SOLUTION / AMOUNT	CATHETER TYPE / SIZE	SITE	RATE ml/HOUR	ADDITIVES	INITIALS	FINISH TIME	AMOUNT ABSORBED	
PTA	NSS 1000cc		[illegible]						
6:09A	[illegible] NS	18	(R) AC						

INTAKE TOTALS:

LABS

TIME	AGB'S O2 FLOW	PO2	SAT	pH	PCO2	BICARB	BE (BASE EXCESS)	TIME	GLUC	PCV/Hgb	K
								6:15p	127		
								6:10p	To lab		

OUTPUT

TIME	GASTRIC	URINE	OTHER
TOTALS			

PROGRESS NOTES

TIME	PROGRESS NOTES	INITIALS
6:07pm	Focal to Grand mal seizure x 30 seconds Airway Sxned, Valium given	HH
	DR. Fox @ bedside	HH
6:10pm	Patient quiet, ABDomenal breathing, O2 Sat 100%	HH
	ABRASION to back of head.	HH
6:15pm	CXR done & C-Spine Film	HH
6:20pm	DR. Fox in. Patient quient. C-Spine cleared ō x-ray read	HH
6:30pm	To CAT of Head	HH
6:40pm	BACK TO ER. PATIENT AWAKE MAE confused and combative	HH
6:50pm	Tom Sarsdale, Patient's boss contacted, "History of seizures". No family contact @ this time.	HH

TIME	PROGRESS NOTES	INITIALS
1845	Post CT scan pt [illegible] "let me go" [illegible] [illegible]	
1847	[illegible] Valium 2.5mg IV [illegible] Dr Fox [illegible]	
1850	[illegible]	
1900	[illegible] 2" [illegible]	
1915	[illegible]	

NAME	INITIALS
Heidi Hayden RN	HH
[illegible signature]	

W = WITH W/P = WITHOUT CSM = CIRCULATION, SENSORY, MOTOR LAC = LACERATION NA = NOT APPLICABLE

WHITE - CHART YELLOW - EMERGENCY ROOM PINK - PHYSICIAN

EL CAMINO HOSPITAL EMERGENCY DEPT. RECORD

Room # TRB 98127

Name/Time Called/PCP Called/ ______ Name/Time Consult Called ______

ED-L2-1859-01 - EL CAMINO H
FALK STEVEN
828049 M123
FOX,DAN E MD
F0403800216 02/07/04

Date:	Patient's Name:		
Arrival Time: 6005p	Mode to ER: ☒ Ambulance ☐ Wheel Chair ☐ Walking ☐ Carried	☐ PMD ☐ ER Panel	
Triage Time:	Sex: ☐ M ☐ F / DOB:	Pediatrics: Weight ____ kg; Head Circumference < (36mo) ____; Immunizations Current: ☐ Yes ☐ No	Level

LMP — Tetanus Hx ☐ > 5 ☐ < 5 ☐ > 25 ☐ Unknown

CHIEF COMPLAINT Mother # 941-922-5044
Robert Pitman # Work 403-653-4443
Cell 408-761-2537

TRIAGE CLASSIFICATION ☐ Immediate ☐ Delayed ☐ Minor

VITAL SIGNS (TIME)	T	P	R	B/P	O_2Sat	PAIN SCALE (0-10)

Speaks/understands English: ☐ Yes ☐ No
If no, language spoken: ______
Information obtained from: ☐ patient ☐ parent ☐ Other ______ (relationship)
Needs interpreter: ☐ Yes ☐ No Interpretive Service ______
Family/friends in waiting room: ☐ Yes ☐ No

MED HX: ☐ None ☐ Cardiovascular ☐ Respiratory ☐ CVA ☐ Diabetes ☐ HTN ☐ Seizures ☐ Hepatitis ____ ☐ Renal ☐ DNR Directive ☐ Substance Abuse ☐ Alcohol ☐ Tobacco ☐ Other

CURRENT MEDICATIONS ☐ None ☐ See Attached List — Dr. McCormick – Dr. Calloway
Pervitte – Contentrol } Prozac
Neurontin

☐ NKDA ALLERGIES/REACTION

NURSING INTERVENTION AT TRIAGE: ☐ N/A ☐ Elevate ☐ X-Ray ☐ Drsg ☐ Splint/Sling ☐ Other ____ ☐ Ice ☐ U/A

DOMESTIC VIOLENCE SCREEN	TIME	MEDICATION	DOSE	ROUTE	SITE	INIT
☐ DV+ ☐ DV–						
☐ DV? ☐ Pt < 13 yr.		MFG./Lot #			Exp Date	

DISPOSITION: FROM TRIAGE ☐ Directly to Tx Rm ☐ To Tx Rm after Triage ☐ To Waiting room — Triage RN:

NURSING NOTES

TIME TO ROOM: ☐ See Nursing Care Record

C-spine of ringed — Think
CT ghns — 1.3 x 6 cm Epidural c̄ skull fx —
and fluid in sphenoid.

HISTORY & EXAM

EXAM TIME: ☐ Note Dictated

WBC 15.6 ?? 8/1/c HgB 1520 ...
CXR – ... x ... 45
Blood ... – ...
CEMS/CPK – 5.0/346 – 22
Dx 426.3

PA ASSESSMENT ☐ AGREE ☐ SEEN & AGREE ☒ EXAMINED & AGREE

DX IMPRESSION: 1) Epi ...

CONDITION ON D/C: ☐ Improved ☒ Unchanged ☐ Stable PA Sign ______ / MD Signature [signature] Time ______

DISPOSITION ☐ Home ☐ LWBS ☐ AMA ☐ Morgue ☐ Coroner **ADMIT TO:** ☐ Inpatient ___ ☐ Observation ___ ☐ Transfer To ______

TEACHING METHOD: ☐ Discussion ☐ Demonstration ☐ Handout

DISCHARGE INSTRUCTIONS: ... Dr. Green would will contact ... Mike Lee → will consult
Verbalizes Understanding ☐ ACI ☐

MODE OF DISCHARGE ☐ Walk ☐ W/C ☒ AMB ☐ Car ☐ Police ☐ Taxi

RECEIVED BY: PATIENT/RESPONSIBLE PERSON SIGNATURE: ______
DISCHARGED BY SIGNATURE/TITLE: [signature] DATE ______ TIME 8:45p

EL CAMINO HOSPITAL

FALK STEVEN
828049 M123
FOX,DAN E MD
F0403800216 02/07/04

EMERGENCY DEPARTMENT
NURSING CARE RECORD

TRIAGE TIME: AM PM | MODE OF ARRIVAL ☐ AMBULATORY ☐ AMBULANCE ☐ CRUTCHES ☐ IN ARMS ☐ WHEELCHAIR

CHIEF COMPLAINT:

ALLERGIES:

MEDS:

WT: LMP:

TRIAGE NURSE:

PRE HOSPITAL: ☐ PARAMEDIC ☐ EMT
V.S.:
MEDS:

☐ C-SPINE PREC. ☐ BACKBOARD

TETANUS
☐ >5 YEARS
☐ <5 YEARS
☐ >25 YEARS
PRIMARY LANGUAGE
TRANSLATOR

PAST MEDICAL HISTORY
☐ NONE
☐ CVD _____
☐ DIABETES
☐ HEPATITIS TYPE _____
☐ HYPERTENSION
☐ CVA
☐ SEIZURES _____
☐ MIGRAINE HEADACHES
☐ RENAL _____
☐ PULM. DISEASE _____
☐ SUBSTANCE ABUSE
☐ _____
☐ _____
☐ _____
☐ _____

PRIMARY NURSE ASSESSMENT TIME: AM PM

AIRWAY
☐ CLEAR
☐ QUIET
☐ PATENT
☐ NOISY
☐ NASAL FLARE

MENTAL STATUS
☐ AWAKE
☐ ALERT
☐ LETHARGIC
☐ RESTLESS
☐ AGITATED
☐ COMBATIVE
☐ UNCOOPERATIVE
☐ UNCONSCIOUS
☐ ETOH ODOR
☐ _____

ORIENTED
☐ TIME
☐ PERSON
☐ PLACE
☐ EVENT

SPEECH
☐ COHERENT
☐ INCOHERENT
☐ SILENT
☐ SLURRED
☐ PREVERBAL
☐ UNABLE ___
☐ NON-ENGLISH
☐ INTUBATED

HEAD/NECK
☐ N/A
☐ _____
☐ _____

VISUAL ACUITY
☐ N/A
PUPILS W/WO CORRECTION
OD _____/_____
OS _____/_____

SKIN MOISTURE & COLOR / TEMP
☐ DRY
☐ MOIST
☐ DIAPHORETIC
☐ PINK
☐ PALE
☐ ASHEN
☐ FLUSHED
☐ CYANOTIC
☐ JAUNDICED
☐ MOTTLED
☐ HOT
☐ WARM
☐ COOL
☐ COLD
☐ _____

CHEST ☐ N/A
☐ RETRACTIONS
R L
☐ ☐ _____
☐ ☐ CLEAR
☐ ☐ CRACKLES _____
☐ ☐ GURGLES _____
☐ ☐ WHEEZES _____
☐ ☐ DECREASED _____
☐ ☐ ABSENT _____

ABDOMEN R L
☐ N/A
☐ SOFT
☐ FIRM
☐ DISTENDED
☐ NONTENDER
☐ TENDER _____
☐ BOWEL SOUNDS + −
☐ OBESE

1 2 3
4 5 6
7 8 9

G.U.
☐ N/A
☐ DIAPERED
☐ _____
☐ VAGINAL BLEED
AMT: _____
☐ _____

EXTREMITIES ☐ N/A ☐ CSM INTACT ☐ BLEED CNTRL
☐ AREA OF DEFICIT ☐ LAC SIZE cm _____
☐ ECCHYMOSIS
☐ DISTAL PULSES + −
☐ RADIAL
☐ PEDAL
☐ EDEMA
☐ SWELLING
☐ DEFORMITY

TIME												
BLOOD PRESSURE	/	/	/	/	/	/	/	/	/	/	/	/
TEMP												
PULSE												
RESP RATE/ PATTERN	/	/	/	/	/	/	/	/	/	/	/	/
EKG												
PAIN SCALE (0 – 10)												
O_2 SAT												
PUPILS	R / L	/	/	/	/	/	/	/	/	/	/	/
EYE OPENING												
VERBAL												
MOTOR												
INITIALS												

PUPIL GUIDE
B = BRISK
S = SLUGGISH
F = FIXED

7mm 6mm 5mm 4mm 3mm 2mm

RESP PATTERN
N = NONLABORED S = SHALLOW
L = LABORED I = IRREGULAR

Best Verbal Response	Eyes Open	SPONTANEOUSLY 4
		TO VERBAL COMMAND 3
		TO PAIN 2
		NO RESPONSE 1
		ORIENTED AND CONVERSES 5
		DISORIENTED AND CONVERSES 4
		INAPPROPRIATE WORDS 3
		INCOMPREHENSIBLE SOUNDS 2
		NO RESPONSE 1
Best Motor Response	TO VERBAL COMMAND	OBEYS 6
	TO PAINFUL STIMULI	LOCALIZES PAIN 5
		FLEXION WITHDRAWAL 4
		FLEXION ABNORMAL 3
		EXTENSION 2
		NO RESPONSE 1

FORM 3065 (3/01)

MEDICATIONS

TIME	DRUG	DOSE	ROUTE / SITE	REASON	INITIALS	TIME	RESPONSE	INITIALS
	O2							
							LOT # MFG	

INTAKE

INTRAVENOUS									OTHER
START TIME	SOLUTION / AMOUNT	CATHETER TYPE / SIZE	SITE	RATE ml/HOUR	ADDITIVES	INITIALS	FINISH TIME	AMOUNT ABSORBED	
								INTAKE TOTALS:	

LABS

	AGB'S											
TIME	O2 FLOW	PO2	SAT	pH	PCO2	BICARB	BE (BASE EXCESS)	TIME	GLUC	PCV/Hgb	K

OUTPUT

TIME	GASTRIC	URINE	OTHER
TOTALS			

TIME	PROGRESS NOTES	INITIALS	TIME	PROGRESS NOTES	INITIALS
2020	CXR done pt c/o nausea				
	then vomited 100cc				
	brown fluid c undigested				
	food particles then				
	[illegible] quickly on since				
	[illegible] dyspnea				
2030	[illegible] dizzy (c)				
	[illegible] occipital				
	area as per wife [illegible]				
	[illegible]				
2048	Report to RN CCU				
2047	to CCU c RN				

			NAME	INITIALS

W = WITH W/P = WITHOUT CSM = CIRCULATION, SENSORY, MOTOR LAC = LACERATION NA = NOT APPLICABLE

WHITE - CHART YELLOW - EMERGENCY ROOM PINK - PHYSICIAN

EL CAMINO HOSPITAL

FALK STEVEN
828049 M123
FOX,DAN E MD
F0403800216 02/07/04

EMERGENCY DEPARTMENT
NURSING CARE RECORD

TRIAGE TIME: AM PM | MODE OF ARRIVAL ☐ AMBULATORY ☐ AMBULANCE ☐ CRUTCHES ☐ IN ARMS ☐ WHEELCHAIR

CHIEF COMPLAINT:

ALLERGIES:

MEDS:

WT: LMP:

TRIAGE NURSE:

PRE HOSPITAL: ☐ PARAMEDIC ☐ EMT

V.S.:

MEDS:

☐ C-SPINE PREC. ☐ BACKBOARD

TETANUS
☐ >5 YEARS
☐ <5 YEARS
☐ >25 YEARS

PRIMARY LANGUAGE

TRANSLATOR

PAST MEDICAL HISTORY
☐ NONE
☐ CVD _____
☐ DIABETES
☐ HEPATITIS TYPE ____
☐ HYPERTENSION
☐ CVA
☐ SEIZURES _____
☐ MIGRAINE HEADACHES
☐ RENAL _____
☐ PULM. DISEASE _____
☐ SUBSTANCE ABUSE
☐ _____
☐ _____
☐ _____
☐ _____

PRIMARY NURSE ASSESSMENT TIME: AM PM

AIRWAY
☐ CLEAR
☐ QUIET
☐ PATENT
☐ NOISY
☐ NASAL FLARE

MENTAL STATUS
☐ AWAKE
☐ ALERT

ORIENTED
☐ TIME
☐ PERSON
☐ PLACE
☐ EVENT

☐ LETHARGIC
☐ RESTLESS
☐ AGITATED
☐ COMBATIVE
☐ UNCOOPERATIVE
☐ UNCONSCIOUS
☐ ETOH ODOR
☐ _____

SPEECH
☐ COHERENT
☐ INCOHERENT
☐ SILENT
☐ SLURRED
☐ PREVERBAL
☐ UNABLE ___
☐ NON-ENGLISH
☐ INTUBATED

HEAD/NECK
☐ N/A
☐ _____
☐ _____

VISUAL ACUITY
☐ N/A

PUPILS W/WO CORRECTION
OD _____/_____
OS _____/_____

SKIN MOISTURE & COLOR / TEMP
☐ DRY
☐ MOIST
☐ DIAPHORETIC
☐ PINK
☐ PALE
☐ ASHEN
☐ FLUSHED
☐ CYANOTIC
☐ JAUNDICED
☐ MOTTLED
☐ HOT
☐ WARM
☐ COOL
☐ COLD
☐ _____

CHEST ☐ N/A
☐ RETRACTIONS
R L
☐ ☐ _____
☐ ☐ CLEAR
☐ ☐ CRACKLES _____
☐ ☐ GURGLES _____
☐ ☐ WHEEZES _____
☐ ☐ DECREASED _____
☐ ☐ ABSENT _____

ABDOMEN R L

1	2	3
4	5	6
7	8	9

☐ N/A
☐ SOFT
☐ FIRM
☐ DISTENDED
☐ NONTENDER
☐ TENDER _____
☐ BOWEL SOUNDS + –
☐ OBESE

G.U.
☐ N/A
☐ DIAPERED
☐ _____
☐ VAGINAL BLEED
AMT: _____
☐ _____

EXTREMITIES ☐ N/A ☐ CSM INTACT ☐ BLEED CNTRL
☐ AREA OF DEFICIT ☐ LAC SIZE cm _____
_____
☐ ECCHYMOSIS
_____
☐ DISTAL PULSES + –
☐ RADIAL _____
☐ PEDAL _____
☐ EDEMA _____
☐ SWELLING _____
☐ DEFORMITY _____

TIME	1415	1930	1942	2005						
BLOOD PRESSURE	127/57	117/86	128/72	140/81						
TEMP										
PULSE	125	126	118	110						
RESP RATE/ PATTERN	16	16	16	16						
EKG	SR	SR	SR	SR						
PAIN SCALE (0 – 10)										
O_2 SAT	100%	100%	100%	100%						
	RA									
PUPILS	R 3 3			4 3 3						
EYE OPENING	3	3	3	3						
VERBAL	4	4	5	5						
MOTOR	6	6	6	6						
INITIALS										

PUPIL GUIDE
B = BRISK
S = SLUGGISH
F = FIXED

7mm 6mm 5mm 4mm 3mm 2mm

RESP PATTERN
N = NONLABORED S = SHALLOW
L = LABORED I = IRREGULAR

Eyes Open	SPONTANEOUSLY	4
	TO VERBAL COMMAND	3
	TO PAIN	2
	NO RESPONSE	1
Best Verbal Response	ORIENTED AND CONVERSES	5
	DISORIENTED AND CONVERSES	4
	INAPPROPRIATE WORDS	3
	INCOMPREHENSIBLE SOUNDS	2
	NO RESPONSE	1
Best Motor Response	TO VERBAL COMMAND: OBEYS	6
	TO PAINFUL STIMULI: LOCALIZES PAIN	5
	FLEXION WITHDRAWAL	4
	FLEXION ABNORMAL	3
	EXTENSION	2
	NO RESPONSE	1

FORM 3065 (3/01)

MEDICATIONS

TIME	DRUG	DOSE	ROUTE / SITE	REASON	INITIALS	TIME	RESPONSE	INITIALS
	O2							
							LOT # MFG	

INTAKE

INTRAVENOUS									OTHER
START TIME	SOLUTION / AMOUNT	CATHETER TYPE / SIZE	SITE	RATE ml/HOUR	ADDITIVES	INITIALS	FINISH TIME	AMOUNT ABSORBED	
INTAKE TOTALS:									

LABS

	AGB'S										
TIME	O2 FLOW	PO2	SAT	pH	PCO2	BICARB	BE (BASE EXCESS)	TIME	GLUC	PCV/Hgb	K

OUTPUT

TIME	GASTRIC	URINE	OTHER
TOTALS			

PROGRESS NOTES

TIME	PROGRESS NOTES	INITIALS
1915	pt [illegible] head [illegible] at side rails pt repeatedly [illegible] "please please my head hurts" [illegible] refuses to [illegible] state eyes closed [illegible] [illegible] Dr [illegible] called [illegible] c Dr Fox	
1930	no obvious signs of [illegible] moved to [illegible] pt states he feels "like I'm going to throw up" Dr Fox aware	
1931	[illegible]	
1940	[illegible]	
1948	[illegible]	

TIME	PROGRESS NOTES	INITIALS
	no obvious signs of [illegible]	
1950	Dr Fox [illegible] at this time [illegible] lungs = [illegible]	
2008	Dr K. [illegible] to see pt [illegible] 4-29-05.	
2015	[illegible] Dr Fox [illegible]	

NAME	INITIALS
[illegible]	

W = WITH W/P = WITHOUT CSM = CIRCULATION, SENSORY, MOTOR LAC = LACERATION NA = NOT APPLICABLE

WHITE - CHART YELLOW - EMERGENCY ROOM PINK - PHYSICIAN

PREHOSPITAL CARE REPORT

CA - Santa Clara

Case #: 04038161 **Pt #** 1 **of** 1 **Unit ID:** 412 **Date:** 2/7/2004

DISPATCH INFORMATION

Received:	17:24	**Transferred:**	17:35	**Available:**	**Incident Location:**	**MCI Dec.:**	
On Scene:	17:34	**Transport:**	17:45	**Cancel:**	3009 Middlefield, E. Palo Alto, CA	**Response Code:**	Code 3
At Pt. Side:	17:35	**Arrive:**	18:07			**Change Code:**	

Responding With: Fire Department

Nature of Call:

PATIENT DEMOGRAPHICS

Name:	Falk, Steven		☐ Age Estimated		
Address:	2059 Camden ave, 166	**D.O.B.:**	**Age:** 30 years	**Months:**	**Days:**
City, State, Zip:	San Jose, CA 95124	**Ethnicity:**	**Sex:** Male	**Weight:**	
Phone :	(408) 904-5819	**Physician:**	**Triage Tag :**		
SSN:		**Employer:**			
		Responsible Party:	Falk, Steven	**Phone:**	(408) 904-5819

HISTORY OF PRESENT ILLNESS

Chief Complaint:

HPI: Pt states that ...

Mechanism of Injury:

Safety Equipment:

Contributing Factors:

Environmental Factors:

Factors Affecting Delivery Of Care:

PAST MEDICAL HISTORY

History: Unknown.

Allergies: Unknown.

Medications: Unknown.

CLINICAL IMPRESSION

Working Diagnosis: Seizure - active/status epilepticus

Secondary Diagnosis(es):

FALK STEVEN
828049 M 48
LEE,JANE MD
F0403800216 02/07/04

PATIENT FINDINGS

☑ **PTA** **Time:** 17:34 **By:** pafd

Pt. Position: Sitting	**Pulse**	**Skin**	**Cardiac Rhythm**
Blood Pressure: 160 / 70	**Rate:** 100	**Color:** Pink	**Rate:** N/A
	Regularity: Regular	**Temp:** Warm	**ECG:** N/A
	Strength: Strong	**Moisture:** Diaphoretic	**Ectopy:** N/A
Body Temp: F	**Location:** Radial	**Cap Refill:** N/A	**12Lead Interpretation:**
Body Temp Locat			N/A

GCS	**Level of Consciousness**	**Respiratory**	**ETCO2**
Eyes: 3	Conscious	**Rate:** N/A	**CO2 Value:** N/A
Verbal: 4	**RespondTo:** N/A	**Effort:** N/A	**CO2 Color:** N/A
Motor: 5		**Depth:** N/A	**Lung Sounds**
Total: 12	Not Orientated		**Right:** N/A
	Pupils: N/A	**SAO2:** N/A	**Left:** N/A

Acuity: N/A **Comments:**

PHYSICAL FINDINGS

Skin	Within Normal Limits	
Head	Within Normal Limits	
Face	Within Normal Limits	Nose blood from left nostril
Neck	Within Normal Limits	
Chest	Within Normal Limits	
Back	Within Normal Limits	
Abdomen	Within Normal Limits	
Pelvis	Incontintent of urine	
Arm (s)	Within Normal Limits	
Leg (s)	Within Normal Limits	

NARRATIVE

☐ **Special Study**

Pt states that ...

Per bystanders Pt was coaching tennis when he collapsed to turf and had full body seizure lasting unknown time. Bystanders moved pt to van and called 911. On 412 arrival FD is in middle of extricating pt from van In c-spine. Pt placed on gurney strapped to board. Pt opens eyes on command, has blood from left nostril, takes NPA w/o difficulty, FD suctions pt mouth- pt has gurgling at back of throat (clear fluid from mouth). Pt had tonic-clonic seizure lasting approx two minuets on scene. En-route pt resp tracked using BVM and 15l O2. Pt Remained post-ictal for >10 minuets, then began opening eyes on command and answering age. Pt then became extremely combative and ripped head out of c-spine. Ambulance pulled over and partner assisted placing pt in soft restraints. Pt remained combative until hospital arrival. Pt w/o ost other than blood from nose and minor head abrasion.

30 year old Male

PMH: Unknown.

ALLERGIES: Unknown.

MEDICATIONS: Unknown.

PRIMARY ASSESSMENT: Seizure - active/status epilepticus.

TREATMENT AND RESPONSE

PTA	Time	Medic	Procedure
☑	1733	PAFD	Manual C-spine
☑	1733	PAFD	Oxygen - Non-rebreather Mask at 15 lpm.
☐	1735	Jones, Kristie,AMR	Spinal Immobilisation performed withShort Collar, Long Spine Board, Head Immobilizer Device, Tape, Straps (9'), Head in Neutral position
☐	1739	PAFD	BLS Airway Management -NPA, (note size in comments)
☐	1741	PAFD	BLS Airway Management -Oral suctioning
☐	1745	Jones, Kristie,AMR	Oxygen - Bag-Valve Device at 15 lpm.
☐	1746	Jones, Kristie,AMR	Vascular Access - 18 gauge Peripheral IV TKO at Left AC with 1000cc bag. Successful in 1 attempts. Solution: Normal Saline.
☐	1748	Jones, Kristie,AMR	Blood Glucose - 111 mg/dL.
☐	1749	Jones, Kristie,AMR	Vital Sign/ECG - Patient Supine. BP: 130 / 70 , Pulse at Radial 128 Regular Strong . Respirations: 20 Non-labored Normal . Pulse Oximetry: 99 % on O2 . Cardiac Rhythm: Sinus Tachycardia at 130 . Ectopy: None. Temperature: F .
☐	1750	Jones, Kristie,AMR	Pupils - PERL. 7mm, slow to respond.
☐	1750	Jones, Kristie,AMR	NeuroExam - Left Arm: No deficits, Right Arm: No deficits.
☐	1752	Jones, Kristie,AMR	Other, see narrative Pt placed in soft wrist restraints because combative.
☐	1803	Jones, Kristie,AMR	Vital Sign/ECG - Patient Supine. BP: 160 / 70 , Pulse at Radial 112 Regular Strong . Respirations: 20 Non-labored Normal . Pulse Oximetry: 99 % on Room . Cardiac Rhythm: Sinus Rhythm at 112 . Ectopy: None. Temperature: F .
☐	1809	Jones, Kristie,AMR	Transfer of care at destination Report given to team at ECH.

TRAUMA TRIAGE

Physiological Criteria:
Anatomic Criteria :
Mechanism :

Paramedic Judgment: N/A

PATIENT DISPOSITION

Dispostion:	Transport	**Receiving Hospital:**	ECH	**MD Consult:**	☐
Est Time Death:		**Other Hospital:**		**Base Physcian:**	
Mode of Transport:		**Rendezvous Point:**		**Transport Priority:**	Code 2
Air Request By:		**First Respond Assist:**	☐	**Change In Priority:**	
Reason For Air:		**Base Hospital:**		**MileageScene:**	0
Destination Decis:	Closest Appropriate	**Base Hosp Contact:**	☐	**Mileage Hospital:**	6.3
Hosp Divert From:		**Base Contact Time:**		**Total Mileage:**	**6.30**

Physician Order:

1st Attendant: Jones, Kristie,AMR **2nd Attendant:** Sushereba, Tabata,AMR **3rd Attendant:** **Hospital Signature:**

Number: P19100 **Number:** E15980

EL CAMINO HOSPITAL
MOUNTAIN VIEW, CALIFORNIA
JANE I. LEE, M.D.

Falk, Steven
MR#: 828049
DOB: 04/29/1955
HISTORY & PHYSICAL

cc: JANE I. LEE, M.D.

DATE OF ADMISSION: 02/07/2004

ADMITTING DIAGNOSES:
1. Epidural hematoma.
2. Seizure disorder.

HISTORY OF PRESENT ILLNESS: A 38-year-old tennis instructor with a history of seizure disorder and OxyContin prescription addiction had a grand mal seizure, subsequent fall and developed an epidural hematoma. Patient is unable to give detailed history. Most of the information was provided by his father, Robert Falk, and domestic partner, Brian.

PAST MEDICAL HISTORY:
1. Seizure disorder, first episode April 2002.
2. Motor vehicle accident with chronic low back pain (seen a neurosurgeon in the past but no surgery has been recommended).
3. OxyContin prescription addiction.
4. Alcoholism.
5. Depression (used to be on Prozac).

PAST SURGICAL HISTORY: Hemorrhoid surgery.

MEDICATIONS: Neurontin and Carbatrol (apparently he has been tapering Carbatrol for unknown reasons).

ALLERGY HISTORY: No known history of allergies.

SOCIAL HISTORY: He is a tennis instructor. He has a domestic partner. Denies tobacco use but history of alcoholism and admitted recent relapse in January. Detailed amount of alcohol use not clear even to his close family members. Patient has been in a drug rehab program in March of 2003 and he is well known to Mission Oaks Hospital, specifically by Dr. Colloway.

FAMILY HISTORY: Alcoholism on father's side.

REVIEW OF SYSTEMS: Patient has been reported to behave like on drugs.

PHYSICAL EXAMINATION:

GENERAL: Patient is sedated but arousable with 1 word questions.
VITAL SIGNS: Blood pressure 160/90, pulse 90 to 100.
HEENT: Patient has a skull fracture with dressing on it.
CHEST: Clear to auscultation.
HEART: Tachycardia, regular rhythm.
ABDOMEN: Soft and nontender.
EXTREMITIES: No edema.
NEUROLOGIC: Moving all extremities. Arousable but lethargic. No focal neurological deficit.

LABORATORY INFORMATION: CPK total is 342, MB fraction is 5.5. Troponin within normal limits. Blood drug screen: Alcohol less than 5. Electrolytes: Sodium 144, potassium 3.6, chloride 94, bicarb 11, blood sugar 145, BUN 18, creatinine 1.5. Liver functions within normal limits. White count is 15.6 with 39% neutrophils, 2% bands. Hematocrit is 46.3. CT scan final report reported to be a left occipital epidural hematoma.

ASSESSMENT AND PLAN: A 38-year-old man with seizure activity resulting in a fall and subsequent epidural hematoma. Patient has a complicated prescription drug abuse history and alcoholism. The seizure disorder etiology is not a simple one. Patient will be observed closely. A CT scan of the head will be repeated in the morning and urine drug screen is pending at the present time. Patient has been resumed on Neurontin and Carbatrol and benzodiazepine as needed for recurrent seizure activities as needed.

JANE I. LEE, M.D.

JL:hs383967/32707/
D000383967 C406094
D: 02/07/2004 10:17 P
T: 02/07/2004 10:24 P

EL CAMINO HOSPITAL
MOUNTAIN VIEW, CALIFORNIA
DAN FOX, M.D.

Falk, Steven CCH
FIN#: F0403800216 MR# 828049
DOB: 04/29/1955
EMERGENCY VISIT HISTORY

cc:

DATE: 02/07/2004

SUBJECTIVE INFORMATION: This is an approximately 35-year-old male who is a tennis coach and was in the middle of a tennis lesson when he suddenly lost consciousness, had a tonic-clonic seizure, fell posteriorly striking the back of his head. He woke up after approximately 1 minute after a 1-minute long seizure, was confused, was helped to the back of a car and had another tonic-clonic seizure at that time. Paramedics were summoned and he was transported by ambulance code 3 to the emergency department at El Camino Hospital. Shortly after arrival of the ambulance and paramedics, he had another tonic-clonic seizure. He had an IV started, was placed on oxygen and transported code 3 to the emergency department. A blood sugar was found to be 112 mg%. He arrived in that status. It is uncertain, at least initially, if he has ever had any seizures before. Although ultimately we discussed with his father that he had had seizures in the past, probably secondary to drug withdrawal approximately a year ago. He is in the drug detox center. He is supposed to be taking Tegretol and Neurontin for his anti-seizure medications. He states that he has had no other health problems. He has not had any other new medications that anyone is aware of. There is no one with him at this time and father states that he has not talked to him in 6 months. The remainder of the history is unobtainable due to the patient's condition.

SOCIAL HISTORY: The patient evidently lives independently. It is uncertain if he drinks or smokes cigarettes.

FAMILY HISTORY: No seizure activities per father.

PAST MEDICAL HISTORY: Hospitalization secondary to previous surgeries, but not here.

REVIEW OF SYSTEMS: GENERAL: No high blood pressure or cholesterol problems. ENT: No ear, nose, or throat disease. EYES: No glaucoma or visual symptoms. PULMONARY: No emphysema or asthma. CARDIAC: No congestive heart failure or acute myocardial infarctions. GI: No ulcers or GI bleeds. GU: No urinary problems or carcinomas. MUSCULOSKELETAL: No intrinsic muscle or joint diseases. SKIN: No intrinsic skin diseases or ulcers. NEURO: Negative with exception of those problems noted above. PSYCH: No psychiatric hospitalization or medications. ENDOCRINE: No diabetes or thyroid problems. ALLERGIES: No known allergies.

OBJECTIVE INFORMATION:
GENERAL: This is a comatose male when he arrived in no acute distress.

VITAL SIGNS: Stable and normal as noted on the chart with the exception of a tachycardia approximately 120.
HEENT: He is normocephalic with a macerated contused area of his occipital skull in full C-spine precaution. Pupils are conjugate gaze with roving. Nose, mouth, lips, teeth and tongue are normal. He is breathing normally. Tympanic membranes are clear bilaterally.
NECK: No apparent posterior neck deformity or tenderness.
CHEST: No signs of trauma to the chest. No tenderness to palpation over the clavicles. Chest is clear bilaterally.
HEART: Regular rhythm at 120 without murmur.
ABDOMEN: Soft without hepatosplenomegaly or masses. No tenderness, guarding, rebound or peritoneal signs.
EXTREMITIES: Moving all four extremities. No abrasions noted.
SKIN: No rashes.
MENTATION: The patient is obviously comatose.

EMERGENCY DEPARTMENT COURSE: During his emergency department course of approximately 2 hours he had a cross-table C-spine to clear his spine, which appeared to be well-maintained vertebral bodies. No soft tissue swelling. He had an IV of normal saline, which was continued at the keep open rate. Shortly after arrival in the emergency department, he had a seizure which began in his right hand and tonic-clonic in nature, progressed up his arm after approximately 30 minutes and then became generalized for a total of approximately 60 seconds. He was given 5 mg of Valium, which seemed to terminate that seizure and had no further seizures since that time. He had a noncontrast CT of his head, per the radiologist, which showed a 1.3 cm x 6 cm epidural hematoma with associated skull fracture, which did not appear to be significantly depressed. There does not appear to be any mass effect. No other signs of injury or trauma. He was placed on 5 liters of nasal oxygen. His white blood count was elevated at 15,600, slight shift to the left. Hemoglobin normal at 15.0 grams. Chem 13 was essentially normal. He had blood tox screen which was negative for all tests. He had a urine tox screen that is still pending. Cardiac enzymes consisting of CK MB, CPK and troponin I were all negative for cardiac injury status. The patient continued to be intermittently agitated requiring sedation with Valium. Discussed with Dr. Jane Lee. Will admit the patient and neurosurgeon, Dr. Ronald Greenwald, will evaluate the patient for possible surgical intervention, which is unlikely at this time. Total critical care time on this patient was 1 hour.

Computer Code Signature
DAN FOX, M.D. 02/09/2004 01:46
DAN FOX, M.D.

DF:hs384201/32888/
D000384201 C406095
D: 02/07/2004 11:22 P
T: 02/08/2004 5:52 A

EL CAMINO HOSPITAL
MOUNTAIN VIEW, CALIFORNIA
RONALD GREENWALD, M.D.

Falk, Steven
MR#: 828049
DOB: 04/29/1955
CONSULTATION REPORT

cc: DAN FOX, M.D.
RONALD GREENWALD, M.D.
JANE I. LEE, M.D.

DATE OF CONSULTATION: 02/07/2004

REFERRING DOCTOR:

CHIEF COMPLAINT:
1. Craniocerebral trauma, secondary to number two.
2. Seizure.
3. History of seizure disorder.
4. History of drug abuse.

HISTORY OF PRESENT ILLNESS: This 30-year-old, right-handed white male was giving a tennis lesson at _____ Park tonight. He has a history of seizure disorder. Apparently he had a seizure and struck the back of his head. He was postictal and brought to the emergency room and has slowly woken-up. He is complaining of headache. He had vertigo and had some nausea and vomiting. No diplopia. He has a long history of seizure disorder. Takes Tegretol and Neurontin but the dose is not available.

His CT scan done on an emergency basis revealed:

1. Left occipital skull fracture and probably diastasis of the lambdoid suture.
2. A small left occipital epidural hematoma without significant mass effect.
3. The remainder of the intracranial contents appear within normal limits.

PAST MEDICAL HISTORY: Is significant for a seizure disorder. Other history is not obtainable.

PHYSICAL EXAMINATION:
GENERAL: He is lethargic, but arousable. Follows commands. He is postictal, complaining of a headache. He is otherwise a well-developed, well-nourished, 30-year-old, right-handed white male.
HEENT: Reveals a contusion to the back of his skull. He has, otherwise, no focal deficit appreciated.

DIAGNOSTIC IMPRESSION: Craniocerebral trauma, secondary to seizure in a patient with a known seizure disorder with a small, left occipital epidural hematoma.

PLAN: Admit to ICU for observation and repeat CT scan in the a.m. The patient will definitely need Tegretol and Neurontin.

RONALD GREENWALD, M.D.

RG:hs 383640/35635/29358
D000383640 C406077
D: 02/07/2004 8:39 P
T: 02/07/2004 10:01 P

EL CAMINO HOSPITAL
MOUNTAIN VIEW, CALIFORNIA
JIAYI LI, MD

Falk, Steven CC 11
MR#: 828049
DOB: 04/29/1965
CONSULTATION REPORT

cc: JIAYI LI, MD

DATE OF CONSULTATION: 02/16/2004

REFERRING DOCTOR: Scott Wachhorst, MD

REASON FOR CONSULTATION: I was asked to see Mr. Falk at the request of Dr. Wachhorst for abnormal liver enzymes.

HISTORY OF PRESENT ILLNESS: The patient was hospitalized on February 7, 2004, due to sudden loss of consciousness due to seizure. Subsequently, the patient was found to have cranial cerebral trauma which caused a left occipital epidural hematoma. Subsequently, the patient had craniotomy for evacuation of epidural hematoma on February 8, 2004.

