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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 IV 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

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
JOBS CLUB	WARD 41G1	10/[illegible]-94

REASON FOR REQUEST (Complaints and findings)

PLEASE ASSIST IN OBTAINING NEEDED WORK DOCUMENTS, JOB SEARCH TOOLS, SECURING JOB LEADS AND OTHER IDENTIFIED NEEDS. VETERAN HAS DISCHARGE DATE OF:
VETERAN WAS LAST EMPLOYED ON: AS A:
TRANSPORTATION: APPLYING FOR DOM: TYPE WORK SEEKING:

PROVISIONAL DIAGNOSIS

SUBSTANCE ABUSE

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	[ ]ROUTINE [ ]TODAY
[illegible]		[ ] BEDSIDE [ ] ON CALL	[ ]72 HOURS [ ]EMERGENCY

CONSULTATION REPORT

PSYCHOLOGY SERVICE JOBS CLUB

SCHEDULE: VETERAN WILL BE SEEN ON TUESDAYS AND THURSDAYS FROM 2:45-4:00 IN THE JOBS CLUB, LOCATED IN ROOM 101 OF BUILDING 57.

GOAL: TO PROVIDE VETERAN EDUCATION AND RESOURCES TO OBTAIN NEEDED WORK DOCUMENTS, CONSTRUCT EMPLOYMENT SEEKING TOOLS , SECURE JOB LEADS AND PREPARE TO FOLLOW THROUGH ON THOSE LEADS.

INDIVIDUAL OBJECTIVES:

✓ MASTER JOB APPLICATION ✓ RESUME' ___MINI RESUME' CARD

___COMPLETE FORM/APPLICATION TO OBTAIN NEEDED WORK DOCUMENTS

✓ SECURE JOB LEADS ✓ OBTAIN OCCUPATIONAL/EDUCATIONAL INFORMATION

___CONTACT POTENTIAL REFERENCES ___DRAFT NEEDED LETTER

METHODS: THE VETERAN WILL UTILIZE THE CLASSIFIED ADS, THE STATE EMPLOYMENT SERVICE, THE YELLOW PAGES, THE FEDERAL AND NONFEDERAL JOB LISTINGS, THE DICTIONARY OF OCCUPATIONAL TITLES, ETC. HE WILL ALSO RECEIVE JOB SEEKING TRAINING AND TIPS ON HOW TO IMPROVE RESPONSES ON EMPLOYMENT APPLICATIONS.

PROGRESS: DOCUMENTATION OF PROGRESS WILL BE ACCOMPLISHED BY THE UNDERSIGNED.

(Continued on reverse side)

SIGNATURE AND TITLE			DATE
[illegible]			10/[illegible]-94
IDENTIFICATION NO.	ORGANIZATION	REGISTER NO.	WARD NO.
[redacted]			

[redacted] IDENTIFICATION (For typed or written entries give: Name-last,first,middle; grade; rate; hospital or medical facility)

DAVE [illegible]

CONSULTATION SHEET
STANDARD FORM 513

SATP-R PSY/SOC

MEDICAL RECORD | **CONSULTATION SHEET** INWARD

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
SATP	MHC	9/21/94.

REASON FOR REQUEST (Complaints and findings)

WF c H/O ETOH Dependence. Recent relapse. Abstinent 2-3 days. Place. Med. staff

PROVISIONAL DIAGNOSIS

ETOH Dep. Adjustment Disorder.

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
		☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

37 y/o NSC, W/F, married 4 1/2 years, 3rd marriage. No children. Previous inpatient treatment at Andrews AFB, Wash D.C. Vet abstinent last two days. Spent previous week on a binge, preceded by husband informing her he wants a divorce. Vet in BO throughout binge period. Last attended AA 5 years ago. First drink at approx. age 14. Regular use started at age 18 in service. Became problematic during a remote at age 21. Drinking in room, and in larger amounts. Decreased after returning to the states. Prior to treatment Vet drinking was habitual excessive, daily consuming 3 or 4 beers and 3 or 4 shots of whiskey. Coincided with medical problems, involved stomach disorder. Experimented with marijuana, last use over 5 years ago. Denies use of other drugs. No IV drug use. History of BOs prior to last binge. Denies history of DTs or seizures. No history of violent episodes. No current homicide ideation's. Spoke to psychiatrist about thoughts of suicide. No current suicide ideation's. Other than pending divorce no pending legal problems. No jail or prison time. Reports serious pelvic distress, wrist problems and headaches. No other medical problems outside alcohol dependence.. Reports needing dental work. Positive family history for alcoholism, i.e. paternal grandfather, paternal uncle. No known drug addiction or mental illness in family. Has support of father for treatment. Father resides in Vet's home. No known diagnosis for psychiatric problems. Vet reports being a rape victim while on active duty. Vet is not homeless at this time. She is unemployed. Prescribed medication by MHC psychiatrist reportly for depression an sleeplessness. RECOMMENDATION: SATP inpatient. ADMISSION DATE: 10/04/94

(Continued on reverse side)

SIGNATURE AND TITLE			DATE
Alvin J Dyke Addiction Therapist (ACAC)			9/21/94
IDENTIFICATION NO.	ORGANIZATION	REGISTER NO	WARD NO.

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

DOVE GAYLE

515 64 6094

CONSULTATION SHEET
STANDARD FORM 513 (Rev. 9-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
513-108

MEDICAL RECORD | CYTOPATHOLOGY - ORIGINAL Pg 1

ubmitted by: ALBERT L DIAZ MD Date obtained: SEP 22, 1994

pecimen (Received SEP 22, 1994 15:24):
AG

rief Clinical History:

reoperative Diagnosis:

perative Findings:

ostoperative Diagnosis:

Surgeon/physician: ALBERT L DIAZ MD

PATHOLOGICAL REPORT

aboratory: BILOXI/GULFPORT VAMC Accession No. C94 849

ross Description:

icroscopic Description:
DIAGNOSIS: CYTOLOGY, PAP SMEAR, VAGINAL: WITHIN NORMAL LIMITS.

NOTE: The report was submitted by S. Holmes, CT, and QA'd by L. Hart, CT, KAFBMC.

NOMED code(s):
-8X210: vaginal cytologic material
M-09460: negative for malignant cells

(End of report)

DWARD C. KRECKER MD / SAAD P. SHAHEEN MD jd | Date OCT 6, 1994

OVE,GAYLE A SSN: [redacted] CYTOPATHOLOGY Report
EX: F DOB: [redacted] AGE: 37 CUR LOC: 4G-SATP
DM:OCT 4, 1994 DX:ETOH ALBERT L DIAZ MD

MEDICAL RECORD	GYNECOLOGIC CYTOLOGY 849

SECTION I—CLINICAL DATA TO BE COMPLETED BY EXAMINING INSTALLATION

DATE OBTAINED	LMP FIRST DAY	DATE RECEIVED IN LABORATORY
9/22/94	Hysterectomy	

SOURCE OF SPECIMEN

☐ COMBINED CERVIX AND VAGINA ☐ CERVIX ☒ VAGINA ☐ OTHER (specify)

AGE	PREGNANCY	GRAVIDA	PARA	PREVIOUS ABNORMAL CYTOLOGIC EXAMINATION
37	☐ YES ☐ NO			Not Available ☐ YES (Give date) ☐ NO

CLINICAL HISTORY (Surgery, drugs, hormones, radiation, etc.)
Recurrent Abdominal pain
Prior Hysterectomy, due to Adhesions

PHYSICAL EXAMINATION (Pelvic findings, etc.)
no masses palpable

SPECIMEN SUBMITTED BY (Facility)	SIGNATURE AND TITLE	SUBMITTING FACILITY ACCESSION NUMBER
Biloxi VA med Ctr		

SECTION II—CYTOLOGIC FINDINGS FROM REPORTING INSTALLATION ONLY

NAME OF LABORATORY	ACCESSION NUMBER

CHECK (✓) ONE	YES	NO	CHECK (✓) ONE	YES	NO	
Granulocytes			Endocervical cells			MATURATION INDEX
Leptothrix						PARABASALS
Trichomonas			SCREENED BY			INTERMEDIATES
Candida						SUPERFICIALS

COMMENTS AND RECOMMENDATIONS

PATHOLOGIST'S SIGNATURE	TITLE	DATE

PATIENT'S IDENTIFICATION (Name—Last, first, middle; grade; rank; rate; hospital or medical facility)	REGISTER NO.	WARD OR CLINIC
X DOVE, GAGLE A [redacted]		

STANDARD FORM 541 (Rev. 11-77)
Prescribed by GSA and ICMR, FPMR 101-11.806-8
541-110

☆ U.S. GOVERNMENT PRINTING OFFICE: 1993 - 515-802 - 1303/81313

DOA: 1-5-7

KEESLER MEDICAL CENTER, KEESLER AFB, MS 39534-5300
CYTOLOGY REPORT ON ACCESSION NUMBER C-46649-94
FINAL REPORT

PATIENT:		COLLECTED:	RECEIVED:	SOURCE:	LMP:
DOVE, GAYLE A [redacted]	SEX: F	22-SEP-94	26-SEP-94	VAGINA	
	AGE: 37				

HISTORY: hysterectomy

CL INFO:
Recurrent Abdominal Pain, Prior Hyst Due to Adhesions, No Masses Palpable

ORDERING PHYSICIAN: ILLEGIBLE

SEND TO: Outside accession number C-849-94
DEPARTMENT OF VETERANS AFFAIRS, MEDICAL CENTER (385-5778 DR KRECKER)
BILOXI MS: 39531-2410

PREVIOUS ACCESSIONED CASES:

SPECIMEN ADEQUACY/ENDOCERVICAL SAMPLING:
Specimen satisfactory, no endocervical components seen, consistent with history of hysterectomy and/or vaginal specimen source.

DIAGNOSIS:
WITHIN NORMAL LIMITS

L. Hart
QA CYTOTECNOLOGIST

S. Holmes
CYTOTECHNOLOGIST

04-OCT-94
DATE EXAMINED

PERSONAL DATA - PRIVACY ACT OF 1974 (5 USC 552a)

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
Dr. Springer	SATP	10/24/94

REASON FOR REQUEST (Complaints and findings)

Please evaluate rash on arms & @ waistline

PROVISIONAL DIAGNOSIS

Cracked dry

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	☐ ROUTINE ☐ TODAY
dr. Elk / D		☐ BEDSIDE ☐ ON CALL	☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

WT 145 US: 993 100/62

HT 66½" multiple indurated lesion

NKA that are progressing from

Cervicothoracic space to trunk bilat

Rx Medrol Dosepak

Derm consult

(Continued on reverse side)

SIGNATURE AND TITLE			DATE
J Springer MD			10/24/94
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 number)

DOVE, GAYL A
5246 A STREET
BILOXI MS 39530

047

[redacted] [redacted]

C-55# 5 8

CONSULTATION SHEET
STANDARD FORM 513 (Rev. 9-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
513-108

Radiology Diagnostic Report
VETERANS ADMINISTRATION MEDICAL CENTER
Division: Biloxi, MS (CONS)

iME: DOVE,GAYLE A
iN : [redacted]
iTE OF EXAM: OCT 6,1994 08:30
:PORTED : OCT 7,1994
:ANSCRIBED : OCT 7,1994 13:22

CASE: 670
REQUESTED BY: EHIK,JULIUS
TECHNOLOGIST: SUTHERLIN,CONSTANCE D.
AGE: 37 SEX: FEMALE
WARD/CLINIC : 4G-SATP

:OCEDURE : CHEST, TWO VIEW

Exam Modifiers : None

Clinical History:
R/O INFILTRATES FOR ADMT

Report:
CHEST: Two views demonstrate no acute infiltrate. The heart, mediastinum, and diaphragm appear normal. The bone structure is unremarkable.

Impression:
No acute disease.

.lms were read by QUAN HUU HA (Staff Physician).

;DB

AME: DOVE,GAYLE A
[redacted]

WARD/CLINIC: 4G-SATP

MEDICAL RECORD

DOCTOR'S ORDERS

Revision to Standard Form 508 Approved by OMB

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
		~~SATP ADMISSION ORDERS (PAGE 1 OF 2)~~		
10.5.94	1.	D/C Previous Orders		
	2.	Admit to SATP:		
	3.	Allergies/Sensitivities/Reactions		
	4.	Regular diet as tolerated		
	5.	Theravit w/minerals one P.O. qd @ 0600		
	6.	Thiamine HCL 100mg P.O. qd @ 0600		
	7.	Folic Acid 1mg P.O. qd @ 0600		
	8.	Acetaminophen 650mg P.O. q4hr PRN pain/temp		
	9.	Milk of Magnesia 30ml P.O. qd PRN constipation		
	10.	Attapulgite 30ml P.O. each diarrhea stool PRN		
	11.	Alum & Mag Hydrx 15ml P.O. q4hr PRN indigestion		
	12.	Promethazine 25mg P.O./IM q4hr PRN for nausea/vomiting		
	13.	Dimetapp 1 tab P.O. q12hr PRN for cold symptoms		
	14.	Benzonatate 100mg P.O. q4hr PRN cough		
	15.	Cepastat throat lozenges 1 P.O. q2hr PRN sore throat		
	16.	~~Laboratory Workup (if not previously done on this admission~~		
		~~Urinalysis, CBC, RPR, FBS, BUN, Creatinine, Mg++,~~		
		~~Serum Electrolytes, Liver Profile, Hepatitis Profile,~~		
		~~Cholesterol Level, Triglycerides~~		
	17.	EKG, Chest X-ray (R/O infiltrates)		

Enter on specimen: PATIENT IDENTIFICATION – TREATING FACILITY – WARD NO. – DATE

D[redacted]
5246 A STREET
BILOXI MS 39530

[redacted]

10-5-94

MEDICAL RECORD
DOCTOR'S ORDERS

EXISTING [redacted]

C-554 5 8

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
		Do 10/5/94 Do 10/25/94		
		~~SATP ADMISSION ORDERS~~ (PAGE 2 OF 2)		
	18.	HIV Pre & Post Test Counseling Dziah, Pc LADD 295583		
	19.	HIV Test (AFTER PATIENT CONSENT IS OBTAINED)		
	20.	Initial Dental Exam		
	~~21.~~	~~PPD~~		
		Inherent Rum		
		① Orudis 50 mg PO TID prn for pain		
		② Provera 2.5 mg PO daily	V O	
		③ Sertaline 50 mg PO Q AM	V O	
		④ Premarin 1.25 mg - one tablet on days 1 to 25	V O	
		⑤ Vistaril 50 mg QHS for sleep V.O. Dr. Liberto / Jim Dziah, RN	V O	
		10-5-94-mk		

Enter in space below: PATIENT IDENTIFICATION – TREATING FACILITY – WARD NO. – DATE

SATP Emdsne #9

DOVE,GAYLE A
5240 A STREET
BILOXI

[redacted]

C-55N 5 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]

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
10/4/94	9)	D/C orders	
14:31	2)	Motrin 400 mg PO TID p.r.n. pain fever	
10/5/94 MK		CTP 10/4/94 1444	
Oct. 11, 94			
		Again renal spray was ordered Tuesday. Tomorrow yet Derm spray for patient pain as directed well. wound care by Derm.	Grace Hagen 10/11/94 1800
10/12/94		K. Smith RNC	Grace Hagen 10/14/94 1800
10/24/94		Medrol - per Dosepak. amounts Consult x pharmacy for directions Dermatology consult	[redacted] 10/24/94
		CTP EMDMC #5	Karl Gallina RN 10/24/94

Enter in space below: PATIENT IDENTIFICATION — TREATING FACILITY — WARD NO. — DATE

[redacted] . SAYLE A
5240 A STREET
BILOXI

25
C47
MS 39530

[redacted] MF 081557 520

C-55% [redacted] 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

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.)	V	NURSE'S SIGNATURE
10/26/94		D/C Folic acid		
1400		25/0 Dr. Chik/Pat Lunch		
		#2 c-TP 10/26 1410		
				10/27/94

Enter in space below: PATIENT IDENTIFICATION – TREATING FACILITY – WARD NO. – DATE

DOVE, GAYLE A
5246 A STREET
BILOXI MS 39530

[redacted]

C-SSN 5 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

Department of Veterans Affairs

CONTINUING MEDICATION RECORD

MONTH: OCT YEAR: 1994

ORIG. ORD. DATE	START DATE	STOP DATE	MEDICATIONS DOSE/ROUTE/FREQUENCY	ADMIN. TIMES:	DATE: 4	5	6	7	8	9	10	11	12	13	14	15	16	17
10/04	10/04	11/03/94 13:00 (D6094)	SERTRALINE 50MG TAB C Give: 50MG PO QD RPH: RN:GT	0600	NK													
10/04	10/04	11/03/94 13:00 (D6094)	HYDROXYZINE HCL 50MG U/D C Give: 50MG PO HS FOR SLEEP RPH: RN:GT	2100														

ADDRESSOGRAPH

INJECTION SITES

INDICATE RIGHT (R) OR LEFT (L)
1. DELTOID
2. ABDOMEN
3. ILIAC CREST

SIGNATURE/TITLE

INIT.

ALLERGIES: NKA

1512

Department of Veterans Affairs

CONTINUING MEDICATION RECORD

MONTH: Oct YEAR: 1994

ORIG. ORD. DATE	START DATE	STOP DATE	MEDICATIONS DOSE/ROUTE/FREQUENCY	ADMIN. TIMES:	DATE 4	5	6	7	8	9	10	11	12	13	14	15	16	17
10/04	10/04	11/03/94 13:00 (D6094)	ESTROGENS, CONJUGATED 1.25MG U/D C Give: 1.25MG PO QD TAKE ONE TAB FOR DAYS 1-25 RPH: RN:GT	0600	NK													
10/04	10/04	11/03/94 13:00 (D6094)	FOLIC ACID 1MG U/D C Give: 1MG PO QD RPH: RN:GT	0600	NK													
10/04	10/04	11/03/94 13:00 (D6094)	MEDROXYPROGESTRONE 2.5MG TAB C Give: 2.5MG PO QD PROVERA RPH: RN:GT	0600	NK													
10/04	10/04	11/03/94 13:00 (D6094)	THERAVIT W/MINERALS U/D C Give: 1 PO QD RPH: RN:GT	0600	NK													
10/04	10/04	11/03/94 13:00 (D6094)	THIAMINE 100MG U/D C Give: 100MG PO QD RPH: RN:GT	0600	NK													

ADDRESSOGRAPH

[redacted]

08/15/57 (37)

INJECTION SITES

INDICATE RIGHT (R) OR LEFT (L)
1. DELTOID
2. ABDOMEN
3. ILIAC CREST
4. GLUTEAL
5. THIGH

117-1

NOT POUR

SIGNATURE/TITLE

INIT.

ALLERGIES
NKA

1513

Department of Veterans Affairs

CONTINUING MEDICATION RECORD

MONTH: Oct. YEAR: 1994

ORIG. OR DA	START	STOP	MEDICATIONS	ADMIN.	DATE: 16	19	20	21	22	23	24	25	26	27	28	29	30	31
	10/04	10/04	11/03/94 13:00 (D6094) ESTROGENS, CONJUGATED 1.25MG U/D C Give: 1.25MG PO QD TAKE ONE TAB FOR DAYS 1-25 RPH:DML RN:GT	0600	NK													
	10/04	10/04	11/03/94 13:00 (D6094) FOLIC ACID 1MG U/D C Give: 1MG PO QD RPH:DML RN:GT	0600	NK													
	10/04	10/04	11/03/94 13:00 (D6094) MEDROXYPROGESTRONE 2.5MG TAB C Give: 2.5MG PO QD RPH:DML RN:GT	0600	NK													
	10/04	10/04	11/03/94 13:00 (D6094) THERAVIT W/MINERALS U/D C Give: 1 PO QD RPH:DML RN:GT	0600	NK													
	10/04	10/04	11/03/94 13:00 (D6094) HYDROXYZINE HCL 50MG U/D C Give: 50MG PO HS FOR SLEEP RPH:DML RN:GT	~~2100~~														

DC'd 10/26/94

ADDRESSOGRAPH

DOVE,GAYLE A [redacted] [redacted] (37) 125-21
FEMALE DI: ETOH NOT FOUND
10/04/94 14:14 NEW ORDER
4G-SATP 4G-SATP

INJECTION SITES

INDICATE RIGHT (R) OR LEFT (L)
1. DELTOID
2. ABDOMEN
3. ILIAC CREST
4. GLUTEAL
5. THIGH

SIGNATURE/TITLE	INIT.	ALLERGIES
Noami Travers, RNC	NK	NKA
Dawn Tolbert, RN	DT	
Tim Clark, RN	TC	
Carol Griffith, RN	CG	
Sarah Lehagh, RN	SL	

1514

Department of Veterans Affairs

CONTINUING MEDICATION RECORD

MONTH: Oct. Y 1994

ORIG. ORD. DATE	START DATE	STOP DATE	MEDICATIONS DOSE/ROUTE/FREQUENCY	ADMIN. TIMES:	DATE: 18	19	20	21	22	23	24	25	26	27	28	29	30	31
10/04	10/04	11/03/94 13:00 (D6094) 0600	SERTRALINE 100MG U/D Give: 50MG PO QAM GIVE 1/2 TABLET RPH:DML RN:NK	C	NK													
10/04	10/04	11/03/94 13:00 (D6094) 0600	THIAMINE 100MG U/D Give: 100MG PO QD RPH:DML RN:GT	C	NK													

ADDRESSOGRAPH

DOVE,GAYLE A [redacted] 125-21
[redacted] (37) NOT FOUND
DX: ETOH
10/04/94 14:14 NEW ORDER
4G-SATP 4G-SATP

INJECTION SITES

INDICATE RIGHT (R) OR LEFT (L)
1. DELTOID
2. ABDOMEN
3. ILIAC CREST
4. GLUTEAL
5. THIGH

SIGNATURE/TITLE	INIT.	ALLERGIES
Naomi Tugwell RNC	NK	NKA
Gail Ozaki, R	GO	
Ethel Scott RNC	ES	

VA FORM [illegible] EXISTING STOCK OF VA FORM 10-2970, AUG 1982 NAME: BED # PAGE ___ OF ___

1515

Department of Veterans Affairs

CONTINUING MEDICATION RECORD

MONTH: Oct/Nov YEAR: 1994

ORIG. ORD. DATE	START DATE	STOP DATE	MEDICATIONS DOSE/ROUTE/FREQUENCY	ADMIN. TIMES	DATE: 25	26	27	28	29	30	31	1	2	3	4	5	6	7
10/24	10/24	11/23/94 13:00 (D6094)	METHYLPREDNISOLONE 4MG TAB C Give: UD PO UD SEE SPECIAL INSTRUCTIONS FOR MEDS BELOW RPH:VRM RN:CRW															
			DAY ONE 2 Tablets before Bfast and hs	0600														
				2100	ES													
			DAY ONE 1 Tablet after Lunch and after Dinner	1300	R													
				1800														
			DAY TWO 1 Tablet before Bfast After Lunch and Dinner	0600	→													
				1300	→	R												
				1800	→	M												
			DAY TWO 1½ Tablets hs	2100	→	M												

TAKE AS FOLLOWS: TO BEGIN THERAPY, START IN THE MORNING AT BREAKFAST.
DAY ONE: TWO TABLETS BEFORE BREAKFAST, ONE TABLET AFTER LUNCH AND DINNER, TWO TABLETS AT BEDTIME.
DAY TWO: ONE TABLET BEFORE BREAKFAST, ONE TABLET AFTER LUNCH AND DINNER, TWO TABLETS AT BEDTIME.
DAY THREE: ONE TABLET BEFORE BREAKFAST, ONE TABLET AFTER LUNCH AND DINNER, ONE TABLET AT BEDTIME.
DAY FOUR: ONE TABLET BEFORE BREAKFAST, ONE TABLET AFTER LUNCH AND [redacted], ONE TABLET AT BEDTIME.
DAY FIVE: ONE TABLET BEFORE BREAKFAST AND ONE TABLET AT BEDTIME.
DAY SIX: ONE TABLET BEFORE BREAKFAST.

ADDRESSOGRAPH

HOVE, GAYLE A [redacted] (37)
FEMALE DX: STOM
10/24/94 16:20 NEW ORDER
4G-SATP

125-2. NOT POSNI
4G-SATI

INJECTION SITES

INDICATE RIGHT (R) OR LEFT (L)
1. DELTOID
2. ABDOMEN
3. ILIAC CREST
4. GLUTEAL
5. THIGH

SIGNATURE/TITLE	INIT.	ALLERGIES
Red Walker RN	m	NKA
Pat Soder RN	SO	
Clark Smith RN	ES	

1516

Department of Veterans Affairs

CONTINUING MEDICATION RECORD

MONTH: Oct Nov YEAR: 1994

ORIG. ORD. DATE	START DATE	STOP DATE	MEDICATIONS DOSE/ROUTE/FREQUENCY	ADMIN. TIMES:	DATE: 25	26	27	28	29	30	31	1	2	3	4	5	6	7
			DAY THREE 1 tablet before B'fast after lunch and Dinner and hs	0600	→	→	→											
				1300	→	→	→											
				1800	→	→	→											
				2100	→	→	→											
			DAY FOUR 1 tablet before Bfast after lunch and hs	0600	→	→	→	→										
				1300	→	→	→	→										
				2100	→	→	→	→										
			DAY FIVE 1 tablet before Bfast and hs	0600	→	→	→	→	→									
				2100	→	→	→	→	→									
			DAY SIX 1 tablet before B'fast	0600	→	→	→	→	→	→	→							

10/24 | 10/24 | 11/23/94 13:00 (D6094) |
METHYLPREDNISOLONE 4MG TAB C|
Give: UD PO UD |
SEE SPECIAL INSTRUCTIONS FOR MEDS |
ABOVE RPH:VRM RN:CRN |

ADDRESSOGRAPH

DOVE, GAYLE A
[redacted] [redacted] (37)
FEMALE DX: ECOH
10/24/94 16:20 NEW ORDER
4G-SAPP

125-2. NOT FOUND
4G-SATI

INJECTION SITES

INDICATE RIGHT (R) OR LEFT (L)
1. DELTOID
2. ABDOMEN
3. ILIAC CREST
4. GLUTEAL
5. THIGH

SIGNATURE/TITLE	INIT.	ALLERGIES
Rod Walker RN		NKA
Tim Cook RN		
Naomi Kimura, RNC		

1517

Department of Veterans Affairs

TREATMENT RECORD

MONTH: OCT / Nov. YEAR: 1994

ORIG. ORD. DATE	START DATE	STOP DATE	TREATMENT	ADMIN TIMES:	DATE: 10/28	29	30	31	11/1	2	3	4	5	6	7	8	9	10
10/28	10/28	11/27/94 13:00 (D6094)	BENZOYL PEROXIDE 10% GEL 45GM C Give: 10% TOP BID APPLY BID. MAY SELF MEDICATE. RPH:____ RN:GT	0600	—	nk	[illegible]	nk	nk	[redacted]								
				2100	VC	VC	AF	AF	AF									
10/28	10/28	11/27/94 13:00 (D6094)	TRIAMCINOLONE 0.1% OINTMENT,15GM R Give: 0.1% TOP BID APPLY BID. MAY SELF MED RPH:____ RN:GT	0600	—	nk	[illegible]	nk	nk									
				2100	VC	VC	AF	AF	AF									

ADDRESSOGRAPH

DOVE,GAYLE A [redacted] [redacted] (37) 125-2a NOT FOUND
FEMALE DX: ETOH
10/28/94 14:00 NEW ORDER
4G-SATP 4G-SATP

SIGNATURE/TITLE

Peggy Gallimore RN:
Verna Campbell NA
Regina Lambert RN
Ida Fry Walth NA

INIT.	ALLERGIES
PG	NKA
VC	
AF	

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Department of Veterans Affairs

PRN AND ONE-TIME MEDICATION RECORD

MONTH: OCT YEAR: 1994

START DATE	STOP DATE	MEDICATIONS DOSE/ROUTE/FREQUENCY
10/04	10/04	11/03/94 13:00 (D6094) MILK OF MAGNESIA,OZ R Give: 30ML PO QD PRN CONSTIPATION RPH: RN:GT
10/04	10/04	11/03/94 13:00 (D6094) IBUPROFEN 400MG U/D P Give: 1 OR 2 PO TID PRN PAIN RPH: RN:GT
10/14	10/12	11/11/94 13:00 (D6094) SODIUM CHLORIDE 0.65% NASAL SPRAY,EA R Give: UD NSL PRN AS DIRECTED. SELF-MEDICATE RPH:____ RN:SR
10/04	10/04	11/03/94 13:00 (D6094) CEPASTAT LOZENGES, (18/BX),LOZ,EA R Give: 1 PO Q2HR PRN SORE THROAT RPH: RN:GT
~~10/11~~	~~10/11~~	~~10/12/94~~ 06:00 (D6094) OXYMETAZOLINE 0.05% NASAL SPRAY 15ML P Give: UD NSL PRN AS NEEDED TODAY RPH:____ RN:SR

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT.	REASON	RESULTS	TIME	INITIALS
10/4/94	2000	Motrin 800mg po	[illegible]	c/o pain	effective	2100	[illegible]
10/4/94	0820	Milk of Magnesia 30ml po.	[illegible]	c/o constipation	effective	0930	[illegible]
10/5/94	1315	Motrin 800mg PO	[illegible]	c/o pain	effective		
10/5/94	1830	Motrin 800mg po	[illegible]	c/o pain	"out"	2030	[illegible]
10/6	0630	MOM 30cc PO	[illegible]	c/o constipation			
10/6	1100	Motrin 800mg PO	[illegible]	c/o pain	effective	1200	[illegible]
10/6	1830	Motrin 800mg po	[illegible]	c/o Pain	effective	1918	[illegible]
10/7/94	1125	Motrin 800mg PO.	[illegible]	c/o Pain	effective	1230	[illegible]
10/7/94	2030	Motrin 800mg PO	[illegible]	c/o pain	effective	2130	[illegible]
10/8/94	0807	MOM 30ml PO.	[illegible]	c/o constipation	effective	1820	[illegible]
10/8/94	0807	Ibuprofen 800mg po.	[illegible]	c/o Pain	effective	0900	[illegible]
10/8/94	1820	Motrin 800mg PO	[illegible]	c/o pain	effective	1930	[illegible]

ADDRESSOGRAPH

DOVE,GAYLE A [redacted] FEMALE DX: ETOH (37) 117-1 NOT FOUN
10/04/94 14:10 NEW ORDER
4G-SATP
4G-SAW

INJECTION SITES

Indicate Right (R) or Left (L)
1. DELTOID
2. ABDOMEN
3. ILIAC CREST
4. GLUTEAL
5. T HIGH

SIGNATURE/TITLE	INIT.	ALLERGIES
[illegible] RN	[illegible]	NKA
[illegible] RN	[illegible]	
[illegible] RN	[illegible]	
[illegible] RN	[illegible]	
[illegible]	[illegible]	

VA FORM OCT 1989 568d SUPERSEDES VA FORM 10-5568d, NOV 1984, WHICH WILL BE USED.

NAME: BED # IE____OF____

034832

1519

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT.	REASON	RESULTS	TIME	INITIALS
10/9/94	1425	Motrin 800mg po.	[illegible]	c/o pain	effective	1530	[illegible]
10/9/94	2230	Motrin 800 mg po	[illegible]	c/o pain	effective	2330	[illegible]
10/10/94	1130	Motrin 800mg po	[illegible]	c/o Pain		1250	[illegible]
10/10/94	2030	Motrin 800mg po	[illegible]	c/o pain	effective	2130	[illegible]
10/11/94	0645	Motrin 800mg i po	[illegible]	c/o pain	effective	0745	[illegible]
10/11	1310	Motrin 800mg + Po	[illegible]	severe H.A.	[illegible]	1403	[illegible]
10/11	1610	Cigrin nasal spray	[illegible]	nasal cong	[illegible]	1630	[illegible]
10/11/94	2110	Motrin 800mg po	[illegible]	c/o abd pain	effective	2200	[illegible]
10/12/94	0610	Motrin 800mg po	[illegible]	c/o abd pain	effective	0710	[illegible]
10/12	1430	Motrin 800 mg Po	[illegible]	abd. pain	[illegible]	1535	[illegible]
10/12/94	180	oxymetazoline NSL	[illegible]	c/o nasal congest	[illegible]	1900	[illegible]
10/12/	22:05	Motrin 800mg po.	[illegible]	c/o pain	[illegible]	2300	[illegible]
10/13	0935	Motrin 800 mg Po	[illegible]	c/o pain	effective	1030	[illegible]
10/13/94	1803	Oxymetazoline NSL	[illegible]	c/o nasal congestion	[illegible]	1900	[illegible]
10/13/94	2000	Motrin 800 mg po.	[illegible]	c/o pain	effective	2100	[illegible]
10-14	0725	motrin 800mgs po	[illegible]	lower abdomen pain	[illegible]	0800	[illegible]
10/14/94	1700	Motrin 800mg po	[illegible]	c/o pain	effective	1800	[illegible]
10/14/94	0000	Motrin 800mg po	[illegible]	c/o pain	effective	0100	[illegible]
10/15/94	1830	motrin 800 mg Po	[illegible]	c/o Pain	[illegible]	1915	[illegible]

SIGNATURE/TITLE	INIT.	SIGNATURE/TITLE	INIT.	SIGNATURE/TITLE	INIT.
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

1520

Department of Veterans Affairs

PRN AND ONE-TIME MEDICATION RECORD

MONTH: Oct '94

RPH:DML RN:GT

10/04 | 10/04 | 11/03/94 13:00 (D6094) | P
BROMPHENIRAMINE M/PHENYL SR U/D
Give: 1 PO Q12HR PRN

RPH:DML RN:GT NK

10/04 | 10/04 | 11/03/94 13:00 (D6094) | P
IBUPROFEN 400MG U/D
Give: 1 OR 2 PO TID PRN
PAIN NK

RPH:DML RN:GT

10/04 | 10/04 | 11/03/94 13:00 (D6094) | P
PROMETHAZINE 25MG U/D
Give: 25MG PO Q4HR PRN
IM OR PO AS NEEDED FOR N/V NK

START STOP MEDICATIONS

RPH:DML RN:GT

10/04 | 10/04 | 11/03/94 13:00 (D6094) | R
ALUM & MAG HYDRX CONC & SIMETHI 50Z,EA
Give: 15ML PO Q4HR PRN NK
INDIGESTION\

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT.	REASON	RESULTS	TIME	INITIALS
10/19/94	0858	Prometh 25mg po Ibuprofen 400mg po	CS	C/O abd pain	effective	1000	ES
10/19/94	1720	Motrin 800mg PO	CS	C/O pain	effective	1830	CS
10/17	0730	motrin 800mgs po	NK	10 w/d c abd. pain	effective	0900	NK
10/17	0815	Promethazine 25mg PO	DO	C/O nausea	effective	1200	DO
10/17/94	1700	Motrin 800 mg PO	CS	C/O Pain	effective	1800	CS
10/18	1200	Motrin 800 mg PO	DO	C/O pain	effective	1400	DO
10/18/94	2015	Motrin 800 mg PO	CS	C/O Pain	effective	2130	CS
10/19/94	1450	Motrin 800mg PO	MS	C/O Pain	effective	1530	MS
10/20	1150	Motrin 800 mg PO	DO	abd. pain	effective	1250	DO
10/20	1150	Promethazine 25 mg PO	DO	nausea	effective	1230	DO
10/21	0800	motrin 800 mgs po	NK	Headache	effective	0900	NK
10/21	1315	motrin 800 mg PO	MS	C/O Abd Pain	effective	1480	ES

ADDRESSOGRAPH

4G-SATP 4G-SATP

DOVE,GAYLE A [redacted] [redacted] (37) 125-21
FEMALE DX: ETOH NOT FOUND
10/04/94 14:20 NEW ORDER

INJECTION SITES

Indicate Right (R) or Left (L)
1. DELTOID
2. ABDOMEN
3. ILIAC CREST
4. GLUTEAL
5. T HIGH

SIGNATURE/TITLE	INIT.	ALLERGIES
CS Smith RPh	CS	
Walker RN		
Russell RN		
Graham RN		
Pat Foden		

VA FORM OCT 1989 568d SUPERSEDES VA FORM 10-5568d, NOV 1984, WHICH WILL BE USED.

NAME BED # PAGE OF

034932

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DATE	TIME	MEDICATION/DOSE/ROUTE	INIT.	REASON	RESULTS	..E	INITIALS
10/23/94	1210	Motrin 800 mg PO	m	C/O abd Pain	eff	1300	m
10/22/94	2015	Motrin 800 mg PO	ES	C/O abd pain	effective	23,1	ES
10/23/94	0930	Motrin 800 mg PO	m	C/O abd Pain	eff	1 00	m
10/23/94	1700	Motrin 800 mg PO	ES	C/O abd pain	effective	1800	ES
10/24/94	2015	Motrin 800 mg PO	m	C/O abd Pain	eff	2100	m
10/25/94	1710	Motrin 800 mg i PO	ES	C/O abd pain	effective	1810	ES
10/26	0720	Motrin 800 mg PO	DO	C/O abd pain	eff	0800	DO
10/26	1850	Motrin 800 mg PO	m	C/O abd Pain	eff	1945	m
10/27/94	0907	Motrin 800 mg p.o	D	C/O pain	eff	1030	D
10/27/94	1832	Motrin 800 mg PO	m	C/O abd Pain	eff	2000	m
10/28	0726	Motrin 800 mg PO	DO	C/O abd pain	eff	0900	DO
10/28	1715	Motrin 800 mg PO	m	C/O abd Pain	eff	1900	m
10/29/94	0905	Motrin 800 mg i PO	ES	C/O abd pain	effective	1000	ES
10/29/94	1800	Motrin 800 mg i PO	m	C/O abd Pain	eff	1900	m
10/30	0800	motrin 800 mg s.t. po	MK	abd. pain.	eff	0	MK
10/30/94	1850	Motrin 800 mg PO	SR	C/O abd pain	effective	2000	SR
10/31/94	1645	Motrin 800 mg PO	SR	C/O abd pain	effective	1715	SR

SIGNATURE/TITLE	INIT.	SIGNATURE/TITLE	INIT.	SIGNATURE/TITLE	INIT.
Naomi Krause, RN	MK		DO		SR

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Department of Veterans Affairs

PRN AND ONE-TIME MEDICATION RECORD

MONTH: Oct YEAR: 1994

START DATE	STOP DATE	MEDICATIONS DOSE/ROUTE/FREQUENCY
10/04	10/04	11/03/94 13:00 (D6094) ACETAMINOPHEN 325MG U/D P Give: 650MG PO Q4HR PRN PAIN/TEMP RPH: RN:GT
10/04	10/04	11/03/94 13:00 (D6094) BENZONATATE 100MG CAP P Give: 100MG PO Q4HRP PRN COUGH RPH: RN:GT
10/04	10/04	11/03/94 13:00 (D6094) BROMPHENIRAMINE W/PHENYL SR U/D P Give: 1 PO Q12HR PRN COLD SYMPTOMS RPH: RN:GT
10/04	10/04	11/03/94 13:00 (D6094) PROMETHAZINE 25MG U/D P Give: 25MG PO Q4HR PRN IM OR PO AS NEEDED FOR N/V RPH: RN:GT
10/04	10/04	11/03/94 13:00 (D6094) ALUM & MAG HYDRX CONC & SIMETHI 502,EA R Give: 15ML PO Q4HR PRN INDIGESTION RPH: RN:GT
10/04	10/04	11/03/94 13:00 (D6094) ATTAPULGITE SUSP,OZ R Give: 30ML PO PRN IM OR PO AS NEEDED FOR N /V RPH: RN:GT

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT.	REASON	RESULTS	TIME	INITIALS
10/2/94	0120	Tylenol gr x 80	SD	C/o abd pain			
10/3/94	1820	Acetaminophen 650mg po	SR	C/o headache	effective	1900	SR
10/5/94	1820	Dimetapp ÷ po	SR	C/o cold symptoms	effective	1900	SR
10-10	0600	Tylenol 650 mgs po	NK	for discomfort	T. 98.6 eff.	0800	NK
10-10	0600	Dimetapp ÷ po	NK	cold symptoms	eff.	0800	NK
10-10	0600	Benzonatate 100mg capt	NK	for cough	eff.	0800	NK
10-10	0600	Cepastat loz. po	NK	for sore throat	eff.	0800	NK
10/10/94	1610	Acetaminophen 650mg po	SR	C/o headache	effective	1700	SR
10/10/94	1815	Dimetapp ÷ po	SR	C/o cold symptoms	effective	1930	SR
10/11/94	0600	Dimetapp ÷ po	SD	C/o cold symptoms	effective	0700	SD
10/11/94	1815	Dimetapp ÷ po	SR	C/o cold symptoms	effective	1930	SR
10/12/94	0610	Dimetapp ÷ po	SD	C/o cold symptoms	effective	0710	SD

ADDRESSOGRAPH

DOVE,GAYLE A [redacted] 117-1
FEMALE DX: [redacted] (37) NOT FOUND
10/04/94 14:10 NEW ORDER
4G-SATP 4G-SAT

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]	SR	NKA
Sarah Nyhan, RN	S	
Naomi Tuuk/RPNE	N	
Ward Clerk PRT		

VA FORM OCT 1989 568d SUPERSEDES VA FORM 10-5568d, NOV 1984, WHICH WILL BE USED.

NAME: BED # E OF

034932

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DATE	TIME	MEDICATION/DOSE/ROUTE	INIT.	REASON	RESULTS	TIME	INITIALS
10/12/94	0800	Maalox 15 ml PO	ED	c/o indigestion	effective	0905	ED
10/12/94	1815	Dimetapp ÷ PO	[illegible]	c/o cold sx	[illegible]	2000	[illegible]
10-13	0600	Dimetapp ÷	MK	cold symptoms	E.E.	0800	MK
10/13/94	1823	Dimetapp ÷ PO	[illegible]	c/o cold sx			
10/13/94	2000	Tylenol 650 mg p.o	[illegible]	c/o headache	[illegible]	2100	[illegible]
10-14	0600	Dimetapp ÷ po	MK	cold SX.'s	eff.	0800	MK
10/14/94	1830	Dimetapp ÷ po	[illegible]	c/o cold symptoms	effective	1930	[illegible]
10/15/94	1830	Dimetapp ÷ Po	[illegible]	c/o Cold sx's	[illegible]	1915	[illegible]
10/16/94	1435	Maalox 15 ml po	ED	c/o indigestion	effective	1535	ED
10/17	1215	Tylenol gr x Po	[illegible]	c/o headache	[illegible]	1600	[illegible]
10/18	0945	Tylenol ÷ Po	[illegible]	c/o H.A.	[illegible]	1030	[illegible]
10/19	0930	Tylenol ÷ Po	[illegible]	c/o H.A	[illegible]	1030	[illegible]
10/23/94	0345	Tylenol 650 mg po	ED	c/o body pain	effective	0415	ED
10/24	0800	Tylenol 650 mg Po	[illegible]	abd. pain	effective	0900	[illegible]
10/24/94	1310	Tylenol 650 mg po	ES	c/o headache	Effective	1400	ES
10/31/94	1845	Promethazine 25 mg po	[illegible]	c/o nausea	effective	2045	[illegible]

SIGNATURE/TITLE	INIT.	SIGNATURE/TITLE	INIT.	SIGNATURE/TITLE	INIT.
[illegible] Naomi Hand, RN		[illegible]	[illegible]	[illegible] Jane Dziak, RN	[illegible]

Department of Veterans Affairs

PRN AND ONE-TIME MEDICATION RECORD

MONTH: Oct.-Nov. 1994

START	STOP	MEDICATIONS
10/04	10/04	11/03/94 13:00 (D6094)
		ALUM & MAG HYDRX CONC & SIMETHI 50Z,EA R Give: 15ML PO Q4HR PRN INDIGESTION\ RPH:DML RN:GT NK
10/04	10/04	11/03/94 13:00 (D6094)
		ATTAPULGITE SUSP,OZ R Give: 30ML PO PRN IN OR PO AS NEEDED FOR N /V RPH:DML RN:GT NK
10/04	10/04	11/03/94 13:00 (D6094)
		CEPASTAT LOZENGES, (10/BX),LOZ,EA R Give: 1 PO Q2HR PRN SORE THROAT RPH:DML RN:GT NK
10/14	10/12	11/11/94 13:00 (D6094)
		SODIUM CHLORIDE 0.65% NASAL SPRAY,EA R Give: UD BSL PRN AS DIRECTED. SELF-MEDICATE RPH:DML RN:SR NK

START DATE	STOP DATE	MEDICATIONS DOSE/ROUTE/FREQUENCY
10/31	10/31	10/31/94 08:00 (D6094)
		INFLUENZA VACCINE 0.5ML,1DOSE/VI,DOSE D Give: 0.5MG IM ONCE RPH:____ RN:JO

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT.	REASON	RESULTS	TIME	INITIALS
10/31	0640	Influenza vac. 0.5cc IM R, gm	JO	Dr. order			

ADDRESSOGRAPH

DOVE,GAYLE A [redacted] 125-21
[redacted] NOT FOUND
FEMALE DX: ETOH [redacted]
10/04/94 14:19 NEW ORDER
4G-SAVD 4G-SAVD

INJECTION SITES

Indicate Right (R) or Left (L)
1. DELTOID
2. ABDOMEN
3. ILIAC CREST
4. GLUTEAL
5. THIGH

SIGNATURE/TITLE	INIT.	ALLERGIES
[signature]	JO	NKA

1525

Department of Veterans Affairs

PRN AND ONE-TIME MEDICATION RECORD

MONTH: oct- nov. | Y | 1994

START	STOP	MEDICATIONS
10/04	10/04	11/03/94 13:00 (D6094)
		ACETAMINOPHEN 325MG U/D P
		Give: 650MG PO Q4HR PRN
		PAIN/TEMP
		RPH:DML RN:GT NK
10/04	10/04	11/03/94 13:00 (D6094)
		BENZONATATE 100MG CAP P
		Give: 100MG PO Q4HRT PRN
		COUGH
		RPH:DML RN:GT NK
10/04	10/04	11/03/94 13:00 (D6094)
		BROMPHENIRAMINE M/PHENYL SR U/D P
		Give: 1 PO Q12HR PRN
		COLD SYMPTOMS
		RPH:DML RN:GT NK
10/04	10/04	11/03/94 13:00 (D6094)
		IBUPROFEN 400MG U/D P
		Give: 1 OR 2 PO TID PRN
		PAIN
		RPH:DML RN:GT NK
10/04	10/04	11/03/94 13:00 (D6094)
		PROMETHAZINE 25MG U/D P
		Give: 25MG PO Q4HR PRN
		IN OR PO AS NEEDED FOR N/V
		RPH:DML RN:GT NK
10/04	10/04	11/03/94 13:00 (D6094)
		MILK OF MAGNESIA,OZ B
		Give: 30ML PO QD PRN
		CONSTIPATION
		RPH:DML RN:GT NK

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT.	REASON	RESULTS	TIME	INITIALS

ADDRESSOGRAPH

DOVE,GAYLE A
[redacted]
FEMALE DI: [redacted] (37) 125-2
10/04/94 14:10 NEW ORDER NOT FOUN
4G-SAT
4G-SAT

INJECTION SITES

Indicate Right (R) or Left (L)
1. DELTOID
2. ABDOMEN
3. ILIAC CREST
4. GLUTEAL
5. T HIGH

SIGNATURE/TITLE	INIT.	ALLERGIES
Naomi Kinsey RNC	NK	NKA

1526

Department of Veterans Affairs

PRN AND ONE-TIME MEDICATION RECORD

MONTH: Oct/Nov YEAR: 1994

START DATE	STOP DATE	MEDICATIONS DOSE/ROUTE/FREQUENCY
10/04	10/04	11/03/94 13:00 (D6094) ACETAMINOPHEN 325MG U/D P Give: 650MG PO Q4HR PRN PAIN/TEMP RPH:DML RN:GT
10/04	10/04	11/03/94 13:00 (D6094) BENZONATATE 100MG CAP P Give: 100MG PO Q4HRT PRN COUGH RPH:DML RN:GT
10/04	10/04	11/03/94 13:00 (D6094) BROMPHENIRAMINE M/PHENYL SR U/D P Give: 1 PO Q12HR PRN COLD SYMPTOMS RPH:DML RN:GT
10/04	10/04	11/03/94 13:00 (D6094) PROMETHAZINE 25MG U/D P Give: 25MG PO Q4HR PRN IN OR PO AS NEEDED FOR N/V RPH:DML RN:GT
10/04	10/04	11/03/94 13:00 (D6094) ALUM & MAG HYDRX CONC % SIMETHI 50Z,EA R Give: 15ML PO Q4HR PRN INDIGESTION\ RPH:DML RN:GT
10/04	10/04	11/03/94 13:00 (D6094) ATTAPULGITE SUSP,OZ R Give: 30ML PO PRN IN OR PO AS NEEDED FOR N /V RPH:DML RN:GT

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT.	REASON	RESULTS -	TIME	INITIALS

ADDRESSOGRAPH

DOVE,GAILE A [redacted] 125-2)
[redacted] (37) NOT FOUN
DX: [redacted]
10/04/94 14:20 NEW ORDER
4G-SATP 4G-SATI

INJECTION SITES

Indicate Right (R) or Left (L)
1. DELTOID
2. ABDOMEN
3. ILIAC CREST
4. GLUTEAL
5. T HIGH

SIGNATURE/TITLE

Jean Ozyath, Rn

INIT. JO

ALLERGIES NKA

1527

Department of Veterans Affairs

PRN AND ONE-TIME MEDICATION RECORD

MONTH: Oct. 1994

START | STOP | MEDICATIONS

10/04 | 10/04 | 11/03/94 13:00 (D6094)
ACETAMINOPHEN 325MG U/D P
Give: 650MG PO Q4HR PRN
PAIN/TEMP
NK
RPH:DML RN:GT

10/14 | 10/12 | 11/11/94 13:00 (D6094)
SODIUM CHLORIDE 0.65% NASAL SPRAY,EA R
Give: UD NSL PRN
AS DIRECTED. SELF-MEDICATE
NK

RPH:DML RN:GT

10/04 | 10/04 | 11/03/94 13:00 (D6094)
BENZONATATE 100MG CAP P
Give: 100MG PO Q4HRT PRN
COUGH
NK

RPH:DML RN:GT

10/04 | 10/04 | 11/03/94 13:00 (D6094)
CEPASTAT LOZENGES, (18/BX),LOZ,EA R
Give: 1 PO Q2HR PRN
SORE THROAT
NK

RPH:DML RN:GT Y

10/04 | 10/04 | 11/03/94 13:00 (D6094)
MILK OF MAGNESIA,OZ R
Give: 30ML PO QD PRN
CONSTIPATION
NK

RPH:DML RN:GT

10/04 | 10/04 | 11/03/94 13:00 (D6094)
ATTAPULGITE SUSP,OZ R
Give: 30ML PO PRN
IN OR PO AS NEEDED FOR N /V
NK

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT.	REASON	RESULTS	TIME	INITIALS
10/25	1130	Tylenol 650 mg PO	D	Headache	good	1230	D

ADDRESSOGRAPH

4G-SATP 4G-SATP

DOVE,GAYLE A 125-21
[redacted] [redacted] (37) NOT FOUND
FEMALE DX: ETOH
10/04/94 14:19 NEW ORDER

INJECTION SITES

Indicate Right (R) or Left (L)
1. DELTOID
2. ABDOMEN
3. ILIAC CREST
4. GLUTEAL
5. THIGH

SIGNATURE/TITLE

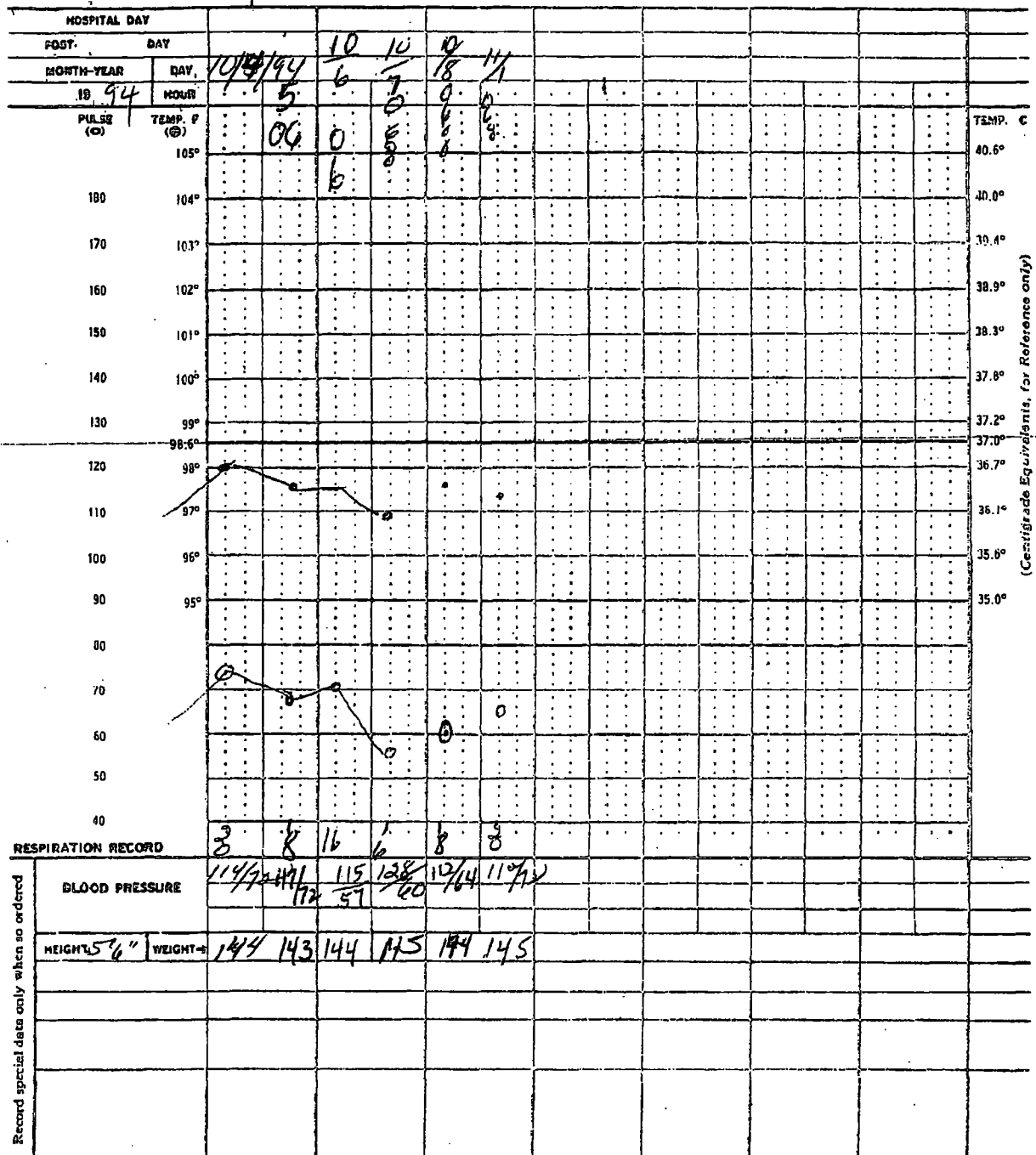
Naomi Kaiser, RNC NK
Pat Peden

INIT. ALLERGIES

NKA

1528

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.

511-113

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 (●)

PULSE (O)	TEMP. F (●)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	37.2°
	98.6°	37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT:

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*)

DOVE, GAYLE A 25
5246 A STREET C47
BILOXI MS 39530

[redacted]

C-SSN 5 8

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

MEDICAL RECORD	WEIGHT CHART

DIAGNOSIS

YEAR	MONTH						
94	10	10	10	10	10	10	11
	3 DAY	24	5	6	7	8	1

POUNDS

145
140

AGE AND HEIGHT		WEIGHT						
DATE OF BIRTH	HEIGHT	UPON ADMISSION	AT DISCHARGE	GAIN	LOSS	MINIMUM	MAXIMUM	NORMAL
	5 FT. 6 IN.	144 LBS.	LBS.	LBS.	LBS.	LBS.	LBS.	LBS.

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. - DATE

25
047
MS 39530

DOYC, GAYLE A
5240 A STREET
BILOXI

[redacted] 081557 520

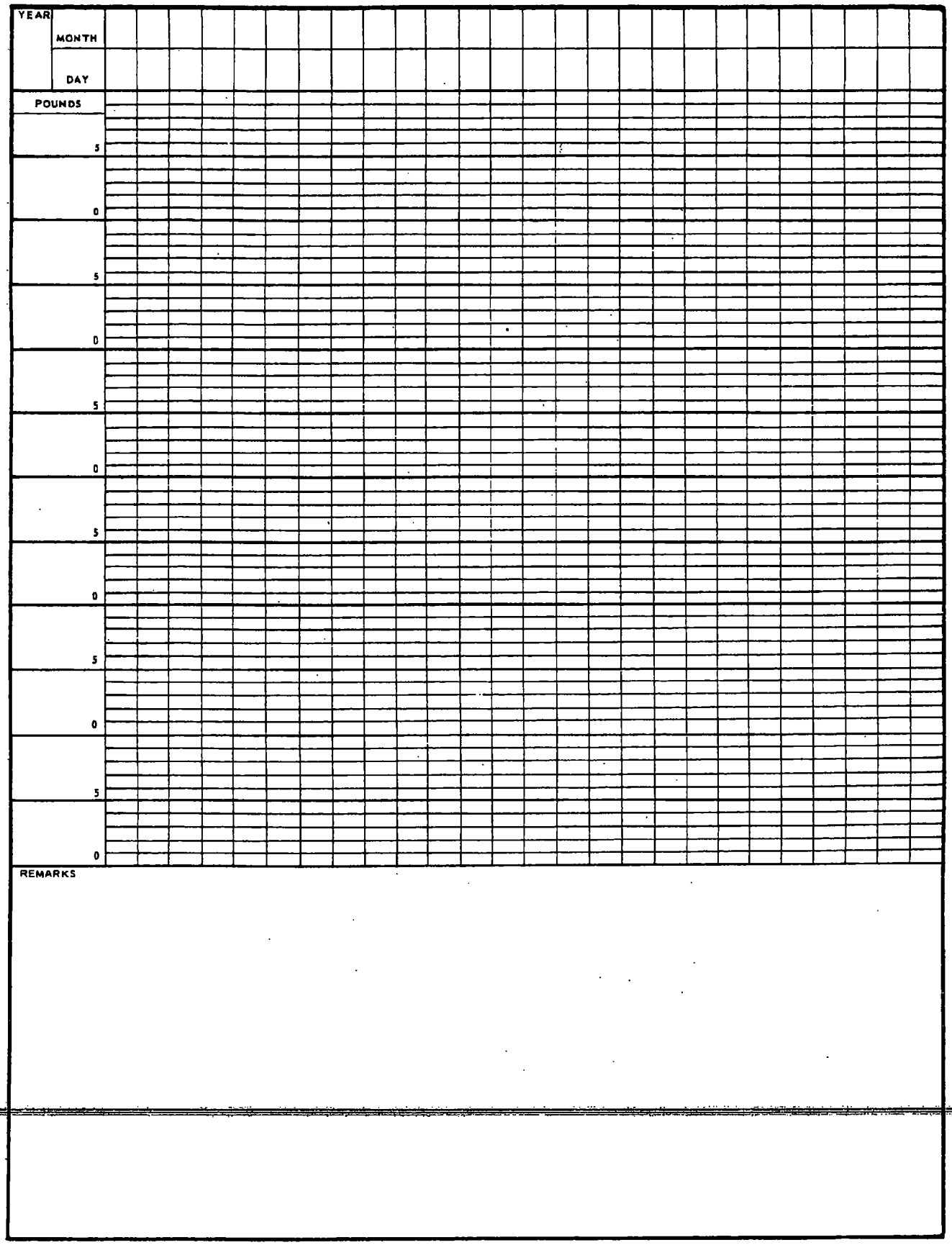
C-55M SMF B 27

REMARKS

VA FORM 10-2614f
NOV 1970

EXISTING STOCK OF VA FORM 10-2614f, APR 1965, WILL BE USED.

[redacted] WEIGHT CHART



★U.S.GPO:1988-0-202-991/73406

512-205

MEDICAL RECORD — PLOTTING CHART—BLOOD PRESSURES

DATE	10/3	10/5	10/6	10/7	10/8	11/1
TIME	0940	0600	0600	0800	0900	0800

250 245 240 235 230 225 220 215 210 205 200 195 190 185 180 175 170 165 160 155 150 145 140 135 130 125 120 115 110 105 100 95 90 85 80 75 70 65 60 55 50 45 40

PULSE

DATE

TIME

PULSE

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

[redacted]
5240 A STREET
BILOXI MS 39530

[redacted] 0815 523

REGISTER NO.

WARD NO.

PLOTTING CHART—BLOOD PRESSURES

STANDARD FORM 512-A (Rev. 8-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

512-205

MEDICAL RECORD

PLOTTING CHART—BLOOD PRESSURES

| DATE | | |

CONSENT FOR HUMAN IMMUNODEFICIENCY VIRUS (HIV)
ANTIBODY TESTING

I have asked or been asked to have my blood tested for antibodies to the HIV (Human Immunodeficiency Virus), the virus which causes AIDS. It has been explained to me that the test is for HIV infection. It is not a test for AIDS. If I do have antibodies to the virus (a POSITIVE test), this means that I have been infected with the virus. If I do not have antibodies (a NEGATIVE test) but am in a group of people who are at high risk for AIDS (people who have had multiple sex partners or who share needles when using drugs), this does not mean that I will not become infected in the future. In fact, I may already be infected but have not yet had time to develop antibodies.

I have been told that the blood tests for antibodies to the virus are not foolproof. In a small number of people, other things such as another virus or disease may wrongly cause a positive test. This is called a false positive test. It is also possible to have a false negative test. In this case, I do have the antibodies to the virus but the test did not show this. If the first test on my blood is positive, the test will be repeated. If positive again, a different test will be conducted. These tests will all be done on the blood taken after I sign this consent.

I have been told that HIV is spread through the blood from an infected person. It is also spread by having sex with an infected person. I understand that if my test is positive, I can spread the infection to others. I must not give blood or plasma or donate my organs or sperm if I am positive.

If I have a positive test, I should explain this to any sexual partner. If I am unable to tell my spouse or any other sexual partner whom I have identified, my doctor or counselor may do so but only to protect their health.

If I have a positive test, my case may be reported to public health agencies. However, the public health staff may only use or give out that information for the public health purpose for which it was given. Otherwise, information about my HIV testing cannot be revealed to anyone outside the VA without my written permission, or, a court order, a medical emergency, for research, Congressional oversight, or audit purposes, or for medical treatment provided to me by the Armed Forces.

I have been told that the results of my test (positive or negative) will be in my medical record. I understand that any VA employee who improperly releases information about my HIV testing is subject to a fine. Even though I understand every effort will be made to protect the results of my test, I also understand that disclosure of a positive test result can lead to discrimination in housing, jobs and other areas in some communities.

VA Form
DEC 1988 10-0121

I have been counseled about the HIV test and have been given a chance to ask questions. I understand what a positive and a negative test means. I understand that the test is voluntary and that I will still receive care from the VA if I refuse to have the test done.

Therefore, I give my permission for my blood to be tested for HIV antibodies.

Gayle A. Dove — 10/5/94
PATIENT or LEGAL GUARDIAN — DATE

[redacted] — 10/5/94
WITNESS — DATE

VA Form 10-0121

DEC 1988

*U.S. GPO: 1989-241-838/92604

DOVE, GAYLE A 29
5240 A STREET 047
BILOXI MS 39530

[redacted]

C-SSN 5 8

INFORMATION ABOUT INFLUENZA (FLU) VACCINE

The Disease

Influenza (flu) is caused by viruses. When people get flu they may have fever, chills, headache, dry cough or muscle aches. Illness may last several days or a week or more, and complete recovery is usual. However, complications may lead to pneumonia or death in some people. For the elderly and people with diabetes or heart, lung, or kidney diseases, flu may be especially serious.

The Vaccine

Today's flu vaccines cause fewer side effects than those used in the past. In contrast with some other vaccines, flu vaccine can be taken safely during pregnancy; however, flu vaccine should be given to pregnant women according to the chronic illness criteria applied to other persons.

One shot will protect most people from influenza during the next flu season.

Possible Vaccine Side Effects

Most people will have no side effects from the vaccine. However, tenderness at the site of the shot may occur and last for several days. Some people will also have fever, chills, headache, or muscle aches within the first 48 hours.

Special Precautions

As with any vaccine or drug, the possibility of severe or potentially fatal reactions exists. However, flu vaccine has rarely been associated with severe or fatal reactions. An uncommon illness characterized by ascending paralysis (Guillain-Barre Syndrome) has been reported following other flu vaccines but not in association with this flu vaccine; however, it must be assumed that the risk is present. In some instances people receiving vaccine have had allergic reactions. You should note very carefully the following precautions:

- People with known allergy to eggs should receive the vaccine only for specific indications and under special medical supervision.
- People with fever should delay getting vaccinated until the fever is gone.
- People who have received another type of vaccine in the past 14 days should consult a physician before taking the flu vaccine.

If you have any questions about flu or flu vaccine, please ask.

CONSENT FORM

I have read the above statement about influenza (flu), the vaccine, and the special precautions. I have had an opportunity to ask questions, and understand the benefits and risks of flu vaccination. I request that it be given to me or to the person named below of whom I am the parent or guardian.

GAYLE A. DOVE
Name of Person to Receive Vaccine (Please Print)

10/31/94
Date Vaccinated

Wyeth 4948144
Manuf. & Lot No.

Gayle A. Dove
Signature of Person Receiving Vaccine or Parent or Guardian

31 OCT 94
Date Signed

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE -

INFORMATION ABOUT INFLUENZA (FLU) VACCINE

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)

PLEASE SEE REVERSE SIDE FOR CONSENT FORM

_____

which is to be performed by or under the direction of Dr. _____

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: _____
(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)

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 of Patient) (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) (Signature of Sponsor/Legal Guardian) (Date and Time)

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

REGISTER NO.	WARD NO.

STANDARD FORM 522 (Rev. 10-76)
General Services Administration &
Interagency Comm. on Medical Records
FIRMR (41 CFR) 201-45.505
52
☆ P.O.: 1990- 262-755/17300

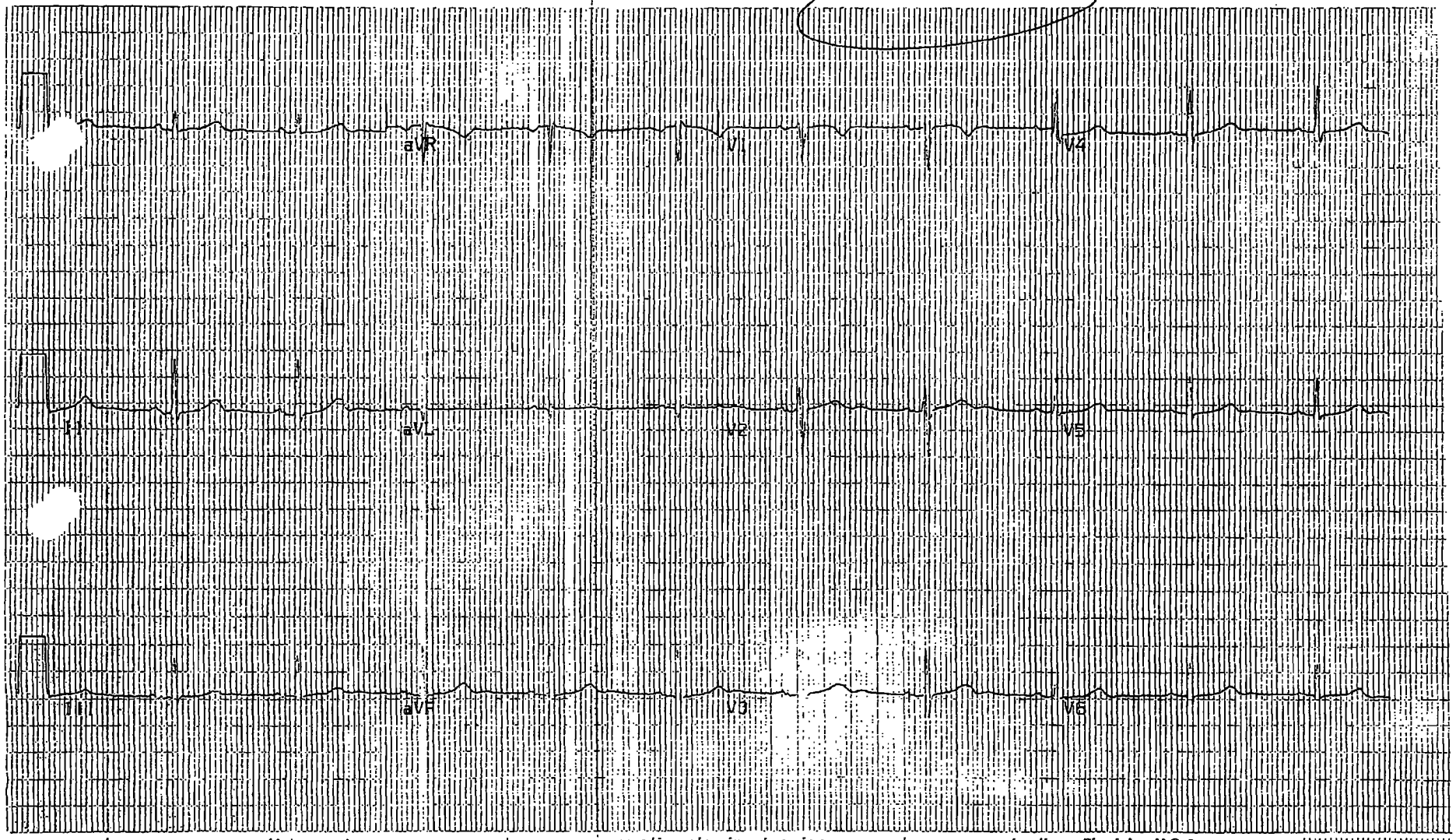
25mm/s
10mm/mV
40Hz
Pgm 002A
12SL v68
S

Med:
37yr 66in 143lb
Sex: F Race: Cauc
Loc: 7 Room: 4G
Option: 13 BP: 117/ 72
Vent. rate 63 BPM
PR interval 148 ms
QRS duration 76 ms
QT/QTc 416/422 ms
P-R-T axes 30 69 53

NORMAL SINUS RHYTHM
NORMAL ECG

Referred by: DR EHIK

Unconfirmed



Universal | marquette electronics, inc. | Jupiter, Florida USA

1539

BIGUAT VARC

NORMAL SINUS RHYTHM

ROUTINE ECG

DOVE, GAYLE A
ID:515646094 LOC:GULF
37YR 66IN 143LB CAU FEM
MED:
OPT:13 BP:117/ 72 RM:4G
ECG TAKEN: 07-OCT-94 14:26
VENT. RATE 63 BPM
PR INTERVAL 148 MS
QRS DURATION 76 MS
QT/QTC 416/422 MS
P-R-T AXES 30 69 53

NORMAL ECG
NO PREVIOUS ECGS AVAILABLE

REFERRED BY: DR EHIK

REVIEWED BY: ASHOK KANADE M.D.



1540

Veterans Administration

ADMISSION ORIENTATION CHECKLIST

	Initails/	date
1. Ward Rules/ Policies	GAD	10/4
a. Rule Booklet Presented/Responsible for Contents		
b. Use/Location/Number/Restrictions of Phone		
c. Visitation Policy		
d. Smoking Policy		
e. Appropriate Dress		
f. Contraband/Medications turned in to Nurse		
g. Off Limit Areas/Gazebo/Cars		
h. Lock-up Times		
i. Kitchen Privileges/Location		
j. Coffee Policy/Cup Distribution		
2. ID Bracelet		
3. Procedures		
a. Wake-Up/VS/Medications		
b. Appointment Schedule/Recreation Schedule		
c. Lab Procedures		
d. Sign-Out Book		
e. Linen Schedule		
f. Pajama Regulations		
g. Shower/Location/Times		
h. Lights Off/TV/Cards		
4. Patient Responsibilities		
a. Keeping Room Clean/Feet on Furniture		
b. Acceptable Behavior During Activities		
1. On Time		

Veterans Administration

	INITIALS	DATE
~~2. No Disruptive Behavior~~	HDD	HDD
3. No Leaving for Coffee		
c. Library Books		
d. Laundry/Patient Effects		
5. Services		
a. Canteen Services		
b. Chaplain Services/Church		
c. Dietary Services/Menu		
d. VA representative/DAV Representative		
6. Family Counseling		
a. Counseling Available		
b. Activities Families are Encouraged to Attend		

STAFF SIGNATURE Richard Foxworth PATIENT SIGNATURE Gayle A. Dove

S A T P PATIENT AGREEMENT

I am voluntarily requesting admission to the Substance Abuse Treatment Program; as such, I understand and agree to the following:

1. I understand that the goal of this program is to help me achieve complete abstinence from abusive substances.

2. I will be expected to fully participate in all activities of the program. Failure to participate in a satisfactory manner will result in my discharge from the program and the hospital.

3. No vocal or physical abuse toward staff or other patients will be tolerated. Infraction of this rule will result in immediate discharge.

4. I will submit to breathalizer testing and/or give a witnessed urine specimen for drug testing when requested. Failure to do so is grounds for immediate discharge.

5. The program is 28 days in length. I will be discharged from the Veterans Administration Medical Center, Substance Abuse Treatment Program, on 11/1/94. If, at the conclusion of the program I feel I need treatment for some other condition, I must apply for readmission through the Outpatient department at the Biloxi Division.

6. If a medical, dental, psychiatric, or legal problem develops which would interfere with my participation in the program, I will be released from the program and be transferred or discharged as appropriate. I know of no such problem at this time.

7. No routine passes will be granted while I am a patient in the program.

8. Participation in Narcotics and Alcoholics Anonymous meetings is a requirement while in the program.

9. Sleeping medication will not be given while in the program.

10. I will not be eligible for placement in a Halfway House, Community Residential Care Home, or Domiciliary unless I have completed the program.

11. I understand that rule infractions and repeated poor performance not only indicates non-compliance, but also jeopardizes other patients' progress, and is therefore, grounds for discharge.

12. I agree to comply with ward rules and hospital policies.

Gayle A. Dove 10/4/94 — Signature/Date

[signature] RN 10/4/94 — Witness/Date

516 1760

PROGRESS NOTES

DATE

10/23/98 Restricted Gastro & E Dr Overlon
JKH T 98.7 P 53 R 16 BP 110/66
10:25 Age 61 Wt 130.5 Ht 66"
Elizabeth Ron

follow-up

Recurrent Dyspepsia
Hx. PUD / NSAID: induced gastroparesis
with ulcers
EGD in 1996.

Recent labs →
H. pylori serology ⊖ told to ↑ prevacid to 30 bid
Albi 3.7 (Only mild improvement)
gastrin 279 ↑
HCV ⊖ Still nauseated - requires
CBC: WNL Phenergan
HBV ⊖ ⊖ Heme-fecal
Still smoking 1 pack x day
⊖ ETOH
taking Risperidone fluoxetine Trazodone
gained a little weight →
off NSAID's. PO

Xray epigastric tenderness ⊖ masses
⊖ LIVER

Plan Add Carafate x 2 weeks
Keep on prevacid 1 x day.
+ smoking to at least 10 x day
Schedule for U/S of abdomen (Recurrent
pain / n/v — R/O ...)

LOVE, GAYLE A [redacted]

MARTIN AVALOS, MD
AS3285170-541

STANDARD FORM 509 BACK (Rev. 11-77)

MUHLER, EARL N
80 yr
Male Caucasian
70in 160lb
Room:2
Loc:2 Option:44

ID: [redacted]

Vent. rate		
PR interval		
QRS duration	84	ms
QT/QTc	340/402	ms
P-R-T axes	-1 -47	102
BP	154/67	

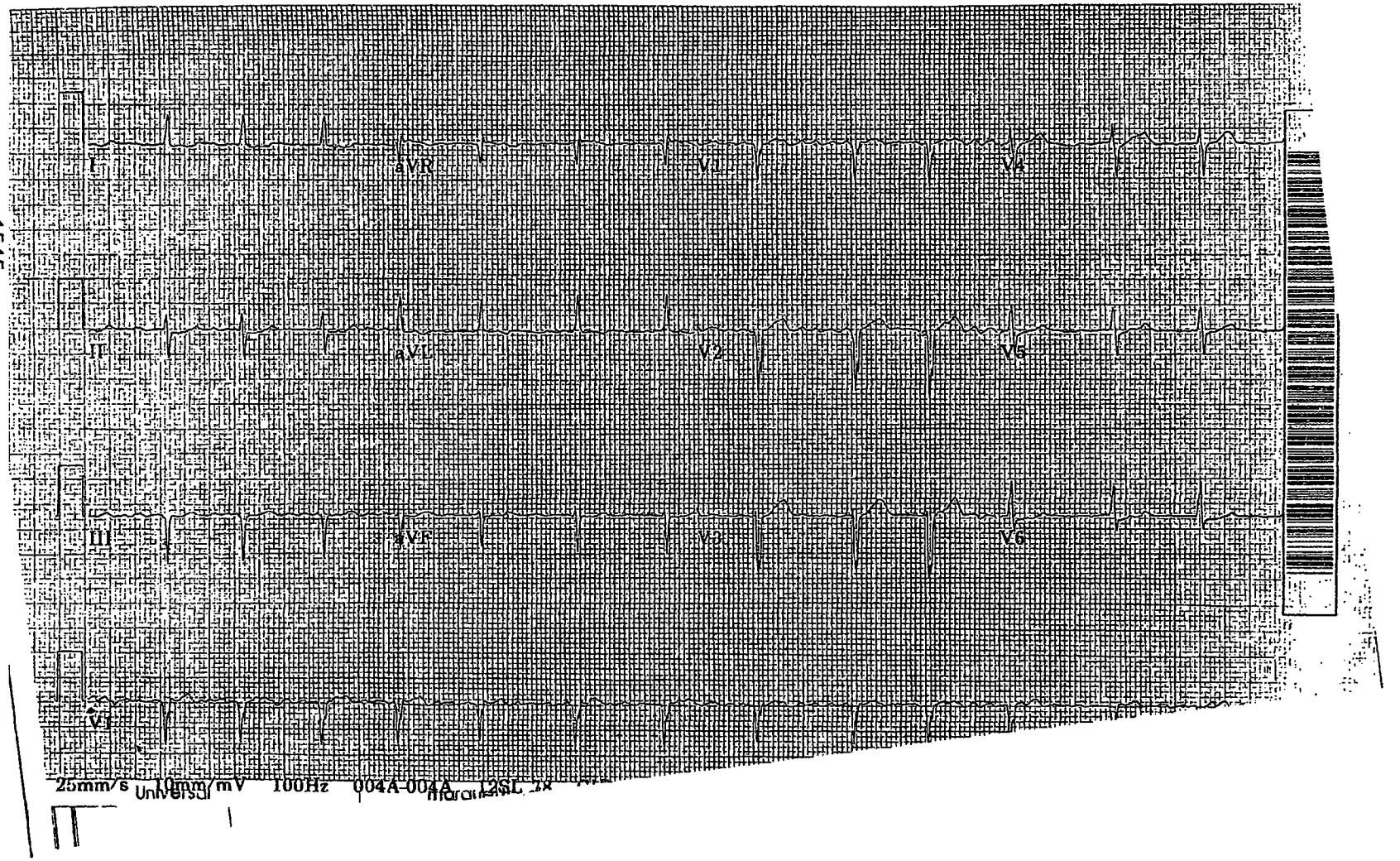
Technician: ER ER

Meds: Unknown

30-SEP-1998 06:58 BILOXI VAMC-ER ROUTINE R

ATRIAL FIBRILLATION WITH A COMPETING JUNCTIONAL
PACEMAKER
LEFT AXIS DEVIATION
SEPTAL INFARCT (CITED ON OR BEFORE 26-JUL-1996)
ABNORMAL ECG
WHEN COMPARED WITH ECG OF 13-APR-1998 11:01,
QUESTIONABLE CHANGE IN INITIAL FORCES OF ANTERIOR LEAI

Referred by: HILL Confirmed by: BASSAM OMAR 1



1545

E,GAYLE A [redacted]

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 2,1998	SALLEY,FLORENCE E
4. VERIFICATION METHOD	**5. SERVICE VERIFICATION DATE**	
HINQ	APR 2,1998	

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. Dare	X 18 Sep 98

FOR VA USE ONLY	VA FACILITY NUMBER	ADMISSION DATE	AUTHORITY FOR ADMISSION OR TREATMENT
	520	9-18-98 1-3W	17.47.(a) (1)

Reg Date/Time: SEP 22,1995@09:17 PRINTED: SEP 18, 1998@11:21:54 Clerk: PLC/1761

Migraine Headaches

AUTOMATED VA FORM 10-10 PAGE: 4

JE,GAYLE A [redacted]

PART VI - INCOME SCREENING DATA OR ANNUAL INCOME

.. CURRENT MARITAL STATUS: DIVORCED	1B. DATE OF MARRIAGE: APR 15,1990

.. WAS PATIENT MARRIED OR SEPARATED AT THE END OF LAST CALENDAR YEAR?: YES

1. NAME OF SPOUSE	2C. SEX OF SPOUSE	2D. SPOUSE'S SOCIAL SECURITY NO	2E. SPOUSE'S DATE OF BIRTH
PARKE,RICHARD A	MALE	[redacted]	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: SEP 18, 1998@11:21:54 Clerk: PLC/1761

E,GAYLE A [redacted]

PART III - APPLICANT/SPOUSE DATA

APPLICANT'S EMPLOYMENT STATUS: 3. NOT EMPLOYED

SPOUSE'S EMPLOYMENT STATUS: NOT APPLICABLE

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

PART IV - MILITARY SERVICE DATA

1A. LAST BRANCH OF SERVICE	1B. LAST SERVICE NUMBER	1C. LAST DATE OF ENTRY	1D. LAST DISCHARGE DATE	1E. DISCHARGE TYPE
AIR FORCE	515646094	SEP 4,1975	SEP 16,1987	HONORABLE
2A. PRIOR BRANCH OF SERVICE	2B. PRIOR SERVICE NUMBER	2C. PRIOR DATE OF ENTRY	2D. PRIOR DISCHARGE DATE	2E. DISCHARGE TYPE
NOT APPLICABLE				
3A. PRIOR BRANCH OF SERVICE	3B. PRIOR SERVICE NUMBER	3C. PRIOR DATE OF ENTRY	3D. PRIOR DISCHARGE DATE	3E. DISCHARGE TYPE
NOT APPLICABLE				

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:	$ 24468		

PRINTED: SEP 18, 1998@11:21:54

Date/Time: SEP 22,1995@09:37

MATED VA FORM 10-10

DEPARTMENT OF VETERANS AFFAIRS

ACILITY: Biloxi, MS (CONS) (520) APPLICATION FOR MEDICAL BENEFITS

SEE ATTACHMENT FOR PAPERWORK REDUCTION INFORMATION AND PRIVACY ACT INFORMATION

PART I - PATIENT DATA

. Type of benefit applied for: HOSPITAL/OUTPATIENT TREATMENT

. Applicant's Name	3. Other names used (Alias)	4. Social Security Number
DOVE,GAYLE A	VOGLE,GAYLE A PARKER,GAYLE A	[redacted]

. Claim Number	6. LOCATION OF CLAIMS FOLDER	7. DATE OF BIRTH	8. PLACE OF BIRTH
[redacted]	323JACKSON-RO	AUG 15,1957	WITCHIA FALLS, TEXAS

. PERMANENT ADDRESS		10. TEMPORARY ADDRESS	
A. STREET ADDRESS: 4457 POPPS FERRY RD.LOT 195		10A. STREET ADDRESS: NOT APPLICABLE	
B. CITY: BILOXI	9C. STATE: MISSISSIPPI	10B. CITY:	10C. STATE:
D. ZIP CODE: 39532	9E. COUNTY: HARRISON	10D. ZIP CODE:	10E. COUNTY:
F. HOME TELEPHONE NUMBER: 228-396-1919		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	228-396-1919	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	228-396-1919	UNANSWERED
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	228-396-1919	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.

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: ORGAN DONOR/MCCR NEEDS NEW INSURANCE INFO.

5. Fathers Name: RAYMOND (L)
Mothers Name: MARLYN (L)
Mothers Maiden Name: MOSSMAN

6a. Enrollment Clinic(s): ZZZWOMEN'S MHPC GOLD DEROMA, WOMEN'S MHPC GOLD GROUP-GPT, ZZZ GYNECOLOGY CLINIC, AUDIOLOGY-BILOXI, WOMEN'S MHPC GOLD PSYCHIA-GPT, CAT SCAN CLINIC, ZZZPC PURPLE PSYCHOLOGY JONES, PC PURPLE PENNISSON, PC GOLD PSYCHOLOGY-HANSON, PASTORAL CARE OUTPATIENT,

6b. Future Appointments: WOMEN'S MHPC GOLD PSYCHIA-GPT (SEP 29,1998@09:30), WOMEN'S MHPC GOLD SAPORITI-GPT (SEP 29,1998@10:30), PC PURPLE PSYCHOLOGY-HANSON (OCT 15,1998@08:00), LABORATORY (OCT 15,1998@08:30), EYE-CARRIERE (OCT 20,1998@13:00), PC PURPLE PENNISSON (NOV 17,1998@09:00), GASTRO AVALOS (MAY 21,1999@10:00),

7a. Last Admission: LAST ADMISSION PTF DATA NO LONGER STORED

8. Eligibility Status: VERIFIED | Status Date: APR 2,1998
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

MEDICAL RECORD **NEURO** PROGRESS NOTES

DATE

10/20/05 F/u for V Nalluri
WKB Age 41 wt 87.7 HT 66"
0905 T 97.9 P 48 R 18 BP 102/62
no chart available Elizabeth Ro
Neuro:- Pt c migraine headaches.
Pt. c/o HA x 2 wks in back of head & neck. Was
also on Depakote 500 mg x 1 wk &
d/c'd for 2-3 days.
She smokes, ppd. Trying to quit.
She was referred to Dr. Hansen for smoking cessation
Rec to reschedule appointment with
Dr. Hansen for smoking cessation &
also for relaxation tech for headaches.
Denied CP/SOB/N&V.
She is on Inderal for headaches.
She tried all other migraine medications.
d/t migraine headaches →
cont Inderal, Imitrex PRN.

Follow up 3 months

M. [illegible]
V.K. NALLURI, MD
AS3285170-396

(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.

9

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR(41CFR)201-45.508
509-111

DOVE, GAYLE A
[redacted]

NOTE DATED: 10/20/98 13:44 KINESIOTHERAPY - INTERIM NOTE
VISIT:-10/19/98 10:00 KT POOL GULFPORT

Discipline: ** KT-THERAPY POOL
Number of treatments this report period: ** 6
Diagnosis: ** DEPRESSION AND STRESS REDUCTION
Problem: ** PTSD
Precautions: ** STANDARD

Assessment/Re-Assessment: THE PT. ATTENDS THE THERAPY POOL ON A REGULAR BASIS AND PARTICIPATES MAXIMALLY EACH SESSION. PT. PERCEIVES IMPROVEMENT. THE PT. STATES AN INCREASE IN BALANCE, BODYWEIGHT, ENDURANCE, AND A SENSE OF WELL-BEING. THE PT. ALSO STATES A DECREASE IN STRESS AND NO CHANGE IN PAIN. PT. IS VERY DEPENDENT ON THERAPIST AND REQUIRES 1-ON-1.
Patient/Family Education:
PLAN OF TREATMENT:

Objectives/Short Term Goals/Time frame: STG'S: TO DECREASE PT.'S PERCEPTION OF SEVERITY AND FREQUENCY OF PAIN BY 5% ON 12-1-98. LTG'S: TO IMPROVE GENERAL FITNESS, IMPROVE SENSE OF WELL-BEING AND MAINTAIN OPTIMUM LEVEL OF FUNCTION WITH MINIMAL DISCOMFORT.

Method of treatment: THE PT. UTILIZES BOTH SHALLOW AND DEEP WATER USING BOUYANCY RESISTIVE DEVICESAND AQUA-FLEX PADDLES. THE PT. REQUIRES SUPERVISION AND ASSISTANCE WITH THERAPY POOL PROGRAM.

