RECEIVED
OCT - 9 2014
S.C. Supreme Court

THE STATE OF SOUTH CAROLINA
In The Supreme Court

APPEAL FROM CHEROKEE COUNTY
Court of Common Pleas

J. Michael Baxley, Circuit Court Judge

Case No. 2012-212107

JONATHAN KYLE BINNEY, SK 6009 ..... Petitioner/Respondent,

v.

STATE OF SOUTH CAROLINA ..... Respondent/Petitioner.

SUPPLEMENTAL APPENDIX
VOLUME III OF V

EMILY C. PAAVOLA
Death Penalty Resource & Defense Center
900 Elmwood Avenue, Suite 101
Columbia, South Carolina 29201
(803) 765-1044

JOHN H. BLUME
Cornell Law School
Myron Taylor Hall
Ithaca, NY 14853
(607) 255-1030

Counsel for Petitioner

WILLIAM EDGAR SALTER, III
Office of the Attorney General
P.O. Box 11549
Columba, SC 29211
(803) 734-6305

Counsel for Respondent

RAPID DEVELOPMENTAL SCREENING CHECK-LIST

"No responses at the appropriate age may constitute a signal indicating a possible developmental lag. If there is a substantial deviation from these values then the child should be evaluated with DDST."

ONE MONTH

- Chin up prone
- Focuses on object when object in line of vision
- Startles easily to stimulation

TWO MONTHS

- Follows moving person 180°
- Smiles and coos

THREE MONTHS

- Supports head steadily when propped in sitting position
- Reaches and misses a toy
- Holds object and looks at object
- Vocalizes

FOUR MONTHS

- Hands engage midline
- Puts object to mouth
- Laughs aloud

SIX MONTHS

- Rolls over supine to prone
- Sits leaning forward on hands
- Rolls prone to supine

EIGHT MONTHS

- Sits erect alone if placed up to sit
- Plays with toes; feet to mouth

TEN MONTHS

- Crawls
- Plays peek-a-boo
- Waves bye-bye
- Goes from sitting to prone
- Pulls self up to stand, stands holding on, and lowers self

TWELVE MONTHS

- Cruises by holding on the furniture
- Walks with only one hand held
- Repeats a word; uses four words
- Responds to his name, no-no and "give it to me."
- Holds own cup to drink

FIFTEEN MONTHS

- Walks alone
- Responds to familiar phrases

EIGHTEEN MONTHS

- Runs
- Throws a ball
- Points to nose, eyes, ears
- Turns pages 2 or 3 at a time
- Uses 10 single words
- Carries out 2 or 4 simple directions
- Uses spoon

TWO YEARS

- Uses 3 word phrases
- Names familiar animals or objects
- Can open doors
- Turns pages quickly
- Kicks ball

THREE YEARS

- Draws a circle from copy without aid of demonstration ✓
- Repeats 3 digits in correct order
- Gives sex ✓
- Gives a last name ✓
- Can ride a bike ✓
- Can wash hands and perhaps brush teeth ✓

FOUR YEARS

- Can copy a square
- Counts 4 pennies
- Points out longer of two lines
- Buttons clothes
- Draws a cross from copy

FIVE YEARS

- Draws triangle from copy
- Performs three tasks in succesion
- Knows age
- Names four colors
- Laces shoes

SIX YEARS

- Counts 13 pennies
- Knows AM and PM
- Defines common objects and uses
- Knows right and left
- Knows 3 of 4 different coins

CASE NO. _____ PATIENT'S NAME Jonathan

DATE MO.	DAY	YR.	SUBSEQUENT VISITS AND FINDINGS
7	25	78	temp x 4day, rash developed 7-25-78
			macular papular rash - face & extension surfaces of arms.
			EWT
			Lungs Clear
			Abdomen negative
			Viral Exanthem
			8/18/78 Impetigo - spreading Keflink X 10 days.
			6-22-81 - DPT, OPV4 Time given
7	31	81	7 years 2 3/4 months 42# 45 1/2" urine - A/G Neg pH 6.0 eyes - O.S. 20/30 O.D. 20/30 tonsils & ① Rest - to surgery. ② Nose - stuffy & snoring, eyes itchy Spring → Feel. ③ allergic Conj / Rhinitis Exanthem d/t / Keflex dormist - 1 Rx prn.
6	4	83	problems breathing because nose plugged x 1 yr. allergic Rhinitis. CBC 11% Eos Pgt. 223 units 6-6-83 - HCH 8:30 a.m. Rx Tavist-1
8	11	84	Wheezing - Prednisone. 100 mg 1½ po QAM

CASE NO. _____ PATIENT'S NAME _____

CASE NO. 399-2559-[illegible] PATIENT'S NAME Jonathan Binney

DATE MO.	DAY	YR.	SUBSEQUENT VISITS AND FINDINGS 5-9-84 399-6592
10	19	84	✓ middle (R) finger - peeling, - 5 warts on top of (L) hand (1 wart on (R) nostril
			BCA @ hand (5) and 1 @ nostril.
			@ middle finger ⇒ tape. -2
11	2	84	R.V Warts
11	9	84	10 [illegible] lemonades DT.
			56 1/2 # Urine) A/G neg
			51 1/2" pH 5.0
			eyes OS 20/20
			OD
			Concern: Wart.
			C/o legs. "Hate June."
			C/o eye (sunken (dry)
			Reassurance w/surgery. ↑ ± exertion.
11	20	84	R.V Wart
			Wart @ @ under fingers - BCA. Warts (perungual) @ middle finger - tape
12	3	84	RV Wart. - mom cancelled Appt " Sing looks good no need to come in."
			7/10/85 - C/o itching legs - knee * not growing = C/o pain 3-4 yrs. Rx:

CASE NO.

PATIENT'S NAME

HISTACOUNT® FORM NO. 1592 HISTACOUNT CORPORATION, MELVILLE, L. I., N. Y. 11746

CONSOLIDATED BIOMEDICAL LABORATORIES
SUBSIDIARY OF MORAN AND HAAS COMPANY

DIRECT INQUIRIES TO:
CBL COLUM. 3
P.O. BOX 2289
COLUMBUS, OHIO 43216
LOCAL: (614) 889-1061
OHIO: (800) 282-7300
NATIONAL: (800) 848-7360

[redacted]

BINNEY, JONATHAN
HUMAN MALE 09 YR

HHS NO. 34-1030

COLLECTED 06/07/83 9:20AM
RECEIVED 06/08/83
REPORTED 06/10/83
431849

TEST	RESULT	REFERENCE RANGE AGE	DIAGNOSTIC INFORMATION. ++ GEOMETRIC MEAN PLUS 1 SD U/ML	GEOMETRIC MEAN PLUS 2 SD U/ML
IMMUNOGLOBULIN E, S	223			
		1-11MOS	< 12	< 56
		1 YR	< 15	< 83
		2 YRS	< 29	<133
		3 YRS	< 35	<101
		4 YRS	< 33	<144
		5 YRS	< 56	<148
		6 YRS	< 95	<573
		7 YRS	< 88	<552
		8 YRS	< 71	<271
		9 YRS	< 38	<464
		10YRS	<110	<421
		11-14YRS	<111	<456
		15-19YRS	< 96	<384
		20-30YRS	< 59	<240
		31-50YRS	< 79	<324
		51-80YRS	< 48	<197

THE ABOVE REFERENCE RANGES ARE EXPRESSED IN A GEOMETRIC FORMAT TO REFLECT THE POPULATION DISTRIBUTION OF IGE LEVELS AND TO COMPLEMENT CURRENT LITERATURE WHICH SUPPORTS THE FOLLOWING GENERAL GUIDELINES:

VALUES LESS THAN +1 SD: NOT ASSOCIATED WITH ATOPIC ALLERGY.

VALUES BETWEEN +1 SD AND +2 SD: MAY PREDICT FUTURE ONSET OF ALLERGIC DISEASE IN NON-ATOPIC PATIENTS.

VALUES GREATER THAN +2 SD: ASSOCIATED WITH ATOPIC ALLERGY.

DAVID L. PALMER MD, DIRECTOR

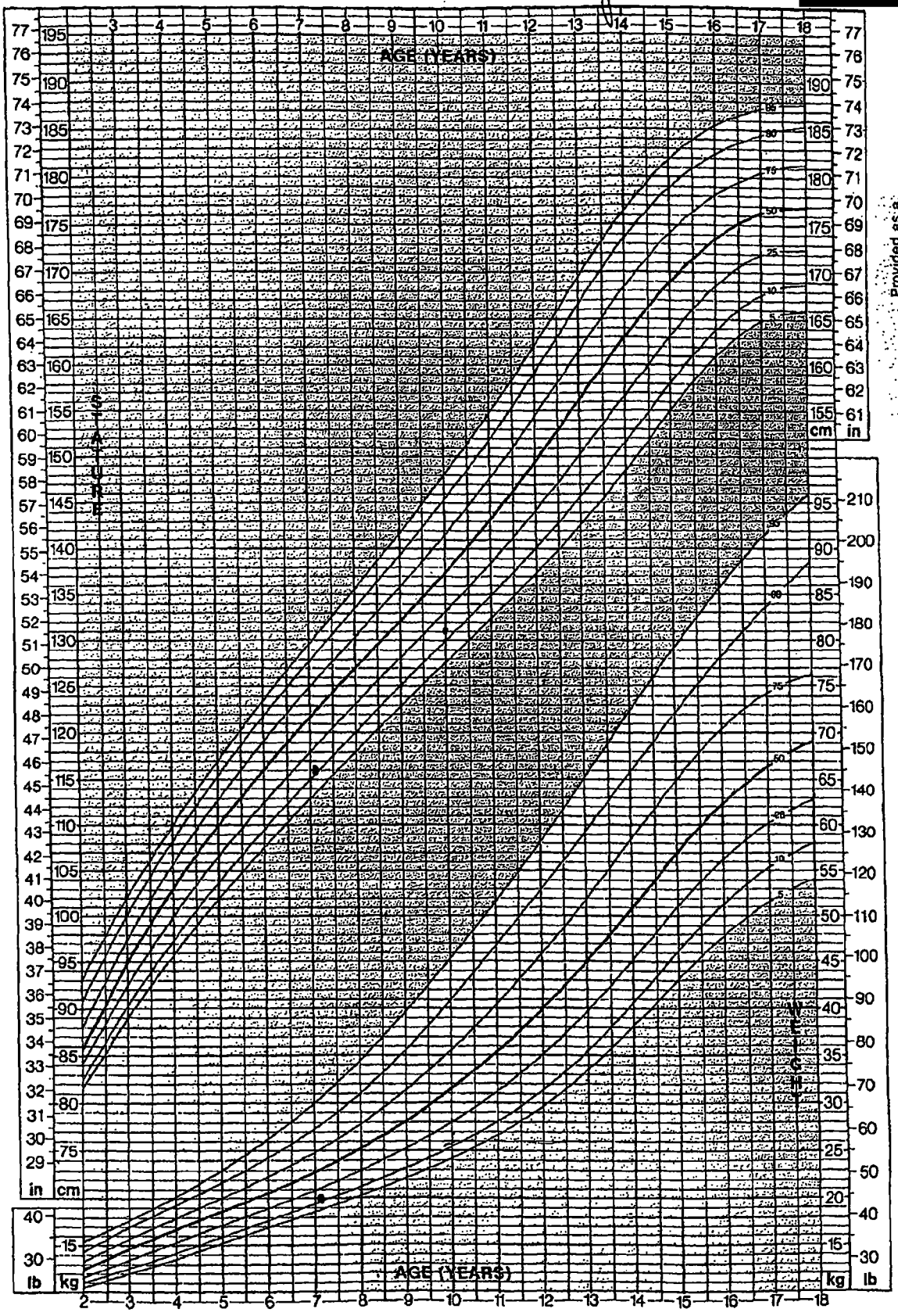
HOLLAND COMMUNITY HOSPITAL 62
LABORATORY-JANE FAIRBANKS
602 MICHIGAN AVENUE
HOLLAND MI 49423

BINNEY, JONATHAN
DR ID:
++ TESTING SITE
S=SACRAMENTO,CA D=DENVER,CO
R=RICHMOND,VA W=WICHITA,KS
B=BURLINGTON,NC N=RARITAN,NJ

62
SEQ# 5*I1

BOYS: 2 TO 18 YEARS
PHYSICAL GROWTH
NCHS PERCENTILES*

NAME Jonathan Binney RECORD [redacted]



Provided as a service of Ross Laboratories

*Adapted from: Hamill PVV, Drizd TA, Johnson CL, Reed AB, Roche AF, Moore WM: Physical growth: National Center for Health Statistics percentiles. Am J CLIN NUTR 32:607-629,1979. Data from the National Center for Health Statistics (NCHS) Hyattsville, Maryland.

© 1980 ROSS LABORATORIES

STATE OF MISSISSIPPI

MISSISSIPPI STATE DEPARTMENT OF HEALTH
VITAL RECORDS

VS-41

MISSISSIPPI STATE BOARD OF HEALTH

CERTIFICATE OF BIRTH
STATE OF MISSISSIPPI

STATE FILE NUMBER 13661

1. Place of birth a. County: Forrest b. City, Town or Location: Hattiesburg

2. Full name of child: Jonathan Kyle Binney

3. Sex: Male 4. Date of birth: [redacted]

FATHER	MOTHER
5. Full name: James Dale Binney	11. Full name Before marriage: Sandra Lee Canavan
6. Address: Hammond, Indiana	12. Address: Hammond, Indiana
7. Color or Race: Caucasian 8. Age: 28 Yrs.	13. Color or Race: Caucasian 14. Age: 27 Yrs.
9. Birthplace: Dallas, Texas	15. Birthplace: Hammond, Indiana
10. Occupation: Pastor	16. Occupation: Housewife

I hereby certify that this child was born alive on the date stated above.

This the 16 day of September 19 74

File date May 27, 1974

James M. Bledsoe
Deputy State Registrar

By Frances Guillory
Authorized Clerk in Department

REVISED 9-1-58

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE ON FILE IN THIS OFFICE

Brian W. Amy M.D.
Brian W. Amy, MD, MHA, MPH
STATE HEALTH OFFICER

Judy Moulder
Judy Moulder
STATE REGISTRAR

NOV - 8 2006

WARNING: A REPRODUCTION OF THIS DOCUMENT RENDERS IT VOID AND INVALID. DO NOT ACCEPT UNLESS EMBOSSED SEAL OF THE MISSISSIPPI STATE BOARD OF HEALTH IS PRESENT. IT IS ILLEGAL TO ALTER OR COUNTERFEIT THIS DOCUMENT.

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND ON WHITE PAPER. THIS IS WATERMARKED PAPER. DO NOT ACCEPT WITHOUT FIRST HOLDING TO LIGHT TO VERIFY WATERMARK.

FILED

AUG 16 1974

IN THE CHANCERY COURT OF FORREST COUNTY, MISSISSIPPI

Estelle M. Catching
Chancery Clerk

EX PARTE PETITION OF JAMES DALE BINNEY AND WIFE, SANDRA LEE BINNEY, FOR THE ADOPTION OF THE CHILD DESCRIBED IN THE PETITION

CAUSE NO. 969

PETITION FOR ADOPTION

COMES NOW the Petitioner, Baby Boy Dove, a minor, by and through Jerry A. Evans, adult next friend, and James Dale Binney and wife, Sandra Lee Binney, and file this their Petition for Adoption, and in support thereof would show unto the Court the following facts, to-wit:

1.

That your Petitioners, James Dale Binney and wife, Sandra Lee Binney, are members of the White Race and are adult resident citizens of Forrest County, Mississippi, and have been resident citizens for more than ninety (90) days preceding the filing of this Petition.

2.

That your Petitioners, James Dale Binney and wife, Sandra Lee Binney, now have in their care, custody and control in Forrest County, Mississippi, a male child designated as Baby Boy Dove who was born May 9, 1974, in Hattiesburg, Forrest County, Mississippi, and that the said Baby Boy Dove was released by its natural mother and only living parent directly to your Petitioners, James Dale Binney and wife, Sandra Lee Binney, and Petitioners attach hereto the natural mother's consent and makes the same a part of this Petition as if the same were copied at length herein, being attached hereto and marked Exhibit "A".

3.

Petitioners would show unto this Court that said minor has been examined by a competent physician as to his physical

and mental condition, said physician's certificate being attached hereto and marked Exhibit "B" and made a part hereof as if fully copied and set out at length herein; furthermore, that said minor owns no property nor has any assets or income, all as shown by sworn statement, attached hereto and marked Exhibit "C" and made a part hereof as if fully copied and set out at length herein.

4.

That these Petitioners have had the custody and control of said minor child since approximately two weeks after his birth and that they desire to adopt said minor child for their own and to confirm all rights provided by law for said child as if it were their natural child. That Petitioners further show that it is for the best interest of said minor child and for his best protection that said child be adopted by your Petitioners.

5.

That your Petitioner, James Dale Binney, is a Pastor and that he and his wife, Sandra Lee Binney, reside at 300 S. 23rd Street, Hattiesburg, Forrest County, Mississippi, and that they are financially able to adequately provide a good home and education for said child. Therefore, according to the rules of civil law the six months waiting period is not necessary and that it would be to the best interest of said minor to be adopted without any delay and without an interlocutory decree.

6.

Petitioners, James Dale Binney and wife, Sandra Lee Binney, urge that the Court permit them to have said minor's name changed from that of Baby Boy Dove to that of Jonathan Kyle Binney and that a certified copy of the Final Decree be

furnished to the Bureau of Vital Statistics of the State Board of Health at Jackson, Mississippi, with the directions that a new birth certificate be issued showing that the minor's name is now Jonathan Kyle Binney and that he was born in Forrest County, Mississippi, on the 9th day of May, A. D., 1974, and that the mother of said minor is Sandra Lee Binney and that the father of said minor is James Dale Binney and that the said parties reside in Forrest County, Mississippi.

WHEREFORE, PREMISES CONSIDERED, Petitioners pray that this their petition be received and filed and that the Court, after having heard and considered said Petition and testimony in support hereof, will enter a Decree adopting said minor child, Baby Boy Dove, to James Dale Binney and wife, Sandra Lee Binney, and that the said minor's name be changed to Jonathan Kyle Binney and that the said Jonathan Kyle Binney be given all the rights of inheritance from his adopting parents and from any children of said adopting parents, and that the adopting parents and any children they may have be given the rights of inheritance from the adopted child and that this child and these Petitioners be vested with all the rights and obligations as granted by Chapter 34 of the Mississippi Laws of 1955, and Chapter 267 of the Mississippi Laws of 1958, and that the Court will, after hearing this cause, enter a Final Decree of Adoption of said minor child to your Petitioners. That if your Petitioners be mistaken in the relief prayed for, then they pray for such other or further relief, either general or special, as they in equity would be entitled to have and receive and as in duty bound they will ever pray.

James Dale Binney
JAMES DALE BINNEY, PETITIONER

Sandra Lee Binney
SANDRA LEE BINNEY, PETITIONER

Jerry A. Evans
JERRY A. EVANS, ADULT NEXT FRIEND

STATE OF MISSISSIPPI

COUNTY OF FORREST

Personally appeared before me, the undersigned authority in and for the above named County and State, James Dale Binney and wife, Sandra Lee Binney, and Jerry A. Evans, Adult Next Friend of said minor, who, after being duly sworn by me, states on oath that all of the matters and things contained in the foregoing Petition for Adoption are true and correct as therein stated and set forth.

James Dale Binney
JAMES DALE BINNEY

Sandra Lee Binney
SANDRA LEE BINNEY

Jerry A. Evans
JERRY A. EVANS

SWORN TO AND SUBSCRIBED BEFORE ME on this, the 16th day of August, A. D., 1974.

Thomas J. Riley
NOTARY PUBLIC

My Commission Expires:
7-31-77

STATE OF MISSISSIPPI

COUNTY OF FORREST

CONSENT OF ADOPTION BY UNMARRIED MOTHER

I, Gayle Ann Dove, a resident of Forrest County, Mississippi, do hereby release and forever relinquish unto James Dale Binney and wife, Sandra Lee Binney, of Hattiesburg, Mississippi, all my rights as parent in and to a male child born unto me on the 9th day of May A. D., 1974, in the Forrest General Hospital at Hattiesburg, Forrest County, Mississippi, which said male child was born out of wedlock, and I do hereby specifically and respectfully request any court of competent jurisdiction to enter an order of adoption in said matter.

I further consent to the aforesaid James Dale Binney and wife, Sandra Lee Binney, to remove said male child from the Forrest General Hospital in Hattiesburg, Forrest County, Mississippi, where said minor child was born, as soon as possible after birth, and I do further hereby release the said Forrest General Hospital and any and all doctors, nurses, attendants or any other personnel connected with said hospital from any and all liability concerning said minor male child.

I further waive all rights of custody, care or control of said minor child and further waiver the right of having any and all citations, summons and/or legal notices of the hearing of the petition to adopt the aforesaid minor male child, and further waive notice of any hearing or motions concerning said minor male child.

WITNESS MY SIGNATURE on this the 31st day of May A. D., 1974.

Gayle Ann Dove
GAYLE ANN DOVE

EXHIBIT "A"

WITNESSES:

Hubert B Barnwell

Dorothy C Barnwell

STATE OF MISSISSIPPI

COUNTY OF FORREST

This day personally appeared before me, the undersigned authority in and for the above named County and State, the within named, Gayle Ann Dove, who acknowledged that she signed and executed the foregoing Consent of Adoption by Unmarried Mother, the same being executed freely and voluntarily for the purposes therein stated on the day and year therein mentioned.

Gayle Ann Dove
GAYLE ANN DOVE

SWORN TO AND SUBSCRIBED BEFORE ME on this the 31st day of May A. D., 1974.

Thomas L. Riles
NOTARY PUBLIC

My Commission Expires:

7-31-77

STATE OF MISSISSIPPI

COUNTY OF FORREST

I, the undersigned, Tom C. Temple, a duly licensed practicing physician of Hattiesburg, Forrest County, Mississippi, do hereby certify that I have this day examined one Baby Jonathan Kyle Binney, a minor male child, and from such examination I find the said child to be in good mental and physical condition, and not to be suffering from any affliction of any kind insofar as can be determined at this time.

WITNESS MY SIGNATURE on this, the 15th day of August, A. D., 1974.

Tom C. Temple M. D.

EXHIBIT "B"

STATE OF MISSISSIPPI

COUNTY OF FORREST

This day personally appeared before me, the undersigned authority in and for the above named County' and State, James Dale Binney and wife, Sandra Lee Binney, who, after being duly sworn by me, state on oath that Baby Boy Dove, a male child born May 9, A. D., 1974, and proposed to be adopted by James Dale Binney and wife, Sandra Lee Binney, has no real property and no personal property, and further, that said minor has no assets of any nature whatsoever.

James Dale Binney
JAMES DALE BINNEY

Sandra Lee Binney
SANDRA LEE BINNEY

SWORN TO AND SUBSCRIBED BEFORE ME on this, the 16th day of August, A. D., 1974.

Thomas J. Kilby
NOTARY PUBLIC

My Commission Expires:
7-31-77

EXHIBIT "C"

FILED

AUG 16 1974

Clyde M. Castleberry
Chancery Clerk

IN THE CHANCERY COURT OF FORREST COUNTY, MISSISSIPPI

EX PARTE PETITION OF JAMES DALE BINNEY AND WIFE, SANDRA LEE BINNEY, FOR THE ADOPTION OF THE CHILD DESCRIBED IN THE PETITION

CAUSE NO. 969

FINAL DECREE OF ADOPTION

THIS DAY this cause came on to be heard upon sworn Petition of James Dale Binney and wife, Sandra Lee Binney, and Jerry A. Evans, as adult next friend of Baby Boy Dove, together with the consent of the natural mother of said minor, and the Court, after having found that it has jurisdiction of the parties and the subject matter and having jurisdiction to hear and determine this cause at this time and place finds as follows:

1.

That the child herein proposed to be adopted is a male child, Baby Boy Dove, who was born May 9, 1974, in Forrest County, Mississippi, and that the said Baby Boy Dove has resided with your Petitioners, James Dale Binney and wife, Sandra Lee Binney, in Hattiesburg, Forrest County, Mississippi, since approximately two weeks after birth.

2.

That the natural mother and only living parent of said minor has signed a sworn release and consent to said adoption, thereby releasing Baby Boy Dove to your Petitioners, James Dale Binney and wife, Sandra Lee Binney, and the Court finds that said minor is in good physical and mental condition as indicated by a physician's certificate, and that said minor owns no property as indicated by sworn statement.

3.

The Court further finds that the Petitioners herein, James Dale Binney and wife, Sandra Lee Binney, reside at

8 | 121-23

300 S. 23rd Street, Hattiesburg, Forrest County, Mississippi, and are physically and financially able to provide the proper home and education for the child herein sought to be adopted and that it would be to the best interest of Baby Boy Dove that he be adopted by the Petitioners, James Dale Binney and wife, Sandra Lee Binney.

4.

The Court further finds, after investigation, that the six months waiting period is not necessary and that this Decree of Adoption shall be a Final Decree.

IT IS, THEREFORE, ORDERED, ADJUDGED AND DECREED that the male child born May 9, 1974, in Forrest County, Mississippi, described as Baby Boy Dove, be and he is hereby adopted to James Dale Binney and wife, Sandra Lee Binney, and that said minor child shall hereafter be for all purposes the child of the said James Dale Binney and wife, Sandra Lee Binney, as if said child had been born to them in lawful wedlock, and said child is hereby named and shall hereafter be Jonathan Kyle Binney and the said Jonathan Kyle Binney shall inherit from and through James Dale Binney and wife, Sandra Lee Binney, as if said child had been born to them in lawful wedlock, and shall likewise inherit from other children of the adopting parents, shall any they have, to the extent and under the same conditions as provided for the inheritance between brothers and sisters of the full blood by the laws of descent and distribution of the State of Mississippi, and the adopting parents and any children of the adopting parents shall inherit from Jonathan Kyle Binney just as if said child had been born to James Dale Binney and wife, Sandra Lee Binney, in lawful wedlock.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Jonathan Kyle Binney and his adoptive parents and adoptive kindred are vested with all rights, powers, duties and

obligations as if said child had been born to the adopting parents in lawful wedlock, including all rights existing by virtue of Section 11-7-13 of the Mississippi Code of 1972, annotated and amended.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that the Clerk of this Court prepare and forward to the Bureau of Vital Statistics of the State Board of Health at Jackson, Mississippi, a certified copy of this Final Decree, requesting it to issue a new birth certificate showing that the said minor's name is now Jonathan Kyle Binney and that he was born on the 9th day of May, A. D., 1974, in Forrest County, Mississippi, and that James Dale Binney is the father of said minor and that Sandra Lee Binney is the mother of said minor, and that said parties reside in Hattiesburg, Forrest County, Mississippi.

SO ORDERED, ADJUDGED AND DECREED on this, the 15th day of August, A. D., 1974.

CHANCELLOR

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

CHARLES BELL, M.D.
ACTING COMMISSIONER

1100 W. 49th Street • Austin, Texas 78756
1-888-963-7111 • http://www.dshs.state.tx.us
TDD: 512-458-7708

February 21, 2007

JILL RIDER
1247 SUMTER ST STE 201
COLUMBIA SOUTH CAROLINA 29201

RE:
Req. P294952 02/05/2006 $22.00

Dear Customer:

We received your application for a birth certificate. Although we would like to service your request, we are currently unable to process the application.

The original birth record appears to be incorrect regarding the name of the registrant. Enclosed is a form that you may use to amend the certificate.

Part I on the Application to Amend a Certificate of Birth shows the information on the birth record as recorded in our office. Please review **Part II** to insure that the proper corrections will be made. **Part III** would need to be signed by an older relative in the presence of a notary public. **The fee to amend a certificate of birth is $15.00.**

PLEASE NOTE: PLEASE SEND THE DOCUMENTS WITH THIS LETTER TO OUR OFFICE TO RECEIVE CREDIT FOR THE FEE ALREADY SUBMITTED.

My phone number and email address are listed below my name if you need further assistance. You may also write to me at the address above.

Sincerely,

Marianela Charles
Processing Specialist
Vital Statistics
Toll Free # (Mon-Fri, 8-5): (888) 963-7111 ext 2543
Email: Marianela.Charles@dshs.state.tx.us

CERTIFICATION OF VITAL RECORD

DEPARTMENT OF STATE HEALTH SERVICES
VITAL STATISTICS UNIT

TEXAS DEPARTMENT OF HEALTH
REC'D SEP 11 1957
BUREAU OF VITAL STATISTICS

TEXAS DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

DECEASED 23386
DOD 2-25-02 FILE # Georgia
142-57-156287

CERTIFICATE OF BIRTH

STATE OF TEXAS

BIRTH NO.

1. PLACE OF BIRTH a. COUNTY: Wichita		2. USUAL RESIDENCE OF MOTHER (Where does mother live?) a. STATE: Texas	b. COUNTY: Wichita
b. CITY (If outside corporate limits, write RURAL and give precinct no.) OR TOWN: Wichita Falls		c. CITY (If outside corporate limits, write RURAL and give precinct no.) OR TOWN: Wichita Falls	
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital or institution, give street address or location): 3750th USAF Hospital		d. STREET ADDRESS (If rural, give location): 1814 Grant Street	
3. CHILD'S NAME (Type or print) a. (First): GAYLE	b. (Middle): ANN	c. (Last): DOVE	
4. SEX: Female	5a. THIS BIRTH SINGLE [X] TWIN [ ] TRIPLET [ ]	5b. IF TWIN OR TRIPLET (This child born) 1ST [ ] 2ND [ ] 3RD [ ]	6. LEGITIMATE? Yes
7. DATE OF BIRTH [redacted]			

FATHER OF CHILD

8. FULL NAME a. (First): Raymond	b. (Middle): Henry	c. (Last): Dove, Jr.	9. COLOR OR RACE: White
10. AGE (At time of this birth): 22 YEARS	11. BIRTHPLACE (State or foreign country): New York	12a. USUAL OCCUPATION: Airman	12b. KIND OF BUSINESS OR INDUSTRY

MOTHER OF CHILD

13. FULL MAIDEN NAME a. (First): Marilyn	b. (Middle): Virginia	c. (Last): Mossman	14. COLOR OR RACE: White
15. AGE (At time of this birth): 23 YEARS	16. BIRTHPLACE (State or foreign country): Kansas	17a. USUAL OCCUPATION: Housewife	17b. KIND OF BUSINESS OR INDUSTRY

18. CHILDREN PREVIOUSLY BORN TO THIS MOTHER (Do NOT include this child) a. How many OTHER children are now living? 2	b. How many OTHER children were born alive but are now dead? 0	c. How many OTHER children were stillborn (born dead after 20 weeks pregnancy)? 0	19a. INFORMANT: Mother: Mrs. Raymond Henry Dove, Jr.
			19b. ADDRESS: 1814 Grant Street, Wichita Falls, Texas

20. *I hereby certify that I attended the birth of this child who was born alive on the date stated above at 7:18 P.M.*

21a. ATTENDANT'S SIGNATURE: Charles A. Dafoe		21b. ATTENDANT AT BIRTH M.D. [X] D.O. [ ] MIDWIFE [ ] OTHER (Specify)	
21c. ATTENDANT'S ADDRESS: CHARLES A. DAFOE, Captain, USAF (MO)		21d. DATE SIGNED: 16 August 1957	
22a. REGISTRAR'S FILE NO.: 1786	22b. DATE REC'D BY LOCAL REGISTRAR: AUG 28 1957	22c. REGISTRAR'S SIGNATURE: Tara Lee Blevins	

K629309

This is a true and correct reproduction of the original record as recorded in this office. Issued under authority of Section 191.051, Health and Safety Code.

ISSUED FEB 2 1 2007

Geraldine R. Harris
GERALDINE R. HARRIS
STATE REGISTRAR

THE STATE OF TEXAS

DEPARTMENT OF STATE HEALTH SERVICES
STATE OF TEXAS
VITAL STATISTICS

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

This application, supporting document(s), and the statutory filing fee of $15.00 should be submitted to: This fee does not include the cost of a certified copy of the record after the amendment is filed. Please enclose the additional fee of $22.00 for each copy of the amended certificate requested.

VITAL STATISTICS UNIT
DEPARTMENT OF STATE
HEALTH SERVICES
P O BOX 12040
AUSTIN TEXAS 78711-2040
1-888-963-7111

TEXAS Department of State Health Services

APPLICATION TO AMEND CERTIFICATE OF BIRTH

STATE OF TEXAS

This application cannot be used to add the fathers information

NO.

Name _____ (Last) (First) (Middle)

Street Address _____ Telephone # _____ (8am-5pm)

City _____ State _____ Zip Code _____

Signature: _____

PART I. ENTER INFORMATION AS IT APPEARS ON THE ORIGINAL BIRTH CERTIFICATE. IF THE CHILD'S NAME DOES NOT APPEAR ON BIRTH CERTIFICATE, ENTER "NOT SHOWN" IN THE FIRST ITEM. (Type or Print)

1. FULL NAME OF CHILD		2. DATE OF BIRTH
3. PLACE OF BIRTH	4. SEX	5. STATE FILE NO. (If known)
6. FULL NAME OF FATHER	7. FULL MAIDEN NAME OF MOTHER	

PART II. ITEM(S) ON ORIGINAL BIRTH CERTIFICATE TO BE CORRECTED. (Type or Print)

8. ITEM OR ITEM NO.	9. ENTRY ON ORIGINAL CERTIFICATE	10. CORRECT INFORMATION

AFFIDAVIT OF OLDER RELATIVE

PART III. THIS SECTION MUST BE SIGNED BY THE ATTENDING PHYSICIAN, PARENTS, AN OLDER SISTER OR BROTHER. IF CHILD IS A MINOR, BOTH PARENTS MUST SIGN AFFIDAVIT.

This section MUST be signed in the presence of a Notary Public.

STATE OF TEXAS
COUNTY OF _____

Before me on this day appeared _____ (Name)

now residing at _____ (Street Address) (City) (State), who is related to the person named in Item I above as _____

and who on oath deposes and says that the birth certificate identified in Part I is in error with respect to the entries shown in Item 9 above and that the information shown in Item 10 is true and correct.

Signature _____ Father/Legal Guardian Signature _____ Mother/Legal Guardian

Sworn to and subscribed before me, this _____ day of _____, 20____

Signature of Notary Public

Commission Expires

OFFICE USE ONLY

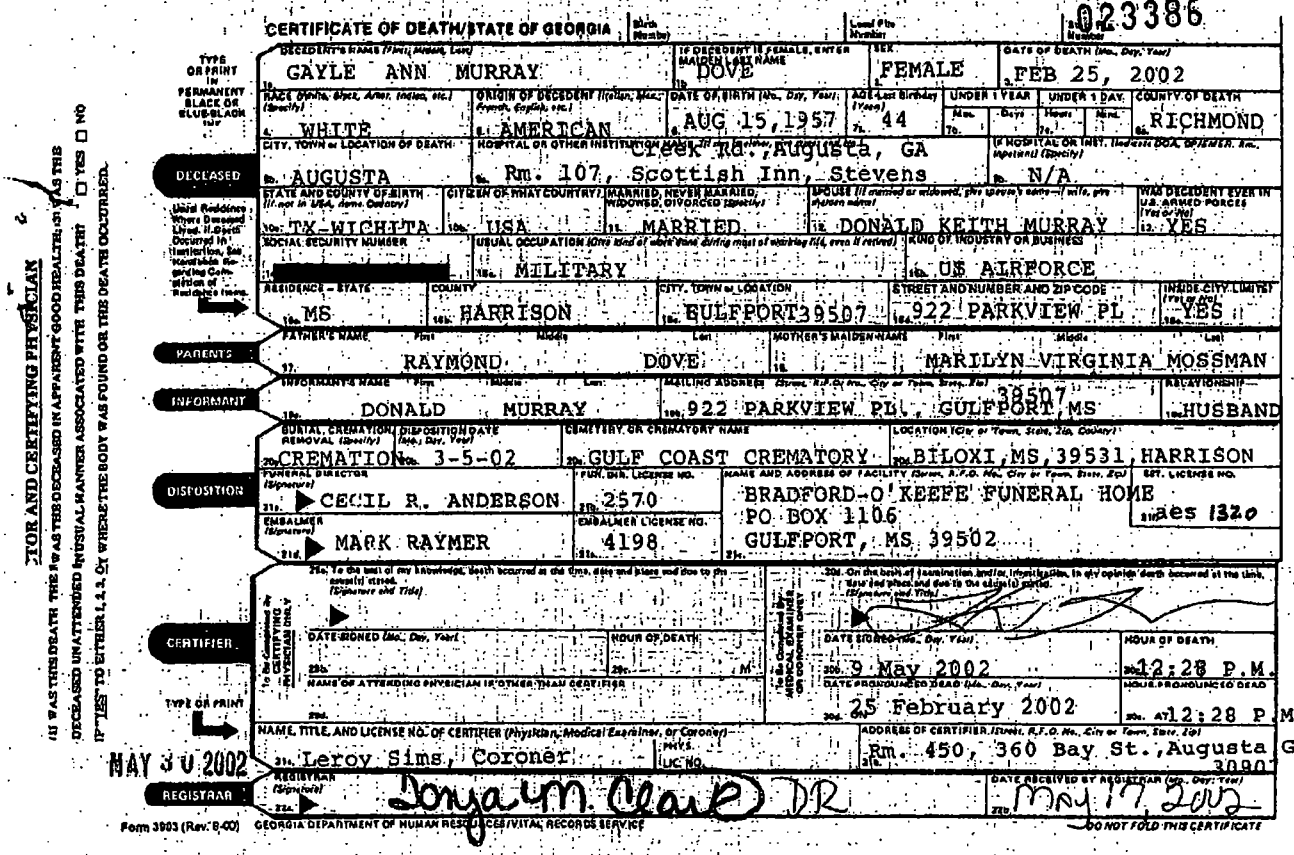
Typed or Printed Name

Street Address

City and State

WARNING: The penalty for knowingly making a false statement in this form can be 2-10 years in prison and a fine of up to $10,000.

VS-170 REV. 12/2005



CERTIFICATE OF DEATH/STATE OF GEORGIA

023386

1. DECEDENT'S NAME	GAYLE ANN MURRAY
2. IF DECEDENT IS FEMALE, ENTER MAIDEN LAST NAME	DOVE
3. SEX	FEMALE
3. DATE OF DEATH	FEB 25, 2002
4. RACE	WHITE
5. ORIGIN OF DECEDENT	AMERICAN
6. DATE OF BIRTH	AUG 15, 1957
7. AGE-Last Birthday	44
8. COUNTY OF DEATH	RICHMOND
9. CITY, TOWN or LOCATION OF DEATH	AUGUSTA
9. HOSPITAL OR OTHER INSTITUTION	Creek Rd., Augusta, GA Rm. 107, Scottish Inn, Stevens
9. IF HOSPITAL OR INST.	N/A
10. STATE AND COUNTRY OF BIRTH	TX-WICHITA
10. CITIZEN OF WHAT COUNTRY	USA
11. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED	MARRIED
12. SPOUSE	DONALD KEITH MURRAY
12. WAS DECEDENT EVER IN U.S. ARMED FORCES	YES
13. SOCIAL SECURITY NUMBER	[redacted]
14. USUAL OCCUPATION	MILITARY
15. KIND OF INDUSTRY OR BUSINESS	US AIRFORCE
16. RESIDENCE - STATE	MS
16. COUNTY	HARRISON
16. CITY, TOWN or LOCATION	GULFPORT 39507
16. STREET AND NUMBER AND ZIP CODE	922 PARKVIEW PL
16. INSIDE CITY LIMITS	YES
17. FATHER'S NAME	RAYMOND DOVE
18. MOTHER'S MAIDEN NAME	MARILYN VIRGINIA MOSSMAN
19. INFORMANT'S NAME	DONALD MURRAY
19. MAILING ADDRESS	922 PARKVIEW PL., GULFPORT, MS 39507
19. RELATIONSHIP	HUSBAND
20. BURIAL, CREMATION, REMOVAL	CREMATION
20. DISPOSITION DATE	3-5-02
20. CEMETERY OR CREMATORY NAME	GULF COAST CREMATORY
20. LOCATION	BILOXI, MS, 39531, HARRISON
21. FUNERAL DIRECTOR	CECIL R. ANDERSON
21. FUN. DIR. LICENSE NO.	2570
NAME AND ADDRESS OF FACILITY	BRADFORD-O'KEEFE FUNERAL HOME PO BOX 1106 GULFPORT, MS 39502
21. EMBALMER	MARK RAYMER
21. EMBALMER LICENSE NO.	4198
22. DATE SIGNED	9 May 2002
22. HOUR OF DEATH	12:28 P.M.
23. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER	
23. DATE PRONOUNCED DEAD	25 February 2002
23. HOUR PRONOUNCED DEAD	12:28 P.M.
24. NAME, TITLE, AND LICENSE NO. OF CERTIFIER	Leroy Sims, Coroner
24. ADDRESS OF CERTIFIER	Rm. 450, 360 Bay St., Augusta GA 30901
REGISTRAR	Donya M. Clark DR
DATE RECEIVED BY REGISTRAR	May 17, 2002

IF YES TO EITHER 1, 2, OR 3, WHERE THE BODY WAS FOUND OR THE DEATH OCCURRED

IF WAS THIS DEATH THE RESULT OF AN UNUSUAL MANNER ASSOCIATED WITH THIS DEATH? ☐ YES ☐ NO

DECEASED UNATTENDED BY

TOR AND CERTIFYING PHYSICIAN

MAY 30 2002

Form 3903 (Rev. 8-00) GEORGIA DEPARTMENT OF HUMAN RESOURCES/VITAL RECORDS SERVICE

DO NOT FOLD THIS CERTIFICATE

THIS IS TO CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF THE CERTIFICATE FILED WITH THE STATE OFFICE OF VITAL RECORDS, GEORGIA DEPARTMENT OF HUMAN RESOURCES. THIS CERTIFIED COPY IS ISSUED UNDER THE AUTHORITY OF CHAPTER 31-10, CODE OF GEORGIA AND 290-1-3 DHR RULES AND REGULATIONS.

STATE REGISTRAR AND CUSTODIAN
GEORGIA STATE OFFICE OF VITAL RECORDS

DATE DEC 11 2006

(VOID WITHOUT IMPRESSED SEAL OR IF ALTERED OR COPIED)

Augusta GEORGIA

AUGUSTA RICHMOND COUNTY CORONERS OFFICE

Grover Tuten
Coroner

Mark Bowen
Chief Deputy Coroner

Charlena Graham
Deputy Coroner

Blume Weyble & Norris, LLC
1247 Sumter Street
Second Floor
Columbia, S.C. 29201
Attention; Ms. Jill A. Rider

Re: Request for records, Jonathan Binney case

I have received your request for the release of records contained in my file on Gale A. Murray, deceased. You have included a release form signed by the "son of the deceased"; Jonathan Binney. This office does not show the son as the next of kin for the deceased but rather a husband, Mr. Donald Murray. Information this office has is that Mrs. Murray gave her son up for adoption at birth, if true, then the son has no standing to authorize the release of medical information. A signed release from the husband of the deceased should be submitted for the release of records.

I have included the records that are public information.

Grover Tuten

912 8th Street Augusta, Georgia 30901 Phone (706) 821-2382 Fax (706) 821-2869
www.augustaga.gov

Augusta
GEORGIA

Augusta-Richmond County Coroner

Coroner's Investigative Report

Gail Dove Murray

Case Number : 02-036504

Race	White	**Sex**	Female	**Age**	44	**SSN**	[redacted]
HGT	5-06	**WGT**	140	**DOB**	[redacted]	**Hair**	**Eye**

Address 922 Park View Place
Gulfport, MS 0.00

Date Of Death	02/25/2002	**Time Of Death**	12:28
Type Of Death	Suicide - Self Inflected Gunshot Wound		
Place Of Death	Scottish Inn, Rm 107, Stevens Creek Rd.		
Place Of Injury	Room 107, Scottish Inn, Stevens Creek Rd.		

ME Notified On	**ME Inv**	**Emp By**
Autopsy Performed	Yes	
Body Released To	Atlanta Embalming Service	

Investigative Officers

Officer Name	Employed By	Division
Inves. Joann Nutter , Car 745	RCSD	

4/25/2007

Augusta-Richmond County Coroner

Coroner's Investigative Report

Gail Dove Murray

Case Number : 02-036504

I received this call from the EMS dispatcher. At the scene, a motel room at the Scottish Inn on Stevens Creek Rd., I observed a female lying on the bed. This female is clad in a blue & white cotton nightgown and multi-colored panties, no other clothing is seen on the victim. The victim is lying face up with her head on the pillows. There is a large area of blood seen at the right ear and it flows down onto the carpet. The first Deputy on the scene states that he removed a semi-auto pistol from the top of the right elbow, the pistol was identified as a Beretta, 32 Cal. "Tom Cat". One spent casing is observed lying on the floor next to the bed, the clip of the weapon has seven rounds and one round is in the chamber. Weapon is turned over to the RCSD for processing. I examined the body and observed the following, a tattoo of a heart with the word "DON" is seen on the lower left leg. The left eye is blacken and swollen, no other wounds are seen. The jaw is in full rigor and the mouth is not forced opened for examination.

The body is placed in a body bag and all rings and jewelry are removed and turned over to the sheriff's department for safe keeping. Her vehicle, a Chevrolet, is impounded at 402 Walton Way by the RCSD. Body is transported to the SCL- Augusta to await transportation to the SCL- in Atlanta where an autopsy has been scheduled for Tuesday 022602.

On Tuesday, Feb. 26, 2002 at 1310 hours, I spoke with Donald Murray at the Gulfport, Ms. VA Hospital and he states that Ms. Dove and He were married in April 2000 at Mobil, Al. Mr. Murray requested that Braford O'Keefe Funeral Home (phone number 228- 865-0090) in Gulfport, Ms. be given the body. Atlanta Embalming Service was contacted by the F.H. to pick up the body.

Grover Tuten
Deputy Coroner

4/25/2007

PATIENT INFORMATION CONFIDENTIAL

(PLEASE PRINT)

Date 3-22-00

Age 25 Social Security # [redacted]

Name Jonathan (FIRST) K. (MI) Binney (LAST) Birthdate [redacted] Home Phone 864-578-4400

Address 225 River Forest Dr. City Boiling Springs State SC Zip 29316

Check Appropriate Box: ☐ Minor ☐ Single ☑ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's Employer Wal/Mart Supercenter Work Phone

Business Address City Boiling Springs State SC Zip

Spouse or Parent's Name Melanie Binney Employer Nestle Work Phone 487-7111 Ex: 654

Whom May We Thank for Referring You?

Person to Contact in Case of an Emergency wife - Melanie Phone 474-1724

Method of Payment: ☐ Cash ☑ Check ☐ Visa / Mastercard Card #

RESPONSIBLE PARTY

Name of Person Responsible for this Account self Relationship To Patient

Address Home Phone

Driver's License # Birthdate Social Security #

Employer Work Phone

Is this Person Currently a Patient in Our Office? ☐ Yes ☐ No

INSURANCE INFORMATION

Name of Insured Melanie Lee Binney Relationship To Patient Spouse

Birthdate 10-30-60 Social Security # [redacted] Date Employed

Name of Employer Nestle Work Phone 864-487-7111

Address of Employer City Gaffney State SC Zip

Insurance Company Group # Union or Local #

Insurance Company Address City State Zip

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☑ NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured Relationship To Patient

Birthdate Social Security # Date Employed

Name of Employer Work Phone

Address of Employer City State Zip

Insurance Company Group # Union or Local #

Insurance Company Address City State Zip

SIGNATURE

X [signature] Signature of Patient or Parent if Minor

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

	YES	NO
1. Are you under medical treatment now?	☑	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including nonprescription medicine?	☑	☐
If yes, what medication(s) are you taking? Tortab		
4. Do you use tobacco?	☑	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☑
6. Are you wearing contact lenses?	☐	☑
7. Are you allergic to or have you had reactions to the following?		
Local Anesthetics (eg. Novocaine)	☐	☑
Penicillin or Other Antibiotics	☐	☑
Sulfa Drugs	☐	☑
Barbiturates	☐	☑
Sedatives	☐	☑
Iodine	☐	☑
Aspirin	☐	☑
Other _____	☐	☑
8. Women only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

9. Do you have or have you had any of the following?	YES	NO
High Blood Pressure	☐	☑
Heart Attack	☐	☑
Rheumatic Fever	☐	☑
Swollen Ankles	☐	☑
Fainting / Seizures	☐	☑
Asthma	☐	☑
Low Blood Pressure	☐	☑
Epilepsy / Convulsions	☐	☑
Leukemia	☐	☑
Diabetes	☐	☑
Kidney Diseases	☐	☑
AIDS or HIV Infection	☐	☑
Thyroid Problem	☐	☑
Heart Disease	☐	☑
Cardiac Pacemaker	☐	☑
Heart Murmur	☐	☑
Angina	☐	☑
Frequently Tired	☐	☑
Anemia	☐	☑
Emphysema	☐	☑
Cancer	☐	☑
Arthritis	☐	☑
Joint Replace or Implant	☐	☑
Hepatitis / Jaundice	☐	☑
Sexually Transmitted Disease	☐	☑
Stomach Troubles / Ulcers	☐	☑
Chest Pains	☐	☑
Easily Winded	☐	☑
Stroke	☐	☑
Hay Fever / Allergies	☑	☐
Tuberculosis	☐	☑
Radiation Therapy	☐	☑
Glaucoma	☐	☑
Recent Weight Loss	☐	☑
Liver Disease	☐	☑
Heart Trouble	☐	☑
Respirator Problems	☐	☑
Other _____	☐	☐

PATIENT DENTAL HISTORY

Dentist Dunbar _____ Office Phone _____

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☑
2. Are your teeth sensitive to hot or cold liquids/foods?	☑	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☑
4. Do you feel pain to any of your teeth?	☑	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☑
6. Have you had any head, neck or jaw injuries?	☑	☐
7. Have you ever experienced any of the following problems in your jaw?		
A - Clicking?	☐	☑
B - Pain (joint, ear, side of face)?	☐	☑
C - Difficulty in opening or closing?	☐	☑
D - Difficulty in chewing?	☐	☑

	YES	NO
8. Do you have frequent headaches?	☐	☑
9. Do you clench or grind your teeth?	☐	☑
10. Do you bite your lips or cheeks frequently?	☐	☑
11. Have you ever had any difficult extractions in the past?	☐	☑
12. Have you had any orthodontic work?	☐	☑
13. Have you ever had prolonged bleeding following extractions?	☐	☑
14. Have you ever had instruction on the correction method of brushing your teeth?	☑	☐
15. Have you ever had instructions on the care of your gums?	☑	☐

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X _____

Name Jonathan - Binney

AGE 23 SEX M TEL. NO. 218-444-

OCCUPATION

REF'D BY

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

Remarks: Cons 3rds & 1 Ext

Surg time 45

2 = 95
16 = 95
17 = 240
32 = 240
OA = 230

900

NKA

DATE MO.	DAY	YR.	TOOTH NO.	DESCRIPTION OF WORK	TIME	ACCOUNT RECORD CHARGE	PAID	BALANCE
3	22	00		Cons. for removal of #2,16,17,32 - I OA Pano Chest x-ray ordered By Surgeon Plus x20 Keflex 500 X10				
3	23	00		Removal of #2,16,17,32 I OA Dr Reed - Code:	#17 + 2			

DATE MO.	DAY	YR.	TOOTH NO.	DESCRIPTION OF WORK	TIME	ACCOUNT RECORD CHARGE	PAID	BALANCE

This is to certify that I, the undersigned, consent to the performing of any Oral Surgery Procedure that may be decided upon to be necessary or advisable and to the use of Local or General Anesthetic as indicated.

Signature Jonathan Binney Date 3-22-00

Pulse
BP
Respiration
Hbg
Height

CENTER for Oral and Maxillofacial SURGERY, P.C.

H. Clinton Belk, D.M.D.

DATE: 3-23-00 NPO STATUS: NPO SINCE: 11:59 PM

NAME: Jonathon Birney ADDRESS: 255 River Forest Dr. Boiling Springs SC. 29316

SURGICAL PROCEDURE: Removal of 2, 16, 17, 32

VITAL SIGNS: PRE-OP B/P: 108/72 PULSE: 68

POST-OP B/P: 107/66 PULSE: 79

ANESTHESIA TIME: START: 10:26 STOP: 11:00

CLASS II
FENTANYL 0.1 Mg

N20/02: 40/60 %

CLASS III, IV, V
VERSED 5.0 Mg
BREVITAL 20 Mg

2% LIDOCAINE W/1:100,000 EPI.
1.8 cc X 5

0.5% MARCAINE W/1:200,000 EPI.
1.8 cc X 2

NON-CONTROLLED
KETAMINE 30 Mg
DROPERIDOL ____ Mg
DECADRON 8 Mg
OTHER Robaxin 25 Mg

PRESCRIPTIONS

		REFILL
LORTAB 5.0/ASA	#____	X____
LORTAB 5.0 Mg	#____	X____
LORCET PLUS	#____	X____
DARVOCET N-100 Mg	#____	X____
LORTAB LIQUID	#____	X____
AMOXIL 500 Mg	#____	X____
PCN 500 MG	#____	X____
DURICEF 500 Mg	#____	X____
KEFTAB 500 Mg	#____	X____
PHENERGAN 25 Mg	#____	X____

SUTURE: 4 CS

POST-OP INSTRUCTIONS GIVEN:
YES ✓ NO ____

RETURN APPOINTMENT: ____

ASSISTANT: CA

COMPLICATIONS: ∅

OTHER: ____

X-RAY TYPE: ____

LOCATION PLACEMENT OF PATIENT SHIELDING: ____

SIGNATURE: HCB

Zanesville-Muskingum Co. Health Department
205 N. Seventh Street • Zanesville, Ohio 43701-3709 • 614-454-9741

August 30, 1994

Mr. William A. Champlin
Probation Officer
Licking Co. Court House
Newark, Ohio 43055

Dear Mr. Champlin,

This is written at the request of my patient, Jonathan K. Binney, DOB 05/09/74. Jonathan was seen for a follow-up visit regarding his Attention Deficit Hyperactivity Disorder on 08/24/94. He continues to be treated with a stimulate medication for his disorder. Jonathon is to stay in contact with me by phone and return for his next clinic visit within the 3-4 months.

Sincerely,

Ross E. Williams, M.D., F.A.A.P.

Medications/Refills for John Bunney
(Patient's Name)

Date Called In	Medication	Dosage	Number Refills	Pharmacy
5/18/94	Office Visit Cylert 75 mg	1 Q AM	R 3-4 wks.	
8/24/94	Office Visit Cylert 75 mg	3/4 Tabs @ 8-10 am.		

PROGRESS NOTES

NAME: John Bierney

DATE

7/5/94 Phone call (+ mother) is having headaches & difficulty sleeping at night visual disturbance etc

Plan: Adderall 10 mg 37.5 mg QD
D/c on ritalin 5 mg pill bottle
Rx written 7/12, 30 min/more

7/20/94 NCN 5 patient was to be seen for follow up on ADD ——— Bernedo Norris

7/24/94 20 3/12 y o w M Hx c hypothyroidism
Will attend Hiles-Anderson — in Crownpoint Indiana (Music)
On Cylert 37.5 mg QD. 8-10 AM
Doing well on present dose.
L. Barker R.N.

Wt 134 3/4 lbs
Ht 69 1/4 in
BP 118/64

7/24/94 PE WD WN
EOM - wnl
Chest - clear A&P
Abd - soft
Skin - clear
Neuro - wnl

Imp: ADHD; Hx of conduct disorder

Plan: 1 to 75 mg 3/4 tab QD

d/c 8/29/94

note to Dr. William Champlin (PD) Licking Co. Comm. Mental Health Center, Newark OH 43055 for visit.

A. 3 - 0000

1031

PROGRESS NOTES

NAME: Binney, Jonathan

DATE	
7/18/94	Social — Patient reports he is currently living with his adoptive parents. Patient has been incarcerated at Southeastern-Ohio Regional Correctional Center from Sept 23, 1993 until May 16, 1994 when he was released on shock probation. Currently he is on intensive probation wherein he must stay with his parents and not be around alcohol or weapons of any type. He did not receive any counseling while incarcerated. He states he has not had any alcohol in a long time and denies an alcohol or drug problem. He states he was jailed on charges of receiving stolen property. Conversely, he states he has been employed in the past as a security guard. He states he has a male friend who has offered him a job in Las Vegas as a supervisor of a hardware store. Arrangements such as transportation and apartment are already taken care of. He states he is unsure if he is going to move away or not. He states he's feeling overwhelmed with so many choices to make. Refuses counseling as his adoptive father is a "Christian Psychologist". He has a probation officer in Fairfield County. Patient advised to apply for GA Benefits through Dept of Human Services. He has drivers license and G.E.D. certificate. Wants medication to control his impulsive behavior. Outlined role of Social Worker and offered services as needed. J. Edwards-Conrad LSW

MEDICAL HISTORY
ADMISSIONS OFFICE
HYLES-ANDERSON COLLEGE
8400 Burr Street
Crown Point, Indiana 46307
Phone: (219) 365-4031
or: (219) 769-4901

Name Jonathan Kyle Ellis
Address Box 267
New Concord (City) OH (State) 43762 (Zip)
Marital Status S (S,M,W,D) Age 20 Sex M Race W
Occupation None
Do you intend to enroll - Part-time? _____ Full-time? Yes
Do you intend to live in the dormitories? Yes

THIS TO BE COMPLETED BY STUDENT
(Required of everyone)

STUDENT HISTORY
Check those you have had (X).

- ☐ Drug Flashbacks
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Rheumatic Fever
- ☐ Arthritis
- ☐ Scarlet Fever
- ☐ Frequent Head Colds
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Anemia
- ☐ Mumps
- ☐ Sinus Disease
- ☐ Measles
- ☑ Chicken Pox
- ☐ Whooping Cough
- ☐ Venereal Disease
- ☐ Kidney or Bladder Disease
- ☐ Jaundice
- ☐ Heart Disease
- ☐ Liver Disease
- ☑ Weight Loss of Over 10 Pounds During Last Year
- ☐ Service with U.S.A. Overseas
- ☐ Frequent Tonsillitis
- ☐ Frequent Chest Colds
- ☐ Diptheria
- ☐ Fainting Attacks
- ☐ Pleurisy
- ☑ Allergies
- ☐ Pneumonia
- ☐ Trouble with Eyes
- ☐ Malaria
- ☐ Frequent Headaches
- ☐ Typhoid Fever
- ☑ Asthma

FAMILY HISTORY
(Parents, grandparents, brothers and sisters)

- ☑ Allergy
- ☐ Venereal Disease
- ☐ Mental Disease
- ☐ Brain Tumors
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Leukemia
- ☐ Kidney Disease
- ☐ Diabetes

History of Injuries: If any, give short account. If none, indicate "none." None

History of Operations: If any, when? what? If none, indicate "none." None

List any medications you take regularly: — Cylert

Have you ever sought psychiatric counsel? ☐ yes ☑ no
If yes, please explain in a separate letter, including the circumstances and medication which was given. _____

THIS TO BE COMPLETED BY YOUR PHYSICIAN
(This portion not required for part-time off-campus students). — Not to be completed more than one year prior to enrollment.

Date 5/18/94
Height 68 3/4 in. Weight 131 1/2 lbs. Blood pressure 120/70 Temp. _____ Pulse _____
Vision without glasses: Right 20/30 Left 20/30
Vision with glasses: Right ___/___ Left ___/___
E.E.N.T. ✓
Heart ✓ Extremities ✓
Lungs ✓ Reflexes ✓
Abdomen ✓ Genitals _____
Urine: Sugar _____ Albumin _____ Microscopic _____
TB Tine _____ Chest X-ray, if positive _____
The following blood tests are recommended, but not required: VDRL _____ CBC _____
List any limitations on the back of this sheet. None
Does this person seem to be physically capable of being enrolled in school? ☐ yes ☐ no
Physician [illegible] Address 205 N. 7th St. (Street) Jamesville (City) Ohio (State) 43701 (Zip)
6/30/94 Original sent to College @ above address

PROGRESS NOTES

NAME: John Binns

DATE	
2/13/01	C/o ↓ BM for 4d burning & urination. Objects. Sore throat began one week ago. Began drinking cranberry juice for same. PR. Drain BM.
	No sex for 6 wks. Unprotected.
	No discharge, rashes.
	No hx of trichomonas - prostatitis, nonul surgery - not taken.
	Past Urethritis.
	Doxycycline 100 BID x 15.

W. 132½ T. 98.8 U/A. Trace Bld

Dear DR. Williams would you please fill this Med History Sheet and send it to Hyles-Anderson College? Me & my parents decided I could use some "wise instruction". If you have any questions you can call me at home. We are going to be gone for a week but I have an appt. to see you soon.

Thanks

Jonathan Pinson

PROGRESS NOTES

NAME: Birney, Jonathan

DATE

2/5/93 phone c mother:
he took off last week gone for 3 days
staying c "friend" in Columbus & working
for work (met at [illegible] TCF)
have asked him to talk c me P.O. and
his psych & a friend locally
had some improvement c med.

2/2/93 NCNS had appt for HDHD — Chlordiaz

1/8/94 20yr. fr f/u — ADD.
wants med for impulsiveness
also has Sx of [illegible] syncope last time 10/93
Doc fr Bvl down,
had headaches & lightheadedness
neg TG test 12/93

wt 124 lbs
Ht 68 3/4 in.

Rein
Dr - pharm adv.
Client - dx
Dx - wx
Rx - dx
dx - tx pm

not depressed or suicidal

Dx: ADHD
Conduct disorder/adult
Tx: meds
for Effexor 75 mg BID
progress report week
call for appt. c Job Corps, etc.
R. 3 - 4 wks.

Phenytoin

[redacted]

PHYSICIAN: V. Whitacre, M.D.
Page 2

When questioned about how the patient acted afterwards, they said he seemed a little sleepy and not quite himself after this did happen. The patient did not have any shaking after he was on the floor.

IMPRESSION: 1. Acute syncope.
2. Acute labyrinthitis.

It was explained to the patient that I did not feel this was a true convulsion. I thought it was a syncopal episode with shaking due to lack of blood supply to the brain because of the syncopal episode. The patient is to be kept basically at bed rest for the next 3-5 days and is to have help going to the rest room. He was started on Antivert 25 mg 1 tid as needed for dizziness and a four pack of Antivert was given. He is to follow up with Dr. Williams or a local doctor within the next five days if he is no better. He is also to return if he has further shaking spells.

VICKI WHITACRE, M.D.

VW/sld
cc: Dr. Williams
D: 11/27/93
T: 11/30/93

EMERGENCY DEPARTMENT REPORT

BETHESDA
HOSPITAL
2951 Maple Avenue · Zanesville, Ohio 43701

BETHESDA HOSPITAL
EMERGENCY DEPARTMENT REPORT

BINNEY, JONATHAN [redacted] V. WHITACRE, M.D.

DATE IN ER: 11/27/93

Mr. Binney is a 19-year-old who comes in complaining of being dizzy and having a "possible convulsion". The patient is brought by local Sheriff as he is incarcerated. He says he was up in the cell block going to get a drink of water at about 12:30 a.m. today. He felt like the blackness was coming over him and he had some kind of shaking, jerking spell, that he thinks lasted 4-6 seconds. He describes it as a convulsion. He says he could not see and could not control the shaking and he fell down. The patient says that he was then passed out for about 3-5 seconds. He was on the floor when he woke up. This has never happened to him before. The detective said they brought him to be checked. They watched him at the jail for a little bit and they had some trouble getting to the hospital as someone had locked the keys in a running police car. Other inmates were interviewed by the police and they said that he did shake all over. The patient said he has had some ringing in his ears for 2-3 hours before this spell happened.

The patient is normally on Cylert with which he is being treated for attention deficit syndrome. He has had none for the last 2.5 months while he has been incarcerated in the jail. He sees Dr. Williams for this.

PHYSICAL EXAM: Blood pressure 109/74, pulse 96, respirations 20, temperature 97.7.

HEENT: Nontender. Face is nontender. Eyes: PERRL, extraocular muscles intact. Fundi benign. He has bilateral nystagmus and this is made worse by moving or shaking his head around which gives him some symptoms of feeling a little dizzy or somewhat vertiginous. TM's are clear. Throat is clear.

NECK: Nontender. It is supple with full range of motion.

CHEST: Clear.

HEART: Regular sinus rhythm. No murmur.

ABDOMEN: Soft, no masses, organomegaly, or tenderness.

BACK: Nontender.

EXTREMITIES: Nontender with good pulses and good range of motion.

NEURO: The patient is alert and oriented and in no difficulty.

Zanesville-Muskingum Co. Health Department

205 N. Seventh Street • Zanesville, Ohio 43701-3709 • 614-454-9741

PREPARED FOR Bureau of Disability DATE PREPARED 01/11/94

PATIENT NAME Binney, Jonathan BIRTH DATE [redacted]

FIRST EXAM 08/19/93 LAST EXAM 08/19/93

ILLNESSES 08/19/93 ADD, conduct disorder; refer for a nutritional consult, consult with Social Security, Cylert 37.5 mg, d/c Ritalin

HOSPITALIZATION None

ABNORMAL TESTS None

IMMUNIZATIONS None available

DRUG ALLERGIES None

LATEST HEIGHT & WEIGHT 08/19/93 Wt. 131 1/2#; Ht. 5'9"

REMARKS None

If you need any other information, please write me.

Sincerely,

Ross E. Williams, M.D., F.A.A.P.

PROGRESS NOTES

NAME: John K. Brady

DATE	
11/9/93	A 19 yr 3 mo old White Male to get help for ADD. Did not notice many problems 6th - 7th grade. Had a explosive verbal temperament and much difficulty concentrating. Quit school at age 16 but acquired GED at age 18. Would like to go to college. Interested in computers and broadcast engineering. Approx. 14 months ago overdosed on ASA. Lives in Columbus for auto theft (jury-rigging). States he is very impulsive in his decision-making. Takes Ritalin 20mg (SR) + last @ 10:00 A.M. Thinks he has side-effects of nicotine - feels like mouth-system is dried out. Headaches.

E. Moore R.N.

side effects: headaches & nausea
is under better control
still having trouble getting to sleep
can't tell when med wears off.

PE Pain WD adolescent
HEENT WNL
Chest-Abd Clear
Other WNL
Back Skin Clear
Ext & Spine WNL
Neuro WNL

Dx: ADD
Conduct disorder

Plan: refer Nat. Consult
refer S.C. Consult
Cafcit 325 mg B.D.; call me in 1-2 wks
DC Ritalin
F. / mo.

Wt 131½#
Ht 5' 9"
BP 120/70
UA - pH 7.0
Sp. Grav. 1.025
Hearing WNL
Vision:
FAR - L 20/20 Jaeger
NEAR - R 20/30 Orot
L 20/20
Color - Red/Green Deficient

is to be called for intake at 6-Co

not employed
wants to go to
College (Nexus)
Rock Smith
problems w/ O.D. in
N.Y. State

YOUR NAME Jonathan Binney

CHILD'S NAME _____

DATE RECEIVED 8-19-93

Your Health Department's Social Service Department is available to confidentially assist you and your family with any areas of special concern. To better help us assist you, we ask that you take a few moments to carefully answer each of the following by marking either Yes or No after each question.

All information will be held in strictest confidence.

I setting

Thank you.

SECTION I. Your Children

A. Do ~~your children~~ I have any problems that worry you? ___no ✓yes

B. Have any of your children ever been placed in a foster home? ✓no ___yes

C. Do your children get along with others? ✓yes ✓no

D. Are you satisfied with your child's development? ___yes ✓no

E. Do you have any concerns about your child's behavior? ___no ✓yes

F. Are you interested in a parenting class? ~~___no ___yes~~

SECTION II. Health Matters For Parents

A. Do you have any medical problems that worry you? ✓no ___yes

B. Are you feeling nervous or easily depressed? ✓no ___yes

C. Is there too much stress in your life? ✓no ___yes

D. Do you take time for yourself each day? ✓yes ___no

E. Do you or anyone in your household use any of the following?

1. Drugs ✓no ___yes
2. Alcohol ✓no ___yes
3. Tobacco ✓no ___yes

F. Are you interested in information on alcohol or drug treatment? ✓no ___yes

G. Are you interested in information on a class for learning how to stop smoking? ✓no ___yes

Continued

SECTION III. Family Matters

A. Are there any problems in the way you and your child's father get along? ✓ no ___ yes

B. Are there any problems in the way you and your parents or other family members get along? ✓ no ___ yes

C. Is there someone you could turn to for help if you had a problem? ✓ yes ___ no

D. Do you have excessive financial worries? ___ no ✓ yes

E. Do you need help with obtaining birth control? ✓ no ___ yes

F. Do your parents or family members live nearby? ___ yes ✓ no

G. Do you feel isolated at times? ___ no ✓ yes

SECTION IV. Education

A. Are you still in school? ✓ no ___ yes

B. Did you graduate from high school? ___ yes ✓ no

C. Are you interested in returning to school? ✓ no ___ yes

D. Are you interested in finding a job? ___ no ✓ yes

E. Are you in a training program now? ✓ no ___ yes

F. Are you working with any other agency now? ✓ no ___ yes

G. Check any/all of the following which may be a problem for you.

✓ Housing ___ Food ___ WIC ___ Assistance with Human Services ✓ Clothing

✓ Hospital Bills ___ Relationships ___ Other _____

G. Any concerns not mentioned? ✓ no ___ yes

Thank you for answering!

Adolescent Health History Questionnaire

Please complete this form and bring it, with your shot records, and income verification to clinic _____ at _____.

Completed by _____ Date _____

Patient's Name Binney, Jonathan, Kyle Jon
Last First Middle Nickname

Patient's Age 19 Birthdate [redacted] Sex M Race White

Patient's Address Box 312
New Concord, OH 43762 Phone 672-3816

Parent's Address (if different from patient) _____
_____ Phone _____

1. Patient's Father Jim Patient's Mother Sandra
Maiden Name Sandra Canavan
Age 49 Height 5'10" Weight 190 Age 48 Height 5'7" Weight 140
Health Fair Health Normal

2. Please list your brothers and sisters and their ages:

	First & Last Name	Age	Health
1.	None,		
2.	I'm Adopted		
3.			
4.			
5.			
6.			

3. When and where was your last routine check-up? ?
4. With what Doctor was your last check-up? ? Dr. Williams
5. Are you allergic to any medicines? No Yes ?
If so, what _____
6. Have you ever reacted poorly to any immunizations, shots, or medicines? No (Yes)
If so, what Diprivine

7. Circle any of the following diseases that your parents, grandparents, aunts, uncles, brothers, sisters, or cousins have had, and state who had it:

Diabetes ?	Bleeding Problems
Thyroid Problems	Anemia
Heart Disease	Cancer
High Blood Pressure	Psychiatric Problems
Kidney or Urinary Problems	Eczema
Birth Defects	Allergies
Convulsions	Epilepsy
Mental Retardation	Other
Asthma or Bronchitis	

8. Have you ever been put in a hospital? yes

Age	Hospital	Illness or Operation
17	Good Sam	
	Bethesda	Overdose

9. Circle any of the following diseases that you have had:

ten day measles	rheumatic fever
three day measles	pneumonia
(chicken pox)	hepatitis
mumps	(asthma)
whooping cough	convulsions
tuberculosis	urinary or kidney infection
scarlet fever	meningitis
impetigo	other _____

The following questions only require that you circle yes or no. Please note, the yes and no are not always in the same column.

10. While your mother was pregnant with you, did she have any problems? If yes, please list _____. No Yes

11. How much did you weigh when you were born? _____

12. Did you have any trouble in the newborn nursery? No Yes

13. Do you think you are healthy? (Yes) No

14. Have you grown too slowly? (Yes) No

15. Is your appetite usually good? (Yes) No

16. Have you ever been anemic? No Yes

17. Do you have any bowel problems, constipation, or diarrhea? (No) Yes

18. Have you ever:

- been seriously burned? (No) Yes
- Taken any medicines or poisons accidentally? (No) Yes
- broken any bones? No (Yes)
- had a severe head injury or been knocked out? No (Yes)
- had any other serious accidents or injuries? (No) Yes

19. Have you ever lost any weight? No (Yes)

20. Have you ever had asthma or wheezing? No (Yes)

21. Do you tend to have a stuffy nose or constant cold? No (Yes)

22. Do you often have a sore throat or hoarseness? (No) Yes

23. Have you had an ear infection more than two times? (No) Yes

24. Have you ever had a draining or runny ear? (No) Yes

25. Have you ever had frequent nosebleeds for no apparent reason? (No) Yes

26. Do you hear well? (Yes) No

27. Do you see well? (Yes) No

28. Do your eyes ever cross? (No) Yes

29. Are you either wearing or supposed to be wearing glasses? (No) Yes

30. Have you ever had red, painful, or swollen joints? (No) Yes

31. Have you ever had to urinate more frequently than usual? (No) Yes

32. Have you ever had pain while urinating? (No) Yes

33. Have you ever had blood in the urine? (No) Yes

34. Do you have trouble with your teeth? No (Yes) ?

35. When did you last see a dentist? Date _____
Dentist's Name: _____

36. Do you have a heart murmur or anything wrong with your heart? (No) Yes

37. Do you wet the bed? (No) Yes

38. Do you wet or soil your clothes? (No) Yes

39. Have you ever had serious reactions to bee or wasp stings? (No) Yes

40. Have you ever reacted poorly to any shots? No (?) Yes
If so, list _____

41. Have you ever had a convulsion, fit, or spell? (No) Yes

42. Do you have trouble with your feet or legs? (No) Yes

43. Are you usually happy? (Yes) (No)

44. Do you get along well with others? (Yes) (No)

45. Have you ever been exposed to anyone with tuberculosis? (No) Yes

46. Have you ever been tested for tuberculosis? (No) Yes

47. Was the test negative? Yes No

48. If you are attending school, which school do you attend? _____

49. Do you enjoy school? Yes (No)

50. Do you think your school work should be better? No (Yes)

51. Do the teachers think your school work should be better? No (Yes)

52. Have you ever had to repeat a grade? No (Yes)

53. Are you in a special class or getting special help? (No) Yes

54. Has the school ever recommended intelligence tests or a special class for you? (No) Yes

55. Is your behavior a problem in school? ~~No Yes~~

56. Do you have pets? If so, list them _____ (No) Yes

57. Are you employed? If so, where _____ (No) Yes
Hours per week _____.

58. Are you (single) married, divorced, or separated? (please circle) (No) Yes
How Long? ___ Spouse's Name _____

59. Do you have children? If so, please list: (No) Yes

	First & Last Name	Birthday	Health
1.			
2.			
3.			
4.			

60. Have you had any of the following? (Please Circle)

clumsiness	stuttering
too active	cry too much
(excessive tiredness)	fight too much
(easily upset)	(legal problems)
bad temper	(suicide)
(high strung or nervous)	lying
(trouble sleeping)	(stealing)
frequent headaches	starting fires
nightmares	too shy
nail biting	(probation)
thumbsucking	picky eater
(can't stick to one thing long enough)	(smoking)
	(drinking)
poor speech	drugs
menstruation problems	

COMMENTS: (If you need additional space, use reverse side. please describe any special problems or concerns you may have.)

ADOLESCENT WELLNESS INFORMATION GUIDE

Here in the Clinic, we understand that maintaining good health (wellness) means getting the facts, making good choices, and practicing healthy habits. We can provide information on many health-related issues and problems. We'll work with you to find some important answers.

Below are some health concerns mentioned in a recent survey by teenagers asked which topics they wanted to discuss with their physician. Please mark whether these topics are "very much", "a little", or "not at all" of interest to you. Please be truthful and remember that discussions with your physician are confidential.

Interest			
Very	Little	None	
✓			Exercise and keeping in shape
✓			Nutrition and eating right
		✓	Thinness
	✓		Fatness
	✓		Sexually transmitted diseases
		✓	Contraception or birth control
		✓	Sexual activity
		✓	Sexual Abuse
✓			Acne
		✓	Fear of cancer
		✓	Feelings of sadness
✓			Problems with boyfriend or girlfriend
		✓	Menstruation and menstrual problems
		✓	Drinking
		✓	Drugs
	✓		Lack of confidence
	✓		Male and female body changes
		✓	Illness in family
		✓	Smoking
		✓	Conflicts
	✓		Problems at school

This form is for use today and will not be kept in your permanent medical record.

Augusta GEORGIA

AUGUSTA RICHMOND COUNTY CORONERS OFFICE

Grover Tuten
Coroner

Mark Bowen
Chief Deputy Coroner

Charlena Graham
Deputy Coroner

Blume Weyble & Norris, LLC
1247 Sumter Street
Second Floor
Columbia, S.C. 29201
Attention; Ms. Jill A. Rider

Re: Request for records, Jonathan Binney case

I have received your request for the release of records contained in my file on Gale A. Murray, deceased. You have included a release form signed by the "son of the deceased"; Jonathan Binney. This office does not show the son as the next of kin for the deceased but rather a husband, Mr. Donald Murray. Information this office has is that Mrs. Murray gave her son up for adoption at birth, if true, then the son has no standing to authorize the release of medical information. A signed release from the husband of the deceased should be submitted for the release of records.

I have included the records that are public information.

Grover Tuten

912 8th Street Augusta, Georgia 30901 Phone (706) 821-2382 Fax (706) 821-2869
www.augustaga.gov

Augusta
GEORGIA

Augusta-Richmond County Coroner

Coroner's Investigative Report

Gail Dove Murray

Case Number : 02-036504

Race	White	**Sex**	Female	**Age**	44	**SSN**	[redacted]
HGT	5-06	**WGT**	140	**DOB**	[redacted]	**Hair**	**Eye**

Address 922 Park View Place
Gulfport, MS 0.00

Date Of Death	02/25/2002	**Time Of Death**	12:28
Type Of Death	Suicide - Self Inflected Gunshot Wound		
Place Of Death	Scottish Inn, Rm 107, Stevens Creek Rd.		
Place Of Injury	Room 107, Scottish Inn, Stevens Creek Rd.		

ME Notified On	**ME Inv**	**Emp By**
Autopsy Performed	Yes	
Body Released To	Atlanta Embalming Service	

Investigative Officers

Officer Name	Employed By	Division
Inves. Joann Nutter , Car 745	RCSD	

4/25/2007

Augusta-Richmond County Coroner

Coroner's Investigative Report

Gail Dove Murray

Case Number : [redacted]

I received this call from the EMS dispatcher. At the scene, a motel room at the Scottish Inn on Stevens Creek Rd., I observed a female lying on the bed. This female is clad in a blue & white cotton nightgown and multi-colored panties, no other clothing is seen on the victim. The victim is lying face up with her head on the pillows. There is a large area of blood seen at the right ear and it flows down onto the carpet. The first Deputy on the scene states that he removed a semi-auto pistol from the top of the right elbow, the pistol was identified as a Beretta, 32 Cal. "Tom Cat". One spent casing is observed lying on the floor next to the bed, the clip of the weapon has seven rounds and one round is in the chamber. Weapon is turned over to the RCSD for processing. I examined the body and observed the following, a tattoo of a heart with the word "DON" is seen on the lower left leg. The left eye is blacken and swollen, no other wounds are seen. The jaw is in full rigor and the mouth is not forced opened for examination.

The body is placed in a body bag and all rings and jewelry are removed and turned over to the sheriff's department for safe keeping. Her vehicle, a Chevrolet, is impounded at 402 Walton Way by the RCSD. Body is transported to the SCL- Augusta to await transportation to the SCL- in Atlanta where an autopsy has been scheduled for Tuesday 022602.

On Tuesday, Feb. 26, 2002 at 1310 hours, I spoke with Donald Murray at the Gulfport, Ms. VA Hospital and he states that Ms. Dove and He were married in April 2000 at Mobil, Al. Mr. Murray requested that Braford O'Keefe Funeral Home (phone number 228- 865-0090) in Gulfport, Ms. be given the body. Atlanta Embalming Service was contacted by the F.H. to pick up the body.

Grover Tuten
Deputy Coroner

4/25/2007

Zanesville–Muskingum Co. Health Department
205 N. Seventh Street • Zanesville, Ohio 43701-3709 • 614-454-9741

August 30, 1994

Mr. William A. Champlin
Probation Officer
Licking Co. Court House
Newark, Ohio 43055

Dear Mr. Champlin,

This is written at the request of my patient, Jonathan K. Binney, DOB 05/09/74. Jonathan was seen for a follow-up visit regarding his Attention Deficit Hyperactivity Disorder on 08/24/94. He continues to be treated with a stimulate medication for his disorder. Jonathon is to stay in contact with me by phone and return for his next clinic visit within the 3-4 months.

Sincerely,

Ross E. Williams, M.D., F.A.A.P.

Medications/Refills for John Binney
(Patient's Name)

Date Called In	Medication	Dosage	Number Refills	Pharmacy
5/18/94	Office Visit Cylert 75 mg	1 PO QD R 3-4 wks		
8/24/94	Office Visit Cylert 75 mg	3/4 Tabs @ 8-10 am.		

PROGRESS NOTES

NAME: John Birney

DATE	
7/5/94	Phone call (+ mother) is having headaches & difficulty sleeping at night & some vague visual disturbances also. Plan: Tylenol #3 325 mg PRN D/c on ritalin but better R. to school 7/12. Soon/nurse
7/20/94	NCNS patient Wants to be seen for follow up on ADD — Bernedo notified
8/29/94	20 yr 6 mo old WM Hx of hyperkinesis Will attend Hiles-Anderson - in Crawfordsville Indiana (Music) On Cylert 37.5 mg QD. 8-10 AM Doing well on present dose. L. Barker R.N.
8/29/94	PE: WD WN EOMI - sl Chest - clear Abd - soft, nontender, no HSM Skin - clear Neuro - sl Dx: ADHD; Hx of conduct disorder Plan: 1 to 75 mg 3/4 tab QD Note to Dr William A Champlin (PD) transfer visit. Licking Co. Comm Hosp; Newark OH 43055 A. 3-4 mo

Wt 134 3/4 lbs
Ht 69 1/4 in
BP 118/64

Lic # 8/29/94

PROGRESS NOTES

NAME: Binney, Jonathan

DATE	
7/18/94	Social — Patient reports he is currently living with his adoptive parents. Patient has been incarcerated at Southeastern-Ohio Regional Correctional Center from Sept 23, 1993 until May 16, 1994 when he was released on shock probation. Currently he is on intensive probation wherein he must stay with his parents and not be around alcohol or weapons of any type. He did not receive any counseling while incarcerated. He states he has not had any alcohol in a long time and denies an alcohol or drug problem. He states he was jailed on charges of receiving stolen property. Conversely, he states he has been employed in the past as a security guard. He states he has a male friend who has offered him a job in Las Vegas as a supervisor of a hardware store. Arrangements such as transportation and apartment are already taken care of. He states he is unsure if he is going to move away or not. He states he's feeling overwhelmed with so many choices to make. Refuses counseling as his adoptive father is a "Christian Psychologist." He has a probation officer in Licking County. Patient advised to apply for GA Benefits through Dept of Human Services. He has drivers license and G.E.D. certificate. Wants medication to control his impulsive behavior. Outlined role of Social Worker and offered services as needed. J. Edwards-Conrad, LSW

MEDICAL HISTORY
ADMISSIONS OFFICE
HYLES-ANDERSON COLLEGE
8400 Burr Street
Crown Point, Indiana 46307
Phone: (219) 365-4031
or: (219) 769-4901

Name Jonathan Kyle Ellis
Address Box 267
New Concord (City) OH (State) 43762 (Zip)
Marital Status S (S,M,W,D) Age 20 Sex M Race W
Occupation None
Do you intend to enroll - Part-time? _____ Full-time? Yes
Do you intend to live in the dormitories? Yes

THIS TO BE COMPLETED BY STUDENT
(Required of everyone)

STUDENT HISTORY
Check those you have had (X)

- ☐ Drug Flashbacks
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Rheumatic Fever
- ☐ Arthritis
- ☐ Scarlet Fever
- ☐ Frequent Head Colds
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Anemia
- ☐ Mumps
- ☐ Sinus Disease
- ☐ Measles
- ☑ Chicken Pox
- ☐ Whooping Cough
- ☐ Venereal Disease
- ☐ Kidney or Bladder Disease
- ☐ Jaundice
- ☐ Heart Disease
- ☐ Liver Disease
- ☑ Weight Loss of Over 10 Pounds During Last Year
- ☐ Service with U.S.A. Overseas
- ☐ Frequent Tonsillitis
- ☐ Frequent Chest Colds
- ☐ Diptheria
- ☐ Fainting Attacks
- ☐ Pleurisy
- ☑ Allergies
- ☐ Pneumonia
- ☐ Trouble with Eyes
- ☐ Malaria
- ☐ Frequent Headaches
- ☐ Typhoid Fever
- ☑ Asthma

FAMILY HISTORY
(Parents, grandparents, brothers and sisters)

- ☑ Allergy
- ☐ Venereal Disease
- ☐ Mental Disease
- ☐ Brain Tumors
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Leukemia
- ☐ Kidney Disease
- ☐ Diabetes

History of Injuries: If any, give short account. If none, indicate "none." None

History of Operations: If any, when? what? If none, indicate "none." None

List any medications you take regularly: — Cylert

Have you ever sought psychiatric counsel? ☐ yes ☑ no
If yes, please explain in a separate letter, including the circumstances and medication which was given. _____

THIS TO BE COMPLETED BY YOUR PHYSICIAN
(This portion not required for part-time off-campus students). — Not to be completed more than one year prior to enrollment.

Date 5/18/94
Height 6' 8 3/4" in Weight 131 1/2 lbs Blood pressure 120/70 Temp. _____ Pulse _____
Vision without glasses: Right 20/30 Left 20/30
Vision with glasses: Right ___/___ Left ___/___
E.E.N.T. ✓
Heart ✓ Extremities ✓
Lungs ✓ Reflexes ✓
Abdomen ✓ Genitals ✓
Urine: Sugar _____ Albumin _____ Microscopic _____
TB Tine _____ Chest X-ray, if positive _____
The following blood tests are recommended, but not required: VDRL _____ CBC _____
List any limitations on the back of this sheet. None
Does this person seem to be physically capable of being enrolled in school? ☐ yes ☐ no
Physician [signature] Address 205 N. 7th St. (Street) Zanesville (City) Ohio (State) 43701 (Zip)
6/30/94 Copy sent to College @ above address

PROGRESS NOTES

NAME: John Binns

DATE	
2/13/01	C/o sore throat + cough + burning ? Urination. Pain began one week ago. Began coughing cranberry juice ~~for~~ Pain on Urination. Frequency
	No sexual hx. Unprotected.
	No discharge, rectum.
	No area of tenderness - Prostate normal size + not tender.
	Chest Unremarkable.
Chest	

WT. 134½ T. 98.8 U/A. Trace Bld

Doxycycline 100 Bid #15.

Dear DR. Williams would you please fill this Med History Sheet and send it to Hyles-Anderson College? Me & my parents decided I could use some "wise instruction". If you have any questions you can call me at home. We are going to be gone for a week but I have an appt. to see you soon.

Thanks

Jonathan Pierce

RECEIVED
JUN 13 1994
JESSILL-INGALLS-COLLINS COUNTY
GENERAL HEALTH DISTRICT

PROGRESS NOTES

NAME: Binney, Jonathan

DATE	
25/93	phone c mother: he took off last week gone for 3 days staying c "friend" is / Columbus & working for work (met at [illegible]) TCP have asked him to talk c me P.O. and his psych & a friend locally had some improvement c med.
2/2/93	NCNS had appt for HDHD — Called Lee
1/8/94	20yo. for f/u for ADD. wants med for symptom worse also has sig. stress / separated since 10/93 Sees Sue Bradham had headaches c Ritalin neg TB test 12/93 Pt Rein OA - plays stud. Chest - clr Abd - WNL Ext - clr Skin - clr & pink not depressed or suicidal Dx: ADHD Pharmacotx Conduct disorder/adult Rx: Ritalin 25 mg BID prescription given call for appt c Jo Ann, etc. R. 3-4wks.

wt 124 lbs
Ht 68 3/4 in.

BINNEY, JONATHAN
[redacted]
PHYSICIAN: V. Whitacre, M.D.
Page 2

When questioned about how the patient acted afterwards, they said he seemed a little sleepy and not quite himself after this did happen. The patient did not have any shaking after he was on the floor.

IMPRESSION: 1. Acute syncope.
2. Acute labyrinthitis.

It was explained to the patient that I did not feel this was a true convulsion. I thought it was a syncopal episode with shaking due to lack of blood supply to the brain because of the syncopal episode. The patient is to be kept basically at bed rest for the next 3-5 days and is to have help going to the rest room. He was started on Antivert 25 mg 1 tid as needed for dizziness and a four pack of Antivert was given. He is to follow up with Dr. Williams or a local doctor within the next five days if he is no better. He is also to return if he has further shaking spells.

VICKI WHITACRE, M.D.

VW/sld
cc: Dr. Williams
D: 11/27/93
T: 11/30/93

BETHESDA
HOSPITAL
2951 Maple Avenue Zanesville, Ohio 43701

BETHESDA HOSPITAL
EMERGENCY DEPARTMENT REPORT

BINNEY, JONATHAN [redacted] V. WHITACRE, M.D.

DATE IN ER: 11/27/93

Mr. Binney is a 19-year-old who comes in complaining of being dizzy and having a "possible convulsion". The patient is brought by local Sheriff as he is incarcerated. He says he was up in the cell block going to get a drink of water at about 12:30 a.m. today. He felt like the blackness was coming over him and he had some kind of shaking, jerking spell, that he thinks lasted 4-6 seconds. He describes it as a convulsion. He says he could not see and could not control the shaking and he fell down. The patient says that he was then passed out for about 3-5 seconds. He was on the floor when he woke up. This has never happened to him before. The detective said they brought him to be checked. They watched him at the jail for a little bit and they had some trouble getting to the hospital as someone had locked the keys in a running police car. Other inmates were interviewed by the police and they said that he did shake all over. The patient said he has had some ringing in his ears for 2-3 hours before this spell happened.

The patient is normally on Cylert with which he is being treated for attention deficit syndrome. He has had none for the last 2.5 months while he has been incarcerated in the jail. He sees Dr. Williams for this.

PHYSICAL EXAM: Blood pressure 100/74, pulse 96, respirations 20, temperature 97.7.

HEENT: Nontender. Face is nontender. Eyes: PERRL, extraocular muscles intact. Fundi benign. He has bilateral nystagmus and this is made worse by moving or shaking his head around which gives him some symptoms of feeling a little dizzy or somewhat vertiginous. TM's are clear. Throat is clear.

NECK: Nontender. It is supple with full range of motion.

CHEST: Clear.

HEART: Regular sinus rhythm. No murmur.

ABDOMEN: Soft, no masses, organomegaly, or tenderness.

BACK: Nontender.

EXTREMITIES: Nontender with good pulses and good range of motion.

NEURO: The patient is alert and oriented and in no difficulty.

Zanesville-Muskingum Co. Health Department

205 N. Seventh Street • Zanesville, Ohio 43701-3709 • 614-454-9741

PREPARED FOR Bureau of Disability DATE PREPARED 01/11/94

PATIENT NAME Binney, Jonathan BIRTH DATE [redacted]

FIRST EXAM 08/19/93 LAST EXAM 08/19/93

ILLNESSES 08/19/93 ADD, conduct disorder; refer for a nutritional consult, consult with Social Security, Cylert 37.5 mg, d/c Ritalin

HOSPITALIZATION None

ABNORMAL TESTS None

IMMUNIZATIONS None available

DRUG ALLERGIES None

LATEST HEIGHT & WEIGHT 08/19/93 Wt. 131 1/2#; Ht. 5'9"

REMARKS None

If you need any other information, please write me.

Sincerely,

Ross E. Williams, M.D., F.A.A.P.

PROGRESS NOTES

NAME: John K. Bracey

DATE	
7/19/93	A 19 yr 3 mo old White Male to get help for ADD. Did not notice many problems until 6th - 7th grade. Had a explosive verbal temperament and much difficulty concentrating. Quit school at age 16, later acquired GED at age 18. Would like to go to college. Interested in computers and product engineering. Approx. 14 months ago overdosed on ASA. Hx TCY in Columbus for auto theft (joy-riding). States he is very impulsive in his decision-making. Took Ritalin 20mg (SR) + last @ 10:00 A.M. Thinks he has side-effects of insomnia - feels like mouth - system is dry and headaches.

E Mauger R.N.

side effect: headaches & nausea
is under better control
still having trouble getting to sleep
can't tell when med wears off.

Pt Pain WD athlete.
HEENT WNL
Chest - clear
Abdomen WNL
Back Skin Pt
Ext - no spinal
Neuro WNL

Dx: ADD
Conduct disorder

Plan: resp. Nat. counsel
resp. S.C. counsel
Collat 3rd yr D.D.; call me in 1 wk
Rx Ritalin
R. 1 mo

WNL

Wt 131½"
Ht 5' 9"
BP 120/70
UA - PH 7.0
Sp. Grav. 1.015
Hearing WNL
Vision:
FAR - 20/20 Both
NEAR - @ 20/30 Both
or 20/20
Color - Field Deficits

is to be called if
in lake of 6-Co

not employed
wants to go to
College next yr
BOK Smith
problems c ADD in
NY. State

YOUR NAME Jonathan Binney

CHILD'S NAME _____

DATE RECEIVED 8-19-93

Your Health Department's Social Service Department is available to confidentially assist you and your family with any areas of special concern. To better help us assist you, we ask that you take a few moments to carefully answer each of the following by marking either Yes or No after each question.

All information will be held in strictest confidence.

I setting

Thank you.

SECTION I. Your Children

A. Do ~~your~~ ~~children~~ I have any problems that worry you? ___no ✓yes

B. Have any of your children ever been placed in a foster home? ✓no ___yes

C. Do your children get along with others? ✓yes ✓no

D. Are you satisfied with your child's development? ___yes ✓no

E. Do you have any concerns about your child's behavior? ___no ✓yes

F. Are you interested in a parenting class? ~~___no ___yes~~

SECTION II. Health Matters For Parents

A. Do you have any medical problems that worry you? ✓no ___yes

B. Are you feeling nervous or easily depressed? ✓no ___yes

C. Is there too much stress in your life? ✓no ___yes

D. Do you take time for yourself each day? ✓yes ___no

E. Do you or anyone in your household use any of the following?

1. Drugs ✓no ___yes
2. Alcohol ✓no ___yes
3. Tobacco ✓no ___yes

F. Are you interested in information on alcohol or drug treatment? ✓no ___yes

G. Are you interested in information on a class for learning how to stop smoking? ✓no ___yes

Continued

SECTION III. Family Matters

A. Are there any problems in the way you and your child's father get along? ✓ no ___ yes

B. Are there any problems in the way you and your parents or other family members get along? ✓ no ___ yes

C. Is there someone you could turn to for help if you had a problem? ✓ yes ___ no

D. Do you have excessive financial worries? ___ no ✓ yes

E. Do you need help with obtaining birth control? ✓ no ___ yes

F. Do your parents or family members live nearby? ___ yes ✓ no

G. Do you feel isolated at times? ___ no ✓ yes

SECTION IV. Education

A. Are you still in school? ✓ no ___ yes

B. Did you graduate from high school? ___ yes ✓ no

C. Are you interested in returning to school? ✓ no ___ yes

D. Are you interested in finding a job? ___ no ✓ yes

E. Are you in a training program now? ✓ no ___ yes

F. Are you working with any other agency now? ✓ no ___ yes

G. Check any/all of the following which may be a problem for you.

✓ Housing ___ Food ___ WIC ___ Assistance with Human Services ✓ Clothing

✓ Hospital Bills ___ Relationships ___ Other _____

G. Any concerns not mentioned? ✓ no ___ yes

Thank you for answering!

Adolescent Health History Questionnaire

Please complete this form and bring it, with your shot records, and income verification to clinic _____ at _____.

Completed by _____ Date _____

Patient's Name Binney, Jonathan, Kyle Jon
Last First Middle Nickname

Patient's Age 19 Birthdate [redacted] Sex M Race White

Patient's Address Box 312
New Concord, OH 43762 Phone 672-3816

Parent's Address (if different from patient) _____
_____ Phone _____

1. Patient's Father Jim Patient's Mother Sandra
Maiden Name Sandra Canavan
Age 49 Height 5'10" Weight 190 Age 48 Height 5'7" Weight 140
Health Fair Health Normal

2. Please list your brothers and sisters and their ages:

	First & Last Name	Age	Health
1.	None,		
2.	I'm Adopted		
3.			
4.			
5.			
6.			

3. When and where was your last routine check-up? ?
4. With what Doctor was your last check-up? ? Dr. Williams
5. Are you allergic to any medicines? No Yes ?
If so, what _____
6. Have you ever reacted poorly to any immunizations, shots, or medicines? No (Yes)
If so, what Disiprimine

7. Circle any of the following diseases that your parents, grandparents, aunts, uncles, brothers, sisters, or cousins have had, and state who had it:

Diabetes ?	Bleeding Problems
Thyroid Problems	Anemia
Heart Disease	Cancer
High Blood Pressure	Psychiatric Problems
Kidney or Urinary Problems	Eczema
Birth Defects	Allergies
Convulsions	Epilepsy
Mental Retardation	Other
Asthma or Bronchitis	

8. Have you ever been put in a hospital? yes

Age	Hospital	Illness or Operation
17	Good Sam or Bethesda	Overdose

9. Circle any of the following diseases that you have had:

ten day measles	rheumatic fever
three day measles	pneumonia
(chicken pox)	hepatitis
mumps	(asthma)
whooping cough	convulsions
tuberculosis	urinary or kidney infection
scarlet fever	meningitis
impetigo	other _____

The following questions only require that you circle yes or no. Please note, the yes and no are not always in the same column.

10. While your mother was pregnant with you, did she have any problems? If yes, please list _____. No Yes

11. How much did you weigh when you were born? _____

12. Did you have any trouble in the newborn nursery? No Yes

13. Do you think you are healthy? (Yes) No

14. Have you grown too slowly? (Yes) No

15. Is your appetite usually good? (Yes) No

16. Have you ever been anemic? No Yes

17. Do you have any bowel problems, constipation, or diarrhea? (No) Yes

18. Have you ever:

    been seriously burned? (No) Yes

    Taken any medicines or poisons accidentally? (No) Yes

    broken any bones? No (Yes)

    had a severe head injury or been knocked out? No (Yes)

    had any other serious accidents or injuries? (No) Yes

19. Have you ever lost any weight? No (Yes)

20. Have you ever had asthma or wheezing? No (Yes)

21. Do you tend to have a stuffy nose or constant cold? No (Yes)

22. Do you often have a sore throat or hoarseness? (No) Yes

23. Have you had an ear infection more than two times? (No) Yes

24. Have you ever had a draining or runny ear? (No) Yes

25. Have you ever had frequent nosebleeds for no apparent reason? (No) Yes

26.	Do you hear well?	(Yes) No
27.	Do you see well?	(Yes) No
28.	Do your eyes ever cross?	(No) Yes
29.	Are you either wearing or supposed to be wearing glasses?	(No) Yes
30.	Have you ever had red, painful, or swollen joints?	(No) Yes
31.	Have you ever had to urinate more frequently than usual?	(No) Yes
32.	Have you ever had pain while urinating?	(No) Yes
33.	Have you ever had blood in the urine?	(No) Yes
34.	Do you have trouble with your teeth?	No (Yes)
35.	When did you last see a dentist? Date ? Dentist's Name: _____	
36.	Do you have a heart murmur or anything wrong with your heart?	(No) Yes
37.	Do you wet the bed?	(No) Yes
38.	Do you wet or soil your clothes?	(No) Yes
39.	Have you ever had serious reactions to bee or wasp stings?	(No) Yes
40.	Have you ever reacted poorly to any shots? If so, list _____	No (Yes)?
41.	Have you ever had a convulsion, fit, or spell?	(No) Yes
42.	Do you have trouble with your feet or legs?	(No) Yes
43.	Are you usually happy?	(Yes) (No)
44.	Do you get along well with others?	(Yes) (No)
45.	Have you ever been exposed to anyone with tuberculosis?	(No) Yes
46.	Have you ever been tested for tuberculosis?	(No) Yes
47.	Was the test negative?	Yes No
48.	If you are attending school, which school do you attend? _____	

49. Do you enjoy school? Yes (No)

50. Do you think your school work should be better? No (Yes)

51. Do the teachers think your school work should be better? No (Yes)

52. Have you ever had to repeat a grade? No (Yes)

53. Are you in a special class or getting special help? (No) Yes

54. Has the school ever recommended intelligence tests or a special class for you? (No) Yes

55. Is your behavior a problem in school? ~~No Yes~~

56. Do you have pets? If so, list them _____ (No) Yes

57. Are you employed? If so, where _____ (No) Yes
Hours per week _____.

58. Are you (single) married, divorced, or separated? (Please Circle) (No) (Yes)
How Long? ___ Spouse's Name _____

59. Do you have children? If so, please list: (No) Yes

	First & Last Name	Birthday	Health
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

60. Have you had any of the following? (Please Circle)

clumsiness
too active
excessive tiredness
easily upset
bad temper
high strung or nervous
trouble sleeping
frequent headaches
nightmares
nail biting
thumbsucking
can't stick to one thing long enough
poor speech
menstruation problems
stuttering
cry too much
fight too much
legal problems
suicide
lying
stealing
starting fires
too shy
probation
picky eater
smoking
drinking
drugs

COMMENTS: (If you need additional space, use reverse side. please describe any special problems or concerns you may have.)

ADOLESCENT WELLNESS INFORMATION GUIDE

Here in the Clinic, we understand that maintaining good health (wellness) means getting the facts, making good choices, and practicing healthy habits. We can provide information on many health-related issues and problems. We'll work with you to find some important answers.

Below are some health concerns mentioned in a recent survey by teenagers asked which topics they wanted to discuss with their physician. Please mark whether these topics are "very much", "a little", or "not at all" of interest to you. Please be truthful and remember that discussions with your physician are confidential.

Interest			
Very	Little	None	
✓			Exercise and keeping in shape
✓			Nutrition and eating right
		✓	Thinness
	✓		Fatness
	✓		Sexually transmitted diseases
		✓	Contraception or birth control
		✓	Sexual activity
		✓	Sexual Abuse
✓			Acne
		✓	Fear of cancer
		✓	Feelings of sadness
✓			Problems with boyfriend or girlfriend
		✓	Menstruation and menstrual problems
		✓	Drinking
		✓	Drugs
	✓		Lack of confidence
	✓		Male and female body changes
		✓	Illness in family
		✓	Smoking
		✓	Conflicts
	✓		Problems at school

This form is for use today and will not be kept in your permanent medical record.

PATIENT INFORMATION CONFIDENTIAL

(PLEASE PRINT)

Date 3-22-00

Age 25 Social Security # [redacted]

Name Jonathan (FIRST) K. (MI) Binney (LAST) Birthdate [redacted] Home Phone 864-578-4400

Address 225 River Forest Dr. City Boiling Springs State SC Zip 29316

Check Appropriate Box: ☐ Minor ☐ Single ☑ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's Employer Wal/Mart Supercenter Work Phone _____

Business Address _____ City Boiling Springs State SC Zip _____

Spouse or Parent's Name Melanie Binney Employer Nestle Work Phone 487-7111 Ex: 654

Whom May We Thank for Referring You? _____

Person to Contact in Case of an Emergency wife - Melanie Phone 474-1724

Method of Payment: ☐ Cash ☑ Check ☐ Visa / Mastercard Card # _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account self Relationship To Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Social Security # _____

Employer _____ Work Phone _____

Is this Person Currently a Patient in Our Office? ☐ Yes ☐ No

INSURANCE INFORMATION

Name of Insured Melanie Lee Binney [redacted] Relationship To Patient Spouse

Birthdate 10-30-60 Social Security # [redacted] Date Employed _____

Name of Employer Nestle Work Phone 864-487-7111

Address of Employer _____ City Gaffney State SC Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Insurance Company Address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship To Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Insurance Company Address _____ City _____ State _____ Zip _____

SIGNATURE

X Jonathan Binney Signature of Patient or Parent if Minor

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

	YES	NO
1. Are you under medical treatment now?	☑	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including nonprescription medicine?	☑	☐
If yes, what medication(s) are you taking? lortab		
4. Do you use tobacco?	☑	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☑
6. Are you wearing contact lenses?	☐	☑
7. Are you allergic to or have you had reactions to the following?		
Local Anesthetics (eg. Novocaine)	☐	☑
Penicillin or Other Antibiotics	☐	☑
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other _____	☐	☐
8. Women only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

9. Do you have or have you had any of the following?	YES	NO
High Blood Pressure	☐	☑
Heart Attack	☐	☑
Rheumatic Fever	☐	☐
Swollen Ankles	☐	☐
Fainting / Seizures	☐	☐
Asthma	☐	☐
Low Blood Pressure	☐	☐
Epilepsy / Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney Diseases	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Frequently Tired	☐	☐
Anemia	☐	☑
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Joint Replace or Implant	☐	☐
Hepatitis / Jaundice	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles / Ulcers	☐	☐
Chest Pains	☐	☐
Easily Winded	☐	☐
Stroke	☐	☐
Hay Fever / Allergies	☑	☐
Tuberculosis	☐	☑
Radiation Therapy	☐	☐
Glaucoma	☐	☑
Recent Weight Loss	☐	☑
Liver Disease	☐	☑
Heart Trouble	☐	☑
Respirator Problems	☐	☑
Other _____	☐	☐

PATIENT DENTAL HISTORY

Dentist Dunbar Office Phone _____

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☑
2. Are your teeth sensitive to hot or cold liquids/foods?	☑	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☑
4. Do you feel pain to any of your teeth?	☑	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☑
6. Have you had any head, neck or jaw injuries?	☑	☐
7. Have you ever experienced any of the following problems in your jaw?		
A - Clicking?	☐	☑
B - Pain (joint, ear, side of face)?	☐	☑
C - Difficulty in opening or closing?	☐	☑
D - Difficulty in chewing?	☐	☑

	YES	NO
8. Do you have frequent headaches?	☐	☑
9. Do you clench or grind your teeth?	☐	☑
10. Do you bite your lips or cheeks frequently?	☐	☑
11. Have you ever had any difficult extractions in the past?	☐	☑
12. Have you had any orthodontic work?	☐	☑
13. Have you ever had prolonged bleeding following extractions?	☐	☑
14. Have you ever had instruction on the correction method of brushing your teeth?	☑	☐
15. Have you ever had instructions on the care of your gums?	☑	☐

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X _____

Name Jonathan ~ Binney

AGE ~ SEX ~ TEL. NO.

OCCUPATION

REF'D BY

8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8

Remarks: Cons 3-3rds + 1 Ext Surg time 45

2 = 95
15 = 45
17 = 240
32 = 240
OA = 280 (900)

NKA

DATE MO.	DAY	YR.	TOOTH NO.	DESCRIPTION OF WORK	TIME	ACCOUNT RECORD CHARGE	PAID	BALANCE
3	22	00		Consult for removal of #2,16,17,32 & OA Panoramic x-ray planned for Surgery Plus x 20 Medications 500 x 10				
3	23	00		Removal of #2,16,17,32 & OA Local Anesthesia #17 + 32				

DATE MO.	DAY	YR.	TOOTH NO.	DESCRIPTION OF WORK	TIME	ACCOUNT RECORD CHARGE	PAID	BALANCE

This is to certify that I, the undersigned, consent to the performing of any Oral Surgery Procedure that may be decided upon to be necessary or advisable and to the use of Local or General Anesthetic as indicated.

Signature Jonathan Binney Date 3-22-00

Pulse
BP
Respiration
Hbg
Height

C E N T E R
for Oral and Maxillofacial
SURGERY, P.C.

H. Clinton Belk, D.M.D.

DATE: 3-23-00 NPO STATUS: NPO SINCE: 11:59 PM

NAME: Jonathon Binns ADDRESS: 255 River Forest Dr. Boilings Springs SC. 29316

SURGICAL PROCEDURE: Removal of 2, 16, 17, 32

VITAL SIGNS: PRE-OP
B/P: 108/72
PULSE: 68

POST-OP
B/P: 107/66
PULSE: 79

ANESTHESIA TIME: START: 10:26 STOP: 11:00

CLASS II
FENTANYL 0.1 Mg

N20/02: 40/60 %

CLASS III, IV, V
VERSED 5.0 Mg
BREVITAL 20 Mg

2% LIDOCAINE W/1:100,000 EPI.
1.8 cc X 5

0.5% MARCAINE W/1:200,000 EPI.
1.8 cc X 2

NON-CONTROLLED
KETAMINE 30 Mg
DROPERIDOL ____ Mg
DECADRON 8 Mg
OTHER Robaxin 25 Mg

PRESCRIPTIONS

		REFILL
LORTAB 5.0/ASA	#____	X____
LORTAB 5.0 Mg	#____	X____
LORCET PLUS	#____	X____
DARVOCET N-100 Mg	#____	X____
LORTAB LIQUID	#____	X____
AMOXIL 500 Mg	#____	X____
PCN 500 MG	#____	X____
DURICEF 500 Mg	#____	X____
KEFTAB 500 Mg	#____	X____
PHENERGAN 25 Mg	#____	X____

SUTURE: 4 CS

POST-OP INSTRUCTIONS GIVEN:
YES ✓ NO____

RETURN APPOINTMENT: ____

ASSISTANT: Cheryl

COMPLICATIONS: None

OTHER: ____

X-RAY TYPE: ____

LOCATION PLACEMENT OF PATIENT SHIELDING: ____

SIGNATURE: HCB

55 pg

Vol 1

4

Veterans Administration

REFERENCE SLIP

TO (Name or title—Mail routing symbol)	INITIALS—DATE
1. 211 Monette, Christi K	
2. VA REGIONAL OFFICE	
3. Jackson	
4. ATTN: ADJUDICATION DIVISION	
5.	

REASON FOR REFERENCE

- ☐ AS REQUESTED
- ☐ FOR YOUR FILES
- ☐ NOTE AND RETURN
- ☐ COMMENTS
- ☒ INFORMATION
- ☐ PER CONVERSATION
- ☐ CONCURRENCE
- ☐ NECESSARY ACTION
- ☐ SIGNATURE

REMARKS

NAME: Dove, Gayle

C#: 5-15 64 6094

SS#: 11 11 11

- ☐ HOSPITAL SUMMARY
- ☐ INTERIM SUMMARY
- ☐ OUTPATIENT RECORDS
- ☐ RECORDS TRANSFERRED TO
- ☐ AMBULATORY SURGERY
- ☒ OTHER Copy of all records from 3-6-97 to present
- ☐ DOM DISCHARGE PROGRESS NOTE
- ☐ NO RECORDS AT THIS FACILITY

FROM 520/19B1 DS
400 Veterans Avenue
Biloxi, MS 39531-2410

DATE 10-15

TEL. EXT. FTS: 5245

VA FORM MAY 1980 3230 EXISTING STOCKS OF VA FORM 3210, AUG 1978, WILL BE USED.

IE 7131 NEW REQUEST REPORT FOR DOVE,GAYLE A **Long Version**

FOR BILOXI VAMC 520, DIVISION BILOXI

VE,GAYLE A [redacted]

REQUEST DATE: 05/28/1998

Items Requested:

OPT TREATMENT REPORT (BILOXI): 03-06-97 TO THE PRESENT

marks:

PLEASE FURNISH ALL HS & OPTR FROM 03-06-97 TO THE PRESENT TO SUPPORT VET'S CLAIM FOR INCREASED SC FOR MIGRAINE HEADACHES. REQUESTED THESE RECORDS ON 03-25-98. 2ND REQUEST - PLEASE EXPEDITE

equested by: MONETTE,CHRISTI K AT JACKSON-RO

[E 7131 NEW REQUEST REPORT FOR 03/25/98 TO 03/25/98 * LONG VERSION *
FOR BILOXI VAMC 520, DIVISION BILOXI

/E,GAYLE A SSN: [redacted]

ACTIVITY DATE: 03/13/97
REQUEST DATE: 03/25/98

Items Requested:

OPT TREATMENT REPORT (BILOXI): 03-06-97 TO THE PRESENT

narks:

PLEASE FURNISH ALL HS & OPTR FROM 03-06-97 TO THE PRESENT TO SUPPORT VET'S CLAIM FOR INCREASED SC FOR MIGRAINE HEADACHES. REQUESTED THESE RECORDS ON 03-25-98.

quested by: GUNN,JAMES RODNEY AT JACKSON-RO

TRANSACTION REPORT

Ma 17-00 Fri 4:35 PM

Type	Receiving				
Date	Start	Sender	TX/RX Time	Pages	Note
Mar-17	4:30 PM		4m18s	12	OK

VA Gulf Coast
Veterans Health Care
System
400 Veterans Avenue
Biloxi, Mississippi 39531

Release of Information Office (19B1)

FAX NUMBER	228.523.4922
TELEPHONE NUMBER	228.523.5759

DATE: 3-17-00

Number of Pages: 12
(includes cover sheet)

TO: Greenville SC
Address: _____

TELEPHONE: _____
FAX: 864-422-2023
FROM: Vanessa Extension: 5759

Regarding Veteran: Dave Gayle SS# [redacted]

In response to your request, the following information is provided:

☐Hospital Summary(ies)dated: _____
Outpatient Records dated: _____
Domiciliary Records dated: _____
Other: _____

Note: This FAX is intended only for the use of the person or office to which it is addressed, and may contain information that is privileged, confidential, or protected by law. All others are hereby notified that the receipt of this FAX does not waive any applicable privilege or exemption for disclosure, and that any dissemination, distribution, or copying of this communication is prohibited. If you receive this FAX in error, please notify this office immediately at the telephone number listed above.

