

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM MARLBORO COUNTY
Court of General Sessions

Benjamin H. Culbertson, Circuit Court Judge

Appellate Case No.: 2021-000688

The State of South Carolina,

Respondent,

v.

Haneef A. Childs,

Appellant.

RECORD ON APPEAL
VOLUME 2 OF 2

December 11, 2023

/s/ Aimee J. Zmroczek

Aimee J. Zmroczek, Esq. [S.C. Bar No.: 77193]

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Attorney for Appellant

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SC Court of Appeals

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aimee@ajzlawfirm.com
Attorney for Appellant

SUMMARY/COMMENTS/PLANS:

D) Group is a dynamic discussion of the impacts of stressors on self-esteem. These include the label of mental illness, negative thought processes, hallucinations and the challenges of managing relationships. Group's focus is identifying personal challenges faced by consumers and to work with peers and staff towards healthy resolution of these challenges. Group is also a forum for addressing treatment challenges, presenting complaints and working cooperatively towards formulation of goals.

A) Despite repeated encouragement consumer did not attend.

P) Team will continue to encourage future attendance and review group topic and materials with consumer individually.



COUNSELOR SIGNATURE AND CREDENTIALS

11-3-15
Date

11:00am
Time

 Mercy Philadelphia Hospital
A member of Mercy Health System

COUNSELOR GROUP NO. 11



CHILDS, HANEEB A

8 27 M



11/3/15 11:00am

COUNSELOR GROUP NOTE

DATE: 11/03/15 TIME: 2PM GROUP DURATION: 45MINS

GROUP TOPIC(S) AS IT PERTAINS TO THE TREATMENT PLAN: _____

"My Perfect Life"

ATTENDANCE:

- | | |
|---|--|
| ☐ Minimal encouragement required | ☐ Repeated encouragement required |
| ☒ Did not attend | ☐ Excused |

ENTRY STATE:

- | | | |
|---|-----------------------------------|---|
| ☐ Relaxed/calm | ☐ Euphoric | ☐ Blunted affect |
| ☐ Agitated/anxious | ☐ Angry | ☐ Withdrawn |
| ☐ Sad effect | | |

PROBLEM ARE FOCUS:

- | | | |
|--|--|--|
| ☐ Aggression/anger management | ☐ Discharge issues | ☐ Impulse control |
| ☐ Agitation/anxiety | ☐ Maintain sobriety | ☐ Physical complaints |
| ☐ Coping/stress | ☐ Relationship issues | ☐ Self concept |
| ☐ Denial of problem | ☐ Spiritual issues | ☐ Other: _____ |

LEVEL OF PARTICIPATION:

- | | | |
|--|--------------------------------------|---------------------------------------|
| ☐ Active | ☐ Intrusive | ☐ Uninvested |
| ☐ Alert but passive | ☐ Left group | ☐ Other: _____ |
| ☐ Sleeping | ☐ Interactive | |

FACILITATOR'S INTERVENTION:

- | | | |
|---|---|---------------------------------------|
| ☐ Assist problem-solving | ☐ Structured activity | ☐ Education |
| ☐ Redirective/prompting | ☐ Encourage group feedback | ☐ Other: _____ |
| ☐ Directed to resources | ☐ Supportive | |

OUTCOME:

- | | |
|--|---|
| ☐ Meeting goals of treatment plan | ☐ Identified coping strategies |
| ☐ Expressed thoughts and feelings | ☐ Identified symptoms/problems |
| ☐ Gained insight into problem areas | ☐ Minimal progress |
| ☐ Helped peers with their problems | ☐ Other: _____ |

DEPARTURE STATE:

- | | | |
|---|--|---------------------------------------|
| ☐ Agitated/anxious | ☐ Confused/frustrated | ☐ Relaxed/calm |
| ☐ Angry | ☐ Depressed | ☐ Sad affect |
| ☐ Flat affect | ☐ Withdrawn | ☐ Other: _____ |
| ☐ Bright affect | ☐ Blunted affect | |

Mercy Philadelphia Hospital
A member of Mercy Health System

COUNSELOR GROUP NOTE



Page 1 of 2
Form PS338 Rev. 01/2011
PCS X OTHER

CHILDS, HANEEF A

27 M



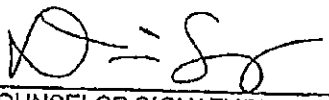
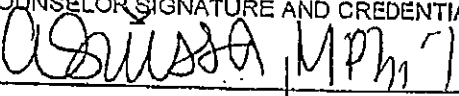
SUMMARY/COMMENTS/PLANS:

D-Using paper and markers, clients were asked to draw a depiction of their perfect life. They were then asked to write three steps to achieving that life.

A-Patient did not attend group and will be encouraged to attend all groups in the future.

P-Continue to offer opportunities for growth and creative expression.

POOR QUALITY ORIGINAL

 (BA Psychology) 11/03/15 3PM
COUNSELOR SIGNATURE AND CREDENTIALS Date Time


 Mercy Philadelphia Hospital
A member of Mercy Health System

COUNSELOR GROUP NOTE



Page 2 of 2
Form PS316, Rev. 01/2011
PCS.X OTHER

CHILDS, HANEEF A
11/03/15 27 M



COUNSELOR GROUP NOTE

DATE: 11-4-18 TIME: 1045A GROUP DURATION: 45 MIN.

GROUP TOPIC(S) AS IT PERTAINS TO THE TREATMENT PLAN: TREATMENT GOALS

Psychoeducation: Coping skills (recognizing negative, developing positive skills)

ATTENDANCE:

- ☐ Minimal encouragement required
☒ Did not attend

- ☐ Repeated encouragement required
☒ Excused (Meeting with staff)

ENTRY STATE:

- ☐ Relaxed/calm
☐ Agitated/anxious
☐ Sad affect

- ☐ Euphoric
☐ Angry

- ☐ Blunted affect
☐ Withdrawn

PROBLEM ARE FOCUS:

- ☒ Aggression/anger management
☒ Agitation/anxiety
☒ Coping/stress
☒ Denial of problem

- ☒ Discharge issues
☒ Maintain sobriety
☒ Relationship issues
☒ Spiritual issues

- ☒ Impulse control
☒ Physical complaints
☒ Self concept
☐ Other: _____

LEVEL OF PARTICIPATION:

- ☐ Active
☐ Alert but passive
☐ Sleeping

- ☐ Intrusive
☐ Left group
☐ Interactive

- ☐ Uninvested
☐ Other: _____

FACILITATOR'S INTERVENTION:

- ☐ Assist problem-solving
☐ Redirective/prompting
☐ Directed to resources

- ☒ Structured activity
☐ Encourage group feedback
☐ Supportive

- ☒ Education
☐ Other: _____

OUTCOME:

- ☐ Meeting goals of treatment plan
☐ Expressed thoughts and feelings
☐ Gained insight into problem areas
☐ Helped peers with their problems

- ☐ Identified coping strategies
☐ Identified symptoms/problems
☐ Minimal progress
☐ Other: _____

DEPARTURE STATE:

- ☐ Agitated/anxious
☐ Angry
☐ Flat affect
☐ Bright affect

- ☐ Confused/frustrated
☐ Depressed
☐ Withdrawn
☐ Blunted affect

- ☐ Relaxed/calm
☐ Sad affect
☐ Other: _____

Mercy Philadelphia Hospital
A member of Mercy Health System

COUNSELOR GROUP NOTE



Page 1 of 2
Form PS318 Rev. 01/2011
PCS, X OTHER

CHILDS, HANEEF A

27 M

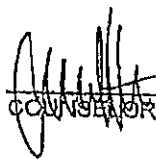


SUMMARY/COMMENTS/PLANS:

D) Coping with psychological stressors - commonly triggered by change - is a necessary part of maintaining mental health. The changes demands of patients and their families may lead to stress as they move from illness into sustained recovery; providing patients with positive coping is a necessary part of that process. Group is an interactive discussion of styles of coping and a variety of positive coping methods and skills.

A) Despite repeated encouragement consumer did not attend group.

P) Team will continue to encourage future attendance and review group topic and materials with consumer individually.



COUNSELOR SIGNATURE AND CREDENTIALS

11-11-15
Date

11:50
Time

 Mercy Philadelphia Hospital
A member of Mercy Health System

COUNSELOR GROUP NOTE



Page 2 of 2
Form PS336, Rev. 01/2011
PCS.X OTHER

CHILDS, HANESE, A
DOB: [REDACTED] 27 M



COUNSELOR GROUP NOTE

DATE: 11/4/15 TIME: 2PM GROUP DURATION: 45MINS

GROUP TOPIC(S) AS IT PERTAINS TO THE TREATMENT PLAN: Interpersonal skills

ATTENDANCE:

- | | |
|---|--|
| ☐ Minimal encouragement required | ☐ Repeated encouragement required |
| ☒ Did not attend | ☐ Excused |

ENTRY STATE:

- | | | |
|---|-----------------------------------|---|
| ☐ Relaxed/calm | ☐ Euphoric | ☐ Blunted affect |
| ☐ Agitated/anxious | ☐ Angry | ☐ Withdrawn |
| ☐ Sad affect | | |

PROBLEM ARE FOCUS:

- | | | |
|--|--|--|
| ☐ Aggression/anger management | ☐ Discharge issues | ☐ Impulse control |
| ☐ Agitation/anxiety | ☐ Maintain sobriety | ☐ Physical complaints |
| ☐ Coping/stress | ☐ Relationship issues | ☐ Self concept |
| ☐ Denial of problem | ☐ Spiritual issues | ☐ Other: _____ |

LEVEL OF PARTICIPATION:

- | | | |
|--|--------------------------------------|---------------------------------------|
| ☐ Active | ☐ Intrusive | ☐ Uninvested |
| ☐ Alert but passive | ☐ Left group | ☐ Other: _____ |
| ☐ Sleeping | ☐ Interactive | |

FACILITATOR'S INTERVENTION:

- | | | |
|---|---|---------------------------------------|
| ☐ Assist problem-solving | ☐ Structured activity | ☐ Education |
| ☐ Redirective/prompting | ☐ Encourage group feedback | ☐ Other: _____ |
| ☐ Directed to resources | ☐ Supportive | |

OUTCOME:

- | | |
|--|---|
| ☐ Meeting goals of treatment plan | ☐ Identified coping strategies |
| ☐ Expressed thoughts and feelings | ☐ Identified symptoms/problems |
| ☐ Gained insight into problem areas | ☐ Minimal progress |
| ☐ Helped peers with their problems | ☐ Other: _____ |

DEPARTURE STATE:

- | | | |
|---|--|---------------------------------------|
| ☐ Agitated/anxious | ☐ Confused/frustrated | ☐ Relaxed/calm |
| ☐ Angry | ☐ Depressed | ☐ Sad affect |
| ☐ Flat affect | ☐ Withdrawn | ☐ Other: _____ |
| ☐ Bright affect | ☐ Blunted affect | |

Mersey Philadelphia Hospital
A member of Mersey Health System

COUNSELOR GROUP NOTE



Page 1 of 2
Form PS336 Rev. 01/2011
PCS X OTHER

CHILDS, HANEEF A

27X M

[Redacted patient information]



D- The group focused on interpersonal skills and socializing in a healthy environment. Clients were given a variety of activities to choose from and engage with others.

A - Pt. did not attend group and will be encouraged to attend all groups in the future.

P- Will continue to offer opportunities for therapeutic growth and interpersonal interaction

~~POOR QUALITY ORIGINAL~~

Agustin MPhil
COUNSELOR SIGNATURE AND CREDENTIALS

Date _____

Time

COUNSELOR GROUP NOTE



CHILDS, HANEEF A

27 M



Interdisciplinary Integrated
Progress Notes

11-5-15 1AM NSS - Received pt awake, and on 1:1 observed
for suicidal precautions, pt requested med for
Sleep, Vicodin 25mg po qid @ 12:40AM, also
request for visio eye drops ———— Surfa

11-5-15 2AM NSS - pt was still awake, anxious, paranoid,
restless & preoccupied, unable to lay down in bed.
Admin 2mg Rm 1mg po qid @ 1:30AM, pt took the
meds, says "if anything happens to me, I'm gonna
see you, Nurse Sur, ", and about 40 minutes later
pt came out of room again, says "Whatever you gave
to me, it's not working" "Don't try to pop me up."
pt was irritable, agitated. Observed pt wearing a
sweat pants & a string. Requested pt to change to
disposable pajama pants, pt was uncooperative &
argumentative, refused to take off. Two security guards
came to the unit to assist. A string was cut off,
remain of string is stitched on back of the pants &
appear safe to pt to wear. pt was argumentative
& uncooperative & a MHT assigned to 1:1, says
"I don't feel safe with him, I felt threatened" other
Mak MHT reassigned to Haneef. Will continue to
monitor pt via 1:1 observed for safety of self &
other ———— Surfa

11-5-15 4⁴⁵ NSS Observed pt sleeping soundly in room
2AM. Will continue to monitor pt per protocol Surfa

11-5-15 6¹⁰ NSS pt woke up around 5AM, Calmer
pt is aware that MHC today. ———— Surfa

11-5-15 7A NSS 10AM Ability & Nicotine Patch given
to pt, VIC (BP) 110/66 @ 35.7 @ 94 @ 18 ———— Surfa

Mercy Philadelphia Hospital
A member of Mercy Health System

Interdisciplinary Integrated
Progress Notes



Page 1 of 2
Form M1133, Rev. 11/2009
PON X PROGRESS

CHILDS, HANEEF A

DOB [REDACTED] 27Y M

[REDACTED]



COUNSELOR GROUP NOTE

DATE: 11.5.15 TIME: 1045A GROUP DURATION: 45 MINUTES

GROUP TOPIC(S) AS IT PERTAINS TO THE TREATMENT PLAN: Developing Supports

Psychoeducation: Problem Solving and working with others

ATTENDANCE:

- ☐ Minimal encouragement required
☒ Did not attend

- ☐ Repeated encouragement required
☒ Excused (MENTAL HEALTH CARE)

ENTRY STATE:

- ☐ Relaxed/calm
☐ Agitated/anxious
☐ Sad affect

- ☐ Euphoric
☐ Angry

- ☐ Blunted affect
☐ Withdrawn

PROBLEM ARE FOCUS:

- ☒ Aggression/anger management
☒ Agitation/anxiety
☒ Coping/stress
☒ Denial of problem

- ☒ Discharge issues
☒ Maintain sobriety
☒ Relationship issues
☒ Spiritual issues

- ☒ Impulse control
☒ Physical complaints
☒ Self concept
☐ Other: _____

LEVEL OF PARTICIPATION:

- ☐ Active
☐ Alert but passive
☐ Sleeping

- ☐ Intrusive
☐ Left group
☐ Interactive

- ☐ Uninvested
☐ Other: _____

FACILITATOR'S INTERVENTION:

- ☐ Assist problem-solving
☐ Redirective/prompting
☐ Directed to resources

- ☒ Structured activity
☐ Encourage group feedback
☐ Supportive

- ☒ Education
☐ Other: _____

OUTCOME:

- ☐ Meeting goals of treatment plan
☐ Expressed thoughts and feelings
☐ Gained insight into problem areas
☐ Helped peers with their problems

- ☐ Identified coping strategies
☐ Identified symptoms/problems
☐ Minimal progress
☐ Other: _____

DEPARTURE STATE:

- ☐ Agitated/anxious
☐ Angry
☐ Flat affect
☐ Bright affect

- ☐ Confused/frustrated
☐ Depressed
☐ Withdrawn
☐ Blunted affect

- ☐ Relaxed/calm
☐ Sad affect
☐ Other: _____

 Mercy Philadelphia Hospital
A member of Mercy Health System

COUNSELOR GROUP NOTE



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Form PS336 Rev. 01/2011
PCS, X OTHER

CHILDS, HANEEF A

27 M

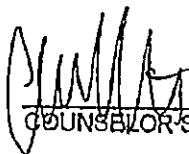


SUMMARY/COMMENTS/PLANS:

D) Group Focuses on the development of effective problem-solving techniques. Consumers work with counselor and peers to create a six-step problem-solving model: 1) recognize and identify problems and challenges 2) identify various ways of solving problems 3) evaluate potential positive and negative consequences of each solution set 4) identify resources to help aid in problem-solving 5) select the best possible solution 6) identify supports for following through with this plan. Consumers are encouraged to apply steps to treatment.

A) Despite repeated encouragement, client did not attend.

P) Consumer will be encouraged to attend all future groups. Staff will meet with client individually to review group materials.



COUNSELOR SIGNATURE AND CREDENTIALS

11-9-15
Date

11:30a
Time

Mercy Philadelphia Hospital
A member of Mercy Health System

COUNSELOR GROUP NOTE



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Form PS336, Rev. 01/2011
PCS X OTHER

CHILDS, HANEEF A

27 M

[REDACTED]



11-5-15

1:20 PM

Psychiatrists: Mental Health Court Note

Mr. [redacted] for purpose of 303 hearing yesterday in ZNF and today at Mental Health Court. Mental Status Examination.

Mr. [redacted] is unkempt and markedly agitated. His loud and pressured speech with tangential thought process.

Markedly paranoid & makes suicidal threats. Poor insight.

APP

Expert testimony & his suicide attempt was presented before the court. Mr. [redacted] was committed for up to 20 days of inpatient treatment. On 11-5-15, Mr. [redacted] was self-harming and required sedation at mental health court.

JM (MAGSW)

610-908-7351

11-5-15

Ng 9 Note

It was noted the mental health court. That you completed and staff. idly. make an effort to feel. It was further noted that you were distressed. Staff will work to make an effort. [redacted] 8/17

Mercy Philadelphia Hospital
A member of Mercy Health System

Interdisciplinary Integrated
Progress Notes



Page 2 of 2
Form MR133, Rev. 11/2008
PGN X-PROGRESS

CHILDS, HANEEF A

27Y M



COUNSELOR GROUP NOTE

DATE: 11/5/15 TIME: 2PM GROUP DURATION: 45MINS

GROUP TOPIC(S) AS IT PERTAINS TO THE TREATMENT PLAN: _____

Stress Management

ATTENDANCE:

- ☐ Minimal encouragement required
☐ Did not attend
☐ Repeated encouragement required
☒ Excused

ENTRY STATE:

- ☐ Relaxed/calm
☐ Agitated/anxious
☐ Sad affect
☐ Euphoric
☐ Angry
☐ Blunted affect
☐ Withdrawn

PROBLEM ARE FOCUS:

- ☐ Aggression/anger management
☐ Agitation/anxiety
☐ Coping/stress
☐ Denial of problem
☐ Discharge issues
☐ Maintain sobriety
☐ Relationship issues
☐ Spiritual issues
☐ Impulse control
☐ Physical complaints
☐ Self concept
☐ Other: _____

LEVEL OF PARTICIPATION:

- ☐ Active
☐ Alert but passive
☐ Sleeping
☐ Intrusive
☐ Left group
☐ Interactive
☐ Uninvested
☐ Other: _____

FACILITATOR'S INTERVENTION:

- ☐ Assist problem-solving
☐ Redirective/prompting
☐ Directed to resources
☐ Structured activity
☐ Encourage group feedback
☐ Supportive
☐ Education
☐ Other: _____

OUTCOME:

- ☐ Meeting goals of treatment plan
☐ Expressed thoughts and feelings
☐ Gained insight into problem areas
☐ Helped peers with their problems
☐ Identified coping strategies
☐ Identified symptoms/problems
☐ Minimal progress
☐ Other: _____

DEPARTURE STATE:

- ☐ Agitated/anxious
☐ Angry
☐ Flat affect
☐ Bright affect
☐ Confused/frustrated
☐ Depressed
☐ Withdrawn
☐ Blunted affect
☐ Relaxed/calm
☐ Sad affect
☐ Other: _____

Mercy Philadelphia Hospital
A member of Mercy Health System

COUNSELOR GROUP NOTE



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Form PS336 Rev. 01/2011
POS X OTHER

CHILDS, HANEEF A

27Y M



245

SUMMARY/COMMENTS/PLANS:

D- The group focused on the physical aspects of stress and tool for managing it. After discussing specific stressors and past tools that clients utilized, the group participated in worksheets focused on various ways to handle stress.

A- Individual did not attend group as was at mental health court and will be encouraged to attend all groups in the future.

P- Will continue to offer opportunities for therapeutic growth and encourage clients to continue utilizing various techniques for stress.

POOR QUALITY ORIGINAL

[Signature]
COUNSELOR SIGNATURE AND CREDENTIALS

11/5/15 3PM
Date Time

Mercy Philadelphia Hospital
A member of Mercy Health System

COUNSELOR GROUP NOTE



Page 2 of 2
Form PS316, Rev. 01/2011
PCS X OTHER

CHILDS, HANEEF A

27 M



COUNSELOR GROUP NOTE

DATE: 11/6/15 TIME: 2PM GROUP DURATION: 45MINS

GROUP TOPIC(S) AS IT PERTAINS TO THE TREATMENT PLAN: _____

Acceptance and Change in Recovery

ATTENDANCE:

- | | |
|---|--|
| ☐ Minimal encouragement required | ☐ Repeated encouragement required |
| ☒ Did not attend | ☐ Excused |

ENTRY STATE:

- | | | |
|---|-----------------------------------|---|
| ☐ Relaxed/calm | ☐ Euphoric | ☐ Blunted affect |
| ☐ Agitated/anxious | ☐ Angry | ☐ Withdrawn |
| ☐ Sad affect | | |

PROBLEM ARE FOCUS:

- | | | |
|--|--|--|
| ☐ Aggression/anger management | ☐ Discharge issues | ☐ Impulse control |
| ☐ Agitation/anxiety | ☐ Maintain sobriety | ☐ Physical complaints |
| ☐ Coping/stress | ☐ Relationship issues | ☐ Self concept |
| ☐ Denial of problem | ☐ Spiritual issues | ☐ Other: _____ |

LEVEL OF PARTICIPATION:

- | | | |
|--|--------------------------------------|---------------------------------------|
| ☐ Active | ☐ Intrusive | ☐ Uninvested |
| ☐ Alert but passive | ☐ Left group | ☐ Other: _____ |
| ☐ Sleeping | ☐ Interactive | |

FACILITATOR'S INTERVENTION:

- | | | |
|---|---|---------------------------------------|
| ☐ Assist problem-solving | ☐ Structured activity | ☐ Education |
| ☐ Redirective/prompting | ☐ Encourage group feedback | ☐ Other: _____ |
| ☐ Directed to resources | ☐ Supportive | |

OUTCOME:

- | | |
|--|---|
| ☐ Meeting goals of treatment plan | ☐ Identified coping strategies |
| ☐ Expressed thoughts and feelings | ☐ Identified symptoms/problems |
| ☐ Gained insight into problem areas | ☐ Minimal progress |
| ☐ Helped peers with their problems | ☐ Other: _____ |

DEPARTURE STATE:

- | | | |
|---|--|---------------------------------------|
| ☐ Agitated/anxious | ☐ Confused/frustrated | ☐ Relaxed/calm |
| ☐ Angry | ☐ Depressed | ☐ Sad affect |
| ☐ Flat affect | ☐ Withdrawn | ☐ Other: _____ |
| ☐ Bright affect | ☐ Blunted affect | |

 Mercy Philadelphia Hospital
A member of Mercy Health System

COUNSELOR GROUP NOTE



Page 1 of 2
Form PS338 Rev. 01/2011
PCS X OTHER

CHILDS, HANEEF A

27Y M

[Redacted Address]



SUMMARY/COMMENTS/PLANS:

D - The group focused on the serenity prayer and differentiating between things one can change versus cannot change. They were asked to choose one item from a generated list of possible areas of change and reflect on steps they could take and the impact making that change would have on their life.
A - Client did not attend group despite repeated encouragement and will be encouraged to attend all groups in the future.
P - Will continue to offer opportunities for therapeutic growth and self-reflection.

POOR QUALITY ORIGINAL

A. Sussa, MPhI
COUNSELOR SIGNATURE AND CREDENTIALS

11/6/15 3PM
Date Time

Morey Philadelphia Hospital
A Division of Morey Health System

COUNSELOR GROUP NOTE



Page 2 of 2
Form PS336, Rev. 01/2011
PCS X OTHER

CHILDS, HANEEF A

27 M



COUNSELOR GROUP NOTE

DATE: 11/10/15 TIME: 10:45AM GROUP DURATION: 45 MIN

GROUP TOPIC(S) AS IT PERTAINS TO THE TREATMENT PLAN: Treatment goals

Psychoeducation: Treatment goals (highlighting short + long-term treatment goals)

ATTENDANCE:

- | | |
|---|---|
| ☐ Minimal encouragement required | ☒ Repeated encouragement required |
| ☐ Did not attend | ☐ Excused |

ENTRY STATE:

- | | | |
|--|-----------------------------------|---|
| ☒ Relaxed/calm | ☐ Euphoric | ☐ Blunted affect |
| ☐ Agitated/anxious | ☐ Angry | ☐ Withdrawn |
| ☐ Sad affect | | |

PROBLEM ARE FOCUS:

- | | | |
|---|---|---|
| ☒ Aggression/anger management | ☒ Discharge issues | ☒ Impulse control |
| ☒ Agitation/anxiety | ☒ Maintain sobriety | ☒ Physical complaints |
| ☒ Coping/stress | ☒ Relationship issues | ☒ Self concept |
| ☒ Denial of problem | ☒ Spiritual issues | ☐ Other: _____ |

LEVEL OF PARTICIPATION:

- | | | |
|--|--------------------------------------|---------------------------------------|
| ☒ Active | ☐ Intrusive | ☐ Uninvested |
| ☐ Alert but passive | ☐ Left group | ☐ Other: _____ |
| ☐ Sleeping | ☐ Interactive | |

FACILITATOR'S INTERVENTION:

- | | | |
|--|---|---|
| ☒ Assist problem-solving | ☒ Structured activity | ☒ Education |
| ☐ Redirective/prompting | ☐ Encourage group feedback | ☐ Other: _____ |
| ☐ Directed to resources | ☐ Supportive | |

OUTCOME:

- | | |
|---|--|
| ☒ Meeting goals of treatment plan | ☒ Identified coping strategies |
| ☒ Expressed thoughts and feelings | ☒ Identified symptoms/problems |
| ☐ Gained insight into problem areas | ☐ Minimal progress |
| ☐ Helped peers with their problems | ☐ Other: _____ |

DEPARTURE STATE:

- | | | |
|---|--|--|
| ☐ Agitated/anxious | ☐ Confused/frustrated | ☒ Relaxed/calm |
| ☐ Angry | ☐ Depressed | ☐ Sad affect |
| ☐ Flat affect | ☐ Withdrawn | ☐ Other: _____ |
| ☐ Bright affect | ☐ Blunted affect | |

Mercy Philadelphia Hospital
A member of Mercy Health System

COUNSELOR GROUP NOTE



CHILDS, HANEEF A

27 M



SUMMARY/COMMENTS/PLANS:

D) Group is a dynamic discussion of treatment objectives providing opportunities to review related issues such as length of hospital stay, medication and treatment expectations and the factors impacting these issues (support, recovery, housing and medical issues.) Consumers are also encouraged to address presenting issues such as symptoms and stressors contributing to hospitalization.

A) Haneef actively engaged in group process as evidenced by his verbalization of participating in treatment by sleeping regularly and praying.

E) Consumers are encouraged to continue to work towards resolution of treatment goals with staff and peers. They will also be encouraged to integrate these concepts into ongoing course of treatment, aftercare and ongoing recovery process.

KD-S (BA Psychology)

COUNSELOR SIGNATURE AND CREDENTIALS

11/10/15

Date

(2PM)

Time

Mercy Philadelphia Hospital
A member of Mercy Health System

COUNSELOR GROUP NOTE



Page 2 of 2
Form PS336, Rev. 01/2011
PCS.X OTHER

CHILDS, HANEEF A

27 M



COUNSELOR GROUP NOTE

DATE: 11/10/13 TIME: 2PM GROUP DURATION: 45MINS

GROUP TOPIC(S) AS IT PERTAINS TO THE TREATMENT PLAN: _____

Positive Affirmations

ATTENDANCE:

- | | |
|--|--|
| ☒ Minimal encouragement required | ☐ Repeated encouragement required |
| ☐ Did not attend | ☐ Excused |

ENTRY STATE:

- | | | |
|--|-----------------------------------|---|
| ☒ Relaxed/calm | ☐ Euphoric | ☐ Blunted affect |
| ☐ Agitated/anxious | ☐ Angry | ☐ Withdrawn |
| ☐ Sad effect | | |

PROBLEM ARE FOCUS:

- | | | |
|---|---|--|
| ☒ Aggression/anger management | ☒ Discharge issues | ☐ Impulse control |
| ☒ Agitation/anxiety | ☒ Maintain sobriety | ☐ Physical complaints |
| ☒ Coping/stress | ☒ Relationship issues | ☒ Self concept |
| ☐ Denial of problem | ☐ Spiritual issues | ☐ Other: _____ |

LEVEL OF PARTICIPATION:

- | | | |
|--|--|---------------------------------------|
| ☒ Active | ☐ Intrusive | ☐ Uninvested |
| ☐ Alert but passive | ☒ Left group | ☐ Other: _____ |
| ☐ Sleeping | ☐ Interactive | |

FACILITATOR'S INTERVENTION:

- | | | |
|--|--|---|
| ☒ Assist problem-solving | ☒ Structured activity | ☒ Education |
| ☒ Redirective/prompting | ☒ Encourage group feedback | ☐ Other: _____ |
| ☐ Directed to resources | ☒ Supportive | |

OUTCOME:

- | | |
|---|--|
| ☒ Meeting goals of treatment plan | ☒ Identified coping strategies |
| ☒ Expressed thoughts and feelings | ☒ Identified symptoms/problems |
| ☐ Gained insight into problem areas | ☐ Minimal progress |
| ☐ Helped peers with their problems | ☐ Other: _____ |

DEPARTURE STATE:

- | | | |
|---|--|--|
| ☐ Agitated/anxious | ☐ Confused/frustrated | ☒ Relaxed/calm |
| ☐ Angry | ☐ Depressed | ☐ Sad affect |
| ☐ Flat affect | ☐ Withdrawn | ☐ Other: _____ |
| ☐ Bright affect | ☐ Blunted affect | |

 **Mercy Philadelphia Hospital**
A member of Mercy Health System

COUNSELOR GROUP NOTE



Page 1 of 2
Form PS336 Rev. 01/2011
PCS X.OTHER

CHILDS, HANEET A

27Y M



SUMMARY/COMMENTS/PLANS:

D-Group focused on the use of positive affirmations as a tool to combat low self-esteem. After self-generating a list of their own positive and negative traits, individuals came up with an affirmation to help maintain positive self talk.

A- Hameef actively engaged in group process as evidenced by identification of positive and negative traits. However, he left early due to "negative energy".

P- Continue to offer opportunities for therapeutic growth and skill building.

POOR QUALITY ORIGINAL

A. Swissa, MPhil
COUNSELOR SIGNATURE AND CREDENTIALS

11/10/15 3PM
Date Time

Mercy Philadelphia Hospital
A member of Mercy Health System

COUNSELOR GROUP NOTE



Page 2 of 2
Form PS336, Rev. 01/2011
PCS X, OTHER

CHILDS, HAMEEF A

DOB [REDACTED] 27 M



COUNSELOR GROUP NOTE

DATE: 11/11/15 TIME: 2PM GROUP DURATION: 45MINS

GROUP TOPIC(S) AS IT PERTAINS TO THE TREATMENT PLAN: Interpersonal Skills

ATTENDANCE:

- | | |
|--|--|
| ☒ Minimal encouragement required | ☐ Repeated encouragement required |
| ☐ Did not attend | ☐ Excused |

ENTRY STATE:

- | | | |
|--|-----------------------------------|---|
| ☒ Relaxed/calm | ☐ Euphoric | ☐ Blunted affect |
| ☐ Agitated/anxious | ☐ Angry | ☐ Withdrawn |
| ☐ Sad effect | | |

PROBLEM ARE FOCUS:

- | | | |
|---|---|---|
| ☒ Aggression/anger management | ☒ Discharge issues | ☒ Impulse control |
| ☒ Agitation/anxiety | ☒ Maintain sobriety | ☐ Physical complaints |
| ☒ Coping/stress | ☒ Relationship issues | ☒ Self concept |
| ☐ Denial of problem | ☐ Spiritual issues | ☐ Other: _____ |

LEVEL OF PARTICIPATION:

- | | | |
|--|--|---------------------------------------|
| ☒ Active | ☐ Intrusive | ☐ Uninvested |
| ☐ Alert but passive | ☒ Left group | ☐ Other: _____ |
| ☐ Sleeping | ☐ Interactive | |

FACILITATOR'S INTERVENTION:

- | | | |
|---|--|---|
| ☐ Assist problem-solving | ☒ Structured activity | ☒ Education |
| ☒ Redirective/prompting | ☒ Encourage group feedback | ☐ Other: _____ |
| ☐ Directed to resources | ☒ Supportive | |

OUTCOME:

- | | |
|---|--|
| ☒ Meeting goals of treatment plan | ☒ Identified coping strategies |
| ☒ Expressed thoughts and feelings | ☒ Identified symptoms/problems |
| ☐ Gained insight into problem areas | ☐ Minimal progress |
| ☐ Helped peers with their problems | ☐ Other: _____ |

DEPARTURE STATE:

- | | | |
|---|--|--|
| ☐ Agitated/anxious | ☐ Confused/frustrated | ☒ Relaxed/calm |
| ☐ Angry | ☐ Depressed | ☐ Sad affect |
| ☐ Flat affect | ☐ Withdrawn | ☐ Other: _____ |
| ☐ Bright affect | ☐ Blunted affect | |

Mercy Philadelphia Hospital
A member of Mercy Health System

COUNSELOR GROUP NOTE



Page 1 of 2
Form PS336 Rev 01/2011
PC9,X,OTHER

CHILDS, HANEEF A

28 27Y M



SUMMARY/COMMENTS/PLANS:

D-The group focused on interpersonal skills and socializing in a healthy environment. Clients were given a variety of activities to choose from and engage with others.

A-Haneef actively engaged in group process as evidenced by participation in playing and healthy interactions with peers. However, he left in the middle and did not return.

P-Will continue to offer opportunities for therapeutic growth and interpersonal interaction.

POOR QUALITY ORIGINAL

Quissa, MPhil

COUNSELOR SIGNATURE AND CREDENTIALS

11/11/15 3PM

Date

Time

Mercy Philadelphia Hospital
A member of Mercy Health System

COUNSELOR GROUP NOTE



Page 2 of 2
Form PS336, Rev. 01/2011
PCS.X.OTHER

CHILDS, HANEEF A

27 M



COUNSELOR GROUP NOTE

DATE: 11/12/15 TIME: 2PM GROUP DURATION: 45MINS

GROUP TOPIC(S) AS IT PERTAINS TO THE TREATMENT PLAN: _____

Stress management

ATTENDANCE:

- ☒ Minimal encouragement required
☐ Did not attend

- ☐ Repeated encouragement required
☐ Excused

ENTRY STATE:

- ☒ Relaxed/calm
☐ Agitated/anxious
☐ Sad effect

- ☐ Euphoric
☐ Angry

- ☐ Blunted affect
☐ Withdrawn

PROBLEM ARE FOCUS:

- ☐ Aggression/anger management
☒ Agitation/anxiety
☒ Coping/stress
☐ Denial of problem

- ☒ Discharge issues
☐ Maintain sobriety
☐ Relationship issues
☐ Spiritual issues

- ☒ Impulse control
☐ Physical complaints
☐ Self concept
☐ Other: _____

LEVEL OF PARTICIPATION:

- ☒ Active
☐ Alert but passive
☐ Sleeping

- ☐ Intrusive
☐ Left group
☐ Interactive

- ☐ Uninvested
☐ Other: _____

FACILITATOR'S INTERVENTION:

- ☒ Assist problem-solving
☐ Redirective/prompting
☐ Directed to resources

- ☒ Structured activity
☒ Encourage group feedback
☒ Supportive

- ☒ Education
☐ Other: _____

OUTCOME:

- ☒ Meeting goals of treatment plan
☒ Expressed thoughts and feelings
☒ Gained insight into problem areas
☐ Helped peers with their problems

- ☒ Identified coping strategies
☒ Identified symptoms/problems
☐ Minimal progress
☐ Other: _____

DEPARTURE STATE:

- ☐ Agitated/anxious
☐ Angry
☐ Flat affect
☐ Bright affect

- ☐ Confused/frustrated
☐ Depressed
☐ Withdrawn
☐ Blunted affect

- ☒ Relaxed/calm
☐ Sad affect
☐ Other: _____

Mercy Philadelphia Hospital
A member of Mercy Health System

COUNSELOR GROUP NOTE



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PCS X OTHER

CHILDS, HANEEF A

27 M



SUMMARY/COMMENTS/PLANS:

D- The group focused on the physical aspects of stress and tool for managing it. After discussing specific stressors and past tools that clients utilized, the group participated in worksheets focused on various ways to handle stress.

A- Haneef actively engaged in group process as evidenced by verbalization of relationships as a major stressor and using creative arts to cope.

P- Will continue to offer opportunities for therapeutic growth and encourage clients to continue utilizing various techniques for stress.

POOR QUALITY ORIGINAL

[Signature]
COUNSELOR SIGNATURE AND CREDENTIALS

11/12/15 *3PM*
Date Time

Meroy Philadelphia Hospital
A member of Meroy Health System

COUNSELOR GROUP NOTE



Page 2 of 2
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PCS X OTHER

CHILDS, HANEEF A

27 M



MERCY HEALTH SYSTEM
MERCY PHILADELPHIA LABORATORY
501 SOUTH 54th STREET
PHILADELPHIA PA, 19143
SAMIA HENIEN, M.D. MEDICAL DIRECTOR

LABORATORY REPORT

NAME: CHILDS, HANEEF A
AGE/SEX: 27/M
ATTEND DR: MAQSOOD, TAHIR, MD

DOS: 11/02/15
ACCT: [REDACTED]

LOC: PH2NE
HR: [REDACTED]

KEY H - Abn High *H - Critical High * - High or Low (Alpha results) # - Delta Check
L - Abn Low *L - Critical Low * - Microbiology Abn Result

Test	Day	Date	Time	Result	Reference	Units
=> AMPHET UR SCREE	10	NOV 12	UNK	NEGATIVE	(NEGATIVE)	
=> BARB URINE SCRE	10	NOV 12	UNK	NEGATIVE	(NEGATIVE)	
=> BENZO UR SCREEN	10	NOV 12	UNK	NEGATIVE	(NEGATIVE)	
=> COCAINE UR SCR	10	NOV 12	UNK	NEGATIVE	(NEGATIVE)	
=> METHADONE UR SC	10	NOV 12	UNK	NEGATIVE	(NEGATIVE)	
=> OPIATES UR SCR	10	NOV 12	UNK	NEGATIVE	(NEGATIVE)	
=> PCP URINE SCREE	10	NOV 12	UNK	NEGATIVE	(NEGATIVE)	
=> THC UR SCREEN	10	NOV 12	UNK	NEGATIVE	(NEGATIVE)	
=> PROPOXYPHENE, U	10	NOV 12	UNK	NEGATIVE	(NEGATIVE)	
=> TCA UR SCREEN	10	NOV 12	UNK	(a)	(NEGATIVE)	
=> OXYCODONE UR SC	10	NOV 12	UNK	(c)	(NEGATIVE)	

NOTES: (a) NEGATIVE

See also (b)

- (b) Screening test only. Result is presumptive.
Cutoff concentration for a positive result is:
- | | |
|---------------------|-----------|
| Amphetamines | 500 ng/mL |
| Benzodiazepines | 100 ng/mL |
| Cocaine | 300 ng/mL |
| Cannabinoids (THC) | 50 ng/mL |
| Opiates | 300 ng/mL |
| Tricyclics | 300 ng/mL |
| Phencyclidine (PCP) | 25 ng/mL |
| Barbiturates | 200 ng/mL |
| Methadone | 300 ng/mL |
| Propoxyphene | 300 ng/mL |

(c) NEGATIVE

Screening test only. Result is presumptive.
Cutoff concentration for a positive result is 100 ng/mL.

NAME: CHILDS, HANEEF A

UNIT: M000611175

PRINTED: 11/15/15 0001

ACCT: [REDACTED]

PAGE: 1 ** CONTINUED ON NEXT PAGE **

MERCY HEALTH SYSTEM
MERCY PHILADELPHIA LABORATORY
501 SOUTH 54th STREET
PHILADELPHIA PA, 19143
SAMIA HENIEN, M.D. MEDICAL DIRECTOR

LABORATORY REPORT

NAME: CHILDS, HANEEF A DOS: 11/02/15 LOC: PH2NE
AGE/SEX: 27/M ACCT: MF
ATTEND DR: MAQSOOD, TAHIR, MD

KEY H - Abn High *H - Critical High * - High or Low (Alpha results) # - Delta Check
L - Abn Low *L - Critical Low * - Microbiology Abn Result

MERCY PHILADELPHIA CANCELED SPECIMEN LIST

PH1102:UC00004S CAN. Coll: 11/02/15-0121 Recd: - (R00983826) TRAN, JUDITH T, MD
Ordered: DRUG SCREEN URI
Comment: Auto-cancelled after 3 days.

NAME: CHILDS, HANEEF A

UNIT: M000611175

PRINTED: 11/15/15 0001

ACCT: **
PAGE: 2 ** END OF REPORT **

Mercy Philadelphia Hospital
Mercy Health System
Department of Radiology
5301 Cedar Avenue
Philadelphia PA 19143
215-748-9432

David P Mayer, MD/MS,FACR, Chairman
Robert Borden, MD
Aaron Brandis, MD
Michael Brooks, MD, JD
Fraser Brown, MD

Stanley Chan, MD
Malgorzata Goralczyk, MD
Caroline Ho, MD
Justin Mackey, MD
John Manning, MD

Scott Rotenberg, MD
Gimble Shah, MD
Selmi Sirmans, MD
Oleg Teytelboym, MD

Patient: **CHILDS,HANEEF A**
Med Rec #: **M000611175**
Date of Birth: [REDACTED] Gender: M
Phone #: [REDACTED]
Ordering Physician: **HALLUR,RAVINDRA C, MD**
CC:
Order Date: **11/10/15**

Acct #: [REDACTED]
Order #: **1111-0026**
Accession #: **564608.001**
Report #: **1111-0118**

Exam Date: **11/11/15**
Status: **ADM IN**
Location: **208-1**
RAD #:

Procedure Reason: Left subconjunctival hemorrhage

Exam: CT Brain WO

***** Signed Status *****

IMPRESSION:

1. Brain within normal limits.
2. Sinus thickening.

INDICATION: 27 years old; Male. Symptom/Location/Duration: Left sub-conjunctival hemorrhage. Schizophrenia.

TECHNIQUE: Unenhanced CT of the head with axial, coronal, sagittal reformats. Comparison: None

FINDINGS:

POSTOPERATIVE CHANGES: None.

BRAIN VOLUME: Normal volume for age.

ACUTE INFARCT: No focal hypodensity to suggest acute infarct.

CHRONIC INFARCT: None.

MASS LESIONS: None.

WHITE MATTER: White matter is within normal limits.

HEMORRHAGE: No intracranial hemorrhage.

VASCULATURE: No hyperdense vascular thrombus. No calcified intracranial plaque.

MSK: No fractures or soft tissue swelling.

SINUSES/MASTOIDS: There is mucoperiosteal thickening in the ethmoid sinuses. A tiny cyst or polyp is seen in the superior aspect of the right maxillary sinus. The sinuses are incompletely evaluated in this noncontrast head CT. Mastoid air cells are clear.

OTHER: None.

Thank you for choosing Mercy Health System

<Electronically signed by MICHAEL L BROOKS, MD in OV>
Clinical Associate Professor of Radiology, Drexel Univ. College of Medicine

e-Sign Pager: (610)221-9213

Interpreting: **BROOKS, MICHAEL L MD** Dictated: 11/11/15 1250

Signoff: 11/11/15 1251

PATIENT IMAGES or REPORTS: (215) 748-9432

SCHEDULING: (610) 237-2525

DATE: 11/14/15 @ 0012
USER: PHTURCOT

Mercy Philadelphia Hospital PHA *LIVE*
PHA Intervention List
From 11/03/15 Thru 11/14/15

PAGE 1

Date	Time Required	User	Status	Intervention	Intervention Name	Workload	Count
11/04/15		PHTURCOT	C	INAPFORM	INAPPROPRIATE DOSAGE FORM		
<u>Staff Type</u> <u>Staff Member</u>							
PHARM	PHTURCOT	THOMAS F TURCO					
<u>Drug</u> <u>Drug Name</u> <u>Generic</u> <u>Class</u> <u>Keywords</u>							
ARIP10TA2	ARIPiprazole			ARIPIP	28:16.08		
ARIP15TA2	ABILIFY						
<u>Related Rx</u> <u>Generic Name</u>							
Patient	CHILDS, HANEEF A		Account Num	PA1303162331	Location	PH2NE	Room 208 Bed 1
Severity	MI	MINOR					
Outcome	OPT	OPTIMIZE DRUG THERAPY					

DATE: 11/14/15 @ 0010
USER: CONOVITH

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 1

Patient **CHILDS, HANEFF A** Responsible Doctor MAQSOOD, TAHIR, MD
Account Number PA1303162331 Location PH2NE Unit Number M000611179
Age/Sex 27/M Room 208 Registered Date 11/03/15
Status DIS IN Bed 1 Discharged Date 11/13/15

Height 5 ft 7.75 in 172.09 cm Body Surface Area 1.72 m2
Weight 134 lb 7.71 oz 61 kg
Hem-Onc No

Transfers

FROM: 210-1 TO: 208-1 on 11/10/15-2228
FROM: 218-3 TO: 210-1 on 11/04/15-1415

Drug Allergies quetiapine (From Seroquel)

ADRS

Creatinine Test Results
No results available.

