CENTEGRA Health System

DISCHARGE DATE | TIME

ACCOUNT NO.	ADMISSION DATE/TIME	BY	STATION ROOM	ACC	SERVICE	TYPE	AT	AS	UNIT NO AME DICAL RECORD NO
B 11179-00323	06/28/11 0246pm	MXC	EDB -		EMD	EDB	1	1	B0000109381

SEX	RC	MS	BIRTHDATE	SOC SEC NO	CLERGY	AD	OD	INJURY	FIN CLASS
M		S	03/19/70 41Y	323-76-4001		N		AT WORK	L LIAB-MVA/M

PATIENT NAME AND ADDRESS
ENGLISH
DULBERG, PAUL R
4606 HAYDEN CT (847)497-4250
CELL#
MCHENRY IL 60051-7918 *MCHENRY CNTY, IL

PREVIOUS NAME

PATIENT EMPLOYER
SHARP PRINTING
4606 HAYDEN CT (847)497-4250
SELF EMP
MCHENRY IL 60050

GUARANTOR NAME AND ADDRESS
DULBERG, PAUL R
4606 HAYDEN CT (847)497-4250
SELF
MCHENRY IL 60051-7918 CELL#

SOC SEC NO 323-76-4001 PHI CONTACT: Y

GUARANTOR EMPLOYER
SHARP PRINTING
4606 HAYDEN CT (847)497-4250
SELF EMP
MCHENRY IL 60050

EMERGENCY CONTACT / RELATIVE 1
DULBERG, HERBERT (847)497-4250
4606 HAYDEN CT *FATHER
MCHENRY IL 60051-7918
PHI CONTACT: Y

SOC SEC NO

RELATIVE 1 EMPLOYER

EMERGENCY CONTACT 2
DULBERG, BARBARA (847)497-4250
4606 HAYDEN CT *MOTHER
MCHENRY IL 60051-7918
PHI CONTACT: Y

PATIENT ALTERNATE ADDRESS

INSURANCE 1
PAUL DULBERG/ACCIDENT 1 601067
4606 HAYDEN CT
JOHNSBURG IL 60051 DOB: 03/19/70
ACCIDENT DULBERG, PAUL R
99999 999999999
(847)497-4250

INSURANCE 2
DOB:

INSURANCE 3
DOB:

INSURANCE 4
DOB:

DIAGNOSIS/COMPLAINT
ER

COMPLAINT

ATTENDING PHYSICIAN
FORD, APIWAT W

ADMITTING PHYSICIAN
FORD, APIWAT W

PRIMARY CARE PHYSICIAN
SEK, FRANK

ADDITIONAL PHYSICIAN

STN: ERA

PRINCIPAL DIAGNOSIS

COMPLICATIONS AND COMORBIDITIES

PRINCIPAL PROCEDURE & DATE

OTHER PROCEDURES & DATE

PRINTED BY: SJS0422

I CERTIFY THAT THE NARRATIVE DESCRIPTIONS OF THE PRINCIPAL AND SECONDARY DIAGNOSES & THE MAJOR PROCEDURES PERFORMED ARE ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

SIGNATURE _____ M D DATE _____

RESTRICTIONS / RELEASE FORM

☒ **Northern Illinois Medical Center**
Emergency Department
4201 Medical Center Drive
McHenry, Illinois 60050
(815) 344-5000

☐ **Memorial Medical Center**
3701 Doty Rd.
Woodstock, Illinois 60098
(815) 334-3900

PATIENT NAME Paul Dulberg DATE 6/28/2011

PHYSICIAN SIGNATURE [signature]

1117900323
DULBERG, PAUL R
M 41Y 03/19/1970
06/28/2011 B 0000109381

☐ May return to ☐ work ☐ school ☒ gym without restriction.

☒ May not return to ☒ work ☐ school ☐ gym for 2 day(s).

☐ May return to school with the following restrictions:

- ☐ Gym/Sports restrictions are _____ for _____ day(s).
- ☐ Must take prescription medication for _____ day(s).

☐ May return to work with the following restrictions:

- ☐ No lifting greater than _____ lbs. for _____ day(s).
- ☐ Machinery/Driving restriction while on medication that can cause drowsiness.
- ☐ No continuous ☐ standing ☐ sitting for _____ day(s).
- ☐ Must keep _____ elevated for _____ day(s).
- ☐ Sedentary work only for _____ day(s).
- ☐ Must use crutches for _____ day(s).
- ☐ No overhead work for _____ day(s).
- ☐ No bending or twisting for _____ day(s).
- ☐ Must wear immobilizer for _____ day(s).
- ☐ No climbing on ladder or stairs for _____ day(s).
- ☐ Other _____

☐ LIMITED WORK WITH
☐ NO WORK WITH

☐ Right Hand	☐ Left Hand
☐ Arm	☐ Arm
☐ Foot	☐ Foot
☐ Leg	☐ Leg

For _____ Days

☐ See your physician in _____ days for reevaluation.

All patients are referred to their personal physicians or a doctor on the staff of this hospital. Release from restriction must be obtained from that doctor and not the Emergency Department.

I (or responsible person) have/has received and understand(s) the instructions to follow as noted above.

Patient signature (or responsible person): Paul Dulberg

PRINTED BY: SJS0422
DATE 12/08/2011

EO 102 NIMC/MMC

EMCARE, INC

MEDICAL RECORDS COPY

Centegra Northern Illinois Medical Center
4201 Medical Center Drive
McHenry, IL 60050
(815) 344-5000

Patient: PAUL DULBERG, Med. Rec. #: B0000109381, Visit #: B1117900323, Date: 06/28/2011 Time: 17:02

Home Care Instructions

IMPORTANT: We examined and treated you today on an emergency basis only. This was not a substitute for, or an effort to provide, complete medical care. In most cases, you must let your doctor check you again. Tell your doctor about any new or lasting problems. We cannot recognize and treat all injuries or illnesses in one Emergency Department visit. If you had special tests, such as EKG's or X-rays, we will review them again within 24 hours. We will call you if there are any new suggestions. You were treated today by: Ford, Apiwat W..

After your visit to our Emergency Department, you may receive a survey in the mail. We want to be sure we have given you very good care and we ask that you please fill out the survey and return it in the mail.

After you leave, please follow the instructions below.

This Information is About Your Follow Up Care

Call as soon as possible to make an appointment to see your doctor in 10 days for suture removal. You can reach your doctor by calling their clinic phone number.

