ontellus
Accelerating Insight

Please note:
This file may contain sensitive information that we are not legally authorized to redact per ***California Business and Professions Code § 22458.***

Additionally, the copy or copies following this page may be difficult to read.

We have done our best to produce a legible copy of any original documents that were not in good condition.

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD

ADEL HANNA
DOB: 3/29/1946
SSN: XXX-XX-XXXX

AKA:
DOB:
SSN:

VS.

CALIFORNIA INSTITUTION FOR MEN , STATE FUND - RIVERSIDE - STATE CONTRACTS

Case No: ADJ15547702
(IF APPLICATION HAS BEEN FILED, CASE NUMBER MUST BE INDICATED REGARDLESS OF DATE OF INJURY)

SUBPOENA DUCES TECUM

(When records are mailed, identify them by using the above Case No. or attaching copy of the subpoena.)

NO PERSONAL APPEARANCE NECESSARY

Please refer to the In Bold summary description found below to identify the documents requested by this Subpoena

The People of the State of California Sends Greetings to: ***Custodian Of Records***

CITY OF HOPE NATIONAL MEDICAL CENTER - MEDICAL

WE COMMAND YOU to appear before **A NOTARY PUBLIC**

At **ONTELLUS, 27450 Ynez Road, Suite 300, Temecula, CA 92591-4680**

On the **14th** day of **February** , **2023** , at **9** o'clock **A.** M. to testify in the above-entitled matter and to bring with you and produce the following described documents:

ANY AND ALL MEDICAL/TREATMENT RECORDS PERTAINING TO THE CARE, TREATMENT AND EXAMINATION OF CLAIMANT/APPLICANT REGARDLESS OF TIME PERIOD WHEN SERVICES WERE RENDERED. ***INCLUDING RECORDS OF DR. EVELYN BONILLA AND DR CLAYTON LAU***

(Do not produce X-rays unless specifically mentioned above.)

For failure to attend as required, you may be deemed guilty of a contempt and liable to pay to the parties aggrieved all losses and amages sustained thereby and forfeit one hundred dollars in addition thereto.
This subpoena is issued at the request of the person making the declaration on the reverse hereof, or on the copy which is served herewith.

Date 01/30/2023

WORKERS' COMPENSATION APPEALS BOARD SEAL

WORKERS' COMPENSATION APPEALS BOARD
OF THE STATE OF CALIFORNIA

Suzanne M Bynke

Workers Compensation Judge

Records copied and submitted to the designated court by ONTELLUS will be deemed as full compliance with this Subpoena.

CC: NATALIA FOLEY ESQ
295923

FOR INJURIES OCCURING ON OR AFTER JANUARY 1, 1990 AND BEFORE, JANUARY 1, 1994:

If no Application for Adjudication of Claim has been filed, a declaration under penalty of perjury that the Employee's Claim for Workers' Compensation Benefits (Form DWC-1) has been filed pursuant to Labor Code Section 5401 must be executed properly.

SEE REVERSE SIDE
[SUBPOENA INVALID WITHOUT DECLARATION]

Order Ref #: 1957134

You may fully comply with this subpoena by mailing the records described (or authenticated copies, Evid Code 1561) to the person and place stated above within ten (10) days of the date of service of this subpoena.
This subpoena does not apply to any member of the Highway Patrol, Sheriff's Office or City Police Department unless accompanied by notice from this Board that deposit of witness fee has been made in accordance with Government Code 68097.2 et seq.

DWC WCAB 32 (Slide 1) (REV. 06/18)

DECLARATION FOR SUBPOENA DUCES TECUM

Case No.: ADJ15547702

STATE OF CALIFORNIA, County of **RIVERSIDE**

The undersigned states:
That he / she is (one of) the representative(s) for the defendant in the action captioned on the reverse hereof.

That CITY OF HOPE NATIONAL MEDICAL CENTER - MEDICAL has in his / her possession or under his / her control the documents described on the reverse hereof. That said documents are material to the issues involved in the case for the following reason:
To determine present and/or past physical condition; nature, extent and duration of sickness; injury, disability and/or necessity of further treatment.

☐ **Declaration for Injuries on or After January 1, 1990 and before January 1, 1994**

That an Employee's Claim for Workers' Compensation Benefits (DWC Form 1) has been filed in accordance with Labor Code Section 5401 by the alleged injured worker whose records are sought, or if the worker is deceased, by the dependant(s) of the decedent, and that a true copy of the form filed is attached hereto. (Check Box if applicable and part of declaration below, See instructions on front of subpoena.)

I declare under penalty of perjury that the forgoing is true and correct.

Executed on 01/30/2023, at Temecula, California

Signature | ONTELLUS, 27450 Ynez Road, #300 (Address) | (951) 694-5770 (Telephone)

ONTELLUS FOR:
THE INSURANCE CARRIER:
/S/

STATE FUND - RIVERSIDE - STATE CONTRACTS
DIANA MUNOZ
PO BOX 65005 ATTN: CLAIMS PROCESSING
FRESNO, CA 93650-5005
(888) 782-8338

DECLARATION OF SERVICE

STATE OF CALIFORNIA, County of: _____

I, the undersigned, state that I served the forgoing subpoena by showing the original and delivering a true copy thereof, together with a copy of the Declaration in support thereof, to each of the following named persons , personally, at the date and place set forth opposite each name.

Name of Person Served	Date	Place
	January, 30 2023	

I declare under penalty of perjury that the forgoing is true and correct.

Executed on _____ at DUARTE, California

Signature

ADEL HANNA, CITY OF HOPE NATIONAL MEDICAL CENTER - MEDICAL

* 1 9 5 7 1 3 4 P O S *

Order Ref #: **1957134**

ONTELLUS
27450 Ynez Road, Suite 300
Temecula, CA 92591-4680
(800) 660-1107 - FAX (951) 595-4875

CCP 1013 E SERVICE BY FACSIMILE

AFFIDAVIT

PROOF OF SERVICE BY FACSIMILE

STATE OF CALIFORNIA, COUNTY OF RIVERSIDE

I, the undersigned, am employed in the County of Riverside, State of California . I am over the age of eighteen years and not a party to the within action; my business address is ONTELLUS, 27450 Ynez Road,Suite 300, Temecula CA 92591.

On 01/30/2023 , I served the forgoing document described as:

Subpoena Duces Tecum on the Custodian of Records , by FAXING a true copy there of attached here to (626) 218-8443 ,addressed as follows to :

CITY OF HOPE NATIONAL MEDICAL CENTER - MEDICAL
1500 E DUARTE RD ATTN: MEDICAL RECORDS
DUARTE, CA 91010

//

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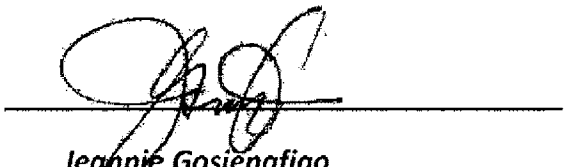
//

Executed on 01/30/2023 at Temecula, California. I declare, under penalty of perjury, that the above is true and correct.



Jeannie Gosiengfiao
Deposition Officer(s)

CCP 1013 E SERVICE BY FACSIMILE

Service by facsimile transmission shall be permitted only where the parties agree and a written confirmation of that agreement is made.

Form 81(m) (Rev. September 4, 1998

SUBP-025

ATTORNEY OR PARTY WITHOUT ATTORNEY (*Name and Address*): DIANA MUNOZ STATE FUND - RIVERSIDE - STATE CONTRACTS PO BOX 65005 ATTN: CLAIMS PROCESSING FRESNO, CA 93650-5005 (888) 782-8338 ATTORNEY FOR (*Name*): CALIFORNIA INSTITUTION FOR MEN / STATE FUND - RIVERSIDE - STATE CONTRACTS	*FOR COURT USE ONLY*
NAME OF COURT: WCAB - SAN BERNARDINO STREET ADDRESS: 464 W 4TH ST STE 239 CITY AND ZIP CODE: SAN BERNARDINO, CA 92401-1411 BRANCH NAME: SAN BERNARDINO DISTRICT OFFICE	CASE NUMBER: ADJ15547702
PLAINTIFF/PETITIONER: ADEL HANNA DEFENDANT/RESPONDENT: CALIFORNIA INSTITUTION FOR MEN / STATE FUND - RIVERSIDE - STATE CONTRACTS	
NOTICE TO CONSUMER OR EMPLOYEE AND OBJECTION **(Code Civ. Proc., §§ 1985.3, 1985.6)**	

NOTICE TO CONSUMER OR EMPLOYEE

TO *(name)*: ADEL HANNA **VIA HIS/HER ATTORNEY OF RECORD**

1. PLEASE TAKE NOTICE THAT **REQUESTING PARTY *(name)*: DIANA MUNOZ, STATE FUND - RIVERSIDE - STATE CONTRACTS** SEEKS YOUR RECORDS FOR EXAMINATION by the parties to this action on *(specify date)*:02/14/2023

The records are described in the subpoena directed to *(specify name and address of person or entity from whom records are sought)*: **CITY OF HOPE NATIONAL MEDICAL CENTER - MEDICAL 1500 E DUARTE RD ATTN: MEDICAL RECORDS DUARTE, CA 91010**

A copy of the subpoena is attached.

2. IF YOU OBJECT to the production of these records, YOU MUST DO ONE OF THE FOLLOWING BEFORE THE DATE SPECIFIED. IN ITEM a. OR b. BELOW:
   a. If you are a party to the above-entitled action, you must file a motion pursuant to Code of Civil Procedure section 1987.1 to quash or modify the subpoena and give notice of that motion to the **witness** and the **deposition officer** named in the subpoena at least five days before the date set for production of the records.
   b. If you are not a party to this action, you must serve on the **requesting party** and on the **witness,** before the date set for production of the records, a written objection that states the specific grounds on which production of such records should be prohibited. You may use the form below to object and state the grounds for your objection. You must complete the Proof of Service on the reverse side indicating whether you personally served or mailed the objection. The objection should **not** be filed with the court. **WARNING:** IF YOUR OBJECTION IS NOT RECEIVED BEFORE THE DATE SPECIFIED IN ITEM 1, YOUR RECORDS MAY BE PRODUCED AND MAY BE AVAILABLE TO ALL PARTIES.
3. YOU OR YOUR ATTORNEY MAY CONTACT THE UNDERSIGNED to determine whether an agreement can be reached in writing to cancel or limit the scope of the subpoena. If no such agreement is reached, and if you are not otherwise represented by an attorney in this action, YOU SHOULD CONSULT AN ATTORNEY TO ADVISE YOU OF YOUR RIGHTS OF PRIVACY.

Date: 01/30/2023

DIANA MUNOZ ▶ /S/ DIANA MUNOZ

(TYPE OR PRINT NAME) (SIGNATURE OF ☑ REQUESTING PARTY ☐ ATTORNEY)

OBJECTION BY NON-PARTY TO PRODUCTION OF RECORDS

1. ☐ I object to the production of all of my records specified in the subpoena.
2. ☐ I object only to the production of the following specified records:

3. The specific grounds for my objection are as follows:

Date:

▶

(TYPE OR PRINT NAME) (SIGNATURE)

SUBP-025

PLAINTIFF/PETITIONER: ADEL HANNA DEFENDANT/RESPONDENT: CALIFORNIA INSTITUTION FOR MEN	CASE NUMBER: ADJ15547702

PROOF OF SERVICE OF NOTICE TO CONSUMER OR EMPLOYEE AND OBJECTION
(Code Civ. Proc., §§ 1985.3,1985.6)

☐ **Personal Service** ☒ **Mail** Order #: 1957134

1. At the time of service I was at least 18 years of age and **not a party to this legal action.**
2. I served a copy of the *Notice to Consumer or Employee and Objection* as follows *(check either a or b)*:
   a. ☐ **Personal service.** I personally delivered the *Notice to Consumer or Employee and Objection* as follows:
      (1) Name of person served:
      (2) Address where served:
      (3) Date served:
      (4) Time served:
   b. ☒ **Mail.** I deposited the *Notice to Consumer or Employee and Objection* in the United States mail, in a sealed envelope with postage fully prepaid. The envelope was addressed as follows:
      (1) Name of person served : WORKERS DEFENDERS ANAHEIM /Opposing Counsel
      (2) Address: NATALIA FOLEY (295923) State Bar
      751 S WEIR CANYON RD STE 157-455 ANAHEIM, CA 92808
      (3) Date of mailing: 01/30/2023
      (4) Place of mailing *(city and state)*:
      Temecula, CA
      (5) I am a resident of or employed in the county where the *Notice to Consumer or Employee and Objection* was mailed.
   c. My residence or business address is *(specify)*: ONTELLUS, 27450 Ynez Rd, Temcula CA 92591
   d. My phone number is *(specify)*: (800) 660-1107

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
Date: 01/30/2023

Jeannie Gosiengfiao
(TYPE OR PRINT NAME OF PERSON WHO SERVED)

▶ _____
(SIGNATURE OF PERSON WHO SERVED)

PROOF OF SERVICE OF OBJECTION TO PRODUCTION OF RECORDS
(Code Civ. Proc., §§ 1985.3,1985.6)

☐ **Personal Service** ☐ **Mail**

1. At the time of service I was at least 18 years of age and **not a party to this legal action.**
2. I served a copy of the *Objection to Production of Records* as follows *(complete either a or b)*:
   a. ON THE REQUESTING PARTY
      (1) ☐ **Personal service.** I personally delivered the *Objection to Production of Records* as follows:
         (i) Name of person served:
         (ii) Address where served:
         (iii) Date served:
         (iv) Time served:
      (2) ☐ **Mail.** I deposited the *Objection to Production of Records in* the United States mail, in a sealed envelope with postage fully prepaid. The envelope was addressed as follows:
         (i) Name of person served:
         (ii) Address:
         (iii) Date of mailing:
         (iv) Place of mailing *(city and state)*:
         (v) I am a resident of or employed in the county where the *Objection to Production of Records* was mailed.
   b. ON THE WITNESS
      (1) ☐ **Personal service.** I personally delivered the *Objection to Production of Records* as follows:
         (i) Name of person served:
         (ii) Address where served:
         (iii) Date served:
         (iv) Time served:
      (2) ☐ **Mail.** I deposited the *Objection to Production of Records in* the United States mail, in a sealed envelope with postage fully prepaid. The envelope was addressed as follows:
         (i) Name of person served:
         (ii) Address:
         (iii) Date of mailing:
         (iv) Place of mailing *(city and state)*:
         (v) I am a resident of or employed in the county where the *Objection to Production of Records* was mailed.
3. My residence or *business* address is *(specify)*:
4. My phone number is *(specify)*:

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
Date: 01/30/2023

_____
(TYPE OR PRINT NAME OF PERSON WHO SERVED)

▶ _____
(SIGNATURE OF PERSON WHO SERVED)

Ontellus

Accelerating Insight

DECLARATION OF CUSTODIAN OF RECORDS

REGARDING: ADEL HANNA
DOB : 3/29/1946
SSN : XXX-XX-XXXX

AKA :
DOB :
SSN :

LOCATION: CITY OF HOPE NATIONAL MEDICAL CENTER - MEDICAL

ORDER REF #: *1957134 CNR*

****
THIS FORM MUST BE SIGNED
& RETURNED WHETHER OR
NOT YOU HAVE RECORDS.
****
THANK YOU!

I, the undersigned, being the duly authorized Custodian of Records, or other qualified witness, and having authorization to certify the records declare:

x[ ] **CERTIFICATE OF RECORDS COPIED:** *All records* requested by the attached Subpoena Duces Tecum / Authorization / Notice of Deposition were produced and delivered to ONTELLUS for duplication and conform to the Health Insurance Portability and Accountability Act.No records or documents have been withheld or removed from this file. If items have been omitted, please explain:

_____

[ ] **CERTIFICATE OF NO RECORDS:** A thorough search of our files, carried out under my direction and control revealed no documents requested in the attached Subpoena Duces Tecum / Authorization / Notice of Deposition. It is understood that records could exist under another name, spelling or classification but that with the information furnished, no such records could be found. ***(Please check appropriate box(es) below)***

[ ] Medical Records [ ] Billing [ ] X-Rays / Films [ ] Employment [ ] Other

Requested documents have been:

[ ] Lost / Misplaced [ ] Never Existed [ ] Destroyed after _____years

[ ] Other Comments_____

_____

I certify under penalty of perjury under the laws of the State of California that the forgoing is true and correct.

Executed on 2/2/2023 at, (city/state) Duarte, CA

Signature _____ Print Name Melissa Lopez

Phone Number (626)218-2446

ONTELLUS, 27450 YNEZ ROAD SUITE 300 TEMECULA, CA 92591-4680
www.ontellus.com lab@ontellus.com
Phone (800) 660-1107 FAX (951) 595-4875
Phone (951) 694-5770

Ref#: 1957134

Patient

Demographics

Name: Dr. Adel Hanna
Address: PO BOX 238 CHINO HILLS CA 91709

Date of birth: 3/29/1946	Sex: Male	Gender identity: Male
Language: English	Email: stmariamedical@yahoo.com	Work phone: 909-578-6061
Mobile: 949-244-7759		

09/25/2018 - Office Visit in Urology

Clinic Note

Progress Notes

Cecilio Cay V, NP at 9/25/2018 1420

MRN # 11031634 **CSN:** 303010582 **Age:** 72 y.o. (3/29/1946)	**Patient Name:** **Adel Hanna** **Gender:** male	**Encounter Department:** DUARTE UROLOGY 1500 East Duarte Rd Duarte, CA 91010-3012 626-256-4673

Progress Note

Reason for Visit

Chief Complaint

Patient presents with

- Post-op

Subjective

BPH

Elevated PSA

Status post transrectal ultrasound-guided prostate biopsy last September 17, 2018

History of Present Illness

Adel Hanna is a 72 y.o. male and a retired physician with a history of elevated PSA within the range of 2.9-3.5. The patient was being followed by his local urologist in Chino Hills–Dr. Michael Loui. His last digital rectal exam in September 2018 showed benign findings. It was a 35 g prostate as per note. In addition the patient was seen as a consult for the first time by Dr. Lau last September 13, 2018 for elevated PSA and obstructive lower urinary tract symptoms. He was previously on testosterone supplementation and was given 200 mg intramuscular supplement every 2 weeks and he stopped taking the supplements 4 months ago. Moreover, he has a family history of prostate cancer. His father died at the age of 65 years old. There is no family history of breast cancer.

On September 17, 2018 he underwent for a transrectal ultrasound-guided prostate biopsy done by Dr. Lau which revealed benign prostatic tissue.

Today, the patient is here for discussion of his pathology results. A copy of his pathology report was given to the patient. His lower urinary tract symptoms have remained to be stable and not bothersome for him. During the night he wakes up twice or 3 times and has remained to be stable. During the day he voids every 3-4 hours. The patient has the habit of drinking plenty fluids and water at night and for him this is his normal lifestyle. He has good bowel movement regimen daily as well. Denied hematuria, fever, chills, dysuria, abdominal pain or flank pain. He is able to empty his bladder subjectively to completion.

Diagnosis and Problem List

Diagnosis/Cancer Staging:

1. Elevated prostate specific antigen (PSA)

Patient Active Problem List

Diagnosis

- Elevated prostate specific antigen (PSA)

Medical History

09/25/2018 - Office Visit in Urology (continued)

Clinic Note (continued)

Past Medical History:

Past Medical History:

Diagnosis	Date
• Hypertension	
• Sinus infection	

Past Surgical History:

Past Surgical History:

Procedure	Laterality	Date
• CARDIAC CATHETERIZATION		
• COLONOSCOPY		
• GENERAL	N/A	9/17/2018
Procedure: transrectal ultrasound guided prostate biopsy; Surgeon: Clayton S Lau, MD; Location: HCRH OR; Service: Urology and Urological Oncology		
• VASECTOMY		

Family History:

No family history on file.

Social History:

Social History

Social History

• Marital status:	Divorced
Spouse name:	N/A
• Number of children:	N/A
• Years of education:	N/A

Occupational History

- Not on file.

Social History Main Topics

• Smoking status:	Never Smoker
• Smokeless tobacco:	Never Used
• Alcohol use	0.6 oz/week
1 Shots of liquor per week	
Comment: 2 drinks a week	
• Drug use:	No
• Sexual activity:	No

Other Topics	Concern
• Not on file	

Social History Narrative

- No narrative on file

Medications

Current Medications:

09/25/2018 - Office Visit in Urology (continued)

Clinic Note (continued)

Current Outpatient Prescriptions:
- amLODIPine (NORVASC) 2.5 MG tablet, Take 5 mg by mouth daily., Disp: , Rfl:
- aspirin 81 MG EC tablet, Take 81 mg by mouth daily., Disp: , Rfl:
- atenolol (TENORMIN) 25 MG tablet, Take 50 mg by mouth daily., Disp: , Rfl:
- CINNAMON PO, Take by mouth., Disp: , Rfl:
- DAILY MULTIPLE VITAMINS tablet, Take 1 tablet by mouth daily., Disp: , Rfl:
- GINKGO BILOBA COMPLEX PO, Take by mouth., Disp: , Rfl:
- GLUCOSAMINE-CHONDROITIN PO, Take by mouth., Disp: , Rfl:

Allergies/Intolerances

Reglan [metoclopramide]

Review of Systems

Review of Systems

Objective
General: No complaints of chest pain, dizziness, lightheadedness
Cardiovascular: Denies chest pain, palpitations, shortness of breath,
Pulmonary: Denies shortness of breath, paroxysmal nocturnal dyspnea, wheezing or cough
Gastrointestinal: Denies diarrhea, constipation, abdominal pain, nausea, vomiting, abdominal cramping.
Genito-Urinary: Denies dysuria, frequency, urgency, incomplete bladder emptying, bilateral CVA tenderness.
Musculoskeletal: Denies muscle tingling, numbness, weakness, cramps, bone pain
Neurological: Denies headaches, blurring of vision, tremors, slurred speech

Physical Exam

Vitals:

Vitals:

	09/25/18 1358
BP:	135/86
Pulse:	62
Resp:	18
Temp:	36.5 °C (97.7 °F)
TempSrc:	Oral
SpO2:	95%
Weight:	77.1 kg (169 lb 15.6 oz)
Height:	172.7 cm (5' 7.99")

Physical Exam
General: Alert and oriented x 4. Not in respiratory distress. Ambulatory.
Heart: Regular rate and rhytmn, no S3, No murmurs. Unable to visualize JVD.
Lungs: Clear breath sounds bilaterally.
Abdomen: round, active bowel sounds all quadrants, soft, non-tender. No rigidity or rebound tenderness noted.
Genitourinary: No testicular swelling, no urethral discharge or bleeding. No bilateral CVA tenderness noted.
No suprapubic tenderness.
Extremities: No edema, cyanosis or clubbing.

Laboratory Results Review:

WBC

Date	Value	Ref Range	Status

09/13/2018	4.1	3.6 - 10.1 K/uL	Final

Hemoglobin, Whole Blood

Date	Value	Ref Range	Status
09/13/2018	16.6 (H)	12.8 - 16.1 g/dL	Final

Hematocrit, Whole Blood

Date	Value	Ref Range	Status
09/13/2018	50.2 (H)	37.6 - 47.2 %	Final

Platelet Count

Date	Value	Ref Range	Status
09/13/2018	118 (L)	150 - 350 K/uL	Final

Blood Urea Nitrogen Level, Blood

Date	Value	Ref Range	Status
09/13/2018	11	7 - 25 mg/dL	Final

Creatinine Level, Blood

Date	Value	Ref Range	Status
09/13/2018	0.96	0.70 - 1.30 mg/dL	Final

Sodium Level, Blood

Date	Value	Ref Range	Status
09/13/2018	141	137 - 145 mmol/L	Final

Potassium Level, Blood

Date	Value	Ref Range	Status
09/13/2018	4.7	>3.5-<5.1 mmol/L	Final

Medical Imaging Review

Xr Chest Posterioranterior Lateral

Result Date: 9/13/2018
Impression: 1. Elevated right hemidiaphragm lateral minimal pleural thickening. Probable scarring. 2. No acute inflammatory or metastatic disease seen.

Assessment and Plan

Assessment:
Elevated PSA
That is post transrectal ultrasound-guided prostate biopsy done last September 17, 2020 which showed benign prostatic tissue in all 6 cores.
Lower urinary tract symptom

Plan:
Copy of the pathology report regarding the prostate biopsy completed on September 17, 2018 was given to the patient. Due to the fact that he has strong family history of prostate cancer we can see him back in 6 months time with a PSA level. Thereafter if he remains to be stable then we can space out his follow-up visits possibly on an annual basis with PSA and DRE

09/25/2018 - Office Visit in Urology (continued)

Clinic Note (continued)

All questions were answered to patient's satisfaction. The patient and his wife both verbalized agreement and understanding of the recommendations discussed. There were both encouraged to call city of Hope for urgent issues or concerns.

Electronic Signature:
Cecilio Cay V, NP
9/25/2018
2:47 PM

Electronically signed by Cecilio Cay V, NP at 9/25/2018 2:59 PM

09/25/2018 - Office Visit in Urology (continued)

Other Orders

Appointment Requests

Clinic Appointment Request MD/DO follow up; LAU, CLAYTON S (s/p prostate biopsy) [19066104] (Completed)

Electronically signed by: **Brian M. Blair, MD on 09/17/18 1623** Status: **Completed**
This order may be acted on in another encounter.
Ordering user: Brian M. Blair, MD 09/17/18 1623
Ordering provider: Brian M. Blair, MD
Authorized by: Brian M. Blair, MD
Ordering mode: Standard
Frequency: Routine 09/17/18 -
Class: Clinic Performed
Quantity: 1
Instance released by: Carmen Chavarin 9/25/2018 1:52 PM
Diagnoses
Elevated prostate specific antigen (PSA) [R97.20]

Questionnaire

Question	Answer
Reason for follow up	MD/DO follow up
Appointment provider	LAU, CLAYTON S Comment - s/p prostate biopsy

Scheduling instructions
This order should NOT be used for referrals or consults.

Indications

Elevated prostate specific antigen (PSA) [R97.20 (ICD-10-CM)]

09/25/2018 - Office Visit in Urology (continued)

Flowsheets

Custom Formula Data

Row Name	09/25/18 1358
Pct Wt Change	0 %
Mifflin Resting Metabolic Rate (Male)	1495.36
Total Daily Calories Needed (Male)	2243.04
High Biological Total Daily Protein Needed (ounces) (Male)	10.06
Water Needs - Holliday Segar Method (> 65 years)	2356.5
Mifflin Resting Metabolic Rate (Female)	1329.36
Total Daily Calories Needed (Female)	1994.04
High Biological Total Daily Protein Needed (ounces) (Female)	8.94
BSA (Calculated - sq m)	1.92 sq meters
Weight in (lb) to have BMI = 25	164
BMI (Calculated)	25.9
10% Adjustment, Tetra (IBW)	63.78
15% Adjustment, Tetra (IBW)	60.24
10% Adjustment, Para (IBW)	63.78
5% Adjustment, Para (IBW)	67.33
RDA Male (11-14 years) (kcal)	4240.5
RDA Male (15-18 years) (kcal)	3469.5
50 Kcal/Kg (kcal)	3855
25 Kcal/Kg (kcal)	1927.5
45 Kcal/Kg (kcal)	3469.5
20 Kcal/Kg (kcal)	1542
40 Kcal/Kg (kcal)	3084
35 kcal/kg (kcal)	2698.5
30 Kcal/Kg (kcal)	2313
120 kcal/kg (kcal)	9252
60 kcal/kg (kcal)	4626
140 kcal/kg (kcal)	10794
80 kcal/kg (kcal)	6168
160 kcal/kg (kcal)	12336
180 kcal/kg (kcal)	13878
200 kcal/kg (kcal)	15420
20 kcal/kg (kcal)	1542

09/25/2018 - Office Visit in Urology (continued)

Flowsheets (continued)

100 kcal/kg (kcal)	7710
40 kcal/kg (kcal)	3084
30 kcal/kg (kcal)	2313
RDA Method (kcal/day)	7864.2
RDA (4-6 years) (kcal)	6939
RDA (7-10 years) (kcal)	5397
40 KCAL/KG (BMI<18.5) (kcal)	3084
25 KCAL/KG (BMI>25-34) (kcal)	1927.5
20 KCAL/KG (BMI>34) (kcal)	1542
30 KCAL/KG (BMI>18.5-24.9) (kcal)	2313
40 KCAL/KG (BMI<18.4) (kcal)	3084
25 KCAL/KG (BMI>25-33.9) (kcal)	1927.5
20 KCAL/KG (BMI>34) (kcal)	1542
30 KCAL/KG (BMI>18.5-24.9) (kcal)	2313
Schofield Male (4-10 years) (kcal)	2150.31
WHO Equation Female (0-3 years) (kcal)	4652.1
WHO Equation Female (4-10 years) (kcal)	2233.75
WHO Equation Female (11-18 years) (kcal)	1686.62
% Ideal Body Weight	108.79
*Ideal Body Weight (IBW) (kg)	70.87
Ideal Body Weight (IBW lower range) (kg)	55.2
Ideal Body Weight (IBW upper range) (kg)	74.3
WHO Equation (kcal/day)	4641.39
WHO Equation Male (4-10 years) (kcal)	2245.17
WHO Equation Male (11-18 years) (kcal)	2000.25
RDA (0-6 month old) (kcal)	8326.8

09/25/2018 - Office Visit in Urology (continued)

Flowsheets (continued)

RDA (> 6 months-1 year old) (kcal)	7555.8
RDA Female (11-14 years) (kcal)	3623.7
RDA Female (15-18 years) (kcal)	3084
Current Weight (gm)	77100
RMR (Mifflin-St. Jeor) (kcal/day)	1495
Holliday-Segar Method (<= 10 kg) (mL)	7710
Holliday-Segar Method (> 20 kg) (mL)	4355
Holliday-Segar (mL)	4355
Holliday-Segar (mL)	3042
BMI (kg/m2)	25.9
IBW/kg (Calculated)	68.38
Low Range Vt 6mL/kg	410.28 mL/kg
Adult Moderate Range Vt 8mL/kg	547.04 mL/kg
Adult High Range Vt 10mL/kg	683.8 mL/kg

Encounter Vitals

Row Name	09/25/18 1358
BP	135/86
Pulse	62
Resp	18
Temp	36.5 °C (97.7 °F)
Temp src	Oral
SpO2	95 %
Weight	77.1 kg (169 lb 15.6 oz)
Height	172.7 cm (5' 7.99")
Pain Score	0-No pain

Screenings

Row Name	09/25/18 1358
History of Falling	No
Secondary Diagnosis	Yes
Ambulatory Aids	None/bedrest/nurse assist
Intravenous Therapy/Heparin/ Saline Lock	No
Gait/Transferring	Normal/bedrest/wheelchair
Mental Status	Oriented to own ability

09/25/2018 - Office Visit in Urology (continued)

Flowsheets (continued)

Morse Fall Risk Score	15

Vitals Reassessment

Row Name	09/25/18 1358
Restart Vitals Timer	Yes

09/25/2018 - Office Visit in Urology (continued)

Coding Summary

Account Information

Hospital Account	Primary Payor	Affiliated Recurring Accounts	Combined from HAR
3000304432 - HANNA,ADEL	BLUE CROSS [308002208]	None	None

Admission Information

Arrival Date/Time:	09/25/2018 1352	Admit Date/Time:	09/25/2018 1352	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Office	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	
Transfer Source:		Service Area:		Unit:	
Admit Provider:	Clayton S Lau, MD	Attending Provider:	Clayton S Lau, MD	Referring Provider:	Brian M. Blair, MD

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
09/25/2018 2359	Home Or Self Care	None	None	Urology

Admission Diagnoses / Reasons for Visit (ICD-10-CM)

Code	Description	Comments
R97.20	Elevated prostate specific antigen (PSA)	

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
R97.20 **[Principal]**	Elevated prostate specific antigen (PSA)				
N40.0	Benign prostatic hyperplasia without lower urinary tract symptoms				
Z80.42	Family history of malignant neoplasm of prostate				

09/17/2018 - Admission (Discharged) in Operating Room

Op Note

Op Note

Clayton S Lau, MD at 9/17/2018 1619

OPERATIVE NOTE

transrectal ultrasound guided prostate biopsy

Pre-Op Diagnosis Code: Elevated prostate specific antigen (PSA) [R97.20]

Post-Op Diagnosis Code: Elevated prostate specific antigen (PSA) [R97.20]

Surgeon: Clayton S Lau, MD

Assistants: none

Anesthesiologist: Evelyn J Bonilla, MD

Anesthesia: General endotracheal

Findings:

60 gms, no hypoechoic area

Indications:

Adel Hanna is a 72 y.o. male from Chino Hills with Obstructive Lower Urinary Tract SyAdel Hanna is a 72 y.o. male from Chino Hills with Obstructive Lower Urinary Tract Symptom. On Testerone Supplementation. PSA 2.9-3.5. DRE normal with 35 gram prostate. His brother who is 10 years his Sr. Has a history of prostate cancer and is doing well after treatment. The patient's father died at the age of 65 and had no known prostate cancer. There is no family history of breast cancer.

ExoDx=31.57 indicating higher chance of high grade cancer. Could not tolerate office TRUS Prostate Biopsy. The patient is self-referred to the city of Hope and would like to undergo a prostate biopsy under general anesthesia
.
SHIM-10
IPSS-6mptom. On Testerone Supplementation. PSA 2.9-3.5. DRE normal with 35 gram prostate. His brother who is 10 years his Sr. Has a history of prostate cancer and is doing well after treatment. The patient's father died at the age of 65 and had no known prostate cancer. There is no family history of breast cancer.

ExoDx=31.57 indicating higher chance of high grade cancer. Could not tolerate office TRUS Prostate Biopsy. The patient is self-referred to the city of Hope and would like to undergo a prostate biopsy under general anesthesia
.
SHIM-10
IPSS-6

Procedure Details

Obtaining informed consent the patient was brought to the procedure room. he got Levaquin and Gentamicin preoperatively. He was anesthetized by anesthesia with LMA. He had signed the consent before the procedure and

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Op Note (continued)

again the risk and benefits were reviewed and perioperative expectations. He confirmed he tooked the antibiotics and did the enemas. Using BK Biplanar Ultrasound we measured the prostate and 3 dimesion. 18 cores taken lateral to medial from base, mid, and apex. Patient tolerated the procedure well.

