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This document is part of the legal medical record.

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HANNA, ADEL S

Admitted: 12/23/14 at 1149 Room/Bed: 228T B Attending: Lally, James M.

Chino Valley Medical Center

NURDE1 Acct: V0000060380 Unit: MOOO27 81

. . Personal Belongings Inventory 12/24/14 0949 ED

Inventory Date: 12/24/14 Inventory Time: 0949 Performed By: Deharo, Eric Reason For Inventory: DISCHARGE

-N Contacts	-Y Glasses	Disposition: BELONGINGS KEPT BY PT	Disposition:
-N Full Dentures -N Partial Upper -N Hearing Aid	-N Lower	Disposition: Disposition: Disposition:	Disposition:

Any Belongings Sent To Hospital Safe: N

Any Belongings Sent Home With Family: N

Date:

NOTE: Chino Valley Medical Center will only be responsible for items logged at the time of admission. Should Dentures, Hearing Aids, Eye Glasses be brought to the patient after admission, they must be logged with the Primary Nurse or Charge Nurse. Chino Valley Medical Center will not be responsible for any item not logged on the Belongings Form.

<< RELEASE OF LIABILITY OF VALUABLES KEPT WITH PATIENT >> By Signing Below I Indicate I Have Been Advised To Send My Valuables Home With Family/ Friends, And Have Been Given The Opportunity To Have My Valuables Locked Up.

If I Refuse To Have My Valuables Locked Up Or Sent Home With Family Or Friends, I Release Chino Valley Medical Center From Any Liability For Lost Valuables.

PATIENT:	
WITNESS:	

By Signing Below J Indicate I Have All My Belongings At The Time Of Discharge. Date: 1 (PATIENT: WITNESS:

Admitted: 12/23/14 at 1149 Room/Bed: 228T B Attending: Lally, James M.

NURDE1

Deharo,Eric

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ED

Chino Valley Medical Center



Monogram Initials Name Nurse Type

RN

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02/15/2023

FOOD - DRUG INTERACTION SHEET

If you are taking a drug, the food you eat could affect the speed and amount of absorption of your medication. Please refer to the following chart to determine how you should take your medication(s). Medications should be taken with a full glass of water to decrease the chances of nausea and vomiting unless instructed otherwise.

.

1	ANTICOAGULANTS	F00	DS HIGH IN:
Warfarin Coumadin	 Limit foods in vitamin K Avoid nutritional supplements high in vitamin K / vitamin E Limit caffeine Limit fried or boiled onions Limit cranberry juice (less than 8 oz. day) Limit soybean oil 	VITAMIN K Leafy green vegetables, broccoli, cabbage, cauliflower, lettuce, peas, spinach, turnip greens, green herbal teas PROTEIN Meat, fish, milk, eggs,	POTASSIUM Avocado, artichokes, bananas, milk, legumes, mushrooms, peaches, raisins, tomatoes, dates, figs, melons, nectarines, potatoes, rhubarb, turnip greens VITAMIN C
Digitalis Digitoxin Crystodigin Digitoxin Digoxin Lanoxin Lanoxicap Quinidine	 ANTIARRHYTHMICS Take separately from high . bran fiber or high pectin foods Maintain diet high in potassium - low in sodium Avoid licorice Best if taken on empty stomach Use caution when taking potassium supplements 	poultry, cheese, peanut butter CALCIUM Milk, cheese, Ice cream, yogurt, salmon, leafy green vegetables, tofu, corn tortillas, sardines BRAN FIBER	Oranges and/or other citrus fruit or juices, tomatoes and/or juice, strawberries, pineapple and/or juice TYRAMINE Aged cheese, aged meat, anchovies, avocados, beer, broad beans, pickled
Ciprofloxacin Doxycycline Tetracycline Quinolone	 ANTIBIOTICS Take separately from dairy foods, foods high in calcium content Limit caffeine Take magnesium, calcium, iron or zinc supplements separately 	Bran bread, bran cereals IRON Iron fortified cereals, organ meats, meat, fish, poultry, raisins PECTIN Apples, broccoli,	herring, sausages, sour cream, soy sauce, wine, brewers yeast, meat extracts, yogurt, fava beans, snow peas SODIUM Table salt / garlic salt / onion salt, food or seasonings
Penicillin Zyvox	 Take with water or empty stomach Avoid acidic beverages Avoid foods high in tyramines 	brussel sprouts, pears, spinach, sweet potatoes Your dietitian can pro	containing greater than 450 mg per serving wide additional food & drug
-	 Avoid foods high in pressor amines/tyramines Limit Caffeine May need pyruvic supplement ANTIPSYCHOTIC 	Interaction information. Instruction Given By: If you have any questions or how to take your m	Date/Time s about Adverse Drug Reactions nedication, please consult your
Lithium	 Drink 8 - 10 cups of water daily. Maintain consistent level of salt/ sodium intake daily Do not begin a low sodium diet Take after a meal or snack Limit caffeine intakes: coffee, tea, colas 	pharmacist or physician. I understand the instruction. PATIENT OR RESP. PARTY:	tions and have received verbal
Chino Valley Medical C 3451 Walnut Ave Chin		AT1 03/	INA,ADEL S DG DR. Lally,James 29/1946 68Y M M000273781 000603802 IN 12/23/2014
FOOD-DRUG INTER EDUCATION PHSI-180-008 (12/09)	ORIGINAL - CHART COPY -PATIENT	PAGE 1 of 2	

Bumex Dyazide Edecrin Esidrix Hydrochlorothiazide Hygroton Lasix Maxzide Zaroxolyn

Ferrous Fumarate

Ferrous gluconate

Femiron

Fergon Ferrous sulfate

Feosol

DIURETICS (Loop-K depleting)

- Increase intake of foods high in potassium and/or supplement with potassium
- Avoid licorice
- Low sodium diet recommended

IRON SUPPLEMENTS

- Do not take with bran or high fiber supplements
- Take separately from caffeine
- Take separately from dairy foods and/or calcium
- Take with foods high in vitamin C
- Take with meat

TAKE WITH MEALS

(To avoid stomach upset) Amitriptyline Nitrofurantoin Allopurinol (Zyloprin) **Oral Hypoglycemics** Carbamazepine Pancrease (Tegretol) Prednisone Cimetidine (Tagament) Propanolol Doxycycline Quinine Extrogens Salicvlates Hydrocortisone Spironolactone Sulfasalazine Imuran Isoniazid Thioridazine KCL (Micro K & other Thorazine K supplements) Trazodone Metronidozole Trental MVI/minerals Macrodantin Niacin Meclizine NSAID (Non-Seroidal Anti-Inflammatory Agents)

NOT TO BE TAKEN WITH ALCOHOLIC BEVERAGES

Amantadine (Symmetrel)
Anticonvulsants
Antihistamines
Barbiturates
Carbamazepine
(Tegretol) - Avoid all forms
of grapefruit
Darvocet N 100
Doxycyline
Disulfiram

Metronidazole Flagyl Narcotic Analgesics Nitrates Oral Diabetic Agents Propranolol Sedatives/Hypnotics Tranquilizers Tylenol & Codeine Vicodin

Chino Valley Medical Cente 3451 Walnut Ave Chino C.		P	ATIENT ID	HANNA,ADEL S ATTDG DR. Lally,James 03/29/1946 68Y M M000273781 V00000603802 IN 12/23/2014
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PHSI-180-008 (12/09)	ORIGINAL - CHART COPY - PATIENT	PAGE 2 of 2		

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Sinusitis

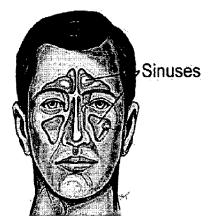
Sinusitis is redness, soreness, and swelling (*inflammation*) of the paranasal sinuses. Paranasal sinuses are air pockets within the bones of your face (beneath the eyes, the middle of the forehead, or above the eyes). In healthy paranasal sinuses, mucus is able to drain out, and air is able to circulate through them by way of your nose. However, when your paranasal sinuses are inflamed, mucus and air can become trapped. This can allow bacteria and other germs to grow and cause infection.

Sinusitis can develop quickly and last only a short time (*acute*) or continue over a long period (*chronic*). Sinusitis that lasts for more than 12 weeks is considered chronic.

CAUSES

Causes of sinusitis include:

- Allergies.
- Structural abnormalities, such as displacement of the cartilage that separates your nostrils (*deviated septum*), which can decrease the air flow through your nose and sinuses and affect sinus drainage.



• Functional abnormalities, such as when the small hairs (*cilia*) that line your sinuses and help remove mucus do not work properly or are not present.

SYMPTOMS

Symptoms of acute and chronic sinusitis are the same. The primary symptoms are pain and pressure around the affected sinuses. Other symptoms include:

- Upper toothache.
- Earache.
- Headache.
- Bad breath.
- Decreased sense of smell and taste.
- A cough, which worsens when you are lying flat.
- Fatigue.
- Fever.
- Thick drainage from your nose, which often is green and may contain pus (*purulent*).
- Swelling and warmth over the affected sinuses.

DIAGNOSIS



Your caregiver will perform a physical exam. During the exam, your caregiver may:

- Look in your nose for signs of abnormal growths in your nostrils (*nasal* polyps).
- Tap over the affected sinus to check for signs of infection.
- View the inside of your sinuses (*endoscopy*) with a special imaging device with a light attached (*endoscope*), which is inserted into your sinuses.

If your caregiver suspects that you have chronic sinusitis, one or more of the following tests may be recommended:

- Allergy tests.
- Nasal culture-A sample of mucus is taken from your nose and sent to a lab and screened for bacteria.
- Nasal cytology-A sample of mucus is taken from your nose and examined by your caregiver to determine if your sinusitis is related to an allergy.

TREATMENT

Most cases of acute sinusitis are related to a viral infection and will resolve on their own within 10 days. Sometimes medicines are prescribed to help relieve symptoms (pain medicine, decongestants, nasal steroid sprays, or saline sprays).

However, for sinusitis related to a bacterial infection, your caregiver will prescribe antibiotic medicines. These are medicines that will help kill the bacteria causing the infection.

Rarely, sinusitis is caused by a fungal infection. In theses cases, your caregiver will prescribe antifungal medicine.

For some cases of chronic sinusitis, surgery is needed. Generally, these are cases in which sinusitis recurs more than 3 times per year, despite other treatments.

HOME CARE INSTRUCTIONS

- Drink plenty of water. Water helps thin the mucus so your sinuses can drain more easily.
- Use a humidifier.
- Inhale steam 3 to 4 times a day (for example, sit in the bathroom with the shower running).
- Apply a warm, moist washcloth to your face 3 to 4 times a day, or as directed by your caregiver.
- Use saline nasal sprays to help moisten and clean your sinuses.



• Take over-the-counter or prescription medicines for pain, discomfort, or fever only as directed by your caregiver.

SEEK IMMEDIATE MEDICAL CARE IF:

- You have increasing pain or severe headaches.
- You have nausea, vomiting, or drowsiness.
- You have swelling around your face.
- You have vision problems.
- You have a stiff neck.
- You have difficulty breathing.

MAKE SURE YOU:

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- Understand these instructions.
- Will watch your condition.
- Will get help right away if you are not doing well or get worse.

Document Released: 12/18/2006 Document Revised: 03/11/2013 Document Reviewed: 01/01/2013 ExitCare(R) Patient Information (C)2013 ExitCare, LLC.



IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS

If you are a Medicare patient review the following message from Medicare about your rights.

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services

OMB Approval No. 0938-0692

AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS

AS A HOSPITAL INPATIENT, YOU HAVE THE RIGHT TO:

- * Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- * Be involved in any decisions about your hospital stay, and know who will pay for it.
- * Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:
 Health Services Advisory Group (HASG)
 Appeal Line - 800-841-1602
 TDD - 800-881-5980

YOUR MEDICARE DISCHARGE RIGHTS

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

IF YOU THINK YOU ARE BEING DISCHARGED TOO SOON:

- * You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- * You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
 - * If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.
 - * If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- * If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- * Step by step instructions for calling the QIO and filing an appeal are below.

To speak with someone at the hospital about this notice, call the Director of Case Management at 909-464-8662.

STEPS TO APPEAL YOUR DISCHARGE

* STEP 1: You must contact the QIO no later than your planned discharge date and



before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).

* Here is the contact information for the CIO: Health Services Advisory Group (HASG)
700 N. Brand Blvd. Suite 370 Glendale, California 92103
Appeal Line - 800-841-1602, FAX# - 866-800-8757
Open 365 days/8-5 PST

* You can file a request for an appeal any day of the week. Once you speak to someone or leave a message, your appeal has begun.

* Ask the hospital if you need help contacting the QIO.

* The name of this hospital is Chino Valley Medical Center.

The Provider ID number is 050586.

* STEP 2: You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.

* STEP 3: The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.

* STEP 4: The QIO will review your medical records and other important information about your case.

* STEP 5: The QIO will notify you of its decision within 1 day after it receives all necessary information.

* If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.

* If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

IF YOU MISS THE DEADLINE TO APPEAL, YOU HAVE OTHER APPEAL RIGHTS: * You can still ask the QIO or your plan (if you belong to one) for a review of your case:

- * If you have Original Medicare: Call the QIO listed above.
- * If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.

* If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227) or TTY: 1-877-486-2048.

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Service	Service	Magnetic Resonance I	maging Orders	
Date	Time	Procedure	Status Result Co	de Report Status
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12/23/14	1735	MRI BRAIN W/WO CONTRAST	IN PRO	Draft
12/23/14	1735	MRI ANGIO BRAIN	IN PRO	Draft
Service	Service	Bharmagy Or	ders	
Date	Time	Pharmacy Or Procedure	Status	
12/23/14	1027	MEDICATIONS	DC ·	
12/23/14	1027	MEDICATIONS	DC	
12/23/14	1137	INTRAVENOUS	ONE	
	1137	IVPB	DC	4
	1138	MEDICATIONS	DC	
12/23/14	-	PYXIS MEDICATION	DC	
12/23/14	1153	MEDICATIONS	ACTIVE	
12/23/14	1153	MEDICATIONS	ACTIVE	
12/23/14	1153	MEDICATIONS	ACTIVE	
12/23/14	1153	MEDICATIONS	ACTIVE	
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Barting Service Specimen to Obtain Orders 12/23/14 1153 SPECIMEN TO OBTAIN TRANS Mondgram Initials Name Nurse Type MLM RXMML Hernandez, Maria L PTECH	ge: 3 of 3				ADEL S (AD			8 M	، Age/Sex:
Date Time Procedure Status Report Number Report 12/23/14 1153 SPECIMEN TO OBTAIN TRANS Wondgram Initials* Name Nurse Type MLM RXMML Hernandez, Maria L PTECH		12/24/14		м.	ly, James	Lall		00000603802	Account#:
Monogram Initials Name	Status	Report S	eport Number				ocedure	and a second state of the	Constraints and a second second second second second
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				е Туре	Nurse		Name	nitials	Monogram
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Age/Sex: 6 Unit #: M Account#: V Admitted: 1	000273781 00000603802	DU-2 Lally,	L S (ADM IN) 228T-B James M. 12 edical Center NUR		Page: 1 1 12/23/14 at 1 12/23/14 at 24 HOUR C
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002877456	BAYER CHILDREN'S A	SP 81 MG	DAILY PO	12/24/14 (01/23/15
002877455	TENORMIN	50 MG	DAILY PO	12/24/14 ()1/23/15 .
002877333	COLACE	100 MG	DAILY PO	12/24/14 (01/23/15
002877332	PRILOȘEC	20 MG	ACBK PO		01/23/15
002877399	FIORICET	1 TAB	Q4HP/PRN PO)1/22/15
002877306	TYLENOL	650 MG	Q6HP/PRN PO)1/22/15
002877308	ZOFRAN	4 MG	Q4HP/PRN IV		01/22/15
002877305	MORPHINE SULFATE	2.MG	Q3HP/PRN IV		12/26/14
002877307	NORCO 7.5/325 TABL		Q4HP/PRN PO		12/26/14
002877281	SODIUM CHL 0.9%	1,000 ML	ONCE/ONE IV		12/23/14
002877309 002877282	SODIUM CHL 0.9% SODIUM CHL 0.9% IV	1,000 ML	Q16H IV ONCE/ONE IV		12/23/14 *DC 12/23/14 *DC
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002877301	UNASYN	5 011	.STK-MED .ROU	12/23/14	12/23/14 *DC
002877283	SUBLIMAZE	25 MCG	ONCE/ONE IV		12/23/14 *DC
002877181	COMPAZINE	5 MG	ONCE/ONE IM		12/23/14 *DC
002877180	MORPHINE SULFATE	4 MG	ONCE/ONE IM		12/23/14 *DC
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Date T	ime Procedure		Status R	eport«Number»	Report Statu
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Date T	ime Procedure		Status R	eport Number	Report Statu
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Account#:				hours ending	12/23/14 at 1700
Admitted:	12/23/14	at 1149 Chino Valley Medica	1 Center NUR		24 HOUR CHECK
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Service	Service	Food and Nutrition S	ervices Order	s	
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12/23/14	1027	COMPREHENSIVE METABOLIC PANEL	COMP		
12/23/14	1027	CBC	COMP		
12/23/14 12/23/14	1153 1153	MAGNESIUM PHOSPHOROUS	COMP COMP		
12/23/14	1153	GLYCOSYLATED HEMOGLOBIN (A1C)	COMP		
12/23/14	1153	BRAIN NATRIURETIC PEPTIDE	COMP		
12/23/14	1153	THYROID PANEL	COMP		
		PROTHROMBIN TIME	COMP		
12/23/14	1153	PARTIAL THROMBOPLASTIN TIME	COMP		
12/23/14	1153	AMYLASE	COMP		
12/23/14	1153	LIPASE	COMP		
Service		Microbiology			
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12/23/14	1153	MRSA CULTURE	IN PRO	NARES	
12/23/14	1232	MRSA CULTURE	IN PRO	NARES	
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NURSING DOCUMENTATION SITE Code: CVMC Name: HANNA, ADEL S

Acct: V00000603802

HANNA, ADEL S (DIS IN) Age/Sex: 68 M Page: 1 of 3 Unit #: M000273781 Printed 12/30/14 at 1649
 Unit #: M000273781
 DU-228T-B
 Printed 12/30/14 at 1649

 Account#: V00000603802
 Lally, James M.
 Date Range:Beginning to 12/30/14
 DU-228T-B Admitted: 12/23/14 at 1149 Chino Valley Medical Center NUR CVMC: NURSING NOTES Recorded Notes: All Categories Occurred Date Time by Author Date Time by Category 12/23/14 1020 MOB Bacani,Marlene O 12/23/14 1023 MOB ED Nursing Notes Abnormal? N Confidential? N ED PHYSICIAN AT BEDSIDE FOR PATIENT EVALUATION. MEDICAL SCREENING EXAMINATION COMPLETED BY ED PHYSICIAN. Note Type Description _____ -----None No Туре 12/23/14 1041 MOB Bacani, Marlene 0 12/23/14 1041 MOB ED Nursing Notes Abnormal? N Confidential? N PT TAKEN TO CT SCAN VIA GURNEY. Note Type Description No Type None 12/23/14 1051 MOB Bacani,Marlene O 12/23/14 1101 MOB ED Nursing Notes Abnormal? N Confidential? N MEDICATED PT AS ORDERED, SEE MAR. WILL MONITOR FOR ADVERSE REACTIONS Note Type Description ----------None No Туре 12/23/14 1130 MOB Bacani, Marlene O 12/23/14 1130 MOB ED Nursing Notes Abnormal? N Confidential? N ALL TEST RESULTS COMPLETE, PATIENT READY FOR MD RE-EVALUATION. Note Type Description -----_____ ______ No Type None 12/23/14 1155 MOB Bacani,Marlene O 12/23/14 1159 MOB ED Nursing Notes Abnormal? N Confidential? N PT TAKEN TO CT SCAN VIA WHEELCHAIR. Note Type Description _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ No Type None 12/23/14 1200 MOB Bacani, Marlene O 12/23/14 1250 MOB ED Nursing Notes Abnormal? N Confidential? N PT BACK IN ROOM FROM CT SCAN VIA WHEELCHAIR. Note Type Description No Type None 12/23/14 1236 MOB Bacani,Marlene O 12/23/14 1251 MOB ED Nursing Notes Abnormal? N Confidential? N MEDICATED PT AS ORDERED, SEE MAR. WILL MONITOR FOR ADVERSE REACTIONS. Note Type Description _____ None No Туре 12/23/14 1325 JL1 Liu, Jing 12/23/14 1629 JL1 Nurse Notes Abnormal? N Confidential? N ADMITTED 68 MALE FROM ER, TRANSFERED BY GURNEY, PT AMBULATE TO BED, CHEIF COMPLAINE HEADACHE, UPON ADMISSION PT IS ALERT, ORIENTED, CLEAR SPEECH, NO WEAKNESS, NEURO ASSESSMENT WITHIN NORMAL LIMITS, NO SOB, EVEN UNLABORED BREATH ON ROOM AIR, CLEAR LUNG SOUNDS, DENIES CHEST PAIN, APPLIED TELE#34 WITH SR, ABDOMEN SOFT WITH ACTIVE BS, STRONG PULSES BUE AND BLE, IV TO RIGHT WRIST PATENT WITH IVF AND UNASYN INFUSSING FROM ER, RESUME IV MEDICATION, ORIENTED PT TO ROOM, CALL LIGHT SYSTEM, PT ABLE TO VERBALIZED UNDERSTANDING, VITAL SINGS STABLE, BED IN LOWEST POSITION, KEEP CLOSE MONITOR. Note Type Description ---------_____ No Type None

HANNA, ADEL S (DIS IN) Age/Sex: 68 M Page: 2 of 3 Unit #: M000273781 Printed 12/30/14 at 1649
 Unit #: M000273781
 DU-228T-B
 Printed 12/30/14 at 1649

 Account#: V00000603802
 Lally, James M.
 Date Range:Beginning to 12/30/14

 Admitted: 12/23/14 at 1149
 Chino Valley Medical Center NUR
 CVMC: NURSING NOTES
 DU-228T-B Occurred Recorded Notes: All Categories Date Time by Author Date Time by Category 12/23/14 1430 JL1 Liu, Jing 12/23/14 1719 JL1 Nurse Notes Abnormal? N Confidential? N PT C/O OF HEADACHE 7/10 INTENSITY, FIORICET GIVEN AS ORDERED, PT TOLERATED WELL. Note Type Description ------No Type None 12/23/14 1530 JL1 Liu, Jing 12/23/14 1630 JL1 Nurse Notes Abnormal? N Confidential? N PT WENT DOWNSTAIR WITH WHEELCHAIR WITH NURSE FOR MRI. Note Type Description No Type None 12/23/14 1710 JL1 Liu,Jing 12/23/14 1720 JL1 Nurse Notes Abnormal? N Confidential? N PT BACK TO MRI, NO CHANGE IN CONDITION, NO C/O OF HEADACHE AT THIS TIME, KEEP CLOSE MONITOR. Note Type Description _ None No Туре 12/23/14 1917 JL1 Liu, Jing 12/23/14 1917 JL1 Abnormal? N Confidential? N Nurse Notes PT RESTING IN BED, NO DISTRESS, NO C/O OF HEADACHE AT THIS TIME, WILL ENDORSE TO COMING SHIFT TO CONTINUE CARE. Note Type Description No Type None 12/23/14 1935 LC Ciupala,Liliana 12/24/14 0222 LC Nurse Notes Abnormal? N Confidential? N PT IS A/O X4. SPEECH CLEAR . DX ON ADMISSION HEADACHE. PT DENIES ANY HEADACHE AT THIS TIME. ON TELE# 34 WITH NSR . PT DENIES ANY CHEST PAIN AT THIS TIME. BREATH SOUNDS CTA BILAT. RESPIRATION EVEN AND UNLABORED ON ROOM AIR. IV SALINE LOCKED ON R WRIST. IV SITE CLEAR AND DRY WITHOUT REDNESS OR INFILTRATION NOTED. BOWEL SOUNDS ACTIVE X4. LAST BM ON 12/23/14 WITH FORMED STOOL. PT VOIDS FREELY WITHOUT DYSURIA REPORTED. SKIN INTACT WITHOUT ACTIVE WOUNDS NOTED. SCD'S IN PLACE BLE. CALL LIGHT IN REACH AND BED IN LOW POSITION. WILL CONTINUE TO MONITOR. Note Type Description _____ None No Туре 12/24/14 0549 LC Ciupala,Liliana 12/24/14 0550 LC Nurse Notes Abnormal? N Confidential? N PT RESTED WELL. NO C/O HEADACHE DURING THE NIGHT. CALL LIGHT IN REACH AND BED IN LOW POSITION. WILL CONTINUE TO MONITOR. Note Type Description No Type None 12/24/14 0750 ED Deharo,Eric 12/24/14 0947 ED Nurse Notes Abnormal? N Confidential? N PT RECEIVED SITTING IN BED, ALERT AND ORIENTED X4, FOLLOWS COMMANDS. TELE # 34 SR, PT DENIES CP AT THIS TIME. BREATH SOUNDS CLEAR BILATERALLY ON RA, UNLABORED RESPIRATIONS. BOWEL SOUNDS ACTIVE X4, LBM 12.23.14, PT DENIES N/V/D. AMBULATORY WITH BRP, VOIDS FREELY. SKIN INTACT, RADIAL/PEDAL PULSES PRESENT AND MODERATE, SCD'S IN USE. PT DENIES HA AT THIS TIME, EXPRESSES PRESSURE TO FOREHEAD. IV TO RIGHT WRIST, SALINE LOCKED, NO REDNESS, SWELLING OR PAIN NOTED AT THIS TIME. PT ORIENTED TO SURROUNDINGS AND USE OF CALL LIGHT, CALL LIGHT

Age/Sex: 68 MHANNA, ADEL S (DIS IN)Page: 3 of 3Unit #: M000273781DU-228T-BPrinted 12/30/14 at 1649Account#: V0000603802Lally, James M.Date Range:Beginning to 12/30/14Admitted: 12/23/14 at 1149Chino Valley Medical Center NURCVMC: NURSING NOTES					
Occurred Recorded Notes: All Categories Date Time by Author Date Time by Category					
12/24/14 0750 ED Deharo,Eric 12/24/14 0947 ED (continued) WITHIN REACH, WILL CONTINUE TO MONITOR. Note Type Description					
Note Type Description No Type None 12/24/14 1213 ED Deharo,Eric 12/24/14 1215 ED Nurse Notes Abnormal? N Confidential? N PT BEING DISCHARGED AT THIS TIME, REVIEWED WITH PT DISCHARGE INSTRUCTIONS AND PERSONAL BELONGINGS LIST, PT VEBALIZED UNDERSTANDING OF DISCHARGE INSTRUCTIONS AND PERSONAL BELONGINGS LIST, PT VEBALIZED UNDERSTANDING OF DISCHARGE INSTRUCTIONS AND PERSONAL BELONGINGS LIST, PT VEBALIZED UNDERSTANDING OF DISCHARGE INSTRUCTIONS AND IS LEAVING WITH ALL PERSONAL BELONGINGS, IV DC'D CATHETER INTACT, NO REDNESS, SWELLING OR PAIN NOTED AT THIS TIME, SCD'S AND TELE MONITOR REMOVEDE, TELE MONITOR RETURNED TO TELE ROOM. ALL PT'S QUESTIONS ANSWERED, PT STABLE UPON DISCHARGE, NO DISTRESS NOTED, PT ESCORTED TO LOBBY VIA WALKING BY RN ERIC. Note Type Description No Type None 12/24/14 1344 SM Montoya-Bell,Susan 12/24/14 1344 SM Case Management Notes Abnormal? N Confidential? N INITIAL DISCHARGE PLANNING SCREEN/CHART REVIEWED. PT LIVES WITH HIS SPOUSE AND IS INDDEPENDENT WITH ADLS AND DECISION MAKING. PT DISCHARGED WITH NO FURTHER DC PLANNING COMPLETED. Note Type Description					
No Type None					
Monogram Initials Name Nurse Type					
EDNURDE1Deharo,EricRNJL1NURLJ1Liu,JingRNLCNURCL1Ciupala,LilianaRNMOBEDBMOBacani,Marlene ORNSMSWMSMontoya-Bell,SusanSS					

Agre/Sect 68 M	Attending: Lally, James M.	HANNA, ADEL S]	Page: 1 of 16
Onit 4: M000273781 Admitted: 12/23/14 at 1149 Status: DIS IN	Account #: 70000503802 Location: DU CP Room/led: 228T-B	ino Valley Medical Center NUR **LI DISCHARGE PATIENT AUDIT FORMAT	VE**	Printed 12/30/14 at 1649
Intervention Description	Sts Directions	From Intervention		Sta Directions - From
Activity cocurred Type Date Tim	Recorded Documented He by Date Time by Comment Units	Rotivity Shange Type	Dechired Recorded Date Time by Date Time by O	Documented gament Units Change
Adr fviry Date: 12/23/14	Time: 1020	Activity Date	12/23/14 T.me: 1235	
Patient Notes: ED Nursing No		Patient Notes:	EE Nursing Notes	
 Create 12/23/14 102 Abnormal? Confidenti 	0 MOB 12/23/14 1023 MOB	- Create Abnormal?	12/23/14 1236 MOB 12/23/14 1251 MOB Confidential?	
	A.: DE FOR PATIENT EVALUATION. MEDICAL SCREENING EXA		D FT AS ORDERED, SEE MAR. WILL MONITOR FO	R ADVERSE REACTIONS.
COMPLETED BY ED PHYSIC	IAN.			
Activity Date: 12/23/14	Time: 1041	Activity Date	12/23/14 Time: 1322	
		1000 B .	ADMISSION/TRANSFER: Quick Start Form + .	a on admission/trans as
Patient Notes: ED Nursing No		- Create	12/23/14 1322 JL1 12/23/16 1322 JL1	
 Create 12/23/14 104 Abnormal? Confidenti 	H1 MOB 12/23/14 1041 MOB Lair	- Document Patient Type	12/23/14 1322 JL1 12/23/14 1322 JL1 : MED/SCR3/TELE New Admit	
PT TAKEN TO CI SCAN VI			: 68 Admit Order Present on Admission	
Activity Date: 12/23/14	Fime: 1051		ALL REGISTRY PERSONNEL MUST DOCUMENT	A WHEN APPLICABLE CP
Patient Notes: ED Nursing No	btes		THIS INTERVENTION ONCE PER SHIFT. 12/23/14 (332 JL) 12/23/14 1322 JL)	
	51 MOB 12/23/14 1101 MOB	1041	Smcking Cessation	A ON ADMISSION CP
Abnormal? Confidenti				
MEDICATED PT AS ORDERE	D, SEE MAR. WILL MONITOR FOR ADVERSE REACTIONS		Shift Reassessment 12/23/14 1322 JL1 12/23/14 1322 JL1	A QE & Q4H IN 1CU CP
Activity Date: 12/23/14	Time: 1110	1500	I&C: Monitor +	A Q12H (0559,1739) CP
			19/23/14 1922 351 12/23/14 1982 351	
Patient Notes: ED Nursing No - Create 12/23/14 113	DES 10 MOB 12/23/14 1130 MOB	15000 - Create	Care Plan: RN Review + 12/23/14 1322 JL1 12/23/14 1322 JL1	a Q12H CP
Abnormaly Confidenti			VS: Monitor -	A AS ORDERED CP
ALL TEST RESULTS COMPL	JETE, PATIENT READY FOR MD RE-EVALUATION.			
Activity Date: 12/23/14	Time::1153		VIEW PRCTOCOL	A .BED OF SHIFT/TX CP
150000 Vital Signs	λ		12/23/14 1322 JL1 12/23/14 1322 JL1 Nutrition/Activity/ADL Flowsheet (A OS BY CAREGIVER CP
	·3 12/23/14 1162			
	er Extremity SCD A			A INS/REMCVAL/CONVERT CP
Comment: Thrombotic Preve - Create 12/22/14 115				A AS NEEDED CP

Activity Date: 12/23/14	Time: 1155	40250	Position Change +	A Q2E CP
Patient Notes: ED Nursing No	a trans			A WHEN NECESCARY CF
	5 MOR 12/23/14 1189 MO3		12/23/14 1322 JL1 12/23/16 1332 CL1	
Abnormal? Confident:				A QS BY CAREGIVER CP
PT TAKEN TO CT SCAN VI	A WHEELCHAIR.		12/23/14 1322 JL1 12/23/14 1322 JL1	
Activity Date: 12/23/14	Time: 1200		DIS: Patient Discharge Instructions + . 12723/14 1122 Uni 11/23/14 1192 Uni	A ON DISCHARGE CP
				A CP
Patient Notes: ED Nursing No			13/23/14 1322 JL1 12/53/14 1322 dL1	
 Create 12/23/14 120 Abnormal? Confidenti 	00 MDB 12/23/14 1250 MOB		Pheumococcal Vaccine Assessment 12/23/14 1322 JL1 12/23/14 1322 JL1	A ON ADMISSION CP
PT BACK IN ROCM FROM C			Influenza Vaccine Assessment	A ON ADM-CCT TO MARCH CP

Age/Sec: 68 M Attending Tally, James M. Whit 4: NO0273781 Account H: V0000603802 Admitted: 12/23/14 at 1149 Cocation DU C	HANNA, ADEL S	
Status: DIS IN Room/Bed: 228T-B	DISCHARGE PATIENT AUD	JIT FORMAT
Intervention Sts Directions Activity occurred Recordes Docurrenced Type Date Time by Date Time by Comment Units	From Int	ervention Description Sts Directions From Activity Occurred Recorded Documented Type Date Time by Date Time by Comment Units Change
Act fully Bate: 12/23/14 """"	Rdt	ivity Jars: 12/23/14 Trme: 1511
1000481 Multidisciplinary Pt Care Tean Notes λ WHEN APPLICABLE - Greate 12/23/14 13/23 JL 12/23/14 13/23 JL 1001034 Aye Guidelines: 66+ 00LDEN ADULT A VIEW FROTOCOL/D - Greate 12/23/14 13/23 JL A VIEW FROTOCOL/D - Greate 12/23/14 13/23 JL A SE NEEDED 990001 Daily Chart Check 12/23/14 13/23 UL A 6600 4 1800 - Greate 12/23/14 13/23 JL A 6600 4 1800 - Greate 12/23/14 13/23 JL A A A	DI QS CP Addr CP Pain CP Pain	105 IV: seline Lock & Flugh A OE mate 14/23/14 1511 12/23/14 1511 ivity Date: 12/23/14 1510 12/23/14 1510 ent Kotes: Nurse Notes 13/23/14 1630 11 greate 12/23/14 13/23/14 1630 11 whtermal: N Confidential: N 10 pr ware Dockmarks With Histochkik With KORSE FOR MRI. 10/23/14 Tume: 1548
 Patient Notes: Nurse Notes Create: 12/23/14 1325 Jul 13/23/14 1625 Jul Absormal: N Gonfidental2 N ADMITTED GO MALE FROM ER, TRANSFERED BY GURNEY, PT AMEULATE TO BED, COMPLAINE HERACHE, UPON ADMISSION PT IS ALERT, ORIENTED, CLEAR SPEE WEAKNESS, NEURO ASSESSENT WITHIN NORVAL LUTHS, NO SOG, SUEN ONLAGO ON ROOM ALT, CLEAR LUNG SOUNDS, DENIES CHEST PAIN, APPLIED TELESAN M ABDUREN SOFT WITH ACTIVE BS, STROND PLEESE BUG AND BLE, 14 TO NIGHT PATENT WITH IN ACTIVE BS, STROND PLEESE BUG AND BLE, 14 TO NIGHT PATENT WITH IN AND SYSTEM, PT ABLE TO VERBALIZED UNDERSTANDING, STRESS STARLE, BED IN LOWEST POSITION, KERP CLOSE MONITOR. 	CHEIF - 30 CHEIF - 30 RED BERATH VITH SR, WL-57 CRESWTED VITM	
<pre>Refivity Date: 12/23/14 Time: 1430 Patient Notes: Nurse Notes - Create 12/23/14 1430 JL1 12/23/14 1719 JL1 Abnormal? N Confidential? N PT C/0 OF HEADACHE 7/10 INTENSITY, FIORICET GIVEN AS ORDERED, PT TCL WELL. Activity Date: 12/23/14 Time: 1457</pre>	JERATED Prim	<pre>http://doing.org/link.complaint: HEADACHE ary Diagnosis: HEADACHE yTTAL SIGNS === prrature(7: 57.2. Temp Source: TEMPORAL Refter) prlse: 60 Pulse Source: ADTOMATC NONINVASIVE splitions: 18 Respiration Source or Secreto yTerssure: 144/97 BP Source: ADTOMATCO Size: LEFT.UPPER ARM Head Source: Pulse Connective Sp024: 96 Probe Location: HARD NC Note: Note: Filter Flow(FTO2): Pulse Connective Sp024: 96 Probe Location: HARD NC </pre>
2010 V3: Monitor - A AS ORCERED Document 12/23/14 1457 D6 12/23/14 1458 D5 Tencerature/: 5V/2 Temp Source: TEMPORAL ANTER: Pulse: 50 Pulse Source: AttroAMTIC, XXNINVASIVE Respirations: 80 Resp Source: ANTONNITC Blood Pressure: 144/97 BF Source: ANTONNITC Site: LBET UPPER ARM - C/O Pain: N Pain Scale: 0/10	ср навения и полособа ====	ADMISSION HEIGHT/WEIGHT/ALLERGIES === Height - Peet: 5 In: 8 OR Cm: 172.72 Weight L: 186 Oz: 0 OR Kg: 76.65 Weight Source: BEOSCALS PAIN SCRIEN === Pain: 2 *** Chest Fain to be bocumented on Cardiac Problem ***
== CNA/LICENSED Documentation == Confort Magaures Inplemented: Nurse Notified of Pain: (If Medicated, Document on Intervention Pain: Management of ***IF on oxygen Device: ROOM ATR Oxygen Device: ROOM ATR Cp02 (r): 96. F102:	:) W1	<pre>Paint 5 *** Chest Paint to Bookinenced on Catalace Problem *** Where Paint is Present: Paint Socale: 2/10 Describe the Paint XCHTNS* Onset: INTERNYTINNY at Increases the Paint Phat Relieves the Paint Phat Relieves the Paint Control Goal: 0/10 Control: 57* REPUSED PAIN VEDICATION AT THE TIME</pre>

Age/Sex. 68 M Attending: Tally, James M. Wait 4: M000273781 Account 1: V0000503802 Admitted: 12/23/14 at 1149 Location: DU Status: DIS IN Room/Sed: 2287-B	HANNE, ADEL S Chino Valley Medical Center KUR **LI DESCHARGE PATIENT AUDIT FORMAT	Page: 3 of 16 E** Printed 12/30/14 at 1649
Statust for In Roomyself Address Trigition Sta Directions Activity Cocurred Records1 Docurented Type Date	From Intervention Activity	escription Sts Directions From Deculared Decumented Date Time by Date Time by Comment Units Change
Ref 1917y Date: 12/23/14 "Fime: 1948 (continued)	Addivity Dare	12/23/14 Time: 1948 (continued)
1005-H AEM: ADULT Admission History - (continued) ; The manufacture of the second sec	Condition 3) Is the pt ish: 2	IM: ADLIT Admission History : (continued) The main of the History - (continued) now experiencing, or nay experience once discharged, any of the following: Problems with ADLE due to health problems: H Problems with transportation: H Mental health and/or substance abuse problems: H Is Family Involved With Fr: Y Itorminal illness: H
Beliefs Affecting Care: Spiritual Coordinator Visit Requested: N Contact Person: HANNAY CAMER Home Phone: (595)345 5958 Work Phone: (545;433-8570 Cell/Pa Add'l Contact Information:	other:	
PATIENT HISTORY Manage Family Medical History: NCNE	wto will be Anticipated Di	Parling Pt lives with: PANILY wing Arrangements: HO05E whing Patient Home: PANILY charge Destination: HOME
Pneumococcal Vaccination: Vaccine UNAVATABLE Pneumococcal Vaccinat Influenza Vaccination: PREVIOUS VACCINETION Influenza Vaccinat Vaccine Comment: NOT GUALIFIED FOR PNEUMOCOUCAL VACCINATION	ion Date: 01/05/14 === FAMILY NOT Has family been Would you hi	
Smcking Oessation: MEWER EXAMPLE Currently Using Tobacco: A Type: Mrount/How Often: Currently Using Alcohol: B Type: Arount/How Otten: Number of Other Substarce Use (comment): DENTER	Years: Document the N Prior to This J DR Edit Result:	SICIANS/PRACTITIONERS === mes and Phone Numbers of the Physicians/Practitioners Seeing the Patient oopitalization: 12723/14 [548]UDI 12/23/14 1574 UDI : MIGRAINE, SIBUSICIS [NONE] 0]
Hospitalized in the Last 30 Days: 0 NO Decubitus Ulcer/Open Surgical Wound: 9 NO	-Total Score: D Infection Rick- Low: y derate (2): 1000466	
 social SERVICES SCREEN === Dees 3t Have an Advance Directive: w IF YES: Parily instructed to bring in copy and Physician notified: w What is the intent of the Advance Directive for this hospital stay: *IF OTHER THAN A FULL CORE NOTIFY HYSICIAN* Does pt have a condition which may require additional care when disci 	(A) INCLUSION	NE ASSESSMENT (October through March): 55 RITERIA: (Patient is qualified to receive vaccine if one or more is selected) Patient is age 6 months and older: 55

App/Secs 68 M Attending, Lally, James M. Wait 1, M000273781 Account H v00000503802 Admitted: 12/23/14 at 1149 Location: DU Status DE IN Book/Bed 2287-B	HANNA, AI Chino Valley Medical (DISCHARGE PATIENT	Center NUR **LIV	Page: 4 of 16 ** Printed 12/30/14 at 1649
Intervention Description Sta Directions Activity occurred Recorded Documente Type Date Time by Date Time by Comment Unit	Fron		scription Ste Directions Prom becurred Recorded Documented Date Time by Date Time by Comment Units Change
activity Date: 12/23/14 Time: 1644 (continued)		Activity Date:	12/23/14 Time: 1855 (continued)
 1000465 Influenza Vaccine Assessment (continued) (6) EXCLUSION CRITERIA: "No not give if any box is YES" Received influenza vaccine within the current fluesason: Patient has anaphylactic large allergy: Nypersensitivity to eggs or other components of vaccine: (excludes painful injectione: Provious history of hypersensitive reaction to vaccine: Provious history of hypersensitive reaction to vaccine: Bistory of bone merrow transplant during toopitalization: History of bone merrow transplant during toopitalization: Bistory of Sullan Barre Syndrome: Leaves against medical advice (AVA): (C) INFLIENCA VACCINE ADMINISTRATION: (October through March) 1. At least one exclusion criteria is present: ¥ 2. At least one exclusion criteria is present: ¥ 3. At least one exclusion criteria is present: ¥ 4. At least one exclusion criteria is present: ¥ 4. At least one exclusion criteria is present: ¥ 4. At least one inclusion criteria is present: ¥ 4. At least one is an least one is an least one is at least one is at	: 87	(B) EXCLUSION CF Fin (ages 5-18) Meceived	<pre>eumococcal vaccine Assessment (continued) Chronic Renal Failure, ESRD, Nephrotic Syndrome: Chronic Cardiovascular Disease excluding Hypertension: (example: Congestive Heart Sailure, Cardiomyopathies) Vaccination Status Onknown: Vaccination Status Onknown: UTERLA: *UD not give if any box is YUS* Received TWD (2) pneumococcal vaccines doses: M Vaccinated less that : years ago: N Date Received: Vaccinated less that : years ago: N Date Received: Vaccinated since si years old: N iexcludes paint] injections; Previous history of hypersonative reaction to vaccine: N iexcludes paint] injections; Patient with an organ transplant within the last 12 months: N Received a conjugate vaccine within the previous 8 weeks: N chemotherapy or radiation during hospitalization. M ages 5-10; With anthm and no other high risk conditions: N Received shingles vaccine (Sotawa) within last 4 weeks: N Leaves agains: medical advice (ANA): N Chemotherapical Saiton: N Received shingles vaccine (Sotawa) within last 4 weeks: N Leaves agains: medical advice (ANA): N Pregnant: M Pregnant: M Pregnant:</pre>
 Vaccine Comment: NOT CURLETED FOR PREUMOCOCOL VACCINATION	op provide the second second op provide the second second risk conditions:	At lea If both YES -TF Re Vaccination Comm (D) Education p: *VAcCII 7000103 Al greate	A VACCINE ADMINISTRATION: (Year Round) st one inclusion criteria is present: N No exclusion criteria are identified: N order Ensumococcal Vaccine (primerry) Pneumococcal Vaccine (Siven: N FT ENFIRES A REAGON MIET ER ENTERS- futal Reacon and the ENTERS- futal Reacon in the ENTERS- covided regarding vaccination administration/refusal: T EINFORMATION SHEET (VIS) MOET BS 01/20 TO PATIENT* Vaccine Information Statement Published Date: 00/10/14 N: Risk Assessment - Suicide A ON ADMISSION & PRN AS 12/23/14 ISS5 JLI 12/23/14 ISS6 JLI
Diabetes: Functional Asplenia (Sic) HLV/ALDS: Anatomical Asple (ages 19-64) Aschma: Immunocompromi Alcoholism: Condidate For or Recipient Of	<pre>cle Cell Disease): nia (Splenectomy): sed or Suppressed:</pre>	l. Patien with act	<pre>=== SUICLE First Assessment === : reports current or history of psychiatric illness, ite exacerbation of symptoms within the last 30 days: N 2. Pationt has positive history of suicide attempt: N 3. Patient voicing suicidal intent/ideation: N</pre>

Age/Sex: 68 M According: Tally, James M.	HANNA, ADEL S	Page: 5 of 16
Whit 4 MO00273781 Account # Y00000503802 Admitted 12/32/14 1149 Locations DU Status DIS IN Koom/Bed, 2287-B DU	Chino Valley Medical Cente: Discharge Patient AUD	
Intervention Sts Dire		rvention pescription Sta Directions From stiviny Occurred Recorded Documented ype Date Time by Date Time by Comment Units Change
Activity Date: 12/23/14 Time: 1555 (continued)	Rct	vity dare 12/23/14 Time 1986 (continued)
7000103 AEM: Risk Assessment - Suicide (continued) 4. Patient has active suicide p If patient answered YES to guestions #1 or #2 only, refer to Soc If patient answered YES to guestions #3 and/or #4,IMMEDIATELY in	cial Services for follow-up. nstitute suicide precautions. If R.	rt Rate Irregular: Hear: Tones: Syncope/Fainting: Vertigo/Dizziness: Chest Pain: Pain Quality: Jiating. Describe:
=== SUICIDE 1NBCRJTICKS ===	***I 	Pain Treatment: ON CREINC MONITOR/TELEMETRY*** Treatment Outcome: Monitor #: 34 Cardiac Rhythm: MAMPAL-ULMAG HNYTHMI ac Commert: DENIES OFFERIN Cardiac Rhythm: MAMPAL-ULMAG HNYTHMI
Security at individe or stand Security at individe or stand Secure or renve any/all safety has (weapons, sharp objects, medications, contraband, patient belo Provide close/continuous supervi Notify physician to order paych eval or MRT toam assessment (for assessment of lethality and recommendations (for assessment of lethality and recommendations Activity Date: 12/23/14 Time: 1555	ards: CIRC ongingg, cords, belts, etc.) ion: Store s for care)	LATORY Assessment, within Norral Limits: x amity Temp: Left Radial Pulse: STRONG Mity Color: Right Radial Pulse: STRONG Sersation: Left Pedal Pulse: STRONG Sdema: Sight Pedal Pulse: STRONG Latory Comment: NO EDECA ROTED
- Document 12/23/14 1556 JL1 12/23/14 1630 JL1	MUSC Musc ate: 12/32/14 Trme: 1566	LOSKELETAL Assessment Within Normal Limits: 2 loskeletal Comment: AMBULATORY:
NEUNOLOGICAL Assessment Within Normal limits: N = PUPI LOC: MWARK/ALEXT Reaction OD: SRISK Orientation: DEFRON PLACE AND TIME Reaction OD: SRISK Responds to: VERBAL STIMULO: Speech: CHERK Headaches: 7 Dencribe; ACHING Recent Seizure Activity; N Seizure Precautions initiated or bein Neuro Comment: C/O OF HEADACHE, NO NAUSER OF VONITYS, NO WERKNE	LL, REACTION CHECK == Prio Internet displayments in S.22 (2017) Antonia (2017) (2017) (2017) (2017) Antonia (2017) (2017) (2017) (2017) (2017) Antonia (2017) (2017	Mobility: Mobility in the second seco
EENT Assessment Wilbin Normal Linits: 📅 EENT Comment: The state of th	Incol	OURINARY Assessment Mithin Normal Limits: tinence:
RESPIRATORY Assessment Within Normal Limits: * Breath Sounds: Bffort: Effort: Chest Expansion: Cough: Chest Tubes P: Cough: Chest Tubes P:	*	I (FMAIe** Diccing/Discharge: Describe: Advance advanc
Color:	FIC2:	MENTARY Assessment Within Normal Limits: Y malities Photo Documented: legation: Location: Dressing Type/Condition: legation: Location:
CARDIAC Assessment Within Normal Limits: 🚿		lteration: Location: Dressing Type/Condition:

Age/Sex: 68 M	Attending: Lally, James M.	HANNA, AI	DEL S	Page: 6 of 16
Unit #: M000273781 Admitted: 12/23/14 at 1149 Status: DIS IN	hcconat #s 700000503802 Location: DU Ch Room/Red: 228T-B	nino Valley Medical (DISCHARGE PATIEN)		E** Printed 12/30/14 at 1649
Intervention Description Activity cocurred Type Date Time	Sts Directions Recoide1 Documented by Date Time by Comment Units	From	Intervention D Activity Type	
Act fviry Date: 12/23/14	™(mé: 1556° (continu≉d)		Activity date:	
Alteration: Eressing Type	Ission Assessment + (continued) Location: include the second seco		Educational Nee Educational Nee	IN: ADULT Admission Assessment + (continued) d Priority #2: SAFETY PRECULTIONS d Priority #3: DED_CATIONS d Priority #4: DEFASE PROCESS
Nobility: * Eurom Futrition a except Priction and Sheer: 1 NGAB Scoring PSYCHOSOCIAL Assessment With: Fears/Anxiety Related to Hosy Suppected Abues/Heglect: D Alteration in Growth/Deve/ Comment: === NUTRITION1 Assessment within Diet at Home: Beutung	INTERFERENCE INTERFERENCE CONSTRUMENT INTERFERENCE INTERF	high Risk: col Guidolines Support System:	Physiologic L Raychologi Cognitive L Thaching Merload Comment: Entrie === DVT RISK AS Admission DX in-	imitations: NORE cal Limits: NORE Freferred: Discussion Egg Plaster Cast or Brace: 0 NO Varicos Voins: 0 NO Hormone Replacement: 0 NO cludes: CHF,COED,M., Sepsie, Phenomenia: 0 NO Bed Rest with Limited Activity: 0 NO Major Surgery (> 60 minutes) 2 NO Major Surgery (> 60 minutes) 2 NO Fresent Cancer or Chemotheragy; 0 NO Fresent Cancer or Chemotheragy; 0 NO Hintory of SVT, DVT/P2: 0 NO Felvis, or Leg Fracture (< 1 month): 0 NO
<pre>=== NUTRITION RISK SCREEDING Appears Underweight, Naisse, Vomiting, or Diarrhee Unintentional %t Loss :/oi Admitted with Potential R: Foor PO Intake Unable to Ingest Tube F === ASPIRATION RISK SCREENIN: Impaired Mental Status Difficulty Swallowing Food Sticking in Mouth/Throat Coughing/Choking Food Sticking in Mouth/Throat Coughing/Choking === FALL RISK ASSESSMENT=== Mental Status Eensory Perceptual Status Elimination Status Recent History of Falls</pre>	=== //walnourished: 0.00 T 1 Gor >3 Days: 0 NO =NU in Pact Month: 0 NO =NU isk Diagnosis: 0 NO =NU bit for Age: 0 NO =NU stor > Days: 0 NO =Aug stor > Days: 0 NO =Aug stor > Days: 0 NO =Aug stor > Days: 0 NO Mcde stor > Days: 0 NO =Aug stor > Days: 0 NO Mcde	total Score: 0 trition Risk= Low (0-1): High (4+): 0 traton Risk= Low (0-1): Low (0-1): Kigh (2-5): total Score: 0 traton Risk= Low (0-2): High (2-5): total Score: 0 total Score	SAFETY Tsolat Restraints in IV ASSESSME IV Loss IV Start/Resta 1041 SI Socument	Paralysis (c 1 month): 9 NO Patient's Age: 5 KG-74 YE2RBG Total Score: 2 =DVT R:6Ke, Low (0.1): 1 Moderate (2: V) High (3:): TSICIAN IF DVT RISK SCOME > 1 AND DOCUMENT IN PT CARE NOTES *** ion: STANDARD FROM SEQUENCE TSICIAN IF DVT RISK SCOME > 1 AND DOCUMENT IN PT CARE NOTES *** ion: STANDARD FROM SEQUENCE TSICIAN IF DVT RISK SCOME > 1 AND DOCUMENT IN PT CARE NOTES *** IOS: N Describe: NT === coation: RISHT WRIST T Date: 52/23/14 moking Cessation: NZVER ENDOKEZ Smoked in the last 12 months: N Do you dip or chew tobacco: N
=== EDUCATION SCREENING === Educational Need Priority #1	TREATMENT DURPOS		Approximatel	y how παπy eigarcttes per day: 1999 20 Cigarettes = 1 Pack

Age/Sex: 68 M Attending, Lally, James M. Wait 4: M000273781 Account 4: Y000006503802	HANNA, ADEL S			Page: 7 of 16
Admitted: 12/23/14 at 1149 Location. DU . Status: DIS IN Room/Bed: 2287-B	Chino Walley Medical Center NU DISCHARGE PATIENT AUDIT N			Printed 12/30/14 at 1649
Intervention Sta Directions Activity cloured Records1 Documented Type Date Time by Date Time by Comment Units	From Interve Ret	ntion Description vity occurred f Date Time by De		tions From cumented Units Change
Activity hate: 12/23/16 "Yime: 1556 [condinged]			1749 (continued)	
- 1041 Stoking Cessation (continued)	1500	I@C: Monitor + (contin H2O:	TPN:	Other Intake:
Level of Dependence:		IV'S: 50 UT: SEIFT TOTAL ===	Lipids:	Total Intake: 460
If you are a former smoker, when ald you quit: provide any and the provide a start of the provide any provid		of Voids/Incent: 2 # of Stocls: 0 Urinc:	Colostomy: Jejunostomy: ilcostomy:	Hemovac #1: Hemovac #2:
Initiate information on Smoking Cessation: Initiate Smoking Educati Activity Eate: 12/21/14 Time: 1600	on Date: 12/23/14	Stool, Liquid: Jack Fmesis: Jack NG Tube: 0		GU Irrigant, Cut: Dialysts Net: Est. Blood Loss: Other Output:
3120 Problem: Neurological + A Q5 & Q4H IN IC Organe 12/23/14 1600 JL1 12/23/14 1600 JL1 12/23/14 1600 JL1 Activity Date: 12/23/14 Time: 1710			=== TOTAL SHIFT	Total Output:
Patient Notes: Nurse Notes - Gredete 12/23/14 1710 Jul 13/23/14 1720 Jul Abournell N Confidential? 8 PT BACK TO MRI, NO CHANGE IN CONDITION, NO C/O OF HEADACHE AT THIS ' CLOSE MONITOR.		Contract of the second se	1826 Flowsheet + A OS BY	
NATE FORTING.	~ Docume	NUT FILLEN/ACTIVITY/ADD NL 12/23/14 1926 DS 12 ITION ===		
20010 VS: Monitor - A AS ORDERED - Document 12/23/14 1757 DS 12/23/14 1757 DS Tengerature/F: 56.1 Pemp Source: TEMPORAL ARTERY Pulse: 55 Pulse Source: AFTGAWTIC, Jackitwickitys Reopirations: 16 Resp Source: ASTGAWTIC, Jackitwickitys Bilood pressure: 155/92 BP Source: ASTGAWTIC	CP 11 AD	ropriate:		
Site: LEFT UPPER ARM	PO Nut	ritional Supplement Taken: N Supplemental Snacks: N : N	A A	mcunt Taken: National State
== CNA/LICENSED Documentation == Comfort Measures Implemented: Nurse Notified of Pain: (If Medicated, Document On Intervention Pain: Management C	Activ: Activ:	VITY/ADL === ty Type: BATHROOM PRIVIL ty Tolerance: GOOD ROT APPLICABLE	Linen Changed: Y Oral Hygienc: S Last BM:	
IF ON OXYOSEN Oxygen Device: ROOM AIR Sp02 (1) 97 P102: Comment:	Elim: Comme	nation Comment:	Incont (BM): M Description:	
Activity Pate: 12/23/14 Time: 1759	Activi	/ Date 12/23/14 Time:	1850	
	/Eroduct: The Prod	Routine Care: MED/SURG, VIEW PRCTCCOL 12/23/14 1850 JLf 12 tice Cuidelines Appropriate f n Met Throughout The Shift: 5	1/23/14 1850 JL1 For The Patient And Withir Th	

Age/Sex: 68 M Attending: Lally, James M.	HANNA, ADEL S	Page: 8 of 16
Whit #: M000373781 Account H: V0000503802 Admitted: 12/23/14 at 1149 Location: DO Ch Status: DIS IN	ino Valley Medical Center NUR **L DISCHARGE PATIENT AUDIT FORMAT	
Thervention Sis Directions Activity occurred Recorded Docurrenced Type Date Time by Date Time by Comment Units		Description StanDirections Prom occurred Recorded Documented Date Time by Oate Time by Comment Units Change
Activity base, 12/23/14 """"" Time: 1980 (continued)	kdtivity dar	: 12/23/14 time: 1945 (scotinued)
21090 Routine Care: MED/SURG/TELE + (continued)	1070	shift Reassessment - (continued)
Signature: Diu.Jung Schift: 0700 - 19	Neuro Comment EENT Assess EENT Comment:) Assessment within Normal Limits: N . ADMITEED PT FOR HEADACHE PT IS A/O 34. FOLLOW COMANDS NO N/V, NO WEAKNESS . PT DENIES MAY READACHE AT THIS TIME. WILL CONTINUE TO MEMITAR ment Within Normal Limits: Y
Patient/Family Education Provided This Shift:	RESPIRATORY	Assessment Within Normal Limits: Y mment: BREATH Southe CTA ETTAT, BREATEATION TWEE AND INTARGED ON ROCH ATE
Isolation: STANDARD - ROCEDURSE Restraints in Use: N Describe: +Total Hrs. In Restraints This Shift: Location: Sitter Used: N Comment:	Cardiac Rhyt Cardiac Comme	semert Kichin Hormal Lizits: Y IF on CARDIAC MONITOR/TELEMETRY: IN RORMAL PIRUS RUFTH AND NONITOR #: 34 t: PT DENIES ANY CREAT PAIN AT THIS TING
=== IV ASSESSMENT === Throughout Shift: IV location: RTGHT WRITE IV Site Condition: IV start/Reff.art Date: 12/23/14	Circulatory C MUSCULOSKEL Musculoskelet 1 Linits:	Assessment Within Normal Limits: ¥ mment: BG EDEMA NOVED TAL Assessment Within Normal Limits: ¥ al Comment: SELF AMSULATORW Assessment Within Normal Limits: ¥ Assessment Within Normal Limits: ¥
IV Location: IV Stet Condition: IV Stat/Restart Date: IV Comment IV SALINE LOCK, PAYERT 990001 Daily Chart Check A 600 & 1800 Dodment 12/2/1/4 1860 Chi 12/2/1/4 1860 Dit 12 Four Chart Check Completed: % 24 Four Chart Check Completed: %	1 Limits: GR TROINTES GI Commert: 3 GE NITOURINE GU Commert: 9 GU Commert: 9 INTEGNES Skir Dummert:	TINAL Assessment Within Normal Limits: ¥ WEL COUNDS RATIVE X4 QUADE LAST EM 12/23/14 WITH NORMAL STOOL Y Assessment Within Normal Limits: ¥ F WOIDS FREELY WITHOUT DYSURIA REPORTED WITARY Assessment Within Normal Limits: ¥ SKIN IBIACT WITHOUT ACTIVE WOUNDS NORMO
This verifies that all current orders have been completed or are i Activity Data: 12/21/14 Thme: 1917	PSY 2KOSOCTA	; Assessment Within Borral Limits: Y Somrer: PT GALM AND GOOPERAFIYS WITH GAR: ;
Patient Notes: Nurse Botes Create 12/23/14 1917 JL1 12/23/14 1917 JL1 Advocmmaly N Confidentially N PT RESTING IN HED, NO DISTRESS, NO C/D OF HEADRCHE AT THIS TIME, WILL TO COMING SUIFT TO CONTINUE CARE. ACTIVITY Data: 13/23/14 Tume: 1936 IU/C Shift Reassessment + A QS & QAH IN ICU Document 12/23/14 1955 DC 13/24/14 0210 DC Reassessment Obtained Date: 12/23/14 Time: 1936	ENDORSE ENDORSE CP CP CP CP CP CP CP CP CP CP	Following To Be Documented On Once A Shift ==== X ASSESSMENT== minal Status: 0 NOT ANTERED Total Score: 2 ility Status: 0 NOT ANTERED For 0 NOT ANTERED For 0 SOT ANTERED FOR

Age/Sex: 68 M Attending: Lally, James M.	HANNA, AD	EL S	Page: 9 of 16
Totait #: N000273781 Account #: V0000503802 Admitted: 12/23/14 at 1149 Location: DU Ch Status: DIS IN Macon/Red: 2287-B Ch	nino Valley Medical C DISCHARGE PATIENT		
Thervention Description Sts Directions Activity occurred Records 1 Documented	Fritsa	Intervention D Retivity	Description Sts Difections From Occurred Recorded Dorumented
Type Date Time by Date Time by Comment Units	Shange	Туре	Date Time by Date Time by Comment Units Change
Activity Date; 12/23/14 Time: 1935 (continued)		Activity Date:	es 12/23/14 Time: 1915 (sontinued)
 1070 Shift Reassessment + (continued) Moisture: % RARSLY MOIST 19-23 = No Risk: 15-18 = At Risk: 15-18 = At Risk: 13-14 = Moderate Ri Nutrition: % ADEQUATE Priction and Sheer: 3 NO APPARENT PREMIEW 9 Or Lower = Very H Scoring of 18 Or Lower - Initiate Skin Integrity Proto 	ý sk: Sigh Risk: Scol Guidelines	21200 8	Care Plan: RT Review + (continued)
DVT RISK ASSESSMENT Leg Plaster Cast of Brace: 0 NG Varicose Veis: 0 NG Hormone Raplacement: 0 NG Admission DX includes: CHF,COPD,MI,Sepsia, Protunnia: 0 NG		- Noriument Altered Neurolo (If ND, Conside:	Forein reducing a 1 - 2/24/14 A21 B2 - 1/22/14 1935 For 2/24/14 A21 B2 logical Status/Function Remains Active Problem 7 der Inactivating or Completing Intervention) Only on Interventions Related to Patient's Altered Status/Function. ***
Bed Rest with Limited Activity: 0 NO Obesity: 0 NO Major Surgery (> 60 minutes): 0 NO Panily History of DVT/PE: 0 NO Present Cancer or Chemotherapy: 0 NO History of SVT, DVT/PE: 0 NO		Neuro History:	<pre>> Assessment Within Normal Limits: Y ,</pre>
Hip, Pelvis, or Leg Fracture (< 1 month): O NO Stroke (< 1 month): O NO Paralysis (< 1 month): O NO Paralysis (< 1 month): O BOUTHANS Patient's Age: 2 60-74 YEARS Total Score: 2 = -DVT N	tisk=	Fye Response Verbal Response Motor Response Total	CMA SCORE === [Best Response] == PUZLI REACTION CHECK == se: 4587CMTANKOLE == se: SEORIENTED == STORE Reaction OS: BRISK se: SEORIENTED == STORE Size: 3 al: 15
Low (0-1 Moderate (2 High (3+ *** NOTIFY PHYSICIAN IF DVT RISK SCORE > 1 AND DOCUMENT IN FT CARE NOTES		=== SEIZURE INF Recent Seizure : Describe Seizur :	
sequential Compression Device in place: 9 Chemical Prophy axis in use: 90 Comment: SCD-S TW PLACE BILL SECTION OF STREET STREET		~Additional New Trevel of Con O: Re	L NOURO ASSESSMENT === euro Assessment Performed and XNL; ¥ onsciousness: Crientation: Responds to: Memory: Pluttations:
Isolation: STANDARD PROCEDURS: Allergy Bracelet On: Y ID Ban Restraints in Use: B Describe: Constraints in Use: B	nd on : ₩	Weakness	ught Process: 特特斯卡波波与特别的现在分词 : 是 Cpccify: 自由的影響 自己的影响的影响的问题。 : 第 Specify: 自己的影响和自己的影响的影响的问题。
=== IV ASSESSMENT === IV LOGATION: RIGHT ORISI IV Site Within Normal L IV Site Condition:			lex Positive: 🖑
IV Start/Restart Date: 12/23/14 1500 Caro Flan: REPerior + A Q12H - Document: 12/23/14 1935 LC 12/24/14 0157 LC PATIENT FROBLEM LIST AS PECONTIZED ON CARE PLAN: Problem (5) Identified: PROBLEM: Impaired Resurgisial Function: Status:	CP	Problems Observ Food	L SKALLOKING ASSESSMENT === Yvod vith Dwalloving: "State of the state
: CTMC STANDARD OF CARE : STANDARD OF PRACTICE M/S/TILE :	A A A		: ACMITERD PRIOR HEADACHE OF 15 A/O 2.1. FOLION COMANDS NO N/V, RO WEARNESS. : 71 DENIES ANY READACHE AT THIS TIME. WILL CORTINUE TO MONIFOR.