Please return to the Emergency Department in 10 days for suture removal if you would prefer to have the sutures removed in the ER. We do recommend that you follow-up with your Primary Care Physician but you can return to the ER for removal of your stitches if you choose..

This Information is About Your Illness and Diagnosis

WOUND CARE (with stitches)
Your wound was closed with stitches. These are small threads that keep the skin closed to help it heal. You have 3 internal and 11 external stitches. These should be removed in 10 days.

At home, please follow these instructions:
- Wash your hands before touching the dressing or wound.
- Keep the wound clean and dry.
- After 2 days, wash the wound gently with warm water and soap. Pat it dry.
- Put a light dressing on it if it rubs or there is drainage.

Call your doctor if:
- you have redness, pain, or swelling in the area of your stitches.
- your wound drains pus.
- your stitches come out before your wound is healed.
- you have any new or bothersome symptoms.

This is Information About Your New Medications - Start taking as prescribed.

HYDROCODONE and ACETAMINOPHEN (Vicodin, Vicodin ES, Lortab, Lortab elixir, Zamicet, Norco, Zydone, Anexsia, Anolor, Bancap HC)

Take this medicine by mouth with food in the following dose: one 10mg/325mg tablet every 4 to 6 hours if needed for pain. Do not take more than as directed per day (24 hours).

This is a mixture of medicines (hydrocodone and acetaminophen) used to relieve moderate to severe pain. This medicine may be used for other reasons, as prescribed by your doctor.

Side effects may include:
- sleepiness or dizziness
- upset stomach, nausea or vomiting
- constipation

Other side effects may occur, but are not as common. **Allergy would show up as: rash or itching, facial or throat swelling, wheezing or shortness of breath.** This medicine can be habit forming if used for a long period of time.

Follow these instructions:
- Never take more of this medicine than prescribed. Too much acetaminophen in your body can cause liver damage.
- Read the labels of non-prescription medicines before taking them. Many contain acetaminophen. To avoid an overdose, do not take any other medicines that contain acetaminophen.
- Talk to your doctor or pharmacist before taking medicines for sleep, colds or allergies. Severe drowsiness may occur.
- Do not share this medicine with others as this medicine is a controlled-substance. Sharing this medicine with others is against the law.
- To avoid constipation while taking this medicine:
  - Drink plenty of liquids. Try to drink 8 to 10 eight-ounce glasses of water or juice each day.
  - Include extra fiber in your diet.
  - Exercise daily.
- Watch for signs of dependence:
  - feeling that you "cannot live without this medicine".
  - you need more of this medicine than before to get the same relief.
- Do not drink alcohol, drive or operate machinery until you know how this medicine affects you.
- Store this medicine away from heat, moisture or direct light.
- If you are taking this on a regular schedule and you miss a dose, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and return to your regular schedule. Do not double the doses.
- **Talk with your doctor before taking any other medicines (including vitamins and herbals) as you may require additional monitoring.**

Call your doctor if you have:
- any sign of dependence or allergy.
- increased pain not helped by the pain medicine.
- slow, weak breathing.
- seizures.
- slow or irregular heart beat.
- a yellow-color to your skin or eyes, or dark urine.
- stomach pain.
- unusual or extreme tiredness.
- any new or severe symptoms.

CEFADROXIL (Duricef)

Take this medicine **until gone** in the following dose: 500 mg by mouth 2 times a day for 5 days.

Centegra Northern Illinois Medical Center
4201 Medical Center Drive
McHenry, IL 60050
(815) 344-5000

Cefadroxil is an antibiotic used to treat infections caused by bacteria. Antibiotics kill bacteria or prevent them from growing inside your body. This medicine may be used for other reasons, as prescribed by your doctor.

Side effects may include:

- diarrhea
- upset stomach, nausea or vomiting
- headache

Other side effects may occur, but are not as common. An upset stomach is not a sign of allergy. Allergy would show up as rash or itching, facial or throat swelling, wheezing or shortness of breath.

Follow these instructions:

- Space your medicine doses evenly throughout the day. This medicine works best if there is a constant amount in your blood.
- Take this medicine with food to avoid an upset stomach.
- Swallow the capsule and tablet form of this medicine whole with a full 8-ounce glass of water.
- For diabetics, this medicine can cause false test results when testing your urine for sugar. Talk with your doctor if you have questions.
- Store the tablet or capsule form of this medicine away from heat, moisture or direct light.
- Store the liquid form of this medicine in the refrigerator. Shake the liquid well before each use.
- If you miss a dose, take it as soon as possible. If it is almost time for your next dose, skip the missed dose. Do not double the doses.
- Talk with your doctor before taking any other medicines (including vitamins and herbals) as you may require additional monitoring.

Call your doctor if you have:

- any sign of allergy.
- no improvement after you've taken all the medicine.
- a seizure.
- any sign of a new infection (fever, general aches, chills, or unusual tiredness or weakness).
- ongoing nausea, vomiting or stomach pain.
- white patches in your mouth.
- women: itching in or change in discharge from your vagina.
- inflammation (pain and swelling) in your intestine during treatment or up to weeks after you've finished this medicine:
  - ongoing diarrhea
  - stomach pain or cramping
  - blood or mucus in your bowel movements
- any new or bothersome symptoms.

SMOKING CESSATION

Smoking is the nation's leading preventable cause of death. It significantly increases the risk of coronary heart disease, stroke and cancer. In fact, more than half of all smoking related deaths in America each year are from heart disease, stroke, or other cardiovascular diseases. The good news is, that one year after quitting, the risk of heart disease is cut in half. After five to fifteen smoke-free years, the risk is that of a person who never smoked!

If you or someone you love is interested in quitting, consider joining our "Freedom From Smoking "classes for adults. Centegra Health System and the McHenry County Department of Health have partnered together to bring you an effective program that will help you quit smoking. Call 877-CENTEGRA, (877-236-8347) for more information regarding this program. To speak with a counselor immediately, call the Illinois Tobacco line at 1-866-QUIT-YES.