Specimens:

ID	Type	Source	Tests	Collected by	Time	Destination
A : Right Base	Tissue	Prostate	SURGICAL PATHOLOGY	Clayton S Lau, MD	9/17/2018 1630	
B : Right Mid	Tissue	Prostate	SURGICAL PATHOLOGY	Clayton S Lau, MD	9/17/2018 1630	
C : Right Apex	Tissue	Prostate	SURGICAL PATHOLOGY	Clayton S Lau, MD	9/17/2018 1630	
D : Left Base	Tissue	Prostate	SURGICAL PATHOLOGY	Clayton S Lau, MD	9/17/2018 1630	
E : Left Mid	Tissue	Prostate	SURGICAL PATHOLOGY	Clayton S Lau, MD	9/17/2018 1630	
F : Left Apex	Tissue	Prostate	SURGICAL PATHOLOGY	Clayton S Lau, MD	9/17/2018 1630	

Drains: none

Implants: * **No implants in log** *

Estimated Blood Loss: minimal

Total IV Fluids: 500ml

Blood Products: Blood Products
None

Complications: None

Disposition: PACU

Condition: stable

Counts: Needle and sharps counts were correct X2

Clayton S Lau, MD

Electronically signed by Clayton S Lau, MD at 9/17/2018 4:46 PM

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Labs

Type and Screen [18957039] (Edited Result - FINAL)

Electronically signed by: **Felicia Nicole Kinnard, PA on 09/13/18 1335** Status: **Completed**
Ordering user: Felicia Nicole Kinnard, PA 09/13/18 1335
Ordering provider: Felicia Nicole Kinnard, PA
Authorized by: Felicia Nicole Kinnard, PA
Ordering mode: Standard
Frequency: Routine Once 09/17/18 1449 - 1 occurrence
Class: Unit Collect
Quantity: 1
Lab status: Edited Result - FINAL
Instance released by: Yossyanne A Simbolon, NP (auto-released) 9/17/2018 2:48 PM

Specimen Information

ID	Type	Source	Collected By
18260B-BB0055	Blood	—	Yossyanne Simbolon, NP 09/17/18 1525

Type and Screen [18957039]

Resulted: 09/17/18 1610, Result status: Edited Result - FINAL

Ordering provider: Felicia Nicole Kinnard, PA 09/17/18 1448
Order status: Completed
Filed by: Coh Interface, Bloodbank Test Results In 09/17/18 1610
Collected by: Yossyanne Simbolon, NP 09/17/18 1525
Resulting lab: ATC BLOOD BANK LAB
CLIA number: 05D0665695

Components

Component	Value	Reference Range	Flag	Lab
Specimen Expiration Date	20180920	—	—	ATC BB
ABO/Rh Typing	A RH POSITIVE	—	—	ATC BB
Antibody Screen	NEGATIVE	—	—	ATC BB

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
34 - ATC BB	ATC BLOOD BANK LAB	Dennis D Weisenburger, MD	CLIA #05D0665695 1500 E Duarte Rd Duarte CA 91010	02/28/18 1705 - 01/04/19 0000

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Pathology

Surgical Pathology [19066086] (Final result)

Electronically signed by: **Clayton S Lau, MD on 09/17/18 1709**
Status: **Completed**
Mode: Ordering in Verbal with readback mode
Communicated by: Kristian Perfecto, RN
Ordering user: Kristian E. Perfecto, RN 09/17/18 1631
Ordering provider: Clayton S Lau, MD
Authorized by: Clayton S Lau, MD
Ordering mode: Verbal with readback
Frequency: Timed 09/17/18 1631 - 1 occurrence
Class: Unit Collect
Quantity: 1
Lab status: Final result
Instance released by: Kristian E. Perfecto, RN 9/17/2018 4:31 PM
Diagnoses
Elevated prostate specific antigen (PSA) [R97.20]

Lab Result Document - Document on 9/19/2018 3:16 PM (below)

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Pathology (continued)

CITY OF HOPE NATIONAL MEDICAL CENTER
Department of Pathology
Dennis D. Weisenburger, MD, Laboratory Director
CLIA ID# 05D0665695
1500 E. Duarte Road, Duarte CA 91010-0269
(626) 359-8111 FAX: (626) 218-8145

Case ID:	**S18-07575**
Patient:	**Hanna, Adel**
MRN:	**11031634**
Date of Birth:	**3/29/1946**
Gender:	**Male**

Surgical Pathology (Final result) S18-07575

Authorizing Provider:	Clayton S Lau, MD	Ordering Provider:	Clayton S Lau, MD
Ordering Location:	Operating Room	Collected:	09/17/2018 1630
Pathologist:	Huiqing Wu, MD	Received:	09/17/2018 1804

Final Diagnosis

PROSTATE, CORE BIOPSIES:

RIGHT BASE (A):
- Benign prostatic tissue

RIGHT MID (B):
- Benign prostatic tissue

RIGHT APEX (C):
- Benign prostatic tissue

LEFT BASE (D):
- Benign prostatic tissue

LEFT MID (E):
- Benign prostatic tissue
- See microscopic description

LEFT APEX (F):
- Benign prostatic tissue

Electronically signed by Huiqing Wu, MD on 9/19/2018 at 1515

Microscopic Description

Examination of histologic sections was performed and contributed to the final diagnosis.

RESULT - IMMUNOHISTOCHEMISTRY (Block E1):

PIN4 - No prostatic adenocarcinoma

Appropriate positive and negative controls were employed for each immunohistochemical stain. Some of the tests reported here have been developed and performance characteristics determined by the Department of Pathology, City of Hope National Medical Center. These tests have not been cleared or approved by the U.S. Food and Drug Administration (FDA). The FDA has determined that such clearance or approval is not necessary. Test results are to be used for clinical purposes and should not be regarded as investigational or for research. This Laboratory is certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) as qualified to perform high complexity clinical laboratory testing.

Gross Description

A. Prostate, Right Base, Tissue: The specimen is labeled with the patient's name Adel Hanna and MRN 11031634. Received in formalin are 2 soft tan tissue cores measuring 0.7 x 0.1-1.3 x 0.1 cm which are entirely submitted.

S18-07575

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Pathology (continued)

CITY OF HOPE NATIONAL MEDICAL CENTER
1500 E. Duarte Road, Duarte CA 91010-0269
(626) 359-8111 FAX: (626) 218-8145

Case ID: **S18-07575**
Patient: **Hanna, Adel**
Date of Birth: **3/29/1946**

Cassette Summary
1) Tissue cores - 2

B. Prostate, Right Mid, Tissue: The specimen is labeled with the patient's name Adel Hanna and MRN 11031634. Received in formalin are 3 soft tan tissue cores ranging from 0.7 x 0.1-1.0 x 0.1 cm which are entirely submitted.
Cassette Summary
1) Tissue cores - 3

C. Prostate, Right Apex, Tissue: The specimen is labeled with the patient's name Adel Hanna and MRN 11031634. Received in formalin are 3 soft tan tissue cores averaging 0.8 x 0.1 cm in greatest dimension. Received additionally in the container is a 0.3 cm in greatest dimension aggregate of soft tan tissue. Entirely submitted.
Cassette Summary
1) Tissue cores - 3+

D. Prostate, Left Base, Tissue: The specimen is labeled with the patient's name Adel Hanna and MRN 11031634. Received in formalin are 3 soft tan tissue cores ranging from 0.6 x 0.1-1.0 x 0.1 cm which are entirely submitted.
Cassette Summary
1) Tissue cores - 3

E. Prostate, Left Mid, Tissue: The specimen is labeled with the patient's name Adel Hanna and MRN 11031634. Received in formalin are 4 soft tan tissue cores ranging from 0.4 x 0.1-1.1 x 0.1 cm which are entirely submitted.
Cassette Summary
1) Tissue cores - 4

F. Prostate, Left Apex, Tissue: The specimen is labeled with the patient's name Adel Hanna and MRN 11031634. Received in formalin is a 0.4 cm in greatest dimension aggregate of soft tan tissue which is entirely submitted.
Cassette Summary
1) Formalin fixed tissue - multiple

Additional Information
As the senior attending pathologist whose electronic signature appears on this report, I have reviewed the slides and edited the gross and/or microscopic portion of the report in rendering the final diagnosis.

Specimens
A Prostate, Right Base
B Prostate, Right Mid
C Prostate, Right Apex
D Prostate, Left Base
E Prostate, Left Mid
F Prostate, Left Apex

Specimen Information

ID	Type	Source	Collected By
A	Tissue	Prostate	Clayton S Lau, MD 09/17/18 1630
B	Tissue	Prostate	Clayton S Lau, MD 09/17/18 1630
C	Tissue	Prostate	Clayton S Lau, MD 09/17/18 1630
D	Tissue	Prostate	Clayton S Lau, MD 09/17/18 1630

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Pathology (continued)

E	Tissue	Prostate	Clayton S Lau, MD 09/17/18 1630
F	Tissue	Prostate	Clayton S Lau, MD 09/17/18 1630

Surgical Pathology [19066086] Resulted: 09/19/18 1515, Result status: Final result

Ordering provider: Clayton S Lau, MD 09/17/18 1631
Filed by: Huiqing Wu, MD 09/19/18 1515

Order status: Completed
Collected by:
Clayton S Lau, MD 09/17/18 1630
Clayton S Lau, MD 09/17/18 1630
Clayton S Lau, MD 09/17/18 1630
Clayton S Lau, MD 09/17/18 1630
Clayton S Lau, MD 09/17/18 1630
Clayton S Lau, MD 09/17/18 1630

Resulting lab: HCRH PATHOLOGY LAB
CLIA number: 05D0665695
Acknowledged by: Clayton S Lau, MD on 09/19/18 2104

Components

Component	Value	Reference Range	Flag	Lab
Final Diagnosis	--	—	—	HCRH PATH

Result: PROSTATE, CORE BIOPSIES:

RIGHT BASE (A):
- Benign prostatic tissue

RIGHT MID (B):
- Benign prostatic tissue

RIGHT APEX (C):
- Benign prostatic tissue

LEFT BASE (D):
- Benign prostatic tissue

LEFT MID (E):
- Benign prostatic tissue
- See microscopic description

LEFT APEX (F):
- Benign prostatic tissue

Electronically signed by Huiqing Wu, MD on 9/19/2018 at 1515

Microscopic Description	--	—	—	HCRH PATH

Result: Examination of histologic sections was performed and contributed to the final diagnosis.

RESULT - IMMUNOHISTOCHEMISTRY (Block E1):

PIN4 - No prostatic adenocarcinoma

Appropriate positive and negative controls were employed for each immunohistochemical stain. Some of the tests reported here have been developed and performance characteristics determined by the Department of Pathology, City of Hope National Medical Center. These tests have not been cleared or approved by the U.S. Food and Drug Administration (FDA). The FDA has determined that such clearance or approval is not necessary. Test results are to be used for clinical purposes and should not be regarded as investigational or for research. This Laboratory is certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) as qualified to perform high complexity clinical laboratory testing.

Gross Description	--	—	—	HCRH PATH

Result: A. Prostate, Right Base, Tissue: The specimen is labeled with the patient's name Adel Hanna and MRN 11031634. Received in formalin are 2 soft tan tissue cores measuring 0.7 x 0.1-1.3 x 0.1 cm which are entirely submitted.
Cassette Summary

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Pathology (continued)

1) Tissue cores - 2

B. Prostate, Right Mid, Tissue: The specimen is labeled with the patient's name Adel Hanna and MRN 11031634. Received in formalin are 3 soft tan tissue cores ranging from 0.7 x 0.1-1.0 x 0.1 cm which are entirely submitted.
Cassette Summary
1) Tissue cores - 3

C. Prostate, Right Apex, Tissue: The specimen is labeled with the patient's name Adel Hanna and MRN 11031634. Received in formalin are 3 soft tan tissue cores averaging 0.8 x 0.1 cm in greatest dimension. Received additionally in the container is a 0.3 cm in greatest dimension aggregate of soft tan tissue. Entirely submitted.
Cassette Summary
1) Tissue cores - 3+

D. Prostate, Left Base, Tissue: The specimen is labeled with the patient's name Adel Hanna and MRN 11031634. Received in formalin are 3 soft tan tissue cores ranging from 0.6 x 0.1-1.0 x 0.1 cm which are entirely submitted.
Cassette Summary
1) Tissue cores - 3

E. Prostate, Left Mid, Tissue: The specimen is labeled with the patient's name Adel Hanna and MRN 11031634. Received in formalin are 4 soft tan tissue cores ranging from 0.4 x 0.1-1.1 x 0.1 cm which are entirely submitted.
Cassette Summary
1) Tissue cores - 4

F. Prostate, Left Apex, Tissue: The specimen is labeled with the patient's name Adel Hanna and MRN 11031634. Received in formalin is a 0.4 cm in greatest dimension aggregate of soft tan tissue which is entirely submitted.
Cassette Summary
1) Formalin fixed tissue - multiple

Additional Information -- — — HCRH PATH
Result: As the senior attending pathologist whose electronic signature appears on this report, I have reviewed the slides and edited the gross and/or microscopic portion of the report in rendering the final diagnosis.

Case Report -- — — HCRH PATH
Result:
Surgical Pathology Case: S18-07575
Authorizing Provider: Clayton S Lau, MD Collected: 09/17/2018 1630
Ordering Location: Operating Room Received: 09/17/2018 1804
Pathologist: Huiqing Wu, MD
Specimens: A) - Prostate, Right Base
B) - Prostate, Right Mid
C) - Prostate, Right Apex
D) - Prostate, Left Base
E) - Prostate, Left Mid
F) - Prostate, Left Apex

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
20 - HCRH PATH	HCRH PATHOLOGY LAB	Dennis D Weisenburger, MD	CLIA #05D0665695 1500 E Duarte Rd Duarte CA 91010	04/10/18 0944 - 12/03/18 1306

Indications

Elevated prostate specific antigen (PSA) [R97.20 (ICD-10-CM)]

All Reviewers List

Clayton S Lau, MD on 9/19/2018 21:04

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Pathology (continued)

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Anesthesia on 09/17/18

Notes

Anesthesia Postprocedure Evaluation

Evelyn J Bonilla, MD at 9/17/2018 1707

Patient: Adel Hanna

Procedure Summary

Date: 09/17/18
Anesthesia Start: 1610
Procedure: transrectal ultrasound guided prostate biopsy (N/A)

Surgeon: Clayton S Lau, MD
Anesthesia Type: general

Room / Location: HOR1 / HCRH OR
Anesthesia Stop: 1644
Diagnosis:
Elevated prostate specific antigen (PSA)
(Elevated prostate specific antigen (PSA) [R97.20])
Responsible Provider: Evelyn J Bonilla, MD
ASA Status: 2

Anesthesia Type: general
Last vitals

BP	128/85 (09/17/18 1700)
Temp	36.4 °C (97.5 °F) (09/17/18 1640)
Pulse	57 (09/17/18 1700)
Resp	19 (09/17/18 1700)
SpO2	96 % (09/17/18 1700)

Anesthesia Post Evaluation

Patient location during evaluation: **PACU**
Patient participation: **complete - patient participated**
Level of consciousness: **awake and alert**
Pain management: **adequate**
Airway patency: **patent**
Anesthetic complications: **no**
Cardiovascular status: **hemodynamically stable**
Respiratory status: **spontaneous ventilation and acceptable**
Hydration status: **acceptable**

Electronically signed by Evelyn J Bonilla, MD at 9/17/2018 5:07 PM

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Anesthesia on 09/17/18 (continued)

Anesthesia Preprocedure Evaluation

Evelyn J Bonilla, MD at 9/14/2018 1424

HPI:
IDENTIFICATION:
Patient is a 72-year-old male, retired cardiac thoracic surgeon scheduled on 9/17/2018 for transrectal ultrasound-guided prostate biopsy with Dr. Lau.

HISTORY OF PRESENT ILLNESS:
Elevated PSA.

PAST MEDICAL HISTORY:
Hypertension diagnosed about 5 years ago. On atenolol for migraine headaches for the past 30 years. GERD. Non cardiac chest pain, states angiogram done 4 years ago was negative.

PAST SURGICAL HISTORY:
Vasectomy. Cholecystectomy 1986.

ANESTHESIA HISTORY:
Denies any complications from anesthesia. No family history of anesthesia complications.

ALLERGIES:
-- Reglan (Metoclopramide)
-- Shaking symptoms

MEDICATIONS:

Current Outpatient Prescriptions:
- amLODIPine (NORVASC) 2.5 MG tablet, Take 5 mg by mouth daily., Disp: , Rfl:
- aspirin 81 MG EC tablet, Take 81 mg by mouth daily., Disp: , Rfl:
- atenolol (TENORMIN) 25 MG tablet, Take 50 mg by mouth daily., Disp: , Rfl:
- CINNAMON PO, Take by mouth., Disp: , Rfl:
- DAILY MULTIPLE VITAMINS tablet, Take 1 tablet by mouth daily., Disp: , Rfl:
- GINKGO BILOBA COMPLEX PO, Take by mouth., Disp: , Rfl:
- GLUCOSAMINE-CHONDROITIN PO, Take by mouth., Disp: , Rfl:

SOCIAL HISTORY:
Social History
Marital status: Divorced Spouse name:
Years of education: Number of children:

Occupational History
None on file

Social History Main Topics
Smoking status: Never Smoker

Smokeless tobacco: Never Used
Alcohol use: Yes 0.6 oz/week
Shots of liquor: 1 per week

Comment: 2 drinks a week
Drug use: No
Sexual activity: No

Other Topics Concern
None on file

Social History Narrative
None on file

FAMILY HISTORY:
States brother had a fatal MI in his mid 50s. Denies any family history of CVAs.

REVIEW OF SYSTEMS:
Patient does endorse in the past he has had angiograms for noncardiac chest pain. States he was told it was acid reflex. Last one was about 4 years ago. Denies any recent upper respiratory infections or urinary tract infections. Patient denies snoring. Denies heart palpitations. Denies neuropathy or edema. No history of seizure, stroke or TIA.

Anesthesia Evaluation

Neuro/Psych (-) syncope, no seizure disorder,
GI/Liver
Endo/Other
GU
Renal
Hematology/Lymphatic/Musculoskeletal
Relevant Cancer History
Cardiovascular
Exercise tolerance: > or = 4 METS (Patient states he can walk 4 blocks and climb 2 flights of stairs easily. He does live in a two-story home. He carries 5 gallons of water as needed for his fish tank. Denies any chest pain, chest pressure, shortness of breath with activity.)
(+) hypertension,
(-) murmur, carotid bruits, peripheral edema

ECG reviewed (-) chest pain,
Pulmonary
(-) recent URI

PHYSICAL EXAM

Airway
Mallampati: II
TM distance: >3 FB
Neck ROM: full
Dental - **normal exam**
Cardiovascular PE - **normal exam**

Pulmonary PE clear to auscultation- **normal exam**
Abdominal

Other findings:

	09/14/18
	1403
BP:	127/72
Pulse:	58
Resp:	18
Temp:	36.8 °C (98.2 °F)
SpO2:	96%

BMI:

comparison made to previous images

all labs reviewed

Specialty Testing:

Chest x-ray done 9/13/2018 states:
The right hemidiaphragm and right lateral costophrenic angle are elevated. Mild pleural thickening in the right lower lung laterally is noted. Reticular opacities noted in the right apex. No pulmonary nodules, infiltrates or congestion are seen. The heart is normal in size with moderate to marked tortuosity of the descending aorta. No lytic or blastic bone lesions and no fracture identified.

EKG done 9/13/2018 states marked sinus bradycardia, heart rate 44. Abnormal EKG. No previous EKGs available. Confirmed by Dr. CAI. (Pt states he took a beta blocker)

Lab Results

Component	Value	Date
WBC	4.1	09/13/2018
RBCCNT	5.93 (H)	09/13/2018
HGBB	16.6 (H)	09/13/2018
HCTB	50.2 (H)	09/13/2018
MCV	84.7	09/13/2018
MCH	28.0	09/13/2018
MCHC	33.1	09/13/2018
RDW	17.2 (H)	09/13/2018
PLTCNT	118 (L)	09/13/2018

MPV	10.1	09/13/2018

Lab Results

Component	Value	Date
CAB	10.0	09/13/2018
NAB	141	09/13/2018
KB	4.7	09/13/2018
CLB	104	09/13/2018
CO2B	31 (H)	09/13/2018
GLUB	88	09/13/2018
BUNB	11	09/13/2018
CREATB	0.96	09/13/2018
EGFRO		09/13/2018

Comment:
RESULT NOT VALID Results using the MDRD study equation have not been validated for use with patients under 18 and over 70 years of age, pregnant women, patients with serious comorbid conditions, or persons with extremes of body size, muscle mass, or nutritional status. Chronic Kidney Disease <60 mL/min/1.73sq M Kidney Failure <15 mL/min/1.73sq M

EGFRA		09/13/2018

Comment:
RESULT NOT VALID Results using the MDRD study equation have not been validated for use with patients under 18 and over 70 years of age, pregnant women, patients with serious comorbid conditions, or persons with extremes of body size, muscle mass, or nutritional status. Chronic Kidney Disease <60 mL/min/1.73sq M Kidney Failure <15 mL/min/1.73sq M

AGPB	6 (L)	09/13/2018

NP Assessment/Plan:
ASSESSMENT:
The patient is a 72-year-old male who is scheduled for a transrectal ultrasound-guided prostate biopsy with a medical history of GERD, hypertension, noncardiac chest pain.

PLAN:
Preoperative teaching was done with the patient by the RN. Patient is aware not to take any aspirin, Advil, Motrin, Aleve, herbal supplements, green tea, or fish oil prior to surgery. Patient was instructed he does not need to take any medication on day procedure.

Unable to find outside cardiac records, specifically angiograms. This case has been discussed with Dr. Gray, a full evaluation has been completed. Patient may proceed with surgery.

Anesthesia Plan

ASA 2

general

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Anesthesia on 09/17/18 (continued)

I have discussed the risks and benefits of the anesthetic plan, including any applicable alternatives, with the patient and/or legal health care proxy/guardian. All questions were answered and the patient and/or legal health care proxy/guardian expressed an understanding and acceptance of the anesthetic plan and wishes to proceed. Patient accepted.
Use of blood products discussed with patient whom consented to blood products.

Electronically signed by Evelyn J Bonilla, MD at 9/17/2018 3:25 PM

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Anesthesia on 09/17/18 (continued)

Anesthesia Procedure Notes

Evelyn J Bonilla, MD at 9/17/2018 1620

Procedure Orders
1. INTUBATION [18957050] ordered by Evelyn J Bonilla, MD

Intubation
Date/Time: 9/17/2018 4:20 PM
Urgency: elective

Airway not difficult

General Information and Staff

Patient location during procedure: OR

Indications and Patient Condition
Indications for airway management: anesthesia
Spontaneous Ventilation: absent
Sedation level: deep
Preoxygenated: yes
Patient position: sniffing
Mask difficulty assessment: 1 - vent by mask

Final Airway Details
Final airway type: supraglottic airway

Successful airway: I-Gel
Size 4

Number of attempts at approach: 1

Electronically signed by Evelyn J Bonilla, MD at 9/17/2018 4:20 PM

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Anesthesia on 09/17/18 (continued)

Anesthesia Orders

INTUBATION [18957050] (In process)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Completed**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620
Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD
Ordering mode: Standard
Frequency: Routine Once 09/17/18 1621 - 1 occurrence
Class: Normal
Quantity: 1
Lab status: In process
Instance released by: Evelyn J Bonilla, MD 9/17/2018 4:20 PM
Order comments: This order was created via procedure documentation

INTUBATION [18957050] Resulted: 09/17/18 1620, Result status: In process

Ordering provider: Evelyn J Bonilla, MD 09/17/18 1620
Order status: Completed
Filed on: 09/17/18 1620
Narrative:
Evelyn J Bonilla, MD 9/17/2018 4:20 PM
Intubation
Date/Time: 9/17/2018 4:20 PM
Urgency: elective

Airway not difficult

General Information and Staff

Patient location during procedure: OR

Indications and Patient Condition
Indications for airway management: anesthesia
Spontaneous Ventilation: absent
Sedation level: deep
Preoxygenated: yes
Patient position: sniffing
Mask difficulty assessment: 1 - vent by mask

Final Airway Details
Final airway type: supraglottic airway

Successful airway: I-Gel
Size 4

Number of attempts at approach: 1

Procedures Performed	Chargeables
PR AN ELECTIVE SUPRAGLOTTIC AIRWAY [ANE714]	

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Anesthesia on 09/17/18 (continued)

Anesthesia Medications

ondansetron (ZOFRAN) injection [18957048] (Discontinued)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1619** — Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1619 — Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD — Ordering mode: Standard
PRN reasons: nausea vomiting
Frequency: Routine PRN 09/17/18 1614 - 09/17/18 1707 — Class: Normal
Discontinued by: Evelyn J Bonilla, MD 09/17/18 1707 — Package: 63323-373-02
[Anesthesia Stop]

dexamethasone (DECADRON) injection [18957047] (Discontinued)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1619** — Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1619 — Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD — Ordering mode: Standard
Frequency: Routine PRN 09/17/18 1614 - 09/17/18 1707 — Class: Normal
Discontinued by: Evelyn J Bonilla, MD 09/17/18 1707 — Package: 63323-165-01
[Anesthesia Stop]

lidocaine PF (XYLOCAINE) 2 % injection [18957046] (Discontinued)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1619** — Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1619 — Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD — Ordering mode: Standard
Frequency: Routine PRN 09/17/18 1614 - 09/17/18 1707 — Class: Normal
Discontinued by: Evelyn J Bonilla, MD 09/17/18 1707 — Package: 0409-2066-05
[Anesthesia Stop]

fentaNYL citrate (PF) injection [18957045] (Discontinued)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1619** — Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1619 — Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD — Ordering mode: Standard
Frequency: Routine PRN 09/17/18 1614 - 09/17/18 1707 — Class: Normal
Discontinued by: Evelyn J Bonilla, MD 09/17/18 1707 — Package: 0409-9094-22
[Anesthesia Stop]

propofol (DIPRIVAN) injection [18957044] (Discontinued)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1619** — Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1619 — Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD — Ordering mode: Standard
Frequency: Routine PRN 09/17/18 1614 - 09/17/18 1707 — Class: Normal
Discontinued by: Evelyn J Bonilla, MD 09/17/18 1707 — Package: 63323-269-29
[Anesthesia Stop]

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Other Orders

Appointment Requests

Clinic Appointment Request MD/DO follow up; LAU, CLAYTON S (s/p prostate biopsy) [19066082] (Completed)

Electronically signed by: **Brian M. Blair, MD on 09/17/18 1623** Status: **Completed**
Ordering user: Brian M. Blair, MD 09/17/18 1623
Ordering provider: Brian M. Blair, MD
Authorized by: Brian M. Blair, MD
Ordering mode: Standard
Frequency: Routine 09/17/18 -
Class: Clinic Performed
Quantity: 1
Diagnoses
Elevated prostate specific antigen (PSA) [R97.20]

Questionnaire

Question	Answer
Reason for follow up	MD/DO follow up
Appointment provider	LAU, CLAYTON S Comment - s/p prostate biopsy

Scheduling instructions
This order should NOT be used for referrals or consults.

Indications

Elevated prostate specific antigen (PSA) [R97.20 (ICD-10-CM)]

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Other Orders (continued)

Case Request

Case Request [18957029] (Completed)

Electronically signed by: **Yossyanne Simbolon, NP on 09/17/18 1439** Status: **Completed**
Ordering user: Yossyanne Simbolon, NP 09/17/18 1439
Authorized by: Clayton S Lau, MD
Frequency: Routine Once 09/17/18 1440 - 1 occurrence
Quantity: 1
Ordering provider: Clayton S Lau, MD
Ordering mode: Standard
Class: Hospital Performed (Duarte admitted patients only)
Instance released by: Yossyanne A Simbolon, NP 9/17/2018 2:39 PM

Diagnoses
Elevated prostate specific antigen (PSA) [R97.20]

Indications

Elevated prostate specific antigen (PSA) [R97.20 (ICD-10-CM)]

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Other Orders (continued)

CORE MEASURES

Intermittent pneumatic compression device applied [18957041] (Completed)

Electronically signed by: **Felicia Nicole Kinnard, PA on 09/13/18 1335** Status: **Completed**
Ordering user: Felicia Nicole Kinnard, PA 09/13/18 1335
Authorized by: Felicia Nicole Kinnard, PA
Frequency: Routine Once 09/17/18 1449 - 1 occurrence
Quantity: 1
Ordering provider: Felicia Nicole Kinnard, PA
Ordering mode: Standard
Class: Normal
Instance released by: Yossyanne A Simbolon, NP (auto-released) 9/17/2018 2:48 PM

Questionnaire

Question	Answer
Laterality	Bilateral

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Other Orders (continued)

Diet

Diet NPO [19066101] (Discontinued)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620
Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD
Ordering mode: Standard
Frequency: Routine Effective now 09/17/18 1638 - Until Specified
Class: Hospital Performed (Duarte admitted patients only)
Quantity: 1
Diet: NPO
Instance released by: Douglas Robbins, RN (auto-released) 9/17/2018 4:37 PM
Discontinued by: Automatic Discharge Provider 09/17/18 2026 [Patient Discharge]

Diet [19066078] (Discontinued)

Electronically signed by: **Brian M. Blair, MD on 09/17/18 1623** Status: **Discontinued**
Ordering user: Brian M. Blair, MD 09/17/18 1623
Ordering provider: Brian M. Blair, MD
Authorized by: Brian M. Blair, MD
Ordering mode: Standard
Frequency: Routine 09/17/18 -
Class: Clinic Performed
Quantity: 1
Discontinued by: User Epic 10/01/19 0113 [Order Expired]

Questionnaire

Question	Answer
Diet type	Regular (No Restrictions)

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Other Orders (continued)

Discharge

Discharge patient when criteria met [19066083] (Discontinued)

Electronically signed by: **Brian M. Blair, MD on 09/17/18 1623** Status: **Discontinued**
Ordering user: Brian M. Blair, MD 09/17/18 1623
Ordering provider: Brian M. Blair, MD
Authorized by: Brian M. Blair, MD
Ordering mode: Standard
Frequency: Routine Once 09/17/18 1619 - 1 occurrence
Class: Hospital Performed (Duarte admitted patients only)
Quantity: 1
Instance released by: Brian M. Blair, MD (auto-released) 9/17/2018 4:23 PM
Discontinued by: Automatic Discharge Provider 09/17/18 2026 [Patient Discharge]

Questionnaire

Question	Answer
Is this an extended recovery patient?	No

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Other Orders (continued)

IV

Discontinue IV [19066084] (Discontinued)

Electronically signed by: **Brian M. Blair, MD on 09/17/18 1623** Status: **Discontinued**
Ordering user: Brian M. Blair, MD 09/17/18 1623
Ordering provider: Brian M. Blair, MD
Authorized by: Brian M. Blair, MD
Ordering mode: Standard
Frequency: Routine Once 09/17/18 1620 - 1 occurrence
Class: Hospital Performed (Duarte admitted patients only)
Quantity: 1
Instance released by: Brian M. Blair, MD (auto-released) 9/17/2018 4:23 PM
Discontinued by: Automatic Discharge Provider 09/17/18 2026 [Patient Discharge]

Insert peripheral IV [18957040] (Discontinued)

Electronically signed by: **Felicia Nicole Kinnard, PA on 09/13/18 1335** Status: **Discontinued**
Ordering user: Felicia Nicole Kinnard, PA 09/13/18 1335
Ordering provider: Felicia Nicole Kinnard, PA
Authorized by: Felicia Nicole Kinnard, PA
Ordering mode: Standard
Frequency: Routine Once 09/17/18 1449 - 1 occurrence
Class: Hospital Performed (Duarte admitted patients only)
Quantity: 1
Instance released by: Yossyanne A Simbolon, NP (auto-released) 9/17/2018 2:48 PM
Discontinued by: Automatic Discharge Provider 09/17/18 2026 [Patient Discharge]

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Other Orders (continued)

Nursing

Remove arterial line [19066100] (Discontinued)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620
Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD
Ordering mode: Standard
Frequency: Routine Once 09/17/18 1638 - 1 occurrence
Class: Hospital Performed (Duarte admitted patients only)
Quantity: 1
Instance released by: Douglas Robbins, RN (auto-released) 9/17/2018 4:37 PM
Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]
Order comments: When transferring to regular ward (maintain arterial line if patient is transferred to ICU).

Vital Signs [19066088] (Discontinued)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620
Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD
Ordering mode: Standard
Frequency: Routine q15 min 09/17/18 1638 - Until Specified
Class: Hospital Performed (Duarte admitted patients only)
Quantity: 1
Instance released by: Douglas Robbins, RN (auto-released) 9/17/2018 4:37 PM
Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]
Order comments: 1. Update frequency to every 4 hours if patient is stable after first hour. 2. In the case of an Epidural setting change continue vital checks at every 15 minutes x 4, then update frequency to every 4 hours if patient is stable after first hour.

Cardiac monitoring [19066089] (Discontinued)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620
Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD
Ordering mode: Standard
Frequency: Routine Continuous 09/17/18 1638 - Until Specified
Class: Hospital Performed (Duarte admitted patients only)
Quantity: 1
Instance released by: Douglas Robbins, RN (auto-released) 9/17/2018 4:37 PM
Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]

Pulse Oximetry [19066090] (Discontinued)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620
Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD
Ordering mode: Standard
Frequency: Routine Per unit protocol 09/17/18 1638 - Until Specified
Class: Hospital Performed (Duarte admitted patients only)
Quantity: 1
Instance released by: Douglas Robbins, RN (auto-released) 9/17/2018 4:37 PM
Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]

Notify physician (specify) Temperature greater than: 38.3; Systolic blood pressure greater than: 160; Systolic blood pressure less than: 95; Diastolic blood pressure greater than: 90; Diastolic blood pressure less than: 60; Heart rate greater than... [19066091] (Discontinued)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620
Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD
Ordering mode: Standard
Frequency: Routine Until discontinued 09/17/18 1638 - Until Specified
Class: Hospital Performed (Duarte admitted patients only)
Quantity: 1
Instance released by: Douglas Robbins, RN (auto-released) 9/17/2018 4:37 PM
Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]

Questionnaire

Question	Answer
Temperature greater than	38.3
Systolic blood pressure greater than	160
Systolic blood pressure less than	95
Diastolic blood pressure greater than	90
Diastolic blood pressure less than	60
Heart rate greater than	120

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Other Orders (continued)

Heart rate less than	50
Respiratory rate greater than	25
Respiratory rate less than	10
SpO2 less than	92
Urine output less than:	0.5 mL/kg/hr
Other	For Glucose Point of Care results below 70 mg/dL or greater than 200 mg/dL

Neuro checks [19066092] (Discontinued)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620
Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD
Ordering mode: Standard
Frequency: Routine q15 min 09/17/18 1638 - Until Specified
Class: Hospital Performed (Duarte admitted patients only)
Quantity: 1
Instance released by: Douglas Robbins, RN (auto-released) 9/17/2018 4:37 PM
Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]
Order comments: 1. Update frequency to every 1 hour x 4 if patient is stable after the first hour and then every 4 hours if patient is stable. 2. In the case of an Epidural setting change continue vital checks at every 15 minutes x 4, then update frequency to every 1 hour x 4 if patient is stable after the first hour and then every 4 hours if patient is stable.

Nursing communication [19066099] (Discontinued)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620
Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD
Ordering mode: Standard
Frequency: Routine Until discontinued 09/17/18 1638 - Until Specified
Class: Hospital Performed (Duarte admitted patients only)
Quantity: 1
Instance released by: Douglas Robbins, RN (auto-released) 9/17/2018 4:37 PM
Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]
Order comments: PACU Anesthesia Orders. Remove LMA or oral / nasal airway when criteria are met, then follow designated Oxygen Therapy order

Post-Discharge Activity: Normal activity as tolerated. [19066077] (Discontinued)

Electronically signed by: **Brian M. Blair, MD on 09/17/18 1623** Status: **Discontinued**
Ordering user: Brian M. Blair, MD 09/17/18 1623
Ordering provider: Brian M. Blair, MD
Authorized by: Brian M. Blair, MD
Ordering mode: Standard
Frequency: Routine 09/17/18 -
Class: Clinic Performed
Quantity: 1
Discontinued by: User Epic 10/01/19 0113 [Order Expired]
Order comments: Normal activity as tolerated.

Call provider for: temperature >100.4 [19066079] (Discontinued)

Electronically signed by: **Brian M. Blair, MD on 09/17/18 1623** Status: **Discontinued**
Ordering user: Brian M. Blair, MD 09/17/18 1623
Ordering provider: Brian M. Blair, MD
Authorized by: Brian M. Blair, MD
Ordering mode: Standard
Frequency: Routine 09/17/18 -
Class: Clinic Performed
Quantity: 1
Discontinued by: User Epic 10/01/19 0113 [Order Expired]

Call provider for: persistent nausea or vomiting [19066080] (Discontinued)

Electronically signed by: **Brian M. Blair, MD on 09/17/18 1623** Status: **Discontinued**
Ordering user: Brian M. Blair, MD 09/17/18 1623
Ordering provider: Brian M. Blair, MD
Authorized by: Brian M. Blair, MD
Ordering mode: Standard
Frequency: Routine 09/17/18 -
Class: Clinic Performed
Quantity: 1
Discontinued by: User Epic 10/01/19 0113 [Order Expired]

Call provider for: severe uncontrolled pain [19066081] (Discontinued)

Electronically signed by: **Brian M. Blair, MD on 09/17/18 1623** Status: **Discontinued**
Ordering user: Brian M. Blair, MD 09/17/18 1623
Ordering provider: Brian M. Blair, MD
Authorized by: Brian M. Blair, MD
Ordering mode: Standard
Frequency: Routine 09/17/18 -
Class: Clinic Performed
Quantity: 1
Discontinued by: User Epic 10/01/19 0113 [Order Expired]

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Other Orders (continued)

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Medication Orders

Medications

HYDROmorphone (DILAUDID) injection 0.3 mg [18957063] (Discontinued)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620 Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD Ordering mode: Standard
PRN reasons: severe pain (pain scale 7-10)
Frequency: Routine q5 min PRN 09/17/18 1637 - 09/17/18 1712 Class: Normal
Released by: Douglas Robbins, RN 09/17/18 1637 Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]
Acknowledged: Douglas Robbins, RN 09/17/18 1637 for Placing Order
Admin instructions: PACU Anesthesia Orders.
May give a total combined maximum dose of 2 mg for HYDROmorphone.
Package: 0641-0121-25

HYDROmorphone (DILAUDID) injection 0.3 mg [18957063]

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620 Ordering provider: Evelyn J Bonilla, MD
PRN reasons: severe pain (pain scale 7-10)
Frequency: q5 min PRN 09/17/18 1637 - 09/17/18 1712 Released by: Douglas Robbins, RN 09/17/18 1637
Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]
Acknowledged: Douglas Robbins, RN 09/17/18 1637 for Placing Order
Package: 0641-0121-25

HYDROmorphone (DILAUDID) injection 0.3 mg [18957063] Result status: No result

Ordering provider: Evelyn J Bonilla, MD 09/17/18 1637

All Administrations of HYDROmorphone (DILAUDID) injection 0.3 mg

ⓘ The administrations shown are only for this specific order and not for other orders for the same medication that may be in this encounter.