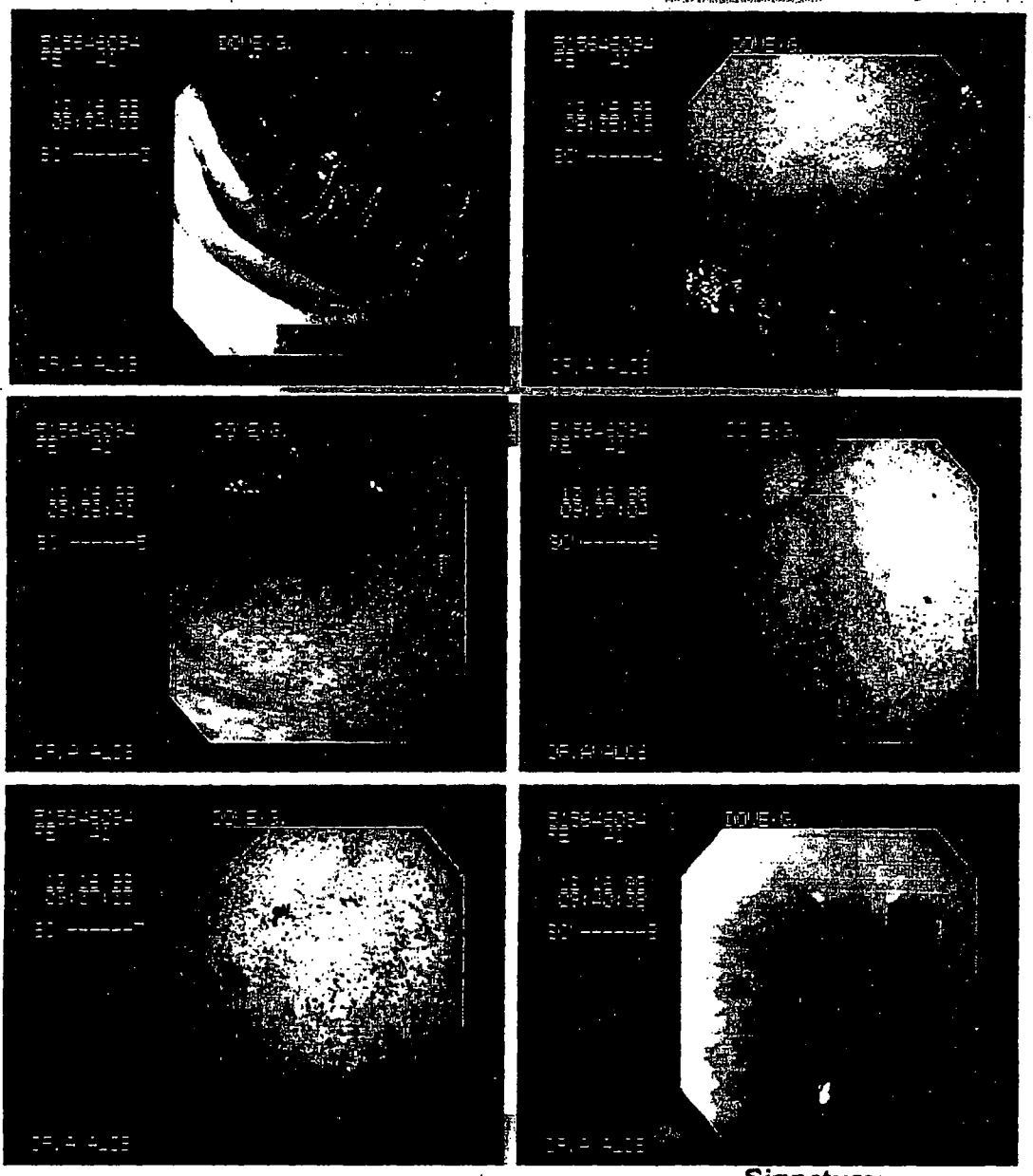
Rehab potential: GOOD IF THERAPY IS CONTINUED.

Signed by: /es/ LATONYA DANCY
KT STUDENT 10/20/98 13:59
Cosigned by: /es/ PERCY C. MOORE JR.
K.T. 10/20/98 14:54

AMBULATORY SURGERY
DAY OF SURGERY
CONT.

Date/Time:

Post-Op Notes: Plan ✓gastrin level
✓Bx Reports



Signature:

AMBULATORY SURGERY
DAY OF SURGERY

DATE/TIME: 12/16/98. 9 AM

EGD.

PRE-OP DIAG: Recurrent Dyspepsia / Intermittent on/off upper therapy with Prevacid / Cimetidine

FINDINGS: H. NSAIDs: gastropathy in post → ulcer

POST-OP DIAG: Histology / RUT ⊖ in post ⊖ Ultrasound of abdomen

PROCEDURE:

ANES: ⊕ findings:

SURGEON: 1. small island of metaplastic epithelium in distal esophagus close to GE junction.

ASST:

BLOOD LOSS: 2. diffuse gastric mucosal erythema with microhemorrhages and "mosaic" pattern mostly in fundus / body (Bx taken)

BLOOD:

FLUIDS: 3. erythematous mucosa in Antrum (PYLORI-TEK test → ⊖)

DRAINS:

4. Bulbar small superficial ulceration with edema

POST-OP COND: NO complications

SPECIMEN: 1 bx Diffuse gastritis mostly in fundus Small Duodenal Bulb Ulcer → Mild Esophagitis

Repeated gastric ulcer 139 (0-100)

MARTIN AVALOS, MD AS32861 0-541

Resident Signature

Attending Signature

*** For all EGD/Colonoscopy attach form - Date/Time/Sign Each

SIGNATURE AND TITLE OF PRACTITIONER

SEE REVERSE

MARTIN AVALOS, MD AS32861 0-541

DATE 12/16/98.

IMPRINT PATIENT DATA CARD (Name, Address and Social Security Number)

LOVE, GAYLE A [redacted]

MEDICAL RECORD

SUPPLEMENT TO PROGRESS NOTE FOR SPECIALIZED DISCIPLINES-VERTICAL

[redacted] Revised July 1995

VA FORM 10-0114.I(R)

CONTINUE ON BACK WHEN NECESSARY

Department of Veterans Affairs

MEDICAL CERTIFICATE Pain 9/10

1. DATE	2. TIME	3. AGE	4. SEX	5. ON ARRIVAL PATIENT WAS	6. PHONE NUMBER	7. HOMELESS
10-1-99	1530 (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
NKDA	132.1	97.1	90	16	105/75	☒ NO ☐ YES

9. CURRENT MEDICATIONS Zantac, Maalox, TUMS, ASA, Tylenol.

10. TRIAGE c/o migraine headache x 2 days.

11. SIGNATURE CO allan RN

12. HISTORY AND PHYSICAL

As above
hx migraine, relieved c Nasal Spray analgesic
Afebrile, no focal neurologic symptoms

Neuro: Sensation & motor
Cerv. ROM
Gait: normal
Migraine
neurologic intact.

13. DIAGNOSTIC IMPRESSIONS migraine

14. PLAN 1 refill Butorphanol N asal Spray
1° Care f/u
Neurology f/u 1-2 weeks 10/4/99

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 A
[redacted] [redacted]

7. PATIENT INSTRUCTIONS

10 01 99

I CERTIFY THAT I RECEIVED AND UNDERSTAND THESE INSTRUCTIONS

8. PATIENT'S SIGNATURE

VA FORM MAR 1992 10-10M SUPERSEDES VA FORM

TIME	VITAL SIGNS				TIME	ORDERS	MD SIGNATURE	TIME	NURSE SIGNATURE	EFFECTIVENESS
	TEMP	PULSE	RESP	B/P						

CONTINUATION FROM FRONT / PROGRESS NOTE

1630 Pharmacy will not refill Butorphanol. Paged Dr. V. Nelluri ☎ no answer. Reft to DR. Galla tRN

STUDIES REQUESTED	RESULTS

MEDICAL RECORD — **PROGRESS NOTES**

NEURO

DATE

9/18/58

1005 T 97.7 P 59 B/P 91/53

NRA F/u neuro c Dr. Nalluri & J. McCubbrey RN

Neuro:- no chart available.

10 days ago pt with hyperacute reactions.

c/o T decr'g occ'l diplopia - was visual

hallucinations, dizziness but not definite.

Sx had D/C'd about 6 months

ago & wants to try again IV D&B Tue

neuro - alert, oriented x3, speech fluent

except - normal

EOM: opn. does photophobia.

Pupils equal reactive to light

and accom, no nystagmus.

Fundus - disc margins sharp.

No facial asymmetry.

Motor: no involuntary movements.

~~DTR's~~ Power - 5/5 throughout

Tone normal.

Sensory: intact to light touch - not diminished

pain

now. No deficits

IV Hyperacute reaction - pt's decr'g

sx's wants to try again on D&B Tue

Salmi (Continued on reverse side) D/C'd Tue

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

REGISTER NO.

WARD NO.

V. K. NALLURI, MD

PROGRESS NOTES AS3285170-396

STANDARD FORM 509 (Rev. 11-77)

Prescribed by GSA/ICMR,

FIRMR(41CFR)201-45.505

509-111

DOVE, GAYLE A [redacted] [redacted]

PROGRESS NOTES

DATE	

*U.S.GPO:1997-426-359

APPROVED

04/25/95 15:48 PSYCHOLOGY
WOMEN'S STRESS CLINIC: VET ATTENDED INDIVIDUAL SESSION. DISCUSSED PROGRESS IN ADDRESSING PROBLEMS IN RELATIONSHIP DIRECTLY AND HOW THIS PROGRESS REDUCED PROBLEMS THAT MIGHT HAVE OTHERWISE CONTRIBUTED TO RELAPSE. VET'S ENHANCED SELF-ESTEEM WAS ATTRIBUTED TO FINANCIAL INDEPENDENCE, COMMUNICATION IN RELATIONSHIPS, AND RECENT SUCCESS IN FOLLOW-THROUGH WITH PLANNED WEIGHT LOSS. VET WILL CONTINUE TO ATTEND THERAPY SESSIONS WITH SIGNIFICANT OTHER AT VET CENTER WITH TIM MURR.

Signed by: /es/ VIRGINIA M. DEROMA
STAFF PSYCHOLOGIST 04/25/95 15:54

09/30/96 20:18

********** CONFIDENTIAL SURGERY CLINIC SUMMARY pg. 1 **********

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

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

Address: 4457 POPPS FERRY RD.LOT 195 Phone: 601-396-1919
BILOXI, MISSISSIPPI 39532 County: HARRISON

Marital Status: DIVORCED Age: 39
Religion: PROTESTANT, NO DENOMINATION Sex: FEMALE
Occupation: DEALER
Period of Service: POST-VIETNAM
Branch of Service: AIR FORCE 09/04/75 TO 09/16/87
Combat: N POW: N
Eligibility: SERVICE CONNECTED 50% to 100% Status: VERIFIED
S/C %: 80
Means Test: NO LONGER REQUIRED
NOK: RAY DOVE JR Relation: FATHER
4457 POPPS FERRY RD.LOT 195 Phone: 601-396-1919
BILOXI, MISSISSIPPI 39532

---------- DS - Disabilities ----------

Eligibility: SERVICE CONNECTED 50% to 100% VERIFIED
Total S/C %: 80

POST-TRAUMATIC STRESS DISORDER	50%	S/C
REMOVAL OF UTERUS AND OVARIES	50%	S/C
MIGRAINE HEADACHES	30%	S/C
RHINITIS	0%	S/C
BENIGN GROWTH OF THE SKIN	0%	S/C

---------- ADR - Adv React/Allerg ----------

No data available

---------- SCLU - Lab Cum Selected (max 2 occurrences) ----------

Collection DT	Spec	GLU	WBC	RBC	HGB	BUN	NA	K
08/22/96 14:08	PLASMA	89.				7. L	146. H	5.0 H
08/22/96 14:08	BLOOD		7.7	4.60	15.0			

** Additional Results available outside occurrence limit **

Collection DT	Spec	CL2	URIC AC	TRIGLYC	CHOL	CRE	T. BIL	D BILI
09/18/96 14:52	PLASMA						.3	.2
08/22/96 14:08	PLASMA	107.	3.1 L			0.9	.3	.2

** Additional Results available outside occurrence limit **

Collection DT	Spec	ALK PHO	SGOT	SGPT	CO2	ANI GAP
09/18/96 14:52	PLASMA	77.	35.	34.		
08/22/96 14:08	PLASMA	72.	39. H	64. H	26.0	14.0

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

---------- SCLU - Lab Cum Selected (max 2 occurrences) ----------
(continued)

** Additional Results available outside occurrence limit **

---------- ADC - Admission/Discharge (max 12 months) ----------

No data available

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

10/02/96 10:00 SURGERY POST OP
10/02/96 13:00 NEUROLOGY-DR V NALLURI
10/03/96 10:00 X-RAY (ULTRASOUND)
10/03/96 14:00 WOMEN'S GOLD MHPC-GPT-BLD
10/08/96 09:00 GASTRO AVALOS (RESTRICTED
10/08/96 14:00 WOMEN'S MHPC PSYCHIATRY
02/03/97 08:15 GYNECOLOGY CLINIC
04/15/97 13:00 EYE-CARRIERE

---------- CVP - Past Clinic Visits (max 4 occurrences) ----------

09/30/96 09:00 GASTRO AVALOS (RESTRICTED CANCELLED BY CLINIC
09/26/96 14:02 WOMEN'S GOLD MHPC-GPT-BLD UNSCHEDULED
09/26/96 14:00 WOMEN'S GOLD MHPC-GPT-BLD
09/24/96 13:32 WOMEN'S MHPC PSYCHIATRY UNSCHEDULED

---------- RXOP - Outpatient Pharmacy (max 45 days) ----------

Drug	Rx #	Stat	Qty	Issued	Last Filled	Rem
LORAZEPAM 1MG TAB	2278372	S	60	07/30/96	10/07/96	(0)
T1 TAB PO BID						
Provider: SCHULTZ,DAVID PAUL	Cost/Fill: $ 0.60					
BISACODYL 5MG EC TAB	4749454	S	60	08/12/96	10/01/96	(3)
T2 TAB PO BID QOD						
Provider: MOORE,JON MICHAEL	Cost/Fill: $ 0.54					
ESTROGENS CONJUGATD 0.625	4754660	A	42.5	09/04/96	09/24/96	(4)
APPLY ONE APPLICATORFUL EVERY THIRD DAY						
Provider: NEUMASTER,TERRY DAVID	Cost/Fill: $ 17.17					
MECLIZINE HCL 25MG TAB	4754663	A	90	09/04/96	09/24/96	(4)
T1 TAB Q8H PRN FOR NAUSEA						
Provider: NEUMASTER,TERRY DAVID	Cost/Fill: $ 0.81					
FLUOCINONIDE 0.05% CREAM	4754686	A	60	09/04/96	09/24/96	(2)
APPLY DAILY TO HANDS PRN AND AS DIRECTED						
Provider: FONTENELLE,LARRY J	Cost/Fill: $ 2.52					
CODEINE 30MG/ACETAMINOPHE	2000969	A	15	09/24/96	09/24/96	(0)
T1 TAB PO Q8H PRN FOR SEVERE PAIN						

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

---------- RXOP - Outpatient Pharmacy (max 45 days) ----------
(continued)

Drug	Rx #	Stat	Qty	Issued	Last Filled	Rem
Provider: SCHULTZ,DAVID PAUL		Cost/Fill: $ 0.48				
AMOXICILLIN 250MG CAP	2281457	A	30	09/24/96	09/24/96	(0)
T1 CAP PO TID						
Provider: SCHULTZ,DAVID PAUL		Cost/Fill: $ 0.90				
PROCHLORPERAZINE MALEATE	2281458	A	30	09/24/96	09/24/96	(1)
T1 TAB PO QHS PRN FOR NAUSEA						
Provider: SCHULTZ,DAVID PAUL		Cost/Fill: $ 1.47				
TRAZODONE HCL 50MG TAB	2281459	A	90	09/24/96	09/24/96	(0)
T3 TAB PO QHS						
Provider: SCHULTZ,DAVID PAUL		Cost/Fill: $ 2.88				
FLUOXETINE HCL 20MG CAP	2278371	C	30	07/30/96	09/18/96	(0)
T1 CAP PO QAM						
Provider: SCHULTZ,DAVID PAUL		Cost/Fill: $ 36.45 Exp/Can Dt: 09/24/96				
CISAPRIDE 10MG TAB	4757735	A	120	09/18/96	09/18/96	(0)
T1 TAB PO AC AND HS						
Provider: AVALOS,MARTIN		Cost/Fill: $ 45.24				
FAMOTIDINE 20MG TAB	4757736	A	60	09/18/96	09/18/96	(0)
T1 TAB PO BID						
Provider: AVALOS,MARTIN		Cost/Fill: $ 30.18				
CYPROHEPTADINE HCL 4MG TA	4753081	A	30	08/28/96	09/17/96	(0)
T K PO BID						
Provider: NALLURI,VASANTHI KUMARI		Cost/Fill: $ 0.36				
IBUPROFEN 800MG TAB	4746726	A	100	07/30/96	09/08/96	(0)
T1 TAB QID WF PRN FP						
Provider: SNOOK,BRANDON TIMOTHY		Cost/Fill: $ 2.90				
PROMETHAZINE HCL 25MG TAB	4746727	A	60	07/30/96	08/27/96	(0)
T1 TAB TID PRN FOR NAUSEA						
Provider: SNOOK,BRANDON TIMOTHY		Cost/Fill: $ 0.54				
TRAZODONE HCL 50MG TAB	2278373	C	90	07/30/96	08/27/96	(1)
T3 TAB PO HS						
Provider: SCHULTZ,DAVID PAUL		Cost/Fill: $ 2.88 Exp/Can Dt: 09/24/96				
CODEINE 30MG/ACETAMINOPHE	2000954	E	15	08/27/96	08/27/96	(0)
T1 TAB PO Q4H PRN FOR SEVERE HEADACHE						
Provider: SCHULTZ,DAVID PAUL		Cost/Fill: $ 0.48 Exp/Can Dt: 09/06/96				
PROCHLORPERAZINE MALEATE	2279886	E	42	08/27/96	08/27/96	(0)
T1 TAB PO TID PRN FOR NAUSEA						
Provider: SCHULTZ,DAVID PAUL		Cost/Fill: $ 2.06 Exp/Can Dt: 09/10/96				
PHOSPHATES ENEMA	4748060	E	1	08/05/96	08/05/96	(0)
USE UD						
Provider: FONTENELLE,LARRY J		Cost/Fill: $ 0.63 Exp/Can Dt: 09/04/96				
UMATRIPTAN 6MG/0.5ML INJ	2278370	E	1	07/30/96	07/30/96	(0)
USQ AS DIRECTED NOT TO EXCEED 3 TIMES A WEEK						
Provider: SCHULTZ,DAVID PAUL		Cost/Fill: $ 21.39 Exp/Can Dt: 08/29/96				
HYDROXYPROGESTERONE ACETA	4667005A	A	1	02/07/96	07/29/96	(1)
I. 1 ML IM Q 3 MONTHS						

---------- RXOP - Outpatient Pharmacy (max 45 days) ----------
(continued)

Drug	Rx #	Stat	Qty	Issued	Last Filled	Rem
Provider: DIAZ,ALBERT L		Cost/Fill: $ 18.48				
TERCONAZOLE 0.4% VAG CREA	4725738	A	45	04/29/96	07/18/96	(0)
U. HS UD FOR ONE WEEK						
Provider: DIAZ,ALBERT L		Cost/Fill: $ 11.70				

---------- RP - Radiology Profile (max 2 occurrences) ----------

08/22/96 CT HEAD W/O CONT
CPT Code: 70450

Status: COMPLETE
Rpt Status: VERIFIED
Staff Radiologist: SMITH,ROBERT E
Res. Radiologist: TIEMAN,ELIZABETH

History: CHRONIC NAUSEA W/LITTLE RELIEF FROM PHEUERGAN. NO ABDOMINAL ETIOLOGY CENTRAL ETIOLOGY W/POSITIVE OPHTHO-KINETIC TESTING

Report: CT HEAD W/WO/CONTRAST:

TECHNIQUE: Before and after IV contrast administration, multiple contiguous 5 and 8 mm axial images through the brain obtained.

There is no prior study available for comparison.

FINDINGS: The ventricular system has a normal appearance. There is no evidence of acute hemorrhage, mass effect, or midline shift. Within the head of the caudate nucleus on the right, an approximately 4 x 8 mm hyodense lesion is identified with no enhancement or surrounding edema. This finding is most consistent with lacunar infarcts. No other focal abnormalities identified. No abnormally enhancing lesions are seen.

Impression: 1. Hypodense lesions in the head of the right caudate nucleus, consistent with lacunar infarct. Otherwise unremarkable scan.

08/22/96 CT HEAD W/IV CONT
CPT Code: 70460

Status: COMPLETE
Rpt Status: VERIFIED
Staff Radiologist: SMITH,ROBERT E
Res. Radiologist: TIEMAN,ELIZABETH

History: CHRONIC NAUSEA W/LITTLE RELIEF FROM PHEUERGAN. NO ABDOMINAL ETIOLOGY CENTRAL ETIOLOGY W/POSITIVE OPHTHO-KINETIC TESTING

Report: CT HEAD W/WO/CONTRAST:

TECHNIQUE: Before and after IV contrast administration, multiple contiguous 5 and 8 mm axial images through the brain obtained.

There is no prior study available for comparison.

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

---------- RP - Radiology Profile (max 2 occurrences) ----------
(continued)

FINDINGS: The ventricular system has a normal appearance. There is no evidence of acute hemorrhage, mass effect, or midline shift. Within the head of the caudate nucleus on the right, an approximately 4 x 8 mm hyodense lesion is identified with no enhancement or surrounding edema. This finding is most consistent with lacunar infarcts. No other focal abnormalities identified. No abnormally enhancing lesions are seen.

Impression: 1. Hypodense lesions in the head of the right caudate nucleus, consistent with lacunar infarct. Otherwise unremarkable scan.

---------- BSR - Brief Surgery Rpts (max 5 years) ----------

08/12/96	C-SCOPE	(COMPLETED)
11/30/95	EXCISION PAINFUL KNOT IN INCISION	(COMPLETED)
03/13/95	LYSIS OF ADHESIONS	(COMPLETED)

---------- SP - Surgical Pathology (max 2 years) ----------

Collected: 11/30/95 Acc: SP 95 2567
Specimen: PROLENE KNOTS FROM ABD INCISION.
Brief Clinical Hx:

44-year-old, white female with painful lump in abdominal incision.

Gross Description:

An irregular tan-white soft tissue structure is attached to a prolene suture, and it measures 0.5 cm in maximum dimension. Another 0.7 cm portion of pink-tan soft tissue is included. After separating the smaller fragment from the suture material, that fragment is inked, and it along with the larger one are entirely submitted in one cassette. NOTE: The larger one is bisected. (SPS/njf)

Microscopic Exam:

MICROSCOPIC DESCRIPTION: These are irregular portions of fibrocollagenous tissue with focal prominent stromal fibroblasts which are not neoplastic. There are focal small-caliber vessels within areas of hyalinization fibrosis. No malignant neoplasm or giant cell reaction are seen.

DIAGNOSIS:

S-2567-95; SOFT TISSUE, ABDOMINAL-INCISION RELATED, EXCISION: FIBROSIS AND FOCAL ORGANIZATION.

---------- BI - Immunization (520) ----------

---------- BI - Immunization (520) ----------
(continued)

No immunization record found

*** END ******** CONFIDENTIAL SURGERY CLINIC SUMMARY pg. 6 **********

MEDICAL RECORD | **CONSULTATION SHEET** 9:50

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
Surg	GYN	11/6/95

REASON FOR REQUEST (Complaints and findings)

Pain in area of incision

PROVISIONAL DIAGNOSIS

R/O Hematoma

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
		☐ BEDSIDE ☐ ON CALL ☐ CLINIC	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

SURGERY CLINIC 0920 11-22-95 38Y0 HT 5'6" WT 143.4

NKA 0920 T 98.7 P-81 R-20 B/P 130/74

Has a tender mass in the center of lumpectomy incision. Should be sterile.

Orlando Garcia ASOC
11-30-94

2

(Continued on reverse side)

SIGNATURE AND TITLE			DATE
DR Hansen			11-22-95
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
[redacted]

CONSULTATION SHEET
STANDARD FORM 513 (Rev. 9-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
513-108

11/8

INTERDISCIPLINARY ADMISSION ASSESSMENT

EMERGENCY ROOM/CLINIC ASSESSMENT, GAYLE A [redacted]

I. Date: 4-2-99 Time: 0815 Age: 41 HT: 66 WT: 128
Mode of Arrival: [ ]Ambulance [ ]Walk In [ ]Extended Care Facility
[ ]Other:
Source of Information: [ ]Patient [ ]Family/Friend [ ]Old Chart [ ]Other:
Chief Complaint: seizures
Allergies: NKA
Reactions to Anesthesia:
Medical History/Past Surgeries/Hospitalizations: Migraine, hx of seizures peript.
Present Medications: Prozac, Trazedone, Risperidone, Vistaril, Inderal, Darvocet, Elavil, Estrogen, Prn Tylenol, Phenergan
Marital Status: D
Religious Preference: Blood/Blood ProductTransfusion Preference:
Emergency Notification
Relative/Friend: Ray Dove Relationship: Father
Phone Number: 228-396-1919

II. **LEVEL OF CONSCIOUSNESS:**
[ ]Alert [ ]Oriented { }Person { }Place { }Time
[ ]Verbally Responsive [ ]Confused/Disoriented [ ]Responds to Pain
BEHAVIOR
[ ]Cooperative [ ]Uncooperative [ ]Combative [ ]Withdrawn
[ ]Other:
EMOTIONAL/PSYCHOSOCIAL STATUS:
[ ]Calm [ ]Anxious [ ]Fearful [ ]Depressed [ ]Suicidal
ADL's/Level of Functioning:
Bathing S/A/T Dressing S/A/T Eating S/A/T: Mobility S/A/T
Oral Hygiene S/A/T Toileting S/A/T
Comments:

VITAL SIGNS				
TIME	B/P	PULSE	RESP	TEMP
←	130/76	56	22	98.2
↑→	105/56	66	22	
↕	82/45	64	22	
1230	134/83	88	20	

III. **PATIENT RIGHTS**
Advanced Directive [ ]YES [ ]NO
Type:
Location:
Organ Donor [ ]YES [ ]NO
Tissue Donor: [ ]YES [ ]NO
Information/Pamphlet Provided:
[ ]YES [ ]NO [ ]Refused
Signature/Title: Grace E. Saddler RN Date/Time: 4-2-99 0830
Date/Time:

Comments:

IV. **POTENTIAL ABUSE**
[ ]Not Applicable
[ ]Rape or Other Sexual Molestation
[ ]Domestic Abuse
[ ]Abuse or neglect of elders or children
[ ]Evidence of Physical Assault
{ }Unexplained Bruises
{ }Unexplained Injuries
{ }Unkempt, dirty, poor hygiene
If yes to the above, **initiate Center Memorandum 122-17** (Mandatory Reporting of Adult and Child Abuse or Neglect) and contact Social Worker.
Date/Time Initiated:
Method of Notification:
Comments:

Readmission/Reassessment within 30 days:
Reviewer(s):
Signature/Title: Date/Time:
Date/Time:

[redacted]

INTERDISCIPLINARY ADMISSION ASSESSMENT
EMERGENCY ROOM/CLINIC ASSESSMENT

V. SKIN

[ ]Hot [✓]Warm [ ]Cool [✓]Dry [ ]Diaphoretic
[ ]Pink [ ]Cyanotic [ ]Rash [ ]Lesions [ ]Decubiti
[ ]Lacerations [ ]Hematoma [ ]Flushed [ ]Other:_____

CARDIOVASCULAR

[ ]No Problem Identified [ ]Chest Pain { }Exertional { }Rest
Chest Pain: Location: Duration:
Frequency:_____ Severity:_____(0 - 10 Scale)
Rhythm: [ ]Regular [ ]Irregular
Leg Pain: [ ]Exertional [ ]Rest

PULSES		
	Left	Right
Radial		
DP		
PT		

PUPILS		
	LEFT	RIGHT
Size	4	4
React	Slow resp	Slow response
Fixed		
Dilated		
Constricted		

Breath Sounds:		
	Left	Right
Clear	✓	✓
Wheezing		
Rhonchi		
Rales	✓	✓
Other		

RESPIRATORY

Breathing Pattern: [✓]Normal [ ]Dyspnea { }Exertional { }At Rest
Cough: [ ]None [ ]Non-Productive [ ]Productive
Comments:_____

MUSCULOSKELETAL

[✓]Moves all 4 Extremities [ ]Hemiplegia [ ]Paraplegia [ ]Quadriplegia
[ ]Amputee [ ]Contractures [ ]Other:_____
Comments:_____

GASTROINTESTINAL

Abdomen: [✓]Soft [ ]Rigid [ ]Distended [ ]Non-Tender
[ ]Tender [✓]Bowel Sounds { }Normal { }Absent
{ }Hypoactive { }Hyperactive
Last Bowel Movement:_____ Other:_____
Comments:_____

GENITOURINARY

[✓]No Problem Identified [ ]Burning [ ]Frequency [ ]Hematuria
[ ]Incontinence Last Menstrual Period:_____ Last Pap Smear:_____
Last Mammogram:_____ [ ]Other:_____
Signature/Title: Grace E. Kelleher RN Date/Time: 4-2-99
Date/Time:_____

Readmission/Reassessment within 30 days:
Reviewer(s)
Signature/Title:_____ Date/Time:_____
Date/Time:_____

VIII. PHYSICAL DISABILITIES

Arthritis	YES	NO
Coordination Problems	YES	NO
Limb Loss	YES	NO
Seizures	YES	NO

Emotional Status:
Calm / Apprehensive / Cooperative

Paralysis	YES	NO
Pain:	YES	NO

Severity (0 - 10):_____
Tolerable Level of Pain_____
Location:_____
Comments:_____
_____

ELIMINATION:

Incontinence	YES	NO
Indwelling Foley	YES	NO
Ileostomy	YES	NO
Colostomy	YES	NO
Constipation	YES	NO
Diarrhea	YES	NO
Black, tarry stools	YES	NO
Renal:	YES	NO
Prostate	YES	NO

Comments:_____

GASTROINTESTINAL:

Nausea & Vomiting	YES	NO
Feeding Tube	YES	NO
Hx of Ulcers	YES	NO
ETOH Use	YES	NO

_____/wk. Last drink:_____

Dysphagia	YES	NO

Religious Food Preference:_____
Type of Diet:_____
Comments:_____

TEETH

Bridges	YES	NO
Dentures:	YES	No

Upper: Full:_____Partial:_____
Lower: Full:_____Partial:_____

Broken	YES	NO
Loose	YES	NO
Missing	YES	NO

PULMONARY:

Smoker	YES	NO

Packs Per Day:_____# of Years:_____

Recent URI	YES	NO
COPD	YES	NO
Tracheostomy	YES	NO
O2 Adm	YES	NO
TB	YES	NO
Asthma	YES	NO
SOB	YES	NO
Cough	YES	NO

Productive: _____
Non-Productive: _____
Color of Sputum: _____

Comments:_____
_____
_____

CARDIOVASCULAR/CIRCULATION:

CHF	YES	NO
Angina	YES	NO

Last Occurrence: _____
Location: _____
Severity (0-10): _____
Relieved by: _____

MI	YES	NO
Arrhythmias	YES	NO
Hx Vascular Disease	YES	NO
HTN	YES	NO
CVA	YES	NO
Pacemaker/AICD	YES	NO
Thyroid Disease	YES	NO
Hepatitis	YES	NO
HIV	YES	NO
Previous Blood Transfusion	YES	NO

Comments:_____
_____
_____

Comments:_____

Signature/Title:_____Date/Time:_____
_____Date/Time:_____

Readmission/Reassessment within 30 days:
Reviewer(s):
Signature/Title:_____Date/Time:_____
_____Date/Time:_____

INTERDISCIPLINARY ADMISSION ASSESSMENT
EMERGENCY ROOM/CLINIC ASSESSMENT

VI. TREATMENTS DONE: NS-dc'd C 1250 100cc's in LOVE, GAYLE A

[ ]IVF: #22 Rt Fin (Flow sheet started) [ ]NG Tube [[redacted]

[ ]EKG [ ]ABG [ ]CXR [ ]KUB

[ ]Aerosol Treatment:

[ ]Chem 7 [ ]Chem 10 [ ]Cardiac Enzymes [ ]CBC #s 10 70 [ ]PT/PTT

[ ]Accucheck: Pulse Oximeter:

[ ]Other:

MEDICATIONS ADMINISTERED:

TIME	MEDICATION	DOSE	RESPONSE	SIGNATURE
0855	Imitrex	6mg SQ	(R) 4/10 Pain 10 → 4/10	Grace Eo Sadler RN
0905	Phenergan	25mg IM	(R) GM 10 → Nausea resolved	Grace Eo Sadler RN
1250	Demerol 50mg / Phenergan 25mg		(R) GM 4/10 1330	Grace Eo Sadler RN

VII. Disposition Of Patient/Care Setting: Time: 1330

[C]Discharged to Home [ ]Admitted to Medicine Service [ ] Admitted to Surgery Service

[ ] Admitted to ICU [ ] Admitted to Mental Health

[ ]Transferred to another Facility:

[ ]To be admitted at a later date for surgery; Date TBA:

[ ]Other

Patient placed on Seriously Ill List: [ ]YES [ ]NO

Chaplain Notified: [ ]N/A [ ]YES [ ]NO

List Items Brought to Hospital:

Disposition of Valuables: [ ]Agent Cashier [ ]MAA [ ]Patient Effects
[ ]Patient [ ]Family/Home

PROGRESS NOTES:

0930 - Pt sent to CT scan. 1020. Pt back from CT scan
1215 - Pt c/o nausea + headache is back. Pt is wearing sunglasses, chewing gum + has a relaxed facial appearance.
1250 - Pt medicated for headache + nausea. Grace Eo Sadler RN
1315 - Pt states her headache is better. Pt d/c'd home in stable condition. Friend to drive her home. Pt is steady gait upon discharge.

EKG RHYTHM STRIP

(If Applicable)

Signature/Title: Grace Eo Sadler RN Date/Time: 4-2-99 @ 1330

Date/Time:

Readmission/Reassessment within 30 days:

Reviewer(s):

Signature/Title: Date/Time:

Date/Time:

[redacted]

IX. SLEEP/REST ASSESSMENT

Usual Number of Hours of Sleep:_____ Goes to Sleep at:_____ Rises at:_____
Difficulty Sleeping: YES NO Sleeping Aids: YES NO
Why?_____ What?_____

MISCELLANEOUS:

Glasses	YES	NO
Contact Lens	YES	NO
Hearing Aid	YES	NO
Artificial Eye	YES	NO
Crutches	YES	NO
Artificial limb	YES	NO
Brace	YES	NO
Walker	YES	NO
Cane	YES	NO
Wheelchair	YES	NO
Infusaport/Hickman	YES	NO

Comments:_____

SKIN INTEGRITY

Rashes	YES	NO
Bruises	YES	NO
Infections	YES	NO
Cuts	YES	NO
Edema	YES	NO

Site:_____
Degree:_____
General Problems:_____
_____
Comments:_____
_____
_____

X. ULCER DOCUMENTATION

DATE ACQUIRED	LOCATION	SIZE	STAGE	DRAINAGE

BRADEN RISK SCALE

SCORE	1	2	3	4	TOTAL
SENSORY PERCEPTION	Unresponsive	Responds to Pain	Responds to Verbal	No Problem	
MOISTURE	Always Wet	Often Wet	Rarely Wet	Dry	
ACTIVITY	Bedfast	Chairfast	Slightly Limited	Walks Frequently	
MOBILITY	Completely immobile	Limited Movement	Slightly Limited	No Limits	
NUTRITION	Very Poor Intake	Inadequate <1/2 meal	Adequate >1/2 meal	Excellent	
FRICTION	Max assist to move to bed	Minimum assist to move to bed	No Problem	No Problem	
				TOTAL	

If Score is < 16 Initiate Nursing Procedure 311 and Notify Enterostomal Therapy Nurse
Method of Notification:_____
Comments:_____
_____

Signature/Title:_____ Date/Time:_____
_____ Date/Time:_____

Readmission/Reassessment within 30 days:
Reviewer(s):
Signature/Title:_____ Date/Time:_____
_____ Date/Time:_____

[redacted]

XI. PREDISPOSITION FOR FALLING

[ ]Unsteady on feet [ ]Poor Eyesight [ ]Dizziness/Fainting
[ ]Poor Bladder Control [ ]Confused/Disoriented [ ]65 Years or Older
[ ]Neurological Problems [ ]Physical Disability [ ]Unsafe Footwear
[ ]Current Medication: Narcotics, Hypnotics, Sedatives, Diuretics [ ]Prior Falls

Patient placed on fall risk precautions: [ ]YES [ ]NO

Explanation: _____

_____

Signature/Title of Initiator: _____ Date/Time: _____

PROGRESS NOTES: _____

Signature/Title: _____ Date/Time: _____

_____ Date/Time: _____

Readmission/Reassessment within 30 days:
Reviewer(s):
Signature/Title: _____ Date/Time: _____

_____ Date/Time: _____

XII. INPATIENT SCREENING TOOL

NUTRITIONAL SCREENING **Need Identified: ☐ Yes ☐ No**

Unintentional Weight Loss of 5lbs in last week: ☐ Yes ☐ No
NPO > 3 Days: ☐ Yes ☐ No
Unintentional Weight Loss of 10lbs in last month: ☐ Yes ☐ No
Tube Feeding/IV Nutritional Support: ☐ Yes ☐ No Type:_____
Non-Formulary Nutritional Support (Tube Feeding/Parenteral) Products: ☐ Yes ☐ No
Type:_____
If any of the above identified, contact Clinical Dietitian
Method of Notification:_____ Date/Time Notified:_____
Signature/Title:_____

SOCIAL WORK/DISCHARGE PLANNING SCREENING **Need Identified: ☐ Yes ☐ No**

Patient will need supportive care or support of caregiver at discharge for activities of daily living: ☐ Yes ☐ No
Patient lives alone and is capable of independent living: ☐ Yes ☐ No
Patient is capable of planning for own care: ☐ Yes ☐ No
Patient is homeless: ☐ Yes ☐ No
Abuse suspected: ☐ Yes ☐ No
If any of the above identified, contact Social Worker:
Method of Notification:_____ Date/Time Notified:_____
Signature/Title:_____

FUNCTIONAL SCREENING **Need Identified: ☐ Yes ☐ No**

Able to Perform Activities of Daily Living without Assistance ☐ Yes ☐ No
Developed within the last month:
[ ]CVA [ ]Head Trauma [ ]Brain Injury [ ]Fall
Newly Identified weakness/paralysis
If any of the above identified notify Rehabilitation Medicine
Method of Notification:_____ Date/Time Notified:_____
Signature/Title:_____

TEACHING ASSESSMENT

Learns best: ☐Seeing ☐Hearing ☐Doing Able to read: ☐YES ☐NO Education Level:_____
Barriers /limitations: ☐Physical ☐Visual ☐Cognitive ☐Auditory ☐Language ☐Emotional
☐Other_____ ☐None
Describe barriers/limitations and note plan to adapt patient teaching:_____
_____
Age Specific Needs:_____
Cultural/Religious practices affect the patient's healthcare? ☐NO ☐ YES If yes, describe and document plan to adapt teaching:_____
_____
Signature/Title:_____ Date:_____
***Document teaching needs on the Interdisciplinary Patient and Family Teaching Record which is attached to the Collaborative Interdisciplinary Plan of Care/Progress Note/Discharge Planning Form.**

Signature/Title:_____ Date/Time:_____
_____ Date/Time:_____

Readmission/Reassessment within 30 days:
Reviewer(s):
Signature/Title:_____ Date/Time:_____
_____ Date/Time:_____

INTERDISCIPLINARY ADMISSION ASSESSMENT

DATE/TIME	PROGRESS NOTES

MEDICAL RECORD | INTERDISCIPLINARY ASSESSMENT: HISTORY & PHYSICAL EXAM

CHIEF COMPLAINT:

Admission date: _____ Time: _____ am pm
Admitted from: [] AEC [] Clinic Other: _____
Primary Care Provider: _____

HISTORY OF PRESENT ILLNESS:

addressograph

MEDICAL RECORD	INTERDISCIPLINARY ASSESSMENT - HISTORY & PHYSICAL EXAM

FAMILY HISTORY:

PERTINENT MILITARY HISTORY:

SOCIAL HISTORY: (Include: alcohol, tobacco [pack-years], illicit drug use; hx of sexual trauma; current living condition; occupation)

REVIEW OF SYSTEMS

GENERAL:

EYES/VISION:

EARS/NOSE/THROAT: (Include hearing, smell/taste)

Neck/Throat:

Chest:

Heart:

Breasts:

Lungs:

Abdomen:

Genitalia:

Female:
Pap smear done: ___ Yes ___ No

Rectal:
prostate:
occult blood:

MEDICATIONS

Drug	Indication	Dose	Frequency	Last Dose Taken

Over-the-counter:

ADVANCED DIRECTIVES

[] has one [] desires one
[] does not desire one [] wants further information

BLOOD TRANSFUSION: [] discussed pt's preferences regarding blood transfusion [] N/A

PAST MEDICAL HISTORY:

(Include surgeries/hospitalizations/injuries)

Immunizations: [] influenza date: _____ PPD: date: _____
[] pneumococcal date: _____ results: _____
[] diphtheria/tetanus booster date: _____

FEMALE: last *mammogram*: _____ results: _____ Monthly breast self exams [] Yes [] No
last Pap smear: _____ results: _____

ALLERGIES & SENSITIVITIES

(Include reaction)

Medication: _____

Food/other: _____

PHYSICAL EXAMINATION

BP: _____ P: _____ R: _____ T: _____

Ht: _____ Wt: _____

GENERAL APPEARANCE & MENTAL STATUS:

Head:

Eyes:

Ears:

Nose:

Mouth:

Teeth:

Neck/Throat:

Chest:

Heart:

Breasts:

Lungs:

Abdomen:

Genitalia:

Female:
Pap smear done: ___ Yes ___ No

Rectal:
prostate:
occult blood:

PHYSICAL EXAMINATION cont.

Back/Spine:

Skin:

Extremities:

Lymphatics:

Neurological:

DIAGNOSTIC TESTS

LAB VALUES:

EKG:

XRAYS:

DIAGNOSTIC IMPRESSION

PLAN

DISCHARGE PLAN

Sign and print name	(Intern/other)	date/time	pager #
Sign and print name	(Resident)	date/time	pager #
Residency pgm:			
Sign and print name	(Attending)	date/time	pager #

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
3-2-99	0800 AM/PM	41	☐ M ☒ F	☒ AMBULATORY ☐ STRETCHER ☐ WHEELCHAIR	(329)396-1919	☐ YES ☒ NO

8A. ALLERGIES	8B. WEIGHT	8C. TEMPERATURE	8D. PULSE	8E. RESPIRATION	8F. B/P	8G. DUE TO INJURY
NKDA	128.3	98.7	63	18	98/66	☒ NO ☐ YES

9. CURRENT MEDICATIONS Prozac, Trazodone, Risperidon, Vistaril, Inderal, Depakote, Stadol, estrogen, Discodyl, Phenergan

10. TRIAGE Pt c stated hx of seizures over past year - states she has then Q 3 mths or so. Pt states she had 3 seizures last evening.

17. SIGNATURE [signature]

12. HISTORY AND PHYSICAL

says she has been having spells of "epileptic seizures" last 2 months. She had 3 last night. She says after she awakened over a stiffness and she was unconscious for some of them. Also says she vomited blood 3 days ago. PRE - has amount brown stool → guaiac (+)
A/P - 63 yrs w/ hx seizures
Lungs: clear b A+P
Abd - soft
EXT - WNL intact (+) Babinski
Psych - depressed, anxious

Says she takes Depakote and Inderal qd AM & Dilantin qhs for migraine prevention. Hasn't mentioned seizures to physicians until today.

Migraine cephalgia, N/V/seizure

13. DIAGNOSTIC IMPRESSIONS R/O Seizure Disorder - R/O Drug Rx

14. PLAN 1240 - Benadryl 50 @ Phenergan 25 IM - Compazine 10 mg IM - Benadryl 50 mg IM - Imitrex 6 mg SQ, √done 1055 4/10 0930 3/10 Phenergan 25 IM. √done 0905 0930 nausea relieved
CBC, CMP, Dilantin, Tegretol, Depakote on 3-28-99 EEG, Mon. 4-5-99 @ 2:00 PM
Dilantin level, Depakote level, Tegretol level, Neurology consult

15A. ATTENDING OF RECORD Joseph Brainwell Wilson

15B. EXAMINER'S SIGNATURE [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	4/2/99 1330	[signature]

IMPRINT PATIENT DATA CARD

Howe, Gayle A
[redacted]

7. PATIENT INSTRUCTIONS

See Dr Natwi 4/6/99 - 11:30 AM
√ Inderal Keep appt. Dr Walker
Start Depakote, Tegretol; EEG 4-5-99 2pm
Keep appt Dr Wilson
Keep MAC appt as scheduled
Continue all other medications as prescribed

I CERTIFY THAT I RECEIVED AND UNDERSTAND THESE INSTRUCTIONS

8. PATIENT'S SIGNATURE [signature] Gayle A. Howe

VA FORM MAR 1992 10-10M 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

Pt. states last wife began getting dizzy & then her legs started shaking & arms started shaking for approximately 1 minute she would shake. Pt states above activity would occur during time she got out of bed. Denies LOC, bowel or bladder incontinance. ——— Diane Ea Scobee RN

STUDIES REQUESTED	RESULTS

MEDICAL RECORD — CONSULTATION SHEET

REQUEST

TO: Neurology Dr. Wallace

FROM: (Requesting physician or agent) ER

DATE OF REQUEST 4-2-99

REASON FOR REQUEST (Complaints and findings)

Pt Fay. she has been having seizure like activity where she has a blank stare and stiffens out & has bowel incontinence on some occasions. Pt says this has happened 3x last year & several times over last 2 months. Been to numerous physicians and tried more.

PROVISIONAL DIAGNOSIS

R/O Seizure Disorder ; Migraine Hx. R/O Drug reaction

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	ROUTINE / TODAY
Ferrell		☐ BEDSIDE ☐ ON CALL	☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

c/o episodes of dizziness when pt is up & then start shaking (whole body) & grab to something & sometimes she falls - but she was aware of shaking, couple times - she lost cons for couple of sec - no tongue bite or prime incont. but she wet bed sometimes. She has chronic headache & pt is having headache daily. She reports that she does vomit blood. H/O ulcers. She reports that she has been taking Excedrin BC & on from 1 yr but pattern more frequent recently. (continued on reverse side) Pt shaking - She pts numbness in whole body

SIGNATURE AND TITLE

DATE 4/2/99

IDENTIFICATION NO. | ORGANIZATION | REGISTER NO. | WARD NO 10-5

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

CONSULTATION SHEET
STANDARD FORM 513 (Rev. 9-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
513-108

Dove, Gayle [redacted]

K-2Pa

Med: Inspac 20 mg IV 1H, Ranitidine (mg 50 mg,
Tramadol 50 mg - 6 tab 8 hr, Enoxaparin 40 mg IV 8 PM,
Clonazepam (mg 1 tab,
Ventolin - alert, Duolin x 3. Sputum culture
reports awaited to start
appropriate, no significant
no focal deficit, other systemic
Motor: no atrophy, no involuntary movements
power 4/5 UL & LL
tone normal
sensory: intact
reflex: no brisk
Dysarthria - Negative
Hx/o episodes of slurring of speech
Recent - not typical seizure type
No driving as on medication
Plan: Dc Enoxaparin
(1) IVBG, (2) ABG, (3) ABG
(4) Inj Tazobactam 100 mg IV BD
Nebulization - Ventolin (as prescribed)
(5) follow up - new clinic visit - 4/6 - 11.30 AM

V.K. NAGURU MD
AS3285170-396

Wt 123.7 #

MEDICAL RECORD **PURPLE TEAM** **PROGRESS NOTES**

DATE	
9/11/91	41 410 T 97.5 P 80 R 18 BP 99/61
1345	C/O migraine HA since waking this am.
NKDA	Took TI 3 mit rest injections per self report
	& 0730 and c900 & relief. Here requesting TK
	for migraine HA. was seen in ER last week
	for same. Referred to L. Fernandez.
	Rec CK main sx & denies vomiting. Took Phenergan
	& 0830 per self & home. — Chris Jennes
	CHART NOT AVAILABLE
	Pt interviewed & examined & RN Mary Ryan
	S 41yo wm & h/o r SC. for chronic migraine
	on @ side of head; c nausea, dizzy, nausea
	has take 2 tonitrex injections & Phenergan &
	no relief. Pt has now was treated last
	wk by Dr Jennison & was Demerol &
	Phenergan
	O- Hx & labwork flow-up eye exam
	CT & MRI & past ①
	A. Migraine
	P. ① Demerol 50 mg } PM x 6 CK. & monitor V/S done 1515
	Phenergan 25 mg }
	Pt may ambulate (Continued on reverse side) monitoring after
	② keep appt & Dr Hubbard

PATIENT'S IDENTIFICATION (For typed or written entries, enter 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

L. D. FERNANDES, MD
AS3285170-382

DOVE, GAYLE A
[redacted] 08/15/57

PROGRESS NOTES

1440

DATE	
9/1/98	BP 104/56 HR 51 Resp 18 ← W. Benton RN
1515	Demerol 50mg & Phenergan 25mg IM given per order Dr Fernandes Pt to ward Drowsy & Nod given to monitor J Sadler RN
1615	Pt verbalizes relief of headache from injection BP ~~98/59~~ (98/59) P 50 R 18 Grace E. Sadler RN

STANDARD FORM 509 BACK (Rev. 11-77)

*U.S.GPO:1997-426-359

)RM 10-1338 WORK COPY Biloxi Division
Biloxi, MS (CONS) CLINICAL LABORATORY REPORT

)VE,GAYLE A 04/02/1999 10:17
[redacted] SEX: F AGE: 41 LOC: ER

Provider: PIERCE,ROBERT H
Specimen: BLOOD
:cession [UID]: HE 0402 47 [2490920047]

Test name	04/02/1999 09:55 Result	units	Ref. range
WBC	13.3 H	#/cmm	4.8 - 10.8
RBC	4.25	#/cmm	4.2 - 5.4
HGB	13.9	g/dl	12 - 16
HCT	40.7	%	37 - 47
MCV	95.8	fL	81 - 99
MCH	32.8 H	pg	27 - 31
MCHC	34.2	g/dl	32 - 36
RDW	12.6	%	11.5 - 14.5
PLT	317	#/cmm	130 - 400
MPV	7.2 L	fL	7.4 - 10.4
LYMPH%	17.5 L	%	20.5 - 51.1
NEUTRO%	75.7 H	%	42.2 - 75.2
MONOS%	4.8	%	4 - 12
Eval: Reference Range <4/29/97 = 1.7 - 10.0 / Range edited 4/29/97			
EOSINO%	1.8	%	0 - 11
BASO%	0.2	%	0 - 2
NEUTRO#	10.1 H	#/cmm	1.4 - 6.5
LYMPH#	2.3	#/cmm	1.2 - 3.4
MONOS#	0.6	#/cmm	.1 - .7
EOSINO#	0.2	#/cmm	0 - .7
BASO#	0.0	#/cmm	0 - .2

omment: -For Test: CBC
-STAT

KEY: "L"=Abnormal low, "H"=Abnormal high, "*"=Critical value

Debbie cardiology resp 3rd a ash hair wood or sprang

04/02/1999 08:23

********** CONFIDENTIAL Ambulatory Care SUMMARY pg. 1 **********

)OVE,GAYLE A [redacted] DOB: [redacted]

---------- CD - Advance Directive ----------

lo data available

---------- PLA - Active Problems ----------

33 Active Problems

PROBLEM	LAST MOD	PROVIDER
784.0-HEADACHE	10/28/1997	JONES,KENNETH R
614.6-FEM PELVIC PERITON ADHES	04/02/1998	
305.1-TOBACCO USE DISORDER	04/03/1998	HANSON,JOHN C.
346.90-MIGRAINE UNSPEC W/O INTRACT.	04/16/1998	
309.81-PROLONG POSTTRAUM STRESS	04/24/1998	
300.01-PANIC DISORDER	04/24/1998	
388.30-TINNITUS NOS	04/24/1998	
389.10-SENSORNEUR HEAR LOSS NOS	04/24/1998	
614.8-FEM PELV INFLAM DIS NEC	04/24/1998	
564.0-CONSTIPATION	04/24/1998	
568.0-PERITONEAL ADHESIONS	04/24/1998	
789.00-ABDOM PAIN, UNSP SITE	04/24/1998	
623.8-NONINFLAM DIS VAGINA NEC	04/24/1998	
296.30-RECURR DEPR DISORDER-UNSP	04/24/1998	
789.09-ABDOM PAIN, OTH SPEC SITE	04/24/1998	
536.8-STOMACH FUNCTION DIS NEC	04/24/1998	
531.31-AC STOMACH ULC NOS-OBSTR	04/24/1998	
309.9-ADJUSTMENT REACTION NOS	04/24/1998	
535.50-NOS GASTR & GASTRODUO W/O HEMO	04/24/1998	
300.4-NEUROTIC DEPRESSION	04/24/1998	
367.9-REFRACTION DISORDER NOS	04/24/1998	
303.90-ALCOH DEP NEC/NOS-UNSPEC	04/24/1998	
627.2-FEMALE CLIMACTERIC STATE	04/24/1998	
346.00-MIGRAINE W/O INTRACATABLE	04/24/1998	

365.02-ANATOMICAL NARROW ANGLE	04/24/1998
682.9-CELLULITIS NOS	06/18/1998PIERCE,ROBERT H
706.2-SEBACEOUS CYST	07/13/1998NEUMASTER,TERRY
V65.44-HIV COUNSELING	07/13/1998HANSON,JOHN C.
300.00-ANXIETY STATE NOS	07/20/1998TAYLOR,JANICE
346.81-OTHER MIGRAINE, INTRACTABLE	09/02/1998SADLER,GRACE E
307.81-TENSION HEADACHE; Onset 09/18/1998	10/24/1998
311.-DEPRESSIVE DISORDER NEC; Onset 09/18/1998	10/24/1998
530.11-REFLUX ESOPHAGITIS	02/19/1999OKEAKPU,DONALD

---------- PLI - Inactive Problems ----------

lo data available

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

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

Marital Status: DIVORCED Age: 41
Religion: PROTESTANT, NO DENOMINATION Sex: FEMALE
Occupation: DEALER
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 %: 100
Means Test: NO LONGER REQUIRED
NOK: RAY DOVE JR Relation: FATHER
4457 POPPS FERRY RD.LOT 195 Phone: 228-396-1919
BILOXI, MISSISSIPPI 39532

---------- DS - Disabilities ----------

ligibility: SERVICE CONNECTED 50% to 100% VERIFIED
otal S/C %: 100

OST-TRAUMATIC STRESS DISORDER	70%	S/C
EMOVAL OF UTERUS AND OVARIES	50%	S/C
IGRAINE HEADACHES	30%	S/C
HINITIS	0%	S/C
EOPLASM, BENIGN, SKIN	0%	S/C

---------- BADR - ADV REACT/ALLERGY ----------

o data available

---------- CW - Clinical Warnings ----------

o data available

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

^

	--NEXT--	--LAST--
AP SMEAR	DUE NOW	unknown

---------- CM - Reminder Maintenance ----------

^

	--NEXT--	--LAST--
AMMOGRAM	12/11/1999	12/11/1998

2/6/1997 Encounter Procedure: 76091-MAMMOGRAM, BOTH BREASTS

Prov. Narr. - MAMMOGRAM BILAT
Final Frequency and Age Range used: 1 year for ages 25 to 70.
12/11/1998 Radiology Procedure: 76091-MAMMOGRAM, BOTH BREASTS; MAMMOGRAM BILAT

'AP SMEAR DUE NOW unknown
9/22/1998 Hospitalization Diagnosis: 311.-DEPRESSIVE DISORDER NEC
2/19/1999 Problem Diagnosis: 530.11-REFLUX ESOPHAGITIS
3/28/1999 Encounter Diagnosis: 784.0-HEADACHE
2/3/1997 Encounter Procedure: 88150-CYTPATH C/VAG MANUAL
Prov. Narr. - CYTOPATHOLOGY, PAP SMEAR
Final Frequency and Age Range used: 1 year for ages 16 to 99.

utrition/Obesity Education
The reminder Nutrition/Obesity Education was inactivated

EMOGLOBIN A1C N/A
Final Frequency and Age Range used: 0Y - Not Indicated for all ages.

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

---------- CVP - Past Clinic Visits (max 4 occurrences) ----------

4/02/1999 08:20 WALK IN EMERGENCY ROOM
4/01/1999 10:30 WOMEN'S MHPC GOLD SAPORIT NO ACTION TAKEN
3/29/1999 08:08 WALK IN TRIAGE
3/28/1999 21:08 WALK IN EMERGENCY ROOM

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

4/20/1999 09:30 WOMEN'S MHPC GOLD PSYCHIA
4/20/1999 10:30 EYE-CARRIERE
4/23/1999 09:00 PC PURPLE PENNISSON
4/27/1999 11:20 NEUROLOGY-DR V NALLURI
5/18/1999 09:30 WOMEN'S MHPC GOLD PSYCHIA
7/08/1999 08:40 PC PURPLE PENNISSON
8/26/1999 10:00 GASTRO AVALOS (START 7/1/

---------- ADC - Admission/Discharge (max 12 months) ----------

9/18/1998 - 09/22/1998 LOS: 4
Last Tr Specialty: GENERAL(ACUTE MEDICINE) Last Prov: NALLURI,VASANTH
Bedsection: GENERAL(ACUTE MEDICINE)
DXLS: MIGRAINE UNSPEC W/O INTRACT. 346.90
ICD DX: TENSION HEADACHE 307.81
DEPRESSIVE DISORDER NEC 311.
PROLONG POSTTRAUM STRESS 309.81
TOBACCO USE DISORDER 305.1

---------- SCLU - Lab Cum Selected (max 1 year) ----------

ollection DT	Spec	WBC	RBC	HCT	HGB	PLT	NA	K
3/28/1999 22:41	PLASM						133 L	4.2
3/28/1999 22:41	BLOOD	13.2 H	3.77 L	36.3 L	12.2	270		
9/18/1998 13:44	PLASM						141.	4.4
9/18/1998 13:44	BLOOD	8.5	4.34	41.4	13.9	237		
5/07/1998 07:41	PLASM						138.	5.1 H
5/07/1998 07:41	BLOOD	5.1	4.69	44.4	15.1	241		
4/03/1998 06:00	PLASM						143.	4.5
4/03/1998 06:00	BLOOD	5.4	4.00 L	38.8	13.0	244		

ollection DT	Spec	CL2	CO2	BUN	CRE	GLU	T. BIL	D BILI
3/28/1999 22:41	PLASM	101.0		12	0.7	131 H	0.3	
9/18/1998 13:44	PLASM	102.		6. L	0.9	88.	.5	
7/13/1998 12:49	PLASM						.5	.4
5/07/1998 07:41	PLASM	101.	28.0	4. L	0.8	96.	.6	.5 H
4/03/1998 06:00	PLASM	109.	28.0					

ollection DT	Spec	ALK PHO	SGOT	SGPT	ANI GAP	BILIRUB	KETONES	GLU
3/28/1999 22:41	PLASM	105	24					
9/19/1998 02:06	URINE					NEG	NEG	NEG
9/18/1998 13:44	PLASM	65.	24.					
7/13/1998 12:49	PLASM	59.	42.	3. L				

5/07/1998 07:41	PLASM	80.	53.	20.	9.0			
4/03/1998 06:00	PLASM				7.0			

ollection DT	Spec	PROTEIN	COLOR	BLOOD	NITRITE	SP.GRAV	pH	UrUrob
3/19/1998 02:06	URINE	NEG	YELLOW	NEG	NEG	1.010 L	5.5	0.2E.U./dL

ollection DT	Spec	LEUKOCY	CLARITY	MCH	MCHC	MPV	MONOS	EOSINO
3/28/1999 22:41	BLOOD			32.4 H	33.8	7.2 L	3.4 L	1.1
3/19/1998 02:06	URINE	NEG	CLEAR					
3/18/1998 13:44	BLOOD			32.1 H	33.6	7.5	4.1	3.5
5/07/1998 07:41	BLOOD			32.1 H	34	7.4	9.9	1.2
4/03/1998 06:00	BLOOD			32.5 H	33.5	7.6	6	4

ollection DT	Spec	BASO	RDW	LYMPH %	NEUTRO%	LYMPH#	MONOS#	NEUTRO#
3/28/1999 22:41	BLOOD	0.3	12.4	14.5 L	80.7 H	1.9	0.4	10.6 H

---------- SCLU - Lab Cum Selected (max 1 year) ----------
(continued)

ollection DT	Spec	BASO	RDW	LYMPH %	NEUTRO%	LYMPH#	MONOS#	NEUTRO#
9/18/1998 13:44	BLOOD	.9	12.2	31.4	60.1	2.7	.3	5.1
5/07/1998 07:41	BLOOD	.9	12.0	30.3	57.7	1.5	.5	3
4/03/1998 06:00	BLOOD	.9	12.1	34.2	54.9	1.8	.3	3.1

ollection DT	Spec	EOSINO#	BASO#	ALB	CA	MCV
3/28/1999 22:41	PLASM			2.8 L	8.6	
3/28/1999 22:41	BLOOD	0.1	0.0			96.0
0/15/1998 09:24	PLASM			3.7 L		
9/18/1998 13:44	PLASM			4.0	8.7	
9/18/1998 13:44	BLOOD	.3	.1			95.3
7/13/1998 12:49	PLASM			4.2		
5/07/1998 07:41	BLOOD	.1	0			94.6
4/03/1998 06:00	BLOOD	.2	0			97.1

---------- CY - Cytopathology (max 3 occurrences) ----------

Collected: 02/03/1997 Acc: CY 97 144
Specimen: A)PAP SMEAR.

icroscopic exam:

pecimen satisfactory, no endocervical components seen, consistent with
istory of hysterectomy and/or vaginal specimen source.

IAGNOSIS:

97-144A: CYTOLOGY, PAP SMEAR, VAGINAL:

WITHIN NORMAL LIMITS.

INFLAMMATORY EXUDATE PRESENT.

IOTE: THIS STUDY (C-04429-97) WAS PERFORMED AT KAFB MEDICAL CENTER.

Collected: 02/05/1996 Acc: CY 96 132
Specimen: A) PAP-GYN.

iicroscopic exam:

specimen satisfactory, no endocervical components seen, consistent with
iistory of hysterectomy and/or vaginal specimen source.

)IAGNOSIS:

:96-132A: CYTOLOGY, PAP SMEAR, VAGINAL: WITHIN NORMAL LIMITS.
ABUNDANT BACTERIA.

NOTE: THIS STUDY (C-05815-96) WAS PERFORMED AT KAFB MEDICAL CENTER.

Collected: 09/22/1994 Acc: CY 94 849
Specimen: VAG

icroscopic exam:
IAGNOSIS: CYTOLOGY, PAP SMEAR, VAGINAL: WITHIN NORMAL LIMITS.

OTE: The report was submitted by S. Holmes, CT, and QA'd by
. Hart, CT, KAFBMC.

---------- BSR - Brief Surgery Rpts (max 24 months) ----------

2/16/1998	ESOPHAGOGASTRODUODENOSCOPY	(COMPLETED)
7/10/1998	EXCISION OF CYST ON MIDBACK	(COMPLETED)
6/16/1998	INCISION AND DRAINAGE OF CYST ON BACK	(COMPLETED)

---------- MIC - Microbiology (max 2 occurrences) ----------

rug.....	Rx #	Stat	Qty	Issued	Last Filled	Rem
JTORPHANOL TARTRATE 1MG 14D NASAL SPRAY						
	4995222	S	1	01/19/1999	05/09/1999	(0)
SIG: USE 1 SPRAY IN 1 NOSTRIL FOR SEVERE HEADACHE						
Provider: NALLURI.VASANTHI KUMAR Cost/Fill: $ 38.32						
_UOXETINE HCL 20MG CAP						
	4961438BS		60	02/16/1999	05/07/1999	(0)
SIG: T2 CAP PO QAM						
Provider: GELDER.MAURICE D Cost/Fill: $ 70.68						
ISPERIDONE 1MG TAB						
	2325170	S	30	02/16/1999	05/07/1999	(0)

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

---------- RXOP - Outpatient Pharmacy (max 91 days) ----------
(continued)

ıg..... Rx #	Stat	Qty	Issued	Last Filled	Rem
;IG: T1 TAB PO HS Provider: GELDER,MAURICE D	Cost/Fill: $ 36.18				
AZODONE HCL 50MG TAB 2321574AS		180	03/16/1999	05/05/1999	(1)
SIG: T6 TAB PO QHS Provider: GELDER,MAURICE D	Cost/Fill: $ 4.50				
OPRANOLOL HCL 40MG TAB 4961450AS		120	11/17/1998	04/30/1999	(6)
SIG: T2 TAB PO BID Provider: PENNISSON,ANNE M	Cost/Fill: $ 0.60				
.OMETHAZINE HCL 25MG TAB 4968645AS		30	11/17/1998	04/28/1999	(6)
SIG: T1 TAB Q12H PRN Provider: PENNISSON,ANNE M	Cost/Fill: $ 0.21				
.ONAZEPAM 1MG TAB 2325171 S		90	02/16/1999	04/08/1999	(1)
SIG: T1 TAB PO TID PRN Provider: GELDER,MAURICE D	Cost/Fill: $ 11.79				
YDROXYZINE HCL 25MG TAB 2326632 A		90	03/16/1999	04/05/1999	(0)
SIG: T1 TAB PO TID PRN FO AN Provider: GELDER,MAURICE D	Cost/Fill: $ 2.07				
PAP 325/BUTALBITAL 50/CAFF 40MG TAB 5018492 A		30	03/29/1999	03/29/1999	(0)
SIG: T1 TAB PO Q8H PRN FOR MIGRAIN Provider: SAIJA,PRAVINCHANDRA	Cost/Fill: $ 0.78				
ZITHROMYCIN 250MG TAB 5018547 A		6	03/29/1999	03/29/1999	(0)
SIG: Z PAK Provider: HUBBARD,JOHN E	Cost/Fill: $ 22.37				
;UAIFENESIN 100MG/5ML SYRUP 5018551 A		120	03/29/1999	03/29/1999	(0)
SIG: T2 TEASPOONFULL Q6H PRN FOR COUGH Provider: HUBBARD,JOHN E	Cost/Fill: $ 0.72				
CODEINE 30MG/ACETAMINOPHEN 325MG TAB 5020140 A		12	03/22/1999	03/22/1999	(0)
SIG: T1 TAB Q4H PRN FP Provider: HUBBARD,JOHN E	Cost/Fill: $ 0.47				
BISACODYL 5MG EC TAB 4961445 A		100	09/22/1998	03/11/1999	(0)

SIG: T2 TAB PO QD
Provider: NALLURI,VASANTHI KUMAR Cost/Fill: $ 1.30

JMATRIPTAN SUCCINATE 25MG TAB
4995219 A 15 01/19/1999 03/08/1999 (0)
SIG: 1 OR 2 TABLETS EVERY 12 HOURS PRN
Provider: NALLURI,VASANTHI KUMAR Cost/Fill: $ 96.77

JMATRIPTAN SUCC 6MG/0.5ML STATDOSE RFL
4995221 A 6 01/19/1999 03/08/1999 (0)
SIG: 1 INJECTION PRN FOR SEVERE HEADACHE
Provider: NALLURI,VASANTHI KUMAR Cost/Fill: $298.80

XYCODONE 5MG/ACETAMINOPHEN 325MG TAB
4043916 E 12 02/25/1999 02/25/1999 (0)

---------- RXOP - Outpatient Pharmacy (max 91 days) ----------
(continued)

ug..... Rx #	Stat	Qty	Issued	Last Filled	Rem
SIG: T2 TAB PO Q8H Provider: OKEAKPU,DONALD O Cost/Fill: $ 0.47 Exp/Can Dt: 02/28/1999					
DEINE 30MG/ACETAMINOPHEN 325MG TAB 5003578	E	6	02/11/1999	02/11/1999	(0)
SIG: T1 TAB Q6H PRN FP Provider: PIERCE,ROBERT H Cost/Fill: $ 0.35 Exp/Can Dt: 03/13/1999					
.ONAZEPAM 1MG TAB 2320234	C	90	10/27/1998	01/16/1999	(0)
SIG: T1 TAB PO TID Provider: GELDER,MAURICE D Cost/Fill: $ 11.79 Exp/Can Dt: 02/16/1999					
.UOXETINE HCL 20MG CAP 4961438AC		60	10/27/1998	01/15/1999	(0)
SIG: T2 CAP PO QAM Provider: GELDER,MAURICE D Cost/Fill: $ 76.80 Exp/Can Dt: 02/16/1999					
ISPERIDONE 1MG TAB 4961440AC		60	10/27/1998	01/15/1999	(0)
SIG: T2 TAB PO HS Provider: GELDER,MAURICE D Cost/Fill: $ 72.36 Exp/Can Dt: 02/16/1999					
RAZODONE HCL 50MG TAB 2321574	C	180	11/24/1998	01/13/1999	(0)
SIG: T6 TAB PO QHS Provider: GELDER,MAURICE D Cost/Fill: $ 4.50 Exp/Can Dt: 03/16/1999					
STROGENS CONJUGATED 0.625MG TAB 4961443	A	30	09/22/1998	01/10/1999	(0)
SIG: T1 TAB PO QD Provider: NALLURI,VASANTHI KUMAR Cost/Fill: $ 6.72					
IUTRITION SUPL ENSURE/VANILLA PWD 4961453	A	4800	09/22/1998	12/29/1998	(0)
SIG: MIX 1/2 CUP WITH 3/4 CUP WATER OR MILK AND DRINK TID A DAY Provider: NALLURI,VASANTHI KUMAR Cost/Fill: $ 33.60					
.ANSOPRAZOLE 30MG SA CAP 4986284	E	30	12/16/1998	12/16/1998	(0)
SIG: 1 CAPSULE QD Provider: AVALOS,MARTIN Cost/Fill: $ 50.55 Exp/Can Dt: 01/15/1999					
METOCLOPRAMIDE HCL 10MG TAB 4986286	E	120	12/16/1998	12/16/1998	(0)
SIG: 1 TABLET AC AND HS Provider: AVALOS,MARTIN Cost/Fill: $ 0.60 Exp/Can Dt: 01/15/1999					
SUMATRIPTAN SUCCINATE 25MG TAB 4961448	C	10	09/22/1998	12/11/1998	(0)

SIG: T1 OR 2 TAB PO Q12H PRN
Provider: NALLURI,VASANTHI KUMAR Cost/Fill: $ 66.83 Exp/Can Dt: 01/19/1999

LBUTEROL 90/IPRATROP 18MCG 200D PO INHL
4983291 E 1 12/05/1998 12/05/1998 (0)
SIG: USE 2 PU QID
Provider: GILES,HERBERT Cost/Fill: $ 20.38 Exp/Can Dt: 01/04/1999

UTORPHANOL TARTRATE 1MG 14D NASAL SPRAY
4977684 E 1 11/17/1998 11/17/1998 (0)
SIG: USE 1 SPRAY IN 1 NOSTRIL FOR SEVERE
HEADACHE MAY REPEAT IN 1 HOUR IF NEEDED
Provider: NALLURI,KRISHNA RAO Cost/Fill: $ 37.76 Exp/Can Dt: 01/16/1999

UMATRIPTAN SUCC 6MG/0.5ML STATDOSE RFL
4961452 C 3 09/22/1998 11/11/1998 (0)

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

---------- RXOP - Outpatient Pharmacy (max 91 days) ----------
(continued)

rug.....

	Rx #	Stat	Qty	Issued	Last Filled	Rem

SIG: USE 1 PRN UD BY PHYSICIAN
Provider: NALLURI,VASANTHI KUMAR Cost/Fill: $149.40 Exp/Can Dt: 01/19/1999

---------- BI - Immunization (520) ----------

OCT 28, 1997 INFLUENZA TRIVALENT A&B 0.5CC
Comment(s): INSTRUCTED TO WAIT IN AREA X 30 MIN & REPORT ADVERSE RXN
JAN 14, 1999 INFLUENZA TRIVALENT A&B 0.5CC
Comment(s):

---------- VSB - Vital Signs (BMI) (max 3 occurrences) ----------

easurement DT	TEMP F(C)	PULSE	RESP	BP	HT IN(CM)	WT LB(KG)	BMI
3/29/99 08:25	99.4(37.4)	63	18	88/56	66(167.64)	133.9(60.86)	21.64
6/24/98 15:14	97.2(36.2)	52	20	102/65	66(167.64)	130(59.09)	21.01
6/16/98 08:30	96.4(35.8)	62	18	99/62	66(167.64)	130.5(59.32)	21.09

PURPLE TEAM

Wt Renn

MEDICAL RECORD	PROGRESS NOTES
DATE	
11-9-98	Wt 128.5 TPR 97.2 55 20 BP 115/69
1000	age 41 C/O Migraine - Refer
NKDA	to Dr Pierce — Thomas Stone
	Dx Migraine HA.
	Wants Demerol + Phen + Fiorocet for HA,
	Maxell Symmetrel - dec
	Headache @ Temp
	Demerol 75mg @ Phenergan 25mg IM/IV Tolerated
	Robert H. Pierce, DO
	AS32851 70-725
11/9/98	Im Demerol 45mg + 25mg Phenergan in Rt hip.
1045	Vs stable when leaves clinic. Will observe x 30' Gayle Stroder
1120	Pt walked out of exam stating her time was up
	and she was ready to go. Pt d/c'd in stable
	condition. — Grace E. Ladlera

(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]

REGISTER NO.	WARD NO.

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

11:30

MEDICAL RECORD **GASTRO** PROGRESS NOTES

DATE	
11/9/98.	follow up
	Recurrent Dyspepsia →
	Still using Aspirin on/off for Headaches
	EGD 1996 → multiple Antral ulcers →
	Chelsea ⊖ 1996
	10/98 H.P serology ⊖
	treated with prevacid / Cisapride
	U/S Abdomen today →
	Recent labs → WNL
	Plan Add Misoprostol since pt still taking Aspirin.
	NSAIDs.
	pt has had hysterectomy → NO risk of pregnancy.
	RTC in 1 month

MARTIN AVALOS, MD
AS32851.70-541

(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]

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	GYN CLINIC
10/30/95	WT 145.7 age 38 T98.4 P76 R18 B/P 108/68
NKA	7/4 for pain in pelvis, hypofluoria injection.
0900	Pt here for scheduling of removal of neuroma will need to talk to Dr Dietz. Depo-provera 150mg given Dtm in Lt gluteal 5 difficulty Reaction
	Please refer to Surg

(Continued 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.

DYE, GAYLE A 25
457 POPPS FERRY RD. LO 047
BILOXI MS 39532

[redacted]

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

NOTE DATED: 07/17/98 14:35 PSYCHOLOGY-MENTAL HEALTH
VISIT: 07/17/98 10:00 WOMEN'S MHPC GOLD GROUP-GPT
WOMEN'S MHPC CLINIC/ GOLD TEAM/ RELAXATION GROUP/ PROBLEM #3/ GAF: 76

MS. DOVE ATTENDED TODAY'S GROUP WHICH FOCUSED ON THE DEMONSTRATION OF VISUALIZATION FOR STRESS MANAGEMENT. THE PT. ACTIVELY PARTICIPATED IN THE VISUALIZATION EXERCISES AND ASKED APPROPRIATE QUESTIONS. MS. DOVE REPORTED THAT SHE FOUND THE GROUP TO BE HELPFUL IN GETTING HER TO FEEL MORE RELAXED.

Signed by: /es/ JANICE K. TAYLOR, B.S.
PSYCHOLOGY INTERN 07/17/98 14:38
Cosigned by: /es/ SAUNDRA SAPORITI, PSY.D.
STAFF PSYCHOLOGIST 07/17/98 15:13

DOVE, GAYLE A
42 yr
Female Caucasian
66in 136lb
Room:PREA
Loc:3

ID: [redacted]

Vent. rate	57	BPM
PR interval	134	ms
QRS duration	82	ms
QT/QTc	424/412	ms
P-R-T axes	22 62	54

28-OCT-1999 09:20

BILOXI VAMC-PA

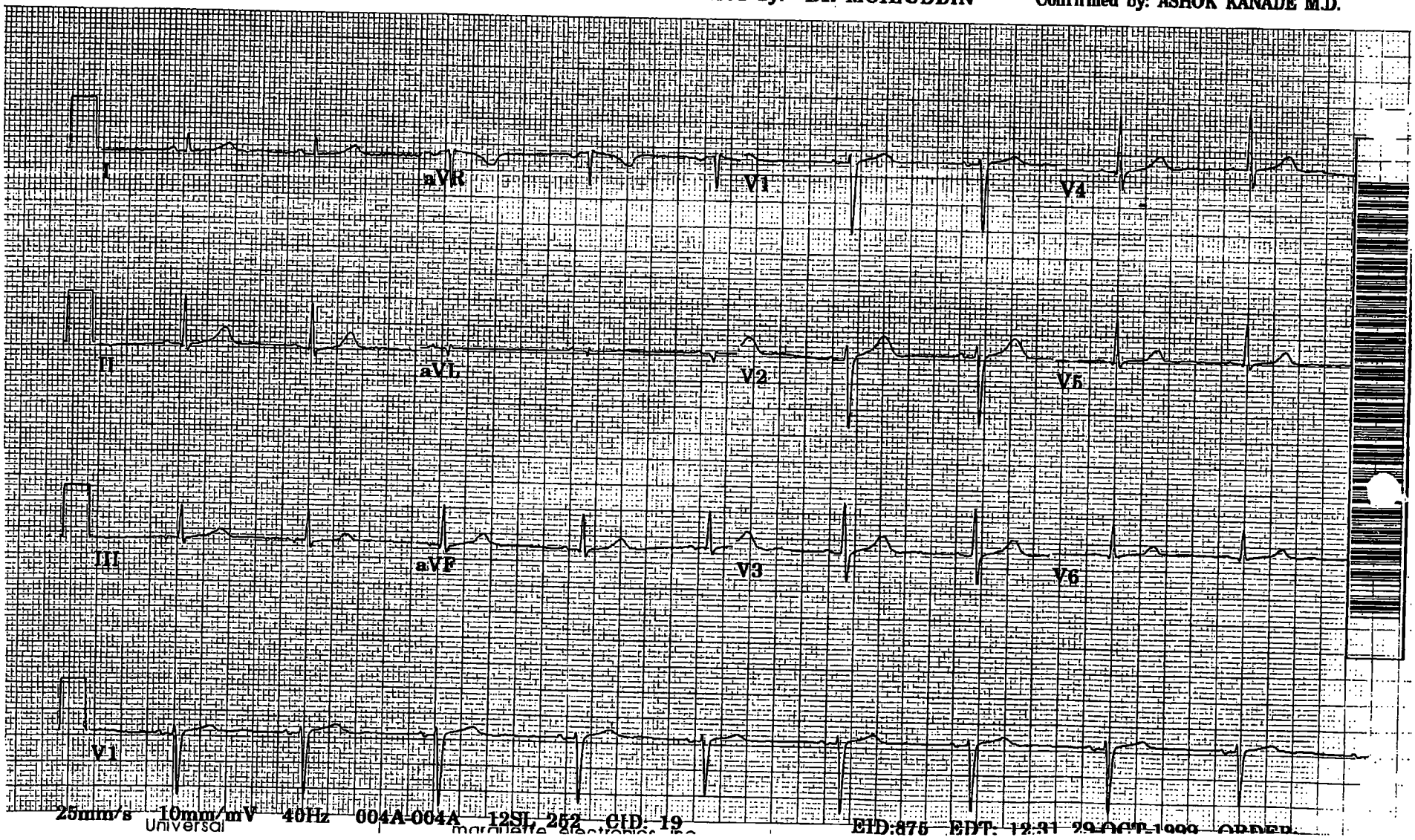
ROUTINE RECORD

SINUS BRADYCARDIA
OTHERWISE NORMAL ECG
WHEN COMPARED WITH ECG OF 22-JUL-1999 18:56,
QT HAS SHORTENED

Technician: LANA JORDAN

Referred by: DR MOHIUDDIN

Confirmed by: ASHOK KANADE M.D.



1610

DOVE, GAYLE A
41 yr
Female Caucasian
66in 125lb

ID: [redacted]

Vent. rate	76	BPM
PR interval	120	ms
QRS duration	76	ms
QT/QTc	404/454	ms
P-R-T axes	60 78	41
BP	110/75	

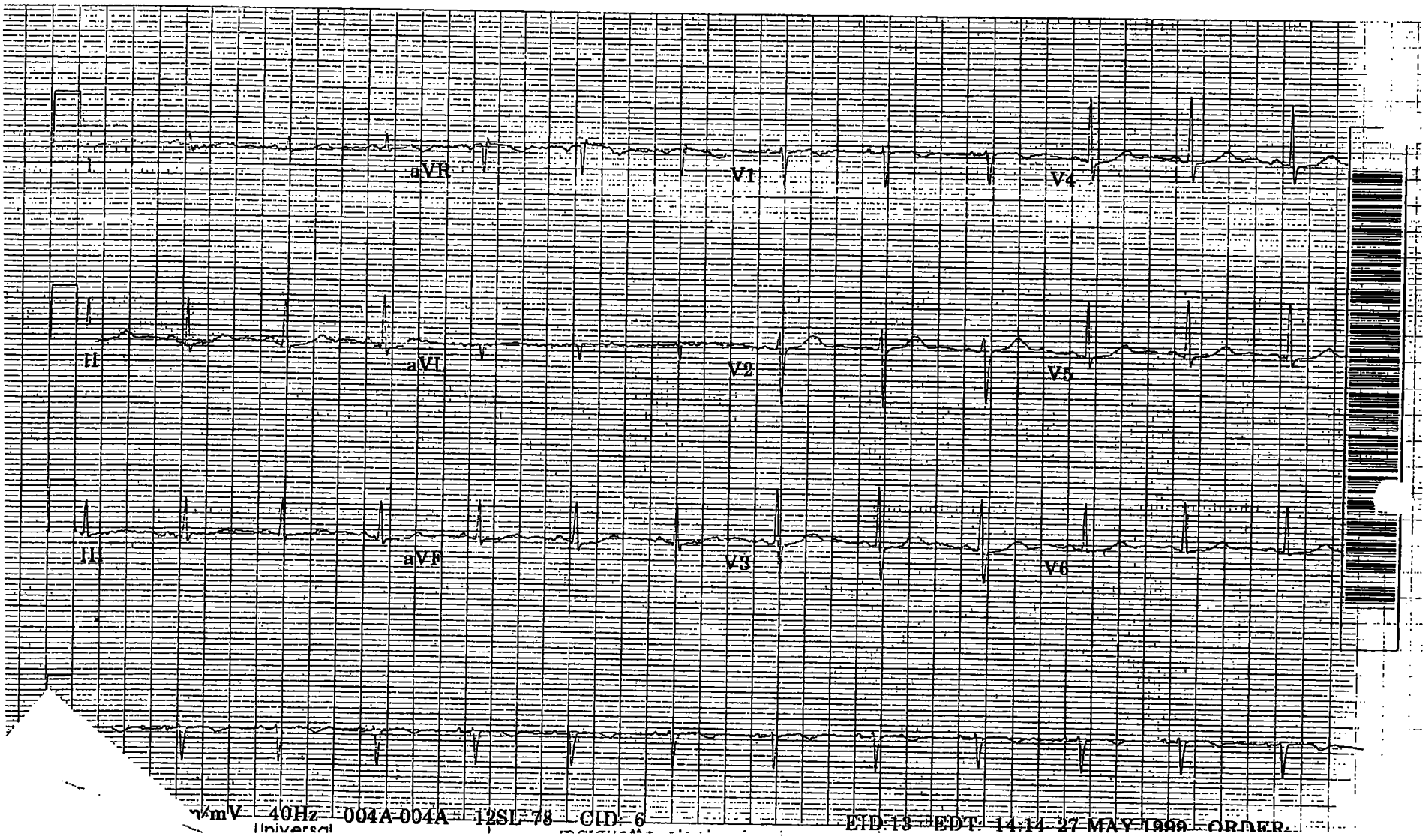
25-MAY-1999 23:28

BILOXI VAMC-* ROUTINE RECORD

NORMAL SINUS RHYTHM
NONSPECIFIC ST ABNORMALITY
ABNORMAL ECG
WHEN COMPARED WITH ECG OF 18-SEP-1998 13:53,
NO SIGNIFICANT CHANGE WAS FOUND

Referred by: GILES

Confirmed by: BASSAM OMAR M.D.



1611

Radiology Diagnostic Report
VETERANS ADMINISTRATION MEDICAL CENTER
Division: Biloxi, MS (CONS)

NAME: DOVE,GAYLE A
SSN : [redacted]
DATE OF EXAM: JAN 30,1997 10:33
REPORTED : JAN 31,1997
TRANSCRIBED : JAN 31,1997 11:55

CASE: 2245
REQUESTED BY: SCHERER,VICTOR E
TECHNOLOGIST: JOHNSON,GINA G
AGE: 39 SEX: FEMALE
WARD/CLINIC : C&P SCHERER

PROCEDURE : CHEST, TWO VIEW

Exam Modifiers : None

Clinical History:
C&P EXAM

Report:
CHEST TWO VIEW:

Two views of the chest demonstrate no acute infiltrate. The heart, mediastinum, and diaphragm appear normal. The bone structure is unremarkable.

Impression:
1) Normal chest. No change since 10/17/96.

Primary Interpreting Staff:
QUAN HUU HA, Staff Physician

VERIFIED BY:

/CS

NAME: DOVE,GAYLE A
SSN : [redacted]

WARD/CLINIC: C&P SCHERER

VAF 10-9034 VICE SF 519B RADIOLOGY/NUCLEAR MEDICINE REPORT

Radiology Diagnostic Report
VETERANS ADMINISTRATION MEDICAL CENTER
Division: Biloxi, MS (CONS)

NAME: DOVE,GAYLE A
SSN : [redacted]
DATE OF EXAM: OCT 25,1996 11:17
REPORTED : OCT 25,1996
TRANSCRIBED : NOV 13,1996 08:04

CASE: 1855
REQUESTED BY: NALLURI,VASANTHI KUMARI
TECHNOLOGIST:
AGE: 39 SEX: FEMALE
WARD/CLINIC : KEESLER SHARING

PROCEDURE : MRI, BRAIN W/CONT

Exam Modifiers : None

Clinical History:
THIS IS A 38 YR OLD FEMALE WITH CHRONIC HEADACHES AND VERTIGO. R/O POSTERIOR FOSSA LESION

Report: Status: VERIFIED
MRI HEAD W/GADOLINIUM, 15 OCT 96;

TECHNIQUE: High resolution coronal and axial cuts through the posterior fossa were obtained before and after the administration of intravenous Gadolinium. Supplemental axial and proton density T2 weighted images were also obtained of the entire brain.

FINDINGS: There is no evidence of an intra-axial or extra-axial mass lesion or fluid collection. The size and configuration of the CSF spaces is within normal limits. High resolution images of the posterior fossa reveal no specific abnormality. Both internal auditory canals appear intact and no evidence of mass lesion or abnormal vascular structure is noted in the region of the cerebella pontine angle cisterns.

Impression:
1) Essentially negative examination.

THIS IS NOT A VA REPORT. THIS IS NOT AN OFFICIAL REPORT. THIS EXAMINATION WAS PERFORMED AT KEESLER MEDICAL CENTER BY DR. SCHOENBERGER.

Primary Interpreting Staff:
JOSEPH A SCHOENBERGER, Staff Physician

VERIFIED BY:
RAYMOND J DES ROSIERS, M.D.

NAME: DOVE,GAYLE A
SSN : [redacted]
WARD/CLINIC: KEESLER SHARING

Radiology Diagnostic Report
VETERANS ADMINISTRATION MEDICAL CENTER
Division: Biloxi, MS (CONS)

NAME: DOVE,GAYLE A
SSN : [redacted]
DATE OF EXAM: OCT 25,1996 11:17
REPORTED : OCT 25,1996
TRANSCRIBED : NOV 13,1996 08:04

CASE: 1855
REQUESTED BY: NALLURI,VASANTHI KUMARI
TECHNOLOGIST:
AGE: 39 SEX: FEMALE
WARD/CLINIC : KEESLER SHARING

PROCEDURE : MRI, BRAIN W/CONT

/CS

NAME: DOVE,GAYLE A
SSN : [redacted]

WARD/CLINIC: KEESLER SHARING

VAF 10-9034 VICE SF 519B RADIOLOGY/NUCLEAR MEDICINE REPORT

[redacted] OCT 25,1996 11:17
MRI, BRAIN W/CONT

Personal Data - Privacy Act 1974 (PL 93-579)

RADIOLOGIC EXAMINATION REPORT
(Automated Version of SF519-B)

Patient: DOVE,GAYLE A
Date of Birth: [redacted]
Age: 39
Outpatient Record Loc.:
Duty Station/Unit:
KEESLER MEDICAL CENTER
Procedure: MRI,GADOLINIUM
Requested by: PROVIDER,OUTSIDE
Ward/Clinic: VA HOSPITAL - BILOXI

FMP/SSN: [redacted]
Sex: FEMALE
Home Phone: 6013961919
Work Phone:
Register #:
MRI
Exam Date: 15 Oct 1996@1358
Status: COMPLETE
Exam #: 96084737
Pregnant: n

Reason for Order:
THIS IS A 38 Y/O FEMALE WITH CHRONIC HEADACHES AND VERTIGO. R/O POSTERIOR FOSSA LESION.

Order Comment:

KEESLER MEDICAL CENTER
Procedure: MRI,HEAD
Requested by: PROVIDER,OUTSIDE
Ward/Clinic: VA HOSPITAL - BILOXI

MRI
Exam Date: 15 Oct 1996@1358
Status: COMPLETE
Exam #: 96084736
Pregnant: n

Reason for Order:
THIS IS A 38 Y/O FEMALE WITH CHRONIC HEADACHES AND VERTIGO. R/O POSTERIOR FOSSA LESION.

Order Comment:

Result Code: SEE REPORT TEXT

Report:

DATE DICTATED: 15 OCT 96

DATE TRANSCRIBED: 16 OCT 96/CLB

JOB # 6257

MRI HEAD W/GADOLINIUM, 15 OCT 96;

TECHNIQUE: High resolution coronal and axial cuts through the posterior fossa were obtained before and after the administration of intravenous Gadolinium. Supplemental axial and proton density T2 weighted images were also obtained of the entire brain.

FINDINGS: There is no evidence of an intra-axial or extra-axial mass lesion or fluid collection. The size and configuration of the CSF spaces is within normal limits. High resolution images of the posterior fossa reveal no specific abnormality. Both internal auditory canals appear intact and no evidence of mass lesion or abnormal vascular structure is noted in the region of the cerebella pontine angle cisterns.

IMPRESSION:

Personal Data - Privacy Act 1974 (PL 93-579)

RADIOLOGIC EXAMINATION REPORT
(Automated Version of SF519-B)

Patient: DOVE, GAYLE A
Date of Birth: 15 Aug 1957
Age: 39
Outpatient Record Loc.:
Duty Station/Unit:

FMP/SSN: [redacted]
Sex: FEMALE
Home Phone: 6013961919
Work Phone:
Register #:

1) Essentially negative examination.