PAIN MANAGEMENT AFTER DISCHARGE:

A person may feel less pain just by being in familiar surroundings. Here are some frequently asked questions about your pain management:

- What can I do to help my pain management? A person's level of relaxation and their environment can affect their pain. If you are tired, over stimulated (too many visitors) are anxious about your diagnosis, or a past experience with a hospitalization, your pain perception may be impacted and your tolerance decreased. Ask questions, and inform us about any problems or concerns that you may have, re: pain. Partner with your health team for your best pain management.
- What if the medication is not working? Tell your health-care provider; physician, home health nurse, etc. You may need a different dose or type of medicaton.
- What if I feel I'm not getting enough pain control? Talk to your physician or home health nurse about it. Together you may be able to develop a plan to prevent or ease your pain. Depending on the cause of your pain, your health-care provider may suggest exercise, use of heat/cold, massage, repositioning, immobilization of the affected part, or distraction such as music or rest.
- There are other methods of pain management. Let your health-care provider assist you in finding the best one for you.

Weight management is one step to help maintain a healthy lifestyle. For certain medical problems, such as congestive heart failure, weight should be monitored daily.

YOU ARE THE MOST IMPORTANT FACTOR IN YOUR RECOVERY.

Follow the above instructions carefully. Take your medicines as prescribed. Most important, see a doctor again as discussed.

If you have problems that we have not discussed, or your problem changes or gets worse, Call or visit your doctor right away. If you cannot reach your doctor, return to the Emergency Department immediately.

Centegra Health System is very concerned about your safety and well being. As part of our efforts to always provide very good care, any medications you received during this visit were reconciled with medication you are currently taking. This reconciliation was based on the information you or your representative provided regarding your current medications and allergies.

"I have received this information and my questions have been answered. I have discussed any challenges I see with this plan with the nurse or physician."

Paul Dulberg
PAUL DULBERG or Responsible Person

PAUL DULBERG or Responsible Person has received this information and tells me that all questions have been answered.

W T Dobio
RN Staff Signature

Pain 4
Time 1713.

PRINTED BY: S JS0422
DATE 2/6/2011 PATIENT Name PAUL R
Account Number, B1117900323

Centegra Northern Illinois Medical Center
4201 Medical Center Drive
McHenry, IL 60050
(815) 344-5000

PAUL DULBERG was discharged on 06/28/2011 at 17:06 from the hospital. The following is a summary of the discharge instructions given to PAUL before discharge:

This Information Is About Your Follow Up Care

Call as soon as possible to make an appointment to see your doctor in 10 days for suture removal. You can reach your doctor by calling their clinic phone number.
Please return to the Emergency Department in 10 days for suture removal if you would prefer to have the sutures removed in the ER. We do recommend that you follow-up with your Primary Care Physician but you can return to the ER for removal of your stitches if you choose..

This Information Is About Your Illness and Diagnosis

WOUND CARE (with stitches)

This is Information About Your New Medications - Start taking as prescribed.

HYDROCODONE and ACETAMINOPHEN (Vicodin, Vicodin ES, Lortab, Lortab elixir, Zamicet, Norco, Zydone, Anexsia, Anolor, Bancap HC)
one 10mg/325mg tablet every 4 to 6 hours if needed for pain. Do not take more than as directed per day (24 hours).
CEFADROXIL (Duricef)
500 mg by mouth 2 times a day for 5 days.

1. How are you and/or your family doing today?

2. Is your pain/or symptoms better today?

3. Did you understand your discharge instructions?

4. Are you following up with a Doctor?

PRINTED BY: SJS0422
DATE 12/08/2011
Patient Name, PAUL R
Account Number, B1117900323

5. Comments:

Signature of nurse making phone call;_____
Date:_____Time;_____

FORM GOES TO MEDICAL RECORDS

PRINTED BY: SJS0422
DATE 12/08/2011
Patient Name, PAUL R
Account Number, B1117900323

CentegraHealthSystem

1117900326
WELTER, KAITLYN D
F 10Y 11/28/2000
06/28/2011 B 0000297787

Initials

RELEASE FROM LIABILITY FOR VALUABLES

I understand my belongings are my responsibility and I have been advised to send any items of value home. I release CHS from any liability for the loss, damage to, or theft of any of my belongings. Safes or lockers are available at the hospital facilities and may be used to store valuables.

PATIENT PRE-CERTIFICATION RESPONSIBILITY

I understand I am responsible for the notification to my insurance company to obtain authorization before service is rendered. I further understand that if I do not pre-certify I may incur a reduction or loss of paid benefits to the hospital for which I will be liable.

ASSIGNMENT OF BENEFITS/ AGREEMENT FOR PAYMENT

I hereby authorize payment to be made directly to CHS and to the independent professional(s) for all insurance benefits otherwise payable to me. I understand I am financially responsible to CHS and independent professionals for all charges incurred. Patient "out-of-pocket" amounts will be requested prior to or upon discharge. In the event of default or non-payment, CHS shall be entitled to the right of recovery of all collection expenses, including court costs and reasonable attorney's fees for the purpose of securing payment. It is further agreed that any credit balance may be applied on any other account owed CHS by the guarantor/responsible party, or any open account for his/her dependent family.

PATIENT INFORMATION OFFERED

- Patient Rights/Responsibilities ..... Yes Declined If No, Explain: _____
- Advance Directive Information ..... Yes Declined If No, Explain: _____
- Notice of Privacy Practices..... Yes Declined If No, Explain: _____
- Patient Billing Information ..... Yes Declined If No, Explain: _____

PATIENT CERTIFICATION

By signing this General Consent and Acknowledgement Form, I acknowledge I have read and understand the information contained in this form and accept its terms. I also acknowledge I have received a copy of this form for my records.

INPATIENTS ONLY:

TRICARE (Military) Insurance PATIENTS ____Yes, I have received TRICARE "Important Message"

Patient/ Authorized Person | Relationship: Mother | Date: 6/28/11

Witness

I, _____, have interpreted/translated the above form to the patient. The patient has informed me he/she fully understands and agrees to the terms set out in this consent form.

Interpreter/Translator (Please Print Name) | Language | Interpretation/Translation Provider (Company name or Relationship to Patient)

PRINTED BY: SJS0422

1117900326
WELTER, KAITLYN D
F 10Y 11/28/2000
06/28/2011 B 0000297787

CentegraHealthSystem

☑ CH - M ☐ CH - W
☐ Other (Specify) _____

GENERAL CONSENT AND ACKNOWLEDGMENT

Account Number/Effective Date: _____ _____

CONSENT FOR MEDICAL TREATMENT

I have come to Centegra Health System (CHS) for medical treatment and consent to the customary examinations, tests, and procedures performed on patients in my condition. I understand and consent that independent professionals (such as my attending physician, on-call physicians, emergency medicine physicians, radiologists, anesthesiologists, pathologists, surgeons, obstetricians, consultants, nurse practitioners, physician assistants, certified registered nurse anesthetists and other specialists) may participate in my care as deemed necessary.