WARNING: Many FAX machines produce copies on thermal paper. The image produced is unstable and will deteriorate over time. If your machine uses this technology, this message should be copied on a plain paper copier prior to filing as a record.

Informational Rx Profile Run Date: MAR 17,2000 Page: 1
Sorted by drug classification for Rx's currently active
and for those Rx's that have been inactive less than 120 days. Site: VAMC Biloxi, MS ((
NS) (520)

Name : DOVE,GAYLE A [redacted]
DOB : [redacted] Address : 4457 POPPS FERRY RD.LOT 195
BILOXI, MISSISSIPPI 39532
Phone : 228-396-1919

WEIGHT(Kg): 61.18 (12/10/1999) HEIGHT(cm): 167.64 (12/10/1999)
DISABILITIES: POST-TRAUMATIC STRESS DISORDER-70% (SC),
REMOVAL OF UTERUS AND OVARIES-50% (SC), MIGRAINE HEADACHES-30% (SC),
RHINITIS-0% (SC), NEOPLASM, BENIGN, SKIN-0% (SC),

ALLERGIES:

ADVERSE REACTIONS:

Pending Outpatient Clinic Appointments:

APR 17,2000@08:40	PC PURPLE PENNISSON *** Canceled ***
APR 20,2000@07:30	LABORATORY (34 days)
JUL 5,2000@09:00	EYE-CARRIERE (110 days)
JUL 18,2000@08:40	NEUROLOGY-DR V NALLURI (123 days)
AUG 22,2000@11:00	PC PURPLE PENNISSON (NEW) (158 days)

Informational Rx Profile Run Date: MAR 17,2000 Page: 2
Sorted by drug classification for Rx's currently active
and for those Rx's that have been inactive less than 120 days. Site: VAMC Biloxi, MS ((
NS) (520)

Name : DOVE,GAYLE A [redacted]
DOB : [redacted] Address : 4457 POPPS FERRY RD.LOT 195
BILOXI, MISSISSIPPI 39532
Phone : 228-396-1919

WEIGHT(Kg): 61.18 (12/10/1999) HEIGHT(cm): 167.64 (12/10/1999)

Medication/Supply	Expiration Date	Provider	Rx#	Status

Classification: AH500 - ANTIHISTAMINES,PIPERAZINE

HYDROXYZINE HCL 25MG TAB Qty: 120 for 30 Days 2337854 Expired
12-23-1999 GELDER,MAURICE D
Sig: TAKE 1 TABLET BY MOUTH FOUR TIMES A DAY AS NEEDED FOR ANXIETY
Filled: 11-23-1999 Past Fills: 06-14-1999 05-25-1999 04-05-1999 03-16-1999
Remaining Refills: 0 Clinic: MENTAL HYGIENE
Price: $2.64

Classification: CN101 - OPIOID ANALGESICS

N/F BUTORPHANOL TARTRATE 1MG 14D NASAL SPRAY Qty: 1 for 60 Days 5095862 Active
06-11-2000 NALLURI,VASANTHI KUMARI
Sig: USE ONE SPRAY ONE NOSTRIL AS NEEDED
Filled: 01-29-2000 12-10-1999 Past Fills: 10-01-1999
Remaining Refills: 0 Clinic: BILOXI PHARMACY
Price: $38.31

Classification: CN105 - ANTIMIGRAINE AGENTS

SUMATRIPTAN SUCC 6MG/0.5ML STATDOSE RFL Qty: 4 for 30 Days 5095859 Active
12-10-2000 NALLURI,VASANTHI KUMARI
Sig: I. UNDER THE SKIN (SUBCUTANEOUSLY) AS NEEDED HEADACHE
Filled: 02-28-2000 01-29-2000 01-03-2000 12-10-1999
Remaining Refills: 0 Clinic: NEUROLOGY-DR V NALLURI
Price: $186.00

SUMATRIPTAN SUCCINATE 25MG TAB Qty: 9 for 30 Days 5095860 Active
12-10-2000 NALLURI,VASANTHI KUMARI
Sig: TAKE 1 TABLET BY MOUTH AS NEEDED
Filled: 02-28-2000 01-29-2000 01-03-2000 12-10-1999
Remaining Refills: 0 Clinic: NEUROLOGY-DR V NALLURI
Price: $56.55

Classification: CN302 - BENZODIAZEPINE DERIVATIVE SEDATIVES/HYPNOTICS

LORAZEPAM 1MG TAB Qty: 60 for 30 Days 2341093 Expired
02-24-2000 CROWDER,WADE A
Sig: TAKE 1 TABLET(S) BY MOUTH TWICE A DAY
Filled: 01-25-2000

Remaining Refills: 0 Clinic: WOMEN'S MHPC GOLD PSYCHIA-GPT
Price: $18.18

Classification: CN309 - SEDATIVES/HYPNOTICS,OTHER

BUSPIRONE HCL 10MG TAB Qty: 120 for 30 Days 2341091 Expired
02-24-2000 CROWDER,WADE A
Sig: TAKE 4 TABLETS BY MOUTH EVERY DAY IN DIVIDED DOSES AS DIRECTED
Filled: 01-25-2000 Past Fills: 11-23-1999 10-05-1999
Remaining Refills: 0 Clinic: WOMEN'S MHPC GOLD PSYCHIA-GPT
Price: $76.92

Informational Rx Profile Run Date: MAR 17,2000 Page: 3
Sorted by drug classification for Rx's currently active
and for those Rx's that have been inactive less than 120 days. Site: VAMC Biloxi, MS (C
NS) (520)

Name : DOVE,GAYLE A [redacted]
DOB : [redacted] Address : 4457 POPPS FERRY RD.LOT 195
BILOXI, MISSISSIPPI 39532
Phone : 228-396-1919

WEIGHT(Kg): 61.18 (12/10/1999) HEIGHT(cm): 167.64 (12/10/1999)

Medication/Supply Rx# Status
Expiration Provider
Date

Classification: CN400 - ANTICONVULSANTS

GABAPENTIN 300MG CAP Qty: 150 for 30 Days 2334547A Active
10-05-2000 GELDER,MAURICE D
Sig: TAKE 1 CAPSULE BY MOUTH THREE TIMES A DAY BEFORE MEALS AND TAKE 2 CAPSULES AT BEI
IME
Filled: 02-12-2000 01-23-2000 01-03-2000 11-24-1999 10-05-1999
Remaining Refills: 1 Clinic: MENTAL HYGIENE
Price: $92.85

Classification: CN609 - ANTIDEPRESSANTS,OTHER

FLUOXETINE HCL 20MG CAP Qty: 90 for 30 Days 2341092 Active
01-25-2001 CROWDER,WADE A
Sig: Take 3 caps CAPSULE(S) BY MOUTH EVERY MORNING
Filled: 02-14-2000 01-25-2000 Past Fills: 01-12-2000 12-13-1999 11-23-1999 10-05-19
9
05-07-1999 04-07-1999 03-08-1999 02-16-1999
Remaining Refills: 2 Clinic: WOMEN'S MHPC GOLD PSYCHIA-GPT
Price: $103.23

Classification: CN709 - ANTIPSYCHOTICS,OTHER

OLANZAPINE 5MG TAB Qty: 30 for 30 Days 2334548A Active
10-05-2000 GELDER,MAURICE D
Sig: TAKE 1 TABLET BY MOUTH AT BEDTIME
Filled: 02-12-2000 01-23-2000 01-03-2000 11-24-1999 10-05-1999
Remaining Refills: 1 Clinic: MENTAL HYGIENE
Price: $99.24

Classification: CV100 - BETA BLOCKERS/RELATED

ATENOLOL 25MG TAB Qty: 30 for 30 Days 5091798 Active
11-29-2000 T HART,BARBARA J
Sig: TAKE 1 TABLET EVERY DAY
Filled: 12-19-1999 11-29-1999
Remaining Refills: 1 Clinic: BILOXI PHARMACY
Price: $0.57

Classification: GA202 - HYPEROSMOTIC LAXATIVES

MAGNESIUM CITRATE LIQUID Qty: 300 for 5 Days 5091797 Expired
12-04-1999 T HART,BARBARA J
Sig: DRINK 1/2 BOTTLE ON ICE FOLLOWED BY A LOT OF WATER AS NEEDED FOR CONSTIPATION
Filled: 11-29-1999
Remaining Refills: 0 Clinic: BILOXI PHARMACY
Price: $210.00

Informational Rx Profile Run Date: MAR 17,2000 Page: 4
Sorted by drug classification for Rx's currently active
and for those Rx's that have been inactive less than 120 days. Site: VAMC Biloxi, MS (C
NS) (520)

Name : DOVE,GAYLE A [redacted]
DOB : [redacted] Address : 4457 POPPS FERRY RD.LOT 195
BILOXI, MISSISSIPPI 39532
Phone : 228-396-1919

WEIGHT(Kg): 61.18 (12/10/1999) HEIGHT(cm): 167.64 (12/10/1999)

Medication/Supply		Rx#	Status
Expiration Date	Provider		

Classification: GA301 - HISTAMINE ANTAGONISTS

RANITIDINE HCL 300MG TAB — Qty: 60 for 30 Days — 5085831 — Active
11-05-2000 MOHIUDDIN,JAVED
Sig: TAKE ONE TABLET BY MOUTH TWICE A DAY
Filled: 11-05-1999
Remaining Refills: 5 Clinic: BILOXI PHARMACY
Price: $3.96

Classification: GA700 - ANTIEMETICS

PROCHLORPERAZINE 25MG RTL SUPP — Qty: 12 for 6 Days — 5091796 — Active
11-29-2000 T HART,BARBARA J
Sig: INSERT 1 SUPP. RECTALLY EVERY TWELVE HOURS AS NEEDED
Filled: 12-08-1999 11-29-1999
Remaining Refills: 0 Clinic: BILOXI PHARMACY
Price: $21.31

Classification: HS300 - ESTROGENS

ESTRADIOL 2MG TAB — Qty: 8 for 30 Days — 2334550 — Active
09-09-2000 DONALDSON,MARGO A
Sig: TAKE 1/4 TABLET BY MOUTH EVERY DAY
Filled: 01-19-2000 12-20-1999 09-09-1999
Remaining Refills: 0 Clinic: MENTAL HYGIENE
Price: $0.58

----------PENDING ORDERS----------

No pending orders for this patient!

03/17/2000 15:21

********** CONFIDENTIAL AD HOC SUMMARY pg. 1 **********

DOVE,GAYLE A [redacted] DOB: [redacted]

---------- DCS - Discharge Summary (max 10 occurrences or 1 year) ----------

08/29/1999 - 09/09/1999 Status: COMPLETED
Last Tr Specialty: GEN INTERMEDIATE PSYCH Dict'd By: MATHIS,DAVID M
Approved By: MATHIS,DAVID M

DISCHARGE DIAGNOSIS:
AXIS I. BIPOLAR AFFECTIVE DISORDER, TYPE II.
AXIS II. BORDERLINE PERSONALITY DISORDER.
AXIS III. MIGRAINE HEADACHE.
AXIS IV. MODERATE TO SEVERE STRESSORS.
AXIS V. ADMISSION GAF 35, DISCHARGE GAF 60, BEST IN PAST YEAR 60.

DIAGNOSES NOTED BUT NOT TREATED:
NONE.

OPERATIONS/PROCEDURES PERFORMED:
NONE

SUMMARY:
HISTORY OF PRESENT ILLNESS:
This is a 42 year old caucasian female who was admitted with a complaint of "another friend died and my step-mother died and ever since I left last time, it has been a tug of war between me, my father and my boyfriend." Patient reports that she was having suicidal thoughts with a plan to shoot herself with her father's rifle. Her drug screen was positive for opiates and the patient states that her father gave her Tylenol #3 for migraine headaches.

ALLERGIES:
Patient reports no known allergies.

PHYSICAL EXAMINATION:
Temperature 98, pulse 82, respirations 20, blood pressure 110/60.

HEAD - normocephalic.
EYES - PERRLA, EOMI.
NECK - supple.
LUNGS - clear to auscultation.
HEART - S1S2, no murmur.
ABDOMEN - soft, with normal bowel sounds.

LABORATORY VALUES:
X-rays, there are none on available on the chart.

03/17/2000 15:21

DOVE,GAYLE A [redacted] DOB: [redacted]

---------- DCS - Discharge Summary (max 10 occurrences or 1 year) ----------
(continued)

HOSPITAL COURSE:
Patient was continued on her current medication of Prozac 40 mg a day, Premarin 0.265 mg a day. Patient was also on Neurontin 300 mg in the morning and 600 mg at bedtime. She was also no Buspar 2 mg three times a day and olanzapine 5 mg at bedtime. Patient was also using aspirin and reglan on an as needed basis for her migraine and she reports that that seemed to be helpful.

Throughout her hospital stay, she denied any further suicidal thoughts and she denied homicidal thoughts. There was no evidence of psychosis and there were no cognitive deficits.

The patient stated that her mood had improved significantly during her hospital stay and she is requesting discharge. She also reports that her migraine headaches have gotten better while in the hospital. With her request for discharge, she will be discharged today and have a follow-up appointment to see me in one week in the Mental Health Clinic. She was discharged on the above described medications.

/wyh

Signed by: /es/ DAVID M MATHIS
DO 09/13/1999 08:33

Digital Pager: 101

08/18/1999 - 08/21/1999 Status: COMPLETED
Last Tr Specialty: SUBSTANCE ABUSE RES TRMT PROGDict'd By: EHIK,JULIUS
Approved By: EHIK,JULIUS

DISCHARGE DIAGNOSIS:
AXIS I. SUBSTANCE DEPENDENCE, ANALGESICS, PRESCRIPTION DRUGS,CONTINUOUS MAINLY OPIATES.
DEPRESSION NOT OTHERWISE SPECIFIED.
AXIS II. PERSONALITY DISORDER WITH BORDERLINE FEATURES.
AXIS III. STATUS POST ABDOMINAL SURGERY X 3 AND GANGLION REMOVED ON RIGHT WRIST. MIGRAINE HEADACHES.
AXIS IV. PSYCHOSOCIAL STRESSORS MODERATE.
AXIS V. GAF AT ADMISSION WAS AROUND 68, HIGHEST 74.

DIAGNOSES NOTED BUT NOT TREATED:

OPERATIONS/PROCEDURES PERFORMED:

03/17/2000 15:21
********** CONFIDENTIAL AD HOC SUMMARY pg. 3 **********
DOVE,GAYLE A [redacted] DOB: [redacted]

---------- DCS - Discharge Summary (max 10 occurrences or 1 year) ----------
(continued)

SUMMARY:
HISTORY OF PRESENT ILLNESS:
Ms Dove is a 43 year old white female admitted to the residential substance abuse treatment program on August 18, 1999 and left AMA on August 21, 1999. Her chief complaint upon admission was that she is addicted to cocaine and some opiates. This is the second program for her, she was here in 1994 at which time she was addicted to alcohol. She stated that never did drink after she got out of this program but developed several migraine headaches and getting a variety of medications. She was taking tylenol #3, percocet, demerol and was on Klonopin, vistaril.

She started drinking at age 15 and was drinking heavily until she was here in 1994. She is a service connected veteran. 100% for PTSD, sexual assault and hysterectomy. She has no known allergies.

FAMILY HISTORY:
Father is an alcoholic and parents divorced when she was five years old. Her mother raised here and she feels that her mother was schizophrenic. She has two brothers and they are alcoholic. She married three times and she was abused in her second marriage. She does have a retired Coast Guard man for her boyfriend.

SOCIAL HISTORY:
Military 1975 to 1987 as a radar operator. She smokes two packs of cigarettes per day.

PAST MEDICAL HISTORY:
She had surgery two times for adhesions. She had surgery four times for ganglion, right wrist.

MENTAL STATUS EXAMINATION:
She was coherent, oriented. She was rather anxious and has a lot of repressed hostility which she doesn't know how to deal with.

She did not display any evidence of any thought disorder. Her memory is unimpaired. She functions within normal limits of intellect and she is not suicidal or homicidal. She has a history of sexual abuse.

LABORATORY DATA:
Her urine was positive for opiates. Urinalysis was negative. TSH normal, RPR nonreactive and biochemestries normal. Liver function tests normal. CBC within normal limits. She had chest x-ray which revealed normal chest.

PHYSICAL EXAMINATION:
She was first taken to the psychiatric unit where the physical examination

03/17/2000 15:21
********** CONFIDENTIAL AD HOC SUMMARY pg. 4 **********
DOVE,GAYLE A [redacted] DOB: [redacted]

---------- DCS - Discharge Summary (max 10 occurrences or 1 year) ----------
(continued)

was performed. This was not repeated here.

HOSPITAL COURSE:
She announced on Saturday that she was going to leave, without any further explanation. She had her father come pick her up.

DISCHARGE INSTRUCTIONS:
There were no arrangements made for aftercare since the patient left against medical advice.

/wyh

Signed by: /es/ JULIUS EHIK
M.D. 08/29/1999 18:13

Digital Pager: 623

07/22/1999 - 07/29/1999 Status: COMPLETED
Last Tr Specialty: GEN INTERMEDIATE PSYCH Dict'd By: MATHIS,DAVID M
Approved By: MATHIS,DAVID M

DISCHARGE DIAGNOSIS:
AXIS I: MAJOR DEPRESSION, RECURRENT, WITHOUT PSYCHOTIC FEATURES.
SEVERE DYSTHYMIA.
RULE-OUT SUBSTANCE ABUSE.
AXIS II: DEFERRED.
AXIS III: MIGRAINES.
AXIS IV: MODERATE TO SEVERE STRESSORS.
AXIS V: ADMISSION GAF 35, DISCHARGE GAF 60, BEST GAF IN THE PAST YEAR 60.

DIAGNOSES NOTED BUT NOT TREATED:
NONE.

OPERATIONS/PROCEDURES PERFORMED:
None.

SUMMARY:
HISTORY OF PRESENT ILLNESS:
This is a 41 year old Caucasian female admitted on July 22, 1999 and discharged on July 29, 1999. She was admitted with the chief complaint of "I wanted to Dr. Saporiti about talking to Dr. Gelder because I didn't think my medication was working and I broke-up with my fiance, and my friend died, all within the past week." She is followed at the Woman's

03/17/2000 15:21

********** CONFIDENTIAL AD HOC SUMMARY pg. 5 **********

DOVE, GAYLE A [redacted] DOB: [redacted]

---------- DCS - Discharge Summary (max 10 occurrences or 1 year) ----------

(continued)

Clinic by Dr. Saporiti for therapy and Dr. Gelder for medication management, who has currently been on gabapentin, Prozac, Klonopin, and vistaril, and had been having some suicidal thoughts prior to coming to the hospital for several days, without a specific plan. The patient has a history of migraines and states that she has been having almost constant migraines. She then reported that she had had thoughts of death for several months. The patient has a history of overdosing twice; once in 1973 and once in 1993, and states she was not hospitalized after either time. The patient denies any history of self-injurious behavior. The patient does report she is a recovering alcoholic and states she has been sober for almost five years. The patient denies a history of drug abuse but, of concern, the patient apparently has been going to the Emergency Room frequently seeking narcotics for her migraines. The patient is prescribed prn Stadol spray for her migraines.

ALLERGIES:
She has no known allergies.

PHYSICAL EXAMINATION:
She had a temperature of 98, pulse 87, respirations 18, blood pressure 114/73. Head - normocephalic. Eyes - PERRLA. Neck - supple. Lungs - clear to auscultation. Heart - S1, S2, no murmur. Abdomen - soft, normal bowel sounds.

LABORATORY DATA/X-RAY FINDINGS:
There are none available on the chart.

HOSPITAL COURSE:
She denied any suicidal or homicidal thoughts throughout her hospital stay. We did discuss making some medication changes, including that I stressed to her that it was probably important to try to limit narcotic use as much as possible as I felt that that was contributing to her depressed mood. We also felt that she needed to go on a Klonopin taper and get off benzodiazepines, as well. We put her on Zyprexa 5 mg at bedtime and continued her on her gabapentin and Prozac.

She denied any suicidal or homicidal thoughts throughout her hospital stay. There was no evidence of psychosis and there are no cognitive deficits. The patient continued to be drug-seeking throughout her hospital stay, and we eventually placed her on nonsteroidal anti-inflammatories for her migraine headaches. The patient was requesting to go to her out-patient group therapy appointment at the Woman's Clinic. I felt that she could continue her treatment on an out-patient basis, so we discharged her today so that she could attend her Out-Patient Clinic appointment for group therapy and continue her treatment on an out-patient basis.

DISCHARGE RECOMMENDATIONS:
She has a follow-up appointment scheduled to see Dr. Gelder in the Woman's Clinic on August 3, 1999 at 9:30 a.m.

Name : DOVE,GAYLE A [redacted] Action Date: _____
DOB : [redacted] Address : 4457 POPPS FERRY RD
LOT 195
BILOXI, MISSISSIPPI 39532
Phone : 228 396 1919

WEIGHT(Kg): 60.45 (01/26/2000) HEIGHT(cm):

Instructions to the provider:
A. A prescription blank (VA FORM 10-2577f) must be used for the following: 1) any new medication
2) any changes in dosage, direction or quantity
3) all class II narcotics.
B. To continue a medication as printed:
1. If "Remaining Refills" are sufficient to complete therapy or last until next scheduled clinic appointment, no action is required.
2. If "Remaining Refills" are not sufficient to complete therapy or last until next scheduled clinic appointment, sign "RENEW/MD" line, enter VA# and date, and circle total number of refills needed. This action creates a new prescription with refills as indicated.
C. To discontinue a medication, sign DISCONTINUE/MD line and enter VA# and date.
D. Any medications not acted upon will continue to be available to the patient until all refills are used or until expiration.

NOTE: '(R)' indicates a fill was returned to stock.

Medication/Supply	Rx#	Status	Expiration Date	Provider
Classification: AH100 - ANTIHISTAMINES,PHENOTHIAZINE				
PROMETHAZINE HCL 25MG TAB Qty: 12 for 30 Days	10474675A	Active	01-26-2001	WEST,MARY H
Sig: TAKE ONE TABLET BY MOUTH EVERY FOUR HOURS AS NEEDED FOR NAUSEA				
Filled: 01-26-2000 Past Fills: 01-26-2000 12-17-1999				
Remaining Refills: 3 Clinic: G-UNSCH EDWARDS-PM				Price: $0.08
RENEW/MD:_____VA#:_____DATE_____ REFILL 0 1 2 3 4 5 6 7 8 9 10 11				
DISCONTINUE/MD:_____VA#:_____DATE_____				
Classification: CN103 - NON-OPIOID ANALGESICS				
APAP 325/BUTALBITAL 50/CAFF 40MG TAB Qty: 60 for 30 Days	10486034	Expired	02-25-2000	WEST,MARY H
Sig: TAKE ONE BY MOUTH EVERY SIX HOURS FOR PAIN				
Filled: 01-26-2000				
Remaining Refills: 0 Clinic: G-UNSCH EDWARDS-PM				Price: $1.74
RENEW/MD:_____VA#:_____DATE_____ REFILL 0 1 2 3 4 5 6 7 8 9 10 11				

Action Rx Profile Run Date: MAR 17,2000 Page: 3
Sorted by drug classification for Rx's currently active
and for those Rx's that have been inactive less than 45 days. Site: VAMC COLUMBIA, SC (544)

Name : DOVE,GAYLE A [redacted] Action Date: _____
DOB [redacted] Address : 4457 POPPS FERRY RD
LOT 195
BILOXI, MISSISSIPPI 39532
Phone : 228 396 1919

Medication/Supply	Rx#	Status	Expiration Date	Provider
Classification: CN105 - ANTIMIGRAINE AGENTS				
SUMATRIPTAN SUCCINATE 50MG TAB Qty: 6 for 30 Days	10486035	Expired	02-25-2000	WEST,MARY H

Sig: TAKE ONE-HALF TABLET AS DIRECTED AND MAY REPEAT IN AN HOUR IF NOT RELEIVED
Filled: 01-26-2000
Remaining Refills: 0 Clinic: G-UNSCH EDWARDS-PM Price: $52.00

RENEW/MD:_____VA#:_____DATE_____ REFILL 0 1 2 3 4 5 6 7 8 9 10 11

----------PENDING ORDERS----------

No pending orders for this patient!

Sorted by drug classification for Rx's currently active
and for those Rx's that have been inactive less than 45 days. Site: VAMC COLUMBIA, SC (544)

Name : [redacted] Action Date: _____
DOB : [redacted] Address : 4457 POPPS FERRY RD
LOT 195
BILOXI, MISSISSIPPI 39532
Phone : 228 396 1919

WEIGHT(Kg): 60.45 (01/26/2000) HEIGHT(cm):

ALLERGIES: _____

ADVERSE REACTIONS: _____

Instructions to the provider:
A prescription blank (VA FORM 10-2577f) must be used for All Class II NARCOTICS.

OTHER MEDICATIONS:

Name: DOVE,GAYLE A [redacted] DOB: AUG 15,1957

1 Medication: _____

Outpatient Directions: _____
___SC___NSC Quantity: _____ Days Supply _____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

_____ _____ _____
Provider's Signature DEA # Date/Time

Name: DOVE,GAYLE A [redacted] DOB: AUG 15,1957

2 Medication: _____

Outpatient Directions: _____
___SC___NSC Quantity: _____ Days Supply _____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

_____ _____ _____
Provider's Signature DEA # Date/Time

Name: DOVE,GAYLE A [redacted] DOB: AUG 15,1957

3 Medication: _____

Outpatient Directions: _____
___SC___NSC Quantity: _____ Days Supply _____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

_____ _____ _____
Provider's Signature DEA # Date/Time

Name: DOVE,GAYLE A [redacted] DOB: AUG 15,1957

4 Medication: _____

Outpatient Directions: _____
___SC___NSC Quantity: _____ Days Supply _____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

_____ _____ _____
Provider's Signature DEA # Date/Time

DOVE,GAYLE A [redacted] DOB: [redacted]

---------- DEM - Demographics ----------

Address: 4457 POPPS FERRY RD Phone: 228 396 1919
LOT 195
BILOXI, MISSISSIPPI 39532 County: HARRISON

Marital Status: DIVORCED Age: 42
Religion: PROTESTANT, OTHER Sex: FEMALE
Occupation: MIL
Period of Service: POST-VIETNAM
Branch of Service: AIR FORCE 09/04/1975 TO 09/16/1987
Combat: N POW: N
Eligibility: SERVICE CONNECTED 50% to 100% Status: VERIFIED
S/C %: 90
NOK: JON Relation: SON
4471 OLD PACOLET RD Phone: 864 474 1724
SPARTANBURG, SOUTH CAROLINA 29307

---------- CVP - Past Clinic Visits (max 9 occurrences or 9 months) ----------

03/17/2000 15:22 G-UNSCH KHAN-PM
01/26/2000 14:49 G-UNSCH EDWARDS-PM
12/16/1999 14:49 G-UNSCH EDWARDS-PM
11/12/1999 14:30 G-UNSCH EDWARDS-PM

---------- CVF - Fut Clinic Visits ----------

07/24/2000 13:00 G-KHAN

---------- PLL - All Problems ----------

1 Problems

ST	PROBLEM	LAST MOD	PROVIDER
A	346.90-MIGRAINE UNSPEC W/O INTRACT.	12/17/1999	MEGA,JEROME FRA

---------- PN - Progress Notes (max 3 occurrences or 1 year) ----------

01/26/2000 18:10 Title: GOPC UNSCHEDULED VISIT TL
GOPC UNSCHEDULED VISIT

CHIEF COMPLAINTS/HISTORY OF PRESENT ILLNESS:MIGRANES-SEE NURING
TAKES BIRTH CONTROL--SMOKES CIGERATES-STATES HOUSE IS UP FOR CLOSING THIS WEEK END AND PLANS TO LIVE IN GREENVILLE
MEDICATIONS: REVIEWED
ALLERGIES:
Allergies Unknown
REVIEW OF SYSTEMS:

DENIES CHILLS, FEVER, NIGHT SWEATS, WEIGHT LOSS/GAIN; HEADACHES, VISUAL CHANGES; CHEST PAIN, SOB; ABDOMINAL PAIN, N/V/D; CHANGES IN BOWEL OR BLADDER FUNCTION; SWOLLEN OR PAINFUL JOINTS, PERIPHERAL EDEMA; PARASTHESIAS; SKIN CHANGES; MOOD SWINGS, SUICIDAL OR HOMOCIDAL IDEATIONS.

PHYSICAL EXAM:

GENERAL APPEARANCE: WELL-DEVELOPED, WELL-NOURISHED FEMALE IN APPARENT DISTRESS WITH HEADACHE

VITAL SIGNS:

HEIGHT:
WEIGHT: 133 (01/26/2000 16:29)
TEMPERATURE: 98.6 (01/26/2000 16:29)
PULSE: 72 (01/26/2000 16:29)
BLOOD PRESSURE: 82/58 (01/26/2000 16:29)
RESPIRATION: 16 (01/26/2000 16:29)

HEENT: NC/AT, FACE SYMMETRICAL;PERRL,EOMI. CANALS PATENT, TM'S INTACT W/O ERYTHEMA, BULGING OR RETRACTION. MMM. NO LESIONS NOTED. OROPHARYNX NON-INJECTED, NO EXUDATES. PHONATES W/O DIFFICULTY. SINUSES NON-TENDER.

NECK: SUPPLE; TRACHEA MIDLINE. NO CAROTID BRUITS. NO JVD
NO LYMPHADENOPATHY

---------- PN - Progress Notes (max 3 occurrences or 1 year) ----------
(continued)

CHEST: CHEST EXPANSION SYMMETRICAL. BBS COARSE
RESPIRATIONS REGULAR AND NONLABORED.

HEART: RRR; NO RMG.

ABDOMEN: BOWEL SOUNDS ACTIVE, NO BRUITS; SOFT/NT/ND. NO HSM, OR MASSES.

BACK: NO CVAT; FROM

EXTREMETIES: FROM, NO CCE. PERIPHERAL PULSES PALPABLE. MUSCLE STRENGTH SYMMETRIC.

INTEG: INTACT, NO LESIONS, TURGOR ADEQUATE.

NEURO/PSYCH: ALERT, ORIENTED, COOPERATIVE. SPEECH CLEAR. GAIT STEADY. NO FOCAL DEFICITS. NO ABNORMAL MOVEMENTS.

DIAGNOSTICS: REVIEWED/PENDING

IMPRESSION/PLAN:HX MIGRANES-CONTINUE PHENERGAN-FIROCET Q6H PRN PAIN/#60-IMETREX 50MG 1/2 25MG ONCE AND REPEAT IN 1 HOUR IF NOT RELEAVED-# 6-APP. 6MOS AND F/U PRN-

PATIENT VERBALIZES UNDERSTANDING OF INSTRUCTIONS AND IS AGREEABLE TO TREATMENT PLAN.

Signed by: /es/ MARY H WEST
01/26/2000 18:14

01/26/2000 16:34 Title: G-NURSING NOTE TL
UNSCHEDULED
PATIENT C/O SEVERE HA....HX OF MIGRAINES....N/V
NEEDS IMITREX....AT LAST VISIT PATIENT WAS VISITING.....NOW PLANS ON MOVING HERE.....NEEDS F/U APPT.

Vital Signs:		
	Temperature :	98.6 (01/26/2000 16:29)
	Pulse:	72 (01/26/2000 16:29)
	Respirations:	16 (01/26/2000 16:29)
	Blood Pressure:	82/58 (01/26/2000 16:29)
	Weight:	133 (01/26/2000 16:29)
	Height:	
	Pain Scale:	10 (01/26/2000 16:29)

Signed by: /es/ DONNA F BURRELL
RNc 01/26/2000 16:36

12/16/1999 16:36 Title: NURSE PRACTITIONER NOTE
DEC 16, 1999

Vital Signs:		
	Weight:	131 (12/16/1999 15:41)
	Temperature:	98.4 (12/16/1999 15:41)
	Pulse:	80 (12/16/1999 15:41)
	Respiration:	18 (12/16/1999 15:41)
	Blood Pressure:	139/81 (12/16/1999 15:41)

Allergies/ADR's: Allergies Unknown

No active problems in computerized problem list as of 12/16/99@16:36

Active Outpatient Medications:
No current outpatient medications found in computer.

S/O: DOVE,GAYLE A is a 42y/o FEMALE patient who presents in triage clinic today w/ complaint of Visiting veteran from Biloxi VA here for second unscheduled visit to GOPC for migraine headache. States she is visitng her daughter and

---------- PN - Progress Notes (max 3 occurrences or 1 year) ----------
(continued)

grandchildren in Greenville area for a couple months. Is unsure when she is returning to the Biloxi area. c/o migraine headache "I woke up with it this morning", with nausea and vomiting. Has taken imitrix injection and tabs as well as tylenol today without relief. Is 30% service connected for migraine headaches. HX OF MIGRAINES. HAD AURA WITH THIS HA AS WELL AS N&V.

Stat labs reveal:

A:MIGRAINE

P:RENEW: PERCOCET #60 1 PO QD-BID PRN NO REF. PER DR. EDWARDS.; PHENERGAN 25MG #40 1 PO Q6H PRN 2 REF.
NUR: DEMEROL 75MG AND PHENERGAN 25MG IM TODAY (DR. EDWARDS SIGNATURE TO CHART). RTC PRN.

Signed by: /es/ JEROME FRANCIS JR MEGA
NURSE PRACTITIONER 12/16/1999 16:40

---------- CR - Reminders Due ----------

The following reminders are offered as clinical guidelines only.

	--NEXT--	--LAST--
SF-36 Survey	DUE NOW	unknown

DOVE,GAYLE A [redacted] DOB: [redacted]

---------- BDEM - Brief Demographics ----------

Address: 4457 POPPS FERRY RD
LOT 195
BILOXI, MISSISSIPPI 39532
Phone: 228 396 1919
Eligibility: SERVICE CONNECTED 50% to 100%
Age: 42
Sex: FEMALE
Race: WHITE, NOT OF HISPANIC ORIGIN

---------- BLO - Brief Lab Orders (max 10 occurrences or 1 year) ----------

No data available

---------- BMIC - Brief Microbiology (max 10 occurrences or 1 year) ----------

No data available

---------- BSR - Brief Surgery Rpts (max 10 occurrences or 1 year) ----------

No data available

---------- RS - Imaging Status (max 10 occurrences or 1 year) ----------

No data available

---------- SCLU - Lab Cum Selected (max 10 occurrences or 1 year) ----------

No selection items chosen for this component.

---------- DC - Discharges (max 10 occurrences or 1 year) ----------

No data available

Spartanburg Regional Healthcare System

Emergency Department

101 E. Wood St., Spartanburg, SC 29303

(864)560-6222

For NON-emergency questions and concerns call Ask-A-Nurse at 591-7999.
Take-Home Instructions for the Patient

Patient's Name: Murray, Gayle | **Date: 08/27/2000**
Medical Record Number: 0[redacted] | **Medical Provider: Rodier MD, Sophia**
Diagnosis: Fracture ribs | **Primary Care Provider: Unassigned,**

PLEASE NOTE: The examination and treatment that you have received in the Emergency Department have been rendered on an emergency basis only and are not intended to be a substitute for or an effort to provide complete medical service. A follow-up doctor or facility is named below. It is important that you be checked again as recommended below and report any new or remaining problems at that time, because it is impossible to recognize and treat all elements of injury or illness in a single Emergency Department visit. In addition, if an X-Ray has been taken here, it has been read on a preliminary basis only, and a final review will be made by the Radiologist..

Call to arrange an appointment to see the following physician for follow-up care.

Referral:

****

Follow-up in Orthopedics clinic as scheduled.

****

When you call for an appointment, say that you were referred from this Emergency Department.

If you cannot see the above doctor and your condition worsens so that you require emergency treatment, come back to this department.

PLEASE TAKE THIS WITH YOU WHEN YOU SEE DOCTOR LISTED ABOVE

Dove, [redacted] Gayle

Spartanburg Regional Healthcare System

[redacted]

Spartanburg Regional Healthcare System

Emergency Department

101 E. Wood St., Spartanburg, SC 29303

(864)560-6222

RIB FRACTURES:

Your exam shows that you have one or more fractured ribs. These injuries are often very painful. Broken ribs will heal in 4-6 weeks if treated properly. You should get plenty of rest until your pain improves. Take some deep breaths or cough every hour to keep your chest clear. This is especially important if your doctor has given you a rib belt to reduce your pain.

Fractured ribs can cause serious complications. These include: internal bleeding, lung collapse, and pneumonia. You should see your doctor or go to the emergency room at once if you have any of the following problems:

- Pain or shortness of breath that are getting worse.
- Persistent coughing.
- Fever or chills.
- Adbominal pain, vomiting, severe weakness or fainting.

RIB BELT:

Your doctor has given you a rib belt to help control the pain from a chest injury. This belt gives gentle support to the injured area. It also helps reduce chest motion. To apply your rib belt, place it across your back and stretch the ends out and forward across your rib cage. Press the Velcro areas together when there is a gentle pressure on the chest wall. Do not make the rib belt too tight to breath comfortably.

If you are older or have lung disease, rib belts can increase the risk of getting pneumonia after a chest injury. You must be sure to breath deeply and cough at least several times every hour to keep your lungs clear. Do not use a rib belt if it does not help your pain. Take it off at night when you go to bed. Most rib belts can be washed by machine and hung dry.

NARCOTIC PAIN MEDICINE:

You have been prescribed a narcotic for pain relief. These drugs are usually combined with acetaminophen (Tylenol#3, Percocet, Darvocet, Anexsia, Vicodin) or aspirin (Empirin#3, Percodan, Synalgos-DC) for increased effect. Narcotics act on the central nervous system to reduce pain; they also impair mental alertness and physical abilities. We advise you not to drink alcohol, drive a car, or operate dangerous equipment when you are taking one of these drugs. Long term use of narcotic pain medications may be habit-forming.

You can lessen stomach irritation from your medicine by taking it with meals or a full glass of water. Common side effects of narcotics are: nausea and vomiting, heartburn, constipation, dizziness, sleepiness, and mood changes. If you have bothersome side effects or symptoms of an allergic reaction (itching, hives, rash), stop taking your medicine and call your doctor or the emergency room right away. Please keep your narcotic medicine well out of the reach of children.

Spartanburg Regional Healthcare System

Emergency Department
101 E. Wood St., Spartanburg, SC 29303
(864)560-6222

Prescriptions Received: Lortab 5 1-2 q4-6h prn pain #_____

Discharge Instructions Received: RIB FRACTURES, RIB BELT, Free Text Instruction (append note)

Drug Instructions Received: NARCOTIC PAIN MEDICINE

Referral:

I hereby acknowledge receipt of the instructions indicated above. I understand that I have had emergency treatment and that I may be released before all my medical problems are known or treated. I will arrange for follow-up care as instructed above.

****
Follow-up in Orthopedics clinic as scheduled.
****

Date/Time: 08/27/2000 17:18 Treating MD: Rodier MD, Sophia

Patient Signature: _____

Account Number: [redacted]

Medical Record Number [redacted]

[redacted] have explained the instructions and have given a copy to the patient.

Nurse's Signature: _____ Date: _____

Action Rx Profile Run Date: MAY 12,2000 Page: 1

Sorted by drug classification for Rx's currently active
and for those Rx's that have been inactive less than 45 days. Site: VAMC COLUMBIA, SC (544)

Name : DOVE,GAYLE A [redacted] Action Date: _____
DOB : [redacted] Address : 4457 POPPS FERRY RD
LOT 195
BILOXI, MISSISSIPPI 39532
Phone : 228 396 1919

WEIGHT(Kg): 57.27 (03/17/2000) HEIGHT(cm):
DISABILITIES: POST-TRAUMATIC STRESS DISORDER-70% (SC), REMOVAL OF UTERUS AND OVARIES-50% (SC), MIGRAINE HEADACHES-30% (SC), RHINITIS-0% (SC), NEOPLASM, BENIGN, SKIN-0% (SC),

ALLERGIES:_____

ADVERSE REACTIONS:_____

Pending Outpatient Clinic Appointments:
MAY 12,2000@14:05 G-UNSCH KHAN-PM (0 days)
JUL 24,2000@13:00 G-KHAN (73 days)

Action Rx Profile Run Date: MAY 12,2000 Page: 2
Sorted by drug classification for Rx's currently active
and for those Rx's that have been inactive less than 45 days. Site: VAMC COLUMBIA, SC (544)

Name : DOVE,GAYLE A [redacted] Action Date: _____
DOB : [redacted] Address : 4457 POPPS FERRY RD
LOT 195
BILOXI, MISSISSIPPI 39532
Phone : 228 396 1919

WEIGHT(Kg): 57.27 (03/17/2000) HEIGHT(cm):

Instructions to the provider:

A. A prescription blank (VA FORM 10-2577f) must be used for the following: 1) any new medication
2) any changes in dosage, direction or quantity
3) all class II narcotics.

B. To continue a medication as printed:
1. If "Remaining Refills" are sufficient to complete therapy or last until next scheduled clinic appointment, no action is required.
2. If "Remaining Refills" are not sufficient to complete therapy or last until next scheduled clinic appointment, sign "RENEW/MD" line, enter VA# and date, and circle total number of refills needed. This action creates a new prescription with refills as indicated.

C. To discontinue a medication, sign DISCONTINUE/MD line and enter VA# and date.

D. Any medications not acted upon will continue to be available to the patient until all refills are used or until expiration.

NOTE: '(R)' indicates a fill was returned to stock.

Medication/Supply		Rx#	Status	Expiration Date	Provider
Classification: AH100 - ANTIHISTAMINES,PHENOTHIAZINE					
PROMETHAZINE HCL 25MG TAB	Qty: 40 for 30 Days	10480090	Discontinued	12-17-2000	MEGA,JEROME FRANCIS J
Sig: TAKE ONE EVERY SIX HOURS AS NEEDED FOR NAUSEA					
Filled: 01-26-2000 12-17-1999					
Remaining Refills: 1	Clinic: UNKNOWN				Price: $0.28
RENEW/MD:_____VA#:_____DATE_____ REFILL 0 1 2 3 4 5 6 7 8 9 10 11					
Classification: CN101 - OPIOID ANALGESICS					
OXYCODONE 5MG/APAP 325MG	Qty: 20 for 30 Days	1031353	Expired	04-28-2000	ADAMS,JOHN DOUGLAS
Sig: 1-2 EVERY FOUR HOURS AS NEEDED FOR PAIN (20 FOR 30 DAYS)					
Filled: 03-29-2000					
Remaining Refills: 0	Clinic: G-UNSCH KHAN-AM				Price: $0.76

Sorted by drug classification for Rx's currently active
and for those Rx's that have been inactive less than 45 days. Site: VAMC COLUMBIA, SC (544)

Name : DOVE,GAYLE A [redacted]4 Action Date: _____
DOB : [redacted] Address : 4457 POPPS FERRY RD
LOT 195
BILOXI, MISSISSIPPI 39532
Phone : 228 396 1919

Medication/Supply	Rx#	Status	Expiration Date	Provider

Classification: GA700 - ANTIEMETICS

PROCHLORPERAZINE MALEATE 10MG TAB Qty: 10 for 30 Days 10495125 Expired 04-16-2000 WEST,MARY H
Sig: TAKE ONE TABLET BY MOUTH EVERY EIGHT HOURS AS NEEDED FOR NAUSEA AND MIGRAINES
Filled: 03-17-2000
Remaining Refills: 0 Clinic: G-UNSCH KHAN-PM Price: $1.12

RENEW/MD:_____VA#:_____DATE_____ REFILL 0 1 2 3 4 5 6 7 8 9 10 11

----------PENDING ORDERS----------

No pending orders for this patient!

Action Rx Profile Run Date: MAY 12,2000 Page: 4

Sorted by drug classification for Rx's currently active

and for those Rx's that have been inactive less than 45 days. Site: VAMC COLUMBIA, SC (544)

Name : DOVE,GAYLE A [redacted] Action Date: _____

DOB : [redacted] Address : 4457 POPPS FERRY RD

LOT 195

BILOXI, MISSISSIPPI 39532

Phone : 228 396 1919

WEIGHT(Kg): 57.27 (03/17/2000) HEIGHT(cm):

ALLERGIES: _____

ADVERSE REACTIONS: _____

Instructions to the provider:

A prescription blank (VA FORM 10-2577f) must be used for All Class II NARCOTICS.

OTHER MEDICATIONS:

Name: DOVE,GAYLE A [redacted] DOB: AUG 15,1957

1 Medication: _____

Outpatient Directions: _____

___SC___NSC Quantity: _____ Days Supply _____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

_____ _____ _____

Provider's Signature DEA # Date/Time

Name: DOVE,GAYLE A [redacted] DOB: AUG 15,1957

2 Medication: _____

Outpatient Directions: _____

___SC___NSC Quantity: _____ Days Supply _____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

_____ _____ _____

Provider's Signature DEA # Date/Time

Name: DOVE,GAYLE A [redacted] DOB: AUG 15,1957

3 Medication: _____

Outpatient Directions: _____

___SC___NSC Quantity: _____ Days Supply _____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

_____ _____ _____

Provider's Signature DEA # Date/Time

DOVE,GAYLE A [redacted] DOB: [redacted]

---------- DEM - Demographics ----------

Address: 4457 POPPS FERRY RD Phone: 228 396 1919
LOT 195
BILOXI, MISSISSIPPI 39532 County: HARRISON

Marital Status: DIVORCED Age: 42
Religion: PROTESTANT, OTHER Sex: FEMALE
Occupation: MIL
Period of Service: POST-VIETNAM
Branch of Service: AIR FORCE 09/04/1975 TO 09/16/1987
Combat: N POW: N
Eligibility: SERVICE CONNECTED 50% to 100% Status: VERIFIED
S/C %: 90
NOK: JON DOVE Relation: SON
4471 OLD PACOLET RD Phone: 864-474-1724
SPARTANBURG, SOUTH CAROLINA 29307

---------- CVP - Past Clinic Visits (max 9 occurrences or 9 months) ----------

05/12/2000 14:05 G-UNSCH KHAN-PM NO ACTION TAKEN
04/18/2000 15:00 G-EDWARDS CANCELLED BY PATIENT
04/03/2000 09:00 G-LAB
03/29/2000 11:21 G-UNSCH KHAN-AM
03/17/2000 15:22 G-UNSCH KHAN-PM
01/26/2000 14:49 G-UNSCH EDWARDS-PM
12/16/1999 14:49 G-UNSCH EDWARDS-PM
11/12/1999 14:30 G-UNSCH EDWARDS-PM

---------- CVF - Fut Clinic Visits ----------

07/24/2000 13:00 G-KHAN

---------- PLL - All Problems ----------

1 Problems

ST	PROBLEM	LAST MOD	PROVIDER
A	346.90-MIGRAINE UNSPEC W/O INTRACT.	12/17/1999	MEGA,JEROME FRA

---------- PN - Progress Notes (max 3 occurrences or 1 year) ----------

03/29/2000 12:42 Title: GOPC UNSCHEDULED VISIT TL
GOPC UNSCHEDULED VISIT

CHIEF COMPLAINTS/HISTORY OF PRESENT ILLNESS:Typical Headache of gradual onset. Began last night. R sided throbbing with photophobia and nausea
MEDICATIONS: REVIEWED

ALLERGIES:

Allergies Unknown

REVIEW OF SYSTEMS:

---------- PN - Progress Notes (max 3 occurrences or 1 year) ----------
(continued)

DENIES CHILLS, FEVER, NIGHT SWEATS, WEIGHT LOSS/GAIN;
HEADACHES, VISUAL CHANGES; CHEST PAIN, SOB; ABDOMINAL PAIN, N/V/D; CHANGES IN BOWEL OR BLADDER FUNCTION; SWOLLEN OR PAINFUL JOINTS, PERIPHERAL EDEMA; PARASTHESIAS; SKIN CHANGES; MOOD SWINGS, SUICIDAL OR HOMOCIDAL IDEATIONS.

PHYSICAL EXAM:

GENERAL APPEARANCE: WELL-DEVELOPED, WELL-NOURISHED FEMALE IN NO APPARENT DISTRESS.

VITAL SIGNS:Stable

HEIGHT:
WEIGHT: 126 (03/17/2000 16:14)
TEMPERATURE: 99.1 (03/17/2000 16:14)
PULSE: 62 (03/17/2000 16:14)
BLOOD PRESSURE: 108/61 (03/17/2000 16:14)
RESPIRATION: 16 (03/17/2000 16:14)

HEENT: NC/AT, FACE SYMMETRICAL;PERRL,EOMI. CANALS PATENT, TM'S INTACT W/O ERYTHEMA, BULGING OR RETRACTION. MMM. NO LESIONS NOTED. OROPHARYNX NON-INJECTED, NO EXUDATES. PHONATES W/O DIFFICULTY. SINUSES NON-TENDER.

NECK: SUPPLE; TRACHEA MIDLINE. NO CAROTID BRUITS. NO JVD
NO LYMPHADENOPATHY

CHEST: CHEST EXPANSION SYMMETRICAL. BBS CTA.
RESPIRATIONS REGULAR AND NONLABORED.

HEART: RRR; NO RMG.

ABDOMEN: BOWEL SOUNDS ACTIVE, NO BRUITS; SOFT/NT/ND. NO HSM, OR MASSES.

BACK: NO CVAT; FROM

EXTREMETIES: FROM, NO CCE. PERIPHERAL PULSES PALPABLE. MUSCLE STRENGTH SYMMETRIC.

INTEG: INTACT, NO LESIONS, TURGOR ADEQUATE.

NEURO/PSYCH: ALERT, ORIENTED, COOPERATIVE, SPEECH CLEAR. GAIT STEADY. NO FOCAL DEFICITS. NO ABNORMAL MOVEMENTS.

DIAGNOSTICS: REVIEWED/PENDING

IMPRESSION/PLAN:Migraine Headache
PATIENT VERBALIZES UNDERSTANDING OF INSTRUCTIONS AND IS AGREEABLE TO TREATMENT PLAN.
See Chart

---------- PN - Progress Notes (max 3 occurrences or 1 year) ----------
(continued)

Signed by: /es/ JOHN DOUGLAS ADAMS
Emergency Med MD 03/29/2000 12:50

Digital Pager: 864 390 4991

03/17/2000 17:44 Title: NURSE PRACTITIONER
s. states she stopped in montgomery. treated for pneumonia there. was driving through that area checked self in marriot motel. when checking in room "they" realized that i needed help. i was admitted to local va after "they" talked to my son. not seen in biloxi recently but treated for migranes from biloxi va.
states maxed on imetrex today and now not feeling well. most of pain at present lf. temporal area. continues to smoke some. states takes gabapentan and stadol which usually helps if taken as directed.this is prescribed by neurology in biloxi. requesting demoral and phenergan today.
o.pupils dialated 4cm and nonreactive. wearing sun glasses which were removed for exam. tm bil. clear, nostril red no edema or crustation noted. pharynx neg. lungs coarse heart rrr.wearing long pants and long sleaved top. no inspection of skin done.

Vital Signs:		
	Temperature :	99.1 (03/17/2000 16:14)
	Pulse:	62 (03/17/2000 16:14)
	Respirations:	16 (03/17/2000 16:14)
	Blood Pressure:	108/61 (03/17/2000 16:14)
	Weight:	126 (03/17/2000 16:14)
	Height:	
	Pain Scale:	6 (03/17/2000 16:14)

a/p. due to questionable hx and general state at this time will use compazine 10mg q8h prn nausea #10. get labs next week. sch. dr. e. clinic within month. get record from montgomery va and biloxi. f/u care as indicated

Signed by: /es/ MARY H WEST
03/17/2000 18:01

03/17/2000 16:15 Title: G-NURSING NOTE TL

Vital Signs:		
	Temperature :	99.1 (03/17/2000 16:14)
	Pulse:	62 (03/17/2000 16:14)
	Respirations:	16 (03/17/2000 16:14)
	Blood Pressure:	108/61 (03/17/2000 16:14)
	Weight:	126 (03/17/2000 16:14)
	Height:	
	Pain Scale:	6 (03/17/2000 16:14)

UNSCHEDULED VISIT:
S: VET HAS HAD MIGRAINE H/A SINCE 3-16 PM, H/A EASED SOME LAST NIGHT AND THEN RETURNED THIS AM HAS TAKEN 2 IMITREX INJECTIONS TODAY LAST ONE AT 12N, ALSO TAKEN FORICET AND IS NAUSEATED. RATES PAIN 6/10 SCALE
VET STATES SHE WAS RELEASED FROM BILOXI,MS VA 2-28 AFTER A 2 WEEK STAY FOR PNEUMONIA. STATES WAS SENT MEDICINE BY BILOXI MS VA BUT VET DID NOT BRING

DOVE,GAYLE A [redacted] DOB: [redacted]

---------- PN - Progress Notes (max 3 occurrences or 1 year) ----------
(continued)

THEM WITH HER.
O: SEE VS
A: AS ABOVE P: REFER TO NP/MD, PDX RECIEVED FROM BILOXI VA, NO DSC SUMMARY AVAILABLE YET. WILL HAVE FILE ROOM TRY AND GET SOME INFORMATION

Signed by: /es/ NANCY LEE HRUSCHAK,R.N.
R.N. 03/17/2000 16:21

---------- CR - Reminders Due ----------

The following reminders are offered as clinical guidelines only.

	--NEXT--	--LAST--
SF-36 Survey	DUE NOW	unknown

05/12/2000 15:24

********** CONFIDENTIAL SAMPLE 1 SUMMARY pg. 1 **********

DOVE,GAYLE A [redacted] DOB: [redacted]

---------- BDEM - Brief Demographics ----------

Address: 4457 POPPS FERRY RD Phone: 228 396 1919
LOT 195
BILOXI, MISSISSIPPI 39532
Eligibility: SERVICE CONNECTED 50% to 100% Age: 42
Sex: FEMALE
Race: WHITE, NOT OF HISPANIC ORIGIN

---------- BLO - Brief Lab Orders (max 10 occurrences or 1 year) ----------

Collection DT	Test Name	Specimen	Urgency	Status
03/17/2000	CBC	BLOOD	ROUTINE	ORDERED
03/17/2000	CHEM 7	SERUM	ROUTINE	ORDERED
03/17/2000	LIPID PROFILE	SERUM	ROUTINE	ORDERED
03/17/2000	LIVER FUNCTION TEST	SERUM	ROUTINE	ORDERED
03/17/2000	URINALYSIS	URINE	ROUTINE	ORDERED

---------- BMIC - Brief Microbiology (max 10 occurrences or 1 year) ----------

No data available

---------- BSR - Brief Surgery Rpts (max 10 occurrences or 1 year) ----------

No data available

---------- RS - Imaging Status (max 10 occurrences or 1 year) ----------

No data available

---------- SCLU - Lab Cum Selected (max 10 occurrences or 1 year) ----------

No selection items chosen for this component.

---------- DC - Discharges (max 10 occurrences or 1 year) ----------

No data available

*** END ********** CONFIDENTIAL SAMPLE 1 SUMMARY pg. 1 **********

PRINTING OF ENCOUNTER FORMS IS COMPLETE for 05/12/00

MEDICAL RECORD	PROGRESS NOTES
DATE	

5/12/2000 SEE CPN.
Wayne Hruschak RN

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)*

[redacted]

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR.
FIRMR(41CFR)201-45.505
509-111

PROGRESS NOTES

DATE

Typed headache log last 5pm
@ ⓟ called Hendley / pharmacy

Eon NS neuro Coord for
H20 PERRL Sclera
Neck Supple
Resp Regular HR
Pharm x Dressed 75
Resp 60 } Dry

TCN Neurology Consult 4/16
Oxycodone 5/325 #20 0 Refills

JD Hood

IVP Decrease 75mg, Phenergan 50mg
IM ⓡ gluteal. Pt's son
to pick her up Gloria Hood

☆ U.S. GPO:1998-443-732

STANDARD FORM 509 BACK (Rev. 11-77)

MEDICAL RECORD	PROGRESS NOTES

DATE

1-26 dc DHCP — Donna Burnett RN

CRRS
1/24/00

PRN
Dr 6 mos

2/17/2000
4:30p DEC SHLP / DMAGE
NOTE Wm Knowles

3-29-00 Triage
12:34p A: C/o migraine headache since last night. Rates at 8.5 on pain scale
O BP 98/70 TPR 99 4-16-24
Ant. for bed life support
A NAD
P- Refer to Dr Gloria Elwood

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

Howe, Gayle

[redacted]

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR(41CFR)201-45.505
509-111

CONTINUE ON BACK WHEN NECESSARY

Department of Veterans Affairs

MEDICAL CERTIFICATE

1. DATE	2. TIME	3. AGE	4. SEX	5. ON ARRIVAL PATIENT WAS	6. PHONE NUMBER	7. HOMELESS
12/10/91	1535 AM PM		☐ M ☐ F	☐ AMBULATORY ☐ STRETCHER ☐ WHEELCHAIR	( )	☐ YES ☐ NO

8A. ALLERGIES Diabetes Seizures Allergies:	8B. WEIGHT	8C. TEMPERATURE	8D. PULSE	8E. RESPIRATION	8F. B/P	8G. DUE TO INJURY ☐ NO ☐ YES

9. CURRENT MEDICATIONS

10. TRIAGE S - See DHCP - Sara Mena

11. SIGNATURE

12. HISTORY AND PHYSICAL

note on DHCP

13. DIAGNOSTIC IMPRESSIONS

14. PLAN Demerol 75 mg and Phenergan 25 IM

4/55 Demerol 75 mg and Phenergan 25 mg IM (L) gluteal per order — Carolyn C. Moore RN

15A. ATTENDING OF RECORD

15B. EXAMINER'S SIGNATURE

SECTION II - FOR PATIENT

1. DISPOSITION / CLINIC APPOINTMENT	2. AFTER CARE SHEET GIVEN ☐ YES ☐ NO	3. FOLLOWUP - ACTIVITY - LIMITATIONS

4. CONDITION ☐ IMPROVED ☐ SATISFACTORY ☐ UNCHANGED	5. DATE / TIME OF DISCHARGE	6. SIGNATURE TO INDICATE INSTRUCTIONS GIVEN

IMPRINT PATIENT DATA CARD

7. PATIENT INSTRUCTIONS

12 14 99

DOVE, GAYLE A

[redacted] [redacted]

I CERTIFY THAT I RECEIVED AND UNDERSTAND THESE INSTRUCTIONS

8. PATIENT'S SIGNATURE

VA FORM [illegible] SUPERSEDES VA FORM 10-10M MAY 1990

CONTINUE ON BACK WHEN NECESSARY

Department of Veterans Affairs

MEDICAL CERTIFICATE

1. DATE	2. TIME	3. AGE	4. SEX	5. ON ARRIVAL PATIENT WAS:	6. PHONE NUMBER	7. HOMELESS
11-12-99	1100 AM PM	42	☐ M ☒ F	☒ AMBULATORY ☐ STRETCHER ☐ WHEELCHAIR	( )	☐ YES ☐ NO

8A. ALLERGIES	8B. WEIGHT	8C. TEMPERATURE	8D. PULSE	8E. RESPIRATION	8F. B/P	8G. DUE TO INJURY
Diabetes NO Seizures NO Allergies: NKDA	127 lb	99.2	79	18	137/86	☐ NO ☐ YES

9. CURRENT MEDICATIONS prozac, olanzepine prn, estradiole,

10. TRIAGE Visiting vet from Biloxi, Mississippi. C/O migraine headache today on left temporal & parietal area. light sensitivity, N/V. Has taken gabapentin, imitrix tabs & tylenol today. (O) see vitals. (A) Amb, NAD

11. SIGNATURE

12. HISTORY AND PHYSICAL (P) Refer to NP/NP. Soon Mercer

A: ab. HA migr H/A; Cont Tx. hx. not helped last Tx. Tx (P) s. del HA Pt Left.

O: A+O, NAD

PERRLA, Fem; wnl

neck - supple,

Cvs RRR

Chest CTA-O-

EAT wnl

13. DIAGNOSTIC IMPRESSIONS 1) Migraine H/A

14. PLAN Phenergan 25mg IM #12

Permit #12

Toradol 30mg IM

2.5mg IM

15A. ATTENDING OF RECORD

15B. EXAMINER'S SIGNATURE

Phenergan 25mg PR

NTC

SECTION II - FOR PATIENT

1. DISPOSITION / CLINIC APPOINTMENT	2. AFTER CARE SHEET GIVEN	3. FOLLOWUP - ACTIVITY - LIMITATIONS
	☐ YES ☐ NO	

4. CONDITION	5. DATE / TIME OF DISCHARGE	6. SIGNATURE TO INDICATE INSTRUCTIONS GIVEN
☐ IMPROVED ☐ SATISFACTORY ☐ UNCHANGED		

IMPRINT PATIENT DATA CARD

7. PATIENT INSTRUCTIONS

01 00 8

DOVE, GAYLE A

[redacted]

I CERTIFY THAT I RECEIVED AND UNDERSTAND THESE INSTRUCTIONS

8. PATIENT'S SIGNATURE

DEPARTMENT OF VETERANS AFFAIRS

FACILITY: COLUMBIA, SC (544) APPLICATION FOR MEDICAL BENEFITS

SEE ATTACHMENT FOR PAPERWORK REDUCTION INFORMATION AND PRIVACY ACT INFORMATION

PART I - PATIENT DATA

1. Type of benefit applied for: HOSPITAL/OUTPATIENT TREATMENT

2. Applicant's Name DOVE,GAYLE A	3. Other names used (Alias)	4. [redacted]	
5. [redacted]	[redacted]	7. DATE OF BIRTH AUG 15,1957	8. PLACE OF BIRTH WICHITA FALLS, TEXAS
[redacted]		10. TEMPORARY ADDRESS	
9A. STREET ADDRESS: 4457 POPPS FERRY RD LOT 195		10A. STREET ADDRESS: NOT APPLICABLE	
9B. CITY: BILOXI	9C. STATE: MISSISSIPPI	10B. CITY:	10C. STATE:
9D. ZIP CODE: 39532	9E. COUNTY: HARRISON	10D. ZIP CODE:	10E. COUNTY:
9F. HOME TELEPHONE NUMBER: 228 396 1919		10F. HOME TELEPHONE NUMBER:	
11. PATIENT'S SEX FEMALE	12. MOTHER'S MAIDEN NAME MOSSMEN	13. MOTHER'S NAME MARILYN	14. FATHER'S NAME RAYMOND
15. RELIGIOUS PREFERENCE PROTESTANT, OTHER	16. DATE OF PREVIOUS CARE 1999	17. LOCATION OF PREVIOUS CARE BILOXI, MS (CONS)	18. SPINAL CORD INJURY NOT APPLICABLE

PART II - EMERGENCY CONTACT DATA

1A. FIRST NEXT OF KIN JON	1B. RELATIONSHIP SON	1C. HOME TELEPHONE NUMBER 864 474 1724	1D. WORK TELEPHONE NUMBER NONE
1E. ADDRESS (Number, Street, City, State, ZIP Code) 4471 OLD PACOLET RD, SPARTANBURG, SOUTH CAROLINA, 29307-			
2A. SECOND NEXT OF KIN UNANSWERED	2B. RELATIONSHIP	2C. HOME TELEPHONE NUMBER	2D. WORK TELEPHONE NUMBER
2E. ADDRESS (Number, Street, City, State, ZIP Code)			
3A. FIRST CONTACT IN AN EMERGENCY JON	3B. RELATIONSHIP SON	3C. HOME TELEPHONE NUMBER 864 474 1724	3D. WORK TELEPHONE NUMBER NONE
3E. ADDRESS (Number, Street, City, State, ZIP Code) 4471 OLD PACOLET RD, SPARTANBURG, SOUTH CAROLINA, 29307-			
4A. SECOND CONTACT IN AN EMERGENCY UNANSWERED	4B. RELATIONSHIP	4C. HOME TELEPHONE NUMBER	4D. WORK TELEPHONE NUMBER
4E. ADDRESS (Number, Street, City, State, ZIP Code)			

I DESIGNATE THE FOLLOWING PERSON TO RECEIVE POSSESSION OF ALL PERSONAL PROPERTY LEFT ON THE PREMISES UNDER VA CONTROL AFTER I LEAVE SUCH PLACE OR AT TIME OF MY DEATH (This does not constitute a will or transfer of title.)

5A. DESIGNEE JON	5B. RELATIONSHIP SON	5C. HOME TELEPHONE NUMBER 864 474 1724	5D. WORK TELEPHONE NUMBER NONE
5E. ADDRESS (Number, Street, City, State, ZIP Code) 4471 OLD PACOLET RD, SPARTANBURG, SOUTH CAROLINA, 29307-			

NOTE - The law (38 USC 8520 et seq.) provides that upon the death of any veteran receiving care or treatment by the Department of Veterans Affairs in any institution or of a dependent or survivor of a veteran admitted to a VA medical facility leaving no surviving spouse or next of kin or heir entitled to inherit, all personal property, including money or balances in bank, all claims and choses in action, owned by such person, and not disposed of by will or otherwise will become the property of the United States as trustee for the general Post Fund.

Reg Date/Time: NOV 12,1999@14:23 PRINTED: NOV 12, 1999@14:23:54 Clerk: REG/62

AUTOMATED VA FORM 10-10 PAGE:

DOVE,GAYLE A 515-64-6094

PART III - APPLICANT/SPOUSE DATA

1. APPLICANT'S EMPLOYMENT STATUS: 3. NOT EMPLOYED

2. SPOUSE'S EMPLOYMENT STATUS: NOT APPLICABLE

3. APPLICANT INFORMATION	4. SPOUSE'S INFORMATION
3A. OCCUPATION: MIL	4A. OCCUPATION: NOT APPLICABLE
3B. EMPLOYER (Name, Street Address, City, State, Zip) NOT APPLICABLE	4B. EMPLOYER (Name, Street Address, City, State, Zip) NOT APPLICABLE
3C. WORK TELEPHONE NUMBER:	4C. WORK TELEPHONE NUMBER:

PART IV - MILITARY SERVICE DATA

1A. LAST BRANCH OF SERVICE	1B. [redacted] NUMBER	1C. LAST DATE OF ENTRY	1D. LAST DISCHARGE DATE	1E. DISCHARGE TYPE
[redacted]	[redacted]	SEP 4,1975	SEP 16,1987	HONORABLE
[redacted] NOT APPLICABLE	[redacted] CE NUMBER	2C. PRIOR DATE OF ENTRY	2D. PRIOR DISCHARGE DATE	2E. DISCHARGE TYPE
3A. PRIOR BRANCH OF SERVICE NOT APPLICABLE	3B. PRIOR SERVICE NUMBER	3C. PRIOR DATE OF ENTRY	3D. PRIOR DISCHARGE DATE	3E. DISCHARGE TYPE

PART V - ELIGIBILITY STATUS DATA

1. PATIENT TYPE: SC VETERAN

2. IS NEED FOR MEDICAL CARE RELATED TO AN ON THE JOB INJURY: NO	3. IS THE NEED FOR MEDICAL CARE RELATED TO AN ACCIDENT: NO	4. IS PATIENT ELIGIBLE FOR MEDICAID: NO
5A. DOES PATIENT HAVE HEALTH INSURANCE COVERAGE: NO	5B. IF YES, COVERAGE PROVIDED BY: NOT APPLICABLE	

6. DOES VETERAN HAVE GI INSURANCE: NO	7. PRIMARY ELIGIBILITY CODE SERVICE CONNECTED 50% to 100%	8. OTHER ELIGIBILITY CODE UNANSWERED	9. PERIOD OF SERVICE POST-VIETNAM

10. RATED SERVICE CONNECTED CONDITIONS:
POST-TRAUMATIC STRESS DISORDER (70%)
REMOVAL OF UTERUS AND OVARIES (50%)
MIGRAINE HEADACHES (30%)
RHINITIS (0%)
NEOPLASM, BENIGN, SKIN (0%)

11. OTHER ELIGIBILITY DATA

A. VETERAN	YES	L. SERVICE IN PERSIAN GULF THEATER	NO
B. PRISONER OF WAR STATUS	NO	M. DENTAL INJ. UNANSWERED TEETH EXTRACTED	UNANSWERED
C. EXPOSURE TO AGENT ORANGE	NO	N. SERVICE CONNECTED: 90%	YES
D. EXPOSURE TO RADIATION	NO	O. RECEIVING AID & ATTENDANCE	NO
E. COMBAT SERVICE	NO	P. RECEIVING HOUSEBOUND	NO
F. MILITARY DISABILITY	NO	Q. RECEIVING VA PENSION	NO
G. VIETNAM SERVICE	NO	R. RECEIVING VA DISABILITY	YES
H. LEBANON SERVICE	NO	S. SERVICE IN SOMALIA	NO
I. GRENADA SERVICE	NO		
J. PANAMA SERVICE	NO		
K. PERSIAN GULF SERVICE	NO	T. VA MONETARY AMOUNT: $ 24768	

Reg Date/Time: NOV 12,1999@14:23 PRINTED: NOV 12, 1999@14:23:54 Clerk: REG/62

PART VI - INCOME SCREENING DATA OR ANNUAL INCOME

1A. CURRENT MARITAL STATUS: DIVORCED	1B. DATE OF MARRIAGE:

2A. WAS PATIENT MARRIED OR SEPARATED AT THE END OF LAST CALENDAR YEAR?: NO

2B. NAME OF SPOUSE	2C. SEX OF SPOUSE	2D. SPOUSE'S SOCIAL SECURITY NO	2E. SPOUSE'S DATE OF BIRTH
NOT APPLICABLE			

3. DEPENDENTS

A. NAME	B. SOCIAL SECURITY NO	C. SEX	D. DATE OF BIRTH	E. RELATIONSHIP	F. DEPENDENT AS OF (DATE)
NONE INDICATED					

4. PREVIOUS CALENDAR YEAR (1998) INCOME INFORMATION

	CHECK ALL APPLICABLE BOXES	AMOUNT VETERAN	SPOUSE	DEPENDENTS	TOTAL
X	1. SOCIAL SECURITY (NOT SSI)	$9384.00	-	-	$9384.00
	2. U.S. CIVIL SERVICE	-	-	-	-
	3. U.S. RAILROAD RETIREMENT	-	-	-	-
	4. MILITARY RETIREMENT	-	-	-	-
	5. UNEMPLOYMENT COMPENSATION	-	-	-	-
	6. OTHER RETIREMENT	-	-	-	-
	7. TOTAL INCOME FROM EMPLOYMENT	-	-	-	-
	8. INTEREST, DIVIDEND, OR ANNUITY INCOME	-	-	-	-
	9. WORKERS COMPENSATION/BLACK LUNG BENEFITS	-	-	-	-
X	10. ALL OTHER INCOME	$24768.00	-	-	$24768.00
	11. TOTAL INCOME				$34152.00

PART VII - INELIGIBLE/MISSING DATA

1. INELIGIBLE DATE	2. TWX SOURCE	3. TWX CITY	4. TWX STATE

5. REASON:

6. VACO DECISION:

7. MISSING DATE	8. TWX SOURCE	9. TWX CITY	10. TWX STATE

11. REASON:

Reg Date/Time: NOV 12,1999@14:23 PRINTED: NOV 12, 1999@14:23:54 Clerk: REG/62

DOVE,GAYLE A . 515-64-6094

THIS PAGE MAY BE REPLACED BY PAGE #4 OF VA FORM 10-10 WHICH CONTAINS PRIVACY ACT NOTICE & CONSENT TO RELEASE INFORMATION

1. ELIGIBILITY STATUS	2. STATUS DATE	3. STATUS ENTERED BY
VERIFIED	NOV 12,1999	GILBERT,RUBY E
4. VERIFICATION METHOD	5. SERVICE VERIFICATION DATE	
HINQ	NOV 12,1999	

* WARNING: If you knowingly make a false statement of any material fact in or in connection with this application, you are subject to prosecution in a U.S. Court.

* Completion of this form with signature of the veteran is certification that the veteran has received a copy of the Privacy Act Statement.

* I UNDERSTAND THE QUESTIONS, AND ALL THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I AGREE TO ACCEPT TRANSFER TO ANOTHER FACILITY IF, IN THE OPINION OF THE MEDICAL STAFF, SUCH TRANSFER IS DEEMED APPROPRIATE.

SIGNATURE OF APPLICANT OR APPLICANT'S REPRESENTATIVE	DATE
Gayle A. Dove	11-12-99

FOR VA USE ONLY	VA FACILITY NUMBER	ADMISSION DATE	AUTHORITY FOR ADMISSION OR TREATMEN
	544		

Reg Date/Time: NOV 12,1999@14:23 PRINTED: NOV 12, 1999@14:23:54 Clerk: REG/62

AUTOMATED VA FORM 10-10 PAGE:

MailMan message for GILBERT,RUBY E PATIENT SERVICE ASSISTANT
Printed at COLUMBIA-SC.VA.GOV 12 Nov 99 13:09
Subj: HINQ response for /requested by GILBERT,RUBY E [#9077155] 12 Nov 99 13:08 59 lines
From: POSTMASTER In 'IN' basket. Page 1

VBA name = GADOVE
Name = GAYLE A DOVE
Address = 4457 POPPS FERRY RD
Address = LOT 195
Address = BILOXI MS
ZIP = 39532
Sex = FEMALE
Date of Birth = AUG 15, 1957
C&P SSN = 515646094 Verified SSA

[redacted] = [redacted]
= [redacted]
= [redacted]
POW = Not applicable
Total Active Svc = 12 yr 14 days
INDICATORS(Active Duty Training NO Disability NO Homeless Veteran NO)

Verified Svc-Data
Original Award = FEB 01, 1995
Networth = Zero Networth
Combat Disability = NONE
SSI Income = Never

Service data	C&P	BIRLS
Branch of Service =	Air Force	AF
EOD =	SEP 04,1975	SEP 4,1975
RAD =	SEP 16,1987	SEP 16,1987
Char. of Service =	HONORABLE	HON

Additional service = Not an issue
Entitlement = Regular estab.(compensation) - 41
Master Record Type = Veterans Master Record - A

Diary data:
APR, 2000 100% unemployable review - 02

Diary data:
APR, 2016 Expiration of employability control - 32

DISABILITIES(Combined % = 90 SC/Total = 5/5 Additional = 0)

9411 - POST-TRAUMATIC STRESS DISORDER - 70% - Service Connected
7617 - REMOVAL OF UTERUS AND OVARIES - 50% - Service Connected
8100 - MIGRAINE HEADACHES - 30% - Service Connected
6501 - RHINITIS - 00% - Service Connected
7819 - NEOPLASM, BENIGN, SKIN - 00% - Service Connected

Perm.,total Disablity = Cannot be determined
AID & ATTEND = HB and/or A&A NOT GRANTED
Chief Attorney, fiduciary =
Employable indicator = Unemployable
Competency indicator = Competent, or not an issue
Competency Pay Status = Competent,or not an issue,Pay direct

INDICATORS(NO Severence Recoupment NO PFOP/FDIB NO Consolidated Payment)

Anatomical loss = No Amputation - 00
Other loss = Loss or loss of use of creative organ. - 1
Vet married Vet = No spouse or not eligible -
Spec. Month comp. = One disability under (k) - 01
Special Provision = Analogous Ratings - 5

Check Amount= '$2064.00' Hardship Exp.= '$0' Net Award= '$2064.00'

Columbia SC

CONTINUE ON BACK WHEN NECESSARY

Department of Veterans Affairs

Cole

MEDICAL CERTIFICATE

PAIN 0 /10

1. DATE	2. TIME	3. AGE	4. SEX	5. ON ARRIVAL PATIENT WAS	6. PHONE NUMBER	7. HOMELESS
2-26-01	0930 AM/PM	43	☐ M ☒ F	☒ AMBULATORY ☐ STRETCHER ☐ WHEELCHAIR	( )	☐ YES ☒ NO

8A. ALLERGIES	8B. WEIGHT	8C. TEMPERATURE	8D. PULSE	8E. RESPIRATION	8F. B/P	8G. DUE TO INJURY
NKDA	135 Lbs	97.4	126	24	145/83	☒ NO ☐ YES

9. CURRENT MEDICATIONS Fluoxetine, Hydroxyzine, Albuterol, Sumatriptan

10. TRIAGE Patient C/O asthma attack, Patient breathing fast coughing.

Pulse Ox: 97 R/A

11. SIGNATURE Virginia Williams RN

12. HISTORY AND PHYSICAL 26 Feb 01 0930

43 YO F Hx Asthma pt's c/o Respiratory/Sinus Drainage cough Fever N/V no BM no urine output ↓ appetite - Hx also reports Prod Cough yellow Sputum

Soc Hx ⊖ Smoke ETOH ⊖

PE: Gen alert in NAD

HEENT: trachea midline

Chest cl ausc RR ABD: Soft non tender active BS

EXT: MAE

Neuro: Grossly intact

Aerosol Tx

chest cl PTX

13. DIAGNOSTIC IMPRESSIONS ① Hx Asthma / Bronchitis

14. PLAN

Continue Inhaler / Client to f/u PC / Glenn Jones Corp

Syrup see PC this WK

aerosol Tx x 2 done VS.

15A. ATTENDING OF RECORD

15B. EXAMINER'S SIGNATURE

SECTION II - FOR PATIENT

1. DISPOSITION / CLINIC APPOINTMENT	2. AFTER CARE SHEET GIVEN	3. FOLLOWUP - ACTIVITY - LIMITATIONS
	☐ YES ☐ NO	PAIN 0 /10

4. CONDITION	5. DATE / TIME OF DISCHARGE	6. SIGNATURE TO INDICATE INSTRUCTIONS GIVEN
☐ IMPROVED ☒ SATISFACTORY ☐ UNCHANGED	2-26-01 @ 1105	Virginia Williams RN

IMPRINT PATIENT DATA CARD

LOVE, GAYLE A

[redacted]

7. PATIENT INSTRUCTIONS

① Take Medication as prescribed

② ↑ fluids.

③ Rest

I CERTIFY THAT I RECEIVED AND UNDERSTAND THESE INSTRUCTIONS

8. PATIENT'S SIGNATURE Gayle A. Love

VA FORM SUPERSEDES VA FORM 10-10M, MAY 1999

MailMan message for SPAIN,AGATHA M FILE ROOM CLERK
Printed at BILOXI.VA.GOV 4 Aug 00 13:04
Subj: BULLETIN FOR THE REQUEST OR NOTICE OF TRANSFER [#16627453] 04 Aug 00 12:59
43 lines
From: SPAIN,AGATHA M In 'IN' basket. Page 1

NOTICE OF TRANSFER OF VETERANS RECORDS.

	Station Name	Number	Mail Routing Symbol
1a.	COLUMBIA, SC	544	
1b.			
1c.			

4. NAME (Last,First,Middle)
DOVE,GAYLE A

5. [CN] [redacted]

6. [SN] [redacted]

8. TYPE OF TRANSFER [X] Permanent [ ] Temporary

11. TRANSFER CLAIMS FOLDER [ ]

12a. DATE OF TRANSFER	12b. REC. STAT. NO.	12c. TRF. STA. NO.
AUG 04, 2000@12:59	544	520

13. OTHER FOLDER TRANSFER

[ ] LG [ ] PG [ ] OPT [X] MED REC [X] HOSP CORRESP [ ] X-RAY

COUNSELING/TRAINING
[ ] R&E [ ] INS [ ] SUBFOLDER [ ] SPECIFY
SPECIFY:

14. REASON FOR TRANSFER OR REMARKS
PER VET REQUEST

15. ADJUDICATION ACTION PENDING [ ] YES [ ] NO

16. FROM (originating office) Biloxi, MS (CONS)

17. DATE AUG 04, 2000@12:59

18. CHECK WHEN COPY 2 IS SENT TO TELECOM [ ] UNIT

!100A!

DOVE,GAYLE A 515-64-6094

THIS PAGE MAY BE REPLACED BY PAGE #4 OF VA FORM 10-10 WHICH CONTAINS PRIVACY ACT NOTICE & CONSENT TO RELEASE INFORMATION

1. ELIGIBILITY STATUS	2. STATUS DATE	3. STATUS ENTERED BY
VERIFIED	APR 24,1997	SALLEY,FLORENCE E
4. VERIFICATION METHOD	5. SERVICE VERIFICATION DATE	
HINQ	APR 24,1997	

* WARNING: If you knowingly make a false statement of any material fact in or in connection with this application, you are subject to prosecution in a U.S. Court.

* Completion of this form with signature of the veteran is certification that the veteran has received a copy of the Privacy Act Statement.

* I UNDERSTAND THE QUESTIONS, AND ALL THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I AGREE TO ACCEPT TRANSFER TO ANOTHER FACILITY IF, IN THE OPINION OF THE MEDICAL STAFF, SUCH TRANSFER IS DEEMED APPROPRIATE.

The VA is not responsible for clothing/valuables/money taken to the ward with the patient.

SIGNATURE OF APPLICANT OR APPLICANT'S REPRESENTATIVE	DATE
X Gayle A. Dove	X 31 MAR 98

FOR VA USE ONLY	VA FACILITY NUMBER	ADMISSION DATE	AUTHORITY FOR ADMISSION OR TREATMENT
	520		17.47(a)(1)

Reg Date/Time: SEP 22,1995@09:37 PRINTED: MAR 31, 1998@08:21:48 Clerk: PLC/1761

HEADACHES 1-5W

AUTOMATED VA FORM 10-10 PAGE: 4

DOVE, GAYLE A 515-64-6094

PART III - APPLICANT/SPOUSE DATA

1. APPLICANT'S EMPLOYMENT STATUS: 3. NOT EMPLOYED

2. SPOUSE'S EMPLOYMENT STATUS: NOT APPLICABLE

3. APPLICANT INFORMATION	4. SPOUSE'S INFORMATION
3A. OCCUPATION: DEALER	4A. OCCUPATION: NOT APPLICABLE
3B. EMPLOYER (Name, Street Address, City, State, Zip) NOT APPLICABLE	4B. EMPLOYER (Name, Street Address, City, State, Zip) NOT APPLICABLE
3C. WORK TELEPHONE NUMBER:	4C. WORK TELEPHONE NUMBER:

PART IV - MILITARY SERVICE DATA

1A. LAST BRANCH OF SERVICE AIR FORCE	1B. LAST SERVICE NUMBER 515646094	1C. LAST DATE OF ENTRY SEP 4,1975	1D. LAST DISCHARGE DATE SEP 16,1987	1E. DISCHARGE TYPE HONORABLE
2A. PRIOR BRANCH OF SERVICE NOT APPLICABLE	2B. PRIOR SERVICE NUMBER	2C. PRIOR DATE OF ENTRY	2D. PRIOR DISCHARGE DATE	2E. DISCHARGE TYPE
3A. PRIOR BRANCH OF SERVICE NOT APPLICABLE	3B. PRIOR SERVICE NUMBER	3C. PRIOR DATE OF ENTRY	3D. PRIOR DISCHARGE DATE	3E. DISCHARGE TYPE

PART V - ELIGIBILITY STATUS DATA

1. PATIENT TYPE: SC VETERAN

2. IS NEED FOR MEDICAL CARE RELATED TO AN ON THE JOB INJURY: NO	3. IS THE NEED FOR MEDICAL CARE RELATED TO AN ACCIDENT: NO	4. IS PATIENT ELIGIBLE FOR MEDICAID: NO
5A. DOES PATIENT HAVE HEALTH INSURANCE COVERAGE: NO	5B. IF YES, COVERAGE PROVIDED BY: NOT APPLICABLE	
6. DOES VETERAN HAVE GI INSURANCE: NO	7. PRIMARY ELIGIBILITY CODE SERVICE CONNECTED 50% to 100%	8. OTHER ELIGIBILITY CODE UNANSWERED	9. PERIOD OF SERVICE POST-VIETNAM

10. RATED SERVICE CONNECTED CONDITIONS:
POST-TRAUMATIC STRESS DISORDER (70%)
REMOVAL OF UTERUS AND OVARIES (50%)
MIGRAINE HEADACHES (30%)
RHINITIS (0%)
NEOPLASM, BENIGN, SKIN (0%)

11. OTHER ELIGIBILITY DATA

A. VETERAN	YES	L. SERVICE IN PERSIAN GULF THEATER	NO
B. PRISONER OF WAR STATUS	NO	M. DENTAL INJ. UNANSWERED	TEETH EXTRACTED UNANSWERED
C. EXPOSURE TO AGENT ORANGE	NO	N. SERVICE CONNECTED: 100%	YES
D. EXPOSURE TO RADIATION	NO	O. RECEIVING AID & ATTENDANCE	NO
E. COMBAT SERVICE	NO	P. RECEIVING HOUSEBOUND	NO
F. MILITARY DISABILITY	NO	Q. RECEIVING VA PENSION	NO
G. VIETNAM SERVICE	NO	R. RECEIVING VA DISABILITY	YES
H. LEBANON SERVICE	NO	S. SERVICE IN SOMALIA	NO
I. GRENADA SERVICE	NO		
J. PANAMA SERVICE	NO		
K. PERSIAN GULF SERVICE	NO	T. VA MONETARY AMOUNT: $ 23976	

PART VI - INCOME SCREENING DATA OR ANNUAL INCOME

1A. CURRENT MARITAL STATUS: DIVORCED	1B. DATE OF MARRIAGE: APR 15,1990

2A. WAS PATIENT MARRIED OR SEPARATED AT THE END OF LAST CALENDAR YEAR?: YES

2B. NAME OF SPOUSE	2C. SEX OF SPOUSE	2D. SPOUSE'S SOCIAL SECURITY NO	2E. SPOUSE'S DATE OF BIRTH
PARKE,RICHARD A	MALE	352-66-4136	JUL 3,1963

3. DEPENDENTS

A. NAME	B. SOCIAL SECURITY NO	C. SEX	D. DATE OF BIRTH	E. RELATIONSHIP	F. DEPENDENT AS OF (DATE)
NONE INDICATED					

4. PREVIOUS CALENDAR YEAR (1994) INCOME INFORMATION

	CHECK ALL APPLICABLE BOXES	AMOUNT VETERAN	SPOUSE	DEPENDENTS	TOTAL
	1. SOCIAL SECURITY (NOT SSI)	-	-	-	-
	2. U.S. CIVIL SERVICE	-	-	-	-
	3. U.S. RAILROAD RETIREMENT	-	-	-	-
	4. MILITARY RETIREMENT	-	-	-	-
	5. UNEMPLOYMENT COMPENSATION	-	-	-	-
	6. OTHER RETIREMENT	-	-	-	-
X	7. TOTAL INCOME FROM EMPLOYMENT	$2000.00	$18000.00	-	$20000.00
	8. INTEREST, DIVIDEND, OR ANNUITY INCOME	-	-	-	-
	9. WORKERS COMPENSATION/BLACK LUNG BENEFITS	-	-	-	-
	10. ALL OTHER INCOME	-	-	-	-
	11. TOTAL INCOME				$20000.00

PART VII - INELIGIBLE/MISSING DATA

1. INELIGIBLE DATE	2. TWX SOURCE	3. TWX CITY	4. TWX STATE

5. REASON:

6. VACO DECISION:

7. MISSING DATE	8. TWX SOURCE	9. TWX CITY	10. TWX STATE

11. REASON:

Reg Date/Time: SEP 22,1995@09:37 PRINTED: MAR 31, 1998@08:21:48 Clerk: PLC/1761

Biloxi, MS (CONS) (520) SUPPLEMENTAL DATA SHEET

1. Applicant's Name: DOVE,GAYLE A | 2. SSN: 515-64-6094

3. Other Name(s): VOGLE,GAYLE A; PARKER,GAYLE A;

4. Remarks: ***mccr needs new insurance information***

5. Fathers Name: RAYMOND (L)
Mothers Name: MARLYN (L)
Mothers Maiden Name: MOSSMAN

6a. Enrollment Clinic(s): WOMEN'S MHPC GOLD DEROMA-GPT, WOMEN'S MHPC GOLD GROUP-GPT, ZZZ GYNECOLOGY CLINIC, AUDIOLOGY-BILOXI, WOMEN'S MHPC GOLD PSYCHIA-GPT, CAT SCAN CLINIC, PC PURPLE PSYCHOLOGY JONES, PC PURPLE PENNISSON, PC GOLD PSYCHOLOGY-HANSON,

6b. Future Appointments: WOMEN'S MHPC GOLD PSYCHIA-GPT (APR 7,1998@09:00), EYE-CARRIERE (APR 14,1998@13:00), LABORATORY (MAY 7,1998@08:00), PC PURPLE PENNISSON (MAY 14,1998@10:40),

7a. Last Admission: MAR 12,1995@10:27:05 (DISCHARGED 'MAR 19,1995@18:00')

7b. Discharge Diagnosis(es): (614.6)-FEM PELVIC PERITON ADHES;

7c. Admit Diagnosis: UNSPECIFIED

7d. Diagnosis Responsible for Greatest Length of Stay: (614.6)-FEM PELVIC PERITON ADHES

8. Eligibility Status: VERIFIED | Status Date: APR 24,1997
Verification Method: HINQ | By: SALLEY,FLORENCE E
Ineligible Date: ELIGIBLE APPLICANT -- NOT APPLICABLE | TWX Source: NOT APPLICABLE
TWX City: NOT APPLICABLE | TWX State: NOT APPLICABLE
VARO Decision: NOT APPLICABLE

9. Vietnam Service: NO From: NOT APPLICABLE To : NOT APPLICABLE
Agent Orange: NO Reg : NOT APPLICABLE Exam : NOT APPLICABLE Reg #: NOT APPLICABLE
ION Radiation: NO Reg : NOT APPLICABLE Method: NOT APPLICABLE
Prisoner of War: NO From: NOT APPLICABLE To : NOT APPLICABLE Where: NOT APPLICABLE
Combat: NO From: NOT APPLICABLE To : NOT APPLICABLE Where: NOT APPLICABLE

10. Next of Kin, Address and Zip Code: | Relationship: FATHER
Name: RAY DOVE JR
4457 POPPS FERRY RD.LOT 195 | Phone: 228-396-1919
BILOXI, MISSISSIPPI 39532

reg: SEP 22,1995@09:37 clerk: PLC/1761

DATE PRINTED: MAR 31, 1998

NAME: DOVE,GAYLE A

PT ID: 515-64-6094

INSURANCE CARRIER:
ADDRESS:
PHONE: POLICY #: GROUP #:
PRE-CERT PHONE: BILLING PHONE:

INSURANCE CARRIER:
ADDRESS:
PHONE: POLICY #: GROUP #:
PRE-CERT PHONE: BILLING PHONE:

INSURANCE CARRIER:
ADDRESS:
PHONE: POLICY #: GROUP #:
PRE-CERT PHONE: BILLING PHONE:

ADMITTING DX: HEADACHES
WARD: 1-5WMED
SCHEDULED ADMISSION DATE:
ADMISSION DATE: MAR 31, 1998@08:19:08

PRE-ADMISSION CERTIFICATION:

_____NUMBER DAYS CERTIFIED _____AUTHORIZATION NUMBER
_____NOT REQUIRED
_____FAILURE TO MEET ESTABLISHED ADMISSION CRITERIA
_____MEDICAL INFORMATION IS INSUFFICIENT
_____OPT CARE IS MORE APPROPRIATE
_____OTHER LEVELS OF SERVICE ARE MORE APPROPRIATE (NURSING HOME VS HOSPITAL)
_____POLICY DOES NOT COVER MEDICAL CARE REQUIRED
_____COVERAGE EXHAUSTED
_____OTHER

PREPARED BY_____

SECOND SURGICAL OPINION NEEDED: _____YES _____NO
SECOND SURGICAL OPINION OBTAINED: _____YES _____OUTSIDE MD RECOMMENDED AGAINST SURGERY
_____NOT APPLICABLE _____OTHER
_____NOT RECEIVED

PREPARED BY_____

LOS REVIEW DATE: _____ DATE APPROVED:_____
NUMBER OF DAYS EXTENDED: _____
_____AUTHORIZATION NUMBER
_____PRE-OP DAYS DENIED _____APPROPRIATE ALTERNATIVE TREATMENT OPTIONS EXIST
_____MORE MEDICAL INFORMATION NEEDED _____ALTERNATVE TREATMENT NOT COVERED BY POLICY
_____FAILURE TO MEET CONTINUED STAY CRITERIA _____AVAILABILITY OF ALTERNATIVE TREATMENT
_____APPROPRIATE ALTERNATIVE TREATMENT OPTIONS EXIST _____COVERAGE EXHAUSTED
_____OTHER

PREPARED BY_____

BILLS DENIED IN FULL:
_____EXCLUSIONARY CLAUSE STILL IN EFFECT
_____DEDUCTIBLE/COPAYMENT APPLIES
_____TYPE OF CARE NOT COVERED BY POLICY
_____PATIENT DOES NOT HAVE CURRENT COVERAGE
_____INSURER WILL NOT PAY PER DIEM RATES
_____TREATMENT/ADMISSION NOT AUTHORIZED BY INSURANCE CARRIER
_____OTHER

BILL DENIED IN PART:
_____DEDUCTIBLE/COPAYMENT APPLIES
_____PORTION OF CARE NOT COVERED BY POLICY
_____EXCEEDS USUAL AND CUSTOMARY CHARGES
_____PAYMENT LIMITED TO PREAUTHORIZED DAYS
_____OTHER

_____BILL PAID IN FULL

PREPARED BY_____

REMARKS:

NOTE DATED: 04/23/98 14:40 GROUP THERAPY
VISIT: 04/23/98 13:30 WOMEN'S MHPC GOLD RESIDENT-GPT
DEPRESSION AND WEIGHT MANAGEMENT GROUP THERAPY: PROBLEM -- (2)DEPRESSION

VET SEEN FOR FOURTH GROUP THERAPY SESSION. SESSION INCLUDED A REVIEW OF HOMEWORK FOCUSING ON PARTICIPANTS DAILY ACTIVITY SCHEDULES AND PLEASURE RATINGS. OVERALL, PARTICIPANTS FOUND THAT THEY DID MORE THAN THEY REALIZED AND THAT MANY OF THEIR DAILY ACTIVITIES WERE MORE PLEASURABLE FOR THEM THAN THEY HAD EXPECTED. SESSION THEN FOCUSED ON HEALTHY LIVING HABITS AND WEIGHT MANAGMENT ISSUES, INCLUDING IDENTIFYING CUES AND HABITS ASSOCIATED WITH EATING, DECREASING CUES BY DECALORIZING THE HOME AND DESIGNATING EATING AREAS, AND INCREASING ENERGY OUTPUT THROUGH AN EXERCISE PROGRAM AND/OR INCREASING ENERGY EXPENDITURE ASSOCIATED WITH DAILY ACTIVITIES (WITH PARTICIPANTS GENERATING SPECIFIC WAYS TO ALTER ACTIVITIES TO INCREASE ENERGY OUTPUT). GAYLE REPORTED THAT SHE WAS SURPRISED WITH THE NUMBER OF ACTIVITIES THAT FILLED HER DAILY ACTIVITY SCHEDULE AND WAS ALSO SURPRISED BY THE NUMBER OF PLEASURABLE THINGS. HW: CHOOSE AT LEAST ONE OF SEVERAL POSSIBLE ACTIVITIES LISTED RELATED TO THE ISSUES DISCUSSED TODAY TO COMPLETE (DAILY EATING RECORD; SKETCH OF HOME AND RECORD OF WHERE EACH MEAL & SNACK OCCURS; DECALORIZE THE HOME; DESIGNATE EATING PLACES; DAILY RECORD OF EXERCISE AND ACTIVITY). GAF=60.

Signed by: /es/ JULIE V BATTLE
PSYCHOLOGY RESIDENT 04/23/98 14:56
Cosigned by: /es/ VIRGINIA M. DEROMA
STAFF PSYCHOLOGIST 04/30/98 08:38

AMIE 7131 NEW REQUEST REPORT FOR 02/11/97 TO 02/11/97 * LONG VERSION *
FOR BILOXI VAMC 520, DIVISION BILOXI

DOVE,GAYLE A

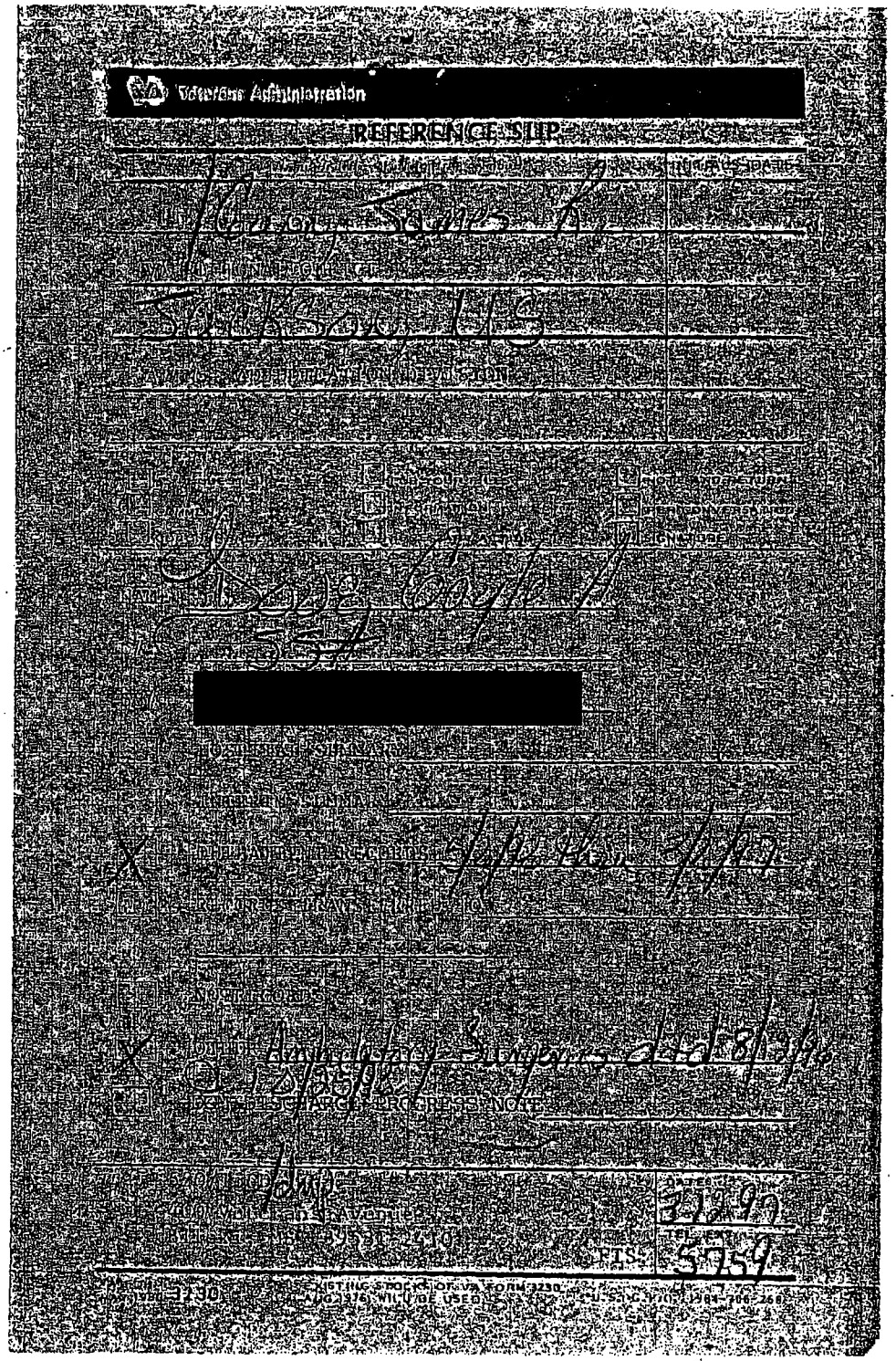
Items Requested:

OPT TREATMENT REPORT (BILOXI): 05-01-96 TO THE PRESENT

Remarks:

ON 11-20-96 WE REQUESTED YOU TO FURNISH ALL HS & OPTR FROM 5-1-96 TO THE PRESENT. WE HAVE NOT RECEIVED THESE RECORDS. PLEASE EXPEDITE YOUR ACTION ON THIS 2ND REQUEST, MADE ON 02-11-97.

Requested by: GUNN,JAMES RODNEY AT JACKSON-RO


Veterans Administration
REFERENCE SLIP
[redacted]
FTS
3230
3.1.99
5359

AMIE 7131 NEW REQUEST REPORT FOR 11/20/96 TO 11/20/96 * LONG VERSION *
FOR BILOXI VAMC 520, DIVISION BILOXI

DOVE,GAYLE A [redacted]

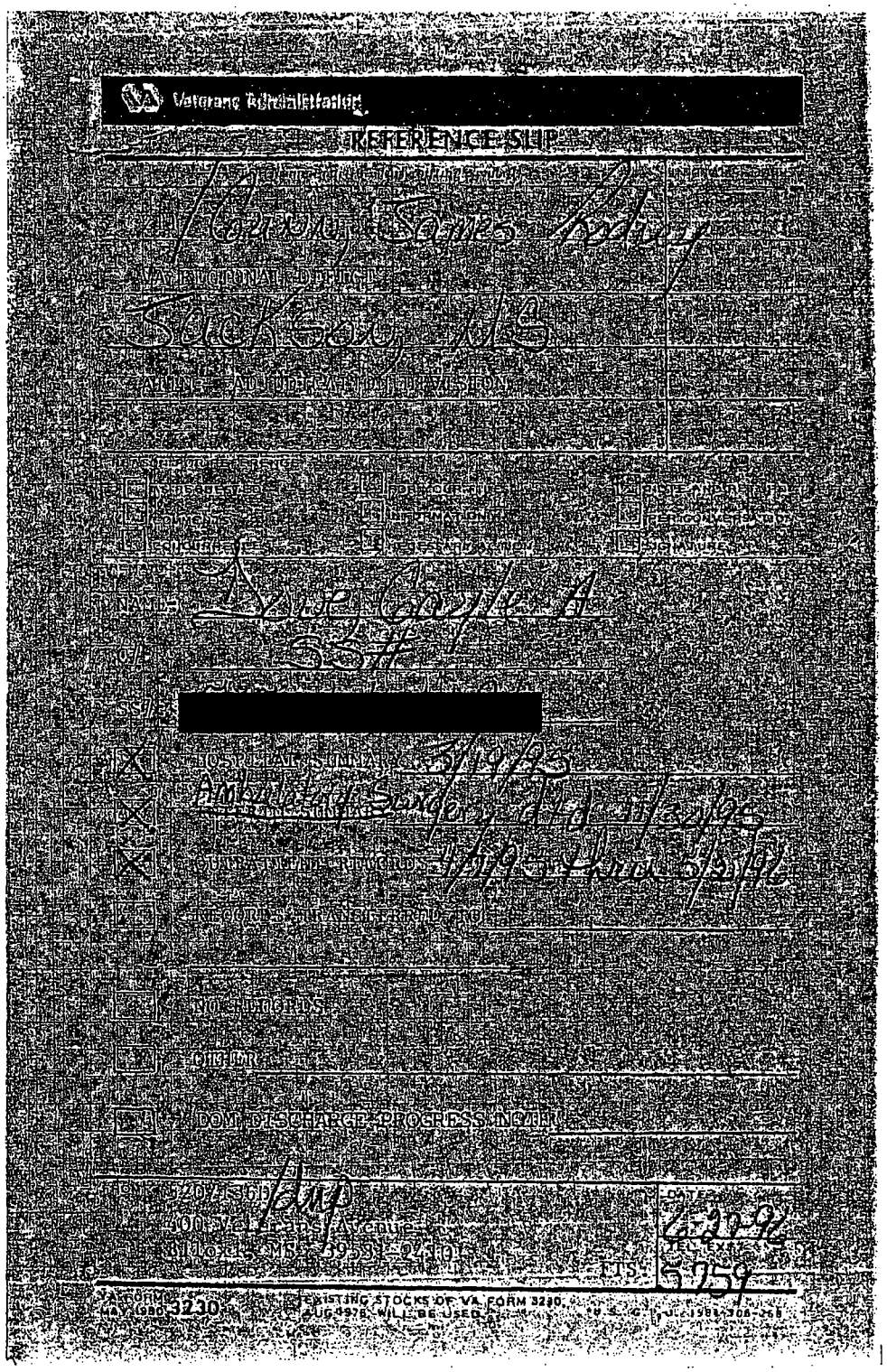
Items Requested:

OPT TREATMENT REPORT (BILOXI): 05-21-96 TO THE PRESENT

Remarks:

PLEASE FURNISH ALL HS & OPTR FROM 05-21-96 TO THE PRESENT. REQUESTED ON 11-20-96.

Requested by: GUNN,JAMES RODNEY AT JACKSON-RO


Veterans Administration

REFERENCE SLIP

[redacted]

1135

AMIE 7131 NEW REQUEST REPORT FOR 05/28/96 TO 05/28/96 * LONG VERSION *
FOR BILOXI VAMC 520, DIVISION BILOXI

DOVE,GAYLE A

[redacted]

Items Requested:

OPT TREATMENT REPORT (BILOXI): 04-04-95 TO THE PRESENT

Remarks:

PLEASE FURNISH ALL HS & OPTR FROM 04-04-95 TO THE PRESENT. REQUESTED ON 04-08-96. THIS REQUEST IS MADE 5-28-96.

Requested by: GUNN,JAMES RODNEY AT JACKSON-RO

AMIE 7131 NEW REQUEST REPORT FOR 04/08/96 TO 04/08/96 * LONG VERSION *
FOR BILOXI VAMC 520, DIVISION BILOXI

DOVE,GAYLE A [redacted]

Items Requested:

OPT TREATMENT REPORT (BILOXI): 04-04-95 TO THE PRESENT

Remarks:

PLEASE FURNISH ALL HS & OPTR FROM 04-04-95 TO THE PRESENT. REQUESTED ON 04-08-96.

Requested by: GUNN,JAMES RODNEY AT JACKSON-RO

DOVE,GAYLE A 515-64-6094

THIS PAGE MAY BE REPLACED BY PAGE #4 OF VA FORM 10-10 WHICH CONTAINS PRIVACY ACT NOTICE & CONSENT TO RELEASE INFORMATION

1. ELIGIBILITY STATUS	2. STATUS DATE	3. STATUS ENTERED BY
VERIFIED	MAR 13,1995	SALLEY,FLORENCE E
4. VERIFICATION METHOD	5. SERVICE VERIFICATION DATE	
DD214/HINQ	MAR 13,1995	

* WARNING: If you knowingly make a false statement of any material fact in or in connection with this application, you are subject to prosecution in a U.S. Court.

* Completion of this form with signature of the veteran is certification that the veteran has received a copy of the Privacy Act Statement.

* I UNDERSTAND THE QUESTIONS, AND ALL THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I AGREE TO ACCEPT TRANSFER TO ANOTHER FACILITY IF, IN THE OPINION OF THE MEDICAL STAFF, SUCH TRANSFER IS DEEMED APPROPRIATE.

The VA is not responsible for clothing/valuables/money taken to the ward with the patient.

SIGNATURE OF APPLICANT OR APPLICANT'S REPRESENTATIVE	DATE
x Gayle A. Dove	9-22-95

FOR VA USE ONLY	VA FACILITY NUMBER	ADMISSION DATE	AUTHORITY FOR ADMISSION OR TREATMENT
	520		

Reg Date/Time: SEP 22,1995@09:37 PRINTED: SEP 22, 1995@09:44:20 Clerk: PLC/1761

AUTOMATED VA FORM 10-10 PAGE: 4

DEPARTMENT OF VETERANS AFFAIRS

FACILITY: Biloxi, MS (CONS) (520) APPLICATION FOR MEDICAL BENEFITS

SEE ATTACHMENT FOR PAPERWORK REDUCTION INFORMATION AND PRIVACY ACT INFORMATION

PART I - PATIENT DATA

1. Type of benefit applied for: HOSPITAL/OUTPATIENT TREATMENT

2. Applicant's Name	3. Other names used (Alias)	4. Social Security Number
DOVE,GAYLE A	VOGLE,GAYLE A PARKER GAYLE A	[redacted]

5.			
[redacted]94	[redacted]317ST.PETERSBURG-RO[redacted]	[redacted]AUG 15,1957	[redacted]WITCHIA FALLS, TEXAS

9. PERMANENT ADDRESS		10. TEMPORARY ADDRESS	
9A. STREET ADDRESS: 4457 POPPS FERRY RD.LOT 195		10A. STREET ADDRESS: NOT APPLICABLE	
9B. CITY: BILOXI	9C. STATE: MISSISSIPPI	10B. CITY:	10C. STATE:
9D. ZIP CODE: 39532	9E. COUNTY: HARRISON	10D. ZIP CODE:	10E. COUNTY:
9F. HOME TELEPHONE NUMBER: 601-396-1919		10F. HOME TELEPHONE NUMBER:	

11. PATIENT'S SEX	12. MOTHER'S MAIDEN NAME	13. MOTHER'S NAME	14. FATHER'S NAME
FEMALE	MOSSMAN	MARLYN (L)	RAYMOND (L)
15. RELIGIOUS PREFERENCE	16. DATE OF PREVIOUS CARE	17. LOCATION OF PREVIOUS CARE	18. SPINAL CORD INJURY
PROTESTANT, NO DENOMINATION	UNANSWERED	UNANSWERED	NOT APPLICABLE

PART II - EMERGENCY CONTACT DATA

1A. FIRST NEXT OF KIN	1B. RELATIONSHIP	1C. HOME TELEPHONE NUMBER	1D. WORK TELEPHONE NUMBER
RAY DOVE JR	FATHER	601-396-1919	UNANSWERED
1E. ADDRESS (Number, Street, City, State, ZIP Code) 4457 POPPS FERRY RD.LOT 195, BILOXI, MISSISSIPPI, 39532-			
2A. SECOND NEXT OF KIN	2B. RELATIONSHIP	2C. HOME TELEPHONE NUMBER	2D. WORK TELEPHONE NUMBER
UNANSWERED			
2E. ADDRESS (Number, Street, City, State, ZIP Code)			
3A. FIRST CONTACT IN AN EMERGENCY	3B. RELATIONSHIP	3C. HOME TELEPHONE NUMBER	3D. WORK TELEPHONE NUMBER
RAY DOVE JR	FATHER	601-396-1919	NONE
3E. ADDRESS (Number, Street, City, State, ZIP Code) 4457 POPPS FERRY RD.LOT 195, BILOXI, MISSISSIPPI, 39532-			
4A. SECOND CONTACT IN AN EMERGENCY	4B. RELATIONSHIP	4C. HOME TELEPHONE NUMBER	4D. WORK TELEPHONE NUMBER
UNANSWERED			
4E. ADDRESS (Number, Street, City, State, ZIP Code)			

I DESIGNATE THE FOLLOWING PERSON TO RECEIVE POSSESSION OF ALL PERSONAL PROPERTY LEFT ON THE PREMISES UNDER VA CONTROL AFTER I LEAVE SUCH PLACE OR AT TIME OF MY DEATH (This does not constitute a will or transfer of title.)

5A. DESIGNEE	5B. RELATIONSHIP	5C. HOME TELEPHONE NUMBER	5D. WORK TELEPHONE NUMBER
RAY DOVE JR	FATHER	601-396-1919	UNANSWERED
5E. ADDRESS (Number, Street, City, State, ZIP Code) 4457 POPPS FERRY RD.LOT 195, BILOXI, MISSISSIPPI, 39532-			

NOTE - The law (38 USC 8520 et seq.) provides that upon the death of any veteran receiving care or treatment by the Department of Veterans Affairs in any institution or of a dependent or survivor of a veteran admitted to a VA medical facility leaving no surviving spouse or next of kin or heir entitled to inherit, all personal property, including money or balances in bank, all claims and choses in action, owned by such person, and not disposed of by will or otherwise will become the property of the United States as trustee for the general Post Fund.