Transcription Date/Time: 16 Oct 1996@1315

Interpreted by: JOSEPH A. SCHOENBERGER, MAJ, USAF, MC

Approved by: JOSEPH A. SCHOENBERGER, MAJ, USAF, MC 17 Oct 1996@1634

Radiology Diagnostic Report
VETERANS ADMINISTRATION MEDICAL CENTER
Division: Biloxi, MS (CONS)

NAME: DOVE,GAYLE A
SSN : [redacted]
DATE OF EXAM: AUG 22,1996 09:37
REPORTED : AUG 22,1996
TRANSCRIBED : AUG 22,1996 13:42

CASE: 1150
REQUESTED BY: MOORE,JON MICHAEL
TECHNOLOGIST: PASSMAN,PATTI A.
AGE: 39 SEX: FEMALE
WARD/CLINIC : SURGERY FOLLOWUP

PROCEDURE : CT HEAD W/IV CONT

Exam Modifiers : CONTRAST MEDIA USED

Clinical History:
CHRONIC NAUSEA W/LITTLE RELIEF FROM PHEUERGAN. NO ABDOMINAL ETIOLOGY
CENTRAL ETIOLOGY W/POSITIVE OPHTHO-KINETIC TESTING

Report:
CT HEAD W/WO/CONTRAST:

TECHNIQUE: Before and after IV contrast administration, multiple contiguous 5 and 8 mm axial images through the brain obtained.

There is no prior study available for comparison.

FINDINGS: The ventricular system has a normal appearance. There is no evidence of acute hemorrhage, mass effect, or midline shift. Within the head of the caudate nucleus on the right, an approximately 4 x 8 mm hyodense lesion is identified with no enhancement or surrounding edema. This finding is most consistent with lacunar infarcts. No other focal abnormalities identified. No abnormally enhancing lesions are seen.

Impression:
1. Hypodense lesions in the head of the right caudate nucleus, consistent with lacunar infarct. Otherwise unremarkable scan.

Primary Interpreting Staff:
ROBERT E SMITH, Staff Physician

Primary Interpreting Resident:
ELIZABETH TIEMAN, Resident Physician

VERIFIED BY:

LI

)))))))) A B N O R M A L R E P O R T (((((((( )))))))) A B N O R M A L R E P O R T (((((((( )))))))) A B N O R M A L R E P O R T ((((((((

NAME: DOVE,GAYLE A
SSN : [redacted]

WARD/CLINIC: SURGERY FOLLOWUP

AF 10-9034 VICE SF 519B RADIOLOGY/NUCLEAR MEDICINE REPORT

Radiology Diagnostic Report
VETERANS ADMINISTRATION MEDICAL CENTER
Division: Biloxi, MS (CONS)

NAME: DOVE,GAYLE A
SSN : [redacted]
DATE OF EXAM: AUG 22,1996 09:37
REPORTED : AUG 22,1996
TRANSCRIBED : AUG 22,1996 13:31

CASE: 1149
REQUESTED BY: MOORE,JON MICHAEL
TECHNOLOGIST: ROBINSON,STEVEN L
AGE: 39 SEX: FEMALE
WARD/CLINIC : SURGERY FOLLOWUP

PROCEDURE : CT HEAD W/O CONT

Exam Modifiers : CONTRAST MEDIA USED

Clinical History:
CHRONIC NAUSEA W/LITTLE RELIEF FROM PHEUERGAN. NO ABDOMINAL ETIOLOGY
CENTRAL ETIOLOGY W/POSITIVE OPHTHO-KINETIC TESTING

Report:
CT HEAD W/WO/CONTRAST:

TECHNIQUE: Before and after IV contrast administration, multiple contiguous 5 and 8 mm axial images through the brain obtained.

There is no prior study available for comparison.

FINDINGS: The ventricular system has a normal appearance. There is no evidence of acute hemorrhage, mass effect, or midline shift. Within the head of the caudate nucleus on the right, an approximately 4 x 8 mm hyodense lesion is identified with no enhancement or surrounding edema. This finding is most consistent with lacunar infarcts. No other focal abnormalities identified. No abnormally enhancing lesions are seen.

Impression:
1. Hypodense lesions in the head of the right caudate nucleus, consistent with lacunar infarct. Otherwise unremarkable scan.

Primary Interpreting Staff:
ROBERT E SMITH, Staff Physician

Primary Interpreting Resident:
ELIZABETH TIEMAN, Resident Physician

VERIFIED BY:

LI

)))))))) A B N O R M A L R E P O R T ((((((((
)))))))) A B N O R M A L R E P O R T ((((((((
)))))))) A B N O R M A L R E P O R T ((((((((

NAME: DOVE,GAYLE A
SSN : [redacted]

WARD/CLINIC: SURGERY FOLLOWUP

VAF 10-9034 VICE SF 519R RADIOLOGY/NUCLEAR MEDICINE REPORT

Radi...gy Diagnostic Report
VETERANS ADMINISTRATION MEDICAL CENTER
Division: Biloxi, MS (CONS)

NAME: DOVE,GAYLE A
SSN : [redacted]
DATE OF EXAM: AUG 12,1996 09:48
REPORTED : AUG 12,1996
TRANSCRIBED : AUG 12,1996 15:13

CASE: 101
REQUESTED BY: SNOOK,BRANDON TIMOTHY
TECHNOLOGIST: ZEIMET,BARBARA
AGE: 39 SEX: FEMALE
WARD/CLINIC : ASOU AMBULATORY SURGERY

PROCEDURE : UGI/SMALL BOWEL SERIES

Exam Modifiers : BARIUM USED

Clinical History:
UGI WITH SBFT 40 YO FEMALE WITH NAUSEA/OCC VOMITTING AND CHRONIC RLQ PAIN; S/P LYSIS OF ADHESIONS IN PAST DUE TO ENDOMETRIOSIS R/O PARTIAL OBSTRUCTION

Report:
UGI/SMALL BOWEL FOLLOW THROUGH:

FINDINGS: Single and double contrast images of the esophagus demonstrate a small sliding type hiatal hernia, otherwise, the mucosal pattern appears normal. There is no evidence of GE reflux with the patient supine and in Valsalva. Gastric mucosa demonstrates no evidence of erosive or mass lesion. The duodenal bulb distends and collapses normally. The SBFT took approximately 1 hour 30 minutes. The terminal ileum appears normal.

Impression:
1. Small sliding hiatal hernia.

2. Otherwise normal upper GI series with SBFT.

FLUOROSCOPY TIME 1.0 MINUTES.

Primary Interpreting Staff:
HENRY A CLARITE, Staff Physician

Primary Interpreting Resident:
BLAINE H HOPPE, Resident Physician

VERIFIED BY:

/LI

NAME: DOVE,GAYLE A
SSN : [redacted]
WARD/CLINIC: ASOU AMBULATORY SURGERY

VAF 10-9034 VICE SF 519B RADIOLOGY/NUCLEAR MEDICINE REPORT

Personal Data - Privacy Act 1974 (PL 93-579) Printed date: 21 Oct 1996@0704
Page: 1

RADIOLOGIC EXAMINATION REPORT

Patient: DOVE,GAYLE A FMP/SSN: [redacted]

KEESLER MEDICAL CENTER
Procedure: MRI,GADOLINIUM
Requested by: PROVIDER,OUTSIDE
Ward/Clinic: VA HOSPITAL - BILOXI

MRI
Exam Date: 15 Oct 1996@1358
Status: COMPLETE
Exam #: 96084737
Pregnant: n

Reason for Order:
THIS IS A 38 Y/O FEMALE WITH CHRONIC HEADACHES AND VERTIGO. R/O POSTERIOR FOSSA LESION.

Order Comment:

KEESLER MEDICAL CENTER
Procedure: MRI,HEAD
Requested by: PROVIDER,OUTSIDE
Ward/Clinic: VA HOSPITAL - BILOXI

MRI
Exam Date: 15 Oct 1996@1358
Status: COMPLETE
Exam #: 96084736
Pregnant: n

Reason for Order:
THIS IS A 38 Y/O FEMALE WITH CHRONIC HEADACHES AND VERTIGO. R/O POSTERIOR FOSSA LESION.

Order Comment:

Result Code: SEE REPORT TEXT

Report:

DATE DICTATED: 15 OCT 96

DATE TRANSCRIBED: 16 OCT 96/CLB

JOB # 6257

MRI HEAD W/GADOLINIUM, 15 OCT 96;

TECHNIQUE: High resolution coronal and axial cuts through the posterior fossa were obtained before and after the administration of intravenous Gadolinium. Supplemental axial and proton density T2 weighted images were also obtained of the entire brain.

[redacted]
SF519-B

DOVE,GAYLE A
15 Aug 1957 / FEMALE
Loc:
Spon: DOVE,GAYLE A
Unit:

VETERANS ADMIN BENEFICIARY
H:6013961919 W:
Rank: D:
RR: 99 OTHER-MUST SPECIFY

RADIOLOGIC EXAMINATION REPORT

Patient: DOVE,GAYLE A FMP/SSN: [redacted]

FINDINGS: There is no evidence of an intra-axial or extra-axial mass lesion or fluid collection. The size and configuration of the CSF spaces is within normal limits. High resolution images of the posterior fossa reveal no specific abnormality. Both internal auditory canals appear intact and no evidence of mass lesion or abnormal vascular structure is noted in the region of the cerebella pontine angle cisterns.

IMPRESSION:

1) Essentially negative examination.

Transcription Date/Time: 16 Oct 1996@1315

Interpreted by: JOSEPH A. SCHOENBERGER,MAJ,USAF,MC

Approved by: JOSEPH A. SCHOENBERGER,MAJ,USAF,MC 17 Oct 1996@1634

10/17/96 18:00 SATP GROUP THERAPY
Location: SATP OUTPT EVENING GROUP
* amended *
VET FAILED TO CALL OR APPEAR FOR A 2ND CONSECUTIVE OUTPATIENT EVENING GROUP SESSION. HE IS ESTABLISHING A PATTERN OF NON-COMPLIANCE. NEXT GROUP SESSION SCHEDULED FOR 10/24/96 AT 1800 HOURS.
Signed by: /es/ ALVIN L DYKE
ADDICTION THERAPIST, ICADC 10/18/96 10:49

10/18/96 15:54 ADDENDUM
VET CALLED TODAY CONCERNED ABOUT MISSING HIS APPOINTMENTS. STATED HE HAS RELAPSED AND WILL BE ADMITTED TO DETOX. NEXT WED, PER PA TAYLOR. WILL DISCHARGE VET UPON VERIFICATION OF ADMISSION TO 1-3EMED. COLLABORATED WITH DETOX. SCREENING SATP THERAPIST N. MACMILLAN AND PA TAYLOR. RECOMMENDED VET BE CONSIDERED FOR SATP INPATIENT TREATMENT.
Signed by: /es/ ALVIN L DYKE
ADDICTION THERAPIST, ICADC 10/18/96 15:57

DOVE, GAYLE A (COMPLETE) (H)	Age 39/02	Sex F	Control #	Patient ID OPT/6094	Phys ID AVALOS
DOB 8/15/57	Fasting	Account Number 23809220 V A MEDICAL CENTER 400 VETERANS BLVD BILOXI, MS 39531-0000 (601) 388-5541			
MO 10 25 #47	Tot Vol 0000				

Spec Date 10/25/96 11:10	Received 10/25/96	Reported 10/28/96 8:20	Seq# 9284

TEST	RESULT	OUT OF RANGE	UNITS	LIMITS	LAB
Gastrin	123	H	pg/mL	0- 100	BN

LAB: BN LABCORP HOLDINGS DIRECTOR: FRANK HANCOCK MD DIR
1447 YORK COURT, BURLINGTON, NC 27215-2230

LAST PAGE OF REPORT

DOVE, GAYLE A [redacted] SPEC DATE:10/25/96

Radiology Diagnostic Report
VETERANS ADMINISTRATION MEDICAL CENTER
Division: Biloxi, MS (CONS)

NAME: DOVE,GAYLE A
SSN : [redacted]
DATE OF EXAM: JUL 29,1996 10:33
REPORTED : JUL 31,1996
TRANSCRIBED : JUL 31,1996 10:42

CASE: 106
REQUESTED BY: DIAZ,ALBERT L
TECHNOLOGIST: JOHNSON,GINA G
AGE: 38 SEX: FEMALE
WARD/CLINIC : GYNECOLOGY CLINIC

PROCEDURE : ABDOMEN, TWO VIEW

Exam Modifiers : None

Clinical History:
FLAT/UPRIGHT R/O BLOCKAGE

Report:
TWO VIEWS OF THE ABDOMEN:

Two views of the abdomen demonstrate a normal bowel gas pattern. No mass is noted. No abnormal calcifications are visualized. There is no free air.

Impression:
1) Normal abdomen. No changes since 04/12/95.

rimary Interpreting Staff:
QUAN HUU HA, Staff Physician

ERIFIED BY:

CS

BTS

ME: DOVE,GAYLE A
N : [redacted]
WARD/CLINIC: GYNECOLOGY CLINIC

10-9034 VICE SF 519B RADIOLOGY/NUCLEAR MEDICINE REPORT

Radiology Diagnostic Report
VETERANS ADMINISTRATION MEDICAL CENTER
Division: Biloxi, MS (CONS)

TJN

NAME: DOVE,GAYLE A
SSN : [redacted]
DATE OF EXAM: OCT 3,1996 09:54
REPORTED : OCT 3,1996
TRANSCRIBED : OCT 3,1996 13:18

CASE: 1491
REQUESTED BY: NEUMASTER,TERRY DAVID
TECHNOLOGIST:
AGE: 39 SEX: FEMALE
WARD/CLINIC : SURGERY ENDO F/U

PROCEDURE : ULTRASOUND, GALL BLADDER

Exam Modifiers : None

Clinical History:
Hx of motion sickness and chronic nausea since 6/96. Has had TAH,BS&), and exploration for pelvic adhesions in past.

Report:
GALLBLADDER US:

TECHNIQUE: Multiple real-time sonographic images of the gallbladder and biliary collecting system were obtained.

FINDINGS: The liver measures 16.8 cm sagittally. The liver appears normal in size, position, and echotexture with no evidence of focal abnormality. Hepatic architecture is maintained. Portal venous flow with Doppler is noted to be hepatopedal. No evidence of perihepatic fluid is seen. No evidence of free intraperitoneal fluid is identified. The gallbladder is well distended and demonstrates no evidence of internal shadowing consistent with sludging or stones. The common bile duct is noted to measure 1.8 mm and this is within normal limits. The spleen measures 9.3 cm and appears homogeneous in echotexture and is also unremarkable. The kidneys were also noted to be within normal limits bilaterally.

Impression:
1) Normal abdominal ultrasound.

Primary Interpreting Staff:
BRANKO M. PLAVSIC, Staff Physician

Primary Interpreting Resident:
ALAN C NEWMAN, Resident Physician

VERIFIED BY: CN

/CS

NAME: DOVE,GAYLE A
SSN : [redacted]

WARD/CLINIC: SURGERY ENDO F/U

DOVE, GAYLE (COMPLETE) (H)	Age 39/01	Sex F	Control #	Patient ID OPT6094	Phys ID
DOB 8/15/57	Fasting	Account Number 23809220 V A MEDICAL CENTER 400 VETERANS BLVD BILOXI, MS 39531-0000 (601) 388-5541			
MO 9-18 # 214/213	Tot Vol 0000				

pec Date 9/19/96	Received 9/19/96	Reported 9/23/96 8:40	Seq# 8672

TEST	RESULT	OUT OF RANGE	UNITS	LIMITS	LAB
Hep B Surface AB	0.6		RU		
			Interpretation Table:		
			Negative	<2.1	
			Borderline	2.1 -9.9	
			(Low titer of anti-HBs detected. Immune status questionable.)		
			Positive	>9.9	
			(High titer of anti-HBs detected. Consistent with immunity.)		
IMMUNOBLOT HCV ASSAY(RIBA)					
Band Patterns:					
5-1-1	-				BN
C100-3	-				BN
C33C	-				BN
C22-3	-				BN
SOD	-				BN
RIBA Interpretation:	NEGATIVE				BN
					BN

NOTE: A positive result is indicative of antibodies to HCV. A negative result may not exclude the possibility of exposure to or infection with HCV. All indeterminate results are repeated before being reported.

Band Pattern Interpretation:
Pos. - 1+ or greater reactivity to two or more HCV antigens corresponding to antigens encoded by different parts of HCV genome.
Indeterm.- Single 1+ or greater antigen activity or SOD reactivity in addition to any antigen reactivity or reactivity of 1+ or greater to HCV 5-1-1 and C100-3 bands only.
Neg. - No bands of 1+ or greater antigen reactivity present or reactivity to SOD band alone.

AB: BN LABCORP HOLDINGS DIRECTOR: FRANK HANCOCK MD DIR
1447 YORK COURT, BURLINGTON, NC 27215-2230

AB: MB LABCORP HOLDINGS DIRECTOR: JAMES A DAVIS III MD
1801 FIRST AVENUE SOUTH, BIRMINGHAM, AL 35233-0000

LAST PAGE OF REPORT

OVE, GAYLE [redacted] SPEC DATE: 9/19/96

Radiology Diagnostic Report
VETERANS ADMINISTRATION MEDICAL CENTER
Division: Biloxi, MS (CONS)

NAME: DOVE,GAYLE A
SSN : [redacted]
DATE OF EXAM: MAY 16,1996 13:46
REPORTED : MAY 16,1996
TRANSCRIBED : MAY 16,1996 14:40

CASE: 1189
REQUESTED BY: DIAZ,ALBERT L
TECHNOLOGIST:
AGE: 38 SEX: FEMALE
WARD/CLINIC : GYNECOLOGY CLINIC

PROCEDURE : ULTRASOUND, PELVIS

Exam Modifiers : None

Clinical History:
EX TAH-BBC ENDOMITRIAS

Report:
PELVIC US:

TECHNIQUE: Multiple real-time sonographic images of the pelvis were obtained using a curved 3.0 megahertz transducer in a transabdominal approach.

FINDINGS: The patient is status post hysterectomy. A normal vaginal cuff is noted. There is no evidence of pelvic or adnexal mass. The bladder is unremarkable.

Impression:
1) Normal post hysterectomy on ultrasound.

Films were read by BRADLEY S SHORE (Resident Physician)
with KUNDAN L. GUPTA (Staff Physician).

/CS

NAME: DOVE,GAYLE A
SSN : [redacted]

WARD/CLINIC: GYNECOLOGY CLINIC

VAF 10-9034 VICE SF 519B RADIOLOGY REPORT

Radiology Diagnostic Report
VETERANS ADMINISTRATION MEDICAL CENTER
Division: Biloxi, MS (CONS)

NAME: DOVE,GAYLE A
SSN : [redacted]
DATE OF EXAM: NOV 22,1995 12:34
REPORTED : NOV 22,1995
TRANSCRIBED : NOV 22,1995 13:44

CASE: 598
REQUESTED BY: ROLLER,MICHAEL D
TECHNOLOGIST: SUTHERLIN,CONSTANCE D.
AGE: 38 SEX: FEMALE
WARD/CLINIC : ASOU AMBULATORY SURGERY

PROCEDURE : CHEST, TWO VIEW

Exam Modifiers : None

Clinical History:
PRE OP ASOU, GROIN EXPLORATION, PLEASE DO TODAY WET READ, THANKS

Report:
The chest demonstrates no acute infiltrate. The heart, mediastinum and diaphragm appear normal. The bone structure is unremarkable.

Impression:
No acute disease.

ilms were read by QUAN HUU HA (Staff Physician).

SDB

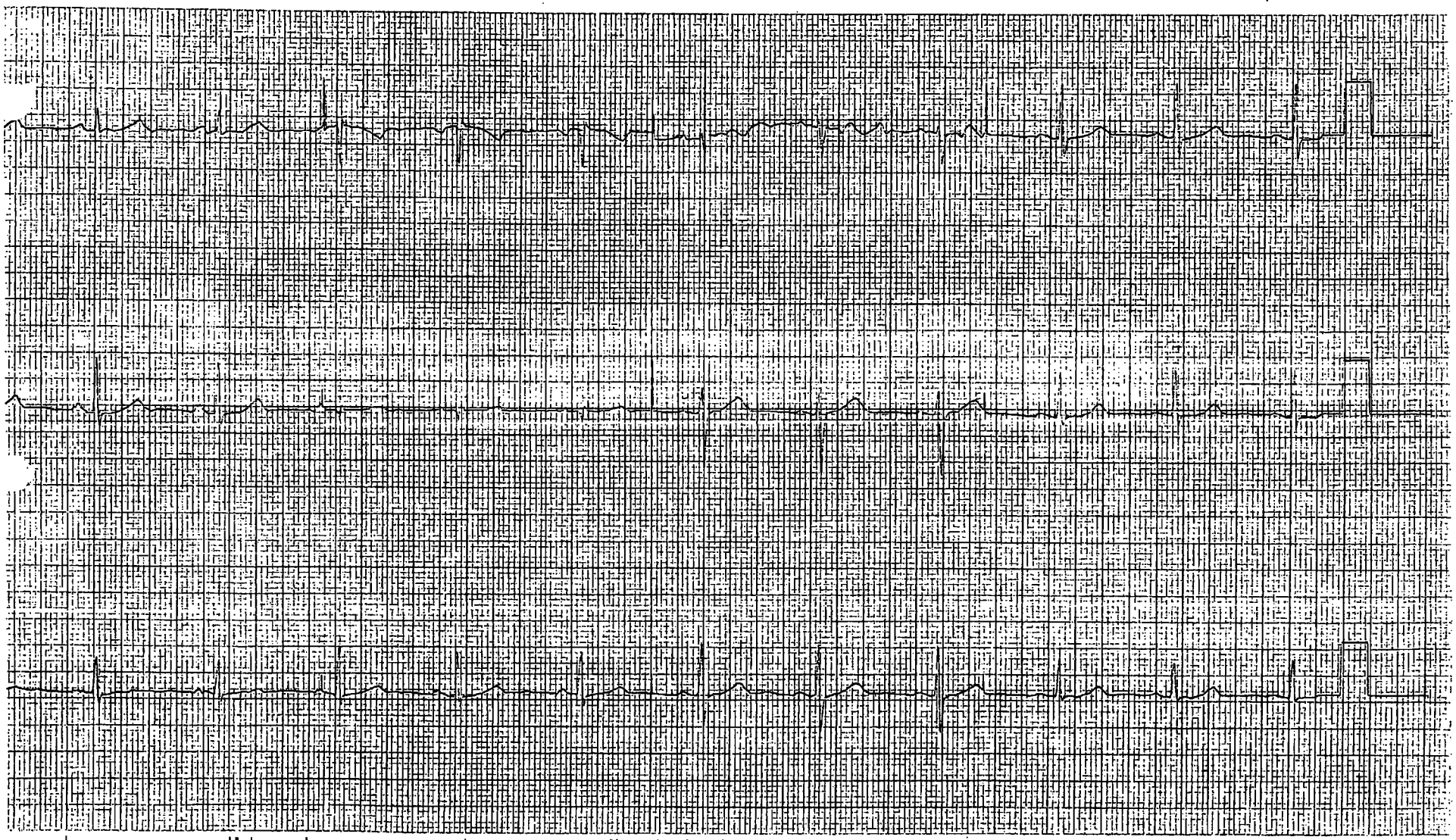
ROUTINE ECG

DOVE, CAYLE A
ID: [redacted] LOC:PACE
37YR 66IN 150LB CAU FEM
MED:
OPT: BP: / RM:PA
ECG TAKEN: 13-FEB-95 12:19
VENT. RATE 66 BPM
PR INTERVAL 144 MS
QRS DURATION 80 MS
QT/QTC 392/405 MS
P-R-T AXES 50 63 46

NORMAL ECG
WHEN COMPARED WITH ECG OF 07-OCT-94 14:26,
NO SIGNIFICANT CHANGE WAS FOUND

REFERRED BY: DR DIAZ

REVIEWED BY: ASHOK KANADE M.D.



1629

Universal | marquette electronics, inc. | Jupiter, Florida U.S.A.

Radiology Diagnostic Report
VETERANS ADMINISTRATION MEDICAL CENTER
Division: Biloxi, MS (CONS)

NAME: DOVE,GAYLE A
SSN : [redacted]
DATE OF EXAM: JAN 16,1995 22:57
REPORTED : JAN 17,1995
TRANSCRIBED : JAN 17,1995 13:07

CASE: 108
REQUESTED BY: LEE,SAMUEL S
TECHNOLOGIST: KUNTZI II,THOMAS R
AGE: 37 SEX: FEMALE
WARD/CLINIC : EMERGENCY ROOM

PROCEDURE : CHEST, TWO VIEW

Exam Modifiers : None

Clinical History:
R/O INFILTRATE

Report:
CHEST: Negative. Heart size normal. Lungs without infiltrates, effusions or suspicious masses. Small calcific granuloma suggested in right infrahilar region. No evidence of non-calcific abnormalities of significance.

Impressions:
Chest negative for active disease.

Films were read by MICHAEL J MORIN (Staff Physician).

/SDR

NAME: DOVE,GAYLE A
SSN : [redacted]
WARD/CLINIC: EMERGENCY ROOM

VAF 10-9034 VICE SF 519R RADIOLOGY REPORT

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: Dr DeRoma | FROM: (Requesting physician or activity) SAI | DATE OF REQUEST 12/20/94

REASON FOR REQUEST (Complaints and findings)

PT EXPERIENCED SEXUAL TRAUMA DURING ACTIVE MILITARY SERVICE. PLEASE EVALUATE AND PROVIDE APPROPRIATE THERAPY.

PROVISIONAL DIAGNOSIS

DEPRESSION, PTSD?, SUBSTANCE ABUSE

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
Gus Stone, MSW		☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☒ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

History: Vet is 37 y/o white, married female veteran who was referred to the womens clinic for screening for appropriateness of therapy. Vet reported an incident of sexual assault by a Sgt who was visiting her under the pretense of checking on her welfare. Vet indicated that she experienced a blackout during the rape, but knows that the rape occurred based on the Sgt's comments to her the next day at work. She also reported that she experienced flashbacks of scenes of uninvited sexual behavior. Vet indicated that she was discharged from the Military after reporting this incident, although the documented reason for discharge was "failure in alcohol rehabilitation." She indicated that she was profoundly affected by the alleged perpetrators suicide days after her accusation and recalled that the Military appeared concerned that she might appear at his funeral, cautioning her against doing so. She also reported a sense of loss of support from her significant other, who she moved to live with in Florida, and indicated that she was disturbed by his prejudicial statements regarding the rape. Vet admitted to experiencing difficulties with intimacy following the rape. She is currently planning to separate from her second husband, who she reports is not supportive of her alcohol recovery.

(Continued on reverse side)

SIGNATURE AND TITLE: Virginia M. DeRoma, PhD., Staff Psychologist | DATE: 12/27/94

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, GAYLE A
5240 A STREET
BILOXI MS 39531

[redacted]

12 1394

CONSULTATION SHEET
STANDARD FORM 513 (Rev. 9-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
513-108

Tests Administered: Clinical Interview

Mental Status: Vet was oriented X3. Speech was coherent and voice was monotone in pitch. Thoughts were goal directed, with no evidence of delusions or hallucinations. ~~Suicidal~~ or homicidal ideation. Affect was restricted and mood was depressed. Insight and judgment were intact. Memory for recent and remote events was adequate.

Diagnosis: Substance Abuse
Adjustment Disorder with depressed Mood.

Disposition: Vet is to participate in weekly therapy in women's clinic to address ↑ self esteem, especially as related to trauma. Vet also agreed to participate in self-esteem group which meets 1x per week x8 weeks.

Thank you for this consultation

Virginia M. DeRosa, PhD
Staff Psychologist

Skin head N° V. Skin tattoos Abdomen, thorax and shoulders. No abnormalities. H/O PTSD. Skin peels clear. Pt is always under the influence of alcohol - tension headache - she says she drinks 2 days per week. Pt has had headaches since childhood - often in the morning. Pt tried - caffeine for diet -

Pupils equal & reactive to light
Face full, no asymmetry. Tongue;
No slurring but no facial weakness
Palate and uvula normal. Tongue in midline

Motor: no atrophy, no involuntary movements
Power 5/5 DTRs 2+, Plantars
Toes normal
Sensory: intact.
Reflexes: no deficits
Gait & Posture & Tandem intact

Rx Follow up in neuroclinic
Try on Zoloft, Celexa
V. Wade

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
		5/13/96.

REASON FOR REQUEST (Complaints and findings)

C&S

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE	APPROVED:	PLACE OF CONSULTATION	☐ ROUTINE ☐ TODAY
		☐ BEDSIDE ☐ ON CALL	☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

Migraine headache → since age 18. Migraine- bright flash that now she is getting migraine headache 1-2/month & lasting longer. Accepts - chest of neck, head & face & then pain moves - pain over R side head usually pain → like excruciating pain, she has to lay down, photophobia & nausea vomits & feels like clamp on head & migraine pain then age she had headache that lasted for before - then - & then - & closed down room & can't & some sitting in bed all day. Has headache frequency from 6 months (Continued on reverse side) she takes Tylenol some Dr. sometime she takes Robaxin. Recently she has developed neck & some pain in head. She has stiff shoulders. She not able to turn head but can & now shoulder pain & stiff & sore & radiates down arm, tingle.

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; mo; hospital or medical facility)

CONSULTATION SHEET
STANDARD FORM 513 (Rev. 9-77)
Prescribed by GSA/ICMR
FIRNR (41 CFR) 201-45.505
513-108

BILOXI VAMC 520
** FINAL **

For JOINTS Exam

==========

Name: DOVE,GAYLE A

C-[redacted])

Address: 4457 POPPS FERRY RD.LOT 195

City,State,Zip+4:
BILOXI MISSISSIPPI 39532

Res Phone: 601-396-1919
Bus Phone: NONE

Entered active service: SEP 4,1975 Last rating exam date:
Released active service: SEP 16,1987

Priority of exam: Original SC

==========

Examining provider: R. EUGENE BASS, M.D.
Examined on: JUL 6,1995

==========

Examination results:

REASON FOR EXAM: 2507 indicates a 37 year old female claiming service connection for the following conditions:
1. Shin splints - She had the onset of problems in basic training when she was doing a lot of strenuous physical activity. She was given conservative treatment. She did not have a bone scan while in the service. She continued to have problems with her legs over the years. She states that she is unable to run, and that prolonged periods of weight bearing will lead to increased pain along the anterior aspect of both lower legs.

2. Ganglion cyst - She has had four separate surgeries on the dorsum of the right wrist secondary to recurrent ganglion cyst formation. She states that she is presently working as a poker dealer at a casino, and even though she is left-hand dominant, she has to use her right hand a great deal and this causes some problems. She states that she frequently loses feeling, particularly in the index and the long fingers of the right hand. She is frequently awakened at night with painful paresthesias.

Since her discharge from the service, she states that she has worked at various jobs including a cocktail waitress, a hotel maid, and a sales clerk. She states that she has been unable to hold any job for any longer than approximately 6 months at a time.

PHYSICAL EXAMINATION: Height is 66.5 inches. Weight is 139 lbs. Station and gait - She walks with an unremarkable gait pattern. Examination of the right wrist reveals a well-healed surgical scar on the dorsum of the wrist with maximum palmar flexion. She appears to have a small cystic appearing lesion which is thought to be compatible with a ganglion cyst formation. She had 70 degrees of dorsiflexion and 60 degrees of palmar flexion. Radial deviation was 15 degrees; ulnar deviation of the wrist was

Continued on next page
VA Form 2507

Exam Results Continued

40 degrees. There was some tenderness to palpation of the dorsum of the wrist. She made a good fist in the hand and could appose the thumb and the remaining fingertips satisfactorily. Grip strength was judged to be essentially equal to that of the left hand. Tinel's sign was thought to be positive as was Phalen's sign. Examination of the lower extremities reveals no evidence of redness, heat, swelling or deformity. There was no particular tenderness to palpation over the anterior tibial region of either lower extremity. She was able to heel and toe walk and was able to squat and arise again.

X-RAYS: X-rays of the right wrists and of both tibias obtained.

IMPRESSION:
1. Postoperative multiple excisions of recurrent ganglion cyst formation, dorsum of the right wrist. Probable carpal tunnel syndrome, right hand.
2. History of bilateral shin splints.

/lr

Approved by: _____ Date: _____

Provider signature: _____ Date: _____

VA Form 2507

For GYNECOLOGICAL Exam

Name: DOVE,GAYLE A [redacted]

DOB: [redacted]

Address: 4457 POPPS FERRY RD.LOT 195

City,State,Zip+4:
BILOXI MISSISSIPPI 39532

Res Phone: 601-396-1919
Bus Phone: NONE

Entered active service: SEP 4,1975 Last rating exam date:
Released active service: SEP 16,1987

Priority of exam: Original SC

Examining provider: A. L. DIAZ, M.D.
Examined on: JUL 3,1995

Examination results:

HISTORY:

The patient comes in with a history of complete hysterectomy and pelvic adhesions. The patient is a 37-year-old female who is being evaluated as a C&P.

PAST HISTORY:

Past history shows a history of previous hysterectomy and treatment of adhesions. It is said to be a complete hysterectomy but not sure about the ovaries. However, the patient is currently not on hormonal therapy, and would guess that the ovaries are present. The patient does have a history in 1987 of being raped by her supervisor and is currently receiving therapy for this condition.

The patient currently has a history of pain in her lower abdomen. This is present when she bends over. Otherwise, there are no known problems.

FAMILY HISTORY:

Noncontributory. She is not a drinker or smoker.

Continued on next page

Name: DOVE,GAYLE A [redacted] C[redacted]
For GYNECOLOGICAL Exam

Exam Results Continued

PHYSICAL EXAMINATION:

Physical examination shows a well-developed, well-nourished female. B.P. is 98/58. EENT were PERLA and normal EOM's. Neck was supple. Chest showed normal anterior/posterior diameter. Breasts revealed no masses or tenderness. Lungs were clear to auscultation and percussion. Heart showed a normal sinus rhythm with no murmurs, bruits or thrills. Abdomen showed no signs of organomegaly. Breasts revealed evidence of fibrocystic breasts. Pelvis showed normal external female genitalia with labias major/minor, clitoris, Bartholin's gland, and Skene ducts to be normal. Cervix was not present. Vaginal cuff was well healed. On movement and bimanual examination, she does have mild to moderate pelvic pain. She could have a neuroma at the apex of the vaginal cuff. She probably has pelvic adhesions.

/njf

Approved by: _____ Date: _____

Provider signature: _____ Date: _____

VA Form 2507

BILOXI VAMC 520
** FINAL ** XMT
Processing time:
For GENERAL MEDICAL Exam

Name: DOVE,GAYLE A

C-N [redacted] 4)

DOB: [redacted]

Address: 4457 POPPS FERRY RD.LOT 195

City,State,Zip+4:
BILOXI MISSISSIPPI 39532

Res Phone: 601-396-1919
Bus Phone: NONE

Entered active service: SEP 4,1975
Released active service: SEP 16,1987

Last rating exam date:

Priority of exam: Increase

Examining provider: V. SCHERER, M.D.
Examined on: JAN 30,1997

Examination results:

A. Occupational history (List most current first):

Name/Address of employer (if unemployed, enter none)	Type Work	Monthly Wages	Emp dates from/to	Time Lost last 12 mo

This veteran is unemployed.

State if time from employment was lost and give reasons.

N/A.

B. Medical history (since last rating exam):

This veteran developed sleep disorder and depression shortly following ~~his~~ her discharge from the military in 1987. At present, she is under treatment by the Mental Health Clinic at the Gulfport Division of the VA. The veteran had a hysterectomy and bilateral oophorectomy in the military at Langley Air Force Base, VA in 1987 for pelvic adhesions. The veteran now complains of chronic intermittent low abdominal pain and she had a repeat laparotomy for further lysis of adhesions in March of 1985 at the Biloxi VA Medical Center. The veteran specifically denies any diagnosis of endometriosis. The veteran still complains of the low abdominal intermittent bilateral pain and tenderness. The veteran was diagnosed with chronic migraine headaches at Duluth IAP, MN Air Base and was treated with multiple medications including Midrin with no results and is now controlled on Elavil and sumatriptan. The headaches are not as severe but she does complain of two to three headaches per week. There is a long history of vasomotor rhinitis and sinusitis with frequent frontal headaches. The veteran treats these with over-the-counter Tylenol -- sinus. There is a long history of recurrent ganglion cyst on the dorsum

Continued on next page
VA Form 2507

Exam Results Continued

of the right wrist. The ganglion cyst was initially excised in 1979 in Greenland and the second excision was done at Eglin Air Force Base in 1981. The third excision was done at Fort Wainwright in Alaska. In 1982, the last excision was repeated at Fort Wainwright in 1983. The lesion has recurred, is tender and interferes with the veteran ability to grip. There is a history of multiple gastric ulcers diagnosed on endoscopy at this facility in October of 1996 for which the veteran uses prilosec with considerable relief in her symptoms and further she avoids coffee, tea or any high spiced or acid foods.

C. Present complaints (symptoms only, NOT diagnosis):

1. Painful tender cyst over the dorsum of the right wrist.
2. Symptoms of PTSD with depression and sleep disorder.
3. Migraine headaches, chronic.
4. Nasal congestion with frontal headaches, chronic.

D. Examination data:

This veteran is a Caucasian female who appears anxious and somewhat apprehensive during this examination. She is alert and oriented.

Height: 5'6" Weight: 127 Maximum weight past year: 157

Build and state of nutrition:

She is of medium build and adequate nutrition.

Temperature: 97.8 Time: 1:00 p.m. Carriage: Normal

Posture: Erect Gait: no limp Left-handed,
(How determined)

E. Skin, including appendages (describe type, area, extent of lesions and report injuries, including burns in the Musculoskeletal section of this form):

The skin is negative except for a palpable, moveable, tender, 1 cm in diameter, obvious ganglion cyst over the dorsum of the right wrist underlying a 3 cm longitudinal scar over the wrist dorsum.

F. Lymphatic and hemic systems (describe local or generalized adenopathy, enlargement, tenderness, suppuration blocking of lymphatic circulation, etc.):

There is no lymphadenopathy, no splenomegaly and no edema.

Continued on next page

Name: DOVE,GAYLE A [redacted]
For GENERAL MEDICAL Exam

Exam Results Continued

G. Head, face and neck:

The head is normocephalic. The face and neck are negative. The trachea is in the midline. There are no cervical lymph nodes palpable. There is normal range of motion of the cervical spine. The thyroid gland is not palpable.

H. Nose, sinuses, mouth and throat (include gross dental findings):

There is considerable edema to the nasal mucosa and moderate amount of postnasal drainage. There is good oral and dental hygiene.

I. Ears (describe canals, drums, perforations, discharge):

External auditory canals are normal. Tympanic membranes are normal. There is adequate hearing acuity at the spoken and whispered voice.

J. Eyes (describe external eye, pupil reaction, movements, field of vision, any uncorrectable refractive error or any retinopathy):

The pupils are equal and normally react. Ocular movements are normal. Funduscopic examination is negative. The veteran wears contact lenses for presbyopia.

K. Cardiovascular system (describe thrust, size, rhythm, sounds, and condition of peripheral vessels):

Examination of the heart reveals a normal sinus rhythm, normal rate, normal S1 and S2. There are no audible murmurs, no palpable cardiomegaly. There are no carotid bruits. The peripheral pulses are equal and adequate.

	Pulse	Blood pressure	Respiration
Sitting	66	108/69	18
Recumbent	70	104/70	18
Standing	64	76/52	18
Sitting after exercise	The veteran has a problem exercising due		
2 minutes after exercise	to orthostatic hypotension.		

L. Varicose veins (describe location, size, extent, ulcers, scars, and

Continued on next page
VA Form 2507

Exam Results Continued

competency of deep circulation):

There are no varicosities.

M. Respiratory system (describe cough, expectoration, mobility, palpation, percussion, and auscultation and specify the area as well as the veteran's tolerance for exercise, such as how far can he walk, how many flights of stairs can he climb, etc.):

The chest is symmetrical with equal and adequate expansion 46 1/2" to 48". There are no audible rales, rhonchi, or wheezing. The veteran has no problem walking and no problem climbing stairs.

N. Digestive system (describe findings on inspection and palpation, enlargements, masses, tenderness or rigidity, hemorrhoids (internal/ external), fissures, bowel movements - control or lack of):

At present, there is no epigastric tenderness. Examination of the abdomen reveals no masses and no splinting. The peristolic sounds are normal. Rectal examination is deferred at this time.

O. Hernia (describe type, location, size, whether complete, reducible, recurrent, supported by truss or belt, and whether operable):

There are no obvious herni noted.

P. Genitourinary system (describe kidneys, bladder, frequency of urination and control of lack thereof, prostate, seminal vesicles, testes, cord, penis, and appendages; evidence of past or present venereal disease; for females report pelvic exam, if indicated):

There is no history of any STDs. The pelvic examination is deferred at this time.

Q. Musculoskeletal system:

1. Diseases and injuries (include effect of gunshot wounds and other injuries on skin and underlying structures) -

Negative.

2. Scars (describe location, measurements, depression, type of tissue loss, adherence, disfiguration, and tenderness) -

There is a 3 cm longitudinal scar over the dorsum of the right wrist. There is a 22 cm transverse, low abdominal scar from the previous laparotomies. These scars are nontender, nondepressed, and without keloid

Continued on next page

Name: DOVE,GAYLE A [redacted] [redacted]
For GENERAL MEDICAL Exam

Exam Results Continued

formation.

3. Functional effects (describe location, swelling, atrophy, tenderness, degree of limitation of flexion and extension, angle of fixation, fracture or disease, fibrous or bony residual and specify mechanical aid used and benefit) -

Normal. The veteran can walk on her heels and toes. She has no problem touching her toes.

4. Feet (describe objective evidence of pain at rest and on manipulation, rigidity, spasm, circulatory disturbance, swelling, callus, strength, mobility of ankles, feet, toes and limitation in degrees and indicate whether right or left, acquired or congenital) -

Negative.

5. Burns (indicate degree, shape and dimension, specifying inches or centimeters) -

None.

R. Endocrine system (describe disease of thyroid, pituitary, adrenals, gonads, other body systems affected, etc.):

Negative.

S. Nervous system:

1. Neurological (describe motor status, coordination, reflexes, sensory status, equilibrium and give level of lesions) -

The cranial nerves are intact, II-XII. The deep tendon reflexes are equal and active. No abnormal reflexes are elicited.

2. Psychiatric and Personality (describe behavior, comprehension, coherence of response, emotional reaction, orientation, memory, signs of tension and response as to social and industrial capacity) -

The veteran is under treatment for PTSD at the Gulfport VA - Mental Health Clinic.

3. State whether the veterar is capable of managing his/her benefit payments in the individual's own best interests without restriction (a physical disability which prevents the veteran from attending to financial matters in person is not proper basis for a finding of incompetency unless the veteran is, by reason of that disability, incapable of directing

Continued on next page
VA Form 2507

Name: DOVE,GAYLE A [redacted]
For GENERAL MEDICAL Exam

Exam Results Continued

someone else in handling the individual's financial affairs) -

The veteran is capable of handling her own affairs.

T. Remarks:

U. Other tests/exams recommended:

V. Diagnostic/clinical test results:

W. Diagnoses:

1. POST-TRAUMATIC STRESS DISORDER.
2. POSTHYSTERECTOMY - OOPHORECTOMY WITH CHRONIC LOW ABDOMINAL INTERMITTENT PAIN.
3. MIGRAINE HEADACHES, CHRONIC.
4. CHRONIC VASOMOTOR RHINITIS.
5. GANGLION CYST, RECURRENT DORSUM OF THE RIGHT WRIST.

/klw

Approved by: _____ Date: _____

Provider signature: [signature] acting for Dr Scherer Date: 2-6-97

VA Form 2507

DILOXI VAMC 520
** FINAL **
Processing time:
For POST TRAUMATIC STRESS DISORDER (PTSD) Exam

Name: DOVE,GAYLE A

C-N [redacted]

DOB: [redacted]

Address: 4457 POPPS FERRY RD.LOT 175

City,State,Zip+4:
DILOXI MISSISSIPPI 39532

Res Phone: 601 396 1919
Bus Phone: NONE

Entered active service: SEP 4,1975 Last rating exam date: JAN 15,1990
Released active service: SEP 16,1987

Priority of exam: Review

Examining provider: B. FRANK VOGEL, M.D.
Examined on: JAN 26,1990

Examination results:

This veteran is service-connected for post-traumatic stress disorder and comes in today for review of her condition.

MENTAL STATUS EVALUATION:
This is a 46 year-old, divorced, white woman who is 5'6" tall and weighs 135 pounds. Her forehead is lined, her eyes are pouched, she is both tired and sad.

She will not talk about her traumatic sex experiences nor watch movies or news casts or read articles in which women have been hurt, attacked or harassed. She has troubling, intrusive thoughts four times a week, nightmares three times a week, flashbacks about three times a week. However, these flashbacks have diminished and have disappeared since risperidone was begun a year ago.

She avoids people, and says, "I've lost faith and trust in them, I expect to be hurt or criticized by them."

She had a number of interests and she has given them all up. She used to braid rugs, read books, go bowling, go to bingo, go to the casinos, visit with friends and she has given all of these up. She said "I have no relationships of any kind with a man since these things happened to me."

She will always sit in the back of a room if she has a choice;and at a sudden noise she has a very marked startle reaction, jumps, screams and sometimes will run into the house.

She keeps checking doors and windows three times a day to make sure that

Continued on next page

Name: DOVE,GAYLE A [redacted]
For POST TRAUMATIC STRESS DISORDER (PTSD) Exam

Exam Results Continued

they are solidly locked. In addition, she counts on a dog that belongs to a neighbor who lives in back of her house, but this dog will bark at the sound or sight of any stranger and she feels that this is an added security.

This woman is also markedly sad. She cries about twice a day, but feels that she wants to cry an extra five times a week. She has a low energy level, but is restless. Sleep is broken, lasts about five hours, and is tired when she wakes up but she does not take any naps. Her appetite is very poor, she skips breakfast and sometimes lunch and has lost 10 pounds in the past month and a half. Her concentration and comprehension is poor, and three times a day she finds herself at a loss, in another room, having forgotten her errand.

She has no friends, no hobbies, and about three times a week finds herself wishing she would not wake up from sleep and has suicidal thoughts, that are fleeting, by overdosing, at least twice a week.

Her present medication is Prozac 20 mg in the morning, Trazodone 100 mg at bedtime and risperidone 2 mg at bedtime, and Ativan 2 mg.

Risperidone is one of the newer antipsychotic medications that is very potent. It is possible that it has been prescribed because the claimant may have had psychotic features together with her depression. Usually it is not prescribed simply to mitigate the number of nightmares that an individual complains of.

This woman is in the range of average intelligence and is competent for VA purposes.

DIAGNOSIS:
AXIS I. POST TRAUMATIC STRESS DISORDER, 309.81.
DYSTHYMIC DISORDER, 300.4.
AXIS II. V71.09.
AXIS III. PELVIS ADHESIVE DISEASE; MIGRAINE; RHINITIS.
AXIS IV. UNEMPLOYMENT; NO SOCIAL NETWORK; TRAUMATIC SEXUAL EXPERIENCES: EXTREME.
AXIS V. CURRENT GAF #45.

COMMENTS:

This woman just lives with her father, occasionally with help him with some paper work that he does for the VFW and accompany him to large hardware stores to get materials that he uses in fixing up the house, but otherwise stays at home, except when she leaves it to come for therapy.

Continued on next page
VA Form 2507

Name: DOVE,GAYLE A [redacted]
For POST TRAUMATIC STRESS DISORDER (PTSD) Exam [redacted]

Exam Results Continued

She has no interests, no hobbies, she is not continuing with her college education, she is doing nothing at all. She is practically housebound. I urged her to consider having interviews with vocational rehabilitation, and she said she will consider doing this.

/pf

Approved by: _____ Date: _____

Provider signature: _____ Date: Feb 2 1998

VA Form 2507

BILOXI VAMC 520
** FINAL **
Processing time:
For POST-TRAUMATIC STRESS DISORDER Exam

B

==========

Name: DOVE,GAYLE A

C-Num [redacted]
DOB: [redacted]

Address: 4457 POPPS FERRY RD.LOT 195

City,State,Zip+4:
BILOXI MISSISSIPPI 39532

Res Phone: 601-396-1919
Bus Phone: NONE

Entered active service: SEP 4,1975 Last rating exam date:
Released active service: SEP 16,1987

Priority of exam: Increase

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Examining provider: B.FRANK VOGEL, PSYCHIATRIST
Examined on: DEC 16,1996

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Examination results:

This veteran is service-connected for post-traumatic stress disorder and comes in today claiming an increase in her emotional symptoms and also claiming individual unemployability because of her condition.

MENTAL STATUS EVALUATION:
This is a 39-year-old, divorced, white female who is 5'6" tall and weighs 125 lbs. She is casually dressed and neatly groomed; has a small gold stud in the top part of her left ear. Her forehead is lined. Her eyes are pouched. She appears depressed but during the interview, she did smile once or twice toward the end of the session.

She said, "I was dealing blackjack in the pit at one of the casinos. I was very tense. People were all over the place and they were looking over my shoulder. My doctor had to put me on Ativan, I was so anxious. I was getting so tense I was getting nauseated."

"I went to the Biloxi V.A. to the clinics and I was going there for about three months until they found I had four ulcers. Now, I am on medical leave from the casino. It was the job that made me feel nervous. Those people did criticize me. My supervisors did and even the players were telling me how to deal. That was during my 20 minute break."

"I haven't worked since August. I was at the hospital in Biloxi 2-3 times a week for examinations and lab tests and upper GI series, a colonoscopy. Finally, they did an endoscopy and that showed the ulcers."

"I keep to myself. I've gotten so bad, I can't even go to play poker at the casino."

"Everytime I see a black man, I feel like stabbing him with a metal nail

Continued on next page

Name: DOVE,GAYLE A [redacted]
For POST-TRAUMATIC STRESS DISORDER Exam [redacted]

Exam Results Continued

file that I carry. When I see a black man coming in the door, I think it's the one who raped me. It couldn't be because the one who did is dead. He killed himself two days after I turned him in. That was back in 1987."

This woman would not talk about her experience except with a great deal of difficulty and only in professional situations. She avoids watching war movies and westerns or anything that has to do with racial involvement on the TV.

She has troubling intrusive thoughts daily and these have become more frequent and more severe. Nightmares also occur about five times a week and also are more frequent.

She has no actual flashbacks or re-experiencing the entire situation but everytime she sees a black man, she has a feeling of terror.

She will always choose to sit in the back of the room "Where noone could come up behind me. I had to quit playing slot machines at the casino because people were walking pass me all the time and I couldn't stand it. I had to leave the place. I haven't been back since. I don't think I can work in the casino anymore because people do stand behind me. We are in a pit and there are at least two pit bosses constantly behind the dealer and they are looking for mistakes."

At a sudden noise she said, "I jump up and I put my hand on my chest and then I take a look to see what made the noise."

This woman told me that her relationship with a man broke up in August because she had been refusing to have sex for a number of months. She said, "I didn't want to. I found it revolting. I felt nauseated at a sexual touch and I'm sure the way I felt and acted caused the break-up of the relationship."

She went on to say "If I'm touched in some intimate matter it makes me pull away. I'm having problems in the AA at the meetings because, you know, there when we finish a meeting we do hug each other and I don't like it and I've been having a problem with it."

This woman is markedly depressed. She cries daily, has a low energy level, sleeps 4-5 hours and the sleep is broken and she feels tired when she wakes up. She tries to take a nap the next day but she sleeps so lightly that she can hear the cats playing and also the TV changing programs.

She feels that her thinking is slower than it used to be. Her concentration is much poorer. She finds she can't sit through a movie because she cannot keep her mind on the action of the movie. Her

Continued on next page

Name: DOVE,GAYLE A [redacted]
For POST-TRAUMATIC STRESS DISORDER Exam [redacted]

Exam Results Continued

immediate memory is so poor that at least 10 times a day she will find herself in her bathroom or her bedroom without remembering why she came there.

Her sexual feelings are at a low level. She doesn't want any sexual relationship. She doesn't even want a friendly relationship. She finds it difficult to even make friends with another woman.

Suicidal thoughts occur about twice a week and with the questions always in her mind, "Why am I around? Why bother?" There are vague plans of taking a handful of pills or using a gun.

She does not have any friends at all. She has acquaintances,particularly the people at the A.A. meetings that she attends 5-7 times a week. If she misses one meeting, she makes it up by going to two meetings the next day.

She has been reading books by Stephen King which have to do with horror experiences and she has stopped reading them and now reads the Harlequin series, the love stories. She also play solitaire by herself and once or twice has gone to bingo. She walks around the neighborhood for exercise about three times a week; occasionally goes to the mall but doesn't like to, because of all the people there. She finds herself so suspicious of people, so distrustful, that she is always asking herself "What do they want from me?"

This woman is in the high range of average intelligence and is competent for V.A. purposes.

There are no psychotic indices.

DIAGNOSIS:

AXIS I.	1. POST-TRAUMATIC STRESS DISORDER- 309.81 2. MAJOR DEPRESSIVE DISORDER WITHOUT PSYCHOTIC FEATURES- 296.23
AXIS II.	V71.09
AXIS III.	MIGRAINES; GASTRIC ULCER; PEPTIC PAINS
AXIS IV.	MONEY PROBLEMS; TRAUMATIC RAPE EXPERIENCE: EXTREME
AXIS V.	CURRENT GAF 45

This woman's dual diagnosis of post-traumatic stress disorder and major depressive disorder make for such severe impairment both socially and vocationally that her earning capacity has been very severely effected. She had to stop working and cannot bring herself even to think of returning to work. At this time, this veteran must be considered individually unemployable.

Continued on next page

Name: DOVE,GAYLE A [redacted] [redacted]
For POST-TRAUMATIC STRESS DISORDER Exam

Exam Results Continued

/yyh

Approved by: _____ Date: _____

Provider signature: _____ Date: Dec. 23, 1996

VA Form 2507

BILOXI VAMC 520
** FINAL **
Processing time:
For MISCELLANEOUS NEUROLOGICAL DISORDERS Exam

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Name: DOVE,GAYLE A

C-Num [redacted]
DOB: [redacted]

Address: 4457 POPPS FERRY RD.LOT 195

City,State,Zip+4:
BILOXI MISSISSIPPI 39532

Res Phone: 601-396-1919
Bus Phone: NONE

Entered active service: SEP 4,1975 Last rating exam date:
Released active service: SEP 16,1987

Priority of exam: Increase

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Examining provider: K. NALLURI, NEUROLOGIST
Examined on: JAN 16,1997

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Examination results:

This is a 39-year-old, left-handed, white, female referred to neurology clinic for C&P evaluation. She was in the U.S. Air Force from 9/75 until 9/87. She was evaluated in the past by neurology. Please refer to prior examination dated 7/17/95 for details of history at that time.

The patient reports that she has three types of headaches. Migraines headaches are more frequent, at least once a week and lasting for two hours up to three days. She takes Imitrex tablets or an injection for migraine headaches. She also gets tension headaches daily. She also has sinus headaches which are usually occurring when the weather is bad. She recently tried taking Depakote and quit because of side-effects such as bloating. She had a CT scan of the head that showed a possible lacunar infarct. She had MI of the brain in October 1996 and reported normal.

PAST MEDICAL HISTORY:
Post-traumatic stress disorder; hysterectomy; pelvic adhesions; gastric ulcer. No history of diabetes or hypertension.

FAMILY HISTORY:
Positive for diabetes

SOCIAL HISTORY
Smokes one pack of cigarettes daily. She is divorced and disabled. ETOH-quit two years ago. Denied drug abuse. She last worked in August of 1996 as a blackjack dealer.

MEDICATIONS:
Prozac, Trazodone, Risperidone, Imitrex, Vistaril, Omeprazole, Ativan.

ALLERGIES:

Continued on next page

Name: DOVE,GAYLE A [redacted]
For MISCELLANEOUS NEUROLOGICAL DISORDERS Exam

Exam Results Continued

NKDA

PHYSICAL EXAMINATION:
This is a well-developed, well-nourished, white, female currently in no acute distress. VITAL SIGNS- stable- BP 102/59, resp 18, pulse 69, temp 97.6, weight 124 lbs.

The head is normocephalic and atraumatic. Neck appeared supple, no bruits. Heart- regular. Lungs- clear. Abdomen- soft. Extremities- no cyanosis or edema. NEUROLOGICAL EXAMINATION- awake, alert, and oriented x 3. Speech is fluent. Language intact. Higher intellectual functions intact. Visual fields are full. Pupils are equal and react to light. Fundus examination revealed sharp disc margins. Extraocular movements are full, no nystagmus. Fifth nerve- normal. Seventh nerve- smile is symmetric. Eighth nerve- air conduction better than bone conduction. Ninth through twelfth nerve within normal limits. MOTOR EXAMINATION- no drift; 5/5 strength throughout. SENSORY EXAMINATION- intact to all modalities. Deep tendon reflexes 2- and symmetric. Toes downgoing. No finger-to-nose ataxia. Gait- non-antalgic.

IMPRESSION:
This is a 39-year-old female with history of headaches. She has three types of headaches with on type being chronic migraine headaches. She is advised to consider a trial of Amitriptyline again and with the combination of Amitriptyline and Prozac, she may do better. Consider weaning her off Trazodone if she is being started on Amitriptyline. The patient appears to be willing to do this. She also has tension headaches and sinus headaches. History of post-traumatic stress disorder. Advised to follow-up by Dr. V. Nalluri as scheduled.

/yyh

Approved by: _____ Date: _____

Provider signature: K Nalluri Date: 2/10/97

VA Form 2507

BILOXI VAMC 520
** FINAL **
Processing time:
For MISCELLANEOUS NEUROLOGICAL DISORDERS Exam

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Name: DOVE,GAYLE A

C-Num [redacted]
DOB: [redacted]

Address: 4457 POPPS FERRY RD.LOT 195

City,State,Zip+4:
BILOXI MISSISSIPPI 39532

Res Phone: 601-396-1919
Bus Phone: NONE

Entered active service: SEP 4,1975 Last rating exam date:
Released active service: SEP 16,1987

Priority of exam: Increase

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Examining provider: V. NALLURI, M.D.
Examined on: MAY 20,1996

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Examination results:

The patient referred for a C&P with General Remarks of migraine headaches. According to the patient, she had headaches since the age of 18 or before, longer than that. Now the headaches are getting more frequent and lasting longer. She reports that the headaches, she gets about once or twice per week. She gets cloudiness or blue spots and then gets nauseous before headaches. She gets pain over the right side of the head. She reports that the pain is excruciating and she has to lay down and also it is associated with photophobia and gets worse with noise. She describes the pain like a clamp on the head and very painful. She reported that she had a headache a few weeks ago. Usually before the headaches last for three hours and she stays in a closed, dark room, and with ice packs and sometimes just sitting in bed all day. The headaches are more frequent from about six months. She takes tylenol and also sometimes Robaxin. She is also using some pain medications at times. She tried Elavil. She reports that she is not able to work full-time anymore and now doing part-time work. She was also tried on Inderal. She had to have CAT scan of the head three years ago. Headaches are associated with nausea and vomiting. She takes Phenergan sometimes for vomiting. As noted above she gets headaches about two per week. History of post traumatic stress disorder. She says that she is always under stress. She learned relaxation techniques that helps the tension headaches. She reports that she has tension type headaches daily and the pain is over the forehead. She wakes up with pain daily which she described as a dull pain and last the whole day. She reports that for the most part, she had headaches daily constantly. She also tried caffeine free diet.

On Neurological examination - Patient alert, oriented x3, speech fluent. The pupils are equal, reacting to light. Extra-ocular movements full. No nystagmus. Fundus - there is right nasolabial fold flattening. No facial weakness. Palatal arch is normal. Tongue in midline. Motor examination -

Continued on next page
VA Form 2507

Name: DOVE,GAYLE A [redacted]
For MISCELLANEOUS NEUROLOGICAL DISORDERS Exam

Exam Results Continued

Normal skull atrophy, no involuntary movements. Power 5 out of 5 in the upper and lower extremities. Deep tendon reflexes +2, plantars downgoing, tone normal. Sensory intact. Neck no bruits.

IMPRESSION:
1. MIGRAINE HEADACHES AND ALSO TENSION HEADACHES. SHE TRIED ELAVIL AND INDERAL BEFORE. SHE REPORTS THAT HEADACHES ARE MORE FREQUENT NOW THAN BEFORE. IT IS RECOMMENDED THAT PATIENT FOLLOW-UP IN NEUROLOGY CLINIC, MAY TRY IMITREX OR CALCIUM-CHANNEL BLOCKERS.

/cls

Approved by: _____ Date: _____

Provider signature: [signature] Date: 5/24/96

VA Form 2507

BILOXI VAMC 520
** FINAL **
Processing time:
For POST-TRAUMATIC STRESS DISORDER Exam

Name: DOVE,GAYLE A

C-[redacted]

DOB: [redacted]

Address: 4457 POPPS FERRY RD.LOT 195

City,State,Zip+4:
BILOXI MISSISSIPPI 39532

Res Phone: 601-396-1919
Bus Phone: NONE

Entered active service: SEP 4,1975
Released active service: SEP 16,1987

Last rating exam date:

Priority of exam: Increase

Examining provider: B. FRANK VOGEL, M.D.
Examined on: MAY 6,1996

Examination results:

This veteran is service connected for post traumatic stress disorder and comes in today claiming an increase in her symptoms and increased problems in adjusting to people, especially to men. It is to be noted that her traumatic experiences have to do with a forcible rape while she was serving in the Air Force.

The claimant says, "I can't sleep more than an hour at a time, this has been getting worse. Everything now irritates me and I feel very angry inside and I have a hard time holding it in."

"I get Prozac and three Trazodones at night and I have been getting that for the last three months because I've complained about my sleep and anger getting ~~worse~~ much worse. It is helping only a little bit."

"I had to get divorced last July because I couldn't stand for my husband even to touch me, to say nothing of having ~~sex~~ intercourse. I haven't let him have intercourse with me for a whole year."

MENTAL STATUS EVALUATION:
This is a 38-year-old, divorced, white women who is 5'6" tall, weighs 132 pounds. She is neatly, but casually groomed and dressed. Her forehead is lined, her eyes are pouched, she appears somewhat depressed. She complains of broken sleep because she has been having so many nightmares. The nightmare content has to do with her past traumatic experiences. She will not talk about her traumatic experiences and actually has no one to talk to. She has no close women friends. She does occasionally watch movies and gets upset if there is violence towards women in the movies. She does not watch news T.V. at all, because she says, "They're always filled with violence."

Continued on next page
VA Form 2507

Exam Results Continued

She has troubling intrusive thoughts daily and these have become more frequent. Nightmares now occur five times a week and are both more frequent and more severe. She feels extremely insecure and apprehensive with black people of either sex and with men especially, and it doesn't matter if they are black men or white men.

When she found herself becoming so upset even at the mildest of physical caresses by her husband, ~~that~~ she would show her irritation and her displeasure, and this lead to more and more quarrels, finally a divorce. She does not like to be touched even in a friendly fashion by another person, and more especially by a man.

She says she distrusts people because she finds herself unable to get close to people. She has noted that she used to attend AA meetings and after the meetings would go with several of the members of the Chapter to a place just to have coffee and talk afterwards for several minutes. ~~and~~ She finds that she no longer can make herself do this because she feels so uncomfortable with them, that she has avoided these get-togethers. This has been especially in the picture for the past six months.

She will always choose to sit in the back in the corner of a room so she can see people coming in and especially to see that no one gets behind her. She says, "I don't trust people behind me. They might come and grab me." She has a very marked startled reaction and at a sudden noise she will scream, jump, turn around, and then yell at the person who made the noise. She says this happens a couple of times a week and her reaction has become more severe than it has in the past.

Last July she actually bought a pellet air rifle to use in case her husband continued coming and trying to persuade her to agree to a reconciliation. However, he has taken her finally at her word, and no longer comes around. She has never had to use this rifle.

This women also is definitely depressed. She has crying spells three times a week. Feels as if she needs to cry but holds it in at least that number of times a week also. Sleep is poor, broken, about 4-5 hours. She has these constant nightmares that contain the materials of the rape situation and feels tired the next day. She needs to stop and rest.

She has been working at the Copa Casino in the poker room full time and was doing well until for some reason the company decided to close the poker room. They get little revenue from the poker players. She has started learning to be a black jack dealer, actually began the course yesterday. ~~and~~ When she completes the course she knows that the only job ~~will be~~ available will be a part-time job. She finds that her memory is so poor that she has had to go over several times the material that she learned yesterday during the instruction period, and yet she says she knows

Continued on next page

Exam Results Continued

black jack since a small child and has played that as a family game when she was growing up. She also has to make a list of things to do, places to go and items to buy. She finds herself in another room daily without remembering why she came there and similarly opening the refrigerator door without remembering what she wanted to take out. These indications of memory impairment have been increasing in the last six months.

Suicidal ideas occur twice a week, but these are fleeting thoughts and the vague plan is to shoot herself.

She just has no friends, visits no one, no one visits her. She has really nothing that interests her and she reads mystery stories and once a week does go to play bingo. About twice a week when she goes to bed she will wish not to wake up. During the day time about once every two weeks she will have the thought, " Everybody would be better off if I were dead."

This women stopped drinking 19 months ago and has been attending the AA ever since. She never used drugs.

This women is in the range of average intelligence, did very well in ~~interpretating~~ average intelligence three proverbs and I would put her in the range, and she is competent for ~~the~~ VA purposes.

DIAGNOSIS:

AXIS I. POST TRAUMATIC STRESS DISORDER, 309.81.
AXIS II. V71.09.
AXIS III. POST UTERINE SURGERY PROBLEMS; MIGRAINES.
AXIS IV. MONEY PROBLEMS; CONCERN ABOUT NIECE'S COMING MARRIAGE; MOTHER'S DECLINING HEALTH; AND HER OWN TRAUMATIC EXPERIENCES: EXTREME.
AXIS V. CURRENT GAF 50.

This veteran is attending the Women's Clinic since October 1994. She is receiving Prozac 20 mg in the morning and Trazodone 150 mg at bedtime, but is not receiving individual therapy and consequently is not really working at the main problem of her post traumatic stress disorder and her depression. She does say that she is talking occasionally to a resident in Psychology, but this person does not touch on her traumatic experiences and she has not consequently brought them up.

/CLS

Continued on next page

Name: DOVE,GAYLE A
For POST-TRAUMATIC STRESS DISORDER Ex [redacted]

Approved by: _____ Date: _____

Provider signature: _____ Date: May 13, 1996

VA Form 2507

For MISCELLANEOUS NEUROLOGICAL DISORDERS Exam

Name: DOVE,GAYLE A

C-Num [redacted]

Address: 4457 POPPS FERRY RD.LOT 195

DOB: [redacted]

City,State,Zip+4:
BILOXI MISSISSIPPI 39532

Res Phone: 601-396-1919
Bus Phone: NONE

Entered active service: SEP 4,1975
Released active service: SEP 16,1987

Last rating exam date:

Priority of exam: Original SC

Examining provider: V. NALLURI, M.D.
Examined on: JUL 17,1995

Examination results:

XAMINATION RESULTS:
he patient referred for C & P evaluation with the general remarks of igraine headaches, ganglion cyst, pelvic adhesions with complete ysterectomy, sinusitis and PTSD.

he patient reports that she has headaches since her early 20's. The last ew years she has more constant headaches. She says that she has three ifferent kinds of headaches. She has a migraine, tension and sinus eadaches. With the migraine headaches, she gets pain over the right rontal temporal region usually. She describes somebody getting a knife id sticking it into her head. She also gets aura sometimes. She says she its black spots flowing in front of the eyes. She also gets usea and vomiting. She also gets dizzy. She feels weak. She can not t out of the shade when she gets the migraine headaches. The headaches st for about two hours up to two days. She gets migraine-type headaches ery two weeks. They are getting more frequent. Sometimes the graine-type headaches are also throbbing and pulsating. She takes four lenol tablets every nine hours and using a cold cloth and goes to a iet, dark room and doesn't move. She also has photophobia and she orts that noise aggravates the headache.

h the tension type headaches, she wakes up with a headache and also s to bed with a headache. She gets pain over the bitemporal and ehead region like a band around the head. She describes the pain as a eezing sensation. She gets the tension headaches daily. She tried a ferent medication for headaches but it didn't help. She also tried feedback. She tried Elavil, Inderal but it didn't help. She also ed other medications but she is unable to tell the names.

reports that with the sinus headaches she gets pain over the nasal

tinued on next page
orm 2507

Name: DOVE,GAYLE A
For MISCELLANEOUS NEUROLOGICAL DISORDERS Exam
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Exam Results Continued

bridge near the medial side of the eyes. She gets the sinus headaches a couple of times per week.

She reports with the migraine headaches in her 20's she would get only three or four per year. Later about once a month but now she gets a couple of times per month.

Family History - no family history of migraine headaches.

Medications - She takes Tylenol #3 only with migraine headaches. For regular headaches she takes regular Tylenol.

NEUROLOGICAL EXAMINATION
The patient is alert and oriented times three. Speech is fluent. Gait is normal. Memory is intact. Cranial nerves - pupils equal, reacting to light. Extraocular movements are full. No nystagmus. Visual acuity - 20/20 on the right side. Left side is 20/15. Fundus - disc margins are sharp. No facial asymmetry. Other cranial nerves are intact.

On motor examination - no involuntary movements. No drift. Power is 4+/5 in the upper and lower extremities. Deep tendon reflexes: +1 to +2 bilaterally and symmetrically. Plantars downgoing. No cerebellar signs. Good finger to nose. There is mild past pointing but no atypical ataxia.

Sensory examination - Questionable decreased pin prick, left upper and lower extremities. Neck - no carotid bruits.

IMPRESSION:
Migraine headaches. She also has tension and sinus headaches. She has tried several medications for migraine headaches.

I recommend a CAT scan of the head with and without contrast if she has not had a CAT scan before.

/tad

Approved by: _____ Date: _____

r signature: Vasanthi K. Mallesu Date: 4/19/95

n 2507

For GENERAL MEDICAL Exam

Name: DOVE,GAYLE A

C-Num: [redacted]

DOB: [redacted]

Address: 4457 POPPS FERRY RD.LOT 195

City,State,Zip+4:
BILOXI MISSISSIPPI 39532

Res Phone: 601-396-1919
Bus Phone: NONE

Entered active service: SEP 4,1975 Last rating exam date:
Released active service: SEP 16,1987

Priority of exam: Original SC

Examining provider: R. AMDALL, M.D.
Examined on: JUL 5,1995

Examination results:

A. Occupational history (List most current first):

Name/Address of employer (if unemployed, enter none)	Type Work	Monthly Wages	Emp dates from/to	Time Lost last 12 mo

This veteran was in the U.S. Air Force from September, 1975 until September, 1987. She worked in Aerospace Control and Warning. She currently is working at the Copa Casino as a dealer. Last employment history is significant in that she has not been able to hold a job for more than six months since her separation from the Air Force. Probable reason for this will become apparent later.

State if time from employment was lost and give reasons.

B. Medical history (since last rating exam): This 37 year old caucasian female states that she had the onset migraine headaches in her 20's. A typical headache begins with bright and dark spots in her visual field. This occurs approximately thirty minutes before the onset of a pounding headache which is accompanied by nausea and occasionally vomiting. The headaches are usually right-sided but have occurred on the left. At the present time she has one migraine headache approximately every two weeks. She takes over the counter analgesics, such as Tylenol and Advil for relief. In addition to her migraine headaches, she has a headache that is characterized by constant pain in the frontal area that occurs daily. She was treated for this with biofeedback for a period of three months. It was not successful.

She had a total hysterectomy for pelvic pain secondary to adhesions in March of 1987 at the age of 30. The pain recurred following the surgery. She again had surgery for abdominal pain in March of 1995 at which time

Continued on next page
VA Form 2507

Name: DOVE,GAYLE A
For GENERAL MEDICAL Exam
[redacted]

Exam Results Continued

she was found to have wide spread adhesions. She is currently being treated with Depo-Provera in an attempt to control her pelvic pain. She is also on a stool softener. She continues to have lower abdominal pain as well as some superficial tenderness in the region of her most recent scar. Please see Gyn consult.

She has pain and cramps in the region of the tibialis anterior muscle with any running and with prolonged walking.

She has nasal stuffiness throughout the year. It is worse in the summer. She also has maxillary sinus pain frequently. Ordinarily the maxillary pain is relieved by over the counter sinus medications but she requires antibiotics for sinusitis on two occasions per year.

She has a ganglion on her right wrist for which she has had surgery four times. The ganglion has recurred and she has pain in the wrist in the region of the ganglion. This has been a problem to her in her job as a dealer at a casino.

Shortly before her separation from the Air Force, she reports that she was raped by her supervisor. She states that the incident was reported and as the investigation began the accused supervisor committed suicide. She received no psychological support therapy at that time. Since her separation from the Air Force, she has had marked difficulty with interpersonal relationships and has been unable to hold jobs for more than about six months. She was on Zoloft and Vistaril for a short period of time approximately a year ago but discontinued them. She continues to be tearful and to have dreams from which she awakens with anxiety. She does not recall the content of the dreams. Please see Psychiatry consult for details.

C. Present complaints (symptoms only, NOT diagnosis):
The most troublesome complaint that she has are those related to the PTSD. The second most troublesome complaint is that of her recurrent abdominal pain,

D. Examination data:

Height: 5'6 1/2" Weight: 142.3 lbs Maximum weight past year: 158 lbs

Build and state of nutrition:
She is well developed, well nourished.

Temperature: 98.7 Time: 8:30 a.m. Carriage: Normal

Posture: Normal Gait: Normal left-handed, by history
(How determined)

Continued on next page
VA Form 2507

Name: DOVE,GAYLE A
For GENERAL MEDICAL Exam

Exam Results Continued

E. Skin, including appendages (describe type, area, extent of lesions and report injuries, including burns in the Musculoskeletal section of this form): Unremarkable.

F. Lymphatic and hemic systems (describe local or generalized adenopathy, enlargement, tenderness, suppuration blocking of lymphatic circulation, etc.): No localized or generalized adenopathy.

G. Head, face and neck: Unremarkable.

H. Nose, sinuses, mouth and throat (include gross dental findings): There is minimal nasal obstruction present at the time of the examination. Mouth and throat are unremarkable. The teeth are in a good state of repair and her oral hygiene is good.

I. Ears (describe canals, drums, perforations, discharge): External auditory canals and tympanic membranes are normal.

J. Eyes (describe external eye, pupil reaction, movements, field of vision, any uncorrectable refractive error or any retinopathy): The pupils are round, regular and equal and react to light. EOM are normal. Visual fields are full by confrontation. Funduscopic examination is normal. Visual acuity is 20/20 and 20/15, OD and OS respectively.

K. Cardiovascular system (describe thrust, size, rhythm, sounds, and condition of peripheral vessels): The heart is not clinically enlarged. The heart tones are of good quality and of normal intensity. There are no murmurs.

Peripheral pulses are present and symmetrical.

	Pulse	Blood pressure	Respiration
Sitting	70	96/63	18
Recumbent	72	92/52	18
Standing	71	103/75	18
Sitting after exercise	79	108/78	20
2 minutes after exercise	68	108/66	20

.. Varicose veins (describe location, size, extent, ulcers, scars, and

Continued on next page
VA Form 2507

Standard Form 507 — 048—16—61472-8 GPO

CLINICAL RECORD

10/13/94

Report on Dove, Gayle

or

Continuation of S. F. Psychology Report

(Strike out one line) (Specify type of examination or data)

(Sign and date)

Tests Administered: Ms Dove was administered the MMPI-2 on 10/11/94 and her chart has been reviewed.

Results: Ms Dove obtained a valid profile. Patients of this kind are often described as having a definite drinking problem and are more likely to be labeled as alcoholics than patients generally. This type of patient is also more likely to be labeled diagnostically as depressive neurosis and to display depressive mood than the average patient. A recent history of crying episodes and, more important, of suicidal behavior may be present. The latter usually takes the form of attempts or gestures. Scores in this range suggest adequate regard and consideration for others, a flexible approach and no undue sensitivity. Such persons are likely to display a normal combination of practical and theoretical interests. Normal energy and activity level are suggested. A capacity to maintain rewarding social relationships is suggested. Trauma scales were mildly elevated and she felt this was due to an abusive relationship she was involved in many years ago. She has a poor self concept, is self-dissatisfied, and lacking in the skills that would lead to her improvement. Daily life is not interesting nor exciting.

Danger to Self or Others: Ms Dove denied recent suicidal thoughts. She is uncertain if she will be going through a divorce in the very near future and she stated that she has had thoughts of physically harming her husband but she has no plans to do so. She made a suicide attempt at the age of 16 by an overdose of pills after learning that she was pregnant. She was taken to a hospital and released the same day.

Mental Health History: Ms Dove stated that she has never been treated for mental health related issuses as an inpatient. In 1987 while still on active duty in the Air Force she was prescribed Elavil for Major Depression. She reported that she was also prescribed an antidepressant by Dr. Bain at the MHC in Gulfport shortly before entering this program. She is currently on Zoloft. This is her second treatment program for Alcohol Depenedence.

Diagnostic Impression: Major Depression, Moderate

Steve McNally PhD
Steve McNally PhD
Staff Psychologist

DOVE, GAYLE A
5246 A STREET
BILOXI MS 39530

25
047

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle initial; 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

Standard Form 507 — 648—16—81472-3 GPO

CLINICAL RECORD

Report on ~~Diagnostic Summary~~
or
Continuation of S. F. ~~Master Treatment Plan~~ /
(Strike out one line) (Specify type of examination or data)

(Sign and date)

Diagnosis: AXIS: I
Alcohol Dependence
2ND TX Program - 1prior TX. in Military 1987 Andrews, AFB

History Substance Abuse Dependence:
Vet is a 32 year old Female, Alcoholic Binge drinker. She started drinking at age 14 and it became a problem for her at age 21. She has been drinking for 23 years. She drinks Vodka ½ Pint - her longest Period of Sobriety is 8 months. She has a Positive Fm. Hx. - Father & 2 brothers Are Alcoholics

Psychiatric/Psychological:
Vet is Alert & Oriented Thoughts are relevant & Coherent - Recent/Remote memory is Intact. She denies any suicidal ideation. She is somewhat Depressed (marital Problems) She is pleasant & Cooperative - She denies any Physical Abuse - but was sexually Abused at age 9 by a non-family member.

Social Support Network/Recreational Skills/Spiritual Orientation:
Vet has 2 brothers who are both Alcoholics and her Father is recovering at present - Mother is a non drinker. She has poor AA Attendance: Last Attended AA - 5 years ago. She enjoys Bowling & Shooting Pool in her Leisure Time. She also enjoys collecting old Coins as a hobby. She believes in and calls GOD her "Higher Power" married X3 Divorced X2 no children currently married for 4 ½ years - Husband informed her - He WANTS a divorce

Medical/Legal/ Vocational:
veteran has a severe pelvic inflammatory disease with adhesions and has had a hysterectomy. LAB work completed prior to admission All LAB work is within normal Limits - Some Further Testing has been ordered. no Acute Distress Normal Hetero sexual development No legal issues are pending. ganglion @ wrist
She has A High School Ed. and has 3 years of College - She has worked as an auditor until 2 yrs ago. She also worked in a warehouse - she is presently unemployed

Assessment of Needs/Outpatient Referrals: - She has some Denial - Appears to be motivated & is receptive to Treatment
AA & Sponsor
MHC - Follow-up SATP out patient clinic - VA Gulfport ms.

Aftercare Planning
Support System
Unable to Control urges to DRINK
Improving Marital Relations
vet will return Home after Completion of Treatment

(Continue on reverse side)

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

DOVE, GAYLE A
5246 A STREET
BILOXI

25
047
MS 39530

REGISTER NO.

WARD NO.

CHSMPA

REPORT ON _____ or CONTINUATION OF

Case Manager

STANDARD FORM 507
General Services Administration and Interagency Committee on Medical Records

Department of Veterans Affairs

MEDICAL RECORD | SUPPLEMENT DEFINED DATA BASE

SUPPLEMENT TO STANDARD FORMS (Check one): ☐ SF 504 ☐ SF 505 ☐ SF 506

SUPPLEMENT TO VAF 10-7978g SERIES (Check one): PART ☐ I ☐ II ☐ IV ☐ V

PREPARED BY (Signature & Title)	SERVICE	DATE
Edward R. Dorsey Chaplain	CH	10/17/94

CHAPLAIN SERVICE SPIRITUAL ASSESSMENT

1. CURRENT RELIGIOUS PREFERENCE: Episc

2. RELIGIOUS UPBRINGING: Bapt

3. PRESENT RELIGIOUS PARTICIPATION:

___ MUCH ___ SOME ✓ LITTLE ___ NONE

4. COMMENTS: (Significant changes, activities, if any, etc.)

5. PASTORAL CARE PLAN:

✓ INFORM OF CHAPLAIN SERVICE RESOURCES

✓ ENCOURAGE WORSHIP ATTENDANCE

___ FURTHER VISITS FOR PASTORAL SUPPORT

___ PASTORAL COUNSELING

✓ PROVIDE LITERATURE AS REQUESTED AND APPROPRIATE

___ OTHER (Specify)

___ NONE INDICATED

6. ADDITIONAL COMMENTS:

(Continued on reverse)

DOVE, GAYLE A
5240 A STREET
BILOXI

25
04-7
MS 39530

[redacted]

SUPPLEMENT
DEFINED
DATA BASE

VA FORM 10-7978g

SPIRITUAL HISTORY

1. Who knows or care that you are here? husband, father, mother, some friends

2. From whom do you seek help with your problems? father

3. To whom were you closest as you were growing up? ~~mother~~ no one

4. Describe your relationship with your family (parents, brothers, sisters, spouse, children) best friends with father, close to mother, friendly but distanced from one brother, non-speaking terms with oldest brother, friendly but strained relations with husband.

5. What significant events happened to you in the past year? Earlier in your life? father came to live with me and my husband.

6. If you have had an important spiritual experience in your life, what was it like?

7. What has been your experience with wonder or awe? I've always been awed by nature

8. How would you describe your relationship to God? I've been away for a long time, but I've come back

Spiritual History - 2

9. What is your religious background? In what way is it significant to you (positive or negative)? Episcopal, Baptist - accepted Christ as my savior.

10. In what religious organization, if any, are you actively involved? none

11. Which of the following, do you think, are blocks to your peace of mind (serenity)?

- ✓ Low self-esteem (I don't feel I'm worth much)
- ___ Distrust (It's hard for me to tell people what I really feel)
- ___ Defiance (Nobody tells me what to do)
- ___ Phoniness (I'm afraid to tell you who I am)
- ___ Selfishness (I want what I want when I want it)
- ___ Overwork
- ✓ Resentments
- ✓ Feeling shame
- ✓ Fear/worry
- ___ Sex
- ✓ Anger
- ✓ Feeling guilty
- ___ Stubbornness

12. What significant losses have you had (death, divorce, job, health, etc)? 2 divorces and getting ready to go through another. Threw away AF career and can't find another. 4 surgeries on wrist. One stomach surgery, awaiting another.

13. What are painful areas of your life? Explain having a baby at age 16, then having to have a hysterectomy at age 29, with no children.

Gayle A. Dove
Patient Signature

17 Oct 94
Date

Staff Notes: Patient states that she is a Christian. She is not active in a church at this time. She states that she needs to start back to going to church. She needs a deeper growing relationship with her Higher Power (God) such as asking for forgiveness and humor.

Edward Dowdy, Chaplain
Staff Signature

10/17/94
Date/Time

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) 10/4/94 — 11/1/94
Please specify DATE and note that if patient remains, the plan must be reviewed on that date. 28 d. program

FUNCTIONAL STRENGTHS & LIMITATIONS:
Strong Denial - Receptive to Tx. - Sincere Tx. Physical/Emotional Abuse - Depressed

SCHEDULED DATE(S) FOR REVIEW:	DATE(S) ACTUALLY REVIEWED:
10/12/94	10/12/94 See Progress Note
10/28/94	10/31/94

ASSIGNED CASE MANAGER/PRIMARY THERAPIST: Luke Tiller, CTRS, M.P.A.

Gayle A. Dove	[illegible] Psychiatrist	Recreation Therapist
Family/Significant Other*	Psychologist	
Nurse	Social Worker	

*Please explain if no family or significant other has been involved:
Making appointment w/ husband (No show)

SIGNATURE/TITLE-PRACTITIONER	SIGNATURE/INITIAL OF APPROVING PHYSICIAN	DATE
CTRS	M.D	10/12/94

Enter in space below - **PATIENT IDENTIFICATION** - *Treating Facility - Ward No.* *Date*

[redacted]

MENTAL HEALTH - Part I

MEDICAL RECORD OVERALL TREATMENT PLAN

[redacted]

EXISTING STOCK OF VAF 10-0043 OBSOLETE

CLINICAL NEED OR CONDITION: Controlling Urges To Drink & Use Drugs.

DATE IDENT.	TREATMENT GOALS	INCREMENTAL OBJECTIVES	TARGET DATES	ACTUAL ACHIEV. DATE	METHOD & FREQUENCY	STAFF RESPONSIBLE	KEY DISCHG. GOAL? Y/N
10/11/94	Develop AN Aftercare PLAN to assist her iN staying Clean & Sober.	PAtient. Veteran will Identify people, Places and situations That could Lead To relapse and 3 new Skills methods To Avoid relapse	11/11/94		Aftercare PLAN daily	Nancy MacMillan NCAC II	Yc
					Step-study Group 2xwk	Bob Davidson NCAC II	
					AA/NA meetings 4xwk	NSG staff	
					Problem Solving 1xwk	Nancy MacMillan	
					Relapse Prevention 2xwk	Sarah Rehage RN NCAC II	
					Steps to Recovery 2xwk	Chaplain Dowdy Father Popielski	
					Leisure Ed 1xwk	Mike Miller CTRS	
					Recreation therapy daily		

10/31/94 Resolved (will work on when ready is.)

Department of Veterans Affairs | **MEDICAL RECORD** | **OVERALL TREATMENT PLAN**

IMPORTANT: CHECK APPROPRIATE BOX: ☑ INITIAL ☑ CHANGE TO TREATMENT PLAN ☐ DISCHARGE PLANNING

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CLINICAL NEED OR CONDITION: Aftercare Support System

DATE IDENT.	TREATMENT GOALS	INCREMENTAL OBJECTIVES	TARGET DATES	ACTUAL ACHIEV. DATE	METHOD & FREQUENCY	STAFF RESPONSIBLE	KEY DISCHG. GOAL? Y/N
10/11/94	Veteran Pt. will work on developing an aftercare plan that will assist her in maintaining her Sobriety.	① Vet will Learn about 12-step Programs and the 12 Principles and the Importance they play in Sobriety.	11/11/94		1st/Step Group 2xwk AA/NA Meetings 4xwk Relapse Prevention Classes 2xwk Problem Solving GP 1xwk Aftercare PLANNING 1xwk	Bob Davidson NCAC II NSG STAFF Sarah Rehage RN NCAC II Nancy MacMillan NCAC II Nancy MacMillan NCAC II	Y
		② Vet will learn to identify high risk situations, feelings/thinking that threatens her Sobriety and demonstrate new skills to aid her Sobriety.	11/4/94		Small group therapy 5xwk To Ventilate feelings Steps To Recovery 2xwk	Bob Davidson NCAC II Champion Dowdy Father Lopelesk	

10/31/94 Temporary Leave Will attend AA/NA meetings

SIGNATURE/TITLE-PRACTITIONER	SIGNATURE/INITIAL OF APPROVING PHYSICIAN	DATE
[signature] CRS		

Enter as many below - **PATIENT IDENTIFICATION** - *Treating Facility - Ward No. Date*

DAVE GAYLE A
SSN: 000-00-0000
5246 A STREET
BILOXI MS 39530

25
047

[redacted]

MENTAL HEALTH - Part II

MEDICAL RECORD
OVERALL TREATMENT PLAN

[redacted]

EXISTING STOCK OF VAF 10-0043 OCT 1988

CLINICAL NEED OR CONDITION: Marital / Relationship problems - 3 marriages - 2 of short duration

DATE IDENT.	TREATMENT GOALS	INCREMENTAL OBJECTIVES	TARGET DATES	ACTUAL ACHIEV. DATE	METHOD & FREQUENCY	STAFF RESPONSIBLE	KEY DISCHG. GOAL? Y/N
10/11/94	Veteran will recognize the negative effects her drinking behaviors have on relationships.	Vet will identify problems in her marriages and their relationship with her drinking.	11/11/94	10/12 10/14	Family Counseling PRN	Pat Joden RN	
					Presentation of Life Story XI	Bob Davidson NCAC II	
					Small Group Therapy To Ventilate feelings	Bob Davidson NCAC II	
		resolved: Will be discd 10/31/94		10/14 10/21 10/7	Substance Abuse and The Family F Friday	Pat Joden RN	
					Referral To ACOA XI	Mike Miller CMHS MFA	

MENTAL HEALTH - Part II

[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.)*

CLINICAL NEED OR CONDITION: _____

DATE IDENT.	TREATMENT GOALS	INCREMENTAL OBJECTIVES	TARGET DATES	ACTUAL ACHIEV. DATE	METHOD & FREQUENCY	STAFF RESPONSIBLE	KEY DISCHG. GOAL? Y/N

SIGNATURE/TITLE-PRACTITIONER | SIGNATURE/INITIAL OF APPROVING PHYSICIAN | DATE

Enter in space below - PATIENT IDENTIFICATION - Treating Facility - Ward No. Date

☆ USS [illegible] 1934-343-6234/74312 23 Q47

5240 A STREET MS 39530

BILOXI

[redacted]

MENTAL HEALTH - Part II

MEDICAL RECORD OVERALL TREATMENT PLAN

[redacted]

EXISTING STOCK OF VAF 10-0043 OBSOLETE

CLINICAL NEED OR CONDITION: _____

DATE IDENT.	TREATMENT GOALS	INCREMENTAL OBJECTIVES	TARGET DATES	ACTUAL ACHIEV. DATE	METHOD & FREQUENCY	STAFF RESPONSIBLE	KEY DISCHG. GOAL? Y/N

[redacted]

Department of Veterans Affairs | MEDICAL RECORD | RECREATION SVC. DATA BASE AND ASSESSMENT

INSTRUCTIONS: *This form will be used by all therapist to document: 1) individual patient data used in multidimensional analysis of health care related factors; 2) findings of Leisure Problem Screening (LPS), Comprehensive Leisure Assessment (CLA) and/or Activity Assessment.*

RECREATION THERAPY SERVICE ASSESSMENT

AGE: 37 MARITAL STATUS: Married x3 BILOXI VAMC - Gulfport DIVISION SATP

Information pertinent to skills, talents, attitudes, aptitudes, needs, interests, life experiences, capacities and any noted deficiencies in leisure functioning.