The patient has remained stable. He denies any abdominal pain. No nausea or vomiting. His appetite is normal. No trouble with diarrhea or constipation. He denies any jaundice. He had normal liver enzymes upon this admission on February 7, 2004, but blood work came back today that revealed SGOT 61, SGPT 213, alkaline phosphatase 152, albumin 3.0, total bilirubin 0.6. Therefore, I called to evaluate the abnormal liver enzymes.

The patient has a history of alcohol abuse. He stopped alcohol about 1 year ago. However, a couple of weeks ago, the patient had relapsed into alcohol abuse. He said he had a 6-pack of beer per day for a few days. In addition, the patient has a seizure disorder. He has been taking Neurontin, Carbatrol for the past couple of years. About several days prior to this admission, the patient was using Ultram about 800 mg per day. The patient is also using Advil for headache. He has been taking that frequently for many years. He denies any Tylenol use. The patient denies any intravenous drug use. No blood transfusions in the past. He is gay, but he had a negative HIV test a year ago. I am not quite sure if he had hepatitis C checked in the past.

PAST MEDICAL HISTORY: Significant for seizure disorder. In addition, the patient has a history of alcohol abuse, chronic low back pain, migraine headache.

ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS AT HOME: The patient was taking Neurontin, Carbatrol, Ultram, Advil. On this admission, the patient has been taking Tylenol p.r.n. medication, hydralazine, gabapentin, ceftriaxone, lansoprazole, labetalol.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS: The patient denies any fever, chills. No nausea or vomiting. No weight loss. No recent change. Denies chest pain, shortness of breath, or cough. No trouble with urination. No neurological, psychological complaints.

PHYSICAL EXAMINATION: The patient is alert, oriented.
VITAL SIGNS: He is afebrile.
SKIN: No spider angioma or palmar erythema.
LYMPHATICS: Lymph nodes were not enlarged.
HEENT: Unremarkable.
NECK: Supple.
LUNGS: Clear to auscultation.
HEART: Regular rhythm without murmur.
ABDOMEN: Flat and soft without any tenderness. Liver and spleen were not palpable.
RECTAL EXAMINATION: Was not performed.
NEUROLOGICAL EXAMINATION: No focal deficit.

LABORATORY DATA: In addition, the patient had blood work performed today. It does reveal the normal chemistry. WBC 12,000, hematocrit 40.1, platelets 400,000, bands 8%, monocytes 14%, eosinophils 7%.

DIAGNOSTIC IMPRESSION: A 38-year-old male hospitalized for epidural hematoma. The patient had normal liver enzymes on admission, but the liver enzymes were found to be abnormal about 10 days into the hospitalization. The potential cause is very likely due to drug-induced liver toxicity. The patient has been taking multiple medications, which can cause toxicity to the liver, such as ceftriaxone, Neurontin, Carbatrol, gabapentin, and Tylenol. Certainly, the patient was taking a lot of Ultram before the admission. Ultram can also cause liver toxicity. Which one is the primary culprit is at this moment difficult to identify.

Although the patient has a history of _____drug toxicity, his liver parameter of abnormal enzymes do not support alcoholic hepatitis. I cannot exclude that as a cause.

The third one either could be from viral hepatitis. Due to his sexual orientation, he is at high risk for hepatitis-B, and hepatitis-C.

I doubt the cause of abnormal liver enzymes due to gallstones, especially since patient is asymptomatic.

In addition, the patient fell which could cause abnormal transaminases due to different sources such as muscle injury, which can cause a rhabdomyolysis.

RECOMMENDATION:
1. Since we do not know the trend of abnormal liver enzymes, we will monitor liver enzymes every day for 3 days.

2. We will check a viral hepatitis panel including hepatitis-A, B, C. It would be of benefit to check an HIV test as well.
3. We will check an antinuclear antibody and mitochondrial antibody, anti-smooth muscle antibody, _____,amylase, lipase, prothrombin time, and a PTT.
4. Will check an abdominal ultrasound.
5. If the liver enzymes are getting worse, may consider stopping Tylenol. If the liver enzymes are continually getting worse despite stopping Tylenol, may consider discontinuing ceftriaxone and gabapentin. We will follow the patient during the hospital course.
6. I also explained the potential causes of elevated liver enzymes to the patient and his parents.

JIAYI LI, MD

JL:hs 561884/34598/
D000561884 C408333
D: 02/16/2004 7:45 P
T: 02/16/2004 10:02 P

EL CAMINO HOSPITAL

AUTHORIZATION AND CONSENT TO SURGERY, ANESTHESIA, DIAGNOSTIC OR THERAPEUTIC PROCEDURES

LABEL-0420-05 - EL CAMINO H
FALK STEVEN M 48
828049
1 LEE, JANE MD CCU
F0403800216

YOUR DOCTOR IS Ronald Greenwald.

THE OPERATION(S) PROCEDURE(S) TO BE PERFORMED IS /ARE:

Craniotomy for Evacuation of Epidural Hemorrhage
(MEDICAL TERMINOLOGY)

(LAY TERMINOLOGY)

1. The hospital maintains personnel and facilities to assist your doctor in his/her performance of various surgical operations and other special diagnostic and therapeutic procedures. These operations and procedures may all involve risks of unsuccessful results, complications, injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure. You have the right to be informed of such risks as well as the nature and purpose of the operation(s) or procedure(s) and the available alternative methods of treatment and this form is not a substitute for such explanation which are provided by the above named physician. Except in cases of emergency, the operation(s) or procedure(s) is/are not performed until the patient has had the opportunity to receive such explanations. You may refuse any proposed operation or procedure anytime prior to it's performance.

2. Your doctor has recommended the operation(s) or procedure(s) set forth above. Upon your authorization and Consent, such operation(s) or procedure(s), together with any different or further procedure(s) which in the opinion of your doctor may be indicated due to any emergency, will be performed on you. The operation(s) or procedure(s) will be performed by the doctor named above together with associates and assistants, including anesthesiologist and radiologist from the medical staff of El Camino Hospital. Your attending physician, surgeon, assistant surgeon, anesthesiologist , and other physicians are not agents, servants or employees of the hospital or your doctor but are independent contractors, and therefore your agents

3. Your signature below authorizes the hospital pathologist to use his or her discretion in disposition of any member, organ or other tissue removed from your person during the above named procedure(s).

34. Your signature below constitutes your acknowledgement **(1)** that you have read and agree to the foregoing;**(2)** that the operation(s) or procedure(s) set forth above has/have been adequately explained to you by your doctor and that you have received all of the information you desire concerning such operation(s) or procedure(s) ; **(3)** that you authorize and consent to the performance of concerning such operation(s) ; and **(4)** that you acknowledge receipt of a copy of this authorization.

SIGNATURE: Robert H Falk
PATIENT / PARENT / LEGAL GUARDIAN

2-8-4 11 20/2
DATE AND TIME

FATHER
RELATIONSHIP

I Swenson RN
WITNESS (NOT PARENT'S DOCTOR)

semi comatose
REASON PATIENT UNABLE TO SIGN

Form 225 (08/03)
AMS Doc.

WHITE - patient chart

CANARY - patient

EL CAMINO HOSPITAL ANESTHESIA RECORD

HT | WT | AGE 35 | ASA STATUS (1) 2 3 4 5 (E) | OR #10 | DATE 1/8/04

FALK STEVEN
828049
1 LEE, JANE MD
F0403800216
M 48
CCU

PRE OP DIAGNOSIS: ↓ LOC

POST OP DIAGNOSIS:

TIME	START	END
ANES	1130 M	1520 M
SURG	1155 M	1510 M

PREMEDICATION S U

PRE OPERATIVE REMARKS

☒ PATIENT HAS BEEN RE-EVALUATED PRIOR TO INDUCTION OF ANESTHESIA AND REMAINS A SATISFACTORY CANDIDATE FOR ANESTHESIA AS PLANNED.

TOTAL

Agent	Dose
PENT/PROP	200
O_2	2 → 6
N_2O	2 → 0
H/E/I	1.0
SUCC	
DTC/PAN	
ATRA/VEC/ROC	60
FENT/SFENT	
DOLAS/ONDS	
MID/DIAZ	
MgSO4	5
N/R	

IV PLACEMENT

☐ RIGHT ARM ☐ LEFT ARM
☐ ARTERIAL LINE ☐ CVP LINE

MONITORS

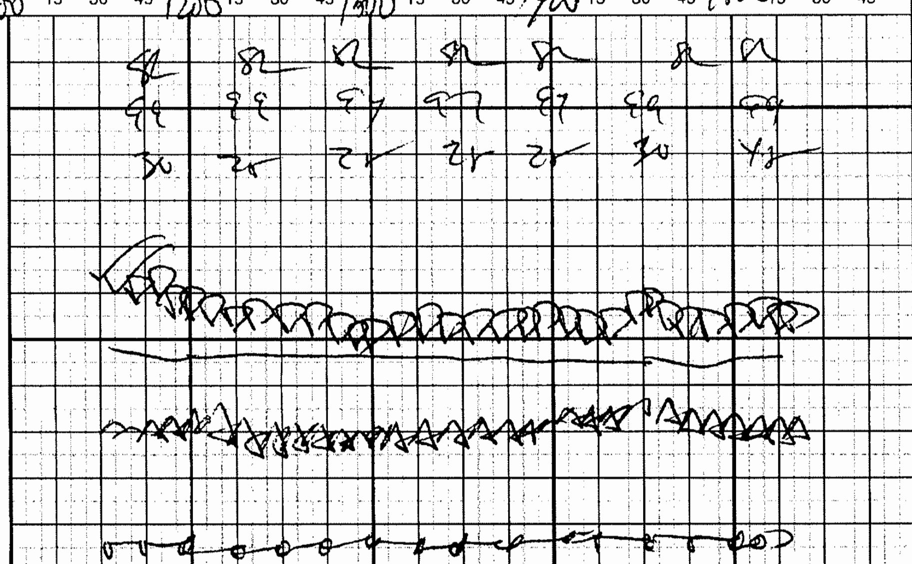
TEMP DOPPLER
(ECG) (AUTO BP) (NMB)
(OXIMETER) (CAP/AGT) (F_IO_2)

IV FLUID

LR ____ 800
BLOOD ____

EBL TOTAL ____
NG TUBE
URINE OUTPUT ____

1100 15 30 45 1200 15 30 45 1300 15 30 45 1400 15 30 45 1500 15 30 45



REMARKS CODE ①

REMARKS

☐ SAFETY CHECKS COMPLETED
☐ MONITORS APPLIED
☐ VITAL SIGNS CHECKED PRIOR TO INDUCTION

AIRWAY: ORAL (NASAL) ENDO TR. TUBE: ORAL NASAL CUFF

ANESTHETIC METHODS: ☐ GENERAL ☐ SPINAL ☐ EPIDURAL

POSITION: (SUPINE) PRONE SITTING LITHOTOMY LATERAL R L

BRACHIAL BLOCK ☐ R ☐ L BIER BLOCK ☐ R ☐ L

☐ IV SEDATION ☐ LOCAL

TOURNIQUET ________ mm/Hg ON ___:___ M OFF ___:___ M

OPERATION: crani for bleed

PAIN MANAGEMENT CATHETER INSERTED BY: ____________
SIGNATURE

ABBREVIATION KEY ON REVERSE

SURGEONS: Greenwald

ANESTHESIOLOGIST'S SIGNATURE

POST OP TO: PACU CCU ROOM

CONDITION: GOOD FAIR POOR

207 (2/02)

WHITE - Patient's Chart CANARY - OR Business Office PINK - Anesthesiologist

EL CAMINO HOSPITAL
2500 GRANT ROAD, P.O. BOX 7025
MOUNTAIN VIEW, CA 94039-7025

FALK STEVEN
828049 M 48
FOX, DAN E MD
F0403800216 02/07/04

ANESTHESIA NOTES

PRE-ANESTHESIA EVALUATION

Date: 2/8/04 Time: 11:30

Planned Procedure: crown

Past Medical History: St.

Medications: [illegible]

Allergies: a

Previous Anesthetic History: ?

Remarks: [illegible]

Physical Exam:
- Airway: ☐ Normal ☐ Abnormal:
- Cardiac: ☐ Normal ☐ Abnormal:
- Chest: ☐ Normal ☐ Abnormal:
- ☐ NPO Status Checked
- ☐ Lab results and other pertinent studies reviewed

Assessment: ASA: (I) II III IV V E

Plan: (General), Regional, MAC, Other:

☐ Procedure, alternative options, risks and benefits of anesthesia discussed with patient and family, who wish to proceed with the anesthesia plan.

SIGNATURE: MD

POST-ANESTHESIA CARE UNIT ADMISSION NOTE

Date: 2/8/04 Time: 1230

☐ See Anesthesia Record.

Condition on Arrival: ☑ Stable ☐ Other

Vital Signs on Arrival: stable

Remarks:

SIGNATURE: MD

POST-ANESTHESIA CARE UNIT DISCHARGE NOTE

Date: 2/8/04 Time: 1330

Post-operative course: ☒ No Problems ☐ Other:

Anesthetic Complications: ☒ None ☐ Other:

Condition at Discharge: ☒ Stable ☐ Other:

Remarks: D/C to PACU with pain under control

SIGNATURE: MD

3118 (10/01)

EL CAMINO HOSPITAL

PERIOPERATIVE NURSING RECORD

PATI FALK STEVEN
PATI 828049 M 48
1 LEE, JANE MD
PHY F0403800216 CCU

PREOPERATIVE ASSESSMENT

DATE 2/8/04 TIME 1130

ASSESSMENT DONE BY (SIGNATURE) M. Goodnight RN

PREFERS TO BE CALLED ______ LANGUAGE IF NOT ENGLISH ______

CONCERNED OTHERS: RELATIONSHIP: ______ LOCATION: ☐ WAITING ROOM OTHER ______

PATIENT ID
- ☐ VERBAL
- ☒ CHART
- ☒ ID BAND

NPO SINCE 2400

CHART REVIEWS
- ☒ H&P
- ☒ INTERIM SUMMARY
- ☒ LAB
- ☒ LABELS
- ☒ ADMIT SHEET
- ☒ EKG
- ☐ ADVANCED DIRECTIVES

PROCEDURE SITE VERIFICATION
- ☐ VERBAL
- ☒ CONSENT FORM
- ☐ SPECIAL RELEASE/PERMITS
- ☒ X-RAYS
- ☐ OPERATIVE SITE MARKED

PERSONAL ITEMS TO OR
- ☐ DENTURES/BRIDGES
- ☐ GLASSES/CONTACTS
- ☐ JEWELRY TAPED
- ☐ HEARING AID
- ☐ LOOSE TEETH/CAPS
- ☐ ______

PRESENT
- ☐ O2
- ☒ IV
- ☐ ART LINE
- ☐ CVP
- ☐ PICC
- ☒ FOLEY
- ☐ NG
- ☐ TRACH
- ☐ CHEST TUBE
- ☐ ET TUBE
- ☐ DIALYSIS ACCESS

LOCATION: ______

MENTAL/EMOTIONAL STATUS
- ☐ CALM
- ☒ ALERT
- ☐ ORIENTED
- ☐ UNRESPONSIVE
- ☐ COMFORTABLE
- ☐ UNCOMFORTABLE
- ☐ ANXIOUS
- ☒ SEDATED
- ☒ DISORIENTED

SKIN ASSESSMENT
- ☐ MOTTLED
- ☐ BRUISED
- ☐ ABRADED
- ☐ CLAMMY
- ☐ RASH
- ☐ DRY
- ☐ ______

PRECAUTIONS
- ☐ PROSTHESIS ______
- ☐ AUDITORY ______
- ☐ VISUAL ______
- ☐ MOBILITY ______
- ☐ DIABETIC ______
- ☐ INFECTIOUS ______

PRE-OP MEDS

BLOOD AVAILABILITY AMT:
- ☐ TYPE/SCREEN ONLY
- ☐ ROUTINE
- ☐ AUTOLOGOUS
- ☐ DIRECTED DONOR

PLACE ID STICKER HERE

ALLERGIES ☒ NONE ☐ BANDED ______

COMMENTS: ______

INTRAOPERATIVE RECORD

OR ROOM # 10

ANESTHESIOLOGIST: A. Spears

ANESTHETIC TYPE: ☒ GENERAL ☐ CAUDAL ☐ SPINAL ☐ EPIDURAL ☐ BLOCK ☐ MAC ☐ LOCAL

☐ INTRA OP X-RAY ☐ C-ARM

WOUND CLASS

TIME — IN OR: 1154 OUT OR: 1512

PROCEDURES

#	Procedure		IN	OUT	Wound class	Time
1.	Ventriculostomy, placement of drain/monitor	SURGEON: R. Greenwald MD ASST: ASST:			(I) II III IV	START: 1210p STOP: 1225p
2.	Craniotomy	SURGEON: R Greenwald MD ASST: ASST:			(I) II III IV	START: 115p STOP: 150[illegible]

PRE OP DIAGNOSIS: Epidural Bleed

POST OP DIAGNOSIS: Same

IMPLANTS/GRAFTS ☒ IMPLANT ☐ EXPLANT ☐ SEE BACK OF FORM

Ventricular Catheter Lot # A27889

SPECIMENS

PATHOLOGY / CYTOLOGY TOTAL: ______
- ___ ROUTINE
- ___ FS
- ___ FRESH
- ___ SENT TO X-RAY
- ___ SENT WITH SURGEON
- ___ SENT WITH PATHOLOGIST
- ___ SENT WITH PATIENT
- ___ DISCARDED
- ___ SENT TO MORGUE

CULTURES SOURCE: **TOTAL:**

		IN	OUT	INITIALS
CIRCULATOR:	M. Goodnight RN		302p	[illegible]
CIRCULATOR:	J. Hugo RN CNOR	315		[illegible]
CIRCULATOR:				
CIRCULATOR:				
CIRCULATOR:				

		IN	OUT
SCRUB:	M. Tan ST		
SCRUB:	E. McMullin ST	1200	1?0p
SCRUB:			
SCRUB:			
SCRUB:			

PERFUSIONIST/CELL SAVER: ______ LASER OPERATOR: ______

OTHER: ______

EL CAMINO HOSPITAL

FALK STEVEN
828049 M 48
1 LEE, JANE MD
F0403800216 CCU

PERIOPERATIVE NURSING RECORD (continued)

POTENTIAL FOR ANXIETY

GOAL: PATIENT DEMONSTRATES ↓ ANXIETY
DATE 2/8/04
PLAN IMPLEMENTATION:
☒ GIVE CLEAR, CONCISE EXPLANATIONS
☒ COMMUNICATE PATIENT CONCERNS TO OTHER PROVIDERS, CONVEY CARE AND SUPPORT
☒ REMAIN WITH PATIENT DURING INDUCTION
COMMENTS: _____

POTENTIAL FOR INJURY

GOAL: PATIENT REMAINS FREE FROM INJURY
ASSESSMENT: RISK FOR LOSS OF SKIN INTEGRITY ☐ O.R. MORE THAN 2 HOURS ☐ CACHEXIA ☐ OBESITY ☐ EDEMA
PLAN AND IMPLEMENTATION: ☐ HISTORY OF PRESSURE SORES ☐ MEDS: (i.e. chemo, steroids)

POSITION:
☒ SUPINE #1 ☐ LATERAL
☒ PRONE #2 ☐ JACKNIFE
☐ SITTING ☐ LITHOTOMY
☐ KNEE CHEST
☐ _____
_____

BED:
☒ STANDARD
☐ CYSTO
☐ FX TABLE
☐ PACEMAKER
☐ _____
_____

CAUTERY GROUND PAD SITE:
ARM L R
THIGH L (R)
FLANK L R
BUTTOCK L R
ELECTROSURGICAL UNIT # 1
UNIT # _____
BIPOLAR # _____
☐ ABC
☐ _____
_____

LASER:
☐ KTP ☐ Nd: YAG ☐ DIODE
☐ PULSE DYE ☐ CO2
MICROMANIPULATOR ☐ CALIBRATED
☐ FIBER

POSITIONING AIDS/DEVICES

HEAD:
MAYFIELDS: #1 ☐ SHEA
☒ HORSESHOE ☐ GEL RING
☒ PIN #2 ☐ TOWELS
☐ SUCTION CUP ☐ BLANKET
☐ TRACTION ☐ PILLOW
☐ _____ ☐ FOAM

BODY:
☐ ANDREWS (2) ☐ VACPAC
☒ CHESTROLLS ☒ GEL PAD (1+2)
☐ FOAM PAD ☐ THYROID PILLOW
☐ SANDBAGS ☒ SAFETY STRAP
☐ AXILLARY ROLL
☐ _____ _____
☐ WILSON # _____

LEGS:
☐ ALLEN ☐ GYN
☐ LAPAROSCOPE ☐ CYSTO
☒ VENODYNE (1+2) ☐ AE HOSE
☒ PILLOWS (2) ☐ FOAM
☒ GEL PAD (2) ☒ SAFETY STRAP (1+2)
☐ TRACTION L R ☐ TAPED
☐ WELL LEG HOLDER L R ☐ _____

ARMS:
BOARD L R
TUCKED/SLEDS L R
HAND TABLE L R
AIRPLANE L R
ALLEN L R
☐ SHOULDER BRACES
☐ GEL PAD ☐ FOAM PAD

TOURNIQUET # _____ SITE _____ APPLIED BY _____ ☐ TESTED
THERMAL UNIT # _____ SITE _____ TEMPERATURE SET _____
BAIR HUGGER # _____ SITE _____ TEMPERATURE SET _____
COMMENTS: _____

POTENTIAL FOR INFECTION

GOAL: MINIMIZE RISK OF NOSOCOMIAL INFECTIONS
PLAN AND IMPLEMENTATION: **SHAVE IN OR BY:** R Oravenold

SKIN PREP:
☒ POVIDONE IODINE SCRUB/PAINT ☒ ALCOHOL
☐ POVIDONE PAINT ☐ CHLORHEXIDINE
☐ POVIDONE GEL ☐ _____

IRRIGATION:
☐ NORMAL SALINE _____
☒ PHYSIO _____
☐ WATER _____
☐ SORBITOL _____
☐ RINGERS _____

URINARY CATHETER:
☐ ROBINSON
☒ FOLEY 16 Fr (SIZE)
☐ SUPRAPUBIC _____
INSERTED BY: Provider
☐ DC ☒ NOT MEASURED
DISCARDED _____ CC
COMMENTS:

PACKING/DRAINS:
TYPE: _____
SIZE: _____
SITE: _____

DRESSINGS:
☒ SOFT DRESSINGS
☐ SPLINT/CAST

MEDICATIONS

MEDICATIONS: *OTHER THAN BY ANESTHESIA*

DRUG	DOSE	ROUTE	SITE	GIVEN BY
Bupivacaine 0.5% c epi 1:200,000	10 cc (10cc)	Local	Skull/Scalp	R Oravenold
Bacitracin Oint	Topical	for pins/dressing	Qs	

CORRECT COUNT

	PROCEDURE 1	FIRST			FINAL	☐ NOT INDICATED	PROCEDURE 2	FIRST			FINAL	☐ NOT INDICATED
SCRUB						☒		MD			MD	
CIRC						☐ UNRESOLVED	CIRC	MD			MD	☐ UNRESOLVED

NURSES NOTES

_____

OUTCOMES/TRANSFER

OUTCOMES:
☒ DEMONSTRATED ADAPTIVE COPING DURING INDUCTION ☒ PRE-OP SKIN CONDITION MAINTAINED
☐ NO INJURY OBSERVED ☒ INFECTION CONTROL MEASURES MAINTAINED
COMMENTS: _____

DISCHARGE TO: ☐ PACU ☒ CCU ☐ PT UNIT
VIA: ☐ GURNEY ☒ BED

_____ SIGNATURE Linda Hegg RNCNSA

EL CAMINO HOSPITAL

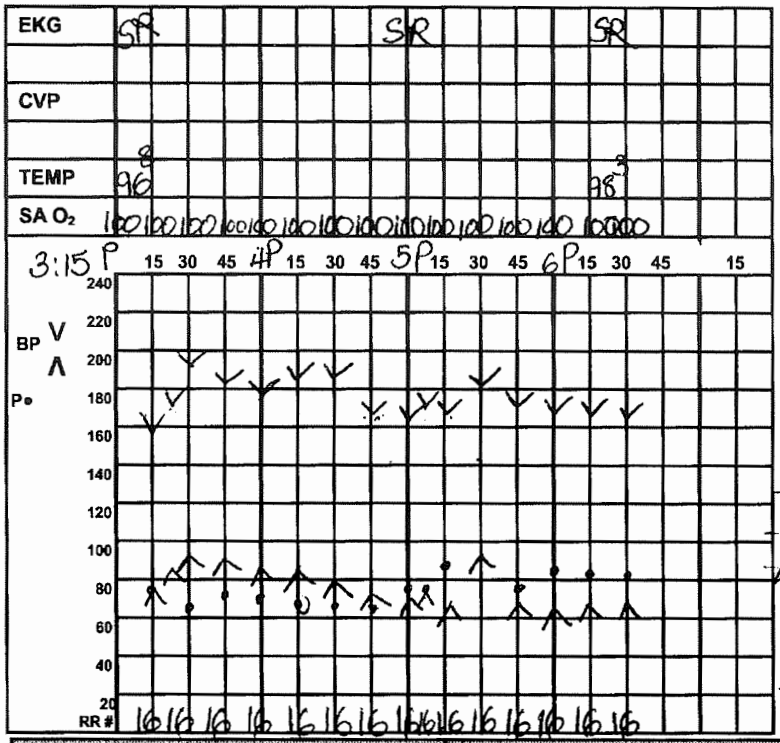
POST ANESTHESIA CARE UNIT NURSING RECORD

(Side 1 of 2)

FALK STEVEN
828049 M 48
FOX, DAN E MD
F0403800216 02/07/04

p 1 of 2

☑ARMBAND ALLERGIES: ☑NONE



DATE: 2/8/04 TIME IN: 3:15 AM PM

ANESTHESIA BY: Spears

☑ GENERAL ☐ EPIDURAL ☐ SPINAL ☐ IV BLOCK ☐ LOCAL

PROCEDURE Craniotomy, ventriculostomy placement of drain / Avomer

EBL ____ OR FLUID ____ OR BLOOD ____

COMMENTS AND PACU ORDER

☐ DEMEROL ____ ☐ DROPERIDOL ____
☐ MORPHINE ____ ☐ ____
☐ FENTANYL ____ ☐ ____

Foley: emptied in OR 1000cc U

TIME	IV FLUID	AMT	SITE	SITE CK	AMT REM	AMT INF
	#2 LR	150	RFA	✓	50	100
3:30 p	#3 LR	1000	"	✓	700	300
4:30 p	Nipride 50mg in 250cc D5W	250	"	✓		
	has NS lock in (L) AC.					

ADMISSION ASSESSMENT BY: K. Lyons

AIRWAY: ☐ NONE ☐ TRACH ☐ ENDOTRACHEAL ☑ NASAL 15 ☑ ORAL 15
TIME REMOVEED: ____ AM PM ____5 AM (PM) ____5 AM (PM)
☐ TEETH INTACT ☐ OTHER ____

OXYGEN: ☐ NONE ☐ TRACHEAL ☐ CATHETER ☑ MASK ☐ CANNULA 10 LMP TIME REMOVED: 5:30 AM (PM)
CONTINUED PER: ☑ CANNULA ☐ MASK 2 LMP TIME REMOVED: ____ AM PM
☐ N.A ☐ EDENTULOUS

SKIN: ☑ WARM ☑ DRY ☐ COOL ☐ MOIST ARTERIAL LINE: ☐ NONE ☑ RIGHT RADIAL ☐ LEFT RADIAL ☐ SITE CK

CATHETERS: ☐ NONE ☑ FOLEY ☐ SUPRAPUBIC ☐ URETERAL
EMPTIED: clr yel, 400cc

SUCTION: ☐ NONE ☐ HEMOVAC ☐ PLEUREVAC ☑ CONSTAVAC ☐ VACUTAINER ☐ JP ☐ OTHER ____ ☐NG ☐ CONSTANT ☐ INTERMITTENT
AMOUNT:

DRESSING & OBSERVATION: Ventriculostomy drain. (L) side of head: dsg behind ear D/I. 2x2 over bit. tiny holes above eyes laterally. compression boots bil.

RECOVERY		TIME	3:15 P	3:30 P	3:45 P	4P	4:15 P	4:30 P	4:45 P	5P	5:15 P	5:30 P	5:45 P	6P
SUSTAINS HEAD LIFT OR HAND GRIP	ACTIVITY					hd grip	hdsv grip	same →	→	✓	✓	✓	✓	✓
WEAKS, UNSUSTAINED HEAD LIFT OR HAND GRIP														
NO MOVEMENT VOLUNTARILY OR ON COMMAND			✓	✓	✓									
RESPIRATION CLEAR AND UNSUPPORTED	RESPIRATION										✓	✓	✓	✓
ADEQUATE RESPIRATION WITH AIRWAY SUPPORT			✓	✓	✓	✓	✓	✓	✓	✓				
APNEIC OR OBSTRUCTED (ASSIST REQ'D)														
AWAKE AND ABLE TO SUMMON ASISTANCE	CONSCIOUSNESS													
AROUSABLE ON CALLING				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
NOT RESPONDING TO VERBAL STIMULUS			✓											
MOVEMENT AND SENSATION RETURNED	REGIONAL ANESTHETIC													
SENSATION LEVEL														
MOVEMENT LEVEL														
RN INITIALS			KL	KL	KL	KL	KL	KL	KL	KL	KL	KL	KL	KL

EL CAMINO HOSPITAL

POST ANESTHESIA CARE UNIT NURSING RECORD
(Side 2 of 2)

FALK STEVEN
828049
1 LEE, JANE MD
F0403800216
M 48
CCU

TIME	REMARKS	TIME	MEDICATIONS
3[15]p	Asleep. HOB↑ slightly. Pupils PERL, Lungs clr bil	3[25]p ✓	Labetalol 5mg = 1cc IV-SCN
3[20]p	BP 173/83. Dr Spears aware.	3[30]p ✓	Labetalol 5mg = 1cc IV-SCN
3[30]p	BP 180/87. (R) arm art.	3[45]p ✓	Vasotec (enalaprilat)
	BP cuff (L) arm 153/98.		1.25 mg = 1cc. —SCN
Late entry	for 3[20]p. Dr Greenwald connected ventriculostomy drain.	3[50]p ✓	Nifedipine 10mg Sub lingual. ~~~SCN
4[05]p	BP art. 182/83. HR; 59	5[55]p ✓	Morphine 2mg IV—SCN
	cuff (L) arm 145/82		
	PERL; Can squeeze fingers slightly bil. Moves legs/knees up slightly. ~~~SCN		
4[15]p	Dr Spears aware of condition. To start Nipride drip.		
4[30]p	Nipride drip started + titrate to keep SBP <150		
5[38]p	16 Fr. NG tube inserted gently by Mary Severson RN in CCU. ✓ for placement confirmed. Taped securely in place. Toler. well. ~~~SCN		
5[45]p	Neuro VS stable. Continue to titrate Nipride drip-SCN		

DISCHARGE ASSESSMENT BY: K Luong RN	OUTPUT	c.c.
REPORT GIVEN TO: Mary (CCU RN)	TOTAL URINE Foley 400cc	
(L) posterior lateral head dsg; D/I	IRRIGANT (ANT REMAINING_____)	
2x2's covering sm. holes slightly lat. above ea. eye D/I.	NET URINE	
	EMESIS	
Moves all extremeties. Dozing on + off. Follows commands + answers questions by yes/no appropriately	NG TUBE	
	JP-CONSTVAC	
	HEMOVAC	
	PLEUUREVAC	
	JP	
PRN Medication Effect:	JP	
☑ POST OP ORDERS ☐ DISCHARGE CRITERIA MET ☑ IV SITE ☐ ARTERIAL LINE SITE		
TIME 6[30]p TO ROOM VIA: ☐ GURNEY ☐ CRIB ☑ BED TRANSPORTED BY: RN + transporters		
CS CHARGES: Dx c/th, tube | 250cc D5W; IV tube		
PATIENT ACCEPTED BY: Mary Severson		

Form 1042 (10/03)
AMS Doc.

EL CAMINO HOSPITAL

POST ANESTHESIA CARE UNIT NURSING RECORD

(Side 1 of 2)

FALK STEVEN
828049 M 48
1 LEE, JANE MD
F0403800216 CCU

p 2 of 2

☐ARMBAND ALLERGIES: ☐NONE _____

EKG
CVP
TEMP
SA O_2

15 30 45 15 30 45 15 30 45 15 30 45 15

BP V Λ
Pe

240 220 200 180 160 140 120 100 80 60 40 20
RR #

DATE: TIME IN: AM PM

ANESTHESIA BY:

☐ GENERAL ☐ EPIDURAL ☐ SPINAL ☐ IV BLOCK ☐ LOCAL

PROCEDURE _____

EBL _____ OR FLUID _____ OR BLOOD _____

COMMENTS AND PACU ORDER

☐ DEMEROL _____ ☐ DROPERIDOL _____

☐ MORPHINE _____ ☐ _____

☐ FENTANYL _____ ☐ _____

TIME	IV FLUID	AMT	SITE	SITE CK	AMT REM	AMT INF

ADMISSION ASSESSMENT BY:

AIRWAY: ☐ NONE ☐ TRACH ☐ ENDOTRACHEAL ☐ NASAL ☐ ORAL ☐ TEETH INTACT
TIME REMOVEED: _____ AM PM _____ AM PM _____ AM PM OTHER _____

OXYGEN: ☐ NONE ☐ TRACHEAL ☐ CATHETER ☐ MASK ☐ CANNULA ____LMP TIME REMOVED: _____ AM PM ☐ N.A
CONTINUED PER: ☐ CANNULA ☐ MASK ____LMP TIME REMOVED: _____ AM PM ☐ EDENTULOUS

SKIN: ☐ WARM ☐ DRY ☐ COOL ☐ MOIST **ARTERIAL LINE:** ☐ NONE ☐ RIGHT RADIAL ☐ LEFT RADIAL ☐ SITE CK

CATHETERS: ☐ NONE ☐ FOLEY ☐ SUPRAPUBIC ☐ URETERAL
EMPTIED:

SUCTION: ☐ NONE ☐ HEMOVAC ☐ PLEUREVAC ☐ CONSTAVAC ☐ VACUTAINER ☐ JP ☐ OTHER _____ ☐NG ☐ CONSTANT
AMOUNT: ☐ INTERMITTENT

DRESSING & OBSERVATION:

RECOVERY		TIME	615p										
SUSTAINS HEAD LIFT OR HAND GRIP	ACTIVITY		✓										
WEAKS, UNSUSTAINED HEAD LIFT OR HAND GRIP													
NO MOVEMENT VOLUNTARILY OR ON COMMAND													
RESPIRATION CLEAR AND UNSUPPORTED	RESPIRATION		✓										
ADEQUATE RESPIRATION WITH AIRWAY SUPPORT													
APNEIC OR OBSTRUCTED (ASSIST REQ'D)													
AWAKE AND ABLE TO SUMMON ASISTANCE	CONSCIOUSNESS												
AROUSABLE ON CALLING			✓										
NOT RESPONDING TO VERBAL STIMULUS													
MOVEMENT AND SENSATION RETURNED	REGIONAL ANESTHETIC		/										
SENSATION LEVEL													
MOVEMENT LEVEL													
RN INITIALS			KE										

EL CAMINO HOSPITAL

POST ANESTHESIA CARE UNIT NURSING RECORD
(Side 2 of 2)

FALK STEVEN
828049 M 48
1 LEE, JANE MD
F0403800216 CCU

TIME	REMARKS	TIME	MEDICATIONS
6P	BP art (R) 166/61 ; cuff (L) arm 122/46.		
6:20p	Dr Greenwald updated on pt's condition.		
	(Dr called here to ✓ on pt). ~~~~ SCN		
	Nipride drip at 2.3 mcg/kg/min. ~~~~ SCN		

DISCHARGE ASSESSMENT BY:	OUTPUT clr yel.	c.c.
REPORT GIVEN TO:	TOTAL URINE foley 400+375 =	775 cc
	IRRIGANT (ANT REMAINING_____)	
	NET URINE	
	EMESIS	
	NG TUBE	
	CONSTVAC	
	HEMOVAC	
	PLEUUREVAC	
	JP	
PRN Medication Effect:	JP	
	Ventriculostomy drain	
☐ POST OP ORDERS ☐ DISCHARGE CRITERIA MET ☐ IV SITE ☐ ARTERIAL LINE SITE	- 40cc clr pink/red in	
TIME / TO ROOM VIA: ☐ GURNEY ☐ CRIB ☐ BED / TRANSPORTED BY:	Ventriculostomy bag	
CS CHARGES:	- 14cc in " cylinder	
PATIENT ACCEPTED BY:		

Form 1042 (10/03)
AMS Doc.

EL CAMINO HOSPITAL

Care Coordination

DISCHARGE PLANNING PROGRESS NOTE

Admission Date	Initial Review Date	Anticipated Discharge Date
2/7/2004	2/9/2004	

Name: FALK, STEVEN
Medical Rec #: 828049
Encounter #: 0403800216
Birthdate: 4/29/1965
Unit: CCU Room #: CC11P

Initial Discharge Planning Assessment 2/9/2004 9:08AM JOAN SANTANA RN

WITNESSED GRAND MAL SEIZURE. FELL HIT HEAD. CT SHOWS SUBDURAL BLEED. TO OR FOR CRANI AND EVAL OF HEMATOMA. NEUROS INTACT PRIOR TO SURGERY. WILL FOLLOW FOR DISCHARGE NEEDS.

Ongoing Discharge Planning Note 2/10/2004 1:24PM JOAN SANTANA RN

MET WITH PATIENT'S PARENTS. THEY ARE VISTING FROM NASHVILLE, TN. PATIENT LIVES WITH PARTNER BRIAN KANTER 650-556-9891.