Reg Date/Time: SEP 22,1995@09:37 PRINTED: SEP 22, 1995@09:44:20 Clerk: PLC/1761

PART III - APPLICANT/SPOUSE DATA

1. APPLICANT'S EMPLOYMENT STATUS: 2. EMPLOYED PART TIME

2. SPOUSE'S EMPLOYMENT STATUS: NOT APPLICABLE

3. APPLICANT INFORMATION	4. SPOUSE'S INFORMATION
3A. OCCUPATION: DEALER	4A. OCCUPATION: NOT APPLICABLE
3B. EMPLOYER (Name, Street Address, City, State, Zip) COPA CASINO HWY 90 GULFPORT, MS, 39501	4B. EMPLOYER (Name, Street Address, City, State, Zip) NOT APPLICABLE
3C. WORK TELEPHONE NUMBER: 863-3330	4C. WORK TELEPHONE NUMBER:

PART IV - MILITARY SERVICE DATA

1A. LAST BRANCH OF SERVICE AIR FORCE	1B. LAST SERVICE NUMBER 515646094	1C. LAST DATE OF ENTRY SEP 4,1975	1D. LAST DISCHARGE DATE SEP 16,1987	1E. DISCHARGE TYPE HONORABLE
2A. PRIOR BRANCH OF SERVICE NOT APPLICABLE	2B. PRIOR SERVICE NUMBER	2C. PRIOR DATE OF ENTRY	2D. PRIOR DISCHARGE DATE	2E. DISCHARGE TYPE
3A. PRIOR BRANCH OF SERVICE NOT APPLICABLE	3B. PRIOR SERVICE NUMBER	3C. PRIOR DATE OF ENTRY	3D. PRIOR DISCHARGE DATE	3E. DISCHARGE TYPE

PART V - ELIGIBILITY STATUS DATA

1. PATIENT TYPE: NSC VETERAN

2. IS NEED FOR MEDICAL CARE RELATED TO AN ON THE JOB INJURY: NO	3. IS THE NEED FOR MEDICAL CARE RELATED TO AN ACCIDENT: NO	4. IS PATIENT ELIGIBLE FOR MEDICAID: NO
5A. DOES PATIENT HAVE HEALTH INSURANCE COVERAGE: NO	5B. IF YES, COVERAGE PROVIDED BY: NOT APPLICABLE	

6. DOES VETERAN HAVE GI INSURANCE: NO	7. PRIMARY ELIGIBILITY CODE NSC	8. OTHER ELIGIBILITY CODE UNANSWERED	9. PERIOD OF SERVICE POST-VIETNAM

10. SERVICE CONNECTED CONDITIONS: NOT APPLICABLE: NOT A SERVICE-CONNECTED APPLICANT

11. OTHER ELIGIBILITY DATA

A. VETERAN	YES	L. SERVICE IN PERSIAN GULF THEATER	NO
B. PRISONER OF WAR STATUS	NO	M. DENTAL INJ. UNANSWERED / TEETH EXTRACTED	UNANSWERED
C. EXPOSURE TO AGENT ORANGE	NO	N. SERVICE CONNECTED	NO
D. EXPOSURE TO RADIATION	NO	O. RECEIVING AID & ATTENDANCE	NO
E. COMBAT SERVICE	NO	P. RECEIVING HOUSEBOUND	NO
F. MILITARY DISABILITY	NO	Q. RECEIVING VA PENSION	NO
G. VIETNAM SERVICE	NO	R. RECEIVING VA DISABILITY	NO
H. LEBANON SERVICE	NO	S. SERVICE IN SOMALIA	NO
I. GRENADA SERVICE	NO		
J. PANAMA SERVICE	NO		
K. PERSIAN GULF SERVICE	NO	T. VA MONETARY AMOUNT: NOT APPLICABLE	

Reg Date/Time: SEP 22,1995@09:37 PRINTED: SEP 22, 1995@09:44:20 Clerk: PLC/1761

PART VI - INCOME SCREENING DATA OR ANNUAL INCOME

1A. CURRENT MARITAL STATUS: DIVORCED	1B. DATE OF MARRIAGE: APR 15,1990

2A. WAS PATIENT MARRIED OR SEPARATED AT THE END OF LAST CALENDAR YEAR?: YES

2B. NAME OF SPOUSE	2C. SEX OF SPOUSE	2D. SPOUSE'S SOCIAL	2E. SPOUSE'S DATE OF BIRTH
PARKE,RICHARD A	[redacted]	[redacted]	[redacted]

3. DEPENDENTS

A. NAME	B. SOCIAL SECURITY NO	C. SEX	D. DATE OF BIRTH	E. RELATIONSHIP	F. DEPENDENT AS OF (DATE)
NONE INDICATED					

4. PREVIOUS CALENDAR YEAR (1994) INCOME INFORMATION

	CHECK ALL APPLICABLE BOXES	AMOUNT VETERAN	SPOUSE	DEPENDENTS	TOTAL
	1. SOCIAL SECURITY (NOT SSI)	-	-	-	-
	2. U.S. CIVIL SERVICE	-	-	-	-
	3. U.S. RAILROAD RETIREMENT	-	-	-	-
	4. MILITARY RETIREMENT	-	-	-	-
	5. UNEMPLOYMENT COMPENSATION	-	-	-	-
	6. OTHER RETIREMENT	-	-	-	-
X	7. TOTAL INCOME FROM EMPLOYMENT	$2000.00	$18000.00	-	$20000.00
	8. INTEREST, DIVIDEND, OR ANNUITY INCOME	-	-	-	-
	9. WORKERS COMPENSATION/BLACK LUNG BENEFITS	-	-	-	-
	10. ALL OTHER INCOME	-	-	-	-
	11. TOTAL INCOME				$20000.00

PART VII - INELIGIBLE/MISSING DATA

1. INELIGIBLE DATE	2. TWX SOURCE	3. TWX CITY	4. TWX STATE

5. REASON:

6. VACO DECISION:

7. MISSING DATE	8. TWX SOURCE	9. TWX CITY	10. TWX STATE

11. REASON:

Reg Date/Time: SEP 22,1995@09:37 PRINTED: SEP 22, 1995@09:44:20 Clerk: PLC/1761

Biloxi, MS (CONS) (520) SUPPLEMENTAL DATA SHEET

1. Applicant's Name: DOVE,GAYLE A | 2. SSN: [redacted]

3. Other Name(s): VOGLE,GAYLE A; PARKER,GAYLE A;

4. Remarks: NO REMARKS CURRENTLY ENTERED FOR THIS APPLICANT

5. Fathers Name: RAYMOND (L)
Mothers Name: MARLYN (L)
Mothers Maiden Name: MOSSMAN

6a. Enrollment Clinic(s): WOMEN'S CLINIC, GYNECOLOGY CLINIC,

6b. Future Appointments: GYNECOLOGY CLINIC (OCT 30,1995@09:00),

7a. Last Admission: MAR 12,1995@10:27:05 (DISCHARGED 'MAR 19,1995@18:00')

7b. Discharge Diagnosis(es): (614.6)-FEM PELVIC PERITON ADHES;
7c. Admit Diagnosis: UNSPECIFIED

7d. Diagnosis Responsible for Greatest Length of Stay: (614.6)-FEM PELVIC PERITON ADHES

8. Eligibility Status: VERIFIED | Status Date: MAR 13,1995
Verification Method: DD214/HINQ | By: SALLEY,FLORENCE E
Ineligible Date: ELIGIBLE APPLICANT -- NOT APPLICABLE | TWX Source: NOT APPLICABLE
TWX City: NOT APPLICABLE | TWX State: NOT APPLICABLE
VARO Decision: NOT APPLICABLE

9. Vietnam Service: NO From: NOT APPLICABLE To : NOT APPLICABLE
Agent Orange: NO Reg : NOT APPLICABLE Exam : NOT APPLICABLE Reg #: NOT APPLICABLE
ION Radiation: NO Reg : NOT APPLICABLE Method: NOT APPLICABLE
Prisoner of War: NO From: NOT APPLICABLE To : NOT APPLICABLE Where: NOT APPLICABLE
Combat: NO From: NOT APPLICABLE To : NOT APPLICABLE Where: NOT APPLICABLE

10. Next of Kin, Address and Zip Code: | Relationship: FATHER
Name: RAY DOVE JR | Phone: 601-396-1919
4457 POPPS FERRY RD.LOT 195
BILOXI, MISSISSIPPI 39532

reg: SEP 22,1995@09:37 clerk: PLC/1761

MailMan message for SALLEY,FLORENCE E CLERK,MEDICAL
Printed at BILOXI.VA.GOV 13 Mar 95 13:18
Subj: HINQ response for DOVE,GAYLE A /requested by HULLENDER,CATHY L [#3318630] 13 Mar 95 08:08 31 Lines
From: POSTMASTER (Sender: PLUTINO,JAMES) in 'IN' basket. Page 1

DOVE,GAYLE A AUG 15,1957 [redacted]
BIRLS Response only - No C&P Record Found

VBA name = VOGEL, GAYLE ANN Verified Svc-Data
Sex = FEMALE
Date of Birth = [redacted]
Folder Location = 317 - ST.PETERSBURG-RO
Power of Attorney = The American Legion - 74
Total Active Svc = 12 yr 14 days
INDICATORS(Active Duty Training NO Disability NO Homeless Veteran NO)

Service data	C&P	BIRLS
Branch of Service =		AF AF
EOD =		SEP 4,1975 DEC 2,1985
RAD =		SEP 16,1987
Char of Service =		UNK HON

DISABILITIES(Combined % = 0 SC/Total = 0/0 Additional = 0)

Diagnostic Verified Indicator is NO.
Verify Service Connections at 317 - ST.PETERSBURG-RO

ELIGIBILITY DOCUME

DOVE,GAYLE A 515-64-6094

THIS PAGE MAY BE REPLACED BY PAGE #4 OF VA FORM 10-10 WHICH CONTAINS PRIVACY ACT NOTICE & CONSENT TO RELEASE INFORMATION

1. ELIGIBILITY STATUS	2. STATUS DATE	3. STATUS ENTERED BY
VERIFIED	OCT 6,1994	SALLEY,FLORENCE E
4. VERIFICATION METHOD	5. SERVICE VERIFICATION DATE	
DD214/HINQ	OCT 6,1994	

* WARNING: If you knowingly make a false statement of any material fact in or in connection with this application, you are subject to prosecution in a U.S. Court.

* Completion of this form with signature of the veteran is certification that the veteran has received a copy of the Privacy Act Statement.

* I UNDERSTAND THE QUESTIONS, AND ALL THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I AGREE TO ACCEPT TRANSFER TO ANOTHER FACILITY IF, IN THE OPINION OF THE MEDICAL STAFF, SUCH TRANSFER IS DEEMED APPROPRIATE.

The VA is not responsible for clothing/valuables/money taken to the ward with the patient.

SIGNATURE OF APPLICANT OR APPLICANT'S REPRESENTATIVE	DATE
X Gayle A. Dove	3/12/95

FOR VA USE ONLY	VA FACILITY NUMBER	ADMISSION DATE	AUTHORITY FOR ADMISSION OR TREATMENT
	520	3/12/95	OPTSC 1-4a 17.47.9.7

Reg Date/Time: MAR 12,1995@09:58 PRINTED: MAR 12, 1995@10:00:08 Clerk: CLH/116

Pelvis Adhesions
4B120-23

1030

AUTOMATED VA FORM 10-10 PAGE:

DEPARTMENT OF VETERANS AFFAIRS

FACILITY: Biloxi, MS (CONS) (520) — APPLICATION FOR MEDICAL BENEFITS

SEE ATTACHMENT FOR PAPERWORK REDUCTION INFORMATION AND PRIVACY ACT INFORMATION

PART I - PATIENT DATA

1. Type of benefit applied for: HOSPITAL/OUTPATIENT TREATMENT

2. Applicant's Name	3. Other names used (Alias)	4. Social Security Number
DOVE,GAYLE A	VOGLE,GAYLE A PARKER,GAYLE A	515-64-6094

5. Claim Number	6. LOCATION OF CLAIMS FOLDER	7. DATE OF BIRTH	8. PLACE OF BIRTH
C- [redacted]	[redacted]	[redacted]	[redacted]

9A. STREET ADDRESS: 5246 A STREET	10. TEMPORARY ADDRESS 10A. STREET ADDRESS: NOT APPLICABLE
9B. CITY: BILOXI / 9C. STATE: MISSISSIPPI	10B. CITY: / 10C. STATE:
9D. ZIP CODE: 39530 / 9E. COUNTY: HARRISON	10D. ZIP CODE: / 10E. COUNTY:
9F. HOME TELEPHONE NUMBER: 601-436-9642	10F. HOME TELEPHONE NUMBER:

11. PATIENT'S SEX	12. MOTHER'S MAIDEN NAME	13. MOTHER'S NAME	14. FATHER'S NAME
FEMALE	MOSSMAN	MARLYN	RAYMOND
15. RELIGIOUS PREFERENCE	16. DATE OF PREVIOUS CARE	17. LOCATION OF PREVIOUS CARE	18. SPINAL CORD INJURY
PROTESTANT, NO DENOMINATION	UNANSWERED	UNANSWERED	NOT APPLICABLE

PART II - EMERGENCY CONTACT DATA

1A. FIRST NEXT OF KIN	1B. RELATIONSHIP	1C. HOME TELEPHONE NUMBER	1D. WORK TELEPHONE NUMBER
RAY DOVE JR	FATHER	601-436-9642	NONE
1E. ADDRESS (Number, Street, City, State, ZIP Code) 5246 A STREET, BILOXI, MISSISSIPPI, 39530-			
2A. SECOND NEXT OF KIN	2B. RELATIONSHIP	2C. HOME TELEPHONE NUMBER	2D. WORK TELEPHONE NUMBER
UNANSWERED			
2E. ADDRESS (Number, Street, City, State, ZIP Code)			
3A. FIRST CONTACT IN AN EMERGENCY	3B. RELATIONSHIP	3C. HOME TELEPHONE NUMBER	3D. WORK TELEPHONE NUMBER
RAY DOVE JR	FATHER	601-436-9642	NONE
3E. ADDRESS (Number, Street, City, State, ZIP Code) 5246 A STREET, BILOXI, MISSISSIPPI, 39530-			
4A. SECOND CONTACT IN AN EMERGENCY	4B. RELATIONSHIP	4C. HOME TELEPHONE NUMBER	4D. WORK TELEPHONE NUMBER
UNANSWERED			
4E. ADDRESS (Number, Street, City, State, ZIP Code)			

I DESIGNATE THE FOLLOWING PERSON TO RECEIVE POSSESSION OF ALL PERSONAL PROPERTY LEFT ON THE PREMISES UNDER VA CONTROL AFTER I LEAVE SUCH PLACE OR AT TIME OF MY DEATH (This does not constitute a will or transfer of title.)

5A. DESIGNEE	5B. RELATIONSHIP	5C. HOME TELEPHONE NUMBER	5D. WORK TELEPHONE NUMBER
RAY DOVE JR	FATHER	601-436-9642	NONE
5E. ADDRESS (Number, Street, City, State, ZIP Code) 5246 A STREET, BILOXI, MISSISSIPPI, 39530-			

NOTE - The law (38 USC 8520 et seq.) provides that upon the death of any veteran receiving care or treatment by the Department of Veterans Affairs in any institution or of a dependent or survivor of a veteran admitted to a VA medical facility leaving no surviving spouse or next of kin or heir entitled to inherit, all personal property, including money or balances in bank, all claims and choses in action, owned by such person, and not disposed of by will or otherwise will become the property of the United States as trustee for the general Post Fund.

Reg Date/Time: MAR 12,1995@09:58 PRINTED: MAR 12, 1995@10:00:08 Clerk: CLH/116

PART III - APPLICANT/SPOUSE DATA

1. APPLICANT'S EMPLOYMENT STATUS: 3. NOT EMPLOYED

2. SPOUSE'S EMPLOYMENT STATUS: 1. EMPLOYED FULL TIME

3. APPLICANT INFORMATION	4. SPOUSE'S INFORMATION
3A. OCCUPATION: SALES	4A. OCCUPATION: U S AIR FORCE
3B. EMPLOYER (Name, Street Address, City, State, Zip) NOT APPLICABLE	4B. EMPLOYER (Name, Street Address, City, State, Zip) KEESLER AFB BILOXI, MS,
3C. WORK TELEPHONE NUMBER:	4C. WORK TELEPHONE NUMBER: UNANSWERED

PART IV - MILITARY SERVICE DATA

1A. LAST BRANCH OF SERVICE AIR FORCE	1B. LAST SERVICE NUMBER 515646094	1C. LAST DATE OF ENTRY SEP 4,1975	1D. LAST DISCHARGE DATE SEP 16,1987	1E. DISCHARGE TYPE HONORABLE
2A. PRIOR BRANCH OF SERVICE NOT APPLICABLE	2B. PRIOR SERVICE NUMBER	2C. PRIOR DATE OF ENTRY	2D. PRIOR DISCHARGE DATE	2E. DISCHARGE TYPE
3A. PRIOR BRANCH OF SERVICE NOT APPLICABLE	3B. PRIOR SERVICE NUMBER	3C. PRIOR DATE OF ENTRY	3D. PRIOR DISCHARGE DATE	3E. DISCHARGE TYPE

PART V - ELIGIBILITY STATUS DATA

1. PATIENT TYPE: NSC VETERAN

2. IS NEED FOR MEDICAL CARE RELATED TO AN ON THE JOB INJURY: NO	3. IS THE NEED FOR MEDICAL CARE RELATED TO AN ACCIDENT: NO	4. IS PATIENT ELIGIBLE FOR MEDICAID: NO
5A. DOES PATIENT HAVE HEALTH INSURANCE COVERAGE: NO	5B. IF YES, COVERAGE PROVIDED BY: NOT APPLICABLE	

6. DOES VETERAN HAVE GI INSURANCE: NO	7. PRIMARY ELIGIBILITY CODE NSC	8. OTHER ELIGIBILITY CODE UNANSWERED	9. PERIOD OF SERVICE POST-VIETNAM

10. SERVICE CONNECTED CONDITIONS: NOT APPLICABLE: NOT A SERVICE-CONNECTED APPLICANT

11. OTHER ELIGIBILITY DATA

A. VETERAN	YES	L. SERVICE IN PERSIAN GULF THEATER			NO
B. PRISONER OF WAR STATUS	NO	M. DENTAL INJ.	UNANSWERED	TEETH EXTRACTED	UNANSWERED
C. EXPOSURE TO AGENT ORANGE	NO	N. SERVICE CONNECTED			NO
D. EXPOSURE TO RADIATION	NO	O. RECEIVING AID & ATTENDANCE			NO
E. COMBAT SERVICE	NO	P. RECEIVING HOUSEBOUND			NO
F. MILITARY DISABILITY	NO	Q. RECEIVING VA PENSION			NO
G. VIETNAM SERVICE	NO	R. RECEIVING VA DISABILITY			NO
H. LEBANON SERVICE	NO	S. SERVICE IN SOMALIA			NO
I. GRENADA SERVICE	NO				
J. PANAMA SERVICE	NO				
K. PERSIAN GULF SERVICE	NO	T. VA MONETARY AMOUNT:	NOT APPLICABLE		

Reg Date/Time: MAR 12,1995@09:58 PRINTED: MAR 12, 1995@10:00:08 Clerk: CLH/116

PART VI - INCOME SCREENING DATA OR ANNUAL INCOME

1A. CURRENT MARITAL STATUS: MARRIED	1B. DATE OF MARRIAGE: APR 15,1990

2A. WAS PATIENT MARRIED OR SEPARATED AT THE END OF LAST CALENDAR YEAR?: YES

2B. NAME OF SPOUSE	2C. SEX OF SPOUSE	2D. SPOUSE'S [redacted]	2E. SPOUSE'S DATE OF BIRTH
PARKE,RICHARD A	[redacted]	[redacted]	[redacted]

3. DEPENDENTS

A. NAME	B. SOCIAL SECURITY NO	C. SEX	D. DATE OF BIRTH	E. RELATIONSHIP	F. DEPENDENT AS OF (DATE)
NONE INDICATED					

4. PREVIOUS CALENDAR YEAR (1994) INCOME INFORMATION

	CHECK ALL APPLICABLE BOXES	AMOUNT VETERAN	SPOUSE	DEPENDENTS	TOTAL
	1. SOCIAL SECURITY (NOT SSI)	-	-	-	-
	2. U.S. CIVIL SERVICE	-	-	-	-
	3. U.S. RAILROAD RETIREMENT	-	-	-	-
	4. MILITARY RETIREMENT	-	-	-	-
	5. UNEMPLOYMENT COMPENSATION	-	-	-	-
	6. OTHER RETIREMENT	-	-	-	-
X	7. TOTAL INCOME FROM EMPLOYMENT	$2000.00	$2000.00	-	$4000.00
	8. INTEREST, DIVIDEND, OR ANNUITY INCOME	-	-	-	-
	9. WORKERS COMPENSATION/BLACK LUNG BENEFITS	-	-	-	-
	10. ALL OTHER INCOME	-	-	-	-
	11. TOTAL INCOME				$4000.00

PART VII - INELIGIBLE/MISSING DATA

1. INELIGIBLE DATE	2. TWX SOURCE	3. TWX CITY	4. TWX STATE

5. REASON:

6. VACO DECISION:

7. MISSING DATE	8. TWX SOURCE	9. TWX CITY	10. TWX STATE

11. REASON:

Reg Date/Time: MAR 12,1995@09:58 PRINTED: MAR 12, 1995@10:00:08 Clerk: CLH/116

Biloxi, MS (CONS) (520) SUPPLEMENTAL DATA SHEET

1. Applicant's Name: DOVE,GAYLE A | 2. SSN: [redacted]

3. Other Name(s): VOGLE,GAYLE A; PARKER,GAYLE A;

4. Remarks: NO REMARKS CURRENTLY ENTERED FOR THIS APPLICANT

5. Fathers Name: RAYMOND
Mothers Name: MARLYN
Mothers Maiden Name: MOSSMAN

6a. Enrollment Clinic(s): URGENT CARE FOLLOWUP-HILL, PSYCHOMETRICS, SATP INPATIENT, WOMEN'S CLINIC, WOMEN'S GROUP,

6b. Future Appointments: WOMEN'S CLINIC (MAR 14,1995@15:00), GYNECOLOGY CLINIC (MAR 20,1995@10:15), SATP RIVERS (MAR 31,1995@13:00), DERMATOLOGY (APR 7,1995@11:10),

7a. Last Admission: OCT 4,1994@10:08:26 (DISCHARGED 'NOV 1,1994@10:16:13')

7b. Discharge Diagnosis(es): (303.91)-ALCOH DEP NEC/NOS-CONTIN; (696.3)-PITYRIASIS ROSEA; (568.0)-PERITONEAL ADHESIONS; (V45.89)-POSTSURGICAL STATES NEC; (727.43)-GANGLION NOS;

7c. Admit Diagnosis: UNSPECIFIED

7d. Diagnosis Responsible for Greatest Length of Stay: (303.91)-ALCOH DEP NEC/NOS-CONTIN

8. Eligibility Status: VERIFIED
Verification Method: DD214/HINQ
Ineligible Date: ELIGIBLE APPLICANT -- NOT APPLICABLE
TWX City: NOT APPLICABLE
VARO Decision: NOT APPLICABLE

Status Date: OCT 6,1994
By: SALLEY,FLORENCE E
TWX Source: NOT APPLICABLE
TWX State: NOT APPLICABLE

9. Vietnam Service: NO From: NOT APPLICABLE To : NOT APPLICABLE
Agent Orange: NO Reg : NOT APPLICABLE Exam : NOT APPLICABLE Reg #: NOT APPLICABLE
ION Radiation: NO Reg : NOT APPLICABLE Method: NOT APPLICABLE
Prisoner of War: NO From: NOT APPLICABLE To : NOT APPLICABLE Where: NOT APPLICABLE
Combat: NO From: NOT APPLICABLE To : NOT APPLICABLE Where: NOT APPLICABLE

10. Next of Kin, Address and Zip Code:
Name: RAY DOVE JR
5246 A STREET
BILOXI, MISSISSIPPI 39530

Relationship: FATHER
Phone: 601-436-9642

reg: MAR 12,1995@09:58 clerk: CLH/116

DOVE,GAYLE A 515-64-6094

THIS PAGE MAY BE REPLACED BY PAGE #4 OF VA FORM 10-10 WHICH CONTAINS PRIVACY ACT NOTICE & CONSENT TO RELEASE INFORMATION

1. ELIGIBILITY STATUS	2. STATUS DATE	3. STATUS ENTERED BY
VERIFIED	OCT 6,1994	SALLEY,FLORENCE E
4. VERIFICATION METHOD	5. SERVICE VERIFICATION DATE	
DD214/HINQ	OCT 6,1994	

* WARNING: If you knowingly make a false statement of any material fact in or in connection with this application, you are subject to prosecution in a U.S. Court.

* Completion of this form with signature of the veteran is certification that the veteran has received a copy of the Privacy Act Statement.

* I UNDERSTAND THE QUESTIONS, AND ALL THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I AGREE TO ACCEPT TRANSFER TO ANOTHER FACILITY IF, IN THE OPINION OF THE MEDICAL STAFF, SUCH TRANSFER IS DEEMED APPROPRIATE.

The VA is not responsible for clothing/valuables/money taken to the ward with the patient.

SIGNATURE OF APPLICANT OR APPLICANT'S REPRESENTATIVE	DATE
Gayle A. Dove	

FOR VA USE ONLY	VA FACILITY NUMBER	ADMISSION DATE	AUTHORITY FOR ADMISSION OR TREATMENT
	520		

Reg Date/Time: JAN 16,1995@22:20 PRINTED: JAN 16, 1995@22:20:54 Clerk: CLH/116

DEPARTMENT OF VETERANS AFFAIRS

FACILITY: Biloxi, MS (CONS) (520) — APPLICATION FOR MEDICAL BENEFITS

SEE ATTACHMENT FOR PAPERWORK REDUCTION INFORMATION AND PRIVACY ACT INFORMATION

PART I - PATIENT DATA

1. Type of benefit applied for: HOSPITAL/OUTPATIENT TREATMENT

2. Applicant's Name	3. Other names used (Alias)	4. Social Security Number
DOVE,GAYLE A	VOGLE,GAYLE A PARKER,GAYLE A	[redacted]

5. Claim Number	6. LOCATION OF CLAIMS FOLDER	7. DATE OF BIRTH	8. PLACE OF BIRTH
[redacted]	317ST PETERSBURG RO	AUG 15,1957	WITCHIA FALLS, TEXAS

9. PERMANENT ADDRESS			10. TEMPORARY ADDRESS	
9A. STREET ADDRESS: 5246 A STREET			10A. STREET ADDRESS: NOT APPLICABLE	
9B. CITY: BILOXI	9C. STATE: MISSISSIPPI		10B. CITY:	10C. STATE:
9D. ZIP CODE: 39530	9E. COUNTY: HARRISON		10D. ZIP CODE:	10E. COUNTY:
9F. HOME TELEPHONE NUMBER: 601-436-9642			10F. HOME TELEPHONE NUMBER:	
11. PATIENT'S SEX: FEMALE	12. MOTHER'S MAIDEN NAME: MOSSMAN		13. MOTHER'S NAME: MARLYN	14. FATHER'S NAME: RAYMOND
15. RELIGIOUS PREFERENCE: PROTESTANT, NO DENOMINATION	16. DATE OF PREVIOUS CARE: UNANSWERED		17. LOCATION OF PREVIOUS CARE: UNANSWERED	18. SPINAL CORD INJURY: NOT APPLICABLE

PART II - EMERGENCY CONTACT DATA

1A. FIRST NEXT OF KIN	1B. RELATIONSHIP	1C. HOME TELEPHONE NUMBER	1D. WORK TELEPHONE NUMBER
RAY DOVE JR	FATHER	601-436-9642	NONE
1E. ADDRESS (Number, Street, City, State, ZIP Code): 5246 A STREET, BILOXI, MISSISSIPPI, 39530			
2A. SECOND NEXT OF KIN: UNANSWERED	2B. RELATIONSHIP	2C. HOME TELEPHONE NUMBER	2D. WORK TELEPHONE NUMBER
2E. ADDRESS (Number, Street, City, State, ZIP Code)			
3A. FIRST CONTACT IN AN EMERGENCY: RAY DOVE JR	3B. RELATIONSHIP: FATHER	3C. HOME TELEPHONE NUMBER: 601-436-9642	3D. WORK TELEPHONE NUMBER: NONE
3E. ADDRESS (Number, Street, City, State, ZIP Code): 5246 A STREET, BILOXI, MISSISSIPPI, 39530			
4A. SECOND CONTACT IN AN EMERGENCY: UNANSWERED	4B. RELATIONSHIP	4C. HOME TELEPHONE NUMBER	4D. WORK TELEPHONE NUMBER
4E. ADDRESS (Number, Street, City, State, ZIP Code)			

I DESIGNATE THE FOLLOWING PERSON TO RECEIVE POSSESSION OF ALL PERSONAL PROPERTY LEFT ON THE PREMISES UNDER VA CONTROL AFTER I LEAVE SUCH PLACE OR AT TIME OF MY DEATH (This does not constitute a will or transfer of title.)

5A. DESIGNEE	5B. RELATIONSHIP	5C. HOME TELEPHONE NUMBER	5D. WORK TELEPHONE NUMBER
RAY DOVE JR	FATHER	601-436-9642	NONE
5E. ADDRESS (Number, Street, City, State, ZIP Code): 5246 A STREET, BILOXI, MISSISSIPPI, 39530			

NOTE - The law (38 USC 8520 et seq.) provides that upon the death of any veteran receiving care or treatment by the Department of Veterans Affairs in any institution or of a dependent or survivor of a veteran admitted to a VA medical facility leaving no surviving spouse or next of kin or heir entitled to inherit, all personal property, including money or balances in bank, all claims and choses in action, owned by such person, and not disposed of by will or otherwise will become the property of the United States as trustee for the general Post Fund.

Reg Date/Time: JAN 16,1995@22:20 — PRINTED: JAN 16, 1995@22:20:54 — Clerk: CLH/116

DOVE, GAYLE A 515-64-6094

PART III - APPLICANT/SPOUSE DATA

1. APPLICANT'S EMPLOYMENT STATUS: 3. NOT EMPLOYED

2. SPOUSE'S EMPLOYMENT STATUS: 1. EMPLOYED FULL TIME

3. APPLICANT INFORMATION	4. SPOUSE'S INFORMATION
3A. OCCUPATION: SALES	4A. OCCUPATION: U.S AIR FORCE
3B. EMPLOYER (Name, Street Address, City, State, Zip) NOT APPLICABLE	4B. EMPLOYER (Name, Street Address, City, State, Zip) KEESLER AFB BILOXI, MS,
3C. WORK TELEPHONE NUMBER:	4C. WORK TELEPHONE NUMBER: UNANSWERED

PART IV - MILITARY SERVICE DATA

1A. LAST BRANCH OF SERVICE AIR FORCE	1B. LAST SERVICE NUMBER 515646094	1C. LAST DATE OF ENTRY SEP 4,1975	1D. LAST DISCHARGE DATE SEP 16,1987	1E. DISCHARGE TYPE HONORABLE
2A. PRIOR BRANCH OF SERVICE NOT APPLICABLE	2B. PRIOR SERVICE NUMBER	2C. PRIOR DATE OF ENTRY	2D. PRIOR DISCHARGE DATE	2E. DISCHARGE TYPE
3A. PRIOR BRANCH OF SERVICE NOT APPLICABLE	3B. PRIOR SERVICE NUMBER	3C. PRIOR DATE OF ENTRY	3D. PRIOR DISCHARGE DATE	3E. DISCHARGE TYPE

PART V - ELIGIBILITY STATUS DATA

1. PATIENT TYPE: NSC VETERAN

2. IS NEED FOR MEDICAL CARE RELATED TO AN ON THE JOB INJURY: NO	3. IS THE NEED FOR MEDICAL CARE RELATED TO AN ACCIDENT: NO	4. IS PATIENT ELIGIBLE FOR MEDICAID: NO	
5A. DOES PATIENT HAVE HEALTH INSURANCE COVERAGE: NO	5B. IF YES, COVERAGE PROVIDED BY: NOT APPLICABLE		
6. DOES VETERAN HAVE GI INSURANCE: NO	7. PRIMARY ELIGIBILITY CODE NSC	8. OTHER ELIGIBILITY CODE UNANSWERED	9. PERIOD OF SERVICE POST-VIETNAM

10. SERVICE CONNECTED CONDITIONS: NOT APPLICABLE; NOT A SERVICE-CONNECTED APPLICANT

11. OTHER ELIGIBILITY DATA

A. VETERAN	YES	L. SERVICE IN PERSIAN GULF THEATER	NO
B. PRISONER OF WAR STATUS	NO	M. DENTAL INJ. UNANSWERED	TEETH EXTRACTED UNANSWERED
C. EXPOSURE TO AGENT ORANGE	NO	N. SERVICE CONNECTED	NO
D. EXPOSURE TO RADIATION	NO	O. RECEIVING AID & ATTENDANCE	NO
E. COMBAT SERVICE	NO	P. RECEIVING HOUSEBOUND	NO
F. MILITARY DISABILITY	NO	Q. RECEIVING VA PENSION	NO
G. VIETNAM SERVICE	NO	R. RECEIVING VA DISABILITY	NO
H. LEBANON SERVICE	NO	S. SERVICE IN SOMALIA	NO
I. GRENADA SERVICE	NO		
J. PANAMA SERVICE	NO		
K. PERSIAN GULF SERVICE	NO	T. VA MONETARY AMOUNT:	NOT APPLICABLE

Reg Date/Time: JAN 16,1995@22:20 PRINTED: JAN 16, 1995@22:20:54 Clerk: CLH/116

DOVE,GAYLE A 515-64-6094

PART VI - INCOME SCREENING DATA OR ANNUAL INCOME

1A. CURRENT MARITAL STATUS: MARRIED 1B. DATE OF MARRIAGE: APR 15,1990

2A. WAS PATIENT MARRIED OR SEPARATED AT THE END OF LAST CALENDAR YEAR?: YES

2B. NAME OF SPOUSE	2C. SEX OF SPOUSE	2D. SPOUSE'S SOCIAL SECURITY NO	2E. SPOUSE'S DATE OF BIRTH
PARKE,RICHARD A	MALE	[redacted]	[redacted]

3. DEPENDENTS

A. NAME	B. SOCIAL SECURITY NO	C. SEX	D. DATE OF BIRTH	E. RELATIONSHIP	F. DEPENDENT AS OF (DATE)
NONE INDICATED					

4. PREVIOUS CALENDAR YEAR (1994) INCOME INFORMATION

CHECK ALL APPLICABLE BOXES		AMOUNT VETERAN	SPOUSE	DEPENDENTS	TOTAL
	1. SOCIAL SECURITY (NOT SSI)	-	-	-	-
	2. U.S. CIVIL SERVICE	-	-	-	-
	3. U.S. RAILROAD RETIREMENT	-	-	-	-
	4. MILITARY RETIREMENT	-	-	-	-
	5. UNEMPLOYMENT COMPENSATION	-	-	-	-
	6. OTHER RETIREMENT	-	-	-	-
X	7. TOTAL INCOME FROM EMPLOYMENT	$2000.00	$2000.00	-	$4000.00
	8. INTEREST, DIVIDEND, OR ANNUITY INCOME	-	-	-	-
	9. WORKERS COMPENSATION/BLACK LUNG BENEFITS	-	-	-	-
	10. ALL OTHER INCOME	-	-	-	-
	11. TOTAL INCOME				$4000.00

PART VII - INELIGIBLE/MISSING DATA

1. INELIGIBLE DATE	2. TWX SOURCE	3. TWX CITY	4. TWX STATE
5. REASON:			
6. VACO DECISION:			
7. MISSING DATE	8. TWX SOURCE	9. TWX CITY	10. TWX STATE
11. REASON:			

Reg Date/Time: JAN 16,1995a22:20 PRINTED: JAN 16, 1995a22:20:54 Clerk: CLH/116

Biloxi, MS (CONS) (520)

1. Applicant's Name: DOVE,GAYLE A

2. [redacted]

3. Other Name(s): VOGLE,GAYLE A; PARKER,GAYLE A;

4. Remarks: NO REMARKS CURRENTLY ENTERED FOR THIS APPLICANT

5. Fathers Name: RAYMOND
Mothers Name: MARLYN
Mothers Maiden Name: MOSSMAN

6a. Enrollment Clinic(s): URGENT CARE FOLLOWUP HILL, PSYCHOMETRICS, SATP INPATIENT, WOMEN'S CLINIC, WOMEN'S GROUP,

6b. Future Appointments: GYNECOLOGY CLINIC (FEB 6,1995@10:15), SATP DYKE GROUP (FEB 8,1995@10:00), GYNECOLOGY CLINIC (MAR 20,1995@10:15), DERMATOLOGY (APR 7,1995@11:10),

7a. Last Admission: OCT 4,1994@10:08:26 (DISCHARGED 'NOV 1,1994@10:16:13')

7b. Discharge Diagnosis(es): (303.91)-ALCOH DEP NEC/NOS-CONTIN; (696.3)-PITYRIASIS ROSEA; (568.0)-PERITONEAL ADHESIONS; (V45.89)-POSTSURGICAL STATES NEC; (727.43)-GANGLION NOS;

7c. Admit Diagnosis: UNSPECIFIED

7d. Diagnosis Responsible for Greatest Length of Stay: (303.91)-ALCOH DEP NEC/NOS-CONTIN

8. Eligibility Status: VERIFIED
Verification Method: DD214/HINQ
Ineligible Date: ELIGIBLE APPLICANT -- NOT APPLICABLE
TMX City: NOT APPLICABLE
VARO Decision: NOT APPLICABLE
Status Date: OCT 6,1994
By: SALLEY,FLORENCE E
TMX Source: NOT APPLICABLE
TMX State: NOT APPLICABLE

9. Vietnam Service: NO From: NOT APPLICABLE To : NOT APPLICABLE
Agent Orange: NO Reg : NOT APPLICABLE Exam : NOT APPLICABLE Reg #: NOT APPLICABLE
ION Radiation: NO Reg : NOT APPLICABLE Method: NOT APPLICABLE
Prisoner of War: NO From: NOT APPLICABLE To : NOT APPLICABLE Where: NOT APPLICABLE
Combat: NO From: NOT APPLICABLE To : NOT APPLICABLE Where: NOT APPLICABLE

10. Next of Kin, Address and Zip Code:
Name: RAY DOVE JR
5246 A STREET
BILOXI, MISSISSIPPI 39530
Relationship: FATHER
Phone: 601-436-9642

reg: JAN 16,1995@22:20 clerk: CLH/116

MailMan message for SALLEY,FLORENCE R CLERK,MEDICAL
Printed at BILOXI.VA.GOV 06 Oct 94 10:46
Subj: HINQ response for DOVE,GAYLE A /requested by MCCOY,JERELYN D. [#2921006] 05 Oct 94 15:55 32 Lines
From: POSTMASTER (Sender: PLUTINO,JAMES) in 'IN' basket. Page 1

Dove #6094

DOVE,GAYLE A AUG 15,1957 SSN:515646094 C-#:515646094 S-#:515646094 Div:GULFPORT
BIRLS Response only - No C&P Record Found

VBA name = VOGEL, GAYLE ANN Verified Svc-Data
Prior names =
DOVE
Sex = FEMALE
Date of Birth = AUG 15, 1957
[redacted]
Folder Location = 317 - ST.PETERSBURG-RO
Total Active Svc = 12 yr 14 days
INDICATORS(Active Duty Training NO Disability NO Homeless Veteran NO)

Service data	C&P	BIRLS
Branch of Service =		AF AF
EOD =		SEP 4,1975 DEC 2,1985
RAD =		SEP 16,1987
Char of Service =		UNK HON

DISABILITIES(Combined % = 0 SC/Total = 0/0 Additional = 0)

Diagnostic Verified Indicator is NO.
Verify Service Connections at 317 - ST.PETERSBURG-RO

ELIGIBILITY DOCUMENT
10-6-94

DOVE,GAYLE A 515-64-6094

THIS PAGE MAY BE REPLACED BY PAGE #4 OF VA FORM 10-10 WHICH CONTAINS PRIVACY ACT NOTICE & CONSENT TO RELEASE INFORMATION

1. ELIGIBILITY STATUS VERIFIED	2. STATUS DATE SEP 21,1994	3. STATUS ENTERED BY CLAYTON,PERCY L
4. VERIFICATION METHOD DD214/HINQ	5. SERVICE VERIFICATION DATE SEP 21,1994	

* WARNING: If you knowingly make a false statement of any material fact in or in connection with this application, you are subject to prosecution in a U.S. Court.

* Completion of this form with signature of the veteran is certification that the veteran has received a copy of the Privacy Act Statement.

* I UNDERSTAND THE QUESTIONS, AND ALL THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I AGREE TO ACCEPT TRANSFER TO ANOTHER FACILITY IF, IN THE OPINION OF THE MEDICAL STAFF, SUCH TRANSFER IS DEEMED APPROPRIATE.

The VA is not responsible for clothing/valuables/money taken to the ward with the patient.

SIGNATURE OF APPLICANT OR APPLICANT'S REPRESENTATIVE	DATE
Gayle A. Dove	10-4-94

FOR VA USE ONLY	VA FACILITY NUMBER	ADMISSION DATE	AUTHORITY FOR ADMISSION OR TREATMENT
	520	10-4-94	4G-STAFF OPIN 17.47(a)(7)

Reg Date/Time: OCT 4,1994@09:16 PRINTED: OCT 04, 1994@09:17:07 Clerk: JDM/17

ETOH
Dr. Ehik

DOVE,GAYLE A 515-64-6094

PART VI - INCOME SCREENING DATA OR ANNUAL INCOME

1A. CURRENT MARITAL STATUS: MARRIED | 1B. DATE OF MARRIAGE: APR 15,1990

2A. WAS PATIENT MARRIED OR SEPARATED AT THE END OF LAST CALENDAR YEAR?: YES

2B. NAME OF SPOUSE	2C. SEX OF SPOUSE	2D. [redacted]	2E. SPOUSE'S DATE OF BIRTH
VOGLE,RAY	MALE	[redacted]	[redacted]

A. NAME	B. SOCIAL SECURITY NO	C. SEX	D. DATE OF BIRTH	E. RELATIONSHIP	F. DEPENDENT OF (DATE)
NONE INDICATED					

4. PREVIOUS CALENDAR YEAR (1993) INCOME INFORMATION

	CHECK ALL APPLICABLE BOXES	AMOUNT VETERAN	SPOUSE	DEPENDENTS	TOTAL
	1. SOCIAL SECURITY (NOT SSI)	-	-	-	-
	2. U.S. CIVIL SERVICE	-	-	-	-
	3. U.S. RAILROAD RETIREMENT	-	-	-	-
	4. MILITARY RETIREMENT	-	-	-	-
	5. UNEMPLOYMENT COMPENSATION	-	-	-	-
	6. OTHER RETIREMENT	-	-	-	-
X	7. TOTAL INCOME FROM EMPLOYMENT	$0.00	$16000.00	-	$16000.00
	8. INTEREST, DIVIDEND, OR ANNUITY INCOME	-	-	-	-
	9. WORKERS COMPENSATION/BLACK LUNG BENEFITS	-	-	-	-
	10. ALL OTHER INCOME	-	-	-	-
	11. TOTAL INCOME				$16000.00

PART VII - INELIGIBLE/MISSING DATA

1. INELIGIBLE DATE	2. TWX SOURCE	3. TWX CITY	4. TWX STATE
5. REASON:			
6. VACO DECISION:			
7. MISSING DATE	8. TWX SOURCE	9. TWX CITY	10. TWX STATE
11. REASON:			

Reg Date/Time: OCT 4,1994@09:16 PRINTED: OCT 04, 1994@09:17:07 Clerk: JDM/1

DOVE,GAYLE A 515-64-6074

PART III - APPLICANT/SPOUSE DATA

1. APPLICANT'S EMPLOYMENT STATUS: 3. NOT EMPLOYED

2. SPOUSE'S EMPLOYMENT STATUS: 1. EMPLOYED FULL TIME

3. APPLICANT INFORMATION	4. SPOUSE'S INFORMATION
3A. OCCUPATION: SALES	4A. OCCUPATION: U S AIR FORCE
3B. EMPLOYER (Name, Street Address, City, State, Zip) NOT APPLICABLE	4B. EMPLOYER (Name, Street Address, City, State, Zip) KEESLER AFB BILOXI, MS,
3C. WORK TELEPHONE NUMBER:	4C. WORK TELEPHONE NUMBER: UNANSWERED

PART IV - MILITARY SERVICE DATA

1A. LAST BRANCH OF SERVICE AIR FORCE	1B. LAST SERVICE NUMBER 515646094	1C. LAST DATE OF ENTRY SEP 4,1975	1D. LAST DISCHARGE DATE SEP 16,1987	1E. DISCHARGE TYPE HONORABLE
2A. PRIOR BRANCH OF SERVICE NOT APPLICABLE	2B. PRIOR SERVICE NUMBER	2C. PRIOR DATE OF ENTRY	2D. PRIOR DISCHARGE DATE	2E. DISCHARGE TYPE
3A. PRIOR BRANCH OF SERVICE NOT APPLICABLE	3B. PRIOR SERVICE NUMBER	3C. PRIOR DATE OF ENTRY	3D. PRIOR DISCHARGE DATE	3E. DISCHARGE TYPE

PART V - ELIGIBILITY STATUS DATA

1. PATIENT TYPE: NSC VETERAN

2. IS NEED FOR MEDICAL CARE RELATED TO AN ON THE JOB INJURY: NO	3. IS THE NEED FOR MEDICAL CARE RELATED TO AN ACCIDENT: NO	4. IS PATIENT ELIGIBLE FOR MEDICAID: NO
5A. DOES PATIENT HAVE HEALTH INSURANCE COVERAGE: NO	5B. IF YES, COVERAGE PROVIDED BY: NOT APPLICABLE	
6. DOES VETERAN HAVE GI INSURANCE: NO	7. PRIMARY ELIGIBILITY CODE NSC	8. OTHER ELIGIBILITY CODE UNANSWERED	9. PERIOD OF SERVICE POST-VIETNAM

10. SERVICE CONNECTED CONDITIONS: NOT APPLICABLE; NOT A SERVICE-CONNECTED APPLICANT

11. OTHER ELIGIBILITY DATA

A. VETERAN	YES	L. SERVICE IN PERSIAN GULF THEATER			NO
B. PRISONER OF WAR STATUS	NO	M. DENTAL INJ.	UNANSWERED	TEETH EXTRACTED	UNANSWERED
C. EXPOSURE TO AGENT ORANGE	NO	N. SERVICE CONNECTED			NO
D. EXPOSURE TO RADIATION	NO	O. RECEIVING AID & ATTENDANCE			NO
E. COMBAT SERVICE	NO	P. RECEIVING HOUSEBOUND			NO
F. MILITARY DISABILITY	NO	Q. RECEIVING VA PENSION			NO
G. VIETNAM SERVICE	NO	R. RECEIVING VA DISABILITY			NO
H. LEBANON SERVICE	NO	S. SERVICE IN SOMALIA			NO
I. GRENADA SERVICE	NO				
J. PANAMA SERVICE	NO				
K. PERSIAN GULF SERVICE	NO	T. VA MONETARY AMOUNT:		NOT APPLICABLE	

Reg Date/Time: OCT 4,1994@09:16 PRINTED: OCT 04, 1994@09:17:07 Clerk: JDM/1

DEPARTMENT OF VETERANS AFFAIRS

FACILITY: Biloxi, MS (CONS) (520) — APPLICATION FOR MEDICAL BENEFITS

SEE ATTACHMENT FOR PAPERWORK REDUCTION INFORMATION AND PRIVACY ACT INFORMATION

PART I - PATIENT DATA

1. Type of benefit applied for: HOSPITAL/OUTPATIENT TREATMENT

2. Applicant's Name	3. Other names used (Alias)	4. Social Security Number
DOVE,GAYLE A	VOGLE,GAYLE A PARKER,GAYLE A	[redacted]

5. Claim Number	6. LOCATION OF CLAIMS FOLDER	7. DATE OF BIRTH	8. PLACE OF BIRTH
[redacted]	3175T,PETERSBURG-RO	[redacted]	WITCHIA FALLS, TEXAS

9. PERMANENT ADDRESS			10. TEMPORARY ADDRESS		
9A. STREET ADDRESS: 5246 A STREET			10A. STREET ADDRESS: NOT APPLICABLE		
9B. CITY: BILOXI	9C. STATE: MISSISSIPPI		10B. CITY:	10C. STATE:	
9D. ZIP CODE: 39530	9E. COUNTY: HARRISON		10D. ZIP CODE:	10E. COUNTY:	
9F. HOME TELEPHONE NUMBER: 601-436-9642			10F. HOME TELEPHONE NUMBER:		
11. PATIENT'S SEX FEMALE	12. MOTHER'S MAIDEN NAME MOSSMAN	13. MOTHER'S NAME MARLYN		14. FATHER'S NAME RAYMOND	
15. RELIGIOUS PREFERENCE PROTESTANT, NO DENOMINATION	16. DATE OF PREVIOUS CARE UNANSWERED	17. LOCATION OF PREVIOUS CARE UNANSWERED		18. SPINAL CORD INJURY NOT APPLICABLE	

PART II - EMERGENCY CONTACT DATA

1A. FIRST NEXT OF KIN RAY DOVE JR	1B. RELATIONSHIP FATHER	1C. HOME TELEPHONE NUMBER 601-436-9642	1D. WORK TELEPHONE NUMBER NONE
1E. ADDRESS (Number, Street, City, State, ZIP Code) 5246 A STREET, BILOXI, MISSISSIPPI, 39530-			
2A. SECOND NEXT OF KIN UNANSWERED	2B. RELATIONSHIP	2C. HOME TELEPHONE NUMBER	2D. WORK TELEPHONE NUMBER
2E. ADDRESS (Number, Street, City, State, ZIP Code)			
3A. FIRST CONTACT IN AN EMERGENCY RAY DOVE JR	3B. RELATIONSHIP FATHER	3C. HOME TELEPHONE NUMBER 601-436-9642	3D. WORK TELEPHONE NUMBER NONE
3E. ADDRESS (Number, Street, City, State, ZIP Code) 5246 A STREET, BILOXI, MISSISSIPPI, 39530-			
4A. SECOND CONTACT IN AN EMERGENCY UNANSWERED	4B. RELATIONSHIP	4C. HOME TELEPHONE NUMBER	4D. WORK TELEPHONE NUMBER
4E. ADDRESS (Number, Street, City, State, ZIP Code)			

I DESIGNATE THE FOLLOWING PERSON TO RECEIVE POSSESSION OF ALL PERSONAL PROPERTY LEFT ON THE PREMISES UNDER VA CONTROL AFTER I LEAVE SUCH PLACE OR AT TIME OF MY DEATH (This does not constitute a will or transfer of title.)

5A. DESIGNEE RAY DOVE JR	5B. RELATIONSHIP FATHER	5C. HOME TELEPHONE NUMBER 601-436-9642	5D. WORK TELEPHONE NUMBER NONE
5E. ADDRESS (Number, Street, City, State, ZIP Code) 5246 A STREET, BILOXI, MISSISSIPPI, 39530-			

NOTE - The law (38 USC 8520 et seq.) provides that upon the death of any veteran receiving care or treatment by the Department of Veterans Affairs in any institution or of a dependent or survivor of a veteran admitted to a VA medical facility leaving no surviving spouse or next of kin or heir entitled to inherit, all personal property, including money or balances in bank, all claims and choses in action, owned by such person, and not disposed of by will or otherwise will become the property of the United States as trustee for the general Post Fund.

Reg Date/Time: OCT 4,1994@09:16 — PRINTED: OCT 04, 1994@09:17:07 — Clerk: JDH/1

Biloxi, MS (CONS) (520) SUPPLEMENTAL DATA SHEET

1. Applicant's Name: DOVE,GAYLE A; 2. [redacted]

3. Other Name(s): VOGLE,GAYLE A; PARKER,GAYLE A;

4. Remarks: NO REMARKS CURRENTLY ENTERED FOR THIS APPLICANT

5. Fathers Name: RAYMOND
Mothers Name: MARLYN
Mothers Maiden Name: MOSSMAN

6a. Enrollment Clinic(s): URGENT CARE FOLLOWUP-HILL,

6b. Future Appointments: MHC DR BAIN (OCT 7,1994@10:00), GYNECOLOGY CLINIC (FEB 6,1995@10:15), GYNECOLOGY CLINIC (MAR 20,1995@10:15),

7a. Last Admission: NO PREVIOUS ADMISSIONS TO THIS FACILITY ON FILE

8. Eligibility Status: VERIFIED — Status Date: SEP 21,1994
Verification Method: DD214/NIND — By: CLAYTON,PERCY L
Ineligible Date: ELIGIBLE APPLICANT — NOT APPLICABLE — TWX Source: NOT APPLICABLE
TWX City: NOT APPLICABLE — TWX State: NOT APPLICABLE
VARO Decision: NOT APPLICABLE

9. Vietnam Service: NO — From: NOT APPLICABLE — To: NOT APPLICABLE
Agent Orange: NO — Reg: NOT APPLICABLE — Exam: NOT APPLICABLE — Reg #: NOT APPLICABLE
ION Radiation: NO — Reg: NOT APPLICABLE — Method: NOT APPLICABLE
Prisoner of War: NO — From: NOT APPLICABLE — To: NOT APPLICABLE — Where: NOT APPLICABLE
Combat: NO — From: NOT APPLICABLE — To: NOT APPLICABLE — Where: NOT APPLICABLE

10. Next of Kin, Address and Zip Code: — Relationship: FATHER
Name: RAY DOVE JR
5246 A STREET — Phone: 601-436-9642
BILOXI, MISSISSIPPI 39530

reg: OCT 4,1994@09:16 clerk: JDM/1734

DOVE,GAYLE A 515-64-6094

THIS PAGE MAY BE REPLACED BY PAGE #4 OF VA FORM 10-10 WHICH CONTAINS PRIVACY ACT NOTICE & CONSENT TO RELEASE INFORMATION

1. ELIGIBILITY STATUS	2. STATUS DATE	3. STATUS ENTERED BY
VERIFIED	SEP 21,1994	CLAYTON,PERCY L
4. VERIFICATION METHOD	5. SERVICE VERIFICATION DATE	
DD214/MING	SEP 21,1994	

* WARNING: If you knowingly make a false statement of any material fact in or in connection with this application, you are subject to prosecution in a U.S. Court.

* Completion of this form with signature of the veteran is certification that the veteran has received a copy of the Privacy Act Statement.

* I UNDERSTAND THE QUESTIONS, AND ALL THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I AGREE TO ACCEPT TRANSFER TO ANOTHER FACILITY IF, IN THE OPINION OF THE MEDICAL STAFF, SUCH TRANSFER IS DEEMED APPROPRIATE.

The VA is not responsible for clothing/valuables/money taken to the ward with the patient.

SIGNATURE OF APPLICANT OR APPLICANT'S REPRESENTATIVE	DATE
X Gayle A. Dove	21 Sep 94

FOR VA USE ONLY	VA FACILITY NUMBER	ADMISSION DATE	AUTHORITY FOR ADMISSION OR TREATMENT
	520		

Reg Date/Time: SEP 21,1994@08:53 PRINTED: SEP 21, 1994@09:03:49 Clerk: PLC/1761

AUTOMATED VA FORM 10-10 PAGE: 1

DOVE,GAYLE A 515-64-6094

PART VI - INCOME SCREENING DATA OR ANNUAL INCOME

1A. CURRENT MARITAL STATUS: MARRIED | 1B. DATE OF MARRIAGE: APR 15,1990

2A. WAS PATIENT MARRIED OR SEPARATED AT THE END OF LAST CALENDAR YEAR?: YES

2B. NAME OF SPOUSE [redacted] | 2C. SEX OF SPOUSE [redacted]

A. NAME	B. SOCIAL SECURITY NO.	C. SEX	D. DATE OF BIRTH	E. RELATIONSHIP	F. DEPENDENT AS OF (DATE)
NONE INDICATED					

4. PREVIOUS CALENDAR YEAR (1993) INCOME INFORMATION

CHECK ALL APPLICABLE BOXES	AMOUNT			
	VETERAN	SPOUSE	DEPENDENTS	TOTAL
1. SOCIAL SECURITY (NOT SSI)	-	-	-	-
2. U.S. CIVIL SERVICE	-	-	-	-
3. U.S. RAILROAD RETIREMENT	-	-	-	-
4. MILITARY RETIREMENT	-	-	-	-
5. UNEMPLOYMENT COMPENSATION	-	-	-	-
6. OTHER RETIREMENT	-	-	-	-
X 7. TOTAL INCOME FROM EMPLOYMENT	$0.00	$16000.00	-	$16000.00
8. INTEREST, DIVIDEND, OR ANNUITY INCOME	-	-	-	-
9. WORKERS COMPENSATION/BLACK LUNG BENEFITS	-	-	-	-
10. ALL OTHER INCOME	-	-	-	-
11. TOTAL INCOME				$16000.00

PART VII - INELIGIBLE/MISSING DATA

1. INELIGIBLE DATE	2. TWX SOURCE	3. TWX CITY	4. TWX STATE
5. REASON:			
6. VACO DECISION:			
7. MISSING DATE	8. TWX SOURCE	9. TWX CITY	10. TWX STATE
11. REASON:			

Reg Date/Time: SEP 21,1994@08:53 PRINTED: SEP 21, 1994@09:03:49 Clerk: PLC/1761

DOVE,GAYLE A 515-64-6094

PART III - APPLICANT/SPOUSE DATA

1. APPLICANT'S EMPLOYMENT STATUS: 3. NOT EMPLOYED

2. SPOUSE'S EMPLOYMENT STATUS: 1. EMPLOYED FULL TIME

3. APPLICANT INFORMATION	4. SPOUSE'S INFORMATION
3A. OCCUPATION: SALES	4A. OCCUPATION: U S AIR FORCE
3B. EMPLOYER (Name, Street Address, City, State, Zip) NOT APPLICABLE	4B. EMPLOYER (Name, Street Address, City, State, Zip) KEESLER AFB BILOXI, MS,
3C. WORK TELEPHONE NUMBER:	4C. WORK TELEPHONE NUMBER: UNANSWERED

PART IV - MILITARY SERVICE DATA

1A. LAST BRANCH OF SERVICE AIR FORCE	1B. LAST SERVICE NUMBER 515646094	1C. LAST DATE OF ENTRY SEP 4,1975	1D. LAST DISCHARGE DATE SEP 16,1987	1E. DISCHARGE TYPE HONORABLE
2A. PRIOR BRANCH OF SERVICE NOT APPLICABLE	2B. PRIOR SERVICE NUMBER	2C. PRIOR DATE OF ENTRY	2D. PRIOR DISCHARGE DATE	2E. DISCHARGE TYPE
3A. PRIOR BRANCH OF SERVICE NOT APPLICABLE	3B. PRIOR SERVICE NUMBER	3C. PRIOR DATE OF ENTRY	3D. PRIOR DISCHARGE DATE	3E. DISCHARGE TYPE

PART V - ELIGIBILITY STATUS DATA

1. PATIENT TYPE: NSC VETERAN

2. IS NEED FOR MEDICAL CARE RELATED TO AN ON THE JOB INJURY: NO	3. IS THE NEED FOR MEDICAL CARE RELATED TO AN ACCIDENT: NO	4. IS PATIENT ELIGIBLE FOR MEDICAID: NO
5A. DOES PATIENT HAVE HEALTH INSURANCE COVERAGE: NO	5B. IF YES, COVERAGE PROVIDED BY: NOT APPLICABLE	

6. DOES VETERAN HAVE GI INSURANCE: NO	7. PRIMARY ELIGIBILITY CODE NSC	8. OTHER ELIGIBILITY CODE UNANSWERED	9. PERIOD OF SERVICE POST-VIETNAM

10. SERVICE CONNECTED CONDITIONS: NOT APPLICABLE; NOT A SERVICE-CONNECTED APPLICANT

11. OTHER ELIGIBILITY DATA

A. VETERAN	YES	L. SERVICE IN PERSIAN GULF THEATER	NO
B. PRISONER OF WAR STATUS	NO	M. DENTAL INJ. UNANSWERED / TEETH EXTRACTED	UNANSWERED
C. EXPOSURE TO AGENT ORANGE	NO	N. SERVICE CONNECTED	NO
D. EXPOSURE TO RADIATION	NO	O. RECEIVING AID & ATTENDANCE	NO
E. COMBAT SERVICE	NO	P. RECEIVING HOUSEBOUND	NO
F. MILITARY DISABILITY	NO	Q. RECEIVING VA PENSION	NO
G. VIETNAM SERVICE	NO	R. RECEIVING VA DISABILITY	NO
H. LEBANON SERVICE	NO	S. SERVICE IN SOMALIA	NO
I. GRENADA SERVICE	NO		
J. PANAMA SERVICE	NO		
K. PERSIAN GULF SERVICE	NO	T. VA MONETARY AMOUNT:	NOT APPLICABLE

Reg Date/Time: SEP 21,1994@08:53 PRINTED: SEP 21, 1994@09:03:49 Clerk: PLC/1761

DEPARTMENT OF VETERANS AFFAIRS

FACILITY: Biloxi, MS (CONS) (520) | APPLICATION FOR MEDICAL BENEFITS

SEE ATTACHMENT FOR PAPERWORK REDUCTION INFORMATION AND PRIVACY ACT INFORMATION

PART I - PATIENT DATA

1. Type of benefit applied for: HOSPITAL/OUTPATIENT TREATMENT

2. Applicant's Name	3. Other names used (Alias)	4. Social Security Number
DOVE,GAYLE A	VOGLE,GAYLE A PARKER,GAYLE A	[redacted]

5. Claim Number	6. LOCATION OF CLAIMS FOLDER	7. DATE OF BIRTH	8. PLACE OF BIRTH
C 515646094	317ST PETERSBURG RO	AUG 15,1957	WITCHIA FALLS, TEXAS

9. PERMANENT ADDRESS		10. TEMPORARY ADDRESS	
9A. STREET ADDRESS: 5246 A STREET		10A. STREET ADDRESS: NOT APPLICABLE	
9B. CITY: BILOXI	9C. STATE: MISSISSIPPI	10B. CITY:	10C. STATE:
9D. ZIP CODE: 39530	9E. COUNTY: HARRISON	10D. ZIP CODE:	10E. COUNTY:
9F. HOME TELEPHONE NUMBER: 601-436-9642		10E. HOME TELEPHONE NUMBER:	

11. PATIENT'S SEX	12. MOTHER'S MAIDEN NAME	13. MOTHER'S NAME	14. FATHER'S NAME
FEMALE	MOSSMAN	MARLYN	RAYMOND
15. RELIGIOUS PREFERENCE	16. DATE OF PREVIOUS CARE	17. LOCATION OF PREVIOUS CARE	18. SPINAL CORD INJURY
PROTESTANT, NO DENOMINATION	UNANSWERED	UNANSWERED	NOT APPLICABLE

PART II - EMERGENCY CONTACT DATA

1A. FIRST NEXT OF KIN	1B. RELATIONSHIP	1C. HOME TELEPHONE NUMBER	1D. WORK TELEPHONE NUMBER
RAY DOVE JR	FATHER	601-436-9642	NONE
1E. ADDRESS (Number, Street, City, State, ZIP Code) 5246 A STREET, BILOXI, MISSISSIPPI, 39530-			
2A. SECOND NEXT OF KIN	2B. RELATIONSHIP	2C. HOME TELEPHONE NUMBER	2D. WORK TELEPHONE NUMBER
UNANSWERED			
2E. ADDRESS (Number, Street, City, State, ZIP Code)			
3A. FIRST CONTACT IN AN EMERGENCY	3B. RELATIONSHIP	3C. HOME TELEPHONE NUMBER	3D. WORK TELEPHONE NUMBER
RAY DOVE JR	FATHER	601-436-9642	NONE
3E. ADDRESS (Number, Street, City, State, ZIP Code) 5246 A STREET, BILOXI, MISSISSIPPI, 39530-			
4A. SECOND CONTACT IN AN EMERGENCY	4B. RELATIONSHIP	4C. HOME TELEPHONE NUMBER	4D. WORK TELEPHONE NUMBER
UNANSWERED			
4E. ADDRESS (Number, Street, City, State, ZIP Code)			

I DESIGNATE THE FOLLOWING PERSON TO RECEIVE POSSESSION OF ALL PERSONAL PROPERTY LEFT ON THE PREMISES UNDER VA CONTROL AFTER I LEAVE SUCH PLACE OR AT TIME OF MY DEATH (This does not constitute a will or transfer of title.)

5A. DESIGNEE	5B. RELATIONSHIP	5C. HOME TELEPHONE NUMBER	5D. WORK TELEPHONE NUMBER
RAY DOVE JR	FATHER	601-436-9642	NONE
5E. ADDRESS (Number, Street, City, State, ZIP Code) 5246 A STREET, BILOXI, MISSISSIPPI, 39530-			

NOTE - The law (38 USC 8520 et seq.) provides that upon the death of any veteran receiving care or treatment by the Department of Veterans Affairs in any institution or of a dependent or survivor of a veteran admitted to a VA medical facility leaving no surviving spouse or next of kin or heir entitled to inherit, all personal property, including money or balances in bank, all claims and choses in action, owned by such person, and not disposed of by will or otherwise will become the property of the United States as trustee for the general Post Fund.

Reg Date/Time: SEP 21,1994@08:53 | PRINTED: SEP 21, 1994@09:03:49 | Clerk: PLC/1761

Biloxi, MS (CONS) (520) SUPPLEMENTAL DATA SHEET

1. Applicant's Name: DOVE,GAYLE A | 2. SSN: [redacted]

3. Other Name(s): VOGLE,GAYLE A; PARKER,GAYLE A;

4. Remarks: NO REMARKS CURRENTLY ENTERED FOR THIS APPLICANT

5. Fathers Name: RAYMOND
Mothers Name: MARLYN
Mothers Maiden Name: MOSSMAN

6a. Enrollment Clinic(s): NOT ACTIVELY ENROLLED IN ANY CLINICS AT THIS TIME

6b. Future Appointments: NO PENDING APPOINTMENTS ON FILE

7a. Last Admission: NO PREVIOUS ADMISSIONS TO THIS FACILITY ON FILE

8. Eligibility Status: VERIFIED | Status Date: SEP 21,1994
Verification Method: DD214/HINQ | By: CLAYTON,PERCY L
Ineligible Date: ELIGIBLE APPLICANT -- NOT APPLICABLE | TWX Source: NOT APPLICABLE
TWX City: NOT APPLICABLE | TWX State: NOT APPLICABLE
VARO Decision: NOT APPLICABLE

9. Vietnam Service: NO From: NOT APPLICABLE To : NOT APPLICABLE
Agent Orange: NO Reg : NOT APPLICABLE Exam : NOT APPLICABLE Reg #: NOT APPLICABLE
ION Radiation: NO Reg : NOT APPLICABLE Method: NOT APPLICABLE
Prisoner of War: NO From: NOT APPLICABLE To : NOT APPLICABLE Where: NOT APPLICABLE
Combat: NO From: NOT APPLICABLE To : NOT APPLICABLE Where: NOT APPLICABLE

10. Next of Kin, Address and Zip Code: | Relationship: FATHER
Name: RAY DOVE JR
5246 A STREET | Phone: 601-436-9642
BILOXI, MISSISSIPPI 39530

reg: SEP 21,1994@08:53 clerk: PLC/1761

MailMan message for CLAYTON,PERCY L CLERK,FILE
Printed at BILOXI.VA.GOV 21 Sep 94 08:42
Subj: HINQ response for /requested by CLAYTON,PERCY L [#2884113] 21 Sep 94 08:37 33 Lines
From: POSTMASTER - POSTMASTER (Sender: CLAYTON,PERCY L - CLERK,FILE (520)) in 'IN' basket. Page 1

Date Requested: 515646094NMDOVE,GAYLE

BIRLS Response only - No C&P Record Found

VBA name = VOGEL, GAYLE ANN [redacted]
Prior names =
DOVE
Sex = FEMALE
Date of Birth = AUG 15, 1957

[redacted]

Service data	C&P	BIRLS
Branch of Service =		AF AF
EOD =		SEP 4,1975 DEC 2,1985
RAD =		SEP 16,1987
Char of Service =		UNK HON

DISABILITIES(Combined % = 0 SC/Total = 0/0 Additional = 0)

Diagnostic Verified Indicator is NO.
Verify Service Connections at 317 - ST.PETERSBURG-RO

Dove

CAUTION: NOT TO BE USED FOR IDENTIFICATION PURPOSES | THIS IS AN IMPORTANT RECORD SAFEGUARD IT | ANY ALTERATIONS IN SHADED AREAS RENDER FORM VOID

DD FORM 214 JUL 79 — PREVIOUS EDITIONS OF THIS FORM ARE OBSOLETE

CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY

1. NAME (Last, first, middle)	DOVE GAILE ANN
2. DEPARTMENT, COMPONENT AND BRANCH	AIR FORCE--REG AF
3a. GRADE, RATE OR RANK	SSG
4b. PAY GRADE	E5
5. DATE OF BIRTH	[redacted]
6. PLACE OF ENTRY INTO ACTIVE DUTY	EGLIN AFB FL
7. LAST DUTY ASSIGNMENT AND MAJOR COMMAND	HQ 1ST AF (TAC)
8. STATION WHERE SEPARATED	LANGLEY AFB VA
9. COMMAND TO WHICH TRANSFERRED	NOT APPLICABLE
10. SGLI COVERAGE	AMOUNT $ 50,000 ☐ NONE

11. PRIMARY SPECIALTY NUMBER, TITLE AND YEARS AND MONTHS IN SPECIALTY (Additional specialty numbers and titles involving periods of one or more years)

27650, AEROSPACE CONTROL AND WARNING SYSTEM OPERATOR, 11 YEARS AND 9 MONTHS.

12. RECORD OF SERVICE	YEAR (s)	MON (s)	DAY (s)
a. Date Entered AD This Period	1985	DEC	02
b. Separation Date This Period	1987	SEP	15
c. Net Active Service This Period	01	09	15
d. Total Prior Active Service	10	02	29
e. Total Prior Inactive Service	00	04	06
f. Foreign Service	02	09	00
g. Sea Service	00	00	00
h. Effective Date of Pay Grade	1981	MAR	01
i. Reserve Oblig. Term. Date	NOT APPLICABLE		

13. DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED (All periods of service)

MERITORIOUS SERVICE MEDAL, AF OUTSTANDING UNIT AWARD, COMBAT READINESS MEDAL, AF GOOD CONDUCT MEDAL WITH THREE OAK LEAF CLUSTERS, AF OVERSEAS SHORT TOUR RIBBON WITH TWO OAK LEAF CLUSTERS, AF LONGEVITY SERVICE AWARD RIBBON WITH TWO OAK LEAF CLUSTERS, NCO PROFESSIONAL MILITARY EDUCATION (SEE REMARKS)

14. MILITARY EDUCATION (Course Title, number weeks, and month and year completed)

AF SYSTEMS COMMAND NONCOMMISSIONED OFFICERS LEADERSHIP SCHOOL, 4 WEEKS, OCT 1981. AF SUPERVISORS COURSE, 3 WEEKS, MAR 1980. ADVANCED AIR DEFENSE TRAINING COURSE, 5 WEEKS, DEC 1977. SPACE SYSTEMS OPERATOR/TECHNICIANS COURSE, 4 WEEKS, AUG 1976. AEROSPACE CONTROL AND WARNING SYSTEMS OPERATOR COURSE, 6 WEEKS, DEC 1979.

15. MEMBER CONTRIBUTED TO POST-VIETNAM ERA VETERANS' EDUCATIONAL ASSISTANCE PROGRAM	16. HIGH SCHOOL GRADUATE OR EQUIVALENT	17. DAYS ACCRUED LEAVE PAID
☐ YES ☒ NO	☒ YES ☐ NO	8 days

18. REMARKS

BLOCK 13: GRADUATE RIBBON, AF TRAINING RIBBON.
MEMBER WAS NOT PROVIDED A COMPLETE DENTAL EXAMINATION WITHIN 90 DAYS PRIOR TO SEPARATION.
CONTINUOUS ACTIVE MILITARY SERVICE DATE: 4 SEP 1975.---NOTHING FOLLOWS---

19. MAILING ADDRESS AFTER SEPARATION	20. MEMBER REQUESTS COPY 6 BE SENT TO VET. DIR. OF VET AFFAIRS
2A AQUARAMINE DRIVE KEY WEST, FL 33040	☒ YES ☐ NO

21. SIGNATURE OF MEMBER BEING SEPARATED	22. TYPED NAME, GRADE, TITLE AND SIGNATURE OF OFFICIAL AUTHORIZED TO SIGN
Gayle A. Dove	DANIEL L. SAMPSON, MSGT, USAF SUPT, QUALITY FORCE SECTION

SPECIAL ADDITIONAL INFORMATION (For use by authorized agencies only)

23. TYPE OF SEPARATION	24. CHARACTER OF SERVICE (Includes upgrades)	
DISCHARGE	HONORABLE	
25. SEPARATION AUTHORITY	26. SEPARATION CODE	27. REENLISTMENT CODE
AFR 39-10	HFD	2C

28. NARRATIVE REASON FOR SEPARATION

ALCOHOL ABUSE REHABILITATION FAILURE

29. DATES OF TIME LOST DURING THIS PERIOD	30. MEMBER REQUESTS COPY 4
	INITIALS

COLUMBIA V.A.
WJB DORN VETERANS' MEDICAL CTR
6439 GARNERS FERRY ROAD
COLUMBIA SOUTH CAROLINA 29209

December 7, 2001

In Reply Refer To: 544/136
DOVE,GAYLE A
[redacted]

GAYLE A DOVE
225 RIVER FOREST DRIVE
BOILING SPRINGS SOUTH CAROLINA 29316

REGARDING: VENDOR: SPARTANBURG REGIONAL MED CTR
FEE PROGRAM: OUTPATIENT
EPISODE OF CARE: Oct 11, 2000

We have carefully reviewed your claim for payment of unauthorized medical services. The following decision has been made:

Claim has been disapproved.

Payment may be made only if all three of the following criteria are met: (1) Care or services were rendered for an adjudicated service-connected disability or for any condition of a veteran who has been determined to be totally and permanently disabled as a result of a service-connected disability; (2) Care and services were rendered in a medical emergency of such a nature that delay would have been hazardous to life or health; (3) VA or other federal facilities were not feasibly available.

The absence of any one of these criteria precludes payment by the US Department of Veteran Affairs.

Reason(s) for not approving claim:
A medical emergency must have existed. Care and services were not rendered in a medical emergency of such nature that delay would have been hazardous to life or health.

VA facilities were feasibly available to provide the care.

VA Form 4107, Notice of Procedural and Appellate Rights, is being sent to the veteran.

If you do not agree with the decision you have the right to appeal. Your appeal rights are enclosed for your review.

If you have any questions concerning this matter, please contact our Claims Clerk at (803) 776-4000, extension 6170. A copy of this letter is being furnished to the provider(s) of care, if applicable.

Sincerely,

Carolyn L. Barrett, Chief, Patient Operations

cc: Vendor

APPROVED OMB NO. 0938-0279

1 PARTANBURG REGIONAL MED
P.O BOX 651602
CHARLOTTE, NC 282651602
8645604123 8645604023 USA

15646094

5 PATIENT CONTROL NO. [redacted] 141

6 FED. TAX NO. 001 | 7 COV D. | 8 M-C D. | 9 C-I D. | 10 L-R D. | 11

576000934 | 101100 | 101100

12 PATIENT NAME
MURRAY, GAYLE D

13 PATIENT ADDRESS
992 PARK VIEW PL GULFPORT, MS 395073637

14 BIRTHDATE	15 SEX	16 MS	17 ONE	ADMISSION 18 HOUR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	29	30	31
08151957	F	M	101100	11	3	1		01	000546015	80							

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 CODE	DATE FROM	DATE THROUGH	37
11	101100	18	020199	42	101100						A
											B
											C

38 MURRAY, GAYLE D
992 PARK VIEW PL

GULFPORT, MS 395073637

	39 VALUE CODES	AMOUNT	40 VALUE CODES	AMOUNT	41 VALUE CODES	AMOUNT
a						
b						
c						
d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
300	LABORATORY - GENERAL CLA	80053		1	2400		
300	LABORATORY - GENERAL CLA	85025		1	2000		
001	TOTAL CHARGE				4400		

50 PAYER	51 PROVIDER NO.			54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
633 VETERANS ADMINISTRATI	576000934	Y	Y			
618 OUTPATIENT MEDICARE	420007	Y	Y			
633 VETERNANS ADMINISTRAT	576000934	Y	Y			

57 DUE FROM PATIENT >

58 INSURED'S NAME	59	60 GROUP NAME	61
MURRAY, GAYLE D	[redacted]		[redacted]
DOVE, GAYLE A			
MURRAY, GAYLE D		VA	

62 TREATMENT AUTHORIZATION CODES	63 ESC	64 EMPLOYER NAME	65 EMPLOYER LOCATION
	3		
	3		
	3		

67 PRIN. DIAG. CD.	68	69	OTHER DIAG CODES 70	71	72	73	74	75	76 ADM. DIAG. CD.	77 E-CODE	78
V7284	5756								5756		42

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
9			LC 0 CA		B	
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	C		D		E	

82 ATTENDING PHYS ID
C65437 STEINBERG,SIDNEY

83 OTHER PHYS ID A
C65437 STEINBERG,SIDNEY

OTHER PHYS ID B
C65437 STEINBERG,SIDNEY

84 REMARKS VETERANS ADMINISTRATION
ASSEMBLY STREET

85 PROVIDER REPRESENTATIVE

U-10017

COLUMBIA V.A.
WJB DORN VETERANS' MEDICAL CTR
6439 GARNERS FERRY ROAD
COLUMBIA SOUTH CAROLINA 29209

October 19, 2001

In Reply Refer To: 544/136
DOVE,GAYLE A
[redacted]

SPARTANBURG REGIONAL MED CTR
PO BOX 651602
CHARLOTTE NC 28265-1602

REGARDING: VETERAN: GAYLE A DOVE
FEE PROGRAM: CIVIL HOSPITAL
EPISODE OF CARE: Mar 30, 2000 to Apr 07, 2000

We have received your request for payment of medical services which were not authorized. Before we are able to process your claim the following information is needed:

PLEASE RETURN ALL COPIES OF VA FORM 10-583

Claim is approved. Completed VA Form 10-583 is required for payment.

We ask that you be prompt in supplying the requested information. Failure to provide all the information within a year will result in an automatic disapproval. Legislation requires that we notify you if your claim cannot be processed if entitlement to the services rendered has not been established. Without the information requested above, we cannot consider your request for payment as a proper invoice.

If you wish us to process this claim, please resubmit the entire claim with the items listed to the above address. We will notify you of our decision.

The U.S. Department of Veterans Affairs assumes no financial responsibility for any costs incurred in obtaining the above information.

Sincerely,

Carolyn L. Barrett, Chief
Patient Operations

cc: Veteran

MEDICAL RECORD | **PROGRESS NOTES**

DATE

UNAUTHORIZED MEDICAL TREATMENT CLAIM

Claims Clerk: Rebecca Bucks Date Claim Sent for Fee Physician Review 8/22/01

Date(s) of Care: 3/30 - 4/7 2000

ELIGIBILITY: P&T

TYPE OF CLAIM:

____AMBULANCE

X NON VA HOSPITALIZATION

____OUTPATIENT MEDICAL

____NONVA EMERGENCY ROOM

____Other:

Explain

9/7/01 Psychiatric Admission - SLM Gardner

Treatment for:

V Treatment for Any Condition, Vet rated 100% Permanent and Total (P&T)

~~Vocational Rehabilitation Enrollee~~

Service Connected Condition

~~Non-Service Connected Condition~~

Condition, Adjunct to Rated Service Connected Condition

Other: Explain

Care Was: Emergent V Not Emergent This was over 1 yr. ago.

VA Facility was Available Not Available Never Eligible Don't Know

Recommend: Approval : All or specify Outpatient Care Dates: _____

Approval: All or specify Inpatient Dates From 3/30/00 To 4/7/2000

Denial of Claim _____

Received 9/21/01 EMM

Comments to support Decision of Approval/Disapproval:

Pt was suicidal.

E M Bucks 9/25/01 Physician Reviewer Date:

K D Jarrell 9/28/01 MAS Reviewer Concurrence/Date

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO. | WARD NO.

NAME: Dove Murray Gail

SSN: [redacted]

PROGRESS NOTES

STANDARD FORM 509 (Rev. 11-77)

Prescribed by GSA/ICMR.

FIRMR(41CFR)201-45.505

509-111

PATIENT NAME: Dove, Gayle [illegible]n
MEDICAL RECORD NO: 000-54-60-15

ADMISSION HISTORY AND PHYSICAL

DATE OF ADMISSION: 03/30/2000 PATIENT LOCATION: 3S 005 A

HISTORY OF PRESENT ILLNESS: The patient is a 42 year old white female who has been admitted secondary to an overdose of Oxycodone that was "accidental." She was complaining of severe migraine headaches and was taking Tylox to stop it. The patient was originally from Biloxi, Mississippi, is on disability secondary to post traumatic stress disorder. She has had two prior psychiatric admissions, last time in Alabama in 2/2000 after a car accident. The patient was in the US Air Force from 1975 to 1987. The patient moved here and bought a house. Father and son live with her.

MEDICATIONS:
Prozac 20 mg in the morning.
Neurontin 300 mg t.i.d., and 600 mg q. h.s.
Ranitidine 150 mg b.i.d.
Tylox 1 q.6 h.
BuSpar 10 mg b.i.d., and 20 mg at 1 p.m.
Zyprexa 5 mg q. h.s.
Estradiol 1 mg 0.5 a day.

PAST MEDICAL HISTORY: Migraine headaches.

DRUG ALLERGIES: No known drug allergies.

PAST SURGICAL HISTORY: None.

SOCIAL HISTORY: Married three times, divorced three times, the last time was 5 years ago. Has a child, on disability secondary to post traumatic stress disorder.

FAMILY HISTORY: Hypertension and migraines, and diabetes, unknown cancer.

HABITS: Smokes about a pack a day, denies alcohol or other drugs other than the Tylox and other medications that the takes.

PHYSICAL EXAMINATION: GENERAL APPEARANCE: Lethargic, arousable to stimulation, speaks in monosyllables, difficult to elicit history. Disheveled.

VITAL SIGNS: Temperature 98.8, pulse 101, respiratory rate 24, blood pressure 93/59.

PRINTED BY: SL18901
DATE 6/1/01

HEENT: Atraumatic, normocephalic. Pupils equal, round, reactive to light. Funduscopic shows sharp disc margins, no AV nicking or papilledema. Tympanic membranes are clear bilaterally. Oropharynx, good dentition, pink and moist.

NECK: Supple without lymphadenopathy or thyromegaly.

CHEST: Clear to auscultation throughout with poor effort.

CARDIOVASCULAR: Mildly tachycardic but no murmurs, gallops, or rubs.

ABDOMEN: Mildly obese, nontender, nondistended. Good bowel sounds, no hepatosplenomegaly. No masses.

EXTREMITIES: No cyanosis, clubbing or edema. 2+ dorsalis pedis and femoral and radial pulses. Brisk capillary refill.

SKIN: Hot and damp, normal turgor.

NEUROLOGICAL: The patient is speaking in monosyllables, difficult to get her to cooperate with exam. The cranial nerves II-XII are grossly intact. Deep tendon reflexes are 2+ and symmetrical but the patient won't really follow commands, lying in bed, cannot test gait, she is lethargic.

LABORATORY DATA: Valproic acid 11.8, cortisol a.m. 24.3. WBC 16.2, hemoglobin 12.5, hematocrit 36.6. Platelets 329; segs 58, bands 19, lymphs 12. Electrolytes mildly elevated at chloride 113, mildly depressed P02 of 16.8. Blood alcohol negative.

Urine drug screen positive for barbiturates and opiates. Acetaminophen level less than 10.

EKG: sinus tachycardia, otherwise normal.

ASSESSMENT:
1. Major depression disorder rule out cyclothymic disorder.
2. Opiate dependency.
3. Personality disorder mixed.
4. Gastritis.
5. Migraine headaches.
6. Status post hysterectomy, ganglion cyst removal on right wrist times four, status post cyst removal on abdomen.

PLAN: Depression and affective disorder workup. DITAA profile, stabilize to outpatient care. Discontinue BuSpar, Prozac. Individual therapy, continue other medications for her medical problems. Elevated white blood cell count likely due to the overdose.

PRINTED BY: SL18901
DATE 6/1/01

Dictated By: Kirsten Kerr, M.D.

Attending Physician: Chris Caston, M.D.

cc: Chris Caston, M.D.
Kirsten Kerr, M.D.

D: 04/01/2000
T: 04/01/2000 / lbe
029535/335186
%%END
Authenticated by Kirsten Suzanne Kerr, M. D. On 4/6/00 2:08:26 PM
Authenticated by Chris Caston, M.D. On 4/11/00 2:47:12 PM

PRINTED BY: SL18901
DATE 6/1/01

PATIENT NAME: Dove, Gayle Ann

MEDICAL RECORD NO: 0[redacted]

DISCHARGE SUMMARY

DATE OF ADMISSION: 03/30/2000

DATE OF DISCHARGE: 04/07/2000

SERVICE: Psychiatry.

ATTENDING PHYSICIAN: Dr. Caston.

REASON FOR ADMISSION: Patient is a 42 year old Caucasian female who has been admitted due to an overdose of oxycodone that was "accidental". "I had severe migraine headaches and was taking Tylox to stop it". This patient is originally from Biloxi, MS. The patient is on disability due to post traumatic stress disorder. The patient has had 2 previous psychiatric admission, the last one in Alabama in February 2000 after a car accident. The patient was in the US Air Force from 1975 to 1987. The patient recently bought a house in the Spartanburg area and is living with her father and son in this area. The patient apparently has been getting her medications from Biloxi, MS.

SOCIAL HISTORY: The patient has a 25 year old son that was fathered by boyfriend many years ago. The patient has also been married 3 times, divorced 3 times and last divorced her 3rd spouse about 5 years ago. The patient currently takes the following MEDICATIONS:

1. Prozac 20 mg qam.
2. Neurontin 300 mg tid and 600 mg qhs.
3. Ranitidine 150 mg bid.
4. BuSpar 10 mg bid and 20 mg q 1:00 PM.
5. Zyprexa 5 mg qhs.

MENTAL STATUS UPON ADMISSION: The patient is oriented to time, place and person. The patient is dressed in disheveled leisure attire. The patient did have psychomotor agitation. The patient is depressed, sad, anxious and thus has disjointed thinking. Patient has no delusions, hallucinations or psychotic symptoms. Patient has a negative cognitive set. Patient does appear to have potential for suicide, but none for violence. Insight is poor. Judgment is fair.

ADMISSION DIAGNOSIS:

Axis I: Clinical psychiatric disorders:
1. Major depression disorder.

2001 JUN 14 PM 1 10

PRINTED BY: SL18901
DATE 6/1/01

2. Cyclothymic disorder.
3. Opiate dependency disorder and withdrawal syndrome.

Axis II: 1. Personality disorder, mixed type.

Axis III: Medical Problem List:
1. Gastritis.
2. Migraine headaches.
3. Post hysterectomy.
4. Post ganglion cystectomy on the right wrist x 4.
5. Post ganglion cystectomy x 2 on the abdomen.

LABORATORY DATA: Valproic acid level on 4/2 is 20 mcg, 28 mcg on 4/5. Lithium level is .37 on 4/6. Dexamethasone suppression test was performed on 4/1 in response to 1 mg of dexamethasone at 11:00 PM on 3/31. 7:30 AM cortisol was 24.3 mcg, 4:00 PM is 13.3 mcg. This is a non-suppressed DST. Repeat DST on 4/5 revealed a 6:00 AM cortisol of 1.9 and a 4:00 PM of 1.6. Thus, the patient's DST converted to a suppressed state during this admission with treatment with valproic acid and lithium.

Sodium 144, potassium 4.0, chloride 113, CO2 16.8, glucose 94, BUN 14, creatinine 0.9, WBCs 16.100, RBCs 3.92, hemoglobin 12.5, hematocrit 36.6, platelet count 329,000. Differential is within normal limits. UA is within normal limits. Blood alcohol level is negative. UDS is positive for barbiturates and opiates. Repeat UDS on 4/2/00 was positive again for opiates and barbiturates.

HOSPITAL COURSE: Patient is placed on the module I adult unit and was begun on home medications with the exception of BuSpar which was discontinued. Patient was started on Depakote 250 mg bid on 3/31 and Zyprexa was reduced to 2.5 mg qhs. Neurontin was changed to 300 mg q 1:00 PM and 1200 mg qhs on 4/1. Zyprexa was discontinued on 4/1. Prozac was reduced to 20 mg qam on 4/1. The patient was started on Butisol 30 mg qid and Tylox 5 mg qd. The patient was then withdrawn from both opiates and barbiturates since she had been taking Fioricet as well. Butisol is reduced to 30 mg bid by 4/3 and then discontinued on 4/5. Neurontin was changed to 600 mg q 1:00 PM and 1200 mg qhs on 4/3. Tylox was reduced to 5 mg bid by 4/4 and then discontinued on 4/5. The patient was seen in consultation by Dr. Gheorghiu who placed the patient on DHE and Reglan for migraine headaches. The patient continued to make good progress, was moved the to the adult unit and appeared to be sufficiently stabilized on 4/6/00 to be discharged to outpatient care on the following medications:

1. Eskalith 450 mg q 8:00 AM and 225 mg q 6:00 PM.
2. Estradiol .5 mg qd.
3. Neurontin 600 mg q 1:00 PM and 1800 mg qhs.
4. Depakote 500 mg q 1:00 PM and 1000 mg qhs.
5. Prozac 20 mg q 8:00 AM.
6. Metoclopramide 10 mg bid.
7. DHE 45 1 mg bid.

2001 JUN 14 PM 1 10

PRINTED BY: SL18901
DATE 6/1/01

8. Thiamin 100 mg qd.
9. Ranitidine 150 mg bid.
10. Darvocet-N 100 mg q6h prn headaches.

This patient will have valproic acid level and lithium level in 1 week. Patient will see Dr. Gheorghiu in 1 week and also at the Mental Health center. Patient will be discharged on 4/7/00.

DISCHARGE DIAGNOSIS:

AXIS I: CLINICAL PSYCHIATRIC DISORDERS:
1. Cyclothymic disorder.
2. Major depression disorder.
3. Opiate dependency disorder.
4. History of post traumatic stress disorder.

AXIS II: 1. Personality disorder, mixed type.

AXIS III: MEDICAL PROBLEM LIST:
1. See Axis III Problem List above.

AXIS IV: Psychosocial stress factors level 4, moderate.

AXIS V: Highest level of GAF (Global Assessment of Functioning) past year level unknown.
Current level of GAF functioning, level 50.
Admission GAF level 20.

Dictated By: Chris Caston, M.D.

cc: Chris Caston, M.D.
Dr. Gheorghiu.
Spartanburg Mental Health center.

D: 04/06/2000
T: 04/13/2000 /kbo
002930/ 339614
%%END
Authenticated by Chris Caston, M.D. On 4/22/00 1:58:04 PM

2001 JUN 14 PM 1 10

PRINTED BY: SL18901
DATE 6/1/01

SPARTANBURG
Regional Healthcare System

☑ SRMC ☐ SHRC ☐ BJW

CONSULTATION REPORT

PAGERS
560 6070
0257

Consulting Physician and/or Service Neurology.

Reason for Request Migraine Headache

Jan Notified 1500 4/4/00
DR Gheorghiu

(Check one or more suitable blanks)

✓ ____ At convenience of consultant
____ Urgent, today if possible
____ Opinion and recommendation only

✓ ____ Evaluate and manage condition in your specialty
____ Accept in transfer, if you will

____ Write diagnostic orders and re-evaluate as indicated
____ Surgical procedure only

Date 4/4/00 Dr. Caston M.D.
Attending Physician

Date and Time Consultant Notified 4:4 Signed [signature]

Report: 42yo F c long hx of migraines & depression — has tried "everything" in the past. Recently has been on Tylox & Glyn and now is in a cycle of frequent migraines (3/week) for which has added a component of rebound headaches from the opiate. ROS otherwise Smoker. Current meds include Neurontin & Depakote.

PMHx as above. NKA. Triggers: fluorescent lights, chocolate, HCE/Estrogen pills, heads dessert. VSS. CN II-XII wnl. Motor & Sensory wnl. Reflexes wnl. Gait wnl. Gastrul

Impr: Chronic migraines + rebound headaches. Continue to taper opiate. Would d/c Phenergan & give a course of 10 days of DHE-45 1mg SC and Reglan 10mg IV/PR BID.
Will follow in office.

Date 4/4/00 Signed [signature] M.D.

Patients Address:

[redacted]

PRINTED BY: SL18901
DATE 7/26/01

1260 (7/1998)

SPARTANBURG
Regional Healthcare System

☐ SRMC ☐ SHRC ☐ BJW

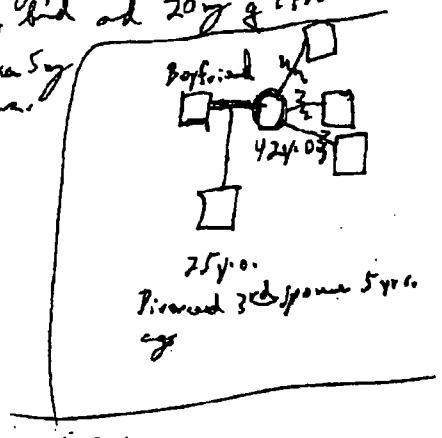
INITIAL PSYCHIATRIC EVALUATION 24 HOURS ADMISSION)

DATE: 3-31-00

I. Psychiatry History:

A. Chief Complaint
B. Presenting Problem/Behavior/ Attitudes:
C. Current Illness:
D. Past Disturbances and Response to Treatment:
E. Family History of Emotion Problems:
F. Current Medications:

42 y.o. WF who was brought in due to an overdose of Oxycodone that was "accidental"; "I had severe migraine headaches and was taking Tylox to stop it."
Pt. is from Biloxi, Mississippi. She is on disability due to PTSD. Two previous psychiatric admissions → both in Alabama. Feb 2000 after a car accident. Pt. was in USAF 1975 → 1987. Pt. bought a home here and her father and son live with her. Pt. got meds from Biloxi, Mississippi:
1. Prozac 20mg q AM 2. Neurontin 300mg tid and 600mg h.s.
3. Ranitidine 150mg bid 4. Buspar 10mg bid and 20mg q 1PM
5. Tylox 1 q 6h. 6. Zyprexa 5mg h.s.



II. Physical Assessment:

A. Physical Status
B. History of Physical Health
C. History of Drug Reactions:

A. Good health
B. Migraine HA
C. NKA

III. Mental Status Exam:

A. General Appearance:
B. Attitude/Psychomotor Behavior:
C. Affect/Mood:
D. Thought Content/ Process:
E. Perception:
F. Sensorium:
G. Intellect/Cognitive Function:
H. Potential for Suicide/Violence:
I. Insight/Judgement:

Disheveled casual attire
Psychomotor agitation
Depressed / Sad / Disjointed thinking
Neg. set. No delusions. No hallucinations
Oriented X 3.
Neg set
Yes / No
Poor / Fair

IV. Reasons for Admission:

A. Suicidal; B. Danger to Others; C. Psychosis; D. Continuous Psychiatric Intervention;
E. Unresponsive to Outpatient Treatment; F. Severe Psychotropic Medication Reaction;
G. Substance Dependency/Detox; H. Toxic Lab Values; I. Eating Disorder;
J. Others: _____

V. Assets (Strengths and Weaknesses):

[redacted]

PRINTED BY: SL18901
DATE 7/26/01
1371 (9/99)

INITIAL PSYCHIATRIC EVALUATION 24 HOURS ADMISSION)

VI. **Clinical Impressions**

Diagnosis:

AXIS I *Clinical Disorders*

Other Conditions That May Be a Focus of Clinical Attention

1. Major Depression Disorder
2. R/o Cyclothymic Disorder
3. Opiate dependency

AXIS II *Personality Disorders*

Mental Retardation

1. Personality Disorder, mixed

AXIS III *General Medical Conditions*

1. Gastritis
2. migraine HA
3. Post hysterectomy
4. Post ganglion cystectomy on right wrist X 4
5. Post gallbladder cystectomy X 2 on abdomen

AXIS IV *Psychosocial and Environmental Problems*

check:

Problems with primary support group *Specify* _____

- ☐ Problems related to the social environment *Specify* _____
- ☐ Educational problems *Specify* _____
- ☐ Occupational problems *Specify* _____
- ☐ Housing problems *Specify* _____
- ☐ Economic problems *Specify* _____
- ☐ Problems with access to health care services *Specify* _____
- ☐ Problems related to interaction with the legal system/crime *Specify* _____
- ☑ Other psychosocial and environmental problems *Specify* _____
- ☐

Axis V *Global Assessment of Functioning Scale* Score 20

VII **Treatment Formulation:**

A. Initial Problems and Goals 1. Depression/Affective Disorder working - DSC/AD profile
2. Stabilize to step care

B. Initial Treatment Plan 1. PC Baspan 2. Prozac 3. Individual therapy

C. Estimated Length of Stay 4-5 days

[redacted]

[redacted]

[redacted]

SPARTANBURG
Regional Healthcare System

☐ SRMC ☐ SHRC ☐ BJW

PROGRESS NOTES

DATE	NOTES
3-31-00	Workup in progress.
4-1-00	VA level = 11 ug on 4-1. DST is nonsuppressed. Very confused and lethargic today. Will DC Zyprexa and begin pain meds. ? withdrawal pending. Will try to detox. as well with limited hx given.
4-2-00	VA level = 20 ug on 4-2. Pt. still has positive drug screen for opiates and ? amphetamines. Will begin to wean Butisol and Tylox to Rx for ? withdrawal. Will ↑ Depakote again. No ataxia. "1900 → 2000, April ?" Better orientation but still disjointed.
4-3-00	VA level = 20.6 on 4-3. More lucid today. Will continue to withdraw from Opiates and barbiturates. "2000, March → April ?, ? day ?" More lucid. Less confused and less disjointed. Will hold at current levels and continue DST.
4-4-00	Pt. made a good transition to Adult unit. "I have a bad HA today." She has seen Neurologists before. Will get a consult for HA control. Sleeps poorly. Will ↑ meds again.

[redacted]

ADDRESSOGRAPH

[redacted]

SPARTANBURG
Regional Healthcare System

☐ SRMC ☐ SHRC ☐ BJW

PROGRESS NOTES

DATE	NOTES
4-5-00	VA = 28 wg on 4-5. Dr. Gheorghui's help appreciated. Pt. is calmer and less disjointed. Will f/u Depakote and Neurontin. HA are ↓ now. Will shape for outp care by 4-7.
4-6-00	Lithium = 0.37. Bright affect. Pt. is stable for discharge to outp care. Pt. will be seen at MHC in 1 week.
4-7-00	Slept pretty well last pm + a/ext. DC plans in order + soon to pick her up today. VA level = 43.6 on 4/6. Pt did ask about her dx. + we reviewed issues of major Dep + mood changes + pos med. usage. Emphasized follow-up plans + compliance.

[redacted]

PRINTED BY: SL18901
DATE 7/26/01

1080 (7/1998)

S[illegible]RTANBURG[illegible]OSPITAL SY[illegible]EM
SPARTANBURG, SOUTH CAROLINA

PHYSICIANS ORDER FORM

TIME 0430 DATE 3-31-00

MARK "PH" FOR PHARMACY ORDER	CHECK (✓) OFF EACH ORDER AS TRANSCRIBED	
	1.	Patient may participate in the following treatment program track:
		___ Intensive Management ___ Adolescent ___ Anxiety
		___ Dual Diagnosis ___ Adult OTHER_____
	2.	Patient may participate in the following speciality groups/therapies:
		___Grief ___Habit Control ___Individual
		___Survivors ___Anxiety/Phobia ___Family/Marital
		___ Chronic Pain
		OTHER:_____
	3.	Specific limitations or restrictions for Field Trips, Exercise, or Physical Activities:
	4.	Biofeedback Assessment:

TIME NOTED	TELEPHONE ORDER BY NURSE	PHYSICIAN SIGNATURE

ADDRESSOGRAPH

	1.	Diet as taken at home: Reg
	2.	Diagnostic Studies: ~~CMA 12~~, CBC, RPR, UA Clean Catch
		· BETA HCG on all fertile females
		EKG if over 40.
	3.	~~Mammogram:~~
	4.	Place Patient's name on History and Physical list
		[redacted]

TIME NOTED	TELEPHONE ORDER BY NURSE	PHYSICIAN SIGNATURE
3/31/00 Thomas 0945	Dr. [redacted]	

DATE 7/26/01

IPO

DR-167 (EP 11/92)

South Carolina DHEC
Department of Health and Environmental Control

South Carolina ...ient Care Rep
Supplemental Form
Division of Emergency Medical Services

Report Number: 498260 Provider Number: 07703 Trip Number: _____ Date: 3-30-00

Patient Name: Gayle A. Dove

Address: 225 Riverforrest Dr Boiling Springs SC 29316

Time	Notes
	Upon EMS arrival found NSFD E-11 out c a 42y/o wf, supine on floor of bedroom. FD stated they found pt folded up underneath an overturned chair At that time pt was unconscious, unresponsive, ∃ radial pulses, c deep snoring respirations. Tx by FD prior to our arrival was to place pt in supine position, open airway and place pt on high flow O2 per Non Rebreather Mas While son gathered medicines pt was placed on Cardiac Monitor which showed sinus Tachycardia ∃ ectopi, Pt BP = 80/60, HR 106, R 24, Pupils wer dialated and slow to react. Pt was placed in trendelenburg position c legs elevated on stool. IV was initiated by Tim Cook EMT-I on 1st attempt using aseptic technique via 18ga protectacath to (R) hand. Blood was drawn for labs & BGL = 105 mg/dl, Pt was given a fluid challenge of 100cc bolus. Pt Meds = OXYCODONE 5mg, OLANZAPINE, FLUOXETINE, BUTALBITAL, RANTADINE, ESTRADIOL, GABAPENTI BUSPIRONE, ATOVENT & ALBUTEROL, NKDA. ? PMHx, PT was given 2mg Narcan IVP(slow & pt began to come around more, becoming CAOX2, Pupils remained the same BP = 100/60, HR 103, R 24 DEEP, Pulse Ox 97% on 15lpm, Radial pulses now noted. Pt was then placed on FW Stretcher and secured in a low fowlers position c straps X3. Pt was transported non-emergent in stable condition to SRMC-ER, ∃ incide SRMC Contacted enroute on 340 c Ø orders requested or received. Upon arrival @ SRMC pt was triaged to room 14 c BRT X2. Pt report given to RN along c Pt. meds. Hard copy of report was placed on chart and pt care was turned over to SRMC Staff for eval & treatment. All of Pt's ID CARDS GIVEN TO Admissions. RBM

Signatures & Numbers

Attendant A: Ron Moorhead (Name) 81147 (No.) Attendant B: David B. Cook (Name) 92647 (No.)

DHEC 1060 (3/1/96)

PRINTED BY: SL18901
DATE 6/1/01

52 Psych Disorder, Suicide Attempt, Overdose (5)

TIME SEEN: 1230 ROOM: 14 *EMS Arrival*

HISTORIAN: __patient __spouse __paramedics _____

__HX / __EXAM LIMITED BY: _____

HPI chief complaint(s):

Depression Suicidal Ideation Suicide Attempt
Agitated Hallucinating Drug Overdose
Self-injury

onset _____ _____

_____ *when?* _____

increased since _____ _____

context/severity: _____

See Psych eval

current/associated complaints:

__depressed / angry / frustrated / agitated / hostile / paranoid

✓ __situational problems

related to: spouse / parent / son / daughter / significant other
work / lost job / school / legal problems

__confused / hallucinating

__suicidal thoughts / specific plan / gesture or attempt

__ingestion (see list below)

suicide attempt *wanted to "escape"* *accidental* *will not answer*

__incised / abraded wrist (R / L)

LIST OF SUBSTANCES INGESTED *(if applicable)*

name	strength	# taken	when taken
acetaminophen Y / N			
aspirin Y / N			
ethanol Y / N			
Trazodone		28	

"RESCUE FACTOR" (if suicide attempt)-
How did ingestion/other acts come to attention?

_____

_____

Arrived by: __private car __ambulance (who called?) _____
__police *patient* *spouse*

__Recently seen/treated by doctor _____

_____

ROS

PULMONARY & CVS
__cough
__trouble breathing
__chest pain

NEURO & EYES
__headache
__visual disturbance

GI - GU
__abdominal pain
__nausea
__vomiting
__diarrhea
__problems urinating

SKIN & LYMPH & MS
__skin rash / swelling
__joint pain

Under much stress

☐ all systems neg. except as marked

PAST HISTORY __negative

__prior suicide attempt

✓ __psychiatric problems
depression *bipolar disorder*
schizophrenia *other*

__other problems
PTSD
SIP pneumonia

__cardiac disease
__hypertension
__diabetes *insulin / oral / diet*
__lung disease
__+HIV / AIDS

Surgeries:
__tonsillectomy
__cholecystectomy
__appendectomy
__hysterectomy

Medications __none __see nurses note

Allergies __NKDA
__see nurses note

SOCIAL HX smoker drugs
recent alcohol use / binge drinking / alcoholism

marital status: __single __married children:

Moved to Int 2100

2001 JUN 14 PM 1 10

000546015 [redacted]

© 1995-99 E.S.C. Circle positives, check normals, backslash (\) negatives

PRINTED BY: SL18901

Spartanburg Regional Healthcare System
EMERGENCY PHYSICIAN RECORD

DATE 6/1/01

☑ Nursing Assessment Reviewed. ☐ BP, HR, RR, Temp reviewed.

PHYSICAL EXAM ✓Alert __Lethargic __Obtunded
Distress- ✓NAD __mild __moderate __severe
__uncooperative for exam

HEENT
__nml ENT inspection
✓pharynx nml
if obtunded:
__nml gag reflex
__ depressed / absent gag reflex
__ abnormal TM (R / L)
__dry mucosa
__gag reflexed diminished / absent

EYES
✓pupils equal, round & reactive to light
✓EOM's intact
__nystagmus
__disconjugate gaze
__mydriasis / meiosis / anisocoria
R Pupil _____ *mm* *L Pupil* _____ *mm*

NEURO/PSYCH *mental status*
__mood/affect nml
__slow / no response to commands. *withdraws to pain* *no response to pain*
__depressed affect
__tearful / hostile / non-communicative
__suicidal ideation

For suicide attempts: On direct query, patient *ADMITS / DENIES* continued consideration of suicide as an option.
If denies, why?

orientation
✓normal x3
__uncooperative / cannot determine
__disoriented.
to: *day-of-week* *day-of-month* *month* *year* *place* *person*

cranial nerves
sensory, motor
✓CN's intact as tested
✓nml motor response
✓nml sensory response
__nml reflexes
__nml gait
__facial droop / CN abnormality.
__motor/sensory deficit
__abnormal gait

NECK/BACK
✓normal inspection
✓neck supple
__cerv. lymphadenopathy (R / L).
__thyromegaly / meningismus

RESPIRATORY
✓no resp. distress
✓breath sounds nml
__wheezing
__rales / rhonchi

CVS
✓regular rate, rhythm
✓heart sounds normal
__irregularly irregular rhythm
__extrasystoles (occasional / frequent)
__tachycardia / bradycardia
__JVD

ABDOMEN
✓non-tender
✓nml bowel sounds
__no organomegaly
__guarding
__hepatomegaly / splenomegaly

SKIN
✓color nml, no rash
✓warm, dry
__cyanosis / diaphoresis / pallor
__skin rash

EXTREMITIES
✓non-tender
__normal ROM
✓no signs of injury
✓no pedal edema
__laceration
__pedal edema

PROCEDURES: ☐ Restraints
☐ Intubated __by ED physician nasal /oral #_____ET tube
__breath sounds equal __ tube position confirmed w CXR
☐ Gastric Lavage __*pill fragments recovered*
☐ Charcoal _____gm given Sorbitol

PRINTED BY: SL16901
DATE 6/1/01

Psych Disorder: Overdose-52

LABS, XRAYS, and PROGRESS

EKG MONITOR STRIP __NSR __abnml

EKG __NML ☐Interp. by me. ☐Reviewed by me Rate_____
__NSR __*nml intervals* __*nml axis* __*nml QRS* __*nml ST/T*

not / *changed from:*

CXR ☐Interp. by me ☐Reviewed by me ☐Discsd w/radiologist.
__*nml/NAD* __*no infiltrates* __*nml heart size* __*nml mediastinm*

not / *changed from:*

CBC *normal except*	**Chemistries** *normal except*	**ABG's** time:	**Toxicology** *normal except*
WBC	Na		acetamin.
Hgb	K		aspirin-
Hct	Cl	pH	ETOH-
Platelets	CO2	pCO2	
segs	Gluc	pO2	Triage™ urine drug screen-
bands	BUN		
lymphs	Creat	__RA	
monos		__O2 ____L	

Pulse Ox _____% on *RA* / ____*L* / ____% *at (time)*_____

*Time*_____ __unchanged __improved __re-examined____

INTERVIEW WITH OTHER RESPONSIBLE ADULT:
Name: *Relationship:*
Considers ongoing suicide risk: high low uncertain
Capable / comfortable with observing patient at home? Yes No N/A

MEDICAL CLEARANCE FOR PSYCHIATRIC REFERRAL (if needed)
Back-slash to indicate that diagnosis is unlikely based on H&P and, when needed, lab testing.
•Toxic (PCP, Amphetamines, Hallucinogens, Acetaminophen, ASA, ETOH, Other)
•Infectious (Meningitis, Encephalitis, Sepsis)
•Metabolic (Thyroid, Hypoglycemia, Drug Withdrawal, Hypoxemia, Electrolytes)
•CNS Vascular and Other (CVA, TIA, Seizure, Trauma)
•Other Unstable Comorbidities ☐cleared medically for psych referral

__Discussed with Dr._____
will see patient in: office / ED / hospital
__Counseled patient / family regarding:
lab results *diagnosis* *need for follow-up*
Rx given __Admit orders written
__CRIT CARE- *30-74 min* *75-104 min* _____ *min*
__Prior records ordered
__Additional history from: *family caretaker paramedics*

CLINICAL IMPRESSION:
Ethanol Intoxication
Depression
major manic
Psychosis Schizophrenia- *acute exac.*
Drug Overdose(Intentional/ accidental)
Suicide Attempt/ Ideation

DISPOSITION- ☐ home ☐ admitted ☐ transfer
CONDITION- ☐ unchanged ☐ improved ☐ stable

PHYSICIAN SIGNATURE- Byrd MD

2001 JUN 14 PM 10

000546015 2009001336
DOVE,GAYLE ANN
08/15/57 42Y F ER EME CH
03/30/00 2357
ADM:PHYSICIANS,ED

SPARTANBURG REGIONAL HEALTHCARE SYSTEM

405-085 (6/98)

ROOM 14

CHIEF COMPLAINT: 2339 Overdose — C. McAbee RN ✓ — SEE EMSTAT SHEET

PHYSICIAN ASSESSMENT

ALLERGIES: Ø

☐ HEADACHE ____ KOH ____
☐ RESTRAINT ____ HEMOCCULT ____

TIME INIT.	TEMP.	PULSE	RESP.	B/P
2350	98.8p	101	24	93/59

RESTRAINTS

DATE: ____ TIME: ____

REASON FOR RESTRAINT (BEHAVIOR): ____

TYPE OF RESTRAINT: ____

MD SIGNATURE: ____

G

X-RAY & LAB: UDS ✓ EDW ✓ — RESULTS: Antimicrobial BMP ✓ — O_2 Sat ____ FeSo ____

DIAGNOSIS: OD - Overdose — ICD-9-CM

PLANS/INTERVENTION: Psych consult — RESPONSE

D/C RSF. WITH: INITIAL:

VALUABLES / CLOTHING / MEDS
☑ WITH PATIENT ☐ LOCKED
☐ WITH FAMILY ☐ NONE

DISPOSITION ☐ HOME ☐ MORGUE TIME: 0245
☐ ADMIT ☐ OR ☐ TRANSFER

DISCHARGE TRANSFER CONDITION: good

DISCHARGED BY: Linda Schofield

DISCHARGE INSTRUCTIONS ☐ LACERATIONS ☐ CAST CARE ☐ ABDOMINAL PAIN ☐ FEVER ☐ PAIN MEDICATION ☐ CHEST PAIN ☐ EAR INFECTION ☐ BRUISE/SPRAIN ☐ HEAD INJURY ☐ VOMIT/DIARRHEA ☐ ANTIBIOTIC INST. ☐ CLEAR LIQUID ☐ GYN PROBLEM ☐ URINARY TRACT INFEC.

I CERTIFY THAT I UNDERSTAND THE INSTRUCTIONS GIVEN ME: X ____ PATIENTS SIGNATURE

LOGGED BY/TIME:

PATIENT DISABLED FOR: ____ DAYS

MAY RETURN TO WORK/SCHOOL ON: ____

BEEPED ____ PAGED ____ RESPONDED ____

BEEPED ____ HOME/OFFICE ____

RX & REF.	ADMIT/ATTENDING PHYSICIAN	DIAGNOSIS	SPECIAL BED REQUEST	MESSAGE SENT ☐ TIME:	INITIAL:
	Admit Psych Med Tech Rm #5 for Psych Services				

William E. Jones, M.D.