1. Current Recreation/Leisure activities or those participated in prior to hospitalizatio
Vet employee Bowling Pool Shooting
2. Educational Background: 3 years College (completed)
3. Occupation: Auditor — not employed
4. Time Available for Leisure Pursuits: Inpatient yes Outpatient yes
5. Special Interest, Skills, Talents: Collects old Coins (Hobby)
6. I AGREE/DISAGREE WITH THE THERAPEUTIC RECREATION ASSESSMENT/TREATMENT PLAN:
PHYSICIAN'S SIGNATURE John Smith M.D. DATE: 10/5/94
RECOMMENDATIONS:

****

7. Answer the following:

YES	NO	N/A		
	✓		a.	Do you have difficulty making leisure choices?
✓			b.	Would you like to learn new leisure skills?
✓			c.	Have you ever been involved in the organization of any recreation Activities?
✓			d.	Do you know your community's recretional areas, facilities and their accessibility?
✓			e.	Are you aware of the leisure time pursuits and adaptive sports activities available at this medical center?
✓			f.	Do you have financial resources available for leisure pursuits?
✓			g.	Since you have been here, have you pursued any recreation activities?
			h.	Do you feel comfortable interacting socially?

(CONTINUED ON REVERSE)

SIGNATURE/TITLE-PRACTITIONER: Michael R. Miller, CTRS, M.P.A. DATE: 10/11/94

PATIENT IDENTIFICATION-(Treating Facility - Ward No.)

DOVE, GAYLE A
5246 A STREET
BILOXI MS 39530

25
047

[redacted]

RECREATION SERVICE DATA BASE AND [redacted]

VA FORM 10-0001

8. Problems or barriers that affect your free time: Alcohol Drugs

Physical Disabilities: Pelvic Inflammatory Disease NONE No Interest N/A

Transportation NONE Other N/A

9. Additional Information: Married x 3 Not employed. Hx of Depression - Husband Active Duty USAF.

10. Observation Data: Vet is alert-Oriented-Cooperative. Has full Range of motion - No Restrictions or limitations. Vet does his own ADL's.

11. GOALS AND OBJECTIVES FOR PATIENT: Increase self-esteem - Socialization skills. - Improve Overall Physical Condition - Active participation → SATP. - Utilization of leisure time in a wise Constructive manner.

REFERENCE SHOULD BE NOTED BELOW REGARDING LEISURE LIFE STYLE AND PROGRAM/ACTIVITY RECOMMENDATIONS:

I. ADAPTED SPORTS

A. BASKETBALL ( )
B. BOWLING ( )
C. BALL THROW ( )
D. PUTT-PUTT GOLF ( )
E. FISHING ( )
F. PITCH & CATCH ( )
G. TIC TAC DOE ( )
H. MISCELLANEOUS ( )
I. WALK/Exercise (L)
J. Swim/Gym (L)

II. PSYCHOSOCIAL ACTIVITIES

A. GROUP DISCUSSIONS (L)
B. SOCIALS ON WARD ( )
C. BINGO ON WARD ( )
D. SOCIALS IN REC HALL (L)
E. BINGO IN REC HALL (L)
F. SOCIALS AT SVC CLUBS (L)
G. MISCELLANEOUS ( )

III. SEDENTARY ACTIVITIES

A. TABLE GAMES (L
B. CHECKERS (
C. CHESS (
D. CARD GAMES (L
E. PUZZLES (
F. CURRENT EVENTS (
G. MOVIES (L
H. MUSIC LISTENING (
I. CONVERSATION (L
J. MISCELLANEOUS (

IV. ARTS/CRAFTS, HOBBIES

A. MODELS (L)
B. PAINT BY NUMBER (L)
C. DOODLE ART (L)
D. LEATHER CRAFT (L)
E. WOODWORKING (L)
F. CERAMICS ( )
G. STICHERY ( )
H. SUNCATCHERS (L)
I. DECO POINT ( )
J. GARDENING ( )
K. MISCELLANEOUS ( )

V. COMMUNITY RE-ENTRY

A. LEISURE EDUCATION (L)
B. LEISURE COUNSELING (L)
C. VAN RIDES (L)
D. LOCAL INTEREST TRIPS (L)
E. ADL'S (L)
F. MISCELLANEOUS ( )

Patient will participate in the abo Therapeutic Rec activities on a daily-Weekly basis.

VI. MISCELLANEOUS ACTIVITIES NOT LISTED: ( )

Department of Veterans Affairs

S.A.T.P. AFTERCARE PLAN

SOBRIETY MAINTENANCE	**What I Will Do: (Goal)** attend AA meetings, find a permanent sponsor, work on the 12 steps, attend Therapy Sessions **How Often Will I Do It: (PLAN - BE SPECIFIC)** I will go to meetings every day, especially women's group. I will find a female sponsor who is working the program and who has been in sobriety for awhile. I will work on the 12 Steps daily and go to therapy as indicated.
VOCATIONAL/ SCHOOL	**What I Will Do: (GOAL)** I will finish college and possibly go for a master's degree. I will get a job that I like that will hopefully lead to a career. **How Will I Do It: (PLAN - BE SPECIFIC)** Check with VA benefits rep. check into grants, go to USM to find out class schedules, requirements, etc. I will compile my resume and send it out to various companies. Will complete a SF171 and check federal job listings.
FAMILY AND/OR PRIMARY RELATIONSHIPS	**What I Will Do: (GOAL)** Obtain a divorce from my husband. Establish a friendship with sister-in-law, get closer to my family. **How Will I Do It: (PLAN - BE SPECIFIC)** ~~I will divorce my husband ASAP~~ I will either call or write my sister-in-law a letter. I will stop distancing myself from the rest of my family. I will call them more often, write letters etc.
SOCIAL/ RECREATIONAL ACTIVITIES	**What I Will Do: (GOAL)** make new friends, become a volunteer at VA and Keesler AFB, keep busy **How Will I Do It: (PLAN - BE SPECIFIC)** See volunteer services rep. take craft classes offered on the base, see base volunteer rep, become involved in base activities, start making rugs and other crafts again.
HEALTH ISSUES: (EXERCISE, DIET, MEDICAL)	**What I Will Do: (GOAL)** I will continue walking start exercising and stay on a diet until I reach goal weight. I will eat healthier. Also ride my bicycle more. **How Will I Do It: (PLAN - BE SPECIFIC)** Will try to power walk daily exercise at least 3-4 days a week. Ride my bicycle instead of driving my car. Stay on a 1200 calorie diet until I reach goal weight then go on a maintenance plan.

Gayle A. Dove
PATIENT SIGNATURE

WITNESS

SIGNATURE AND TITLE OF PRACTITIONER

DATE

IMPRINT PATIENT DATA CARD

DOVE, GAYLE A
5246 A STREET
BILOXI

25
047
MS 39530

[redacted]

MEDICAL RECORD SUPPLEMENT TO PROGRESS NOTE FOR SPECIALIZED DISCIPLINES

[redacted]

VA FORM

EXISTING STOCK OF VA FORMS

Department of Veterans Affairs

The Boost 10-15-94 Group A — Less than Zero 10-6-94 — Staying Clean 10-13-94 — Staying off Cocaine avoiding relapse 10-18-94 — Guidelines 10-19-94 — Staying clean keeping straight 10/17 — Waiting Denial 10/11/94 — Discussing Ego 10-26-94

PATIENT EDUCATION AND ATTENDANCE RECORD-SUBSTANCE ABUSE TREATMENT PROGRAM

AIDS 10/18	ANTABUSE 10/28	ASK YOUR DOCTOR	ALCOHOL AND COCAINE 10-5-94	12 STEPS OF AA	STEP I OF AA	STEP II OF AA	STEP III OF AA
CHALK TALK	COCAINE HIGHS & LOWS 10-14-94	CONQUERING COCAINE 10,19,94	CRACKED UP	CRUEL SPIRITS	DAYS OF WINE & ROSES	DESIGNER DRUGS	DISEASE OF ALCOHOLISM 10-14-94
DRY DRUNK	FAMILY ISSUES 10/14	THE FAMILY	FEELINGS	GUIDE-LINES	GOING HOME 10-27-94	MARIJUANA UPDATE	MEDICAL ASPECTS PT. I
MEDICAL ASPECTS PT. II	MY NAME IS BILL W. 10-8-94	NUTRITION	ONE DAY AT A TIME	OUR FATHER	REWARDS OF RECOVERY	SEXUALITY	SPIRITUAL ASPECTS
SYMPTOMS OF SOBRIETY	THREE-HEADED DRAGON 10.20.94	UNDER THE INFLUENCE 10-29-94	UNRESOLVED ANGER	VIABLE ALTERNA-TIVES	WHAT PROBLEM	How to Sabotage your Treatment 10-12-94	Continued acts of Sabotage 10-7-94

GROUP THERAPY	WEEK 1	WEEK 2	WEEK 3	WEEK 4
MONDAY	10/24/94	Holiday	10/11/94	10/17/94
TUESDAY	10/25/94	Life Story	10/11/94	10/18/94
WEDNESDAY	10/5/94	10/6	10/12/94	10/19/94
THURSDAY	10/26/94	10/6	10/13/94	10/20
FRIDAY	10/27/94	10/7	10/14/94	10/21/94
PROGRESS NOTES	10/25/94			
	10/31/94			

SIGNATURE AND TITLE OF PRACTITIONER

DATE

IMPRINT PATIENT DATA CARD

DOVE,GAYLE A
5246 A STREET
BILOXI
25
047
MS 39530

[redacted]

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.

1160-1

Veterans Administration

Dental Service (160)	Dentist's Signature	Date 10/6/94

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: Gingivitis

RX: Prophy

Diagnosis	Treatment

J. Eliff DDS

SIGNATURE AND TITLE OF PRACTITIONER Robert M. Bates DDS DATE 10/6/94

IMPRINT PATIENT DATA CARD

DOVE, GAYLE A
5240 A STREET
BILOXI MS 39530

25
047

[redacted]

H2 1

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE
FOR SPECIALIZED DISCIPLINES

[redacted]

Department of Veterans Affairs

S.A.T.P Nursing Assessment

Primary Drug of Choice Vodka
Amount and frequency of use 1/2 pt. (Binger)
Length of use/abuse 23 years.
Age of first use 14
Age of first problems associated with use/abuse 23
Date of last use 9/30/94

History of other drugs used None

History of intravenous drug use: YES___ NO ✓ Prior HIV test: YES ✓ NO___ 1992

Number of Detox admissions 1 in military
Number of treatment program admissions 1 1987 Andrews AFB.
Number of treatment programs completed 1

History of: Blackouts YES___ NO ✓; DT's YES___ NO ✓;
Seizures YES___ NO ✓

Noted early withdrawal symptoms None

Family history of substance abuse (specify) Grandfather, uncle

Prior Antabuse Therapy: YES___ NO ✓; Adverse reactions: YES___ NO___
Specify: ___

History of AA/NA attendance: poor
Sponsor utilization: YES___ NO ✓

Length of sobriety: 8 mo

Legal entanglements: DUI's 1 1980, Incarcerations None,
Court dates pending: None

Noted observations/comments during interview:
37 y/o W/F, Co-operative, Cheerful, good eye contact.

SIGNATURE AND TITLE OF PRACTITIONER Jim Ozaki, RN

DATE 10/4/94

IMPRINT PATIENT DATA CARD

DOVE, GAYLE A
5246 A STREET
BILOXI
25
047
MS 39530

[redacted]

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE
FOR SPECIALIZED DISCIPLINES

[redacted]

Veterans Administration

PRE-TEST COUNSELING FOR HIV ANTIBODY SCREEN
(CHECK MARK INDICATES IT IS DONE)

GENERAL INFORMATION:
Date: 10/5/94 Time: 0640
History of High Risk Behavior: Unprotected sex c male (Husband). Husband has had numerous affairs

Aug 94 Date of last possible exposure
1992 Date of previous HIV antibody screen

Additional concerns: _____

✓ There is a Doctor's order for HIV testing

THE FOLLOWING WAS REVIEWED VERBALLY WITH THE VETERAN:
✓ Modes of transmission of HIV
✓ Methods of protection against HIV transmission
✓ The meaning, sensitivity, and specificity of the HIV tests
✓ The consent form for HIV testing was signed freely by veteran and witnessed by counselor
✓ The HIV test result is considered confidential and will be part of the medical record
✓ The disclosure policy to public health authorities
✓ Policy regarding disclosure to spouse/sexual partner(s)
✓ Potential social ramifications of a positive test result
✓ Policy on non-discrimination in health care services for patients with HIV infection
✓ Services available within the Department of Veteran Affairs
✓ Results will be given only in person - must return to clinic for post-couseling

VETERAN:
✓ Participated in counseling and asked appropriate questions
✓ Was given literature on AIDS
✓ Appears to comprehend the significance, meaning, and ramifications of HIV screening
✓ Desires HIV antibody screening
___ Refuses HIV antibody screen at this time
✓ Was instructed to report for blood drawing
✓ Will return to clinic or be seen on the unit for post counseling when results are available
✓ All of veteran's questions WERE answered

COMMENTS:

SIGNATURE AND TITLE OF PRACTITIONER: [signature] RN — DATE: 10/5/94

IMPRINT PATIENT DATA CARD

DOVE, GAYLE A 25
5245 A STREET 247
BILOXI MS 39530

[redacted]

MEDICAL RECORD SUPPLEMENT TO PROGRESS NOTE FOR SPECIALIZED DISCIPLINES

12/91

VA FORM SEP 1988 **10-0114j**

025390

MEDICAL RECORD	PROGRESS NOTES
DATE	
10.4.94 2100	PATIENT EDUCATION: Pt was oriented to rules and regulations all questions was explained verbalize understanding, Pt attended activities on Ward pleasant and cooperative Ada Jafaeetti RA
10-5-94 0200	O. Sleeping Well when checked on Rounds tonight - Will cont to monitor pt. Naomi Tuscey R.N.C.
10/5/94 0800	Urine specimen collected & sent to lab JOrsak, Rn
10-5-94 2100	O - Pt. has Complyed with the ward Rules, Attended activities schedule for this TOS. No problems are noted at this time. Elena Campbell RA
10/6/94 0600	Appeared to sleep well. Jim Orsak 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
5245 A STREET
BILOXI 047
MS 39530

[redacted]

REGISTER NO.	WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR(41CFR)201-46.505
509-111

PROGRESS NOTES

DATE	
10/6/94	GROUP THERAPY
1630	Pt was placed in Small Group yesterday And was introduced to her peers. I introduced myself As the group leader And made her aware that group A meets M-F from 9:45 Until 11:15. She was given a Guideline for Group therapy And was made aware of the group's Confidentiality and how important it be observed. She was given a date so that she can get prepared to tell her life story. Pt was Asked to share some personal Hx c the group And she did. Pt shared that her husband is Asking for a divorce And she began to begin drinking And wants to get Sober so that she will be Able to deal c out the use of Etoh. She appears to be sincere About getting her life together. — Sybil Watson MSW II
10/11/94	Psychology note - chart in can reviewed. opts MMPI-2 Testing and intensive Psychological report will follow. Steven McNally PhD
10/11/94 1430	Psychology note - Mrs Dove was scheduled for a 1300 appointment for MMPI-2 testing. Pt's instrument for testing at 0800 and a patient who was scheduled for 0800 was sent back to the ward because Mrs Dove arrived early and the Psy. Tech Ms Lumsden was not aware of the specific for patient set for testing. This caused schedule problems, and created frustration for staff members and the patient. Steven McNally PhD

815AF

S: Chewing Problems: Y (N)
Dysphagia: Y (N)
Appetite: (+) -
Feeding Assistance Required: Y (N)
Food Allergies: None on file
Food Preferences: None reported

Pre-Admission Diet: Regular
Wt. + - [illegible] # in last ___ months
Nausea: Y (N) Vomiting: Y (N)
Diarrhea: Y (N) Constipation: Y (N)

O: Current Diet: REG
Adm. Dx: ETOH
Age: 37 Sex: F
Height: 5'6
Weight: 143
Usual Weight: 138
Ideal Weight: 130±10%
Amputation %: N/A

Adm. Date: 4-Oct-94 10:08am
Prior Assessment: None
Frame Size:
Weight Taken: 10-5-94
Weight/Usual Wt: 104%
Weight/IBW: 110%

Laboratory Data

Test	Result	units	Ref. range	Date
GLUCOSE	81.	mg/dL	62 - 128	21-Sep-94
UREA NITROGEN	8. L	mg/dL	9 - 21	21-Sep-94
~~CREATININE~~	~~0.7~~	~~mg/dL~~	.5 - 1.4	21-Sep-94
SODIUM	138.	M MOL/L	137 - 145	21-Sep-94
POTASSIUM	4.3	M MOL/L	3.6 - 5	21-Sep-94
TRIGLYCERIDE	~~249. H~~	mg/dL	40 - 180	21-Sep-94
HCT	41.3	%	37 - 47	21-Sep-94
LYMPH#	2	#/cmm	1.2 - 3.4	21-Sep-94

Appearance: Normal

FOOD = DRUG INTERACTION: Y (N)

A: Nutritional Status

- ✓ Not Compromised
- ___ Mildly Compromised
- ___ Moderately Compromised
- ___ Severely Compromised

Nutrition Education

Further Education Required: Y (N)

Comments: Appetite, Intake and Tolerance to meals good. Wt stable to adequate/ht. Elevated triglyceride level.

P: Nutritional Plan

- ✓ Provide basic nutritional care
- ___ Screening data not available: Please order_____
- ___ Nutrition Education
- ___ Recommend Diet Change
- ___ Further Nutritional Assessment

Recommendations:
Attend SDTP Nutrition Session.
Recommend reduced sugar intake to possibly reduce triglycerides

Lynn Giles, Dietitian 10/5/94
Signature Date

GAYLE A BILOXI/GULFPORT VAMC VAF 10-9034

** [redacted] FOR MEDICAL RECORD ** Progress Notes RECREATION THERAPY PROGRESS NOTE

10/12/94 15:24 GENERAL NOTE
INITIAL T.R. ASSESSMENT COMPLETED. VET WILL PARTICIPATE IN THE FOLLOWING: ADAPTED SPORTS, PSYCHOSOCIAL, SEDENTARY, ARTS/CRAFTS AND COMMUNITY RE-ENTRY ON A DAILY BASIS. CONTINUE PRESENT GOALS AND OBJECTIVES.
/es/ MICHAEL R. MILLER
RECREATION THERAPIST 10/12/94 10:00

DOVE,GAYLE A 25
5246 A STREET 047
BILOXI MS 39530

[redacted]

MEDICAL RECORD	PROGRESS NOTES

DATE

7 DAY ADM / D/C PLANNING STAFFING

10-12-94
9.15 A.M.

1st Treatment program.
Pt. denied repeated her recent binge is due to her husband's request for a divorce. She indicates her father helped her realize the extent of her problem and her need to seek help. She reports confusion as to the true nature/timing that her drinking led her husband to be so unhappy as to want to end their marriage. She has no answer regarding the future of her marriage. Has this issue affects her focus upon her treatment. Little regard of benefit from program to this point. Regarding future life she did mention a plan to live with her father should her divorce become a reality. Impression: Marital issues are big. Understand will assess at progress notes. Monday staff mtg.

Robert Wilson MSW II, Peter Byrd NCAC II, Steve McNally PhD
Pat Lee, Julian Eliff M.D., Rob Walker RN

(Continue on reverse side)

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DOVE, GAYLE A
5246 A STREET
BILOXI

25
047
MS 39530

[redacted]

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ISRB,
FIRMR(41CFR)201-45.508
509-111

PROGRESS NOTES

DATE	
10/13/94	PATIENT EDUCATION: Peer Support Group:
0630	Pt attended group and did participate in group We talked about getting along with other people and we talked about going out into our old places and hanging out with the same people and wanting us to go to the old hang outs and drinking and doing drugs. That we need to say NO and to find other activities to do to take the place of some of our old. And to know that some activities that works for one may not work for others. We need to also feel good about ourselves and to have faith in each other go to our AA meeting and keep out of the bars. John R Purnell

[redacted]

10/12/94 13:18 GENERAL NOTE

MARITAL DIFFICULTIES: HUSBAND IS ASKING FOR DIVORCE YET VISITS FREQUENTLY. SHE STATES SHE HAS ASKED HIM IF HE WANTS A DIVORCE, AND HE SAYS, 'I DON'T KNOW'. PT. AND HUSBAND HAVE SPENT ONLY 6 MOS. OF A THREE YR. MARRIAGE TOGETHER. HE IS ON TDY IN SERVICE, AND SHE IS UNABLE TO GO WHERE HE IS. SHE SAYS WHEN HE IS HOME HE DOES NOT STAY AT HOME, AND THEY HAVE NOT BEEN HAVING SEX. MS. DOVE IS OBVIOUSLY DEPRESSED AND WAS ON THE VERGE OF TEARS THROUGHOUT THE INTERVIEW. SHE WAS RECEPTIVE TO THE COMMENT THAT SHE IS IN AN ABUSIVE RELATIONSHIP DEVOID OF MEANINGFUL COMMUNICATION, BUT STATES SHE'D NEVER THOUGHT OF IT THAT WAY.

WRITER REQUESTED TO SEE HUSBAND THURSDAY OR FRIDAY AT 4 PM. SHE STATED SHE WOULD ASK HIM IF HE WAS WILLING TO MEET WITH ME. WILL SET UP APPOINTMENT TO SEE MS. DOVE AFTER SEEING HUSBAND.

/es/ PATRICIA S. LODEN
HEAD NURSE 10/12/94 13:26

10/13/94 08:34

GENERAL NOTE
WOMEN'S GROUP

MRS. DOVE ATTENDED ONE SESSION. IT WAS HER FIRST DAY HERE, SO PARTICIPATION WAS MINIMAL. SHE APPEARED TO CENTER IN ON HER HOPE TO RE-ESTABLISH A RELATIONSHIP WITH HER HUSBAND. SHE, IN THE BEGINNING MINIMIZED THE PROBLEMS IN HER LIFE RELATED TO HER DRINKING. WILL CONTINUE TO ENCOURAGE HER TO LOOK AT HER ATTITUES AND BEHAVIORS THAT CAUSE HER PROBLEMS IN HER LIFE.

/es/ NANCY L. MACMILLAN,NCACII
ADDICTION THERAPIST 10/13/94 08:38

10/13/94 09:06

SATP GROUP THERAPY
VET MET TODAY @ 11:30 UNTIL 12:30 IN ROOM ~~213~~ 103 FOR FIRST STEP GROUP. THE MATERIALS THAT WERE DISCUSSED CAME FROM THE "SATP FIRST STEP BOOKLET". THE GROUP WAS ACTIVE AND PARTICIPATED WELL IN THE OPEN DISCUSSION ON HOW IMPORTANT IT IS THAT THE FIRST STEP OF THE TWELVE STEPS PROGRAM BE TAKEN WITHOUT ANY RESERVATIONS OR DOUBTS. VEY APPEARED TO BE MOTIVATED AND RESPONSIVE TO THE FIRST STEP GROUP.

/es/ ROBERT DAVIDSON
ADDICTION THERAPIST,NCAC II 10/13/94 09:07

MEDICAL RECORD	PROGRESS NOTES

DATE 10/14/94 11:30

GROUP THERAPY

Pat has Completed Nine (9) days in the and has progressed well in Such a Short time. She talks about her Marital problems openly in Small Group and gets good feedback from her peers. She has been elected president of the Ft. Community and that appears to help her Self-Esteem. In group today She began to tell her life Story and was not able to complete it because of the time. What She did disclose was that as a child She had a lot of resentment toward her father and mother. She was Abandoned at a early Age and became pregnant when She was 16 yrs old and went to Hattiesburg to have her child who She never had a chance to See or Hold. She became very tearfull when she shared that but She worked through it. She will Continue her life Story on 10/17/94. She and her present husband are to meet c Pat. Leader RD, HN @ 1600 today to try to resolve the issues Surrounding him Asking her for a divorce. Pat was given a Copy of "Co-Dependency No More" by me So that She may possibly gain Some insight into one of her Many Problems. Pat has a good Attitude and is using this program to meet her needs.

(Continue on reverse side)

DOVE GAYLE A
5248 A STREET
BILOXI MS 39535

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	
10-14-94	2-30 pm Ripley OHC Sup PA Vassar RN
10/20/94	PATIENT EDUCATION: "Perk up" Group. Pt
0655	did attended and did participate in group talk. Pt Turned in paper on Negative and Positive feelings and talked to her about her paper. We talked about how we react to our anger and the different ways we can handle this. The good and the bad part of it. She talked about taking a step back and looking this over before they react. But not always, and some time she would get into a shouting match. Or even screaming at each other. We reinforced + ways to handle this without invading someones private space, and to try and keep a cool handle on the problem. John R Lewis MA

DOVE, GAYLE A 047
5240 A STREET MS 39530
BILOXI

U.S. Government Printing Office: 1993-515-904/81316

STANDARD FORM 509 BACK (Rev. 11-77)

[redacted]

10/14/94 16:21 GENERAL NOTE

MARITAL RELATIONSHIP MADE APPOINTMENT WITH HUSBAND THROUGH PT. WAS TO BE HERE AT 1600 HRS. AND DID NOT SHOW. MS. DOVE TOLD ME SHE HAD PRESSED HIM FOR AN ANSWER TO THE QUESTION, "DID HE WANT A DIVORCE?" AND HE STATED HE DID. HE FURTHER STATED, ACCORDING TO PT., THAT HE WANTED A DIVORCE NOW, BUT HAD SHE DONE THIS (REFERRING TO SATP) A YEAR AGO, HE MIGHT NOT BE WANTING ONE.

WHEN IT BECAME APPARENT HUSBAND WAS NOT KEEPING APPOINTMENT, MS. DOVE STATED, "I TOLD HIM WHEN HE TOLD ME HE WANTED A DIVORCE YESTERDAY, IF THAT WAS THE WAY HE FELT NOT TO BOTHER TO COME FOR THE MEETING (WITH WRITER). MY IMPRESSION IS THAT THE PT. IS HIGHLY MANIPULATIVE, HAVING A GREAT DEAL OF DIFFICULTY BEING HONEST, AND IN CONSIDERABLE DENIAL ABOUT HER DRINKING AND HER MARRIAGE. WILL MEET WITH HER ON MONDAY.

/es/ PATRICIA S. LODEN
HEAD NURSE 10/14/94 16:27

10/20/94 14:36

GENERAL NOTE
MET WITH MS. DOVE ONE-ON-ONE TO ADDRESS ISSUES RELATED TO HOW AND WHAT SHE IS DOING IN THE PROGRAM. WHEN ASKED WHAT SHE THOUGHT SHE HAS GAINED UP TO THIS POINT, SHE DID NOT HAVE AN ANSWER. THROUGHOUT THE FIRST HALF OF THE INTERVIEW SHE WOULD NOT ANSWER EXCEPT TO SAY, "I DON'T KNOW", OR "I DON'T KNOW HOW". WHEN SHE STARTED TO ANSWER QUESTIONS, SHE WOULD HESITATE FOR LONG PERIODS, THEN GIVE VAGUE ANSWERS. SHE WAS ASKED IF SHE HAD STARTED ON HER PROBLEM SOLVING BOOK, HER ANSWER WAS, "I'VE LOOKED AT IT." SHE FINALLY DID SAY THE SHE FELT SHE "STOPPED" HER DRINKING PROBLE BEFORE SHE CAME IN, AND SHE STATED SHE WOULD NOT DRINK AGAIN. IT WAS THEN BROUGHT OUT THAT SHE FELT IF SHE HAD RID HERSELF OF A DRINKING PROBLEM, THEN EVERYTHING WOULD BE O.K. SHE CENTERED ON HER HUSBAND AT ONE POINT STATING, "HE SCREWED AROUND ON ME FOR YEARS." THE QUESTION WAS ASKED OF HER BY WRITER, "DIDN'T YOU DO THE SAME THING?" WITH THAT QUESTION SHE LOOKED AWAY AND NODDED IN THE AFIRMATIVE. IT WAS SUGGESTED TO VET THAT SHE GIVE UP HER POSITION AS PRESIDENT OF THE COMMUNITY TO ENABLE HER TO CONCENTRATE ON HER TREATMENT IN THE NEXT TWO WEEKS. IT HAS BEEN NOTICED BY STAFF THAT SHE IS CENTERING ON OTHER PATIENT'S PROBLEMS. SHE WAS ASKED TO START ON HER WORKBOOK TONIGHT, AND WRITER WILL MEET WITH HER ON A DAILY BASIS. VET APPEARS TO BE IN A STATE OF DENIAL OF THE ATTITUDE AND BEHAVIORS THAT HAVE CAUSED HER DIRECT PROBLEMS IN HER LIFE AS WELL AS HER MARRIAGE. WILL CONTINUE TO ENCOURAGE VET TO CONCENTRATE ON GETTING ALL SHE CAN GET OUT OF THE PROGRAM. WILL MEET WITH HER AGAIN 10/21/94 AT 1345HRS.

/es/ NANCY L. MACMILLAN,NCACII
ADDICTION THERAPIST 10/20/94 14:58

10/20/94 16:47

SATP OUTSIDE COMMUNITY MEETING
PATIENT WAS DESIGNATED TO ATTEND OFF STATION ALCOHOLICS ANONYMOUS COMMUNITY SUPPORT MEETING. ACCOMPANIED BY A STAFF MEMBER AND THIRTEEN OTHER INDIVIDUALS PATIENT. PATIENT TRAVELED BY BUS TO LONG BEACH, MS.WHERE PATIENT PARTICIPATED IN AN OPEN DISCUSSION MEETING.

/es/ ROBERT DAVIDSON
ADDICTION THERAPIST,NCAC II 10/20/94 16:47

MEDICAL RECORD — PROGRESS NOTES

DATE 10/20/94

GROUP THERAPY

1530 Pt has Completed two (2) weeks in the Pro and has been elected president of the Community. It is this writer opion that holding that office has become a distraction for Pt and has been advised that she might Consider what impact that has on her recovery. In group this week Pt Shared that she could not self-disclose because of a former Group Member was Seen by Several Members of Ft. Community Seeking to Cast from the Commissary. Since Pt is the only female in the Community she has been getting A lot of attention and has not focused on the goals and objectives that Caused her to Seek tx. I've given her an Assignment from the Book "Codependency No More" and she will make a presentation this upComing week. So far As her Marital relationship she has not resolved her husband decision About divorcing her. — [illegible]

(Continue on reverse side)

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

VE, CAYLE A
46 A STREET
OXI

25
047
MS 39530

REGISTER NO.

WARD NO.

[redacted]

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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509-111

10/21/94 14:50

GENERAL NOTE
MET WITH MS. DOVE AGAIN THIS AFTERNOON. IT WAS AS IF SHE WAS A DIFFERENT PERSON. SHE NEEDED NO PRODDING AT ALL TO TALK. SHE DISCUSSED DIFFERENT AREAS OF HER LIFE AS WELL AS HER FEELINGS ABOUT HER MOTHER AND HER FATHER. VET STATED "YOU MADE ME THINK ABOUT A LOT OF THINGS." SHE ALSO STARTED WORKING ON HER PROBLEM SOLVING WORKBOOK, WHICH SHE STATES WAS HARD FOR HER TO DO. AT THIS POINT IN TIME SHE APPEARS TO BE GAINING SOME INSIGHT INTO PROBLEMS IN HER LIFE THAT WAS A DIRECT RESULT FROM HER DRINKING, AND DRINKING BEHAVIOR. WILL CONTINUE TO MEET WITH VET ON A DAILY BASIS ONE-ON-ONE.

/es/ NANCY L. MACMILLAN,NCACII
ADDICTION THERAPIST 10/21/94 14:56

Veterans Administration

POST-COUNSELING FOR NEGATIVE HIV ANTIBODY SCREEN
(CHECK MARK INDICATES IT IS DONE)

GENERAL INFORMATION:

Date: 10/25/94 Time: 0615

_____ Date of last possible exposure

THE FOLLOWING HAS BEEN DISCUSSED OR EXPLAINED TO THE VETERAN:

- ✓ The meaning of a negative HIV Antibody Test:
  - a. A negative test does not mean there is immunity from contracting the virus
  - b. A retest in 2nd months due to recent possible exposure is recommended
- ✓ The modes of transmission were reviewed
- ✓ Behavioral methods of risk reduction were reinforced
- ✓ The validity of a negative test result based on last possible exposure
- ✓ The need for retesting if future possible exposure occurs was stressed

VETERAN:

- ✓ Participated in counseling and asked appropriate questions
- ✓ Was given information regarding test sites for future utilization
- ✓ Was encouraged to return to clinic with any future questions or concerns
- ✓ All veteran's questions were answered

COMMENTS:

Voiced relief

SIGNATURE AND TITLE OF PRACTITIONER: [signature] DATE 10/25/94

IMPRINT PATIENT DATA CARD

DOVE,GAYLE A
5246 A STREET
BILOXI MS 39530

[redacted]

25
047

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE
FOR SPECIALIZED DISCIPLINES

12/91

02539

10/25/94 15:42

SATP FIRST STEP GROUP
VET MET TODAY IN ROOM 103 @ 11:30 UNTIL 12:30 FOR FIRST STEP GROUP. THE MATERIALS THAT WERE DICUSSED CAME FROM "THE STEPS WE TOOK" BY THE AUTHOR JOE MCQ.THE GROUP WAS AND PARTICIPATED WELL IN THE OPEN DISCUSSION ONHOW IMPORTANT THE FIRST STEP IS IF VET IS GOING TO WORK A TWELVE STEP RECOVERY PROGRAM.

/es/ ROBERT DAVIDSON
ADDICTION THERAPIST,NCAC II 10/25/94 15:43

MEDICAL RECORD	PROGRESS NOTES
DATE	
10/24/94 0710	PATIENT EDUCATION: Pt attended AA/NA Group. Pt attended and did participate in group talk. Pt and staff talked about goals and getting along with other people. She stated her goals right now was to get a job and find a place to live now and stay on the right track. John R Lewis NA
10/27/94 1300	GROUP THERAPY Vet is in her last week of tx and appears to be anxious to get on w her life. In group this week she missed a few sessions because of other Dept. Vet says that at present her husband is TDY and will not be back until Dec. What isn't sure of if he still wants a divorce. Her plans are to live on Keesler AFB where she will live w her father. She voiced that she knows that she will have to focus on herself and act as though the divorce will be final sooner or later and be prepared mentally. It is of my opinion that she didn't risk much while in the program. I feel that she should have never accepted the Community President's Job. I feel that allowed her enough time not to take a inward look at her disease and avoided some real personal problems in her life. (Continue on reverse side) Gayle Vuturo MSW

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WARD NO.

DOVE, GAYLE A
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PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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10/28/94 09:40

PROBLEM SOLVING GROUP
MS. DOVE HANDED IN A COMPLETED WORKBOOK. THE PROBLEM SHE CHOSE TO WORK ON IS HER WAY OF BLAMING OTHER PEOPLE FOR HER PROBLEMS. SHE WROTE THAT SHE BECOMES VERY DEFENSIVE ABOUT HER DRINKING, AND SHE USES RATIONALI- SATION TO JUSTIFY IT. SHE ALSO ALLOWS OTHER PEOPLE AND EVENTS INFLUENCE HER SO WHEN SHE DOES DRINK SHE CAN JUSTIFY THE DRINKING. SHE ALSO LISTED ISOLATION AS A PROBLEM. SHE STATES SHE ISOLATES HERSELF FROM HER FAMILY AND FRIENDS AS SHE CONVINCES HERSELF THAT THEY DON'T CARE, SO WHY SHOULD SHE. THE THREE ALTERNATIVES SHE CHOSE TO CONSIDER ARE: 1. LET GO OF HER RELATIONSHIP WITH HER HUSBAND AND TRUST THAT IT IS FOR THE BEST. 2. QUIT WORRYING ABOUT WHAT SHE CAN'T CONTROL AND CONCENTRATE ON WHAT SHE CAN. AND; 3. LEARN TO ASK FOR AND ACCEPT HELP WHEN SHE NEEDS IT. HER GOAL FOR HER SELF-CONTRACT FOR CHANGING IS: BY 1 NOV 94 SHE WILL HAVE BECOME RESPONSIBLE FOR HER OWN PROBLEMS, ACTIONS AND HAPPINESS. SHE WILL HELP HERSELF REACH THIS GOAL BY POSITIVE THINKING, DEPENDING ON HER SUPPORT SYSTEM, STUDYING THE BIG BOOK, HAVE FAITH IN HER HIGHER POWER, AND DOING AND LIVING THE 12 STEPS. MS. DOVE APPEARS TO HAVE GAINED INSIGHT INTO PROBLEMS THAT WERE A DIRECT RESULT FROM HER DRINKING AND DRINKING BEHAVIOR. SHE HAS BECOME MORE OPEN FOR FEEDBACK AND HER DEFENSE SYSTEM HAS CRUMBLED.

/es/ NANCY L. MACMILLAN,NCACII
ADDICTION THERAPIST 10/28/94 09:52

/31/94 09:01 GENERAL NOTE
DISCHARGE PLANNING WITH TREATMENT TEAM - THIS WAS VET'S FIRST TREATMENT PROGRAM. SHE WAS IN A GREAT DEAL OF DENIAL WHEN ADMITTED. THE LEADER OF THE WOMEN'S GROUP STATES MS. DOVE HAS MADE PROGRESS IN THE PROGRAM.

PT. SAYS SHE WILL ATTEND A MEETING THE DAY SHE IS DISCHARGED. SHE HAS A TEMPORARY SPONSOR, AND WILL RETURN TO HER HOME WHERE SHE LIVES WITH HER FATHER. IN TREATMENT SHE SAYS SHE HAS DEALTH WITH HER FEELINGS OF SHAME AND HAS ADMITTED SHE IS AN ALCOHOLIC. 'I'M NOT ASHAMED OF IT ANYMORE.' SHE STATES SHE HAS A LOT OF WALLS TO BREAK DOWN; SHE FEARS GETTING CLOSE TO OTHERS, AND HAS ISOLATED HERSELF FROM OTHERS. SHE HAS DIFFICULTY TRUSTING PEOPLE. SHE HAS ONLY BEEN HONEST WITH HER FATHER WHO DOES NOT JUDGE HER.

WHEN ASKED HOW SHE WAS GOING TO DEAL WITH HER PENDING DIVORCE, SHE REPLIED SHE HAS ACCEPTED THE INEVITABILITY OF DIVORCE. SHE AND HER FATHER ARE LIVING IN HER HUSBAND'S HOUSE. THEY WILL LOOK FOR HOUSING RIGHT AWAY AND SHE WILL LOOK FOR A JOB, HOPEFULLY, WITH THE GOVERNMENT.

SHE WAS ENCOURAGED BY THE TEAM TO LOOK INTO COMMUNITY OFFERINGS, AND TO GET INVOLVED IN ACTIVITIES THAT SHE ENJOYS. SHE STATED SHE LIKES ARTS AND CRAFTS AND WILL LOOK INTO WHAT KEESLER HAS TO OFFER. SHE SAYS SHE NEEDS TO LEARN TO TAKE CARE OF HERSELF, AND TO LEARN MORE ABOUT HOW SHE ACTS AND RELATES TO OTHERS. SHE SAYS SHE WILL ASK FOR FEEDBACK FROM FAMILY AND PEERS IN AA.

TEAM BELIEVES SHE HAS GAINED A LOT OF INSIGHT AND UNDERSTANDING, AND IF SHE DOES WHAT SHE SAYS SHE WILL DO, SHE WILL DO WELL.

/es/ PATRICIA S. LODEN
HEAD NURSE 10/31/94 09:19

Ethel Smith, RN, MS
Rosalind B. Hunter LCSW
Peter Bunker NCSC 4.
Mike Miller, CRC, M.P.A.
John Chiu M.D

PROGRESS NOTES

DATE	
Oct. 31. 94	She gained considerable insight and seems to be motivated. A. Shirley
10-31-94 1300 Hours	Discharge Summary (Case Mgr) Mrs. Dove will be discharged on 11-1-94. She has attended all classes, lectures and films in a timely manner. This Dam Vet is in I.P. program. She has completed her after care plan identifying AA and a sponsor (temporary) support system along w her Father. She will be attending AA and working the 12 Steps. She will be dealing w her feelings of being an alcoholic and says she no longer is ashamed of being an alcoholic. Vet is planning on obtaining a Divorce from her husband and stated she had already accepted that fact. She will seek to quit worrying about things she cannot control. Vet will be returning to live w her Father on base housing (Keesler AFB) - She will be followed up in the O.P. Clinic SAVP after Care Program in Biloxi. Michael Miller Case Manager

DOVE, GAYLE A
5246 ★U.S. Government Printing Office: 1993-515-964/81316
BILOXI
C47
MS 39530

STANDARD FORM 509 BACK (Rev. 11-77)

DATE: 9/1/99 PROBLEM # 25 PROBLEM: Rehab Medicine Needs: O.T. Clinic

as manifested by: ~~Non~~ ① Impaired functional and leisure performance

② muscle spasms of neck & shoulders

GOAL: ① Improve problem-solving skills, decision-making skills, socialization and leisure skills

② Provide modalities to reduce muscle spasms/discomfort neck & shoulders

	OBJECTIVES	METHOD & FREQUENCY	STAFF RESPONSIBLE	TARGET DATES	ACHIEVEMENT DATES
①	Problem-solving skills ↑decision-making skills ↑socialization skills ↑leisure skills	Vet will attend and participate in O.T. clinic groups & tasks, 5x/week, M-F, @ 10⁰⁰-2³⁰ pm.	O.T. staff	45 days	9-9-99
②	Manage/decrease level of discomfort	H.P., U.S. & massage Q.D. initially	P.T.	45 d.	

Dove, Gayle- [redacted]

DATE: 8/31/99 PROBLEM # 2 PROBLEM: Depressed Mood

as manifested by: Patient reports of hopelessness + helplessness on admission — Pt's statements of thinking of shooting herself while living in the community before admission.

GOAL: To ↓ feelings of depression

OBJECTIVES	METHOD & FREQUENCY	STAFF RESPONSIBLE	TARGET DATES	ACHIEVEMENT DATES
Pt. to verbalize ↓ in feelings of depression	PSych meds ordered	Physician	9-15-99	9-9-99
	1:1 meetings c Primary RN	RN		
	Pt. to attend unit ~~activities~~ activities	Nursing Staff		

DOVE, GAYLE A.

[redacted]

TREATMENT PLAN

UPDATES

See PN dated: _____

Present: _____

See PN dated: _____

Present: _____

See PN dated: _____

Present: _____

See PN dated: _____

Present: _____

See PN dated: _____

Present: _____

See PN dated: _____

Present: _____

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.)*

DATE: 8/31/99

DIAGNOSES: Axis I: Bipolar Affective Type II — Advance directive exists: No___ Yes✓

Axis II: Borderline Personality Disorder

Axis III: Migraine

Axis IV: moderate to severe stressors

Axis V: Admission GAF: 35

ESTIMATED LENGTH OF STAY (or Treatment for Outpatients): _____
Please specify DATE and note if patient remains, the plan must be reviewed that date.

BARRIERS TO COMMUNICATION/LEARNING: No__ Yes__ If yes, explain_____

ASSIGNED CASE MANAGER/PRIMARY THERAPIST: Ruth Hinton RN

Patient — Social Worker: M. Ellis, OTR/L

Family/Significant Other — Psychologist

Nurse

Family Involvement: Yes__
No__ Refer to PN's dated: _____

SIGNATURE/TITLE PRACTITIONER — PRINTED NAME/INITIAL OF APPROVING PHYSICIAN — DATE

David M. Mathis, DO

Enter in space below - PATIENT IDENTIFICATION - Treating Facility Jacket No. — Date

AS3283170 952

DOVE, GAYLE A.

[redacted]

MEDICAL RECORD
OVERALL TREATMENT PLAN
[redacted]

EXISTING STOCK OF VAF 10-0043, OCT 1987, WILL BE USED.

*U.S. Government Printing Office: 1995 — 621-500/83021

VA FORM SEPT 1989 **10-0043** 031630

30-Aug-99 INITIAL NUTRITION ASSESSMENT | Comprehensive Page 1

S: Chewing Problems: Y (N)
Dysphagia: Y (N)
Appetite: + (-)
Feeding Assistance Required: Y (N)
Food Allergies: None on file none
Food Preferences: noted

Pre-Admission Diet: 2 meals
Wt. + (-) 6# in last 1 ~~months~~ wk
Nausea: (Y) N Vomiting: (Y) N
Diarrhea: (Y) N Constipation: (Y) N
or

2° Migrain Headache

O: Current Diet: REG
Adm. Dx: DEPRESSION, SUICIDIAL
Age: 42 Sex: F
Height: 5'6"
Curr. Weight: 132.6 # c clothes
Last Weight: NA
Usual Weight: 125 #
Ideal Weight: 130 ± 10%

Adm. Date: 29-Aug-99 4:36pm
Prior Assessment: Y
Frame Size: S
Amputation %:
Weight Taken:
Weight/Usual Wt: NA
Weight/IBW:

Laboratory Data

Test	Result	units	Ref. range	Date
GLUCOSE	71	MG/DL	62 - 128	30-Aug-99
UREA NITROGEN	10	MG/DL	9 - 20	30-Aug-99
CREATININE	1.0	MG/DL	.5 - 1.4	30-Aug-99
SODIUM	141	MEQ/L	137 - 145	30-Aug-99
CHOLESTEROL	122 L	MG/DL	146 - 240	20-Aug-99
ALBUMIN	2.6 L	GM/DL	3.9 - 5	30-Aug-99
MAGNESIUM	1.7	MG/DL	1.7 - 2.2	20-Aug-99
TRIGLYCERIDE	97	MG/DL	40 - 180	20-Aug-99
HGB	11.1 L	g/dl	12 - 16	30-Aug-99
HCT	33.6 L	%	37 - 47	30-Aug-99
LYMPH#	3.3	#/cmm	1.2 - 3.4	30-Aug-99

Appearance: WNWF

A: Nutrition Status
___ Normal
✓ Mildly Compromised
___ Moderately Compromised
___ Severely Compromised

Briefly explained diet
Nutrition Education to Pt.
Further Education Required: Y (N)
Food/Drug Interaction

Comments: Eating diet fair. W/in IBW range
Albumin, Chol, Hgb/Hct — V. Needs
1200 Calories + 59 gms protein daily
Diet should be adequate for Pt needs

P: Nutrition Plan
✓ Provide basic nutritional care
___ Screening data not available: Please order _____
___ Nutrition Education
___ Recommend Diet Change
___ Further Nutritional Assessment
Recommendations: Goals (1) wt stable 130 ± 10%
(2) Improve labs
F/up 2 weeks

Signature Date 8/30/99

DOVE, GAYLE A [redacted] Biloxi MS (CONS) [redacted] 1:50pm

PHYSICAL EXAM

General Appearance and Mental Status: Patient is a well developed, well nourished white female in no acute distress. She is alert and oriented to person, place, time and situation. She is oriented to the President. The patient is well groomed and speech appears to be normal.

Head: Normocephalic, atraumatic.

Eyes: Pupils equally round, reactive to light, extra ocular muscles intact.

Ears: TMs are _____ bilaterally.

Nose: No polyps are seen, no septal deviation.

Mouth: No oral lesions.

Throat: No erythema or exudate.

Neck: There is no lymphadenopathy, no goiter, no JVD.

Breasts: Deferred.

Chest: Patient has good chest wall movement with inhalation and exhalation.

Heart: Regular rate and rhythm without murmur, no S3.

Lungs: Clear to auscultation bilaterally.

Abdomen: Nondistended, nontender, soft, no palpable mass, no hepatosplenomegaly.

Genitalia: Deferred.

Rectal: Deferred.

Back: There is no scoliosis.

Skin: No rash.

Extremities: No edema bilateral lower extremities.

Lymphatics: No lymphadenopathy.

** THIS NOTE CONTINUED ON NEXT PAGE **

[redacted]

08/29/1999 20:43 ** CONTINUED FROM PREVIOUS PAGE **

Neurological: Cranial nerves II through XII are intact, motor function is 5/5 bilateral upper extremities and lower extremities. Cerebellar function is intact.

LABORATORY DATA:
Urine drug screen is positive for opiates. Urinalysis is within normal limits except for a low urine specific gravity of 1.007. On August 20, 1999 the patient had a free T4 level of .43 which is low. Also on August 20, 1999 the patient had a WBC of 17.1, hemoglobin of 9.5, hematocrit 28.4, platelet count of 439. On August 20, magnesium was 1.7, glucose 123, creatinine of .8 and BUN of 8, cholesterol 122, triglycerides 97, sodium 140, potassium 4.3, chloride 107, bicarb was 24, albumin 2.2, total bilirubin .1, AST of 65 and ALT 35. Alkaline phosphatase of 190.

DIAGNOSTIC IMPRESSION:
1. Depression with suicidal ideations.
2. Low free T4 level.
3. Normocytic anemia.

PLAN:
1. Admit to psychiatry.
2. Will continue current medical regimen for now, next will repeat free T4 level and also check a TSH. Next will check CBC since patient had a significant anemia on August 20, 1999. Next will also check electrolytes and liver panel.

This report was dictated by John Sherrod, M.D. who is a part-time employee. In order to assure timely availability of the dictated information, the unauthenticated report has been referred to the Service Chief, who has been designated as the author.

/wyh

Signed by: /es/ JOHN LIBERTO MD
PCT MEDICAL DIRECTOR 08/30/1999 07:45



NOTE DATED: 08/29/1999 20:43 HISTORY & PHYSICAL
ADMITTED: 08/29/1999 16:36 62G-1PURPLE
NAME: DOVE,GAYLE A
[redacted]
AGE: 42
SEX: FEMALE

HISTORY

CHIEF COMPLAINT: "I'm going to shoot myself with my father's rifle."

HISTORY OF PRESENT ILLNESS: Ms Dove is a 42 year old white female who presented to the Emergency Room with suicidal ideations. The patient has had two friends and her stepmother die in the past three weeks and she complains of feeling overwhelmed. She also reports having violent thoughts but these thoughts are not towards anyone in particular. The patient describes road rage. The patient denies auditory hallucinations.

ALLERGIES AND SENSITIVITIES: The patient denies any drug allergies.

FAMILY HISTORY: Patient's mother has no significant medical problems. The patient's father has peripheral vascular disease.

SOCIAL HISTORY: Patient smokes one pack per day, she does not use alcohol. The Emergency Room physician reports that the patient has been coming to the Emergency Department on a regular basis for Demerol injections for migraine headaches.

REVIEW OF SYSTEMS: HEENT - patient does have frequent migraine headaches. The patient wears glasses but has no other visual problems. Patient denies tinnitus or dysphagia. Pulmonary - patient denies dyspnea or cough. Cardiac - patient denies chest pain or palpations. GI - patient takes dulcolax for constipation. She denies melena or hematochezia. GU - patient denies dysuria or hematuria. Skin - patient denies rash. Neurological - patient gives a questionable history of seizures. Patient denies stroke in the past.

MEDICATIONS: Prozac 40 mg po q day, premarin 65 mg po q day, dulcolax 2 mg po q day, reglan 10 mg po q day, gabapentin 300 mg before meals and 600 mg at bedtime, hydroxyzine 25 mg po qid, buspar 10 mg po tid, olanzapine 5 mg po q hs, aspirin 1,000 mg po qid.

PAST MEDICAL HISTORY: PTSD secondary to sexual trauma. Depression. Migraine headaches. Rhinitis. "Pelvic adhesive disease."

PAST SURGICAL HISTORY: Patient states that she has had ganglion cyst surgery x 4, total abdominal hysterectomy and bilateral salpingooophorectomy. Patient describes pelvic surgery to remove adhesions.

** THIS NOTE CONTINUED ON NEXT PAGE **

DATE: 8/29/99 PROBLEM # 7 PROBLEM: Dngrous Risk to self

as manifested by: Verbalizes of Suicidal ideation's & plan to shoot self w rifle.

GOAL: Vet will not harm self

OBJECTIVES	METHOD & FREQUENCY	STAFF RESPONSIBLE	TARGET DATES	ACHIEVEMENT DATES
Vet will not harm self during hospital	① assess Vet's ability / Motivation to harm self q day / prn	Nsg Phm Psych S.W. M.D	9/29	9-9-99
	② 1:1 w staff to discuss feelings + Concerns q day		9/29	
	③ Explore alternative coping behaviors		9/29	
	④ Initiate Vame Policy / Procedure 334(a) ; 334(b) if appropriate		9/29	

DOVE, GAYLE A.

[redacted]

DATE:_____ PROBLEM #___ PROBLEM: _____

as manifested by: _____

_____

_____

GOAL: _____

_____

OBJECTIVES	METHOD & FREQUENCY	STAFF RESPONSIBLE	TARGET DATES	ACHIEVEMENT DATES

DATE: 8/31/99 PROBLEM # 19 PROBLEM: FOLLOW-UP CARE AFTER DISCHARGE

as manifested by: CONTINUED NEED FOR TX AFTER DISCHARGE

GOAL: TO ARRANGE AN OUTPATIENT TREATMENT PROGRAM UPON D/SCHARGE

OBJECTIVES	METHOD & FREQUENCY	STAFF RESPONSIBLE	TARGET DATES	ACHIEVEMENT DATES
PT. WILL PARTICIPATE IN DISCHARGE PLAN	1:1 C SOCIAL WORKER PRN	SW	9/30/99	9-9-99
PT. WILL DISCUSS DISCHARGE PLAN C STAFF	DISCHARGE PLANNING GROUP 5° 1x A WK.	SW, RN PSY	9/30/99	

DOVE, GAYLE A. [redacted]

DATE:_____ PROBLEM #___ PROBLEM: _____

as manifested by: _____

_____

_____

GOAL: _____

_____

OBJECTIVES	METHOD & FREQUENCY	STAFF RESPONSIBLE	TARGET DATES	ACHIEVEMENT DATES

DATE: 8/2019 PROBLEM # 21 PROBLEM: Nutritional

as manifested by: Decreased labs
Recent wt loss
N.V.D.C

GOAL: Improve labs
wt stable 130±10%
No problems c N.V.D.C

OBJECTIVES	METHOD & FREQUENCY	STAFF RESPONSIBLE	TARGET DATES	ACHIEVEMENT DATES
Pt will eat >90% of meals	① Pt given diet's meals daily ② Hs snack daily ③ Labs ordered ④ Monthly wt	RD Nsg MD	9/2019	9-9-99

DOVE, GAYLE A
[redacted]

DATE:_____ PROBLEM #___ PROBLEM: _____

as manifested by: _____

_____

_____

GOAL: _____

_____

OBJECTIVES	METHOD & FREQUENCY	STAFF RESPONSIBLE	TARGET DATES	ACHIEVEMENT DATES

CONTINUE ON BACK WHEN NECESSARY

Department of Veterans Affairs

5' 6" **MEDICAL CERTIFICATE** Dam scale 4/10

1. DATE	2. TIME	3. AGE	4. SEX	5. ON ARRIVAL PATIENT WAS	6. PHONE NUMBER	7. HOMELESS
8/29/99	1555 AM/PM	42	M F	AMBULATORY STRETCHER WHEELCHAIR	2813961919	YES NO

8A. ALLERGIES	8B. WEIGHT	8C. TEMPERATURE	8D. PULSE	8E. RESPIRATION	8F. B/P	8G. DUE TO INJURY
NKA	128	99	85	20	134/75	NO YES

9. CURRENT MEDICATIONS admitted on: erythromycin opth; Diphenhydramine ACh, Hydroxyzine, Estazolam, metoclopramide, gabapentin, fluoxetine, naltrexone, Nitrofurantoin, Bisacodyl

10. TRIAGE 2 days "feels like she is falling apart". Thoughts of suicide- took rifle + bullet at + thought of using it. conflict at home between father and ex-Boyfriend - Valium. Tearful, ambivalent.

11. SIGNATURE David S Hadlup MD

12. HISTORY AND PHYSICAL

"I'm going to shot myself with father's rifle"
also requests shot for PTA. Advised she is Diso
meds prescribed - no rx given. Recently left
C.P. (signed out of STTP) doesn't want SA Pt
BP-134/75
Lungs-clear
Abd-soft
Ext-intact
Ext-frontal emph PTA.
Discuss @ mod. C.P. & will accept for tentative SA

13. DIAGNOSTIC IMPRESSIONS Depression w/ suicidal ideation, PTA.

14. PLAN

UA drug screen - Pos Amph & Opiates 8-20-99

Robert H. Pierce, DO
AS3285170-725

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

7. PATIENT INSTRUCTIONS

08 29 99 Admit to C.P. 620-1
pupils

DOVE, GAYLE A
[redacted]

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.

TIME	VITAL SIGNS				TIME	ORDERS	MD SIGNATURE	TIME	NURSE SIGNATURE	EFFECTIVENESS
	TEMP	PULSE	RESP	B/P						

CONTINUATION FROM FRONT / PROGRESS NOTE

STUDIES REQUESTED	RESULTS

INTERDISCIPLINARY BIOPSYCHOSOCIAL ASSESSMENT

SECTION I: Clinical Data Base — NURSING

Date: 8/29/99 Time: 1704 Unit: 626-1

Court Commitment: Yes (No) Admission Dx: Depression c Suicidal ideation

VS: T 99.5 P 80 R 20 B/P 107/58 Rt. Lt. (Sit/Lying) _____ Ht. 6'0" Wt. 128/65 - Pain Sc

DOB: 8/15/57 Race: Caucasian Sex: M (F) Age: 42

PATIENT RIGHTS

Advance Directive: (Yes) No Type: Living Will Location: Biloxi VAMC

Organ Donor: (Yes) No Tissue Donor: (Yes) No Information/Pamphlet Provided: (Yes) No Refused

Presenting Problem/Precipitating Event (Describe Problems/Symptoms "As Evidenced By")

Depressed over deaths of people close to her / Boy friend broke off relationship.

Patient's Perception of Problems & Needs:

Readjust medications

Current Risks (Clarify all affirmative responses):

History of Assaultive Ideation? Yes (No) Assaults? Yes (No)

History of Suicidal or Self Harm Thoughts? (Yes) No Suicide Attempts? (Yes) No How many 2 Dates: 1974 + 1992

Describe: took pills + and drank alcohol

Current Plan? Yes (No) If yes, describe: N/A

Self Harm Attempts? (Yes) No How many 2 Dates: Same as above

Describe: (Same as above)

Problems as Evidenced by: #1 Ongoing risk to self; verbalizing feelings of helplessness / hopelessness

#2 Depressed mood; Verbalizing depressed mood.

Current Medications (Prescription or Nonprescription) Gabapentin Prozac 40mg q day; Estrogen .625mg q day; Bisacodyl 10mg; Reglan 10mg qid, Hydroxyzine 25mg qid; Aldoxyprine 5mg po qHS, Bumex 10mg bid

Drug Sensitivities, Allergies and Allergic Reactions - Describe: NKA.

Food Allergies or Intolerancies - Describe: NKA

#16

Patient and Family Educational Needs: Knowledge deficit: Rx

Problems as Evidenced by: Lack of insight into disease process and current medications

SIGNATURE AND TITLE OF PRACTITIONER: RN BSN Chr NNC — DATE: 8/29/99

IMPRINT PATIENT DATA CARD (Name, Address and Social Security Number)

DOVE, GAYLE A [redacted]

MEDICAL RECORD

SUPPLEMENT TO PROGRESS NOTE FOR SPECIALIZED DISCIPLINES-VERTICAL

[redacted]

VA FORM SEP 1992 10-0114J(R)

*U.S. Government Printing Office: 1997 — 515-805/83728

SECTION II: Nursing Assessment — NURSING

Activities of Daily Living/Level of Functioning

Assess patient's level of functioning, check appropriate box

Items	Self Care	Assist	Total Care	Comments
Bathing	✓			
Dressing	✓			
Mobility	✓			
Oral hygiene	✓			
Toileting	✓			
Foot Care	✓			
Eating	✓			
Other	✓			

Need for Functional Assessment by Occupational Therapist? Yes (No)

Problems as Evidenced by: ✓

NUTRITIONAL ASSESSMENT:

Problems	Yes	No	Unk	Comments
1. Chewing Problems		✓		
2. Swallowing Problems		✓		
3. Nausea	✓			gets sick to stomach when she gets migraines
4. Vomiting		✓		

General Status: ☐ Obese ☑ Well-Nourished ☐ Emaciated ☐ Dehydrated Appetite: ☑ Good ☐ Fair ☐ Poor

Teeth: ☑ Own ☐ Partial Own ☐ Partial Dent ☐ Full Dent

Recent Change in Weight: (Yes) No If yes, **describe:** Lost 8lbs in 2-3wks

Special Diet: Yes (No) If yes, **type:**

Is the patient NPO greater than 3 days? Yes (No)

Is there an unintentional weight loss of 5 pounds or more during the previous week? Yes (No)

Is there an unintentional weight loss of 10 pounds during the previous month? Yes (No)

Is the patient admitted on tube feedings or IV nutritional support? Yes (No)

Is the patient on non formulary nutritional support (tube feedings, parenteral products)? Yes (No)

Nutritional Screening by Clinical Dietitian Needed: (Yes) No Consulted: Yes (No)

Problems as Evidence by: #21 Nutritional problem

ELIMINATION

Bowel Problems: (Yes) No **Describe:** Either constipated or diarrhea

Last BM today days ago Regular bowel habits q day or longer

Problems Urinating: Yes (No) ☐ Starting ☐ Burning ☐ Frequency ☐ Change in color ☐ Incont ☐ Drain/Dischg

Urinate at night (Yes) No How many times? 2X Comments: N/A

Respiratory/Cardiovascular System

Breathing Problems: Yes (No) [ ] Dyspnea [ ] SOB at rest [ ] SOB on exertion [ ] Parox Noc Dyspnea [ ] Orthopnea

Comments: N/A

Cough: (Yes) No If yes: ☑ Prod ☐ NonProd ☐ Trach Hx of TB: Yes (No) Hx of Positive PPD Yes (No)

Any Heart Problems: Yes (No) With activity/at rest Yes (No) Pacemaker Yes (No)

Describe: N/A

Pain Severity (least) 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (most) — N/A

Any other pain? Yes No **Describe:** N/A

What relieves it? N/A

History of High Blood Pressure: Yes (No) How treated: N/A

Musculoskeletal/Neurological

Have you ever lost consciousness: (Yes) No If yes, **describe:** when on inderal wet experienced Seizures

History of: ☐ Amputation ☑ Seizures ☐ Atrophy ☐ Paralysis ☐ Contractures ☐ Spasticity ☐ Other

Assistive Devices Used for Mobility? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Artificial Limb — N/A

Describe: N/A

Cognitive-Sensory/Psychosocial

Changes in Sensory Perception? Yes (No) ☐ Sight ☐ Hearing ☐ Taste ☐ Touch ☐ Smell

If yes, **describe:** N/A

Hallucinations? Yes (No) If yes, **describe:** N/A

Delusions? Yes (No) If yes, **describe:** N/A

Special Need or Cultural Practices? Yes (No) If yes, **describe:** N/A

Speech: ☑ Clear ☐ Slurred ☐ Aphasic ☐ Disorganized

Problems as Evidenced by:

#9 Refused health maintenance - Hx of chronic migrain headaches

Sleep/Rest:

Problems with sleep? (Yes) No If yes, **describe:** difficulty remaining asleep.

Describe usual patterns of sleep frequently awakens from nightmares

Sexual/Reproductive System:

Has your health affected your sexual relationships? (Yes) No If yes, **describe:** Does not have sexual relationship Due to PTSD.

Do you perform routine self breast/testicular exams? (Yes) No

Have you ever been at risk for STD or AIDS? (Yes) No **explain:** Unprotected sex w/ persons that have had hepatitis C.

IMPRINT PATIENT DATA CARD (Name, Address and Social Security Number)

DOVE, GAYLE A.

[redacted]

PREDISPOSITION FOR FALLING

Postural hypotension	☑ Yes ☐ No	Neurological problems	☐ Yes ☑ No	65 or older	☐ Yes ☑ No
Unsteady on feet	☑ Yes ☐ No	Current Meds (Seds)	☐ Yes ☑ No	Dizziness/fainting	☐ Yes ☑ No
Confused/disoriented	☐ Yes ☑ No	Poor bladder control	☐ Yes ☑ No	Unsafe footware	☐ Yes ☑ No
Patient falls previously	☐ Yes ☑ No	Poor eyesight	☐ Yes ☑ No	Narcotics,seds,diuretics	☐ Yes ☑ No

Comments: _____

BRADEN RISK SCALE

SCORE	1	2	3	4	TOTAL
Sensory Perception	Unresponsive	Responds to Pain	Responds to Verbal	No Problem	4
Moisture	Always Wet	Often Wet	Rarely Wet	Dry	4
Activity	Bedfast	Chairfast	Slightly Limited	Walks Frequently	4
Mobility	Completely	Limited	Slightly Limited	No Limits	4
Nutrition	Very Poor	Inadequate <1/2	Adequate >1/2	Excellent	4
Friction	Max assist to move to Bed	Minimum assist to move to bed	No Problem	No Problem	4
				TOTAL	Ø

If Score is <16 Initiate Nursing Procedure 311 and Notify Enterostomal Therapy Nurse

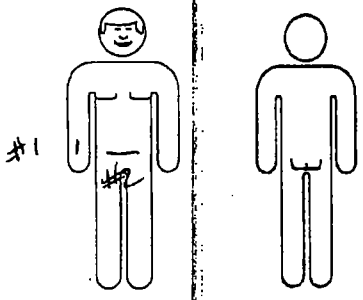
Method of Notification: _____

Comments: _____

SKIN PROBLEMS: ☐ N/A ☐ Itching ☐ Discoloration ☐ Dryness ☐ Sores ☐ Hair-Scalp

Problems as Evidenced by: _____

Identify Location of Skin Breaks/Lesions/Scars/Tattoos:



LOCATION	APPEARANCE	SIZE	STAGE	DRAINAGE
1. (R) wrist	healed	3"	—	Ø
2. lower ABD	healed	10"	—	Ø
3.				

Patient and Family Educational Needs: _____

Problems as Evidenced by: N/A

SECTION III: Substance Abuse Screening — NURSING

History of Substance Use/Abuse: (Yes) No Drug of Choice (Alcohol, Cocaine, etc.) ETOH

Tobacco: (Yes) No History of Substance Abuse Withdrawal/DT's/Seizures: Yes (No)

LAST DRINK OCT 1, 1994

Describe N/A

History of Treatment for Addiction: S.A.R.T.P. x 3 days August 1999

Evidence of Current Intoxication or withdrawal: none

Need for Further Counseling Concerning Substance Abuse? Yes (No)

Problems as Evidenced by: N/A

SECTION IV: Initial Screening for Women — NURSING

Number of normal pregnancies: 1 Number of miscarriages: Ø Describe: _____

Date of last mammogram: 4/99 Date of last pap smear: 1996 Osteoporosis: Yes (No)

Birth control? Yes (No) Present N/A Past 1975 - 1980

Patient and Family Educational Needs: N/A

Problems as Evidenced by: N/A

Nursing Admission Assessment Summary Notes:

#2 8/29/99 @ 1818 ~ Vet presents as poorly groomed, appropriately dressed, ø apparent odors present, affect blunted mood depressed, sustained eye contact, ate approx 50% of evening meal, states that she is depressed and has had suicidal ideations + plan of shooting herself with fathers rifle. Vet denies suicidal ideation/plan @ this time. Oriented vet to unit, Provided copy of Advanced Directives and Patient Rights. Vet verbalizes understanding. will continue to monitor / Reassessed — WS RN, BSN

Orientation To Unit

Unit 020-1	Bed ✓	Unit Guidelines ✓	Rights/Responsibilities ✓
ID Armband: ✓	TV/Telephone: ✓	Meal Hours: ✓	Visiting Hours: ✓
Smoking Policy: ✓	Bathroom: ✓	Nurse/Emergency Call: ✓	Safety: ✓
Bed Controls: ✓	Bed in Low Position: ✓	Slippers: ✓	Contact Lens: N/A
Valuables: Money ✓	Jewelry: ✓	Glasses: N/A	
Hearing Aid: N/A	W/C: N/A		

Clothes: Vet to home family member da laundry

Disposition of Valuables: Home/Agent Cashier/ Patient/Safe

Comments: _____

Signature: _____ Date: _____ Time: _____

RN SIGNATURE: WS RN, BSN **DATE:** 8/29/99 **TIME:** 1830

IMPRINT PATIENT DATA CARD (Name, Address and Social Security Number)

DOVE, GAYLE A.

[redacted]

5

SECTION V: Psychological Issues — PSYCHOLOGY

History of Previous Hospitalizations: yes / Biloxi

History of Prior Outpatient Mental Health Care: yes - ~~Biloxi~~ Gulfport women's clinic in VA.

Does Mental Status Suggest that Patient is Capable of Engaging in Psychotherapy? (Yes) No

History of Alleged or Suspected Abuse or Neglect: (Yes) No Physical/Sexual/Military Trauma (Yes) No

Describe: physical, sexual, emotional abuse in the past

Psycho Social History: Describe Martial Status; Family Constellation and History; Significant Social Issue:
lives w/ her father in Biloxi, has a fiance in Biloxi

Social Support Resources: father, boyfriend

Need for further psychological testing: (Yes) No

Patient and Family Educational Needs: community resources identified, VA women's clinic in Gulf

Problems as Evidenced by: #4 coping ineffective in behavior but not denied

SECTION VI: Religious/Spiritual Profile — PSYCHOLOGY

Belief in God/Higher Power: Yes No Religious/Spiritual Preference: upon request

Name and Address of Church, Synagogue.Temple: Protestant, no denom.

Problems as Evidenced by: WNL

SECTION VII: Recreation Screening — PSYCHOLOGY

Does patient have difficulty making leisure choices? (Yes) No

Any "yes" answer constitutes a referral.

Does patient have problems interacting socially? (Yes) No

E-Mail referral to Recreation Therapy: (Yes) No

Does patient have any problems pursing recreational hobbies in the community? Yes (No)

Problems as Evidenced by: patient, chart

SIGNATURE: Jon McLaurin, BSW DATE: 8-31-99 TIME: 9:04 AM

SECTION VIII: Psycho Social Review — SOCIAL WORK

NOK Name: Ray Dove Relationship: Father

Address: same as patient Daniel Mississippi

Home Phone: same Work Phone: UK 392-6589

Patient Current Address: 4457 Pratt Ford Rd Lot 195 Phone: 228 396-1917

Describe Living Arrangement Prior to this Admission: Biloxi, MS 39531

lives w/ father in Biloxi

Place of Birth: Wichita Falls, TX Marital Status: Divorced

Sexual Orientation: Heterosexual

Legal Problems: Yes / No Describe: none given by pt / denies

Patient and Family Educational Needs: #10 Community Resources

Problems as Evidenced by: denies ETOH, drug use.

SECTION IX: Military Profile — SOCIAL WORK

Military History: Branch USAF DOS: 9/4/75 to 9/16/87

Combat Non Combat Date/Type Discharge: Honorable

WWII/ KOR/VN/P.Gulf: Pt AVN POW — Service Connected (% and Reason) SC 90% at $24,468.00 per yr. PTSD 70%

Patient and Family Educational Needs: Relations H-A-3040

Problems as Evidenced by: PTSD 70%, Impaired of Hearing & Visual 50%, Rhinitis 0% Psoriasis, Skin 0%

IMPRINT PATIENT DATA CARD (Name, Address and Social Security Number)

DOVE, GAYLE A

[redacted]

SECTION X: Sources of Income, Employment History and Education — SOCIAL WORK

Education History: High School

History of Employment: Denies

Sources of Income:

Employer: not employed Salary: -0-

List Amounts and Sources of Unearned Income:

Social Security: not listed NSC Pension: — Aid and Attendance —

Other: 90% SC for 2234.50 per mo.

Name, Address and Phone Number of Guardian or Payee: At pt request to handle funds

Where are Checks Mailed? not sent

Patient and Family Needs: community Medicaid #10;

Problems as Evidenced by: several significant stressors have died recently father & boyfriend making her more relevant them

SECTION XI: Initial Assessment of Discharge Plans/Needs: — SOCIAL WORK

(1) Pt to return to [illegible] home
(2) F/up at VA Med Clinic
(3) taking medicine, patient

SIGNATURE: [signature], RSW **DATE:** 8/31/99 **TIME:** 9:04 AM

Interdisciplinary Patient and Family Teaching Record

TEACHING ASSESSMENT

Learns best: ☐ Seeing ☐ Hearing ☑ Doing **Able to read:** ☑ Yes ☐ No **Education level:** (please specify) 14 yrs

Barriers/limitations: ☐ Physical ☐ Visual ☐ Cognitive ☐ Auditory ☐ Language ☐ Emotional ☐ Other ☑ None

Describe barriers/limitations and note plan to adapt patient teaching: N/A

Age specific needs: none

Cultural/religious practices affect the patient's healthcare? ☑ No ☐ Yes **If yes, describe and document plan to respect patient's need:** N/A

Knowledge of Diagnosis:

1. Understands disease/condition ☑ Yes ☐ No Explain: N/A
2. Understands treatment ☑ Yes ☐ No Explain: N/A
3. Able to demonstrate use of prescribed equipment ☐ Yes ☐ No ☑ N/A Explain: N/A

Knowledge of Medications:

1. Knows when to take ☑ Yes ☐ No Explain: N/A
2. Knows reason medication is prescribed. ☑ Yes ☐ No Explain: N/A

Support System to Assist with Learning: **Circle those applicable:**

Spouse (Family member) Friend No support N/A

Name of person included in teaching: Father

Signature/Title W. Sligh RNC Date 8/29/99

CODES

A. Topic/Teaching
1. Disease/Condition
2. Medications
3. Diet/Nutrition
4. Food/Drug Interaction
5. Treatment/Procedure
6. Equipment Use/Safety
7. Hygiene
8. Rehab/ADLs
9. Health Promotion/ Prevention
10. Community Resources
11. Follow-up Instructions
12. Other

B. Learner
P = Patient
S = Spouse
F = Family member
O = Other

C. Teaching Method
E = Explanation
H = Handouts * (list title)
D = Demonstrate
AV = Audiovisual * (list title)
G = Group Presentation
R = Reinforced

D. Evaluation
1. Verbalizes/Discusses essential concepts
2. Asks appropriate questions
3. Demonstrates
4. Demonstrates with assistance
5. Requires reinforcement
6. No evidence of understanding
7. Refused teaching

For each entry, include appropriate codes from above. *** Asterisk items require additional information in the "Comments" section on the back.**

Date	Time	A. Topic/ Teaching Need(s)	Readiness to learn Y/N *	B. Learner	Instructions/ Discussion	C. Teaching Method	D. Eval.	Initial
8/29/99	1800	12	Y	P	Advanced directives	E,H	1,2	WSL 8/29/99
8/29/99	1800	12	Y	P	Unit orientation	E,H	1,2	WSL 8/29/99
8/29/99	1800	12	Y	P	Pt rights	E,H	1,2	WSL 8/29/99

SIGNATURE AND CORRECT PRACTITIONER DATE

IMPRINT PATIENT DATA CARD (Name, Address and Social Security Number)

DOVE, GAYLE A
[redacted]

MEDICAL RECORD

SUPPLEMENT TO PROGRESS NOTE FOR SPECIALIZED DISCIPLINES-VERTICAL

[redacted]

VA FORM SEP 1992 **10-0114J(R)**

*U.S. Government Printing Office: 1997 — 515-805/63728

Date	Time	A. Topic/ Teaching Need(s)	Readiness to learn Y/N*	B. Learner	Instructions/Discussion	C. Teaching Method	D. Eval.	Initials
8/30/99	2:30pm	3	Y	P	Diet	E	1,2	[illegible]
8/30/99	1030	1,2	Y	P	Medication Regimen, Diagnosis Teaching	E	1,2	CB
8/31/99	1000	6,7	Y	P	Handwashing, Hygiene	E	1,2	CB
8/31/99	1000	5,6,12	Y	P	HIV, AIDS counseling	E,H	1,2	CB
9/1/99	1330	8	Y	P	O.T. group purpose & tasks	E,D	4	MRE
9/2/99	1400	6,7,8,9	Y	P	Safety - fire drills, smoking AIDS, Health prevention-footwear	E,D	1	Rev
9/2/99	1400	7	Y	P	Orientation group/Health Prevn.	E,G	1	Rev
9/9/99	1100	10	Y	P	community	E	1	SL

Date	Time	Initials	Comments

Initials	Signature/Title
WSR	[illegible] RN
[illegible]	[illegible]
SL	[illegible]

Initials	Signature/Title
MRE	Marguerite R. Ellis, OTR/L

Referrals for further education or support (circle P, S, F, and/or O)

P, S, F, O referred to _____ Date _____ Initials _____

P, S, F, O referred to _____ Date _____ Initials _____

P, S, F, O referred to _____ Date _____ Initials _____

Referrals for further education or support (circle P, S, F, and/or O)

P, S, F, O referred to _____ Date _____ Initials _____

P, S, F, O referred to _____ Date _____ Initials _____

P, S, F, O referred to _____ Date _____ Initials _____

MEDICAL RECORD	PROGRESS NOTES

DATE

8/29/99
1955

Brief Admit Note

Pt. is a 42 yo WF c hx of Depression, PTSD, Migraine HA's who presented to E.D. today c c/o "I'm going to shoot myself c my Father's Rifle." She states that 2 friends and her Stepmother died in the past 3 weeks, and she c/o "feeling overwhelmed."

Exam - See Dictated H&P

Lab - See Dictated H&P

Impression: ① Depression c Suicidal Ideations

Plan: ① Admit

② Cont. Current Medical Regimen for Now

See Dictated H&P.

J. Sherrod
John Sherrod M.D.

8/29/99 2200 (LATE ENTRY) #0 Nursing Admit Note ET: See Nursing Biopsychosocial Assessment. - W.S. Khan

(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]

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	

MEDICAL RECORD	PROGRESS NOTES
DATE	HIV/AIDS RISK FACTOR SCREEN

8/30/98
1200

NOTE: THIS FORM SHOULD BE FILLED OUT FOR ALL HIV PRE-TEST COUNSELING PATIENTS, ALL NEWLY DIAGNOSED HIV PATIENTS, AND ALL HIV+ PATIENTS WHO ARE BEING SEEN AT ANY VA MEDICAL CENTER FOR THE FIRST TIME.

Please circle "YES" or "No" for each of the following:

1. Last HIV test done prior to any test done in our system. Include any documented results and clinic location. DATE: 3 months ago
   RESULTS: neg
   CLINIC LOCATION: At Biloxi, VAMC — (YES) NO

2. Any risk factors
   ~~If yes, please explain:~~ high risk partner — (YES) NO

3. Any unprotected sex with women or men
   DATE OF LAST OCCURENCE: 1 year ago — (YES) NO

4. Had a sexual partner that was HIV+ or at risk of AIDS — (YES) NO

5. ~~Had sex with anyone for money or drugs~~ — YES (NO)

6. ~~Given a sexual partner money or drugs for sex~~ — YES (NO)

7. WOMEN ONLY - Ever had a male sexual partner that has had sex with another male even once — YES (NO)

8. Ever had a sexual partner who has taken money or drugs for sex from anyone, even once — (YES) NO

9. Taken/shot up illegal drugs or steroids by needle, even once — (YES) NO

10. Taken clotting factor concentrates for a bleeding disorder, such as hemophilia — YES (NO)

11. Received a blood transfusion
    If yes, WHEN: 1987 — (YES) NO

12. Worked in a health care facility or lab — YES (NO)

13. Ever been stuck with a contaminated needle — YES (NO)

14. Ever been splashed with body fluid — (YES) NO

(Continue on reverse side)

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

1 19 99

Carl Breedlove

8/30/98

DOVE, GAYLE A

[redacted]

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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509-111

[redacted]

PROGRESS NOTES

DATE	

Veterans Administration

PRE-TEST COUNSELING FOR HIV ANTIBODY SCREEN
(CHECK MARK INDICATES IT IS DONE)

GENERAL INFORMATION:

Date: Time:

History of High Risk Behavior: 1 year asd

1 year — Date of last possible exposure

3 months asd — Date of previous HIV antibody screen

Additional concerns: _____

✓ There is a Doctor's order for HIV testing

THE FOLLOWING WAS REVIEWED VERBALLY WITH THE VETERAN:

✓ Modes of transmission of HIV
✓ Methods of protection against HIV transmission
✓ The meaning, sensitivity, and specificity of the HIV tests
✓ The consent form for HIV testing was signed freely by veteran and witnessed by counselor
✓ The HIV test result is considered confidential and will be part of the medical record
✓ The disclosure policy to public health authorities
✓ Policy regarding disclosure to spouse/sexual partner(s)
✓ Potential social ramifications of a positive test result
✓ Policy on non-discrimination in health care services for patients with HIV infection
✓ Services available within the Department of Veteran Affairs
✓ Results will be given only in person - must return to clinic for post-couseling

VETERAN:

✓ Participated in counseling and asked appropriate questions
✓ Was given literature on AIDS
✓ Appears to comprehend the significance, meaning, and ramifications of HIV screening
✓ Desires HIV antibody screening
✓ Refuses HIV antibody screen at this time
✓ Was instructed to report for blood drawing
✓ Will return to clinic or be seen on the unit for post counseling when results are available
✓ All of veteran's questions WERE answered

COMMENTS:

SIGNATURE AND TITLE OF PRACTITIONER: Carol Brasseur — DATE: 8/30/85

IMPRINT PATIENT DATA CARD

1 1999

DOVE, GAYLE A [redacted]

[redacted]

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE
FOR SPECIALIZED DISCIPLINES

VA FORM 10-0114j
SEP 1988

025390

MEDICAL RECORD	PROGRESS NOTES
DATE	
8-30-99	#2 Vet has slept fairly well through night. Up
0530	to desk x 1 requesting PRN medication. When
	told only PRN medication she has is Maalox but
	that she will be receiving 3 aspirin & routine
	AM meds, quietly accepts this and returned to
	room. No agitation or ↑ anxiety noted. - Pat Terrell RN
8/30/99	Discussed medication regimen - R. Herren, PA.
1030	A'd ASA, Dulcolax to PRN. — also
#9	Visteril. Will start Ampicillin QD.
	Margo A. Donaldson, RN, MSN, CS, FNP
8/30/99	#2 Vet. counseled on HIV/AIDS. She participated
1200	and asked appropriate questions. Consent to test
	was signed & faxed to Linda Reynolds —
	Carol Brasseler

(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]

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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509-111

PROGRESS NOTES

DATE	

STANDARD FORM 509 BACK (Rev. 11-77)

*U.S.GPO:1997-426-359

NOTE DATED: 08/30/1999 09:43 CHAPLAINCY ASSESSMENT (BLANK)
ADMITTED: 08/29/1999 16:36 62G-1PURPLE
SAW VETERAN FOR PASTORAL ASSESSMENT.

#0

BACKGROUND:

VETERAN STATES THAT SHE AND HER BOYFRIEND BROKE UP YESTERDAY. VETERAN STATES "THERE IS KIND OF A WAR GOING ON BETWEEN MY FATHER AND MY BOYFRIEND...THEY BOTH ARE TELLING ME I HAVE TO MAKE A CHOICE...WE'VE ARGUED EVERYDAY ABOUT MY FATHER...YESTERDAY IT KIND OF CAME TO A HEAD...HE SAID THAT'S IT...IT'S OVER WITH". VETERAN STATES THAT SHE DOES NOT FEEL THAT SHE AND HER BOYFRIEND WILL BE ABLE TO RECONCILE, AND IS HAVING DIFFICULTY DEALING WITH THE BREAKUP. VETERAN ALSO REPORTS THE RECENT DEATH OF 2 FRIENDS AND A STEP-MOTHER, AND STATES THAT SHE IS HAVING DIFFICULTY DEALING WITH THESE DEATHS. VETERAN ADMITS TO SUICIDAL IDEATIONS YESTERDAY. VETERAN DENIES CURRENT SUICIDAL IDEATIONS. NOTIFIED NURSE C.C. VETERAN ADDITIONALLY REPORTS ONGOING PTSD RELATED DIFFICULTIES FROM A RAPE THAT OCCURRED AT VETERAN'S AGE OF "29". ALSO STATES THAT SHE PUT UP A SON FOR ADOPTION AT HER AGE OF 16, THAT SHE SUBSEQUENTLY FOUND OUT SHE COULD NOT HAVE ANY OTHER CHILDREN, AND STATES THAT NOT HAVING SEEN HER SON BOTHERS VETERAN. VETERAN ADMITS TO A HISTORY OF THE ABUSIVE USE OF ALCOHOL, BUT DENIES ANY USE OF ALCOHOL IN THE LAST 5 YEARS. VETERAN REPORTS GOOD RELATIONSHIP WITH ONE BROTHER. CLAIMS HER FATHER'S RECENT DIFFICULTIES WITH HER BOYFRIEND HAVE STRAINED HER RELATIONSHIP WITH HER FATHER. ALSO REPORTS STRAINED RELATIONSHIPS WITH HER MOTHER, AND OTHER BROTHER. CLAIMS ONE SIGNIFICANT FRIENDSHIP THROUGH HER INVOLVEMENT IN AA. STATES "DOING SERVICE WORK WITH AA...VOLUNTEER WORK FOR THE VFW" GIVES HER LIFE MEANING.

PASTORAL ASSESSMENT:

VETERAN BELIEVES IN GOD. STATES "I TALK TO GOD" DAILY. DENIES CHURCH ATTENDANCE SINCE SHE WAS A TEENAGER. STATES SHE BELIEVES HER RELATIONSHIP WITH GOD IS "STRONGER" SINCE SHE HAS EXPERIENCED RECENT DIFFICULTIES BECAUSE "I THINK HE'S THE ONLY ONE THAT'S HELPING ME THROUGH THIS". STATES THAT HER PERSONAL FAITH IN GOD HAS HELPED HER DEAL WITH TWO OF THE THREE RECENT DEATHS THAT SHE HAS HAD TO DEAL WITH, THAT HER PERSONAL FAITH IN GOD HAS HELPED HER DEAL WITH HER TRAUMATIC MEMORIES, AND THAT HER PERSONAL FAITH IN GOD IMPACTS HER SUICIDALITY. DISCUSSED THE SPIRITUAL COMPONENT OF RECOVERY WITH VETERAN VETERAN STATES SHE HAS EXPERIENCED GOD'S HELP IN DEALING WITH HER ALCOHOL USE IN THE PAST AND FEELS AS THOUGH SHE WILL NEED GOD'S HELP IN THE FUTURE IN DEALING WITH HER ALCOHOL USE. OFFERED PRAYER WITH VETERAN. RECOMMEND FUTURE PASTORAL CONVERSATION CONTINUE TO ADDRESS VETERAN'S FEELINGS CONCERNING THE RECENT BREAKUP OF A SIGNIFICANT FEMALE-MALE RELATIONSHIP , THE RECENT DEATHS OF TWO FRIENDS AND HER STEP-MOTHER, HER TRAUMTAIC MEMORIES, HER FEELINGS CONCERNING NOT HAVING SEEN HER SON, THE RECENT STRAIN IN HER RELATIONSHIP WITH HER FATHER, STRAINED RELATIONSHIPS WITH HER MOTHER AND HER BROTHER, THE SPIRITUAL COMPONENT OF RECOVERY, POSSIBLE SUICIDALITY, AND CONTINUE TO ASSIST VETERAN IN USING HER PERSONAL FAITH IN GOD TO ADDRESS STRESSORS.

Signed by: /es/ HARRY D NICHOLAS JR
CHAPLAIN 08/30/1999 10:19

DOVE,GAYLE A [redacted]

MEDICAL RECORD	PROGRESS NOTES

PO DATE

8-30-99 1900 #2 Very quiet on Ward This P.M. Color, Pale. Record states Normocytic Anemia. Labs PO were done This A.M. Pt being cold. Temp 98.4. Sad facial expression, Voice soft, tone, low. Will Monitor Closely. Paula Overland Tech

8-30-99 2100 #2 Pt. asked for (3) Aspirin @1600 for Headache & recieved same. Pt recieved Vistaril 50mg PO for anxiety. Pt also asked for Aspirin 975mg PO @ 2005 for Headache again. She states the Aspirin Helps (See 8-31-99 0900 Nsg Note)

8/31/99 0900 TREATMENT PLAN UPDATE And Psych Admit Note

42 year old Caucasian female admitted on 8/29 with C/O "Another friend died then my stepmother died after I left last time, then it has been a lot of war over me between my father and my boyfriend". Reports ideation suicidal thoughts with plan to shoot herself with her father's rifle. Drug screen positive for opiates — patient reports her Father gave her Tylenol #3 for her migraine See H&P

MSE: Dressed in hospital gown. with her clothes underneath. Speech: logical and coherent Affect: Blunted Mood: Dysphoric Denies current suicidal or homicidal thoughts. Denies auditory or visual hallucinations. Reservation of thought disorder

(Continue on reverse side)

See Index

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

DOVE, GAYLE A.

[redacted]

REGISTER NO. | WARD NO.

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509-111

David M. Mathis, DO
AS3285170-952

PROGRESS NOTES

DATE

Treatment Team Update and Psych Admit Note

MSE continued

No evidence of cognitive deficits

Dx: Axis I Bipolar Disorder Type II

Axis II Borderline Personality Disorder.

Axis III Migraine

Axis IV Moderate to severe stressors

Axis V Admission. GAF = 35

Plan: Continue Gabapentin, Zyprexa, Buspar.

Continue Depakote and Reglan for migraine.

Work in groups. Recommend continuing individual therapy at Women Clinic after Discharge.