POLY15DR17 - POLYVINYL ALCOHOL 15 ML DROPS (AKWA TEARS)

Dose 1 DROPS (0.066667 OPHTHALMIC SOLUTIONS)
Admin Route EYE BOTH
Frequency Q4H (PRN) PAR= PRN REASON: DRY - DRYNESS
Start Date 11/06/15-1245 Stop Date None DC Date 11/13/15-1530
Ordering Doctor PUESAN, REYNALDO MD
Total Dispensed 2 Total Costs \$5.76 Total Charges \$47.50
Rx Number 001425204

Discontinue Comments DC'd by Discharge

History

11/06/15 1233 - POM ORDER by COPUESAR
11/06/15 1246 - VERIFIED by PHMATHEL
Items Dispensed: 1 Doses Dispensed: 1
For: 11/06/15 - 1245
11/09/15 0551 - DEBIT by PHPATEAS
ITEMS: 1
11/13/15 1551 - DISCONTINUE by DISCHARGE Eff: 11/13/15 1530
DC COMMENTS:
DC'd by Discharge

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
11/07/15	0037	PHHAMILJ	Y			1	
					Dose: 1 DROPS		
11/07/15	0608	PHHAYESS	Y			1	
					Dose: 1 DROPS		
11/08/15	0024	PHCOSTEP	Y			1	
					Dose: 1 DROPS		
11/08/15	2103	PHCOSTEP	Y			1	

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 2

Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number	PA1303162331	Location	PH2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Unit Number	M000611175
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

		Dose: 1 DROPS	
11/09/15	1417 PHCLEMEL	Y	1
		Dose: 1 DROPS	
11/09/15	1638 PHHAMILJ	Y	1
		Dose: 1 DROPS	
11/10/15	0043 PHPARKSU	Y	1
		Dose: 1 DROPS	
11/10/15	0620 PHPARKSU	Y	1
		Dose: 1 DROPS	
11/10/15	1216 PHBAHMOH	Y	1
		Dose: 1 DROPS	
11/11/15	0617 PHCLEMEL	Y	1
		Dose: 1 DROPS	
11/12/15	1138 PHCLEMEL	Y	1
		Dose: 1 DROPS	
11/13/15	0624 PHPARKSU	Y	1
		Dose: 1 DROPS	

Admin Totals

12

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 3

Patient **CHILDS, HANEEF A** Responsible Doctor MAQSOOD, TAHIR, MD
Account Number PA1303162331 Location PH2NE Unit Number M000611175
Age/Sex 27/M Room 208 Registered Date 11/03/15
Status DIS IN Bed 1 Discharged Date 11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

ACET325T10 - ACETAMINOPHEN 325 MG TABLET (TYLENOL)

Dose 650 MG (2 TABLETS)

Admin Route PO

Frequency Q4H (PRN) PAR= PRN REASON: P - PAIN

Start Date 11/02/15-2300

Stop Date None

DC Date 11/13/15-1530

Ordering Doctor NOVITSKY, MARK A. MD

Total Dispensed 8

Total Costs \$0.12

Total Charges \$10.00

Rx Number 001420982

Discontinue Comments DC'd by Discharge

History

11/02/15 2306 - POM ORDER

by CONOVITM

11/02/15 2312 - EDIT

by PHPATEAS

FROM:

DUPLICATE COMMENT:

TO:

DUPLICATE COMMENT: RPH

11/02/15 2312 - VERIFIED

by PHPATEAS

Items Dispensed: 0

Doses Dispensed: 0

11/07/15 0911 - DEBIT

by MSEARIGHT

ITEMS: 2 DOSES: 1

11/07/15 2125 - DEBIT

by PFERRY

ITEMS: 2 DOSES: 1

11/08/15 2126 - DEBIT

by PFERRY

ITEMS: 2 DOSES: 1

11/11/15 1427 - DEBIT

by STEWART

ITEMS: 2 DOSES: 1

11/13/15 1551 - DISCONTINUE

by DISCHARGE Eff: 11/13/15 1530

DC COMMENTS:

DC'd by Discharge

11/13/15 1551 - EDIT

by SYSTEM

TOTAL DOSE ADMIN DATA INITIATED

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
11/07/15	2125	PHCOSTEP	Y			2	
					Dose: 650 MG		
11/08/15	1331	PHSEARIM	Y			2	
					Dose: 650 MG		
11/11/15	1428	PHSTEWAS	Y			2	
					Dose: 650 MG		

Admin Totals

6

203 243

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 4

Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number	PA1303162331	Location	PH2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Unit Number	M000611175
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

MAGN300R - (MAALOX) MAGNESIUM HYDROXIDE/AL HYDROX 30 ML ORAL.SUSP

Dose 30 ML (1 ORAL.SUSP)

Admin Route PO

Frequency Q4H (PRN) PAR= PRN REASON: IN - INDIGESTION

Start Date 11/02/15-2300

Stop Date None

DC Date 11/13/15-1530

Ordering Doctor NOVITSKY, MARK A, MD

Total Dispensed 0

Total Costs \$

Total Charges \$

Rx Number 001420983

Discontinue Comments DC'd by Discharge

History

11/02/15 2306 - POM ORDER

by CONOVITM

11/02/15 2312 - EDIT

by PHPATEAS

FROM:

DUPLICATE COMMENT:

TO:

DUPLICATE COMMENT: RPH

11/02/15 2312 - VERIFIED

by PHPATEAS

Items Dispensed: 0

Doses Dispensed: 0

11/13/15 1551 - DISCONTINUE

by DISCHARGE

Eff: 11/13/15 1530

DC COMMENTS:

DC'd by Discharge

11/13/15 1551 - EDIT

by SYSTEM

TOTAL DOSE ADMIN DATA INITIATED

2901

DATE: 11/14/15 @ 0010
USER: CONOVITH

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 5

Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Num		Location	PH2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Unit Number	M000611175
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

MAGN400010 - (MILK OF MAGNESIA) MAGNESIUM HYDROXIDE 30 ML ORAL SUSP

Dose 30 ML (1 ORAL SUSP)

Admin Route PO

Frequency BEDTIME (PRN) PAR= PRN REASON: C - CONSTIPATION

Start Date 11/02/15-2300

Stop Date None

DC Date 11/13/15-1530

Ordering Doctor NOVITSKY, MARK A, MD

Total Dispensed 0

Total Costs \$

Total Charges \$

Rx Number 001420984

Discontinue Comments DC'd by Discharge

History

11/02/15 2306 - POM ORDER

by CONOVITH

11/02/15 2312 - EDIT

by PHPATEAS

FROM:

DUPLICATE COMMENT:

TO:

DUPLICATE COMMENT: RPH

11/02/15 2312 - VERIFIED

by PHPATEAS

Items Dispensed: 0

Doses Dispensed: 0

11/13/15 1551 - DISCONTINUE

by DISCHARGE

Eff: 11/13/15 1530

DC COMMENTS:

DC'd by Discharge

11/13/15 1551 - EDIT

by SYSTEM

TOTAL DOSE ADMIN DATA INITIATED

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 6

Patient	CHILDS, HANEEF A *	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number		Location	PH2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Unit Number	M000611175
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

HYDR25CA27 - HYDROXYZINE PAMOATE 25 MG CAPSULE (VISTARIL)

Dose	25 MG (1 CAPSULE)	
Admin Route	PO	
Frequency	Q4H (PRN) PAR= PRN REASON: A - ANXIETY	
Start Date	11/02/15-2300	Stop Date None
Ordering Doctor	NOVITSKY, MARK A, MD	DC Date 11/13/15-1530
Total Dispensed	12	Total Costs \$0.96
Rx Number	001420985	Total Charges \$15.00

Discontinue Comments DC'd by Discharge

History

11/02/15 2306 - POM ORDER

by CONOVITM

11/02/15 2312 - EDIT

by PHPATEAS

FROM:

DUPLICATE COMMENT:

TO:

DUPLICATE COMMENT: RPH

11/02/15 2312 - VERIFIED

by PHPATEAS

Items Dispensed: 0 Doses Dispensed: 0

11/05/15 0029 - DEBIT

by SPARK

ITEMS: 1 DOSES: 1

11/05/15 0838 - DEBIT

by SHAYES

ITEMS: 1 DOSES: 1

11/05/15 1712 - DEBIT

by JHAMILTON

ITEMS: 1 DOSES: 1

11/06/15 0916 - DEBIT

by MBAH

ITEMS: 1 DOSES: 1

11/08/15 0019 - DEBIT

by PFERRY

ITEMS: 1 DOSES: 1

11/08/15 0727 - DEBIT

by PFERRY

ITEMS: 1 DOSES: 1

11/09/15 1635 - DEBIT

by JHAMILTON

ITEMS: 1 DOSES: 1

11/10/15 0717 - DEBIT

by SPARK

ITEMS: 1 DOSES: 1

11/10/15 1435 - DEBIT

by LCLEMENTS

ITEMS: 1 DOSES: 1

11/11/15 1103 - DEBIT

by SSTEWARD

ITEMS: 1 DOSES: 1

11/12/15 1727 - DEBIT

by JHAMILTON

ITEMS: 1 DOSES: 1

11/13/15 0513 - DEBIT

by SPARK

ITEMS: 1 DOSES: 1

11/13/15 1551 - DISCONTINUE

by DISCHARGE Eff: 11/13/15 1530

DC COMMENTS:

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 7

Patient CHILDS, HANEEF A Responsible Doctor MAQSOOD, TAHIR, MD
Account Number Location PH2NE Unit Number M000611175
Age/Sex 27/M Room 208 Registered Date 11/03/15
Status DIS IN Bed 1 Discharged Date 11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

DC'd by Discharge
11/13/15 1551.- EDIT by SYSTEM
TOTAL DOSE ADMIN DATA INITIATED

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
11/05/15	1711	PHHAMILJ	Y			1	
		Dose: 25 MG					
11/06/15	1144	PHBAHMOH	Y			1	
		Dose: 25 MG					
11/08/15	0019	PHCOSTEP	Y			1	
		Dose: 25 MG					
11/08/15	0754	PHCOSTEP	Y			1	
		Dose: 25 MG					
11/09/15	1636	PHHAMILJ	Y			1	
		Dose: 25 MG					
11/10/15	0716	PHPARKSU	Y			1	
		Dose: 25 MG					
11/10/15	1434	PHCLEMEL	Y			1	
		Dose: 25 MG					
11/11/15	1101	PHCLEMEL	Y			1	
		Dose: 25 MG					
11/12/15	1727	PHHAMILJ	Y			1	
		Dose: 25 MG					
11/13/15	0513	PHPARKSU	Y			1	
		Dose: 25 MG					

Admin Totals

10

DATE: 11/14/15 @ 0010
USER: CONOVITH

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 8

Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number		Location	PH2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Unit Number	M000611175
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

LORA2TAB29 - LORazepam 2 MG TABLET (ATIVAN)

Dose 2 MG (1 TABLET)

Admin Route PO

Frequency Q4H (PRN) PAR= PRN REASON: AGIT - AGITATION

Start Date 11/02/15-2300

Stop Date None

DC Date 11/13/15-1530

Ordering Doctor NOVITSKY, MARK A. MD

Total Dispensed 17

Total Costs \$0.85

Total Charges \$21.25

Rx Number 001420986

Discontinue Comments DC'd by Discharge

History

11/02/15 2307 - POM ORDER

by CONOVITH

11/02/15 2312 - EDIT

by PHPATEAS

FROM:

DUPLICATE COMMENT:

TO:

DUPLICATE COMMENT: RPH

11/02/15 2312 - VERIFIED

by PHPATEAS

Items Dispensed: 0

Doses Dispensed: 0

11/03/15 2337 - DEBIT

by SPARK

ITEMS: 1 DOSES: 1

11/04/15 0605 - DEBIT

by SPARK

ITEMS: 1 DOSES: 1

11/04/15 0907 - DEBIT

by MBAH

ITEMS: 1 DOSES: 1

11/05/15 0123 - DEBIT

by SPARK

ITEMS: 1 DOSES: 1

11/06/15 0406 - DEBIT

by SPARK

ITEMS: 1 DOSES: 1

11/06/15 1323 - DEBIT

by LCLEMENTS

ITEMS: 1 DOSES: 1

11/06/15 2018 - DEBIT

by JMCLELLAN

ITEMS: 1 DOSES: 1

11/07/15 0911 - DEBIT

by MSEARIGHT

ITEMS: 1 DOSES: 1

11/08/15 0018 - DEBIT

by PFERRY

ITEMS: 1 DOSES: 1

11/08/15 0726 - DEBIT

by PFERRY

ITEMS: 1 DOSES: 1

11/08/15 1331 - DEBIT

by MSEARIGHT

ITEMS: 1 DOSES: 1

11/09/15 0448 - DEBIT

by PFERRY

ITEMS: 1 DOSES: 1

11/09/15 0942 - DEBIT

by LCLEMENTS

ITEMS: 1 DOSES: 1

DATE: 11/14/15 @ 0010
USER: CONOVITH

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 9

Patient **CHILDS, HANEEF A** Responsible Doctor **MAQSOOD, TAHIR, MD**
Account Number **[REDACTED]** Location **PH2NE** Unit Number **M000611175**
Age/Sex **27/M** Room **208** Registered Date **11/03/15**
Status **DIS IN** Bed **1** Discharged Date **11/13/15**

CHILDS, HANEEF A

PA1303162331

(Continued)

11/09/15 1635 - DEBIT by JHAMILTON
ITEMS: 1 DOSES: 1
11/10/15 1744 - DEBIT by JHAMILTON
ITEMS: 1 DOSES: 1
11/11/15 0516 - DEBIT by LCLEMENTS
ITEMS: 1 DOSES: 1
11/12/15 1504 - DEBIT by MBAH
ITEMS: 1 DOSES: 1
11/13/15 1551 - DISCONTINUE by DISCHARGE Eff: 11/13/15 1530
DC COMMENTS:
DC'd by Discharge
11/13/15 1551 - EDIT by SYSTEM
TOTAL DOSE ADMIN DATA INITIATED

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
11/03/15	2338	PHPARKSU	N				
		Dose: 2 MG					
11/04/15	0605	PHPARKSU	Y			1	
		Dose: 2 MG					
11/04/15	0908	PHBAHMOH	Y			1	
		Dose: 2 MG					
11/06/15	0406	PHPARKSU	Y			1	
		Dose: 2 MG					
11/06/15	1323	PHCLEMEL	Y			1	
		Dose: 2 MG					
11/06/15	2017	PHHAMILJ	Y			1	
		Dose: 2 MG					
11/07/15	0918	PHSEARIM	Y			1	
		Dose: 2 MG					
11/08/15	0020	PHCOSTEP	Y			1	
		Dose: 2 MG					
11/08/15	0754	PHCOSTEP	Y			1	
		Dose: 2 MG					
11/08/15	1330	PHSEARIM	Y			1	
		Dose: 2 MG					
11/09/15	0454	PHCOSTEP	Y			1	
		Dose: 2 MG					
11/09/15	0945	PHCLEMEL	Y			1	
		Dose: 2 MG					

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 10

Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number		Location	PH2NE
Age/Sex	27/M	Unit Number	M000611175
Status	DIS IN	Room	208
		Bed	1
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

11/09/15	1636	PHHAMILJ	Y	1
		Dose: 2 MG		
11/10/15	1758	PHHAMILJ	Y	1
		Dose: 2 MG		
11/11/15	0517	PHCLEMEL	Y	1
		Dose: 2 MG		
11/12/15	1505	PHBAHMOH	Y	1
		Dose: 2 MG		

Admin Totals

15

DATE: 11/14/15 @ 0010
USER: CONOVITH

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 11

Patient **CHILDS, HANEEF A** Responsible Doctor **MAQSOOD, TAHIR, MD**
Account Number **1** Location **PH2NE** Unit Number **M000611175**
Age/Sex **27/M** Room **208** Registered Date **11/03/15**
Status **DIS IN** Bed **1** Discharged Date **11/13/15**

CHILDS, HANEEF A

PA1303162331

(Continued)

LORA2VIA13 - LORAZEPAM 2 MG/ML 1 ML VIAL (ATIVAN)

Dose 2 MG (1 ML)
Admin Route IM
Frequency Q4H (PRN) PAR= PRN REASON: AGIT - AGITATION
Start Date 11/02/15-2300 Stop Date None DC Date 11/13/15-1530
Ordering Doctor **NOVITSKY, MARK A. MD**
Total Dispensed 6 Total Costs \$3.36 Total Charges \$30.00
Rx Number 001420987

Discontinue Comments DC'd by Discharge

History

11/02/15 2307 - POM ORDER
11/02/15 2313 - EDIT

by CONOVITH
by PHPATEAS

FROM:

DUPLICATE COMMENT:

TO:

DUPLICATE COMMENT: RPH

11/02/15 2313 - VERIFIED

by PHPATEAS

Items Dispensed: 0 Doses Dispensed: 0

11/03/15 0933 - DEBIT

by MBAH

ITEMS: 1 DOSES: 1

11/04/15 1245 - DEBIT

by MBAH

ITEMS: 1 DOSES: 1

11/09/15 1142 - DEBIT

by MBAH

ITEMS: 1 DOSES: 1

11/09/15 1219 - DEBIT

by MBAH

ITEMS: 1 DOSES: 1

11/11/15 1352 - DEBIT

by SSTEWARD

ITEMS: 1 DOSES: 1

11/13/15 1029 - DEBIT

by MBAH

ITEMS: 1 DOSES: 1

11/13/15 1551 - DISCONTINUE

by DISCHARGE Eff: 11/13/15 1530

DC COMMENTS:

DC'd by Discharge

11/13/15 1551 - EDIT

by SYSTEM

TOTAL DOSE ADMIN DATA INITIATED

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
11/03/15	0955	PHBAHMOH	Y			1	
					Dose: 2 MG		
11/04/15	1355	PHBAHMOH	Y			1	
					Dose: 2 MG		
11/09/15	1211	PHBAHMOH	Y			1	

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 12

Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number		Location	PH2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Unit Number	M000611175
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

FA1303162331

(Continued)

Dose: 2 MG

11/13/15 1028 PHCLEMEL Y
Dose: 2 MG

1

Admin Totals

4

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

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Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number		Location	PH2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Unit Number	M000611175
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

TEMA15CA26 - TEMAZEPAM 15 MG CAPSULE

Dose 15 MG (1 CAPSULE)
Admin Route PO
Frequency BEDTIME (PRN) PAR= PRN REASON: INS - INSOMNIA
Start Date 11/02/15-2300 Stop Date None DC Date 11/13/15-1530
Ordering Doctor NOVITSKY, MARK A, MD
Total Dispensed 6 Total Costs \$0.42 Total Charges \$7.50
Rx Number 001420988

Discontinue Comments DC'd by Discharge

History

11/02/15 2307 - POM ORDER by CONOVITM
11/02/15 2313 - EDIT by PHPATEAS
FROM:
DUPLICATE COMMENT:
TO:
DUPLICATE COMMENT: RPH
11/02/15 2313 - VERIFIED by PHPATEAS
Items Dispensed: 0 Doses Dispensed: 0
11/03/15 2343 - DEBIT by SPARK
ITEMS: 1 DOSES: 1
11/04/15 2133 - DEBIT by JMCCLLELLAN
ITEMS: 1 DOSES: 1
11/07/15 2111 - DEBIT by PFERRY
ITEMS: 1 DOSES: 1
11/08/15 2057 - DEBIT by PFERRY
ITEMS: 1 DOSES: 1
11/10/15 0041 - DEBIT by SPARK
ITEMS: 1 DOSES: 1
11/12/15 0111 - DEBIT by SPARK
ITEMS: 1 DOSES: 1
11/13/15 1551 - DISCONTINUE by DISCHARGE Eff: 11/13/15 1530
DC COMMENTS:
DC'd by Discharge
11/13/15 1551 - EDIT by SYSTEM
TOTAL DOSE ADMIN DATA INITIATED

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
11/03/15	2342	PHPARKSU	Y			1	
					Dose: 15 MG		
11/04/15	2132	PHMCCLEJ	Y			1	
					Dose: 15 MG		
11/07/15	2123	PHCOSTEP	Y			1	

DATE: 11/14/15 @ 0010
USER: CONOVITH

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 14

Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number		Location	PH2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Unit Number	N000611175
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

		Dose: 15 MG	
11/08/15	2104	PHCOSTEP Y	1
		Dose: 15 MG	
11/10/15	0043	PHPARKSU Y	1
		Dose: 15 MG	
11/12/15	0042	PHPARKSU Y	1
		Dose: 15 MG	
		GIVEN BT SUN PARK DURING DOWN TIME, SEE PAPER EMAR	

Admin Totals

6

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

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Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number	[REDACTED]	Location	PH2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Unit Number	M000611175
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

RISP1TAB4 - RISPERIDONE 1 MG TAB.RAPDIS (RISPERDAL MTAB)

Dose 1 MG (1 TAB)

Admin Route PO

Frequency Q4H (PRN) PAR= PRN REASON: PSY - PSYCHOSIS

Start Date 11/02/15-2300

Stop Date None

DC Date 11/13/15-1530

Ordering Doctor NOVITSKY, MARK A, MD

Total Dispensed 11

Total Costs \$71.61

Total Charges \$591.25

Rx Number 001420989

Discontinue Comments DC'd by Discharge

History

11/02/15 2307 - POM ORDER

by CONOVITM

11/02/15 2313 - EDIT

by PHPATEAS

FROM:

INTERACTION COMMENT:

DUPLICATE COMMENT:

TO:

INTERACTION COMMENT: RPH

DUPLICATE COMMENT: RPH

11/02/15 2313 - VERIFIED

by PHPATEAS

Items Dispensed: 0 Doses Dispensed: 0

11/03/15 2337 - DEBIT

by SPARK

ITEMS: 1 DOSES: 1

11/05/15 0123 - DEBIT

by SPARK

ITEMS: 1 DOSES: 1

11/06/15 0404 - DEBIT

by SPARK

ITEMS: 1 DOSES: 1

11/06/15 2016 - DEBIT

by JMCCLELLAN

ITEMS: 1 DOSES: 1

11/07/15 0911 - DEBIT

by MSEARIGHT

ITEMS: 1 DOSES: 1

11/08/15 0018 - DEBIT

by PFERRY

ITEMS: 1 DOSES: 1

11/08/15 0726 - DEBIT

by PFERRY

ITEMS: 1 DOSES: 1

11/08/15 1331 - DEBIT

by MSEARIGHT

ITEMS: 1 DOSES: 1

11/09/15 1634 - DEBIT

by JHAMILTON

ITEMS: 1 DOSES: 1

11/11/15 0518 - DEBIT

by LCLEMENTS

ITEMS: 1 DOSES: 1

11/12/15 1836 - DEBIT

by JHAMILTON

ITEMS: 1 DOSES: 1

11/13/15 1551 - DISCONTINUE

by DISCHARGE Eff: 11/13/15 1530

DC COMMENTS:

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 16

Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number		Location	PH2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Unit Number	M000611175
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

DC'd by Discharge
11/13/15 1551 - EDIT by SYSTEM
TOTAL DOSE ADMIN DATA INITIATED

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
11/03/15	2338	PHPARKSU	N				
		Dose: 1 MG					
11/06/15	0406	PHPARKSU	Y			1	
		Dose: 1 MG					
11/06/15	2017	PHHAMILJ	Y			1	
		Dose: 1 MG					
11/08/15	0019	PHCOSTEP	Y			1	
		Dose: 1 MG					
11/08/15	0754	PHCOSTEP	Y			1	
		Dose: 1 MG					
11/08/15	1330	PHSEARIM	Y			1	
		Dose: 1 MG					
11/09/15	1635	PHHAMILJ	Y			1	
		Dose: 1 MG					
11/11/15	0517	PHCLEMEL	Y			1	
		Dose: 1 MG					
11/12/15	1908	PHHAMILJ	Y			1	
		Dose: 1 MG					
Admin Totals						8	

DATE: 11/14/15 @ 0010
USER: CONOVITH

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 17

Patient CHILDS, HANEEF A Responsible Doctor MAQSOOD, TAHIR, MD
Account Number Location PH2NE Unit Number M000611175
Age/Sex 27/M Room 208 Registered Date 11/03/15
Status DIS IN Bed 1 Discharged Date 11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

HALOSAMP - HALOPERIDOL LACTATE 5 MG/ML INJECTION (HALDOL)

Dose 5 MG (1 ML)
Admin Route IM
Frequency Q6H (PRN) PAR= PRN REASON: SA - SEVERE AGITATION
Start Date 11/02/15-2300 Stop Date None DC Date 11/13/15-1530
Ordering Doctor NOVITSKY, MARK A, MD
Total Dispensed 5 Total Costs \$6.85 Total Charges \$57.50
Rx Number 001420990

Discontinue Comments DC'd by Discharge

History

11/02/15 2307 - POM ORDER by CONOVITH
11/02/15 2313 - EDIT by PHPATEAS

FROM:

INTERACTION COMMENT:
DUPLICATE COMMENT:

TO:

INTERACTION COMMENT: RPH
DUPLICATE COMMENT: RPH

11/02/15 2313 - VERIFIED by PHPATEAS

Items Dispensed: 0 Doses Dispensed: 0

11/03/15 0933 - DEBIT by MBAH

ITEMS: 1 DOSES: 1

11/04/15 1245 - DEBIT by MBAH

ITEMS: 1 DOSES: 1

11/09/15 1142 - DEBIT by MBAH

ITEMS: 1 DOSES: 1

11/11/15 1352 - DEBIT by SSTEWARD

ITEMS: 1 DOSES: 1

11/13/15 1029 - DEBIT by MBAH

ITEMS: 1 DOSES: 1

11/13/15 1551 - DISCONTINUE by DISCHARGE Eff: 11/13/15 1530

DC COMMENTS:

DC'd by Discharge

11/13/15 1551 - EDIT by SYSTEM

TOTAL DOSE ADMIN DATA INITIATED

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
11/03/15	0955	PHBAHMOH	Y			1	
Dose: 5 MG							
11/04/15	1354	PHBAHMOH	Y			1	
Dose: 5 MG							
11/09/15	1211	PHBAHMOH	Y			1	

DATE: 11/14/15 @ 0010
USER: CONOVITH

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

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Patient **CHILDS, HANEEF A** Responsible Doctor MAQSOOD, TAHIR, MD
Account Number **1** Location PH2NE Unit Number M000611175
Age/Sex 27/M Room 208 Registered Date 11/03/15
Status DIS IN Bed 1 Discharged Date 11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

Dose: 5 MG

Admin Totals

3

BENZ1TAB27 - BENZTROPINE MESYLATE 1 MG TABLET (COGENTIN)

Dose 1 MG (1 TABLET)

Admin Route PO

Frequency Q4H (PRN) PAR= PRN REASON: EPS - FOR EPS

Start Date 11/02/15-2300

Stop Date None

DC Date 11/13/15-1530

Ordering Doctor NOVITSKY, MARK A, MD

Total Dispensed 2

Total Costs \$0.20

Total Charges \$2.50

Rx Number 001420991

Discontinue Comments DC'd by Discharge

History

11/02/15 2307 - POM ORDER

by CONOVITH

11/02/15 2313 - EDIT

by PHPATEAS

FROM:

DUPLICATE COMMENT:

TO:

DUPLICATE COMMENT: RPH

11/02/15 2313 - VERIFIED

by PHPATEAS

Items Dispensed: 0

Doses Dispensed: 0

11/07/15 0912 - DEBIT

by MSEARIGHT

ITEMS: 1 DOSES: 1

11/10/15 1206 - DEBIT

by MBAH

ITEMS: 1 DOSES: 1

11/13/15 1551 - DISCONTINUE

by DISCHARGE

Eff: 11/13/15 1530

DC COMMENTS:

DC'd by Discharge

11/13/15 1551 - EDIT

by SYSTEM

TOTAL DOSE ADMIN DATA INITIATED

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
11/07/15	0919	PHSEARIM	Y			1	
					Dose: 1 MG		
11/10/15	1208	PHBAHMOH	Y			1	
					Dose: 1 MG		

Admin Totals

2

DATE: 11/14/15 @ 0010 ... Mercy Philadelphia Hospital PHA *LIVE*
USER: CONOVITH Medication Administration Summary

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Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number		Location	PH2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Unit Number	M000611175
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

BENZ1AMP - BENZTROPINE MESYLATE 2 MG/2 ML INJECTION (COGENTIN)

Dose 2 MG (2 ML)
Admin Route IM
Frequency Q6H (PRN) PAR= PRN REASON: Acute Dystonic Reaction
Start Date 11/02/15-2300 Stop Date None DC Date 11/13/15-1530
Ordering Doctor NOVITSKY, MARK A. MD
Total Dispensed 1 Total Costs \$32.02 Total Charges \$264.00
Rx Number 001420992

Discontinue Comments DC'd by Discharge

History

11/02/15 2307 - POM ORDER

by CONOVITH

11/02/15 2313 - EDIT

by PHPATEAS

FROM:

DUPLICATE COMMENT:

TO:

DUPLICATE COMMENT: RPH

11/02/15 2313 - VERIFIED

by PHPATEAS

Items Dispensed: 0 Doses Dispensed: 0

11/11/15 1352 - DEBIT

by SSTEWARD

ITEMS: 1 DOSES: 1

11/13/15 1551 - DISCONTINUE

by DISCHARGE Eff: 11/13/15 1530

DC COMMENTS:

DC'd by Discharge

11/13/15 1551 - EDIT

by SYSTEM

TOTAL DOSE ADMIN DATA INITIATED

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 20

Patient **CHILDS, HANEEF A** Responsible Doctor **MAQSOOD, TAHIR, MD**
Account Number **[REDACTED]** Location **PH2NE** Unit Number **M000611175**
Age/Sex **27/M** Room **208** Registered Date **11/03/15**
Status **DIS IN** Bed **1** Discharged Date **11/13/15**

CHILDS, HANEEF A

PA1303162331

(Continued)

ARIP15TA2 - ARIPIprazole 15 MG TABLET (ABILIFY)

Dose 10 MG (0.666667 TABLETS)

Admin Route FO

Start Date 11/03/15-1000

Stop Date None

DC Date 11/04/15-1253

Ordering Doctor **NOVITSKY, MARK A, MD**

Total Dispensed 2

Total Costs \$49.02

Total Charges \$404.00

Rx Number 001420993

History

11/02/15 2307 - POM ORDER

by CONOVITM

11/02/15 2313 - EDIT

by PHPATEAS

FROM:

DUPLICATE COMMENT:

TO:

DUPLICATE COMMENT: RPH

11/02/15 2313 - VERIFIED

by PHPATEAS

Items Dispensed: 0 Doses Dispensed: 0

11/03/15 0910 - DEBIT

by MBAH

ITEMS: 1 DOSES: 1

11/04/15 0837 - DEBIT

by MBAH

ITEMS: 1 DOSES: 1

11/04/15 1256 - DISCONTINUE

by COPUESAR

Eff: 11/04/15 1253

Items Auto Credited: 0 Doses Auto Credited: 0

EDIT DOCTOR: PUESAN, REYNALDO MD

EDIT SOURCE: Provider Source

11/04/15 1256 - POM COPY AND EDIT

by COPUESAR

TO: Rx #U000752248

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
11/03/15	1000	PHBAHMOH	Y			1	0.00
(11/03/15) (1000) Dose: 10 MG							
11/03/15	1459	PHBAHMOH	N		GIVEN		
(11/04/15) (1000) Dose: 10 MG							
11/04/15	0903	PHBAHMOH	Y			1	0.00
Dose: 10 MG							

Admin Totals

2

0

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

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Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number		Location	PH2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Unit Number	M000611175
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

LORA2VIA13 - LORAZEPAM 2 MG/ML 1 ML VIAL (ATIVAN)

Dose 2 MG (1 ML)
Admin Route .ROUTE
Start Date 11/02/15-1958 Stop Date 11/02/15 1959 DC Date 11/02/15-1959
Ordering Doctor NOVITSKY, MARK A, MD
Total Dispensed 1 Total Costs \$0.56 Total Charges \$5.00
Rx Number 001421308

Discontinue Comments DC'd by PHPATEAS

History

11/03/15 0657 - ENTER by PHPATEAS
Items Dispensed: 1 Doses Dispensed: 1
For: 11/02/15 - 1958
11/03/15 0657 - DISCONTINUE by STK MED Eff: 11/02/15 1959
Items Auto Credited: 0 Doses Auto Credited: 0
DC COMMENTS:
DC'd by PHPATEAS

DIPH50VI6 - diphenhydramine HCL 50 MG/ML INJECTION (BENADRYL)

Dose 50 MG (1 ML)
Admin Route .ROUTE
Start Date 11/02/15-1958 Stop Date 11/02/15 1959 DC Date 11/02/15-1959
Ordering Doctor NOVITSKY, MARK A, MD
Total Dispensed 1 Total Costs \$0.59 Total Charges \$5.00
Rx Number 001421309

Discontinue Comments DC'd by PHPATEAS

History

11/03/15 0657 - ENTER by PHPATEAS
Items Dispensed: 1 Doses Dispensed: 1
For: 11/02/15 - 1958
11/03/15 0657 - DISCONTINUE by STK MED Eff: 11/02/15 1959
Items Auto Credited: 0 Doses Auto Credited: 0
DC COMMENTS:
DC'd by PHPATEAS

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

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Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number		Location	PH2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Unit Number	M000611175
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

HALOSAMP - HALOPERIDOL LACTATE 5 MG/ML INJECTION (HALDOL)

Dose 5 MG (1 ML)

Admin Route ROUTE

Start Date 11/02/15-1958

Stop Date 11/02/15 1959

DC Date 11/02/15-1959

Ordering Doctor NOVITSKY, MARK A, MD

Total Dispensed 1

Total Costs \$1.37

Total Charges \$11.50

Rx Number 001421310

Discontinue Comments DC'd by PHPATEAS

History

11/03/15 0657 - DISCONTINUE

by STK MED

Eff: 11/02/15 1959

Items Auto Credited: 0 Doses Auto Credited: 0

DC COMMENTS:

DC'd by PHPATEAS

11/03/15 0657 - ENTER

by PHPATEAS

Items Dispensed: 1 Doses Dispensed: 1

For: 11/02/15 - 1958

DATE: 11/14/15 @ 0010
USER: CONOVITH

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

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Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number		Location	PH2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Unit Number	M000611175
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

NICO2GUM8 - NICOTINE POLACRILEX 2 MG GUM (NICORETTE)

Dose 2 MG (1 GUM)
Admin Route PO
Frequency Q2WA (PRN) PAR= PRN REASON: SC - SMOKING CESSATION
Start Date 11/04/15-1100 Stop Date None DC Date 11/13/15-1530
Ordering Doctor PUESAN, REYNALDO MD
Total Dispensed 17 Total Costs \$4.25 Total Charges \$38.25
Rx Number 001422915

Discontinue Comments DC'd by Discharge

History

11/04/15 1051 - POM ORDER

by COPUESAR

11/04/15 1120 - EDIT

by PHMATHEL

FROM:

DUPLICATE COMMENT:

TO:

DUPLICATE COMMENT: RPH

11/04/15 1120 - VERIFIED

by PHMATHEL

Items Dispensed: 0

Doses Dispensed: 0

11/04/15 1901 - DEBIT

by JMCLELLAN

ITEMS: 1 DOSES: 1

11/07/15 1209 - DEBIT

by MSEARIGHT

ITEMS: 1 DOSES: 1

11/07/15 1549 - DEBIT

by MSEARIGHT

ITEMS: 1 DOSES: 1

11/08/15 0640 - DEBIT

by JOWENS

ITEMS: 1 DOSES: 1

11/08/15 1057 - DEBIT

by MSEARIGHT

ITEMS: 1 DOSES: 1

11/08/15 1825 - DEBIT

by MSEARIGHT

ITEMS: 1 DOSES: 1

11/10/15 0603 - DEBIT

by SPARK

ITEMS: 1 DOSES: 1

11/10/15 1612 - DEBIT

by LCLEMENTS

ITEMS: 1 DOSES: 1

11/10/15 2107 - DEBIT

by JHAMILTON

ITEMS: 1 DOSES: 1

11/11/15 0520 - DEBIT

by LCLEMENTS

ITEMS: 1 DOSES: 1

11/11/15 0907 - DEBIT

by LCLEMENTS

ITEMS: 1 DOSES: 1

11/11/15 1744 - DEBIT

by JMCLELLAN

ITEMS: 1 DOSES: 1

11/12/15 0649 - DEBIT

by SPARK

ITEMS: 1 DOSES: 1

DATE: 11/14/15 @ 0010
USER: CONOVITH

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 24

Patient **CHILDS, HANEEF A** Responsible Doctor **MAQSOOD, TAHIR, MD**
Account Number **[REDACTED]** Location **PH2NE** Unit Number **M000611175**
Age/Sex **27/M** Room **208** Registered Date **11/03/15**
Status **DIS IN** Bed **1** Discharged Date **11/13/15**

CHILDS, HANEEF A

PA1303162331

(Continued)

11/12/15 0922 - DEBIT by LCLEMENTS
ITEMS: 1 DOSES: 1
11/12/15 1942 - DEBIT by JHAMILTON
ITEMS: 1 DOSES: 1
11/13/15 0626 - DEBIT by SPARK
ITEMS: 1 DOSES: 1
11/13/15 1110 - DEBIT by MBAH
ITEMS: 1 DOSES: 1
11/13/15 1551 - DISCONTINUE by DISCHARGE Eff: 11/13/15 1530
DC COMMENTS:
DC'd by Discharge
11/13/15 1551 - EDIT by SYSTEM
TOTAL DOSE ADMIN DATA INITIATED

Admin Date	Time	User	Given	Baq	Reason Code	Items	Charge
11/04/15	1914	PHMCCLEJ	Y			1	
		Dose: 2 MG					
11/07/15	1548	PHSEARIM	Y			1	
		Dose: 2 MG					
11/08/15	0649	PHOWENJ	Y			1	
		Dose: 2 MG					
11/10/15	0603	PHPARKSU	Y			1	
		Dose: 2 MG					
11/10/15	1620	PHCLEMEL	Y			1	
		Dose: 2 MG					
11/10/15	2107	PHMCCLEJ	Y			1	
		Dose: 2 MG					
11/11/15	0521	PHCLEMEL	Y			1	
		Dose: 2 MG					
11/11/15	0942	PHCLEMEL	Y			1	
		Dose: 2 MG					
11/11/15	1756	PHMCCLEJ	Y			1	
		Dose: 2 MG					
11/12/15	0649	PHPARKSU	Y			1	
		Dose: 2 MG					
11/12/15	0959	PHCLEMEL	Y			1	
		Dose: 2 MG					
11/12/15	1942	PHHAMILJ	Y			1	
		Dose: 2 MG					

DATE: 11/14/15 @ 0010		Mercy Philadelphia Hospital PHA *LIVE*		PAGE 25
USER: CONOVITM		Medication Administration Summary		
Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD	
Account Number	[REDACTED]	Location	PH2NE	Unit Number M000611175
Age/Sex	27/M	Room	209	Registered Date 11/03/15
Status	DIS IN	Bed	1	Discharged Date 11/13/15
CHILDS, HANEEF A		PA1303162331		(Continued)
11/13/15	0626 PHPARKSU	Y		1
	Dose: 2 MG			
11/13/15	1111 PHBAHMOH	Y		1
	Dose: 2 MG			
Admin Totals				14

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

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Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number		Location	PH2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Unit Number	M000611175
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

NICO1PAT13 - NICOTINE 7 MG/PATCH.TD24 (NICODERM)

Dose 7 MG (1 PATCH)

Admin Route TD

Start Date 11/04/15-1100

Stop Date None

DC Date 11/13/15-1530

Ordering Doctor PUESAN, REYNALDO MD

Total Dispensed 8

Total Costs \$14.00

Total Charges \$116.00

Rx Number 001422917

Discontinue Comments DC'd by Discharge

History

11/04/15 1051 - POM ORDER

by COPUESAR

11/04/15 1051 - NOW DOSE

by COPUESAR

Now Dose: 11/04/15 1100

11/04/15 1051 - KEEP NEXT DOSE

by COPUESAR

Keep Next Dose: 11/05/15 1000

11/04/15 1120 - EDIT

by PHMATHEL

FROM:

DUPLICATE COMMENT:

TO:

DUPLICATE COMMENT: RPH

11/04/15 1120 - VERIFIED

by PHMATHEL

Items Dispensed: 0 Doses Dispensed: 0

11/04/15 1731 - DEBIT

by JHAMILTON

ITEMS: 1 DOSES: 1

11/05/15 0630 - DEBIT

by SPARK

ITEMS: 1 DOSES: 1

11/06/15 1326 - DEBIT

by ICLEMENTS

ITEMS: 1 DOSES: 1

11/07/15 0916 - DEBIT

by MSEARIGHT

ITEMS: 1 DOSES: 1

11/08/15 0853 - DEBIT

by VJORDAN

ITEMS: 1 DOSES: 1

11/09/15 0940 - DEBIT

by ICLEMENTS

ITEMS: 1 DOSES: 1

11/09/15 1054 - CREDIT

by ICLEMENTS

ITEMS: 1 DOSES: 1

11/09/15 1927 - DEBIT

by JMCCLELLAN

ITEMS: 1 DOSES: 1

11/10/15 1610 - DEBIT

by ICLEMENTS

ITEMS: 1 DOSES: 1

11/10/15 1809 - DEBIT

by JMCCLELLAN

ITEMS: 1 DOSES: 1

11/13/15 1551 - DISCONTINUE

by DISCHARGE Eff: 11/13/15 1530

DC COMMENTS:

DC'd by Discharge

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 27

Patient **CHILDS, HANEEF A** Responsible Doctor MAQSOOD, TAHIR, MD
Account Number **[REDACTED]** Location PH2NE Unit Number M000611175
Age/Sex 27/M Room 208 Registered Date 11/03/15
Status DIS IN Bed 1 Discharged Date 11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

11/13/15 1551 - EDIT by SYSTEM
TOTAL DOSE ADMIN DATA INITIATED

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
11/04/15	1914	PHMCCLEJ	Y			1	0.00
(11/04/15)	(1100)	Dose: 7 MG					
11/05/15	1126	PHHAYESS	Y			1	0.00
(11/05/15)	(1000)	Dose: 7 MG					
11/06/15	1326	PHCLEMEL	Y			1	0.00
(11/06/15)	(1000)	Dose: 7 MG					
11/07/15	0918	PHSEARIM	Y			1	0.00
(11/07/15)	(1000)	Dose: 7 MG					
11/08/15	0859	PHSEARIM	Y			1	0.00
(11/08/15)	(1000)	Dose: 7 MG					
11/09/15	1930	PHMCCLEJ	Y			1	0.00
(11/09/15)	(1000)	Dose: 7 MG					
11/10/15	0934	PHCLEMEL	N				
(11/10/15)	(1000)	Dose: 0 MG					
11/10/15	1620	PHCLEMEL	Y			1	0.00
(11/10/15)	(1000)	Dose: 7 MG					
11/11/15	0944	PHCLEMEL	N		REFUSED		
(11/11/15)	(1000)	Dose: 0 MG					
11/12/15	1000	PHCLEMEL	N		REFUSED		
(11/12/15)	(1000)	Dose: 0 MG					
11/13/15	1000	PHCLEMEL	N		REFUSED		
(11/13/15)	(1000)	Dose: 0 MG					

Admin Totals

7

0

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

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Patient **CHILDS, HANEEF A** Responsible Doctor MAQSOOD, TAHIR, MD
Account Number **[REDACTED]** Location PH2NE Unit Number M000611175
Age/Sex 27/M Room 208 Registered Date 11/03/15
Status DIS IN Bed 1 Discharged Date 11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

OLAN10TA2 - OLANzapine 10 MG TABLET (ZYPREXA)

Dose 20 MG (2 TABLETS)

Admin Route PO

Start Date 11/05/15-2200

Stop Date None

DC Date 11/13/15-1530

Ordering Doctor PUESAN, REYNALDO MD

Total Dispensed 16

Total Costs \$7.68

Total Charges \$64.00

Rx Number 001424510

Discontinue Comments DC'd by Discharge

History

11/05/15 1718 - POM ORDER

by COPUESAR

11/05/15 1805 - EDIT

by FINELSOC

FROM:

DUPLICATE COMMENT:

TO:

DUPLICATE COMMENT: RPH

11/05/15 1805 - VERIFIED

by FINELSOC

11/05/15 2025 - DEBIT

by JHAMILTON

ITEMS: 2 DOSES: 1

11/06/15 2038 - DEBIT

by JMCCLELLAN

ITEMS: 2 DOSES: 1

11/07/15 2111 - DEBIT

by PFERRY

ITEMS: 2 DOSES: 1

11/08/15 2057 - DEBIT

by PFERRY

ITEMS: 2 DOSES: 1

11/09/15 2052 - DEBIT

by JHAMILTON

ITEMS: 2 DOSES: 1

11/10/15 2033 - DEBIT

by JMCCLELLAN

ITEMS: 2 DOSES: 1

11/11/15 2012 - DEBIT

by JHAMILTON

ITEMS: 2 DOSES: 1

11/12/15 2013 - DEBIT

by JMCCLELLAN

ITEMS: 2 DOSES: 1

11/13/15 1551 - DISCONTINUE

by DISCHARGE Eff: 11/13/15 1530

DC COMMENTS:

DC'd by Discharge

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
11/05/15	2107	PHHAMILJ	Y			2	0.00
(11/05/15) (2200) Dose: 20 MG							
11/06/15	2116	PHMCCLEJ	Y			2	0.00
(11/06/15) (2200) Dose: 20 MG							
11/07/15	2122	PHCOSTEP	Y			2	0.00

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

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Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number	[REDACTED]	Location	PH2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Unit Number	M000611175
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

(11/07/15)	(2200)	Dose: 20 MG		
11/08/15	2104 PHCOSTEP	Y	2	0.00
(11/08/15)	(2200)	Dose: 20 MG		
11/09/15	2318 PHMCCLEJ	Y	2	0.00
(11/09/15)	(2200)	Dose: 20 MG		
11/10/15	2105 PHMCCLEJ	Y	2	0.00
(11/10/15)	(2200)	Dose: 20 MG		
11/12/15	0042 PHPARKSU	Y	2	0.00
(11/11/15)	(2200)	Dose: 20 MG		
	GIVEN BT SUN PARK DURING DOWN TIME			
11/12/15	2110 PHMCCLEJ	Y	2	0.00
(11/12/15)	(2200)	Dose: 20 MG		