Age/Secci 68 M Attending: Lelly, James M. Tait 1: M000273781 Account 1: 700000503802	HANNA, ADEL S	Pag*: 10 of 16
Admitted, 12/23/14 at 1149 Statue: DIE IN Koom/Red. 2287-B	Chino Valley Medical Center : DISCHARGE PATIENT AUDIT	
Intervention Description Sts Direct	ions From Inter	wention Description From
	urented Ac Units Change Ty	tivity Decurred Recorded Documented pe Date Time by Date Time by Comment Units Change
Scrivity Date: 12/23/14 Time: 1935	kativ	ity Dars: 12/23/14 Time: 1935 (somrinued)
<pre>31320 Pain: Management of * A AS NEED - Document 12/23/14 1935 LC 12/24/14 19213 LC </pre>	: Froblem ***	Education: Patient/Family Teaching + (continued) Person Taught: Teaching Tools: DEMONSTRATEON Other Tools Used: TEPENA other Factors: Note Participation Level: ACTIVE Factors: Note Participation Level: ACTIVE
Comfort Kessures Inclemented: Cther Measures Takes	אר פרארד דאר דר דרס 150000 בייניין אר דרס ססטט בייניין דרס בייניין דרס סטט בייניין דרס	Additional Education: N Educator: Clupala, Liliana Discipline: NURS: NO
Time of Reassessment: The Post Intervention Pain Scale Response to Intervention: The Post of the Scale	Com Social 100103	mert: Thrombotic Prevention ment: 12/23/14 1935 LC 12/24/18 0156 LC
Pain Comment: WILL-CONTINUE TO MUNITOR	Palien # On Re	mente II//3/141 IJI II II/II/14 0214 LO kotes: Nutee Notes *ate 12/23/1411535 LC 12/23/14 0222 LO romal? N Confidential? H PI S A/0 X4. SPECH CLEAR, DX ON ADMISSION HEADACHE. PT DENIES ANY HEADACHE
Instructions Given Related to:		AT THIS TIME. ON TELE# 14 WITH NER. PT DENISS RAY CHEST PAIN AT THIS TIME. Exerth sounde cia bilat. Respiration even and onladored on room air.iv saline Locked on r wrist. IV site clear and dry without redukes or influtration
Pain Management is Part of Treatment Plan: About the Use of the Pain Intensity Rating Scale: M Total Absence of Fain is Often not Realistic/Desirable Goal: Choosing a Pain Control Goal, such as Pain Not Worse than 2: T That Effect of Pain Management Interventions will be Reassessed About the Importance of Requesting and Receiving Pain Reliet Measures Refore Fain Recomes Severe 6 Difficult is G Control: #	at Frequent Intervals: X	NOTED. BOWEL SOUNDS ACTIVE X4. LAST EM ON 12/23/14 WITH FORMED STOOL. PT VOIDS FREELY WITHOUT DYSURIA REPORTED. SKIN INTACT WITHOUT ACTIVE MOUNDS KOTED. SCD'S IN PLACE BLE. CALL LIGHT IN REACH AND BED IN LOW POSITION. WILL CONTINUE TO MONITOR. They Date: 12/23/14 Tume: 2246
About the Importance of Notifying Health Care Providers About == Other Information Taught == ; d0250 Position Change + A Q211 = Potient Solition Change = Right Solition Change = Right Solition Change = Right Solition Change = Night Soliti		VS: Monitor - A AS ORDERED CP ment 12/13/14 2246 ASI 12/21/14 2246 ASI Pulse: 61 Pulse Source: TEXMORAL ARTEX Pulse: 61 Pulse Source: MITOMATIC Respirations: 16 Resp Source: MITOMATIC Site: LEFT UPPER ARM C/O Pain: Y Pain Scale: 7/10 == CRA/LICENSED Documentation ==
BOULD BOUCEION: PATIENC/AMILY TECHING + A VEBT Document 12/23/14 1938. EC 12/24/24 9218 EC PATIENT/FAMILY EDUCATION Information Taught: CARETY FRECAUTIONS Instruction Given: CAEL LIGHT IN FRACH AND BOD IN LOW FO	SITION	Comfort Measures Implemented: """"""""""""""""""""""""""""""""""""
Person Taught: PATIENT		yger. Device: ROCH AIR CTO2 (3): 97 FIC2: c: DT REFUSED PAIN AEDICATION AT THUS TIME

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Agre/Seat: 68 M	Attending: Lally, James M.	HANNA, ADEL	e	Page: 11 of 16
Dait 4: M000273781 Admitted: 12/23/14 at 1149 Status: DIS IN	Account #s 900000503802 Location: DU Ch Room/Bed: 2287-B	ino Valley Medical Cent DISCHARGE PATIENT AU		 Printed 12/30/14 at 1649
Intervention Description Sativity occurred Type Date Tim	SCs Directions		ntervention Des Activity Type D	
Activity Date: 12/28/14	T'ime : 0547	Re	ctiwiry date: 1	2/24/14 Time: 0947 (continued)
=== INTAKE: SHIFT TOTAL === Ice: N CTAI: 240 Tubs Feeding: H20: H20: IV's: ENCLOSE BRP: V 4 of Voids/Incont: 2	47 LC 12/24/14 DS47 LC TVP3's: Chemo: TV93's: Chemo: TV1: Chemo: Colosiony: Colosiony: Hemo:	roduct ant,In: Intake Intake Vac 41	IV IV Site C IV Start/Rest IV ctivity Date: 1 90004 Date	art Date. Marine a Comrant: Brite and an annual and an annual an annual annual an annual annual annual annual annual annual annual annual
<pre># cf stools: Urine: Stool, Liquid: Encesis: NG Tube: Nephrostomy:</pre>	Ileostory GU Irrigan Jackson Pratt #2 Dialys Jackson Pratt #2 Dialys Chest Tube #2 State Other for the state Other for the state	T-Tube: 24 t, Out: Con ia Nct: d Output: 24 Con control Con control Con control Con control Con control Con con con con con con con con con con c	mment: WILL GIV	ck completed; v: s merode no av surge i substantial distantia a finital di sind di distanti ifies that all current orders have been completed or are in process.
21950 Reutine Ceare: VIEW FROTOCOL Sciment: 12/24/34 05: The Practice Guidelines App Have Been Met Throughout The Signature: Ciupala tiliana	TOTAL SHIFT FLUID BALA STATUMANENT I STATUS OF SHIFT/IX NED/SURG/TELE - A .END OF SHIFT/IX 17 LO 15/24/34 DE48 LO SCHOOL 15/24 DE48	CP CP My Practice 200 ad	Abrocinal? W PT R2STED W IN LOW POST ctIVITV Jacet 1 010 Vs: Qocument 1 Temperature/ Pulp Respiration Block Pressur	2/24/14 0549 LC 12/24/18 0590 LC Coolidestal? M FLA NO C/O HEADACKE DIETNS THE NIGHT. CALL LIGHT IN REACH AND BED TION. WILL CONTINUE TO MONITOR. 2/24/14 CTOR: 57/62 Monitor - A AS ONDERED CP 2/24/14 CTOR ADI 12/24/14 0TOR ASI F: 08.2° Temp Source: TEXMODAL RATEXY 0: 18 Nego Source: DESCRUON 0: 18 Nego Source: DESCRUON 0: 142/050 BP Source: SECONDITC.
- Restraints in Use: Nº Describ	on: SYNHDARD PROCEDURGE	2001	(I Oxygen Device S∋O2 (%)	<pre>== CNA/LICENSED Documentation == mfort Measures Implemented: Nures Notified of Pain: f Medicated, Document On Intervention Pain: Management of) ***IF ON OXYSED*** * MOCH ALM* ** UP ON ANA* *** UP ON ANA* **** ****************************</pre>
IV ASSESSMENT Throughout Shift: IV Location: IV Site Condition: IV Start/Restart Date:	Central Line -IV Site Within Norma 12/23/14	Present: N 1 Limits: V 10.	70 shi Document 1	2/24/14 Trme: 0750 ft Reassessment - A (S & Q4H IN ICU CP 2/24/14 0750 ED 12/24/14 0941 ED irod Date: 12/24/14 Time: 0750

Age/Sexs 68 M Attending: Telly, James M. Whit 4. M00273781 Account 8. 706000503802 Admitted, 12/23/14 at 1149 Iccasion: DU Ch Statue: DIS IN Room/Red: 2287-B	HANNAR, RDEL, S Chino Walley Medical Center KUR **LIV DISCHARGE PATIENT AUDIT FORMAT		Page: 12 of 16 2** Printed 12/30/14 at 1649
Intervention Description Sts Directions Activity occurred Records1 Docurrented Type Date Time by Date Fine by Compart Units	From	Therefored be	scription Sta Directions From Decurred Recorded Documented Date Time by Comment Units Change
activity Date: 12/24/14 Time: d750 (continued)		Activity Date:	12/24/14 Tome: 0750 (continued)
1076 shift Reasessment + (continued) NEURO_CGIICAL Assessment Within Normal Limits: Neuro Comment: ZENT Assessment Within Normal Limits: HEAT Comment:			<pre>Mifr Reassessment _ :continue1) Moisture: 4 RAREIN MOIST ID-23 = No Risk: 9 Activity: 4 Not FUTURE INFORMATION ID-14 = Moderate Risk: Nutrition: 3 ADDOTRE INFORMATION ID-12 = Migh Risk: and Sheer: 3 No RAPARENT PROMIEV 9 Or Lower = Very High Risk: Scoring of 18 Or Lower - Initiate skin Integrity Protocol Guidelines</pre>
EESPIRATORY Assessment Within Normal Limits: Y Respiratory Connect: CARDIAC Assessment Within Normal Limits: Y IF ON CARDIAC MONITOR/TELEMETRY: Cardiac Rhythm: GROWAL GINGE RWYTHM Monitor #: 34 Cardiac Comment: PT DENIES OF AT THIS TIME		=== DVT RISK PSS Admission DX inc	Leg Plaster Cast Dr Brace: p No. Varicose Veins: p NO. Hormone Replatement: d NO. Suddes: CHF, COPP, MC, Sepsia, Pneumonia: b NO. Bed Rest with Limited Activity: 0 NO.
CIRCULATORY Assessment Within Normal Limits: Ý Circulatory Comment: MUSCULGKELETAL Assessment Within Normal Limits: Ý Musculoskeletal Comment;		Hip,	<pre>Observe (> 1 month): 0 NO Major Surgery (> 6 0 minutes): 0 NO Family History of DUT/PS: 0 NO Present Cancer or Chemotherapy: 0 NO History of SUT, DUT/PS: 0 NO Felvis, or Leg Fracture (< 1 month): 0 NO Strove (< 1 month): 0 NO</pre>
NUTRITIONAL Assessment Within Normal Limits: Y Nutritional Contrant: GASTROINTESTINAL Assessment Within Normal Limits: Y GI Comment:			Paralysis (< 1 month): O DOL 1999 (< 1 month): O DOL 1999 (< 1 month): O DOL 1999 (Paralysis) For the second
GENITOCINIARY Assessment Within Normal Limits: Y GU Comment: INTEGUMENTARY Assessment Within Normal Limits: Y Skir Comment: PSYCHOSOCIAL Assessment Within Normal Limits: Y Psychosocial Comment: ;		Sequential Comp Chem Comment: SCB/SSS === SAPETY === Isolat:	SICIAN IF DVT RISK SCORE > 1 AND DOCTMENT IN PT CARE NOTES *** ression Levice in place: M cal Prophy.axis in use: N N THRE TRANSFER PROCEEDINGS: A state of the state of t
==== The Following To Be Documented On Once A Shift ==== === FALL RISK ASSESSMENT=== Mental Status: 0 NOT ALTERED Econory Perceptual Status: 0 NOT ALTERED Physical Mobility Status: 0 NOT ALTERED Elimination Status: 0 NOT ALTERED Patient's Age: I dow YAMS ===BRADEN TRESCIEC LUCER RICK RESESSMENT=== Sensory Perception: 4 NOT LIMITED-VANL	R_sk= -2): te (3-6):	IV Site Cor IV Start/Resta 15000 Ca - Document PATIENT PROBLEM	<pre>NT === Scation: HIDHT WRIPT District Status: A List As PROOF TIZED ON CARE FLAN: IN Site Within Normal Limits: Y IN Site Within Normal Line: Y IN Site Within Normal Limits: Y IN Site Wi</pre>

Age/Sex: 68 M Attending: Jally, James M. HA		Page: 13 of 16
Totalt # M000273781 Account # V0000503802 Admitted: 12/23/L4 at 1149 Ecocation: DO Chi Status: DIS IN Noom/Red: 2287-B Chi	no Valley Medical Center DISCHARGE PATIENT AUDI	
Incrivention Description Sts Directions Activity conured Recorded Docurrented		ervention Description Sta Directions From
Type Date Time by Date. Time by Comment. Units		Nype Date Time by Date Time by Comment Units Change
Refuiry mate: 12/24/14 "Time: offs (continued)	Adt I	vity Date: 12/24/14
15000 Care Flan: RE Review - (continued) : and Post-remains the third and remains the second se	31320 - Dog	pain: Management of - A BS NEEDED CP Quent: 12/24/24 0750 BD 42/23/14 0944 BP
		PAIN MANAGEMENT === Time of Patiert's Complaint: 6756 Pair Lecation:
Latient's Flan of Gare was Reviewed and Updated as Reeded: 31200 Problem: Neurological + A Cé & C4H IN ICU r Doument 32/24/14 3756 FD 12/24/14 1944 F1	~P	-pain Scale: 0/10/ Ucacribe the Vain:
Altered Neurological Status/Function Remains Active Problem: W (if No, Consider Inactivating or Completing Intervention) *** Document Only on Interventions Related to Patient's Altered Status/Funct	Comfo	ort Keasures Implemented
-NEUROLOGICAL Assessment Within Normal Limits. Y Neuro History:		Time of Reassessment: Post Intervention Pair Scale: The second state of the second sta
Specifi Headaches: Describ: Behavior/Appearance Inappropriate: Describe:	Patie	ent/Pamily Education Provided: 🕷
		Fain Comment: PT DENIES PKIN AT THIS TIME
== GLASOM COMA SCORE == (Best Response) == 2UFL REACTION CH Fye Response: 4=SRONTANEONS Reaction OD: 30 TSK Verbal Response: 5=CONTANEONS Reaction OS: 90 TSK Motor Response: 5=CONTANEONS	Size: 3 Size: 3	=== Pain Education for Patient/Family ===
Total: 30% === SEIZURE INFORMATION ===	Ins	structions Given Related to:
Recent Seizure Activity: Seizure Precautions Initiated or being U	til:zed: N	Pain Management is Part of Treatment Plan:
Describe Seizure Event Duration Pre/Post Ictal State:		About the Use of the Pain Intensity Rating Scale: W
		al Absence of Pain is Often not Realistic/Desirable Goal: W
=== ADDITIONAL NEURC ASSESSMENT ===		posing a Pain Control Goal, such as Pain Not Worse than 2: 7 At Effect of Pain Management Interventions will be Reassessed at Frequent Intervals: *
		at Effect of Pain Management interventions will be Reassessed at Frequent intervals: #8 out the Importance of Requesting and Receiving Pain Refier
Level of Consciousness:		easures Before Pain Becomes Severe & Difficult to Control: 🕷
Orientation: ICP Mcnitor: Responds to: ICP:		About the Importance of Notifying Health Care Providers About Any Unrelieved Pain: 📆
Memory: Fluctuations: Fluctuations:		== Other Information Taugh1 ==
Weakness: Specify:	40250	
Numbress: Specify: Facial Droop: Describe:		zument 12/24/14 0750 ED 12/24/14 0944 ED i+nt Position Changed =
Factal Droop: We Describe: a tendents and an and a second statements of a need statement of an and a second statement of a second st	Right	lent rostilan chambel = : Side: 1 Left Side: Supine: Trendelenburg: Tment: PFTURNS Bf HAMSELF
=== ADDITIONAL SWALLOWING ASSESSMENT ===	80010	D Education: Patient/Family Teaching + A QS BY CAREGIVER CP
Problems Observed with Swallowing:	300	sumerit 12/24/14.0750 ED 12/24/18 0944 ED
Food Texture Tolerated:		=== PATIENT/FAMILY_EDUCATION === Information_Taught: CAPETY_PRECAUTIONS
FIGIN CONSISCENCY IDLEIGUES COMMUNICATION COMMUNICATION		Instruction Given: CALL GIGHT IN PEACH AND BED IN LOW POSITION
Neuro Comment: ADMITERD PT FOR HEADACHE.PT LE A/O 24. POLLOW COMANDE NO N/V.	NU WEARDESS .	

Person Taught: PATIENT

Agre/Sent: 68 M	Attending: Lally, James M.	HANNA, ADEL S	Page: 14 of 16
Tait #: M000273781 Admitted: 12/23/14 at 1149 Status: DIS IN	Account #: 900000503802 Location: DU C! Room/Bed: 228T-B	nino Valley Medical Center KUR **LI DISCHARGE PATIENT AUDIT FORMAT	VE** Printed 12/30/14 at 1649
Intervention Description Activity Cocurred Type Date Tar	Sts Directions Records Docurenced Me by Date Time by Comment Units	From Intervention Activity Change Type	
Refivity Date: 12/24/14	Time: d750 (continued)	Activity Date	:12/24/14 Time: 0949 (continued)
Person Taught Teaching Tools Other Tools Used Other Tools Used Pactors Affecting Learning Other Pactors Participation Level: Waluation Needs Additional Education Educator Discipline: 1001034 Age Guideline Occument 12224744 07 Patient Notes Discipline: Contes: Nurse Notes Discipline Contes: Nurse Notes Discipline SR, 27 Denkes CP AC '5 UNLADERED RESFIRATIONS AMEULATORY WITH BRP, V AND MODERATE, SCO'S 1 FOREMED. 10 TO RIDOR	Demonstration Terbal Mode Node Node Node Node Node Demarks Understanding Demarks Brid Uters Two Edits The Edits No Edits	Friends, And F If I Refuse Chir If I Refuse Chir PATIENT: WITNESS: By Signing Bel LOS TELE # 34 SOURT SOURT	Invertory Personal Belongings + (continued) ave Been Given The Opportunity To Have My Valuables Locked Up. • Have My Valuables Locked Up or Sent Home With Family Or Friends, • Valley Medical Center From Any Liability For Lost Valuables. • Date: • Date:
ON ADMISSION & HAVE PATIENT & Create 12/23/14 09 - Document 12/24/14 09 Inventory Date: 12/24/14 19	19 ED 12/24/14 0950 ED 19 ED 12/24/14 0950 ED Inventory Time: 0948 Performed By: Dehard,Eric		Does the patient have any wounds/incisions: Ni Core measure requirements completed (if applicable): Y is this a CHP patient: Ni e patient have anticoagulants (Coumadin, Xarelto, etc): Ni Is this a STROKJ/TE patient: Ni
Reason For Inventory: DISCH -N Contacts -B Full Dent -N Fartial C -N Hearing J	-Y Glasses Disposition: HELONGTONE Tures Disposition:		Education provided to the patient: Y ² Health Summary provided to patient: W ³ Instruct pt to bring Health Summary to follow up visit *
admission. Should Dentures, admission, they must be logg Center will not be response as RELEACE OF LIABILITY OF N	tal Safe: M Ary Belorgings Sent Home Denter will only be responsible for items logged Hearing Aids, Bye Glasses be brought to the pat ged with the Primary Nurse or Charge Nurse. Chir ble for any item not logged on the Belongings For FAULWARDS KEDT WITH DATIENT >> I Have Been Advised To Send My Valuables Home F	d at the time of .ient after to Valley Medical grm. P	== FATIEN' DISCHAMBE ASSISSMENT == n Leaving: Alle TO CRAMINICATE ALENT deferte Feeding: INDEFENDENT nsferring: INDEFENDENT

Age/Sex: 68 M Attending: Lally, James M.	HANNA, ADEL S	Pages 15 of 16
Unit #: N000273781 Account #: V00000503802 Admitted: 12/23/14 at 1149 Location: DU Chi Status: DIS IN Room/Red: 2287-B Chi	ino Walley Medical Center NUR **I DISCHARGE PATIENT AUDIT FORMAT	
Thervention Description Sts Directions Activity cocurred Records Docurrented Type Date Time by Date Time by Commant Units	From Interventic Relivity Shange Type	Description Sts Directions From occurred Recorded Documented Date Time by Date. Time by Comment Units Change
Activity Date: 12/24/14 Time: 1029 (continued)	Addiwity Da	e: 12/24/14 T.me: 1029 (continued)
90051 DC: Nursing Discharge Checklist/Assess (continued) Temperature/F: 96.2 SpC2 (%): 97 Pulse: 67 Oxygen Device: Respirations: 18 O2 Amount (L/min): Blood Pressure: 142/96 FIG. 21 Public (L/min):		DC: Kursing Discharge Checklist/Assess (continued) re:
Pair. Scale at Discharge: 0/10 Loin Mcdication Uiven: NO Time/Date of Last Eose: See Medication Reconcilation	Contractic of	e: 12/24/14 T-me: 1213
	- Create Abrornal PT B212 PF B	: Nurse Notes 12/24/14 1213 ED 12/24/14 1215 ED N Confidential? N C DISCHARGED AT THIS TIME, REVIEWED WITH PT DISCHARGE INSTRUCTIONS AND S BELGNAINES LIST, PT VERALIZED UNDERSTANDING OF DISCHARGE INSTRUCTIONS EWAYING WITH ALL PERSONAL BELONDINGS, IT DUE'D CATHETER INTRAT, NO SWELLING OR PAIN MOTED AT THIS TIME, SCJ'S AND TELE MONITOR REMOVEDE, SWELLING OR PAIN MOTED AT THIS TIME, SCJ'S AND TELE MONITOR REMOVEDE, SWELLING OR PAIN MOTED AT THIS TIME, SCJ'S AND TELE MONITOR REMOVEDE, SWELLING OR PAIN MOTED AT THIS TIME, SCJ'S AND TELE MONITOR REMOVEDE, SWELLING OR PAIN MOTED AT THIS TIME, SCJ'S AND TELE MONITOR REMOVEDE, SWELLING OR PAIN MOTED AT THIS TIME, SCJ'S AND TELE MONITOR REMOVEDE, SWELLING OR PAIN MOTED AT THIS TIME, SCJ'S AND TELE MONITOR REMOVEDE, SWELLING OR PAIN MOTED AT THIS TIME, SCJ'S AND TELE MONITOR REMOVEDE, SWELLING OR PAIN MOTED AT THIS TIME, SCJ'S AND TELE MONITOR REMOVEDE, SWELLING OR PAIN MOTED AT THIS TIME, SCJ'S AND TELE MONITOR REMOVEDE, SWELLING OR PAIN MOTED AT THIS TIME, SCJ'S AND TELE MONITOR REMOVEDE, SWELLING OR PAIN MOTED AT THIS TIME, SCJ'S AND TELE MONITOR REMOVEDE, SWELLING TRANSFER: QUICK SLATE FORT + D ON ADMISSION/TRANSF APPINDE UNST DJZAJA X126 HIS DJZ/24/14 THIS DIST DJZAJA X126 HIS DJZ/24/14 THAN DAGESERMENT + D ON ADMISSION AS
USERCKE DISCHARGE INSTRUCTIONS== Pt/Pt Representative provided Stroke Education Material: Patient Educated on Following Topics: Reason Stroke Education Not Initiated: Comments: Information Not Initiated: ==PATIENT DEMONSTRATES UNDERSTANDING OF== Activation of Emergency Medical System: Need For Jollow-up Medical Care Post Discharge: Medications Procer:Ded at Discharge: Medications for Stroke (PAST): Rawk Factors for Stucke:	2041 The Status 1077 Solo	12/24/14 1216 his D ON ADMISSION CP SmcKing Gescation D ON ADMISSION CP 12/24/14 1216 his D ON ADMISSION N +> D Shift Reassessment - D G (S & QHH IN ICU CP N +> D 12/24/14 1216 his D Q1211 (0559, 1739) CP 12/24/14 1216 his 12/24/14 1216 his CP 12/24/14 1216 his 12/24/14 CP N +> D 12/24/14 1216 his 12/24/14 N +> D 12/24/14 1216 his 12/24/14 N +> D 12/24/14 1216 his 12/24/14 N +> D Poutine Groc: <td< td=""></td<>
Other Patient Education Topics Discussed:	21400 AG Status	Nutrition/Activity/ADL Flowsheet + D QS BY CAREGIVER CP 12/24/14 12/24/14 121e his A -> D

==EDUCATION MATERIALS PROVIDED TO PATIENT== TIA Brochure:

	ending: Lally, James M.	HANNA, ADEL S	Page: 16 of 16
Admitted: 12/23/14 at 1149 Lo	comat #: 700000503802 cation: DU com/Red: 228T-B	Chino Valley Medical Center NUR **LIV DISCHARGE PATIENT AUDIT FORMAT	E** Printed 12/30/14 at 1649
Intervention Description	Sis Directions	From Intervention F	escription Stø Difections Prom

Activity Cocurred Recorded Type Date Time by Date Time by C	Docurrented Somrent, Units Change	Activ Type	ity 0 Date	courred Recorded Time by Date	Documented Time by Comment Units Change
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23 Statue 12/24/4 12/6 Nis 12/24/14 12/16 Nis 1200 Problem: Neurological + 3 3 5 1	D INS/PEROVAL/CONVERT CP D Q6 & Q4H IN ICU CP D As NEEDED CP D As NEEDER CP D As NEEDER CP D As NEEDER CP D As NEEDER CP D ON DISCHARGE CP D ON DISCHARGE As D ON DISCHARGE CP D ON DISCHARGE CP D ON DISCHARGE CP D CP CP D As CP D As CP D As CP D ON DISCHARGE As D As CP D As CP D As CP <t< td=""><td>DC</td><td>OLES: CASE I PLANKING COL TRIFICALE RCALWIDO CNARAL CNARDZ NURCEI NURCEI EDBKO SWME</td><td>Management Notes (contin MELETED. Name Dairymple,William Sarpong,Nlex Uarpong,Ucrdt Deharo,Eric Ldu.Jing Ciupala,Lillena Bacani,Marlene D Montoya-Bell,Suman autonatic by program</td><td>ued) Provider CNA RB RN RN RN SS</td></t<>	DC	OLES: CASE I PLANKING COL TRIFICALE RCALWIDO CNARAL CNARDZ NURCEI NURCEI EDBKO SWME	Management Notes (contin MELETED. Name Dairymple,William Sarpong,Nlex Uarpong,Ucrdt Deharo,Eric Ldu.Jing Ciupala,Lillena Bacani,Marlene D Montoya-Bell,Suman autonatic by program	ued) Provider CNA RB RN RN RN SS
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Pallent Notes: Case Management Notes Treate 12/24/14 144 AM 12/24/14 1444 9N Abnormal? N Confidential? N INITIAL Disclarge Planning Schern/charr Eviloged, of live with his groupe and is inddefendent with Able And Decision Making, pt Discharged with No Further

	68 M		: Tally, James M. : 700000603802	HANNA, A	DEL S	Page: 1 of 7
	<pre>M000273781 12/23/14 at 1149</pre>	Location		Chino Walley Medical	Center NUR **LIN	VE** Printed 12/30/14 at 1649
Statu	SI DIS IN	Room/Bed	1 228T-B			Date Range:Beginning to 12/30/14
		Stand	lards of Care Reference			STANDARDS OF PRACTICS: ICJ
The Fo	llowing STANDARDS OF	CARE are R	elated to the Patient, Family/and	or Significant other.	2. Identify pat	tient support system; involve appropriately in plan of care.
1.	Patient Care				3. Assess patie	ent/family/significant other(s) for economic, social cultural,
	Patient Education					nd environmental factors which may affect patient during
	Fatient Discharge F	lanning			hospitalizat	
	Patient Safety Patient Rights				4. Encourage pa care team.	atient/family/significant other(s) to verbalize concerns to health
	Facience Kighes				Care coam.	
			lecting an Ongoing Interdisciplina		NURTIFION:	
			on, Goal Secting, Interventions, An			ritional intake.
			ial Needs and Expectations Of Car			>50% of meal eaten and tolerated well.
			the Plan of Care With Attention To Confidentiality and Special Communi			advance diet as tolerated. eating/feeding if indicated.
Cu	Icular and Kerryrous	, mericia, c	Suridentiality and special communi	Califon Meeds.		sult if NPO > 24 hrs.
2. Th	e Patient will Record	ve Educatio	on about the Nature of His/Her Heal	th Condition,		
			, and Post Discharge Care. Verbali			al nutrition (tube feedings):
			ERnrouraged. Patient Education, Wh			placement g 4 hrs and prior to starting feeding/giving meeds.
			aching Process Is Prioritized Base	d on the Onyoing		dicpaque feeding tube placement verified by CXR after
As	sessment or Individu	al Learning	j Needs.		insertion ar	
a mb	- Estiopt will Port:	cipato in C	Coordinating Resources and Establis	bing Priorition To		ned at 30 degrees as patient condition allows. rance to feeding solution.
3. 10	2 Pariene will Pare.	cipace in c	tooramacing weathres and matabilis	ning ritoricios in		ic residual q4h for continuous feeding.
Pr	eparation for Discha	rae.				ic residual before each intermittent or bolus feeding. If over 100 cc
	•					next feeding.
		ve Care In	An Environment that Minimizes Risk	of Injury for		ral feeding pump for continuous feedings.
Th	emselves or Cthers.					ing container/gavage set q2∈hr.
						ng tube with 20-50 ml water q shift and prn following medication
	e Patient will be Su If Worth, Privacy an		His/Her Effort to Retain Personal	Identity,	administrati	ion. I bag with only a 12 hr measure of feeding solution.
5e	n worth, Privacy at	iu Ani onomy.				e food color in all enteral feedings.
		STAN	DARDS OF PRACTICS: ICU			n care to mare or tube insertion site daily and prn. Change tape q 24 hr.
						unless pat's condition does not permit it.
		d, The Foll	lowing Assessments And Intervention	s Have Been		n administration with enteral feedings -
	leted.					ions to be given on full stomach: Stop feeding, flush with 20cc warm H2O,
SAFETY					administer m	med, flush with 20cc warm H2O, resume feeding.
			cal record number, in place. I with any change in condition.		Por modianti	ions to be given on empty stomach: stop feeding 30 minutes prior to
	tiate safety measure					ion time, flush with 20cc warm H2O, administer medication,
	e rails up.					20cc warm H2O, resume feedings 30 minutes after administration.
Red	in lowest position				7. If on parent	teral nutrition (TPN/PPN):
	wheels locked					via patent central line, using an infusion pump.
	1 bell within reach		condition allows.			PPN solution a minimum of q 24 hr.
	entials within reach		-		Charge tubir	
	ient/family instruct form safety rounds a					be piggybacked into the TPN tubing; Change tubing q 24hrs. ght and glucose according to policy.
			in and prin infection control: additional preca	utions as indicated		se TPN via a midline catheter.
	p environment as qui					
7. Ori	ent patient/family/s	ignificant	other(s) to unit, room, call bell,	bed controls, side	ACTIVITIES / ADL'	ʻ\$:
		fety issues	, visiting hours and smoking polic	y cn admission		performed as ordered:
	prr.					rogressive activity.
e. Mon	itor equipment in us	e quantt a	ina prn			eration of activity. eed for and monitor use of assistive devices.
9 3.00	ompany/menitor all p	allienta ost	ing for procedures/tests unle	es otherwise	2. If on bedres	
			<pre>//mag for</pre>	oo oolokado		st. tion at least g 2hr & prn as condition allows, maintaining
			i home to entrance of hospital.			alignment and assess skin condition.
			-		Perform/assi	ist with range of motion exercises q2-4 hr and prn.
	CCIAL:					
1. Pro	vide privacy for pat	ient/family	/significant other(s).		3. Assist with	hygiene needs daily and prn.

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- Age/Sex: 68 M Unit #: N000273781 Admitted: 12/23/14 at 1149 Attending: Lally, James M. Account II: V00000503802 Location: DU Page: 2 of 7 HANNA ADEL S Chino Valley Medical Center NUR **LIVE** Printed 12/30/14 at 1649 Statue: DIS IN Room/Bed: 228T-B Date Range: Beginning to 12/30/14 STANDARDS OF PRACTICE: ICJ STANDARDS OF FRACTICS: ICU If not performing independently: Assist with personal hygiene a minimum of g2thr. Otter oral hygiene twice daily and prn. If patient intubated or NPO offer oral hygiene g2hr and prn.
 Change linen as necessary to maintain personal hygiene/comfort.
 If patient is incontinent: dependent period and and why which hypics offer oral dependent period. If implanted port present: Acress only with a Huber needle. Charge greasing and access every 7 days. If not in the or following intermittent infusion/blood draws, heparinize with appropriate concentration and amount per policy. With appropriate concentration and amount per policy. Use an influsion purp for all influeions. If invasive monitoring line(s) in use: Transducers zeroed/leveled q shift and prn. 2ero/level with HOB flat unless condition prohibits, and record HOB position/elevation. Cleanse perineal/perianal area and apply skin barrier after each episode
- Change bei linens pri to keep dry. Establish a bladder/bowel program with fixed voiding schedule if appropriate. Toileting offered g2hr and prn.
- SKIN INTEGRITY:
- Perform risk assessment upon admission and daily.
 Evaluate skin condition g4hr and prn:
- Monitor skin integrity.

- Source, shift integrity. Inspect/assess pressure points. 3. Keep skir clean and dry. 4. Prevent/eliminate pressure, friction and shearing forces on skin. 5. Keep linen clean, dry, and wrinkle free.
- 6. Initiate appropriate interventions for inactivity, immobility, incontinence, malnutrition and/or decreased sensation/mental acuity with guidelines verified in the Plan of Care.
- 7. Implementation of specialty beds per bed selection decision-making tree. (under necessary from MD)
- Remove/rotate NIBP cuff/pulse oximetry probe ç4h & prn.
- IF IV/INVASIVE LINES PRESENT:
- Assess site(s) a minimum of q4h & prn for redness, swelling, and/or pain.
 Label all IV dressings and tubings with data, time and nurse's initials. Use nonporous tape to write dates and times or. IV solution bags and tubings
 If peripheral IV site present:
- 4. If peripheral 17 Site present: Verify that 17 site changed a minimum of q72nr % prn. All 17's started out of hospital are changed within 24hr. Saline flushes per protocol. Date vials. 5. For all 17/epidural solutions infusing or invasive monitoring colutions: verify 17/pressure solution and monitor ordered rate of infusion and/or with a given by the solution of the solution of the solution of the solution. site gihr Verify th

Verify that TV/pressure solution(s) changed a minimum of q24br. Verify that TV/pressure tubing and transducers changed a minimum of q72br

and with each site change except as noted below: -Every 12 hours for Diprivan tubing Every 24 hours for lipid tubing -Every 24 hours for CPN tubing

- Control line present: Assess site and apply transparent dressing after insertion of central line. Change transparent dressing/caps q/2hr and prr. Flush inused ports of multi-lumen lines with appropriate solution gBhr and
- Finant integer ports of their financial integers and appropriate solution going and provide integers and the solution of th
- Pressing change and site care done q week by nurse. Fluch nused ports of multi-lumen lines with appropriate solution q24hr and prn following intermittent infusions/blood draws (when allowed). Use IV infusion pump for all infusions.

Maintain pressure bag at 300mmHg. Pulmonary Entery Catheter Monitoring: -PA/CVE g4bz -Hemodynamic grofiles will be recorded on insertion of line and g shift order. CO injectate to consist of 10cc room air or per temp NE unless otherwise ordered of patient condition merits iced or low volume -Measure catheter position q shift and prn. Document initial insertion position Arterial catheter Monitoring: -Correlate with brachial cuff g8hr and prn. -Assess CMS peripherally to arterial catheter g2hr. -Arterial line sites to be changes every 5 days. Discontinuance of sheaths:

Maintain system sterility by use of yellow deadender caps/heparin locks on

all open ports.
 2:1 heparinized solution unless pt. condition prohibits.

- -Central introducers/side ports: remove prior to transfer from ICU. -If patient condition prohibits PIV access, obtain order to maintain prior to transfer from ICU.

- prior to transfer from too. 10. If irrigation solution in use: charge solution q24hr. Chart all solution/flushes with or without medications or MAR.
- PAIN
- PAIN:
 Pair assessment to be performed each time vital signs are recorded and prr. with appropriate interventions: Assess location, type, duration and frequency of pain Assess intensity of pain using an appropriate tool: self-report, scale 0-10.
 If IV opiods administered: Verify drug and dose to be given. Dilute and administer per protocal.
- Monitor sedation level and respiratory rate/quality per policy.
- If PCA in use: Verify medication/program/patency.

- verify medication/program/patency. Instruct patient in use.
 Monitar vital signs and sedation level per policy.
 4. If epidaral catheter in use: verify medications/program/patency.
 Check catheter site/dressing g shift and prn.
 Medications and addition for black as added
 - Monitor vital signs and sedation level per policy. All prn analgesics/sedatives ordered by anesthesiologist only.

RESPIRATORY:

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Notice in dry and intext dreasing. THESPORTISE: Statility means of communication. THESPORTISE: CREDUCT Skin care to insertion site(s). 1. Not continuously monitored. Skin care to insertion site(s). 2. Alars verifed as on with settings r/- DV of patient's baseline. 1. If drainage tube(s) present: (GP, henovac, t-tube, etc.): 3. Boy doc tingges gddm and prm. 2. If folly greener: 4. Monitor all patients discharge to telewithy with R, geV, s gT New content discharge gddm and prm. 5. Wontor all patients discharge to telewithy with cardiac monitor. If folly greeneri: 6. Wontor all patients discharge to telewithy with cardiac monitor. Charge folly may folly det increase in addiment, obstruction, or a break in the closed system. 7. Check Sain Criters for all pre with a cardiac diagnosis. If folly greeneri: 14. Wontor all patients incharge the duples with dopler for past procedure/post on carbater to thigh. Notice catheter present: 7. Check Sain Criters for all pre with a cardiac diagnosis. If requera-putic catheter present: 15. Wontor all patients in the patients: Andro catheter for duple. 16. Wontor all patients in the patients: If adams as ordered. 17. Check Sain Criters for all pre with dopler for past procedure/post on catheter present: If addie duple. 16. Set Sum Fried of Monitors. Andre catheter of thigh. 17. Wontor all patients: If addie d		ourou una chango ao bracica			
Keep space trach of appropriate size at bedside. 1. If (ariange tube(s) present GP, henovac, t-tube, etc.): CNADID: 1. KG continuously monitored. 1. KG continuously monitored. 2. If folgy present: 3. Exp set changes dafut and prn. 2. If folgy present: 4. Boating of KG tracing gebr, with changes and prn with 20, QER, & QT Maintain closed gravity drainage mystem. 5. Monitor all patients discharged to telenetry with cardiac monitor. 7. For external present(or patients): 7. Chest Fain Graves for all pre with a bardiac diagnosis. 7. If augras-public catheter present: 7. Chest Fain Graves for all pre with a bardiac diagnosis. 7. If augras-public catheter present: 7. Chest Fain Graves for all pre with a bardiac diagnosis. 8. If augras-public catheter present: 7. Chest Fain Graves for all pre with dopler for post procedure/post op varing a more catheter to thigh. 9. Virify patency. 7. Main Science Presentions: 7. Bart Science Presentions: 9. If augras-public catheter to thigh. 8. World patients 9. If augras-public catheter present: 9. Urify patency. 9. If augras-public catheter present: 9. If augras-public catheter present: 9. If augras-public catheter present: 9. Chest Fain Graves for all pre with a bardiac diagnosis. 9. If augras-public catheter present: 9. If augras-public catheter prese	Maintain dry and intact	dressing.			
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CXBD/C1 Skin fare to insertion site (s). 1. KBJ continuously monitored. Skin fare to insertion site (s). 1. KBJ continuously monitored. Names contens/werge given and prn or as ordered. 2. Alarsa verifed as on with settings +/- 100 of patient's baseline. If foley present: 3. Exp fact changes given measured/very given and prn with %2, G82, 4 gr Wrifp patency. 4. Posting of KKG tracing given, with changes and prn with %2, G82, 4 gr Maintain closed gravity drainage mystem. 5. Monitor all patients discharged to beleventy with cardiac monitor. Foley present: 6. Zor external pacemaker patients: Performance 7. Chest and orders for all patient discharged to belevent if pacemaker is in use Site care given. 8. Konitor all patients discharged to belevent if pacemaker patients: Charge closered or verify patency. 7. Chest and orders for all pts with a cardiae diagnosis. If augra-public catheter present: 1. Wolf CATHENT: Andor catheter to thigh. 1. Staf add side saile Parity appropriate pailated pulses with dopler for post procedure/post op 2. Wolf add side saile Andor catheter of thigh. 1. Wolf CATHENT: Trap security juit change trape given. 1. Wolf of patients: Trape security juit change trape given. 2. Wolf saile for exclus	Keep spare trach of app	ropriate size at bedside.			
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 intrvals measured/evaluated on strip. Forted on Progress Note on chart. Keep bag below level of bladder at all times. Periaze daily and prn. If foley inserted autoide of hospital, change within 24hr. Change foley have for increase in sediment, obstruction, or a break in the closed system. Closed system. If supra-public catheter present: Chest Pain Orders for all pts with a rardiar diagnosis. If supra-public catheter present: Chest Pain Orders for all pts with dopler for post procedure/post op vacuum patients. If supra-public catheter to thigh. Vascuum Patients. If NURC PatiENT: Ves of seizure presentions: Padded ide rails Patients Presention Presentions: Patients Presention Presentions: Patients Presentions: Patients Presention Presentions: Patients Presentions: Patient Presention Presen					
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Site care q24hr and prn.3. If supra-public catheter present: Clamp as ordered or verify patency.7. Chest Pain Creders for all pts with a pardiac diagnosis.3. If supra-public catheter present: Clamp as ordered or verify patency.14. VASCLLAR PAILENT: 1. Verify appropriated pulses with doppler for post procedure/post op vascular patients.4. If NGT present: Verify patency/placement of tube q shift and prn unless otherwise ordered. Verify patency/placement of tube q shift and prn unless otherwise ordered. Tage securely all change tage q2shr. Trigate tube q shift with 30ce H2D as patient condition allows or as ordered and prn. change trigation set q2shrs (graduate/toory ayringc). A nirway at bedside 2. Maintai HOB elevated per order.1. Use of subarchich benorrhage precautions: tedstaid benorrhage precautions: defined to visitors to room used in activity of patient and visitors to room uint of tube in precaution present: Monitor and record ICP q2hr.3. If supra-public catheter present: Clamp as ordered and prn. Trigate tube (s) present: Norice and record ICP q2hr.9. See of stoal softners pr MD order/sollaborative preactice (I f ventriculostomy present: Monitor and record ICP q2hr.3. If supra-public catheter present: Conterts tube (s) resent: Conterts tube (s) resent: S. If chest tube(s) present: Norice and record ICP q2hr.9. If ventriculostomy present: Monitor and record ICP q2hr.3. If supra-public catheter present: Conterts tube(s) present: Norice patient in the present in the					
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Bed Low position (graduac/foory spring); Airway at bedside Anti RefL: Valve should be in place when NGT connected to suction. 2. Maintain HOB elevated per order. Contents measured gight and prn. 3. Use of subarachicid hemorrhage precautions: Contents measured gight and prn. bediest Charge suction cannister gightre. Quiet environment/decrease stimuli Helication Administration through NO Tube: Jumit activity of patient and visitors to room Administer medication in enough volume to maintain tube patency while Dim lighting -Flush tube with 20 cc warm H20 Use of stoal softners per MD order/collaborative preactice -Clamp tube for a dministration. 4. If Ventriculostomy present: Soft class for air leak, 80 air g4h and prn Worlds and record ICP g2hr. Verify gatcory		016.			
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Bedrest Medication Administration through N3 Tube: Quiet environment/decrease stimuli -Plush tube with 20cc warm H20 Limit activity of patient and visitors to room Administer medication in enough volume to maintain tube patency while administering Dim lighting -Flush tube with 20 cc warm H20 Use of stool softners per MD order/collaborative preactice -Clamp tube for 30 minutes after administration. 4. If Ventriculostomy present: S. If chest tube(s) present: Monitor and record ICP q2hr. Verify gatency					
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4. 1f Ventriculostomy present: Monitor and record ICP q2hr. Verify gatency Verify gatency	Dim lighting				
Monitor and record ICP g2hr. Assess for air leak, SQ air g4h and prn Vorify patency					
Vorify gatency					
	Monitor and record ICP	qznr.			
	TE ORTHOREDIC PATTERNY			verity paten	cγ
	IC ONTROPEDIC PATERNI:			1	

Page: 4 of	HANNA, ADEL S	Attending: Lally, James M.	(Seok: 68 M
Printed 12/30/14 at 10 Date Range:Beginning to 12/30,	lley Medical Center NUR **LIVI	Account #: W00000503802	t #: M000273781 tted: 12/23/14 at 1149 ttus: DIS IN
STANDARDS OF PRACTICE: M/S/T		STANDARDS OF FRACTICS: ICU	
ng pump for continuous feeding.	Use an enterv	and connecting tubing in place	Securely tape chest tub
		ite(s) dry and intact; change per MD order	
iner/gavage set q24hr.			(aintain water sea∣ cha
ith 30-50ml water q4hr and prn following medication		nage system lower than insertion site	
s ordered otherwise.		rainage ql2hr, mark of drainage system	record amount/color of
nare or tube insertion site daily and prn. teral feedings.			
ees at all times.		r and recorded g12hr (+)	
rition (TPN/PPN):		i and recorded gizin (+)	tao co be menicipied qu
ent central line using an IV infusion pump.			a HTT :
ion a minimum of g24hr.		d qd if pt's condition permits.	Weigh pt on admission a
	Change tubin		
acked into the TPN tubing; change tubing q 24hr.	Lipids may be		L SIGNS:
ose and labs according to policy.		and g2hrs (+)	ro be taken on admissio
		q4h unless elevated then q2h (+)	remperatures to be take
	ACTIVITIES / ADD/ S		
per activity guidelines or as ordered.		STANDARDS OF PRACTICE: M/S/T	
	Encourage pro		
		, The Following Assessments And Interventions Have	
nd monitor use of assistive devices			mpleted.
	2. If on bedrest		TY:
east g2hr as condition allows, maintaining proper body alignment.	Turn/reposit:	e and medical record number, in place.	
and a set of the second second second second	De unit en unit de marcia	shift and with any change in condition.	
range of motion exercises q thr and prr. needs daily and prn.		as indicated:	Initiate safety measure Side rails up x 2
	4. If not perfor		ed in lowest position
hygiene a minimum of 24hr.			Sed wheels locked
wice daily and prn.		t all times	all bell within reach
ssary to maintain personal hygiene/comfort.			ssentials within reach
	6. If patient in	d to call for nurse	Patient/family instruct
ianal area and apply skin barrier after each episode			Perform safety rounds a
n to keep dry	indicated. Change bed 1:	ions for infection control: additional precautions	bserve standard precau
hr and prn	Offer toilet:	t as possible	(eep environment as qui
no BM > 2 days notify MD for laxative order	rols, side Record BM da:	gnificant other(s) to unit, room, call hell, bed co	Drient patient/family/s
		ety issues, visiting hours and smoking policy on ac	
	SKIN INTEGRITY:		and prr.
ent upon admission and q shift.		q shift and prn	Monitor equipment in us
ion with each shift assessment:			
	Monitor skin		CHOSOCIATO
ure points:Refer to Depubitus Protocol		ent/family/significant other(s).	
	3. Keep skin cle	system; involve appropriately in plan of care.	
essure, friction & shearing forces on skin y and wrinkle-free		<pre>gnificant other(s) for economic, social cultural, tal factors which may affect patient during hospita</pre>	
y and wrinkle-free		tal factors which may affect patient during hospita /significant other(s) to verbalize concerns to heal	
interventions for inactivity, immobility, incontinence,		Jaight feand Scher (a) to versatize concerna to near	are team.
decreased sensation/mental acuity with guidelines			.ure ccam.
	verified in t		RITICN:
		ke.	Monitor nutritional int
	I&O:	l eaten and tolerated well	
umented g 12hrs	1. I&D measured	as tolerated	ff ordered, advance die
		ng if indicated	Assist with eating/feed
	WEIGHT:	(tube feedings):	if on enteral nutrition
nd qd if pt's condition permits		4hr and prior to feedings/giving meds.	
on TPN and enteral feedings)	(CHF, Renal :		assess tolerance to fee
		4hr for continuous feeding.	
	IF IV/SL PRESEN	efore each intermittent or bolus feeding. If over	
	1. If S/1:		LOOCC notify physician.

Page: 5 of 7	ANNA, ADEL S		Attending:	e/Seac: 68 M
7E★★ Printed 12/30/14 at 1649 Date Range:Beginning to 12/30/14	dical Center NUR **LIVH	Chin	Account I: Location: Room/Bed:	nit #: M000273781 itted: 12/23/14 at 1149 tatus: DIS IN
STANDARDS OF PRACTICE: M/S/T		F PRACTICE: M/S/T	STANDAR	
cheostomy care q shift and prn.		for redness, swelling and/or pai	m of q4hr and	
r cannula g24hr				If IV:
n around stoma with trach care and prn h ties as secure and change as ordered		of infusion and/or site g4hr and	itor ordered :	Verify solution and mon prn.
n cles as secule and change as ordered	Surtian pro	Adar.	ged a minimum	Verify that IV had char
y and intact dressing	Maintain dry	72hr and prn as per policy.	- nged a minimum	Verify that IV site cha
eans of communication			ime, and init	Label site with date, t
trach of appropriate size at bedside	Keep spare to	of 72hr and with each IV site		The state of the s
IC STOCKINGS ORDERED:	TE ENTERMEDIATIO	or vann and with each iv site	nangeo a mini	change.
ckings in place, remove at bathtime and prn for skin assessment		name, time and nurse's initials.	and tubings w	
				If central line present
	or as ordered			Assess site and dressin
Compression Device in place while in bed, remove at bathtime and n assessment or as ordered.		r policy. with appropriate solution g8hr an		Change dressing/caps q/
assessment of as ordered.	prir for skill	od draws, reserve one lumen for 7		
DESERVATION:	POSTOPERATIVE OF			only as per policy. Fol
ve assessment on arrival to floor to include:				Use infusion pumps for
and level of sedation per policy				If implanted port prese
pair and comfort measures te(s) & drainage tubes				Access only with Huber Change dressing and acc
charting on POST OP:SURGICAL ASSESSMENT through the		infusions/blood draws, heparinize		
	Assessment/Fo	. See Venous Access Policy.		
n level with vital signs and level of sedation per policy	2. Monitor pain			Use an IV infusion pump
2 TNOC .	INCISIONS/DRESS:	sician to be called for orders f	h a PICC line	if patient admitted wit care.
	1. If incision p			Cale.
e for bleeding/drainage q4hr and prn				TN:
each dressing change or q4hr & prn if no dressing		l signs are recorded and prn		
	2. If dressing p	« pair management guidelines as p		
nt and prn Inless ordered otherwise	Check g shift Charge pro u	lency of pain		policy. Pain is the 5th Assess location, type,
aniedo erectea ecierator	citatige grif di	riate tool (self report, scale 0-		
ent, monitor vaginal bleeding q4hr and prn		· 60 ·		If IV opioids administe
	4. If vaginal pa			Verify drug and dose to
	Check g shift Kemove only a			Dilute and administer p Monitor sedation level
as ordered	Remove only a	terdeality per policy		It PCA in use: (Follow
	TUBES / DEALNS :			Verify medication/progr
tube(s) present (JP, hemovac, t-tube, ect).				Instruct patient in use
	Verify patend			Monitor vital signs and
p insertion site(s) tents/empty gl2hr or as ordered and prn		(Cific MD orders)		If epidural catheter in Verify medications/prog
	2. If folcy proc	l as per policy		Check catheter site/dre
	Verify patend	er policy	sedation lev	Monitor wital signs and
osed gravity drainage system				
low level of bladder at all times	Keep bag belo Peri-care da:			SPIRATORY:
ally and prn bic catheter present:		st ordered intervals or q4hr and	d deep breath	Assist with coughing an
dered or werify patency		·- ······· ····		as necessary
	Anchor cathet			Monitor pulse oximetry
ining as ordered		/ protocol, unless ordered	te per respir	
ent:	4. If NGT presen			otherwise. If postoperative:
ncy/placement of tube q shift and prn unless otherwise ordered.	Verify patend	14hr and prn.	h g2hr x 8. ti	Turn, cough, deep breat
ly and change tape q24hr.			ordered	Incentive spirometer as
	Anti Reflux 3			If Tracheostomy present

Age/Sex: 68 M Attending: Tally, James M.	HANNA, ADE	ញ ខ	Page: 6 af		
Unit # M000273781 Account #: V00000503802 Admitted: 12/23/14 at 1149 Location: DU O Status: DIS IN Moon/Bed: 228T-B O	Chino Walley Medical Ce	enzer NUR **LIV	IVE** Printed 12/30/14 at 1649 Date Renge:Beginning to 12/30/14		
STANDARDS OF PRACTICE: M/S/T			REFERENCE - DEFINED PAPAMETERS		
HOB elevated 30 degrees at all times.		-	-No Throat Complaints/Abnormal Assessment Such As		
Change suction cannister liner q24hr.			Sore, Red, Swollen, Hoarseness, Hypertrophied Tonsils,		
Medication Administration through N3T:			exudate on tonsils, or postnasal drip		
-Flush tube with 20 cc warm H20			-Buccal Mucosa Pink, Moist And Smooth		
-Rdminister medication in enough volume to maintain tube patency while	e.	-	-Teeth present are intact OR well-fitting dentures		
administering					
-Flush tube with 20 cc warm H20 -Clamp tube for 30 minutes after administration			VRY Paramters: -Breath Sounds Clear/Vesicular (Soft, Low-Pitch Sounds)		
5. If chest tube(s) present:		-	Throughout All Lung Fields And Bronchial Over		
Assess for air leak, SQ air q4hr and prn			Major Airways: No Adventitious Breath Sounds Noted		
Assess for all leak, sy all gant and pro Auscultate breath sounds			-Respirations Unlabored		
Securely tape chest tube and connecting tubing in place			-Equal Chest Expansion Noted		
Dressings to insertion site(s) dry and intact; change prn			-NO Cough Noted		
Maintain water scal chamber/suction as ordered			No Sputum/Secretions Noted		
Maintain chest tube drainage system lower than insertion site		-	-No Chest Tubes in Place		
Clamps X2 at bedside		TE ON OX	YGEN: Document Device And Amount Of Oxygen Delivered		
IF ON TELEMETRY:		CARDIAC	Parameters:		
1. Monitor EKG continuously			-Heart Rate Regular Per Ausculation Or Palpatation		
2. Interpret and post rhythm strips g4hr and prn			Heart Sounds Normal (51 & 52)		
Notify physician of rhythm changes			-No Syncope/Fainting		
4. Change EKG pads daily			-No Dizziness/Vertigo		
			-Denies Chest Pain		
IF ORTHCPEDIC PATIENT: 1. Maintain weight bearing status as ordered		IF ON TE	LEMETRY: Record rhythm		
 Maintain weight bearing status as ordered Utilize immobilizers/braces/collars as ordered 		CIECH DE	'ORY Parameters:		
3. Monitor CMS of affected extremity gBhr and pr.			-Strength of the Radial, Dorsalis Pedis , and Posterior		
 Apply ice pack to surgical site if ordered 			Tibial pulses is expected (2+)		
5. Assess Homan's sign q12hr and prn		-	-Extremities Warm		
6. Use pillows under operative lower extremity only if specifically order	red		-Extremities pink in color		
		-	-Denies sensory changes in extremities		
REFERENCE - DEFINED FARAFETERS			(no numbness, tingling or loss of sensation)		
		-	-No edema noted		
NEUROLOGICAL Parameters:					
Eyes Open Spontaneously			KELETAL Parameters:		
Oriented (Person, Place & Time)			-No skeletal deformities noted		
Follows Commands Speech Clear		-	-Steady Gait And Balance		
No swallowing difficulty/impairment at present as			-No Weakness Noted In Extremities		
evidenced by droeling, coughing, choking or complaint of			-Rothermities With Full ROM		
difficulty			-No Joint Swelling/Tenderness Noted		
No Headache					
Behavior/Appearance Appropriate (Good Hygiene		NUTRITIO	NAL Parameters:		
Appropriate Dress For Season, Well Groomed. Emotions Appr	ropriate		Diarrhea/Nausea/Vomiting For < 3 Days		
Considering Cultural Variations)	-	-	-NPO Or Clear Liquids < 3 Days		
No current seizure activity noted		-	-Not On Dietary Supplementation (TPN/PPN/TUBE FEEDING)		
EENT Parameters:			INAL Parameters:		
Pupils equal and react briskly to light			-Abdomen Flat Or Evenly Rounded, Soft, Symmetrical		
No discharge, redness, pain, edema, blurred or distorted			And Nontender To Palpation.		
vision with glasses/contacts, noted/complained about eyes	5		-Bowel Sounds Active In All 4 Quadrants (5-30/min)		
Able to hear common sounds with and/or without			-Moving bowels within own and no change in consistency		
hearing aids (No hearing impairment)		-	-Denies GI Complaints (Colicky, Cramping, Diarrhea		
No. No. of Complete (Newsmall Dessence) - 2 -			Constipation, Heartburn, Epigastric Burn, Fecal Incentionnes, Balabing, Managebaide, Desugration, Diserty		
No Nasal Complaints/Abnormal Assessment Such As Bleeding, Nasal Discharge (Watery, Mucoid, Purulent),			Incontinence, Belching, Hemorrhoids, Regurgitation, Bloody BM, Flatulence, Upset Stomach, Feeling Of Fullness,		
Congestion, Stuffiness, or Difficulty Breathing Through	Nares		BM, Figurence, opset scomash, recring of Furness, Decrease Appetite, Nausea And/Or Vomiting.)		
congracion, acultiness, or difficulty Breathing infough			Boliowoo reposito, manada Anayor (omiting.)		