No Administrations Recorded

labetalol (TRANDATE) injection 2.5 mg [18957064] (Discontinued)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620 Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD Ordering mode: Standard
PRN reasons: high blood pressure
PRN Comment: SBP >160, DBP >100
Frequency: Routine q15 min PRN 09/17/18 1637 - 09/17/18 1712 Class: Normal
Released by: Douglas Robbins, RN 09/17/18 1637 Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]
Acknowledged: Douglas Robbins, RN 09/17/18 1637 for Placing Order
Admin instructions: Administer IV Push.
PACU Anesthesia Orders. Give in the sequence indicated when limited by maximum dose of 20 mg or pulse rate. Hold if pulse less than 60. If pulse less than 60 give hydrALAZINE.
Package: 0409-2339-34

labetalol (TRANDATE) injection 2.5 mg [18957064]

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620 Ordering provider: Evelyn J Bonilla, MD
PRN reasons: high blood pressure
PRN Comment: SBP >160, DBP >100
Frequency: q15 min PRN 09/17/18 1637 - 09/17/18 1712 Released by: Douglas Robbins, RN 09/17/18 1637
Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]
Acknowledged: Douglas Robbins, RN 09/17/18 1637 for Placing Order
Package: 0409-2339-34

labetalol (TRANDATE) injection 2.5 mg [18957064] Result status: No result

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Medication Orders (continued)

Ordering provider: Evelyn J Bonilla, MD 09/17/18 1637

All Administrations of labetalol (TRANDATE) injection 2.5 mg

The administrations shown are only for this specific order and not for other orders for the same medication that may be in this encounter.

No Administrations
Recorded

ondansetron (ZOFRAN) injection 4 mg [18957068] (Discontinued)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620 Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD Ordering mode: Standard
PRN reasons: nausea vomiting
Frequency: Routine Once PRN 09/17/18 1637 - 1 occurrence Class: Normal
Released by: Douglas Robbins, RN 09/17/18 1637 Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]
Acknowledged: Douglas Robbins, RN 09/17/18 1637 for Placing Order
Admin instructions: PACU Anesthesia Orders.
Administer IV Push.
PRN Priority: First
If nausea is not resolved administer antiemetics in order indicated every 5 minutes. If nausea not resolved and medication final in sequence contact Anesthesiologist.
Package: 63323-373-02

ondansetron (ZOFRAN) injection 4 mg [18957068]

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620 Ordering provider: Evelyn J Bonilla, MD
PRN reasons: nausea vomiting
Frequency: Once PRN 09/17/18 1637 - 1 occurrence Released by: Douglas Robbins, RN 09/17/18 1637
Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]
Acknowledged: Douglas Robbins, RN 09/17/18 1637 for Placing Order
Package: 63323-373-02

ondansetron (ZOFRAN) injection 4 mg [18957068] Result status: No result

Ordering provider: Evelyn J Bonilla, MD 09/17/18 1637

All Administrations of ondansetron (ZOFRAN) injection 4 mg

The administrations shown are only for this specific order and not for other orders for the same medication that may be in this encounter.

No Administrations
Recorded

metoclopramide (REGLAN) injection 10 mg [18957069] (Discontinued)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620 Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD Ordering mode: Standard
PRN Comment: Nuaea/Vomiting
Frequency: Routine Once PRN 09/17/18 1637 - 1 occurrence Class: Normal
Released by: Douglas Robbins, RN 09/17/18 1637 Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]
Acknowledged: Douglas Robbins, RN 09/17/18 1637 for Placing Order
Admin instructions: PACU Anesthesia Orders.
Administer IV Push.
PRN Priority: Fourth

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Medication Orders (continued)

If nausea is not resolved administer antiemetics in order indicated every 5 minutes. If nausea not resolved and medication final in sequence contact Anesthesiologist.
Package: 0703-4502-04

metoclopramide (REGLAN) injection 10 mg [18957069]

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620 Ordering provider: Evelyn J Bonilla, MD
PRN Comment: Nuaea/Vomiting
Frequency: Once PRN 09/17/18 1637 - 1 occurrence Released by: Douglas Robbins, RN 09/17/18 1637
Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]
Acknowledged: Douglas Robbins, RN 09/17/18 1637 for Placing Order
Package: 0703-4502-04

metoclopramide (REGLAN) injection 10 mg [18957069] Result status: No result

Ordering provider: Evelyn J Bonilla, MD 09/17/18 1637

All Administrations of metoclopramide (REGLAN) injection 10 mg

The administrations shown are only for this specific order and not for other orders for the same medication that may be in this encounter.

No Administrations Recorded

lactated ringers infusion [18957061] (Discontinued)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620 Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD Ordering mode: Standard
Frequency: Routine Continuous 09/17/18 1715 - 09/17/18 2026 Class: Normal
Released by: Douglas Robbins, RN 09/17/18 1637 Discontinued by: Automatic Discharge Provider 09/17/18 2026 [Patient Discharged]
Acknowledged: Douglas Robbins, RN 09/17/18 1637 for Placing Order
Admin instructions: PACU Anesthesia Orders.
Package: 0264-7750-00

lactated ringers infusion [18957061]

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620 Ordering provider: Evelyn J Bonilla, MD
Frequency: Continuous 09/17/18 1715 - 09/17/18 2026 Released by: Douglas Robbins, RN 09/17/18 1637
Discontinued by: Automatic Discharge Provider 09/17/18 2026 [Patient Discharged]
Acknowledged: Douglas Robbins, RN 09/17/18 1637 for Placing Order
Package: 0264-7750-00

lactated ringers infusion [18957061] Result status: No result

Ordering provider: Evelyn J Bonilla, MD 09/17/18 1637

All Administrations of lactated ringers infusion

The administrations shown are only for this specific order and not for other orders for the same medication that may be in this encounter.

No Administrations Recorded

HYDROmorphone (DILAUDID) injection 0.2 mg [18957062] (Discontinued)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620 Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD Ordering mode: Standard

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Medication Orders (continued)

PRN reasons: moderate pain (pain scale 4-6)
Frequency: Routine q5 min PRN 09/17/18 1637 - 09/17/18 1712 Class: Normal
Released by: Douglas Robbins, RN 09/17/18 1637 Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]
Acknowledged: Douglas Robbins, RN 09/17/18 1637 for Placing Order
Admin instructions: PACU Anesthesia Orders.
May give a total combined maximum dose of 2 mg for HYDROmorphone.
Package: 0641-0121-25

HYDROmorphone (DILAUDID) injection 0.2 mg [18957062]

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620 Ordering provider: Evelyn J Bonilla, MD
PRN reasons: moderate pain (pain scale 4-6)
Frequency: q5 min PRN 09/17/18 1637 - 09/17/18 1712 Released by: Douglas Robbins, RN 09/17/18 1637
Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]
Acknowledged: Douglas Robbins, RN 09/17/18 1637 for Placing Order
Package: 0641-0121-25

HYDROmorphone (DILAUDID) injection 0.2 mg [18957062] Result status: No result

Ordering provider: Evelyn J Bonilla, MD 09/17/18 1637

All Administrations of HYDROmorphone (DILAUDID) injection 0.2 mg

ⓘ The administrations shown are only for this specific order and not for other orders for the same medication that may be in this encounter.

No Administrations
Recorded

hydrALAZINE (APRESOLINE) injection 5 mg [18957065] (Discontinued)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620 Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD Ordering mode: Standard
PRN reasons: high blood pressure
PRN Comment: SBP >160, DBP >100
Frequency: Routine q15 min PRN 09/17/18 1637 - 09/17/18 1712 Class: Normal
Released by: Douglas Robbins, RN 09/17/18 1637 Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]
Acknowledged: Douglas Robbins, RN 09/17/18 1637 for Placing Order
Admin instructions: Administer IV Push.
PACU Anesthesia Orders.
Give in the sequence indicated when limited by the maximum dose of 20 mg
or pulse rate. Hold if pulse greater than 90. If greater than 90 give
Labetalol.
Package: 0517-0901-25

hydrALAZINE (APRESOLINE) injection 5 mg [18957065]

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620 Ordering provider: Evelyn J Bonilla, MD
PRN reasons: high blood pressure
PRN Comment: SBP >160, DBP >100
Frequency: q15 min PRN 09/17/18 1637 - 09/17/18 1712 Released by: Douglas Robbins, RN 09/17/18 1637
Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]
Acknowledged: Douglas Robbins, RN 09/17/18 1637 for Placing Order
Package: 0517-0901-25

hydrALAZINE (APRESOLINE) injection 5 mg [18957065] Result status: No result

Ordering provider: Evelyn J Bonilla, MD 09/17/18 1637

All Administrations of hydrALAZINE (APRESOLINE) injection 5 mg

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Medication Orders (continued)

The administrations shown are only for this specific order and not for other orders for the same medication that may be in this encounter.

No Administrations Recorded

albuterol (5 MG/ML) 0.5% nebulizer solution 2.5 mg [18957066] (Discontinued)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620 Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD Ordering mode: Standard
PRN reasons: wheezing
Frequency: Routine q4h PRN 09/17/18 1637 - 09/17/18 1712 Class: Normal
Released by: Douglas Robbins, RN 09/17/18 1637 Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]
Acknowledged: Douglas Robbins, RN 09/17/18 1637 for Placing Order
Admin instructions: Modality: Aeroneb
Administer with ipratropium
Package: 0487-9901-30

albuterol (5 MG/ML) 0.5% nebulizer solution 2.5 mg [18957066]

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620 Ordering provider: Evelyn J Bonilla, MD
PRN reasons: wheezing
Frequency: q4h PRN 09/17/18 1637 - 09/17/18 1712 Released by: Douglas Robbins, RN 09/17/18 1637
Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]
Acknowledged: Douglas Robbins, RN 09/17/18 1637 for Placing Order
Package: 0487-9901-30

albuterol (5 MG/ML) 0.5% nebulizer solution 2.5 mg [18957066] Result status: No result

Ordering provider: Evelyn J Bonilla, MD 09/17/18 1637

All Administrations of albuterol (5 MG/ML) 0.5% nebulizer solution 2.5 mg

The administrations shown are only for this specific order and not for other orders for the same medication that may be in this encounter.

No Administrations Recorded

ipratropium (ATROVENT) 0.02 % nebulizer solution 0.5 mg [18957067] (Discontinued)

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620 Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD Ordering mode: Standard
PRN reasons: wheezing
Frequency: Routine q4h PRN 09/17/18 1637 - 09/17/18 1712 Class: Normal
Released by: Douglas Robbins, RN 09/17/18 1637 Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]
Acknowledged: Douglas Robbins, RN 09/17/18 1637 for Placing Order
Admin instructions: Modality: Aeroneb
Administer with albuterol
Package: 0487-9801-01

ipratropium (ATROVENT) 0.02 % nebulizer solution 0.5 mg [18957067]

Electronically signed by: **Evelyn J Bonilla, MD on 09/17/18 1620** Status: **Discontinued**
Ordering user: Evelyn J Bonilla, MD 09/17/18 1620 Ordering provider: Evelyn J Bonilla, MD
PRN reasons: wheezing
Frequency: q4h PRN 09/17/18 1637 - 09/17/18 1712 Released by: Douglas Robbins, RN 09/17/18 1637
Discontinued by: Automatic Transfer Provider 09/17/18 1712 [Patient Transfer]
Acknowledged: Douglas Robbins, RN 09/17/18 1637 for Placing Order
Package: 0487-9801-01

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Medication Orders (continued)

ipratropium (ATROVENT) 0.02 % nebulizer solution 0.5 mg [18957067] Result status: No result

Ordering provider: Evelyn J Bonilla, MD 09/17/18 1637

All Administrations of ipratropium (ATROVENT) 0.02 % nebulizer solution 0.5 mg

The administrations shown are only for this specific order and not for other orders for the same medication that may be in this encounter.

No Administrations Recorded

sodium chloride (NS) 0.9 % irrigation solution [19066087] (Discontinued)

Electronically signed by: **Kristian E. Perfecto, RN on 09/17/18 1631** Status: **Discontinued**
Ordering user: Kristian E. Perfecto, RN 09/17/18 1631
Ordering provider: Clayton S Lau, MD
Authorized by: Clayton S Lau, MD
Ordering mode: Per protocol: no cosign required
Frequency: Routine PRN 09/17/18 1631 - 09/17/18 1643
Class: Normal
Discontinued by: Kristian E. Perfecto, RN 09/17/18 1643 [Patient Discharged]
Acknowledged: Kristian E. Perfecto, RN 09/17/18 1631 for Placing Order
Package: 0264-2201-00

sodium chloride (NS) 0.9 % irrigation solution [19066087]

Electronically signed by: **Kristian E. Perfecto, RN on 09/17/18 1631** Status: **Discontinued**
Ordering user: Kristian E. Perfecto, RN 09/17/18 1631
Ordering provider: Clayton S Lau, MD
Frequency: PRN 09/17/18 1631 - 09/17/18 1643
Discontinued by: Kristian E. Perfecto, RN 09/17/18 1643 [Patient Discharged]
Acknowledged: Kristian E. Perfecto, RN 09/17/18 1631 for Placing Order
Package: 0264-2201-00

sodium chloride (NS) 0.9 % irrigation solution [19066087] Result status: No result

Ordering provider: Clayton S Lau, MD 09/17/18 1631

All Orders and Administrations of sodium chloride (NS) 0.9 % irrigation solution

Orders and Administrations	Action Time	Documented By	Ordered By	Site	Comment	Reason
1,000 mL : : Irrigation	09/17/18 1631 Recorded Time 09/17/18 1631	Kristian E. Perfecto, RN Documented For: Clayton S Lau, MD	Clayton S Lau, MD Frequency As needed			

acetaminophen (TYLENOL) tablet 1,000 mg [18957027] (Completed)

Electronically signed by: **Evelyn J Bonilla, MD on 09/14/18 1431** Status: **Completed**
Ordering user: Evelyn J Bonilla, MD 09/14/18 1431
Ordering provider: Evelyn J Bonilla, MD
Authorized by: Evelyn J Bonilla, MD
Ordering mode: Standard
Frequency: STAT Once 09/17/18 1545 - 1 occurrence
Class: Normal
Released by: Yossyanne Simbolon, NP 09/17/18 1500
Acknowledged: Yossyanne Simbolon, NP 09/17/18 1500 for Placing Order
Package: 0904-1988-61
Status
Mutaz Ahmad, RPh 09/17/18 0731 (Start: 09/14/18 1515 to 09/17/18 1545, End: 09/14/18 1515 to 09/17/18 1509)

acetaminophen (TYLENOL) tablet 1,000 mg [18957027]

Electronically signed by: **Evelyn J Bonilla, MD on 09/14/18 1431** Status: **Completed**
Ordering user: Evelyn J Bonilla, MD 09/14/18 1431
Ordering provider: Evelyn J Bonilla, MD
Frequency: Once 09/17/18 1545 - 1 occurrence
Released by: Yossyanne Simbolon, NP 09/17/18 1500

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Medication Orders (continued)

Acknowledged: Yossyanne Simbolon, NP 09/17/18 1500 for Placing Order
Package: 0904-1988-61
Status
Mutaz Ahmad, RPh 09/17/18 0731 (Start: 09/14/18 1515 to 09/17/18 1545, End: 09/14/18 1515 to 09/17/18 1509)

acetaminophen (TYLENOL) tablet 1,000 mg [18957027] Result status: No result

Ordering provider: Evelyn J Bonilla, MD 09/17/18 1500

All Administrations of acetaminophen (TYLENOL) tablet 1,000 mg

ⓘ The administrations shown are only for this specific order and not for other orders for the same medication that may be in this encounter.

Administration	Action Time	Recorded Time	Documented By	Site	Comment	Reason
Given : 1,000 mg : : Oral	09/17/18 1509	09/17/18 1509	Yossyanne Simbolon, NP			

levofloxacin (LEVAQUIN) in D5W IV 750 mg [18957033] (Completed)

Electronically signed by: **Felicia Nicole Kinnard, PA on 09/13/18 1335** Status: **Completed**
Ordering user: Felicia Nicole Kinnard, PA 09/13/18 1335
Ordering provider: Felicia Nicole Kinnard, PA
Authorized by: Felicia Nicole Kinnard, PA
Ordering mode: Standard
Frequency: Routine Once 09/17/18 1530 - 1 occurrence
Class: Normal
Released by: Yossyanne Simbolon, NP 09/17/18 1448
Acknowledged: Yossyanne Simbolon, NP 09/17/18 1448 for Placing Order

Questionnaire

Question	Answer
Indication (required by CMS and State of California)	Prophylaxis

Admin instructions: To be administered within 2 hour of incision
Package: 25021-132-83

levofloxacin (LEVAQUIN) in D5W IV 750 mg [18957033]

Electronically signed by: **Felicia Nicole Kinnard, PA on 09/13/18 1335** Status: **Completed**
Ordering user: Felicia Nicole Kinnard, PA 09/13/18 1335
Ordering provider: Felicia Nicole Kinnard, PA
Frequency: Once 09/17/18 1530 - 1 occurrence
Released by: Yossyanne Simbolon, NP 09/17/18 1448
Acknowledged: Yossyanne Simbolon, NP 09/17/18 1448 for Placing Order
Package: 25021-132-83

levofloxacin (LEVAQUIN) in D5W IV 750 mg [18957033] Result status: No result

Ordering provider: Felicia Nicole Kinnard, PA 09/17/18 1448

All Administrations of levofloxacin (LEVAQUIN) in D5W IV 750 mg

ⓘ The administrations shown are only for this specific order and not for other orders for the same medication that may be in this encounter.

Administration	Action Time	Recorded Time	Documented By	Site	Comment	Reason
Given : 750 mg : : Intravenous	09/17/18 1616	09/17/18 1619	Evelyn J Bonilla, MD			

lidocaine-prilocaine (EMLA) 2.5-2.5 % cream [18957035] (Discontinued)

Electronically signed by: **Felicia Nicole Kinnard, PA on 09/13/18 1335** Status: **Discontinued**
Ordering user: Felicia Nicole Kinnard, PA 09/13/18 1335
Ordering provider: Felicia Nicole Kinnard, PA
Authorized by: Felicia Nicole Kinnard, PA
Ordering mode: Standard

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Medication Orders (continued)

PRN Comment: for IV insertion
Frequency: Routine PRN 09/17/18 1448 - 09/17/18 2026
Class: Normal
Released by: Yossyanne Simbolon, NP 09/17/18 1448
Discontinued by: Automatic Discharge Provider 09/17/18 2026 [Patient Discharged]
Acknowledged: Yossyanne Simbolon, NP 09/17/18 1448 for Placing Order
Admin instructions: Apply to needle stick area, prior to IV insertion.
Package: 0115-1468-60

lidocaine-prilocaine (EMLA) 2.5-2.5 % cream [18957035]

Electronically signed by: **Felicia Nicole Kinnard, PA on 09/13/18 1335**
Status: **Discontinued**
Ordering user: Felicia Nicole Kinnard, PA 09/13/18 1335
Ordering provider: Felicia Nicole Kinnard, PA
PRN Comment: for IV insertion
Frequency: PRN 09/17/18 1448 - 09/17/18 2026
Released by: Yossyanne Simbolon, NP 09/17/18 1448
Discontinued by: Automatic Discharge Provider 09/17/18 2026 [Patient Discharged]
Acknowledged: Yossyanne Simbolon, NP 09/17/18 1448 for Placing Order
Package: 0115-1468-60

lidocaine-prilocaine (EMLA) 2.5-2.5 % cream [18957035]
Result status: No result

Ordering provider: Felicia Nicole Kinnard, PA 09/17/18 1448

All Administrations of lidocaine-prilocaine (EMLA) 2.5-2.5 % cream

ⓘ The administrations shown are only for this specific order and not for other orders for the same medication that may be in this encounter.

No Administrations Recorded

lidocaine PF (XYLOCAINE) 1 % injection 1 mg [18957036] (Discontinued)

Electronically signed by: **Felicia Nicole Kinnard, PA on 09/13/18 1335**
Status: **Discontinued**
Ordering user: Felicia Nicole Kinnard, PA 09/13/18 1335
Ordering provider: Felicia Nicole Kinnard, PA
Authorized by: Felicia Nicole Kinnard, PA
Ordering mode: Standard
PRN Comment: for IV insertion
Frequency: Routine PRN 09/17/18 1448 - 5 occurrences
Class: Normal
Released by: Yossyanne Simbolon, NP 09/17/18 1448
Discontinued by: Automatic Discharge Provider 09/17/18 2026 [Patient Discharged]
Acknowledged: Yossyanne Simbolon, NP 09/17/18 1448 for Placing Order
Admin instructions: May start with 0.1 mL and may use up to 0.5 mL of 1% lidocaine for skin wheal at IV start site(s).
Package: 63323-492-57

lidocaine PF (XYLOCAINE) 1 % injection 1 mg [18957036]

Electronically signed by: **Felicia Nicole Kinnard, PA on 09/13/18 1335**
Status: **Discontinued**
Ordering user: Felicia Nicole Kinnard, PA 09/13/18 1335
Ordering provider: Felicia Nicole Kinnard, PA
PRN Comment: for IV insertion
Frequency: PRN 09/17/18 1448 - 5 occurrences
Released by: Yossyanne Simbolon, NP 09/17/18 1448
Discontinued by: Automatic Discharge Provider 09/17/18 2026 [Patient Discharged]
Acknowledged: Yossyanne Simbolon, NP 09/17/18 1448 for Placing Order
Package: 63323-492-57

lidocaine PF (XYLOCAINE) 1 % injection 1 mg [18957036]
Result status: No result

Ordering provider: Felicia Nicole Kinnard, PA 09/17/18 1448

All Administrations of lidocaine PF (XYLOCAINE) 1 % injection 1 mg

ⓘ The administrations shown are only for this specific order and not for other orders for the same medication that may be in this encounter.

No Administrations Recorded

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Medication Orders (continued)

lactated ringers infusion [18957030] (Completed)

Electronically signed by: **Felicia Nicole Kinnard, PA on 09/13/18 1335** Status: **Completed**
Ordering user: Felicia Nicole Kinnard, PA 09/13/18 1335 Ordering provider: Felicia Nicole Kinnard, PA
Authorized by: Felicia Nicole Kinnard, PA Ordering mode: Standard
Frequency: Routine Once 09/17/18 1530 - 1 occurrence Class: Normal
Released by: Yossyanne Simbolon, NP 09/17/18 1448
Acknowledged: Yossyanne Simbolon, NP 09/17/18 1448 for Placing Order
Package: 0264-7750-00

lactated ringers infusion [18957030]

Electronically signed by: **Felicia Nicole Kinnard, PA on 09/13/18 1335** Status: **Completed**
Ordering user: Felicia Nicole Kinnard, PA 09/13/18 1335 Ordering provider: Felicia Nicole Kinnard, PA
Frequency: Once 09/17/18 1530 - 1 occurrence Released by: Yossyanne Simbolon, NP 09/17/18 1448
Acknowledged: Yossyanne Simbolon, NP 09/17/18 1448 for Placing Order
Package: 0264-7750-00

lactated ringers infusion [18957030] Result status: No result

Ordering provider: Felicia Nicole Kinnard, PA 09/17/18 1448

All Administrations of lactated ringers infusion

The administrations shown are only for this specific order and not for other orders for the same medication that may be in this encounter.

Administration	Action Time	Recorded Time	Documented By	Site	Comment	Reason
New Bag : Intravenous	09/17/18 1610	09/17/18 1620	Evelyn J Bonilla, MD			

lidocaine PF (XYLOCAINE) 1 % injection - ADS Override Pull [18957042] (Active)

Electronically signed by: **Interface, Ads Dispense on 09/17/18 1515** Status: **Active**
Ordering user: Interface, Ads Dispense 09/17/18 1515 Ordering mode: Standard
Frequency: 09/17/18 1515 - Until Discontinued
Admin instructions: Perfecto, Kristian : cabinet override
Medication comments: Perfecto, Kristian : cabinet override
Package: 0409-4713-12

lidocaine PF (XYLOCAINE) 1 % injection - ADS Override Pull [18957042]

Electronically signed by: **Interface, Ads Dispense on 09/17/18 1515** Status: **Active**
Ordering user: Interface, Ads Dispense 09/17/18 1515
Frequency: 09/17/18 1515 - Until Discontinued Package: 0409-4713-12

lidocaine PF (XYLOCAINE) 1 % injection - ADS Override Pull [18957042] Result status: No result

All Administrations of lidocaine PF (XYLOCAINE) 1 % injection - ADS Override Pull

The administrations shown are only for this specific order and not for other orders for the same medication that may be in this encounter.

No Administrations Recorded

lidocaine 2 % (XYLOCAINE) Urojet - ADS Override Pull [18957043] (Active)

Electronically signed by: **Interface, Ads Dispense on 09/17/18 1517** Status: **Active**
Ordering user: Interface, Ads Dispense 09/17/18 1517 Ordering mode: Standard
Frequency: 09/17/18 1517 - Until Discontinued
Admin instructions: Perfecto, Kristian : cabinet override

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Medication Orders (continued)

Medication comments: Perfecto, Kristian : cabinet override
Package: 76329-3015-5

lidocaine 2 % (XYLOCAINE) Urojet - ADS Override Pull [18957043]

Electronically signed by: **Interface, Ads Dispense on 09/17/18 1517** Status: **Active**
Ordering user: Interface, Ads Dispense 09/17/18 1517
Frequency: 09/17/18 1517 - Until Discontinued Package: 76329-3015-5

lidocaine 2 % (XYLOCAINE) Urojet - ADS Override Pull [18957043] Result status: No result

All Administrations of lidocaine 2 % (XYLOCAINE) Urojet - ADS Override Pull

The administrations shown are only for this specific order and not for other orders for the same medication that may be in this encounter.

No Administrations Recorded

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Flowsheets

Assessment (Adult)

Row Name	09/17/18 1444
Mouth/Teeth WDL	WDL
Oral Mucositis Scale (WHO)	0 (none) - None
Cognitive/Neuro/ Behavioral WDL	WDL
Respiratory WDL	WDL
Cardiac WDL	WDL
Peripheral Neurovascular WDL	WDL
Safety WDL	WDL
Safety Factors	family at bedside;call light in reach
Airway Safety Measures	mask at bedside
Observed Emotional State	accepting;calm
Verbalized Emotional State	acceptance
Trust Relationship/Rapport	care explained
Family/Support Persons	family
Involvement in Care	at bedside;attentive to patient

Assessment (Adult)

Row Name	09/17/18 1716	09/17/18 1710	09/17/18 1640
Cognitive/Neuro/ Behavioral WDL	WDL	WDL	WDL
Airway WDL	WDL	WDL	WDL except;airway symptoms
Airway Symptoms	—	—	artificial airway in place
Respiratory WDL	WDL	WDL	WDL
Cardiac WDL	WDL	WDL	WDL
Rhythm	—	sinus bradycardia	sinus bradycardia
Peripheral Neurovascular WDL	WDL	WDL	WDL
Skin WDL	WDL	WDL	WDL
Safety WDL	WDL	WDL	WDL
Safety Factors	bed/stretcher flat;bed in lowest position;side rail up	bed/stretcher flat;side rail up;bed in lowest position	side rail up;bed in lowest position;bed/stretcher flat
Airway Safety Measures	mask at bedside;suction at bedside	manual resuscitator/mask/valve in room;suction at bedside	manual resuscitator/mask/valve in room;suction at bedside
Diet	sips of water	NPO	NPO
Diet Tolerance	tolerated	tolerated	tolerated
Warming Method	warming blanket	warming blanket	warming blanket
VTE	—	sequential	sequential

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Flowsheets (continued)

Prevention/Management		compression devices on	compression devices on
Trust Relationship/Rapport	care explained;questions answered	care explained	care explained

Care Plan (Perioperative/Perianesthesia) (Adult)

Row Name	09/17/18 1631	09/17/18 1447
Individualized Care Needs	—	None
Patient-Specific Considerations	—	None
Elevated Risk/Problem Identified	—	none
Minimized Risk and Safety Maintenance	making progress toward outcome	making progress toward outcome
Problem/Risk Identified	—	none
Physiologic Homeostasis	making progress toward outcome	making progress toward outcome
Problem/Risk Identified	—	none
Optimal Comfort and Well-being	making progress toward outcome	making progress toward outcome
Plan of Care Reviewed With	—	spouse;patient
Outcome Evaluation	—	Continue with planned procedure
Patient Specific Preferences	—	None

Care Plan (Perioperative/Perianesthesia) (Adult)

Row Name	09/17/18 1825	09/17/18 1716	09/17/18 1710	09/17/18 1640
Individualized Care Needs	—	none	none	none
Patient-Specific Considerations	—	None	None	None
Elevated Risk/Problem Identified	none	—	none	none
Minimized Risk and Safety Maintenance	achieves outcome	achieves outcome	making progress toward outcome	making progress toward outcome
Problem/Risk Identified	—	bleeding	none	none
Physiologic Homeostasis	—	achieves outcome	making progress toward outcome	making progress toward outcome
Problem/Risk Identified	—	pain	pain	pain
Optimal Comfort and Well-being	—	achieves outcome	achieves outcome	making progress toward outcome
Outcome Anesthesia/Sedation Recovery	—	criteria met for discharge	criteria met for transfer	progressing toward baseline
Plan of Care Reviewed With	—	patient;spouse	patient	patient
Outcome	—	vss	patient awake, alert,	patient asleep, vss

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Flowsheets (continued)

Evaluation			vss, denies pain	
Patient Specific Preferences	—	none	none	none

Custom Formula Data

Row Name	09/17/18 1439
Pct Wt Change	0 %
Mifflin Resting Metabolic Rate (Male)	1486.37
Total Daily Calories Needed (Male)	2229.55
High Biological Total Daily Protein Needed (ounces) (Male)	10
Water Needs - Holliday Segar Method (> 65 years)	2343
Mifflin Resting Metabolic Rate (Female)	1320.37
Total Daily Calories Needed (Female)	1980.55
High Biological Total Daily Protein Needed (ounces) (Female)	8.88
10% Adjustment, Tetra (IBW)	63.78
15% Adjustment, Tetra (IBW)	60.24
10% Adjustment, Para (IBW)	63.78
5% Adjustment, Para (IBW)	67.33
RDA Male (11-14 years) (kcal)	4191
RDA Male (15-18 years) (kcal)	3429
50 Kcal/Kg (kcal)	3810
25 Kcal/Kg (kcal)	1905
45 Kcal/Kg (kcal)	3429
20 Kcal/Kg (kcal)	1524
40 Kcal/Kg (kcal)	3048
35 kcal/kg (kcal)	2667
30 Kcal/Kg (kcal)	2286
120 kcal/kg (kcal)	9144
60 kcal/kg (kcal)	4572
140 kcal/kg (kcal)	10668
80 kcal/kg (kcal)	6096
160 kcal/kg (kcal)	12192
180 kcal/kg (kcal)	13716
200 kcal/kg (kcal)	15240
20 kcal/kg (kcal)	1524
100 kcal/kg (kcal)	7620

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Flowsheets (continued)

40 kcal/kg (kcal)	3048
30 kcal/kg (kcal)	2286
RDA Method (kcal/day)	7772.4
RDA (4-6 years) (kcal)	6858
RDA (7-10 years) (kcal)	5334
40 KCAL/KG (BMI<18.5) (kcal)	3048
25 KCAL/KG (BMI>25-34) (kcal)	1905
20 KCAL/KG (BMI>34) (kcal)	1524
30 KCAL/KG (BMI>18.5-24.9) (kcal)	2286
40 KCAL/KG (BMI<18.4) (kcal)	3048
25 KCAL/KG (BMI>25-33.9) (kcal)	1905
20 KCAL/KG (BMI>34) (kcal)	1524
30 KCAL/KG (BMI>18.5-24.9) (kcal)	2286
Schofield Male (4-10 years) (kcal)	2132.69
WHO Equation Female (0-3 years) (kcal)	4597.2
WHO Equation Female (4-10 years) (kcal)	2213.5
WHO Equation Female (11-18 years) (kcal)	1675.64
% Ideal Body Weight	107.52
*Ideal Body Weight (IBW) (kg)	70.87
Ideal Body Weight (IBW lower range) (kg)	55.2
Ideal Body Weight (IBW upper range) (kg)	74.3
WHO Equation (kcal/day)	4586.58
WHO Equation Male (4-10 years) (kcal)	2224.74
WHO Equation Male (11-18 years) (kcal)	1984.5
RDA (0-6 month old) (kcal)	8229.6
RDA (> 6	7467.6

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Flowsheets (continued)

months-1 year old) (kcal)	
RDA Female (11-14 years) (kcal)	3581.4
RDA Female (15-18 years) (kcal)	3048
Current Weight (gm)	76200
RMR (Mifflin-St. Jeor) (kcal/day)	1486
Holliday-Segar Method (<= 10 kg) (mL)	7620
Holliday-Segar Method (> 20 kg) (mL)	4310
Holliday-Segar (mL)	4310
Holliday-Segar (mL)	3024
BMI (kg/m2)	25.6
IBW/kg (Calculated)	68.38
Low Range Vt 6mL/kg	410.28 mL/kg
Adult Moderate Range Vt 8mL/kg	547.04 mL/kg
Adult High Range Vt 10mL/kg	683.8 mL/kg

Education (Adult)

Row Name	09/17/18 1825
Discharge Readiness Evaluation	able to teach back
Patient Education Handouts	received
Person Taught	patient;spouse
Learning Readiness and Ability	no barriers identified
Teaching Focus	discharge instructions
Education Outcome Evaluation	verbalizes understanding

Intake/Output

Row Name	09/17/18 1616	09/17/18 1614	09/17/18 1610
Rate	—	—	—
Dose	*750 mg	—	—
Bolus (mg) Propofol	—	150 mg	—
Concentration Propofol	—	10 mg/mL	—
IV Properties	Placement Date: 09/17/18 Placement Time: 1547 Size (Gauge): 20 G Orientation: Left Location: Arm Site Prep: Alcohol Inserted by: Shirely, RN Insertion attempts: 1 Patient Tolerance: Tolerated well Removal Date: 09/17/18 Removal Time: 1825		

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Flowsheets (continued)

LACE+ Score

Row Name	09/17/18 1826
LACE+ Score	29

NPO Status

Row Name	09/17/18 1443
Date of Last Liquid	09/17/18
Time of Last Liquid	1000
Date of Last Solid	09/16/18
Time of Last Solid	2330
Last Intake Type	Clear fluids

OR Incisions/Wounds

Row Name	09/17/18 1640
Incision Properties	Date First Assessed: 09/17/18 Time First Assessed: 1644 Wound Location Orientation: Other (Comment) Location: Perineum Wound Description (Comments): No dressings
Site Assessment	Clean;Dry;Intact
Peri-wound Assessment	Clean;Dry;Intact

OR Lines/Drains/Airways

Row Name	09/17/18 1640
IV Properties	Placement Date: 09/17/18 Placement Time: 1547 Size (Gauge): 20 G Orientation: Left Location: Arm Site Prep: Alcohol Inserted by: Shirely, RN Insertion attempts: 1 Patient Tolerance: Tolerated well Removal Date: 09/17/18 Removal Time: 1825
Site Assessment	Intact;Dry;Clean
Dressing Type	Transparent
Line Status	Infusing
Dressing Status	Clean;Dry;Intact