I agree to follow the Patient Rights & Responsibilities of CHS and to participate with independent professionals and CHS personnel in my care and treatment.

I understand the practice of Medicine is not an exact science and, therefore, no guarantees have been made regarding the likelihood of success or outcomes of any diagnosis, treatment, test, surgery or examination performed at CHS.

I understand this General Consent and Acknowledgement will remain in effect for this episode of care and will be provided to those areas of CHS where I receive care.

I understand the language in this Consent guides and controls all other forms and consents I may sign during my treatment with Centegra Health System and any inconsistencies shall be interpreted consistent with terms of this document.

Initials **PATIENT ACKNOWLEDGMENT OF INDEPENDENT PHYSICIANS**

I acknowledge the independent professional(s) who provide services to me at CHS are not employees or agents of CHS, but are independent medical practitioners who have been permitted to use its facilities for the care and treatment of their patients. They include but are not limited to, my attending physician, on-call physicians, emergency medicine physicians, radiologists, anesthesiologists, pathologists, surgeons, obstetricians, consultants, nurse practitioners, physician assistants, certified registered nurse anesthetists and other specialists. My decision to seek care is not based upon any representation or advertisement of the independent professionals and I understand they are not employees or agents of CHS. CHS bills do not include physician, surgeon, or other independent professional services and I understand I will receive a separate bill directly from the independent professional. I have read and understand the above terms and confirm I am the patient or am authorized to sign on the patient's behalf.

Initials **PATIENT ACKNOWLEDGMENT OF INDEPENDENT SERVICES**

During the course of my hospital stay, my physician may determine I require care at another medical facility, or I may request care at an alternate facility. I acknowledge that all transportation services provided in connection with my transfer to another facility are provided by an independent third party and I will receive a separate bill directly from the service provider for which I may be responsible.

USE AND DISCLOSURE OF HEALTH INFORMATION

Unless I request otherwise, CHS will provide my room location or telephone number to visitors and callers.

I understand CHS will use and disclose my health information for the purposes of treatment, payment, and health care operations, as permitted by law as described in the CHS Notice of Privacy Practices. Certain information can be used without obtaining my consent. I fully understand that the use or disclosure of my health information may include history, diagnosis and /or diagnostic treatment of mental health/ developmental disabilities conditions, alcohol or drug abuse and Acquired Immune Deficiency Syndrome (AIDS/ HIV).

I understand that if I refuse to allow disclosure of my health information to process my insurance claim, I may be financially responsible for all costs incurred by me for treatment. I agree to release and hold harmless CHS, its agents, and employees from any liability that may arise from the use or disclosure of my health information.

Initials **PICTURES/IMAGES**

I understand photographs, videotapes or other images may be taken to document my care. These images may be kept by CHS and/or by the independent professional involved in my care. I understand I have the right to view or obtain copies of these materials which are in possession of CHS upon written request. It is my responsibility to confirm if such photographs, videotapes or other images have been taken. I understand images identifying me will only be released as allowable under law or with my written authorization.

PRINTED BY: SJS0422

DATE 12/08/2011

CentegraHealthSystem

☑ CH - M ☐ CH - W

☐ Other (Specify) _____

1117900323
DULBERG, PAUL R
M 41Y 03/19/1970
06/28/2011 B 0000109361

GENERAL CONSENT AND ACKNOWLEDGMENT

Account Number/Effective Date: _____ _____

_____ _____

CONSENT FOR MEDICAL TREATMENT

I have come to Centegra Health System (CHS) for medical treatment and consent to the customary examinations, tests, and procedures performed on patients in my condition. I understand and consent that independent professionals (such as my attending physician, on-call physicians, emergency medicine physicians, radiologists, anesthesiologists, pathologists, surgeons, obstetricians, consultants, nurse practitioners, physician assistants, certified registered nurse anesthetists and other specialists) may participate in my care as deemed necessary.

I agree to follow the Patient Rights & Responsibilities of CHS and to participate with independent professionals and CHS personnel in my care and treatment.

I understand the practice of Medicine is not an exact science and, therefore, no guarantees have been made regarding the likelihood of success or outcomes of any diagnosis, treatment, test, surgery or examination performed at CHS.

I understand this General Consent and Acknowledgement will remain in effect for this episode of care and will be provided to those areas of CHS where I receive care.

I understand the language in this Consent guides and controls all other forms and consents I may sign during my treatment with Centegra Health System and any inconsistencies shall be interpreted consistent with terms of this document.

VD _____ PATIENT ACKNOWLEDGMENT OF INDEPENDENT PHYSICIANS

Initials

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VD _____ PATIENT ACKNOWLEDGMENT OF INDEPENDENT SERVICES

Initials

During the course of my hospital stay, my physician may determine I require care at another medical facility, or I may request care at an alternate facility. I acknowledge that all transportation services provided in connection with my transfer to another facility are provided by an independent third party and I will receive a separate bill directly from the service provider for which I may be responsible.

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VD _____ PICTURES/IMAGES

Initials

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PRINTED BY: SJS0422

DATE 12/08/2011

CentegraHealthSystem

1117900323
DULBERG, PAUL R
M 41Y 03/19/1970
06/28/2011 B 0000109381

Verbal
Initials

RELEASE FROM LIABILITY FOR VALUABLES

I understand my belongings are my responsibility and I have been advised to send any items of value home. I release CHS from any liability for the loss, damage to, or theft of any of my belongings. Safes or lockers are available at the hospital facilities and may be used to store valuables.

PATIENT PRE-CERTIFICATION RESPONSIBILITY

I understand I am responsible for the notification to my insurance company to obtain authorization before service is rendered. I further understand that if I do not pre-certify I may incur a reduction or loss of paid benefits to the hospital for which I will be liable.

ASSIGNMENT OF BENEFITS/ AGREEMENT FOR PAYMENT

I hereby authorize payment to be made directly to CHS and to the independent professional(s) for all insurance benefits otherwise payable to me. I understand I am financially responsible to CHS and independent professionals for all charges incurred. Patient "out-of-pocket" amounts will be requested prior to or upon discharge. In the event of default or non-payment, CHS shall be entitled to the right of recovery of all collection expenses, including court costs and reasonable attorney's fees for the purpose of securing payment. It is further agreed that any credit balance may be applied on any other account owed CHS by the guarantor/responsible party, or any open account for his/her dependent family.