Ongoing Discharge Planning Note 2/18/2004 1:51PM CAROL MUMBACH MSW

CONTACTED JOANNE AT FACILITIES PER RN STAFF REQUESTAT ROUNDS TO LOCATE APARTMENT FOR PATIENT'S PARENTS. NOTIFIED RN IN CCU THAT APARTMENT AVAILABLE. RECEIVED VM LATER IN DAY THAT FAMILY IS REFUSING APARTMENT. NO OTHER NEEDS CURRENTLY IDENTIFIED.

Ongoing Discharge Planning Note 2/19/2004 9:37AM JOAN SANTANA RN

ACUTE REHAB BENEFITS: INPATIENT BENEFITS--$200 CO PAY-- 80% COVERAGE-- $500 DED; OP OUT OF NETWORK 60% COVERED 70 DAYS $1000 DED $30 A VISIT. UNABLE TO GIVE ANY FACILITIES IN AREA. CALL PLACED TO BETTY AT UHC UR 866-207-2244X7895 ASKING FOR HER TO SEE IF VMC OR SUH. RECEIVED CALL BACK STATING THAT SUH REHAB IS IN NETWORK. VM LEFT FOR BARBARA NEVINS AT STANFORD REHAB ABOUT PATIENT AND WILL FAX H/P AND PT NOTES.

Ongoing Discharge Planning Note 2/19/2004 4:41PM JOAN SANTANA RN

RECEIVED CALL FROM BARBARA AT SUH REHAB. PATIENT TOO HIGH LEVEL OF FUNCTION FOR IP REHAB.

Ongoing Discharge Planning Note 2/20/2004 4:29PM CAROL MUMBACH MSW

RECEIVED REQUEST TO SPEAK WITH PATIENT AND FAMILY RE: ADVANCE HEALTH CARE DIRECTIVE. PATIENT STATED HE WANTS DIRECTIVE COMPLETED BUT ASKED SW TO SPEAK TO HIS FATHER. CALLED FATHER. FATHER ALSO REQUESTING INFORMATION ON PROCEDURE TO GAIN ACCESS TO PATIENT'S MEDICAL RECORDS. SW EXPLAINED THAT PATIENT IS A+O AND PATIENT WOULD HAVE TO GIVE CONSENT.

EL CAMINO HOSPITAL

PROGRESS NOTES

Date and sign each note

NAME

ID #

PHYSICIAN

2/20/04 N/S

Afeb VSS

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

DR. ____________________
SIGNATURE

EL CAMINO HOSPITAL

PROGRESS NOTES

Date and sign each note

FALK STEVEN
828049 F0403800216 M 38
02/07/04 CCU
1 LEE,JANE MD

2/20/04 NSURG

c/o HA 5 0

AVSS

PE: Neuro - I

D [illegible]

[illegible]

[illegible] diplopia

CT: (P)

SGOT 45 (57)

SGPT 134 (173)

WBC 10.3

A: pt fol removal of EVD. ✓ CT. if [illegible] stable, cancel shun[t] & move to floor - PT/OT for [illegible]

[signature]

2/21/04 NS

[illegible]

[illegible] → D/C [illegible] # 508786

[signature]

DR. ______________
SIGNATURE

211 (1/01)

EL CAMINO HOSPITAL

PROGRESS NOTES

Date and sign each note

FALK STEVEN
828049 F0403800216 M 38
02/07/04 CCU
1 LEE,JANE MD

2/19/04 Neuro
c/o HA ̄s Δ
Pupil 10 15
VSS
PE: Neuro @ baseline
diplopia [illegible]
LABS ©
CT ®
A: [illegible] well ̄c [illegible] clamped > 24 hrs.
VCT today
if CT ok, d/c shunt

2/19/04 Neuro ADDENDUM

CT stable ̄c ventricle changes
Exam stable
D/C EVD.
RPT CT scan tomorrow
Will likely NOT need shunt unless
scan tomorrow changes vs today
Pt/OT, Transfer

MD

DR. ____________
SIGNATURE

211 (1/01)

EL CAMINO HOSPITAL

PROGRESS NOTES

Date and sign each note

LABEL-2405-01 - EL CAMINO
FALK STEVEN
828049 F0403800216 M 38
02/07/04 CCU
1 LEE, JANE MD

2/18/04 NSURG

ICP 10-15

PE: ~~AAA~~ LFT's improving
Neuro stable
Psych eval

A: Pt #01 the cessation of CSF diversion
for now ✓ CT today.
Cont close obs.

DR. _____
SIGNATURE

211 (1/01)

EL CAMINO HOSPITAL

PROGRESS NOTES

Date and sign each note

FALK STEVEN
828049 F0403800216 M 38
02/07/04 CCU
1 LEE,JANE MD

2/17/04 NSurg

Clu ldy

~~Af~~ebrile CSF: 115 ICP 3-9

PE: Neuro [illegible] LAB: SGOT 53 (61)

Dsg [illegible] SGPT 180 (213)

⊖ diplopia WBC 12.2 (12.0)

A: S/P [illegible] PF & DH plt 532

Clonazepam to [illegible] today.

Cont neuro ✓'s

LFT's better today — ? OD of [illegible] ē admission (instead of [illegible] med.

U/S (P).

[illegible] Neurosurg

2/17 GI

No complaints

Abd US: gallbladder sludge

No CBD dilation

Lab: ALK 157, ↓AST / ALT: 43/180

A: Δ LFT is likely due to drug toxicity, but LFT is stable

DR. [illegible] SIGNATURE

P: continue monitor LFT [illegible]

EL CAMINO HOSPITAL

PROGRESS NOTES

Date and sign each note

FALK STEVEN
828049 F0403800216 M 38
02/07/04 CCU
1 LEE, JANE MD

2/16 LFT (1)

Asked to see this 38 year old male for ALFT at the request of Dr. Washhurst. Pt has no abd pain, N/V, or jaundice. He has Hx of ETOH use, last drink was 4 wks ago. He has been taking [redacted] Lortab and Naproxen for years. ↑ this dosing for few days prior to this admission. His LFT was normal on admission (2/7/04) but ↑ AST 61, ALT 213, Alk 152, B.I.D. today.

PMH: Seizures
ETOH
Migraine HA
LBP

SH: (+) ETOH

FH: (-)

Meds:
(1) Ceftriaxone
(2) Gabapentin
(3) Tylenol
(4) Lansoprazole

PE: [redacted] Afebrile, alert, (-) Jaundice
Lungs: CTA, Heart: RRR, (+) murmur
Abd: ND, NT, (-) HSM

A ALFT is likely due to drug toxicity, such as ceftriaxone, Gabapentin, Naproxen, tylenol
ETOH is less likely
(?) Muscle injury due to [redacted] pain
Gallstones or viral hepatitis is less

SIGNATURE

211 (1/01)

EL CAMINO HOSPITAL

PROGRESS NOTES

Date and sign each note

FALK STEVEN
828049 F0403800216 M 38
02/07/04 CCU
1 LEE, JANE MD

(continue) (2)

Plan

1) check LFT daily x 3 da.

2) (w) PT / PTT, ↑PK, Amylase, Lipase

3) Viral hepatitis panel

4) ~~X~~ check HIV

5) ANA, AMA, anti-smooth muscle Ab, retroplasmic

6) Abd US

7) If ↑ LFT → D/c tylenol, then consider D/c ceftriaxone and ciprofloxacin

if ↑↑ LFT

will follow

Dictated

(Jing Li)

DR. _____
SIGNATURE

211 (1/01)

EL CAMINO HOSPITAL

PROGRESS NOTES

Date and sign each note

FALK STEVEN
828049 M 48
1 LEE, JANE MD
F0403800216 CCU

2/16/04 NSURG

c/o HA's CSF 192 ICP 3-9

Tm 99.4 VSS

LAB: CSF WBC 3
RBC 694

RE: AAA
CSF GS ⊖
No neuro c/s
CSF PROT 9
Cont'd subj
diplopia c̄ lt gaze
CSF GLU 73
UA ⊖
Dsy day
CRO
WBC 12.0
HCT 40.1

CT SCAN: Vents WNL PLT 500
NO other signif c/s

132	95	15
3.9	30	.8

67 .6 213 132

A: Neuro stable
Cont'd CSF diversion
LFT's last ✓ @ adm
(nl) but pt had taken several dozen
narcotic pills c̄ tylenol prior to adm
over a period of ~2 d. LFT'S now
elevated. ✓ Hep panel.
GI consult.

[signature]

DR. ____________
SIGNATURE

211 (1/01)

EL CAMINO HOSPITAL

PROGRESS NOTES

Date and sign each note

FALK STEVEN
828049 M 48
1 LEE, JANE MD
F0403800216 CCU

2/15/04 NSURG

C/o HA s̄ Δ. & N, V.

VSS 140cc CSF ICP 4-10

PE: AAO LAB: WBC 12.4 (11.5 2/13)

CN intact x̄ (B) subj Bands 12

diplopia c̄ lat gaze Na 133

otherwise wnl

dsg wnl : wd clean

CSF clear

CT (P)

A: Neuro stable.

~~Start~~ consider medical / Neuro for HA

prophylaxis c̄ prevacid

I am concerned about small ↑ WBC esp

given bands of 12.

w/u c̄ CXR / CXR

[signature]

DR. ________ SIGNATURE

211 (1/01)

EL CAMINO HOSPITAL

PROGRESS NOTES

Date and sign each note

FALK STEVEN
828049
1 LEE,JANE MD
F0403800216

M 48
CCU

2/13/04 N/S POD#5
S/P (R) EVD, Post. Fossa EDH
S/ Alert, O+3
Afebrile
EVD / still draining @ 15cm H_2O ~200 cc/day

A/ ? Shunt dependent

P/ Continue care @ [illegible]
Advance diet.

[illegible]

2/14/04 NSURG POD#6
PF craniectomy for EDH / EVD c/o HA
CSF - 136cc ICP 5-9 c drain @15cm (clear CSF)
Tm 100'
PE: Awake. Somewhat drowsy but appropriate
follows commands
Subj; diplopia c (B) lat gaze, full EOM
[illegible] ⊖ PD. 5/5 5/5
A: Pt dep on CSF diversion. Signif HA c
EVD @ 15cm — Δ ht to 10cm. Cont ICU
Care. Stable neuro. may need shunt if
remains diversion-dependent.

DR. [illegible]
SIGNATURE

211 (1/01)

EL CAMINO HOSPITAL

PROGRESS NOTES

Date and sign each note

FALK STEVEN
828049
FOX, DAN E MD
F0403800216 02/07/04
M123

2/12/04 N/S POD # 4

Afeb VSS

Alert, [illegible]

EVD @ 15 - ↓ Output

No focal deficit

Imp/Plan - Clamp EVD

Continue today

[signature]

2/12/04 Im

S: pt. responsive "Tired"

O: BP 144/84. P 89

chest clear c RRR

Abd (+) BS x 7[illegible]

neuro: see Dr. [illegible] note

A/P POD #4 — Stable. no narcotic withdrawal symptoms.

cont observation

BP normalizing

change daily visit to PRN if needed

[signature]

[signature]

DR. ____________
SIGNATURE

211 (1/01) [redacted]

EL CAMINO HOSPITAL

PROGRESS NOTES

Date and sign each note

FALK STEVEN
828049
1 LEE, JANE MD
F0403800216

M 48

CCU

2/10/04 Im

S: Doing physical therapy c̄ ROM

O: BP 130/64. (on Nipride drip)

P 100.

No chest complain

A/ POD#2 → improving activity level.

P/ ↑BP → continue c̄ IV Nipride

[signature]

2/11/04 N/S POD# 3

SS?-WSS

alert, OX3. EVD/ ? 10cc/hr. @

mild HA, diplopia 10 cm of H_2O

Moves all 4 Ext,

Imp/ c̄ Improved, S/P Post. Fossa EOM

c̄ Obs. Hydrocephalus - ? Dependent

Plan/ ↑ EVD to 15 cm of H_2O

- CT scan of Head in Am

[signature]

DR. ____________
SIGNATURE

211 (1/01)

[redacted]

EL CAMINO HOSPITAL

PROGRESS NOTES

Date and sign each note

FALK STEVEN
828049
1 LEE, JANE MD
F0403800216
M 48
CCU

2/9/04 N/S POD#1

s/p (R) EVD / (L) Sub-Occipital Crani for [illegible]

S/ Awake, follows commands

O/ Afebrile VSS

EVD < 20cc [illegible] EOM - Intact ¢ VI th

CT-brain / 2/9/04 - (1) (L) F-T Contusion [illegible]

(2) ¢ Hydrocephalus; tube in place

(3) ¢ [illegible] / s/p Crani

Imp/ Plan/ [illegible]

Continue present Rx

[signature]

2/10/04 N/S POD#2

100.5 - VSS on [illegible]

EVD / < 10 cc. / hr @ 10cm of H_2O

More alert, c/o of neck pain + "throat"

Moves all 4 ext well

EOM - Intact

Imp/Plan - Continue EVD @ 10 cm.

[illegible]

[signature]

DR. ____________________
SIGNATURE

211 (1/01)

EL CAMINO HOSPITAL
2500 GRANT ROAD, P.O. BOX 7025
MOUNTAIN VIEW, CA 94039-7025

ED-L2-1868-02 - EL CAMINO H
FALK STEVEN
828049 M 48
FOX, DAN E MD
F0403800216 02/07/04

PROCEDURE NOTES

PRE-PROCEDURE NOTE

(To be completed when H&P was dictated more than 24 hours prior to admission.)

Date 2/8/04 Time 1500

- [x] No change in patient's condition from report of history and physical examination.
- [x] The risks, benefits and alternatives for this procedure have been discussed with the patient (or legal representative) and the patient (or legal representative) wishes to proceed.

Updated patient condition ______

______ MD
SIGNATURE

POST-PROCEDURE NOTE

Date 2/8/04 Time ______

#474531

FOR ALL PROCEDURES:

Pre-Procedure Diagnosis (L) Occ./Post Fossa EDH c Obs. Hydrocephalus
Post-Procedure Diagnosis Same
Procedures Performed (1) (R) EVD
(2) (L) Occ/Post Fossa Craniotomy for EDH
Surgeon [illegible]
Assistant Surgeon P. Brown
Type of Anesthesia Gen, GT - B. [illegible]
Condition at end of procedure Fair

AS APPROPRIATE:

Specimens Removed CSF / EDH
Estimated Blood Loss < 200cc Drains (R) EVD / [illegible]
Complications ∅

______ MD
SIGNATURE

EL CAMINO HOSPITAL

PROGRESS NOTES

Date and sign each note

FALK STEVEN
828049 M123
FOX,DAN E MD
F0403800216 02/07/04

2/7/04 IM H-P — see dictation
Briefly, 38 yo man had sz x 2. Tell had epidural hematoma, see Dr. Greenwald's note
now pt. in ICU. responsive but post-ictal.
short or NO answer to questions. agree with
repeat head CT tomorrow.
[signature]

2/8/04 IM
S: NO SZ activity reported last night
and so far since admission
O: responds by opening eyes.
CT — per Dr. Greenwald
A/P EDH — agree with surgical
intervention
[signature]

2/9/04 IM 2047531
S: arousable. had surg 2/8.
O: SBP 160 P110 T100.8
cut congen c̄ m Rx
neuro: per Dr. Greenwald
Labs: 9 CPK 3659, myoglobin: 400s, LDL: 131 HDL 67
A/P postop BP ↑ → continue current
management.
[signature]

DR. ____________
SIGNATURE

211 (1/01) [redacted]

EL CAMINO HOSPITAL

PROGRESS NOTES

Date and sign each note

FALK STEVEN
828049
FOX,DAN E MD
F0403800216 02/07/04

M123

2/7/04 Neurosurgery Consult Dictated/ #473983

CC/ ① Craniocerebral Trauma
② Seizure Disorder
③ Drug Abuse

38% [illegible] c hx. of seizure disorder & [illegible]
seizure tonight & struck head. Post ictal [illegible]
[illegible] ⓛ [illegible], Verity [illegible].
CT/scan/ ⓛ [illegible]. Skull Fracture
ⓒ [illegible] ⓛ [illegible] EDH s mass effect.

Rx/ Tegretol/ Neurontin

c/o [illegible], Post ictal
No focal deficit

Imp/ Seizure Disorder/ Seizure c Head Trauma &
Small ⓛ [illegible]. EDH

Plan/ - Admit ICU / Observe
- Repeat CT scan in AM
-

[signature]

DR. ______
SIGNATURE

211 (1/01)

[redacted]

SIGN

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04

UNSIGNED ORDERS

ORDERS FOR SIGNATURE:

05:04 PM 02/08/04
ENTERED BY: LUONG,KIMSA SIGNATURE:
ENTERED FOR: SPEARS,ROBERT MD
--VERBAL ORDER--

111. LABETALOL(5MG/ML) INJ 5MG MG, SLOW IV (OVER 2 MINUTES) GIVEN AT 03:20PM, IV, <02/08/04 05:04PM>, (RSAG)
112. LABETALOL(5MG/ML) INJ 5 MG, SLOW IV (OVER 2 MINUTES) GIVEN AT 03:30PM, IV, <02/08/04 05:04PM>, (RSAG)
113. ENALAPRILAT 1.25MG, IV GIVEN AT 03:45PM, IV, <02/08/04 05:04PM>, (RSAG)
114. NIFEDIPINE 10MG CAP--SUBLINGUAL TO MAINTAIN SBP 140. GIVEN AT 03:50PM, <02/08/04 05:04PM>, (RSAG)

05:01 PM 02/21/04
ENTERED BY: LOPEZ,MARICEL P SIGNATURE:
ENTERED FOR: GREENWALD,RON MD
--PHONE ORDER--

234. (DC) DISCHARGE PATIENT TODAY IN PM, <02/21/04>, (RG).
235. DISCHARGE PATIENT TOMORROW, <02/22/04>, (RG).
236. *HAVE DISCHARGE PLANNER SEE PT/PARENTS BEFORE DISCHARGE, PT NEEDS A WALKER PER PHYSICAL THERAPY., (RG).

06:24 PM 02/21/04
ENTERED BY: RAHNEMA,MARIAM SIGNATURE:
ENTERED FOR: GREENWALD,RON MD
--PHONE ORDER--

237. *D/C STAPLES. NO STERISTRIPS NECESSARY., (RG).

LAST PAGE

-*-

XXX XXXX XXXX
X X X X X X
X X XXXX X X
X X X X X X
XXX X X XXXX
DISCHARGE REPORT

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

ORDERS ENTERED:02/22/04

01:17 PM 02/22/04
ENTERED BY: MURO,KAREN --COMPUTER CODE SIGNATURE--

238. (MED DC"D AT DIS/EXP) ACETAMINOPHEN 325MG TAB, #2,PO, Q4H, PRN TEMP >100.5 OR MILD PAIN, <02/08/04 03:16PM-..>, (RG).
239. (MED DC"D AT DIS/EXP) ACETAMINOPHEN 650MG SUPP, #1,PR, Q4H, PRN TEMP 100.5 OR MILD PAIN, <02/08/04 03:17PM-..>, (RG).
240. (MED DC"D AT DIS/EXP) HYDRALAZINE 10MG, SLOW IV, Q2H, PRN TO KEEP SBP 150 WHEN HR <90, <02/08/04 03:17PM-..>, (RG).
241. (MED DC"D AT DIS/EXP) HYDRALAZINE 20MG, SLOW IV, Q2H, PRN TO KEEP SBP 150 WHEN HR <90, <02/08/04 03:17PM-..>, (RG).
242. (MED DC"D AT DIS/EXP) GABAPENTIN 300MG CAPSULE, #1,PO, TID, (02/09/04 08AM-..), (RG).
243. (MED DC"D AT DIS/EXP) CARBAMAZEPINE 200MG TAB, #1,PO, TID (8,1,9), (02/08/04 09PM-..), (RG).
244. (MED DC"D AT DIS/EXP) SALINE (0.9% NACL) FOR PERIPHERAL LOCK/FLUSH, FLUSH WITH 3ML, IV, Q8H, (02/11/04 10PM-..), (01 OF 02), (RG).
245. (MED DC"D AT DIS/EXP) SALINE (0.9% NACL) FOR PERIPHERAL LOCK/FLUSH, FLUSH WITH 3ML, IV, PRN PATENCY, <02/11/04 08:27PM-..>, (02 OF 02), (RG).
246. (MED DC"D AT DIS/EXP) LANSOPRAZOLE 30MG CAP, #1,PO, QD, (02/15/04 08AM-..), (SMW).
247. (MED DC"D AT DIS/EXP) HYDROCODONE 10MG & APAP 325MG TABLET (NORCO), #1,PO, Q4H, PRN PAIN, <02/15/04 07:44AM-..>, (SMW).
248. (MED DC"D AT DIS/EXP) MORPHINE SULFATE 2MG, SLOW IV, Q1H, PRN PAIN --HOLD FOR RESP RATE 10 AND O2 SAT <92%, (OSD: 02/08/04 03:17PM), <02/16/04 07:22AM-..>, (SMW).
249. (MED DC"D AT DIS/EXP) MORPHINE SULFATE 4MG, SLOW IV, Q2H, PRN PAIN --HOLD FOR RESP RATE 10 AND O2 SAT <92%, (OSD: 02/08/04 03:17PM), <02/16/04 07:22AM-..>, (SMW).
250. (MED DC"D AT DIS/EXP) DOCUSATE SODIUM 250MG CAP, BID, (02/18/04 08AM-..), (RG).
251. (MED DC"D AT DIS/EXP) ONDANSETRON 4MG, IV, Q8H, PRN NAUSEA & VOMITING, X1-2 DAYS, <02/18/04 06:55PM-..>, (SMW).
252. (MED DC"D AT DIS/EXP) MILK OF MAGNESIA 30 ML,PO, QD, PRN CONSTIPATION, <02/21/04 01:29PM-..>, (RG).

CONTINUED

XXX XXXX XXXX
X X X X X X
X X XXXX X X
X X X X X X
XXX X X XXXX
DISCHARGE REPORT

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA
ORDERS ENTERED:02/22/04

LAST PAGE

ORD

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04

DAILY ORDERS SUMMARY

ORDERS ENTERED 02/20/04 TO 02/21/04

RESPONSE, NEURO-CK WEAKNESS, NEURO-CK SENSORIUM, Q15M 'TIL STABLE, THEN, Q30M, X4H, THEN, Q1H--WHILE IN CCU, (RG).
229VITAL SIGNS, T-P-R/BP, Q4H--NEURO CHECKS Q4, (RG).
130ACTIVITY, UP AD LIB-WITH ASSISTANCE, (RG).
131(DC) ACTIVITY, BEDREST--DAY OF SURGERY, (RG).
149BEDS AND EQUIPMENT: VENODYNE COMP BOOTS, (RG).
129*DC ARTERIAL LINE., (RG).
132(DC) *PLEASE KEEP EVD AT 10CM ABOVE MARK ON TIP OF L EAR, (RG).
139*CLAMP VENTRICULOSTOMY DRAIN AFTER HEAD CT DONE., (RG).
140(DC) *TRANSFER TO TCU--POD 1 IF STABLE AND AFTER APPROVED BY NEUROSURGEON, (RG).
141(DC) *TRANSFER TO SURG--POD 2 IF STABLE AND AFTER APPROVED BY NEUROSURGEON, (RG).
142(DC) *CLAMP VENTRICULOSTOMY DRAIN AFTER HEAD CT DONE., (RG).
148*VENTRICULOSTOMY DRAIN SET AT 15CM HCO, READ AT TOP OF L EAR, (RG).
150(DC) SUPPORTS,BINDER: ANTI-EMBOLISM STOCKING, TOES TO THIGH, BILATERAL, (RG).
227TRANSFER TO --5E, (RG).

LAST PAGE

ORD

DAILY ORDERS SUMMARY

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04

ORDERS ENTERED 02/20/04 TO 02/21/04

06:24 PM 02/21/04
ENTERED BY: RAHNEMA,MARIAM SIGNATURE:
ENTERED FOR: GREENWALD,RON MD
--PHONE ORDER--

237. *D/C STAPLES. NO STERISTRIPS NECESSARY., (RG).

--ALL SIGNED ORDERS FOR DAY--

COUNTERSIGNED BY: GREENWALD,RON MD
03:23 PM 02/21/04 --COMPUTER CODE SIGNATURE--

135(DC) LABETALOL(5MG/ML) INJ 10MG, SLOW IV (OVER 2 MINUTES), Q2H, PRN SBP 150 WHEN HR <90, <02/08/04 03:17PM-..>, (RG).
136(DC) LABETALOL(5MG/ML) INJ 15MG, SLOW IV, (OVER 2 MINUTES), Q2H, PRN SBP 150 WHEN HR <90, <02/08/04 03:17PM-..>, (RG).
137LABETALOL(5MG/ML) INJ 10 MG, SLOW IV (OVER 2 MINUTES), Q2H, PRN SBP 150 WHEN HR >90, <02/11/04 09:26PM-..>, (RG).
138LABETALOL(5MG/ML) INJ 15 MG, SLOW IV (OVER 2 MINUTES), Q2H, PRN SBP 150 WHEN HR >90, <02/11/04 09:26PM-..>, (RG).
154CEFTRIAXONE 1GM/D5W 50ML, IVPB, INFUSE IN 30 MINUTES, STAT, (02/13/04 08:11AM), (01 OF 02), (RG).
155CEFTRIAXONE 1GM/D5W 50ML, IVPB, INFUSE IN 30 MINUTES, Q24H, (02/14/04 08AM-..), (02 OF 02), (RG).
152CHEM-BASIC NON-FASTING, TODAY, SPEC'M COLLECTED, (02/13/04), (RG).
153CBC, TODAY, SPEC'M COLLECTED, (02/13/04), (RG).
128XRAY: CT SCAN HEAD, NO CONTRAST, CTH, INDICATION: FOLLOWUP,PRIOR CT, VIA: BED, TOMORROW, 02/12/04, <02/11/04>, (RG).
157(DC) DIET: FULL LIQUID, (RG).
158DIET: REGULAR, (RG).
224(DC) DIET: NPO-P-MN-EXC-FOR-MEDS, (RG).
225(DC) DIET: REGULAR, (RG).
226DIET: REGULAR, (RG).

COUNTERSIGNED BY: GREENWALD,RON MD
03:24 PM 02/21/04 --COMPUTER CODE SIGNATURE--

228(DC) VITAL SIGNS, BP-P-R, NEURO-CK PUPILS, NEURO-CK

CONTINUED

ORD

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04

DAILY ORDERS SUMMARY

ORDERS ENTERED 02/20/04 TO 02/21/04

P = PREADMIT(SUSPENDED)
# = INPROCESS
C = COMPLETE

01:29 PM 02/21/04
ENTERED BY: GILLESPIE,KRISTINE ENTERED FOR: GREENWALD,RON MD
--WRITTEN ORDER--

230. MILK OF MAGNESIA 30 ML,PO, QD, PRN CONSTIPATION, <02/21/04 01:29PM-..>, (RG).

03:25 PM 02/21/04
ENTERED BY: GREENWALD,RON MD --COMPUTER CODE SIGNATURE--

231. DISCHARGE PATIENT TODAY IN PM, <02/21/04>, (RG).

03:26 PM 02/21/04
ENTERED BY: GREENWALD,RON MD --COMPUTER CODE SIGNATURE--

232. *D/C SUTURES, (RG).

04:07 PM 02/21/04
ENTERED BY: RAHNEMA,MARIAM ENTERED FOR: GREENWALD,RON MD
--WRITTEN ORDER--

C 233. BISACODYL 10MG SUPP, #1,PR, NOW, (02/21/04 04:07PM), (RG).

05:01 PM 02/21/04
ENTERED BY: LOPEZ,MARICEL P SIGNATURE: _____
ENTERED FOR: GREENWALD,RON MD
--PHONE ORDER--

234. (DC) DISCHARGE PATIENT TODAY IN PM, <02/21/04>, (RG).
235. DISCHARGE PATIENT TOMORROW, <02/22/04>, (RG).
236. *HAVE DISCHARGE PLANNER SEE PT/PARENTS BEFORE DISCHARGE, PT NEEDS A WALKER PER PHYSICAL THERAPY., (RG).

CONTINUED

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04

DAILY ORDERS SUMMARY

ORDERS ENTERED 02/19/04 TO 02/20/04

01:13 PM 02/20/04
ENTERED BY: HAASE,STEPHANIE SIGNATURE:_____
ENTERED FOR: GREENWALD,RON MD
--PHONE ORDER--

224. (DC) DIET: NPO-P-MN-EXC-FOR-MEDS, (RG).
225. (DC) DIET: REGULAR, (RG).
226. DIET: REGULAR, (RG).

01:13 PM 02/20/04
ENTERED BY: HAASE,STEPHANIE SIGNATURE:_____
ENTERED FOR: GREENWALD,RON MD
--PHONE ORDER--

227. TRANSFER TO --5E, (RG).

02:03 PM 02/20/04
ENTERED BY: HAASE,STEPHANIE SIGNATURE:_____
ENTERED FOR: GREENWALD,RON MD
--PHONE ORDER--

228. (DC) VITAL SIGNS, BP-P-R, NEURO-CK PUPILS, NEURO-CK RESPONSE, NEURO-CK WEAKNESS, NEURO-CK SENSORIUM, Q15M 'TIL STABLE, THEN, Q30M, X4H, THEN, Q1H--WHILE IN CCU, (RG).
229. VITAL SIGNS, T-P-R/BP, Q4H--NEURO CHECKS Q4, (RG).

--ALL SIGNED ORDERS FOR DAY--
NO ORDERS WERE SIGNED FOR DAY

LAST PAGE

ORD

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04

DAILY ORDERS SUMMARY

ORDERS ENTERED 02/19/04 TO 02/20/04

P = PREADMIT(SUSPENDED)
# = INPROCESS
C = COMPLETE

07:42 AM 02/20/04
ENTERED BY: WACHHORST,SCOTT MD --COMPUTER CODE SIGNATURE--

216. ACTIVITY, AMBULATE WITH ASSIST, TID, (SMW).

07:43 AM 02/20/04
ENTERED BY: WACHHORST,SCOTT MD --COMPUTER CODE SIGNATURE--

217. XRAY: CT SCAN HEAD, NO CONTRAST, CTH, INDICATION: FOLLOWUP,PRIOR CT, VIA: BED, TODAY -TO CHECK VENT SIZE AND DETN IF SHUNT NEEDED., (02/20/04), (SMW).

07:45 AM 02/20/04
ENTERED BY: WACHHORST,SCOTT MD --COMPUTER CODE SIGNATURE--

218. TRANSFER TO SURG--IF CT STABLE., (SMW).
219. *CHANGE VITALS TO Q4HRS AFTER TRANSFER. START DIET (REGULAR AFTER TRANSFER, (SMW).
220. (DC) LABETALOL(5MG/ML) INJ 10 MG, SLOW IV (OVER 2 MINUTES), Q2H, PRN SBP 150 WHEN HR >90, <02/11/04 09:26PM-..>, (SMW).
221. (DC) LABETALOL(5MG/ML) INJ 15 MG, SLOW IV (OVER 2 MINUTES), Q2H, PRN SBP 150 WHEN HR >90, <02/11/04 09:26PM-..>, (SMW).
222. (DC) CEFTRIAXONE 1GM/D5W 50ML, IVPB, INFUSE IN 30 MINUTES, Q24H, (02/14/04 08AM-..), (02 OF 02), (SMW).

07:57 AM 02/20/04
ENTERED BY: WISZOWATY,DIANA
--SECONDARY/ADJUSTING ORDER--

223. (CANCEL) CT HEAD WITHOUT, .
ORDER #: 217, CANCEL REASON: DUPLICATE PAT. ORDER

CONTINUED

ORD

DAILY ORDERS SUMMARY

FALK STEVEN M 38 CC11P
828049 F0403800216 ADM: 02/07/04

ORDERS ENTERED 02/18/04 TO 02/19/04

12:00 NN 02/19/04
ENTERED BY: WACHHORST,SCOTT MD --COMPUTER CODE SIGNATURE--

215. DIET: NPO-P-MN-EXC-FOR-MEDS, (SMW).

--ALL SIGNED ORDERS FOR DAY--

COUNTERSIGNED BY: WACHHORST,SCOTT MD
07:42 AM 02/19/04 --COMPUTER CODE SIGNATURE--

207ONDANSETRON 4MG, IV, Q8H, PRN NAUSEA & VOMITING, X1-2 DAYS, <02/18/04 06:55PM-..>, (SMW).
206*IF ICP > 20, REOPEN SHUNT AT 10CM H2O, (SMW).

LAST PAGE

ORD

DAILY ORDERS SUMMARY

FALK STEVEN M 38 CC11P
828049 F0403800216 ADM: 02/07/04

ORDERS ENTERED 02/18/04 TO 02/19/04

P = PREADMIT(SUSPENDED)
# = INPROCESS
C = COMPLETE

07:42 AM 02/19/04
ENTERED BY: WACHHORST,SCOTT MD --COMPUTER CODE SIGNATURE--

208. CHEM-COMP NON-FASTING, TOM'RO, (02/20/04), (SMW).

07:43 AM 02/19/04
ENTERED BY: WACHHORST,SCOTT MD --COMPUTER CODE SIGNATURE--

209. CBC, TOM'RO, (02/20/04), (SMW).

07:43 AM 02/19/04
ENTERED BY: WACHHORST,SCOTT MD --COMPUTER CODE SIGNATURE--

C 210. XRAY: CT SCAN HEAD, NO CONTRAST, CTH, INDICATION: FOLLOWUP,PRIOR CT, VIA: BED, TODAY, (02/19/04), (SMW).

12:00 NN 02/19/04
ENTERED BY: WACHHORST,SCOTT MD --COMPUTER CODE SIGNATURE--

211. (DC) *VENTRICULOSTOMY DRAIN SET AT 10 CM H20, READ AT TOP OF L EAR., (SMW).
212. (DC) *IF ICP > 20, REOPEN SHUNT AT 10CM H2O, (SMW).
213. ACTIVITY, UP IN CHAIR, TID, (SMW).

12:00 NN 02/19/04
ENTERED BY: WACHHORST,SCOTT MD --COMPUTER CODE SIGNATURE--

214. XRAY: CT SCAN HEAD, NO CONTRAST, CTH, INDICATION: FOLLOWUP,PRIOR CT, TOMORROW, <02/19/04>, (SMW).

CONTINUED

ORD

FALK STEVEN M 38 CC11P
828049 F0403800216 ADM: 02/07/04

DAILY ORDERS SUMMARY

ORDERS ENTERED 02/17/04 TO 02/18/04

P = PREADMIT(SUSPENDED)
# = INPROCESS
C = COMPLETE

07:54 AM 02/18/04
ENTERED BY: WACHHORST,SCOTT MD --COMPUTER CODE SIGNATURE--

205. XRAY: CT SCAN HEAD, NO CONTRAST, CTH, INDICATION: FOLLOWUP,PRIOR CT, VIA: BED, TODAY, (02/18/04), (SMW).

06:54 PM 02/18/04
ENTERED BY: JENSEN,SUZANNE SIGNATURE:_____
ENTERED FOR: WACHHORST,SCOTT
--PHONE ORDER--

206. *IF ICP > 20, REOPEN SHUNT AT 10CM H2O, (SMW).

06:55 PM 02/18/04
ENTERED BY: JENSEN,SUZANNE SIGNATURE:_____
ENTERED FOR: WACHHORST,SCOTT
--PHONE ORDER--

207. ONDANSETRON 4MG, IV, Q8H, PRN NAUSEA & VOMITING, X1-2 DAYS, <02/18/04 06:55PM-..>, (SMW).

--ALL SIGNED ORDERS FOR DAY--
NO ORDERS WERE SIGNED FOR DAY

LAST PAGE

ORD

FALK STEVEN M 38 **CC11P**
828049 F0403800216 **ADM:** 02/07/04

DAILY ORDERS SUMMARY

ORDERS ENTERED 02/16/04 TO 02/17/04

P = PREADMIT(SUSPENDED)
# = INPROCESS
C = COMPLETE

06:22 AM 02/17/04
ENTERED BY: PREMIER LAB REFLEX ENTERED FOR: WACHHORST,SCOTT
--WRITTEN ORDER--

C 203. MANUAL DIFF.*, LIS#0000235009700001, ENTERED BY:SLWA, <02/17/04>, (SMW).

10:13 PM 02/17/04
ENTERED BY: CAMPBELL,MARY ENTERED FOR: GREENWALD,RON MD
--WRITTEN ORDER--

204. DOCUSATE SODIUM 250MG CAP, BID, (02/18/04 08AM-..), (RG).

--ALL SIGNED ORDERS FOR DAY--
NO ORDERS WERE SIGNED FOR DAY

LAST PAGE

ORD

FALK STEVEN M 38 CC11P
828049 F0403800216 ADM: 02/07/04

DAILY ORDERS SUMMARY

ORDERS ENTERED 02/15/04 TO 02/16/04

201. LIPASE-BL, TOM'RO, (02/17/04), (MLAF)
202. ULTRASOUND: ABDOMINAL GENERAL SURVEY, UAS, PREP 52, LIVER, BILE DUCT, GALLBLADDER, PANCREAS, INDICATION: ABNORMAL LIVER ENZYMES, VIA: GUR/IV/O2, TOMORROW, <02/16/04>, (MLAF)

--ALL SIGNED ORDERS FOR DAY--
NO ORDERS WERE SIGNED FOR DAY

LAST PAGE

ORD

FALK STEVEN M 38 CC11P
828049 F0403800216 ADM: 02/07/04

DAILY ORDERS SUMMARY

ORDERS ENTERED 02/15/04 TO 02/16/04

P = PREADMIT(SUSPENDED)
# = INPROCESS
C = COMPLETE

06:45 AM 02/16/04
ENTERED BY: PREMIER LAB REFLEX ENTERED FOR: WACHHORST,SCOTT
--WRITTEN ORDER--

C 186. MANUAL DIFF.*, LIS#0000234854300001, ENTERED BY:WM, <02/16/04>, (SMW).