PACU

Row Name	09/17/18 1800	09/17/18 1730	09/17/18 1725	09/17/18 1720	09/17/18 1716
Reason	—	—	—	—	Post-
Temp	—	—	—	—	36.4 °C (97.5 °F)
Temp src	—	—	—	—	Temporal
Pulse	55	54	58	57	60
Heart Rate Source	—	—	—	—	Device
Resp	18	20	18	20	18
Resp Source	—	—	—	—	Observed
BP	131/72	130/79	132/84	133/79	130/80
NIBP (Mean)	—	—	103 mmHg	—	100 mmHg
BP Location	—	—	—	—	Right arm
BP Method	—	—	—	—	Device
SpO2	96 %	96 %	96 %	96 %	96 %
Patient Position	—	—	—	—	Lying
O2 Delivery Method	—	—	—	—	Room air
Activity	2-->moves 4	—	—	—	2-->moves 4

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Flowsheets (continued)

	extremities voluntarily or on command				extremities voluntarily or on command
Respiration	2-->able to breathe and cough freely	—	—	—	2-->able to breathe and cough freely
Circulation	2-->BP within 20% of preanesthetic level	—	—	—	2-->BP within 20% of preanesthetic level
Consciousness	2-->fully awake	—	—	—	2-->fully awake
O2 Saturation	2-->able to maintain SaO2 above 92% on room air	—	—	—	2-->able to maintain SaO2 above 92% on room air
Aldrete Score	10	—	—	—	10
Head of Bed Elevated	—	—	—	—	HOB 30
Level of Consciousness	Alert	—	—	—	Alert
Orientation Level	Oriented X4	—	—	—	Oriented X4
Cognition	Appropriate judgement;Appropriate safety awareness;Appropriate attention/concentration	—	—	—	Appropriate judgement;Appropriate safety awareness;Appropriate attention/concentration
Speech	Clear	—	—	—	Clear
Respiratory (WDL)	—	—	—	—	Within Defined Limits
Incision Properties	Date First Assessed: 09/17/18 Time First Assessed: 1644 Wound Location Orientation: Other (Comment) Location: Perineum Wound Description (Comments): No dressings				
Presence Of Pain	denies	—	denies	—	denies

Row Name	09/17/18 1710	09/17/18 1705	09/17/18 1700	09/17/18 1655	09/17/18 1650
Pulse	55	56	57	58	57
Resp	25	21	19	26	22
BP	121/80	137/87	128/85	136/84	120/79
NIBP (Mean)	96 mmHg	107 mmHg	101 mmHg	105 mmHg	95 mmHg
SpO2	97 %	96 %	96 %	98 %	99 %
Pulse Oximetry Type	Continuous	—	—	Continuous	Continuous
Patient Activity	At rest	—	—	At rest	At rest
Oxygen Therapy	None	—	—	None	Supplemental oxygen
O2 Delivery Method	Room air	—	—	Room air	Nasal cannula
O2 Flow Rate (L/min)	—	—	—	—	2 L/min
Activity	2-->moves 4 extremities voluntarily or on command	—	—	—	—
Respiration	2-->able to breathe and cough freely	—	—	—	—
Circulation	2-->BP within 20% of preanesthetic level	—	—	—	—
Consciousness	2-->fully awake	—	—	—	—
O2 Saturation	2-->able to maintain SaO2 above 92% on room air	—	—	—	—
Aldrete Score	10	—	—	—	—
Level of	Alert	—	—	—	—

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Flowsheets (continued)

Consciousness					
Orientation Level	Oriented X4	—	—	—	—
Cognition	Appropriate judgement;Follows commands	—	—	—	—
Speech	Clear	—	—	—	—
Incision Properties	Date First Assessed: 09/17/18 Time First Assessed: 1644 Wound Location Orientation: Other (Comment) Location: Perineum Wound Description (Comments): No dressings				
Presence Of Pain	denies	—	—	—	—

Row Name	09/17/18 1645	09/17/18 1640
Reason	—	Post-
Temp	—	36.4 °C (97.5 °F)
Temp src	—	Temporal
Pulse	56	57
Resp	14	15
BP	125/79	122/75
NIBP (Mean)	98 mmHg	94 mmHg
SpO2	100 %	100 %
Pulse Oximetry Type	Continuous	Continuous
Patient Activity	At rest	At rest
Oxygen Therapy	Supplemental oxygen	Supplemental oxygen
O2 Delivery Method	Simple mask	Simple mask
O2 Flow Rate (L/min)	6 L/min	6 L/min
Observations	patient awake, alert, vss	patient asleep, drowsy, vss
Activity	2-->moves 4 extremities voluntarily or on command	0-->moves 0 extremities voluntarily or on command
Respiration	2-->able to breathe and cough freely	1-->dyspnea or limited breathing
Circulation	2-->BP within 20% of preanesthetic level	2-->BP within 20% of preanesthetic level
Consciousness	2-->fully awake	1-->arousable on calling
O2 Saturation	1-->needs O2 to maintain SaO2 above 90%	—
Aldrete Score	9	—
Additional Comfort/Environmental Interventions	—	Warming blanket
Warming Blanket	—	Applied
Head of Bed Elevated	—	HOB 30
Anti-Embolism Devices	—	Sequential compression devices, below knee
Level of Consciousness	Alert	Sedated
Orientation Level	Oriented X4	Unable to assess
Cognition	Appropriate judgement;Follows commands	Unable to assess
Speech	Clear	Unable to assess

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Flowsheets (continued)

Incision Properties	Date First Assessed: 09/17/18 Time First Assessed: 1644 Wound Location Orientation: Other (Comment) Location: Perineum Wound Description (Comments): No dressings
Presence Of Pain	— denies

PADS Discharge Criteria System

Row Name	09/17/18 1818
Vital Signs	BP and pulse within 20% of preoperative baselin
Activity Level	Steady gait, no dizziness, or meets preoperative level
Nausea and Vomiting	Minimal: successfully treated with PO medication
Pain	Acceptable
Surgical Bleeding	Minimal: does not require dressing change
PADS Total Score	10
PADS Total Score	10

Pre-Op Checklist

Row Name	09/17/18 1501
Isolation Type	Not Applicable
Patient ID Verified	Verbal;Armband
ID Band Applied	Yes
Arm Bands On	Fall
Site Marked	Yes
Pulse Oximeter on Patient	No
Plan of Care Documented	Yes
Completed Surgical Consent signed and placed on the chart	Yes
Completed Anesthesia Consent signed and placed on the chart	Yes
Completed Transfusion Consent signed and placed on the chart	Yes
History & Physical within last 30 days present in chart?	Yes
Updated to History & Physical within 24 hours of	No

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Flowsheets (continued)

surgery/procedure	
Sterilization Permit, if required?	Not applicable
CHG Skin Prep Completed?	Yes
Forced Warming Device Applied?	No
Patient Belongings:	Placed in pre-op closet
Jewelry Removed?	Not Applicable
Loose Teeth?	No
Sensory Aids/Prosthesis/Implants	None
Barrier Applied?	No
Psychosocial Exam	Alert/Oriented
Correct Patient	Yes
Correct Site	Yes
Correct Procedure	Yes
Procedure Name	Transrectal Ultrasound Guided Prostate Biopsy- n/a
Correct Laterality	Yes
Family Contact	Irma-wife- 909-374-7216

Pre-op Phone Call Inpatient Preparation

Row Name	09/17/18 1820	09/17/18 1818
Living Arrangements	Spouse/significant other	Spouse/significant other
Support Systems	Spouse/significant other	Spouse/significant other
Type of Residence	Private residence	Private residence

Screening (Adult)

Row Name	09/17/18 1443
Blood Avoidance/Restrictions	none
Previous Transfusion Reaction	no
Reaction to Anesthesia, Patient or Family Member	no previous reaction
Intubation History/Difficult Intubation	previously intubated, problems

Screenings

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Flowsheets (continued)

Row Name	09/17/18 1442
History of Falling	No
Secondary Diagnosis	No
Ambulatory Aids	None/bedrest/nurse assist
Intravenous Therapy/Heparin/ Saline Lock	No
Gait/Transferring	Normal/bedrest/wheelchair
Mental Status	Oriented to own ability
Morse Fall Risk Score	0

Skin Assessment

Row Name	09/17/18 1445
Skin WDL	WDL
Verified by	Shirely, RN
Sensory Perception	4-->no impairment
Moisture	4-->rarely moist
Activity	4-->walks frequently
Mobility	4-->no limitation
Nutrition	4-->excellent
Friction and Shear	3-->no apparent problem
Braden Score	23

Travel and Exposure Screening

Row Name	09/17/18 1442
Traveled outside the U.S. in the last month?	No
Planned travel outside the U.S. in the next 12 months?	No
Contact with someone with a communicable disease in the last month?	No
Positive skin or blood TB screening in the past?	Yes
Received treatment for TB in the past?	No

Vitals Reassessment

Row Name	09/17/18 1800	09/17/18 1730	09/17/18 1725	09/17/18 1720	09/17/18 1716
Restart Vitals Timer	Yes	Yes	Yes	Yes	Yes
Row Name	**09/17/18 1710**	**09/17/18 1705**	**09/17/18 1700**	**09/17/18 1655**	**09/17/18 1650**

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Flowsheets (continued)

Restart Vitals Timer	Yes	Yes	Yes	Yes	Yes

Row Name	09/17/18 1645	09/17/18 1640	09/17/18 1439
Restart Vitals Timer	Yes	Yes	Yes

Vitals/Pain

Row Name	09/17/18 1439
Reason	Pre-
Temp	36.5 °C (97.7 °F)
Temp src	Temporal
Pulse	61
Heart Rate Source	Device
Resp	18
Resp Source	Observed
BP	138/85
BP Location	Left arm
BP Method	Device
SpO2	97 %
Patient Position	Sitting
Pulse Oximetry Type	Intermittent
Patient Activity	At rest
Oxygen Therapy	None
Height	172.7 cm (5' 7.99")
Height Method	Stated
Weight	76.2 kg (167 lb 15.9 oz)
Weight Method	Standing scale
BSA (Calculated - sq m)	1.91 sq meters
BMI (Calculated)	25.5
Weight in (lb) to have BMI = 25	164
Presence Of Pain	denies

Pre-op Phone Call

Row Name	09/13/18 1530
Type of Procedure	General Anesthesia
Arrival time 2 hours before surgery but at least 1 hour before NM/NL time. Verified?	Yes
Nothing to eat or drink (no water) after midnight. Verified?	Yes
The Patient will need a friend or family member to sign them out and drive them home after the procedure. Must	Yes

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Flowsheets (continued)

be over 18 years of age. Verified?	
Patient may not have any jewelry on for the day of procedure (wedding ring, necklace, bracelets, earrings, including jewelry for body piercing) verified?	Yes
Remove all valuables before coming to hospital. Verified?	Yes

09/17/2018 - Admission (Discharged) in Operating Room (continued)

Coding Summary

Account Information

Hospital Account	Primary Payor	Affiliated Recurring Accounts	Combined from HAR
3000293691 - HANNA,ADEL	BLUE CROSS [308002208]	None	None

Admission Information

Arrival Date/Time:		Admit Date/Time:	09/17/2018 1346	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Home	Admit Category:	
Means of Arrival:		Primary Service:	Surgery	Secondary Service:	
Transfer Source:		Service Area:	CITY OF HOPE	Unit:	Operating Room
Admit Provider:	Clayton S Lau, MD	Attending Provider:	Clayton S Lau, MD	Referring Provider:	

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
09/17/2018 1826	Home Or Self Care	None	None	Operating Room

Admission Diagnoses / Reasons for Visit (ICD-10-CM)

Code	Description	Comments
R97.20	Elevated prostate specific antigen (PSA)	

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
R97.20 **[Principal]**	Elevated prostate specific antigen (PSA)				
I10	Essential (primary) hypertension				
G43.909	Migraine, unspecified, not intractable, without status migrainosus				
K21.9	Gastro-esophageal reflux disease without esophagitis				

CPT®/HCPCS Codes

Code	Modifiers	Date	Qty	Performing Provider	APC	Exp Reimb	Px Event
55700 (CPT®)		09/17/2018	1	Clayton S Lau, MD	05373	667.42	1
Description: Prostate needle biopsy any approach							

Procedure Events

Px Event	Provider	Date	ASA Class	Anesthesia Type	Anesthesiologist/CRNA
1	Clayton S Lau, MD	09/17/2018		General	Evelyn J Bonilla, MD

09/14/2018 - Pre Admit Anesthesia Testing in PATC

Flowsheets

LACE+ Score

Row Name	09/18/18 0041
LACE+ Score	31

Adult Patient Profile

Row Name	09/14/18 1416
Source of Information	patient
Admission in Past 90 Days	none
Reaction to Anesthesia, Patient or Family Member	no previous reaction
Blood Avoidance/Restrictions	none
Hearing Difficulty or Deaf	other (see comments)
Wear Glasses or Blind	yes
Concentrating, Remembering or Making Decisions Difficulty	no
Doing Errands Independently Difficulty (such as shopping)	yes
Major Change/Loss/Stressor/Fears	denies
Current Activity Tolerance	good
Feel Rested Upon Awakening	yes
Sleep Aids/Routine	none
Nutrition Risk Screen	no indicators present
Feels Unsafe at Home or Work/School	unable to assess
Feels Threatened by Someone	unable to assess
Does Anyone Try to Keep You From Having Contact with Others or Doing Things Outside Your Home?	unable to assess
Have You Felt Down, Depressed or Hopeless?	no
Have You Felt Little Interest or Pleasure in Doing Things?	no

09/14/2018 - Pre Admit Anesthesia Testing in PATC (continued)

Flowsheets (continued)

Feels Like Hurting Self	no
Feels Like Hurting Others	no
Barriers to Managing Health	none
People in Home	spouse
Walking or Climbing Stairs Difficulty	none
Dressing/Bathing Difficulty	none
Usual Activity Tolerance	good
Primary Source of Support/Comfort	spouse

Custom Formula Data

Row Name	09/14/18 1403
Pct Wt Change	0 %
Water Needs - Holliday Segar Method (> 65 years)	2353.5
RDA Male (11-14 years) (kcal)	4229.5
RDA Male (15-18 years) (kcal)	3460.5
50 Kcal/Kg (kcal)	3845
25 Kcal/Kg (kcal)	1922.5
45 Kcal/Kg (kcal)	3460.5
20 Kcal/Kg (kcal)	1538
40 Kcal/Kg (kcal)	3076
35 kcal/kg (kcal)	2691.5
30 Kcal/Kg (kcal)	2307
120 kcal/kg (kcal)	9228
60 kcal/kg (kcal)	4614
140 kcal/kg (kcal)	10766
80 kcal/kg (kcal)	6152
160 kcal/kg (kcal)	12304
180 kcal/kg (kcal)	13842
200 kcal/kg (kcal)	15380
20 kcal/kg (kcal)	1538
100 kcal/kg (kcal)	7690
40 kcal/kg (kcal)	3076
30 kcal/kg (kcal)	2307
RDA Method (kcal/day)	7843.8
RDA (4-6 years) (kcal)	6921
RDA (7-10 years) (kcal)	5383
40 KCAL/KG (BMI<18.5) (kcal)	3076
25 KCAL/KG (BMI>25-34) (kcal)	1922.5
20 KCAL/KG	1538

09/14/2018 - Pre Admit Anesthesia Testing in PATC (continued)

Flowsheets (continued)

(BMI>34) (kcal)	
30 KCAL/KG (BMI>18.5-24.9) (kcal)	2307
40 KCAL/KG (BMI<18.4) (kcal)	3076
25 KCAL/KG (BMI>25-33.9) (kcal)	1922.5
20 KCAL/KG (BMI>34) (kcal)	1538
30 KCAL/KG (BMI>18.5-24.9) (kcal)	2307
WHO Equation Female (0-3 years) (kcal)	4639.9
WHO Equation Female (4-10 years) (kcal)	2229.25
WHO Equation Female (11-18 years) (kcal)	1684.18
WHO Equation (kcal/day)	4629.21
WHO Equation Male (4-10 years) (kcal)	2240.63
WHO Equation Male (11-18 years) (kcal)	1996.75
RDA (0-6 month old) (kcal)	8305.2
RDA (> 6 months-1 year old) (kcal)	7536.2
RDA Female (11-14 years) (kcal)	3614.3
RDA Female (15-18 years) (kcal)	3076
Current Weight (gm)	76900
Holliday-Segar Method (<= 10 kg) (mL)	7690
Holliday-Segar Method (> 20 kg) (mL)	4345
Holliday-Segar (mL)	4345
Holliday-Segar (mL)	3038

Education (Adult)

Row Name	09/14/18 1420
Person Taught	patient;spouse
Learning Readiness and Ability	no barriers identified
Teaching Focus	perioperative

09/14/2018 - Pre Admit Anesthesia Testing in PATC (continued)

Flowsheets (continued)

	routine
Education	verbalizes
Outcome	understanding
Evaluation	

Pain (Adult)

Row Name	09/14/18 1403
Restart Pain Assessment Timer	Yes

PATC Event Times

Row Name	09/14/18 1457	09/14/18 1454	09/14/18 1402
PATC RN ENTERS EXAM ROOM	—	—	1403
PATC RN EXITS EXAM ROOM	—	1420	—
PATC NP ENTERS EXAM ROOM	1422	—	—
PATC NP EXITS EXAM ROOM	1436	—	—

Travel and Exposure Screening

Row Name	09/14/18 1420
Traveled outside the U.S. in the last month?	No
Planned travel outside the U.S. in the next 12 months?	No
Contact with someone with a communicable disease in the last month?	No
Positive skin or blood TB screening in the past?	No

Vitals Reassessment

Row Name	09/14/18 1403
Restart Vitals Timer	Yes

VITALS/NPO STATUS

Row Name	09/14/18 1403
Reason	Clinic Visit
Temp	36.8 °C (98.2 °F)
Temp src	Oral
Pulse	58
Heart Rate	Device

09/14/2018 - Pre Admit Anesthesia Testing in PATC (continued)

Flowsheets (continued)

Source	
Resp	18
Resp Source	Observed
BP	127/72
SpO2	94 %
Patient Position	Sitting
Weight	76.9 kg (169 lb 8.5 oz)
Weight Method	Actual
BMI (Calculated)	25.8
Pain Assessment	No/denies pain

09/14/2018 - Pre Admit Anesthesia Testing in PATC (continued)

Coding Summary

Account Information

Hospital Account	Primary Payor	Affiliated Recurring Accounts	Combined from HAR
3000294842 - HANNA,ADEL	BLUE CROSS [308002208]	None	None

Admission Information

Arrival Date/Time:		Admit Date/Time:	09/14/2018 1333	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Office	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	
Transfer Source:		Service Area:	CITY OF HOPE	Unit:	PATC
Admit Provider:		Attending Provider:	Clayton S Lau, MD	Referring Provider:	

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
09/17/2018 1345	Home Or Self Care	None	None	PATC

Admission Diagnoses / Reasons for Visit (ICD-10-CM)

Code	Description	Comments
Z01.818	Encounter for other preprocedural examination	

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
Z01.818 **[Principal]**	Encounter for other preprocedural examination				
R97.20	Elevated prostate specific antigen (PSA)				
I10	Essential (primary) hypertension				
K21.9	Gastro-esophageal reflux disease without esophagitis				

09/13/2018 - Appointment in Main Lab

Labs

Basic Metabolic Panel [18957020] (Final result)

Electronically signed by: **Felicia Nicole Kinnard, PA on 09/13/18 1335** Status: **Completed**
This order may be acted on in another encounter.
Ordering user: Felicia Nicole Kinnard, PA 09/13/18 1335
Authorized by: Felicia Nicole Kinnard, PA
Frequency: Routine 09/13/18 -
Quantity: 1
Instance released by: Michelle Rendon 9/13/2018 3:03 PM
Ordering provider: Felicia Nicole Kinnard, PA
Ordering mode: Standard
Class: Lab Collect
Lab status: Final result
Diagnoses
Elevated prostate specific antigen (PSA) [R97.20]

Specimen Information

ID	Type	Source	Collected By
18256C-CH1358	Blood	Blood, Venous	Luis M. Perez 09/13/18 1522

Basic Metabolic Panel [18957020] (Abnormal) Resulted: 09/13/18 1607, Result status: Final result

Ordering provider: Felicia Nicole Kinnard, PA 09/13/18 1503
Filed by: Lab, Background User 09/13/18 1607
Resulting lab: HCRH PATHOLOGY LAB
Acknowledged by: Felicia Nicole Kinnard, PA on 11/01/18 1719
Order status: Completed
Collected by: Luis M. Perez 09/13/18 1522
CLIA number: 05D0665695

Components

Component	Value	Reference Range	Flag	Lab
Sodium Level, Blood	141	137 - 145 mmol/L	—	HCRH PATH
Potassium Level, Blood	4.7	>3.5-<5.1 mmol/L	—	HCRH PATH
Chloride Level, Blood	104	98 - 107 mmol/L	—	HCRH PATH
Carbon Dioxide Level, Blood	31	22 - 30 mmol/L	H ^	HCRH PATH
Blood Urea Nitrogen Level, Blood	11	7 - 25 mg/dL	—	HCRH PATH
Creatinine Level, Blood	0.96	0.70 - 1.30 mg/dL	—	HCRH PATH
eGFR Except African American	—	>=60 mL/min/1.73 sq M	—	HCRH PATH
Comment: RESULT NOT VALID Results using the MDRD study equation have not been validated for use with patients under 18 and over 70 years of age, pregnant women, patients with serious comorbid conditions, or persons with extremes of body size, muscle mass, or nutritional status. Chronic Kidney Disease <60 mL/min/1.73sq M Kidney Failure <15 mL/min/1.73sq M				
eGFR African American	—	>=60 mL/min/1.73 sq M	—	HCRH PATH
Comment: RESULT NOT VALID Results using the MDRD study equation have not been validated for use with patients under 18 and over 70 years of age, pregnant women, patients with serious comorbid conditions, or persons with extremes of body size, muscle mass, or nutritional status. Chronic Kidney Disease <60 mL/min/1.73sq M Kidney Failure <15 mL/min/1.73sq M				
Glucose Level (Random), Blood	88	80 - 128 mg/dL	—	HCRH PATH
Calcium Level, Blood	10.0	8.6 - 10.2 mg/dL	—	HCRH PATH
Anion Gap, Blood	6	8 - 14	L ˅	HCRH PATH

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
20 - HCRH PATH	HCRH PATHOLOGY LAB	Dennis D Weisenburger, MD	CLIA #05D0665695 1500 E Duarte Rd Duarte CA 91010	04/10/18 0944 - 12/03/18 1306

09/13/2018 - Appointment in Main Lab (continued)

Labs (continued)

Indications

Elevated prostate specific antigen (PSA) [R97.20 (ICD-10-CM)]

All Reviewers List

Felicia Nicole Kinnard, PA on 11/1/2018 17:19

Culture, MRSA Screen [18957021] (Final result)

Electronically signed by: **Felicia Nicole Kinnard, PA on 09/13/18 1335** Status: **Completed**
This order may be acted on in another encounter.
Ordering user: Felicia Nicole Kinnard, PA 09/13/18 1335
Authorized by: Felicia Nicole Kinnard, PA
Frequency: Routine 09/13/18 -
Quantity: 1
Instance released by: Michelle Rendon 9/13/2018 3:03 PM
Ordering provider: Felicia Nicole Kinnard, PA
Ordering mode: Standard
Class: Lab Collect
Lab status: Final result
Diagnoses
Elevated prostate specific antigen (PSA) [R97.20]

Specimen Information

ID	Type	Source	Collected By
18256C-MI0094	Swab	Nares	Luis M. Perez 09/13/18 1522

Culture, MRSA Screen [18957021] Resulted: 09/14/18 1436, Result status: Final result

Ordering provider: Felicia Nicole Kinnard, PA 09/13/18 1503
Filed by: Mary Jay Punsal Duran, CLS 09/14/18 1436
Resulting lab: COH MICROBIOLOGY
Acknowledged by: Felicia Nicole Kinnard, PA on 11/01/18 1719
Order status: Completed
Collected by: Luis M. Perez 09/13/18 1522
CLIA number: 05D0665695

Components

Component	Value	Reference Range	Flag	Lab
Methicillin Resistant Staphylococcus aureus (MRSA) Culture	No Methicillin Resistant Staphylococcus aureus isolated.	—	—	62

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
62 - Unknown	COH MICROBIOLOGY	Dennis D Weisenburger, MD	CLIA #05D0665695 1500 E Duarte Rd Duarte CA 91010	03/13/18 1302 - 01/04/19 0000

Indications

Elevated prostate specific antigen (PSA) [R97.20 (ICD-10-CM)]

All Reviewers List

Felicia Nicole Kinnard, PA on 11/1/2018 17:19

Complete Blood Count [18957022] (Final result)

Electronically signed by: **Felicia Nicole Kinnard, PA on 09/13/18 1335** Status: **Completed**
This order may be acted on in another encounter.
Ordering user: Felicia Nicole Kinnard, PA 09/13/18 1335
Authorized by: Felicia Nicole Kinnard, PA
Frequency: Routine 09/13/18 -
Quantity: 1
Instance released by: Michelle Rendon 9/13/2018 3:03 PM
Ordering provider: Felicia Nicole Kinnard, PA
Ordering mode: Standard
Class: Lab Collect
Lab status: Final result
Diagnoses

09/13/2018 - Appointment in Main Lab (continued)

Labs (continued)

Elevated prostate specific antigen (PSA) [R97.20]

Specimen Information

ID	Type	Source	Collected By
18256C-HM0793	Blood	Blood, Venous	Luis M. Perez 09/13/18 1522

Complete Blood Count [18957022] (Abnormal) Resulted: 09/13/18 1551, Result status: Final result

Ordering provider: Felicia Nicole Kinnard, PA 09/13/18 1503
Filed by: Lab, Background User 09/13/18 1551
Resulting lab: COH HEMATOLOGY
Acknowledged by: Felicia Nicole Kinnard, PA on 11/01/18 1719

Order status: Completed
Collected by: Luis M. Perez 09/13/18 1522
CLIA number: 05D0665695

Components

Component	Value	Reference Range	Flag	Lab
WBC	4.1	3.6 - 10.1 K/uL	—	59
RBC Count	5.93	4.01 - 5.29 M/UL	H	59
Hemoglobin, Whole Blood	16.6	12.8 - 16.1 g/dL	H	59
Hematocrit, Whole Blood	50.2	37.6 - 47.2 %	H	59
Platelet Count	118	150 - 350 K/uL	L	59
MCV	84.7	83.3 - 97.0 fL	—	59
MCH	28.0	27.4 - 33.0 pg	—	59
MCHC	33.1	32.8 - 35.0 g/dL	—	59
RDW	17.2	12.5 - 15.0 %	H	59
MPV	10.1	7.1 - 11.2 fL	—	59

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
59 - Unknown	COH HEMATOLOGY	Dennis D Weisenburger, MD	CLIA #05D0665695 1500 E Duarte Rd Duarte CA 91010	03/13/18 1300 - 01/04/19 0000

Indications

Elevated prostate specific antigen (PSA) [R97.20 (ICD-10-CM)]

All Reviewers List

Felicia Nicole Kinnard, PA on 11/1/2018 17:19

09/13/2018 - Appointment in Main Lab (continued)

Coding Summary

Account Information

Hospital Account	Primary Payor	Affiliated Recurring Accounts	Combined from HAR
3000293426 - HANNA,ADEL	BLUE CROSS [308002208]	None	None

Admission Information

Arrival Date/Time:	09/13/2018 1503	Admit Date/Time:	09/13/2018 1415	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Office	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	
Transfer Source:		Service Area:		Unit:	
Admit Provider:	MM MAIN LAB CHAIR 07	Attending Provider:	Clayton S Lau, MD	Referring Provider:	Felicia Nicole Kinnard, PA

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
09/13/2018 1419	Home Or Self Care	None	None	Main Lab

Admission Diagnoses / Reasons for Visit (ICD-10-CM)

Code	Description	Comments
R97.20	Elevated prostate specific antigen (PSA)	

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
R97.20 **[Principal]**	Elevated prostate specific antigen (PSA)				
Z01.810	Encounter for preprocedural cardiovascular examination				
I10	Essential (primary) hypertension				

CPT®/HCPCS Codes

Code	Modifiers	Date	Qty	Performing Provider	APC	Exp Reimb	Px Event
G0463	25	09/13/2018	1	Clayton S Lau, MD	05012	44.75	
Description: Hospital outpt clinic visit; (-25 Signif E/M same phys/day)							

09/13/2018 - X-Ray Exam in X-Ray Radiology

Imaging

Imaging

XR chest posterioranterior lateral [18952591] (Final result)

Electronically signed by: **Felicia Nicole Kinnard, PA on 09/13/18 1335** Status: **Completed**
This order may be acted on in another encounter.
Ordering user: Felicia Nicole Kinnard, PA 09/13/18 1335
Authorized by: Felicia Nicole Kinnard, PA
Frequency: Routine Once 09/13/18 1420 - 1 occurrence
Quantity: 1
Instance released by: Elizabeth Bailey 9/13/2018 2:20 PM
Ordering provider: Felicia Nicole Kinnard, PA
Ordering mode: Standard
Class: Ancillary Performed (COH locations)
Lab status: Final result
Diagnoses
Elevated prostate specific antigen (PSA) [R97.20]

Questionnaire

Question	Answer
Reason for Exam:	Pre-op major surgery

Screening Form

General Information

Patient Name: Hanna, Adel
Date of Birth: 3/29/1946
Legal Sex: Male
MRN: 11031634
Work Phone: 909-578-6061
Mobile: 949-244-7759

Procedure	Ordering Provider	Authorizing Provider	Appointment Information
XR CHEST PA LATERAL	Felicia N Kinnard, PA 626-256-4673	Felicia N Kinnard, PA 626-256-4673	9/13/2018 2:30 PM HCRH XR 1 HCRH XR IMAGING

Screening Form Questions

No questions have been answered for this form.

XR chest posterioranterior lateral [18952591] Resulted: 09/13/18 1534, Result status: Final result

Ordering provider: Felicia Nicole Kinnard, PA 09/13/18 1420
Resulted by: Arnold J Rotter, MD
Performed: 09/13/18 1442 - 09/13/18 1442
Resulting lab: PS360
Order status: Completed
Filed by: Interface, Radiology Results In 09/13/18 1539
Accession number: COH201809130341

Narrative:
HISTORY: Elevated PSA. Preop major surgery.

FULL RESULT: PA and lateral chest x-ray without any prior films for comparison. The right hemidiaphragm and right lateral costophrenic angle are elevated. Mild pleural thickening in the right lower lung laterally is noted. Reticular opacities noted in the right apex. No pulmonary nodules, infiltrates or congestion are seen. The heart is normal in size with moderate to marked tortuosity of the descending aorta. No lytic or blastic bone lesions and no fracture identified.

Impression:
1. Elevated right hemidiaphragm lateral minimal pleural thickening. Probable scarring.
2. No acute inflammatory or metastatic disease seen.

Acknowledged by: Felicia Nicole Kinnard, PA on 11/01/18 1719

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
44 - Unknown	PS360	Unknown	Unknown	03/08/17 0927 - Present

Signed

Electronically signed by Arnold J Rotter, MD on 9/13/18 at 1534 PDT

09/13/2018 - X-Ray Exam in X-Ray Radiology (continued)

Imaging (continued)

All Reviewers List

Felicia Nicole Kinnard, PA on 11/1/2018 17:19

09/13/2018 - X-Ray Exam in X-Ray Radiology (continued)

Flowsheets

LACE+ Score

Row Name	09/14/18 0044
LACE+ Score	23

09/13/2018 - X-Ray Exam in X-Ray Radiology (continued)

Coding Summary

Account Information

Hospital Account	Primary Payor	Affiliated Recurring Accounts	Combined from HAR
3000293426 - HANNA,ADEL	BLUE CROSS [308002208]	None	None

Admission Information

Arrival Date/Time:		Admit Date/Time:	09/13/2018 1415	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Office	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	
Transfer Source:		Service Area:	CITY OF HOPE	Unit:	X-Ray Radiology
Admit Provider:		Attending Provider:	Clayton S Lau, MD	Referring Provider:	Felicia Nicole Kinnard, PA

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
09/13/2018 1419	Home Or Self Care	None	None	X-Ray Radiology

Admission Diagnoses / Reasons for Visit (ICD-10-CM)

Code	Description	Comments
R97.20	Elevated prostate specific antigen (PSA)	

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
R97.20 **[Principal]**	Elevated prostate specific antigen (PSA)				
Z01.810	Encounter for preprocedural cardiovascular examination				
I10	Essential (primary) hypertension				

CPT®/HCPCS Codes

Code	Modifiers	Date	Qty	Performing Provider	APC	Exp Reimb	Px Event
G0463	25	09/13/2018	1	Clayton S Lau, MD	05012	44.75	
Description: Hospital outpt clinic visit; (-25 Signif E/M same phys/day)							

09/13/2018 - Electrocardiogram in Heart Station

Procedures

ECG 12 lead [18957019] (Final result)

Electronically signed by: **Felicia Nicole Kinnard, PA on 09/13/18 1335** Status: **Completed**
This order may be acted on in another encounter.
Ordering user: Felicia Nicole Kinnard, PA 09/13/18 1335
Authorized by: Felicia Nicole Kinnard, PA
Frequency: Routine Once 09/13/18 1443 - 1 occurrence
Quantity: 1
Instance released by: Carissa Marie Nishanian 9/13/2018 2:43 PM
Ordering provider: Felicia Nicole Kinnard, PA
Ordering mode: Standard
Class: Ancillary Performed (COH locations)
Lab status: Final result
Diagnoses
Elevated prostate specific antigen (PSA) [R97.20]

Questionnaire

Question	Answer
Indication/Reason for exam:	Pre-Op

Specimen Information

ID	Type	Source	Collected By
COHMUSE10699 5	—	—	09/13/18 1454

ECG 12 lead [18957019] Resulted: 09/14/18 0829, Result status: Final result

Ordering provider: Felicia Nicole Kinnard, PA 09/13/18 1443
Filed by: Coh Interface, Ekg Results In 09/14/18 0829
Resulting lab: MUSE
Acknowledged by: Felicia Nicole Kinnard, PA on 11/01/18 1719
Order status: Completed
Collected by: 09/13/18 1454
Lab Technician: RHEA ESPINUEVA

Components

Component	Value	Reference Range	Flag	Lab
Ventricular Rate:	44	BPM	—	18
Atrial Rate:	44	BPM	—	18
P-R Interval:	176	ms	—	18
QRS Duration:	92	ms	—	18
QT:	468	ms	—	18
QTC Calculation (Bezet):	400	ms	—	18
P Axis:	35	degrees	—	18
R Axis:	38	degrees	—	18
T Axis:	59	degrees	—	18
QTC Fredericia:	421	ms	—	18
Cardiology Report:	Marked sinus bradycardia	—	—	18
Cardiology Report:	Abnormal ECG	—	—	18
Cardiology Report:	No previous ECGs available	—	—	18
Cardiology Report:	Confirmed by Cai, MD, LiYing (5607) on 9/14/2018 8:29:22 AM	—	—	18

View Image (below)

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
18 - Unknown	MUSE	Unknown	Unknown	12/01/16 0907 - Present

09/13/2018 - Electrocardiogram in Heart Station (continued)

Procedures (continued)

Indications

Elevated prostate specific antigen (PSA) [R97.20 (ICD-10-CM)]

All Reviewers List

Felicia Nicole Kinnard, PA on 11/1/2018 17:19

09/13/2018 - Electrocardiogram in Heart Station (continued)

Flowsheets

LACE+ Score

Row Name	09/14/18 0044
LACE+ Score	23

09/13/2018 - Electrocardiogram in Heart Station (continued)

Coding Summary

Account Information

Hospital Account	Primary Payor	Affiliated Recurring Accounts	Combined from HAR
3000293426 - HANNA,ADEL	BLUE CROSS [308002208]	None	None

Admission Information

Arrival Date/Time:		Admit Date/Time:	09/13/2018 1415	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Office	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	
Transfer Source:		Service Area:	CITY OF HOPE	Unit:	Heart Station
Admit Provider:		Attending Provider:	Clayton S Lau, MD	Referring Provider:	Felicia Nicole Kinnard, PA

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
09/13/2018 1419	Home Or Self Care	None	None	Heart Station

Admission Diagnoses / Reasons for Visit (ICD-10-CM)

Code	Description	Comments
R97.20	Elevated prostate specific antigen (PSA)	

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
R97.20 **[Principal]**	Elevated prostate specific antigen (PSA)				
Z01.810	Encounter for preprocedural cardiovascular examination				
I10	Essential (primary) hypertension				

CPT®/HCPCS Codes

Code	Modifiers	Date	Qty	Performing Provider	APC	Exp Reimb	Px Event
G0463	25	09/13/2018	1	Clayton S Lau, MD	05012	44.75	

Description: Hospital outpt clinic visit; (-25 Signif E/M same phys/day)

09/13/2018 - Office Visit in Urology

H&P Notes

H&P

Clayton S Lau, MD at 9/13/2018 1300

MRN # 11031634 **CSN:** 302915250 **Age:** 72 y.o. (3/29/1946)	**Patient Name:** **Adel Hanna** **Gender:** male	**Encounter Department:** DUARTE UROLOGY 1500 East Duarte Rd Duarte, CA 91010-3012 626-256-4673

History & Physical

Reason for Visit:

Chief Complaint

Patient presents with

- Elevated PSA

  Consult

Subjective

History of Present Illness

Adel Hanna is a 72 y.o. male from Chino Hills with Obstructive Lower Urinary Tract Symptom. On Testerone Supplementation. PSA 2.9-3.5. DRE normal with 35 gram prostate. His brother who is 10 years his Sr. Has a history of prostate cancer and is doing well after treatment. The patient's father died at the age of 65 and had no known prostate cancer. There is no family history of breast cancer.