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Printed 12/30/14 at 1649 Date Range:Beginning to 12/30/14

--No GI tubes present for decompression of GI tract EDUCATIONAL Parameters --No educational barriers identified such as age related issues, HOH, reads only braille, cognitive, cultural deaf, emotional/psychiatric, financial, language, notivational, physical, reading below grade level, cannot read written words, religious, uses sign language (Do not include tubes here for feeding purposes) GENITOURINARY Farameters --Able To Empty Bladder Per Voiding Without Incontinence Cr Catheter (May Use Urinal, BSC, or Bedgan only, and/or decreased vision OR --Ft/Significant other(s) able to understand verbal instructions well (no difficulty related to educational barriers) --Ft/Significant other(s) able to understand written instructions well (no difficulty related to eductional barriers) Et (Significant other(s) able to unterblue broadedee of No Problems Because Dialysis Patient And Does Not Froduce Urine. --Urine Clear And Yellow To Amber In Color. --Denies Uninary Complaints/Problems (Burning, Frequency, --Denies Urinary Complaints/Problems (Burning, Frequency, Orgency, No/Low Urine Output etc.) IF NEMALE VALUENT: NO Unusual Vaginal Blooding Or Vaginal Discharge Noted Or Complained. Vaginal packing in place as ordered --IF MALE PATIENT: NO Penile Discharge Noted Or Coplained. NO Scrotal Edema Noted Or Complained. -IF DIALMISS PATIENT: Document type of dialysis and IF FIGTULA: Fistula with bruit and thrill --Ft/Significant other(s) able to verbalize knowledge of treatment plan/educational needs well (no difficulty related to educational barriers) IV SITE Parameters: IV site patent without redness, swelling. tenderness, or temperature INTEGUMENTARY Parameters: --General Skin Assessment Is Pink/Ethnic Color, Warm And Drv Skin Intact: No Alteration In Skin Integrity (Such As --skin integer: No Alteration in skin integrity (SUch As Abrasion, Blisters, Burn, Decubitus, Srising, Executiation, Hives, Incision, Irritation, Lacerations, Lesions, Peeling, Rash, Scaling, Sloughing, Stoma Present, Skin Tears, Ulcerations, or Wounds. --No brainage Tubes Such As Hemovac, JP, Penrose Drain T-TUBE Etc. Present. PSYCKOSCCIAL Parameters: --No Mood Swings Noted. Patient's Mood Appropriate For Situation With Regards To Cultural Influences. Situation With Regards To Olicural Influences. --Effective coping skills/jattens with regards to cultural influences (ineffective coping can be presented as post traumatic response, abusive behavior to self, threats of self harm, suicidal thoughts, or violent behaviors) --No altered self perceptions noted such as body image disturbance, feeling of hopelessress, personal identity disturbance, feeling of powerless, or altered self esteem

--Normal, age-appropriate, growth and development (Erickson'S) --No signs of suspected abuse

FAIN Parameters: No chronic or acute pain

NO signs of suspected abuse (physical) emotional, neglect, etc.) Signs include delay in troatment, hesitation to explain, injury inconsistent with history, sites of injury, self neglect, nonspecific complaints, patterned markings, recurrent injuries, or injuries in various stages

Age/Sex: 60 M Attraiding: Lal Unit #: M000273781 Account #: V00 Amitted: 12/23/14 at 1149 Accention: JU Status: DIS IN Accention: 220	000603802	HENNA, ADEL S Chino Valley Medical Center NUR **LIVE** Fatient's Flan of Care		Status: Discharged Page Initiated: 12/23/14 Print Completed: 12/23/ Protocol. at 16
	STS INIT BY TRGT	COMP BY INTERVENTIONS	INIT BY COMP B	Y DATE & TIME DIRECTIONS S
RCELDN: Impaired Neurological Purotion *Altered neurologic status related to disease process, trauna and/or surgical procedure.	D 12/29/14 JLA	1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 -		
hprove/maintain neuro function/status.	D 2/23/14 JL1 12/27/14	* Froblem: Neurological +	12/23/14 .0.1	12/23/14 1600 28 4 048 18 100
<pre>evelopmental Age 66+ (OLDER ADULT) Based on Erickson's eight stages of development. Development. Need: - Feel good about how life was lived. - Remonisce. - REMODIC: AGE 66+</pre>	D 12/23/14 JL1			
- HOTCOL: AGE 664 Patient will be able to make informed about health cure.	D 12/23/14 JL1	 Age Guidelines: 561 (OLDER AUCET) PROTOCOL: AGE 564 	12/23/14 JL1	12/23/14 1322 VIEW FROIDCOL/DI QS
VMC STANDARD OF CARE See Standard of Care Profile	D _2/23/14 JL1			
All Farients & 11 Receive The Following		 Shift Rassessment + VS: Nermitor + VS: Nermitor + VS: Nermitor + VS: Sermitor + Sermitor VS: Sermitor + Sermitor +	12/23/14 JL 12/23/14 JL	12/23/14 1322 28 4. (4H TH 101) 12/23/14 1322 28 4. (4H TH 101) 13/23/14 1322 21.84 (0.556, 13.53) 12/23/14 1322 21.84 (0.556, 13.53) 12/23/14 1322 24.84 (0.557, 13.53) 12/23/14 1322 28 87 (28.94 (0.578)) 12/23/14 1322 28 87 (28.94 (0.578)) 12/23/14 1322 21.04 12/23/14 1322 21.04 12/23/14 1322 21.04 12/23/14 1322 21.04 12/23/14 1322 20.01 25.04 (0.578) 12/23/14 1322 24.04 12/23/14 1322 24.04 12/23/14 1322 24.05 12/23/14 1322 24.05 12/24/24 14.05 12/25/24 122 12/24 14.05 12/25/24 122 12/24 14.05 12/25/24 122 12/24 14.05 12/24 1
	D 12/23/14 JL1			
See Standard of Care Protils				
See Standard of Care Profile - PROTOCOL: S.M/S/TELE	Б (22/14 т)			
	D 12/23/14 JL1	* Routine Care: MED/SURG/TELE + VIEW PROTOCOL - FROTOCOL: S.M/S/TELE	12/23/14 ЛЛ	12/23/14 1322 .END OF SHIFT/TX

ADDIT_ONAL INTERVENTIONS	INCT BY CO.	MPBI DATE & TI	ME DIRECTIONS	8_8 867
* Vilal Signs	202202 00:2007 "C: 16 "CONSERVED DE PORT	10250 / 102 / 2001 021 028 000 00 1/ 102 1/ 102	1.1.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2	

Age/Sex: 66 M	Attending: Lally, James M.
Ūbit ⊭. MDCO273781	Accessing #= 1700000603802
Admitted: 12/23/14 at 1149	
Status: DIS IN	Room/Bed: 220T-B

HANNA, ADEL S	
edical Center M nt's Plan of Cau	

Status: Discharged Initiated: 12/23/14 Completed: Prococol:

Page 2 Printed 12/30/14 at 1650

ADDITIONAL INTERVENTIONS	INIT BY	COMP BY	DATE &	TIME	DIRECTIONS		SIS	SRC
* ADMESSION/TRANSFER: Quick Start Form +	12/23/14 JL1		12/23/3	14 1322	ON ADMISSION/TRANS		D	AS
* IV: Saline Lock & Flush	12/23/14		· · · · · ·				D	ОE
* ADM: ADULT Admission History +	12/23/14 JL1		12/23/1	L4 1548	ON ADMISSION		D	AS
* AEM: Risk Assessment - Sulcide	12/23/14 JL1		12/23/1	14 1985	ON ADMISSION & PRK		D	AS
* ADM: ADVET Admission Assessment +	12/23/14 JEL		12/23/1	14 1556	ON ADMISSION		Ð	AS
* Inventory Personal Belongings +	12/24/14 ED		12/24/3	14 0949	ADM. TX.DC		- D	A9
ON ADMISSION & TEAMSPER. PRINT OUT &								É
HAVE PATIENT SIGN COPY.								L. C.
* DC: Mursing Discharge Checklist/Assess	12/24/14 10		12/24/1	4 3029	ON DISCHARCE	10, 11, 10, 10, 10, 10, 20, 00, 11, 11, 11, 10, 10, 10, 10, 10, 1	10	AS

Monogram	Initia's	Name	Nurse Type
	DRDALWIDO	Dalrymple,William	Provider
ED	NUFFEL	Deharo,Erio	RN
JL1	NURLJ1	Liu, Jing	RN

Contract of the second s	VALLEY		Ali .ps Report Data Time: 12/24/2014 03:36:50		
MEDICAI	L CENTER				
Last Name: HANNA Doctor:	,	First Name: ADEL Height: in = cm	ID: 273781 12/23 Weight: lbs = kg	. Bed: 22	28 B * 35
				-MT-Initials	
HR(ECG): 57 BPM	PVC/min: 0		•		
Interpr	etation:	· · · · · · · · · · · · · · · · · · ·		PR:	QRS:
Event: Brady		· · · · · · · · · · · · · · · · ·	·		
ECG Lead II		·			
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	a			•	
		CHINO VALLEY MEDIC	CAL CENTER		
		HANNA, ADEL S	es M.		
1 _		03/29/40 AD	IM 12/25/24		
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x7 11 1 /	. O.	ale / Kildmin eius		12/24/14 /03:	10
Validated	1 By: <u>ЛСД</u> RN/LX	N Signature/Name Printed	Date/Time_	14/1/19 /03.	70
		U			

Print Time: 12/24/2014 03:37

Page 1

Panorama: TELE3

CHINO VALLEY MEDICAL CENTER		Al، ,ps Report Data Time: 12/23/2014 19:01:50	
Last Name: HANNA Doctor:	First Name: ADEL Height: — in = — cm	ID: 273781 12/23 Weight: ibs =	Bed: 228B 36 MT Initials
HR(ECG): 59 BPM PVC/min: 0 Interpretation:	<u>50</u>	•	PR: [9] QRS: [78]
ECG Lead II			
	CHINO VALLE HANNA, ADEL S ATT DR. Lally, 03/29/46 V00000603802	Y MEDICAL CENTER 9990 James M. 9990 69 M000273781 ADM 12/23/14	
Validated By: <u>Lili Art Ar</u> C RN/LV	N Signature/Name Printed	Datc/Tim	e 12/23/14 / 19:05
Print Time: 12/23/2014 19:02	2	Page 1	Panorama: TELE3

DECLARATION OF FINANCIAL RESPONSIBILITY AND AUTHORIZATION TO PAY BENEFITS Chino Emergency Medical Associates ("CEMA") at Chino Valley Medical Center

Federal legislation known as COBRA-EMTALA:

- 1. Requires that any patient who comes to the Emergency Department at *Chino Valley Medical Center* be evaluated, treated, and stabilized regardless of the patient's ability to pay.
- 2. Prohibits the discussion of financial matters, including fees, contracted insurance relationships, and all other billing issues, that may delay your care.

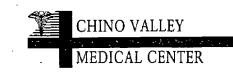
1.	I understand that CEMA, including its contracted physicians, physician assistants and/or nurse practitioners are independent contractors and are NOT employed by the Hospital. CEMA is a separate entity from the hospital.
-2.	- I understand that CEMA's charges for professional fees (charges related to my exam and treatment) are billed separately from the Hospital's charges.
3.' Nev.	if I am not insured, I am responsible for payment for CEMA's services. Based on a review of my situation CEMA may in its sole discretion offer to me a schedule of payments or a discount consistent with their hardship policy.
sister Usigni	If I am insüred, Lam responsible for any co-payments or deductibles associated with my-health insurance policy4 ^{e-l} understand that CEMA may not be not contracted with my HMO; Health Plan; insurance company, or its designed medical group ("Insurance Company").
5.	CEMA does participate in government programs such as Medicare and Medi ² Cal. There are Insurance Companies with which CEMA is non-participating, or is a non-contracted provider. "For these companies CEMA will accept reasonable reimbursement, which we believe is our billed charges.
6.	I understand that my insurance company may not reimburse CEMA for certain medical services (non covered benefits), and that I will not be responsible for unpaid balances if my Insurance Company is regulated by the California Department of Managed Health Care (the "DMHC").
7.	As a courtesy, CEMA will bill my insurance Company. I hereby authorize my insurance Company to directly pay CEMA all amounts due for medical services provided to me. If the insurance Company pays me directly then I agree to turn over these payments to CEMA.
8.	I understand that if CEMA is non-contracted and the payment from the Insurance Company is less than the billed amount, I remain responsible for the balance of the fees unpaid by a non-DMHC regulated Insurance Company, and I may receive a bill for the unpaid amount.

i hereby authorize CEMA to release any information requested by my Health Plan or insurance company regarding my medical condition, illness or injury, in order to determine the liability for payment. By providing my contact information below, I hereby consent and authorize CEMA to contact me using any of the information provided (including e-mail or texting) regarding medical/social/healthcare/billing issues of possible_relevance_or_any_follow-up_or_other_matter______ associated with my visit to the emergency department at *Chino Valley Medical Center*.

If you have any questions regarding CEMA's bill please contact its billing service at 626-447-0296, Extension #254, or visit www.ema.us for further information. By my signature below I agree to all of the terms above.

Signature of Patient or Representative Date	Addressograph
Please Gircle One (Signer Above Is): Patient Spouse Parent or Guardian Relative Other Contact Information (Please Print Legibly). Patient Name:	CHINO VALLEY MEDICAL CENTER HANNA, ADEL S ATT DR. 03/29/46 M 68 M000273781 V00000603802 PRE 12/23/14
Patient's E Mail Address Patient's Cell Phone Patient's Home Address	

Ver 4; 8/28/09



Ebola Virus Disease (EVD) Screening

1. Within the past 21 days, have you traveled to Guinea, Liberia, Nigeria, Sierra Leone, or Senegal?

Yes

No

2. Within the past 21 days have you had contact with a person suspected or known to have EVD?



3. If you answered yes to either of the above, within the past 21 days have you had:

 Fever greater than 36 C or 100.4 F 	Y	Ν
Severe headache	Y	Ν
Muscle pain	Y	Ν
Vomiting	Y	Ν
• Diarrhea	Y	Ν
Abdominal pain	Y	Ν
 Unexplained bleeding 	Y	Ν

Print Name: Add flanvor MD Signature Addree MA Date: 12-23-14

10/22/14 revised

CONDITIONS OF ADMISSION

1. ARBITRATION OPTION: It is understood that any dispute as to medical malpractice, as to whether any medical services rendered under this Contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as approved by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this Contract by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Such arbitration shall be in accordance with the current Hospital Arbitration Regulations of the California Hospital Association-California Medical Association (copies available at Hospital's Admissions Office). This Mutual Arbitration Agreement shall apply to any legal claim or civil action in connection with this hospitalization or outpatient service against the Hospital or its employees and any doctor of medicine agreeing in writing to be bound by this provision. The execution of the Mutual Arbitration Agreement shall not be a precondition to the furnishing of services by the Hospital, and this Mutual Arbitration Agreement may be rescinded by written notice from the patient or patient's representative to the Hospital within 30 days of signature. The Mutual Arbitration Agreement shall bind the parties hereto and their heirs, representatives, executors, administrators, successors and assignees.

NOTICE: BY SIGNING THE CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT. IF YOU DO NOT AGREE TO ARBITRATION. *PLEASE INITIAL*

2. CONSENT TO MEDICAL AND SURGICAL PROCEDURES: The undersigned consents to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services and which may include, but are not limited to, laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, telehealth services, anesthesia, or hospital services rendered to the patient under the general and special instructions of the patient's physician or surgeon.

3. NURSING CARE: The hospital provides only general-duty nursing care unless, upon orders of the patient's physician, the patient is provided more intensive nursing care. If the patient's condition is such as to need the service of a special duty nurse it is agreed that such must be arranged by the patient or his/her legal representative. The hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that the patient is not provided with such additional care.

***4. PERSONAL VALUABLES:** It is understood and agreed that the hospital maintain a fireproof safe for the safe keeping of money and valuables and the hospital shall not be liable for the loss or damage to any money, jewelry, documents, eye glasses, dentures, hearing aids, cell phones, laptops, other personal electronic devices or other articles of unusual value and small size, unless placed therein, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for safekeeping. The liability of the hospital for loss of any personal property which is deposited with the hospital for safekeeping is limited for loss of any personal property which is deposited with the hospital for safekeeping is limited for loss of any personal property which is deposited with the hospital for safekeeping is limited for loss of any personal property which is deposited with the hospital for safekeeping is limited for loss of any personal property which is deposited with the hospital for safekeeping is limited for loss of any personal property which is deposited with the hospital for safekeeping is limited for loss of the hospital by the patient.

5. CONSENT TO PHOTOGRAPH: Photographs may be recorded to document the patient's progress of care and shall be part of the patient's medical records or physician's office medical record. I consent to this and the use of the same for scientific, education or research purposes if approved. The hospital/physician will retain ownership rights to the photographs as well as to the medical records. Photographs may also be taken for the purpose of patient identification.

6. LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS: All physicians and surgeons furnishing services to the patients, including the radiologist, pathologist, anesthesiologist and the like are independent contractors with the patient and are not employees or agents of the hospital. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered to the patient under the general and special instructions of the physician.

CHINO VALLEY MEDICAL CENTER 5451 Walmut Avenue Chino, CA 91710	2 COA	PATIENT I.D.	HANNA, ADEL S ATT DR. 03/29/46 68 M V00000603802 PRE	M000273781 12/23/14
CONDITIONS OF ADMIS	SION) IN A GENTRIC ALTACET CILL TYDIL TRUCE A LATE AND A	III FARAN I AFFERRATION AND A COMPANY AND A COMPANY
PHSI-070-011 CVMC (05/: 3) ORIGINAL - CHART COPY1 - BUSIN	PAGE 1 OF 4 IESS OFFICE COPY2 - PATIENT			

7. EMERGENCY OR LABORING PATIENTS: In accordance with Federal law, I understand my right to receive an appropriate medical screening examination performed by a doctor, or other qualified medical professional, to determine whether I am suffering from an emergency medical condition and, if such a condition exists, stabilizing treatment within the capabilities of the hospital's staff and facilities, even if I cannot pay for these services, do not have medical insurance or I am not entitled to Medicare or Medi-Cal. If I deliver an infant(s) while a patient of this hospital, I agree that these same Conditions of Admission apply to the infant(s).

8. ASSIGNMENT OF INSURANCE OR HEALTH PLAN BENEFITS TO HOSPITAL: The undersigned irrevocably assigns and hereby authorizes, whether he/she signs as agent or as patient, direct payment to the hospital of all insurance benefits otherwise payable to or on behalf of the patient for this hospitalization or for these outpatient services, including emergency services if rendered, at a rate not to exceed the hospital's actual charges. It is agreed that payment to the hospital, pursuant to this authorization, by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for allowed charges not paid pursuant to this assignment. In the event the undersigned's insurance company or health plan makes payment directly to the undersigned for services provided by the hospital, the undersigned shall remit such payment to the hospital within 15 days of his/her receipt of such payment.

9. RELEASE OF INFORMATION: The hospital will obtain the patient's consent and authorization to release medical information, other than basic information, concerning the patient, except in those circumstances when the hospital is permitted or required by law to release information. The undersigned has consented to the release of medical information to entities that provide care in post-acute setting. In accordance with the Safe Medical Device Act of 1990, the undersigned agrees that in the event a permanent medical device is implanted the hospital is hereby authorized to notify the manufacturer of patient's name, address, telephone number, and social security number (if available) as well as other information about the implantation. I authorize a copy of my record to be sent to my family physician or physician of referral at time of discharge.

I authorize release of information regarding the birth of my child, as applicable. Yes No Initial

The hospital is authorized, without further action by or on behalf of the patient to disclose all or any part of the patient's record to any entity which is or may be liable to the hospital, patient or any entity affiliated with patient for all or part of the hospital's or hospital-based physicians' charges for the patient's services (including, without limitation, hospital or medical service companies, insurance companies, workers' compensation carriers, welfare funds; patient's employer, or medical utilization review organization designed by the forgoing).

10. PARTICIPATION IN MEDICAL EDUCATION PROGRAM:

The sunderstood that this hospital is a teaching institution and that unless the hospital is notified to the contrary in writing, the undersigned may participate as a teaching subject in the medical education program of the hospital and may receive treatment by residents, if approved by the undersigned's attending physician, and those clinical students acting under appropriate supervision as required by such medical education and clinical training programs.

11. ORGAN DONATION: California State Law requires hospitals to have a method to identify potential organ and tissue donors. We want you to be aware of the need for organ and tissue donations and to provide you with the opportunity to let your wishes regarding participation be known. Have you signed an organ donor card? <u>Yes</u> No

CHINO VALLEY MEDICAL CENTER 5451 Walnut Avenue Chino, CA 91710	2 COA	PATIENT I.D. HANNA, ADEL S ATT DR. 03/29/46 68 M M000273781 V0000603802 PRE 12/23/14
CONDITIONS OF ADMISSIO	N	
PHSI-070-011 CVMC (05/13) ORIGINAL - CHART COPY1 - BUSINESS (PAGE 2 OF 4 OFFICE COPY2 - PATIENT	

12. PROPOSITION 65 WARNING: You may be exposed to chemicals commonly used in manufacturing processes for medical and drug products and material constituents in products and their packaging which are known to the State of California to cause cancer and birth defects or other reproductive harm.

13. ASSIGNMENT OF INSURANCE OR HEALTH PLAN BENEFITS TO HOSPITAL-BASED PHYSICIANS: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to any hospital-based physician of any insurance or health plan benefits otherwise payable to or on behalf of the patient for professional services rendered during this hospitalization of for outpatient service, including emergency services if rendered, at a rate not to exceed such physician's regular charges. It is agreed that payment to such physician pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligation under the policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment to the extent permitted by state and federal law.

14. HEALTH PLAN OBLIGATION: A list of such plans is available upon request from the Financial Office.

15. HOW YOUR BILL IS DETERMINED: Hospital charges include a basic daily rate, which covers your room, nursing care and food service, or outpatient/emergency services. Additional charges are made for special services ordered by your doctor. Operating room, surgical supplies, medications, treatments, tests, oxygen, x-rays and physical therapy are some examples of such services. Physician charges are billed separately. In addition to receiving bills for services rendered by the hospital and your personal physician, you will receive separate bills from hospital-based physicians who participate in your care. These physicians may represent any of the following areas: anesthesiology, radiology, pathology, nuclear medicine, cardiodiagnostics, and the like.

16. FINANCIAL AGREEMENT: Not withstanding section (6), (Emergency or Laboring Patients), I further understand that I am responsible to the hospital and physician(s) for all reasonable charges, listed in the hospital charge description master and if applicable the hospital's charity care and discount payment policies and state and federal law incurred by me and not paid by third party benefits. In the event that said bill, or any part thereof, is deemed delinquent by the hospital, I understand that I will be responsible for collection expenses as well as reasonable attorney's fees and court costs if a suit in instituted. All delinquent accounts shall bear interest in the maximum rate allowed by law. In the event that hospital is not paid by third parties within three (3) months from the date of billing for payment, I will promptly make arrangements to pay the outstanding account. I authorize the hospital, or collection agancy or other antity contracting with the hospital to obtain credit report about me from the national credit bureaus in connection with payment of my account

NON-COVERED CHARGES: in the event that insurance does not cover particular procedures, medications, and / or services, the undersigned hereby agrees to be personally responsible for payment of such charges, if not prohibited by law.

17. MEDICARE INSURANCE, BENEFITS AND EXCLUSIONS: If the patient is a Medicare beneficiary or will apply for Medicare benefits, the undersigned certifies that the information given about the patient is correct. It is also agreed and understood that we may release certain medical information about the patient to the Social Security Administration and/or its intermediaries and/or its carriers for this or a related Medicare claim. The undersigned requests that payment of authorized benefits be made on the patient's behalf. Some services may not be covered by Medicare, such as the following: 1) Worker's Compensation, 2) Dental, 3) Cosmetic Surgery, 4) Custodial Care, 5) personal comfort Items, and/or any services determined to be unnecessary or unreasonable by Medicare. If the patient is not on file with the Social Security Administration, the usual billing procedures will be used independent of the data access.

18. IF YOU DO NOT HAVE INSURANCE: You may be eligible for the Charity Care and Discounted Payment Program. Please contact the business office.

CHINO VALLEY MEDICAL CENTER 5451 Walnut Avenue Chino, CA 91710 CONDITIONS OF ADMISSION	2 COA	PATIENT I.D. HANNA, ADEL S ATT DR. 03/29/46 68 M M000273781 V00000603802 PRE 12/23/14
PHSI-070-011 CVMC (05/13) ORIGINAL - CHART COPY1 - BUSINESS OFFICE	PAGE 3 OF 4	

19. WAIVER OF LIABILITY: I understand that some or all of these services may not be covered by Medicare and that I am financially responsible if these services are denied.

20. FINANCIAL RESPONSIBILITY AGREEMENT BY PERSON OTHER THAN THE PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE: I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement (Paragraph 7) and Assignment of Health Plan Benefits (Paragraphs 8 and 9) set forth above.

Date/Time

Financially Responsible Party

Witness

Translator: I have accurately and completely read the forgoing document to

(name of patient / person legally authorized to give consent)

in

(the patient's or patient's representatives primary language.)

He/she understood all the terms and conditions and acknowledges his/her agreement thereto by signing this document in my presence.

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

I HAVE READ AND UNDERSTAND THE TERMS AND CONDITIONS OF SERVICE, WHICH BECOME EFFECTIVE AT THE TIME SERVICE IS RENDERED.

PATIENT / PARENT//CONSERVATOR / GUARDIAN

WITNESS

PHSI-070-011 CVMC (05/13)

DATE OF 9

Patient unable to sign: _____

(Reason)

ORIGINAL - CHART COPY1 - BUSINESS OFFICE COPY2 - PATIENT

POLICY HOLDER OR FINANCIALLY RESPONSIBLE PARTY

RELATIONSHIP TO PATIENT

SIGNATURE OF TRANSLATOR

CHINO VALLEY MEDICAL CENTER 5451 Watmut Avonus Chino, CA 91710 CONDITIONS OF ADMISSION

PAGE 4 OF 4

M000273781 12/23/14



EMERGENCY DEPARTMENT REGISTRATION WORKSHEET

PATIENT NAME: LAST: <u>HANNA</u> FIRST: <u>A</u> (NOMBRE DEL PACIENTE) (APELLIDO)	(PRIMER NOMBRE) MIDDLE INTIAL: S (INICIAL DEL SEGUNDO NOMBRE)
PATIENT'S DATE OF BIRTH: 0 3 1 29 (FECHA DE NACIMIENTO) MONTH (MES) DAY (DIA)	<u>1946</u> <u>YEAR</u> (SEXO) (ANO)
PATIENT'S SOCIAL SECURITY NUMBER: 548-6 (NUMERO DEL SEGURO SOCIAL)	
PATIENT ADDRESS: <u>3019</u> Song of (DOMICILIO DEL PACIENTE)	- The winds APT. #:
CITY: Chiko Hills STATE: CA (CIUDAD) (ESTADO)	CODIGO POSTAL)
PATIENT'S TELEPHONE: (909) 342 - (TELÉFONO DEL PACIENTE)	9908
EMAIL ADDRESS: <u>St Maria Medic</u> (DIRECCIÓN ELECTRONICA DEL PACIENTE)	al @ Yahee. Com
PATIENT COMPLAINT Service headaches	
HAVE YOU EVER BEEN IN THIS HOSPITAL BEFORE? (¿HA VENIDO A ESTE HOSPITAL ANTES?)	SI NO €₩
EMERGENCY CONTACT: NAME: IRMA Kawa (CONTACTO EN CASO DE EMERGENCIA) (NOMBRE)	guilie PHONE (909) 374-7216 (TEL.)
PHYSICIAN NAME:	
WERE YOU REFERRED TO ER BY YOUR PHYSICIAN? (¿FUE REFERIDO A EMERGENCIA POR SU DOCTOR?)	☐ YES
CHINO VALLEY MEDICAL CENTER EMERGENCY DEPARTMENT REGISTRATION WORKSHEET	CHINO VALLEY MEDICAL CENTER HANNA, ADEL S ATT DR. 03/29/46 M 68 M000273781 V00000603802 PRE 12/23/14

110-005-CVMC (12/11)

For: ADP03 Fron: Tripathi,Astha M Tue Dec 23, 2014 11:49 am Taken by: SPELLCHECK USER ()

ADMISSION REQUEST FROM ED

Patient Name: HANNA, ADEL S Account Number: V00000603802 Admitting DR: LALJA Attending DR: LALJA Diagnosis: INTRACTABLE HEADACHE Service requested: TELE Registration Type: IN-PATIENT Request Date: 12/23/14 Request Time: 1149

EDUCATION MATERIALS:

All patients will receive the following:

- Patient's Rights and Patient's Responsibilities
- An Important Message from Medicare (Medicare/HMO Medicare Only)
- Notice of Privacy Practices
- MRSA Information
- Charity Care & Discounted Payment Program Information

Inpatients will also receive a Patient Guide. Please review for education on the following:

- Your Right to Make Decisions About Your Medical Treatment
- Understanding Your Pain
- Patient Safety
- Smoking Cessation Information
- Pneumococcal Vaccine Information (Publication date 10/6/09)
- Influenza Vaccine Information (During the Current Flu Season) (Publication date 07/26/2013)

HEALTHCARE DIRECTIVE

Do you have a Healthcare Directive or a Living Will?	YES	<u>∽⊟</u> -NO
 a. Have you provided us with a copy? Yes If no, then note healthcare wishes below: 		Proceed to b.
,		

If you would like further, information or assistance, please contact Social Services.

Kaura Guchi _____ to be involved in the care, treatment and service I permit T KMA decisions during this hospital stay.

By signing below, I acknowledge that I have been provided the required Educational Materials and Healthcare Directive information as requested. 10:35 AM

Signature of Patient / Patient's Representative

If other than patient, indicate relationship.

For staff use only:

PAIRA_

If you are unable to provide any of the above information to the patient because of an emergency treatment situation, describe below the good faith efforts that you made to provide such information to the patient:

Withes

Employee Signature

PHSI-070-013 (04/14)

Date / Time



WHITE - CHART CANARY - PATIENT

PATIENT I.D.			· ·	_
	HANNA, ADEL S ATT DR.			
	03/29/46 68 V00000603802	M PRE	M00C 273781 12/23/14	
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Chino Valley Medical Center	5451 Walnut Avenue.	Chino, CA 91710-2672	F	rinted 06/15/07 0804
Patient		Service/Location St		count/Transcription #
HANNA, ADEL				00000242043
PATIENT Soc Sec No DOB Age Sex MS 548-67-8932 03/29/46 61 M M Race Ethnicity Maiden/Other Name OT NON-HISPAN	AD VIF Conf Religion FC CH 09 Reimb Class FFS	CALIFORNIA 14901 S CE CHINO, CA 9	: (909)606-7144	IN
GUARANTOR HANNA,ADEL SS#: 54 Address: 13678 MONTEVERDE DRIVE CHINO HILLS.CA 91709	SAN BERNARDINO 18-67-8932 SAN BERNARDINO	11 DATE PERSC KAWAGUCHI Home Ph: (9 NEX HANNA, TAME	N TO NOTI IRMA 09)374-7216 CELL DF KIN	Rel: FRIEND Work Ph: Rel: SON
T N S U R A N C E # . BLUE CROSS PRUDENT BUYER PO BOX 60007 LOS ANGELES CA 900600007 Phone: (877)737-7776	Policy #: CPR226A67 Coverage #: Subscriber: HANNA, Rel to Pt: SELF / Eff.: 01/01/01 to Group: CB010A-BLUE	DEL SAME AS PATIENT Rel Assic	Auth #: Pro Revie	IZATIQN Ins Verif: ₩:
INSURANCE # 2	Policy #: Coverage #: Subscriber: Rel to Pt: Eff.: to Group:	Rel Assig	Treat/Precen Ins Verif: Pro Review:	1 I A T I O B t:
Att Phy Shah, Umesh C. / PC Phy Agarwal Chandrahas		E G I S T R A T I O ED F Imitting Diagnosis/Re PIGASTRIC PAIN.DIFFIC	Phy Pason for Visit	Admitted By ADASA
NDE NUMBER	CL.			
		INICAL SUMMARY		
PRINCIPAL DIAGNOSIS (THE CONDITION.	·	· · · · · · · · · · · · · · · · · · ·	·	
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CO-MORBIDITY(IES) (PRE-EXISTING CON OPERATION(S)/PROCEDURE(S):	AFTER STUDY, RESPONSIBLE FOR ADD	MISSION):		AUTOPSY YES ND

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Date (-) [-] Age (Sex M Race	BP130/70 T98 P80 R14
Chief Complaint Heanthyyon	General Condition 0000
Present Illness SID H-H-Yepub	
Screening colononiopy	EENT
Port- HX Colon Komp.	Heart
•	Lungs
	Abdomen
	Extremities
	Specific Findings
Past History H.H. PRILAW - (mmshill)	
E Sio Perfornition	
Allergies MOMO	
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ACCOUNT #: PATIENT: DATE OF SURGERY:

V00000242043 HANNA, ADEL 06/15/2007

cc:

SURGEON:

Umesh C. Shah, M.D.

ASSISTANT:

REFERRING PHYSICIAN:

Chandrahas Agarwal, M.D.

ANESTHESIOLOGIST:

PROCEDURES PERFORMED:

Upper GI endoscopy with biopsy. Colonoscopy with polypectomy.

INDICATIONS:

The patient is a 61-year-old man who is complaining of atypical chest pain, heartburn, indigestion, and prior history of hiatal hernia surgery with some complications. The patient is not responding to the Prilosec over-the-counter. The patient also requesting colon followups. He had a colonoscopy in the past with some polyps removed five years or more ago. The patient is requesting follow-up evaluation.

CONSENT:

The patient was informed about the procedures, the risks, the benefits, and alternatives, possible complications of drug side effects, bleeding, and perforation was discussed. Informed consent was obtained.

PREMEDICATION AND MEDICATIONS USED DURING THE PROCEDURE: Fentanyl 100 mcg and Versed 5 mg.

PROCEDURE #1: Upper GI endoscopy and biopsies.

DESCRIPTION OF PROCEDURE:

The patient was placed in the left lateral position. Bite block was given. Olympus video gastroscope was passed through the pharynx into the esophagus without any problems. The scope was advanced over to the cardia. GE junction was around 40 cm. There were no definite inflammatory changes in the lower esophagus. The esophageal sphincter appears to be fairly tight and normal post plication. The scope was advanced into the stomach. Retroflexion was done. Right below the GE junction, there was a small erosion with oozing of the blood. This

OPERATIVE REPORT

CHINO VALLEY MEDICAL CENTER CHINO, CA 91710 HANNA, ADEL M000273781 Umesh C. Shah, M.D. DATE OF SURGERY: Page 1 of 2

06/15/2007

ACCOUNT #: PATIENT: DATE OF SURGERY:

V00000242043 HANNA, ADEL 06/15/2007

appears to be right part of the surgery for the fundal plication. No chronic ulcer of any significance. There is no significant paraesophageal hiatal hernia identified. The scope was then straighten out and advanced all the way through the pylorus into the duodenum. No peptic ulcer disease. Couples of biopsies were done from the antrum to look for H. pylori. The scope was withdrawn and the procedure is terminated.

IMPRESSION:

Status post fundal plication. Some erosion at the GE junction on the retroflex view. This is probably traumatic.

PLAN:

Await the pathology report for H. pylori and treat appropriately if positive. There are no inflammatory changes in the esophagus. Atypical chest pain, difficult to explain for now.

PROCEDURE #2:

Colonoscopy with polypectomy performed under the same sedation. Anal sphincter was lubricated with KY jelly. Olympus video colonoscope was inserted through the anal sphincter into the rectum. Internal hemorrhoid was noted. Some prominent dented line papillae were noted as well. There is no proctitis. The scope was gradually advanced all the way to the cecum. Position of the scope in the cecum was confirmed by the usual criteria. Careful examination upon withdrawal of the scope shows a tiny polyp in the right colon, which was removed using the cautery and snare, and retrieved by suction method. Rest of the colon exam was unremarkable. Few diverticuli noted in the left colon. Retroflexion of the scope in the rectum showed hypertrophic dented papillae, although it has an unusual appearance. After careful consideration, decision was made not to try to remove this because of the pain associated with it. This will be discussed with the patient and plan as a later if necessary.

Umesh C. Shah, M.D.

DR:	UCS/GSR/BAS
DD:	06/15/2007 09:54
DT:	06/15/2007 21:54
Job #:	059129508

OPERATIVE REPORT

CHINO VALLEY MEDICAL CENTER CHINO, CA 91710 HANNA, ADEL M000273781 Umesh C. Shah, M.D. DATE OF SURGERY: Page 2 of 2

06/15/2007

Chino Valley Medical Center 5451 Walnut Ave. Chino, California 91710 (909) 464-8600 PATHOLOGY CONSULTATION REPORT Robert M. Bearman, MD, Pathologist Medical Director

Patient: HANNA, ADEL DOB: 03/29/46 Age/Sex: 61/M Pt Type: REG SDC Acct. #: V00000242043 Unit #: M000273781 Specimen Number:07:S357Surgery/Collection Date:06/15/07Accession Date:06/15/07Completion Date:06/19/07Surgeon/Doctor:Shah, Umesh C.

COPIES TO

Agarwal, Chandrahas Shah, Umesh C.

PRE-OPERATIVE DIAGNOSIS

HX COLON POLYP

POST-OPERATIVE DIAGNOSIS

HEMORRHOIDS, COLON POLYP

SPECIMEN(S) SUBMITTED

RIGHT COLON POLYP

DIAGNOSIS

LARGE INTESTINE RIGHT, COLONOSCOPY - TUBULAR ADENOMÀ

GROSS DESCRIPTION

يتتندر

The specimen consists of a single light tan soft round tissue fragment measuring 0.1 cm in diameter. The specimen will be submitted in toto in a single cassette. RMB/at 06/19/07

MICROSCOPIC DESCRIPTION

A microscopic examination has been done.

Case read at: Desert Valley Hospital 16850 Bear Valley Road Victorville, CA 92395

Electronically Signed by

Bearman, Robert 06/19/07

** END OF REPORT **

Page 1

	MODERATE SEDATION (Sedation analgesia)
I.	PRE-PROCEDURE DIAGNOSIS: AMMITCUL MENT PUM - GERD
H.	ASA CLASS: Normal healthy patient. Mild systemic disease (includes smokers). Severe systemic disease that limits activity. Severe systemic disease that is a constant threat to life. MORIBUND, not expected to survive
111.	HISTORY AND PHYSICAL COMPLETED and/or UPDATED PRIOR TO PROCEDURE:YES
₩.	PRE-ANESTHESIA ASSESSMENT: 1. POSSIBILITY OF PREGNANCY? YES_NO 2. PROSTHETIC VALVE/HIP? YES_NO 3. PREVIOUS ANESTHESIA YES_NO COMPLICATIONS? YES_NO FAMILY HX? YES_NO UMITED NECK ROM YES_NO
	ANESTHESIA PLAN: PHYSICIAN STATEMENT: I have discussed risks, benefits, alternatives, and consequences of the sedation/analgesia plan with the patient/guardian. The patient has had all questions answered and agrees to the plan. MODERATE SEDATION (sedation analgesia)NOOTHER
	PHYSICIAN PRE-PROCEDURE RE-ASSESSMENT: I have completed a re-assessment immediately before sedation administration and the patient remains a candidate for the planned procedure and choice of sedation analgesia. YES NO
	PHYSICIAN SIGNATURE: UCMUL DATE: 6-15-07 TIME: 9 MM
V.	POST-PROCEDURE: TOLERATED PROCEDURE WELL/NO ADVERSE EVENTS. PATIENT DID NOT TOLERATE PROCEDURE/CANCELLED/ABORTED.
	OTHER: DISPOSITION OF PATIENT: MAY DISCHARGE WHEN DISCHARGE CRITERIA METYESNO OTHER: DISCHARGE INSTRUCTIONS REVIEWED WITH PATIENT AND/OR DESIGNEE:YESNO
	PHYSICIAN'S SIGNATURE:

I, Adel Hanna, acknowledge that my doctor has explained to me that I will have an operation, diagnostic
or treatment procedure. My doctor has explained the risks of the procedure, advised me of alternative treatments and told me
about the expected outcome and what could happen if my condition remains untreated. I also understand that anesthesia
services are needed so that my doctor can perform the operation or procedure.

It has been explained to me that **all** forms of anesthesia involve some **risks** and no guarantees or promises can be made concerning the results of my procedure or treatment. Although rare, unexpected *severe complications* with anesthesia can occur and 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 forms of anesthesia and that additional or specific risks have been identified below as they may apply to a specific type of anesthesia. I understand that the type(s) of anesthesia service checked below will be used for my procedure and that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do, his or her preference, as well as my own desire. It has been explained to me that sometimes an anesthesia technique which 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.

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F

Π	General	Expected Results	Total unconscious state, possible placement of a tube into the windning						
	Anesthesia								
	Allestitesia	Technique	Drug injected 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.						
	Spinal or	Expected Results	Temporary decreased or loss of feeling and / or movement to lower part of the body.						
Ì	Epidural Applacaio /	Technique	Drug injected through a needle / catheter placed either directly into the spinal canal						
	Analgesia / Anesthesia		or immediately outside the spinal canal.						
	Allestitesia	Risks	Headache, backache, buzzing in the ears, convulsions, infection, persistent weakness,						
			numbness, residual pain, injury to blood vessels, "total spinal".						
	Major / Minor	Expected Results	Temporary loss of feeling and / or movement of a specific limb or area.						
	Nerve Block	Technique	Drug injected near nerves providing loss of sensation to the area of the operation.						
		Risks	Infection, convulsions, weakness, persistent numbness, residual pain, injury to blood vessels.						
	Intravenous	Expected Results	Temporary loss of feeling and / or movement of a limb.						
	Regional	Technique	Drug injected into veins of arm or leg while using a tourniquet.						
	Anesthesia	Risks	Infection, convulsions, persistent numbness, residual pain, injury to blood vessels.						
	Monitored	Expected Results	Reduced anxiety and pain, partial or total amnesia.						
	Anesthesia	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes						
	Care		producing a semi-conscious state.						
		Risks	An unconscious state, depressed breathing, injury to blood vessels.						
Ŋ	Moderate	Expected Results							
	Sedation	•	in which protective reflexes are maintained.						
		Technique	Drug injected into bloodstream or administered orally or rectally.						
		Risks	An unconscious state, depressed breathing, injury to blood vessels.						

I hereby consent to the anesthesia service checked above and authorize that it be administered by a provider credentialed to provide anesthesia services at this health facility. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by them. I expressly desire the following considerations be observed (or write "none"):

I certify and acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives and expected results of the anesthesia service and that I had ample time to ask questions and to consider my decision.

____ Date and Time 6 (15/=7-Patient's Signature∠ Substitute Signature_____ Relationship to Patient _ Witness VILLY MELL ADDRESSOGRAPH Chino Valley Medical Center 5451 WALNUT AVENUE, CHINO, CA 91710 3 - 비 : 문화공이제를 CONSENT FOR ANESTHESIA SERVICES 10 100 Million 61 / 1 271781 LOR 03/29/45 205 08/19/07 007528 (6/06) 00.7528 9779-10, \$84%, QRESK C.

INTRA OP / RECOVERY

MODERATE SEDATION RECORD

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Time		Nu	rsing Notes (Addendum)	
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Rhythm	<u>Sl</u> . P	OST PROCEDUI	RE RHYTHM STRIP	
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for a constant	6/570		ue barra, adil	
RN SIGNATU	RE			
DISCHARGE / TRA			DISCHARGE HOME ONLY	
PATIENT DISCHAR	GE TO: 🗌 N/A	MODE	STATUS: IMPROVED OTHER	
		Bed BECLINER		
POTHER <u>OPS</u> <u>report ti</u>	Churry,			
Page 4			ESCORTED BY Name of person taking patient home	

1

	MODERAT	E SEDATI	ON RECOR	ND \				NURSING DIAGNOSIS
Pre-pi	ocedure as	sessment by	, physician:	\setminus			_	Anxiety r/t insuffici
⊐ No d	hanges in p	patient's con	dition at this	time 🔪		ent	nd	knowledge of pre- interventional routine
🛛 Cha	nge in patie	nt conditior	noted:		- ne	e N		and post-intervention alterations / sensatio
		·····			//	, ¹	. <u></u> , <u></u>	PATIENT OUTCOME:
					thy sician			Patient will verbalize w to expect and less anx
Final	/erification	"Time Out"	time:			AIN SCALE		after education.
	y Assessme					lumeric: 0 - 10) = no pain, 10 =	worst pain)	Goals Met
	lass per ph			7	B	laker / Wong F	aces:	Unresolved
	45E	-	/	/				evidenced by verbai and /or non-verbai
TIME		MEDICATIO			SIGN	ATURE		expressions of pain.
0855		gesong	·_					PATIENT OUTCOME: Patient's pain
0900	Sentam	esony,	~	A	Calabe)		characteristics identified and patient expresses
	Jun	a my	/	-\Y\ //	Comme - C			feeling of comfort / rel from pain.
0915	Vurse	c ing			······································			EVALUATION:
								Goals Met
								Risk for altered
<u> </u>								respiratory
								r/t immobility secondary to
								sedation / analgesic/
								anesthetic effects
			<u>+ ^ -</u>					PATIENT
PHYSIC	AN SIGNATURE:	4	to and	u the		·		OUTCOME: Maintain adequate
DATE	TYPE & SOLUTIO	IV RECORD	SITE STARTED BY	TIME D'CD IF	INTAKE	Biopsy	Banding	tidal volume, vital capacity, forced-end
				APPLICABLE		Hot Biopsy		expiratory volume without airway
	·····					Dilatation		intervention
• SCOPE	MODEL	#2		🗆 N/A		PEG Place	ment	EVALUATION:
	VES DNO [N/Az				Removal of	Foreign Body	Goals Met
						U Other	<u>.</u>	L
	OCAUTERY USED ,	,	NA UNI II		POST-PROCEDUR	E ASSESSME	п	
 SITE CC 			guernage		COMMUNICATION:		ENT LIMITATION	ا .
	NDITION BENK		· · ·	- 1 7	OTHER			
	OCAUTERY UNITS	Estre getter	to Guerelli	or by	· MENTAL STATUS:	E CUME		Έ
• SITE CO	OUAUTERT UNITS.		'sha			Chous	y	
• SITE CO • ELECTF	IENS COLLECT	ED			· RESPIRATION:	TUNLABOR		
• SITE CO • ELECTF	IENS COLLECT	ED			Incontinention.	د ا		
• SITE CO • ELECTF SPECIN		<u>ep</u> gkt Cole	s.		• SKIN CONDITION:			
• SITE CO • ELECTE SPECIN		<u>eo</u> ght Cole	<u>su</u>					

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	MODERATE SEDATION RECORD
PROCEDURE ECAL ANDA	
RE-PROCEDURE DIAGNOSIS / PRESENT COM	PLAINT POST PROCEDURE DIAGNOSIS SI Pro Dung and
Hy y Colorfoling - ge	
TY of Colorgency	allation, & active inflamration
JTEAPRETER	PRE-PRÔCEDURE ASSESSMENT
Name:	• EDUCATION PATIENT / FAMILY: Pres INO Color Paly
Yes No XN/A	• COMMUNICATION: INO APPARENT LIMITATION HERION dolds
ISTORY & PHYSICAL ON CHART	
	• RESPIRATION: UNLABORED OTHER
PTHX: <u>BeemAL</u>	
sec H+f	
ALLERGIES: NKA REGLAN	
pergener	• BOWEL PREP: VYES NO RESULTS
PRE-PROCEDURE	VITAL SIGNS
97.5 P 62 A 20 BIP 107/75	
	Arrived to Room: 0850 Out
EQUIPMENT CH	Ended: 0973
	Procedure Began; 0700 Ended: 3990
CARDIAC MONITOR	
PULSE OXIMETER	CRASH CART AVAILABLE PULSE OX X
BLOOD PRESSURE MONITOR	MEDICATIONS AVAILABLE ELECTRODES O
OXYGEN DELIVERY SYSTEM	REVERSAL MEDICATIONS GROUND PAD
	(AVAILABLE BP.CUFF -
1	00
Rhythm	PRE-PROCEDURE RHYTHM STRIP
6.115707	Hanna, adre pre procedure
PHYSICIAN flace	ACLS/PALS RN Gacalade TECHNICIAN <u>Elaldana</u>
RCP if applicable	X-RAY TECH if applicable Other Other INITIALS SIGNATURE SIGNATURE
	A walade &
and the second	A bearance The NEDICAL CLARKER
MODERATE SEDATIO RECORD	
PHSI-020-007 (3/07)	ATTN DR. SHAM, URESH C. PRIN DR. AGARHAL, CHANDRANNS

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Pa	ige 3															

DATE: 6-15-07 TIME:	08	1.15								
					Vital Si		ALLERGIES:		KNOWN	ALLERGIES
Mode of Admission: Dambulatory D wheelchair D stretcher / bed					вр		Bracelet on:	r		
Admitted from: Admitted from:						MP. 92.5 Medications: Deg av				
□ other:					PULSE_			L		
Patient History obtained from: A patient _ other					RESP.	10				···
amily/other (specify)					02 SAT 49-1. Food:					
					HT 5.8 *					
unable to take history (explain)					wт. 16	4 cin	Other (tapes, dyes)			
 Present / Verified O = Not Present 	%	PRE-OP RN	%	OR RN			· ·			
1. IDENTIFICATION BAND	1					Rt hav		e/type	:#2	2
2. CONSENT(S) SIGNED/WITNESSED		0/////			IV Fluid:	NST	20 IV Started by:	ton	n pr	
A. VERIFICATION INF. CONSENT	~					PRE-C	P MEDS / TREAT	MENT	GIVEN	
B. SURGICAL	Ø		<u> </u>		TIME	M	EDICATION/DOSE		ROUTE	SIGNATURE
C. ANESTHESIA	0	C	-	 						
D. ADVANCED DIRECTIVES	0	CN,	\vdash							
E. OTHER: 3. ADDRESSOGRAPH	V	, C1	<u> </u>	 	· · · · ·					NONE
4. HISTORY AND PHYSICAL	đ	87			TIME				0	SIGNATURE
5 REPORTS						OTHER:			.ə	
	0	C-			·				-	L
B. EKG - REQUIRED ON PTS ≥ 50	0	CJ.								
C. UA	10	0-6								
D. CBC - REQUIRED ON ALL PTS	0	CT,		1						
E. PT/PTT-REQUIRED ON ALL PTS	0	61			ANXIOUS CÁLM OTHER: RESPIRATION: UNLABORED OTHER:					
F CHEM PANEL	0	07,								
G. TYPE & SCREEN/CROSS	0	CY,	Į							
H. BHCG POS NEG	0	c7	<u> </u>		PHYSICAL LIMITATION: NONE NOTED					
I. OTHER:	Or	07	12	 						
6. SURGICAL SITE/PROC VERIFIED 7. SURGICAL SITE-CHECKED	V_	107	1	<u> </u>	NURSING NOTES/PATIENT TEACHING:					
	0	c~	ſ							
8. SURGICAL PREP SHAVE	0	6-7	¥							
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Tho PROSTHETICS					٢	\sim			Intensity / C	uality
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D. HEARING AIDS	Ø	1cy	<u> </u>					1121	lal	
E. IMPLANTS: F. OTHER:	0	C.	<u> </u>		WHERE? WAITING ROOM OTHER: WILL CALL					
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12. PT. BELONGINGS INONE AT	1.1	1 7	Ł		1			DISCH	ARGED?	,
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13. NPO SINCE: DATE 06/14/07 TIME 0000					PRE-OP R	N SIGNATI	JRE / INITIALS:	pu	m .	
14. VOIDED @ DATE 06/15/02	TIM	E) ¥_	-00			INITIALS			
Chino Valley Medical Center										
SURGICAL CHECKLIST / P NURSING ASSES			RAT			, 1.	61 03/23/ 05 05/13/	4.5	· ()	

The medication or sedation which was used to calm you will be acting in your body for the next 24 hours, so you might feel a little sleepy. This feeling will slowly wear off. Because the medicine or sedation is still in your system, for the next twenty-four (24) hours, the adult patient:

SHOULD NOT - Drive a car, operate machinery or power tools. SHOULD NOT - Drink any alcoholic beverages (not even beer). SHOULD NOT - Make any important decisions (such as sign important papers). You must be driven home by an adult.

PAIN:

Γ

You may experience some pain and/or discomfort associated with your procedure. Gas, abdominal cramping and small amounts of rectal bleeding are normal in the immediate post procedure period. If this continues longer than twenty-four (24) hours after the procedure or if you experience intense abdominal pain, a firm distended abdomen (rigid) or a fever, (101° or greater) notify your physician immediately.

DIET:

You may resume your normal diet when you arrive home, unless you are instructed otherwise by your physician.

FINDINGS: __

ADDITIONAL INSTRUCTIONS: __

If you have any questions or concerns, call Dr. $U = SMD_{2}$ at phone 59/-52/4. If you are unable to reach him/her or his/her partner, call or come to Chino Valley Medical Center Emergency Department at 464-8670.

The information/instructions above have been discussed with and a copy given to me or a significant other who demonstrates an adequate level of understanding and will give these instructions for care to the individual responsible for my care.

Patient/Significant Other

umn

Physician/Nurse

Date and Time

Chino Valley Medical Center

5451 WALNUT AVENUE, CHINO, CA 91710

POST ENDOSCOPY INSTRUCTIONS LOWER GI COLONOSCOPY

WHITE - CHART YELLOW - PATIENT 000011 604.028 (5/05)

C ADDRESSOGRAPH C C TER

N, SC, 282543

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POST ENDOSCOPY INSTRUCTIONS - UPPER GI ENDOSCOPY

The medication or sedation which was used to calm you will be acting in your body for the next 24 hours, so you might feel a little sleepy. This feeling will slowly wear off. Because the medicine or sedation is still in your system, for the next twenty-four (24) hours, the adult patient

SHOULD NOT - Drive a car, operate machinery or power tools. SHOULD NOT - Drink any alcoholic beverages (not even beer). SHOULD NOT - Make any important decisions (such as sign important papers). You must be driven home by an adult.

PAIN:

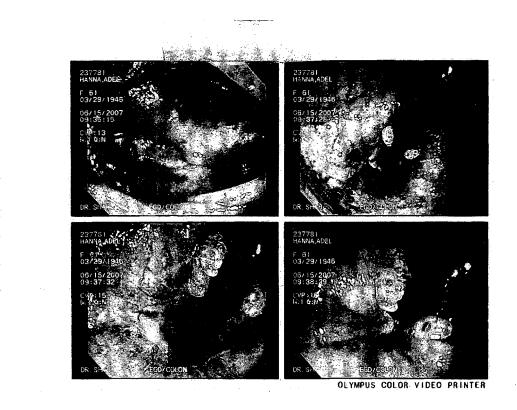
It is normal to have a sore throat after an upper GI Endoscopy. It resolves within twenty-four-(24) hours after the procedure. There should be minimal, if any, bleeding with an upper endoscopy. If there is any measurable amount of bleeding, intense abdominal pain or persistent alteration in GI function notify your physician immediately.

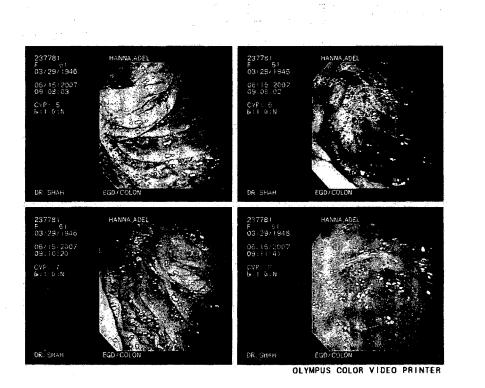
DIET:

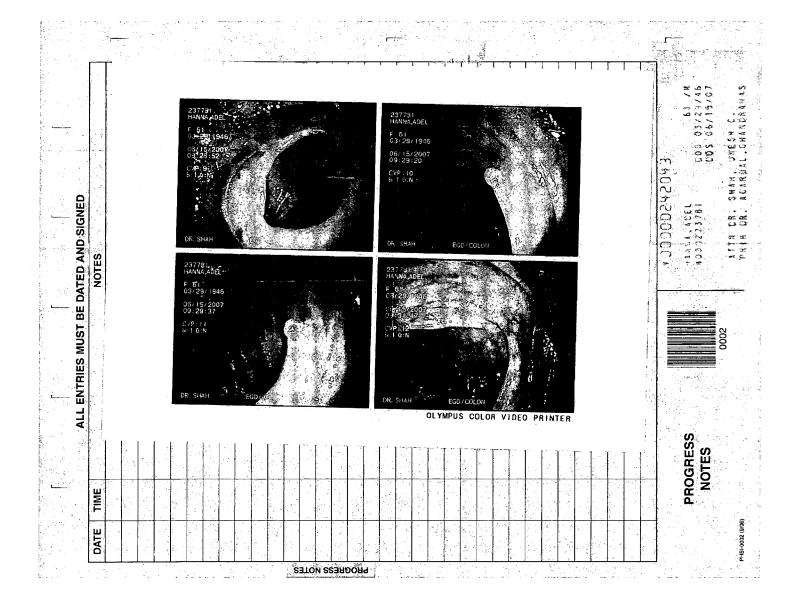
You may resume your normal diet when you arrive home, unless you are instructed otherwise by your physician.