PATIENT INFORMATION OFFERED

- Patient Rights/Responsibilities ..... Yes Declined If No, Explain: _____
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- Patient Billing Information ..... Yes Declined If No, Explain: _____

PATIENT CERTIFICATION

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INPATIENTS ONLY:

TRICARE (Military) Insurance PATIENTS ____Yes, I have received TRICARE "Important Message"

Verbal Per [illegible]
Patient/ Authorized Person — Relationship — Date 6/28/11

Witness

I, _____, have interpreted/translated the above form to the patient. The patient has informed me he/she fully understands and agrees to the terms set out in this consent form.

Interpreter/Translator (Please Print Name) — Language — Interpretation/Translation Provider (Company name or Relationship to Patient)

PRINTED BY: SJS0422

Northern Illinois Medical Center NIMC Radiology
Patient Name: DULBERG, PAUL R
Account Number: B1117900323

Northern Illinois Medical Center

06/28/2011 10135 RIGHT FOREARM 2139703
HISTORY: Chain saw versus forearm, forearm laceration.

IMPRESSION: Right forearm films demonstrate no fracture or radiopaque foreign body. There is deep soft tissue laceration along the ventral surface of the mid forearm.

FINDINGS: This exam consists of two views of the right forearm which demonstrate deep laceration on the ventral aspect of the mid forearm as best visualized on the lateral view. No fracture or radiopaque foreign body is identified.

cc: Apiwat W. Ford, D.O.
Donald R Kennard, M.D.
Frank Sek, M.D.

Electronically Authenticated
Donald R Kennard, M.D. 06/28/2011 18:18
815-759-4683

D 06/28/2011
T 06/28/2011 5:19 P / LBA
Northern Illinois Medical Center NIMC Radiology

PRINTED BY: SJS0422
DATE 12/08/2011

AUL R 0000109381 1117900323

Centegra Hospital-McHenry

CentegraHealthSystem

Centegra Hospital - McHenry

B1117900323
DULBERG, PAUL R
M 41Y 03/19/1970
06/28/2011
0000109381

EMERGENCY ADMISSION ASSESSMENT

TIME TRIAGED: 1450
TIME TO TREATMENT AREA: 1455
ED BED#: 18
EXPRESS BED #:
ESI: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Primary Physician: Sek
Height: 5'9" Weight: 145 # GCS: 15 RTS: 12 BP: 123 P 75 R 14 T 97.4 SPO2 97 ☒ Room air ☐ O2 Pain Level: 9 - 10

BROUGHT BY:
☐ Self ☐ Relative
☐ Police ☒ Friend
☐ Other
Ambulance:

MODE OF ARRIVAL
☒ WC
☐ Stretcher
☐ Carried
☐ Walked

TREATMENT PTA
☐ Ice ☐ Elevate
☐ O2
☐ IV
☐ Med:

☒ Patient Band applied
☐ Hand Off Communication Band applied
☐ Security watch

Time of Injury:

Chief complaint/reason for visit: States chainsaw vs Rt arm 15 min ago ↓ hemat, c/o feeling lightheaded

Triage RN

CURRENT MEDS ☒ Denies		ALLERGIES ☒ NKA	REACTION
		Medications:	
		Food:	
		Other: ☐ Latex ☐ Dye	

Meds reviewed by:
Residence: ☐ Private ☒ Family ☐ Alone ☐ Nursing home ☐ Group home
Language barrier ☐ Yes Interpreter Name/ATT Number: ☐ Other:
Do you feel safe at home? ☒ Yes ☐ No Is there anyone in your life that threatens, intimidates or harms you in any way? ☐ Yes ☒ No
Crisis/Social Worker ☐ Notified: ☐ Here: ☐ DNR Resources called: Time:

Past Medical History ☐ None

Yes	Yes	Yes	Yes	Yes
☐ Autoimmune	☐ Dementia/ Alzheimer's	☐ Headaches/ migraines	☐ Pressure Ulcer	☐ Infectious diseases
☐ Asthma	☐ Endocrine	☐ Head inj past 3 months	☐ Recent exposure	☐ MRSA
☐ Back problems	☐ GI problems	☐ Hypertension	☐ Reproductive problems	☐ VRE
☐ Blood disorders	☐ GU Problems	☐ MusculoSkeletal problems	☐ Respiratory problems	☐ Chicken Pox
☐ Cancer	☐ Glaucoma	☐ Neuro problems	☐ Seizures	☐ Measles
☐ Cardiovascular	☐ HEENT problems	☐ PsychoSocial problems	☐ Skin problems	☐ Shingles
☐ CHF	☐ Heart murmur		☐ Vision problems	☐ Strep Throat
LMP:	☐ Normal ☐ Abnormal			☐ Other:
☐ Pregnant	☐ No ☐ Unsure	Grava Para Ab	FHT	

Expanded/surgical history: Lt arm surg

Implanted medical device: ☐ Pacemaker ☐ IV access ☐ Eye ☐ Knee ☐ Hip ☐ AICD ☐ Other:

TB History

☐ None Ever had a positive TB test? ☐ Yes ☒ No ☐ Self-history of TB ☐ Family history of TB ☐ Cough ☐ Fever ☐ Bloody sputum ☐ Weight loss ☐ Night sweats ☐ Loss of appetite ☐ Fatigue ☐ Recent international travel ☐ Denies signs & symptoms

Vaccine

☐ Flu Tetanus ☐ N/A ☒ Up to date ☐ >5 years ☐ Unsure Pediatric immunization ☐ Up to date ☐ No ☐ Unsure

PRINTED BY: SJS0422
DATE 12/08/2011

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06

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EMERGENCY PHYSICIAN RECORD

Upper Extremity Injury (4)

DATE: 6/28/11 TIME: 1457 ☐ on arrival

ROOM: 18 EMS Arrival

EMS treatments ordered

HISTORIAN: (patient) spouse paramedics

__HX / __EXAM LIMITED BY:

HPI

chief complaint: Injury to: (right) / left
hand wrist (forearm) elbow arm
shoulder collar-bone area

duration / occurred:
just prior to arrival
today
yesterday
__ days ago

where:
home school
neighbor's park
work street

severity of pain:
mild moderate severe

worse / persistent since
pain intermittent / lasting

context: fall blow incised crushed burn

associated symptoms: tingling / numbness distally

ROS

suspected FB (skin lac)
(loss feeling) / power arms / legs
headache / neck pain
double vision / hearing loss
nausea / vomiting

trouble breathing / chest pain
loss of bladder function
recent fever / illness
other injuries
☐ all systems neg except as marked