07:22 AM 02/16/04
ENTERED BY: WACHHORST,SCOTT MD --COMPUTER CODE SIGNATURE--

187. (RENEWED) MORPHINE SULFATE 2MG, SLOW IV, Q1H, PRN PAIN --HOLD FOR RESP RATE 10 AND O2 SAT <92%, (OSD: 02/08/04 03:17PM), <02/16/04 07:22AM-..>, (SMW).
188. (RENEWED) MORPHINE SULFATE 4MG, SLOW IV, Q2H, PRN PAIN --HOLD FOR RESP RATE 10 AND O2 SAT <92%, (OSD: 02/08/04 03:17PM), <02/16/04 07:22AM-..>, (SMW).
189. CHEM-COMP NON-FASTING, TOM'RO, (02/17/04), (SMW).
190. CBC, TOM'RO, (02/17/04), (SMW).

07:26 AM 02/16/04
ENTERED BY: WACHHORST,SCOTT MD --COMPUTER CODE SIGNATURE--

191. HEP ACUTE PANEL, TODAY, (02/16/04), (SMW).

07:26 PM 02/16/04
ENTERED BY: LI,JIAYI MD --COMPUTER CODE SIGNATURE--

192. PROTIME(INR), TOM'RO, (02/17/04), (MLAF)
193. PTT, TOM'RO, (02/17/04), (MLAF)
194. LIVER PANEL, DAILY X3, STARTING TOMORROW, (02/17/04-02/19/04), (MLAF)
195. ANA, TOM'RO, (02/17/04), (MLAF)
196. AMYLASE-BL, TOM'RO, (02/17/04), (MLAF)
197. ANTI-GLIADIN ABY PANEL, TOM'RO, (02/17/04), (MLAF)
198. ANTI-MITOCHOND AB, TOM'RO, (02/17/04), (MLAF)
199. ANTI-SMOOTH MUS AB, TOM'RO, (02/17/04), (MLAF)
200. CERULOPLASMIN, TOM'RO, (02/17/04), (MLAF)

CONTINUED

ORD

DAILY ORDERS SUMMARY

FALK STEVEN M 38 CC11P
828049 F0403800216 ADM: 02/07/04

ORDERS ENTERED 02/14/04 TO 02/15/04

08:05 AM 02/15/04
ENTERED BY: WACHHORST,SCOTT MD --COMPUTER CODE SIGNATURE--

185. (DC) METHYLPREDNISOLONE 4MG TAB DOSE PACK, 1 PKG, TAKE AS DIRECTED ON PACKAGE (MISC MED), <02/15/04 07:43AM-..>, (SMW).

--ALL SIGNED ORDERS FOR DAY--

COUNTERSIGNED BY: WACHHORST,SCOTT MD
07:35 AM 02/15/04 --COMPUTER CODE SIGNATURE--

160CHEM-BASIC FASTING TOMORROW AT 6AM, (02/15/04 06AM), (SMW).
161CBC TOMORROW AT 6AM, (02/15/04 06AM), (SMW).
162(DC) *VENTRICULOSTOMY DRAIN SET AT 15CM HCO, READ AT TOP OF L EAR, (SMW).
163*VENTRICULOSTOMY DRAIN SET AT 10 CM H20, READ AT TOP OF L EAR., (SMW).

COUNTERSIGNED BY: LEE,JANE MD
08:00 AM 02/15/04 --COMPUTER CODE SIGNATURE--

145CBC, TODAY, (02/12/04), (JLAC)
146CHEM-BASIC NON-FASTING, TODAY, (02/12/04), (JLAC)

LAST PAGE

ORD

DAILY ORDERS SUMMARY

FALK STEVEN M 38 CC11P
828049 F0403800216 ADM: 02/07/04

ORDERS ENTERED 02/14/04 TO 02/15/04

07:44 AM 02/15/04
ENTERED BY: WACHHORST,SCOTT MD --COMPUTER CODE SIGNATURE--

171. HYDROCODONE 10MG & APAP 325MG TABLET (NORCO), #1,PO, Q4H, PRN PAIN, <02/15/04 07:44AM-..>, (SMW).

07:46 AM 02/15/04
ENTERED BY: WACHHORST,SCOTT MD --COMPUTER CODE SIGNATURE--

C 172. XRAY: CHEST,PORTABLE, CHTP, INDICATION: PNEUMONIA, VIA: BED, STAT/PRELIM READ, (02/15/04 07:46AM), (SMW).

07:47 AM 02/15/04
ENTERED BY: WACHHORST,SCOTT MD --COMPUTER CODE SIGNATURE--

173. CHEM-COMP NON-FASTING, TOM'RO, (02/16/04), (SMW).
174. CBC, TOM'RO, (02/16/04), (SMW).
C 175. URINALYSIS, STAT, (02/15/04 07:47AM), (SMW).
176. CULT(+SENS,IF IND), US, URINE, TODAY, (02/15/04), (SMW).

07:47 AM 02/15/04
ENTERED BY: WACHHORST,SCOTT MD --COMPUTER CODE SIGNATURE--

177. BL CULTURE, BC, LEFT ARM, AL TODAY, (02/15/04), (SMW).
178. BL CULTURE, BC, RIGHT ARM, AR TODAY, (02/15/04), (SMW).

07:49 AM 02/15/04
ENTERED BY: WACHHORST,SCOTT MD --COMPUTER CODE SIGNATURE--

179. CULT(SENS, IF IND), CS, CSF, TUBE#1, <02/15/04>, (SMW).
C 180. GRAM STAIN(SMEAR), CS, CSF, TUBE#1 TODAY, (02/15/04), (SMW).
181. CULT(SENS, IF IND), CS, CSF, TUBE#1 TODAY, (02/15/04), (SMW).
C 182. CELL COUNT/DIFF, CSF, TUBE#2 TODAY, (02/15/04), (SMW).
C 183. GLUCOSE, CSF, TUBE#2 TODAY, (02/15/04), (SMW).
C 184. PROTEIN, CSF, TUBE#2 TODAY, (02/15/04), (SMW).

CONTINUED

ORD

FALK STEVEN M 38 CC11P
828049 F0403800216 ADM: 02/07/04

DAILY ORDERS SUMMARY

ORDERS ENTERED 02/14/04 TO 02/15/04

P = PREADMIT(SUSPENDED)
# = INPROCESS
C = COMPLETE

06:01 AM 02/15/04
ENTERED BY: PREMIER LAB REFLEX ENTERED FOR: WACHHORST,SCOTT
--WRITTEN ORDER--

C 164. MANUAL DIFF.*, LIS#0000234721800001, ENTERED BY:KRS, <02/15/04>, (SMW).

07:43 AM 02/15/04
ENTERED BY: WACHHORST,SCOTT MD --COMPUTER CODE SIGNATURE--

165. METHYLPREDNISOLONE 4MG TAB DOSE PACK, 1 PKG, TAKE AS DIRECTED ON PACKAGE (MISC MED), <02/15/04 07:43AM-..>, (SMW).

07:44 AM 02/15/04
ENTERED BY: WACHHORST,SCOTT MD --COMPUTER CODE SIGNATURE--

166. (DC) HYDROCODONE 5MG & ACETAMINOPHEN 500MG TAB (VICODIN), #1,PO, Q4H, PRN PAIN --HOLD IF NOT FULLY ALERT., <02/08/04 03:16PM-..>, (SMW).
167. (DC) CODEINE 30MG, IM, Q4H, PRN PAIN, <02/08/04 03:17PM-..>, (01 OF 02), (SMW).
168. (DC) CODEINE 30MG, IM MR X1 --DC WHEN TAKING PO MEDS, <02/08/04 03:17PM-..>, (02 OF 02), (SMW).
169. LANSOPRAZOLE 30MG CAP, #1,PO, QD, (02/15/04 08AM-..), (SMW).

07:44 AM 02/15/04
ENTERED BY: WACHHORST,SCOTT MD --COMPUTER CODE SIGNATURE--

C 170. XRAY: CT SCAN HEAD, NO CONTRAST, CTH, INDICATION: FOLLOWUP,PRIOR CT EVAL VENTS, VIA: BED, TODAY, (02/15/04), (SMW).

CONTINUED

ORD

DAILY ORDERS SUMMARY

FALK STEVEN M 38 CC11P
828049 F0403800216 ADM: 02/07/04

ORDERS ENTERED 02/13/04 TO 02/14/04

P = PREADMIT(SUSPENDED)
# = INPROCESS
C = COMPLETE

07:36 AM 02/14/04
ENTERED BY: WACHHORST,SCOTT MD --COMPUTER CODE SIGNATURE--

159. OCCUPATIONAL THERAPY: -EVALUATION/TREATMENT IN AREAS OF NEED , <02/14/04>, (SMW).

07:37 AM 02/14/04
ENTERED BY: NG,FANNY SIGNATURE:_____
ENTERED FOR: WACHHORST,SCOTT
--VERBAL ORDER--

160. CHEM-BASIC FASTING TOMORROW AT 6AM, (02/15/04 06AM), (SMW).
161. CBC TOMORROW AT 6AM, (02/15/04 06AM), (SMW).
162. (DC) *VENTRICULOSTOMY DRAIN SET AT 15CM HCO, READ AT TOP OF L EAR, (SMW).
163. *VENTRICULOSTOMY DRAIN SET AT 10 CM H20, READ AT TOP OF L EAR., (SMW).

--ALL SIGNED ORDERS FOR DAY--
NO ORDERS WERE SIGNED FOR DAY

LAST PAGE

ORD

DAILY ORDERS SUMMARY

FALK STEVEN M 38 CC11P
828049 F0403800216 ADM: 02/07/04

ORDERS ENTERED 02/12/04 TO 02/13/04

P = PREADMIT(SUSPENDED)
# = INPROCESS
C = COMPLETE

07:09 AM 02/13/04
ENTERED BY: SUN,CHI-MIN ENTERED FOR: LEE,JANE MD
--WRITTEN ORDER--

C 151. POTASS, STAT, (02/13/04 07:09AM), (JLAC)

08:11 AM 02/13/04
ENTERED BY: TROWBRIDGE,CORNELI SIGNATURE:_____
ENTERED FOR: GREENWALD,RON MD
--VERBAL ORDER--

C 152. CHEM-BASIC NON-FASTING, TODAY, SPEC'M COLLECTED, (02/13/04), (RG).
C 153. CBC, TODAY, SPEC'M COLLECTED, (02/13/04), (RG).
C 154. CEFTRIAXONE 1GM/D5W 50ML, IVPB, INFUSE IN 30 MINUTES, STAT, (02/13/04 08:11AM), (01 OF 02), (RG).
155. CEFTRIAXONE 1GM/D5W 50ML, IVPB, INFUSE IN 30 MINUTES, Q24H, (02/14/04 08AM-..), (02 OF 02), (RG).

09:02 AM 02/13/04
ENTERED BY: PREMIER LAB REFLEX ENTERED FOR: GREENWALD,RONALD
--WRITTEN ORDER--

C 156. MANUAL DIFF.*, LIS#0000234404300001, ENTERED BY:IPP, <02/13/04>, (RG).

11:14 AM 02/13/04
ENTERED BY: TROWBRIDGE,CORNELI SIGNATURE:_____
ENTERED FOR: GREENWALD,RON MD
--VERBAL ORDER--

157. (DC) DIET: FULL LIQUID, (RG).
158. DIET: REGULAR, (RG).

CONTINUED

ORD

FALK STEVEN M 38 CC11P
828049 F0403800216 ADM: 02/07/04

DAILY ORDERS SUMMARY

ORDERS ENTERED 02/11/04 TO 02/12/04

07:14 PM 02/12/04
ENTERED BY: PREMIER LAB REFLEX ENTERED FOR: LEE,JANE I MD
--WRITTEN ORDER--

C 147. MANUAL DIFF.*, LIS#0000234240200001, ENTERED BY:LLN, <02/12/04>, (JLAC)

10:41 PM 02/12/04
ENTERED BY: TAYLOR,LYNN SIGNATURE:_____
ENTERED FOR: GREENWALD,RON MD
--PHONE ORDER--

148. *VENTRICULOSTOMY DRAIN SET AT 15CM HCO, READ AT TOP OF L EAR, (RG).

10:45 PM 02/12/04
ENTERED BY: TAYLOR,LYNN SIGNATURE:_____
ENTERED FOR: GREENWALD,RON MD
--PHONE ORDER--

149. BEDS AND EQUIPMENT: VENODYNE COMP BOOTS, (RG).
150. (DC) SUPPORTS,BINDER: ANTI-EMBOLISM STOCKING, TOES TO THIGH, BILATERAL, (RG).

--ALL SIGNED ORDERS FOR DAY--
NO ORDERS WERE SIGNED FOR DAY

LAST PAGE

ORD

DAILY ORDERS SUMMARY

FALK STEVEN M 38 CC11P
828049 F0403800216 ADM: 02/07/04

ORDERS ENTERED 02/11/04 TO 02/12/04

P = PREADMIT(SUSPENDED)
# = INPROCESS
C = COMPLETE

11:10 AM 02/12/04
ENTERED BY: EASTMAN,SALLY SIGNATURE:_____
ENTERED FOR: GREENWALD,RON MD
--VERBAL ORDER--

139. *CLAMP VENTRICULOSTOMY DRAIN AFTER HEAD CT DONE., (RG).

02:24 PM 02/12/04
ENTERED BY: BREGAR,GINA SIGNATURE:_____
ENTERED FOR: GREENWALD,RON MD
--PHONE ORDER--

140. (DC) *TRANSFER TO TCU--POD 1 IF STABLE AND AFTER APPROVED BY NEUROSURGEON, (RG).
141. (DC) *TRANSFER TO SURG--POD 2 IF STABLE AND AFTER APPROVED BY NEUROSURGEON, (RG).
142. (DC) *CLAMP VENTRICULOSTOMY DRAIN AFTER HEAD CT DONE., (RG).

04:48 PM 02/12/04
ENTERED BY: TAYLOR,LYNN ENTERED FOR: GREENWALD,RON MD
--WRITTEN ORDER--

143. (DC) DIET: CLEAR LIQUID, (RG).
144. DIET: FULL LIQUID, (RG).

06:16 PM 02/12/04
ENTERED BY: TAYLOR,LYNN SIGNATURE:_____
ENTERED FOR: LEE,JANE MD
--VERBAL ORDER--

C 145. CBC, TODAY, (02/12/04), (JLAC)
C 146. CHEM-BASIC NON-FASTING, TODAY, (02/12/04), (JLAC)

CONTINUED

ORD

DAILY ORDERS SUMMARY

FALK STEVEN M 38 CC11P
828049 F0403800216 ADM: 02/07/04

ORDERS ENTERED 02/10/04 TO 02/11/04

(RG).

09:26 PM 02/11/04
ENTERED BY: CAYABYAB,JESSE SIGNATURE:
ENTERED FOR: GREENWALD,RON MD
--PHONE ORDER--

135. (DC) LABETALOL(5MG/ML) INJ 10MG, SLOW IV (OVER 2 MINUTES), Q2H, PRN SBP 150 WHEN HR <90, <02/08/04 03:17PM-..>, (RG).
136. (DC) LABETALOL(5MG/ML) INJ 15MG, SLOW IV, (OVER 2 MINUTES), Q2H, PRN SBP 150 WHEN HR <90, <02/08/04 03:17PM-..>, (RG).
137. LABETALOL(5MG/ML) INJ 10 MG, SLOW IV (OVER 2 MINUTES), Q2H, PRN SBP 150 WHEN HR >90, <02/11/04 09:26PM-..>, (RG).
138. LABETALOL(5MG/ML) INJ 15 MG, SLOW IV (OVER 2 MINUTES), Q2H, PRN SBP 150 WHEN HR >90, <02/11/04 09:26PM-..>, (RG).

--ALL SIGNED ORDERS FOR DAY--
NO ORDERS WERE SIGNED FOR DAY

LAST PAGE

ORD

FALK STEVEN M 38 CC11P
828049 F0403800216 ADM: 02/07/04

DAILY ORDERS SUMMARY

ORDERS ENTERED 02/10/04 TO 02/11/04

P = PREADMIT(SUSPENDED)
# = INPROCESS
C = COMPLETE

06:40 AM 02/11/04
ENTERED BY: DAVIS,LAURIE ENTERED FOR: GREENWALD,RON MD
--WRITTEN ORDER--

127. (DC) OXIMETRY, CONTINUOUS, SET LOW ALARM LIMIT TO 90%, TITRATE FIO2 TO 92% OR GREATER----DC WHEN ON RA, <02/08/04>, (RG).

03:04 PM 02/11/04
ENTERED BY: EASTMAN,SALLY SIGNATURE:_____
ENTERED FOR: GREENWALD,RON MD
--VERBAL ORDER--

128. XRAY: CT SCAN HEAD, NO CONTRAST, CTH, INDICATION: FOLLOWUP,PRIOR CT, VIA: BED, TOMORROW, 02/12/04, <02/11/04>, (RG).
C 129. *DC ARTERIAL LINE., (RG).
130. ACTIVITY, UP AD LIB-WITH ASSISTANCE, (RG).
131. (DC) ACTIVITY, BEDREST--DAY OF SURGERY, (RG).

03:56 PM 02/11/04
ENTERED BY: EASTMAN,SALLY SIGNATURE:_____
ENTERED FOR: GREENWALD,RON MD
--VERBAL ORDER--

132. (DC) *PLEASE KEEP EVD AT 10CM ABOVE MARK ON TIP OF L EAR, (RG).

08:27 PM 02/11/04
ENTERED BY: CAYABYAB,JESSE ENTERED FOR: GREENWALD,RON MD
--WRITTEN ORDER--

133. SALINE (0.9% NACL) FOR PERIPHERAL LOCK/FLUSH, FLUSH WITH 3ML, IV, Q8H, (02/11/04 10PM-..), (01 OF 02), (RG).
134. SALINE (0.9% NACL) FOR PERIPHERAL LOCK/FLUSH, FLUSH WITH 3ML, IV, PRN PATENCY, <02/11/04 08:27PM-..>, (02 OF 02),

CONTINUED

ORD

DAILY ORDERS SUMMARY

FALK STEVEN M 38 **CC11P**
828049 F0403800216 ADM: 02/07/04

ORDERS ENTERED 02/09/04 TO 02/10/04

119*PLEASE KEEP EVD AT 10CM ABOVE MARK ON TIP OF L EAR, (RG).

LAST PAGE

ORD

FALK STEVEN M 38 CC11P
828049 F0403800216 ADM: 02/07/04

DAILY ORDERS SUMMARY

ORDERS ENTERED 02/09/04 TO 02/10/04

P = PREADMIT(SUSPENDED)
# = INPROCESS
C = COMPLETE

12:53 PM 02/10/04
ENTERED BY: EASTMAN,SALLY ENTERED FOR: GREENWALD,RON MD
--WRITTEN ORDER--

123. (DC) DIET: REGULAR, (RG).
124. (DC) DIET: CLEAR LIQUID--(ADVANCE AS TOL) POD 1, (RG).

12:53 PM 02/10/04
ENTERED BY: EASTMAN,SALLY ENTERED FOR: GREENWALD,RON MD
--WRITTEN ORDER--

125. (DC) DIET: NPO-EXC-ICE--DAY OF SURGERY, (RG).

12:54 PM 02/10/04
ENTERED BY: EASTMAN,SALLY ENTERED FOR: GREENWALD,RON MD
--WRITTEN ORDER--

126. DIET: CLEAR LIQUID, (RG).

--ALL SIGNED ORDERS FOR DAY--

COUNTERSIGNED BY: GREENWALD,RON MD
07:43 AM 02/10/04 --COMPUTER CODE SIGNATURE--

115 GABAPENTIN 300MG CAPSULE, #1,PO, TID, (OSD: 02/08/04 08AM), (02/09/04 08AM-..), (RG).
116 CARBAMAZEPINE 200MG TAB, #1,PO, TID, (OSD: 02/08/04 08AM), (02/09/04 08AM-..), (RG).
117GABAPENTIN 300MG CAPSULE, #1,PO, TID, (02/09/04 08AM-..), (RG).
118CARBAMAZEPINE 200MG TAB, #1,PO, TID (8,1,9), (02/08/04 09PM-..), (RG).
110*PLEASE RESTART PT'S USUAL TEGRETOL + NEURONTIN DOSE., (RG).

CONTINUED

ORD

DAILY ORDERS SUMMARY

FALK STEVEN M 38 CC11P
828049 F0403800216 ADM: 02/07/04

ORDERS ENTERED 02/08/04 TO 02/09/04

(DEF).

LAST PAGE

ORD

DAILY ORDERS SUMMARY

FALK STEVEN M 38 CC11P
828049 F0403800216 ADM: 02/07/04

ORDERS ENTERED 02/08/04 TO 02/09/04

P = PREADMIT(SUSPENDED)
# = INPROCESS
C = COMPLETE

11:59 AM 02/09/04
ENTERED BY: COPATH ORDER ENTERED FOR: GREENWALD,RON MD
--WRITTEN ORDER--

120. PATHOLOGY: BLOOD CLOT, COPATH#S04-1353, ENTERED BY:PAMELA* BERAN, <02/09/04>, (RG).

09:33 PM 02/09/04
ENTERED BY: UPADHYAYA,MASKELL ENTERED FOR: GREENWALD,RON MD
--WRITTEN ORDER--

121. IV LINE-START D5/W,500ML W, NITROPRUSSIDE 100MG, CONT TIL DC'D, BP TITRATION RATE; MAINTAIN SYSTOLIC UNDER 150 MMHG *CONT TIL DC'D*....OTHER MISC--WHEN UNRESPONSIVE TO LABETALOL AND/OR HYDRALAZINE, <02/09/04-..>, (RG).
122. 88 (DC) IV LINE-START D5/W,250ML W, NITROPRUSSIDE 50MG, CONT TIL DC'D, BP TITRATION RATE; MAINTAIN SYSTOLIC UNDER 150 MMHG *CONT TIL DC'D*....OTHER MISC--WHEN UNRESPONSIVE TO LABETALOL AND/OR HYDRALAZINE, <02/08/04-..>, (RG).

--ALL SIGNED ORDERS FOR DAY--

COUNTERSIGNED BY: FOX,DAN E MD
01:52 AM 02/09/04 --COMPUTER CODE SIGNATURE--

20ED:PROMETHAZINE 12.5MG, SLOW IV, NOW, (02/07/04 07:34PM), (DEF).
19.
MEDICAL/SURGICAL RESTRAINT, PT ON EMERG....BEGIN DATE/TIME: 02/07/04 6:30PM, END DATE/TIME: 02/08/04 6:00PM....WRIST LEFT....WRIST RIGHT....ANKLE LEFT....ANKLE RIGHT- CLINICAL JUSTIFICATION....PROTECTION OF LINES- CLINICAL JUSTIFICATION....TO PROTECT CONTINUATION OF PROCESSES IMPORTANT FOR PHYSICAL HEALING- CLINICAL JUSTIFICATION.... TO PROTECT THE PATIENT FROM HARM- CLINICAL JUSTIFICATION,

CONTINUED

ORD

FALK STEVEN M 38 CC11P
828049 F0403800216 ADM: 02/07/04

DAILY ORDERS SUMMARY

ORDERS ENTERED 02/07/04 TO 02/08/04

05:04 PM 02/08/04
ENTERED BY: LUONG,KIMSA SIGNATURE:_____
ENTERED FOR: SPEARS,ROBERT MD
--VERBAL ORDER--

C 111. LABETALOL(5MG/ML) INJ 5MG MG, SLOW IV (OVER 2 MINUTES) GIVEN AT 03:20PM, IV, <02/08/04 05:04PM>, (RSAG)
C 112. LABETALOL(5MG/ML) INJ 5 MG, SLOW IV (OVER 2 MINUTES) GIVEN AT 03:30PM, IV, <02/08/04 05:04PM>, (RSAG)
C 113. ENALAPRILAT 1.25MG, IV GIVEN AT 03:45PM, IV, <02/08/04 05:04PM>, (RSAG)
C 114. NIFEDIPINE 10MG CAP--SUBLINGUAL TO MAINTAIN SBP 140. GIVEN AT 03:50PM, <02/08/04 05:04PM>, (RSAG)

05:40 PM 02/08/04
ENTERED BY: SEVERSON,MARY L SIGNATURE:_____
ENTERED FOR: GREENWALD,RON MD
--VERBAL ORDER--

C 115. (RESTART) GABAPENTIN 300MG CAPSULE, #1,PO, TID, (OSD: 02/08/04 08AM), (02/09/04 08AM-..), (RG).
C 116. (RESTART) CARBAMAZEPINE 200MG TAB, #1,PO, TID, (OSD: 02/08/04 08AM), (02/09/04 08AM-..), (RG).

06:27 PM 02/08/04
ENTERED BY: SEVERSON,MARY L SIGNATURE:_____
ENTERED FOR: GREENWALD,RON MD
--VERBAL ORDER--

117. GABAPENTIN 300MG CAPSULE, #1,PO, TID, (02/09/04 08AM-..), (RG).
118. CARBAMAZEPINE 200MG TAB, #1,PO, TID (8,1,9), (02/08/04 09PM-..), (RG).

10:16 PM 02/08/04
ENTERED BY: PICKETT,RAYMOND SIGNATURE:_____
ENTERED FOR: GREENWALD,RON MD
--PHONE ORDER--

119. *PLEASE KEEP EVD AT 10CM ABOVE MARK ON TIP OF L EAR, (RG).

CONTINUED

ORD

FALK STEVEN M 38 CC11P
828049 F0403800216 ADM: 02/07/04

DAILY ORDERS SUMMARY

ORDERS ENTERED 02/07/04 TO 02/08/04

03:17 PM 02/08/04
ENTERED BY: GREENWALD,RON MD --COMPUTER CODE SIGNATURE--

102. OXYGEN THERAPY: INDICATIONS- POST OP; OXYGEN THERAPY ORDER-NASAL CANNULAE 2L/M, PRN, KEEP O2 SAT >94, <02/08/04>, (RG).
103. ATLECTASIS PREVENTION & RX,, DEEP-BREATH INDICATOR WITH ONE DEMO BY THERAPIST: INDICATION- OTHER:POST-OP, <02/08/04>, (RG).
104. NURSING--HAVE PATIENT TAKE 10 DEEP BREATHS Q1H WITH DEEP BREATH INDICATOR WHENEVER POSSIBLE DURING FIRST 48HRS POST-OP, (RG).
105. OXIMETRY, CONTINUOUS, SET LOW ALARM LIMIT TO 90%, TITRATE FIO2 TO 92% OR GREATER----DC WHEN ON RA, <02/08/04>, (RG).
106. WHEN AWAKE AND TAKING DIET CHANGE IV MEDS TO PO AND SALINE LOCK IV, (RG).
C 107. *EVD@ 10CM ABOVE HEAD, (RG).

03:34 PM 02/08/04
ENTERED BY: GREENWALD,RON MD --COMPUTER CODE SIGNATURE--

108. XRAY: CT SCAN HEAD, NO CONTRAST, CTH, INDICATION: HYDROCEPHALUS, INDICATION: FOLLOWUP,PRIOR CT, TOMORROW, 08:00AM, <02/08/04>, (RG).

03:43 PM 02/08/04
ENTERED BY: WONG,REBECCA
--SECONDARY/ADJUSTING ORDER--
109. (CANCEL) CHEST-PORTABLE, .
ORDER #: 5, CANCEL REASON: DUPLICATE PAT. ORDER

04:12 PM 02/08/04
ENTERED BY: LUONG,KIMSA SIGNATURE:_____
ENTERED FOR: GREENWALD,RON MD
--VERBAL ORDER--

110. *PLEASE RESTART PT'S USUAL TEGRETOL + NEURONTIN DOSE., (RG).

CONTINUED

ORD

FALK STEVEN M 38 CC11P
828049 F0403800216 ADM: 02/07/04

DAILY ORDERS SUMMARY

ORDERS ENTERED 02/07/04 TO 02/08/04

).

86. OCCUPATIONAL THERAPY: -EVALUATION/TREATMENT IN AREAS OF NEED , <02/08/04>, (RG).
87. OCCUPATIONAL THERAPY: -ORAL-BULBAR EVALUATION--IF APPROPRIATE POD 1, <02/08/04>, (RG).
88. IV LINE-START D5/W,250ML W, NITROPRUSSIDE 50MG, CONT TIL DC'D, BP TITRATION RATE; MAINTAIN SYSTOLIC UNDER 150 MMHG *CONT TIL DC'D*....OTHER MISC--WHEN UNRESPONSIVE TO LABETALOL AND/OR HYDRALAZINE, <02/08/04-..>, (RG).
89. IV LINE-START 0.9% NACL(NS),1000ML W, KCL 20MEQ, CONT TIL DC'D, 65ML/HR (11/65GTT) *CONT TIL DC'D*, <02/08/04-..>, (RG).
90. HYDROCODONE 5MG & ACETAMINOPHEN 500MG TAB (VICODIN), #1,PO, Q4H, PRN PAIN --HOLD IF NOT FULLY ALERT., <02/08/04 03:16PM-..>, (RG).
91. ACETAMINOPHEN 325MG TAB, #2,PO, Q4H, PRN TEMP >100.5 OR MILD PAIN, <02/08/04 03:16PM-..>, (RG).

03:17 PM 02/08/04
ENTERED BY: GREENWALD,RON MD --COMPUTER CODE SIGNATURE--

92. ACETAMINOPHEN 650MG SUPP, #1,PR, Q4H, PRN TEMP 100.5 OR MILD PAIN, <02/08/04 03:17PM-..>, (RG).
93. LAXATIVE OR BOWEL CARE OF CHOICE, (RG).
94. LABETALOL(5MG/ML) INJ 10MG, SLOW IV (OVER 2 MINUTES), Q2H, PRN SBP 150 WHEN HR <90, <02/08/04 03:17PM-..>, (RG).
95. LABETALOL(5MG/ML) INJ 15MG, SLOW IV, (OVER 2 MINUTES), Q2H, PRN SBP 150 WHEN HR <90, <02/08/04 03:17PM-..>, (RG).
96. HYDRALAZINE 10MG, SLOW IV, Q2H, PRN TO KEEP SBP 150 WHEN HR <90, <02/08/04 03:17PM-..>, (RG).
97. HYDRALAZINE 20MG, SLOW IV, Q2H, PRN TO KEEP SBP 150 WHEN HR <90, <02/08/04 03:17PM-..>, (RG).
98. CODEINE 30MG, IM, Q4H, PRN PAIN, <02/08/04 03:17PM-..>, (01 OF 02), (RG).
99. CODEINE 30MG, IM MR X1 --DC WHEN TAKING PO MEDS, <02/08/04 03:17PM-..>, (02 OF 02), (RG).
100. MORPHINE SULFATE 2MG, SLOW IV, Q1H, PRN PAIN --HOLD FOR RESP RATE 10 AND O2 SAT <92%, <02/08/04 03:17PM-..>, (RG).
101. MORPHINE SULFATE 4MG, SLOW IV, Q2H, PRN PAIN --HOLD FOR RESP RATE 10 AND O2 SAT <92%, <02/08/04 03:17PM-..>, (RG).

CONTINUED

ORD

FALK STEVEN M 38 CC11P
828049 F0403800216 ADM: 02/07/04

DAILY ORDERS SUMMARY

ORDERS ENTERED 02/07/04 TO 02/08/04

P = PREADMIT(SUSPENDED)
# = INPROCESS
C = COMPLETE

03:14 PM 02/08/04
ENTERED BY: GREENWALD,RON MD --COMPUTER CODE SIGNATURE--

67. *PATIENT ON CLINICAL PATH FOR CRANIOTOMY SURGERY POST-OP.., <02/08/04>, (RG).
68. VITAL SIGNS, BP-P-R, NEURO-CK PUPILS, NEURO-CK RESPONSE, NEURO-CK WEAKNESS, NEURO-CK SENSORIUM, Q15M 'TIL STABLE, THEN, Q30M, X4H, THEN, Q1H--WHILE IN CCU, (RG).
69. VITAL SIGNS, BP-P-R, NEURO-CK PUPILS, NEURO-CK RESPONSE, NEURO-CK WEAKNESS, NEURO-CK SENSORIUM, Q4H, POD 1 WHEN TRANSFERRED TO TCU., (RG).
70. VITAL SIGNS, BP-P-R, NEURO-CK PUPILS, NEURO-CK RESPONSE, NEURO-CK WEAKNESS, NEURO-CK SENSORIUM--ROUTINE POST OP DAY 2 WHEN TRANSFERRED TO SURGICAL FLOOR, (RG).
71. VITAL SIGNS, TEMP-ORAL, Q4H, (RG).
72. DIET: NPO-EXC-ICE--DAY OF SURGERY, (RG).
73. DIET: CLEAR LIQUID--(ADVANCE AS TOL) POD 1, (RG).
74. DIET: REGULAR, (RG).
75. DIET: AS TOLERATED, (RG).
76. RECORD I & O, (RG).
77. FOLEY CATH CONNECT TO DRAINAGE, (RG).
78. IF FOLEY CATH INSERTED REMOVE ON POST OP DAY 2, (RG).
79. ACTIVITY, BEDREST--DAY OF SURGERY, (RG).
80. POSITIONING: ELEVATE HD OF BED 30 DEG--UNLESS ORDERED FLAT, (RG).

03:16 PM 02/08/04
ENTERED BY: GREENWALD,RON MD --COMPUTER CODE SIGNATURE--

81. SUPPORTS,BINDER: ANTI-EMBOLISM STOCKING, TOES TO THIGH, BILATERAL, (RG).
82. DRESSINGS--OBSERVE DRESSING Q8H AND WHEN DRESSING REMOVED OBSERVE INCISION Q8H, (RG).
83. *TRANSFER TO TCU--POD 1 IF STABLE AND AFTER APPROVED BY NEUROSURGEON, (RG).
84. *TRANSFER TO SURG--POD 2 IF STABLE AND AFTER APPROVED BY NEUROSURGEON, (RG).
85. PHYSICAL THERAPY: EVALUATE & TREAT--POD 1, <02/08/04>, (RG

CONTINUED

ORD

FALK STEVEN M 48 CC15P
828049 F0403800216 ADM: 02/07/04

DAILY ORDERS SUMMARY

ORDERS ENTERED 02/06/04 TO 02/07/04

09:05 PM 02/07/04
ACTIVATED BY: WOOD,MELANIE
ENTERED BY: GREENWALD,RON MD --COMPUTER CODE SIGNATURE--

51. HYDROCODONE 5MG & ACETAMINOPHEN 500MG TAB (VICODIN), #2,PO, Q4,TO,Q6H, PRN PAIN, <02/07/04 09:05PM-..>, (RG).
52. PROMETHAZINE 25MG, SLOW IV, Q3H, PRN NAUSEA, <02/07/04 09:05PM-..>, (RG).
53. TEGRETOL LEV, <02/07/04>, (RG).
54. DIET: NPO--UNTIL FULLY AWAKE THEN CLEAR LIQUIDS AND ADVANCE AS TOLERATED, (RG).
55. ACTIVITY, BEDREST--WITH HOB UP 20-30DEGREES, (RG).
56. *MAY GIVE PHENERGAN IV,IM, OR PO, (RG).
57. IV LINE-FOLLOW PRESENT IV W D5/.45% NACL,1000ML W, KCL 20MEQ, CONT TIL DC'D, 85ML/HR (14/85GTT) *CONT TIL DC'D*, <02/07/04-..>, (RG).

09:06 PM 02/07/04
ENTERED BY: GREENWALD,RON MD --COMPUTER CODE SIGNATURE--

58. XRAY: CT SCAN HEAD, NO CONTRAST, CTH, INDICATION: FOLLOWUP,PRIOR CT, INDICATION: FOLLOWUP,PRIOR CT, TOMORROW, 08:00AM, <02/07/04>, (RG).

09:37 PM 02/07/04
ENTERED BY: LEE,JANE MD --COMPUTER CODE SIGNATURE--

C 59. CKMB TODAY AT 11PM, (02/07/04 11PM), (JLAC)
C 60. TROPONIN I TODAY AT 11PM, (02/07/04 11PM), (JLAC)
C 61. MYOGLOBIN TODAY AT 11PM, (02/07/04 11PM), (JLAC)
62. CKMB TOMORROW IN AM, (02/08/04), (JLAC)
63. TROPONIN I TOMORROW IN AM, (02/08/04), (JLAC)
64. MYOGLOBIN TOMORROW IN AM, (02/08/04), (JLAC)
65. LORAZEPAM(ATIVAN) 2MG, IV, Q4H, PRN SEIZURE ACTIVITY, <02/07/04 09:37PM-..>, (JLAC)
C 66. LIPID PANEL NON-FAST, SPEC'M COLLECTED, <02/07/04>, (JLAC)

CONTINUED

ORD

FALK STEVEN M 48 CC15P
828049 F0403800216 ADM: 02/07/04

DAILY ORDERS SUMMARY

ORDERS ENTERED 02/06/04 TO 02/07/04

<02/07/04-..>, (DEF).