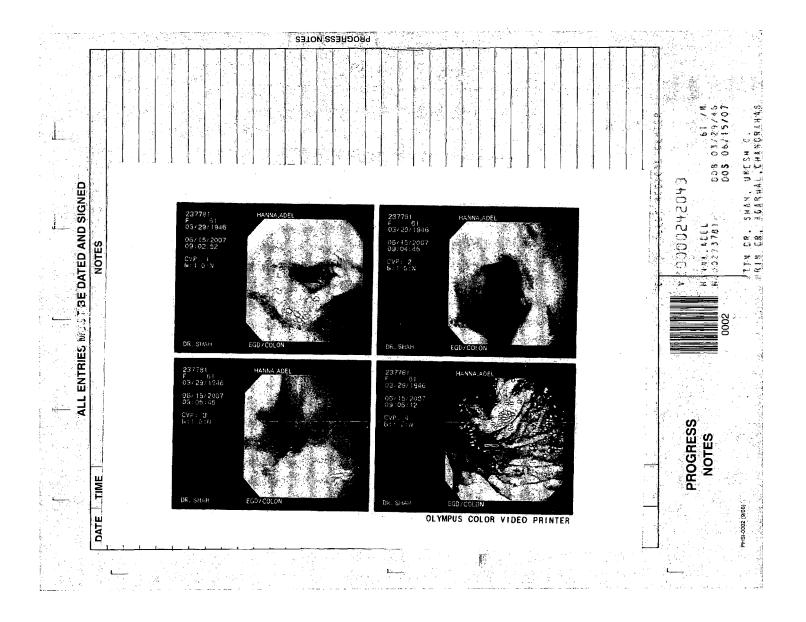
FINDINGS: Call	e Dosttah with any problems
ADDITIONAL INSTRUCTIONS: - Conf - Fol Meeds	inne preceious Medications Tow up with Dr. Shah if
If you have any questions or concerns, c phone <u>54) - 6412</u> his/her partner, call or come to Chino Val at 464-8670.	all Dr. <u>M. SMM</u> at If you are unable to reach him/her or ley Medical Center Emergency Department
	been discussed with and a copy given to me an adequate level of understanding and will ividual responsible for my care.
Patient/Significant Other	
Physician/Nurse	ENDOSCOPE
Date and Time	DUODENUM
Chino Valley Medical Center 5451 WALNUT AVENUE, CHINO, CA 91710	ADDRESSOGRAPH
POST ENDOSCOPY INSTRUCTIONS UPPER GI ENDOSCOPY	 (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)
WHITE - CHART YELLOW - PATIENT 0010 604.027 (5/05)	

TIME: 0820	a formúlary equivalent (unde ted. Non-Proprietary Equival DATE	ent Drug may be	37	B:03/ B:03/ S:066/	
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ADRESS	<u>AGE</u> <u>AGE</u> <u>T</u> ONE DATE <u>T</u> ONE MARCHENE PYA 2 \CL	Signature ADAMA NSSIGNATURE Cature To M	Date 15for time 10	M/61 SDC	HYSICIAN ORDERS
NFEW Den Woort-Park Hereiter (CERD) Hereiter	An and a second state of E			HANNA, ADEL Acct# V000000242043 DOB:03/29/46 DOS:06/15/07 Shah, Umesh C;	
Aefili times DO NOT SUBSTITUTE To ensure brand name disponsing, check at		Signature		M/61 SDC M0000273781	
o		DISCHARDE PATIENT		HANNA, ADEL Acct# V00000242043 DOB: 03/29/46 DOS: 06/15/07 Shah, Umesh C.	
PHYSICIAN SIGNATURE TRANSCRIBER SIGNATURE DA 24 HR CHART CHECK BY NURSE DA PHYSICIAN S ORDER SHEET	TE TIME NOTING F	IN'S SIGNATURE		M000273781	and the second
PHSHOOD (908) WHITE - CHART YELLO			N THIS ARE	A management of a second state of	









DATE	TIME		PRE-PROCED	URENOTE		
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			<u> </u>	1U		·
				Physician	Signature	
DATE	TIME		POST-PROCED	URE NOTE	- · · ·	
6-15-07	920	Physician: 1 8NM	· · · · ·		· · · · · · · · · · · · · · · · · · ·	
0 (om				· · ·	
		Type of Anesthesia: 🛛 General	U-Sedation A	Analgesia		
	/	Post-Procedure Diagnosis: ECD	T BODY	184	2.	
		Colonorcom		mecho	mist	
		Operative Procedures Used:	J	10	Jall	
		SIP Mission Pliculto	n - Ma	o achive	mAC	mound
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	Chino Va	alley Medical Center	V · · · ·		ESSOGRAPH	
		NUT AVENUE, CHINO, CA 91710				
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000147 733.0	w (10/05)		• • • • • • • • •	1.140.11	i vili i konstruktur. Nel se	•

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TEST RESULTS FOR HELICOBACTOR PYLORI TEST: (H. PYLORI TEST WITH PYLORITEK TEST KIT BY G.I. LAB)

DATE: ____

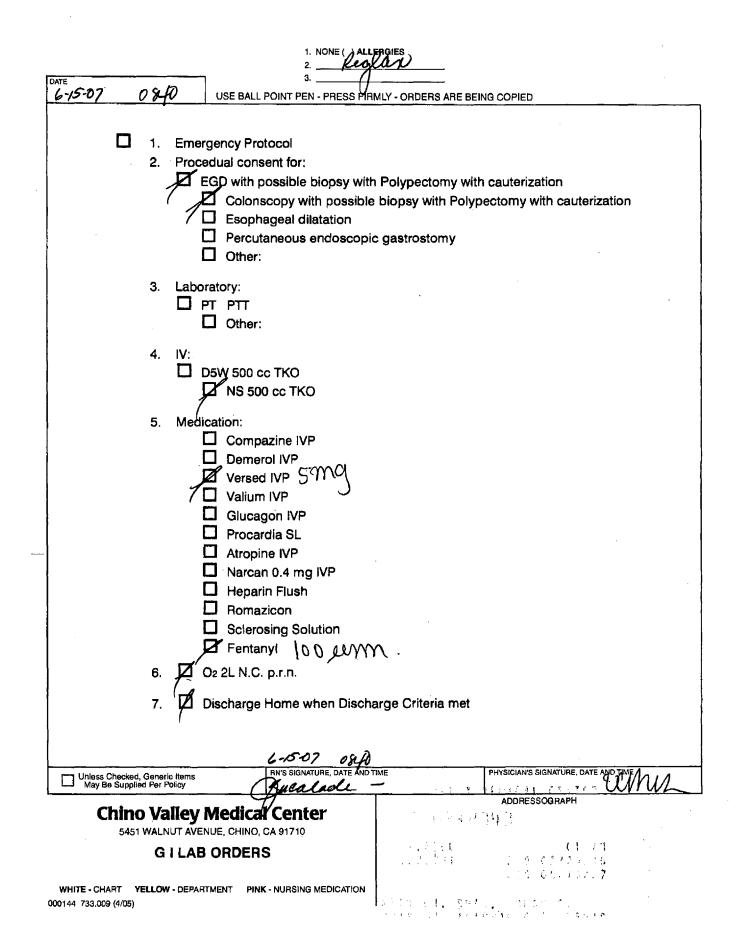
	POSITIVE:	
	NEGATIVE:	
START TIME:	0915 COMPLETED TIME:0	15
	READ BY: Aucalad	
	DATE: 6-15-07	

Chino Valley Medical Center 5451 WALNUT AVENUE, CHINO, CA 91710

H. PYLORI RESULTS

WHITE - CHART YELLOW - DOCTOR 000091 733.004 (2/99)

479 of 774



Site Codes	1. Righ 2. Left	ht Abdomer Abdomen	n 3, 1 4, 1	Right Upper	' Arm Arm	5. Right Butt 6. Left Butto	ock (uppe sk (upper)	r outer quadrant) outer quadrant)	7. Right Anterior Th 8. Left Anterior Thi
Onig A	teme Soc	ingth, Doer	Se Formatium	Start Time	Stop Time	Time Per		Time Period	Time Period
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Patient Name				Patient No.		PATIENT IDENTIFIC	ATION		
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Allergies	Red	ibr)			1594.4 EL 33873781		<pre>\ 10 208 03/25/80 200 200 </pre>	AT STATES
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N dat to to d.			HANNA, AL	L L		Page: 1
Admitted: Room/Bed: Attending:	Shah, Umesh (ino Valley Medi	cal Center	Acct: Unit:	MURLC V00000242043 M000273781
		Perso	nal Belongings	Inventory		06/15/07_0824_CL
	Date: 06/15/0 Inventory: A			formed By: In	etum, Chusr	
	-N Conta	acts	-Y Glasses	Disposition:	BELONGING	S KEPT BY PT
	14.104	Dentures ial Upper ing Aid	-N Lower	Disposition: Disposition: Disposition:		
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y Signing riends, An if I Refuse I Release C I Have Also	Below I Indi d Have Been (To Have My) Chino Valley I Been Advised	cate I Have B Given The Opp Valuables Loc Medical Cente d To Keep Aud	KEPT WITH PATI een Advised To wortunity To Hav ked Up Or Sent r From Any Liab lio/Video Equipm ssumes No Liabi	Send My Valua e My Valuable Home With Fam dility For Los Ment In My Pos	s Locked Uj ily Or Frig t Valuables session At	p. ends, s. All Times,
PATIENT X WITNESS :	Hana Ch	uston n			Date: <u> </u>	5/15/07
By Signing	Below I Indi	cate I Have A	All My Belonging	s At The Time	Of Discha	rge.
PATIENT:	Hana	M. 49			Date:	J1502
WITNESS: Monogram I	nitials N	ame	Nurse	Туре	15	
3		uetum,Chusri	RN			
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DATE OF PROCEDURE	6-15-07	TIME	0850
PROCEDURE / PHYSICIAN _	Ess: Color/	1 Share	<u>, </u>
CONSENT SIGNED	YES NO	`	
PROCEDURE VERIFIED			

TIME OUT !!! FINAL VERIFICATION

PATIENT IDENTIFIERS:

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PATIENT ID BAND CHECKED	V
MR# MATCHED TO ID BAND	<u></u>
PATIENT NAME VERIFIED	_¥
PATIENT DATE OF BIRTH VERIFIED	

SIGNATURE	Avealade	(MD / DO (RN)
SIGNATURE_	V. Hernander	(RN / LVN / GI TECH)

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Chino Valley Medical Center	V		ADDRESSOGRAPH
GI LAB VERIFICATION CHECKLIST	н С	N, 8211 2272251	61 /4 104 03/29/46 105 06/10/07
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Date 00-14-07	NIVERSAL ADMISSION FORM	Chino Valley Medical Center
I. Source of Admission	an a	
Home Office SNE Pr Admitting Doctor: SNE Pr Primary Care Physiclan: DE A Diagnosis & ICD9s	atient's Primary Lenguage: DE English D Spanish Surgeon: Consultant:	h 🗆 Other
Patient Status	Peds DOU DTCU DOB DICU D	9 JWAIIOWIN 19
II. ADMITTING Information		
CardioPulmonary: EKG ABG Radiology: Chest X-Ray Other: Therapy: Crutch Tng NWB	UCG Chem Panel: PT PTT Teach use of incentive spirometer Toe-touch UWBAT	
Procedure (as stated on consent);	Folloganocc	0.0-1-6(1-5-(1)) ¹
CPT Codes:	Physician Signature;	um
III, SURGERY Information	Surgery 464.6618	
Surgeon:	Surgery Time:	100 Di Local Di Spinel Di MAC
Special requests for equipment:		
IV. PATIENT Information? + anna , Ad-	el MO.	
Address MONT	everde Dr. CH. (91	29) 902-1147
Social Security: 58 - 107 -	<u>893</u> 2 sex M F D.O.B.D.3 24	149 Marital Status: D.
Employer	Work Phone	1
Spouse's Name	(Same Phone Number?)	
Spouse's Employer	Work Phone	
Subscriber and Responsibility of the CP	HE PPO	
Group Number	Policy Number	
Authorization Number	TAR Numiser, V a	LEY MEDICAL CENTER
Other Insurance		242043
V. Workers Companyation		БІ /М. Гов С3/29/45
Industrial Carrier	Photo: 22737	81
Carrier Address	City Zip	
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RUN DATE: RUN TIME: RUN USER:	1306		ey Medical List Patie	Center NUR **LIVE** ent Notes	PAGE 1
	HANNA, ADEL V00000242043			Unit #: M000273781	
Age/Sex: Location: Room/Bed;	GI			Attending: Shah, Umesh C Admitted: Status: REG SDC	
	Date Time 06/15/07 1155 06/15/07 1300	CL Luetum,C	000 00000000000000000000000000000000000	Nurse Type RN RN	Category Nurse Notes
Abnormal?	<u>N</u> c	Confidential?	Ň		
DIET WELL.		1 WITH ASSISTE	ED, VOIDED. I	C/O PAIN.TAKING ORAL FLUID A INSTRUCTIONS AND PRESCRIPTION AUTO.	
Note Type		Description NONE			

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A THE R. P. LEWIS CO., LANSING MICH.

Age/Sex	Attending; Shah. Umesh C. Account #: V00000242043	HDEL			Page: 1 of 3
Admitted Status: REG SDC	Location: GI Room/Bed:	Chino Valley Medical Center NUA CHINO VALLEY ADMISSION ASSES	R **LIVE** SSMENT		Printed 06/15/07 at 0842 Period ending 06/15/07 at 0842
	Administrative Data		D	ay Surgery Admission	06/15/07 0837 CL
Hold Tray: Date Condition CMT	MEAL RELEASE HT 5 FL 0 1 VISITORS ALLOWED WT 163 10 15.6 PAIN DIFFICULTY SWALLOWING	n 152.4 cm 8 oz 74.38 kg The Cu	Advance Directive: # urrent Desire for this Patie J) Code	Reviewed with Patient nt Regarding Life Suppor	t Is as Follows:
Primary Diagnosi Date of Surgery/Procedur Isolatio Allergies: REGEAN Food Allergies: NKFA Advance Directiv Diber/Additiona	s:	Comment : SUBS1	III Code Cther, Currently Using Tobacco: i Annount/How Often: Currently Using Alcohol: Annount/How Often: Using Recreational Drugs: Ho	N Type:	Number of Years: ***
Relationship: Phone #: Pager/Cell #: Patient Type: ADMIT Patient Age: 61 Source of Inform Patient	Relationship: ADM: Ourckstart Form DS DAY SURGERY New Admit ½ Day Surgery Admission DAY SURGERY ADMISSION Wation	Current ly 06/15/07_0824_Ct 06/15/07_0837_Ct	1. ATERUCOLSONG 2. ANALAPRIL 5 MG 3. NEXTURY JONG 4. DIFLICAN 200NG BID 5. "NTLL" TAKE BYP HED 6. 7. 7. 8 9. 10. 11. 12. 13. 14. 15.	IN: PH AS USUA:	t Pills: N Herbal Supplement: N
ADMISSION HEIGHT/WEI Height - Fee I OR C DEMOGRAPHIC DATA— Primary Language: ENDLIS Religion: CHRISIIAN Comment: Allergies: REELAN Other Allocate WDA	GHT/ALLERGIES t: 5 Weight - Lb: 154 0z: 0R Kg n: Weight Source: PATIENT STATED H Comment: IS MD Beliefs Affecting Care: TAMER Alternate Phone Fager 13-8670 CELL Cell Phone	: 74:38 - PATIE	18. ENT MEDICAL HX ==== ****HIS Reurological: %L: FENT: %L:	TORY ONLY-NOT for Patien	-Referral Needed: 3 t's Current Assessment****
Age/Sex: 61 M Unit #: M000273781 Admitted: at	Attending: Shah. Umesh C. Account #: V00000242043 Status: REG SDC	HANNA, ADEL CHINO VALLEY ADMISSION ASSESS	IENT		tion: GI Room: Printed 06/15/07 at 0842 5/07 at 0842 NURLC

Page: 2 of ** Printed 06/15/07 at 08 Period ending 06/15/07 at 08	≡EL Center NUR **LIVE** ISION ASSESSMENT	Chino Valley Medical CHINO VALLEY ADMIS	Attending: Shah. Unesh C. Account #: V00000242043 Location: GI Room/Bed:	Ge/Sex: Unit #: MOCOZ73781 Mitted: Status: REG SDC
Day Surgery Admission 06/15/07 0837 CL		Ø <u>6/</u> 15/07 0837 CL	Day Surgery Admission	
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ing Valuables/Honey to the Hospital st Op Routines on the Nursing Floor ility Testing if Applicable instructions: TEP HOADS NPO P MN TO TAKE B/P HED THIS EVENING AS USUAL	Pre and Post Op Routines Out of Facility Testing Other Teaching/Instructions:		ure: 06/15/07 COLONOSCOPY Ion: ECD COLONOSCOPY Ite: 06/15/07. Signature: Lüetum.Chüsri	Dationt's Description
Location: GI Room: Printed 06/15/07 at 0842 Period ending 06/15/07 at 0842 WORLC	ADEL	HANNA,	Attending: Shah. Umesh C. Account #: V0000242043 Status: REG SDC	ge/Sex: 61 M nit #: M000273781

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Unit #: M000273781 Admitted: Status: REG SDC	Attending: Shah, Umesh C. Account #: V00000242043 Cocation: GI Room/Bed:	Chino Valley Medical CHINO VALLEY ADMIS	Center NUR **LIVE** SSION ASSESSMENT			Printed 06/15/07 at Period ending 06/15/07 at
	Day Surgery Admission	06/15/07 0837 CL		Day S	urgery Admission	06/15/07 0837
Participation Le Evaluat Needs Additional Educat Educat	vel: ACTIVE ion: VERBALIZES UNDERSTANDING: ion: N tor: Luetum:Chusri ine: NURSING		Pain Managem Will Be Disc Liquids. H Procedure Teaching IV If Applic Where the Pr Recovery Aft	Has Voided, and Can Am µAs Follows: ₩	and Outpatient Unit able. Able to Tolerate bulate Safely Involved	P.O.
			Participati Ev Needs Additional E	on Level: ACTIVE aluation: VERBALIZES	UNDERSTANDING	
PAIN ASSESSMENT			Monogram Initials		Nurse Type	
-Pain Scale Describe the Pain Onset What Increases the Pain What Relieves the Pain Pain Location -Pain Scale Describe Pain			CL NURLC	Luetum, Chushi	RN	
PATIENT/FAMILY EDU Person Taught: #ATI Person Taught: Pre and Post Op Teachin IV Surgery Holding A	ENT Teaching Tools: W Dther Tools Used: g As Follows: Prep If Applica rea Recovery Room	ERGAL				
Incentive Spirome Age/Sex: 61 M Unit #: M000273781 Admitted: at	Attending: Shah. Umesh C. Account #: V00000242043 Status: REG SDC	HANNA,	ADEL		Locati Period ending 06/15/4	Printed 06/15/07 at 0842

Unit #: M000273781 Account #: V00000242043 mitted: Location: GI Status: REG SDC Room/Bed:	Chino Valley Medical Center NUR **LIVE** CHINO VALLEY ADMISSION ASSESSMENT	Printed 06/15/07 at 1 Period ending 06/15/07 at 1
Administrative Data		Day Surgery Admission 06/15/07 0837
EMPORARY LOCATION OLD TRAY, DATE MEAL RELEASE HT 5 ONDITION VISITORS ALLOWED WT 1 HT ISIT REASON EPIGASTRTC PAIN, DIFF FCULTY SWALLOWING	ft 0 in 152.4 cm 63 lb 15.68 cz 74.38 kg The Current Desire for thi	Copy on File at CVMC: Reviewed with Patient/Representative:
Primary Diagnosis: ate of Surgery/Procedure: Isolation: Allergies: REGLAN ood Allergies: NKFA Advance Directive: Other/Additional: Primary Language: ENGLISH	SUBSTANCE USE HISTORY Currently Using To Amount/How Currently Using A	obacco: N. Type: Often: Number of Years:
Contact Person: Decision Relationship: Phone #: Pager/Cell #: Relation ADM: Quickstart Form DS Patient Type: ADMIT: DAY SURGERY New Admit: Patient Age: 61: Day Surgery Admission Day SURGERY ADMISSION Patient: #	Name: Currently Taking ASA. N Ant iship.	ticogulants: WiSteroids: Wi Diet Pills: WiHerbal Supplement: MG MG MPP MED INF MP AS USUAL
<pre>ther (name/relationship): ADMISSION HEIGHT/WEIGHT/ALLERGIES Height - Feet: 5 Weight - Lb: 164. 0z: In: Weight Source: PATIENT.S OR On: 152:40 DEMOGRAPHIC DATA rimary Language: ENGISH Comment: IS MD Religion: CHRISTIAN Beliefs Affecting Car Comment: Ulergies: REGLAM Other Allergies: NKOA Contact Person: HANIA.TAMER Altern Relationship: SO Phone Number: (949)413:6670 CELL C ADVANCE DIRECTIVES</pre>	OR Kg: 74.38 STATED PATIENT HEDICAL HX ~ Neurological: N: EENT: N: Cardiac: N: Respiratory: Y: POSS Hypertension: Y: RX Circulatory: N: Blood Disorder/Clots: N: Hypertension: N: Blood Disorder/Clots: N: Hypertension: N: Blood Disorder/Clots: N: Hypertension: N: Blood Disorder/Clots: N: Hypertension: N: Hypertensio	-Referral Needed: % ****HISTORY ONLY-NOT for Patient's Current Assessment**** STBLE MILD ASTHMA

Admitted: Status: REG SDC	Location: GI Room/Bed:	Chino Valley Medical (CHINO VALLEY ADMIS	Center NUR **LIVE** SION ASSESSMENT		Printed 06/15/07 at Period ending 06/15/07 at
	Day Surgery Admission			Day Surgery Admissi	on06/15/07_0837
Gynecological: Skin Disorder: N: Cancer: N:	LVP: DLE.COPEN.J.			15	
Psychological: M: Pain: Other: M: Pregnant:	LMP:		AM Meds Taken: NO	BULATORY HE DO Date: 06/14/07	
	OLE.(OPEN) Anesthesia Reaction: M		Blood Pressure: 10 BP Source: AU Site: 30		lse: 62 ce: AUTOMATIC: NONINVASIVE
Family Hictory of Prob	lems with Anesthesia:∦ on: № Blood Reaction:		Position: SU Temperature/F: 97 Temp Source: OR	PINE (LYING DOWN) Resp Sour 5 Sp A On	ce: DBSERVED. D2%: 99 02: Ni LPM:
Does Patient Live with P Does Family/Frie Who Wi Anticipa	eople who Rely on Him/Her: N nds Assist with Home Care: ¥ 11 be Taking Patient Home: FAMIEY Led Discharge Destination: HOME	1	-NEUROLOGICAL Ass EENT Ass	ENT DAY OF PROCEDURE=== sessment Within Normal Limits: ¥: sessment Within Normal Limits: ¥:	
Is Patient Using Homecan	e/Outside Agency/Facility: 🕅		CARDIAC ASS CIRCULATORY ASS MUSCULOSKELETAL ASS	sessment Within Normal Limits: ¥: sessment Within Normal Limits: ¥: SesSment Within Normal Limits: ¥: cerement Within Normal Limits: ¥:	
 Decreased Functional A Prior: Mobility: Ambulatory Assistive De 	bility in Last 30 Days: N Current: Mobility vice Used: ng Assist: N ~Referred to Prim		GENTROTATESTINAL ASS GENTROURINARY ASS INTEGUMENTARY ASS PSYCHOSOCIAL ASS	sessment Within Normal Limits: 3: 3 sessment Within Normal Limits: 3: 3 sessment Within Normal Limits: 3: 3 sessment Within Normal Limits: 3: 3	
MUTDITION DISK SCORE	NINC		Pulse Location #2:	Pulse Char	acter #1:
Unintentional Weigh ~Admitted with P	Underweight/Nainourished: 0 NO. or Diarrhea for >3 Days: 0 NO. t Loss >10∯ in Past Month: 0 NO. Potential Risk Diagnosis: 0 NO. oor PO Intake for >4 Days: 0 NO. a ba Lanch Dist for an 0 NO.		Assessment Cor Patient/Family Educa	nment:	
	le to Ingest Diet for Age: 0 NO Tube Feeding or TPN: 0 NO Total Score: 0Nutritional Ri Referred to Primary Ph	YS1C1dA: NC	Education Com	mment: FOUCATION - PRE ADMISSION	
- EDUCATION SCREENING		Problem: No •	Person Taught: Person Taught: Pre Admission Teach		g Tools: VERBAL Is Used:
	G. T S: NONE S: NONE S: NONE G: DTSCUSSION		NPO/Take med Report Time Need to Arra	ining AS Follows: an ications the Morning of Surgery to the Hospital nge Transportation Home Makeup, Contacts	Pain Management/Scale Post Op Prescription
Education Commen	ť: e: 05/15/07		No Smoking 24 Do Not Bring Pre and Post	4 Hours Before Surgery Valuables/Money to the Hospital Op Routines on the Nursing Floor ity Testing if Applicable	
Patient's Descriptio History Obtained Dat	COLONOSCOPY n: EGD COLONOSCOPY e: 06/15/07 Signature: Luetum Chusid:		Other Teaching/Inst	• • •	THIS EVENING AS USUAL
Age/Sex: 61 M Unit #: M000273781 Admitted: at	Attending: Shah, Umesh C. Account #: V0000242043 Status: REG SDC	HANNA, A	DEL DN ASSESSMENT	Period endin	Location: GI Room: Printed 06/15/07 at 1301 g 06/15/07 at 1301 NURLC

Age/Sex	Account #: V00000242043 Location: GI Room/Bed:	Chino Valley Medical Center NUR **LIVE** CHINO VALLEY ADMISSION ASSESSMENT	Printed 05/15/07 at Period ending 05/15/07 at
	Day Surgery Admission	06/15/07 0837 CL Day	/ Surgery Admission 06/15/07/0837
Participation L Evalua Needs Additional Educa Educa	evel: ACTIVE tion: VERA4IZES.UNDERSTANDING tion: N ator: Luetum:Chusra. line: NURSING	Pain Management in Recovery Roc Will Be Discharged When VS Are Liquids. Has Voided, and Can Procedure Teaching As Follows: X IV If Applicable Where the Procedure is Done Recovery After Procedure and Ti Where Relatives/Visitors Should Other Teaching/Instructions;	m and Outpatient Unit Stable. Able to Tolerate P.O. Ambulate Safely ime Involved
PAIN ASSESSMENT ==		Comment: Participation Level: ACTIVE Evaluation: VERAALIZI Needs Additional Education: Luetum,Cl Educator: Luetum,Cl Discipline: NURSING Monogram Initialis Name	LS UNDERSTANDING
-Pain Scal Describe the Pai Onse What increases the Pai What Relieves the Pai	n:	CL NURLC Luetum, Chusri	RN
Onse What Increases the Pai What Relieves the Pai	n: 	(1999) A. B. Contraction (1997) State of the Antonio (1997) A. B. Contraction (1997) A. B. Contraction (1997) A. B. Contraction (1997) A. B. Co	
=== PATIENT/FAMILY EDU Person Taught: PAT Person Taught: ****	CATION - OPS Teaching Tools: WE Other Tools Used	IDAL	
Pre and Post Op Teachi IV Surgery Holding Incentive Spiron	Prep If Applicab	ie .	
Age/Sex: 61 M Unit #: M000273781 Admitted: at	Attending: Shah, Umesh C. Account #: V00000242043 Status: REG SDC	HANNA, ADEL	Location: GI Room: Printed 06/15/07 at 1301 Period ending 06/15/07 at 1301 NURLC

Age/Sex: 61 M Attending: Shah. Umest Unit #: M000273781 Account #: Admitted: at Status:	A C. HANNA, AD CWC DAY SURGERY: EDUC	EL ATION FORM	Location: GI Printed (Period ending 06/15/07 at 130	Room: 16/15/07 at 1302 12 NURLC
-		<u></u>	• <u></u>	
Educational Need Priority #3: Educational Need Priority #4: Education Comment:				
Understands English: Religion: CHRISTIAN Beliefs Affecting Care: Physiologic Limitations: NOME Psychological Limits: NOME Cognitive Limitations: NOME Teaching Method Preferred: DISCUSSION Educational Need Priority #2: Educational Need Priority #3: Educational Need Priority #4: Educational Need Priority #3: Educational Need Priority #4: Educational Need Priority #4: Educational Need Priority #4: Educational Need Priority #4: Educational Need Priority #4: Education Comment:				
Primary Language: ENGLISH Understands English: Religion: CHRISTIAN Beliefs Affecting Care:				
=== EDUCATIONAL ASSESSME	NT			

((A)
Procedure: EG-D + COLONOSCOM	Phone: (202) 902-1147
Anesthetic: 🗖 General 🛛 Local 🕅 MAC	Regional Spinal
1. Are you having any problems getting up and about?	
2. Did you have any problems breathing?	k
 Did you have any nausea or vomiting? No Yee* Did you need any medication for it? No Yes Was the medication effective? No* Yes 	How long did it last?
4. Did you have any pain? / 10 before m □ No pain med. ordered □ Pain not relieved □ Pain med. effective □ Needed to contain	
5. Did you have any unexpected bleeding? D No D Yes Comments:	
6. Did you have a temperature over 100.5°? 🗋 No 🛛	I Yes* DNO answer Cliriton 1100 I Yes* DNO answer C 1220
7. Did you have any difficulty with urination?	Ives* 2) No answer c 1220
8. Extremity: IN/A I Pink and warm I Normal sense	ation D Normal movement
9. Patient contacted surgeon regarding:	· · · · · · · · · · · · · · · · · · ·
10. *Comments:	
11. D Patient instructed to call surgeon for any problems.	
12. Please rate your satisfaction with your Outpatient experie	ance: / 10
13. Please rate your satisfaction with your Admitting experier	nce:/ 10
14. Do you have any suggestions to improve our Outpatient	program?
15. Unable to reach.	L18-07
Nurse Signature	
Chino Valley Medical Center 5451 WALNUT AVENUE • CHINO, CALIFORNIA 91710	ADDRESSOGRAPH
OUTPATIENT POST-OP CALL FORM	61 /4 527571 EOR 03/25/46 EOS 05/15/07
101071 786.003 (04/02)	ANTE THE BALA, JECCH C.

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Age/Séx 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	Account #: V00000242043 Location: GI Room/Bed:	Chino Valley Medical Center DISCHARGE PATIENT AUD	IT FORMAT		Printed 06/15/07 at 1
Intervention Description	Sts Directions	From Inte	ervention Description	Sts	Directions Fr
	d Recorded Document ime by Date Time by Comment Uni	ed i	Activity Occurred	Recorded e by Date: <u>Time by Comme</u>	Documented
Activity Date: 06/14/07		Act	ivity Date: 06/14/07	Time: 0738 (continued)	
 Create 06/14/07 1 	ERY: ADULT Procedure + A ON ADMISSION 738 KW 06/14/07 0739 KW 738 KW 06/14/07 0739 KW DAY SURGERY ADMISSION ===	AS Act	ivity Date: 06/14/07 7. 8. 9.	Time: 0738 (continued)	
Source of Information			10. 11. 12.		
ADMISSION DETENTIONETC			15.		
Height - Feet	Weight - Lb: 02: OR Kg: Weight Source:		17. 18.		~Referral Needed: ** nt's Current Assessment****
Primary Language ENGLISH	Comment		- Neurological: EENT: :: Cardiac: Respiratory: :		
Allergies: HEGLAN Other Allergies: NKOA Contact Person: HANNA;T Relationship: SD Phone Number: (949)41	MER Alternate Phone ∲: Pager ∯. 3:3670 Cell Phone ∳:	Bloo	Hypertension: Circulatory: d Disorder/Clots: Musculoskeletal: Gastrointestinal: Y: GER	D. HX COLON POLYPS	nt's Current Assessment****
ADVANCE DIRECTIVES Advance Directiv		hart: A CVMC: 7 tive: 4	Endocrine: : Genitourinary: : Gynecological: :		
. 🔅 Full Code	this Patient Regarding Life Support Is as Fol . © Other/Additional	lows:	Cancer: . Psychological: . Pain: .		
SUBSTANCE USE HISTORY		Pri	Other: :: Pregnant: LM evious Surgeries:	P	
Currently Usin	Alcohol:	of Yoars:	ious Anesthesia: Ane	sthesia Reaction:	
Currently Using Recreatio	nal Drugs: Type:	Of Years:	ious Blood Transfusion: DISCHARGE PLANNING	Blood Reaction:	
HOME MEDS (DOSE/FREQ/	Anticopoulante, Schemmide, Diet Dille,		Does Family/Friends Who Will b	e who Rely on Him/Her: Assist with Home Care: e Taking Patient Home: Discharge Destination:	
- 1.		Is P. Name	atient Using Homecare/Ou /Phone # of agency:	tside Agency/Facility: 😣	
4. 5		- De	FUNCTIONAL STATUS creased Functional Abili or: Mobility:		lity: "\$2000 - v&@@c.e.o.M

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Age/Sex ###### Unit # 1000273781 Admitted. Status: REG SDC	Attending: Shah, Umesh C. Account#: V00000242043 Decetion: GI Room/Bed:	Chino Valley Nedical Center NUR **EL DISCHARGE PATIENT AUDIT FORMAT	Page: 2 of 11 VE** Printed 06/15/07 at 1304
	ed Recorded Docume	ented Activity inits Change Type	Description Sts Directions From Occurred Recorded Documented Date Time by Date Time by Comment Units Change - 06/14/07 Time: 0738 (continued)
Hygiene Assist: Bredin Appears U NUTRITION RISK SCREEN Appears U Nutertional Weight Admitted with I Por Unable 	ING	PSYCHOSCC Pulse Location Pulse Location Assessmu Patient/Family Patient/Family Person Ta Person Ta Per	<pre>:: D6/14/07 Time: D738 (continued) RY Assessment Within Normal Limits: AL Assessment Within Norma</pre>

Age/Sex ###### Unit #: P000273781 Whitted: Status: REG SDC	Account # V00000242043 Location: GL Room/Bed:	Chino Valley Medical Center NUR **LIVE** DISCHARGE PATIENT AUDIT FORMAT	Printed 06/15/07 at 1
Activity Occurre Type Date T	Sts Direct d Recorded Doc fme by Data Time by Comment	tions From Intervention Description umented Activity Occurred Recorded Units Change Type Date Fine by Date Time by	Documented Comment Units Change
Activity Date: 06/14/07	Time: 0738 (continued)		
Activity Date: 06/14/07	Time: 0738 (continued)	Activity Date: 06/14/07 Time: 0738 (continue Needs Additional Education: Educator:	
PAIN ASSESSMENT		Discipline:	
Dain Coalo.		Activity Date: 06/14/07 Time: 0904	
Describe the Pain:		1006-A ADN DAY SURGERY: ADULT Procedure + Document: 06/14/00-0904 KW 06/14/07-0907 KW — DAY SURGERY ADMISSI	
		=== Source of Information ===	
		Patient: ¥ Other (name/relationship):	i dana katika 200
What Increases the Pain: What Relieves the Pain:		Height - Feet: 5 Weight - Lb: 164 In: Weight Source: PATH	Oz: OR Kg: 74.38 ENT STATED
 PATIENT/FANILY EDUCAT Person Taught: Person Taught: Pre and Post Op Teaching IV Surgery Holding Are Incentive Spirometr Where Relatives/Vis Pain Management in 	Prep If Applicabl a Recovery Room if Applicable itors Should Wait Recovery Room and Outpatient Unit	Primary Language: ENGLISH Comment: Religion: CHRISTIAN Behrefs Affectin Comment: Allergies: RECLAN Other Allergies: HKOS Contact Person: HANNA TANER A Relationship: 50 Phone Number: (249)413-8670 — ADVANCE DIRECTIVES Advance Directive: N **1F YES Reviewed with	Iternate Phone # Pager # Cell Phone #:
Will Be Discharged	When VS Are Stable. Able to Tolerate P.C led, and Can Ambulate Safely	The Current Desire for this Patient Regarding Life	e Support Is as Follows:
Procedure Teaching As Fol IV If Applicable Where the Procedure		. ¥ Full Code . © Other/Additional Comment:	
	edure and Time Involved	SUBSTANCE USE HISTORY Currently Using Tobacco: N Type: Amount/How Often: Currently Using Alcohol: N	Number of Years:
Other Teaching/Instructio Comment:	ns: 	Amount/How Often:	Number of Years: ﷺ Numbers Of Years: ﷺ Numbers Of Years: %
Participation Lev	al: 2	HOME NEDS (DDSE/FREG/LAST DDSE/DISP)	

Age/Sex	Attending: Shah. Umesh C. Account #: V00000242043 Location: GI Room/Bed:	Chino Valley Medical Center NUR **LIVE** DISCHARGE PATIENT AUDIT FORMAT	Page: 4 of Printed 06/15/07 at 13
Activity Occurre	Sts Dir d. Recorded ine by Date Time by Comment	Documented Activity Occurred Re	Sts Directions Fro conded Documented e Time by Comment Units Change
Activity Date: 06/14/07	Time 0904 (continued)	Activity Date: 06/14/07 Time:	0904 (Continued)
1. ATENOLOL	Time: 0904 (continued) Anticoagulants: N Steroids: N Diet P 50MG 5.MG	Pills: N Herbal Supplement: N Anticipated Discharge Is Patient Using Homecare/Outside Ager	0904 (continued) Destination: HOME cy/Facility: N
3. NEXTUM 40 4. Dificuean 5. Will Tak 6. 7.	hg 200mg BID E-B/P Med TN PM as Usual	Ambulatory Assistive Device Used: Hygiene Assist: N Feeding Assist: W == NUTRITION RISK SCREINING	Current: Mobility: -Referred to Primary Physician: W
12. 13. 14.		Nausea, Vomiting, or Diarrhea	talnourished: for -3 Days: Past Month: k Diagnosis: for +4 Days: bet for Age: bding or TPN;
17. 18.		-Referral Needed:	-Referred to Primary Physician:
~ Neurological: N:	****HISTORY ONLY-NDT for Patient's OSSIBLE AILD ASTHMA X	== EDUCATION SCREENING == Education Needs Assessed: Y	by PCP or Specialist for Problem: 🏁
Cardiac: N:		Physiologic Limitations: MBNE. Psychological Limits: NONE	
Hypertension Y: F	X	Cognitive Limitations: KONE	
Circulatory: N: Blood Disorder/Clots: N:		Teaching Hethod Preferred: DISCUSSION Pre Admission Teaching: Y	
Musculoskeletal: N:	CRO HY CREAN POLYPS	Education Comment:	
Hepatitis: N:		Date Of Surgery/Procedure: 06/15/07 Suspice) Decodure: 66/15/07	
Genitourinary: N:		Patient's Description: EGD EGEON	J2CDPA
Gynecological: :: Skin Disorder: W:		History Obtained Date: 06/14/07	Signature: Wagner.Kathleen
Cancer: N:			•
Pain:		Mode of Arrival:	
Other: M: Pregnant:	LMP:	Arrival From: NPO Since: Date:	
Previous Surgeries: CHO	ERD: HX COLON POLYPS ENP: E1(COPEN:)	AM Meds Taken:	
Previous Anesthesia: Y 4	unesthesia Reaction: N mms with Anesthesia: N	Blood Pressure:	Pulse:
Previous Blood Transfusion	1: & Blood Reaction	Position Temperature/F	Respirations: Resp Source: SoO2%:
Does Patient Live with Peo	ple who Rely on Him/Her: N	Temp Source:	0n 02: LPM: 100
	is Assist with Home Care: Y	1	Pain:

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ter in all for the transmission while pay

Age/Sex ###### Unit #: 4000273781 Omitted: Status: REG SDC	Attending: Shah, Umesh C. Account #: V00000242043 Location: GI Room/Bed:	Chino Valley Medical Center NUR **LIVE** DISCHARGE PATIENT AUDIT FORMAT	Page: 5 of 1 Printed 06/15/07 at 13(
Activity Occurr	ang an	ented Activity Occurre	Sts Directions Fro d Recorded Documented ime by Date Time by Comment Units Change
Activity Date: 06/14/07	Time 0904 (continued)	Activity Date: 06/14/07	Time, 0904 (continued)
EENT Assessme RESPIRATORY Assessme CARDIAC Assessme USCULOSKELETAL Assessme ASTROINTESTINAL Assessme GENITOURINARY Assessme JATECIMENTAPY Assessme	Time: 0904 (continued) nt Within Normal Limits:		Time: 0904 (continued)
ulse Location #1:	Pulse Character #1 Pulse Character #2	Pain Location:	
Assessment Comment:		-Pain Scale: Describe the Pain: Oncot	
 atient/family Education: Education Comment: PATIENT/FAMILY EDUCA Person Taught: PATTE Person Taught: Pre- Admission Teaching A HPO/Take medication Report Time to the Need to Arrange Tr No Jewelry. Makeup No Smoking 24 Hour Do Not Bring Valua Pre and Post Op & RO Qut of Facility Te Other Teaching/Instruction Comment. USING PREP.TOAPY .TO: REPORT.0000 	TION - PRE ADMISSION TT Teaching Tools: VERB Other Tools Used: s Follows Y ns the Horning of Surgery Pain Hane Hospital Post Op F ansportation Home . Contacts s Before Surgery bles/Honey to the Hursing Floor sting if Applicable	AS-USUA AS-	ION - OPS Teaching Tools: Other Tools Used: As Follows: Prep If Applicable Recovery Room
Needs Additional Educati Educat		Procedure Teaching As Fo IV If Applicable Where the Procedure	lows: *** is Done educe and Time Involved

140.5

Age/Sex: Attending Shah, Unesh Unit## 0000273781 Account # 00000024204; Looatited Status; REG SDC Room/Bed	3 Chino Valley Medical DISCHARGE PATIEN	DEL Page: 6 of 11 Center NUR **LIVE** Printed 06/15/07 at 1304 IT AUDIT FORMAT Printed 06/15/07 at 1304
Intervention Description Activity Occurred Recorded Type Date Time by Date Time b	v Counteric On res Charles	Intervention Description Sts Directions From Activity Occurred Recorded Documented Type Date Time by Date Time by Comment Units Change
Activity Date: 06/14/07 Jime: 0904 (continu	ued)	Activity Date: 06/15/07
Activity Date: 06/14/07 Time: 0904 (contin Other Teaching/Instructions: Comment:		Activity Date: 06/15/07 Time: 0824 (continued) Describe: Describe: Disposition: Disposition:
Participation Level: Evaluation Needs Additional Education		Jewelry: Jewelry: Describe: Decribe: Disposition: Disposition: HW Wallet Describe: Disposition:
Educator Discipline Activity Date: 06/15/07. Time: 0824		HW Wallet Describe: Disposition: NP Purse Describe: Disposition: Comment:
1000-B ADMISSION/TRANSFER: 0uick Start Form Create 06/15/07/0824 06/15/07/0824 Document 06/15/07/0824 06/15/07/0824 Aptient Type: ADMIT_DAY_SURGERY New A Patient Age: 61 New A 321 Patient OPS Management of + 66/15/07/0824 - Greate 06/15/07/0824 06/15/07/0824	Liseration in a second se	Interly Dept Notified to Evaluate Flectical Applance Other Item(s) Of Value To The Patient: ELOTHING AND SAUCS Disposition: LOCKED ON UNIT Compared to Previous Belongings List: NO <
1321 Parti: UPS indiagement: UP + for expension Greate 06/15/07 0824 CL 06/15/07 0824 CL 20010 VS: Monitor + Create		If I Refuse To Have My Valuables Locked Up Or Sent Home With Family Or Friends. I Release Chino Valley Medical Center From Any Llability For Lost Valuables. I Have Also Been Advised To Keep Audio/Video Equipment In My Possession At All Times. And I Understand That The Hospital Assumes Nb Liability For Such Equipment.
Create 06/15/07.0824 CL 06/15/07.0824 C 22300 IV/Invasive Lines: Insert/Remove + Create: 06/15/07.0824 CL 06/15/07.0824 C 0010 Notify: MD +	A INS/REMOVAL/CONVERT CP L A WHEN NECESSARY CP	PATIENT: Date: Date:
Openate 06/15/07.0824 CL06/15/07.0824 Science 0010 Education: Patient/Panily Paching + 06/15/07.0824 CL06/15/07.0824 C 075050 Inventory Personal Belongings + ON 04 ADMISSION & TRANSFER. PRINT OUT &	Let get a start of the second s	By Signing Below I Indicate I Have All Ny Belongings At The Time Of Discharge. PATIENT: Date: Date:
HAVE PATIENT SIGN COPY. Create. 06/15/07 0824 CL 06/15/07 0826 C Document 06/15/07 0824 CL 06/15/07 0826 C Inventory Date: 06/15/07 1nventory Time: 0815 Per Reason For Inventory: ADMISSION 300-1C.NU-PF)	formed By: Luetum;Chusri	WITNESS: Age Guidelines: 41-65 (NID ADULT) A VIEW PROTOCOL/DI QS CP Create 06/15/07 0824 CL 06/15/07 0824 CL 06/15/07 0824 CL 06/15/07 0824 CL 1557/300 Post Op Assessment: Perform + A C CP Create 06/15/07 0824 CL 06/15/07 0824 CL C S 5010100 Day Surgery: Discharge + A ON DISCHARGE CP
-X Contacts -X Glasses	Disposition: BELONGINGS KEPT BY PT	- Create 06/15/07/0824 CL 06/15/07/0824 CL
-N Full Dentures -N Partial Upper -N Lower -N Hearing Aid	Disposition: Disposition: Disposition:	Activity/Date: D6/15/07 Time D8/37 1006-A ADM DAY SURGERY: ADULT Procedure + D6/15/07 A_ON ADMISSION AS Documents D6/15/07 D8/15/07 D8/15/07 AS
-N Prosthesis Describe -N Assistive Device : Jewelry: NONE-NO JEWEURY	Disposition: Disposition: Jewelry:	Document 06/15/07_083/ CL_06/15/07_0842 CL DAY SURGERY ADMISSION Source of Information

Attending: Shah, Umesh C. Account #: V00000242043 Location: GI Room/Bed: Age/Sex: Page: 7 of 11 DEL Chino Valley Medical Center NUR **LIVE** DISCHARGE PATIENT AUDIT FORMAT Printed 06/15/07 at 1304 Admitted: Status: REG SDC Sts Directions Sts Directions Intervention Description Intervention Description From From Recorded Activity Occurred Recor Type Date Time by Date Activity Occurred Recorded Type Date Time by Date Time by Comment Documented Documented Recorded Time by Comment Units Change: Units Change Activity Date: 06/15/07 Time: 0837 (continued) Patient: ¥ Other (name/relationship): 13. 14. 15. 16. 17. -Referral Needed: 18 PATIENT MEDICAL HX
 Possible: MILD ASTMMA
 Po ****HISTORY ONLY-NOT for Patient's Current Assessment**** Cancer: N: Psychological: N: HOME MEDS (DOSE/FREQ/LAST DOSE/DISP)
 Currently Taking ASA: N Anticoagulants: N Steroids: N Diet Pills: A Herbal Supplement: N

 ATEMOLO: 50MG
 MALAPRIL 55 MG
 MELL TAKE B7P MED IN PH AS JUGUAL
 WILE TAKE B7P MED IN PH AS JUGUAL

 --- FUNCTIONAL STATUS ----8. 9. 10. 11. 12

Age/Sex	Attending: Shah, Umesh C. Account #: V0000242043 Llocation: Gl Room/Bed:	Chino Valley Medical Cer DISCHARGE PATIENT			Page: 8 of 1 Printed 06/15/07 at 130
Activity Occuri Type Date	Sts Directions ed Recorded Documente <u>Time: by Oata</u> Time <u>by Common Unit</u> Time: 0837 (contanued)	ed ts <u>Change</u>	Activity Occurred Type Date Tim	Récorded se by Date Time by (Time 0837 (continued	Documented
Activity Date: 06/15/07 -Admitted with Winab Alrea == EDUCATION SCREENING Education Needs Assesses Physiological Limitation Psychological Limitation Feaching Method Preference Pre Admission Teaching Education Commen Nethological Commen Education Commen Education Commen Education Commen	Time: 0837 (continued) Potential Risk Diagnosis: 0 NO or PO Intake for >4 Days 10 NO Tube Feeding or TPN: 0 NO Total Score: 0Nutritional Risk: 100 Referred to Primary Physician: ty Being Seen by PCP or Specialist for Problem: 1 Y S NONE S NONE S NONE S NONE S NONE	P. N	Activity Date: 06/15/07 Assessment Comment: atient/Family Education: ¥ Education Comment: === PATIENT/FAMILY EDUCATIL Person Taught: #UIENT Person Taught: Pre Admission Teaching As f NPD/Take medications Report Time to the H Need to Arrange Trams No Smoking 24 Hours i Do Not Bring Valuabil Do Not Bring Valuabil	Time: 0837 (continued) N - PRE ADMISSION — Teaching Other Too Follows: * the Morning of Surgery spital portation Home Contacts seffore Surgery seffore Surgery seffore Hursing Floor	
VITAL SIGNS Blood Pressure: 107775 BP Source: AUTOMAT Site: DEFTUP	DRY E: 05 1+ 07 Pulse: 62 Pulse Source: 62 Pulse Source: AltOMATIC, NO PER-ARM Respirations: 20 (LYING DGWN) Resp Source: QESERVED Sp022: 99 On 02: N LPM: Pain: N	NINVASTVE	Participation Leve) Evaluation Needs Additional Education Educator	ACTIVE VERBALIZES UNDERSTANDING N Luctum Chusht NURSING	
NEROLOGICAL Assessm RESPIRATORY Assessm CAROIAC Assessm CIROULAITORY Assessm GUROULGSKELETAL Assessm GENITTOURINARY Assessm INTEGURENTARY Assessm PSYCHOSOCIAL Assessm	Ar Or Productore ent Within Normal Limits: Y: ent Within Normal Limits: Y: Pulse Character #1: Pulse Character #2:		≪== PAIN ASSESSMENT ≈= Pain Location:		·

Age/Sex Attending: Shah, Unesh C. Unit # V000273781 Account # V00000242043 duritted Location; GI Communication; GI Com	Page: 9 of no Valley Medical Center NUR **LIVE** DISCHARGE PATIENT AUDIT FORMAT
Intervention Description. Sts Directions Activity Occurred Reconded Documented Type Date Time by Comment Units	From Intervention Uescription Sts Directions Fro Activity Occurred Recorded Documented
Activity Date: 06/15/07 Time: 0837 (continued)	Activity Date: 06/15/07 Time: 0858
Activity Date: 06/15/07 Time: 0837 (continued) -Pain Scale: Describe the Pain: Onset: What Increases the Pain: What Relieves the Pain: Pain Location: -Pain Scale:	IV Location: RACHTERAND Catheter Size (ga.): 22 IV Location: Catheter Size (ga.): 22 Saline Lock: N
Describe the Pain: Onset: What Increases the Pain: What Relieves the Pain: Comment:	1001037 Ang Suidelings: 41,65 (MID ADULT) A VIEW PROTOCOL/DI OS CP
PATIENT/FAMILY EDUCATION - OPS === Person Taught: EATIENT Person Taught: EATIENT Other Jools Used: Other Jools Used: V Prep If Applicable Surgery Holding Area Recovery Room Incentive Spirometer if Applicable Here Relatives: Misitars Should Wait Pain Management in Recovery Room and Outpatient Unit Will be Discharged When VS Are Stable, Able to Tolerate P.O. Liquids, Has Voided, and Can Ambulate Safely	20010 VS: Monitor + A PER UNIT POLICY CP + Document. 06/13/07 1112 CL 06/15/07 1250 CL. Temperature/F: 97.2 Temp Source: ORAL Pulse: 64 Pulse Source: AUTOWATIC: NONINVASIVE Respirations: 188 Resp Source: AUTOWATIC: Blood Pressure: 166/73 BP Source: AUTOWATIC: Site: UEFF UPPER ARM - C/0 Pain: N = CNA/LICENSED Decomentation == Comfort Measures Implemented: Nurse Notified of Pain: 3 (If Medicated, Document On Intervention Pain: Management Of)
Procedure Teaching As Follows: 第 IV If Applicable Where the Procedure is Done Recovery After Procedure and Time Involved Where Relatives/Visitors Should Wait	+++1F ON OKYGEN++++ Oxygen Device: ROOH'AIR 02 Amount (L/min). Sp02 (1): 99 FI02: Comment 22300 IV/Invasive Lines: Insert/Remove + A INS/REMOVAL/CONVERT CP Document 06/15/07.1250 CL IV/INSERT/DISCONTINUE
Other Teaching/Instructions: Comment: Participation Level: ACTIVE Evaluation: VERBALIZES UNDERSTANDING Needs Additional Education: N Educator: Luétim Chuseri Discipline: NURSING	Insertion/Reinsert Date: # of Attempts: Catheter Size (ga.): IV Location: Catheter Size (ga.): Saline Lock: Discontinued Date: D6/15/07 IV/SL DC'd - Cath. Intact: * IV Converted to Saline Lock: N IV Comment: SITE CLEAR

70.2.4

Age/Sex: unit # 4000273781 Admitted: Status: REG SDC	Attending: Shah. Umesh C. Account #: V00000242043 Location: GI Room/Bed:	H Chino Valley Medical (DISCHARGE PATIEN	DEL Denter NUR **LIVE** FAUDIT FORMAT			age: 10 of 11 15/07 at 1304
Activity Occur	ed Recorded Sts. Directions red Recorded Bocument Time by Date Time by Comment Uni	From. .ed	Activity Occurr	ed Recorded		From
Activity Date: 06/15/07	Time: <u>1112</u>		Activity Date: 05/15/07	Time 1155 (continu	ed)	
EDOCUMENT 06/15/07 LOC: 2 Pain: Nausea:		CP	~ C/O Pain: 🕅 = Comfort Me Nurs	Time: 1155 (continu UPPER ARM = CNA/LICENSED Documentatio asures Implemented: e Notified of Pain: ted. Document On Interventi	in —	
Respiratory Difficulty: Respiratory Rhythm: Extremity Monitored: Extremity Temp: Extremity Color: Sensation: Extremity Comment: Dressing: Incision Open To Air: Location:	n Recollar Not Applicable		0xygen Device: ROOM A SpO2 (%): 97. Comment: 21099 Routine Car Uler PROIC Document 06/15/07. The Practice Guidelines A Have Been Met Throughout Signature: Luetum.Chusri	IF ON OXYGEN*** IR 02 02 Amou FIG2: 2 e. DS/PAIN CL OL 1155 CL 06/15/07 1255 CL ppropriate For The Patient The Shift: YES NO COMMENT	nt (L/min): A END OF SHIFT/TX:LIC And Within The Scope Of My P Shift: 0700 1930	ractice
Vaginai Eleeding/Disch: Comment: IV Fluid: % Current Rate (cc/rr): IV Site Co IV Comment: %	N ndition:	2	1557300 Post Op Ass Document 06/15/07 LOC: 4 Pain: 3	essment: Perform + 1155 °CL °06/15/07 1256 CL WAKE/ALLRT	Δ.	СР
Tolerating Diet/Fluids: Voided:	Y Outpatient Pain B	Education: Ý	Abdominal Appearance: S Respiratory Difficulty: M Respiratory Rhythm: Extremity Monitored: M Extremity Temp: Extremity Color: Sensation:	arm/dry of t/round	1.14	2 21-21-1
Activity Date: 06/15/07 20010 VS: Monito -Document 06/15/07 Tenpërature/F: 97:6 Pulse: 55 Respirations: 18 Blood Pressure: 124/	T + A PER UNIT POL 1155 CL 06/16/07.1254 CL Temp Source: OR4L Pulse Source: AUTOWATIC, KONINVASIVE Resp Source: GBSERVED	LICY - CP	Vaginal Bleeding/Disch: N			00012-1

Age/Sex Unit #: HOUO273781 dmitted Status: REG SDC	Attending: Shah, Umesh C. Account #: V00000242043 Location: GI .Room/Bed:	Chino Valley Medical Center NUR **LIVE DISCHARGE PATIENT AUDIT FORMAT								
Intervention Description Activity Occurred Type Date T	Sts Directions	ited Activity	escription	Documented						
Activity Date: 06/15/07	Time: 1155 (continued)	Activity Date:	06/15/07 Time 1155							
Activity Date: 06/15/07 IV Fluid: IV Fluid Remaining: Current Rate (cc/hr) IV Site Cond		- Create Abnormal? N PT 15 ALER DIET WELL GIVEN PT L	Patient Notes: Nurse Notes Of/15/07-1155 EL: 06/15/07-1300 CL Abnormal? N Confidential? M PT IS ALERT AND ORIENTED. VITAL SIGNS STABLE NO C/O PAIN. TAKING ORAL FLUID AND DIET WELL UP TO BATHROOM WITH ASSISTED. VOIDED. INSTRUCTIONS AND PRESCRIPTION GIVEN.PT IS DISCHARGED HOME VIA W/C TO PRIVATE AUTO.							
iv Lamment: ***** olerating Diet/Fluids: ⅔ Voided: ∦	Outpatient Pain	Monogram Initia	Luetum, Chusri RN	e						
Activity and Mental S Activity and Mental S Pain. Hauses. and/or Vom Surgical Ble Intake and O	- 									
	DISCHARGE SUMMARY									
D Acco ent Home With All Bedside Discharge I Dischar	Medications: Y ge Rx/Teach: Y									
Printed Instruc	tions Given: Y viewed With: PT									
atient/Family Verbalizes	Signed By: PT Given To: PT Understanding of Instructions: #									
		1								

Age/Sex. E Attending. S Unit # M000273781 Account # V Admitted Location G Status REG SDC Room/Bed		0000242043			HEL Chino Valley Medical Center NUR **LIVE** Patient's Plan of Care				Status: Activi Initiated: 06/14. Completed Protocol	
		STS INI		COMP BY	INTERVENTIONS	INIT BY	COMP BY	DATE & TIME	DIRECTIONS	S
<pre>velopmental Age 41-65 () Based on Erickson's eig development</pre>	nt stages of eration understanding herapy/treatment	A 0671		1	* Age Guidellines: 41-65 (MID ADULT) - PROTICOL: AGE 41-66		1	1	VIEW PROTOCOL/D1 CS	
that may be beneficial their family	to themselves and									
PROBLEM: Post Op Care Potential for complicat surgery/procedure. Alteration in comfort n or procedure. Risk of complications w and/or identified in a	ions related to elated to surgery ill be minimized	A 0671			* Post Op Assessment: Perform +	06/15 C				
Patient states they are or pain controlled and	free from pain	A 06/1	5 CL		* Pain: OPS Management of +	06/15 C		06/15 0824	PPN	
comfortable facial expr ANDARD OF PRACTICE DS/G	ession.	A 06/1	<u> </u>							<u>'</u>
STANDARD OF CARE CVHC The following STANDARDS related to the patient. significant other 1 Patient Care	OF.CARE are family.and/or									
4 Patient Safety 5 Patient Rights										
 The patient will of effecting an engoing -1 ery process of assessme identification goal se interventions and eval ins/her specific biologs and expectations of car The patient will be 	ychosocial needs									
1b. The patient will be plan of care with atten specific needs, cultura beliefs, confidentialit communication needs.	tion to age 1 and religious 2 and special									
 The patient will rec- about the nature of his condition, procedures. Chre. and post dischargy verbalization of questi- will be encouraged. Pat wilch is an interactive interdisciplinary teach prioritized based on th assessment or ind widas. 	etve education (her health treatments, self e care ons and concerns ient education ing process is e ongoing Latearing meeds									
가지는 것이 너희 것이 가지만, 말을 했다.		- N - 1 - 12	No an Sola	9 June - 1					그는 그는 그 가장	

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Age/Sex:						H→→→→→EL Chino Valley Medical Center NUR **LIVE** Patient's Plan of Care			•		Status: Active Initiated: 06/14/07 Completed: Protocol:	Pag Prin OĠ/15 at 1
			INIT BY		COMP BY	INTERVENTIONS		INIT BY	COMP BY	DATE & TIME	DIRECTIONS	
coordinating resources and priorities in preparation 4. The patient will receive environment. that mitning zes injury for themselves and o 5. The patient will be supplisher effort to retain per hisher effort to retain per denisty. self worth, priva	for discharge care in an risk of others ported in ersonal											
autonomy Patient will receive stand as per unit specific stand	ardized care ards		6/15 CL			* VS: Honitor + * Notify HD + * Education, Patient/Fami * IV/Invasive_Lines_ Inse * Day Surgery: Discharge	°t/Remove +	05/15 CL 06/15 CL 06/15 CL 06/15 CL 06/15 CL 06/15 CL		06/15 0824 06/15 0824 06/15 0824	PER UNIT POLICY WEN INCESSARY PAN INS/REMOVAL/CONVERT ON DISCHARGE	
PRACTICE GUIDELINES ** CO NOT EDIT OR ALTER TH	IS STATEMENT**		6/15 CL			* Routine Care: DS/PAIN C VIEW PROTOCO		06/15 CL		L	END OF SHIFT/TX LIC	
***ROUTINE CARE/PRACTICE G FOR DAY SURGERY/PAIN CLINI						- PROTOCOL: S.DS	1943), 1947), an an Arian.					
UNCESS OTHERHISE DOCUMENTED FOLLOWING ASSESSMENTS AND HAVE BEEN VERIFIED												
Safety 1 Verify acheand with name hirth medical record.numb allergies on patient 2. Evaluate for Risk of F. Admission: Patients determ	me date of er. medication al] on ined to be at											
greater misk for fails the cubicles that are within s murses station and have ' potential' armband. 3. Initiate safety measur indicated *side rails up x 2	ight of the fall es as							3 979 999 ACC / CS				
"bed in lowest position "bed or chair wheels loc "call bell within reach within direct view of nucs all times	ked or patient ing staff at											
<pre>*essentials within reach *patient/family instruct nurse </pre>	ed to call for											
4. Perform safety rounds nrs. and prin 5. Observe Standard Preca infection control additio precautions as indicated 6. Keep environment as qu possible	utions for nal											
<pre>pussione 7. Orient patient/family/ other(s) to Unit. room. ca rails safety issues. visi and smoking palicy on admi </pre>	significant li bell side ting policy	4 12										

	imesh C. 242043		H====EL Chino Valley Medical Center NUR **LLVE** Patient's Plan of Care					Status Active Initiated: 06/14/07 Completed: Protocol	Page Prints 06/15/0 at 130		
		S INIT BY	TRGT	COMP BY	INTERVENTIONS	(1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.	INIT BY	COMP BY	DATE & TIME	DIRECTIONS	
B.Monitor equipment in use o pro											
 9 Patient acknowledges givin consent by signing consent for 	rm prior										
to procedure, or physician in Datient needs more informatio											
igning consent 0. Pre-op/procedure test res	ulte								l		
eviewed prior to surgery/pro	cedure and										
Dnormals reported to physici	an										
SYCHOSOCIAL 1. Provide privacy for patie	nt, family.										
ignificant other(s) 2. Identify patient support	system and										
nvolve appropriately in the are											
3 Assess patient/family/sig								ļ			
ther(s) for economic. social eligious, and environmental	factors	100000									
hich may affect patient duri ospitalization	ng										
 Encourage patient/family/ ther(s) to verbalize concern 											
are team	그는 그 같아.										1. S. A.
 Discuss expected outcomes ealistic expectations with p 				-0.1							
amily/significant other(s).											
UTRITION 1. Monitor PO intake										The second s	an in 199 Second
2 Diet as ordered. Patient							in - International				
ble to tolerate PO fluids pr Fischarge	ior to										
3. Assist with eating/feed) eeded	ng if			i ki ara							
CTIVITY. 1 Activity performed per ad	tivity										
uidelines or as ordered: *advise patient to call for	assist the										
irst time 008 *monitor how patient tolers	ites										
ctivity *determine the need for an											
se of assistive devices	· · · · · · · · · · · · · · · · · · ·										
If the patient is unable eposition him/herself, he/sl		1									
urned or assisted with repo											
ilignment											
SKIN INTEGRITY											
 Evaluate skin condition ind document. 	on admission	1									
2 Keep skin clean and dry.		1	1215						1		보고 있
Prevent/eliminate pressu friction and sheering force	s on skin.		192								
4. Keep_linen_clean. dry. a	na i sikis	quinger and	1	1	1.0.000.0000000000000000000000000000000	se é la subserv		12222	11112038844.4	Construction of the second se	