PHYSICIAN'S SIGNATURE: [signature] — CONSULTING PHYSICIAN'S SIGNATURE

I.M. 1. LEFT DELTOID 2. RIGHT DELTOID 3. RT. VASTUS LATERALIS 4. LT. VASTUS LATERALIS 5. RT. VENTRO GLUTEAL 6. LT. VENTRO GLUTEAL 7. RT. GLUTEUS 8. LT. GLUTEUS S.C. 9. ABD WALL 10. RT. ARM 11. LT. ARM 12. RT. LEG 13. LT. LEG

BATCH TIME INITIAL

PATIENT

ACCOUNT NO.	ADMISSION DATE / TIME	FC	DATE OF BIRTH	AGE	SEX	RACE	MS	SERVICE		PAT. TYPE	BY	UNIT NUMBER
S 2009001336	03/30/00 2357	CH	08/15/57	42Y	F	1	U	EME	1	ER	MC	000-546015

ADMITTING DOCTOR	ATTENDING DOCTOR	ACCIDENT / WORK RELATED	ACCIDENT DATE / TIME	ADM. TYPE	SOURCE
PHYSICIANS.ED	PHYSICIANS.ED	NO		1	5

PATIENT INFORMATION
DOVE,GAYLE ANN
225 RIVER FOREST DR
BOILING SPRINGS SC 29316 (864)578-2316

SOC.SEC. NO. 515-64-6074 — PRINTED BY: SLIBRAND — DATE 6/1/01

PATIENT EMPLOYER — TELEPHONE NO.

CHART COPY

Spartanburg Regional Healthcare System
101 E. Wood St.

Emergency Department
(864)560-6222
Assessment Sheet

MR # 000546015 Sex: Female DOB: 08/16/1957
Name: Dove, Gayle
Phone:
Address: , ,
Unit Code: TRARM Account # 2009001336 Age: 42

Complaint: Overdose
Arrival Date/Time: 23:35 03/30/2000
Arrived by: Ambulance
Mobility: Stretcher
Primary Care: Caston, Chris
Accompanied By:

Acuity: 3 - Non-urgent
Insurance:
Amb/Helicopter: SPARTANBURG EMS
Referring Facility:
Emergency Physician: Byrd MD, Rich

Complaint Code:
Treatment PTA:

Triage Nurse: McAbee RN, Carrie A

Past Medical Hx:
Tetanus History:
Social History:
Weights:
LMP Date:

Medications

Medication	Dosage	Freq	Prescribing Phys	Started
*Other - See Note				

Allergy

Allergy	Allergic Reaction
*No Known Allergies	

Vital Signs

Inits	Time	Temp	Blood Pressure	Pulse	Resp
AS	02:42	98.8	93/59 „	101	24

Pain

Time	Scale

Pulse Ox.

Time	%

Pupils

Time	L(mm)	R(mm)

Glasgow Coma

Time	Score

Disposition Information
Primary Diagnosis: Overdose, drug or medicinal substance
Secondary Diagnosis:
Disposition: Admit - Inpatient
Report Called By:
Prescriptions:
Discharge Instructions:
Disability Statement:
Follow-up Care:
Discharge Time: 02:42 03/31/2000

Family Notification:
Report Given To:

Appt Date/Time:

Initials	Name	Initials	Name

PRINTED BY: SL18901
DATE 6/1/01

Spartanburg Regional Healthcare System
101 E. Wood St.

Emergency Department
(864)560-6222
Assessment Sheet

MR # 000546015 Sex: Female DOB: 08/16/1957
Name: **Dove, Gayle**
Phone:
Address: , ,
Unit Code: TRARM Account # 2009001336 Age: 42

Complaint: **Overdose**
Arrival Date/Time: **23:35 03/30/2000**
Arrived by: **Ambulance**
Mobility: **Stretcher**
Primary Care: **Caston, Chris**
Accompanied By:

Acuity: **3 - Non-urgent**
Insurance:
Amb/Helicopter: **SPARTANBURG EMS**
Referring Facility:
Emergency Physician: **Byrd MD, Rich**

Complaint Code:
Treatment PTA:

Triage Nurse: **McAbee RN, Carrie A**

Past Medical Hx:
Tetanus History:
Social History:
Weights:
LMP Date:

Medications

Medication	Dosage	Freq	Prescribing Phys	Started
*Other - See Note				

Allergy

Allergy	Allergic Reaction
*No Known Allergies	

Vital Signs

Inits	Time	Temp	Blood Pressure	Pulse	Resp
AS	02:42	98.8	93/59 „	101	24

Pain

Time	Scale

Pulse Ox.

Time	%

Pupils

Time	L(mm)	R(mm)

Glasgow Coma

Time	Score

Disposition Information
Primary Diagnosis: **Overdose, drug or medicinal substance**
Secondary Diagnosis:
Disposition: **Admit - Inpatient**
Report Called By:
Prescriptions:
Discharge Instructions:
Disability Statement:
Follow-up Care:
Discharge Time: **02:42 03/31/2000**

Family Notification:
Report Given To:

Appt Date/Time:

Initials	Name	Initials	Name

PRINTED BY: SL18901
DATE 6/1/01

Triage/Initial Assessment

23:36 03/30/2000 - Initial Triage Info -- Carrie McAbee RN
Chief Complaint: Overdose
Initial Triage Acuity: 3 - Non-urgent
Quick Assessment: Alert and oriented X3, Breathing present, no distress noted.
Note: per ems pt possibly overdosed on oxycodone 5mg. ate 8 tabs missing out of bottle.

Assessment

23:36 03/30/2000 - Allergy Information -- Carrie McAbee RN
Allergy A: *No Known Allergies
23:37 03/30/2000 - Medicine -- Carrie McAbee RN
Medication A: *Other - See Note
Note: see list
02:26 03/31/2000 - Providers -- Janet Dawkins WS
PCP Relationship: On-call
Physician 1, Specialty: Psychiatry
02:42 03/31/2000 - Discharge Condition -- Angelique Schofield EMT
Acuity: 3 - Non-urgent
Condition: good
02:42 03/31/2000 - Vital Signs -- Angelique Schofield EMT
Temp: 98.8
BP: 93/59
HR: 101
Resp: 24

2001 JUN 14 PM 1 10

SPA[illegible]NBURG REGIONAL HEALTHCAF[illegible]YSTEM Form 405-015 (12/97)

ATTENDING PHYSICIAN	CONSULTING PHYSICIAN	ICD-9-CM

PRINCIPAL DIAGNOSIS

Cyclothymic Disorder
Opiate dependence disorder

ADDITIONAL DIAGNOSES

Major Depression Disorder
Headaches

PRINCIPAL SURGERY

—

ADDITIONAL SURGERY

DATE

OTHER SIGNATURE

OTHER SIGNATURE

ASSEMBLED	CODED	ANALYZED	FINAL CHECK
4-8-00			

ATTENDING PHYSICIAN

ACCOMMODATION
☐ C.C.U. ☐ I.C.U.
☐ NEURO. ☐ POST C.C.U.

SPARTANBURG REGIONAL HEALTHCARE SYSTEM

DISCHARGED DATE 4-7-00 TIME

DISCHARGE DISPOSITION ☐ ALIVE ☐ AUTOPSY ☐ DEATH +48 ☐ DEATH -48 ☐ STILLBORN ☐ TRANSFERRED

UNIT NUMBER 000-546015

PATIENT

ACCOUNT NO.	ADMISSION DATE / TIME	FC	DATE OF BIRTH	AGE	SEX	RACE	MS	SERVICE	STATION	ROOM NO.	ACC	PAT. TYPE
S [redacted]	03/30/00 2357	CH	08/15/57	42Y	F	1	U	PSY	3S	005-A	P	NII

RESIDENT/REFERRING DOCTOR	ADMITTING DOCTOR	ACCIDENT / WORK RELATED	ACCIDENT DATE / TIME	ADM. TYPE / SOURCE
CASTON,CHRIS	CASTON,CHRIS	NO		1 7

PATIENT

PATIENT INFORMATION
DOVE,GAYLE ANN
225 RIVER FOREST DR
BOILING SPRINGS SC 29316

SOC. SEC. NO. [redacted]
TELEPHONE NO. (864)578-2316

EMPLOYERS

PATIENT EMPLOYER

TELEPHONE NO.

GUARANTOR

GUARANTOR NAME AND ADDRESS
DOVE,GAYLE ANN
225 RIVER FOREST DR
BOILING SPRINGS SC 29316

SOC. SEC. NO. [redacted]
(864)578-2316
RELATION SELF

GUARANTOR EMPLOYER

TELEPHONE NO.
OCCUPATION DISABLED

RELAT

RELATIVE 1
[redacted],JOPHN
(864)578-[redacted]
DAUGHTER/SON
80093

RELATIVE EMPLOYER
UNK

INSURANCE

INSURANCE 1
CHAMPUS/TRICARE
P O BOX 7031
CAMDEN SC 29020-7031
AF DOVE,GAYLE;ANN
RET E5 [redacted]
1

INSURANCE 2
CHAMPUS/1500
P O BOX 7031
CAMDEN SC 29020-7031
AF [redacted];ANN
RET E5 [redacted]
1

INSURANCE 3
MEDICARE PSYC
2300 SPRINGDALE DRIVE
CAMDEN SC 29020
DOVE,GAYLE;A [redacted]
1

INSURANCE 4

MISC

DIAGNOSIS / COMPLAINT
977.9-POISON-MEDICINAL AGT NOS

ARRIVAL MODE	PUB / VAL	ADM. BY
EMS	N	KBM

ADV. DIR.	PAT CLA	DENOM
		UNK

PRINTED BY: SL18901
DATE 6/1/01

PREVIOUS ADMIT NAME / DATE

OBSERVATION: ☐ YES ☐ NO

AD1

REPORT NO. (1-9) 498260

DHEC PATIENT CARE FORM

Q.A. NO. 546015

ZIP NO.

PATIENT IDENTIFICATION (Please Print)

LAST NAME (10–29): DOVE | FIRST NAME (30–45): GAYLE | MI (46): A

STREET (47–71): 225 River Forrest Dr | APT. #:

CITY (72–87): Boiling Springs | STATE (88–89): SC | ZIP CODE (90–94): 29316

SEX (95): 2 Female

RACE (96): 1 White

AGE (97–100): 08-23 — CHECK ONE: 1 YRS.

8-15-57

DISPOSITION (101–102)

01 TREAT/NO TRANS.
02 DOA AT SCENE
03 HOSPITAL ER
04 HOSP. DIR. ADMIT.
05 TRAUMA CENTER
06 PATIENT'S HOME
07 NURSING HOME
08 DR.'S OFFICE
09 OUTPATIENT
10 PT. REFUSED TREAT.

TYPE OF INCIDENT

TRAUMA (103): 1 MVA; 2 MC; 3 BIKES; 4 PED; 5 ASSAULT; 6 FALL; 7 FIRE; 8 INTERFAC; 9 OTHER

MEDICAL (104): 1 ENVIRON; 2 BEHAV; 3 OB/GYN; 4 RESP; 5 CARDIAC; 6 INTERFAC; 7 OTHER

PATIENT STATUS

	TO SCENE (105)	ON SCENE (106)	FROM SCENE (107)
1	EMERGENT	EMERGENT	EMERGENT
2	NONEMERGENT	NONEMERGENT	NONEMERGENT
CODE	3	5	1

INCIDENT LOCATION

ST. OR HWY. NAME OR NO.: 225 Riverforrest Dr

CITY: Boiling Springs | COUNTY (108–109): 42

SAFETY EQP (110)

1 Seatbelts; 2 Helmets; 3 Airbags; 4 Child Seat; 5 None; 6 Unkn.

SITE OF INCIDENT (111)

1 ROADWAY; 2 RESIDENCE; 3 INDUSTRIAL; 4 RECREATIONAL; 5 AGRICULTURAL; 6 OTHER

PRELIMINARY IMPRESSIONS (MARK NO MORE THAN 4) (112–119)

03 Seizure; 04 Diabetic; 11 Abrasion/Contusions; 13 Laceration; 23 Fracture; 24 Multitrauma/Shock; 30 Head Injury; 32 Spinal Injury; 64 Stroke; 51 G.I. Problems; 74 Respiratory Distress; 80 Coronary Problems; 83 Cardiac Arrest; Other; Other

PRIMARY IMPRESSION (120–121)

94

TREATMENT PROCEDURES (122–155)

01 Dressing Applied; 02 Limb Splinted; 03 Spine Immobilized; 04 Neck Immobilized; 05 OB Assistance; 06 Oral Airway Used; 07 Oxygen Given; 08 Suction Used; 09 Antishock Trousers; 10 Airway Maintained; 11 Antishock Treatment; 12 Artificial Resp.; 13 Cardiac Massage; 14 Bleeding Controlled; 15 Cold Application; 16 Patient Restrained; 17 Other (Use Comments)

ICD9 CODE (156–160)

SITE OF TRAUMA (161–169)

1 Head; 2 Face; 3 Neck; 4 Chest; 5 Abdomen; 6 Hip/Pelvis; 7 Upper Extr.; 8 Lower Extr.; 9 Back

ADVANCED PROCEDURES (170–197)

1. EKG Monitored — Rhythm: ST — Time: 0309
2. First Defib Attempted — Watt Sec — Time
   Post Defib — Rhythm
3. Second Defib Attempted — Watt Sec — Time
   Post Defib — Rhythm
4. Third Defib Attempted — Watt Sec — Time
   Post Defib — Rhythm
5. INTUBATED (Method) — Size
6. EXTERNAL PACING
7. BLOOD DRAWN — DEXTROSE 50% — 10
8. IV STARTED/GAUGE 18 — SOLUTION NS — RATE 200cc/hr — IV TIME 0247 — IV VOLUME 100
9. IV STARTED/GAUGE — SOLUTION — RATE — IV TIME — IV VOLUME
10. PLEURAL DECOMPRESSION
11. INTRAOSSEOUS INF. — 14. IV ATTEMPTED
12. AUTOMATIC DEFIB
13. PATIENT/ASSISTED MEDS

Ordering Physician (Name) (Signature)

DRUGS USED (198–213)

	DRUG	DOSE	TIME	DRUG	DOSE	TIME
1	IV	2mg	0248			
2						
3						
4						

REVISED TRAUMA SCORE

GCS: (214) EYES 4; (215) VERBAL 2; (216) MOTOR 5; (217–218) GLASGOW 11

(219–221) SBP 3; (222–224) RR 4; RTS (226–227)

(225) ANATOMICAL INJ. 1 YES 2 NO

VITAL SIGNS

BP	PULSE	RESPIRATONS	PUPIL	LEVEL OF CONSC.	TIME
80/64	RATE 106 REG. IRREG.	RATE 24 REG. IRREG.	D	P	2259
90/60	103 REG. IRREG.	20 REG. IRREG.	B	V	2310
100/53	101 REG. IRREG.	24 REG. IRREG.	E	A	2330
1	REG. IRREG.	REG. IRREG.			
1	REG. IRREG.	REG. IRREG.			

AVPU

EXPOSURE TO PT's BODY FLUIDS? (228) 1. YES 2. NO

1ST Responder (229) 1. YES Name NSED E-11 2. NO

COMMENTS (INCLUDE CHIEF COMPLAINTS, OBSERVATIONS AT SCENE, RESPONSE TO STIMULI)

42 y/o overdose pt requiring O2, Man IV, Meds & transport

SEE PG 11

Patient Care Form Left In (230): 1. ED 2. ICU 3. OTHER

See Page 2

TIME RECORD

RUN DATE (231–238): MONTH 03 DAY 30 YEAR 00

Call Received (239–242)	2259
Call Dispatched (243–246)	2253
Departed Base (247–250)	2254
Arrive Scene (251–254)	2259
Departed Scene (255–258)	2322
Arrive Destination (259–262)	2330

CAUSE OF DELAY

PRINTED BY: [illegible]

DATE 3/30/00

DHEC PERMIT NO. (263–267): 57601

RECEIVING AGENCY (268–271): 7020

SENDING AGENCY (272–275)

PROVIDER TIME (OPTIONAL): 2018

ATTENDANT'S SIGNATURE & CERTIFICATION NO.

PRIMARY PATIENT ATTENDANT (276–280): 92644

2ND ATTENDANT/DRIVER (281–285)

3RD ATTENDANT/DRIVER (286–290)

(RECEIVING NURSE OR PHYSICIAN)

DHEC 1050 REV. (08/1998)

RECEIVER'S COPY

FIELD DRUGS

01 Sodium Bicarbonate
02 Epinephrine SQ
03 Epinephrine IV
04 Atropine Sulfate
05 Lidocaine HCL
06 Furosemide
08 Diphenhydramine
09 Heparin Lock Flush
10 Diazepam
11 Naloxone
13 Nitroglycerin Spray
14 Nitroglycerin Sublingual
15 Dextrose 50%
16 Nitrous Oxide
17 Bretylium Tosylate
18 Dobutamine HCL
19 Nalbuphine HCL
22 Morphine Sulfate
23 Oxytocin
24 Dopamine HCL
25 Procainamide HCL
26 Terbutaline Sulfate SQ
27 Syrup of Ipecac
28 Activated Charcoal USP
29 Adenosine
30 Glucagon USP
31 Albuterol
33 Proparacaine HCL
34 Calcium Gluconate
35 Thiamine
36 Aspirin
37 Ativan
38 Diltiazem
39 Flumazenil
40 Ibuprofen
41 Labetalol
42 Racemic Epinephrine

PATIENT COMPLAINT SIGNALS

Type of Incident

TRAUMA
11 ABRASION/CONTUSION
12 AVULSION
13 LACERATION
14 PUNCTURE/STAB
15 GUNSHOT WOUND
16 BURN
17 HEMORRHAGE
18 ELECTROCUTION
19 CHEST INJURY
20 CRUSHING
21 AMPUTATION
22 DISLOCATION
23 FRACTURE
24 MULTITRAUMA/SHOCK
25 PATIENT TRAPPED
28 EYE INJURY
29 SPRAIN/STRAIN
30 HEAD INJURY
31 PARALYSIS
32 SPINAL INJURY
37 ANIMAL BITE
38 SNAKE BITE

CARDIAC/STROKE
80 CORONARY PROBLEM
81 CONGESTIVE HEART FAILURE
82 HYPERTENSION
83 CARDIAC ARREST
84 CVA/TIA/STROKE
85 HYPOTENSION

RESPIRATORY
70 APNEA
71 AIRWAY OBSTRUCTION/ CHOKING
72 HYPERVENTILATION
73 PULMONARY EDEMA
74 RESPIRATORY DISTRESS
75 ANAPHYLACTIC/TOXIN SHOCK
76 NEAR DROWNING

ENVIRONMENTAL
01 HEAT EXHAUSTION
02 HEAT STROKE

BEHAVIORAL
40 HYSTERIA
41 FAINTING
43 PSYCHIATRIC/ BEHAVIORAL
44 OVERDOSE
45 IMPAIRMENT SIMILAR TO ALCOHOL

OB/GYN
60 OB PRENATAL
61 OB POSTNATAL
62 OB EMERGENCY
63 OB ABORTION
64 GYN PROBLEM
65 OB DELIVERY

OTHER
03 SEIZURE
04 DIABETIC [illegible]
05 INSULIN SHOCK
06 POISONING
07 COMMUNICABLE DISEASE
08 UNCONSCIOUS
09 DEAD ON ARRIVAL-NO TRANS.
10 DEAD ON ARRIVAL-TRANS.
50 VOMITING
51 G.I. PROBLEMS
52 G.U. PROBLEMS
90 UNKNOWN COMPLAINT
91 TRANSPORT FOR EXAM
92 NONEMERGENCY TRANSPORT
93 NO TRANSPORT
94 CANCELLED CALL
95 FALSE CALL

GLASGOW

EYE OPENING:	
SPONTANEOUS	4
TO VOICE	3
TO PAIN	2
NONE	1
VERBAL:	
ORIENTED	5
CONFUSED	4
INAPPROPRIATE WORDS	3
INCOMPREHENSIBLE	2
NONE	1
MOTOR:	
OBEYS COMMANDS	6
LOCALIZES PAIN	5
WITHDRAW (Pain)	4
FLEXION (Pain)	3
EXTENSION (Pain)	2
NONE	1

INTERHOSPITAL DRUGS

52 HEPARINE SODIUM INF.
53 HYPERALIMENTATION INF.
54 INSULIN INFUSION
55 MAGNESIUM SULFATE INF.
56 MANNITOL INFUSION
57 MULTI-VITAMIN INF.
58 NITROGLYCERIN INF.
59 POTASSIUM CHLORIDE INF.
60 SODIUM NITROPRUSSIDE INF.
61 SOLU-MEDROL INF.
62 STREPTOKINASE INF.
63 TISSUE PLASMINOGEN ACT. INF.
64 WHOLE BLD/PACK RED CELL INF.
65 DEXTROSE 10% INF.
66 ANTIBIOTICS
67 AMINOPHYLLINE
68 PROMETHAZINE
69 IV H2 ANTAGONISTS

REVISED TRAUMA SCORE

GLASGOW COMA SCORE	SYSTOLIC BP	RESPIRATORY RATE	CODE VALUE
13–15	>89	10–29	4
9–12	76–89	>29	3
6–8	50–75	6–9	2
4–5	1–49	1–5	1
3	0	0	0

SELECTED ANATOMICAL INJURIES

1. ALL PENETRATING INJURIES TO HEAD, NECK, TORSO AND EXTREMITIES PROXIMAL TO ELBOW AND KNEE.
2. FLAIL CHEST.
3. COMBINATION TRAUMA WITH BURNS.
4. TWO OR MORE PROXIMAL LONG BONE FRACTURES.
5. PELVIC FRACTURES.
6. LIMB PARALYSIS.
7. AMPUTATION PROXI[illegible] TO WRIST AND ANKLE.

VITAL SIGNS

PUPILS	LEVEL OF CONSC.
E = EQUAL	A = ALERT
U = UNEQUAL	V = VERBAL ST.
N = NO RESP.	P = PAINFUL ST.
C = CONSTR.	U = UNRESP.
D = DILATED	

LIST OF CODE NUMBERS OF S.C. COUNTIES

01	Abbeville	24	Greenwood
02	Aiken	25	Hampton
03	Allendale	26	Horry
04	Anderson	27	Jasper
05	Bamberg	28	Kershaw
06	Barnwell	29	Lancaster
07	Beaufort	30	Laurens
08	Berkeley	31	Lee
09	Calhoun	32	Lexington
10	Charleston	33	McCormick
11	Cherokee	34	Marion
12	Chester	35	Marlboro
13	Chesterfield	36	Newberry
14	Clarendon	37	Oconee
15	Colleton	38	Orangeburg
16	Darlington	39	Pickens
17	Dillon	40	Richland
18	Dorchester	41	Saluda
19	Edgefield	42	Spartanburg
20	Fairfield	43	Sumter
21	Florence	44	Union
22	Georgetown	45	Williamsburg
23	G[illegible]nville	46	Yo[illegible]

DHEC 105[illegible] 8/1998)

SPARTANBURG HOSPITAL SYSTEM

MEDICAL HISTORY (within 48 hours after admission)

Date: _____ Time: _____

RECORD ALL POSITIVE & NEGATIVE FINDINGS:

1. Chief Complaints
2. History of Present Illness
3. History of Past Illness
   a. Operations
   b. Serious Illness
   c. Allergies
4. Family History
5. Social History
6. Habit History
7. System Review
   a. General
   b. Skin
   c. Head, EENT
   d. Neck
   e. Cardiovascular
   f. Respiratory
   g. GI
   h. GU
   i. GYN
   j. Musculoskeletal
   k. Neuro-psychiatric

4-1-00
Dictated
KKW, MD

[redacted]

SPARTANBURG HOSPITAL SYSTEM
MEDICAL HISTORY
CLINICAL RECORD
01

444-414 (Rev. 7/89 PHS Print Shop)

SPARTANBURG
Regional Healthcare System

☐ SRMC ☐ SHRC ☐ BJW

PHYSICIAN'S ORDER FORM

CHECK (✓) OFF EACH ORDER AS TRANSCRIBED		TIME 0430 DATE 3/31/00
	Call Dr Caston @ 0700 for orders Admit to Dr Caston's services Ht 5'6 Wt 144 lbs Allergies - NKA * RECORD FINAL DIAGNOSIS ON THE FACE SHEET	
TIME NOTED 3/31/00 Thomas RN 0940	TELEPHONE ORDER BY NURSE Nancy Reid LVN (CASH)	PHYSICIAN
✓		TIME _____ DATE _____
	* RECORD FINAL DIAGNOSIS ON THE FACE SHEET	
TIME NOTED	TELEPHONE ORDER BY NURSE	PHYSICIAN
✓		TIME _____ DATE _____
	* RECORD FINAL DIAGNOSIS ON THE FACE SHEET	
TIME NOTED	TELEPHONE ORDER BY NURSE	PHYSICIAN

PRINTED BY: SL18901
DATE 7/26/01

1107 (4/1999)

[redacted]

SPARTANBURG
Regional Healthcare System

☐ SRMC ☐ SHRC ☐ BJW

PHYSICIAN'S ORDER FORM

CHECK (✓) OFF EACH ORDER AS TRANSCRIBED		TIME 0930 DATE 3/31/00
	Home Meds: Estradiol 1mg ½ tab Q am Thiamine 100mg Q am Ranitidine 150mg BID Gabapentin 300mg tid and 600mg QHS Fluoxetine 20mg 3 tabs Qam 325/Butalbital 50/caffe 40mg Q 6° prn pain * RECORD FINAL DIAGNOSIS ON THE FACE SHEET	
TIME NOTED	TELEPHONE ORDER BY NURSE R Thomas RN / Dr Caston	PHYSICIAN
✓		TIME DATE
	Oxycodone 5mg 1-2 tabs Q 4° prn Olanzapine 5mg @ QHS Buspirone 10mg 1 tab Qam; 2 @ lunch; 1 @ HS * RECORD FINAL DIAGNOSIS ON THE FACE SHEET	
TIME NOTED	TELEPHONE ORDER BY NURSE R Thomas RN / Dr Caston	PHYSICIAN
✓		TIME DATE 3-31-00
	(1) Dc Buspirone (2) Depakote 250 mg stat then 250 mg bid (1pm + hs) (3) VA level in Am (4) ↓ Zyprexa to 2.5 mg qhs (5) ↑ Neurontin to 300 mg tid and 1200 mg qhs (6) Gabapentin level in Am * RECORD FINAL DIAGNOSIS ON THE FACE SHEET	
TIME NOTED	TELEPHONE ORDER BY NURSE	PHYSICIAN

FAXED

FAXED

FAXED

[redacted]
REF CASTON,CHRIS
[redacted]

PRINTED BY: SL18901
DATE 7/26/01
1107 (4/1999)

SPARTANBURG
Regional Healthcare System

☐ SRMC ☐ SHRC ☐ BJW

PHYSICIAN'S ORDER FORM

CHECK (✓) OFF EACH ORDER AS TRANSCRIBED

TIME _____ DATE 3-31-00

FAXED

1. Transfer to Adults Unit/ 2023.
2. Dexamethasone 1mg elixir at 11 PM tonight only
3. Cortisol levels at 7 AM and 4 PM on 4-1
4. Dexamethasone level in AM
5. Fasting Amino Acid Profile in AM

Lymeric RN 1510

* RECORD FINAL DIAGNOSIS ON THE FACE SHEET

TIME NOTED 3-31-00 1530 | TELEPHONE ORDER BY NURSE | PHYSICIAN

✓ TIME _____ DATE 4-1-00

Dave Doyle RD

FAXED

1. D/C Zyprexa
2. ↓ Prothe to 20 mg q 6 AM only
3. VA level in AM
4. Change Depakote to 250 mg q 8 AM and 500 mg q hs
5. Buspirol 30 mg qid
6. Tylox 5 mg bid (9 AM and 4 PM)

Y. Gaskell RN 1545 4/1/00

* RECORD FINAL DIAGNOSIS ON THE FACE SHEET

TIME NOTED ✓ | TELEPHONE ORDER BY NURSE | PHYSICIAN

✓ TIME _____ DATE _____

Dave Doyle RD

FAXED

1. Change Neurontin to 300 mg q 8 PM and 1200 mg hs
2. Urine drug screen today

Y. Gaskell RN 1545 4/4/00

* RECORD FINAL DIAGNOSIS ON THE FACE SHEET

TIME NOTED 1430 | TELEPHONE ORDER BY NURSE | PHYSICIAN

[redacted]

PRINTED BY: SL18901
DATE 7/26/01
1107 (4/1999)

SPARTANBURG
Regional Healthcare System

☐ SRMC ☐ SHRC ☐ BJW

PHYSICIAN'S ORDER FORM

CHECK (✓) OFF EACH ORDER AS TRANSCRIBED

TIME _____ DATE 4-2-00

FAXED

1. Change Tylox to 5 mg tid (9, 4, hs)
2. Change Depakote to 250 mg bid (1 Pm & 6 Pm) and 500 mg q hs.
3. Change Neurontin to 300 mg bid (1 Pm & 6 Pm) and 1200 mg q hs.
4. Dexamethasone 1 mg elixir at 11 Pm tonight

* RECORD FINAL DIAGNOSIS ON THE FACE SHEET

4/3

TIME NOTED 1450 | TELEPHONE ORDER BY NURSE | PHYSICIAN

TIME _____ DATE _____

FAXED

5. Cortisol levels at 7 Pm and 4 Pm on 4-3
6. VA level in Am
7. Gabapentin level in Am
8. On 4-3 ↓ Butisol to 30 mg tid (9, 1, 6)

* RECORD FINAL DIAGNOSIS ON THE FACE SHEET

4/3

TIME NOTED 1450 | TELEPHONE ORDER BY NURSE | PHYSICIAN

TIME _____ DATE 4-3-00

FAXED

1. On 4-4 change Butisol to 30 mg bid (9 & 6)
2. On 4-4 change Tylox to 5 mg bid (9 & 6)
3. Change Depakote to 250 mg bid (1 Pm & 6 Pm) and 750 mg q hs.
4. VA level in Am
5. Change Neurontin to 600 mg q 1 Pm 1230 and 1200 mg q hs.

V. Earlell 4/3/00

* RECORD FINAL DIAGNOSIS ON THE FACE SHEET

TIME NOTED 1100 | TELEPHONE ORDER BY NURSE | PHYSICIAN

[redacted]

PRINTED BY: SL18901
DATE 7/26/01
1107 (4/1999)

SPARTANBURG
Regional Healthcare System

☐ SRMC ☐ SHRC ☐ BJW

PHYSICIAN'S ORDER FORM

CHECK (✓) OFF EACH ORDER AS TRANSCRIBED		TIME _____ DATE 4-3-00
✓	① Transfer to Adult Unit 2023	
	FAXED 4/Earlerd 1125 4/3/00	
	* RECORD FINAL DIAGNOSIS ON THE FACE SHEET	
TIME NOTED 1135	TELEPHONE ORDER BY NURSE	PHYSICIAN
✓		TIME _____ DATE 4-3-00
	① PC prn Xylox and prn Fioricet	
	4/Earlerd 1125 4/3/00 FAXED	
	* RECORD FINAL DIAGNOSIS ON THE FACE SHEET	
TIME NOTED 1135	TELEPHONE ORDER BY NURSE	PHYSICIAN
✓		TIME _____ DATE 4-4-00
	① Dexamethasone 1mg elixir at 11 PM tonight only ② Cortisol level at 7 AM and 4 PM on 4-5 ③ Please notify Becky of VA level this AM and Cortisol at 4 PM on 4-3 not being drawn ④ On 4-5 ↓ Betisol to 30 mg @ 9 AM only FAXED	
	* RECORD FINAL DIAGNOSIS ON THE FACE SHEET	
TIME NOTED	TELEPHONE ORDER BY NURSE	PHYSICIAN

4/4/00 1550 ar

PRINTED BY: SL18901
DATE 7/26/01
1107 (4/1999)

[redacted]

SPARTANBURG
Regional Healthcare System

☐ SRMC ☐ SHRC ☐ BJW

PHYSICIAN'S ORDER FORM

CHECK (✓) OFF EACH ORDER AS TRANSCRIBED

TIME _____ DATE 4-4-00

FAXED

1. VA level in Arm
2. + Tylox #6 1 bid (9 + 6)
3. Change Neurontin to 600 mg bid (1 PM + 6PM) and 1200 mg qhs
4. Neurology consult: Re: "Migrain HA"
5. Parrotec N-100 1 q 4 hrs prn HA and Phenergan 25 mg q.o.q 4 hrs prn HA - Give together

* RECORD FINAL DIAGNOSIS ON THE FACE SHEET

TIME NOTED	TELEPHONE ORDER BY NURSE	PHYSICIAN

✓

TIME _____ DATE 4-4

6. Tobrepatin level in Arm
7. Parrotec N-100 1 stat
8. Phenergan 25 mg 1 stat

FAXED

Riddle RN 4/4/00 1545 AR

* RECORD FINAL DIAGNOSIS ON THE FACE SHEET

TIME NOTED	TELEPHONE ORDER BY NURSE	PHYSICIAN

✓

TIME 6PM DATE 4/4/00

FAXED

1. DHE-45 1 mg SC BID x 10 days
2. Reglan 10 mg PR BID x 10 days (together with DHE-45)
3. NC Phenergan
4. Pt to Dr. Geraghty office in 6 weeks

(Christian) 4/4/00 1820

* RECORD FINAL DIAGNOSIS ON THE FACE SHEET

TIME NOTED	TELEPHONE ORDER BY NURSE	PHYSICIAN

[redacted]

PRINTED BY: SL18901
DATE 7/26/01
1107 (4/1999)

SPARTANBURG
Regional Healthcare System

☐ SRMC ☐ SHRC ☐ BJW

PHYSICIAN'S ORDER FORM

CHECK (✓) OFF EACH ORDER AS TRANSCRIBED		TIME _____ DATE 4-5
FAXED	① On 4-6 ↓ Tylox to 1 q 9 Am only ② DC Butisol ③ Change Neurontin to 600 mg q 1 Pm and 1800 mg q h.s. ④ Dexamethasone Ivy elixir 8 mg 11 Pm tonight only ⑤ Cortisol level at 7 Am and 4 Pm on 4-6 ⑥ Change Depakote to 250 mg bid (1 Pm & 6 Pm) and 1000 mg q h.s. * RECORD FINAL DIAGNOSIS ON THE FACE SHEET	
TIME NOTED	TELEPHONE ORDER BY NURSE	PHYSICIAN

		TIME _____ DATE 4-5
FAXED	⑦ VA level in Am ⑧ Esgalith 450 mg stat then 450 mg q 9 Am ⑨ Lithium level in Am * RECORD FINAL DIAGNOSIS ON THE FACE SHEET	
TIME NOTED 1520 T. Kirby 4-5-00	TELEPHONE ORDER BY NURSE	PHYSICIAN

✓		TIME _____ DATE 4/6
	DC Dexamethasone elixir tonight. Cancel Cortisol AM + PM for ~~4/5~~ 4/6 Donna Palmer RN 4/5/00 1940 * RECORD FINAL DIAGNOSIS ON THE FACE SHEET	
TIME NOTED	TELEPHONE ORDER BY NURSE	PHYSICIAN

PRINTED BY: SL18901
DATE 7/26/01

1107 (4/1999)

[redacted]

SPARTANBURG
Regional Healthcare System

☐ SRMC ☐ SHRC ☐ BJW

PHYSICIAN'S ORDER FORM

CHECK (✓) OFF EACH ORDER AS TRANSCRIBED

TIME _____ DATE 4-6-00

(1) Change Eskalith to 450 mg q 9Am and 225 mg q 6 Pm
(2) Lithium level in Am and in 1 week 7/6 ✓
(3) Discharge on 4-7 : List all meds
✓ 1. Eskalith 450 mg q 8Am and 225 mg q 6Pm
2. Estradiol 0.5 mg q day
✓ 3. Neurontin 600 mg q 1Pm and 1800 mg q h.s.

* RECORD FINAL DIAGNOSIS ON THE FACE SHEET

TIME NOTED	TELEPHONE ORDER BY NURSE	PHYSICIAN

✓ TIME _____ DATE _____

✓ 4. Depakote 500 mg q 1Pm and 1000 mg q h.s.
✓ 5. Prozac 20 mg q 8Am
6. Metoclopramide 10 mg bid (Ps. Ghoreishi)
7. DHE 45 ~~Inj~~ 1 mg bid (Ps. Ghoreishi)
8. Thiamine 100 mg q day
9. Ranitidine 150 mg bid

* RECORD FINAL DIAGNOSIS ON THE FACE SHEET

TIME NOTED	TELEPHONE ORDER BY NURSE	PHYSICIAN

FAXED

TIME _____ DATE _____

✓ 10. Percocet N-100 1 q 6h prn headache
(4) VA level in Am and in 1 week
(5) Carbopentin level in 1 week
(6) BMP in 1 week
(7) Appt Dr. Ghoreishi in 1 week - 4-14-00 @ 3:30 pm
(8) Appt Spartanburg MHC in 1 week / 4-14-00 @ 10 AM c Kathy
(9) Ativan 1 mg IM x 1 now

* RECORD FINAL DIAGNOSIS ON THE FACE SHEET

TIME NOTED	TELEPHONE ORDER BY NURSE	PHYSICIAN

AUG 8 PM 3 Q

PRINTED BY: SL18901
DATE 7/26/01
1107 (4/1999)

[redacted]

COLUMBIA V.A.
WJB DORN VETERANS' MEDICAL CTR
6439 GARNERS FERRY ROAD
COLUMBIA SOUTH CAROLINA 29209

May 11, 2001

In Reply Refer To: 544/136
DOVE,GAYLE A
515-64-6094

SPARTANBURG REGIONAL MED CTR
PO BOX 651602
CHARLOTTE NC 28265-1602

REGARDING: VETERAN: GAYLE A DOVE
FEE PROGRAM: CIVIL HOSPITAL
EPISODE OF CARE: Mar 30, 2000 to Apr 07, 2000

We have received your request for payment of medical services which were not authorized. Before we are able to process your claim the following information is needed:

DOCTOR'S DAILY PROGRESS NOTES REQUIRED

History and Physical needed for this episode of care.

Discharge summary is needed for this episode of care.

EMERGENCY ROOM MEDICAL REPORT IS NEEDED.

We ask that you be prompt in supplying the requested information. Failure to provide all the information within a year will result in an automatic disapproval. Legislation requires that we notify you if your claim cannot be processed if entitlement to the services rendered has not been established. Without the information requested above, we cannot consider your request for payment as a proper invoice.

If you wish us to process this claim, please resubmit the entire claim with the items listed to the above address. We will notify you of our decision.

The U.S. Department of Veterans Affairs assumes no financial responsibility for any costs incurred in obtaining the above information.

Sincerely,

Carolyn L. Barrett, Chief
Health Benefits Office

cc: Veteran

2009001336 3

APPROVED OMB NO. 0938-02

SPARTANBURG REG
PO BOX 651607
CHARLOTTE NC 28265-1602
(864) 560-4123

[redacted]

3 PATIENT CONTROL NO. [redacted] | 4 TYPE OF BILL: 111

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N- [redacted]
576000934	033000	040700	008	

12 PATIENT NAME	13 PATIENT ADDRESS
MURRAY,GAYLE DOVE	992 PARK VIEW PL GULFPORT MS 39507-3637

14 BIRTHDATE	15 SEX	16 MS	ADMISSION DATE	HR	TYPE	SRC	19 D HR	20 STAT	21 MEDICAL RECORD NO.	CONDITION CODES 22	23	24	25	26	27	28	29	30
08151957	F	M	033000	23	1	7	11	01	[redacted]	80								

	31 CODE	31 OCCURANCE DATE	32 CODE	32 OCCURANCE DATE	33 CODE	33 OCCURANCE DATE	34 CODE	34 OCCURANCE SPAN FROM	THROUGH	37
a	11	033100	18	020199	42	040700				A
b										B 9
										C 9

MURRAY,GAYLE DOVE
992 PARK VIEW PL
GULFPORT MS 39507-3637

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	02	000	08	000	09	0
b						
c						
d						

	42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	114	PSYCH/PVT	580.00		8	464000		
2	250	PHARMACY			6	41628		
3	259	DRGS/OTHER			196	170049		
4	270	MED/SUR SUPPLY			9	3200		
5	300	LABORATORY			24	262400		
6	450	EMERGENCY ROOM			1	7100		
7	636	DRUGS/DETAIL CODE			1	754		
8	730	EKG/ECG			1	3300		
9	981	PRO FEE/ER			1	13100		
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	001	TOTAL CHARGES	4-28-80 1862			965531		

	50 PAYER	51 PROVIDER	52 REL MED	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	618 MEDICARE PSYC	42S007	Y	Y	87483		
B	620 MEDICARE PART B COMP/	3365	Y	Y			
C	633 VETERNANS ADMINISTRAT	576000934	Y	Y			

57 DUE FROM PATIENT

	58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	DOVE,GAYLE ANN	01	[redacted]		
B	DOVE,GAYLE ANN	01			
C	MURRAY,GAYLE A	01		VA	[redacted]

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A	Poison poisons	8		
B		8 DISABLED		
C				

67 PRIN. DIAG. CD.	68	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM.DIAG.CD.	77 E-CODE	78
96500	30400	30113	29620	30189	34690	E8499			9779	E8502	04

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	82 OTHER PROCEDURE CODE	DATE
9	9465	033000	A		B	
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	C		D		E	

84 REMARKS VETERNANS ADMINISTRATION SUPP
1801 ASSEMBLY STREET

COLUMBIA SC 29201

[redacted]

CASTON CHRIS
A
CASTON CHRIS
B
CASTON CHRIS

95 PROVIDER REPRESENTATIVE X Williams Sandra | 96 DATE 041701

SPARTANBURG REGIONAL HEALTHCARE SYSTEM — TE — 405-085 (8/98)

ROOM 3

CHIEF COMPLAINT: SOB/cough/vomiting x 4 days ☐ SEE EMSTAT SHEET

PHYSICIAN ASSESSMENT ☐

Amicar

ALLERGIES: NKDA

☐ HEADACHE ____ KOH ____
☐ RESTRAINT ____ HEMOCCULT ____

TIME INIT.	TEMP.	PULSE	RESP.	B / P
	99.4	102	30	140/66

RESTRAINTS

DATE: ____ TIME: ____

REASON FOR RESTRAINT (BEHAVIOR): ____

TYPE OF RESTRAINT: ____

MD SIGNATURE: ____

X-RAY & LAB ☐ PCXR/EKG 2205

RESULTS Vomiting SM resolved x3 Mucinex 0.5cm " BP Prednisone 50mg po

RA O2 Sat 100% FeBs ____

DIAGNOSIS: ____ ICD-9-CM ____

PLANS/INTERVENTION ☐ RESPONSE

HHN Tx Initiated noted

1. Ventolin 5mg / Atrovent 0.5mg x3
2. Prednisone 50mg po
3. Tylenol #3 2 po

D/C-TRSF. INSTR. INITIAL

VALUABLES / CLOTHING / MEDS
☐ WITH PATIENT ☐ LOCKED
☑ WITH FAMILY ☐ NONE

DISPOSITION ☐ HOME ☐ MORGUE TIME:
☐ ADMIT ☐ OR ☐ TRANSFER

DISCHARGE / TRANSFER CONDITION Good

DISCHARGED BY: ____

DISCHARGE INSTRUCTIONS ☐ LACERATIONS ☐ CAST CARE ☐ ABDOMINAL PAIN ☐ FEVER ☐ PAIN MEDICATION ☐ CHEST PAIN ☐ EAR INFECTION ☐ BRUISE/SPRAIN ☐ HEAD INJURY ☐ VOMIT/DIARRHEA ☐ ANTIBIOTIC INST. ☐ CLEAR LIQUID ☐ GYN PROBLEM ☐ URINARY TRACT INFEC.

I CERTIFY THAT I UNDERSTAND THE INSTRUCTIONS GIVEN ME: X Gayle A. Murray PATIENT'S SIGNATURE

LOGGED BY/TIME:

X-RAY & REF.	ADMIT/ATTENDING PHYSICIAN	DIAGNOSIS	SPECIAL BED REQUEST	MESSAGE SENT ☐ TIME:	INITIAL:

PATIENT DISABLED FOR: ____ DAYS

MAY RETURN TO WORK/SCHOOL ON: ____

BEEPED ____ PAGED ____ RESPONDED ____

BEEPED ____ HOME/OFFICE ____

PHYSICIAN'S SIGNATURE AP

CONSULTING PHYSICIAN'S SIGNATURE

I.M. 1. LEFT DELTOID 2. RIGHT DELTOID 3. RT. VASTUS LATERALIS 4. LT. VASTUS LATERALIS 5. RT. VENTRO GLUTEAL 6. LT. VENTRO GLUTEAL 7. RT. GLUTEUS 8. LT. GLUTEUS S.C. 9. ABD WALL 10. RT. ARM 11. LT. ARM 12. RT. LEG 13. LT. LEG

BATCH TIME INITIAL

PATIENT

ACCOUNT NO.	ADMISSION DATE / TIME	FC	DATE OF BIRTH	AGE	SEX	RACE	MS	SERVICE		PAT. TYPE	BY
[redacted]	11/06/00 2156	MC	08/15/57	43Y	F	1	M	EME	8	ER	SAM

ATTENDING DOCTOR	ACCIDENT / WORK RELATED	ACCIDENT DATE / TIME	ADM. TYP
PHYSICIANS,ED	NO		1 7

PATIENT INFORMATION
MURRAY,GAYLE DOVE
225 RIVER FOREST DR
BOILING SPRINGS SC 29316 (864)578-8093

SOC. SEC. NO. [redacted]
DATE OF BIRTH 5/10/01
TELEPHONE NO. 515-64-6094

PATIENT EMPLOYER

TELEPHONE NO.

PRINTED BY: JA16169

CHART COPY

I understand that my physician, Dr. _____, has been consulted by phone and that he has prescribed treatment for me. I agree to accept this treatment without examination by my physician.

PATIENT SIGNATURE _____ DATE _____ WITNESS _____ DATE _____

RELEASE FROM RESPONSIBILITY FOR DISCHARGE

I certify that the patient named on this charge is being discharged against the advice of the attending physician and of the hospital administration. I acknowledge that I have been informed of the risks involved and hereby release the attending physician, his associates, and the hospital and any of its personnel from all responsibility for any ill effects which may result from such discharge.

DATE _____ NAME OF PATIENT _____

WITNESS _____ SIGNATURE OF PATIENT OR AUTHORIZED PERSON _____

RELATIONSHIP TO PATIENT _____

HEADACHES

Onset _____ Duration _____
Similarity to past HA: _____
Age at onset HA: _____
Family Hx list relatives: _____
Date of last visit to ED: _____ LMD _____
Headache MD _____ Last visit _____
List Meds taken for this HA: _____
Pain Scale 1 = slight - 10 = worse: _____

LONG SPINE BOARD/CERVICAL COLLAR REMOVAL BY RN

Mechanism of Injury _____
GSC _____ Trauma Score _____
Pain _____ (Location)
Motor Strength: 1 2 3 4 5
RA
LA
RL
LL
Time of board removal _____
Time of C-collar removal _____
RN Signature _____

REVISED TRAUMA SCORE

I. Glascow Coma Scale
a. Eye Opening
Spontaneous 4
To Voice 3
To Pain 2
None 1
b. Verbal Response
Oriented 5
Confused 4
Inappropriate 3
Incomprehensible Words 2
None 1
c. Motor Response
Obeys Commands 6
Purposeful Movements 5
Withdrawn (pain) 4
Flexion (pain) 3
Extension (pain) 2
None 1
GCS = a+b+c
Total GCS points Coded Value
13-15 4
9-12 3
6-8 2
4-5 1
3 0

II. Respiratory Rate
10-29/min. 4
>29/min. 3
6-9/min. 2
1-5/min. 1
None 0

III. Systolic Blood Pressure
Actual SBP
>89 4
76-89 3
50-75 2
1-49 1
0 0

RTS=I+II+III

[redacted] DATE 5/10/01

SPARTANBURG HOSPITAL SYSTEM
EMERGENCY DEPARTMENT
NURSES' PROGRESS NOTES

VITAL SIGNS NAME UNIT #

22:06	140/106(113) mmHg	PR=115 (NIBP)
22:10	124/ 75(80) mmHg	PR=119 (NIBP)
22:25	98/ 42(69) mmHg	PR=108 (NIBP)
22: 40	143/ 85(102) mmHg	PR=107 (SPO2)
22:55	NO READING	

INTERVAL q 15 min
LAST BP= 02:5[illegible] 11/07

NIBP

NO READING
NO DATA
???

INITIALS	FULL NAME	TITLE

Murray, Gail

PRINTED BY: JAG 2001 MAY 11 PM 12:38

DATE: DATE 5/10/01

SHS-466-188-B

Spartanburg Regional Healthcare System
101 E. Wood St.

Emergency Department
(864)560-6222
Assessment Sheet

MR # 546015 Sex: Female DOB: 08/15/1956
Name: Murray, Gayle A
Phone:
Address: , ,
Unit Code: BLUZN [redacted]6 Age: 44

Complaint: Resp distress
Arrival Date/Time: 21:39 11/06/2000
Arrived by: (-Private Vehicle)
Mobility: Ambulatory
Primary Care: Unassigned,
Accompanied By: friend/family

Acuity: 1 - Emergent
Insurance:
Amb/Helicopter:
Referring Facility:
Emergency Physician: Reynolds, Stuart

Complaint Code: Respiratory
Treatment PTA:

Triage Nurse: Barnett RN, Tami

Past Medical Hx:
Tetanus History:
Social History:
Weights:
LMP Date:

Medications

Medication	Dosage	Freq	Prescribing Phys	Started
Inhaler				
*Other - See Note				

Allergy

Allergy	Allergic Reaction
*No Known Allergies	

Vital Signs

Inits	Time	Temp	Blood Pressure	Pulse	Resp
MM	21:42	98.4 O	125/84 Automatic,Sitting,Right Arm	132	20

Pain

Time	Scale

Pulse Ox.

Time	%

Pupils

Time	L(mm)	R(mm)

Glasgow Coma

Time	Score

Disposition Information
Primary Diagnosis: Asthma
Secondary Diagnosis: Bronchitis
Disposition: Disch - Home
Report Called By:
Prescriptions: Acetaminophen w/codeine 1-2 q3-4 #12), Biaxin 500 mg 1 p.o. BID, Flovent inhaler puffs bid, Ventolin inhaler, Prednisone 20 mg
Discharge Instructions: ASTHMA, ACUTE BRONCHITIS
Disability Statement:
Follow-up Care:
Discharge Time: 02:41 11/07/2000

Family Notification:
Report Given To:

Appt Date/Time:

Initials	Name	Initials	Name

PRINTED BY: JA16169 DATE 5/10/01

Spartanburg Regional Healthcare System
101 E. Wood St.

Emergency Services
(864)560-6222
Assessment Sheet

MR # 546015 Sex: Female DOB: 08/15/1956
Name: Murray, Gayle A
Phone:
Address: , ,
Unit Code: BLUZN [redacted]

Triage/Initial Assessment

21:42 11/06/2000 - Vital Signs -- Mandy Madrigal PCT
Temp: 98.4 Oral
BP: 125/84, Automatic, Sitting, Right Arm, regular cuff
HR: 132
Resp: 20
21:49 11/06/2000 - Initial Triage Info -- Tami Barnett RN
Quick Assessment: Alert and oriented X3, Ambulatory to Emergency Dept., BREATHING cough productive, BREATHING short of breath, SKIN diaphoretic
Complaint Category: Respiratory
Chief Complaint: Tr
Initial Triage Acuity: 2 - Urgent
Note: Pt. unable to talk due to cough. Hx of pneumonia and bronchitis.

Assessment

21:49 11/06/2000 - Allergy Information -- Tami Barnett RN
Allergy A: *No Known Allergies
21:50 11/06/2000 - Medicine -- Tami Barnett RN
Medication A: Inhaler
Medication B: *Other - See Note
Note: dayquil and nyquil.
23:20 11/06/2000 - Reassessment -- Jim Hardin RN
Note: Received report from Stephen Baldwin, RN. Pt taking HHN TX. vitals stable.
23:21 11/06/2000 - Primary Survey -- Laura Ellis
Airway: INTACT
Breathing: PRESENT
Breath sounds - L: Diminished - lower, Ronchi, Upper airway congestion, Wheezing - audible, Wheezing - inspiratory
Breath sounds - R: Diminished - lower, Ronchi, Upper airway congestion, Wheezing - inspiratory, Wheezing - audible
Circulation: adequate
Radial - L: Present
Radial - R: Present
Dorsal Pedis - L: Present
Dorsal Pedis - R: Present
Cap refill: brisk
RUE Strength: normal
RLE Strength: normal
LUE Strength: normal
LLE Strength: normal
Note: pt. a/ox3,peri VSS ,skin p/w/d, ABD . soft nt nd pos. bs mAE NAD noted
23:23 11/06/2000 - Secondary Survey -- Laura Ellis
Note: relates she has had sob and a non-productive cough last 2 days that has gotten worse today with cold sweats some n/v no diarrhea , ? fever denies other c/o
00:08 11/07/2000 - Reassessment -- Donna Threlkeld WS
Other Assessment: Family at bedside, Resting comfortably, Respiratory therapist with patient
01:18 11/07/2000 - Reassessment -- Donna Threlkeld WS
Other Assessment: Family at bedside, Physician with patient, Resting comfortably
02:39 11/07/2000 - Reassessment -- Donna Threlkeld WS
Other Assessment: Family at bedside, Resting comfortably
02:41 11/07/2000 - Discharge Condition -- Donna Threlkeld WS
Acuity: 3 - Non-urgent
Condition: good
Mobility at Discharge: Ambulatory
Patient Teaching: Follow-up plan of care reviewed w/ pt, Pt voiced understanding of plan of care, Written dx instructions reviewed w/ pt
Mode of Discharge: Private Vehicle

PRINTED BY: JA16169
DATE 5/10/01

32 Dyspnea (COPD, CHF, and Other) (5)

TIME SEEN: 2230 ROOM: 3 __ EMS Arrival
HISTORIAN: ✓patient __spouse __paramedics
__HX / __EXAM LIMITED BY:

HPI
chief complaint: shortness of breath *(hx of: asthma / COPD / CHF)*

started: 10/7

__continues in E.D.
__gone now __better
__intermittent
__worse

severity:
mild moderate severe

exacerbated by:
exertion laying flat
coughing

associated symptoms:

PULMONARY
✓cough
sputum
non-productive
blood-tinged sputum
frank hemoptysis
✓fever
subjective / to ____ °F
__chills
✓sweating

CVS
__chest discomfort
left / right / central
upper / lower
pain / discomfort / tightness
sharp / burning / pressure
worse with deep breaths
constant / intermittent
duration:
__leg/calf pain (R / L)
__ankle swelling

OTHER
__light-headed / dizzy
__anxiety
__tingling/numb
hands / feet / face
__heart racing

__Similar symptoms previously

__Recently seen/treated by doctor

ROS

ENT
__sore throat
__sinus drainage

GI
__nausea
✓vomiting c Cough
__abdominal pain
__black/bloody stools
__diarrhea

NEURO & EYES
✓headache
__fainting
__visual disturbance

GU & ENDOCRINE
__pain with urination
__excessive urination

SKIN & LYMPH & MS.
__skin rash / swelling
__joint pain
__muscle aches

✓all systems neg. except as marked

PAST HISTORY __negative *=PE Risk Factors

__asthma
__emphysema
__heart disease
*CHF CAD angina MI
__kidney failure/dialysis
__*PE / DVT
__*risk factors for PE/DVT
__other problems

__*hypertension
__diabetes *insulin / oral / diet*
__high cholesterol
__*CVA
✓pneumonia
__pneumothorax
__bronchitis
acute chronic

Surgeries/Procedures: __none __non-contributory

__prior intubation
__cardiac bypass
__cardiac cath
__angioplasty
__cholecystectomy
__appendectomy
__hysterectomy
__pacemaker

2 CA Carcinoma

Medications __none __see nurses note
__ASA __NSAID __acetaminophen
__*BCP's __home O2 @ ____ L
__home nebulizer
Ventolin

Allergies ✓NKDA
__see nurses note

SOCIAL HX *smoker drugs
alcohol (recent / heavy / occasional)

FAMILY HX __CAD

[redacted]
10/08/00 2156
IADM: PHYSICIANS, ED

© 1995-99 E.S.C. Circle positives, check normals, backslash (/) negatives.

Spartanburg Regional Healthcare System
EMERGENCY PHYSICIAN RECORD 10/10/01

PRINTED BY: SAC1691 10/10/00

☐ Nursing Assessment Reviewed. ☑ BP, HR, RR, Temp reviewed

PHYSICAL EXAM ✓Alert __Anxious _____

Distress: __NAD ✓mild __moderate __severe

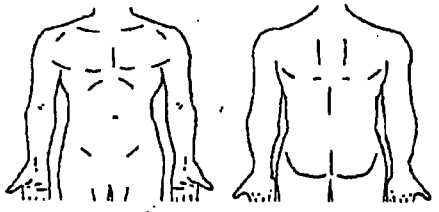
HEENT
- ✓ENT: nml inspection
- ✓pharynx nml
- __scleral icterus / pale conjunctivae
- __purulent nasal drainage
- __pharyngeal erythema

NECK
- ✓nml inspection
- __thyromegaly
- __lymphadenopathy (R / L)

RESPIRATORY
- __no resp. distress
- __breath sounds nml
- __see diagram
- __respiratory distress
- __fatigue
- ✓prolonged expirations
- __accessory muscle use
- __retractions
- __splinting
- __dull on percussion
- __decr. air movement
- __stridor
- __rhonchi
- ✓wheezing BILAT Mono
- __rales
- __chest wall tenderness

CVS
- ✓regular rate, rhythm
- ✓no JVD
- ✓no murmur
- ✓no gallop
- ✓no friction rub
- __irregularly irregular rhythm
- __extrasystoles (occasional / frequent)
- __tachycardia / bradycardia
- __JVD present
- __murmur grade ___ /6 sys / dias
  cresc / cresc-decresc / decresc
- __gallop (S3 / S4)
- __decreased pulse(s)

T=tenderness R=rebound m=mild mod=moderate sv=severe
Example: Tsv indicates severe tenderness.



ABDOMEN
- ✓non-tender
- ✓no organomegaly
- __tenderness
- __guarding
- __rebound
- __hepatomegaly /splenomegaly / mass

RECTAL
- __non-tender
- __heme positive stool
- __heme trace positive stool
- __heme neg stool

SKIN
- __color nml, no rash
- __warm, dry
- __cyanosis / diaphoresis / pallor
- __skin rash

EXTREMITIES
- __non-tender
- __normal ROM
- __no pedal edema
- __pedal edema
- __calf tenderness

NEURO/PSYCH
- __oriented x3
- __mood/affect nml
- __CN's nml as tested
- __no motor/sensry deficit
- __disoriented to person / place / time
- __depressed affect
- __facial droop/EOM palsy/anisocoria
- __weakness / sensory loss

PRINTED BY: [redacted]

EKG, LABS, XRAYS, and PROGRESS

EKG MONITOR STRIP __NSR __abnml

EKG __NML ☐Interp. by me. ☐Reviewed by me Rate

__NSR __nml intervals __nml axis __nml QRS __nml ST/T

not / changed from:

CXR ☐Interp. by me ☐Reviewed by me ☐Discsd w/radiologist.

__nml/NAD ✓no infiltrates __nml heart size __nml mediastinm

not / changed from:

CBC	Chemistries		UA
normal except	*normal except*	CK	*normal except*
WBC	Na	CKMB	WBC
Hgb	K	Troponin	RBC's
Hct	Cl		bacteria
Platelets	CO2		dip:
segs	Gluc	PT	
bands	BUN	INR	
lymphs	Creat	PTT	
monos			
eos	Theoph=		

ABG's time: __RA **Peak Flow**
pH __O2 time:
pCO2 ___L L/Min
pO2 ___% ___% predicted

Pulse Ox 96 % on (RA) ___L ___% at (time) Normal

Time __unchanged __improved __re-examined

air movement __poor __fair __good

RA-0130-AIE-better-pulses-PEFR 250-pred 380

Much improved

__Discussed with Dr. _____
will see patient in: office / ED / hospital
__Counseled patient / family regarding: (*lab results*) (*diagnosis*) (*need for follow-up*)
__Rx given __Admit orders written

__CRIT CARE- *30-74 min* *75-104 min* ____ *min*
__Prior records ordered
__Additional history from: *family caretaker paramedics*

CLINICAL IMPRESSION

- ~~Dyspnea- acute~~
- Asthma- *acute exacerbation*
- Status Asthmaticus- *acute*
- COPD- *acute exacerbation*
- Bronchospasm
- Bronchitis- *acute asthmatic*
- Hyperventilation
- Myocardial Infarction
- Acute Respiratory Failure
- CHF Pulmonary Edema
- Pulmonary Embolus
- Pneumothorax
- Pneumonia- acute
- Diabetic Ketoacidosis

Bronchitis

DISPOSITION- ☐ home ☐ admitted ☐ transferred

CONDITION- ☐ unchanged ☐ improved ☐ stable

PHYSICIAN SIGNATURE- [redacted]

Spartanburg Regional Healthcare System

Emergency Department
101 E. Wood St., Spartanburg, SC 29303
(864)560-6222

Prescriptions Received: Acetaminophen w/codeine 1-2 q3-4 #12), Biaxin 500 mg 1 p.o. BID, Flovent inhaler puffs bid, Ventolin inhaler, Prednisone 20 mg

Discharge Instructions Received: ASTHMA {ACUTE BRONCHITIS}

Drug Instructions Received: NARCOTIC PAIN MEDICINE, CORTISONE-LIKE DRUGS, MACROLIDE ANTIBIOTICS

Referral:

I hereby acknowledge receipt of the instructions indicated above. I understand that I have had emergency treatment and that I may be released before all my medical problems are known or treated. I will arrange for follow-up care as instructed above.

Date/Time: 11/07/2000 01:58 Treating MD: Reynolds, Stuart

Patient Signature: Gayle A. Murray

Account Number:

Medical Record Number:

I have explained the instructions and have given a copy to the patient.

Nurse's Signature: _____ Date: 11/7/00

PRINTED BY: [illegible] 2001 MAY 11 PM 12:53
DATE: 5/16/01

[redacted]

MEDICARE HEALTH INSURANCE

HEALTH CARE FINANCING ADMINISTRATION

NAME OF BENEFICIARY
GAYLE A DOVE

[redacted]

SEX
FEMALE

IS ENTITLED TO
HOSPITAL (PART A) BENEFITS ONLY

EFFECTIVE DATE
02-01-1999

SIGN HERE

[redacted]

000546015
MURRAY, GAYLE D
08/15/57 43Y F ER EME M
11/06/00 2156
ADM:PHYSICIANS,ED

PRINTED BY: JA16169
DATE 5/10/01

[redacted]

SPARTANBURG
Regional Healthcare System

☒ SRMC ☐ SHRC ☐ BJW

PATIENT AUTHORIZATION ASSIGNMENT OF BENEFITS RELEASE

The following are the conditions for services provided by the Spartanburg Regional Healthcare Services, Inc. for the patient whose name appears at the bottom of this page.

1. The undersigned authorizes Spartanburg Regional Health Services District, Inc., its staff, with attending physicians, medical residents, nursing students, rehabilitation students (PT, OT, ST), dietician interns, and other healthcare interns or students to render to the patient all customary care, therapy, treatment, tests and procedures considered advisable, including emergency treatment. I understand that medicine is not an exact science and acknowledge that no guarantees have been made to me as to the results of treatment at SRHS. The undersigned recognizes that certain healthcare professionals furnishing services to the patient, including, but not limited to, radiologist, pathologist, anesthesiologist, and emergency room physicians are independent contractors with the patient and are not employees or agents SRHS.

2. I/we hereby authorize SRHS and attending physicians to furnish my information concerning this hospitalization and treatment for the purpose of insurance, Medicare, Workers' Compensation, CHAMPUS and other similar benefits to insurance companies, their designated agents and to any other parties requiring such information in order to process claims for payment and for the patient's further medical treatment or Discharge planning. I/we agree to hold SRHS, its employees, and agents and all attending physicians harmless as to the release of such information.

3. Where Medicare or Medicaid benefits are applicable, I/we certify that the information given by me in applying for payment under the applicable provisions of the Social Security Act is correct. Should the patient be eligible for Medicare or Medicaid benefits, I/we direct that payment of authorized Medicare or Medicaid benefits be made to SRHS on the patient's behalf.

4. I/we understand that I/we am/are obligated to pay the patient's account according to the regular rates and terms of SRHS. I/we do hereby appoint SRHS as my/our true and lawful attorney-in-fact to collect benefits and claims from responsible third parties utilizing whatever legal means SRHS deems necessary, to endorse checks made payable for the patient and/or SRHS and to give full and final receipt for all amounts collected. In the event the benefits exceed the actual charges for this account I/we authorize SRHS to apply the overpayment to any other account for which I/we am/are responsible. If insurance coverages are subject to a coordination of benefits clause. I/we further authorize the refund of overpaid insurance benefits in accordance with my insurance policy conditions.

5. Medicare and Medicaid will not pay for a private room unless medically necessary. In requesting a private room, I/we understand that I/we will be billed for and will be obligated to pay SRHS the difference between the private room rate and the semiprivate room rate.

6. I/we acknowledge that all licensed health care providers providing services to the patient in SRHS as a staff or charity patient have, prior to rendering such services, agreed to do so without compensation or expectation or promise of compensation. I/we agree to such non-compensated services in the event the patient should receive such services as a staff or charity patient.

7. I/we, for value received, including but not limited to, the services rendered do hereby assign to SRHS any proceeds from the following: CHAMPUS benefits, major medical insurance benefits, hospital benefits, PIP (personal injury protection), sick benefits, injury benefits, physician benefits, accident or welfare benefits of any type or form relating to the patient, whether insured or self-funded, proceeds of any liability settlement or judgment being paid by or on behalf of a third party, or any other benefits due from any insurance policy. I/we do further agree to seek recovery of hospital, medical and similar expenses and to include SRHS in any settlement for damages, satisfaction of any judgment or payment of any other claim. I/we do also direct that the amount of this assignment be paid directly to SRHS. All amounts collected will be applied to the patient's account. I/we understand that I/we am/are responsible for any charges not covered by insurance, Medicare, Medicaid or any other benefits, including, but not limited to the amount of any health insurance deductibles and coinsurance. I/we do further warrant and represent that any insurance or any plan which we assign is valid insurance and in effect and that I/we have the right to make this assignment. I/we further accept the full responsibility for the completion and submission of a claim form and/or explanation of insurance or Medicare Benefits to either the insurance company and/or employer if such a form is required prior to payment being made to SRHS, a physician or supplier. In the event a claim for payment submitted by SRHS to my insurance carrier or plan administrator is denied, I/we hereby authorize SRHS to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of my plan or policy. If my plan or policy is provided pursuant to the Federal Employees Health Benefits Act, 5 U.S.C. § 8901, et seq., this review process will include, but is not limited to, a review by the Office of Personnel Management.

8. I/we understand SRHS could obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection or collected pursuant to the S.C. Setoff Debt Collection Act, the undersigned shall pay all collection fees and costs, including reasonable attorney's fees.

9. I/we certify to the accuracy of the information recorded on the hospital's on-line MSP questionnaire for this date of service.

RELEASE OF RESPONSIBILITY AND LIABILITY FOR PERSONAL VALUABLES: I understand and agree that SRHS is not responsible for personal valuables or belongings brought into the hospital, or claimed to have been brought into the hospital, by the named patient or his/her agent. Personal valuables or belongings include, but are not limited to, clothing, personal hygiene products, toiletries, dentures, glasses, prosthetic devices such as hearing aides, artificial limbs, assist devices such as canes, walkers, wheelchairs, credit cards, jewelry and money.

I understand that SRHS discourages retaining personal valuables at the bedside and that a locked safe is available for securing my personal valuables.

5-6-01 DATE — SIGNATURE OF WITNESS — SIGNATURE OF PATIENT OR RESPONSIBLE PARTY (Relationship to patient)

DATE — SIGNATURE OF WITNESS — SIGNATURE OF INSURED (Relationship to patient)

PLEASE PRINT NAME & SOCIAL SECURITY NUMBER FOR VERIFICATION

[redacted]

PRINTED BY: JA16169 — ADM:PHYSICIANS,ED

DATE 5/10/01

MURRAY,GAYLE,DOVE ER DOB: [redacted] 43Y Sex: F
Act: [redacted] Unit: S000546015 Phys: PHYSICIANS,ED
Adm: 11/06/00 2156

HHN TREATMENT Performed: 11/06/00 2215 MAW
RT Progress Note: Complete Pract Name: Watson,Melissa A RCP

11/06 HHN teaching was an initial session, with patient/family.
2217 Written HHN instructions were given.
Barriers to HHN learning process were none.
Evaluation of HHN teaching was pt./family verbalized, demonstrated.
HHN was an initial treatment
HHN circuit was an initial set-up.
Medication used was Albuterol 2.5mg/3ml.
The route used to administer treatment was a mask.
The heart rate before and after procedure was 101/101
The respiratory rate before and after procedure was 30/30
The patient's cough was dry, non-productive.
The breath sounds were equal and clear.
The breath sounds on the left were clear.
The breath sounds on the right were clear.
Patient tolerated therapy well.
The patient appeared to have no apparent dyspnea.
Following therapy oxygen was on standby.

All Patient Notes (External)
From 11/06/00 2215 through 11/06/00 2215

RESPIRATORY THERAPY End of Report

PRINTED BY: JA16169
DATE 5/10/01

MURRAY,GAYLE,DOVE ER DOB: [redacted] 43Y Sex: F
Act: [redacted] Unit: S000546015 Phys: PHYSICIANS,ED
Adm: 11/06/00 2156

HHN TREATMENT Performed: 11/06/00 2215 MAW
RT Progress Note: Complete Pract Name: Watson,Melissa A RCP

11/06 HHN teaching was an initial session, with patient/family.
2217 Written HHN instructions were given.
Barriers to HHN learning process were none.
Evaluation of HHN teaching was pt./family verbalized, demonstrated.
HHN was an initial treatment
HHN circuit was an initial set-up.
Medication used was Albuterol 2.5mg/3ml.
*The route used to administer treatment was a mouthpiece.
(11/06/00 2218), ~a mask.
The heart rate before and after procedure was 101/101
The respiratory rate before and after procedure was 30/30
The patient's cough was dry, non-productive.
The breath sounds were equal and clear.
The breath sounds on the left were clear.
The breath sounds on the right were clear.
Patient tolerated therapy well.
The patient appeared to have no apparent dyspnea.
Following therapy oxygen was on standby.

All Patient Notes (External)
From 11/06/00 2215 through 11/06/00 2215

RESPIRATORY THERAPY End of Report

PRINTED BY: [illegible] 2001 MAY 11 09:12:53
DATE 5/10/01

MURRAY,GAYLE,DOVE [redacted] ER DOB: [redacted] 43Y Sex: F
[redacted] Phys: PHYSICIANS,ED
[redacted] 11/06/00 2156

HEART NEB TREATMENT Performed: 11/06/00 2255 MAW
RT Progress Note: Complete Pract Name: Watson,Melissa A RCP

11/06 Heart Neb circuit was an initial set-up.
2301 Medication used was Albuterol 2.5mg/3ml., Atrovent .5mg/2.5ml.
The route used to administer treatment was a mask.
Heart rate was 101
Respiratory rate was 30
The breath sounds were equal but abnormal.
The breath sounds on the left were wheezes.
The breath sounds on the right were wheezes.
The patient's cough was dry, non-productive.
The patient appeared to have no apparent dyspnea.
Heart Neb in continuous use for 1 hour.

All Patient Notes (External)
From 11/06/00 2255 through 11/06/00 2255

RESPIRATORY THERAPY End of Report

2001 MAY 11 PM 12:53

PRINTED BY: JA16169
DATE 5/10/01

MURRAY,GAYLE,DOVE. ER DOB: [redacted] 43Y Sex: F
Act: [redacted] Phys: PHYSICIANS,ED

HHN TREATMENT Performed: 11/06/00 2215 MAW
RT Progress Note: Complete Pract Name: Watson,Melissa A RCP
11/06 HHN teaching was an initial session, with patient/family.
2217 Written HHN instructions were given.
Barriers to HHN learning process were none.
Evaluation of HHN teaching was pt./family verbalized, demonstrated.
HHN was an initial treatment
HHN circuit was an initial set-up.
Medication used was Albuterol 2.5mg/3ml.
*The route used to administer treatment was a mouthpiece.
(11/06/00 2218), ~a mask.
The heart rate before and after procedure was 101/101
The respiratory rate before and after procedure was 30/30
The patient's cough was dry, non-productive.
The breath sounds were equal and clear.
The breath sounds on the left were clear.
The breath sounds on the right were clear.
Patient tolerated therapy well.
The patient appeared to have no apparent dyspnea.
Following therapy oxygen was on standby.

HEART NEB TREATMENT Performed: 11/06/00 2255 MAW
RT Progress Note: Complete Pract Name: Watson,Melissa A RCP
11/06 Heart Neb circuit was an initial set-up.
2301 Medication used was Albuterol 2.5mg/3ml., Atrovent .5mg/2.5ml.
The route used to administer treatment was a mask.
Heart rate was 101
Respiratory rate was 30
The breath sounds were equal but abnormal.
The breath sounds on the left were wheezes.
The breath sounds on the right were wheezes.
The patient's cough was dry, non-productive.
The patient appeared to have no apparent dyspnea.
Heart Neb in continuous use for 1 hour.

All Patient Notes (External)
From 11/06/00 0000 through 11/06/00 2359

RESPIRATORY THERAPY End of Report

2001 MAY 11 PM 12 53
PRINTED BY: JA16169
DATE 5/10/01

MURRAY,GAYLE,DOVE [redacted] ER DOB: [redacted] 43Y Sex: F
[redacted] [redacted] [redacted] [redacted] Phys: PHYSICIANS,ED
Adm: 11/06/00 2156

PEAK FLOW PROCEDURE Performed: 11/07/00 0143 MAW
RT Progress Note: Complete Pract Name: Watson,Melissa A RCP
11/07 Peak flow meter was an initial set-up.
0143 Peak flow in liters/min was
250
Peak flow before therapy was 250
Peak flow after therapy was 250
Peak flow teaching was an initial session, with patient/family.
Written peak flow instructions were given.
Barriers to peak flow learning process were none.
Evaluation of peak flow teaching was pt./family verbalized, demonstrated.

All Patient Notes (External)
From 11/07/00 0143 through 11/07/00 0143

RESPIRATORY THERAPY End of Report

PRINTED BY: [illegible] 2001 MAY 11 PM 12:53
DATE 5/10/01

HOM MURRAY,GAYLE,DOVE ER DOB: [redacted] 43Y Sex: F
Act: [redacted] Phys: REYNOLDS,STUART F
Adm: 11/06/00 2156 Dis: 11/06/00 2359

PEAK FLOW PROCEDURE Performed: 11/07/00 0143 MAW
RT Progress Note: Complete Pract Name: Watson,Melissa A RCP
11/07 Peak flow meter was an initial set-up.
0143 Peak flow in liters/min was
250
Peak flow before therapy was 250
Peak flow after therapy was 250
Peak flow teaching was an initial session, with patient/family.
Written peak flow instructions were given.
Barriers to peak flow learning process were none.
Evaluation of peak flow teaching was pt./family verbalized, demonstrated.

All Patient Notes (External)
From 11/07/00 0000 through 11/07/00 2359

RESPIRATORY THERAPY End of Report

PRINTED BY: JA16169
DATE 5/10/01

SP[illegible]ANBURG REGIONAL HEALTHCARE [illegible]YSTEM
SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

NAME: MURRAY,GAYLE DOVE
ORDERING PHYSICIAN: BYRD,R G
[redacted]
Pt. Type:ER

Exam
10052 ER CHEST P** Date: 11/06/00 2205
Ord Diag: 786.09-RESPIRATORY ABNORM NEC** Portab

Exam Start : 11/6/00 2115

PORTABLE CHEST 11-06-2000 2215 HOURS

INDICATION: Shortness of breath.

There are no prior films for comparison.

The heart and mediastinum are normal, and the lungs are clear.

IMPRESSION: NEGATIVE PORTABLE CHEST.

2246

Read By: Peter Ryan, M.D.
Released By: Peter Ryan, M.D.

EAM

FINAL ** Portable **

PRINTED BY: JA[illegible]
DATE 5/10/01

2001 MAY 11 PM 12 53

SPARTANBURG
Regional Healthcare System

☐ SRMC ☐ SHRC ☐ BJW

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: Dove, Gayle DOB: [redacted]
Patient Address: 225 River Forest Dr. SS#: [redacted]
Boiling Springs, SC 29316 Phone: 578-2316

The undersigned hereby authorizes SRHS to release information contained in my medical records to: SAMHC Attn: Kathy Richardson
(address) 209 Catawba St.
Spbg, SC 29303

Covering records for the period from _____ to _____
Date Date

Specific information to be disclosed: _____

Purpose of Release: _____

This authorization places no restrictions on any information to be released, including any treatment for alcohol, drug abuse, HIV testing, Psychiatric or Sickle Cell Trait. If any restrictions are to be placed on information released, please state: _____

X Gayle A. Dove
Signature of Patient

3-31-00
Date

Witness

Signature of Parent/Guardian

Identification

Expiration of this authorization is one year from date of signature, unless otherwise specified.

ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSES DISCLOSURE.

PRESENTED BY: JA16
DATE 5/10/01

1081 (7/1998)

ADDRESSOGRAPH

313100 313102 0001750L

SPARTANBURG REGIONAL MED CTR
101 E. WOOD ST.
SPARTANBURG, SC 29303-3072

RETURN SERVICES REQUESTED

7984

FOR THE ACCOUNT OF: [redacted] GAYLE DOVE MURRAY

STATEMENT DATE: 12/18/00

PATIENT INFORMATION

IF PAYING BY CREDIT CARD, SEE REVERSE SIDE

☐ MASTERCARD ☐ VISA

PAY THIS AMOUNT $

AMOUNT ENCLOSED $

REMIT TO:

SPARTANBURG REGIONAL
HEALTHCARE SYSTEM
P.O. BOX 651602
CHARLOTTE, NC 28265-1602

ADDRESSEE:

GAYLE DOVE MURRAY
225 RIVER FOREST DR
BOILING SPRINGS, SC 29316

] Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

DETAIL STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMEN

ACCOUNT NUMBER	PATIENT NAME	ADMIT DATE	DISC DATE	PATIENT TYPE	F C

*****THIS IS NOT A BILL*****

A CLAIM HAS BEEN SUBMITTED TO MEDICARE ON YOUR BEHALF.
THIS STATEMENT IS FOR YOUR RECORDS ONLY. IF THERE IS A REMAINING
BALANCE DUE AFTER ALL CARRIERS HAVE PAID OR DENIED, YOU WILL BE NOTIFIED.
THANK YOU FOR ALLOWING SPARTANBURG REGIONAL HEALTHCARE SYSTEMS TO PROVIDE
YOUR HEALTHCARE NEEDS.

*****THIS IS NOT A BILL*****

[redacted]	GAYLE DOVE MURRAY	11/06/00	11/06/00	ER	MC
	Account Balance		797.21		

SUMMARY OF ACCOUNT FOR: GAYLE DOVE MURRAY

BALANCE FORWARD OF ACCOUNT / ACCOUNTS	
TOTAL CHARGES AND ADJUSTMENTS	
TOTAL INSURANCE PAYMENTS	
TOTAL PATIENT PAYMENTS	
TOTAL ACCOUNT BALANCE	
ESTIMATED INSURANCE LIABILITY	
AMOUNT DUE	

2001 MAY 11 PM 12:53

Srv Cd	Qty	Service		Qty	Service
			442		O_2/RT
			430		Drug
			430		Drug
			430		Drug
			378		
			378		
			378		
			3781071		Oximeter
			3781055		Accucheck
			3781066		Int
			3781013		Cardiac Monitor
			3781048		Cardiac Care / Hr.
			3781018		Code 7 - 15 Min.
			3781014		Code 7 - 30 Min.
			3781016		Code 7 - 60 Min.
			3781006		Code 8 - Hourly Observation
			3781111		**Prompt Care**
			3781112		**Prompt Care**
			3781113		**Prompt Care**
			Physician	**Qty**	**E.D.** **Qty** **Service**
			3771901		3782001 Level 1
			3771902		3782002 Level 2
			3771903		3782003 Level 3
			3771904		3782004 Level 4
			3771905		3782005 Level 5
			3771921		3782006 Level 6-TRT
			3771922		3782007 Add 30 / 6A-TRT
			3772010		RPR Simple 2 - 5 cm
			3772011		Simple 6 - 7.5 cm
			3772012		Simple 7.6 - 12.5 cm
			3772016		Face Simple 2.5 cm or Less
			3772017		Face Simple 2.6 - 5.0 cm
			3772018		Face Simple 5.1 - 7.5 cm
			377		
			377		
			377		
			377		

PATIENT

ACCOUNT NO.	ADMISSION DATE / TIME	FC	DATE OF BIRTH	AGE	SEX	RACE	MS	SERVICE		PAT. TYPE	BY	UNIT NUMBER
[redacted]	11/06/00 2156	MC	[redacted]	45Y	F	[redacted]		EME	8	ER	SAM	00-018015

ADMITTING DOCTOR	ATTENDING DOCTOR	ACCIDENT / WORK RELATED	ACCIDENT DATE / TIME	ADM. TYPE / SOURCE
PHYSICIANS,ED	PHYSICIANS,ED	NO		1 2

PATIENT INFORMATION
MURRAY,GAYLE DOUP
225 RIVER FOREST DR
BOILING SPRINGS SC 29316 (864)578-0095

SOC. SEC. NO. [redacted]

PRINTED BY: JA[illegible]

PATIENT EMPLOYER
[illegible]01

TELEPHONE NO.

2001 MAY 11 PM 12 52

COMPUTER COPY

COLUMBIA V.A.
WJB DORN VETERANS' MEDICAL CTR
6439 GARNERS FERRY ROAD
COLUMBIA SOUTH CAROLINA 29209

June 12, 2001

In Reply Refer To: 544/136
[redacted]

SPARTANBURG REGIONAL MED CTR
PO BOX 651602
CHARLOTTE NC 28265-1602

REGARDING: VETERAN: GAYLE A DOVE
FEE PROGRAM: CIVIL HOSPITAL
EPISODE OF CARE: Nov 06, 2000

We have received your request for payment of medical services which were not authorized. Before we are able to process your claim the following information is needed:

PLEASE RETURN ALL COPIES OF VA FORM 10-583

Claim is approved. Completed VA Form 10-583 is required for payment.

We ask that you be prompt in supplying the requested information. Failure to provide all the information within a year will result in an automatic disapproval. Legislation requires that we notify you if your claim cannot be processed if entitlement to the services rendered has not been established. Without the information requested above, we cannot consider your request for payment as a proper invoice.

If you wish us to process this claim, please resubmit the entire claim with the items listed to the above address. We will notify you of our decision.

The U.S. Department of Veterans Affairs assumes no financial responsibility for any costs incurred in obtaining the above information.

Sincerely,

Carolyn L. Barrett, Chief
Health Benefits Office

cc: Veteran

MEDICAL RECORD	PROGRESS NOTES

DATE

UNAUTHORIZED MEDICAL TREATMENT CLAIM

Claims Clerk: Rebecca Bickley Date Claim Sent for Fee Physician Review 5/22/01

Date(s) of Care: 11/6/00 P&T 9PM Spartanburg Reg

ELIGIBILITY: PTSD 70% SC
Removal of Uterus and Ovaries 50% SC
migraine headaches 30%
Rhinitis 0%
neoplasm benign, skin 0%

TYPE OF CLAIM:

____AMBULANCE ____NON VA HOSPITALIZATION

____OUTPATIENT MEDICAL X NONVA EMERGENCY ROOM

____Other:

Explain

Treatment for:

✓ Treatment for Any Condition, Vet rated 100% Permanent and Total (P&T)
____Vocational Rehabilitation Enrollee
____Service Connected Condition
____Non-Service Connected Condition
____Condition, Adjunct to Rated Service Connected Condition
____Other: Explain

Care Was: Emergent X Not Emergent ____

VA Facility was Available ____ Not Available X

Recommend: Approval: All or specify Outpatient Care Dates:
Approval: All or specify Inpatient Dates From 11/6/00 To BSK

Denial of Claim ____

Comments to support Decision of Approval/Disapproval: Asthma flare-ups

Physician Reviewer (Continue on reverse side) MAS Reviewer Concurrence/Date

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; race; hospital or medical facility)

REGISTER NO. WARD NO.

NAME: Murray, Gail (Dove)

[redacted]

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR.
FIRMR(41CFR)201-45.505
509-111

OMB NO: 2900-0080
Estimated Burden: 15 min.

Department of Veterans Affairs

CLAIM FOR PAYMENT OF COST OF UNAUTHORIZED MEDICAL SERVICES

NOTICE: Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to VA Clearance Officer (723), 810 Vermont Avenue NW, Washington DC 20420, and to the Office of Information and Regulatory Affairs, Project Officer (2900-0080), Office of Management and Budget, Washington DC 20503. DO NOT send applications to this address.

The information requested on this form is solicited under authority of Title 38, United States Code, "Veterans Benefits," and will be used to assist us in determining your entitlement to reimbursement for services rendered. It will not be used for any other purpose. Disclosure is voluntary. However, failure to furnish the information will result in our inability to process your claim. Failure to furnish this information will have no adverse effect on any other benefit to which you may be entitled.

PART I

1A. VETERAN'S NAME (Last, first, middle initial)	1B. CLAIM NUMBER	1C. SOCIAL SECURITY NUMBER
MURRAY, GAYLE DAVE	C-	[redacted]

1D. VETERAN'S ADDRESS (Include complete ZIP Code)

922 PARK VIEW PLACE GULFPORT MS 39501-3637

2A. NAME AND ADDRESS OF PERSON, FIRM OR INSTITUTION MAKING CLAIM (Leave blank if same as above)	2B. SOCIAL SECURITY NO. OR EMPLOYEE IDENTIFICATION NO.
1616 E. Wood St Alla. Reg. Med Ctr, STDG SC. 29303	

3. STATEMENT OF CIRCUMSTANCES UNDER WHICH THE SERVICES WERE RENDERED (Include diagnosis, symptoms, whether emergency existed, and reason VA facilities were not used)

Recv'd
JUN 2 1 2001
Pymt. Assur.

11/6/00

4. AMOUNT CLAIMED	
$ 797.21	Attach bills or receipts showing services furnished, dates and charges

5. COMPLETE A OR B AS APPROPRIATE

A. Amount charged does not exceed that charged the general public for similar services. Payment has not been received.	B. I certify that the amount claimed has been paid and reimbursement has not been received.
Carolyn Barrett 7-5-01 SIGNATURE AND TITLE OF PROVIDER OF SERVICE AND DATE	SIGNATURE OF VETERAN OR REPRESENTATIVE AND DATE

PART II - FOR VETERANS AFFAIRS USE ONLY

6. ACTION	CLAIM MEETS THE REQUIREMENTS OF VA REGULATION	
☐ APPROVED $_____ ☐ DISAPPROVED	☐ 6080	☐ 6081

7. SIGNATURE OF CHIEF, MEDICAL ADMINISTRATION SERVICE	8. DATE	9. ADMINISTRATIVE VOUCHER NUMBER
CAROLYN L. BARRETT, CHIEF, PO	8/1/4	

VA FORM 10-583(R)
SEP 1992

☆ U.S. G.P.O.: 1996-723-259/85097

01130-01-22-00001 PAID SYSTEM

SPARTANBURG REGIONAL MED
P O BOX 651602
CHARLOTTE, NC 282651602
8645604123 8645604023 USA

APPROVED OMB NO. 0938-0

2 [redacted]

3 PATIENT CONTROL NO. [redacted] 131

5 FED. TAX NO. 001 | 6 STATEMENT COVERS PERIOD FROM [redacted] THROUGH | 7 COV'D. | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: DOVE, GAYLE A

13 PATIENT ADDRESS: 225 RIVER FOREST D BOILING SP, SC 29316

14 BIRTHDATE	15 SEX	16 MS	17 DATE ADMISSION	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	31
08151957	F	M	110600	21	1	7	23	01	[redacted]	80	

32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	THROUGH	37
11	110600	42	110600						A
									B
									C

MURRAY, GAYLE
225 RIVER FOREST D

BOILING SPRINGS, SC 29316

38 CODE	38 VALUE CODES AMOUNT	39 CODE	39 VALUE CODES AMOUNT
a			
b			
c			
d			

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
259	PHARMACY - OTHER			3	5721	5721	
270	MEDICAL SURGICAL SUPPLIE			3	9900		
320	RADIOLOGY-DIAGNOSTIC - G	71010	110600	1	32400		
410	RESPIRATORY - GENERAL CL	94664	110600	1	2500		
410	RESPIRATORY - GENERAL CL	94665	110600	1	2800		
450	EMERGENCY ROOM - GENERAL	9928425	110600	1	22500		
460	PULMONARY FUNCTION - GEN	94010	110600	1	3900		
001	TOTAL CHARGE				79721	5721	

136742 C13754

BATCH 31605 CONTROL POINT 221

CODE 1 SUSPEND 502.46

PAY 294.75 DATE 8/10/01

ADMINISTRATIVE CERTIFICATION: FEES FOR SERVICES AND/OR SUPPLIES FURNISHED AS APPROVED IN THE AMOUNTS BILLED WITH THE FOLLOWING EXCEPTIONS:

DESIGN. CLINIC DIRECTOR Rebecca Bixler

50 PAYER (PAGE 01 OF 01)	51 PROVIDER NO.	52 REL	53 ASG	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
618 MEDICARE	[redacted]	Y	Y			

57 DUE FROM PATIENT

58 INSURED'S NAME		59	60	61 GROUP NAME	62 INSURANCE GROUP NO.
DOVE, GAYLE A	01	[redacted]			

[redacted] AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
asthma, unspecified	3		

67 DIAG. CD.	68 CODE	69 CODE	OTHER DIAG. CODES 70 CODE	71 CODE	72 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
7392	490 bronchitis					78605		42

80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE		82 ATTENDING PHYS. ID
				FILED	OTH000 REYNOLDS, STUART F
OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE		83 OTHER PHYS. ID
					OTH000 REYNOLDS, STUART F
					OTHER PHYS. ID
					OTH000 REYNOLDS, STUART F

REMARKS

85 PROVIDER REPRESENTATIVE: Y KING ROSE

86 DATE: 010401

SPARTANBURG RADIOLOGICAL ASSOC., P
PO BOX 60100
CHARLESTON SC 29419-0100

33#33
Return Service Requested
12044-7760

Place of Service: SPARTANBURG REGIONAL ER
CDC*331*2031101546 33#33

GAYLE D MURRAY
225 RIVER FOREST DR
BOILING SPRINGS SC 29316-8359

PATIENT NAME
GAYLE D MURRAY
ACCOUNT NUMBER [redacted] STATEMENT DATE 12-20-00
AMOUNT DUE 31.00 AMOUNT PAID

SPARTANBURG RADIOLOGICAL ASSOC., F
PO BOX 60100
CHARLESTON SC 29419-0100

1257522328000002031101546332000031004 6

PLEASE DETACH AND RETURN TOP PORTION WITH PAYMENT

DATE	DOCTOR	CODE	DESCRIPTION	AMOUNT
11-06-00	FORREST P RYAN, MD	71010	CHEST SINGLE VIEW	31.00
12-15-00				
12-15-00	NO PART B MEDICARE			

ACCESS/CHANGE YOUR ACCOUNT VIA THE INTERNET anytime!!!
Visit us at http://www.peryourhealth.com and enter your account number of 1677-2031101546 and password C9DHCV

Billing questions? Call: 800/922-0346

ACCOUNT NUMBER	DATE OF STATEMENT	PAYMENTS AFTER THIS DATE WILL APPEAR ON YOUR NEXT STATEMENT	BALANCE	AMOUNT DUE
[redacted]	12-20-00			31.00

PATIENT NAME
GAYLE D MURRAY

INSURANCE HAS DENIED PAYMENT ON YOUR ACCOUNT. YOU ARE RESPONSIBLE FOR PAYMENT IN FULL. PLEASE MAIL PAYMENT WITHIN 20 DAYS. THANK YOU.

MAKE CHECKS PAYABLE TO:
SPARTANBURG RADIOLOGICAL ASSOC., PA

L.N. WARREN, JR, MD
F.P. RYAN, JR, MD
NEIL H. PARNES, MD
MARK D MONSON, MD
DOUGLAS M FOLTZ, MD
BRIAN BAGHDADY, MD
J. A. KAVANAGH, MD
R. E. MITCHELL, MD
J. A. HARRILL, MD
WILLIAM T. JOYCE, MD
COLE GRAHAM, MD

[redacted]

Place of service: SPARTANBURG REGIONAL ER
Referring Doctor: RICHARD G BYRD MD

SPARTANBURG RADIOLOGICAL ASSOC., PA
PO BOX 60100
CHARLESTON SC 29419-0100
800/922-0346

Spartanburg Regional Healthcare System

Emergency Department

101 E. Wood St., Spartanburg, SC 29303

(864)560-6222

For NON-emergency questions and concerns call Ask-A-Nurse at 591-7999.
Take-Home Instructions for the Patient

Patient's Name: Murray, Gayle | **Date: 11/07/2000**
Medical Record Number: | **Medical Provider: Reynolds, Stuart**
Diagnosis: | **Primary Care Provider: Unassigned,**

PLEASE NOTE: The examination and treatment that you have received in the Emergency Department have been rendered on an emergency basis only and are not intended to be a substitute for or an effort to provide complete medical service. A follow-up doctor or facility is named below. It is important that you be checked again as recommended below and report any new or remaining problems at that time, because it is impossible to recognize and treat all elements of injury or illness in a single Emergency Department visit. In addition, if an X-Ray has been taken here, it has been read on a preliminary basis only, and a final review will be made by the Radiologist.

Call to arrange an appointment to see the following physician for follow-up care.

Referral:

When you call for an appointment, say that you were referred from this Emergency Department.

If you cannot see the above doctor and your condition worsens so that you require emergency treatment, come back to this department.

PLEASE TAKE THIS WITH YOU WHEN YOU SEE DOCTOR LISTED ABOVE

ASTHMA:

Your exam shows you have asthma. This means you get wheezing and shortness of breath due to narrowing of the bronchial tubes in the lungs. Asthma is often brought on by allergies and respi-

ratory infections. Air pollution, smoking, strenuous exercise, and emotional upsets can also bring on asthma attacks.

Treatment is aimed at opening the narrowed airways. Mild asthma is relieved usually with inhaled bronchodilators such as Alupent, Ventolin, or Proventil. Sometimes bronchodilator tablets or theophylline drugs are used. Cortisone medicine and antibiotics may be needed when an attack is severe or brought on by an infection. Allergies may also play an important role so you should talk with your doctor about allergy prevention and treatment.

Be sure to drink plenty of clear liquids so you do not become dehydrated. This helps thin the mucus and makes it easier to clear your chest. Do not smoke cigarettes and avoid passive smoke exposure. If you have allergies, try to avoid exposure to dust and pollens. Exercise-induced asthma can be prevented by using an inhaler 10 minutes before exercise.

Asthma can be a life threatening disease that comes and goes. Careful medical attention by your doctor is important, especially if your asthma is severe. Some patients use a peak flow meter to measure their breathing and then select the proper dose of medicine. Be sure to see your doctor for follow-up. Call your doctor or return here right away if you have marked increased wheezing or shortness of breath, a high fever, or other serious symptoms.

ACUTE BRONCHITIS:

You have acute bronchitis. This means the airway passages in your lungs are inflamed. Bronchitis may be caused by viruses or bacteria. Inhaling cigarette smoke will always make it worse. Exposure to irritating chemicals or second hand smoke as well as allergies can contribute to bronchitis. Repeat episodes of bronchitis may cause lifelong lung problems.

Acute bronchitis is usually treated with rest, fluids, cough medicine, and possibly antibiotics or inhaled medicine to open up the small airways. It is very important that you avoid smoke and drink increased amounts of fluids. A cool air vaporizer can help thin bronchial secretions. This makes it easier to cough and clear your chest. If you are a cigarette smoker, consider using nicotine gum or skin patches to help you withdraw.

Recovery from bronchitis is often slow, but you should start feeling better after 2-3 days of treatment. Please call your doctor or return here if you have any of the following symptoms:

- Increased fever, chills, or chest pain.
- Severe shortness of breath or bloody sputum.
- Do not improve after 3 days of proper treatment.

NARCOTIC PAIN MEDICINE:

You have been prescribed a narcotic for pain relief. These drugs are usually combined with acetaminophen (Tylenol#3, Percocet, Darvocet, Anexsia, Vicodin) or aspirin (Empirin#3, Percodan,

2001 JAN 11 P1:48

Synalgos-DC) for increased effect. Narcotics act on the central nervous system to reduce pain; they also impair mental alertness and physical abilities. We advise you not to drink alcohol, drive a car, or operate dangerous equipment when you are taking one of these drugs. Long term use of narcotic pain medications may be habit-forming.

You can lessen stomach irritation from your medicine by taking it with meals or a full glass of water. Common side effects of narcotics are: nausea and vomiting, heartburn, constipation, dizziness, sleepiness, and mood changes. If you have bothersome side effects or symptoms of an allergic reaction (itching, hives, rash), stop taking your medicine and call your doctor or the emergency room right away. Please keep your narcotic medicine well out of the reach of children.

CORTISONE-LIKE DRUGS:

Your doctor has prescribed a cortisone-like drug for you. These medicines are used to treat many conditions including: asthma, chronic lung disease, allergies, skin problems (poison oak, hives), arthritis, and swelling due to certain infections of the ear and throat. Cortisone and related drugs work by reducing swelling and inflammation. They may be given by injection, pills, liquids, creams or ointments. Always take the prescribed amount of medicine for the full period of treatment to gain the full benefit.

Most of the time short-term treatment with these medicines causes very few side effects. Take your medicine with food to prevent stomach upset. Common side effects include: mood changes, restlessness, insomnia, headache, increase in appetite, and fluid retention. Long-term treatment with cortisone-like drugs can lead to more serious side effects including ulcers, osteoporosis, and unusual weight gain; check with your doctor for further information. Please contact your doctor if you have any of these symptoms: fever, blurred vision, stomach pain, vomiting, or stools that are bloody or black.

MACROLIDE ANTIBIOTICS:

Your doctor has prescribed a macrolide antibiotic for you. Examples of this group include the erythromycin drugs, as well as Biaxin and Zithromax. These medicines are used to treat respiratory, throat, sinus, skin, and genital infections. While erythromycin often causes intestinal side effects such as nausea, diarrhea, and abdominal pain, this is uncommon with Biaxin and Zithromax. However, Biaxin should not be taken if you are pregnant because of the risk of birth defects. Please note that birth control pills may not work as well as normal when you are taking an antibiotic medicine.

Biaxin is usually given every 12 hours with or without meals; Zithromax should be taken once daily at least an hour before or two hours after a meal. Please call your doctor or return here if you

have severe side effects, if your illness is not better after 3 days of treatment, or if you have any of the following symptoms:

- Drug allergy reaction (rash, itching, hives, breathing problems)
- Repeated vomiting, severe stomach pain, jaundice, or dark urine

On Monday night, Nov. 6th at about 9:30 P.M. I had a severe asthma attack and was unable to breathe. I was rushed to Spartanburg Regional Hospital ER, where I was treated for several hours & then released. I could not have made it to the Dorn VA. I am sending this bill for the X-ray & the diagnosis along with the receipts for the prescriptions I had to have filled. I would like to be reimbursed as much as possible. I will send the bill when it is received.

GAYLE A. DOVE
Gayle A. Dove
[redacted]

98 JAN 11 PM 1 '98

ECKERD #8039 (864)578-3730 Mu
8951 VALLEY FALLS RD Boiling Springs, SC 29316
NABP: 4220187
[redacted]
Murray, Gayle DOB 08/15/XX
225 Riverforest Dr
Boiling Springs, SC 29316 (864)578-8093
PREDNISONE 20MG TABS #8 TA (SCHE)
NDC#00364-**0442**-01 ER
Days supply: 4
11/07/00 Pr. S Reynolds MD
Rx#:6192025-00 **Cash Regular $7.99**
Auth:
Ask us about cost savings using generics
NO REFILLS REMAINING
PLEASE KEEP THIS RECEIPT FOR TAX AND INSURANCE PURPOSES.

ECKERD DUPLICATE RECEIPT

#8039 (864)578-3730 Mu
8951 VALLEY FALLS RD Boiling Springs, SC 29316
NABP: 4220187
[redacted]
Murray, Gayle DOB 08/15/XX
225 Riverforest Dr
Boiling Springs, SC 29316 (864)578-8093
PREDNISONE 20MG TABS 8 TA SCHE
NDC#00364-**0442**-01 ER
Days supply: 4
11/07/00 Pr. S Reynolds MD
Rx#:6192025-00 **Cash Regular $7.99**
Auth:
Ask us about cost savings using generics
NO REFILLS REMAINING

DUPLICATE RECEIPT

YOUR ECKERD PHARMACIST IS AVAILABLE TO ANSWER ANY QUESTIONS YOU HAVE ABOUT YOUR MEDICATIONS.

PATIENT INFORMATION

Comments:

For your convenience fill your next Rx online at www.eckerd.com.

P/U Date: P/U Time: 00:00 AM # Rx's:
11/07/00 NO ALLERGIES - HAS MED INFO

Rx#: 6192025
Tx#: 0460752
Murray
11/07/00
Patient Pay: $7.99
Baker

1234

ECKERD #8039 (864)578-3730
8951 VALLEY FALLS RD Boiling Springs, SC 29316
NABP: 4220187
[redacted]
225 Riverforest Dr
Boiling Springs, SC 29316 (864)578-8093
APAP/CODEINE 30MG TABLET #12 TA (TEVA)
NDC#00093-**0150**-10 ER
Days supply: 2
11/07/00 Pr. S Reynolds MD
Rx#:3192026-00 **Cash Regular $7.99**
Auth:
You have saved $1.90 by choosing a generic
NO REFILLS REMAINING
PLEASE KEEP THIS RECEIPT FOR TAX AND INSURANCE PURPOSES.

ECKERD DUPLICATE RECEIPT

#8039 (864)578-3730 Mu
8951 VALLEY FALLS RD Boiling Springs, SC 29316
NABP: 4220187
[redacted]
225 Riverforest Dr
Boiling Springs, SC 29316 (864)578-8093
APAP/CODEINE 30MG TABLET 12 TA TEVA
NDC#00093-**0150**-10 ER
Days supply: 2
11/07/00 Pr. S Reynolds MD
Rx#:3192026-00 **Cash Regular $7.99**
Auth:
You have saved $1.90 by choosing a generic
NO REFILLS REMAINING

DUPLICATE RECEIPT

YOUR ECKERD PHARMACIST IS AVAILABLE TO ANSWER ANY QUESTIONS YOU HAVE ABOUT YOUR MEDICATIONS.

PATIENT INFORMATION

Comments:

For your convenience fill your next Rx online at www.eckerd.com.

P/U Date: P/U Time: 00:00 AM # Rx's:
11/07/00 NO ALLERGIES - HAS MED INFO

Rx#: 3192026
Tx#: 0460753
Gayle Murray
11/07/00
Patient Pay: $7.99
Baker

1235

ECKERD #8039 (864)578-3730

8951 VALLEY FALLS RD Boiling Springs, SC 29316

NABP: 4220187

Murray, Gayle DOB 08/15/XX

225 Riverforest Dr

Boiling Springs, SC 29316 (864)578-8093

VENTOLIN INH #17 AE (ALLE)

NDC#00173-0321-88 ER

Days supply: 5

11/07/00 Pr. S Reynolds MD

Rx#:6192024-00 **Cash Regular $37.89**

Auth:

Ask us about cost savings using generics

NO REFILLS REMAINING

PLEASE KEEP THIS RECEIPT FOR TAX AND INSURANCE PURPOSES.

Rx#: 6192024
Tx#: 0460751

Gayle Murray
11/07/00
Patient Pay: $37.89
Baker

ECKERD DUPLICATE RECEIPT

#8039 (864)578-3730

8951 VALLEY FALLS RD Boiling Springs, SC 29316

NABP: 4220187

Murray, Gayle DOB 08/15/XX

225 Riverforest Dr

Boiling Springs, SC 29316 (864)578-8093

VENTOLIN INH 17 AE ALLE

NDC#00173-0321-88 ER

Days supply: 5

11/07/00 Pr. S Reynolds MD

Rx#:6192024-00 **Cash Regular $37.89**

Auth:

Ask us about cost savings using generics

NO REFILLS REMAINING

DUPLICATE RECEIPT

YOUR ECKERD PHARMACIST IS AVAILABLE TO ANSWER ANY QUESTIONS YOU HAVE ABOUT YOUR MEDICATIONS.

PATIENT INFORMATION

Comments:

For your convenience fill your next Rx online at www.eckerd.com.

P/U Date: P/U Time: 00:00 AM # Rx's:

11/07/00 NO ALLERGIES - HAS MED INFO

ECKERD #8039 (864)578-3730

8951 VALLEY FALLS RD Boiling [redacted]

225 Riverforest Dr

Boiling Springs, SC 29316 (864)578-8093

FLOVENT 220MCG INH #13 AE (GLAX)

NDC#00173-0495-00 ER

Days supply: 25

11/07/00 Pr. S Reynolds MD

Rx#:6192029-00 **Cash Regular $115.19**

Auth:

Ask us about cost savings using generics

NO REFILLS REMAINING

PLEASE KEEP THIS RECEIPT FOR TAX AND INSURANCE PURPOSES.

Rx#: 6192029
Tx#: 0460759

Gayle Murray
11/07/00
Patient Pay: $115.19
Baker

ECKERD DUPLICATE RECEIPT

#8039 (864)578-3730

8951 VALLEY FALLS RD Boiling Springs, SC 29316

NABP: 4220187

Murray, Gayle DOB 08/15/XX

225 Riverforest Dr

Boiling Springs, SC 29316 (864)578-8093

FLOVENT 220MCG INH 13 AE GLAX

NDC#00173-0495-00 ER

Days supply: 25

11/07/00 Pr. S Reynolds MD

Rx#:6192029-00 **Cash Regular $115.19**

Auth:

Ask us about cost savings using generics

NO REFILLS REMAINING

DUPLICATE RECEIPT

YOUR ECKERD PHARMACIST IS AVAILABLE TO ANSWER ANY QUESTIONS YOU HAVE ABOUT YOUR MEDICATIONS.

PATIENT INFORMATION

Comments:

For your convenience fill your next Rx online at www.eckerd.com.

P/U Date: P/U Time: 00:00 AM # Rx's:

11/07/00 NO ALLERGIES - HAS MED INFO

ECKERD #8039 **(864)578-3730** **Mu**

8951 VALLEY FALLS RD Boiling Springs, SC 29316

NABP: 4220187 [redacted]

Murray, Gayle DOB 08/15/XX

225 Riverforest Dr

Boiling Springs, SC 29316 (864)578-8093

BIAXIN 500MG TABS #14 TA (ABBO)

NDC#00074-2586-60 ER

Days supply: 7

11/07/00 Pr. S Reynolds MD

Rx#:6192027-00 **Cash Regular $65.79**

Auth:

Ask us about cost savings using generics

NO REFILLS REMAINING

PLEASE KEEP THIS RECEIPT FOR TAX AND INSURANCE PURPOSES.

DUPLICATE RECEIPT

ECKERD #8039 **(864)578-3730** **Mu**

8951 VALLEY FALLS RD Boiling Springs, SC 29316

NABP: 4220187 [redacted]

225 Riverforest Dr

Boiling Springs, SC 29316 (864)578-8093

BIAXIN 500MG TABS 14 TA ABBO

NDC#00074-2586-60 ER

Days supply: 7

11/07/00 Pr. S Reynolds MD

Rx#:6192027-00 **Cash Regular $65.79**

Auth:

Ask us about cost savings using generics

NO REFILLS REMAINING

DUPLICATE RECEIPT

YOUR ECKERD PHARMACIST IS AVAILABLE TO ANSWER ANY QUESTIONS YOU HAVE ABOUT YOUR MEDICATIONS.

PATIENT INFORMATION

Comments:

Change your toothbrush after the flu to prevent reinfection

For your convenience fill your next Rx online at www.eckerd.com.

P/U Date: P/U Time: 00:00 AM # Rx's:

11/07/00 NO ALLERGIES - HAS MED INFO

Rx#: 6192027
Tx#: 0460755

Gayle Murray
11/07/00
Patient Pay: $65.79
Baker 0006

1236

COLUMBIA V.A.
WJB DORN VETERANS' MEDICAL CTR
6439 GARNERS FERRY ROAD
COLUMBIA SOUTH CAROLINA 29209

January 12, 2001

In Reply Refer To: 544/136
DOVE,GAYLE A
[redacted]

GAYLE A DOVE
225 RIVER FOREST DR
BOILING SPRINGS SOUTH CAROLINA 29316

REGARDING: VENDOR: SPARTANBURG RADIOLOG AS
FEE PROGRAM: CIVIL HOSPITAL
EPISODE OF CARE: Aug 27, 2000

We have carefully reviewed your claim for payment of unauthorized medical services. The following decision has been made:

Claim has been disapproved.

Payment may be made only if all three of the following criteria are met: (1) Care or services were rendered for an adjudicated service-connected disability or for any condition of a veteran who has been determined to be totally and permanently disabled as a result of a service-connected disabilty; (2) Care and services were rendered in a medical emergency of such a nature that delay would have been hazardous to life or health; (3) VA or other federal facilities were not feasibly available.

The absence of any one of these criteria precludes payment by the US Department of Veteran Affairs.

Reason(s) for not approving claim:
Medical treatment was for non-service connected condition which was clinically determined not an adjunct condition to the service connected disability.

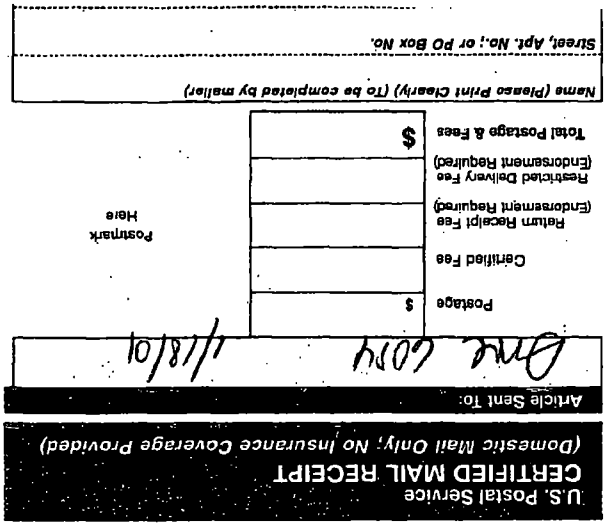
If you do not agree with the decision you have the right to appeal. Your appeal rights are enclosed for your review.

If you have any questions concerning this matter, please contact our Claims Clerk at (803) 776-4000, extension 6170. A copy of this letter is being furnished to the provider(s) of care, if applicable.

Sincerely,

Carolyn L. Barrett, Chief, Health Benefits Office

cc: Vendor



Is your RETURN ADDRESS completed on the reverse side?

SENDER:
- Complete items 1 and/or 2 for additional services.
- Complete items 3, 4a, and 4b.
- Print your name and address on the reverse of this form so that we can return this card to you.
- Attach this form to the front of the mailpiece, or on the back if space does not permit.
- Write "*Return Receipt Requested*" on the mailpiece below the article number.
- The Return Receipt will show to whom the article was delivered and the date delivered.

OCT 10 2001

I also wish to receive the following services (for an extra fee):
1. ☐ Addressee's Address
2. ☐ Restricted Delivery

Consult postmaster for fee.

3. Article Addressed to:

GAYLE A DOVE
225 RIVER FOREST DRIVE
BOILING SPRINGS SC 29316

4a. Article Number
7099 3220 0009 0742 3908

4b. Service Type — X
☐ Registered ☐ Certified
☐ Express Mail ☐ Insured
☐ Return Receipt for Merchandise ☐ COD

7. Date of Delivery
10.23.01 BLG

5. Received By: *(Print Name)*
GAYLE A. DOVE

6. Signature: *(Addressee or Agent)*
X Gayle A. Dove

8. Addressee's Address *(Only if requested and fee is paid)*

Thank you for using Return Receipt Service.

PS Form 3811, December 1994 102595-97-B-0179 Domestic Return Receipt

Admin

OMB Number: 2900-0260
Estimated Burden: 2 minute

Department of Veterans Affairs

REQUEST FOR A[illegible] CONSENT TO RELEASE OF MEDICAL RECORDS PROTECTED BY 38 U.S.C. 7332

PAPERWORK REDUCTION ACT INFORMATION: Public reporting burden for this collection of information is estimated to average 2 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to VA Clearance Officer (723), 810 Vermont Avenue NW, Washington DC 20420, and to the Office of Information and Regulatory Affairs, Paperwork Reduction Project (2900-0260), Office of Management and Budget, Washington DC 20503. DO NOT send applications to this address.