Admin Totals

16

0

DATE: 11/14/15 @ 0010
USER: CONOVITH

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 30

Patient **CHILDS, HANEEF A** Responsible Doctor **MAQSOOD, TAHIR, MD**
Account Number **[REDACTED]** Location **PH2NE** Unit Number **M000611175**
Age/Sex **27/M** Room **208** Registered Date **11/03/15**
Status **DIS IN** Bed **1** Discharged Date **11/13/15**

CHILDS, HANEEF A

PA1303162331

(Continued)

ZOLP5TAB2 - ZOLPIDEM TARTRATE 5 MG TABLET (AMBIEN)

Dose 5 MG (1 TABLET)
Admin Route PO
Frequency BEDTIME (PRN) PAR= PRN REASON: INSOMNIA - INSOMNIA
Start Date 11/05/15-1730 Stop Date None DC Date 11/13/15-0530
Ordering Doctor PUESAN, REYNALDO MD
Total Dispensed 1 Total Costs \$0.04 Total Charges \$1.25
Rx Number 001424511

Discontinue Comments Reached Renew Stop Date

History

11/05/15 1718 - POM ORDER

by COPUESAR

11/05/15 1805 - EDIT

by FINELSOC

FROM:

DUPLICATE COMMENT:

TO:

DUPLICATE COMMENT: RPH

11/05/15 1805 - VERIFIED

by FINELSOC

11/05/15 2108 - DEBIT

by JMCCELLAN

ITEMS: 1 DOSES: 1

11/12/15 1730 - RENEW STOP FILED

by SYSTEM

11/13/15 0531 - DISCONTINUE

by RENEW STOP Eff: 11/13/15 0530

DC COMMENTS:

Reached Renew Stop Date

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
11/05/15	2108	PHHAMILJ	Y			1	

Dose: 5 MG

Admin Totals

1

DATE: 11/14/15 @ 0010
USER: CONOVITH

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

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Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number		Location	PH2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Unit Number	M000611175
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

FA1303162331

(Continued)

TRAM50TA27 - tramADol HCL 50 MG TABLET (ULTRAM)

Dose 100 MG (2 TABLETS)

Dose Instruction *PRN*

MAX OF THREE DOSES PER 24 HOURS

Admin Route PO

Frequency Q6H (PRN) PAR= PRN REASON: MSP - MODERATE/SEVERE PAIN

Start Date 11/05/15-1845

Stop Date None

DC Date 11/13/15-1530

Ordering Doctor NOVITSKY, MARK A, MD

Total Dispensed 20

Total Costs \$1.40

Total Charges \$25.00

Rx Number 001424554

Discontinue Comments DC'd by Discharge

History

11/05/15 1834 - POM ORDER

by CONOVITH

11/05/15 1918 - EDIT

by FINELSOC

FROM:

INTERACTION COMMENT:

TO:

INTERACTION COMMENT: RPH

11/05/15 1918 - VERIFIED

by FINELSOC

11/05/15 1944 - DEBIT

by JMCCLELLAN

ITEMS: 2 DOSES: 1

11/06/15 0638 - DEBIT

by SPARK

ITEMS: 2 DOSES: 1

11/06/15 1636 - DEBIT

by JHAMILTON

ITEMS: 2 DOSES: 1

11/07/15 0611 - DEBIT

by SHAYES

ITEMS: 2 DOSES: 1

11/07/15 0855 - DEBIT

by MSEARIGHT

ITEMS: 2 DOSES: 1

11/08/15 1940 - DEBIT

by MSEARIGHT

ITEMS: 2 DOSES: 1

11/09/15 1925 - DEBIT

by JMCCLELLAN

ITEMS: 2 DOSES: 1

11/10/15 0716 - DEBIT

by SPARK

ITEMS: 2 DOSES: 1

11/10/15 2107 - DEBIT

by JHAMILTON

ITEMS: 2 DOSES: 1

11/11/15 0906 - DEBIT

by LCLEMENTS

ITEMS: 2 DOSES: 1

11/13/15 1551 - DISCONTINUE

by DISCHARGE

Eff: 11/13/15 1530

DC COMMENTS:

DC'd by Discharge

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
------------	------	------	-------	-----	-------------	-------	--------

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

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Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number		Location	PH2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Unit Number	M000611175
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

11/05/15	1945 PHMCCLEJ	Y	2
	Dose: 100 MG		
11/06/15	0638 PHPARKSU	Y	2
	Dose: 100 MG		
11/06/15	1639 PHHAMILJ	Y	2
	Dose: 100 MG		
11/07/15	0613 PHHAYESS	Y	2
	Dose: 100 MG		
11/07/15	1432 PHSEARIM	Y	2
	Dose: 100 MG		
11/08/15	1940 PHSEARIM	Y	2
	Dose: 100 MG		
11/09/15	1930 PHMCCLEJ	Y	2
	Dose: 100 MG		
11/10/15	0717 PHPARKSU	Y	2
	Dose: 100 MG		
11/10/15	2107 PHMCCLEJ	Y	2
	Dose: 100 MG		
11/11/15	0941 PHCLEMEL	Y	2
	Dose: 100 MG		

Admin Totals

20

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

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Patient **CHILDS, HANEEF A** Responsible Doctor **MAQSOOD, TAHIR, MD**
Account Number **[REDACTED]** Location **PH2NE** Unit Number **M000611175**
Age/Sex **27/M** Room **208** Registered Date **11/03/15**
Status **DIS IN** Bed **1** Discharged Date **11/13/15**

CHILDS, HANEEF A

PA1303162331

(Continued)

HALO5TAB12 - HALOPERIDOL 5 MG TABLET (HALDOL)

Dose 5 MG (1 TABLET)

Admin Route PO

Start Date 11/08/15-1000

Stop Date 11/09/15 1211

DC Date 11/09/15-1211

Ordering Doctor **TRAN, JUDITH T, MD**

Total Dispensed 3

Total Costs \$1.17

Total Charges \$9.75

Rx Number 001426879

History

11/08/15 0730 - POM ORDER

by COTRANJ

11/08/15 0736 - EDIT

by PHPATEAS

FROM:

INTERACTION COMMENT:

DUPLICATE COMMENT:

TO:

INTERACTION COMMENT: RPH

DUPLICATE COMMENT: RPH

11/08/15 0736 - VERIFIED

by PHPATEAS

11/08/15 0853 - DEBIT

by VJORDAN

ITEMS: 1 DOSES: 1

11/08/15 2058 - DEBIT

by PFERRY

ITEMS: 1 DOSES: 1

11/09/15 0940 - DEBIT

by LCLEMENTS

ITEMS: 1 DOSES: 1

11/09/15 1220 - EDIT

by COPUESAR

EDIT DOCTOR: PUESAN, REYNALDO MD

EDIT SOURCE: Provider Source

FROM:

START: 11/08/15-1000 STOP: None SOFT STOP:

TO:

START: 11/08/15-1000 STOP: 11/09/15-1211 SOFT STOP:

11/09/15 1220 - DISCONTINUE

by COPUESAR

Eff: 11/09/15 1211

EDIT DOCTOR: PUESAN, REYNALDO MD

EDIT SOURCE: Provider Source

11/09/15 1220 - POM COPY AND EDIT

by COPUESAR

TO: Rx #U000755050

11/09/15 1222 - REVIEW PROVIDER ACTIVITY

by PHNOCHRI

by COPUESAR Eff: 11/09/15 1220

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
11/08/15	0857	PHSEARIM	Y			1	0.00
(11/08/15) (1000) Dose: 5 MG							
11/08/15	2104	PHCOSTEP	Y			1	0.00
(11/08/15) (2200) Dose: 5 MG							

DATE: 11/14/15 @ 0010		Mercy Philadelphia Hospital PHA *LIVE*		PAGE 34	
USER: CONOVITM		Medication Administration Summary			
Patient CHILDS, HANEEF A		Responsible Doctor MAQSOOD, TAHIR, MD			
Account Number		Location	PH2NE	Unit Number	M000611175
Age/Sex	27/M	Room	208	Registered Date	11/03/15
Status	DIS IN	Bed	1	Discharged Date	11/13/15
CHILDS, HANEEF A		PA1303162331		(Continued)	
11/09/15 0945 PHCLEMEL Y		1		0.00	
(11/09/15) (1000) Dose: 5 MG					
Admin Totals		3		0	

DATE: 11/14/15 @ 0010
USER: CONOVITH

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

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Patient **CHILDS, HANEEF A** Responsible Doctor **MAQSOOD, TAHIR, MD**
Account Number **[REDACTED]** Location **PH2NE** Unit Number **M000611175**
Age/Sex **27/M** Room **208** Registered Date **11/03/15**
Status **DIS IN** Bed **1** Discharged Date **11/13/15**

CHILDS, HANEEF A

PA1303162331

(Continued)

BENZ1TAB27 - BENZTROPINE MESYLATE 1 MG TABLET (COGENTIN)

Dose **1 MG (1 TABLET)**
Admin Route **PO**
Start Date **11/08/15-1000** Stop Date **None** DC Date **11/13/15-1530**
Ordering Doctor **TRAN, JUDITH T, MD**
Total Dispensed **11** Total Costs **\$1.10** Total Charges **\$13.75**
Rx Number **001426880**

Discontinue Comments DC'd by Discharge

History

11/08/15 0730 - POM ORDER by COTRANJ
11/08/15 0736 - EDIT by PHPATEAS
FROM:
DUPLICATE COMMENT:
TO:
DUPLICATE COMMENT: RPH
11/08/15 0736 - VERIFIED by PHPATEAS
11/08/15 0853 - DEBIT by VJORDAN
ITEMS: 1 DOSES: 1
11/08/15 2058 - DEBIT by PFERRY
ITEMS: 1 DOSES: 1
11/09/15 0940 - DEBIT by LCLEMENTS
ITEMS: 1 DOSES: 1
11/09/15 2052 - DEBIT by JHAMILTON
ITEMS: 1 DOSES: 1
11/10/15 0934 - DEBIT by LCLEMENTS
ITEMS: 1 DOSES: 1
11/10/15 2034 - DEBIT by JMCCELLAN
ITEMS: 1 DOSES: 1
11/11/15 0906 - DEBIT by LCLEMENTS
ITEMS: 1 DOSES: 1
11/11/15 2012 - DEBIT by JHAMILTON
ITEMS: 1 DOSES: 1
11/12/15 0922 - DEBIT by LCLEMENTS
ITEMS: 1 DOSES: 1
11/12/15 2013 - DEBIT by JMCCELLAN
ITEMS: 1 DOSES: 1
11/13/15 0914 - DEBIT by LCLEMENTS
ITEMS: 1 DOSES: 1
11/13/15 1551 - DISCONTINUE by DISCHARGE Eff: 11/13/15 1530
DC COMMENTS:
DC'd by Discharge

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
11/08/15	0857	PHSEARIM	Y			1	0.00

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 36

Patient	CHILDS HANEEF A	Responsible Doctor	NAQSOOD, TAHIR, MD
Account Number		Location	PH2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

(11/08/15) (1000) Dose: 1 MG

11/08/15	2103 PHCOSTEP	Y	1	0.00
----------	---------------	---	---	------

(11/08/15) (2200) Dose: 1 MG

11/09/15	0945 PHCLEMEL	Y	1	0.00
----------	---------------	---	---	------

(11/09/15) (1000) Dose: 1 MG

11/09/15	2318 PHMCCLEJ	Y	1	0.00
----------	---------------	---	---	------

(11/09/15) (2200) Dose: 1 MG

11/10/15	0933 PHCLEMEL	Y	1	0.00
----------	---------------	---	---	------

(11/10/15) (1000) Dose: 1 MG

11/10/15	2106 PHMCCLEJ	Y	1	0.00
----------	---------------	---	---	------

(11/10/15) (2200) Dose: 1 MG

11/11/15	0941 PHCLEMEL	Y	1	0.00
----------	---------------	---	---	------

(11/11/15) (1000) Dose: 1 MG

11/12/15	0042 PHPARKSU	Y	1	0.00
----------	---------------	---	---	------

(11/11/15) (2200) Dose: 1 MG

GIVEN BT SUN PARK DURING DOWN TIME

11/12/15	0959 PHCLEMEL	Y	1	0.00
----------	---------------	---	---	------

(11/12/15) (1000) Dose: 1 MG

11/12/15	2111 PHMCCLEJ	Y	1	0.00
----------	---------------	---	---	------

(11/12/15) (2200) Dose: 1 MG

11/13/15	0942 PHCLEMEL	Y	1	0.00
----------	---------------	---	---	------

(11/13/15) (1000) Dose: 1 MG

Admin Totals

11 0

DATE: 11/14/15 @ 0010
USER: CONOVITH

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 37

Patient CHILDS, HANEEF A Responsible Doctor MAQSOOD, TAHIR, MD
Account Number Location PH2NE Unit Number M000611175
Age/Sex 27/M Room 208 Registered Date 11/03/15
Status DIS IN Bed 1 Discharged Date 11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

LORA2VIA13 - LORAZEPAM 2 MG/ML 1 ML VIAL (ATIVAN)

Dose 2 MG (1 ML)

Admin Route IM

Start Date 11/09/15-1209

Stop Date 11/09/15 1210

DC Date 11/09/15-1210

Ordering Doctor PUESAN, REYNALDO MD

Total Dispensed 0

Total Costs \$

Total Charges \$

Rx Number 001427952

Warnings

Type: SINGLE DOSE

Range: LORAZEPAM (2 MG/ML)

Condition: ALL COMMON INDICATIONS

Daily Dose Dosing range is 0.05 MG/KG/DAY - 4 MG/DAY. Ordered dose of 0.03
MG/KG/DAY is below the Low Daily Dose. Factoring in variances, the
range of values for this dose is Low: 2.96 MG High: 0 MG Max: 0 MG.

General Warnings Elimination half-life is 10 - 20 hours

Discontinue Comments Reached Stop Date

History

11/09/15 1211 - POM ORDER

by COPUESAR

11/09/15 1214 - EDIT

by PHCORRAA

FROM:

DUPLICATE COMMENT:

TO:

DUPLICATE COMMENT: RPH

11/09/15 1214 - VERIFIED

by PHCORRAA

11/09/15 1214 - DISCONTINUE

by PHABKGJOB

Eff: 11/09/15 1210

DC COMMENTS:

Reached Stop Date

FROM:

RX COMMENTS:

Order filed UNV:

Dose Warnings differ from order entry

TO:

RX COMMENTS:

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
11/09/15	1228	PHBAHNOH	Y			1	0.00
(11/09/15) (1209) Dose: 2 MG							

Admin Totals

1

0

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 36

Patient **CHILDS, HANEEF A** Responsible Doctor **MAQSOOD, TAHIR, MD**
Account Number **91** Location **PH2NE** Unit Number **M000611175**
Age/Sex **27/M** Room **208** Registered Date **11/03/15**
Status **DIS IN** Bed **1** Discharged Date **11/13/15**

CHILDS, HANEEF A

PA1303162331

(Continued)

HALOSTAB12 - HALOPERIDOL 5 MG TABLET (HALDOL)

Dose 5 MG (1 TABLET)

Admin Route PO

Start Date 11/10/15-1000

Stop Date None

DC Date 11/12/15-1558

Ordering Doctor PUESAN, REYNALDO MD

Total Dispensed 4

Total Costs \$1.56

Total Charges \$13.00

Rx Number 001427963

History

11/09/15 1220 - POM COPY AND EDIT by COPUESAR

FROM: Rx #001426879

Result of Frequency/Schedule Edit

Ordering Doctor: PUESAN, REYNALDO MD

Last Scheduled Administration Time: 11/09/15 - 1000

Last Actual Administration Time: 11/09/15 - 0945

Old Freq/Sch: BID (SCH)

New Freq/Sch: DAILY (SCH)

Old Order Stop: 11/09/15 - 1211

New Order Start: 11/10/15 - 1000

New Order Stop:

11/09/15 1225 - EDIT by PHNOCHRI

FROM:

INTERACTION COMMENT:

DUPLICATE COMMENT:

TO:

INTERACTION COMMENT: RPH

DUPLICATE COMMENT: RPH

11/09/15 1225 - VERIFIED

by PHNOCHRI

11/10/15 0934 - DEBIT

by LCLEMENTS

ITEMS: 1 DOSES: 1

11/10/15 1744 - DEBIT

by JHAMILTON

ITEMS: 1 DOSES: 1

11/11/15 0516 - DEBIT

by LCLEMENTS

ITEMS: 1 DOSES: 1

11/12/15 0922 - DEBIT

by LCLEMENTS

ITEMS: 1 DOSES: 1

11/12/15 1602 - DISCONTINUE

by COPUESAR

Eff: 11/12/15 1558

EDIT DOCTOR: PUESAN, REYNALDO MD

EDIT SOURCE: Provider Source

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
11/10/15	0933	PHCLENEL	Y			1	0.00
(11/10/15) (1000) Dose: 5 MG							
11/10/15	1757	PHHAMILJ	Y			1	0.00

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital. PHA *LIVE*
Medication Administration Summary

PAGE 39

Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number	1	Location	PH2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Unit Number	M000611175
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

Dose: 5 MG

11/11/15	0941 PHCLEMEL	Y	1	0.00
(11/11/15)	(1000) Dose: 5 MG			

11/12/15	0959 PHCLEMEL	Y	1	0.00
(11/12/15)	(1000) Dose: 5 MG			

Admin Totals

4

0

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 40

Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number		Unit Number	M000611175
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

HAL05TAB12 - HALOPERIDOL 5 MG TABLET (HALDOL)

Dose 10 MG (2 TABLETS)

Admin Route PO

Start Date 11/10/15-2200

Stop Date 11/12/15 1558

DC Date 11/12/15-1558

Ordering Doctor PUESAN, REYNALDO MD

Total Dispensed 4

Total Costs \$1.58

Total Charges \$13.00

Rx Number 001429137

History

11/10/15 1211 - POM ORDER

by COPUESAR

11/10/15 1220 - EDIT

by PHNOCHRI

FROM:

INTERACTION COMMENT:

DUPLICATE COMMENT:

TO:

INTERACTION COMMENT: RPH

DUPLICATE COMMENT: RPH

11/10/15 1220 - VERIFIED

by PHNOCHRI

11/10/15 2033 - DEBIT

by JMCCELLAN

ITEMS: 2 DOSES: 1

11/11/15 2012 - DEBIT

by JHAMILTON

ITEMS: 2 DOSES: 1

11/12/15 1602 - EDIT

by COPUESAR

EDIT DOCTOR: PUESAN, REYNALDO MD

EDIT SOURCE: Provider Source

FROM:

START: 11/10/15-2200 STOP: None SOFT STOP:

TO:

START: 11/10/15-2200 STOP: 11/12/15-1558 SOFT STOP:

11/12/15 1602 - DISCONTINUE

by COPUESAR

Eff: 11/12/15 1558

EDIT DOCTOR: PUESAN, REYNALDO MD

EDIT SOURCE: Provider Source

11/12/15 1602 - POM COPY AND EDIT

by COPUESAR

TO: Rx #U000757051

11/12/15 1604 - REVIEW PROVIDER ACTIVITY

by FINELSOC

by COPUESAR Eff: 11/12/15 1602

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
11/10/15	2103	PHMCCLJ	Y			2	0.00
(11/10/15) (2200) Dose: 10 MG							
11/11/15	0042	PHPARKSU	Y			2	0.00
(11/11/15) (2200) Dose: 10 MG							
GIVEN BT SUN PARK DURING DOWN TIME							

DATE: 11/14/15 @ 0010
USER: CONOVITH

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

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Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number		Location	PK2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Unit Number	M000611175
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

Admin Totals

4

0

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

PAGE 42

Patient **CHILDS, HANEEF A** Responsible Doctor MAQSOOD, TAHIR, MD
Account Number **[REDACTED]** Location PH2NE Unit Number M000611175
Age/Sex 27/M Room 208 Registered Date 11/03/15
Status DIS IN Bed 1 Discharged Date 11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

CLON1TAB25 - clonazepam 1 MG TABLET (KLONOPIN)

Dose 1 MG (1 TABLET)

Admin Route PO

Start Date 11/12/15-2200

Stop Date None

DC Date 11/13/15-1530

Ordering Doctor PUESAN, REYNALDO MD

Total Dispensed 2

Total Costs \$0.10

Total Charges \$2.50

Rx Number 001431695

Discontinue Comments DC'd by Discharge

History

11/12/15 1602 - POM ORDER

by COPUESAR

11/12/15 1605 - EDIT

by FINELSOC

FROM:

DUPLICATE COMMENT:

TO:

DUPLICATE COMMENT: RPH

11/12/15 1605 - EDIT

by FINELSOC

FROM:

MED: CLON0.5T23 - clonazepam

RX ID: clonazepam 0.5 MG TABLET (KLONOPIN)

CHARGE: \$2.50

TO:

MED: CLON1TAB25 - clonazepam

RX ID: clonazepam 1 MG TABLET (KLONOPIN)

CHARGE: \$1.25

DUPLICATE COMMENT: RPH

11/12/15 1605 - VERIFIED

by FINELSOC

11/12/15 2124 - DEBIT

by JMCCELLAN

ITEMS: 1 DOSES: 1

11/13/15 0914 - DEBIT

by LCLEMENTS

ITEMS: 1 DOSES: 1

11/13/15 1551 - DISCONTINUE

by DISCHARGE Eff: 11/13/15 1530

DC COMMENTS:

DC'd by Discharge

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
11/12/15	2124	PHMCCEJ	Y			1	0.00
(11/12/15) (2200) Dose: 1 MG							
11/13/15	0942	PHCLEMEL	Y			1	0.00
(11/13/15) (1000) Dose: 1 MG							

Admin Totals

2

0

DATE: 11/14/15 @ 0010
USER: CONOVITH

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

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Patient **CHILDS, HANEEF A** Responsible Doctor MAQSOOD, TAHIR, MD
Account Number **[REDACTED]** Location PH2NE Unit Number M000611175
Age/Sex 27/M Room 208 Registered Date 11/03/15
Status DIS IN Bed 1 Discharged Date 11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

HALOSTAB12 - HALOPERIDOL 5 MG TABLET (HALDOL)

Dose 10 MG (2 TABLETS)
Admin Route PO
Start Date 11/12/15-2200 Stop Date None DC Date 11/13/15-1530
Ordering Doctor PUESAN, REYNALDO MD
Total Dispensed 4 Total Costs \$1.58 Total Charges \$13.00
Rx Number 001431696

Discontinue Comments DC'd by Discharge

History

11/12/15 1602 - POM COPY AND EDIT by COPUESAR

FROM: Rx #001429137

Result of Frequency/Schedule Edit

Ordering Doctor: PUESAN, REYNALDO MD

Last Scheduled Administration Time: 11/11/15 - 2200

Last Actual Administration Time: 11/11/15 - 0042

Old Freq/Sch: BEDTIME (SCH)

New Freq/Sch: BID (SCH)

Old Order Stop: 11/12/15 - 1558

New Order Start: 11/12/15 - 2200

New Order Stop:

11/12/15 1605 - EDIT

by FINELSOC

FROM:

INTERACTION COMMENT:

DUPLICATE COMMENT:

TO:

INTERACTION COMMENT: RPH

DUPLICATE COMMENT: RPH

11/12/15 1605 - VERIFIED

by FINELSOC

11/12/15 2013 - DEBIT

by JMCCLLELLAN

ITEMS: 2 DOSES: 1

11/13/15 0914 - DEBIT

by LCLEMENTS

ITEMS: 2 DOSES: 1

11/13/15 1551 - DISCONTINUE

by DISCHARGE Eff: 11/13/15 1530

DC COMMENTS:

DC'd by Discharge

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
11/12/15	2111	PHMCCLEJ	Y			2	0.00
(11/12/15) (2200) Dose: 10 MG							
11/13/15	0945	PHCLEMEL	Y			2	0.00
(11/13/15) (1000) Dose: 10 MG							

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

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Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number		Location	PH2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Unit Number	M000611175
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

Admin Totals

4

0

ARIP15TA2 - ARIPIprazole 15 MG TABLET (ABILIFY)

Dose 25 MG (1.666667 TABLETS)

Admin Route PO

Start Date 11/05/15-1000

Stop Date None

DC Date

Ordering Doctor PUESAN, REYNALDO MD

Total Dispensed

Total Costs \$

Total Charges \$

Rx Number U000752248

History

11/04/15 1256 - POM COPY AND EDIT

by COPUESAR

FROM: Rx #001420993

11/04/15 1315 - CANCEL

by PHTURCOT

Items Auto Credited: 0

Doses Auto Credited: 0

CANCELLATION COMMENTS:

CHANGED TO SPLIT MED

Cancelled by PHTURCOT

314

DATE: 11/14/15 @ 0010
USER: CONOVITM

Mercy Philadelphia Hospital PHA *LIVE*
Medication Administration Summary

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Patient	CHILDS, HANEEF A	Responsible Doctor	MAQSOOD, TAHIR, MD
Account Number		Location	PH2NE
Age/Sex	27/M	Room	208
Status	DIS IN	Bed	1
		Unit Number	M000611175
		Registered Date	11/03/15
		Discharged Date	11/13/15

CHILDS, HANEEF A

PA1303162331

(Continued)

ARIP10TA2 - ARIPIprazole 10 MG TABLET (ABILIFY) - 10 MG
ARIP15TA2 - ARIPIprazole 15 MG TABLET (ABILIFY) - 15 MG

Dose 25 MG (2 TABLETS)

Admin Route PO

Start Date 11/05/15-1000

Stop Date None

DC Date 11/06/15-0842

Ordering Doctor PUESAN, REYNALDO MD

Total Dispensed 2

Total Costs \$45.54

Total Charges \$375.50

Rx Number 001423063

History

11/04/15 1315 - ENTER

by PHTURCOT

Items Dispensed: 0

Doses Dispensed: 0

11/05/15 0630 - DEBIT

by SPARK

ITEMS: 2 DOSES: 2

11/06/15 0843 - DISCONTINUE

by COPUESAR

Eff: 11/06/15 0842

EDIT DOCTOR: PUESAN, REYNALDO MD

EDIT SOURCE: Provider Source

11/06/15 0843 - EDIT

by SYSTEM

TOTAL DOSE ADMIN DATA INITIATED

Admin Date	Time	User	Given	Bag	Reason Code	Items	Charge
11/05/15	1126	PHHAYESS	Y			2	0.00
(11/05/15) (1000) Dose: 25 MG							

Admin Totals

2

0

This is the end of the MAR Summary for Patient PA1303162331 - CHILDS, HANEEF A.

MEDICATION RECONCILIATION FORM

Source of Medication List: Pt/mother report

LIST BELOW ALL OF THE PATIENT'S MEDICATIONS TAKEN/PREScribed PRIOR TO ADMISSION INCLUDING
OTC, HERBAL, MEDS, & STREET OR ILLICIT DRUGS

ALL orders must be written in the Physician Order Sheet ☐ check here if additional pages are used

Drug Allergies: Penicillin

	MEDICATION NAME (WRITE LEGIBLY)	DOSE	ROUTE	FREQ	LAST DOSE DATE/TIME
1.	Marijuana	1 Blunt/5x a week	x1/yr	1x	3 days ago
2.					
3.					
4.					
5.	<u>Prescribed Meds</u>				
6.	Abilify	5mg po	daily		?
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					

MEDICATION HISTORY RECORDED BY:

[Signature]

DATE: 11/2/15
TIME: 5pm

Physician / LIP Review: Physician / LIP Review:

[Signature]

DATE: 11/2/15 TIME: 7pm

Physician / LIP Review: Physician / LIP Review:

DISCHARGE DATE: _____

Mercy Philadelphia Hospital
A member of Mercy Health System

MEDICATION RECONCILIATION FORM



Page 1 of 1
Form NS485F, Rev. 12/11/2007
MEO X.OTIER

CHILDS, HANEFF A

27 M

[Redacted]



210

Medication Administration Record

PA1303162331 CHILDS, HANSEF A
 Medical Record Num [REDACTED] PH2NE 210 1 Primary Dx SCHIZOPHRENIA
 Age 27 Sex M Weight 61 kg Body Surface Area 1.72 Admin Comments F20.9
 Admitted 11/03/15 Physician HAQSOOD, TAHIR, MD MAR Date 11/04/15-1530 - 11/05/15-1529
 Notes Run Date/Time 11/04/15-2256
 Verified By _____

Allergies

ADRs

Rx Num	Medication	Start/Stop
--------	------------	------------

***** Scheduled Meds *****

001422917 NICOTINE 7 MG/PATCH, TD24 (NICODERM) (7 MG) 11/04/15
 (NICOTINE TRANSDERMAL)
 Ordering Doctor PUESAN, REYNALDO MD
 Dose 7 MG TD DAILY SCH
 Label Comments REMOVE PREVIOUS PATCH BEFORE APPLYING NEW PATCH
 INDICATION: CURB SMOKING CRAVINGS, NICOTINE
 WITHDRAWAL
 SIDE EFFECTS: HICCUPS, INABILITY TO SLEEP,
 NERVOUSNESS, HA, MOUTH IRRITATION, UPSET STOMACH,
 COUGH
 *** Floor Stock Item ***
 Last Ack 11/04/15-1224 (INITIAL) PHBAHMOH

1000
 6/4/15
 applied on
 chest

001423063 ARIPIprazole 10 MG TABLET (ABILIFY) (10 MG) 11/05/15
 (ARIPIprazole)
 ARIPIprazole 15 MG TABLET (ABILIFY) (15 MG)
 (ABILIFY)
 Ordering Doctor PUESAN, REYNALDO MD
 Dose 25 MG PO DAILY SCH
 Label Comments INDICATIONS: SCHIZOPHRENIA, DEPRESSION, STABILIZE MOOD
 SIDE EFFECTS: FATIGUE, DIZZINESS, HA, UPSET STOMACH,
 NERVOUSNESS, WEIGHT GAIN, INCREASE BLOOD SUGAR
 *** Floor Stock Item ***
 Last Ack 11/04/15-1353 (INITIAL) PHBAHMOH

1000
 given @
 6/4/15

CHILDS, HANSEF A
 DOB [REDACTED] 27 M
 AD [REDACTED]
 AC [REDACTED]
 [REDACTED] 11175


***** PRN Meds *****

Signature	Init.	Signature	Init.	Signature	Init.
				<i>[Signature]</i>	<i>[Init.]</i>

Medication Administration Record

#A1303162331 CHILDS, HANEEF A PH2NS | 210 1 Primary Dx SCHIZOPHRENIA
 Medical Record Num [REDACTED] Admin Comments F20.9
 Age 27 Sex M Weight 61 kg Body Surface Area 1.72 MAR Date 11/04/15-1530 - 11/05/15-1529
 Admitted 11/03/15 Physician MAQSOOD, TAHIR, MD Run Date/Time 11/04/15-2256
 Notes Verified By _____

Allergies

ADRs

Rx Num	Medication	Start/Stop		
***** PRN Meds *****				
001420982	ACETAMINOPHEN 325 MG TABLET (TYLENOL) (650 MG)	11/02/15		
	(TYLENOL)			
	Ordering Doctor NOVITSKY, MARK A, MD			
	Dose 650 MG PO Q4H	PRN		
	PRN Reason PAIN			
	*** Floor Stock Item ***			
	Last Ack 11/03/15-0959 (INITIAL) PHBAHMOH			
001420983	(MAALOX) MAGNESIUM HYDROXIDE/AL HYDROX 30 (30 ML) 11/02/15			
	(MAALOX SUSPENSION)			
	Ordering Doctor NOVITSKY, MARK A, MD			
	Dose 30 ML PO Q4H	PRN		
	PRN Reason INDIGESTION			
	*** Floor Stock Item ***			
	Last Ack 11/03/15-0959 (INITIAL) PHBAHMOH			
001420984	(MILK OF MAGNESIA) MAGNESIUM HYDROXIDE 30 (30 ML) 11/02/15			
	(MILK OF MAGNESIA)			
	Ordering Doctor NOVITSKY, MARK A, MD			
	Dose 30 ML PO BEDTIME	PRN		
	PRN Reason CONSTIPATION			
	*** Floor Stock Item ***			
	Last Ack 11/03/15-0959 (INITIAL) PHBAHMOH			
001420985	HYDROXYZINE PAMOATE 25 MG CAPSULE (VISTAR) (25 MG) 11/02/15			
	(HYDROXYZINE PAMOATE)			
	Ordering Doctor NOVITSKY, MARK A, MD			
	Dose 25 MG PO Q4H	PRN		
	PRN Reason ANXIETY			
	*** Floor Stock Item ***			
	Last Ack 11/03/15-0959 (INITIAL) PHBAHMOH			
001420986	LORAZEPAM 2 MG TABLET (ATIVAN) (2 MG) 11/02/15			
	(LORAZEPAM)			
	Ordering Doctor NOVITSKY, MARK A, MD			
	Dose 2 MG PO Q4H	PRN		
	PRN Reason AGITATION			
	*** Floor Stock Item ***			
	Last Ack 11/03/15-0959 (INITIAL) PHBAHMOH			
001420987	LORAZEPAM 2 MG/ML 1 ML VIAL (ATIVAN) (2 MG) 11/02/15			
	(LORAZEPAM)			
	Ordering Doctor NOVITSKY, MARK A, MD			
	Dose 2 MG IM Q4H	PRN		
	PRN Reason AGITATION			
	Label Comments If patient is unable to take PO			
	*** Floor Stock Item ***			
	Last Ack 11/03/15-0959 (INITIAL) PHBAHMOH			

CHILDS, HANEEF A

DOB [REDACTED]

27

M

AD [REDACTED]

M [REDACTED]

M [REDACTED]

M [REDACTED]

M [REDACTED]

M [REDACTED]

M [REDACTED]

M [REDACTED]

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M [REDACTED]

M [REDACTED]

M [REDACTED]

M [REDACTED]

M [REDACTED]

Signature	Init.	Signature	Init.	Signature	Init.
				Supp	✓

Medication Administration Record

#A1303162331 CHILDS, HANEEF A
 Medical Record Number [REDACTED] PH2NE | 210 1 Primary Dx SCHIZOPHRENIA
 Age 27 Sex M Weight 61 kg Body Surface Area 1.72 Admin Comments F20.9
 Admitted 11/03/15 Physician MAQSOOD, TAHIR, MD MAR Date 11/04/15-1530 - 11/05/15-1529
 Notes Run Date/Time 11/04/15-2256
 Verified By _____

Allergies

ADRs

Rx Num	Medication	Start/Stop	-	-	-
***** PRN Meds *****					
001420980	TEMAZEPAM 15 MG CAPSULE (15 MG) (TEMAZEPAM)	11/02/15			
	Ordering Doctor NOVITSKY, MARK A, MD				
	Dose 15 MG PO BEDTIME PRN				
	PRN Reason INSOMNIA				
	*** Floor Stock Item ***				
	Last Ack 11/03/15-0959 (INITIAL) PHEAHMOH				
001420989	RISPERIDONE 1 MG TAB. RAPDIS (RISPERDAL MTA (1 MG) 11/02/15 (Risperdal M)				
	Ordering Doctor NOVITSKY, MARK A, MD				
	Dose 1 MG PO Q4H PRN				
	PRN Reason PSYCHOSIS				
	*** Floor Stock Item ***				
	Last Ack 11/03/15-0959 (INITIAL) PHEAHMOH				
001420990	HALOPERIDOL LACTATE 5 MG/ML INJECTION (HAL (5 MG) 11/02/15 (HALOPERIDOL LACTATE)				
	Ordering Doctor NOVITSKY, MARK A, MD				
	Dose 5 MG IM Q6H PRN				
	PRN Reason SEVERE AGITATION				
	** Floor Stock Item ***				
	Last Ack 11/03/15-0959 (INITIAL) PHEAHMOH				
001420991	BENZTROPINE MESYLATE 1 MG TABLET (COSENTIN (1 MG) 11/02/15 (BENZTROPINE MESYLATE)				
	Ordering Doctor NOVITSKY, MARK A, MD				
	Dose 1 MG PO Q4H PRN				
	PRN Reason FOR EPS				
	*** Floor Stock Item ***				
	Last Ack 11/03/15-0959 (INITIAL) PHEAHMOH				
001420992	BENZTROPINE MESYLATE 2 MG/2 ML INJECTION ((2 MG) 11/02/15 (BENZTROPINE MESYLATE)				
	Ordering Doctor NOVITSKY, MARK A, MD				
	Dose 2 MG IM Q6H PRN				
	PRN Reason Acute Dystonic Reaction				
	*** Floor Stock Item ***				
	Last Ack 11/03/15-0959 (INITIAL) PHEAHMOH				

CHILDS, HANEEF A
 DOB [REDACTED]
 AD [REDACTED]

27 M



Signature	Init.	Signature	Init.	Signature	Init.
				<i>[Signature]</i>	<i>[Init.]</i>

JAI303162331 CHILDS, HANEEF A
 Medical Record N [REDACTED] PH2NE | 210 1 Primary Dx SCHIZOPHRENIA
 Age 27 Sex M Weight 61 Kg Body Surface Area 1.72 Admin Comments F20.9
 Admitted 11/03/15 Physician MAQSOOD, TAHIR, MD MAR Date 11/04/15-1530 - 11/05/15-1529
 Notes Run Date/Time 11/04/15-2256
 Verified By _____

Allergies

ADRs

Rx Num	Medication	Start/Stop	-	-	-
***** PRN Meds *****					
001422915	NICOTINE POLACRILEX 2 MG GUM (NICORETTE) (2 MG)	11/04/15			
	(Nicotine Gum)				
	Ordering Doctor PUESAN, REYNALDO MD				
	Dose 2 MG PO Q2WA PRN				
	PRN Reason SMOKING CESSATION				
	Label Comments INDICATION: CURB SMOKING CRAVINGS, NICOTINE WITHDRAWAL				
	SIDE EFFECTS: HICCUPS, INABILITY TO SLEEP, NERVOUSNESS, HA, MOUTH IRRITATION, UPSET STOMACH, COUGH				
	*** Floor Stock Item ***				
	Last Ask 11/04/15-1224 (INITIAL) PHBAHMOH				

CHILDS, HANEEF A

DOB: [REDACTED] 27 M

ADM: [REDACTED]



Signature	Init.	Signature	Init.	Signature	Init.

Medication Administration Record						Page 1
PA1303162331 CHILDS, HANEEF A		PH2HE 2008 1		Primary Dx SCHIZOPHRENIA		
Medical Record Num [REDACTED]				Admin Comments P20.9		
Age 27	Sex M	Weight 61 kg	Body Surface Area 1.72	MAR Date 11/11/15-2330 - 11/12/15-2329		
Admitted 11/03/15		Physician MAQSOOD, TAHIR, MD		Run Date/Time 11/11/15-2202		
Notes				Verified By _____		
Allergies						
ADRs						
Rx Num	Medication			Start/Stop		
***** Scheduled Meds *****						
001422917	NICOTINE 7 MG/PATCH.TD24 (NICODERM) (7 MG) (NICOTINE TRANSDERMAL)			11/04/15	1000	
Ordering Doctor PUESAN, REYNALDO MD						
Dose 7 MG		TD	DAILY	SCH		
Label Comments:						
REMOVE PREVIOUS PATCH BEFORE APPLYING NEW PATCH						
INDICATION: CURB SMOKING CRAVINGS, NICOTINE						
WITHDRAWAL						
SIDE EFFECTS: HICCUPS, INABILITY TO SLEEP,						
NERVOUSNESS, HA, MOUTH IRRITATION, UPSET STOMACH,						
COUGH						
*** Floor Stock Item ***						
Last Ack: 11/04/15-1224 (INITIAL) PHBAHMOH						
001424510	OLANzapine 10 MG TABLET (ZYPREXA) (20 MG) (OLANzapine)			11/05/15	2200	
Ordering Doctor PUESAN, REYNALDO MD						
Dose 20 MG		PO	BEDTIME	SCH		
Label Comments: INDICATIONS: MANIA, PSYCHOSIS, DEPRESSION						
SIDE EFFECTS: DIZZINESS, NERVOUSNESS, INCREASED						
LIPIDS, CONSTIPATION, HOSTILITY, DRY MOUTH, WEIGHT						
GAIN, HIGH BLOOD SUGAR, INABILITY TO SLEEP, BLURRY						
VISION, FATIGUE						
*** Floor Stock Item ***						
Last Ack: 11/05/15-1723 (INITIAL) PHMCCLBJ						
001426880	BENZTROPINE MESYLATE 1 MG TABLET (COGENTIN) (1 MG)			11/08/15	1000 2200	
(BENZTROPINE MESYLATE)						
Ordering Doctor TRAN, JUDITH T, MD						
Dose 1 MG		PO	BID	SCH		
Label Comments: INDICATION: PARKINSON'S; SCHIZOPHRENIA						
SIDE EFFECTS: DRY MOUTH, CONSTIPATION						
*** Floor Stock Item ***						
Last Ack: 11/08/15-0049 (INITIAL) PHSEARIM						

CHILDS, HANEEF A

DOB: [REDACTED] 27 M

ADM: [REDACTED]

ACC: [REDACTED]



Signature	Init.	Signature	Init.	Signature	Init.

Medication Administration Record						Page 2
PA1303162331 CHILDS, HANEER A		PH2NE 208 1		Primary Dx SCHIZOPHRENIA		
Medical Record Num [REDACTED]				Admin Comments P20.9		
Age 27	Sex M	Weight 61 kg	Body Surface Area 1.72	MAR Date 11/11/15-2330 - 11/12/15-2329		
Admitted 11/03/15		Physician HAQSOOD, TAHIR, MD		Ren Date/Time 11/11/15-2202		
Notes				Verified By _____		
Allergies						
ADRs						
Rx Num	Medication			Start/Stop		
***** Scheduled Meds *****						
001427963	HALOPERIDOL 5 MG TABLET (HALDOL) (5 MG) (HALOPERIDOL)			11/10/15	1000	
Ordering Doctor PUESAN, REYNALDO MD						
Dose 5 MG PO DAILY SCH						
Label Comments: INDICATION: SCHIZOPHRENIA OR DEMENTIA OR TOURETTE'S SYNDROME						
SIDE EFFECTS: DIZZINESS, CONSTIPATION, DRY MOUTH, WEIGHT GAIN, CHANGE IN SEXUAL FUNCTION						
*** Floor Stock Item ***						
Last Ack: 11/09/15-1329 (INITIAL) PHGLEMBL						
001429137	HALOPERIDOL 5 MG TABLET (HALDOL) (10 MG) (HALOPERIDOL)			11/10/15	2200	
Ordering Doctor PUESAN, REYNALDO MD						
Dose 10 MG PO BEDTIME SCH						
Label Comments: INDICATION: SCHIZOPHRENIA OR DEMENTIA OR TOURETTE'S SYNDROME						
SIDE EFFECTS: DIZZINESS, CONSTIPATION, DRY MOUTH, WEIGHT GAIN, CHANGE IN SEXUAL FUNCTION						
*** Floor Stock Item ***						
Last Ack: 11/10/15-1517 (INITIAL) PHBAHMOH						
CHILDS, HANEER A DOB [REDACTED] 27 M A [REDACTED] A [REDACTED]						
						
***** PRN Meds *****						

Signature	Init.	Signature	Init.	Signature	Init.

Medication Administration Record

PA1303162331 CHILDS, HANEEF A

PH2NE [200 1

Primary Dx SCHIZOPHRENIA

Medical Record #

Admin Comments P20.9

Age 27 Sex M Weight 61 kg

Body Surface Area 1.72

MAR Date 11/11/15-2330 - 11/12/15-2329

Admitted 11/03/15

Physician MAQSOOD, TAHIR, MD

Run Date/Time 11/11/15-2202

Notes

Verified By

Allergies

ADRs

Rx Num

Medication

Start/Stop

***** PRN Meds *****

001420982 ACETAMINOPHEN 325 MG TABLET (TYLENOL) (650 MG) 11/02/15
(TYLENOL)

Ordering Doctor NOVITSKY, MARK A, MD

Dose 650 MG

PO

Q4H

PRN

PRN Reason: PAIN

*** Floor Stock Item ***

Last Ack: 11/03/15-0959 (INITIAL) PHBAHMOH

001420983 (MAALOX) MAGNESIUM HYDROXIDE/AL HYDROX 30 (30 ML) 11/02/15
(MAALOX SUSPENSION)

Ordering Doctor NOVITSKY, MARK A, MD

Dose 30 ML

PO

Q4H

PRN

PRN Reason: INDIGESTION

*** Floor Stock Item ***

Last Ack: 11/03/15-0959 (INITIAL) PHBAHMOH

001420984 (MILK OF MAGNESIA) MAGNESIUM HYDROXIDE 30 (30 ML) 11/02/15
(MILK OF MAGNESIA)

Ordering Doctor NOVITSKY, MARK A, MD

Dose 30 ML

PO

BEDTIME

PRN

PRN Reason: CONSTIPATION

*** Floor Stock Item ***

Last Ack: 11/03/15-0959 (INITIAL) PHBAHMOH

001420985 HYDROXYZINE PAMOATE 25 MG CAPSULE (VISTAR) (25 MG) 11/02/15
(HYDROXYZINE PAMOATE)

Ordering Doctor NOVITSKY, MARK A, MD

Dose 25 MG

PO

Q4H

PRN

PRN Reason: ANXIETY

*** Floor Stock Item ***

Last Ack: 11/03/15-0959 (INITIAL) PHBAHMOH

001420986 LORAZEPAM 2 MG TABLET (ATIVAN) (2 MG) 11/02/15
(LORAZEPAM)

Ordering Doctor NOVITSKY, MARK A, MD

Dose 2 MG

PO

Q4H

PRN

PRN Reason: AGITATION

*** Floor Stock Item ***

Last Ack: 11/03/15-0959 (INITIAL) PHBAHMOH

CHILDS, HANEEF A
DOB: 11/11/15
ADM: 11/03/15
ACC: 11/11/15
27 M

Signature	Init.	Signature	Init.	Signature	Init.