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ge/Sex 5 ALLending Sha Unit # M000273781 Account # VOO Mnilled, Location GI Status REG SDC Rogm/Bed				Chino Valley Medical Ce Patient's Plan				Status: Active Initiated: 06/14/ Completed: Protocol:	
	STS INIT B	r tr <u>gt</u>	COMP BY	INTERVENTIONS	 INIT BY	COMP BY	DATE & TIM	E DIRECTIONS	
wriakle-free 5. If incontinent *cleanse.perimeal/perianal area after each opisode *change bed lines printo keep patient									
dry *offer toileting g 2 hrs and pro									
IF IV/SLAINE LOCK PRESENT. I Assess site(s) on return from procedure, prior to discharse; and q 4 hes if the patient slays overnight and prin, for redness, swelling, and/or pain 2. Verify solution and monitor, ordered rate of infusion q 1 hr and pri-									
PAIN: 1. Pain assessment performed on admission. Immediately after surgery or procedure, and prior to discharge, with appropriate interventions: *Assess location. Lype duration. And frequency of pain. *Assess inclusity of pein using an appropriate tool 1f the patient stays overnight, assess pain each time the VS are taken and, pcn. 2. If IV spoids administered: *Vertly, drug and dose to be given toilute, and administere per protocol									
*monitor pain relief, sedation level and respiratory rate/quality per policy. PESPLAIDRY 1. Honitor pulse oximatry prn as appropriate on as ordered 2. If postoprative *turn, cough, and deep breather q 2 hrs x8, then q 4 hrs and prn *incentive spirometry as ordered 3. If tracheostomy present "verify trach thes are secure									
*suction prn *maintain dry and intact dressing *establish means of communication									
POSTOPERATIVE GRSERVATION 1. Postoperative/Post.Procedure assessment on annival to unit. to include *45 and level of sedation *presence of pair and/comfort measure regulred *Appropriate chartsing or postop care or post procedure assessment and	꾀감 가 가슴								
intervention INCISIONS/DRESSINGS 1 If incision present, monitor site									

ge/Sex = Attending: Shal Unit# MOOD273781 Account # VOOD mitted: Location: Gi Status: REG SDC Room/Bed						EL Di Center NUR **LIVE** Plan of Care		,		Status Active Initiated 06/14/07 Completed Protocol	Page Print 06/15/ at 13
	STS_INI	r by	TRGT	COMP BY	INTERVENTIONS	·	INIT BY	COMP BY	DATE & TIME DIRE		S
for Dieding/drainage un return to unit. at time of discharge and prim 2. If dressing present: "Scheck on return to unit, at time of discharge of a hrs. and prim "pathem: instructed to keep dressing dry and intact much follow-up visit to physician unless instructed otherwise by physician. 3. If GW pathent, monitor vaginal bledding on return to unit: q 4 hrs. at discharge and prim. "If veginal packing present, remove only, per order.											
TUBES/DRATHS. 1 If drainage tubers) present 19P, merovar, T. Uober etc) *verify patency *borpty and measure contents prior. Lo discharge *petients going home with tubes will be tauget how to empty and record. output 2 If foley present *verify patency *keep big below. level of bladder at all times. *if patient_is going home with foley. teach how to empty the drainage bag and sitch betwen bedside bag and len bag.											
In DRHAPLOIC PATIENT 1. Heintain weight, bearing status as indexed 2. Use timpoilizers: braces- on collars as ordered 3. Monitor Circulation sensation. Wetor response of atfactde extremity on return to unit, g 8 hrs. on discharge and pro- 4. Apply tee pack to surgical site ff											
ordered Within OF BMED FARAGETERS NEUROLOGICAL parameters Altert and oriented to person, place and that Follows commands Balance and galt staedy No visual disturbances No numbress Equal extremity strength No quartysis		5 CL									
EENT Parameters No discharge, redness pain, edema, blurned or distorted vision with or without glasses/contacts noted or complained about											

Unit#:MODO273781 Acco dmitted: Loc	nding Shah. unt #: VOCOO ation GI m/Bed.	umesn u. 0242043			Chino Valley Medical Center NUR **LIVE** Patient's Plan of Care	-			Status Active Initiated 06/14/07 Completed Protocol	Pa Pr 06/3 at
,"··		TS INIT BY	TRGT	COMP_BY	INTERVENTIONS	INIT BY	COMP BY	DATE & TIME DIR	ECTIONS	
or without hearing aides (no h impairment), no discharge from										
 ear pain No nasal complaants/abnorma 	,									
assessment noted such as bleed	ing from			[····						
names (watery purulent, mucoi tenderness, stuffiness, conges										
difficulty breathing through n			an e							
 No throat complaints/abnorm assessment noted such as sore; 										
swollen throat. hypertrophied	tonsils.									
exudate on tonsils, postnasal hodrsness	dçip ve									
 No mouth complaints/abnorma 		- [·····		and and in						
assessment noted such as bleed cracking, dryness, inflamation				1						
redness, swelling, or ulcerati	on of 👌 🕴									
membranes. No cleft lip/palate abnormalities.										
RESPIRATORY Parameters No abnormal breath sounds		S 633.03		Pasas.						
Respirations regular, unlab	ored		1462	p						-0.32
- No cough							and the state			
CARDIAC Parameters:		a in and		1.						
 No chest pain Heart rhythm regular 						0.00				
영상 중에 가지 아파가 가지 않는 것이 없다. 같은 것이 없는 것이 없이 없는 것이 없이 없이 않이	the second states in					69.98 4 90				
CIRCULATORY Parameters: Capillary refull less than:										
- Temperature of extremities	warm									
 No tingling or numbress in: e trainitie; 		19 39 663 (P. 16) 	1.000							999 1992
- Color of estremities normal	for									04
patient Pedial/dorsalis pedis pulse	s equally									
palpable										
MUSCULOSKELETAL Parameters:										
 No muscle weakness Full range of motion of ext 	Sallana Ada S			1						
 No skeletal deformities 										
 No amputations No contractures 			1							
			1			1. 1995 (A.				
GASTROINTESTINAL Parameters Active bowel sounds							1			
 Abdomen not distended 					2010 B 10 10 10 10 10 10 10 10 10 10 10 10 10					
 Abdomen nontender to palpat Continent of stool 	100									
그는 것같이 쉽는 것을 가장했어야?										
GENITOURIHARY Parameters No unimary drainage system										
- Not on dialysis										
 Continent of unine. Bladder nondistended 		1 .		1			[• • • •		한 같은 것이 같아요.	
 Ho complaints of frequency. 	ungency.			1.2.22						
burning, dysunia		adaina Silili	152-5	1	<u>120 - 131 - 1717</u> - 1717 - 1818 - 1818 - 1818	i (si shi ki	<u>p. 2005. j</u>	<u></u>		<u>7939995</u>

	STS INIT BY	TRGT CO	MP BY	INTERVENTIONS	INIT BY	COMP BY	DATE & TEME	DIRECTIONS	
TECHMENTARY Parameters Skin warm and dry									
Skin normal color for patient Mucous membranes moist									
YCHOSOCIAL Parameters No mood swings noted: Patient's mood.									
propriate for situation with regard to [tura] influences. [ffective coping skills/patterns with									
pard to cultural influences. neffective coping can be presented as st traumatic response, abusive									
navior to self threats of self harm. Icidal thoughts, or violent behavior) Adequate support system									
Normal age appropriate growth and velopment (Erickson's) No signs of suspected abuse									
iysical, emotional, neglect, etc.) ans include delay in treatment. sitation to explain, injury									
onstistent with history sites of pury self neglect nonspecific mplaints patterned markings									
current injuries or injuries in tious stages of healing									
No fears or anxiety related to spitalization									걸렸던

ON ADMI		I Belongings + ANSFER. PRINT OUT & COPY.	06/15 CL	06/15 0824	ADM.TX.DC	
Monogram	Initials	Name	Nurse Type		_	
CL	NURLC	Luetum,Chusri	RN			
KW	NURWK	Naoner Kathleen	RN I			

8. ASSIGNMENT OF INSURANCE OR HEALTH PLAN BENEFITS TO HOSPITAL-BASED PHYSICIANS: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment ny hospital-based physician of any insurance or health plan benefits otherwise payable to or on alf of the patient for professional services rendered during this hospitalization of for outpatient service, including emergency services if rendered, at a rate not to exceed such physician's regular charges. It is agreed that payment to such physician pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligation under the policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

9. HEALTH PLAN OBLIGATION: A list of such plans is available upon request from the Financial Office.

10. BELEASE OF INFORMATION: The hospital will obtain the patient's consent and authorization to release medical information, other than basic information, concerning the patient, except in those circumstances when the hospital is permitted or required by law to release information. The undersigned has consented to the release of medical information to entities that provide care in post-acute setting. In accordance with the Safe Medical Device Act of 1990, the undersigned agrees that in the event a permanent medical device is implanted the hospital is hereby authorized to notify the manufacturer of patient's name, address, telephone number, and social security number (if available) as well as other information about the implantation. I authorize a copy of my record to be sent to my family physician physician of referral at time of discharge.

/sician Name/Address <u>Dr. Chah</u>

I authorize release of information regarding the birth of my child, as applicable.

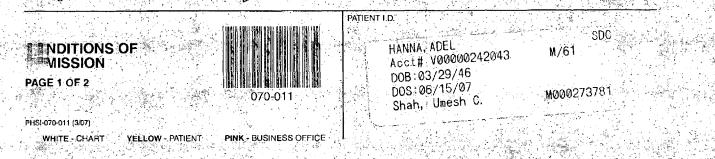
The hospital is authorized, without further action by or on behalf of the patient to disclose all or any part of the patient's record to any entity which is or may be liable to the hospital, patient or any entity affiliated with patient for all or part of the hospital's or hospital based physicians' charges for the patient's record to any entity affiliated with patient for all or part of the hospital's or hospital based physicians' charges for the patient's record to any entity affiliated with patient for all or part of the hospital's or hospital based physicians' charges for the patient's record to any entity affiliated with patient for all or part of the hospital or medical service companies, insurance companies

11. HOW YOUR BILL IS DETERMINED: Hospital charges include a basic daily rate, which covers your room, nursing care and food service, or outpatient/emergency services. Additional charges are made for special services ordered by your doctor. Operating room, surgical supplies, mediations, treatments, tests, oxygen, x-rays and physical therapy are some examples of such services. Physician in rges are billed separately. In addition to receiving bills for services rendered by the hospital and r personal physician, you will receive separate bills from hospital-based physicians who purticipate in your care. These physicians may represent any of the following areas: anesthesiology, radiology, pathology, nuclear medicine, cardiodiagnostics, and the like.

12. PARTICIPATION IN MEDICAL EDUCATION PROGRAM: (NA

It is understood that this hospital is a teaching institution and that unless the hospital is notified to the contrary in writing, the undersigned may participate as a teaching subject in the medical education program of the hospital and may receive treatment by residents, if approved by the undersigned's attending physician, and those clinical students acting under appropriate supervision as required by such medical education and clinical training programs.

13. ORGAN DONATION: California State Law requires hospitals to have a method to identify potential organ and tissue donors. We want you to be aware of the need for organ and tissue donations and to provide you with the opportunity to let your wishes regarding participation be known. Have you signed, an organ donor card?



CONDITIONS OF ADMISSION

1. CONSENT TO MEDICAL AND SURGICAL PROCEDURES: The undersigned consents to procedures which may be performed during this hospitalization or on an outpatient basis, inclucing emergency treatment or services and which may include, but are not limited to, laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, anesthesia, or hospital services rendered to the patient under the general and special instructions of the patient's physician or surgeon.

2. NURSING CARE: The hospital provides only general-duty nursing care unless, upon orders of the patient's physician, the patient is provided more intensive nursing care. If the patient's condition is such as to need the service of a special duty nurse it is agreed that such must be arranged by the patient or his/her legal representative. The hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that the patient is not provided with such additional care.

3. PERSONAL VALUABLES: It is understood and agreed that the hospital maintain a fireproof safe for the safekeeping of money and valuables and the hospital shall not be liable for the loss or damage to any money, jewelry, documents, furs, fur coats and fur garments or other articles of unusual value and small size, unless placed therein, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for safekeeping. The liability of the hospital for loss of personal property which is deposited with the hospital for safekeeping is limited for loss of any person property which is deposited with the hospital for safekeeping is limited by statute to five hundred dollars (\$500.00) unless a written receipt for a greater amount has been obtained from the hospital by the patient.

4. CONSENT TO PHOTOGRAPH: Photographs may be recorded to document the patient's progress of care and shall be part of the patient's medical records or physician's office medical record. I consent to this and the use of the same for scientific, education or research purposes if approved. The hospital/physician will retain ownership rights to the photographs as well as to the medical record. Photographs may also be taken for the purpose of patient identification.

5. LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS: All physicians and surgeons furnishing services to the patients, including the radiologist, pathologist, anesthesiologist and the like are independent contractors with the patient and are not employees or agents of the hospital. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to mediate or surgical treatment, special diagnostic or therapeutic procedures, or hospital services renderent's the patient under the general and special instructions of the physician.

6. EMERGENCY OF LABORING PATIENTS: In accordance with Federal law, I understand my right to receive an appropriate medical screening examination performed by a doctor, or other qualified medical professional, to determine whether I am suffering from an emergency medical condition and, if such a condition exists, stabilizing treatment within the capabilities of the hospital's staff and facilities, even if I cannot pay for these services, do not have medical insurance or I am not entitled to Medicare or Medi-Cal.

7. ASSIGNMENT OF INSURANCE OR HEALTH PLAN BENEFITS TO HOSPITAL: The undersigned irrevocably assigns and hereby authorizes, whether he/she signs as agent or as patient, direct payment of the hospital of all insurance benefits otherwise payable to or on behalf of the patient for this hospitalization or for these outpatient services, including emergency services if rendered, at a rate not to exceed the hospital's actual charges. It is agreed that payment to the hospital, pursuant to this authorization, by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligations under a policy to the extent of such payment. It is understing by the undersigned that he/she is financially responsible for allowed charges not paid pursuant to assignment.

NOTICE BY SIGNING THE CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO URY OR COURT TRIAL. IF YOU DO NOT AGREE TO ARBITRATION, PLEASE INITIAL AND

CORRECT.

19. FINANCIAL RESPONSIBILITY AGREEMENT BY PERSON OTHER THAN THE PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE: | agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement (Paragraph 7) and Assignment of Health Plan Benefits (Paragraphs 8 and 9) set forth above.

Witness

Financially Responsible Party Date/Time

Translator: I have accurately and completely read the forgoing document to

del s. faune, M.D.

(name of patient / person legally authorized to give consent)

he patient's or patient's representatives primary language.)

He/she understood all the terms and conditions and acknowledges his/her agreement thereto by signing this document in my presence.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to market the above and accept its terms.

AVE READ AND UNDERSTAND THE TERMS AND CONDITIONS OF SERVICE, WHICH BECOME EFFECTIVE AT THE TIME SERVICE IS RENDERED.

CONSERVATOR / GUARDIAN POLICY HOLDER OR FINANCIALLY RESPONSIBLE PARTY **RELATIONSHIP TO PATIENT** WITNESS SIGNATURE OF TRANSLATOR DATE OF SIGNING TIME OF SIGNING Patient unable to sign: (Reason) PATIENT I.D. SDC **MANDITIONS OF** HANNA, ADEL MISSION Acct# V00000242043 PAGE 2 OF 2 DOB:03/29/46 DOS:06/15/07 070-011 4 M000273781 Shah, Umesh C. PHSI-070-011 (3/07) PINK - BUSINESS OFFICE WHITE - CHART YELLOW - PATIENT

CONDITIONS OF ADMISSION

14. FINANCIAL AGREEMENT: Not withstanding section (6), (Emergency or Laboring Patient further understand that I am responsible to the hospital and physician(s) for all reasonable char incurred by me and not paid by third party benefits. In the event that said bill, or any part thereof, is deemed delinquent by the hospital. I understand that I will be responsible for collection expenses as well as reasonable attorney's fees and court costs if a suit is instituted. All delinquent accounts shall bear interest at the maximum rate allowed by law. In the event that hospital is not paid by third parties with three (3) months for the date of billing for payment, I will promptly make arrangements to pay the outstanding account.

NON-COVERED CHARGES: In the event that insurance does not cover particular procedures, medications, and/or services, the undersigned hereby agrees to be personally responsible for payment of such charges, if not prohibited by law.

15. MEDICARE INSURANCE, BENEFITS AND EXCLUSIONS: If the patient is a Medicare beneficiary or will apply for Medicare benefits, the undersigned certifies that the information given about the patient is correct. It is also agreed and understood that we may release certain medical information about the patient to the Social Security Administration and/or its intermediaries and/or its carriers for this or a related Medicare claim. The undersigned requests that payment of authorized benefits be made the patient's behalf. Some services may not be covered by Medicare, such as the following: 1) Worke Compensation, 2) Dental, 3) Cosmetic Surgery, 4) Custodial Care, 5) personal comfort Items, and/or any services determined to be unnecessary or unreasonable by Medicare. If the patient is not on file with the Social Security Administration, the usual billing procedures will be used independent of the data access.

16. IF YOU DO NOT HAVE INSURANCE: You may be eligible for the Charity Care and Discounted Payment Program. Please contact the business office.

17. WAIVER OF LIABILITY: I understand that some or all of these services may not be covered UM Medicare and that I am financially responsible if these services are denied.

18. ARBITRATION OPTION: It is understood that any dispute as to medical malpractice, as to whether any medical services rendered under this Contract were unnecessary or unauthorized or were improperly. negligently or incompetently rendered, will be determined by submission to arbitration as approved by California law, and not by a lawsuit or resort to court process except as California law provides judicial review of arbitration proceedings. Both parties to this Contract by entering into it, are gi up their constitutional right to have any such dispute decided in a court of law before a jury, and instare accepting the use of arbitration. Such arbitration shall be in accordance with the current Hospital Arbitration Regulations of the California Hospital Association-California Medical Association (copies available at Hospital's Admissions Office). This Mutual Arbitration Agreement shall apply to any legal claim or civil action in connection with this hospitalization or outpatient service against the Hospital or its employees and any doctor of medicine agreeing in writing to be bound by this provision. The execution of the Mutual Arbitration Agreement shall not be a precondition to the furnishing of services by the Hospital, and this Mutual Arbitration Agreement may be rescinded by written notice from the patient or patient's representative to the Hospital within 30 days of signature. The Mutual Arbitration Agreement shall bind the parties hereto and their heirs, representatives, executors, administrators, successors and assigns hospitalization or outpatient service against the Hospital or its employees and any doctor of medicine agreeing in writing to be bound by this provision. The execution of the Mutual Arbitration Agreement shall not be a precondition to the furnishing of services by the Hospital, and this Mutual Arbitration Agreement may be rescinded by written notice from the patient or patient's representative to the Hospital within 30 days of signature. The Mutual Arbitration Agreement shall bind the parties hereto and their heirs, representatives, executors, administrators, successors and assigns.

Adel Hanna To: (Name of Patient)

- 5. Your signature on this form indicates (1) that you have read and understand the information provided in this form, (2) that the operation or procedure set forth below has been adequately explained to you by your physician, (3) that you have had a chance to ask questions, (4) that you have received all of the information you desire concerning the operation or procedure and (5) that you authorize and consent to the performance of the operation or procedure.
- 6. Your attending physician is Dr. <u>Chandrahas</u> <u>Agarwal</u> and your supervising physician or surgeon is Dr. <u>Umesh</u> <u>Shah</u>.
- Procedure:
 Esophagogastroduodenoscopy-Passage of tube through mouth into stomach

 for purpose of visual inspection of mouth, esophagus, stomach, and upper portion of small

 bowel, with possible biopsy, polypectomy and cauterization and possible schlerotherapy.

 Possible Dilation.
 □

 Possible Esophageal Variceal Banding

Alluna _____ Date: 6/15/07___ Time: 8:30 am Signature: 7

If signed by other than patient, indicate relationship: (Surrogate decision maker can be family member or someone designated in writing, i.e., power of attorney, court order, etc.)

Witness:

Date: 0/15/02 Time: 08-30

Chino Valley Medical Center 5451 WALNUT AVENUE, CHINO, CA 91710 INFORMED CONSENT BY PATIENT OR SURROGATE DECISION MAKER

Churt

ESOP / POSSIBLE DILATION

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Chino Valley Medical Center

5451 WALNUT AVENUE, CHINO, CA 91710

AUTHORIZATION FOR AND CONSENT TO SURGERY OR SPECIAL DIAGNOSTIC OR THERAPEUTIC PROCEDURES THIS MUST BE ACCOMPANIED BY "INFORMED CONSENT BY PHYSICIAN"

Do not complete this form if patient lacks capacity to give consent and no surrogate decision maker is available.

1. The hospital maintains personnel and facilities to assist your physicians and surgeons in their performance of various surgical operations and other special diagnostic or therapeutic procedures. These operations and procedures may all involve risks of unsuccessful results, complications, injury, or even death, from both known and unknown and unforeseen causes, and no warranty or guarantee is made as to result or cure.

You have the right to be informed of such risks as well as the nature of the operation or procedure, the expected benefits or effects of such operation or procedure, and the available alternative methods of treatment and their risks and benefits. Except in cases of emergency, operations or procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to consent to or to refuse any proposed operation or procedure at any time prior to its performance.

2. Your physicians and surgeons have recommended the operations or procedures set forth below.

Upon your authorization and consent, this operation or procedure, together with any different or further procedures which in the opinion of the supervising physician or surgeon may be indicated due to any emergency, will be performed on you. The operations or procedures will be performed by the supervising physician or surgeon named below (or in the event that the physician is unable to perform or complete the procedure, a qualified substitute supervising physician or surgeon), together with associates and assistants, including anesthesiologist, pathologists and radiologists from the medical staff of CHINO VALLEY MEDICAL CENTER to whom the supervising physician or surgeon may assign designated responsibilities. The person in attendance for the purpose of performing specialized medical services such as the anesthesiologist, radiologist or pathologist are not agents, servants, or employees of the hospital or your supervising physician or surgeon. They are independent contractors and therefore are your agents, servants, or employees.

- 3. By your signature below you authorize the pathologist to use his or her discretion in disposing of any member, organ, or other tissue removed from your person during the operation or procedure set forth below.
- 4. To make sure that you fully understand the operation or procedure, your physician will fully explain the operation or procedure to you before you decide whether or not to give consent. If you have questions you are encouraged and expected to ask them.

Adel Hanna To: (Name of Patient)

- Your signature on this form indicates (1) that you have read and understand the information 5. provided in this form, (2) that the operation or procedure set forth below has been adequately explained to you by your physician, (3) that you have had a chance to ask questions, (4) that you have received all of the information you desire concerning the operation or procedure and (5) that you authorize and consent to the performance of the operation or procedure.
- Your attending physician is Dr. Chandrahas Agarwal and your 6. supervising physician or surgeon is Dr. Umesh

Procedure: Colonoscopy - Viewing of the colon by insertion of a tubular instrument. With possible biopsy, possible polypectomy and possible cauterization.

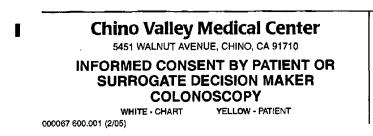
 Possible Hemorroidal Banding ÷ . .

Signature: X Hanno

Date: 6/15/07 Time: 28:3 - 2m

If signed by other than patient, indicate relationship: (Surrogate decision maker can be family member or someone designated in writing, i.e., power of attorney, court order, etc.)

hurter Date: O/(5/0) Time: O(5.30) M Witness: (



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Chino Valley Medical Center

5451 WALNUT AVENUE, CHINO, CA 91710

AUTHORIZATION FOR AND CONSENT TO SURGERY OR SPECIAL DIAGNOSTIC OR THERAPEUTIC PROCEDURES THIS MUST BE ACCOMPANIED BY "INFORMED CONSENT BY PHYSICIAN"

Do not complete this form if patient lacks capacity to give consent and no surrogate decision maker is available.

1. The hospital maintains personnel and facilities to assist your physicians and surgeons in their performance of various surgical operations and other special diagnostic or therapeutic procedures. These operations and procedures may all involve risks of unsuccessful results, complications, injury, or even death, from both known and unknown and unforeseen causes, and no warranty or guarantee is made as to result or cure.

You have the right to be informed of such risks as well as the nature of the operation or procedure, the expected benefits or effects of such operation or procedure, and the available alternative methods of treatment and their risks and benefits. Except in cases of emergency, operations or procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to consent to or to refuse any proposed operation or procedure at any time prior to its performance.

2. Your physicians and surgeons have recommended the operations or procedures set forth below.

Upon your authorization and consent, this operation or procedure, together with any different or further procedures which in the opinion of the supervising physician or surgeon may be indicated due to any emergency, will be performed on you. The operations or procedures will be performed by the supervising physician or surgeon named below (or in the event that the physician is unable to perform or complete the procedure, a qualified substitute supervising physician or surgeon), together with associates and assistants, including anesthesiologist, pathologists and radiologists from the medical staff of CHINO VALLEY MEDICAL CENTER to whom the supervising physician or surgeon may assign designated responsibilities. The person in attendance for the purpose of performing specialized medical services such as the anesthesiologist, radiologist or pathologist are not agents, servants, or employees of the hospital or your supervising physician or surgeon. They are independent contractors and therefore are your agents, servants, or employees.

- 3. By your signature below you authorize the pathologist to use his or her discretion in disposing of any member, organ, or other tissue removed from your person during the operation or procedure set forth below.
- 4. To make sure that you fully understand the operation or procedure, your physician will fully explain the operation or procedure to you before you decide whether or not to give consent. If you have questions you are encouraged and expected to ask them.

Name/Description of Procedure: <u>EUD E Col</u> <u>Polypeumony</u> (See reverse sid	e of form for additional instructions and definitional
Section I to be completed by treating physician	
<u>PART I:</u> Complete this section if consent is being given I, the treating physician, have provided the nature of the following potential risks, complications, potential/expected	above stated procedure in laymen's terms, including the
I have provided this information to:	l
Patient (or)	
Surrogate Decision Maker: A surrogate decision ma capacity at this time to make informed decisions regarding apply):	
Altered Level of Consciousness	
Name of Surrogate Decision Maker:	Relationship:
Interpreter Used; Name:	:
To be completed by treating physician if <u>patient lacks</u> of a second sec	icity to give consent and would likely do so it able. Furthe
To be completed by treating physician if <u>patient lacks</u> of I, the treating physician, certify that the patient lacks capa there is no surrogate decison-maker available to provide identify and/or contact said person. The patient has been assessed and has been determine	acity to give consent and would likely do so it able. Furthe consent in the patient's behalf in spite of diligent efforts ned to lack capacity to give consent at this time for th
Minor not meeting criteria to give conse	acity to give consent and would likely do so it able. Further consent in the patient's behalf in spite of diligent efforts ned to lack capacity to give consent at this time for th ent commended procedure is medically emergent and delay in llowing (check all that apply): s of function Unrelieved, serious pain
To be completed by treating physician if patient lacks of I, the treating physician, certify that the patient lacks capa there is no surrogate decison-maker available to provide identify and/or contact said person. The patient has been assessed and has been determine following reasons (check all that apply): Altered Level of Consciousness Minor not meeting criteria to give consec Other: It is necessary to proceed without consent because the rea- providing this procedure could result in any or all of the fol Death Significant/Serious loss See progress notes for additional discussion in this mati-	acity to give consent and would likely do so it able. Further consent in the patient's behalf in spite of diligent efforts and to lack capacity to give consent at this time for the ent commended procedure is medically emergent and delay in lowing (check all that apply): s of function \Box Unrelieved, serious pain tter.
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Instructions for completing "Informed Consent by Physician"

- 1) This form is to be completed by the treating physician
- 2) This form is to be accompanied by "Informed Consent by Patient/Surrogate Decision-Maker" or similar form relative to a specialized procedure, such as Hysterectomy, Sterilization, Blood Transfusion, etc., unless the patient lacks capacity to give consent and there is no available surrogate decision-maker.
- 3) Cross out all unused sections-do not leave any section blank.
- Section I: to be completed if the patient or a surrogate decision maker is able to give consent.
- 5) <u>Section II</u> to be completed only if patient lacks capacity to give consent and there is no available decision-maker.
- 6) Definitions:
 - a) Adult patient with capacity to consent: patient is 18 years old and can understand the risks and benefits of the procedure that is being offered; an adult with "capacity" can include mentally ill adults and developmentally disabled (mentally retarded) adults as long as the physician feels the patient can understand what is being offered.
 - b) Minor patient (17 or under) with capacity to consent; patient is one of following:
 - Legally emancipated (15 or older, emancipated via court order or is a selfsufficient minor living on own).
 - On active military duty
 - Receiving pregnancy-related care
 - Being treated for a reportable disease (12 or older)
 - Being treated relative to a rape or sexual assault (12 or older for rape)
 - Being treated for a mental health problem (12 or older)
 - Being treated for a drug/ETOH problem (12 or older)
 - Married
 - Making a blood donation, (17 or older)
 - c) Surrogate Decision-Maker can be any one of the following:
 - A family member (or friend if there is no known family) who appears to be acting according to the patient's wishes and best interests
 - An adult designated in writing, such as a Power of Attorney for Healthcare, court order, etc. (Supporting documents need to be on medical record).

EDUCATION MATERIALS	······································
Patient's Rights / Patient's Responsibilit	uire that we provide you with the following: ties
Notice of Privacy Practices	
□ Inpatients will also receive:	
 Your Right to Make Decisions About An Invitation to Become a Member of 	
 Understanding Your Pain 	
Patient Safety	
 Smoking Cessation Information Patient Guide 	· · · ·
Fall Risk Information	
Child Safety Seat	
 Pneumococcal Vaccine Information Influenza Vaccine Information (Durin 	g the Current Flu Season)
HEALTHCARE DIRECTIVE	
Do you have a Healthcare Directive or a L	Living Will?
a. Have you provided us with a co	ppy? 🗆 Yes 🗶 No
b. Do you wish to receive informat	tion on healthcare directives?
If you would like further information or assis	stance, please contact Social Services.
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PERSONAL STREET

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Chino Valley Medical	center					Printed 11/19/08 1938
Patient		Med. Rec/Unit #				Account/Transcription #
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FOR HIM USE ONLY** ASSEMBLE_

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ANALYZE____

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ACCOUNT #: PATIENT: DATE OF ADMISSION: DATE OF DISCHARGE: V00000305742 HANNA, ADEL S. 11/19/2008 11/21/2008

cc:

DISCHARGE DIAGNOSES:

Intractable acute abdominal pain. Acute small bowel obstruction. Intractable acute nausea, vomiting, and diarrhea. Dehydration. Migraine. Depression. Possible acute/chronic systolic/diastolic heart failure.

ADMISSION DIAGNOSES: Acute small bowel obstruction. Intractable acute abdominal pain. Intractable acute nausea, vomiting, and diarrhea. Dehydration. Migraine. Depression. Possible acute/chronic systolic/diastolic heart failure. Diverticulosis.

CAUSE FOR ADMISSION:

The patient is a 62-year-old male with past medical history of migraine, depression, and cholecystectomy who was brought in by wife with history of two days of abdominal pain, which is 5/10, cramping, diffuse, and continuous pain with chill, fever, dizziness, diarrhea, and also with generalized body aches. The patient states that he was unable to tolerate food or drinking for two days and no urination for two days. Also, the patient took Tylenol for fever, which helped a little bit. The patient denies chest pain, shortness of breath, or any other complaints.

HISTORY: As dictated.

PHYSICAL: As dictated.

LABS AND STUDIES: As charted.

PROCEDURES:

EKG showed normal sinus rhythm. CT of the abdomen showed findings consistent with small bowel obstruction with transition point in the right mid abdomen status post cholecystectomy.

DISCHARGE SUMMARY

CHINO VALLEY MEDICAL CENTER CHINO, CA 91710 HANNA, ADEL S. M000273781 Daljinder Takhar, D.O. DATE OF ADMISSION: DATE OF DISCHARGE: Page 1 of 3

11/19/2008 11/21/2008 ACCOUNT #: PATIENT: DATE OF ADMISSION: DATE OF DISCHARGE: V00000305742 HANNA, ADEL S. 11/19/2008 11/21/2008

Normal appendix was identified. X-ray of the pelvis fluid overload noted and scattered diverticula are seen in the sigmoid colon without CT evidence for acute diverticulitis. Chest x-ray showed bibasilar discoid atelectasis. KUB showed nasogastric tube in place as described and recommending advanced G-tube placement for findings suggestive for distal small bowel obstruction. Repeat KUB showed slight improvement in the distal small bowel obstruction, feeding tube was within the distal stomach and duodenum. Another repeat KUB showed slight decease in small bowel ileus pattern. Repeat CT of the abdomen without contrast on 11/21/2008 showed nasogastric tube terminated in the ascending duodenum, no pattern of small bowel obstruction, and lack of distention versus thickening of the wall of the sigmoid colon with marked adjacent inflammatory change. IV fluid was running at 100 mL/hour of normal saline.

CONSULTANTS:

Anthony S. Oh, M.D., surgeon. Mukesh S. Amin, M.D., internist.

HOSPITAL COURSE:

The patient is a 62-year-old male with migraine, depression, and cholecystectomy who came in complaining of diffuse and cramping abdominal pain x2 days with chills, fever, dizziness, and diarrhea. The patient was admitted to medical/surgical with NG tube placement in the ER with intermittent loss of low suction. The patient was put on NPO and IV fluid 100 mL/hour of normal saline with Zofran 4 mg IV q.4h. p.r.n. nausea and vomiting, morphine 2 mg IV q.4h. p.r.n. pain, Ativan 1 mg IV q.4h. p.r.n. anxiety, Protonix 40 mg IV daily for GERD, Ambien 5 mg p.o. at bedtime, Toradol 30 mg IV q.6h. p.r.n. pain, ampicillin 1 g q.8h. for possible sepsis, atenolol 50 mg p.o. at bedtime for migraine prophylaxis was continued, and Benadryl. Dr. Oh was consulted for small bowel obstruction and he recommended NPO, NG tube suction out-ofbed, and DVT prophylaxis. The patient tolerated full liquid diet starting on the discharge date and per Dr. Oh, the patient was okay to be discharged. The patient was also increased Ativan 2 mg IV q.4h. p.r.n. agitation, K-Phos 2 mEq in two liter of normal saline was given for low phosphate, Gaviscon 15 mL p.o. q.i.d. was given p.r.n. for digestion, and Cepacol was given p.o. q.4h. p.r.n. for sore throat. The patient was given incentive spirometer for bibasilar discoid atelectasis, out-of-bed, and decreased IV fluid to 90 mL/hour of normal saline because the patient's BUN and creatinine was improving with less dehydration. Also, sodium phosphate rider was given 40 mEq in 250 mL per normal saline due to the patient's low phosphate. NG tube was removed on 11/21/2008 at 1000 hours, which the patient tolerated well. A repeat CT showed no apparent small bowel obstruction. Upon discharge, the patient's vitals were temperature 98.6 degrees, heart rate 62, respirations 20, blood pressure 137/91, and saturation 96% on room air with no pain. At this point, the patient has no nausea, vomiting, and tolerating full liquid diet without any complication. The patient was agreeable to be discharged. The

DISCHARGE SUMMARY

CHINO VALLEY MEDICAL CENTER CHINO, CA 91710 HANNA, ADEL S. M000273781 Daljinder Takhar, D.O. DATE OF ADMISSION: DATE OF DISCHARGE: Page 2 of 3

11/19/2008 11/21/2008 ACCOUNT #: PATIENT: DATE OF ADMISSION: DATE OF DISCHARGE: V00000305742 HANNA, ADEL S. 11/19/2008 11/21/2008

patient got better with hospital course. There was no chest pain, abdominal pain, or headache upon discharge and the patient's hydration resolved too.

DISPOSITION:

The patient and family were made well aware of all diagnoses and procedures during their stay. The patient was discharged home by private auto.

DIET: Full liquid diet to regular diet as tolerated.

ACTIVITY: As tolerated.

MEDICATIONS: Atenolol 50 mg p.o. at bedtime for migraine prophylaxis, Lexapro 15 mg p.o. daily for depression, Zomig 2.5 mg p.o. p.r.n. for migraine, and Tylenol 500 mg p.o. b.i.d. for p.r.n. fever.

FOLLOW-UP:

The patient is to follow with Dr. Oh, surgeon on 11/26/2008, also with Dr. Agarwal, his cardiologist, and also with Dr. Shah, the patient's GI doctor for CT result of thickening of sigmoid wall. Due to the patient's comorbid medical condition including SBO, intractable acute abdominal pain, dehydration, migraine, depression, possible acute/chronic systolic/diastolic heart failure, CT result of lack of distention versus thickening to the wall of the sigmoid colon, and diverticulosis, the patient may return to our facility sooner than expected.

POINT OF CONTACT: The patient's point of contact is sister Amon Hanna at #909-374-7216.

Yoonjung Jang, RES D.O.

Daljinder Takhar, D.O.

DR:	YJ/SSP
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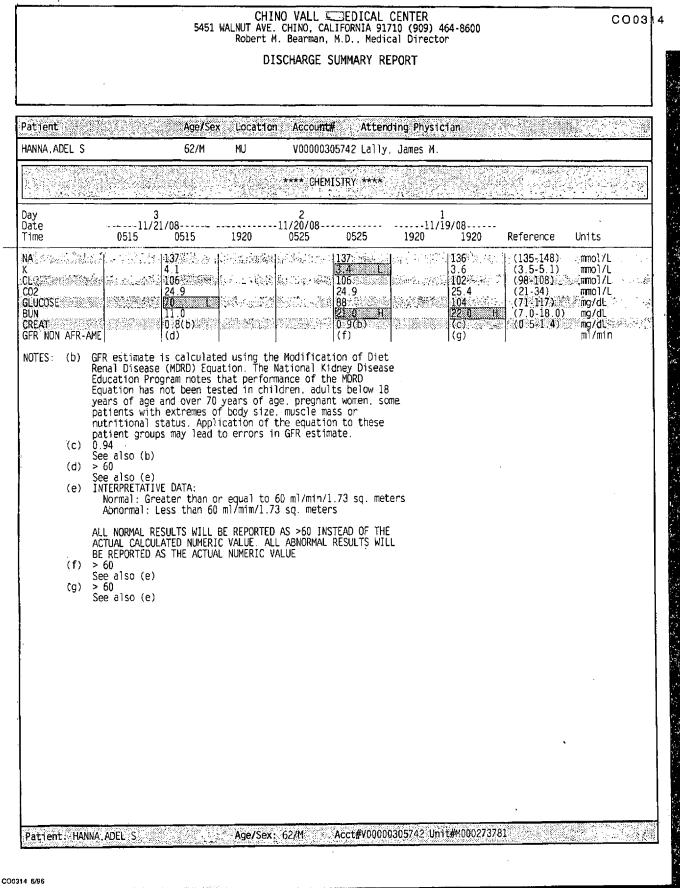
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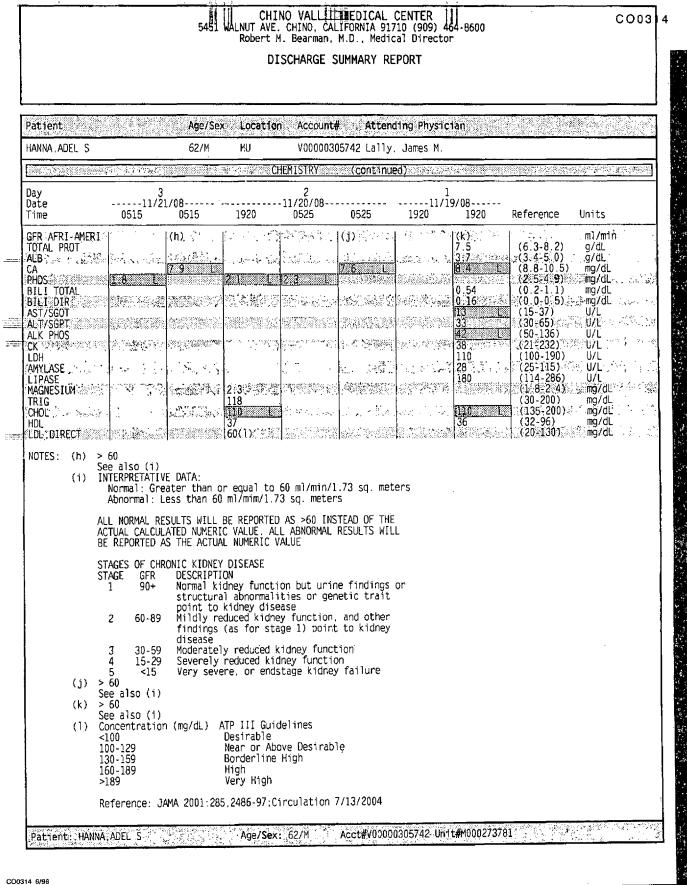
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CHINO, CA 91710	Daljinder Takhar, D.O.	11/19/2008
	DATE OF DISCHARGE:	11/21/2008
	Page 3 of 3	

	5451 WALNUT AVE. CHINO, CALIFORNIA 91710 (909) 464-8600 Robert M. Bearman. M.D., Medical Director	
	DISCHARGE SUMMARY REPORT	
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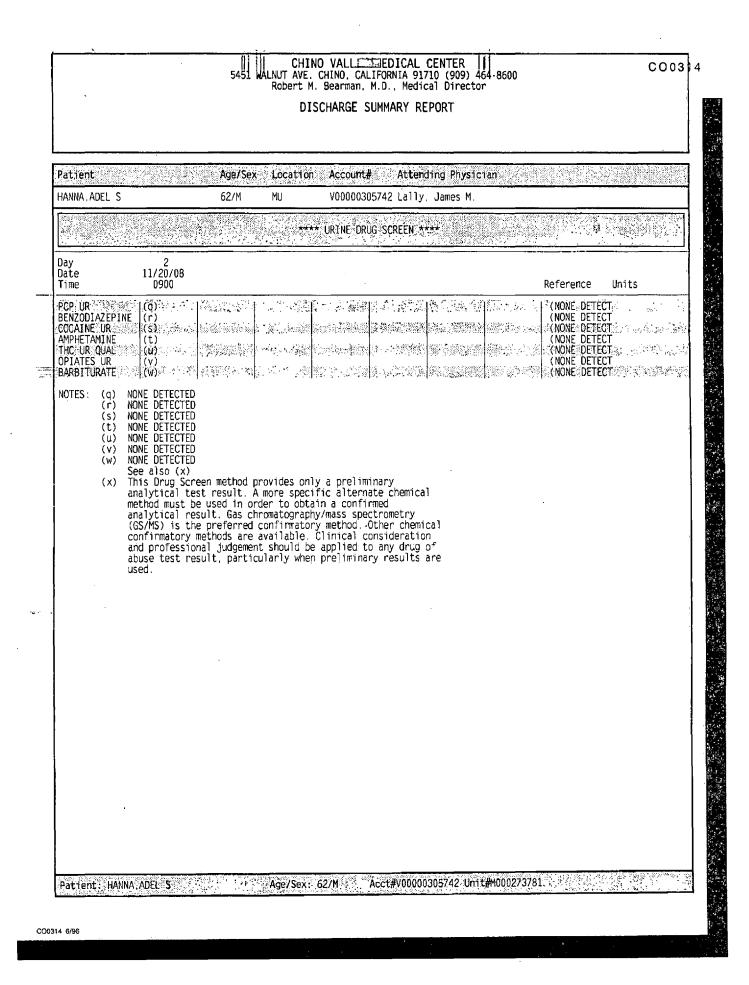


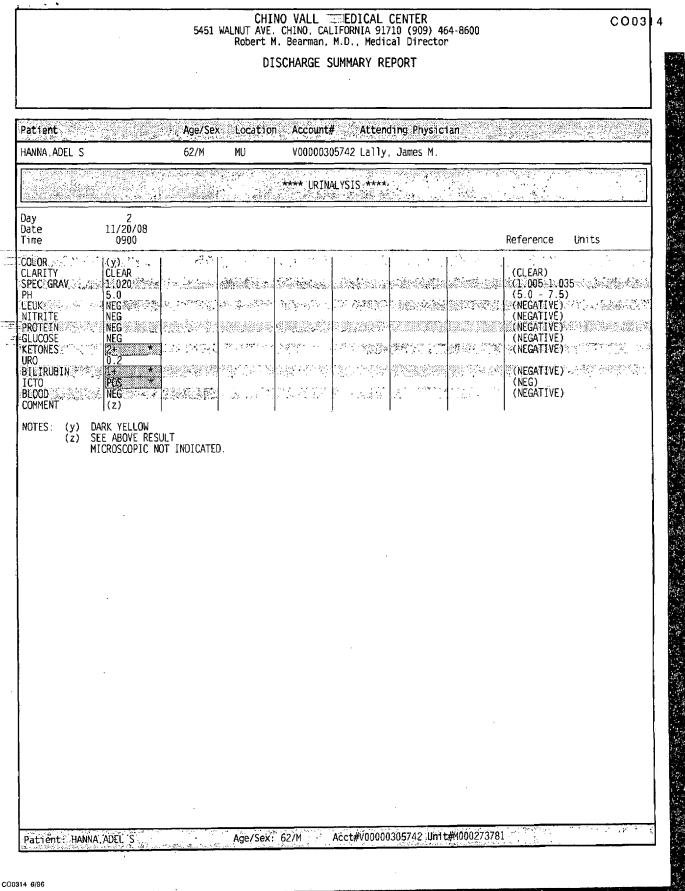
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Patient: HAN	NA ADEL S	Age/Sex: 62/M	Acct#V00000305742 Unit#40002	73781	

	54	51 WALNUT .	CHINO VALL AVE. CHINO, CAU rt M. Bearman,	LIFORNIA 9171	0 (909) 464-8600	C003
			DISCHARGE S			
		the second density				
Patient HANNA.ADEL S		<u> a san ƙasar a</u>	tion Account	# Attend1 05742 Lally,	ng Physician	
				···· · · ·)	
Day	3	· · · · · · · · · · · · · · · · · · ·	2		1	
Date Time	0515 0515	1920	11/20/08 0525	0525	11/19/08 1920 1920 Referen	nce Units
CHOLZHDI		13.0(m)		1 I	.1 1	mg/dL
RISK CKMB		≷ି <mark> 3,0</mark> ∷⊸	e dat des alter des desta	and a support of the		5.5) 2) ng/mL
CKMBI MYOGLOBIN TROPONIN I			ana nango ango Lina dalaman	and and a second se	(0) 37.0 12-1 106) ng/mL ng/mL
NOTES: (m)				یوی هند بر ۲ هم برم می	a na kana kana pana ditana na prova na mana fina ina mana kana kana kana kana kana kana ka	· · · · · · · · · · · · · · · · · · ·
			ISK INTERPRETAT		-	
	Cholesterol (mg/dl)	HDL Ch (mg/dL	Risk nol Factor _) (Chol/HDL)	Risk Assess		
	<200 Desireable level		×45 <5.0 45 5.0	Decreased Average		
	200-239 Borderline High		<45 >5.0	Increas e d		
	>239 High Level	FEMALES	>55 <4.4 55 4.4 <55 >4.4	Decreased Average Increased	-	
					=	
(n)			RANGE *******			
	0 - 2.2 ng/mL 0 - 5.6 ng/mL	For Patie Cardiac p currently	thy Patients ents with a His pathologies, bu y not experience	it who are		
(0)	Test not performed See also (p)	Myocardia	al Infarction.			
(p)	NOTE: CK-MB is incon INDEX is elevated, bu	clusïve if t not both	only the CK-ME	3 or the CKMB		
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Age/Sex: 62 M Attending: Lally. James M. Unit #: M000273781 Account #: V00000305742 Admitted: 11/19/08 at 2033 Location: MU Status: DIS IN Room/Bed: 228-B	HANNA.ADEL S Chino Valley Medical Center NUR ** DISCHARGE PATIENT AUDIT FORMA	Т
Intervention Description Sts B Activity Occurred Recorded Type Date Time by Date Time by Comment		n Description Sts Directions F Occurred Recorded Documented Date Time by Date Time by Comment Units Change
Activity Date: 11/19/08 Time: 1910	Activity Da	te: 11/19/08 Time: 1916: (continued)
Patient Notes: ED Nursing Notes - Create: 11/19/08 1910 SA 11/19/08 1926 SA Abyornal?: Confidentia?? DR KACHIL AT BEDSIDE FOR EXAM. 12 LEAD EKG COMPLETED BY DR KACHIL.	PATIENT	te: 11/19/08 Time: 1916 (continued) Oate:
Activity Date: 11/19/08 Time: 1916 975050 Inventory Personal Belongings + A ADI ON ADMISSION & TRANSFER. PRINT OUT & HAVE PATIENT SIGN COPY. Create: 11/19/08 1916 MD 11/19/08:1919 MD Document: 11/19/08 1916 MD 11/19/08:1919 MD Inventory Date: 11/19/08 Inventory Time: 1916 Performed By: Reason For Inventory: 4DMISSION: (ED:STAFF)	N.TX.DC AS PATIENT:	elow I Indicate I Have All My Belongings At The Time Of Discharge
-₩ Full Dentures Dispositi -₩ Partial Upper -₩ Lower Dispositi -₩ Hearing Aid Dispositi	on: Activity Dat Patient Note:	? Confidential? DRAWN BY JOHN, PHLEBOTOMIST. Le: 11/19/08. Time: 1925. s: ED Nursing Notes
- AF Prosthesis Describe: Disposition - AF Assistive Device : Disposition - Develry: HONE - MO JEWELRY Describe: Disposition: Disposition - Disposition: Disposition: Disposition - Disposition: Disposition: Disposition - Disposition: Disposition	on: - Create Abnormal: PT TRAV Activity.034 Patient Note: - Create Abnormal: Activity.034 Patient Note: - Create Abnormal: REURA	11/19/08/1925 SA 11/19/08/1926 SA Confidential? KS TO CT VIA GUERNEY WITH JIM, CT TECH. te 11/19/08 Time: 1931 S: ED Nursing Notes 11/19/08/1931 SA 11/19/08/1931 SA ? Confidential? D FROM CT, PCKR COMPLETED AT BEDSIDE BY XRT.
Heallet Describe: Disposition NP Purse Describe: Disposition Comment: Disposition Describe: NE File Describe: Disposition Describe: NE File Describe: Disposition Describe: St Fon, Dept Notified To Evaluate Electrical Appliance Other Item(s) Of Value To The Patient: MiTE PARTS, BRGMA JACI Compared to Previous Belongings. List: Stack Stept SY. PT Compared to Previous Belongings. List: <	Activity Dat Activity Dat Patient Notes Create Abromal SALINE VET MATTE SHIRT VET MATTE SHIRT Activity Dat Activity Dat Activity Dat CMFOR Activity Dat	te: 11/19/08 Time: 1935 S: ED Nursing Notes 11/19/08 1935 SA 11/19/08 1944 SA Confidential? LOCK STARTED WITH GOOD BLOOD RETURN NOTED. IV FLUSHED WITH 5 ML NS & SECURELY IN PLACE. NS BOLLS STARTED VIA PUMP PER ORDERS, PT TOLERATED SITE CLEAR, SPOUSE REMAINS AT BEDSIDE. PILLOW GIVEN, LIGHTS DIMMED FOR I. Te: 11/19/08 1944 SA 11/19/08 1944 SA Confidential? TED NUrsing Notes 11/19/08 1944 SA 11/19/08 1944 SA Confidential? TED WITH ZORAM & ATIVAM IVP BY D. LOPEZ, RN.