The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. and will authorize release of information you specify. Your disclosure of the information requested on this form is voluntary. However, if the information is not furnished, Department of Veterans Affairs will be unable to comply with the request.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA-CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

11/14/98

PATIENT NAME (Last, First, Middle Initial)

Dove Gayle

SOCIAL SECURITY NUMBER

[redacted]

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

4457 Popps Ferry Rd Lot 195
Biloxi, MS 39532

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☑ COPY OF HOSPITAL SUMMARY ☑ COPY OF OUTPATIENT TREATMENT NOTE(S) ☑ OTHER (Specify)

— Copy of all 3 Volumes —
Migraines

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED

Personal

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that th information given above is accurate to the best of my knowledge. I understand that I may revoke th authorization at any time except to the extent that action has already been taken to comply with it. Redisclosure c my medical records by those receiving the above authorized information may not be accomplished without n further written consent. Without my express revocation, the consent will automatically expire: (1) upon satisfactic of the need for disclosure; (2) on _____ (date supplied by patient); or (3) under the followir condition(s):

DATE	SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT
16 Dec 98	Gayle A. Dove

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (Name, Address, Social Security Number)	TYPE AND EXTENT OF MATERIAL RELEASED	
	DATE RELEASED	RELEASED BY

VA FORM 10-5345(D)

*U.S. Government Printing Office: 1995 — 62(

$38.00 0615* PAGE 1 (M) BSW
DEPT OF VETERAN AIRS
1801 ASSEMBLY ST ET
COLUMBIA SC 29201

s/c for NSC condition

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
☐ (Medicare #)	☐ (Medicaid #)	☐ (Sponsor's SSN)	☐ (VA File #)	☐ (SSN or ID)	☐ (SSN)	☒ (ID)

1a. INSURED'S I.D. NUMBER: [redacted] (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOVE GAYLE

3. PATIENT'S BIRTH DATE: 08 15 1957 SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 225 RIVER FOREST DR

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): SAME

CITY: BOILING SPRINGS STATE: SC

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

ZIP CODE: 29316 TELEPHONE (Include Area Code): ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☒ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 12 05 2000

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY 08 26 2000 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: SOPHIA RODIER MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE (faxed to Rodier MD)

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1. 807 01 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 08 27 2000	08 27 2000	23	4	71100	26	1	38 00	1				157948
2												
3												
4												
5												
6												

2000 DEC 12 PM 4:40

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
57-0523224	☐	☐	331*2024000167	☒ YES ☐ NO	$ 38 00	$	$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

L N WARREN JR, MD 12 05 2000

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

SPARTANBURG REGIONAL ER
101 EAST WOOD STREET
SPARTANBURG, SC 29303

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE 800/922-0346

SPARTANBURG RADIOLOGICAL ASSOC.
PO BOX 60100
CHARLESTON SC 29419-0100
157948

PIN # GRP #

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) DDD01/231/0615

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

SPARTANBURG RADIOLOGICAL ASSOC., P
PO BOX 60100
CHARLESTON SC 29419-0100

18#18
Return Service Requested
11967-3130

Place of Service: SPARTANBURG REGIONAL ER
CDC*331*2024000167 18#18

GAYLE DOVE
225 RIVER FOREST DR
BOILING SPRINGS SC 29316-8359

PATIENT NAME
515-64-6094
GAYLE DOVE

ACCOUNT NUMBER	STATEMENT DATE
[redacted]7	10-05-00

AMOUNT DUE	AMOUNT PAID
38.00	

SPARTANBURG RADIOLOGICAL ASSOC.,
PO BOX 60100
CHARLESTON SC 29419-0100

1257522328000002024000167092000038092

PLEASE DETACH AND RETURN TOP PORTION WITH PAYMENT

DATE	DOCTOR	CODE	DESCRIPTION	AMOUNT
08-27-00	L N WARREN JR, MD	71100	RIBS UNI MIN 2 VIEW	38.00
09-29-00				
09-29-00	NO PART B MEDICARE			

- ACCESS/CHANGE YOUR ACCOUNT VIA THE INTERNET anytime!!!
- Visit us at http://www.peryourhealth.com and enter your account
- number of 1677-2024000167 and password 74BR7P

Billing questions? Call: 800/922-0346

ACCOUNT NUMBER	DATE OF STATEMENT	PAYMENTS AFTER THIS DATE WILL APPEAR ON YOUR NEXT STATEMENT	BALANCE	AMOUNT DUE
[redacted]	10-05-00			38.00

PATIENT NAME
GAYLE DOVE

INSURANCE HAS DENIED PAYMENT ON YOUR ACCOUNT. YOU ARE RESPONSIBLE FOR PAYMENT IN FULL. PLEASE MAIL PAYMENT WITHIN 20 DAYS. THANK YOU.

MAKE CHECKS PAYABLE TO:
SPARTANBURG RADIOLOGICAL ASSOC., PA

L.N. WARREN, JR, MD
F.P. RYAN, JR, MD
NEIL H. PARNES, MD
MARK D MONSON, MD
DOUGLAS M FOLTZ, MD
BRIAN BAGHDADY, MD
J. A. KAVANAGH, MD
R. E. MITCHELL, MD
J. A. HARRILL, MD
WILLIAM T. JOYCE, MD
COLE GRAHAM, MD

[redacted]
Place of service: SPARTANBURG REGIONAL E
Referring Doctor: ~~SOPHIA RODIER~~ MD
Diagnosis: 807.01

SPARTANBURG RADIOLOGICAL ASSOC., PA
PO BOX 60100
CHARLESTON SC 29419-0100
800/922-0346

To: VA

I am a 100% disabled vet living in Boiling Springs, S.C. On Aug. 27th, I slipped on the rug in the bathroom and fell on the edge of the tub. I was in so much pain that my husband took me to Spartanburg Regional Hospital. The X-Ray showed a fractured rib on my left side. I wasn't able to ride all the way to Columbia, and considered this an emergency, so I am permitt[redacted] bill to you. My S.S.# is [redacted]

Thank You,
Gayle Dove
(864) 578-8093

2000 OCT 18 PM 3 13

MailMan message for BICKER,REBECCA ANN FEE BASIS CLERK
Printed at COLUMBIA-SC.VA.GOV 09 May 01 14:08
Subj: HINQ response for DOVE,GAYLE A /requested by BICKER,REBECCA ANN [#2409051] 09 May 01 14:01 66 lines
From: POSTMASTER In 'IN' basket. Page 1

DOVE,GAYLE A AUG 15,1957 SSN: [redacted]
VBA name = GADOVE — Verified Svc-Data
Name = GAYLE A DOVE — Original Award = FEB 01, 1995
Address = 922 PARKVIEW PL — Networth = Zero Networth
Address = GULFPORT MS — Combat Disability = NONE
ZIP = 39507 — SSI Income = Never
Sex = FEMALE
Date of Birth = AUG 15, 1957
C&P SSN = [redacted]

Claim Number = [redacted]
Service Number = [redacted]
Folder Location = 323 - JACKSON-RO
POW = Not applicable
Total Active Svc = 12 yr 14 days
INDICATORS(Active Duty Training NO Disability NO Homeless Veteran NO)

Service data	C&P	BIRLS
Branch of Service =	Air Force	AF
EOD =	SEP 04,1975	SEP 4,1975
RAD =	SEP 16,1987	SEP 16,1987

Char of Service = HONORABLE HON
Additional service = Not an issue
Entitlement = Regular estab.(compensation) - 41
Master Record Type = Veterans Master Record - A

Diary data:
APR, 2002 100% unemployable review - 02

Diary data:
MAR, 2009 RO-issue Dependency Verification form. - 24

Diary data:
APR, 2016 Expiration of employability control - 32

DISABILITIES(Combined % = 90 SC/Total = 5/5 Additional = 0)

9411 - POST-TRAUMATIC STRESS DISORDER - 70% - Service Connected
7617 - REMOVAL OF UTERUS AND OVARIES - 50% - Service Connected
8100 - MIGRAINE HEADACHES - 30% - Service Connected
6501 - RHINITIS - 00% - Service Connected
7819 - NEOPLASM, BENIGN, SKIN - 00% - Service Connected

Perm.,total Disablity = Cannot be determined
AID & ATTEND = HB and/or A&A NOT GRANTED
Chief Attorney, fiduciary =
Employable indicator = Unemployable
Competency indicator = Competent, or not an issue
Competency Pay Status = Competent,or not an issue,Pay direct

INDICATORS(NO Severence Recoupment NO PFOP/FDIB NO Consolidated Payment)

Anatomical loss = No Amputation - 00
Other loss = Loss or loss of use of creative organ. - 1
Vet married Vet = No spouse or not eligible -
Spec. Month comp. = One disability under (k) - 01

Spouse name = DONALD DOB = AUG 19, 1955

CHAMPVA = Eligible Number of CHILDREN

School = Helpless School = Depend. total = V-S This Award = V-S

Check Amount= '$2306.00' Hardship Exp.= '$0' Net Award= '$2306.00'

Aaron

OMB Number: 2900-0260
Estimated burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND CONSENT TO RELEASE OF MEDICAL RECORDS PROTECTED BY 38 U.S.C. 7332

PAPERWORK REDUCTION ACT INFORMATION: Public reporting burden for this collection of information is estimated to average 2 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to VA Clearance Officer (723), 810 Vermont Avenue NW, Washington DC 20420, and to the Office of Information and Regulatory Affairs, Paperwork Reduction Project (2900-0260), Office of Management and Budget, Washington DC 20503. DO NOT send applications to this address.

The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. and will authorize release of information you specify. Your disclosure of the information requested on this form is voluntary. However, if the information is not furnished, Department of Veterans Affairs will be unable to comply with the request.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

PATIENT NAME (Last, First, Middle Initial)
X DOVE, GAYLE A.

SOCIAL SECURITY NUMBER
X [redacted]

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☐ OTHER (Specify)

X-Ray July 22, 99
May 25, 99
Apr. 2, 99
H/C

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time except to the extent that action has already been taken to comply with it. Redisclosure of my medical records by those receiving the above authorized information may not be accomplished without my further written consent. Without my express revocation, the consent will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); or (3) under the following condition(s):

DATE: 27 Sep 99

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT: Gayle A. Dove

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

VA FORM [illegible]

[illegible] U.S. Government Printing Office: 1998 - 621-031/83053

EXAMINER: JO Ann Summers
UNIT: 1

MAY 20 1999

Admin

0011134129

REQUEST FOR MEDICAL INFORMATION FROM RECORDS OF VETERANS ADMINISTRATION

The veteran named below has filed an application for a period of disabili and/or disability benefits under a disability program administered by th Social Security Administration and has authorized the Veterans Administration to release to the Social Security Administration any medical information from their records concerning the claimant.

(Be Sure to Indicate Hospital, Clinic, Domiciliary or Regional Office)

VA MEDICAL CENTER
400 VETERANS BLVD
BILOXI MS 39531

I IDENTIFYING INFORMATION (To Be Completed by SSA)

VETERAN'S NAME (LAST, FIRST, MIDDLE)
DOVE, GAYLE A

SOCIAL SECURITY NUMBER
[redacted]

CLAIM NUMBER
C-[redacted]

SERVICE SERIAL NUMBER (IF C NO. NOT AVAILABLE)
DOB: 08/15/57

DATE OF REQUEST
May 18, 1999

ORIGINATING OFFICE (IF NOT PARALLEL DO)
Disability Determination Services
Post Office Box 1271
Jackson, Mississippi 39215-1271

II INFORMATION NEEDED BY SSA

(Only checked items are needed)

A. [X] HOSPITAL SUMMARIES OR EQUIVALENT INFORMATION
(If veteran is still hospitalized and the period covered by the latest summary ended over 3 months ago, please also furnish response to treatment and current diagnosis and prognosis. If a summary has not been prepared, please furnish history; copy of admission examination, subsequent laboratory reports and examinations; treatment and response; diagnosis; and prognosis.)
→ HOSPITALIZED AT: VA BILOXI
→ DATES: 3/98 TO 5/99

B. [ ] EXAMINATION FOR COMPENSATION OR PENSION → DATE:

C. [X] RECORDS OF OUT-PATIENT TREATMENT → DATES: 3/98 - 5/99

D. [ ] STATEMENT OF COMPETENCY TO MANAGE FUNDS
(If summaries or reports furnished do not contain determination of competency to manage funds made within past year, please complete block III-B below.)

E. [X] OTHER SPECIFIC INFORMATION

ANY AVAILABLE RECORDS

III VA RESPONSE

A. USE THIS SPACE FOR REPLY TO II-E OR FOR OTHER REMARKS:

If additional space is necessary, use reverse or attach additional sheet.

B. STATEMENT OF COMPETENCY TO MANAGE FUNDS (Complete only if II-D checked above)
THIS VETERAN CONSIDERED BY THE VETERANS ADMINISTRATION [ ] COMPETENT TO MANAGE FUNDS [ ] INCOMPETENT TO MANAGE FUNDS

THIS DECISION HAS BEEN [ ] ADJUDICATED BY VA [ ] DETERMINED BY MEDICAL STAFF — DATE OF DECISION

Return to
DISABILITY DETERMINATION SERVICE
POST OFFICE BOX 1271
JACKSON, MISSISSIPPI 39215-1271

I certify the above information is taken from the medical records at this station and that all opinions expressed are those of our medical staff.

SIGNATURE OF REGISTRAR, MED. ADM. OFF. OR DESIGNEE
Vanessa M Dickson
Robert A Bidwell, RRA

DATE: 5/25/99
TITLE: Health Information Manager

Form SSA-828-U4 (11-77)

	TO BE COMPLETED BY SSA NUMBER HOLDER Gayle A. Dove SOCIAL SECURITY NUMBER [redacted] EMPLOYEE/CLAIMANT/BENEFICIARY *(If other than Number Holder)*

AUTHORIZATION FOR SOURCE TO RELEASE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

INFORMATION ABOUT MEDICAL OR OTHER SOURCE-PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS OF SOURCE *(Include Zip Code)*	RELATIONSHIP TO DISABLED PERSON
VA Biloxi	

INFORMATION ABOUT DISABLED PERSON-PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS *(If known)* AT TIME DISABLED PERSON HAD CONTACT WITH SOURCE *(Include Zip Code)*	DATE OF BIRTH	DISABLED PERSON'S I.D. NUMBER *(If known and different than SSN) (Clinic/Patient No.)*
	8/15/57	

APPROXIMATE DATES OF DISABLED PERSON'S CONTACT WITH SOURCE *(e.g., dates of hospital admission, treatment, discharge, etc.)*

8/98 Present

TO BE COMPLETED BY DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF

GENERAL AND SPECIAL AUTHORIZATION TO RELEASE MEDICAL AND OTHER INFORMATION IN ACCORDANCE WITH THE PROVISIONS OF THE SOCIAL SECURITY ACT; THE PUBLIC HEALTH SERVICE ACT, SECTIONS 523 AND 527; AND TITLE 38 U.S.C. VETERANS BENEFITS, SECTION 4132.

I hereby authorize the above-named source to release or disclose to the Social Security Administration or State agency the following information for the period(s) identified above:

1) All medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV), or sexually transmitted diseases;
2) Information about how my impairment(s) affects my ability to complete tasks and activities of daily living;
3) Information about how my impairment(s) affected my ability to work.

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above.

I understand that this authorization, except for action already taken, may be voided by me at anytime. If I do not void this authorization, it will automatically end when a final decision is made on my claim. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.

READ IMPORTANT INFORMATION ON REVERSE BEFORE SIGNING FORM BELOW.

SIGNATURE OF DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF	RELATIONSHIP TO DISABLED PERSON (If other than self)	DATE
Gayle A. Dove		5/18/99

STREET ADDRESS	TELEPHONE NUMBER (Area Code)

CITY	STATE	ZIP CODE

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by the Social Security Administration, but without it the source may not honor this authorization.

SIGNATURE OF WITNESS	STREET ADDRESS	
CITY	**STATE**	**ZIP CODE**

MailMan message for SALLEY,FLORENCE E CLERK,MEDICAL
Printed at BILOXI.VA.GOV 24 Apr 97 [illegible]43
Subj: HINQ response for DOVE,GAYLE A [illegible]equested by SALLEY,FLORENCE E [#5536762] [illegible]pr 97 14:42 64 Lines
From: POSTMASTER (Sender: SALLEY,FLORENCE E) in 'IN' basket. Page 1

DOVE,GAYLE A AUG 15,1957 SSN:515646094 C-#:515646094 S-#:515646094 Div:BILOXI
VBA name = GADOVE Verified Svc-Data
Name = GAYLE A DOVE Original Award = FEB 01, 1995
Address = 4457 POPPS FERRY RD Networth = Zero Networth
Address = LOT 195 Combat Disability = NONE
Address = BILOXI MS SSI Income = Never
ZIP = 39532
Sex = FEMALE
Date of Birth = AUG 15, 1957
BIRLS SSN = [redacted]

Claim Number = [redacted]

Folder Location = 323 - JACKSON-RO
POW = Not applicable
Total Active Svc = 12 yr 14 days
INDICATORS(Active Duty Training NO Disability NO Homeless Veteran NO)

Service data	C&P	BIRLS
Branch of Service =	Air Force	AF
EOD =	SEP 04,1975	SEP 4,1975
RAD =	SEP 16,1987	SEP 16,1987

Char of Service = HONORABLE HON
Additional service = Not an issue
Entitlement = Regular estab.(compensation) - 41
Master Record Type = Veterans Master Record - A

Diary data:
DEC, 1997 Future physical examination - 01

Diary data:
APR, 1998 100% unemployable review - 02

Diary data:
APR, 2016 Expiration of employability control - 32

DISABILITIES(Combined % = 90 SC/Total = 5/5 Additional = 0)

9411 - POST-TRAUMATIC STRESS DISORDER - 70% - Service Connected
7617 - REMOVAL OF UTERUS AND OVARIES - 50% - Service Connected
8100 - MIGRAINE HEADACHES - 30% - Service Connected
6501 - RHINITIS - 00% - Service Connected
7819 - NEOPLASM, BENIGN, SKIN - 00% - Service Connected

Perm.,total Disablity = Not permanently and totally disabled
AID & ATTEND = HB and/or A&A NOT GRANTED
Chief Attorney, fiduciary =
Employable indicator = Unemployable
Competency indicator = Competent, or not an issue
Competency Pay Status = Competent,or not an issue,Pay direct

INDICATORS(NO Severence Recoupment NO PFOP/FDIB NO Consolidated Payment)

Anatomical loss = No Amputation - 00
Other loss = Loss or loss of use of creative organ. - 1
Vet married Vet = No spouse or not eligible -
Spec. Month comp. = One disability under (k) - 01
Special Provision = Analogous Ratings - 5

Check Amount= '$1998.00' Hardship Exp.= '$0' Net Award= '$1998.00'

DEPARTMENT OF VETERANS AFFAIRS
Regional Office
100 West Capitol Street
JACKSON MS 39269

MAR 2 6 1997

In Reply Refer To: 323/2114
[redacted]
DOVE, G A

GAYLE A DOVE
4457 POPPS FERRY RD
LOT 195
BILOXI MS 39532

Dear Ms. Dove:

We made a decision on your claim for increased compensation.

What We Decided

We found the following disability has increased in severity. Here is the condition and its evaluation.

Your Posttraumatic stress disorder which was 50% has increased to 70% disabling.

We also granted your claim for entitlement to Individual Unemployability.

We did not find any evidence which would suggest a change in the evaluation for the disability listed below:

Your Migraine headaches remains 30% disabling.

Your overall or *combined* evaluation is 90%. The percentages of your individual disabilities may not add up to your overall evaluation. We use a "combined rating table" to decide how disabled you are. The percentages in this table are set by regulation.

How We Made Our Decision

We carefully considered all the evidence we received. We have attached a copy of the Rating Decision. It shows the evidence we used and the reasons for our decision.

CSS 515 64 6094
Dove, G A

Your Monthly Compensation

Your monthly compensation is shown below. Please understand that the law (38 U.S.C. 5111) says payments must begin the first day of the month after you've become entitled to the benefit.

Starting December 1, 1996, you're entitled to $1,998.00 monthly ***because*** date increased VA benfits first payable.

We're paying you as a single veteran with no dependents.

How To Complete Your Claim For Dependents

The information you sent us about your dependents is incomplete. Before we can pay additional benefits for any dependents you have, you must send us the following:

- VA Form 21-686c. Please fill out every blank which applies to you.
- The Social Security number of any dependents claimed. Write the number on the attached VA Form 21-4138 or call us with the information.

When We Need The Evidence

Please send the information on your dependent(s) right away, within 60 days if possible. If we receive your response after March 26, 1998, we won't be able to pay you any "back benefits".

You may be eligible for Department of Veterans Affairs (VA) vocational rehabilitation. The enclosed VA Form 28-8890 explains this benefit. To apply, complete VA Form 28-1900, and return it to this office.

If You Think We're Wrong

If you think our decision is wrong, you should write and tell us why. The enclosed VA Form 4107 explains your right to appeal.

We've also attached a VA Form 21-8764, Disability Compensation Award Attachment--Important Information, which explains certain factors concerning your benefits.

CSS 515 64 6094
Dove, G A

Direct Deposit

Your money may be deposited directly into your checking or savings account. This is the safest and most reliable way to get your money. To get more information about Direct Deposit, please call us at the toll free number below.

Sincerely yours,

Jerry W. Mitchell

JERRY W. MITCHELL
Adjudication Officer

Enclosure(s): Rating Decision
VA Form 21-686c
VA Form 21-4138
VA Form 28-1900
VA Form 28-8890
VA Form 21-8764
VA Form 4107

cc: AL

2114/084/rod

OMB Approved No. 2900-0043
Respondent Burden: 15 minutes

Department of Veterans Affairs

DECLARATION OF STATUS OF DEPENDENTS

PRIVACY ACT INFORMATION: The responses you submit are considered confidential (38 U.S.C. 5701). They may be disclosed outside the Department of Veterans Affairs (VA) only if the disclosure is authorized by the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22, Compensation, Pension, Education, and Rehabilitation Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies.

Income information and employment information furnished by you will be compared with information obtained by VA from the Secretary of Health and Human Services or the Secretary of the Treasury under clause (viii) of section 6103(1)(7)(D) of the Internal Revenue Code of 1986. Any infomation provided by you including your Social Security Number, may be used in matching programs conducted in connection with any proceeding for the collection of an amount owed the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs.

RESPONDENT BURDEN: Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the VA Clearance Officer (045A4), 810 Vermont Ave., NW, Washington, DC 20420. SEND COMMENTS ONLY, NOT THIS FORM OR REQUESTS FOR BENEFITS TO THIS ADDRESS.

INSTRUCTIONS: This form must be completed and returned to VA. Copies of public records may be obtained free in some jurisdictions if the county clerk or similar custodian of such records is informed that they are required by VA in determining eligibility for benefits. If you previously submitted a copy of a birth or marriage record, you need not furnish another copy.

1A. FIRST - MIDDLE - LAST NAME OF VETERAN	2A. NAME OF CLAIMANT *(If other than veteran)*	3. FILE NUMBER
G A Dove		[redacted]
1B. VETERAN'S SOCIAL SECURITY NUMBER	2B. CLAIMANT'S SOCIAL SECURITY NUMBER	

4. ADDRESS OF CLAIMANT *(No. and street or rural route, city or P.O., State and ZIP Code)*

GAYLE A DOVE LOT 195
4457 POPPS FERRY RD BILOXI MS 39532

5A. MARITAL STATUS *(Check one)*	5B. IF MARRIED, SPOUSE'S DATE OF BIRTH
☐ MARRIED ☐ DIVORCED ☐ NEVER MARRIED *(If checked, do not complete items 6 thru 10)* ☐ WIDOWED ☐ SEPARATED	

NOTE: Furnish the following information about each of your marriages including your current marriage. A copy of the public or church record of your current marriage is required unless previously submitted. Begin with your current marriage.

6A. DATE AND PLACE OF MARRIAGE	6B. TO WHOM MARRIED *(First, middle, last name)*	6C. SOCIAL SECURITY NUMBER	6D. HOW MARRIAGE TERMINATED *(Death, Divorce)*	6E. DATE AND PLACE TERMINATED

NOTE: Furnish the following information about each previous marriage of your present spouse.

7A. DATE AND PLACE OF MARRIAGE	7B. TO WHOM MARRIED *(First, middle, last name)*	7C. HOW MARRIAGE TERMINATED *(Death, Divorce)*	7D. DATE AND PLACE TERMINATED

EXISTING STOCKS OF VA FORM 21-686c, AUG 1994, WILL BE USED.

(Continued on Reverse)

OMB Approved No. 2900-0075
Respondent Burden: 15 minutes

Department of Veterans Affairs

STATEMENT IN SUPPORT OF CLAIM

PRIVACY ACT INFORMATION: The law authorizes us to request the information we are asking you to provide on this form (38 U.S.C. 501(a) and (b)). The responses you submit are considered confidential (38 U.S.C. 5701). They may be disclosed outside the Department of Veterans Affairs (VA) only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22, Compensation, Pension, Education and Rehabilitation Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Clearance Officer (723), 810 Vermont Ave., NW, Washington, DC 20420; and to the Office of Management and Budget, Paperwork Reduction Project (2900-0057), Washington, DC 20503. PLEASE DO NOT SEND THIS FORM OR APPLICATIONS FOR BENEFITS TO THESE ADDRESSES.

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN *(Type or print)*	SOCIAL SECURITY NO.	VA FILE NO.
G A Dove		[redacted]

The following statement is made in connection with a claim for benefits in the case of the above-named veteran:

(CONTINUE ON REVERSE)

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

SIGNATURE	DATE SIGNED	
ADDRESS	TELEPHONE NUMBERS *(Include Area Code)*	
	DAYTIME	EVENING

PENALITY: The law provides severe penalties which include fine or inprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false.

VA FORM APR 1994 21-4138 (JF)

EXISTING STOCKS OF VA FORM 21-4138(JF), OCT 1993, WILL BE USED

OMB Approved No. 2900-0009
Respondent Burden: 1/4 hour

Department of Veterans Affairs

DISABLED VETERANS APPLICATION FOR VOCATIONAL REHABILITATION
(Chapter 31 - Title 38, U.S.C.)

PAYEE NO. | TRANS CODE

IMPORTANT: Please read information on reverse before completing this form. TYPE OR PRINT IN INK.

1. SERVICES AND ASSISTANCE NEEDED *(Check all that apply)*

- ☐ I WANT TO GO TO COLLEGE OR VOCATIONAL SCHOOL
- ☐ I WANT TO BECOME MORE INDEPENDENT IN DAILY LIVING
- ☐ I AM NOT SURE, BUT I WANT TO SEE WHAT VA HAS AVAILABLE
- ☐ I WANT AN APPRENTICESHIP OR OTHER ON-JOB TRAINING SCHOOL
- ☐ I NEED HELP IN GETTING A JOB

2. FIRST, MIDDLE, LAST NAME OF VETERAN	3. SOCIAL SECURITY NO.	4. VA [redacted] NO.
G A Dove		[redacted]

5. MAILING ADDRESS *(No. and street or rural route, city, State, and ZIP Code)*	6. HOME TELEPHONE NO. *(Include Area Code)*	7. WORK TELEPHONE NO. *(Include Area Code)*	8. DATE OF BIRTH
4457 POPPS FERRY RD LOT 195 BILOXI MS 39532			

9. VA OFFICE WHERE RECORDS ARE LOCATED *(If known)*

10. PERMANENT ADDRESS *(If different than Item 5)*

11. SEX ☐ MALE ☐ FEMALE

12. SERVICE INFORMATION *(Enter the following information for each period of active duty. Show ALL active duty)*

SERVICE NUMBER *(Prefix and suffix)* (A)	BRANCH OF SERVICE (B)	DATE ENTERED ACTIVE DUTY (C)	DATE SEPARATED FROM ACTIVE DUTY (D)	TYPE OF SEPARATION OR DISCHARGE (E)	GRADE OR RANK AT SEPARATION OR DISCHARGE (F)

13. IF NOW HOSPITALIZED, GIVE NAME AND LOCATION OF HOSPITAL

(DO NOT WRITE IN THIS SPACE)
(VA DATE STAMP)

14. VA BENEFITS PREVIOUSLY APPLIED FOR

- ☐ A. HOSPITALIZATION OR MEDICAL CARE
- ☐ B. WAIVER OF NSLI PREMIUM
- ☐ C. DENTAL OR OUTPATIENT TREATMENT
- ☐ D. VOCATIONAL REHABILITATION *(Chapter 31)*
- ☐ E. VETERANS' EDUCATIONAL ASSISTANCE *(Chp. 30, 32, 33, or 34)*
- ☐ F. WAR ORPHANS' OR DEPENDENTS' EDUCATIONAL ASSIST. *(Chp. 35)*
- ☐ G. PENSION
- ☐ H. SERVICE-CONNECTED DISABILITY COMPENSATION *(If receiving compensation, complete Items 14L and 14M)*
- ☐ I. VOCATIONAL TRAINING FOR VA PENSIONERS *(Chapter 15)*
- ☐ J. MONTGOMERY GI BILL SELECTED RESERVE
- ☐ K. NONE
- ☐ L. OTHER *(Specify)*

COMPLETE ONLY IF ITEM 14H IS CHECKED ▶	L. VA DISABILITY RATING %	M. NATURE OF DISABILITY

15. DEPENDENTS *(Check applicable boxes. If VA authorizes training, you may have to submit documentary evidence before additional subsistence allowance benefits for dependents may begin)*

☐ NONE ☐ SPOUSE ☐ CHILDREN *(Specify No.)* ☐ PARENTS DEPENDENT ON YOU FOR SUPPORT *(Specify No.)*

16. EDUCATIONAL LEVEL *(Indicates the highest level completed)*

☐ LESS THAN HIGH SCHOOL DIPLOMA *(Specify last grade level)* ☐ HIGH SCHOOL DIPLOMA/GED ☐ COLLEGE *(Specify years completed)* ☐ GRADUATE DEGREE

17. PREVIOUS NON-VA REHABILITATION SERVICES

HAVE YOU RECEIVED VOCATIONAL REHABILITATION SERVICES FROM AGENCIES OTHER THAN VA?

☐ YES ☐ NO *(If "Yes," name each agency which provided service, the types of services provided, and the beginning and ending dates when you received the services)*

I HEREBY CERTIFY THAT all the information I have entered on this form is true and complete to the best of my knowledge and belief and I realize that making willful false statements concerning a material fact in a claim for vocational rehabilitation benefits is a punishable offense which may result in fine or imprisonment or both.

18A. SIGNATURE OF APPLICANT *(Do not print) (Sign in ink)*	18B. DATE

19. AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize release of school, employment and other records to VA for use in counseling me and supervising my rehabilitation program. I also authorize VA to release to schools, other training establishments, job placement or related agencies, and to potential employers any information, to include my name and address, which will assist me in my vocational rehabilitation program or in my search for gainful employment.

A. SIGNATURE OF APPLICANT *(Do not print) (Sign in ink)*	B. DATE

FOR VA USE ONLY ▶	DEP ▶			ED. LEVEL ▶			CLAIM STATUS ▶			DATE REFERRED VR&C ▶	

VA FORM MAR 1991 28-1900 (JF)

SUPERSEDES VA FORM 28-1900, MAY 1990, WHICH WILL NOT BE USED.

Department of Veterans Affairs

[redacted]
G A Dove

IMPORTANT INFORMATION ABOUT VOCATIONAL REHABILITATION BENEFITS

(ATTACHMENT TO VA FORM 28-1900)

If you are a veteran with a service-connected disability or disabilities which VA has rated at least 20 percent disabling, you may be eligible for the Department of Veterans Affairs program of vocational rehabilitation.

The training and other services which this program provides can help you prepare for and obtain a good job. If you are too seriously disabled to train for employment, VA may also provide services to help you to learn to live more independently. This program's benefits are in addition to any VA compensation or military retirement benefits you are entitled to receive.

If VA finds you eligible for this program, a VA counselor will meet with you to evaluate your needs for educational and vocational training, employment assistance, and services and assistance to help you to live more independently. Based on this evaluation, the counselor and others will work with you to develop a plan of training and services to prepare you for employment.

In a vocational rehabilitation program, you may attend a college, university, or vocational school or pursue an on-farm, on-job, or apprenticeship program. VA may even arrange to provide training and assistance in your own home or in special facilities if your disability prevents you from attending regular facilities in the community.

VA will pay the costs of your training and other services. While you are training and for 2 months after you complete a training program, VA will pay you a monthly living allowance. VA will also arrange for any medical or special assistance you need to finish your rehabilitation program.

After you complete any needed training, VA will help you find a job. You may also receive job assistance without training if VA finds that you only need this assistance to obtain a suitable job.

Generally, you must complete a rehabilitation program within 12 years from the date VA notifies you that you are entitled to compensation at the 20-percent rate or higher. Under certain conditions, this period may begin at an earlier date or may be extended.

If you are interested in vocational rehabilitation or would like to come in to discuss the opportunities the program offers, please complete and forward to us the enclosed application, VA Form 28-1900, Disabled Veterans Application for Vocational Rehabilitation. Sending us this form does not obligate you in any way nor will it affect any VA compensation, other VA education benefits, or military retirement pay you may receive.

VA FORM [redacted]
JUL 1991

SUPERSEDES VA FORM 28-8890, NOV 1989, WHICH WILL NOT BE USED.

Department of Veterans Affa..

[redacted]
G A Dove

DISABILITY COMPENSATION AWARD ATTACHMENT IMPORTANT INFORMATION

VA CHECK DELIVERY

A check covering the initial amount due under this award will be mailed within 15 days. Thereafter, checks will be delivered at the beginning of each month for the preceding month.

VA HOSPITALIZATION AND OUTPATIENT TREATMENT

You are entitled to priority admission to a VA hospital or to outpatient treatment for all service-connected conditions. A priority Patient Data Card which identifies you as being entitled to priority treatment may be obtained from your nearest VA health facility. If you have a service-connected disability or disabilities evaluated at 50% or more, you may also qualify for outpatient medical treatment for conditions not due to military service. Although the enclosed award letter is not an authorization for treatment, it will help you establish your entitlement and should be presented to the nearest VA Medical Center or Outpatient Clinic when you apply for the priority Patient Data Card or should the need for treatment arise before the card is received by you.

DENTAL TREATMENT

If you are evaluated as 100% disabled for service-connected disabilities or as 100% disabled because of Individual Unemployability, you may be eligible for VA dental treatment. For additional information, contact your nearest VA Medical Center or Outpatient Clinic.

ADDITIONAL COMPENSATION FOR DEPENDENTS

Veterans having a 30% or more service-connected condition may be entitled to additional compensation for a spouse, dependent parents, or unmarried children under 18 (or under 23 if attending an approved school) or when prior to age 18 the child has become permanently incapable of self-support because of mental or physical defect. The additional benefit for a spouse is payable in a higher amount upon receipt of evidence establishing that the spouse is a patient in a nursing home or so disabled as to require the aid and attendance of another person.

INDIVIDUAL UNEMPLOYABILITY

If your service-connected disabilities are seriously disabling, but are not total and are not solely of a psychiatric nature, and you are unable to secure and follow a substantially gainful occupation because of those disabilities, you may be entitled to receive benefits at the rate for total disability. If you wish to claim this benefit, you should contact the nearest VA office and complete 21-8940, Veteran's Application for Increased Compensation Based on Unemployability.

VOCATIONAL REHABILITATION

As a disabled veteran you may be eligible for the training and employment services provided under the vocational rehabilitation program. VA pays the full cost for tuition, fees and other services furnished and you receive a monthly payment to help you meet your regular living expenses. These benefits are in addition to any compensation or retirement pay. If your disability was incurred on or after September 16, 1940, and you are interested in this program or desire additional information, you should contact your nearest VA office.

EDUCATIONAL BENEFITS

If you were discharged after January 31, 1955, you may be eligible for educational benefits in addition to compensation or retired pay. A monthly educational assistance allowance is payable to veterans who qualify for one of VA's educational assistance programs. Each program has unique eligibility specified by law, but only one program can be used at any given time. These programs are alternatives to the above-mentioned Vocational Rehabilitation. If you desire additional information, you should write or call the nearest VA office.

NONASSIGNABILITY AND EXEMPT STATUS OF BENEFITS

Compensation payments are exempt from claims of creditors. With certain exceptions the payments are not assignable and are not subject to attachment, levy or seizure except as to claims of the United States.

GOVERNMENT LIFE INSURANCE

If you are paying premiums on Government life insurance (GI insurance) and are unable to work, you may be entitled to certain benefits as provided for in your policy. For complete information contact the VA regional office where you pay premiums.

CHANGE OF ADDRESS NOTICE

Please notify this office immediately, in writing over your signature, of any change of address.

CONDITIONS AFFECTING RIGHT TO PAYMENT

1. Your award of disability compensation is subject to future adjustment upon receipt of evidence showing any change in the degree of disability.
2. Your payments may also be affected by any of the following circumstances which you must promptly call to our attention.
   a. Reentrance into active military or naval service.
   b. Receipt of armed forces service retirement pay, unless your retirement pay has been reduced because of award of disability compensation.
   c. Receipt of benefits from the Office of Federal Employees Compensation.
   d. Receipt of active duty or drill pay as a reservist or member of the Federally recognized National Guard.
3. If you have a disability rating of 30% or more, you must promptly advise us of any change in the status of your dependents.
4. If your award includes special monthly compensation due to need for aid and attendance, this additional allowance is generally subject to reduction from the first day of the second calendar month of admission to hospitalization, nursing home or domiciliary care at VA expense.
5. Benefits will be reduced upon incarceration in a Federal, State or local penal institution in excess of 60 days for conviction of a felony. The amount not payable may be apportioned to a spouse, dependent children or parents.
6. Monthly payments of your award may be stopped, if you fail to furnish evidence as requested; fail to cooperate or submit to a VA examination when requested; or if you furnish VA or cause to be furnished any false or fraudulent evidence.
7. Information submitted is subject to verification through computer matching programs with other agencies.
8. The law provides severe penalties which include fine or imprisonment, or both, for the fraudulent acceptance of any payment to which you are not entitled.

VA FORM
FEB 1990 [redacted]

EXISTING STOCKS OF VA FORM 21-8764, JUL 1988 WILL BE USED.

Department of Veterans Affairs

NOTICE OF PROCEDURAL AND APPELLATE RIGHTS

IF YOU DO NOT AGREE WITH THIS ACTION

We have based our determination on the evidence of record and the applicable law. If you do not agree with the action we have taken, you have two choices. (1) You may reopen your claim by sending VA new and material evidence which we have not considered. (2) You may appeal to the Board of Veterans' Appeals (BVA).

REOPENING YOUR CLAIM

NEW EVIDENCE. You may give us evidence we do not have to strengthen your claim. Testimony may be that kind of evidence. To have a hearing before regional office personnel, see the instructions below. It is in your interest to send us any new evidence as soon as possible. We will consider it and let you know whether it changes our determination. You may also submit additional evidence, with some time limitations, if you appeal to the BVA.

HEARINGS BEFORE REGIONAL OFFICE PERSONNEL. We do not require you to have a hearing. You may testify in your own behalf before regional office personnel. You may also bring witnesses. To request a hearing before regional office personnel, send a letter to this office. We will arrange a time and place for the hearing. You can request a hearing before regional office personnel at any time. VA will furnish the hearing room, provide hearing officials and make a transcript of the hearing. The transcript will be placed in your claims folder. Regional office personnel will decide, based on the testimony and other evidence, whether your claim is successfully reopened and whether it can be granted. If your claim remains denied, you may appeal to the BVA. The record sent to the BVA will include the transcript of the hearing. If you appeal our decision, you may also request a hearing before the BVA. See Your Appellate Rights below. You may have a hearing before both regional office personnel and the BVA.

YOUR APPELLATE RIGHTS

This notice summarizes your procedural and appellate rights. For complete information, refer to the Rules of Practice of the Board of Veterans' Appeals (38 CFR Part 20).

APPEAL OF THIS DETERMINATION. You may appeal our determination to the BVA. To appeal, send this office a Notice of Disagreement within 1 year from the date of the letter which accompanies this form. A Notice of Disagreement is a letter telling this office that you wish to appeal. If more than one benefit is involved, you should identify the benefit or benefits for which you are appealing. After you have filed a Notice of Disagreement, we will send you a Statement of the Case containing the facts, the applicable laws and regulations, and the reasons for our determination.

HEARINGS. You may still have a hearing before regional office personnel even after you file a Notice of Disagreement. If you want a hearing before regional office personnel, see the instructions above. In addition, you may have a hearing before the BVA after you appeal the determination contained in the letter which accompanies this form. The BVA does not require a hearing. You may present evidence and argument, and bring witnesses. The testimony will be a part of the record. VA will set the time and date of the hearing, provide the hearing room and hearing officials, and record the hearing. VA cannot pay any other expenses of a hearing. The BVA holds hearings in Washington, D.C., or at a VA regional office. If you request a hearing before the BVA in Washington, D.C., the BVA will tell you the time and date of the hearing. To request a hearing before the BVA at a regional office, write to this office. We fill these requests in the order of receipt. This office can tell you the expected waiting period for a BVA hearing at this office.

REPRESENTATION. An accredited representative of a recognized service organization may represent you without charge. An agent or attorney, such as a legal aid attorney or one in private practice, may also represent you. VA cannot pay fees of agents or attorneys.

ATTORNEY OR AGENT FEE LIMITATION. Except in loan cases, no fee may be charged, allowed, or paid for services provided by agents or attorneys before the BVA first makes a final decision in your claim. After the first final BVA decision in your claim, an attorney or accredited agent may charge you a fee under certain circumstances for representing you before VA, including the BVA, or the United States Court of Veterans Appeals. An attorney or agent may charge you a reasonable fee in writing in connection with any proceeding in a case arising out of a loan made, guaranteed, or insured under chapter 37 of title 38, United States Code for services provided after October 9, 1992. For more information, refer to Section 5904, Title 38, United States Code. If an attorney or accredited agent represents you before VA, a copy of any agreement between you and the attorney or accredited agent about the payment of the attorney's or agent's fees must be filed at the following address: Counsel to the Chairman (01C3), Board of Veterans' Appeals, 810 Vermont Avenue, N.W., Washington, D.C. 20420.

APPEAL OF BVA DECISION. You may appeal a final BVA decision to the United States Court of Veterans Appeals (the Court). You must file a Notice of Appeal with the Clerk of the Court within 120 days from the date on which the BVA mailed the notice of the BVA decision.

VA FORM
AUG 1993(RS) **4107 (JF)**

NAME OF VETERAN	VA FILE NUMBER		POA
G A VOGEL	[redacted]	[redacted]	American Legion

[redacted]

ISSUE:

1. Evaluation of migraine headaches currently evaluated as 30 percent disabling.
2. Evaluation of posttraumatic stress disorder currently evaluated as 50 percent disabling.

EVIDENCE:

VA examination dated 05-06-96 and 05-20-96 conducted at VA medical Center, Biloxi, Mississippi.
Outpatient treatment reports from VA Medical Center, Biloxi, Mississippi, from 04-07-95 to 05-21-96.
Physician's statement dated 03-05-96.

DECISION:

1. Evaluation of migraine headaches, which is currently 30 percent disabling, is continued.
2. Evaluation of posttraumatic stress disorder, which is currently 50 percent disabling, is continued.

REASONS AND BASES:

1. Cited VA Medical Center outpatient treatment records were negative for treatment for migraine headaches. Reports from the veteran's Women's Group meetings shows that on 04-16-96 the veteran reported having to leave work early on occasion because of her migraine headaches. On 05-17-96, the veteran indicated that she had a new job and was working long hours. There was no mention of problems with headaches. On 05-21-96, the veteran reported much improvement in her headaches on her medication. On VA examination of 05-20-96, she reported that she gets her headaches about twice a week. These type of headaches are associated with nausea and vomiting and she sometimes takes Phenergan. She reported having tension-type headaches everyday which were described as a dull pain. The evaluation of migraine headaches is continued as 30 percent disabling. An evaluation of 30 percent is granted whenever there are characteristic prostrating attacks occurring on an average of once a month over the last several months. A higher evaluation of 50 percent is not warranted unless there are very frequent, completely prostrating, and prolonged attacks productive of severe economic inadaptability. Since this disability may be subject to improvement, the assigned evaluation is not considered permanent and is subject to a future review examination.

2. VA Medical Center outpatient treatment records show that the veteran attends her Women's Group on a regular basis. On psychiatric evaluation of 02-27-96, she reported increasing social isolation, insomnia, irritability, difficulty concentrating and inability to experience pleasure in most areas. It was noted that she was working at a casino dealing poker and was now dating. She stated that her partner commented on how unhappy she always seemed. On 03-05-96, she requested her physician to write a letter describing her severe limitations due to her posttraumatic stress disorder. The physician's letter indicates that the veteran has severe inability to establish and maintain effective relationships with people and he felt that her condition caused severe impairment in her ability to retain employment. (However, it should be noted that the veteran is employed). On 03-26-96, the veteran reported that she was sleeping better but still having some breakthrough nightmares. She reported being less irritable at work. On 04-16-96, she indicated that she was being laid off at work because of a reduction in workforce. She reported increased depression. On 05-02-96, she indicated that the manager had offered her a day position because he was pleased with her work

performance. It was indicated that a position was being made for her. She reported that her isolation was a 4-5 on a scale of 10. On VA examination of 05-06-96, she appeared depressed and complained of broken sleep. She reported having no close friends and indicated that she distrusted others. She reported crying spells at least 3 times a week. She reported decreased concentration and memory. She stated that she had no friends and no interests other than going to play bingo once a week. On 05-07-96, she indicated that she was interacting better with others at work and that her new job was less stressful. On 05-17-96, she indicated that she was getting along well with everyone at work, but was somewhat stressed over learning her new job. She stated that she was working long hours and was very tired after work which was placing stress on her relationship with her boyfriend. On 05-21-96, she indicated that she had much improvement in her anxiety. She stated that her mood and concentration were improved. She indicated that she was sleeping well. Her job was going well. She reported no crying spells. She reported that she and her boyfriend were working different shifts, so she didn't have much social life. She was pleasant and friendly. Her affect was appropriate and her mood was euthymic. The evaluation of posttraumatic stress disorder is continued as 50 percent disabling. An evaluation of 50 percent is granted if the ability to establish or maintain effective or favorable relationships with people is considerably impaired. By reason of psychoneurotic symptoms the reliability, flexibility, and efficiency levels are so reduced as to result in considerable industrial impairment. A higher evaluation of 70 percent is not warranted unless the record shows severe inability to establish and maintain effective or favorable relationships with people; the psychoneurotic symptoms are of such severity and persistence that there is severe impairment in the ability to obtain or retain employment. Since this disability may be subject to improvement, the assigned evaluation is not considered permanent and is subject to a future review examination.

DEPARTMENT OF VETERANS AFFAIRS
Medical Center
400 Veterans Avenue
Biloxi MS 39531-2410

In Reply Refer To:

520/11W [redacted]

GAYLE A DOVE
4457 POPPS FERRY RD LOT 195
BILOXI MS 39532

Dear Ms. Dove,

✓ The results of your pap smear done on 02-03-97 are within normal limits.

_____ The results of your pap smear done on _____ indicate your need for medication therapy. The medication(s) issued will be sent to you in the mail. Please use medication(s) as directed.

_____ Further examination is necessary. Please call the number(s) provided below for more information.

_____ The results of your mammogram on _____ are within normal limits.

_____ Your mammogram results indicate that further examination and/or testing is necessary. Please call the number(s) provided below for more information.

If you have any questions regarding these results or your scheduled appointment, you may contact Renee Davis, RN, BSN, Women Veteran's Coordinator at (601)388-5541, Ext. 5639 or beeper #335, Monday thru Friday, from 7:30 a.m. to 4:00 p.m.

Sincerely,

Renee Davis RN

Renee Davis, RN, BSN
Women Veteran's Coordinator

EXAMINER: Willie Silg
UNIT: 7

[redacted]

REQUEST FOR MEDICAL INFORMATION FROM RECORDS OF VETERANS ADMINISTRATION

The veteran named below has filed an application for a period of disability and/or disability benefits under a disability program administered by the Social Security Administration and has authorized the Veterans Administration to release to the Social Security Administration any medical information from their records concerning the claimant.

(Be Sure to Indicate Hospital, Clinic, Domiciliary or Regional Office)

VA MEDICAL CENTER
400 VETERANS BLVD
BILOXI MS 39531

I IDENTIFYING INFORMATION (To Be Completed by SSA)

VETERAN'S NAME (LAST, FIRST, MIDDLE)
DOVE, GAYLE A

SOCIAL SECURITY NUMBER
[redacted]

CLAIM NUMBER
C-

SERVICE SERIAL NUMBER AND/OR V.A. NO. (IF NOT AVAILABLE)
DOB: [redacted]

DATE OF REQUEST
May 21, 1997

ORIGINATING OFFICE (IF NOT PARALLEL DO)
Disability Determination Services
Post Office Box 1271
Jackson, Mississippi 39215-1271

II INFORMATION NEEDED BY SSA

(Only checked items are needed)

A. [X] HOSPITAL SUMMARIES OR EQUIVALENT INFORMATION
(If veteran is still hospitalized and the period covered by the latest summary ended over 3 months ago, please also furnish response to treatment and current diagnosis and prognosis. If a summary has not been prepared, please furnish history; copy of admission examination, subsequent laboratory reports and examinations; treatment and response; diagnosis; and prognosis.)
→ HOSPITALIZED AT: VA HOSPITAL BILOXI
→ DATES: 03/04/97 TO 05/21/97

B. [ ] EXAMINATION FOR COMPENSATION OR PENSION → DATE:

C. [X] RECORDS OF OUT-PATIENT TREATMENT → DATES: 03/04/97

D. [ ] STATEMENT OF COMPETENCY TO MANAGE FUNDS
(If summaries or reports furnished do not contain determination of competency to manage funds made within past year, please complete block III-B below.)

E. [ ] OTHER SPECIFIC INFORMATION

III VA RESPONSE

A. USE THIS SPACE FOR REPLY TO II-E OR FOR OTHER REMARKS:

Attached are copies of outpatient records dated 3/3/97 thru 5/20/97.
No hospitalization at this facility for 3/4/97 to 5/21/97.

If additional space is necessary, use reverse or attach additional sheet.

B. STATEMENT OF COMPETENCY TO MANAGE FUNDS (Complete only if II-D checked above)
THIS VETERAN CONSIDERED BY THE VETERANS ADMINISTRATION [ ] COMPETENT TO MANAGE FUNDS [ ] INCOMPETENT TO MANAGE FUNDS

THIS DECISION HAS BEEN [ ] ADJUDICATED BY VA [ ] DETERMINED BY MEDICAL STAFF — DATE OF DECISION

Return to
DISABILITY DETERMINATION SERVICE
POST OFFICE BOX 1271
JACKSON, MISSISSIPPI 39215-1271

I certify the above information is taken from the medical records at this station and that all opinions expressed are those of our medical staff.

SIGNATURE OF REGISTRAR, MED. ADM. OFF., OR DESIGNEE
Deborah N. Parker
Robert A. Bidwell, RRA

DATE: 6/11/97

TITLE: Health Info. Manager

[redacted]

DOVE, GAYLE A
07 WILLIE SILAS JKK

EMPLOYEE/CLAIMANT/BENEFICIARY *(If other than Number Holder)*

AUTHORIZATION FOR SOURCE TO RELEASE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

INFORMATION ABOUT MEDICAL OR OTHER SOURCE-PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS OF SOURCE *(Include Zip Code)*: VA Medical Ctr

RELATIONSHIP TO DISABLED PERSON:

INFORMATION ABOUT DISABLED PERSON-PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS (if known) AT TIME DISABLED PERSON HAD CONTACT WITH SOURCE *(Include Zip Code)*

DATE OF BIRTH [redacted]

DISABLED PERSON'S I.D. NUMBER *(If known and different than SSN) (Clinic/Patient No.)*

APPROXIMATE DATES OF DISABLED PERSON'S CONTACT WITH SOURCE *(e.g. dates of hospital admission, treatment, discharge, etc)*: 3/4/97 — 5/21/97

TO BE COMPLETED BY DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF

GENERAL AND SPECIAL AUTHORIZATION TO RELEASE MEDICAL AND OTHER INFORMATION IN ACCORDANCE WITH THE PROVISIONS OF THE SOCIAL SECURITY ACT; THE PUBLIC HEALTH SERVICE ACT, SECTIONS 523 AND 527; AND TITLE 38 U.S.C. VETERANS BENEFITS SECTION 4132.

I hereby authorize the above-named source to release or disclose to the Social Security Administration or State agency the following information for the period(s) identified above:

1) All medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, or human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS), or tests for HIV;
2) Information about how my impairment(s) affects my ability to complete tasks and activities of daily living;
3) Information about how my impairment(s) affected my ability to work.

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above.

I understand that this authorization, except for action already taken, may be voided by me at anytime. If I do not void this authorization, it will automatically end when a final decision is made on my claim. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.

READ IMPORTANT INFORMATION ON REVERSE BEFORE SIGNING FORM BELOW.

SIGNATURE OF DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF: Gayle A. Dove

RELATIONSHIP TO DISABLED PERSON (if other than self):

DATE: 5/21/97

STREET ADDRESS:

TELEPHONE NUMBER (Area Code):

CITY:

STATE:

ZIP CODE:

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by the Social Security Administration, but without it the source may not honor this authorization.

SIGNATURE OF WITNESS: Gayle A. Dove

STREET ADDRESS:

CITY:

STATE:

ZIP CODE:

Form SSA-827 (8-94) Use Prior Editions (OVER)

Printed on recycled paper

OMB Number: 2900[illegible]
Estimated Burden: 4 minutes

artment of Veterans Affairs

PRESCRIPTION AND AUTHORIZATION FOR EYEGLASSES

Public reporting burden for this collection of information is estimated to average 4 minutes per response, including the time for reviewing ns, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to VA s Officer (723), 810 Vermont Avenue NW, Washington DC 20420, and to the Office of Information and Regulatory Affairs, Project Officer 88), Office of Management and Budget, Washington DC 20503. DO NOT send applications to this address.

PART I – TO BE COMPLETED BY EXAMINING EYE CLINIC (PLEASE PRINT OR TYPE LEGIBILY)

1. VETERAN'S NAME (Last, first, middle initial)	2. CLAIM NUMBER (If known)	3. SOCIAL SECURITY NUMBER (If known)
[illegible]	C- Dove, Gayle	[redacted]

PART II – TO BE FULLY COMPLETED BY EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST

	4A. SPHERE	4B. CYLINDER	4C. AXIS	4D. PRISM	4E. BASE	4F. BC	4G. MRP
R	+0.25 DP	–	–				
L	+0.25 DP	–	–				

NEAR		5A. ADDITION	5B. HEIGHT	5C. TYPE	5D. WIDTH	5E. NEAR INSET	5F. TOTAL INSET	5G. PD
	R	+1.25	16	25				FAR 63
	L	+1.25	~~[illegible]~~					NEAR

6A. FRAME NAME	6B. COLOR	6C. MANUFACTURER
HONEYSUCKLE 4	Pink.	

6D. EYESIZE	6E. BRIDGE SIZE	6F. TEMPLE LENGTH & STYLE
48	16	135

*SPECIAL INSTRUCTIONS: VA FRAMENAME JUSTA FLT COLOR HONEYSUCKLE

7A. LENSES ONLY	8A. GLASS LENSES	9A. SINGLE VISION	10A. SUPPLY CASE	11. DELIVERY RECOMMENDATION
7B. USE ENCLOSED FRAMES	8B. PLASTIC LENSES	9B. BIFOCAL	10B. TINT*	11A. VETERAN'S RESIDENCE
7C. FRAME ONLY	8C. SAFETY LENSES	9C. TRIFOCAL	10C. OTHER*	11B. EYE CLINIC
				11C. PROSTHETICS

12. SIGNATURE AND DEGREE OF EXAMINER: V. GARRIERE, M.D. OPHTHALMOLOGY — M.D./O.D.

13. DATE OF EXAMINATION: 4/14/98

PART III – TO BE FULLY COMPLETED BY THE PROSTHETIC ACTIVITY OR PROSTHETIC CLERK

TO: 14A. CONTRACTOR: LUX OPTICS INC — 14B. CONTRACT NUMBER:

15. VETERAN'S ADDRESS (Type name if unclear above):

16. ORDERING VA MEDICAL CENTER (Name, Address, Symbol): VA Biloxi [illegible] 121

17. AUTHORITY FOR ISSUANCE
- [x] VA 6115 (Charge Medical Care Appropriation)
- [ ] VA 6115.3 (Charge appropriation 36X0102, account 3403)
- [ ] OTHER

18. ELIGIBILITY STATUS (Check all appropriate boxes)
- [ ] SC
- [x] NSC
- [ ] IP
- [ ] OP
- [x] VNE
- [ ] A&A
- [x] 50%
- [ ] RET. MIL.
- [x] INITIAL

DISABILITY CODE	SC	NSC
40/9/95		X

19. CONTRACT INFORMATION

ITEM	CONTRACT ITEM	COST
RIGHT LENS	RB	—
LEFT LENS		
LENS TINT		
FRAME COMPLETE	UF	30–
FRAME FRONT ONLY		
FRAME TEMPLE RIGHT		
FRAME TEMPLE LEFT		
OTHER		
CASE	4	—
TOTAL COST	[illegible]	30–

20. INSTRUCTIONS TO CONTRACTOR – MAIL TO:
- [ ] VETERAN AT ABOVE ADDRESS
- [x] ORDERING FACILITY - EYE CLINIC
- [ ] ORDERING FACILITY - PROSTHETIC

21. SIGNATURE AND TITLE OF APPROVING OFFICIAL: Willie McNeil

PART IV – TO BE COMPLETED BY CONTRACTOR

22. COMMENTS:

23. THE GLASSES AUTHORIZED HAVE BEEN MAILED TO:
- [x] THE PATIENT AT THE ABOVE ADDRESS M 5.22.98
- [ ] VA EYE CLINIC DELIVERY POINT
- [ ] VA PROSTHETICS DELIVERY POINT

24. OBLIGATION SYMBOL (order will be rejected unless completed)	25. ORDER DATE	26. ESTIMATED DELIVERY DATE
C89L24 0390	4/27/98	5/11/98

27. SIGNATURE OF COMPANY OFFICIAL

28. DATE

VA FORM 10-2914(D)

CONTRACTOR'S COPY - 1

EXAMINER: Karen Keck
UNIT: 8

[redacted]

REQUEST FOR MEDICAL INFORMATION FROM RECORDS OF VETERANS ADMINISTRATION

The veteran named below has filed an application for a period of disability and/or disability benefits under a disability program administered by the Social Security Administration and has authorized the Veterans Administration to release to the Social Security Administration any medical information from their records concerning the claimant.

(Be Sure to Indicate Hospital, Clinic, Domiciliary or Regional Office)

VA MEDICAL CENTER
400 VETERANS BLVD
BILOXI MS 39531

I IDENTIFYING INFORMATION (To Be Completed by SSA)

VETERAN'S NAME (LAST, FIRST, MIDDLE)
DOVE, GAYLE A

SOCIAL SECURITY NUMBER
[redacted]

CLAIM NUMBER
C- [redacted]

SERVICE SER[redacted]. NOT AVAILABLE)
DOB: [redacted]

DATE OF REQUEST
January 24, 1997

ORIGINATING OFFICE (IF NOT PARALLEL DO)
Disability Determination Services
Post Office Box 1271
Jackson, Mississippi 39215-1271

II INFORMATION NEEDED BY SSA

(Only checked items are needed)

A. [X] HOSPITAL SUMMARIES OR EQUIVALENT INFORMATION
(If veteran is still hospitalized and the period covered by the latest summary ended over 3 months ago, please also furnish response to treatment and current diagnosis and prognosis. If a summary has not been prepared, please furnish history; copy of admission examination; subsequent laboratory reports and examinations; treatment and response; diagnosis; and prognosis.) →
HOSPITALIZED AT: VA MEDICAL CENTER AT GULFPORT
DATES: 01/01/96 TO 01/23/97

B. [ ] EXAMINATION FOR COMPENSATION OR PENSION →
DATE:

C. [X] RECORDS OF OUT-PATIENT TREATMENT →
DATES: 01/01/96 TO 01/23/97

D. [ ] STATEMENT OF COMPETENCY TO MANAGE FUNDS
(If summaries or reports furnished do not contain determination of competency to manage funds made within past year, please complete block III-B below.)

E. [X] OTHER SPECIFIC INFORMATION

ALL MENTAL RECORDS
ALL RECORDS FROM THE VA IN GULFPORT

III VA RESPONSE

A. USE THIS SPACE FOR REPLY TO II-E OR FOR OTHER REMARKS:

Attached are copies of the following: Ambulatory Surgeries dated 8/12/96, 10/25/96 and outpatient records dated 2/5/96 thru 3/6/97.

If additional space is necessary, use reverse or attach additional sheet.

B. STATEMENT OF COMPETENCY TO MANAGE FUNDS (Complete only if II-D checked above)
THIS VETERAN CONSIDERED BY THE VETERANS ADMINISTRATION [ ] COMPETENT TO MANAGE FUNDS [ ] INCOMPETENT TO MANAGE FUNDS

THIS DECISION HAS BEEN [ ] ADJUDICATED BY VA [ ] DETERMINED BY MEDICAL STAFF

DATE OF DECISION

Return to
DISABILITY DETERMINATION SERVICE
POST OFFICE BOX 1271
JACKSON, MISSISSIPPI 39215-1271

I certify the above information is taken from the medical records at this station and that all opinions expressed are those of our medical staff.

SIGNATURE OF REGISTRAR, MED. ADM. OFF. OR DESIGNEE
Robert A. Bidwell, RRA

DATE: 3/12/97

TITLE: Health Info. Manager

Form SSA-828-U4 (11-77)

EXAMINER: Karen Kec
UNIT: 8

[redacted]

[redacted] by SSA

Department of Health and Human Services
Social Security Administration

REQUEST FOR MEDICAL INFORMATION FROM MILITARY FACILITIES OR RECORDS CENTERS

The patient named in Section I has filed an application for disability benefits under the provisions of the Social Security Act. He has authorized any military facility or records center to release to the Social Security Administration or State agency which has contracted to make disability determinations for SSA any medical information from their records concerning him.

INDICATE NAME OF HOSPITAL OR SPECIFIC RECORD CENTER

VA MEDICAL CENTER
400 VETERANS BLVD
BILOXI MS 39531

PATIENT'S NAME AND ADDRESS
GAYLE A DOVE
4457 POPPS FERRY RD
LOT 195
BILOXI MS 39532

PATIENT'S [redacted] SERVICE SERIAL NO.

PATIENT'S OR SPONSOR'S [S]

BRANCH OF SERVICE	STATUS	SPONSOR	PATIENT
	ACTIVE SEVICEMAN	☐	☐
DATE OF LAST SEP. FROM ACTIVE DUTY	RETIRED SERVICEMAN	☐	☐
	SERVICE DEPENDENT		
RANK/GRADE	CIVILIAN EMPLOYEE	☐	☐
	CIV./EMP. DEPENDENT		

NAME OF SPONSOR IF OTHER THAN PATIENT

PATIENT'S RELATIONSHIP TO SPONSOR | SPONSOR'S SOCIAL SECURITY NO.

NAME OF W/E IF OTHER THAN PATIENT OR SPONSOR

W/E SOCIAL SECURITY NO. [redacted]

Section II. Originating State Agency

STATE AGENCY
DISABILITY DETERMINATION SERVICES
POST OFFICE BOX 1271
JACKSON, MISSISSIPPI 39215-1271

[redacted]

DATE OF REQUEST
1/24/97

Section III. Items Checked Indicate Information Needed

1. [X] **HOSPITALIZATION** - Please furnish a copy of "Clinical Record-Narrative Summary" SF-502 covering this hospitalization. (If no summary has been prepared, please furnish a copy of admission history, results of physical examination and diagnosis.)

NAME OF TREATMENT FACILITY
VA MEDICAL CENTER AT BILOXI

DATE OF TREATMENT
FROM 01/01/96 TO 01/23/97

2. [X] **OUT-PATIENT TREATMENT** - please furnish a copy of "Health Record-Chronological Record of Medical Care" SF-600 or DAB-255 covering outpatient treatment at:

NAME OF TREATMENT FACILITY

DATES OF TREATMENT
FROM 01/01/96 TO 01/23/97

3. [X] **OTHER** - Describe: ALL MENTAL RECORDS

Section IV. When Information Not Available Complete This Section

1. ☐ No medical reports on record at this facility
2. ☐ Unable to identify
3. ☐ Records transferred to another facility
4. ☐ Medical records sent to VA

COMPLETE WHEN EITHER 3 OR 4 CHECKED

NAME OF FACILITY

CITY STATE

C#- DATE

Section V. Parallel SSA Office is

DISABILITY DETERMINATION SERVICES
POST OFFICE BOX 1271
JACKSON, MISSISSIPPI 39215-1271

PLEASE MAIL THIS FORM AND ALL ATTACHMENTS TO OFFICE SHOWN AT LEFT

FORM SSA-829-U4 (9-77)

EXAMINER: Karen Kec
UNIT: 8

[redacted]

Department of Health and Human Services
Social Security Administration

REQUEST FOR MEDICAL INFORMATION FROM MILITARY FACILITIES OR RECORDS CENTERS

The patient named in Section I has filed an application for disability benefits under the provisions of the Social Security Act. He has authorized any military facility or records center to release to the Social Security Administration or State agency which has contracted to make disability determinations for SSA any medical information from their records concerning him.

INDICATE NAME OF HOSPITAL OR SPECIFIC RECORD CENTER

VA MEDICAL CENTER
400 VETERANS BLVD
BILOXI MS 39531

Section I. Identifying Information (To be completed by SSA)

PATIENT'S NAME AND ADDRESS
GAYLE A DOVE
4457 POPPS FERRY RD
LOT 195
BILOXI MS 39532

PATIENT'S DATE OF BIRTH [redacted]

SERVICE SERIAL NO.

PATIENT'S OR SPONSOR'S [5]

BRANCH OF SERVICE	STATUS	SPONSOR	PATIENT
	ACTIVE SEVICEMAN	☐	☐
DATE OF LAST SEP. FROM ACTIVE DUTY	RETIRED SERVICEMAN	☐	☐
	SERVICE DEPENDENT		
RANK/GRADE	CIVILIAN EMPLOYEE	☐	☐
	CIV./EMP. DEPENDENT		

NAME OF SPONSOR IF OTHER THAN PATIENT

PATIENT'S RELATIONSHIP TO SPONSOR

SPONSOR'S SOCIAL SECURITY NO.

NAME OF W/E IF OTHER THAN PATIENT OR SPONSOR

W/E SOCIAL SECURITY NO.
515-64-6094

Section II. Originating State Agency

STATE AGENCY
DISABILITY DETERMINATION SERVICES
POST OFFICE BOX 1271
JACKSON, MISSISSIPPI 39215-1271

DATE OF REQUEST
1/24/97

Section III. Items Checked Indicate Information Needed

1. [X] **HOSPITALIZATION** - Please furnish a copy of "Clinical Record-Narrative Summary" SF-502 covering this hospitalization. (If no summary has been prepared, please furnish a copy of admission history, results of physical examination and diagnosis.)

NAME OF TREATMENT FACILITY
VA MEDICAL CENTER AT BILOXI

DATE OF TREATMENT
FROM 01/01/96 TO 01/23/97

2. [X] **OUT-PATIENT TREATMENT** - please furnish a copy of "Health Record-Chronological Record of Medical Care" SF-600 or DA8-255 covering outpatient treatment at:

NAME OF TREATMENT FACILITY

DATES OF TREATMENT
FROM 01/01/96 TO 01/23/97

3. [X] **OTHER** - Describe: ALL MENTAL RECORDS

Section IV. When Information Not Available Complete This Section

COMPLETE WHEN EITHER 3 OR 4 CHECKED

1. ☐ No medical reports on record at this facility
2. ☐ Unable to identify
3. ☐ Records transferred to another facility
4. ☐ Medical records sent to VA

NAME OF FACILITY

CITY STATE

C#- DATE

Section V. Parallel SSA Office is

DISABILITY DETERMINATION SERVICES
POST OFFICE BOX 1271
JACKSON, MISSISSIPPI 39215-1271

PLEASE MAIL THIS FORM AND ALL ATTACHMENTS TO OFFICE SHOWN AT LEFT

FORM SSA-826-BK (8-77)

TO BE COMPLETED BY SSA

NUMBER HOLDER

[redacted] INDIV

DOVE, GAYLE A

08 KAREN KECK

NMM

AUTHORIZATION FOR SOURCE TO RELEASE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

INFORMATION ABOUT MEDICAL OR OTHER SOURCE PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS OF SOURCE *(Include Zip Code)*	RELATIONSHIP TO DISABLED PERSON
VA Med Center	

INFORMATION ABOUT DISABLED PERSON PLEASE PRINT, TYPE, OR WRITE CLEARLY

NAME AND ADDRESS (If known) AT TIME DISABLED PERSON HAD CONTACT WITH SOURCE *(Include Zip Code)*	DATE OF BIRTH	DISABLED PERSON'S I.D. NUMBER *(If known and different than SSN) (Clinic/Patient No.)*
	8-15-57	

APPROXIMATE DATES OF DISABLED PERSON'S CONTACT WITH SOURCE *(e.g. dates of hospital admission, treatment, discharge, etc)*

TO BE COMPLETED BY DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF

GENERAL AND SPECIAL AUTHORIZATION TO RELEASE MEDICAL AND OTHER INFORMATION IN ACCORDANCE WITH THE PROVISIONS OF THE SOCIAL SECURITY ACT; THE PUBLIC HEALTH SERVICE ACT, SECTIONS 523 AND 527; AND TITLE 38 U.S.C. VETERANS BENEFITS SECTION 4132.

I hereby authorize the above-named source to release or disclose to the Social Security Administration or State agency the following information for the period(s) identified above:

1) All medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, or human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS), or tests for HIV;
2) Information about how my impairment(s) affects my ability to complete tasks and activities of daily living;
3) Information about how my impairment(s) affected my ability to work.

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above.

I understand that this authorization, except for action already taken, may be voided by me at anytime. If I do not void this authorization, it will automatically end when a final decision is made on my claim. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.

READ IMPORTANT INFORMATION ON REVERSE BEFORE SIGNING FORM BELOW.

SIGNATURE OF DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF	RELATIONSHIP TO DISABLED PERSON (if other than self)	DATE
Gayle A. Dove		1-24-97

STREET ADDRESS	TELEPHONE NUMBER (Area Code)

CITY	STATE	ZIP CODE

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by the Social Security Administration, but without it the source may not honor this authorization.

SIGNATURE OF WITNESS	STREET ADDRESS	
Gayle A. Dove		
CITY	STATE	ZIP CODE

Form SSA-827 (8-94) Use Prior Editions

Printed on recycled paper

(OVER)

EXAMINER: Karen Keck
UNIT: 8

[redacted]

Department of Health and Human Services
Social Security Administration

REQUEST FOR MEDICAL INFORMATION FROM MILITARY FACILITIES OR RECORDS CENTERS

The patient named in Section I has filed an application for disability benefits under the provisions of the Social Security Act. He has authorized any military facility or records center to release to the Social Security Administration or State agency which has contracted to make disability determinations for SSA any medical information from their records concerning him.

INDICATE NAME OF HOSPITAL OR SPECIFIC RECORD CENTER

USAF MEDICAL CENTER - KEESLER
ATTN: SGRR
KAFB
BILOXI MS 39534

Section I. Identifying Information [redacted] SSA)

PATIENT'S NAME AND ADDRESS
GAYLE A DOVE
4457 POPPS FERRY RD
LOT 195
BILOXI MS 39532

PATIENT'S [redacted]

SERVICE SERIAL NO.

PATIENT'S OR SPONSOR'S [redacted]

BRANCH OF SERVICE	STATUS	SPONSOR	PATIENT
	ACTIVE SEVICEMAN	☐	☐
DATE OF LAST SEP. FROM ACTIVE DUTY	RETIRED SERVICEMAN	☐	☐
	SERVICE DEPENDENT		
RANK/GRADE	CIVILIAN EMPLOYEE	☐	☐
	CIV./EMP. DEPENDENT		

NAME OF SPONSOR IF OTHER THAN PATIENT

PATIENT'S RELATIONSHIP TO SPONSOR | SPONSOR'S SOCIAL SECURITY NO.

NAME OF W/E IF OTHER THAN PATIENT OR SPONSOR

W/E SOCIAL SE [redacted]

Section II. Originating State Agency

STATE AGENCY
DISABILITY DETERMINATION SERVICES
POST OFFICE BOX 1271
JACKSON, MISSISSIPPI 39215-1271

DATE OF REQUEST
1/24/97

Section III. Items Checked Indicate Information Needed

1. ☒ **HOSPITALIZATION** - Please furnish a copy of "Clinical Record-Narrative Summary" SF-502 covering this hospitalization. (If no summary has been prepared, please furnish a copy of admission history, results of physical examination and diagnosis.)

NAME OF TREATMENT FACILITY: KEESLER AIR FORCE BASE HOSPIT

DATE OF TREATMENT: FROM 01/01/96 TO 01/23/97

2. ☒ **OUT-PATIENT TREATMENT** - please furnish a copy of "Health Record-Chronological Record of Medical Care" SF-600 or DA8-255 covering outpatient treatment at:

NAME OF TREATMENT FACILITY

DATES OF TREATMENT: FROM 1990 01/01/96 TO 01/23/97

3. ☒ **OTHER** - Describe: ALL MENTAL RECORDS

Section IV. When Information Not Available Complete This Section

COMPLETE WHEN EITHER 3 OR 4 CHECKED

1. ☒ No medical reports on record at this facility
2. ☐ Unable to identify
3. ☐ Records transferred to another facility
4. ☐ Medical records sent to VA

NAME OF FACILITY

CITY STATE

C#: DATE

Section V. Parallel SSA Office is

DISABILITY DETERMINATION SERVICES
POST OFFICE BOX 1271
JACKSON, MISSISSIPPI 39215-1271

PLEASE MAIL THIS FORM AND ALL ATTACHMENTS TO OFFICE SHOWN AT LEFT

FORM SSA-829-U4 (9-77)

OFFICE OF DISABILITY DETERMINATION SERVICES
POST OFFICE BOX 1271
JACKSON, MISSISSIPPI 39215-1271

FEB 27 RECD

Toll-Free Number 1-800-962-2230
Local Number 853-5100
Toll-Free Fax Number 1-800-280-2263 or -2250
Local Fax Number 853-5515 or -5682

F O L L O W - U P R E Q U E S T

REQUEST FOR MEDICAL INFORMATION FROM RECORDS OF VETERANS ADMINISTRATION

Date: February 21, 1997

Facility Address:
VA MEDICAL CENTER
400 VETERANS BLVD
BILOXI MS 39531

Patient Information:
Name: [redacted]

[redacted] **L RECORDS**

ATTACHED IS A COPY* OF A REQUEST FOR MEDICAL INFORMATION (FORM SSA-828) SENT TO YOU 30 DAYS AGO BY OUR OFFICE ON THIS INDIVIDUAL. PLEASE NOTE THAT THE ORIGINAL REQUEST INCLUDED HIS/HER AUTHORIZATION TO RELEASE INFORMATION TO OUR AGENCY.

OUR AGENCY IS STILL IN NEED OF THIS INFORMATION TO DOCUMENT THIS INDIVIDUAL'S CLAIM FOR DISABILITY BENEFITS WITH THE SOCIAL SECURITY ADMINISTRATION.

PLEASE SEND COPIES OF YOUR MEDICAL RECORDS AT YOUR EARLIEST OPPORTUNITY. IF YOU HAVE ALREADY SENT YOUR REPORT, PLEASE ACCEPT OUR THANKS AND DISREGARD THIS SECOND REQUEST.

ATTACHMENT

==========

THIS SECTION FOR DDS USE

***Important Note to Disability Examiner: BE SURE TO ATTACH A COPY OF THE ORIGINAL SSA-828.**

EXAMINER: Karen Keck
UNIT CODE: 8
TDN: 0003811094 **MVAFU**

OFFICE OF DISABILITY DETERMINATION SERVICES
POST OFFICE BOX 1271
JACKSON, MISSISSIPPI 39215-1271

Toll-Free Number 1-800-962-2230
Local Number 853-5100
Toll-Free Fax Number 1-800-280-2263 or -2250
Local Fax Number 853-5515 or -5682

F O L L O W - U P R E Q U E S T
REQUEST FOR MEDICAL INFORMATION FROM RECORDS OF VETERANS ADMINISTRATION

Date: February 28, 1997

Facility Address:
VA MEDICAL CENTER
400 VETERANS BLVD
BILOXI MS 39531

Patient Information:
Name: DOVE, GAYLE A
SSN: [redacted]
DOB: 08/15/57

MAR 07 RECD

ATTENTION: MEDICAL RECORDS

ATTACHED IS A COPY* OF A REQUEST FOR MEDICAL INFORMATION (FORM SSA-828) SENT TO YOU 30 DAYS AGO BY OUR OFFICE ON THIS INDIVIDUAL. PLEASE NOTE THAT THE ORIGINAL REQUEST INCLUDED HIS/HER AUTHORIZATION TO RELEASE INFORMATION TO OUR AGENCY.

OUR AGENCY IS STILL IN NEED OF THIS INFORMATION TO DOCUMENT THIS INDIVIDUAL'S CLAIM FOR DISABILITY BENEFITS WITH THE SOCIAL SECURITY ADMINISTRATION.

PLEASE SEND COPIES OF YOUR MEDICAL RECORDS AT YOUR EARLIEST OPPORTUNITY. IF YOU HAVE ALREADY SENT YOUR REPORT, PLEASE ACCEPT OUR THANKS AND DISREGARD THIS SECOND REQUEST.

ATTACHMENT

==========

THIS SECTION FOR DDS USE

*Important Note to Disability Examiner: BE SURE TO ATTACH A COPY OF THE ORIGINAL SSA-828.

EXAMINER: Karen Keck
UNIT CODE: 8
TDN: [redacted]

MVAFU

EXAMINER: Karen Keck
UNIT: 8

[redacted]

REQUEST FOR MEDICAL INFORMATION FROM RECORDS OF VETERANS ADMINISTRATION

The veteran named below has filed an application for a period of disability and/or disability benefits under a disability program administered by the Social Security Administration and has authorized the Veterans Administration to release to the Social Security Administration any medical information from their records concerning the claimant.

(Be Sure to Indicate Hospital, Clinic, Domiciliary or Regional Office)

VA MEDICAL CENTER
400 VETERANS BLVD
BILOXI MS 39531

I IDENTIFYING INFORMATION (To Be Completed by SSA)

VETERAN'S NAME (LAST, FIRST, MIDDLE)
DOVE, GAYLE A

SOCIAL SECURITY NUMBER
[redacted]

CLAIM NUMBER
C- [redacted]

SERVICE [redacted] NO. NOT AVAILABLE)
DOB: [redacted]

DATE OF REQUEST
March 4, 1997

ORIGINATING OFFICE (IF NOT PARALLEL DD)
Disability Determination Services
Post Office Box 1271
Jackson, Mississippi 39215-1271

II INFORMATION NEEDED BY SSA

(Only checked items are needed)

A. [X] HOSPITAL SUMMARIES OR EQUIVALENT INFORMATION
(If veteran is still hospitalized and the period covered by the latest summary ended over 3 months ago, please also furnish response to treatment and current diagnosis and prognosis. If a summary has not been prepared, please furnish history; copy of admission examination, subsequent laboratory reports and examinations; treatment and response; diagnosis; and prognosis.)
→ HOSPITALIZED AT: VA MEDICAL CENTER IN BILOXI AN Gulfport
→ DATES: 01/01/96 TO 03/03/97

B. [ ] EXAMINATION FOR COMPENSATION OR PENSION → DATE:

C. [X] RECORDS OF OUT-PATIENT TREATMENT → DATES: 01/01/96

D. [ ] STATEMENT OF COMPETENCY TO MANAGE FUNDS
(If summaries or reports furnished do not contain determination of competency to manage funds made within past year, please complete block III-B below.)

E. [X] OTHER SPECIFIC INFORMATION

ALL AVAILABLE RECORDS FROM BOTH FACILITIES

III VA RESPONSE

A. USE THIS SPACE FOR REPLY TO II-E OR FOR OTHER REMARKS.

If additional space is necessary, use reverse or attach additional sheet.

B. STATEMENT OF COMPETENCY TO MANAGE FUNDS (Complete only if II-D checked above)
THIS VETERAN CONSIDERED BY THE VETERANS ADMINISTRATION [ ] COMPETENT TO MANAGE FUNDS [ ] INCOMPETENT TO MANAGE FUNDS

THIS DECISION HAS BEEN [ ] ADJUDICATED BY VA [ ] DETERMINED BY MEDICAL STAFF — DATE OF DECISION

Return to
DISABILITY DETERMINATION SERVICE
POST OFFICE BOX 1271
JACKSON, MISSISSIPPI 39215-1271

I certify the above information is taken from the medical records at this station and that all opinions expressed are those of our medical staff.

SIGNATURE OF REGISTRAR, MED. ADM. OFF. OR DESIGNEE

DATE | TITLE

FILE COPY

be ...spitals and Domiciliaries for requesting non-stocked prosthetic appliances and/or repairs thereto for inpatients.*

SECTION I – *(To be completed by Prescribing Physician)*

TO 1. Prosthetics | 3.

2. | 4. Chief, Prosthetics Activity or Prosthetics Clerk ( )

DESCRIPTION OF APPLIANCE OR REPAIR REQUESTED *(Attach any required measurement forms or work orders)*

Tens Unit + Hypoallergenic electrodes

METHOD OF ISSUE

☒ PERMANENT ISSUE

☐ TEMPORARY LOAN

MEDICAL DATA

DISABILITY FOR WHICH APPLIANCE OR REPAIR IS REQUIRED

Chronic Abdominal Pain

DISABILITY FOR WHICH PATIENT IS HOSPITALIZED

IF APPLIANCE OR REPAIR REQUIRED FOR AN ASSOCIATED OR AGGRAVATING DISABILITY, WHAT IS THE BASIC DISABILITY?

ESTIMATED REMAINING PERIOD OF HOSPITALIZATION

YEARS	MONTHS	DAYS

DATE OF REQUEST	REQUESTED BY *(Signature of Physician or ward clerk**)*	TITLE OF PRESCRIBING PHYSICIAN
8/12/96	J Moore MD J. MOORE, MD AS3285170-899	

SECTION II – *(To be completed by Prosthetics Activity or Prosthetics Clerk)*

DATE OF ACTION	PATIENT OR MEMBER IS –	ACTION TAKEN *(Specify)*	SIGNATURE AND TITLE
8-19-96	☒ ELIGIBLE ☐ INELIGIBLE ☒ ENTITLED ☐ NOT ENTITLED	17.160 A	Willie Mull PA

SECTION III – REMARKS *(Use reverse side, if necessary)*

IF REQUEST IS DISAPPROVED, IF PATIENT OR MEMBER IS DECLARED INELIGIBLE OR NOT ENTITLED, OR IF REQUEST IS RETURNED TO PRESCRIBING PHYSICIAN FOR ANY REASON, EXPLAIN IN DETAIL.

PROSTHETIC SERVICE 520-121
VA MEDICAL CENTER
400 VETERANS AVENUE
BILOXI, MS 39531
PH. NO. (601) 385 5725

[redacted]

8/29
8:30 I HAVE RECEIVED TRAINING ON THE [redacted] AND CARE OF THE ABOVE PROSTH[redacted]
Gayle A. Dove

EQUIPMENT Tens Unit $129.48
MANUFACTURER EMP
SERIAL [redacted] 47[redacted]
MODEL [redacted]
STATUS Outpatient
DATE 8/29/96

*Minor items stocked in the Hospital or Outpatient Clinic may be requested by physicians on VA Form 10-2319, Prescription.
**Ward clerk may sign for doctor when the request is supported by physician statement in the Clinical Record.

(Imprint from Patient Data Card or type or print name, claim no., Social Security No., name and address of veteran and next of kin)

[redacted]
4457 POPPS FERRY RD. LOT 047
BILOXI MS 39532

[redacted]

EMPI ELECTRODES 841

REQUEST FOR PROSTHETIC SERVICES

VA FORM 10-2431
EXISTING STOCK OF VA FORM 10-2431, JUL 1974, WILL BE USED.
*U.S. Government Printing Office: 1991 — 282-804/46215

MailMan message for SALLEY,FLORENCE E CLERK,MEDICAL
Printed at BILOXI.VA.GOV 02 Oct 95 [illegible]:38
Subj: HINQ response for /requested SALLEY,FLORENCE E [#3851579] 02 Oct 95 10:37 67 Lines
From: POSTMASTER (Sender: SALLEY,FLORENCE E) in 'IN' basket. Page 1

Data Requested: SS# 515646094

VBA name = GAVOGEL
Name = GAYLE A[redacted]
Address = 4457 POPPS FERRY RD
Address = LOT 195
Address = BILOXI MS
ZIP = 39532
Sex = FEMALE
Date of Birth = AUG 15, 1957
[redacted]

Claim Number = [redacted]
Folder Location = 323 - JACKSON-RO
POW = Not applicable
Total Active Svc = 12 yr 14 days
INDICATORS(Active Duty Training NO Disability NO Homeless Veteran NO)

Verified Svc-Data
Original Award = FEB 01, 1995
Networth = Zero Networth
Combat Disability = NONE
SSI Income = Never

Service data	C&P	BIRLS
Branch of Service =	Air Force	AF
EOD =	SEP 04,1975	SEP 4,1975
RAD =	SEP 16,1987	SEP 16,1987

Char of Service = HONORABLE HON
Additional service = Not an issue
Entitlement = Regular estab.(compensation) - 41
Master Record Type = Veterans Master Record - A

Diary data:
JUL, 1996 Future physical examination - 01

Diary data:
SEP, 2003 RO-issue Dependency Verification form. - 24

DISABILITIES(Combined % = 80 SC/Total = 5/5 Additional = 0)

9411 - POST-TRAUMATIC STRESS DISORDER - 50% - Service Connected
7617 - REMOVAL OF UTERUS AND OVARIES - 50% - Service Connected
8100 - MIGRAINE HEADACHES - 30% - Service Connected
6501 - RHINITIS - 00% - Service Connected
7819 - BENIGN GROWTH OF THE SKIN - 00% - Service Connected

Perm.,total Disablity = Not permanently and totally disabled
AID & ATTEND = HB and/or A&A NOT GRANTED
Chief Attorney, fiduciary =
Employable indicator = Employable or not an issue
Competency indicator = Competent, or not an issue
Competency Pay Status = Competent,or not an issue,Pay direct

INDICATORS(NO Severence Recoupment NO PFOP/FDIB NO Consolidated Payment)

ELIGIBILITY DOCUMENT

Anatomical loss = No Amputation - 00
Other loss = Loss or loss of use of creative organ. - 1
Vet married Vet = No spouse or not eligible -
Spec. Month comp. = One disability under (k) - 01
Special Provision = Analogous Ratings - 5

Spouse name = RICHARD DOB = JUL 03, 1963

CHAMPVA = Not Eligible Number of CHILDREN

School = Helpless School = Depend. total = V-S This Award = V-S

Check Amount= '$1130.00' Hardship Exp.= '$0' Net Award= '$1130.00'

DOVE, GAYLE A 515-64-6094

4. Was employment income reported for a child in item C7	FOR VA USE ONLY	5. Enter child's income exclusion
NOT APPLICABLE		$6400.00

6. List each child for whom employment income was reported in item C7.

Child's Name (A)	Employment income from item C7 (B)	Exclusion from item D(5) (C)	Subtract (C) from (B) (if "0", skip (E) and enter "0" in (F)) (D)	Child's post-secondary education expenses (E)	Child's countable employment income (F)
NOT APPLICABLE					

TO BE COMPLETED BY VA (VETERANS AFFAIRS)

7. Child's Reported Employment Income (Item D6(B) above)	NOT APPLICABLE
8. Child's Countable Employment Income (Item D6(F) above)	NOT APPLICABLE
9. Child's Employment Income Exclusion (Subtract Item D8 from Item D7))	NOT APPLICABLE
10. Total Deductible Expenses (Add Items D1, D2, D3 and D9)	$0.00
11. Attributable Income (Subtract Item D10 from C11)	$2000.00

E. Previous Calendar Year Net Worth

Type of Asset	Veteran	Spouse	Total
1. Cash, Amounts in Bank Accounts (Include IRA's)	$0.00		$0.00
2. Stocks and Bonds	$0.00		$0.00
3. Real Property (Not including your primary residence) (market value of property minus incumbrances)	$0.00		$0.00
4. Other Property or Assets not Shown Elsewhere	$0.00		$0.00
5. Debts (Include any debts that will reduce the value of property listed in E4)(Cannot exceed E4)	-		$0.00
6. Net Worth (Line E1 + E2 + E3 + E4 minus line E5)			$0.00
7. TOTAL (Add items D(11) and E(6))			$2000.00

Completion of this form with signature of veteran is certification that the veteran has received a copy of the privacy act statement.

THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.	Signature of Veteran or Designee	Date
	X Gayle A Dove	7-22-95

F. TO BE COMPLETED BY DISCRETIONARY VETERANS WHO ARE REQUIRED TO MAKE COPAYMENTS

Eligibility Category	
A	Veterans in Category C must agree to pay VA a Deductible not to exceed the Medicare Deductible plus a per diem for Hospital and Nursing Home care. A per Visit Deductible is required for Category C Veterans to receive Outpatient care. The Billing Period and Rates are specified in 38 U.S.C.

I AGREE TO PAY THE VA THE APPLICABLE DEDUCTIBLE FOR MY MEDICAL CARE.	Signature of Veteran or Designee NOT APPLICABLE	Date

Special Note(s):

Date of Test: SEP 22,1995 Completion Date/time: SEP 22,1995@09:38 By: PLC/1761 Printed: SEP 22,1995@09:39:13

VA FORM 10-10F

DEPARTMENT OF VETERANS AFFAIRS — FINANCIAL WORKSHEET

THE LAW PROVIDES SEVERE PENALTIES FOR WILLFUL SUBMISSION OF FALSE INFORMATION
SEE PAGE 3 FOR PRIVACY ACT AND PAPERWORK REDUCTION ACT INFORMATION

Applicant's Name: DOVE,GAYLE A | Social Security Number: 515-64-6094

A. Marital Status

1. Were you married last calendar year. (If "NO", go to Section B).	2. Did you live with your spouse last calendar year. (If "YES", go to Section B).	3. If you did not live with your spouse, show the amount you contributed to your spouse's support last calendar year
YES	NO	$0.00

B. Dependent Children

During last calendar year, did you have any UNMARRIED children or stepchildren who are under the age of 18 or between the ages of 18 and 23 and attending school? OR did you have any unmarried children over the age of 17 who became permanently incapable of self-support before reaching the age of 18? NO (If "NO", go to Section C)

Child's Name (1)	Permanently incapable of self-support (2)	Did the child live with you (3)	Did you contribute to the child's support? (4)	Did the child have any income? (5)	Was the child's income available to you? (6)
NOT APPLICABLE					

C. Previous Calendar Year Gross Income for 1994 (including amounts deducted for taxes, insurance, Medicare, etc.)

Type of Income	Veteran	Spouse	Children	Total
1. Social Security (Not SSI)	-			$0.00
2. U.S. Civil Service	-			$0.00
3. U.S. Railroad Retirement	-			$0.00
4. Military Retirement	-			$0.00
5. Unemployment Compensation	-			$0.00
6. Other Retirement (Company, state, local, etc.)	-			$0.00
7. Total Income from Employment (Wages, salary, earnings, tips)	$2000.00			$2000.00
8. Interest, Dividend, or Annuity Income	-			$0.00
9. Workers Compensation or Black Lung Benefits	-			$0.00
10. All Other Income	-			$0.00
11. Total Income				$2000.00

D. Deductible Expenses

1. List medical expenses ACTUALLY paid by you during the previous calendar year (include Medicare and other health insurance expenses). -
2. List amounts paid by you during the previous calendar year for funeral and burial expenses of a deceased spouse or child. -
3. List amounts paid by you during the previous calendar year for YOUR educational expenses. (Do NOT show spouse's or children's payments) -

Date of Test: SEP 22,1995 Completion Date/time: SEP 22,1995@09:38 By: PLC/1761 Printed: SEP 22,1995@09:39:03

4. Was employment income reported for a child in item C7	FOR VA USE ONLY	5. Enter child's income exclusion
NOT APPLICABLE		$6207.00

6. List each child for whom employment income was reported in item C7.

Child's Name (A)	Employment income from item C7 (B)	Exclusion from item D(5) (C)	Subtract (C) from (B) (if "0", skip (E) and enter "0" in (F)) (D)	Child's post-secondary education expenses (E)	Child's countable employment income (F)
NOT APPLICABLE					

TO BE COMPLETED BY VA (VETERANS AFFAIRS)

7. Child's Reported Employment Income (Item D6(B) above)	NOT APPLICABLE
8. Child's Countable Employment Income (Item D6(F) above)	NOT APPLICABLE
9. Child's Employment Income Exclusion (Subtract Item D8 from Item D7))	NOT APPLICABLE
10. Total Deductible Expenses (Add Items D1, D2, D3 and D9)	$0.00
11. Attributable Income (Subtract Item D10 from C11)	$18000.00

E. Previous Calendar Year Net Worth

Type of Asset	Veteran	Spouse	Total
1. Cash, Amounts in Bank Accounts (Include IRA's)	$0.00	$0.00	$0.00
2. Stocks and Bonds	-	-	$0.00
3. Real Property (Not including your primary residence) (market value of property minus incumbrances)	$0.00	$0.00	$0.00
4. Other Property or Assets not Shown Elsewhere	-	-	$0.00
5. Debts (Include any debts that will reduce the value of property listed in E4)(Cannot exceed E4)	$0.00	$0.00	$0.00
6. Net Worth (Line E1 + E2 + E3 + E4 minus line E5)			$0.00
7. TOTAL (Add items D(11) and E(6))			$18000.00

Completion of this form with signature of veteran is certification that the veteran has received a copy of the privacy act statement.

THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.	Signature of Veteran or Designee	Date
	X Gayle A. Dove	10-4-94

F. TO BE COMPLETED BY DISCRETIONARY VETERANS WHO ARE REQUIRED TO MAKE COPAYMENTS

Eligibility Category	Veterans in Category C must agree to pay VA a Deductible not to exceed the Medicare Deductible plus a per diem for Hospital and Nursing Home care. A per Visit Deductible is required for Category C Veterans to receive Outpatient care. The Billing Period and Rates are specified in 38 U.S.C.
A	

I AGREE TO PAY THE VA THE APPLICABLE DEDUCTIBLE FOR MY MEDICAL CARE.	Signature of Veteran or Designee	Date
	NOT APPLICABLE	

Special Note(s):

Date of Test: SEP 21,1994 Completion Date/time: OCT 4,1994@09:28 By: JDM/1734 Printed: OCT 4,1994@09:30:12

DEPARTMENT OF VETERANS AFFAIRS — FINANCIAL WORKSHEET

THE LAW PROVIDES SEVERE PENALTIES FOR WILLFUL SUBMISSION OF FALSE INFORMATION
SEE PAGE 3 FOR PRIVACY ACT AND PAPERWORK REDUCTION ACT INFORMATION

[redacted]

A. Marital Status

1. Were you married last calendar year. (If "NO", go to Section B).	2. Did you live with your spouse last calendar year. (If "YES", go to Section B).	3. If you did not live with your spouse, show the amount you contributed to your spouse's support last calendar year
YES	YES	NOT APPLICABLE

B. Dependent Children

During last calendar year, did you have any UNMARRIED children or stepchildren who are under the age of 18 or between the ages of 18 and 23 and attending school? OR did you have any unmarried children over the age of 17 who became permanently incapable of self-support before reaching the age of 18? NO (If "NO", go to Section C)

Child's Name (1)	Permanently incapable of self-support (2)	Did the child live with you (3)	Did you contribute to the child's support? (4)	Did the child have any income? (5)	Was the child's income available to you? (6)
NOT APPLICABLE					

C. Previous Calendar Year Gross Income for 1993 (including amounts deducted for taxes, insurance, Medicare, etc.)

Type of Income	Veteran	Spouse	Children	Total
1. Social Security (Not SSI)	-	-		$0.00
2. U.S. Civil Service	-	-		$0.00
3. U.S. Railroad Retirement	-	-		$0.00
4. Military Retirement	-	-		$0.00
5. Unemployment Compensation	-	-		$0.00
6. Other Retirement (Company, state, local, etc.)	-	-		$0.00
7. Total Income from Employment (Wages, salary, earnings, tips)	$000.00	$18000.00		$18000.00
8. Interest, Dividend, or Annuity Income	-	-		$0.00
9. Workers Compensation or Black Lung Benefits	-	-		$0.00
10. All Other Income	-	-		$0.00
11. Total Income				$18000.00

D. Deductible Expenses

1. List medical expenses ACTUALLY paid by you during the previous calendar year (include Medicare and other health insurance expenses). -
2. List amounts paid by you during the previous calendar year for funeral and burial expenses of a deceased spouse or child. -
3. List amounts paid by you during the previous calendar year for YOUR educational expenses. (Do NOT show spouse's or children's payments) -

Date of Test: SEP 21,1994 Completion Date/time: OCT 4,1994@09:28 By: JDM/1734 Printed: OCT 4,1994@09:29:36

DOVE,GAYLE A [redacted]

4. Was employment income reported for a child in item C7	FOR VA USE ONLY	5. Enter child's income exclusion
. NOT APPLICABLE		$6207.00

6. List each child for whom employment income was reported in item C7.

Child's Name (A)	Employment income from item C7 (B)	Exclusion from item D(5) (C)	Subtract (C) from (B) (if "0", skip (E) and enter "0" in (F)) (D)	Child's post-secondary education expenses (E)	Child's countable employment income (F)
NOT APPLICABLE					

TO BE COMPLETED BY VA (VETERANS AFFAIRS)

7. Child's Reported Employment Income (Item D6(B) above)	NOT APPLICABLE
8. Child's Countable Employment Income (Item D6(F) above)	NOT APPLICABLE
9. Child's Employment Income Exclusion (Subtract Item D8 from Item D7))	NOT APPLICABLE
10. Total Deductible Expenses (Add Items D1, D2, D3 and D9)	$0.00
11. Attributable Income (Subtract Item D10 from C11)	$16000.00

E. Previous Calendar Year Net Worth

Type of Asset	Veteran	Spouse	Total
1. Cash, Amounts in Bank Accounts (Include IRA's)	-	-	$0.00
2. Stocks and Bonds	-	-	$0.00
3. Real Property (Not including your primary residence) (market value of property minus incumbrances)	$0.00	$0.00	$0.00
4. Other Property or Assets not Shown Elsewhere	-	-	$0.00
5. Debts (Include any debts that will reduce the value of property listed in E4)(Cannot exceed E4)	-	-	$0.00
6. Net Worth (Line E1 + E2 + E3 + E4 minus line E5)			$0.00
7. TOTAL (Add items D(11) and E(6))			$16000.00

Completion of this form with signature of veteran is certification that the veteran has received a copy of the privacy act statement.

THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.	Signature of Veteran or Designee Gayle A. Dove	Date 21 Sep 94

F. TO BE COMPLETED BY DISCRETIONARY VETERANS WHO ARE REQUIRED TO MAKE COPAYMENTS

Eligibility Category	
A	Veterans in Category C must agree to pay VA a Deductible not to exceed the Medicare Deductible plus a per diem for Hospital and Nursing Home care. A per Visit Deductible is required for Category C Veterans to receive Outpatient care. The Billing Period and Rates are specified in 38 U.S.C.

I AGREE TO PAY THE VA THE APPLICABLE DEDUCTIBLE FOR MY MEDICAL CARE.	Signature of Veteran or Designee NOT APPLICABLE	Date

Special Note(s):

Date of Test: SEP 21,1994 Completion Date/time: SEP 21,1994@08:54 By: PLC/1761 Printed: SEP 21,1994@09:04:48

VA FORM 10-10F

DEPARTMENT OF VETERANS AFFAIRS — FINANCIAL WORKSHEET

THE LAW PROVIDES SEVERE PENALTIES FOR WILLFUL SUBMISSION OF FALSE INFORMATION
SEE PAGE 3 FOR PRIVACY ACT AND PAPERWORK REDUCTION ACT INFORMATION

Applicant's Name: DOVE,GAYLE A | Social Security Number: [redacted]

[redacted]

A. Marital Status

1. Were you married last calendar year. (If "NO", go to Section B).	2. Did you live with your spouse last calendar year. (If "YES", go to Section B).	3. If you did not live with your spouse, show the amount you contributed to your spouse's support last calendar year
YES	YES	NOT APPLICABLE

B. Dependent Children

During last calendar year, did you have any UNMARRIED children or stepchildren who are under the age of 18 or between the ages of 18 and 23 and attending school? OR did you have any unmarried children over the age of 17 who became permanently incapable of self-support before reaching the age of 18? NO (If "NO", go to Section C)

Child's Name (1)	Permanently incapable of self-support (2)	Did the child live with you (3)	Did you contribute to the child's support? (4)	Did the child have any income? (5)	Was the child's income available to you? (6)
NOT APPLICABLE					

C. Previous Calendar Year Gross Income for 1993 (including amounts deducted for taxes, insurance, Medicare, etc.)

Type of Income	Veteran	Spouse	Children	Total
1. Social Security (Not SSI)	-	-		$0.00
2. U.S. Civil Service	-	-		$0.00
3. U.S. Railroad Retirement	-	-		$0.00
4. Military Retirement	-	-		$0.00
5. Unemployment Compensation	-	-		$0.00
6. Other Retirement (Company, state, local, etc.)	-	-		$0.00
7. Total Income from Employment (Wages, salary, earnings, tips)	$0.00	$16000.00		$16000.00
8. Interest, Dividend, or Annuity Income	-	-		$0.00
9. Workers Compensation or Black Lung Benefits	-	-		$0.00
10. All Other Income	-	-		$0.00
11. Total Income				$16000.00

D. Deductible Expenses

1. List medical expenses ACTUALLY paid by you during the previous calendar year (include Medicare and other health insurance expenses). -
2. List amounts paid by you during the previous calendar year for funeral and burial expenses of a deceased spouse or child. -
3. List amounts paid by you during the previous calendar year for YOUR educational expenses. (Do NOT show spouse's or children's payments) -

Date of Test: SEP 21,1994 Completion Date/time: SEP 21,1994@08:54 By: PLC/1761 Printed: SEP 21,1994@09:04:37

BLUME & WEYBLE, LLC

ATTORNEYS AT LAW

JOHN H. BLUME
KEIR M. WEYBLE
SUSAN B. HACKETT
DAVID I. BRUCK *OF COUNSEL*

1247 SUMTER STREET, SECOND FLOOR
COLUMBIA, SOUTH CAROLINA 29201
MAILING ADDRESS:
POST OFFICE BOX 11744
COLUMBIA, SC 29211
PHONE: (803) 765-1044
FAX: (803) 765-1143

April 18, 2006

Zanesville Christian School
2400 Chandlersville Road
Zanesville, Ohio 43701

Re: *Jonathan Binney v. State of South Carolina*

To Whom It May Concern:

Please be advised that our office represents Jonathan Binney. This letter is to respectfully request that we be provided with a copy of any and all records that you may have concerning Mr. Binney. I have included a release for these records.

If you should have any questions, please do not hesitate to contact me. Thank you in advance for your cooperation on this matter.

Sincerely,

Jill A. Rider

Jill A. Rider
Paralegal

Enclosure

REPORT TO PARENTS

STUDENT Binney (LAST) Jonathan (FIRST) Kyle (MIDDLE) Grade 8 Year 19 89 19 90

SUBJECTS	PERIODS 1	2	Sem. Ex.	Sem. Gr.	Sem. Avg.	3	4	Sem. Ex.	Sem. Gr.	Sem. Avg.	Final Gr.
English	C	C			C	D+					
Bible	F	D			D-	F					
Science	C-	C			C	F					
Math	F	D			D-	D-					
History	D	F			F	F	F				
Art	B	B			B-	B-	B			B	B
Chorus	A	A			B	B					
Band											
Physical Education	C+	C			C	C					
Athletics							-				

A — Excellent B — Above average C — Average D — Below average F — Failure I — Incomplete

Absence from school can never be made up. Regular attendance and promptness are necessary for good school progress.

Days Absent		2	4	4	
Times Tardy		1	1	1	

Personal Qualities	PERIODS 1	2	3	4
Cooperation				
Courtesy				
Work Habits				
Dependability				
Obedience				
Citizenship				
~~Demerits~~	21	19	27	32

(WE SUGGEST USING A FINE BALL POINT PEN WITH HEAVY PRESSURE)

Comments: 25 DEMERITS - NOT IN [illegible] ATTENDANCE.

Citizenship and academic training are equally important in the educational experience. Parents and teachers should work together in close cooperation and we encourage you to visit school and confer with the teachers. The above personal qualities evaluation is for your added information. A check (✓) after any of the above indicates a need for improvement. No check indicates an acceptable or better evaluation.

This report need not be returned to the school.

[signature]
SUPERINTENDENT / PRINCIPAL

523-775 (No.8891f) Rev. / School Specialty Supply, Inc., Salina, KS

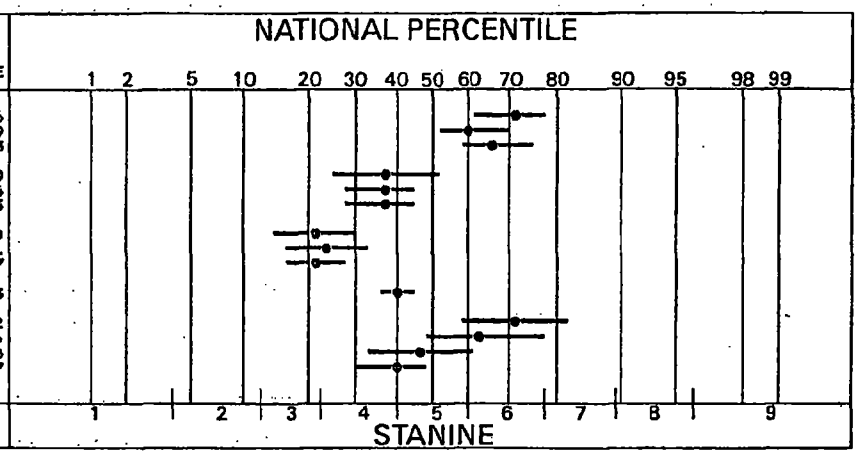
CAT CALIFORNIA ACHIEVEMENT TESTS, FORMS E&F — CTB/MCGRAW-HILL

INDIVIDUAL TEST RECORD

STUDENT: BINNEY, JONATH K
BIRTH DATE: [redacted]

SPECIAL CODES: .....
CLASS: MCLAMB R
SCHOOL: CORNERSTONE
DISTRICT: FAYETTEVILLE
CITY/STATE: FAYETTEVILLE NC
FORM/LEVEL: E/17
GRADE: 7.7
TEST DATE: 04/11/88
RUN DATE: 05/28/88

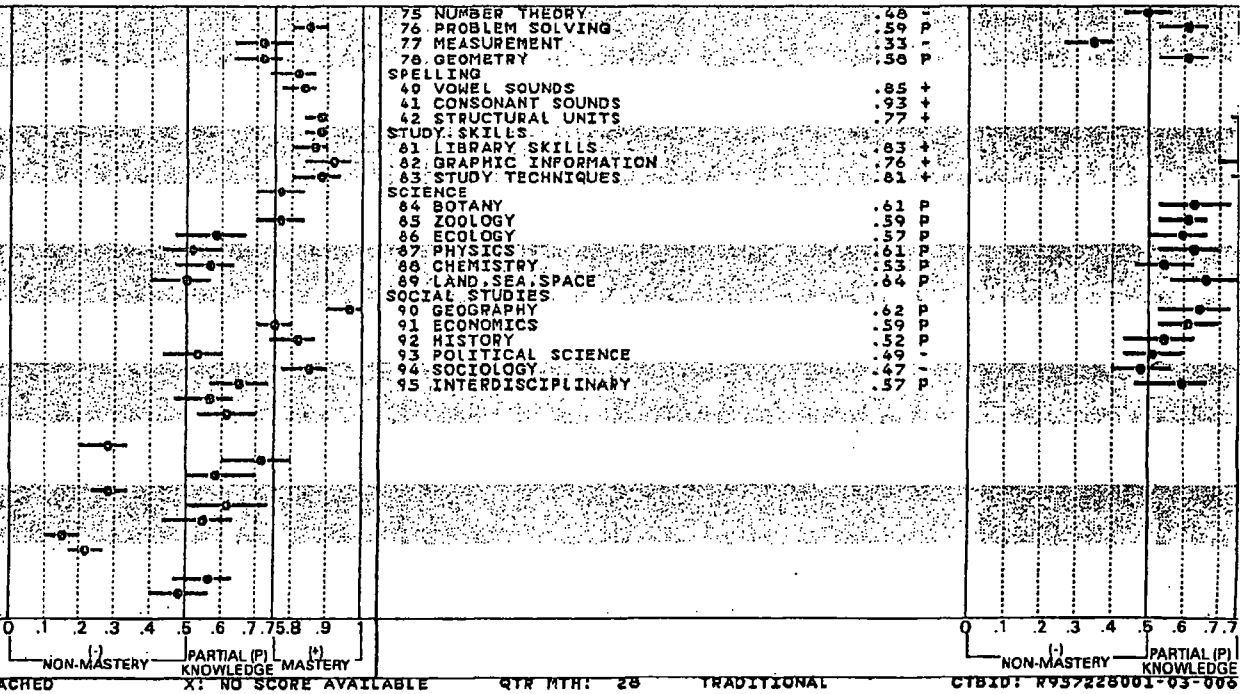
	GE	SS	OMS	NCR	NP	RANGE
VOCABULARY	9.8	772	3/ 5	44	70	62-76
COMPREHENSION	8.5	754	6/ 6	46	61	52-69
TOTAL READING	9.1	763		90	67	61-73
LANGUAGE MECHANICS	5.7	701	1/ 5	20	37	26-50
LANGUAGE EXPRESSION	5.3	702	4/ 8	38	36	30-44
TOTAL LANGUAGE	5.5	702		58	37	30-45
MATH COMPUTATION	5.7	751	0/ 8	23	22	15-30
MATH CONCEPTS & APPL	5.5	709	0/ 6	29	23	17-31
TOTAL MATHEMATICS	5.6	730		52	21	16-27
TOTAL BATTERY	6.7	732		200	40	36-43
SPELLING	9.7	755	3/ 3	29	71	59-82
STUDY SKILLS	9.1	754	3/ 3	20	63	49-76
SCIENCE	7.5	702	0/ 6	24	46	34-58
SOCIAL STUDIES	6.5	696	0/ 6	22	39	32-47



GE : GRADE EQUIVALEN
SS : SCALE SCOI
OMS : NUMBER OB. MASTERED
NCR : NUMBER COI
NP : NATIONAL PERCENTILI

OBJECTIVES PERFORMANCE INDEX

	OPI		OPI
VOCABULARY		75 NUMBER THEORY	.48 -
24 SYNONYMS	.84 +	76 PROBLEM SOLVING	.59 P
25 ANTONYMS	.72 P	77 MEASUREMENT	.33 -
26 HOMONYMS	.72 P	78 GEOMETRY	.58 P
27 AFFIXES	.81 +	SPELLING	
28 WORDS IN CONTEXT	.83 +	40 VOWEL SOUNDS	.85 +
COMPREHENSION		41 CONSONANT SOUNDS	.93 +
32 PASSAGE DETAILS	.87 +	42 STRUCTURAL UNITS	.77 +
35 CHARACTER ANALYSIS	.87 +	STUDY SKILLS	
36 CENTRAL THOUGHT	.86 +	81 LIBRARY SKILLS	.83 +
37 INTERPRETING EVENTS	.91 +	82 GRAPHIC INFORMATION	.76 +
38 FORMS OF WRITING	.87 +	83 STUDY TECHNIQUES	.81 +
39 WRITING TECHNIQUES	.77 +	SCIENCE	
LANGUAGE MECHANICS		84 BOTANY	.61 P
43 PRONOUN I,NOUN,ADJECT	.77 +	85 ZOOLOGY	.59 P
44 BEGINNING WORDS, TITLES	.58 P	86 ECOLOGY	.57 P
45 PERIOD;QUEST,EXCLAM	.53 P	87 PHYSICS	.61 P
46 COMMA;COLON;SEMI;QUOT	.57 P	88 CHEMISTRY	.53 P
47 PROOFREADING	.51 P	89 LAND,SEA,SPACE	.64 P
LANGUAGE EXPRESSION		SOCIAL STUDIES	
49 PRONOUNS	.96 +	90 GEOGRAPHY	.62 P
50 VERBS	.76 +	91 ECONOMICS	.59 P
51 ADJECTIVES,ADVERBS	.81 +	92 HISTORY	.52 P
53 SENTENCE PATTERNS	.54 P	93 POLITICAL SCIENCE	.49 -
54 SENTENCE RECOGNITION	.84 +	94 SOCIOLOGY	.47 -
56 SENTENCE COMBINING	.66 P	95 INTERDISCIPLINARY	.57 P
57 TOPIC SENTENCE	.57 P		
58 SENTENCE SEQUENCE	.62 P		
MATH COMPUTATION			
64 SUBTRACT FRACTIONS	.29 -		
65 MULTIPLY WHOLE NUMBERS	.71 P		
66 MULTIPLY DECIMALS	.60 P		
67 MULTIPLY FRACTIONS	.31 -		
68 DIVIDE WHOLE NUMBERS	.63 P		
69 DIVIDE DECIMALS	.55 P		
70 DIVIDE FRACTIONS	.17 -		
71 INTEGERS,PERCENTS	.23 -		
MATH CONCEPTS & APPL			
73 NUMERATION	.57 P		
74 NUMBER SENTENCES	.50 P		



* MAXIMUM/MINIMUM OBTAINED N: NOT ALL ITEMS REACHED X: NO SCORE AVAILABLE QTR MTH: 28 TRADITIONAL CTBID: R957228001-03-006

1283

PARENT/TEACHER REPORT

NAME: BINNEY JONATH K
TEACHER: HADLEY M
SCHOOL: CORNERSTONE C
SYSTEM: CORNERSTONE C

GRADE: 06.7
CTB STUDENT ID: 10546982

LEA/REGION: 260-4
BATCH/GROUP: 2346-112/002
RUN DATE: 05/21/87
TEST DATE: SPRING 87

5425

GRADE 6

SUMMARY OF STUDENT'S SCORES

HE NORTH CAROLINA SCIENCE AND SOCIAL STUDIES TESTS ARE EACH COMPOSED OF 60 ITEMS WHICH SAMPLE A STUDENT'S CUMULATIVE SCIENCE AND SOCIAL STUDIES KNOWLEDGE. A TUDENT'S ACHIEVEMENT ON THESE BASIC SKILLS TESTS IS BEST SUMMARIZED BY HIS OR HER TOTAL TEST SCORES. THIS STUDENT CORRECTLY ANSWERED 32 OF THE SCIENCE ITEMS AN 6 OF THE SOCIAL STUDIES ITEMS. HIS SCIENCE TOTAL SCORE IS BETTER THAN APPROXIMATELY 31 PERCENT OF THE STATE'S SIXTH GRADERS AND HIS SOCIAL STUDIES TOTAL SCORE S BETTER THAN APPROXIMATELY 39 PERCENT OF THE STATE'S SIXTH GRADERS. THEREFORE, HIS OVERALL ACHIEVEMENT IS SLIGHTLY BELOW AVERAGE IN SCIENCE AND SLIGHTLY BELOW VERAGE IN SOCIAL STUDIES AS COMPARED TO OTHER NORTH CAROLINA SIXTH-GRADE STUDENTS.