NUMBNESS @ STOMACH

SOCIAL HX smoker +
recent ETOH
lives at home +
drug use / abuse —
lives alone
lives in nursing home

FAMILY HX (negative)

PAST HX ✓ negative R / L HANDED prior injury
diabetes Type I Type 2 diet / oral / insulin
HTN heart disease DEGENERATIVE DISC
Meds- (none) / see nurses note
Allergies- (NKDA) / see nurses note

☑ Nursing Assessment Reviewed ☑ Vitals Reviewed ☐ Tetanus immun. UTD

PHYSICAL EXAM

GENERAL APPEARANCE
__no acute distress
✓ alert

c-collar (PTA / in ED) / backboard
mild (moderate) / severe distress
anxious

EXTREMITIES

HAND
✓ nml inspection
✓ non-tender

__see diagram
__tenderness soft-tissue / bony
__swelling / ecchymosis
__deformity

WRIST
✓ nml inspection
✓ non-tender
✓ nml ROM*

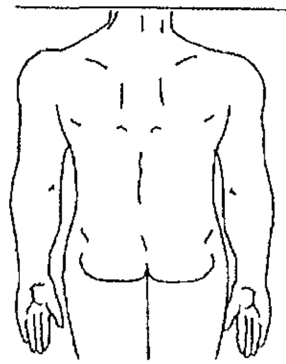
__see diagram
__tenderness soft-tissue / bony
__tenderness in anatomical snuff box
__wrist pain on axial thumb load
__swelling / ecchymosis
__limited ROM
__deformity

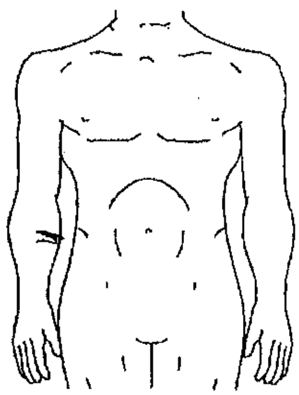
FOREARM / ELBOW
__nml inspection
__non-tender
✓ nml ROM*

✓ see diagram SCM LACERATION (R) FOREARM BELLY
__tenderness soft-tissue / bony
__swelling / ecchymosis
__limited ROM
__deformity

ARM / SHOULDER
✓ nml inspection
✓ non-tender
✓ nml ROM*

__see diagram
__tenderness soft-tissue / bony
__swelling / ecchymosis
__limited ROM
__deformity





T=Tenderness PtT=Point Tenderness S=Swelling E=Ecchymosis B=Burn C=Contusion L=Laceration A=Abrasion M=Muscle spasm PW=Puncture Wound
(Ø = without m=mild mod=moderate s=severe)
Example: Ts = Tenderness on palpation (severe)

NEURO / VASC / TENDON
✓ sensation intact
✓ motor intact
✓ no vascular compromise
✓ tendon function normal

__sensory / motor deficit
__pallor / cool skin / abnml cap refill
__pulse deficit radial ulnar
__deficit in tendon function

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SKIN
__warm, dry
__diaphoretic / cool / cyanotic

HEAD / ENT
__nml inspection
__pharynx nml
__tenderness
__swelling / ecchymosis

NECK / BACK
__nml inspection
__non-tender
__tenderness
__swelling / ecchymosis

RESPIRATORY
__chest non-tender
__breath snds nml
__tenderness
__swelling / ecchymosis / abrasions
__crepitus / subcutaneous emphysema
__decreased breath sounds
__wheezes / rales / rhonchi

CVS
__heart sounds nml
__tachycardia / bradycardia

GI (ABDOMEN)
__non-tender
__no organomegaly
__nml bowel snds*
__tenderness / guarding

XRAYS ☐Interp. by me ☐Reviewed by me ☐Discrd w/ radiologist

R / L *hand wrist forearm elbow humerus shoulder*

__normal / NAD
__no fracture
__nml alignment
__no foreign body
__DJD
__dislocation
__soft-tissue swelling
__positive anterior fat-pad sign
__positive posterior fat-pad sign
__foreign body
__fracture *non-displaced displaced*
transverse oblique comminuted angulated impacted torus

Other study:
☐See separate report

PROCEDURES

Wound Description / Repair
length 8cm location R FOREARM Belly
linear irregular flap stellate
superficial *subcut muscle through-and-through
contused tissue lip laceration
clean contaminated *minimally / moderately / *heavily
with

distal NVT: neuro & vascular status intact no tendon injury
anesthesia: local LET / tetracaine / adrenaline / cocaine 15 mL
marcaine 0.25% 0.5% lidoc 1% 2% epi / bicarb digital / metacarpal block
☐moderate sedation required; see attached 23d template
prep: SURGICLENS TOPAZ
Betadine / scrub
irrigated / washed w/ saline 1L NSS
*minimal / mod. / *extensive*
wound explored
foreign material removed
partially completely
*minimal / mod. / *extensive*
no foreign body identified
debrided
*minimal / mod. / * / *extensive*
undermined
*minimal / mod. / *extensive*
*wound margins revised
multiple flaps aligned

repair: *Wound closed with: wound adhesive / steri-strips*
SKIN- #11 4-0 nylon / prolene / staples
interrupted running simple mattress (h / v)
*SUBCUT-#3 4-0 vicryl / chromic
interrupted running simple mattress (h / v)
OTHER- # -0 material
interrupted running simple mattress (h / v)
*may indicate intermediate repair *may indicate complex repair

splint *Velcro OCL / Ortho-glass / Plaster Aluminum-foam*
Volar Thumb spica Ulnar Wrist Sugar-Tong Cock-up Colles
applied by ED Physician / Orthopedist / Tech
examined post splint application *NV intact alignment good*
deformity reduced no compartment syndrome
sling
nursemaid's elbow reduced with supination
foreign body removed *with forceps with incision*
closed reduction *finger traps traction*

PROGRESS

Time ____ unchanged improved re-examined
__initial fracture care provided: follow-up on
__Rx given
__referred to / discussed with Dr.
will see patient in: *ED / hospital / office* in ____ *days*

CLINICAL IMPRESSION

Fall *Alleged Assault*

Contusion R / L shoulder forearm wrist
Hematoma arm elbow hand
Sprain / Strain
Dislocation
Laceration
Fracture R / L radius *distal / shaft / proximal*
ulna *distal / shaft / proximal / ulnar styloid*
humerus *distal / shaft / proximal / supracondylar*
Colles fracture *stabilized / restorative*

DISPOSITION- ☐transferred ☑home ☐admitted ☐expired
Time ____ ☐AMA
CONDITION- ☐good ☑fair ☐poor ☐critical ☑improved
☐stable ☐unchanged

RESIDENT / PA / NP SIGNATURE

ATTENDING NOTE:
__Resident / PA / NP's history reviewed, patient interviewed and examined.
Briefly, pertinent HPI is:
My personal exam of patient reveals:
Assessment and plan reviewed with resident / midlevel. Lab and ancillary studies show:
I confirm the diagnosis of:
__Care plan reviewed. Patient will need:
Please see resident / midlevel note for details.