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Medication Administration Record

PA1303162331 CHILDS, HANEEF A
 Medical Record Number [REDACTED] PH2NB | 208 1 Primary Dx SCHIZOPHRENIA
 Age 27 Sex M Weight 61 kg Body Surface Area 1.72 Admin Comments F20.9
 Admitted 11/03/15 Physician MAQSOOD, TAHIR, MD MAR Date 11/11/15-2330 - 11/12/15-2329
 Notes Run Date/Time 11/11/15-2202
 Verified By _____

Allergies

ADRS

Rx Num	Medication	Start/Stop
***** PRN Meds *****		

001420987 LORAZEPAM 2 MG/ML 1 ML VIAL (ATIVAN) (2 MG) 11/02/15
 (LORazepam)
 Ordering Doctor NOVITSKY, MARK A, MD
 Dose 2 MG IM Q4H PRN
 PRN Reason: AGITATION
 Label Comments: If patient is unable to take PO
 *** Floor Stock Item ***
 Last Ack: 11/03/15-0955 (INITIAL) PHBAHHOH

001420988 TENAZEPAM 15 MG CAPSULE (15 MG) 11/02/15
 (TENAZEPAM)
 Ordering Doctor NOVITSKY, MARK A, MD
 Dose 15 MG PO BEDTIME PRN
 PRN Reason: INSOMNIA
 *** Floor Stock Item ***
 Last Ack: 11/03/15-0959 (INITIAL) PHBAHHOH

*11/12
 9:00
 @ 12:00pm
 ✓*

001420989 RISPERIDONE 1 MG TAB. RAPDIS (RISPERDAL MTA (1 MG) 11/02/15
 (RisperDAL M)
 Ordering Doctor NOVITSKY, MARK A, MD
 Dose 1 MG PO Q4H PRN
 PRN Reason: PSYCHOSIS
 *** Floor Stock Item ***
 Last Ack: 11/03/15-0959 (INITIAL) PHBAHHOH

001420990 HALOPERIDOL LACTATE 5 MG/ML INJECTION (HAL (5 MG) 11/02/15
 (HALOPERIDOL LACTATE)
 Ordering Doctor NOVITSKY, MARK A, MD
 Dose 5 MG IM Q6H PRN
 PRN Reason: SEVERE AGITATION
 *** Floor Stock Item ***
 Last Ack: 11/03/15-0955 (INITIAL) PHBAHHOH

001420991 BENZOTROPINE MESYLATE 1 MG TABLET (COGENTIN (1 MG) 11/02/15
 (BENZOTROPINE MESYLATE)
 Ordering Doctor NOVITSKY, MARK A, MD
 Dose 1 MG PO Q4H PRN
 PRN Reason: FOR EPS
 *** Floor Stock Item ***
 Last Ack: 11/03/15-0959 (INITIAL) PHBAHHOH

CHILDS, HANEEF A 27 M
 DOB: [REDACTED]
 ADM: [REDACTED]
 ACC: [REDACTED]



Signature	Init.	Signature	Init.	Signature	Init.
				<i>Surpa</i>	<i>Q</i>

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Medication Administration Record

PA1303162331 CHILDS, HANEESH A
 Medical Record Num [REDACTED] PH2NE 1208 1 Primary Dx SCHIZOPHRENIA
 Age 27 Sex M Weight 61 kg Body Surface Area 1.72 Admin Comments F20.9
 Admitted 11/03/15 Physician MAQSOOD, TAHIR, MD MAR Date 11/11/15-2330 - 11/12/15-2329
 Notes Run Date/Time 11/11/15-2202
 Verified By _____

Allergies

ADRs

Rx Num	Medication	Start/Stop
***** PRN Meds *****		
001420992	BENZTROPINE MESYLATE 2 MG/2 ML INJECTION ((2 MG) 11/02/15 (BENZTROPINE MESYLATE) Ordering Doctor NOVITSKY, MARK A, MD Dose 2 MG IM Q6H PRN PRN Reason: Acute Dystonic Reaction *** Floor Stock Item *** Last Ack: 11/03/15-0959 (INITIAL) PHBAHHOH	
001422915	NICOTINE POLACRILEX 2 MG GUM (NICORETTE) (2 MG) 11/04/15 (Nicotine Gum) Ordering Doctor PUESAN, REYNALDO MD Dose 2 MG PO Q2WA PRN PRN Reason: SMOKING CESSATION Label Comments: INDICATION: CURB SMOKING CRAVINGS, NICOTINE WITHDRAWAL SIDE EFFECTS: HICCUPS, INABILITY TO SLEEP, NERVOUSNESS, HA, MOUTH IRRITATION, UPSET STOMACH, COUGH *** Floor Stock Item *** Last Ack: 11/04/15-1224 (INITIAL) PHBAHHOH	
001424511	ZOLPIDEM TARTRATE 5 MG TABLET (AMBIEN) (5 MG) 11/05/15 (ZOLPIDEM TARTRATE) Ordering Doctor PUESAN, REYNALDO MD Dose 5 MG PO BEDTIME PRN PRN Reason: INSOMNIA Label Comments: INDICATIONS: INSOMNIA SIDE EFFECTS: NAUSEA, DIARRHEA, DIZZINESS, HA, SOMNOLENCE. VISUAL DISTURBANCES *** Floor Stock Item *** Last Ack: 11/05/15-1723 (INITIAL) PHMCCLJ	
001424554	tramadol HCL 50 MG TABLET (ULTRAM) (100 MG) 11/05/15 (tramadol HCL) Ordering Doctor NOVITSKY, MARK A, MD Dose 100 MG PO Q6H PRN PRN Reason: MODERATE/SEVERE PAIN Dose Instructions: *PRN* MAX OF THREE DOSES PER 24 HOURS Label Comments: SIDE EFFECTS: DIZZINESS, HA, UPSET STOMACH *** Floor Stock Item *** Last Ack: 11/05/15-1858 (INITIAL) PHMCCLJ	

CHILDS, HANEESH A
 DOB: [REDACTED]
 ADM: [REDACTED] 27 M
 ACC: [REDACTED]



Signature	Init.	Signature	Init.	Signature	Init.

Medication Administration Record

PA1303162331 CHILDS, HANEEF A PH2NE | 208 1 Primary Dx SCHIZOPHRENIA
 Medical Record Num [REDACTED] Admin Comments F20.9
 Age 27 Sex M Weight 61 kg Body Surface Area 1.72 MAR Date 11/11/15-2330 - 11/12/15-2329
 Admitted 11/03/15 Physician HAQSOOD, TAHIR, MD Run Date/Time 11/11/15-2202
 Notes Verified By _____

Allergies

ADRs

Rx Num

Medication

Start/Stop

***** PRN Meds *****

001425204 POLYVINYL ALCOHOL 15 ML DROPS (AKWA TBA (1 DROPS) 11/06/15
 (AKWA TEARS)

Ordering Doctor PUESAN, REYNALDO MD

Dose 1 DROPS

EYE BOTH Q4H

PRN

PRN Reason: DRYNESS

Last Ack: 11/06/15-1310 (INITIAL) PHDAIMOH

CHILDS, HANEEF A
 DOB: [REDACTED] 27 M
 ADM: [REDACTED]
 ACC: [REDACTED]



Signature	Init.	Signature	Init.	Signature	Init.

INVENTORY OF SUICIDE RISK FACTORS

***This assessment must be completed on all inpatient psychiatric admissions including medical and critical care transfers.

CHECK (☒) ANY RISK FACTORS IDENTIFIED DURING CLINICAL EVALUATION:**

PRIMARY RISK FACTORS

Note: If a primary risk factor is identified in category 1 or 2 consider patient to be a **HIGH RISK** for suicide.

1. ATTEMPT WITH:

- ☐ Lethal method (guns, hanging, jumping) ☒ NONE
- ☐ Moderate/severe injury or toxicity
- ☐ Low likelihood of being rescued
- ☐ Regret it was unsuccessful, continued ideation or refusal of treatment

2. ACTIVE SUICIDAL PLAN/INTENT:

- ☐ Definite suicide plan ☒ NONE
- ☐ Specific lethal method selected
- ☐ Intent to commit suicide imminently
- ☐ Access to firearms/lethal means
- ☐ Preparations for death (suicide note, giving away possessions, business or insurance arrangements)
- ☐ Extreme hopelessness/unable to focus on positive future events

SECONDARY RISK FACTORS

3. CURRENT CLINICAL INDICATORS:

- ☐ Delusional ☐ NONE
- ☐ Command hallucinations
- ☒ Depressed mood, especially with
- ☐ extreme level of anxiety
- ☐ agitation
- ☐ significant insomnia
- ☐ Committed violence in past year
- ☒ Impulsive or risky behavior
- ☒ Expressing anger and hostility

4. SOCIAL AND DEMOGRAPHIC FACTORS:

- ☐ Age less than 19 or greater than 45 ☐ NONE
- ☒ Male
- ☐ Male age 65 or older
- ☐ Lack of Psychosocial support/isolated
- ☐ Living alone
- ☒ Separated, divorced, widowed

These risk factors may be considered modifiable and may improve or resolve with therapeutic interventions

** (Inventory may be completed by RN or Intake Worker, but must be reviewed by psychiatrist.)

5. HISTORY OF:

- ☐ NONE
- ☒ Previous suicide attempt(s) (If checked, how many) # _____
- ☒ Previous psychiatric treatment
- ☒ Psychiatric hospitalization in past year
- ☐ Self destructive behavior
- ☐ Family/close friend suicide
- ☐ Physical or sexual abuse in childhood
- ☐ Bipolar disorder
- ☒ Alcohol and/or substance use/abuse
- ☐ Schizophrenia
- ☐ Borderline personality disorder

6. STRESSORS AND LOSSES:

- ☐ Recent or impending loss ☐ NONE
- ☒ Chronic, painful, or terminal medical disorder
- ☐ Newly diagnosed serious medical problem/s
- ☐ Overwhelming or humiliating stressor
- ☐ Unresolved legal issues
- ☐ Unemployed/Loss of job
- ☐ Financial stress

7. PROTECTIVE FACTORS:

- Note: These are not risk factors but may prevent the person from acting on suicidal thoughts. ☐ NONE*
- ☐ Moderate to strong religious beliefs
- ☐ Currently clean and sober
- ☐ Adequate coping/problem solving skills
- ☐ Sense of responsibility to children, family and others including pets
- ☐ Employed
- ☒ Available social supports
- ☒ Positive therapeutic relationship
- ☒ Accepts treatment
- *Note: Fewer protective factors increases risk.

8. CURRENT SUICIDAL IDEATION?

- ☒ NONE/Denies
- ☐ YES

DATE: 11/09/15 TIME: 11Am

Signature RN/Int: Mohamed M. B.

Psychiatrist has reviewed information on above risk factors and in conjunction with assessment data determines current suicide risk as:

☐ NONE ☒ LOW ☐ MEDIUM ☐ HIGH

DATE: 11-09-15 TIME: 11-30AM

Signature Psychiatrist: [Signature]

Mercy Philadelphia Hospital
A member of Mercy Health System

INVENTORY OF SUICIDE RISK FACTORS



DOE CHILDS, HANEEF A
Adm DOB: [REDACTED] 27 M
Acc ADM: [REDACTED]
ACV: [REDACTED]



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Patient Name Hanef Childs DOB [REDACTED] Social Security # [REDACTED] Insurance CBH

Address: [REDACTED] Phone: [REDACTED]

Car on Premises ☐ Yes ☐ No Car Location: _____

Religion: Islam Marital Status: S Maiden Name: _____

Emergency Contact Name: [REDACTED] Relation: [REDACTED]

Address: [REDACTED] Phone: [REDACTED]

Special Needs: ☐ Wheelchair ☐ Interpreter ☐ Deaf ☐ Other _____

Events Leading to Presentation/Chief Complaint: At home mother & grandmother. Mother

irate that pt not kept in hospital when seen here at 2AM to 5

day. Demanding to 302 pt so you will have to keep him. (Cont)

Substances used within last 24 hours: (include details in medication reconciliation) _____

Last used marijuana 3 days ago.

Withdrawal Symptoms ☐ Yes ☒ No Details: _____

Suicidal Ideation ☐ Yes ☒ No Plan ☐ Yes ☐ No ☒ N/A Means ☐ Yes ☐ No ☒ N/A

Family History ☐ Yes ☒ No History of Attempts ☐ Yes ☒ No Number of Attempts _____

Details: _____

Homicidal Ideation ☐ Yes ☒ No Plan ☐ Yes ☐ No ☒ N/A Means ☐ Yes ☐ No ☒ N/A

Details: _____

Aggression ☐ Yes ☒ No Details: _____

Hallucinations ☐ Yes ☒ No Details: _____

Delusions ☒ Yes ☐ No Details: At irate to people.

Medical Issues (VS, Breathalyzer, HCG and Accu Chek to be placed on Point of Care Result Form)

Allergies: Amoxicillin LMP: N/A

Diabetes ☐ Yes ☒ No Type: _____ Last Blood Sugar: _____

Asthma ☐ Yes ☒ No Cardiac Issues ☐ Yes ☒ No Details: _____

Integumentary Issues: ☐ Yes ☒ No Details: _____

Seizure Disorder ☐ Yes ☒ No If yes, when and what type was last seizure? _____

HIV ☐ Yes ☒ No Details: _____ Hepatitis ☐ Yes ☒ No Details: _____

Nutritional Deficits ☐ Yes ☒ No Details: _____

H/O Falls ☐ Yes ☒ No If yes, last fall and what led to it? _____

Pain ☐ None ☒ Chronic ☐ Acute Type, Source, Current Rating (1-10): Lower Back = 10

Are there any other medical problems we should be aware of? _____

Medical Advance Directives ☐ Yes ☒ No ☐ Unknown Psychiatric Advance Directives ☐ Yes ☒ No ☐ Unknown

RN Signature: [Signature] Time: 5pm Date: 11/2/15

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CCG Nursing Trlage



Page 1 of 2
Form CRC002, Rev. 03/2013
ASLX.OTHER

CHILDS, HANEEF A

DOB: [REDACTED] 27 M

ADM: [REDACTED]

AC: [REDACTED] 7:55 PM



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Further Comments If Needed:

11/15 (cont) Pt agreeable to re-eval by another psychiatrist. Admits to feelings of paranoia - showed this unit a picture of some plastic & string wrapped around it and said someone put it in his basement. Reports another man following him everywhere. Says he only sleeps 1-2 hours per night. Speech loud & pressured. J. Gansler

11/2/15 5^{pm} - Pt refusing now to cooperate & assessment. Demanding to be released but then refusing to do so. In lobby yelling at his mother and grandmother. Insisting nothing wrong to him. Refusing to follow any staff re-direction. Very intimidating to other patients. Pt escorted from unit by security. Mother stayed in CCL to attempt a 302 petition. J. Gansler

11/2/15 Patient present to the CEC by police at 1755pm. Patient was agitated and uncooperative. Patient was hallucinating and delusional. Patient was treated. Vital signs are stable. J. Gansler, LOM

RN Signature:

J. Gansler

Time:

5 pm

Date:

11/2/15

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A member of Mercy Health System

CPC Nursing Trlaga



Page 2 of 2
Form CRC002, Rev. 03/2013
ASH X OTHER

CHILDS, HANEEF A
D(DOB 27 M
Ac ADM
Ac ACC



Suicide Lethality Scale (Attachment A)

Instructions: During assessment, utilizing questioning and observation techniques, check off the categories below which most closely apply to the patient's situation or behavior under low or high lethality.

LOW INTENSITY INDICATORS	Score	✓	HIGH INTENSITY INDICATORS	Score	✓
Mild/Moderate Anxiety	2		High Anxiety or Panic	7	
Mild Depression	2	✓	Withdrawn or Isolated	6	
Several Resources	0	✓	Few Resources	6	✓
Constructive Coping Strategies	0	✓	Destructive Coping Strategies	7	
No Declarative Statements	0	✓	Verbal Statements of Intent	10	
No Professional help in the past or no positive experiences associated with this help	0		Negative view of Professional help in the past	7	
No non-verbal behavior indicating self-destructiveness	0	✓	Non-verbal behavior indicating self destructive thoughts	8	
Stable Lifestyle	0		Unstable Lifestyle	8	✓
Use of alcohol or drugs to excess infrequently	1		Excessive use of alcohol or drugs	7	✓
Vague/fleeting thoughts of suicide with no plan or method	2		Specific suicide plan	10	
No means to complete suicide	1	✓	Recent or Significant loss(es)	8	✓
No Previous Suicide Attempts	0	✓	Self-deprecating remarks	7	✓
No recent or significant loss in the past	0		Impulsive behavior	9	✓
In good physical health, few or no medical problems	0	✓	Hearing command hallucinations for self harm	10	
Rampant hostility/aggressiveness	1	✓	In poor health, numerous medical problems	6	
Score on Low Indicators (total score)	1		Score on High Indicators (total score)	38	

Total Score On combined Low and High Intensity Indicators: 39

Score is 0 - 20:	Suicide Risk None/Very Low	Not verbalizing or suggesting suicidal ideation
Score is 21 - 39:	Suicide Risk Low	Occasional or fleeting suicidal ideation, no plan, will contract for safety
Score is 40 - 79:	Suicide Risk Moderate	Ongoing suicidal ideation, vague plan, minimal insight, ambivalent about contracting
Score is 80 - 125:	Suicide Risk High	Ongoing suicidal ideation, command hallucinations, or clear intent with concrete plan

Staff Signature: [Signature]

Time: 5:10 pm

Date: 11/2/15

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Suicide Lethality Scale



Page 1 of 1
Form CRCC03, Rev. 03/2013
ASM, X, OTHER

CHILDS, HANEEF A

DOB: [REDACTED] 27 M

ADM: [REDACTED]

ACC: [REDACTED]



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Date: 11-2-15

CHIEF COMPLAINT:

*Simplex has been seen & told
at 10:00 AM 11/2/15*

HISTORY OF PRESENT ILLNESS: PT here 3X, IN 24 hrs. 1st seen ~ 12:35 AM endorsing depression, paranoia, anxiety ~~in past 30 days~~ report of bag but is EN (not subconjunctival hemorrhage). He was here to doctor - became angry & then & was asked to leave. Then he came back later but demanded to leave. He is recent from 3024 pt. For reports "PT HAS dx of CPS. Not taken meds in past 30 days. He is very paranoid. He believes that London people are following him & trying to kill him. I am afraid he is going to burn himself, or someone else. He freaks out, yells & gets loud."

Upon arrival to ER pt is 5'x heavy build, unshaven, unkempt, misperceptual, aggressive, threats. Paranoia, persecutory & process of falling into guilt. Reported 1st hospital stay, March 29, 2015, 12 days. (He'd already said pt says he's been competent yet, mother reports no treatment past 30 days) in past 24 hrs he did admit to feeling very paranoid & that someone put something in his breast & was following him. Only sleeping 1-2 hrs/night. Displayed psychotic behavior earlier - demanding to leave ER. Refusing to go. 1st asking for help. Then refusing to follow directions. On current exam pt clearly appears to be delusional & HUS.

Anglo, never moved

on Paradox till 2020 spent 30 days in prison this year 3/2015. 4 children 2F) 11th grade. unemployed. lives in mother's.

PAST PSYCHIATRIC HISTORY

Prior Diagnoses: 1. CPS. 2. ? Bipolar depression

Most Recent Hospitalization and Date of Discharge: none documented.

Current Outpatient Treatment: CPT work in past - none C present

Current Medications and Response:

I have reviewed and signed Medication Reconciliation Form ☒

Compliant with medication currently ☐ Yes ☐ No Reason _____

*none in 3 weeks
was in A&E 11/2/15 20:00*

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CRC PSYCHIATRIC EVALUATION



Page 1 of 5
Form CRC080, Rev. 04/2012
ASMLX BEHAV

CHILDS, HANEEF A

DOB: [redacted] 27Y M

Adm: [redacted]

Acc: [redacted]



Response to current and prior medications including adverse effects _____

Prior Inpatient and Outpatient Treatments: _____

First Psychiatric Hospitalization/Treatment: ? 155 in 2010.

Summary of Other Treatments: _____

History of Suicide Attempts/Gestures: ☒ No ☐ Yes (details): _____

History of Physical /Sexual Abuse Including Domestic Violence: φ

D & A HISTORY:

Result of UDS: Negative Positive:

Drug/Class	Last Use	Amount Used	Route	Frequency	Duration of Use
1. Nicotine	11/02/15	1 PPD	snrk	daily	5 yrs 16 yrs.
2. Alcohol	⊖				
3. Marijuana	11/01/15	one 62 Dhr	snrk	daily	years
4 Cocaine/Crack	⊖				
5. Opiates	⊖				
6. Benzodiazepines	⊖				
7 Stimulants	⊖				
8. PCP/LSD	⊖				

Current Withdrawal Symptoms or H/O Withdrawal if Intoxicated: (circle all applicable)

Restlessness Tremors Anxiety Panic Attack Sweating Tachycardia Elevated Blood Pressure

H/O Delirium HO Seizures Hallucinations Disorientation Headache Runny Nose

Itching/Numbness Body Aches Nausea/vomiting Diarrhea

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GRC PSYCHIATRIC EVALUATION



Page 2 of 6
Form GRC080, Rev. 04/2012
ASM, X, DEHAV

CHILDS, HANEEF A

DOB: [REDACTED] 27X M

Adm: [REDACTED]

Ac: [REDACTED]



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Previous Treatment and Periods of Sobriety: in tx a "few" times' not really sober.

Family History of Psychiatric Illness: Wife / cousin - Schizophrenia

MEDICAL HISTORY

Current Medical Diagnoses: Ⓜ

M1 - General

Prior Hospitalizations for Medical Surgical Problems: Ⓜ

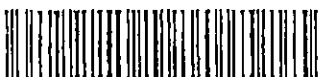
Family History of Medical Illness: ☒ Hypertension ☐ CAD ☐ COPD ☐ Diabetes ☐ Cancer

Other: None

Review of Systems:	Normal/Abnormal	Comment if Abnormal
Constitutional/General	☒ Normal ☐ Abnormal	
Skin	☒ Normal ☐ Abnormal	
HEENT	☐ Normal ☒ Abnormal	<u>seen + noted E Sub conjunctiva benign growth in POCUS 10/5/12</u>
Respiratory	☒ Normal ☐ Abnormal	
Cardiovascular	☒ Normal ☐ Abnormal	
Gastrointestinal	☒ Normal ☐ Abnormal	
Genitourinary	☒ Normal ☐ Abnormal	
Musculoskeletal	☒ Normal ☐ Abnormal	
Endocrine	☒ Normal ☐ Abnormal	
Neurological	☒ Normal ☐ Abnormal	

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CRC PSYCHIATRIC EVALUATION



Page 3 of 6
Form 6888, Rev. 04/2012
ASM X BEHAV

CHILDS, HANEEF A

DOB: 11/11/87 27Y M

Adm: [REDACTED]

Acc: [REDACTED]



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MENTAL STATUS EXAMINATION

Level of consciousness: Alert Drowsy Lethargic Oblunded Asleep *Does not sleep*
 Oriented to: Person Yes No Place Yes No Time Yes No
 General Appearance and Behavior: Appears close to: Slated age Older Younger
In hospital gown Street clothes Neat/well groomed Unkempt Disheveled
 Appropriately dressed: Yes No (details) _____
 Cooperative Uncooperative Guarded Hostile/threatening Eye contact: Good Poor
 Other Observation: PT, MS, Meezyet, Paranoid.
 Speech: Normal Loud Pressured Decreased amount Soft tone Mumbling Mute
 Affect: Angry Anxious Sad Tearful Constricted Blunted Flat Labile Elated
Appropriate To The Content: Yes No (details) _____
 Mood: Normal/Euthymic Depressed Dysphoric Anxious Frustrated Euphoric Paranoid
 Thought Process: Goal Directed Circumstantial Tangential Flight of ideas Thought Blocking Thought Insertion
 Thought Broadcasting Poverty of content of thought Loosening of associations
 Thought Content: (Please circle and give details) Paranoid Ideation Ideas of reference Grandiosity Religious
 Preoccupation Sexual preoccupation Obsessive thoughts Apprehensions Phobias
 Hopeless Helpless Guilty thoughts Sense of shame Nihilistic Ideation
 Other Preoccupations: Feels someone is following him.
 Delusions: Paranoid, Euphoric
 Suicidal thoughts (plan): Yes
 Homicidal thoughts (plan): Yes
 Will patient contract for safety? Yes No (precautions taken).
 Hallucinations. Denies Yes (describe):

Responding to internal stimuli: No Yes (details): _____
 Cognitions/Memory: Attention Diminished Concentration Diminished
 Recall Poor Recent Memory Poor Remote Memory Poor
 Insight and Judgment: Good Fair Impaired (details): _____

DSM-V/ICD 10:

Schizophrenia
new Schizophrenia vs. Bipolar & features
Compulsions are denied.

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CRC PSYCHIATRIC EVALUATION



Page 4 of 6
 Form #000, Rev. 10/2015
 ASM X.BEHAV

CHILDS, HANEEF A

DOB: 27Y M

Adm: [Redacted]

Acc: [Redacted]



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Recommendations for Level of Care:

Please check all the applicable items

I. ☐ Send to ER for Medical Treatment:

Reason: _____

II. Admit to Acute Psychiatric Unit:

- ☐ Suicidal and unable to contract for safety
- ☐ Homicidal and unable to contract for safety
- ☐ Dangerous and/or unable to care for self due to Psychosis
 - ☒ Disorganized thought process
 - ☒ Active hallucinations/responding to hallucinations
 - ☒ Delusions interfering with ability to make rational decisions

Other significant clinical concerns: _____

III. Admit to Co-Occurring Disorder Unit:

- ☒ Meets criteria for admission to Acute Psychiatric Unit and also has active or significant history of drug abuse/dependence.

IV. Admit to Detoxification Unit:

- ☐ Meets criteria for Dependence and has active History of withdrawal

V. Transfer to Acute Care Hospital: Name: _____

VI. Transfer to Subacute/Crisis Residence Facility: Name: _____

VII. Place in Observation: Hospital: _____

VIII. Admit to Rehab Facility: Name: _____

IX. Discharge with Outpatient Follow-up:

- ☐ Patient does not exhibit any acute psychotic symptoms or significant mood disorder.
- ☐ Patient does not express any suicidal or homicidal thoughts and is able to contract for safety
- ☐ Patient has the required medications or has been provided with a prescription.
- ☐ Outpatient appointment has been made and family/ICM informed: ☐ Yes ☐ No
- ☐ Housing Situation : ☐ Family ☐ Shelter ☐ Residential Facility
- ☐ Other _____
- ☐ Other Pertinent Clinical Detail _____

Physician's Signature _____

Time _____

Date _____

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PRC PSYCHIATRIC EVALUATION



Page 5 of 5
Form CRC080, Rev. 04/2012
ASM X BEHAV

CHILDS, HANEEF A

DOB: [REDACTED] 27Y M

Adm: [REDACTED]

ACC: [REDACTED]



DRUG REACTION HISTORY MUST BE COMPLETED BEFORE DRUG CAN BE DISPENSED

PATIENT HAS HISTORY OF DRUG ALLERGY, SENSITIVITY OR ADVERSE REACTION TO:	DESCRIPTION OF EVENT
CHECK HERE IF PATIENT DENIES HISTORY OF ALLERGIES, SENSITIVITIES OR ADVERSE REACTIONS	

Age: _____ Gender: Male

Care Unit: 2NE

Shift: 7:30 A - 4 PM

DATE	TIME	FAXED	ORDERS	TRANSCRIBED BY
11/03/15	9:30 AM		BEHAVIORAL RESTRAINT ASSESSMENT PART I ☒ Initial Assessment ☒ Reassessment (Nursing to Complete): A. Nursing Assessment ☒ Severe Agitation ☐ Assaultive/ Risk of Injury ☐ Combative/Striking Out ☐ Violent/ Aggressive Behavior ☐ Self-Abusive ☐ Unsafe Behavior due to Impaired Judgment/ Cognition/ Psychosis ☐ Suicidal ☐ Persistent aggressive verbal threats ☐ Throwing Objects ☐ Hitting/ Kicking/ Biting ☐ Damaging Property ☐ Behavior Dangerous to Self or Others ☐ Self-Mutilating ☐ Other: _____ B. Identify the less-restrictive alternatives tried in order to modify behaviors: ☒ De-escalation ☐ Calming Medication ☐ 1:1 Observation ☐ Set Clear, Firm Limits ☐ PEAT Code ☐ Family Members ☐ Diversion/Activity ☐ Quiet Room / Time-Out ☐ Active Listening ☐ Allow to Ventilate ☐ Minimum Stimulation ☐ Offer Alternatives / Choices ☐ Other/Describe: _____ C. Patient's Response to Above Alternatives: <u>Pt became very loud and destructive, not following re-orientation.</u> The above alternatives have been tried and have been unsuccessful; there is a need for more restrictive restraint interventions. RN Signature: <u>Mohamed M. Bahr</u> Date: <u>11/3/15</u> Time: <u>9:30 AM</u> PART II PHYSICIAN ORDERS (Physician to Complete): A. Clinical Justification: ☐ Imminent danger of harm to self or others ☐ Combative/ Assaultive/ Violent behavior ☐ Other: _____ B. Time: Ages 18 & above - 4 hour max. / Ages 9 to 17 years - 2 hour max. / Under 9 years of age - 1 hour max. APPLY FROM (TIME) <u>9:30 AM</u> TO (TIME) <u>10:30 AM</u> C. Type of restraint: ☐ Locked Seclusion (Psychiatric Units Only) ☐ 3-4 Side rails ☒ Locked Velcro Restraints ☐ 1 Point ☐ 3 Point ☐ 2 Point ☐ Soft Limb ☐ 4 Point ☐ Other D. Continuous observation face-to-face by assigned staff for duration of episode. Note: Face-to-face LIP / Physician visit must be completed within one hour and Progress note written. E. Signatures: Doctor: _____ Time: _____ Signature: _____ Pager#: _____ Date: _____ Time: _____ Unit Secretary Signature: _____ Date: <u>11/3/15</u> Time: <u>9:30A</u> Registered Nurse Signature: <u>Mohamed M. Bahr</u> ☐ If verbal order, readback and verified by _____ RN	

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BEHAVIORAL RESTRAINT ASSESSMENT



Page 1 of 2
Form #PH719, Rev. 01/2008
ASM X OTHER

CHILDS, HANEEF A
DOB: [REDACTED] 27Y M
AC: [REDACTED]
AO: [REDACTED]



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PART III NURSING CARE

(Nursing to Complete):

A. Family Notification / Patient and Family Education:

Name of Family Member notified: 15/11

Date/Time: 11/3/15

☐ PI, Refused

☐ Unavailable

Patient and family educated regarding reason for restraints and given hospital brochure.

Behaviors required to discontinue the restraints were explained to patient and family.

Restraint prevention and use were identified on Inter-disciplinary Plan of Care / Team Treatment Plan.

B. Continuous Patient Observation and Revised Plan of Care for Restraints / Seclusion:

Assigned observer's signature signifies that the following care and / or observations were completed every 15 minutes:

Behavior, Cognitive Function, Response to restraints and Readiness for Release

Circulation: for presence of pulses & good color, Skin Assessment & Assessment for Patient Injury;

Range-of-motion exercises and restraint release of all limbs one at a time - provide every 2 hours and more frequently if needed per q. 15 minute observations.

Evaluate need for Food, Fluids, Hygiene and Toileting; provide every 2 hours and more frequently if needed per q. 15 minute observations.

Behavioral Key:

1 = Threatening
7 = Uncooperative
13 = Drank (Describe)

2 = Combative
8 = Calmer

3 = Violent
9 = Quiet

14 = Other (See Comments)

4 = Assaultive
10 = Cooperative

5 = Loud/Yelling
11 = Medicated

6 = Agitated
12 = Ate (Describe)

RN Initials: mk

Time every 15 min.	Behavior Key	Circle Restrained Limbs	Comments/Observations/interventions	Assigned Staff Observer Signature
9:30	2, 5, 6	RA LA RL LL		<u>mk</u>
9:45	2, 3, 5, 6	RA LA RL LL		<u>mk</u>
10:00	2, 3, 5, 6	RA LA RL LL		<u>mk</u>
10:15	2, 3, 5, 6	RA LA RL LL		<u>mk</u>
10:30	6	RA LA RL LL		<u>mk</u>
10:45	6	RA LA RL LL		<u>mk</u>
11:00	8, 9	RA LA RL LL		<u>mk</u>
11:15	8, 9	RA LA RL LL		<u>mk</u>
11:30	8, 9	RA LA RL LL		<u>mk</u>
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		

C. Reassessment: Nurse reassess the patient at the end of the time ordered or when released.

Date: 11/3/15

Time: 10:30 AM

Pt - Content for safety and good behavior

☐ Continue Restraints

☐ New order obtained

Signature/Title: Mohamed A. Bahar

Vital Signs: Time _____

T. _____

P. _____

R. _____

BP _____

D. Restraints Discontinued: The patient has met the following criteria for restraint removal or release from locked seclusion:

Criteria for Removal (✓) as appropriate, complete when released

☐ Increased behavioral control

☐ No assaultive threats

☐ Demonstrates calm behavior

☐ Improved mental status

☐ Improved communication

☐ Other _____

☐ Decreased agitation

☐ No threats of self harm

☐ Follows directions

☐ Interacts with staff

☐ Agrees to Safety Contract

Signature/Title: Mohamed A. Bahar

Date Ended: 11/3/15

Time Ended: 11:30 AM

E. (Psychiatry only) Debriefing occurred with patient, family & staff and recorded on Debriefing Form ☒ Yes ☐ No

☐ Clinical leadership notified for episode > 12 hours or 2 or more episode within 12 hours.

Total Time Restrained: 2 Hours 0 Minutes

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BEHAVIORAL RESTRAINT ASSESSMENT



Page 2 of 2
Form #PH110, Rev. 01/2008
ASM.X.OTHER

CHILDS, MONEE A

D. 27Y M

Adm

2



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INVENTORY OF SUICIDE RISK FACTORS

***This assessment must be completed on all inpatient psychiatric admissions including medical and critical care transfers.

CHECK (☒) ANY RISK FACTORS IDENTIFIED DURING CLINICAL EVALUATION.**

PRIMARY RISK FACTORS

Note: If a primary risk factor is identified in category 1 or 2 consider patient to be a **HIGH RISK** for suicide.

1. ATTEMPT WITH:

- ☐ Lethal method (guns, hanging, jumping)
☐ Moderate/severe injury or toxicity
☐ Low likelihood of being rescued
☐ Regret it was unsuccessful, continued ideation or refusal of treatment

☒ NONE

2. ACTIVE SUICIDAL PLAN/INTENT:

- ☐ Definite suicide plan
☐ Specific lethal method selected
☐ Intent to commit suicide imminently
☐ Access to firearms/lethal means
☐ Preparations for death (suicide note, giving away possessions, business or insurance arrangements)
☐ Extreme hopelessness/unable to focus on positive future events

☒ NONE

SECONDARY RISK FACTORS

3. CURRENT CLINICAL INDICATORS:

- ☐ Delusional
☒ Command hallucinations
☐ Depressed mood, especially with
☐ extreme level of anxiety
☐ agitation
☐ significant insomnia
☐ Committed violence in past year
☒ Impulsive or risky behavior
☒ Expressing anger and hostility

☐ NONE

4. SOCIAL AND DEMOGRAPHIC FACTORS:

- ☐ Age less than 19 or greater than 45
☒ Male
☐ Male age 65 or older
☐ Lack of Psychosocial support/isolated
☐ Living alone
☐ Separated, divorced, widowed

☐ NONE

These risk factors may be considered modifiable and may improve or resolve with therapeutic interventions

**(Inventory may be completed by RN or Intake Worker, but must be reviewed by psychiatrist.)

5. HISTORY OF:

- ☐ Previous suicide attempt(s) (If checked, how many) # _____
☒ Previous psychiatric treatment
☒ Psychiatric hospitalization in past year
☒ Self destructive behavior
☐ Family/close friend suicide
☐ Physical or sexual abuse in childhood
☐ Bipolar disorder
☒ Alcohol and/or substance use/abuse
☒ Schizophrenia
☐ Borderline personality disorder

☐ NONE

6. STRESSORS AND LOSSES:

- ☐ Recent or impending loss
☒ Chronic, painful, or terminal medical disorder
☐ Newly diagnosed serious medical problem/s
☐ Overwhelming or humiliating stressor
☐ Unresolved legal issues
☒ Unemployed/Loss of job
☐ Financial stress

☐ NONE

7. PROTECTIVE FACTORS:

Note: These are not risk factors but may prevent the person from acting on suicidal thoughts.

- ☐ Moderate to strong religious beliefs
☐ Currently clean and sober
☐ Adequate coping/problem solving skills
☐ Sense of responsibility to children, family and others including pets
☐ Employed
☒ Available social supports
☐ Positive therapeutic relationship
☐ Accepts treatment

☐ NONE

*Note: Fewer protective factors increases risk.

8. CURRENT SUICIDAL IDEATION?

- ☒ NONE/Denies
☐ YES

DATE: 11/3/15

TIME: 11:30pm

Signature RNW:

Shannon D. [Signature]

Psychiatrist has reviewed information on above risk factors and in conjunction with assessment data determines current suicide risk as:
☐ NONE ☒ LOW ☐ MEDIUM ☐ HIGH

DATE: 11/3/15

TIME: 11:00pm

Signature Psychiatrist:

[Signature]

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INVENTORY OF SUICIDE RISK FACTORS



CHILDS, HANEEF A

DOB: [REDACTED] 27Y M

Adm: [REDACTED]

A: [REDACTED]



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11-3-15 11-6
11-9 11-11 11-14

Addiction Services

Consumer Name: HANEEF Childs Date: 11-3-15 Age: 27YD

Drug and Alcohol History:

- 1) How old were you when you first tried Alcohol or drugs? _____
- 2) What was the first substance that you used? _____
- 3) At what age do you believe that drugs became a problem? _____
- 4) Were there any precipitating factors (e.g. abuse, medical issues)? _____
- 5) How long have you been using since your last clean time? _____

Current Drug Use:

Nicotine: ☒ Yes ☐ No Age of 1st Use 16YD Current use: Quantity 1 Pack
Frequency DL Last 11-3-15

Substance: MARIJUANA Age of 1st Use 16YD Prescription Drug ☐ Street Drug ☒
Current use: Quantity 1-2 blunts Frequency DL Method of use SMOKE
Last use 11-1-15

Substance: _____ Age of 1st Use _____ Prescription Drug ☐ Street Drug ☐
Current use: Quantity _____ Frequency _____ Method of use _____
Last use _____

Substance: _____ Age of 1st Use _____ Prescription Drug ☐ Street Drug ☐
Current use: Quantity _____ Frequency _____ Method of use _____
Last use _____

Drug/Alcohol Treatment History:

12 Step Programs

☐ No prior participation

☐ Attended: ☐ AA ☐ NA ☐ CA

I went _____ time(s) a week for _____ months/years.

Did you have a sponsor? ☐ Yes ☐ No

Did you use your sponsor? ☐ Yes ☐ No

Do you have and attend a homegroup? ☐ Yes ☐ No

What is your attitude toward AA/NA? ☐ Like ☐ Dislike Why? _____

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DETOX HISTORY AND ASSESSMENT



Page 1 of 8
Form NS620, Rev. 01/2011
ASM X OTHER

CHILDS, HANEEF A

DOB: 11-3-15 27Y M

Adm: 11-3-15

Acc: 11-3-15



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Prior D/A Treatment:

☐ No prior treatment

Level of Care	Provider	When Month/Year	Duration of Time In Treatment	Did you complete?
Detox				☐ Yes ☐ No
Rehab				☐ Yes ☐ No
IOP				☐ Yes ☐ No
Outpatient				☐ Yes ☐ No

What was your longest period of abstinence? _____ When? _____

Reason/Circumstances for Relapse: _____

Mental Health Treatment:

1. Have you ever received counseling or psychiatric treatment? ☐ Yes ☐ No ☐ Outpatient ☐ Inpatient

2. List last two Outpatient and Inpatient Treatments

Provider	When Month/Year	Reason/ Diagnosis	List of Medications Taken	Medication Compliance
Outpatient			LM -	☐ Yes ☐ No
				☐ Yes ☐ No
Inpatient				☐ Yes ☐ No
				☐ Yes ☐ No

~~1st Inpatient 2010~~

Suicide History:

Did you ever attempt to harm yourself? ☐ Yes ☐ No

If yes the number of attempts: _____

Are you currently suicidal? ☐ Yes ☐ No (If patient answers yes then contact On-Call Physician)

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DETOX HISTORY AND ASSESSMENT



Page 2 of 9
Form NS020, Rev. 01/2011
ASM X OTHER

CHILDS, HANEEF A

DOB [REDACTED] 27Y M

Adm [REDACTED]

Acc [REDACTED]



Trauma History:

Were you sexually or physically abused as a child? ☐ Yes ☐ No If yes details: _____

Were you a victim of rape or domestic violence as an adult? ☐ Yes ☐ No If yes details: _____

Family:

Where were you born? _____ Who raised you? _____

Were your parents together when you were young? _____

Are your parents together now? _____

What was your relationship with your mother/stepmother like when you were young?

Circle: Good Fair Poor Describe _____

Now: Circle: Good Fair Poor Deceased Describe _____

What was your relationship with your father/stepfather like when you were young?

Circle: Good Fair Poor Describe _____

Now: Circle: Good Fair Poor Deceased Describe _____

Do you have siblings? ☐ Yes ☐ No If yes, how many brothers? _____ How many sisters? _____

How many stepbrothers? _____ How many stepsisters? _____

Where do you fit age wise? _____

What was your relationship with your siblings like when you were growing up?

Circle: Good Poor N/A Describe _____

Now: Circle: Good Fair Poor N/A Describe _____

What was your home environment like when you were young?