ExoDx=31.57 indicating higher chance of high grade cancer. Could not tolerate office TRUS Prostate Biopsy. The patient is self-referred to the city of Hope and would like to undergo a prostate biopsy under general anesthesia
.

SHIM-10
IPSS-6

Diagnosis and Problem List

Diagnosis/Cancer Staging:

1. Elevated prostate specific antigen (PSA)

Problem List:

There is no problem list on file for this patient.

Medical History

Past Medical History:

Past Medical History:

Diagnosis — Date

- Hypertension
- Sinus infection

Past Surgical History:
Past Surgical History:

Procedure	Laterality	Date
• CARDIAC CATHETERIZATION		
• COLONOSCOPY		
• VASECTOMY		

Family History:
No family history on file.

Social History:
Social History

Social History

• Marital status:	Divorced
Spouse name:	N/A
• Number of children:	N/A
• Years of education:	N/A

Occupational History
- Not on file.

Social History Main Topics

• Smoking status:	Never Smoker
• Smokeless tobacco:	Never Used
• Alcohol use	0.6 oz/week
1 Shots of liquor per week	
Comment: 2 drinks a week	
• Drug use:	No
• Sexual activity:	No

Other Topics	Concern
• Not on file	

Social History Narrative
- No narrative on file

Medications

Current Medications:

Current Outpatient Prescriptions:
- amLODIPine (NORVASC) 2.5 MG tablet, Take 5 mg by mouth daily., Disp: , Rfl:
- aspirin 81 MG EC tablet, Take 81 mg by mouth daily., Disp: , Rfl:
- atenolol (TENORMIN) 25 MG tablet, Take 50 mg by mouth daily., Disp: , Rfl:

Allergies/Intolerances

Reglan [metoclopramide]

Review of Systems

Review of Systems
Constitutional: Negative.
HENT: Negative.
Eyes: Negative.
Respiratory: Negative.
Cardiovascular: Positive for chest pain.
Non cardiac origin
Gastrointestinal: Negative.
Genitourinary: Negative.
Musculoskeletal: Negative.
Skin: Negative.
Allergic/Immunologic: Negative.
Neurological: Negative.
Hematological: Negative.
Psychiatric/Behavioral: Negative.

Objective

Physical Exam

Vitals:

Vitals:

	09/13/18 1212
BP:	151/87
Pulse:	60
Resp:	17
Temp:	36.5 °C (97.7 °F)
TempSrc:	Oral
SpO2:	96%
Weight:	76.7 kg (169 lb 1.5 oz)
Height:	172.7 cm (5' 8")

Physical Exam

General: No acute distress
HEENT: Anicteric sclera. Extraocular muscles intact. Mucous membranes moist.
Neck: No lymphadenopathy. Supple.
Chest: Normal respiratory effort with no use of accessory muscles.
Cardiovascular: Regular rate and rhythm
Abdomen: Soft, nontender, nondistended. No costovertebral angle tenderness.
Extremities: No clubbing cyanosis or edema in all 4 extremities

Laboratory Results Review:

No results found for: WBC, WBCLC, HGB, HGBB, HEMOGLOBINLC, HCT, HCTB, HEMATOCRITLC, PLT, PLTCNT, PLATELETSLC, BUN, BUNB, CREATB, SGOTB, SGPTB, TBILB, NA, NAB, K, KB, ALB, ALBB

I have reviewed all pertinent labs.

Medical Imaging Review

No results found.

I have reviewed all pertinent imaging results.

Assessment/Plan

Assessment and Plan

Assessment:
Elevated PSA. Obstructive LUTS. ExoDX was high. 30 minutes was spent with this patient, greater than 50% of the time dedicated to counseling and coordinating subsequent care. All questions raised were answered.

Plan:
Transrectal ultrasound-guided prostate biopsy in the operating room at a mutually convenient time. The patient will be consented today for the procedure and given biopsy instructions. He will perform a Fleet enema the night before in the morning of surgery and IV antibiotics will be given intraoperatively.

Electronic Signature:

Felicia Nicole Kinnard, PA
9/13/2018
1:01 PM

Electronically signed by Felicia Nicole Kinnard, PA at 9/13/2018 2:03 PM

09/13/2018 - Office Visit in Urology (continued)

Clinical Notes

Addendum Note

Felicia Nicole Kinnard, PA at 9/13/2018 1300

Addended by: KINNARD, FELICIA N on: 9/13/2018 02:02 PM

Modules accepted: Level of Service

Electronically signed by Felicia Nicole Kinnard, PA at 9/13/2018 2:02 PM

09/13/2018 - Office Visit in Urology (continued)

Nursing Notes

Progress Notes

Rebecca Lee, RN at 9/13/2018 1300

Questions for new patients

Seen on 9/13/18

1. How did you feel your visit with Dr. Lau went?
It was very good.

2. Do you have any questions about the recommendation or care plan.
None, I will have a prostate biopsy under general anesthesia.

3. Did any future appointments get scheduled or arranged?
It will be on 9/17/18

4. Is there anything else we can answer for you?
Prep for prostate biopsy explained.

Electronically signed by Rebecca Lee, RN at 9/18/2018 9:22 AM

09/13/2018 - Office Visit in Urology (continued)

Flowsheets

Custom Formula Data

Row Name	09/13/18 1212
Pct Wt Change	0 %
Mifflin Resting Metabolic Rate (Male)	1491.49
Total Daily Calories Needed (Male)	2237.24
High Biological Total Daily Protein Needed (ounces) (Male)	10.04
Water Needs - Holliday Segar Method (> 65 years)	2350.5
Mifflin Resting Metabolic Rate (Female)	1325.49
Total Daily Calories Needed (Female)	1988.24
High Biological Total Daily Protein Needed (ounces) (Female)	8.92
BSA (Calculated - sq m)	1.92 sq meters
Weight in (lb) to have BMI = 25	164.1
BMI (Calculated)	25.7
10% Adjustment, Tetra (IBW)	63.8
15% Adjustment, Tetra (IBW)	60.26
10% Adjustment, Para (IBW)	63.8
5% Adjustment, Para (IBW)	67.35
RDA Male (11-14 years) (kcal)	4218.5
RDA Male (15-18 years) (kcal)	3451.5
50 Kcal/Kg (kcal)	3835
25 Kcal/Kg (kcal)	1917.5
45 Kcal/Kg (kcal)	3451.5
20 Kcal/Kg (kcal)	1534
40 Kcal/Kg (kcal)	3068
35 kcal/kg (kcal)	2684.5
30 Kcal/Kg (kcal)	2301
120 kcal/kg (kcal)	9204
60 kcal/kg (kcal)	4602
140 kcal/kg (kcal)	10738
80 kcal/kg (kcal)	6136
160 kcal/kg (kcal)	12272
180 kcal/kg (kcal)	13806
200 kcal/kg (kcal)	15340
20 kcal/kg (kcal)	1534

09/13/2018 - Office Visit in Urology (continued)

Flowsheets (continued)

100 kcal/kg (kcal)	7670
40 kcal/kg (kcal)	3068
30 kcal/kg (kcal)	2301
RDA Method (kcal/day)	7823.4
RDA (4-6 years) (kcal)	6903
RDA (7-10 years) (kcal)	5369
40 KCAL/KG (BMI<18.5) (kcal)	3068
25 KCAL/KG (BMI>25-34) (kcal)	1917.5
20 KCAL/KG (BMI>34) (kcal)	1534
30 KCAL/KG (BMI>18.5-24.9) (kcal)	2301
40 KCAL/KG (BMI<18.4) (kcal)	3068
25 KCAL/KG (BMI>25-33.9) (kcal)	1917.5
20 KCAL/KG (BMI>34) (kcal)	1534
30 KCAL/KG (BMI>18.5-24.9) (kcal)	2301
Schofield Male (4-10 years) (kcal)	2142.51
WHO Equation Female (0-3 years) (kcal)	4627.7
WHO Equation Female (4-10 years) (kcal)	2224.75
WHO Equation Female (11-18 years) (kcal)	1681.74
% Ideal Body Weight	108.19
*Ideal Body Weight (IBW) (kg)	70.89
Ideal Body Weight (IBW lower range) (kg)	55.2
Ideal Body Weight (IBW upper range) (kg)	74.3
WHO Equation (kcal/day)	4617.03
WHO Equation Male (4-10 years) (kcal)	2236.09
WHO Equation Male (11-18 years) (kcal)	1993.25
RDA (0-6 month old) (kcal)	8283.6

09/13/2018 - Office Visit in Urology (continued)

Flowsheets (continued)

RDA (> 6 months-1 year old) (kcal)	7516.6
RDA Female (11-14 years) (kcal)	3604.9
RDA Female (15-18 years) (kcal)	3068
Current Weight (gm)	76700
RMR (Mifflin-St. Jeor) (kcal/day)	1492
Holliday-Segar Method (<= 10 kg) (mL)	7670
Holliday-Segar Method (> 20 kg) (mL)	4335
Holliday-Segar (mL)	4335
Holliday-Segar (mL)	3034
BMI (kg/m2)	25.76
IBW/kg (Calculated)	68.4
Low Range Vt 6mL/kg	410.4 mL/kg
Adult Moderate Range Vt 8mL/kg	547.2 mL/kg
Adult High Range Vt 10mL/kg	684 mL/kg

Encounter Vitals

Row Name	09/13/18 1212
BP	151/87
Pulse	60
Resp	17
Temp	36.5 °C (97.7 °F)
Temp src	Oral
SpO2	96 %
Weight	76.7 kg (169 lb 1.5 oz)
Height	172.7 cm (5' 8")
Pain Score	0-No pain

Screenings

Row Name	09/13/18 1215
History of Falling	No
Secondary Diagnosis	Yes
Ambulatory Aids	None/bedrest/nurse assist
Intravenous Therapy/Heparin/ Saline Lock	No
Gait/Transferring	Normal/bedrest/wheelchair
Mental Status	Oriented to own ability

09/13/2018 - Office Visit in Urology (continued)

Flowsheets (continued)

Morse Fall Risk Score	15

Travel and Exposure Screening

Row Name	09/13/18 1215
Traveled outside the U.S. in the last month?	No
Planned travel outside the U.S. in the next 12 months?	No
Contact with someone with a communicable disease in the last month?	No

Vitals Reassessment

Row Name	09/13/18 1212
Restart Vitals Timer	Yes

09/13/2018 - Office Visit in Urology (continued)

Coding Summary

Account Information

Hospital Account	Primary Payor	Affiliated Recurring Accounts	Combined from HAR
3000293426 - HANNA,ADEL	BLUE CROSS [308002208]	None	None

Admission Information

Arrival Date/Time:	09/13/2018 1203	Admit Date/Time:	09/13/2018 1415	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Office	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	
Transfer Source:		Service Area:		Unit:	
Admit Provider:	Clayton S Lau, MD	Attending Provider:	Clayton S Lau, MD	Referring Provider:	Felicia Nicole Kinnard, PA

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
09/13/2018 1419	Home Or Self Care	None	None	Urology

Admission Diagnoses / Reasons for Visit (ICD-10-CM)

Code	Description	Comments
R97.20	Elevated prostate specific antigen (PSA)	

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
R97.20 **[Principal]**	Elevated prostate specific antigen (PSA)				
Z01.810	Encounter for preprocedural cardiovascular examination				
I10	Essential (primary) hypertension				

CPT®/HCPCS Codes

Code	Modifiers	Date	Qty	Performing Provider	APC	Exp Reimb	Px Event
G0463	25	09/13/2018	1	Clayton S Lau, MD	05012	44.75	
Description: Hospital outpt clinic visit; (-25 Signif E/M same phys/day)							

09/13/2018 - Appointment in New Patient Services

Flowsheets

Travel and Exposure Screening

Row Name	09/13/18 1146
Traveled outside the U.S. in the last month?	No
Planned travel outside the U.S. in the next 12 months?	No
Contact with someone with a communicable disease in the last month?	No
Positive skin or blood TB screening in the past?	Yes
Received treatment for TB in the past?	Yes

09/13/2018 - Appointment in New Patient Services (continued)

Coding Summary

Account Information

Hospital Account	Primary Payor	Affiliated Recurring Accounts	Combined from HAR
3000293426 - HANNA,ADEL	BLUE CROSS [308002208]	None	None

Admission Information

Arrival Date/Time:	09/13/2018 1152	Admit Date/Time:	09/13/2018 1415	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Office	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	
Transfer Source:		Service Area:		Unit:	
Admit Provider:	NEW PATIENT REPRESENTATIVE 03	Attending Provider:	Clayton S Lau, MD	Referring Provider:	Felicia Nicole Kinnard, PA

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
09/13/2018 1419	Home Or Self Care	None	None	New Patient Services

Admission Diagnoses / Reasons for Visit (ICD-10-CM)

Code	Description	Comments
R97.20	Elevated prostate specific antigen (PSA)	

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
R97.20 **[Principal]**	Elevated prostate specific antigen (PSA)				
Z01.810	Encounter for preprocedural cardiovascular examination				
I10	Essential (primary) hypertension				

CPT®/HCPCS Codes

Code	Modifiers	Date	Qty	Performing Provider	APC	Exp Reimb	Px Event
G0463	25	09/13/2018	1	Clayton S Lau, MD	05012	44.75	

Description: Hospital outpt clinic visit; (-25 Signif E/M same phys/day)

You were seen on Thursday September 13, 2018.

Thursday September 13 1:00 PM
Located on the 2nd Floor of Brawerman.

Urology
1500 East Duarte Rd
Duarte, CA 91010
800-934-5555
Arrive at: 2D

Your Medication List as of 9/13/2018 11:53 AM

You have not been prescribed any medications.

MyCityofHope allows you to send messages to your doctor, view your test results (including currently pending ones), renew your prescriptions, schedule appointments, and more!

To sign up, go to http://www.mycityofhope.org and click the **Sign Up Now** link in the New User box. Enter your MyCityofHope Activation Code as it appears below along with the last four digits of your Social Security Number and your Date of Birth to complete the sign-up process. If you do not sign up before the expiration date, you must request a new code.

MyCityofHopeActivation Code: FWQZG-QSVJ7-6F2NN
Expires: 10/28/2018 11:53 AM

If you have questions, you can call **844-777-4673** to talk to our MyCityofHope staff.
Remember, MyCityofHopeActivation is NOT to be used for urgent needs. For medical emergencies, dial **911**.

Instructions

Talk with your provider about your medications

ASK how to take:

amLODIPine 2.5 MG tablet (NORVASC)

aspirin 81 MG EC tablet

atenolol 25 MG tablet (TENORMIN)

CINNAMON PO

DAILY MULTIPLE VITAMINS tablet

GINKGO BILOBA COMPLEX PO

GLUCOSAMINE-CHONDROITIN PO

Review your updated medication list below.

You were seen on Friday September 14, 2018.

HCRH OR
1500 East Duarte Rd
Duarte, CA 91010

MyCityofHope allows you to send messages to your doctor, view your test results (including currently pending ones), renew your prescriptions, schedule appointments, and more!

To sign up, go to http://www.mycityofhope.org and click the **Sign Up Now** link in the New User box. Enter your MyCityofHope Activation Code as it appears below along with the last four digits of your Social Security Number and your Date of Birth to complete the sign-up process. If you do not sign up before the expiration date, you must request a new code.

MyCityofHopeActivation Code: FWQZG-QSVJ7-6F2NN
Expires: 10/28/2018 11:53 AM

If you have questions, you can call **844-777-4673** to talk to our MyCityofHope staff.
Remember, MyCityofHopeActivation is NOT to be used for urgent needs. For medical emergencies, dial **911**.

Collected on 9/13/2018
Resulted on 9/13/2018
Authorized by
Felicia Nicole Kinnard, PA
Resulting Agency:
HCRH PATHOLOGY LAB
CLIA #05D0665695 1500 E Duarte Rd
Duarte, CA 91010
626-218-2308
Specimen:
Blood - Blood, Venous

Sodium Level, Blood

mmol/L
Reference Range 137 - 145

Potassium Level, Blood

mmol/L
Reference Range >3.5-<5.1

Chloride Level, Blood

mmol/L
Reference Range 98 - 107

▲ **Carbon Dioxide Level, Blood**

mmol/L
Reference Range 22 - 30

Blood Urea Nitrogen Level, Blood

mg/dL
Reference Range 7 - 25

Creatinine Level, Blood

mg/dL
Reference Range 0.70 - 1.30

eGFR Except African American
Reference Range >=60
Comment: RESULT NOT VALID

Results using the MDRD study equation have not been validated for use with patients under 18 and over 70 years of age, pregnant women, patients with serious comorbid conditions, or persons with extremes of body size, muscle mass, or nutritional status.
Chronic Kidney Disease <60 mL/min/1.73sq M
Kidney Failure <15 mL/min/1.73sq M

eGFR African American
Reference Range >=60
Comment: RESULT NOT VALID

Results using the MDRD study equation have not been validated for use with patients under 18 and over 70 years of age, pregnant women, patients with serious comorbid conditions, or persons with extremes of body size, muscle mass, or nutritional status.
Chronic Kidney Disease <60 mL/min/1.73sq M
Kidney Failure <15 mL/min/1.73sq M

Glucose Level (Random), Blood

mg/dL
Reference Range 80 - 128

Calcium Level, Blood

mg/dL
Reference Range 8.6 - 10.2

▼ **Anion Gap, Blood**

Reference Range 8 - 14

Collected on 9/13/2018
Resulted on 9/14/2018
Authorized by
Felicia Nicole Kinnard, PA
Resulting Agency:
COH MICROBIOLOGY
CLIA #05D0665695 1500 E
Duarte Rd
Duarte, CA 91010
Specimen: Swab - Nares

METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA) CULTURE

Collected on 9/13/2018
Resulted on 9/13/2018
Authorized by
Felicia Nicole Kinnard, PA
Resulting Agency:
COH HEMATOLOGY
CLIA #05D0665695 1500 E
Duarte Rd
Duarte, CA 91010
Specimen:
Blood - Blood, Venous

WBC

K/uL
Reference Range
3.6 - 10.1

▲ **RBC Count**

M/UL
Reference Range
4.01 - 5.29

▲ **Hemoglobin, Whole Blood**

g/dL
Reference Range
12.8 - 16.1

▲ **Hematocrit, Whole Blood**

%
Reference Range
37.6 - 47.2

▼ **Platelet Count**

K/uL
Reference Range
150 - 350

MCV

fL
Reference Range
83.3 - 97.0

MCH

pg
Reference Range
27.4 - 33.0

MCHC

g/dL
Reference Range
32.8 - 35.0

▲ **RDW**

%
Reference Range
12.5 - 15.0

MPV

fL
Reference Range
7.1 - 11.2

Collected on 9/13/2018
Resulted on 9/14/2018
Authorized by
Felicia Nicole Kinnard, PA
Resulting Agency:
MUSE

Ventricular Rate:
BPM
Atrial Rate:
BPM
P-R Interval:
ms
QRS Duration:
ms
QT:
ms
QTC Calculation (Bezet):
ms
P Axis:
degrees
R Axis:
degrees
T Axis:
degrees
QTC Fredericia:
ms
Cardiology Report:
Cardiology Report:

Cardiology Report:
Cardiology Report:

Collected on 9/13/2018
Resulted on 9/13/2018
Authorized by
Felicia Nicole Kinnard, PA
Resulting Agency:
PS360

Narrative
HISTORY: Elevated PSA. Preop major surgery. FULL RESULT: PA and lateral chest x-ray without any prior films for comparison. The right hemidiaphragm and right lateral costophrenic angle are elevated. Mild pleural thickening in the right lower lung laterally is noted. Reticular opacities noted in the right apex. No pulmonary nodules, infiltrates or congestion are seen. The heart is normal in size with moderate to marked tortuosity of the descending aorta. No lytic or blastic bone lesions and no fracture identified.

Impression
1. Elevated right hemidiaphragm lateral minimal pleural thickening. Probable scarring. 2. No acute inflammatory or metastatic disease seen.

Your Medication List

ASK your doctor about these medications

	Morning	Around Noon	Evening	Bedtime	As Needed

amLODIPine 2.5 MG tablet
Commonly known as: NORVASC
Take 5 mg by mouth daily.
ASK

aspirin 81 MG EC tablet
Take 81 mg by mouth daily.
ASK

atenolol 25 MG tablet
Commonly known as: TENORMIN
Take 50 mg by mouth daily.
ASK

CINNAMON PO
Take by mouth.
ASK

DAILY MULTIPLE VITAMINS tablet
Take 1 tablet by mouth daily.
ASK

GINKGO BILOBA COMPLEX PO
Take by mouth.
ASK

GLUCOSAMINE-CHONDROITIN PO
Take by mouth.
ASK

Instructions

No changes were made to your medications.

☐ Diet

Post-Discharge Activity: Normal activity as tolerated.
Normal activity as tolerated.

Diet
Diet type:
Regular (No Restrictions)

Call provider for: persistent nausea or vomiting
Complete by: Sep 17, 2018

Call provider for: severe uncontrolled pain
Complete by: Sep 17, 2018

Call provider for: temperature >100.4
Complete by: Sep 17, 2018

You currently have no upcoming appointments scheduled.

Send messages to your doctor, view your test results, renew your prescriptions, schedule appointments, and more.

Go to , click " ", and enter your personal activation code: . Activation code expires 10/28/2018.

Medication List

Morning Afternoon Evening Bedtime As Needed

amLODIPine 2.5 MG tablet
Commonly known as: NORVASC
Take 5 mg by mouth daily.

aspirin 81 MG EC tablet
Take 81 mg by mouth daily.

atenolol 25 MG tablet
Commonly known as: TENORMIN
Take 50 mg by mouth daily.

CINNAMON PO
Take by mouth.

DAILY MULTIPLE VITAMINS tablet
Take 1 tablet by mouth daily.

GINKGO BILOBA COMPLEX PO
Take by mouth.

GLUCOSAMINE-CHONDROITIN PO
Take by mouth.

Hospital Switchboard (main telephone number)	626-256-4673	24 hours, 7 days a week
For questions concerning your symptoms, contact RN Triage Call Center	626-471-7133	24 hours, 7 days a week
For pediatric patients, during business hours, ask to speak with your physician. After hours, ask for the pediatrician on call.	626-256-4673	24 hours, 7 days a week
Pharmacy, for prescription refill or renewal	626-301-8304	Mon.-Fri. 8:30 am - 6:00 pm Saturday 8:30 am - 3:30 pm Sunday Closed
To change, cancel, reschedule an outpatient appointment, contact the Scheduling Call Center	800-934-5555	Mon. - Fri. 7:00 am - 5:30 pm
Women's Health Center	626-256-8692	Mon. - Fri. 8:00 am - 5:00 pm
To request a copy of your medical records	626-218-2446	Mon. - Fri. 8:00 am - 4:30 pm

STATEMENT FOR FREEDOM OF CHOICE

A comprehensive discharge planning evaluation has been completed by the City of Hope Case Management Department on my behalf for use in establishing an appropriate, comprehensive discharge plan for me. The results of this evaluation has been discussed with me and/or my caregiver as well as my medical team. Together we have developed the post-hospital discharge plan.

I have been explained the services available to me after my discharge from City of Hope National Medical Center and I have been offered the opportunity to choose among the providers offered for these services. I have been provided education regarding the services coordinated on my behalf once I leave the hospital and how to contact them. I understand that my financial responsibility for post acute care hospital services is based upon my individual insurance plan coverage.

I, Adel Hanna (or my parent/guardian), on 09/17/18, certify that I (or my parent/guardian) have read the above information and received all referenced documentation. I (or my parent/guardian) agree to the terms of this after visit summary (AVS).

Signature: _____

CITY OF HOPE NATIONAL MEDICAL CENTER
Department of Pathology
Dennis D. Weisenburger, MD, Laboratory Director
CLIA ID# 05D0665695
1500 E. Duarte Road, Duarte CA 91010-0269
(626) 359-8111 FAX: (626) 218-8145

Case ID:	**S18-07575**
Patient:	**Hanna, Adel**
MRN:	**11031634**
Date of Birth:	**3/29/1946**
Gender:	**Male**

Surgical Pathology (Final result) S18-07575

Authorizing Provider:	Clayton S Lau, MD	Ordering Provider:	Clayton S Lau, MD
Ordering Location:	Operating Room	Collected:	09/17/2018 1630
Pathologist:	Huiqing Wu, MD	Received:	09/17/2018 1804

Final Diagnosis

PROSTATE, CORE BIOPSIES:

RIGHT BASE (A):
- Benign prostatic tissue

RIGHT MID (B):
- Benign prostatic tissue

RIGHT APEX (C):
- Benign prostatic tissue

LEFT BASE (D):
- Benign prostatic tissue

LEFT MID (E):
- Benign prostatic tissue
- See microscopic description

LEFT APEX (F):
- Benign prostatic tissue

Electronically signed by Huiqing Wu, MD on 9/19/2018 at 1515

Microscopic Description

Examination of histologic sections was performed and contributed to the final diagnosis.

RESULT - IMMUNOHISTOCHEMISTRY (Block E1):

PIN4	-	No prostatic adenocarcinoma

Appropriate positive and negative controls were employed for each immunohistochemical stain. Some of the tests reported here have been developed and performance characteristics determined by the Department of Pathology, City of Hope National Medical Center. These tests have not been cleared or approved by the U.S. Food and Drug Administration (FDA). The FDA has determined that such clearance or approval is not necessary. Test results are to be used for clinical purposes and should not be regarded as investigational or for research. This Laboratory is certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) as qualified to perform high complexity clinical laboratory testing.

Gross Description

A. Prostate, Right Base, Tissue: The specimen is labeled with the patient's name Adel Hanna and MRN 11031634. Received in formalin are 2 soft tan tissue cores measuring 0.7 x 0.1-1.3 x 0.1 cm which are entirely submitted.

Cassette Summary
1) Tissue cores - 2

B. Prostate, Right Mid, Tissue: The specimen is labeled with the patient's name Adel Hanna and MRN 11031634. Received in formalin are 3 soft tan tissue cores ranging from 0.7 x 0.1-1.0 x 0.1 cm which are entirely submitted.
Cassette Summary
1) Tissue cores - 3

C. Prostate, Right Apex, Tissue: The specimen is labeled with the patient's name Adel Hanna and MRN 11031634. Received in formalin are 3 soft tan tissue cores averaging 0.8 x 0.1 cm in greatest dimension. Received additionally in the container is a 0.3 cm in greatest dimension aggregate of soft tan tissue. Entirely submitted.
Cassette Summary
1) Tissue cores - 3+

D. Prostate, Left Base, Tissue: The specimen is labeled with the patient's name Adel Hanna and MRN 11031634. Received in formalin are 3 soft tan tissue cores ranging from 0.6 x 0.1-1.0 x 0.1 cm which are entirely submitted.
Cassette Summary
1) Tissue cores - 3

E. Prostate, Left Mid, Tissue: The specimen is labeled with the patient's name Adel Hanna and MRN 11031634. Received in formalin are 4 soft tan tissue cores ranging from 0.4 x 0.1-1.1 x 0.1 cm which are entirely submitted.
Cassette Summary
1) Tissue cores - 4

F. Prostate, Left Apex, Tissue: The specimen is labeled with the patient's name Adel Hanna and MRN 11031634. Received in formalin is a 0.4 cm in greatest dimension aggregate of soft tan tissue which is entirely submitted.
Cassette Summary
1) Formalin fixed tissue - multiple

Additional Information

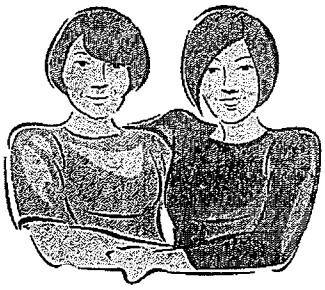
As the senior attending pathologist whose electronic signature appears on this report, I have reviewed the slides and edited the gross and/or microscopic portion of the report in rendering the final diagnosis.

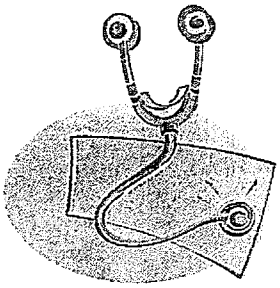
Specimens

A Prostate, Right Base
B Prostate, Right Mid
C Prostate, Right Apex
D Prostate, Left Base
E Prostate, Left Mid
F Prostate, Left Apex

California Advance Health Care Directive

This form lets you have a say about how you want to be treated if you get very sick.





This form has 3 parts. It lets you:

Part 1: Choose a medical decision maker.

A medical decision maker is a person who can make health care decisions for you if you are too sick to make them yourself.

Part 2: Make your own health care choices.

This form lets you choose the kind of health care you want.

This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.

Part 3: Sign the form.

It must be signed before it can be used.

You can fill out Part 1, Part 2, or both.
Fill out only the parts you want. Always sign the form in Part 3.
2 witnesses need to sign on page 11 or a notary public on page 12.

Your Name: Hanna Adel MRN 1103.16.34

If you only want to name a medical decision maker go to Part 1 on page 3.

If you only want to make your own health care choices go to Part 2 on page 6.

If you want both then fill out Part 1 and Part 2.

Always sign the form in Part 3 on page 9.
2 witnesses need to sign on page 11 or a notary public on page 12.

What if I change my mind?

- Fill out a new form.
- Tell those who care for you about your changes.
- Give the new form to your medical decision maker and doctor.

What if I have questions about the form?

Ask your doctors, nurses, social workers, friends or family to answer your questions. Lawyers can help too.

What if I want to make health care choices that are not on this form?

Write your choices on page 9.

Share this form and your choices with your family, friends, and medical providers.

Part 1 Choose your medical decision maker

The person who can make health care decisions for you if you are too sick to make them yourself

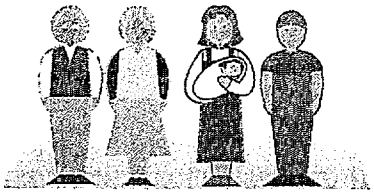
Whom should I choose to be my medical decision maker?

A family member or friend who:

- is at least 18 years old
- knows you well
- can be there for you when you need them
- you trust to do what is best for you
- can tell your doctors about the decisions you made on this form

Your decision maker cannot be your doctor or someone who works at your hospital or clinic, unless he/she is a family member.

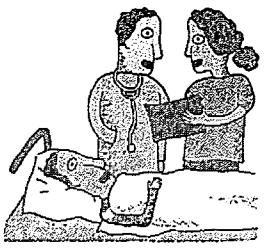
What will happen if I do not choose a medical decision maker?



If you are too sick to make your own decisions, your doctors will turn to family or friends or a judge to make decisions for you. This person may not know what you want.

The kinds of decisions your medical decision maker can make

She or he will be able to choose:



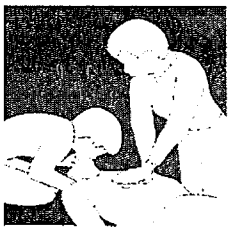
- doctors, nurses, social workers, caregivers
- hospitals, clinics, nursing homes
- medications, tests, or treatments
- what kind of personal care you get, such as where you live
- who can look at your medical information
- what happens to your body and organs after you die

More decisions your medical decision maker can make:

Life support treatments – medical care to try to help you live longer

- **CPR or cardiopulmonary resuscitation**

  cardio = heart pulmonary = lungs resuscitation = to bring back

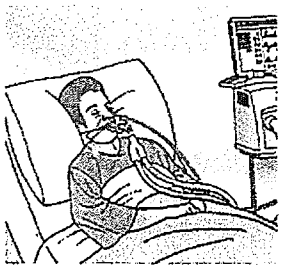


This may involve:

- pressing hard on your chest to keep your blood pumping
- electrical shocks to jump start your heart
- medicines in your veins

- **Breathing machine or ventilator**

  The machine pumps air into your lungs and breathes for you. You are not able to talk when you are on the machine.



- **Dialysis**

  A machine that cleans your blood if your kidneys stop working.

- **Feeding Tube**

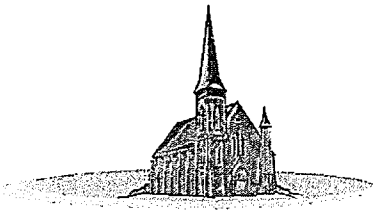
  A tube used to feed you if you cannot swallow. The tube is placed down your throat into your stomach. It can also be placed by surgery.

- **Blood transfusions**

  To put blood in your veins.

- **Surgery**
- **Medicines**

End of life care – if you might die soon your medical decision maker can:



- call in a spiritual leader
- decide if you die at home or in the hospital
- decide where you should be buried or cremated

Write down any decisions you <u>do not</u> want your medical decision maker to make:

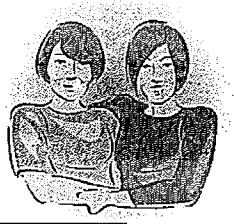
_____

_____

Talk to your medical decision maker about this form and your choices.

Your Name: Hanna, Adel MR# 1103-16-34

Your Medical Decision Maker



I want this person to make my medical decisions if I cannot make my own

IRMA Kawaguchi
first name last name

(909) 374-7216 ( ) -
home number work number relationship

3019 Song of the winds, Chino Hills, CA 91709
street address city state zip code

If the first person cannot do it, then I want this person to make my medical decisions

Yolla ZoGHEiB
first name last name

(909) 261-0624 ( ) -
home number work number relationship

16064 Medlar lane, Chino Hills, CA 91709
street address city state zip code

Put an X next to the sentence you agree with.

☐ My medical decision maker can make decisions for me right after I sign this form.

☒ My medical decision maker will make decisions for me **only** after I cannot make my own decisions.

How do you want your medical decision maker to follow your healthcare wishes? Put an X next to the one sentence you most agree with.

☐ **Total Flexibility:** It is OK for my decision maker to change any of my medical decisions if my doctors think it is best for me at that time.

☒ **Some Flexibility:** It is OK for my decision maker to change some of my decisions if the doctors think it is best. But, these are some wishes I never want changed:

_____

_____

☒ **No flexibility:** I want my decision maker to follow my medical wishes exactly, no matter what. It is **not OK** to change my decisions, even if the doctors recommend it.

To make your own health care choices go to Part 2 on the next page.

If you are done, you must sign this form on page 9.

Part 2 Make your own health care choices

Write down your choices so those who care for you will not have to guess.

Think about what makes your life worth living.
Put an X next to all the sentences you most agree with.

My life is only worth living if I can:

- ◉ talk to family or friends
- ○ wake up from a coma
- ◉ feed, bathe, or take care of myself
- ○ be free from pain
- ◉ live without being hooked up to machines
- ○ My life is always worth living no matter how sick I am
- ○ I am not sure

If I am dying, it is important for me to be:

❑ at home ☒ in the hospital ❑ I am not sure

Is religion or spirituality important to you?