39. (DC AT END EMERG).
FOLEY CATH, INSERT NOW, CONNECT TO DRAINAGE, (DEF).
40. (DC AT END EMERG) ED:DIPHTHERIA TETANUS TOXOID (ADULT), 0.5ML, IM, NOW, (02/07/04 06:30PM), (DEF).
41. (DC AT END EMERG) ED:DIAZEPAM 10 MG, IV, NOW, (02/07/04 06:30PM), (DEF).
42. (DC AT END EMERG).
MEDICAL/SURGICAL RESTRAINT, PT ON EMERG....BEGIN DATE/TIME: 02/07/04 6:30PM, END DATE/TIME: 02/08/04 6:00PM....WRIST LEFT....WRIST RIGHT....ANKLE LEFT....ANKLE RIGHT- CLINICAL JUSTIFICATION....PROTECTION OF LINES- CLINICAL JUSTIFICATION....TO PROTECT CONTINUATION OF PROCESSES IMPORTANT FOR PHYSICAL HEALING- CLINICAL JUSTIFICATION.... TO PROTECT THE PATIENT FROM HARM- CLINICAL JUSTIFICATION.... EVIDENCE THAT BEHAVIORS ARE DISRUPTIVE TO THE CONTINUATION OF TREATMENT , (DEF).
43. (DC AT END EMERG) ED:PROMETHAZINE 12.5MG, SLOW IV, NOW, (02/07/04 07:34PM), (DEF).

09:05 PM 02/07/04
ACTIVATED BY: WOOD,MELANIE
ENTERED BY: GREENWALD,RON MD --COMPUTER CODE SIGNATURE--

44. ACETAMINOPHEN 650MG SUPP, #1,PR, Q4,TO,Q6H, PRN ., <02/07/04 09:05PM-..>, (RG).
45. CODEINE 30MG, IM, PRN PAIN--(HOLD IF NOT FULLY AWAKE), <02/07/04 09:05PM-..>, (RG).
46. ACETAMINOPHEN 325MG TAB, #1,PO, Q4,TO,Q6H, PRN ., <02/07/04 09:05PM-..>, (RG).
47. ACETAMINOPHEN 325MG TAB, #2,PO, Q4,TO,Q6H, PRN ., <02/07/04 09:05PM-..>, (RG).
48. GABAPENTIN 300MG CAPSULE, #1,PO, TID, (02/08/04 08AM-..), (RG).
49. CARBAMAZEPINE 200MG TAB, #1,PO, TID, (02/08/04 08AM-..), (RG).
50. HYDROCODONE 5MG & ACETAMINOPHEN 500MG TAB (VICODIN), #1,PO, Q4,TO,Q6H, PRN PAIN, <02/07/04 09:05PM-..>, (RG).

CONTINUED

ORD

DAILY ORDERS SUMMARY

FALK STEVEN M 48 CC15P
828049 F0403800216 ADM: 02/07/04

ORDERS ENTERED 02/06/04 TO 02/07/04

06:45 PM 02/07/04
ENTERED BY: FOX,DAN E MD --COMPUTER CODE SIGNATURE--

C 17. DRUG SCRN BLOOD ED PANEL, STAT, (02/07/04 06:45PM), (DEF).
C 18. DRUG SCRN URINE ED PANEL, STAT, (02/07/04 06:45PM), (DEF).

07:18 PM 02/07/04
ENTERED BY: HAYDEN,HEIDI SIGNATURE:_____
ENTERED FOR: FOX,DAN E MD
--VERBAL ORDER--

19. MEDICAL/SURGICAL RESTRAINT, PT ON EMERG....BEGIN DATE/TIME: 02/07/04 6:30PM, END DATE/TIME: 02/08/04 6:00PM....WRIST LEFT....WRIST RIGHT....ANKLE LEFT....ANKLE RIGHT- CLINICAL JUSTIFICATION....PROTECTION OF LINES- CLINICAL JUSTIFICATION....TO PROTECT CONTINUATION OF PROCESSES IMPORTANT FOR PHYSICAL HEALING- CLINICAL JUSTIFICATION.... TO PROTECT THE PATIENT FROM HARM- CLINICAL JUSTIFICATION.... EVIDENCE THAT BEHAVIORS ARE DISRUPTIVE TO THE CONTINUATION OF TREATMENT , (DEF).

07:34 PM 02/07/04
ENTERED BY: FRANDSEN,SHARON A SIGNATURE:_____
ENTERED FOR: FOX,DAN E MD
--VERBAL ORDER--

20. ED:PROMETHAZINE 12.5MG, SLOW IV, NOW, (02/07/04 07:34PM), (DEF).

08:03 PM 02/07/04
ENTERED BY: FOX,DAN E MD --COMPUTER CODE SIGNATURE--

\# 21. EMERG XRAY: CHEST,PORTABLE, CHTPE, STAT/ER, INDICATION: TRAUMA, <02/07/04>, (DEF).

09:02 PM 02/07/04
THE FOLLOWING EMERGENCY DEPT ORDERS WERE
DISCONTINUED WHEN THE PATIENT WAS ADMITTED

36. (DC AT END EMERG).
READY FOR ED REG, (DEF).
37. (DC AT END EMERG) GET OLD CHART, <02/07/04>, (DEF).
38. (DC AT END EMERG) ED: IV LINE-START 0.9% NACL(NS),1000ML, IV BAG, CONT TIL DC'D, KEEP OPEN: 20 ML/HR, *CONT TIL DC'D*,

CONTINUED

ORD

DAILY ORDERS SUMMARY

FALK STEVEN M 48 CC15P
828049 F0403800216 ADM: 02/07/04

ORDERS ENTERED 02/06/04 TO 02/07/04

P = PREADMIT(SUSPENDED)
# = INPROCESS
C = COMPLETE

06:30 PM 02/07/04
ENTERED BY: FOX,DAN E MD --COMPUTER CODE SIGNATURE--

1. READY FOR ED REG, (DEF).
C 2. CBC, BL#:, STAT, (02/07/04 06:30PM), (DEF).
C 3. URINALYSIS, BL#:, STAT, (02/07/04 06:30PM), (DEF).
4. EMERG EKG: STANDARD, STAT, (02/07/04 06:30PM), (DEF).
5. EMERG XRAY: CHEST,PORTABLE, CHTPE, STAT/ER, INDICATION: STROKE, <02/07/04>, (DEF).
6. GET OLD CHART, <02/07/04>, (DEF).
7. ED: IV LINE-START 0.9% NACL(NS),1000ML, IV BAG, CONT TIL DC'D, KEEP OPEN: 20 ML/HR, *CONT TIL DC'D*, <02/07/04-..>, (DEF).
8. EMERG XRAY: CT HEAD, CTH, STAT, INDICATION: STROKE, <02/07/04>, (DEF).
9. FOLEY CATH, INSERT NOW, CONNECT TO DRAINAGE, (DEF).
C 10. CHEM-COMP NON-FASTING, STAT, (02/07/04 06:30PM), (DEF).
C 11. CKMB(STAT), (02/07/04 06:30PM), (DEF).
C 12. TROPONIN-I(STAT), (02/07/04 06:30PM), (DEF).
13. EMERG XRAY: SPINE, CERVICAL AP&LAT, CSP2, STAT/ER, INDICATION: TRAUMA, <02/07/04>, (DEF).
14. ED:DIPHTHERIA TETANUS TOXOID (ADULT), 0.5ML, IM, NOW, (02/07/04 06:30PM), (DEF).
15. ED:DIAZEPAM 10 MG, IV, NOW, (02/07/04 06:30PM), (DEF).

06:42 PM 02/07/04
ENTERED BY: PREMIER LAB REFLEX ENTERED FOR: FOX,DAN E MD
--WRITTEN ORDER--

C 16. MANUAL DIFF.*, LIS#0000233362700001, ENTERED BY:JJN, <02/07/04>, (DEF).

CONTINUED

PRE

FALK STEVEN M 48 **CCX4**
828049 F0403800216 **ADM:** 02/07/04
MD: LEE,JANE MD

PRE ADMISSION SUMMARY

FOLEY CATH, INSERT NOW, CONNECT TO DRAINAGE, (DEF).
40. (DC AT END EMERG) ED:DIPHTHERIA TETANUS TOXOID (ADULT), 0.5ML, IM, NOW, (02/07/04 06:30PM), (DEF).
41. (DC AT END EMERG) ED:DIAZEPAM 10 MG, IV, NOW, (02/07/04 06:30PM), (DEF).
42. (DC AT END EMERG).
MEDICAL/SURGICAL RESTRAINT, PT ON EMERG....BEGIN DATE/TIME: 02/07/04 6:30PM, END DATE/TIME: 02/08/04 6:00PM....WRIST LEFT....WRIST RIGHT....ANKLE LEFT....ANKLE RIGHT- CLINICAL JUSTIFICATION....PROTECTION OF LINES- CLINICAL JUSTIFICATION....TO PROTECT CONTINUATION OF PROCESSES IMPORTANT FOR PHYSICAL HEALING- CLINICAL JUSTIFICATION....TO PROTECT THE PATIENT FROM HARM- CLINICAL JUSTIFICATION.... EVIDENCE THAT BEHAVIORS ARE DISRUPTIVE TO THE CONTINUATION OF TREATMENT , (DEF).
43. (DC AT END EMERG) ED:PROMETHAZINE 12.5MG, SLOW IV, NOW, (02/07/04 07:34PM), (DEF).

NO ORDERS ACTIVATED

CONTINUED

PRE

PRE ADMISSION SUMMARY

FALK STEVEN M 48 **CCX4**
828049 F0403800216 **ADM:** 02/07/04
MD: LEE,JANE MD

07:34 PM 02/07/04 **VERBAL ORDER**
ENTERED BY: FRANDSEN,SHARON A **ENTERED FOR: FOX,DAN E MD**

20. ED:PROMETHAZINE 12.5MG, SLOW IV, NOW, (02/07/04 07:34PM), (DEF).

08:03 PM 02/07/04
ENTERED BY: FOX,DAN E MD --MD COMPUTER-CODE SIGNATURE--

\# 21. EMERG XRAY: CHEST,PORTABLE, CHTPE, STAT/ER, INDICATION: TRAUMA, <02/07/04>, (DEF).

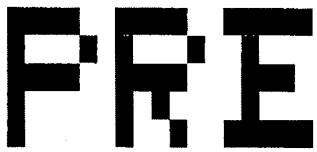
08:44 PM 02/07/04
ENTERED BY: GREENWALD,RON MD --MD COMPUTER-CODE SIGNATURE--

P 22. TEGRETOL LEV, (RG).
P 23. ACTIVITY, BEDREST--WITH HOB UP 20-30DEGREES, (RG).
P 24. ACETAMINOPHEN 650MG SUPP, #1,PR, Q4,TO,Q6H, PRN ., (RG).
P 25. CODEINE 30MG, IM, PRN PAIN--(HOLD IF NOT FULLY AWAKE), (RG).
P 26. ACETAMINOPHEN 325MG TAB, #1,PO, Q4,TO,Q6H, PRN ., (RG).
P 27. ACETAMINOPHEN 325MG TAB, #2,PO, Q4,TO,Q6H, PRN ., (RG).
P 28. IV LINE-FOLLOW PRESENT IV W D5/.45% NACL,1000ML W, KCL 20MEQ *CONT TIL DC'D*, CONT TIL DC'D, 85ML/HR (14/85GTT), (RG).
P 29. GABAPENTIN 300MG CAPSULE, #1,PO, TID, (RG).
P 30. CARBAMAZEPINE 200MG TAB, #1,PO, TID, (RG).
P 31. DIET: NPO--UNTIL FULLY AWAKE THEN CLEAR LIQUIDS AND ADVANCE AS TOLERATED, (RG).
P 32. HYDROCODONE 5MG & ACETAMINOPHEN 500MG TAB (VICODIN), #1,PO, Q4,TO,Q6H, PRN PAIN, (RG).
P 33. HYDROCODONE 5MG & ACETAMINOPHEN 500MG TAB (VICODIN), #2,PO, Q4,TO,Q6H, PRN PAIN, (RG).
P 34. PROMETHAZINE 25MG, SLOW IV, Q3H, PRN NAUSEA, (RG).
P 35. *MAY GIVE PHENERGAN IV,IM, OR PO, (RG).

09:02 PM 02/07/04 **THE FOLLOWING EMERGENCY DEPT ORDERS WERE DISCONTINUED WHEN THE PATIENT WAS ADMITTED**

36. (DC AT END EMERG).
READY FOR ED REG, (DEF).
37. (DC AT END EMERG) GET OLD CHART, <02/07/04>, (DEF).
38. (DC AT END EMERG) ED: IV LINE-START 0.9% NACL(NS),1000ML, IV BAG, CONT TIL DC'D, KEEP OPEN: 20 ML/HR, *CONT TIL DC'D*, <02/07/04-..>, (DEF).
39. (DC AT END EMERG).

CONTINUED



PRE ADMISSION SUMMARY

FALK STEVEN M 48 **CCX4**
828049 F0403800216 **ADM:** 02/07/04
MD: LEE,JANE MD

PRE-ADMIT ORDERS:

P = PREADMIT(SUSPENDED)
\# = INPROCESS
C = COMPLETED

06:30 PM 02/07/04
ENTERED BY: FOX,DAN E MD --MD COMPUTER-CODE SIGNATURE--

1. READY FOR ED REG, (DEF).
C 2. CBC, BL#:, STAT, (02/07/04 06:30PM), (DEF).
3. URINALYSIS, BL#:, STAT, (02/07/04 06:30PM), (DEF).
4. EMERG EKG: STANDARD, STAT, (02/07/04 06:30PM), (DEF).
5. EMERG XRAY: CHEST,PORTABLE, CHTPE, STAT/ER, INDICATION: STROKE, <02/07/04>, (DEF).
6. GET OLD CHART, <02/07/04>, (DEF).
7. ED: IV LINE-START 0.9% NACL(NS),1000ML, IV BAG, CONT TIL DC'D, KEEP OPEN: 20 ML/HR, *CONT TIL DC'D*, <02/07/04-..>, (DEF).
\# 8. EMERG XRAY: CT HEAD, CTH, STAT, INDICATION: STROKE, <02/07/04>, (DEF).
9. FOLEY CATH, INSERT NOW, CONNECT TO DRAINAGE, (DEF).
C 10. CHEM-COMP NON-FASTING, STAT, (02/07/04 06:30PM), (DEF).
C 11. CKMB(STAT), (02/07/04 06:30PM), (DEF).
C 12. TROPONIN-I(STAT), (02/07/04 06:30PM), (DEF).
13. EMERG XRAY: SPINE, CERVICAL AP&LAT, CSP2, STAT/ER, INDICATION: TRAUMA, <02/07/04>, (DEF).
14. ED:DIPHTHERIA TETANUS TOXOID (ADULT), 0.5ML, IM, NOW, (02/07/04 06:30PM), (DEF).
15. ED:DIAZEPAM 10 MG, IV, NOW, (02/07/04 06:30PM), (DEF).

06:42 PM 02/07/04 SIGNED ORDER
ENTERED BY: PREMIER LAB REFLEX ENTERED FOR: FOX,DAN E MD

C 16. MANUAL DIFF.*, LIS#0000233362700001, ENTERED BY:JJN, <02/07/04>, (DEF).

06:45 PM 02/07/04
ENTERED BY: FOX,DAN E MD --MD COMPUTER-CODE SIGNATURE--

C 17. DRUG SCRN BLOOD ED PANEL, STAT, (02/07/04 06:45PM), (DEF).
18. DRUG SCRN URINE ED PANEL, STAT, (02/07/04 06:45PM), (DEF).

CONTINUED

PRE

PRE ADMISSION SUMMARY

FALK STEVEN M 48 **CCX4**
828049 F0403800216 **ADM:** 02/07/04
MD: LEE,JANE MD

ORDERS STILL REQUIRING ACTIVATION:

P 22. TEGRETOL LEV, (RG).

P 23. ACTIVITY, BEDREST--WITH HOB UP 20-30DEGREES, (RG).

P 24. ACETAMINOPHEN 650MG SUPP, #1,PR, Q4,TO,Q6H, PRN ., (RG).

P 25. CODEINE 30MG, IM, PRN PAIN--(HOLD IF NOT FULLY AWAKE), (RG).

P 26. ACETAMINOPHEN 325MG TAB, #1,PO, Q4,TO,Q6H, PRN ., (RG).

P 27. ACETAMINOPHEN 325MG TAB, #2,PO, Q4,TO,Q6H, PRN ., (RG).

P 28. IV LINE-FOLLOW PRESENT IV W D5/.45% NACL,1000ML W, KCL 20MEQ *CONT TIL DC'D*, CONT TIL DC'D, 85ML/HR (14/85GTT), (RG).

P 29. GABAPENTIN 300MG CAPSULE, #1,PO, TID, (RG).

P 30. CARBAMAZEPINE 200MG TAB, #1,PO, TID, (RG).

P 31. DIET: NPO--UNTIL FULLY AWAKE THEN CLEAR LIQUIDS AND ADVANCE AS TOLERATED, (RG).

P 32. HYDROCODONE 5MG & ACETAMINOPHEN 500MG TAB (VICODIN), #1,PO, Q4,TO,Q6H, PRN PAIN, (RG).

P 33. HYDROCODONE 5MG & ACETAMINOPHEN 500MG TAB (VICODIN), #2,PO, Q4,TO,Q6H, PRN PAIN, (RG).

P 34. PROMETHAZINE 25MG, SLOW IV, Q3H, PRN NAUSEA, (RG).

P 35. *MAY GIVE PHENERGAN IV,IM, OR PO, (RG).

CONTINUED

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

SUMMARY MEDICAL CARE PLAN

ADVANCE DIRECTIVE:N ACCOM CODE: 2

DIAGNOSIS:
PRINCIPAL DX-.
EPIDURAL HEMATOMA 852.40
CLINICAL PATH: CRANIOTOMY SURGERY POST-OP..
PROCEDURE: CRANIOTOMY WITH EVACUATION OF HEMATOMA: EPIDURAL ..61310 01.24
02-08-04:CRANIOTOMY,EVACUATION OF OCCIPITAL EPIDURAL BLEED,INSERTION OF VENTRICULOSTOMY BY DR GREENWALD

ALLERGIES:
02/08/04 MED ALLERGY: NONE KNOWN

PATIENT ADMISSION DATA:

02/08	ADMISSION DATA....TYPE OF ADMISSION: EMERGENCY.... ADMITTED PER GURNEY	MMND
02/08	PRESENTING SIGNS & SYMPTOMS -GRAND MAL SEIZURE (UNKNOWN TIME); 2ND SZ X2 MINS, POST ICTAL AND THEN COMBATIVE WITNWSSWD SZ IN ER. FELL AFTER FIRST SZ, LACERATION TO BACK OF HEAD; ICE/DRSNG TO HEAD	MMND
02/08	PATIENT'S DESIRE FOR TREATMENT --ACCEPTING	MMND
02/08	SKIN INTEGRITY: ALL BONY PROMINENCES HAVE BEEN ASSESSED ....YES, SKIN INTACT	MMND
02/08	EXPECTED LENGTH OF STAY- UNKNOWN	MMND
02/08	PAST/EXISTING MEDICAL PROB/SURGERIES HX SZ DISORDER, HERNIATED DISC, R SHOULDER SURGERY NOV 2003. MVA.	MMND
02/08	MEDS TAKEN AT HOME....PRESCRIPTION--NEURONTIN, CARBETROL, PROZAC,....HERBS/VITAMINS/SUPPLEMENTS--MULTIVIT.... OVER THE COUNTER--VITS....MEDS TAKEN TODAY--AS ABOVE	MMND
02/08	CAFFEINE INTAKE OF 2 CUPS/DAY	MMND
02/08	PATIENT'S DESCRIPTION OF ALCOHOL/DRUG USE--HAS BEEN TO REHAB; GOES TO AA	MMND
02/08	CURRENTLY SMOKING, AMOUNT NONE	MMND
02/08	COGNITIVE/PERCEPTUAL....HEARING NORMAL, BOTH....VISION NORMAL, BOTH....HX OF CONFUSION W/PRIOR HOSPITALIZAT'N NO	MMND
02/08	LEVEL OF CONSCIOUSNESS: DISORIENTED/OTHER....ORIENTED TO PERSON PLACE....SPEECH SOUNDS CLEAR ANSWERS QUESTIONS W/APPROPRIATE USE OF "YES" AND "NO".... MOTOR RESPONSE: WITHDRAWS EXTREMITIES TO PAINFUL STIMULI....MOTOR RESPONSE: FOLLOWS COMMANDS WITHOUT PROMPTING....MOTOR RESPONSE: LIMB STRENGTH: BOTH HAND(S) NORMAL POWER....GAIT PROBLEM....BEHAVIOR APPROPRIATE TO SITUATION	MMND
02/08	RELIGIOUS/CULTURAL BELIEFS THAT WOULD AFFECT HOSPITAL	

CONTINUED

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

SUMMARY MEDICAL CARE PLAN

	STAY--NONE	MMND
02/08	INFORMATION COLLECTED BY: HISTORY--FROM CHART	MMND
02/08	INFORMATION COLLECTED BY: ASSESSMENT--P UPADHYAYA, RN	MMND
02/08	PRIMARY CAREGIVER....NAME: BRIAN KANTER, REL:FR....PH HM: 650/556-9891....WK: 650/6386765....AVAILABLE TO COME TO HOSPITAL PRIOR TO DISCHARGE FOR INSTRUCTIONS?- YES, HOURS AVAILABLE: ANYTIME --CELL NO. 650-464-3781	MMND
02/08	BELONGINGS IN HOSPITAL	MMND
02/08	ADMIT VITAL SIGNS & STATS....96.1 (T-O), 96 REGULAR (P-A), 14 (RESP), 140/85 LYING (BP-L/A)	MMND
02/08	HT:6FT,2IN	MMND
02/08	WT:81.9KG, RIGHT HANDED	MMND
02/08	HAVE YOU SMOKED A CIGARETTE IN THE PAST YEAR....NO	MMND
02/08	NO - PATIENT DOES NOT HAVE ADVANCE DIRECTIVE - REFUSES INFORMATION AT THIS TIME	MMND

PLAN OF CARE:

02/08	PROBLEM #1: NURSING --POTENTIAL INJURY R/T SEIZURES			MMND
	DESIRED OUTCOMES:	LOS:	DD:	
02/18	NO INJURY CHG DD:	5 DAY	02/25	JPAI
	PLAN:			
02/08	FOLLOW SZ PROTOCOL			MMND
02/08	PROBLEM #2: NURSING --PAIN R/T HEAD TRAUMA			MMND
	DESIRED OUTCOMES:	LOS:	DD:	
02/18	PAIN RELIEVED CHG DD:	5 DAY	02/25	JPAI
	PLAN:			
02/08	MONITOR, ASSESS, HYDRATE AND MEDICATE,			MMND
02/09	PROBLEM #3: PHYS MED --DECREASED FUNCTIONAL MOBILITY			GPG
	DESIRED OUTCOMES:	LOS:	DD:	
02/18	PATIENT WILL BE ABLE TO TRANSFER BED-CHAIR, AMBULATE WITH SUPERVISION CHG DD:	7 DAY	02/25	JPAI
	PLAN:			
02/09	PT DAILY FOR UE, LE EXERCISES, PROGRESS TO TRANSFERS AND GAIT TRAINING WHEN OFF BEDREST ORDERS			GPG
02/11	PROBLEM #4: NUTRITION --POTENTIAL NUTRITIONAL RISK R/T INADEQUATE NUTRITION X 4DAYS			BFAD
02/13	PROBLEM #4: NUTRITION --POTENTIAL NUTRITIONAL RISK R/T INADEQUATE NUTRITION X 4DAYS (COMPLETE)			KJS
	DESIRED OUTCOMES:	LOS:	DD:	

CONTINUED

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

SUMMARY MEDICAL CARE PLAN

02/11	PT ABLE TO TOLERATE ADVANCED P.O. DIET BY 2/13/04 CHG DD:	5DAYS	02/18	ICNC
PLAN:				
02/11	RECOMMEND NUTRITION SUPPORT IF PT UNABLE TO TOLERATE ADVANCED P.O. DIET BY 2/13/04			BFAD
02/11	PROBLEM #5: NUTRITION --DVT PROPHYLAXIS			ICNC
DESIRED OUTCOMES:		LOS:	DD:	
02/18	PREVENT DVT CHG DD:	7D	02/25	JPAI
PLAN:				
02/11	APPLY SCD AS PRESCRIBED BY MD			ICNC
02/13	PROBLEM #6: NUTRITION --POTENTIAL RISK R/T TRANSITIONING TO PO DIET (WAS NPO X4 DAYS)			KJS
DESIRED OUTCOMES:		LOS:	DD:	
02/18	PO WILL CONTINUE TO MEET STANDARD OF 75% OR GREATER CHG DD:	7D	02/25	JPAI
PLAN:				
02/13	CATER TO FOOD PREFERENCES, ENCOURAGE ADEQUATE INTAKE, MONITOR PROGRESS			KJS

DISCHARGE PLAN:

02/22	DISCH TO HOME	KM

UNIVERSAL DATA:

02/08/04	ADVANCE DIRECTIVE...NO - PATIENT DOES NOT HAVE ADVANCE DIRECTIVE - REFUSES INFORMATION AT THIS TIME	MMND
02/07/04	RELIGION: UNKN	HBOC
02/08/04	EMERG CONTACT: FALK BOB...RELATIONSHIP: FA	HBOC
02/08/04	HOME PHONE: 615/352-4080	HBOC
02/08/04	WORK PHONE: 650/638-6765 --(650)464-3781 CELL	MMND

PT TEACHING ASSESSMENT:

02/08	TEACHING DEFERRED: MEDICAL CONDITION: SEVERITY OF ILLNESS PREVENTS TEACHING AT THIS TIME	MMND

PATIENT TEACHING DATA:

NURSING		
02/22	HOME CARE INSTRUCTION BOOKLET/ SURGERY GIVEN TO PATIENT	WC
PHYSICAL MEDICINE		
02/14	PT INSTRUCTED IN JOINT PRECAUTIONS	KAWA

CONTINUED

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                                        XXX  X  X X     X     XXX XXXX
                                       X     X  X XX   XX    X    X   X
==================================     XXX  X  X X X X X    X    XXXX
FALK STEVEN                 M 38 523A     X X  X X  X  X    X    X
 828049   F0403800216 ADM: 02/07/04 M.S  XXX   XX  X     X     XXX X
   LEE,JANE MD                          ================================
CARE COORDINATOR: JOAN SANTANA            SUMMARY MEDICAL CARE PLAN
================================================================================

  02/14  PT INSTRUCTED IN POSITIONING IN BED                              KAWA
  02/14  PT INSTRUCTED IN ENERGY CONSERVATION TECHNIQUES                  KAWA

  MISC PT DATA & POSS. PROBLEMS:
  02/08  --ADDITIONAL SUPPORT: BRIAN KANTER; CELL PH (650)464-3781;
              HM PH (650)556-9891; WK PH(650)638-6765                     MMND
  02/20  TRANSFERRED FROM CCU TO 5E                                       SRHB
  02/20  SUMMARY--PT TRANSFERRED SELF FROM BED TO GURNEY WITHOUT
              DIFFICULTY STRONG GAIT;DENIES HA;LAST PAIN MEDS 4PM;
              NO NEURO DEFICITS NOTED;                                    SRHB
  02/20  PATIENT/FAMILY INSTRUCTED REGARDING:  --MOTHER AT BEDSIDE        SRHB

  BASIC CARE NEEDS:
  02/08  FALL RISK ASSESSMENT: MENTAL STATUS LIMITATIONS                  MMND
  02/08  FALL RISK ASSESSMENT: THUD II                                    MMND
  02/08  BRADEN SCALE SCORE: 8.                                           MMND
  02/08  ACTIVITY: BEDREST                                                MMND
  02/08  BED BATH COMPLETE                                                MMND
  02/08  BED CHANGE OCCUPIED                                              MMND
  02/08  IV INSERTED 02/07, 05:30PM                                       MMND
  02/08  ADDITIONAL PERIPHERAL LINE INFO --L AC                           MMND
  02/08  IV INSERTED 02/07, 06:10PM                                       MMND
  02/08  IV TUBING CHNG'D 02/01, 09:10PM                                  MMND
  02/08  ADDITIONAL PERIPHERAL LINE INFO --R AC                           MMND
  02/08  ELIMINATION: URINAL                                              MMND
  02/11  IV TUBING CHNG'D 02/11, 10:00AM                                  ICNA
  02/11  ADDITIONAL PERIPHERAL LINE INFO --MAINTENANCE IVF LINE.          ICNA
  02/11  MULTI-DISC PLAN OF CARE REVIEW....DATE: 02/11/04 09:30AM,
              TEAM MEMBERS:, RN, CNS, MSW, DIETICIAN, CARE COORD,
              CLINICAL MGR, PHARMACY, PROBLEM LIST REVIEWED:
              UPDATES ENTERED IN MIS                                      ICNC
  02/13  IV TUBING CHNG'D 02/01, 09:10PM (COMPLETE)                        MON
  02/13  ADDITIONAL PERIPHERAL LINE INFO --R AC (COMPLETE)                 MON
  02/16  BED BATH COMPLETE (COMPLETE)                                      MON
  02/16  ELIMINATION: URINAL (COMPLETE)                                    MON
  02/16  IV TUBING CHNG'D 02/11, 10:00AM (COMPLETE)                        MON
  02/16  ADDITIONAL PERIPHERAL LINE INFO --MAINTENANCE IVF LINE.
              (COMPLETE)                                                   MON
  02/16  BED BATH WITH ASSISTANCE                                          MON
  02/16  HAS FOLEY CATH                                                    MON
  02/16  IV TUBING CHNG'D 2/16, 8:00AM                                     MON
  02/16  ADDITIONAL PERIPHERAL LINE INFO --L AC (COMPLETE)                 SRK
  02/16  IV INSERTED 02/07, 06:10PM (COMPLETE)                             SRK
  02/16  IV INSERTED 02/06, 10:00P                                         SRK
  02/17  IV INSERTED 02/07, 05:30PM (COMPLETE)                             MON
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                                        XXX  X  X X     X     XXX XXXX
                                       X     X  X XX   XX    X    X   X
==================================     XXX  X  X X X X X    X    XXXX
FALK STEVEN                 M 38 523A      X X  X X  X  X    X    X
 828049   F0403800216 ADM: 02/07/04 M.S  XXX   XX  X     X     XXX X
   LEE,JANE MD                          ================================
CARE COORDINATOR: JOAN SANTANA            SUMMARY MEDICAL CARE PLAN
================================================================================
  02/17  IV INSERTED 02/06, 10:00P (COMPLETE)                              MON
  02/17  IV INSERTED 2/16, 10:00AM                                         MON
  02/18  MULTI-DISC PLAN OF CARE REVIEW....DATE: 02/18/04 09:3A M,
              TEAM MEMBERS:, RN, CNS, MSW, DIETICIAN, CARE COORD,
              CLINICAL MGR, PHARMACY INFECTION CONTROL, PROBLEM
              LIST REVIEWED: UPDATES ENTERED IN MIS                        JPAI
  02/19  BED BATH WITH ASSISTANCE (COMPLETE)                               RNAJ
  02/19  HAS FOLEY CATH (COMPLETE)                                         RNAJ
  02/19  IV TUBING CHNG'D 2/16, 8:00AM (COMPLETE)                          RNAJ
  02/08  ADMIT HT:6FT,2IN                                                  MMND
  02/08  ADMIT WT:81.9KG, RIGHT HANDED                                     MMND
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LAST PAGE

FALK STEVEN M 38 **523A**
828049 F0403800216 **ADM:** 02/07/04 M.S
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

MULTIDISCIPLINARY CARE PLAN

DIAGNOSIS:
PRINCIPAL DX-.
EPIDURAL HEMATOMA 852.40
CLINICAL PATH: CRANIOTOMY SURGERY POST-OP..
PROCEDURE: CRANIOTOMY WITH EVACUATION OF HEMATOMA: EPIDURAL ..61310 01.24
02-08-04:CRANIOTOMY,EVACUATION OF OCCIPITAL EPIDURAL BLEED,INSERTION OF VENTRICULOSTOMY BY DR GREENWALD

ALLERGIES:
02/08/04 MED ALLERGY: NONE KNOWN

PLAN OF CARE REVIEW
02/11 MULTI-DISC PLAN OF CARE REVIEW DATE: 02/11/04 09:30AM
TEAM MEMBERS: RN CNS MSW DIETICIAN CARE COORD
CLINICAL MGR PHARMACY PROBLEM LIST REVIEWED: UPDATES
ENTERED IN MIS ICNC

02/18 MULTI-DISC PLAN OF CARE REVIEW DATE: 02/18/04 09:3A M
TEAM MEMBERS: RN CNS MSW DIETICIAN CARE COORD
CLINICAL MGR PHARMACY INFECTION CONTROL PROBLEM LIST
REVIEWED: UPDATES ENTERED IN MIS JPAI

PLAN OF CARE:

02/08 **PROBLEM #1: NURSING --POTENTIAL INJURY R/T SEIZURES** **MMND**
DESIRED OUTCOMES: **LOS: DD:**
02/18 NO INJURY CHG DD: 5 DAY 02/25 JPAI
PLAN:
02/08 FOLLOW SZ PROTOCOL

02/08 **PROBLEM #2: NURSING --PAIN R/T HEAD TRAUMA** **MMND**
DESIRED OUTCOMES: **LOS: DD:**
02/18 PAIN RELIEVED CHG DD: 5 DAY 02/25 JPAI
PLAN:
02/08 MONITOR, ASSESS, HYDRATE AND MEDICATE,

02/09 **PROBLEM #3: PHYS MED --DECREASED FUNCTIONAL MOBILITY** **GPG**
DESIRED OUTCOMES: **LOS: DD:**
02/18 PATIENT WILL BE ABLE TO TRANSFER
BED-CHAIR, AMBULATE WITH SUPERVISION CHG
DD: 7 DAY 02/25 JPAI
PLAN:
02/09 PT DAILY FOR UE, LE EXERCISES, PROGRESS TO TRANSFERS
AND GAIT TRAINING WHEN OFF BEDREST ORDERS

02/11 **PROBLEM #4: NUTRITION --POTENTIAL NUTRITIONAL RISK R/T INADEQUATE NUTRITION X 4DAYS** **BFAD**

CONTINUED

FALK STEVEN M 38 **523A**
828049 F0403800216 **ADM:** 02/07/04 M.S
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

MULTIDISCIPLINARY CARE PLAN

02/13 **PROBLEM #4: NUTRITION --POTENTIAL NUTRITIONAL RISK R/T INADEQUATE NUTRITION X 4DAYS (COMPLETE)** KJS

		LOS:	DD:	
DESIRED OUTCOMES:				
02/11	PT ABLE TO TOLERATE ADVANCED P.O. DIET BY 2/13/04 CHG DD:	5DAYS	02/18	ICNC

PLAN:
02/11 RECOMMEND NUTRITION SUPPORT IF PT UNABLE TO TOLERATE ADVANCED P.O. DIET BY 2/13/04

02/11 **PROBLEM #5: NURSING --DVT PROPHYLAXIS** ICNC

		LOS:	DD:	
DESIRED OUTCOMES:				
02/18	PREVENT DVT CHG DD:	7D	02/25	JPAI

PLAN:
02/11 APPLY SCD AS PRESCRIBED BY MD

02/13 **PROBLEM #6: NUTRITION --POTENTIAL RISK R/T TRANSITIONING TO PO DIET (WAS NPO X4 DAYS)** KJS

		LOS:	DD:	
DESIRED OUTCOMES:				
02/18	PO WILL CONTINUE TO MEET STANDARD OF 75% OR GREATER CHG DD:	7D	02/25	JPAI

PLAN:
02/13 CATER TO FOOD PREFERENCES, ENCOURAGE ADEQUATE INTAKE, MONITOR PROGRESS

PT TEACHING ASSESSMENT:
02/08 TEACHING DEFERRED: MEDICAL CONDITION: SEVERITY OF ILLNESS PREVENTS TEACHING AT THIS TIME MMND

PHYSICAL MEDICINE
02/14 PT INSTRUCTED IN JOINT PRECAUTIONS KAWA
02/14 PT INSTRUCTED IN POSITIONING IN BED KAWA
02/14 PT INSTRUCTED IN ENERGY CONSERVATION TECHNIQUES KAWA

BASIC CARE NEEDS:
02/08 FALL RISK ASSESSMENT: MENTAL STATUS LIMITATIONS MMND
02/08 ACTIVITY: BEDREST MMND
02/08 BED BATH COMPLETE MMND
02/08 BED CHANGE OCCUPIED MMND
02/08 ELIMINATION: URINAL MMND
02/16 BED BATH COMPLETE (COMPLETE) MON
02/16 ELIMINATION: URINAL (COMPLETE) MON
02/16 BED BATH WITH ASSISTANCE MON
02/16 HAS FOLEY CATH MON
02/19 BED BATH WITH ASSISTANCE (COMPLETE) RNAJ
02/19 HAS FOLEY CATH (COMPLETE) RNAJ
02/08 FALL RISK ASSESSMENT: THUD II MMND
02/08 ADMIT HT:6FT,2IN MMND
02/08 ADMIT WT:81.9KG, RIGHT HANDED MMND

CONTINUED

FALK STEVEN M 38 **523A**
828049 F0403800216 **ADM:** 02/07/04 M.S
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

MULTIDISCIPLINARY CARE PLAN

UNIVERSAL DATA:

02/08/04	ADVANCE DIRECTIVE...NO - PATIENT DOES NOT HAVE ADVANCE DIRECTIVE - REFUSES INFORMATION AT THIS TIME	MMND
02/07/04	RELIGION: UNKN	HBOC
02/08/04	EMERG CONTACT: FALK BOB...RELATIONSHIP: FA	
02/08/04	HOME PHONE: 615/352-4080	HBOC
02/08/04	WORK PHONE: 650/638-6765 --(650)464-3781 CELL	MMND

PATIENT ADMISSION DATA:

02/08	ADMISSION DATA....TYPE OF ADMISSION: EMERGENCY.... ADMITTED PER GURNEY	MMND
02/08	ADMIT VITAL SIGNS & STATS....96.1 (T-O), 96 REGULAR (P-A), 14 (RESP), 140/85 LYING (BP-L/A)	MMND
02/08	HT:6FT,2IN	MMND
02/08	WT:81.9KG, RIGHT HANDED	MMND
02/08	NO - PATIENT DOES NOT HAVE ADVANCE DIRECTIVE - REFUSES INFORMATION AT THIS TIME	MMND
02/08	NUTRITIONAL NEEDS ASSESSED, NO NEEDS IDENTIFIED	MMND
02/08	PRESENTING SIGNS & SYMPTOMS -GRAND MAL SEIZURE (UNKNOWN TIME); 2ND SZ X2 MINS, POST ICTAL AND THEN COMBATIVE WITNWSSWD SZ IN ER. FELL AFTER FIRST SZ, LACERATION TO BACK OF HEAD; ICE/DRSNG TO HEAD	MMND
02/08	PATIENT'S DESIRE FOR TREATMENT --ACCEPTING	MMND
02/08	SKIN INTEGRITY: ALL BONY PROMINENCES HAVE BEEN ASSESSED ....YES, SKIN INTACT	MMND
02/08	EXPECTED LENGTH OF STAY- UNKNOWN	MMND
02/08	PAST/EXISTING MEDICAL PROB/SURGERIES HX SZ DISORDER, HERNIATED DISC, R SHOULDER SURGERY NOV 2003. MVA.	MMND
02/08	MEDS TAKEN AT HOME....PRESCRIPTION--NEURONTIN, CARBETROL, PROZAC,....HERBS/VITAMINS/SUPPLEMENTS--MULTIVIT.... OVER THE COUNTER--VITS....MEDS TAKEN TODAY--AS ABOVE	MMND
02/08	CAFFEINE INTAKE OF 2 CUPS/DAY	MMND
02/08	PATIENT'S DESCRIPTION OF ALCOHOL/DRUG USE--HAS BEEN TO REHAB; GOES TO AA	MMND
02/08	HAVE YOU SMOKED A CIGARETTE IN THE PAST YEAR....NO	MMND
02/08	CURRENTLY SMOKING, AMOUNT NONE	MMND
02/08	COGNITIVE/PERCEPTUAL....HEARING NORMAL, BOTH....VISION NORMAL, BOTH....HX OF CONFUSION W/PRIOR HOSPITALIZAT'N NO	MMND
02/08	LEVEL OF CONSCIOUSNESS: DISORIENTED/OTHER....ORIENTED TO PERSON PLACE....SPEECH SOUNDS CLEAR ANSWERS QUESTIONS W/APPROPRIATE USE OF "YES" AND "NO".... MOTOR RESPONSE: WITHDRAWS EXTREMITIES TO PAINFUL STIMULI....MOTOR RESPONSE: FOLLOWS COMMANDS WITHOUT PROMPTING....MOTOR RESPONSE: LIMB STRENGTH: BOTH HAND(S) NORMAL POWER....GAIT PROBLEM....BEHAVIOR APPROPRIATE TO SITUATION	MMND

CONTINUED

FALK STEVEN M 38 **523A**
828049 F0403800216 **ADM:** 02/07/04 M.S
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

MULTIDISCIPLINARY CARE PLAN

02/08	RELIGIOUS/CULTURAL BELIEFS THAT WOULD AFFECT HOSPITAL STAY--NONE	MMND
02/08	PSYCHOSOCIAL ASSESSMENT....LIVES W/ROOMMATE	MMND
02/08	PRIOR TO HOSPITALIZATION FUNCTIONAL ASSESSMENT INDEPENDENT IN ADLS....USUAL PHYSICAL ACTIVITY PRIOR TO THIS HOSPITALIZATION- ENERGY LEVEL LOW....CHEST PAIN OR SOB WITH EXERTION- NO	MMND
02/08	BELONGINGS IN HOSPITAL	MMND
02/08	INFORMATION COLLECTED BY: HISTORY--FROM CHART	MMND
02/08	INFORMATION COLLECTED BY: ASSESSMENT--P UPADHYAYA, RN	MMND
02/08	PRIMARY CAREGIVER....NAME: BRIAN KANTER, REL:FR....PH HM: 650/556-9891....WK: 650/6386765....AVAILABLE TO COME TO HOSPITAL PRIOR TO DISCHARGE FOR INSTRUCTIONS?- YES, HOURS AVAILABLE: ANYTIME --CELL NO. 650-464-3781	MMND

LAST PAGE

X X XXXX
XX X X X
X X X XXXX XXXX
X XX X X
X X X X
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==========
FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA
==========

DISCHARGE REPORT
==========

DATA ENTERED DURING: 02/21 11:59 PM TO 11:59 PM 02/22

==========

MEDICATIONS:

GABAPENTIN 300MG CAPSULE
02/22 08:00AM #1,PO,GIV WC
02/22 01:00PM #1,PO,NOT GIV,BECAUSE,DISCHARGED WC
CARBAMAZEPINE 200MG TAB
02/22 08:00AM #1,PO,GIV WC
02/22 01:00PM #1,PO,NOT GIV,BECAUSE,DISCHARGED WC
SALINE (0.9% NACL) FOR PERIPHERAL LOCK/FLUSH
02/22 06:00AM FLUSH WITH 3ML,GIV,SALINE LOCK LRA
HYDROCODONE 10MG & APAP 325MG TABLET
02/22 12:00MN #1,PO,GIV,(NORCO),--PO,FOR,INC PAIN,--BACK OF HEAD,(PATIENT'S RATING OF LEVEL OF PAIN:), LEVEL 7 LRA
02/22 08:00AM #1,PO,GIV,(NORCO),FOR,INC PAIN,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 7 WC
LANSOPRAZOLE 30MG CAP
02/22 08:00AM #1,PO,GIV WC
DOCUSATE SODIUM 250MG CAP
02/22 08:00AM ,GIV WC

LAST PAGE

N-R
NURSING RECORDS

FALK STEVEN M 38 523A
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/21 07:15 AM TO 07:15 AM 02/22

MEDICATIONS:

MORPHINE SULFATE 4MG
02/21 08:00AM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,ACTUAL DOSE GIVEN:4 MG,FOR,PAIN, --HEAD,(PATIENT'S RATING OF LEVEL OF PAIN:), LEVEL 8
GILLESPIE,KRISTINE RN KRGC
02/21 03:30PM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,FOR,PAIN,--HEAD,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 7
GILLESPIE,KRISTINE RN KRGC

GABAPENTIN 300MG CAPSULE
02/21 08:00AM #1,PO,GIV
GILLESPIE,KRISTINE RN KRGC
02/21 01:00PM #1,PO,GIV
GILLESPIE,KRISTINE RN KRGC
02/21 05:00PM #1,PO,GIV
RAHNEMA,MARIAM RN MRR

CARBAMAZEPINE 200MG TAB
02/21 08:00AM #1,PO,GIV
GILLESPIE,KRISTINE RN KRGC
02/21 01:00PM #1,PO,GIV
GILLESPIE,KRISTINE RN KRGC
02/21 09:00PM #1,PO,GIV
RAHNEMA,MARIAM RN MRR

SALINE (0.9% NACL) FOR PERIPHERAL LOCK/FLUSH
02/21 02:00PM FLUSH WITH 3ML,GIV,IV
GILLESPIE,KRISTINE RN KRGC
02/21 10:00PM FLUSH WITH 3ML,GIV,SALINE LOCK
RAHNEMA,MARIAM RN MRR
02/22 06:00AM FLUSH WITH 3ML,GIV,SALINE LOCK
AGPOON,LEILANI RN LRA

HYDROCODONE 10MG & APAP 325MG TABLET
02/21 08:00AM #1,PO,GIV,(NORCO),FOR,PAIN,--HEAD,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 8
GILLESPIE,KRISTINE RN KRGC
02/21 01:45PM #1,PO,GIV,(NORCO),FOR,PAIN,--HEAD,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 7
GILLESPIE,KRISTINE RN KRGC
02/21 05:20PM #1,PO,GIV,(NORCO),FOR,INC PAIN,--HEAD
RAHNEMA,MARIAM RN MRR

CONTINUED

N-R
NURSING RECORDS

FALK STEVEN M 38 523A
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/21 07:15 AM TO 07:15 AM 02/22

02/22 12:00MN #1,PO,GIV,(NORCO),--PO,FOR,INC PAIN,--BACK OF HEAD,(PATIENT'S RATING OF LEVEL OF PAIN:), LEVEL 7
AGPOON,LEILANI RN LRA
LANSOPRAZOLE 30MG CAP
02/21 08:00AM #1,PO,GIV
GILLESPIE,KRISTINE RN KRGC
DOCUSATE SODIUM 250MG CAP
02/21 08:00AM ,GIV
GILLESPIE,KRISTINE RN KRGC
02/21 05:00PM ,GIV
RAHNEMA,MARIAM RN MRR
BISACODYL 10MG SUPP
02/21 04:15PM #1,PR,GIV,FOR,CONSTIPATION
RAHNEMA,MARIAM RN MRR
MILK OF MAGNESIA
02/21 01:30PM 30 ML,PO,GIV,FOR,CONSTIPATION
GILLESPIE,KRISTINE RN KRGC

** END OF SECTION **

LAST PAGE

N-R
NURSING RECORDS

FALK STEVEN M 38 523A
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/20 07:15 AM TO 07:15 AM 02/21

MEDICATIONS:

MORPHINE SULFATE 4MG
02/20 08:45AM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV
HAASE,STEPHANIE RN SRHB
02/20 12:30PM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,AS ORD
HAASE,STEPHANIE RN SRHB
02/20 06:00PM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,HEP LOCK,ACTUAL DOSE GIVEN:4MG,FOR, PAIN,--NECK,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 8
BLACKWELL,LAURA M RN LPAB
02/20 08:30PM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,HEP LOCK,ACTUAL DOSE GIVEN:4MG,FOR, INC PAIN,--INCISIONAL.
PADDOCK,SANDRA L RN SPAJ
02/21 12:00MN SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,FOR,INC PAIN,--HEAD,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 9
AGPOON,LEILANI RN LRA
02/21 04:00AM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,ACTUAL DOSE GIVEN:4MG,FOR,PAIN, --HEAD TO NECK,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 9
PRISK,MARLEEN M RN MTAD

GABAPENTIN 300MG CAPSULE
02/20 08:00AM #1,PO,GIV
HAASE,STEPHANIE RN SRHB
02/20 01:00PM #1,PO,GIV
HAASE,STEPHANIE RN SRHB

CARBAMAZEPINE 200MG TAB
02/20 08:00AM #1,PO,GIV
HAASE,STEPHANIE RN SRHB
02/20 01:00PM #1,PO,GIV
HAASE,STEPHANIE RN SRHB
02/20 09:00PM #1,PO,GIV
PADDOCK,SANDRA L RN SPAJ

SALINE (0.9% NACL) FOR PERIPHERAL LOCK/FLUSH
02/20 10:00PM FLUSH WITH 3ML,GIV,SALINE LOCK
PADDOCK,SANDRA L RN SPAJ

CONTINUED

N-R
NURSING RECORDS

FALK STEVEN M 38 523A
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/20 07:15 AM TO 07:15 AM 02/21

02/21 06:00AM FLUSH WITH 3ML,GIV,SALINE LOCK
AGPOON,LEILANI RN LRA
HYDROCODONE 10MG & APAP 325MG TABLET
02/20 08:45AM #1,PO,GIV,(NORCO),AS ORD
HAASE,STEPHANIE RN SRHB
02/20 12:30PM #1,PO,GIV,(NORCO)
HAASE,STEPHANIE RN SRHB
02/20 08:00PM #1,PO,GIV,(NORCO),ACTUAL DOSE GIVEN:#1TAB,FOR,
INC PAIN,--HEAD.
PADDOCK,SANDRA L RN SPAJ
02/21 12:00MN #1,PO,GIV,(NORCO),--PO,FOR,INC PAIN,--HEAD,
(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 9
AGPOON,LEILANI RN LRA
02/21 04:00AM #1,PO,GIV,(NORCO),FOR,PAIN,--HEAD TO NECK,
(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 9
PRISK,MARLEEN M RN MTAD
LANSOPRAZOLE 30MG CAP
02/20 08:00AM #1,PO,GIV
HAASE,STEPHANIE RN SRHB
DOCUSATE SODIUM 250MG CAP
02/20 08:00AM ,GIV
HAASE,STEPHANIE RN SRHB

** END OF SECTION **

LAST PAGE

7MED

FALK STEVEN M 38 523A
828049000F0403800216 **ADM:** 02/07/04

7 DAY MEDICATIONS SUMMARY

NOTE: * PRECEDES 'NOT GIVEN' MED

MEDICATIONS	02/14 SAT AM	02/14 SAT PM	02/15 SUN AM	02/15 SUN PM	02/16 MON AM	02/16 MON PM	02/17 TUE AM	02/17 TUE PM	02/18 WED AM	02/18 WED PM	02/19 THU AM	02/19 THU PM	02/20 FRI AM	02/20 FRI PM
CARBAMAZEPINE 200MG TAB #1,PO	8	19	8	19	8	19	8	19	8	19	8	19	8	19
CEFTRIAXONE 1GM/D5W 50ML IVPB	8		8		8		8		9		8			
CODEINE 30MG IM	6													
DOCUSATE SODIUM 250MG CAP									8	5	8	5	8	
GABAPENTIN 300MG CAPSULE #1,PO	8	15	8	15	8	1	8	15	8	15	8	15	8	1
HYDROCODONE 10MG & APAP 325MG TABLET #1,PO			9	159			2 6 11	3 11	5 10	2 6	2 10	4 9	1 9	1
HYDROCODONE 10MG & APAP 325MG TABLET ACTUAL DOSE GIVEN:#1TAB #1,PO														8
HYDROCODONE 10MG & APAP 325MG TABLET ACTUAL DOSE GIVEN:1 TAB #1,PO					9	15								
HYDROCODONE 5MG & ACETAMINOPHEN 500MG TAB #1,PO	1 5 9	1 5 9												
HYDROCODONE 5MG & ACETAMINOPHEN 500MG TAB ACTUAL DOSE GIVEN:1TAB #1,PO			6											

CONTINUED

7MED

FALK STEVEN M 38 523A
828049000F0403800216 **ADM:** 02/07/04

7 DAY MEDICATIONS SUMMARY

NOTE: * PRECEDES 'NOT GIVEN' MED

MEDICATIONS	02/14 SAT AM	02/14 SAT PM	02/15 SUN AM	02/15 SUN PM	02/16 MON AM	02/16 MON PM	02/17 TUE AM	02/17 TUE PM	02/18 WED AM	02/18 WED PM	02/19 THU AM	02/19 THU PM	02/20 FRI AM	02/20 FRI PM
IV LINE- 0.9% NACL(NS),1000ML *CONT TIL DC'D* W KCL 20MEQ	1	7												
LANSOPRAZOLE 30MG CAP #1,PO			8		8		8		8		8		8	
MORPHINE SULFATE 2MG ACTUAL DOSE GIVEN:2MG SLOW IV		MN	3 6 7			7								
MORPHINE SULFATE 2MG SLOW IV		7		1 2 4 9			2 6		8	6	3 6 8			
MORPHINE SULFATE 4MG ACTUAL DOSE GIVEN:4MG SLOW IV														6 9
MORPHINE SULFATE 4MG SLOW IV							7	9	2 6			MN	6 9	1
SALINE (0.9% NACL) FOR PERIPHERAL LOCK/FLUSH IV FLUSH WITH 3ML	6	10	6	2 9	6	10	2 6 7	2 10	2	2	6 6		6	10

LAST PAGE

N-R
NURSING RECORDS

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/19 07:15 AM TO 07:15 AM 02/20

MEDICATIONS:

MORPHINE SULFATE 2MG
02/19 08:15AM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV
RAINES,VILMA RN VRR
MORPHINE SULFATE 4MG
02/20 12:00MN SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,FOR,HEADACHE
PHAM,TERI RN IDN
02/20 05:30AM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,FOR,HEADACHE
PHAM,TERI RN IDN
GABAPENTIN 300MG CAPSULE
02/19 08:00AM #1,PO,GIV
RAINES,VILMA RN VRR
02/19 01:00PM #1,PO,GIV
BARILI,MARGARET RN RNAJ
02/19 05:00PM #1,PO,GIV
BARILI,MARGARET RN RNAJ
CARBAMAZEPINE 200MG TAB
02/19 08:00AM #1,PO,GIV
RAINES,VILMA RN VRR
02/19 01:00PM #1,PO,GIV
BARILI,MARGARET RN RNAJ
02/19 09:00PM #1,PO,GIV
BARILI,MARGARET RN RNAJ
SALINE (0.9% NACL) FOR PERIPHERAL LOCK/FLUSH
02/20 06:00AM FLUSH WITH 3ML,GIV,IV
PHAM,TERI RN IDN
HYDROCODONE 10MG & APAP 325MG TABLET
02/19 09:30AM #1,PO,GIV,(NORCO)
RAINES,VILMA RN VRR
02/19 04:00PM #1,PO,GIV,(NORCO)
BARILI,MARGARET RN RNAJ
02/19 09:00PM #1,PO,GIV,(NORCO),FOR,HEADACHE,FOR,INC PAIN, (PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 6
BARILI,MARGARET RN RNAJ
02/20 01:00AM #1,PO,GIV,(NORCO),FOR,HEADACHE
PHAM,TERI RN IDN
LANSOPRAZOLE 30MG CAP

CONTINUED

N-R
NURSING RECORDS

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/19 07:15 AM TO 07:15 AM 02/20

02/19 08:00AM #1,PO,GIV
RAINES,VILMA RN VRR
DOCUSATE SODIUM 250MG CAP
02/19 08:00AM ,GIV
RAINES,VILMA RN VRR
02/19 05:00PM ,GIV
BARILI,MARGARET RN RNAJ
CEFTRIAXONE 1GM/D5W 50ML
02/19 08:00AM IVPB,GIV,INFUSE IN 30 MINUTES,IV
RAINES,VILMA RN VRR

** END OF SECTION **

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P-N

PATIENT NOTES

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM:02/07/04

DATA ENTERED DURING: 02/19 07:15 AM TO 07:15 AM 02/20

PATIENT NOTES:

02/19/04 03:00PM ENTERED BY: SCHROEDER,KAREN J. RD KJS
RD NOTE #5
DIET RX: REGULAR
NPO-P-MN 2/19/04
S: PT ASLEEP AT RD VISIT, PT'S MOTHER PRESENT, SAYS PT'S APPETITE
IS ABOUT THE SAME, DRINKING BOOST SUPPLEMENT
O: LABS: ALBUMIN 3.0
A/P: PO INTAKE REMAINS FAIR, TOLERATING BOOST SUPPLEMENT
ALBUMIN WNL
P: CONTINUE TO SEND BOOST AND ICE CREAM SNACKS
MONITOR LABS/WTS/PROGRESS

** END OF SECTION **

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N-R
NURSING RECORDS

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/18 07:15 AM TO 07:15 AM 02/19

MEDICATIONS:

MORPHINE SULFATE 2MG
02/18 08:10AM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,FOR,PAIN,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 7,HEAD
JENSEN,SUZANNE RN ION
02/18 06:20PM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,FOR,PAIN,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 7,HEAD
JENSEN,SUZANNE RN ION
02/19 03:00AM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,FOR,HEADACHE
CAMPBELL,MARY RN IJNC
02/19 06:15AM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,AS ORD
ONYANGO,PATRICIA RN PRO

GABAPENTIN 300MG CAPSULE
02/18 08:00AM #1,PO,GIV
JENSEN,SUZANNE RN ION
02/18 01:00PM #1,PO,GIV
JENSEN,SUZANNE RN ION
02/18 05:00PM #1,PO,GIV
JENSEN,SUZANNE RN ION

CARBAMAZEPINE 200MG TAB
02/18 08:00AM #1,PO,GIV
JENSEN,SUZANNE RN ION
02/18 01:00PM #1,PO,GIV
JENSEN,SUZANNE RN ION
02/18 09:00PM #1,PO,GIV
ONYANGO,PATRICIA RN PRO

SALINE (0.9% NACL) FOR PERIPHERAL LOCK/FLUSH
02/18 01:35PM FLUSH WITH 3ML,GIV,IV
JENSEN,SUZANNE RN ION
02/19 06:00AM FLUSH WITH 3ML,GIV,IV
ONYANGO,PATRICIA RN PRO
02/19 06:15AM FLUSH WITH 3ML,GIV,IV,AS ORD
ONYANGO,PATRICIA RN PRO

HYDROCODONE 10MG & APAP 325MG TABLET
02/18 10:00AM #1,PO,GIV,(NORCO),FOR,PAIN,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 7,HEAD
JENSEN,SUZANNE RN ION

CONTINUED

N-R
NURSING RECORDS

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/18 07:15 AM TO 07:15 AM 02/19

02/18 02:15PM #1,PO,GIV,(NORCO),FOR,PAIN,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 7,HEAD
JENSEN,SUZANNE RN ION
02/18 06:20PM #1,PO,GIV,(NORCO),FOR,PAIN,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 7
JENSEN,SUZANNE RN ION
02/19 02:10AM #1,PO,GIV,(NORCO),AS ORD
ONYANGO,PATRICIA RN PRO
LANSOPRAZOLE 30MG CAP
02/18 08:00AM #1,PO,GIV
JENSEN,SUZANNE RN ION
DOCUSATE SODIUM 250MG CAP
02/18 08:00AM ,GIV
JENSEN,SUZANNE RN ION
02/18 05:00PM ,GIV
JENSEN,SUZANNE RN ION
CEFTRIAXONE 1GM/D5W 50ML
02/18 08:35AM IVPB,GIV,INFUSE IN 30 MINUTES,IV
JENSEN,SUZANNE RN ION

** END OF SECTION **

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N-R
NURSING RECORDS

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/17 07:15 AM TO 07:15 AM 02/18

MEDICATIONS:

MORPHINE SULFATE 4MG
02/17 08:40PM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,FOR,PAIN,FOR,HEADACHE
CAMPBELL,MARY RN IJNC
02/18 02:20AM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,AS ORD
ONYANGO,PATRICIA RN PRO
02/18 06:20AM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,AS ORD
ONYANGO,PATRICIA RN PRO

GABAPENTIN 300MG CAPSULE
02/17 08:00AM #1,PO,GIV
TROWBRIDGE,CORNELI RN MON
02/17 01:00PM #1,PO,GIV
TROWBRIDGE,CORNELI RN MON
02/17 05:00PM #1,PO,GIV
CAMPBELL,MARY RN IJNC

CARBAMAZEPINE 200MG TAB
02/17 08:00AM #1,PO,GIV
TROWBRIDGE,CORNELI RN MON
02/17 01:00PM #1,PO,GIV
TROWBRIDGE,CORNELI RN MON
02/17 09:00PM #1,PO,GIV
CAMPBELL,MARY RN IJNC

SALINE (0.9% NACL) FOR PERIPHERAL LOCK/FLUSH
02/17 02:00PM FLUSH WITH 3ML,GIV,SALINE LOCK
TROWBRIDGE,CORNELI RN MON
02/17 10:00PM FLUSH WITH 3ML,GIV,IV
CAMPBELL,MARY RN IJNC
02/18 02:20AM FLUSH WITH 3ML,GIV,IV,AS ORD
ONYANGO,PATRICIA RN PRO
02/18 06:00AM FLUSH WITH 3ML,GIV,IV
ONYANGO,PATRICIA RN PRO

HYDROCODONE 10MG & APAP 325MG TABLET
02/17 10:30AM #1,PO,GIV,(NORCO),FOR,HEADACHE
TROWBRIDGE,CORNELI RN MON
02/17 02:45PM #1,PO,GIV,(NORCO),FOR,HEADACHE
TROWBRIDGE,CORNELI RN MON
02/17 11:15PM #1,PO,GIV,(NORCO),FOR,HEADACHE
CAMPBELL,MARY RN IJNC

CONTINUED

N-R
NURSING RECORDS

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/17 07:15 AM TO 07:15 AM 02/18

02/18 04:45AM #1,PO,GIV,(NORCO),AS ORD
ONYANGO,PATRICIA RN PRO
LANSOPRAZOLE 30MG CAP
02/17 08:00AM #1,PO,GIV
TROWBRIDGE,CORNELI RN MON
CEFTRIAXONE 1GM/D5W 50ML
02/17 08:00AM IVPB,GIV,INFUSE IN 30 MINUTES,IV
TROWBRIDGE,CORNELI RN MON

** END OF SECTION **

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NURSING RECORDS

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/16 07:15 AM TO 07:15 AM 02/17

MEDICATIONS:

MORPHINE SULFATE 2MG
02/16 07:15PM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,ACTUAL DOSE GIVEN:2MG,FOR,PAIN, --HEDACHE,(PATIENT'S RATING OF LEVEL OF PAIN:) ,LEVEL 7
KELLEHER,SIOBHAN RN SRK
02/17 01:30AM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,AS ORD
ONYANGO,PATRICIA RN PRO
02/17 06:00AM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,AS ORD
ONYANGO,PATRICIA RN PRO

MORPHINE SULFATE 4MG
02/17 07:00AM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,AS ORD
ONYANGO,PATRICIA RN PRO

GABAPENTIN 300MG CAPSULE
02/16 08:00AM #1,PO,GIV
TROWBRIDGE,CORNELI RN MON
02/16 01:00PM #1,PO,GIV
TROWBRIDGE,CORNELI RN MON

CARBAMAZEPINE 200MG TAB
02/16 08:00AM #1,PO,GIV
TROWBRIDGE,CORNELI RN MON
02/16 01:00PM #1,PO,GIV
TROWBRIDGE,CORNELI RN MON
02/16 09:00PM #1,PO,GIV
KELLEHER,SIOBHAN RN SRK

SALINE (0.9% NACL) FOR PERIPHERAL LOCK/FLUSH
02/16 10:00PM FLUSH WITH 3ML,GIV,IV
KELLEHER,SIOBHAN RN SRK
02/17 01:30AM FLUSH WITH 3ML,GIV,IV,AS ORD
ONYANGO,PATRICIA RN PRO
02/17 06:00AM FLUSH WITH 3ML,GIV,IV
ONYANGO,PATRICIA RN PRO
02/17 07:00AM FLUSH WITH 3ML,GIV,IV,AS ORD
ONYANGO,PATRICIA RN PRO

HYDROCODONE 10MG & APAP 325MG TABLET
02/16 09:00AM #1,PO,GIV,(NORCO),ACTUAL DOSE GIVEN:1 TAB,FOR, HEADACHE
TROWBRIDGE,CORNELI RN MON

CONTINUED

N-R
NURSING RECORDS

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/16 07:15 AM TO 07:15 AM 02/17

02/16 01:00PM #1,PO,GIV,(NORCO),ACTUAL DOSE GIVEN:1 TAB,FOR, HEADACHE
TROWBRIDGE,CORNELI RN MON
02/16 05:15PM #1,PO,GIV,(NORCO),ACTUAL DOSE GIVEN:1 TAB,FOR, PAIN,--HEADACHE,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 6
KELLEHER,SIOBHAN RN SRK
02/17 01:30AM #1,PO,GIV,(NORCO),AS ORD
ONYANGO,PATRICIA RN PRO
02/17 06:00AM #1,PO,GIV,(NORCO),AS ORD
ONYANGO,PATRICIA RN PRO
LANSOPRAZOLE 30MG CAP
02/16 08:00AM #1,PO,GIV
TROWBRIDGE,CORNELI RN MON
CEFTRIAXONE 1GM/D5W 50ML
02/16 08:00AM IVPB,GIV,INFUSE IN 30 MINUTES,IV
TROWBRIDGE,CORNELI RN MON

** END OF SECTION **

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NURSING RECORDS

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/15 07:15 AM TO 07:15 AM 02/16

MEDICATIONS:

MORPHINE SULFATE 2MG
02/15 01:20PM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV
CALLENS,BARBARA E. RN BEC
02/15 02:20PM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,FOR,PAIN,--NECK PAIN,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 5
CALLENS,BARBARA E. RN BEC
02/15 04:15PM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,FOR,PAIN,--HEADACHE,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 5
PHALEN,DEBRA J RN DJP
02/15 08:30PM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,FOR,PAIN,--C/O H/A,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 8
WOOD,MELANIE RN IUNB

GABAPENTIN 300MG CAPSULE
02/15 08:00AM #1,PO,GIV
CALLENS,BARBARA E. RN BEC
02/15 01:00PM #1,PO,GIV
CALLENS,BARBARA E. RN BEC
02/15 05:00PM #1,PO,GIV
PHALEN,DEBRA J RN DJP

CARBAMAZEPINE 200MG TAB
02/15 08:00AM #1,PO,GIV
CALLENS,BARBARA E. RN BEC
02/15 01:00PM #1,PO,GIV
CALLENS,BARBARA E. RN BEC
02/15 08:30PM #1,PO,GIV
WOOD,MELANIE RN IUNB

SALINE (0.9% NACL) FOR PERIPHERAL LOCK/FLUSH
02/15 02:00PM FLUSH WITH 3ML,GIV,IV
CALLENS,BARBARA E. RN BEC
02/15 09:00PM FLUSH WITH 3ML,GIV,IV
WOOD,MELANIE RN IUNB
02/16 06:00AM FLUSH WITH 3ML,GIV,IV
UPADHYAYA,MASKELL RN MMND

HYDROCODONE 10MG & APAP 325MG TABLET
02/15 08:30AM #1,PO,GIV,(NORCO),FOR,HEADACHE
CALLENS,BARBARA E. RN BEC

CONTINUED

N-R

NURSING RECORDS

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/15 07:15 AM TO 07:15 AM 02/16

02/15 12:40PM #1,PO,GIV,(NORCO),FOR,HEADACHE
CALLENS,BARBARA E. RN BEC
02/15 05:00PM #1,PO,GIV,(NORCO),IV,FOR,PAIN,--NECK,
(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 2
PHALEN,DEBRA J RN DJP
02/15 09:10PM #1,PO,GIV,(NORCO),AS ORD,FOR,HEADACHE
WOOD,MELANIE RN IUNB
LANSOPRAZOLE 30MG CAP
02/15 08:00AM #1,PO,GIV
CALLENS,BARBARA E. RN BEC
CEFTRIAXONE 1GM/D5W 50ML
02/15 08:00AM IVPB,GIV,INFUSE IN 30 MINUTES,IV
CALLENS,BARBARA E. RN BEC

IV LINE-....0.9% NACL(NS),1000ML
02/15 01:00PM #11,W,KCL 20MEQ,::,DC'D
PHALEN,DEBRA J RN DJP

** END OF SECTION **

LAST PAGE

N-R
NURSING RECORDS

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/14 07:15 AM TO 07:15 AM 02/15

MEDICATIONS:

MORPHINE SULFATE 2MG

02/14 07:20PM	SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,FOR,HEADACHE,FOR,-9/10		
	CHAN,MEI	RN	MRCA
02/15 12:00MN	SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,ACTUAL DOSE GIVEN:2MG,FOR,HEADACHE		
	CHEN,YI-XIN	RN	YC
02/15 03:00AM	SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,ACTUAL DOSE GIVEN:2MG		
	CHEN,YI-XIN	RN	YC
02/15 05:40AM	SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,ACTUAL DOSE GIVEN:2MG,FOR,HEADACHE		
	CHEN,YI-XIN	RN	YC
02/15 07:15AM	SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,ACTUAL DOSE GIVEN:2MG,FOR,HEADACHE		
	CHEN,YI-XIN	RN	YC

GABAPENTIN 300MG CAPSULE

02/14 08:00AM	#1,PO,GIV		
	NG,FANNY	RN	FNZ
02/14 01:00PM	#1,PO,GIV		
	NG,FANNY	RN	FNZ
02/14 05:00PM	#1,PO,GIV		
	CHAN,MEI	RN	MRCA

HYDROCODONE 5MG & ACETAMINOPHEN 500MG TAB

02/14 08:30AM	#1,PO,GIV,(VICODIN),--HOLD IF NOT FULLY ALERT. ,FOR,ANXIETY		
	NG,FANNY	RN	FNZ
02/14 12:30PM	#1,PO,GIV,(VICODIN),--HOLD IF NOT FULLY ALERT. ,FOR,HEADACHE		
	NG,FANNY	RN	FNZ
02/14 04:30PM	#1,PO,GIV,(VICODIN),--HOLD IF NOT FULLY ALERT. ,FOR,HEADACHE,FOR,-7/10		
	CHAN,MEI	RN	MRCA
02/14 09:15PM	#1,PO,GIV,(VICODIN),--HOLD IF NOT FULLY ALERT. ,FOR,HEADACHE,FOR,-7/10		
	CHAN,MEI	RN	MRCA
02/15 05:45AM	#1,PO,GIV,(VICODIN),--HOLD IF NOT FULLY ALERT. ,ACTUAL DOSE GIVEN:1TAB,FOR,HEADACHE		
	CHEN,YI-XIN	RN	YC

CARBAMAZEPINE 200MG TAB

CONTINUED

N-R
NURSING RECORDS

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/14 07:15 AM TO 07:15 AM 02/15

02/14	08:00AM #1,PO,GIV		
	NG,FANNY	RN	FNZ
02/14	01:00PM #1,PO,GIV		
	NG,FANNY	RN	FNZ
02/14	09:00PM #1,PO,GIV		
	CHAN,MEI	RN	MRCA

SALINE (0.9% NACL) FOR PERIPHERAL LOCK/FLUSH

02/14	10:00PM FLUSH WITH 3ML,GIV,IV		
	CHAN,MEI	RN	MRCA
02/15	06:00AM FLUSH WITH 3ML,GIV,IV		
	CHEN,YI-XIN	RN	YC

CEFTRIAXONE 1GM/D5W 50ML

02/14	08:00AM IVPB,GIV,INFUSE IN 30 MINUTES,IV		
	NG,FANNY	RN	FNZ

IV LINE-....0.9% NACL(NS),1000ML

02/14	01:00AM #10,W,KCL 20MEQ,**,ADDED		
	NG,FANNY	RN	FNZ
02/14	01:00AM #9,W,KCL 20MEQ,::,COMPLETED		
	NG,FANNY	RN	FNZ
02/14	06:30PM #10,W,KCL 20MEQ,::,COMPLETED,ALL TAKEN		
	CHAN,MEI	RN	MRCA
02/14	06:30PM #11,W,KCL 20MEQ,**,ADDED		
	CHAN,MEI	RN	MRCA

** END OF SECTION **

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N-R
NURSING RECORDS

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/13 07:15 AM TO 07:15 AM 02/14