Circle: Good Fair Poor Describe _____

Have either of your parents had problems with drugs or alcohol? _____

Have any of your siblings had a problem with drugs or alcohol? _____

Do you currently have a close relationship with anyone in your family? _____ Who? _____

Do you feel your substance use has affected your relationships with family members? _____

Who? _____ How? _____

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DETOX HISTORY AND ASSESSMENT



Page 3 of 8
Form HS620, Rev. 01/2011
ASM X OTHER

CHILDS, HANEEF A

DOB: _____ 27Y M

Adm: _____

Acc: _____



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Marital Status/Dating:

What is your sexual orientation? Circle: Heterosexual Homosexual Bisexual Unsure
Are you aware of safe sex practices? _____ Do you practice safe sex? _____
Age of first sexual experience? _____ How many "serious" relationships have you had? _____
Have you ever been married? NO What is your current marital status? single
Are you in a committed relationship? _____
Does your current partner use drugs or alcohol? _____ Have most of your partners used drugs? _____
Do you have any minor children? yes How many? 4 Who cares for your children? _____
Do you have any adult children? NO How many? NA 10, 8, 4, 1
Do you have contact with your children? _____
Do you feel your substance use has affected your relationships with your partner/children? _____

Interpersonal Relationships:

Would you describe yourself as outgoing or more of a loner? _____
How many friends do you have that you consider part of your support system? _____
How many sober friends do you have? _____
Do you feel your use of drugs and/or alcohol has affected your relationship with friends? _____
How? _____

Environment:

Who do you reside with? Circle: Family Friends Spouse Live alone Homeless
How many times have you changed living arrangements in the last year? 1006 and 1007
Do you have a place to live when you leave treatment? yes
If yes, are there any active substance abusers at that residence? _____
Do you have any concerns that your living arrangements will impact on your ability to stay clean and sober? _____

Legal:

Have you ever been arrested? yes If yes, on what charges? _____
SECURITY SERVICES 30 DAYS IN PRISON
Do you have a P.O.? _____ On Probation until? EDRD
Does your P.O. know that you are here? _____
Do you currently have any open court cases? _____ What are the charges and court dates? _____

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DETOX HISTORY AND ASSESSMENT



Page 4 of 8
Form H5620, Rev. 1/2011
ASIM.X.0115R

CHILDS, HANEEF A

DOB: [REDACTED] 27Y M
Adm: [REDACTED]
Acc: [REDACTED] 5



Education:

How far did you go in school? 11th grade

If you did not complete school, why not? _____

Have you ever attempted GED? _____ If no, why not? _____

What kind of student were you? Circle: Good Fair Poor Special Education

Do you have any technical or vocational training? _____

Do you have any educational or vocational goals at this time? _____

Do you feel your substance use affected your school performance? _____

Financial:

Do you have any financial resources? _____

Are you currently employed? no If yes, how long have you been on this job? _____

If unemployed, how long has it been since you last worked? _____

What type of work did you do? _____

Have you ever lost or quit a job because of your substance abuse? _____

Military History:

Were you in the armed forces? no Which branch? NA When? NA

Highest rank achieved? NA Were you ever disciplined in the military? NA

Did you see combat? ☐ Yes ☒ No Describe NA

Date of discharge from the service? NA

Type of discharge NA

Describe your drinking/drug use while you were in the service NA

Recreation/Social Support System:

What are your hobbies/interests? _____

How has your drug/alcohol use affected your recreational activities? _____

With whom do you socialize? _____

Do they use Drugs or Alcohol? _____

Who is supportive of your treatment and recovery? _____

Do you belong to any groups or organizations that will be supportive? _____

Nutrition: ☒ Appears adequately nourished ☐ Needs Consult (See Nursing Assessment)

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DETOX HISTORY AND ASSESSMENT



Page 6 of 8
Form NS620, Rev. 01/2011
ASMLX, OTHER

CHILDS, HANEEF A

DOB: 01/27/1987 27Y M

Adm: 01/27/2011

Ac: 01/27/2011



Spirituality:

	Yes	No	Describe (if appropriate)
Were you raised in an organized religion?	☐	☐	_____
Are you currently active in a religion?	☐	☐	_____
Do you believe in God or a Higher power?	☐	☐	_____
Do you pray?	☐	☐	_____
Do you engage in any other spiritual practices?	☐	☐	_____
Have you had any bad experiences with religion?	☐	☐	_____
Has drug/alcohol use affected your spirituality?	☐	☐	_____

Primary Care Physician Information:

☐ Yes ☐ No

Name: _____

Address: _____ Phone Number: _____

Patient Self-Assessment :

How would you rate your level of motivation for treatment? ☐ Low ☐ Moderate ☐ High

Explain _____

What are the things you value most in life? _____

What are your goals in life? _____

Besides your drug/alcohol use, what would you like to change about yourself? _____

Aftercare Planning:

Do you believe you need ongoing treatment at discharge? _____

If yes, what treatment would you request? _____

Do you have a photo ID? _____

Psychosocial (Diagnostic) Summary - Use Evidence Based Statements:

1. Client Profile:

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DETOX HISTORY AND ASSESSMENT



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Form NS620, Rev. 01/2011
ASM X OTHER

CHILDS, HANEEF A

DOB: [REDACTED] 27Y M

Rdm [REDACTED]
Acc [REDACTED]



2. Presenting and Underlying Problem(s):

3. Problems that might inhibit treatment involvement/success:

4. Strengths:

5. Weaknesses:

6. Potential or Available Support Network:

7. Preferred Coping Mechanisms:

8. Conclusions regarding:

- Appearance: (Use Descriptions)* _____
- Reactions to Intake Process: ☐ Cooperative ☐ Uncooperative
- Explain* _____

9. Conclusions regarding:

- Attitude toward treatment process: ☐ Positive ☐ Negative
- Explain* _____

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DETOX HISTORY AND ASSESSMENT



Page 7 of 8
Form NS620, Rev. 01/2011
ASM.X.OTHER

CHILDS, HANEEF A

DOB: [REDACTED] 27Y M

Adm: [REDACTED]

Acc: [REDACTED]



▪ Motivation to participate in treatment: ☐ Internal ☐ External

Explain* _____

10. Primary Treatment Needs:

11. Recommendation for treatment :

Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: GAF = _____

*Use evidenced-based statements

Counselor Signature and Degree

Time

Date

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DETOX HISTORY AND ASSESSMENT



Page 6 of 8
Form NS620, Rev. 01/2011
ASMX OTHER

CHILDS, HANEEF A

DOB: [REDACTED] 27Y M

Adm: [REDACTED]

Acc: [REDACTED]



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IS DRUG REACTION HISTORY MUST BE COMPLETED BEFORE DRUG CAN BE DISPENSED

PATIENT HAS HISTORY OF DRUG ALLERGY, SENSITIVITY OR ADVERSE REACTION TO:	DESCRIPTION OF EVENT
CHECK HERE IF PATIENT DENIES HISTORY OF ALLERGIES, SENSITIVITIES OR ADVERSE REACTIONS	

Age: _____ Gender: Male

Care Unit: 2NE

Shift: 730A-4PM

DATE	TIME	FAXED	ORDERS	TRANSCRIBED BY
11/4/15	1250 PM		BEHAVIORAL RESTRAINT ASSESSMENT PART I ☒ Initial Assessment ☐ Reassessment (Nursing to Complete): A. ☒ Severe Agitation ☒ Assaultive/ Risk of Injury ☒ Combative/Striking Out ☒ Violent/ Aggressive Behavior ☒ Self-Abusive ☒ Unsafe Behavior due to Impaired Judgment/ Cognition/ Psychosis ☒ Suicidal ☒ Persistent aggressive verbal threats ☒ Throwing Objects ☒ Hitting/ Kicking/ Biting ☒ Damaging Property ☒ Behavior Dangerous to Self or Others ☒ Self-Mutilating ☐ Other: _____ B. Identify the less-restrictive alternatives tried in order to modify behaviors: ☒ De-escalation ☒ Calming Medication ☒ 1:1 Observation ☐ Set Clear, Firm Limits ☒ PEAT Code ☒ Family Members ☒ Diversion/Activity ☐ Quiet Room / Time-Out ☒ Active Listening ☒ Allow to Ventilate ☒ Minimum Stimulation ☐ Offer Alternatives / Choices ☐ Other/Describe: _____ C. Patient's Response to Above Alternatives: <u>Pt remains combative, yelling, screaming not following</u> <u>re-directions.</u> The above alternatives have been tried and have been unsuccessful; there is a need for more restrictive restraint interventions. RN Signature: <u>Michael M. Bah R.N.</u> Date: <u>11/4/15</u> Time: <u>1 PM</u> PART II PHYSICIAN ORDERS (Physician to Complete): A. Clinical Justification: ☒ Imminent danger of harm to self or others ☒ Combative/ Assaultive/ Violent behavior ☐ Other: <u>attempts to strangle, by choking him, via hanging by towel.</u> B. Time: Ages 18 & above - 4 hour max. / Ages 9 to 17 years - 2 hour max. / Under 9 years of age - 1 hour max. APPLY FROM (TIME) <u>12:15 AM</u> TO (TIME) <u>3:15 AM</u> C. Type of restraint: ☐ Locked Seclusion (Psychiatric Units Only) ☐ 3-4 Side rails ☒ Locked Velcro Restraints ☒ 4 Point ☐ 3 Point ☐ 2 Point ☐ Soft Limb ☐ 4 Point ☐ Other D. Continuous observation face-to-face by assigned staff for duration of episode. Note: Face-to-face LIP / Physician visit must be completed within one hour and Progress note written E. Signatures: Licensed Independent Practitioner Date: _____ Time: _____ Signature: _____ Pager# _____ Unl Secretary Signature Date: <u>11/4/15</u> Time: <u>1 PM</u> Registered Nurse Signature: <u>Michael M. Bah R.N.</u> ☐ If verbal order, readback and verified by _____ RN	

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BEHAVIORAL RESTRAINT ASSESSMENT



CHILDS, HANBEE A
DOB: _____ 27Y M
Adm: _____
Acc: _____



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RT III NURSING CARE

(Nursing to Complete):

Family Notification / Patient and Family Education: N/A

Name of Family Member notified: _____

Date/Time: 11/4/15

☐ PI, Refused

☐ Unavailable

Patient and family educated regarding reason for restraints and given hospital brochure.

Behaviors required to discontinue the restraints were explained to patient and family.

Restraint prevention & use were identified on Inter-disciplinary Plan of Care / Team Treatment Plan.

B. Continuous Patient Observation and Revised Plan of Care for Restraints / Seclusion:

Assigned observer's signature signifies that the following care and / or observations were completed every 15 minutes:

Behavior, Cognitive Function, Response to restraints and Readiness for Release

Circulation: for presence of pulses & good color, Skin Assessment & Assessment for Patient Injury;

Range-of-motion exercises and restraint release of all limbs one at a time - provide every 2 hours and more frequently if needed per q. 15 minute observations

Evaluate need for Food, Fluids, Hygiene and Toileting; provide every 2 hours and more frequently if needed per q. 15 minute observations.

Behavioral Key:

1 = Threatening

2 = Combative

3 = Violent

4 = Assaultive

5 = Loud/Yelling

6 = Agitated

7 = Uncooperative

8 = Calmer

9 = Cautel

10 = Cooperative

11 = Medicated

12 = Ate (Describe)

13 = Drank (Describe)

14 = Other (See Comments)

Time every 15 min.	Behavior Key	Circle Restrained Limbs	Comments/Observations/Interventions	Assigned Staff Observer Signature
1:00	1, 5, 6, 7	RA LA RL LL		JS
1:15	1, 5, 6, 7	RA LA RL LL		JS
1:30	1, 5, 6, 7	RA LA RL LL	Pt ripped restraint off	JS
1:45	1, 5, 6, 7	RA LA RL LL		JS
2:00	6, 8	RA LA RL LL		JS
2:15	6, 8	RA LA RL LL		JS
2:30	5, 6	RA LA RL LL		JS
2:45	5, 6	RA LA RL LL		JS
3:00	5, 6	RA LA RL LL		K.G. L
3:15	5, 6	RA LA RL LL	Pt D/C from restraints	KGL
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		

C. Reassessment: Nurse reassess the patient at the end of the time ordered or when released.

Date: 11/4/15

Time: 3:15 PM

Pt. contacted for safety and good behavior
all restraints removed.

☐ Continue Restraints

☐ New order obtained

Signature/Title: Mahesh M. Bala

Vital Signs: Time 3:10

T. 36.2

P. 73

R. 16

BP 104 / 59

D. Restraints Discontinued: The patient has met the following criteria for restraint removal or release from locked seclusion:

Criteria for Removal (✓) as appropriate, complete when released

☐ Increased behavioral control

☐ No assaultive threats

☐ Demonstrates calm behavior

☐ Improved mental status

☐ Improved communication

☐ Other _____

☐ Decreased agitation

☐ No threats of self harm

☐ Follows directions

☐ Interacts with staff

☐ Agrees to Safety Contract

Signature/Title: Mahesh M. Bala

Date Ended: 11/4/15

Time Ended: 3:15 AM

E. (Psychiatry only) Debriefing occurred with patient, family & staff and recorded on Debriefing Form

☒ Yes ☐ No

☐ Clinical leadership notified for episode > 12 hours or 2 or more episode within 12 hours.

Total Time Restrained: 2 Hours 20 Minutes

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BEHAVIORAL RESTRAINT ASSESSMENT



Page 2 of 2
Form #PH719, Rev. 01/2008
ASM.X.OTHER

CHILDS, HANEEF A

DOB: [REDACTED] 27Y M

Adm: [REDACTED]

Age: [REDACTED]



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INVENTORY OF SUICIDE RISK FACTORS

***This assessment must be completed on all inpatient psychiatric admissions including medical and critical care transfers.

CHECK (X) ANY RISK FACTORS IDENTIFIED DURING CLINICAL EVALUATION.**

PRIMARY RISK FACTORS

Note: If a primary risk factor is identified in category 1 or 2 consider patient to be a HIGH RISK for suicide.

1. ATTEMPT WITH:

- ☐ Lethal method (guns, hanging, jumping)
☐ Moderate/severe injury or toxicity
☐ Low likelihood of being rescued
☐ Regret it was unsuccessful, continued ideation or refusal of treatment

☒ NONE PTA

attempt in hospital

2. ACTIVE SUICIDAL PLAN/INTENT:

- ☐ Definite suicide plan
☐ Specific lethal method selected
☐ Intent to commit suicide imminently
☐ Access to firearms/lethal means
☐ Preparations for death (suicide note, giving away possessions, business or insurance arrangements)
☐ Extreme hopelessness/unable to focus on positive future events

☒ NONE

SECONDARY RISK FACTORS

3. CURRENT CLINICAL INDICATORS:

- ☐ Delusional
☐ Command hallucinations
☒ Depressed mood, especially with
☐ extreme level of anxiety
☐ agitation
☐ significant insomnia
☐ Committed violence in past year
☐ Impulsive or risky behavior
☐ Expressing anger and hostility

☐ NONE

4. SOCIAL AND DEMOGRAPHIC FACTORS:

- ☐ Age less than 19 or greater than 45
☐ Male
☐ Male age 65 or older
☐ Lack of Psychosocial support/isolated
☐ Living alone
☐ Separated, divorced, widowed

☐ NONE

A* These risk factors may be considered modifiable and may improve or resolve with therapeutic interventions

** (Inventory may be completed by RN or Intake Worker, but must be reviewed by psychiatrist.)

5. HISTORY OF:

- ☐ Previous suicide attempt(s) (If checked, how many) # _____
☐ Previous psychiatric treatment
☐ Psychiatric hospitalization in past year
☒ Self destructive behavior
☐ Family/close friend suicide
☐ Physical or sexual abuse in childhood
☐ Bipolar disorder
☐ Alcohol and/or substance use/abuse
☐ Schizophrenia
☐ Borderline personality disorder

☐ NONE

6. STRESSORS AND LOSSES:

- ☐ Recent or impending loss
☐ Chronic, painful, or terminal medical disorder
☐ Newly diagnosed serious medical problem/s
☐ Overwhelming or humiliating stressor
☐ Unresolved legal issues
☒ Unemployed/Loss of job
☐ Financial stress

☐ NONE

7. PROTECTIVE FACTORS:

Note: These are not risk factors but may prevent the person from acting on suicidal thoughts.

- ☐ Moderate to strong religious beliefs
☐ Currently clean and sober
☐ Adequate coping/problem solving skills
☐ Sense of responsibility to children, family and others including pets
☐ Employed
☒ Available social supports
☐ Positive therapeutic relationship
☐ Accepts treatment

☐ NONE*

*Note: Fewer protective factors increases risk.

8. CURRENT SUICIDAL IDEATION?

- ☒ NONE/Denies
☐ YES

DATE:

11/4/15

TIME:

11:30 PM

Signature RN/IA:

[Signature]

Psychiatrist has reviewed information on above risk factors and in conjunction with assessment data determines current suicide risk as:

☐ NONE ☐ LOW ☐ MEDIUM ☒ HIGH

DATE:

11/4/15

TIME:

12:00 PM

Signature Psychiatrist:

[Signature]

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INVENTORY OF SUICIDE RISK FACTORS

CHILDS, HANEEF A

DOB: [REDACTED] 27Y M

Adm: [REDACTED]

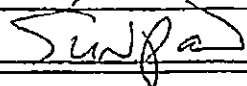
Acc: [REDACTED]



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Musculoskeletal	
Musculoskeletal System Parameters	☐ WDL Full range of motion. Steady unassisted gait. Full weight bearing. No assistive equipment. <i>If there are any deviations from the standard assessment, you must document exceptions below.</i>
	☐ WDL, except for:
Gastrointestinal	
Gastrointestinal System Parameters	☐ WDL Abdomen soft, non-tender, and without distention. Bowel sounds active in all quadrants. Continent of stool. Bowel movements within usual pattern of frequency. Bowel movements formed, brown to dark brown. Tolerates prescribed diet, without nausea and vomiting. No gastrointestinal tubes present. <i>If there are any deviations from the standard assessment, you must document exceptions below.</i>
	☐ WDL, except for:
Genitourinary	
Genitourinary System Parameters	☐ WDL voids without difficulty. Denies dysuria, frequency, hesitancy, nocturia, and burning. Bladder non-distended. Continent of urine. Males with natural stream. Urine clear yellow to straw colored with minimal odor. There is no penile or vaginal discharge or drainage. No tubes, drains, catheters, or ostomy present. No dialysis. <i>If there are any deviations from the standard assessment, you must document exceptions below.</i>
	☐ WDL, except for:
Integumentary	
Integumentary System Parameters	☐ WDL Skin warm, dry, smooth, and intact with good skin turgor. Skin color natural for race. No jaundice, cyanosis, bruises, rashes. Turgor is elastic. No evidence of infection. <i>If there are any deviations from the standard assessment, you must document exceptions below.</i>
	☐ WDL, except for:
Psychosocial	
Psychosocial System Parameters	☐ WDL Behavior, mood, affect, appearance appropriate to situation. Denies hallucinations, depression, anxiety. Family/caregiver involved in care if applicable. <i>If there are any deviations from the standard assessment, you must document exceptions below.</i>
	☒ WDL, except for: paranoia, depressed pt is on 1:1 observation for safety

RN Signature:



Date/Time:

11/5/15 4:45 AM

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Nursing Systems Assessment - Downtime Form


Page 2 of 7
Form NDFNUASIA, Rev. 1/2014
ASM XOTHER

CHILDS, HANEEF A

27Y M



050

VTE Prophylaxis - Occurrence 1	
VTE Prophylaxis	☐ No ☐ Yes, please answer following questions
VTE Equip Side	☐ Left ☐ Right ☐ Bilateral
VTE Equip Location	☐ Calf ☐ Foot ☐ Thigh
Type of Mechanical Device Applied	☐ Anti Embolic Stockings ☐ Intermittent Pneumatic CD ☐ Venous Foot Pump
VTE Chemical Prophylaxis Ordered	☐ No ☐ Yes, please describe:

BRADEN SCALE					SCORE
Sensory Perception:	1. Completely Limited	2. Very Limited	3. Slightly Limited	4. No Impairment	4
Moisture:	1. Consistently Moist	2. Very Moist	3. Occasionally Moist	4. Rarely Moist	4
Activity:	1. Bed Rest	2. Chairfast	3. Walks Occasionally	4. Walks Frequently	4
Mobility:	1. Completely Immobile	2. Very limited	3. Slightly Limited	4. No Limitations	4
Nutrition:	1. Very Poor	2. Probably Inadequate	3. Adequate	4. Excellent	3
Friction/Shear:	1. Problem	2. Potential Problem	3. No Apparent Problem		3
TOTAL SCORE: Patients with a total score of 18 or less are considered to be at risk for developing pressure ulcers. Mild or Low Risk: 15 - 18 Moderate Risk: 13 - 14 High Risk: 10 - 12 Very High Risk: 9 or below					Total 22

PAIN ASSESSMENT	
Complaint of Pain:	☐ Yes ☒ No ☐ Unable to Assess
Pain Scale Used:	☐ Numeric ☐ FLACC ☐ Wong Baker
Pain Sensitivity: (0 out of 10)	Location:
Describe:	

DIET	
Diet Type	Regular
Thickened Liquids	☐ Yes ☒ No
Feeding	☒ Self ☐ Partial ☐ Setup ☐ Complete
Breakfast	☐ 0 to 25% ☐ 26 to 50% ☐ 51 to 75% ☐ 76 to 100% ☐ Refused
Lunch	☐ 0 to 25% ☐ 26 to 50% ☐ 51 to 75% ☐ 76 to 100% ☐ Refused
Dinner	☐ 0 to 25% ☐ 26 to 50% ☐ 51 to 75% ☐ 76 to 100% ☐ Refused
Snack	☐ 0 to 25% ☐ 26 to 50% ☐ 51 to 75% ☐ 76 to 100% ☐ Refused
Tube Feed	
Tube Feed Type	Tube Feed Rate (mL/h)
Tube Feed Flushed Per Order	☐ Yes ☐ No
Nutritional Supplement	
Parenteral Nutrition	☐ TPN ☐ PPN
Other	Tube Feed Rate (mL/h)
Fluid Restrictions	(mL)
Aspirations Precautions Maintained	☐ Yes ☐ No
Calorie Count	☐ Yes ☒ No
Nutrition Comment	

Safety	
☐ Assessed for fall risks	☐ Fall Precautions
☐ SIDERAILS: ☐ Up ☐ Top x2 ☐ x4	☐ Fall Bracelet On
☐ Bed in low position	☐ Fall Slippers
☐ Other:	☐ ID Bracelet on
	☐ Isolation

RN Signature: Sun Park

Date/Time: 11/5/15 4:10 PM

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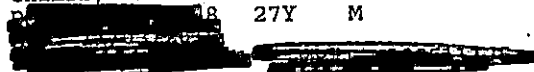
Nursing Systems Assessment - Downtime Form



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Form #DTNUSM, Rev. 1/2014
ASM, XOTHER

CHILDS, HANEEL A

27Y M



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Patient ADL Assessment

Activity				
Patient Activity	☒ Up Ab Lib	☐ Ambulates	☐ Passive ROM	
	☐ OOB	☐ BRP	☐ Active ROM	
	☐ OOB to Chair	☐ Bedside Commode	☐ Heels Elevated	
	☐ Bedrest	☐ Turn Q2hrs	☐ Dangle Feet	
Activity Ability	☒ 0 Independent	☐ 0 Partial Assist	☐ 0 Full Assist	
Assistive Devices	☐ Abduction Pillow	☐ Air Transfer Mattress	☐ Anti-emb Hose	☐ Assisted Lifting
	☐ Brace	☐ Cane	☐ Compression Boots	☐ Crutches
	☐ Elbow Pads	☐ Gait Belt	☐ Heel Protectors	☐ Immobilizer
	☐ K-Pad	☐ Orthotic Device	☐ Prosthesis	☐ Rolling Walker
	☐ Sling	☐ Trapeze	☐ Walker	☐ Wheelchair
	☐ Wheeled Transfer Aid	☒ None		
Activity Tolerance	☒ 0 Good	☐ 0 Fair	☐ 0 Poor	
Eating Ability	☒ 0 Independent	☐ 0 Partial Assist	☐ 0 Full Assist	
Toileting				
Toileting Ability	☒ 0 Independent	☐ 0 Partial Assist	☐ 0 Full Assist	
Toileting Assistive Devices	☒ Toilet	☐ External	☐ Raised Toilet Seat	☐ Urostomy
	☐ Urinal	☐ Incontinence Catheter	☐ Incontinence Pads	☐ Nephrostomy Tube
	☐ Fecal Management System			
	☐ Bedpan	☐ Self Catheterization	☐ Fecal Bag	☐ Ileostomy
	☐ Bedside Commode	☐ Hydraulic Lift	☐ Diaper	☐ Colostomy
Dressing				
Dressing Ability	☒ 0 Independent	☐ 0 Partial Assist	☐ 0 Full Assist	
Hygiene				
Care Provided	☐ Bath	☐ Shower	☐ Catheter Care	☐ Shampoo
	☐ Sponge Bath	☐ Mouthcare	☐ Pericare	☐ Sitz Bath
	☐ Partial Bath	☐ Shave	☐ Skincare	☐ Backcare
	☐ Complete Bath	☐ Denture Care		
Bathing Ability	☒ 0 Independent	☐ 0 Partial Assist	☐ 0 Full Assist	
Oral Care Ability	☒ 0 Independent	☐ 0 Partial Assist	☐ 0 Full Assist	
Sleep Assessment	☐ Normal	☐ Sleep Walks	☐ Difficulty Staying Asleep	
	☐ Drowsy	☐ Nightmares	☐ Early Morning Awakening	
	☐ Restless	☒ Difficulty Falling Asleep	☐ Hypersomnia	
Sleep Aids	☐ None	☐ Television	☐ Warm Beverage	☐ Reading
	☐ Multiple Pillows	☐ Medication	☐ Relaxation Techniques	☐ Music
Additional Comment	7:15:00 on 11/5/15 observation error (50) observation			

RN Signature: Sunja

Date/Time: 11/5/15 4:12 PM ☐ Only check off one answer ☐ Multiple answers allowed

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Nursing Systems Assessment - Downtime Form



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Form #0TADL, Rev. 01/2013
ASM.X.OTHER

CHILDS, HANEEF A

27Y M



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DATE

Hendrich II Risk Model TM ©2007 Adopted from Hendrich II Fall Risk Model 2007		
Risk Factor	Risk Points	
Check applicable boxes in columns to the right		
Confusion/Disorientation/Impulsivity	4	
Symptomatic Depression	2	✓
Altered Elimination	1	
Dizziness/Vertigo	1	
Gender (Male)	1	✓
Any Administered Antiepileptics (anticonvulsants): (Carbamazepine, Divalproex Sodium, Ethotoin, Ethosuximide, Felbamate, Fosphenytoin, Gabapentin, Lamotrigine, Mephenytoin, Methsuximide, Phenobarbital, Phenytoin, Primidone, Topiramate, Trimethadione, Valproic Acid)	2	
Any administered Benzodiazepines: (Alprazolam, Chlordiazepoxide, Clonazepam, Clorazepate Dipotassium, Diazepam, Flurazepam, Halazepam, Lorazepam, Midazolam, Oxazepam, Temazepam, Triazolam)	1	

Get Up-and-Go Test: "Rising from a Chair"

**If unable to assess, monitor for change in activity level, assess other risk factors, document both on patient chart with date and time.*

Ability to rise single movement - No loss of balance with steps	0	✓
Pushes up, successful in one attempt	1	
Multiple attempts but successful	3	
Unable to rise without assistance during test (OR if a medical order states the same and/or complete bed rest is ordered)	4	
<i>*If unable to assess, document MIs on the patient chart with the date and time</i>		
TOTAL SCORE (A score of 5 or greater = High Risk)		3

Confusion/Disorientation/Impulsivity	Patient may be disoriented to time, place and/or person. Patient is unable to retain or receive instructions, or displays impaired safety or personal judgment: a cluster of global, transient changes and disturbances in attention, cognition, and/or sleep/wake cycles, impulsive behavior, hallucinations, agitation, unrealistic, inappropriate or unusual behavior, or behavior in origin. Stroke patients (left hemi) may exhibit impulsive, unpredictable behavior as a result of the cerebral insult.	4
Symptomatic Depression	Medical diagnosis of depression. Nursing assessment finds the patient appears depressed, hopeless, in a melancholic mood, is not interacting appropriately, and/or is tearful, withdrawn, displays a flat affect or seeming lack of interest or the patient states he/she is depressed. A general loss in life events. If the depression is managed with drugs and/or therapies, they do NOT score additional points when the depression is in therapeutic control.	2
Altered Elimination	Altered elimination from the clinical norm, such as incontinence, nocturia, frequency, urgency or stress incontinence, diarrhea, or related to use of cathartics; any toileting self-care deficit, e.g., physical impairment. This does NOT include a Foley or indwelling catheter UNLESS it causes symptoms referenced above while in use with the patient. When the catheter is removed, it can be a high-risk time until normal elimination is established.	1
Dizziness/Vertigo	Medical diagnosis or vertigo or the patient reports a sensation of spinning. Sway path may be present when the patient stands (circular motion upon arising). This is often seen in the aging adult with poor gait and balance and can occur as a result of some drug side effects. Often seen in the newly delivered obstetric patient.	1
Gender	Male. The "go it alone" factor and for "I don't want a female nurse to help me". Does NOT apply to obstetrics and pediatrics.	1
Any Administered Antiepileptics	Carbamazepine, Divalproex Sodium, Ethotoin, Ethosuximide, Felbamate, Fosphenytoin, Gabapentin, Lamotrigine, Mephenytoin, Methsuximide, Phenobarbital, Phenytoin, Primidone, Topiramate, Trimethadione, Valproic Acid	2
Any Administered Benzodiazepines	Alprazolam, Chlordiazepoxide, Clonazepam, Clorazepate, Dipotassium, Diazepam, Flurazepam, Halazepam, Lorazepam, Midazolam, Oxazepam, Temazepam, Triazolam	1

Get-Up-and-Go-Test

With patient sitting in a chair (preferred) or on the side of the bed, place palm of hands flat on thighs and ask the patient to stand without assistance. Score the patient according to the guidelines below. *If the patient is unable to perform the test (traction, debilitation/atrophy, and/or bed rest order) score all other risk factors that can be assessed. If the patient scores a 5 or greater (without the Get-Up-and-Go) and can ATTEMPT to get up, they should be considered "high risk for falls." If they cannot attempt to get up at all, but have risk points, they should be considered "pending high risk" and placed on the fall prevention guidelines as soon as they can ATTEMPT to get up. If the patient is comatose or in a drug-induced coma and the assessment for fall risk cannot be completed, document "unable to assess fall risk status at this time due to _____" and note on the patient record. Once the condition changes, all or a portion of the risk assessment should be completed as described above.

CHILDS, HANEUF A

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Nursing Systems Assessment - Downtime Form
Downtime Hendrich II Risk Model



DRUG REACTION HISTORY MUST BE COMPLETED BEFORE DRUG CAN BE DISPENSED

PATIENT HAS HISTORY OF DRUG ALLERGY, SENSITIVITY OR ADVERSE REACTION TO	DESCRIPTION OF EVENT

Age: _____ Gender: Male

Care Unit: 2 NE

Shift: 7³⁰A - 4 PM

☐ CHECK HERE IF PATIENT DENIES HISTORY OF ALLERGIES, SENSITIVITIES OR ADVERSE REACTIONS

DATE	TIME	FAXED	ORDERS	TRANSCRIBED BY																														
11/5/15	9 AM		PART I BEHAVIORAL RESTRAINT ASSESSMENT ☒ Initial Assessment ☐ Reassessment A. (Nursing to Complete): <table border="0"> <tr> <td>☒ Severe Agitation</td> <td>☐ Assaultive/ Risk of Injury</td> </tr> <tr> <td>☐ Combative/Striking Out</td> <td>☒ Violent/ Aggressive Behavior</td> </tr> <tr> <td>☐ Self-Abusive</td> <td>☐ Unsafe Behavior due to Impaired Judgment/ Cognition/ Psychosis</td> </tr> <tr> <td>☒ Suicidal</td> <td>☐ Persistent aggressive verbal threats</td> </tr> <tr> <td>☐ Throwing Objects</td> <td>☐ Hitting/ Kicking/ Biting</td> </tr> <tr> <td>☐ Damaging Property</td> <td>☐ Behavior Dangerous to Self or Others</td> </tr> <tr> <td>☐ Self-Mutilating</td> <td>☒ Other: <u>MHC Protocol</u></td> </tr> </table> B. Identify the less-restrictive alternatives tried in order to modify behaviors: <table border="0"> <tr> <td>☐ De-escalation</td> <td>☐ Calming Medication</td> <td>☒ 1:1 Observation</td> <td>☐ Set Clear, Firm Limits</td> </tr> <tr> <td>☐ PEAT Code</td> <td>☐ Family Members</td> <td>☐ Diversion/Activity</td> <td>☐ Quiet Room / Time-Out</td> </tr> <tr> <td>☒ Active Listening</td> <td>☒ Allow to Ventilate</td> <td>☐ Minimum Stimulation</td> <td>☐ Offer Alternatives / Choices</td> </tr> <tr> <td colspan="4">☒ Other/Describe: <u>MHC Protocol</u></td> </tr> </table> C. Patient's Response to Above Alternatives: <u>For transportation to MHC as Protocol</u> The above alternatives have been tried and have been unsuccessful; there is a need for more restrictive restraint interventions. RN Signature: <u>Mohamed M. Bahke RN</u> Date: <u>11/5/15</u> Time: <u>9 AM</u> PART II PHYSICIAN ORDERS (Physician to Complete): A. Clinical Justification: ☒ Imminent danger of harm to self or others ☐ Combative/ Assaultive/ Violent behavior ☐ Other: _____ B. Time: Ages 18 & above - 4 hour max. / Ages 9 to 17 years - 2 hour max. / Under 9 years of age - 1 hour max. APPLY FROM (TIME) <u>9 AM</u> TO (TIME) <u>1:15 AM</u> C. Type of restraint: ☐ Locked Seclusion (Psychiatric Units Only) ☐ 3-4 Side rails ☐ Locked Velcro Restraints ☐ 4 Point ☐ 3 Point ☒ 2 Point ☐ Soft Limb ☐ 4 Point ☐ Other D. Continuous observation face-to-face by assigned staff for duration of episode. Note: Face-to-face LIP / Physician visit must be completed within one hour and Progress note written. E. Signatures: Date: <u>11/5/15</u> Time: <u>9:10 AM</u> Licensed Independent Practitioner Signature: <u>[Signature]</u> Pager# _____ Date: _____ Time: _____ Unit Secretary Signature: _____ Date: <u>11/5</u> Time: <u>9 AM</u> Registered Nurse Signature: <u>Mohamed M. Bahke</u> ☐ If verbal order, readback and verified by _____ RN	☒ Severe Agitation	☐ Assaultive/ Risk of Injury	☐ Combative/Striking Out	☒ Violent/ Aggressive Behavior	☐ Self-Abusive	☐ Unsafe Behavior due to Impaired Judgment/ Cognition/ Psychosis	☒ Suicidal	☐ Persistent aggressive verbal threats	☐ Throwing Objects	☐ Hitting/ Kicking/ Biting	☐ Damaging Property	☐ Behavior Dangerous to Self or Others	☐ Self-Mutilating	☒ Other: <u>MHC Protocol</u>	☐ De-escalation	☐ Calming Medication	☒ 1:1 Observation	☐ Set Clear, Firm Limits	☐ PEAT Code	☐ Family Members	☐ Diversion/Activity	☐ Quiet Room / Time-Out	☒ Active Listening	☒ Allow to Ventilate	☐ Minimum Stimulation	☐ Offer Alternatives / Choices	☒ Other/Describe: <u>MHC Protocol</u>				
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PLEASE NOTE: DO NOT WRITE ON REVERSE SIDE OF THIS FORM

Mercy Philadelphia Hospital
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BEHAVIORAL RESTRAINT ASSESSMENT



Page 1 of 2
Form #Ph718, Rev. 01/2008
ASM X OTHER

CHILDS, HANBEF A

27Y M



354

RT III NURSING CARE

(Nursing to Complete):

A. Family Notification / Patient and Family Education:

N/A

Date/Time: 11/5/15

☐ PI, Refused
☐ Unavailable

Name of Family Member notified:

RN Initials: MKS

Patient and family educated regarding reason for restraints and given hospital brochure.

Behaviors required to discontinue the restraints were explained to patient and family.

Restraint prevention & use were identified on Inter-disciplinary Plan of Care / Team Treatment Plan.

B. Continuous Patient Observation and Revised Plan of Care for Restraints / Seclusion:

Assigned observer's signature signifies that the following care and / or observations were completed every 15 minutes:

Behavior, Cognitive Function, Response to restraints and Readiness for Release

Circulation: for presence of pulses & good color, Skin Assessment & Assessment for Patient Injury;

Range-of-motion exercises and restraint release of all limbs one at a time - provide every 2 hours and more frequently if needed per q. 15 minute observations.

Evaluate need for Food, Fluids, Hygiene and Toileting; provide every 2 hours and more frequently if needed per q. 15 minute observations.

Behavioral Key:

1 = Threatening
7 = Uncooperative
13 = Drank (Describe)

2 = Combative
8 = Calmer

3 = Violent
9 = Quiet
14 = Other (See Comments)

4 = Assaultive
10 = Cooperative

5 = Loud/Yelling
11 = Medicated

6 = Agitated
12 = Ate (Describe)

Time every 15 min.	Behavior Key	Circle Restrained Limbs	Comments/Observations/interventions	Assigned Staff Observer Signature
9:30	8, 10	RA CA RL DL		
9:45	8, 10	RA CA RL DL		
10:00	8, 10	RA CA RL DL		
10:15	8, 10	RA CA RL DL		
10:30	8, 10	RA CA RL DL		
10:45	8, 10	RA CA RL DL		
11:00	8, 10	RA CA RL DL	lunch	
11:15	8, 10	RA CA RL DL		
11:30	8, 10	RA CA RL DL		
11:45	8, 10	RA CA RL DL		
12:00	2, 5	RA CA RL DL		
12:15	2, 5	RA CA RL DL		
12:30	8, 10	RA CA RL DL		
12:45	8, 10	RA CA RL DL		
1:00	8, 10	RA CA RL DL		
1:15	8, 10	RA CA RL DL		

C. Reassessment: Nurse reassess the patient at the end of the time ordered or when released.

Date: 11/5/15

Time: 2:30 PM

☐ Continue Restraints

☐ New order obtained

Signature/Title:

Vital Signs: Time 2:30 T. 96.8 P. 97 R. 18 BP 126/74

D. Restraints Discontinued: The patient has met the following criteria for restraint removal or release from locked seclusion:

Criteria for Removal (*) as appropriate, complete when released

☐ Increased behavioral control ☐ No assaultive threats ☐ Demonstrates calm behavior ☐ Improved mental status ☐ Improved communication ☐ Other

☐ Decreased agitation ☐ No threats of self harm ☐ Follows directions ☐ Interacts with staff ☐ Agrees to Safety Contract

Signature/Title: Melissa M. Behr Date Ended: 11/5/15 Time Ended: 1:15 PM AM/PM

E. (Psychiatry only) Debriefing occurred with patient, family & staff and recorded on Debriefing Form ☐ Yes ☐ No

☐ Clinical leadership notified for episode > 12 hours or 2 or more episode within 12 hours.

Total Time Restrained: 3 Hours 45 Minutes

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BEHAVIORAL RESTRAINT ASSESSMENT



Page 2 of 2
Form #PH719, Rev. 01/2006
ASM X OTHER

CHILDS, HANEEF A

27Y M



355

INVENTORY OF SUICIDE RISK FACTORS

***This assessment must be completed on all inpatient psychiatric admissions including medical and critical care transfers.

CHECK (☒) ANY RISK FACTORS IDENTIFIED DURING CLINICAL EVALUATION.**

PRIMARY RISK FACTORS

Note: If a primary risk factor is identified in category 1 or 2 consider patient to be a **HIGH RISK** for suicide.

1. ATTEMPT WITH:

- ☒ NONE *PTA*
- ☐ Lethal method (guns, hanging, jumping) *in hospital*
- ☐ Moderate/severe injury or toxicity *have wounds*
- ☐ Low likelihood of being rescued *wrapped*
- ☐ Regret it was unsuccessful, continued ideation or refusal of treatment *submerged neck*

2. ACTIVE SUICIDAL PLAN/INTENT:

- ☒ NONE
- ☐ Definite suicide plan
- ☐ Specific lethal method selected
- ☐ Intent to commit suicide imminently
- ☐ Access to firearms /lethal means
- ☐ Preparations for death (suicide note, giving away possessions, business or insurance arrangements)
- ☐ Extreme hopelessness/unable to focus on positive future events

SECONDARY RISK FACTORS

3. CURRENT CLINICAL INDICATORS:

- ☐ NONE
- ☒ Delusional
- ☐ Command hallucinations
- ☒ Depressed mood, especially with
- ☒ Extreme level of anxiety
- ☐ agitation
- ☐ significant insomnia
- ☐ Committed violence in past year
- ☒ Impulsive or risky behavior
- ☒ Expressing anger and hostility

4. SOCIAL AND DEMOGRAPHIC FACTORS:

- ☐ NONE
- ☐ Age less than 19 or greater than 45
- ☒ Male
- ☐ Male age 65 or older
- ☐ Lack of Psychosocial support/isolated
- ☐ Living alone
- ☐ Separated, divorced, widowed

These risk factors may be considered modifiable and may improve or resolve with therapeutic interventions

**(Inventory may be completed by RN or Intake Worker, but must be reviewed by psychiatrist.)

5. HISTORY OF:

- ☐ NONE
- ☐ Previous suicide attempt(s) (if checked, how many) # _____
- ☒ Previous psychiatric treatment
- ☒ Psychiatric hospitalization in past year
- ☒ Self destructive behavior
- ☐ Family/close friend suicide
- ☐ Physical or sexual abuse in childhood
- ☐ Bipolar disorder
- ☒ Alcohol and/or substance use/abuse
- ☐ Schizophrenia
- ☐ Borderline personality disorder

6. STRESSORS AND LOSSES:

- ☐ NONE
- ☐ Recent or impending loss
- ☒ Chronic, painful, or terminal medical disorder
- ☐ Newly diagnosed serious medical problem/s
- ☐ Overwhelming or humiliating stressor
- ☐ Unresolved legal issues
- ☒ Unemployed/Loss of job
- ☐ Financial stress

7. PROTECTIVE FACTORS:

Note: These are not risk factors but may prevent the person from acting on suicidal thoughts.

- ☐ NONE*
- ☐ Moderate to strong religious beliefs
- ☐ Currently clean and sober
- ☐ Adequate coping/problem solving skills
- ☐ Sense of responsibility to children, family and others including pets
- ☐ Employed
- ☐ Available social supports
- ☐ Positive therapeutic relationship
- ☐ Accepts treatment

*Note: Fewer protective factors increases risk.

8. CURRENT SUICIDAL IDEATION?

- ☒ NONE/Denies
- ☐ YES

DATE: 11-5-15 TIME: 11:00A

Signature RN/WW: *Sharon Vayner*

Psychiatrist has reviewed information on above risk factors and in conjunction with assessment data determines current suicide risk as:

☐ NONE ☐ LOW ☒ MEDIUM ☐ HIGH

DATE: 11/5/15 TIME: 1:00 PM

Signature Psychiatrist: *[Signature]*

Mercy Philadelphia Hospital
A member of Mercy Health System

INVENTORY OF SUICIDE RISK FACTORS



CHILDS, HANEE A

27Y M



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INVENTORY OF SUICIDE RISK FACTORS

***This assessment must be completed on all inpatient psychiatric admissions including medical and critical care transfers.

CHECK (☒) ANY RISK FACTORS IDENTIFIED DURING CLINICAL EVALUATION:**

PRIMARY RISK FACTORS

Note: If a primary risk factor is identified in category 1 or 2 consider patient to be a **HIGH RISK** for suicide.

1. ATTEMPT WITH:

- ☒ Lethal method (guns, hanging, jumping) ☒ NONE PTH
☐ Moderate/severe injury or toxicity attempt in hospital
☐ Low likelihood of being rescued
☐ Regret it was unsuccessful, continued ideation or refusal of treatment

2. ACTIVE SUICIDAL PLAN/INTENT:

- ☐ Definite suicide plan ☒ NONE
☐ Specific lethal method selected
☐ Intent to commit suicide imminently
☐ Access to firearms /lethal means
☐ Preparations for death (suicide note, giving away possessions, business or insurance arrangements)
☐ Extreme hopelessness/unable to focus on positive future events

SECONDARY RISK FACTORS

3. CURRENT CLINICAL INDICATORS:

- ☐ Delusional ☐ NONE
☐ Command hallucinations
☒ Depressed mood, especially with
☐ extreme level of anxiety
☐ agitation
☐ significant insomnia
☐ Committed violence in past year
☒ Impulsive or risky behavior
☐ Expressing anger and hostility

4. SOCIAL AND DEMOGRAPHIC FACTORS:

- ☐ Age less than 19 or greater than 45 ☐ NONE
☒ Male
☐ Male age 65 or older
☐ Lack of Psychosocial support/isolated
☐ Living alone
☒ Separated, divorced, widowed

*These risk factors may be considered modifiable and may improve or resolve with therapeutic interventions

**(Inventory may be completed by RN or Intake Worker, but must be reviewed by psychiatrist.)

5. HISTORY OF:

- ☐ Previous suicide attempt(s) (if checked, how many) # _____ ☐ NONE
☐ Previous psychiatric treatment
☒ Psychiatric hospitalization in past year
☐ Self destructive behavior
☐ Family/close friend suicide
☐ Physical or sexual abuse in childhood
☐ Bipolar disorder
☐ Alcohol and/or substance use/abuse
☐ Schizophrenia
☐ Borderline personality disorder

6. STRESSORS AND LOSSES:

- ☐ Recent or impending loss ☐ NONE
☒ Chronic, painful, or terminal medical disorder
☐ Newly diagnosed serious medical problem/s
☐ Overwhelming or humiliating stressor
☐ Unresolved legal issues
☐ Unemployed/Loss of job
☐ Financial stress

7. PROTECTIVE FACTORS:

Note: These are not risk factors but may prevent the person from acting on suicidal thoughts.

- ☐ Moderate to strong religious beliefs ☐ NONE*
☐ Currently clean and sober
☐ Adequate coping/problem solving skills
☐ Sense of responsibility to children, family and others including pets
☐ Employed
☒ Available social supports
☒ Positive therapeutic relationship
☒ Accepts treatment

*Note: Fewer protective factors increases risk.

8. CURRENT SUICIDAL IDEATION?

- ☒ NONE/Denies
☐ YES

DATE: 11/6/16 TIME: 1500

Signature RN/NW: [Signature]

Psychiatrist has reviewed information on above risk factors and in conjunction with assessment data determines current suicide risk as:

☐ NONE ☐ LOW ☒ MEDIUM ☐ HIGH

DATE: 11/6/16 TIME: 1500

Signature Psychiatrist: [Signature]

Mercy Philadelphia Hospital
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INVENTORY OF SUICIDE RISK FACTORS



CHILDS, HANEEF A

27Y M

[Redacted Address]



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INVENTORY OF SUICIDE RISK FACTORS

*****This assessment must be completed on all Inpatient psychiatric admissions including medical and critical care transfers.**

CHECK (☒) ANY RISK FACTORS IDENTIFIED DURING CLINICAL EVALUATION.**

PRIMARY RISK FACTORS

Note: If a primary risk factor is identified in category 1 or 2 consider patient to be a **HIGH RISK** for suicide.

1. ATTEMPT WITH:

- ☐ Lethal method (guns, hanging, jumping)
- ☐ Moderate/severe injury or toxicity
- ☐ Low likelihood of being rescued
- ☐ Regret it was unsuccessful, continued ideation or refusal of treatment

☒ NONE PTA

*placed
towel
around
neck*

2. ACTIVE SUICIDAL PLAN/INTENT:

- ☐ Definite suicide plan
- ☐ Specific lethal method selected
- ☐ Intent to commit suicide imminently
- ☐ Access to firearms /lethal means
- ☐ Preparations for death (suicide note, giving away possessions, business or insurance arrangements)
- ☐ Extreme hopelessness/unable to focus on positive future events

☒ NONE

SECONDARY RISK FACTORS

3. CURRENT CLINICAL INDICATORS:

- ☐ Delusional
- ☐ Command hallucinations
- ☒ Depressed mood, especially with
 - ☐ extreme level of anxiety
 - ☐ agitation
 - ☐ significant insomnia
- ☐ Committed violence in past year
- ☒ Impulsive or risky behavior
- ☒ Expressing anger and hostility

☐ NONE

4. SOCIAL AND DEMOGRAPHIC FACTORS:

- ☐ Age less than 19 or greater than 45
- ☒ Male
- ☐ Male age 65 or older
- ☐ Lack of Psychosocial support/isolated
- ☐ Living alone
- ☒ Separated, divorced, widowed

☐ NONE

* These risk factors may be considered modifiable and may improve or resolve with therapeutic interventions

** (Inventory may be completed by RN or Intake Worker, but must be reviewed by psychiatrist.)

5. HISTORY OF:

☐ NONE

- ☒ Previous suicide attempt(s) (If checked, how many) # _____
- ☒ Previous psychiatric treatment
- ☒ Psychiatric hospitalization in past year
- ☐ Self destructive behavior
- ☐ Family/close friend suicide
- ☐ Physical or sexual abuse in childhood
- ☐ Bipolar disorder
- ☒ Alcohol and/or substance use/abuse
- ☐ Schizophrenia
- ☐ Borderline personality disorder

6. STRESSORS AND LOSSES:

☐ NONE

- ☐ Recent or impending loss
- ☒ Chronic, painful, or terminal medical disorder
- ☐ Newly diagnosed serious medical problem/s
- ☐ Overwhelming or humiliating stressor
- ☐ Unresolved legal issues
- ☐ Unemployed/Loss of job
- ☐ Financial stress

7. PROTECTIVE FACTORS:

☐ NONE*

Note: These are not risk factors but may prevent the person from acting on suicidal thoughts.

- ☐ Moderate to strong religious beliefs
- ☐ Currently clean and sober
- ☐ Adequate coping/problem solving skills
- ☐ Sense of responsibility to children, family and others including pets
- ☐ Employed
- ☒ Available social supports
- ☒ Positive therapeutic relationship
- ☒ Accepts treatment

*Note: Fewer protective factors increases risk.