TEST	SCORES	
	NUMBER CORRECT	PERCENTAGE OF STATE 6TH GRADERS WHO SCORED BELOW THIS STUDENT
TOTAL SCIENCE	32	31
TOTAL SOCIAL STUDIES	36	39

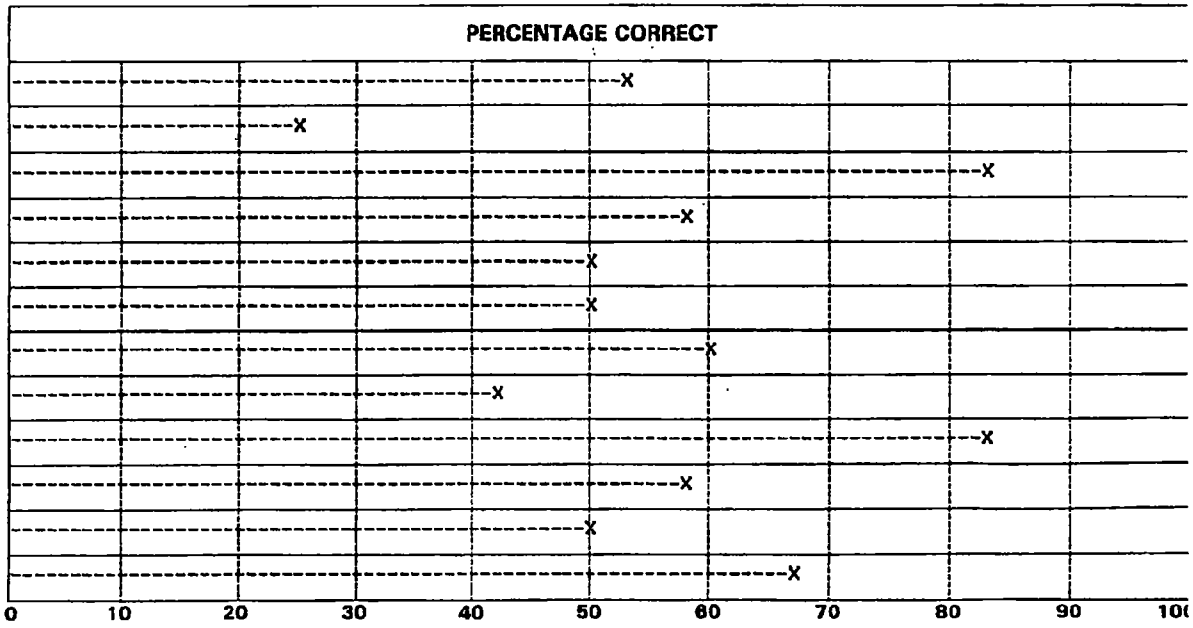
PROFILE OF STUDENT'S SCORES

WELL BELOW AVERAGE	SLIGHTLY BELOW AVERAGE	AVERAGE	SLIGHTLY ABOVE AVERAGE	WELL ABOVE AVERAGE
	X			
	X			

5 15 25 35 45 55 65 75 85 95
PERCENTILE

The profile below shows scores on the broad areas of science and social studies. While these scores might be more valid on a longer test, the items that are included do give a general impression of how this student did in each area. The type of information covered in the test is best explained through examples shown on the reverse side of this form.

AREA	NUMBER CORRECT
SCIENCE	32 OF 60
LIFE SCIENCE	3 OF 12
PHYSICAL SCIENCE	10 OF 12
EARTH SCIENCE	7 OF 12
NATURE OF SCIENCE	6 OF 12
PROCESS SKILLS	6 OF 12
SOCIAL STUDIES	36 OF 60
HISTORY	5 OF 12
GEOGRAPHY	10 OF 12
ECONOMICS	7 OF 12
GOVERNMENT	6 OF 12
ANTHROPOLOGY-SOCIOLOGY	8 OF 12



* = TEST AND/OR TEST SECTION OMITTED

TEACHER COMMENTS: _____

I have reviewed this report and have made additional comments where necessary. Please, do not hesitate to contact me for a more detailed explanation of the scores or further assistance in this matter.

SIGNED:

1284

Student Diagnostic Profile
Level 16
Forms C and D

CALIFORNIA ACHIEVEMENT TESTS

CAT

Published by CTB/McGraw-Hill, Del Monte Research Park, Monterey, California 93940. Copyright © 1977 by McGraw-Hill, Inc. All Rights Reserved. Printed in the U.S.A. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without the prior written permission of the publisher.

DIRECTIONS

The CAT C and D Student Diagnostic Profile is designed to serve as a record of a student's test scores as well as a source of information for instructional planning. Instructions for completing Parts 1, 2, and 3 of the report follow.

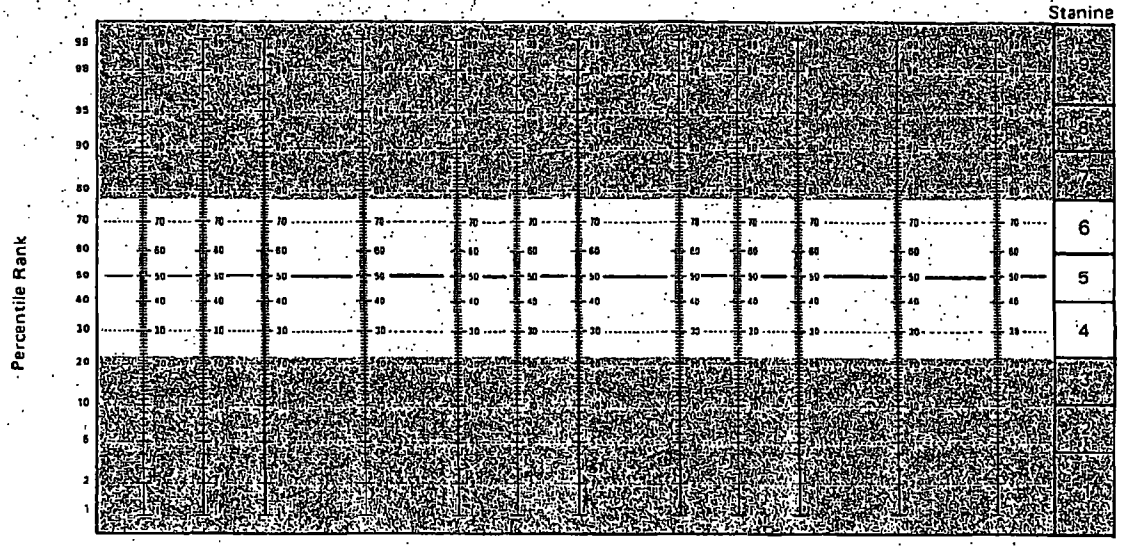
PART 1 STUDENT IDENTIFYING DATA: Record the student's name, teacher's name, grade, test form, and test date on the lines below:

NAME Binney Jonathan TEST FORM C
TEACHER Wall TEST DATE 5-28-86
GRADE 6

PART 2 SUMMARY OF STUDENT SCORES AND PERCENTILE RANK PROFILE: (1) On the table below, enter the student's raw score for each test and each total in the blanks next to the words "Raw Score." (2) Refer to the Norms Tables for Level 16 of the *California Achievement Tests, Forms C and D* to convert the student's raw scores to percentile ranks, stanines, grade equivalents, and scale scores. Also refer to the Norms Tables to convert the student's percentile ranks to normal curve equivalents (NCEs). (3) Enter the derived scores in the appropriate spaces. (4) Below each of the percentile ranks you have entered, make a dot on the vertical bar at the point that corresponds to the student's percentile rank score. (5) Draw a line connecting each dot to complete the profile.

Test	Reading Vocabulary	Reading Comprehension	Total Reading	Spelling	Language Mechanics	Language Expression	Total Language	Mathematics Computation	Mathematics Concepts & Applications	Total Mathematics	Total Battery	Reference Skills
Possible Score	30	40	70	20	25	38	63	40	45	85	238	25
Raw Score	20	19	39	17	17	28	45	17	21	38	139	16
Percentile Rank	71	48	57	74	60	71	67	52	61	58	65	60
Stanine	6	5	5	8	6	6	6	5	6	5	6	6
Grade Equivalent	6.6	5.3	5.8	11.5	6.3	7.2	6.7	5.5	5.9	5.6	6.1	6.1
Scale Score	497	474	475	622	528	530	524	447	485	462	479	502
Normal Curve Equivalent	—	—	—	—	—	—	—	—	—	—	—	—

2
38
45
17
39
139



94856

PART 3 OBJECTIVES MASTERY SUMMARY: (1) Find the column labeled "Item Numbers." Notice that there is one list of item numbers for Form C and another for Form D. In the appropriate column, circle the item number of each incorrect or nonvalid response. (For example, circle (2) (5) (14) (24) and so on.) (2) Look at the column labeled "Number Items Correct." The number shown in this column is the total number of items for the objective. To find the number of correct items, count the circled items and subtract this number from the total items. Record the total correct on the line. (3) Find the column labeled "Mastery Criterion." The "N" in this column represents nonmastery, the "P" partial knowledge, and the "M" mastery. Circle the letters next to the numerals that correspond to the number of items the student answered correctly. (4) Review the "Objectives Mastery Summary," noting which category objectives were mastered and which were not. Review the specific skills listed under each objective for additional information. (5) Plan instructional activities to teach or review those objectives not mastered by individual students and/or your class as a whole. Refer to the CAT C and D Class Management Guide for planning information and suggested instructional activities.

OBJECTIVES MASTERY SUMMARY

CATEGORY OBJECTIVES	ITEM NUMBERS FORM C	ITEM NUMBERS FORM D	NUMBER ITEMS CORRECT	MASTERY CRITERION
READING VOCABULARY				
32 Same Meaning	1 2 3 4 5 (6) 7 8 9 10 (11) 12 13 14 15 (16) 17 18 (19) 20	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	16/20	N 0-12 P 13-15 M 16-20
33 Opposite Meaning	(21) (22) (23) (24) (25)	21 22 23 24 25	0/5	N 0-3 P 4 M 5
34 Multimeaning	26 27 (28) 29 30	26 27 28 29 30	4/5	N 0-3 P 4 M 5
READING COMPREHENSION				
Literal Comprehension				
36 Recall of Facts			2/6	N 0-3 P 4 M 5-6
Person	(50)	31		
Thing	(45)	48		
Event	31	35 58		
Place	58	61		
Sequence	(60)	50		
Time	(62)			
Interpretive Comprehension			5/7	N 0-4 P 5 M 6-7
38 Inferred Meaning				
Main Idea	51 (61)	34 49 63		
Conclusion	32 35	59 64		
	49 (63)			
Cause/Effect	59		—/8	N 0-4 P 5 M 6-8
		36 51 62		

39 Character Analysis			4/8	N 0-4 P 5 M 6-8
Feeling	34	37 47		
Motive	45 (48)	33 46		
Trait	(36) (47)	45 60		
Attitude	33			
Compare Characters	37 (64)	32	—/7	N 0-4 P 5 M 6-7
40 Figurative Language			6/7	N 0-4 P 5 M 6-7
Simile	(38) 53 54	41 53		
Metaphor	52	38 39		
Hyperbole		52 64		
Onomatopoeia	40	40		
Personification	39 41			
Critical Comprehension				
42 Author Attitude/Position			1/6	N 0-3 P 4 M 5-6
Fact/Opinion	66 (67) (69)	66 68 69		
Viewpoint	(65) (68)	65 67 70		
Compare Viewpoints	(70)			
43 Techniques of Persuasion			1/6	N 0-3 P 4 M 5-6
Negative Words	(57)	42 57		
Positive Words	(43) (55)	56		
Transfer				
Testimonial		43		
Appeal to Join				
Inadequate Information	(42)	55		
Purpose	(44)	44		
SPELLING				
44 Consonant Phonemes/Graphemes			5/5	N 0-3 P 4 M 5
x /ks/	4	1		
Silent Single Letter	12 15	16 20		
Silent Double Letter	9	5		
ph /f/	3	14		
45 Vowel Phonemes/Graphemes			8/8	N 0-4 P 5 M 6-8
Short e	18			
Short e, ea		6		
Long e, ei		9		
Long o, oa	1			
Combination ou		3		
Combination ue	5			
Schwa	8 16	17 19		
R-controlled	11	2 8 15		
Schwa/r-controlled	14 19			
46 Morphemic Units			4/5	N 0-3 P 4 M 5
f to v -es	7	7		
Ends in o -es	20	13		
Suffix, -able	6			
Suffix, -ful		11		
Suffix, -ion	(17)			
Suffix, -ly		18		
Compound Words	13	10		
Correct Words	(2) (10)	4 12	Not an objective.	
LANGUAGE MECHANICS				
Capitalization				
48 I/Proper Nouns/Adjectives			4/5	N 0-3 P 4 M 5
Pronoun I	1	1 2 3		
Geographical Name	4 (0)	7 9		
Personal Name	5	5		
Proper Adjective	7			

50 Beginning Words/Titles			3 /4	N 0-2
Beginning Word	2 6 8			P 3
Title	9			M 4
Punctuation				
51 End Marks			3 /4	N 0-2
Period	11			P 3
Question Mark	17 24			M 4
Exclamation Point	19			
53 Comma			4 /5	N 0-3
Direct Address	14			P 4
Quotation	16			M 5
Introductory Word	18			
Interrupter	20			
Clause Separator	22			
54 Quotation Marks			1 /5	N 0-3
Undivided	12 23			P 4
Divided	21 25			M 5
Title of Short Work	15			
Correct Sentences	3 13		Not an objective.	
LANGUAGE EXPRESSION				
Usage				
57 Pronouns			4 /5	N 0-3
Personal, nominative	27 30			P 4
Personal, possessive	28			M 5
Personal, objective	29			
Demonstrative	26			
58 Verbs			4 /5	N 0-3
Agreement	31 32			P 4
Tense	33 34 35			M 5
59 Adjectives			5 /5	N 0-3
Positive	39			P 4
Comparative	37 40			M 5
Superlative	36 38			
Sentence Structure				
60 Subjects/Verbs			3 /6	N 0-3
Subject	47 48 49			P 4
Verb	50 51 52			M 5-6
62 Modifying/Transitional Words			5 /6	N 0-3
Modifiers	41 42 43			P 4
Transitional Words	44 45 46			M 5-6
63 Complete/Incomplete/Run-on			2 /5	N 0-3
Complete Sentence	55			P 4
Incomplete Sentence	53 56			M 5
Run-on Sentence	54 57			
Paragraph Organization				
67 Sequence/Topic Sentence			4 /6	N 0-3
Sentence Sequence	58 59 60			P 4
Topic Sentence Development	61 62 63			M 5-6

MATHEMATICS COMPUTATION			
69 Addition		2 /10	N 0-6
3 Three-Digit			P 7
2 Four-Digit + 2 Three-Digit			M 8-10
Horiz., Up to Three-Digits	1		
2 Five-Digit + 2 Four-Digit	2		
Like Fractions	5		
Unlike Fractions	25		
Mixed Numbers	22		
Decimal Fractions, horiz., no regr.	3		
Decimal Fractions			
Decimal Fractions, horiz.	24		
Decimal Numbers, horiz., no regr.	21		
Decimal Numbers, horiz.			
Decimal Number + Decimal Fraction, horiz., no regr.	23		
Money	4		
70 Subtraction		6 /10	N 0-6
2 Four-Digit	7		P 7
Like Fractions	6		M 8-10
Unlike Fractions	29		
Mixed Number — Whole Number	26		
Whole Number — Fraction			
Whole Number — Fraction, horiz.	30		
Mixed Number — Fraction, no regr.	27		
Mixed Numbers, no regr.	28		
Decimal Fractions, no regr.	10		
Decimal Fractions, horiz., no regr.			
Decimal Fractions			
Decimal Numbers, horiz., no regr.			
Decimal Numbers	8		
Decimal Number — Decimal Fraction, horiz., no regr.	9		
Decimal Number — Decimal Fraction, horiz.			
71 Multiplication		5 /10	N 0-6
Three-Digit x One-Digit	11		P 7
2 Two-Digit	13		M 8-10
Three-Digit x Two-Digit, horiz.			
Whole Number x Fraction	34 35		
Like Fractions	33		
Unlike Fractions	14 15		
Mixed Number x Whole Number			
One x Decimal Fraction, horiz.	12		
Whole Number x Decimal Number	31 32		
Decimal Number x Whole Number, horiz.			
Money x Two-Digit			
72 Division		4 /10	N 0-6
Two-Digit ÷ One-Digit	16		P 7
Three-Digit ÷ One-Digit, no rem.			M 8-10
Three-Digit ÷ One-Digit	17 19		
2 Two-Digit	18		
Three-Digit ÷ Mult. of 10, no rem.			
Four-Digit ÷ Two-Digit	36		
Like Fractions	37 40		
Mixed Number ÷ Fraction	39		
Money ÷ One-Digit	20 38		
Money ÷ Two-Digit			

MATHEMATICS CONCEPTS AND APPLICATIONS

73 Numeration

Expanded Notation, Three-Digit			3/6	N 0-3
Expanded Notation, Five-Digit	41			P 4
Greatest Value of 4 in Five-Digit				M 5-6
Value of Digit in Ten Thousands' Place	42			
Value of Digit in Tenth's Place				
Fractional Part, Set	63			
Fractional Part, Figure	78			
Point on Number Line, Decimal Number	68			
Point on Number Line, Mixed Number	82			
Estimate to Nearest Hundred				

74 Number Theory

Rename 654, Hundreds + Tens + Ones	47		2/6	N 0-3
Another Name for a Number, 81				P 4
Another Name for a Number, Fraction	53			M 5-6
Greatest Common Factor	57			
Factor of 14				
Factor of 144	64			
Number with Factor of 4, 8, 12				
Sequence, Pictorial	67			
Sequence, Add Consecutive Numbers				
Equivalent Fractions, Mixed Number	80			
Equivalent Fractions, Improper Fraction				

76 Number Sentences

Sign to Make Sentence True, ÷	43		2/6	N 0-3
Inequality, Supply ≠ Sign	79			P 4
Inequality, Supply > Sign				M 5-6
Number to Solve Inequality	72			
Solve for Unknown	52 76			
Identify True Sentence				
Identify Untrue Sentence	66			

78 Number Properties

Commutative Property, Add.			3/4	N 0-2
Commutative Property, Mult.	46			P 3
Associative Property, Mult.	59			M 4
Identity Element, Mult.				
Fact Family, Add./Subt.	44 51			
Fact Family, Mult./Div.				

83 Geometry/Measurement

Identify Acute Angle			2/6	N 0-3
Angle Measurement, Protractor	69			P 4
Measure Angle in Triangle				M 5-6
Congruent Rectangles				
Congruent Triangles	50			
Parallel Lines	85			
Convert Meters to Cm	60			
Convert Cm to Meter				
Convert Liters to Ml	75			
Gram Equivalents	81			
Convert Grams to Kg				

84 Graphs

Circle Graph	48 49	45 46	4/8	N 0-4
Picture Graph	61 62	81 82		P 5
Bar Graph	70 71	70		M 6-8
Line Graph	83 84	65 66		
Ordered Pairs		68		

88 Story Problems

Divide/Multiply	54 55	63	5/9	N 0-5
Average	74	66		P 6
Multiply/Divide	77			M 7-9
Multiply/Add		59		
Distance, Rate, Time		73		
Needed Data, Information	45 58	83		
Needed Data, Operation	56	48 69		
Fractional Part, Half	55			
Fractional Part, Three-Fourths		61		
Fractional Part, Three-Fifths		78		
Multiply Money	73			

REFERENCE SKILLS

92 Dictionary Page

Guide Words	5	5	1/4	N 0-2
Definitions	6	8		P 3
Homograph Entries		9		M 4
Syllabication		6	/5	N 0-3
Accent Mark	8			P 4
Pronunciation Key	7	7		M 5

93 Map

Key	21 22	22 23 25	3/5	N 0-3
Map Shading	23 25			P 4
Cardinal Directions		21		M 5
Intermediate Directions		24		
Key/Cardinal Directions	24			

94 Table

Subject(s), characteristic(s)	1 2 3 4	1 3	3/4	N 0-2
Subject(s), compared characteristics		2 4		P 3
				M 4

95 Library Catalog Cards

Author Card	9 10	12	4/6	N 0-3
Title Card	11 13	10 14 15		P 4
Subject Card	12 14	11 13		M 5-6

96 Diagram

Cycle, stage	15 19		5/6	N 0-3
Cycle, description	18 20			P 4
Cycle, stages/description	16 17			M 5-6
Cross Section, numbered part		16	/5	N 0-3
Cross Section, description		17 19 20		P 4
Cross Section, description/numbered part		18		M 5

Mathematics
Level 14
Forms C and D

CALIFORNIA ACHIEVEMENT TESTS

NAME
J [redacted] LAST FIRST MIDDLE INITIAL

TEACHER
Mr Wall

SCHOOL
RPBA

DATE OF TEST
5 [redacted] YEAR

DATE OF BIRTH
[redacted] YEAR

GRADE
4

BOOK NUMBER

Published by CTB/McGraw-Hill
Monterey, California 93940
Copyright © 1985
by McGraw-Hill, Inc. All Rights Reserved.
Printed in the U.S.A.

TEST 6 MATHEMATICS COMPUTATION

L a b c d e

	6 f g h i k	13 f g h i k	20 a b c d e	27 f g h i k	34 a b c d e
	7 f g h i k	14 a b c d e	21 f g h i k	28 a b c d e	35 f g h i k
1 f g h i k	8 a b c d e	15 f g h i k	22 a b c d e	29 f g h i k	36 a b c d e
2 f g h i k	9 f g h i k	16 a b c d e	23 f g h i k	30 a b c d e	37 f g h i k
3 f g h i k	10 a b c d e	17 f g h i k	24 a b c d e	31 f g h i k	38 a b c d e
4 f g h i k	11 f g h i k	18 a b c d e	25 f g h i k	32 a b c d e	39 f g h i k
5 f g h i k	12 f g h i k	19 f g h i k	26 a b c d e	33 f g h i k	40 a b c d e

TEST 7 MATHEMATICS CONCEPTS AND APPLICATIONS

M f g h i k

	46 f g h i k	54 f g h i k	62 f g h i k	70 f g h i k	78 f g h i k
	47 a b c d e	55 a b c d e	63 a b c d e	71 a b c d e	79 a b c d e
	48 f g h i k	56 f g h i k	64 f g h i k	72 f g h i k	80 f g h i k
41 a b c d e	49 a b c d e	57 a b c d e	65 a b c d e	73 a b c d e	81 a b c d e
42 f g h i k	50 f g h i k	58 f g h i k	66 f g h i k	74 f g h i k	82 f g h i k
43 a b c d e	51 a b c d e	59 a b c d e	67 a b c d e	75 a b c d e	83 a b c d e
44 f g h i k	52 f g h i k	60 f g h i k	68 f g h i k	76 f g h i k	84 f g h i k
45 a b c d e	53 a b c d e	61 a b c d e	69 a b c d e	77 a b c d e	85 a b c d e

SCORE2E 6:

Reading and Reference Skills
Level 14
Forms C and D

CALIFORNIA ACHIEVEMENT TESTS

CAT

NAME Binner Jo | 1ST | K | e
LAST FIRST MIDDLE INITIAL

TEACHER Pinwall

DATE OF TEST 5-3-7
MONTH DAY YEA

SCHOOL RIB 7

DA [redacted]
MONT

GRADE 4

SEX F M

BOOK NUMBER
14C ● 14D ○

Published by CTB/McGraw-Hill, Del Monte Research Park, Monterey, California 93940. Copyright © 1977 by McGraw-Hill, Inc. All Rights Reserved. Printed in the U.S.A.

TEST 1 READING VOCABULARY Jonath an

1 f g h j	7 f g h j	13 f g h j	19 f g h j	25 f g h j
2 a b c d	8 a b c d	14 a b c d	20 a b c d	26 a b c
3 f g h j	9 f g h j	15 f g h j	21 f g h j	27 f g h
4 a b c d	10 a b c d	16 a b c d	22 a b c d	28 a b c
5 f g h j	11 f g h j	17 f g h j	23 f g h j	29 f g h
6 a b c d	12 a b c d	18 a b c d	24 a b c d	30 a b d

TEST 2 READING COMPREHENSION Jonathan

36 f g h j	43 a b c d	50 f g h j	57 a b c d	64 f g h j
37 a b c d	44 f g h j	51 a b c d	58 f g h j	65 a b c d
31 a b c d	38 f g h j	45 a b c d	52 f g h j	59 a b c d	66 f g h j
32 f g h j	39 a b c d	46 f g h j	53 a b c d	60 f g h d	67 a b c d
33 a b c d	40 f g h d	47 a b c d	54 f g h j	61 a b c d	68 f g h j
34 f g h j	41 a b c d	48 f g h j	55 a b c d	62 f g h j	69 a b c d
35 a b c d	42 f g h j	49 a b c d	56 f g h d	63 a b c d	70 f g h j

TEST 8 REFERENCE SKILLS

1 f g h j	6 a b c d	11 f g h d	16 a b c d	21 f g h d
2 a b c d	7 f g h j	12 f g h d	17 f g h d	22 a b c d
3 f g h j	8 a b c d	13 f g h j	18 f b c d	23 f g h j
4 a b c d	9 f g h j	14 a b c d	19 f g h j	24 f b c d
5 f g h d	10 a b c d	15 f g h j	20 a b c d	25 f g h j

H59638

CORRECTED 66

Spelling and Language
Level 14
Forms C and D

CALIFORNIA ACHIEVEMENT TESTS

CAT

NAME Jo 9th Pilly (LAST) Ky- (MIDDLE INITIAL)

TEACHER Mr. Wall

DATE OF TEST 5-30- (MONTH DAY YEAR)

SCHOOL RPEA

DA[redacted]TH (MONTH DAY YEAR)

GRADE 4

SEX F

BOOK NUMBER 14C ◉ 14D ○

Published by CTB/McGraw-Hill, Del Monte Research Park, Monterey, California 93940. Copyright © 1977 by McGraw-Hill, Inc. All Rights Reserved. Printed in the U.S.A.

TEST 3 SPELLING

E ◉ ○ ○

1 ◉ ○ ○	5 ◉ ○ ○	9 ○ ◉ ○	13 ○ ○ ◉	17 ◉ ○ ○
2 ○ ◉ ○	6 ◉ ○ ○	10 ◉ ○ ○	14 ○ ○ ◉	18 ○ ○ ◉
3 ○ ○ ◉	7 ○ ○ ◉	11 ○ ○ ◉	15 ◉ ○ ○	19 ○ ○ ◉
4 ◉ ○ ○	8 ◉ ○ ○	12 ○ ○ ◉	16 ◉ ○ ○	20 ◉ ○ ○

TEST 4 LANGUAGE MECHANICS

F ○ ◉ ○ ○ ◉
G ○ ○ ○ ◉ ○

1 ◉ ○ ○ ○ ○	6 ○ ○ ○ ○ ◉	11 ○ ○ ○ ◉ ○	16 ◉ ○ ○ ○ ○	21 ○ ◉ ○ ○ ○
2 ○ ○ ○ ◉ ○	7 ○ ○ ○ ○ ◉	12 ○ ○ ◉ ○ ○	17 ○ ○ ○ ○ ◉	22 ○ ○ ◉ ○ ○
3 ○ ○ ○ ○ ◉	8 ○ ○ ○ ○ ◉	13 ○ ○ ○ ○ ◉	18 ○ ○ ◉ ○ ○	23 ○ ○ ○ ○ ◉
4 ○ ○ ○ ◉ ○	9 ○ ○ ◉ ○ ○	14 ○ ○ ○ ○ ◉	19 ○ ○ ○ ○ ◉	24 ○ ○ ◉ ○ ○
5 ○ ○ ○ ◉ ○	10 ○ ○ ○ ○ ◉	15 ○ ◉ ○ ○ ○	20 ○ ○ ◉ ○ ○	25 ○ ○ ◉ ○ ○

TEST 5 LANGUAGE EXPRESSION

H ◉ ○ ○ ○
I ◉ ○ ○
K ○ ○ ○ ◉ ○

	29 ◉ ○ ○	36 ○ ◉ ○	43 ◉ ○	50 ○ ○ ◉ ○	57 ◉ ○ ○
	30 ○ ◉ ○	37 ○ ○ ◉	44 ◉ ○ ○ ○	51 ○ ○ ◉ ○	58 ○ ○ ◉ ○
	31 ○ ◉	38 ○ ◉ ○	45 ○ ○ ○ ◉	52 ○ ◉ ○ ○	59 ○ ○ ◉ ○
	32 ◉ ○	39 ◉ ○ ○	46 ○ ○ ○ ◉	53 ○ ○ ◉	60 ○ ◉ ○ ○
26 ○ ◉	33 ○ ○ ◉ ○	40 ○ ○ ◉	47 ○ ○ ◉ ○	54 ○ ◉ ○	61 ◉ ○ ○ ○
27 ◉ ○	34 ○ ◉ ○ ○	41 ○ ◉	48 ◉ ○ ○ ○	55 ○ ◉ ○	62 ○ ○ ◉ ○
28 ○ ◉	35 ○ ○ ○ ◉	42 ○ ◉	49 ○ ◉ ○ ○	56 ○ ○ ○ ◉	63 ○ ○ ◉ ○

H95658

Student Diagnostic Profile
Level 14
Forms C and D

CALIFORNIA ACHIEVEMENT TESTS

Published by CTB/McGraw-Hill, Del Monte Research Park, Monterey, California 93940. Copyright © 1977 by McGraw-Hill, Inc. All Rights Reserved. Printed in the U.S.A. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without the prior written permission of the publisher.

DIRECTIONS

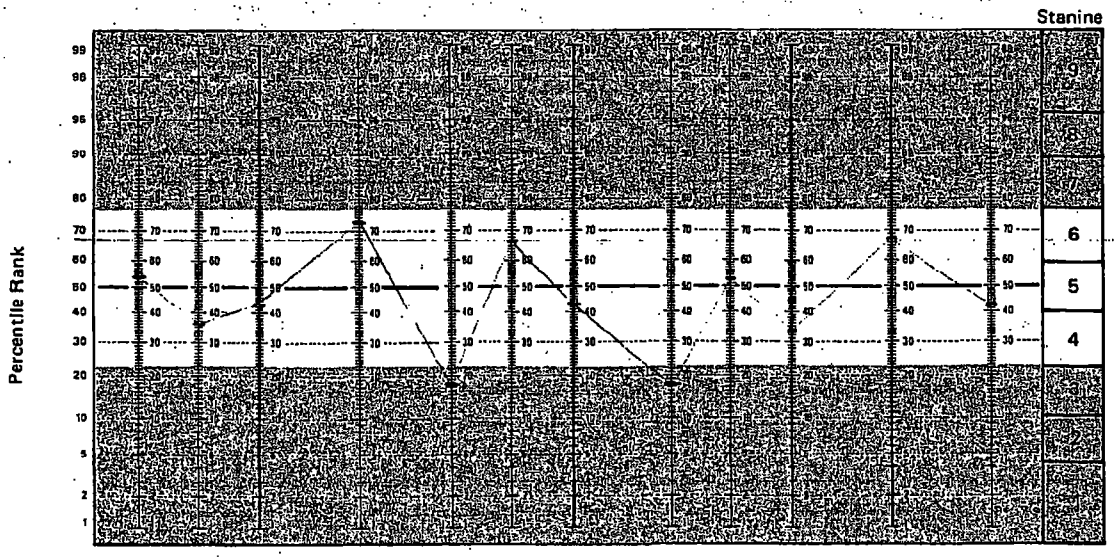
The CAT C and D Student Diagnostic Profile is designed to serve as a record of a student's test scores as well as a source of information for instructional planning. Instructions for completing Parts 1, 2, and 3 of the report follow.

PART 1 STUDENT IDENTIFYING DATA: Record the student's name, teacher's name, grade, test form, and test date on the lines below:

NAME Jonathan Binney TEST FORM 14-C
TEACHER Mr. Knell TEST DATE May 30, 1984
GRADE 4

PART 2 SUMMARY OF STUDENT SCORES AND PERCENTILE RANK PROFILE: (1) On the table below, enter the student's raw score for each test and each total in the blanks next to the words "Raw Score." (2) Refer to the Norms Tables for Level 14 of the *California Achievement Tests, Forms C and D* to convert the student's raw scores to percentile ranks, stanines, grade equivalents, and scale scores. Also refer to the Norms Tables to convert the student's percentile ranks to normal curve equivalents (NCEs). (3) Enter the derived scores in the appropriate spaces. (4) Below each of the percentile ranks you have entered, make a dot on the vertical bar at the point that corresponds to the student's percentile rank score. (5) Draw a line connecting each dot to complete the profile.

Test	Reading Vocabulary	Reading Comprehension	Total Reading	Spelling	Language Mechanics	Language Expression	Total Language	Mathematics Computation	Mathematics Concepts & Applications	Total Mathematics	Total Battery	Reference Skills
Possible Score	30	40	70	20	25	38	63	40	45	85	238	25
Raw Score	22	19	41	15	9	31	40	14	27	41	178	17
Percentile Rank	55	37	44	73	18	67	42	15	72	34	68	41
Stanine	5	4	5	6	3	6	5	3	5	4	6	5
Grade Equivalent	4.8	4.0	4.4	5.5	3.1	4.3	4.3	3.7	4.8	4.2	5.5	4.2
Scale Score	450	434	440	529	527	512	469	398	448	440	462	456
Normal Curve Equivalent	—	—	—	—	—	—	—	—	—	—	—	—



94854

72 Division			___/10	N	0-6
Two-Digit ÷ One-Digit	17 19	10 17		P	7
		18 38		M	8-10
Two-Digit ÷ One-Digit, no rem.	16	20			
Three-Digit ÷ One-Digit, no rem.	20	36 57			
Three-Digit ÷ One Digit	39				
Four-Digit ÷ One Digit, no rem.	18				
Four-Digit ÷ One-Digit	40				
2 Two-Digit, no rem.	38	19			
Three-Digit ÷ Mult. of 10, no rem.	36	39 40			
Mult. of 100 ÷ Mult. of 10	37				

MATHEMATICS CONCEPTS AND APPLICATIONS

73 Numeration			___/5	N	0-3
				P	4
Greatest Value, Four-Digit	50	61		M	5
Value of Digit in Hundred's Place					
Value of Digit in Thousand's Place	43				
Digit in Ten Thousand's Place		76			
Point on Number Line, Mixed Number	41	80			
Fractional Part		51			
Expanded Notation, Four-Digit	84				
Round to Nearest Hundred		62			
Estimate to Nearest Hundred	78	81			

74 Number Theory			___/5	N	0-3
				P	4
Word Name to Numeral, 501		46		M	5
Rename Hundreds and Ones	44				
Sequence, Subtract Fours	60				
Sequence, Add Threes		47			
Odd Numbers	75				
Classify Odd Number		56			
Factor of 8 and 10	62				
Number with Factors of 5, 10		83			
Equivalent Fractions	80	82			

76 Number Sentences			___/5	N	0-3
				P	4
Recognize ≠ Sign		77		M	5
□ as Placeholder, Mult.	82	58			
□ as Placeholder, Add./Mult.	83				
Equality, Supply = Sign		70			
Sign to Make Sentence True, ÷	74				
Identify Division Sentence	42				
Identify True Sentence	76				
Identify Untrue Sentence		74			

78 Number Properties			___/4	N	0-2
				P	3
Commutative Property, Add.		41		M	4
Commutative Property, Mult.	47				
Associative Property, Add.	64	68			
Identity Element, Add.	45				
Identity Element, Mult.		69			
Fact Family, Div./Mult.	52	54			

80 Common Scales			___/6	N	0-3
Money, Total Value	51			P	4
Money, Add Quarter	58			M	5-6
Equivalent Coins		50			
Money, Equivalent Expression		59			
Add Time to Clock	70	78			
Time, Addition		65			
Calendar, Date On Day	53				
Calendar, Day on Date	54				
Convert Weeks to Days		71			
Read Thermometer/Subt. Temperatures	85	81			

81 Geometry			___/5	N	0-3
Triangles	56			P	4
Cone	46			M	5
Sphere		66			
Point on Line	63				
Intersection of Lines		60			
Line Segment	66	67			
Parallel Lines	61	66			

82 Measurement			___/6	N	0-3
Convert Grams to Kg	67			P	4
Convert Grams to Cg		43		M	5-6
Read Scale	69	49			
Convert Meters to Km	77	57			
Add Liters	59				
Add Kilometers	79				
Divide Kilometers		44			
Multiply Kilograms		55			
Area, Rectangle	81	84			

84 Graphs			___/4	N	0-2
Picture Graph	48 49	76		P	3
Bar Graph	72 73	52		M	4
Line Graph		52 53			

88 Story Problems			___/5	N	0-3
Subtract	55			P	4
Multiply		48		M	5
Divide	57	62			
Add/Multiply	68				
Add/Subtract		42			
Needed Data, Operation(s)	65 71	43 71			

REFERENCE SKILLS

89 Title Page/Copyright Page			___/7	N	0-4
Title Page	1 2 3 4	1 2 4		P	5
Copyright Page	5 6 7	5 6 7		M	6-7

90 Table of Contents			___/5	N	0-3
Chapter Number	8	8		P	4
Subject of Chapter	9 10	10		M	5
Glossary	11	12			
Information Included/Excluded	12	11			

91 Index			___/5	N	0-3
Subject	14 15			P	4
Description of Subject	16 17	13		M	5
Subdivision of Subject	13	14			

92 Dictionary Page			___/4	N	0-2
Guide Words	18 20	18 20		P	3
Definitions	19	19		M	4
Homograph Entries	21	21			
Syllabication					

93 Map			___/4	N	0-2
Key	23	22 23 24		P	3
Cardinal Directions	24 25	25			

PART 3 OBJECTIVES MASTERY SUMMARY: (1) Find the column labeled "Item Numbers." Notice that there is one list of item numbers for Form C and another for Form D. In the appropriate column, circle the item number of each incorrect or nonvalid response. (For example, circle (2) (5) (14) (24) and so on.) (2) Look at the column labeled "Number Items Correct." The number shown in this column is the total number of items for the objective. To find the number of correct items, count the circled items and subtract this number from the total items. Record the total correct on the line. (3) Find the column labeled "Mastery Criterion." The "N" in this column represents nonmastery, the "P" partial knowledge, and the "M" mastery. Circle the letters next to the numerals that correspond to the number of items the student answered correctly. (4) Review the "Objectives Mastery Summary," noting which category objectives were mastered and which were not. Review the specific skills listed under each objective for additional information. (5) Plan instructional activities to teach or review those objectives not mastered by individual students and/or your class as a whole. Refer to the CAT C and D Class Management Guide for planning information and suggested instructional activities.

OBJECTIVES MASTERY SUMMARY

CATEGORY OBJECTIVES	ITEM NUMBERS FORM C	ITEM NUMBERS FORM D	NUMBER ITEMS CORRECT	MASTERY CRITERION
READING VOCABULARY				
32 Same Meaning	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	___/20	N 0-12 P 13-15 M 16-20
33 Opposite Meaning	21 22 23 24 25	21 22 23 24 25	___/5	N 0-3 P 4 M 5
34 Multimeaning	26 27 28 29 30	26 27 28 29 30	___/5	N 0-3 P 4 M 5
READING COMPREHENSION				
Literal Comprehension				
36 Recall of Facts			___/9	N 0-5 P 6 M 7-9
Person	31	31		
Thing	52 58 59	52 58 59		
Event	49 62	49 62		
Place	36 64	36 48 64		
Sequence		51 53		
Time	56	52		
Interpretive Comprehension			___/8	N 0-4 P 5 M 6-8
38 Inferred Meaning				
Main Idea	34 50 61	33 50 61		
Conclusion	51 60	45 56		
		63 65		
Cause/Effect	53 63 65	37 49 53		
39 Character Analysis			___/10	N 0-6 P 7 M 8-10
Feeling	33 40	33 40		
Motive	32 38 39	39 60		
Trait	35 67	32 35 67		
Attitude	54	54		
Compare Characters	37 55	37 55	___/8	N 0-4 P 5 M 6-8
40 Figurative Language			___/8	N 0-4 P 5 M 6-8
Simile	46 66 68	46 66 68		
Metaphor	47 69	47 69		
Hyperbole	67 70	45 46 70		
Personification	48	48		
Critical Comprehension				
42 Author Attitude/Position			___/5	N 0-3 P 4 M 5
Fact/Opinion	41 42 43 45	41 42 43		
Viewpoint		44		
Compare Viewpoints	44			
SPELLING				
44 Consonant Phonemes/Graphemes			___/6	N 0-3 P 4 M 5-6
c /s/	9	9		
g /j/	5	10		
wh /hw/	15	15		
Silent Single Letter	2 10	2		
Silent Double Letter	14	14		
nk /ngk/		20		
45 Vowel Phonemes/Graphemes			___/8	N 0-4 P 5 M 6-8
Short e, ea		16		
Short i	17	17		
Short i, irregular	19	19		
Long e, ee	6	6		
Long i, igh		8		
Long o, oa	16	16		
Long o, ow		2		
Combination au		4		
Diphthong oi	4	4		
Schwa	12	12		
R-controlled	1 8	1 8		
46 Morphemic Units			___/4	N 0-2 P 3 M 4
y to i -es	7 20	7 20		
Double Final Letter -ing	11	11		
Double Final Letter -ed	18	18		
Compound Words		13		
			___/5	N 0-3 P 4 M 5
Correct Words	3 13	3 13	Not an objective.	
LANGUAGE MECHANICS				
Capitalization				
48 I/Proper Nouns/Adjectives			___/5	N 0-3 P 4 M 5
Pronoun I	5	5		
Calendar Reference	2	2		
Geographical Name	4	4		
Personal Name	7	7		
Proper Adjective	8	8		

50 Beginning Words/Titles			___/4	N	0-2
Beginning Word	1 6 10			P	3
Title	9			M	4
Punctuation					
51 End Marks			___/4	N	0-2
Period	11			P	3
Question Mark	15 22			M	4
Exclamation Point	18				
53 Comma			___/5	N	0-3
Date	12			P	4
Introductory Word	13			M	5
Quotation	17				
Series	21				
City/State	24				
54 Quotation Marks			___/5	N	0-3
Undivided	19 23			P	4
Divided	14 25			M	5
Title of Short Work	20				
Correct Sentences	3 16		Not an objective.		
LANGUAGE EXPRESSION					
Usage					
57 Pronouns			___/5	N	0-3
Personal, objective	26 30			P	4
Personal, possessive	27			M	5
Personal, nominative	29				
Reflexive	28				
58 Verbs			___/5	N	0-3
Agreement	31 32			P	4
Tense	33 34 35			M	5
59 Adjectives			___/5	N	0-3
Positive	39			P	4
Comparative	36 38			M	5
Superlative	37 40				
Sentence Structure					
60 Subjects/Verbs			___/6	N	0-3
Subject	47 48 49			P	4
Verb	50 51 52			M	5-6
62 Modifying/Transitional Words			___/6	N	0-3
Modifiers	41 42 43			P	4
Transitional Words	44 45 46			M	5-6
63 Complete/Incomplete/Run-on			___/5	N	0-3
Complete Sentence	54			P	4
Incomplete Sentence	53 56			M	5
Run-on Sentence	55 57				
Paragraph Organization					
66 Sequence			___/6	N	0-3
Sentence Sequence	58 59 60 61 62 63			P	4
				M	5-6

MATHEMATICS COMPUTATION					
69 Addition			___/10	N	0-6
2 Two-Digit				P	7
2 Two-Digit + One-Digit, horiz., no regr.				M	8-10
3 Two-Digit	5				
Three-Digit + Two-Digit, horiz., no regr.	1				
Three-Digit + Two-Digit					
Three-Digit + 2 Two-Digit, no regr.	3				
2 Three-Digit	21				
2 Four-Digit, no regr.					
2 Four-Digit	4				
3 Four-Digit	2				
4 Four-Digit					
Column, Up to Three-Digit					
Column, Up to Four-Digit	22				
Horiz., Up to Three-Digit	23				
Like Fractions	25				
Decimal Fractions, no regr.					
Decimal Number + Decimal Fraction	24				
70 Subtraction			___/10	N	0-6
2 Two-Digit	7			P	7
Multiple of 10 — Two-Digit, horiz.				M	8-10
Three-Digit — Two-Digit, horiz., no regr.	27				
Three-Digit — Two-Digit					
2 Three-Digit	9				
Four-Digit — Three-Digit	30				
2 Four-Digit	29				
Five-Digit — Three-Digit					
2 Five-Digit, no regr.	26				
2 Five-Digit					
Like Fractions	10				
Mixed Number — Whole Number	8				
Decimal Fractions, no regr.					
Decimal Fractions	28				
Decimal Numbers, no regr.	6				
71 Multiplication			___/10	N	0-6
2 One-Digit				P	7
2 One-Digit, horiz.	14			M	8-10
Multiple of 10 x One-Digit, horiz.	11				
Two-Digit x One-Digit					
Two-Digit x One-Digit, horiz.	12				
Three-Digit x One-Digit, no regr.					
Three-Digit x One-Digit	15				
Four-Digit x One-Digit, horiz., no regr.	13				
Four-Digit x One-Digit					
2 Multiples of 10, horiz.					
Multiple of 10 x Two-Digit	32				
2 Two-Digit, no regr.	35				
Mult. of 100 x Mult. of 10					
Mult. of 100 x Mult. of 10, horiz.	31				
Three-Digit x Two-Digit, no regr.					
Three-Digit x Two-Digit	33				
2 Multiples of 100					
Multiple of 100 x Three-Digit	34				

NAME (LAST)	(FIRST)	(MIDDLE)	(NICKNAME)	I. D. NUMBER (IN PENCIL) (TO BE COMPLETED BY SCHOOL)
BINNEY,	Jonathan	Kyle	-	

SEX	RACE	BIRTHDATE
M	○ AMER. INDIAN ○ BLACK ○ ASIAN ○ HISPANIC ⊗ WHITE	[redacted]

CORNERSTONE CHRISTIAN ACADEMY

ELEMENTARY STANDARDIZED TEST RECORD FORM

This form must follow pupil when transferred.

ENTER ELEMENTARY TEST RESULTS ON THIS SIDE OF FORM IN DATE ORDER SEQUENCE. ENTER SECONDARY TEST RESULTS ON REVERSE OF FORM. IF ENTRY TYPED OR HANDWRITTEN, SCORES SHOULD BE LABELED USING THE FOLLOWING CODE: PERCENTILE - %, STANINE - S, GRADE EQUIVALENT - G.E., INTELLIGENCE QUOTIENT - I.Q. ANY OTHER TYPE OF TEST RESULTS SHOULD BE EXPLAINED: NAME OF TEST, DATE GIVEN, AND ACTUAL GRADE PLACEMENT AT TIME OF TESTING SHOULD ALSO BE RECORDED.

GRADE 6.7
SPRING 1987

CORNERSTONE C
BINNEY JONA
10546982 2346-112

CAT E&F LEVEL 16	TOTAL READING	TOTAL LANGUAGE	TOTAL MATHEMATICS	TOTAL BATTERY	Sci	SS	SPELLING
SCALE SCORE ▶	735.5	695.5	689.5	706.83	656	689	750
GRADE EQUIVALENT ▶	6.6	4.9	3.8	5.1	5.3	6.0	9.0
NATIONAL PERCENTILE ▶	48	32	9	25	31	39	73
NORMAL CURVE EQUIV. ▶	49	40	23	36	40	44	63

260-4 RUN DATE: 05/12 82505

Education and Remediation Clinic

201 South McPherson Church Road
Suite 219 McPherson Square
Fayetteville, North Carolina 28304
(919) 864-5691

P.R. Manarino-Leggett, Ph.D.
Director
Reading Specialist

Staffed by Specially Trained & Certified Teachers

- *Diagnosis and Treatment of Learning Disabilities Children and Adults*
- *Remediation of Reading Disabilities*
- *Tutoring in Math*
- *Specialized Classes*

DIAGNOSTIC EVALUATION AND REPORT OF
REPORT OF PROGRESS

CLIENT: Jonathan Binney GRADE: 7
PARENTS: Dr. and Mrs. James Binney C.A.: 14 years
ADDRESS: 390 Hilliard BIRTHDATE: [redacted]
Fayetteville, NC 28311 TESTDATE: 10-26-88

REASON FOR REFERRAL:

Jonathan was seen at the clinic as requested by his parents who were concerned over his progress in school, especially in the independent or structured curriculum.

TESTS ADMINISTERED AND RESULTS:

The following tests were administered on October 26, 1988.

Diagnostic Achievement Test for Adolescents

	%ile	Std. Scores
Word Identification	68	11
Reading Comprehension	75	12
Math Calculation	5	5
Math Problem Solving	2	4
Spelling	25	8
Written Composition	5	5
Science	37	9
Social Studies	25	8
Reference Skills	9	6

Key Math Test	7.5 grade level
Slosson Oral Reading Test	9.3 grade level
Slosson Intelligence Test	Range 95-103 (Average)
Botel Test of Word Opposites	7-8 grade level

According to the test results, Jonathan's main problems appeared to be in math computation, problem solving, and written expression.

THE LEARNING CENTER
Ross E. Williams, M.D., F.A.A.P.
Physician's Pavillion; Suite 240
945 Bethesda Drive
Zanesville, Ohio 43701
(614) - 454-4070

TO: Zanesville Christian School
2400 Charlestville Rd
Zanesville, Ohio
Attn: Mr. Thompson + Paul Shover

You are hereby authorized to furnish a copy of school performance information, including individual or group testing scores and any psychological evaluations, and current I.E.P. regarding

Jonathon Benney (pt. name) Date of Birth 5/9/72

to The Learning Center.

Signature X Sandra Benney

Date 1/13/92

Witness: J. Gore

sent 1/17/92 cs

REPORT OF INSTRUCTION AND PROGRESS

Jonathan has received a total of 25 hours of instruction, one-on-one between October and May 1989. The main area of instructional focus were math and English/Language arts. Most of the math instruction centered on fractions using all four operations using the Heath seventh grade math series. Additional work was done on the following areas: subtracting from zeros, multiplying with zeros, story problems, decimals, greatest common factors and metrics.

Jonathan maintained a writing journal and several lessons on mechanics were conducted from that. He grasped material quickly and appeared to have a good understanding of all concepts. He does need to have more review on metrics.

P. Manarino-Leggett, Ed.D.

ZANESVILLE CHRISTIAN SCHOOL

2400 CHANDLERSVILLE ROAD · ZANESVILLE, OHIO 43701 · (614) 453-9516

New ✓
Returning ____

Boy ✓
Girl ____

STUDENT APPLICATION
DATE 8-30-89

STUDENT'S NAME Binney / JONATHAN Kyle
last first middle

ADDRESS 13940 CLAYSVILLE RD. NEW CONCORD OHIO- 437
street city state zip

PARENT OR GUARDIAN (Underline which)

Home Phone 872-3816 Business Phone SAME

Church MARANATHA BIBLE Pastor MCCALLISTER

Child's Age 15 Date of Birth [redacted] Grade entering 8th

School Year 1989 to 1990 Name of Previous School CORNERSTONE

Brothers or Sisters in our Schools:

Name Jerry!? Grade ____
Name ____ Grade ____
Name ____ Grade ____
Name ____ Grade ____
Name ____ Grade ____

PARENT'S NAMES:

Father Binney / JAMES Occupation ?
last first

Employer SELF? ____
address phone

Check if Applicable: Widower ____ Divorced ____ Separated ____

Mother Binney / SANDRA Occupation ____
last first

Employer NONE ____
address phone

Check if Applicable: Widower ____ Divorced ____ Separated ____

MEDICAL RECORD	PROGRESS NOTES
DATE	

PATIENT'S IDENTIFICATION *(For typed or written ent. grade; rank; rate; hospital*

FIRMR(41CFR)201-45.505
609-111

MEDICAL RECORD	PROGRESS NOTES
DATE 13 MAR 95	PRE-OP DIAG: Pelvic Pain
	FINDINGS: Multiple dense Adhesions
	POST-OP DIAG: "
	PROCEDURE: Laparoscopy, LOA, Laparotomy, LOA
	ANES: GETA
	SURGEON: Schneider
	ASST: Diaz-Staff
	EST. BLOOD LOSS: 80cc
	BLOOD: Ø
	FLUIDS: 1500cc LR
	URINE: Ø
	POST-OP COND: Good
	SPECIMEN: NONE
	[signature] MD
14 MAR 95 0650	Surg
	S: no c/o
	O: VSS, Afeb
	A: S/P lap
	P: 1) cont pain control, NGT, Foley
	[signature]

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)*

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR.
FIRMR(41CFR)201-45.505
509-111

DOVE, GAYLE A [redacted] 28 01 56 CB155

PROGRESS NOTES

DATE	
15 MAR 95	Surg
0645	S: no c/o
	O: VSS, 101 [2]
	A: S/P lysis of adhesions
	P: 1) cont pain control, NPO, IVF
	Mchd Lgly
16 MAR 95	Surg
0640	S: no c/o
	O: VSS, Afeb
	A: S/P lysis of adhesions
	P: 1) cont NPO, IVF, PCA
	Mchd Lgly
3/18/95	Surg
	↓ c/o
	VSS AF
	S/P lysis of adhesions
	Ring well
	D/c Soon.
	WENDELL R. SMITH, M.D. 70-647

DOVE, CAYLE A [redacted]

Department of Veterans Affairs

MEDICAL RECORD - DISCHARGE INSTRUCTIONS

DATE OF ADMISSION	DATE OF DISCHARGE	TYPE OF DISCHARGE
12 Mar 95	19 Mar 95	

1. DIAGNOSES AND DATE TO BE FOLLOWED ON OUTPATIENT SERVICES

Pelvic Adhesive Disease

2. SUGGESTED PLAN FOR FOLLOWUP

Return to Post Op / Follow-Up Clinic on 29 Mar 95

3. DISCHARGE MEDICATIONS AND INSTRUCTIONS

Premarin 1.25 mg p.o. q day
Percocet ÷ 1 p.o. q 4° prn

4. DISCHARGE DIETARY INSTRUCTIONS *(Check one)*

☑ NO RESTRICTIONS ☐ RESTRICTIONS *(Specify and include drug and food interactions)*

5. PHYSICAL ACTIVITY LIMITATIONS *(Check one)*

☐ NO RESTRICTIONS ☑ RESTRICTIONS *(Specify)*

No Heavy lifting - > 10 lbs for ÷ month

6. OTHER *(Include employment status)*

Pt to Convalesce from work for one week

PATIENT IDENTIFICATION *(Name, Address, Social Security Number)*	SIGNATURE OF PHYSICIAN/DENTIST	DATE
Dove, [redacted]	[signature]	3/19/95
	I HAVE RECEIVED AND UNDERSTAND MY DISCHARGE INSTRUCTIONS	
	SIGNATURE OF PATIENT: Gayle A. Dove	DATE: 19 Mar 95

VA FORM **10-7978M** EXISTING STOCKS OF VA FORM 10-7978M, NOV 1987 WILL BE USED. MEDICAL RECORD

Department of Veterans Affairs

MEDICAL RECORD - NURSING DOCUMENTATION

NURSING ADMISSION ASSESSMENT

SECTION I: PATIENT DATA:

DATE: 3-12 TIME: 1115 REASON for ADMISSION: Pelvic adhesions

SOURCE OF INFO: pt MARITAL STATUS: S/M/D/W RELIGIOUS PREFERENCE: Prot
CAREGIVER Avail on D/C Y/N LIVES Alone/with husband
ADM STATUS: [] Oriented [] Disoriented [] Unable to Communicate [] Unresponsive
VS: T 98.2 P 114 R 18 B/P (R/L) Sit/Lying 134/90 Ht 5'6½ Wt 150

ITEMS BROUGHT TO HOSPITAL/ASSISTIVE DEVICES:
[] Money: [] Jewelry: Yellow & stainless watch
[] Clothing: Street clothes [] ID Bracelet Verified As Correct
[] Glasses [] Contact lens [] Dentures [] Hearing aid [] Wheelchair [] Cane
[] Artificial limb [] Crutches [] Other: Comb
DISPOSITION OF MONEY/JEWELRY: [] Home [] Agent/Cashier [] MAA [] Patient
SIGNATURE: Lynne Burkhalter RN/LPN/NA

SECTION II: HEALTH MANAGEMENT PROBLEM Y/N

GENERAL APPEARANCE: [] Well Groomed [] Unkempt [] Other:

ALLERGIES: Y/N Describe:
ARE YOU TAKING ANY MEDICATION, PERFORMING TREATMENTS? Y/N
If Yes, list: Female Hormone

Non-prescribed Drugs: Tylenol
Alcohol: Y/N Tobacco: Y/N 1 pack

SECTION III: ACTIVITIES OF DAILY LIVING/LEVEL OF FUNCTIONING PROBLEM Y/N
Assess patient's level of functioning, check appropriate box

ITEMS	SELF CARE	ASSIST	TOTAL CARE	COMMENTS
Bathing				
Dressing				
Eating				
Mobility				
Oral Hygiene				
Toileting				
Foot Care				
Other				

ENTER IN SPACE BELOW – PATIENT IDENTIFICATION – TREATING FACILITY – WARD NO. (Continue on Reverse)

DOVE, CAYLE A
5[redacted] A STREET
B[redacted] MS 3955[redacted] 50
[redacted]

[redacted]

EXISTING STOCKS OF VA FORM 10-0096, SEP 1985, WILL BE USED.

*U.S. Government Printing Office: 1991 — 282-804/46006

SECTION IV: RESPIRATORY/CARDIOVASCULAR SYSTEM **PROBLEM: Y/N**

BREATHING PROBLEMS? Y/N [] Dyspnea [] SOB at rest [] SOB on exertion
[] Parox Noc Dyspnea [] Orthopnea [] Comments:

COUGH? Y/N If Yes: [] Productive [] NonProductive [] TRACH? Y/N
ANY HEART PROBLEMS? Y/N With activity/at rest Pacemaker Y/N
ANY CHEST DISCOMFORT/PAIN? Y/N Now/Prior to admission
Location: Duration:
SEVERITY OF YOUR PAIN (least) 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (most)
WHAT CAUSES PAIN? abdominal pain WHAT RELIEVES IT? nothing
Hx OF HIGH BLOOD PRESSURE? Y/N How treated?
LEG PAIN? Y/N R/leg L/leg Pain Occurs: When walking At Rest Other
SWELLING? Y/N If yes, Site(s) & Duration:
DEGREE: [] Mild [] Moderate [] Severe

SECTION V: NUTRITION/ELIMINATION **PROBLEM: Y/N**

GENERAL STATUS: [] Obese [] Well-Nourished [] Emaciated [] Dehydrated
RECENT CHANGE IN WEIGHT? Y/N If Yes, describe:
DIFFICULTY CHEWING/SWALLOWING? Y/N If yes, describe:
SPECIAL DIET? Y/N If Yes, type: reg

PROBLEMS WITH YOUR BOWELS? Y/N [] Constipation []Incontinent [] Diarrhea
[] Black, tarry stools [] Hard, formed stools [] Comments:
Last BM 3-1- days ago Regular bowel habits: Yes

PROBLEMS URINATING? Y/N: [] Starting [] Burning [] Frequency
[] Change in color [] Incontinent [] Drainage/discharge [] Urinate at night?
Y/N How may times? [] Comments:

SECTION VI: MUSCULOSKELETAL/NEUROLOGICAL **PROBLEM: Y/N**

HAVE YOU EVER LOST CONSCIOUSNESS: Y/N IF Yes, describe:

Hx OR PRESENCE OF: [] Amputation [] Seizures [] Atrophy [] Paralysis [] Contractures
[] Spasticity [] Other If Yes, describe: N/A

ASSISTIVE DEVICES USED FOR MOBILITY? [] Cane [] Walker [] Wheelchair
[] Artificial Limb [] Comments:

PAIN Y/N If Yes, describe: None

SECTION VII: COGNITIVE-SENSORY/PSYCHOSOCIAL **PROBLEM: Y/N**

TROUBLE REMEMBERING THINGS? Y/N If Yes, [] Short Term Memory [] Long Term Memory
CHANGES IN SENSORY PERCEPTION? Y/N [] Sight [] Hearing [] Taste [] Touch [] Smell
If Yes, describe:
~~SPECIAL NEED OR CULTURAL PRACTICES? Y/N If yes, describe:~~
SPEECH: [] Clear [] Slurred [] Aphasic [] Disorganized
BEHAVIOR: [] Cooperative [] Withdrawn [] Agitated [] Bizarre [] Other
SUICIDAL/COMBATIVE Y/N If Yes, describe
ADDITIONAL COMMENTS:

SIGNATURE: Lynne Burkhalter RN/LPN

Department of Veterans Affairs

MEDICAL RECORD - NURSING DOCUMENTATION

SECTION VIII: PREDISPOSITION FOR FALLING PROBLEM: Y/N

Instructions: Check applicable items

____ Postural hypotension	____ Poor bladder control
____ Unsteady on feet	____ Poor eyesight
____ Confused/disoriented	____ 65 y.o. or older
____ Patient has fallen previously	____ Physical disabilities
____ Dizziness/fainting	____ Neurological problems
____ Unsafe footwear	____ Current medications including sedatives, narcotics, hypnotics, or diuretics

COMMENTS: _____

SECTION IX: SKIN PROBLEM: Y/N

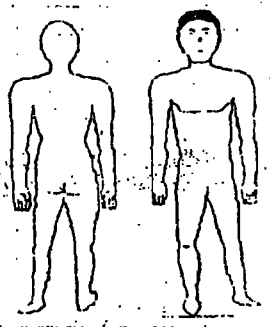
NORTON PRESSURE SORE RISK FACTORS SCALE

>14 low risk 12-14 at risk <12 high risk

Circle the level for each category, total the points PATIENT SCORE: _____

PHYSICAL		MENTAL		ACTIVITY		MOBILITY		INCONTINENT	
Good	4	Alert	4	Ambulant	4	Full	4	Not	4
Fair	3	Apathetic	3	Walk-help	3	Sl limited	3	Occasional	3
Poor	2	Confused	2	Chairbnd	2	Limited	2	Usually urine	2
Serious	1	Stupor	1	Bed	1	Immobile	1	Doubly	1

SKIN PROBLEMS: [] N/A [] Itching [] Discoloration [] Dryness [] Sores
[] Hair-Scalp COMMENTS: _____



LOCATION	APPEARANCE	SIZE	STAGE	DRAINAGE
1.				
2.				
3.				
4.				

ENTER IN SPACE BELOW – PATIENT IDENTIFICATION – TREATING FACILITY – WARD NO. (Continue on Reverse)

[redacted]

MEDICAL RECORD

[redacted]

VA FORM 10-0096 FEB 1990 EXISTING STOCKS OF VA FORM 10-0096, SEP 1985, WILL BE USED

*U.S. Government Printing Office: 1991 — 282-804/46005

SECTION X: SLEEP/REST PROBLEM: Y/N

PROBLEMS WITH SLEEP? Y/N If Yes, describe: Benadryl
Usual hours of sleep 8-9 From: _____ To: _____

SECTION XI: SEXUAL/REPRODUCTIVE SYSTEM PROBLEM: Y/N

Has your health affected your sexual relationships? Y/N If yes, describe: _____

Do you perform routine self breast/testicular exams? Y/N
Do you think you are or have ever been at risk for sexually transmitted diseases or AIDS such as Blood Transfusion prior to 1985? Y/N If Yes, explain: _____

SIGNATURE Lynne Bistrovich RN/LPN

SECTION XII: ADDITIONAL COMMENTS, IF INDICATED:

SECTION XIII: ASSESSSMENT AND ANALYSIS OF DATA

DISCHARGE PLANNING NEEDS: Describe: D/C Home to Husband

LEARNING NEEDS:

[X] Medications	[] Disease Process	[] Diet
[X] Procedure	[] Self-Care	[] Other

Comments: _____

PRIORITY PATIENT CARE NEEDS:

1. Comfort
2. Management of heart
3. _____

Problems discussed with patient/significant other by me at 3/12/95 1135.
Time/Date

SIGNATURE Patti Mauldin RN

Veterans Administration

Pre-operative Patient Teaching

	Date	Init.	Patient and family verbalize understan Yes	No *
Orientation to Ward|Unit	3/2/95	CMRN	✓	
Storage of valuables|medications				
Explaination of procedures,drains,etc.				
Betadine shower|bath				
NPO after midnight except meds				
Shave|Prep				
Pre-op medications				
Recovery Room|Unit routine				
Family waiting area				
Post-op pain medication				
Post-op activities				

* Patient\|family request additional instructions regarding

See NCP for follow-up plan. pre-op, post-op & D/C teaching given, verbalized understanding

SIGNATURE AND TITLE OF PRACTITIONER [redacted] 3/10/95 1050

IMPRINT PATIENT DATA CARD

[redacted]

[redacted] RECORD
SUPPLEMENT TO PROGRESS NOTE
FOR SPECIALIZED DISCIPLINES

[redacted]

025396

MEDICAL RECORD	PROGRESS NOTES
DATE	
3/10/95 1050	Alert + oriented x3, oriented to room + ward, denies any present s/s of distress noted, ambulatory, denies any allergies — Carol Manuel RN
3/10/95 1500	D. Whitespirement Hab. — [illegible]
3/12/95 2055	Alert x3, Amb. ad. lib. VSS. A/C voiced. Call light at hand. NPO for MN for Surgery — Linda Nauth RN
3-13-95 0145	Pt alert & oriented x3. VSS & no complt of distress noted. Bed in low position and call light in reach. Remains NPO for procedure. — [illegible]
3-13-95 1500	VS: 96.8 - 74 - 18 114/74

POST-OP R.N. DOCUMENTATION

Patient assessed by RN upon return from OR:

a. Level of consciousness Alert & oriented x 3.

b. Dressing/OP site ~~Vertical~~ & abdominal dsg's D/I.

c. Mobility/sensation MAE - Good results obtained pre-op.

d. IV Fluids Patent.

e. Drainage tubes/catheters, removals: ~~Foley draining sufficient quantities~~ clear yellow urine w/ Bag ↓ level of Wonder. NG to LCS.

Signed by: Carol Burton R.N.

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle) [redacted] 50

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR(41CFR)201-45.505
509-111

C-SSN [redacted]

PROGRESS NOTES

DATE	
3/13/95	Resp - IS started @ This time val.
2115	Achieved 2000cc x 10 cycles Nonprod Cough. Mylene Acker

POST-OP R.N. DOCUMENTATION

3/13/95 2300

Patient assessed by RN upon return from OR:

a. Level of Consciousness Alert x 3, VSS

b. Dressing/OP site DSG dry & intact.

c. Mobility/Sensation able to move all ext. limbs well. PCA MSO4 1mg c 6-10 L.O. for pain control - relief obtain

d. IV Fluids D5 1/2 NS c 20 Meq KCL @ 125°

e. Drainage tubes, i.e. catheters, nemovacs, suction apparatus foley patent & draining well. NBJ to LCS. Linda Sood R.N.

Signed by:

POST-OP R.N. DOCUMENTATION

3/14/95 0200

Patient assessed upon return from OR:

a. Level of Consciousness Alert et oriented, VS stable. SR x 4, call light w/n

b. Dressing/OP site Dry et intact w/n

c. Mobility/Sensation Moves all ext. sensation to all extremities ambulating slowly down hallway.

d. IV Fluids D5 1/2 c 20K @ 125° PCA MSO4 to clear site

e. Drainage tubes, i.e. catheters, nemovacs, suction NG to LC WS apparatus foley to gravity bag drains sufficient quantities of clear yellow urine

Signed by: Joanne Domingo R.N.

3/14/95 0230

Pt c/o nausea, medicated c 25 mg Phenergan c satisfactory results — Joanne Domingo RN

* U.S. Government Printing Office: 1994-378-437

STANDARD FORM 509 BACK (Rev. 11-77)

DOVE, GAYLE A
515 64 6094

Anesthetic procedures may be associated with, but not limited to:

infection
hemorrhage (excessive bleeding)
drug reactions
blood clots
loss of sensation
loss of limb function
paralysis
organ damage
heart attack
stroke
loss of life
blood reactions (including rash, itching, nausea, vomiting & shock)

Other risks/complications associated with <u>General Anesthesia</u>

sore throat
hoarseness
shortness of breath
difficulty in breathing
injury to teeth
injury to eyes
injury to airway
injury to arteries or veins
awareness under anesthesia
pain or discomfort continuing after discharge from the hospital

Other risks/complications associated with <u>regional, spinal or epidural anesthesia</u>

pain or discomfort
injury to arteries or veins
residual pain
residual sensation
residual dysfunction
low blood pressure
headache
high blood pressure
seizure
failure of regional, spinal or epidural anesthesia & subsequent need for general anesthesia

Department of Veterans Affairs

PRE OP ANESTHESIA INFORMED CONSENT

SURGICAL SERVICE

DATE\TIME: 3/13/95 1530 PATIENT COMPETENT: YES ✓ NO _____

BRIEF SUMMARY: DERMIC HD ABSCESS

PATIENT CONDITION: AWAKE, ALERT
(i.e. awake, alert, sedated, anxious, confused, lethargic, unconscious, intubated, other)

PROPOSED PROCEDURE\TREATMENT PLAN: I & D ABSCESS SCALP / I & D ABSCESS TOE, L
G. E. T. A.

POSSIBLE RISKS\COMPLICATIONS: ANESTHESIA RISK CONDUCTED, G. A. D, T
ANESTHESIA & RISKS DISCUSSED + PT

ALTERNATIVE TREATMENT IDENTIFIED TO PATIENT\GUARDIAN: N/A

Patient and\or guardian\next of kin has been given opportunity to ask questions:
Yes ✓ No _____

Patient (and\or guardian\next of kin comprehends what has been proposed and why:
Yes _____ No _____

Patient and\or guardian\next of kin has agreed and freely consented to the proposed procedure\treatment plan without duress or coercion: Yes ✓ No _____

ATTENDING ANESTHESIOLOGIST CONCURS with proposed\treatment plan: Yes ✓ No _____

ATTENDING ANESTHESIOLOGIST NOTE: _____

CRNA\ANESTHESIA RESIDENT

ATTENDING ANESTHESIOLOGIST 3/13/95

SIGNATURE AND TITLE OF PRACTITIONER | DATE

IMPRINT PATIENT DATA CARD

DOUG, G
1094
[redacted]

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE
FOR SPECIALIZED DISCIPLINES
[redacted]

INFORMED CONSENT (cont.)

Benefits: R Excise Abscess and relief relieve addictions

Patient's condition Good, i.e., awake, alert, sedated, anxious, confused, lethargic, unconscious, etc...

Alternative Treatment identified to patient/guardian: No Surgery

Next of kin/guardian _____ (Name) Contacted: Yes ___ No ___

Patient Competent: Yes ___ No ___

Patient and/or guardian/next of kin has been given opportunity to ask questions: Yes ___ No ___

Patient and/or guardian/next of kin comprehends what has been proposed and why: Yes ___ No ___

Patient and/or guardian has agreed and freely consented to the proposed procedure/ treatment plan without duress or coercion: Yes ___ No ___

Patient and/or next of kin has been informed of the Surgical Team: Dr. _____ (Attending Staff), Schneider (Surgeon), _____ (Members).

Attending surgeon concurs with proposed procedure/treatment plan: Yes ___ No ___

Attending Surgeon Note: Consultation Surgery Alternative methods and risks discussed and patient agrees with plan of action

_____ Resident Surgeon

_____ Attending Surgeon

Department of Veterans Affairs

AMBULATORY SURGERY

PRE-OP INFORMED CONSENT

TIME: _____

Diagnosis:

Pelvic pain

Brief Summary:

Pt 37 y.o. WF ÷ 2mo h/o constant pelvic pain. Had h/o hysterectomy

Proposed Procedure/Treatment Plan:

Laparoscopy, possible lysis of Adhesions
Potential for laparotomy

Possible Risks/Complications:

Bleeding, infection, possible open procedure
Potential no benefit from procedure

SIGNATURE AND TITLE OF PRACTITIONER
SEE REVERSE

DATE

IMPRINT PATIENT DATA CARD

[redacted] 2[redacted] 61 90

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE
FOR SPECIALIZED DISCIPLINES

[redacted] FEBRUARY 1994

VA FORM MAY 1990 10-0114i

EXISTING STOCK OF VA FORM 10-0114j, SEPT 1988.

MEDICAL RECORD | NURSE INTRAOPERATIVE REPORT PAGE 1

Operating Room: OR 2 Surgical Priority: ELECTIVE
Patient in Hold: MAR 13, 1995 08:35 Patient in OR: MAR 13, 1995 08:45
Operation Begin: MAR 13, 1995 09:30 Operation End: MAR 13, 1995 11:00
Patient Out OR: MAR 13, 1995 11:05

Surgeon: SCHNEIDER,MICHAEL J. First Assistant: DIAZ,ALBERT L
Attending Surg: DIAZ,ALBERT L Second Assistant: VU,DANNY X
Anesthetist: EVERETT,KEVIN L Assistant Anesth: COOPER,WILLIAM M
Other Scrubbed Assistants: N/A

OR Support Personnel:
Scrubbed Circulating
GRIFFITH,MELANIE D (FULLY TRAINED) SCHMITT,DONNA EASTER (FULLY TRAINED)

Other Persons in OR:
CHRIS FEOLA (AUTOSUTURE REP)
KIRK GIBY (AUTOSUTURE REP)

Preop Mood: RELAXED Preop Consc: ALERT-ORIENTED
Preop Skin Integ: INTACT Preop Converse: N/A
Valid Consent/ID Band Confirmed By: GRIFFITH,MELANIE D
Skin Prep By: SCHMITT,DONNA EASTER Skin Prep Agent: POVIDONE IODINE SC
Skin Prep By (2): SCHMITT,DONNA EASTER 2nd Skin Prep Agent: POVIDONE IODINE
Preop Shave By: DIAZ,ALBERT L

Surgery Position(s): LITHOTOMY Placed: MAR 13, 1995 09:10
Restraints and Position Aids:

SAFETY STRAP	Applied By: N/A
SURGERY ARMBOARD	Applied By: N/A
GEL PADS	Applied By: N/A
GEL PAD DOUGHNUT	Applied By: N/A
STIRRUPS	Applied By: N/A
OTHER	Applied By: N/A

Electrocautery Unit: VALLYLAB
Electroground Position(s): RIGHT FLANK

Major Operations Performed:
Primary: LAPAROSCOPY CPT Code: NOT ENTERED
Other: EXPLORATORY LAPAROTOMY WITH LYSIS OF ADHESIONS CPT Code: NOT ENTERED

Material Sent to Laboratory for Analysis:
Specimens: N/A
Cultures: N/A

Anesthesia Technique(s):
INHALATION (PRINCIPAL)
Agent: ISOFLURANE
FENTANYL .35 mg
MIDAZOLAM 2 mg

Tubes and Drains:
#16/5CC GU FOLEY/NG

NURSE'S SIG: [signature] MAR 13, 1995@11:26
DOVE,GAYLE A
WARD: 1-4WSUR [redacted] ROOM-BED: 4B120-23
VAMC: Biloxi, MS (CONS) SF 509 PROGRESS NOTES

Tourniquet: N/A
Thermal Unit: N/A
Prosthesis Installed: N/A
Medications: N/A
Irrigation Solution(s):
NORMAL SALINE
Time Used: MAR 13, 1995 10:30
Amount: 50 Provider: DIAZ,ALBERT L
Blood Replacement Fluids: N/A
Sponge Count: CORRECT
Sharps Count: CORRECT
Instrument Count: CORRECT
Counter: GRIFFITH,MELANIE D
Counts Verified By: SCHMITT,DONNA EASTERLY
Dressing: 2X2 TEGADERM,4X8 AND PAPERTAPE
Packing: NONE
Blood Loss: 0 cc's Urine Output: 0 cc's
Postoperative Mood: RELAXED
Postoperative Consciousness: ANESTHETIZED
Postoperative Skin Integrity: INTACT
Postoperative Skin Color: N/A
Type of Laser: N/A
Sequential Compression Device: NO

Wound Classification: CLEAN
Operation Disposition: PACU (RECOVERY ROOM)
Discharged Via: STRETCHER W/SAFETY STRAP,S/R UP
Nursing Care Comments:
PT IDENTIFIED PER PT STATEMENT,NAMECARD AND WRIST BAND. PT PROCEDURE CONFIRMED PER DR SCHNEIDER STATED POSSIBLE OPEN LAPAROTOMY--CONSENT STATES LAPAROSCOPY AND OR SUPERVISOR NOTIFIED (DAWN BELLAIS RN)•INFORMED SURGICAL CONSENT STATES POSSIBLE LAPAROTOMY. PT TRANSFERRED TO GELPADDED OR BED WITH PT'S HEAD RESTING ON GELPADDED DOUGHNUT. BOTH OF PT'S ARMS PLACED ON GELPADDED ARMREST. AFTER INDUCTION AND INTUBATION BOTH OF PT'S LEGS RAISED SIMUTANEOUSLY AND PLACED IN GELPADDED STIRRUPS. PEDAL PULSES PRESENT BILATERALLY. SURGICAL PREP TO ABDOMEN AND VAGINAL VAULT INCLUDING PERINEUM. #16/5CC GU FOLEY INSERTED WITH CLEAR YELLOW URINE RETURN ~250CC TO GRAVITY DRAIN. 10:00A OPEN LAPAROTOMY BEGAN. DISCHARGE NOTE: PT TOLERATED PROCEDURE WELL AND TRANSFERRED TO PACU STABLE CONDITION WITH TEGADERM PRESENT IN UMBILICUS AND DRESSING TO LOW ABDOMEN DRY AND SECURE. FOLEY CATHETER DRAINING CLEAR YELLOW URINE. NG CLAMPED. PT TRANSPORTED WITH O2 PER FACE MASK.

NURSE'S SIG: [signature] MAR 13, 1995@11:26
DOVE,GAYLE A [redacted]
WARD: 1-4WSUR ROOM-BED: 4B120-23
VAMC: Biloxi, MS (CONS) [redacted]

MEDICAL RECORD [redacted]

DATE	
3/14/95 0500	Resp I/S vol. achieved 2000 mL x 10 goals. NO cough BBS clear. / Jshurell cpt
3/14/95 7A-7P	Resp - I/S ac o dsmd, achvd goals 2000-2500 x 12 breaths, good cough & deep breathe. IPC tolerated well - Smith cpt
3-14-95 2315	D. NG discontinued via Dr's on 3b-12 tour of duty. Edith B. Calabrese,
3/15/95 0230	Pt ↑ ambulating in hallway, alert et oriented x4, breathing reg et unlabored, tolerating P.O ice chips q 4° 5 difficulty, foley to gravity bag draining clear yellow urine, pt instructed to continue to use IS q 1° WA et verbalized agreement to do so, D5 1/2 c 20K running at 125 cc° to clear site, movement et sensation to all extremities, pain controlled effectively @ 1-2 on scale c PCA MS04. pt returned to bed at this time, SR x4 Call light w/r Joanne Donigan rn

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)*

[redacted]

DOVE, CAYLE A [redacted]

PROGRESS NOTES

DATE	
3-15-95	Foley catheter d/c'd ~ 1200 cc of
1245	clear light yellow) urine. Pt tolerated
	procedure well. Notify staff Lynne Bierschbach

DOVE, KYLE A
515 : 4 80 74

Chewing Problems: Y (N)
Dysphagia: Y (N)
Appetite: (A) —
Feeding Assistance Required: Y (N)
Food Allergies: None on file N/K
Food Preferences: no fish or liver

Pre-Admission Diet: Regular
Wt. (↓) - 15 # in last 2 months
Nausea: Y (N) Vomiting: Y (N)
Diarrhea: (Y) N Constipation: (Y) N

Current Diet: NPO x2 days s/p ex lap w/ lysis of adhesions 3/12
Adm. Dx: PELVIC ADHESION
Age: 37 Sex: F
Height: 5'6 1/2"
Weight: 150#
Usual Weight: 130's
Ideal Weight: 133 #±10%
Amputation %: —

Adm. Date: 12-Mar-95 10:27am
Prior Assessment: N/A
Frame Size:
Weight Taken:
Weight/Usual Wt:
Weight/IBW:

Laboratory Data

Test	Result	units	Ref. range	Date
GLUCOSE	72.	mg/dL	62 - 120	12-Mar-95
UREA NITROGEN	9.	mg/dL	9 - 21	12-Mar-95
CREATININE	0.9	mg/dL	.5 - 1.4	12-Mar-95
SODIUM	142.	M MOL/L	137 - 145	12-Mar-95
POTASSIUM	4.5	M MOL/L	3.6 - 5	12-Mar-95
CHOLESTEROL	196.	mg/dL	146 - 240	6-Oct-94
ALBUMIN	4.0	gms/dl	3.9 - 5	12-Mar-95
TRIGLYCERIDE	248. H	mg/dL	40 - 190	21-Sep-94
HCT	37.8	%	37 - 47	12-Mar-95
LYMPH#	2.8	#/cmm	1.2 - 3.4	12-Mar-95

Appearance: WNWF

Nutritional Status

__✓__ Not Compromised
___ Mildly Compromised
___ Moderately Compromised
___ Severely Compromised

Nutrition Education

Further Education Required: Y (N)

Food/Drug interaction Ø

Comments: NPO x 2 days

Nutritional Plan

__✓__ Provide basic nutritional care
___ Screening data not available: Please order_____
___ Nutrition Education
__✓__ Recommend Diet Change Progress to P.O. as tolerated.
___ Further Nutritional Assessment

Recommendations:
If he remains NPO > 3-4 days, suggest alternate form of nutrition support.

Linda B Jones RD 3/15/95 @ 1500
Signature Date

MEDICAL RECORD	PROGRESS NOTES
DATE 3/16/95 @	2100 pm: Pt. awake, alert, oriented x4. Has been off ward this TOD c family. IVF infiltrated. Dr. Sobey informed and IVF D/c c SCA. Percocet ordered po for pain. ——— Jolene Martinez

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)	REGISTER NO.	WARD NO.
DOVE, GAYLE A [redacted]	C8155	

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR(41CFR)201-45.505
509-111

MEDICAL RECORD	PROGRESS NOTES
DATE	
3/16/95	Pt ambulating in hallway c minimal
0300	difficulty, pain adequately controlled
	c PCA MSO4, new HL site this TOD,
	pt voiding sufficient quantities of clear
	yellow urine c difficulty, alert et
	oriented x4, VS stable, breathing
	reg et unlabored, SR x4 w/rails up
	bed, call light w/r — Jane Dongay RN
3/16/95	Pt states that she has swelling
0700	in Hands et ankles, MD notified, IV
	d to 100 cc° — Jane Dongay RN
3/18/95	O- Met T and about on ward and down
0600	hall more voided x no C/O VSS stable @ this
	time. Remind pt that Dr's said she could get Shower Wednesday

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO.

WARD NO.

DOVE, GAYLE A [redacted]

09155

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR(41CFR)201-45.505
509-111

Veterans Administration

NURSING DISCHARGE PROGRESS NOTE

1. Discharge living arrangements: D/C Home
2. Accompanied by: Family member
3. Ambulation: ambulatory
4. TPR: See V/S Graphic Sheet BP:
5. General condition (including resolved and unresolved nursing diagnosis):
   alert & oriented x3, denies any c/o c/o distress noted

6. Nursing care needed following discharge (including Nursing Care Referral):

   None

7. Patient/family education, instructions, medications, follow-up and assessment of understanding:

   PT. VERBALIZES UNDERSTANDING OF:

   a. DRESSING CHANGES AND/OR WOUND CARE Ø
   b. ACTIVITY-PHYSICAL LIMITATIONS no heavy lifting 2 10lbs x 1 mnt
   c. DIETARY REGIME Ø
   d. MEDICATIONS Given IK at D/C
   e. FOLLOW-UP APPOINTMENT F/u Surg CL March 29th, 1995

SIGNATURE AND TITLE OF PRACTITIONER: Mabel Mawhee RN 3/19/95 RN 1725 | DATE/TIME:

IMPRINT PATIENT DATA CARD

DOVE, GAYLE A [redacted] CB155

[redacted]

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE
FOR SPECIALIZED DISCIPLINES

---- CBC PROFILE ----

LOOD	03/12/95 12:20	Units	Reference Ranges
BC	8.6	#/cmm	4.8-10.8
BC	4.11 L	#/cmm	4.2-5.4
GB	12.7	g/dl	12-16
CT	37.8	%	37-47
CV	91.9	fL	81-99
CH	30.9	pg	27-31
CHC	33.6	g/dl	32-36
DW	12.6	%	11.5-14.5
LT	296	#/cmm	130-400
PV	7.9	fL	7.4-10.4
EUTRO%	58.8	%	42.2-75.2
YMPH%	32.2	%	20.5-51.1
IONOS%	6.4	%	1.7-10
OSINO%	1.7	%	0-11
ASO%	.9	%	0-2
IEUTRO#	5	#/cmm	1.4-6.5
.YMPH#	2.8	#/cmm	1.2-3.4
IONOS#	.6	#/cmm	.1-.7
OSINO#	.1	#/cmm	0-.7
ASO#	.1	#/cmm	0-.2
EGSm		%	36-76
ANDSm		%	2-10
.YMPHSm		%	20-40
IONOSm		%	2-8
OSINOm		%	0-4
ASOm		%	0-1
ETAm		%	0-0
YELOm		%	0-0
ROMYEm			
LASTSm		%	0-0
NRBC			
PLT.EST			Adq
NORMOCY			
ANISO		0-4+	
MACRO		0-4+	
MICROCY		0-4+	
NORMOCH			
HYPOCHR		0-4+	
POLYCHR		0-4+	
BASOPHI		0-4+	
TOXIC G		0-4+	

--------- COMMENTS ---------

KEY: "L"=Abnormal low, "H"=Abnormal high, "*"=Critical value

DOVE,GAYLE A [redacted] ROUTING: 1-4WSUR

** DISCHARGE SUMMARY ** From: 03/12/95 To: 03/19/95

BILOXI,MS PAGE: 1:1

HEMATOLOGY

---- URINALYSIS PROFILE ----

RINE	03/12/95 11:16	Units	Reference Ranges
OLOR	YELLOW		
LARITY	CLEAR		
P.GRAV	1.015		1.015-1.025
ROBILI	.2	EU/dl	.2-.2
LOOD	NEG		Neg.
ILIRUB	NEG		Neg.
ETONES	NEG		Neg.
LU	NEG		Neg.
ROTEIN	NEG		Neg.
ITRITE	NEG		Neg.
EUKOCY	NEG		Neg.
H	6.0		5-9
BC/HPF		/HPF	0-2
BC/HPF		/HPF	0-2
PITH C			
Q.EPTH		/HPF	0-2
E.EPTH		/HPF	NEG
R.EPTH		/HPF	
CASTS			
BC/CAS		/LPF	
BC/CAS		/LPF	
YALINE		/LPF	
GRANULA		/HPF	
AXY/CA			
FATTY/C			
R.BACT		/HPF	NEG
R CRY		/HPF	NEG
M PHOS			
M URAT		/HPF	
RI PHO		/HPF	
A++ OX		/HPF	
RIC AC		/HPF	
CYSTINE			
LEUCINE		/HPF	
TYROSIN			
H CRYS			
MUCUS			
YEAST			
RCMONA			
SPERM			
ICTO			NEG

Comments: a

- - - - - - - - C O M M E N T S - - - - - - - -

KEY: "L"=Abnormal low, "H"=Abnormal high, "*"=Critical value

a. URINE MICROSCOPIC NOT INDICATED

---- CHEM PROFILE ----

ERUM	03/12/95 12:20	Units	Reference Ranges
GLUCOSE	72.	mg/dL	62-128
CREAT	0.9	mg/dL	.5-1.4
BUN	9.	mg/dL	9-21
URIC AC		mg/dL	3.5-8.5
PROTEIN		gms/dl	6.3-8.2
ALBUMIN	4.0	gms/dl	3.9-5
CHOL		mg/dL	146-240
TRIGLYC		mg/dL	40-180
NA	142.	M MOL/L	137-145
K	4.5	M MOL/L	3.6-5
CL2	105.	M MOL/L	101-111
CO2	25.4	M MOL/L	22-31
CA		mg/dL	8.4-10.2
PO4		mg/dL	2.4-4.4
D BILI		mg/dL	0-.4
T. BIL		mg/dL	.2-1.3
FE		ug/dl	34-196
TIBC		ug/dl	260-400
CPK		U/L	30-135
SGOT		U/L	5-35
LDH		U/L	75-196
SGPT		U/L	7-56
ALK PHO		U/L	38-126
ACID PH		U/L	.2-.7
MG		mg/dL	1.7-2.2
AMYLASE		U/L	30-110
LITHIUM		mEq/l	.6-1.2
LIPASE		U/DL4	U/DL-25 U/DL
ETOH		mg/dL	0
LDH.		U/L	313-618
2HR PP		MG/DL	
ACETONE			ABSENT
CK-MB		U/L	
OSMOLAR		mOsm/kg	280-290
ANI GAP	12.0	meq/L	

- - - - - - - - C O M M E N T S - - - - - - - -

KEY: "L"=Abnormal low, "H"=Abnormal high, "*"=Critical value

******** MISCELLANEOUS TESTS ********

DATE	TIME	SPECIMEN	TEST	VALUE		Ref ranges
3/12/95	11:16	URINE	HCG:	NEG	MIU/ML	NEG-<150

Radiology Diagnostic Report
VETERANS ADMINISTRATION MEDICAL CENTER
Division: Biloxi, MS (COWS)

NAME: DOVE,GAYLE A
SSN : [redacted]
[redacted] 11:30
REPORTED : MAR 14,1995
TRANSCRIBED : MAR 14,1995 10:40

CASE: 13
REQUESTED BY: LAUGHREY,MICHAEL S
TECHNOLOGIST: PURVIS,PETER C.
AGE: 37 SEX: FEMALE
WARD/CLINIC : 1-4WSUR

PROCEDURE : CHEST, TWO VIEW

Exam Modifiers : None

Clinical History:
admissions chest. dx: pelvic adhesion

Report:
CHEST: There is no acute infiltrate. The heart, mediastinum, and diaphragm appear normal. The bone structure is unremarkable.

Impression:
No acute disease. No change since 1/16/95.

Films were read by QUAN HUU HA (Staff Physician).

/SDB

NAME: DOVE,GAYLE A
SSN : [redacted]

WARD/CLINIC: 1-4WSUR

ON CALL TO OR:

Physical disabilities: ~~—~~

____ Pre-op and post-op teaching accomplished
____ Most current COMBINED MEDICAL RECORD with patient
____ Patient data card on chart
____ Medication sheets on chart
____ Betadine AM/PM showers accomplished
____ NPO after midnight
____ Voided (within one hour pre-op)

REMOVE THE FOLLOWING:

____ Dentures
____ Jewelry
____ Wig/Hairpiece
____ Glasses/Contacts
____ Prosthesis
____ Hearing Aid
____ Make-up
____ Nail polish
____ Hairpins

Temp 96.7 Respirations 20
Pulse 55 BP 99/56
Weight ____
Pre-op medication on chart Ancef 1 gm
Pre-op medication to be given (on call) ____

Pre-op medication given by: ____
(signature)

____
(date/time)

Patient identified to OR by: Carol Burson RN
(signature)

3-13-95 0830
(date/time)

Department of Veterans Affairs | MEDICAL RECORD - NURSING DOCUMENTATION

SURGICAL CHECKLIST

(Check if accomplished)

~~Patient has ID armband on~~

Consent completed

~~Op Report (SF 515) on chart~~

edmc Tissue Examination (SF 515) on chart

edmc Most current COMBINED MEDICAL RECORD available 1-4-2

edmc Type and [screen/cross] accomplished (if ordered)

edmc Units of blood available 2 (number)

Allergies/Drug Sensitivities (according to Doctor's order):

NKA

Patient has red armband on

Pre-op lab/cxr/ekg (must be accomplished within 30 days of surgery)

edmc CXR 3/12/95 - - - - [~~Results on chart~~/not available/in computer]

edmc EKG 3/13/95 - - - - [~~Results on chart~~/not available/in computer]

edmc URINALYSIS Pregnancy Test Normal [~~Results on chart~~/not available/in computer]

edmc CBS 3/12/95 - - - - [~~Results on chart~~/not available/in computer]

edmc LYTES 3/12/95 - - - - [~~Results on chart~~/not available/in computer]

OTHER: HGB [~~Results on chart~~/not available/in computer]

[Results on chart/not available/in computer]

[Results on chart/not available/in computer]

(over)

ENTER IN SPACE BELOW - PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. (Continue on Reverse)

LOVE, CAYLE A [redacted] 08155

MEDICAL RECORD

[redacted] JUL 1992

VA FORM FEB 1990 10-0096 EXISTING STOCKS OF VA FORM 10-0096, SEP 1985, WILL BE USED.

*U.S. Government Printing Office: 1991 — 282-804/46005

Standard Form 517

CLINICAL RECORD — ANESTHESIA

ANESTHETIC(S) — HOUR: 0845 · 0930 · 1000 · 1030 · 1100 · 1130 · 1200

PERSEDON/ARSINE / ATROPINE/BENDRO / O.T.C./ANECTINE / NORO/TRAC/PAV / ALFENTANIL / Nitro/Labetalol / ETH/ISOR / AIR/N2O / OXYGEN / CO_2 ABSORP.

LEVEL OF ANAL-ANES.

	0845	0900	0915	0930	0945	1000	1015	1030	1045
SKIN	G.R	SR	SR	SR	SR	SR	SR	SR	SR
FiO_2	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
SaO_2									
TEMP SK/ESO		35.2	35.1	35.0	34.8	34.6	34.4	34.3	34.4
CVP	BP		18	12	18	17	17		
PAP	CO			33	30	32	33	36	
PCWP									
ND/CP									

CODE: ● PULSE, ○ RESP., V/Λ B. P., X ANES., ⓞ OPER., T TOURN.

FLUIDS: B BLOOD, N SALINE, G 5% G/W, DX EXPAND

NUMBERS FOR REMARKS

IV FLUIDS: G# CORTIS G# — 900 — 1200

POSITION: EBL — 110 — 150 — 160; Foley

AGENTS AND TECHNICS

MONITORS: EKG, NIBP, SaO2, ET CO2, FiO2, STETH, PREC ESOP, A/Line, S/G, CVP, Warm (I.V.), PCWP, Temp, Skin ESOP, C.O./C.I., Foley

KIT
Lot No.
Exp. Dt.

ENDOTRACHEAL: SIZE 6.0 BLADE MAC 3 ORO ✓ NASO — CUFF ✓ PACK
REMARKS: Direct Vision, Atraumatic Stylet ✓ Y/N ✓ BBS, Lido X Y/N, OU Taped ○ Y/N Taped at 21 Cm.

OPERATION PERFORMED: Expl. Lap for adhesion takedown

TOTAL FLUIDS: LR 1300cc; NS; PPF; SC( ); PRBC( ); FFP( )

NAME(S) OF SURGEON(S): KZC

Signature of Anesthetist.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

TOTAL 1300

REGISTER NO. | WARD NO. | DATE

INDUCTION
SATIS Sch's
UNSATIS AND WHY

REMARKS
Xs 0845 E 1120
Os 0938 DE 1050
ID, ALL EQUIP. ✓ & O.K. MONITORS APPLIED

At info OR, monitors applied Dr McClain attending
I - smooth, NSI
① Ign Ketorol IV
② start op
③ Extubated & head LA, following commands, s/o, breathing & ④ve
RR - to PACU, stable Report

RECOVERY
REFLEX IN O.R. yes
EMESIS NO
ASPIR. NO
EXCITEMENT NO
HYPOTENSION NO
OTHERS —

ANESTHESIA

DOVE, GAYLE A [redacted] C8155

APPROVED
PER OMcC

GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505 517-111-01
OCTOBER 1975

DOE, G. 6094 1/15/96

PREANESTHETIC SUMMARY

Hx Bld Trans. ___Y/N___

OPERATION PROPOSED: LAPAROSCOPY/ LA HARTOTOMY

AGE: 37

WEIGHT (LBS): 0

Ht. 5 ft. 6 in.

PHYSICAL STATUS: ASA 1 (2) 3 4 5 6 7

SPECIAL INFORMATION: Airway DIFFICULT

—

URINALYSIS: NORMAL WNL

ABNORMAL AND WHY?
WBC ___HPF
RBC ___HPF
Bact ___
Prot ___

HEMATOLOGY: HGB 14.1 RBC 4.58 HCT 41.2
OTHER WBC 7.5 PLT. 388
PT/PTT 11.6/33.7

BLOOD CHEMISTRY: Glu 119, Cr 0.8, Bun 7, Sod 139, Kcl 5.1 H, Cl 103, CO_2 26

RESPIRATORY SYSTEM

(X-RAY, ASTHMA, OTHER PATHOLOGY) Lungs (-)

PFT: FVC ___ FEV ___

ABG: ___/___/___/___

TB/Asthma (-)

Tob. PPD 1 x 12 Yrs.

CXR N.A.D

CIRCULATORY SYSTEM

BP 108/64 PULSE 70

ECG (IF PERTINENT)

CAD, HTN, MI, Ang., CHF, ASPVD (-)

Muga/ECHO ___ EF ___ %

P.Thal ___

CENTRAL NERVOUS SYSTEM

(CEREBROVASCULAR, POLIO, NEUROLOGICAL)

CVA (-)

Seizures (-)

Oriented x 3 ___Y/N___

OTHER SYSTEMS

(ALLERGIES) NKDA Y (N)

Hepatitis (-)

DM (-)

H/O DUB H/ (-)

ETOH: H/O ABUSE

PREVIOUS ANESTHETICS AND COMPLICATIONS

- GALLBLADDER TODAY
- HYSTERECTOMY TODAY

PRESENT DRUG THERAPY: E.G., STEROIDS, TRANQUILIZERS

- DEPAKOTE 1,125 qd

PREOPERATIVE DIAGNOSIS

- PELVIC ADHESIONS
- PELVIC PAIN

PREMEDICATION

qd

SIGNATURE OF EVALUATING PHYSICIAN: [signature]

DATE: 3/13/95

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

3/13/95 @ 1110 hrs. (PACU)/SICU.

AWAKE ✓, TALKING ___, RESPONDING ___, INTUBATED NO

VS. BP 147/91, HR 82, R 14, SaO_2 99, Temp 94.6

O_2 NASAL ___ T-PIECE ___ REPORT GIVEN ✓ YES
MASK ✓ VENT ___

3/15/95 @ ___ hrs. Anesthesia Post OP Note.

NAD

*U.S. Government Printing Office: 1990-262-755/16969

MEDICAL RECORD | ANESTHESIA REPORT

Preop Status: 2-MILD DISTURB. Operating Room: OR 2
Principal Operation: LAPAROSCOPY
Anesthesia Technique(s):
INHALATION (PRINCIPAL)
Agents: ISOFLURANE
FENTANYL .35 mg
MIDAZOLAM 2 mg

Intubated: YES
Approach: DIRECT VISION LARYNGOSCOPY Route: ORAL
Laryngoscope Type: MACINTOSH
Laryngoscope Size: 3
Stylet Used: YES
Lidocaine IV: NO
Tube Type: PVC LOW PRESSURE Tube Size: 8
Trauma: NONE
Extubated In: OR Extubated By: EVERETT,KEVIN L
Bacteria Filter in Circuit: YES
Anesthesia Start: MAR 13, 1995 08:45 Anesthesia Stop: MAR 13, 1995 11:25
Anesthetist: EVERETT,KEVIN L Relief Anesth:
Anesthesiologist: MCCLAIN,DEBORAH A
Assistant Anesth: COOPER,WILLIAM M Min Intraoperative Temp: 34.5
Intraoperative Blood Loss: 150cc Urine Output: 160cc
Operation Disposition: PACU (RECOVERY ROOM)
PAC(U) Admit Score: PAC(U) Discharge Score:
Postop Anesthesia Note:

ANESTHETIST'S SIG: [redacted]
DOVE,GAYLE A
WARD: 1-4WSUR
VAMC: Biloxi, MS (CONS)

Standard Form 507 — 048-16-81472-3 GPO

CLINICAL RECORD

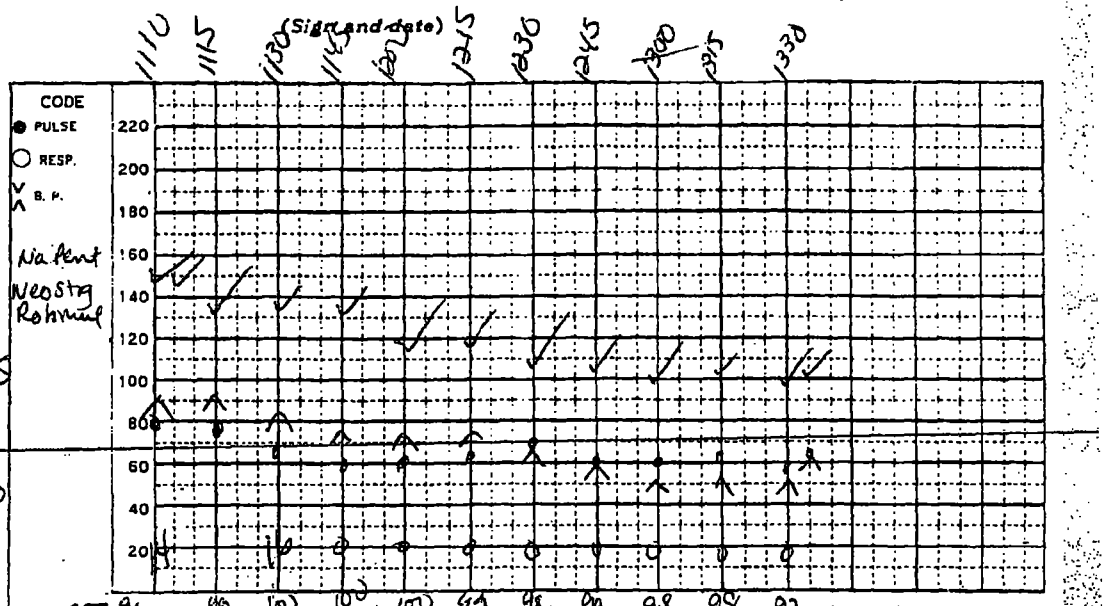
Report on _____
or
Continuation of S. F. _____
(Strike out one line) (Specify type of examination or data)

TIME IN: 1110
OPERATION: Exp lap lysis adhesions

ANESTHESIA: general
Fentanyl 350mcg
Versed 2mg
Ketrol 1gm 0915

Fluids R.R.
LR LTC 600

Fluids O.R.
LR/300



	Admit 1110	1130	1200	1230	1300	1330				
Chest Tubes ø										
N.G. Tube 18Fr – placement VR secured										
Urine 16Fr							160	13	17	42
I-Tube ø										
Other										
EBL							150			

P.A.R.S.

	Admit 1110	1130	1200	1230	1300	1330				
Color	2	2	2	2	2	2				
Activity	2	2	2	2	2	2				
Respiration	2	2	2	2	2	2				
Circulation	1	2	2	2	2	2				
Conciousness	1	1	2	2	2	2				
Total Score	8	9	10	10	10	10				

lower abd dsg (yes) no — umbilical dsg - mod amt drng
Dressing (yes) no — Dressing dry (yes) no

Oxygen 40% f / t — off @ 1205 (SaO2 98%)

PRE OP VS: 35.2 essp — DR - 108/78 59 — NARD - 99/56 108/64 56-68 — RA 100%

EKG NSR HR 66

TIME OF DISCHARGE 1345

DATE 3-13-95

SIGNATURE Carol DuBoeuf

FAMILY: yes
ALLERGIES: NKDA
HISTORY: (P) Smoker
past H/O ETOH

BREATH SOUNDS: clear bilaterally
HOBR. Pt C&DB four
ABD: soft, round
BOWEL SOUNDS: hypoactive
Palpable pedal pulse
18ga Dwnst site clear

PATIENT'S IDENTIFICATION
Dove, Gayle 6094

WARD NO. 14W

or CONTINUATION OF _____

STANDARD FORM 507
General Services Administration and Interagency Committee on Medical Records
FIRMR (41 CFR) 201-45.505
October 1975 507-107
*U.S. GPO: 1989-241-638/92615

REMARKS CONTINUED:

1112 Pt c/o abd pain - MSO4 2mg IVP slow given CD
1115 Pt still c/o pain - MSO4 2mg IVP slow given CD
1125 Pt still c/o pain - MSO4 2mg IVP slow given CD
1130 Pt still c/o abd pain - MSO4 2mg IVP slow given CD
1140 PCA MSO4 # 11750 ↑ per orders - pt demonstrates understanding by pressing PCA button CD
1150 Pt still c/o abd pain - Dr McClain notified - Dracol 60mg IVP given CD
1205 Pt still c/o pain - Dr McClain here. Uop 17cc last hr. 300cc LR - bolus started. Demerol 25mg IVP slow given CD
1230 Bolus complete. Demerol 12.5mg IVP slow given. Pt states that she is more comfortable. CD
1300 umbilical dsg saturated. Dr Schneider notified of pt status, I&O. Foley secured. umbilical dsg d/d using sterile technique. Old packing in umbilicus - Dr Schneider aware CD

PACU TRANSFER NOTE

LEVEL OF CONSCIOUSNESS: AWAKE ✓ CONFUSED ___ ORIENTED X 3 ✓ OTHER ___

SKIN CONDITION: AS PREOPERATIVE ✓ OTHER Skin warm & dry

IV SITE: CLEAR ___ REDDENED ___ INFILTRATED ___ ~~LR~~ D5½NS @ 20K cc 1000 cc LTC OR 1300 PACU 600 TOTAL 1900

DRESSING: DRY ✓ INTACT ✓ OTHER ___

PATENT: TUBES CATHETERS DRAINS YES ✓ NO ___ COMMENTS: NGT PCA MSO4

TRANSPORTED VIA: STRETCHER SIDERAILS UP ✓ WHEELCHAIR ___ AMBULATORY ___

TRANSFERRED TO: SICU ADMIT ___ SICU/RECOVERY ___ WARD ✓ HOME ___ ASOU ___

REPORT GIVEN TO: Burson RN

FAMILY MEMBERS NOTIFIED: YES ✓ NO ___ NO FAMILY PRESENT ___

POST OP INSTRUCTIONS DISCUSSED & PATIENT: yes

PATIENT VOICED UNDERSTANDING: yes

NURSES SIGNATURE Carol DuBree RN

POST ANESTHETIC RECOVERY SCORE

Activity	
Moves 4 Extremities	= 2
Moves 2 Extremities	= 1
Moves 0 Extremities	= 0
Respirations	
Deep-breathes and Coughs	= 2
Dyspnea-Limited Breathing	= 1
Apneic	= 0
Circulation	
BP ± 20 - Preanesthesia	= 2
BP ± 20/50 - Preanesthesia	= 1
BP ± 50 - Preanesthesia	= 0
Consciousness	
Fully Awake	= 2
Arousable on Calling	= 1
Not Responding	= 0
Color	
Pink	= 2
Pale, dusky, blotchy	= 1
Cyanotic	= 0
Score Must = 8 or Above	

Preoperative Diagnosis:
Primary: PELVIC ADHESIONS ICD9 Code: NOT ENT
Surgeon: SCHNEIDER,MICHAEL J Surgical Priority: ELECTIVE
Attend Surgeon: DIAZ,ALBERT L Attend Code: 1. ATTENDING IN O.R.
1st Assistant: DIAZ,ALBERT L 2nd Assistant: VU,DANNY X

Other Scrubbed Assistants: NONE ENTERED
Anesthetist: EVERETT,KEVIN L Asst Anesthetist: COOPER,WILLIAM
Attending Anesthesiologist: MCCLAIN,DEBORAH A
Anesthesia Supervisor Code: N/A
Perfusionist: N/A Asst. Perfusionist: N/A
OR Support Personnel:
Scrubbed Circulating
GRIFFITH,MELANIE D (FULLY TRAINED) SCHMITT,DONNA EASTER (FULLY TRAIN
Anesthesia Technique(s):
INHALATION (PRINCIPAL)
Agent: ISOFLURANE
FENTANYL
MIDAZOLAM
Anesthesia Begin: MAR 13, 1995 08:45 Anesthesia End: MAR 13, 1995 11:
Operation Begin: MAR 13, 1995 09:30 Operation End: MAR 13, 1995 11:
Tubes and Drains:
#16/5CC GU FOLEY/NG
Tourniquet: N/A
Material Sent to Laboratory for Analysis:
Specimens: N/A
Cultures: N/A
Postoperative Diagnosis:
Primary: PELVIC ADHESIONS ICD9 Code: NOT ENT
Major Operations Performed:
Primary: LAPAROSCOPY CPT Code: NOT ENTERED
Other: EXPLORATORY LAPAROTOMY WITH LYSIS OF ADHESIONS CPT Code: NOT

Concurrent Procedure(s): N/A
Date/Time of Dictation: NOT ENTERED
Date/Time Transcribed: MAR 14, 1995 02:02
Indications for Operation:
PELVIC ADHESIONS
Surgeon's Dictation:
INDICATION: The patient is a 37 year old white female with a history of hysterectomy for adhesive disease who presents with chronic constant pelvic pain.

FINDINGS: Multiple dense adhesions.

PROCEDURE: After informed consent was obtained, the patient was taken

SURGEON'S SIG: MAR 14, 1995 02:03
DOVE,GAYLE A AGE: 37 ID#: [redacted]
WARD: INPAT ROOM-BED: 4B120-23
VAMC: Biloxi, MS (CONS) REPLACEMENT FORM 516

Exception to Standard Form 508
Approved by OMB

MEDICAL RECORD

DOCTOR'S ORDERS

NOTE: Physician's signature must accompany each entry including standing orders. Date and time for instituting and discontinuing the orders must be recorded.

DATE AND TIME	PROB. NO.	ORDERS (Another brand, equal in quality, of the same basic drug may be dispensed, UNLESS checked.)	✓	NURSE'S SIGNATURE
		GENERAL SURGERY ADMISSION ORDERS		cdme
	1.	Admit to Surgical Service (Gold/Purple) team	3/12/95 (Date)	cdme
	2.	Diagnosis: Pelvic Adhesions		CM - cdme
	3.	Procedure: Laparoscopic / Laparotomy		CM
	4.	Date of Procedure: 3/13/95		CM
	5.	Diet: As tolerated NPO past midnight		cdme noted cdme
	6.	Allergies: NKA.		CM
	7.	Vital Signs: routine.		CM
	8.	Activity: Ambulate 3268-37	2-13	CM
339962 339963 cdme	9.	Routine Pre-op labs: CBC with platelets, U/A, Lytes, BUN, Albumin, Creatinine, Glucose, PA and lateral Chest x-ray, 12 lead EKG.		
	10.	Other labs: *ON ADMISSION: Type and screen 2 units*		CM cdme
	11.	Medications: Purulent to Dc		CM
		Noted Ambulate 3/10/95 1109		

Physician Signature

Enter in space below: PATIENT IDENTIFICATION – TREATING FACILITY – WARD NO. – DATE

Dove, Gayle
[redacted]
DOVE, GAYLE A
5152461 A Street 6815
Biloxi, MS 39530
C-SSN

CTP 1-4N 3/12/95 11:10 AM cdme
Sunday Clinic

MEDICAL RECORD
DOCTOR'S ORDERS
[redacted] DEC 1992

VA FORM OCT 1975 10-1158

EXISTING STOCK OF VA FORM 10-1158, MAY 1973 AND VA FORM 10-1158c, NOV 1972, WILL BE USED.