MEDICATIONS:

```
MORPHINE SULFATE 2MG
 02/13  09:00AM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2
                SAT <92%,IV,FOR,HEADACHE
                  TROWBRIDGE,CORNELI RN            MON
 02/13  12:30PM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2
                SAT <92%,IV,FOR,HEADACHE
                  TROWBRIDGE,CORNELI RN            MON
 02/13  04:00PM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2
                SAT <92%,IV,FOR,HEADACHE,FOR,-6/10
                  CHAN,MEI           RN            MRCA
 02/13  05:30PM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2
                SAT <92%,IV,FOR,HEADACHE,FOR,-8/10
                  CHAN,MEI           RN            MRCA
 02/13  10:30PM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2
                SAT <92%,IV,FOR,HEADACHE
                  CHAN,MEI           RN            MRCA
 02/14  12:15AM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2
                SAT <92%,IV,FOR,HEADACHE
                  CHAN,MEI           RN            MRCA
CODEINE 30MG
 02/14  06:25AM IM,GIV,FOR,HEADACHE,LA THIGH
                  NG,FANNY           RN            FNZ
GABAPENTIN 300MG CAPSULE
 02/13  08:00AM #1,PO,GIV
                  TROWBRIDGE,CORNELI RN            MON
 02/13  01:00PM #1,PO,GIV
                  TROWBRIDGE,CORNELI RN            MON
 02/13  05:00PM #1,PO,GIV
                  CHAN,MEI           RN            MRCA
HYDROCODONE 5MG & ACETAMINOPHEN 500MG TAB
 02/14  12:50AM #1,PO,GIV,(VICODIN),--HOLD IF NOT FULLY ALERT.
                ,FOR,HEADACHE
                  CHAN,MEI           RN            MRCA
 02/14  04:30AM #1,PO,GIV,(VICODIN),--HOLD IF NOT FULLY ALERT.
                ,FOR,HEADACHE
                  NG,FANNY           RN            FNZ
CARBAMAZEPINE 200MG TAB
 02/13  08:00AM #1,PO,GIV
                  TROWBRIDGE,CORNELI RN            MON
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CONTINUED

N-R
NURSING RECORDS

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/13 07:15 AM TO 07:15 AM 02/14

02/13 01:00PM #1,PO,GIV
TROWBRIDGE,CORNELI RN MON
02/13 09:00PM #1,PO,GIV
CHAN,MEI RN MRCA
SALINE (0.9% NACL) FOR PERIPHERAL LOCK/FLUSH
02/13 02:00PM FLUSH WITH 3ML,GIV,SALINE LOCK
TROWBRIDGE,CORNELI RN MON
02/13 10:00PM FLUSH WITH 3ML,GIV,IV
CHAN,MEI RN MRCA
02/14 06:00AM FLUSH WITH 3ML,GIV,IV
NG,FANNY RN FNZ
CEFTRIAXONE 1GM/D5W 50ML
02/13 10:00AM IVPB,GIV,INFUSE IN 30 MINUTES,IV
TROWBRIDGE,CORNELI RN MON

IV LINE-....0.9% NACL(NS),1000ML
02/13 08:00AM #8,W,KCL 20MEQ,::,COMPLETED,ALL TAKEN
TROWBRIDGE,CORNELI RN MON
02/13 08:00AM #9,W,KCL 20MEQ,**,ADDED
TROWBRIDGE,CORNELI RN MON

** END OF SECTION **

LAST PAGE

7MED

FALK STEVEN M 38 **CC11P**
828049000F0403800216 **ADM:** 02/07/04

7 DAY MEDICATIONS SUMMARY

NOTE: * PRECEDES 'NOT GIVEN' MED

MEDICATIONS	02/07 SAT AM	02/07 SAT PM	02/08 SUN AM	02/08 SUN PM	02/09 MON AM	02/09 MON PM	02/10 TUE AM	02/10 TUE PM	02/11 WED AM	02/11 WED PM	02/12 THU AM	02/12 THU PM	02/13 FRI AM	02/13 FRI PM
CARBAMAZEPINE 200MG TAB #1,PO			*8	7 9	8	1 9	8	1 9	8	2 9	8	1 9	8	1 9
CEFTRIAXONE 1GM/D5W 50ML IVPB													10	
CODEINE 30MG IM			2 5		1 5	8								
ENALAPRILAT 1.25MG IV			4											
GABAPENTIN 300MG CAPSULE #1,PO			8		8	1 5	8	1 5	8	1 6	8	1 5	8	1 5
HYDRALAZINE 10MG SLOW IV									4					
HYDRALAZINE 20MG SLOW IV			8 11		1 3 6		8							
HYDROCODONE 5MG & ACETAMINOPHEN 500MG TAB #1,PO							8		8	2 6 10	8	6	2	
HYDROCODONE 5MG & ACETAMINOPHEN 500MG TAB #2,PO	11													
HYDROCODONE 5MG & ACETAMINOPHEN 500MG TAB ACTUAL DOSE GIVEN:1TAB #1,PO									4		3			

CONTINUED

7MED

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM: 02/07/04

7 DAY MEDICATIONS SUMMARY

NOTE: * PRECEDES 'NOT GIVEN' MED

MEDICATIONS	02/07 SAT AM	02/07 SAT PM	02/08 SUN AM	02/08 SUN PM	02/09 MON AM	02/09 MON PM	02/10 TUE AM	02/10 TUE PM	02/11 WED AM	02/11 WED PM	02/12 THU AM	02/12 THU PM	02/13 FRI AM	02/13 FRI PM
IV LINE- 0.9% NACL(NS),1000ML *CONT TIL DC'D* W KCL 20MEQ					10		3		7 10		1	5	8	
IV LINE- D5/.45% NACL,1000ML *CONT TIL DC'D* W KCL 20MEQ			10	10										
IV LINE- D5/W,250ML *CONT TIL DC'D* OTHER MISC--WHEN UNRESPONSIVE TO LABETALOL AND/OR HYDRALAZINE W NITROPRUSSIDE 50MG			5 9		1 4	NN								
IV LINE- D5/W,500ML *CONT TIL DC'D* OTHER MISC--WHEN UNRESPONSIVE TO LABETALOL AND/OR HYDRALAZINE W NITROPRUSSIDE 100MG					11	8	4	3 7 MN						
LABETALOL(5MG/ML) INJ 10 MG (OVER 2 MINUTES) ACTUAL DOSE GIVEN:10MG SLOW IV												5		
LABETALOL(5MG/ML) INJ 10 MG (OVER 2 MINUTES) ACTUAL DOSE GIVEN:5MG SLOW IV												5		

CONTINUED

7MED

FALK STEVEN M 38 **CC11P**
828049000F0403800216 **ADM:** 02/07/04

7 DAY MEDICATIONS SUMMARY

NOTE: * PRECEDES 'NOT GIVEN' MED

MEDICATIONS	02/07 SAT AM	02/07 SAT PM	02/08 SUN AM	02/08 SUN PM	02/09 MON AM	02/09 MON PM	02/10 TUE AM	02/10 TUE PM	02/11 WED AM	02/11 WED PM	02/12 THU AM	02/12 THU PM	02/13 FRI AM	02/13 FRI PM
LABETALOL(5MG/ML) INJ 10 MG (OVER 2 MINUTES) SLOW IV											9			
LABETALOL(5MG/ML) INJ 10MG (OVER 2 MINUTES) ACTUAL DOSE GIVEN:10MG SLOW IV								MN						
LABETALOL(5MG/ML) INJ 10MG (OVER 2 MINUTES) SLOW IV			8		6				1					
LABETALOL(5MG/ML) INJ 15MG (OVER 2 MINUTES) ACTUAL DOSE GIVEN:15MG SLOW IV								4 7						
LABETALOL(5MG/ML) INJ 15MG (OVER 2 MINUTES) SLOW IV			10 MN		2 4 6	2 4 10	4 6 11	1						
LABETALOL(5MG/ML) INJ 5 MG (OVER 2 MINUTES) SLOW IV			4											
LABETALOL(5MG/ML) INJ 5MG MG (OVER 2 MINUTES) SLOW IV			3											
MORPHINE SULFATE 2MG ACTUAL DOSE GIVEN:2MG SLOW IV										MN				

CONTINUED

7MED

7 DAY MEDICATIONS SUMMARY

FALK STEVEN M 38 **CC11P**
828049000F0403800216 **ADM:** 02/07/04

NOTE: * PRECEDES 'NOT GIVEN' MED

MEDICATIONS	02/07 SAT AM	02/07 SAT PM	02/08 SUN AM	02/08 SUN PM	02/09 MON AM	02/09 MON PM	02/10 TUE AM	02/10 TUE PM	02/11 WED AM	02/11 WED PM	02/12 THU AM	02/12 THU PM	02/13 FRI AM	02/13 FRI PM
MORPHINE SULFATE 2MG SLOW IV			6 8 9 11						8		4	9 MN	3 5 7 9	1 4 6 11
MORPHINE SULFATE 4MG SLOW IV					2 4	10 MN	6 8	NN						
NIFEDIPINE 10MG CAP			4											
SALINE (0.9% NACL) FOR PERIPHERAL LOCK/FLUSH IV FLUSH WITH 3ML									10		6	*2 10	6	2 10

LAST PAGE

N-R

NURSING RECORDS

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/11 07:15 AM TO 07:15 AM 02/12

MEDICATIONS:

LABETALOL(5MG/ML) INJ 10MG
02/11 01:15PM SLOW IV,GIV,(OVER 2 MINUTES),IV,FOR,-BP 166/60
EASTMAN,SALLY RN ICNA

MORPHINE SULFATE 2MG
02/11 08:15AM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,FOR,HEADACHE,FOR,-&NECK PAIN9/10
EASTMAN,SALLY RN ICNA
02/11 11:40PM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,ACTUAL DOSE GIVEN:2MG,FOR,INC PAIN ,--HEAD,(PATIENT'S RATING OF LEVEL OF PAIN:), LEVEL 8
CAYABYAB,JESSE RN JCCB
02/12 04:00AM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,FOR,INC PAIN,--HEAD,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 8
CAYABYAB,JESSE RN JCCB

GABAPENTIN 300MG CAPSULE
02/11 08:00AM #1,PO,GIV
EASTMAN,SALLY RN ICNA
02/11 01:00PM #1,PO,GIV
EASTMAN,SALLY RN ICNA
02/11 06:25PM #1,PO,GIV
EASTMAN,SALLY RN ICNA

HYDROCODONE 5MG & ACETAMINOPHEN 500MG TAB
02/11 08:15AM #1,PO,GIV,(VICODIN),--HOLD IF NOT FULLY ALERT. ,FOR,HEADACHE,FOR,-NECK PAIN 9/10
EASTMAN,SALLY RN ICNA
02/11 02:05PM #1,PO,GIV,(VICODIN),--HOLD IF NOT FULLY ALERT. ,FOR,HEADACHE
EASTMAN,SALLY RN ICNA
02/11 06:25PM #1,PO,GIV,(VICODIN),--HOLD IF NOT FULLY ALERT. ,FOR,HEADACHE,FOR,-5/10
EASTMAN,SALLY RN ICNA
02/11 10:00PM #1,PO,GIV,(VICODIN),--HOLD IF NOT FULLY ALERT. ,FOR,INC PAIN,--HEAD,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 6
CAYABYAB,JESSE RN JCCB
02/12 02:40AM #1,PO,GIV,(VICODIN),--HOLD IF NOT FULLY ALERT. ,ACTUAL DOSE GIVEN:1TAB,FOR,INC PAIN,--HEAD, (PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 8
CAYABYAB,JESSE RN JCCB

CARBAMAZEPINE 200MG TAB

CONTINUED

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM: 02/07/04

NURSING RECORDS

DATA ENTERED DURING: 02/11 07:15 AM TO 07:15 AM 02/12

02/11 08:00AM #1,PO,GIV
EASTMAN,SALLY RN ICNA
02/11 02:00PM #1,PO,GIV
EASTMAN,SALLY RN ICNA
02/11 09:00PM #1,PO,GIV
CAYABYAB,JESSE RN JCCB
SALINE (0.9% NACL) FOR PERIPHERAL LOCK/FLUSH
02/11 10:00PM FLUSH WITH 3ML,GIV,IV
CAYABYAB,JESSE RN JCCB
02/12 06:00AM FLUSH WITH 3ML,GIV,IV
CAYABYAB,JESSE RN JCCB

IV LINE-....0.9% NACL(NS),1000ML
02/11 07:00AM #5,W,KCL 20MEQ,**,--STARTED ON 2/10,INCORRECT
IV LINE ORDERED.
EASTMAN,SALLY RN ICNA
02/11 10:00AM #6,W,KCL 20MEQ,**,ADDED
EASTMAN,SALLY RN ICNA
02/11 10:00AM #5,W,KCL 20MEQ,::,COMPLETED
EASTMAN,SALLY RN ICNA
02/12 01:00AM #6,W,KCL 20MEQ,::,COMPLETED
CAYABYAB,JESSE RN JCCB
02/12 01:00AM #7,W,KCL 20MEQ,**,ADDED
CAYABYAB,JESSE RN JCCB

IV LINE-....D5/W,500ML
02/11 07:00AM #5,W,NITROPRUSSIDE 100MG,::,--ORDERED
INCORRECTLY,#5 SHOULD BE IVF.
EASTMAN,SALLY RN ICNA
02/11 04:15PM #N10,W,NITROPRUSSIDE 100MG,::,DC'D,--CHARTED
FOR PMS RN, SALLY
CAYABYAB,JESSE RN JCCB

** END OF SECTION **

LAST PAGE

N-R
NURSING RECORDS

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/09 07:15 AM TO 07:15 AM 02/10

MEDICATIONS:

LABETALOL(5MG/ML) INJ 15MG
02/09 01:45PM SLOW IV,GIV,(OVER 2 MINUTES),IV
CALLENS,BARBARA E. RN BEC
02/09 03:45PM SLOW IV,GIV,(OVER 2 MINUTES),IV,AS ORD,FOR,BP 160/58
RITZ,MICHELLE M RN MMRD
LABETALOL(5MG/ML) INJ 10MG
02/09 06:00PM SLOW IV,GIV,(OVER 2 MINUTES),IV,AS ORD,FOR,BP 184/68
RITZ,MICHELLE M RN MMRD
LABETALOL(5MG/ML) INJ 15MG
02/09 09:30PM SLOW IV,GIV,(OVER 2 MINUTES),IV,FOR,BP 164/57
UPADHYAYA,MASKELL RN MMND
02/10 03:30AM SLOW IV,GIV,(OVER 2 MINUTES),IV,FOR,BP 152/64
VERZOSA,FLORDELIZA RN IRNC
02/10 05:30AM SLOW IV,GIV,(OVER 2 MINUTES),IV,FOR,BP 155/66
UPADHYAYA,MASKELL RN MMND
MORPHINE SULFATE 4MG
02/09 10:00PM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,FOR,HEADACHE
UPADHYAYA,MASKELL RN MMND
02/09 12:00MN SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,FOR,HEADACHE,--AND NECK PAIN
UPADHYAYA,MASKELL RN MMND
02/10 06:00AM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,FOR,HEADACHE,--AND NECK PAIN
UPADHYAYA,MASKELL RN MMND
CODEINE 30MG
02/09 07:45PM IM,GIV,RA THIGH,FOR,HEADACHE
UPADHYAYA,MASKELL RN MMND
GABAPENTIN 300MG CAPSULE
02/09 08:00AM #1,PO,GIV
CALLENS,BARBARA E. RN BEC
02/09 01:00PM #1,PO,GIV
CALLENS,BARBARA E. RN BEC
02/09 05:00PM #1,PO,GIV
RITZ,MICHELLE M RN MMRD
CARBAMAZEPINE 200MG TAB
02/09 08:00AM #1,PO,GIV
CALLENS,BARBARA E. RN BEC

CONTINUED

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM: 02/07/04

NURSING RECORDS

DATA ENTERED DURING: 02/09 07:15 AM TO 07:15 AM 02/10

02/09 01:00PM #1,PO,GIV
CALLENS,BARBARA E. RN BEC
02/09 09:00PM #1,PO,GIV
UPADHYAYA,MASKELL RN MMND

IV LINE-....0.9% NACL(NS),1000ML
02/09 09:45AM #3,W,KCL 20MEQ,**,STARTED
CALLENS,BARBARA E. RN BEC
02/10 02:30AM #3,W,KCL 20MEQ,::,COMPLETED,ALL TAKEN
UPADHYAYA,MASKELL RN MMND
02/10 02:30AM #4,W,KCL 20MEQ,**,ADDED
UPADHYAYA,MASKELL RN MMND

IV LINE-....D5/.45% NACL,1000ML
02/09 09:45AM #2,W,KCL 20MEQ,::,COMPLETED
CALLENS,BARBARA E. RN BEC

IV LINE-....D5/W,500ML
02/09 11:00AM #N6,W,NITROPRUSSIDE 100MG,**,ADDED,BY--S
RITZ, RN
UPADHYAYA,MASKELL RN MMND
02/09 08:15PM #N6,W,NITROPRUSSIDE 100MG,::,COMPLETED,ALL
TAKEN
UPADHYAYA,MASKELL RN MMND
02/09 08:15PM #N7,W,NITROPRUSSIDE 100MG,**,ADDED
UPADHYAYA,MASKELL RN MMND
02/10 04:00AM #N7,W,NITROPRUSSIDE 100MG,::,COMPLETED,ALL
TAKEN
VERZOSA,FLORDELIZA RN IRNC
02/10 04:00AM #N8,W,NITROPRUSSIDE 100MG,**,ADDED
VERZOSA,FLORDELIZA RN IRNC

IV LINE-....D5/W,250ML
02/09 11:00AM #N-5,W,NITROPRUSSIDE 50MG,::,COMPLETED,ALL
TAKEN,--BY S RITZ, RN
UPADHYAYA,MASKELL RN MMND
02/09 12:00NN #N-4,W,NITROPRUSSIDE 50MG,::,COMPLETED
CALLENS,BARBARA E. RN BEC
02/09 12:00NN #N-5,W,NITROPRUSSIDE 50MG,**,STARTED
CALLENS,BARBARA E. RN BEC

** END OF SECTION **

LAST PAGE

N-R
NURSING RECORDS

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/08 07:15 AM TO 07:15 AM 02/09

MEDICATIONS:

ENALAPRILAT 1.25MG
02/08 03:45PM IV,IV,
LUONG,KIMSA RN SCN
LABETALOL(5MG/ML) INJ 5MG MG
02/08 03:20PM SLOW IV,IV,(OVER 2 MINUTES),
LUONG,KIMSA RN SCN
LABETALOL(5MG/ML) INJ 5 MG
02/08 03:30PM SLOW IV,IV,(OVER 2 MINUTES),
LUONG,KIMSA RN SCN
LABETALOL(5MG/ML) INJ 10MG
02/08 07:30PM SLOW IV,GIV,(OVER 2 MINUTES),IV
PICKETT,RAYMOND RN MFNR
LABETALOL(5MG/ML) INJ 15MG
02/08 09:30PM SLOW IV,GIV,(OVER 2 MINUTES),IV,FOR,-SBP GREATER THAN 150MMHG
PICKETT,RAYMOND RN MFNR
02/08 11:30PM SLOW IV,GIV,(OVER 2 MINUTES),IV,FOR,-SBP GREATER THAN 150MMHG
PICKETT,RAYMOND RN MFNR
02/09 01:30AM SLOW IV,GIV,(OVER 2 MINUTES),IV,FOR,-SBP GREATER THAN 150MMHG
PICKETT,RAYMOND RN MFNR
02/09 04:15AM SLOW IV,GIV,(OVER 2 MINUTES),IV,FOR,-SBP GREATER THAN 150MMHG
PICKETT,RAYMOND RN MFNR
02/09 06:15AM SLOW IV,GIV,(OVER 2 MINUTES),IV,FOR,-SBP GREATER THAN 150MMHG
PICKETT,RAYMOND RN MFNR
NIFEDIPINE 10MG CAP
02/08 03:50PM ,,--SUBLINGUAL TO MAINTAIN SBP 140.,
LUONG,KIMSA RN SCN
MORPHINE SULFATE 2MG
02/08 05:55PM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,PT IN PACU,FOR,INC PAIN,--NODDED WHEN ASKED IF HAVE PAIN. DOES NOT RATE ON PAIN SCALE.
LUONG,KIMSA RN SCN
02/08 08:25PM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,FOR,INC PAIN,--HEAD,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 8
PICKETT,RAYMOND RN MFNR

CONTINUED

N-R

NURSING RECORDS

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/08 07:15 AM TO 07:15 AM 02/09

02/08 09:25PM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,FOR,INC PAIN,--HEAD,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 5
PICKETT,RAYMOND RN MFNR

02/08 11:00PM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,FOR,INC PAIN,--HEAD,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 8
PICKETT,RAYMOND RN MFNR

MORPHINE SULFATE 4MG

02/09 01:30AM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,LV GLUT,FOR,INC PAIN,--HEAD, (PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 8
PICKETT,RAYMOND RN MFNR

02/09 03:30AM SLOW IV,GIV,--HOLD FOR RESP RATE 10 AND O2 SAT <92%,IV,FOR,INC PAIN,--HEAD,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 7
PICKETT,RAYMOND RN MFNR

CODEINE 30MG

02/09 12:45AM IM,GIV,LM DELT,FOR,INC PAIN,--HEAD,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 8
PICKETT,RAYMOND RN MFNR

02/09 05:00AM IM,GIV,RM DELT,FOR,INC PAIN,--HEAD,(PATIENT'S RATING OF LEVEL OF PAIN:),LEVEL 7
PICKETT,RAYMOND RN MFNR

GABAPENTIN 300MG CAPSULE

02/08 08:00AM #1,PO,GIV
SEVERSON,MARY L RN MLS

CARBAMAZEPINE 200MG TAB

02/08 08:00AM #1,PO,NOT GIV,BECAUSE,--PT CHOKED ON LAST PILL
SEVERSON,MARY L RN MLS

02/08 07:00PM #1,PO,GIV,AS ORD
SEVERSON,MARY L RN MLS

02/08 09:00PM #1,PO,GIV
PICKETT,RAYMOND RN MFNR

HYDRALAZINE 20MG

02/08 08:15PM SLOW IV,GIV,IV,FOR,-SBP >150MMHG
PICKETT,RAYMOND RN MFNR

02/08 11:00PM SLOW IV,GIV,IV,FOR,-SBP GREATER THAN 150MMHG
PICKETT,RAYMOND RN MFNR

02/09 01:00AM SLOW IV,GIV,IV,FOR,-SBP GREATER THAN 150MMHG
PICKETT,RAYMOND RN MFNR

CONTINUED

N-R
NURSING RECORDS

FALK STEVEN M 38 CC11P
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/08 07:15 AM TO 07:15 AM 02/09

02/09 03:00AM SLOW IV,GIV,IV,FOR,-FOR SBP GREATER THAN 150M
PICKETT,RAYMOND RN MFNR
02/09 05:30AM SLOW IV,GIV,IV,FOR,-SBP GREATER THAN 150MMHG
PICKETT,RAYMOND RN MFNR

IV LINE-....D5/.45% NACL,1000ML
02/08 10:00AM #2,W,KCL 20MEQ,**,ADDED
SEVERSON,MARY L RN MLS
02/08 10:00AM #1,W,KCL 20MEQ,::,COMPLETED,ALL TAKEN
SEVERSON,MARY L RN MLS
02/08 09:30PM #1,W,KCL 20MEQ,**,ADDED
SEVERSON,MARY L RN MLS

IV LINE-....D5/W,250ML
02/08 04:30PM #N-1,W,NITROPRUSSIDE 50MG,**,STARTED
LUONG,KIMSA RN SCN
02/08 09:00PM #N-1,W,NITROPRUSSIDE 50MG,::,COMPLETED,ALL TAKEN
PICKETT,RAYMOND RN MFNR
02/08 09:00PM #N-2,W,NITROPRUSSIDE 50MG,**,ADDED
PICKETT,RAYMOND RN MFNR
02/09 01:00AM #N-2,W,NITROPRUSSIDE 50MG,::,COMPLETED,ALL TAKEN
PICKETT,RAYMOND RN MFNR
02/09 01:00AM #N-3,W,NITROPRUSSIDE 50MG,**,ADDED
PICKETT,RAYMOND RN MFNR
02/09 04:00AM #N-3,W,NITROPRUSSIDE 50MG,::,COMPLETED,ALL TAKEN
PICKETT,RAYMOND RN MFNR
02/09 04:00AM #N-4,W,NITROPRUSSIDE 50MG,**,ADDED
PICKETT,RAYMOND RN MFNR

** END OF SECTION **

LAST PAGE

N-R
NURSING RECORDS

FALK STEVEN M 48 CC15P
828049000F0403800216 ADM: 02/07/04

DATA ENTERED DURING: 02/07 07:15 AM TO 07:15 AM 02/08

MEDICATIONS:

CODEINE 30MG
02/08 01:40AM IM,GIV,--(HOLD IF NOT FULLY AWAKE),RUOQ,FOR, HEADACHE
UPADHYAYA,MASKELL RN MMND
02/08 04:45AM IM,GIV,--(HOLD IF NOT FULLY AWAKE),RUOQ,FOR, HEADACHE
UPADHYAYA,MASKELL RN MMND
HYDROCODONE 5MG & ACETAMINOPHEN 500MG TAB
02/07 11:20PM #2,PO,GIV,(VICODIN),FOR,HEADACHE
UPADHYAYA,MASKELL RN MMND

VITAL SIGNS:

	T-O	T-R	P-R	P-A	R	BP
02/07 09:00PM ADMIT VITAL SIGNS & STATS....96.1 (T-O), 96 REGULAR (P-A), 14 (RESP), 140/85 LYING (BP-L/A)						

UPADHYAYA,MASKELL RN MMND

** END OF SECTION **

LAST PAGE

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XXXX XXXX X X X
X X XX
X X X
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DISCHARGE REPORT
==========

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

==========

DATA ENTERED DURING: 02/21 11:59 PM TO 11:59 PM 02/22

==========

PATIENT NOTES:

02/21/04 11:45PM ENTERED BY: AGPOON,LEILANI RN LRA
RESPIRATORY ASSESSMENT....LUNG SOUNDS: CLEAR BILAT....O2 SAT: 97% IN ROOM AIR **
ABDOMINAL ASSESSMENT....ABDOMEN: ROUNDED AND SOFT....BOWEL SOUNDS: PRESENT AND NOT EXPELLING FLATUS
PAIN ASSESSMENT....LOCATION:--BACK OF HEAD....PAIN ON A SCALE OF 1-10 IS:7....INTERVENTION: MEDICATED
VASCULAR ACCESS, SITE CLEAR, DRESSING DRY & INTACT
DRESSING(S)/INCISION --INCISION TO TOP OF HEAD, AND BACK OF HEAD, CLEAN, DRY AND INTACT.
NEUROLOGICAL ASSESSMENT....ORIENTED TO EVENT PLACE PERSON TIME.... SPEECH SOUNDS CLEAR INITIATES APPROP CONVERSATION.... MOTOR RESPONSE: FOLLOWS COMMANDS WITHOUT PROMPTING.... MOTOR RESPONSE: LIMB STRENGTH: NORMAL POWER HAND(S) GRIP NORMAL POWER LEG(S)

02/22/04 01:00AM ENTERED BY: AGPOON,LEILANI RN LRA
PT ASLEEP P MED
PAIN DECREASED

02/22/04 05:00AM ENTERED BY: AGPOON,LEILANI RN LRA
ACTIVITY/TOL --PT AMBULATED TO THE BATHROOM WITH ASSIST OF MOTHER, UNSTEADY GAIT.

02/22/04 08:00AM ENTERED BY: CALDWELL,WANDA J RN WC
RESPIRATORY ASSESSMENT....LUNG SOUNDS: CLEAR
ABDOMINAL ASSESSMENT....ABDOMEN: SOFT....BOWEL SOUNDS: PRESENT EXPELLING FLATUS
MENTAL STATUS....ORIENTATION: ORIENTED TO PERSON PLACE....ATTENTION: AWAKE....ATTENTION: CAN FOLLOW COMMANDS....BEHAVIOR: QUIET
DRESSING(S)/INCISION....INCISION IS CLEAN --DRY AND INTACT TO THE TOP AND BACK OF HEAD
MEDS OBSERVATION....PAIN DECREASED....INTERVENTION(S): --MED FOR INCISIONAL PAIN

02/22/04 11:00AM ENTERED BY: CALDWELL,WANDA J RN WC
ACTIVITY/TOL....AMBULATED....TO B/R WITH ASSIST OF--1, UNSTEADY GAIT
NUTRITION....BREAKFAST TOLERATED WELL
SKIN ASSESSMENT....
PATIENT CARE NOTE.....--DR GREENWALD PHONED IN AND SPOKE TO PT'S DAD PRIOR TO DISCHARGE.

CONTINUED

XXXX X X
X X XX X
XXXX XXXX X X X
X X XX
X X X
==========
DISCHARGE REPORT
==========

==========

FALK STEVEN M 38 523A
828049 F0403800216 ADM: 02/07/04 M.S: X
LEE,JANE MD
CARE COORDINATOR: JOAN SANTANA

==========

02/22/04 11:30AM ENTERED BY: CALDWELL,WANDA J RN WC
NSG DISCH SUMMARY, PT TO BE DISCHARGED FROM 5EAST
ACTIVITIES OF DAILY LIVING: NEEDS ASSISTANCE WITH--ADLS
BLADDER/BOWEL: VOIDING WITHOUT DIFFICULTY
COMFORT/PAIN: PAIN RELIEVED BY--NORCO
DIET/FLUIDS: TOLERATED WITHOUT DIFFICULTY
DISCHARGE PLANNING: POST HOSPITAL ARRANGEMENTS COMPLETE
DISCHARGE PLANNING: PATIENT HAS ALL PERSONAL BELONGINGS ACCOUNTED FOR ON DISCHARGE
DISCHARGE PLANNING: DISCHARGED TO HOME
TEACHING: IS ABLE TO EXPLAIN REASONS FOR AND DEMONSTRATES USE OF DIET, MEDS, EQUIPMENT, AND TECHNIQUES NEEDED FOR MAXIMAL FUNCTION
FOLLOW-UP: PATIENT AWARE OF MD FOLLOW-UP NEEDED
FOLLOW-UP: FAMILY AWARE OF MD FOLLOW-UP NEEDED
02/22/04 01:17PM ENTERED BY: MURO,KAREN NA KM
DISCH TO HOME

TRANSFERS AND DISCHARGES:

ENTERED BY: MURO,KAREN NA KM
DISCHARGED: 02/22/04 12:00NN

LAST PAGE

P-N

PATIENT NOTES

FALK STEVEN M 38 523A
828049000F0403800216 ADM:02/07/04

DATA ENTERED DURING: 02/21 07:15 AM TO 07:15 AM 02/22

PATIENT NOTES:

02/21/04 08:00AM ENTERED BY: GILLESPIE,KRISTINE RN KRGC
ABDOMINAL ASSESSMENT....ABDOMEN: SOFT....BOWEL SOUNDS: PRESENT....
COMPLAINS OF: CONSTIPATION
PATIENT CARE NOTE....--PRUNE JCE GIVEN, PATIENT HAS NOT HAD A BM IN
A FEW DAYS. WILL INFORM DR.
MUSCULOSKELETAL ASSESSMENT....MEETS DOCUMENTATION ASSESSMENT
STANDARD
NEUROLOGICAL ASSESSMENT....MEETS DOCUMENTATION ASSESSMENT STANDARD
PAIN ASSESSMENT....LOCATION:--HEAD....PAIN ON A SCALE OF 1-10 IS:
8....INTERVENTION: MEDICATED
RESPIRATORY ASSESSMENT....MEETS DOCUMENTATION ASSESSMENT STANDARD
VASCULAR ACCESS, SITE CLEAR, DRESSING DRY & INTACT
DRESSING(S)/INCISION....DRESSING DRY & INTACT
02/21/04 09:20AM ENTERED BY: GILLESPIE,KRISTINE RN KRGC
ACTIVITY/TOL....AMBULATED....TO B/R ACCOMPANIED BY--CNA, TOL WELL
02/21/04 03:45PM ENTERED BY: RAHNEMA,MARIAM RN MRR
ABDOMINAL ASSESSMENT....ABDOMEN: SOFT....BOWEL SOUNDS: PRESENT AND
EXPELLING FLATUS
MUSCULOSKELETAL ASSESSMENT....CIRCULATION: CAPILLARY REFILL
ADEQUATE....CIRCULATION: PEDAL PULSE PRESENT BILATERAL....
SENSATION: INTACT BILATERAL ARM(S) LEG(S)
NEUROLOGICAL ASSESSMENT....ORIENTED TO EVENT PLACE PERSON TIME CLEAR
INITIATES APPROP CONVERSATION....MOTOR RESPONSE: FOLLOWS
COMMANDS WITHOUT PROMPTING --GRIPS EQUAL. PERRL.
RESPIRATORY ASSESSMENT....LUNG SOUNDS: CLEAR BILAT
VASCULAR ACCESS....PERIPHERAL VASCULAR ACCESS: PERIPHERAL OTHER: ___,
SITE CLEAR, DRESSING DRY & INTACT, LT ARM --SALINE LOCKED.
DRESSING(S)/INCISION....STAPLES DRY & INTACT TO INCISION --LT BACK
OF HEAD --SUTURES C/D/I TO RT FRONT/TOP OF HEAD.
ACTIVITY/TOL....AMBULATED WITH WALKER --WITH ASSIST OF PHYSICAL
THERAPY
PAIN ASSESSMENT....LOCATION:--HEAD INCISIONS....PAIN ON A SCALE OF
1-10 IS:8 --RECENTLY MEDICATED
02/21/04 05:30PM ENTERED BY: RAHNEMA,MARIAM RN MRR
DRESSING(S)/INCISION --STAPLES AND SUTURES TO HEAD INCISION REMOVED
PER MD ORDER. PT TOL WELL.
02/21/04 10:30PM ENTERED BY: RAHNEMA,MARIAM RN MRR
PATIENT CARE NOTE....--PT MORE DROWSY, RESP RATE 8/MIN, IRREGULAR.
AROUSABLE, BUT FALLS BACK TO SLEEP QUICKLY. ORIENTED TO
PERSON, PLACE, TIME, EVENT. PERRL. FOLLOWS COMMANDS WITH
REPEATED PROMPTING. FAMILY STATES HE IS MORE DROWSY THAN
HE HAS BEEN IN THE PAST. O2 SAT 96% ON RA. MD NOTIFIED.
NO NEW ORDERS.

CONTINUED

P-N

PATIENT NOTES

FALK STEVEN M 38 523A
828049000F0403800216 ADM:02/07/04

DATA ENTERED DURING: 02/21 07:15 AM TO 07:15 AM 02/22

02/21/04 11:45PM ENTERED BY: AGPOON,LEILANI RN LRA
RESPIRATORY ASSESSMENT....LUNG SOUNDS: CLEAR BILAT....O2 SAT: 97% IN ROOM AIR **
ABDOMINAL ASSESSMENT....ABDOMEN: ROUNDED AND SOFT....BOWEL SOUNDS: PRESENT AND NOT EXPELLING FLATUS
PAIN ASSESSMENT....LOCATION:--BACK OF HEAD....PAIN ON A SCALE OF 1-10 IS:7....INTERVENTION: MEDICATED
VASCULAR ACCESS, SITE CLEAR, DRESSING DRY & INTACT
DRESSING(S)/INCISION --INCISION TO TOP OF HEAD, AND BACK OF HEAD, CLEAN, DRY AND INTACT.
NEUROLOGICAL ASSESSMENT....ORIENTED TO EVENT PLACE PERSON TIME.... SPEECH SOUNDS CLEAR INITIATES APPROP CONVERSATION.... MOTOR RESPONSE: FOLLOWS COMMANDS WITHOUT PROMPTING.... MOTOR RESPONSE: LIMB STRENGTH: NORMAL POWER HAND(S) GRIP NORMAL POWER LEG(S)

02/22/04 01:00AM ENTERED BY: AGPOON,LEILANI RN LRA
PT ASLEEP P MED
PAIN DECREASED

02/22/04 05:00AM ENTERED BY: AGPOON,LEILANI RN LRA
ACTIVITY/TOL --PT AMBULATED TO THE BATHROOM WITH ASSIST OF MOTHER, UNSTEADY GAIT.

** END OF SECTION **

LAST PAGE

P-N

PATIENT NOTES

FALK STEVEN M 38 523A
828049000F0403800216 ADM:02/07/04

DATA ENTERED DURING: 02/20 07:15 AM TO 07:15 AM 02/21

PATIENT NOTES:

02/20/04 04:45PM ENTERED BY: PADDOCK,SANDRA L RN SPAJ
PATIENT CARE NOTE.....--REC'D FROM CCU VIA GURNEY. NEUROS INTACT-PERL 3 PLUS. DRESSING CLEAN, DRY & INTACT. DENIES PAIN. VS: 98.8-90-18-140/80. HOB ELEVATED. BREATH SOUNDS CLR.ABDOMEN SOFT WITH ACTIVE BOWEL SOUNDS. TEDS IN PLACE.

02/20/04 09:30PM ENTERED BY: PADDOCK,SANDRA L RN SPAJ
ACTIVITY/TOL....AMBULATED....IN HALL WITH ASSIST OF--1, UNSTEADY GAIT
ABDOMINAL ASSESSMENT....ABDOMEN: SOFT....BOWEL SOUNDS: PRESENT.... COMPLAINS OF: CONSTIPATION....INTERVENTION(S): --MOM GIVEN.
GU ASSESSMENT....VOIDED
MUSCULOSKELETAL ASSESSMENT....MEETS DOCUMENTATION ASSESSMENT STANDARD
NEUROLOGICAL ASSESSMENT....MEETS DOCUMENTATION ASSESSMENT STANDARD
RESPIRATORY ASSESSMENT....MEETS DOCUMENTATION ASSESSMENT STANDARD
VASCULAR ACCESS....PERIPHERAL VASCULAR ACCESS: PERIPHERAL OTHER: __, SITE CLEAR, DRESSING DRY & INTACT
PAIN ASSESSMENT....LOCATION:--INCISIONAL.....INTERVENTION: MEDICATED
MEDS OBSERVATION....PAIN RELIEVED
NUTRITION....DINNER TOLERATED WELL
PATIENT CARE NOTE.....--HOB ELEVATED.

02/20/04 11:45PM ENTERED BY: AGPOON,LEILANI RN LRA
RESPIRATORY ASSESSMENT....LUNG SOUNDS: CLEAR BILAT --TRI-FLOW IN USE. ABLE TO RAISE 2 BALLS.....O2 SAT: 97% IN ROOM AIR. **
ABDOMINAL ASSESSMENT....ABDOMEN: ROUNDED AND SOFT....BOWEL SOUNDS: PRESENT AND EXPELLING FLATUS
PAIN ASSESSMENT....LOCATION:--HEAD....PAIN ON A SCALE OF 1-10 IS: 9....INTERVENTION: MEDICATED
VASCULAR ACCESS, SITE CLEAR, DRESSING DRY & INTACT
DRESSING(S)/INCISION --DRESSING AROUND HEAD, CLEAN, DRY AND INTACT.
NEUROLOGICAL ASSESSMENT....ORIENTED TO EVENT PLACE PERSON TIME.... SPEECH SOUNDS CLEAR INITIATES APPROP CONVERSATION.... MOTOR RESPONSE: FOLLOWS COMMANDS WITHOUT PROMPTING.... MOTOR RESPONSE: LIMB STRENGTH: NORMAL POWER BOTH HAND(S) LEG(S)

02/21/04 01:00AM ENTERED BY: AGPOON,LEILANI RN LRA
PT ASLEEP P MED
PAIN DECREASED

CONTINUED

P-N

PATIENT NOTES

FALK STEVEN M 38 523A
828049000F0403800216 ADM:02/07/04

DATA ENTERED DURING: 02/20 07:15 AM TO 07:15 AM 02/21

02/21/04 05:00AM ENTERED BY: AGPOON,LEILANI RN LRA
ACTIVITY/TOL --PT BEDREST, HOB UP, TOL WELL. PT AMBULATES TO THE BATHROOM WITH ASSIST OF 1, UNSTEADY GAIT.
PT QUIET P MED
PAIN DECREASED

TRANSFERS AND DISCHARGES:

ENTERED BY: SAUNDERS,LAUREN ADSUP MCL
05:01PM 5EAST
ENTERED BY: SAUNDERS,LAUREN ADSUP MCL
02/20/04

** END OF SECTION **

LAST PAGE

EL CAMINO HOSPITAL

LABEL-0420-04 - EL CAMINO H
FALK STEVEN
828049 M 48
1 LEE,JANE MD
F0403800216 CCU

MEDICAL-SURGICAL RESTRAINT FLOWSHEET

Date: 2-8-04

☐ Initial episode (complete section 1-4) ☐ On-going episode (complete section 2-4)

TIME/DATE CURRENT ORDER EXPIRES _____

☐ Renewal order obtained

Section 1

Alternative attempted prior to initiation of restraint (check all that apply):

- ☐ Bed Alarm
- ☑ Anticipate/provide basic needs
- ☐ Promote normal sleep patterns
- ☐ Relaxation (massage)
- ☑ Exercise & activity (ROM, sit at nurses' station)
- ☐ Sensory aides (hearing aides, glasses)
- ☐ Alter treatment regime (saline lock IV, massage, etc)
- ☑ Change position
- ☐ Move room assignment closer to nurses' station
- ☐ Diversion (TV, folding linen)
- ☑ Decrease lighting/noise/reduce stimulation
- ☑ Increase lighting
- ☑ Reorientation/calming touch
- ☐ Family at bedside
- ☐ Active listening/verbal de-escalation

Result of Attempted Alternatives (check all that apply):

- ☑ Pt continues to attempt to remove lines/tubes
- ☑ Pt continues to attempt to get out of bed and is THUD II
- ☐ Other: _____

Section 2

Clinical Justification for Restraint (circle all that apply):

1. Protection of lines
2. To protect continuation of processes important for physical healing
3. To protect the patient from harm
4. Evidence that behaviors are disruptive to the continuation of treatment

☐ Patient/Family informed

☐ Plan of Care entered into MIS

Restraint Device (circle all that apply):

1. Vest
2. Wrist Left
3. Wrist Right
4. Ankle Left
5. Ankle Right
6. Mitten Left
7. Mitten Right
8. 4 Side Rails Raised

Section 3

Nursing Assessment	Shift	Day Shift				PM Shift				Noc Shift			
Clinical Justification for continuation of restraints (write in appropriate number from section 2)	[redacted]					1,2,3							
Restraint type & placement (if changes, write time & change of equipment)		☐ unchanged ☐ restraint removed, time: ____				☑ unchanged ☑ restraint removed, time: 11pm				☐ unchanged ☐ restraint removed, time: ____			
q2h safety check completed: airway clearance, circulation, proper application of restraint	Time	8a	10a	12n	2p	4p	6p	8p	10p	12m	2a	4a	6a
	RN initial							DP	DP				

Section 4

Patient ADLs	Time	8a	10a	12n	2p	4p	6p	8p	10p	12m	2a	4a	6a
Provided range-of-motion exercises, offered toileting, offered fluids/meals/snacks prn, and assisted with mouth care	RN, LVN, or CNA initials							DP	DP				

Initials: DP Signature [signature] Initials: ____ Signature _____ Initials: ____ Signature _____