Age/Sex: 62 M Unit # M000273781 Admitted: 11/19/08 at 2033 Status: DIS IN	Attanding: Lally, James M. Account #: V00000305742 Location: MJ Room/Bed: 228-8	HANNA ADEL S Chino Valley Medical Center NUR **LIVE** DISCHARGE PATIENT AUDIT FORMAT	Page: 2 of 33 Printed 11/22/08 at 0926
Intervention Description	Sts	Directions From Intervention-Description Sts	Directions From

Activity Occurred Recorded Documented Type Date Time by Date Time by Connent Units Change	Activity Occurred. Recorded Documented Type Data. Time by Date Time by Comment Units Change
Activity Date: 11/19/08 Time: 2005	Activity Date: 11/19/08 Time: 2059
Patient Notes: ED Nursing Notes - Create 11/19/08 2005 SA 11/19/08 2013 SA Abnormal? Confidential? PT RE-EVAL'D BY DR KACHHI.	Patient Notes: ED Nursing Notes - Create 11/19/08 2059 SA 11/19/08 2059 SA Abnormal? Confidential? RESIDENT & MED STUDENT AT BEDSIDE FOR EXAM. - Create 11/19/08 2059 SA 11/19/08 2059 SA
Activity Date: 11/19/08 Jame: 2013	Abnormal? Confidential? REPORT CALLED TO M/S. SPOKE WITH BEN, RN.
Patient Notes: ED Nursing Notes Create 1/19/08 2013 SA 11/19/08 2013 SA Abnormal? Confidential?	Activity Date: 11/19/08 Time: 2100
PT REQUEST TO * MAKE PHONE CALLS BEFORE INSERTING NG TUBE". PT ALLOWED PRIVACY. Activity Date: 11/19/08. Tume: 2023	Patient Notes: ED Nursing Notes - Create 11/19/08 2100 SA 11/19/08 2109 SA Abnormal? Confidential? MEDICATED WITH UNASYM IVB BY J. DEL VALLE, RN.
Patient Notes: ED Nursing Notes - Create 11/19/08 2021 AS 11/19/08 2021 AS Abnormal? Confidential?	Activity Date: 11/19/08 Fime: 2120
PLEASE ENTER FULL NAMES OF LVN/RN Patient data collected by (LVN):STACEY ALVAREZ Assessment reviewed and completed by (RN): JOHN DEL VALLE ACTIVITY Date: 1/19/08 Time: 2035	Patient Notes: ED Nursing Notes - Create 1/19/08 2120 SA 11/19/08 2136 SA Abnormal? Confidential? NG TUBE INSERTED INTO LT NARE W/O DIFF. PT STILL ANXIOUS BUT DECREASED SINCE ATIVAN GIVEN. SPOUSE REMAINS AT BEDSIDE. TUBE AUSCULTATED & ASPIRATED PLACEMENT, VELLOW GASTRIC SECRETIONS ASPIRATED. NG TUBE TO LOW WALL SUCTION.
Patient Notes: ED Nursing Notes - Create 11/19/08 2035 SA 11/19/08 2052 SA Abnormal? Confidential? MRSA PROTOCOL EXPLAINED TO PT & SPOUSE. NASAL SWAB OBTAINED PER PROTOCOL. SPECIMEN SENT TO LAB PER ORDERS.	Activity Date: 11/19/08 Time: 21.36 Patient Notes: ED Nursing Notes - Create 11/19/08 2136 SA 11/19/08 2136 SA Abnormal? Confidential? LINDA.XRT AT BEDSIDE FOR PKUB FOR TUBE PLACEMENT.
Activity Date: 11/19/06 Time: 2040	Activity Date: 11/19/08 Time: 2138
Patient Notes: ED Nursing Notes - Create IL/19/08 2040 SA 11/19/08 2046 SA Abnormal? Confidential? ATTEMPTED TO INSERT NG TUBE INTO LT NARE. MIN BLEEDING NOTED. PT COURNING & REQUESTED TUBE FOR DE REPOVED. TUBE DCTO PER REQUEST. PT REQUESTING " VERSED OR SOMETHING". STS. " MY THROAT IS VERY SENSITIVE". DR KACHHI INFORMED. ACTIVITY Date: 11/19/08 Time: 2050	Patient Notes: ED Nursing Notes - Create 11/19/08 2138 SA 11/19/08 2143 SA Abnormal? Confidential? PT TRANS TO MYS RM 228 AMAKE. ALERT. & ORIENTED VIA GUERNEY. RESP EVEN & UNLABORED. NO SOB/DYSPNEA/COUGH NOTED PRESENTLY. NG TUBE INTACT LT NARE CLAMPED FOR TRANSPORT. UN SITKO INTO LT HAND. SITE CLEAR. ALL BELONGINGS SENT WITH PT TO FLOOR. SPOUSE ACCOMPANIED PT TO FLOOR. PT TRANS BY D. LOPEZ, RN
Patient Notes: ED Nursing Notes Create 11/19/08 2050 SA 11/19/08 2051 SA	Activity Date: 11/19/08 Time: 2200
- Create Information 2003 SA Information 2005 SA Abnormatic Confidencial: PT MEDICATED WITH ATIVAN IVP BY D. LOPEZ. RN	Patient Notes: Nurse Notes - Create 11/19/08 2200 BT 11/19/08 2352 BT Abnormal? N Confidential? N ADMITTED PT FROM ER VIA GUERNEY WITH DX SB0.PT AMAKE ALERT AND VERBALLY RESPONSIVE, ABLE TO MAKE NEEDS KNOWN.NGT TO LINARES INTACT.C/O ABD PAIN 3/10 TO "UNCOMPORTABLE FEELING" HEADCHE TO DULL 5/10. BACK PAIN 7/10 FROM MID-BACK TO R SIDE OF THE BACK.IV TO LH INTACT.PT VERBALIZES NO URINE OUTPUT X 20XYS, STARTED WITH EPISODES OF THEBACK.VV LAST NOC. "CANNOT HOLD ANYTHING IN".LAST EPISODE

Age/Sex: 62 M Attending: Lally, James M. Unit # M000273781 Account # V00000305742	HANNA, ADEL S	Page: 3 of 33
dnifted: 11/19/08 at 2033 Location: MU Status: DIS IN Roba/Bed: 228-B	Chino Valley Medical Center NUR **LIVE** DISCHARGE PATIENT AUDIT FORMAT	Printed 11/22/08 at 0926
Intervention Description Sti-Direction Activity Occurred Recorded Docume Type Date Time by Date Time by Comment O	is From Intervention Description Inted Activity Occurred Record Inits Change Type Date Time by Date	Sts Directions From Documented Time by Commenc Units Change
Activity Date 11/19/06 Time: 2200 (continued)	Activity Date: 11/19/08 Time- 2203	(continued)
atient Notes: Nurse Notes (continued) OF VONITING TO WATERY EMESIS.ALSO WITH CHILLS AND FEVER LAST NO TO MONITOR AWAITING FOR KUR RESULT FOR GT PLACEMENT TO PLACE ON INTERMITTENT SUCTION AS ORDERED. Activity Date: 11/19/08	C.WILL CONTINUE LOW C/O Pain: X *** Chest Pain to be Documente When Pain is Present: Pain Location: ABOOMEN Pain Scale: 3710 Describe the Pain 2007#R (SSEF CDM	MENT)
000-B ADMISSION/TRANSFER: Quick Start Form + A ON ADMISSI Create: 11/19/08-2202 BT 11/19/08-2203 BT Document 11/19/08-2202 BT 11/19/08-2203 BT Patient Type: HE2SUBC/FELE: New Admit: 3 Patient Age: 62	What Relieves the Pain: Pain Control Goal	
Activity.Date 11/19/08 Time: 2203 001 Agency Documentation + A WHEN APPLIG ALL REGISTRY PERSONNEL MUST DOCUMENT THIS INTERVENTION ONCE PER SHIFT.	CABLE CP Beliefs Affecting Care: Spiritual Coordinator Visit Requested: 20	
Create 11/19/08 2203 BT 11/19/08 2203 BT 005-H ADM: ADULT Admission History + A CN ADMISSIN A CN ADMISSIN Create: 11/19/08 2203 BT 11/19/08 2213 BT Document 11/19/08 2203 BT 11/19/08 2219 BT History Obtained	Add'l Contact Information:	
ARRIVAL INFORMATION Time of Arrival: 2200 Mode of Arrival: GUERG Arrived From: JOHERGENCY DEPT Accompanied By: NURSE Source of Information Patient: #Other (name/relationship). Chief Complaint: BONEL OBSTRUCTION Chief Complaint: BONEL OBSTRUCTION	CHRONEC STRUSTISS DEVIAT Has Patient Ever Received Preunococcal Vacc HOVE MEDS — Med/Osce/Frequercy/ 1. SEE HEDICATION RECONCILIATION FORM 2. 3.	D.NASA_SEPTUM.RFMIETION OF INFERIOR TER ine: ¥ ast Dose *Include ALL over the counter meds 4. 5. 5.
VITAL SIGNS Temperature/F: 90:78: Temp Source: TEMPORAL ARTERY Pulse: 94 Pulse Source: AUTOWATIC. HOWLMYASIVE Respirations: 78: Respiration Source: ROSERVED Tood Pressure: IBM 20: 9P Source: AUTOWATIC. Site: RICE 2 in use: Willier Flow/FIG2: Probe	HCME MEDS (CCNTINUED) 7. 8. 9. 10. 10. 11. Location: MAND:RT 12. 13. Home Med Comment: ************************************	14. 15. 16. 17. 18. 19. 20.
	SUBSTANCE USE HISTORY — Currently Using Tobacco: N Type: Apount/low Often: Currently Using Alcohol: Y Type: WHYSKY Amount/How Often: OCCASSI Other Substance Use (comment):	Number of Years: 25 DNAL Number of Years: 15
PAIN SCREEN	$= \sum_{m=1}^{n} \frac{1}{m} \sum_$	•

Age/Sex: 62 M Attending: Lally, James M. Unit # M000273781 Account # v00000305742 Admitted: 11/19/08 at 2033 Location: MU Status: DIS IN Room/Bed: 228-8	HANNA ADE Chino Valley Medical Ce DISCHARGE PATIENT	enter NUR **LIVE	5. 5 2				: 4 of 3 8 at 092
Intervention Description Sts Direct Activity Occurred Recorded Doc Type Date Time by Date Time by Comment	umented	Intervention De Activity	Occurred	Recorded Date Time I		tions cunented	Eroa hange
Activity Date: 11/19/08 Time: 2203 (continued)		Activity Date:	11/19/08 Ti	ne+ 2203			
Activity Date: 11/19/08 Time: 2203 (continued) 	-Total Score: 0 2 -Infection Risk- Low: ¥ Noderate (1-2): 2 High (3+): 2 d notify physician. Stay: 6 any of the following: 99 Nems: N Hiton: N 11 Nems: 4 h Pt: Y	Create 5000 Ca 5000 Ca 5000 Ca 5000 Create 1090 Ko Create VI Ollo Ko Create VI Create VI Ollo Ed Create SOIO VI Create SOIO Ed Create SOIO SOIO We Create SOIO SOIO We Create SOIO	0. Monitor + 11/19/08 203 81. re Plan: NR Review 11/19/08 203 81. Konitor + 11/19/08 203 81. 11/19/08 203 81. 11/	+ 11/19/08 2203 [11/19/08 2203 [11/19/18 [11/19/08 2203 [11/19/18 [11/18/18 [11/18/18 [11/18/18 [11/18/18 [11/18/18 [A Q12H A AS ORDE TA AS ORDE TA ENO OF A ENO OF A INS/REP TA AS NEED TA AS NEED TA OS BY C TA ON DISC TA A VIEW PR	RED SHIFT/TX AREGIVER OVAL/CONVERT HED CESSARY AREGIVER HARGE STOCOL/DI OS	93 93 94 95 95 95 95 95 95 95 95 95 95 95 95 95
Other: DISCHARGE PLANNING Pt lives with: WIFE Living Arrangements: HOUSE Who Will be Taking Patient How: FAMILY Anticipated Discharge Destination: HOME Comment:	97	Document Patient Type Patient Age 75050 In ON HAN	MISSION/TRANSFER: G 19/19/08/2303/SGS 2: MED/SURG/TELE	11/19/08 2303 SG New A longings + ER, PRINT OUT & Y.	S dmit: Y A ADM.TX.	DC	AS AS
Has family NOTIFICATION Has family been notified of hospitalization: ? Would you like your family to be notified: Comment: WIFE AT BEDSIDE	ĨĨ	nventory Date: eason For Invent	E1/19/08 Inventor cory: ADNISSION (OU N Contacts	y Time: 2303 Per	formed By: Sall Disposition: P	baba,Selina G ATLENT WEARLNG/TAPE	
OURRENT PHYSICIANS/PRACTITIONERS Document the Names and Phone Numbers of the Physicians/Practitioner Prior to This Hospitalization: 1070 Shift Reassessment + A CS & C4H Create 11/19/08/2203 BT 11/19/08/2203 BT	-31	∙ ëProsthesis De		-Ni Lower	Disposition: Disposition: Disposition: Disposition:		

Intervention Description	Sts Directions Recorded Document	From	Intervention Description Activity Documed Recorded	
Type Date Til	ne by Date Finne by Comment lin	ts Change	Type Date Time by Date	Time by Comment Units
	Time: 2303 (continued)		Activity Date: 11/19/08 Time: 2305	
Activity Date: 11/19/08 Jewelry:	Time: 2303 (continued)		Activity Date: 11/19/08 Time: 2305 - # Partial Upper - # Lowe - # Hearing Aid	(continued) r Disposition: Disposition:
	Jewelry: Decribe: Disposition:		-Ni Prosthesis Describe: -Ni Assistive Device :	Disposition:
N Wallet Describe: N Purse Describe: Comment:			Jeweiry: NONE:ND.JEWELRY Describe: Disposition:	Jewelry: Describe: Disposition:
-# Electrical Appliances -# Eng. Dept Notified To Eva Other Item(s) Of Value To Th	Duate Electrical Appliance Patient: WHITE PANIS, BROWN JACKET, WHITE BEACK, SANDALS (sposition: BEACKSINGS, KEET, BY, PT.)	SHIPT	Jewelry: Describe: Disposition:	Jewelry: Decribe: Disposition:
D Compared to Previous Belong	sposition: BELONGINGS KEPT BY PT jings List: N/A		-N:Wallet Describe:	Disposition: Disposition:
Friends. And Have Been Giver If J Refuse To Have My Value I Release Chino Valley Mcdri I Have Aiso Been Advised To And I Understand That The Ho PATIENT: WITNESS:	I Have Been Advised To Send My Valuables Mt I The Opportunity To Have My Valuables Locke bles Locked Up Or Sent Home With Family Or al Center From Any Ligbility For Lost Valua Keep Audio/Vide Equipment In My Possession spital Assumes No Liability For Such Equipm Date I Have All My Belongings At The Time Of Dis	d Up. Friends. blos. At All Times. ent. ::	A Electrical Appliances N Eng. Dept Notified To Evaluate Electrical Other Item(s) Of Value To The Patient: HIME HIME	Describe: JAHDME Appliance PAMTS JERORN JACKET, WHITE SHIRT SANDALS GINES KEPT BY PT TH PATIENT >> sed To Send My Valuables Home With Fami To Have My Valuables Locked Up. r Sent Home With Family Or Friends.
PATIENT:	· ·		And I Understand That The Hospital Assumes N	o Liability For Such Equipment.
Activity Date: 11/19/08	Time: 2305		PATIENT:	Date:
Decument 11/19/08/23 Patient Type: McD/SIRG Patient Age: 62 975050 Inventory Per: ON ADMISSION I	ISFER: Quick Start Form + A ON ADMISSION 45 SGS 11/19/06 2305 SGS TRELE New Admit: 3 Sonal Belongings + A ADM.TX.OC 1 TRMSFER. PRINT OUT & SIGN COPY. 5 SGS 11/19/08 2306 SGS	AS	By Signing Below I Indicate I Have All My Be PATIENT:	Date:
	SGS 11/19/08 2306 SGS rwentory Time: 2303 Performed By: Salibaba, SGN (OU.IC.NE.PE) -¥-Glasses Disposition: PATTER tures Disposition:	T WEARING/TAPED	1005-S ADM: ADULT Admission Assessment Create 11/19/08 2352 BT 11/19/08 - Document 11/19/08 2352 BT 11/19/08 - Assessment Obtained Signa Signa	t + A ON ADMISSION 2358 BT 2358 BT Date: 11/19/08 Tim ture: Trinidad Bienvenido

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Age/Sex: 62 M Attending: Lally. Jancs M. Unit #: M000273781 Account #: V00000305742 Amitted: 11/19/08 at 2033 Location: MU Status: DIS IN Room/Bed: 228-B	Chino Valley DISCHAF	HANNA ADEL S Page: 6 ey Medical Center NUR **LIVE** RRGE PATIENT AUDIT FORMAT
intervention Description St Activity Occurred Recorded Type Date Time by Date Time by Com	s Directions Documented ment Units Cf	From Intervention Description Sts Directions f Activity Decurrod Recorded Documented Thange Type Date Time by Date Time by Common Units Change
Activity Date: 11/19/08 Time: 2352 (continued)		Activity Date: 11/19/09 Time: 2362 (continued)
Activity Date: 11/19/08 Time: 2352 (continued)	— PUPIL REACTION CHECK — Size: 2 Size: 2	Activity Date: 11/19/08 Time: 2352 (continued) Has the Patient's Functional Ability Decreased in the Last 6 Months: N Prior Mobility: Current Mobility: 3 Ambulatory Assistive Device Used: 3 Hygiene Assist: 30 Feeding Assist: 30
Speech: Headaches: Describe: Recent Seizure Activity: Seizure Precautions Initiated o Neuro Comment: ALERT AND ORIENTED X4	or being Utilized: 13.	GASTROINTESTINAL Assessment Within Normal Limits: N Last BM: 11/19/08 Describe Stool: DIARNEA Ostomy: GI Tube: GI Comment: NGT:INTACT:ACTIVE NOWEL SDUNDS:NO.N/V.NOTED AT THIS TIME
EENT Assessment, Within Normal Limits: W EENT Comment: WG1 10 NARES RESPIRATORY Assessment Within Normal Limits: % Breath Sounds: Location: Chest Expansion		GENITOURINARY Assessment Within Normal Limits; # Incontinence: N Cath: N Type: GU Problem: **If Female** Bleeding/Discharge: Describe: **If Female** Scrotal Edema: Penile Discharge: — IF DIALYSIS PATIENT — Type of Dialysis: Fistula with Bruit/Thrill: #
·	es Present: 💥	If Quinton or Ash Split Cath, Site Without Redness/Drainage GU Comment: CZ0-NO-URINE X-2-DAYS INTEGUMENTARY Assessment Within Normal Limits: Abnormalities Photo Occumented:
Comment: CLEAR BREATHSOUNUS ON ROCHALR BREATHING BASY AND	NUN-LABUKED	Alteration: Location: Dressing Type/Condition: Alteration: Location: Dressing Type/Condition: Dressing Type/Condition:
Syncope/Fainting: Vertigo/Dizziness: Chest Pain: Pain Quality:		Dressing Type/Condition: Drainage Tube: Describe: Skin Comment: SKIN INTACT.
IT Radiating, Describe: Pain Scale: ***IF ON CARDIAC MONITOR/TELEMETRY*** Monitor #: Cardiac Comment: DENIES CHESTMAIN AT THIS TIPE		BRADEN PRESSURE ULCER RISK ASSESSMENT- Sensory Perception: # NOT-LIMMTED-NML Noisure: # KANHY NOISY Activity: # BEDEAST Activity: # BEDEAST
Extremity Color: Right Radial Sensation: Left Pedal Edema	Pulse: STRONG Pulse: STRONG Pulse: STRONG I Pulse: STRONG	Friction and Sheer: 3 NO APPARENT PROBLEM High (<13); PSYCHOSOCIAL Assessment Within Normal Limits:
Circulatory Comment: PALPABLE PULSES: NO EDEMA		Fears/Anxiety Related to Hospital Stay: "Ineffective Coping: "Inadequate Support System Suspected Abuse/Neglect: "Describe: Alteration in Grout/Development: Comment: CALH AND COOPERATIVE WITH CARE.
		NUTRITION === NUTRITIONAL Assessment

Page: 7 of 33	ADEL S	HANNA.	Attending: Lally. James M. Account #: V0000305742	/Sex: 62 M 115 #F: M000273781
Printed 11/22/08 at 0926	NT AUDIT FORMAT	Chino Valley Medical DISCHARGE PATIER	Location: MU Room/Bed: 228-B	tted: 11/19/08 at 2033 atus: DIS IN
Sts Directions From	Intervention Description		Sts Ølrect	······································
Recorded Documented Time by Date Time by Comment Units Change	Activity Decure	comented Units Change	Recorded Dox ne by Date Fine by Comment	Activity Occurred Type Date Ta
Time 2352 (continued)	Activity Date: 11/19/08		Time: 2352 (continued)	ivity Date 11/19/08
Time: 2352 (continued) Stroke (< 1 month): 0 MO Paralysis (< 1 month): 0 MO Patient's Age: 2 60-74 TEARS	Activity Date: 11/19/08		Time: 2352 (continued)	ivity Date: 11/19/08 t at Home: REGULAR Comment: NPO AT THIS
Total Score: 20 Horsen		Total Score: 0	/Maloounichod 0:80	NUTRITION RISK SCREENIN Appears Underweigh
High (3+): DVT RISK SCORE > 2 AND DOCUMENT IN PT CARE NOTES ***	SAFFTY	=Nutrition Risk= Low (0-1): % Moderate (2-3):	in Past Month: 0 NO in Past Month: 0 NO isk Diagnosis: 0 NO e for 20 Days: 0 NO	dmitted with Potential
SAC PRECAUTIONS Allergy Bracelet On: ¥ 1D Band On: ¥ ribe:	Isolation: UNIVER Restraints in Use: N Desc	High (4+):	e for >4 Days: 0 NO Diet for Age: 0 NO eeding or TPN: 0 NO	Unable to Inges Tube
FT-HAND IV Site Within Normal Limits: X	IV ASSESSMENT IV Location: IV Site Condition: IV Start/Restart Date: IV Start St	Total Score: 0 =Aspiration Risk= Low (0-1): 2	IS: 10 NO Ig: 10 NO	Difficulty Swallowin Sticking in Nouth/Theo
	Activity Date 11/19/08	Moderate (2): High (3-5):	g: 0 NU 5: 0 NU	FALL RISK ASSESSMENT
338 BT 11/19/08-2359 BT A OS & Q4H IN TCU CP 358 BT 11/19/08-2359 BT A OS & Q4H IN TCU CP 358 BT 11/19/08-2359 BT A OS & Q4H IN TCU CP 358 BT 11/19/08-2359 BT A OS & Q4H IN TCU CP	31260 Problem: Mus Create 11/19/08 2 31270 Problem: Gas Create 11/19/08 2	Total Score: 3 -Fall Risk- Low (0-2): Moderate (3-6): 4 High (7+):	0 NOT ALTERED 0 NOT ALTERED 0 NOT ALTERED 3 ALTERED 0 NO FALLS 0 ~ 65 YEARS	ensory Perceptual Statu: Physical Mobility Statu: Elimination Statu: Recent History Of Fall:
ntourinary + A QS & Q4H IN ICU CP 358 BT 11719/08-2359 BT Time: 0233	• Create 11/19/08 2		: ACTIVITY : DIET	EDUCATION SCREENING === ational Need Priority #
	Patient Notes: Nurse Notes		MEDICATIONS SAFETY PRECAUTIONS	ational Need Priority #
HATAI7 N FOR NGT PLACEMENT.NGT IN PLACED -RECOMMEND ADVANCING TUBE STIVE FOR DISTAL SED ADVANCED NGT 6 CM.MILL ORDER ANDTHER	Abriontal? N Confide RECEIVED KUB RESULT		AIN CMF	BARRIERS TO LEARNING
Time: 0554	Activity Date: 11/20/08		ORE XPLANATION	hing Method Preferred: ent DVT RISK ASSESSMENT
554 RMF 11/20/08 0556 RMF Temp Source: DRA	20010 VS: Monitor - Document 11/20/08 0 Temperature/E 97.5		g Plaster Cast or Brace: 0 NO Varicose Veins: 0 NO Hormone Replacement: 0 NO	
Pulse Source: AltOrATIC, NCMINYASIVE Resp Source: (DESEMVED BP Source: AltOMATIC	Pulse: 81 Respirations: 18 Blood Pressure: 112/70		OPD.MI.Sepsis.Pneumonia: 0.NO t with Limited Activity: 0.NO Obesity: 0.NO	ssion DX includes: CHF Bed Re
UPPER ARM	Site: #RIGHT## - C/O Pain: #		Surgery (> 60 minutes): 0:NG amily History of DVT/PE: 0:NG	· · ·
sures Implemented:	Comfort Mea		History of SVT, DVT/PE: 0 NG reg Fracture (< 1 month): 0 NO	· · ·

Age/Sex 62 M Unit # M000273781 Admitted: 11/19/08 at 2033 Status: DIS IN	Attending: Lally, James M. Account # V0000305742 Location: MU Room/Bed: 228-B	Chino Valley Medica	A ADEL S Page: 8 of 33 Center NUR **LIVE** LENT AUDIT FORMAT
Intervention Description Activity Occurred Type Date Th	Sta D Recorded re by Date Time by Comment	Documented	
Activity Date: 21/20/08	Time: 0554 (continued)		Activity Date: 11/20/08 Tim: 0559 (continung)
Activity Date: 11/20/08 (If Medicated	Time: 0554 (continued) 1. Document On Intervention Pain: H	Management Of)	Activity Date: 11/20/08 Time: 0559 (continued)
Oxygen Device: ROOM AIR SpO2 (I): 96 Comment:	ON OXYGEN*** 02 Amount (L/min F102: 1ime: 0559		
INTAKE: SHIFT TOTAL Ice: W Oral: 0 Tube Feeding: IV's: 1000 	9 BT 11/20/08:0520 BT 11/20/08:0520 BT 11/20/08:0520 BT 11/20/08:0520 BT 11/20/08:05 TPN: 500	Blood/Product: GU Inrigant.In: Other Intake: 2050 Hemovac 11:	IV Site Condition: IV Start/Restart Date: Patient Notes: Nurse Notes Create 11/20/08 0550 BF: 11/20/08 0623 BF Annormal? N. Confidential? N. Confidential? K-PMOS INFUSING AT HIS TIME ADMINISTERED AMPICILLIN IV ATB AND WELL TOLERATED. NO ASE NOTED. ADMINISTERED TORADOL 30 MG IV X1 FOR ABD PAIN WITH GOOD RELIEF.ATIVAN 2 MG IV ADMINISTERED TORADOL 30 MG IV X1 FOR ABD PAIN WITH GOOD RELIEF.ATIVAN 2 MG IV ADMINISTERED FOR RESTLESSNESS.KUB DOME ANALTING FOR
<pre># of Stools: 0 Urine: Stool. Liquid: Emesis: NG Tube: Comment:</pre>	Ilecstony: Jackson Pratt #1: Jackson Pratt #2: Chest Tube #1: Chest Tube #2:	T-Tube: ####################################	RESULT.WILL CONTINUE TO MONITOR. Activity Date: 11/20/08 Time: 0650 Patient Notes: Nurse Notes - Create 11/20/08 0650 BT 11/20/08 0652 BT Abronmal? N Confidential? N DR. GHOLSTON MADE AWARE.NO URINE OUTPUT SINCE ADMISSION.DENTES BLADDER DISCOMPORT OR DISTENTION.OFERED IF HE WANTS TO BE CATHETHERIZED BUT STRONGLY REFUSED.NGT TO LOW INTERNITIENT SUCTION STARTED.KUB RESULT -NGT IN STOMACH/DUDGENUM, WILL ENDORSE TO AM SHIFT.
2000 Routine Care: VIEW PROTOCOL Document 11/20/08 055 he Practice Guidelines Appr	MED/SURG/TELE + A .EN 9 ST 11/20/08 0620 BT opriate For The Patient And Withir Shift: YES NO COMMENT	D OF SHJFT/TX CP	Activity Date: 11/20/08 Time 0758
			 Pt. Reviewed. No Needs Identified; Will Return to Prior Living Arrangement: No Further Intervention Required at This Time. Pt. Requires Additional Discharge Planning and has been Referred to the Hospital OC Planner Pt. Requires Additional Discharge Planning and is being Managed by an Outside Case Manager. Pt. has been Referred to Section 2010 (2010)
estraints in Use: W Describ	n: STANDARD: PRECAUTIONS		Pt. Requires Social Service Assistance and has been Referred To the Hospital Social Worker; See QRM Hultidisciplinary notes for Further Documentation. Pt. Requires Case Management Assistance and has been Referred to the Hospital Case Manager: See QRM Multidisciplinary Notes for Further Documentation.
Total Hrs. In Restraints Th Sitter Used: 🕱 Comment	is Shift: Location		2. DISCHARGE PLANNINC ASSESSMENT: (Prior to Admission)
		· · ·	

Age/Sex: 62 M Unit # MC00273781 Admitted: 11/19/08 at 2033 Status: DIS IN	Attending: Lally. James M. Account #: V0000305742	HANNA,	ADEL S	, 11	. Page: 9 of
	Location: MU Chino Valley		dical Center NUR **LIVE** Printed 11/22/08 at 0 PATIENT AUDIT FORMAT		
Intervention Description	Sts Directio	ns Fron	Intervention Description	Sts I	nections Fr
Activity Occurred Type Date Tim		ented Units Change	Activity Occurred Type Date Time by	Recorded Date Fine by Comment	Decomontad
Activity Date: 11/20/08	Time: 0758 (continued)		Activity Date: 11/20/08	ime: 0800	
Home Safety Barriers: Independent W/ADL's: Uses DME:	Ambulation: ※	Patient Notes: Nurse Notes - Create 11/20/08 0800 ATS 11/20/08 2006 ATS Abnormal? N Confidential? N ALERT AND ORIENTED. NGT TO WALL INTERMITTENT SUCTION SCANTY GREEN FLUID IN CANISTER. NPO. DR. A. OH IN TO SEE PT THIS AN. ABOMMEN SOFT AND ROWND. ACTIVE BOWEL SOUNDS. NO INFUSING JOB OC CHOUR TO LEFT HAND. RECEIVES AMPICILLIN IV.VSS. NO PAIN AT THIS TIME. CALL LIGHT WITHIN REACH.			
Assistance W/ADL's: Homecare Assistance: Provider and # of Krs.			Activity Date: 11/20/08 1	ime: 1417	
Meals on Wheels: Home Health Care:			Respirations: 18 R Blood Pressure: 118/74	11/20/08 1417 RMV emp Source: ORAL lse Source: ANTOMATIC, NOMIN esp Source: OBSERVED BP Source: ANTOMATIC	WASIVE
 EDUCATIONAL NEEDS: Patient/Family Have Educatio 	nal Needs 🔅		- C/O Pain: W	M CENSED Documentation ==	
4. DISCHARGE PLAN: Summary of Assessment/Plan: ADLS: NO DC PLANNING: NEEDS FOLIDM AS NEEDFD.	PT LIVES WITH HIS SPOUSE AND IS INDEPEND ANTICIPATED WILL AWAIT PHYSICIAN ADVIS	ent with Ement and	Comfort Measures I Nurse Notifi	mplemented: ed of Pain: % ument On Intervention Pain: 6	
	d: 🐺 See ORM Multidisciplinary Notes.	. :#	***IF ON OX Oxygen Device: ROOM AIR SpO2 (1): 94 Comment:	02 Amount (L/min	
Information Toucht	PATIENT/FAMILY EDUCATION —		21400 Nutrition/Activity/ Document 11/20/08:3417 RMV — MCRITION — % Meal intake Breakfast: 0 Diet: Lunch: 0 Diet: Dimer: 2 Diet:	11/20/08 1418 RMV	BY CAREGIVER CP
Person Taught:			Dinner: Diet: Comment: NPO		
Person Taught: Teaching Tools: Other Tools Used: Factors Affecting Learning: Other Factors:			If Appropriate: 'PO Nutritional Supplement Taken Supplemental Snacks: N	NORE	Amount Taken: 0
Participation Level: Evaluation: Needs Additional Education:			Activity Tolerance: FAIR	BLE Oral Hygiene:	SELF : Y SELF
Educator: Discipline:		ene generation Alternation de la composition	Elimination Comment: 140-8.4.4	Last BM: Incont (BM): Description: TATHIS TIME:	
		а ;	Comment:		
			1		

Unit #: M000273781 Account #: V00000305742 Admitted: 11/19/08 at 2033 Excetion: MU Chino Valley Medi	NA_ADEL S Page: 10 of cal Center NUR **LIVE** TIENY AUDIT, FORMAT
Intervention Description Sts Directions Fr Activity Occurred Recorded Occurrented Type Date Time by Date Time by Comment Units Change	on Intervention Description Sts Directions Pro Activity Occurred Recorded Docurrented Type Date Time by Date Time by Comment Units Change
Activity Date: 11/20/08 Jine: 1443	Activity Data: 11/20/08 Time: 1445 (continued)
Patient Notes: Multidisciplinary Notes Greate 11/20/08.1443 TLF 11/20/08.1445 TLF Abnormal? N Confidential? N ***PT REFUSES ECHO.STATES ITS NOT NECESSARY AND THE DR CAN CALL DR C AGRAWAL FOR COMPLETE CARDIAC WORK UP REPORT.	Activity Date: 11/20/08 Time: 1445 (continued)
Activity Date, 31/70/08 Time, 1445 1070 Shift Reassessment + A OS & Q4H IN ICU CP Document 11/20/08 1445 ATS 11/20/08 1449 ATS	Physical Mobility Status: 3 ACTABEDFall Risk- Elimination Status: 3 ACTABED Low (0-2): Recent History Of Falls: 6 NO FALLS Hoderate (3-6): Y Patient's Age: 0 < 65 YEARS High (7+):
Reassessment Obtained Date: 11/20/08 Time: 0800 NEUROLOGICAL Assessment Within Normal Limits: N Neuro Comment: ALERT AND:ORIENTED EENT Assessment Within Normal Limits: N EENT Comment: NGT-TO.RI.MARE	BRADEM PRESSURE ULCER RISK ASSESSMENT— Sensory Perception: 4: NOT ALMITED: NAL Moisure: 4: RARELY: MOIST Activity: 1: BEDFAST Activity: 1: BEDFAST
RESPIRATORY Assessment Within Normal Limits: * Respiratory Comment: 96 t SATON RA	ADVANCE DIRECTIVES
CARDIAC Assessment Within Normal Limits: # IF ON CARDIAC MONITOR/TELEMETRY:	Code Status: If DNR. Purple Amband in Place: Comment:
Cardiac Rhythm Monitor # ardiac Comment NO CHEST PAIN BP 112/70 HR 81	ALLERGIES
CIRCULATORY Assessment Within Normal Limits: irculatory Comment: NO EDEMA: PALPABLE PRISES MUSCULOSKELETAL Assessment Within Normal Limits: MUSCULOSKELETAL Comment, MYDES ALL EXTREMITES	Allergies: #EECAN Food Allergies: #KFA Other Allergies: #KOA
NUTRITIONAL Assessment Within Normal Limits: N utritional Comment: DERCENTLY MPD APPEARS ADEQUATERY MOURTSHED	VALUABLES AT THE BEDSIDE Eyeglasses: Y: PT WEARING
GASTROINTESTINAL Assessment Within Normal Limits: N 11 Comment: ABOOMEN SOFT AND ROLAD: ALTIVE BOWEL SOLNDS: LBM:11/18/08 : NO AMAGEAL NOT TO LOW INTERMITENT SUCTION GENITURINARY Assessment Within Normal Limits: X NU Comment: PT VOIDED 300 CC AMBER URINE THIS AM	Contact Lenses: W : Dertures: W : Hearing Ald: N : Prostnesis: N : Comment: 1500 Document: 11/20/08:1445:4TS 1445:145 11/20/08:1445:4TS
INTEGUMENTARY Assessment Within Normal Limits: * kin Comment: INTACT	PATIENT PROBLEM LIST AS PRIORITIZEO DI CARE PLAN: Problem(s) Identified: COME STANDARD OF CARE : A
PSVCHOSOCIAL Assessment Within Normal Limits: X sychosocial Comment: CALH.RELAXED AND COOFERATIVE W/ CARE	CHL STANDAU OF UNCLE M/SATELE A STANDAU OF HACITLE M/SATELE A PROBLEM Impaired EENT Function A PROBLEM Impaired EENT Function A PROBLEM Altered ELFunction A PROBLEM Altered ELFunction A

Unit # M000273781 Account # V00000305742 mitted: 11/19/08 at 2033 Location: MU Chino Valley Medic:	A ADEL S Page: 11 I Center NUR **LIVE** Printed 11/22/08 at ENT AUDIT FORMAT
ntervention Description Sts Directions From Activity Occurred Recorded Documented Type Date Fime by Date Time by Commont Units Charge	Activity Occurred Recorded Documented
ctivity Date: 11/20/08 Time: 1445 (continued)	Activity Date: 1/20/08 Time: 1445 (continued)
ctivity Date: 11/20/08 Time: 1445 (continued) Patient's Plan of Care was Reviewed and Updated as Needed: ¥ 200 Problem: Gastrointestional + A 05 & 04H IN ICU CP Decement 11/20/08 1443 AIS 11/20/08 1528 AIS Ered GI Function/Status Remains an Active Problem: 3 f NO, Consider Inactivating on Completing Intervention f No Consider Inactivating on Completing Intervention f Socument Only on Interventions Related to Patient's Altered Status/Function. ***	Nephrostomy: @Nephrostomy Type: Urinary Complaint/Problems:
- REASSESSMENT ASTROINTESTINAL Assessment Within Normal Limits: W Abdominal Appearance: SOCTIACHED Bescribe Stool: FORMED Abdominal Pain: W Conv: GI Tube: Drainage Color: Drainage Color: Nause: N Vomiting: W Diarrhea: N Constipation: W GI Bleeding: W	Catheter Inserted/Discontinued: ####################################
Compaint: Comment: ARCHMENT SUFF. AND HOLMO. ACTIVE BOWEL SCIENCS (BM 11/18/08 : SKST TO RT HARE: DRAINING DARK GREENISH FLUID = GIRTH MEASUREMENTS	<pre>**If Female** Vaginal Bleeding: # Describe: Vaginal Discharge: # Describe: Vaginal Packing: # f of Pads Last Hour: ## Drainage Color: Tissue Observed in Drainage: # Haldorous: # Comment: # Commen</pre>
ecify Care Rendered: = ELIMINATION	**If Male** Penile Discharge: Describe: Scrotal Edema:
Tube Inserted/Discontinued: # (Do Not Include Tubes Inserted for Feeding Purposes) GI Tube Inserted (Type): # Attempts: # Difficult Insertion: # Attempts: # Difficult Insertion: # Attempts: # Difficult Insertion: # Attempts: # Tube Discontinued (Date): Time: # Attempts: Problem: Genitourinary + A Q5 & Q4H IN ICU CP Document: 11/26/08/3445 ATS Time: *** Freed Genitourinary Function/Status Remains an Active Problem: ** F0. Consider Inactivating or Completing: Intervention)	

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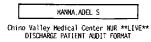
Type Date Time by Comment Units Change Jype ivity Date: 11/20/08 Time: 1445 (continued) Activity Date: 1/20/08 ivity Date: 11/20/08 Time: 1445 (continued) Activity Date: 1/20/08 Time of Patient's Complaint: 0600 Pain Location: Activity Date: 1/01/03 — Pain Scale: 0/18 Outremt Document Notice: 0/01/03 Observice Describe the Pain: Outremt Document Notice: Notice: Other Measures Implemented: Outremt Post Intervention Pain Scale: Notice: Notice: Notice: Time of Reassessment: Post Intervention Pain Scale: Notice: Notice: Notice: Notice: Notice: Pain Comment: MILL=MONITCR Interventions Notice:	ription Sts Directions Docurred Recorded Documented te Time by Date Time by Comment Units Chang
<pre>ivity Date: 11/20/08 Time: 1445 (continued) Time of Patient's Complaint: 0800 Pain Location:</pre>	
 -Pain Scale: Ø/10% Describe the Pain: Onset: Comment: DENIES PAIN & THIS TIME intervent: Post Intervention Pain Scale: intervent: Post Pain Banagement Intervent: Post Pain Pain Pain Pain Pain Pain Pain Pain	
Other Measures Taken: 3774002 Nut Time of Reassessment: Post Intervention Pain Scale:	Educator: Schirger Anthea T scriptine: guidelines: 41-65 (MID ADULT) A VIEW PROTOCOL/DI QS C 720/08 1445 ATS 11/20/08 1530 ATS 720/08 Thile: 1547
ent/Family Education Provided: Y Appetite Pain Comment: WILLMONITOR Food Allergies —— Pain Education for Patient/family — Food Allergies structions Given Related to: Nature Pain Management is Part of Treatment Plan: Y Nature About the Use of the Pain Intensity Rating Scale: Y Abdominal Pain: Absence of Pain is Ofter not Realistic/Desirable Goal: Y Primary costing a Pain Control Goal, such as Pain Not Worse than 2: Y Primary st Effect of Pain Management Intervalis: Y Die Education: Patient/family Eaching Pain Relief e- Other Information Taught — Other All Providers About Any Unrelieved Pain: Y e- Other Information Taught — Information Taught: 100/00: 1405/01: 500 ATS Information Taught: 102/02: 1030 ATS 11/20/02: 1030 ATS 11/2	ition Screen: Adult + A F /20/08 1547 CBH 11/20/08 1547 CBH /20/08 1547 CBH 11/20/08 1548 CBH ENING BY DIET TECHNICIAN —
structions Given Related to: Pain Management is Part of Treatment Plan: * About the Use of the Pain Intensity Rating Scale: * tal Absence of Pain is Often not Realistic/Desirable Gcal: * oosing a Pain Control Goal: such as Pain Nat Worse than 2: * at Effect of Pain Management Interventions will be Reassessed at Frequent Intervals: * About the Importance of Requesting and Receiving Pain Relief essures Before Pain Becomes Severe & Difficult to Control: * About the Importance of Notifying Health Care Providers About Any Unrelieved Pain: * — Other Information Taught — 0 Education: Patient/Family Teaching + A OS BY CAREGIVER CP Instruction Given: EXPLAINCE MST IS TO KEEP. #RESSURE OFF. STOMACH. Per	PET IS NPO GENER MEANS FOR SELECTION WITH DIET IS ORDERED WERA WERA De Comment: NRO:AF THIS STUME.
Instruction Given: EXPLAINED NET 15 TO KEEP PRESSURE OFF STOMACH Per	v Last BH: 13/28/06 V Describe Stool: ≠00460
Person Taught: #ATIENT Factors Affectin Person Taught: #ATIENT for the factors Affectin Person Taught: #ERBAL for the factors Affecting Tools: #ERBAL Feaching Tools: #ERBAL Participa	n Taught: n Taught: ng Tools: Dis Used: Learning: Factors: on Level:

Intervention Description Sts Directions	From Intervention Description SLS - Directions
Activity Occurred Recorded Documented Type Date Time by Date Time by Comment Units	Activity Document Recorded Documented Change Type Date Time by Date Time by Comment Units
Activity Date: 11/20/08 Time: 1741	Activity Date 11/20/08 Time 2000 (continued)
Patient Notes: Nurse Notes - Create 11/20/08 1741 ATS 11/20/08 1741 ATS Abnormal? N Confidential? N DR. HANNA REFUSED ZND EKG TO BE DONE. Activity Date: 11/20/08 Comment 11/20/08 1821 CC 11/20/08 1821 CC - NURTION	Activity Date: 11/20/08 Time: 2000 (continued) CUTPUT: SHIFT TOTAL BRP: BRP: Ostony: # of Voids/Incont: Jejunostony: # of Stools: Ileostony: Urine: 725 Jackson Pratt #1: CP Emestion: KG Tube: 100 Chest Tube #1: KG Tube: 100 Chest Tube #2:
\$ Meal Intake Breakfast: ○ Diet: Lunch: ○ Diet: Dinner: 0≥ Diet: MPD Comment:	Total Output — TOTAL SHIFT FLUID BALANCE — Comment: 21090 Routine Care: HED/SURG/TELE + A _END OF SHIFT/TX
If Appropriate: PO Nutritional Supplement Taken: Supplemental Snacks: :: ACTIVITY/ADL PERSONAL HYGIENE Activity Type: Bath:	VIEW PROTOCOL
Activity Tolerance: Control Charged: Cinen Charged: Gait: Crail Hygiene: Last BH: Incont (BM): Description. Elimination Comment:	Practice Guidelines Comment:
Activity Date: 11/20/08 Time: 1958 Patient Notes: Nurse Notes Create: 11/20/08:056 YYC: 11/20/08:2001 YYC Abnormal?: N: Confidentinal?: N: SSEM PT RESTING IN BED. A/O X3. RESP EVEN AND NOT LABORED TO ROOM AIR. AE SOFT AND NON-DISTENDED W/ACTIVE BS, NO BM TODAY. NG TUE: TO LIS W/ GREENI IDRAINAGE NOTED DENIES PAIN OR NAUSACYOHITING, NO MAINTAINS. ON AMPICID	ISH · · ·
ICH IVPB QBH. VOIDED VIA URINAL WELL, IVF, SAFTY MAINTAINS, CALL LIGHT W/ REACH. Activity/Dates 13/20/08. Time, 2000	Throughout Shift: IV Location: USFT: HWND IV Location: USFT: HWND IV Site Condition: IV Start/Restart Date: 18/39/08
1500 I&O: Monitor + A Q12H (0559,1759) Document 11/20/08 2000 ATS 11/20/08 2001 ATS INTAKL: SHFT TOTAL IVP8's: Blood/Produ Oral: Chemo: GU Irright, Tube Feeding: TPN: Other Inte IV's: 3200 Lipids: Total Inte	IV Location: IV Site Within Normal Limit UV Site Condition: IV Site Within Normal Limit IV Start/Restart Date: In: IV Comment: IV INCUSING.WELL

Age/Sax 62 M Unit # M0002/3/81 Admitted 11/19/08 at 2033 Status: DIS IN	Attending: Lally, James M. Account # V0000305742 Deather MJ Room/Ded: 228-8	HANNA / Chino Valley Medical DISCHARGE PATIEN	Center NUR **LIVE** T AUDIT FORMAT		Printed	Page: 14 of 33 11/22708 at 0926
Intervention Description	Sts Di		Intervention Description		Sts Directions	From
Activity Occurred Type Date Tim	Recorded e by Date Time by Comment	Bocumentad Units Change	Activity Occurred Type Date Time	Recorded by Date Time by E	Occumented comment thits	Change
Activity Date 31/20/08	Tine, 2001		Activity Date: 11/20/08	Time: 2001 (continued)		
1070 Shift Reassess Occurrent 11/20/08/200 Reassessment Obtained Date	1 YYC 11/20/08 2008 YYC	& Q4H IN ICU CP	Activity Date: 11/20/08 BRADEN PRESSURE ULCER RISK Sensory Perception:	NOT LIMITED-WN		
CENT Associate Mitchie No.	AND ORIENTED X3. DENIES HEADACHE OF		Activity: 1 Mobility: 3 Nutrition: 3	RARELY MOTST BEDEAST SLIGHTLY LIMITED Adecuate No: Apparent Problem	-Risk Sc Low (16+	·)· ¥ (13-15).
RESPIRATORY Assessment Wit Respiratory Comment: RESP.EV CARDIAC Assessment Within I	hin Normal Limits: ﴾ EN AND NOT LABORED TO ROOM AIR		ADWANCE DIRECTIVES	If DMR	. Purple Armband in Pl	ace:
Cardiac Rhythm Cardiac Comment: DENFES S/SK CIRCULATORY Assessment Wit Circulatory Comment: MUSCULOSKELETAL Assessment MUSCULOSKELETAL Assessment	Honitor #: DISCOMPORT/CIEST PAIN hin Normal Limits: ¥ Within Normal Limits: X ALL EXTREMITIES MEEDS FEW ASSIST	T W/ ADLS	ALLERGIES			
NUTRITIONAL Assessment With Nutritional Comment: NPD AT GASTROINTESTINAL Assessment CL Comment: ADD SOFT ANN	t Within Normal Limits: ₩ F DISTENDED W/ACTIVE BS NO NAUSEA/	Aurumet a fue:	Eyeglasses: Y : PT WEARIN Contact Lenses: N : Dentures: N : Hearing Aid: N : Prosthesis: N	6		
GU Comment: VOIDED VIA URINAL INTEGUMENTARY Assessment Skin Comment: PSYCHOSOCIAL Assessment wit Psychosocial Comment: CALM AP	wELL t Within Normal Limits: 著		Document 11/20/08 2001 PATIENT PROBLEM LIST AS PRIORI Problem(s) Identified: STAN PROB	STANDARD OF CARE ARD OF PRACTICE M/S/TELE FM: Impatred SENT Function	Status: A A A A	
The Following To Bo	e Documented On Once A Shift		: PROBL	 Altered GU Function Altered GU Function Ampaired Misc/Skeleta 	A Function 6	
-Mental Status: 0 Sensory Perceptual Status: 0 Physical Mobility Status: 0 Elimination Status: 3 Recent History Of Falls: 0 Patient's Age: 0	NOT ALTERED NOT ALTERED ALTERED	Low (0-2): Moderate (3-6): 3	Patient's Pla 31210 Problem: EENT + - Document 11/20/06 2001 Altered EENT Function/Status (If NO, Consider Inactijiiting	YYC 11/20/08 2009 YYC Remains an Active Problem	A QS&Q4HINICU	CP
		see a second sec		• •		2

Age/Sex:	62 M
	M000273781
Admitted:	11/19/08 at 2033
Status:	DIS IN

Attending: Lally, James M. Account # V0000305742 Location: MU Room/Bed: 228-8



Intervention Description Sts Directions From Activity Occurred Recorded Documented Type Bate Time by Date Time by Comment Units Change	Intervention Description Sts Directions From Activity Occurred Recorded Documented Type Date Time by Date Time by Comment Units Change
Activity Date 34720/08 Tame. 2001 (continued)	Activity Date: 11/20/08 Time 2001 (continued)
Activity Date: 11/20/08 Time: 2001 (continued) *** Document Only on Interventions Related to Patient's Altered Status/Function. *** REASSESSMENT	Activity Date: 11/20/08 Time: 2001 (continued) Extremity: Cast Condition: Extremity Elevated: Hours On This Shift: Peripheral Pulse Palpable: Skin Around Cast Intact: Hours On This Shift: Peripheral Pulse Palpable:
EENT Assessment Within Normal Limits: R Oral Microw Membranes: Nasal: NG:FUBE TO LT:WARES Throat/Mouth: Right Eye: Left Eye: Left Eye:	Image: PIN CARE
EYE CARL/ADDITIONAL ASSESSMENT == Eye Care/Additional Assessment Performed: Eye Drainage (Describe): Eye Care Provided (Describe): Limited Eye Movement: If Yes (Describe):	CPM — Hours On This Shift: CPM Being Utilized: H Total Hours in CPM This Shift: Skin Integrity Checked: Alignment Checked: CPM Comment: Skin Integrity Checked: CPM Comment: Alignment Checked: CPM Comment: Alignment A OS & 04H IN ICU CP
	Councert 11/20/06/2006 YVC 11/20/06/2009 YVC Altered GI Function/Status Remains an Active Problem: * (If NO. Consider Inactivating or Completing Intervention) *** Occument Only on Interventions Related to Patient's Altered Status/Function. ***
EENT Comment: %G.TUBE INPLACE 31250 Problem: Musculoskeletal + A QS & Q4H IN IQU CP Document 11/20/08 2001 YPC II/20/08 2009 YPC CP Altered Musculoskeletal Function/Status Remains an Active Problem: % (If NO, Consider Inactivating or Completing Intervention) *** *** Document Only on Interventions Related to Patient's Altered Status/Function. ***	—— REASSESSMENT —— —
← REASSESSMENT ← MUSCULOSKELETAL Assessment Within Normal Limits: Weakness: Gait/Balance: Range of Motion: Range of Motion:	Drainage Color: Nausea: Nº Vomiting: Nº Diarrhea: Nº Constipation: Nº GI Bleeding: GI Complain: GI Comment: XBDL SOFT AND NOT DISTENDED N/ACTIVE BS, NO MAUSEA/VOMITING
Gait/Balance Range of Motion Location of Limited ROM Joints Joints Contractures/Deformities Musculoskeletal Comment: HOWE ALL EXTREMITIES, NEEDS FEW ASSISTENT ABLS	GIRIH MEASUREMIS
TRACTION CASTS	ELIMINATION
Traction in Use: M Cast Location: Cast Location: Cast Type of Traction:	GI Tube Inserted/Discontinued: 🎊

#ge/Sex: 62 M Dhit#: M0002737B1 miit#: 11/19/08 at 2033 Status: DIS IN	Attending: Laliy, James M. Account # V00000305742 Location: MJ Room/Bed: 228-8	Chino Valley Medic	A.ADEL S al Center NUR **LIVE** TENT AUDIT FORMAT
Intervention Description	Sts Ø	rections Fro	m Intervention Description Sts Directions Prov
Activity Occurred Type Date Tim	Recorded ne by Date Time by Comment	Bocumented Units Change	Activity Occurred Recorded Bocurented Type Date Time by Date Tame by Comment Units Charge
Activity Date: 11/20/08	Time, 2001 (continued)		Activity Date: 11/20/08. Time: 2001, (continued)
GI Tube Inserted (Type):	8		Activity Date: 11/20/08 Time: 2001 (continued) Type of Dialysis: Dialysis Access Comment: Fistula with Bruit/Thrill: If Quinton or Ash Split Cath, Site Without Redness/Drainage
onnent: 1280 Problem: Genit Occument 11/20/08 200 tered Genitourinary Functi		8 Q4H IN ICU CP m: M	GU Comment: VOIDED VFA URINAL WELL 31320 Pain: Management Of + A AS NEEDED CP + Document: 11/20/08 2001 YYC 11/20/08 2010 YYC *** Chest Pain to be Documented on Cardiac Problem ***
	: Dysuria Anuria: Polyuria: Type: olor:		PAIN MANAGEMENT Time of Patient's Complaint: 2000 Pain Location: Pain Scale: Describe the Pain: Onset: Comment:
inary Complaint/Problems: i theter Inserted/Discontinu Urinary Catheter Inserti Str Catheter Discontinu	ed:	Size (# Fr): ##	Comfort Measures Implemented: Other Measures Taken: Time of Reassessment: Response to Intervention: Patient/Family Education Provided: *
ment:			Pain Comment: DENIES PAIN AT THIS JIME
	or to Catheterization: r to Catheterization ∯ of Voids/Im bt Catheterization	continent: XXXX	Pain Education for Patient/Family
[f Female Vaginal Bleeding: Descr Jaginal Discharge: Descr Vaginal Packing:	iha.	\$ \$	Instructions Given Related to: Pain Managoment is Part of Treatment Plan: ** About the Use of the Pain Intensity Rating Scale: ** Total Absence of Pain is Often not Realistic/Desirable Goal: ** Choosing a Pain Control Goal. such as Pain Not Worse than 2: **
of Pads Last Hour: 🗰 Drain Tissue Observed in Malodorous: 🗮 Comm	nage Color:		That Effect of Pain Management Interventions will be Reassessed at Frequent Intervals: About the Importance of Requesting and Receiving Pain Relief Measures Before Pain Becomes Severe & Difficult to Control: About the Importance of Notifying Health Care Providers About Any Unrelieved Pain:
If Male Penile Discharge: Descr Scrotal Edema:	ibe:		Other Information Taught 80010 Education: Patient/Family Teaching + A OS BY CAREGIVER CP Bocument 11/20/08-2001 YVC 11/20/08-2011 YVC PATIENT/FAMILY EDUCATION
= 1F DIALYSIS PATIENT ====			

Printed J	NDEL S Center NUR **LIVE** IT AUDIT FORMAT	Chino Valley Medic	Attending: Lally, James M. Account #: V00000305742 Location: MU Room/Bed: 228-8	Age/Sex 62 M Unit # M000273781 Agnitted: 11/19/08 at 2033 Status: DIS IN
Sts Directions ed Recorded Documented Time by Date Time by Comment Units	Intervention Description Activity Occurred Type Date Tim	Ifrections Fro Documented Units Change		Intervention Description Activity Occurred Type Date Thr
Time: 2107 (continued)	Activity Date: 11/20/00		fime: 2001 (continued)	Activity Date: 11/20/08
Time: 2107 (continued) = CNA/LICENSED Documentation	Comfort Measu Nurse N	AS NEEDED, CALL 11GHT W/14	Time 2001 (continued) ENCOURAGED PT TO USE CALL LIGHT / REACH	Activity Date: 11/20/08 Instruction Given:
IF ON CXYGEN+++ R 02 Amount (L/min): 555 FIO2: 555	***16		VERBAL	Person Taught: Teaching Tools: Other Tools Used: Factors Affecting Learning: Other Factors:
5	Patient Notes: Nurse Notes Create 11/20/08/215 Abnormal? N Confident MEDICATED ATENOLOL 50	ew protocol/di qs cp	YERSALIZES: UNDERSTANDING N Chang, Ye, Yun NERSING : 41-65 (MID ADULT) A VIE	Evaluation: Needs Additional Education: Educator: Educator: Discipline:
A Q12H (0559,1759) 0547 YYC 11/21/08:0548 YYC	Activity Date: 11/21/08	ction. Admin Morphine 2 Urine Anger, NPO		Patient Notes: Nurse Notes Create <u>1/20/08</u> 200 Abnormal? N Confident PT RESTING QUIETLY AT NG IV X 1 THIS SHIFT.
IVP8's: 100 8100d/Proc Chemo: 0	Ice: N Oral: 0 Tube Feeding: 0 IV's: 900			SUCTION CANISTER. VSS Activity Date: 11/20/08
Ostomy: 0 Hemovac Jejunostomy: 0 Hemovac Ileostomy: 0 T-T Jackson Pratt #1: 0 Gli Irrigant. Jackson Pratt #2: 0 Dilysis Chest Tube #1: 0 Est. Blood L Chest Tube #2: 0 Other Out		& Q4H IN ICU CP	1 YrC 11/20/08 2011 YYC tion + A QS 1 YrC 11/20/08 2011 YYC A QS Time 2020 0 YYC 11/20/08 2200 YYC	1300 Problem: Nutri Create 11/20/08 201 Activity Date: 11/20/08 Patient Notes: Nurse Notes Create 11/20/08 202
Total Qu Total SHIFT FLUID BALANCE		AT THIS TIME.	1412 N HAT PT WILL BE HOLD PO MEDICATION	Abnormal? N Confident
547 TYC 11/21/08 0548 YYC propriate for The Patient And Within The Scope Of My he Shift: YES NO COMMENT.	21090 Routine Care: 1 VIEW PROTOCOL Document 11/21/09/054	VASINE	7 REF 11/20/08 2107 REF	Pulse: 89 Respirations: 18 Blood Pressure: #16/28

Age/Sex: 62 M Unit # M00273781 Armitted 11/19/08 at 2033 Status: 015 IN	Attending: Lally, James M. Account ≢: V00006305742 Location: MJ Room/Red: 228-B	Chino Valley Medica	A ADEL S al Center NUR ***LIVE** LENT, AUDIT FORMAT. Printed 11/22/08 at 0926
Intervention Description Activity Occurred		irections From	n Intervention Description Sts. Directions From Activity Occurred Recorded Documented
Type Date Tin	ne by Date Time by Comment	Units Change	Type Date Time by Date Time by Comment: Units Change
Activity Date: 11/21/08	Time, 0547 (continued)		Activity Date: 11/21/08 Time: 0623 (continued)
Activity Date: 11/21/08	Time: 0547 (continued)		Activity Date: 11/21/08 Time: 0527 (continued)
Practice Guidelines Comment:			twwfF DN DXYGEN*** Dxygen Device: R00# AIR 02 Amount (L/min): 02 Sp02 (t): 96: F102: 02
Patient/Family Education Pro	ovided This Shift: 🎉		Activity Date: 11/21/08 Time: 0800
Restraints in Use: 🕷 Descrit +Total Hrs. In Restraints Th		n; ••••••••••••••••••••••••••••••••••••	1070 Shift Reassessment + A QS & Q4H IN ICU · CP Document 11/21/08 0800 PAS 11/21/08 1157 PAS Reassessment Obtained Date: 41/21/08 Time: 0800
IV ASSESSMENT		Central Line Present: M	NEUROLOGICAL Assessment Within Normal Limits: X Neuro Comment: ALERT AND ORIENTED TIMES TOR EENT Assessment Within Normal Limits: N EENT Comment: No. TO THE WARE AND ON INTERMITTANT SUCTIONING
IV Location: 4 IV Site Condition: IV Start/Restart Date: 4	EFT HAND -IV Site 1/19/08	Within Normal Limits: 🕷	RESPIRATORY Assessment Within Normal Limits: N Respiratory Comment: DIMINSINED AND ENCOURAGE TO USE SPIROPETER AND TO DEEP BREATH
IV Location: IV.Site Condition: IV Start/Restart Date: IV Comment: I	IV Site	Within Normal Limits: 🐰	CARDIAC Assessment Within Normal Limits: 3 IF ON CARDIAC MONITOR/TELEMETRY: Cardiac Rhythm: Monitor #: Cardiac Comment: NO CHEST PAIN OR SDB
	Time: 0622		CIRCULATORY Assessment Within Normal Limits: ¥ Circulatory Comment: PULSES STRONG AND NO FUENA.NOTED
Create 11/21/08/062 Abnorma12 N Confident SLEPT FAIR AT NIGHT, N	22 YYC 11/21/08 0622 YYC Jał? N IG TO LIS DRAINAGES TO SOML OF GREE ABDL SOFT AND NOT DISTENDED W/ AC	NISH OUTPUT. DENIES	HUSCULOSKELETAL Assessment Within Normal Limits: % Musculoskeletal Comment: MOVES ALI EXTREMITES WELL NUTRITIONAL Assessment Within Normal Limits: %
AMPICILLIN IVPB GIVEN	AS DUE TIME, SAFTY MAINTAINS, CALL Time: 0627	LIGHT W/IN REACH.	Nutritional Comment: WHO AS INDICATED GASTROINTESTINAL Assessment Within Normal Limits: %
Temperature/F: 97.8	7 PB 11/21/08 0628 PB Temp Source: TEMPORAL ARTERY		GI Comment: DISTENDED AND HIGERATELY FIRM. HYPORCITYE BOWEL SOUNDS AND NOTED SBO GENITOURINARY Assessment Within Normal Limits: 3/ GU Comment: URINATING WITHOUT PROBLEMS
Pulse: 67 Respirations: 20 Blood Pressure: 118774 Site: LEFT UPP	Pulse Source: ABTOMATIC NUMINA Resp Source: OBSERVED BP Source: ABTOMATIC	ASIVE	INTEGUMENTARY Assessment Within Normal Limits: % Skin Comment: UNTACT AND WARM AND DRY
Comfort Measu Nurse N	NA/LICENSED Documentation == res Implemented: btified of Pain: . Document On Intervention Pain: H		PSYCHOSOCIAL Assessment. Within Normal Limits: Y Psychosocial Comment: COOPERATIVE WITH CARE:
(If Medicated	, Document on Intervention Pain: M	lan — OF)	

Age/Sec: 62 M Attending: Lally Unit # MO0027781 Account # V0000 Admitted I/1/9708 at 2033 Location MU Status: DIS IN Room/Bed: 228-B	Chino Valley DISCHAR	Medical Center NUR **LIVE** GE PATIENT AUDIT FORMAT	Printed 11/22/08
Intervention Description Activity Occurred Recorded Type Date Time by Date T	Sts Birections Documented ne by Comment Units Ch	Activity Dourced	Sts Directions Recorded Documented Date Time by Comment Units Cha
Activity Date: 11/21/08 Time: 0800 (c	ontinued)	Activity Date: il/21/08 Tim	e: 0800 (continued)
Activity Date: 11/21/08 Time: 0800 (c The Following To Be Documented On Or 	Total Score: 3 Fall Risk- Low (0-2): Moderate (3-6):	: CVHC:STAND : STANDARD 0 : Patient's Plan of 21400 Nutrition/Activity/AD - Occument 11/21/08 0800 PAS 4	e: 0800 (continued) ARD OF CARE A F PRACTICE M/S/TELE A Care was Reviewed and Updated as Needed: % Flowsheet + A QS BY CAREGIVER H/21/0B-1150-PAS
Patient's Age: 0 ≈ 65 YEARS ==BRADEN PRESSURE ULCER RISK ASSESSMENT== - Sensory Perception: 44 NOT LIMITED: ANI Moisine: 4 RARELY MOISI Activity: 1 BEDFAST Nobility: 3 SLIGHTLY LIMITED Nutrition: 3 ADEDIATE Friction and Sheer: 3 NO APPARENT PROBL	-Skin Risk Score: Risk Score: Low (16+): Moderate (13-15)	If Appropriate:	ORDERED
ADVANCE DIRECTIVES Code Status: FULL DODE Comment:	If DNR, Purple Armband in Place: 🖗	Activity Tolerance: FAIR Gait: NOT APPLICABLE	
		Comment: - Document 11/21/08 0800 NIV 1 	1/21/08 1323 NIV
Eyeglasses: ¥ : PT WEARING Contact Lenses: N : Dentures: N : Hearing Aid: N : Prosthesis: N : Comment:		If Appropriate: PO Nutritional Supplement Taken: # Supplemental Snacks: #	
15000 Care Plan: RN Review + Bocument: 11/21/08 0000 PAS 11/21/08 11 PATTENT PROPIEM LIST AS PRIORITIZED ON CARE PL	A 012H Status: A Al: Effection : A Function : A Munction : A Munction : A Triblant Status : A CSteletal Function : A	Activity Tolerance LAN	Oral Hygiene: SELF Last BN: 13721708 Incont (BM): H Description:

	DISCHARGE PATIENT A			rinted 11/22/08 at 09
Intervention Description Sts. Directions	······	Intervention Description	Sts Directions	Fro
Activity Occurred Recorded Documented Type Date Time by Date Time by Comment Units	Glange	Activity Occurred	Recorded Document Date Time by Comment. Un	ted
Activity Date: 33/21/08 Time: 0500	A	Activity Date: 11/21/08 Time	s: 9800 (continued)	
22300 IV/Invasive Lines: Inser:/Remove + A INS/REMOVAL/CONVEL Document IV/21/08 0800 PAS 11/21/06 1158 PAS IV INSERT/DISCONTINUE	CONCIMUM AND ADDRESS AND CONCIMUM.	Activity Date: 11/21/08 Time euro Comment: ALERE AND ORIENTED E	e: 0800 (continued) MES FOUR	
Insertion/Reinsert Date: # of Attempts: # IV Location: Catheter Size (ga. IV Location: Catheter Size (ga. Saline Lock: #):	Document 11/21/08 0800 PAS 1 Altered EENT Function/Status Remain If NO, Consider Inactivating or Con	H/21/08 1158 PAS	100 07
Oiscontinued Date: IV/SL DC'd - Cath. Intact: IV Converted to Saline Loc	ck: 🖉 🗕	- REASSESSMENT		
IV Comment: INTACI AND NO REDNESS OR SWELLING NOTED 1200 Problem: Neurological + A OS & QHI IN ICU Document II/2/100 000 PAS II/2/100 1150 PAS Altered Neurological Status/Function Remains Active Problem: N (If MD, Consider Inactivating or Completing Intervention) *** Document Only on Interventions Related to Patient's Altered Status/Funct:	CP Or: Thi	EENT Assessment Within Normal I al Nucous Newbranes: Nasal: NS TURE TO LT NARES moat/Mouth: Right Eye: Left Eye:		:
-NEUROLOGICAL Assessment Within Normal Limits: Neuro History: Speech: Headaches: Describe: Schavior/Appearance Inappropriate: Describe:		 EYE CARE/ADDITIONAL ASSESSMENT - Eye Care/Additional Assessment Eye Drainage (Describe): e Care Provided (Describe): Limited Eye Movement: 		
Motor Response: Total: 98 Stille INCOMMICA	Size: 3		.Performed:	
escribe Seizure Activity: Seizure Precautions Initiated or being Ut escribe Seizure Event, Duration, Pre/Post Ictal State:		: :::::::::::::::::::::::::::::::::::::	INTERMITTANT SUCTIONING	
	A11 (11 	260 Problem: Musculoskelet Document 11/21/08/0600 PAS 1 Lered Musculoskeletal Function/Sta f NO, Consider Inactivating or Com	al + A OS & 04H IN 1/21/08 HIS8 PAS tus Remains an Active Problem: Y: pleting Intervention) elated to Patient's Altered Status/	ICU CP
ADDITIONAL ŠWALLOWING ASSESSMENT roblems Observed with Swallowing: Food Texture Tolerated: Fluid Consistency Tolerated:	Con Mus	ntractures/Deformities: sculoskeletal Comment: MOVES ALL E	RTREMITES WILL	

a/Sex: 62 M Attanding: Lally. James N. http://www.andity.com/file/andity.james N. Account # v00000305742	HANNA, ADEL S	Page: Page: 1/22/08
itted: 11/19/08 at 2033 Location: MU atus: DIS IN Room/Bed: 228-B	Chino Valley Medical Center NU DISCHARGE PATIENT AUDIT P	FORMAT
		ention Description Sts Directions
tervention Description Sts Direction Activity Occurred Recorded Docum	is From Interve	
Activity Occurred Recorded Docume Type Date Time by Date Time by Comment 1	nted Act nits Change Type	ivity Occurred Recorded Documented e Date Time by Date Time by Comment Units Cha
civity Date, 11/21/D8 Time: 0800 (continued)	Activit	ty Date: 11/21/08 Fime: 0800 (continued)
tivity Date: 11/21/08 Time: 0800 (continued)	Activit	ty Date: 11/21/08 Time: 0800 (continued)
· · ·	EL II	MINATION
	Support	Enema Given: # Type: Results: Result: Result:
TRACTION CASTS		SILDIY GIVEN: 40 Type.
Traction in Use: N Cast Location: Type of Traction: Cast Type:		Inserted/Discontinued: 38
Extremity: Weight (lbs):	(Do	Not Include Tubes Inserted for Feeding Purposes) Tube Inserted (Type):
rs On This Shift: Peripheral Pulse Pal	pable:	# Attempts: MM Difficult Insertion:
PIN CARE === Skin Around Cast I		gastric Auscultation: 🗱 to Verify Placement: 🐘
hopedic Pin Care Given: 🕸 🛛 🔤 BRACES 🚥	GI Tube	Discontinued (Date):
Pin Location: Brace being Utilized: n Site Appearance: Type of Brace: In Site Care With: Extremity: Extremity:	31280	: SPO AND NPO AND WITH NG TO INTERMITTANT SUCTIONING Problem: Genitourinary + A QS & Q4H IN ICU
in Site Appearance: Site Care With: Extremity: Hours On This Shift:	Docume	ent 11/21/08 0800 PAS 11/21/08 1159 PAS Genitourinary Function/Status Remains an Active Problem: #
Extremity:	(If NO	Consider Inactivating or Completing Intervention)
CPM === Hours On This Shift:	*** Doci	ument Only on Interventions Related to Patient's Altered Status/Function. ***
al Hours in CPM This Shift: 000 Ortho Comment:		······································
Skin Integrity Checked: Alignment Checked:	-GENIT	SSESSMENT TOURINARY Assessment Within Normal Limits: 38
Comment: A QS & Q4H I		nence: Wilses Diapers: Willowia Winneria: Polyuria: Wilses Diapers: Wilses Type: Wilses Margine Wilses
11/01/00/01/10/00/00/00/00/00/00/01/00/01/10/06C	chordena heart ann an fhannais contratación aitean	Color
ered GI Function/Status Remains an Active Problem: ↑ NO. Consider Inactivating or Completing Intervention)	Nephros Urinary	stony: Nephrostony Type: Complaint/Problems:
Document Only on Interventions Related to Patient's Altered Statu	s/Function. ***	r Inserted/Discontinued: 👹
REASSESSMENT		cary Cathoton Incertion Date:
STRDINTESTINAL Assessment Within Normal Limits: # Abdominal Appearance: DISTENDED/FIRM		Type: Straight Cath: ************************************
Bowel Sounds: ACTIVE Last BM: 11/18	708	Catheter Discontinued Date: Time:
Describe Stool: COMMED Abdominal Pain: W		
ongy:NN GITube:	POST	T VOID RESIDUAL
Suction: Suction: Drainage Color:	- If Ung	measurable Urine Prior to Catheterization # of Voids/Incontinent: ****
Nausea: ## Vomiting: ## Diarrhea. ## Constipation: ## Complaint:	I Bleeding: N: Anount	t of Urine per Straight Cath:
Comment: DISTENDED AND MODERATELY FIRM HYPOACTIVE BOWEL SOUNDS AN	DINOTED SBO	Fenale**
	Vagina Vagina	al Bleeding: © Describe:
GIRTH MEASUREMENTS — Abdominal Girth (inches):	Vagir	nal Packing: 🕷
OSTOMY CARE		
Ostomy Type: Periostomal Skin:	f of Pad	ds Last Hour: I Drainage Color:
tony Care Provided: Mapliance Changed: March Cooking Skill		Malodorous: Comment:

Intervention Description	Sts B	Hections Fro	a Intervention Description Sts Directions Fr
Activity Occurred Type Date Tim	Recorded	Documented	
Activity Date: 11/21/06	Time: 0600 (continued)		Activity Date: 11/21/09
Activity Date: 11/21/08	Time: 0800 (continued)		Activity Date: 11/21/08 Time: 0800 (continued)
If Male Penile Discharge: Descr Scrotal Edema:	ibe:		Nutritional Comment: NPD AS INDICATED 31320 Pain: Management Of + A AS NEEDED CP Document 11/21/08/0800/PAS 11/21/08/1200/PAS
- IF DIALYSIS PATIENT Dialysis Access Comment: %** If Quinton on Ash Split Cat Comment: ****	Type of Dialysis: Fistula with Bruit/Thrill: h. Site Without Redness/Drainage		
31300 Problem: Nutri Ducument: 11/21/08 080 Altered MUTRITIONAL Function (1f ND. Consider Inactivatin	0 PAS <u>11/21/08</u> 1159 PAS /Status Remains Active Problem: ¥	& C4H IN ICU CP	Confort Measures Implemented: Other Measures Taken: Time of Reassessment: 0000 Post Intervention Pain Scale: 0/10 Response to Intervention: MOCOMPLAINTS-OF PAIN Patient/Family Education Provided %
Nausea, Vomiting, NPO, Poor Appetite, or on Cl-	ent Within Normal Limits: M or Diarrhea for > 3 Days: M ear Liquids for > 3 Days: M n (TPN/PPN/Tube Feeding): M		Pain Comment:
If Boluses, Amount (ml): Gastric Residual Checked:	Type of Feedir If Continuous Frequency: wount (ml): Disposition. ***		Instructions Given Related to: Pain Management is Part of Treatment Plan: * About the Use of the Pain Intensity Rating Scale: * Total Absence of Pain is Often not Realistic/Oesirable Goal: * Thotal Absence of Pain is Often not Realistic/Oesirable Goal: * Thotal Absence of Pain Such as Pain Not Worse than 2: * That Effect of Pain Management Interventions will be Reassessed at Frequent Intervals: * About the Importance of Requesting and Receiving Pain Relief Measures Before Pain Becomes Severe & Difficult to Control: * About the Importance of Notifying Health Care Providers About Any Unrelieved Pain: *
. Epigastric Ausculta	inued: d for Gastric Decompression)		Other Information Taught 80010 Education: Patient/Family Teaching + A OS BY CAREGIVER CP

Age/Sex: 62 M Unit ∰: M000273781 Admitted: 11/19/08 at 2033 Status: DIS IN	Attending: Lally, James M. Account #: V0000305742 Location: MJ Room/Bed: 228-B	HANNA., Chino Valley Medical DISCHARGE PATIE	Center NUR **LIVE**	Page: 23 Printed 11/22/08 at
Intervention Description Activity Occurred Type Date Tim	Sts Direction Recorded Document e by Date Time by Comment i	ns Erom ented	Intervention Descr Activity Type Date	iption Sts Directions Occurred Recorded Documented e Tine by Date Time by Comment Units Chang
Activity Date: 11/21/08	Time: 0800 (continued)		Activity Date: 11/	21/08Time: 12:00(cont.inued)
Other Tools Used: Factors Affecting Learning Other Factors: Participation Level: Evaluation: Needs Additional Education: Otics: Document: 1001031 Age Guidelines: Document: 11/21/06 080 Activity:Date: 11/21/06 108 Activity:Date: 11/21/06 108 Activity:Date: 11/21/06 108 Create: 11/21/08 114 Anomal?: N Confident RECENTE AND ADDORE AND WITH DRAINAGE THAT HYPOACTIVE AND ADDORED AND CONFINITIONAL BE RE IMPROVEMENT: PATIENT DICATED	ACTIVE N Studbs, Pauline A 41-65 (MID ADULT) A VIEW PROTO 0: PAS 11/21/08:1200:PAS Take: 1148 8: PAS 11/21/08:1153:PAS 5a72 N AND ORTENTED TIMES FOUR. TV INTACT AND N IS DISTENDED AND FIRM. LUNKS ARE CLEAR B BREATH, PATIENT DENIES PAIN AT THIS TIME. H WAS IN TO SEE AND ORDERS PENDING. ADVIS S ANJOUST DO KNOW THE RESULTS. WILL BE PR S ANJOUST DO KNOW THE RESULTS. WILL BE PR	IG TO SUCTION SARE JUT DIMINISHED FOR CT OF THE ED THE PATIENT ITH MARKED LEPPING FOR NG AND IF	If Appropriate: PO Nutritional Sup Supplement 	Diet: NPO Diet: NPO DIE DIET: NPO DIET: NPO DIET: NPO DIET: NPO DIET:
NAUSEA WILL REATTACH A ANTIBIOTICS AND NO ADV DRY. VITALS AT THIS TI CONTINUE TO UPDATE WIT T	ND SUCTION OUT IF INDICATED. PATIENT CONT ERSE REACTION NOTED. PULSES STRONG AND SK ME AT 97.8, 67, 20, 118/74, 98% on ROOM A H PLAN OF CARE.	'INUED ON IV IN IS WARM AND	Pulse: Respirations: Blood Pressure: Site: ~ C/O Pain:	62 Pulse Source: AUTOMATIC: NONTINASIVE 20 Resp Source: OBSERVED 137791 BP Source: AUTOMATIC LEFT LIPPER ADM 34 CRAM LEFINED Documentation ==
	1154 by PAS Stubbs,Pauline A. RN		Comfo	The Most of Pains and Alexandration and Alexandration and Alexandration and Alexandration and Alexandratic Al
Patient Notes: Nurse Notes - Create 11/21/08 115 Abnormal? N Confident STARTED PREP AND NG CL	Time: 1154 4 PAS 11/21/08 1154 PAS tal? N AMPED AS INDICATED. GIVEN ABOUT 120CC EVE ELL AND NO COMPLAINTS OF NAUSEA AT THIS T	RY HALF AN HOUR	Oxygen Device: # SpO2 (%): 9 Comment:	edicated, Document Dn Intervention Pain: Management Of) ****[F ON DYTSEN*** ODF-AIR: F102: 02 Amount (L/min): 03.8 8' F102: 02 Amount (L/min): 03.8 1/08 Time: 1450
Activity Date: 11/21/08 21400 Nutrition/Acti - Document 11/21/08 120	Time 1200 vity/ADL Flowsheet + A QS BY CARE Q:NIV_11/21/08_1324_NIV A A	GIVER CP	VISITORS AT TH GASTROGRAPHIN	Notes 1708 1450 PAS 11/21/08 1451 PAS officiential? N 18 REDSIDE PATIENT DENTES PAIN AND DENTES NAUSEA. TOLERATE THE WELL. CONTINUED TO MONITOR AND NG TO REMAIN CLAMPED AS
NUTRITION I Meal Intake	- · · · · · · · · · · · · · · · · · · ·		INDICATED.	*

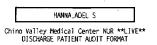
Age/Sex: 62 M Attending: Lally. Janes M. Unit # M000273781 Account # V00000305742 Account # V00000305742 Amitted 11/19/08 at 2033 Location: MU Status: DIS IN Room/Ged. 228-B		ADEL S Page: 24 of 33 Center NUR **LIVE** NT AUDIT FORMAT Printed 11/22/08 at 0926
Intervention Description Sts Activity Occurred Recorded Type Date Time by Date Time by Comm	Bocumented	Activity Occurred Recorded Documented
Activity Date, 11/21/08 Fime, 1755		Activity Date 11/21/08 Time: 1759 (continued)
Document 11/21/08 1755 LAB 11/21/08 1755 LAB == NUTR[T[0]	15 BY CAREGIVER CP	Activity Date: 11/21/08 Time: 1759 (continued) Emesis: Chest Tube #1: Est. Blood Loss: MG Tube: Chest Tube #2: Other Output: Total Output: 1356
Activity Type: Bath:	Amount Taken:	Orment: Comment: Comment: Comment: LIO90 Routine Care: MED/SURG/TELE + A _END OF SHIFT/TX CP VIEW PROTOCOL Document: Il/21/08 1735 PAS II/21/08 1927 PAS The Practice Guidelines Appropriate For The Patient And Within The Scope Of My Practice Have Been Met Throughout The Shift: YES.NO.COMMENT Signature: Stubbs.Pauline A. Shift: 0700 1930 Practice Guidelines Comment:
Lincont (BM Elimination Comment: Comment: - Edit Results 11/21/08 1755 LAB 11/21/08 1854 LAB PO Nucritional Supplement Taken: N/A [] Arount Taken: 0 [] Supplemental Snacks: N [] : N/A [] Activity Type: BATHROOM PRIVILEGES [] Activity Tolerance: FAIR []		Patient/Family Education Provided This Shift: # Isolation: STAMBARD PRECAUTIONS Restraints in Use: # Describe: +Total Hrs. In Restraints This Shift: Location:
Gait: SLOW [] Bath: SELF [] Linen Changed: Y [] Oral Hygiene: SELF [] Incont (BH): N [] Activity Date: 11/21/08. Time: 1759		IV ASSESSMENT Throughout Shift: IV Location: LEFT HAMD: IV Site Condition: IV Stert/Restart Date: #1219708
1500 I&O: Monitor + A C Document 11/21/08:1750:PAS 11/21/08:1926:PAS INTAKE: SHIFT TOTAL == Icc: IVPB's: 50 Oral: 1000 Chemo: Tube Feeding: IPN: IPN: IV's: 900 Lipids:	Blood/Product: GU Irrigant.In: Other Intake: Total Intake: 1950	IV Location: IV Site Condition: IV Start/Restart Date: IV Comment: Activity Date: 11/22/08 Time: 1855
- DUTPUT: SHIFT TOTAL	Hemovac #1: Hemovac #2: T-Tube: GU Irrigant, Out:	Patient Notes: Nurse Notes Create 11/21/08 1855 PAS 11/21/08 1857 PAS Abnormal? N Confidential? N CALLED UR OF WITH RESULTS OF THE CT OF THE ABOUMEN. AWAITING CALL BACK AT THIS TIME. PATIENT IS ANKIOUS TO FINE OF AND TO GO HOME, PATIENT REMOVED THE NG PRIOR TO ORDER AND ADVICTIN THE STAFF HE DID SO AND KNOWS THERE IS NO OBSTRUCTION
•		

Age/Sex: 62 M Attending: Lally. James M. Unit #: M000273781 Account #: V00000305742	HANNA, ADEL S	Page: 25 of 3
Admitted: 11/19/08 at 2033 Location: MU (Status: DIS IN Reem/Bed: 228-B	DISCHARGE PATIENT AUDIT FORMAT	ted 11/22/08 at 09
Intervention Description Sts Directions Activity Occurrent Recorded Documented Type Date Time by Comment Units	From intervention Description Sts_Directions Activity Occurred Recorded Documented Change Type Date Time by Date Time by Comment Units	Frç Change
Activity Date: 11/21/08 Time: 1855 (continued)	Activity Date: 11/21/09 Time: 2000 (continued)	
Patient Notes: Nurse Notes (continued) ANYMORE. PATIENT REMINDED STAFF HE IS A DOCTOR AND VERSED IN THESE CALLED DR DH AGAIN AND AWAITING CALL BACK AT THIS TIME.	Nutritional Comment: DIEF ICL ON FUEL ENDIN	
Activity Date: 11/21/08 Tume: 1929	GASTROINTESTINAL Assessment Within Normal Limits: % GI Comment: ACTIVE BS: NO N/V	
Patient Notes: Nurse Notes - Create 11/21/U8 1929 PAS 11/21/08 1931 PAS Abnormal? N Confidential? N PAGED DR AGAIN MAKING A TOTAL OF FOUR PAGES. AMAITING CALL BACK AT T PATIENT HAS HAD AN ISSUE ABOUT THE HYPERTENSIVE MEDICATIONS LAST NIC MILL REQUEST ALONG WITH FOOD AN ORDER FOR HIS MEDICATIONS IF DR DKS. DENIES NAUSEA OR YOMITING AND DENIES PAIN. HE DOES THOUGH STATE HE I HUNGERY. AMAITING CALL BACK AT THIS TIME.	GENITOURINARY Assessment Within Normal Limits: * GU Comment: VOIDS IS TIME. AND INTECUMENTARY Assessment Within Normal Limits: * PATIENT Skin Comment: INTEGU	
Activity Date: 11/21/08 Time: 1948		
Patient Notes: Nurse Notes - Create 11/21/08 1948 PAS 11/21/08 1950 PAS Abnormal? N Confidential? N DR OH CALLED BACK AND STATES CAN REMOVE NG AND START ON FULL LIQUID TONIGHT. PATIENT CAN HAVE HIS ATENULD. THIS EVENING AS WELL. POSSIBL DISCHARGE TOMORROW IF TOLERATES WELL. Activity Date: 11/21/08 Time: 2000 1070 Shift Reassessment + Document 11/21/08:2001 MPR 11/21/08 2017 MPR Reassessment Obtained Date: 11/21/08 Time: 2000		I Score: 00 Risk- (0-2): *** ate (3-6): *** (7+): **** Risk Score: 20
NEUROLOGICAL Assessment Within Normal Limits 🛠 Neuro Comment: ALERT AND ORIENTED EENT Assessment Within Normal Limits: 🕺 EENT Comment: ADP	Activity # WeikSFREDEINTY	<pre>< Score= (16+): ************************************</pre>
RESPIRATORY Assessment Within Normal Limits: ¥ Respiratory Comment: RESP. EVEN AND UN ADDRED	ADVANCE DIRECTIVES	
CARDIAC Assessment Within Normal Limits: 37 IF ON CARDIAC MONITOR/TELEMETRY: Cardiac Rhythm: Monitor #: 200 Cardiac Comment: DENLES-CHEST PAIN	Code Status: FULL CODE If DNR. Purple Annound in Comment:	Place:
CIRCULATORY Assessment Within Normal Limits: % Circulatory Comment: HBLSES PALPAGLE MUSCULOSKELETAL Assessment Within Normal Limits: % MUSCULOSKELETAL Comment: ANBREATORY		
Musculoskeletal Comment: AMBBLATCRY		

Account of University Control of	Chino Valley Med	NMA,ADEL S Pagë: 26 of 33 TCal Center NUR ***LIVE** ATLENT AUDIT FORMAT Printed 11/22/08 at 0926 ATLENT AUDIT FORMAT
Intervention Description Sta Activity Occurred Recorded Type Date Time by Date Time by Comme	Documented	Activity Occurred Recorded Documented
Activity Date: 11/21/08 Time: 2000 (continued)		Activity Date: 11/21/98 Time: 2000 (continued)
PAILEN PROBLEM LIST AS PRIORITIZED ON CARE PLAY: Problem(s) Identified MROBLEM, impaired EENT Function PROBLEM, Appaired GL Function PROBLEM: Altered Os Function PROBLEM: Altered Os Function PROBLEM: Antered Respiratory Func PROBLEM: Impaired Respiratory Func Developmental Ace 41-65 (MID ADD	QL2H Ct Status: A A Social Soc	Activity Date 11/21/08 Time: 2017 31200 Problem: Neurological + A 05 & 04H IN 1CU CP Document 11/21/08:2017 MPR 11/21/08:2017 MPR Altered Neurological Status/Function Remains Active Problem: # (11F NO. Consider Inactivating or Completing Intervention) *** Document Only on Interventions Related to Patient's Altered Status/Function. ***
: CYMC 57 ANDARD OF CARE STANDARD OF PRACTICE M/S/TELE Patient's Plan of Care was Reviewed and Up Pain: Management Of + on one owner A	dated as Needed: 3%	-NEUROLOGICAL Assessment Within Normal Limits: * Neuro History: Speech: Headaches: Describe: Behavior/Appearance Inappropriate: Describe:
	Cardiac Problem ***	= GLASCON COMA SCORE (Best Response) PUPIL REACTION CHECK Eve Response: 4-SPANTANEOUS Reaction OD: BRISK Size: 3 Verbal Response: 5-OREENTED Reaction OS: BRISK Size: 3 Notor Response: 5-OREENTED Reaction Size: 3 Total: 15 SEIZURE INFORMATION Recent Seizure Activity: Seizure Precautions Initiated or being Utilized: Describe Seizure Event, Duration, Pre/Post Ictal State:
Confort Measures Implemented Other Measures Taken: Time of Reassessment: Response to Intervention: Patient/Family Education Provided: Reasonable Pain Comment:	Scale:	ADDITIONAL NEURO ASSESSMENT Additional Neuro Assessment Performed and WNL: Level of Consciousness: Orientation: Responds to: ICP Monitor: ICP Monitor: ICP Memory: Thought Process: Weakness: Specify:
Pain Education for Patient/Famil	y	Numbress: Soperity: Factal Droop: Describe: Babinski Reflex Positive: %
Instructions Given Related to: Pain Management is Part of Treatment Pla About the Use of the Pain Intensity Rating Scal		ADDITIONAL SNALLOWING ASSESSMENT Problems Observed with Swallowing: Food Texture Tolerated: Fluid Consistenc ul Tala rated:

Attending: Lally, James M. Account #: V0000305742 2033 Location: MJ Room/Bed 228-B

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Intervention Description Sts Directions From Activity Occurred Recorded Documented Type Date Time by Date Time by Comment Units Change	Intervention Description Sts Directions From Activity Occurred Recorded Documented Type Date Time by Date Time by Comment Units Charge
Activity Bate: 11/21/08 Time: 2017 (continued)	Activity Date 11/21/08 Fine 2018 (continued)
Activity Date: 11/21/08 Time: 2017 (continued)	Activity Date: 11/21/08 Time: 2018 (continued) ***TF ON OXYGEN***
Neuro Comment ALGERT AND ORIENTED	Dxygen Device: #00H Alk
Activity Date: 11/21/08 Time: 2018	
31210 Problem: EENT + A OS & 04H IN ICU CP "Occurrent 11/21/08-2018:MPR = 11/21/08.2018 MPR COS & 04H IN ICU CP "AlLered EDAT Function/Status Remains an Active Problem * (If NO. Consider Inactivating or Completing Intervention) **** "EXEASESSMENT	Respiratory Comment: RESP. EVEN AND UNLABORED ::::::::::::::::::::::::::::::::::::
HASAL CARE/ADDITIONAL ASSESSMENT	Altered Musculoskeltal Function/Status Remins an Active Problem: % (If NO, Consider Inactivating or Completing Intervention) *** Document Only on Interventions Related to Patient's Altered Status/Function, ***
EENT Comment: WDP 31220 Problem: Respiratory + A OS & Q4H IN ICU CP Document t1/21/08/2018/HPR 11/21/08/2018/HPR CP Altered RESPIRATORY Status Remains an Active Problem: # COnsider inactivating or Completing Intervention) *** *** Document Only on Interventions Related to Patient's Altered Status/Function. *** *** Document Only on Interventions Related to Patient's Altered Status/Function. *** *** REASSESSMENT == Location: RESPIRATORY Assessment Within Normal Limits: # Dereath Sounds: Location: Location: Breath Sounds: Location: Cough: Secretions, Ant: Color: Cleared by:	REASSESSMENT MUSCULOSKELETAL Assessment Within Normal Limits: X Weakness: Gait/Balance: Range of Motion: Location of Limited ROM: Joints: Contractures/Deformities: Musculoskeletal Comment: AMBULATORY
	- TRACTION - CASTS - CASTS -

Age/Sex: 62 M Attending: Lally. Ja Linit #. M000273781 Account. #. V00000305 dmitred: 11/19/08 at 2033 Location: MU Status: DIS IN Room/Bed: 228-B	Chino Va	HANNA.ADEL S 11ey Medical Center NOR **LIVE CHARGE PATIENT AUDIT.FORMAT	1997 - 1997 -	Ŷ	Page: 28 of 33 finted 11/22/08 at 0926
Intervention Description	Sts Directions	From Intervention De	scription	Sts Directions	
Activity Occurred Recorded Type Date Time by Date Time	Documented by Comment Units	Activity Change Type	Occurred Recorded Date Time by Date		
Activity Date: 11/21/08 Time: 2018 (cont	noed)	Activity Date:	11721708 Time: 2018	(continued)	
Weight (1b5) ours On This Shift: PIN CARE	Cast Location: Cast Type: Extremity Elevated: Extremity Elevated: Skin Around Cast Intact: Skin Around Cast Intact: - BRACES	GI Tube Inserted (CO Not Incl. GI Tube Inserted (CO Not Incl. GI Tube Inserted Epigastric A X-Ray to Verif, GI Tube Discont i Comment: %658 31280 Pr Document: Altered Genitour (If NO. Consider *** Document Only -GENITOURINARY Incontinence: (CP CP CP CP Cepison Constant -GENITOURINARY Unclinence: Wephrostony: %1 Urinary Complain Catheter Inserted Urinary Cathe	/Discontinued: # ude Tubes Inserted for Feedi tred (Type): # Attempts: Difficult In uscultation: # Placement: uscultation: # blem: GeniLourinary + 11/22/08/2014 MRR 11/22/06 inary Function/Status Remain Inactivating or Completing y on Interventions Related t Assessment Within Normal Li Ises Diapers: Dysuria An Type: Color: kephrostomy Type: /Problems: /Discontinued: # ter Insertion Date: Type:	ng Purposes) sertion: Time: T	/Function. ***
Abdominal Appearance: Bowel Sounds: Abdominal Pain:: Suction: Drainage Color: Mausea: Vomiting: ≥ Diarrhea: Complaint: Comment: ACTEVE BS: NO!NUN == GIRTH MEASUREMENTS ===	Constitution: © 61 Blooding: "	20ST VOID RES Anount of Uring If Unmeasurable Amount of Uring **[f Female**	Discontinued Date: DOUAL	ation: ********* tion # of Voids/Incontinent	
Addminal Girth (inches): Addminal Girth (inche		of Pads Last Ho Tissue Malodoro **[f Ma]e** Penile Dischar	wr: Drainage Color: Deserved in Drainage: Us: Comment: Deserved co		

Age/Sex: 62 M Unit #: M000273781	Attending: Lally, James M. Account #: V0000305742	HANNA, A	oel s				Page: 2	9 of 33
Admitted: 11/19/08 at 2033 Status: DIS IN		Chino Valley Medical DISCHARGE PATIEN		E**			Printed 11/22/08	at 0926
Activity Occurred	Sts Directions Recorded Documented ne by Date Time by Commut Units		Intervention D Activity Type		Recorded			Erom nge
Activity Date: 11/21/08	Time, 2018 (continued)		Activity Date:	11/21/08 T	ime: 2019 (contin	ued)		
Activity Date: 11/21/08 — IF DIALYSIS PATIENT — Dialysis Access Comment: If Quinton or Ash Solit Cat Comment:	Time: 2018 (continued) Type of Dialysis: State Fistula with Bruit/Thrill: Ste Site Without Redness/Drainage St		Document	: ducation: Patient// 11/21/08 2019 MPR	11/21/08 2020 MP T/FAMILY EDUCATIO	A QSBYCAR R N ——		CP
Activity Date: 11/21/08 31300 Problem: Nutri- Document 11/21/08 201 Altered KUTRITIONAL Function (If NO. Consider Inactivatir *** Document Only on Interve - NUTRITIONAL Assess	<pre>19 prgr.11/21/06:2019 HPR v/Status Remains Active Problem: 3: go r Completing Intervention) entions Related to Patient's Altered Status/Fun ment Within Normal Limits: 3:</pre>	J CP	Pe Tea Other Factors Affect Of Particip	erson Taught: PATI erson Taught: aching Tools: VER8 Tools Used ing Learning: NOME ber Factors: pation Level: ACTIN Evaluation: VER8 I Education: N Educator: Rapa Discipling: NMES	u TE LL(2ES UNDERSTAND) a Maureene F.	NG		
NPO, Poor Appetite, or on Cl	or Diarrhea for > 3 Days: lear Liquids for > 3 Days: m (TPN/PPN/Tube Feeding):			<u>11/21/08</u> Tige Guidelines: 41-6		A VIEW PROT		
NUTRITIONAL SUPPLEMENTS Supplement Taken: Supplemental Snacks: N :			Document Patient Notes: Create Atmonsal?	11/21/08 2020 HPR Vurse Notes 11/21/08 2020 MPR Confidential?	11/21/08 2020 MP 11/21/08 2021 MP N	R .		
If Boluses, Amount (ml): 2000 Gastric Residual Checked: 2000	Amount (m1): Disposition:		Activity Date:	AMBULATING IN THE T TOL. NO N/V. WIL LI/2L/09 TI MISSION/TRANSFER:	<u>l cont.to monitor</u> me• 2053	<u>. CALL LIGHT WITH</u>	IN <u>REACH.</u>	
 Feeding Tube Inserted/Discor 	ntinued: ## ted for Gastric Decompression)		 Bocument Patient Type Patient Age 	11/21/08 2053 SGS pe: MED/SURG/TELE : 62	11721/08 2053 SG New A	S dmit: 36		
Feeding Tube Inserted - Epigastric Auscult	- Date: Time: Time: Site: Site		ON HZ	NVENTORY PERSONAL E NADMISSION & TRANS AVE PATIENT SIGN CC 11/21/08 2053 SGS 11/21/08 Invento 11/21/08 Invento	FER. PRINT OUT &	A ADM.TX.DC S formed By: Salibal		AS
Feeding Tube Discontinued								
Feeding Tube Insert/OC Comme Nutritional Comment: DIET II			1999 - 199	+H Contacts -W Full Dentures M Partial Upper -W Hearing Aid	-କି Glasses -କି Lower	Disposition:	ient mearing/taped	

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Status DIS IN Room/Bedi 228-B DISCHARGE PAT	al Center NUR **LIVE** TENT AUDIT FORMAT
Intervention Description Sts Directions Fro Activity Occurred Recorded Documented	
Type Date Time by Date Time by Comment Units Change	Activity Occurred Recordod Documented Type Date Time by Date Time by Comment Units Change
Activity Date: 11/21/08 Time 2053 (continued)	Activity Date: 11/2)/08 Time: 2106 (continued)
Activity Date: 11/21/08 Time: 2053 (continued)	Activity Date: 11/21/08 Time: 2106 (continued) Accompanied By: SPOUSE
-N Prosthesis Describe: Disposition: Disposition:	Discharge Comment: DISCHARGE INSTRUCTIONS GIVEN TO PATIENT
Jewelry: NONE-NO JEWELRY Jewelry: Describe: Describe: Describe: Disposition: Disposition:	Vital Signs: Temperature/F: 98744 Respirations: 20° Blood Pressure: 1327822 Pulse: 64% Pain Controlled by Oral Medications: 785 Comment: Defines? Pain Art 3HTS time Voiding/Adequate Urinary Drainage: 785 Voiding/Adequate Urinary Drainage: 785
Jewelry: Jewelry: Describe: Decribe: Disposition: Disposition:	Patient Passing Flatus/Stool: 37 Comment: Wound/Incision Assessment: #0005
-# Wallet Describe: Disposition:	Photograph Taken On Discharge and Placed On Chart: Diabetic: N **IF YES** Follow Up To Be Done By: The Patient Was Given Instructions in the Following: Activity: NAY RESUME ALL ACTIVITY: Restrictions:
Y Electrical Appliances Describe: 1040WE. -W Eng. Dept Notified To Evaluate Electrical Appliance Other Item(s) Of Value To The Patient HHITE PANTS, BRYAN ACKET, WHITE SHIRT - BUACK SANDALS Disposition: BELOWEINGS KEPT BY PT Compared to Previous Belongings List: N/A	Bath: Diet: Calories: Additional Education given: MORSENTAG SYMPTOMS HD FORING SYMPTOMS HD FORING UP Comment:
<< RELEASE OF LIABILITY OF VALUABLES KEPT WITH PATIENT >> By Signing Below I Indicate I Have Been Advised To Send My Valuables Home With Family/ Friends, And Have Been Given The Opportunity To Have My Valuables Locked Up. If I Refuse To Have My Valuables Locked Up Or Sent Home With Family Or Friends. I Release Chino Valley Medical Center From Any Liability For Lost Valuables. I Have Also Been Advised To Keep Audio/Video Equipment In My Possession At All Times, And I Understand That The Hospital Assumes No Liability For Such Equipment.	Comment: Prescriptions/Education given: N Food/Drug Interaction Form Given: X List DC Meds and Time next dose is due (if applicable): : ATRNER: SOME OF MOUTH EVERY NIGHT : EXEMPC JSMC OF MOUTH AC INTERNIE : TO EMEL SOME OF MOUTH AS INTERED FOR ingraine : TO EMEL SOME OF MOUTH AS INTERED FOR INGRAINE : TO EMEL SOME OF MOUTH AS INTERED FOR INGRAINE : TO EMEL SOME OF MOUTH AS INTERED FOR INGRAINE : TO EMEL SOME OF MOUTH AS INTERED FOR INGRAINE
PATIENT: Date: Date:	- Special Instructions: FOLIDALIP APPT ATTHEDR SHALLETME THEORY INCOMENTS OF STRATT
By Signing Below I Indicate 1 Have All My Belongings At The Time Of Discharge.	WALL Sent Hume With All Relongings: V. Personal Relongings Inventory Reviewed/Singed
PATIENT: Date:	Sent Home With All Belongings: X Personal Belongings Inventory Reviewed/Signed: X Discharge Instructions Reviewed With PARTERN Preumococal Vaccine Given: N Date Given:
WITNESS:	Discharge Plan: **TO BE COMPLETED BY ORM STAFF ONLY** Home Health: ** Agency Name/Phone #:
Activity Date: 11/21/08 Time: 2006	Discharge Plan: **TO BE COMPLETED BY QMM STAFF OHLY** Home Health: Agency Name/Phone #: Arranged By: Other:
90013 DIS: Patient Discharge Instructions + A ON DISCHARGE CP - Document: 11/21/08-2106 MPR 11/21/08-2122 MPR PR Please bring this Sheet with your to your follow up visit with: DR. AGARGAL AND:DR. OH on (Date/Time): NOV. 26. 2008 ** OR ** OR ** - Art of the sheet with your to your follow up visit with: DR. AGARGAL AND:DR. OH - On (Date/Time): NOV. 26. 2008 ** OR ** - Start of the sheet with your to your follow up visit with: DR. AGARGAL AND:DR. OH - On (Date/Time): NOV. 26. 2008 ** OR ** - Start of the sheet with your follow up visit with: DR. AGARGAL AND:DR. OH - Discharge Date: 11/21/08 Discharge Time: 2100 Discharge To: NOVE - NO NECDS - By: AUTOMOBILE Via: With the sheet and the sh	

Intervention Description Sts Directions From	Intervention Description Sts Offections
Activity Occurred Perorited Documented Type Date Time by Date Time by Comment Units Change	Activity Occurred Recorded Documented Type Date Time by Date Time by Comment Units Charg
Activity Date: 11/21/08. Time, 2106 (continued)	Activity Date 11/21/00: Fime 2006 (continued)
Activity Date: 11/21/08 Time: 2106 (continued) the local public health clinic to find out where this vaccine may be available.	Activity Date: 11/21/08 Time: 2106 (continued) * Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here: LUMETRA 415-677-2000 or 800-841-160
SPECIAL INSTRUCTIONS FOR THE CARDIAC/CHF PATIENT: A. Patients with congestive heart failure must weigh every morning, record weight, and avoid smoking.	YOUR MEDICARE DISCHARGE RIGHTS
B. Medication: Know your medications. Don't stop taking your medications or change your dosage unless your doctor tells you to. Keep a list of your current medications. If you have Nitroglycerin, keep it with you at all times. C. Activity: Start off slowly, plan your activities and get enough rest.	Planning For Your Discharge: During your hospital stay, the hospital staff will be worki with you to prepare for your safe discharge and arrange for services you may need after leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.
Stop activity if you have any of these signs: Chest discomfort, severe or unusual fatigue, dizziness or faintness, irregular or rapid heartbeat, shortness of breath. D. Smoking constructions is recommended. Smoking contributes to medical complications.	<pre>IF YOU THINK YOU ARE BEING DISCHARGED TOO SOON: * You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.</pre>
E. Call your doctor if: * Breathing becomes more difficult, or you have a cough with increased sputum or blood * You notice you're getting tired faster * Rapid or irregular heartbeat	* You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare t look at your case to decide whether you are ready to leave the hospital. * If you want to appeal, you must contact the QIO no later than your planned
* You have dizzy spells or you faint * You begin urinating less frequently * You think you are having side effects from your medication * You have tightness or pain in your chest (Not relieved by Nitroglycerin)	<pre>discharge date and before you leave the hospital. * If you do this, you will not have to pay for the services you receive during appeal (except for charges like copays and deductibles). * If you do not appeal, but decide to stay in the hospital past your planned dischar </pre>
* If you have a rapid weight gain of 2 pounds in 1 or 2 days or your feet or ankles swell more than usual	date, you may have to pay for any services you receive after that date. * Step by step instructions for calling the QIO and filing an appeal are below.
Your physician may have recommended that Home Health provide care to you as a part of your discharce. If so, the hospital staff has made this arrangement in your behalf, However, if	To speak with someone at the hospital about this notice, call the Director Of Nursing. STEPS TO APPEAL YOUR DISCHARGE
Unscharge 11 so, the hospital start has made this arrangement in your behalt, nowever, if you would like to change your care to an alternate agency, the following agencies are being provided for your consideration:	STEP I: You must contact the 010 no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the apoeal (exceed for charges like coarses and deductibles).
1. Heartland Home Health: (951) 369-8054 2. Visiting Nurses Association: (909) 624-3574 3. Sun Plus:(909) 605-7000	 Here is the contact information for the QLO: Lumetra One Sansome Street Suite 600
If you would like additional resources, you may contact the hospital social services for for help. Further, if you have an insurance other than Medicare or Medi-Cal, we recommend	San Francisco 94104-4448 415-677-2000 or 800-841-1602 * You can file a request for an appeal any day of the week. Once you speak to
that you contact your insurance to verify which Home Health agencies are covered by your insurance.	someone or leave a message, your appeal has begun. * Ask the hospital if you need help contacting the QIO. * The name of this hospital is Chino Valley Nedical Center. The Provider ID number is 050586.
If you are a Medicare patient review the following message from Medicare about your rights. . DEPARMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services . OMB Approval No. (9938-0692	STEP 2: You will receive a detailed notice from the hospital or your Medicare Advantag or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS AS A HOSPITAL INPATIENT, YOU HAVE THE RIGHT TO: * Receive Medicare covered services. This includes medically necessary hospital	* STEP 3: The QIO will ask for your opinion. You or your representative need to be avail to speak with the QIO, if requested. You or your representative may give the QIO a , written statement, but you are not required to do so.
doctor. You have a right to know about these services, who will pay for them, and where you can get them.	* STEP 4: The QIO will review your medical records and other important information about your case. * STEP 5: The QIO will notify you of its decision within 1 day after it receives all
* Be involved in any decisions about your hospital stay, and know who will pay for it.	necessary information.

ga/Sex: 62 M Attending: Lally, James M. Jnit # M000273781 Account # V00000305742 mitted: 11/19/08 at 2033 Location: MU Status: DIS IN Room/Red: 228-8	Chino Valley Médical	ADEL S Center NUR **LIVE* NT AUDIT FORMAT				Page: 32 of 33 /22/08 at 0926
ntervention Description Sts Dira Activity Occurred Recorded I Type Date Time by Date Time by Comment		Intervention Des Activity Type I	cription Occurred Reco ate Time by Date	rded		From Change
clivity Date: 11/21/08 Time: 2106 (continued)		Activity Date: 1	1/21/08 Time: 21	19		
<pre>tivity Date: 11/21/08 Time: 2106 (continued) * If the D10 finds that you are not ready to be dischar to cover your hospital services. * If the Q10 finds you are ready to be discharged. Med your services until noon of the day after the Q10 noi YOU MISS THE DEADLINE TO APPEAL, YOU HAVE OTHER APPEAL RIGHTS YOU can still ask the Q10 or your plan (if you belong to ane) * If you have Driginal Medicare: Call Q10 listed above. * If you belong to a Medicare Advantage Plan or other N Call your plan. (If you still and discharge date. * nore information. call 1-800-MEDICARE (1-800-633-4227) or TI ditional Information:</pre>	icare will continue to cover tifies you of its decision. 5: for a review of your case: Medicare managed care plan: any services you receive	Ed. Status Car 15000 Car Ed. Status 1 20010 Vir Ed. Status 1 21090 Ro. VI Fd. Status 21400 NU Ed. Status 1 22300 IV Fd. Status 1 31200 Pro 51210 Pro 51210 Pro 31220 Pro 51210 Pro 51220 Pro	: Monitor + 1/21/08:2149 hts 11/21; e Plan: RN Reviee + 1/22/08:2149 hts 11/21; Monitor + 1/22/08:2149 hts 11/21; tine Care: MED/SURA/TC1 W VROTOCU: 1/22/08:2149 hts 11/21; 1/21/08:2149 hts 11/21; 1/21/08:2149 hts 11/21; Dem: Neuroing(cal + 1/21/08:2149 hts 11/21; Dem: ENIT on(calcal) + 1/21/08:2149 hts 11/21; Dem: EENIT at 11/21; Dem: Respiratory + 1/21/08:2149 hts 11/21; 1/21/08:2149 hts 11/21; 1/	V08 2149 hts 0 V08 2149 hts 0 V08 2149 hts 0 ·+ 0 V08 2149 hts 0 ·+ 0 006 2149 hts 0 vclet + 0 006 2149 hts 0 vclet 2149 hts 0	012H (0559.1759) 012H AS ORDERED .END OF SHIFT/TX 05 BY CAREGIVER TNS/REMOVAL/CONVERT 05 & 04H IN TCU 05 & 04H IN TCU 05 & 04H IN TCU	A = 0 $A = 0$ $A = 0$ CP $A = 0$ CP
<pre>ave received a copy of these instructions and they have been i I understand the instructions. :ient/Family Signature:</pre>	explained to me	31260 Pro Ed Status 1 31270 Pro	blem: Musculoskeletal + 1/21/08 2149 hts 11/21/ blem: Gastrointestional 1/21/08 2149 his 11/21/	/08 2149 his + D	QS & Q4H IN ICU QS & Q4H IN ICU	CP A> D CP A> D
CLVN Signature: Da	te:	31280 Pro Ed Status 1	blem: Genitourinary + 1/21/08 2149 bis 11/21/	0 08 2149 hts	QS & Q4H IN ICU	CP A⇔D
** This is Part of Patient's Permanent Medica	1 Record **	- Ed Status I	Dlem: Nutrition + 1/21/08 2149 his 11/21/	'08 2149 his	QS & Q4H IN ICU	CP A => D
Livity Date: 11/21/08 Time 2130 ient Notes: Nurse Notes Create 11/21/08 2130 HPR 11/21/08 2135 HPR Akurana 17 N Contractination N STER BY DR. OH. ORDERS NOTED FOR D/C HOME, DISCHARGE INSTR AND VERBALIZED UNDERSTANDING IN NO APARENT DISTRESS.		- Ed Status 1 60010 Not - Ed Status 1 80010 Edu - Ed Status 1	n: Management Of + 1/21/08 2149 hts 11/21/ 1/5: MO + 1/21/08 2149 hts 11/21/ Cation: Patient/Family T 1/21/08 2149 hts 11/21/ Patient Discharge Inst	08 2149 bis D 08 2149 his eaching + D 08 2149 his	AS NEEDED WHEN NECESSARY QS BY CAREGIVER ON DISCHARGE	CP A ~~ 0 CP A => 0 CP A ~> 0 CP
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AT: B	S NURSAT	Schroer, Anthea T Trinidad, Bienvenido	RN RN								
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PA Pi REI	s Nurspa B Cnabp	Stubbs Pauline A. Bisong Priscilla Fuentes Rosa Elvira	RN CNA CNA								
RM RM S	F CNAFRM V CNANRM	Flores.Rosa Maria Vargas.Rachel M	CNA CNA LVN								
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Diagnosis: <u>4</u> b	0. inbutwhle acute and pain.	dehydater, mariane, depression	duala
Discharge to:		Full Image: Notice of the sector of the se	
Discharge Via: 🔀	Private Auto	ALS Amb. 🗌 BLS Amb. 🔲 Other_	
Allergies:		Allergies: reglan (' Elychme)	
Catheter:	rNone 🛛 Foley 🗌	Condom L Straight Cath PRN	
	None 🗌 Heplock 🗋	Allergies: <u>Peolan (2dychmc)</u> Condom Straight Cath PRN @Cc/hr (No Pota Cardiac Renal Mecha	assium)
Diet:	Regular L ADA L	Cardiac 🗌 Renal 🗌 Mecha	inical
	Low Protein 🖄 Other: <u>//gn/cl</u>	BRP Only D Chair K As Tol	<u>p</u>
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Additional Order:			
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Follow up with:	☐ Primary Physician within	_days for an appointment Di. Agarin	l.
Working Ability:	May return to work on next bus	within days for <u></u> <i>bh_(suge</i> iness day (Work release note written)	26 08
	Return to work on	(Work release note written)	10.00.
	Temporary disability. Length:	Reason:	
	Permanent disability (>12 mo.)	Reason:	
	🕅 N/A		
Ancillary Support	: Home Health; Agency:		
	Hospice; Agency:		
	PT/OT/ST (Eval. & Tx); Agency	· · · · · · · · · · · · · · · · · · ·	
	U Durable medical equipment or	lered (Rx written):	
	区 N/A	_	
		E FWW 3:1 comm	iode
		Chair 🔲 Other	
Patient Education	Becommend Smoking Cessati		
,	Weight Gain +3-5 lbs, <i>Call you</i>	r Doctor.	r Doctor
	Wound Care	pain, SOB, leg swelling, etc.) <i>Call you</i>	Docior.
Rehab Potential:	Good Fair SPool	r 🗆 N/A	
	ly aware of Diagnosis, Prognosis and I		
	Copy K Yes C No		
N	lurse's Signature	A Date Tim	e
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	- Dury Ripol Takhar VU	$\int \frac{1/2}{\text{Date}} Tim$	
Pny	vsician's Signature		<u> </u>
Chino Va	lley Medical Center	ADDRESSOGRAPH	7
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	I DISCHARGE ORDERS	DOB:03/29/46 MR#: M0002	/3781
AND	INSTRUCTIONS		
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Admitted: 11/19/08 at 2033 Room/Bed: 228 B Attending: Lally, James M.

Chino Valley Medical Center

Page: 1 NURRMP Acct: V00000305742 Unit: M000273781

DISCHARGE INSTRUCTIONS 11/21/08 2106 MPR
Please bring this sheet with you to your follow up visit with: DR. AGARWAL AND DR. OH on (Date/Time): NOV. 26, 2008 ** OR ** Call for an appointment before: 11/26/08 Physician's Office Number: (909)621-7647
Call for an appointment before: 11/26/08 Physician's Office Number: (909)621-7647
Discharge Date: 11/21/08 Discharge Time: 2100 Discharge To: HOME - NO NEEDS : By: AUTOMOBILE Via: WHEELCHAIR Accompanied By: SPOUSE
Discharge Comment: DISCHARGE INSTRUCTIONS GIVEN TO PATIENT General Condition on Discharge:
Vital Signs: Temperature/F: 98.4 Respirations: 20 Blood Pressure: 132/82 Pulse: 64
Pain Controlled by Oral Medications: YES
Comment: DENIES PAIN AT THIS TIME
Voiding/Adequate Urinary Drainage: YES
Comment:
Patient Passing Flatus/Stool:
Comment:
wound/Incision Assessment: NONE
Photograph Taken On Discharge and Placed On Chart:
Diabetic: N **IF YES** Follow Up To Be Done By:
The Patient Was Given Instructions in the Following:
Activity: MAY RESUME ALL ACTIVITY Restrictions: Bath: Diet: Calories:
Restrictions:
Additional Education given:
: WORSENING SYMPTOMS :
: MD FOLLOW UP :
: NUTRITION/DIET :
Comment:
Prescriptions/Education given: 🕷 Food/Drug Interaction Form Given: 🕱
List DC Meds and Time next dose is due (if applicable):
: ATENOLOL 50MG BY MOUTH BVERY NIGHT : LEXAPRO 15MG BY MOUTH DAILY (depression) : ZOMIG 2 5MG BY MOUTH AS NEEDED FOR migraine
: ZOMIG 2.5MG BY MOUTH AS NEEDED FOR migraine
: TYLENOL 500MG BY MOUTH TWICE A DAY AS NEEDED FOR FEVER.
Wound/skin care:
Special Instructions: FOLLOW UP APPT. WITH DR. SHAH FOR THICKENING OF SIGMOID
· WALL:
Sent Home With All Belongings: W Personal Belongings Inventory Reviewed/Signed: W
Discharge Instructions Reviewed With: PATTENT Printed Instructions Given: Y
Pneumococcal Vaccine Given: N Date Given:
Discharge Plan: **TO BE COMPLETED BY QRM STAFF ONLY** Home Health: M
Agency Name/Phone #:
Arranged By:
Other:

If you smoke, it is recommended that you quit. Please contact the American Cancer Society - 800-227-2345 or the American Lung Association - 800-LUNGUSA for assistance. If you were treated at this hospital for any respiratory condition, such as pneumonia, it is recommended that you follow up with your primary care physician to be evaluated for a pneumococcal vaccine. If you do not have a primary care physician, please contact the local public health clinic to find out where this vaccine may be available.

Admitted: 11/19/08 at 2033 Room/Bed: 228 B Attending: Lally, James M.

Chino Valley Medical Center

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DISCHARGE INSTRUCTIONS 11/21/08 2106 MPR

SPECIAL INSTRUCTIONS FOR THE CARDIAC/CHF PATIENT:

- A. Patients with congestive heart failure must weigh every morning, record weight, and avoid smoking.
- B. Medication: Know your medications. Don't stop taking your medications or change your dosage unless your doctor tells you to. Keep a list of your current medications. If you have Nitroglycerin, keep it with you at all times.
- C. Activity: Start off slowly, plan your activities and get enough rest.
 - Stop activity if you have any of these signs:
 - Chest discomfort, severe or unusual fatigue, dizziness or faintness, irregular or rapid heartbeat, shortness of breath.
- D. Smoking cessation is recommended. Smoking contributes to medical complications.

E. Call your doctor if:

- * Breathing becomes more difficult, or you have a cough with increased sputum or blood
- * You notice you're getting tired faster
- * Rapid or irregular heartbeat
- * You have dizzy spells or you faint
- * You begin urinating less frequently
- * You think you are having side effects from your medication
- * You have tightness or pain in your chest (Not relieved by Nitroglycerin)
- * If you have a rapid weight gain of 2 pounds in 1 or 2 days or your feet or ankles swell more than usual

Your physician may have recommended that Home Health provide care to you as a part of your discharge. If so, the hospital staff has made this arrangement in your behalf. However, if you would like to change your care to an alternate agency, the following agencies are being provided for your consideration:

- 1. Heartland Home Health: (951) 369-8054
- 2. Visiting Nurses Association: (909) 624-3574
- 3. Sun Plus: (909) 605-7000

If you would like additional resources, you may contact the hospital social services for --for help. Further, if you have an insurance other than Medicare or Medi-Cal, we recommend --that you contact your insurance to verify which Home Health agencies are covered by your insurance.

If you are a Medicare patient review the following message from Medicare about your rights.

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services OMB Approval No. 0938-0692

AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS

- AS A HOSPITAL INPATIENT, YOU HAVE THE RIGHT TO:
 - * Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
 - * Be involved in any decisions about your hospital stay, and know who will pay for it.
 - * Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here: LUMETRA 415-677-2000 or 800-841-1602

YOUR MEDICARE DISCHARGE RIGHTS

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

Admitted: 11/19/08 at 2033 Room/Bed: 228 B Attending: Lally, James M.

Chino Valley Medical Center

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DI CCUARCE INCOMPACTIONS	11/21/08 2106 MPR

IF YOU THINK YOU ARE BEING DISCHARGED TOO SOON:

- * You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- * You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
 - * If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.
 - * If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- * If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- * Step by step instructions for calling the QIO and filing an appeal are below.

-To speak with someone at the hospital about this notice, call the Director Of Nursing.

STEPS TO APPEAL YOUR DISCHARGE

- * STEP 1: You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles). * Here is the contact information for the QIO:

Lumetra One Sansome Street Suite 600 San Francisco 94104-4448 415-677-2000 or 800-841-1602

- * You can file a request for an appeal any day of the week. Once you speak to someone or leave a message, your appeal has begun.
- * Ask the hospital if you need help contacting the QIO.
- * The name of this hospital is Chino Valley Medical Center.
 - The Provider ID number is 050586.
- * STEP 2: You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
- * STEP 3: The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.
- * STEP 4: The QIO will review your medical records and other important information about your case.
- * STEP 5: The QIO will notify you of its decision within 1 day after it receives all . necessary information.
 - * If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
 - * If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

IF YOU MISS THE DEADLINE TO APPEAL, YOU HAVE OTHER APPEAL RIGHTS:

- * You can still ask the QIO or your plan (if you belong to one) for a review of your case: * If you have Original Medicare: Call QIO listed above.
 - * If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- * If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227) or TTY: 1-877-486-2048.

Admitted: 11/19/08 at 2033 Room/Bed: 228 B Attending: Lally, James M.

Chino Valley Medical Center

Page: 4 NURRMP Acct: V00000305742 Unit: M000273781

		DISCHARGE INSTRUCTIONS 11/21/08 2106 MPR
Addition	nal Informati	n:
and I un Patient,	received a co nderstand the /Family Signa Signature: *	ure: x Date: 11 21 08 2130
Monogr	am Initials	Name Nurse Type
MPR	NURRMP	Ragaza, Maureene P. RN

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Ragaza, Maureene P.