*U.S.GPO:1982-0-313-106/63698

Exception to Standard Form 508
Approved by OMB

MEDICAL RECORD

DOCTOR'S ORDERS

NOTE: Physician's signature must accompany each entry including standing orders. Date and time for instituting and discontinuing the orders must be recorded.

DATE AND TIME	PROB. NO.	ORDERS (Another brand, equal in quality, of the same basic drug may be dispensed, UNLESS checked.)	√	NURSE'S SIGNATURE
12 MAR 95 1530		Premarin 1.25 mg PO qD Hydrocortisone 1% apply BID MICHAEL S. LAUGHREY, M.D. AS3285170-6441		
		FTP		Dated Linda Knowles RN 3/12/95 1725
3/12/95 1900	1	NPO ÷ MN		
	2	Amhbx sheet		
	3	Heparin 5,000 ~ SQ this PM in AM		
	4	Pt to void on call to OR		
	5	Witness Consent		
				Noted Linda Knowles 3/12/95 2045

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. - DATE

3-13-95 — SB

MEDICAL RECORD

DOCTOR'S ORDERS

VA FORM OCT 1975 10-1158

EXISTING STOCK OF VA FORM 10-1158, MAY 1973 AND VA FORM 10-1158c, NOV 1972, WILL BE USED

Exception to Standard Form 508
Approved by OMB

MEDICAL RECORD

DOCTOR'S ORDERS

NOTE: Physician's signature must accompany each entry including standing orders. Date and time for instituting and discontinuing the orders must be recorded.

DATE AND TIME	PROB. NO.	ORDERS (Another brand, equal in quality, of the same basic drug may be dispensed, UNLESS checked.)	√	NURSE'S SIGNATURE

ANTIBIOTICS ORDER SHEET

Diagnosis: Pelvic Pain **Allergies:** NKA

3/12

Surgical Prophylaxis	Automatic Stop 24 Hours	Procedure: Abdominal (✓) Biliary ( ) Cardiothoracic ( ) Head & Neck ( ) Neurosurgery ( ) OB/GYN ( ) Orthopedic ( ) Other
Empiric Therapy	Automatic Stop 7 Days	Culture Order: Blood ( ) Sputum ( ) Wound ( ) Urine ( ) CSF ( ) Other
Documented Infection	Duration Days	Pathogens

Circled Desired Antibiotic(s)

Penicillin G K		DOSE	ROUTE	q	4	6	8	h
Ampicillin		DOSE	ROUTE	q	4	6	8	h
Ampicillin/Sulbactam		DOSE	ROUTE	q	6	8	12	h
Cefazolin		DOSE 1g	ROUTE IV	q	8		ONC	h
Cefotetan		DOSE	ROUTE	q		12	24	h
Piperacillin		DOSE	ROUTE	q	6	8		h
Ticarcillin/Clavulanic Acid		DOSE	ROUTE	q	6	8		h
Imipenem/Cilastatin		DOSE	ROUTE	q	6	8		h
Cefotaxime		DOSE	ROUTE	q	8	12		h
Gentamicin		DOSE	ROUTE	q	8			h
Amikacin		DOSE	ROUTE	q	8			h
Ciprofloxacin		DOSE	ROUTE	q	12			h
Clindamycin		DOSE	ROUTE	q	8	24		h
Metronidazole		DOSE	ROUTE	q	8	24		h
TMP/SMX		DOSE	ROUTE	q	6	8	12	h
Erythromycin		DOSE	ROUTE	q	6	8	12	h

OTHER (specify below: PATIENT IDENTIFICATION – TREATING FACILITY – WARD NO. – DATE

3-13-95

DOVE, CAYLE A [redacted] 08155

MEDICAL RECORD

DOCTOR'S ORDERS

3/12/95

VA FORM OCT 1975 10-1458 EXISTING STOCKS OF VA FORM 10-1458 AND WILL [redacted]

[redacted] 1/96/63098

IN 4-0

Exception to Standard Form 5(B
Approved by OMB

MEDICAL RECORD

DOCTOR'S ORDERS

NOTE: Physician's signature must accompany each entry including standing orders. Date and time for instituting and discontinuing the orders must be recorded.

DATE AND TIME	PROB. NO.	ORDERS (Another brand, equal in quality, of the same basic drug may be dispensed, UNLESS checked.)	√	NURSE'S SIGNATURE
3/13/95	(1)	Admit to PACU → 1-4W	—	mfmc
1110	(2)	Dx - S/P Laparoscopy, converted to laparotomy, LOA		mfmc
	(3)	Condition - Good		MB
	(4)	V. Stats - q Shift		MB
	(5)	All - NKA	—	mfmc
	(6)	Act - BR - ad to get OOB this evening ℞ PRN		MB MB
	(7)	Notify - MD Tm > 101.5, SBP > 140 < 90 DBP > 100 < 60 HR > 120 < 60 UOP < 290 cc/8°		MB MB MB
✓	(8)	Diet - NPO ± meds ÷ small sips	—	mfmc
✓	(9)	IVF - D5½NS ÷ 20 meq KCl @ 125cc/hr		MB
✓	(10)	Meds - PCA		MB
		Premarin 1.25 mg po q day		MB
	(11)	Labs - ℞		MB
	(12)	Extra - NG to LCWS		MB
✱		- D/C Foley		order in chart
		- Incentive Spirometry q1°		Welch 3.00
		- [illegible]		
		- Phenergan 25 mg IM q 4-6° prn		MB

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. - DATE

(T) CTP 3/13/95 [signature]

1-4W [signature] @ 3 pm 10

MEDICAL RECORD
DOCTOR'S ORDERS

VA FORM OCT 1975 10-1158

EXISTING STOCK OF VA FORM 10-1158, MAY 1973 AND VA FORM 10-1158c, NOV 1972, WILL BE USED

Exception to Standard Form 508
Approved by OMB

MEDICAL RECORD

DOCTOR'S ORDERS

NOTE: Physician's signature must accompany each entry including standing orders. Date and time for instituting and discontinuing the orders must be recorded.

DATE AND TIME	PROB. NO.	ORDERS (Another brand, equal in quality, of the same basic drug may be dispensed, UNLESS checked.)	NURSE'S SIGNATURE
3-13-95	1113	MSO4 2-8mg IVP for c/o pain in PACU VO Dr McClain / Carol DuBoeuf RN DMcCl	given CD
3/13/95	1150	Tornadol 60mg IV pain DMcClain	given CD
3/13/95	1213	Demerol 25-50mg IV pain DMcClain	given CD
3/13/95	1213	300cc LR bolus now VO Dr McClain / Carol DuBoeuf RN DMcClain	given CD
3/13/95	1320	Foley to remain DMcClain noted Carol DuBoeuf RN 3/13/95 1345	done CD
3/13/95	1315	Leave foley in place Δ umbilical drsg VO Dr Schneider / Carol DuBoeuf RN	done Carol DuBoeuf RN 3-13-95

Enter in space below PATIENT IDENTIFICATION – TREATING [redacted] – DATE

DONE. GIVEN Dever gayle [redacted] M.D. 3/13/95 1-4 PM

[redacted]

MEDICAL RECORD

DOCTOR'S ORDERS

VA FORM OCT 1975 10-1158

EXISTING STOCK OF VA FORM 10-1158, MAY 1973 AND VA FORM 10-1158c, NOV 1972, WILL BE USED

Exception to Standard Form 508
Approved by OMB

MEDICAL RECORD

DOCTOR'S ORDERS

NOTE: Physician's signature must accompany each entry including standing orders. Date and time for instituting and discontinuing the orders must be recorded.

DATE AND TIME	PROB. NO.	ORDERS (Another brand, equal in quality, of the same basic drug may be dispensed, UNLESS checked.)	√	NURSE'S SIGNATURE
		PCA INFUSOR PHYSICIAN ORDER FORM		
		**Physician must complete numbers 1, 3 & 4 to initiate order.		
	1.	Drug (check one:) Morphine 5mg/ml (30ml)_____. Meperidine 10mg/ml (30ml)_____.		
	2.	Loading Dose (optional) Ø. Note: Can be given if patient has pain prior to the initiation of PCA. Avg IV postop loading dose: 2mg Morphine or 20mg Meperidine. Usual range: 2-5mg morphine or 20-50mg meperidine.		
	3.	PCA Dose:_____. Usual dose: 5mg morphine or 10mg meperidine Range: 0.5mg-5.0mg morphine or 5mg-50mg meperidine.		
	4.	Lock-Out Interval 6 minutes. Note: This is the period during which the PCA dose cannot be delivered. Usual lockout interval: 6-10 minutes (allows time for dose to take effect, and patient to assess pain relief.)		
	5.	Ranges: 5-99 minutes Continuous Rate (optional) Ø mg/hr. Note: the amount of drug administered continuously and not under the patient's control. Usual dose: 1mg/hr of Morphine 1mg/ml. Usual range: 0.5mg-2.0mg/hr of Morphine		
	6.	Four-hour dose limit (optional) 24. The 4 hour limit controls the maximum dose of medication delivered to the patient over any 4 hour period and acts as a safeguard.		
	7.	If level of pain/consciousness not appropriate following above guidelines, notify physicians.		
	8.	Vital signs every 2 hours for the first 8 hours, then ever 4 hours thereafter.		
	9.	If no IV fluid infusing, hang D5 ½ NS at KVO rate. (specify fluid)		
	10.	Other orders:		
		Physician Signature		

Called Ryndes 3-13-95 1545

Enter in space below: PATIENT IDENTIFICATION – TREATING FACILITY, WARD NO. – DATE

3/14/95

DOVE, GAYLE A
SSN [redacted]
DOB [redacted]
Dove, Gayle

[redacted]

MEDICAL RECORD

DOCTOR'S ORDERS

VA FORM 10-1158
OCT 1975

EXISTING STOCK OF VA FORM 10-1158, MAY 1973 AND VA FORM 10-1158c, NOV 1972, WILL BE USED

G.P.O. 1987 - 191-585

Exception to Standard Form 508
Approved by OMB

MEDICAL RECORD

DOCTOR'S ORDERS

NOTE: Physician's signature must accompany each entry including standing orders. Date and time for instituting and discontinuing the orders must be recorded.

DATE AND TIME	PROB. NO.	ORDERS (Another brand, equal in quality, of the same basic drug may be dispensed, UNLESS checked.)	√	NURSE'S SIGNATURE
14MAR95 0650		1) renew IVF 2) renew PCA Mdald Lgly		
		Noted Orders 3-14-95 @ 0715		
14 Mar 95	(1)	Pt may ice Chips — 4oz q		
	(2)	Chloroseptic lozenges q4h prn		
		Noted Orders 3/14/95		
√ 3/15/95				
15 MAR 95 1230		D/C Foley Noted Orders 3-15-95 1230 Mdald Lgly		

Enter in space below PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. - DATE

√ 3/16/95

MEDICAL RECORD

DOCTOR'S ORDERS

VA FORM OCT 1975 10-1158

EXISTING STOCK OF VA FORM 10-1158, MAY 1973 AND VA FORM 10-1158c, NOV 1972, WILL BE USED

Exception to Standard Form 508
Approved by OMB

MEDICAL RECORD

DOCTOR'S ORDERS

NOTE: Physician's signature must accompany each entry including standing orders. Date and time for instituting and discontinuing the orders must be recorded.

DATE AND TIME	PROB. NO.	ORDERS (Another brand, equal in quality, of the same basic drug may be dispensed, UNLESS checked.)	√	NURSE'S SIGNATURE
18 MAR 95 0640		1) ↓ IVF to 100 cc/hr		
		Noted Joanne Domingo RN 3/16/95 @ 0700		
3/16/95 1115		Clear liquids	√	LBJ
		WENDELL R. SMITH M.D. AS3285170-647		3/16/95
3/16/95 @ 2030/PM		D/C IVF D/C PCA pain control Percocet T/TT PO q 4° PO PRN for pain w/o Dr. Ashley / Joanne Valentin RN Bobby Domingo RN 3/17/95	√	BR 120 √ 120 BD
√ 3/17/95		BD		

Enter in space below PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. - DATE

MEDICAL RECORD

DOCTOR'S ORDERS

VA FORM OCT 1975 10-1158

EXISTING STOCK OF VA FORM 10-1158, MAY 1973 AND VA FORM 10-1158c, NOV 1972, WILL BE USED

Exception to Standard Form 508
Approved by OMB

MEDICAL RECORD	DOCTOR'S ORDERS

NOTE: Physician's signature must accompany each entry including standing orders. Date and time for instituting and discontinuing the orders must be recorded.

DATE AND TIME	PROB. NO.	ORDERS (Another brand, equal in quality, of the same basic drug may be dispensed, UNLESS checked.)	√	NURSE'S SIGNATURE
18/Mar 95	1	Regular Diet → Pt already receiving		CM
	2	Pt May Shower		CM
	3			CM
		Noted Clearwater RN 3/18/95 0238		
3-19-95		@ 24°		
19 MAR 95	1	D/C To Home		CM
845	2	RTC General Surgery Clinic 29 Mar 95		
		Follow-up - Post Op		CM
	3	Scripts on Chart		CM
	4	Chart Dictated		CM
		Noted Clearwater RN 3/19/95 1700 already sent to Pharmacy at this time		

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. - DATE

MEDICAL RECORD

DOCTOR'S ORDERS

VA FORM OCT 1975 10-1158

EXISTING STOCK OF VA FORM 10-1158, MAY 1973 AND VA FORM 10-1158c, NOV 1972, WILL BE USED

Department of Veterans Affairs

CONTINUING MEDICATION RECORD

MONTH: March YEAR: 1995

DATE:

ORIG. ORD. DATE	START DATE	STOP DATE	MEDICATIONS DOSE/ FREQUENCY ADMIN
3/13	3/14	4/14	[redacted]

[redacted]

INJECTION SITES
INDICATE RIGHT (R) OR LEFT (L)
1. DELTOID
2. ABDOMEN
3. ILIAC CREST
4. GLUTEAL
5. THIGH

SIGNATURE/TITLE	INIT.	ALLERGIES
Carole Benson RN	CB	DKA
Diane Dominguez RN	DD	
[illegible]	CMRT	
Bellaire Burnes RN	BJ	

EXISTING STOCK OF VA FORM 10-2970, AUG 1982, WILL BE USED.

NAME: BED # PAGE ____ OF ____

026946

1346

DOCUMENTATION OF OMITTED DOSES OF MEDICATION

MEDICATIONS DOSE/ROUTE/FREQUENCY	DOSE OMITTED	REASON FOR OMISSION	INITIALS

U.S. Government Printing Office: 1994 — 523-176/82120

Department of Veterans Affairs

CONTINUING MEDICATION RECORD

MONTH: March | YEAR: 95

ORIG. ORD. DATE	START DATE	STOP DATE	MEDICATIONS DOSE/ROUTE/FREQUENCY	ADMIN. TIMES:	DATE: 12	13	14	15	16	17	18	19	20	21	22	23	24	25
3/12	3/13	4/12	Premarin 1.25mg PO QD	0600	—	CS												

ADDRESSOGRAPH

[redacted]

INJECTION SITES

[redacted]

SIGNATURE/TITLE

[redacted]

INIT.

CMR

ALLERGIES

NKDA

VA FORM APR 1989 **10-2970** EXISTING STOCK OF VA FORM 10-2970, AUG 1982, WILL BE USED.

NAME: BED # PAGE ___ OF ___

026946

1348

DOCUMENTATION OF OMITTED DOSES OF MEDICATION

MEDICATIONS DOSE/ROUTE/FREQUENCY	DOSE OMITTED	REASON FOR OMISSION	INITIALS
Pravastatin 1.25mg PO	3/13 0600	Not available	

IV FLOW SHEET

DATE/TIME/INITIALS	CURRENT SITE SITE	GAUGE	COND	DISCONTINUED SITE DATE/TIME/INIT.	COND.	OLD SITES INIT.@24	[redacted]		
3-13-95 1445 [redacted]	L4	18	1	New Δ Thru					
3-13-95 1600 [redacted]	L4	18	1		1				
3/14/95 0100 [redacted]	L4	18	1						
3/14/95 0800 [redacted]	L4	18	1						
3-14-95 1600 [redacted]	L4	—	1						
3/15/95 0100 [redacted]	L4	18	1						
3-15-95 0800 [redacted]	L4		1						
3-16-95 1600 [redacted]	L4	—	1	DC'd 3	16 CT	3	[redacted]		
3/16/95 0100 [redacted]	R13	18	1	New Site Δ sat					
3-16-95 1600 [redacted]	R13		1	DC'D	1 9/JCM	3	[redacted]		

SITE ASSESSMENT CODE

1. Clear
2. Red
3. Swollen
4. Streaked
5. Sero-sang. Drainage
6. Purulent Drainage

CHART COMPLICATIONS & OBSERVATIONS ON REVERSE

IV SITE CODES:

ANTERIOR

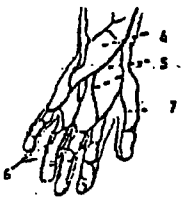
1. Jugular
2. Subclavian
3. Hickman - Broviac
4. Wrist
5. Hand
6. Fingers
7. Thumb
8. Ankle
9. Foot

INDICATE AS NEEDED:
R= Right
L= Left
P= Proximal
D= Distal

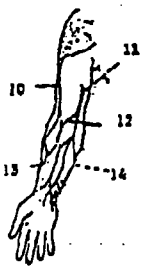
POSTERIOR

10. Upper arm - Lateral
11. Upper arm - Medial
12. Antecubital fossa
13. Forearm - Lateral
14. Forearm - Medial
15. Other_____

ANTERIOR



[redacted]



IMPRINT PATIENT DATA CARD (Name, Address and Social Security Number)

DOVE, GAYLE A [redacted]

C-SSN 5 P

MEDICAL RECORD

NURSING DOCUMENTATION

[redacted] JUNE 1991

VA FORM 10-0096(R)
SEP 1992

DATE	TIME	INITIALS	SITE	SOLUTION & AMOUNT HUNG
3-13-95	1500	[illegible]	L4	↑ D5 1/2 ± 20 K 125cc/o 1000
3/13/95	2300	[illegible]	L4	↑ 1000 D5 1/2 + 20K 125°
3-14-95	0200	[illegible]	L4	↑ 1000 D5 1/2 ± 20 K 125cc/o
3/15/95	2400	[illegible]	L4	↑ 1000 D5 1/2 ± 20K @ 125cc°

SIGNATURE/TITLE	INIT.	ALLERGIES
Linda Snow LPN	[illegible]	

tment of Veterans Affairs

PRN AND ONE-T[illegible] MEDICATION RECORD

MONTH: March 1995

START DATE	STOP DATE	MEDICATIONS DOSE/ROUTE/FREQUENCY	START DATE	STOP DATE	MEDICATIONS DOSE/ROUTE/FREQUENCY	START DATE	STOP DATE	MEDICATIONS DOSE/ROUTE/FREQUENCY
3/13	3/14	IVF D5 1/2 NS						
3/14	3/15	@ 20 meq KCL @ 125 cc/hr						
3/13		Phenergan 25 mg IM						
		q 4-6° PRN						
3/13		MS04 2-8 mg IVP						
		for c/o pain						

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT.	REASON	RESULTS	TIME	INITIA

ADDRESSOGRAPH

[redacted]

C-[redacted] 5 8

INJECTION SITES

[redacted]

4. GLUTEAL
5. THIGH

SIGNATURE/TITLE | INIT. | ALLERGIES

[redacted]

NAME: BED # PAGE ___ OF ___

1352

Department of Veterans Affairs

PRN AND ONE[illegible]E MEDICATION RECORD

MONTH: Mar YEAR: 95

START DATE	STOP DATE	MEDICATIONS DOSE/ROUTE/FREQUENCY	START DATE	STOP DATE	MEDICATIONS DOSE/ROUTE/FREQUENCY	START DATE	STOP DATE	MEDICATIONS DOSE/ROUTE/FREQUENCY
3/13	3/13	Aricept 5mg QD JU on call to OR						

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT.	REASON	RESULTS	TIME	INITIAL

ADDRESSOGRAPH

DOVE, GAYLE A [redacted] 2[redacted] 01 96

INJECTION SITES

Indicate Right (R) or Left (L)
1. DELTOID
2. ABDOMEN
3. ILIAC CREST
4. GLUTEAL
5. THIGH

SIGNATURE/TITLE	INIT.	ALLERGIES
Linda Snowden	AS	NKA

SUPERSEDES VA FORM 10-5584 NOV 1984

NAME: BED # PAGE ___ OF ___

1353

Department of Veterans Affairs

PRN AND ONE-TIME MEDICATION RECORD

MONTH: March | YEAR: 95

START DATE	STOP DATE	MEDICATIONS DOSE/ROUTE/FREQUENCY	START DATE	STOP DATE	MEDICATIONS DOSE/ROUTE/FREQUENCY	START DATE	STOP DATE	MEDICATIONS DOSE/ROUTE/FREQUENCY
3/12	3/13	Heparin 5,000u SQ this PM + in AM						

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT.	REASON	RESULTS	TIME	INITIAL
3/12	2130	Heparin 5,000u SQ this pm		as ordered	pending	2300	
3/13	0600	Heparin 5,000 u SQ in am		per order (RI)			

DOVE, GAYLE A ADDRESSOGRAPH 25 01
[redacted] A STREET
BILOXI MS 39533
[redacted]
C-SSN 5 R

INJECTION SITES
Indicate Right (R) or Left (L)
1. DELTOID
2. ABDOMEN
3. ILIAC CREST
4. GLUTEAL
5. T HIGH

SIGNATURE/TITLE	INIT.	ALLERGIES
[signature] RN		NKDA
[signature]		
[signature]		

NAME BED # PAGE ___ OF ___

1354

Department of Veterans Affairs

PRN AND ONE-TIME MEDICATION RECORD

MONTH: MARCH YEAR: 1995

START DATE	STOP DATE	MEDICATIONS DOSE/ROUTE/FREQUENCY	START DATE	STOP DATE	MEDICATIONS DOSE/ROUTE/FREQUENCY	START DATE	STOP DATE	MEDICATIONS DOSE/ROUTE/FREQUENCY
3/13	4/13	Phenergan 25mg IM q6° PRN	3/16	3/19	Percocet 1/1 PO q4° PRN for pain BA			
3/13	3/16	PCA - MSO4 1mg/6" LO 24mg/4° dose limit						
3/16	3/19							
3/14	4/14	Chloroseptic Lozenges q4° PRN						

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT.	REASON	RESULTS	TIME	INITIALS
3/13	1910	Phenergan 25mg IM	LS	c/o nausea	effective	2000	LS
3/13	3½-12	TOD PCA MSO4	JM	pain control	effective	12MN	JM
3/14	0600	PCA MSO4	JM	pain control	effective (1-2)	—	JM
3/14	1030	PCA MSO4	L	pain control	effective (1-2)	1100	L
3/14	1030	Phenergan 25mg IM	L	c/o nausea	effective	1100	L
3/14	1045	Chloroseptic Lozenges	L	c/o sore throat	effective	1100	L
3/14/95	3½-12	PCA MSO4	JM	pain control	effective (1-2)	—	JM
3/15/95	1050	Phenergan 25mg IM	LB	pt request	effective	1150	LB
3/17/95	0100	Percocet Tab 1/1 PO	BA	Request for pain	effective	0230	BA
3/17/95	0405	Percocet 1/1 tabs PO	CMR	c/o pain requested	effective	1030	CMR
3/17/95	1540	Percocet 1/1 tabs PO	CMR	c/o stomach pain	effective (1)	1700	CMR
3/17/95	2000	Percocet 2 tabs PO	LS	Requested (4)	effective (1)	2130	LS

ADDRESSOGRAPH

120

[redacted]

C-SSN [redacted]

INJECTION SITES

Indicate Right (R) or Left (L)
1. DELTOID
2. ABDOMEN
3. ILIAC CREST
4. GLUTEAL
5. T HIGH

SIGNATURE/TITLE	INIT.	ALLERGIES
Carol Simonsen RN	CS	NKA
Carol Simonsen RN	CMR	
Linda Williams RN	LS	
Joann Clarke RN	JM	
Joanne Comings RN	JC	
Bobbye Dudley RN	BA	
Lynne Bartholomew RN	LB	

VA FORM OCT 1989 10-5568d SUPERSEDES VA FORM 10-5568d, NOV 1984, WHICH WILL BE USED.

NAME: BED # PAGE ___ OF ___

034932

1355

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT.	REASON	RESULTS	TIME	INITIALS
3/18/95	0350	Percocet 1/1 PO	BA	for Pain	effective	0430	BA
3/18/95	0630	Phenergan 25mg IM	BA	Request for nausea	effective	0700	BA
3/18/95	0835	Percocet 1/1 tabs PO	CMR	Pain requested	effective	1000	CMR
3/18/95	1305	Percocet 1/1 tabs PO	CMR	per request	effective	1400	CMR
3/18/95	1705	Percocet 1/1 PO	LS	requested for pain	effective	1800	LS
3/18/95	2145	Percocet 1/1 PO	LS	c/o pain	effective	2230	LS
3-19-95	0400	Percocet 1/1 PO tabs	M	c/o pain (7)	effective	0500	M
3-19-95	0700	Phenergan 25mg IM	M	c/o nausea	effective	0800	M
3/19	0830	Percocet 1/1 PO	SS	Requested (5)	effective	0920	SS
3/19	1245	Percocet tabs 1/1 PO	SS	Requested (7)	effective	1315	SS

SIGNATURE/TITLE	INIT.	SIGNATURE/TITLE	INIT.	SIGNATURE/TITLE	INIT.
		[signature]	BA		

1356

Department of Veterans Affairs

TREATMENT RECORD

MONTH: Mar YE: 95

DATE:

ORIG. ORD. DATE	START DATE	STOP DATE	TREATMENT	ADMIN TIMES:	12	13	14	15	16	17	18	19	20	21	22	23	24	25
3/12	3/12	3/19	Hydrocortisone 1% apply Bid [redacted]	0800	—	(B)		Self	Self	Self	Self							
				1800						Self	Self							

[redacted] CAYLE A [redacted] 01 96

SIGNATURE/TITLE	INIT.	ALLERGIES
Linda Crowder	LC	NKA
Linda Jerondo LPN	LJ	
Willie Pendon VA	WP	
Edith B. Waltrip, LPN	EBW	
Lynne Bostwhistle Lpn	LB	
Martha B. Wood ARNP	MBW	

[redacted] EXISTING STOCK OF VA FORM 10-2970a, WILL BE USED.

NAME: BED # PAGE ___ OF ___

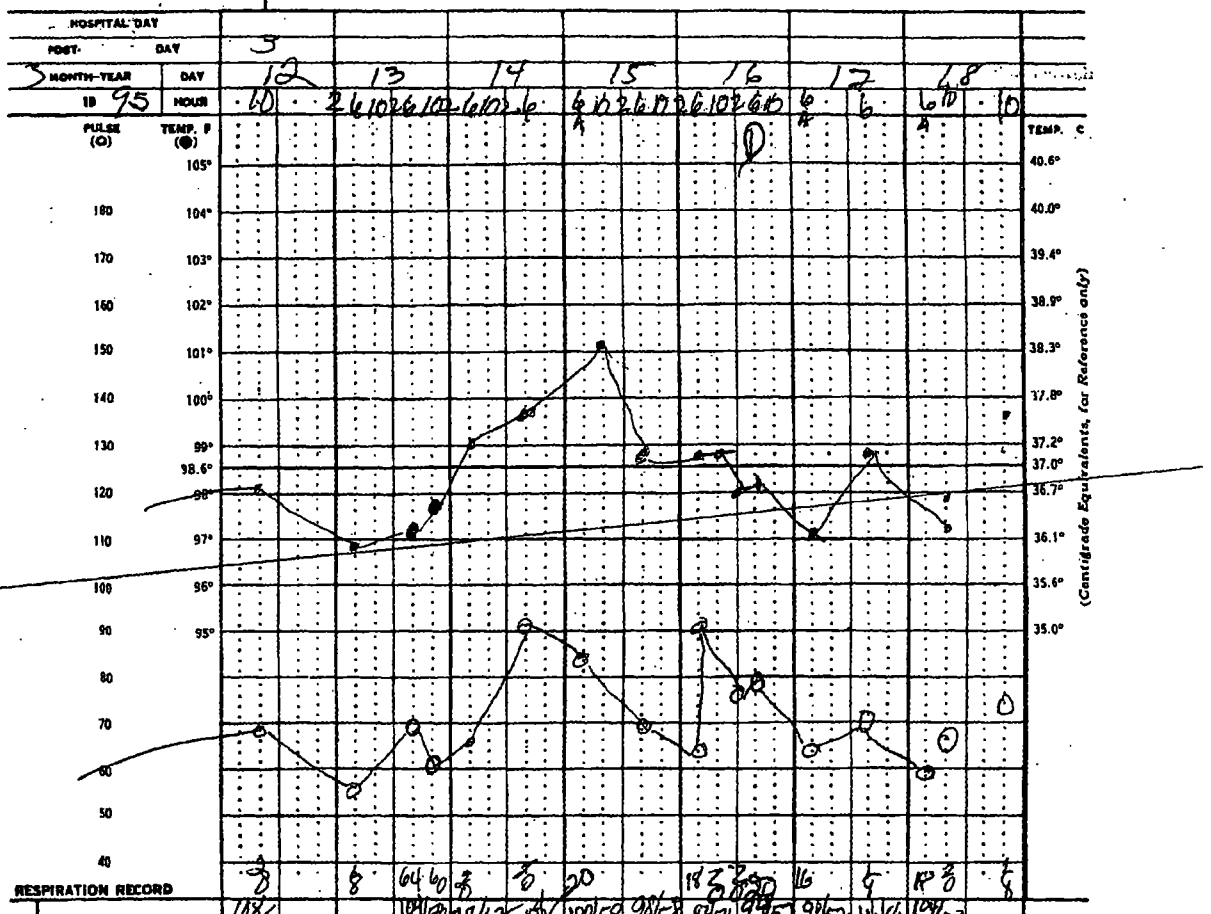
626373

1357

DOCUMENTATION OF OMITTED TREATMENTS

TREATMENT ORDERED	SPECIFIC TREATMENT OMITTED	REASON FOR OMISSION	INITIALS
Hydrocortisone 1% to apply BID	3/13/95 0600	Surgery	LF

MEDICAL RECORD — VITAL SIGNS RECORD



PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; rank; rate; hospital or medical facility)

REGISTER NO.

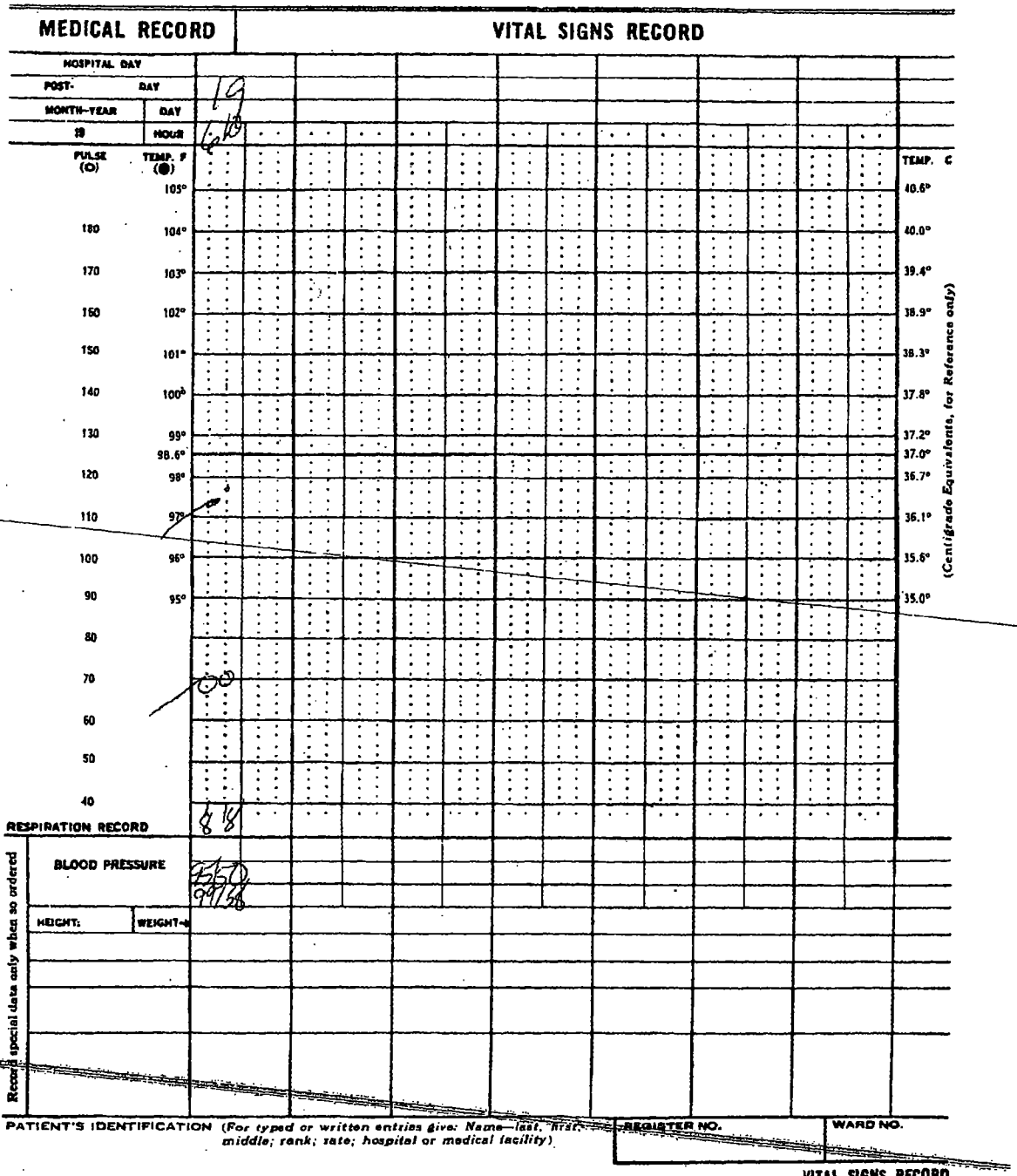
WARD NO. 7-400

511-113

DOVE, CAYLE A [redacted]

VITAL SIGNS RECORD

STANDARD FORM 511 (REV. 9-79)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505


MEDICAL RECORD
VITAL SIGNS RECORD
HOSPITAL DAY
POST-
DAY
MONTH-YEAR
DAY
19
HOUR
PULSE (O)
TEMP. F (●)
TEMP. C
105°
104°
103°
102°
101°
100°
99°
98.6°
98°
97°
96°
95°
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40
40.6°
40.0°
39.4°
38.9°
38.3°
37.8°
37.2°
37.0°
36.7°
36.1°
35.6°
35.0°
(Centigrade Equivalents, for Reference only)
RESPIRATION RECORD
BLOOD PRESSURE
HEIGHT:
WEIGHT-lb
Record special data only when so ordered
PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; rank; rate; hospital or medical facility)
REGISTER NO.
WARD NO.
511-113
VITAL SIGNS RECORD
STANDARD FORM 511 (REV. 9-79)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

120-23 DOUE

PATIENT CARE FLOW SHEET

Activity Level	Sensory Deficit	Communication	Dietary	Mental Status	Dentures
Ambulatory Unaided	Speech	No Comm	Eats in Room	Oriented	Own Teeth
Ambulatory Assisted	Hearing	Verbal	Ward Dining Room	Disoriented	Edentulous
Hoyer Lift	Vision	Foreign Language	DOM Dining Room		Lower_____
Geri Chair	Touch	Non-Verbal	Spoon Feed		Upper_____
Walker	Smell		G. Tube		
Cane			N.G. Tube		
Bedfast			Choke Risk		
W/Chair					

Linen Change Day:_____

Month: 3 Year: 95 Date: 12 13 14 15 16 17 18 19

Restorative Nursing Measures: (1) ROM to: _____ (2) Position Change every 2 hrs. (3) Assisted Ambulation	N				5	5	5			
	D	4						4	4	8
	E							4		
Foot Care-Daily-HS	E									
Protect Devices - Types : Approp. Application/ position verified every 2 hours	N									
	D				-			SBSR		
	E									
Diet: Food Intake (1) 25% (2) 50% (3) 75%, (4) All (5) Refused to eat	B									
	L	A						4	4	
	D							5		
Bath Days:_____ Includes Nail Care, Shampoo (1) Bed Bath (2) Shower (3) Tub (4) Whirlpool Self Assist Total	N									
	D							2		
	E									
Oral Care: (1) Partial Assist (2) Independent (3) Total Assist	N				2	2	2			
	D	2						2	2	
	E							3		
Bowel Movement: (1) Normal (2) Diarrhea, (3) Constipation (4) None (5) Incontinent	N				4	4	4	4		
	D	4						4	1	
	E							4		
Bladder Elimination: (1) Continent (2) Incontinent (3) EUD Care (4) Foley Cath- Care	N				1	1	1	1		
	D	1						1	1	
	E							1		
Activity: (1) Bed (2) Chair (3) Independent	N				3	3	3	3		
	D	3						3	3	
	E							3		

1361

Department of Veterans Affairs

MEDICAL RECORD - NURSING DOCUMENTATION

PATIENT CARE FLOW SHEET

[redacted]

Dates:	Nursing Comments:	Initials :

GENERAL INSTRUCTIONS:

1. Stamp patient identification and enter date, month, and year in spaces indicated as such.
2. Registered Nurse enters specific information / nursing orders as appropriate.
3. Enter appropriate number in block corresponding to tour of duty and date to document routine aspects of nursing care provided.
4. Draw diagonal lines thru blocks not applicable.
5. Write initials of caregiver in appropriate block and sign full name and title with initials in the signature validation section of the form.

| 2/95 | | | | | | | | | | Caregivers Initials | | | | | | | | | |

MEDICAL RECORD | **REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES**

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

Laparoscopy, potential lysis of Adhesions

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be

(Description of operation or procedure in layman's language)

Examine the Abdomen and pelvis with laparoscope, possibly release internal scar tissue

which is to be performed by or under the direction of Dr. Schneider / Dear

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: None

(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES (Appropriate items in Parts A and B must be completed before signing)

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

(Signature of Counseling Physician/Dentist) 3/12/95

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

Linda Snow CN — (Signature of Witness, excluding members of operating team)

Gayle A. Dove — (Signature of Patient) 3/12/95 2110 — (Date and Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)

PATIENT'S IDENTIFICATION (For typed or written entries give Name—last, first, middle; grade, date; hospital or medical facility)

DOVE, GAYLE A [redacted] C8155

[redacted] Services Administration & Interagency Comm. on Medical Records
FIRMR (41 CFR) 201-45.505
522-110

*U.S. GPO: 1993-721-101/80004

PATIENT NAME/SSN:_____ DATE:_____

SURGICAL SPECIALTY Gyn

PREOPERATIVE RISK INFORMATION

GENERAL
Diabetes Mellitus: No / Oral / Insulin
Cigarette smoker within two weeks prior to admission: Yes / No
ETOH> 2 drinks per day within 2 weeks prior to admission: Yes / No
Drug Addiction: Yes / No
Dyspnea: None / Minimal exertion / At rest
DNR Status: Yes / No
Functional Status: Independent / Partially dependent / Totally dependent

PULMONARY
Ventilator dependent > 48 hours: Yes / No
History of severe COPD: Yes / No
Current Pneumonia: Yes / No

HEPATOBILIARY
Hepatomegaly: Yes / No
Ascites: Yes / No
Esophageal varices: Yes / No
Active hepatitis: Yes / No

CARDIAC
History of MI within past 6 months: Yes / No
Previous PTCA: Yes / No
Previous operation with CPB[1]: Yes / No
Angina w/i 1 month prior to surgery: Yes / No
CHF 1 month prior to surgery: Yes / No
Hypertension requiring medication: Yes / No

RENAL
Acute Renal Failure: Yes / No
Currently on dialysis: Yes / No

VASCULAR
History of revascularization/ amputation for PVD: Yes / No
Rest pain/gangrene: Yes / No
Absent peripheral pulses: Yes / No

CENTRAL NERVOUS SYSTEM
Impaired sensorium: Yes / No
Severe head trauma w/in past month: Yes / No
Coma: Yes / No
Quadriplegia/quadriparesis: Yes / No
Paraplegia/paraparesis: Yes / No
Hemiplegia/hemiparesis: Yes / No
History of TIA's: Yes / No
CVA/residual neuro deficit: Yes / No
CVA/no neuro deficit: Yes / No
Neuromuscular degenerative disease: Yes / No
Tumor involving CNS: Yes / No

NUTRITIONAL/IMMUNE/OTHER
Disseminated cancer: Yes / No
Open wound or infection: Yes / No
Chronic steroid use: Yes / No
> 10% loss body weight last 6 months: Yes / No
Bleeding disorders: Yes / No
Transfusion>4 RBC units: Yes / No
Number of operations this admission prior to this one:____

OPERATIVE INFORMATION

Surgical Specialty: Gyn
Principal Operative Procedure: Laparoscopy
PGY of Primary Physician: 3

Redo Procedure: Yes / No
Intraoperative blood loss:_____
Intraoperative RBC's:_____

Postoperative diagnosis from MAS package:_____
(ICD 9)_____
Postoperative LOS:_____
Thirty day postoperative status:_____

PATIENT IDENTIFICATION CARD

DOVE, CAYLE A
[redacted]
08155?

PHYSICIAN SIGNATURE:

PATIENT NAME	AGE	SEX	RACE	SSN	ER
DOVE,GAYLE A	37	F		[redacted]	

ADM DATE	DISC DATE	TYPE OF RELEASE	INP	ABS	WARD NO
OCT 4, 1994	NOV 1, 1994	NON-SERV (OPT-NSC)	28	0	4G-SATP

12/19/94 RC

DICTATION DATE: NOV 1, 1994 TRANSCRIPTION DATE: NOV 2, 1994
TRANSCRIPTIONIST: DIAMOND,BETTY A

DISCHARGE DIAGNOSES:
Axis I: Alcohol dependence and dysthymic disorder
Axis II: No diagnosis
Axis III: Pityriasis rosea, recovered
Abdominal adhesions, secondary to hysterectomy
Status post hysterectomy
Ganglion on the right wrist
Axis IV: Severe
Axis V: 60/70

303.91
3004
696.3
568.0
V45.89
727.43

DIAGNOSES NOTED BUT NOT TREATED:

94.61
94.02
94.46
94.44

OPERATIONS/PROCEDURES PERFORMED:

SUMMARY
HISTORY OF PRESENT ILLNESS: Patient is a 37 year old female patient admitted to the SATP program on October the 5th, 1994. The chief complaints that she is a binge drinker and has been drinking excessively and feels that that ruins her life. She is seeking help. She has been in one program in 1987 that was, however, just before she was terminated from the military service.

PHYSICAL EXAMINATION: At the time of admission physical examination has ben done which has been within normal limits. She did have numerous surgical procedures for a ganglion on her right wrist and it appears this may be recurring at this time. She also had a lot of abdominal complaints since the procedure. Since they are female patients they are referred for gynecological evaluation. She has been seen by a gynecologist who found that her abdominal discomfort my originate from adhesions secondary to abdominal surgery, hysterectomy and she had a PAP smear which was negative.

PATIENT NAME	AGE	SEX	RACE	SSN	CLAIM NUMBE
DOVE,GAYLE A	[redacted]	[redacted]		[redacted]	[redacted]

ADM DATE	DISC DATE	TYPE OF RELEASE	INP	ABS	WARD NO
OCT 4, 1994	NOV 1, 1994	NON-SERV (OPT-NSC)	28	0	4G-SATP

LABORATORY DATA: Her laboratory data indicated that her RPRs were nonreactive. HIV negative. The liver profile for hepatitis profile was negative. Her liver function tests have been within normal limits. CBC normal. Urinalysis negative. Her electrocardiogram was normal.

HOSPITAL COURSE: The patient, while in the hospital broke out with rash. Referred her to Internal Medicine where medicine has been prescribed for her in diminution dosages and it has also been recommended that she be seen by the dermatologist who gave her the diagnosis of pityriasis rosea and gave her medication to be applied to the rash.

The rash completely disappeared by the time of the patient's discharge. Of course, while in the hospital, she received hormones in the form of conjugated estrogens 1.25 daily and she had Vistaril 50 mg. for sleep and Zoloft 50 mg. for her depression. It has been felt in the psychiatric evaluation that she is moderately depressed and this has been confirmed by psychological testing which was administered to her by the Dept. of Psychology. During the time she was in this program she participated in all the activities. She did participate in all the meetings, lectures and the daily group therapy. She also is being seen individually in the group for females and our therapist and she made a very substantial progress. While in this facility she has good insight and she does understand more about the nature of her illness. Her biggest problem is that she is in the process of divorce with her husband which still remains somewhat unresolved but she is determined to follow through with the divorce proceedings. She will reside with her father at Keesler for the time being and she will attend outpatient clinic here.

At the time of her discharge she has been furnished with after care plan according which she is suppose to get a sponsor, attend AA meetings regularly and keep her appointments at the Outpatient Clinic at Gulfport.

PATIENT NAME	AGE	SEX	RACE	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

ADM DATE	DISC DATE	TYPE OF RELEASE	INP	ABS	WARD NO
OCT 4, 1994	NOV 1, 1994	NON-SERV (OPT-NSC)	28	0	4G-SATP

SIGNATURE APPROVING PHYSICIAN/DENTIST

/es/ JULIUS EHIK
JULIUS EHIK

PATIENT: DOVE,GAYLE A [redacted]
VA FORM 10-1000 DISCHARGE SUMMARY ELECTRONICALLY SIGNED CHART COPY

SOCIAL WORK DATA BASE/ASSESSMENT

ıte Printed: OCT 24,1994
ɔurce of Referral: 4G
ɔurce of Information: Veteran, chart and the computer.
ɛferral Date: OCT 24,1994

. Demographic
1. Date of Admission: OCT 4,1994@10:08:26
2. Date of Previous Admission: NONE
3. Veterans's Home Address:
5246 A STREET BILOXI, MISSISSIPPI 39530
4. Veteran's Telephone: HOME #: 601-436-9642 WORK #:
5. Next-of-kin: RAY DOVE JR / FATHER
ADDRESS:5246 A STREET
BILOXI, MISSISSIPPI 39530
HOME #: 601-436-9642 WORK #:
6. Veteran's date of birth: AUG 15,1957
7. Veteran's place of birth: WITCHIA FALLS, TEXAS
8. Veteran's sex: FEMALE
9. Veteran's race:
10. Veteran's religious preference: PROTESTANT, NO DENOMINATION

I. Employment/Financial
1. Veteran's employment status: NOT EMPLOYED
2. Usual Occupation: SALES
3. Present Source of Funds:
Total Income: _____
HB: _____ Employment: _____ Social Security: _____
VA Pension: _____ Retirement: _____
SSI: _____ VA Compensation: _____ Other Disability: _____
A&A: _____ None: _____ Other: _____
4. Potential source of other financial resources:

5. Assets: _____
6. Potential Employability: YES
7. Insurance Coverage:

'eteran's Name: DOVE,GAYLE A
:D#: [redacted]
/ARD NO.: 4G-SATP
ɜED-SECTION: 125-21

GUS RIVERS, MSW, CSW, Social Worker

Social Work Service Reports and Summaries
10-9034 VAF VICE 10-1349

8. Employment/Financial Assessment:
Usually employed in clerical positions.

I. Education:
1. Highest educational level attained: 12 - 16 YEARS
2. Special educational training or skills:

3. Is not, or unknown if currently enrolled in an educational program or trade school.
4. Educational Assesment:
Veteran completed 10 years 0of public education, earned a GED and completed 100 hours of college credits toward a degree.

V. Military History:
1. Period of Service: POST-VIETNAM
2. POW - NO
3. Combat - NO
4. Service Connected Disability:
5. Military Assessment:
Veteranb is NSC with service in the U. S. Air Force 9/4/75 to 9/16/87. Military Occupational speciality was Aerospace control and warning systems operator. Highest paygrade wa E-5. No substance use related disciplianry action with the exception of a letter of reprimend for a DUI citation. Receive an honorable ischarge.

. Social/Family Relationship:
1. Marital status: MARRIED
2. Spouse:
3. Children:
4. Describe Social Support System:
SOCIAL SUPPORT NETWORK: Veteran's father is willing tpo participate in treatment and discharge planning.

'eteran's Name: DOVE,GAYLE A
:D#: [redacted]
IARD NO.: 4G-SATP
3ED-SECTION: 125-21 GUS RIVERS, MSW, CSW, Social Worker

5. Present use of Community Resources:
Reports no use of community resources prior to admission.

6. Current Living arrangements: SPOUSE
7. Social/Family Assessment:
SEXUAL HISTORY: First sexual experience at 15 with an older male. She considers herself heterosexual in orientation and denies any history of homosexual activities pr being a sexual abuser. She acknowledges being a victim of sexual abuse. Multiple episodes of sexual abuse to include childhood and adult life, while on active duty. Received brief therapy for incident of abuse, while on active duty. Not current involved in VA Sexual Trauma treatment program. Not sexually active. When sexually active report relationship with a single partner. Reports sexual dysfunction as evident by lost of desire, uncomfortable with touching of a sexual nature and numbing during experience. Results from most recent HIV test pending.

MARITAL HISTORY: In 1980, shie was married to Michael Bruce Vogel. They had no children and the marriage lasted for two years. Substande use was not considered a contributing factor by veteran. !in 1983, she was married to Lloyd Smith Howell. They had no children and the marriage lated for 18 months. Substance abuse was a factor in the divorce, as both were substance abuser and she reports physical abuse by her husband. There was a subsequent mariage in 1990 to Richard Allen Parke. There substance use has been a source of marital discord and she has no plans for reconciliation.

FAMILY BACKGROUND. SOCIAL AND CULTURAL INFLUENCES AND SPIRITUAL ORIENTATION: Veteran grew up in a single parent dysfunctiional household consisting of her mother, Marilyn who was a turnpike tole collector and two brothers. Reports no physical abuse during early childhood, however she recalls mental abuse as a teenager. His father and mother separated by her secon birthday and was divorced when she was five. She is the youngest child. Early religious orientation was as Episcopalian and orientation during teen years was Baptist. Maintains contact with familly of origin. Expresses a belief in a higher power, however she is not active in organized religion.

eteran's Name: DOVE,GAYLE A
D#: [redacted]

GUS RIVERS, MSW, CSW, Social Worker

Social Work Service Reports and Summaries
10-9034 VAF VICE 10-1349

I. Legal Situation:

Living Will: NO

Legal Assessment:
Report A DUI, in 1981. The incident occured on a military base. Denies any history of jail or prison and there are no pending legal issues, which will impact on treatment.

II. Current Substance Abuse Problems: YES

Comments on Substance Abuse:
HISTORY OF SUBSTANCE USE/ABUSE : Reports first drink of beer at 14 with an increase in consumption prior to entry in the Air Force at 17. At 21 regular drinking commenced and she recalls averaging about six mixed drinks a day. This pattern continued for about a year and decreased folowing her transfer from Greenland. She recalls drinking about a 12 pack of beer a week and continued at this level until 1984. She was transferred to Alaska and consumed about 20 mixed drinks a week and maintained this pattern until 1986, when there was a decrease in consumption. In 1987 there was a gradual escalation to daily drinking of at least the equivalent of 12 ounces of whiskey for most of 1987 with a breg period of reduction, followed by an increase to a case of beer and two liters of whiskey a week. This pattern continued to 1990, when wine became beverage of choice and she consumed an average of a gallon of wine a week. She continued this pattern for six months. She maintained six months sobriety in 1991. There was a return to drinking wine. She reports having two glasses of wine a day for a period of about four months, then she switced to mixed drinks and consumed three to four a day. This pattern continued to 1994,

when drinking was restricted to Cosino Visits about twice a month. She drank until she got drunk at the cosino and reports that she no longer drank at home. This pattern continued until she presented for treatment in September 1994. There is a history of blackouts, however she recalls no incidents of DT's or seizures. This is her second treatment program. She completed a 28 day program in the Air Force, prior to release from active duty in 1987. Treatment is voluntary.

FAMILY'S HISTORY OF SUBSTANCE USE/ABUSE: There a history of her father's father and brother dying from alcohol related conditions. Her father had an alcohol problem until 1987, when he stopped drinking, her brother had a substance abuse problem and stopped using when he became a Morman about eight years ago. She considers her older brother a "controlled drinker". No other patterns of familial substance abuse disclosed.

III. Psycho-Social Assessment:

OTHER HEALTH PROBLEMS: Veteran reports history of brief therapy following suicide of person who sexual assualted her. She has received no therapy for sexual trauma. Medical issues of concern includes pelvic adhesive disease, recurring cyst right wrist and history of headaches almost daily.
No DOM history.

PATIENT'S DAILY ACTIVITY PATTERNS: Hobbies includes making rugs and needle works. Leisure activities includes bowling, playing pool, gambling and shopping at the mall. She was working prior to admission and reports getting up about 1800, report for work at 2000 and worked until 0320, go home and change clothes prior to a night at the cosino. When she did not go to the cosino to drink and gamble, She watched

televison until about 0700. There is a pattern of sleep disruption aand she reports getting about five hours sleep a day. This pattern was repeated routinely.

PATIENT'S PERCEPTION OF OWN DEPENDENCY: Veteran is of the opinion that her dependency has contributed to marital problems and divorce, affected work ethic, ending military career and relationship problems.

Expectations from treatment includes, education about the disease concept, tools to improve coping skills and initiate behavioral changes necessary to maintain long term sobriety.

IMPRESSION/ASSESSMENT OF PATIENT: Veteran is motivated for treatment and should have no problems relating to peers in treatment or meeting the criteriors for satisfactory completion of inpatient SATP. Recommend referral to address sexual trauma issues. Asset includes support system and some financial resource. Liabilities includes issues around pending divorce, addressing housing needs following divorce.

TENTATIVE DISCHARGE PLAN: Veteran will participate in MHC-SATP, as a continuum of care for a period of a year to address unresolved issues and reinforce inpatient treatment inorder to facilitate continuing sobriety.

X. Preliminary List of Problems
1. SUBSTANCE
2. SEXUAL DYSFUNCTION
3. OTHER BEHAVIOR PROBLEMS

Initial Plan of Action
She remained at home awaiting treatment and attended pre -amission groups at MHC-SATP.

eteran's Name: DOVE,GAYLE A
D#: [redacted]

GUS RIVERS, MSW, CSW, Social Worker

Social Work Service Reports and Summaries [redacted]

OCT 5, 1994 at 11:12 AM CHIEF COMPLAINT:

This is a 37-year-old female admitted to the SATP on 10/5/94. Her chief complaint is that she is an alcoholic who is a binge drinker. She said she doesn't drink every day, but once a week or every two weeks she will drink and when she drinks she drinks a lot. She says she does not want to live this way any longer because it is ruining her life, and she is seeking help. She was in one program in 1987; this was just before she was terminated from the service.

ZEHR, JULIUS

OCT 5, 1994 at 11:13 AM HISTORY OF PRESENT ILLNESS:

She started drinking at age 14. By age 21, her drinking was out of control.

She works as an auditor until two years ago. She quit that job and worked in a warehouse, but obviously she hasn't been regularly employed due to her excessive drinking. She served in the Air Force from 1975 to 1987; she was discharged from the service because of her drinking, but she did receive an honorable discharge.

Her father is a retired cook; he is an alcoholic but stopped drinking several years ago. Her mother works as a toll collector on a turnpike; she does not drink. She has two brothers who are both alcoholics; one still drinks and the other quit drinking. She has been married three times; the first marriage was at age 23 and lasted two years. She said they were separated because of the service. Her husband got out of the service and she remained in the service, and that made the marriage impossible. She married again to an alcoholic who became very abusive; this lasted 1 1/2 years. Her third marriage was at age 33; she is still married to him. He is in the Air Force. He is two years younger than she is, and he wants a divorce. She has no children because she has severe pelvic inflammatory disease with adhesions and had a hysterectomy.

As a child, she had mumps, chickenpox, and measles but no serious illnesses. She has had surgery on the right wrist times four for a ganglion which keeps recurring. She had a hysterectomy in 1987 and said she may have to have further surgery. She had a complete gynecological examination two weeks ago and is scheduled for a mammogram in about a month. She has no known allergies.

SYSTEM REVIEW: In general, this is a well-developed, 37-year-old female who appears her stated age. HEENT/neck - Negative. Respiratory - Negative. Cardiovascular - Negative. Gastrointestinal - Negative. Genitourinary - She has a history of severe adhesive pelvic disease and had a hysterectomy in the past. Hemopoietic - Negative. Lymphatic - Negative. Musculoskeletal - Repeated surgery for a ganglion of the right wrist. Neurological- Negative.

MENTAL STATUS EVALUATION: Reveals that this 37-year-old white female is well oriented as to time, place, and person. She is coherent. There is no evidence of any overt thought disorder. There is no evidence of any delusional thought content or paranoid ideations. She is moderately depressed; she is on Zoloft 50 mg qAM. She said that her depression manifests by her having crying spells, not sleeping well, and she lost about ten pounds. When her husband informed her that he wants a divorce, this made her more depressed. She is not suicidal or homicidal. She has not had DTs or seizures but experienced blackouts in the

(Continued on next page)

(Continued from previous page)

past. Recent and remote memory is not impaired. She gives a good past history with dates and names, and she can recall very well the events of the day before. She can recall four presidents. She does mathematics with ease. She is capable of interpreting proverbs and is able to think in an abstract manner. She denies any physical abuse, but she was sexually abused at age nine by a non-family member.

Julius Erik M.D.
ERIK,JULIUS

OCT 5, 1994

Name DOVE,GAYLE A SSN [redacted] Age 37 FEMALE
Height 65 in. Weight 144 lb. Temp. 98 F.
Height cm. Weight Kg. Temp. C.
Pulse 74 B.P. 114/72 Resps. 18

---------- Summary ----------

Omitted or Partially Omitted Examinations:
PELVIC.
RECTUM.

Abnormal Findings:
EXTREMITIES: Scars on the right wrist from numerous operations for a ganglion; it appears that this is recurring.

Physical Examination

General Appearance - She is a well-developed, 37-year-old female who looks her stated age.

Head - Normal shape and size, no tenderness, deformity, trauma, or other abnormalities.

Eyes - Conjunctivae, corneae, and sclerae normal. No icterus. External ocular movements normal. Pupils equal, regular, and react normally to light and accommodation. Fundi normal including discs and vessels. No hemorrhages or exudates.

Ears - External meatus normal. Drums visualized and normal without scars, inflammation, or perforations. Hearing grossly normal.

Nose - Normal mucosa and airways, no septal deviation.

Mouth - Normal lips, breath, teeth, gums, tonsils, pharynx, and tongue.

Neck - Normal motion of neck, trachea in midline, thyroid normal size, no bruit, no masses or other abnormalities.

Chest and breasts - Chest normal shape and symmetrical. No masses, tenderness, or other abnormalities of breasts or nipples.

Lungs - Normal to inspection, palpation, and auscultation.

Heart - Normal to inspection, palpation, and auscultation. Sinus rhythm, S1 and S2 normal, no murmurs, gallops, clicks or rubs.

Abdomen - No tenderness. Spleen and liver not enlarged. No palpable masses. Bowel sounds normal.

Pelvic exam - Exam omitted.

(Continued on next page)

(Continued from previous page)

Rectum - Exam omitted.

Back - Normal curvature and mobility. No pain or tenderness. No costovertebral angle tenderness.

Extremities - The joints and the radial and pedal pulsations were examined. The extremities were inspected for edema, varicosities, cyanosis, and lesion
NORMAL EXCEPT FOR Scars on the right wrist from numerous operations for a ganglion; it appears that this is recurring.

Neurological - Cranial nerves, muscle strength, sensation, deep tendon reflexes, coordination, gait & station, position, and vibratory sense normal.

Skin - Normal color and texture.

Lymph nodes - No enlargement or tenderness of cervical, axillary, or inguinal nodes.

Initial Impression:

This is an alcohol dependent patient who, prior to admission here, had lab work done. Her CBC was normal. The electrolytes were normal. The urinalysis was negative. Further tests have been ordered. Initially, she will remain on Zoloft. She will be on Provera and Premarin. She has Motrin prescribed for abdominal pain and Vistaril 50 mg for sleep. She is able to participate fully in the program.

EHIK,JULIUS

09/28/95 08:11 WVC WALK-IN/TELEPHONE

WVC-TELEPHONE PROGRESS NOTE
OUTPATIENT

DATE/TIME: 9-27-95@1100 WHO: Veteran
PHONE NO.:
INITIATED BY: Patient

PURPOSE: Inquiry:
Benefits Info:
Service Info:
Medication Inquiry:
Appointment Inquiry: Pt states that she needs to see GYN Dr.
Test Results:
Other: States that she is having pain and needs meds for infection.

Allergies, if pertinent:

ACTION: Appointment Scheduled: Date: 10-2-95@0900
Consultation With Provider:
Call Referred To:
Information Mailed on:
Education: Pt instructed for appt. 10-2-95 and she would be seen for complaints.

CLASSIFICATION: Non-Urgent

DISPOSITION:
Caller advised: Xa. Seek medical attention in 10-2-95
b. Call back if mailed info not received.
Xc. Call back PRN.
Unscheduled patient visit prevented: Yes
Multiple calls: No

CPT CODES:
_ _99371 BRIEF
_ X _99372 INTER
_ _99373 COMPLEX

COMPLETION TIME: 9-27-95@1110

Signed by: /es/ RENEE N DAVIS
RN 09/28/95 08:18

[redacted] VAMC Biloxi, MS (CONS) Printed:09/28/95 08:18
Pt Loc: OUTPATIENT Vice SF 509

MEDICAL RECORD	PROGRESS NOTES
DATE 10/2/95 GYN CLINIC	Wt 143.4 age 38 T 98.5 P 70 R 20 B/P 108/69
NKA	7th D&N for CD Pain on & off for months.
0900	B.J. McCaslin LVN
	C.C. negative
	urethritis has yeast after
	taking antibiotics
	RJ Tetzlaff Nurse Practitioner
10/2/95	Pt verbalizes understanding of Tx. meds
0955	+ F/U visit 10/30/95 Linda Haynie RN

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

DOVE, GAYLE A 25
4457 POPPS FERRY RD. LO 047
BILOXI MS 39532

[redacted]

C-SSN 5 8

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR
FIRMR(41CFR)201-45.505
509-111

CONTINUE ON BACK WHEN NECESSARY

Department of Veterans Affairs

MEDICAL CERTIFICATE

1. DATE	2. TIME	3. AGE	4. SEX	5. ON ARRIVAL PATIENT WAS:	6. PHONE NUMBER	7. HOMELESS
9-22-95	1000 AM PM	38	☐ M ☒ F	☒ AMBULATORY ☐ STRETCHER ☐ WHEELCHAIR	( )	☐ YES ☐ NO

8A. ALLERGIES	8B. WEIGHT	8C. TEMPERATURE	8D. PULSE	8E. RESPIRATION	8F. B/P	8G. DUE TO INJURY
NKA	142	98	66	18	108/68	☐ NO ☐ YES

9. CURRENT MEDICATIONS

10. TRIAGE 0935 Lesions on feet x 1 wk, lesions on hands x 4 days mp
Pt. has blisters on feets + hands. C/o itching. Pt has used triacta, c no improvement
Refer to nurse provider. — 11. SIGNATURE Cathy Jones

12. HISTORY AND PHYSICAL

1020
(S) rash started on feet, moved to hands, tried relief c topicals, also using H_2O_2 + rubbing alcohol, & home known exposures

(O) GBM - alert, NAD
SKIN - some dryness between toes, dry lesions to palms/fingers c 4 lesions (L) hand / 5 lesions (R) hand & localized erythema

13. DIAGNOSTIC IMPRESSIONS dermatitis c localized cellulitis

14. PLAN
- dicloxacillin 250mg TID x 10 days NR
- TAC cream 2 tubes - apply BID affected areas c itching NR

15A. ATTENDING OF RECORD — **15B. EXAMINER'S SIGNATURE** Mark D Fabre PA-C

SECTION II - FOR PATIENT

1. DISPOSITION / CLINIC APPOINTMENT	2. AFTER CARE SHEET GIVEN	3. FOLLOWUP - ACTIVITY - LIMITATIONS
	☐ YES ☐ NO	

4. CONDITION	5. DATE / TIME OF DISCHARGE	6. SIGNATURE TO INDICATE INSTRUCTIONS GIVEN
☐ IMPROVED ☐ SATISFACTORY ☒ UNCHANGED		

IMPRINT PATIENT DATA CARD

DOVE, GAYLE A 25
4457 POPPS FERRY RD. LO 047
BILOXI MS 39532

[redacted]

C-SSN 5 8

7. PATIENT INSTRUCTIONS
09.22.95 - follow up if worsens or persists without relief

I CERTIFY THAT I RECEIVED AND UNDERSTAND THESE INSTRUCTIONS — 8. PATIENT'S SIGNATURE

VA FORM [illegible] SUPERSEDES VA FORM 10-10M MAY 1990

TIME	VITAL SIGNS				TIME	ORDERS	MD SIGNATURE	TIME	NURSE SIGNATURE	EFFECTIVENESS
	TEMP	PULSE	RESP	B/P						

CONTINUATION FROM FRONT / PROGRESS NOTE

PATIENT HEALTH EDUCATION
AMBULATORY CARE CLINIC

9/22/95

INSTRUCTIONS ON: Dx, meds, + FU

LEARNING BARRIERS: (NONE) PHYSICAL, VISUAL, AUDITORY,
MENTAL STATUS, LEARNING ABILITY,
OTHER: _____

COMMENTS: _____

VERBALIZED UNDERSTANDING

PATIENT SIGNATURE: Gayle A Dove

STAFF SIGNATURE: Linda Haynie RN

STUDIES REQUESTED	RESULTS

12/22/94 14:23 GENERAL NOTE
SATP INP/OPT WOMEN'S GROUP

PROBLEM, ALCOHOLISM. MS DOVE REPORTED FOR GROUP. SHE HAD DENTAL WORK DONE EARLIER IN THE DAY, SO THE TIME WAS CUT SHORT. SHE IS STILL GOING TO AA REGULARLY, WHICH SHE STATES, THAT IS THE TIME WHEN SHE FEELS BEST, WHEN SHE IS AT AN AA MEETING. SHE AND HER HUSBAND ARE BEGINING TO HAVE DIALOGUE BETWEEN THEM. HE IS VERBALIZING INTEREST IN GETTING COUNSELING WHILE HE IS IN ITALY. SHE WILL ASK HIM IF HE WOULD BE WILLING TO COME IN TO SEE WRITER BEFORE HE LEAVES IN THE NEXT TWO WEEKS. VET WILL RETURN FOR GROUP AGAIN ON 12/29/94.

/es/ NANCY L. MACMILLAN,NCACII
ADDICTION THERAPIST 12/22/94 14:30

MEDICAL RECORD	PROGRESS NOTES
DATE 7/31/15	GYN clinic pt here to get 2nd injection of Depo-provera. Pt states not having any problems as of now. Pt instructed to return in 3mths for next injection. Pt states she understands — Adams RN

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)*

REGISTER NO.

WARD NO.

DOVE, GAYLE A 25 28 23 08
4457 POPPS FERRY RD. LO 047
BILOXI MS 39532

[redacted] MF 081557 520

C-SSN 5 [redacted] 8

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR
FIRMR(41CFR)201-45.505
509-111

MEDICAL RECORD Progress Notes

07/10/95 09:00 SATP F/U
Location: SATP RIVERS

Veteran has failed to keep followup appointments or call clinic.
Terminated from clinic for noncompliance.

Signed by: /es/ GUS RIVERS, MSW, CSW
SOCIAL WORKER, MHC-SATP 07/10/95 09:24

MEDICAL RECORD Progress Notes

06/23/95 09:00 SATP F/U
Location: SATP RIVERS

Veteran failed to keep scheduled appointment. Reschedule appointment.

Signed by: /es/ GUS RIVERS, MSW, CSW
SOCIAL WORKER, MHC-SATP 06/23/95 09:45

5489 396-1919

MEDICAL RECORD | **PROGRESS NOTES**

DATE

4-12-95

SURGERY CLINIC 37 yo Ht 5'6" wt 145.8 T 97.8

1018 P-59 R 16 B/P 106/73 Here for c/o pain Rt inq Area s/p Lap for Adhesions done 3-13-95 Mary Pyro

NKA

CT Scan 22 Gynd 95 0830 AM

CBC & diff ✓

UA ✓

Upright & flat KUB ✓

BRUCE V. MATHIS, M.D.
AS3286170-55B

Her Refer to Clinic

3-5-2012

Pt Hx Pyelonephritis Pelvic Surg Sept 1994. started hurting Rt Groin region Pain has become more severe. Now constant localized Lower quadrant worse on Rt. Hurting to touch Very painful. Lap & probe appears only Stage 1 adhesion which is not significant. Pt Pain Has returned and is Constant Ok guarding RLQ, no rebound pain Pt not Discharged & Vomited

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO. | WARD NO.

DOVE, GAYLE A
4457 POPPS FERRY RD.LO 047
BILOXI MS 39532

[redacted]

C-SSN 5 8

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR.
FIRMR(41CFR)201-45.505
509-111

PROGRESS NOTES

DATE	
	Cpl Lang Yes testimony R Adm Bob Brass Certain Tuesday. — the area. Utero and wales applied Rash o CBC of Ulna Flat Post neg plan CT Pelvis & Contrast R/O ... Ortho DT Dr Lang told Hyperkeratosis + Bilateral onychomycosis 2 Lamisil T Qd 1 yr 3 Free Clinic 4 Dermatt T 96 ct Rx #30 5 - Return pt to Cal Clinic Recall to contract PRN 4 - ~~Cal Clinic~~ DC Thompson DC Adams

*U.S. Government Printing Office: 1994 — 383-720

[redacted], JAYLE A
4[redacted] POPPS FERRY RD.LO 047
BIL 3x1 MS 39532

396-1919

MEDICAL RECORD	PROGRESS NOTES

DATE: 4/13/95

TELEPHONE PROGRESS NOTE

TIME: 0836

Caller: (Veteran) Family/Significant Other _____

Initiated By: (Patient) ✓ Staff ___

PURPOSE:

Chief Complaint: C/o abd. pain. Pt called and scheduled for CT of pelvis w contrast 4/22/95

Medication, if pertinent:

Allergies, if pertinent:

ACTION:

~~If scheduled with Primary Care Provider:~~

~~If consultation with provider:~~ ~~Lab work ordered for 4/18/95~~ will need to reprint slips for pt to go to lab

Call Referred to:

Education: Instructed pt to call if pain get worse

CLASSIFICATION: Emergent/Urgent/(Non-Urgent)

~~DISPOSITION:~~ ~~Caller advised:~~

~~a. seek medical attention immediately~~

~~b. appointment < 24 hours~~

~~c. appointment > 24 hours~~

d. Call back if no improvement

Unscheduled patient visit prevented: Yes No Multiple calls:

COMPLETION TIME:

Signature: Renee Davis R.N.

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

NAME: Dore, Gayle [redacted]

TELEPHONE: (201) 396-1919

PROVIDER: Dr Hanner

REGISTER NO.

WARD NO.

PROGRESS NOTES

STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR.
FIRMR(41CFR)201-45.505
509-111

CPT CODES
___ 99371 BRIEF
✓ 99372 INTER
___ 99373 COMPLEX

520-00P-114-11A OCTOBER 1993
Revised: JANUARY 1995

PROGRESS NOTES

DATE	

MEDICAL RECORD	PROGRESS NOTES

DATE: 4/26/95

TELEPHONE PROGRESS NOTE

TIME: 1513

Caller: Veteran/Family/Significant Other _____

Initiated By: Patient ____ Staff ✓

PURPOSE:

Chief Complaint: Pt called to schedule GYN appt. Left message on machine for pt to be here 5/1/95 for GYN Flu. — nDavis —

Medication, if pertinent:

Allergies, if pertinent:

ACTION:

If scheduled with Primary Care Provider:

If consultation with provider:

Call Referred to:

Education:

CLASSIFICATION: Emergent/Urgent/Non-Urgent

DISPOSITION: Caller advised: a. seek medical attention immediately

b. appointment < 24 hours

c. appointment > 24 hours

d. Call back if no improvement

Unscheduled patient visit prevented: Yes No Multiple calls:

COMPLETION TIME:

Signature: RDavis RN R.N.

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

NAME: Done, Dawn

SS#: [redacted]

TELEPHONE: (601) 396-1212

PROVIDER: Diaz

REGISTER NO.

WARD NO.

PROGRESS NOTES

STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICNR.
FIRMR(41CFR)201-45.505
509-111

CPT CODES
99371 BRIEF
✓ 99372 INTER
99373 COMPLEX

520-00P-114-11A OCTOBER 1993
Revised: JANUARY 1995

PROGRESS NOTES

DATE	

☆ U.S. Government Printing Office: 1994-378-437

MEDICAL RECORD *S/N* **PROGRESS NOTES**

DATE	
8/1/95	Wt 145.2 age 37 T 98.2 P 59 R 20 BP 98/82 10/41
NCA	7/4 y CT scan, call by L Davis RN to come in
0905	today. S. J. McCaddon RN

Have discussed Pros & Cons
if Endometriosis Depo Provera should help
if adhering it won't

Rx Depo Provera 150 – 93 mg

R.T.C 6 mo

10/30/95 Depo provera 150mg given IM in Lt gluteal. Pt education given as to medication and side effects. Pt verbalizes understanding will return in 3mths for next injection

RDawson

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)*

Dove Hoyle A
6094

REGISTER NO.	WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR(41CFR)201-45.505
509-111

PROGRESS NOTES

DATE	

☆ U.S. Government Printing Office: 1993-515-904/81316

MEDICAL RECORD Progress Notes

04/11/95 15:19 PSYCHOLOGY
WOMEN'S STRESS CLINIC/PSYCHOLOGY NOTE: VET REPORTED THAT SHE IS STILL EXPERIENCING PAIN POST-SURGERY.
PROBLEM: SELF-ESTEEM
PROGRESS WITH PROBLEM: VET REPORTED HEIGHTENED SENSE OF SELF-ESTEEM SINCE HER MOVE TO LIVE INDEPENDENTLY FROM HUSBAND AND HER NEW JOB. SHE RELATED POSITIVE COMMENTS THAT OTHERS HAVE PROVIDED TO HER ON THE JOB AND DISCUSSED HER ASSERTION WITH SIGNIFICANT OTHER IN POINTING OUT IMPORTANCE OF WORK WHEN HIS COMMENTS SUGGESTED THAT HE WAS BOTHERED BY HER SCHEDULE. PROACTIVE EFFORTS THAT VET HAS MADE (E.G., PURCHASE OF RESIDENCE) WERE HIGHLIGHTED AS REASONS FOR VET'S SUCCESS.
ASSIGNMENT: VET TO IDENTIFY FUTURE GOALS FOR
MAINTENANCE: TERMINATION PLANNED FOR TWO WEEKS FROM TODAY'S SESSION.
Signed by: /es/ VIRGINIA M. DEROMA
STAFF PSYCHOLOGIST 04/11/95 15:23

DOVE,GAYLE A [redacted]

D/C
3/19/95

MEDICAL RECORD	PROGRESS NOTES
DATE	

3-29-95 [redacted] [SURG] Wt 151 NKDA
1005 B/P 104/70 P 71 R 16 Temp 98
F/u pelvic IAP - Uncomplicated

Pt RTC for F/u - S/P Ex Lap LOA
14 Mar 95. Now has some ↓ op
pain, but is ambulating ↓ assistance
tolerating Regular Diet - ↑ Regular
BM.
Pt back to work & doing well
↑ that.
will refill prn percocet
Pt to cont ↑ walking & stair
climbing. Still to do No heavy
lifting for 4 more weeks

MICHAEL J. SCHNEIDER, Capt, USAF, MC
504-78-9577 45S1
81st MEDICAL GROUP, KEESLER AFB MS

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

DOVE, GAYLE A
5246 A STREET
BILOXI MS 39530

[redacted]

C-SSN 5 8

REGISTER NO.	WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR.
FIRMR(41CFR)201-45.505
509-111

PROGRESS NOTES

DERM

4/7/95

No show
Reason for F/U not found
in chart
next available

[redacted]

"U.S. Government Printing Office: 1994 — 383-720 25 247"

STANDARD FORM 509 BACK (Rev. 11-77)

[redacted]
5246 A STREET
BILOXI MS 39530

[redacted]

C-SSN 5

WXD
3-2055

Fi

MEDICAL RECORD — CONSULTATION SHEET

REQUEST

TO	FROM: (Requesting physician or activity)	DATE OF REQUEST
~~Surgery~~ GYN	Unscheduled Labs	9-22-94 0944

REASON FOR REQUEST (Complaints and findings)

Rx Hysterectomy Hx Recurrent low abdominal pain
exc chem U/A neg on 9/21/94
(Preop) pelvic rectal Chest = normal limits
PT going into SATP 10/4/94 for 30 days - Please schedule for after 11/4/94. THANKS

PROVISIONAL DIAGNOSIS

Rx Adhesion

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	ROUTINE / TODAY
[signature]		☐ BEDSIDE ☐ ON CALL	☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

(Continued on reverse side)

SIGNATURE AND TITLE			DATE
IDENTIFICATION NO.	**ORGANIZATION**	**REGISTER NO.**	**WARD NO.**

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

DOVE, GAYLE A
5246 A STREET
BILOXI MS 39530

[redacted]

C-SSN 5 8

CONSULTATION SHEET
STANDARD FORM 513 (Rev. 9-77)
Prescribed by GSA/ICMR
FIRNR (41 CFR) 201-45.505
513-108

#1351
9-26-94

03/14/95 16:24 PSYCHOLOGY
Location: 1-4WSUR
PT REPORTED THAT SURGERY WAS MORE INTENSIVE THAN EXPECTED AND REQUIRED LONGER RECOVERY THAN EXPECTED. SHE ALSO REPORTED RELIEF REGARDING HER ADDRESSING RELATIONSHIP ISSUES WITH HUSBAND IN DIRECT FASHION - EVENTS FRAMED AS POSITIVE IN TERMS OF HER PHYSICAL RECOVERY. VET DISCUSSED PLANS TO MOVE OUT OF HOME IN NEXT THREE WEEKS AND TO PURCHASE A TRAILER FOR RESIDENCE. ADJUSTMENT TO POST-OP PAIN APPEARED POSITIVE.

Signed by: /es/ VIRGINIA M. DEROMA
STAFF PSYCHOLOGIST 03/14/95 16:27

03/01/95 09:00 SATP F/U
Location: SATP RIVERS

Appointment cancelled. Future appointment scheduled.

Signed by: /es/ GUS RIVERS, MSW, CSW
SOCIAL WORKER, MHC-SATP 03/02/95 08:37

02/17/95 13:00 SATP F/U

Progress not of 2/16/95 erroneously reflected that veteran failed to keep scheduled appointment on that date, however further review indicates that appointment was in fact scheduled for 2/17/95. The previous note is correct in all other respect. Veteran reported this date for appointment as scheduled. She indicates that the therapeutic relation ship with Dr. DeRoma is very positive and productive. She enjoys the sessions and the method of issue resolution is producing results. Helath issues are being addressed and divorce is not being actively persued, however she intends to dealy with the matter following recovery form pending surgical procedure. A claim for service connected benefits is in progress and the process for correction of military records to deal with injustice was outlined. Today there is a positive face, which appears sincere and focused. Veteran and I mutually agreed that at this point Dr. DeRoma will provide all therapy and MHC-SATP will provide followup and treatment plan update, when appropriate. Future appointment scheduled.

/es/ GUS RIVERS, MSW, CSW
SOCIAL WORKER, MHC-SATP 02/17/95 14:50

02/16/95 13:00 SATP F/U

Veteran failed to keep sheduled appointment, however a review of her chart indicates she is following the treatment plan. Treatment plan will be update on next clinic visit. Reschedule appointment in two weeks.

/es/ GUS RIVERS, MSW, CSW
SOCIAL WORKER, MHC-SATP 02/16/95 13:21

MEDICAL RECORD	PROGRESS NOTES
DATE	
2/14/95	Psychology note/Women's Clinic/Group note: Veteran came to Self-esteem group prepared with homework completed. Social factors on Self-esteem were reviewed. Information on developing goals was presented. Characteristics of managable goals include being realistic, promoting growth, developing self worth and viewing weakness in a positive way. Vet developed short terms of exercising twice a week and losing two pounds this week. Long term goals included finishing school, working in hotel management and finishing tapestry. —— Virginia M. DeBoer, PhD. Staff Psychologist.

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO.

WARD NO.

[redacted]

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR
FIRMR(41CFR)201-45.505
509-111

02/14/95 16:07 PSYCHOLOGY
PT DISCUSSED UNREALISTIC ASPECTS OF EXPECTATIONS FOR RELATIONSHIPS. TENDENCY TO ATTEMPT TO CONTROL OTHER PEOPLE'S THOUGHTS OF FEELINGS IN RELATIONSHIPS (TO AVOID WITNESSING PAINFUL REACTIONS) WERE ALSO HIGHLIGHTED. VET IDENTIFIED LIST OF BOUNDARIES IMPORTANT FOR SELF IN RELATIONSHIP(S). PROGRESS IN AA REPORTEDLY DOING WELL. VET AGREED TO MAKE LIST OF BOUNDARIES MORE SPECIFIC (E.G., DEFINABLE BY OBSERVABLE BEHAVIORS).

/es/ VIRGINIA M. DEROMA
STAFF PSYCHOLOGIST 02/14/95 16:10

MEDICAL RECORD	PROGRESS NOTES
DATE	

7Feb.95 Psychology note/Women's Stress Clinic/Group note: Veteran came to group prepared with homework completed. Patterns of negative thinking was reviewed and discussion on personal patterns identified. Information on the steps to increase self-esteem was presented. Steps included pampering oneself, recognizing both positive and negative personal characteristics, dealing w/guilt, and learning from past mistakes. Vet participated in group discussions on increasing self-esteem. Vet agreed to increase social interaction with other veterans. She will engage in social behaviors including, being a good listener, smiling and making others feel important.
-Virginia D. Bellon PhD., Staff Psychologist

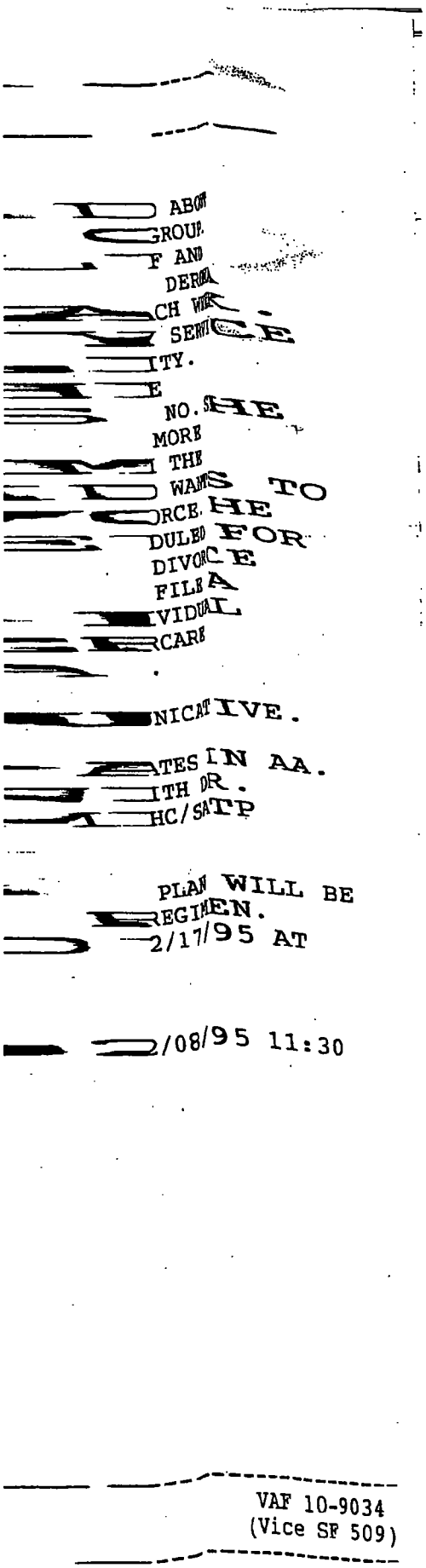
(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)*

Dove, Gayle
[redacted]

REGISTER NO.	WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR.
FIRMR(41CFR)201-45.505
509-111



VAF 10-9034
(Vice SF 509)

MEDICAL RECORD Progress Note

02/08/95 10:00

SATP INDIVIDUAL THERAPY
S: VET. WAS ON TIME FOR THE APPOINTM
BEING READMITTED TO THE MHC OUTPATIE
STATED THE SATP WOMEN'S GROUP CONSIS
THE FACILITATOR. STATED SHE CONTINU
FOR SUPPORTIVE THERAPY AND A SELF E
SHE IS ATTENDING AA DAILY AND PROVI
ASSOCIATED WITH AA AT THE COUNTY DE
ASKED IF SHE DESIRED GROUP INVOLVEM
SERVICES BEING PROVIDED AND AA. HE
OFFERED TO CONTINUE WITH THE WOMEN
INDIVIDUALS START TO ATTEND. TOLD
WOMEN'S GROUP FACILITATOR. VET. SA
RECONCILE BUT SHE HAS DECIDED TO F
IS CURRENTLY TDY OVERSEAS. SHE HAS
MID MARCH AND INTENDS TO FOLLOW TH
AFTER THE MEDICAL PROBLEMS ARE RE
DISABILITY CLAIM WITH THE VA. WIL
ONCE PER MONTH TO SUSTAIN SUBSTAN
CONTACT. WILL CONTINUE THERAPY W

O: OUTWARD PHYSICAL APPEARANCE W

A: CONTINUES TO ABSTAIN AND ACTI
AFTERCARE FOLLOW ON SUFFICIENT W
DEROMA WEEKLY AND INDIVIDUAL AFT
MONTHLY.

P: UPON RECEIPT OF MEDICAL RECO
REVISED TO REFLECT CHANGES TO H
APPOINTMENT WITH SATP RIVERS SC
1300. ~~AFTERCARE NEEDS~~ Go

/es/ ALVIN L DYKE
ADDICTION THERAPI

DOVE,GAYLE A VAMC
[redacted]

MEDICAL RECORD	PROGRESS NOTES
DATE	
1/24/95	Psychology note/ Women's Clinic / Group Therapy Vet attended Self-Esteem Group. Internal thoughts that can lead to low self-esteem were reviewed. Being perfect, trying hard, pleasing others, hurrying, and being strong were identified as possible thoughts leading to low self-esteem. Vet identified the "I must be strong" as a contributor to her low self-esteem. Vet contributed during group and agreed to complete homework. Myrna R. Miller, PhD Staff Psychologist

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)*

Dove, Gayle
[redacted]

REGISTER NO.	WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR(41CFR)201-45.505
509-111

01/25/95 09:28 PSYCHOLOGY

Vet discussed tendency to hold emotions in and related this pattern to home life in which mother did not express verbal or physical affection and father was unknown to her until age 14. She recalled a turning point in her withholding of emotions involving her step-mother lecturing her when she went to live with her father. Her sense of dependence of staying in the home of father may have contributed to holding anger/rage in at that time. Vet also disclosed that her giving her son up for adoption at her mother's pursuasion was also traumatic for her, especially following hysterectomy. She discussed how these experiences lowwered the likelihood that she would make herself vulnerable in relationships. Assignment: To visually draw a picture of her defensesj.

/es/ VIRGINIA M. DEROMA
STAFF PSYCHOLOGIST 01/25/95 09:33

MEDICAL RECORD	PROGRESS NOTES
DATE	
31 Jan 95	Psychology Service / Women's Stress Clinic / Group Note: Reviewed previous groups internal thoughts that lead to self-esteem. Vet participated in overview discussion. Information was presented cognitive styles that effect self-esteem. Concepts included: overgeneralization, global labeling, filtering, polarized thinking, personalization, mind reading, control fallacies, and emotional fallacies. Vet identified filtering as negative thinking pattern. Vet agreed to attempt to reduce this negative thinking pattern and become more aware of it. Lynn M. Dolen PhD. Staff Psychologist

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

Dove, Gayle
[redacted]

REGISTER NO.	WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/IDMR
FIRMR(41CFR)201-45.505
509-111

01/19/95 16:30 SATP GROUP THERAPY
ADDICTION THERAPIST...WOMEN'S GROUP FACILITATOR FEEDBACK REFLECTS VET. HAS MISSED LAST TWO GROUP SESSIONS DUE TO ILLNESS.

/es/ ALVIN L DYKE
ADDICTION THERAPIST, NCADC 01/20/95 14:46

MEDICAL RECORD	PROGRESS NOTES
DATE	GYN
2-6-95	CLINIC Age 37 wt 153 T 98.4(o) P 73 R 14 B/P 108/72
1015	S/O Pt here for pelvic pain worsening past few weeks hx pelvic adhesive
NKDA	disease. Last PAP Sept '94. P- Refer to
	clinic Referred per Kessler Pamela Lee RN
	C.C. Pelvic pain
	Hx pelvic adhesive
	being tx at "K" & good results
	PHY: on depo
	gray mass
	c stenger along R side
	of uter.
	Imp Pelvic adhesion
	if conservative therapy not working
	recc Laparoscopic / Laparotomy
	for Pelvic Pain

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)*

DOVE, GAYLE A
5246 A STREET
BILOXI MS 39530

25
047

S-SSN [redacted]

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR(41CFR)201-45.505
509-111

01/10/95 16:11 GENERAL NOTE
VET DID NOT ATTEND SESSION TODAY. SHE CALLED TO CANCEL GROUP ATTENDANCE, BUT INDICATED THAT SHE WANTED TO KEEP HER INDIVIDUAL THERAPY APPOINTMENT.

/es/ VIRGINIA M. DEROMA
STAFF PSYCHOLOGIST 01/10/95 16:11

CONTINUE ON BACK WHEN NECESSARY

Department of Veterans Affairs

MEDICAL CERTIFICATE

1. DATE	2. TIME	3. AGE	4. SEX	5. ON ARRIVAL PATIENT WAS:	6. PHONE NUMBER	7. HOMELESS
11695	2235 AM/PM	37	☐ M ☒ F	☒ AMBULATORY ☐ STRETCHER ☐ WHEELCHAIR	( )	☐ YES ☒ NO

8A. ALLERGIES	8B. WEIGHT	8C. TEMPERATURE	8D. PULSE	8E. RESPIRATION	8F. B/P	8G. DUE TO INJURY
NKA Ht. 66"	140	99	77	20	129/91	☒ NO ☐ YES

9. CURRENT MEDICATIONS See page 6 - Keflex Prozac Orudis

10. TRIAGE Pt. c/o cold symptoms x 2 days, generalized malaise, congestion c/o SOB, chest pain, feels like he "choked"

11. SIGNATURE Dan Hess

12. HISTORY AND PHYSICAL

37 y/o WF smoker c/o above Sx x 2-3 days
NO T/C/N/V Ø x bowel habits
dry nonproductive cough

PE: NAD RA sat 95%
CW - NT throat - slt inflamed O/W ©
lungs (+) scattered rhonchi & wheezes

CXR - Normal

13. DIAGNOSTIC IMPRESSIONS Bronchitis

14. PLAN
Guaifenesin
Amoxil 500 mg tid
F/u PC PRN

15A. ATTENDING OF RECORD

15B. EXAMINER'S SIGNATURE S Rees

SECTION II - FOR PATIENT

1. DISPOSITION / CLINIC APPOINTMENT	2. AFTER CARE SHEET GIVEN	3. FOLLOWUP - ACTIVITY - LIMITATIONS
	☐ YES ☐ NO	

4. CONDITION	5. DATE / TIME OF DISCHARGE	6. SIGNATURE TO INDICATE INSTRUCTIONS GIVEN
☐ IMPROVED ☐ SATISFACTORY ☐ UNCHANGED		

IMPRINT PATIENT DATA CARD

[redacted]

7. PATIENT INSTRUCTIONS

I CERTIFY THAT I RECEIVED AND UNDERSTAND THESE INSTRUCTIONS

8. PATIENT'S SIGNATURE Gayle A Dove

VA FORM 10-10M SUPERSEDES VA FORM 10-10M MAY 1980

Veterans Administration

MEDICAL RECORD - NURSING DOCUMENTATION

VAMC - BILOXI, MS

EMERGENCY ROOM NURSING ASSESSMENT

Date: 11/16/95
Time in: 2235
Allergies NKA

Mode Of Entry: Ambulatory: ☑ From: Home ☑
Wheelchair: ☐ Foster Home: ☐
Ambulance: ☐ Nursing Home: ☐
Other: ☐

Chief Complaint Hurts to breathe / Cough

Accompanied by family: Yes__ No✓ Who Friend

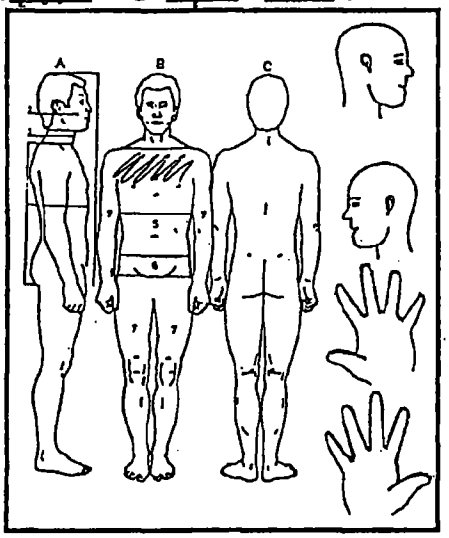
Mental status: Alert✓ Awake,but Confused:__ Lethargic__ Unresponsive

Behavior: Cooperative ✓ Uncooperative__ Combative__ Other

Physical Assessment: Height (in inches) 66½" Weight 140 lbs____ kg.

VITAL SIGNS

Time	B/P	P	R	T
2235	124/81	77	20	99



SKIN:
Hot:
Warm:
Cool:
Dry:
Diaphoretic:
Pink: Color good
Cyanotic:
Rash:
Lesions:
Decubiti:
Lacerations:
Hematoma:
Flushed
other
Pupils: Lt. Rt.
Size:
React:
Fixed:
Dilated:
Constricted:

CARDIOVASCULAR

Pulses: Lt. Rt.
Radial: ✓ ✓
Do Pedis ✓ ✓
P. Tibal ✓ ✓

HEART
Apical:
Rhythm ✓
Regular ✓ ✓
Irregular ✓

CHEST PAIN
Location Upper
Duration resp.
Frequency
Intensity ✓

Chest Pain Scale 0-10
0(no pain) to 10(worse pain)

MUSCOSKELETAL

Extremities:
Moves X 4 ✓
Hemiplegia
Paraplegia
Amputee
Contractures
other

RESPIRATORY

Chest: Lt. Rt.
Lungs Clear ✓ ✓
Wheezing
rhonchi
rales
other Smoke <1/2 ppd

GASTROINTESTINAL

Abdomen:
Soft N/A
rigid
Distended
Non-tender
tender
Bowel sounds
other
Last BM
Diarrhea
other

GENITOURINARY

No Problem Denies
Burning
Frequency
Hematuria
Incontinence
other

List size as: 2 3 4 5 6 7 8 9
List reaction as: B-brisk S-sluggish N-none

ENTER IN SPACE BELOW - PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. (Continue on Reverse)

Dean H... L...

LOVE, GAYLE A
[redacted]
11 15 95
[redacted]
[redacted]
SSN ... 5 8

MEDICAL RECORD

VA FORM SEP 1986 10-0096

*U.S. Government Printing Office: 1988-241-638/92342

R. Treatments:
:___(Flow sheet started___)
; tube:___(Size:___Time:___)
:G:___
)G:___
b tests:___
rosol Tx:___
)und Care:___
tures___
stric lavage:___
iger stick glucose:___@___=___
lse oximeter: 95% on L
Ray___

Medications Administered/Response to Medication:
Tet. Tox (0.5 mil IM):
Procardia (10mg SL):
NTG (mg. SL):
___:
___:
___:
___:

EKG RHYTHM STRIP

NA

isposition of Patient: Time: 2310 Mode:Ambulatory ✓ Wheelchair:____ Stretcher:____
:compañied by: friend /P.O.V. ✓ : Taxi___: Station Car:_____
nbulance_____: Security/Police _____
): Home ✓ Admit_____Ward:_____Report called @___

isposition of personal belongings: To Family: _____
ther:_____ _____
pecific Name) (Specific Name)
appropriate hospital area for safekeeping
___(list all items and to where: _____

NA

Signature _____

PATIENT HEALTH EDUCATION (PHE)
EMERGENCY ROOM

Brief Explanation/Rationale/Booklet on disease process (fibroelastosis) discussed with Patient/Family. NA
Instructed to return to ER/Ambulatory Care Clinic if health-related problem worsens/does not improve over next___hours. pain NA NA
Dosage, Time, route, identification of proper medication, and precautions on dispensed medication provided. ampicillin NA
When applicable, demonstration given on NA profenesis and successful return demonstration provided by patient. Not NA
Verbalizes understanding: Patient/Family.
Comment:

Patient Sep-1010 11. C-11

MEDICAL RECORD	PROGRESS NOTES
DATE	

12/27/94 Moreno Stress Clinic / Psychology Service / Individual Therapy: Pt discussed effect of discharge from military, rape, and termination of long-standing relationship on self-esteem. She targeted self-esteem as issue to address in therapy & agreed to attend self esteem group. — Wynona M. Dillon, Staff Psychologist.

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)*

Dove, Gayle. [redacted]

REGISTER NO.	WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/IOMR,
FIRMR(41CFR)201-45.505
509-111

PROGRESS NOTES

DATE	

☆ U.S. Government Printing Office: 1993-515-904/81316

MEDICAL RECORD	PROGRESS NOTES
DATE	
1/6/95	Self Esteem Group / Women's Stress Clinic / Psychology Note: Vet was introduced to group and goals of SELF-Esteem Enhancement. Self-Image was defined and components of self-esteem were identified, including relationships, sense of belonging, values, appearance, accomplishments, job, and background. Vet received a score of 107 on the Self-Esteem Inventory, which is indicative of severely low-self-esteem. Vet was cooperative in group. Virginia M. Deller, PhD, Staff Psychologist
12/3/95	Individual therapy / Women's Clinic / Psychology Note: Veteran discussed issues of ambivalence related to relationship with husband and how fear of rejection motivated distressing behavior. Themes of sense of rejection experienced in past trauma also explored. Vet agreed to identify past experiences with rejection in childhood for next week Virginia Deller, PhD., Staff Psychologist.

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade, rank; rate; hospital or medical facility)

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR(41CFR)201-45.505
509-111

Dow, Gayle
[redacted]

Department of Veterans Affairs | **MEDICAL RECORD** | **OVERALL TREATMENT PLAN**

IMPORTANT: CHECK APPROPRIATE BOX: ☐ INITIAL ☐ CHANGE TO TREATMENT PLAN ☐ DISCHARGE PLANNING

INSTRUCTIONS: *Following an assessment of the patient's problems, the initial treatment plan will be documented on this form. This plan will specify the overall diagnostic and therapeutic activities that will be undertaken in regard to each of the patient's problems and the specific staff members responsible for carrying out these activities. Specific mention will be made of plans for specialized rehabilitation services, patient education, discharge, and followup. Revisions of the treatment plan will be made on this form, if appropriate, or on additional copies of this form. (VAF 10-0043a will be used – Service Treatment Plan, if needed.)*

DIAGNOSES: Axis I: Alcohol Dependence

Axis II: _____

Axis III: _____

Axis IV: #____

Axis V: #____

ESTIMATED LENGTH OF STAY (or Treatment for Outpatients)
Please specify DATE and note that if patient remains, the plan must be reviewed on that date.

FUNCTIONAL STRENGTHS & LIMITATIONS:

SCHEDULED DATE(S) FOR REVIEW:	DATE(S) ACTUALLY REVIEWED:
02/18/94	

ASSIGNED CASE MANAGER/PRIMARY THERAPIST: _____

Gayle A. Dove	[signature]	
Patient	Psychiatrist	Recreation Therapist
	[signature]	
Family/Significant Other*	Psychologist	
	[signature], MSW	
Nurse	Social Worker	

*Please explain if no family or significant other has been involved:

Filed for divorce -

SIGNATURE/TITLE-PRACTITIONER	SIGNATURE/INITIAL OF APPROVING PHYSICIAN	DATE
[signature] (ICPDC) Addiction Therapist	[signature]	11-28-94

Enter in space below - PATIENT IDENTIFICATION - Treating Facility - Ward No. *Date*

Dove, Gayle 11-18-94

[redacted]

MENTAL HEALTH - Part I

MEDICAL RECORD
OVERALL TREATMENT PLAN

April 1992

CLINICAL NEED OR CONDITION: Outpatient Aftercare Supportive Therapy

DATE IDENT.	TREATMENT GOALS	INCREMENTAL OBJECTIVES	TARGET DATES	ACTUAL ACHIEV. DATE	METHOD & FREQUENCY	STAFF RESPONSIBLE	KEY DISCHG. GOAL? Y/N
11-15-94	Establish an alcohol free lifestyle	Participate in MHC/SPTP Outpatient Clinic Group and/or Individual Supportive Therapy Sessions			Attend OP and/or Individual Therapy sessions once per week	Addiction Therapist	Y

Department of Veterans Affairs | **MEDICAL RECORD** | **OVERALL TREATMENT PLAN**

IMPORTANT: CHECK APPROPRIATE BOX: ☐ INITIAL ☐ CHANGE TO TREATMENT PLAN ☐ DISCHARGE PLANNING

INSTRUCTIONS: *Following an assessment of the patient's problems, the initial treatment plan will be documented on this form. This plan will specify the overall diagnostic and therapeutic activities that will be undertaken in regard to each of the patient's problems and the specific staff members responsible for carrying out these activities. Specific mention will be made of plans for specialized rehabilitation services, patient education, discharge, and followup. Revisions of the treatment plan will be made on this form, if appropriate, or on additional copies of this form. (VAF 10-0043a will be used – Service Treatment Plan, if needed.)*

CLINICAL NEED OR CONDITION: Outpatient Aftercare Supportive Therapy

DATE IDENT.	TREATMENT GOALS	INCREMENTAL OBJECTIVES	TARGET DATES	ACTUAL ACHIEV. DATE	METHOD & FREQUENCY	STAFF RESPONSIBLE	KEY DISCHG. GOAL? Y/N
11-18-94	Establish contact with community support groups.	Participant in AA. Obtain a sponsor			Attend AA minimum of 7 x per week. Seek a sponsor. (Note: Patient has sponsor with 12 yrs sobriety)	Addiction Therapist	Y

SIGNATURE/TITLE-PRACTITIONER	SIGNATURE/INITIAL OF APPROVING PHYSICIAN	DATE
Blair L. Duke Addiction Therapist		

Enter in space below - PATIENT IDENTIFICATION - *Treating Facility - Ward No.* *Date*

Dave Gayle [redacted]

11-18-94

MENTAL HEALTH - Part II

MEDICAL RECORD OVERALL TREATMENT PLAN
April 1992

CLINICAL NEED OR CONDITION:_____

DATE IDENT.	TREATMENT GOALS	INCREMENTAL OBJECTIVES	TARGET DATES	ACTUAL ACHIEV. DATE	METHOD & FREQUENCY	STAFF RESPONSIBLE	KEY DISCHG. GOAL? Y/N

12/07/94 10:00

SATP GROUP THERAPY
S: VETERAN WAS ON TIME FOR HER 1ST SATP RELAPSE PREVENTION GROUP SESSION. SHE INTRODUCED HERSELF, ACKNOWLEDGING BEING ALCOHOLIC. FOCUSED ON THE DISCUSSION RELATED TO ASSERTIVE, NON-ASSERTIVE AND AGGRESSIVE BEHAVIOR. AFFIRMED SHE IS ACTIVE (DAILY) IN AA AND HAS A SPONSOR.

O: OUTWARD APPEARANCE GOOD. OPEN TO LIMITED EXTENT.

A: CONCERNED PATIENT TENDS TO MANIPULATE MALE PEERS, BEING MORE COMFORTABLE IN AN OTHERWISE ALL MALE GROUP. WILL ASSESS HER ASSIMULATION AND CLINICAL BENEFIT. MAY REQUEST CONSULT FOR ADMISSION TO A WOMEN'S AFTERCARE GROUP. FURTHER ASSESSMENT PENDING.

P: CONTINUE IN RELAPSE PREVENTION GROUP. PATIENT RECENTLY MET WITH SATP SOCIAL WORKER. CONSULT SOCIAL WORKER.

/es/ ALVIN L DYKE
ADDICTION THERAPIST, NCADC 12/09/94 15:13

MEDICAL RECORD	PROGRESS NOTES
DATE	

Male

10-15-94 37 y wh female - seen in Sub Urban - pt was referred by [redacted] because of pt's husband recently told her he wanted divorce - pt was depressed recently & lost 5 lbs. in last 3 days w/ physical problems. yesterday she found out he went away & gave for her medical Rx - she now very angry at husband & says her depression is better. She has suicidal ideation but has not acted. She has also been angry enough to want to kill him - she doesn't feel she would do it however - "I'm strong to just walk away"

I see no indication of psychosis. At this time pt denies suicidal & homicidal ideation.

1) ↑ Serzone to 100 mg qhs

2) Vistaril 25 mg PO TID prn for anxiety

RTC 1 mo

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last, first, middle; grade; rank; rate; hospital or medical facility)

DOVE, GAYLE A
5246 A STREET
BILOXI
25
047
MS 39530

[redacted]

[redacted]

SUIC
1 1 V 1

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 508 (Rev. 11-77)
Prescribed by GSA/ICMR.
FIRMR(41CFR)201-45.505
509-111

PROGRESS NOTES

DATE	

☆ U.S. Government Printing Office: 1993-515-004/81316

12/14/94 10:00 SATP GROUP THERAPY
VET CALLED IN PRIOR TO THE GROUP START TIME STATING SHE IS SICK. STATED HE IS HAVING SOME STOMACH PROBLEMS. CANCELED RELAPSE PREVENTION GROUP SESSION THIS DATE.

/es/ ALVIN L DYKE
ADDICTION THERAPIST, NCADC 12/15/94 13:26

12/19/94 09:35

SATP INDIVIDUAL THERAPY
Veteran reported for scheduled appointment. During the last visit we discussed the potential benefits of referal to Dr. DeRoma for evaluation and therapy for service related sexual trauma, to eliminate any contatransference. Dr. DeRoma will see veteran on 12/20/94 at 1500. She recently saw Dr. Ramsey at MHC to alay anxiety and deal with her depression, her medications were adjusted and she reports significant improvement. Veteran has been referred to the Women's Group conducted by Ms. McMillian on 4G-SATP. Followup visit scheduled in six weeks. Clinical Record was not available for scheduled appointment.

/es/ GUS RIVERS, MSW, CSW
SOCIAL WORKER, MHC-SATP 12/19/94 09:45

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
SATP - McMillan	MHC/SATP - Dyke	12/15/94

REASON FOR REQUEST (Complaints and findings)

37 4/0 NSC W/F presently involved in SATP Outpatient aftercare. Vet currently active in AA and has sponsor. Unresolved marital issues. Completed SATP inpatient Ward 4C on 11/18/94. Request screening/consult for SATP Women's Group.

PROVISIONAL DIAGNOSIS

Alc Dep

~~DOCTOR'S~~ SIGNATURE	APPROVED	PLACE OF CONSULTATION	
Alvin F Dyke ICADC Addiction Therapist		☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

12/16/94 - Have met & talked with Mrs Dove on numerous occasions & she have voiced interest in attending the SATP Women's Group. She is an appropriate candidate for the groups. The first Group session will be on 12/22/94 at 1330 hrs. on Building 46-1.

12-19-94 - Vet notified. aed

(Continued on reverse side)

SIGNATURE AND TITLE			DATE
Nancy McMillan, MA, MSW II			12/16/94
IDENTIFICATION NO.	ORGANIZATION	REGISTER NO	WARD NO

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle, grade: rank, rate: hospital or medical facility)

Dove, [redacted]

[redacted]

CONSULTATION SHEET
STANDARD FORM 513 (Rev. 9-77)
Prescribed by GSA/ICMR
FIRNR (41 CFR) 201-45.505
513-108

MEDICAL RECORD	PROGRESS NOTES
DATE 9/22/94 0905	S/O. "I am here for Lab Results!" B Wt. 145 165, Ht 5'6½" Age 37 / T 98° P 84 R BP 102/62 P A/N appointment in Urgent Care Clinic c Dr. Hill for Pelvic Pain. Annie Chambers. No Records
9/22/94 0933	S Heal Lab - negative, Not as Nausea Appetite Better Pain o. O Skin LRQ pain and Burn, no Heat Lesion A Rx Adhesion Hx Hysterectomy. P Appt Surgery 5/13 Rec as Scheduled / Wants Help
	Pelvic - Hysterectomy - No Mass - no Tenderness moderate White mucous, Adnexa negative / Hyperemia
	Rectal - no mass Hemoccult negative
	Breast - Self Exam no Masses no Discharge Attended by Nurse Pamela Wing / Wants Pain

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last first, middle; grade; rank; rate; hospital or medical facility)

DOVE, GAYLE A [redacted] 29 10 [redacted] 520

C-55N 5 8

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR(41CFR)201-45.505
509-111

MEDICAL RECORD	PROGRESS NOTES
DATE	
	Light W.T.
9/2/97	37yo wm told x who esp by spouse he would divorce her. Has subjective SOB than last wk ETOH past 3 dys. 2 anxiety, salute, gen sleep. L epistaxis act. Suicide id occ. but no plan.
	Exp. Help. Reaction + depressed mood.
	Rec. Zoloft 100 mg po qam
	Ambien 10 mg hs prn sleep
	RTC 3 wks.
	Refer EATP.

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

DOVE, GAYLE A
5240 A STREET
[redacted]

25
047
MS 39530

0921

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 508 (Rev. 11-77)
Prescribed by GSA/ICMR.
FIRMR(41CFR)201-45.505
509-111

C-SSN 5 8

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
Psychology	Unscheduled Walk-In	9-21-94 0952

REASON FOR REQUEST (Complaints and findings)

Hx of depression

Needs Evaluation

PROVISIONAL DIAGNOSIS

Depression

DOCTOR'S SIGNATURE	APPROVED	[redacted]	[redacted] TODAY

[redacted]

Psychology Evaluation

Hx+Obs: 37. y.o. ♀ c hx of depression and ETOH abuse dependence. Pt also has hx of chronic pain and headaches. She stated that her husband injured her 2 weeks ago that he wanted a divorce. She has never been on medication for her depression. She has experienced some suicidal ideation in the past, but none currently. No homicidal ideation. Ox3 goal directed + cooperative. Speech = normal in rate, rhythm, content + volume. No evidence of psychosis. Tongues spells, ↓ sleep ↓ appetite. Mood reported as depressed. Affect is congruent c reported mood. Comprehension, judgement + insight are good. Memory + attention/concentration are WNL upon good exam. Chart was reviewed

Tests: Clinical Interview (9-21-94)

Results: See above

Dx/rule: ETOH abuse
Adjustment Disorder c Depressed Mood

Rec's Refer to MHC [redacted]

SIGNATURE AND TITLE	[redacted]

IDENTIFICATION NO.	ORGANIZATION	[redacted]	[redacted]
DOVE, GAYLE A	25		

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; race; hospital or medical facility) [redacted]

[redacted]

Department of Veterans Affairs

MEDICAL CERTIFICATE

1. DATE	2. TIME	3. AGE	4. SEX	5. ON ARRIVAL PATIENT WAS:	6. PHONE NUMBER	7. HOMELESS
9/21/94	0150 AM PM	37	☐ M ☒ F	☒ AMBULATORY ☐ STRETCHER ☐ WHEELCHAIR	( )	☐ YES ☐ NO

8A. ALLERGIES	8B. WEIGHT	8C. TEMPERATURE	8D. PULSE	8E. RESPIRATION	8F. B/P	8G. DUE TO INJURY
NKA	143	98.8	81	18	105/69	☐ NO ☐ YES

9. CURRENT MEDICATIONS C/O RLQ abd pain. HHO pelvic adhesions. HHO ganglion cyst on Rt wrist. C/O numbness R/O depression also. To U.C. K Jones

10. TRIAGE 0915 - S/O C/O RLQ pain for past 2 wks. Has been suicidal at times but is not now. Depression present for past 1½ wks.
P- Refer to psychology + Dr. Hill

11. SIGNATURE Pamela Aiken

12. HISTORY AND PHYSICAL Also - has been having headaches every day for over 1 year - taking Tylenol. - Rx tension H/a - tx at Keesler.

Having Pelvic pain Some on & before when last Hysterectomy 87
Pain RLQ, Has Nausea, Smells Diarrhea Some days.
Nausea last few days, last 2 wks. This onset last more so now,
No Vaginal discharge, Had Appendectomy at Some time, Had Blt tuboplasty
Ganglion Cyst Rt wrist 4 Sinkeys, Headaches, goes to mental health.
Request to see due to depression and alcohol problem. Last pelvic 1-2 yrs
2 partners, no dysuria, last lab 1 yr ago - 1 child age 16 Son here
Heart Heart Lungs Neg. Skin pale Abdomen Soft Tender LRQ
Bleeds Rt Left Tender, Had C.T. Xrays and Sonogram Neg.