Form 1092 (rev. 11/02)

EL CAMINO HOSPITAL

NEURO OBSERVATION CHAR

FALK STEVEN
828049 F04038002 S M 38
02/07/04 5EA
1 LEE, JANE MD

2/21/04
TIME STARTED 12a TIME ENDED
DATE

2-21-04 2/22/04

TIME: 12a 4p 8p 9:30p 10p 10:30p 12A 2 4 A

MISCELLANEOUS INFORMATION

B/P = ● (red ink)
Pulse = ●

VITAL SIGNS

RESPIRATORY PATTERNS
N = Normal
CS = Cheyne Strokes
CNH = Central Neurogenic Hyperventl
AP = Apneustic
AT = Ataxic

270 260 250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

CS
CNH
AP
AT

Respiration Rate Type: 20 18 18 20 8 8 18 20 18 18
CONTROLLED VENTILATION - C

Temperature: 98.4 98.8 98.6 99.2 99.2 98.2

Intracranial Pressure

PUPILS

RIGHT Size: 3 2 3
Reaction: + + x
LEFT Size: 3 2 3
Reaction: + x x

+ REACTS
— NO REACTION
C - CLOSED

COMA SCALE

EYES OPEN
- Spontaneously ✓
- To Speech ✓ ✓ ✓ ✓
- To Pain
- Never

EYES CLOSED BY SWELLING - C

BEST VERBAL RESPONSE
- Oriented ✓ ✓ ✓ ✓ ✓
- Confused
- Inappropriate Words
- Incomprehensible Sounds
- None

ET TUBE or TRACH = T

BEST MOTOR RESPONSE
- Obeys Commands ✓ ✓ ✓ ✓ ✓
- Localizes Pain
- Flexion to Pain
- Extension to Pain
- None

USUALLY REFLECTS BEST ARM RESPONSE

LIMB MOVEMENT

ARMS
- Normal Power ✓ ✓ ✓
- Weakness
- Spastic Flexion
- Extension
- No Response

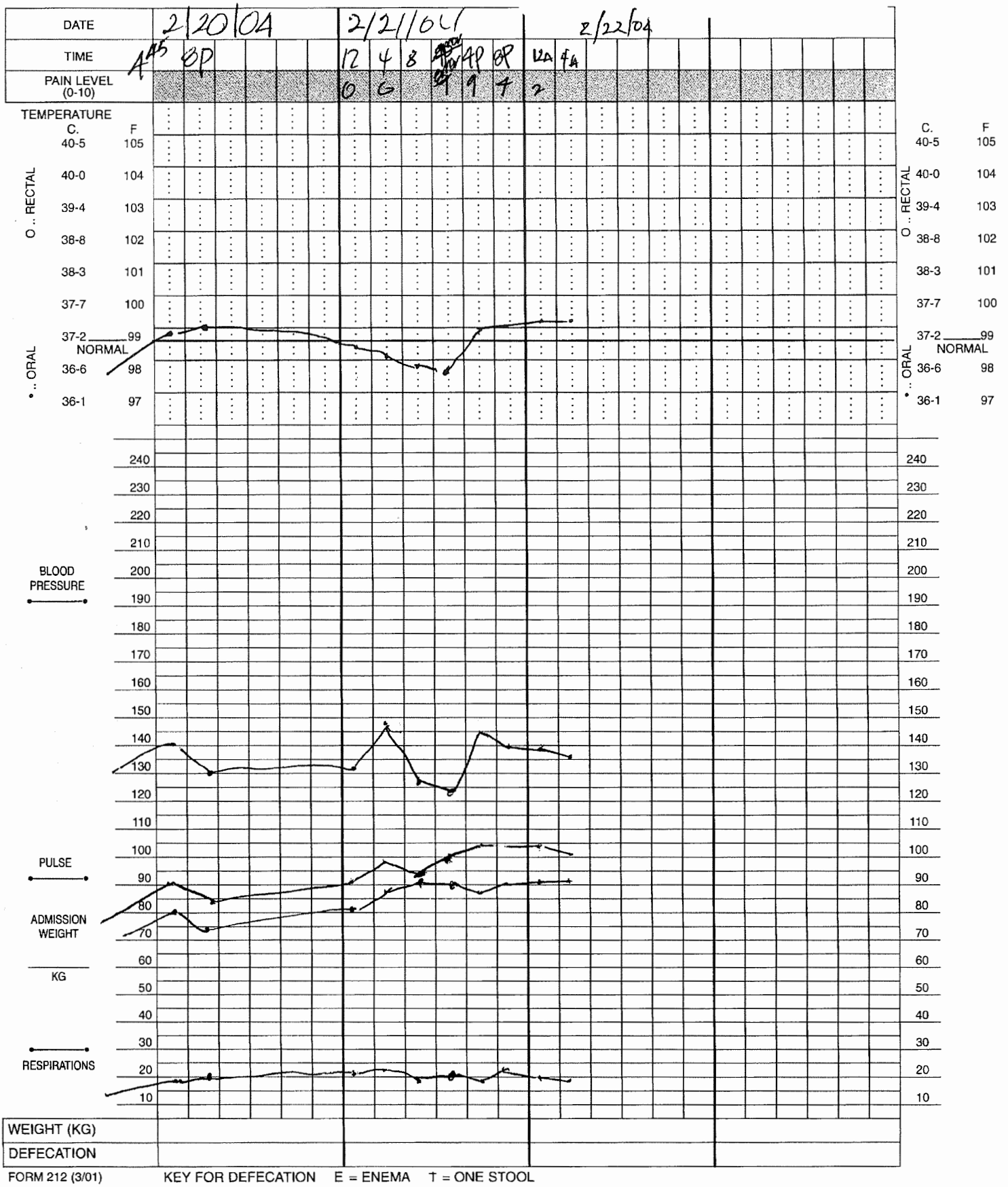
LEGS
- Normal Power ✓ ✓ ✓
- Weakness
- Withdraw
- Extension
- No Response

RECORD RIGHT (R) & LEFT (L) SEPARATELY IF THERE IS A DIFFERENCE

EL CAMINO HOSPITAL

FALK STEVEN
828049 F0403800216 M 38
02/07/04 5EA
1 LEE,JANE MD

GRAPHIC CHART



FORM 212 (3/01)

KEY FOR DEFECATION E = ENEMA T = ONE STOOL

EL CAMINO HOSPITAL
INTAKE AND OUTPUT RECORD

FALK STEVEN
828049 F0403800216 M 38
02/07/04 5EA
1 LEE,JANE MD

INTAKE					OUTPUT						
TOTAL IV	INTRAVENOUS			TUBE FEED	ORAL	TIME	URINE	NG	EMESIS	BM	MISC
					DATE 2 20 04						
						6-2					
					420	2-10	500				
					300	10-6	400				
					350	24°	900				
					DATE 02.21.04						
						6-2					
					500	2-10	BRP x3				
					450	10-6	1100				
					950	24°	0S				
					DATE						
						6-2					
						2-10					
						10-6					
						24°					
					DATE						
						6-2					
						2-10					
						10-6					
						24°					

Form 213 (9/03)

EL CAMINO HOSPITAL

FALK STEVEN
828049 M123
FOX,DAN E MD
F0403800216 02/07/04

MEDICAL-SURGICAL RESTRAINT FLOWSHEET

Date: 1-7-04

☒ Initial episode (complete section 1-4) ☐ On-going episode (complete section 2-4)

TIME/DATE CURRENT ORDER EXPIRES _____

☐ Renewal order obtained

Section 1

Alternative attempted prior to initiation of restraint (check all that apply):

- ☐ Bed Alarm
- ☐ Anticipate/provide basic needs
- ☐ Promote normal sleep patterns
- ☐ Relaxation (massage)
- ☐ Exercise & activity (ROM, sit at nurses' station)
- ☐ Sensory aides (hearing aides, glasses)
- ☐ Alter treatment regime (saline lock IV, massage, etc)
- ☐ Change position
- ☐ Move room assignment closer to nurses' station
- ☐ Diversion (TV, folding linen)
- ☐ Decrease lighting/noise/reduce stimulation
- ☐ Increase lighting
- ☐ Reorientation/calming touch
- ☐ Family at bedside
- ☐ Active listening/verbal de-escalation

Result of Attempted Alternatives (check all that apply):

- ☐ Pt continues to attempt to remove lines/tubes
- ☐ Pt continues to attempt to get out of bed and is THUD II
- ☐ Other: _____

Section 2

Clinical Justification for Restraint (circle all that apply):

1. Protection of lines
2. To protect continuation of processes important for physical healing
3. To protect the patient from harm
4. Evidence that behaviors are disruptive to the continuation of treatment per ectrial - from 3 weeks

☐ Patient/Family informed

☐ Plan of Care entered into MIS

Restraint Device (circle all that apply):

1. Vest
2. Wrist Left
3. Wrist Right
4. Ankle Left
5. Ankle Right
6. Mitten Left
7. Mitten Right
8. 4 Side Rails Raised

Section 3

Nursing Assessment	Shift	Day Shift				PM Shift				Noc Shift			
Clinical Justification for continuation of restraints (write in appropriate number from section 2)	[redacted]	134				1845 Renewed 1940							
Restraint type & placement (if changes, write time & change of equipment)		☐ unchanged ☐ restraint removed, time: ____				☐ unchanged ☒ restraint removed, time: 1940				☐ unchanged ☐ restraint removed, time: ____			
q2h safety check completed: airway clearance, circulation, proper application of restraint	Time	8a	10a	12n	2p	4p	6p	8p	10p	12m	2a	4a	6a
	RN initial												

Section 4

Patient ADLs	Time	8a	10a	12n	2p	4p	6p	8p	10p	12m	2a	4a	6a
Provided range-of-motion exercises, offered toileting, offered fluids/meals/snacks pm, and assisted with mouth care	RN, LVN, or CNA initials												

Initials: _____ Signature_____ Initials: _____ Signature_____ Initials: _____ Signature_____

Form 1092 (rev. 11/02)

EL CAMINO HOSPITAL

OPERATING ROOM PRE OPERATIVE CHECKLIST

FALK STEVEN
828049 M 48
1 LEE, JANE MD
F0403800216 CCU

	Circle Yes, No, or Not Applicable (N/A):	NURSING UNIT	OR
FORMS	SURGICAL CONSENT	(Yes) No	
	SPECIAL RELEASES/PERMITS (Hysterectomy, Limb Disposal-2 copies,)	Yes No (N/A)	
	HISTORY & PHYSICAL Dictated 2/7/04	(Yes) No	
	INTERIM SUMMARY	(Yes) No N/A	
	ADMIT/DISCHARGE	(Yes) No	
	LAB REPORTS	(Yes) No N/A	
	LABELS (24)	(Yes) No	
ALLERGY	DRUG ALLERGIES: NKDA	Yes (No)	
	Any known allergy to: IODINE	Yes (No)	
	ADHESIVE TAPE	Yes (No)	
	Allergy Band Attached	Yes No (N/A)	
PROSTHESIS	Removable Partials/Plates (none) removed in place		
	Permanent Bridge, Caps, Loose teeth (none) location		
	Glasses/Contacts (none) removed in place		
	Hearing Aid (none) removed in place Right Ear Left Ear		
	Other: (pacemaker)		
PERSONAL	Hair Pieces Removed	(None)	
	Jewelry, Medals - Taped (if impossible to remove) Taped (R) 4th finger Removed	None	
	Make up, Face Removed	(None)	
	Tampons Removed	(None)	
	Underwear Removed	(None)	
PATIENT DATA	NPO 12 MN Time		
	Voided Time	(Yes) No	
	Blood: No. of Units Autologous/Directed Donor	N/A	
	WBC 15.6 HGB 15 HCT 46.3 K 3.6		
	Temp Pulse Resp B/P WT 81.9 KG		
	Time Pre Op Meds Given:	none ordered	
	Surgical Prep Done by:	none ordered	
COMMENTS	SPECIAL CONCERNS:		
	Infection (specify) History of Hepatitis? Yes No		
	Primary language other than English		

CHECKLIST COMPLETED BY: _____ (RN SIGNATURE) _____ (DATE) _____ (OR NURSE SIGNATURE)

243 (2/95)

EL CAMINO HOSPITAL

OPERATING ROOM PRE OPERATIVE CHECKLIST

FALK STEVEN
828049
FOX, DAN E MD
F0403800216 02/07/04
M123

	Circle Yes, No, or Not Applicable (N/A):	NURSING UNIT	OR
FORMS	SURGICAL CONSENT	Yes No	
	SPECIAL RELEASES/PERMITS (Hysterectomy, Limb Disposal-2 copies,)	Yes No (N/A)	
	HISTORY & PHYSICAL	(Yes) No	
	INTERIM SUMMARY	Yes No (N/A)	
	ADMIT/DISCHARGE	Yes (No)	
	LAB REPORTS	(Yes) No N/A	
	LABELS (24)	(Yes) No	
ALLERGY	DRUG ALLERGIES:	Yes (No)	
	Any known allergy to: IODINE	Yes (No)	
	ADHESIVE TAPE	Yes (No)	
	Allergy Band Attached	Yes (No) N/A	
PROSTHESIS	Removable Partials/Plates (none) removed in place		
	Permanent Bridge, Caps, Loose teeth (none) location		
	Glasses/Contacts (none) removed in place		
	Hearing Aid (none) removed in place Right Ear Left Ear		
	Other: (pacemaker)		
PERSONAL	Hair Pieces Removed	(None)	
	Jewelry, Medals - Taped (if impossible to remove) Removed	None	
	Make up, Face Removed	(None)	
	Tampons Removed	(None)	
	Underwear Removed	None	
PATIENT DATA	NPO unknown Time		
	Voided Time	Yes (No)	
	Blood: No. of Units Autologous/Directed Donor	(N/A)	
	WBC HGB HCT K		
	Temp Pulse Resp B/P WT 72.7 KG		
	Time Pre Op Meds Given: Valium 7.5mg IV @ 1804 - 1847	none ordered	
	Surgical Prep Done by: 1931 Phenergan 12.5mg 1912 Procyclidine	none ordered	
COMMENTS	SPECIAL CONCERNS: 6'2" 160 lbs per pt IV		
	Infection (specify) None	History of Hepatitis? Yes (No)	
	Primary language other than English NO		

CHECKLIST COMPLETED BY: _____ 1-7-04 _____

RN SIGNATURE DATE OR NURSE SIGNATURE

243 (2/95) DPS FORM

EL CAMINO HOSPITAL

FALK STEVEN
828049
FOX,DAN E MD
F0403800216 02/07/04

M 48

OCCUPATIONAL THERAPY
Neuro EVALUATION

Diagnosis ☐ CVA ☐ TIA Date of event: 02/07/04 Admit Date: 2/7/04

☒ (R) occipital skull fx Seizure 2° result of Subdural hematoma Evaluation Date: 2/14/04

Physician Order: OT Eval & Tx Frequency each day Duration 10 days

Medical History: 38 y.o. ♂ (R) handed teaching tennis class & had seizure (lasting 1 min); struck back of head as fell resulting in headache, vertigo, nausea, & vomitting; had 2 subsequent seizures same day; Hx of seizure disorder, drug abuse & ETOH abuse

Social History: pt lives c partner; hasn't spoken to father in 6 mths; tennis coach

Function Prior to Admission (ADLs, transfers, ambulation) (E) c ADL's & fx'l txfrs; drove;

CURRENT ASSESSMENT

Affected side: R L

UPPER EXTREMITY: ROM Supine / Sitting	R PROM / AROM	L PROM / AROM
Shoulder	WFL	WFL
Elbow	weak	weak
Wrist		
Fingers		
Gross Grasp		
Muscle Tone	normal	normal
Strength / Voluntary control	3/5 grossly	3/5 grossly
Pain (subjective 0-10 scale)	0	0
Gross Coordination	intact	intact
Fine Coordination	intact	intact
Sensation	intact	intact

Cognition ☒ Alert, oriented X 3 ☐ Disoriented ☐ Other

Perception ☒ Intact ☐ Impaired

Memory ☒ Intact ☐ Impaired

Safety Awareness ☒ Intact ☐ Impaired

Problem Solving ☒ Intact ☐ Impaired

FOX, DAN E MD
F0403800216 02/07/04

OCCUPATIONAL THERAPY NEURO EVALUATION . . page 2

Dates: from 2/14/04 to _____ **Week #** 1

	Eval	1 week Goals	Treatments Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Weekly Update	
Date:	2/14/04	2/14/04	2/15	2/16	2/17	2/18	2/19	2/20	2/21	2/22
Rolling to R	(S)	(I)	error				CGA	S	NT	NT
Rolling to L	(S)	(I)					CGA	S	NT	NT
Supine → Sit	min/mod	(I)					CGA	S	(I)	(S)
Sit → Supine	minA	(I)					S	pt left up	S	NT
Sit → Stand	pt refused	(S)					minA	CGA	S	S
Functional Transfer	NT	(S)					minA	CGA	CGA	
Balance Sitting - Static	(S)	(I)					S	I	I	I
Balance Sitting - Dynamic	minA	(I)					S	I	I	NT
Balance Standing - Static	NT	TBA 2/22 (I)					S	I	S	S
Balance Standing - Dynamic	NT	TBA 2/22 (I)					CGA	S	min S device CGA S device	
Bathing Upper Body	S	(I)					S	I	NT	
Bathing Lower Body	S	(I)					S		NT	
Dressing Upper Extremity	NT	(I)					S		(I)	
Dressing Lower Extremity	min S c SUX	(I) c AE					SBX S		(I) sock shoe	
Self Feeding	NT	(I)					(I)	I	I	
Grooming	NT	(I)					S p s/u	I		
Personal Hygiene	Foley	(I)					foley d/c'd today	I		
Therapist Initials	KW						KW	KW	MM	MM
Charges	Eval ADL TA						ADL 2x TA 1x Ind 1x	ADL 1x TA 1x Ind 2x	ADL 1x Ind 2x	

Kim Wihtol, OTR/L KW — Name / Title — Initials

Name / Title — MM — Initials

KEY for FUNCTION **WNL** = Within Normal Limits **WFL** = Within Functional Limits

I = **Independent.** Patient requires no verbal cues (vc) or physical assistance but may use assistive device.
S = **Supervised.** Patient requires no physical assistance but requires vc for safety (after ~10 sec. observation); and/or requires setup.
CG = **Contact Guard.** Patient requires hands-on assistance to maintain static and/or dynamic balance or for intermittent physical needs, (i.e. guiding extremity)
min = **Minimum Asistance.** Patient requires 25% assistance for functional activity
mod = **Moderate Assistance.** Patient requires 50% assistance for functional activity
max = **Maximum Assistance.** Patient requires 75% assistance for functional activity
dep = **Dependent.** Patient requires total assistance of 1 or 2 persons for functional activity.

KEY FOR BALANCE

I = Independent w/or s/assist. device. No falls
s = Requires intermittent 1-hand support
min = Requires frequent touch support
mod = Requires frequent moderate support
max = Unable to maintain without full support

Treatment Plan:

☐ Neuromuscular Re-Education ☒ ROM / Stretching ☐ Balance Re-Training ☒ Therapeutic Exercise
☒ Caregiver Training ☒ ADL Re-Training ☐ Assistive Device Training ☐ _____

Rehabilitation Potential: ☐ Excellent ☒ Good ☐ Fair

Kim Wihtol, OTR/L 2/14/04
Therapist Signature — Date

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(side 1 of 2)
- [ ] PHYSICAL THERAPY
- [x] OCCUPATIONAL THERAPY
- [ ] SPEECH-LANGUAGE PATHOLOGY

Date and sign each note

1/4/04 OT eval rec'd. Chart reviewed. Eval initiated. Pt. cooperative; pt's partner (Brian) present for cgvr trng; pt sat c EOB ~ 10-15 min. pt may require AE for LB drsg but may ↑ (I) c sit in chair; please see OT eval for details. Cont. c LB ADL's & fxl txfrs to/from commode; pt c/o tight hamstrings, will inform P.T. Kim Wahl, OTR/L Eval ADL TA

2/19/04: Pt's staples removed today; pt agreeable for tx, sat c bedside chair ~ 20 min. for self-grooming activity; pt c/o tiredness & requested P.TB p 10 min sitting up but c encouragement sat 10 min. longer. Pt will require additional skilled OT/PT to ↑ max. level of (I) c ADL's & fx / txfrs. Pt put BTB p tx. Kim Wahl, OTR/L 2x ADL 1x TA

2/20/04: Pt ↑ alertness; RN interrupted tx session for private conversation c pt.; pt agreeable to get OOB & sit on EOB during discussion c RN (per RN); pt up total of 40 min+ & left up in chair; Please see OT grid for funct. levels. Pt to be seen for higher level ADL's & UE ther ex to ↑ endurance & strength; HR ↑ to 139 but ↓ quickly to 105 p rest break. Kim Wahl, OTR/L ADL, TA, Ind ex

2/21/04. See grid Pt was unstable in hallway Father/mother didn't feel comfortable s device c FWW Pt is (S)/CGA(A). Spoke c Charge Nurse & rec FWW Pt will be DC tomorrow [illegible] ADL 1x [illegible]

2/22/04 Attempted to see Pt for OT Pt got up & wanted to use bathroom & then after walking to bathroom pt stated he is too tired & requested commode Pt will be DC today. [illegible]

(over)

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- EL CAMINO H
M 48

(side 2 of 2)

- ☐ PHYSICAL THERAPY
- ☒ OCCUPATIONAL THERAPY
- ☐ SPEECH-LANGUAGE PATHOLOGY

Date and sign each note

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1 LEE, JANE MD

☒ PHYSICAL THERAPY
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☐ SPEECH-LANGUAGE PATHOLOGY

(side 1 of 2)

Date and sign each note

2/2/04 Discharge Summary: Pt exercised (A) and with resistance (B) LE's supine - able to do "bicycling" (approximation error) "Stepping" and bridging ~ problems or specific weakness. Overall strength is 3/5. (I) supine → sit → supine. Sat @ EOB for UE exercises. Stood - and becomes "dizzy" - more "nausea than dizzy" once upright. Able to ambulate in room ~ assistive device - trial a FWW into hallway & back. No visual field deficits or LOB c ambulation. Will not need a walker @ home. Mother present & will be able to assist pt if needed @ home. Would benefit from home PT for strengthening of a back to normal, & full ex remitted, c weights. & Young, PT

(over)

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1 LEE,JANE MD

(side 2 of 2)

☒ PHYSICAL THERAPY
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Date and sign each note

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ED-L2-1868-01 - EL CAMINO H
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PHYSICAL THERAPY
Neuro EVALUATION

Diagnosis ☐ CVA ☐ TIA Date of event: ~~2-7-04~~ (L) Occipital Skull Fx, (L) Occipital Epidural Hematoma s/p Craniotomy for EDH 2-8-04 & Obstructive Hydrocephalus s/p
☑ Seizure & Craniocerebral Trauma Admit Date: 2-7-04
Evaluation Date: 2-9-04
Physician Order: Eval & treat POD #1 Frequency QD Duration 7 days
Reason for current admission: seizure → hit the back of head while giving tennis lesson
Medical History Seizure Disorder since 4-02, Drug Abuse, MVA & Chronic LBP, Depression, Alcoholism
Function Prior to Admission (ADLs, transfers, ambulation) (I) S (A) device, athletic
Social / Living Arrangements: is a tennis instructor, has domestic partner

CURRENT ASSESSMENT (only List Deviations from "Within Normal Limits")

ROM / Tone / Function **Affected Side:** R L

Neck / Trunk pt very lethargic, ↓ eye opening, not able to turn head to (L)
Upper Extremity (B) UE's grossly 3-/5
Lower Extremity (B) LE's grossly 3-/5
strength testing limited by pt.'s lethargy, ↓ ability to follow commands

Pain (subjective 0-10 scale) ✓ stated
MENTATION: lethargic, follows some commands & max facilitation
SENSORY DEFICITS (sensation, proprioception, neglect)
Apraxia / Ataxia

KEY for FUNCTION **WNL** = Within Normal Limits **WFL** = Within Functional Limits

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- **S = Supervised.** Patient requires no physical assistance but requires verbal cues for safety (after ~10 sec. observation); and/or requires setup.
- **CG = Contact Guard.** Patient requires hands-on assistance to maintain static and/or dynamic balance or for intermittent physical needs, i.e: guiding extremity
- **min = Minimum Asistance.** Patient requires 25% assistance for functional activity
- **mod = Moderate Assistance.** Patient requires 50% assistance for functional activity
- **max = Maximum Assistance.** Patient requires 75% assistance for functional activity
- **dep = Dependent.** Patient requires total assistance of 1 or 2 persons for functional activity.

Functional Mobility: see next page

* 2-8 MD order: Keep EVD at 10 cms above mark on Tip of (L) Ear

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PHYSICAL THERAPY NEURO EVALUATION . . page 2

Dates: from 1-9 to _____ **Week #** 1

FUNCTIONAL STATUS	Eval.	1 week Goals	Treatments Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Weekly Update
Date:	1-9		1-10	1-11	1-12	1-13	1-14	1-15	1-16
Rolling to ___	max	~~mm~~ max	pt	to (L) max	max				
Supine → Sit	pt. not able	min	still	mod	mod				
Sit → Supine	↓	min	on	mod	mod				
Sit → Stand	↓	mod	bed	pt. not able	pt. unable				
Pivot Transfer	↓	mod	rest	↓	↓				
Ambulation: Assistive Device	↓	∅	pts.	↓	↓				
Ambulation: Distance	↓	5 steps	see	↓	↓				
Ambulation: Assistance	↓	mod	notes	↓	↓				
Balance: Sitting - Static	↓	min		CGA	sup				
Balance: Sitting - Dynamic	↓	min		min	CGA				
Balance: Standing - Static	↓	mod		pt. not able	pt. unable				
Balance: Standing - Dynamic	↓	mod		↓	↓				
Therapist Initials	~~GG~~	~~GG~~	~~GG~~	~~GG~~	~~GG~~				
Charges	IE, Ind. Act		TE, Ind. Act	TE, TA Ind. Act	TE, TA				

Gait Analysis Pt. not able to ambulate as of this time

Greg G Guanlao PT ~~GG~~
Name / Title Initials

Name / Title Initials

Name / Title Initials

Name / Title Initials

BALANCE KEY

I = Independent w/or s/assist. device. No falls	**Static** = maintain position with no body movement or external support
S = Requires intermittent 1-hand support	
min = Requires frequent touch support	
mod = Requires frequent moderate support	**Dynamic** = static PLUS actively moving trunk or extremities
max = Unable to maintain without full support	

Treatment Plan:

☑ Neuromuscular Re-Education ☑ ROM / Stretching ☑ Progressive Mobility / Transfer Training
☑ Balance Re-Training ☑ Pre-Gait Training ☐ Gait Training w/ _____ ☐ Curb/Stair Training
☐ Caregiver Training ☐ _____

Rehabilitation Potential: ☐ Excellent ☑ Good ☐ Fair
Initial Assessment of Appropriate Rehab Program level: ☐ Acute Rehab ☐ SNF Rehab ☑ OP Rehab
☐ No deficits - not necessary ☐ Unable to benefit

Functional Status at Discharge:
☐ Ambulates alone with or without device [I or S]
☐ Ambulate with assist from other person(s) [cg, min, mod]
☐ Not able to ambulate [max, dep]

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☒ PHYSICAL THERAPY
(side 1 of 2) ☐ OCCUPATIONAL THERAPY
☐ SPEECH-LANGUAGE PATHOLOGY

Date and sign each note

2-15-04 Summary note – (Ther ex 1, ind act 1) – Pt tired but agreed to UE/LE ther ex in bed. Did not want to sit EOB. Ther ex for UE & LE's – encouraged pt to do these ex (I) during the day as tol. – pick one each ½ hr. Still need to have nurse clamp drain if pts head position changes ↑ or ↓.
Cont Rx

Laura Wallace PTA /
Greg G. Ivanhoe, PT

(over)

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(side 2 of 2)

- ❑ PHYSICAL THERAPY
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- ❑ SPEECH-LANGUAGE PATHOLOGY

Date and sign each note

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☑ PHYSICAL THERAPY
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(side 1 of 2)

Date and sign each note

2-9-04 Summary Note

3:10 PM > Eval and tx completed. Barbara, pt.'s nurse reports pt. is still on bed rest. Active & assisted ex on all 4's x 10 reps/plane

> Will increase activity in coordination c MD orders.

Greg G Granlee, PT

2-10-04 Summary Notes

2 PM > Checked c Sally, RN, pt.'s nurse. Pt. still on bed rest & has ventricular drain. VS stable per RN. Okay to do ex in bed.

> (B) UE LE ex x 10 reps/plane. Pt. req mm (A) to supervision. Pt. still very sleepy.

> Will get pt. OOB when medically appropriate.

Greg G Granlee, PT

2-11-04 Summary Notes

3:20 PM > Spoke c Dr. Greenwald. Dr. Greenwald states/ordered that ventricular drain can be clamped for several hours so pt. can get out of bed.

> Pt. sat on the side of the bed ~ 3 mins p which pt. had to lay down 2° to headache & dizziness. VS stable.

> Sally, RN reported that NBP is more accurate than art BP.

> Will get pt. up in chair tomorrow. Will make D/C recommendations

(over)

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☑ PHYSICAL THERAPY
(side 2 of 2) ☐ OCCUPATIONAL THERAPY
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Date and sign each note

2-11-04 PT Notes cont.

? based on pt.'s performance tomorrow

Greg D. Granlar, PT

2-12-04 Summary Notes

4:10 PM > Lynn, RN, pt.'s nurse reports that pt had multiple procedures this am & today & that pt. seems more lethargic.

> RN ~~clamped~~ clamped ventricular drain. Pt. sat on the side of the bed ~ 7 mins while doing (B) LE LE ex x 10 reps/plane. Pt. not able to stand today bec. pt. feels dizzy; pt. refuses to stand up bec. he does not feel well yet.

> Cont. gradual mobilization. Will try pt → stand tomorrow, hopefully pivot to chair too.

Add. VS stable during PT.

Greg D. Granlar, PT

ggranlar, PT

2-13-04 Spoke to RN Connie who clamped vent-ivalve drain

@ pt responsive but keeps eyes closed

c/o neck + butt pain. Had morphine 3 ½ hours earlier - not due for more meds

- bed level exercisese as before. attempted supine -> sit but pt winced + agreed he was resisting movement. RN mei alerted to unclamp. ventric drain

A: pain limits today

P: Continue tomorrow. coordinate c RN for p. meds

Recommend OT eval

Teresa Allen mpt.

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PATIENT BELONGINGS TRANSFER RECORD

(see instructions on back of page)

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M123

This form is to be used when
- Transferring a patient from unit to unit
- Patient expires
- Patient is transferred to another facility

*Depending on patient's condition, it may be necessary to check pockets.

**Describe.

	Items To Safe in Admitting Envelope Deposit # _____	Transfer #1 From Admitting/ER (Circle one) To _____ (Unit) Sending Unit	Transfer #1 Receiving Unit	Transfer #2 From CCM To 3EAST (Unit) Sending Unit	Transfer #2 Receiving Unit	Transfer #3 From _____ To _____ (Unit) Sending Unit	Transfer #3 Receiving Unit
Jewelry							
Ring(s)**							
1. white metal (Rt hand)			✓	✓			
2.							
3.							
Other Jewelry**							
1.							
2.			✓ clothing white bag				
Watch**				✓			
Wallet*							
Purse							
Keys*		✓	✓ pant pocket	* home w/ Father 2.8.4 MS			
Dentures							
Upper							
Lower							
Partial(s)							
Glasses							
1.							
2.							
Contact Lens							
Hearing Aid(s)							
Clothing Bag**		✓	✓	✓			
Suitcase**							
Electric Razor							
Other							
1. first aid kit			✓	✓			
2.							

	NAME	DATE	NAME	DATE	NAME	DATE	NAME	DATE	NAME	DATE	NAME	DATE	NAME	DATE
			A. Hayden	2/3/04			[illegible]	2/20/04						

_____ Medications sent to pharmacy

_____ Patient expired _____ Patient transferred to another facility.

Discharged by _____ Date _____ Items taken by _____ Date _____

Nurse's Signature Relative, Other Signature

#216 (REV. 11/98) BLUE-chart CANARY-family or patient

EL CAMINO HOSPITAL
2500 GRANT ROAD, P.O. BOX 7025
MOUNTAIN VIEW, CA 94039-7025

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

El Camino Hospital makes a good faith effort to obtain a written acknowledgment from the patient of his/her receipt of this Notice of Privacy Practices. You have the right to review our Notice before signing this acknowledgment.

By signing this form, you acknowledge that you have received a copy of our current Notice of Privacy Practices which covers the privacy practices of all health care professionals, employees, contract staff, students and volunteers for El Camino Hospital and its specialty units located on or off campus.

Date: _____

Code 3
Patient Name (Print)

DOE JOHN
828049 M123
FOX,DAN E MD
F0403800216 02/07/04

JA / R.S.
Signature of Patient or Representative

Representative's Relationship to Patient

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2500 GRANT ROAD, P.O. BOX 7025
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URGENT OR EMERGENT CONDITION OF ADMISSION

5. RELEAS OF INFORMATION FOR BILLING: State law permit the Hospital to 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 Hospital for all or part of the Hospital's charge, including, but not limited to hospital or medical services companies, carriers, welfare funds, representatives of the California State Department of Health Services (if the patient is a Medi-Cal beneficiary), or the patient's employer.

6. FINANCIAL AGREEMENT: The undersigned agrees, weather he or she signs as a patient or as patient's agent or representative, that in consideration of the services to be rendered to the patient, he or she hereby individually agrees to pay the account of the Hospital in accordance with the regular rates and term of the Hospital. All delinquent accounts shall bear interest at the legal rate.

7. CONSENT TO CONTACT EMPLOYERS AND FAMILY MEMBERS: The undersigned hereby specifically authorizes Hospital, its employees, or it agent to contact the undersigned's present or past employer(s) and the undersigned's family members by any lawful means necessary regarding the patient's Hospital dept. the undersigned understands that in making such contact with regard to the undersigned's Hospital dept, the Hospital, its employees or its agents will request only such information as may be necessary to collect payment of the Hospital bill

8. ASSIGNMENT OF INSURANCE BENEFITS: In the event the patient is entitled to hospital benefits arising out of any insurance policy, the undersigned hereby assigns such benefits to the Hospital for application's to the patient's bill. Payment by the insurer will discharge the said the insurance company of its obligations under the policy to the extent of such payment. The undersigned is responsible for charges not covered by this insurance policy. The patient understands he or she is responsible for any health insurance deductibles and the uninsured percentage of the remaining of the regular charges.

9. STATEMENT TO PERMOT PAYMENT OF HOSPITAL AND MEDICAL INSURANCE BENEFITS TO HOSPITAL: The undersigned hereby certifies that the information given by him or her in applying for payment under Titles XVIII and XIX of the Social Security Act is correct and the Hospital authorized to release any information needed to act on this request. In addition, the undersigned understands that Section 51476 and 51487 of Title XXII of the California Administration Code authorizes Medi-Cal review personnel to review the patient's record and to visit and examine the patient if necessary. The undersigned also hereby request that payment of authorized benefits be made in his or her behalf, and hereby assigns to the Hospital payment for the unpaid charges of the physician(s) for whom the Hospital is authorized to bill in connection with it services.
The undersigned understands he or she is responsible for any health insurance deductible and the uninsured percentage of the remaining reasonable charges.

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

EL CAMINO HOSPITAL

By: TCH / R.S.
It duly authorized representative

Date: _____ Hour _____ m.

Code 3
Patient's Name

Patient's agent or representative

Relationship to patient

A signed copy of this document is to be delivered to Patient or Patient's Agent.