❑ no ☒ yes If you have one, what is your religion?

Christian orthodox

What should your doctors know about your religious or spiritual beliefs?

has to call one from my orthodox church to pray for me.

If you are sick, your doctors and nurses will always try to keep you comfortable and free from pain.

Your Name: Adel S. Hanna, M.D. Hanna MD

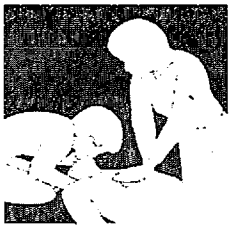
MRN 1103.10.34

Life support treatments are used to try to keep you alive. These can be CPR, a breathing machine, feeding tubes, dialysis, blood transfusions, or medicine.

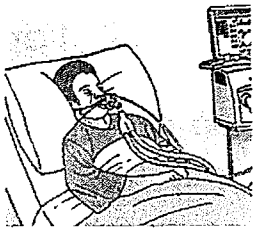
Please read this whole page before you make your choice.

Put an X next to the one choice you most agree with.

If I am so sick that I may die soon:



- ❑ Try all life support treatments that my doctors think might help. If the treatments do not work and there is little hope of getting better, **I want to stay on life support machines** even if I am suffering.



- ☒ Try all life support treatments that my doctors think might help. If the treatments do not work and there is little hope of getting better, **I do NOT want to stay on life support machines**. If I am suffering, I want to stop.
- ❑ **I do not want life support treatments**, and I want to focus on being comfortable. I prefer to have a natural death.
- ❑ I want my **medical decision maker** to decide for me.
- ❑ I am not sure.

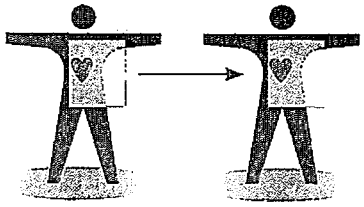
If you want to write down medical wishes that are not on this form, go to page 9.

Your Name: Adel S. Hanna, MD Hanna MD
MRH 1103.16.34

Your doctors may ask about organ donation and autopsy after you die. Please tell us your wishes.

Put an X next to the one choice you most agree with.

Donating (giving) your organs can help save lives.



- ☐ I **want** to donate my organs.

  Which organs do you want to donate?

  - ○ any organ
  - ○ only_____.

- ☒ I **do not** want to donate my organs.
- ☐ I want my **decision maker** to decide.
- ☐ I am not sure.

An autopsy can be done after death to find out why someone died. It is done by surgery. It can take a few days.

- ☐ I **want** an autopsy.
- ☒ I **do not** want an autopsy.
- ☐ I **only** want an autopsy if there are questions about my death.
- ☐ I want my **decision maker** to decide.
- ☐ I am not sure.

What should your doctors know about how you want your body to be treated after you die? Do you have funeral or burial wishes?

_____

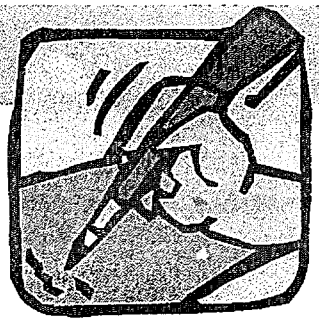
_____

What other wishes are important to you?

if I am not able to Decide
Medical/Surgical decision will be Discussed between
My Doctors and share opinion with Irma Kawaguchi
and Yalla Terz only. No one Else.
My Sons Tamer Hanna and
John Hanna and My daughter
Enas Hanna/Nasr Should not
participate in any decision with Regard
to My life support or Medical decision
Adel Hanna MD
9-17-2018

Part 3 Sign the form

Before this form can be used, you must:



- sign this form if you are at least 18 years of age
- have two witnesses sign the form or a notary public

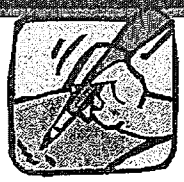
Sign your name and write the date.

Adel S. Hanna, MD Adel Hanna MD 9/17-2018
sign your name date

ADEL HANNA
print your first name print your last name

3019 Song of the Winds Chino Hills CA 91709
address city state zip code

Part 3 Witnesses



Before this form can be used you must have 2 witnesses sign the form or a notary public

Your witnesses must:

- be over 18 years of age
- know you
- see you sign this form

Your witnesses cannot:

- be your medical decision maker
- be your health care provider
- work for your health care provider
- work at the place that you live (if you live in a nursing home go to page 12).

Also, one witness cannot:

- be related to you in any way
- benefit financially (get any money or property) after you die

If you do not have witnesses, a notary public must sign on page 12.

- A notary public's job is to make sure it is you signing the form.

Witnesses need to sign their names on the next page.

If you do not have witnesses, take this form to a notary public and have them sign on page 12.

Have your witnesses sign their names and write the date

By signing, I promise that _____ signed this form while I watched.
(name)

He/she was thinking clearly and was not forced to sign it.

I also promise that:

- I know this person and he/she could prove who he/she was.
- I am 18 years or older
- I am not his/her medical decision maker
- I am not his/her health care provider
- I do not work for his/her health care provider
- I do not work where he/she lives

One witness must also promise that:

- I am not related to him/her by blood, marriage, or adoption
- I will not benefit financially (get any money or property) after he/she dies

Witness #1

_____ / /
sign your name date

_____
print your first name print your last name

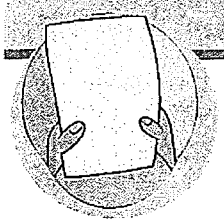
_____
address city state zip code

Witness #2

_____ / /
sign your name date

_____
print your first name print your last name

_____
address city state zip code



You are now done with this form.

Share this form with your family, friends, and medical providers. Talk with them about your medical wishes

Notary Public Take this form to a notary public **ONLY** if two witnesses have not signed this form. Bring photo I.D. (driver's license, passport, etc.)

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

A Notary Public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Los Angeles

On September 17, 2018 (Date) before me, Carolina de la Pena, Notary Public (Here insert name and title of the officer), personally appeared Hanna, Adel (Name(s) of Signer(s))

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Signature of Notary Public)

CAROLINA DE LA PENA
Commission No. 2177657
NOTARY PUBLIC-CALIFORNIA
LOS ANGELES COUNTY
My Comm Expires DECEMBER 30, 2020

(Notary Seal)

Description of Attached Document
Title or Type of document: CA AD Directive
Date: 9/17/18 Number of pages: 12

Capacity(ies) Claimed by Signer(s)
Signer's Name: _____
☒ Individual
☐ Guardian or conservator
☐ Other _____

RIGHT THUMBPRINT OF SIGNER
Top of thumb here

For California Nursing Home Residents ONLY

Give this form to your nursing home director **ONLY** if you live in a nursing home. California law requires nursing home residents to have the nursing home ombudsman as a witness of advance directives.

STATEMENT OF THE PATIENT ADVOCATE OR OMBUDSMAN

"I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code."

_____ / / _____
sign your name date

_____
print your first name print your last name

_____
address city state zip code

CONSENT FOR ANESTHESIA SERVICES

1 My surgeon/physician has recommended that I have the following surgery, procedure or treatment Ultrasound guided prostate biopsy ("Procedure") to which I have already given my informed consent I have also been informed that anesthesia services are necessary in order for my surgeon/physician to perform this Procedure

2 I acknowledge that all forms of anesthesia involve some risk Although rare, unexpected severe complications can occur with anesthesia, these include the remote possibility of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death I understand that these risks apply to all types of anesthesia and that additional or specific risks have been identified on Page 2 as they may apply to a specific type of anesthesia

3 I understand that the anesthetic technique recommended for my Procedure is determined by many factors, including my physical condition, the nature of the procedure, the preference of my surgeon/ physician, and my own likes and dislikes The plan for anesthesia for my particular Procedure is based upon a consideration of these factors The physician who will administer anesthesia has discussed the benefits, risks, discomforts, and alternatives of the plan for anesthesia with me, and I hereby give my informed consent to the type(s) of anesthesia service for this Procedure as check-marked on Page 2

4 I authorize that anesthesia be administered by Bonilla M D , or his or her associates, all of whom are credentialed to provide anesthesia services at this hospital I acknowledge that these persons performing anesthesia services are not employees or agents of this hospital, they are independent contractors It has been explained to me that sometimes an anesthesia technique that involves the use of local anesthetics, with or without sedation, may not succeed completely, and therefore, another technique may have to be used - including general anesthesia I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by them

5 I certify and acknowledge that (a) I have read and understood the information provided in this form, (b) the plan for anesthesia for my particular Procedure has been adequately explained to me by the above-named physician, along with the benefits and effects, risks, discomforts, and alternative methods of anesthesia and their risks and benefits, (c) I have had an opportunity to ask questions, and my questions have been answered, (d) I have received all information I desire concerning the anesthesia for my Procedure, and (e) I authorize and consent to the use of the anesthesia check-marked on page 2, and any alternative type of anesthesia deemed appropriate and necessary by the above-named physician or his/her associates

(Continued on Page 2)

TRANSLATION (if necessary) - I have accurately and completely read the foregoing document to the signator identified below in the patient's / patient representative's primary language He/she understood all terms and conditions and acknowledged his/her agreement by signing this document in my presence

PRIMARY LANGUAGE IF NOT ENGLISH			

TRANSLATOR PRINTED NAME	SIGNATURE TITLE / DEPT	DATE	TIME

PATIENT OR PERSONAL REPRESENTATIVE PRINTED NAME	SIGNATURE	DATE	TIME
Hanna, Adel		9/17/18	1500

If Personal Representative has signed above, indicate your relationship to the patient
☐ Parent ☐ Guardian ☐ Conservator ☐ Agent ☐ Other

REASON PATIENT DID NOT SIGN

WITNESS PRINTED NAME	SIGNATURE TITLE / DEPT	DATE	TIME
Yossyanne Simbooton	RN	9/17/18	1500

PHYSICIAN CERTIFICATION I have discussed the recommended anesthesia plan and anesthetic technique with this patient, including the risks and benefits, discomforts and any adverse reactions that may reasonably be expected to occur, and any alternative methods of sedation that may be medically viable I have answered the patient's questions regarding the recommended anesthesia and anesthetic technique, and the patient has indicated that he/she understands and wishes to proceed

PHYSICIAN / ANESTHESIOLOGIST PRINTED NAME	SIGNATURE TITLE	DATE	TIME
Bonilla		9/17/18	1500

Hanna,Adel
MRN 11031634
Sex male DOB 3/29/1946 (72 yrs)
Admit Date.9/17/2018
CSN 302953104

CONSENT FOR ANESTHESIA SERVICES

☐ **General Anesthesia**

EXPECTED RESULTS	Total unconscious state, possible placement of a tube into the windpipe
TECHNIQUE	Drug injection into the bloodstream, breathed into the lungs, or by other routes
RISKS	Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, aspiration pneumonia, death

☐ **Spinal or Epidural Analegesia/Anesthesia** ☐ **With sedation** ☐ **Without sedation**

EXPECTED RESULTS	Total unconscious state, possible placement of a tube into the windpipe
TECHNIQUE	Drug injection into the bloodstream, breathed into the lungs, or by other routes
RISKS	Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, aspiration pneumonia, death

☐ **Major/Minor Nerve Block** ☐ **With sedation** ☐ **Without sedation**

EXPECTED RESULTS	Temporary loss of feeling and/or movement of specific limb or area
TECHNIQUE	Drug injected near nerves in or through the skin, providing loss of sensation to the area of the operation
RISKS	Infection, convulsions, weakness, persistent numbness, residual pain, injury to blood vessels, aspiration pneumonia, death

☐ **Intravenous Regional** ☐ **With sedation** ☐ **Without sedation**

EXPECTED RESULTS	Temporary loss of feeling and/or movement of limb
TECHNIQUE	Drug injection into veins of arm or leg while using a tourniquet
RISKS	Infection, convulsions, persistent numbness, residual pain, injury to blood vessels, aspiration pneumonia, death

☐ **Monitored Anesthesia Care, with sedation**

EXPECTED RESULTS	Reduced anxiety and pain, partial or total amnesia
TECHNIQUE	Drug injected into the bloodstream, breathed into the lungs, or by other routes producing a semi-conscious state
RISKS	An unconscious state, depressed breathing, injury to blood vessels, aspiration pneumonia, death

☐ **Monitored Anesthesia Care, without sedation**

EXPECTED RESULTS	Measurement of vital signs, availability of anesthesia provider for further intervention
TECHNIQUE	None
RISKS	Increased awareness, anxiety and/or discomfort, aspiration pneumonia, death

CONSENT FOR BLOOD TRANSFUSION

1. Your physician and/or surgeon has determined that you may require blood transfusion as part of your medical treatment and/or surgical procedure at City of Hope National Medical Center ("Hospital").
2. Should transfusion be necessary, the specific blood products used and amounts administered will be determined according to the best medical judgment of the physician or surgeon responsible for your medical care. Physicians and surgeons are not employees of this Hospital; they are independent medical practitioners.
3. Although blood and blood products never can be 100% safe, the risk of infection from blood is low. Many procedures are in place to promote the safety of the blood supply. Blood donors are screened for a variety of infections that could be transmitted by blood, such as hepatitis, HIV, syphilis and other infectious agents. Even though the risk of infection from blood transfusion is small, no warranty or guarantee can be made that the blood transfusion will be 100% free of infectious agents.
4. Blood transfusion can also cause uncommon but serious problems such as severe bacterial infections, lung injury, and damage of red blood cells due to blood incompatibility, and these complications may be life-threatening or fatal. More common, but less severe, are temporary reactions such as fever, chills, hives and/or itching; these can be treated fairly easily and usually are not serious.
5. You have the right to consent or to refuse blood transfusion based upon a complete explanation of the benefits and risks of blood transfusion provided by your physician, surgeon, or authorized designee (including another physician, a physician assistant or a nurse practitioner). This includes a discussion about the alternatives to blood transfusion and having your questions answered.
6. Your signature on this Consent for Blood Transfusion form constitutes your acknowledgement that:
   (a) You have received a copy of the California Department of Health Services brochure, *A Patient's Guide to Blood Transfusion*, and are aware of the options available relating to blood transfusion, including pre-donation.
   (b) The risks and discomforts, possible complications, and benefits of blood transfusion have been adequately explained to you by your physician, surgeon, or authorized designee, and you have had the opportunity to have your questions answered.
   (c) Your consent will remain in effect for the duration of your treatment but must be renewed:
      - " Prior to the first surgical/interventional procedure or medical procedure during a hospitalization that may require blood transfusion which will cover the entire hospitalization.
      - " Annually for ongoing treatment of chronic conditions.
   (d) Upon your request, you may change your decision to consent to blood transfusion.
   (e) You have read this Consent for Blood Transfusion form and understand the information provided in this form.

CONSENT: I hereby agree to receive blood transfusion(s) as may be deemed necessary and prescribed by the physician or surgeon responsible for my medical care.

TRANSLATION (if necessary) - I have accurately and completely read the foregoing document to the signator identified below in the patient's / patient representative's primary language. He/she understood all terms and conditions and acknowledged his/her agreement by signing this document in my presence.

Primary Language, if not English:

TRANSLATOR PRINTED NAME	SIGNATURE / TITLE / DEPT	DATE	TIME
		9/14/18	

PATIENT/ PERSONAL REPRESENTATIVE PRINTED NAME	SIGNATURE	DATE	TIME
X Adel S Hanna, M.D.	X	9/14/18	1434

IF PERSONAL REPRESENTATIVE HAS SIGNED ABOVE, PLEASE INDICATE YOUR RELATIONSHIP TO THE PATIENT.
☐ Parent ☐ Guardian ☐ Conservator ☐ Agent ☐ Other

Reason patient did not sign: 9/14/18

WITNESS PRINTED NAME	SIGNATURE / TITLE / DEPT	DATE	TIME
Amber Freeman	RN	9/14/18	1434

PHYSICIAN'S CERTIFICATION: I, or my authorized designee who signs below, have provided the patient with a copy of the California Department of Health Services brochure, *A Patient's Guide to Blood Transfusion*, concerning the advantages, disadvantages, risks and benefits of autologous blood and of directed and non-directed homologous blood from volunteers. I, or my authorized designee, have also allowed adequate time prior to surgery for the patient or other person to pre-donate blood for transfusion purposes, except where there is a life-threatening emergency, there are medical contraindications, or the patient has waived this right.

Printed Name of Physician responsible for consent process	SIGNATURE / TITLE	DATE	TIME

Printed Name of Designee (if applicable)	SIGNATURE / TITLE	DATE	TIME
Janet Courtlitz	MD	9/14/18	1434

City of Hope National Medical Center
1500 East Duarte Road, Duarte, CA 91010

CONSENT FOR BLOOD TRANSFUSION

DOS: 09/14/2018
HANNA,ADEL
DOB 03/29/1946 72Y M
CSN:302953606 MRN 11031634
ATTN MD: , OUTPATIENT

CONSENT FOR BLOOD TRANSFUSION

1 Your physician and/or surgeon has determined that you may require blood transfusion as part of your medical treatment and/or surgical procedure at City of Hope National Medical Center ("Hospital")

2 Should transfusion be necessary, the specific blood products used and amounts administered will be determined according to the best medical judgment of the physician or surgeon responsible for your medical care Physicians and surgeons are not employees of this Hospital, they are independent medical practitioners

3 Although blood and blood products never can be 100% safe, the risk of infection from blood is low Many procedures are in place to promote the safety of the blood supply Blood donors are screened for a variety of infections that could be transmitted by blood, such as hepatitis, HIV, syphilis and other infectious agents Even though the risk of infection from blood transfusion is small, no warranty or guarantee can be made that the blood transfusion will be 100% free of infectious agents

4 Blood transfusion can also cause uncommon but serious problems such as severe bacterial infections, lung injury, and damage of red blood cells due to blood incompatibility, and these complications may be life-threatening or fatal More common, but less severe, are temporary reactions such as fever, chills, hives and/or itching, these can be treated fairly easily and usually are not serious

5 You have the right to consent or to refuse blood transfusion based upon a complete explanation of the benefits and risks of blood transfusion provided by your physician, surgeon, or authorized designee (including another physician, a physician assistant or a nurse practitioner) This includes a discussion about the alternatives to blood transfusion and having your questions answered

6 Your signature on this Consent for Blood Transfusion form constitutes your acknowledgement that
(a) You have received a copy of the California Department of Health Services brochure, *A Patient's Guide to Blood Transfusion*, and are aware of the options available relating to blood transfusion, including pre-donation
(b) The risks and discomforts, possible complications, and benefits of blood transfusion have been adequately explained to you by your physician, surgeon, or authorized designee, and you have had the opportunity to have your questions answered
(c) Your consent will remain in effect for the duration of your treatment but must be renewed
- " Prior to the first surgical/interventional procedure or medical procedure during a hospitalization that may require blood transfusion which will cover the entire hospitalization
- " Annually for ongoing treatment of chronic conditions

(d) Upon your request, you may change your decision to consent to blood transfusion
(e) You have read this Consent for Blood Transfusion form and understand the information provided in this form

CONSENT I hereby agree to receive blood transfusion(s) as may be deemed necessary and prescribed by the physician or surgeon responsible for my medical care

TRANSLATION (if necessary) - I have accurately and completely read the foregoing document to the signator identified below in the patient's / patient representative's primary language He/she understood all terms and conditions and acknowledged his/her agreement by signing this document in my presence		Primary Language if not English	
TRANSLATOR PRINTED NAME	SIGNATURE TITLE / DEPT	DATE	TIME
PATIENT / PERSONAL REPRESENTATIVE PRINTED NAME	SIGNATURE	DATE 9/17/18	TIME 1100
IF PERSONAL REPRESENTATIVE HAS SIGNED ABOVE PLEASE INDICATE YOUR RELATIONSHIP TO THE PATIENT ☐ Parent ☐ Guardian ☐ Conservator ☐ Agent ☐ Other		Reason patient did not sign	
WITNESS PRINTED NAME	SIGNATURE TITLE / DEPT	DATE 9/17/18	TIME

PHYSICIAN'S CERTIFICATION I or my authorized designee who signs below have provided the patient with a copy of the California Department of Health Services brochure *A Patient's Guide to Blood Transfusion* concerning the advantages disadvantages risks and benefits of autologous blood and of directed and non-directed homologous blood from volunteers 1 or my authorized designee have also allowed adequate time prior to surgery for the patient or other person to pre-donate blood for transfusion purposes except where there is a life threatening emergency, there are medical contraindications, or the patient has waived this right

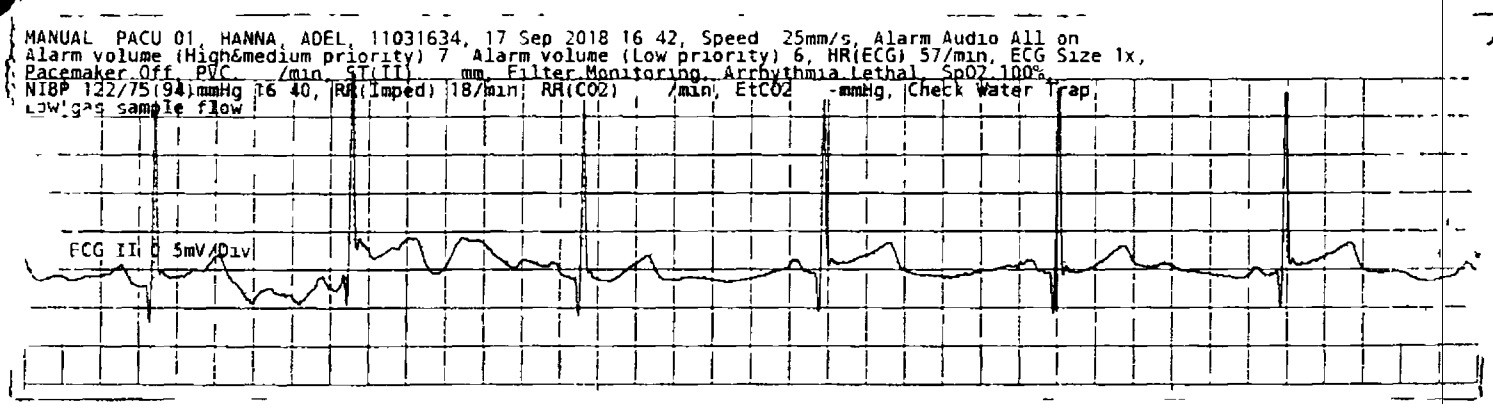
Printed Name of Physician responsible for consent process	SIGNATURE TITLE	DATE	TIME
Printed Name of Designee (if applicable)	SIGNATURE TITLE	DATE	TIME

City of Hope National Medical Center
1500 East Duarte Road, Duarte, CA 91010

CONSENT FOR BLOOD TRANSFUSION

Hanna,Adel
MRN 11031634
Sex male DOB 3/29/1946 (72 yrs)
Admit Date 9/17/2018
CSN 302953104

RHYTHM STRIP RECORD



RATE P-P INTERVAL QRSINTERVAL Q T INTERVAL RHYTHM

RATE P-P INTERVAL QRSINTERVAL Q T INTERVAL RHYTHM

P-P INTERVAL QRSINTERVAL Q T INTERVAL RHYTHM

City of Hope National Medical Center
1500 East Duarte Road Duarte CA 91010

RHYTHM STRIP RECORD

Hanna,Adel
MRN 11031634
Sex male DOB 3/29/1946 (72 yrs)
Admit Date 9/17/2018
CSN 302953104

1. **CONSENT TO MEDICAL AND SURGICAL PROCEDURE** - The person who signs below as the patient, or the representative on behalf of the patient, consents to be cared for as an inpatient at City of Hope National Medical Center ("Hospital"), Duarte, California, a licensed hospital in the State of California. This care may include, but is not limited to: laboratory procedures, x-ray examination including use of contrast injections, medical or surgical treatment or procedures, telehealth services, local anesthesia, and services provided to the patient under the general and special instructions of the patient's physician or surgeon. Persons in training, such as medical students, residents, nurses, physician assistants, and post-graduate fellows, under the supervision of the attending physician or surgeon, may observe and participate in the care of the patient as a part of the education program of the Hospital.
2. **NURSING CARE** - The Hospital provides general nursing care unless the physician orders more intensive nursing care. If the patient's family or physician determines the need for a special-duty nurse, it is agreed that the patient or his/her representative will make these arrangements. The Hospital is not responsible for providing special-duty nursing care and is released from any liability for not providing this additional care.
3. **LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS** - All physicians and surgeons providing services to the patient, including the radiologist, pathologist, anesthesiologist, and the like, are independent contractors and are not employees or agents of the Hospital. The patient is cared for and supervised by his/her attending physician or surgeon. The physician or surgeon must obtain the patient's informed consent when medical or surgical treatment, special diagnostic or therapeutic procedures or Hospital services are rendered to the patient. The patient understands that any questions he/she asks will be answered to the best of the ability of his/her physician or the Hospital, as appropriate.
4. **RELEASE OF INFORMATION** - The Hospital may use and disclose patient-identifiable health information for purposes of treatment, payment and health care operations and as otherwise required or permitted by law and Hospital policy. For example, the Hospital may release patient information from records to any person or company which is or may be responsible to pay for the Hospital's services, including Medicare, Medi-Cal, insurance companies, health care plans and/or workers' compensation carriers. In addition, State law requires the Hospital to report certain cases of infectious disease and cancer to governmental health agencies. For all other purposes, the patient's written authorization permitting release of identifiable health information to others will be obtained. Please see the Hospital's Notice of Privacy Practices, Section IV, for details regarding your rights concerning the use and disclosure of patient-identifiable health information.
5. **CONSENT TO PHOTOGRAPH** - The patient or representative approves of the taking of photographs and videotapes of medical and surgical procedures for purposes of treatment, payment, and health care operations and also approves of their use for educational purposes provided the patient is not identified.
6. **DOCUMENTATION RECEIVED** - The patient, or representative on behalf of the patient, has received two Hospital brochures, *Patient's Rights and Responsibilities* and *Be a Partner in Safe Patient Care*, and the Hospital's Notice of Privacy Practices. Information on Advance Directives and options regarding the giving of instructions for care has also been provided.
7. **PERSONAL VALUABLES** - The Hospital is not responsible for lost or damaged clothing, money, jewelry, glasses, dentures, documents, cellular phones, computers or other electronic equipment, devices or other articles.

Continued on other side.

8. FINANCIAL AGREEMENT - The person who signs below as the patient, or the representative of the patient, agrees to be financially responsible to pay for the services provided to the patient according to the reimbursement rates listed in the Hospital's charge description master and, if applicable, the Hospital's charity care and discount policies unless the Hospital otherwise agrees in writing. The Hospital reserves the right to require proof of the patient's ability to pay and may require a deposit before admission or visit. Any deposit shall be applied to the total Hospital bill. All available benefits from other sources including insurance, health care service plans and governmental organizations will be considered. If the account is referred to an attorney or collection agency for collection, the patient agrees to pay actual attorneys' fees and collection expenses. All delinquent accounts will bear interest at the legal rate, unless prohibited by law.

The patient, or the patient's representative on behalf of the patient, may receive monies from a settlement, judgment, contract of insurance or estate. If monies are owed to the Hospital for services, the patient/ representative agrees that the Hospital is entitled to claim a share of those monies in the amount owed to the Hospital.

9. ASSIGNMENT OF INSURANCE BENEFITS - The patient agrees to assign to the Hospital any and all rights and interests in insurance proceeds, benefits or policy provisions payable to, or on behalf of, the patient for services rendered. The patient directs all insurance companies, health care service plans, other third-party payors, and governmental agencies ("Payors") to make payment on the patient's behalf directly to the Hospital in an amount not to exceed the Hospital charges. The patient accepts primary financial responsibility for all charges not covered by this assignment even if the Hospital agrees to accept payment directly from the patient's Payors, unless otherwise stated by applicable law or contract. The patient remains responsible for the payment of all unpaid amounts and for all services provided to the patient, which are not covered services under the patient's health insurance coverage.

10. HEALTHCARE SERVICE PLAN OBLIGATION - The Hospital maintains a list of contracted healthcare service plans. This is available upon request from the Hospital's Admitting Department. The Hospital has a contract only with those plans appearing on the list. As a service to the patient, the Hospital may agree to accept payment from a patient's non-listed health service plan if the person signing below agrees to be financially responsible for all unpaid Hospital charges.

11. AUTHORIZED REPRESENTATIVE - The person who signs below, as the patient or the representative of the patient, authorizes the Hospital and its agents to assist, represent and act on behalf of the patient in obtaining benefits from applicable insurance policies, health care service plans, other private third-party or self-insurance arrangements, Medicare, Medi-Cal, or other governmental or private programs which provide benefits relating to services or supplies provided by the Hospital. These services may include handling applications, appeals and hearings to the extent permitted by law. The Hospital is not obligated to provide this service. The patient agrees to assist as necessary.

12. NONDISCRIMINATION - The Hospital complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Hospital does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Hospital provides:

- Free aids and services to people with disabilities to communicate effectively such as qualified sign language interpreters or written information in other formats (large print, audit, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as qualified interpreters or information written in other languages.

If you need these services contact: the City of Hope Department of Clinical Social Work at 626-256-4673, ext. 62282.

Continued on next page.

If you believe that the Hospital has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: the City of Hope Patient Advocate at (626) 256-4673, Ext. 62285.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

https://ocr.portal.hhs.gov/ocr/portal/lobby.jsf

or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html

AUTHORIZED SIGNATURE - I certify that I have read the above information and received all referenced documentation. I agree to the terms of this General Consent for Treatment and understand that I will receive a copy. I direct Payors to receive a copy of the General Consent for Treatment in lieu of an original.

TRANSLATION (if necessary) - I have accurately and completely read the foregoing document to the signator identified below in the patient's/ patient representative's primary language. He/she understood all terms and conditions and acknowledged his/her agreement by signing this document in my presence.		**PRIMARY LANGUAGE, IF NOT ENGLISH**	
TRANSLATOR PRINTED NAME	SIGNATURE TITLE / DEPT	DATE	TIME
PATIENT OR PERSONAL REPRESENTATIVE PRINTED NAME HANNA,ADEL	SIGNATURE 	DATE 09/17/2018	TIME 01:55
If Personal Representative has signed above, indicate your relationship to the patient: ☐ Parent ☐ Guardian ☐ Conservator ☐ Agent ☐ Other		REASON PATIENT DID NOT SIGN	
WITNESS PRINTED NAME	SIGNATURE TITLE / DEPT E-Signed: Melissa Shiegel	DATE 09/17/2018	TIME 01:55

Continued on other side.

LANGUAGE ASSISTANCE SERVICES ARE AVAILABLE

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 626-256-4673, ext. 62282

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 626-256-4673, ext. 62282

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 626-256-4673, ext. 62282

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 626-256-4673, ext. 62282

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.626-256-4673, ext. 62282 번으로 전화해 주십시오

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 626-256-4673, ext. 62282

هجوت: اب. دشابی م مهارف امشی ارب ناگیار تروصبی نابز تلای‌هست د،یکی م وگتفگ سرافی نابز هب رگا 626-256-4673 ext. 62282 دیریگ تماس.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 626-256-4673, ext. 62282

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます626-256-4673, ext. 62282

(مقر 626-256-4673 ext. 62282 ثدحتت ركذا ةغلا، نإف تامدخ ةدعاسملا وغلاية رفاوتت كل ناجملاب. لصتا مقرب
ةظوحلم: اذإ تنك

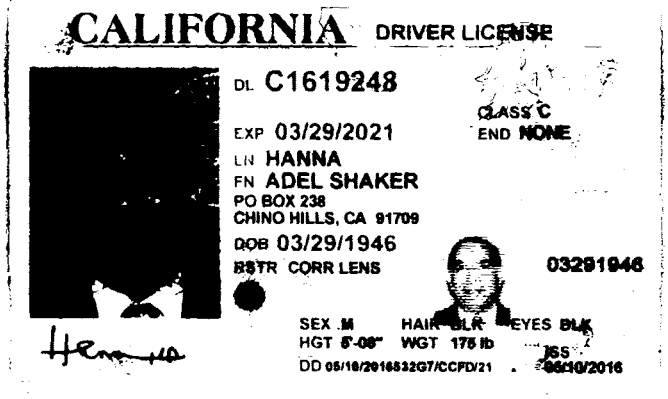
ਧਿਆਨ ਿਦਓ: ਜੇ ਤੁਸ ◌ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ◌ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 626-256-4673, ext. 62282

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល
គឺអាចមានសំរាប់បំរើអ្នក។ ជូរ ទូរស័ព្ទ 626-256-4673, ext. 62282

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 626-256-4673, ext. 62282

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 626-256-4673, ext. 62282

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 626-256-4673, ext. 62282


CALIFORNIA DRIVER LICENSE

DL C1619248

CLASS C

EXP 03/29/2021

END NONE

LN HANNA

FN ADEL SHAKER

PO BOX 238

CHINO HILLS, CA 91709

DOB 03/29/1946

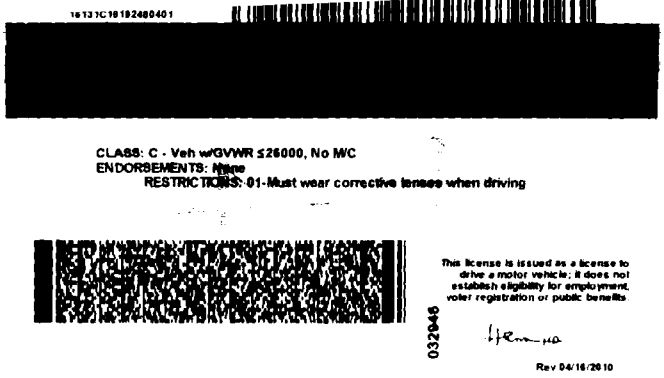
RSTR CORR LENS

03291946

SEX M HAIR BLK EYES BLK

HGT 5'-08" WGT 175 lb

DD 05/10/2016832G7/CCFD/21 . 05/10/2016



CLASS: C - Veh w/GVWR ≤26000, No M/C
ENDORSEMENTS: None
RESTRICTIONS: 01-Must wear corrective lenses when driving

This license is issued as a license to drive a motor vehicle; it does not establish eligibility for employment, voter registration or public benefits.

032946

Rev 04/16/2010

MEDICARE **HEALTH INSURANCE**

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
ADEL S HANNA

MEDICARE CLAIM NUMBER
548-67-8932-A

SEX
MALE

IS ENTITLED TO
HOSPITAL (PART A) BENEFITS ONLY

EFFECTIVE DATE
10-01-2011

SIGN HERE ➡ _____

1. Carry your card with you when you're away from home.
2. Let your hospital or doctor see your card when you need hospital, medical, or health services under **Medicare**.
3. Your card is good wherever you live in the United States.

WARNING: Issued only for use of the named beneficiary. Intentional misuse of this card is unlawful and may be punishable by fines, imprisonment, and other penalties. If found, drop in nearest U.S. Mail Box.

Centers for Medicare & Medicaid Services
Baltimore, MD 21244-1850
Form CMS-1966 (04 2015)

Questions about Medicare:
- **visit Medicare.gov**
- **call 1-800-MEDICARE (1-800-633-4227); (TTY: 1-877-486-2048)**

Anthem BlueCross

PERS Choice BASIC

ADEL HANNA

Identification Number
CPR226A67822

Group No	**CB010A**
Plan Code	**040**
Coverage(s)	
Medical	

PPO Ofc Visit Copay	**$20**
RxBIN	**610011**
RxPCN	**IRX**
RxGroup	**CALPANTH**

See EOC for Benefit Specifics

Blue Cross PPO
A Preferred Buyer Plan Product

PPO

anthem.com/ca/calpers

Member Services	**1-877-737-7776**
24/7 NurseLine	**1-800-700-9185**
Pre-Service Review	**1-800-451-6780**
Coverage While Traveling	**1-800-810-2583**
Pharmacy Services*	**1-855-505-8110**

MEMBERS When submitting inquiries always include your member number from the face of this card. Possession or use of this card does not guarantee payment.

Blue Cross and/or Blue Shield Plan: To ensure prompt claims processing, include the 3-digit alpha prefix that precedes the patient's identification number listed on the front of this card.