David M. Mathis, D.O.
AS3285170-952

Clerkship Student
Independent

8/31/99 1400 Pt very cooperative, escorted by staff to pt. Expect to collect (Rx) clothes. Interacting w/ peers & staff. Denies any complaints of pain & discomfort. Admitted to 5 Psych. [signature]

8-31-99 2100 Pt. cooperative, ate well. Denied complaints. Interacts well w/ peers & staff. [signature]

8-31-99 2100 Veteran received Tylenol 650mg PO for HA #8 & good effect [signature]

STANDARD FORM 509 BACK (Rev. 11-77)

*U.S.GPO:1997-426-359

NOTE DATED: 09/01/1999 10:48 PURPLE/GENERAL NOTE
ADMITTED: 08/29/1999 16:36 62G-1PURPLE

#0 VET. PARTICIPATED IN MORNING CALL GROUP THIS AM. ORIENTATION WARD RULES WERE DISCUSSED. PT. ASKED APPROAPRIATE QUESTIONS AND ACTIVELY PARTICIPATED DURING GROUP ACTIVITY. VERBALIZED UNDERSTANDING OF MATERIALS COVERED.

Signed by: /es/ CARL P. BRESSLER
RN 09/01/1999 10:48

NOTE DATED: 09/01/1999 15:34 OCCUPATIONAL THERAPY - INITIAL NOTE
ADMITTED: 08/29/1999 18:36 62G-1PURPLE
#25 - REHAB MEDICINE NEEDS

___ ON-WARD _X_ OFF-WARD, CLINIC

INITIAL ACKNOWLEDGEMENT OF NOTE

DATE OF ORDER: 8/31/99
INITIAL VISIT DATE: 9/1/99

ORDER FOR O.T. CLINIC WAS RECEIVED AND VET ATTENDED SESSION ON THIS DATE. AFFECT WAS FLAT. MOOD WAS DEPRESSED. GROOMING WAS FAIR. SPEECH WAS INTELLIGIBLE AND GOAL-ORIENTED. VET SELECTED AND ATTENDED TO TASK WITH MINIMAL ASSISTANCE FROM STAFF. INTERACTION WITH STAFF AND PEERS WAS SPONTANEOUS AND WITHIN SOCIAL NORMS.

VET IDENTIFIED GOAL TO IMPROVE PROBLEM SOLVING SKILLS WITH FAMILIAR AND NEW PROBLEMS. COMPREHENSIVE EVALUATION WITH GOALS TO FOLLOW IN TWO WEEKS - 9/15/99.

PLAN: VET WILL ATTEND O.T. CLINIC GROUPS AND TASKS, 5X/WEEK, MONDAY THROUGH FRIDAY, AT 1:00-2:30PM.

Signed by: /es/ MARQUIS R ELLIS
OCCUPATIONAL THERAPIST, REGISTERED
09/01/1999 15:37

NOTE DATED: 09/02/1999 18:08 PURPLE/GENERAL NOTE
ADMITTED: 08/29/1999 16:36 62G-1PURPLE
SUBJECT: PROBLEM # 0 - DAILY PROGRESS NOTE

1900 HOURS - PATIENT HAS HAD QUIET HOURS THIS AFTERNOON. NO UNUSUAL INCIDENTS TO REPORT. PATIENT HAS TID PRIVILEGES AND DID GO OUT IMMEDIATELY FOLLOWING THE SUPPER MEAL. SHE IS IN GOOD SPIRITS AND CLAIMS TO HAVE NO ADDITIONAL EPISODES OF SEEING "FLASHING LIGHTS" SINCE HER RETURN FROM THE EYE DOCTOR.

Signed by: /es/ CHARLES R CRUTHIRDS
587226933 09/02/1999 18:52

NOTE DATED: 09/03/1999 19:04 PURPLE/GENERAL NOTE
ADMITTED: 08/29/1999 16:36 626-1PURPLE
SUBJECT: PROBLEM # 0 - DAILY PROGRESS NOTE

1900 HOURS - PATIENT HAS TID GROUNDS PRIVILEGES AND DID GO OUTSIDE ON EVENING GROUNDS. PATIENT HAS HAD GOOD HOURS AND ATE 100% OF HER EVENING MEAL. AFTER GROUNDS PATIENT RETURNED TO UNIT TOOK HER EVENING BATH, AND TOOK HER EVENING MEDICATIONS'. AN UNEVENTFUL EVENING.

Signed by: /es/ CHARLES R CRUTHIRDS
587226933 09/03/1999 19:05

MEDICAL RECORD	PROGRESS NOTES
DATE	
9-01-99	#0 pt slept most of night, voided
0500	no complaints, no distress noted.
	Joe H-Vonnegna
9/1/99	#25 O.T. note. Orders for O.T. clinic received and pt
1350	attended session this date. Refer to "O.T. Initial
	Note" dated 9/1/99.
	M. Ellis, OTR/L
9-1-99	#2-1800-Veteran in pleasant mood
	and has visitor(male) at this time
	See Mar
9-1-99	-0-2100-Vistaril 25mg given per request
	to good effect See Mar
9-02-99	#0 pt slept most of night,
0500	offers no complaints, no distress
	noted. Joe H-Vonnegna
9/2/99	#2 Pt approached nurses station & reported that
1100	she had a condition called "lattice" & was
	seeing lights flashing in her (R) eye. N.P.
	notified - Carol Brenneke, R
9/2/99	As above - has a floating lattice - type
1115	now C/o flashing type lights Rt eye
#9	
	Margo A. Donaldson RN

(Continue on reverse side)

Margo A. Donaldson, RN, MSN, CS, FNP

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]

PROGRESS NOTES
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PROGRESS NOTES

DATE	
9-2-99 1330	#0 - Pt returned from eye clinic in B/L Ptx NO Acute distress. To have F/U App in 6 mo. Pt states MD told her "It was probably the onset of migrane headache." Will continue to monitor & support. —— Ruth Hinton
9/4/99 2/30 1	#2. Depression-decreasing-active on unit - Enjoyed Bingo this pm. UAD noted - #7 denies S/I ideations - Eating / hydrating well - continue to monitor and support —— Celeen Fourshee RN
9-5-99 1100	# 7 - Vet alert & cooperative this TSO Goes out on grounds & returns on time. Denies feelings of suicidal ideations. #2 - Continues to have quiet moments but usually interacts c pers & staff. Pleasant. Flat affect which is improving c day. Vet smiles & speaks frequently to staff. Denies feelings of hopelessness or helplessness. #9 - Vet talked on phone & had verbal altercation on phone. P phone call vet requested medication for migrain headache which was on PRN scale #10. Vistaril 25 for restlessness
9-5-99 1300	#0 - Vet states medication effective. Also states she thinks her medication which is prescribed for her is effective & helpful and also the migrane medication —— Ruth Hinton

STANDARD FORM 509 BACK (Rev. 11-77)

*U.S.GPO:1997-426-359

Done

[redacted]

PATIENT ALERT AND COOPERATIVE AT THIS TIME. PATIENT WENT OUT ON GROUNDS AND RETURNED ON TIME. WHILE SITTING AT DESK STAFF HEARD VET HAVE A VERBAL ALTERCATION ON THE PHONE. PATIENT STATES SHE DID NOT WANT TO TALK ABOUT THE INCIDENCE AT THIS TIME. AT THIS TIME PATIENT REQUESTED ASA AND REGLAN FOR HEADACHE AT THIS TIME.

Signed by: /es/ RUTH ANNA HINTON
RN 09/04/1999 14:31

Weekly
RN ~~MONTHLY~~ SUMMARY

Date: 9/5/99

ADL's: ✓ Independent __ With Assistance __ With Prompts
MANNER OF DRESS: ✓ Appropriate __ Inappropriate
NUTRITIONAL STATUS: ✓ Meals on ward __ Meals in dining room
✓ Feeds self __ Needs assistance with feeding
WEIGHT: ____ __ Loss __ Gain __ Stable
APPETITE: ✓ Good __ Fair __ Poor
INCONTINENCE: __ Bowel __ Bladder __ Frequent __ Infrequent Vistaril 25mg
SLEEP: Approximate hours nightly: 8 __ With sleep med ✓ Without sleep med
__ Awakens frequently __ Awakens seldom
AMBULATION: ✓ Independent __ With assistance __ Nonambulatory
AMBULATORY AIDS: __ Cane __ Crutches __ Wheelchair __ Other
SAFETY DEVICES: (none) (NA)
HIGH RISK FOR FALLS: ✓ No __ Yes
Explain — Intervention: —

PATIENT EDUCATION:
MEDICATION INSTRUCTION: ✓ Med time ✓ Purpose ✓ Side effects
METHOD: ✓ Oral __ Written __ Video
✓ Can recall information
__ Can recall some information, but needs more instruction
__ Can recall no information and needs more instruction
__ Unable to comprehend Reason: —

PATIENT EDUCATION:
HEALTH MAINTENANCE: (List subject) Migraine,
METHOD: ✓ Oral __ Written __ Video ✓ Demonstration __ Return Demo
✓ Can recall information
__ Can recall some information, but needs more instruction
__ Can recall no information and needs more instruction
__ Unable to comprehend Reason: —

PARTICIPATION IN STRUCTURED ACTIVITIES:
Ward groups: (List groups and identify progress toward goals by documenting beside each group.) Medication group — effective & informative
unit Orientation group — very informative

PM&RS, OT, KT, PT, Recreation:
List assignments and progress toward goals by each group.

8/31/99 OT group — state she enjoys OT

1 1999

IMPRINT PATIENT DATA CARD (Name, Address and Social Security Number)
Dover Gayle 6014
[redacted]

MEDICAL RECORD

NURSING DOCUMENTATION

[redacted]

VA FORM 10-0096(R)
SEP 1992

☆ U.S. GOVERNMENT PRINTING OFFICE: 1993 343-134/7432

MENTAL STATUS:

ORIENTATION/MEMORY: ✓ Time ✓ Place ✓ Person ✓ Situation
Confused: __ At intervals __ All the time
RECALL: Recent events: ✓ Good __ Fair __ Poor
Remote events: ✓ Good __ Fair __ Poor

MOTOR STATUS: Posture Erect
Gait steady
Other mannerisms _____

CONTENT OF THOUGHT:
Hallucination: ✓ No __ Yes List type: _____
Delusion: ✓ No __ Yes List type: _____
Suicidal/homicidal: __ No ✓ Yes List type: Suicidal ideations
Complaints of depression: __ No ✓ Yes Symptoms: flat affect

BEHAVIOR: ✓ Friendly __ Aloof __ Afraid __ Angry __ Irritable
__ Exhibitionistic __ Demanding __ Negative __ Manipulative
__ Withdrawn __ Overactive __ Other: _____

SPEECH: __ Loud __ Soft ✓ Normal
__ Overtalkative __ Undertalkative
__ Coherent __ Incoherent
__ Blocking __ Circumstantial __ Preseveration
__ Flight of ideas __ Mute __ Other: _____

PHYSICAL ILLNESS: __ No ✓ Yes Type: (Lattice) eye condition

DISCHARGE PLAN: ✓ 0-3 months __ 3-6 months __ 6-12 months
Disposition: _____
Other comments and progress toward goals on treatment plan:
met = m not met = nm partially met = pm

pm Problem #2 Depressed mood: Verbalizing feelings of hopelessness & helplessness. (Vet goes to OT & interacts c peers)

M Problem #7 Injury Risk to self: Verbalized suicidal ideations. Denies feelings of ~~suicidal~~ suicide this week

PM Problem #9 Altered Health Maintenance: Chronic migrane HA (Pt recieves medication for HA frequently

FAMILY INVOLVEMENT: ✓ Yes 1 No
1 Visits __ Calls __ Attends treatment meeting __ Other: _____

NOTE DATED: 09/06/1999 11:36 PURPLE/GENERAL NOTE
ADMITTED: 08/29/1999 16:36 620-1PURPLE

PROBLEM(S) #2, #7

VET CALM AND COOPERATIVE THIS TOD. NO C/O DEPRESSED MOOD. MOOD IS EUTONIC AND AFFECT IS CONSISTANT WITH MOOD. VET READILY INTERACTS WITH STAFF AND PEERS. VET SAYS THAT SHE WANTS TO TALK TO HER PRIMARY M.D. TO DISCUSS POSSIBLE DISCHARGE PLANS. VET RECEIVED A PRN DOSE OF MAALOX THIS TOD FOR C/O DYSPEPSIA. VET STATES THAT SHE DOESN'T WISH TO RECEIVE ANY PHONE CALLS OR VISITS FROM ESTRANGED BOY FRIEND. STATES THAT HER MEDICINE IS WORKING WELL TO CONTROL FEELINGS OF DEPRESSION. VET HAS TID OFF WARD PRIVILEGES AND HAS BEEN COMPLIANT WITH AM AND AFTERNOON TIMES.

ENCOURAGED VET TO DISCUSS FEELINGS AND CONCERNS OPENLY. PROVIDED VET WITH (+) REINFORCEMENT FOR CURRENT BEHAVIORAL TREND. WILL TELL PRIMARY M.D. OF VET'S REQUEST TO SEE HIM. WILL CONTINUE TO MONITOR AND REDIRECT PRN.

Signed by: /es/ W.S.KEBER
REGISTERED NURSE 09/06/1999 15:17

[redacted]

MEDICAL RECORD	PROGRESS NOTES
DATE	
9-5-99	#2 Cooperative, ate well, voided. No
2200	complaints. Interacts well w staff & peers. Geo[illegible]
9/6/99	#2 Awake, Alert, oriented & cooperative. Rec'd
1730	Tour. Smiling & friendly. No Visitors 25mpw PO for restlessness requested & received @ 1600. Enjoyed Visitors @ 1630. No S/S of depression noted. Eating & hydrating well. Cont to Monitor
	Paula Overland Sw
9-6-99	#0 Pt rested quietly through the night. No
0500	signs of distress noted — Tonya D Coleman NA
9-4-99	#0 Pt very pleasant, cooperative. Interact
1340	c staff and peers. Tolerated meals
	& difficulty. D Bailey LPN
9/7/99	Hx dyspepsia. Hx L/e bleeding & GERD.
1530	Reviewed Op. report by Dr Arabo 12/98.
#9	Currently taking Multidose of ASA & Maalox.
	Will d/c ASA, start Zantac & Multivit Tab.
	Discussed c length c Mrs. Dove —
	Will continue to monitor
	Margo Donaldson FNP
	Margo A. Donaldson, RN, MSN, CS, FNP

(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]

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	
9/8/99 0450	#1 Vet. awake, A&O at nurse station for meds, ambulated back to room. Martha Williams
9-8-99	#1-1000 - Veteran requested Vistaril 25mg po for anxiety. Is smiling while requesting medication RL Susan Marsee
9/8/99 1600 #9	Feels that she is ready for discharge. Will be discharged in AM Margo J Marshall RN
9/8/99 2330	#2 Depression resolved. Veteran showing appropriate interaction c peers - more cheerful, smiling, joking c staff. #7 - Denies any suicidal intention - feels ready for discharge - will be discharged on 9/9/99 - Pillum Marshall RN
9/09/99 0500	#0 pt slept all night, had no complaints, no distress noted. Jan H. Jones RN

Veterans Administration

NURSING DISCHARGE PROGRESS NOTE

1. Discharge living arrangements: 4457 Popps Ferry Rd Lot 195 Biloxi, MS. 39532 [redacted]
2. Accompanied by: self
3. Ambulation: self
4. TPR: 99.3 70 -20 BP: 120/73
5. General condition (including resolved and unresolved nursing diagnosis):

#2 Depressed Mood - resolved
#7 Impaired Role Performance Resolved #21 Nutritional - resolved
#16 Knowledge Deficit - resolved #25 Rehab - resolved
#19 Follow up after Discharge - resolved
#9 Altered Health Maintenance - resolved

6. Nursing care needed following discharge (including Nursing Care Referral):

Follow up in mental hygiene clinic
9-22-99 @ 1pm

7. Patient/family education, instructions, medications, follow-up and assessment of understanding:

meds given and explained to pt who verbalized understanding

1300

SIGNATURE AND TITLE OF PRACTITIONER: Susan Massey RN C — DATE/TIME: 9-9-99

IMPRINT PATIENT DATA CARD

DOVE, GAYLE A.
[redacted]

[redacted]

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE
FOR SPECIALIZED DISCIPLINES

VA FORM 10-0114j
SEP 1988

026398

VAMC: Biloxi, MS (520/6) (522)

VA FORM: 10-7170a
Effective Date:

DOVE,GAYLE A Ward: 62G-1PUBLIC

[redacted]

Allergies: _____
ADR: _____

Next scheduled clinic visit is on 09/09/99 at PHYSICAL THERAPY-GULFPORT

DIETARY INSTRUCTIONS: (Check One)
X NO RESTRICTIONS __ RESTRICTIONS (Specify) _____

PHYSICAL ACTIVITY LIMITATIONS: (Check One)
X NO RESTRICTIONS __ RESTRICTIONS (Specify) _____

Follow up in dental hygiene clinic 9-20-99 @ 1pm

SPECIAL INSTRUCTIONS: (List print information, handouts, or other instructions pertinent to patient's condition) _____

DIAGNOSES: _____

RVC
Susan Merry 9-9-99 1300
Nurse's Signature Date AND Time

Margo A. Donaldson, RN, MSN, CS, FNP
Margo A Donaldson NP 1600. 9/8/99.
Physician's Signature Date AND Time

>>>> I HAVE RECEIVED AND UNDERSTAND <<<<
>>>> MY DISCHARGE INSTRUCTIONS <<<<

Gayle A. Dove 9-9-99
Patient's Signature Date AND Time

DOVE,GAYLE A 515-64-6074 08/13/1937

VA FORM: 10-7978M
Effective Date:

Instructions to the physician:

A. A prescription blank (VA FORM 10-2577F) must be used for:
   1. all controlled substances
   2. any medications marked as 'nonrenewable'
   3. any new medications in addition to those entered on this form.

B. If a medication is not to be continued, mark 'TAKE NO ACTION".

C. To continue a medication, you MUST:
   1. enter directions, quantity, and refills
   2. sign the order, enter your DEA number, and enter the date AND time.

DOVE,GAYLE A Ward: 62G-1PURPLE
PID: [redacted] Room-Bed: 138-31 Ht(cm): 167.64 (08/29/1999)
DOB: 06/15/1957 (42) Team: * NF * Wt(kg): 59.23 (09/05/1999)
Sex: FEMALE Admitted: 08/29/1999
Dx: DEPRESSION,SUICIDIAL
Allergies: _____
ADR: _____

___ AUTHORIZED ABSENCE <96 HOURS ___ AUTHORIZED ABSENCE >96 HOURS
NUMBER OF DAYS: ____ (NO REFILLS allowed on AA/TA85 meds)

___ REGULAR DISCHARGE ___ OPT NSC ___ SC

SC Percent: 90%
Disabilities:

POST-TRAUMATIC STRESS DISORDER	70% - SERVICE CONNECTED
REMOVAL OF UTERUS AND OVARIES	50% - SERVICE CONNECTED
MIGRAINE HEADACHES	30% - SERVICE CONNECTED
RHINITIS	0% - SERVICE CONNECTED
NEOPLASM, BENIGN, SKIN	0% - SERVICE CONNECTED

Next scheduled clinic visit is on 09/09/99 at PHYSICAL THERAPY-GULFPORT

No.	Medication	Schedule Type	Cost per Dose
1	ACETAMINOPHEN 325MG O/D Inpt Dose: 650MG PO Q6H PRN Special Instructions: PAIN/FEVER	PRN	0.016

X TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: _____

Qty: ____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Physician's Signature DEA # Date AND Time

PATIENT CONTINUED ON NEXT PAGE...

VA FORM: 10-7979H
DOVE,DAYLE A [redacted]

No.	Medication	Schedule Type	Cost per Dose
2	ALOH/MGOH/SIMTH XTRA STRENGTH LIQ Inpt Dose: 15CC PO Q4HRS PRN Special Instructions: FOR INDIGESTION	FILL on REQUEST	0.451

X TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: _____

Qty: ____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Physician's Signature | DEA # | Date AND Time

3	BISACODYL 5MG EC U/D Inpt Dose: 5 TO 10 MG PO QD PRN Special Instructions: 1-2 TABS	PRN	0.04

X TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: _____

Qty: ____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Physician's Signature | DEA # | Date AND Time

4	BUSPIRONE HCL 10MG TAB Inpt Dose: 10MG PO TID	CONTINUOUS	0.341

___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: _____

Qty: 90 Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Margo A. Donaldson, RN, MSN, CS, FNP

Margo A. Donaldson, RN, MSN, CS, FNP — 9/8/99

Physician's Signature | DEA # | Date AND Time

5	DOCUSATE CA 240MG U/D Inpt Dose: 240MG PO QD	CONTINUOUS	0.043

1600

___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: as above - for constipation

Qty: ____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Margo A. Donaldson, RN, MSN, CS, FNP

Margo A. Donaldson, RN, MSN, CS, FNP — 9/8/99 — 1600.

Physician's Signature | DEA # | Date AND Time

PATIENT CONTINUED ON NEXT PAGE...

VA FORM: 10-7978M
DOVE,GAYLE A [redacted]

No.	Medication	Schedule Type	Cost per Dose
6	ESTROGENS CONJUGATED 0.625MG U/D Inpt Dose: 0.625MG PO QD	CONTINUOUS	0.252

X TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: _____

Qty: ____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Physician's Signature | DEA # | Date AND Time

7 FLUOXETINE HCL 20MG U/D — CONTINUOUS — 2.65
Inpt Dose: 40MG PO QD
Special Instructions: DOSE IS (2) 20MG CAPS

___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: as above

Qty: 60 Refills: (0) 1 2 3 4 5 6 7 8 9 10 11

Margo A Donaldson FNP 9/8/99-1600
Physician's Signature | DEA # | Date AND Time

Margo A. Donaldson, RN, MSN, CS, FNP

8 GABAPENTIN 300MG U/D — CONTINUOUS — 0.675
Inpt Dose: 300MG PO AC
Special Instructions: GIVE BEFORE MEALS

___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: take TID - before meals

Qty: 90 Refills: (0) 1 2 3 4 5 6 7 8 9 10 11

Margo A Donaldson FNP 9/8/99-1600
Physician's Signature | DEA # | Date AND Time

Margo A. Donaldson, RN, MSN, CS, FNP

9 GABAPENTIN 300MG U/D — CONTINUOUS — 1.37
Inpt Dose: 600MG PO QHS

___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: as above.

Qty: 60 Refills: (0) 1 2 3 4 5 6 7 8 9 10 11

Margo A Donaldson FNP 9/8/99-1600.
Physician's Signature | DEA # | Date AND Time

Margo A. Donaldson, RN, MSN, CS, FNP

PATIENT CONTINUED ON NEXT PAGE...

VA FORM: 10-7575M
DOVE,DAYLE A [redacted]

No.	Medication	Schedule Type	Cost per Dose
10	HYDROXYZINE HCL 25MG U/D Inpt Dose: 25MG PO Q6H PRN Special Instructions: RESTLESSNESS/AGITATION	PRN	0.033

X TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: _____

Qty: ____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Physician's Signature | DEA # | Date AND Time

11	METOCLOPRAMIDE HCL 10MG U/D Inpt Dose: 10MG PO QID PRN Special Instructions: GIVE WITH TYLENOL	PRN	0.034

X TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: _____

Qty: ____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Physician's Signature | DEA # | Date AND Time

12	MULTIVITAMIN U/D Inpt Dose: ONE TAB PO QD	CONTINUOUS	0.038

X TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: _____

Qty: ____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Physician's Signature | DEA # | Date AND Time

13	OLANZAPINE 5MG U/D Inpt Dose: 5MG PO QHS	CONTINUOUS	3.306

___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: as above

Qty: 30 Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Margo A. Donaldson RN, MSN, CS, FNP 4/8/94-1605
Physician's Signature | DEA # | Date AND Time

Margo A. Donaldson, RN, MSN, CS, FNP

PATIENT CONTINUED ON NEXT PAGE...

VAMC: Biloxi, MS (COMS) (520)

VA FORM: 10-7978M
DOVE,GAYLE A [redacted]

No.	Medication	Schedule Type	Cost per Dose
14	RANITIDINE HCL 150MG TAB Inpt Dose: 150MG PO BID	CONTINUOUS	0.032

__ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: for stomach

Qty: 60 Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Margo Donaldson FNP — 9/8/99-1600

Physician's Signature — DEA # — Date AND Time

Margo A. Donaldson, RN, MSN, CS, FNP

OTHER MEDICATIONS:

15 Medication: Estrace 1.0 mg

Outpatient Directions: 1/2 tab PO QD

Qty: 15 Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Margo Donaldson FNP — 9/8/99 1600

Physician's Signature — DEA # — Date AND Time

Margo A. Donaldson, RN, MSN, CS, FNP

16 Medication: _____

Outpatient Directions: _____

Qty: ____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Physician's Signature — DEA # — Date AND Time

17 Medication: _____

Outpatient Directions: _____

Qty: ____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Physician's Signature — DEA # — Date AND Time

18 Medication: _____

Outpatient Directions: _____

Qty: ____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Physician's Signature — DEA # — Date AND Time

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
Physical Therapy	Cobb	9/2/99

REASON FOR REQUEST (Complaints and findings)

42 y/o w f. c neck discomfort - Muscle spasms neck + shoulders

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	ROUTINE / TODAY
Mathis Jgne		BEDSIDE / ON CALL	72 HOURS / EMERGENCY

Problem # 25 CONSULTATION REPORT

Pt. previously known to P.T. seen for initial treatment, this date. Electronic note to follow.

(Continued on reverse side)

SIGNATURE AND TITLE	DATE
H. Boudreaux Supv PTC 9:18.99	9.3.99

IDENTIFICATION NO.	ORGANIZATION	REGISTER NO	WARD NO
DOVE, GAYLE A [redacted]			SC

CONSULTATION SHEET
STANDARD FORM 513 (Rev. 9-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
513-108

Dove, Gayle [redacted]

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
8-29-99 1600		Admit to G.P.		NKA,
		Dx Depression & suicidal ideation x plan.		
		(2) Transfer via PA police attendant		
		(3) Further orders mod G.P.		
		Robert H. Pierce, DO AS3286170-725		
		Natl w.s Illness 8/29/99 @ 1709		John Sherrod M
8/29/99 1930		Admission Orders Continued		
		(1) Condition - Stable		WS
		(2) Vitals per Routine		WS
		(3) Allergies - NKDA		WS
		(4) Diet - Regular		WS
		(5) Meds - Prozac, 40mg po q d		WS
		Premacin, .625mg po q d		WS
		Dulcolax, 10mg po q d		WS
		John Sherrod M.D.		

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. DATE

[redacted] Natl: W S Illness 8/29/99 @ 2

MEDICAL RECORD
DOCTOR'S ORDERS

- CTP -
240 / 8-30-99 @ 0225 A

VA FORM DEC 1995 10-1158

EXISTING STOCK OF VA FORM 10-1156, OCT. 197 WILL BE USED.

Exception to Standard Form 5
Approved by OI

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
8/29/99 1940	/	Meds Cont.		
		Reglan, 10mg po QID	✓	WSL
		Gabapentin, 300mg po ac and 600mg po hs		WSL
		Hydroxyzine, 25mg po QID		WSL
		Buspar, 10mg po TID		WSL
		Olanzapine, 5mg po q4s		WSL
		Asprin, ~~650~~ 975 mg po QID		WSL
		Maalox, 15cc po q 4° prn indigestion		WSL
				J. Sherrod John Sherrod M.D.

Noted: W.S.I.C.U. RNC 8/29/99 @2030

-CTP -

24° 8-30-99 @ 0228 PT

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. DATE

DOVE, GAYLE A.

[redacted]

MEDICAL RECORD
DOCTOR'S ORDERS

VA FORM DEC 1995 **10-1158**

EXISTING STOCK OF VA FORM 10-1158, OCT. 1978 WILL BE USED.

Exception to Standard Form 5
Approved by O.

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
8/29/99 2030		① CBC, ~~Chem 7~~, ~~Liver Panel~~, Complete Metabolic Profile (Lipids)		
		② TSH, Free T4 Index		
		③ Ferritin Level, B12 Level, Folate, All labs to be drawn in a.m.		#39118 WSC
				J. Stroud
				John Stroud M.D.
		Notified: WS Clinic 8/29/99 @ 2049		
		— ETP —		
		24°V 8-30-99 @ 0228 A		
8/30/99 0950		A ASA 975 to QID PRN Headache x 7 days then re-evaluate	√ one	
		A Vistaril 50 to 25 mg PO q 6° PRN restlessness / agitation	√ one	
		Inderal 240 mg PO QD	√ one	
	A	Dilantin 5N 10 mg PO QD PRN Convulsion	√ one	
		Robinul PRN Atropine	√ one	
		Robert Flint Ashley	Margo A. Donaldson RN, MSN, CS, FNP	

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. DATE

DOVE, GAYLE A.

[redacted]

Margo A. Donaldson RN, MSN, CS, FNP

MEDICAL RECORD
DOCTOR'S ORDERS

8/30/99 @ 0945 — Clell Cutt RN

24°V 8/31/99 @ 0300 Pt noted

VA FORM DEC 1995 10-1158

EXISTING STOCK OF VA FORM 10-1158, OCT 1975 WILL BE USED.

Exception to Standard Form 5
Approved by OM

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
8/31/99 0900		Please change Reglan to 10 mg po qid for headache		TWS
		David M. Mathis, D.O. AS3285170-952		
		Mated: W.S.Clem RNC 8/31/99 @ 1115		
8/31/99 1105		Clarify above order - to be given c Asst	√	TWS
		Margo A. Donaldson, RN, MSN, CS, FNP		FNP
		Mated: W.S.Clem RNC 8/31/99 @ 1115		
		-CTP-		
8/31/99. 1500.		OT Consult.		
		Margo A. Donaldson, RN, MSN, CS, FNP		FNP
		Dep 8/31/99 @ 310 624 1/gn		
		Mated: W.S.Clem RNC 8/31/99 @ 1530		
		24°V 9-1-99 @ 0100 RH		

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. DATE

DOVE, GAYLE A.

[redacted]

MEDICAL RECORD
DOCTOR'S ORDERS

VA FORM DEC 1995 10-1158

EXISTING STOCK OF VA FORM 10-1158, OCT.1978 WILL BE USED.

Exception to Standard Form !
Approved by O

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
9/1/99 1010		2 hours grounds bid DC pm Bed rest. David M. Mathis, D.O. AS3285170-952 D mmathis noted: 9/1/99 @ 11[00] – called Patt RN 11 9/2/99 0200	√ cm √ cm	
9/2/99 0830		Full grounds Physical therapy referral. David M. Mathis, D.O. AS3285170-952 Change to General Intensity D mmathis	√ cs √ cs √ cs	
		Up 9/2/99 @ 0950 bid/pc Noted Carl Breeden 9/2/99 @ 1000		
9/2/99 1115.		Optical Consult – please see today – "Lotrisone" Rx eye Margaret Donaldson, RN, MSN, CS, FNP	– gs	
		Patt Hinton RN 9/2/99 @ 1130		
		11 9/3/99 0300		
		11 9/4/99 0200		
		24 √ 9/5/99 @ 0335	cs	

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. DATE

DOVE, GAYLE A.

[redacted]

MEDICAL RECORD
DOCTOR'S ORDERS

VA FORM DEC 1995 **10-1158**

EXISTING STOCK OF VA FORM 10-1158, OCT. 1978 WILL BE USED.

Exception to Standard Form 5
Approved by OI

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
		24° ✓ 9/6/99 @ 0124 CB		
		24° ✓ 9-7-99 @ 0030 RH		
9/7/99 0940		D/C grounds David M. Mathis, D.O. AS3285170 952		
		noted: 9/7/99 @ 0940 - [illegible] RN		
9/7/99 1100		U GI - Continued symptomatic tx/comfort R/O ulcer disease Margo A. Donaldson, RN, MSN, CS, FNP		
		@ 9/7/99 @ 1110 624 [illegible]		
		noted: 9/7/99 @ 1130 - [illegible] RN		
9/7/99 1530		Zantac 150 mg PO BID	√ CB	
		Slup @ HOS 7 IV 2 pillows	√ CB	
		d/c ASA Margo A. Donaldson, RN, MSN, CS, FNP	√ CB	
		Tylenol 650 mg PO q 4° PRN pain/fever	√ CB	
		d/c caffeine free diet Margo A. Donaldson, RN, MSN, CS, FNP	√ CB	
		low fat		

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. DATE

LOVE, GAYLE A
[redacted]

Noted Carl P Brearley RN 9/7/99 @ 1630

MEDICAL RECORD
DOCTOR'S ORDERS
24° ✓ 9-8-99 @ 0110 RH

VA FORM 10-1158 DEC 1995

EXISTING STOCK OF VA FORM 10-1158, OCT. 1978 WILL BE USED.

Exception to Standard Form 5
Approved by OI

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
9/7/99 1545		Multi vit buccal PO QD. Regular Ho Insulin TYL Margo A. Donaldson, RN, MSN, CS, FNP		FNP
		Δ Tyl to ≥ 6° PRN		
		cc Noted Care Breeder R 9/7/99 1638		
		24 hr 9-8-99 @ 0900 RH		
9/8/99 0905		2° Grounds TID Margo A. Donaldson, RN, MSN, CS, FNP		FNP
		Noted: WSIC on RNC 9/8/99 @ 0900		
9/8/99 1555		Estrace 0.5 mg PO QD d/c Premarin Discharge on 9/9/99 F/u MHC in 1-2 wks. Keep all other scheduled appt. Dr Mathis Co-sign + dictate Margo A. Donaldson, RN, MSN, CS, FNP		FNP
E-Mail to Chief				9-20-99 @ 1pm & noted &

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - DATE AND TIME

LOVE, GAYLE A
[redacted]
AS3285170-952

David M. Mathis, D.O.
9/9/99 0800

Margo A. Donaldson, RN, MSN, CS, FNP
C&P 9/9/99 0900

MEDICAL RECORD
DOCTOR'S ORDERS

VA FORM DEC 1995 10-1158

EXISTING STOCK OF VA FORM 10-1158, OCT. 1978 WILL BE USED.

Name: DOVE,GAYLE A
PID: [redacted] (42)
Sex: FEMALE Dx: DEPRESSION,SUICIDIAL
Allergies: NKA ADR:

Weight (kg): 56.18 (Oct -/1999)
Height (cm): 167.64 (Oct -/1999)
Room-Bed: 138-31
Admitted: 08/29/1999 16:36

Order	Start	Stop	Admin Times	AUG 29	30	31	SEP 01	02	03	04	05	06	07	08	09	10	11	not
08/29 ASPIRIN TAB 325mg U/D Give: 975MG PO QID DOSE IS (3) TABS RPH: ___ RN: WSK	08/29 20:19	09/28/99 13:00 (D6094)	0600 1200 C 1800 2100	**** C3 **** C3 **** C3 2														
08/29 BISACODYL TAB,EC 5mg U/D Give: 10MG PO QD DOSE IS (2) TABS RPH: ___ RN: WSK	08/29 20:08	09/28/99 13:00 (D6094)	C 0600	**** C3														
08/29 BUSPIRONE TAB Give: 10MG PO TID RPH: ___ RN: WSK	08/29 20:16	09/28/99 13:00 (D6094)	0600 C 1200 2100	**** C3 **** C3 2														
08/29 ESTROGENS TAB Give: 0.625MG PO QD DC 9/8/99 RPH: ___ RN: WSK	08/29 20:05	09/28/99 13:00 (D6094)	C 0600	**** C3														
08/29 ESTROGENS TAB Give: 0.625MG PO QD RPH:RLH RN:WSK	08/29 20:05	09/08/99 21:09 (D6094)	C	**														
08/29 FLUOXETINE CAP,ORAL 20mg U/D Give: 40MG PO QD DOSE IS (2) 20MG CAPS RPH: ___ RN: WSK	08/29 20:04	09/28/99 13:00 (D6094)	C 0600	**** C3														
08/29 GABAPENTIN CAP,ORAL Give: 300MG PO AC GIVE BEFORE MEALS RPH: ___ RN: WSK	08/29 20:12	09/28/99 13:00 (D6094)	0630 C 1100 1700	**** C3 **** C3 **** C3														

SIGNATURE/TITLE	INIT	INJECTION SITES	MED/DOSE OMITTED	REASON	INI
W.S.K. RNC	WSK	Indicate RIGHT (R) or LEFT (L)	Bisacodyl	NA	C3
Pat Tezzell RN	PT	(IM) (SUB Q)			
Ruth Hunter RN	RH	1. DELTOID 6. UPPER ARM			
Dana Humphreys RN	DH	2. VENTRAL GLUTEAL 7. ABDOMEN			
M May RN	MM	3. GLUTEUS MEDIUS 8. THIGH			
Paula Overland RN	PO	4. MID(ANTERIOR) THIGH 9. BUTTOCK			
Charles Cates RN	CC	5. VASTUS LATERALIS 10. UPPER BACK			
Chris George RN	CG	PRN: E=Effective N=Not Effective			

Name: DOVE,GAYLE A
PID: [redacted]
Sex: FEMALE Dx: DEPRESSION,SUICIDIAL
Allergies: _____ ADR: _____

Weight (Kg): 58.18 (08/[illegible]/1999)
Height (cm): 167.64 (08/29/1999)

Ward: 62C-1PURPLE
Room-Bed: 139-31
Admitted: 08/29/1999 16:36

Order	Start	Stop		Admin Times	AUG 29	30	31	SEP 01	02	03	04	05	06	07	08	09	10	11	not
08/29	08/29 20:13	09/28/99 13:00	(D6094)																
GABAPENTIN CAP,ORAL			C	2100	2														
Give: 600MG PO QHS																			
			RPH: ____ RN: WSK																
08/29	08/29 20:14	09/28/99 13:00	(D6094)	0600															
HYDROXYZINE TAB			C	1200															
Give: 25MG PO QID				1800															
				2100	2														
			RPH: ____ RN: WSK																
08/29	08/29 20:10	09/28/99 13:00	(D6094)	0600															
METOCLOPRAMIDE TAB			C	1200															
Give: 10MG PO QID				1800															
				2100	2														
			RPH: ____ RN: WSK																
08/29	08/29 20:18	09/28/99 13:00	(D6094)																
OLANZAPINE TAB			C	2100	2														
Give: 5MG PO QHS																			
			RPH: ____ RN: WSK																
08/30	08/30 10:39	09/29/99 13:00	(D6094)																
DOCUSATE CAP,ORAL			C																
Give: 240MG PO QD				0600															
			RPH: ____ RN: CRC																
09/07	09/07 16:08	10/07/99 13:00	(D6094)	0600															
RANITIDINE TAB			C																
Give: 150MG PO BID																			
			RPH: ____ RN: CPB	2100															

SIGNATURE/TITLE	INIT	INJECTION SITES	MED/DOSE OMITTED	REASON	INIT
W. Sick RNC	WSK	Indicate RIGHT (R) or LEFT (L)			
[illegible]	[illegible]				
[illegible]	CAE	(IM) (SUB Q)			
[illegible]	[illegible]	1. DELTOID 6. UPPER ARM			
[illegible]	[illegible]	2. VENTRAL GLUTEAL 7. ABDOMEN			
[illegible]	[illegible]	3. GLUTEUS MEDIUS 8. THIGH			
[illegible]	[illegible]	4. MID(ANTERIOR) THIGH 9. BUTTOCK			
[illegible]	[illegible]	5. VASTUS LATERALIS 10. UPPER BACK			
		PRN: E=Effective N=Not Effective			

CONTINUOUS SHEET 08/29/1999 through 09/11/1999

VAMC: Biloxi, MS (COVS) (520) Printed on 09/07/1999 11:

Name: DOVE,GAYLE A Weight (kg): 89.53 (08/28/1999) Ward: 520 1PURPLE

PID: [redacted] Height (cm): 167.64 (08/28/1999) Room-Bed: 130-31

Sex: FEMALE Dx: DEPRESSION,SUICIDIAL Admitted: 08/28/1999 16:24

Allergies: _____ ADR: _____

Order	Start	Stop	Admin Times	AUG 29	30	31	SEP 01	02	03	04	05	06	07	08	09	10	11
	09/07	09/07 16:11	10/07/99 13:00 (D6094)														
	MULTIVITAMINS TAB		C 0600														
	Give: ONE TAB PO QD																
			RPH:____ RN:CPB														
	09/08	09/08 21:10	10/08/99 13:00 (D6094)														
	ESTRADIOL TAB		C 0600														
	Give: 0.5MG PO QD																
	GIVE 0.5MG																
			RPH:____ RN:LLM														

SIGNATURE/TITLE	INIT	INJECTION SITES	MED/DOSE OMITTED	REASON	INIT
Whitney RN/ Charlene Clark, RN	W CMC	Indicate SIGHT (R) or LEFT (L)	Estradiol 1mg PO qd		
		(IM) (SUB Q)			
		1. DELTOID 6. UPPER ARM			
		2. VENTRAL GLUTEAL 7. ABDOMEN			
		3. GLUTEUS MEDIUS 8. THIGH			
		4. MID-ANTERIOR THIGH 9. BUTTOCK			
		5. VASTUS LATERALIS 10. UPPER BACK			
		R=Not Effective			

DOVE,GAYLE A [redacted] VA FORM 10-27

CONTINUOUS SHEET

VAMC: Biloxi, MS (COMS: 5320) 14 DAY RMS 08/29/1999 through 09/11/1

Name: DOVE,GAYLE A Weight (kg): 59.23 (08/25/1999) Printed on 09/07/1999 1

PID: [redacted] Height (cm): 167.64 (08/29/1999) Ward: 6B-1PURPLE

Sex: FEMALE Dx: DEPRESSION,SUICIDIAL Room-Bed: 138-31

Allergies: _____ ADR: _____ Admitted: 08/29/1999 1612

Order	Start	Stop	Admin Times	AUG 29	30	31	SEP 01	02	03	04	05	06	07	08	09	10	11	NOT

Sleep with HOB T
or with 2 pillows

SIGNATURE/TITLE	INIT	INJECTION SITES	MED/DOSE OMITTED	REASON	INIT
		Indicate RIGHT (R) or LEFT (L)			
		(IM) (SUB Q)			
		1. DELTOID 6. UPPER ARM			
		2. VENTRAL GLUTEAL 7. ABDOMEN			
		3. GLUTEUS MEDIUS 8. THIGH			
		4. MID(ANTERIOR) THIGH 9. BUTTOCK			
		5. VASTUS LATERALIS 10. UPPER BACK			
		A-PRN; E-Effective N-Not Effective			

DOVE,GAYLE A [redacted]

VAMC: Bilox1, MS (G0RS) (520)

Name: DOVE,GAYLE A
PID: [redacted]
Sex: FEMALE Dx: DEPRESSION,SUICIDIAL
Allergies: _____ ADR: _____

Weight (kg): 58.18 (08/..../1999)
Height (cm): 167.64 (08/29/1999)

Printed on 08/29/1999 20:
Ward: 62G-1PURPLE
Room-Bed: 138-31
Admitted: 08/29/1999 16:36

Order	Start	Stop	Admin Times	AUG 29	30	31	SEP 01	02	03	04	05	06	07	08	09	10	11	not
8/30	8/30/99	8/30/99	W	MW	MW													
			D															
			E															

Bedrest PRN Today

SIGNATURE/TITLE	INIT
W Sick RN	WS
Pat Terrell RN	PT
Kathy Pinto RN	KP
Martha Williams	mw

INJECTION SITES

Indicate RIGHT (R) or LEFT (L)

(IM)	(SUB Q)
1. DELTOID	6. UPPER ARM
2. VENTRAL GLUTEAL	7. ABDOMEN
3. GLUTEUS MEDIUS	8. THIGH
4. MID(ANTERIOR) THIGH	9. BUTTOCK
5. VASTUS LATERALIS	10. UPPER BACK

PRN: E=Effective N=Not Effective

MED/DOSE OMITTED	REASON	INIT

DOVE,GAYLE A [redacted]

VA FORM 10 [illegible]

DOVE,TIME/PRN SHEET

CONTINUOUS SHEET

VAMC: Biloxi, MS (CONS) (520)

Name: POTTER,PHIL LAMAR NKA/eAlert

PID: [redacted]

Sex: MALE Dx: DEP

Allergies: NKA ADR:

14 DAY MAR

Weight (kg): 86.36 (04/14/1999)

Height (cm): 182.88 (04/14/1999)

08/12/1999 through 08/25/1999

Printed on 08/12/1999 22:08

Ward: 62G-1PURPLE

Room-Bed: 111-09

Admitted: 08/12/1999 14:30

Order	Start	Stop	Admin Times	AUG 12	13	14	15	16	17	18	19	20	21	22	23	24	25	notes
08/12	08/12 22:06	09/11/99 13:00 (P2564)																
LEVOTHYROXINE TAB			C 0600															
Give: 0.125MGM PO QD																		
		RPH: RN: PJO																
08/13	08/13 10:14	09/12/99 13:00 (P2564)	0600															
FLUOXETINE CAP,ORAL			C															
Give: 20MG PO TID			1200															
		RPH: RN:WSK	2100															
08/13	08/13 10:17	09/12/99 13:00 (P2564)	0600															
GABAPENTIN CAP,ORAL			C															
Give: 300MG PO TID			1200															
		RPH: RN:WSK	2100															
08/13	08/13 10:32	09/12/99 13:00 (P2564)																
SIMVASTATIN TAB			C															
Give: 10MG PO QD			1700															
TAKE WITH EVENING MEALS																		
		RPH: RN:WSK																
08/13	08/13 10:15	09/12/99 13:00 (P2564)																
CLONAZEPAM TAB			C															
Give: 1MG PO QHS			2100															
WS		RPH: RN:WSK																
08/13	08/13 15:11	08/20/99 13:00 (P2564)	0600															
AMOXICILLIN CAP,ORAL			C															
Give: 500MG PO TID			1200															
X7DAYS		RPH: RN:TRD	2100															

SIGNATURE/TITLE	INIT
Paula Overland RN	PO
Mikey RN	M
Barbara RN	B
W.S.C.A. nurse	WSC
Ruth Hinton	RH
Pat Terrell RN	PT
[illegible]	CJ
Ellen Brandeis	EB
W.S.C.A. nurse	WSC

INJECTION SITES

Indicate RIGHT (R) or LEFT (L)

(IM) (SUB Q)

1. DELTOID 6. UPPER ARM
2. VENTRAL GLUTEAL 7. ABDOMEN
3. GLUTEUS MEDIUS 8. THIGH
4. MID(ANTERIOR) THIGH 9. BUTTOCK

MED/DOSE OMITTED	REASON	INIT

CONTINUOUS SHEET

VAMC: Biloxi, MS (CONS) (520)
Name: POTTER,PHIL LAMAR
PID: [redacted]
Sex: MALE Dx: DEP
Allergies: _____ ADR: _____

Weight (kg): 87.27 (08/12/1999)
Height (cm): 182.88 (08/12/1999)

Printed on 08/24/1999 10
Ward: 62G-1PURPLE
Room-Bed: 111-09
Admitted: 08/12/1999 14:30

Order	Start	Stop	Admin Times	AUG 12	13	14	15	16	17	18	19	20	21	22	23	24	25	not
	08/24	08/24 09:48	09/23/99 13:00 (P2564) C															
	OXYBUTYNIN CHLORIDE TAB		2100															
	Give: 5MG PO QHS																	
			RPH:____ RN:RAH															

SIGNATURE/TITLE	INIT	INJECTION SITES	MED/DOSE OMITTED	REASON	INI
Ruth Horton RN	RH	Indicate RIGHT (R) or LEFT (L)			
Dawn Overland RN	DO				
		(IM) (SUB Q)			
		1. DELTOID 6. UPPER ARM			
		2. VENTRAL GLUTEAL 7. ABDOMEN			
		3. GLUTEUS MEDIUS 8. THIGH			
Chris George LPN	CG	4. MID(ANTERIOR) THIGH 9. BUTTOCK			
		5. VASTUS LATERALIS 10. UPPER BACK			
		PRN: E=Effective N=Not Effective			

POTTER,PHIL LAMAR [redacted]

VA FORM 10-297

Name: DOVE,GAYLE A
PID: [redacted]
Sex: FEMALE Dx: DEPRESSION,SUICIDIAL
Allergies: _____ ADR: _____

Weight (kg): 59.23 (09/03/1999)
Height (cm): 167.64 (08/29/1999)

Printed on 09/03/1999
Ward: 623 TURTLE
Room-Bed: 138-31
Admitted: 08/29/1999 16:38

Order	Start	Stop	
08/30	08/30 10:33	09/06/99 21:00	(D6094)
ASPIRIN TAB			P
Give: 975MG PO QID PRN			
3 TABS FOR HEADACHE TIMES 7 DAYS			
RPH: RLH RN: CRC			

Order	Start	Stop	
08/30	08/30 10:39	09/27/99 13:00	(D6094)
HYDROXYZINE TAB			P
Give: 25MG PO Q6H PRN			
RESTLESSNESS/AGITATION			
RPH: RLH RN: CRC			

Order	Start	Stop	
08/30	08/30 10:46	09/29/99 13:00	(D6094)
BISACODYL TAB,EC			P
Give: 5 TO 10 MG PO QD PRN			
1-2 TABS			
RPH: RLH RN: CRC			

Order	Start	Stop	
08/31	08/31 11:10	09/30/99 13:00	(D6074)
METOCLOPRAMIDE TAB			P
Give: 10MG PO QID PRN			
FOR STOMACH UPSET--GIVE WITH AS NEEDED ASPIRIN FOR HEADACHE			
RPH: RLH RN: WSK			

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT	REASON	RESULTS	TIME	INIT
9/5/99	1330	Hydroxyzine 25mg PO	WSK	agitation	Effective	1445	WS
9-5-99	2000	ASA 975mg PO	[illegible]	H/A #8	E #1	2100	[illegible]
9-5-99	2000	Reglan 10mg PO	[illegible]	stomach	E	2100	[illegible]
9-5-99	2200	Hydroxyzine 25mg PO	[illegible]	restless	E	2300	[illegible]
9/6/99	0415	ASA 975mg PO	M	H/A #7	E	0500	M
9/6/99	0415	Vistaril 25mg PO	M	restlessness	E	0500	M
9/6/99	0520	Reglan 10mg PO	C3	stomach	"N"	0620	M
9/6/99	0645	Maalox 15cc PO	M	indigestion/"stomach"			M
9/6/99	1600	Vistaril 25mg PO	PO	Restless	effective	1700	PO
9-6-99	2000	ASA 975mg PO	CS	H/A	eff	2200	CS
9-6-99	2200	Vistaril 25mg PO	CS	restlessness	eff	2300	CS
9-7-99	0330						
9-7-99	1915	Vistaril 25mg PO	PO	c/o anxiety/restless	effective	2015	PO
9-8-99	0800	Vistaril 25mg PO	[illegible]	anxiety	E	0810	[illegible]
9-8-99	1630	Hydroxyzine 25mg PO	[illegible]	anxiety	E	(73)	[illegible]
9/9/99	0645	Vistaril 25mg PO	M	restlessness	E	0745	M

SIGNATURE/TITLE	INIT
W.S. Chance RN	WSK
[illegible] RN	E
M Hay RN	M
Paula Overcast RN	PO
Charlene Cottonham, RN	CME
Chris Reed Jr LPN	CS

INJECTION SITES

Indicate RIGHT (R) or LEFT (L)

(IM)	(SUB Q)
1. DELTOID	6. UPPER ARM
2. VENTRAL GLUTEAL	7. ABDOMEN
3. GLUTEUS MEDIUS	8. THIGH
4. MID-ANTERIOR THIGH	9. BUTTOCK
5. VASTUS LATERALIS	10. UPPER BACK

PRN: E=Effective N=Not Effective

SIGNATURE/TITLE	INIT

DOVE,GAYLE A [redacted]

Name: DOVE,GAYLE A
PID: [redacted]
Sex: FEMALE Dx: DEPRESSION,SUICIDIAL
Allergies: _____ ABR: _____

Weight (kg): 57.23 (07/ /1999)
Height (cm): 167.64 (08/2/1999)

Ward: 620-PURPLE
Room-Bed: 136-31
Admitted: 08/29/1999 16:36

Order	Start	Stop	
08/29	08/29 20:21	09/28/99 13:00 (D6094)	ALUH/MGOH/SIMTH XTRA STRENGTH SUSP,ORAL R Give: 15CC PO Q4HRS PRN FOR INDIGESTION RPH: RLH RN: WSK
09/07	09/07 16:17	10/07/99 13:00 (D6094)	METOCLOPRAMIDE TAB P Give: 10MG PO QIDPRN GIVE WITH TYLENOL RPH:____ RN:CPB
09/08	09/08 03:12	10/08/99 13:00 (D6094)	ACETAMINOPHEN TAB P Give: 650MG PO Q6H PRN PAIN/FEVER RPH:____ RN:RAH
09/07	09/07 16:18	10/07/99 13:00 (D6094)	ACETAMINOPHEN TAB P Give: 650MG PO ~~Q4HRSPRN~~ PAIN/FEVER DC 9-8-99 RPH:____ RN:CPB

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT	REASON	RESULTS	TIME	INI
9-7-99	0330	Maalox 15cc po	RH	indigestion	gp	0830	RH
9/7/99	1330	Mylanta 15cc PO	WSK	indigestion	[illegible]	1400	WSK
9/7/99	2115	Maalox 15cc po	PO	c/o indigestion	Effective	2100	PO

SIGNATURE/TITLE	INIT	INJECTION SITES	SIGNATURE/TITLE	INI
[illegible]	WSK	Indicate RIGHT (R) or LEFT (L)		
Chelsea Luttrell RN	CAL	(IM) (SUB Q)		
Paula Overland RN	PO	1. DELTOID 6. UPPER ARM		
		2. VENTRAL GLUTEAL 7. ABDOMEN		
		3. GLUTEUS MEDIUS 8. THIGH		
		4. MID(ANTERIOR) THIGH 9. BUTTOCK		
		5. VASTUS LATERALIS 10. UPPER BACK		
		PRN: E-Effective N-Not Effective		

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VAMC: Biloxi, MS (CONS) (520)
Name: DOVE,GAYLE A
PID: [redacted]
Sex: FEMALE Dx: DEPRESSION,SUICIDIAL
Allergies: _____ ADR: _____

Weight (kg): 58.18 (08/29/1999)
Height (cm): 167.64 (08/29/1999)

Printed on 08/31/1999 11:
Ward: 62G-1PURPLE
Room-Bed: 138-31
Admitted: 08/29/1999 16:36

Order	Start	Stop		Order	Start	Stop
08/31	08/31 11:10	09/30/99 13:00 (D6094)				
METOCLOPRAMIDE TAB		P				
Give: 10MG PO QID PRN						
GIVE WITH AS NEEDED ASA FOR HEADACHE						
x3 ✓ RPH:____ RN:WSK						

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT	REASON	RESULTS	TIME	INI
8/31/99	2100	Reglan & ASA	[illegible]	H/A # 8	E #2	2200	[illegible]
9-3-99	2310	Reglan & ASA	[illegible]	H/A # 8	E #2	2400	[illegible]
9-4-99	1400	Reglan 10 mg PO	RH	C/O H/A #10	PO #2	1530	RH
9-4-99	2350	Reglan 10 mg po (& ASA)	[illegible]	H/A # 6	E #1	2330	[illegible]
9-5-99	1030	Reglan 10 mg po	WSL	C/O H/A #8	E #1	1200	N[illegible]

SIGNATURE/TITLE	INIT	INJECTION SITES	SIGNATURE/TITLE	INI
Judith Hinton RN	JH2	Indicate RIGHT (R) or LEFT (L)		
Barbara Lewis LPN	[illegible]	(IM) (SUB Q)		
W. Sillivans	WSL	1. DELTOID 6. UPPER ARM		
		2. VENTRAL GLUTEAL 7. ABDOMEN		
		3. GLUTEUS MEDIUS 8. THIGH		
		4. MID(ANTERIOR) THIGH 9. BUTTOCK		
		5. VASTUS LATERALIS 10. UPPER BACK		
		PRN: E=Effective N=Not Effective		

Name: DOVE,GAYLE A
PID: [redacted]
Sex: FEMALE Dx: DEPRESSION,SUICIDIAL
lergies: _____ ADR: _____

Weight (kg): 50.10 (08/29/1999) Ward: 020 1 SHELL
Height (cm): 167.64 (08/29/1999) Room-Bed: 138-01
Admitted: 08/29/1999 16:36

Order Start Stop

08/29 |08/29 20:21 |09/28/99 13:00 (D6094)
ALOH/MGOH/SIMTH XTRA STRENGTH SUSP,ORAL P
Give: 15CC PO Q4HRS PRN
FOR INDIGESTION
RPH: ____ RN: WSK

08/30 |08/30 10:33 |09/06/99 21:00 (D6094)
ASPIRIN TAB P
Give: 975MG PO QID PRN
3 TABS FOR HEADACHE TIMES 7 DAYS
RPH: ____ RN:CRC

08/30 |08/30 10:46 |09/29/99 13:00 (D6094)
BISACODYL TAB,EC P
Give: 5 TO 10 MG PO QD PRN
1-2 TABS
RPH: ____ RN:CRC

08/30 |08/30 10:39 |09/29/99 13:00 (D6094)
HYDROXYZINE TAB P
Give: 25MG PO Q6H PRN
RESTLESSNESS/AGITATION
RPH: ____ RN:CRC

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT	REASON	RESULTS	TIME	INI
8/29/99	2100	Maalox 15cc PO	WSK	Gen pain	effective	2115	WSK
8/30/99	1145	975 mg Aspirin	CB	H/A # 3			
8/30/99	1145	Vistaril 25 mg	CB	Agitation			
8-30-99	1600	Aspirin 975 mg PO	CR	Headache	eff.	1700	CR
8-30-99	1605	Bisacodyl 10 mg	CR	To relieve constipation	eff.	1700	CR
8-30-99	1800	Vistaril 25 mg PO	CR	ANXIETY	eff.	1900	CR
8-30-99	2005	ASA 975 mg PO	CR	To relieve Pain	eff.	2100	CR
8/31/99	0800	ASA 325 mg PO	CRC	H/A pain # 5	Eff	0900	CRC
8/31/99	1045	Vistaril 25 mg PO	SL	restlessness	effect	1200	SL
9/1/99	1130	Vistaril 25 mg po	WSK	anxiousness	E	1200	WSK
9/1/99	1900	Vistaril 25 mg PO	SL	restlessness	E	2000	SL
9/2/99	0630	Vistaril 25 mg PO	M	restlessness	E	0730	M
9/2/99	0630	Bisacodyl 10 mg PO	M	c/o constipation			
9/2/99	1515	Vistaril 25 mg po	PAT	Agitation	eff	1600	PAT
9-2-99	2115	Hydroxyzine 25 mg po	SL	Restlessness	E	2215	SL
9/3/99	0615	Vistaril 25 mg PO	M	restlessness	E	0700	M
9/3/99	1230	Vistaril 25 mg PO	SL	restless	E	1300	SL
9-3-99	2115	Hydroxyzine 25 mg po	SL	Restless	E	2215	SL
9-3-99	2310	ASA 975 mg PO	L	H/A # 5	E #2	2400	L
9/4/99	0630	Vistaril 25 mg PO	M	restlessness	E	0730	M
9-4-99	1330	Vistaril 25 mg PO	PAT	Pt c/o restless	eff	1530	PAT
9-4-99	1440	ASA 3 tabs PO	PAT	c/o H/A #10	eff #2	1530	PAT
9-4-99	2000	Hydroxyzine 25 mg PO	L	Restless	E	2100	L
9-4-99	2300	ASA (3 tabs) 975 mg PO	L	H/A # 6	E #1	2350	L
9/5/99	0630	Vistaril 25 mg PO	M	restlessness	E	0730	M
9/5/99	0900	ASA 975 mg PO	WSK	c/o HA #8	E #1	1200	WSK

SIGNATURE/TITLE	INIT
W.S. Kluever	WSK
Sandra Lamplugh RN	SL
Pamela Simpleyton LPN	PS
Patricia Hinton RN	PH
Cheri Bergen LPN	CB

INJECTION SITES

Indicate RIGHT (R) or LEFT (L)

(IM)	(SUB Q)
1. DELTOID	6. UPPER ARM
2. VENTRAL GLUTEAL	7. ABDOMEN
3. GLUTEUS MEDIUS	8. THIGH
4. MID(ANTERIOR) THIGH	9. BUTTOCK
5. VASTUS LATERALIS	10. UPPER BACK

PRN: E=Effective N=Not Effective

SIGNATURE/TITLE	INI

DOVE,GAYLE A [redacted] LAST PAGE: 3 VA FORM 10-55

CONSENT FOR HUMAN IMMUNODEFICIENCY VIRUS (HIV)
ANTIBODY TESTING

I have asked or been asked to have my blood tested for antibodies to the HIV (Human Immunodeficiency Virus), the virus which causes AIDS. It has been explained to me that the test is for HIV infection. It is not a test for AIDS. If I do have antibodies to the virus (a POSITIVE test), this means that I have been infected with the virus. If I do not have antibodies (a NEGATIVE test) but am in a group of people who are at high risk for AIDS (people who have had multiple sex partners or who share needles when using drugs), this does not mean that I will not become infected in the future. In fact, I may already be infected but have not yet had time to develop antibodies.

I have been told that the blood tests for antibodies to the virus are not foolproof. In a small number of people, other things such as another virus or disease may wrongly cause a positive test. This is called a false positive test. It is also possible to have a false negative test. In this case, I do have the antibodies to the virus but the test did not show this. If the first test on my blood is positive, the test will be repeated. If positive again, a different test will be conducted. These tests will all be done on the blood taken after I sign this consent.

I have been told that HIV is spread through the blood from an infected person. It is also spread by having sex with an infected person. I understand that if my test is positive, I can spread the infection to others. I must not give blood or plasma or donate my organs or sperm if I am positive.

If I have a positive test, I should explain this to any sexual partner. If I am unable to tell my spouse or any other sexual partner whom I have identified, my doctor or counselor may do so but only to protect their health.

If I have a positive test, my case may be reported to public health agencies. However, the public health staff may only use or give out that information for the public health purpose for which it was given. Otherwise, information about my HIV testing cannot be revealed to anyone outside the VA without my written permission, or, a court order, a medical emergency, for research, Congressional oversight, or audit purposes, or for medical treatment provided to me by the Armed Forces.

I have been told that the results of my test (positive or negative) will be in my medical record. I understand that any VA employee who improperly releases information about my HIV testing is subject to a fine. Even though I understand every effort will be made to protect the results of my test, I also understand that disclosure of a positive test result can lead to discrimination in housing, jobs and other areas in some communities.

VA Form
DEC 1988 10-0121

I have been counseled about the HIV test and have been given a chance to ask questions. I understand what a positive and a negative test means. I understand that the test is voluntary and that I will still receive care from the VA if I refuse to have the test done.

Therefore, I give my permission for my blood to be tested for HIV antibodies.

Gayle A Dare
PATIENT or LEGAL GUARDIAN

30 Aug 99
DATE

Carol Breedlove
WITNESS

8/30/99
DATE

VA Form 10-0121

DEC 1988

*U.S. Government Printing Office: 1996 — 723-238/83854

CONSENT FOR HUMAN IMMUNODEFICIENCY VIRUS (HIV)
ANTIBODY TESTING

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If I have a positive test, my case may be reported to public health agencies. However, the public health staff may only use or give out that information for the public health purpose for which it was given. Otherwise, information about my HIV testing cannot be revealed to anyone outside the VA without my written permission, or, a court order, a medical emergency, for research, Congressional oversight, or audit purposes, or for medical treatment provided to me by the Armed Forces.

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Therefore, I give my permission for my blood to be tested for HIV antibodies.

Gayle A. Dare — PATIENT or LEGAL GUARDIAN

30 Aug 99 — DATE

Carl F. Bressler, LCSW — WITNESS

8/30/99 — DATE

VA Form 10-0121

DEC 1988

*U.S. Government Printing Office: 1996 — 723-238/83654

PATIENT NAME	AGE	SEX	RACE	[redacted]	CLAIM NUMBER
DOVE,GAYLE A	42	F	WHIT		

ADM DATE	DISC DATE	TYPE OF RELEASE	INP	ABS	WARD NO
AUG 18, 1999	AUG 21, 1999	IRREGULAR	3	0	4G-1SARRTP

DICTATION DATE: AUG 25, 1999 TRANSCRIPTION DATE: AUG 28, 1999
TRANSCRIPTIONIST: wyh

304.61

DISCHARGE DIAGNOSIS:
AXIS I. SUBSTANCE DEPENDENCE, ANALGESICS, PRESCRIPTION DRUGS, CONTINUOUS MAINLY OPIATES. 304.0
DEPRESSION NOT OTHERWISE SPECIFIED. 311
AXIS II. PERSONALITY DISORDER WITH BORDERLINE FEATURES. 301.83
AXIS III. STATUS POST ABDOMINAL SURGERY X 3 AND GANGLION REMOVED ON RIGHT WRIST, MIGRAINE HEADACHES. 346.9
AXIS IV. PSYCHOSOCIAL STRESSORS MODERATE. 305.1
AXIS V. GAF AT ADMISSION WAS AROUND 68, HIGHEST 74.

DIAGNOSES NOTED BUT NOT TREATED:

3-74.68

OPERATIONS/PROCEDURES PERFORMED:

94.64
9445
9449
9339

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.

NOTE DATED: 08/19/1999 07:58 HISTORY & PHYSICAL
ADMITTED: 08/18/1999 13:43 4G-1SARRTP

NAME: DOVE,GAYLE A
SSN: [redacted]
AGE: 42
SEX: FEMALE

HISTORY

CHIEF COMPLAINT: Ms. Dove is a 42-year-old white female who has been admitted to the Residential Substance Abuse Treatment Program on August 18, 1999. Her chief complaint that she is addicted to analgesics, mainly codeine and some opiates.

HISTORY OF PRESENT ILLNESS: This is the second program for Ms. Dove. She had been here in 1994, at which time she was addicted to alcohol. She said that after she left here she never did drink anymore but she developed severe migraine headaches and was getting a variety of medications for that. She was getting Tylenol #3, Percocet, Demerol shots in different Emergency Rooms and she was on Klonopin, Vistaril and Klonopin have been given to her for her anxiety, tension and depression.

Her history of present illness indicates that she started drinking at age fourteen and obviously she was able to quit drinking after the program here. She is a service-connected veteran 100% for PTSD and sexual assault.

ALLERGIES AND SENSITIVITIES: She has no known allergies.

FAMILY HISTORY: Past family history indicates that her father is a retired cook. He is an alcoholic and mother retired from working on the Kansas turnpike collecting fees. They have been divorced since she was five years of age but her mother raised her until she was a teenager. She and her mother never got along and at one point she was told that her mother may have been a schizophrenic. She has two brothers and they are alcoholics.

She has been married three times. First she married at age twenty-three for two years, no children. The problem with that marriage was that she was stationed at one place in the service and her husband was living somewhere else and she said that she wanted to stay where his family was and the marriage didn't work out. Her second marriage lasted one and a half years and no children. She had been physically abused by that husband. Her third marriage lasted five years and, again, no children but the husband was gone most of the time. He was going out with the boys and gone for weeks. He was a functional alcoholic, she thought. At the present time she lives with her father in a mobile home. She is pretty

** THIS NOTE CONTINUED ON NEXT PAGE **

much upset about the situation because she also has a boyfriend, a retired Coast Guard man. She said that she made a promise to her father that she will provide him with a home and, of course, this is becoming quite a burden by now and there is a lot of suppressed resentment and hostility present about those feelings. The boyfriend is also difficult to get along with and she realizes that she has to make some changes in those areas.

SOCIAL HISTORY: She was in the military from 1975 to 1987 and she was a radar operator. She smokes two packs of cigarettes a day.

REVIEW OF SYSTEMS:

MEDICATIONS:

PAST MEDICAL HISTORY: She has had abdominal surgery three times for adhesions. She had pelvic irritations and she had surgery four times for a ganglion on the right wrist.

MENTAL STATUS EVALUATION: Mental status evaluation on this patient reveals that she is oriented as to time, place and person. There is no evidence of any hallucinations, delusions or paranoid ideations much. She is rather histrionic and maybe and a lot of anxiety. Mostly, however, she has a great amount of resentment and repressed hostility she doesn't know how to deal with. While on the surface she is pleasant, one can sense that her migraine headaches and tension headaches are most likely secondary to her repressed hostilities.

She did not display here any evidence of any overt thought disorder. Her recent and remote memory are unimpaired. She is functioning within the normal range of intellect. She has a history of sexual abuse and, of course, she was sexually abused in the service, for which she is also service-connected.

She is maybe borderline personality but that would be difficult to determine at this point and psychological tests will be obtained.

INITIAL TREATMENT PLAN: She will be assigned to a case manager. She will be told the rules and her rights. She will start fully participating. On the level of medication we will have to gradually withdraw her from some of her pain medications and regulate her medications. She should be able to fully participate in the program. After six days she will be reevaluated and at that point a treatment plan will be established. It appears to me that she is motivated. She has been able to stop drinking, which maybe can be considered as a positive asset.

ADMITTING DIAGNOSIS:
AXIS I. SUBSTANCE DEPENDENCE, ANALGESICS, PRESCRIPTIONS DRUGS.

** THIS NOTE CONTINUED ON NEXT PAGE **

08/19/1999 07:58 ** CONTINUED FROM PREVIOUS PAGE **

AXIS II. DEPRESSION NOT OTHERWISE SPECIFIED.
AXIS III. STATUS POST ABDOMINAL SURGERY THREE TIMES.
RIGHT WRIST GANGLION REMOVED IN SURGERY.
MIGRAINE HEADACHES.
AXIS IV. MODERATE
AXIS V. HER GLOBAL ASSESSMENT OF FUNCTIONING AT THE TIME OF ADMISSION IS AROUND 68.

/bs

Signed by: /es/ JULIUS EHIK
M.D. 08/19/1999 09:57

NOTE DATED: 07/26/1999 10:13 HISTORY & PHYSICAL
ADMITTED: 07/22/1999 18:15 62G-1PURPLE
NAME: DOVE,GAYLE A
[redacted]
AGE: 41
SEX: FEMALE

HISTORY

CHIEF COMPLAINT: This is a 41 year old white female originally wanting to talk to Dr. Saporiti about discussing her medication regime with Dr. Gelder.

HISTORY OF PRESENT ILLNESS: This patient is followed in the Women's Health Clinic by Dr. Saporiti and by Dr. Gelder in the Women's Clinic. She recently had undergone some problems. She broke up with her fiance on last Monday and very close friend died last week.
She is also followed by Dr Pennison in Primary Care & Neurology Clinic.

ALLERGIES AND SENSITIVITIES: She has no known drug allergies.

FAMILY HISTORY: Her mother is alive at age 65 and is on an antidepressant. Her father is age 64. Both are otherwise in fair health although her father has had a heart attack.

SOCIAL HISTORY: Occupation - she last worked in 1996 as a poker dealer. She now volunteers at AA and is a senior vice president of the V.F.W. in D'Iberville of the Ladies Auxiliary. She was in the United States Air Force from 1975 to 1987 as a radar operator. She is a recovering alcoholic, sober x five years. Smokes one and a half packs of cigarettes per day. She realizes this is not good and has tried using the Nicotine patches. She feels this has only made her smoke more. She denies any current use of drugs.

REVIEW OF SYSTEMS: Head - no vertigo, no double vision. She wears glasses and is followed in the Eye Clinic for lattice. She is seen there every six months. Ears - no frequent infection. Nose - chronic sinus infection. Uses Afrin nose drops periodically, recent round of Amoxil. Sinus infections usually at the change of every season. Throat - she has a polyp diagnosed by dental. She has frequent colds and sore throats. Her allergy testing that she had had previously was negative. She also has had bronchitis several times. She denies any chest pain. Denies any shortness of breath. She has a history of ulcer disease followed by Dr. Avalos. She had intermittent bouts of constipation and diarrhea. GU - she has occasional frequency and with burning on urination. She has had seizure like activity due to the fact that she was on Inderal. She has had no seizures since the Inderal was discontinued. She is currently on Gabapentin up to five tablets a day. Neuro - she had tension rebound, migraine and sinus headaches. She also has a history of hiatal hernia.

** THIS NOTE CONTINUED ON NEXT PAGE **

07/26/1999 10:13 ** CONTINUED FROM PREVIOUS PAGE **

She went through the Substance Abuse Program in 1994 and no previous psychiatric admissions.

MEDICATIONS: Her current medications include Gabapentin, Prozac, Klonopin, Vistaril, Risperdal. This patient is also on Estrogen replacement.

PAST MEDICAL HISTORY: She has had a history of drug overdose, once in 1973 and once in December of 1993. She was not hospitalized after either time. No history of self destructive behavior. She reports that she is a recovering alcoholic, sober x five years. Denies any history of drug abuse. She had her last mammogram two or three months ago and she has had a GYN consult within the last two years.

She had the usual childhood illnesses; measles, mumps and chicken pox. Adult illnesses include migraine headaches, ulcer disease, chronic pain.

PAST SURGICAL HISTORY: She had a hysterectomy and has had laparotomy for pelvic adhesions x two, four wrist surgeries on ganglions. She had a cracked elbow which required a casting only and a motor vehicle accident a number of years ago with sutures to her lower chin. No loss of consciousness.

PHYSICAL EXAM

HEIGHT:	5'6"
WEIGHT:	130
TEMPERATURE:	99.3
PULSE:	87
RESPIRATIONS:	18
BLOOD PRESSURE:	114/73

General Appearance and Mental Status: This is a 41 year old white female in no acute distress, alert and oriented x 3, in hospital pajamas.

Head: Normal shape and size without tenderness or deformity, trauma or other abnormalities.

Eyes: Pupils are equal and reactive to light and accommodation. Fundi are normal including disks and vessels. No hemorrhage or exudates. EOM's normal. Conjunctiva, cornea and sclera are normal.

Ears: External meatus. Drums visualized. Normal without scars, inflammation or perforation. Hearing is grossly normal.

Nose: Normal mucosa and airways. No deviation.

Mouth: Normal lips, breath. Has some poor dentition and is undergoing

** THIS NOTE CONTINUED ON NEXT PAGE **

07/26/1999 10:13 ** CONTINUED FROM PREVIOUS PAGE **

dental work at the Dental Clinic. She also has a centimeter polyp on her left oropharynx.

Throat: Normal pink mucosa.

Neck: Normal motion of neck. Trachea is midline. Thyroid is normal. No bruits or masses noted.

Breasts:

Chest: Normal size and shape. No tenderness noted.

Heart: Regular rate and rhythm. No murmur, gallops, clicks or rubs.

Lungs: Clear to auscultation.

Abdomen: No tenderness. Bowel sounds are normal.

Genitalia: Deferred/refused pelvic.

Rectal: Refused.

Back: Normal curvature and mobility. No pain or tenderness. No CVA tenderness.

Skin: Normal color and texture.

Extremities: No edema or varicosities, cyanosis.

Lymphatics: Negative for lymphadenopathy.

Neurological: Strength is equal, grossly normal.

DIAGNOSTIC IMPRESSION:
AXIS I: DEPRESSION.
DYSTHMIA.
AXIS II: DEFERRED
AXIS III: MIGRAINE HEADACE.
AXIS IV: MODERATE TO SEVERE STRESSORS.
AXIS V: ADMISSION GAF OF 35

PLAN: Medications were written by Dr. Mathis earlier, on 7/23/99, when she was staffed. She will be started on Bactrim due to her urinary frequency with burning. A regime of Gatorade prn x three days and Atrovent nasal spray for her sinuses.

Her immunizations - she needs as DT which will also be done and fasting

** THIS NOTE CONTINUED ON NEXT PAGE **

07/26/1999 10:13 ** CONTINUED FROM PREVIOUS PAGE **

labs were re-done on 7/26/99.

The patient will be returned to her home environment upon discharge.

/tp

Signed by: /es/ MARGO A DONALDSON
RN,MSN,FNP 07/26/1999 11:40
Cosigned by: /es/ DAVID M MATHIS
DO 07/26/1999 11:54

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.)*

DATE: _____

DIAGNOSES: Axis I: _____ Advance directive exists:

_____ No___

Axis II: _____ Yes__

Axis III: _____

Axis IV: _____

_____

Axis V: GAF-68

ESTIMATED LENGTH OF STAY (or Treatment for Outpatients): 21 DAYS
Please specify DATE and note if patient remains, the plan must be reviewed that date.

9/8/99

BARRIERS TO COMMUNICATION/LEARNING: No ✓ Yes__ If yes, explain_____

_____

_____

ASSIGNED CASE MANAGER/PRIMARY THERAPIST: Sarah Rehage, RN MHC

Patient | Social Worker | _____

Family/Significant Other | Psychologist | _____

Nurse | _____ | _____

Family Involvement: Yes__
No ✓ Refer to PN's dated: _____

SIGNATURE/TITLE-PRACTITIONER	SIGNATURE/INITIAL OF APPROVING PHYSICIAN	DATE
Sarah Rehage RN MHC		

Enter in space below - **PATIENT IDENTIFICATION** - *Treating Facility - Ward No. Date*

DOVE, GAYLE A
[redacted]

MEDICAL RECORD
OVERALL TREATMENT PLAN
[redacted]

EXISTING STOCK OF VAF 10-0043, OCT 1987, WILL BE USED.

*U.S.GPO:1998-723-373/83882

VA FORM SEPT 1989 **10-0043** 031630

TREATMENT PLAN

UPDATES

See PN dated: _____ See PN dated: _____

Present: _____ Present: _____

See PN dated: _____ See PN dated: _____

Present: _____ Present: _____

See PN dated: _____ See PN dated: _____

Present: _____ Present: _____

DATE: 9/25/85 PROBLEM # 9 PROBLEM: Altered Health Maintance

as manifested by: Elevated temp; Coughing; Sore throat, Nausea.

GOAL: Symptom free

OBJECTIVES	METHOD & FREQUENCY	STAFF RESPONSIBLE	TARGET DATES	ACHIEVEMENT DATES
Comply with Medical Regimen.	Bed Rest - PRN	Dr. Ehik	8/31/85	
	Temperature check Vital Signs - PRN	RN on duty		
	Encourage fluids	NSG Staff		
Prevent spread of illness - Wear Mask when outside room.	Tray on ward -	Dietary Service		
	Antibiotics as ordered.	Dr. Ehik		
	ASA as ordered			

DOVE, GAYLE A [redacted]

DATE: 8/20/99 PROBLEM # 4 PROBLEM: Substance Abuse

as manifested by: Abusing prescription medications -

GOAL: Decrease medications and take only as prescribed. Stop opiates - codeine - containing analgesics.

OBJECTIVES	METHOD & FREQUENCY	STAFF RESPONSIBLE	TARGET DATES	ACHIEVEMENT DATES
Make a plan in writing with goals/objectives how she is going to stop her abuse of prescription drugs	Aftercare Planning 1x wk. Problem Solving Skills 1x wk. Group therapy 5x wk.	N. MacMillan, NCAC-II	9/8/99	
	Relapse Prevention 2x wk.	S. Rehage, RN MAC		
	AA/NA meetings 4x wk.	V. Campbell, NA		
	Big Book 2x wk.	J. Johnson RT		
	Promises of Recovery 1x Sponsorship 1x	R. Walker, RN		

E

Department of Veterans Affairs

PATIENT EDUCATION AND ATTENDANCE RECORD-SUBSTANCE ABUSE TREATMENT PROGRAM

AIDS	ANTABUSE	ASK YOUR DOCTOR	ALCOHOL AND COCAINE	12 STEPS OF AA	STEP I OF AA	STEP II OF AA	STEP III OF AA
CHALK TALK	COCAINE HIGHS & LOWS	CONQUERING COCAINE	CRACKED UP	CRUEL SPIRITS	DAYS OF WINE & ROSES	DESIGNER DRUGS	DISEASE OF ALCOHOLISM
DRY DRUNK	FAMILY ISSUES	THE FAMILY	FEELINGS	GUIDE-LINES	GOING HOME	MARIJUANA UPDATE	MEDICAL ASPECTS PT. I
MEDICAL ASPECTS PT. II	MY NAME IS BILL W.	NUTRITION	ONE DAY AT A TIME	OUR FATHER	REWARDS OF RECOVERY	SEXUALITY	SPIRITUAL ASPECTS
SYMPTOMS OF SOBRIETY	THREE-HEADED DRAGON	UNDER THE INFLUENCE	UNRESOLVED ANGER	VIABLE ALTERNA-TIVES	WHAT PROBLEM		

GROUP THERAPY	WEEK 1	WEEK 2	WEEK 3	WEEK 4
MONDAY				
TUESDAY				
WEDNESDAY				
THURSDAY				
FRIDAY				
PROGRESS NOTES				

SIGNATURE AND TITLE OF PRACTITIONER

DATE

IMPRINT PATIENT DATA CARD

DOVE, GAYLE A [redacted]

MEDICAL RECORD SUPPLEMENT TO PROGRESS NOTE FOR SPECIALIZED DISCIPLINES

[redacted]

VA FORM MAY 1990 **10-0114j**

EXISTING STOCK OF VA FORM 10-0114j, SEPT 1988, WILL BE USED.

*U.S. Government Printing Office: 1991 — 282-804/46333

Department of Veterans Affairs

AD HAS NOT DRANK FOR 5YRS

S.A.T.P. ~~Nursing~~ Assessment

Primary Drug of Choice ALCOHOL - PRESCRIPTION MEDS - MJ PAIN

Amount and frequency of use DAILY - TAKING MORE THAN PRESCRIBED

Length of ~~use~~/abuse 1 YR

Age of first use

Age of first problems associated with use/abuse

Date of last use LAST WEEK

History of other drugs used DARVACET, TYLONOL 3, PERCOCET, STADOL

History of intravenous drug use: YES___ NO X Prior HIV test: YES X NO___ LAST 6 MO'S

Number of Detox admissions 8

Number of treatment program admissions 2

Number of treatment programs completed 2

History of: Blackouts YES ✓ NO___; DT's YES ✓ NO___; Seizures YES ✓ NO___

Noted early withdrawal symptoms SHAKEY (MEDICINE)

Family history of substance abuse (specify) FATHER + BOTH BROTHERS ALCOHOLIC

Prior Antabuse Therapy: YES___ NO X; Adverse reactions: YES___ NO___ Specify:

History of AA/~~NA~~ attendance: 5 YRS 3 X WKLY Sponsor utilization: YES ✓ NO___

Length of sobriety: 5 YRS

Legal entanglements: DUI's N/A, Incarcerations N/A, Court dates pending: N/A

Noted observations/comments during interview:
Pt states she is willing to address her problem of abusing pain meds.

SIGNATURE AND TITLE OF PRACTITIONER [illegible], MA CAC DATE 8/18/99

IMPRINT PATIENT DATA CARD

DOVE, GAYLE A [redacted]

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE
FOR SPECIALIZED DISCIPLINES

[redacted]

VA FORM MAY 1990 10-0114j

EXISTING STOCK OF VA FORM 10-0114j, SEPT 1988, WILL BE USED.

*U.S. Government Printing Office: 1991 — 282-804/46333

GENERAL INFORMATION:

Date: Time:

History of High Risk Behavio.. HAD RELATIONSHIP WITH MEN WHO HAD HEPATITIS C

AUG-98 Date of last possible exposure

LESS THAN 6 MO Date of previous HIV antibody screen

Additional concerns: _____

___ There is a Doctor's order for HIV testing

THE FOLLOWING WAS REVIEWED VERBALLY WITH THE VETERAN:

✓ Modes of transmission of HIV
✓ Methods of protection against HIV transmission
✓ The meaning, sensitivity, and specificity of the HIV tests
✓ The consent form for HIV testing was signed freely by veteran and witnessed by counselor
✓ The HIV test result is considered confidential and will be part of the medical record
✓ The disclosure policy to public health authorities
✓ Policy regarding disclosure to spouse/sexual partner(s)
✓ Potential social ramifications of a positive test result
✓ Policy on non-discrimination in health care services for patients with HIV infection
✓ Services available within the Department of Veteran Affairs
✓ Results will be given only in person - must return to clinic for post-couseling

VETERAN:

✓ Participated in counseling and asked appropriate questions
✓ Was given literature on AIDS
✓ Appears to comprehend the significance, meaning, and ramifications of HIV screening
___ Desires HIV antibody screening
X Refuses HIV antibody screen at this time
✓ Was instructed to report for blood drawing
✓ Will return to clinic or be seen on the unit for post counseling when results are available
✓ All of veteran's questions WERE answered

COMMENTS:

SIGNATURE AND TITLE OF PRACTITIONER [redacted] DATE 8/18/99

IMPRINT PATIENT DATA CARD

DOVE, GAYLE A

[redacted]

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE
FOR SPECIALIZED DISCIPLINES

12/91

A FORM EP 1099.10-0114j

MEDICAL RECORD	PROGRESS NOTES
DATE 8/21/98	MUD note Pt wanted to leave AMA. Her family came to pick her up, the man of intermediate in Kannada at this time. Kaberi Samantha, M.D. AS3285170-586

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; race; 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

PROGRESS NOTES

DATE

Adhesive Area
Keep Clear

*U.S.GPO:1997-426-359

NOTE DATED: 08/21/1999 06:43 SARRTP/GENERAL NURSING NOTE
ADMITTED: 08/18/1999 13:43 4G-1SARRTP
PROBLEM #4-- AT 0615 PATIENT STATED "I'M LEAVING THIS MORNING MY FATHER WILL BE HERE TO PICK ME UP". MOD CALL TO REPORT THE ABOVE.

PATIENT LEFT WITH HER RELATIVE AT THE ABOVE TIME.

T98.6-P107-R18-B/P108/66.

PATIENT DID NOT VOICE ANY REASON FOR LEAVING AMA.

Signed by: /es/ GENEVIEVE M LYONS
G. LYONS, NA 08/21/1999 06:49

NOTE DATED: 08/20/1999 17:14 SARRTP/GENERAL NURSING NOTE
ADMITTED: 08/18/1999 13:43 4G-1SARRTP
#9: VET REMAINS ON BED REST. TEMP AT THIS TIME IS 99.5. WILL CONTINUE TO TRAY ON WARD. ENCOURAGED FLUIDS. STATES HER THROAT IS STILL SORE AND HAS A HEADACHE.

Signed by: /es/ SARAH T REHAGE
RN,MAC 08/20/1999 17:16

NOTE DATED: 08/20/1999 14:40 SARRTP PSYCHIATRIST NOTE
ADMITTED: 08/18/1999 13:43 4G-1SARRTP

Problem # 9

This am I notified thet Ms Dove has elevated temperature of 102.2.She doews have respiratory infection,with some cough ,nausea and nasal congestion.By 10.30 AM her temperature was 99.7.She said she feelt week and sick.She also had some urinary discomfort.Bedrest for todayt ordered and Bactrim ds bid prescibed for her.

Signed by: /es/ JULIUS EHIK
M.D. 08/20/1999 14:52

NOTE DATED: 08/20/1999 11:08 SARRTP/GENERAL NURSING NOTE
ADMITTED: 08/18/1999 13:43 4G-1SARRTP
#0: IT WAS REPORTED THAT VET HAD AN ELEVATED TEMP. THIS AM. RECHECKED AT 0945; TEMP WAS 99.8. SYMPTOMS INCLUDE: HEADACHE, COUGHING, AND NAUSEA. WARD PHYSICIAN NOTIFIED OF VET'S CONDITION. INFECTION CONTROL NURSE NOTIFIED OF NEW CASE OF VIRAL SYNDROME. VET ALREADY IN PRIVATE ROOM AND SHE HAS A MASK TO WEAR WHEN AROUND OTHERS.

Signed by: /es/ SARAH T REHAGE
RN,MAC 08/20/1999 11:10

NOTE DATED: 08/20/1999 07:04 SARRTP/GENERAL NURSING NOTE
ADMITTED: 08/18/1999 13:43 4G-1SARRTP
PROBLEM #4--THIS PATIENT STAYED IN BED ALL THIS TOD. STATED "I FEEL REAL BAD THIS MORNING". 0600 V/S TAKEN T101-P118-R20-122/66.
0640 V/S T102-P100-B/P120/66.
ALL THE ABOVE REPORTED TO WARD DOCTOR. PATIENT WAS EXCUSED FROM THE AM WALK, WAS GIVEN EXTRA FLUIDS, AND ENCOURAGED TO DRINK FLUIDS. FASTING LAB DONE THIS AM, URINE COLLECTED FOR LAB TEST.

Signed by: /es/ GENEVIEVE M LYONS
G. LYONS, NA 08/20/1999 07:15

NOTE DATED: 08/18/1999 23:18 SARRTP/GENERAL NURSING NOTE
ADMITTED: 08/18/1999 13:43 4G-1SARRTP
PROBLEM # 4: RESIDENT APPEARS TO BE ADJUSTING TO WARD ROUTINE WITHOUT DIFFICULTY. OBSERVED INTERACTING WITH PEERS IN CONGENIAL MANNER. HAS BEEN PLEASANT AND COOPERATIVE WITH STAFF. NO PROBLEMS NOTED NOR HAS RESIDENT VOICED ANY COMPLAINTS AS OF THIS TIME.

Signed by: /es/ GLADYS F. BRASFIELD
NA,SATP 08/18/1999 23:18

NOTE DATED: 08/19/1999 06:48 SARRTP/GENERAL NURSING NOTE
ADMITTED: 08/18/1999 13:43 4G-1SARRTP
PROBLEM #4--"CAN I GET SOME TYLENOL I HAVE A HEADACHE, I WANT BE ABLE TO SLEEP". PATIENT WAS UP AT 0230 STATED THE ABOVE, BUT WANT BACK TO BED. "CAN UP LET ME OUT TO SMOKE FOR 10MIN, I FEE LIKE I AM GOING INTO DT'S" THIS TIME WAS 0430 PATIENT WAS TOLD THAT THE DOOR WILL BE OPEN AT 0600, PATIENT WANT BACK TO HER BEDROOM, OUT AT 0600. T-98.3 P-101 R-20 B/P110/63. "DR. EHIK TOLD ME THAT I CAN WEAR SUN GLASSES IN THE BUILDING BECAUSE OF THE LIGHT BEING TOO BRIGHT, AND IT MAKES ME HAVE HEADACHES". THIS WAS STATED BY THIS PATIENT AFTER TALKING WITH WARD DOCTOR.