Rutford 9025
Physician Signature *RTI #* *turned care over at*

Physician Signature *RTI #* *assumed care at*

Underline *indicates organ system*
* *equivalent or minimum required for organ system lesion*

☐Template Complete ☐Additional T-Sheet

PRINTED BY: SJS0422

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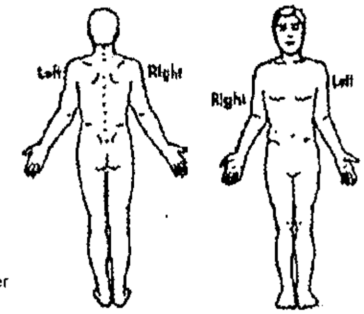
ADMISSION ASSESSMENT

Do you currently have pain? ☒ Yes 9-10 (1-10) ☐ No If yes, is it ☐ Chronic ☐ New Onset
Type of pain: ☐ Burning ☐ Dull Pressure ☐ Cramping ☐ Heavy ☐ Sharp ☐ Achy
☐ Other:______
Pain Scale used: ☐ Wong Baker ☐ FLACC ☐ Numeric

ALCOHOL INTAKE: ☒ Never ☐ Occasionally ☐ DAILY
Type:______ Amount: ______ Last Drink:______
STREET/REC DRUGS: ☒ Never ☐ Occasionally ☐ DAILY
Type:______ Amount: ______ Last Used:______
TOBACCO HISTORY: ☐ Never ☐ Occasionally ☒ DAILY
Type: 1 pk/d. Amount: ______ Date Quit:______

Mark drawing with number:
1. Abrasion
2. Amputation
3. Avulsion
4. Bleeding
5. Burn
6. Bruise
7. Deformity
8. Fracture
9. GSW
10. Hematoma
11. Laceration
12. Pain
13. Stab wound
14. Foreign body
15. Pressure ulcer
16. Leg ulcer



Neurological ☐ NA
LOC ☐ Yes ☐ No
☒ Conscious ☐ Unconscious
☒ Alert ☒ Oriented X 3
☐ Crying ☐ Lethargic ☐ MAE
☐ Slurred speech
☐ Irritable
☐ Combative
Pupils ☐ NA ☒ PERL R L
Reactive ☐ ☐
Sluggish ☐ ☐
Fixed ☐ ☐
Nonreactive ☐ ☐
Pupil size
AVPU ☐ A ☐ V ☐ P ☐ U
GCS: ___

FALL RISK ASSESSMENT
☐ Medically unsafe to be independently mobile
☐ Unaware or forgetful of physical limitations
☐ Recent history of falls
ANY POSITIVE ANSWER INDICATES ENHANCED FALL RISK ☐ No risks noted

Cardiac/Circulatory: ☐ NA
☒ Pink ☒ Warm ☐ Dry ☐ Cool
☐ Hot ☐ Flushed ☐ Diaphoretic
☐ Dusky ☐ Ashen ☐ Jaundice
☐ Pale ☐ Clammy ☐ Cyanotic
RADIAL PULSES R L
Present ☒ ☒
Absent ☐ ☐
PEDAL Present: ☒ ☒
Absent ☐ ☐
Cap Refill ☒ <2Sec ☐ >2 Sec
Ankle edema ☐ Yes ☒ No
Monitor: ______

Respiratory ☒ NA
☐ Distress ☐ None ☐ Mild
☐ Moderate ☐ Severe
☐ Stridor ☐ Nasal Flaring
☐ Retractions
☐ Productive cough: ______
☐ Unproductive cough

Lung Sounds ☐ NA R L
Clear ☒ ☒
Rales ☐ ☐
Wheezing ☐ ☐
Rhonchi ☐ ☐
Diminished ☐ ☐
Absent ☐ ☐

EENT: ☐ NA ☒ Denies
VISUAL ACUITY ☐ NA
L. ______ R: ______
☐ Correction ☐ No Correction
Ear Drainage: ☐ Yes ☐ No
Describe: ______
Epistaxis: ☐ NA R L
Controlled ☐ ☐
Uncontrolled ☐ ☐
THROAT:
☐ Diff. swallowing
☐ Diff. speaking
☐ Drooling

GI/Abdominal: ☐ NA ☐ Denies
☒ Soft ☐ Distended ☐ Firm
☒ Nontender ☐ Tender
Bowel sounds: ☐ Present ☐ Absent
☐ Hypoactive ☐ Hyperactive
Last BM: ______
☐ Diarrhea x ___ ☒ Denies
☐ Vomiting x ___ ☒ Denies
☐ Nausea ☐ Yes ☒ No
Last oral intake: ______
Comments: ______

Genito-Urinary: ☐ NA ☒ Denies
URINARY ☐ NA
☐ Frequency ☐ Pain
☐ Hematuria ☐ Incontinent
☐ Unable to void ☐ CUD
VAGINAL/PENILE ☐ NA
☐ Discharge ☐ Bleeding
Character: ______
Amount: ______

(1455) Pt accompanied to ED by co-worker for c/o laceration by chainsaw to (R) forearm. Pt out to xray (1505) Pt back in ER#18 Dr Ford at bedside (1522) Pt medicated as ordered (1530) Wound irrigated and cleaned. Dr Ford for sutures. (1713) D/C instructions to pt. all questions addressed Pt verbalized understanding

Associate Signature/Initials: [illegible] Associate Signature/Initials:______

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EMERGENCY ADMISSION ASSESSMENT