8. CURRENT SUICIDAL IDEATION?

- ☒ NONE/Denies
- ☐ YES

DATE: 11-7-15

TIME: 5:24p

Signature RN/Intake Worker: *[Signature]*

Psychiatrist has reviewed information on above risk factors and in conjunction with assessment data determines current suicide risk as:

☐ NONE ☐ LOW ☐ MEDIUM ☐ HIGH

DATE: 11-7-15

TIME: 8:00AM

Signature Psychiatrist: *[Signature]*

Mercy Philadelphia Hospital
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INVENTORY OF SUICIDE RISK FACTORS



Page 1 of 1
Form NUTPGN, Rev. 05/2015
ASMLX.OTHER

CHILDS, HANEEF A

27Y M



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INVENTORY OF SUICIDE RISK FACTORS

*****This assessment must be completed on all inpatient psychiatric admissions including medical and critical care transfers.**

CHECK (☒) ANY RISK FACTORS IDENTIFIED DURING CLINICAL EVALUATION:**

PRIMARY RISK FACTORS

Note: If a primary risk factor is identified in category 1 or 2 consider patient to be a **HIGH RISK** for suicide.

1. ATTEMPT WITH:

- ☒ Lethal method (guns, hanging, jumping) *place around neck*
☐ Moderate/severe injury or toxicity
☐ Low likelihood of being rescued
☐ Regret it was unsuccessful, continued ideation or refusal of treatment

2. ACTIVE SUICIDAL PLAN/INTENT:

- ☐ Definite suicide plan
☐ Specific lethal method selected
☐ Intent to commit suicide imminently
☐ Access to firearms /lethal means
☐ Preparations for death (suicide note, giving away possessions, business or insurance arrangements)
☐ Extreme hopelessness/unable to focus on positive future events

SECONDARY RISK FACTORS

3. CURRENT CLINICAL INDICATORS:

- ☐ Delusional
☒ Command hallucinations
☒ Depressed mood, especially with
☐ extreme level of anxiety
☐ agitation
☐ significant insomnia
☐ Committed violence in past year
☒ Impulsive or risky behavior
☐ Expressing anger and hostility

4. SOCIAL AND DEMOGRAPHIC FACTORS:

- ☐ Age less than 19 or greater than 45
☒ Male
☐ Male age 65 or older
☐ Lack of Psychosocial support/isolated
☐ Living alone
☒ Separated, divorced, widowed

These risk factors may be considered modifiable and may improve or resolve with therapeutic interventions

**Inventory may be completed by RN or Intake Worker, but must be reviewed by psychiatrist.

5. HISTORY OF:

- ☒ Previous suicide attempt(s) (If checked, how many) # _____
☒ Previous psychiatric treatment
☐ Psychiatric hospitalization in past year
☐ Self destructive behavior
☐ Family/close friend suicide
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☐ Schizophrenia
☐ Borderline personality disorder

6. STRESSORS AND LOSSES:

- ☐ Recent or impending loss
☒ Chronic, painful, or terminal medical disorder
☐ Newly diagnosed serious medical problem/s
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☐ Unemployed/Loss of job
☐ Financial stress

7. PROTECTIVE FACTORS:

Note: These are not risk factors but may prevent the person from acting on suicidal thoughts.

- ☐ Moderate to strong religious beliefs
☐ Currently clean and sober
☐ Adequate coping/problem solving skills
☐ Sense of responsibility to children, family and others including pets
☐ Employed
☒ Available social supports
☒ Positive therapeutic relationship
☒ Accepts treatment

*Note: Fewer protective factors increases risk.

8. CURRENT SUICIDAL IDEATION?

- ☒ NONE/Denies
☐ YES

DATE:

Signature RN/Intake Worker:

Psychiatrist has reviewed information on above risk factors and in conjunction with assessment data determines current suicide risk as:

☐ NONE ☐ LOW ☐ MEDIUM ☐ HIGH

DATE:

Signature Psychiatrist:

Mercy Philadelphia Hospital
A member of Mercy Health System

INVENTORY OF SUICIDE RISK FACTORS



Page 1 of 1
Form NUTPON, Rev. 05/2015
ASMX OTHER

CHILDS, HANEEB A

27Y M



DRUG REACTION HISTORY MUST BE COMPLETED BEFORE DRUG CAN BE DISPENSED

PATIENT'S HISTORY OF DRUG ALLERGY, SENSITIVITY OR ADVERSE REACTION TO:	DESCRIPTION OF EVENT
	Aggressive / Violent Behavior
	Elopement risk
☐ CHECK HERE IF PATIENT DENIES HISTORY OF ALLERGIES, SENSITIVITIES OR ADVERSE REACTIONS	

Age: 27 Gender: Male
Care Unit: 2NE
Shift: 7:30 A - 4 PM

DATE	TIME	FAXED	ORDERS	TRANSCRIBED BY
11/9/15	11:45 AM		BEHAVIORAL RESTRAINT ASSESSMENT PART I ☒ Initial Assessment ☐ Reassessment (Nursing to Complete): A. Nursing Assessment ☒ Severe Agitation ☐ Assaultive / Risk of Injury ☒ Combative / Striking Out ☐ Violent / Aggressive Behavior ☐ Self-Abusive ☐ Unsafe Behavior due to Impaired Judgment / Cognition / Psychosis ☐ Suicidal ☐ Persistent aggressive verbal threats ☒ Throwing Objects ☒ Hitting / Kicking / Biting ☐ Damaging Property ☒ Behavior Dangerous to Self or Others ☐ Self-Mutilating ☒ Other: <u>Elopement</u> B. Identify the less-restrictive alternatives tried in order to modify behaviors: ☒ De-escalation ☒ Calming Medication ☒ 1:1 Observation ☒ Set Clear, Firm Limits ☒ PEAT Code ☐ Family Members ☐ Diversion / Activity ☐ Quiet Room / Time-Out ☒ Active Listening ☐ Allow to Ventilate ☐ Minimum Stimulation ☐ Offer Alternatives / Choices ☒ Other / Describe: C. Patient's Response to Above Alternatives: <u>He continued to be very agitated, uncooperative, trying to get out of the restraints.</u> The above alternatives have been tried and have been unsuccessful; there is a need for more restrictive restraint interventions. RN Signature: <u>Mohamed M. Bah</u> Date: <u>11/9/15</u> Time: <u>11:45 AM</u> PART II PHYSICIAN ORDERS (Physician to Complete): A. Clinical Justification: ☒ Imminent danger of harm to self or others ☒ Combative / Assaultive / Violent behavior ☐ Other: <u>Elopement risk</u> B. Time: Ages 18 & above - 4 hour max. / Ages 9 to 17 years - 2 hour max. / Under 9 years of age - 1 hour max. APPLY FROM (TIME) <u>11:45 AM</u> TO (TIME) <u>11:15 PM</u> C. Type of restraint: ☐ Locked Seclusion (Psychiatric Units Only) ☐ 3-4 Side rails ☐ Locked Velcro Restraints ☒ 4 Point ☐ 3 Point ☐ 2 Point ☐ Soft Limb ☐ 4 Point ☐ Other D. Continuous observation face-to-face by assigned staff for duration of episode. Note: Face-to-face LIP / Physician visit must be completed within one hour and Progress note written. E. Signatures: Date: <u>11/9/15</u> Time: <u>12:15 PM</u> Licensed Independent Practitioner Signature: <u>[Signature]</u> Pager# _____ Date: _____ Time: _____ Unit Secretary Signature _____ Date: <u>11/9/15</u> Time: <u>11:45 AM</u> Registered Nurse Signature: <u>Mohamed M. Bah</u> ☐ If verbal order, readback and verified by _____ RN	

Mercy Philadelphia Hospital
A member of Mercy Health System

BEHAVIORAL RESTRAINT ASSESSMENT



Page 1 of 2
Form #PH719, Rev. 01/2009
ASM X OTHER

CHILDS, HANEEF A

27Y M



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ART III NURSING CARE
(Nursing to Complete):

A. Family Notification / Patient and Family Education:

Name of Family Member notified: N/A
Patient and family educated regarding reason for restraints and given hospital brochure.
Behaviors required to discontinue the restraints were explained to patient and family.

Date/Time: 11/9/15
☐ Pt. Refused
☐ Unavailable

RN initials: ms

Restraint prevention & use were identified on Inter-disciplinary Plan of Care / Team Treatment Plan.

B. Continuous Patient Observation and Revised Plan of Care for Restraints / Seclusion:

Assigned observer's signature signifies that the following care and / or observations were completed every 15 minutes:

Behavior, Cognitive Function, Response to restraints and Readiness for Release

Circulation: for presence of pulses & good color, Skin Assessment & Assessment for Patient Injury;

Range-of-motion exercises and restraint release of all limbs one at a time - provide every 2 hours and more frequently if needed per q. 15 minute observations.

Evaluate need for Food, Fluids, Hygiene and Toileting; provide every 2 hours and more frequently if needed per q. 15 minute observations

Behavioral Key:

- | | | | | | |
|-----------------------|---------------|---------------------------|------------------|------------------|---------------------|
| 1 = Threatening | 2 = Combative | 3 = Violent | 4 = Assaultive | 5 = Loud/Yelling | 6 = Agitated |
| 7 = Uncooperative | 8 = Calmer | 9 = Quiet | 10 = Cooperative | 11 = Medicated | 12 = Ate (Describe) |
| 13 = Drank (Describe) | | 14 = Other (See Comments) | | | |

Time every 15 min.	Behavior Key	Circle Restrained Limbs	Comments/Observations/interventions	Assigned Staff Observer Signature
11:45	2	RA LA RD CL		<i>[Signature]</i>
12:00	2	RA LA RD CL		<i>[Signature]</i>
12:15	2	RA LA RD CL		<i>[Signature]</i>
12:30	2	RA LA RD CL		<i>[Signature]</i>
12:45	5	RA LA RD CL		<i>[Signature]</i>
1:00	10	RA LA RD CL		<i>[Signature]</i>
1:15 pm	8-10	RA LA RL LL	Restraints removed	<i>[Signature]</i>
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		
		RA LA RL LL		

C. Reassessment: Nurse reassess the patient at the end of the time ordered or when released.

Date: 11/9/15 Time: 1:15 PM

Restraints removed per conducted for safety and non violent behavior.

☐ Continue Restraints ☐ New order obtained
Vital Signs: Time 2 AM T. 36.0 P. 106 R. 16 BP 117 88

Signature/Title: Mehmet M. Behn

D. Restraints Discontinued: The patient has met the following criteria for restraint removal or release from locked seclusion:

Criteria for Removal (✓) as appropriate, complete when released

- | | | | | | |
|---|--|---|---|--|--------------------------------------|
| ☐ Increased behavioral control | ☐ No assaultive threats | ☐ Demonstrates calm behavior | ☐ Improved mental status | ☐ Improved communication | ☐ Other _____ |
| ☐ Decreased agitation | ☐ No threats of self harm | ☐ Follows directions | ☐ Interacts with staff | ☐ Agrees to Safety Contract | |

Signature/Title: Mehmet M. Behn Date Ended: 11/9/15 Time Ended: 1:15 AM/PM

E. (Psychiatry only) Debriefing occurred with patient, family & staff and recorded on Debriefing Form ☐ Yes ☐ No

☐ Clinical leadership notified for episode > 12 hours or 2 or more episode within 12 hours.

Total Time Restrained: 1 Hours 30 Minutes

Mercy Philadelphia Hospital
A member of Mercy Health System

BEHAVIORAL RESTRAINT ASSESSMENT



Page 2 of 2
Form #PH719, Rev. 01/2008
ASM.X.OTHER

CHILDS, HANEE A

DOB: [Redacted] 27Y M

Adm: [Redacted] Acc: [Redacted]



361

INVENTORY OF SUICIDE RISK FACTORS

***This assessment must be completed on all Inpatient psychiatric admissions including medical and critical care transfers.

CHECK (☒) ANY RISK FACTORS IDENTIFIED DURING CLINICAL EVALUATION:**

> PRIMARY RISK FACTORS

Note: If a primary risk factor is identified in category 1 or 2 consider patient to be a HIGH RISK for suicide.

1. ATTEMPT WITH:

☒ NONE

- ☐ Lethal method (guns, hanging, jumping)
- ☐ Moderate/severe injury or toxicity
- ☐ Low likelihood of being rescued
- ☐ Regret it was unsuccessful, continued ideation or refusal of treatment

2. ACTIVE SUICIDAL PLAN/INTENT:

☒ NONE

- ☐ Definite suicide plan
- ☐ Specific lethal method selected
- ☐ Intent to commit suicide imminently
- ☐ Access to firearms /lethal means
- ☐ Preparations for death (suicide note, giving away possessions, business or insurance arrangements)
- ☐ Extreme hopelessness/unable to focus on positive future events

SECONDARY RISK FACTORS

3. CURRENT CLINICAL INDICATORS:

☐ NONE

- ☐ Delusional
- ☐ Command hallucinations
- ☒ Depressed mood, especially with
 - ☐ extreme level of anxiety
 - ☐ agitation
 - ☐ significant insomnia
- ☐ Committed violence in past year
- ☒ Impulsive or risky behavior
- ☐ Expressing anger and hostility

4. SOCIAL AND DEMOGRAPHIC FACTORS:

☐ NONE

- ☐ Age less than 19 or greater than 45
- ☒ Male
- ☐ Male age 65 or older
- ☐ Lack of Psychosocial support/isolated
- ☒ Living alone
- ☐ Separated, divorced, widowed

These risk factors may be considered modifiable and may improve or resolve with therapeutic interventions

(Inventory may be completed by RN or Intake Worker, but must be reviewed by psychiatrist.)

5. HISTORY OF:

☐ NONE

- ☒ Previous suicide attempt(s) (If checked, how many) # _____
- ☒ Previous psychiatric treatment
- ☒ Psychiatric hospitalization in past year
- ☐ Self destructive behavior
- ☐ Family/close friend suicide
- ☐ Physical or sexual abuse in childhood
- ☐ Bipolar disorder
- ☒ Alcohol and/or .. substance use/abuse
- ☐ Schizophrenia
- ☐ Borderline personality disorder

6. STRESSORS AND LOSSES:

☐ NONE

- ☐ Recent or impending loss
- ☒ Chronic, painful, or terminal medical disorder
- ☐ Newly diagnosed serious medical problem/s
- ☐ Overwhelming or humiliating stressor
- ☐ Unresolved legal issues
- ☐ Unemployed/Loss of job
- ☐ Financial stress

7. PROTECTIVE FACTORS:

☐ NONE*

Note: These are not risk factors but may prevent the person from acting on suicidal thoughts.

- ☐ Moderate to strong religious beliefs
- ☐ Currently clean and sober
- ☐ Adequate coping/problem solving skills
- ☐ Sense of responsibility to children, family and others including pets
- ☐ Employed
- ☒ Available social supports
- ☒ Positive therapeutic relationship
- ☒ Accepts treatment

*Note: Fewer protective factors increases risk.

8. CURRENT SUICIDAL IDEATION?

- ☒ NONE/Denies
- ☐ YES

DATE:

11/10/15

TIME:

11:30pm

Signature RN/IV:

Sup

Psychiatrist has reviewed information on above risk factors and in conjunction with assessment data determines current suicide risk as:			
☐ NONE	☒ LOW	☐ MEDIUM	☐ HIGH
DATE: 11/10/15		TIME: 12:00 PM	
Signature Psychiatrist: [Signature]			

Mercy Philadelphia Hospital
A member of Mercy Health System

INVENTORY OF SUICIDE RISK FACTORS



CHILDS, HANEEF A

DOB: [REDACTED] 27Y M

Adm: [REDACTED]

Acc: [REDACTED]



362

INVENTORY OF SUICIDE RISK FACTORS

***This assessment must be completed on all inpatient psychiatric admissions including medical and critical care transfers.

CHECK (☒) ANY RISK FACTORS IDENTIFIED DURING CLINICAL EVALUATION:**

> PRIMARY RISK FACTORS

Note: If a primary risk factor is identified in category 1 or 2 consider patient to be a HIGH RISK for suicide.

1. ATTEMPT WITH: ☐ NONE

- ☒ Lethal method (guns, hanging, jumping)
- ☐ Moderate/severe injury or toxicity
- ☐ Low likelihood of being rescued
- ☐ Regret it was unsuccessful, continued ideation or refusal of treatment

2. ACTIVE SUICIDAL PLAN/INTENT: ☒ NONE

- ☐ Definite suicide plan
- ☐ Specific lethal method selected
- ☐ Intent to commit suicide imminently
- ☐ Access to firearms /lethal means
- ☐ Preparations for death (suicide note, giving away possessions, business or insurance arrangements)
- ☐ Extreme hopelessness/unable to focus on positive future events

SECONDARY RISK FACTORS

3. CURRENT CLINICAL INDICATORS: ☐ NONE

- ☒ Delusional
- ☐ Command hallucinations
- ☒ Depressed mood, especially with
 - ☐ extreme level of anxiety
 - ☒ agitation
 - ☐ significant insomnia
- ☒ Committed violence in past year
- ☒ Impulsive or risky behavior
- ☒ Expressing anger and hostility

4. SOCIAL AND DEMOGRAPHIC FACTORS: ☐ NONE

- ☐ Age less than 19 or greater than 45
- ☒ Male
- ☐ Male age 65 or older
- ☐ Lack of Psychosocial support/isolated
- ☐ Living alone
- ☒ Separated, divorced, widowed

**These risk factors may be considered modifiable and may improve or resolve with therapeutic interventions

**(Inventory may be completed by RN or Intake Worker, but must be reviewed by psychiatrist.)

5. HISTORY OF: ☐ NONE

- ☒ Previous suicide attempt(s) (If checked, how many) # _____
- ☒ Previous psychiatric treatment
- ☐ Psychiatric hospitalization in past year
- ☐ Self destructive behavior
- ☐ Family/close friend suicide
- ☐ Physical or sexual abuse in childhood
- ☒ Bipolar disorder
- ☐ Alcohol and/or .. substance use/abuse
- ☐ Schizophrenia
- ☐ Borderline personality disorder

6. STRESSORS AND LOSSES: ☐ NONE

- ☐ Recent or impending loss
- ☒ Chronic, painful, or terminal medical disorder
- ☐ Newly diagnosed serious medical problem/s
- ☐ Overwhelming or humiliating stressor
- ☒ Unresolved legal issues
- ☐ Unemployed/Loss of job
- ☐ Financial stress

7. PROTECTIVE FACTORS: ☐ NONE

Note: These are not risk factors but may prevent the person from acting on suicidal thoughts.

- ☐ Moderate to strong religious beliefs
- ☐ Currently clean and sober
- ☐ Adequate coping/problem solving skills
- ☐ Sense of responsibility to children, family and others including pets
- ☐ Employed
- ☒ Available social supports
- ☐ Positive therapeutic relationship
- ☐ Accepts treatment

*Note: Fewer protective factors increases risk.

8. CURRENT SUICIDAL IDEATION?

- ☐ NONE/Denies
- ☐ YES

DATE: 11/11/15 TIME: 1530

Signature RN/Int: Cheryl Stewart, RN

Psychiatrist has reviewed information on above risk factors and in conjunction with assessment data determines current suicide risk as:

☒ NONE ☐ LOW ☐ MEDIUM ☐ HIGH

DATE: 11/11/15 TIME: 1600

Signature Psychiatrist: [Signature]

Mercy Philadelphia Hospital
A member of Mercy Health System

INVENTORY OF SUICIDE RISK FACTORS



Page 1 of 1
Form NUTPGN, Rev. 05/2015
ASM.X OTHER

CHILDS, HANEEF A
DOB: [REDACTED] 27Y M
Adm: [REDACTED]
Ac: [REDACTED]



363

INVENTORY OF SUICIDE RISK FACTORS

***This assessment must be completed on all inpatient psychiatric admissions including medical and critical care transfers.

CHECK (☒) ANY RISK FACTORS IDENTIFIED DURING CLINICAL EVALUATION:**

PRIMARY RISK FACTORS

Note: If a primary risk factor is identified in category 1 or 2 consider patient to be a **HIGH RISK** for suicide.

1. ATTEMPT WITH:

☐ NONE

- ☒ Lethal method (guns, hanging, jumping)
- ☐ Moderate/severe injury or toxicity
- ☐ Low likelihood of being rescued
- ☐ Regret it was unsuccessful, continued ideation or refusal of treatment

2. ACTIVE SUICIDAL PLAN/INTENT:

☒ NONE

- ☐ Definite suicide plan
- ☐ Specific lethal method selected
- ☐ Intent to commit suicide imminently
- ☐ Access to firearms/lethal means
- ☐ Preparations for death (suicide note, giving away possessions, business or insurance arrangements)
- ☐ Extreme hopelessness/unable to focus on positive future events

SECONDARY RISK FACTORS

3. CURRENT CLINICAL INDICATORS:

☐ NONE

- ☒ Delusional
- ☒ Command hallucinations
- ☒ Depressed mood, especially with
 - ☐ extreme level of anxiety
 - ☐ agitation
 - ☐ significant insomnia
- ☒ Committed violence in past year
- ☒ Impulsive or risky behavior
- ☒ Expressing anger and hostility

4. SOCIAL AND DEMOGRAPHIC FACTORS:

☐ NONE

- ☐ Age less than 19 or greater than 45
- ☒ Male
- ☐ Male age 65 or older
- ☐ Lack of Psychosocial support/isolated
- ☐ Living alone
- ☒ Separated, divorced, widowed

*These risk factors may be considered modifiable and may improve or resolve with therapeutic interventions

** (Inventory may be completed by RN or Intake Worker, but must be reviewed by psychiatrist.)

5. HISTORY OF:

☐ NONE

- ☒ Previous suicide attempt(s) (If checked, how many) # _____
- ☒ Previous psychiatric treatment
- ☒ Psychiatric hospitalization in past year
- ☐ Self destructive behavior
- ☐ Family/close friend suicide
- ☐ Physical or sexual abuse in childhood
- ☐ Bipolar disorder
- ☐ Alcohol and/or .. substance use/abuse
- ☐ Schizophrenia
- ☐ Borderline personality disorder

6. STRESSORS AND LOSSES:

☐ NONE

- ☐ Recent or impending loss
- ☒ Chronic, painful, or terminal medical disorder
- ☐ Newly diagnosed serious medical problem/s
- ☐ Overwhelming or humiliating stressor
- ☒ Unresolved legal issues
- ☐ Unemployed/Loss of job
- ☐ Financial stress

7. PROTECTIVE FACTORS:

☐ NONE*

Note: These are not risk factors but may prevent the person from acting on suicidal thoughts.

- ☐ Moderate to strong religious beliefs
- ☐ Currently clean and sober
- ☐ Adequate coping/problem solving skills
- ☐ Sense of responsibility to children, family and others including pets
- ☐ Employed
- ☒ Available social supports
- ☐ Positive therapeutic relationship
- ☐ Accepts treatment

*Note: Fewer protective factors increases risk.

8. CURRENT SUICIDAL IDEATION?

- ☒ NONE/Denies
- ☐ YES

DATE: 11/12/15 TIME: 1348

Signature RN/IW: [Signature]

Psychiatrist has reviewed information on above risk factors and in conjunction with assessment data determines current suicide risk as:			
☐ NONE	☒ LOW	☐ MEDIUM	☐ HIGH
DATE: <u>11/12/15</u>		TIME: <u>1500PM</u>	
Signature Psychiatrist: <u>[Signature]</u>			

Mercy Philadelphia Hospital
A member of Mercy Health System

INVENTORY OF SUICIDE RISK FACTORS



CHILDS, HANEEF A
DOB: [REDACTED] 27Y M
AC: [REDACTED]



364

INVENTORY OF SUICIDE RISK FACTORS

***This assessment must be completed on all inpatient psychiatric admissions including medical and critical care transfers.

CHECK (☒) ANY RISK FACTORS IDENTIFIED DURING CLINICAL EVALUATION:**

> PRIMARY RISK FACTORS

Note: If a primary risk factor is identified in category 1 or 2 consider patient to be a **HIGH RISK** for suicide.

1. ATTEMPT WITH: ☒ NONE

- ☐ Lethal method (guns, hanging, jumping)
- ☐ Moderate/severe injury or toxicity
- ☐ Low likelihood of being rescued
- ☐ Regret it was unsuccessful, continued ideation or refusal of treatment

2. ACTIVE SUICIDAL PLAN/INTENT: ☒ NONE

- ☐ Definite suicide plan
- ☐ Specific lethal method selected
- ☐ Intent to commit suicide imminently
- ☐ Access to firearms/lethal means
- ☐ Preparations for death (suicide note, giving away possessions, business or insurance arrangements)
- ☐ Extreme hopelessness/unable to focus on positive future events

SECONDARY RISK FACTORS

3. CURRENT CLINICAL INDICATORS: ☐ NONE

- ☐ Delusional
- ☐ Command hallucinations
- ☒ Depressed mood *AN*, especially with
 - ☐ extreme level of anxiety *AN*
 - ☐ agitation *AN*
 - ☐ significant insomnia *AN*
- ☐ Committed violence in past year
- ☒ Impulsive or risky behavior *AN*
- ☐ Expressing anger and hostility *AN*

4. SOCIAL AND DEMOGRAPHIC FACTORS: ☐ NONE

- ☐ Age less than 19 or greater than 45
- ☒ Male
- ☐ Male age 65 or older
- ☐ Lack of Psychosocial support/isolated *AN*
- ☐ Living alone
- ☒ Separated, divorced, widowed

AN These risk factors may be considered modifiable and may improve or resolve with therapeutic interventions

**(Inventory may be completed by RN or Intake Worker, but must be reviewed by psychiatrist.)

5. HISTORY OF:

☐ NONE

- ☒ Previous suicide attempt(s) (If checked, how many) #
- ☒ Previous psychiatric treatment
- ☒ Psychiatric hospitalization in past year
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- ☐ Family/close friend suicide
- ☐ Physical or sexual abuse in childhood
- ☐ Bipolar disorder
- ☐ Alcohol and/or .. substance use/abuse
- ☐ Schizophrenia
- ☐ Borderline personality disorder

6. STRESSORS AND LOSSES:

☐ NONE

- ☐ Recent or impending loss
- ☒ Chronic, painful, or terminal medical disorder
- ☐ Newly diagnosed serious medical problem/s
- ☐ Overwhelming or humiliating stressor
- ☐ Unresolved legal issues
- ☐ Unemployed/Loss of job
- ☐ Financial stress

7. PROTECTIVE FACTORS:

☐ NONE*

Note: These are not risk factors but may prevent the person from acting on suicidal thoughts.

- ☐ Moderate to strong religious beliefs
- ☐ Currently clean and sober
- ☐ Adequate coping/problem solving skills
- ☐ Sense of responsibility to children, family and others including pets
- ☐ Employed
- ☒ Available social supports
- ☒ Positive therapeutic relationship
- ☒ Accepts treatment

*Note: Fewer protective factors increases risk.

8. CURRENT SUICIDAL IDEATION?

- ☒ NONE/Denies
- ☐ YES

DATE: 11/13/15 TIME: 0820

Signature RN/AD: [Signature]

Psychiatrist has reviewed information on above risk factors and in conjunction with assessment data determines current suicide risk as:

☐ NONE ☐ LOW ☐ MEDIUM ☐ HIGH

DATE: 11/13/15 TIME: 1:30 PM

Signature Psychiatrist: [Signature]

Mercy Philadelphia Hospital
A member of Mercy Health System

INVENTORY OF SUICIDE RISK FACTORS



CHILDS, HANEFF A

DOB: 27Y M

Ad: ME:



245

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Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0635 Page 2	
Age/Sex: 27 M	Referring: MAGSOD, TANGIR, MD	CHILDS, HANEEF A		Discharge Date: 11/03/15 at 0715	Room/Bed: 208-1
MRN: M000611175	Account: PA1303162331			Location: 7E2NB	Room/Bed: 208-1

INT-0500680 <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th>Activity</th> <th>Occurred</th> <th>Recorded</th> <th>By</th> <th>Time</th> <th>By</th> <th>Doc/Units</th> <th>Change</th> <th>From</th> </tr> <tr> <td>Type</td> <td>Date</td> <td>Time</td> <td>By</td> <td>Date</td> <td>Time</td> <td>Doc/Units</td> <td>Change</td> <td></td> </tr> </table> 0510680 Height and Weight.....ADMISSION.....PS Height Calculated Centimeters.....172.09 cm Height Calculated Centimeters Result.....172.09 cm Weight Kilograms.....61.00 Kg Weight Calculated Pounds.....134 lbs Weight in Calculated Ounces.....7.7 oz Weight in Calculated Grams.....61000.000 g Calculated BSA.....1.72 calculated All questions must be answered to calculate BSA Calculated BMI.....20.6 calculated All questions must be answered to calculate BMI Date: 11/03/15 1500 0250012 Screening Assessment.....ADMISSION.....PS Document 11/03/15 1500 MMB 11/03/15 1503 MMB Beliefs Identified.....Religious Assistance with Spiritual Needs.....Patient Denies Assistance with Cultural or Personal Preferences.....N Spiritual Care Referral.....Declined at this Time Sign Language Interpreter Offered to Patient or Guardian.....NA Diet Prior to Admission.....Regular Supplements.....N Nutritional Referral Indication.....No Risk Identified Physical Therapy Referral Indication.....Not Indicated Durable Medical Equipment Prior to Admit.....None Acute Stroke.....N If Yes MUST answer onset of symptom questions below Does Not Meet MRSA Criteria.....Yes No Cultures to Be Done Patient Refused Swab.....N History of MRSA.....N If Patient Has History of MRSA Do Not Collect Swab Is the patient in a clinical trial.....No Date: 11/03/15 1503 0250130 ADM: General Admission Asmt.....ADMISSION.....PS Document 11/03/15 1503 MMB 11/03/15 1510 MMB ADM General Assessment Known Signs of Infection.....N Patient presenting with ANY of the following: fever, headache, joint and muscle aches, weakness, fatigue, vomiting, diarrhea, stomach pain and lack of appetite, and in some cases bleeding. Ebola Infection Screening.....No Risk Have you traveled to West Africa in the last 21 days or had any exposure to a person with the Ebola virus disease? Click on External Link (Globe) in lower right corner for updated information - CDC Ebola Information Readmit within 30 Days.....N Date of Arrival on Unit.....11/03/15 Time of Arrival on Unit.....0715 Accompanied By.....Tech	Activity	Occurred	Recorded	By	Time	By	Doc/Units	Change	From	Type	Date	Time	By	Date	Time	Doc/Units	Change		INT-0250130 <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th>Activity</th> <th>Occurred</th> <th>Recorded</th> <th>By</th> <th>Time</th> <th>By</th> <th>Doc/Units</th> <th>Change</th> <th>From</th> </tr> <tr> <td>Type</td> <td>Date</td> <td>Time</td> <td>By</td> <td>Date</td> <td>Time</td> <td>Doc/Units</td> <td>Change</td> <td></td> </tr> </table> Mode of Arrival.....Wheelchair Admitted From.....Crisis Center History Provided By.....Patient Notification of Admission permission obtained from.....Patient Permission from patient/family/other to notify a family member/representative/physician about the patient's admission Chief Complaint.....unknown Onset of Chief Complaint.....unknown Emergency Contact.....grand mother Emergency Contact Phone Number.....215 747 3588 Enter phone number for patient's Emergency Contact..... Orientation To.....Phone use TV Bathroom No Smoking Policy Visiting Policy Educational Resources Environment Spiritual Resources Meal Times Belongings and Valuables Processed per Facility Policy.....Y Home Medication Disposition.....No Meds Brought In Date: 11/03/15 1510 0250150 ADM: Physical Assessment.....ADMISSION.....PS Document 11/03/15 1510 MMB 11/03/15 1516 MMB ADM HEENT Assessment HEENT System Parameters.....WDL Head and Neck: Dentis pain and limitations of movement. Eyes: Open spontaneously. Sclera clear. No discharge. Dentis visual problems. Ears: No discharge. No observable or reported hearing impairment. Nose: No discharge. Mouth and Throat: Swallows without difficulty. Membranes moist. No dentition problems. Trachea midline. If there are any deviations from the standard assessment, you must complete the identified problem area. Document 11/03/15 1510 MMB 11/03/15 1516 MMB ADM Neurological Assessment Neurological System Parameters.....WDL Alert and oriented to person, place, time and situation. Moves all extremities equally. Pupils round, equal, and reactive to light. No facial weakness. Speech clear. If there are any deviations from the standard assessment, you must complete the identified problem area. Document 11/03/15 1510 MMB 11/03/15 1516 MMB ADM Cardiac Assessment Cardiovascular System Parameters.....WDL Heart rhythm regular. No chest pain, syncope, palpitations, clubbing, activity intolerance, intermittent claudication, numbness, or tingling. Skin warm and dry without cyanosis.	Activity	Occurred	Recorded	By	Time	By	Doc/Units	Change	From	Type	Date	Time	By	Date	Time	Doc/Units	Change	
Activity	Occurred	Recorded	By	Time	By	Doc/Units	Change	From																													
Type	Date	Time	By	Date	Time	Doc/Units	Change																														
Activity	Occurred	Recorded	By	Time	By	Doc/Units	Change	From																													
Type	Date	Time	By	Date	Time	Doc/Units	Change																														

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Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0033 Page 3	
MRN: 27 H	Attending: MAGSOOD, TARIK, MD	CHILDS, HANEEF A		Signature: DTS IN	Admitted: 11/03/15 at 0719
MRN: M000611175	Account: PA130J162331			Location: PH2NE	Room/Bed: 208-1

Activity		Occurred		Recorded		Date		Time		By		Doc		Unit		Change	
0250150 ADMISSION ES Peripheral pulses palpable and equal bilaterally. No edema. No JVD at 30-45 degrees reclining. No calf tenderness. Denies chest pain. If there are any deviations from the standard assessment, you must complete the identified problem area. *Document VTE Prophylaxis Measures when applicable: VTE Prophylaxis.....N Document 11/03/15 1510 MMB 11/03/15 1516 MMB ADM Respiratory Assessment Respiratory System Parameters.....RDL Respirations regular, unlabored, no retractions. Symmetrical chest expansion. Breath sounds clear, nondiminshed bilaterally. No cough or stridor noted. No sputum or clear sputum production. If there are any deviations from the standard assessment, you must complete the identified problem area. Document 11/03/15 1510 MMB 11/03/15 1516 MMB ADM Musculoskeletal Assessment Musculoskeletal System Parameters.....RDL Full range of motion. Steady, unassisted gait. Full weight bearing. No assistive equipment. If there are any deviations from the standard assessment, you must complete the identified problem area. Document 11/03/15 1510 MMB 11/03/15 1516 MMB ADM GI Assessment Gastrointestinal System Parameters.....RDL Abdomen soft, non-tender, and without distention. Bowel sounds active in all quadrants. Continent of stool. Bowel movements within usual pattern of frequency. Bowel movements formed, brown to dark brown. Tolerates prescribed diet without nausea and vomiting. No gastrointestinal tubes present. If there are any deviations from the standard assessment, you must complete the identified problem area. Document 11/03/15 1510 MMB 11/03/15 1516 MMB ADM Genitourinary Assessment Genitourinary System Parameters.....RDL Urinary voids without difficulty. Denies dysuria, frequency, hesitancy, nocturia, and burning. Bladder non-distended. Continent of urine. Males with natural stream. Urine clear yellow to straw colored with minimal odor. There is no penile or vaginal discharge or drainage. No tubes, drains, catheters, or ostomy present. No dialysis. If there are any deviations from standard assessment, you must complete the identified problem area. nt 11/03/15 1510 MMB 11/03/15 1516 MMB Reproductive Assessment Reproductive Parameters.....RDL The following were assessed and found to be within defined limits: *No tenderness or pain present *No scrotal, penile, perineal, or vaginal discharge, odor, swelling, bruising or lesions If there are any deviations from the standard assessment additional documentation is required Current Reproductive Signs and Symptoms.....None Document 11/03/15 1510 MMB 11/03/15 1516 MMB ADM Integumentary Assessment Integumentary System Parameters.....RDL Skin warm, dry, smooth and intact with good skin turgor based on a visual head to toe skin inspection. Skin color natural for race. No pressure related skin changes over bony prominences, no jaundice, cyanosis, bruises, rashes. Turgor is elastic. No evidence of infection. If there are any deviations from the standard assessment, you must complete the identified problem area. Document 11/03/15 1510 MMB 11/03/15 1516 MMB ADM Psychosocial Assessment Psychosocial System Parameters.....RDL, except for Behavior, mood, affect, appearance appropriate to situation. Denies hallucinations, depression, anxiety. Family/caregiver involved in care if applicable. If there are any deviations from the standard assessment, you must complete the identified problem area. Patient Behavior.....Aggressive Personal Appearance And Hygiene.....Disheveled Coping Strategies Appropriate for the Situation...N Anxiety Level.....Moderate Precipitating Stress Factors.....Psychiatric Condition Coping and Decision Making Ability.....Autonomous Coping Response Appropriateness.....Destructive Support System.....Family Support System Response.....Hostile Document 11/03/15 1510 MMB 11/03/15 1516 MMB ADM Safety Assessment Is Patient on Anticoagulation Therapy.....N A Yes response will trigger a suggested problem of High Risk of Injury from Fall Identification Bracelet.....On ER and Community Bands Removed.....Y Call Bell Within Reach.....N n/a Bed Locked in Lowest Position.....Y Bed and Rail Position.....Low Fall Prevention Alarm Utilized and Active...N																	

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Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0035 Page 4	
Age: 27 M	Referring: HAQSOOD, TAQUR, MD	CHILDS, HANEEF A		DIS IN	11/03/15 at 0715
MRN: MD00611175	Account #: PA1303162321			Location: 2K2NE	Room/Bed: 208-1

Activity	Occurred	Recorded	Site	Frequency	Unit	Change	From
0250150	Admission	11/03/15 1516 MMB	11/03/15 1517 MMB	Standard			
Isolation and Precautions.....Standard							
0250210	Vaccination Record	11/03/15 1516 MMB	11/03/15 1517 MMB				
Document 11/03/15 1516 MMB 11/03/15 1517 MMB							
Hx Influenza Vaccination.....unknown							
Enter Date Of Administration Or Unknown In							
The Comment Field							
Hx Pneumococcal Vaccination.....unknown							
Enter Date Of Administration Or Unknown In							
The Comment Field							
Hx Hepatitis A Vaccination.....unknown							
Enter date of administration under comments							
Hx Hepatitis B Vaccination.....unknown							
Enter date of administration and which							
injection in series under comment							
Hx Meningococcal Vaccination.....unknown							
Enter date of administration under comment							
Hx Tetanus Diphtheria Pertussis Vaccination.....unknown							
Enter Date Of Administration Or Unknown In							
The Comment Field							
Hx Tetanus Toxoid Vaccination.....unknown							
Enter Date Of Administration In Comment Field							
Date: 11/03/15 1517							
0250215	Vaccination Record	11/03/15 1517 MMB	11/03/15 1519 MMB				
Document 11/03/15 1517 MMB 11/03/15 1519 MMB							
Pneumonia Vaccine Contraindications.....Patient refused							
If any of the above, STOP, Do not give							
vaccine							
Pneumonia Vaccine Excluded Populations...No Conditions							
INDICATED CONDITION: Age 2-64 years with an							
indicated condition and has received 1 dose							
of vaccine. * (See List Below)							
INDICATED CONDITION: Age 65 or greater with							
an indicated condition and had received 1							
dose of vaccine, < 5 years ago * (See List							
Below)							
IMMUNOCOMPROMISED: Has received 2 doses of							
vaccine or 1 dose less than 5 years ago *							
(See List Below)							
NO CONDITIONS: Age 2 - 64 with NO indicated							
condition, non-smoker, no immunocompromising							
condition * (See List Below)							
If any of the above, STOP, Do not give							
vaccine.							
Pneumococcal Vaccine to be Given.....N							
Influenza Vaccine Excluded Populations....Patient refused							
Only check Hx of Guillian-Barre syndrome if							
it occurred within 6 weeks of receiving the							
influenza vaccine.							
If any of the above STOP, Do not give vaccine							
Influenza Vaccine to be Given.....N							

Activity	Occurred	Recorded	Site	Frequency	Unit	Change	From
0250910	Admission	11/03/15 1519 MMB	11/03/15 1522 MMB				
Document 11/03/15 1519 MMB 11/03/15 1522 MMB							
History Provided By.....Patient							
Hx HENT Problems.....N							
Document 11/03/15 1519 MMB 11/03/15 1522 MMB							
Hx Neurological Problems.....N							
Document 11/03/15 1519 MMB 11/03/15 1522 MMB							
Hx Cardiac Problems.....N							
Document 11/03/15 1519 MMB 11/03/15 1522 MMB							
Hx Respiratory Problems.....N							
Document 11/03/15 1519 MMB 11/03/15 1522 MMB							
Hx Endocrine Problems.....N							
Document 11/03/15 1519 MMB 11/03/15 1522 MMB							
Hx Gastrointestinal Problems.....N							
Document 11/03/15 1519 MMB 11/03/15 1522 MMB							
Hx Genitourinary Problems.....N							
Document 11/03/15 1519 MMB 11/03/15 1522 MMB							
Hx Reproductive Problems.....N							
Sender.....Male							
Hx Reproductive Disorders.....N							
Document 11/03/15 1519 MMB 11/03/15 1522 MMB							
Hx Musculoskeletal Problems.....N							
Document 11/03/15 1519 MMB 11/03/15 1522 MMB							
Hx Skin Problems.....N							
Document 11/03/15 1519 MMB 11/03/15 1522 MMB							
Hx Psychosocial Problems.....Y							
Hx Anxiety.....Y							
Hx Depression.....N							
Hx Psychosocial stressors.....Y							
Hx Schizophrenia.....Y							
Hx Sleep Difficulties.....N							
Document 11/03/15 1519 MMB 11/03/15 1522 MMB							
Hx Drug Resistant Organism.....N							
Document 11/03/15 1519 MMB 11/03/15 1522 MMB							
Hx Miscellaneous Medical Problems.....N							
Hx Anesthesia Reaction.....N							
Hx Autoimmune Disease.....N							
Hx Blood Transfusions.....N							
Hx Blood Transfusion Reaction.....N							
Hx Cancer.....N							
Hx Chemotherapy.....N							
Hx Falls.....N							
Hx Fall with Injury.....N							
A Yes response will trigger a suggested							
problem of High Risk of Injury from Fall							
Hx Hospitalization.....unknown							
Hx Malignant Hyperthermia.....unknown							
Hx Radiation Therapy.....N							
Hx Sickle Cell Disease.....N							
Hx Systemic Lupus Erythematosus.....N							
Hx Organ Transplant.....N							
Hx Surgeries.....N							
Date: 11/03/15 1522							
0250200	Admission	11/03/15 1522 MMB	11/03/15 1522 MMB				
Document 11/03/15 1522 MMB 11/03/15 1522 MMB							

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Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0035 Page 5	
Age: 27 M	Attending: NAQSOOD, TAHIR, MD	CHILDS, HANEEF A		Dis IN	Admitted: 11/03/15 at 0715
MRN: M000611175	Account: PA1303162331			Location: PH2NE	Room/Sec: 208-1

0255020 Advance Directive ADMISSION PS Document 11/03/15 1522 MMB 11/03/15 1522 MMB Patient has Advance Directive.....A Copy of Advance Directive on Current Chart...N Advance Directive Information Given.....N Does patient have Power of Attorney.....N Enter name and phone number of legal power of attorney..... Is patient an organ donor.....N Date: 11/03/15 1522 0255060 Right-Breastings Checklist ADMISSION PS Document 11/03/15 1524 MMB 11/03/15 1525 MMB Clothing Location.....Locker on Unit Date: 11/03/15 1525 0255200 Readmission Risk Assessment ADMISSION PS Document 11/03/15 1525 MMB 11/03/15 1527 MMB Fallitive Care.....No prior history Life-threatening illness - Illness/disease that may lead to death within 1 year Length of stay.....No previous admission Adm w/in 6mo <3 days - Previous admission within past six months for less than 3 days Adm w/in 6mo >3 days - Previous admission within past six months for more than 3 days Acute Admission.....Inpatient Comorbidity.....No prior history Mild - DM no complications, cerebrovascular disease, history of MI, FVD, FUD Mild to moderate - Mild liver disease, DM with end organ damage, CHF, COPD, Cancer, Leukemia, lymphoma, any tumor, cancer, moderate to severe renal disease Moderate - Dementia, psychiatric diagnoses or a connective tissue disease Moderate to severe - Moderate or severe liver disease or HIV disease Severe - Metastatic cancer Emergency Room Visits During Previous 6 Months...1 visit Supportive Care.....Self care Self care - No caregiver required Poor health outcomes - History of self determination leading to poor health outcomes Assistance needed - Absence of caregiver to assist with discharge and home care. Readmission Risk Assessment Total Score.....4 points Score of 11 or greater = Referral to Care Transition Nurse Date: 11/03/15 1541	1750030 Assessment ADMISSION PS Document 11/03/15 1541 MMB 11/03/15 1544 MMB Patient Activity.....Up Ab Lib Activity Ability.....Independent Activity Tolerance.....Good Eating Ability.....Independent Toileting Ability.....Independent Dressing Ability.....Independent Bathing Ability.....Independent Oral Care Ability.....Independent Sleep Assessment.....Normal Sleep Aids.....None Date: 11/03/15 1544 1750670 Fall Risk Assessment ADMISSION PS Document 11/03/15 1547 MMB 11/03/15 1552 MMB Confusion Disorientation Impulsivity Fall Risk.....No If "Yes" Response, Patient May Be Disoriented To Time, Place, And/Or Person. Patient Is Unable To Retain Or Receive Instructions, Or Displays Impaired Safety Or Personal Judgement: A Cluster Of Global, Transient Changes And Disturbances In Attention, Cognition, Psychomotor Activity, Level Of Consciousness, And/Or Sleep/Wake Cycles, Impulsive Behavior, Hallucinations, Agitation, Unrealistic, Inappropriate Or Unusual Behavior. This May Be A Progressive Neurological State, Drug Induced, Or Behavioral In Origin. Stroke Patients (Left Hemis) May Exhibit Impulsive, Unpredictable Behavior As A Result Of The Cerebral Insult. Symptomatic Depression Fall Risk.....No If "Yes" Response, Medical Diagnosis Of Depression. Nursing Assessment Finds The Patient Appears Depressed, Hopeless, In A Melancholic Mood, Is Not Interacting Appropriately, And/Or Is Tearful, Withdrawn. Displays A Flat Affect Or Seeming Lack Of Interest, Or The Patient States He/She Is Depressed. A General Loss Of Interest In Life Events. If The Depression Is Managed With Drugs And/Or Therapies, They Do NOT Score Additional Points When The Depression Is In Therapeutic Control. Altered Elimination Fall Risk.....No If "Yes" Response, Altered Elimination From The Clinical Norm, Such As Incontinence, Nocturia, Frequency, Urgency Or Stress Incontinence, Diarrhea, Or Related To Use Of Cathartics; Any Toileting Self-care Deficit. e.g., Physical Impairment. This Does NOT Include A Foley Or Indwelling Catheter UNLESS It Causes Symptoms Referenced Above While In Use With The Patient. When The Catheter Is Removed, It Can Be A High-Risk Time Until Normal Elimination Is Established. Dizziness Vertigo Sway Path Loss Of Balance.....No
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Date Range: Beginning - 11/17/15		Korey Philadelphia Hospital ECS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0035 Page 5	
Page 5/90	27 M	Attending: BAQGOOD, TAMIR, MD	Status: DIS IN		Admission: 11/03/15 at 0715
Unit: MD00611175	Account: PA1303162331	CHILDS, HANEEF A		Location: PR2NE	Room/Wed: 209-1