Signed by: /es/ GENEVIEVE M LYONS
G. LYONS, NA 08/19/1999 07:12

Department of Veterans Affairs

MEDICAL RECORD - DISCHARGE INSTRUCTIONS

DATE OF ADMISSION	DATE OF DISCHARGE	TYPE OF DISCHARGE
Aug 18. 99	Aug 21 . 99	Irregular

1. DIAGNOSES AND DATE TO BE FOLLOWED ON OUTPATIENT SERVICES

Substance dependency analgesics

2. SUGGESTED PLAN FOR FOLLOWUP

None

3. DISCHARGE MEDICATIONS AND INSTRUCTIONS

4. DISCHARGE DIETARY INSTRUCTIONS *(Check one)*

☐ NO RESTRICTIONS ☐ RESTRICTIONS *(Specify and include drug and food interactions)*

NA

5. PHYSICAL ACTIVITY LIMITATIONS *(Check one)*

☐ NO RESTRICTIONS ☐ RESTRICTIONS *(Specify)* NA

6. OTHER *(Include employment status)*

PATIENT IDENTIFICATION *(Name, Address, Social Security Number)*	SIGNATURE OF PHYSICIAN/DENTIST	DATE
[redacted]	[signature] MD	Aug 21. 99
	I HAVE RECEIVED AND UNDERSTAND MY DISCHARGE INSTRUCTIONS	
	SIGNATURE OF PATIENT	DATE

VA FORM 10-7978M
JAN 1990

EXISTING STOCKS OF VA FORM 10-7978M, NOV 1987, WILL BE USED.

MEDICAL RECORD

Clinical Pathway for Residential Substance Abuse
Biloxi, MS VA Medical Center

PERFORMANCE MEASURES:
1. ASI testing will be completed on all patients in the program.
2. Follow up appointment will be made within seven (7) days of completion of the program.

ICD9# 303, 304, 305 except 305.1 DATE: TIME:

CARE FUNCTION	DAY 1 INTERVENTIONS/ADMIT	CHECK OFF	VARIANCE & ACTION
MEDICAL INTERVENTIONS	Admit to SARRTP program Allergies:_____ H&P		
MEDICATIONS	Theravit w/minerals 1 PO qd @0600 Thiamine HCl 100 mg PO qd @0600 Folic Acid 1 mg PO qd @0600 Acetaminophen 650 mg q4h PO PRN pain/temp Milk of Magnesia 30 ml PO PRN constipation Alum & Mag Hydr 15 ml PO q4h PRN indigestion Promethazine 25 mg PO /IMq4h PRN N&V Dimetapp 1 tab PO q12h PRN cold symptoms Benzonatate 100 mg PO q4h PRN cough Cepastat throat lozenges 1 PO q2h PRN sore throat Attapulgite 30 ml PO PRN each diarrhea stool		
DIAGNOSTIC TESTS	Lab workup if not done this admission: Uninalysis CBC RPR FBS BUN Creatinine MG++ Serum electrolytes Liver Profile Triglycerides Cholesterol Renal panel Urine toxicology EKG Chest X-ray PA & Lat (RO infiltrates) HIV Pre & Post Test Counseling HIV Test following consent PPD		

OVER FOR CONTINUATION OF ORDERS FOR PATHWAY - LINE THROUGH ORDERS NOT DESIRED - PROVIDER SIGN BOTH SIDES

SIGNATURE AND TITLE OF PRACTITIONER	DATE
Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. DATE DOVE, GAYLE A [redacted]	MEDICAL RECORD DOCTOR'S ORDERS 520-OP-235A-11 August 1997

VA FORM DEC 1995 10-1158

EXISTING STOCK OF VA FORM10-1158, OCT.1978 WILL BE USED

Outpatient Clinical Pathway for Substance Abuse
Continuation - Day 1, Page 2
Biloxi, MS VA Medical Center

TREATMENT/PROCEDURES	Breathalyzer: if positive, arrange for appropriate location of care		
NURSING INTERVENTIONS	Vital Signs Biophychosocial Assessment TB/Hepatitis Screening Assignment of Case Manager and Small Group		
ACTIVITY	As described on patient schedule		
CONSULTS	Initial Dental exam		
SOCIAL WORKER/COUNSELOR	Assess home situation Assess need for alternate discharge needs		
NUTRITION/ DIETITIAN	Assess dietary needs Regular diet as tol		
FOLLOW UP PLANNING			
PSYCHOSOCIAL/ SPIRITUAL	Addiction Severity Index (ASI) assessment		
PATIENT/ FAMILY/ SIGNIFICANT OTHER TEACHING	Orientation to the program and the facilities		
SIGNATURE BLOCK	_____ Clerk _____ RN (NOTE) _____ RN (24 HR CHECK)		

LINE THROUGH ORDERS NOT DESIRED

SIGNATURE AND TITLE OF PRACTITIONER	DATE

Clinical Pathway for Residential Substance Abuse
Biloxi, MS VA Medical Center

PERFORMANCE MEASURES:
1. ASI testing will be completed on all patients in the program.
2. Follow up appointment will be made within seven (7) days of completion of the program.

ICD9# 303, 304, 305, except 305.1 DATE: TIME:

CARE FUNCTION	DAYS 2 THROUGH 21 INTERVENTIONS	CHECK OFF	VARIANCE & ACTION
MEDICAL INTERVENTIONS	Determination of individualization of treatment plan		
MEDICATIONS	Continue as ordered on Day 1		
DIAGNOSTIC TESTS	Review results of tests from Day 1		
TREATMENT/PROCEDURES	Describe		
CASE MANAGEMENT	Interview, Treatment Planning Diagnostic Summary Discharge Planning		
ACTIVITY	As described on Patient Schedule		
CONSULTS	Consult based on results of tests from Day 1		
SOCIAL WORKER/COUNSELOR	Psychosocial Assessment/History Assess need for follow up care or residential placement, completing the appropriate requirements		
NUTRITION/ DIETITIAN	As prescribed following nutritional assessment		
FOLLOW UP PLANNING	Plan for placement if necessary Schedule follow up appointment within 7 days of program completion		
PSYCHOSOCIAL/ SPIRITUAL	Addiction Severity Index (completed prior to 7-day staffing) MMPI (completed prior to 7 day staffing) Assess anxiety and need for communication of anxieties and/or fears		
PATIENT/ FAMILY/ SIGNIFICANT OTHER TEACHING	Explain treatment and discharge plans See patient schedule		
SIGNATURE BLOCK	_____ Clerk _____ RN (NOTE) _____ RN (24 HR CHECK)		

LINE THROUGH ORDERS NOT DESIRED

SIGNATURE AND TITLE OF PRACTITIONER	DATE

Label in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. DATE

DOVE, GAYLE A
[redacted]

MEDICAL RECORD

DOCTOR'S ORDERS
520-OP-235B-11 August 1997

VA FORM DEC 1995 10-1158

EXISTING STOCK OF VA FORM10-1158, OCT.1978 WILL BE USED

Exception to Standard Form 5
Approved by ON

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
8/21/98		May leave AMA		
		TC		
		Keberi Samantha, M.D. AS3285170-586		

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. DATE

DOE, GATLE A
[redacted]

MEDICAL RECORD
DOCTOR'S ORDERS

VA FORM DEC 1995 **10-1158**

EXISTING STOCK OF VA FORM 10-1158, OCT 197[illegible] WILL BE USED.

MENTAL HEALTH FUNCTIONAL PROBLEM LIST

(Check one) ☐ FIRST LIST (New) ☐ CONTINUATION OF LIST

DO NOT USE ABBREVIATIONS WHEN LISTING PROBLEMS. This form may be used for inpatient, patient – members and outpatients. Place form in the Medical Records folder (Type II) on the top of right or left side, whichever is appropriate. Upon READMISSION, remove form and place with current records on ward. DO NOT CREATE A NEW Problem List for each readmission.

PROBLEM NUMBER	APPROX. DATE OF ONSET	DATE PROBLEM RECORDED	ACTIVE PROBLEMS	INACTIVE/RESOLVED (Add Date)
#5	8/1955	8/20/99	Adjustment Disorder with Anxiety and Depressed Mood	
#4	8/1955	8/20/99	Substance Abuse Disorder Drugs	

ENTER IN SPACE BELOW: PATIENT IDENTIFICATION – TREATMENT FACILITY – WARD NO. – DATE

DOVE, GAYLE A [redacted]

(CONTINUE ON REVERSE)

MENTAL HEALTH FUNCTIONAL PROBLEM LIST

[redacted]

MENTAL HEALTH FUNCTIONAL PROBLEM LIST

PROBLEM NUMBER	APPROX. DATE OF ONSET	DATE PROBLEM RECORDED	ACTIVE PROBLEMS	INACTIVE/RESOLVED *(Add Date)*

PATIENT NAME	AGE	SEX	RACE	SSN	CLAIM NUMBE
DOVE,GAYLE A	41	F	WHIT	[redacted]	[redacted]

ADM DATE	DISC DATE	TYPE OF RELEASE	INP	ABS	WARD NO
JUL 22, 1999	JUL 29, 1999	OPT-SC	7	0	62G-1PURPLE

DICTATION DATE: JUL 29, 1999 TRANSCRIPTION DATE: AUG 02, 1999
TRANSCRIPTIONIST: sb

DISCHARGE DIAGNOSIS:
AXIS I: MAJOR DEPRESSION, RECURRENT, WITHOUT PSYCHOTIC FEATURES. 296.32
SEVERE DYSTHYMIA. 300.4
RULE-OUT SUBSTANCE ABUSE. 305.90
AXIS II: DEFERRED.
AXIS III: MIGRAINES. 346.90
AXIS IV: MODERATE TO SEVERE STRESSORS.
AXIS V: ADMISSION GAF 35, DISCHARGE GAF 60, BEST GAF IN THE PAST YEAR 60. 305.1

3-60-35

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 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.

PATIENT NAME	AGE	SEX	RACE	SSN	CLAIM NUMBE
DOVE,GAYLE A	41	F	WHIT	[redacted]	[redacted]

ADM DATE	DISC DATE	TYPE OF RELEASE	INP	ABS	WARD NO
JUL 22, 1999	JUL 29, 1999	OPT-SC	7	0	62G-1PURPLE

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.

/sdb

SIGNATURE APPROVING PHYSICIAN/DENTIST

/es/ DAVID M MATHIS
DO
Signed: 08/02/1999 12:54

MENTAL HEALTH FUNCTIONAL PROBLEM LIST

(Check one) ☑ FIRST LIST (New) ☐ CONTINUATION OF LIST

DO NOT USE ABBREVIATIONS WHEN LISTING PROBLEMS. This form may be used for inpatient, patient – members and outpatients. Place form in the Medical Records folder (Type II) on the top of right or left side, whichever is appropriate. Upon READMISSION, remove form and place with current records on ward. **DO NOT** CREATE A NEW Problem List for each readmission.

PROBLEM NUMBER	APPROX. DATE OF ONSET	DATE PROBLEM RECORDED	ACTIVE PROBLEMS	INACTIVE/RESOLVED (Add Date)
✓ #2		7/22/99	Depressed Mood: crying; unable to stop. Friend died recently.	7/28/99 (Resolved)
✓ #9		7/22/99	Altered Health Maintenance: Migraine Headaches; claim to have injected Demerol.	Maintenance Care (ongoing) 7/28/99
✓ #16		7/22/99	Knowledge Deficit: See Teaching Assessment (Medications + Disease Process)	See Education Record 7/28/99 (ongoing)
✓ #19		7/22/99	Follow-up care after discharge: need for ongoing care after discharge.	7/28/99 (Resolved)
✓ #17		7/22/99	Ongoing risk to self: verbalizes thoughts of self harm. History of suicide attempts.	7/28/99 (Resolved)
#21		7/23/99	Nutritional: (1) Malnourished (2) Recent weight loss (3) Weight Maintenance	7/28/99 (Resolved)
25		7/26/99	Rehab Medicine Needs: O.T. Clinic: Impaired functional & leisure performance	7/28/99 (Resolved)

ENTER IN SPACE BELOW: PATIENT IDENTIFICATION – TREATMENT FACILITY – WARD NO. – DATE

(CONTINUE ON REVERSE)

MENTAL HEALTH FUNCTIONAL PROBLEM LIST

DOVE, GAYLE

[redacted]

[redacted]

MENTAL HEALTH FUNCTIONAL PROBLEM LIST

PROBLEM NUMBER	APPROX. DATE OF ONSET	DATE PROBLEM RECORDED	ACTIVE PROBLEMS	INACTIVE/RESOLVED *(Add Date)*

Veterans Administration

Place In Front Of Medical Record

Advance Directives

Documentation to initiate, revise/review, revoke, or provide education for VA Living Will, Durable Power of Attorney, for Health Care, or Treatment Preferences.

Date/Time: 7/22/99
Documentation: States has Living Will on file at BVAMC. Paula Outland RN

IMPRINT PATIENT DATA CARD

[redacted]

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE
FOR SPECIALIZED DISCIPLINES

DOVE, GAYLE

[redacted]

VA FORM
SEP 1988 10-0114j

025396

ADVANCE DIRECTIVE ACKNOWLEDGEMENT

(Suggested format for screening document which can be overprinted on VAF 10-0114] -- Medical Record Supplement to Progress Note for Specialized Disciplines.)

The Department of Veterans Affairs (VA) recognizes the right of a patient to have an advance directive (AD). It is the policy of VA to comply with such ADs.

Your Rights

1. You have the **right to accept or refuse any medical treatment.**
2. You have the **right to create a Durable Power of Attorney for Health Care** (DPAHC) to choose someone to make health care decisions for you if you become unable to make them for yourself. That person is called your Agent or Health Care Agent (HCA).
3. You have the **right to make a Living Will.** It is a statement you write while you are able to make decisions about what you want done for you in the event you are no longer able to make decisions for yourself. You may state whether you want life-sustaining treatment to be withheld or withdrawn in certain circumstances, for example, in the event of terminal illness, or other specific requests that are important to you regarding your treatment.

Do you have an Advance Directive (DPAHC or Living Will)?

☑ Yes *It is your responsibility to provide a copy for your medical record, in order to be sure that your wishes will be carried out.*

☐ No *Would you like a health care provider to discuss this with you?* ☐ *Yes* ☐ *No*

an Enclosed Blank Copy

Your Signature: Gayle A. Dove **Date:** 2-23-99

A copy of this form was provided to the patient by: C. L. Brennan MD Psychology
(Employee's name and title)

NOTE: *The original Advance Directive should stay with the patient; copy to the medical record.*

2/23/99

A-1

7

DOVE, GAYLE [redacted]

SEVERE DEPRESSION/W/SUICIDE I
62G-1
DR MATHIS

NOTE DATED: 07/26/99 10:13 HISTORY & PHYSICAL
ADMITTED: 07/22/99 18:15 62G-1PURPLE
NAME: DOVE,GAYLE A
SSN: [redacted]
AGE: 41
SEX: FEMALE

HISTORY

CHIEF COMPLAINT: This is a 41 year old white female originally wanting to talk to Dr. Saporiti about discussing her medication regime with Dr. Gelder.

HISTORY OF PRESENT ILLNESS: This patient is followed in the Women's Health Clinic by Dr. Saporiti and by Dr. Gelder in the Women's Clinic. She recently had undergone some problems. She broke up with her fiance on last Monday and very close friend died last week.
She is also followed by Dr Pennison in Primary Care & Neurology Clinic.

ALLERGIES AND SENSITIVITIES: She has no known drug allergies.

FAMILY HISTORY: Her mother is alive at age 65 and is on an antidepressant. Her father is age 64. Both are otherwise in fair health although her father has had a heart attack.

SOCIAL HISTORY: Occupation - she last worked in 1996 as a poker dealer. She now volunteers at AA and is a senior vice president of the V.F.W. in D'Iberville of the Ladies Auxiliary. She was in the United States Air Force from 1975 to 1987 as a radar operator. She is a recovering alcoholic, sober x five years. Smokes one and a half packs of cigarettes per day. She realizes this is not good and has tried using the Nicotine patches. She feels this has only made her smoke more. She denies any current use of drugs.

REVIEW OF SYSTEMS: Head - no vertigo, no double vision. She wears glasses and is followed in the Eye Clinic for lattice. She is seen there every six months. Ears - no frequent infection. Nose - chronic sinus infection. Uses Afrin nose drops periodically, recent round of Amoxil. Sinus infections usually at the change of every season. Throat - she has a polyp diagnosed by dental. She has frequent colds and sore throats. Her allergy testing that she had had previously was negative. She also has had bronchitis several times. She denies any chest pain. Denies any shortness of breath. She has a history of ulcer disease followed by Dr. Avalos. She had intermittent bouts of constipation and diarrhea. GU - she has occasional frequency and with burning on urination. She has had seizure like activity due to the fact that she was on Inderal. She has had no seizures since the Inderal was discontinued. She is currently on Gabapentin up to five tablets a day. Neuro - she had tension rebound, migraine and sinus headaches. She also has a history of hiatal hernia. She went through the Substance Abuse Program in 1994 and no previous psychiatric admissions.

MEDICATIONS: Her current medications include Gabapentin, Prozac, Klonopin, Vistaril, Risperdal. This patient is also on Estrogen replacement.

** THIS NOTE CONTINUED ON NEXT PAGE **

07/26/99 10:13 ** CONTINUED FROM PREVIOUS PAGE **

PAST MEDICAL HISTORY: She has had a history of drug overdose, once in 1973 and once in December of 1993. She was not hospitalized after either time. No history of self destructive behavior. She reports that she is a recovering alcoholic, sober x five years. Denies any history of drug abuse. She had her last mammogram two or three months ago and she has had a GYN consult within the last two years.

She had the usual childhood illnesses; measles, mumps and chicken pox. Adult illnesses include migraine headaches, ulcer disease, chronic pain.

PAST SURGICAL HISTORY: She had a hysterectomy and has had laparotomy for pelvic adhesions x two, four wrist surgeries on ganglions. She had a cracked elbow which required a casting only and a motor vehicle accident a number of years ago with sutures to her lower chin. No loss of consciousness.

PHYSICAL EXAM

HEIGHT:	5'6"
WEIGHT:	130
TEMPERATURE:	99.3
PULSE:	87
RESPIRATIONS:	18
BLOOD PRESSURE:	114/73

General Appearance and Mental Status: This is a 41 year old white female in no acute distress, alert and oriented x 3, in hospital pajamas.

Head: Normal shape and size without tenderness or deformity, trauma or other abnormalities.

Eyes: Pupils are equal and reactive to light and accommodation. Fundi are normal including disks and vessels. No hemorrhage or exudates. EOM's normal. Conjunctiva, cornea and sclera are normal.

Ears: External meatus. Drums visualized. Normal without scars, inflammation or perforation. Hearing is grossly normal.

Nose: Normal mucosa and airways. No deviation.

Mouth: Normal lips, breath. Has some poor dentition and is undergoing dental work at the Dental Clinic. She also has a centimeter polyp on her left oropharynx.

Throat: Normal pink mucosa.

Neck: Normal motion of neck. Trachea is midline. Thyroid is normal. No bruits or masses noted.

Breasts:

Chest: Normal size and shape. No tenderness noted.

** THIS NOTE CONTINUED ON NEXT PAGE **

07/26/99 10:13 ** CONTINUED FROM PREVIOUS PAGE **

Heart: Regular rate and rhythm. No murmur, gallops, clicks or rubs.

Lungs: Clear to auscultation.

Abdomen: No tenderness. Bowel sounds are normal.

Genitalia: Deferred/refused pelvic.

Rectal: Refused.

Back: Normal curvature and mobility. No pain or tenderness. No CVA tenderness.

Skin: Normal color and texture.

Extremities: No edema or varicosities, cyanosis.

Lymphatics: Negative for lymphadenopathy.

Neurological: Strength is equal, grossly normal.

DIAGNOSTIC IMPRESSION:
AXIS I: DEPRESSION.
DYSTHMIA.
AXIS II: DEFERRED
AXIS III: MIGRAINE HEADACE.
AXIS IV: MODERATE TO SEVERE STRESSORS.
AXIS V: ADMISSION GAF OF 35

PLAN: Medications were written by Dr. Mathis earlier, on 7/23/99, when she was staffed. She will be started on Bactrim due to her urinary frequency with burning. A regime of Gatorade prn x three days and Atrovent nasal spray for her sinuses.

Her immunizations - she needs as DT which will also be done and fasting labs were re-done on 7/26/99.

The patient will be returned to her home environment upon discharge.

/tp

Signed by: /es/ MARGO A DONALDSON
RN,MSN,FNP 07/26/99 11:40
Analog Pager: 672/122
Digital Pager: 672/122
REQUIRES COSIGNATURE

Department of Veterans Affairs | **MEDICAL RECORD** | RECREATION THERAPY SVC. DATA BASE AND ASSESSMENT

INSTRUCTIONS: *This form will be used by all therapist to document: 1) individual patient data used in multidimensional analysis of health care related factors; 2) findings of Leisure Problem Screening (LPS), Comprehensive Leisure Assessment (CLA) and/or Activity Assessment,*

RECREATION THERAPY SERVICE ASSESSMENT

AGE: 41 MARTIAL STATUS: NO ~~BILOXI~~ VAMC - G2. I DIVISION

Information pertinent to skills, talents, attitudes, aptitudes, needs, interests, life experiences, capacities and any noted deficiencies in leisure functioning.

1. Current Recreation/Leisure activities or those participated in prior to hospitalization Enjoy most all types of water sports
2. Educational Background: High School
3. Occupation: N/A
4. Time Available for Leisure Pursuits: Inpatient 100% Outpatient _____
5. Special Interest, Skills, Talents: Fishing And water games
6. Answer the following:

YES	NO	N/A		
	✓		a.	Do you have difficulty making leisure choices?
✓			b.	Would you like to learn new leisure skills?
	✓		c.	Have you ever been involved in the organization of any recreation activities?
	✓		d.	Do you know your community's recreational areas, facilities and their accessibility?
✓			e.	Are you aware of the leisure time pursuits and adaptive sports activities available at this medical center?
	✓		f.	Do you have financial resources available for leisure pursuits?
✓			g.	Since you have been here, have you pursued any recreation activities?
✓			h.	Do you feel comfortable interacting socially? (Continued on Reverse)

SIGNATURE/TITLE-PRACTITIONER [signature] DATE 7/26/99

PATIENT IDENTIFICATION-(Treating Facility - Ward No.) DATE

Doue, Gatle [redacted]

RECREATION THERAPY SERVICE DATA BASE AND ASSESSMENT

[redacted]

*U.S.GPO:1997-516-772/83791

VA FORM 10-0091 MAR 1997

7. Problems or barriers that affect your free time:
No Interest: _____ Physical Disabilities: none

Transportation : no Other: _____

8. Additional Information: _____

9. Observation Data: Pt shows an interest in most all types of RT

10. Goals and Objectives for Patient: Pt will be in as much R.T. as health will allow - needs stimulus to participate

THERAPIST PROGRAM/ACTIVITY RECOMMENDATIONS FOR PATIENT REGARDING INDIVIDUAL LEISURE LIFE STYLE:

I. ADAPTED SPORTS

A.	BASKETBALL	( )
B.	BOWLING	( )
C.	BALL THROW	( )
D.	PUTT-PUTT GOLF	( )
E.	FISHING	(+)
F.	PITCH & CATCH	( )
G.	TIC TAC TOE	( )
H.	OTHER:	( )

II. PSYCHOSOCIAL ACTIVITIES

A.	GROUP DISCUSSIONS	(+)
B.	SOCIALS ON WARD	(+)
C.	BINGO ON WARD	(+)
D.	SOCIALS IN REC HALL	(+)
E.	BINGO IN REC HALL	(+)
F.	SOCIALS AT SVC CLUBS	(+)
G.	OTHER:	( )

III. SEDENTARY ACTIVITIES

A.	TABLE GAMES	( )
B.	CHECKERS	( )
C.	CHESS	( )
D.	CARD GAMES	( )
E.	PUZZLES	( )
F.	CURRENT EVENTS	(+)
G.	MOVIES	(+)
H.	MUSIC LISTENING	(+)
I.	CONVERSATION	(+)
J.	OTHER:	( )

IV. ARTS/CRAFTS/HOBBIES

A.	MODELS	( )
B.	PAINT BY NUMBER	( )
C.	DODDLE ART	( )
D.	LEATHER CRAFT	( )
E.	WOODWORKING	( )
F.	CERAMICS	( )
G.	STITCHERY	( )
H.	SUNCATCHERS	( )
I.	DECO POINT	( )
J.	GARDENING	(+)
K.	OTHER:	( )

V. COMMUNITY RE-ENTRY

A.	LEISURE EDUCATION	( )
B.	LEISURE COUNSELING	( )
C.	VAN RIDES	(+)
D.	LOCAL INTEREST TRIPS	( )
E.	ACTIVITIES OF DAILY LIVING	( )
F.	SHOPPING TRIPS	(+)
G.	OTHER:	( )

11. PROBLEMS IDENTIFIED: #20

12. EDUCATIONAL NEEDS: _____

S: Chewing Problems: Y (N)
Dysphagia: Y (N)
Appetite: + − fair
Feeding Assistance Required: Y (N)
Food Allergies: ~~None on file~~ ϕ
Food Preferences: Mixed

Pre-Admission Diet: 1-2 meals
stable Wt. + − [redacted] # in last 6 months
Nausea: (Y) N ~~soon~~ Vomiting: (Y) N
Diarrhea: Y (N) Constipation: (Y) N
3 days 7/20, 21, 22
C/O migraines

O: Current Diet: REG
Adm. Dx: DEPRESSION
Age: 41 Sex: F
Height: 5'6"
Curr. Weight: 130#
Last Weight: NR
Usual Weight: 125-130#
Ideal Weight: 130±10%

Adm. Date: 22-Jul-99 6:15pm
Prior Assessment: ϕ wt. hx: 2/98 - 1
6/98 - 1
6/99 - 1
7/99 - 1
Frame Size: M
Amputation %:
Weight Taken: } NA
Weight/Usual Wt:
Weight/IBW:

Laboratory Data

Test	Result	units	Ref. range	Date
GLUCOSE	93	MG/DL	62 - 128	26-Jul-99
UREA NITROGEN	9	MG/DL	9 - 20	26-Jul-99
CREATININE	0.9	MG/DL	.5 - 1.4	26-Jul-99
SODIUM	139	MEQ/L	137 - 145	26-Jul-99
CHOLESTEROL	185	MG/DL	146 - 240	26-Jul-99
ALBUMIN	3.5 L	GM/DL	3.9 - 5	26-Jul-99
TRIGLYCERIDE	200 H	MG/DL	40 - 160	26-Jul-99
HGB	13.1	g/dl	12 - 16	22-Jul-99
HCT	37.9	%	37 - 47	22-Jul-99
LYMPH#	3.7 H	#/cmm	1.2 - 3.4	22-Jul-99

Appearance: WNWF

Briefly explained diet
Nutrition Education ~~to pt.~~
Further Education Required: Y (N)
ϕ Food Allergies

A: Nutrition Status
___ Normal
✓ Mildly Compromised
___ Moderately Compromised
___ Severely Compromised

Tolerating diet now. W/in IBW range.
Comments: Albumin - L. Needs at least 1700 Calories + 59 - 87 gms protein daily for repl tissues

P: Nutrition Plan
✓ Provide basic nutritional care
___ Screening data not available: Please order _____
___ Nutrition Education
___ Recommend Diet Change
___ Further Nutritional Assessment
Recommendations: Provide pt c HS snack as requested
(1) wt stable 130±10%
(2) Albumin > 3.5
(3) Decrease nausea & vomiting
(4) Bowel regularity - daily or every other day

Flag: for one week

[redacted] RD 7/26/99
Signature Date

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.)*

DATE: 7/23/98

DIAGNOSES: Axis I: Major Depression recurrent without psychotic features
Dysthymia,

Advance directive exists: No___ Yes X

Axis II: Deferred

Axis III: Migraine Headache

b1G2504: Axis IV: moderate to severe stressors

Axis V: Admission GAF=35

ESTIMATED LENGTH OF STAY (or Treatment for Outpatients): 15 days
Please specify DATE and note if patient remains, the plan must be reviewed that date.

BARRIERS TO COMMUNICATION/LEARNING: No ✓ Yes__ If yes, explain_____

ASSIGNED CASE MANAGER/PRIMARY THERAPIST:

Gayle A. Dove — Patient

Social Worker

M. Ellis, OTR/L

Family/Significant Other

Psychologist

Nurse

Family Involvement: Yes__ No ✓ Refer to PN's dated: 7-23-98

SIGNATURE/TITLE PRACTITIONER: David M. Mathis, D.O. — SIGNATURE/INITIAL OF APPROVING PHYSICIAN — DATE: 7-23-98

Enter in space below - PATIENT IDENTIFICATION (Name, Social Security No., Ward No.) — *Date*

AS3285170.952

MEDICAL RECORD OVERALL TREATMENT PLAN

[redacted]

EXISTING STOCK OF VAF 10-0043, OCT 1987, WILL BE USED.

*U.S. Government Printing Office: 1995 — 621-500/83021

VA FORM SEPT 1989 **10-0043** 031630

TREATMENT PLAN

UPDATES

See PN dated:_____

Present:_____

See PN dated:_____

Present:_____

See PN dated:_____

Present:_____

See PN dated:_____

Present:_____

See PN dated:_____

Present:_____

See PN dated:_____

Present:_____

DATE: 7-23-97 PROBLEM # 2 PROBLEM: Depressed Mood

as manifested by: Reports of patient crying + being unable to stop

GOAL: To decrease ~~Pts~~ feelings of depression

OBJECTIVES	METHOD & FREQUENCY	STAFF RESPONSIBLE	TARGET DATES	ACHIEVEMENT DATES
① Pt. to verbalize decrease in feelings of depression. Pt. to report ↓ in episodes of "crying spells"	Psych meds ordered 1:1 meetings c RN Pt. to attend unit activities	MD RN Nursing staff Psychology Social Work	8-15-97	7/27/97

DOVE

[redacted]

DATE: 7/22/99 PROBLEM # 7 PROBLEM: Injury Risk to Self:

as manifested by: Verbalized Ideation of Suicide, History of Suicide attempts.

GOAL: To remain free of injury/harm while in the Hospital.

OBJECTIVES	METHOD & FREQUENCY	STAFF RESPONSIBLE	TARGET DATES	ACHIEVEMENT DATES
(1) Pt will not harm/injure self while in the Hospital.	1:1 Observation while on S.O. Observe for S/S of ↑ in mood. Monitor closely	Nursing M.D. Social Worker Psychology	8/99	7/29/99
(2) Pt will report to Staff when feeling out of control.	1:1 PRN Adm routine et PRN Medication as ordered.	Nursing MD Pharmacy	8/99	

DATE: 7/23/89 PROBLEM #19 PROBLEM: Follow-up care

as manifested by: need for continued treatment for mental problem (dysthymia)

GOAL: will have a scheduled treatment Plan upon discharge.

OBJECTIVES	METHOD & FREQUENCY	STAFF RESPONSIBLE	TARGET DATES	ACHIEVEMENT DATES
will meet w the social worker to discuss discharge Plan	1-1 PRN	social worker	8/15/89	7/28/89
will attend ward Groups and activities	Groups 4 hr. 4 x wk.	social worker Nursing staff Psych	8/15/89	

POVE

[redacted]

DATE: 7/26/99 PROBLEM #25 PROBLEM: Rehab Medicine Needs

as manifested by: Impaired functional and leisure performance.

GOAL: Improve concentration, problem solving skills, sense of accomplishment, and leisure performance.

OBJECTIVES	METHOD & FREQUENCY	STAFF RESPONSIBLE	TARGET DATES	ACHIEVEMENT DATES
↑concentration ↑problem-solving skills ↑sense of accomplishment ↑leisure skills	Vet will attend and participate in O.T. Clinic, 5x/week, M-F, @ 1:00-2:30 pm.	O.T. Staff	45 days 9/10/99	7/27/99

Dove, Gayle - [redacted]

DATE: 7/23/99 PROBLEM # 2 PROBLEM: Nutritional Problem

as manifested by: ① Nausea
② Weight Maintenance
③ Decreased albumin

GOAL: ① Control nausea
② wt stable 130 ± 10%
③ Increased albumin > 3.5

OBJECTIVES	METHOD & FREQUENCY	STAFF RESPONSIBLE	TARGET DATES	ACHIEVEMENT DATES
Pt will eat >90% of meals	① Regular diet 3 meals daily ② Monthly wt ③ Labs as ordered ④ Medication as ordered for nausea	RD MD Nsg	8/23/99	7/29/99

DOVE [redacted]

DATE:_____ PROBLEM #___ PROBLEM: _____

as manifested by: _____

_____

_____

GOAL: _____

_____

OBJECTIVES	METHOD & FREQUENCY	STAFF RESPONSIBLE	TARGET DATES	ACHIEVEMENT DATES

DATE: _____ PROBLEM #20 PROBLEM: Leisure Time Problem

as manifested by: inappropriate Socialization

GOAL: Patient will experience an acceptable level of Socialization with staff and peers

OBJECTIVES	METHOD & FREQUENCY	STAFF RESPONSIBLE	TARGET DATES	ACHIEVEMENT DATES
(1) Patient will be oriented as to what is proper Conduct	Participate in Group Session for Reality feedback from staff and peers	Nursing R.T. Therapy	30 days	
(2) Patient will Report a decrease in inappropriate Socialization	1-1 meeting 2 X wk.	R.T.		

Doug, Gayle

[redacted]

DATE:_____ PROBLEM #___ PROBLEM: _____

as manifested by: _____

_____

_____

GOAL: _____

_____

OBJECTIVES	METHOD & FREQUENCY	STAFF RESPONSIBLE	TARGET DATES	ACHIEVEMENT DATES

INPATIENT ORAL EXAMINATION

X	2	3	4	5	6	7	8	9	10	11	12	13	14	15	X
X	31	30	29	28	27	26	25	24	23	22	21	20	19	18	X

ASSESSMENT (Initial) (Subsequent)

Oral Hygiene——— (Good) (Fair) (Poor)

Masticatory Function——— (Adequate) (Inadequate) With dentures

Masticatory Function——— (Adequate) (Inadequate) Without dentures

Oral Mucosa/Gingiva——— Color – (light) (medium) (dark) (other)
(no gross oral pathosis noted)
(oral pathosis present as described)

Salivary Hydration——— (good) (fair) (poor)

Plans:

Admission Dx:

DX: Gingivitis

RX: Tx deferred

Service Connection:

Diagnosis	Treatment

SIGNATURE & TITLE OF PRACTIONER [signature] DATE 9/30/99

IMPRINT PATIENT DATA (NAME, ADDRESS, & SSN

DOVE,GAYLE A [redacted]

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE FOR SPECIALIZED DISCIPLINES

[redacted]

VA FORM 10-0114J ®

*U.S. GPO: 1995-622-059/83055

DOB: [redacted]

SECTION VIII: Psycho Social Review — SOCIAL WORK

NOK Name: Kay Dove, Jr Relationship: Father

Address: Same as patient

Home Phone: (228) 396-1919 & Work Phone: N/A

Patient Current Address: 4457 Pepper Ferry Biloxi, MS 39532 Phone: 228 396-1919

Describe Living Arrangement Prior to this Admission: Mother

Place of Birth: Whitchita Falls, TX Marital Status: Divorced

Sexual Orientation: Heterosexual - had a fiancee

Legal Problems: Yes (No) Describe: none

Patient and Family Educational Needs: AA - sobriety x 5 yrs

Problems as Evidenced by: loss of appetite, ↓ sleep, guilt, helpless, suicidal ideations

ORGAN DONOR - LIV. will on file IN Biloxi VA

SECTION IX: Military Profile — SOCIAL WORK

Military History: Branch USAF DOS: 9/4/75 - 9/16/87

Combat (Non Combat) Date/Type Discharge: Honorable, 1987

WWII/ KOR/VN/P.Gulf: Post VIETN POW — Service Connected (% and Reason) at 90%

PTSD 70%, removal of uterus, anxiety 50%,

Patient and Family Educational Needs: N/A

Problems as Evidenced by: migraine headaches, 300, Rhinitis, ↓ neoplasm, benign, skin, depression

IMPRINT PATIENT DATA CARD (Name, Address and Social Security Number)

DOVE, GAYLE
[redacted]
SEVERE DEPRESSION/W/SUICIDE I
62G-1
DR MATHIS

7

SECTION X: Sources of Income, Employment History and Education — SOCIAL WORK

Education History: 14 years

History of Employment: Prior at cause

Sources of Income:

Employer: unemployed Salary: -0-

List Amounts and Sources of Unearned Income:

Social Security: — NSC Pension: — Aid and Attendance N/A

Other: 90% SC at $24,468 per yr

Name, Address and Phone Number of Guardian or Payee: Competent - manages

of her own medicines

Where are Checks Mailed? Direct deposit to the home

Patient and Family Needs: Educate pt, family on community

resources

Problems as Evidenced by: #1: 7, 9, 16 ~~7~~, 19

TW RD

SECTION XI: Initial Assessment of Discharge Plans/Needs — SOCIAL WORK

1. Stabilize medically
2. If pt wants to call VCK, fill out
consent release form
3. Suicide precautions
4. Plan to file for Bdfts, attend
5. Aftercare at VAMC in Gulfport MS

SIGNATURE: Kim M McKeever MSW **DATE:** 7/23/99 **TIME:** 8:43

EMERGENCY ROOM/CLINIC ASSESSMENT

I. Date: 7/22/99 Time: _____ Age: 41 Ht.: 5'6" Wt.: 130 Gender: F

Mode of Arrival: ☐ Ambulance ☒ Walk-In ☐ Extended Care Facility ☐ Other: _____

Source of Information: ☒ Patient ☐ Family/Friend ☐ Old Chart ☐ Other: _____

Chief Complaint: c/o HA, depression

Allergies: ☒ Medications ☐ Food ☐ Insects ☐ Latex (must complete Latex Allergy questionnaire) NKDA

Reactions to Anesthesia: none

Medical History/Past Surgeries/Hospitalizations: HA, depressive disorder, reflux esophagitis, stomach ulcer, PTSD

Present Medications: Zoloft 100mg

Marital Status: ☐ Married ☐ Single ☒ Divorced ☐ Separated ☐ Widowed

Religious Preference: Protestant

Blood/Blood Product Transfusion Preference: ☒ None ☐ Yes; Explain: _____

EMERGENCY NOTIFICATION:

Relative/Friend: Ray Dove Relationship: Father Phone Number: 228-396-1919

II. **LEVEL OF CONSCIOUSNESS:**

☒ Alert ☒ Oriented ☒ Person ☒ Place ☒ Time

☐ Verbally Responsive ☐ Confused/Disoriented ☐ Responds to Pain

BEHAVIOR: ☒ Cooperative ☐ Uncooperative ☐ Combative ☐ Withdrawn ☐ Other: _____

EMOTIONAL/PSYCHOSOCIAL STATUS:

☐ Calm ☐ Anxious ☐ Fearful ☒ Depressed ☐ Suicidal ☐ Apathetic

ADL's/Level of Functioning: *S = Self A = Assist T = Total*

Bathing: (S) / A / T Dressing: (S) A / T Eating: (S) A / T Mobility: (S) A / T

Oral Hygiene: (S) / A / T Toileting: (S) A / T

Comments: _____

VITAL SIGNS

Time	BP	Pulse	R	T	Pulse Oximeter	Pain Assessment (0-10 Scale) Comments
1830	103/66	66	21	91	98 n/a	9/10 Headache

Signature/Title: Gail S. Hallupme Date/Time: 7/22/99 1830

Date/Time: _____

Readmission/Reassessment within 30 days:

Reviewers:

Signature/Title: _____ Date/Time: _____

7/22/99 Date/Time: _____

IMPRINT PATIENT DATA CARD (Name, Address and Social Security Number)

[redacted]

[redacted]

REV. 6/99

EMERGENCY ROOM/CLINIC ASSESSMENT

III. PATIENT RIGHTS (If Yes, must be on chart):

Advance Directives: ☒ Yes ☐ No
Type: Living Will
Location: Med
Organ Donor: ☒ Yes ☐ No
Tissue Donor: ☒ Yes ☐ No
Information/Pamphlet Provided:
☐ Yes ☒ No ☐ Refused
Patient requests further information on:
☐ Advance Directives
☐ Organ Donation
☐ Tissue Donation
Comments: _____

IV. POTENTIAL ABUSE:

☒ Not Applicable
☐ Rape or Other Sexual Molestation
☐ Domestic Abuse
☐ Abuse or Neglect of Elders or Children
☐ Evidence of Physical Assault
☐ Unexplained Bruises
☐ Unexplained Injuries
☐ Unkempt, Dirty, Poor Hygiene
If yes to above, **Initiate Center Memorandum 11-13-98** (Mandatory Reporting of Adult and Child Abuse or Neglect) and contact Social Worker.
Date/Time Initiated: _____
Method of Notification: _____
Comments: _____

V. SKIN:

☐ Hot ☒ Warm ☒ Cool ☒ Dry ☐ Diaphoretic ☒ Pink ☐ Cyanotic
☐ Rash ☐ Lesions ☐ Decubiti ☐ Lacerations ☐ Hematoma ☐ Flushed
☐ Other: _____

VI. CARDIOVASCULAR/CIRCULATION:

☒ No Problem Identified ☐ Chest Pain ☐ Exertional ☐ Rest
Chest Pain: Location: na Duration: na
Frequency: na Severity: 9/10 NAD (0-10 Scale)
What relieves pain: _____
Rhythm: ☒ Regular ☐ Irregular Leg Pain: ☐ Exertional ☐ Rest

PULSES	Left	Right
Radial	2+	2+
Dorsalis Pedal		
Posterior Tibial		

PUPILS	Left	Right
Size	3	3
React	3	3
Fixed		
Dilated		
Constricted		

1MM 2MM 3MM 4MM 5MM

BREATH SOUNDS	Left	Right
Clear	←	←
Wheezing		
Rhonchi		
Rales		
Other		

Sinus Drainage

VII. RESPIRATORY:

Breathing Pattern: ☒ Normal ☐ Dyspnea ☐ Exertional ☐ At Rest
Cough: ☒ None ☐ Non-Productive ☐ Productive

Signature/Title: Gail S. Hartsprung Date/Time: 7/8/99 1830
Date/Time: _____

Readmission/Reassessment within 30 days:
Reviewers:
Signature/Title: _____ Date/Time: _____
Date/Time: _____

[redacted]

EMERGENCY ROOM/CLINIC ASSESSMENT

VIII. MUSCULOSKELETAL:
☒ Moves All 4 Extremities ☐ Hemiplegia ☐ Paraplegia ☐ Quadriplegia
☐ Amputee ☐ Contractures ☐ Other: _____
Comments: _____

IX. GASTROINTESTINAL:
Abdomen: ☒ Soft ☐ Rigid ☐ Distended ☒ Non-Tender ☐ Tender
Bowel Sounds: ☒ Normal ☐ Absent ☐ Hypoactive ☐ Hyperactive
Last Bowel Movement: 7/21/99 Other: _____
Comments: _____

X. GENITOURINARY:
☒ No Problem Identified ☐ Burning ☐ Frequency ☐ Hematuria ☐ Incontinence
☐ Last Menstrual Period: _____ ☐ Last Mammogram: _____
☐ Last Pap Smear: _____ ☐ Other: _____

XI. TREATMENTS DONE:
☐ IV: _____ (Flow Sheet Started) ☐ N/G Tube ☐ Foley
☒ EKG ☐ ABG ☒ CXR ☐ KUB
☐ Aerosol Treatment: _____
☐ Chem 7 ☐ CMP ☐ Cardiac Enzymes ☒ CBC ☐ PT/PTT
☐ Other: thyroid, LFT, RPR, UA, UA drug screen
☐ Glucose Monitor: _____ ☐ Pulse Oximeter: _____
☐ Other: _____

MEDICATIONS ADMINISTERED:

Time	Medication	Dose	Response	Signature

XII. DISPOSITION OF PATIENT/CARE SETTING: Time: _____
☐ Discharged to Home ☐ Admitted to Ward: _____
☐ Admitted to ICU ☐ Admitted to Mental Health Ward: _____
☐ Transferred to Another Facility: _____
Method of Discharge: ☐ Own Vehicle ☐ Significant Other's Vehicle ☐ Ambulance ☐ Escorted to Gate
Accompanied By: _____ ☐ Other: _____
Report Called To: _____
Patient Placed on Seriously Ill List: ☐ Yes ☐ No Chaplain Notified: ☐ N/A ☐ Yes ☐ No
List Items Brought to Hospital: _____
Disposition of Valuables: ☐ Agent Cashier ☐ MAA ☐ Patient Effects ☐ Patient ☐ Family/Home

Signature/Title: _____ Date/Time: _____
_____ Date/Time: _____

Readmission/Reassessment within 30 days:
Reviewers:
Signature/Title: _____ Date/Time: _____
_____ 7/21/99 Date/Time: _____

IMPRINT PATIENT DATA CARD (Name, Address and Social Security Number)

LOVE, GAYLE A
[redacted]

REV. 6/99

PROGRESS NOTES

EKG RHYTHM STRIP
(If Applicable)

Signature/Title: _____ Date/Time: _____
_____ Date/Time: _____

Readmission/Reassessment within 30 days:
Reviewers:
Signature/Title: _____ Date/Time: _____
_____ Date/Time: [redacted]

Interdisciplinary Patient and Family Teaching Record

TEACHING ASSESSMENT

Learns best: ☐ Seeing ☐ Hearing ☑ Doing **Able to read:** ☑ Yes ☐ No **Education level:** (please specify) 14 yrs

Barriers/limitations: ☐ Physical ☐ Visual ☑ Cognitive ☐ Auditory ☐ Language ☐ Emotional ☐ Other ☐ None

Describe barriers/limitations and note plan to adapt patient teaching: Poor short term memory pt reports

Age specific needs:

Cultural/religious practices affect the patient's healthcare? ☑ No ☐ Yes **If yes, describe and document plan to respect patient's need:** N/A

Knowledge of Diagnosis:

1. Understands disease/condition ☑ Yes ☐ No Explain: Verbalizes understanding
2. Understands treatment ☑ Yes ☐ No Explain: Verbalizes understanding
3. Able to demonstrate use of prescribed equipment ☑ Yes ☐ No ☐ N/A Explain: Has own unit. not used in a while

Knowledge of Medications:

1. Knows when to take ☑ Yes ☐ No Explain: Verbalizes understanding
2. Knows reason medication is prescribed. ☑ Yes ☐ No Explain: Explains reasons for taking

Support System to Assist with Learning: **Circle those applicable:**

Spouse (Family member) Friend No support N/A

Name of person included in teaching: Ray Dove - Father

Signature/Title Paula Overland Rn Date 7/22/99

CODES

A. Topic/Teaching

~~1.~~ Disease/Condition
2. Medications
~~3.~~ Diet/Nutrition
~~4.~~ Food/Drug Interaction
~~5.~~ Treatment/Procedure
~~6.~~ Equipment Use/Safety
~~7.~~ Hygiene
~~8.~~ Rehab/ADLs
~~9.~~ Health Promotion/ Prevention
~~10.~~ Community Resources
11. Follow-up Instructions
12. Other

B. Learner

P = Patient
S = Spouse
F = Family member
O = Other

C. Teaching Method

E = Explanation
H = Handouts * (list title)
D = Demonstrate
AV = Audiovisual * (list title)
G = Group Presentation
R = Reinforced

D. Evaluation

1. Verbalizes/Discusses essential concepts
2. Asks appropriate questions
3. Demonstrates
4. Demonstrates with assistance
5. Requires reinforcement
6. No evidence of understanding
7. Refused teaching

For each entry, include appropriate codes from above. *** Asterisk items require additional information in the "Comments" section on the back.**

Date	Time	A. Topic/ Teaching Need(s)	Readiness to learn Y/N *	B. Learner	Instructions/ Discussion	C. Teaching Method	D. Eval.	Initial
7/22/99	2020	12	Y	P	Oriented to Ward / Staff	E	1,2	PO
7/22/99	2020	12	Y	P	Pt. Rights	E,H	1,2	PO
7/22/99	2020	7	Y	P	Discussed Good hygiene	E	1	PO

SIGNATURE AND TITLE OF NURSE PRACTITIONER DATE

IMPRINT PATIENT DATA CARD (Name, Address and Social Security Number)

DOVE, GAYLE
[redacted]
SEVERE DEPRESSION/W/SUICIDE I
62G-1
DR MATHIS

MEDICAL RECORD

SUPPLEMENT TO PROGRESS NOTE FOR SPECIALIZED DISCIPLINES-VERTICAL

[redacted]

VA FORM SEP 1992 10-0114J(R)

*U.S. Government Printing Office: 1997 — 515-805/83728

Date	Time	A. Topic/ Teaching Need(s)	Readiness to learn Y/N*	B. Learner	Instructions/Discussion	C. Teaching Method	D. Eval.	Initials
7/23/99	9:00 AM	5	Y	P	Treatment Team Mtg.	E	1,2	GM
7/23/99	9:00 AM	10	Y	P	Educate on community resources	E	1,2	KMR
7/23/99	9:30 AM	1	Y	P	Discuss Disease Condition / Exam	E	1,2	SMM
7/23/99	2:50 pm	3,4	Y	P	Briefly explained dept	E	1,2	[illegible]
7/22/99	1330	8	Y	P	Pt expressed understanding of O.T. group purpose & tasks	E,D	4	MRE
7/26/99	1000	12	Y	P	Orientation Group	E	1,2	RL
7/26/99	0930	6,7,8,9	Y	P	Discussed Safety, wearing socks & shoes, Handwashing, Smoking, pulling	E	1,2	RL
7/28/99	1000	2	Y	P	Medications - currently taking	E	1	SM
7/29/99	0800	12	Y	P	Fill out Appt	E	1	CS

Date	Time	Initials	Comments

Initials	Signature/Title
DO	Paula Ouellette, Occupational Therapy
CM	[illegible]
KMR	[illegible]
SMM	[illegible]
GM	[illegible]

Initials	Signature/Title
MRE	Marguis R Ellis, OTR/L

Referrals for further education or support (circle P, S, F, and/or O)	Referrals for further education or support (circle P, S, F, and/or O)
P, S, F, O referred to _____ Date _____ Initials _____	P, S, F, O referred to _____ Date _____ Initials _____
P, S, F, O referred to _____ Date _____ Initials _____	P, S, F, O referred to _____ Date _____ Initials _____
P, S, F, O referred to _____ Date _____ Initials _____	P, S, F, O referred to _____ Date _____ Initials _____

NOTE DATED: 07/22/99 16:22 PSYCHOLOGY-MENTAL HEALTH
VISIT: 07/22/99 10:15 WOMEN'S MHPC GOLD WALK-IN
WOMENS MHPC CLINIC/ CRISIS INTERVENTION/ PROB #2,3,7/ GAF=45

S: Pt presents for unscheduled visit. She c/o severe depression and anxiety with suicidal ideation. She reports breaking up with her fiance last week, which has exacerbated her current sxs. Pt reports that she is feeling so overwhelmed by psychosocial stressors that she had contemplated drinking; pt has been sober 5 years. Current sxs include: depressed mood, crying, loss of appetite, poor sleep (approx. 3 hours per night with initial insomnia), hopelessness, helplessness, feelings of guilt, anxiety, and suicidal ideation (thoughts of shooting herself). Pt reports that sxs have been worsening over the past few weeks.

O: Fatigued. Crying. Appears depressed, anxious, and scared. Casually dressed.

A: Major Depression, Recurrent, Severe with suicidal ideation; PTSD

P: Admit pt to psychiatry for stabilization of sxs and medication evaluation. Pt has contracted for safety. Her father will bring her to the ER for admission this afternoon.

Signed by: /es/ SAUNDRA SAPORITI, PSY.D.
STAFF PSYCHOLOGIST 07/22/99 16:45

ATTACHMENT D

Restraint/Seclusion/Suicide Observation Flow Sheet

CARE PROVIDED CODE:

1. Procedure explained to patient
2. Placed in restraints
3. Placed in seclusion
4. Circulation/skin check q. 15 min.
5. ROM exercises (R.A.,L.A.,L.L.,R.L.)
6. Elevate HOB 30 degrees
7. Refused fluids offered
8. Drank fluids (enter on I & O sheet)
9. % of meal eaten
10. Toilet/Urinal offered
11. Voided
12. B.M.
13. Vital Signs
14. Shower/Bath
15. P.R.N. med. given by nurse
16. Checked for contraband
17. Out of restraints
18. Out of seclusion
19.
20.
21.
22.

BEHAVIOR CODE:

a. Combative
b. Yelling/Screaming
c. Threatening
d. Cursing
e. Quiet
f. Sleeping
g. Mumbling
h. Crying
I. Laughing
j. Singing
k Disrobing
l. Beating door
m. Lying Rm 123
n. Walking
o. Standing still
p. Spitting
q. Verbalizing
r. Interviewed By N.
s. Talking w Doctor
t.
u.

CHECKS MADE ON PATIENT - CODE AND INITIAL

0015	0615	1215	1815
0030	0630	1230	1830
0045	0645	1245	1845
0100	0700	1300	1900
0115	0715	1315	1915
0130	0730	1330	1930
0145	0745	1345	1945
0200	0800	1400	2000
0215	0815	1415	2015
0230	0830	1430	2030 I, 8, 10, 16, E 10
0245	0845	1445	2045 R,Q —
0300	0900	1500	2100 R,Q —
0315	0915	1515	2115
0330	0930	1530	2130 R Q —
0345	0945	1545	2145
0400	1000	1600	2200 M,E,I —
0415	1015	1615	2215
0430	1030	1630	2230 M,E,S
0445	1045	1645	2245
0500	1100	1700	2300 M,E,10 —
0515	1115	1715	2315
0530	1130	1730	2330 M,E —
0545	1145	1745	2345
0600	1200	1800	2400 M,E —

I	2400-0800	O	I	0800-1600	O	I	1600-2400	O
NAME		INITIAL	NAME		INITIAL	NAME		INITIAL
Jacqueline D Greenwood		JDG						

(Circle One) RESTRAINT SECLUSION SUICIDE Date 7-22-99

IMPRINT PATIENT DATA CARD (Name, Address and Social Security Number)

1 1999

8 30 Min

MEDICAL RECORD

SUPPLEMENT TO PROGRESS NOTE FOR SPECIALIZED DISCIPLINES-VERTICAL

[redacted]

LOVE, GAYLE A

[redacted]

VA FORM SEP 1992 10-0114J(R)

NOTE DATED: 07/23/99 08:30 CHAPLAINCY ASSESSMENT (BLANK)
ADMITTED: 07/22/99 18:15 62G-1PURPLE
SAW VETERAN FOR INITIAL PASTORAL ASSESSMENT.

BACKGROUND:

VETERAN STATES CURRENT HOSPITALIZATION WAS INITIATED BECAUSE 'I BROKE UP WITH MY FIANCEE ON MONDAY...I HAD A FRIEND THAT DIED A FEW DAYS AGO'. VETERAN ADMITS TO RECENT SUICIDAL IDEATIONS, DENIES CURRENT IDEATIONS STATING 'I DON'T WANT TO DIE BUT I JUST DON'T FEEL LIKE I HAVE ANYTHING TO LIVE FOR'. NOTIFIED NURSE C.C. VETERAN REPORTS POST TRAUMATIC STRESS DISORDER RELATED DIFFICULTIES FROM A RAPE THAT OCCURRED AT HER AGE OF 28 OR 29. STATES THESE DIFFICULTIES HAVE ADVERSELY EFFECTED HER RECENT FEMALE-MALE RELATIONSHIP. VETERAN ADMITS TO A HISTORY OF THE ABUSIVE USE OF ALCOHOL, BUT DENIES ANY USE OF ALCOHOL IN THE LAST 5 YEARS. STATES THAT SHE HAD A SON AT AGE 16, AND THAT SHE PLACED THIS CHILD UP FOR ADOPTION. STATES THAT SHE FOUND OUT LATER THAT SHE CAN NOT HAVE ANY OTHER CHILDREN, AND THE FACT THAT SHE HAS NEVER SEEN HER SON BOTHERS VETERAN. VETERAN CLAIMS GOOD RELATIONSHIPS WITH HER FATHER AND ONE BROTHER. REPORTS STRAINED RELATIONSHIPS WITH HER MOTHER AND ANOTHER BROTHER. VETERAN CLAIMS '1' SIGNIFICANT FRIENDSHIP THROUGH HER INVOLVEMENT IN AA. STATES THAT SHE IS HAVING DIFFICULTY DEALING WITH THE DEATH OF HER FRIEND LAST WEEK. VETERAN DOES ADMIT TO BEING LONELY. STATES 'I DON'T KNOW' WHAT GIVES HER LIFE MEANING AT THE PRESENT TIME. STATES 'WHEN I WAS IN THE MILITARY...I WAS GOOD AT WHAT I DID' AND THAT THIS USED TO GIVE HER LIFE MEANING.

PASTORAL ASSESSMENT:

VETERAN BELIEVES IN GOD. STATES SHE 'TALKS TO GOD' DAILY. DENIES CHURCH ATTENDANCE 'SINCE I WAS A TEENAGER'. VETERAN STATES HER RELATIONSHIP WITH GOD 'COULD BE BETTER', AND EXPRESSED INTEREST IN FURTHER EXPLORING HER SPIRITUALITY AT THE PRESENT TIME. DISCUSSED THE SPIRITUAL COMPONENT OF RECOVERY WITH VETERAN. VETERAN STATES THAT SHE HAS EXPERIENCED GOD'S HELP IN THE PAST IN DEALING WITH HER ALCOHOL USE, AND FEELS SHE WILL NEED GOD'S HELP IN THE FUTURE IN DEALING WITH HER ALCOHOL USE. VETERAN STATES THAT HER PERSONAL FAITH IN GOD HAS HELPED HER DEAL WITH THE RECENT DEATH OF HER FRIEND AND THAT SHE 'SOMETIMES' DERIVES COMFORT FROM HER PERSONAL FAITH IN GOD. DENIES THAT HER PERSONAL FAITH IN GOD HELPS HER DEAL WITH HER TRAUMATIC MEMORIES, OR IMPACTS HER POSSIBLE SUICIDALITY. OFFERED PRAYER WITH VETERAN. RECOMMEND FUTURE PASTORAL CONVERSATION CONTINUE TO ADDRESS VETERAN'S TRAUMATIC MEMORIES, THE EFFECT OF HER TRAUMATIC EXPERIENCE ON CURRENT FEMALE-MALE RELATIONSHIPS, THE RECENT DEATH OF HER FRIEND, THE RECENT BREAK UP OF HER SIGNIFICANT FEMALE-MALE RELATIONSHIP, HER FEELINGS CONCERNING HAVING PLACED HER SON FOR ADOPTION, STRAINED RELATIONSHIPS WITH HER MOTHER AND BROTHER, HER LONELINESS, THE MEANING OF HER LIFE, THE SPIRITUAL COMPONENT OF RECOVERY, HER POSSIBLE SUICIDALITY, AND CONTINUE TO ENCOURAGE VETERAN IN HER EXPRESSED DESIRE TO FURTHER EXPLORE HER SPIRITUALITY AT THE PRESENT TIME.

Signed by: /es/ HARRY D NICHOLAS JR
CHAPLAIN 07/23/99 08:50

ATTACHMENT D

Restraint/Seclusion/Suicide Observation Flow Sheet

CARE PROVIDED CODE:

1. Procedure explained to patient
2. Placed in restraints
3. Placed in seclusion
4. Circulation/skin check q. 15 min.
5. ROM exercises (R.A.,L.A.,L.L.,R.L.)
6. Elevate HOB 30 degrees
7. Refused fluids offered
8. Drank fluids (enter on I & O sheet)
9. % of meal eaten
10. Toilet/Urinal offered
11. Voided
12. B.M.
13. Vital Signs
14. Shower/Bath
15. P.R.N. med. given by nurse
16. Checked for contraband
17. Out of restraints
18. Out of seclusion
19. S.O. Die'd
20.
21.
22.

BEHAVIOR CODE:

a. Combative
b. Yelling/Screaming
c. Threatening
d. Cursing
e. Quiet
f. Sleeping
g. Mumbling
h. Crying
i. Laughing
j. Singing
k Disrobing
l. Beating door
m. Lying
n. Walking
o. Standing still
p. Spitting
q. Verbalizing
r. awake
s. Smoking
t. Watching TV
u. Dayroom
v. & Chaplain
w. in staffing
x. talking to MD

CHECKS MADE ON PATIENT - CODE AND INITIAL

0015 16, e f	BW	0615 ef	BW	1215		1815	
0030 e f	BW	0630 r, 13, 15,	BW	1230		1830	
0045 e f	BW	0645 r, 5, 9	BW	1245		1845	
0100 e f	BW	0700 r, 7	BW	1300		1900	
0115 e f	BW	0715 r 9 90's	BW	1315		1915	
0130 e f	BW	0730 r 5	BW	1330		1930	
0145 e f	BW	0745 r 7	BW	1345		1945	
0200 e f	BW	0800 16, u, t, a	SC	1400		2000	
0215 e f	BW	0815 e, v	PT	1415		2015	
0230 e f	BW	0830 e, v, b	PT	1430		2030	
0245 e f	BW	0845 e, u, t	PT	1445		2045	
0300 e f	BW	0900 e, w, x	PT	1500		2100	
0315 e f	BW	0915 e, w, x, 19	PT	1515		2115	
0330 e f	BW	0930		1530		2130	
0345 e f	BW	0945		1545		2145	
0400 e f	BW	1000		1600		2200	
0415 e f	BW	1015		1615		2215	
0430 e f	BW	1030		1630		2230	
0445 e f	BW	1045		1645		2245	
0500 e f	BW	1100		1700		2300	
0515 e f	BW	1115		1715		2315	
0530 e f	BW	1130		1730		2330	
0545 e f	BW	1145		1745		2345	
0600 e f		1200		1800		2400	

I	2400-0800	O	I	0800-1600	O	I	1600-2400	O

NAME	INITIAL	NAME	INITIAL	NAME	INITIAL
Geraldine Wanda	Wa				
Pat Terrell RN	PT				

(Circle One) RESTRAINT SECLUSION SUICIDE Date 7-23-96

IMPRINT PATIENT DATA CARD (Name, Address and Social Security Number) 1 1 9 99

LOVE GAYLE A [redacted]

MEDICAL RECORD

SUPPLEMENT TO PROGRESS NOTE FOR S[redacted]PLINES-VERTICAL
JUNE 1995

VA FORM
SEP 1992 10-0114J(R)

MEDICAL RECORD	PROGRESS NOTES
DATE	

7/22/99 Mac Admit Note

10^00 pm

Hx yo ♀ HL Depression placed, for some ♀ SI. Regards into Stable of ♀ fiancé lost wk ♀ dear friend Kathy died. Cont to have migraine HA despite cmpt. Short unbearable tearful ⊖SI

133 | 101 | 7 / 86 TSH 3.8
1.3 | — | .8

EKG NSR ⊖ acute Δs

UA ⊖

On estrogens — conjugated ♀ migraines (?) will discuss Medicine

13.1
8.6 3.13
37.9

♀ pt wishes to see Neurology for migraines — pt does smoke

D Hess

7/23/99 0745 #7 - Slept soundly entire night — Has voiced to suicidal ideation on this TOD. Obs / documentation per Hosp policy for suicidal observation

Sharon Batsell RN

7/23/99 mrl -

(Continue on reverse side)

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

DOVE, GAYLE A

[redacted]

1 1999

REGISTER NO.

WARD NO.

1 1999

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

1

PROGRESS NOTES

DATE

TREATMENT PLAN UPDATE

7/23/99 0845 And Psych Attending Note

41 yo old Caucasian female, c c/o of " I wanted to talk to someone about talking to Dr Goldberg because I didn't think it was working, I broke up with my Fiance on last Monday, my friend died last week"

Current Outpatient Psychotherapy, Prozac, Klonopin, Vistaril - previously on Zoloft, Ativan, Trazodone. Reports Suicidal thoughts. given to hospital for several days without plan. Sx reports due to mixture and pt has had thoughts of death for several months.

Hx hx of overdose twice. one. 1973 - one. 1993 - not hospitalized after either time. No hx of self injurious behaviors. Reports she is A Recovering Alcoholic - sober almost 5 years.

Denies any hx of Drug abuse.

See H&P

MSE: Trend in grooming. Speech: loud and Cohesive Affect: Blunted mood: Dysphoric Denies current suicidal or homicidal thoughts Denies hallucinations or delusions. No evidence of thought disorder. no cognitive deficits, no current withdrawal symptoms

Dx: Axis I Major Depression Recurrent
Dysthymia
Axis II Deferred
~~Axis III Migraine~~
Axis IV moderate to severe stressors
Axis V Admission GAF: 35

Plan: will manage medications, Psychotherapy, Suicide precautions

David M. Mathis, D.O
AS3285170-952

☆ U.S. GPO:1998-443-732

STANDARD FORM 509 (Rev. 9-97)

1850

NOTE DATED: 07/23/99 13:56 PSYCHOLOGY-INPATIENT
ADMITTED: 07/22/99 18:15 62G-1PURPLE
Ms. Dove reports she is 100 % s.c. for pay purposes and receives social security. She has 14 yrs. educ., but reports she lacks job skills. She was in the AirForce for 12 years (75 to 87), received an Honorable discharge with failure for alcohol rehab. Sheis serviced connected for multiple physical problems. She has lived on the Mississippi Coast since 1990. She is active in AA and assists in their central office. Reports an active life style. Her mood is normal at this time, thoughts well organizedand presents no new problems. Her miagraines, she reports happpen about 4 times a week and last 2 hours to several days. reports when she is depressed she cries, won't eat, and has sleep problems. advised patient to see me when needed.

#0 Signed by: /es/ CARNESS I. PERSONS, PH.D.
PSYCHOLOGIST 07/23/99 14:02

PROGRESS NOTES

DATE	
4/24/99 0500	#1 Det. Has been observed during this TOD et has appeared to have slept & any distress. Martha Willis
7/24/99 0700	#9 VA rested quietly & incident or apparent acute distress this TOD til 1. When ↑ to nursing station for AM meds, rpt do severe H/A. Medicated for same. Will continue to monitor closely. ——— Lu Kay RN
7-24-99 9:00 AM	Dental: Pt crown on #3 came off - No pain. No ones. Cement crown with Dycal. POIC. RTC for eval & Dr Battles. Charles T. Hall DDS Charles T. Hall DDS.
7-24-99 2300	#9 Pt requesting Tylenol #3 ii po for migraine H/A at 1700 pt #9, effective #2 at 1800, and at 2100 #10 pain, slight effects at 2200 #8 pain, at 2300 requesting sumatriptan + po for cont pain of #8, has seen effective at this time Pat Faderski
7/25/99 0700	#9 VA has requested pain medication x ii this Pt. Complaints of migraine headache continue around the clock. Continuing to monitor closely. Will report to oncoming staff / MD. ——— Lu Kay RN
7/25/99 2100	#9 Continues to request & receive Tylenol #3 ii tabs for Migraine Headache & po offered + Tab but refused. Stated "I need 2." Will pass on to staff. Cont Paula Durland

MEDICAL RECORD	PROGRESS NOTES
DATE	
7/23/99 0915	#7 Vet. stated she no longer wishes to "Kill herself." Physician notified. She has been removed from 1:1 Suicidal observation. will monitor & report - Carol Breeden
7/23/99 1400	S/ Not Completed 4o recent Denial of #9 Was taking Amoxil & using Ayrus. O-Serious +1 tenderness A- Seriousness P- Atrovent Nasal spray Hal Saline Nasal spray Diet. Bactrim DS x14 days Margo Donaldson FNP
	Margo A. Donaldson, RN, MSN, CS, FNP
7/23/99 1920	#9 Veteran reported lost Dr Orcon - MOD notified. will try to locate Dental service in regards to same Tylenol #3 x2 - given per request for Migraine H/A - continue to monitor - Pellum Marshall
7/23/99 2100	#9 Dr. Hall (Dentist) called and will evaluate Dental problem in am Pellum Marshall
7/23/99 2105	#9 Veteran requested Sumatriptan for migraine ~~H/A - Received 25mg PO~~ Pellum Marshall

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

REGISTER NO. | WARD NO.

Pellum Marshall

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

1 1999

DOVE, GAYLE A [redacted]

MEDICAL RECORD	PROGRESS NOTES
DATE 7/25/99 2100	Nursing Note Continued — for evaluation by M.D. Received Visitors this PM until 2000. Calm & Cooperative to Management (behavior) Problem. Paula Overland RN
7-25-99 2330	#9 at 2230 pt requested medication for migrain #10 pain, was given tylenol #3, ii PO, sumatriptan 1 PO, she says this helped the nausea medication helped #3 pain at this time, lying quietly in bed. Pat Caldwell
7/26/99 0245	#9 Vet ↑ to nursing station exactly 4 hrs. p last dose of PRN medication c/o migrane headache. Medication given as ordered & vet stating pain as "a #12 on a scale of 10". Vet then smiled and returned back to bedroom. Will continue to monitor and will report to primary physician vet's continued complaints. — McKay RN
	RECREATION THERAPY PROGRESS NOTE
7/26/99 8:00	#20 OT will be on as much R-Z as health will allow. Will look for an area to socialize. J. Hagen RT

(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

1 1999

DOVE, GAYLE A
[redacted]

PROGRESS NOTES

DATE	
7/26/99 1250	Psychiatry S: I want privileges" O: Has been taking Tylenol #3 frequently and Imitrex for headache. Denies any suicidal or homicidal thoughts Mood described as depressed and anxious Denies hearing or other hallucinations. No cognitive deficits A: stable P: same continue known drug D/C Tylenol #3 Use Tylenol or Motrin for headache 2 more groups held David M. Mathis, D.O. Case Broderick Jan Hedgecock Colleen Kelly Margo Donaldson FNP
7/26/99 1330	#25 O.T. note. Order for O.T. clinic received. Pt attended session on this date. Refers to "O.T. Initial Note" dated 7/26/99 M. Ellis, OTR/L
7/26/99 1700 #9	I was a Legatus - Recruit had a Bowel Movement Basic Friday - pt has intermittent Constipation/diarrhea normally. Will order MOM + Colace PRN Constipation Margo A. Donaldson FNP Margo A. Donaldson, RN, MSN, CS

☆ U.S. GPO:1998-443-732 STANDARD FORM 509 BACK (Rev. 11-77)

NOTE DATED: 07/26/99 18:24 SOCIAL WORK NOTE-MENTAL HEALTH
ADMITTED: 07/22/99 18:15 62G-1PURPLE
PROBLEM #19 AFTERCARE

MS DOVE WAS ADMITTED TO THE UNIT ON 7-22-99 WITH COMPLAINTS OF FEELING DESPONDENT FOLLOWING THE RECENT DEATH OF A CLOSE FRIEND AND THE RECENT BREAKUP WITH A BOYFRIEND. SHE THOUGHT OF HARMING HERSELF AND HAS A HISTORY OF SUICIDE ATTEMPTS. SHE WAS CRYING UPON ADMISSION AND UNABLE TO STOP. SHE IS 90%SC FROM REMOVAL OF HER UTERUS AND OVARIES. SHE HAS BEEN SOBER FROM ALCOHOL FOR FIVE YEARS. SHE WILL RETURN TO LIVE IN BILOXI WITH HER FATHER. AFTERCARE WILL BE AT THE MHC AT THIS FACILITY.

Signed by: /es/ KEN M MCKELVAIN
MSW 07/26/99 18:30

NOTE DATED: 07/26/99 14:06 PURPLE/GENERAL NOTE
ADMITTED: 07/22/99 18:15 62G-1PURPLE
TITLE: PURPLE/GENERAL NOTE
DATE OF NOTE: JUL 21, 1999@10:29 ENTRY DATE: JUL 21, 1999@10:30:11
AUTHOR: HINTON,RUTH ANNA EXP COSIGNER:
URGENCY: STATUS: COMPLETED

#0

PATIENT PARTICIPATED IN MORNING ORIENTATION/INFORMATION GROUP. APPOINTMENTS AND ACTIVITY FOE THE DAY WERE DISCUSSED. PATIENT ASKED APPROPRIATE QUESTIONS. PATEINTS STATED THIS SESSION WAS VERY INFORMATIVE.

#0

VET ATTENDED UNIT ORIENTATION GROUP. WARD UNIT RULES AND ROUTINES WERE DISCUSSED. REINFORCED IMPORTANCE OF KEEPING VALUABLES LOCKED UNDER LOCK AND KEY. VET PARTICIPATED IN THE GROUP AND ASKED SIGNIFICANT QUESTIONS.

/es/ RUTH ANNA HINTON
RN
Signed: 07/21/99 10:30

Signed by: /es/ RUTH ANNA HINTON
RN 07/26/99 14:07

NOTE DATED: 07/26/99 15:22 OCCUPATIONAL THERAPY - INITIAL NOTE
ADMITTED: 07/22/99 18:15 62G-1PURPLE
#25 - REHAB MEDICINE NEEDS

___ ON-WARD _X_ OFF-WARD, CLINIC

INITIAL/ ACKNOWLEDGEMENT OF ORDER NOTE

DATE OF ORDER: 7/26/99
INITIAL VISIT DATE: 7/26/99

ORDER FOR O.T. CLINIC WAS RECEIVED AND VET ATTENDED SESSION ON THIS DATE. AFFECT WAS FLAT. MOOD WAS DEPRESSED. GROOMING WAS FAIR. SPEECH WAS 100% INTELLIGIBLE. THOUGHT CONTENT WAS GOAL-ORIENTED MOST OF THE TIME. VET SELECTED AND ATTENDED TO TASK WITH MINIMAL ASSISTANCE FROM STAFF. VET FOLLOWED TWO-STEP DIRECTIONS WITH LESS THAN MINIMAL ASSISTANCE. INTERACTION WITH STAFF AND PEERS WAS SPONTANEOUS AND WITHIN SOCIAL NORMS.

VET IDENTIFIED GOAL TO INCREASE INTEREST AND ENGAGEMENT IN TASKS. COMPREHENSIVE EVALUATION WITH GOALS TO FOLLOW IN TWO WEEKS - 8/9/99.

PLAN: VET WILL ATTEND AND PARTICIPATE IN O.T. CLINIC GROUPS AND TASKS, 5X/WEEK, MONDAY THROUGH FRIDAY, AT 1:00-2:30PM.

Signed by: /es/ MARQUIS R ELLIS
OCCUPATIONAL THERAPIST, REGISTERED
07/26/99 15:28

MEDICAL RECORD	PROGRESS NOTES
7/26/99	#9 c/o Migraine headache. Imitrex 0.5 cc SQ
2255	Q am as ordered. — Paula Overland RN
7-27-99	#0 got up x1 during this T.O.D.
0500	otherwise slept all night,
	no distress noted while making
	rounds this T.O.d. — Gae H. Jones RN
7/27/99	Psychiatry.
0910	S:
	Patient out on grounds. Will interview later today.
	D M Mathis David M. Mathis, D.O
	AS3285170-952
7/27/99	0 — Med exam & assessment. Ans. consult
1445	Paul M. Bartle MD
7-27-99	#9 Pt complained of Headache & Received Tylenol
2200	x 2. Pt still complains of being constipated.
	Pt cooperative & went to AA Meeting on Bldg.
	#2 has been no management problem. Geo Gr
7/28/99	#1 Wet. ↑ x1 during the noc to
0512	c/o a headache. Pt have pitcher
	filled c ice for ice pack for
	Head. — Martha Willis

(Continue on reverse side)

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

COVE, GAYLE A [redacted]

1 19 99

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

7/28/99 Assessment

0850 S: "I'm doing okay"

1/2 O: Mood reports is improved but still depressed

Denies suicidal or homicidal thoughts

Denies auditory visual hallucinations

No evidence of thought disorder

A: Stable

P: Finalize Discharge plans for tomorrow morning

Isaac appt for symptoms tomorrow at Women's Clinic

David M. Mathis, D.O.

David M. Mathis, D.O.
AS3285170-552

STANDARD FORM 509 BACK (Rev. 11-77)

*U.S.GPO:1997-425-359

NOTE DATED: 07/27/99 13:55 PURPLE/GENERAL NOTE
ADMITTED: 07/22/99 18:15 62G-1PURPLE
PROBLEM(S) #2, #9

VET PRESENTS TODAY WITH EUTONIC MOOD, AFFECT IS CONSISTANT WITH MOOD. VET ACTIVELY INTERACTING WITH PEERS/STAFF TODAY. STARTED ON NON-MEDICATED COLD PACK FOR CHRONIC HEAD ACHE AND IMITREX INJECTION SUBCUTANEOUS. VET HAS NOT HAD ANY C/D TODAY. WILL CONTINUE TO MONITOR AND REDIRECT PRN.

Signed by: /es/ W.S.KEBER
REGISTERED NURSE 07/27/99 14:02

NOTE DATED: 07/28/99 10:55 PURPLE/MEDICATION TEACHING GROUP
ADMITTED: 07/22/99 18:15 62G-1PURPLE
PURPLE TEAM PRIMARY CARE MEDICATION GROUP EDUCATIONAL NOTE:

This patient has attended a class entitled "MEDICATIONS: EFFECTS, SIDE-EFFECTS AND INTERACTIONS" presented by the Purple Team Primary Care Registered Pharmacist and Registered Nurse. The purpose of this class is to review the patient's medication profile and discuss medication effects, side-effects, adverse reactions and interactions with other drugs, foods and alcohol. Questions are encouraged during the presentation of each patient's medication profile, and there was a question and answer session at the end of the class to aid the patient in comprehending the subject matter.

PROBLEM #16

Signed by: /es/ DENNIS M JR LANDRY
R.PH. 07/28/99 10:55

NOTE DATED: 07/28/99 09:24 PURPLE/GENERAL NOTE
ADMITTED: 07/22/99 18:15 62G-1PURPLE
VETERANS PARTICIPATED IN MED-TEACHING CLASS TODAY AT 1000. CLASS WAS CONDUCTED BY DENNIS LANDRY AND MYSELF.
EACH MEDICATION WAS REVIEWED ALONG WITH SIDE EFFECTS DOSAGE AND TIMES. VETERAN GIVEN OPPORTUNITY TO DISCUSS EFFECTS AND ADVANTAGES OF THEIR MEDICATIONS. CLASS LASTED APPROXIMATELY 45 MINUTES WITH GOOD PARTICIPATION OF PATIENT.

Signed by: /es/ SUSAN D MASSEY
REGISTERED NURSE 07/28/99 09:24

07/28/99 10:28 Addendum
PROZAC-FOR HER DEPRESSION
GABAPENTEN-MIGRANES AND MOOD SWING
OLANZAPIN-FOR MENTAL AND EMTIONAL DISORDER
ZANTAC-STOMACH ACID
KLONOPIN -TAPER(HISTORY OF ETOH ABUSE)

PATIENT STATES SHE IS HAPPY WITH HER MEDICATIONS
Signed by: /es/ SUSAN D MASSEY
REGISTERED NURSE 07/28/99 10:30

7/28/99
1041

NOTE DATED: 07/29/99 05:41 PURPLE/GENERAL NOTE
ADMITTED: 07/22/99 18:15 62G-1PURPLE
PROBLEM #9

VET OUT TO NURSES STATION REQUESTING TYLENOL AT 0330. APPARENTLY NOT EFFECTIVE. AT APPROX. 0415 ASKED FOR "MIGRANE ICE" WHICH WAS GIVEN BY NURSE AND RETURNED TO ROOM. REPORTEDLY OUT AGAIN AT APPROX. 0450 WHILE NURSE WAS OFF FLOOR ON 62G-2 GETTING MEDICATIONS FROM DOCUMED FOR NEW PATIENT BUT HAD RETURNED TO ROOM WHEN NURSE RETURNED. AT APPROX. 0510 NURSE NOTIFIED BY STAFF THAT PT. WAS AT NURSES STATION AND NEEDED ASSISTANCE. PT. TEARFUL. DEMANDING TO GO TO E.R. FOR MIGRANE HEADACHE. DR. ZEN NOTIFIED. VERBAL ORDERS RECEIVED TO GIVE TYLENOL #3- 2 TABS STAT. GIVEN AND PATIENT RETURNED TO ROOM. AFTER SHE RETURNED TO ROOM NURSE NOTIFIED BY STAFF THAT PT. HAD BEEN MAKING RACIAL SLURRS AND DERROGATORY ACCUSATIONS ABOUT FEMALE NURSING ASSISTANT WHO WAS AT DESK WHEN PT. RETURNED @0510.

Signed by: /es/ PATRICIA E TERRELL
PAT TERRELL RN 07/29/99 05:58

MEDICAL RECORD	PROGRESS NOTES
DATE	
7/29-99	#0 Vet ask the undersigned for some ice and
0510	I got her the ice and told her the RN
	was upstairs getting medecine and when
	she return I will tell her the pt want something
	for pain. When she return later I told her
	pt the RN was in bear room and I told
	pt I had reported her pain to R.N. pt return
	to her room and close the door very loudly.
	Later she came to desk crying "I don't think
	Stuff I leaving now" She Wanted
	know who that "Big fat ass Black
	Woman was". I told her my name, you
	been mean to her. I apologize to her if
	I said or did anything to upset her.
	pt had been up & down all NOC
	Geraldine Wesley NA
7/29/99	#0 Vet up to desk Crying, asked
0515	undersigned who is that big fat
	ass black Woman. Above reported
	to R.N. Mike Cramer NA.
7/29/99	#0 Vet - discharged c her father. She has
0815	received Meds. c instructions & F/U Appt time.
	She has verbalized understanding - Carol Brooks 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.

1999

PROGRESS NOTES

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

PROGRESS NOTES

DATE

STANDARD FORM 509 BACK (Rev. 11-77)

*U.S.GPO:1997-426-359

Veterans Administration

NURSING DISCHARGE PROGRESS NOTE

1. Discharge living arrangements: Discharged with her father
2. Accompanied by: father
3. Ambulation: self
4. TPR: 97.8 84 20 BP: 142/82
5. General condition (including resolved and unresolved nursing diagnosis):

#2 Resolved
#7 Resolved
#9 maintenance
#14 Resolved
#21 Resolved
#25 Resolved
#19 F/u 8/3/93 @ 0930

6. Nursing care needed following discharge (including Nursing Care Referral):

F/u @ womens clinic 8/3/93 @ 0930

7. Patient/family education, instructions, medications, follow-up and assessment of understanding:

Vet. has received medications & instructions. She has received F/u Appt time @ womens clinic. She has verbalized understanding.

SIGNATURE AND TITLE OF PRACTITIONER
Carol Brueggen RN

DATE/TIME:
7/29/93 @ 0930

IMPRINT PATIENT DATA CARD

DOVE GAYLE
[redacted]

[redacted]

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE
FOR SPECIALIZED DISCIPLINES

VA FORM 10-0114j
SEP 1988

025396

AUTHORIZED ABSENCE/D--.HARGE INSTRUCTIONS 07/29/1999 08:51
VAMC: Biloxi, MS (CONS) (520)

VA FORM: 10-7978M
Effective Date:

==========

DOVE,GAYLE A [redacted] Ward: 62G-1PURPLE
Room-Bed: 138-28 Ht(cm): 167.64 (07/18/1999)
DOB: 08/15/1957 (41) Team: * NF * Wt(kg): 59.09 (07/18/1999)
Sex: FEMALE Admitted: 07/22/1999
Dx: DEPRESSION
Allergies: _____
ADR: _____

==========

Next scheduled clinic visit is on 07/29/99 at WOMEN'S MHPC GOLD GROUP-GPT

==========

DIETARY INSTRUCTIONS: (Check One)
__ NO RESTRICTIONS __ RESTRICTIONS (Specify) _____

_____

_____

==========

PHYSICAL ACTIVITY LIMITATIONS: (Check One)
__ NO RESTRICTIONS __ RESTRICTIONS (Specify) _____

_____

_____

==========

SPECIAL INSTRUCTIONS: (list print information, handouts, or other instructions pertinent to patient's condition)_____

F/U @ Women's clinic 8/3/99 @ 0930
c Dolan, M.D.

==========

DIAGNOSES: _____

_____

_____

Carl Bressler 7/29/99 0855
Nurse's Signature Date AND Time

[signature] 7/29/99 0900
Physician's Signature Date AND Time

==========

>>>>> I HAVE RECEIVED AND UNDERSTAND <<<<<
>>>>> MY DISCHARGE INSTRUCTIONS <<<<<

==========

Gayle A. Dove 7/29/99
Patient's Signature [redacted] Date And Time

DOVE,GAYLE A 08/15/1957

AUTHORIZED ABSENCE/DISCHARGE ORDERS 07/28/1999 08:51
VAMC: Biloxi, MS (CONS) (520)

VA FORM: 10-7978M
Effective Date: Page: 1

Instructions to the physician:
A. A prescription blank (VA FORM 10-2577F) must be used for:
1. all controlled substances
2. any medications marked as 'nonrenewable'
3. any new medications in addition to those entered on this form.
B. If a medication is not to be continued, mark "TAKE NO ACTION".
C. To continue a medication, you MUST:
1. enter directions, quantity, and refills
2. sign the order, enter your DEA number, and enter the date AND time.

DOVE,GAYLE A Ward: 62G-1PURPLE
PID: [redacted] Room-Bed: 138-2B Ht(cm): 167.64 (07/18/1999)
DOB: 08/15/1957 (41) Team: * NF * Wt(kg): 59.09 (07/18/1999)
Sex: FEMALE Admitted: 07/22/1999
Dx: DEPRESSION
Allergies: _____
ADR: _____

___ AUTHORIZED ABSENCE <96 HOURS ___ AUTHORIZED ABSENCE >96 HOURS
NUMBER OF DAYS: ____ (NO REFILLS allowed on AA/PASS meds)

___ REGULAR DISCHARGE ___ OPT NSC ___ SC

SC Percent: 90%
Disabilities:

POST-TRAUMATIC STRESS DISORDER	70% - SERVICE CONNECTED
REMOVAL OF UTERUS AND OVARIES	50% - SERVICE CONNECTED
MIGRAINE HEADACHES	30% - SERVICE CONNECTED
RHINITIS	0% - SERVICE CONNECTED
NEOPLASM, BENIGN, SKIN	0% - SERVICE CONNECTED

Next scheduled clinic visit is on 07/29/99 at WOMEN'S MHPC GOLD GROUP-GPT

No.	Medication	Schedule Type	Cost per Dose
1	ACETAMINOPHEN 325MG U/D	PRN	0.018

Inpt Dose: 650MG PO Q4-6HRSPRN
Special Instructions: PAIN/FEVER

___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: _____

Qty: ____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

_____ _____ _____
Physician's Signature DEA # Date AND Time

PATIENT CONTINUED ON NEXT PAGE...

VA FORM: 10-7978M
DOVE,GAYLE A [redacted] [redacted]

No.	Medication	Schedule Type	Cost per Dose
2	CLONAZEPAM 0.5MG U/D Inpt Dose: 0.5MG PO QD Special Instructions: X 3 DAYS	FILL on REQUEST	0.337

___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: _____

Qty: ____ Refills: 0 1 2 3 4 5

Physician's Signature | DEA # | Date AND Time

No.	Medication	Schedule Type	Cost per Dose
3	CLONAZEPAM 0.5MG U/D Inpt Dose: 0.5MG PO BID Special Instructions: X 3 DAYS	FILL on REQUEST	0.337

___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: _____

Qty: ____ Refills: 0 1 2 3 4 5

Physician's Signature | DEA # | Date AND Time

No.	Medication	Schedule Type	Cost per Dose
4	FLUOXETINE HCL 20MG U/D Inpt Dose: 40MGM PO QAM	CONTINUOUS	2.65

___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: ii po qam

Qty: 60 Refills: 0 1 2 3 4 5 6 7 8 9 10 11

D Mmatt | | 7/28/99 0900
Physician's Signature | DEA # | Date AND Time

No.	Medication	Schedule Type	Cost per Dose
5	GABAPENTIN 300MG CAP Inpt Dose: 300MGM PO TID	CONTINUOUS	0.636

___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: i po tid

Qty: 90 Refills: (0) 1 2 3 4 5 6 7 8 9 10 11

D Mmatt | | 7/28/99 0900
Physician's Signature | DEA # | Date AND Time

PATIENT CONTINUED ON NEXT PAGE...

VA FORM: 10-7978M
DOVE,GAYLE A [redacted] [redacted]

No.	Medication	Schedule Type	Cost per Dose
6	GABAPENTIN 300MG CAP Inpt Dose: 600MGM PO QHS	CONTINUOUS	1.272

___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: II po qhs

Qty: 60 Refills: (0) 1 2 3 4 5 6 7 8 9 10 11

D M Mad — 7/28/99 0900
Physician's Signature — DEA # — Date AND Time

7 IPRATROPIUM BR 0.03% NASAL SPRAY — FILL on REQUEST 0.708
Inpt Dose: 2 SPRAYS NASAL BID PRN

___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: as above - for allergies

Qty: 1 Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Margo A. Donaldson, RN, MSN, CS, FNP — FNP — 7/28/99-1100
Physician's Signature — DEA # — Date AND Time

8 IPRATROPIUM BR 0.03% NASAL SPRAY — FILL on REQUEST 0.708
Inpt Dose: 2 SPRAYS NASAL BID
Special Instructions: X 4 DAYS THEN AS NEEDED

___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: _____

Qty: ____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Physician's Signature — DEA # — Date AND Time

9 MILK OF MAGNESIA WITH CASCARA,OZ — FILL on REQUEST 0.109
Inpt Dose: 30CC PO QDPRN
Special Instructions: CONSTPATION

___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: _____

Qty: ____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Physician's Signature — DEA # — Date AND Time

PATIENT CONTINUED ON NEXT PAGE...