Time	Blood pressure	Pulse	Resp	Temp	SpO2	O2	GCS E/V\M	Monitor	Intake	Output
							/ \			
							/ \			
							/ \			
							/ \			
							/ \			
							/ \			
	Orthostatic Lying:_____ Sitting:_____ Standing:_____									

Treatments/Procedures:
☐ O_2 Therapy: _____ ☐ Intubated _____ ☐ Respiratory treatment: _____ Neb Tx: _____ ☐ Cont Pulse Ox _____
☐ Chest tube: _____ ☐ Time Out: _____ ☐ Eye irrigation: _____ ☐ Ear irrigation: _____
☐ NG tube # _____ @ _____ Character: _____ ☐ Gastric lavage: _____
☐ Lumbar puncture: _____ ☐ Time Out: _____ ☐ See neuro assessment sheet
☐ Pelvic exam: _____ Straight Cath/CUD @ _____ ☐ Bladder scan Amount: _____
Blood Glucose value: _____ Time: _____ By: _____ ☐ Continuous Cardiac Monitoring
Normal Values Age 60 or more (80-99 mg/dl), 13-60 yr. (75-99), 1 mo.-13 yr. (60-99) Critical Value less than 40 or more than 400
Normal Value: Age newborn to 1d (40-60 mg/dl) 1d-1 Mo. (50-99) Critical Value less than 40 or more than 200

☐ Wound Care
☐ Irrigation: 1 Liter NS
☐ Soak: _____
☐ Antiseptic Wash
☐ Other: _____

☐ Dressing: _____ ☐ Ortho Care: _____
☐ Antibiotic ☐ Ice Time: _____ ☐ Cast
☐ Adaptic ☐ Elevate Time: _____ ☐ Sling
☐ 4X4 ☐ Splint: _____ ☐ Tubi Grip
☐ Kling ☐ Knee immobilizer: _____
☐ Tube gauze ☐ Shoulder Immobilizer
☐ Steristrip ☐ Ace Wrap
☐ Burn dressing ☐ SMV's after immobilization

☐ Crutches
☐ Patient's own crutches
☐ Crutch walking instr/ret demo
☐ Velcro Splint: _____
☐ Posterior mold: _____
☐ Location: _____
☐ Width: _____
☐ Length: _____

Isolation Type: _____

DISPOSITION: ☐ Home ☐ Jail ☐ Nursing home/ECC
☐ Other facility: _____ ☐ Expired ☐ AMA
Mode: ☐ WC ☐ Walk ☐ Carry ☐ Ambulance: _____
☐ Other: _____
LEFT WITH: ☐ Self ☐ Family ☐ Friend ☐ Police
☐ Discharge Instructions given-expresses understanding
☐ Discharge Pain Level: _____ (0-10) GCS: _____ RTS: _____
☐ Discharge by: _____ @ _____
Discharge Vital Signs: _____
Discharge Summary _____
RN: _____ Initials: _____
Tech: _____ Initials: _____

☐ Inpatient ☐ Observation ☐ Surgical
☐ Mode: _____ Time: _____ Accompanied by: _____
☐ ER hold from ____ to ____
☐ To unit/room # _____
☐ No old chart ☐ Old chart in ED ☐ Chart to floor
☐ Discharge Pain Level: _____ (0-10)
GCS: _____ RTS: _____

Skin Integrity Intact ☐ Yes ☐ No (see documentation)

RN: _____ Initials: _____

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Lab	MD/DO Order Time MD/DO Initials	Lab	MD/DO Order Time MD/DO Initial	Lab	MD/DO Order Time MD/DO Initial	Medical Imaging	MD/DO Order Time MD/DO Initial
☐ ABG		☐ PTT		☐ wound culture		☐ T Spine	
☐ Amylase		☐ RSV		☐		☐ LS Spine	
☐ Blood Culture		☐ Salicylate				☐ Ultrasound-	
☐ BMP		☐ Sputum culture				☐ CT Scan-Brain	
☐ BNP		☐ Strep				☐ CT Scan-C Spine	
☐ CBC w/diff		☐ *Trichimonas*				☐ CT Scan-Chest	
☐ CMPL		☐ Troponin ☐ POC		**Other/Miscellaneous**		☐ CT Scan-Chest PE	
☐ D. Dimer		☐ Tylenol		☐ O_2		☐ CT Scan-Abd/Pelvis	
☐ Digoxin Level		☐ Type & screen		☐ EKG Time Acquired		☐ MRI	
☐ ETOH		☐ Type & cross		Time Read		☐ **FAST Scan**	
☐ GC/Chlamydia		of units		☐ EKG Time Acquired		☐ ED Preg Ltd US	
☐ Hepatic Panel		☐ UA		Time Read		☐ ED Preg follow up US	
☐ HCG Qualitative		☐ UA/Reflex culture		**Medical Imaging**		☐ ED Pelvis Ltd US	
☐ HCG Quantitative		☐ Urine Culture		☐ Chest PA/Lat		☐ ED Abd Aorta US	
☐ Influenza Screen		☐ Urine Drug Screen		☐ Chest Port		☐ ED Doppler pelvis	
☐ Lipase		☐ Urine HCG ☐ Pos ☐ Neg ☐ POC		☐ C-Spine		☐ ED Venous Duplx Ext	
☐ MRSA		☐ Urine Dip ☐ POC		☐ X-Table		☐ ED Trauma trans echo	
☐ PT		☐ Wet prep		☐ Pelvis		☐ ED Trauma abd ltd	

MD/DO Order Time & Initials	ORB	Start Time	Stop Time	IV Solution & Amount	Warm Y/N	Additives	Site	Cath Size	Rate	Amt Infused	Initials

Pt Height: 5'09" Pt Weight: 165 Allergies: NKDA

MD/DO Order Time & Initials	ORB	Time Given	Stop Time	Pain Scale	Medication/Order	Dosage	Route	Site	Initials	Time	Effects	Pain Scale	Initials

☐ Td 0.5mL ☐ Tdap 0.5mL ☐ TT 0.5mL Time:___ Site:___ RN: ___ Lot# _____ Exp___ Mfr _____ ☐ VIS Given

☐ Nursing Assessment and Medication Reconciliation Reviewed

☐ Vitals Reviewed _____

Tech: _____ Initials: _____ Tech: _____ Initials: _____

RN: _____ Initials: _____ Physician: _____ Initials: _____

RN: _____ Initials: _____ Physician: _____ Initials: _____

Rev 04/04/11

PRINTED BY: SJS0422

DATE/TIME: 06/28/2011 12:07:28