RN

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DATE:			CHECK IN TIME:		AM / PM
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PATIENTS SOCIAL S (NUMERO DEL SEG	SECURITY NUMB	·	· · ·	8932	
PATIENT ADDRESS (DOMICILIO DEL PA	CIENTE	<u>3-x 23</u>	8 Mai		
CITY (CIUDAE)) /	Hills	ZIP CODE (CODIGO		1
PATIENT'S TELEPH (TELEFONO DEL PA		109) 60	<u>s6-714</u>	4 Work	ビ
PATIENT COMPLAI	NT: <u> </u>	B. B. DUELE)	dy ache. P	(linery.	x lo
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ER CONTACT: NAM (CONTACTO EN EL DEPT.)	E:Y M a DE EMERGENCIA)	Kalzagua (NOMBRE)	<u>, , , , , , , , , , , , , , , , , , , </u>	9 = 9) 374. (TEL.)	-7216
PHYSICIAN NAME: (NOMBRE DEL DOC	TOR)	Lal	14 101	WITE NUL	VZ
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EMERGENCY DEPARTMENT TRIAGE SIGN-IN	110	PATI	HANNA, ADE 100000305 2008:03/29 2008:11/19 Kachhi, Pr	742 46	
PH\$I-110-005 (7/08)				· • -	

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M.D. ORDERS (Standing and Additional) MARK DONE & TIME MD ORDER CLERK TIME ORDERED TIME General O-Via Nasal Cannula / Mask / Other Ø CBC 435 ĂХ JV Saline Look Botus of BMF Not: _io run at rate of _____ mls / hr CMP 145 Gardiac Monitoring Pulse Ox 767 N UA (total/dip) Pain Protocol Hydromorphone PT/INB Pain Protocol Morphine Dean Protocol Fentanyl A. inal Pain Panel Abylom D Accu./ P.O. Fluid Challenge almylase/Lipas/ 17 Serum Ammonia one char. Part Hunast Pain D. . CCU panel ≫ . \Box Infombolytic panel P FKG EKG #2 Troponin BNP PT/INR/PTT D-dimer Π Sepsis Secsis pane Continue Additional-MD orders Form PHSI 110-003B Serum Laclate Culture LAB: 2050 nvan Blood Vaginal Discharge panel Uring X-RAY: Other Respiratory Peak Flow before/after/predicted 🖸 NL 🛛 Hypoxemia 📋 Corrective Action SAO2% HHN Albulerol 2.5mg/5mg Ipratroplum 0.5mg Cardiac Monitor: 🗆 NSR 🗆 ABNORMAL Racemic Epi 2.25% ABG on ____ EKG: OB/GYN HCG UA Quant BHCC Informed Consent: The patient was apprised of the risks, benefits, alternatives, and Physician's Blood Typ/Rh aims of further management, had no further questions, and wished to proceed. Initials: Procedures: FHT's

 Procedures:
 Digital Block
 ETT Intubation
 NG Tube
 Gastric Lavage

 Cardiovert
 CPR/ACLS
 Splint/Immobilization
 IV
 Disloc/Reduction

 Central Line
 Cerumen Removal,
 Foley
 Epistaxis Control
 Lumbar Puncture

 Chest Tube
 Time Out Performed
 ASA Score
 Sedation

 Frauma/Active Bleeding Hgb/Hci TS/TC x Units Taxicalogy Laceration: Simple D Intermediate D Complex Wound Length ETOH Wound Depth cm Inspection Urine drug screen Acetaminophen/Aspirin Prep Irrigation Medicaation level Suture Type # Anesthesia Digoxin Staples 🛛 # Dermabond Dressing: Dilantin Other Cultures Blood x 1 / 273 Urine / Spulum / Stoo Wound Source Radiology: HAGNOSTIC IMPRESSION CXA (rav 4 多时 Time Accepted Institution Adcepting Pl HCHAR Discharge with After Care Instruction
AMA LWBS
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Expired Transfer وبلح Contla nral/N Other disposition: Vascular Home SNF Convalescent Other Disposition lo Miscellaneous Auto 🗋 Taxi 🗌 EMT 🗖 Other Transportation: Medical Records Ambulatory B. Wheelphall D Gurney D Other Left dept: Calls to, Condition on discharge: 🗆 Good Stable ain 🗆 Serious 🗖 Critical Signature: MSE completed D Supervising Physician Signature ID # Da Dictated No Dictation Required Scoloh EMERGENCY DEPARTMENT HANNA, ADEL ER **PHYSICIAN RECORD /** V00000305742 ₫/62 **ORDER FORM** DOB:03/29/46 DOS:11/19/08 MR# M000273781 110-003 PHSI-110-303A (6/07) WHITE - CHART YELLOW - PHARMACY PINK - E.R. PHYSICIAN GOLD - BILLING

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Documentation & Dictation Guidelines

- Time and Method of Arrival
- Time of first physician contact
- Source of history and competency statement
- Indicate additional or alternative sources of information
- Indicate use of interpreter and identify the interpreter
- CHIEF COMPLAINT/-REASON FOR PRESENTATION/-PRESENT ILLNESS (list if more than one)
- History of Present Illness (be system focused and time & date specific)
- ROS: 10 systems required with 2 elements mentioned from each system for Level 5 State each system that you have inquired about. They are:

Constitutional/Eyes/ENT/CVS/Pulmonary/Gi/GU/Gyne/Musculoskeletal/Skin/Neuro/ Psych/Endocrine/Hematologic/Immunity/

- Personal Family Social
 - o not required for Levels 1,2,3
 - o 3 components are:
 - PMH Family History Social History
 - Mention one element from each area to qualify for level 4 & 5
- Physical Exam
- Management

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- o Investigations (Diagnostics)
 - EKG, X-Ray, Pulse Oximetry, Monitor Strips require a physician order, interpretation, and mention of any treatment or intervention
 - o Intervention & Treatment
- Review of Pre-Hospital Care notes
- Review of Nursing Notes
- Review Previous Medical Records
- INTERVAL NOTES
 - o note time and specifics of each re-exam and change of therapy
- Medical Decision Making
- Procedures
- Diagnostic Impression
- Discharge time and plan
- CRITICAL CARE TIME
 - a time driven code requires minimum of 30 minutes of patient dedicated activity and does not include procedure time

	CHIEF COMI TEMP	O PULSE 70 RESP 20 B/P 161/0000 RA WT. kgs Introversive to Room Reserve via: □ Paramedic/EMT □ Automobile □ Police Patient is □ Ambulatory □ Wheelchair □ Assisted □ Bedridden □ Review Prehosp. Notes □
	 Preferred I 	anguage 🗆 English 🗋 Other Translator 🖾 Yes 🗆 No
	 Other/Add HISTORY 	titional Sources of Medical Information OF PRESENT ILLNESS: (time nature onset, location, severity, duration, quality, modifying factors, associated signs & symptoms, relieves, context)
		SYSTEMS (círcle all positives)
	NEG	NEG
		st: fever chills wt loss fatigue 🕹 appetite diaphoresis 🛛 💭 Musc: bone/joint pain back pain neck pain restricted ROM
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	CV:	
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PHSI-110-003A (6/07) WHITE - CHART

YELLOW - PHARMACY PINK - E.R. PHYSICIAN

Documentation & Dictation Guidelines

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- Personal Family Social
 - o not required for Levels 1,2,3
 - 3 components are:
 - PMH Family History Social History
 - Mention one element from each area to qualify for level 4 & 5
- Physical Exam
- Management
 - Investigations (Diagnostics)
 - EKG, X-Ray, Pulse Oximetry, Monitor Strips require a physician order, interpretation, and mention of any treatment or intervention
 - o Intervention & Treatment
- Review of Pre-Hospital Care notes
- Review of Nursing Notes
- Review Previous Medical Records
- - note time and specifics of each re-exam and change of therapy
- Medical Decision Making
- Procedures
- Diagnostic Impression
- Discharge time and plan
- CRITICAL CARE TIME
 - a time driven code requires minimum of 30 minutes of patient dedicated activity and does not include procedure time

RUN DATE: 11/ RUN TIME: 185 RUN USER: ADD	57	Chino Va Nursing Med	lley Medical ication Admi	Center AL nistration	CM **LIVE n Record	** Form		PAGE 1
Patient Name: Account #:	HANNA, ADEL V00000305742 SHORTNESS OF BREATH	Tr' MA GENERALIZED WE	iage Date: R# : M000273 AKNESS,NOT U	781 RINA	DOB: 0	3/29/46 Age: 62 ED Doctor:	Sex: M	1
Allergies:								
Time	Medication / Dose	/ Route	Initials	Time	Re	esponse	In	itials
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1945 At	Wan Trail	rechar		90K	ðð		Ø	
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Time	IV Solution	Gauge Site	Add i	itive	Rate 1906-05	Infused	Stop Time	Initials
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2100 NS	100 cc	18	3crans U	r asy -	100	ec lust	233	\square
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NJECT SITES: 1-RT ABCOMEN 3.RT UPPER ARM 5.RT BUTTOCK (upper outer quadrant) 7-RT ANTERIOR THIGH 2-LT ABDOMEN 4-LT UPPER ARM 5-LT BUTTOCK (upper outer quadrant) 8-LT ANTERIOR THIGH

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RUN DATE: 11/20/08	Chino Vallev Me	11-19-07 ed Center EDM **LIV	···		PAGE	1
RUN TIME 1155 RUN USER: HIRG	-	tient Record				
atient HANNA, ADEL S ge/Sex 62/M			nt No. V000 it No. M000	ST. 106 S2008-3		
ER Caregivers			Arrival			
Physician Kachhi, Pr Practitioner Nurse Alvarez,St			Triage	Time Date Time	11/19/08	
PCP	-					·
Stated Complaint SMALL BO Chief Complaint SHORTNES						
Priority	Severity	9				
Departure Disposition X Departure Diagnosis A Departure Comment Departure Condition	TR TO INTERNAL ACUI C SBO	TE CARE	Departure		11/19/08 2138	
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5	Asi	lessments				
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Di	ate 11/19/08 Time	1859 User Bacan.	.,Marlene O			
Insurance: BLUE CROSS PI		Patient Age: 0	52 Work	ers Co	mp:	
Insurance: BLUE CROSS PI TRIAGE LEVEL: 2	RUDENT BUYER	Patient Age: 0 Temperature/F: 98	52 Work 3.5	ers Co	mb :	
Insurance: BLUE CROSS PI	RUDENT BUYER	Patient Age: 0 Temperature/F: 9 Source: 01	52 Work 3.5		· - · · · · · · · · · · · · · · · · · ·	<
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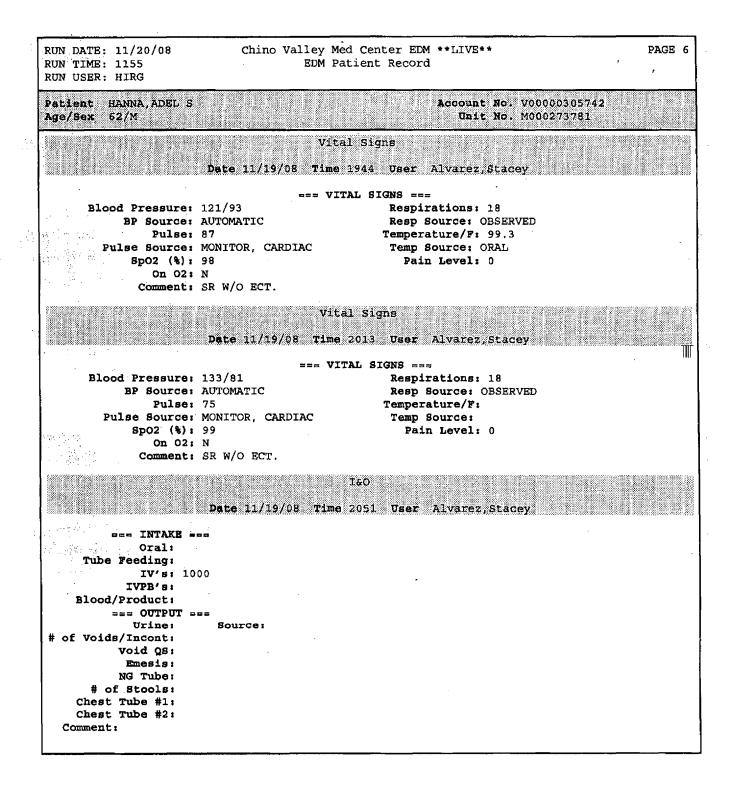
Chino Valley Med Center EDM **LIVE** RUN DATE: 11/20/08 PAGE 2 RUN TIME: 1155 EDM Patient Record RUN USER: HIRG Patient HANNA, ADEL S Account No. V00000305742 Age/Sex 62/M Unit No. M000273781 8. Fearful of Caregiver: 9. Depression: 10. Denial of Injury Ever Occurring: 11. Malnourished Patient: Any YES answer requires documentation of intervention carried out to communicate suspected abuse with charge nurse, ER physician and/or law enforcement, APS or CPS. Personal Belongings List Date 11/19/08 Time 1916 User Diaz, Michael Inventory Date: 11/19/08 Inventory Time: 1916 Performed By: Diaz, Michael Reason For Inventory: ADMISSION (ED STAFF) -N Contacts -Y Glasses Disposition: PATIENT WEARING/TAPED -N Full Dentures Disposition: -N Partial Upper -N Lower Disposition: -N Hearing Aid Disposition: -N Prosthesis Describe: Disposition: -N Assistive Device Disposition: NONE-NO JEWELRY Jewelry: Jewelry: Describe: Describes Disposition: Disposition: Jewelry: Jewelry: Describe: Decribe: Disposition: Disposition: -N Wallet Describe: Disposition: -N Purse Describe: Disposition: Comment: -N Electrical Appliances Describe: -N Eng. Dept Notified To Evaluate Electrical Appliance Other Item(s) Of Value To The Patient: WHITE PANTS, BROWN JACKET, WHITE SHIRT : BLACK SANDALS Disposition: BELONGINGS KEPT BY PT Compared to Previous Belongings List: << RELEASE OF LIABILITY OF VALUABLES KEPT WITH PATIENT >> By Signing Below I Indicate I Have Been Advised To Send My Valuables Home With Family/ Friends, And Have Been Given The Opportunity To Have My Valuables Locked Up. If I Refuse To Have My Valuables Locked Up Or Sent Home With Family Or Friends, I Release Chino Valley Medical Center From Any Liability For Lost Valuables. I Have Also Been Advised To Keep Audio/Video Equipment In My Possession At All Times, And I Understand That The Hospital Assumes No Liability For Such Equipment. PATIENT: Date: WITNESS: By Signing Below I Indicate I Have All My Belongings At The Time Of Discharge. PATIENT: Date: WITNESS:

PAGE 3 RUN DATE: 11/20/08 Chino Valley Med Center EDM **LIVE** RUN TIME: 1155 EDM Patient Record RUN USER: HIRG Patient HANNA, ADEL S Account No. V00000305742 Unit No. M000273781 Age/Sex 62/M ED Assessment Date 11/19/08 Time 1920 User Alvarez, Stacey ====NEUROLOGICAL ASSESSMENT==== NEUROLOGICAL Assessment Within Normal Limits: Y Neuro History: Speech: **Headaches:** Describe: Describe: Behavior/Appearance Inappropriate: == GLASGOW COMA SCORE === (Best Response) == PUPIL REACTION CHECK == Eye Response: Reaction OD: Verbal Response: Size: Motor Response: Reaction OS: Total: Size: === SEIZURE INFORMATION === ⇒cent Seizure Activity: Seizure Precautions Initiated or being Utilized: Duration of Seizure: Seconds Seizure Comment: Additional Neuro Assessment Performed and WNL: Y Memory: Thought Process: Weakness: Specify: Numbness: Specify: Facial Droop; Describe: Neuro Comment: AWAKE, ALERT, & ORIENTED **EXERCISE ASSESSMENT RESPIRATORY Assessment Within Normal Limits:** Y Breath Sounds: Location: Breath Sounds: Location: Effort: Chest Expansion: Cough: Color: ***IF ON OXYGEN*** 02 @: Via: Pulse Oximetry: Sp02 (%): Probe Location: Comment: RESP EVEN & UNLABORED. NO SOB/DYSPNEA/COUGH NOTED PRESENTLY. ====CARDIAC ASSESSMENT===== CARDIAC Assessment Within Normal Limits: N Chest Pain: **Provoked:** Quality: Radiating: Location/Describe: Pain Level: Time/Duration: Heart Rate Irregular: Vertigo/Dizziness: Syncope/Fainting: Pt placed on O2: O2 @: Viat Pt placed on Cardiac Monitor: Y Cardiac Rhythm: NORMAL SINUS RHYTHM Comment: **GASTROINTESTINAL ASSESSMENT** GASTROINTESTINAL Assessment Within Normal Limits: N

RUN DATE: 11/20/08 Chino Valley Med Center EDM **LIVE** PAGE 4 RUN TIME: 1155 EDM Patient Record RUN USER: HIRG Patient HANNA, ADEL S Account No. V00000305742 Unit No. M000273781 Age/Sex 62/M Abdominal Appearance: SOFT/ROUND Abdominal Pain: N Location: Nausea: Y Vomiting: Y Diarrhea: Y Constipation: N GI Bleeding: N Emesis: Rectal: Ostomy: N --Last PO Intake=-Food: Fluid: Comment: C/O VOMITING & DIARRHEA STARTED LAST NOC GI Comment: ====UROLOGICAL ASSESSMENT==== UROLOGY Assessment Within Normal Limits: N Pain/Dysuria: Burning: Frequency: Incontinence: Hematuria: Retention: Anuria: Y Foley Cath PTA: Comment: PT STS, " NO URINE OUTPUT IN 2 DAYS". ====GYNECOLOGICAL ASSESSMENT==== GYNECOLOGICAL Assessment Within Normal Limits: LMP : EDC : Gestation Weeks: Days: SAB: Gravida: Para: TAB: Vaginal Bleeding: Tissue Passed: # of Pads Last Hour: Vaginal Discharge: Malodorous: Pelvic Pain: Describe: Comment: ----SKIN ASSESSMENT SKIN Assessment Within Normal Limits: Y Skin Color: Skin Moisture: Skin Temperature: Turgor: Skin Integrity: Rash: Type/Describe: Comment: ====NEUROVASCULAR ASSESSMENT==== NEUROVASCULAR Assessment Within Normal Limits: Y RA Within Normal Limits: Temp: Pulse: Sensation: Mobility: LA Within Normal Limits: Temp: Pulse: Sensation: Mobility: RL Within Normal Limits: Pulse: Sensation: Mobility: Temp:

Patient HANNA, ADEL S			No. V00000305742	
Age/Sex 62/M		Unit	No. M000273781	
LL Within Normal Limits		Connection.		
Temp: Comment:	Pulse:	Sensation:	Mobility:	
====EYE ASSESSMENT====				
EYE Assessment Within N	formal Limits: Y			
Visual Acuity OD:	08:			
Pain: Location:	Pain Lev Location:	vel:		
Foreign Body: Redness:	Location:			
Drainage:				
Cataract:	Location: Location:			
Glasses:				
Contact Lenses:				
Blind: Comment:				
====EAR ASSESSMENT=====				
AR Assessment Within N	formal Limits Y			
Pain: Locati	.on: Pa	in Scale:		
Discharge: Locati				
Foreign Body: Locati	.01:			r i
Hearing Aid: Locati Tinnitus:	.OD:			
Comment:				
====NOSE ASSESSMENT	,			
NOSE Assessment Within				L.
Pain: :				
Foreign Body: : Deformity: :				
Drainage: :				
Nasal Packing: :				
Comment:				
-		I&O me 1935 User Alvarez,	Stacey	
=== INTAKE === Oral:	1			
Tube Feeding:				
IV's: 5				
IVPB's:				
Blood/Product:				
OUTPUT Urine:	Source:			
# of Voids/Incont:	POUTOGI			
Void QS:				
Emesis:				
NG Tube:				
# of Stools:				
Chest Tube #1; Chest Tube #2;				
Comment:				

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RUN DATE: 11/20/08 RUN TIME: 1155 RUN USER: HIRG	-	Med Center EDM * Patient Record	*LIVE**	PAGE 7
Patient HANNA, ADEL S Age/Sex 62/M		A	ccount No. V00000 Unit No. M00027	
	V Date 11/19/08 Ti	itel Signs me 2052 User Al	varez,Stacey	
		VITAL SIGNS ===		
Blood Pressure: BP Source: Pulse:	116/90 AUTOMATIC 98	Respirat Resp Sou Temperatu	rce: OBSERVED	
Sp02 (%): On 02:		Temp Sou Pain L	rce: ,evel: 0	
		ital Signs me 2130 User Al	varez, Stadey	
	===	VITAL SIGNS ===		
Blood Pressure:	105/82		ions: 18	
BP Source:		· =	Irce: OBSERVED	
Pulse: Fulse Source:	MONITOR, CARDIAC	Temperatu Temp Sou		
Sp02 (%):	99	•	evel: 0	· ·
On O2: Comment:	N ST W/O ECT			· · · · ·
		D Discharge me 2138 User Al	varez,Stacey	
	====DISCHAR	GE/DISPOSITION===		
Home: N		Admit/Transfer		
Time: Accompanied By:		Dispos	Time: 2143 sition: ADMIT	
Mode:			/Room: 228	
=ftercare Instruction		Accompan	ied By: NURSE	
Pt Verbalizes Unders	tanding:	Penort Cal	Mode: GURNEY	
		gings Sent With F	Patient: Y	
Blood Broggerros 105 (9)		ngings Sent with	- · · · · · · · · · · · · · · · · · · ·	8002 (%) • 00
Blood Pressure: 105/8 Pain Level: 0	Condition on Dis		Jeracure/Mi 33.3	6944 (V) 77
	OR TRANSPORT. IV NS ENT TO FLOOR WITH E	TKO LT HAND, SIT T. SPOUSE ACCOMPA		
FLOOR, PT TR	ANS BY D. LOPEZ, RM	I.		
				·

RUN DATE: 11/20/08Chino Valley Med Center EDM **LIVE**RUN TIME: 1155EDM Patient RecordRUN USER: HIRG	PAGE
Pstient HANNA, ADEL S Account No. V000 Age/Sex 52/M Unit No. M000	
Patient Notes	
Alvarez, Stacey - 11/19/08 - 1910 DR KACHHI AT BEDSIDE FOR EXAM. 12 LEAD EKG COMPLETED BY M. DIAZ, EMT. DR KACHHI.	RESULT TO
Alvarcz,Stacey - 11/19/08 - 1920 BLOOD DRAWN BY JOHN, PHLEBOTOMIST.	
Alvarez, Stacey - 11/19/08 - 1925 PT TRANS TO CT VIA GUERNEY WITH JIM, CT TECH.	
Alvarez, Staccy - 11/19/08 - 1931 RETURNED FROM CT. PCXR COMPLETED AT BEDSIDE BY XRT.	
Alvaroz, Stacey 11/19/08 - 1935 SALINE LOCK STARTED WITH GOOD BLOOD RETURN NOTED. IV FLUSHED WITH 5 ML TAPED SECURELY IN PLACE. NS BOLUS STARTED VIA PUMP PER ORDERS. PT TOLE WELL. SITE CLEAR. SPOUSE REMAINS AT BEDSIDE. PILLOW GIVEN, LIGHTS DIMM COMFORT.	RATED
Alvarez, Stacey 11/19/08 - 1944 MEDICATED WITH ZOFRAN & ATIVAN IVP BY D. LOPEZ, RN.	
Alvarez, Stacey - 11/19/08 - 2005 PT RE-EVAL'D BY DR KACHHI.	
Alvarez, Stacey 11/19/08 - 2013 PT REQUEST TO " MAKE PHONE CALLS BEFORE INSERTING NG TUBE". PT ALLOWEI	PRIVACY.
Serpas, Ulises 11/19/08 - 2021 **PLEASE ENTER FULL NAMES OF LVN/RN**	
Patient data collected by (LVN):STACEY ALVAREZ Assessment reviewed and completed by (RN): JOHN DEL VALLE	
Alvarez, Stacey - 11/19/08 - 2035 MRSA PROTOCOL EXPLAINED TO PT & SPOUSE. NASAL SWAB OBTAINED PER PROTOC SPECIMEN SENT TO LAB PER ORDERS.	COL.
Alvarez, Stacey 11/19/08 2040 ATTEMPTED TO INSERT NG TUBE INTO LT NARE. MIN BLEEDING NOTED. PT COUGH REQUESTED TUBE TO BE REMOVED. TUBE DC'D PER REQUEST. PT REQUESTING " SOMETHING". STS, " MY THROAT IS VERY SENSITIVE". DR KACHHI INFORMED.	
Alvarez, Stacey - 11/19/08 - 2050 PT MEDICATED WITH ATIVAN IVP BY D. LOPEZ, RN	
Alvarez, Stacey - 11/19/08 - 2059 RESIDENT & MED STUDENT AT BEDSIDE FOR EXAM.	

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RUN DATE: 11/20/08Chino Valley Med Center EDM **LIVE**RUN TIME: 1155EDM Patient RecordRUN USER: HIRG	PAGE 9
Patient HANNA, ADEL S Account No. V00000305742 Age/Sex 62/M Unit No. M000273781	
Alvarez, Stacey - 11/19/08 - 2059 REPORT CALLED TO M/S. SPOKE WITH BEN, RN.	
Alvarez, Stacey - 11/19/08 - 2100 MEDICATED WITH UNASYN IVPB BY J. DEL VALLE, RN.	
Alvarez, Stacey - 11/19/08 - 2120 NG TUBE INSERTED INTO LT NARE W/O DIFF. PT STILL ANXIOUS BUT DECREASED SINCE ATIVAN GIVEN. SPOUSE REMAINS AT BEDSIDE. TUBE AUSCULTATED & ASPIRATED PLACEMENT. YELLOW GASTRIC SECRETIONS ASPIRATED. NG TUBE TO LOW WALL SUCTION.	
Alvarez, Stacey - 11/19/08 - 2136 LINDA, XRT AT BEDSIDE FOR PKUB FOR TUBE PLACEMENT.	
Alvarez, Stacey - 11/19/03 - 2138 PT TRANS TO M/S RM 228 AWAKE, ALERT, & ORIENTED VIA GUERNEY. RESP EVEN & UNLABORED. NO SOB/DYSPNEA/COUGH NOTED PRESENTLY. NG TUBE INTACT LT NARE CLAMPED FOR TRANSPORT. IV NS TKO INTO LT HAND. SITE CLEAR. ALL BELONGINGS SENT WITH PT TO FLOOR. SPOUSE ACCOMPANIED PT TO FLOOR. PT TRANS BY D. LOPEZ, RN	. ·
Treatments	
IV Management Date 11/19/08 Time 1935 User Alvarez,Stacey	
====IV MANAGEMENT==== IV ESTABLISHED PTA: N	
Established Date: 11/19/08 IV Location: LT HAND Catheter Size (ga.): 18 IV Location: Catheter Size (ga.): Catheter Size (ga.): Discontinued Time: Anglocath Intact: IV Converted to Saline Lock: Comment: X 1 ATTEMPT	
NG Tube Date 11/19/08 Time 2120 User Alvarez,Stacey	
====NASOGASTRIC TUBE==== Nasogastric Tube Inserted: Y Nares: LT NGT Size: 16F Time: 2120 # Attempts: 2 Difficult Insertion: N	
Epigastric Auscultation: Y X-Ray to Verify Placement: Y Nasgastric Tube Discontinued: Time: Comment: XR CALLED FOR TUBE PLACEMENT FILMS BY M. ESPINOZA, MT.	

RUN TIME: RUN USER:	1155	/08 Chino Valley Med Cer EDM Patient		PAGI
Patient H Age/Sex 6	10005 (Constant Consta	ADEL S	Account No. V Unit No. M	NG 1977 COMPANY AND
· <u></u>		Ordei	:8	
Date T	ime	Procedure	Orderin	g Provider
11/19/08 1			Kachhi,	
		BASIC METABOLIC PROFILE	Kachhi,	
11/19/08 1			Kachhi,	
		CHOLESTEROL	Kachhi,	
11/19/08 1	918	CKMB CARDIAC TEST	-	Pranav
11/19/08 1	918	CREATINE KINASE (CK)		Pranav
		CT ABDOMEN+PELVIS W/O CON		Pranav
11/19/08 1	918	ELECTROCARDIOGRAM		Pranav
		HDL CHOLESTEROL	•	Pranav
		HEPATIC FUNCTION PROFILE		Pranav
		LACTIC DEHYDROGENASE (LDH)		Pranav
11/19/08 1			-	Pranav
		MYOGLOBIN BLOOD		Pranav
11/19/08 1	918	PARTIAL THROMBOPLASTIN TIME		Pranav
		PROTHROMBIN TIME		Pranav
		TROPONIN I		Pranav
11/19/08 1	1918	XR CHEST: 1V (AP/PA)	Kachni,	Pranav
•				
Date	Time	Test	Result	Reference
11/19/08	1920	ALBUMIN	3.7	Reference 3.4-5.0 g/dL
11/19/08 11/19/08	1920 1920	ALBUMIN ALKALINE PHOSPHATASE		
11/19/08 11/19/08 11/19/08	1920 1920 1920	ALBUMIN ALKALINE PHOSPHATASE ALT/SGPT	3.7 42 L 33	3.4-5.0 g/dL 50-136 U/L 30-65 U/L
11/19/08 11/19/08 11/19/08 11/19/08	1920 1920 1920 1920 1920	ALBUMIN ALKALINE PHOSPHATASE ALT/SGPT AMYLASE	3.7 42 L 33 28	3.4-5.0 g/dL 50-136 U/L 30-65 U/L 25-115 U/L
11/19/08 11/19/08 11/19/08 11/19/08 11/19/08	1920 1920 1920 1920 1920	ALBUMIN ALKALINE PHOSPHATASE ALT/SGPT AMYLASE AST/SGOT	3.7 42 L 33 28 13 L	3.4-5.0 g/dL 50-136 U/L 30-65 U/L 25-115 U/L 15-37 U/L
11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08	1920 1920 1920 1920 1920 1920	ALBUMIN ALKALINE PHOSPHATASE ALT/SGPT AMYLASE AST/SGOT BASOPHIL #	3.7 42 L 33 28 13 L 0.0	3.4-5.0 g/dL 50-136 U/L 30-65 U/L 25-115 U/L 15-37 U/L 0-0.2 10^3/ul
11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08	1920 1920 1920 1920 1920 1920 1920	ALBUMIN ALKALINE PHOSPHATASE ALT/SGPT AMYLASE AST/SGOT BASOPHIL # BASOPHIL %	3.7 42 L 33 28 13 L 0.0 0.7	3.4-5.0 g/dL 50-136 U/L 30-65 U/L 25-115 U/L 15-37 U/L 0-0.2 10^3/ul 0-2 %
11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08	1920 1920 1920 1920 1920 1920 1920 1920	ALBUMIN ALKALINE PHOSPHATASE ALT/SGPT AMYLASE AST/SGOT BASOPHIL # BASOPHIL * BILIRUBIN DIRECT	3.7 42 L 33 28 13 L 0.0 0.7 0.16	3.4-5.0 g/dL 50-136 U/L 30-65 U/L 25-115 U/L 15-37 U/L 0-0.2 10^3/ul 0-2 % 0.0-0.5 mg/dL
11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08	1920 1920 1920 1920 1920 1920 1920 1920	ALBUMIN ALKALINE PHOSPHATASE ALT/SGPT AMYLASE AST/SGOT BASOPHIL # BASOPHIL * BILIRUBIN DIRECT BILIRUBIN TOTAL	3.7 42 L 33 28 13 L 0.0 0.7 0.16 0.54	3.4-5.0 g/dL 50-136 U/L 30-65 U/L 25-115 U/L 15-37 U/L 0-0.2 10^3/ul 0-2 % 0.0-0.5 mg/dL 0.2-1.1 mg/dL
11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08	1920 1920 1920 1920 1920 1920 1920 1920	ALBUMIN ALKALINE PHOSPHATASE ALT/SGPT AMYLASE AST/SGOT BASOPHIL # BASOPHIL * BILIRUBIN DIRECT BILIRUBIN TOTAL BLOOD UREA NITROGEN	3.7 42 L 33 28 13 L 0.0 0.7 0.16 0.54 22.0 H	3.4-5.0 g/dL 50-136 U/L 30-65 U/L 25-115 U/L 15-37 U/L 0-0.2 10^3/ul 0-2 % 0.0-0.5 mg/dL 0.2-1.1 mg/dL 7.0-18.0 mg/dL
11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08	1920 1920 1920 1920 1920 1920 1920 1920	ALBUMIN ALKALINE PHOSPHATASE ALT/SGPT AMYLASE AST/SGOT BASOPHIL # BASOPHIL * BILIRUBIN DIRECT BILIRUBIN TOTAL BLOOD UREA NITROGEN CALCIUM	3.7 42 L 33 28 13 L 0.0 0.7 0.16 0.54 22.0 H 8.4 L	3.4-5.0 g/dL 50-136 U/L 30-65 U/L 25-115 U/L 15-37 U/L 0-0.2 10^3/ul 0-2 % 0.0-0.5 mg/dL 0.2-1.1 mg/dL 7.0-18.0 mg/dL 8.8-10.5 mg/dL
11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08	1920 1920 1920 1920 1920 1920 1920 1920	ALBUMIN ALKALINE PHOSPHATASE ALT/SGPT AMYLASE AST/SGOT BASOPHIL # BASOPHIL * BILIRUBIN DIRECT BILIRUBIN TOTAL BLOOD UREA NITROGEN CALCIUM CARBON DIOXIDE	3.7 42 L 33 28 13 L 0.0 0.7 0.16 0.54 22.0 H 8.4 L 25.4	3.4-5.0 g/dL 50-136 U/L 30-65 U/L 25-115 U/L 15-37 U/L 0-0.2 10 ³ /ul 0-2 % 0.0-0.5 mg/dL 0.2-1.1 mg/dL 7.0-18.0 mg/dL 8.8-10.5 mg/dL 21-34 mmol/L
11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08	1920 1920 1920 1920 1920 1920 1920 1920	ALBUMIN ALKALINE PHOSPHATASE ALT/SGPT AMYLASE AST/SGOT BASOPHIL # BASOPHIL * BILIRUBIN DIRECT BILIRUBIN TOTAL BLOOD UREA NITROGEN CALCIUM CARBON DIOXIDE CHLORIDE SERUM	3.7 42 L 33 28 13 L 0.0 0.7 0.16 0.54 22.0 H 8.4 L 25.4 102	3.4-5.0 g/dL 50-136 U/L 30-65 U/L 25-115 U/L 15-37 U/L 0-0.2 10^3/ul 0-2 % 0.0-0.5 mg/dL 0.2-1.1 mg/dL 7.0-18.0 mg/dL 8.8-10.5 mg/dL 21-34 mmol/L 98-108 mmol/L
11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08	1920 1920 1920 1920 1920 1920 1920 1920	ALBUMIN ALKALINE PHOSPHATASE ALT/SGPT AMYLASE AST/SGOT BASOPHIL # BASOPHIL * BILIRUBIN DIRECT BILIRUBIN TOTAL BLOOD UREA NITROGEN CALCIUM CARBON DIOXIDE CHLORIDE SERUM CHOLESTEROL	3.7 42 L 33 28 13 L 0.0 0.7 0.16 0.54 22.0 H 8.4 L 25.4 102 110 L	3.4-5.0 g/dL 50-136 U/L 30-65 U/L 25-115 U/L 15-37 U/L 0-0.2 10^3/ul 0-2 % 0.0-0.5 mg/dL 0.2-1.1 mg/dL 7.0-18.0 mg/dL 8.8-10.5 mg/dL 21-34 mmol/L 98-108 mmol/L 135-200 mg/dL
11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08	1920 1920 1920 1920 1920 1920 1920 1920	ALBUMIN ALKALINE PHOSPHATASE ALT/SGPT AMYLASE AST/SGOT BASOPHIL # BASOPHIL * BILIRUBIN DIRECT BILIRUBIN TOTAL BLOOD UREA NITROGEN CALCIUM CARBON DIOXIDE CHLORIDE SERUM CHOLESTEROL CKMB TEST FOR CARDIAC	3.7 42 L 33 28 13 L 0.0 0.7 0.16 0.54 22.0 H 8.4 L 25.4 102 110 L 1.2	3.4-5.0 g/dL 50-136 U/L 30-65 U/L 25-115 U/L 15-37 U/L 0-0.2 10 ³ /ul 0-2 % 0.0-0.5 mg/dL 0.2-1.1 mg/dL 7.0-18.0 mg/dL 8.8-10.5 mg/dL 21-34 mmol/L 98-108 mmol/L 135-200 mg/dL 0-5.0 ng/mL
11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08	1920 1920 1920 1920 1920 1920 1920 1920	ALBUMIN ALKALINE PHOSPHATASE ALT/SGPT AMYLASE AST/SGOT BASOPHIL # BASOPHIL * BILIRUBIN DIRECT BILIRUBIN TOTAL BLOOD UREA NITROGEN CALCIUM CARBON DIOXIDE CHLORIDE SERUM CHOLESTEROL CKMB TEST FOR CARDIAC CKMBI	3.7 42 L 33 28 13 L 0.0 0.7 0.16 0.54 22.0 H 8.4 L 25.4 102 110 L 1.2 Test not performed	3.4-5.0 g/dL 50-136 U/L 30-65 U/L 25-115 U/L 15-37 U/L 0-0.2 10 ³ /ul 0-2 % 0.0-0.5 mg/dL 0.2-1.1 mg/dL 7.0-18.0 mg/dL 8.8-10.5 mg/dL 21-34 mmol/L 98-108 mmol/L 135-200 mg/dL 0-5.0 ng/mL 0-2.5 %
11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08	1920 1920 1920 1920 1920 1920 1920 1920	ALBUMIN ALKALINE PHOSPHATASE ALT/SGPT AMYLASE AST/SGOT BASOPHIL # BASOPHIL # BASOPHIL * BILIRUBIN DIRECT BILIRUBIN TOTAL BLOOD UREA NITROGEN CALCIUM CARBON DIOXIDE CHLORIDE SERUM CHOLESTEROL CKMB TEST FOR CARDIAC CKMBI CREATINE KINASE (CK)	3.7 42 L 33 28 13 L 0.0 0.7 0.16 0.54 22.0 H 8.4 L 25.4 102 110 L 1.2 Test not performed 38	3.4-5.0 g/dL 50-136 U/L 30-65 U/L 25-115 U/L 15-37 U/L 0-0.2 10^3/ul 0-2 % 0.0-0.5 mg/dL 0.2-1.1 mg/dL 7.0-18.0 mg/dL 21-34 mmol/L 98-108 mmol/L 135-200 mg/dL 0-5.0 ng/mL 0-2.5 % 21-232 U/L
11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08	1920 1920 1920 1920 1920 1920 1920 1920	ALBUMIN ALKALINE PHOSPHATASE ALT/SGPT AMYLASE AST/SGOT BASOPHIL # BASOPHIL # BASOPHIL % BILIRUBIN DIRECT BILIRUBIN TOTAL BLOOD UREA NITROGEN CALCIUM CARBON DIOXIDE CHLORIDE SERUM CHOLESTEROL CKMB TEST FOR CARDIAC CKMBI CREATINE KINASE (CK) CREATININE SERUM	3.7 42 L 33 28 13 L 0.0 0.7 0.16 0.54 22.0 H 8.4 L 25.4 102 110 L 1.2 Test not performed 38 0.94	3.4-5.0 g/dL 50-136 U/L 30-65 U/L 25-115 U/L 15-37 U/L 0-0.2 10^3/ul 0-2 % 0.0-0.5 mg/dL 0.2-1.1 mg/dL 7.0-18.0 mg/dL 21-34 mmol/L 98-108 mmol/L 135-200 mg/dL 0-5.0 ng/mL 0-2.5 % 21-232 U/L 0.5-1.4 mg/dL
11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08	1920 1920 1920 1920 1920 1920 1920 1920	ALBUMIN ALKALINE PHOSPHATASE ALT/SGPT AMYLASE AST/SGOT BASOPHIL # BASOPHIL # BILIRUBIN DIRECT BILIRUBIN TOTAL BLOOD UREA NITROGEN CALCIUM CARBON DIOXIDE CHLORIDE SERUM CHOLESTEROL CKMB TEST FOR CARDIAC CKMBI CREATINE KINASE (CK) CREATININE SERUM EOSINOPHIL %	3.7 42 L 33 28 13 L 0.0 0.7 0.16 0.54 22.0 H 8.4 L 25.4 102 110 L 1.2 Test not performed 38 0.94 3.8	3.4-5.0 g/dL 50-136 U/L 30-65 U/L 25-115 U/L 15-37 U/L 0-0.2 10^3/ul 0-2 % 0.0-0.5 mg/dL 0.2-1.1 mg/dL 7.0-18.0 mg/dL 8.8-10.5 mg/dL 21-34 mmol/L 135-200 mg/dL 0-5.0 ng/mL 0-2.5 % 21-232 U/L 0.5-1.4 mg/dL 0.0-11.0 %
11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08	1920 1920 1920 1920 1920 1920 1920 1920	ALBUMIN ALKALINE PHOSPHATASE ALT/SGPT AMYLASE AST/SGOT BASOPHIL # BASOPHIL # BASOPHIL * BILIRUBIN DIRECT BILIRUBIN TOTAL BLOOD UREA NITROGEN CALCIUM CARBON DIOXIDE CHLORIDE SERUM CARBON DIOXIDE CHLORIDE SERUM CHOLESTEROL CKMB TEST FOR CARDIAC CKMBI CREATINE KINASE (CK) CREATININE SERUM EOSINOPHIL * EOSINOPHILS #	3.7 42 L 33 28 13 L 0.0 0.7 0.16 0.54 22.0 H 8.4 L 25.4 102 110 L 1.2 Test not performed 38 0.94 3.8 0.2	3.4-5.0 g/dL 50-136 U/L 30-65 U/L 25-115 U/L 15-37 U/L 0-0.2 10 ³ /ul 0-2 % 0.0-0.5 mg/dL 0.2-1.1 mg/dL 7.0-18.0 mg/dL 8.8-10.5 mg/dL 21-34 mmol/L 135-200 mg/dL 0-5.0 ng/mL 0-2.5 % 21-232 U/L 0.5-1.4 mg/dL 0.0-11.0 % 0-0.5 10 ³ /uL
11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08 11/19/08	1920 1920 1920 1920 1920 1920 1920 1920	ALBUMIN ALKALINE PHOSPHATASE ALT/SGPT AMYLASE AST/SGOT BASOPHIL # BASOPHIL # BASOPHIL * BILIRUBIN DIRECT BILIRUBIN TOTAL BLOOD UREA NITROGEN CALCIUM CARBON DIOXIDE CHLORIDE SERUM CARBON DIOXIDE CHLORIDE SERUM CHOLESTEROL CKMB TEST FOR CARDIAC CKMBI CREATINE KINASE (CK) CREATININE SERUM EOSINOPHIL * EOSINOPHILS # ESTIMATED GFR AFRICAN AMERICAN	3.7 42 L 33 28 13 L 0.0 0.7 0.16 0.54 22.0 H 8.4 L 25.4 102 110 L 1.2 Test not performed 38 0.94 3.8 0.2 > 60	3.4-5.0 g/dL 50-136 U/L 30-65 U/L 25-115 U/L 15-37 U/L 0-0.2 10 ³ /ul 0-2 % 0.0-0.5 mg/dL 0.2-1.1 mg/dL 7.0-18.0 mg/dL 8.8-10.5 mg/dL 21-34 mmol/L 98-108 mmol/L 135-200 mg/dL 0-5.0 ng/mL 0-2.5 % 21-232 U/L 0.5-1.4 mg/dL 0.0-11.0 % 0-0.5 10 ³ /uL ml/min
11/19/08 11/19/08	1920 1920 1920 1920 1920 1920 1920 1920	ALBUMIN ALKALINE PHOSPHATASE ALT/SGPT AMYLASE AST/SGOT BASOPHIL # BASOPHIL # BASOPHIL * BILIRUBIN DIRECT BILIRUBIN TOTAL BLOOD UREA NITROGEN CALCIUM CARBON DIOXIDE CHLORIDE SERUM CARBON DIOXIDE CHLORIDE SERUM CHOLESTEROL CKMB TEST FOR CARDIAC CKMBI CREATINE KINASE (CK) CREATININE SERUM EOSINOPHIL * EOSINOPHIL * EOSINOPHILS # ESTIMATED GFR AFRICAN AMERICAN ESTIMATED GFR NON AFRI-AMERI	3.7 42 L 33 28 13 L 0.0 0.7 0.16 0.54 22.0 H 8.4 L 25.4 102 110 L 1.2 Test not performed 38 0.94 3.8 0.2 > 60 > 60	3.4-5.0 g/dL 50-136 U/L 30-65 U/L 25-115 U/L 15-37 U/L 0-0.2 10 ³ /ul 0-2 % 0.0-0.5 mg/dL 0.2-1.1 mg/dL 7.0-18.0 mg/dL 8.8-10.5 mg/dL 21-34 mmol/L 98-108 mmol/L 135-200 mg/dL 0-5.0 ng/mL 0-2.5 % 21-232 U/L 0.5-1.4 mg/dL 0.0-11.0 % 0-0.5 10 ³ /uL ml/min ml/min
11/19/08 11/19/08	1920 1920 1920 1920 1920 1920 1920 1920	ALBUMIN ALKALINE PHOSPHATASE ALT/SGPT AMYLASE AST/SGOT BASOPHIL # BASOPHIL # BASOPHIL * BILIRUBIN DIRECT BILIRUBIN TOTAL BLOOD UREA NITROGEN CALCIUM CARBON DIOXIDE CHLORIDE SERUM CARBON DIOXIDE CHLORIDE SERUM CHOLESTEROL CKMB TEST FOR CARDIAC CKMBI CREATINE KINASE (CK) CREATININE SERUM EOSINOPHIL * EOSINOPHIL * EOSINOPHILS # ESTIMATED GFR AFRICAN AMERICAN ESTIMATED GFR NON AFRI-AMERI GLUCOSE SERUM	3.7 42 L 33 28 13 L 0.0 0.7 0.16 0.54 22.0 H 8.4 L 25.4 102 110 L 1.2 Test not performed 38 0.94 3.8 0.2 > 60 > 60 104	3.4-5.0 g/dL 50-136 U/L 30-65 U/L 25-115 U/L 15-37 U/L 0-0.2 10 ³ /ul 0-2 % 0.0-0.5 mg/dL 0.2-1.1 mg/dL 7.0-18.0 mg/dL 21-34 mmol/L 98-108 mmol/L 135-200 mg/dL 0-5.0 ng/mL 0-2.5 % 21-232 U/L 0.5-1.4 mg/dL 0.0-11.0 % 0-0.5 10 ³ /uL ml/min ml/min 71-117 mg/dL
11/19/08 11/19/08	1920 1920 1920 1920 1920 1920 1920 1920	ALBUMIN ALKALINE PHOSPHATASE ALT/SGPT AMYLASE AST/SGOT BASOPHIL # BASOPHIL # BASOPHIL * BILIRUBIN DIRECT BILIRUBIN TOTAL BLOOD UREA NITROGEN CALCIUM CARBON DIOXIDE CHLORIDE SERUM CHOLESTEROL CKMBI CREATINE KINASE (CK) CREATININE SERUM EOSINOPHIL * EOSINOPHIL * EOSINOPHILS # ESTIMATED GFR AFRICAN AMERICAN ESTIMATED GFR NON AFRI-AMERI GLUCOSE SERUM HDL CHOLESTEROL	3.7 42 L 33 28 13 L 0.0 0.7 0.16 0.54 22.0 H 8.4 L 25.4 102 110 L 1.2 Test not performed 38 0.94 3.8 0.2 > 60 > 60	3.4-5.0 g/dL 50-136 U/L 30-65 U/L 25-115 U/L 15-37 U/L 0-0.2 10 ³ /ul 0-2 % 0.0-0.5 mg/dL 0.2-1.1 mg/dL 7.0-18.0 mg/dL 8.8-10.5 mg/dL 21-34 mmol/L 98-108 mmol/L 135-200 mg/dL 0-5.0 ng/mL 0-2.5 % 21-232 U/L 0.5-1.4 mg/dL 0.0-11.0 % 0-0.5 10 ³ /uL ml/min ml/min

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RUN DATE: 1 RUN TIME: 1 RUN USER: H	155		Center EDM **LIVE** ent Record	PAGE 11
atient HA ge/Sex 62		DEL S		V00000305742 M000273781
		INTERNATIONAL NORMAL RATIO	1.13	0-3.0
1/19/08 1	920	LACTIC DEHYDROGENASE (LDH)	110	100-190 U/L
• . • .	920 -	LIPASE	180	114-286 U/L
		LYMPHOCYTE #	1.4	1.0-4.8 10 ³ /ul
		LYMPHOCYTE %	31.5	25-45 %
		MANUAL DIFF REQUIRED?	NO	
		MEAN CELL HGB CONCENTRATION	34	32-37 pg
· · · ·		MEAN CELL HGB	28	27-31 pg
• •		MEAN CELL VOLUME	83	80-99 fl
		MEAN PLT VOLUME	10.0	7.4-10.4 fl
• • • - • •		MONOCYTE #	0.4	0-0.8 10 ³ /ul
		MONOCYTE %	8.7	2.5-10.0 %
		MYOGLOBIN BLOOD	37.0	12-110 ng/mL
		NEUTROPHIL %	55.3	40-70 %
		NEUTROPHIL	2.5	1.8-7.7 10 ³ /uL
		PARTIAL THROMBOPLASTIN TIME	29.0	21.7-33.9 sec
	1920	PLATELET COUNT	177	130-400 x10^3mcL
	L920	POTASSIUM SERUM	3.6	3.5-5.1 mmol/L
	L920	PROTHROMBIN TIME PATIENT	12,1	10.1-12.8 sec
			5.51	4.52-5.90 M/mm3
		RED CELL DISTRIBUTION WIDTH	14.3	11.5-14.5 %
11/19/08 1	L920	SODIUM SERUM	136	135-148 mmol/L
	L920	TOTAL PROTEIN SERUM	7.5	6.3-8.2 g/dL
		TROPONIN I	0.06	<1.4 ng/mL
11/19/08 1	L920	WHITE BLOOD CELL	4.5	4.5-11.0 K/mm3
Date	Time		y Results Result Code	
11/19/2008	1918	CT-ABDOMEN+PELVIS W/O CON	ſ	
	Imp	ression:		
	-	ression:		
		Findings consistent with smal	1 bowel obstruction w:	ith a transition
		it in the right mid abdomen.		
	2.	~		
		Normal appendix is identified		
	3. 4.	Tiny nonspecific free pelvic		
	3. 4. 5.		n in the sigmoid color	n without CT
11/19/2008	3. 4. 5. evic	Tiny nonspecific free pelvic Scattered diverticula are see dence for acute diverticulitis	n in the sigmoid color	n without CT
11/19/2008	3. 4. 5. evic 1918 Impr	Tiny nonspecific free pelvic Scattered diverticula are see dence for acute diverticulitis XR CHEST: 1V (AP/PA) cession:	n in the sigmoid color	n without CT
11/19/2008	3. 4. 5. evic 1918 Imp: CONC	Tiny nonspecific free pelvic Scattered diverticula are see dence for acute diverticulitis XR CHEST: 1V (AP/PA)	n in the sigmoid color	n without CT

RUN DATE: 11/20/08 Chino Valley Med Center EDM **LIVE** PAGE 12 RUN TIME: 1155 EDM Patient Record ÷ RUN USER: HIRG Patient HANNA, ADEL S Account No. V00000305742 Unit No. M000273781 Age/Sex 62/M Patient Call Log Call Received by: Espinoza, Maria E When: 11/19/08 2009 Call Type: ADMISSION Caller: DR. TAKHAR Summary of Call: PMD called/paged for an ER admission. ,

RUN DATE: 11/19/08 Chino Valley Med Center EDM **LIVE** PAGE 1 RUN TIME: 1902 EDM Assessments RUN USER: EDBMO V00000305742 HANNA, ADEL atient Adult Triage Date 11/19/08 Time 1859 User Bacani, Marlene O Insurance: BLUE CROSS PRUDENT BUYER Patient Age: 62 Workers Comp: TRIAGE LEVEL: 2 Temperature/F: 98.5 Time: 1859 Date: 11/19/08 Source: ORAL Mode: WALK-IN Pulse: 90 Respirations: 20 Informant: PATIENT Blood Pressure: 131/88 Sp02 (%): 96 MICN Run: N Weight - Lb: Oz: Kg: Pain Scale: Chief Complaint: SHORTNESS OF BREATH, GENERALIZED WE Mode of Injury: ONSET SINCE MON Tetanus UTD: LMP : Medications: ATENOLOL Allergies: REGLAN Suspected Abuse: N === MEDICAL HISTORY === DM: rior Hx: Y Asthma: Arrythmia: Seizures: COPD: HTN: Liver: Dementia: Cardiac: CVA: Renal: Psych: CHF : TIA: Thyroid: Other: MIGRAINE HA ===TRIAGE ABUSE SCREENING=== 1. Story Inconsistent With Injury: 2. Delay in Seeking Medical Care: 3. Evidence Of: Unexplained Human Bite Marks: Unexplained Burns: Unexplained Lacerations: Unexplained Facial Injuries: 4. Bruising in Various Stages of Healing: 5. Injuries Inconsistent with Age/Level of Activity: 6. Oversolicitous Caretaker/Partner: 7. Pattern of Injury Visits: Fearful of Caregiver:
 Depression: 0. Denial of Injury Ever Occurring: 11. Malnourished Patient: Any YES answer requires documentation of intervention carried out to communicate suspected abuse with charge nurse, ER physician and/or law enforcement, APS or CPS.

ACCOUNT #: PATIENT: DATE OF ADMISSION: V00000305742 HANNA, ADEL S. 11/19/2008

cc: Yoonjung Jang, RES D.O. James M. Lally, D.O.

INFORMANT: The history was obtained from the patient who is alert and oriented to person, place, and time and who appears to be an accurate historian, comprehends and speaks English adequately.

CHIEF COMPLAINT: Abdominal pain with nausea x2 days.

HISTORY OF PRESENT ILLNESS: The patient is a 62-year-old Caucasian male, brought into the emergency room by his wife with two days' history of abdominal pain. The patient states that his abdominal pain is 5/10, which also is accompanied with chills, fever, dizziness, diarrhea, and generalized body ache. The patient states that he was unable to tolerate the food or drink for two days due to nausea, vomiting, and diarrhea. The patient has no urinary output for two days either. The patient describes the abdominal pain as continuous cramping and generalized everywhere. Also, the patient tried Tylenol to control his fever. The patient has a history of depression and migraine.

PAST MEDICAL HISTORY: Migraine and depression.

PAST SURGICAL HISTORY:

Cholecystectomy in 1986, hiatal hernia repair in 1992. Complication from surgery included perforated viscus and empyema. The patient is status post angiogram and Cardiolite, which was negative.

ALLERGIES: REGLAN, which makes him have shortness of breath and breathing difficulty.

MEDICATIONS: Atenolol 50 mg daily for migraine prophylaxis, Lexapro 15 mg daily for depression, Zomig 2.5 mg p.r.n. migraine, and Tylenol 500 mg p.o. b.i.d. for fever.

SOCIAL HISTORY:

The patient denies smoking and drinks occasionally; however, denies drinking caffeine or recreational drug use. The patient is married. He lives with his wife. His primary care physician is Dr. Agarwal. The patient's code status is FULL CODE. The patient is a physician working in the prison.

FAMILY HISTORY: The patient denies any other cancer, tuberculosis, or blood disorders; however, the patient states that his brother has heart disease.

HISTORY & PHYSICAL

CHINO VALLEY MEDICAL CENTER CHINO, CA 91710 HANNA, ADEL S. M000273781 James M. Lally, D.O. DATE OF ADMISSION: 11/19/2008 Page 1 of 6

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ACCOUNT #: PATIENT: DATE OF ADMISSION:

V00000305742 HANNA, ADEL S. 11/19/2008

REVIEW OF SYSTEMS:

GENERAL: The patient denies any recent changes in weight; however, the patient has had fevers, chills, and fatigue for couple of days. He denies night sweats.

SKIN: The patient denies any rashes, changes in hair or nails, or skin lesions.

HEENT: The patient states that he has migraine and has been taking atenolol and Zomig for prophylaxis. The patient denies any trauma. The patient has no decreased vision or visual changes. No complaints such as blurriness, increased tearing, or photophobia. The patient admits to having high frequency hearing loss in the right ear. The patient denies pain. He denies discharge or vertigo. The patient admits to having a sore throat for a couple of days. The patient denies nasal trauma, pain, obstruction, epistaxis, head cold, discharge, or rhinitis.

ORAL: The patient admits he was having soreness of the throat. The patient denies any history of soreness of the mouth or tongue. No history of mouth ulcers. The patient does not wear dentures.

THROAT: The patient denies dysphagia, laryngitis, or speech defect. However, the patient admits to having sore throat for a couple of days. The patient was taking the candies for sore throat.

NECK: The patient denies history of goiter, swelling, enlarged nodes, trauma, stiffness, or limitations with range of motion.

BREASTS: The patient denies any masses, pain, discharges, or infections.

RESPIRATORY: The patient denies chest pain, asthma, recent URI and/or night sweats; however, the patient admits to having nonproductive cough for a couple of days, which is causing shortness of breath.

CARDIOVASCULAR: The patient denies chest pain, pressure, dyspnea, cardiac irregularities, orthopnea, palpitations, or peripheral edema, cramps, and/or varicosities.

GASTROINTESTINAL: The patient admits to having food intolerance due to nausea and vomiting for the last couple of days. Also, complaining of nausea, vomiting, and abdominal pain for a couple of days. However, denies hematemesis, jaundice, mclcna, constipation, and also admits to having diarrhea.

GENITOURINARY: The patient complains of no urinary output for two days.

METABOLIC: The patient denies any recent changes in weight. The patient has decreased appetite for two days.

ENDOCRINE: The patient denies thyroid disease or diabetes mellitus, excessive thirst, change in skin color or texture.

HEMOPOIETIC/BLOOD: The patient denies history of anemia or other blood disorders. No bleeding tendencies or transfusions.

LYMPHATICS: The patient denies history of enlarged, swollen and/or tender lymph nodes.

EXTREMITIES/MUSCULOSKELETAL/OSTEOPATHIC: The patient denies history of trauma, arthritis, fracture, or limited range of motion. The patient complains of generalized body aches.

HISTORY & PHYSICAL

CHINO VALLEY MEDICAL CENTER CHINO, CA 91710 HANNA, ADEL S. M000273781 James M. Lally, D.O. DATE OF ADMISSION: 1 Page 2 of 6

11/19/2008

ACCOUNT #: PATIENT: • DATE OF ADMISSION:

V00000305742 HANNA, ADEL S. 11/19/2008

NEUROLOGIC: The patient complains of history of migraines, which are controlled. The patient denies strokes, seizures, loss of consciousness, paresthesia or numbness, changes in thinking or memory.

PSYCHIATRIC: The patient denies history of nervousness, anxiety, mood swings, hallucinations, schizophrenia, psychiatric consultation or hospitalizations. The patient has history of depression and use of medication for depression, which is Lexapro for the past three years.

PHYSICAL EXAMINATION:

GENERAL: The patient is a 62-year-old male, well developed, well nourished, alert and oriented to person, place, and time.

VITALS: Temperature is 98.5 degrees Fahrenheit, pulse 90 beats per minute, respirations 20, and blood pressure 131/88. Weight is 167 pounds and height 5 feet 8 inches.

HEENT: Normocephalic and atraumatic. The patient has binocular vision. Pupils are equal, round, and reactive to light. Extraocular movements are intact. Funduscopic examination reveals physiologic cup-to-disc ratio without AV nicking or evidence of papilledema, hemorrhages and/or exudates. The pinnae are symmetrical. External auditory canals are intact. No sign of infection. Nose is midline and patent. Septum is without ulcerations and/or perforation. No sign of nasal obstruction. Sinuses are nontender to palpation. Lips are dry and symmetrical. Teeth are in good repair. Tongue is midline and protrudes to the midline without deviation. No sign of ulcerations or leukoplakia. Good phonation without hoarseness. No difficulty with swallowing.

SKIN: Skin is warm and dry with good turgor. Normal color and pigmentation without lesions. NECK: Supple. Full range of motion. No jugular venous distention. No bruit. No lymphadenopathy. No thyroid enlargement and/or other masses. Trachea is midline without obstruction.

LUNGS: Clear to auscultation bilaterally. No rhonchi, rales, wheezes or crepitus.

HEART: Regular rate at 90 beats per minute without murmur. Point of maximum impulse is in the fifth intercostal space. Normal S1 and S2. No S3, S4, thrill, friction rubs and/or gallops.

ABDOMEN: Bowel sounds are present. Abdomen is soft and tender to palpation in all four quadrants. There is guarding. Negative rebound. No organomegaly noted.

RECTAL: Deferred by the patient.

EXTREMITIES/MUSCULOSKELETAL/OSTEOPATHIC: Joint examination reveals no tenderness, swelling, redness, and restriction of range of motion. No clubbing, cyanosis, or edema.

Radial, femoral, popliteal, and pedal pulses are palpable and equal bilaterally. Upper and lower extremities are normal for size, shape, strength, and symmetry. Homans sign is negative. Muscle size and strength are within normal limits, 5/5.

HISTORY & PHYSICAL

CHINO VALLEY MEDICAL CENTER CHINO, CA 91710 HANNA, ADEL S. M000273781 James M. Lally, D.O. DATE OF ADMISSION: 11/19/2008 Page 3 of 6

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V00000305742 HANNA, ADEL S. 11/19/2008

Shoulders and iliac crest heights are equal. Thoracic, cervical and lumbar spines are without spasm. Nontender to palpation. Range of motion shows no abnormal or asymmetrical changes. Lateral curvatures are within normal limits.

Paravertebral musculature shows no tissue and/or texture changes or tendency. No costovertebral angle tenderness noted bilaterally.

FOOT EXAMINATION: Pulses are equal. Skin is warm. Capillary refill is within two seconds. There are no varicosities. No stasis ulcers. No deformities. No swollen joints or bone spurs, blisters, friction sites, corns, calluses, erythema, edema, or ulcers. No yellow or thickened nails, tinea or plantar warts.

LYMPHATICS: No cervical, axillary, supraclavicular and/or inguinal lymphadenopathy.

NEUROLOGIC: The patient's general behavior reveals level of consciousness oriented to person, place, and time.

CN I: The patient is able to perceive smell.

CN II, III, IV, & VI: The patient has binocular vision and visual acuity within normal limits. Passes visual fields to confrontation.

Extraocular movements are intact. Pupils are equal and reactive to light and accommodation. No nystagmus.

CN V: The patient is able to clench jaws, able to move jaw from side to side. Corneal reflex is intact as demonstrated by spontaneous blink.

CN VII: The patient demonstrates facial expression and has taste to anterior two-thirds of tongue.

CN VIII: The patient can hear spoken words whispered. No nystagmus.

CN IX: Taste is intact for the posterior one-third of the tongue.

CN X: Soft palate and uvula pull upward in the midline, and good phonation without hoarseness. Positive gag reflex.

HISTORY & PHYSICAL

CHINO VALLEY MEDICAL CENTER CHINO, CA 91710 HANNA, ADEL S. M000273781 James M. Lally, D.O. DATE OF ADMISSION: 11/19/2008 Page 4 of 6

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ACCOUNT #: PATIENT: 'DATE OF ADMISSION:

V00000305742 HANNA, ADEL S. 11/19/2008

CMP and magnesium phosphatase, coag panels and blood are not done. UA and urine drug screen is not done. Echocardiogram is to be read by Dr. Agarwal for possible heart failure. Toradol 30 mg IV every six hours p.r.n. for pain x6, ampicillin 1 mg IV every eight hours for shortness of breath and possible sepsis, atenolol 50 mg p.o. every night for migraine prophylaxis, and Benadryl IV 25 mg x1 p.r.n. for agitation. Consult Dr. Quianzon for small bowel obstruction who may participate in the patient's care. BMP for possible renal failure and CBC for possible sepsis in the a.m. Consult Dr. <u>Amm</u> who may participate in the patient's care and management for abdominal pain.

Care was discussed with the patient's family at length. She is aware and they are in agreement with plan of treatment.

PROGNOSIS: Guarded.

DISPOSITION:

The patient is to be discharged upon medical treatment.

James M. Lally,

Yoonjung Jang, RES D.O.

DR:	YJ/NKK
DD:	11/19/2008 23:08
DT:	11/20/2008 07:16
Job #:	059713410

HISTORY & PHYSICAL

CHINO VALLEY MEDICAL CENTER CHINO, CA 91710 HANNA, ADEL S. M000273781 James M. Lally, D.O. DATE OF ADMISSION: 11/19 Page 6 of 6

11/19/2008

	ACCOUNT #:	V00000305742
	PATIENT:	HANNA, ADEL S.
•	DATE OF CONSULTATION:	11/20/2008

cc:

REQUESTING PHYSICIAN:	James M. Lally, D.O.
CONSULTING PHYSICIAN:	Mukesh S. Amin, M.D.

REASON FOR CONSULTATION:

Multiple problems, which includes abdominal pain, SBO, azotemia, and dehydration.

Thank you, Dr. Lally, for letting me to evaluate your patient on a full complex medical consultation.

HISTORY OF PRESENT ILLNESS:

This is a very pleasant 62-year-old male with multiple past medical histories, which includes migraine and depression who was essentially admitted with abdominal pain, nausea x2 days, chills, fever, dizziness, and some generalized body ache. The abdominal pain was continuous. The patient was admitted and found to have SBO. NG tube was placed and IV Protonix was started and IV ampicillin was started as well. No fever, chills, and no other associated symptomatology.

PAST MEDICAL HISTORY:

Significant for:

1. Migraine.

2. Depression.

PAST SURGICAL HISTORY:

Significant for:

- 1. Cholecystectomy.
- 2. Hiatal hernia repair.
- 3. Also, complication from surgery as well.

MEDICATIONS:

- 1. Atenolol.
- 2. Lexapro.
- 3. Zomig.
- 4. Tylenol.

ALLERGIES: REGLAN.

CONSULTATION

CHINO VALLEY MEDICAL CENTER CHINO, CA 91710 HANNA, ADEL S. M000273781 Mukesh S. Amin, M.D. DATE OF CONSULTATION: 11/20/2008 Page 1 of 3

ACCOUNT #: PATIENT: DATE OF CONSULTATION:

V00000305742 HANNA, ADEL S. 11/20/2008

SOCIAL HISTORY:

No smoking. Occasional alcohol use. No drugs.

FAMILY HISTORY: Brother is with heart disease.

REVIEW OF SYSTEMS:

GENERAL: No fever or chills noted in the hospital. HEENT: The patient has sore throat plus high frequency hearing loss. ORAL: Without any soreness. CARDIAC: No chest pain, orthopnea, or palpitations. GASTROINTESTINAL: As per HPI. GENITOURINARY: Negative. MUSCULOSKELETAL: Mild body ache. HEMATOLOGIC: No history of anemia. ENDOCRINE: No history of diabetes mellitus. NEUROLOGIC: No seizure, CVA, or syncope.

PHYSICAL EXAMINATION:

GENERAL: The patient is a well-developed, well-nourished male, currently in no apparent distress.

VITAL SIGNS: Blood pressure is 118/82, pulse 94, respirations 18, and temperature 99.7 degrees.

HEENT: Extraocular muscles are intact. Pupils are equal and reactive to light. Conjunctivae are pink. Sclerae are anicteric. Mucous membranes are dry.

NECK: Supple. No JVD or thyromegaly. No lymphadenopathy. Carotids are 4+ bilaterally without bruit.

LUNGS: Clear.

HEART: Regular rate and rhythm. Normal S1 and S2. Negative S3. No murmur or rub heard. ABDOMEN: Soft and nontender. Normoactive bowel sounds. Liver and spleen are not palpable.

EXTREMITIES: No cyanosis, clubbing, or edema.

NEUROLOGIC: Nonfocal.

LABORATORY AND DIAGNOSTIC DATA:

EKG showed normal sinus rhythm with nonspecific ST-wave changes. Sodium was 136, potassium 3.6, chloride 102, bicarbonate 25.0, glucose 104, BUN 22, creatinine 0.94, and calcium 8.4. LFTs were normal. Amylase was 28. Cholesterol was 110. ProTime was 12.1. INR was 1.13. WBC count was 4.5, hemoglobin 15.6, and hematocrit 46.

ASSESSMENT:

- 1. Abdominal pain, small bowel obstruction.
- 2. Dehydration, azotemia.
- 3. Depression.
- 4. Migraine.

CONSULTATION

CHINO VALLEY MEDICAL CENTER CHINO, CA 91710 HANNA, ADEL S. M000273781 Mukesh S. Amin, M.D. DATE OF CONSULTATION: 11/20/2008 Page 2 of 3

ACCOUNT #: PATIENT: DATE OF CONSULTATION:

V00000305742 HANNA, ADEL S. 11/20/2008

PLAN/RECOMMENDATIONS:

- 1. Agree with current treatment.
- 2. IV fluids.
- 3. Follow up chem-7.
- 4. Add 40 mEq of KCl in IV.
- 5. UA C&S.
- 6. Agree with other care plan rendered and we will closely monitor and follow the patient for further evaluation pending the results.

Mukesh S. Amin, M

DR:	MSA/TN
DD:	11/20/2008 07:46
DT:	11/20/2008 23:18
Job #:	059713445

CONSULTATION

CHINO VALLEY MEDICAL CENTER CHINO, CA 91710 HANNA, ADEL S. M000273781 Mukesh S. Amin, M.D. DATE OF CONSULTATION: 11/20/2008 Page 3 of 3