VA FORM: 10-7978M
DOVE,GAYLE A [redacted] [redacted]

No.	Medication	Schedule Type	Cost per Dose
10	OLANZAPINE 5MG U/D Inpt Dose: 5MG PO QHS	CONTINUOUS	3.306

___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: i po qhs

Qty: 30 Refills: (0) 1 2 3 4 5 6 7 8 9 10 11

D m Mac 7/28/99 0900

Physician's Signature DEA # Date AND Time

11 RANITIDINE HCL 150MG TAB — CONTINUOUS — 0.032
Inpt Dose: 150MGM PO BID

___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: i po bid

Qty: 60 Refills: (0) 1 2 3 4 5 6 7 8 9 10 11

D m Mac 7/28/99 0900

Physician's Signature DEA # Date AND Time

12 SODIUM CHLORIDE 0.65% SOLN NASAL SPRAY — FILL on REQUEST — 0.022
Inpt Dose: 1-2 SPRAYS NASAL QID PRN
Special Instructions: FOR CONGESTION

___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: _____

Qty: ____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Physician's Signature DEA # Date AND Time

13 SULFAMETHOXAZOLE 800/TRIMETH 160MG U/D — CONTINUOUS — 0.058
Inpt Dose: 1 TAB PO BID
Special Instructions: GIVE X14DAYS

___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: i po bid

Qty: 20 Refills: (0) 1 2 3 4 5 6 7 8 9 10 11

D m Mac 7/28/99 0900

Physician's Signature DEA # Date AND Time

PATIENT CONTINUED ON NEXT PAGE...

VA FORM: 10-7978M
DOVE,GAYLE A [redacted] [redacted]

No.	Medication	Schedule Type	Cost per Dose
14	SUMATRIPTAN SUCC 6MG/0.5ML VI Inpt Dose: .5CC SC QD PRN Special Instructions: GIVE ONLY ONCE Q 24HRS. FOR MIGRANE HEADACHE	FILL on REQUEST	21.54

___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

Outpatient Directions: _____

Qty: ____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Physician's Signature _____ DEA # _____ Date AND Time _____

OTHER MEDICATIONS:

15 Medication: Estrace 1mg tab PO.

Outpatient Directions: Take one tab by day -

Qty: 30 Refills: 0 (1) 2 3 4 5 6 7 8 9 10 11

Physician's Signature [illegible] DEA # _____ Date AND Time 7/28/99-095.

16 Medication: _____

Outpatient Directions: _____

Qty: ____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Physician's Signature _____ DEA # _____ Date AND Time _____

17 Medication: _____

Outpatient Directions: _____

Qty: ____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Physician's Signature _____ DEA # _____ Date AND Time _____

18 Medication: _____

Outpatient Directions: _____

Qty: ____ Refills: 0 1 2 3 4 5 6 7 8 9 10 11

Physician's Signature _____ DEA # _____ Date AND Time _____

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
PT	626-1	7/26/99

REASON FOR REQUEST (Complaints and findings)

c/o neck + shoulder discomfort & tension

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
Donaldson/gs		☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

Initial Eval. Problem #25 a.m.b. neck and upper back discomfort
Pt. gives hx of muscle tension genius and migraine HA's. Most recently a migraine HA x 4 days. She notes ↑ tension in neck and upper back which she attributes to recent acute stress in her life. Pt. states massage and chiropractic treatments have helped in past. Pt. she will be D/C from V.A.G tomorrow, 7.29.99.

Following application of moist heat and massage, manipulation of the spine and upper thoracic area was performed and well tolerated. MS Doe was then instructed in cervical isometric and interscapular exercises and given a copy of McKenzies "Treat Your Own Neck". After D/C she will return for 1 session to reinstruct in the use of her TENS unit.

(Continued on reverse side)

SIGNATURE AND TITLE			DATE
A. Donaldson, PT			7-28-99
IDENTIFICATION NO.	ORGANIZATION	REGISTER NO	WARD NO
			626-1/SC

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

LOVE, GAYLE A
[redacted]

4457 Popps Ferry Rd.
Lot 195
Biloxi, MS 39532

CONSULTATION SHEET
STANDARD FORM 513 (Rev. 9-77)
Prescribed by GSA/ICMR
FIRNR (41 CFR) 201-45.505
513-108

Kee
7-27-99

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
Dental	Obgyn	7/26/99

REASON FOR REQUEST (Complaints and findings)

F/u on temporary Crown

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
Donaldson /gwe		☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

Crown on tooth #3 was temporarily recemented on Sat 7/24. She is scheduled as an outpt. to have the crowns #2&3 replaced in Sept. due to caries under existing crowns. No further TX is indicated @ this time.

(Continued on reverse side)

SIGNATURE AND TITLE	DATE
Paul M. Bowles DDS	7/27/99

IDENTIFICATION NO.	ORGANIZATION	REGISTER NO	WARD NO
	1199		

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

LOVE, GAYLE [redacted]

CONSULTATION SHEET
STANDARD FORM 513 (Rev. 9-77)
Prescribed by GSA/ICMR
FIRNR (41 CFR) 201-45.505
513-108

Exception to Standard Form 50
Approved by OM

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
7/22/99		Please admit to Gulfport VA 62G-1		
		Dx Major Depression / Suicidal Ideation		
		Condition: Stable		
		Allergy: NKA		
		Vital q 6°		
		Activity as tolerated	✓	PD
		Diet Regular	✓	PD
		Identify and resume home meds		
		Inform NOC upon patient's arrival		
		Initial consult.		
		clarified through pharmacy - please		
7/22/99	①	Butorphanol tartrate – 1 spray 1 Nostril q 3h prn severe headache	HA ✓	PD
10pm		Gabapentin 300 mg T TID po & 1 at hs	✓	PD
		Sumatriptan 25 mg T-1 po prn q 2h prn migraine	✓	PD
		Zantac 150 mg T po BID	✓	PD
		Benadryl 50 mg 1 po qhs	✓	PD
		Visteril 25 mg T po TID prn anxiety	✓	PD
		Fluoxetine 20 mg 1 po q am	✓	PD
		Clonazepam 1 mg T po TID prn anxiety	✓	PD
	②	Δ Vs to q s	✓	PD
	③	SO	✓	PD

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. DATE

④ Med Neurol consult on front of chart

Dore, Gayle A CTP [redacted]

Paula Cleveland RN 2350 7/22/99

11 7/23/99 0230

MEDICAL RECORD
DOCTOR'S ORDERS

VA FORM 10-1158

EXISTING STOCK OF VA FORM 10-1158, OCT. 1978 WILL BE USED.

Exception to Standard Form 5
Approved by OM

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
7/23/99 0910	(1)	DK Suicide observation.		VCB
	(2)	Klonopin taper as follows 0.5 g po tid – x 3 days then 0.5 g po bid x 3 days – then 0.5 g po qhs x 3 days, then DIC –		VCB
	(3)	Zyprexa 5 g po qhs — David M. Mathis, D.O. AS3285170-952		VCB
	(4)	DIC Visteril — Dmma		VCB
	(5)	DIC Benadryl		VCB
7/23/99 1000		Tylenol #3 1 tab po q4° prn headache x 3 days — Dmma — David M. Mathis, D.O. AS3285170-952		VCB
7/23/99 1020		d/c Ativan — Prn Benadryl — Margo A. Donaldson, RN, MSN, CS, FNP		VCB
		Noted Case Broadcast 7/23/99 @ 1105 — CF		

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. DATE 7/24/99 0130

DOVE, GAYLE

[redacted] I

MEDICAL RECORD
DOCTOR'S ORDERS

VA FORM DEC 1995 10-1158

EXISTING STOCK OF VA FORM 10-1158, OCT 197 WILL BE USED.

Exception to Standard Form 50
Approved by OM

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
7/23/99 1400		Bactrim DS one tab PO BID		WSL
		x 14 days		
		Gatorade PRN x 3 days.		
		Atrovent 0.03% nasal spray — 2 sprays ea. nostril BID x — 4 days then BID PRN		WSL
		Saline nasal spray 1-2 sprays QID PRN congestion (alternate Atrovent)		WSL
		OT Consult for		WSL
		Fasting lab 7/26/99		Margo A. Donaldson, RN, MSN, CS, FNP 3/4/1997
		CMP, Lipid Profile		
		Noted. W.S W.S IC by RNC 7/23/99 @ 1500		
		CTP		
7/23/99 1502		OT Consult on ward		Margo A. Donaldson RN, MSN, CS, FNP
		CMP 7/23/99 @ 315 Lab.		
		Noted Carl Breslin 7/23/99 @ 1510		

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. DATE

DOVE, GAYLE

[redacted] IDE I

11 7/24/99 0200
11 7/25/99 0130
11 7/26/99 0130

MEDICAL RECORD
DOCTOR'S ORDERS

VA FORM DEC 1995 10-1158

EXISTING STOCK OF VA FORM 10-1158, OCT. 1979 WILL BE USED.

Exception to Standard Form 5
Approved by OM

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
7/26/99 1020.		Pt Consent - c/o neck & shoulder discomfort - tension Margo A Donaldson RN, MSN, CS, FNP Noted Carl Brasher 7/26/99 1230		VCB
7/26/99 1185.		Cx Tyl #3 1 tab - per Dr Mathis 2 more 7/26/99 1230 David M. Mathis, D.O. AS3285170-952 Margo A. Donaldson, RN, MSN, CS, FNP Noted Carl Brasher, RN 7/26/99 1230		VCB
7/26/99 1245.		dental Consent - EU w Temp. crown Tylenol 650 mg Po q 4-6° PRN pain / fever Grouse pain 2° Bid OT in clinic Noted Carl Brasher 7/26/99 1800 Margo A. Donaldson, RN, MSN, CS, FNP		VCB VCB VCB
7/26/99 1400		d/c Imitrex Po from ED and Imitrex 6mg/0.5 cc subcut. inj Give 0.5 cc Admin Subcutaneous PRN q 24° PRN Migraine Headache Margo A Donaldson RN, MSN, CS, FNP		VCB One

Refer to space below PATIENT IDENTIFICATION (PASTE IN HERE) DATE

noted: 7/26/99 @ 1521
24° √ 7-27-99 @ 0228

DOCTOR'S ORDERS

VA FORM 10-1158 DEC 1995

EXISTING STOCK OF VA FORM 10-1158, OCT.19 WILL BE USED.

Exception to Standard Form 5
Approved by OI

MEDICAL RECORD | DOCTOR'S ORDERS

NOTE: Physician's signature must accompany each entry including standing orders. Date and time for initiating 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)	V	NURSE'S SIGNATURE
~~7/25~~				
7/26/99 1700		Mom é Cascara 30 cc PO QD PRN Constipation May use "Mygrin" Gtt's for her Headache QD PRN — Margo A. Donaldson, RN, MSN, CS, FNP		VS
		Noted Code Blue called 7/26/99 @ 1720 24hr 7-27-99 @ 0231 A		
7/27/99 1220		May attend AA meetings in PM's — Margo A. Donaldson, RN, MSN, CS, FNP		
		24hr 7-28-99 @ 0002 A — David M. Mathis, D.O. AS3285170-952		
7/28/99 0815		D/C for Klonopin. Discharge tomorrow. Follow up with Golden Women's Clinic in one to two weeks. — David M. Mathis D.O. AS3285170-952		
7/28/99 0820		Noted: W-5 Klonopin error 7/25/99 @ 0947 Disulfiram 250 mg PO QD PRN Constipation Acute Enema - PRN QD Constipation if no results from prev. Laxative & to gen intensity — Margo A. Donaldson, RN, MSN, CS, FNP		

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. DATE

DOE, GAILE A [redacted]

MEDICAL RECORD — DOCTOR'S ORDERS

Noted: CP 7/28/99 @ 930 — W-5 Klonopin error 7/28/99 @ 0953

VA FORM DEC 1995 10-1158 — EXISTING STOCK OF VA FORM 10-1158, 0019 WILL BE USED.

Exception to Standard Form 5
Approved by OM

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
7/28/99 0950		Natural Lens, PO/D Margo A. Donaldson, RN, MSN, CS, FNP		
		Noted: W.S KC RNC 7/28/99 @ 1021		
		CTP 24°√ 7-29-99 @ 0212 PT		
7/28/99 2240		Tylenol #3 ii PO "Stat" T.O. Dr Zen / Paula Overland RN	√	PO
		CTP 7/29/99 0806 David M. Mathis, D.O. AS3285170-952		
		Overland RN 7/28/99 2255 Zen, MD		
7/29/99 0515		Tylenol #3 ii p.o. stat T.O. Dr. Zen / Pat Terrell RN	ISMIN Zen, MD √	Pat Terrell RN 7/29/99 @ 051
Tylenol Zen Mark		7/29/99 0815 CTP 62G-1 David M. Mathis, D.O. AS3285170-952		
		Zen MD ISMIN Zen, MD		

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. DATE

Dove Gayle

[redacted]

MEDICAL RECORD
DOCTOR'S ORDERS

VA FORM DEC 1995 10-1158

EXISTING STOCK OF VA FORM 10-1158, OCT.1971 WILL BE USED.

VANC: Biloxi, MS (CONS) (520)
Name: DOVE,GAYLE A
PID: [redacted] DOB: [redacted] (41)
Sex: FEMALE Dx: DEPRESSION
Allergies: _____ ADR: _____

Weight (kg): 59.09 (07/—.999)
Height (cm): 167.64 (07/18/1999)

Printed on 07/23/1999 14:
Ward: 62G-1PURPLE
Room-Bed: 138-28
Admitted: 07/22/1999 18:15

Order	Start	Stop	Admin Times	JUL 22	23	24	25	26	27	28	29	30	31	AUG 01	02	03	04	not
	07/23	07/23 14:20	08/06/99 06:00 (D6094)	0600		N	N	N	PT	PT	PT							
	SULFAMETHOXAZOLE/TRIMETHOPRIM DS TAB C																	
	Give: 1 TAB PO BID																	
	GIVE X14DAYS																	
			RPH:____ RN:WSK	2100		2	2	2	PO	PO								
								LAST DOSE 8/6/99@0600										
	07/23	07/23 14:23	07/27/99 06:00 (D6094)	0600		N	N	N										
	IPRATROPIUM SOLN,SPRAY,NASAL R																	
	Give: 2 PUFFS NASAL BID																	
	GIVE 2 PUFFS TWICE A DAY X14DAYS->then PRN each nostril		RPH:____ RN:WSK	2100		2	2	2										
								LAST DOSE 7/27/99@0600										

SIGNATURE/TITLE	INIT	INJECTION SITES	MED/DOSE OMITTED	REASON	INI
W S Chapman	WSC	Indicate RIGHT (R) or LEFT (L)			
[illegible]	[illegible]				
[illegible]	N	(IM) (SUB Q)			
Carol Brasseaux	CB	1. DELTOID 6. UPPER ARM			
Ruth Hinton	RH	2. VENTRAL GLUTEAL 7. ABDOMEN			
Pat Terrell RN	PT	3. GLUTEUS MEDIUS 8. THIGH			
Paula Overland RN	PO	4. MID(ANTERIOR) THIGH 9. BUTTOCK			
[illegible]	[illegible]	5. VASTUS LATERALIS 10. UPPER BACK			
		PRN: E=Effective N=Not Effective			

DOVE,GAYLE A [redacted] VA FORM 10-29

CONTINUOUS SHEET

VAMC: Biloxi, MS (CONS) (520)
Name: DOVE,GAYLE A
PID: [redacted]
Sex: FEMALE Dx: DEPRESSION
Allergies: NKA ADR:

Weight (kg): 59.09 (07/18/1999)
Height (cm): 167.64 (07/18/1999)

Printed on 07/23/1999 10:
Ward: 62G-1PURPLE
Room-Bed: 138-2B
Admitted: 07/22/1999 18:15

Order	Start	Stop	Admin Times	JUL 22	23	24	25	26	27	28	29	30	31	AUG 01	02	03	04	not
	07/23	07/23 12:00	07/26/99 06:00 (D6094)	0600														
	CLONAZEPAM TAB		C															
	Give: 0.5MG PO TID		1200															
	X 3 DAYS																	
	WS	RPH:____ RN:CPB	2100															
	07/23	07/26 21:00	07/26/99 21:00 (D6094)	~~0600~~														
	CLONAZEPAM TAB		C	0600														
	Give: 0.5MG PO BID																	
	X 3 DAYS																	
	WS	RPH:____ RN:CPB	2100															
	07/23	07/29 06:00	07/31/99 06:00 (D6094)															
	CLONAZEPAM TAB		C															
	Give: 0.5MG PO QD		~~0600~~															
	X 3 DAYS		0600															
	WS	RPH:____ RN:CPB																
	07/28	07/28 10:18	08/27/99 13:00 (D6094)															
	ESTRADIOL TAB 2mg/UD		C															
	Give: 1MG PO QD		0600															
	DOSE IS 1/2 TAB																	
		RPH:____ RN:WSK																

SIGNATURE/TITLE	INIT	INJECTION SITES	MED/DOSE OMITTED	REASON	INI
[signature] RN	cm	Indicate RIGHT (R) or LEFT (L)			
[signature] LPN	L				
[signature] RN	M	(IM) (SUB Q)			
Pat Tierrell RD	PT	1. DELTOID 6. UPPER ARM			
[signature]	CB	2. VENTRAL GLUTEAL 7. ABDOMEN			
[signature]	R	3. GLUTEUS MEDIUS 8. THIGH			
Paula Overland RN	PO	4. MID(ANTERIOR) THIGH 9. BUTTOCK			
[signature] LPN	VS	5. VASTUS LATERALIS 10. UPPER BACK			
		PRN: E=Effective N=Not Effective			

DOVE,GAYLE A [redacted] VA FORM 10-29

VAMC: Biloxi, MS (CONS) (520)
Name: DOVE,GAYLE A
PID: [redacted]
Sex: FEMALE Dx: DEPRESSION
Allergies: NKA ADR:

Weight (kg): 59.09 (07/18/1999)
Height (cm): 167.64 (07/18/1999)

Printed on 07/22/1999 23:
Ward: 62G-1PURPLE
Room-Bed: 138-28
Admitted: 07/22/1999 18:15

Order	Start	Stop		Admin. Times	JUL 22	23	24	25	26	27	28	29	30	31	AUG 01	02	03	04	not
07/22	07/22 23:23	08/21/99 13:00	(D6094)																
DIPHENHYDRAMINE CAP,ORAL			C	2100	****														
Give: 100MGM PO QHS																			
RPH: ____ RN: PJO																			
				0600	****	N	N	C3	PR	PR	PT	PT							
07/22	07/22 23:17	08/21/99 13:00	(D6094)																
GABAPENTIN CAP,ORAL			C	1200	****	PT	C3	PR	PR	PO									
Give: 300MGM PO TID				2100 1800	****	2	2	2	C2	PO	PO								
RPH: ____ RN: PJO																			
07/22	07/22 23:18	08/21/99 13:00	(D6094)																
GABAPENTIN CAP,ORAL			C	2100	****	2	2	2	C2	PO	PO								
Give: 600MGM PO QHS																			
RPH: ____ RN: PJO																			
				0600	****	N	N	C3	PR	PR	PT	PT							
07/22	07/22 23:22	08/21/99 13:00	(D6094)																
RANITIDINE TAB			C																
Give: 150MGM PO BID				2100	****	2	2	2	C2	PO	PO								
RPH: ____ RN: PJO																			
07/22	07/22 23:58	08/21/99 13:00	(D6094)																
FLUOXETINE CAP,ORAL			C																
Give: 40MGM PO QAM				0600		N	N	C3	PR	PR	PT	PT							
RPH: ____ RN:PJO						CPE													
07/23	07/23 10:37	08/22/99 13:00	(D6094)																
OLANZAPINE TAB			C																
Give: 5MG PO QHS				2100		2	2	N	C2	PO	PO								
RPH: ____ RN:CPB																			

SIGNATURE/TITLE	INIT	INJECTION SITES	MED/DOSE OMITTED	REASON	INI
Douglas O'Neal RPh	D	Indicate RIGHT (R) or LEFT (L)	Gabapentin 300mg PO Tid 0600 7/23 unavailable	N	
Nancy RN	N		Citrus Prozac 40mg PO QAM 0600 7/23 unavailable	N	
Cecile Lotich RN	CIE	(IM) (SUB Q)			
Gail Gadow LPN	G	1. DELTOID 6. UPPER ARM			
Pat Terrell RN	PT	2. VENTRAL GLUTEAL 7. ABDOMEN			
Cene Breaux RN	C3	3. GLUTEUS MEDIUS 8. THIGH			
Ruth Hunter RN	RH	4. MID(ANTERIOR) THIGH 9. BUTTOCK			
Chris Dees RPh	CD	5. VASTUS LATERALIS 10. UPPER BACK			
		PRN: E=Effective N=Not Effective			

DOVE,GAYLE A [redacted] PAGE: 1 VA FORM 10-29

CONTINUOUS SHEET
VAMC: Biloxi, MS (CONS) (520)
Name: DOVE,GAYLE A
PID: [redacted]
Sex: FEMALE Dx: DEPRESSION
Allergies: _____ ADR: _____

14 DAY MAR
Weight (Kg): 59.09 (07/18/1999)
Height (cm): 167.64 (07/18/1999)

07/22/1999 through 08/04/1
Printed on 07/22/1999 23
Ward: 62G-1PURPLE
Room-Bed: 138-28
Admitted: 07/22/1999 18:15

Order	Start	Stop	Admin Times	JUL 22	23	24	25	26	27	28	29	30	31	AUG 01	02	03	04	not
7/22/99			0600	→														
Vital Signs T Shift			1300	→														
			2100	→														
PRN Bed Rest																		
7/23	7/26																	
GATORADE PRN X 3 days																		
7/26	8/26																	
May use "migraine Ice" For her headaches QD PRN																		

SIGNATURE/TITLE	INIT
[illegible] RN	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
Pat Terrell RD	PT
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]

99

VAMC: Biloxi, MS (CONS) (520)
Name: DOVE,GAYLE A
PID: [redacted]
Sex: FEMALE Dx: DEPRESSION
Allergies: NKA ADR:

Weight (Kg): 59.09 (07/18/1999)
Height (cm): 167.64 (07/18/1999)

Printed on 07/28/1999 08
Ward: 62G-iPURPLE
Room-Bed: 138-2B
Admitted: 07/22/1999 18:15

Order	Start	Stop		
07/26	07/26 13:09	08/25/99 13:00	(D6094)	P

ACETAMINOPHEN TAB
Give: 650MG PO Q4-6HRSPRN
PAIN/FEVER
RPH: DHD RN: CPB

Order	Start	Stop		
07/24	07/27 13:00	08/23/99 13:00	(D6094)	R

IPRATROPIUM SOLN,SPRAY,NASAL
Give: 2 SPRAYS NASAL BID PRN
RPH: RLH RN: JS

Order	Start	Stop		
07/26	07/26 17:20	08/25/99 13:00	(D6094)	R

CASCARA/MAGNESIUM HYDROXIDE LIQUID
Give: 30CC PO QDPRN
CONSTPATION
RPH: DML RN: CPB

Order	Start	Stop		
07/23	07/23 15:39	08/22/99 13:00	(D6094)	R

SODIUM CHLORIDE SOLN,SPRAY,NASAL
Give: 1-2 SPRAYS NASAL QID PRN
FOR CONGESTION
RPH: DML RN: JS

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT	REASON	RESULTS	TIME	IN
7/28/99	0830	Tylenol 650mg PO	JO	C/o pain #9	#2 E	1040	
7/28/99	1520	Tylenol 650mg PO	JO	C/o HA #9	#2 E	1600	
7/29/99	0330	Tylenol 650mg PO	PT	C/o HA #9	not eff	0430	PT

SIGNATURE/TITLE	INIT	INJECTION SITES	SIGNATURE/TITLE	INI
Jo Ann Thompson RN	JO	Indicate RIGHT (R) or LEFT (L)		
Pat Terrell RN	PT			
		(IM) (SUB Q)		
		1. DELTOID 6. UPPER ARM		
		2. VENTRAL GLUTEAL 7. ABDOMEN		
		3. GLUTEUS MEDIUS 8. THIGH		
		4. MID(ANTERIOR) THIGH 9. BUTTOCK		
		5. VASTUS LATERALIS 10. UPPER BACK		
		PRN: E=Effective N=Not Effective		

UNE-TIME/PRN SHEET 14 DAY MAR 07/22/1999 through 08/04/1999

VAMC: Biloxi, MS (CONS) (520)
Name: DOVE,GAYLE A
PID: [redacted]
Sex: FEMALE Dx: DEPRESSION
Allergies: _____ ADR: _____

Weight (kg): 59.09 (07/18/1999)
Height (cm): 167.64 (07/18/1999)

Printed on 07/28/1999 23
Ward: 62G-1PURPLE
Room-Bed: 138-28
Admitted: 07/22/1999 18:15

Order	Start	Stop		Order	Start	Stop
07/28	07/28 22:58	~~07/28/99 22:58 (D6094)~~	****			
ACETAMINOPHEN/CODEINE TAB			O ****			
Give: tabs 2 PO ONCE			EX'D			
give once for migraine.			****			
WS		RPH:___ RN:PJO	****			
07/29	07/29 05:21	~~07/29/99 05:21 (D6094)~~	****			
ACETAMINOPHEN/CODEINE TAB			O ****			
Give: 2 TABS PO STAT			EX'D			
FOR MIGRANE HEADACHE			****			
WS		RPH:___ RN:PET	****			

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT	REASON	RESULTS	TIME	IN
7/28/99	2345	Tylenol #3 2 tabs PO	PO	Migraine H/A	Eff. reliev	2345	P
7/29/99	0515	Tylenol #3 2 tabs po	PT	Migraine HA #10			

SIGNATURE/TITLE	INIT	INJECTION SITES	SIGNATURE/TITLE	IN
Paula Overland RN	PO	Indicate RIGHT (R) or LEFT (L)		
		(IM) (SUB Q)		
		1. DELTOID 6. UPPER ARM		
		2. VENTRAL GLUTEAL 7. ABDOMEN		
		3. GLUTEUS MEDIUS 8. THIGH		
		4. MID(ANTERIOR) THIGH 9. BUTTOCK		
		5. VASTUS LATERALIS 10. UPPER B...		
		PRN: E=Effective N=Not Effective		

VAMC: Biloxi, MS (CONS) (520)
Name: DOVE,GAYLE A
PID: [redacted]
Sex: FEMALE Dx: DEPRESSION
Allergies: NKA ADR:

Weight (kg): 59.09 (07/19/1999)
Height (cm): 167.64 (07/18/1999)

Printed on 07/20/1999 08
Ward: 63B-1PURPLE
Room-Bed: 138-2B
Admitted: 07/22/1999 18:15

Order	Start	Stop		Order	Start	Stop	
07/26	07/26 15:07	08/25/99 13:00	(D6094)	07/28	07/28 09:18	08/27/99 13:00	(D6094)
SUMATRIPTAN INJ			R	SODIUM BIPHOSPHATE/SODIUM PHOSPHATE ENEMA			R
Give: .5CC SC QD PRN				Give: AS DIRECTED RTL QD PRN			
GIVE ONLY ONCE Q 24HRS. FOR MIGRANE HEADACHE				See next label for continuation			
RPH: DHD RN: CRC							
07/28	07/28 09:36	08/27/99 13:00	(D6094)				
BISACODYL TAB,EC			P				
Give: 10MG PO QD PRN							
FOR CONSTIPATION							
RPH:DML RN:SDM							

FOR CONSTIPATION IF NO RESULTS FROM PRIVIOUS LAXATIVE

RPH:____ RN:WSK

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT	REASON	RESULTS	TIME	IN
7/28/99	1300	~~Sodium Biphosphate~~		~~Constipation~~	~~ema 7-28-99~~		
7-28-99	1500	1) BISACodyl 10mg		constipation	effective	2130	pc

SIGNATURE/TITLE	INIT	INJECTION SITES		SIGNATURE/TITLE	IN
[signature]	JO	Indicate RIGHT (R) or LEFT (L)			
Paula Overland Rn	PO				
		(IM)	(SUB Q)		
		1. DELTOID	6. UPPER ARM		
		2. VENTRAL GLUTEAL	7. ABDOMEN		
		3. GLUTEUS MEDIUS	8. THIGH		
		4. MID(ANTERIOR) THIGH	9. BUTTOCK		
		5. VASTUS LATERALIS	10. UPPER BACK		
		PRN: E=Effective N=Not Effective			

Name: DOVE,GAYLE A
PID: [redacted]
Sex: FEMALE Dx: DEPRESSION
Allergies: _____ ADR: _____

Weight (kg): 59.09 (07/ 999)
Height (cm): 167.64 (07/18/1999)

Ward: 62G-1PURPLE
Room-Bed: 138-28
Admitted: 07/22/1999 18:15

Order	Start	Stop	
	07/23	07/27 06:00	08/16/99 13:00 (D6094)
	IPRATROPIUM SOLN,SPRAY,NASAL		R
	Give: 2 PUFFS NASAL BID PRN sprays		
	RPH:____ RN:WSK		

Order	Start	Stop	
	07/23	07/23 14:36	07/23/99 14:36 (D6094)
	DIPHTHERIA TOXOID/TETANUS TOXOID INJ		O
	Give: 0.5CC IM NOW		EX
	GIVE ONE TIME INTRAMUSCULAR		***
	RPH:____ RN:WSK		***

Order	Start	Stop	
	07/23	07/23 14:32	08/22/99 13:00 (D6094)
	SALINE SOLN,NASAL		R
	Give: 1-2 PUFFS NASAL QID PRN FOR CONGESTION sprays		
	RPH:____ RN:WSK		

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT	REASON	RESULTS	TIME	INI
7/23/A	1500	TETANUS DIPTHERIA	WSK	Ordered			

SIGNATURE/TITLE	INIT	INJECTION SITES	SIGNATURE/TITLE	INI
W S K RN C	WSK	Indicate RIGHT (R) or LEFT (L)		
Carl Brassler	CB			
		(IM) (SUB Q)		
		1. DELTOID 6. UPPER ARM		
		2. VENTRAL GLUTEAL 7. ABDOMEN		
		3. GLUTEUS MEDIUS 8. THIGH		
		4. MID(ANTERIOR) THIGH 9. BUTTOCK		
		5. VASTUS LATERALIS 10. UPPER BACK		
		PRN: E=Effective N=Not Effective		

DOVE,GAYLE A [redacted] VA FORM 10-55

VAMC: Biloxi, MS (CONS) (520) | Printed on 07/22/1999 23:

Name: DOVE,GAYLE A | Weight (kg): 59.09 (07/18/1999) | Ward: 62G-1PURPLE

PID: [redacted] | Height (cm): 167.64 (07/18/1999) | Room-Bed: 138-28

Sex: FEMALE Dx: DEPRESSION | Admitted: 07/22/1999 18:15

Allergies: NKA ADR: _____

Order	Start	Stop	
07/22	07/22 23:29	08/21/99 13:00	(D6094)

CLONAZEPAM TAB P
Give: 1MGM PO TID PRN
ANXIETY
WS RPH: ____ RN: PJO

Order	Start	Stop	
07/22	07/22 23:21	08/21/99 13:00	(D6094)

SUMATRIPTAN TAB P
Give: 1-2 TABS PO Q12H PRN
FOR PAIN
DC'd 7/23/99 2215 PO
RPH: ____ RN: PJO

Order	Start	Stop	
07/22	07/22 23:25	08/21/99 13:00	(D6094)

HYDROXYZINE TAB P
Give: 25MGM PO TID PRN
FOR ANXIETY
D/c'd CB
RPH: ____ RN: PJO

Order	Start	Stop	
07/22	07/22 23:15	08/21/99 13:00	(D6094)

BUTORPHANOL SOLN,SPRAY,NASAL P
Give: ONE SPRAY NASAL PRN
ONE SPRAY ONE NOSTRIL AS NEEDED SEVERE HEADACHE.
DC'd 7/23/99 CLO
RPH: ____ RN: PJO

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT	REASON	RESULTS	TIME	INI
7/23/99	10[illegible]	SUMATRIPTAN 2 TABS	[illegible]	H/A #10	EFF	11[illegible]	[illegible]
7/23/99	2215	Sumatriptan 1 PO tab	[illegible]	H/A #7	E #1	2315	[illegible]
7/24/99	0930	SUMATRIPTAN 1 TAB	[illegible]	H/A #10	EFF #3	1030	[illegible]
7/24/99	2200	Sumatriptan 1 tab PO	[illegible]	H/A #8	E #1	2300	[illegible]
7/25/99	2946	Sumatriptan 1 tab PO	CB	H/A #10			
7/25/99	2235	Sumatriptan 1 tab PO	[illegible]	H/A #10	E #3	2335	[illegible]
7/26/99	1100	Sumatriptan 1 tab PO	PT	C/O H/A #7	effective #3	1245	PT
7/27/99	2335	Clonazepam 1 mgm PO	PO	% Anxiety	eff sleeping	0030	PT

SIGNATURE/TITLE	INIT
Paula Overlayd RN	PO
Campbell Cottrell RN	CMC
Cathy Bradley RN	CB
Pat Terrell RN	PT

INJECTION SITES	
Indicate RIGHT (R) or LEFT (L)	
(IM)	(SUB Q)
1. DELTOID	6. UPPER ARM
2. VENTRAL GLUTEAL	7. ABDOMEN
3. GLUTEUS MEDIUS	8. THIGH
4. MID(ANTERIOR) THIGH	9. BUTTOCK
5. VASTUS LATERALIS	10. UPPER BACK

SIGNATURE/TITLE	INI

Name: DOVE,GAYLE A
PID: [redacted]
Sex: FEMALE Dx: DEPRESSION
Allergies: _____ ADR: _____

Weight (kg): 59.09 (07/. .999)
Height (cm): 167.64 (07/18/1999)

Ward: 62G-1PURPLE
Room-Bed: 138-28
Admitted: 07/22/1999 18:15

PAIN SCALE
0 5 10

Order	Start	Stop
07/23	07/23 10:42	07/26/99 13:00 (D6094)
ACETAMINOPHEN/CODEINE TAB		P
Give: 1-2 PO Q4HRSPRN		
1-2 PRN HEADACHE X 3 DAYS		
HS pain or ↓		
RPH:____ RN:CPB		

Order	Start	Stop
07/26	07/26 17:20	08/25/99 13:00 (D6094)
CASCARA/MAGNESIUM HYDROXIDE LIQUID		P
Give: 30CC PO QDPRN		
CONSTPATION		
RPH:____ RN:CPB		

Order	Start	Stop
07/26	07/26 13:09	08/25/99 13:00 (D6094)
ACETAMINOPHEN TAB		P
Give: 650MG PO Q4-6HRSPRN		
PAIN/FEVER		
RPH:____ RN:CPB		

Order	Start	Stop
07/26	07/26 15:07	08/25/99 13:00 (D6094)
SUMATRIPTAN INJ		R
Give: .5CC SC QD PRN q 24 hrs		
MIGRAINE HEADACHE		
RPH:DHD RN:CRC		

DATE	TIME	MEDICATION/DOSE/ROUTE	INIT	REASON	RESULTS	TIME	INI
7/23/99	0030	T-4 #3 - 2 tabs	cmc	H/A #10	Eff #5	0100	cmc
7/23/99	1530	T-4 #3 - 2 tabs	cmc	H/A #10	Eff #5	1630	cmc
7-23-99	1930	acetaminophen #3 ii po	k	H/A pain #10	Eff #2	2030	k
7/24/99	0016	Tylenol #3 ii po	M	c/o H/A #10	slight eff	0800	PT
7/24/99	1030	Tylenol #3 ii po	PT	c/o HA #8	eff #3	1125	PT
7-24-99	1700	Acetaminophen #3 ii po	k	H/A # 9 pain	Eff #2	1800	k
7-24-99	2100	Acetaminophen #3 ii po	k	H/A # 10 pain	Sl-E #3	2200	k
7/25/99	0235	Tylenol #3 ii PO	M	c/o H/A #10	Eff #2	0400	M
7/25/99	0630	Tylenol #3 ii po	C3	c/o H/A #10	N Eff	100	C3
7/25/99	1030	Tylenol #3 ii po	C3	c/o H/A #10	Eff #4	1130	C3
7/25/99	1930	T-4 #3 ii PO	cmc	c/o H/A # 9	Eff #3	1530	cmc
7/25/99	1635	Tylenol #3 ii PO	PO	c/o headache #8	Effective #2	1935	PO
7-25-99	2235	Tylenol #3 ii po	k	H/A #10	E #3	2335	k
7/26/99	0235	Tylenol #3 ii tabs PO	M	c/o H/A "#12" so.. #10	effective #2	0530	M
7/26/99	0700	Tylenol #3 ii tabs po	PT	c/o HA #10	eff	0800	PT
7-26-99	1620	Tylenol po	CR	c/o H/A #4-5	#1 effective	1820	CR
7-26-99	2000	M.O.M & Dulcolax 30cc PO	CR	Constipation	eff.	2100	CR
7-26-99	1030	Acetaminophen 650 mg PO	CJ	c/o H/A #6	not eff	2300	CJ
7-26-99	1045	Sumatriptan INJ .5cc SC	PO	c/o Migraine #6	Effective	2345	PO
7/27/99	0325	Acetaminophen 650mg po	PT	c/o H A # 7	eff sleeping	0400	PT
7/27/99	0750	Acetaminophen 650mg po	PT	c/o HA # 5	effective SL	0830	PT
7-27-99	1200	Acetaminophen 650 mg PO	PT	c/o H/A	effective SL	1300	PT
7/27/99	1600	Tylenol 650 mg po	PO	c/o headache #5	effective #2	1700	PO
7/27/99	2000	Tylenol 650 mg po	PO	c/o headache #7	effective #1	2100	PO
7/27/99	2245	Sumatriptan .5cc SC	PO	c/o Migraine #7	Effective #1	2345	PO
7/28/99	0410	Tylenol 650mg po	PT	c/o HA #7	eff #2	0500	PT

SIGNATURE/TITLE	INIT
Pat Tackett LSW	k
Tinsley RN	M
Pat Schnell RN	PT
Carol Brazier	C3
Paula Dvelcamp RN	PO
Ruth Hinton RN	RH
Chris Dean CM	CM

INJECTION SITES

Indicate RIGHT (R) or LEFT (L)

(IM) (SUB Q)
1. DELTOID 6. UPPER ARM
2. VENTRAL GLUTEAL 7. ABDOMEN
3. GLUTEUS MEDIUS 8. THIGH
4. MID(ANTERIOR) THIGH 9. BUTTOCK
5. VASTUS LATERALIS 10. UPPER BACK

PRN: E=Effective N=Not Effective

SIGNATURE/TITLE	INI

DOVE,GAYLE A [redacted]

VA FORM 10-55

DOVE, GAYLE A ID: [redacted] 22-JUL-1999 18:56 BILOXI VAMC-* ROUTINE RECORD

41 yr
Female Caucasian
66in 130lb

Option:99

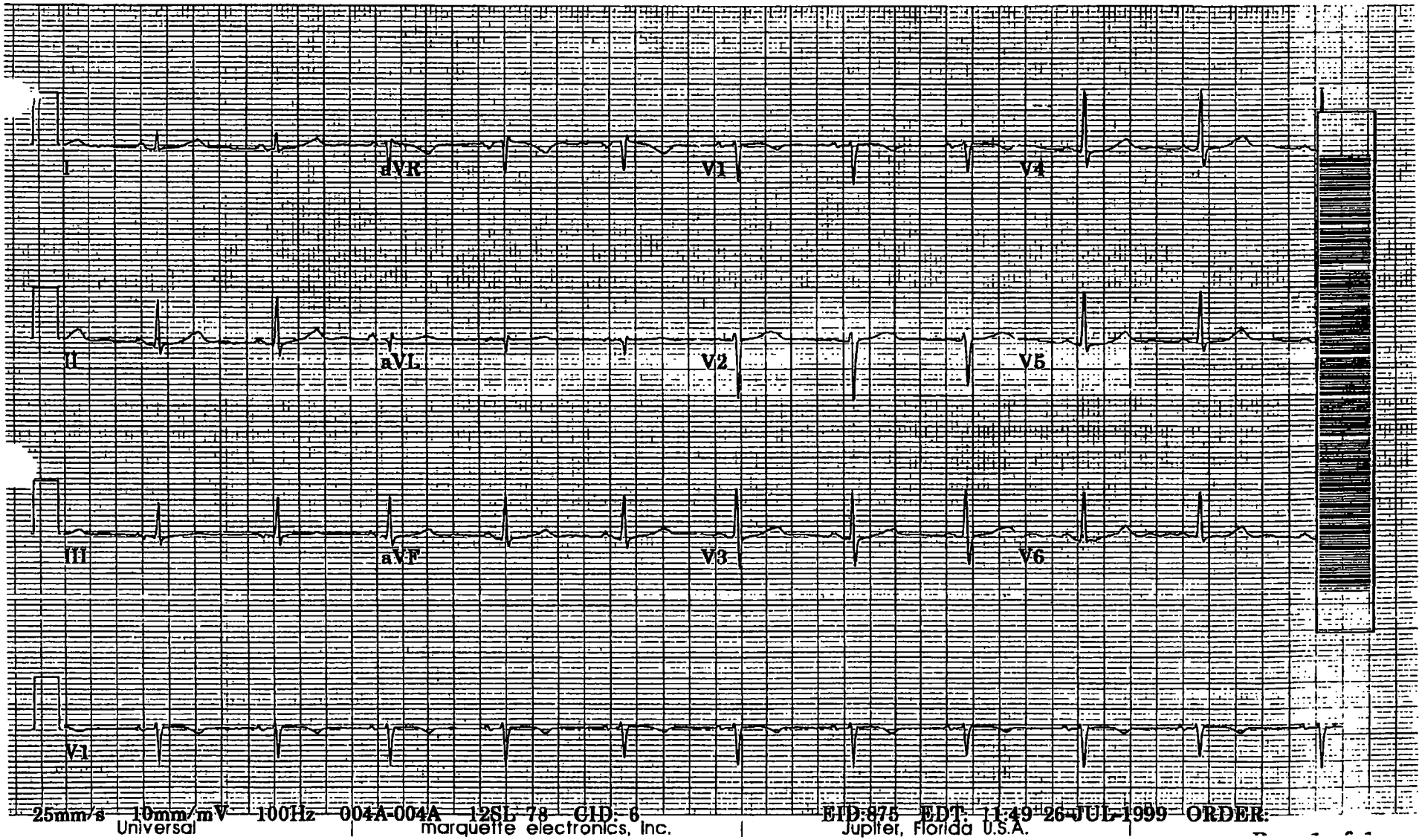
Vent. rate	65	BPM
PR interval	132	ms
QRS duration	80	ms
QT/QTc	448/466	ms
P-R-T axes	49 70	51
BP	103/66	

NORMAL SINUS RHYTHM
NORMAL ECG
WHEN COMPARED WITH ECG OF 25-MAY-1999 23:28,
NO SIGNIFICANT CHANGE WAS FOUND

Meds: Unknown

Referred by: MICHEL

Confirmed by: ASHOK KANADE M.D.



25mm/s 10mm/mV 100Hz 004A-004A 12SL 78 CID: 6 EID:875 EDT: 11:49 26-JUL-1999 ORDER:
Universal | marquette electronics, inc. | Jupiter, Florida U.S.A. |

MENTAL HEALTH FUNCTIONAL PROBLEM LIST

(Check one) ☐ FIRST LIST *(New)* ☐ CONTINUATION OF LIST

DO NOT USE ABBREVIATIONS WHEN LISTING PROBLEMS. This form may be used for inpatient, patient – members and outpatients. Place form in the Medical Records folder (Type II) on the top of right or left side, whichever is appropriate. Upon READMISSION, remove form and place with current records on ward. **DO NOT** CREATE A NEW Problem List for each readmission.

PROBLEM NUMBER	APPROX. DATE OF ONSET	DATE PROBLEM RECORDED	ACTIVE PROBLEMS	INACTIVE/RESOLVED *(Add Date)*
#2	B-25-85	2-25-85	IRRITABILITY, ANGER, MOOD SWINGS	

MENTAL HEALTH FUNCTIONAL PROBLEM LIST

PROBLEM NUMBER	APPROX. DATE OF ONSET	DATE PROBLEM RECORDED	ACTIVE PROBLEMS	INACTIVE/RESOLVED *(Add Date)*

Department of Veterans Affairs

AMBULATORY SURGERY HISTORY & PHYSICAL EXAM

Diagnosis: Recurrent Dyspepsia → Reflux - nausea/

Procedure Scheduled: EGD.

Date of Procedure: 12/16/98.

Chief Complaint / History of Present Illness: 41 F-[redacted]. Recurrent Dyspepsia Reflux symptoms x/s high dose PPI/Carafate taking a lot of Alka Seltzer →

Past History / Prior Surgeries / Social History / Review of Systems:

U/S abdomen ⊖ 11/98.

Migraine H/A →

Depression / PTSD.

S/P Hysterectomy (on Estrogens)

EGD: ( ): multiple ulcers (-NSAIDs induced ??)

HP ⊖ by RUT and histology.

Risk Factors / Co-Morbidity: none above

Adverse Drug Reactions / Allergies: None

Current Medications / Dose (attached computer printout):

see printout

Physical Exam (only pertinent positive or negative findings):

B.P._____, P._____, Wt._____ Alert oriented x 3 NAD

Lungs: clear b/l Heart: NSR

Abdomen: soft, non-tender

SIGNATURE AND TITLE OF PRACTITIONER

[signature] MD 12/10/98

IMPRINT PATIENT DATA CARD

MARTIN AVALOS
AS3285170 541

[redacted]

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE
FOR SPECIALIZED DISCIPLINES

[redacted]

VA FORM MAY 1990 10-0114j

EXISTING STOCK OF VA FORM 10-0114j, SEPT 1988, WILL BE USED.

*U.S. Government Printing Office: 1991 — 282-804/46333

Veterans Administration

Place In Front Of Medical Record

Advance Directives

Documentation to initiate, revise/review, revoke, or provide education for VA Living Will, Durable Power of Attorney, for Health Care, or Treatment Preferences.

Date/Time:
Documentation: 12/10/98 — Living Will DPOA Computer Print out Front of Chart. 4/1/98. [redacted]

IMPRINT PATIENT DATA CARD

[redacted]

DOVE, GAYLE A
[redacted]

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE
FOR SPECIALIZED DISCIPLINES

VA FORM
SEP 1988 10-0114j

026396

INTERDISCIPLINARY ADMISSION ASSESSMENT

AMBULATORY SURGERY OBSERVATION UNIT ADMISSION ASSESSMENT

I. Time of Admission: 0715 Designated Driver: Father
NPO Since: MN Medications (This AM): Inderal @ 0530
Mode of Arrival: [X]Ambulatory [ ]W/C [ ]Stretcher [ ]Other
Physician: Avelos

Disposition of Valuables: [ ]Agent Cashier [ ]MAA [ ]Patient Effects
[ ]Patient [ ]Family/Home

II. SKIN

[ ]Hot [X]Warm [ ]Cool [X]Dry [ ]Diaphoretic
[X]Pink [ ]Cyanotic [ ]Rash [ ]Lesions [ ]Decubiti
[ ]Lacerations [ ]Hematoma [ ]Flushed [ ]Other:

III. CARDIOVASCULAR/CIRCULATION:

[X]No Problem Identified [ ]Chest Pain { }Exertional { }Rest
Chest Pain: Location: Duration:
Frequency: Severity: (0 - 10 Scale)
Rhythm: [X]Regular [ ]Irregular
Leg Pain: [X] [ ]Exertional [ ]Rest

PULSES		
	Left	Right
Radial	2+	2+
DP		
PT	1+	1+

PUPILS		
	LEFT	RIGHT
Size	4mm	2mm
React	✓	✓
Fixed		
Dilated		
Constricted		

IV. RESPIRATORY

Breathing Pattern: [X]Normal [ ]Dyspnea { }Exertional { }At Rest
Cough: [X]None [ ]Non-Productive [ ]Productive

Breath Sounds:		
	Left	Right
Clear	✓	✓
Wheezing		
Rhonchi		
Rales		
Other		

V. MUSCULOSKELETAL

[X]Moves all 4 Extremities [ ]Hemiplegia [ ]Paraplegia [ ]Quadriplegia
[ ]Amputee [ ]Contractures [ ]Other:
Comments:

Signature/Title: Lawrence Benzie RN Date/Time: 12/16 @ 0735
Date/Time:

DOVE, GAYLE A [redacted]

Signature/Title: Date/Time:
Date/Time:

[redacted]

INTERDISCIPLINARY ADMISSION ASSESSMENT

AMBULATORY SURGERY OBSERVATION UNIT

VI. GASTROINTESTINAL

Abdomen: [X] Soft [ ] Rigid [ ] Distended [ ] Non-Tender
[ ] Tender [X] Bowel Sounds [X] Normal { } Absent
{ } Hypoactive { } Hyperactive

Last Bowel Movement: Yest Other: _____

VII. GENITOURINARY

[X] No Problem Identified [ ] Burning [ ] Frequency [ ] Hematuria
[ ] Incontinence [X] Last Menstrual Period Feb 87
[ ] Other: nyst.

VIII. SLEEP/REST ASSESSMENT

Usual Number of Hours of Sleep: 8 Goes to Sleep at: 11 P Rises at: Varies 7A
Difficulty Sleeping: (YES) NO Sleeping Aids: (YES) NO
Why? PTSD What? Trazadone

IX. MISCELLANEOUS:

Glasses	(YES)	NO	Brace	YES	(NO)
Contact Lens	(YES)	NO	Walker	YES	NO
Hearing Aid	YES	(NO)	Cane	YES	NO
Artificial Eye	YES	NO	Wheelchair	YES	NO
Crutches	YES	NO	Infusaport/Hickman	YES	NO
Artificial limb	YES	NO			

Comments: _____

X. COLLABORATIVE INTERDISCIPLINARY PLAN OF CARE

PROBLEM	PLAN	GOAL	PROBLEM ID BY (INITIALS)	RESOLVED/ UNRESOLVED/ ONGOING
	See care plan			

***If problem remains unresolved or ongoing, document plan for follow-up care. (i.e. in Primary Care, Surgery Clinic, Mental Health, etc.)**

Signature/Title: [signature] Date/Time: 12/16/98 0735
Date/Time: _____

Readmission/Reassessment within 30 days:
Reviewers:
Signature/Title: _____ Date/Time: _____
Date/Time: _____

II. SCIPLINARY ADMISSION ASSESS

OBSERVATION AND DISCHARGE NOTES

Arrival Time: 0937
Procedure: EGD & BR
IV Solution: NS
LTC: 500
Site: #20 Lt hand

Marital Status: M Married
Alert: ✓ Drowsy:
Dressing:
Dry: N/A: ✓
Drainage:
NSR: x 21

Drain: NO ✓ YES
Pain: NO ✓ YES
Nausea: NO ✓ YES
CM: NO ✓ YES
Oximetry: NO: ✓ YES:
Other:

TIME	0937	1050				
TEMP	96					
O2 SAT	97	97				
200						
180						
160						
140						
120						
100	✓	✓				
80						
60	A	A				
40						
20	O	O				

NURSES NOTES

Side Rails Up: ✓ Family Present: ✓ Up in Chair: ✓ Amb to BR: ✓

Alert oriented x 3. Color pale pink, skin wd HR Reg - Tongue pink moist, PERL Throat gag ? Front teeth, wd removed, rest Hyps Lungs Sounds - to Bases Bilat - Has non productive Cough related to sinus. — B Dinsmore

MEDICATION RECORD

TIME	MEDICATION	DOSE	ROUTE	SITE	GIVEN BY

INTAKE
IV:
PO: 360

OUTPUT
URINE
EMESIS 0

DISCHARGE SUMMARY AND INSTRUCTIONS

Discharge Time: 1130
Alert-Oriented: YES: ✓ NO:
Tolerated Fluids: YES: ✓ NO:
Pain: YES: NO: ✓
Nausea: YES: NO: ✓
IV DC'd: 20 #Intact: 0
Flds. Abs.

Drain: N/A: DC'd:
Intact on D/C:
Voided: YES: NO:
Urge: Discomfort:
Valuables Returned:
YES: ✓ None:

Instructions: YES ✓ NO
Copy of Instructions given: YES ✓ NO
RX given: YES ✓ NO
Mode of D/C: W/C ✓
D/C with: family
By: Car ✓ Other:
Nurse: Laura Bergren

Dressing: Dry N/A ✓

Verbalized/Demonstrated Understanding of D/C

POST-OPERATIVE

Follow-Up: PRN
Date/Time: 12/17/98 @ 0915
Yes: No Phone: No Answer:
Problems Noted: headache from anest
Recommendations: call for problems

DOVE Signature/Title: [redacted] Laura Bergren RN Date/Time: 12/17/98 @ 0915
Date/Time:

Readmission/Reassessment within 30 days:
Reviewers:
Signature/Title: [redacted] Date/Time:

PROGRESS NOTES

DATE/TIME	

12/16

INTERDISCIPLINARY ADMISSION ASSESSMENT

SURGERY SERVICE
PREADMIT CLINIC ASSESSMENT

I. Date: 12/10/98 Time: 1245 Age: 41 HT: 5'6" WT: 127#
Mode of Arrival: [ ]Ambulance [✓]Walk In [ ]Extended Care Facility
[ ]Other:
Source of Information: [✓]Patient [ ]Family/Friend [ ]Old Chart [ ]Other:
Chief Complaint: Nausea H/O ulcer → EGD
Allergies: NKA
Reactions to Anesthesia: none
Medical History/Past Surgeries/Hospitalizations: Hysterectomy '87
Hernia wrist RX4 EGD '96
Present Medications: Bisacodyl, Fluoxetine, Risperidone, Tegaderm, Estrogen, Propanolol, Promethazine, Clonazepin, Sumatriptan, Albuterol, Cytotec, Mirapristone
Marital Status: Divorced
Religious Preference: Protestant Blood/Blood ProductTransfusion Preference: accepts
Emergency Notification
Relative/Friend: Raymond Dove Relationship: father
Phone Number: 996-1919

II. **LEVEL OF CONSCIOUSNESS:**
[✓]Alert [✓]Oriented [✓]Person [✓]Place [✓]Time
[ ]Verbally Responsive [ ]Confused/Disoriented [ ]Responds to Pain
BEHAVIOR
[✓]Cooperative [ ]Uncooperative [ ]Combative [ ]Withdrawn
[ ]Other:
EMOTIONAL/PSYCHOSOCIAL STATUS:
[✓]Calm [ ]Anxious [ ]Fearful [ ]Depressed [ ]Suicidal
ADL's/Level of Functioning:
Bathing S/A/T Dressing S/A/T Eating S/A/T: Mobility S/A/T
Oral Hygiene S/A/T Toileting S/A/T
Comments:

VITAL SIGNS				
TIME	B/P	PULSE	RESP	TEMP
	103/65	59	16	97.8

96%

III. **PATIENT RIGHTS**
Advanced Directive [✓]YES [ ]NO
Type: DPOA / Living will
Location: Computer — front of chart
Organ Donor [ ]YES [✓]NO
Tissue Donor [ ]YES [✓]NO
Information/Pamphlet Provided:
[ ]YES [✓]NO [ ]Refused
Comments:

IV. **POTENTIAL ABUSE**
[✓]Not Applicable
[ ]Rape or Other Sexual Molestation
[ ]Domestic Abuse
[ ]Abuse or neglect of elders or children
[ ]Evidence of Physical Assault
{ }Unexplained Bruises
{ }Unexplained Injuries
{ }Unkempt, dirty, poor hygiene

If yes to the above, **initiate Center Memorandum 122-17** (Mandatory Reporting of Adult and Child Abuse or Neglect) and contact Social Worker.
Date/Time Initiated:
Comments:

Signature/Title: [redacted] Date/Time: 12/10/98 1300
Date/Time:

DOVE GAYLE A

[redacted]

0 days:

Date/Time:
Date/Time:

INTERDISCIPLINARY ADMISSION ASSESSMENT

PREADMIT CLINIC ADMISSION ASSESSMENT

V. PHYSICAL DISABILITIES

Arthritis	YES	(NO)
Coordination Problems	YES	(NO)
Limb Loss	YES	(NO)
Seizures	YES	(NO)
Emotional Status: (Calm / Apprehensive / Cooperative)		
Paralysis	YES	(NO)
Pain:	(YES)	NO

Severity (0 - 10): 9

Tolerable Level of Pain 7

Location: migrane

Comments: 8

ELIMINATION:

Incontinence	YES	(NO)
Indwelling Foley	YES	(NO)
Ileostomy	YES	(NO)
Colostomy	YES	NO
Constipation	(YES)	NO
Diarrhea	YES	(NO)
Black, tarry stools	YES	(NO)
Renal:	YES	(NO)
Prostate	YES	(NO)

Comments: (-) dysuria

GASTROINTESTINAL:

(Nausea & Vomiting)	(YES)	NO
Feeding Tube	YES	(NO)
Hx of Ulcers	(YES)	NO
ETOH Use	YES	(NO)

_____/wk. Last drink: _____

Dysphagia YES (NO)

Religious Food Preference: none

Type of Diet: regular

Comments: (-) diabetes (+) GERD

TEETH

Bridges	YES	(NO)
Dentures:	YES	(NO)
Upper: Full: _____	Partial: _____	
Lower: Full: _____	Partial: _____	
Broken	YES	(NO)
Loose	YES	(NO)
Missing	YES	(NO)

Comments: crowns

PULMONARY:

Smoker	(YES)	NO

Packs Per Day: 1 # of Years: _____

Recent URI	(YES)	NO
COPD	YES	(NO)
Tracheostomy	YES	(NO)
O2 Adm	YES	(NO)
TB	YES	(NO)
Asthma	YES	(NO)
SOB	YES	(NO)
Cough	(YES)	NO

Productive: _____

Non-Productive: ✓

Color of Sputum: _____

Comments: wheezes - bilateral (inspiratory & expiratory) Sinus infection resolving

CARDIOVASCULAR/CIRCULATION:

CHF	YES	(NO)
Angina	YES	(NO)

Last Occurrence: _____

Location: _____

Severity (0-10): _____

Relieved by: _____

MI	YES	(NO)
Arrhythmias	YES	(NO)
Hx Vascular Disease	YES migrane	NO
HTN	YES	(NO)
CVA	YES	(NO)
Pacemaker/AICD	YES	(NO)
Thyroid Disease	YES	(NO)
Hepatitis	YES	(NO)
HIV	YES	(NO)
Previous Blood Transfusion	(YES)	NO

Comments: migranes 3-4 x's / wk

Signature/Title: [signature] RN Date/Time: 12/10/98 1300

Date/Time: _____

Readmission/Reassessment within 30 days:

Reviewers:

Signature/Title: _____ Date/Time: _____

Date/Time: _____

INTERDISCIPLINARY ADMISSION ASSESSMENT
PREADMIT CLINIC ADMISSION ASSESSMENT

SLEEP/REST ASSESSMENT

Usual Number of Hours of Sleep: _____ Goes to Sleep at: Varies

Difficulty Sleeping: YES NO Sleeping Aids: YES NO

Why? PTSD What? Ambien Trazadone

MISCELLANEOUS:

Glasses	YES	NO
Contact Lens	YES	NO
Hearing Aid	YES	NO
Artificial Eye	YES	NO
Crutches	YES	NO
Artificial limb	YES	NO
Brace	YES	NO
Walker	YES	NO
Cane	YES	NO
Wheelchair	YES	NO
Infusaport/Hickman	YES	NO

Comments: _____

SKIN INTEGRITY

Rashes	YES	NO
Bruises	YES	NO
Infections	YES	NO
Cuts	YES	NO
Edema	YES	NO

Site: _____

Degree: _____

General Problems: _____

Comments: _____

VI. PRE-OP TEACHING

Signed Pre-op Instructions: Yes Waiting Area: Family/Significant Other: Father

Peri-Operative Care: Yes Pamphlets: AD, To Your Health

Approximate Time in OP/OR/RR: Yes Must have Designated Driver: Yes

Instructed on Prep Video: Verbal Questions Answered: Yes

Prep Kit Given: 0 Home Phone Number: 396-1919 (D'Sleeville)

X Patient Signature: Gayle A. Dove Nurse Signature: [signature]

VII. PRE-OP CALL:

Spoke with: [L]Patient [ ]Other: _____

[ ]Left Message [ ]No Answer [ ]No Phone [ ]To Return Call

Discussed: [L]NPO after MN [L]Except am Medicine: Inderal 12/16

[ ]Do Not Take Medicine [ ]Bring Medicine YES NO

Arrival Time: 0730 AEDN 12/16 Designated Driver: father

Prep: [ ]Colon _____ [ ]Skin _____

[ ]Laxative _____

Patient Questions:	YES	NO	Discussed	YES	NO
Changes in Physical Condition:	YES	NO	Fever	YES	NO
Infection/Draining Wound	YES	NO			

Pre Post-Op Lodging Protocol: NA Discussed: YES NO

Voiced Understanding of Pre-OP Instruction Sheet/Standard Post-Op Care YES NO

Progress Notes: _____

DOVE, GAYLE A [redacted] M Cornelius RN Date/Time: 12/10/98 0800

_____ Date/Time: _____

Readmission Reassessment within 24hrs:

Reviewers:

Signature/Title: _____ Date/Time: _____

_____ Date/Time: _____

[redacted]

INTERDISCIPLINARY ADMISSION ASSESSMENT

VIII. PREADMIT CLINIC SCREENING TOOL

NUTRITIONAL SCREENING Need Identified: ☐ Yes ☐ No

Unintentional Weight Loss of 5lbs in last week: ☑ Yes ☐ No

NPO > 3 Days: ☐ Yes ☒ No

Unintentional Weight Loss of 10lbs in last month: ☐ Yes ☒ No

Tube Feeding/TV Nutritional Support: ☐ Yes ☒ No Type: _____

~~Non-Formulary Nutritional Support (Tube Feeding/Parenteral) Products: ☐ Yes ☐ No~~

Type: _____

Being evaluated by Dr. Avelos

If any of the above identified, contact Clinical Dietitian

Method of Notification: _____ Date/Time Notified: _____

Signature: _____

SOCIAL WORK/DISCHARGE PLANNING SCREENING Need Identified: ☐ Yes ☒ No

Patient will need supportive care or support of caregiver at discharge for activities of daily living: ☐ Yes ☒ No

Patient lives alone and is capable of independent living: ☑ Yes ☐ No

Patient is capable of planning for own care: Yes

Patient is homeless: ☐ Yes ☒ No

If any of the above identified, contact Social Worker:

Method of Notification: _____ Date/Time Notified: _____

Signature: _____

FUNCTIONAL SCREENING Need Identified: ☐ Yes ☒ No

Able to Perform Activities of Daily Living without Assistance ☑ Yes ☐ No

Developed within the last month: 0

[ ]CVA [ ]Head Trauma [ ]Brain Injury [ ]Fall

Newly Identified weakness/paralysis

If any of the above identified notify Rehabilitation Medicine

Method of Notification: _____ Date/Time: _____

Signature: _____

TEACHING ASSESSMENT

Learns best: ☐Seeing ☐Hearing ☑Doing Able to read: ☑YES ☐NO Education Level: 2yrs college

Barriers/limitations: ☐Physical ☒Visual ☐Cognitive ☐Auditory ☐Language ☐Emotional ☐Other _____ ☐None

Describe barriers/limitations and note plan to adapt patient teaching: needs glasses/contact lens for reading

Age Specific Needs: _____

Cultural/Religious practices affect the patient's healthcare? ☐NO ☐ YES If yes, describe and document plan to adapt teaching: _____

Signature/Title: _____ Date/Time: 12/10/98

POST-OP DISCHARGE PLANNING

Do you care for yourself at home? (YES) NO Who will help you? father

Does anyone depend on your care at home? (YES) NO Transportation: father

Lodging: [ ]Preop [ ]Postop ~~Room Number:~~ _____

Nurse Signature: _____ Date/Time: 12/10/98

Signature/Title: _____ Date/Time: 12/10/98 1300

Date/Time: _____

Readmission/Reassessment within 30 days:

Reviewers:

Signature/Title: _____ Date/Time: _____

Date/Time: _____

COLLABORATIVE INTERDISCIPLINARY PLAN OF CARE/PROGRESS NOTE/DISCHARGE PLANNING

Admission: 12/10/98
Diagnosis: EGD

[ ] Palliative Care
[ ] Patient and/or [ ] Significant other will be knowledgeable about medications, diet, activity, treatments, and follow-up care.
[ ] Discussed discharge plans with family/significant other.
[ ] Patient will be discharged to Nursing Home.
[ ] Discharge to home.

DATE	PROBLEM	PLAN	GOAL	PROBLEM ID BY (INITIALS)	DATE COMPLETED
12/10/98	KNOWLEDGE DEFICIT REGARDING DIAGNOSIS AND SURGICAL INTERVENTION NEEDED.	SURGEON WILL DISCUSS WITH PT/FAMILY IF PRESENT DX, PROCEDURE RISKS BENEFITS ALTERNATIVES IF ANY	PT/FAMILY WILL HAVE TIME TO DISCUSS WITH SURGEON PROCEDURE AND IF CONCUR WILL SIGN CONSENT	M.A	12/10/98
12/10/98	KNOWLEDGE DEFICIT REGARDING ANESTHESIA TYPES.	~~MD~~/CRNA WILL DISCUSS OF ANESTHESIA BEST FOR PT INCLUDING RISKS AND BENEFITS	PT/FAMILY WILL VERBALIZE UNDERSTANDING OF ANESTHESIA TO BE USED AND WILL CONCUR BY SIGNING ANESTHESIA CONSENT		12/10/98
12/10/98	KNOWLEDGE DEFICIT REGARDING ADVANCED DIRECTIVES.	PRE-ADMIT NURSE/SOCIAL WORKER/CHAPLAIN WILL DISCUSS AD WITH PT/FAMILY & COMPLETE IF PT WISHES.	PT/FAMILY WILL VERBALIZE UNDERSTANDING AND SIGN AD ACKNOWLEDGEMENT		12/10/98
↓	KNOWLEDGE DEFICIT REGARDING PREOPERATIVE INSTRUCTIONS.	PRE-ADMIT RN WILL REVIEW PRE-OP INSTRUCTIONS WITH PT/FAMILY AND GIVE WRITTEN INSTRUCTIONS TO PT.	PT/FAMILY WILL VERBALIZE UNDERSTANDING BY RESTATING INSTRUCTIONS.	↓	↓
↓	UNDERSTANDING OF PROCEDURE TIME.	PRE-ADMIT RN WILL CALL PT DAY BEFORE PROCEDURE AND VERIFY TIME WITH PT	PT WILL UNDERSTAND TIME AND WILL HAVE ANY FURTHER QUESTIONS ANSWERED IF NEEDED.	↓	↓
12/10/98	ANXIETY REGARDING OPERATING ROOM.	OR RN WILL FOLLOW NURSING PLAN OF CARE FOR OR AND WILL ENCOURAGE PT TO EXPRESS ANY FEARS/CONCERNS.	PT WILL VERBALIZE ANY FEARS HE/SHE MAY HAVE.	MC	MC

Problems resolved upon discharge Yes [ ] No [ ]
If no, explain: _____

Signature: _____
Patient Identification:

PROGRESS NOTE:

MEETING DATES:		12/10					
ATTENDANCE	SIGNATURE	INITIAL	INITIAL	INITIAL	INITIAL	INITIAL	INITIAL
CHIEF OF SURGERY							
STAFF SURGEON							
~~ANESTHESIOLOGIST~~/CRNA	[illegible]	[illegible]					
RESIDENT							
PC DOCTOR							
CONSULTING DOCTOR	[illegible]	M.A					
REGISTERED NURSE	[illegible]	[illegible]					
REGISTERED NURSE	Melanie Covaceuich RN	MC					
REGISTERED NURSE							
SOCIAL WORKER							
REGISTERED DIETITIAN							
PHARMACIST							
KT/OT/PT/SPEECH							
RESPIRATORY TECH							
I.C. NURSE							
PT./SIGNIFICANT OTHER							

COLLABORATIVE INTERDISCIPLINARY PLAN OF CARE/PROGRESS NOTE/DISCHARGE PLANNING

Admission: 12/16/98
Diagnosis: EGD

[ ] Palliative Care
[✓] Patient and/or [✓] Significant other will be knowledgeable about medications, diet, activity, treatments, and follow-up care.
[✓] Discussed discharge plans with family/significant other.
[ ] Patient will be discharged to Nursing Home.
[✓] Discharge to home.

DATE	PROBLEM	PLAN	GOAL	PROBLEM ID BY (INITIALS)	DATE COMPLETED
12/16/98	POTENTIAL FOR AIRWAY OBSTRUCTION HEMODYNAMIC INSTABILITY, ALTERED STATE OF CONSCIOUSNESS & POST OPERATIVE DISCOMFORT/PAIN	PACU RN WILL MONITOR VS. PT STATUS ACCORDING TO PACU ADMISSION DISCHARGE CRITERIA.	PT WILL REMAIN HEMODYNAMICALLY HAVE PARS SCORE OF 10 OR EQUAL TO PRE-OP STATUS. PT WILL HAVE TOLERABLE	CD	12/16/98
			LEVEL OF PAIN AS DOCUMENTED IN PT. ASSESSMENT.		
12/16/98	KNOWLEDGE DEFICIT REGARDING POST-OPERATIVE INSTRUCTIONS	SURGEON WILL DISCUSS WITH PT/FAMILY POST-OP INSTRUCTIONS	PT/FAMILY WILL VERBALIZE UNDERSTANDING OF POST-OPERATIVE INSTRUCTIONS	M.a	12/16/98
12/16	CONFIRMATION OF UNDERSTANDING POST-OPERATIVE INSTRUCTIONS	ASOU RN WILL VERBALLY REVIEW POST-OPERATIVE INSTRUCTIONS AND GIVE PT A WRITTEN COPY. THE RN	PT/FAMILY WILL VERBALIZE UNDERSTANDING OF POST-OPERATIVE INSTRUCTIONS BY RESTATING INSTRUCTIONS &	CD	12/14
		WILL ALSO GIVE PT A CARD WITH NAME OF MD AND PHONE NUMBER TO CALL IF ANY PROBLEM.	WHAT TO DO IF PROBLEMS OCCUR. PT WILL VERBALIZE RETURN APPOINTMENT DATE & TIME.	CD	
12/17	POST-OPERATIVE FOLLOW-UP	THE ASOU RN WILL CALL PT 24 HOURS AFTER SURGERY TO SEE IF PT HAS ANY PROBLEMS.	PT WILL BE ASSURED WE ARE CONCERNED ABOUT HIM/HER.	CD	[redacted]

Problems resolved upon discharge Yes [✓] No [ ]
If no, explain:

Signature: Bobbye Dunnam
Patient Identification:

1907

PROGRESS NOTE:								
MEETING DATES:		12/16						
ATTENDANCE	SIGNATURE	INITIAL	INITIAL	INITIAL	INITIAL	INITIAL	INITIAL	
CHIEF OF SURGERY								
STAFF SURGEON								
ANESTHESIOLOGIST/CRNA								
RESIDENT								
PC DOCTOR								
CONSULTING DOCTOR	Martin avalos	M.a						
REGISTERED NURSE	Carol DuBOSEN	CD						
REGISTERED NURSE	Bobbye Dunnellon	BD						
REGISTERED NURSE								
SOCIAL WORKER								
REGISTERED DIETITIAN								
PHARMACIST								
KT/OT/PT/SPEECH								
RESPIRATORY TECH								
I.C. NURSE								
PT./SIGNIFICANT OTHER								

Interdisciplinary Patient and Family Teaching Record

TEACHING ASSESSMENT

Learns best: ☐ Seeing ☐ Hearing ☐ Doing **Able to read:** ☒ Yes ☐ No **Education level:** College

Barriers/limitations: ☐ Physical ☐ Visual ☐ Cognitive ☐ Auditory ☐ Language ☐ Emotional ☐ Other ☐ None

Describe barriers/limitations and note plan to adapt patient teaching: _____

Cultural/religious practices affect the patient's healthcare? ☒ No ☐ Yes **If yes, describe and document plan to adapt teaching:** _____

Signature/Title Sarah Kelly RN Date 11/17/14

CODES

A. Topic/Teaching Need
1. Disease/Condition
2. Medications
3. Diet/Nutrition
4. Food/Drug Interaction
5. Treatment/Procedure
6. Equipment Use/Safety
7. Hygiene
8. Rehab/ADLs
9. Health Promotion/ Prevention
10. Community Resources
11. Follow-up Instructions
12. Other

B. Learner
P = Patient
S = Spouse
F = Family member
O = Other

C. Teaching Method
E = Explanation
H = Handouts * (list title)
D = Demonstrate
AV = Audiovisual * (list title)
G = Group Presentation
R = Reinforced

D. Evaluation
1. Verbalizes/Discusses essential concepts
2. Asks appropriate questions
3. Demonstrates
4. Demonstrates with assistance
5. Requires reinforcement
6. No evidence of understanding
7. Refused teaching

For each entry, include appropriate codes from above. | *** Asterisk items require additional information in the "Comments" section on the back.**

A. Topic/ Teaching Need(s)	Readiness to learn Y/N *	B. Learner	Instructions/ Discussion	C Teaching Method	D. Eval.	Date/ Initial
PT	Y	P	RTC to MD	E	2	11/17/14
			Meds per MD			

SIGNATURE AND TITLE OF PRACTITIONER [signature] DATE

IMPRINT PATIENT DATA CARD (Name, Address and Social Security Number)

[redacted]

MEDICAL RECORD

SUPPLEMENT TO PROGRESS NOTE FOR SPECIALIZED DISCIPLINES-VERTICAL

[redacted]

VA FORM SEP 1992 **10-0114J(R)**

*U.S. GPO: 1995-822-059/83055

A. Topic/ Teaching Need(s)	Readiness to learn Y/N	B. Learner	Instructions/ Discussion	C. Teaching Method	D. Eval	Date/ Initial

Date	Time	Initials	Comments

Initials	Signature/Title	Initials	Signature/Title

Referrals for further education or support (circle P, S, F and/or O)

P,S,F,O referred to _____ Date_____ Initial_____

P,S,F,O referred to _____ Date_____ Initial_____

A. Topic/Teaching Need		B. Learner	C. Teaching Method
1. Disease/Condition	8. Rehab/ADLs	P = Patient	E = Explanation
2. Medications	9. Health Promotion/ Prevention	S = Spouse	H = Handouts * (list title)
3. Diet/Nutrition	10. Community Resources	F = Family member	D = Demonstrate
4. Food/Drug Interaction	11. Follow-up Instructions	O = Other	AV = Audiovisual * (list title)
5. Treatment/Procedure	12. Other		G = Group Presentation
6. Equipment Use/Safety			R = Reinforced
7. Hygiene			

D. Evaluation

1. Verbalizes/Discusses essential concepts
2. Asks appropriate questions
3. Demonstrates
4. Demonstrates with assistance
5. Requires reinforcement
6. No evidence of understanding
7. Refused teaching

For each entry, include appropriate codes from above. * Asterisk items require additional information in the "Comments" section on the back.

A. Topic/ Teaching Need(s)	Readiness to learn Y/N *	B. Learner	Instructions/ Discussion	C Teaching Method	D. Eval.	Date/ Initial
1,2,5	Y	P	SEE SURGICAL INFORMED CONSENT (MD)	E, H	1,2,7	12/10/98 MA
1,2,5	Y	P	SEE ANESTHESIA INFORMED CONSENT (MDA/CRNA)	E	1	12/10/98
1,2	Y	P	SEE ADVANCED DIRECTIVE ACKNOWLEDGEMENT (RN/SOCIAL WORKER/CHAPLAIN)	E, H	1,2	12/10/98 SL
2,3,5	Y	P	SEE PRE-OPERATIVE INSTRUCTIONS (RN)	E, H	1,2	12/10/98 SL
5,6	Y	D	PT ORIENTED TO OR ENVIRONMENT AND PACU PROTOCOL. PT ENCOURAGED TO ASK QUESTIONS & EXPRESS CONCERN (OR RN)	E	1,2	12-16-98 MC
3,5,6,8	Y	P	SEE PACU FLOW SHEET (PACU RN)	E, R	1,2	12-16-98 CM
			DISCUSS FINDINGS & POST-OP INSTRUCTIONS WITH PT/FAMILY(MD)			
1,3,5,11	Y	P	REVIEW POST-OP INSTRUCTIONS WITH PT/FAMILY. WRITTEN COPY GIVEN TO PT, RETURN APPOINTMENT, # TO CALL-PROBLEMS(ASOU RN)	E, R	1,2	[redacted]
9	Y	P	PAMPHLET "TO YOUR HEALTH" DISCUSSED WITH PT AND FAMILY	E, H	1,2	

1911

A. Topic/ Teaching Need(s)	Readiness to learn Y/N *	B. Learner	Instructions/ Discussion	C. Teaching Method	D. Eval	Date/ Initial

Date	Time	Initials	Comments

Initials	Signature/Title
On	
Sa	
MC	Melanie Covarrubias
M.a	Martha Avalos.

Initials	Signature/Title
CD	Carol DuBois
BD	Bobbye Dunlap JM

Referrals for further education or support (circle P, S, F and/or O)

P,S,F,O referred to _____ Date_____ Initial_____

P,S,F,O referred to _____ Date_____ Initial_____

Department of Veterans Affairs

PRE OP ANESTHESIA INFORMED CONSENT

SURGICAL SERVICE

DATE\TIME: 12/10/98 1300 PATIENT COMPETENT: YES ✓ NO _____

BRIEF SUMMARY: 41y/o S/P THR - PTD - reflux

Allergic ASA

PATIENT CONDITION: awake alert
(i.e. awake, alert, sedated, anxious, confused, lethargic, unconscious, intubated, other)

PROPOSED PROCEDURE\TREATMENT PLAN:
EGD c MAC

POSSIBLE RISKS\COMPLICATIONS:
see nurse

ALTERNATIVE TREATMENT IDENTIFIED TO PATIENT\GUARDIAN:
Ø

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: _____

DEBORAH McCLAIN, MD
ANESTHESIOLOGIST

CRNA \ ANESTHESIA RESIDENT

ATTENDING ANESTHESIOLOGIST 1300 12/10/98

SIGNATURE AND TITLE OF PRACTITIONER	DATE

IMPRINT PATIENT DATA CARD

[redacted]

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE
FOR SPECIALIZED DISCIPLINES

[redacted]

VA FORM MAY 1990 10–0114j

EXISTING STOCK OF VA FORM 10–0114j, SEPT 1988 WILL BE USED.

*U.S. Government Printing Office: 1991 — 282-804/46333

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

Gayle A. Dove

MEDICAL RECORD	NURSE INTRAOPERATIVE REPORT	PAGE 1

Operating Room: OR E1 | Surgical Priority: ELECTIVE
Patient in Hold: DEC 16, 1998 08:10 | Patient in OR: DEC 16, 1998 08:10
Operation Begin: DEC 16, 1998 08:30 | Operation End: DEC 16, 1998 08:45
Patient Out OR: DEC 16, 1998 08:52

Surgeon: AVALOS,MARTIN | First Assistant: N/A
Attending Surg: AVALOS,MARTIN | Second Assistant: N/A
Anesthetist: BARCLAY,VIVEK | Assistant Anesth: N/A

Other Scrubbed Assistants: N/A

OR Support Personnel:
Scrubbed: LEE,BRENDA B (FULLY TRAINED)
Circulating: COVACEVICH,MELANIE D (FULLY TRAINED)

Other Persons in OR: N/A

Preop Mood: RELAXED | Preop Consc: ALERT-ORIENTED
Preop Skin Integ: INTACT | Preop Converse: N/A

Valid Consent/ID Band Confirmed By: COVACEVICH,MELANIE D
Skin Prep By: N/A | Skin Prep Agent: N/A
Skin Prep By (2): N/A | 2nd Skin Prep Agent: N/A
Preop Shave By: N/A

Surgery Position(s): SUPINE | Placed: N/A

Restraints and Position Aids:
SAFETY STRAP | Applied By: N/A

Electrocautery Unit: N/A
ESU Coagulation Range: N/A
ESU Cutting Range: N/A
Electroground Position(s): N/A

Major Operations Performed:
Primary: ESOPHAGOGASTRODUODENOSCOPY CPT Code: NOT ENTERED

Material Sent to Laboratory for Analysis:
Specimens:
A. GASTRIC BIOPSY TO PATHOLOGY
B. GASTRIC BIOPSY FOR H. PYLORI DONE IN ENDO
C. BIOPSY DISTAL ESOPHAGUS

Cultures: N/A
Anesthesia Technique(s): N/A
Tubes and Drains: N/A
Tourniquet: N/A
Thermal Unit: N/A
Prosthesis Installed: N/A
Medications: N/A
Irrigation Solution(s): N/A
Blood Replacement Fluids: N/A

Sponge Count: N/A
Sharps Count: N/A
Instrument Count: N/A
Counter: N/A
Counts Verified By: N/A

NURSE'S SIG: Melanie Covacevich RN | DEC 16, 1998@08:52
DOVE,GAYLE A | 515-64-6094
WARD: | ROOM-BED:
VAMC: Biloxi, MS (CONS) | SF 509 PROGRESS NOTES

Dressing: N/A
Packing: N/A
Blood Loss: 0 cc's Urine Output: 0 cc's
Postoperative Mood: RELAXED
Postoperative Consciousness: SEDATED
Postoperative Skin Integrity: INTACT
Postoperative Skin Color: N/A
Type of Laser: N/A
Sequential Compression Device: NO

Wound Classification: CONTAMINATED
Operation Disposition: PACU (RECOVERY ROOM)
Discharged Via: STRETCHER W/SAFETY STRAP,S/R UP
Nursing Care Comments:
PT TRANSFERRED TO ENDO PROCEDURE PERFORMED ON STRETCHER. PT GARGLED WITH HURRICANE SPRAY ADMINISTERED PER DR AVALOS. TOLERATED PROCEDURE WELL TRANSFERRED TO PACU.
SCOPE NUMBER 2801478

NURSE'S SIG: Melanie Covaccevich RN DEC 16, 1998@08:52
DOVE,GAYLE A
WARD:
VAMC: Biloxi, MS (CONS) SF 509 PROGRESS NOTES

AMBULAT... SURGERY - POST OP ENDOSCOPIC INSTRUCTIONS

Department of Veterans Affairs

MEDICAL RECORD - DISCHARGE INSTRUCTIONS

DATE OF ADMISSION	DATE OF DISCHARGE	TYPE OF DISCHARGE
12/16/98	12/16/98.	

1. DIAGNOSES AND DATE TO BE FOLLOWED ON OUTPATIENT SERVICES

DX: GASTritis →

SURGEON: avalos ATTENDING STAFF: VA Phone 1-800-296-8872 Ext:

F/U Appt: Date/Time: prn Clinic: VA Phone #(601)388-5541 Ext:

If you are unable to keep your appointment, please call and reschedule.

2. SUGGESTED PLAN FOR FOLLOWUP

If you are coughing up or vomiting excessive blood, having chest or abdominal pain, difficulty breathing, fainting, fever, or have any questions about symptoms you are experiencing after 1630 call 388-5541, ask the operator to page the surgical resident.

Tell him or her your symptoms or you may come directly to the emergency room.

3. DISCHARGE MEDICATIONS AND INSTRUCTIONS

MEDS: Resume routine medicine.

Instructions: Prevacid. 30g PO qd

Reglan 10g AC/HS.

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. Call Dr. if nausea and/or vomiting more than 12 hours.

Anti-Reflux measures →

5. PHYSICAL ACTIVITY LIMITATIONS *(Check one)*

☐ NO RESTRICTIONS ☐ RESTRICTIONS *(Specify)*

No driving or operating anything that requires coordination.
It is necessary to have a responsible adult with you for 24 hours.
Specific:

6. OTHER *(Include employment status)*

PATIENT IDENTIFICATION *(Name, Address, Social Security Number)*	SIGNATURE OF PHYSICIAN/DENTIST	DATE
DOVE, GAYLE A [redacted]	MARTIN AVALOS, MD AS3285170-541	12/16/98

I HAVE RECEIVED AND UNDERSTAND MY DISCHARGE INSTRUCTIONS

SIGNATURE OF PATIENT	DATE
Gayle A Dove	12/16/98

VA FORM 10-7978M JAN 1990 EXISTING STOCKS OF VA FORM 10-7978M, NOV 1987, WILL BE USED. [redacted] MEDICAL RECORD

Department of Veterans Affairs

MEDICAL RECORD - NURSING DOCUMENTATION

SURGICAL CHECKLIST

(Check if accomplished)

✓ Patient has ID armband on — ISOLATION: YES NO (circle)

✓ Consent completed

ON CALL TO OR:

Physical disabilites: _____

✓ Pre-op and post-op teaching accomplished

✓ Most current COMBINED MEDICAL RECORD with patient

✓ Patient data card on chart

Inderal @ 0530

✓ 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/Hairpins

✓ Glasses/Contacts ✓ Prosthetesis ✓ Hearing Aid ✓ Make-up ✓ Nail polish

Pulse ox 95 Temp 98.2 Respirations 20 Pulse 58 BP 94/52 Weight 127

Pre-op medication on chart _____

Pre-op medication to be given (on call) _____

Pre-op medication given by: _____

Patient identified to OR by: Laurel Kenyon MD 12/16/98 0805
(Signature/Date)

12/14/98 Chart Review
Dr Ander
No orders A

DOVE, GAYLE A [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

MEDICAL RECORD | ANESTHESIA REPORT

ASA Code: 2-MILD DISTURB. Operating Room: OR E1
Principal Operation: ESOPHAGOGASTRODUODENOSCOPY
Anesthesia Technique(s):
MONITORED ANESTHESIA CARE (PRINCIPAL)
Agents: MIDAZOLAM 3.5 mg
FENTANYL .1 mg

Intubated: NO
Anesthesia Start: DEC 16, 1998 08:10 Anesthesia Stop:
Anesthetist: BARCLAY,VIVEK Relief Anesth: N/A
Anesthesiologist: BARCLAY,VIVEK
Assistant Anesth: N/A Min Intraoperative Temp: N/A
Intraoperative Blood Loss: N/A Urine Output: N/A
Operation Disposition: PACU (RECOVERY ROOM)

ANESTHETIST'S SIG: DEC 16, 1998@09:01:09
DOVE,GAYLE A
WARD:
VAMC: Biloxi, MS (CONS)

PACU FLOWSHEET

Standard Form 507

c43—16—81472-3 GPO

DATE: 12-16-98
TIME IN: 0855
SURGERY/PROCEDURE: EGD C Bx

ALINE:

ANESTHESIA: Versed 3.5 mg, Fentanyl 100 mg

FLUIDS IN OR: CR 300

FLUIDS LEFT TO COUNT: LR 650

TIME: 0855 0900 0915 0925

CODE
● PULSE
○ RESP.
X B.P.

220 200 180 160 140 120 100 80 60 40 20

SaO2 93% 95% 95 93 93
TEMP 96.8
CM Sinus brady off
OXY. 3LN/C ↓ 2LN/C

P.A.R.S.	0855	0900	0915	0925
Color	2	2	2	
Activity	2	2	2	
Respiration	2	2	2	
Circulation	2	2	2	
Conciousness	1	1	2	
Total Score	9	9	10	

OR PACU ADMIT

CHEST TUBES:		
NG TUBE:		
URINE:		
T-TUBE		
OTHER		
EBL:		

DRESSING: YES (NO)
#1 DRY SOILED SITE:
#2 DRY SOILED SITE:

ITAL SIGNS:

R:	BP 96/50	P 55	R	RASaO2 94 93
ARD:	BP 103/55	P 59	R 16	RASaO2 96
	BP 94/58	P 580	R 30	RASaO2 95

KG: Sinus brady HR53

NURSE SIGNATURE:
1. Carol DuBrock
2.

PATIENT'S IDENTIFICATION
Dove, Gayle
6094

HISTORY:
HA
reflux
PTSD
TAH
ganglion cyst

MEDS: prozac, Inderal, clonazepin

FAMILY: yes
ALLERGY: NKDA

PACU ASSESSMENT
BREATH SOUNDS: Clear bilateral
ABD: flat, soft
BOWEL SOUNDS: active
PEDAL PULSES: warm palpable bilateral
IV: Jega (R) hand-site clear
HOB: ↑

ASA 2 | WARD NO. ASOR

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: 1992-624-458/60127

T 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	

0900 Pt denies discomfort c/o

Dove, gayle 6094 12-16-98 @ 0900 Lead II
PR 0.14 QRS 0.08



LEVEL OF CONSCIOUSNESS: ALERT ✓ ORIENTED ✓ CONFUSED ___ OTHER ___

SKIN CONDITION: WARM ✓ DRY ✓ OTHER ___

COLOR: PINK ✓ OTHER ___

IV SITE: CLEAR ✓ PATENT ✓ REDDENED ___ OTHER ___

DRESSING: DRY NA INTACT ___ OTHER ___

CATHETERS/DRAINS: PATENT NA OTHER ___
#1 ___
#2 ___
#3 ___

TRANSPORTED VIA: STRETCHER/SIDERAILS UP ✓ WHEELCHAIR ___ AMBULATORY ___

TRANSFERRED TO: WARD ___ ASOU ✓ SICU ADMIT ___ SICU RECOVERY ___ HOME ___

~~POST OP INSTRUCTIONS: DISCUSSED WITH PATIENT ___~~ RE: IV adjust pt activity

RE: ___

PATIENT VOICED UNDERSTANDING: YES ✓ OTHER ___

FAMILY NOTIFIED OF PATIENT TRANSFER: YES ✓ NO FAMILY PRESENT ___

REPORT GIVEN TO: Dunomes RN

TIME OF DISCHARGE: 0931

NURSE SIGNATURE: Carol DuBois RN

LR LIC (500 ~~150~~ cc

OR 300 cc

PACU 150 cc

TOTAL 450 cc

MEDICAL RECORD OPERATION REPORT PAGE 1
CASE # 5307785

Preoperative Diagnosis:
Primary: DYSPEPSIA ICD9 Code: NOT ENTERED

Surgeon: AVALOS,MARTIN Surgical Priority: ELECTIVE
Attend Surgeon: AVALOS,MARTIN Attend Code: 1. ATTENDING IN O.R.
1st Assistant: N/A 2nd Assistant: N/A

Other Scrubbed Assistants: NONE ENTERED
Anesthetist: BARCLAY,VIVEK 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
LEE,BRENDA B (FULLY TRAINED)	COVACEVICH,MELANIE D (FULLY TRAINED)

Anesthesia Technique(s):
MONITORED ANESTHESIA CARE (PRINCIPAL)
Agent: MIDAZOLAM
FENTANYL
Anesthesia Begin: DEC 16, 1998 08:10 Anesthesia End: N/A
Operation Begin: DEC 16, 1998 08:30 Operation End: DEC 16, 1998 08:45
Tubes and Drains:
N/A
Tourniquet: N/A
Material Sent to Laboratory for Analysis:
Specimens:
A. GASTRIC BIOPSY TO PATHOLOGY
B. GASTRIC BIOPSY FOR H. PYLORI DONE IN ENDO
C. BIOPSY DISTAL ESOPHAGUS
Cultures: N/A
Postoperative Diagnosis:
Primary: DIFFUSE GASTRITIS ICD9 Code: NOT ENTERED
Major Operations Performed:
Primary: ESOPHAGOGASTRODUODENOSCOPY CPT Code: 43239

Concurrent Procedure(s): N/A
Date/Time of Dictation: NOT ENTERED
Date/Time Transcribed: DEC 28, 1998 07:57
Indications for Operation:
DYSPEPSIA
Surgeon's Dictation:
INDICATIONS:
Recurrent episodes of dyspepsia manifested by nausea on and off despite receiving therapy with Prevacid and cisapride. Patient has a history of nonsteroidal anti-inflammatory agent induced gastropathy in the past, when after an upper endoscopy was performed, several gastric ulcers were found. He has had Helicobacter pylori serology as well as rapid urease testing

SURGEON'S SIG: MZA
DOVE,GAYLE A
WARD: OPT
VAMC: Biloxi, MS (CONS)

DEC 28, 1998 07:57
AGE: 41 I [redacted]
ROOM-BED:
REPLACEMENT FORM 516

during endoscopy which were negative in the past. A recent ultrasound of the abdomen was unremarkable.