All non-emergency hospital admissions must be pre-certified 3 full days in advance. Emergency admissions must be registered within 24 hours.

For services rendered in CA, file medical claims to: P.O. BOX 60007 LOS ANGELES, CA 90060

This card is for identification only in the PERS Choice Health Plan.

livehealthonline.com

*Contracts directly with group

SURGERY/ PROCEDURE PRE-OP INSTRUCTIONS

How the patient may be contacted two days before surgery:

Home: _____ Work: _____ Alternate: _____

- **Seven days before your surgery: STOP** taking Aspirin, Ibuprofen and/or herbals, unless otherwise instructed by your physician.
- **Day of your surgery: STARTING AT MIDNIGHT NO FOOD OR LIQUIDS**
- **Day of your surgery: TAKE** the following medications with sip(s) of water: Amlodipine with a small sip of water
- **Additional Instructions:** ~~Clear Liquid Diet~~

We will call you between 3:00pm and 5:00pm two days before your surgery to let you know what time to arrive at the hospital. If your surgery is on Monday, we will call you on Friday.

- **Call City of Hope if:**
  - You are unable to keep your appointment.
  - You have a cold, fever or an infection or have been exposed to a contagious disease.
  - We have not called you by 5:00pm two days before your surgery.

Monday - Friday, 8:00am – 5:00pm: Call the Pre-Anesthesia Testing Clinic at 626-218-3785.

Monday - Friday, 5:00pm – 8:00am and on weekends: Call the Nurse Triage Call Center at 626-471-7133. *

- **On the day of your surgery:**
  - Do not wear makeup, artificial nails, gel manicure, cologne, or perfume. Wear comfortable clothing. Remove all jewelry and valuables before coming to the hospital.
  - Bring a list of all medications, vitamins, and/or herbs that you are currently taking. Include the dosage of each and how often you take it.
  - If you have an Advance Directive, a Durable Power of Attorney for Health Care, or a Living Will for Health Care please bring a copy with you to the hospital.
  - Please check-in at the Admitting Office on the first floor of the Helford Building, or the third floor of the Amini Building. Check-in location will be confirmed when we call you two days before your surgery.
- **If you are having an Outpatient procedure, you MUST have an adult designated driver available to drive you home. Outpatient procedures will be canceled if you do not have an adult designated driver to accompany you home at the time of discharge.**
- **If you are scheduled for an Outpatient procedure, you may need to be admitted to the hospital if circumstances change.**

IF THE PATIENT IS UNDER 18

- A parent or legal guardian must accompany him/her and sign the necessary forms.
- If the patient is an infant or young child, please bring a bottle, cup, diaper, favorite blanket and/or toy.
- If the patient is under six years of age or weighs less than 60 pounds, he/she must be restrained in a safety seat. If the patient is six or older and weighs 60 pounds or more, he/she must use a seat belt.

I have read and understand the above instructions.

PRINTED NAME	SIGNATURE	DATE	TIME
ADEL HANNA		9/14/18	
Adel S Hanna	Hanna MD	9.14.18	02.15 pm

City of Hope National Medical Center
1500 East Duarte Road, Duarte, CA 91010

SURGERY/PROCEDURE PRE-OP INSTRUCTIONS

DOS: 09/14/2018
HANNA,ADEL
DOB 03/29/1946 72Y M
CSN 302953606 MRN 11031634
ATTN MD: , OUTPATIENT

FALLS SAFETY ACKNOWLEDGMENT

City of Hope is a partner in your care, and your safety is important to us Policies are in place to help keep you safe, and these policies have been explained to you Your willingness to comply is key to keeping you safe This document is an acknowledgment of important reminders concerning Falls Safety, for which we request your signature below

1 **I have been educated by my nurse, and understand that many of the following things may put me at a high risk for falls**

- Medications that make me weak and dizzy (such as medicines that treat pain, nausea, trouble sleeping, or needed before a blood transfusion)
- Weakness from long periods of bed rest or inactivity
- Being in an unfamiliar setting
- Use of bulky patient care equipment (IV tubes, IV poles and pumps, EKG wires, oxygen tubing, surgical tubes)
- Potential loss of control of stool and urine Need to use the restroom suddenly and/or often

2 **I know that falling can cause serious injuries such as** bruising, bleeding, head injuries, and broken bones I understand that these injuries can lead to a longer stay in the hospital and transfer to an intensive care unit In some cases, these injuries can be life threatening

3 **As a City of Hope patient, I agree to do all I can to protect myself from falling**

I will

- Use the call light to ask for help when I need to get out of bed
- Wait for help before getting up from my bed, or the toilet
- Immediately report feelings of dizziness or weakness to my caregiver/nurse
- Keep my room free of clutter and unnecessary items
- Avoid leaning on items with wheels such as IV pole and bedside table
- Wear non-skid socks provided by my caregiver

4 **I understand that my care providers, on the unit, will do all they can to protect me from falls They will**

- Answer my call light promptly
- Check on me at least every hour to ensure I have been to the restroom, belongings are within reach, I am comfortable and not in pain
- Assure that I get help to use the restroom if I am getting medicines that may make me weak or dizzy
- Assist me to the restroom, in the middle of the night, to make sure I do not wake up with a feeling of urgency
- If I have been identified as a risk for falling, I will be helped to and from the bathroom each time

TRANSLATION (if necessary) – I have accurately and completely read the foregoing document to the signator identified below in the patient's / patient representative's primary language He/she understood all terms and conditions and acknowledged his/her agreement by signing this document in my presence			PRIMARY LANGUAGE IF NOT ENGLISH	
TRANSLATOR PRINTED NAME ID #	SIGNATURE TITLE / DEPT		DATE	TIME
PATIENT / PERSONAL REPRESENTATIVE PRINTED NAME	SIGNATURE		DATE 9/17/18	TIME 1480

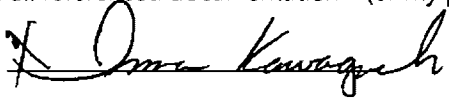
City of Hope National Medical Center
1500 East Duarte Road, Duarte, CA 91010

FALLS SAFETY ACKNOWLEDGMENT

Hanna,Adel
MRN 11031634
Sex: male DOB 3/29/1946 (72 yrs)
Admit Date 9/17/2018
CSN 302953104

Patient Signature

I, Adel Hanna (or my parent/guardian), on 09/17/18, certify that I (or my parent/guardian) have read the above information and received all referenced documentation I (or my parent/guardian) agree to the terms of this after visit summary (AVS)

Signature 

CSN 302953104

City of Hope

8024-C053 DSRT – Demographic Self-Report

SELF-REPORTED DEMOGRAPHIC

Please use only **BLACK ink** and solidly fill in bubbles to indicate your responses as this form is being computer read

City of Hope is required to participate in state and federal programs that capture race and ethnicity data. This information helps us to improve care, furthers our understanding of cancer and other diseases, and is used to develop strategies and policies for its prevention, treatment, and control. Your response will not impact your care. Please assist us in this effort by providing the following information.

1. **Are you of Hispanic, Latino, or Spanish origin?**
   - ● No, I am not of Hispanic, Latino or Spanish origin.
   - ○ Yes, I am of Hispanic, Latino or Spanish origin. My ancestors are:
     - **(please mark ALL that apply):**
     - ○ Mexican, Mexican American, Chicano
     - ○ Puerto Rican
     - ○ Cuban
     - ○ Another country of origin (Examples: Argentina, Colombia, Spain), Specify: _____
   - ○ I Prefer Not to Answer (non-disclosed)

2. How do you identify yourself? (racial heritage, not place of birth)
   (please mark ALL that apply):
   - ● White (including Armenian, Australian, Caucasian, Central and South American, Cuban, Mexican, Persian, Iranian, North African, Saudi Arabian, and European)
   - ○ Black/African American
   - ○ Asian
     - **(please mark ALL that apply):**
     - ○ Asian Indian ○ Chinese ○ Japanese ○ Filipino ○ Korean
     - ○ Vietnamese ○ Other Asian (Examples: Thai, Hmong), Specify: _____
   - ○ American Indian or Alaska Native (specify enrolled or principal tribe; examples: Aleutian, Cahuilla): _____
   - ○ Pacific Islander
     - **(please mark ALL that apply):**
     - ○ Native Hawaiian ○ Guamanian or Chamorro ○ Samoan
     - ○ Other Pacific Islander (Examples: Fijian, Tongan), Specify: _____
   - ○ I Prefer Not to Answer (non-disclosed)

City of Hope National Medical Center
1500 East Duarte Road, Duarte, CA 91010

SELF-REPORTED DEMOGRAPHIC FORM

Hanna,Adel
MRN: 11031634
Sex: male DOB: 3/29/1946 (72 yrs)

Form No 8024-C053-E | Revised: 03-21-2017 | DSRT | Registration Information | Patient Level

17817

inTeleScans powered by Teleform

City of Hope
Medical Foundation

SEXUAL HEALTH INVENTORY FOR MEN

Name _____ Date _____

How do you rate your confidence that you could get and keep an erection?

Very Low	Low	Moderate	High	Very High
1	(2)	3	4	5

When you had erections with sexual stimulation, how often were erections hard enough for penetration (entering your partner)?

No Sexual Activity	Almost Never or Never	A Few Times (Much Less than Half the time)	Sometimes (About Half the time)	Most Times (Much More than Half the time)	Almost Always or Always
0	1	(2)	3	4	5

During sexual intercourse, how often were you able to maintain your erection after you had penetration (entered your partner)?

No Sexual Activity	Almost Never or Never	A Few Times (Much Less than Half the time)	Sometimes (About Half the time)	Most Times (Much More than Half the time)	Almost Always or Always
0	1	(2)	3	4	5

During sexual intercourse, how difficult was it to maintain your erection for completion of intercourse?

No Sexual Activity	Extremely Difficult	Very Difficult	Difficult	Slightly Difficult	Not Difficult
0	1	(2)	3	4	5

When you attempted sexual intercourse, how often was it satisfactory to you?

No Sexual Activity	Almost Never or Never	A Few Times (Much Less than Half the time)	Sometimes (About Half the time)	Most Times (Much More than Half the time)	Almost Always or Always
0	1	(2)	3	4	5

City of Hope Medical Foundation

SEXUAL HEALTH INVENTORY FOR MEN

Foundation Form No. 7071-F036-E Revised: 05-02-13

Patient Identification / Label

Hanna,Adel
MRN: 11031634
Sex: male DOB: 3/29/1946 (72 yrs)
CSN: 302915250

2 of 2

PROSTATE QUESTIONNAIRE

This questionnaire covers material that is sensitive and personal. There are no "right" or "wrong" answers, but rather a recall of your experience. It is important that you read each question carefully and answer accurately and honestly.

PLEASE MARK ONE RESPONSE PER QUESTION	Not at All	Less Than 1 Time in 5	Less than Half the Time	About Half the Time	More than Half the Time	Almost Always
Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	(0)	1	2	3	4	5
Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	(1)	2	3	4	5
Over the past month, how often have you found that you stopped and started again several times when you urinated?	0	(1)	2	3	4	5
Over the past month, how often have you found it difficult to postpone urination?	0	1	(2)	3	4	5
Over the past month, how often have you had a weak urinary stream?	(0)	1	2	3	4	5
Over the past month, how often have you had to push or strain to begin urination?	(0)	1	2	3	4	5
Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	(2)	3	4	5
TOTAL I-PSS SCORE = 6						

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?

Delighted	Pleased	Mostly Satisfied	Mixed About Equally Satisfied	Dissatisfied	Unhappy	Terrible
	✓					

Patient Health Summary

Patient Name: Adel S. Hanna

Hanna,Adel
MRN: 11031634
Sex: male DOB: 3/29/1946 (72 yrs)

Introduction

Thank you for completing the City of Hope National Medica
information you provide us in this summary will help us to provide you with the best possible care. Please ask your health care provider any questions you have about the questions or answer options on this summary.

Personal / Social History

1. Date of Birth (month/day/year) 0 3 / 2 9 / 1 9 4 6
2. Place of Birth: State EGYPT Country _____
3. Please check your **current employment status**:
   - ☒ Employed 32 hours or more per week
   - ☐ Employed less than 32 hours per week
   - ☐ Employed 32 hours or more per week and part-time student
   - ☐ Unemployed or seeking work
   - ☐ On medical leave
   - ☐ Other – please specify _____
   - ☐ Homemaker
   - ☐ Full time student
   - ☐ Part time student
   - ☐ Retired
   - ☐ Disabled
4. Please check the **highest level of education completed**:
   - ☐ Some grade school
   - ☐ Some high school
   - ☐ High school graduate
   - ☐ Vocational or technical school beyond high school
   - ☐ Other – please specify _____
   - ☐ Some college or Associates degree
   - ☐ College degree
   - ☒ Graduate or Professional School (MA,MS,MPH,MBA,PhD,(MD))
5. Please check any **current household members** (Please choose all that apply)
   - ☒ Spouse / significant other
   - ☐ Child(ren)
   - ☐ Close friend(s)
   - ☐ Other – please specify _____
   - ☐ Parent(s)
   - ☐ Sister(s) / Brother(s)
   - ☐ Aunt(s) / Uncle(s)

6a. Sexual Orientation: How do you identify?
   - ☒ Straight or heterosexual
   - ☐ Lesbian, gay, or homosexual
   - ☐ Bisexual
   - ☐ Don't know
   - ☐ Something else – please specify _____

6b. What is your current gender identity? (Check all that apply): ☒ Male ☐ Female
   - ☐ Transgender: Female-to-Male (FTM) / Transgender Male / Trans Man
   - ☐ Transgender: Male-to-Female (MTF) / Transgender Female / Trans Woman
   - ☐ Gender nonconforming (neither exclusively male nor female)
   - ☐ Additional Gender Category (or Other) – please specify _____
   - ☐ Decline to answer – please explain _____

6c. Preferred gender pronoun: ☒ He/Him ☐ She/Her
   - ☐ Something else – please specify _____
   - ☐ Preferred name – please specify _____

6d. What sex were you assigned at birth and is on your original birth certificate? ☒ Male ☐ Female
   - ☐ Decline to answer – Please explain _____

7. Do you or have you ever used **tobacco?**
- [ ] Never (Skip to Question 8)
- [x] Previously
- [ ] Currently

- **What did you smoke?** (Please choose all that apply.)
  - [x] Cigarettes
  - [ ] Cigars
  - [ ] Pipe
  - [ ] Other, specify
- ON THE AVERAGE, **how many packs** per day did you smoke or do you currently smoke?
  - [ ] Never smoked
  - [x] Less than ½ pack per day
  - [ ] ½ - 1 pack per day
  - [ ] 1-1½ packs per day
  - [ ] 1½ - 2 pack per day
  - [ ] More than 2 packs per day
- How many **total years** have you smoked or do you smoke? [1][0] (Years)

8. Do you or have you ever consumed **alcohol?**
- [ ] Never (Skip to Question 9)
- [ ] Previously
- [x] Currently

- If you have ever consumed alcoholic beverages, on average, how many alcoholic beverages did you drink, or do you currently drink? Please approximate the number of **beverages per week** in the space provided.
  - [ ] None
  - [ ] Less than one alcoholic beverage per week
  - [x] More than one alcoholic beverage per week, specify:
    - [ ] Beer [ ][ ] Bottles per week
    - [ ] Wine [ ][ ] Glasses per week
    - [ ] Mixed Drinks [ ][2] Drinks per week with Water

9. Do you or have you ever used **recreational/street drugs?**
- [x] Never (Skip to next section "Medical History")
- [ ] Currently
- [ ] Previously

Medical History

Please check **ALL** previous illnesses or conditions below:

- [ ] Heart Problems
- [ ] Lung Problems
- [ ] Bone/Joint Problems
- [ ] Circulation Problems
- [ ] Liver Problems
- [ ] Weight Problems
- [ ] Intestinal Problems
- [ ] Kidney/Urine Problems
- [ ] Frequent Infections
- [ ] Stroke
- [ ] Seizure
- [x] Hospitalizations
- [ ] HIV/AIDS
- [ ] Transfusions, how many [ ][ ][ ]
- [ ] Recent Travel or lived outside of the United States or Canada?
- [ ] Other, specify: p.fundupliceton

Eye, Ear, Nose and Throat

1. Do you have a history of chronic sinusitis (sinus infections)?	☐ No	☒ Yes
2. Do you have a history of glaucoma?	☐ No	☐ Yes
3. Do you have a history of cataracts?	☐ No	☐ Yes
4. Do you have a history of hearing disorders?	☐ No	☒ Yes
5. Do you wear eyeglasses?	☐ No	☒ Yes

Heart / Circulation

6. Have you ever had a heart attack?	☒ No	☐ Yes
7. Do you have high blood pressure?	☐ No	☒ Yes
8. Have you ever been treated for heart failure? (Your doctor may have told you that you had fluid in your lungs or that your heart was not pumping well.)	☒ No	☐ Yes
9. Do you have a history of heart arrhythmias (irregular heart beat)?	☒ No	☐ Yes
10. Have you ever had an operation to unclog the arteries in your legs?	☒ No	☐ Yes
11. Do you have high cholesterol?	☒ No	☐ Yes

Lung / Respiratory

12. Do you have asthma?	☒ No	☐ Yes
13. Do you have emphysema?	☒ No	☐ Yes
14. Do you have chronic bronchitis or chronic obstructive lung disease?	☒ No	☐ Yes
IF Yes, Do you take medicine for your condition (either on a regular basis or just for flare-ups)?	☒ No	☐ Yes

Liver / Stomach / Intestinal

15. Do you have cirrhosis or serious liver damage?	☒ No	☐ Yes
16. Do you have a history of hepatitis?	☒ No	☐ Yes
17. Do you have stomach ulcers or peptic ulcer disease?	☒ No	☐ Yes
IF Yes, Was this condition diagnosed by *endoscopy* (where the Doctor looks into your stomach through a scope), **or** *an upper GI* **or** *barium swallow study* (where you swallow chalky dye and then x-rays are taken)?	☐ No	☐ Yes
18. Do you have inflammatory bowel disease?	☒ No	☐ Yes
19. Have you had polyps removed from your colon or rectum?	☐ No	☒ Yes
IF Yes, When: ☐☐☐☐ (year first detected)	Total Number ☐☐ ?	

Urinary / Reproductive

20. Have you ever had problems with your kidneys?	☒ No	☐ Yes
IF Yes, Have you ever:		
a. Had poor kidney function with blood testing showing high creatinine levels?	☒ No	☐ Yes
b. Used hemodialysis or peritoneal dialysis?	☒ No	☐ Yes
c. Received a kidney transplant?	☒ No	☐ Yes

21. Have you ever had urinary tract infections?	☒ No	☐ Yes
22. Have you ever been pregnant?	☐ No	☐ Yes
IF Yes, Number of pregnancies ☐ Number of live births ☐		

Bones / Joints / Musculoskeletal

23. Do you have rheumatoid arthritis?	☐ No	☐ Yes
IF YES, Do you take medications for it regularly?	☐ No	☐ Yes
24. Do you have lupus (systemic lupus erythematosus) or polymyalgia rheumatica?	☐ No	☐ Yes

Brain / Neurological

25. Have you had a stroke, cerebrovascular accident, blood clot or bleeding in the brain, or transient ischemic attack (TIA)?	☐ No	☐ Yes
IF Yes, Do you have difficulty moving an arm or leg as a result of a stroke or a cerebrovascular accident?	☐ No	☐ Yes
26. Do you have a seizure disorder (epilepsy)?	☐ No	☐ Yes

Psychological

27. Do you have Alzheimer's Disease or another form of dementia?	☐ No	☐ Yes
28. Are you currently being treated for depression or anxiety?	☐ No	☐ Yes

Hormonal / Endocrine

29. Do you have diabetes or high blood sugar?	☒ No	☐ Yes
IF Yes, Is it treated by:		
a. Modifying your diet?	☐ No	☐ Yes
b. Medications taken by mouth?	☐ No	☐ Yes
c. Insulin injections?	☐ No	☐ Yes
d. Has your diabetes caused problems with your kidneys or problems with your eyes treated by an ophthalmologist?	☐ No	☐ Yes
30. Do you have a history of thyroid disease or thyroid problems?	☐ No	☐ Yes

Blood / Hematological

31. Do you have anemia?	☐ No	☐ Yes
32. Do you have a history of easily bleeding or bruising?	☐ No	☐ Yes
33. Do you have a history of having blood clots?	☐ No	☐ Yes

Infectious Diseases

34. Do you have chronic tuberculosis (TB), malaria or another infectious disease?	☐ No	☐ Yes
35. Do you have a history of sexually transmitted disease (STDs)?	☐ No	☐ Yes

Cancer History

36. Do you have cancer or have you had cancer in the past? ☒ No ☐ Yes

a. IF Yes, Has the cancer spread, or metastasized, to other parts of your body? ☐ No ☐ Yes

IF YES, please check the type(s) of cancer, indicate the year of diagnosis and check all treatments you have received for each cancer in the table below:

Cancer Type	Year of Diagnosis	Chemo-Therapy	Radiation Therapy	Hormone Therapy	Surgery
Lung	☐☐☐☐	☐	☐	☐	☐
Colorectal	☐☐☐☐	☐	☐	☐	☐
Melanoma	☐☐☐☐	☐	☐	☐	☐
Other Skin Cancer	☐☐☐☐	☐	☐	☐	☐
Lymphoma	☐☐☐☐	☐	☐	☐	☐
Leukemia or Polycythemia Vera	☐☐☐☐	☐	☐	☐	☐
Prostate	☐☐☐☐	☐	☐	☐	☐
Breast	☐☐☐☐	☐	☐	☐	☐
Ovarian	☐☐☐☐	☐	☐	☐	☐
Endometrial / Uterine	☐☐☐☐	☐	☐	☐	☐
Cervical	☐☐☐☐	☐	☐	☐	☐
Other Cancer	☐☐☐☐	☐	☐	☐	☐

Surgical History

1. Have you ever had a surgery or surgical procedure (i.e. needle biopsy) ☐ No ☒ Yes

IF NO, Please skip to the next section "Review of Systems"

IF YES, did you have **problems** with:

Anesthesia? ☒ No ☐ Yes

Bleeding/Clotting? ☒ No ☐ Yes

Please list or check below all procedures you have had in the table:

Type of Surgery / Procedure	Year(s) of Surgery/Procedure	Clinician Comment
Eye		
☐ Cataract surgery No		
☐ Other, specify		
Ear, Nose and Throat		
☐ Tonsillectomy, and/or adenoidectomy NO		
☐ Other, specify		
Heart / Circulation		
☐ Coronary angiogram (cardiac cath) → yes		
☐ Angioplasty / Stent NO		
☐ Coronary bypass surgery NO		
☐ Other, specify		
Lung / Respiratory		
☐ Bronchoscopy		
☐ Other, specify		
Stomach / Intestinal		
☐ Upper endoscopy (EGD) — yes		
☐ Lower endoscopy (colonoscopy/sigmoidoscopy) yes		
☐ Appendectomy NO		
☐ Gallbladder removal yes		
☐ Hernia repair No		
☐ Other, specify		

Type of Surgery / Procedure	Year(s) of Surgery/Procedure	Clinician Comment
Urinary / Reproductive		
☐ Bladder repair/bladder suspension		
☐ Prostatectomy, ☐ Open and/*or* ☐ Radical		
☐ Transurethral Resection of the Prostate (TURP)		
☒ Vasectomy or tubal ligation		
☐ Hysterectomy (removal of uterus)		
☐ Oophorectomy (removal of ovaries)		
☐ Caesarian Section (C-Section):		
☐ Other, specify		
Bones / Joints / Musculoskeletal		
☐ Joint replacement NO		
☐ Other, specify		
Skin, Breast, or Endocrine		
☐ Removal of a mole, nevus or skin cancer		
☐ Breast surgery		
☐ Thyroid surgery NO		
☐ Lymph node biopsy		
☐ Other, specify		

Other Diseases / Surgeries

Are you being treated or have you been diagnosed for any other medical conditions, diseases or surgeries?

☐ No IF NO, Please skip to the next section "Review of Systems"

☐ Yes IF YES, please describe below:

Review of Systems

Check all the following problems you are having now:

1. Which option below best describes your current level of physical activity WITHIN THE PAST WEEK?
(Please choose ONE response only.)

- [x] Fully active, able to carry on all usual activities without restriction
- [ ] Restricted in activity; can walk; able to carry out light housework
- [ ] Able to care for self, can walk; up more than ½ day
- [ ] Need some help taking care of self, spend more than ½ day in bed or chair
- [ ] Cannot take care of self at all, and spend all of my time in bed/chair

Please list or check below all the problems you have had within the past week.

General Problems

- [x] NONE
- [ ] Fever/Chills
- [ ] Fatigue
- [ ] Weight Gain, how much gained ☐☐☐ lbs
- [ ] Loss of Sex Drive
- [ ] Weight Loss, how much lost ☐☐☐ lbs
- [ ] Change in Sleep Habits/Difficulty Sleeping
- [ ] Pain, please specify location
- [ ] OTHER, please specify

Neurological

- [x] NONE
- [ ] Memory Change
- [ ] Weakness
- [ ] Seizure
- [ ] Numbness/Tingling
- [ ] Headache
- [ ] Unbalanced Walking
- [ ] Blurred Vision
- [ ] Ringing Ears
- [ ] Dizziness/Fainting
- [ ] Hearing Difficulty
- [ ] Speech Changes
- [ ] OTHER, please specify

Head and Neck

- [x] NONE
- [ ] Nosebleeds
- [ ] Hoarseness
- [ ] Sore Throat
- [ ] Sores in Mouth or Throat
- [ ] OTHER, please specify

Breast

- [x] NONE
- [ ] New Lump
- [ ] Skin Changes
- [ ] Nipple Discharge
- [ ] Pain
- [ ] OTHER, please specify

Heart

- [ ] NONE
- [x] Chest Pain Not Cardiac origin
- [ ] Chest Tightness
- [ ] Leg Pain / Swelling
- [ ] Fast Heartbeat
- [ ] OTHER, please specify

Lungs / Respiratory

☒ NONE ☐ Cough ☐ Wheezing ☐ Bloody Phelgm/Sputum
☐ Shortness of Breath
☐ OTHER, please specify

Stomach / Intestinal

☒ NONE ☐ Indigestion ☐ Reflux ☐ Vomiting
☐ Yellow Skin or Eyes ☐ Problems Swallowing ☐ Stomach Pain
☐ Cramping / Gas Pains ☐ Blood in Stools ☐ Nausea
☐ Black Stools ☐ Change in Appetite/Diet ☐ Constipation
☐ Diarrhea ☐ Feeling Full Quickly
☐ Difficulty postponing bowel movement
☐ Change in number of bowel movements per *day*
☐ Number of bowel movements per *day* ☐☐
☐ Number of bowel movements per *week* ☐☐
☐ Do you use laxatives on a regular basis?
IF Yes, Which ones:
☐ OTHER, please specify

Urinary / Reproductive

☒ NONE ☐ Burning on urination ☐ Frequent urination ☐ Unable to Control Bladder
☐ Blood in Urine ☐ Dribbling
☐ OTHER, please specify

Bones / Joints / Musculoskeletal

☒ NONE ☐ Joint Swelling ☐ Joint/Back Pain ☐ Stiffness
☐ Trauma ☐ Falls
☐ OTHER, please specify

Skin

☒ NONE ☐ Open Sore ☐ Change in Moles ☐ Abnormal Color
☐ Rashes
☐ OTHER, please specify

Hormonal / Endocrine

☒ NONE ☐ Cold /Heat Intolerance ☐ Hot Flashes
☐ OTHER, please specify

Blood / Hematological

☒ NONE ☐ Abnormal Bleeding ☐ Prior Transfusion ☐ Easy Bruising
☐ Swelling in groin/armpit/neck
☐ OTHER, please specify

Psychological

☒ NONE ☐ Worried/Anxiety ☐ Sad/Depressed ☐ Stressed
☐ OTHER, please specify

Female

☒ NONE ☐ Unusual bleeding/discharge Could you be Pregnant? ☐ No ☐ Yes
Are you using Birth Control? ☐ No ☐ Yes
IF Yes, What kind
Date of Last Menstrual Period: ☐☐/☐☐/☐☐☐☐ (Month/Day/Year)
☐ OTHER, please specify

Male

☐ NONE ☐ Problems with Passing Urine
☒ Enlarged Prostate
Date of Last Prostate Exam: 09/2018 (Month/Year)
☐ OTHER, please specify

Cancer Screening

Type of Exam	Year of Last Exam	Results	Clinician Comment
☐ Colonoscopy	☐☐☐☐	☐ Normal ☐ Abnormal	
☐ Sigmoidoscopy	☐☐☐☐	☐ Normal ☐ Abnormal	
☒ PSA	☐☐☐☐	☒ Normal ☐ Abnormal	W.N.L
☐ Mammogram	☐☐☐☐	☐ Normal ☐ Abnormal	
☐ Pap Smear	☐☐☐☐	☐ Normal ☐ Abnormal	
☐ Other, please specify:	☐☐☐☐	☐ Normal ☐ Abnormal	

Family History

1. Which best describes your marital status? ☐ Married/Life Partner ☐ Single/Never Married ☐ Widowed ☒ Divorced

2. Are you adopted? ☐ Yes IF Yes, Please **stop** here
☒ No IF No or unknown, please complete the following information about your blood relatives (including children). Exclude adoptive relatives.

PATIENT HEALTH SUMMARY

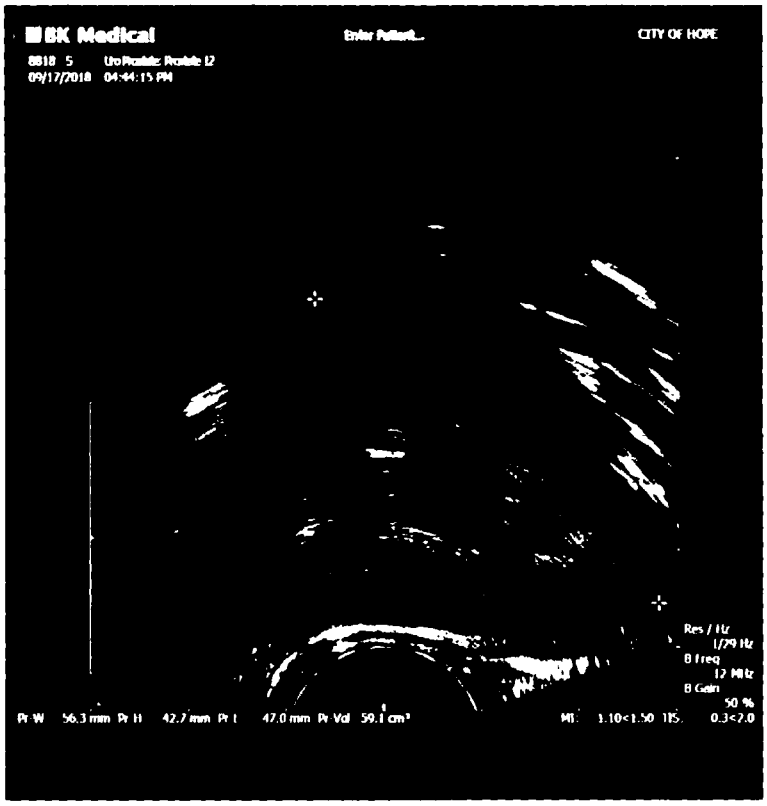
Please complete the following family information below. Place a check mark in the appropriate boxes to identify all illnesses/conditions that **you know have occurred in your blood relatives.**

	FAMILY MEMBERS																				
	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Father	Mother	Brother - 1st	Brother - 2nd	Brother - 3rd	Sister - 1st	Sister - 2nd	Sister - 3rd	Son - 1st	Son - 2nd	Son - 3rd	Daughter - 1st	Daughter - 2nd	Daughter - 3rd	Other, Maternal Relative	Other, Maternal Relative	Other, Paternal Relative	Other, Paternal Relative
Vital Status																						
If **Alive**, check:																						
Current Age (Years)																						
If **Deceased**, check:	✓	✓			✓	✓	✓	✓	✓	✓												
Age at Death (Years)	103	100			70	86	76	84	60	65												
Illnesses / Conditions																						
Anesthesia Complications																						
Diabetes																						
Heart Disease																						
Stroke/TIA																						
Gastrointestinal Cancer																						
Breast Cancer																						
Colorectal Cancer																						
Lung Cancer																						
Ovarian Cancer																						
Prostate Cancer																						
Other Cancer, [ ]	dcd	dcd																				

Signature

PATIENT SIGNATURE: Hanna MD

DATE (MONTH/DAY/YEAR): 0 9 | 1 2 | 2 0 1 8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MI 1.10<1.50 TIS 0.3<2.0

MRN -103/434

City of Hope

CERTIFICATION OF COMPLETION OF THE INFORMED CONSENT

Principal Investigator: Dennis Weisenburger, MD
Department/Division: Pathology

IRB#: 07047

Study Title: A City of Hope Protocol for Collecting, Banking and Release of Human Biological Materials for Research

Consent Title: CITY OF HOPE – Adult/Adolescent 13-17 Consent – Group A Streamlined (English)

I have discussed the "Informed Consent for Participation in Research Activities" for the above referenced research study, with the research participant listed below (or the research participant's legally authorized representative), including the possible benefits, risks, and discomforts involved in his/her participation on the study, as well as potential alternatives.

The research participant has been encouraged to ask questions and has received answers to any questions asked. The research participant has affirmed that he/she has received all information that he/she desires at this time, and has indicated that he/she understands and wishes to proceed with participation in the research study.

By his/her signature on the informed consent, the research participant has authorized and consented to participation in the research study, and has been provided with a copy of the signed consent form.

INDIVIDUAL PERFORMING CONSENT (PLEASE PRINT)	SIGNATURE TITLE	DATE	TIME
	E-Signed: Stella Montes	09/13/2018	11:44

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IRB #07047: A City of Hope Protocol for Collecting, Banking and Releasing Human Biological Materials and Health Information for Research (Adult CF/Parent CF/ Adolescent 13-17 Assent)

("You" below refers to you or your child)

EXPERIMENTAL SUBJECT'S - BILL OF RIGHTS

Below are the rights of every person asked to be in a research study ("research") as an experimental subject:

1. To be told what the research is trying to find out
2. To be told what will happen to you and whether any of the procedures, drugs, or devices to be used is different from what would be used in standard practice
3. To be told the risks, side effects, or discomforts of the things that will happen to you as part of the research
4. To be told if you can expect any benefit from participating in the research, and, if so, what the benefit might be
5. To be told of the other choices you have and how they may be better or worse than being in the research
6. To be allowed to ask any questions concerning the research, both before agreeing to be in the research and during the course of the research
7. To be told what medical treatment is available if any complications arise,
8. To refuse to participate in the research or change your mind about participation after the research is started. To be informed that this decision will not affect your right to receive the care you would receive if you were not in the research
9. To receive a copy of the signed and dated research consent form,
10. To be free of pressure when considering whether you wish to agree to be in the research.

PURPOSE: City of Hope's mission is the prevention, treatment and cure of cancer and other diseases through research and patient care. In keeping with our mission, researchers need to study various types of tumors, cancer cells and genes to better understand what causes cancer and learn new ways to prevent, treat, and cure it. The "*City of Hope Protocol for Collecting, Banking and Releasing Human Biological Materials and Health Information*" is a research program to collect and bank tissue and other biological specimens that are left-over from routine procedures required for your medical care. Tissue samples may be used immediately for research or may be banked indefinitely for future research efforts at City of Hope and collaborating institutions. Taking part in this research is voluntary. Your alternative is not to participate. Your decision whether or not to participate will not affect your care at City of Hope. There are two components to this research:

1. **Specimen Banking (Tissue & Blood)**: Tissues left-over from any clinically-necessary procedures performed at City of Hope, may be used by researchers for future studies. Under this protocol, researchers may also request access to your stored specimens from other institutions where you have received treatment. In addition, a small sample of blood (approximately three tablespoons) may be collected, up to 4 times per year, during a routine lab visit when other blood tests are drawn. No extra needle-stick is required to obtain this blood sample.
2. **Medical Information**: Researchers may review your past, current and future medical records to study all aspects of your medical care including, but not limited to, diagnosis, treatment information and outcomes. Under this consent, researchers may also request your medical information from other institutions where you have received treatment.