NT-U-0670								NT-U-0670								
Activity	Occurred	Recorded	Site	Time/Target	PA	From	Change	Activity	Occurred	Recorded	Site	Time/Target	PA	From	Change	
Type	Date	Time	By	Date	Time	By	Doc/Unit	Type	Date	Time	By	Date	Time	By	Doc/Unit	Change
1750670	Full Risk Assessment		A				.ADMISSION									
If "Yes" Response, Medical Diagnosis Of Vertigo Or The Patient Reports A Sensation Of Spinning. Sway Path May Be Present When The Patient Stands (Circular Motion Upon Rising). This Is Often Seen In The Aging Adult With Poor Gait And Balance And Can Occur As A Result Of Some Drug Side Effects. Often Seen In The Newly Delivered Obstetric Patient. Gender Fall Risk.....Male Prescribed Administered Antiepileptics Or Anticonvulsants...No If "Yes" Response, This List Is Including, But Not Limited To The Following Medications: Carbamazepine, Divalproex Sodium, Ethosuximide, Felbamate, Fosphenytoin, Gabapentin, Lamotrigine, Mephenytoin, Methsuximide, Phenobarbital, Phenytoin, Primidone, Topiramate, Trimethadione, Valproic Acid. Prescribed And Or Administered Benzodiazepines.....No If "Yes" Response, This List Is Including, But Not Limited To The Following Medications: Alprazolam, Clonazepam, Clonazepam, Clonazepam Dipotassium, Diazepam, Flurazepam, Halazepam, Lorazepam, Midazolam, Oxazepam, Temazepam, Triazolam. Get Up And Go Test Fall Risk... ..Able Rise Single Movement If Unable To Assess, Monitor For Change In Activity Level, Assess Other Risk Factors, Document Both On Patient's Chart With Date And Time.								They Should Be Considered "High Risk For Falls". If The Patient Is Comatose Or In A Drug-Induced Coma And The Assessment For Fall Risk Cannot Be Completed, Document 'Unable To Assess Fall Risk Status At This Time.....' And Make A Comment On The Section Below As To The Reason. Once The Condition Changes, All Or A Portion Of The Risk Assessment Should Be Completed As Described Above. Copyright 2019 AMI Of Indiana Inc. All Rights Reserved. United States Patent #7,262,031. Federal Laws Prohibits The Replication, Distribution Or Use Without Written Permission From AMI Of Indiana Incorporated. Total Fall Risk Score.....1 score A Score Of 5 Or Greater = High Risk Fall Risk Level.....Standard Standard Interventions Are Implemented On All Patients Regardless Of Fall Risk. Is Patient Over 85.....N Answer required on admission only. A Yes response will trigger a suggested problem of High Risk of Injury from Fall Is Patient Post Surgical This Shift.....N Answer required for post-surgical only. A Yes response will trigger a suggested problem of High Risk of Injury from Fall Teaching Method Fall Risk.....Explained Teach Recipient Fall Risk.....Patient Teaching Response Fall Risk.....Verbalizes understanding								
Able Rise Single Movement - Pt Is Able To Rise In Single Movement By Placing Hands On Thighs - No Loss Of Balance With Steps. Pushes Up In One Attempt - Pushes Up, Successful In One Attempt. Multiple Attempts, Succeed - Multiple Attempts, But Successful. Unable Rise Without Help - Pt Is Unable To Rise Without Assistance. Ordered Complete Bedrest - If A Medical Order Is Documented On Chart.								2750001 Document 11/03/15 1552 MMS 11/03/15 1555 MMS Complaint Of Pain.....N								
With The Patient Sitting In A Chair (Preferred) Or On The Side Of The Bed, Place Palm Of Hands Flat On Thighs And Ask The Patient To Stand Without Assistance. Score The Patient According To The Guidelines Below. If The Patient Is Unable To Perform The Test (Traction, Debilitation/Atrophy, And/Or Bed Rest Order) Score All Other Risk Factors That Can Be Assessed. If The Patient Scores 5 Or Greater (Without The Get-Up-And-Go) And Can ATTEMPT To Get Up,								3250001 Document 11/03/15 1554 MMS 11/03/15 1555 MMS Diet Type.....Regular Thickened Liquids.....N Feeding.....Self Nutrition Breakfast.....75 to 100% Aspiration Precautions Maintained.....N Caloric Count.....N								
3750140 Document 11/03/15 1555 MMS 11/03/15 1555 MMS Moisture.....Rarely Moist Sensory Perception.....No Limitation Activity.....Balks Frequently Mobility.....No Limitation Nutrition.....Adequate Friction and Shear.....No Apparent Problem Total Score Skin Risk Assessment...22 score 19-23 = No Risk 15-18 = Low Risk 13-14 = Moderate Risk																

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Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0035 Page 8	
Age/Sex: 27 M	Referring: MAGSOD, TARIK, MD	CHILDS, HANEEF A		Status: DIS IN	Admitted: 11/03/15 at 0715
Unit: M000611175	Account: PA1303162331			Location: PH2NE	Room/Bed: 208-1

INT: D50403F		INT: 460065	
Activity	Occurred	Recorded	Activity
Type	Date	Time	Type
1750030	ADL Assessment	OSHIPT	Withdrawn
Dressing Ability.....Independent			Speech.....Low Volume
Care Provided.....Shower			Clear
Bathing Ability.....Independent			Mood and Affect.....Anxious
Oral Care Ability.....Independent			Apprehensive
Sleep Assessment.....Normal			Depressed
Sleep Aids.....None			Dysphoric
2750001	Complaint Of Pain.....N	OADMSHIFTPTN	Frustrated
Document 11/03/15 2205 JM 11/03/15 2220 JM			Labile
3250001	Personal Assessment	OSHIPTPTN	Suspicious
Document 11/03/15 2205 JM 11/03/15 2220 JM			Withdrawn
Diet Type.....REGULAR			Helpless
Thickened Liquids.....N			Preoccupied
Feeding.....Self			Delusions.....N
Nutrition Breakfast.....76 to 100%			Hallucinations.....None
Nutrition Dinner.....76 to 100%			Thought Process.....Tangential
Nutrition Snack.....76 to 100%			Circumstantial
Tube Feed Flushed.....N/A			Flight of Ideas
Aspiration Precautions Maintained.....N N/A			Disorganized
Calorie Count.....N N/A			Insight and Judgment.....Poor
3750420	Personal Assessment	OSHIPT	Danger to Self or Others.....N
Document 11/03/15 2205 JM 11/03/15 2220 JM			Suicidal Thoughts.....N
3750140	Personal Assessment	OADMSHIFTPTN	Does Patient Have a Plan.....N
Document 11/03/15 2205 JM 11/03/15 2220 JM			Homicidal Thoughts.....N
Moisture.....Rarely Moist			Contract for Safety.....Y
Sensory Perception.....No Limitation			Contract for Nonviolence.....Y
Activity.....Walks Frequently			Psych Comment.....302
Mobility.....No Limitation			Court Date.....11/05/15
Nutrition.....Adequate			5259900
Friction and Shear.....No Apparent Problem			Teaching Record
Total Score Skin Risk Assessment...22 score			Document 11/03/15 2215 JM 11/03/15 2220 JM
19-23 = No Risk			Was Patient Specific Education Provided Identified by CENRT.....N
15-18 = Low Risk			This is patient education content provided
13-14 = Moderate Risk			via the Info Button
10-12 = High Risk			CENRT=Certified Electronic Health Record
Less Than 9 = Very High Risk			Technology
460065	Personal Assessment	OSHIPT	Were the Problems or Medications or Labs Reviewed.....Y
Document 11/03/15 2205 JM 11/03/15 2220 JM			Education Portinence...
Mental Status.....Alert			..MENTAL HEALTH DISEASE AND MEDICATION COMPLIANCE
Orientation.....Person			Education Topics.....Disease Process
.....Place			Medications
.....Time			Safety
Patient Appearance.....Dishveled			Signs and Symptoms
Independant ADLS.....Y			Stress Management
Eating Independently.....Y			Treatment Plan
Sleep Pattern.....Interrupted Sleep			Need for Followup Care
Attendance to Meetings.....Good			When to Call 911
Participation in Meetings.....NONE			Teach Fall Risk Safety Components.....Orient to Surroundings
Compliance With Medications.....Y			Medication Education Topics.....Action
Seclusions and or Restraints...N			Side Effects
Behavior.....Compliant			Administration
.....Depressed			Frequency
.....Disorganized			Dosage
.....Guarded			Route
.....Seclusive			Tobacco Use Education.....Patient Declined
			Practical Counseling includes: Recognizing
			dangerous situation, developing coping

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Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0035 Page 9	
27 M	MAQSOOD, HAKEEM, MD	CHILDS, HANEEF A		DIS ID:	11/03/15 at 0715
M000611175	PA1309162331			Location:	208-1

Activity	Occurred	Recorded	Site	Freq/Target	Pri	From
5259900	Teaching: Record					
skills. and providing basic information about quitting. Patient Referred to Outpatient Counseling after Discharge.....Declined Enrollment Referred to evidence based outpatient counseling. Outline. Teaching Recipient.....Patient Readiness to Learn.....Disinterested Barriers to Learning.....Unmotivated Emotional Unreceptive Cognitive Teaching Methods.....Explained Response to Teaching... ..Verbalizes understanding Interpreter Required.....N Follow Facility Specific Interpreter Guidelines						
0010012 ADL Assessment 11/04/15 0252 SHP 11/04/15 0253 SHP .OSHIPTPRN .PS						
Document 11/04/15 0252 SHP 11/04/15 0253 SHP						
4610065 ADL Assessment 11/04/15 0252 SHP 11/04/15 0253 SHP .OSHIPTPRN .PS						
Document 11/04/15 0252 SHP 11/04/15 0253 SHP						
Presenting Problem.....PARANOID, PREOCCUPIED Independent ADLs.....Y Eating Independently.....Y Sleep Pattern.....Difficulty Falling Asleep Compliance With Medications.....N REFUSEL PQ PRN MEDS Seclusions and or Restraints...N Ed Results 11/04/15 0252 SHP 11/04/15 0416 SHP Sleep Pattern.....Difficulty Falling Asleep Early Awakening						
Date: 11/04/15 0253 1750030 ADL Assessment 11/04/15 0253 SHP 11/04/15 0253 SHP .OSHIPTPRN .PS						
Document 11/04/15 0253 SHP 11/04/15 0253 SHP						
Patient Activity.....Up Ab Lib Activity Ability.....Independent Assistive Devices.....None Activity Tolerance.....Good Eating Ability.....Independent Toileting Ability.....Independent Toileting Assistive Devices...Toilet Dressing Ability.....Independent Bathing Ability.....Independent Oral Care Ability.....Independent Sleep Assessment.....Difficulty Falling Asleep Sleep Aids.....Medication Ed Results 11/04/15 0253 SHP 11/04/15 0416 SHP Sleep Assessment.....Difficulty Staying Asleep Difficulty Falling Asleep Early Morning Awakening Difficulty Falling Asleep						
2750001 PAIN Assessment 11/04/15 0253 SHP 11/04/15 0253 SHP .QADNHSIPTPRN .PS						
Document 11/04/15 0253 SHP 11/04/15 0253 SHP						
Complaint Of Pain.....N						
3250001 NUTRITIONAL Assessment 11/04/15 0253 SHP 11/04/15 0253 SHP .OSHIPTPRN .PS						
Document 11/04/15 0253 SHP 11/04/15 0253 SHP						
et Type.....REGULAR						

Activity	Occurred	Recorded	Site	Freq/Target	Pri	From
3750140	Thickened Liquids...N					
Feeding.....Self Calorie Count.....N 3750140 PAIN Assessment 11/04/15 0253 SHP 11/04/15 0253 SHP .QADNHSIPTPRN .PS						
Document 11/04/15 0253 SHP 11/04/15 0253 SHP						
Moisture.....Rarely Moist Sensory Perception.....No Limitation Activity.....Walks Frequently Mobility.....No Limitation Nutrition.....Adequate Friction and Shear.....No Apparent Problem Total Score Skin Risk Assessment...22 score 19-23 = No Risk 15-18 = Low Risk 13-14 = Moderate Risk 10-12 = High Risk Less Than 9 = Very High Risk						
Date: 11/04/15 0253 0500000 VITALS 11/04/15 0725 BHP 11/04/15 0726 BHP .PS						
Document 11/04/15 0725 BHP 11/04/15 0726 BHP						
Temperature Celsius.....35.8 degrees C Temperature Calculated Fahrenheit.....96.4 degrees F Temperature Source.....Oral Pulse Location Modifier.....Right Pulse Location.....Brachial Pulse Rate Adult 18 And Older.....61 Beats Per Minute Respiratory Rate Adult 18 And Older.....26 Breaths Per Minute Blood Pressure Systolic Adult 18 And Older.....121 mmHg Blood Pressure Diastolic Adult 18 And Older.....73 mmHg						
Date: 11/04/15 1331 0061930 PAIN Assessment 11/04/15 1331 SHP 11/04/15 1332 SHP .continuous .PS						
Document 11/04/15 1331 SHP 11/04/15 1332 SHP						
Date: 11/04/15 1500 1750030 ADL Assessment 11/04/15 1500 SHP 11/04/15 1502 SHP .OSHIPTPRN .PS						
Document 11/04/15 1500 SHP 11/04/15 1502 SHP						
Patient Activity.....Up Ab Lib Activity Ability.....Independent Assistive Devices.....None Activity Tolerance.....Good Eating Ability.....Independent Toileting Ability.....Independent Toileting Assistive Devices...Toilet Dressing Ability.....Independent Bathing Ability.....Shower Oral Care Ability.....Independent Sleep Assessment.....Difficulty Staying Asleep Sleep Aids.....Medication Ed Results 11/04/15 1501 MMB 11/04/15 1502 MMB Complaint Of Pain.....N						

Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0035 Page 10	
Age/Sex: 27 M	Accounting: MACSOOD, TAHIR, MD	CHILDS, HANEEF A		Starts: DIS ID	Admitted: 11/03/15 at 0713
Unit #: H000611175	Account #: PA1303162331			Location: JH2NE	Room/Bed: 200-1

Activity	Occurred	Recorded	Site	Pres/Target	PSI	From
Type	Date	Time	By	Date	Time	By
3250001 11/04/15 1602 MMB 11/04/15 1602 MMB .GSMITPRN PS						
Document 11/04/15 1602 MMB 11/04/15 1602 MMB						
Diet Type.....REGULAR						
Thickened Liquids.....N						
Feeding.....Self						
Nutrition Breakfast.....76 to 100%						
Nutrition Snack.....51 to 75%						
Tube Feed Flushes.....N/A						
Aspiration Precautions Maintained.....N N/A						
Calorie Count.....N						
3750140 11/04/15 1602 MMB 11/04/15 1602 MMB .GADNSHIFTPRN PS						
Document 11/04/15 1602 MMB 11/04/15 1602 MMB						
Moisture.....Rarely Moist						
Sensory Perception.....No Limitation						
Activity.....Walks Frequently						
Mobility.....No Limitation						
Nutrition.....Adequate						
Friction and Shear.....No Apparent Problem						
Total Score Skin Risk Assessment.....22 score						
19-23 = No Risk						
15-18 = Low Risk						
13-14 = Moderate Risk						
10-12 = High Risk						
Less Than 9 = Very High Risk						
4600065 11/04/15 1602 MMB 11/04/15 1602 MMB .GSHIFT PS						
Document 11/04/15 1602 MMB 11/04/15 1602 MMB						
Presenting Problem.....PARANOID, PREOCCUPIED						
Mental Status.....Alert						
Orientation.....Person						
.....Place						
.....Time						
Patient Appearance.....Disheveled						
Independent ADLs.....Y						
Eating Independently.....Y						
Attendance to Meetings.....Good						
Participation in Meetings.....NONE						
Compliance With Medications.....N REFUSED PO PRN MEDS						
Seclusions and or Restraints.....N						
Behavior.....Compliant						
.....Depressed						
.....Disorganized						
.....Guarded						
.....Seclusive						
.....Withdrawn						
Speech.....Low Volume						
.....Clear						
Mood and Affect.....Anxious						
.....Apprehensive						
.....Depressed						
.....Dysphoric						
.....Frustrated						
.....Labile						
.....Suspicious						
.....Withdrawn						
.....Helpless						
.....Preoccupied						

Activity	Occurred	Recorded	Site	Pres/Target	PSI	From
Type	Date	Time	By	Date	Time	By
5259900 11/04/15 1602 MMB 11/04/15 1602 MMB .GSHIFTPRN PS						
Document 11/04/15 1602 MMB 11/04/15 1602 MMB						
Was Patient Specific Education Provided Identified by CHERT.....Y						
This is patient education content provided via the Info Button						
CHERT=Certified Electronic Health Record Technology						
Were the Problems or Medications or Labs Reviewed.....Y						
Education Pertinence.....						
..MENTAL HEALTH DISEASE AND MEDICATION COMPLIANCE						
Education Topics.....Disease Process						
.....Medications						
.....Safety						
.....Signs and Symptoms						
.....Stress Management						
.....Treatment Plan						
.....Need for Followup Care						
.....When to Call 911						
Teach Fall Risk Safety Components.....Orient To Surroundings						
Medication Education Topics.....Action						
.....Side Effects						
.....Administration						
.....Frequency						
.....Dosage						
.....Route						
Tobacco Use Education.....Patient Declined						
Practical Counseling includes: Recognizing dangerous situation, developing coping skills, and providing basic information about quitting.						
Patient Referred to Outpatient Counseling after Discharge.....Declined Enrollment						
Referred to evidence based outpatient counseling, Outline.						
Teaching Recipient.....Patient						
Readiness to Learn.....Disinterested						
Barriers to Learning.....Unmotivated						
.....Emotional						
.....Unreceptive						
.....Cognitive						
Teaching Methods.....Explained						
Response to Teaching.....						
..Verbalizes understanding						

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Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0035 Page 12	
Reg/Hes: 27 M	Acct/Hes: KAQSOOD, TAEKE, MD	CHILDS, HANEEF A		Reg/Hes: DIS XM	Mod/Hes: 11/03/15 at 0715
Unit: H000611175	Account: PA1303162331			Location: PEENE	Room/Bed: 208-1

INT 46000055 Activity Occurred Recorded Site Pres/Target P-1 From Type Date Time By Date Time By Doc Units Change 3750140 Braden Scale [A] .CADMSHIFTRN [PS] Nutrition.....Adequate Friction and Shear.....No Apparent Problem Total Score Skin Risk Assessment...22 score 19-23 = No Risk 15-18 = Low Risk 13-14 = Moderate Risk 10-12 = High Risk Less Than 9 = Very High Risk 5259900 [A] .OSHIPTFRN [PS] Document 11/04/15 1735 JRN 11/04/15 1742 JRN Was Patient Specific Education Provided Identified by CERRT.....N This is patient education content provided via the Info Burton CERRT=Certified Electronic Health Record Technology Were the Problems or Medications or Labs Reviewed.....Y Education Topics.....Medications Stress Management Treatment Plan Medication Education Topics.....Action Side Effects Administration Frequency Dosage Route Other Medication Education Topic... ..Nicotine patch and gun, Ability increase Teaching Recipient.....Patient Readiness to Learn.....Expresses Interest Barriers to Learning.....Emotional Cognitive Teaching Methods.....Explained Response to teaching... ..Verbalizes understanding Interpreter Required.....N Follow Facility Specific Interpreter Guidelines 46C0065 [A] .QSHIFR [PS] Document 11/04/15 1738 JRN 11/04/15 1742 JRN Presenting Problem... ..impulsive, suicidal (now denies), frustrated, poor insight and judgment Mental Status.....Alert Orientation.....Person Place Time Patient Appearance.....Disheveled Independent ADLs.....Y Eating Independently.....Y Compliance With Medications...Y Seclusions and or Restraints...N Behavior.....Anxious Compliant Depressed Disorganized Guarded	INT 46000055 Activity Occurred Recorded Site Pres/Target P-1 From Type Date Time By Date Time By Doc Units Change Speech.....Low Volume Clear Mood and Affect.....Anxious Apprehensive Depressed Dysphoric Frustrated Labile Preoccupied Delusions.....N Hallucinations.....None Thought Process.....Circumstantial Goal Oriented Insight and Judgment.....Poor Danger to Self or Others.....N Suicidal Thoughts.....Y attempted to hang himself on day shift, now denies Does Patient Have a Plan.....Y Homicidal Thoughts.....N Contract for Safety.....Y Contract for Nonviolence.....Y Psych Comment.....302 Court Date.....11/05/15 0500000 [A] BID [PS] Document 11/05/15 0659 SHP 11/06/15 0230 SHP Temperature Celsius.....35.7 degrees C Temperature Calculated Fahrenheit.....96.3 degrees F Pulse Location Modifier.....Right Pulse Location.....Brachial Pulse Rate Adult 18 And Older.....94 Beats Per Minute Respiratory Rate Adult 18 And Older.....18 Breaths Per Minute Blood Pressure Systolic Adult 18 And Older.....120 mmHg Blood Pressure Diastolic Adult 18 And Older...66 mmHg 0500000 [A] DID [PS] Document 11/05/15 1642 NM 11/05/15 1643 NM Temperature Celsius.....37.0 degrees C Temperature Calculated Fahrenheit.....98.6 degrees F Pulse Location Modifier.....Right Pulse Location.....Brachial Pulse Rate Adult 18 And Older.....96 Beats Per Minute Respiratory Rate Adult 18 And Older.....16 Breaths Per Minute Blood Pressure Systolic Adult 18 And Older.....134 mmHg Blood Pressure Diastolic Adult 18 And Older...91 mmHg Blood Pressure Source.....Automatic Cuff Blood Pressure Location.....Left Upper Arm Blood Pressure Position.....Sitting 1750030 [A] .QSHIFR [PS] Document 11/05/15 1724 JM 11/05/15 1734 JM Patient Activity.....Up Ab Lib Ambulates COB BRP Active ROM Activity Ability.....Independent Assistive Devices.....None
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Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0033 Page 15	
Page/Side: 27 M	Referring: HAQSDOD, TARIK, MD	CHILDS, HANEEF A		State: DIS IN	Admitted: 11/03/15 at 0719
Unit: M000611175	Account: PA1303162331			Location: 2B2NE	Room/Bed: 208-1

Activity Occurred										Activity Recorded									
Type	Date	Time	By	Date	Time	By	Doc	Units	Change	Type	Date	Time	By	Date	Time	By	Doc	Units	Change
2750001 PAID Assessment [REDACTED] Document 11/06/15 1253 MMB 11/06/15 1254 MMB Complaint Of Pain.....N 3250001 NUTRITIONAL ASSESSMENT [REDACTED] Document 11/06/15 1253 MMB 11/06/15 1254 MMB Diet Type.....REGULAR Thickened Liquids.....N Feeding.....Self Nutrition Breakfast.....75 to 100% Nutrition Lunch.....75 to 100% Tube Feed Flushed.....N/A Aspiration Precautions Maintained.....N/A Calorie Count.....N 3750140 SKIN RISK ASSESSMENT [REDACTED] Document 11/06/15 1253 MMB 11/06/15 1254 MMB Moisture.....Paroly Moist Sensory Perception.....No Limitation Activity.....Walks Frequently Mobility.....No Limitation Nutrition.....Adequate Friction and Shear.....No Apparent Problem Total Score Skin Risk Assessment...22 score 19-23 = No Risk 15-18 = Low Risk 13-14 = Moderate Risk 10-12 = High Risk Less Than 9 = Very High Risk 46C0065 Nursing Shift Assessment [REDACTED] Document 11/06/15 1254 MMB 11/06/15 1254 MMB Presenting Problem.....DEPRESSED, DISORGANIZED, UNPREDICTABLE BEHAVIOR Mental Status.....Alert Orientation.....Person Place Time Patient Appearance.....Disheveled Independent ADLs.....Y Eating Independently.....Y Attendance to Meetings.....Good Participation in Meetings.....NONE Compliance with Medications.....Y Seclusions and or Restraints..... ..N PT IS ON 1:1 OBSERVATION FOR SAFETY OF SELF AND OTHERS Behavior.....Anxious Compliant Depressed Disorganized Guarded Speech.....Low Volume Clear Mood and Affect.....Anxious Apprehensive Depressed Dysphoric Frustrated Labile Preoccupied Delusions.....N Hallucinations.....None Thought Process.....Circumstantial Goal Oriented Insight and Judgment.....Poor Danger to Self or Others.....N Suicidal Thoughts.....Y attempted to hang himself on day shift, now denies Does Patient Have a Plan.....Y Homicidal Thoughts.....N Contract for Safety.....Y Contract for Nonviolence.....Y Psych Comment.....302 Court Date.....11/05/15 5259900 Teaching Record [REDACTED] Document 11/06/15 1254 MMB 11/06/15 1254 MMB Was Patient Specific Education Provided Identified by CERRT.....Y This is patient education content provided via the Info Button CERRT=Certified Electronic Health Record Technology Were the Problems or Medications or Labs Reviewed.....Y Education Pertinence... ..MENTAL HEALTH DISEASE AND MEDICATION COMPLIANCE Education Topics.....Medications Stress Management Treatment Plan Teach Fall Risk Safety Components.....Orient to Surroundings Medication Education Topics.....Action Side Effects Administration Frequency Dosage Route Other Medication Education Topic... ..Nicotine patch and gum, Abilify increase Tobacco Use Education.....Patient Declined Practical Counseling includes: Recognizing dangerous situation, developing coping skills, and providing basic information about quitting. Patient Referred to Outpatient Counseling after Discharge.....Declined Enrollment Referred to avoidance based outpatient counseling, Quitline. Teaching Recipient.....Patient Readiness to Learn.....Expresses Interest Barriers to Learning.....Emotional Cognitive Teaching Methods.....Explained Response to Teaching... ..Verbalizes understanding Interpreter Required.....N Follow Facility Specific Interpreter Guidelines																			

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Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0035 Page 16	
Age/sex: 27 M	Attending: MAGSOOD, TAKIR, MD	CHILDS, HANEEF A		Status: DIS IN	Admitted: 11/03/15 at 0715
Unit #: NU00611175	Account #: PAJ303162331			Location: PH2NE	Room/Bed: 208-1

Activity	Occurred	Recorded	Site	Freq/Target	Pri	Change	Activity	Occurred	Recorded	Site	Freq/Target	Pri	Change
Type	Date	Time	By	Date	Time	By	Type	Date	Time	By	Date	Time	By

1750030 **PHYS ASSESSMENT** [A] [A] .QSHIPT

Document 11/06/15 1842 JM 11/06/15 1844 JM

Patient Activity.....Up Ab Lib

.....Ambulates

.....OCB

.....BRP

.....Active ROM

Activity Ability.....Independent

Assistive Devices.....None

Activity Tolerance.....Good

Eating Ability.....Independent

Toileting Ability.....Independent

Toileting Assistive Devices...Toilet

Dressing Ability.....Independent

Care Provided.....Shower

Bathing Ability.....Independent

Oral Care Ability.....Independent

Sleep Assessment.....Difficulty Staying Asleep

.....Early Morning Awakening

.....Difficulty Falling Asleep

Sleep Aids.....Medication

2750001 **PHYS ASSESSMENT** [A] [A] .QADMSHIFTFRN

Document 11/06/15 1842 JM 11/06/15 1844 JM

Complaint Of Pain....N

3250001 **NOTICE OF PHYS ASSESSMENT** [A] [A] .QSHIPTFRN

Document 11/06/15 1842 JM 11/06/15 1844 JM

Diet Type.....REGULAR

Thickened Liquids.....N

Feeding.....Self

Nutrition Breakfast.....76 to 100%

Nutrition Lunch.....76 to 100%

Nutrition Dinner.....76 to 100%

Nutrition Snack.....76 to 100%

Tube Feed Flushed.....N/A

Aspiration Precautions Maintained.....N/A

Calorie Count.....N/A

3750140 **PHYS ASSESSMENT** [A] [A] .QADMSHIFTFRN

Document 11/06/15 1842 JM 11/06/15 1844 JM

Moisture.....Rarely Moist

Sensory Perception.....No Limitation

Activity.....Walks Occasionally

Mobility.....No Limitation

Nutrition.....Adequate

Friction and Shear.....No Apparent Problem

Total Score Skin Risk Assessment...21 score

19-23 = No Risk

15-18 = Low Risk

13-14 = Moderate Risk

10-12 = High Risk

Less Than 9 = Very High Risk

3750420 **Check Process Plan** [A] [A] .QSHIPT

Document 11/06/15 1842 JM 11/06/15 1844 JM

4600065 **PHYS ASSESSMENT** [A] [A] .QSHIPT

Document 11/06/15 1843 JM 11/06/15 1844 JM

Presenting Problem.....DEPRESSED, DISORGANIZED, UNPREDICTABLE BEHAVIOR

Mental Status.....Alert

Orientation.....Person

.....Place

.....Time

Patient Appearance.....Disheveled

Independent AMES.....Y

Eating Independently.....Y

Sleep Pattern.....Difficulty Falling Asleep

Attendance to Meetings.....Good

Participation in Meetings.....NONE

Compliance With Medications....Y

Seclusions and or Restraints...

..N PT IS ON 1:1 OBSERVATION FOR SAFETY OF SELF AND OTHERS

Behavior.....Anxious

.....Compliant

.....Depressed

.....Disorganized

.....Guarded

.....Restless

.....Suspicious

.....Withdrawn

Speech.....Low Volume

.....Clear

Mood and Affect.....Anxious

.....Apprehensive

.....Depressed

.....Dysphoric

.....Frustrated

.....Labile

.....Withdrawn

.....Confused

.....Preoccupied

Delusions.....N

Hallucinations.....None

Thought Process.....Circumstantial

.....Goal Oriented

Insight and Judgment.....Poor

Danger to Self or Others.....N

Suicidal Thoughts.....Y attempted to hang himself on day shift, now denies

Does Patient Have a Plan.....Y

Homicidal Thoughts.....N

Contract for Safety.....Y

Contract for Nonviolence.....Y

Psych Comment.....302

Court Date.....11/05/15

5259900 **Teaching Record** [A] [A] .QSHIPTFRN

Document 11/06/15 1844 JM 11/06/15 1844 JM

Was Patient Specific Education Provided Identified by CENRT.....Y

This is patient education content provided via the Info Button

CENRT=Certified Electronic Health Record Technology

Were the Problems or Medications or Labs Reviewed.....Y

Education Pertinence...

..MENTAL HEALTH DISEASE AND MEDICATION COMPLIANCE

Education Topics.....Medications

.....Stress Management

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Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0635 Page 17	
Age: 27 M	Gender: MALE	MRN: MU00611175	Account: PAL303162331	Room: 208-1	Room/Bed: 208-1
CHILDS, HANEEF A					

Activity	Occurred	Recorded	Sta	Prog/Target	Prn	Change
5219900 Teaching Record Treatment Plan Teach Fall Risk Safety Components Orient To Surroundings Medication Education Topics Action Side Effects Administration Frequency Dosage Route Other Medication Education Topic Nicotine patch and gum, Abilify increase Tobacco Use Education Patient Declined Practical Counseling includes: Recognizing dangerous situation, developing coping skills, and providing basic information about quitting. Patient Referred to Outpatient Counseling after Discharge . . . Declined Enrollment Referred to evidence based outpatient counseling, Outline. Teaching Recipient Patient Readiness to Learn Expresses Interest Barriers to Learning Emotional Cognitive Teaching Methods Explained Response to Teaching Verbalizes understanding Interpreter Required N Follow Facility Specific Interpreter Guidelines 3250001 Nutrition Assessment Document 11/07/15 0307 SAH 11/07/15 0308 SAH Diet type REGULAR Thickened Liquids N Feeding Self Nutrition Breakfast 76 to 100% Nutrition Lunch 76 to 100% Nutrition Dinner 76 to 100% Nutrition Snack 76 to 100% Tube Feed Flushed N/A Aspiration Precautions Maintained . . . N/A Calorie Count N/A						
3750140 Moisture/Skin Risk Assessment Document 11/07/15 0307 SAH 11/07/15 0308 SAH Moisture Rarely Moist Sensory Perception No Limitation Activity Walks Occasionally Mobility No Limitation Nutrition Adequate Friction and Shear No Apparent Problem Total Score Skin Risk Assessment . . 21 score 19-23 = No Risk 15-18 = Low Risk 13-14 = Moderate Risk 10-12 = High Risk Less Than 9 = Very High Risk 4600065 Mental Status Assessment Document 11/07/15 0307 SAH 11/07/15 0308 SAH Presenting Problem DEPRESSED, DISORGANIZED, UNPREDICTABLE BEHAVIOR Mental Status Alert Orientation Person Place Time Patient Appearance Disheveled Independent ADLs Y Eating Independently Y Sleep Pattern Difficulty Falling Asleep Attendance to Meetings Good Participation in Meetings NONE Compliance With Medications . . . Y Seclusions and or Restraints N PT IS ON 1:1 OBSERVATION FOR SAFETY OF SELF AND OTHERS Behavior Anxious Compliant Depressed Disorganized Guarded Restless Suspicious Withdrawn Speech Low Volume Clear Mood and Affect Anxious Apprehensive Depressed Dysphoric Frustrated						

Activity	Occurred	Recorded	Sta	Prog/Target	Prn	Change
1710030 ADL Assessment Document 11/07/15 0307 SAH 11/07/15 0308 SAH Patient Activity Up Ab Lib Ambulates QOB BRP Active ROM Activity Ability Independent Assistive Devices None Activity Tolerance Good Eating Ability Independent Toileting Ability Independent Toileting Assistive Devices . . Toilet Dressing Ability Independent Care Provided Shower Bathing Ability Independent Oral Care Ability Independent Sleep Assessment Difficulty Staying Asleep Early Morning Awakening Difficulty Falling Asleep Sleep Aids Medication 2710001 Pain Assessment Document 11/07/15 0307 SAH 11/07/15 0308 SAH Complaint of Pain N						

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Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0033 Page 18	
Age/sex: 27 M	Admission: RAQSOOD, TAKER, MD	CHILDS, HANEEF A		Status: DIS IN	Admitted: 11/03/15 at 0715
Unit: M000611175	Account #: RA13B3162331			Location: JH2NS	Room/Sec: 208-1

Activity		Occurred		Revised		Site		Range		From	
Type	Date	Time	By	Date	Time	By	Doc	Unit	Range	From	Change
460065	BRIEF NURSING SHIFT ASSESSMENT										
Delusions.....N Hallucinations.....None Thought Process.....Circumstantial Insight and Judgment.....Poor Danger to Self or Others.....N Suicidal Thoughts.....Y attempted to hang himself on day shift, now denies Does Patient Have a Plan.....Y Homicidal Thoughts.....N Contract for Safety.....Y Contract for Nonviolence.....Y Psych Comment.....302 Court Date.....11/05/15											
05C0000	VS Adult										
Document	11/07/15 0745	RC	11/07/15 0746	RC							
Temperature Celsius.....35.7 degrees C Temperature Calculated Fahrenheit.....96.3 degrees F Temperature Source.....Oral Pulse Location Modifier.....Right Pulse Location.....Brachial Pulse Rate Adult 18 And Older.....105 Beats Per Minute Respiratory Rate Adult 18 And Older.....20 Breaths Per Minute Blood Pressure Systolic Adult 18 And Older.....138 mmHg Blood Pressure Diastolic Adult 18 And Older.....96 mmHg											
0010012	ADL Assessment										
Document	11/07/15 1719	VJ	11/07/15 1722	VJ							
17E0030	ADL Assessment										
Document	11/07/15 1719	VJ	11/07/15 1722	VJ							
Patient Activity.....Up Ab Lib BRP Active ROM Activity Ability.....Independent Assistive Devices.....None Activity Tolerance.....Fair Eating Ability.....Independent Toileting Ability.....Independent Toileting Assistive Devices.....Toilet Dressing Ability.....Independent Care Provided.....Shower Bathing Ability.....Independent Oral Care Ability.....Independent Sleep Assessment.....Normal Sleep Aids.....None											
37E0420	Check Patient Plans Suggested Problems										
Document	11/07/15 1719	VJ	11/07/15 1722	VJ							
27E0001	ADL Assessment										
Document	11/07/15 1720	VJ	11/07/15 1722	VJ							
32E	MED NURSING ASSESSMENT										

Activity		Occurred		Revised		Site		Range		From	
Type	Date	Time	By	Date	Time	By	Doc	Unit	Range	From	Change
Document	11/07/15 1720	VJ	11/07/15 1722	VJ							
Diet Type.....REGULAR Thickened Liquids.....N Feeding.....Self Nutrition Breakfast.....76 to 100% Nutrition Lunch.....76 to 100% Tube Feed Flushed..... Aspiration Precautions Maintained..... Calorie Count..... Braden Scale.....											
37S0140	Braden Scale										
Document	11/07/15 1720	VJ	11/07/15 1722	VJ							
Moisture.....Rarely Moist Sensory Perception.....Slightly Limited Activity.....Walks Occasionally Mobility.....No Limitation Nutrition.....Adequate Friction and Shear.....No Apparent Problem Total Score Skin Risk Assessment.....20 score 19-23 = No Risk 15-18 = Low Risk 13-14 = Moderate Risk 10-12 = High Risk Less Than 9 = Very High Risk											
460065	BRIEF NURSING SHIFT ASSESSMENT										
Document	11/07/15 1720	VJ	11/07/15 1722	VJ							
Presenting Problem.....thought process Mental Status.....Alert Orientation.....Person Place Patient Appearance.....Clean Independent ADLs.....Y Eating Independently.....Y Sleep Pattern.....Normal Attendance to Meetings.....Intermittent Participation in Meetings.....With Encouragement Compliance With Medications.....Y Seclusions and or Restraints..... ..N PT IS ON 1:1 OBSERVATION FOR SAFETY OF SELF AND OTHERS Behavior.....Anxious Compliant Depressed Disorganized Fearful Guarded Restless Suspicious Withdrawn Speech.....Low Volume Clear Mood and Affect.....Anxious Apprehensive Depressed Dysphoric Fearful Frustrated Labile Suspicious											

CJA

Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0035 Page 19	
Age/sex: 27 M	Attending: MAGOOD, TAIHR, MD	CHILD, HANEEF A		Status: DIS IN	Admitted: 11/08/15 at 0715
Unit: M000611175	Account: PA1303162331			Location: PH2NE	Room/Bed: 208-1

DT	Activity	Occurred	Recorded	Site	Drug/Target	Pct	Change
45C0065	PHN Nursing Skill Assessment						.QSHIFT
.....Withdrawn Confused Irritable Preoccupied Delusions.....N Hallucinations.....None Thought Process.....Loose Associations Flight of Ideas Disorganized Insight and Judgment.....Poor Danger to Self or Others.....N Suicidal Thoughts.....N Does Patient Have a Plan.....N Homicidal Thoughts.....N Contract for Safety.....Y Contract for Nonviolence.....Y Psych Comment.....							
0010012	ADLs	11/08/15 0039	JO	11/08/15 0043	JO		.continuous
0061830	ADLs	11/08/15 0039	JO	11/08/15 0043	JO		.ADMISSION
02E5300	Ed Status	11/08/15 0039	JO	11/08/15 0039	JO		A->C
17E0030	ADLs	11/08/15 0039	JO	11/08/15 0043	JO		.QSHIFT
Patient Activity.....Up Ab Lib Activity Ability.....Independent Assistive Devices.....None Activity Tolerance.....Good Eating Ability.....Independent Toileting Ability.....Independent Toileting Assistive Devices.....Toilet Dressing Ability.....Independent Bathing Ability.....Independent Oral Care Ability.....Independent Sleep Assessment.....Difficulty Staying Asleep Difficulty Falling Asleep Sleep Aids.....Medication							
37E0420	ADLs	11/08/15 0039	JO	11/08/15 0043	JO		.QSHIFT
27E0001	ADLs	11/08/15 0040	JO	11/08/15 0043	JO		.QADMSHIFTPRN
Document 11/08/15 0040 JO 11/08/15 0043 JO Complaint Of Pain.....Y Pain Location Modifier.....Lower Pain Location.....Back Pain Description.....Aching Does Pain Radiate.....N If Yes, Please Describe The Radiation Location..... Pain Scale Used.....Numeric Pain Intensity.....8 out of 10 Pain Management Goal.....0-10 Symptoms And Behaviors Observed.....None Aggravating Factors.....None							

DT	Activity	Occurred	Recorded	Site	Drug/Target	Pct	Change
32E0001	Measures Used To Relieve Pain...Medication						.QSHIFTPRN
Document 11/08/15 0040 JO 11/08/15 0043 JO Diet Type.....regular house Thickened Liquids.....N Feeding.....Self Aspiration Precautions Maintained.....Y Calorie Count.....N							
37E0140	ADLs	11/08/15 0041	JO	11/08/15 0043	JO		.QADMSHIFTPRN
Document 11/08/15 0041 JO 11/08/15 0043 JO Moisture.....Rarely Moist Sensory Perception.....Slightly Limited Activity.....Walks Frequently Mobility.....No Limitation Nutrition.....Adequate Friction and Shear.....No Apparent Problem Total Score Skin Risk Assessment...21 score 19-23 = No Risk 15-18 = Low Risk 13-14 = Moderate Risk 10-12 = High Risk Less Than 9 = Very High Risk Pressure Inducing Devices in Use.....No Device in Use Any response, except No, will trigger a suggested problem of High Risk of Pressure Ulcer from Devices.							
4E00055	ADLs	11/08/15 0041	JO	11/08/15 0043	JO		.QSHIFT
Document 11/08/15 0041 JO 11/08/15 0043 JO Presenting Problem.....altered thought process Mental Status.....Alert Orientation.....Person Place Patient Appearance.....Clean Disheveled Independent ADLs.....Y Eating Independently.....Y Sleep Pattern.....Difficulty Falling Asleep Interrupted Sleep Compliance With Medications.....Y Seclusions and or Restraints..... ..N PT IS ON 1:1 OBSERVATION FOR SAFETY OF SELF AND OTHERS Behavior.....Anxious Compliant Depressed Disorganized Fearful Guarded Restless Suspicious Withdrawn Speech.....Low Volume Clear Mood and Affect.....Anxious Apprehensive Depressed Dysphoric							

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Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital RCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0035 Page 20	
Age/Sex: 27 M	Attending: NAQSOOD, TAKIR, MD	CHILDS, HANEEF A		Status: DIS IN	Admitted: 11/03/15 at 0715
Unit: M000611175	Account: PA1303162331			Location: PH2NE	Room/Bed: 208-1

INT 460065	INT 5259900
Activity Occurred Recorded Sts Prog/Target Pts From Type Date Time By Date Time By Doc Units Change 460065 RRR Nursing Shift Assessment [A] .QSHIPT [PS] Fearful Frustrated Labile Suspicious Withdrawn Confused Irritable Preoccupied Delusions.....N Hallucinations.....None Thought Process.....Loose Associations Flight of Ideas Disorganized Insight and Judgment.....Poor Danger to Self or Others.....N Suicidal Thoughts.....N Does Patient Have a Plan.....N Homicidal Thoughts.....N Contract for Safety.....Y Contract for Nonviolence.....Y 5259900 Teaching Record [A] .QSHIPTPRN [PS] Document 11/08/15 0041 JO 11/08/15 0043 JO Was Patient Specific Education Provided Identified by CHRT.....Y This is patient education content provided via the Info Button CHRT-Certified Electronic Health Record Technology Were the Problems or Medications or Labs Reviewed.....Y Education Pertinence.....Mental illness Education Topics.....Disease Process Hospital Policy Medications Safety Signs and Symptoms Stress Management Treatment Plan Need for Followup Care When to Call 911 Additional Education Topics.....1:1 for safety Teach Fall Risk Safety Components.....Orient To Surroundings Pt Ask For Assistance Environmental Safety Medication Education Topics.....Action Side Effects Administration Frequency Doseage Route Adverse Reaction Other Medication Education Topic... tylenol, zyprexa, restoril, etivan, risperdal, vistaril Tobacco Use Education.....Patient Declined Practical Counseling includes: Recognizing dangerous situation, developing coping skills, and providing basic information about quitting.	Patient Referred to Outpatient Counseling after Discharge.....Declined Enrollment Referred to evidence based outpatient counseling, Outline. Teaching Recipient.....Patient Readiness to Learn.....Expresses Interest Barriers to Learning.....Emotional Cognitive Teaching Methods.....Explained Response to Teaching.....Reinforcement needed Interpreter Required.....N Follow Facility Specific Interpreter Guidelines 11/08/15 0816 0847 [A] [PS] 0500000 Vital Signs [A] BID [PS] Document 11/08/15 0847 KS 11/08/15 0648 KS Temperature Celsius.....36.1 degrees C Temperature Calculated Fahrenheit.....97.0 degrees F Temperature Source.....Oral Pulse Location Modifier.....Right Pulse Location.....Brachial Pulse Rate Adult 18 And Older.....99 Beats Per Minute Pulse Rhythm.....Regular Pulse Strength.....Strong Respiratory Rate Adult 18 And Older.....20 Breaths Per Minute Respiratory Depth.....Deep Blood Pressure Systolic Adult 18 And Older.....131 mmHg Blood Pressure Diastolic Adult 18 And Older.....68 mmHg Blood Pressure Location.....Left Upper Arm Blood Pressure Position.....Sitting 11/08/15 1509 [A] [PS] 0010012 Amputate Up Ab Lib [A] [PS] Document 11/08/15 1509 VJ 11/08/15 1513 VJ 1750030 ADL Assessment [A] .QSHIPT [PS] Document 11/08/15 1509 VJ 11/08/15 1513 VJ Patient Activity.....Up Ab Lib BRE Active ROM Activity Ability.....Independent Assistive Devices.....None Activity Tolerance.....Fair Eating Ability.....Independent Toileting Ability.....Independent Toileting Assistive Devices.....Toilet Dressing Ability.....Independent Care Provided.....Shower Bathing Ability.....Independent Oral Care Ability.....Independent Sleep Assessment.....Normal Sleep Aids.....None 3750420 Check Patient Plans/Suggested Problems [A] .QSHIPT [PS] Document 11/08/15 1509 VJ 11/08/15 1513 VJ 11/08/15 1513 [A] [PS] 2750001 Pain Assessment [A] .QADNKSIFTERN [PS] Document 11/08/15 1518 VJ 11/08/15 1513 VJ Complaint Of Pain.....N