13. DIAGNOSTIC IMPRESSIONS Hx Pelvic Adhesions

14. PLAN Lab CBC, Chem 10, U/A
513 Psychology
513 Bone
RTC Thursday - Keesler
Phenergan 25g + 10 PRN

15A. ATTENDING OF RECORD

15B. EXAMINER'S SIGNATURE

SECTION II - FOR PATIENT

1. DISPOSITION / CLINIC APPOINTMENT	2. AFTER CARE SHEET GIVEN	3. FOLLOWUP - ACTIVITY - LIMITATIONS
	☐ YES ☐ NO	

4. CONDITION	5. DATE / TIME OF DISCHARGE	6. SIGNATURE TO INDICATE INSTRUCTIONS GIVEN
☐ IMPROVED ☐ SATISFACTORY ☒ UNCHANGED		

IMPRINT PATIENT DATA CARD

Dove Gayle
[redacted]

7. PATIENT INSTRUCTIONS

I CERTIFY THAT I RECEIVED AND UNDERSTAND THESE INSTRUCTIONS	8. PATIENT'S SIGNATURE

VA FORM MAR 1992 **10-10M** SUPERSEDES VA FORM 10-10M, MAY 1990, WHICH WILL NOT BE USED.

Radiology Diagnostic Report
VETERANS ADMINISTRATION MEDICAL CENTER
Division: Biloxi, MS (CONS)

NAME: DOVE,GAYLE A [redacted]
DATE OF EXAM: JUN 29,1995 09:39
REPORTED : JUN 30,1995
TRANSCRIBED : JUN 30,1995 13:39

CASE: 824
REQUESTED BY: AMDALL,ROBERT O
TECHNOLOGIST: SUTHERLIN,CONSTANCE D.
AGE: 37 SEX: FEMALE
WARD/CLINIC : C&P AMDALL

PROCEDURE : CHEST, TWO VIEW

Exam Modifiers : None

Clinical History:
ROUTINE COMP & PENSION EXAM

Report:
CHEST:

There is no acute infiltrate. The heart, mediastinum, and diaphragm appear normal. The bone structure is unremarkable.

Impression:
No acute disease. No change since 3/30/95.

Films were read by QUAN HUU HA (Staff Physician).

/SDB

NAME: DOVE,GAYLE A WARD/CLINIC: C&P AMDALL
SSN : [redacted]

VISN 16 SOTA VICS OF 5108 RADIOLOGY REPORT

FORM 10-1338 **OUTPATIENT FILE COPY**

BILOXI/GULFPORT VAMCCLINICAL LABORATORY REPORT

DOVE,GAYLE A 07/05/95 9:52

SSN: [redacted] SEX: F AGE: 37 LOC: C&P AMD

Ordered By: AMDALL,ROBERT O

Specimen: SERUM. CC 0705 64

07/05/95 07:00

Test name	Result	units	Ref. range
GLUCOSE	105.	mg/dL	62 - 128
CREATININE	0.8	mg/dL	.5 - 1.4
UREA NITROGEN	11.	mg/dL	9 - 21
ANION GAP	16.0	meq/L	
URIC ACID	3.2 L	mg/dL	3.5 - 8.5
TRIGLYCERIDE	199. H	mg/dL	40 - 180
SODIUM	143.	M MOL/L	137 - 145
POTASSIUM	4.4	M MOL/L	3.6 - 5
CHLORIDE	103.	M MOL/L	101 - 111
CO2	23.6	M MOL/L	22 - 31
PO4	3.7	mg/dL	2.4 - 4.4
CALCIUM	10.2	mg/dL	8.4 - 10.2

KEY: 'L'=Abnormal low, 'H'=Abnormal high, '*'=Critical value

Radiology Diagnostic Report
VETERANS ADMINISTRATION MEDICAL CENTER
Division: Biloxi, MS (CONS)

NAME: DOVE,GAYLE A
SSN : [redacted]
DATE OF EXAM: JUN 29,1995 09:39
REPORTED : JUN 30,1995
TRANSCRIBED : JUN 30,1995 13:40

CASE: 826
REQUESTED BY: SOLOMON,JAMES W.
TECHNOLOGIST: SUTHERLIN,CONSTANCE D.
AGE: 37 SEX: FEMALE
WARD/CLINIC : C&P ENT SOLOMON

PROCEDURE : SINUS SERIES

Exam Modifiers : None

Clinical History:
C&P EXAM SINUSITIS

Report:
SINUS SERIES:

There is no evidence of fracture. The sinuses are clear. No osteoblastic or osteolytic lesion is noted.

Impression:
Normal sinuses.

Films were read by QUAN HUU HA (Staff Physician).

/SDB

Radiology Diagnostic Report
VETERANS ADMINISTRATION MEDICAL CENTER
Division: Biloxi, MS (CONS)

NAME: DOVE,GAYLE A
SSN : [redacted]
[redacted]OF EXAM: FEB 13,1995 12:22
REPORTED : FEB 14,1995
TRANSCRIBED : FEB 14,1995 09:48

CASE: 314
REQUESTED BY: DIAZ,ALBERT L
TECHNOLOGIST: ZEIMET,BARBARA
AGE: 37 SEX: FEMALE
WARD/CLINIC : GYNECOLOGY CLINIC

PROCEDURE : CHEST, TWO VIEW

Exam Modifiers : None

Clinical History:
PRE OP

Report:
CHEST - Two views of the chest demonstrated no acute infiltrate. The heart, mediastinum, and diaphragm appear normal. The bone structure is unremarkable.

Impression:
1. No acute disease. 2. No changes since 1/16/95.

Films were read by QUAN HUU HA (Staff Physician).

/STC

NAME: DOVE,GAYLE A
SSN : [redacted]
WARD/CLINIC: GYNECOLOGY CLINIC

BLOOD BANK TEST REPORT

Patient	SSN	Birth Date	ABO Rh
DOVE,GAYLE A	[redacted]	[redacted]	O POS

No UNITS assigned/xmatched

No component requests

Date/time	ABO Rh	AHG(direct) POLY IgG	AHG(direct) C3	AHG(direct) Interpretation	AHG(indirect) (Antibody screen)
03/12/95 12:00	O POS				Neg

FORM 10-1338 **OUTPATIENT FILE COPY**
BILOXI/GULFPORT VAMCCLINICAL LABORATORY REPORT

DOVE,GAYLE A 09/21/94 12:37
SSN: [redacted] SEX: F AGE: 37 LOC: OPT

Ordered By: HILL,JAMES F

Specimen: BLOOD, HE 0921 78
09/21/94 11:20

Test name	Result	units	Ref. range
WBC	6.8	#/cmm	4.8 - 10.8
RBC	4.35	#/cmm	4.2 - 5.4
HGB	13.6	g/dl	12 - 16
HCT	41.3	%	37 - 47
MCV	94.9	fL	81 - 99
MCH	31.3 H	pg	27 - 31
MCHC	33	g/dl	32 - 36
RDW	12.8	%	11.5 - 14.5
PLT	271	#/cmm	130 - 400
MPV	7.9	fL	7.4 - 10.4
LYMPH%	29.1	%	20.5 - 51.1
NEUTRO%	65.3	%	42.2 - 75.2
MONOS%	3.7	%	1.7 - 10
EOSINO%	1.4	%	0 - 11
BASO%	.5	%	0 - 2
NEUTRO#	4.4	#/cmm	1.4 - 6.5
LYMPH#	2	#/cmm	1.2 - 3.4
MONOS#	.3	#/cmm	.1 - .7
EOSINO#	.1	#/cmm	0 - .7
BASO#	0	#/cmm	0 - .2

KEY: "L"=Abnormal low, "H"=Abnormal high, "*"=Critical value

09/29/94 11:00

SATP INDIVIDUAL THERAPY
VET WAS EARLY, APPROPRIATED GROOMED AND UPBEAT. DISCUSSED STATUS OF MARITAL PROBLEMS. HUSBAND IS RETURNING HOME FROM TDY AND WANTS TO TALK ABOUT THE MARRIAGE AND DECIDE IF RECONCILATION IS POSSIBLE. PATIENT DIDN'T APPEAR DISTRESSED OVER THE SITUATION. SAID SHE IS UNSURE OF HER FEELINGS. MEDICAL PROBLEMS CONTINUES. MEDICATION FROM OB/GYN, IF PROBLEM IS NOT CLEARED UP, SURGERY MAY BE REQUIRED. REFERENCE SCREENING CONSULT. VET ACKNOWLEDGED CONSUMING 2 BEERS A COUPLE OF DAYS AGO. HAS AGREED TO ABSTAIN. ENCOURAGED TO ATTEND AA. PROVIDED A SCHEDULE OF MEETINGS. WOULDN'T FIRMLY COMMIT TO ATTENDING.
ASSESSMENT: VET NEEDS TREATMENT BUT IS PLAYING ALCOHOLIC GAMES. PLAN: ENTER INPATIENT TREATMENT NEXT WEEK AS SCHEDULED. BRIEFED VET ON PROCEDURES AND ITEMS TO BRING.

/es/ ALVIN L DYKE
ADDICTION THERAPIST, NCADC 09/29/94 11:58

1/28/94 10:00

SATP INDIVIDUAL THERAPY
VETERAN WAS ON TIME FOR THE SATP AFTERCARE SESSION. AFFIRMED HER SOBRIETY. STATES SHE IS ATTENDING AA DAILY. HER TEMPORARY SPONSOR HAS AGREED TO BECOME HER PERMANENT SPONSOR. FEEDBACK INICATES SHE IS WORKING STEP 3 AT THIS TIME. INQUIRED ABOUT HER DOMESTIC SITUATION. SHE STATED THAT HER HUSBAND IS RECONSIDERING GETTING A DIVORCE. SHE IS NOT SURE THAT STAYING TOGETHER IS A GOOD IDEA. AFRAID HE MAY THREATEN HER WITH DIVORCE AGAIN. SAID SHE'S HAD DIFFICULTY BECAUSE SO MUCH OF IT WAS HER FAULT. CONCERNED ABOUT HIS DESIRE TO ATTEND AA WITH HER. SAYS HE NOT INTERESTED IN ATTENDING ALANON AS SUGGESTED. PATIENT DECIDED TO TALK WITH HUSBAND IN ORDER TO ARRANGE A DATE AND TIME TO BE SEEN IN THIS CLINIC. TALK ABOUT PATIENT SEEING CLINIC SOCIAL WORKER AND ENTERING SATP RELAPSE PREVENTION GROUP. SHE WAS RECEPTIVE TO BOTH.

O: OUTWARD APPEARANCE WAS GOOD. COMMUNICATED WELL THROUGHOUT THE SESSION.

A: PATIENT APPEARS TO BE WORKING A GOOD RECOVERY PROGRAM THROUGH ACTIVE PARTICIPATION IN AA. STILL HAS CONSIDERABLE DOMESTIC PROBLEMS THAT ARE UNRESOLVED. MARITAL THERAPY CONSIDERED APPROPRIATE.

PLAN: PATIENT SCHEDULED TO SEE SATP SOCIAL WORKER AND START RELAPSE PREVENTION GROUP SESSION NEXT WEEK. SHE WILL TALK WITH HUSBAND AND CONTACT THIS ADDITICTION THERAPIST FOR A COUPLE'S SESSION ASAP.

/es/ ALVIN L DYKE
ADDICTION THERAPIST, NCADC 11/28/94 10:55

12/05/94 09:00 SATP F/U

Veteran reported for appointment, as scheduled. Chart was not available for scheduled appointment. She reports attending AA meeting in the community and having a sponser. Since last contact, there was an expresssed desire by her spouse to try reconciliation, however she feels there was a less than genuine effort on his part and the prospect for survival of there marriage deminishes daily. Her spouse has acknowledged three episodes of infidelity and she is angry. There is a lack of trust with little potential for change. She is making satisfactory progress and willing to take advantage of all available recovery resources. Her father is very supportive. There are unresolved sexual trauma issues and veteran will be referred to Dr. DeRoma for evaluation, after next visit. An appointment has been schedule in two weeks. Will see PRN for crisis.

/es/ GUS RIVERS, MSW, CSW
SOCIAL WORKER, MHC-SATP 12/05/94 10:32

MEDICAL RECORD — Progress Notes

11/18/94 10:00

SATP INDIVIDUAL THERAPY

S: VETERAN WAS ON TIME FOR HER INITIAL AFTERCARE APPOINTMENT. STATES SHE STILL RESIDES WITH HER HUSBAND AND FATHER. STILL PENDING DIVORCE. STATED HER HUSBAND IS ALLOWING TIME TO RESOLVE HER MEDICAL PROBLEMS BEFORE GOING THROUGH WITH THE DIVORCE. STATES HE WILL BE TDY TO SOUTHWEST ASIA FOR SEVERAL MONTHS. STATED HE FATHER IS A RECOVERING ALCOHOLIC WITHOUT AA. HE HAS BEEN ABSTINENT FOR 7 YEARS. SHE AFFIRMED GOING TO AA DAILY SOMETIME TWICE A DAY SINCE COMPLETING THE PROGRAM. ENCOURAGED HER TO CONTINUE AA. INITIATED TREATMENT PLAN. SHE WILL BE SEEN IN THE MHC/SATP OUTPATIENT CLINIC PARTICIPATING IN GROUP AND/OR INDIVIDUAL SUPPORTIVE THERAPY SESSIONS. POSSIBLE REFERRAL FOR PARTICIPATION IN A LOCAL VA SATP WOMEN'S GROUP. SHE HAS AGREED TO PARTICPATE IN AA 7 TIMES A WEEK.

O: OUTER APPEARANCE HAS IMPROVED SINCE INITIAL SCREENING, HAIR STYLED AND WEARING MAKEUP. GOOD EYE CONTACT. COMMUNICATED WELL BUT TENDS TO HOLD BACK ON OBVIOUS RESPONSES NECESSITATING FOLLOW UP QUESTIONS.

A: VET FOLLOWING THROUGH ON AA AND HAS A SPONSOR. PERCEIVE SOME GAME PLAYING IN ATTEMPT TO ASSESS THIS THERAPIST. MARTIAL SITUATION IS DYSFUNCTIONAL AND ON GOING. HAS MEDICAL PROBLEMS AND MAY BE PENDING ADDITIONAL SURGURY. CONSIDERED HIGH RISK FACTOR FOR SLIP DESPITE ACTIVE AA INVOLVEMENT.

P: CONTINUE IN AFTERCARE CONTACT. INDIVIDUAL SESSION SCHEDULED. WOMEN'S GROUP MAY NOT START UNTIL 01/01/95. DETERMINE WHICH REGIMEN IS APPROPRIATE, I.E. RELAPSE PREVENTION GROUP OR INDIVIDUAL SESSIONS. IF

/es/ ALVIN L DYKE
ADDICTION THERAPIST, NCADC 11/18/94 13:35

[redacted]

10/28/94 14:29 PATIENT EDUCATION PHARMACY
This patient has received instructions regarding the proper use of the drug(s):

DISULFIRAM

Instructions included:
Name and description of medication.
Dosage form, dose, route of administration, and duratio of therapy.
Intended use and expected action.
Special directions and precautions for the preparation administration and use by the patient.
Common adverse effects of interactions, and therapeutic contraindications that may be encountered, their avoidance and the action required if they occur
Techniques for self monitoring drug therapy.
Proper storage.
Prescription refill information.
Action to be taken in event of a missed dose.

Comments:

The patient understands and intends to comply with instructions.

/es/ DENNIS M JR LANDRY
R.PH. 10/28/94 14:29

10/28/94 14:36 GENERAL NOTE
SATP EDUCATIONAL NOTE: This patient has attended a class in RESPONSIBLE USE OF MEDICATIONS IN SOBRIETY, sponsored by Pharmacy Service. The purpose of this class is to assist the patient in the avoidance of both over-the-counter and prescription medications that could lead to relapse. It also provides information regarding the selection of products that are safe to use, as well as non-pharmaceutical methods to alleviate certain minor but uncomfortable health related problems. There was a question and answer session at the end of the class to aid the patient in comprehending the subject matter.

/es/ DENNIS M JR LANDRY
R.PH. 10/28/94 14:37

FORM 10-1338 **OUTPATIENT FILE COPY**

BILOXI/GULFPORT VAMCCLINICAL LABORATORY REPORT

DOVE,GAYLE A 09/21/94 13:39

[redacted] F AGE: 37 LOC: OPT

Ordered By: HILL,JAMES F

Specimen: SERUM, CC 0921 121
09/21/94 11:20

Test name	Result	units	Ref. range
GLUCOSE	81.	mg/dL	62 - 128
CREATININE	0.7	mg/dL	.5 - 1.4
UREA NITROGEN	8. L	mg/dL	9 - 21
ANION GAP	10.0	meq/L	
URIC ACID	4.3	mg/dL	3.5 - 8.5
TRIGLYCERIDE	248. H	mg/dL	40 - 180
SODIUM	138.	M MOL/L	137 - 145
POTASSIUM	4.3	M MOL/L	3.6 - 5
CHLORIDE	101.	M MOL/L	101 - 111
CO2	27.0	M MOL/L	22 - 31
PO4	4.4	mg/dL	2.4 - 4.4
CALCIUM	9.8	mg/dL	8.4 - 10.2

KEY: 'L'=Abnormal low, 'H'=Abnormal high, '*'=Critical value

FORM 10-1338 **OUTPATIENT FILE COPY**
BILOXI/GULFPORT VAMCCLINICAL LABORATORY REPORT

[redacted]

Ordered By: HILL,JAMES F
Specimen: URINE. URINE 0921 29
07/21/94 11:20

Test name	Result	units	Ref. range
URINE SG	1.015		1.015 - 1.025
URINE pH	5.5		5 - 9
URINE UROBILINIGEN	.2	EU/dl	.2 - .2
LEUKOCYTE ESTERASE	NEG		Neg.
CLARITY	CLEAR		
COLOR	YELLOW		
URINE BILIRUBIN	NEG		Neg.
URINE KETONES	NEG		Neg.
URINE GLUCOSE	NEG		Neg.
URINE PROTEIN	NEG		Neg.
URINE BLOOD	NEG		Neg.
URINE NITRITE	NEG		Neg.

Comment: URINE MICROSCOPIC NOT INDICATED

KEY: 'L'=Abnormal low, 'H'=Abnormal high, '*'=Critical value

AMBULATORY SURGERY

HISTORY & PHYSICAL EXAM

4/30/95
MOD

Diagnosis: Painful (R) groin incision
Possible neuroma VS stitch granuloma

Procedure Scheduled: (R) groin exploration

Date of Procedure: 4/30/95

Chief Complaint/History of present illness:
38 yo WF c painful (R) groin incision since release of pelvic adhesions performed in 3/95. Pain worse c hip flexion, straining. Here for exploration of incision.

Past History/Prior Surgeries:

PMH
Migraines
Ø HTN / ASCAD / DM

PSH
hysterectomy Abdominal 87
Ganglion cystectomy x4 (R)
Pelvic adhesion release 3/95

TYPE OF REPORT (Check one)

[xx] HISTORY & PHYSICAL EXAM SF 504, 505, 506 or VAF 10-7978A, B, D AND E)
[ ] DISCHARGE SUMMARY (VAF 10-1000 & A)
[ ] CONSULTATION SHEET (SF 513)
[ ] OTHER (Specify)
[ ] OPERATION REPORT (SF 516)

SIGNATURE OF PHYSICIAN/DENTIST

PATIENT'S NAME

SOCIAL SECURITY NUMBER | DATE OF BIRTH

VAMC

WARD/SERVICE | DATE DICTATED | DATE TYPED

VA FORM 10-9034B JULY 1994 MEDICAL RECORD REPORT

Risk Factors/Co-Morbidity: ϕ

Physical Exam (only pertinent positive or negative findings:
B.P. 130/74, P. 81, Wt. 143

WNWO WF in NAD A&O2S
HEENT: NC/AT PERRL, EOMI
LCTAB CV: RRR s m/G/R ϕ JVD, ϕ bruits
ABD: soft, NDNT, NABS ϕ masses/HSM
WHSS Pfannenstiel c palpable tender nodule
@ ⓡ later portion of incision

ϕCICIE

Adverse Durg Reactions/Allergies:

NKDA

Current Medications/Dose (attached computer printout):

Depo provera

Surgeon's Signature
MICHAEL D. ROLLER, M.D.
AS3286170-734

Department of Veterans Affairs

PRE OP ANESTHESIA INFORMED CONSENT

SURGICAL SERVICE

DATE\TIME: 1215 22Nov95 PATIENT COMPETENT: YES ✓ NO ____

BRIEF SUMMARY: 38yo white female for lt groin exploration, POS NKDA Smoker
NEGOH abuse Known. hx Pelvic adhesive disease, Migraine headache
hx depression. Pt prefers GETA

PATIENT CONDITION: A&Ox4
(i.e. awake, alert, sedated, anxious, confused, lethargic, unconscious, intubated, other)

PROPOSED PROCEDURE\TREATMENT PLAN: GETA

POSSIBLE RISKS\COMPLICATIONS: See Reverse

ALTERNATIVE TREATMENT IDENTIFIED TO PATIENT\GUARDIAN: Pt prefers GETA

Patient and\or guardian\next of kin has been given opportunity to ask questions:
Yes ✓ No ____

Patient and\or guardian\next of kin comprehends what has been proposed and why:
Yes ✓ No ____

Patient and\or guardian\next of kin has agreed and freely consented to the proposed procedure\treatment plan without duress or coercion: Yes ✓ No ____

ATTENDING ANESTHESIOLOGIST CONCURS with proposed\treatment plan: Yes ____ No ____

ATTENDING ANESTHESIOLOGIST NOTE: ____

CRNA\ANESTHESIA RESIDENT

ATTENDING ANESTHESIOLOGIST

SIGNATURE AND TITLE OF PRACTITIONER: Janice R Gould CRNA

DATE 22Nov95

IMPRINT PATIENT DATA CARD

DOVE, GAYLE A 23
4457 POPPS FERRY RD. LO 047
BILOXI MS 39532

[redacted]

C-SSN 1 080 8

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE
FOR SPECIALIZED DISCIPLINES

520-OP-132-112 FEBRUARY 1994

PREVIOUS STOCK OF VA FORM 10-0114i SEPT 1988

Anesthetic procedures may be associated with, but not limited to:

infection
hemorrhage (excessive bleeding)
drug reactions
blood clots
loss of sensation
loss of limb function
paralysis
organ damage
heart attack
stroke
loss of life
blood reactions (including rash, itching, nausea, vomiting & shock)

Other risks/complications associated with <u>General Anesthesia</u>

sore throat
hoarseness
shortness of breath
difficulty in breathing
injury to teeth
injury to eyes
injury to airway
injury to arteries or veins
awareness under anesthesia
pain or discomfort continuing after discharge from the hospital

Other risks/complications associated with <u>regional, spinal or epidural anesthesia</u>

pain or discomfort
injury to arteries or veins
residual pain
residual sensation
residual dysfunction
low blood pressure
headache
high blood pressure
seizure
failure of regional, spinal or epidural anesthesia & subsequent need for general anesthesia

Pt doesn't want

Steph A Dave

AMBULATORY SURGERY

PRE-OP NOTE - INFORMED CONSENT

RECEIVED BOOTED N.D.

DATE/TIME: 11/22/95 1115

Diagnosis: (R) groin mass/pain

Neuroma vs protruding hernia

Brief Summary: 38 yo WF c Hx of abscess requiring I&D in 3/95. Pt now reports c pain @ (R) lateral incision and nodule. Now wishes to have mass removed.

Proposed Procedure/Treatment Plan: (R) groin exploration

Possible Risks/Complications: Bleeding, wound infection, recurrence of painful mass (neuroma)

SIGNATURE AND TITLE OF PRACTITIONER

SEE REVERSE

DATE

IMPRINT PATIENT DATA CARD (Name, Address and Social Security Number)

[redacted]

C-SSN 1 080 8

MEDICAL RECORD

SUPPLEMENT TO PROGRESS NOTE FOR SPECIALIZED DISCIPLINES-VERTICAL

[redacted] Revised July 1995

INFORMED CONSENT CONT.

Benefits: removal painful mass

Patient's condition: awake, alert, oriented, (i.e., awake, alert, sedated, anxious, confused, lethargic, unconscious, etc.....)

Alternative Treatment identified to patient/guardian: no treatment, excision of scar.

Next of kin/guardian: _____ Contacted: Yes _____ No ✓

NAME:

Patient ***Competent:*** Yes ✓ No _____

Do you have an Advance Directive? Yes _____ No ✓

Patient and/or guardian/next of kin has been given opportunity to ask questions:

Yes ✓ No _____

Patient and/or guardian/next of kin comprehends what has been propsed and why:

Yes ✓ No _____

Patient and/or guardian/next of kin has agreed and freely consented to the proposed procedure/treatment plan without duress or coercion: Yes ✓ No _____

Patient and/or guardian/next of kin has been informed of the Surgical Team:

Hamer	Roller	
Attending Staff	***Surgeon***	***Members***

Attending Surgeon concurs with proposed procedure/treatment plan: Yes ✓ No _____

Attending Surgeon Note: Discussed the pt and mother the use of pain. Agreed upon the procedure with Dr Roller.

Discharge Planning: Estimate date of discharge: 11/22/95 (Date)

Discharged to: Home ✓ NHC _____ IMC _____ Other: _____

~~Patient consulted to Social Work Service? Yes _____ No ✓~~

Special Requirements: none

MICHAEL D. ROLLER, M.D.
A93286170-734

Resident Surgeon **Attending Surgeon**

MEDICAL RECORD	PROGRESS NOTES
DATE 11/24/95 12N	Pre-op lab values (UA abn) CXR / EKG Reports reviewed by Dr Tilley - Orders Noted - R/x-2 taken to Pharmacy - Pt notified @ home of UTI + Infection and R/x in pharmacy - sexually active - to notify partner to be treated - Pt. Voiced understanding Bettye Hobson
11/29/95 0800	Pre-op Call spoke to pt. Concerning - NPO p MN - arrival time 0700 to designated Dunes NO questions - Voiced understanding Bettye Hobson

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)*

DOVE, GAYLE A [redacted] 25

[redacted]

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR(41CFR)201-45.505
509-111

PROGRESS NOTES

DATE	

*U.S. Government Printing Office: 1995 — 621-018/83004

MEDICAL RECORD | NURSE INTRAOPERATIVE REPORT PAGE 1

Operating Room: OR 1 Surgical Priority: ELECTIVE
Patient in Hold: NOV 30, 1995 07:45 Patient in OR: NOV 30, 1995 08:00
Operation Begin: NOV 30, 1995 08:45 Operation End: NOV 30, 1995 09:00
Patient Out OR: NOV 30, 1995 09:13

Surgeon: ROLLER,MICHAEL D First Assistant: N/A
Attending Surg: NEUMASTER,TERRY DAVID Second Assistant: N/A
Anesthetist: LINCOLN,JANIE B Assistant Anesth: N/A

Other Scrubbed Assistants: N/A

OR Support Personnel:

Scrubbed	Circulating
CORLEY,JAMES E	BAKER,VICKY

Other Persons in OR: N/A

Preop Mood: ANXIOUS Preop Consc: ALERT-ORIENTED
Preop Skin Integ: INTACT Preop Converse: N/A

Valid Consent/ID Band Confirmed By: BAKER,VICKY
Skin Prep By: BAKER,VICKY Skin Prep Agent: POVIDONE IODINE
Skin Prep By (2): BAKER,VICKY 2nd Skin Prep Agent: POVIDONE IODINE SC
Preop Shave By: BAKER,VICKY

Surgery Position(s): SUPINE Placed: N/A

Restraints and Position Aids:
SAFETY STRAP Applied By: N/A

Electrocautery Unit: YES
Electroground Position(s): RIGHT ANT THIGH

Major Operations Performed:
Primary: EXCISION PAINFUL KNOT IN INCISION CPT Code: NOT ENTERED

Material Sent to Laboratory for Analysis:
Specimens:
#1 PROLENE KNOTS FROM ABD INCISION
Cultures: N/A

Anesthesia Technique(s): N/A

Tubes and Drains:
NONE

Tourniquet: N/A

Thermal Unit: WARM TOUCH Temperature: 100
Time On: NOV 30, 1995 08:50 Time Off: N/A

Prosthesis Installed: N/A

Medications: N/A

Irrigation Solution(s):
NORMAL SALINE

Blood Replacement Fluids: N/A

Sponge Count: CORRECT
Sharps Count: CORRECT
Instrument Count: CORRECT
Counter: CORLEY,JAMES E
Counts Verified By: BAKER,VICKY

NURSE'S SIG: [signature] NOV 30, 1995@09:06
DOVE,GAYLE A [redacted]
WARD: ROOM-BED:
VAMC: Biloxi, MS (CONS) SF 509 PROGRESS NOTES

Dressing: 4X4 ELASTOPLAST
Packing: NONE

Blood Loss: 15 cc's Urine Output: 0 cc's

Postoperative Mood: RELAXED
Postoperative Consciousness: SEDATED
Postoperative Skin Integrity: SCAR
Postoperative Skin Color: N/A

Type of Laser: N/A
Sequential Compression Device: NO

Wound Classification: CLEAN/CONTAMINATED
Operation Disposition: PACU (RECOVERY ROOM)
Discharged Via: PACU BED

Nursing Care Comments:
PT TO OR TABLE /C MINIMAL ASSISTANCE. PT VERIFIES PROCEDURE AND DENIES ALLERGIES. BOTH ARMS PLACED ON WELL PADDED ARM BOARDS. ENTIRE OR TABLE COVERED /C GEL PAD. WARM TOUCH UPPER BODY WARMER USED DURING PROCEDURE. PT INTUBATED BY J LINCOLN CRNA /C BILL COOPER IN ATTENDANCE. PT TOLERATED THE PROCEDURE WELL. TRANSFERED TO PACU IN STABLE CONDITION. ABD DRESSING DRY AND INTACT.

NURSE'S SIG: [signature] NOV 30, 1995@09:06
DOVE,GAYLE A [redacted]
WARD: ROOM-BED:
VAMC: Biloxi, MS (CONS) SF 509 PROGRESS NOTES

AMBULATORY SURGERY
DAY OF SURGERY

VESSEL 10-13C
MICHAEL D. ROLLER M.D.

DATE/TIME:

11-30-95

0900

PRE-OP DIAG: Painful knot ABD. incision

FINDINGS: Prolene Knot

POST-OP DIAG: "

PROCEDURE: ABD. Incision Exploration & Prolene Knot Removal

ANES: Lincoln, J. General

SURGEON: Roller

ASST: Neumaster

BLOOD LOSS: 15cc

BLOOD: 0

FLUIDS: 1/R 650cc

DRAINS: 0

POST-OP COND: stable

SPECIMEN: #1 prolene knot from ABD incision

MICHAEL D. ROLLER, M.D.
AS3285170-734

Resident Signature

Attending Signature

*** For all EGD/Colonoscopy attach form - Date/Time/Sign Each

SIGNATURE AND TITLE OF PRACTITIONER — SEE REVERSE | DATE

IMPRINT PATIENT DATA CARD (Name, Address and Social Security Number)

[redacted]

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE FOR [redacted]

AMBULATORY SURGERY
DAY OF SURGERY
CONT.

Date/Time: 11/30/95 0900

Post-Op Notes: Pt ō pedline knots x2. Removed ō incident
Pt tolerated procedure well. Tx to PR → ASDU

[illegible]
MICHAEL D. ROLLER M.D.

Plan for Follow Up Care:

Clinic Visit: RTC 12/13/95

Further Treatment Indicated:

None

Follow Up Colonoscopy/EGD:

Discharge Note: Awake, alert, oriented. Tolerated po fluids and ambulation well. Pt to home.

MICHAEL D. ROLLER, M.D.
AS3285170-734

Signature:

MEDICAL RECORD ASOU PRE-OPERATIVE INSTRUCTION

You have been scheduled for Neuroma of Knee - 0700 Nov. 30th Thursday - 1-4E ASOU

1. **DO NOT** eat food or drink any liquids, including water, coffee, tea, juice or alcohol after 12 midnight the night before your surger If you routinely take medication for any condition, ask your surgeon or anesthesiologist whether to take it or to miss taking medicine the day of your surgery. (For example: insulin, blood pressure pills or heart medication). Take your medication with small sips of water. **DO NOT** take any aspirin, aspirin products, motrin, or ibuprofen one week prior to surgery.

2. **DO NOT** smoke, chew tobacco or dip snuff after 12 midnight the night before your surgery.

3. Failure to follow the above instructions could result in cancellation of your surgery.

4. You will need to bring your medications, that you take at home, with you the morning of your surgery.

5. **DO NOT** bring valuables or wear jewelry to the hospital. All jewelry must be removed prior to surgery. The hospital cannot be responsible for these items. You will be asked to remove your glasses, contact lenses, dentures/partials and hearing aides. Please bri the appropriate containers for these items.

6. You will be required to have a responsible adult of your choice licensed to drive and to accompany you from the unit to take you home at the time of discharge. You will be given sedation for the procedure and you will not be able to drive for 24 hours after the procedure for your safety. Your surgery will definitely be cancelled if there is not a designated driver with you. Your designated driver must wait in the waiting room at all times.

7. Remember to wear comfortable loose fitting clothing. Often after surgery, tight clothing will be uncomfortable an could create difficulty in getting dressed.

8. The night before your surgery, you must shampoo your hair with the shampoo of your choice. **DO NOT** use hair spray or other hai products. Take a bath or shower with soap, the night before and the morning of your surgery. **DO NOT** use powder, perfume, oils, deodorant, aftershave lotions. Remove nail polish. The morning of your surgery, you may brush your teeth and shave before your morning bath or shower.

9. Please **DO NOT** bring children with you. We do not have facilities or personnel for adequate supervision for your children.

10. If for any reason you cannot keep this appointment, please call (601)385-5752 or the operating room supervisor, beeper #648.

11. You must report to building 1, ward 1-4 East, Nurses station at the designated time above. If you are late, your surgery may be cancelled. Notify your doctor of any change in your physical condition, such as a bad cold or sore throat.

12. In case of an emergency, your procedure may be delayed. This is rare, but please be aware that this can occur.

Further Instructions: Skin Care
If any questions Call 385-5732 Monday-Friday 0730-1

LARRY J. FONTENELLE, M.D.
Chief, Surgical Service
Biloxi VA Medical Center

PATIENT'S SIGNATURE [signature] WITNESS' SIGNATURE [signature]

SIGNATURE AND TITLE OF PRACTITIONER [signature]

DATE 11/22/95 123

DAVE, GAYLE A 23 [redacted]
4457 PUPPY TERRY RD, BLDG
BILOXI MS 39532

IMPRINT PATIENT DATA PLATE (Name, Address and Social Security Number)

[redacted]

C-SSN 1 080 8

MEDICAL RECORD

SUPPLEMENT TO PROGRESS NOTE FOR SPECIALIZED DISCIPLINES-VERTICAL

[redacted] FEBRUARY 1994

11/30 Neuroma @ Ganglion

AMBULATORY SURGERY OBSERVATION UNIT
NURSING HISTORY AND ASSESSMENT

Chief Complaint/Reason for Surgery: Pain - Neuroma @ side genital Incision H:T: 5 6½ WT: 143 AGE: 38

Allergies: NKA

Anesthesia Reactions: Denies any BP: 123/73 P: 66R R: 20 T: 98.9

Past Surgeries: TAH - 87 - Ganglion cystectomy x4 - last 84 Pelvic adhesions 3/95

Present Medications: Ibuprofen - Depo Estradiol

Communication or Sensory Problems: Denies any

PHYSICAL DISABILITIES:

Arthritis	Yes ___	No ✓
Neuromuscular Coordination Problems	Yes ___	No ✓
Limb Loss	Yes ___	No ✓
Seizures	Yes ___	No ✓

Emotional Status: Calm ✓ Relaxed ___ Apprehensive ___

ELIMINATION:

Incontinence	Yes ___	No ✓
Indwelling Foley	Yes ___	No ✓
Ileostomy	Yes ___	No ✓
Colostomy	Yes ___	No ✓

Other: frequency

LEVEL OF CONSCIENCE:

Alert	Yes ✓	No ___
Oriented	Yes ✓	No ___
Confused	Yes ___	No ✓

Other: ___

PTSD
Migraine H/A Meds & Tylenol
Renal - ND
Hepatitis - ND
CVA - ND
Thyroid - ND

SKIN INTERGRITY:

Rashes	Yes ___	No ✓
Bruises	Yes ___	No ✓
Infections	Yes ___	No ✓
Cuts	Yes ___	No ✓
Edema	Yes ___	No ✓
General Problems	Yes ___	No ✓

Other: ___

NUTRITION:

N & V	Yes ___	No ✓
Feeding Tube	Yes ___	No ✓
Diabetic	Yes ___	No ✓
Hx of Ulcers	Yes ___	No ✓
ETOH Use	Yes ___	No ✓

TB Asthma > ND

CIRCULATION:

CHF	Yes ___	No ✓
Angina	Yes ___	No ✓
M.I.	Yes ___	No ✓
Arrhythmias	Yes ___	No ✓
Hx Vascular Dz	Yes Rt	No ✓
HTN	Yes ___	No ✓
Pacemaker	Yes ___	No ✓

TEETH:

Caps ↑ molars back	Yes ✓	No ___
Bridges	Yes ___	No ✓
Dentures	Yes ___	No ✓
Partial	Yes ___	No ✓
Broken	Yes ___	No ✓
Loose	Yes ___	No ✓

PULMONARY:

Smoker 1 pk/d 25 yrs	Yes ✓	No ___
Recent URI	Yes ___	No ✓
COPD	Yes ___	No ✓
Tracheostomy	Yes ___	No ✓
O2 Adm.	Yes ___	No ✓

Other: ___

MISCELLANEOUS:

Prosthesis	Yes ___	No ✓
Contact Lens	Yes ___	No ✓
Hearing Aid	Yes ___	No ✓
Artificial Eye	Yes ___	No ✓
Eye Glasses	Yes ___	No ___

Other: ___

PRE-OP TEACHING

Signed Pre-op instructions: Yes
Peri-operative care: Yes
Approximate time in OP/OR/RR: Yes
Instructed on prep/video: Verbal
Prep Kit given: Skin care
Waiting area: Family or S.O. father
Phamplets: Written
Must have designated driver: Yes
Questions answered: Yes
Home Phone Number: 396-1919

DISCHARGE PLANNING

Do you care for yourself at home? Yes ✓ No ___
Who will help you? family
Does anyone depend on your care at home? Yes ___ No ✓
VA Consult — Physical Therapy — NCF —
Home Health — Transportation —
Social Services Indicated: Yes — No ___
Education Needs: activity, Skin Care

Gayle A. Dove
PATIENT SIGNATURE:

Betsy Hudson
NURSE SIGNATURE:

DATE/TIME: 11/22/95 1230

NURSING ASSESSMENT

Designated Driver: Father Ray

Time admitted to ASOU 0700 NPO Since: MN Mode of arrival: Ambulatory: ✓ W/C: ___ Stretcher: ___ Other: ___

Physician: Neumaster Disposition of valuables: to locker / father

Skin: warm, dry, pink Circulation: pulses palpable to all extremities Nutrition/Hydration: WNWF & good skin turgor

Sensory: No Δ Skeletal: MAEW, steady gait Elimination: BM x1 yesterday & active BS x4

Ventilation: Lungs Clear bilat & comp Neuro: grasp & set foot flexion bilat equal Psychosocial: alert & oriented x 3, calm, cooperative; appropriate affect

NOTES: Tolerable pain level "2-3"

SIGNATURE AND TITLE OF PRACTITIONER: Joanne Dominguez DATE: ___

IMPRINT PATIENT DATA CARD (Name, Address and Social Security Number)

DOVE, GAYLE A
4457 POPPS FERRY
BILOXI
[redacted]

CASE 1 [redacted] 8

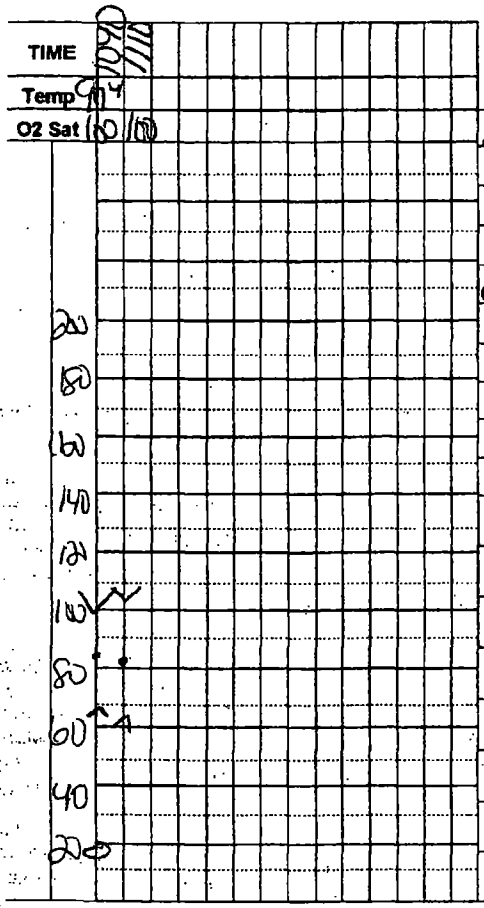
MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE FOR SPECIALIZED DISCIPLINES-VERTICAL
[redacted] FEBRUARY 1994

OBSERVATION AND DISCHARGE NOTES

Arrival Time: 1035
Procedure: Suture removal
IV Solution: NA
LTC: 100
Site: (L) hand

Marital Status: M
Alert: ✓ Drowsy:
Dressing: Lower abdomen
Dry: ✓ NA:
Drainage: Ø
NSR: ✓

Drain: Burning No ✓ Yes
Pain: No ✓ Yes
Nausea: No ✓ Yes
CM: No ✓ Yes
Oximetry: No Yes ✓
Other:



NURSES NOTES

SR's Increased ✓ Family Present ✓ Up in Chair ✓ Amb to BR ✓

A+O x 3, Bil. breath sounds clear, abd soft ± active bowel sounds, dsg to lower abd clean ± dry, skin warm & dry, equal resp, pulses present x4. Ch burning sensation at incision. Dr aware

MEDICATION RECORD

Time	Medication	Dose	Route	Site	Given by:

Intake	Output
IV: 120	Urine: voided
PO: 120	Emesis: Ø

DISCHARGE SUMMARY AND INSTRUCTIONS

Return Time: 1035
VS: 104/64 83 16 96
Discharge Time: 1300
Alert-Oriented: Yes ✓ No
Tolerated Fluids: Yes ✓ No
Pain: Yes ✓ No

Nausea: Yes No ✓
IV DC'd: @ 1120 # Intact: 18G
fids. abs. 120
Dressing: Dry: ✓ NA:
Drainage: Ø
Drain: NA: ✓ DC'd:
Intact on discharge:
Voided: Yes ✓ No Urge Discomfort
Valuables returned: Yes ✓ None

Verbalized-demonstrated understanding of discharge instructions: Yes ✓ No
Copy of instructions given: Yes ✓ No
RX given: Yes ✓ No
Mode of discharge: WC
Discharged with: Foley
By: Car: Other:
Nurse: Adam Cullen

POST-OPERATIVE

Follow-Up: Phone Yes: ✓ No Phone: No Answer:
DATE/TIME: 12-1-95 @ 0915 Problems Noted: none stated
Recommendations: Continue F/U & Gen Surg, Call for any complaint or concern directly to ER
Signature: Jeanne Dennis RN

AMBULATORY SURGERY - GENERAL SURGERY INSTRUCTION

Department of Veterans Affairs

MEDICAL RECORD - DISCHARGE INSTRUCTIONS

DATE OF ADMISSION	DATE OF DISCHARGE	TYPE OF DISCHARGE
11/30/95	11/30/95	home

1. DIAGNOSES AND DATE TO BE FOLLOWED ON OUTPATIENT SERVICES

DX: Prolene knots x2 excised

SURGEON: Roller ATTENDING STAFF: Neumaster

F/U Apot: Date/Time 12/13/95 @ 10h Clinic: Surgery VA Phone #(601)388-5541 Ext: 5693

If you are unable to keep your appointment, please call and reschedule.

2. SUGGESTED PLAN FOR FOLLOWUP

Keep bandage on wound for 48 hours. Keep dry. Remove bandage after the first 48 hours. Wash hands with soap and water before removing. If any redness, swelling, drainage, excessive bleeding, bad oder or extreme pain at wound site or temperature greater than 100 degrees Fahrenheit orally, call Dr. Roller at 388-5541. Have the operator page him/her. Tell him/her your symptoms or you may come directly to the emergency room.

3. DISCHARGE MEDICATIONS AND INSTRUCTIONS

MEDS: Resume routine medicine.

Instructions: Tylenol #3 for pain - take with food.

4. DISCHARGE DIETARY INSTRUCTIONS *(Check one)*

☒ NO RESTRICTIONS ☐ RESTRICTIONS *(Specify and include drug and food interactions)*

Start diet gradually with liquids, then resume previous diet as tolerated. Call Dr. Roller if nausea and/or vomiting more than 12 hours.

5. PHYSICAL ACTIVITY LIMITATIONS *(Check one)*

☒ NO RESTRICTIONS ☐ RESTRICTIONS *(Specify)*

No driving or operating anything that requires coordination for 24 hrs.
It is necessary to have a responsible adult with you for 24 hours following surgery.
Specific: Sponge bathe for first 48 hours. After that, if wound healing well, you may bathe as usual.

6. OTHER *(Include employment status)*

May return to Work on Monday

PATIENT IDENTIFICATION *(Name, Address, Social Security Number)*

DOVE, GAYLE A 25
4457 POPPS FERRY RD. LO 047
BILOXI MS 39532
[redacted]
C-SSN 1 000 0

SIGNATURE OF PHYSICIAN/DENTIST: MICHAEL D. ROLLER, M.D. AS3285170-734 DATE: 11/30/95

I HAVE RECEIVED AND UNDERSTAND MY DISCHARGE INSTRUCTIONS

SIGNATURE OF PATIENT: Gayle A Dove DATE: 11-30-95

Standard Form 507 — 648—16—81472-3 SFO

CLINICAL RECORD	Report on AMBULATORY SURGERY OBSERVATION UNIT or POST OP PHONE CONTACT Continuation of S. F. _____ (Strike out one line) (Specify type of examination or data)

(Sign and date)

SPOKE WITH father DATE/TIME 12-1-95@0915

TYPE OF PROCEDURE/SURGERY fx. sutures from abd. incision NO ANSWER _____

POST EVALUATION	YES	NO	NA	COMMENTS
Is the Dressing Dry? IV Site? WNL	✓			
Did You have Nausea or Vomiting?		✓		
Did You Sleep Well?	✓			
Did You Have Pain? Did You Take Pain Medication? Did It Help?	✓			pain med x 1 c adequate relief
Did You Have Any Circulation Problems? (If Appropriate)			✓	
Are You Having Any Problems with Crutches, Sling, ETC?			✓	
Did You Have to Call SDP Unit, Clinic, or ER for problems? If so, Did They Respond?		✓		
Could We Have Done Anything to Make Your Stay with Us More Pleasant?		✓		
Appointment or Follow-up?	✓			12-13-95 @ 1010
Evaluation Card	✓			

DOVE, GAYLE A 25
4457 POPPS FERRY RD.LO 047
BILOXI [redacted]

(Continued on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name (last, first, middle; grade; date; hospital or medical facility)

[redacted] [redacted]

[redacted] 1 [redacted]

Nurse's Signature [signature] RN

REGISTER NO. _____ WARD NO. 8 ASOU

REPORT ON _____ or CONTINUATION OF _____

STANDARD FORM 507
General Services Administration and Interagency Committee on Medical Records
FIRMR (41 CFR) 201-45.505
October 1975 507-107

[redacted]

*U.S. GPO:1992-624-458/60127

Department of Veterans Affairs | **MEDICAL RECORD - NURSING DOCUMENTATION**

SURGICAL CHECKLIST

(Check if accomplished)

- ✓ Patient has ID armband on
- ✓ Consent completed
- Ø Op Report (SF 515) on chart
- ✓ Tissue Examination (SF 515) on chart
- ✓ Most current COMBINED MEDICAL RECORD available
- Ø Type and [screen/cross] accomplished (if ordered)
- Ø Units of blood available Ø (number)

Allergies/Drug Sensitivities (according to Doctor's order):

NKA

Ø Patient has red armband on

Pre-op lab/cxr/ekg (must be accomplished within 30 days of surgery)

- 11-22 CXR - - - - - - - - - - - [Results on chart/not available/in computer]
- 11-22 EKG - - - - - - - - - - - [Results on chart/not available/in computer]
- 11-22 URINALYSIS - abn - - - - [Results on chart/not available/in computer]
- 11-22 CBS - abn - - - - - - - - [Results on chart/not available/in computer]
- 11-22 LYTES - - - - - - - - - - [Results on chart/not available/in computer]
- OTHER: UA Stat 1130 [Results on chart/not available/in computer]
- _____ [Results on chart/not available/in computer]
- _____ [Results on chart/not available/in computer]

(over)

ENTER IN SPACE BELOW - PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. (Continue on Reverse)

DOVE, GAYLE A [redacted]
4457 PORPS FERRY RD. LO 047
BILOXI MS 39532
S[redacted]
C-SSN 1 080 8

MEDICAL RECORD
[redacted]

VA FORM FEB 1990 **10-0096** EXISTING STOCKS OF VA FORM 10-0096, SEP 1985, WILL BE USED.

*U.S. Government Printing Office: 1991 — 282-804/46006

ON CALL TO OR:

Physical disabilities: None

Pre-op and post-op teaching accomplished
Most current COMBINED MEDICAL RECORD with patient
Patient data card on chart
Medication sheets on chart
Betadine AM/PM showers accomplished
NPO after midnight
Voided (within one hour pre-op)

REMOVE THE FOLLOWING:

- ✓ Dentures
- ✓ Jewelry
- ✓ Wig/Hairpiece
- ✓ Glasses/Contacts
- ✓ Prosthesis
- ✓ Hearing Aid
- ✓ Make-up
- ✓ Nail polish
- ✓ Hairpins

Repeat U/A

Temp 99'
Pulse 76
Weight 143

Respirations 18
BP 96/56

Pre-op medication on chart MA
Pre-op medication to be given (on call) MA

Pre-op medication given by: MA
(signature)

(date/time)

Patient identified to OR by: Joanne Dominguez
(signature)

12-30 95 @ 0735
(date/time)

MEDICAL RECORD | ANESTHESIA REPORT

Preop Status: 2-MILD DISTURB. Operating Room: OR 1
Principal Operation: EXCISION PAINFUL KNOT IN INCISION
Anesthesia Technique(s):
GENERAL (PRINCIPAL)
Agents: ISOFLURANE
FENTANYL .25 mg
MIDAZOLAM 3 mg

Intubated: YES
Approach: DIRECT VISION LARYNGOSCOPY Route: ORAL
Laryngoscope Type: MACINTOSH
Laryngoscope Size: 3
Stylet Used: NO
Lidocaine IV: YES
Tube Type: PVC LOW PRESSURE Tube Size: 7
Trauma: NONE
Extubated In: OR Extubated By: BARCLAY,VIVEK
Heat, Moisture Exchanger Used: YES
Bacteria Filter in Circuit: YES
Anesthesia Start: NOV 30, 1995 08:00 Anesthesia Stop: NOV 30, 1995 09:20
Anesthetist: LINCOLN,JANIE B Relief Anesth:
Anesthesiologist: BARCLAY,VIVEK
Assistant Anesth: Min Intraoperative Temp:
Blood Replacement Fluids:
RINGERS LACTATED SOLUTION Quantity: 900 cc's
Intraoperative Blood Loss: 15 cc's Urine Output: 0
Operation Disposition: PACU (RECOVERY ROOM)
PAC(U) Admit Score: PAC(U) Discharge Score:
Postop Anesthesia Note:

ANESTHETIST'S SIG: James B Lincoln CRNA NOV 30, 1995@09:18:23
DOVE,GAYLE A [redacted]
WARD: ROOM-BED:
VAMC: Biloxi, MS (CONS)

Standard Form 517

OR #1

CLINICAL RECORD — ANESTHESIA

NKDA

ANESTHETIC(S): VERSED/ANAPSINE / AMB/KAPENTROF / D.T.C./ANECTINE / NORC/TRAC/PAV / ADR/FENT/BUF

ETH/FOR / AIR/N2O / OXYGEN / CO2 ABSORP.

LEVEL OF ANAL-ANES.

EKG / FIO2 / SaO2 / TEMP SK/ESO

0800 30 45 0900 15 30 HOUR 45 1000 15 30 45 1100

CODE: ● PULSE ○ RESP. V/^ B.P. X ANES. ⓞ OPER. T TOURN.

CVP / PAP / PCWP / IND/CO

220 200 180 160 140 120 100 80 60 40 20

T.V. / R / PIP

FLUIDS: B BLOOD / N SALINE / G 5% G/W / EXPAND

NUMBERS FOR REMARKS

IV FLUIDS: CR 1000 — CORTISL 18 cc CA

POSITION

EBL: Foley

INDUCTION

SATIS ✓

UNSATIS AND WHY

REMARKS

X 0800 E 0920

Os 0845 E 0900

(1) ID, ALL EQUIP. ✓ & O.K. MONITORS APPLIED Chantachews

(2) TO OR #1

(3) IV started c diff fair acces

(4) Intubation EBBS: 8831

(5) Reversal Neostigmine 3mg Versed Robinule .6mg Ativan

(6) Fentanyl .4mg Vio by Barclay

(7) Extubated

(8) To Pacu

AGENTS AND TECHNICS

MONITORS: EKG / NIBP / SaO2 / ET CO2 / FI O2 / STETH / PREC ESOP

A/Line / S/G / CVP / Warm (I.V.)

PCWP / Skin Temp / ESOP / C.O./C.I. / Foley

FIO2, DTC, Versed, FIO2, STP, Sux, Fent, mO2, N2O, Forane, Ativan

Fentsce sheet used

KIT / Lot No. / Exp. Dt.

ENDOTRACHEAL: SIZE 7.0 BLADE MAC 3 ORO ✓ NASO ⌀ CUFF Min PACK ⌀

REMARKS: Direct Vision, Atraumatic, Stylet ___ Y/N, BBS, Lido ___ Y/N ___ OU Taped ___ Y/N ___ Taped at up 23 Cm.

RECOVERY

REFLEX IN O.R.

EMESIS

ASPIR.

EXCITEMENT

HYPOTENSION

OTHERS

OPERATION PERFORMED: Resection Prolene Suture Knot x3

TOTAL FLUIDS: LR 900 / NS / PPF / SC( ) / PRBC( ) / FFP( ) / TOTAL 900

NAME(S) OF SURGEON(S): Fuller-Neumaster

Janie B. Levecque CRNA

Signature of Anesthetist

PATIENT'S IDENTIFICATION (For typed or written entries give Name—last, first, middle; grade; date; hospital or medical facility)

DOVE, GAYLE
4457 POPPS
BILOXI
[redacted] 520

REGISTER NO. D6094 | WARD NO. A504 | DATE 30 Nov 95

APPROVED

PER [signature]

ANESTHESIA

GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505 — 517-111-01
OCTOBER 1975

520-OR-134 112 FEB 1994

11/30

Plan GETA

PREANESTHETIC SUMMARY

Hx Bld Trans. ___(Y)/N___

OPERATION PROPOSED: Rt groin exploration

AGE: 38

WEIGHT (Lbs.): 143 Ht: 5 ft 6½ in.

PHYSICAL STATUS: ASA 1 (2) 3 4 5 6 7

SPECIAL INFORMATION: Airway Class I 75 mm

URINALYSIS: NORMAL ~~(WNL)~~ pH 5

ABNORMAL AND WHY?: WBC 4-6 HPF; RBC occ HPF; Bact 2+; Prot ~~trace~~ trace HPF

HEMATOLOGY: HGB 13.5 RBC ____ HCT 40.3; OTHER WBC 12.3↑ PLT. 267

BLOOD CHEMISTRY: Glu ____; Cr ____; Bun ____; Sod ____; Kel ____; Cl ____; CO_2 ____; 141 / 23 / 66 / .8; 3.9 / 105 / 21

RESPIRATORY SYSTEM: 20

(X-RAY, ASTHMA, OTHER PATHOLOGY): Lungs Clear

PFT: FVC ____ FEV ____

ABG ___/___/___/___

TB/Asthma -ϕ

Tob. PPD ½ x 25 Yrs.

CXR 11/22 NAD

CIRCULATORY SYSTEM: 98

BP 133/73 PULSE 66

ECG (IF PERTINENT): NSR, WNL

CAD, HTN, MI, Ang., CHF, ASPVD: ϕ

Muga/ECHO ____ EF ____ %

P.Thal ____

ϕ murmurs

CENTRAL NERVOUS SYSTEM

(CEREBROVASCULAR, POLIO, NEUROLOGICAL)

CVA

Seizures ϕ

Oriented x 3 (Y)/N

Migraine Headaches

Depression Hx

Hx Pelvic adhesive disease

OTHER SYSTEMS

(ALLERGIES) NKDA Y/N

Hepatitis, DM, Renal, GI, Cardiac, Thyroid: ϕ

ETOH: Hx abuse ~~drug~~

PREVIOUS ANESTHETICS AND COMPLICATIONS

'84 Rt hand ganglion cyst X4 Beer

'87 TAH + BSO

3/95 Dx laparoscopy ⇒ open lysis adhesions Pen/NVAC

FHAC ϕ

PRESENT DRUG THERAPY: E.G., STEROIDS, TRANQUILIZERS

Depoprovera Shot q 3mo.

PREOPERATIVE DIAGNOSIS

Painful Rt groin incision neuroma vs ICavt

Hx Pelvic adhesive disease

Smoker

PREMEDICATION

ϕ

SIGNATURE OF EVALUATING PHYSICIAN: Janie B. Lincoln CRNA

DATE: 11/30/95

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

30 Nov 95 @ 0920 hrs. (PACU)/SICU.

AWAKE ✓, TALKING ✓, RESPONDING ✓, INTUBATED ϕ,

VS. BP 124/73, HR 89, R 18, SaO2 95%, Temp 97.1°F

O2 NASAL ____ T-PIECE ____ REPORT GIVEN ____ / B Cooper RN

MASK ____ VENT ____

100% Per Pharmacist Recommended

Janie B. Lincoln CRNA

11/30/95 @ 1000 hrs. Anesthesia Post OP Note.

up & dressed

voided

no N/V

Ready to go home

D.M. Clark

[redacted]

[redacted]

DOVE, GAYLE A 25

4457 POPPS FERRY RD. LO 047

BILOXI MS 39532

[redacted]

U.S. Government Printing Office: 1990-262-755/16969

Standard Form 507

PACU FLOWSHEET

CLINICAL RECORD

Report on _____

or

Continuation of S. F. _____

(Strike out one line) (Specify type of examination or data)

(Sign and date)

TIME IN: 915

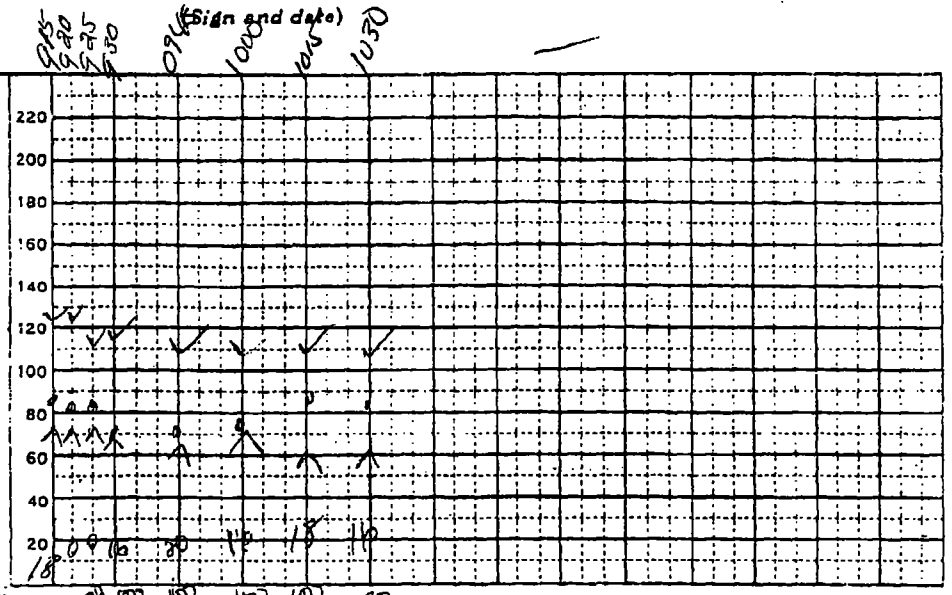
OPERATION: Removal of suture from Lt ear surg.

ANESTHESIA: General
Versed 3mg
Fentanyl 250 mcg
Ancef
Kenacort OT 0910

Fluids R.R.
LR TKO 100
1000 LR ↑ 0945

Fluids O.R.
LR 900

CODE
● PULSE
○ RESP.
V^ B. P.



	OR	Admit	1 HR	2 HR	3 HR	4 HR
Chest Tubes	0					
N.G. Tube	0					
Urine	0					
T-Tube	0					
Other	0					
EBL						

P.A.R.S.

	Admit 915	930	1000	1030
Color	2	2	2	2
Activity	2	2	2	2
Respiration	1	2	2	2
Circulation	2	2	2	2
Conciousness	1	1	1	2
Total Score	8	9	9	10

Dressing (yes) no Dressing (dry) yes no

Oxygen 4Ltr FT — off @ 1000 (SaO2 100%)

PRE OP VS: OR - 108/84 P 75 RA SaO2 99
WARD - 9H 136/86 123/73 66-76

EKG NSR HR64

TIME OF DISCHARGE 1039

DATE 11/30/95

SIGNATURE Barbara Cooper RN

PATIENT'S IDENTIFICATION

Doe Gayle
6094

HISTORY / OR STATUS

FAMILY: yes

ALLERGIES: NKA

HISTORY:

Migraine
Pelvic adhesions

PACU ASSESSMENT

BREATH SOUNDS: clear bilat

ABD: soft, soft

BOWEL SOUNDS: hypoactive

PEDAL PULSES: palpable

IV: 18ga, @ Post hand, site ok

HOB: ↑

WARD NO. ASOU

OVER

or CONTINUATION OF _____

STANDARD FORM 507

General Services Administration and Interagency Committee on Medical Records
FIRMR (41 CFR) 201-45.505
October 1975 507-107

REMARKS CONTINUED: TSC R/L groin no drainage site. Dr Rollins notified. Toradol 30mg IVP given per order Dr Rollins CD
30mg IVP ~~given~~ CD
0950 Pt states minimal pain relief - Dr McClain notified - Dilaudid
0.5mg IVP slow given CD
1000 Pt states less painful but still burning - dilaudid 0.5mg IVP slow given CD
1030 Pt states that she feels better CD

PACU TRANSFER NOTE

LEVEL OF CONSCIOUSNESS: AWAKE ✓ CONFUSED ___ ORIENTED X 3 ✓ OTHER ___

SKIN CONDITION: AS PREOPERATIVE ✓ OTHER skin warm & dry

IV SITE: CLEAR ✓ REDDENED ___ INFILTRATED ___ UR 900 cc CR 900 PACU 200 TOTAL 1100

DRESSING: DRY ✓ INTACT ✓ OTHER ___

PATENT: TUBES CATHETERS DRAINS YES N/A NO ___ COMMENTS: ___

TRANSPORTED VIA: STRETCHER SIDERAILS UP ✓ WHEELCHAIR ___ AMBULATORY ___

TRANSFERRED TO: SICU ADMIT ___ SICU/RECOVERY ___ WARD ___ HOME ___ ASOU ✓

REPORT GIVEN TO: Sherry RN

FAMILY MEMBERS NOTIFIED: YES ___ NO ✓ NO FAMILY PRESENT ___

POST OP INSTRUCTIONS DISCUSSED & PATIENT: Wound R&I, meds, diet

PATIENT VOICED UNDERSTANDING & ___ Yes

NURSES SIGNATURE Carol DuBose RN

POST ANESTHETIC RECOVERY SCORE

Activity	
Moves 4 Extremities	= 2
Moves 2 Extremities	= 1
Moves 0 Extremities	= 0
Respirations	
Deep-breathes and Coughs	= 2
Dyspnea-Limited Breathing	= 1
Apneic	= 0
Circulation	
BP ± 20 - Preanesthesia	= 2
BP ± 20/50 - Preanesthesia	= 1
BP ± 50 - Preanesthesia	= 0
Consciousness	
Fully Awake	= 2
Arousable on Calling	= 1
Not Responding	= 0
Color	
Pink	= 2
Pale, dusky, blotchy	= 1
Cyanotic	= 0
Score Must = 8 or Above	

Preoperative Diagnosis:
Primary: PAINFUL KNOT IN INCISION ICD9 Code: NOT ENTERED
Surgeon: ROLLER,MICHAEL D Surgical Priority: ELECTIVE
Attend Surgeon: NEUMASTER,TERRY DAV Attend Code: 1. ATTENDING IN O.R.
1st Assistant: N/A 2nd Assistant: N/A

Other Scrubbed Assistants: NONE ENTERED
Anesthetist: LINCOLN,JANIE B Asst Anesthetist: N/A
Attending Anesthesiologist: BARCLAY,VIVEK
Anesthesia Supervisor Code: N/A
Perfusionist: N/A Asst. Perfusionist: N/A
OR Support Personnel:

Scrubbed	Circulating
CORLEY,JAMES E	BAKER,VICKY

Anesthesia Technique(s):
GENERAL (PRINCIPAL)
Agent: ISOFLURANE
FENTANYL
MIDAZOLAM
Anesthesia Begin: NOV 30, 1995 08:00 Anesthesia End: NOV 30, 1995 09:20
Operation Begin: NOV 30, 1995 08:45 Operation End: NOV 30, 1995 09:00
Tubes and Drains:
NONE
Tourniquet: N/A
Material Sent to Laboratory for Analysis:
Specimens:
#1 PROLENE KNOTS FROM ABD INCISION
Cultures: N/A
Postoperative Diagnosis:
Primary: PAINFUL KNOT IN INCISION ICD9 Code: NOT ENTERED
Other: PROLENE KNOTS IN ABD INCISION ICD9 Code: NOT ENTERED
Major Operations Performed:
Primary: EXCISION PAINFUL KNOT IN INCISION CPT Code: NOT ENTERED

Concurrent Procedure(s): N/A
Date/Time of Dictation: NOT ENTERED
Date/Time Transcribed: DEC 01, 1995 10:11
Indications for Operation:
PAINFUL KNOT IN INCISION
Surgeon's Dictation:
FINDINGS: Prolene knots times two.

INDICATIONS: The patient is a 38-year-old white female with a painful right mass times two in an old pfannenstiel incision for release of her pelvic adhesions done in March 1995. Pain is worse with hip flexion and straining. The patient is here for exploration of the incision and

Dr Roller dg 11/Lentz

SURGEON'S SIG: DEC 01, 1995 10:13
DOVE,GAYLE A AGE: 38 [redacted]
WARD: OPT ROOM-BED:
VAMC: Biloxi, MS (CONS) REPLACEMENT FORM 516

Exception to Standard Form 508
Approved by OMB

MEDICAL RECORD	DOCTOR'S ORDERS

NOTE: Physician's signature must accompany each entry including standing orders. Date and time for instituting and discontinuing the orders must be recorded.

DATE AND TIME	PROB. NO.	ORDERS (Another brand, equal in quality, of the same basic drug may be dispensed, UNLESS checked.)	✓	NURSE'S SIGNATURE
		1 - Admit to Ambulatory Surgery Observation Unit		
		ASOU on: 11/30/15		DW
		2 - Diagnosis: Painful (R) groin incision Neuroma vs knot		
		3 - Allergies: NKDA		
		4 - Have patient sign consent		
		5 - NPO p midnight on: 11/29/15		
		6 - Pre-op Test:		
#433481		Lab: CBC, Chem 7, UA		DW
11/22 DW		CXR		DW
		EKG		DW
		7 - Have all pre-op test results on chart prior to surgery.		
		8 - Shower c Hibiclens ~~Shampoo c~~ 11/29 pm & Am 11/30		
		9 - Void on call to surgery:		
		10 - Pre-op meds: ϕ		

Physician Signature
[redacted]

Enter in space below: PATIENT IDENTIFICATION—~~TREATING~~ FACILITY—WARD NO.—DATE

DOVE, GAYLE A 25
4457 POPPS FERRY RD. LO 047
BILOXI MS 39532

[redacted]

C-SSN 1 080 B

Noted Joanne Doig RN
12-01-15 0710

MEDICAL RECORD
DOCTOR'S ORDERS

[redacted]

VA FORM OCT 1975 10-1158

[redacted] STOCK OF VA FORM 10-1158, MAY 1973 AND VA FORM 10-1158c, NOV 1972, WILL BE USED.

Exception to Standard Form 508
Approved by OMB

MEDICAL RECORD

DOCTOR'S ORDERS

NOTE: Physician's signature must accompany each entry including standing orders. Date and time for instituting and discontinuing the orders must be recorded.

DATE AND TIME	PROB. NO.	[redacted]	√	[redacted]
24 Nov 95	①	URINE FOR U/A on ARRIVAL		# 434201
1210	②	SCRIPTS FOR FLAGYL + RACTRIM		√2
		MICHAEL C. LILLY, M.D. AS3285170-646		
		Noted Joanne Dong, RN 12-01-95 @ 0710		
11/30/95	①	Tx to RR → ASAP		M
0900	②	GP excision of suture x2		M
	③	Good		M
	④	Vitals per routine		M
	⑤	NKDA		M
✓	⑥	Regular diet as tolerated		M
✓	⑦	D/C IV when tolerating po fluids		M
	⑧	Toradol 30 mg IV/IM x 1		given eso
		may repeat x 1 ~~once~~ Michael Roller		given eso
	⑨	Send script MICHAEL D. ROLLER, M.D. AS3285170-734		M
		noted 11-30-95 1040 Dawn Lewis		
11/30/95	0950	Dilaudid 0.5-2mg IVP prn in PACU		given eso
		VO Dr McClain / Carol DuBose;		
		M. McClain		

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. - DATE

noted 11-30-95 1040 Dawn Lewis

DOVE, GAYLE A
4457 POPPS FERRY [redacted]
BILOXI

[redacted] DF 081597 520

C-SSN [redacted]

MEDICAL RECORD [redacted]

GOVERNMENT PRINTING OFFICE: 1994-365-478

Exception to Standard Form 508
Approved by OMB

MEDICAL RECORD

DOCTOR'S ORDERS

NOTE: Physician's signature must accompany each entry including standing orders. Date and time for instituting and discontinuing the orders must be recorded.

DATE AND TIME	PROB. NO.	ORDERS (Another brand, equal in quality, of the same basic drug may be dispensed, UNLESS checked.)	√	NURSE'S SIGNATURE
11/30/95 1120	(1)	Transfer to Bed — done M Bellyou noted Carol DuBreuil RN 11/30/95 1034		
11/30/95 1200		D/c to home M Roller MICHAEL D. ROLLER, M.D. AS3285170-734		M
		noted 11-30-95 1155 Dawn Cella		

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. - DATE

DOVE, GAYLE A 25 08 08 91
6457 POPPS FERRY RD, LO 047
[redacted] MS 39532
[redacted]

C-55N 1 080 8

MEDICAL RECORD
DOCTOR'S ORDERS

VA FORM OCT 1975 10-1158

EXISTING STOCK OF VA FORM 10-1158, MAY 1973 AND VA FORM 10-1158c, NOV 1972, WILL BE USED

[redacted] CAU FEM

[redacted] M:ASOU

[redacted] 5 11:48

[redacted] BPM

[redacted] MS

[redacted] MS

[redacted] MS

[redacted] 56

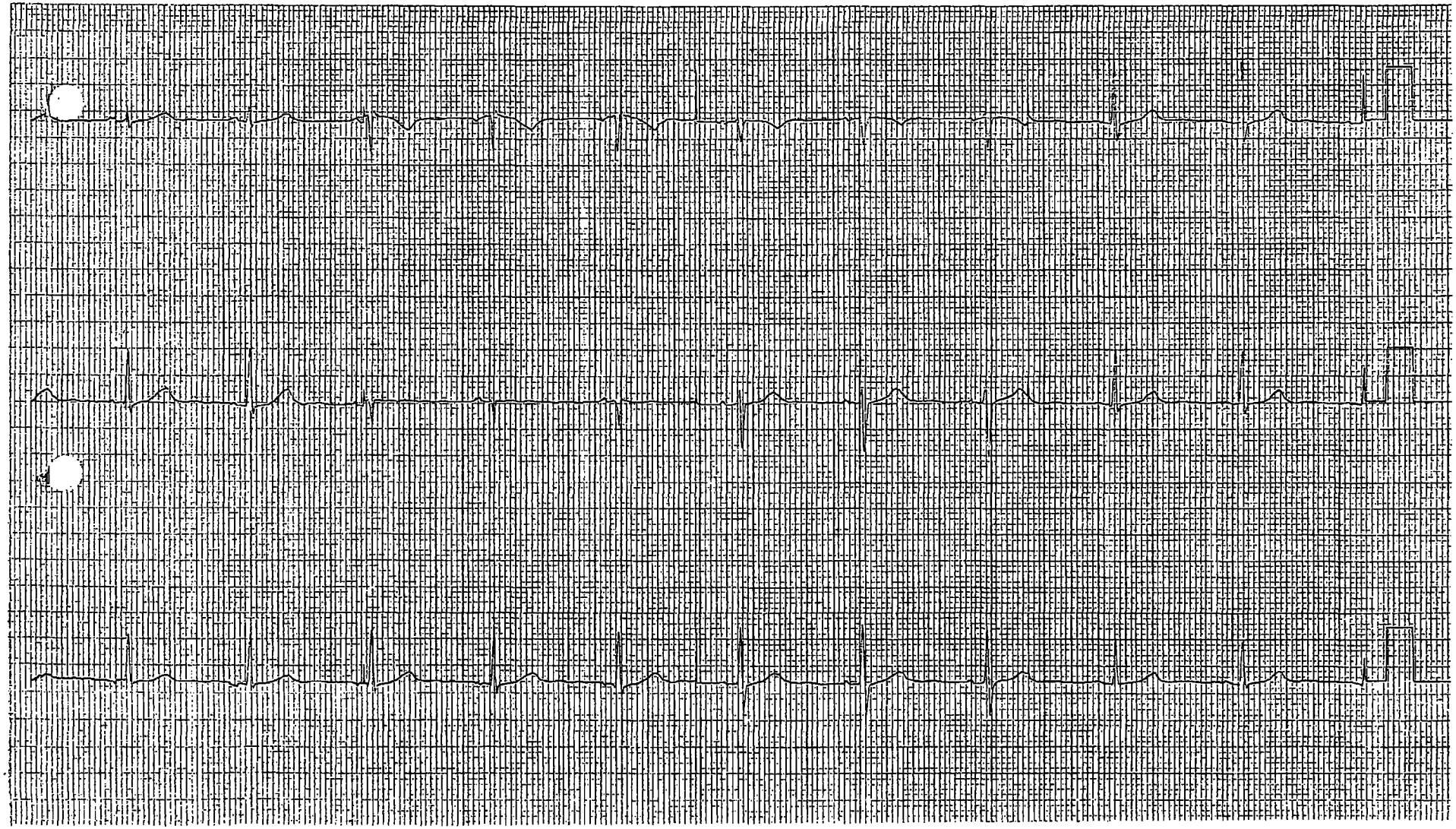
NORMAL SINUS RHYTHM

ROUTINE ECG

NORMAL ECG
WHEN COMPARED WITH ECG OF 05-JUL-95 08:27,
NO SIGNIFICANT CHANGE WAS FOUND

REFERRED BY: ROLLER

REVIEWED BY: ASHOK KANADE M.D.



1475

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

Right groin exploration with excision of neuroma or stitch removal

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be

(Description of operation or procedure in lay (non-medical) language)

Incision over mass and removal of suture or inflamed nerve ending. Risks: recurrence of painful mass, wound infection, bleeding

which is to be performed by or under the direction of Dr. Horner

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: None

(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.
b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES (Appropriate items in Parts A and B must be completed before signing)

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

MICHAEL D. ROLLER, M.D.
AB3285170-734
(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)
Signature only

(Signature of Patient)

11-22-95 @ 1230
(Date and Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

DOVE, GAYLE A 23
[redacted] FERRY RD LO 047
MS 39532
(Signature of Witness, excluding members of operating team)

(Signature of Sponsor/Legal Guardian)

(Date and Time)

PATIENT'S IDENTIFICATION [redacted]

REGISTER NO.	WARD NO.

STANDARD FORM 522 (Rev. 10-76)
General Services Administration &
Interagency Comm. on Medical Records
FIRMR (41 CFR) 201-45.505
522-110

NATIONAL VA SURGICAL QUALITY IMPROVEMENT PROGRAM

Please complete this sheet by circling or checking all positive responses.
*DEFINITIONS ON REVERSE SIDE

SURGICAL SPECIALTY Gen

PATIENT NAME/SSN: [illegible] DATE: 11/30/95

PREOPERATIVE RISK INFORMATION

GENERAL

* Diabetes Mellitus:	(No)	Oral Insulin
* No. of Pack/Years: 25		
Smoke within past year:	(Yes)	~~No~~
ETOH> 2drinks per day within 2 weeks prior to admission:	Yes	(No)
* Dyspnea		(None)
		Minimal exertion
		At rest
* DNR Status:	Yes	(No)
* Functional Status:		(Independent)
		Partially Dependent
		Totally Dependent

PULMONARY

Ventilator dependent > 48 hours:	Yes	(No)
* History of severe COPD:	Yes	No
* Current pneumonia:	Yes	No

HEPATOBILIARY

Ascites:	Yes	(No)

CARDIAC

CHF 1 month prior to surgery:	Yes	(No)

RENAL

* Acute Renal Failure:	Yes	(No)
Currently on dialysis:	Yes	(No)

CENTRAL NERVOUS SYSTEM

* Impaired Sensorium:	Yes	(No)
Coma:	Yes	No
* Hemiplegia/hemiparesis:	Yes	No
* History of TIA's:	Yes	No
* CVA/residual neuro deficit:	Yes	No
CVA/no neuro deficit:	Yes	No
Tumor Involving CNS:	Yes	(No)

NUTRITIONAL/IMMUNE/OTHER

* Disseminated Cancer:	Yes	(No)
* Open wound or wound infection:	Yes	No
* Chronic steroid use:	Yes	No
* > 10% loss body weight last 6 months:	Yes	No
Bleeding disorders:	Yes	No
Transfusions > 4 RBC units:	Yes	No
Chemotherapy within last 30 days:	Yes	No
Radiotherapy within last 90 days:	Yes	No
* Sepsis:	Yes	(No)

PATIENT IDENTIFICATION CARD

FOR OFFICE USE ONLY
Date of admission
Date of transfer to Surgery
Transfer status
Recs

MICHAEL D. ROLLER, M.D.
AS3285170-734

614.6

DISCHARGE DIAGNOSES:
1. ~~History of~~ pelvic adhesive disease

DIAGNOSES NOTED BUT NOT TREATED:

OPERATIONS/PROCEDURES PERFORMED: 54.5 74.2

SUMMARY
HISTORY OF PRESENT ILLNESS: Patient is a 37 year old white female with a history of pelvic pain for the last two months. Is consistent and not relieved by conservative methods as per dietary and prn pain control with medications. She has a history of abdominal adhesive disease and she is status post a hysterectomy in 1987. She denies any chest pain, shortness of breath, dyspnea on exertion. Her last PAP smear was September 22, 1994 which was normal. History is significant only for her previous episode of pelvic adhesive disease.

Surgical history is significant for hysterectomy in 1987 and a resection on a ganglion cyst x 4. She has no known drug allergies. She has taken Premarin 1.25 mg. po q day. Social history is significant for tobacco of one pack per day x 17 years. Alcohol: None currently, but has a history of abuse. She is employed as a casino employee in Biloxi.

PHYSICAL EXAMINATION: Temperature 98.2, pulse is 67, blood pressure 108/64. General: She is a well developed, well nourished white female in no apparent distress. Head and neck: Normocephalic. Pupils equal, respond to light and accommodation. Head full range of motion, no JVD, no bruits. Oropharynx is moist, pink, without erythema. Lungs are clear to auscultation. Heart is regular rate and rhythm. Abdomen is nontender, nondistended, normoactive bowel sounds. She does show some degree of tenderness to deep palpation in the right lower quadrant. She has no evidence of a herniation. She has a well healed surgical scar from a Pfannenstiel incision. Normal external female genitalia. Back: Has no costovertebral angle tenderness. Extremities: No clubbing, cyanosis or edema. She has a nonfocal neurological exam.

LABORATORY DATA: She had an H&H of 12.7 and 37.8, white count 8.7,

ADM DATE	DISC DATE	TYPE RELEASE	INP DAYS	ABS DAYS	WARD NO
03/12/95	03/19/95	REGULAR			1-4WSUR

SIGNATURE OF PHYSICIAN/DENTIST

MICHAEL J. SCHNEIDER, Capt, USAF, MC
504-78-9577
81st MEDICAL GROUP, KEESLER AFB MS
45S1

MICHAEL J. SCHNEIDER, M.D.

D/D: 03/19/95 T/D: 03/22/95 T/C bd

VAF 10-1000 DISCHARGE SUMMARY DOVE,GAYLE A [redacted]

platelets of 296. Her chest x-ray revealed no active disease. Sodium was 142, potassium was 4.5, chloride was 105, bicarb was 25, BUN of 9, creatinine 0.9, glucose of 72. PT and PTT of 11.6 and 23.7. Her UA was negative and urine beta hCG was also negative.

HOSPITAL COURSE: She was admitted on 12 March 95 with the diagnosis of pelvic adhesive disease. She was to have a diagnostic laparoscopy with possible lysis of adhesions through the laparoscope which was performed on 13 March 95. In the course of the laparoscopy it was noted she had very dense adhesions in the right lower pelvis. Held in the adhesions were portions of small bowel, large bowel, all up to the anterior abdominal wall. Secondary to the nature and degree of the adhesions in the right lower quadrant the patient received an open procedure via her old Pfannenstiel incision taking down the adhesions without complication or difficulty. Postoperatively she did well receiving several days of patient controlled analgesia with Morphine converted over to po Percocet as tolerated. She was ambulating, was well motivated with pulmonary toilet and carry on activities of daily living. At time of discharge she was tolerating a regular diet, having bowel movements, ambulating without assistance, afebrile and having adequate pain control. Her staples were removed from her abdominal incision.

DISCHARGE RECOMMENDATIONS: She is to be discharged to her home on her preoperative medications which was the Premarin 1.25 mg. q day. she is to follow up in the General Surgery Clinic on 29 March 95 for follow up. She is, in the meantime, to do no heavy lifting that is greater than 10 pounds. She is convalesce a week from work. She is encouraged to ambulate and continue her activities of daily living as tolerated.

AUTHENTICATED BY _____
VA STAFF PHYSICIAN

L.J. FONTENELLE, M.D.
AS3285170-F1

ADM DATE	DISC DATE	TYPE RELEASE	INP DAYS	ABS DAYS	WARD NO
03/12/95	03/19/95	REGULAR			1-4WSUR

SIGNATURE OF PHYSICIAN/DENTIST

MICHAEL J. SCHNEIDER, M.D.

D/D: 03/19/95 T/D: 03/22/95 T/C: bd

VAF 10-1000 DISCHARGE SUMMARY DOVE,GAYLE A [redacted]

504-110 NSN 7540-00-634-41

MEDICAL RECORD | HISTORY—Part 1

NATURE AND DURATION OF COMPLAINTS (Include circumstance of admission)

pelvic pain

HISTORY OF PRESENT ILLNESSES

37 yo WF c pelvic pain x 2 months that is constant and not relieved by conservative method Pt. has h/o abdominal adhesions and has had hysterectomy Pt. denies CP, SOB, DOE, +syncope.

Last Pap Smear 9/22/94 → Normal

Michael A Lyly

(Continue or reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO.

WARD NO.

DOVE, GAYLE A [redacted]

HISTORY—Part 1
Medical Record

STANDARD FORM 504 (REV. 7-91)

Standard Form 505

CLINICAL RECORD	HISTORY—Part 2

PAST HISTORY

INSTRUCTIONS.—*Include (1) OCCUPATION (Civilian and military), (2) MILITARY HISTORY (Include geographic locations and dates), (3) HABITS (Alcohol, tobacco, and drugs), (4) FAMILY HISTORY, (5) CHILDHOOD ILLNESSES, (6) ADULT ILLNESSES, (7) OPERATIONS, (8) INJURIES, and (9) DRUG SENSITIVITIES AND ALLERGIC REACTIONS.*

1. **OCCUPATION (Civilian and military)**
   poker dealer
2. **MILITARY HISTORY (Include geographic locations and dates)**
3. **HABITS (Alcohol, tobacco, and drugs)**
   tob: ↑ ppdx 17 yrs
   Etoh: Ø, but has abuse hx.
4. **FAMILY HISTORY**
5. **CHILDHOOD ILLNESSES**
6. **ADULT ILLNESSES**
   peluic pain
7. **OPERATIONS**
   ganglionectomy x 4
   hysterectomy
8. **INJURIES**

Meds
Premarin 1.25 qD

9. **DRUG SENSITIVITIES AND ALLERGIC REACTIONS**
   NKDA

Mdalud Lgly

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)	REGISTER NO.	WARD NO.
DOVE, GAYLE A [redacted] C8155		

HISTORY (Parts 2 and 3)
Standard Form 505

[redacted]

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975 505-110

HISTORY—Part 3

SYSTEM REVIEW

INSTRUCTIONS.—*Include (1) GENERAL, (2) HEAD [Including (3) EYE, (4) EAR, (5) NOSE and (6) THROAT], (7) NECK, (8) RESPIRATORY, (9) CARDIOVASCULAR, (10) GASTROINTESTINAL, (11) GENITO-URINARY [and (12) GYNECOLOGICAL], (13) HEMOPOIETIC, (14) LYMPHATIC, (15) MUSCULO-SKELETAL and (16) NEURO-PSYCHIATRIC SYSTEMS.*

1. GENERAL — see HPI
2. HEAD (including)
3. EYE
4. EAR
5. NOSE and
6. THROAT
7. NECK
8. RESPIRATORY
9. CARDIOVASCULAR
10. GASTROINTESTINAL
11. GENITOURINARY
12. GYNECOLOGICAL
13. HEMOPOIETIC
14. LYMPHATIC
15. MUSCULOSKELETAL
16. NEUROPSYCHIATRIC SYSTEMS

SIGNATURE OF PHYSICIAN — Michael D Lyly — DATE 12 MAR 95

*U.S. GPO: 1994-572-032/81374

Standard Form 506

CLINICAL RECORD — PHYSICAL EXAMINATION

DATE OF EXAM.	HEIGHT	WEIGHT			TEMPERATURE	PULSE	BLOOD PRESSURE
		AVERAGE	MAXIMUM	PRESENT			
12 MAR 95	5'7"			150	98.7	67	108/64

INSTRUCTIONS.—Describe (1) General Appearance and Mental Status; (2) Head and Neck (General); (3) Eyes; (4) Ears; (5) Nose; (6) Mouth; (7) Throat; (8) Teeth; (9) Chest (General); (10) Lungs; (11) Cardiovascular; (12) Abdomen; (13) Hernia; (14) Genitalia; (15) Rectum; (16) Prostate; (17) Back; (18) Extremities; (19) Neurological; (20) Skin; (21) Lymphatics.

1. GENERAL APPEARANCE AND MENTAL STATUS:
   WN, WD, NAD, AOx3
2. HEAD AND NECK (GENERAL):
   ØJVD, Øbruits
3. EYES:
   PERRLA, EOMI
4. EARS:
5. NOSE:
6. MOUTH:
7. THROAT:
   Ø erythema
8. TEETH:
9. CHEST (GENERAL):
10. BREASTS:

(Continue on reverse side)

Mabel Lyly

PATIENT'S IDENTIFICATION (*For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility*)

REGISTER NO.

WARD NO.

DOVE, CAYLE A [redacted] 25 01 96 CE1557

PHYSICAL EXAMINATION
Standard Form 506
General Services Administration and Interagency Committee on Medical Records
FIRMR (41 CFR) 201-45.505
October 1975 506-106

[redacted]

PHYSICAL EXAMINATION

11. LUNGS: (B) CTA

12. CARDIOVASCULAR: RRR S (1)

13. ABDOMEN: NT, ND, NABS

14. HERNIA: (-)

15. GENITALIA: NE FG

16. RECTUM: deferred

17. PROSTATE: N/A

18. BACK: ØCVAT

19. EXTREMITIES: ØCCE

20. NEUROLOGICAL: nonfocal

21. SKIN:

22. LYMPHATICS:

PT/PTT 11.6/23.7

UA: (-)

142	105	9 / 72
4.51	25	.9

8.6 \ 12.7 / 296
37.8

CXR: NAD

INITIAL IMPRESSION

A: 37 yo WF c pelvic pain.

P: 1) scope

SIGNATURE OF PHYSICIAN

12 MAR 95

* U.S Government Printing Office1992-313-108/63657

DOVE,GAYLE A Diagnosis:

Date/Stat/Init	Patient Problem	Goals/Expected Outcomes	Date/Stat/Init	Nursing Intervention/Orders	Date/Stat/Init
03/18/95(E) LS 03/11/95 LS	Comfort	Pt will remain free of objective signs of pain	03/16/95(T) LS 03/11/95 LS	Assess character of discomfort	03/11/95 LS
		Pt will verbalize effective pain relief/interventions	03/16/95(T) LS 03/11/95 LS	Anticipate and provide chemical and/or physical intervention	03/11/95 LS
				Teach appropriate positioning/drug use/timing for pain mgmt	03/11/95 LS
03/18/95(E) LS 03/11/95 LS	Management of Health	Pt will follow treatment regime	03/16/95(T) LS 03/11/95 LS	Record teaching outcomes in the patient's clinical record	03/11/95 LS
		Maintains or regains ability for self care in AD	03/16/95(T) LS 03/11/95 LS	Establish reliable communication mode based on pt's needs	03/11/95 LS

Resolved
Cathy Mauldin RN
3/19/95
1900

PATIENT EDUCATION
1-4W SURGERY

Signature)

& familiarized with ward policy Cathy Mauldin RN 3/10/95 1045

ity limitations.

Treatment modalities and LIST: _____

procedures explained. _____

_____

Family or SO present [ ] YES [ ] NO If YES, instruct-

ed on disease process & an planned [illegible].

Medications and possible side effects [illegible]

_____ video tape viewed & basic

rotanding verbalized.

phlets provided: _____

Department of Veterans Affairs

INPATIENT DENTAL EXAMINATION

~~1~~	2	3	4	5	6	7	8	9	10	11	12	13	14	15	~~16~~
~~32~~	31	30	29	28	27	26	25	24	23	22	21	20	19	18	~~17~~

Reassessment (Initial) (Subsequent)

Oral Hygiene (good) (fair) (poor)
Masticatory Function (adequate) (inadequate)
Oral Mucosa (no gross oral pathosis noted)
(oral pathosis present as described)

Plans:

DX: 1. Calculus pelvic adhesions
RX: 1. CDaoffl

Estimated Hospital Stay

defer tx RGW 3/13/95

Patient is physically and mentally able to have dental treatment (yes) (no)

Diagnosis	Treatment

Patient is ( ) or is not ( ) capable of giving consent for anesthesia or oral surgery

SIGNATURE AND TITLE OF PRACTITIONER [signature] DATE 3/13/95

IMPRINT PATIENT DATA CARD

[redacted]

25
081557

03 12 95
1-HW

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE
FOR SPECIALIZED DISCIPLINES

[redacted]

VA FORM [illegible] EXISTING STOCK OF VA FORM 10-0114i SEPT 1988

Department of Veterans Affairs

AMBULATORY SURGERY

PRE-OP INFORMED CONSENT

TIME: _____

Diagnosis:

Pelvic pain

Brief Summary:

Pt 37 y.o. WF ~ 2mo w/o constant pelvic pain. Had w/o hysterectomy

Proposed Procedure/Treatment Plan:

Laparoscopy, possible lysis of Adhesions
Potential for laparotomy

Possible Risks/Complications:

Bleeding, infection, possible open procedure
Potential No benefit from procedure

SIGNATURE AND TITLE OF PRACTITIONER
SEE REVERSE

DATE

IMPRINT PATIENT DATA CARD

DOVE, GAYLE A [redacted]
25 01 96
C81557

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE
FOR SPECIALIZED DISCIPLINES

[redacted]

VA FORM MAY 1990 10-0114i

EXISTING STOCK OF VA FORM 10-0114j, SEPT 1988.

INFORMED CONSENT (cont.)

Benefits: R Examine Abdomen and Pelvis relieve adhesions

Patient's condition Good, i.e., awake, alert, sedated, anxious, confused, lethargic, unconscious, etc...

Alternative Treatment identified to patient/guardian: No Surgery

Next of kin/guardian _____ (Name) Contacted: Yes ___ No ___

Patient Competent: Yes ___ No ___

Patient and/or guardian/next of kin has been given opportunity to ask questions: Yes ___ No ___

Patient and/or guardian/next of kin comprehends what has been proposed and why: Yes ___ No ___

Patient and/or guardian has agreed and freely consented to the proposed procedure/ treatment plan without duress or coercion: Yes ___ No ___

Patient and/or next of kin has been informed of the Surgical Team: Dr. _____ (Attending Staff), Schneider (Surgeon), _____ (Members).

Attending surgeon concurs with proposed procedure/treatment plan: Yes ___ No ___

Attending Surgeon Note: Complications discussed Alternate including none and Need of Including discussed in

_____ (Resident Surgeon) _____ (Attending Surgeon)

Department of Veterans Affairs

PRE OP ANESTHESIA INFORMED CONSENT

SURGICAL SERVICE

DATE\TIME: 3/13/95 1530 PATIENT COMPETENT: YES ✓ NO ____

BRIEF SUMMARY: DEVICE IN KIDNEY

PATIENT CONDITION: AWAKE, ALERT
(i.e. awake, alert, sedated, anxious, confused, lethargic, unconscious, intubated, other)

PROPOSED PROCEDURE\TREATMENT PLAN: LITHO SCOPY / LITHO TODAY TO
G. E. F. A.

POSSIBLE RISKS\COMPLICATIONS: ANESTHESIA MISCELLANEOUS, G. BODY, T
ANESTHESIA OF RISKS DISCUSSED T PT

ALTERNATIVE TREATMENT IDENTIFIED TO PATIENT\GUARDIAN: N/A

Patient and\or guardian\next of kin has been given opportunity to ask questions:
Yes ✓ No ____

Patient (and\or guardian\next of kin comprehends what has been proposed and why:
Yes ____ No ____

Patient and\or guardian\next of kin has agreed and freely consented to the proposed procedure\treatment plan without duress or coercion: Yes ✓ No ____

ATTENDING ANESTHESIOLOGIST CONCURS with proposed\treatment plan: Yes ✓ No ____

ATTENDING ANESTHESIOLOGIST NOTE: ____

CRNA\ANESTHESIA RESIDENT

ATTENDING ANESTHESIOLOGIST 3/13/95

SIGNATURE AND TITLE OF PRACTITIONER	DATE

IMPRINT PATIENT DATA CARD

DOVE, C.
1094

DOVE, GAYLE A [redacted] 01 50

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE
FOR SPECIALIZED DISCIPLINES

[redacted]

Anesthetic procedures may be associated with, but not limited to:

infection
hemorrhage (excessive bleeding)
drug reactions
blood clots
loss of sensation
loss of limb function
paralysis
organ damage
heart attack
stroke
loss of life
blood reactions (including rash, itching, nausea, vomiting & shock)

Other risks/complications associated with <u>General Anesthesia</u>

sore throat
hoarseness
shortness of breath
difficulty in breathing
injury to teeth
injury to eyes
injury to airway
injury to arteries or veins
awareness under anesthesia
pain or discomfort continuing after discharge from the hospital

Other risks/complications associated with <u>regional, spinal or epidural anesthesia</u>

pain or discomfort
injury to arteries or veins
residual pain
residual sensation
residual dysfunction
low blood pressure
headache
high blood pressure
seizure
failure of regional, spinal or epidural anesthesia & subsequent need for general anesthesia

Veterans Administration

NURSING DISCHARGE PROGRESS NOTE

1. Discharge living arrangements: D.C. to home to live with her father
2. Accompanied by: Self
3. Ambulation: no problem. Gait Steady.
4. TPR: 97.3 65 20 BP: 112/72 unless u
5. General condition (including resolved and unresolved nursing diagnosis): Alert. Oriented. Has gained considerable insight into her alcoholism addiction and accepts that she is an alcoholic (no longer in denial.) Has dealt with feelings of anger, Guilt & Shame. Gained tools & skills (now able to name triggers to relapse) for Relapse prevention. Has a workable aftercare plan.
6. Nursing care needed following discharge (including Nursing Care Referral): I.O. Outpatient Clinic SATP @ Gulfport, Ms aftercare
7. Patient/family education, instructions, medications, follow-up and assessment of understanding: No family present for Education or support System. Vet. plans to attend A.A. meetings Regularly & get a Strong sponsor. Verbalizes understanding of all teaching particularly medication teaching & Dosage adm. times & possible side effects of Medications.

SIGNATURE AND TITLE OF PRACTITIONER: Naomi Krause, RNC RN

DATE/TIME: Nov. 5, 1994 0900

IMPRINT PATIENT DATA CARD

DOVE, GAYLE A
5245 A STREET
BILOXI
[redacted]
8

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE
FOR SPECIALIZED DISCIPLINES

VA FORM 10-0114: 026396

Department of Veterans Affairs

MEDICAL RECORD - DISCHARGE INSTRUCTIONS

DATE OF ADMISSION	DATE OF DISCHARGE	TYPE OF DISCHARGE
Oct 5 94	Nov. 1. 94	OPT NSC

1. DIAGNOSES AND DATE TO BE FOLLOWED ON OUTPATIENT SERVICES

Alcohol dependence

2. SUGGESTED PLAN FOR FOLLOWUP

Get sponsor
Attend AA
Follow up at Gulfport OPC

3. DISCHARGE MEDICATIONS AND INSTRUCTIONS

Zoloft 50 mg AM
Conjugated estrogens 1.25 one daily

4. DISCHARGE DIETARY INSTRUCTIONS *(Check one)*

☒ NO RESTRICTIONS ☐ RESTRICTIONS *(Specify and include drug and food interactions).*

5. PHYSICAL ACTIVITY LIMITATIONS *(Check one)*

☒ NO RESTRICTIONS ☐ RESTRICTIONS *(Specify)*

6. OTHER *(Include employment status)*

DOVE, GAYLE A
5246 A STREET
[redacted]

25
047

PATIENT IDENTIFICATION *(Name, Address, Social Security Number)*

[redacted]

-55% 5 8

SIGNATURE OF PHYSICIAN/DENTIST

[signature] M.D

DATE

Nov. 1. 94

I HAVE RECEIVED AND UNDERSTAND MY DISCHARGE INSTRUCTIONS

SIGNATURE OF PATIENT

Gayle A Dove

DATE

1 Nov 94

VA FORM 10-7978M
JAN 1990

EXISTING STOCKS OF VA FORM 10-7978M, NOV 1987, WILL BE USED.

MEDICAL RECORD

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
Dermatology	2A/P	10/27/94

REASON FOR REQUEST (Complaints and findings)

Progressive rash - arms to body -
? Dx + Rx

PROVISIONAL DIAGNOSIS

Fri 0900

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	ROUTINE / TODAY
[signature]		☐ BEDSIDE ☐ ON CALL	☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

DERM 10/27/94

NKDA

wt 147 Ht-5'6 age-37 T-98.4 BP-101/63 P-76 R-20

37 yo WF c 1wk hx of eruption starting on antecubital fossa - pruritic / burning and progressing to rest of body.
Currently on medrol dose pack started 4d ago. Notes some improvement.

O/ lateral trunk, ant cubital fossa, groin
Small erythematous scaling plaques.
Some ? scarlatti scale.

Meds
1. Premarin
2. Provera
3. Motrin
4. Vistaril
5. ? OCP

AP. atypical pityriasis rosea vs Pityriasis lichenoides chronica
1. TAC .1% ointment bid to lesions
2. RTC 2wks if no resolution, consider bx.

(Continued on reverse side) please overbook

SIGNATURE AND TITLE	DATE
[signature]	10/28/94

IDENTIFICATION NO.	ORGANIZATION	REGISTER NO	WARD NO
DOVE.GAYLE A	25		

PATIENT'S IDENTIFICATION (Typed or written entries give: Name-last, first, middle; grade; rank; org; hospital or medical facility)

BILOXI MS 39535

[redacted] [redacted]

C-SSN 5 8

Derm 1-6-95 830

844

CONSULTATION SHEET
STANDARD FORM 513 (Rev. 9-77)
Prescribed by GSA/ICMR
FIRNIR (41 CFR) 201-45.505
513-108

MEDICAL RECORD	CONSULTATION SHEET

REQUEST SM

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
116B-1	SATP	10/11/94

REASON FOR REQUEST (Complaints and findings)

Ms Dove is needing retraining and requested Level II services. After completing this program she will return to KAFB in Biloxi.

Discharge Date 11/1/94

PROVISIONAL DIAGNOSIS

Alcohol Dependence

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	☐ ROUTINE ☐ TODAY
Steve McNally PhD		☐ BEDSIDE ☐ ON CALL	☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

PSYCHOLOGY SERVICE VOCATIONAL REHABILITATION
TREATMENT PLAN

Ms Dove was seen on 10-13-94 and her chart was Reviewed. Per vocational screening, she was determined to be a candidate for vocational rehabilitation. Complete assessment/ treatment plan on attached SF-507.

(Continued on reverse side)

SIGNATURE AND TITLE	DATE
Marsha Gentry MSW	10-13-94

IDENTIFICATION NO.	ORGANIZATION	REGISTER NO	WARD NO
	25		

DOVE GAYLE A
5288 A STREET
BILOXI

PATIENT'S IDENTIFICATION (For typed or written entries: Name—last, first, middle; grade; rank; service; hospital or medical facility) MS 39530

[redacted]

C-SSN 5 8

CONSULTATION SHEET
STANDARD FORM 513 (Rev. 9-77)
Prescribed by GSA/ICMR
FIRNR (41 CFR) 201-45.505
513-108

Standard Form 507 — 649—16—81472-3 GPO

CLINICAL RECORD

Report on _____
or
Continuation of S. F. _____
(Strike out one line) (Specify type of examination or data)

PSYCHOLOGY SERVICE VOCATIONAL REHABILITATION TREATMENT PLAN:

[PERSONAL DATA:]

AGE: 37 SERVICE CONNECTION: No VIETNAM ERA: No

SERVICE DATES: 75-87 DEPARTMENT OF MILITARY: Air Force MILITARY JOB: Radar

[CURRENT MARKETABLE WORK SKILLS FOR IMMEDIATE EMPLOYMENT:]

Clerical (Receptionist)
Computer Entry

[EDUCATIONAL BACKGROUND:]

HIGHEST GRADE COMPLETED: 12 DIPLOMA: yes GED:

VOCATIONAL EDUCATION: 3 years Business / Accounting

COLLEGE: _____

NUMBER OF FAILED COURSES: 0

METHOD OF FUNDING: GI bill / Tuition cost ANY OUTSTANDING LOANS: 0

POTENTIAL TO DEVELOP OR IMPROVE SKILLS: yes

PLANS TO RETURN TO SCHOOL OR GET INVOLVED IN TRAINING: yes

[APTITUDES:]

PAST JOBS REFLECT FOLLOWING APTITUDE: Clerical; general abilities

CANDIDATE FOR APTITUDE TESTING: yes

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

Dow, [redacted]

[redacted]

REGISTER NO. | WARD NO.

REPORT ON _____ or CONTINUATION OF _____

STANDARD FORM 507
General Services Administration and Interagency Committee on Medical Records
FIRMR (41 CFR) 201-45.505

2

Standard Form 507 — 048—16—81472p-3 GPO

CLINICAL RECORD	Report on _____ or Continuation of S. F. _____ (Strike out one line) (Specify type of examination or data)

[VOCATIONAL GOAL(S):] (Sign and date)

TYPE OF WORK SEEKING: Clerical

HIGH RISK AREAS OF DESIRED WORK: n/a

PROBLEMS TO RETURNING TO FULL TIME WORK: medical issues

[MOTIVATION FOR GETTING INVOLVED IN JOB RELATED ACTIVITIES:]

LAST WORKED: 8/94

PERIOD OF UNEMPLOYMENT: 2 months

WILL JOIN THE JOBS CLUB: 10/13/94

[EXPECTATION TO BE DERIVED FROM WORKING:]

FINANCIAL SELF-ESTEEM

[EMPLOYMENT SEEKING SKILLS/EXPERIENCES:]

SECURED PAST EMPLOYMENT THROUGH: WORD OF MOUTH, PERSONAL CONTACT, WANT ADS, STATE EMPLOYMENT, JOB PROGRAM, OTHER:

JOB SEEKING TOOLS: RESUME', JOB APPLICATION

WORK RELATED DOCUMENTS: PICTURE ID, DRIVER'S LICENSE, SOCIAL SECURITY CARD, DD-214

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

Lee [redacted]

REGISTER NO. | WARD NO.

REPORT ON _____ or CONTINUATION OF _____

STANDARD FORM 507
General Services Administration and Interagency Committee on Medical Records
FIRMR (41 CFR) 201-45.505

3

Standard Form 507 — 048—16—81472p-3 GPO

CLINICAL RECORD

Report on _____
or
Continuation of S. F. _____
(Strike out one line) (Specify type of examination or data)

[REPORTED] [WORK HABITS:] *(Sign and date)*	ABOVE-AVERAGE	AVERAGE	POOR
TARDINESS	✓		
ABSENTEEISM		✓	
DEPENDABILITY	✓		
HONESTY	✓		

[REPORTED] [WORK RELATIONSHIPS:]	ABOVE- AVERAGE	AVERAGE	POOR
SUPERVISORS:		✓	
CO-WORKERS:	✓		

[WORK HISTORY:]

LAST 5 YEARS HAVE BEEN: stable TOTAL NUMBER OF JOBS: 2 LONGEST JOB: 6 months

DATES LAST EMPLOYED:	POSITION:	FULL/PART-TIME:	REASON LEFT:
3/84 - 8/92	Warehouse Asst.	full	medical health

LAST 5 YEARS TIMES:	QUIT:	FIRED:	LAID OFF:
	—	—	—

SIGNIFICANT VOCATIONAL DYSFUNCTION BEGAN: reg. hurt work transfer (disliked work)

MAJOR WORKPLACE STRESSORS: —

POSITIVE WORK REFERENCES FOR JOB SEARCH: yes

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

[redacted]

REGISTER NO.

WARD NO.

REPORT ON _____ or CONTINUATION OF _____

STANDARD FORM 507
General Services Administration and Interagency Committee on Medical Records
FIRMR (41 CFR) 201-45.505
October 1975 — 507-107

Standard Form 507 — 668—16—81472p-8 GPO

CLINICAL RECORD	Report on _____ or Continuation of S. F. _____ (Strike out one line) (Specify type of examination or data)

[WORK ADJUSTMENT NEEDS:] (Sign and date)

[PHYSICAL LIMITATIONS:] none

[CHRONIC MEDICAL PROBLEM/MEDICATIONS:] Gender related medical problems affect work participation — scheduled to be corrected

[PSYCHIATRIC DISABILITY:] none reported

[SUBSTANCE ABUSE HISTORY:]

DRUG OF CHOICE: alcohol LENGTH OF ABUSE: 16yrs REHABILITATION ATTEMPT: 1

12 STEPS WORKED IN PAST: 0 PAST USE OF SPONSOR: 0 USE OF AA/NA: 0

MOTIVATION FOR THIS ADMISSION: "had to do something for self"

[SUPPORT SYSTEM/FAMILY/FRIENDS:] family

[FINANCIAL SUPPORT:] husband's pay

[HOMELESSNESS:] no

LENGTH OF TIME: RESIDING:

[CURRENT LEGAL PROBLEMS:] no

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)	REGISTER NO.	WARD NO.
Carl [redacted]		

REPORT ON _____ or CONTINUATION OF _____

STANDARD FORM 507
General Services Administration and Interagency Committee on Medical Records
FIRMR (41 CFR) 201-45.505
October 1975 507-107

5

Standard Form 507 — 048—16—81672-3 GPO

CLINICAL RECORD	Report on _____ or Continuation of S. F. _____ (Strike out one line) (Specify type of examination or data)

(Sign and date)

[PERSONAL GROOMING/APPEARANCE:]

AT TIME OF INTERVIEW: average

ON PAST JOBS: above average

[AMENABILITY TO VOCATIONAL COUNSELING:]

COMPLIANCE WITH PERFORMANCE CONTRACT TO BE PUNCTUAL AND PREPARED: yes

[CRITERIA TO BE ADDRESSED TO BE DETERMINED JOB READY:]

___OBTAIN WORK RELATED DOCUMENTS

_✓_DEVELOP JOB SEARCH TOOLS (MASTER APPLICATION; RESUME')

_✓_RECEIVE JOB SEARCH TRAINING

_✓_SECURE JOB LEADS

_✓_RECEIVE VOCATIONAL GUIDANCE AND COUNSELING

_✓_RECEIVE VOCATIONAL REHABILITATION CASE MANAGEMENT

_✓_PARTICIPATE IN THERAPEUTIC WORK ADJUSTMENT SERVICES

___OBTAIN DRIVER'S LICENSE OR PICTURE ID

[TREATMENT METHODS/DATES OF SERVICE:]

✓ EMPLOYMENT READINESS NEEDS AND JOB SEEKING TRAINING WILL BE ADDRESSED IN THE JOBS CLUB WHICH MEETS EVERY TUESDAY AND THURSDAY FROM 2:45-4:00. THIS STAFF OR CO-WORKER WILL REPORT PROGRESS AT PATIENT'S SCHEDULED DISCHARGE DATE.

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)	REGISTER NO.	WARD NO.
Paul [redacted]		

REPORT ON _____ or CONTINUATION OF _____

STANDARD FORM 507
General Services Administration and Interagency Committee on Medical Records
FIRMR (41 CFR) 201-45.505
October 1975 - 507-107

6

Standard Form 507 — e48—16—81472-3 GPO

CLINICAL RECORD

Report on _____
or
Continuation of S. F. _____
(Strike out one line) *(Specify type of examination or data)*

(Sign and date)

✓ APTITUDE LEVELS AND INTEREST WILL BE EXPLORED VIA TESTING SCHEDULED WITHIN 5 WORKING DAYS AFTER INTAKE. THIS STAFF WILL INTERPRET RESULTS, CONDUCT VOCATIONAL GUIDANCE AND COUNSELING AND WRITE REPORT ON SF-507.

✓ TO ASSIST JOB LEADS, THIS STAFF WILL SET-UP AN INTERVIEW WITH THE MISSISSIPPI STATE EMPLOYMENT SERVICE REPRESENTATIVE. INTERVIEW WILL OCCUR THE WEDNESDAY PRIOR TO SCHEDULED DISCHARGE.

___ THIS STAFF WILL COMPLETE CONSULTATION TO THE DRIVER'S EDUCATION SPECIALIST. STAFF TOMMY JERMYN WILL SCHEDULE APPOINTMENT, ASSIST AND REPORT PROGRESS BY PATIENT'S SCHEDULED DISCHARGE DATE.

[RECOMMENDATIONS:] NOTE:
PENDING NO BEHAVIORIAL OR COMPLIANCE INFRACTIONS;
ADHERENCE TO TOTAL TREATMENT & PROGRAM ACTIVITIES.

✓ THIS VETERAN APPEARS TO BE AN APPROPRIATE CANDIDATE FOR THE HOMELESS VETERANS VOCATIONAL PROGRAM.

___ THIS VETERAN APPEARS TO BE AN APPROPRIATE CANDIDATE FOR WORK READINESS FOLLOW-UP BY A VOCATIONAL REHABILITATION SPECIALIST.

___ THIS VETERAN APPEARS TO BE AN APPROPRIATE CANDIDATE FOR PARTICIPATION IN THE INCENTIVE THERAPY EVALUATIVE PROGRAM FOR IDENTIFIED WORK ADJUSTMENT NEEDS.

✓ THIS VETERAN APPEARS TO BE AN APPROPRIATE CANDIDATE FOR EVALUATION FOR SUPPORTED EMPLOYMENT TO RE-ESTABLISH A POSITIVE EMPLOYMENT RECORD AND WORK REFERENCE.

Marsha Y. Garrett

MARSHA Y. GARRETT, M. Ed.
VOCATIONAL REHABILITATION SPECIALIST

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)* | REGISTER NO. | WARD NO.

Dave [redacted]

REPORT ON _____ or CONTINUATION OF _____

STANDARD FORM 507
General Services Administration and Interagency Committee on Medical Records
FIRMR (41 CFR) 201-45.505