WHAT WOULD BE REQUIRED OF ME TO PARTICIPATE?

1. **What is my time commitment to participate**? Your participation time is only the time required for you to review the consent form and address any questions you may have.
2. **Are there risks to me if I participate in this study**? Because the additional blood will be taken at the same time as a clinically indicated blood draw, there is no additional physical risk. There is a risk that your confidential information could be unintentionally released; however there are security measures in place to

ensure that this risk is small. It is possible that your specimens may be used to study changes in genetic material which may influence the development of diseases including cancer and/or the effectiveness of specific treatments. A federal law established in 2008 called the Genetic Information Nondiscrimination Act (GINA), generally makes it illegal for health insurance companies, group health plans, and employers of 15 or more persons to discriminate against you based on your genetic information.

3. **Will I benefit from participating?** You will not benefit directly from participation in this study, however knowledge gained from your specimens may benefit others in the future.
4. **What kind of research will my specimens be used for?** The scientific, diagnostic and/or medical nature of the future research is not known. Although there have improvements in the diagnosis and management of cancer, there are still many areas that are not well understood. Preclinical research (clinical tests performed with animals or cell lines before being testing in humans) traditionally relies on cell lines (tissue cultures) established from tumor tissues.. Cell lines remain an important way to perform genetic and biochemistry research on different types of cancers. Mouse models using tissue inserted from fresh or frozen human tumors are also used in cancer research. These are called Patient-Derived Tumor Xenografts (PDXs). These are ideal models in cancer research and are renewable sources for tumor tissues. There is a possibility that some of your tumor tissue maybe used to establish cell lines or used in PDX models.. Neither you nor your doctors will be informed of your individual results and they will not affect your treatment in any way. Some of this research may result in new inventions or discoveries that may be of potential commercial value and may be patented and licensed for the development of new products. Donors of blood, tissue and other biological materials do not retain any property rights to the materials. Therefore, you would not share in any money or other benefits that any entity might receive for these inventions or discoveries.
5. **Will my confidentiality be protected?** Federal law requires that City of Hope protect the confidentiality of the information that identifies you. Your specimens will be given a coded number and stored based on that code. This coded number can be linked back to limited health information from your medical record. Your information may also be shared with City of Hope oversight committees and/or regulatory agencies as listed in paragraph 4 of the attached "*Authorization to Use and Disclose Your Protected Health Information (PHI) for Purposes of this Study*" form. If information learned from this study is published, you will not be identified by name.
6. **Will it cost me anything to participate in this study?** No, there is no cost to you to participate.
7. **New Information?** You will be informed if there are any significant protocol changes or other new information related to this study that might affect your willingness to continue to participate.
8. **What if I change my mind later?** You can withdraw from the study at any time by contacting the study staff at (626) 256-HOPE (4673), Ext: 89142 and requesting the "*Withdrawal of Informed Consent for Use of Specimens for Future Research*" form. Once City of Hope processes your signed Withdrawal form, your specimens will not be used in any new research. Specimens already given out to investigators for research cannot be taken back.
9. **What if I have questions?**
   - If you have any additional questions regarding this research program, or feel you have sustained a research-related injury or have been harmed in any way, you may call the Principal Investigator, Dr. Dennis Weisenburger, at (626) 256-HOPE (4673), Ext: 89142.
   - If you have any questions regarding your rights as a research participant, you may call the Office of Human Research Subjects Protection at (626) 256-HOPE (4673), Ext: 62700.

SIGNATURE FOR CONSENT: By signing this consent form, you are making a decision to participate in this research study. Your signature on this informed consent form indicates that you:

- Have had the information in this form explained to you.
- Have had a chance to ask questions and these questions were answered to your satisfaction.

You will receive a copy of this signed consent form, which includes the "Experimental Subject's Bill of Rights."

RESEARCH PARTICIPANT PRINTED NAME: HANNA, ADEL	SIGNATURE:	DATE**: 09/13/2018	TIME**: 11:45
LEGALLY AUTHORIZED REPRESENTATIVE (Parent 1) PRINTED NAME:	SIGNATURE:	DATE**:	TIME**:
IF LEGALLY AUTHORIZED REPRESENTATIVE HAS SIGNED ABOVE, PLEASE INDICATE RELATIONSHIP TO PARTICIPANT:			
LEGALLY AUTHORIZED REPRESENTATIVE (Parent 2) PRINTED NAME:	SIGNATURE:	DATE**:	TIME**:
IF LEGALLY AUTHORIZED REPRESENTATIVE HAS SIGNED ABOVE, PLEASE INDICATE RELATIONSHIP TO PARTICIPANT:			
PRINTED NAME OF CONSENTER:	SIGNATURE: E-Signed: Stella Montes	DATE 09/13/2018	TIME 11:45

*** For paper consent only, date/time must be in participant's handwriting / does not apply to electronic consent*

INTERPRETER: BY SIGNING, I ATTEST I ACTED AS INTERPRETER AND FACILITATED THIS CONSENT PROCESS.			
PRINTED NAME OF TRANSLATOR:	SIGNATURE:	DATE	TIME
WITNESS: BY SIGNING, I ATTEST I WITNESSED THE CONSENT PROCESS AND THE ENTIRE CONSENT FORM WAS DISCUSSED:			
PRINTED NAME OF WITNESS:	SIGNATURE:	DATE	TIME

AUTHORIZATION TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) FOR PURPOSES OF THIS STUDY:

Purpose of this Authorization and Who May Disclose Your Personal Health Information: As part of this research, you are agreeing to allow City of Hope National Medical Center (City of Hope) to use and share with others your protected health information (PHI), as needed for the research study referenced above (the "Study"). You are also agreeing to allow other health care providers to disclose your health information to City of Hope for purposes of the research.

Information About You that is Covered By this Authorization: PHI refers to information that we maintain about you that identifies you, including information in your medical record related to your health, treatment, your medical history, exam and test results and other diagnostic and medical procedures. While this study is not targeting highly confidential information, information about the existence of genetically handicapping conditions may be collected if patients with genetically handicapping conditions agree to participate. If you sign this form, you are allowing City of Hope and the individuals indicated below to use and disclose any PHI we maintain about you, including information about the existence of genetically handicapping conditions for purposes of this study. Additionally, you are authorizing your other health care providers to provide copies of your complete medical record, including information regarding genetically handicapping conditions, to City of Hope for purposes of the research.

Purposes for Uses and Sharing of Your PHI; Who Will Use, Share and Receive Your PHI: Your PHI will be used and shared with others for the purpose of doing this research as described in the Study Consent Form. Your PHI will also be used to keep the research sponsor informed about this Study, for reporting to those individuals and authorities responsible for overseeing our research activities to make sure that the activities are properly conducted, and to report to regulatory agencies as required.

The people authorized to use and disclose your PHI for purposes of the Study include the Principal Investigator and research staff supporting the Study; your City of Hope physicians and health care team; and the Health Information Management Services Department. This also includes any agents or contractors used by these individuals or groups for purposes of conducting or managing this Study. At City of Hope, the Institutional Review Board, Data & Safety Monitoring Committee and other research oversight committees will have access to your PHI to monitor research. You are also allowing your PHI to be shared with regulatory agencies, such as the Office for Human Research Protections, the National Cancer Institute, and with any person or agency as required by law.

This study involves tissue banking (storing your specimens such as blood or tumor tissue). The banked tissue will be stored indefinitely at the City of Hope Biospecimen Repository. No other additional uses and disclosures other than for the purposes of the Study are covered by this authorization. City of Hope's Notice of Privacy Practices will continue to govern the use and disclosure of your PHI for non-Study purposes. If necessary, another separate permission will be obtained from you for any non-Study uses or disclosures of your PHI.

Expiration of this Authorization: One hundred (100) years from the date of your signature.

Further Sharing of Your PHI: City of Hope maintains control over your PHI at present, but once we share this information with a third party (for example, an individual or agency outside of the City of Hope), then it is no longer possible to maintain the same level of protection. The persons outside our control may not be governed by federal or state privacy laws and it is possible that they could share your PHI with others for whom you have not given permission. Information from this Study may be published in scientific journals or presented at scientific meetings but your identity will be kept confidential.

Your Rights Under this Authorization: You may cancel or revoke this Authorization at any time by contacting City of Hope's Privacy Officer at (626) 256-HOPE (4673) ext. 64025. Ask for the **Revocation (Cancellation) of Authorization for Use of Protected Health Information for Research** form. Fill this form out and return it as the form instructs. If you cancel this Authorization, your PHI will no longer be used or disclosed for this Study, and you will no longer be able to participate in the Study. However, PHI shared about you prior to receiving your cancellation cannot be taken back. As a result, PHI already shared prior to the revocation of your authorization will continue to be used as necessary for the integrity of the Study.

Signing this Authorization is Your Choice: Your ability to obtain care at City of Hope will not be affected by your decision to sign this authorization form. You will be able to continue to receive health care at City of Hope if you choose not to sign this authorization form or if you sign this form and later cancel your permission to use and share your PHI.
If you agree to the use and sharing of your PHI, sign below. You will be given a copy of this authorization form.

RESEARCH PARTICIPANT PRINTED NAME: HANNA, ADEL	SIGNATURE:	DATE**: 09/13/2018	TIME**: 11:45
LEGALLY AUTHORIZED REPRESENTATIVE (Parent 1) PRINTED NAME:	SIGNATURE:	DATE**:	TIME**:
IF LEGALLY AUTHORIZED REPRESENTATIVE HAS SIGNED ABOVE, PLEASE INDICATE RELATIONSHIP TO PARTICIPANT:			
LEGALLY AUTHORIZED REPRESENTATIVE (Parent 2) PRINTED NAME:	SIGNATURE:	DATE**:	TIME**:
IF LEGALLY AUTHORIZED REPRESENTATIVE HAS SIGNED ABOVE, PLEASE INDICATE RELATIONSHIP TO PARTICIPANT:			
PRINTED NAME OF CONSENTER:	SIGNATURE: E-Signed: Stella Montes	DATE 09/13/2018	TIME 11:45

*** For paper consent only, date/time must be in participant's handwriting / does not apply to electronic consent.*

INTERPRETER: BY SIGNING, I ATTEST I ACTED AS INTERPRETER AND FACILITATED THIS CONSENT PROCESS.			
PRINTED NAME OF TRANSLATOR:	SIGNATURE:	DATE	TIME
WITNESS: BY SIGNING, I ATTEST I WITNESSED THE CONSENT PROCESS AND THE ENTIRE CONSENT FORM WAS DISCUSSED:			
PRINTED NAME OF WITNESS:	SIGNATURE:	DATE	TIME

City of Hope

CERTIFICATION OF COMPLETION OF THE INFORMED CONSENT

Principal Investigator: Vincent Chung, MD
Department/Division: Dept of Information Sciences

IRB#: 15320

Study Title: The Total Cancer Care Protocol: A Lifetime Partnership with Patients of the City of Hope

Consent Title: CITY OF HOPE – Informed Consent (English)

I have discussed the "Informed Consent for Participation in Research Activities" for the above referenced research study, with the research participant listed below (or the research participant's legally authorized representative), including the possible benefits, risks, and discomforts involved in his/her participation on the study, as well as potential alternatives.

The research participant has been encouraged to ask questions and has received answers to any questions asked. The research participant has affirmed that he/she has received all information that he/she desires at this time, and has indicated that he/she understands and wishes to proceed with participation in the research study.

By his/her signature on the informed consent, the research participant has authorized and consented to participation in the research study, and has been provided with a copy of the signed consent form.

INDIVIDUAL PERFORMING CONSENT (PLEASE PRINT)	SIGNATURE TITLE	DATE TIME
	E-Signed: Stella Montes	09/13/2018 11:46

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INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

IRB #15320: Total Cancer Care Protocol: A Lifetime Partnership with Patients of the City of Hope

EXPERIMENTAL SUBJECT'S - BILL OF RIGHTS

Below are the rights of every person asked to be in a research study ("research") as an experimental subject:

1. To be told what the research is trying to find out
2. To be told what will happen to you and whether any of the procedures, drugs, or devices to be used is different from what would be used in standard practice
3. To be told the risks, side effects, or discomforts of the things that will happen to you as part of the research
4. To be told if you can expect any benefit from participating in the research, and, if so, what the benefit might be
5. To be told of the other choices you have and how they may be better or worse than being in the research
6. To be allowed to ask any questions concerning the research, both before agreeing to be in the research and during the course of the research
7. To be told what medical treatment is available if any complications arise,
8. To refuse to participate in the research or change your mind about participation after the research is started. To be informed that this decision will not affect your right to receive the care you would receive if you were not in the research
9. To receive a copy of the signed and dated research consent form,
10. To be free of pressure when considering whether you wish to agree to be in the research.

PURPOSE: City of Hope's mission is the prevention, treatment and cure of cancer and other diseases through research and patient care. In keeping with our mission, researchers need to study various types of tumors, cancer cells and genes to better understand what causes cancer and learn new ways to prevent, treat, and cure it. Recent research suggests that unique changes in small molecules (such as DNA or proteins) stored in your blood, tissues and body fluids may explain why patients who have the same type of cancer and receive the same treatment do not always have the same results. We believe that by studying the genetic information and clinical data from thousands of patients just like you, we will be better able to develop treatments that are matched to the genetics of each patient – this approach is known as "Personalized Medicine".

The "*Total Cancer Care Protocol*" is a long-term partnership between you, City of Hope and the physicians and scientists who work with us at research affiliates and consortium sites as members of the Oncology Research Information Exchange Network (ORIEN). ORIEN is a unique research collaboration among North America's top cancer centers and our goal is to stay in touch with you for as long as the study remains in progress which we hope will be for your lifetime. We are building a large database of information and biological specimens that will be used for ongoing and future research studies to find better ways to prevent, diagnose and treat cancer. Taking part in this research is voluntary. Your alternative is not to participate. Your decision whether or not to participate will not affect your care at City of Hope. There are three components to this research:

1. **Specimen Banking (Tissue & Blood)**:
   - Tissues, body fluids and blood specimens collected and stored under IRB#07047, "*A City of Hope Protocol for Collecting, Banking and Releasing Human Biological Materials and Health Information for Research*" and IRB#18067, *"A Hematopoietic Tissue Biorepository for Research"* may be used by researchers at City of Hope and other ORIEN research affiliates and consortium sites for ongoing or future studies.
   - Researchers may request your specimens from other institutions where you have received treatment.
2. **Medical Information**:
   - We will review your past, current and future medical records to study all aspects of your medical care, even if your medical care was provided elsewhere or was transferred to another doctor. This may include health questionnaires that you completed during your visit.

- We may also contact you up to one time per year to update your medical history using a brief questionnaire. This will take no longer than 1 hour of your time, no more than once per year.

3. **Future Studies**:
   - Information collected as part of this research will be stored in the study database and may be used for future research purposes and to match patients to future research studies that may benefit them. We may contact you in the future to take part in other research studies, if we find clinical trials that might be suited to you, or to discuss other matters associated with this study. If you chose to take part in future clinical trials, there will be a new informed consent process for those studies.

WHAT WOULD BE REQUIRED OF ME TO PARTICIPATE?

1. **How long will I be asked to stay in this study**? When you agree to take part in this study, we will follow you for as long as the study remains in progress, which we hope will be for the rest of your life.
2. **Are there risks to me if I participate in this study**? There are no physical risks associated with this study. There is a risk that your confidential information could be unintentionally released; however, there are security measures in place to ensure that this risk is small. It is possible that your specimens may be used to study changes in genetic material which may influence the development of diseases including cancer and/or the effectiveness of specific treatments. A federal law established in 2008 called the Genetic Information Nondiscrimination Act (GINA), generally makes it illegal for health insurance companies, group health plans, and employers of 15 or more persons to discriminate against you based on your genetic information.
3. **Will I benefit from participating?** You will not benefit directly from participation in this study. However, knowledge gained from research involving your information or specimens may benefit others in the future. We may contact you about future studies that may involve new study drugs, medications or other research related matters, which may benefit you.
4. **What kind of research will my specimens be used for?** The data, blood, and tissue that you donate to the City of Hope for the purpose of this research study may be used immediately for research or stored indefinitely at City of Hope for future research purposes. These future studies may involve testing on genetic material from your blood and tissue. Future research studies may be conducted by researchers from City of Hope, other universities, the government, and drug- or health-related companies, and no additional informed consent will be obtained from you.

   The scientific, diagnostic and/or medical nature of the future research is not known. You should not expect to get personal results from research performed under this study. Researchers will study samples and information from many people; it will take many years before they know if the results have any meaning. Your specimens and clinical information may be studied by commercial companies and similar organizations working with City of Hope to make drugs for cancer treatment, some of whom may be providing funding that is being used to offset the costs associated with this study. Some of this research may result in new inventions or discoveries that may be of potential commercial value and may be patented and licensed for the development of new products. Donors of blood, tissue and other biological materials do not retain any property rights to the materials. Therefore, you would not share in any money or other benefits that any entity might receive for these inventions or discoveries.
5. **Will my confidentiality be protected?** Federal law requires that City of Hope protect the confidentiality of the information that identifies you. Your records will be kept in a secure environment and protected to the full extent of the law. To conduct this research, your personal health information and specimens will be shared with M2Gen, a private company serving as the coordinating center for the ORIEN consortium project, as well as with other organizations or individuals that participate in this study and also with the City of Hope oversight committees and/or regulatory agencies as listed in paragraph 4 of the attached "*Authorization to Use and Disclose Your Protected Health Information (PHI) for Purposes of This Study*" form.

In addition to medical information such as cancer diagnosis, treatment and follow-up, personal information shared with M2Gen will also include your date of birth, city/state/county/zip code pertaining to your place of residence and dates related to your medical treatment such as dates of diagnosis, treatment, specimen collections, etc. If information learned from this study is published, you will not be identified by name.

6. **Will it cost me anything to participate in this study?** No, there is no cost to you to participate.
7. **What if I change my mind later?** You can withdraw from the study at any time by contacting the study staff at (626) 256-HOPE (4673), Ext: 89142 and requesting the "*Withdrawal of Informed Consent for Use of Specimens for Future Research*" form. Once City of Hope processes your signed Withdrawal form, your specimens and health information will not be used in any new research. Specimens and information already given out to investigators for research, and the results of research already performed prior to withdrawal of consent, cannot be taken back.
8. **What if I have questions?**
   - If you have any additional questions regarding this research program, or feel you have sustained a research-related injury or have been harmed in any way, you may call the Principal Investigator, Dr. Vincent Chung at 626-256-4673, Ext. 89200.
   - If you have any questions regarding your rights as a research participant, you may call the Office of Human Research Subjects Protection at (626) 256-HOPE (4673), Ext: 62700.

SIGNATURE FOR CONSENT:

By signing this consent form, you are making a decision to participate in this research study. Your signature on this informed consent form indicates that you:

- Have had the information in this form explained to you.
- Have had a chance to ask questions and these questions were answered to your satisfaction.

You will receive a copy of this signed consent form, which includes the "Experimental Subject's Bill of Rights."

RESEARCH PARTICIPANT PRINTED NAME:	SIGNATURE:	DATE**: TIME**:
HANNA, ADEL		09/13/2018 11:46
PRINTED NAME OF CONSENTER:	SIGNATURE:	DATE**: TIME**:
	E-Signed: Stella Montes	09/13/2018 11:46

** *For paper consent only, date/time must be in participant's handwriting / does not apply to electronic consent.*

INTERPRETER: BY SIGNING, I ATTEST I ACTED AS INTERPRETER AND FACILITATED THIS CONSENT PROCESS.		
PRINTED NAME OF TRANSLATOR:	SIGNATURE:	DATE TIME
WITNESS: BY SIGNING, I ATTEST I WITNESSED THE CONSENT PROCESS AND THE ENTIRE CONSENT FORM WAS DISCUSSED:		
PRINTED NAME OF WITNESS:	SIGNATURE:	DATE TIME

IRB #15320: Total Cancer Care Protocol:

A Lifetime Partnership with Patients of the City of Hope

AUTHORIZATION TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) FOR PURPOSES OF THIS STUDY:

Purpose of this Authorization and Who May Disclose Your Personal Health Information: As part of this research, you are agreeing to allow City of Hope National Medical Center (City of Hope) to use and share with others your protected health information (PHI), as needed for the research study referenced above (the "Study"). You are also agreeing to allow other health care providers to disclose your health information to City of Hope for purposes of the research.

Information About You that is Covered By this Authorization: PHI refers to information that we maintain about you that identifies you, including information in your medical record related to your health, treatment, your medical history, exam and test results and other diagnostic and medical procedures. While this study is not targeting highly confidential information, information about HIV/AIDS, mental health, substance abuse, and the existence of genetically handicapping conditions may be collected if patients with these conditions agree to participate. If you sign this form, you are allowing City of Hope and the individuals indicated below to use and disclose any PHI we maintain about you, including information about HIV/AIDS, mental health, substance abuse and the existence of genetically handicapping conditions for purposes of this study. Additionally, you are authorizing your other health care providers to provide copies of your complete medical record, including information regarding HIV/AIDS, mental health, substance abuse, and genetically handicapping conditions, to City of Hope for purposes of the research.

Purposes for Uses and Sharing of Your PHI; Who Will Use, Share and Receive Your PHI: Your PHI will be used and shared with others for the purpose of doing this research as described in the Study Consent Form. Your PHI will also be used to keep the research sponsor informed about this Study, for reporting to those individuals and authorities responsible for overseeing our research activities to make sure that the activities are properly conducted, and to report to regulatory agencies as required.

To do this research, the following people and/or organization(s) will be allowed to disclose, use, and receive your information, but they may only use and disclose the information to the other parties on this list, to you or your personal representative, or as permitted by law:

- Every research site for this study, including City of Hope, and each site's study team, research staff and medical staff or any person who provides services in connection with this study. This also includes any agents or contractors used by these individuals or groups for purposes of conducting or managing this Study.
- Pharmaceutical companies, sponsors, clinical research organizations and similar organizations or their agents working with City of Hope in commercial drug research, and companies whom may be providing funding for this study.

- Any organization participating in an approved research-related data or information exchange in connection with this study.
- Any laboratories, individuals, and organizations that use your health information in connection with this study.
- Any federal, state, or local governmental agency that regulates the study, such as the U.S. Food and Drug Administration (FDA), U.S. Department of Health & Human Services (DHHS), Office for Human Research Protections (OHRP), or other government agencies as required by law.
- Controlled-access public research data repositories required for broad data sharing, including NIH-designated data repositories.
- The designated Protocol Review and Monitoring Committees, Institutional Review Boards, Privacy Boards, Data and Safety Monitoring Board and their related staff that have oversight responsibilities for this study.
- The National Cancer Institute in evaluating the ongoing research of any organization participating in this study in connection with their designation as a Comprehensive Cancer Center.

This study involves tissue banking (storing your specimens such as blood or tumor tissue). The banked tissue will be stored indefinitely at the City of Hope Biospecimen Repository. No other additional uses and disclosures other than for the purposes of the Study are covered by this authorization. City of Hope's Notice of Privacy Practices will continue to govern the use and disclosure of your PHI for non-Study purposes. If necessary, another separate permission will be obtained from you for any non-Study uses or disclosures of your PHI.

Expiration of this Authorization: One hundred (100) years from the date of your signature.

Further Sharing of Your PHI: City of Hope maintains control over your PHI at present, but once we share this information with a third party (for example, an individual or agency outside of the City of Hope), then it is no longer possible to maintain the same level of protection. The persons outside our control may not be governed by federal or state privacy laws and it is possible that they could share your PHI with others for whom you have not given permission. Information from this Study may be published in scientific journals or presented at scientific meetings but your identity will be kept confidential.

Your Rights Under this Authorization: You may cancel or revoke this Authorization at any time by contacting City of Hope's Privacy Officer at (626) 256-HOPE (4673) ext. 64025. Ask for the **Revocation (Cancellation) of Authorization for Use of Protected Health Information for Research** form. Fill this form out and return it as the form instructs. If you cancel this Authorization, your PHI will no longer be used or disclosed for this Study, and you will no longer be able to participate in the Study. However, PHI shared about you prior to receiving your cancellation cannot be taken back. As a result, PHI already shared prior to the revocation of your authorization will continue to be used as necessary for the integrity of the Study.

Signing this Authorization is Your Choice: Your ability to obtain care at City of Hope will not be affected by your decision to sign this authorization form. You will be able to continue to receive health care at City of Hope

if you choose not to sign this authorization form or if you sign this form and later cancel your permission to use and share your PHI.

If you agree to the use and sharing of your PHI, please sign below. You will be given a copy of this authorization form.

RESEARCH PARTICIPANT PRINTED NAME:	SIGNATURE:	DATE**: TIME**:
HANNA, ADEL		09/13/2018 11:46
PRINTED NAME OF CONSENTER:	SIGNATURE:	DATE TIME
	E-Signed: Stella Montes	09/13/2018 11:46

*** For paper consent only, date/time must be in participant's handwriting / does not apply to electronic consent.*

INTERPRETER: BY SIGNING, I ATTEST I ACTED AS INTERPRETER AND FACILITATED THIS CONSENT PROCESS.		
PRINTED NAME OF TRANSLATOR:	SIGNATURE:	DATE TIME
WITNESS: BY SIGNING, I ATTEST I WITNESSED THE CONSENT PROCESS AND THE ENTIRE CONSENT FORM WAS DISCUSSED:		
PRINTED NAME OF WITNESS:	SIGNATURE:	DATE TIME

CONSENT FOR SURGERY / PROCEDURE - PROSTATE BIOPSY

1. Upon your authorization and consent, the surgery or procedure listed on the next page will be performed on you at City of Hope National Medical Center ("Hospital"). The surgery or procedure will be performed by the surgeon/physician named on the next page (or in the event that he/she is unable to perform or complete the procedure, a qualified substitute surgeon/physician) together with associates and assistants, including anesthesiologists, radiologists, and pathologists, to whom your surgeon/physician may assign designated responsibilities. Your surgeon/physician, and persons performing specialized medical services such as anesthesiologists, radiologists, and pathologists, are not employees or agents of this Hospital; they are independent contractors. The Hospital maintains personnel and facilities to assist your surgeon/physician in the performance of various surgical and other special diagnostic or therapeutic procedures. Any organ, tissue or body part removed in any surgery/procedure will be processed at the discretion of the pathologist.

2. During the course of the surgery or procedure, different or further procedures, which, in the opinion of the surgeon/physician, may be indicated due to an emergency or due to a previously unforeseen condition that has been revealed during the surgery or procedure and necessitates an extension of the surgery or procedure, will be performed on you. Your signature on this form serves as your authorization and consent that your surgeon/physician may perform such different or further procedures as are necessary per his/her professional judgment.

3. The surgery or procedure may include possible complications, injury or even death, from both known and unknown causes. No warranty or guarantee is made as to result or cure. You have the right to be informed by your surgeon/physician of these risks as well as the nature of the surgery or procedure, the effects and benefits, the discomforts and any adverse reactions that may reasonably be expected to occur, any alternative methods of treatment which may be medically viable and their risks and benefits. Except in cases of emergency, a surgery or procedure will not be performed until you have had the opportunity to receive this information and have given your consent. You also have the right to be informed whether your surgeon/physician has any independent medical research or economic interests related to the performance of the proposed surgery or procedure.

4. Anesthesia or sedation may be recommended for your surgery or procedure. If so, your physician or the anesthesiologist will discuss the plan for anesthesia/sedation and its risks, benefits, discomforts, and alternatives with you and obtain your consent.

5. Your surgeon/physician will inform you if he/she believes that there is a reasonable possibility that you may need a blood transfusion as a result of the surgery or procedure to which you are consenting. The surgeon/physician will also provide you with a brochure published by the California Department of Health Services, which contains information concerning the benefits and risks of the various options for blood transfusions, including pre-donation by yourself and others. You have the right to consent or refuse consent to any transfusion. You should discuss any questions that you may have about transfusions with your surgeon/physician.

6. During the course of the surgery or procedure, your surgeon/physician may photograph or otherwise image the site of the surgery or procedure. These images may be used as part of a scientific presentation or in a professional publication, but you will not be identified without your prior written authorization.

7. Your surgeon/physician is Dr. Clayton Lau who has recommended the following surgery or procedure to be beneficial in the diagnosis and/or treatment of your condition:
Diagnosis/Clinical Impression (simple language): Elevated prostate specific antigen (PSA)
Description of Surgery or Procedure (simple language): **Surgical sampling of prostatic tissue through rectum with a biopsy needle under ultrasound guidance.**
Technical Name of Surgery/Procedure: **Transrectal ultrasound-guided prostate biopsy.**

8. The Centers for Medicare and Medicaid Services require that you be informed of the practitioners performing significant tasks during your surgery or procedure. These practitioners include physician-trainees, such as fellows and residents, and qualified medical practitioners who are not physicians with the requisite skill set and privileges to perform the task, all of whom are supervised by your surgeon/physician in accordance with medical staff and hospital policies. "Significant tasks" include, but are not limited to, opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues, and endoscopic evaluation.
You should also be informed of those persons who may observe your surgery or procedure such as visiting physicians, students, and vendors.
The names and status of the practitioners performing significant tasks and the persons observing will be recorded in your medical record following the surgery or procedure.

9. By signing this form you acknowledge that: (a) you have read and understood the information provided; (b) the nature of the surgery or procedure has been adequately explained to you by your surgeon/physician, along with the benefits and effects, risks, discomforts, and alternative methods of treatment and their risks and benefits; (c) you have had the opportunity to ask questions and your questions have been answered; (d) you have received all information you desire concerning the surgery or procedure; and (e) you authorize and consent to the performance of the surgery or procedure.

TRANSLATION (if necessary) - I have accurately and completely read the foregoing document to the signator identified below in the patient's or personal representative's primary language. He/she understood all terms and conditions and acknowledged his/her agreement by signing this document in my presence.

PRIMARY LANGUAGE, IF NOT ENGLISH:

TRANSLATOR PRINTED NAME	SIGNATURE / TITLE / DEPT	DATE	TIME

PATIENT OR PERSONAL REPRESENTATIVE PRINTED NAME	SIGNATURE	DATE	TIME
x Adel S. Hanna, M.D		9-13-18	13:50

If Personal Representative has signed above, indicate your relationship to the patient:
☐ Parent ☐ Guardian ☐ Conservator ☐ Agent ☐ Other

REASON PATIENT DID NOT SIGN:

WITNESS PRINTED NAME	SIGNATURE / TITLE / DEPT	DATE	TIME
Rebecca Lee	Rebecca Lee RN	9/13/18	1351

CERTIFICATION: I have discussed the above surgery or procedure with this patient, including the risks and benefits, discomforts, likelihood of success and any adverse reactions that may reasonably be expected to occur, and any alternative methods of treatment, which may be medically viable. I have answered the patient's questions regarding the surgery or procedure, and the patient has indicated that he/she understands and wishes to proceed.

PHYSICIAN PRINTED NAME	SIGNATURE / TITLE	DATE	TIME

CONSENT FOR SURGERY / PROCEDURE

1 Upon your authorization and consent, the surgery or procedure listed on the next page will be performed on you at City of Hope National Medical Center ("Hospital") The surgery or procedure will be performed by the surgeon/physician named on the next page (or in the event that he/she is unable to perform or complete the procedure, a qualified substitute surgeon/physician) together with associates and assistants, including anesthesiologists, radiologists, and pathologists, to whom your surgeon/physician may assign designated responsibilities Your surgeon/physician, and persons performing specialized medical services such as anesthesiologists, radiologists, and pathologists, are not employees or agents of this Hospital, they are independent contractors The Hospital maintains personnel and facilities to assist your surgeon/physician in the performance of various surgical and other special diagnostic or therapeutic procedures Any organ, tissue or body part removed in any surgery/procedure will be processed at the discretion of the pathologist

2 During the course of the surgery or procedure, different or further procedures, which, in the opinion of the surgeon/physician, may be indicated due to an emergency or due to a previously unforeseen condition that has been revealed during the surgery or procedure and necessitates an extension of the surgery or procedure, will be performed on you Your signature on this form serves as your authorization and consent that your surgeon/physician may perform such different or further procedures as are necessary per his/her professional judgment

3 The surgery or procedure may include possible complications, injury or even death, from both known and unknown causes No warranty or guarantee is made as to result or cure You have the right to be informed by your surgeon/physician of these risks as well as the nature of the surgery or procedure, the effects and benefits, the discomforts and any adverse reactions that may reasonably be expected to occur, any alternative methods of treatment which may be medically viable and their risks and benefits Except in cases of emergency, a surgery or procedure will not be performed until you have had the opportunity to receive this information and have given your consent You also have the right to be informed whether your surgeon/physician has any independent medical research or economic interests related to the performance of the proposed surgery or procedure

4 Anesthesia or sedation may be recommended for your surgery or procedure If so, your physician or the anesthesiologist will discuss the plan for anesthesia/sedation and its risks, benefits, discomforts, and alternatives with you and obtain your consent

5 Your surgeon/physician will inform you if he/she believes that there is a reasonable possibility that you may need a blood transfusion as a result of the surgery or procedure to which you are consenting The surgeon/physician will also provide you with a brochure published by the California Department of Health Services, which contains information concerning the benefits and risks of the various options for blood transfusions, including pre-donation by yourself and others You have the right to consent or refuse consent to any transfusion You should discuss any questions that you may have about transfusions with your surgeon/physician

6 During the course of the surgery or procedure, your surgeon/physician may photograph or otherwise image the site of the surgery or procedure These images may be used as part of a scientific presentation or in a professional publication, but you will not be identified without your prior written authorization

7 Your surgeon/physician is Dr LAU who has recommended the following surgery or procedure to be beneficial in the diagnosis and/or treatment of your condition

Diagnosis/Clinical Impression (simple language) ELEVATED PSA

Description of Surgery or Procedure (simple language) BIOPSY PROSTATE

Technical Name of Surgery/Procedure TRANSRECTAL ULTRASOUND GUIDED PROSTATE BIOPSY

8 The Centers for Medicare and Medicaid Services require that you be informed of practitioners performing significant tasks during your surgery or procedure These practitioners include physician-trainees, such as fellows and residents, and qualified medical practitioners who are not physicians with the requisite skill set and privileges to perform the task, all of whom are supervised by your surgeon/physician in accordance with medical staff and hospital policies "Significant tasks" include, but are not limited to, opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues and endoscopic evaluation You should also be informed of those persons who may observe your surgery or procedure such as visiting physicians, students, and vendors The names and status of practitioners performing significant tasks and persons observing your surgery or procedure will be recorded in your medical record following the surgery or procedure

9 By signing this form you acknowledge that (a) you have read and understood the information provided, (b) the nature of the surgery or procedure has been adequately explained to you by your surgeon/physician, along with the benefits and effects, risks, discomforts, and alternative methods of treatment and their risks and benefits, (c) you have had the opportunity to ask questions and your questions have been answered, (d) you have received all information you desire concerning the surgery or procedure, and (e) you authorize and consent to the performance of the surgery or procedure

TRANSLATION (if necessary) - I have accurately and completely read the foregoing document to the signator identified below the patient's / patient representative's primary language He/she understood all terms and conditions and acknowledged his/her agreement by signing this document in my presence

PRIMARY LANGUAGE, IF NOT ENGLISH

TRANSLATOR PRINTED NAME	SIGNATURE	TITLE / DEPARTMENT	DATE	TIME

PATIENT OR PERSONAL REPRESENTATIVE PRINTED NAME	SIGNATURE	DATE	TIME
	Hanna MD	9/17/18	1500

If Personal Representative has signed above, please indicate your relationship to the patient
☐ **Parent** ☐ **Guardian** ☐ **Conservator** ☐ **Agent** ☐ **Other**

REASON PATIENT DID NOT SIGN

WITNESS PRINTED NAME	SIGNATURE	TITLE / DEPARTMENT	DATE	TIME
A. ROMERO			9/17/18	1500

CERTIFICATION I have discussed the above surgery or procedure with this patient, including the risks and benefits, discomforts, likelihood of success and any adverse reactions that may reasonably be expected to occur, and any alternative methods of treatment, which may be medically viable I have answered the patient's questions regarding the surgery or procedure, and the patient has indicated that he/she understands and wishes to proceed

PHYSICIAN / SURGEON PRINTED NAME	SIGNATURE	TITLE	DATE	TIME
LAU			9/17/18	1500