PROCEDURE IN DETAIL:
Using the video gastroscope, the esophagus, stomach and duodenum were visualized. The endoscopic findings were as follows: the upper pharynx was visualized within the normal limits. The esophagus in its one-third distally close to the GE junction showed two small islands of metaplastic epithelium from which biopsies were taken. The Z line was a little bit erythematous. The stomach was then examined, and the presence of diffuse gastric mucosal erythema with microhemorrhage and a mosaic pattern type of inflammation in the mucosa located mostly in the fundus and body were noted. Several biopsies were taken of these areas. The antral mucosa looked erythematous also. A Pyloritek test performed on gastric tissue of this patient was negative for Helicobacter pylori at one hour. The pyloric channel was noted within the normal limits. The duodenal bulb showed the presence of a small superficial ulceration with edematous mucosa. The duodenum examined was noted within the normal limits. The patient tolerated the procedure with no complications.

ENDOSCOPIC IMPRESSION:
The endoscopic impression is: (1) diffuse gastritis mostly in the fundus and body areas; (2) a small duodenal bulb ulcer; (3) mild esophagitis.

PLAN:
The plan for this patient is to check the gastrin level and check the biopsy report. In the meantime, we will encourage not to use any type of aspirin-containing medications or nonsteroidal anti-inflammatory agents. We think that she might be using aspirin for her migraine pain and headaches. She will be kept on Prevacid, 30 mgs daily, and Reglan will be given for nausea and bloating symptoms. She will be explained anti-reflux measures and will be followed in the Gastrointestinal Clinic. The biopsies will be checked, and she will be notified accordingly. A gastrin level was sent the day of the procedure, and this came back as 139 - normal is 0 to 100. Liver function tests as well as amylase and lipase have been performed recently, and they are within the normal limits.

/njf

SURGEON'S SIG:
DOVE,GAYLE A
WARD: OPT
VAMC: Biloxi, MS (CONS)

DEC 28, 1998 07:57
AGE: 41
ROOM-BED: [redacted]
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
12/10/96 1120		**ORDERS FOR ESOPHAGOGASTRODUODENOSCOPY**		
	1.	Admit to: Dr Avalos		
awaked	2.	Dx: Recurrent Dyspepsia →		
	3.	Allergies: NKA		
	4.	Routine Vital Signs:		
	5.	Bed rest with activity as tolerated ~~per~~		
	6.	Diet: and NPO after midnight (except medications)		
	7.	Patient ~~Education: EGD Film/Consent for EGD~~		
	8.	CBC, PT/PTT, LYTES, BUN, CREAT, GLUCOSE, UA, EKG, PA&LAT CXR NOW		
	9.	Additional lab orders:		
	10.	Medications: Hold pmt at hs or Needed fasting gastrin level		

and

MARTIN AVALOS, MD
AS3286170-541

12/16 @ 0745

Enter in space below: PATIENT IDENTIFICATION – TREATING FACILITY – WARD NO. – DATE

DOVE, GAYLE A
[redacted]

MEDICAL RECORD

DOCTOR'S ORDERS

[redacted]

VA FORM OCT 1975 10-1158

VA FORM 10-1158, MAY 1973 AND VA FORM 10-1158c, NOV 1972, WILL BE USED.

*U.S.GPO:1992-0-313-106/63698

Exception to Standard Form 5
Approved by OI

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
12/16/98 9AM available		Transfer to ASOU when FULT nurse available — cs In ASOU D/c IVF when pt able to swallow/void clear liquids. + [signature] MARTIN AVALOS, MD AS32251170-511		
12/16/98 09	(1)	Transfer to ASOU [signature] M.D. Bellhye Dunneson 12/16/98		done as
12/16/98 11 available		D/c pt Home today [signature] MARTIN AVALOS, MD AS32251170-511		

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. DATE

DOPE, GAYLE A [redacted]

MEDICAL RECORD
DOCTOR'S ORDERS

VA FORM DEC 1995 10-1158

EXISTING STOCK OF VA FORM 10-1158, OCT.197 WILL BE USED.

IV FLOW SHEET

DATE/TIME/INITIALS	CURRENT SITE SITE	GAUGE	COND	DISCONTINUED SITE DATE/TIME/INIT.	COND.	OLD SITES INIT.@24	INIT.@48	CHANGE DSG	TUBING
				12/16 1100 BJ					

SITE ASSESSMENT CODE

1. Clear
2. Red
3. Swollen
4. Streaked
5. Serosang. Drainage
6. Purulent Drainage

CHART COMPLICATIONS & OBSERVATIONS ON REVERSE

IV SITE CODES:

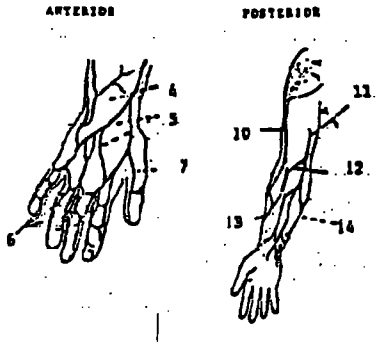
ANTERIOR

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 _____



IMPRINT PATIENT DATA CARD (Name, Address and Social Security Number)

DOVE, GAYLE A

[redacted]

MEDICAL RECORD

NURSING DOCUMENTATION

[redacted]

VA FORM 10-0096(R)
SEP 1992

☆ U.S. GOVERNMENT PRINTING OFFICE: 1993 343-134/74322

DATE	TIME	INITIALS	SITE	SOLUTION & AMOUNT HUNG

SIGNATURE/TITLE	INIT.	ALLERGIES
Bobbye Dillemuth RN	BD	

DOVE, GAYLE A | ID: 515646094 | 18-SEP-1998 13:53 | BILOXI VAMC-MIP | ROUTINE RECORD

41 yr
Female Caucasian
66in 140lb
Room:1-3W
Loc:5

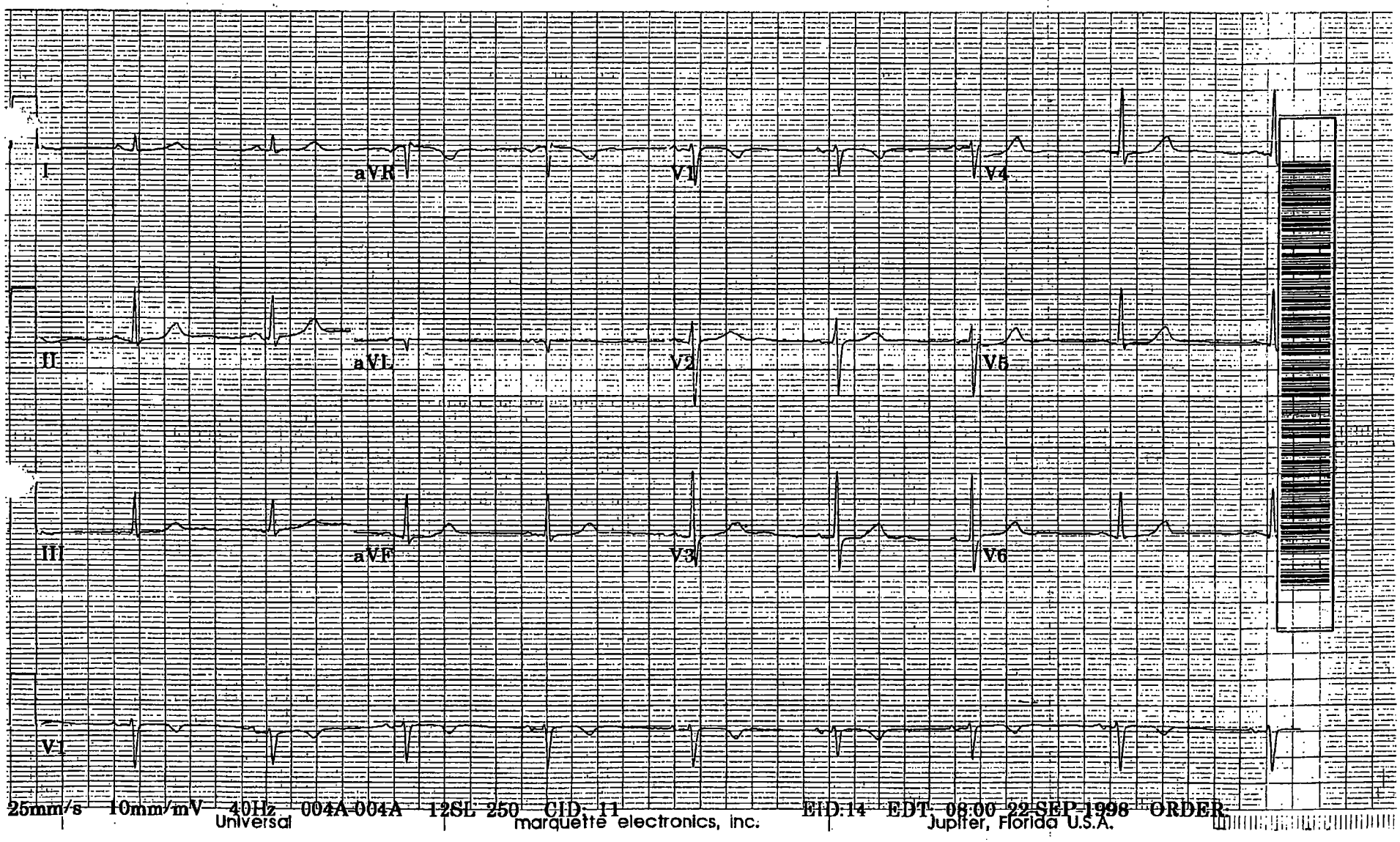
Vent. rate	53 BPM
PR interval	140 ms
QRS duration	88 ms
QT/QTc	450/422 ms
P-R-T axes	36 72 60

SINUS BRADYCARDIA
OTHERWISE NORMAL ECG
WHEN COMPARED WITH ECG OF 31-MAR-1998 13:29,
NO SIGNIFICANT CHANGE WAS FOUND

Technician: PATSY KILPATRICK

Referred by: DR NALLURI

Confirmed by: BASSAM OMAR M.D.



MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

ESOPHAGOGASTRODUODENOSCOPY WITH BIOPSIES/BRUSHINGS/ SCLEROTHERAPY/CAUTERIZATION/DILATION/POLYPECTOMY/VARICEAL BAND LIGATION

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)

LONG FLEXIBLE TUBE TO BE PASSED THROUGH THE MOUTH AND BACK OF THROAT INTO UPPER DIGESTIVE TRACT TO EXAMINE LINING OF ESOPHAGUS, STOMACH, AND FIRST PART OF SMALL BOWEL. RISK OF: perforation/bleeding/infection

which is to be performed by or under the direction of Dr. Avalos, M MARTIN AVALOS, MD AS3285170-541

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:

(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.

MEA 12/10/98. MARTIN AVALOS, MD AS3285170-541

(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)

X Gayle A. Dove (Signature of Patient)

12/10/98 1315 (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) (Signature of Sponsor/Legal Guardian) (Date and Time)

PATIENT'S IDENTIFICATION [redacted] (Give Name—last, first, middle initial or medical facility)

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

☆ U.S. GPO:1994-523-812/82149

MEDICAL RECORD ASOU PRE-OPERATIVE INSTRUCTION

You have been scheduled for 12/16/98 (Wednesday) EGD

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. STOP TODAY

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. Father to drive home

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 ha 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)385-5732~~ 228-385-5732 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: EGD handout
take Inderal AM of surgery with sip of water @ 0600
Pre-OP call 12/15 before 0900

2A109 ASOU

PATIENT'S SIGNATURE WITNESS' SIGNATURE

LARRY J. FONTENELLE, M.D.
Chief, Surgical Service
Biloxi VA Medical Center

SIGNATURE AND TITLE OF PRACTITIONER
Gayle A. Dove

DATE 12/10/98

IMPRINT PATIENT DATA CARD (Name, Address and Social Security Number)

DOVE, GAYLE A
[redacted]

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE FOR SPECIALIZED DISCIPLINES-VERTICAL
[redacted]

VA FORM SEP 1992 10-0114J(R)

MEDICAL RECORD

PROBLEM LIST

(Check one)

☐ FIRST LIST (New) ☐ CONTINUATION OF LIST

DO NOT USE ABBREVIATIONS WHEN LISTING PROBLEMS. This form may be used for inpatient, patient – members and outpatients. Place form in the Medical Records folder (Type II) on the top of right or left side, whichever is appropriate. Upon READMISSION, remove form and place with current records on ward. DO NOT CREATE A NEW Problem List for each readmission.

PROBLEM NUMBER	APPROX. DATE OF ONSET	DATE PROBLEM RECORDED	ACTIVE PROBLEMS	INACTIVE/RESOLVED (Add date)

PROBLEM LIST *(Continued)*

PROBLEM NUMBER	APPROX DATE OF ONSET	DATE PROBLEM RECORDED	ACTIVE PROBLEMS	INACTIVE/RESOLVED *(Add date)*

PATIENT NAME	AGE	SEX	RACE	SSN
DOVE,GAYLE A	41	F	WHIT	[redacted]

ADM DATE	DISC DATE	TYPE OF RELEASE	INP	ABS	WARD NO
SEP 18, 1998	SEP 22, 1998	NON-SERVICE CONNECTED (OPT-NSC)	4	0	1-3WMED

2

10/14/98

DICTATION DATE: SEP 22, 1998 TRANSCRIPTION DATE: SEP 24, 1998
TRANSCRIPTIONIST: sb

DISCHARGE DIAGNOSIS:
1. HEADACHES, MIGRAINE AND TENSION TYPE.
2. DEPRESSION AND POST-TRAUMATIC STRESS DISORDER.

Imitrex nasal spray

346.90
307.81
311
309.81
305.1

DIAGNOSES NOTED BUT NOT TREATED:

OPERATIONS/PROCEDURES PERFORMED:

SUMMARY:
HISTORY OF PRESENT ILLNESS:
This is a 41 year old female with migraine headaches. She was admitted for persistent headaches. She was tried on Migranal, Imitrex, shots and tablets. She was also on Inderal 80 mg bid. She has daily headaches. She had IV DHE treatment about six months ago and had relief of the headaches for about 3-4 months. She started getting the headaches again. She gets pain on the right side of the head, described as a pounding pain, and it lasts for days. She also has had increased headaches recently and has no relief with medications. She has nausea, vomiting, and also headaches associated with photophobia. She denied any new numbness or weakness of the extremities. She also has tension type headaches in the back of the neck and head. She wanted to try again IV DHE treatment. The patient was admitted for IV DHE treatment.

She was worked-up before with an MRI of the brain in 1996 and also she had a recent CAT scan of the head with and without contrast, which were negative.

PATIENT NAME	AGE	SEX	RACE	SSN	CLAIM NUMBER
DOVE,GAYLE A	41	F	WHIT	5[redacted]	

ADM DATE	DISC DATE	TYPE OF RELEASE	INP	ABS	WARD NO
SEP 18, 1998	SEP 22, 1998	NON-SERVICE CONNECTED (OPT-NSC)	4	0	1-3WMED

PAST MEDICAL HISTORY:
Significant for a total hysterectomy with oophorectomy, PTSD, and history of depression.

SOCIAL HISTORY:
She smokes one pack per day. She tried to quit before and is trying again. She denied any alcohol or drug abuse.

PHYSICAL EXAMINATION:
On admission physical examination, HEENT was within normal limits. Neck was supple. Heart was regular rhythm. On neurological examination, the patient was alert and oriented x 3. Speech was fluent. Gait was normal. Cranial nerves were grossly intact. On motor examination, no focal deficits. Power was 4+/5 in the upper and lower extremities. Deep tendon reflexes were +2, plantars were downgoing. Sensory was intact.

LABORATORY DATA:
Urinalysis was within normal limits. Glucose was 88, creatinine 0.9, BUN 6, total protein 6.9, sodium 141, potassium 4.4, chloride 102, albumin 4.0, total bilirubin 0.5, SGOT 24, calcium 8.7, alkaline phosphatase 65. PT/PTT were normal. WBC was 8.5, hemoglobin 13.9, hematocrit 41.4, MCV 95.3.

HOSPITAL COURSE:
This is a 41 year old female with chronic headaches, migraine and tension type, admitted for IV DHE treatment. The patient has had daily headaches recently. She had IV DHE treatments in March 1998 and had relief of her headaches for 3-4 months and then started getting headaches again. The patient wanted to try again on IV DHE treatment. On admission neurological examination was as in the summary of History and Physical.

The patient was started on IV DHE treatment and she had a three day course of IV DHE. She had some relief of headache but she had, again, a headache in the morning. She has also been under stress recently. She has a history of depression and PTSD. She reports she is under stress.

As the patient is stable neurologically, she was discharged.

PATIENT NAME	AGE	SEX	RACE	SSN	CLAIM NUMBER
DOVE,GAYLE A	41	F	WHIT	[redacted]	

ADM DATE	DISC DATE	TYPE OF RELEASE	INP	ABS	WARD NO
SEP 18, 1998	SEP 22, 1998	NON-SERVICE CONNECTED (OPT-NSC)	4	0	1-3WMED

DISCHARGE RECOMMENDATIONS:
Recommend follow-up in MHC Clinic and also follow-up with Psychology. She is recommended to stop smoking. Discharge medications -

1. Prozac 20 mg two tablets q a.m.
2. Trazodone 50 mg five tablet q hs.
3. Risperidone 1 mg two tablets hs.
4. Clonazepam 1 mg po tid.
5. Estrogen 0.625 mg q day.
6. Bisacodyl 5 mg two tablets daily.
7. Lansoprazole 30 mg q a.m.
8. Imitrex shots and tablets prn.
9. Inderal 40 mg two tablets bid.

She is recommended follow-up in the Neurology Clinic in three weeks and also follow-up in the Primary Care and have her seen in the Psychology Clinics. Diet - regular. She is also on Ensure to gain weight.

/sdb

SIGNATURE APPROVING PHYSICIAN/DENTIST

/es/ VASANTHI KUMARI NALLURI
VASANTHI KUMARI NALLURI
M.D.

ACKNOWLEDGMENT

This is to acknowledge that I have received a copy of the brochure entitled 'YOUR PATIENT RIGHTS.' This information includes my right to complete a VA Living Will and/or Durable Power of Attorney for Health Care. I understand that I may seek further counseling through a Chaplain or Social Worker upon request.

Do you have ADVANCE DIRECTIVES?
(If not on file, obtain a copy) ✓ YES ____ NO

Are you interested in completing a VA Living Will and/or Power of Attorney for Health Care? N/A YES ____ NO

Are you an ORGAN DONOR?
(If interested in being an organ donor, information is available in your Patient Rights brochure.) ✓ YES ____ NO

Gayle A. Dove
PATIENT SIGNATURE

Dana Estelyn
WITNESS/DATE

COMMENTS: _____

IMPRINT PATIENT DATA CARD (Name, Address and Social Security Number)

08 26 98

DOVE, GAYLE A [redacted]

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE FOR SPECIALIZED DISCIPLINES-VERTICAL

[redacted]

VA FORM SEP 1992 10-0114J(R)

*U.S. Government Printing Office: 1995 — 622-868/83104

INTERDISCIPLINARY ADMISSION ASSESSMENT
EMERGENCY ROOM/CLINIC ASSESSMENT

VI. TREATMENTS DONE:

[ ]IVF:_____(Flow sheet started) [ ]NG Tube [ ]Foley
[ ]EKG [ ]ABG [ ]CXR [ ]KUB
[ ]Aerosol Treatment:_____
[ ]Chem 7 [ ]Chem 10 [ ]Cardiac Enzymes [ ]CBC [ ]PT/PTT
[ ]Accucheck:_____ Pulse Oximeter:_____
[ ]Other:_____

MEDICATIONS ADMINISTERED:

TIME	MEDICATION	DOSE	RESPONSE	SIGNATURE

VII. Disposition Of Patient/Care Setting:

Time:_____

[ ]Discharged to Home [ ]Admitted to Medicine Service [ ] Admitted to Surgery Service
[ ] Admitted to ICU [ ] Admitted to Mental Health
[ ]Transferred to another Facility:_____
[ ]To be admitted at a later date for surgery; Date TBA:_____
[ ]Other + Amelia

Patient placed on Seriously Ill List: [ ]YES [✓]NO
Chaplain Notified: [ ]N/A [ ]YES [ ]NO

List Items Brought to Hospital: Robe, Pajamas

Disposition of Valuables: [ ]Agent Cashier [ ]MAA [ ]Patient Effects
[ ]Patient [ ]Family/Home

PROGRESS NOTES:

EKG RHYTHM STRIP
(If Applicable)

Signature/Title:_____ Date/Time:_____
Date/Time:_____

Readmission/Reassessment within 30 days:
Reviewer(s):
Signature/Title:_____ Date/Time:_____
Date/Time:_____

[redacted]

08 26 98

INTERDISCIPLINARY ADMISSION ASSESSMENT

INPATIENT ASSESSMENT

DOVE, GAYLE A

[redacted]

Arthritis YES NO
Coordination Problems YES NO
Limb Loss YES NO
Seizures YES NO
Emotional Status:
Calm / Apprehensive / Cooperative
Paralysis YES NO
Pain: YES NO
Severity (0 - 10): _____
Tolerable Level of Pain _____
Location: _____
Comments: _____

ELIMINATION:

Incontinence YES NO
Indwelling Foley YES NO
Ileostomy YES NO
Colostomy YES NO
Constipation YES NO
Diarrhea YES NO
Black, tarry stools YES NO
Renal: YES NO
Prostate YES NO
Comments: _____

GASTROINTESTINAL:

Nausea & Vomiting YES NO
Feeding Tube YES NO
Hx of Ulcers YES NO
ETOH Use YES NO
_____/wk. Last drink: _____
Dysphagia YES NO
Religious Food Preference: None
Type of Diet: Reg
Comments: _____

TEETH

Bridges YES NO
Dentures: YES NO
Upper: Full: _____ Partial: _____
Lower: Full: _____ Partial: _____

Broken YES NO
Loose YES NO
Missing YES NO

Signature/Title: [signature] Date/Time: 9-19-98
_____ Date/Time: _____

PULMONARY:

Smoker YES NO
Packs Per Day: 1/2 # of Years: _____
Recent URI YES NO
COPD YES NO
Tracheostomy YES NO
O2 Adm YES NO
TB YES NO
Asthma YES NO
SOB YES NO
Cough YES NO
Productive: _____
Non-Productive: _____
Color of Sputum: _____

Comments: _____

CARDIOVASCULAR/CIRCULATION:

CHF YES NO
Angina YES NO
Last Occurrence: _____
Location: _____
Severity (0-10): _____
Relieved by: _____
MI YES NO
Arrhythmias YES NO
Hx Vascular Disease YES NO
HTN YES NO
CVA YES NO
Pacemaker/AICD YES NO
Thyroid Disease YES NO
Hepatitis YES NO
HIV YES NO
Previous Blood Transfusion YES NO

Comments: _____

Comments: _____

Readmission/Reassessment within 30 days:
Reviewer(s):
Signature/Title: _____ Date/Time: _____
_____ Date/Time: _____

08 26 98

INTERDISCIPLINARY ADMISSION ASSESSMENT

EMERGENCY ROOM/CLINIC ASSESSMENT

DOVE, GA[redacted]

I. Date: 9/18/98 Time: [redacted] Age: 41 HT: _____ WT: 123

Mode of Arrival: [ ]Ambulance [✓]Walk In [ ]Extended Care Facility
[ ]Other: _____

Source of Information: [✓]Patient [ ]Family/Friend [ ]Old Chart [ ]Other: _____

Chief Complaint: Headache

Allergies: NKA

Reactions to Anesthesia: _____

Medical History/Past Surgeries/Hospitalizations: ETOH, Sp Hysterectomy, PTSD

Present Medications: Prozac, Trazodone, Resp

Marital Status: Divorced

Religious Preference: Prot - Blood/Blood ProductTransfusion Preference: NO

Emergency Notification
Relative/Friend: Father - Ray Dove - 396-1919 Relationship: Father
Phone Number: 396-1919

II. LEVEL OF CONSCIOUSNESS:

[✓]Alert [✓]Oriented [✓]Person [✓]Place [✓]Time
[✓]Verbally Responsive [ ]Confused/Disoriented [✓]Responds to Pain

BEHAVIOR

[✓]Cooperative [ ]Uncooperative [ ]Combative [ ]Withdrawn
[ ]Other: _____

EMOTIONAL/PSYCHOSOCIAL STATUS:

[✓]Calm [ ]Anxious [ ]Fearful [ ]Depressed [ ]Suicidal

ADL's/Level of Functioning:

Bathing (S)A/T Dressing (S)A/T Eating (S)A/T: Mobility (S)A/T
Oral Hygiene (S)A/T Toileting (S)A/T

Comments: _____

VITAL SIGNS				
TIME	B/P	PULSE	RESP	TEMP
12:00	108/67	56	18	98

Comments: _____

III. PATIENT RIGHTS

Advanced Directive [✓]YES [ ]NO
Type: _____
Location: _____
Organ Donor [✓]YES [ ]NO
Tissue Donor: [ ]YES [ ]NO
Information/Pamphlet Provided:
[ ]YES [ ]NO [ ]Refused

Signature/Title: Dana Estelle RN Date/Time: 9-18-98
_____ Date/Time: _____

IV. POTENTIAL ABUSE

[✓]Not Applicable
[ ]Rape or Other Sexual Molestation
[ ]Domestic Abuse
[ ]Abuse or neglect of elders or children
[ ]Evidence of Physical Assault
{ }Unexplained Bruises
{ }Unexplained Injuries
{ }Unkempt, dirty, poor hygiene

If yes to the above, initiate Center Memorandum 122-17 (Mandatory Reporting of Adult and Child Abuse or Neglect) and contact Social Worker.
Date/Time Initiated: _____
Method of Notification: _____
Comments: _____

Readmission/Reassessment within 30 days:
Reviewer(s):
Signature/Title: _____ Date/Time: _____
_____ Date/Time: _____

INTERDISCIPLINARY ADMISSION ASSESSMENT
EMERGENCY ROOM/CLINIC ASSESSMENT

V. SKIN

[ ]Hot [✓]Warm [ ]Cool [✓]Dry [ ]Diaphoretic
[ ]Pink [ ]Cyanotic [ ]Rash [ ]Lesions [ ]Decubiti
[ ]Lacerations [ ]Hematoma [ ]Flushed [ ]Other:_____

CARDIOVASCULAR

[✓]No Problem Identified [✓]Chest Pain [ ]Exertional [ ]Rest

Chest Pain: Location:_____ Duration:_____
Frequency:_____ Severity:_____ (0 - 10 Scale)

Rhythm: [✓]Regular [ ]Irregular
Leg Pain: [ ]Exertional [ ]Rest

PULSES		
	Left	Right
Radial		
DP	2+	1+
PT	2+	1+

PUPILS		
	LEFT	RIGHT
Size	3	3
React	R	R
Fixed		
Dilated		
Constricted		

Breath Sounds:		
	Left	Right
Clear	✓	✓
Wheezing		
Rhonchi		
Rales		
Other		

RESPIRATORY

Breathing Pattern: [✓]Normal [ ]Dyspnea [ ]Exertional [ ]At Rest
Cough: [✓]None [ ]Non-Productive [ ]Productive
Comments:_____

MUSCULOSKELETAL

[✓]Moves all 4 Extremities [ ]Hemiplegia [ ]Paraplegia [ ]Quadriplegia
[ ]Amputee [ ]Contractures [ ]Other:_____
Comments:_____

GASTROINTESTINAL

Abdomen: [✓]Soft [ ]Rigid [ ]Distended [ ]Non-Tender
[ ]Tender [ ]Bowel Sounds [ ]Normal [ ]Absent
[ ]Hypoactive [ ]Hyperactive

Last Bowel Movement: 9/18 Other:_____
Comments:_____

GENITOURINARY

[✓]No Problem Identified [ ]Burning [ ]Frequency [ ]Hematuria
[ ]Incontinence Last Menstrual Period:_____ Last Pap Smear:_____
Last Mammogram:_____ [ ]Other:_____

Signature Title: Dana Eberly R.N. Date/Time: 9-18-98
_____ Date/Time:_____

Readmission/Reassessment within 30 days:
Reviewer(s)
Signature Title:_____ Date/Time:_____
_____ Date/Time:_____

INTERDISCIPLINARY ADMISSION ASSESSMENT
INPATIENT ASSESSMENT

IX. SLEEP/REST ASSESSMENT

Usual Number of Hours of Sleep: 6 - 8 Goes to Sleep at: 11 Rises at: 0500
Difficulty Sleeping: (YES) NO Sleeping Aids: YES (NO)
Why? Due to headache What? _____

MISCELLANEOUS:

Glasses	(YES)	NO
Contact Lens	YES	(NO)
Hearing Aid	YES	(NO)
Artificial Eye	YES	(NO)
Crutches	YES	(NO)
Artificial limb	YES	(NO)
Brace	YES	(NO)
Walker	YES	(NO)
Cane	YES	(NO)
Wheelchair	YES	(NO)
Infusaport/Hickman	YES	(NO)

Comments: _____

SKIN INTEGRITY

Rashes	YES	(NO)
Bruises	YES	(NO)
Infections	YES	(NO)
Cuts	YES	(NO)
Edema	YES	(NO)

Site: _____
Degree: _____
General Problems: _____
Comments: _____

X. ULCER DOCUMENTATION

DATE ACQUIRED	LOCATION	SIZE	STAGE	DRAINAGE

BRADEN RISK SCALE

SCORE	1	2	3	4	TOTAL
SENSORY PERCEPTION	Unresponsive	Responds to Pain	Responds to Verbal	(No Problem)	
MOISTURE	Always Wet	Often Wet	Rarely Wet	Dry	
ACTIVITY	Bedfast	Chairfast	Slightly Limited	Walks Frequently	
MOBILITY	Completely immobile	Limited Movement	Slightly Limited	No Limits	
NUTRITION	Very Poor Intake	Inadequate <1/2 meal	Adequate >1/2 meal	Excellent	
FRICTION	Max assist to move to bed	Minimum assist to move to bed	No Problem	No Problem	
				TOTAL	23

If Score is < 16 Initiate Nursing Procedure 311 and Notify Enterostomal Therapy Nurse
Method of Notification: _____
Comments: _____

Signature/Title: Sara Esterly, RN Date/Time: 9-18-98
_____ Date/Time: _____

Readmission/Reassessment within 30 days:
Reviewer(s):
Signature/Title: _____ Date/Time: _____
_____ Date/Time: _____

[redacted]

INTERDISCIPLINARY ADMISSION ASSESSMENT

XI. PREDISPOSITION FOR FALLING

[ ]Unsteady on feet [ ]Poor Eyesight [ ]Dizziness/Fainting
[ ]Poor Bladder Control [ ]Confused/Disoriented [ ]65 Years or Older
[ ]Neurological Problems [ ]Physical Disability [ ]Unsafe Footwear
[ ]Current Medication: Narcotics, Hypnotics, Sedatives, Diuretics [ ]Prior Falls

Patient placed on fall risk precautions: [ ]YES [NO

Explanation:

Signature/Title of Initiator: Dana E Tully RN, Date/Time:

PROGRESS NOTES:

Signature/Title: Date/Time:

Date/Time:

Readmission/Reassessment within 30 days:

Reviewer(s):

Signature/Title: Date/Time:

Date/Time:

XII. INPATIENT SCREENING TOOL

NUTRITIONAL SCREENING **Need Identified: ☐ Yes ☐ No**

Unintentional Weight Loss of 5lbs in last week: ☐ Yes ☐ No
NPO >3 Days: ☐ Yes ☐ No
Unintentional Weight Loss of 10lbs in last month: ☐ Yes ☐ No
Tube Feeding/IV Nutritional Support: ☐ Yes ☐ No Type:_____
Non-Formulary Nutritional Support (Tube Feeding/Parenteral) Products: ☐ Yes ☐ No
Type:_____
If any of the above identified, contact Clinical Dietitian
Method of Notification:_____ Date/Time Notified:_____
Signature/Title:_____

SOCIAL WORK/DISCHARGE PLANNING SCREENING **Need Identified: ☐ Yes ☐ No**

Patient will need supportive care or support of caregiver at discharge for activities of daily living: ☐ Yes ☐ No
Patient lives alone and is capable of independent living: ☐ Yes ☐ No
Patient is capable of planning for own care: ☐ Yes ☐ No
Patient is homeless: ☐ Yes ☐ No
Abuse suspected: ☐ Yes ☐ No
If any of the above identified, contact Social Worker:
Method of Notification:_____ Date/Time Notified:_____
Signature/Title:_____

FUNCTIONAL SCREENING **Need Identified: ☐ Yes ☐ No**

Able to Perform Activities of Daily Living without Assistance ☐ Yes ☐ No
Developed within the last month:
[ ]CVA [ ]Head Trauma [ ]Brain Injury [ ]Fall
Newly Identified weakness/paralysis
If any of the above identified notify Rehabilitation Medicine
Method of Notification:_____ Date/Time Notified:_____
Signature/Title:_____

TEACHING ASSESSMENT

Learns best: ☐Seeing ☐Hearing ☐Doing Able to read: ☐YES ☐NO Education Level:_____
Barriers /limitations: ☐Physical ☐Visual ☐Cognitive ☐Auditory ☐Language ☐Emotional
☐Other_____ ☐None
Describe barriers/limitations and note plan to adapt patient teaching:_____
_____
Age Specific Needs:_____
Cultural/Religious practices affect the patient's healthcare? ☐NO ☐ YES If yes, describe and document plan to adapt teaching:_____
_____
Signature/Title:_____ Date:_____
***Document teaching needs on the Interdisciplinary Patient and Family Teaching Record which is attached to the Collaborative Interdisciplinary Plan of Care/Progress Note/Discharge Planning Form.**

Signature/Title:_____ Date/Time:_____
_____ Date/Time:_____

Readmission/Reassessment within 30 days:
Reviewer(s):
Signature/Title:_____ Date/Time:_____
_____ Date/Time:_____

[redacted]

INTERDISCIPLINARY ADMISSION ASSESSMENT

PROGRESS NOTES

DATE/TIME	

Signature/Title:_____ Date/Time:_____

_____ Date/Time:_____

Readmission/Reassessment within 30 days:

Reviewer(s):

Signature/Title:_____ Date/Time:_____

_____ Date/Time:_____

MEDICAL RECORD	INTERDISCIPLINARY ASSESSMENT: HISTORY & PHYSICAL EXAM

CHIEF COMPLAINT:

Admission date: 9/18/92 Time: 12:15 am (pm)
Admitted from: ☐ AEC ☒ Clinic Other:
Primary Care Provider: Dr. Pennington

Persistent headaches.

HISTORY OF PRESENT ILLNESS:

This is a 42 yo old female with migraine headaches. She was tried on migrainal, Imitrex tabs / tabs, & on Inderal but this was persistent daily headaches. She had IV D16B Reactine about 6 months ago but had ~~$400~~ relief of headaches for 3-4 months. Pain over L side head, & boundary back & gets daily - in last few weeks increased ~~pain~~ & no relief c med. She does N&V, photophobia, & no new weaknesses or numbness of extremities. She also does tension headaches in back of neck/head. She bleeded out too much c headaches & diffic c.

addressograph

MEDICAL RECORD	INTERDISCIPLINARY ASSESSMENT - HISTORY & PHYSICAL EXAM

FAMILY HISTORY: Grandmother died of Ca lung - dx at age 70s
Mother - Thyroid problem, depression.

PERTINENT MILITARY HISTORY: Air force 1975-87.

SOCIAL HISTORY: (Include: alcohol, tobacco [pack-years], illicit drug use; hx of sexual trauma; current living condition; occupation)
Smokes 1 PPD. - She tried to quit before & ~~to quit before~~ & injury again.
No alcohol or drug use.

REVIEW OF SYSTEMS

GENERAL: well developed.

EYES/VISION: She sees black specks floating in front of eyes

EARS/NOSE/THROAT: (Include hearing, smell/taste) WNL,

Neck/Throat: none

Chest: none

Heart: none

Breasts: none

Lungs: no SOB, no cough.

Abdomen: n/o reflux problem

Genitalia:

had hypic check up this Yr. cough hyperemesis

Female:
Pap smear done: ___ Yes ___ No

Rectal:
prostate:
occult blood:

MEDICATIONS

Drug	Indication	Dose	Frequency	Last Dose Taken
Zoloft	Depression			
Trazodone	"			
Risperidone	"			

Over-the-counter: Tylenol PRN.

ADVANCED DIRECTIVES

[X] has one [] desires one
[] does not desire one [] wants further information

BLOOD TRANSFUSION: [] discussed pt's preferences regarding blood transfusion [] N/A

PAST MEDICAL HISTORY:

(Include surgeries/hospitalizations/injuries)

Total hysterectomy

H/O Depression.

Immunizations: [] influenza date: 1997 PPD: date: _____
[] pneumococcal date: _____ results: _____
[] diphtheria/tetanus booster date: _____

FEMALE: Last mammogram: 2-3 yrs ago results: _____ Monthly breast self exams [] Yes [] No
Last Pap smear: N/A results: _____
(hysterectomy)

ALLERGIES & SENSITIVITIES

(Include reaction)

Medication: None

Food/other: None.

PHYSICAL EXAMINATION

BP: _____ P: _____ R: _____ T: _____

Ht: _____ Wt: _____

GENERAL APPEARANCE & MENTAL STATUS: well developed, not in acute distress, alert, oriented x 3.

Head: normocephalic atraumatic

Eyes: PERRLA

Ears: WNL

Nose: no congestion

Mouth: clear

Teeth: WNL

Neck/Throat: WNL

Chest: S. gynecological

Heart: Heart- regular rate & rhythm

Breasts: no mass palpable

Lungs: clear on auscultation

Abdomen: WNL

Genitalia: Normal appearing external genitalia

Female:
Pap smear done: __ Yes (No)

Rectal: WNL

prostate:

occult blood:

PHYSICAL EXAMINATION cont.

Back/Spine: WNL

Skin: WNL

Extremities: no edema bl

Lymphatics: WNL

Neurological: alert, oriented x3. Cranial nerves-
Coord - normal.
CN: grossly intact -
Motor: no focal deficit U/E WNL
DTR's +2, plantars dd.

DIAGNOSTIC TESTS - ordered.

LAB VALUES: UA - WNL.
8/21 - Glucose 88. BUN: 6 Cr: 0.9. Lytes WNL.
WBC 8.5 Hb: 13.9 Hct: 41.6.

EKG: Sinus bradycardia otherwise normal

XRAYS: Chest x-ray - NC

DIAGNOSTIC IMPRESSION

Headache - migraine.

PLAN

Sko dual relief c IV DHE before 2
want to try again IV DHE Tx -
prolonged IV DHE regimen.

DISCHARGE PLAN

Discharge after IV DHE Tx & relief of headache

V. Nallani (V. NALLANI)		9/10/98	5297
Sign and print name	~~(Intern/other)~~	date/time	pager #
Sign and print name	(Resident)	date/time	pager #
Residency pgm:			
Sign and print name	(Attending)	date/time	pager #

COLLABORATIVE INTERDISCIPLINARY PLAN OF CARE/PROGRESS NOTE/DISCHARGE PLANNING

Admission: 9-18-98
Diagnosis: _____

[ ] Palliative Care
[ ] Patient and/or [ ] Significant other will be knowledgeable about medications, diet, activity, treatments, and follow-up care.
[ ] Discussed discharge plans with family/significant other.
[ ] Patient will be discharged to Nursing Home.
[X] Discharge to home.

DATE	PROBLEM	PLAN	GOAL	PROBLEM ID BY (INITIALS)	DATE COMPLETED
9/21/98	Regular diet Migraine H/A	Regular diet Adjust for preferences	Consume 75-100%	KR	

Problems resolved upon discharge Yes [ ] 09/26/98 No [ ]
If no, explain: _____

Signature: _____
[redacted]on:

[redacted]

[redacted]

DOVE, GAYLE A

1953

PROGRESS NOTE:

MEETING DATES:							
ATTENDANCE	**SIGNATURE**	**INITIAL**	**INITIAL**	**INITIAL**	**INITIAL**	**INITIAL**	**INITIAL**
CHIEF OF SURGERY							
STAFF SURGEON							
ANESTHESIOLOGIST/CRNA							
RESIDENT							
PC DOCTOR							
CONSULTING DOCTOR							
REGISTERED NURSE							
REGISTERED NURSE							
REGISTERED NURSE							
SOCIAL WORKER							
REGISTERED DIETITIAN	Karen Lewis, RD						
PHARMACIST							
KT/OT/PT/SPEECH							
RESPIRATORY TECH							
I.C. NURSE							
Pt./SIGNIFICANT OTHER							

S: Chewing Problems: Y (N)
Dysphagia: Y (N)
Appetite: (+) -
Feeding Assistance Required: Y (N)
Food Allergies: None on file NKA
Food Preferences:

Pre-Admission Diet: Ensure Regular diet
Wt. + (-) 25 # in last 3 months
Nausea: (Y) N Vomiting: Y (N)
Diarrhea: Y (N) Constipation: Y (N)

O: Current Diet: REG
Adm. Dx: MIGRAINE HEADACHES
Age: 41 Sex: F
Height: 5'6"
Curr. Weight: 123 lb
Last Weight:
Usual Weight: 150 lb
Ideal Weight: 130 lb

Adm. Date: 18-Sep-98 11:22am
Prior Assessment:
Frame Size:
Amputation %:
Weight Taken:
Weight/Usual Wt:
Weight/IBW:

Laboratory Data

Test	Result	units	Ref. range	Date
GLUCOSE	88.	MG/DL	62 - 128	18-Sep-98
UREA NITROGEN	6. L	MG/DL	9 - 20	18-Sep-98
CREATININE	0.9	MG/DL	.5 - 1.4	18-Sep-98
SODIUM	141.	MEQ/L	137 - 145	18-Sep-98
ALBUMIN	4.0	GM/DL	3.9 - 5	18-Sep-98
MAGNESIUM	1.8	MG/DL	1.7 - 2.2	31-Mar-98
HGB	13.9	g/dl	12 - 16	18-Sep-98
HCT	41.4	%	37 - 47	18-Sep-98
LYMPH#	2.7	#/cmm	1.2 - 3.4	18-Sep-98

Appearance:

A: Nutrition Status
X Normal
___ Mildly Compromised
___ Moderately Compromised
___ Severely Compromised

Nutrition Education
Further Education Required: Y (N)

Comments: Pt getting DHE Tx. Pt reports Bych gave Rx for Ensure due to Wt loss. Pt weight is slightly below desirable [redacted] weight range.

P: Nutrition Plan
X Provide basic nutritional care
___ Screening data not available: Please order_____
___ Nutrition Education
___ Recommend Diet Change
___ Further Nutritional Assessment

Recommendations:
DC Ensure during day
1 aug @ night

Karen Lewis, RD 9/21/98
Signature Date 2:20p

MEDICAL RECORD	PROGRESS NOTES
DATE	
9/19/98	2000 C- C/O headache request "pain shot" medicated ā Demerol + Vistaril IM as ordered Pt left ward @ 2005 returned to ward @ 2100 Pt instructed to remain on ward for pain injections x 1½-2 hrs Pt voices understanding Linda Broden
9/20/98	2240 - up ck about on ward ck off this pm. Returned to ward - C/O headache - medicated as ordered - IV in progress @ 75cc/hr Linda Broden

(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.

08 26 98

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

DOVE, GAYLE A [redacted]

PROGRESS NOTES

DATE

STANDARD FORM 509 BACK (Rev. 11-77)

*U.S.GPO:1997-426-359

MEDICAL RECORD	PROGRESS NOTES
DATE	

9/21/98 8:24 AM

Neuro: She did not have headache today. No complaints.
VS: stable, afebrile
Lungs: clear
Heart: reg rhythm
Neg for headache. Hydrocodone IV D/C'd
Pain control is adequate for discharge tomorrow

V. Nalluri, MD
V.K. NALLURI, MD
AS3285170-396

9/22/98 8:30 AM

Neuro:- No headache today & tolerating oral some diet morning. The IV D/C'd completed. She is also under care of podiatrist follow up in Psychology and HBC clinic. Follow up neuro in 3 mos. Pt stopped smoking. If pt stable, discharge pt home & follow in clinic.

V. Nalluri
V. K. NALLURI, MD
AS3285170-396

(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.

08 26 98

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

DOVE GAYLE A [redacted]

PROGRESS NOTES

DATE

STANDARD FORM 509 BACK (Rev. 11-77)

*U.S.GPO:1997-425-359

Veterans Administration

NURSING DISCHARGE PROGRESS NOTE

1. Discharge living arrangements: Home
2. Accompanied by: Father
3. Ambulation: Ambulatory
4. TPR: 98.4; 79; 20 BP: 116/70
5. General condition (including resolved and unresolved nursing diagnosis):
Alert & oriented X 3. Ambulatory, States + headache Pain.

6. Nursing care needed following discharge (including Nursing Care Referral):
F/u appts.

7. Patient family education, instructions, medications, follow-up and assessment of understanding:
Reviewed medications & pt verbalized understanding. Instructed NO smoking to pt.

SIGNATURE AND TITLE OF PRACTITIONER: [signature] RN

DATE/TIME: 9/28/98 1130

IMPRINT PATIENT DATA CARD

08 26 98

[redacted]

DOVE, GAYLE A

[redacted]

MEDICAL RECORD
SUPPLEMENT TO PROGRESS NOTE
FOR SPECIALIZED DISCIPLINES

VA FORM 10-0114:

025396

Department of Veterans Affairs

MEDICAL RECORD - DISCHARGE INSTRUCTIONS

DATE OF ADMISSION	DATE OF DISCHARGE	TYPE OF DISCHARGE

1. DIAGNOSES AND DATE TO BE FOLLOWED ON OUTPATIENT SERVICES

a headaches – migraine & tension
a depression & PTSD

2. SUGGESTED PLAN FOR FOLLOWUP

neurology clinic
mhc & psychology clinic as scheduled
pc clinic as scheduled.

3. DISCHARGE MEDICATIONS AND INSTRUCTIONS

as prescribed.

4. DISCHARGE DIETARY INSTRUCTIONS *(Check one)*

☒ NO RESTRICTIONS ☐ RESTRICTIONS *(Specify and include drug and food interactions)*

regular

5. PHYSICAL ACTIVITY LIMITATIONS *(Check one)*

☐ NO RESTRICTIONS ☐ RESTRICTIONS *(Specify)*

OOB as tolerated

6. OTHER *(Include employment status)*

no smoking.

PATIENT IDENTIFICATION *(Name, Address, Social Security Number)*	SIGNATURE OF PHYSICIAN/DENTIST	DATE
DOVE, GAYLE A [redacted]	V. Nalluri V.K. NALLURI, MD	9/22/98
	I HAVE RECEIVED AND UNDERSTAND MY DISCHARGE INSTRUCTIONS	
	SIGNATURE OF PATIENT	DATE
	Gayle A Dove	9/22/98

VA FORM JAN 1990 **10-7978M** EXISTING STOCKS OF VA FORM 10-7978M, NOV 1987, WILL BE USED. **MEDICAL RECORD**

1-3W 123-1

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
9/12/98 1040 AM		Admit pt, Under V. Nalluri, Head Comm Dx: Migraine Headache Tx IV DHE Treatment VS q shift. Neuro exp, Bathroom privileges. Lab: CBC 243870 Chem 10, PT/PTT 243870 UA 243881 EKG Chest X-ray - admission Med: Reglan 75 mg + NS 100 ml IV q 6° PRN Benadryl 25 mg + NS 100 ml IV q 6° PRN Prozac 20 mg PO q AM Trazadone 50 mg 5 tab PO HS Risperidone 1 mg 2 mg HS Clonazepam 1 mg PO TID Zantac 0.625 mg IV q daily Bisacodyl 5 mg PO q daily Lansoprazole 30 mg IV q AM		EA 1145
9/18/98 1145				

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD - DATE

08 26 98

[redacted]

Voided 9/18/98

V. NALLURI/MD
MED AC 38851 70-396

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 !
Approved by O

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
9/18/98 1155 AM		IV D5 1/2 NS 1000cc - at 75cc/hr DHE Regimen → Reglan 10 mg IV wait 15 min and give DHE 0.5 mg IV over 5 min	V	DTS
24 hours after DHE wait 8 hrs Give Reglan 10 mg + DHE 0.5 mg IV Q8° X 3 days		If no N&V 8 hrs after DHE Reglan 10 mg + DHE 0.5 mg IV Q8° X 3 days		If no N&V 8 hrs after DHE continue Reglan 10 mg + DHE 0.5 mg IV
		If N&V in 1st hr after 2nd dose of DHE wait 8 hrs, then Give Reglan 10 mg + DHE 0.75 mg Q8° X 3 days.		If no N&V in 1st hr after 2nd dose, wait 8 hrs & then give Reglan 10 mg + DHE 1 mg IV Q8° X 3 days
		Ensure + Com Tid Request dietician ✓ DR. Nadkarni Noted 9/18/98		
IV D5 1/2 NS 1000cc @ 75cc/hr IV Reglan 10 mg q 8 hr IV DHE 1 mg q 8 hr PC/PO Ensure Tid		9/19/98		Linda Rhodes

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. - DATE 05-26-98

DOVE, GAYLE A Dove

[redacted]

MEDICAL RECORD
DOCTOR'S ORDERS

VA FORM DEC 1995 10-1158

EXISTING STOCK OF VA FORM 10-1158, OCT.197 WILL BE USED.

Exception to Standard Form ! Approved by O

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
9/19/98		D5 1/2 NS at 75cc/h.		
		Noted 9/19/98		
✓ 9/20/98				
9/20/98 0800		Pt may go to Bingo DO Dr Brodley's Transfer Noted 9/20/98		
9/20/98		Renew the D5 1/2 NS at 75cc/h Noted 9/20/98		
~~9/21/98~~		V. K. NALLURI, MD AS3285170-396		
9/21/98 5:30 AM		IV D5 1/2 NS at 75cc/hr Prob Discharge tomorrow AM V. K. NALLURI, MD. AS3285170-396		VLS
		Noted Robert Ramos RN 9/21/98 1000		
		08 26 98		

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. DATE

DOYLE, GAYLE A [redacted]

MEDICAL RECORD

DOCTOR'S ORDERS

VA FORM DEC 1995 10-1158

EXISTING STOCK OF VA FORM 10-1158, OCT.19. WILL BE USED.

Exception to Standard Form 5
Approved by OM

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
9/22/98 2:30 AM		Discharge pt home today DC IV & IV fluids. Follow up w/ Wilma Clinic 3-4 wks Follow up w/ Psychology V.A. Hospital Dy TP 9-22-98 @ 10:25 AM V.K. NALLURI, MD AS3285170-396 1-3 Wks		
		Noted Robert Ramos RN 9/22/98		

Enter in space below: PATIENT IDENTIFICATION - TREATING FACILITY - WARD NO. DATE

08 26 98

DOTE, GAYLE A [redacted]

MEDICAL RECORD
DOCTOR'S ORDERS

VA FORM DEC 1995 **10-1158**

EXISTING STOCK OF VA FORM 10-1158, OCT.197 WILL BE USED.

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD–ANESTHESIA

PROCEDURE: EGD + Bx

ITEM	START	STOP
Anesthesia	0810	0850
Procedure	0830	0845

DATE: 12/16/98 | OR NO: Endo | PAGE: 1 OF | SURGEON(S): Avalos M_D

PRE–PROCEDURE
- ☑ Identified ☐ ID Band ☐ Questioning
- ☑ Chart Review ☐ Permit Signed
- ☑ NPO Since 7a noon
- Pre-anesthetic State: ☐ Calm ☐ Asleep
- ☑ Awake ☐ Confused
- ☑ Apprehensive ☐ Unresponsive
- ☐ Uncooperative

PATIENT SAFETY
- ☑ Anes. Machine # _____ Checked
- ☐ Safety Belt On ☐ Axillary Roll
- ☐ Arm Restraints ☐ Arms Tucked
- ☐ Pressure points checked and padded
- ☐ Eye Care: ☐ Ointment ☐ Saline
- ☐ Taped ☐ Pads ☐ Goggles

MONITORS AND EQUIPMENT
- ☐ Steth ☐ Esoph ☐ Precord ☐ Other
- ☑ Non-Invasive B/P ☐ Nerve Stimulator
- ☑ Continuous EKG ☐ V Lead EKG
- ☑ Pulse Oximeter ☐ Oxygen Analyzer
- ☐ End Tidal CO_2 ☐ Resp Gas Anlyzr
- ☐ Temp _____ ☐ EEG
- ☐ Warming Blanket ☐ Fluid Warmer
- ☐ Airway Humidifier ☐ _____
- ☐ NG/OG Tube ☐ Foley Catheter
- ☐ Art Line _____
- ☐ CVP _____
- ☐ PA Line _____
- ☑ IV(s) 20G (L) hand/WS
- ☐ _____

ANESTHETIC TECHNIQUES
- Method: ☐ General ☐ Spinal
- ☐ Epidural ☐ Caudal ☐ Brachial
- ☐ Bier Block ☐ Ankle Blk ☐ M.A.C.
- General: ☐ Pre-O_2 ☐ L.T.A.
- ☐ Rapid Sequence ☐ Cricoid Pressure
- ☐ Intravenous ☐ Inhalation
- ☐ Intramuscular ☐ Rectal
- Regional: ☑ Portion _____
- ☐ Prep _____ ☐ Local _____
- ☐ Needle _____
- ☐ Drug(s) _____
- ☐ Dose _____ ☐ Attempts x _____
- ☐ Site _____ ☐ Level _____
- ☐ Catheter _____ ☐ See Remarks

AIRWAY MANAGEMENT
- ☐ Intubation ☐ Oral ☐ Nasal
- ☐ Direct Vision ☐ Magill's ☐ Blind
- ☐ Dif. see Rmks ☐ Fiber Op ☐ Stylet
- ☐ Attempts x — ☐ Blade _____
- ☐ Tube size — ☐ Endobronchial
- ☐ Regular ☐ RAE ☐ Armored ☐ Laser
- ☐ Cuffed ☐ Min. occ. pres. ☐ Air ☐ NS
- ☐ Uncuffed, leaks at — cm H_2O
- ☐ Secured at _____ ☐ ET CO_2 Present
- ☐ Breath Sounds _____
- ☐ Circuit: ☐ Circle ☐ Non-rebreathing
- ☐ Airway: ☐ Oral ☐ Nasal ☐ Natural
- ☐ Mask Case ☐ Via Tracheostomy
- ☐ Nasal Cannula ☐ Simple O_2 Mask

RECOVERY ROOM

Time 0850 | B/P 95/39 | O_2 Sat 96% | P 53 | R 10 | T 96.8

- ☑ PACU ☐ ICU ☐ L&D
- ☐ Awake ☐ Spont Resp ☐ Oral Airway
- ☐ Asleep ☐ Ventilator ☐ Nasal Airway
- ☐ Stable ☐ Extubated ☐ Face Shield O_2
- ☐ Unstable ☐ Intubated ☐ T-Piece O_2

CONTROLLED DRUGS

Drug	Used	Destroyed	Returned
Versed			
Fentanyl			

Provider _____ Witness _____

TIME: 0800 · 30 · 0900 · 80 · 1800

AGENTS
- ☐ Hal ☐ Enf ☐ Iso (%)
- ☐ N_2O ☐ Air (L/min)
- Oxygen NC (L/min): 3 — 2 — 3
- Versed (mg): 2 · 1.5
- Fentanyl (mcg): 100
- ( )
- ( )

FLUIDS
- LR: 300

MONITORS
- Urine (ml)
- EBL (ml)
- EKG: SR | SR | SR
- % O_2 Inspired (FIO_2): RA | 1.0 | 1.0
- O_2 Saturation (SaO_2): 94 | 96 | 98
- End Tidal CO_2: — | — | —
- Temp: ☐ °C ☐ °F

VITAL SIGNS

Baseline Values: 96/50 B/P; 55 P; 94% R

VENT
- Tidal Vol. (ml)
- Resp. Rate: SV | SV | SV
- Peak Pres. (cm H_2O)
- PEEP (cm H_2O)

Symbols for Remarks: O2% | ⊗ | R

Position: O2% | → | →

TOTALS: V 3.5 | F 2 cc

SYMBOLS
- × ANESTHESIA
- ⊙ OPERATION
- V / Λ B/PCUFF PRESSURE
- ↓ / ↑ ARTERIAL LINE PRESSURE
- Δ MEAN ARTERIAL PRESSURE
- ● PULSE
- O SPONTANEOUS RESP
- Ø ASSISTED RESP
- ⊗ CONTROLLED RESP
- T TOURNIQUET

ANESTHESIA PROVIDER(S): _____

REMARKS: R2 to RR Report to RN.

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name–last, first, middle: ID No. (SSN or other); hospital or medical facility.)*

DOVE, GAYLE A
[redacted]

ANESTHESIA
Medical Record
OPTIONAL FORM 517 (7–95)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101–11.203(b)(10)

12/16

Analgesia

PRE-ANESTHESIA EVALUATION

9670

AGE	SEX	HEIGHT	WEIGHT	PRE-PROCEDURE VITAL SIGNS
41	☐ M ☒ F	5'6" in./cm.	127 lb./kg.	B/P 103/65 P 59 R 16 T 97.8

PROPOSED PROCEDURE: EGD 12/10

PREVIOUS ANESTHESIA/OPERATIONS (If none, check here ☐): Hysterectomy (TAH) 1987; Exp Lap - adhesion 1995; Tubal ligation @ C-S x 4; EGD - 1996

CURRENT MEDICATIONS (If none, check here ☐): Alka Seltzer; Prozac; Prochlorperazine; Carafate; Trazodone; Clonazepam; Estrogen; Inderal; Combivent 2 puffs

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS (If none, check here ☒): Anesthesia

ALLERGIES (If NKDA, check here ☒)

AIRWAY/TEETH/HEAD AND NECK: Caps - molar; Own teeth - Class I MS 90

HISTORY FROM: ☐ PARENT/GUARDIAN ☐ POOR HISTORIAN ☒ CHART ☐ SIGNIFICANT OTHER ☒ PATIENT

SYSTEM	WNL	COMMENTS	PERTINENT STUDY RESULTS
RESPIRATORY Asthma · Pneumonia Bronchitis · Productive cough COPD · Recent cold Dyspnea · SOB Orthopnea · Tuberculosis	☒	Tobacco Use: ☐ No ☒ Yes 1 Pack/Day for 22 Years bil (wnl) wheez Adeq effort	Chest X-ray · Pulmonary Studies 9/98 scattered calcifications
CARDIOVASCULAR Angina · MI Arrhythmia · Murmur CHF · MVP Exercise Tolerance · Pacemaker Hypertension · Rheumatic fever	☒		EKG 9/98 Sinus brady
HEPATO/GASTROINTESTINAL Bowel obstruction · Jaundice Cirrhosis · N&V Hepatitis · ~~Reflux~~ heartburn Hiatal hernia · Ulcers	☒	Ethanol Use: ☒ No ☐ Yes Frequency_____	
NEURO/MUSCULOSKELETAL Arthritis · Paresthesia Back problems · Syncope CVA/stroke · Seizures DJD · TIAs ~~Headaches~~ · Weakness Loss of consciousness Neuromuscular disease Paralysis	☒	Aura - cloud of spots & blur vision 3-4/wk	
RENAL/ENDOCRINE Diabetes Renal failure/Dialysis Thyroid disease Urinary retention Urinary tract infection Weight loss/gain	☒		
OTHER Anemia Bleeding tendencies Hemophilia Pregnancy Sickle cell trait ~~Transfusion history~~ 1987			

PROBLEM LIST/DIAGNOSES: Dyspepsia & reflux; PTSD

ASA PS: 1 · (2) · 3 · 4 · 5 · E

LAB STUDIES: Hgb/HcT/CBC: 8.5 / 13.9 / 41.4 < 237 9/98; Electrolytes: 141 / 4.4 / 102 / 16 / 88; Urinalysis: .9 dip

Other: MAT urine 9/15/98

PLANNED ANESTHESIA/SPECIAL MONITORS: MAC

PRE-ANESTHESIA MEDICATIONS ORDERED: Inderal

DEBORAH McCLAIN, MD
ANESTHESIOLOGIST

SIGNATURE OF EVALUATOR(S): DMcClain 12/10/98

POST-ANESTHESIA NOTE

MAC

Signed 12/12/98 Date 1110 Time

[redacted]

OPTIONAL FORM 517 BACK

☆U.S. GPO:1998-618-075/91342

AMBULATORY SURGERY
DAY OF SURGERY

DATE/TIME: 12/16/98. 9 AM

EGD

PRE-OP DIAG: Recurrent Dyspepsia / Intermittent on/off tx therapy with Prevacid / Cisapride

FINDINGS: H. NSAID: gastropathy in post → ulcer

POST-OP DIAG: Histologic / RUT ⊖ in post

PROCEDURE: ⊖ Ultrasound of abdomen

ANES: (+) Midazolam

SURGEON: 1. Small island of metaplastic epithelium in distal esophagus close to GE junction.

ASST:

BLOOD LOSS: 2. diffuse gastric mucosal erythema with microhemorrhages and "mosaic" pattern mostly in fundus / body (Bx taken)

BLOOD:

FLUIDS: 3. erythematous mucosa in Antrum (RTLO-Tek brt → ⊖)

DRAINS:

4. Bulbi small ulceration with edema

POST-OP COND: NO Complications

SPECIMEN: (N/A) Diffuse gastritis mostly in fundus
Small Duodenal Bulb Ulcer →
Mild Esophagitis

Repeated gastric ulcer 139 (0-100)

Resident Signature

Attending Signature

MARTIN AVALOS, MD AS32551 / 0-541

*** For all EGD/Colonoscopy attach form - Date/Time/Sign Each

SIGNATURE AND TITLE OF PRACTITIONER

SEE REVERSE

MARTIN AVALOS, MD AS32551 / 0-541

DATE 12/16/98.

IMPRINT PATIENT DATA CARD (Name, Address and Social Security Number)

DOVE, GAYLE A

[redacted]

MEDICAL RECORD

SUPPLEMENT TO PROGRESS NOTE FOR SPECIALIZED DISCIPLINES-VERTICAL

[redacted]

VA FORM SEP 1992 10-0114J(R)

MEDICAL RECORD		PROGRESS NOTES
DATE		
6/2/97	News v Nalleni 7/4	Last visit approx March 96
11:05	Bp 139, Wt 135.1 T 98.5	P 62 R 20 BP 85/54
NKA	Cont to have severe migraine headaches	

Elizabeth Conrad

Nelleni :— Pt. c Ch. headaches
11.45 came to clinic for follow
Bp. no new or current complaints.

The headaches are continue
the tried clavil but didn't help.
She tolles Amitrip 1/2 to help.
HRE brain - 1996 & normal. heart - no
a Ch. headache - migraine / tension
→ he was tried on sumatriptan
clavil, valproic & cid but didn't help
well try Periactin 4mg q daily
& no improvement will try Imitrex.
Pt always does low BP & no symptoms

Follow up k 6 wks
V. Nelleni

7/02/97 @ 11:00

(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]

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	

MEDICAL RECORD	PROGRESS NOTES

DATE 4/17/97 1000

Women's MHC / PC Gold Team / Group Therapy

Problem: Stress Management

~~Progress~~ This is the last group session on stress management. Sessions 1-5 were reviewed, highlighting the positive impact of diaphragmatic breathing, nutrition, & exercise on subjective stress level. Members shared changes they have made +/or plan to make. Therapist facilitated discussion on sleeping habits and offered suggestions for improved sleep. Group concluded c members completing a fill-in-the-blank "Serenity Prayer" in which they identified things they can & cannot change in relation to stressors & stress management. Ms. Dove currently practices several stress management techniques, including progressive muscle relaxation. She demonstrated good insight into roadblocks to enhanced stress management.

Lisandra Apfelt, M.S., Psychology Resident
Virginia A. DeRosa, 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.

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MEDICAL RECORD | **PROGRESS NOTES**

DATE

4/10/97 1000 Women's Clinic / PC Gold / Group Therapy

Problem: Stress Management

The role of "fitness & exercise" in stress management was emphasized. Members participated in a non-impact exercise designed to loosen and energize the muscles. A handout was given for members to assess where changes can be made in their daily routine in order to ↑ physical activity, i.e, taking stairs instead of elevator. Educational handouts on "fitness & nutrition" and "creative exercising" were also given. The session concluded c a group walk around the hospital grounds. Ms. Dove reported that she exercises regularly, and she shared her activities c the group. She reported improved health & self-image as reasons for her exercise.

— Shunalia Agnelli M.S. Psychology Resident
Virginia H. DeRoma, Ph.D., 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
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MEDICAL RECORD | PROGRESS NOTES

DATE

3-27-97 Women's Mental Health Primary Care Clinic / Psychology Note / Gold Team / Stress Management Group

Group Members reviewed assignments from previous week involving limit-setting successes. Principles of taking care of oneself through good nutrition were reviewed. Each group member identified eating habits that promoted positive effects on mood. The role of foods in raising stress reactions was introduced, including sugar surges eventually leading to fatigue; caffeine leading to wash-outs of water-soluble vitamins due to diuretic properties; and alcohol use leading to bodies detoxification system being compromised. A handout of how eating might be tied in with emotions was distributed. Pt shared several practices she uses to ↑ nutrition & discussed their positive effects, physically & emotionally. — Saundra Arnett, MS Psychology Resident

(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

[redacted]

PROGRESS NOTES
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MEDICAL RECORD | **PROGRESS NOTES**

DATE

3/20/97 1000 Women's MHC / PC Gold / Group Therapy Note

Problem: 26- Other (Stress Management)

Members reviewed assignments from last session in which they identified 3 recent stressors, their reaction to it, & possible coping skills. Therapist highlighted coping skills / lifestyle changes that would be taught in future sessions. Therapist provided education on physiological effects of stress. Members completed worksheets that helped them to identify individual stress sxs & stress reducers. Therapist demonstrated diaphragmatic breathing and encouraged its use as a stress reducer. Members were asked to practice one of their stress reducers before next session. Ms. Dove was attentive to group discussion, but participated minimally. To reduce stress in the next week, she agreed to read Ps/insight every day. TRx 3/27 @ 10a

— Saundra Appelt, MS, Psychology Resident
Raymond 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)

Dove, Gayle

[redacted]

REGISTER NO. | WARD NO.

PROGRESS NOTES
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PROGRESS NOTES

DATE

3/25/97 MHC

Doing well - gain wgt - 8 lbs - Sleep adequate
Eldrin help c Tensin & A Still has
Nystagmus Getting out - goes to AA mtg -
Cessna Bingo etc. Some memory
Normal pain Stone Partner Cheryl & Franklins
MS well groomed, pleasant, friendly
cooperative Rational Sensorium.
P- Refilled all meds:
Amitrip. 100 q h.
Ryan 20 q Am
Cozaar 1x BID pm
T3/#3 pm Nystagmus
Dantrium pm Nystagmus.
D/c Tamoxifen
Restart Prilosec 20 qd.
RTC 2mo

5/20/97 MHC

Doing well - Now back on Trazadone 200 q h pm sleep
(Quit & sleep c Eldrin) Aunt died & she's going to funeral
in Kansas. Feeling Sensation of. Tol Prilosec well.
Take T#3 pm Nystagmus & has ~~walker~~ as well.
~~Mr pleasant, friendly well groomed appropriate cooperative, rational~~
Clear Sensorium
Neuro Cont grossly meds ✓ D/c Eldrin restart
Trazadone 200 q h.
RTC 2mo

☆U.S. GPO:1995-397-405 STANDARD FORM 509 BACK (Rev. 11-77)

MEDICAL RECORD	PROGRESS NOTES
DATE 3/6/97	Individual session / Women's Mental Health Primary Care Clinic / Gold Team / Psychology Note: Problem: #2 Depression. Vet reviewed the last session. Problems establishing intimacy, physically and verbally. Emotional closeness very disturbed by impulsive behavior characterized by irresponsibility noted for past partners. Vet's responses to this discussed, including shut-down and tendencies to self-blame (e.g., too jealous). Patterns of evading by calling someone from consequences of confrontation. The days of failing to attend to or report back of hospital, including poor health; low self-esteem, and depression. Assignment: HW: Patterns of Self-Esteem and Willingness to Accept Others' disrespect. Virginia L. 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)

Dave, Gayle

[redacted]

REGISTER NO.	WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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509-111

PROGRESS NOTES

DATE		

☆U.S. GPO:1995-397-405

MEDICAL RECORD	PROGRESS NOTES
DATE 3/4/97 NCA 1250	Age 39 T99.2 P69 B/P 110/69 F/U Neuro c Dr. Nelkin & f. McCaddon Neuro:- Pt visits clinic regularly 1st came to clinic for follow up. Sx is on & level of T 100 up least wk. Has headaches are better & more sporadic about 1/wk (before 3/wk) & also better duration headaches better. no complaints. Still gets nausea at times like before. O: Alert. Headache → Migraine & Tension cont to claim Plan ① Follow up 3-4 months Dr. Nelkin 6/6/97 @ 11:00

LOVE, GAYLE A
4457 POPPS FERRY RD. LO 047
MS 39532

(Continue on reverse side)

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

[redacted]

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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FIRMR(41CFR)201-45.505
509-111

PROGRESS NOTES

DATE	

☆U.S. GPO: 1995-397-405

03/03/97 09:39 PSYCHOLOGY
Location: WOMEN'S GOLD MHPC-GPT-BLDG 57
2/27/97 WOMEN'S MENTAL HEALTH PRIMARY CARE CLINIC/
PSYCHOLOGY NOTE/GOLD TEAM: PROBLEM #2 DEPRESSION
VET REVIEWED PREVIOUS SESSION BASED ON NOTES PROMPTED
TO TAKE IN LAST THERAPY HOUR. LOSS ISSUES ASSOCIATED
WITH MALE FRIEND COMMITING TO, BUT NOT CALLING OR ARRIVING
FOR PLANNED TRIP TO THE HOCKEY GAME WERE ADDRESSED.
VET REPORTED THAT SHE PLANNED TO IGNORE THE ISSUE IF SHE
SAW/HAD CONTACT WITH HIM AGAIN.. THE IMPACT OF THIS PLAN
ON INCREASING MISTRUST OF OTHERS AND EXPECTATIONS THAT
NO-ONE WILL CARE ABOUT VET WERE DISCUSSED AND ADVANTAGES
OF CONFRONTING PERSON DIRECTLY WERE HIGHLIGHTED.. VET
AGREED TO CONFRONT AND ROLE PLAYS WERE CONDUCTED TO HELP
HER PRACTICE EXPRESSING HER FEELINGS, VERBALIZING WHAT
SHE EXPECTED, AND SETTING A LIMIT FOR FUTURE CONTACT AND
EXPECTATIONS AROUND THAT CONTACT. VET SUCCESSFULLY
COMPLETED THE ROLE PLAYS AND AGREED TO GENERALIZE TO
LIFE EXPERIENCES.

Signed by: /es/ VIRGINIA M. DEROMA
STAFF PSYCHOLOGIST 03/03/97 09:43

MEDICAL RECORD	PROGRESS NOTES
DATE	
2/25/97	MDTC Doing well overall c meds. Mood stable Sleep improved ↓ HA c amitriptyline Less paranoid. Self esteem ↑. Seeing Dr. Pelham weekly c much benefit. No SE to med. Still c some tremor & will ↑ amitriptyline to 100 qhs since no SE and symptom. Pt refilled meds incl Prozac 20 qd Zyrtec #3 c 9 Rf qm #30 Ami 50 mg qhs Lorazepam (Ativan) (for emph) Propranolol (Inderal) (for emph) RTC 1mo.

(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)
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FIRMR(41CFR)201-45.505
509-111

PROGRESS NOTES

DATE		

SINGING RIVER HOSPITAL SYSTEM

☐ SINGING RIVER HOSPITAL
PASCAGOULA, MISSISSIPPI

X ☐ OCEAN SPRINGS HOSPITAL
OCEAN SPRINGS, MISSISSIPP

X-RAY REPORT

LAST NAME	FIRST NAME	MIDDLE INITIAL	PHYSICIAN	ROOM #	DATE	X-RAY #
DOVE,GAYLE	A		DIAZ/BVA		02-24-97	110014

HX: ROUTINE SCREENING.

BILATERAL FILM-SCREEN MAMMOGRAM:

Comparison is made with the previous exam of 11/25/94 from Keesler Medical Center. Moderate retroareolar fibroglandular densities are seen bilaterally. The remainder of the breasts are relatively fatty replaced. No suspicious masses, clusters of microcalcifications, architectural distortion or skin changes are seen. There is no evidence of adenopathy.

IMPRESSION: 1. NO MAMMOGRAPHIC EVIDENCE OF MALIGNANCY, UNCHANGED SINCE 11/25/94.

D: 2/28/97
T: 3/1/97/veb 8:55 a.m.

cc: Dr. Diaz/BVA

"Mammography is the most sensitive method for finding small breast cancers, but it does not detect them all, and is not a substitute for careful clinical examination. A negative mammogram does not negate a clinically suspicious finding and should not result in delay in biopsying a clinically suspicious abnormality." Statement of Gulf Coast Radiology Group.

REQ NO: 000000 ORDER NO: 0002
RADIOLOGIST: GARRET P. YOUNG, M.D. PAT ID: 2201798549 MEDREC NO: 0200126406

[redacted] GNED RADIOLOGIST _____ M.D.
PHYSICIAN

X-RAY

PROGRESS NOTES

DATE	
2-20-97	Women's Mental Health Primary Care Clinic / Psychology Note / Goldsean: Pt could not recall last session and was prompted to take notes during each session to provide retention and access of session outside of therapy. Pt agreed and did so. Vet did not complete assignment of comparing Pt's (given) about deception, but did express hurt feelings directly about being ignored / not called. She was confronted with her own failure to reach out to this friend (and even active avoidance by not attending some AA meetings) and yet held him solely responsible for her pain. This was framed as her setting herself up for playing the part of a victim, a behavior that places her at increased risk for depression. Vet's right to confront an ex-boyfriend who appears to be causing friendship boundaries was addressed and a role play was conducted to problem solve for assertive responses RTC X1 with Wynne Williams, Staff Psychologist

*U.S. Government Printing Office: 1994 — 383-720

STANDARD FORM 509 BACK (Rev. 11-77)

MEDICAL RECORD	PROGRESS NOTES
DATE	

2-13-97 Mental Hygiene Clinic / Psychology Note / Goal Statement: Problem #2 Depression. Pt rated happiness as a "2" on a 1-10 scale, with 1 representing minimum happiness. Disappointment in others related to loss in a relationship. Suppressed anger as a pattern of passivity and a negative emotion that pt tries to avoid. Positive effects of anger, including willingness to confront people and assertiveness, were discussed. This issue was discussed as important given emotional "failure to thrive" issues involving her seeing herself as having little control over her life. Passivity as a repeated pattern that reinforces lack of control in her life was noted as behavior to decrease. Role play was conducted to model expression of anger in order to raise likelihood of empowerment

(Continued on reverse side)

Stephen D. Bitter, Ph.D. Psychologist

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

T.R. Warne

REGISTER NO. M.H. Psychology Reader

WARD NO.

DOC, Gayle

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

MEDICAL RECORD	PROGRESS NOTES
DATE	

2-6-97 Women's Mental Health PC Clinic/
Psychology Note/ Gold Team:
Problem #2 Depression.
Vet followed through with assignment
of initiating more interaction in AA.
This behavior was praised by therapist.
Model involving Pt feeling more
accepted when she took steps
to take more of an initiative
role was discussed. Pt's
anxiety, struggles with abstinence
and views regarding compatibility
with others who abstain/do not
abstain from alcohol abuse
were explored. RTC x 1 wk.
Vignard Miller Ph.D., Staff Psychologist
Thomas R Warren, M.D.

(Continue on reverse side)

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

REGISTER NO.	WARD NO.

DOV 6a/lc.

[redacted]

PROGRESS NOTES
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PROGRESS NOTES

DATE	

*U.S. Government Printing Office: 1994 — 383-720

STANDARD FORM 509 BACK (Rev. 11-77)

MEDICAL RECORD	PROGRESS NOTES

DATE 2/3/97

0815

NKDA

HISTORY AND PHYSICAL PROGRESS NOTE

39 y/o, Female G 1 P 1 A 0 LMP 0

Contraception 0

Last Pap Smear Last year 96' Last Mammography 2 yrs ago

GYN Surgeries: Wt 124.6 Ht 5'6" T 98.2 P 78 RR

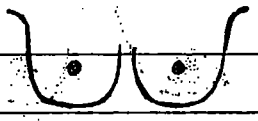
B/P 102/65 March 1987 - Hysterectomy

Physical Exam 0 = No, + = Yes (Explain + in Comments)

Thyroid:

Breasts: Tender/Non Tender Dominant Masses Skin Changes Nipple Discharges

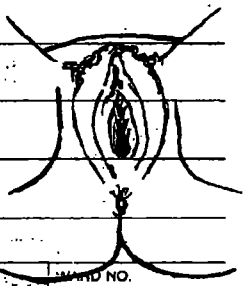
Comments:



Abdomen: Masses Tenderness

Comments:

Mammo # 2881516



Ext. Genitalia: Lesions Erythema Edema Discharge

Comments:

DOVE, GAYLE A 25
4457 POPPS FERRY RD. LO 047

(Continue on reverse side)

B 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
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Prescribed by GSA/ICMR
FIRMR(41CFR)201-45.505
509-111

520-OP-184-136 **March '96**

PROGRESS NOTES

DATE

Cervix: ___Nullip ___Parous Absent ___Lesion ___Discharge

Comments:



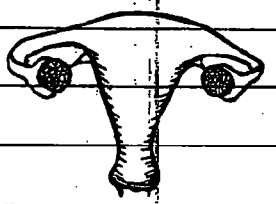
Uterus: ___Normal Size ___Mobile ___Pap Smear

___Position Anteflexes/Anteverted/Retroflexed/Retroverted/Absent

Comments:

Adenexa: ___Non Tense ___Masses Absent

Comments:



Rectovaginal Exam: ___Masses

Comments:

Pelvic Exam Deferred: ___No ___Yes, Reason deferred:

☆U.S. GPO:1995-397-405

MEDICAL RECORD | CYTOPATHOLOGY Pg 1

Submitted by: ALBERT L DIAZ MD Date obtained: FEB 3, 1997

Specimen (Received FEB 4, 1997 08:47):
A)PAP SMEAR.

Brief Clinical History:

Preoperative Diagnosis:

Operative Findings:

Postoperative Diagnosis:

Surgeon/physician: ALBERT L DIAZ MD

PATHOLOGY REPORT

Laboratory: Biloxi, MS (CONS) Accession No. CY97 CY 97 144

Microscopic Description:
Specimen satisfactory, no endocervical components seen, consistent with history of hysterectomy and/or vaginal specimen source.

DIAGNOSIS:

C97-144A; CYTOLOGY, PAP SMEAR, VAGINAL:

WITHIN NORMAL LIMITS.

INFLAMMATORY EXUDATE PRESENT.

NOTE: THIS STUDY (C-04429-97) WAS PERFORMED AT KAFB MEDICAL CENTER.

SNOMED code(s):
T-8X210: vaginal cytologic material
M-09460: negative for malignant cells
M-40400: inflammation, exudative

(End of report)

PAUL V WATSON MD njf| Date FEB 13, 1997

DOVE,GAYLE A STANDARD FORM 515

[redacted] SEX:F DOB:8/15/57 AGE:39 LOC:GYN

ALBERT L DIAZ MD

MEDICAL RECORD — PROGRESS NOTES

DATE

12-13-95 **SURGERY CLINIC** 38 40 HT 5'6½" WT 147.5

10 40 T 98.9 P-83 R-20 B/P 94/62 S/P

NKA Rt groin exp 11-30-95 Mary Ryan

13Dec95 S. Pt here for F/U for Stitch Removal on

11 95 30 Nov 95, s/p Stitch Abcess.

Pt doing well, c N/V c D/C.

P→ Incision c/d/I well healed

Karaplum Steristrips

I→ s/p ≈ 2 wk Stitch Abcess Removal.

P→ RTC prn.

KENNETH J. BOOMGAARD, M.D.
AS3285170-728

1-30-96 Pt here for injection of Depo-provera ~~injection~~ 150 mg given IM in left Rt gluteal ⊼ difficulty. Pt instructed to return in 3 mths for next injection. Pt verbalizes understanding reasons

DOVE, GAYLE A 25
4457 POPPS FERRY RD.LO 347
[redacted]

(Continue on reverse side)

... first, middle

REGISTER NO. | WARD NO.

PROGRESS NOTES
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Prescribed by GSA/ICMR,
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509-111

PROGRESS NOTES

DATE

[redacted]

STANDARD FORM 509 BACK (Rev. 11-77)

*U.S. GPO: 1985-497-

MEDICAL RECORD	GYNECOLOGIC CYTOLOGY	144A

SECTION I—CLINICAL DATA TO BE COMPLETED BY EXAMINING INSTALLATION

DATE OBTAINED	LMP FIRST DAY	DATE RECEIVED IN LABORATORY
2-3-97	Hyst Mar '87	

SOURCE OF SPECIMEN

☐ COMBINED CERVIX AND VAGINA ☐ CERVIX ☑ VAGINA ☐ OTHER (specify)

AGE	PREGNANCY	GRAVIDA	PARA	PREVIOUS ABNORMAL CYTOLOGIC EXAMINATION
39	☐ YES ☐ NO	1	1	☐ YES (Give date) ☐ NO

CLINICAL HISTORY (Surgery, drugs, hormones, radiation, etc.)

Air Force overseas
Smokes Greenland, Alaska
Hyst 87

PHYSICAL EXAMINATION (Pelvic findings, etc.)

WNL

SPECIMEN SUBMITTED BY (Facility)

VAMC Biloxi, MS

SIGNATURE AND TITLE

SUBMITTING FACILITY ACCESSION NUMBER

SECTION II—CYTOLOGIC FINDINGS FROM REPORTING INSTALLATION ONLY

NAME OF LABORATORY

ACCESSION NUMBER

CHECK (√) ONE	YES	NO	CHECK (√) ONE	YES	NO
Granulocytes			Endocervical cells		
Leptothrix					
Trichomonas			SCREENED BY		
Candida					

MATURATION INDEX	
PARABASALS	
INTERMEDIATES	
SUPERFICIALS	

COMMENTS AND RECOMMENDATIONS

DOVE, GAYLE A
4457 POPPS FERRY RD, LO 047
BILOXI MS 39532

PATHOLOGIST'S SIGNATURE | TITLE | DATE

[redacted]

or medical facility) | REGISTER NO. | WARD OR CLINIC

GYN

VAMC BILOXI

STANDARD FORM 541 (Rev. 11-77)
Prescribed by GSA and ICMR, FPMR 101-11.806-6
541-107

*U.S. Government Printing Office: 1996 - 716-917/83299

MEDICAL RECORD	PROGRESS NOTES

DATE 1/30/97

Wt. 127. BP. 99/65 P 80 R 18 T. 97.8
G.I. Fitt. M. Sessions CMO

Hx Dyspepsia nausea } EGD 10/25/96.

diffuse gastritis / multiple ulcers
Stool HH
HP ⊖
CBx ⊖).

Most likely NSAID related
taking Omeprazole since 10/25/96

still a little nauseated on/off
using Tylenol for pain

CBC } WNL
Chem 10 }

Gastrin 127 ↑

4/3/97 @ 8:30

Plan: finish Omeprazole then stop.
will give Pepcid PPX 20 bid PRN
if possible avoid NSAIDs.

PR in 6 months

(Continue on reverse side)

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

DOVEL, GAYLE
4457 POPPS FERRY RD. LO 047
BILOXI

[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 : 1996 O - 171-075

PROGRESS NOTES

DATE	
12	
12897	MHC Return for 7/w; Says Dr Pollard wanted labs done to rule out ca of HA prophylaxis (Shaw people don't know it but I'll write Rx for this) Not fully functional (congestion, malaise) Says not as normal + able to go to Casino 5 times. Stays home, abst — attends AA Missed 7/w c Dr Pollard. Extra prayer is helping ✓ copy spell. No acute dysfunction SI. Rx D/c Trazadone Begin Amitriptyline 50 mg qh x 3 then 75 qh Cont Prozac 20 qAm Cont Risperdal 1-2 mg qh. Rpt #3 ✓ 9wk for short term #30 x 0 RT Serine labs.

LOVE, GAYLE A
USA PURPLE HEART BLVD
BILOXI MS 39532

U.S. GOVERNMENT PRINTING OFFICE: 1996 O - 171-075

STANDARD FORM 509 BACK (Rev. 11-77)

[redacted]

MEDICAL RECORD | **PROGRESS NOTES**

DATE

1/21/97 WT 94 kg 39 T 98.6 P 52 BP 90/57 9.5

NKA Neurology Dr. Kelly McCorkle

1450 Neuro: - Pt with migraine s/p OR. Headaches same to clinic follow up. She got Imitrex & Keppra & Valproic Acid & she stopped it. She was on them before & reports that she did better & wants to try again.

Ch. migraine headaches
Dc valproic acid
Try them 500 mg bid 250 mg bid
will be seen in HOC as needed
or prn before then. (1/23/97)

3/4 97

Follow up 6 weeks prn

V. Kelly

(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]
4457 POPPS FERRY RD. LO 047
BILOXI MS 39532

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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01/09/97 10:53 PSYCHOLOGY
Location: WOMEN'S GOLD MHPC-GPT-BLDG 57
Pt presented in euthymic mood. She rated happiness as "5" on a 1-10 scale, with 10 representing maximum happiness. Recent socialization was highlighted as a coping mechanism that arose, in part, as a result of her focusing more on others and less of herself. The tendency to focus on herself was framed by the therapist as historical and related to her mother's failure to attend to her needs. Other recently used coping mechanisms (e.g., confrontation of family members of how she felt slighted) were also noted and praised by therapist. These coping mechanisms appear to be contributing to decreased hurt and resentment, which also promote the desire to socialize. Replacement of "I don't care attitude" with positive thoughts related to pt is cared about also noted to contribute to the desire to socialize and depend upon vet's recent progress in changing the rule she developed in childhood of no-one caring to acknowledge that this rule does not generalize to everyone. Vet was cooperative in treatment and agreed to the assignment of thinking less about herself (i.e., ruminating less) and documenting this daily.
Signed by: /es/ VIRGINIA M. DEROMA
STAFF PSYCHOLOGIST 01/09/97 11:00

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
1/25/97	2030 AM PM	40	☐ M ☑ F	☑ AMBULATORY ☐ STRETCHER ☐ WHEELCHAIR	( )	☐ YES ☑ NO

8A. ALLERGIES	8B. HEIGHT	8C. TEMPERATURE	8D. PULSE	8E. RESPIRATION	8F. B/P	8G. DUE TO INJURY
NKA	HT 66" 154# WT 140	97.4	88	20	116/57	☑ NO ☐ YES

9. CURRENT MEDICATIONS See Profile

10. TRIAGE Complains of migraine headache since this A.M. Nausea & emesis. Took imitrex & relief @ 2 PM.

11. SIGNATURE Mary L. Brown RN

12. HISTORY AND PHYSICAL

Clear & erect
Eyes & EERJT - EOM - full;
PERLA; fundi WNL
Neurologic exam no focal deficits

13. DIAGNOSTIC IMPRESSIONS Migraine Headache

14. PLAN

Imitrex 75 mg.
Phenergan 25 mg.

R/x. filed 2045 MBrown RN

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	1-25-97 2115	Mary L. Brown RN

IMPRINT PATIENT DATA CARD

7. PATIENT INSTRUCTIONS

01 25 97

Followup as needed

Gayle A. Dave

I CERTIFY THAT I RECEIVED AND UNDERSTAND THESE INSTRUCTIONS	8. PATIENT'S SIGNATURE

DAVE, GAYLE A

[redacted]

VA FORM MAR 1992 **10-10M** SUPERSEDES VA FORM 10-10M, MAY 1990, WHICH WILL NOT BE USED.

TIME	VITAL SIGNS				TIME	ORDERS	MD SIGNATURE	TIME	NURSE SIGNATURE	EFFECTIVENESS
	TEMP	PULSE	RESP	B/P						

CONTINUATION FROM FRONT / PROGRESS NOTE

STUDIES REQUESTED	RESULTS