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Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0035 Page 21	
Acc/Sec: 27 M	Attending: MAOSOOD, TAJIR, MD	Discharge: DIS IN	Admitted: 11/03/15 at 0715		
Unit #: H000611175	Account #: PA1303162331	Location: 7F2NR	Room/Bed: 208-1		
CHILDS, HANEEF A					

Activity	Occurred	Recorded	Sts	Freq/Target	Pr	Change
Type	Date	Time By	Date	Time By	Doc	Units
INT 3250001						
Document	11/08/15 1510	VJ	11/08/15 1513	VJ		
Diet Type.....	regular house					
Thickened Liquids.....	N					
Feeding.....	Self					
Nutrition Breakfast.....	76 to 100%					
Nutrition Lunch.....	76 to 100%					
Tube Feed Flushed.....						
3750140						
Document	11/08/15 1510	VJ	11/08/15 1513	VJ		
Moisture.....	Paraly Moist					
Sensory Perception.....	No Limitation					
Activity.....	Walks Occasionally					
Mobility.....	No Limitation					
Nutrition.....	Adequate					
Friction and Shear.....	No Apparent Problem					
Total Score Skin Risk Assessment.....	21 score					
19-23 = No Risk						
15-18 = Low Risk						
13-14 = Moderate Risk						
10-12 = High Risk						
Less Than 9 = Very High Risk						
160065						
Document	11/08/15 1510	VJ	11/08/15 1513	VJ		
Presenting Problem.....	altered thought process					
Mental Status.....	Alert					
Orientation.....	Person					
.....	Place					
.....	Place					
Patient Appearance.....	Clean					
Independent ADLs.....	Y					
Eating Independently.....	Y					
Sleep Pattern.....	Normal					
Attendance to Meetings.....	Intermittent					
Participation in Meetings.....	With Encouragement					
Compliance With Medications.....	Y					
Seclusions and or Restraints.....						
.....	N PT IS ON 1:1 OBSERVATION FOR SAFETY OF SELF AND OTHERS					
Behavior.....	Anxious					
.....	Compliant					
.....	Depressed					
.....	Disorganized					
.....	Fearful					
.....	Guarded					
.....	Suspicious					
.....	Withdrawn					
Speech.....	Low Volume					
.....	Clear					
Mood and Affect.....	Anxious					
.....	Apprehensive					
.....	Depressed					
.....	Dysphoric					
.....	Fearful					
.....	Flat					
.....	Frustrated					
.....	Labile					
.....	Suspicious					
.....	Withdrawn					

Activity	Occurred	Recorded	Sts	Freq/Target	Pr	Change
Type	Date	Time By	Date	Time By	Doc	Units
INT 4000055						
.....	Irritable					
.....	Preoccupied					
Delusions.....	N					
Hallucinations.....	None					
Thought Process.....	Loose Associations					
.....	Flight of Ideas					
.....	Disorganized					
Insight and Judgment.....	Poor					
Danger to Self or Others.....	N					
Suicidal Thoughts.....	N					
Does Patient Have a Plan.....	N					
Homicidal Thoughts.....	N					
Contract for Safety.....	Y					
Contract for Nonviolence.....	Y					
0051830						
Document	11/08/15 1513	VJ	11/08/15 1513	VJ		
0500000						
Document	11/08/15 1634	JDB	11/08/15 1630	JDB		
Temperature Celsius.....	36.5 degrees C					
Temperature Calculated Fahrenheit.....	97.7 degrees F					
Pulse Location Modifier.....	Right					
Pulse Location.....	Brachial					
Pulse Rate Adult 18 And Older.....	98 Beats Per Minute					
Respiratory Rate Adult 18 And Older.....	16 Breaths Per Minute					
Blood Pressure Systolic Adult 18 And Older.....	124 mmHg					
Blood Pressure Diastolic Adult 18 And Older.....	78 mmHg					
0010012						
Document	11/08/15 2303	JO	11/08/15 2306	JO		
0051830						
Document	11/08/15 2303	JO	11/08/15 2306	JO		
1750030						
Document	11/08/15 2303	JO	11/08/15 2306	JO		
Patient Activity.....	Up Ab Lib					
Activity Ability.....	Independent					
Assistive Devices.....	None					
Activity Tolerance.....	Good					
Eating Ability.....	Independent					
Toileting Ability.....	Independent					
Toileting Assistive Devices.....	Toilet					
Dressing Ability.....	Independent					
Bathing Ability.....	Independent					
Oral Care Ability.....	Independent					
Sleep Assessment.....	Difficulty Staying Asleep					
.....	Difficulty Falling Asleep					
Sleep Aids.....	Medication					
3750420						
Document	11/08/15 2303	JO	11/08/15 2306	JO		
2750001						
Document	11/08/15 2306	JO	11/08/15 2306	JO		
Complaint Of Pain.....	Y					
Pain Location Modifier.....	Lower					
Pain Location.....	Back					
Pain Description.....	Aching					

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Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0035 Page 22	
Page/Sec: 27 M	Referring: HAQSOOD, TAMIR, ND	Location: PH2NE	Room/Bed: 208-1	Printed: 11/03/15 at 0713	
Unit #: M000611175	Account #: PAL304162331	CHILDS, HANEEF A			

INT-2750001 Activity Occurred Recorded Type Date Time By Date Time By Doc Units Change 2750001 PHYSICIAN ASSESSMENT [A] [A] .QADMSHIFTFRN [PS] Does Pain Radiate.....N If Yes, Please Describe The Radiation Location. Pain Scale Used.....Numeric Pain Intensity.....10 out of 10 Pain Management Goal.....0-10 Symptoms And Behaviors Observed...None Aggravating Factors.....None Measures Used To Relieve Pain....Medication 3250001 NUTRITIONAL ASSESSMENT [A] [A] .QSHIFTRN [PS] Document 11/08/15 2304 JO 11/08/15 2306 JO Diet Type.....regular house Thickened Liquids.....N Feeding.....Self Nutrition Snack.....76 to 100% Aspiration Precautions Maintained...Y Calorie Count.....N Date: 11/08/15 2305 3750140 SKIN RISK ASSESSMENT [A] [A] .QADMSHIFTFRN [PS] Document 11/08/15 2305 JO 11/08/15 2306 JO Moisture.....Rarely Moist Sensory Perception.....No Limitation Activity.....Walks Occasionally Mobility.....No Limitation Nutrition.....Adequate Friction and Shear.....No Apparent Problem Total Score Skin Risk Assessment...21 score 19-23 = No Risk 15-18 = Low Risk 13-14 = Moderate Risk 10-12 = High Risk Less Than 9 = Very High Risk Pressure Inducing Devices In Use.....No Device in Use Any response, except No, will trigger a suggested problem of High Risk of Pressure Ulcer from Device. 4610065 WOUND/NURSING SKILL ASSESSMENT [A] [A] .QSHIFTRN [PS] Document 11/08/15 2305 JO 11/08/15 2306 JO Presenting Problem.....altered thought process Mental Status.....Alert Orientation.....Person Place Patient Appearance.....Clean Independent ADLs.....Y Eating Independently.....Y Sleep Pattern.....Normal Compliance With Medications...Y Seclusion and or Restraints... N PT IS ON 1:1 OBSERVATION FOR SAFETY OF SELF AND OTHERS Behavior.....Anxious Compliant Depressed Disorganized Fearful Guarded Suspicious	INT-4610065 Activity Occurred Recorded Type Date Time By Date Time By Doc Units Change Withdrawn Speech.....Low Volume Clear Mood and Affect.....Anxious Apprehensive Depressed Dysphoric Fearful Flat Frustrated Labile Suspicious Withdrawn Irritable Preoccupied Delusions.....N Hallucinations.....None Thought Process.....Loose Associations Flight of Ideas Disorganized Insight and Judgment.....Poor Danger to Self or Others.....N Suicidal Thoughts.....N Does Patient Have a Plan.....N Homicidal Thoughts.....N Contract for Safety.....Y Contract for Nonviolence.....Y 5259900 TEACHING RECORD [A] [A] .QSHIFTRN [PS] Document 11/08/15 2305 JO 11/08/15 2306 JO Was Patient Specific Education Provided Identified by CENRT....Y This is patient education content provided via the Info Button CENRT=Certified Electronic Health Record Technology Were the Problems or Medications or Labs Reviewed.....Y Education Pertinence.....mental illness Education Topics.....Disease Process Hospital Policy Medications Safety Signs and Symptoms Stress Management Treatment Plan Need for Followup Care When to Call 911 Additional Education Topics.....1:1 for safety Teach Fall Risk Safety Components.....Orient To Surroundings Pt Ask For Assistance Environmental Safety Medication Education Topics.....Action Side Effects Administration Frequency Dosage Route Adverse Reaction Other Medication Education Topic...
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Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital RCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0035 Page 23	
Page/Sec: 27 X	Attending: MAQS000, TAKIR, MD	CHILDS, HANEEF A		Page/Sec: 27 X	Attending: MAQS000, TAKIR, MD
Unit: M000611175	Account: PA1303162331			Unit: M000611175	Account: PA1303162331

52E9900 Teaching Record [A] .OSMIFTPN [PS] ..tylenol, zyprexa, restoril, stiven, cimetidal, vistaril Tobacco Use Education.....Patient Declined Practical Counseling includes: Recognizing dangerous situation, developing coping skills, and providing basic information about quitting. Patient Referred to Outpatient Counseling after Discharge.....Declined Enrollment Referred to evidence based outpatient counseling, Outline. Teaching Recipient.....Patient Readiness to Learn.....Expresses Interest Barriers to Learning.....Emotional Cognitive Teaching Methods.....Reinforced Response to Teaching.....Reinforcement needed Interpreter Required.....N Follow Facility Specific Interpreter Guidelines 11/09/15 0656 [A] BID [PS] 05C0000 [A] BID [PS] Document 11/09/15 0656 RS 11/09/15 0657 RS Temperature Celsius.....35.7 degrees C Temperature Calculated Fahrenheit.....96.3 degrees F Temperature Source.....Oral Pulse Location Modifier.....Right Pulse Location.....Brachial Pulse Rate Adult 18 And Older.....92 Beats Per Minute Pulse Rhythm.....Regular Pulse Strength.....Strong Respiratory Rate Adult 18 And Older.....20 Breaths Per Minute Respiratory Depth.....Deep Blood Pressure Systolic Adult 18 And Older.....124 mmHg Blood Pressure Diastolic Adult 18 And Older.....75 mmHg Blood Pressure Location.....Left Upper Arm Blood Pressure Position.....Sitting 11/09/15 1045 [A] A-DX [PS] 0061830 [A] continuous [PS] Ed Status 11/09/15 1045 RP 11/09/15 1045 RP 11/09/15 1220 [A] continuous [PS] 0061830 [A] continuous [PS] Create 11/09/15 1220 RP 11/09/15 1220 RP 11/09/15 1435 [A] .OSMIF [PS] 1750030 [A] .OSMIF [PS] Document 11/09/15 1435 MMB 11/09/15 1436 MMB Patient Activity.....Up Ab lib Activity Ability.....Independent Assistive Devices.....None Activity Tolerance.....Good Eating Ability.....Independent Toileting Ability.....Independent Toileting Assistive Devices.....Toilet Dressing Ability.....Independent Care Provided.....Shower Bathing Ability.....Independent Oral Care Ability.....Independent Sleep Assessment.....Difficulty Staying Asleep	Difficulty Falling Asleep Sleep Aids.....Medication 2750001 [A] .QADNSHIFTPN [PS] Document 11/09/15 1435 MMB 11/09/15 1436 MMB Complaint of Pain.....Y Pain Location Modifier.....Lower Pain Location.....Back Pain Description.....Aching Does Pain Radiate.....N If Yes, Please Describe The Radiation Location. Pain Scale Used.....Numeric Pain Intensity.....10 out of 10 Pain Management Goal.....0-10 Symptoms And Behaviors Observed.....None Aggravating Factors.....None Measures Used To Relieve Pain.....Medication 3250001 [A] .OSMIFTPN [PS] Document 11/09/15 1435 MMB 11/09/15 1436 MMB Diet Type.....regular house Thickened Liquids.....N Feeding.....Self Nutrition Breakfast.....76 to 100% Nutrition Lunch.....76 to 100% Tube Feed Flushed.....Y Aspiration Precautions Maintained.....Y Calorie Count.....N 3750140 [A] .QADNSHIFTPN [PS] Document 11/09/15 1435 MMB 11/09/15 1436 MMB Moisture.....Rarely Moist Sensory Perception.....No Limitation Activity.....Walks Occasionally Mobility.....No Limitation Nutrition.....Adequate Friction and Shear.....No Apparent Problem Total Score Skin Risk Assessment.....21 score 19-23 = No Risk 15-19 = Low Risk 13-14 = Moderate Risk 10-12 = High Risk Less Than 9 = Very High Risk Pressure Inducing Devices in Use.....No Device in Use Any response, except No, will trigger a suggested problem of High Risk of Pressure Ulcer from Devices. 4600065 [A] .OSMIF [PS] Document 11/09/15 1435 MMB 11/09/15 1436 MMB Presenting Problem.....altered thought process Mental Status.....Alert Orientation.....Person Place Patient Appearance.....Clean Independent ADLs.....Y Eating Independently.....Y Sleep Pattern.....Normal Attendance to Meetings.....Intermittent Participation in Meetings.....With Encouragement
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Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital RCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0033 Page 24	
Page/Sec: 27 M	Attending: NAOFOOD, TAMIR, MD	State: DIX IN	Admitted: 11/03/15 at 0715		
Unit #: M000611175	Account #: PA1303162331	Location: PH2NE	Room/Bed: 208-1		

CHILDS, HANEEF A					
Activity	Occurred	Recorded	Std	Prog/Target	Change
46C0065					
Additional Education Topics.....1:1 for safety Teach Fall Risk Safety Components.....Orient to Surroundings Pt Ask For Assistance Environmental Safety Medication Education Topics.....Action Side Effects Administration Frequency Dosage Route Adverse Reaction Other Medication Education Topic... tylenol, Tyrex, restoril, ativan, risperdal, vistoril Tobacco Use Education.....Patient Declined Practical Counseling includes: Recognizing dangerous situation, developing coping skills, and providing basic information about quitting. Patient Referred to Outpatient Counseling after Discharge....Declined Enrollment Referred to evidence based outpatient counseling, Outline. Teaching Recipient.....Patient Readiness to Learn.....Expresses Interest Barriers to Learning.....Emotional Cognitive Teaching Methods.....Explained Response to Teaching.....Reinforcement needed Interpreter Required.....N Follow Facility Specific Interpreter Guidelines					
Document 11/09/15 1850 JM 11/09/15 1853 JM Patent Activity.....Up Ab Lib Ambulates Passive ROM BRP Active ROM Activity Ability.....Independent Assistive Devices.....None Activity Tolerance.....Good Eating Ability.....Independent Toileting Ability.....Independent Toileting Assistive Devices...Toilet Dressing Ability.....Independent Care Provided.....Shower Bathing Ability.....Independent Oral Care Ability.....Independent Sleep Assessment.....Difficulty Staying Asleep Difficulty Falling Asleep Sleep Aids.....Medication					
3750420 Document 11/09/15 1850 JM 11/09/15 1853 JM					
2750001					

Activity	Occurred	Recorded	Std	Prog/Target	Change
46C0065					
Compliance With Medications....Y Seclusions and or Restraints... ..N PT IS ON 1:1 OBSERVATION FOR SAFETY OF SELF AND OTHERS Behavior.....Anxious Compliant Depressed Disorganized Fearful Guarded Suspicious Withdrawn Speech.....Low Volume Clear Mood and Affect.....Anxious Apprehensive Depressed Dysphoric Fearful Flat Frustrated Labile Suspicious Withdrawn Irritable Preoccupied Delusions.....N Hallucinations.....None Thought Process.....Loose Associations Flight of Ideas Disorganized Insight and Judgment.....Poor Danger to Self or Others.....N Suicidal Thoughts.....N Does Patient Have a Plan.....N Homicidal Thoughts.....N Contract for Safety.....Y Contract for Nonviolence.....Y Court Date.....11/05/15 5219900 Document 11/09/15 1435 MMB 11/09/15 1436 MMB Was Patient Specific Education Provided Identified by CENRT....Y This is patient education content provided via the Info Button CENRT-Certified Electronic Health Record Technology Were the Problems or Medications or Labs Reviewed.....Y Education Pertinence.....mental illness Education Topics.....Disease Process Hospital Policy Medications Safety Signs and Symptoms Stress Management Treatment Plan Need for Followup Care When to Call 911					

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Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital RCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0035 Page 25	
Age/Sex: 27 M	Attending: NAOSOOD, TARIK, MD	CHILDS, HANEEF A		Status: DIS IN	Admitted: 11/03/15 at 0715
Room # 11006611175	Account # PA1303162331			Location: 2H2NE	Room/Bed: 208-1

Activity	Occurred	Recorded	Site	Prog/Target	From	Activity	Occurred	Recorded	Site	Prog/Target	From
Type	Date	Time	By	Doc/Units	Change	Type	Date	Time	By	Doc/Units	Change

2750001 Pain Assessment [A] .QADMSHIFPRN [PS]

Document 11/09/15 1851 JM 11/09/15 1853 JM

Complaint Of Pain.....N

Pain Location Modifier.....Lower

Pain Location.....Back

Pain Description.....Aching

Does Pain Radiate.....N

If Yes, Please Describe The Radiation Location.

Pain Scale Used.....Numeric

Pain Intensity.....10 out of 10

Pain Management Goal.....0-10

Symptoms And Behaviors Observed...None

Aggravating Factors.....None

Measures Used To Relieve Pain....Medication

Date: 11/09/15 1852

3250001 Nutritional Assessment [A] .QSHIFPRN [PS]

Document 11/09/15 1852 JM 11/09/15 1853 JM

Diet Type.....REGULAR

Thickened Liquids.....N

Feeding.....Self

Nutrition Breakfast.....76 to 100%

Nutrition Lunch.....76 to 100%

Nutrition Dinner.....76 to 100%

Nutrition Snack.....76 to 100%

Tube Feed Flushed.....N N/A

Aspiration Precautions Maintained.....Y N/A

Calorie Count.....N N/A

3750140 Pressure Scale [A] .QADMSHIFPRN [PS]

Document 11/09/15 1852 JM 11/09/15 1853 JM

Moisture.....Rarely Moist

Sensory Perception.....No Limitation

Activity.....Walks Occasionally

Mobility.....No Limitation

Nutrition.....Adequate

Friction and Shear.....No Apparent Problem

Total Score Skin Risk Assessment...21 score

19-23 = No Risk

15-18 = Low Risk

13-14 = Moderate Risk

10-12 = High Risk

Less Than 9 = Very High Risk

Pressure Inducing Devices in Use.....No Device in Use

Any response, except No, will trigger a suggested problem of High Risk of Pressure Ulcer from Devices.

4600065 Mental Status Assessment [A] .QSHIF [PS]

Document 11/09/15 1852 JM 11/09/15 1853 JM

Presenting Problem.....ALTERED THOUGHT PROCESS

Mental Status.....Alert

Orientation.....Person

.....Place

Patient Appearance.....Clean

Independent ADLs.....Y

Eating Independently.....Y

Sleep Pattern.....Normal

Attendance to Meetings.....Intermittent

Participation in Meetings.....With Encouragement

Compliance With Medications....Y

Seclusions and or Restraints...

..N PT IS ON 1:1 OBSERVATION FOR SAFETY OF SELF AND OTHERS

Behavior.....Anxious

.....Compliant

.....Depressed

.....Disorganized

.....Fearful

.....Guarded

.....Suspicious

.....Withdrawn

Speech.....Low Volume

.....Clear

Mood and Affect.....Anxious

.....Apprehensive

.....Depressed

.....Dysphoric

.....Fearful

.....Flat

.....Frustrated

.....Labile

.....Suspicious

.....Withdrawn

.....Irritable

.....Preoccupied

Delusions.....N

Hallucinations.....None

Thought Process.....Loose Associations

.....Flight of Ideas

.....Disorganized

Insight and Judgment.....Poor

Danger to Self or Others.....N

Suicidal Thoughts.....N

Does Patient Have a Plan.....N

Homicidal Thoughts.....N

Contract for Safety.....Y

Contract for Nonviolence.....Y

Court Date.....11/05/15

Date: 11/10/15 0219

010012 Advance Care Directive [A] [PS]

Document 11/10/15 0219 SHP 11/10/15 0220 SHP

0061830 Medication Observation [A] .continuous [PS]

Document 11/10/15 0219 SHP 11/10/15 0220 SHP

1750030 RBC Assessment [A] .QSHIF [PS]

Document 11/10/15 0219 SHP 11/10/15 0220 SHP

Patient Activity.....Up Ab Lib

Activity Ability.....Independent

Assistive Devices.....None

Activity Tolerance.....Good

Eating Ability.....Independent

Toileting Ability.....Independent

Toileting Assistive Devices...toilet

Dressing Ability.....Independent

Bathing Ability.....Independent

Oral Care Ability.....Independent

Sleep Assessment.....Difficulty Falling Asleep

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Date Range: Beginning - 11/17/15										Nerxy Philadelphia Hospital PCS **LIVS** Archived Discharge Summary										Printed: 11/17/15 at 0035 Page 26			
Page/Sec		27 M		Accounting		MAGSOOD, TANIR, MD		Date		11/03/15 at 0715		Location		PHEN		Room/Bed		209-1					
Unit #		M000611175		Account #		PA1303162331		CHILDS, HANEEF A															
1750030 Activity Occurred Type Date Time By Date Time By Doc Units 1750030 ADT Assessment Sleep Aids.....Medication 4600065 ADT Nursing Shift Assessment Document 11/10/15 0219 SHP 11/10/15 0220 SHP Presenting Problem.....ALTERED THOUGHT PROCESS Independent ADLS.....Y Eating Independently.....Y Sleep Pattern.....Difficulty Falling Asleep Compliance With Medications.....Y Seclusions and or Restraints... ..N PT IS ON 1:1 OBSERVATION FOR SAFETY OF SELF AND OTHERS 10250001 ADT Assessment Document 11/10/15 0220 SHP 11/10/15 0220 SHP Complaint Of Pain....N 3250001 ADT Assessment Document 11/10/15 0220 SHP 11/10/15 0220 SHP Diet Type.....REGULAR Thickened Liquids...N Feeding.....Self Calorie Count.....N 3750140 ADT Assessment Document 11/10/15 0220 SHP 11/10/15 0220 SHP Moisture.....Rarely Moist Sensory Perception.....No Limitation Activity.....Walks Frequently Mobility.....No Limitation Nutrition.....Adequate Friction and Shear.....No Apparent Problem Total Score Skin Risk Assessment...22 score 19-23 = No Risk 15-18 = Low Risk 13-14 = Moderate Risk 10-12 = High Risk Less Than 9 = Very High Risk 0500000 ADT Assessment Document 11/10/15 0714 SY 11/10/15 0715 SY Temperature Celsius.....36.4 degrees C Temperature Calculated Fahrenheit.....97.5 degrees F Pulse Location Modifier.....Right Pulse Location.....Brachial Pulse Rate Adult 18 And Older.....107 Beats Per Minute Respiratory Rate Adult 18 And Older.....20 Breaths Per Minute Blood Pressure Systolic Adult 18 And Older.....129 mmHg Blood Pressure Diastolic Adult 18 And Older.....76 mmHg 0500000 ADT Assessment Document 11/10/15 0720 SHP 11/10/15 0720 SHP Pulse Location Modifier.....Right Pulse Location.....Brachial Pulse Rate Adult 18 And Older...102 Beats Per Minute 1750030 ADT Assessment Document 11/10/15 0902 MMB 11/10/15 0903 MMB Patient Activity.....Up Ab Lab Activity Ability.....Independent 1750030 Activity Occurred Type Date Time By Date Time By Doc Units 1750030 ADT Assessment Assistive Devices.....None Activity Tolerance.....Good Eating Ability.....Independent Toileting Ability.....Independent Toileting Assistive Devices...Toilet Dressing Ability.....Independent Care Provided.....Shower Bathing Ability.....Independent Oral Care Ability.....Independent Sleep Assessment.....Difficulty Falling Asleep Sleep Aids.....Medication 2750001 ADT Assessment Document 11/10/15 0902 MMB 11/10/15 0903 MMB Complaint Of Pain.....N Pain Location Modifier.....Lower Pain Location.....Back Pain Description.....Aching Does Pain Radiate.....N If Yes, Please Describe The Radiation Location. Pain Scale Used.....Numeric Pain Intensity.....10 out of 10 Pain Management Goal.....0-10 Symptoms And Behaviors Observed...None Aggravating Factors.....None Measures Used To Relieve Pain...Medication 3250001 ADT Assessment Document 11/10/15 0902 MMB 11/10/15 0903 MMB Diet Type.....REGULAR Thickened Liquids.....N Feeding.....Self Nutrition Breakfast.....76 to 1034 Tube Feed Flushed.....N N/A Aspiration Precautions Maintained....Y N/A Calorie Count.....N 3750140 ADT Assessment Document 11/10/15 0902 MMB 11/10/15 0903 MMB Moisture.....Rarely Moist Sensory Perception.....No Limitation Activity.....Walks Frequently Mobility.....No Limitation Nutrition.....Adequate Friction and Shear.....No Apparent Problem Total Score Skin Risk Assessment...22 score 19-23 = No Risk 15-18 = Low Risk 13-14 = Moderate Risk 10-12 = High Risk Less Than 9 = Very High Risk Pressure Inducing Devices in Use.....No Device in Use Any response, except No, will trigger a suggested problem of High Risk of Pressure Ulcer from Devices. 4600065 ADT Nursing Shift Assessment																							

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Date Range: Beginning ~ 11/17/15		Mercy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0035 Page 27	
Age/Sex: 27 M	Standing: MAQSOOD, TAHIR, MD	CHILDS, HANEEF A		Status: Dis ID	Admitted: 11/03/15 at 0715
Unit #: W000611175	Account #: PAL303162331			Location: PH2NE	Room/Bed: 208-1

INT: 4600065 <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th>Activity</th> <th>Occurred</th> <th>Recorded</th> <th>By</th> <th>Time</th> <th>By</th> <th>Doc</th> <th>Units</th> <th>Change</th> </tr> <tr> <td>4600065</td> <td>11/10/15 0902</td> <td>11/10/15 0903</td> <td>MHB</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table> Document: 11/10/15 0902 MHB 11/10/15 0903 MHB Presenting Problem.....ALtered THOUGHT PROCESS Mental status.....Alert Orientation.....Person Place Patient Appearance.....Clean Independent ADLs.....Y Eating Independently.....Y Sleep Pattern.....Difficulty Falling Asleep Attendance to Meetings.....Intermittent Participation in Meetings.....With Encouragement Compliance With Medications.....Y Seclusions and or Restraints... ..N PT IS ON 1:1 OBSERVATION FOR SAFETY OF SELF AND OTHERS Behavior.....Anxious Compliant Depressed Disorganized Fearful Guarded Suspicious Withdrawn Speech.....Low Volume Clear Mood and Affect.....Anxious Apprehensive Depressed Dysphoric Fearful Flat Frustrated Labile Suspicious Withdrawn Irritable Preoccupied Delusions.....N Hallucinations.....None Thought Process.....Loose Associations Flight of Ideas Disorganized Insight and Judgment.....Poor Danger to Self or Others.....N Suicidal Thoughts.....N Does Patient Have a Plan.....N Homicidal Thoughts.....N Contract for Safety.....Y Contract for Nonviolence.....Y Court Date.....11/05/15 5259900 <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th>Activity</th> <th>Occurred</th> <th>Recorded</th> <th>By</th> <th>Time</th> <th>By</th> <th>Doc</th> <th>Units</th> <th>Change</th> </tr> <tr> <td>5259900</td> <td>11/10/15 0902</td> <td>11/10/15 0903</td> <td>MHB</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table> Document: 11/10/15 0902 MHB 11/10/15 0903 MHB Was Patient Specific Education Provided Identified by CEHRT.....Y This is patient education content provided via the Info Button CEHRT=Certified Electronic Health Record Technology	Activity	Occurred	Recorded	By	Time	By	Doc	Units	Change	4600065	11/10/15 0902	11/10/15 0903	MHB						Activity	Occurred	Recorded	By	Time	By	Doc	Units	Change	5259900	11/10/15 0902	11/10/15 0903	MHB						Were the Problems or Medications or Labs Reviewed.....Y Education Pertinence.....mental illness Education Topics.....Disease Process Hospital Policy Medications Safety Signs and Symptoms Stress Management Treatment Plan Need for Followup Care When to Call 911 Additional Education Topics.....1:1 for safety Teach Fall Risk Safety Components.....Orient to Surroundings Pt Ask for Assistance Environmental Safety Medication Education Topics.....Action Side Effects Administration Frequency Dosage Route Adverse Reaction Other Medication Education Topic..... Tylenol, Nuprin, Zestoril, Ativan, Risperdal, Vistaril Tobacco Use Education.....Patient Declined Practical Counseling includes: Recognizing dangerous situation, developing coping skills, and providing basic information about quitting. Patient Referred to Outpatient Counseling after Discharge.....Declined Enrollment Referred to evidence based outpatient counseling, outline. Teaching Recipient.....Patient Readiness to Learn.....Expresses Interest Barriers to Learning.....Emotional Cognitive Teaching Methods.....Explained Response to Teaching.....Reinforcement needed Interpreter Required.....N Follow Facility Specific Interpreter Guidelines 1750030 <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th>Activity</th> <th>Occurred</th> <th>Recorded</th> <th>By</th> <th>Time</th> <th>By</th> <th>Doc</th> <th>Units</th> <th>Change</th> </tr> <tr> <td>1750030</td> <td>11/10/15 2125</td> <td>11/10/15 2128</td> <td>JM</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table> Document: 11/10/15 2125 JM 11/10/15 2128 JM Patient Activity.....Up Ab Lib Ambulates COB RRP Active ROM Activity Ability.....Independent Assistive Devices.....None Activity Tolerance.....Good Eating Ability.....Independent Toileting Ability.....Independent Toileting Assistive Devices.....Toilet Dressing Ability.....Independent Care Provided.....Shower	Activity	Occurred	Recorded	By	Time	By	Doc	Units	Change	1750030	11/10/15 2125	11/10/15 2128	JM					
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1750030	11/10/15 2125	11/10/15 2128	JM																																																				

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Date Range: Beginning - 11/13/15		Nancy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0033 Page 28	
Reg/Sex: 27 M	Referring: NAQSOOD, TARIK, MD	CHILDS, HANEEF A		Status: DIS IN	Admitted: 11/03/15 at 0715
Unit #: M000611175	Account #: PA1303162331			Location: PH2NE	Room/Bed: 208-1

Activity	Occurred	Recorded	Site	Freq/Target	Pr	Change	From
1750030	ADL Assessment		A	.QSHLIT			
Bathing Ability.....Independent Oral Care Ability.....Independent Sleep Assessment.....Difficulty Falling Asleep Sleep Aids.....Medication							
3750420	Document	11/10/15 2125 JM	11/10/15 2128 JM		.QSHLIT		
2750001	Pain Assessment		A	.QADMSHIFTPN			
Document 11/10/15 2126 JM 11/10/15 2128 JM Complaint Of Pain.....N Pain Location Modifier.....Lower Pain Location.....Back Pain Description.....Aching Does Pain Radiate.....N If Yes, Please Describe The Radiation Location. Pain Scale Used.....Numeric Pain Intensity.....10 out of 10 Pain Management Goal.....0-10 Symptoms And Behaviors Observed.....None Aggravating Factors.....None Measures Used To Relieve Pain.....Medication							
3250001	Nutritional Assessment		A	.QSHLITPN			
Document 11/10/15 2126 JM 11/10/15 2128 JM Diet Type.....REGULAR Thickened Liquids.....N Feeding.....Self Nutrition Breakfast.....76 to 100% Nutrition Lunch.....76 to 100% Nutrition Dinner.....76 to 100% Nutrition Snack.....76 to 100% Tube Feed Flushed.....N/A Aspiration Precautions Maintained.....Y N/A Calorie Count.....N/A							
3750140	Document	11/10/15 2126 JM	11/10/15 2128 JM		.QADMSHIFTPN		
Moisture.....Rarely Moist Sensory Perception.....No Limitation Activity.....Walks Frequently Mobility.....No Limitation Nutrition.....Adequate Friction and Shear.....No Apparent Problem Total Score Skin Risk Assessment.....22 score 19-23 = No Risk 15-18 = Low Risk 13-14 = Moderate Risk 10-12 = High Risk Less Than 9 = Very High Risk Pressure Inducing Devices In Use.....No Device in Use Any response, except No, will trigger a suggested problem of High Risk of Pressure Ulcer from Devices.							
4650065	Mental Status Assessment		A	.QSHLIT			
Document 11/10/15 2126 JM 11/10/15 2128 JM Presenting Problem.....ALTFRED THOUGHT PROCESS Mental Status.....Alert							

Activity	Occurred	Recorded	Site	Freq/Target	Pr	Change	From
INT 4600055	Orientation						
Orientation.....Person Patient Appearance.....Clean Independent ADLs.....Y Eating Independently.....Y Sleep Pattern.....Difficulty Falling Asleep Attendance to Meetings.....Intermittent Participation in Meetings.....With Encouragement Compliance With Medications.....Y Seclusions and or Restraints..... N PT IS ON 1:1 OBSERVATION FOR SAFETY OF SELF AND OTHERS Behavior.....Anxious Compliant Depressed Disorganized Guarded Interacting with Peers Suspicious Speech.....Low Volume Clear Mood and Affect.....Anxious Apprehensive Appropriate Depressed Dysphoric Frustrated Labile Suspicious Preoccupied Delusions.....N Hallucinations.....None Thought Process.....Loose Associations Flight of Ideas Disorganized Insight and Judgment.....Poor Danger to Self or Others.....N Suicidal Thoughts.....N Does Patient Have a Plan.....N Homicidal Thoughts.....N Contract for Safety.....Y Contract for Nonviolence.....Y Court Date.....11/05/15							
5259900	Teaching Record		A	.QSHLITPN			
Document 11/10/15 2127 JM 11/10/15 2128 JM Has Patient Specific Education Provided Identified by CERT.....N This is patient education content provided via the Info Button CERT=Certified Electronic Health Record Technology Were the Problems or Medications or Labs Reviewed.....Y Education Pertinence..... MENTAL HEALTH DISEASE AND MEDICATION COMPLIANCE Education Topics.....Disease Process Hospital Policy Medications Safety							

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Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0035 Page 29	
Age/Sex: 27 M	Admission: MACSOOD, TAHIR, MD	Discharge: DTS IN	Admitted: 11/03/15 at 0715	Location: 7E2NE	Room/Bed: 208-1
Unit #: M000611175	Account #: PA1303162331	CHILDS, HANEEF A			

Activity	Occurred	Recorded	Date	Time	By	Doc/Unit	Change
E2E9900 Teaching Record [A] [PS] Signs and Symptoms Stress Management Treatment Plan Need for Followup Care When to Call 911 Additional Education Topics..... 1:1 for safety Teach Fall Risk Safety Components..... Orient To Surroundings Pt Ask For Assistance Environmental Safety Medication Education Topics..... Action Side Effects Administration Frequency Dosage Route Adverse Reaction Other Medication Education Topic... tylenol, zyprexa, restoril, ativan, risperdal, vistaril Education Packet Given..... SUBSTANCE ABUSE Tobacco Use Education..... Patient Declined Practical Counseling includes: Recognizing dangerous situation, developing coping skills, and providing basic information about quitting. Patient Referred to Outpatient Counseling after Discharge..... Declined Enrollment Referred to evidence based outpatient counseling, Quitline. Teaching Recipient..... Patient Readiness to Learn..... Expresses Interest Barriers to Learning..... Unmotivated Emotional Sensory Cognitive Teaching Methods..... Explained Response to Teaching..... Reinforcement needed Interpreter Required..... N Follow Facility Specific Interpreter Guidelines 3250001 Pain Assessment [A] [PS] Document 11/11/15 0541 LC 11/11/15 0542 LC Complaint Of Pain..... N Pain Location Modifist..... Lower Pain Location..... Back Pain Description..... Aching Does Pain Radiate..... N If Yes, Please Describe The Radiation Location. Pain Scale Used..... Numeric Pain Intensity..... 10 out of 10 Pain Management Goal..... 0-10 Symptoms And Behaviors Observed..... None Aggravating Factors..... None Measures Used To Relieve Pain..... Medication 3250001 Patient Education [A] [PS] Document 11/11/15 0541 LC 11/11/15 0542 LC Diet Type..... REGULAR Thickened Liquids..... N Feeding..... Self Nutrition Breakfast..... 76 to 100% Nutrition Lunch..... 76 to 100% Nutrition Dinner..... 76 to 100% Nutrition Snack..... 76 to 100% Tube Feed Flushed..... N N/A Aspiration Precautions Maintained..... Y N/A Calorie Count..... N N/A 3750140 Skin Risk [A] [PS] Document 11/11/15 0541 LC 11/11/15 0542 LC Moisture..... Rarely Moist Sensory Perception..... No Limitation Activity..... Walks Frequently Mobility..... No Limitation Nutrition..... Adequate Friction and Shear..... No Apparent Problem Total Score Skin Risk Assessment... 22 score 19-23 = No Risk 15-18 = Low Risk 13-14 = Moderate Risk 10-12 = High Risk Less Than 9 = Very High Risk Pressure Inducing Devices in Use..... No Device in Use Any response, except No, will trigger a suggested problem of High Risk of Pressure Ulcer from Devices. 3750140 Braden Scale [A] [PS] Ed Text 11/11/15 0542 LC 11/11/15 0542 LC 3750420 Choking Risk [A] [PS] Ed Status 11/11/15 0542 LC 11/11/15 0542 LC 4600065 Bowel Function [A] [PS] Document 11/11/15 0542 LC 11/11/15 0542 LC Preventing Problem..... ALTERED THOUGHT PROCESS Mental Status..... Alert Orientation..... Person							

Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0035 Page 30	
Age/Sex: 27 M	Attending: BAQSOOD, TAHIR, MD	CHILDS, HANEEF A		Room/Bed: 2H2NE	Room/Bed: 2B8-1
Guest #: H000611175	Admission #: PA1303162331			Discharge: 11/03/15 at 0719	

Activity	Occurred	Recorded	Site	Prog/Target	Est	Change
46C0065 Nursing Shift Assessment [A] .CSHIFT Place Patient Appearance.....Clean Independent ADLs.....Y Eating Independently.....Y Sleep Pattern.....Difficulty Falling Asleep Attendance to Meetings.....Intermittent Participation in Meetings.....With Encouragement Compliance With Medications.....Y Seclusions and or Restraints..... ..N PT IS ON 1:1 OBSERVATION FOR SAFETY OF SELF AND OTHERS Behavior.....Anxious Compliant Depressed Disorganized Guarded Interacting with Peers Suspicious Speech.....Low Volume Clear Mood and Affect.....Anxious Apprehensive Appropriate Depressed Dysphoric Frustrated Labile Suspicious Preoccupied Delusions.....N Hallucinations.....None Thought Process.....Loose Associations Flight of Ideas Disorganized Insight and Judgment.....Poor Danger to Self or Others.....N Suicidal Thoughts.....N Does Patient Have a Plan.....N Homicidal Thoughts.....N Contract for Safety.....Y Contract for Nonviolence.....Y Court Date.....11/05/15 52E9903 Psychiatric Assessment [A] .CSHIFT Document 11/11/15 0542 LC 11/11/15 0542 LC Was Patient Specific Education Provided Identified by CEHRT.....Y This is patient education content provided via the Info Button CEHRT=Certified Electronic Health Record Technology Were the Problems or Medications or Labs Reviewed.....Y Education Pertinence..... ..MENTAL HEALTH DISEASE AND MEDICATION COMPLIANCE Education Topics.....Disease Process Hospital Policy Medications Safety Signs and Symptoms Stress Management Treatment Plan Need for Followup Care When to Call 911 Additional Education Topics.....1:1 for safety Teach Fall Risk Safety Components.....Orient to Surroundings Pt Ask for Assistance Environmental Safety Medication Education Topics.....Action Side Effects Administration Frequency Dosage Route Adverse Reaction Other Medication Education Topic... ..tylenol, zyprexa, restoril, ativan, risperdal, vistaril Education Packet Given.....SUBSTANCE ABUSE Tobacco Use Education.....Patient Declined Practical Counseling includes: Recognizing dangerous situation, developing coping skills, and providing basic information about quitting. Patient Referred to Outpatient Counseling after Discharge.....Declined Enrollment Referred to evidence based outpatient counseling, quitline. Teaching Recipient.....Patient Readiness to learn.....Expresses Interest Barriers to Learning.....Unmotivated Emotional Sensory Cognitive Teaching Methods.....Explained Response to Teaching.....Reinforcement needed Interpreter Required.....N Follow Facility Specific Interpreter Guidelines						
0500000 Vitals [A] BID Document 11/11/15 0724 SY 11/11/15 0724 SY Temperature Celsius.....36.0 degrees C Temperature Calculated Fahrenheit.....96.8 degrees F Pulse Location Modifier.....Right Pulse Location.....Brachial Pulse Rate Adult 18 And Older.....87 Beats Per Minute Respiratory Rate Adult 18 And Older.....18 Breaths Per Minute Blood Pressure Systolic Adult 18 And Older.....133 mmHg Blood Pressure Diastolic Adult 18 And Older.....69 mmHg 0061830 Protocol: Cont. Obs. Data [A] .continuous Ed Status 11/11/15 1049 RP 11/11/15 1050 RP A-X 1750030 Not Assessment [A] .CSHIFT Document 11/11/15 1518 SS 11/11/15 1519 SS Patient Activity.....Ambulates OOB BRP						

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Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital ECS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0033 Page 31	
Age/Sex: 27 M	Attending: HAQSOOD, TAMER, MD	Status: DIS IN	Admitted: 11/03/15 at 0715	Location: 3K2NE	Room/Bed: 208-1
Unit #: M000611175	Account #: PA1303162331	CHILDS, HANEEF A			

INT 1750030 <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th>Activity</th> <th>Observed</th> <th>Recorded</th> <th>Site</th> <th>Prog/Target</th> <th>Gr.</th> <th>Prnt</th> </tr> <tr> <th>Type</th> <th>Date</th> <th>Time</th> <th>By</th> <th>Date</th> <th>Time</th> <th>By</th> </tr> </table>										Activity	Observed	Recorded	Site	Prog/Target	Gr.	Prnt	Type	Date	Time	By	Date	Time	By	INT 1750140 <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th>Activity</th> <th>Observed</th> <th>Recorded</th> <th>Site</th> <th>Prog/Target</th> <th>Gr.</th> <th>Prnt</th> </tr> <tr> <th>Type</th> <th>Date</th> <th>Time</th> <th>By</th> <th>Date</th> <th>Time</th> <th>By</th> </tr> </table>										Activity	Observed	Recorded	Site	Prog/Target	Gr.	Prnt	Type	Date	Time	By	Date	Time	By
Activity	Observed	Recorded	Site	Prog/Target	Gr.	Prnt																																									
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1750030 ADL Assessment HA .QSHIPT PS Active ROM Activity Ability.....Independent Assistive Devices.....None Activity Tolerance.....Good Eating Ability.....Independent Toileting Ability.....Independent Toileting Assistive Devices...Toilet Dressing Ability.....Independent Care Provided.....Shower Bathing Ability.....Independent Oral Care Ability.....Independent Additional ADL Comment.....patient dressed in hospital scrubs.							4800065 PHYSICIAN CHIEF Assessment HA .QSHIPT PS Document 11/11/15 1520 SS 11/11/15 1523 SS Presenting Problem.....ALTERED THOUGHT PROCESS Mental Status.....Alert Orientations.....Person Place Time Patient Appearance.....Clean Independent ADLs.....Y Eating Independently.....Y Attendance to Meetings.....Intermittent Participation in Meetings.....With Encouragement Compliance With Medications.....Y Seclusions and or Restraints.....N Behavior.....Anxious Compliant Interacting with Peers Suspicious Speech.....Clear Mood and Affect.....Anxious Apprehensive Appropriate Dysphoric Frustrated Suspicious Preoccupied Delusions.....N Hallucinations.....None Thought Process.....Loose Associations Flight of Ideas Disorganized Insight and Judgment.....Poor Danger to Self or Others.....N Suicidal Thoughts.....N Does Patient Have a Plan.....N Suicidal Thoughts.....N Contract for Safety.....Y Contract for Nonviolence.....Y Psych Comment..... patient admits he has delusions that "people are following me in here." Court Date.....11/05/15																																								
2750001 Pain Assessment HA .QADMSHIFTN PS Document 11/11/15 1519 SS 11/11/15 1520 SS Complaint Of Pain.....Y Pain Location Modifier.....Lower Pain Location.....Back Pain Description.....Aching Does Pain Radiate.....N If Yes, Please Describe The Radiation Location..... Pain Scale Used.....Numeric Pain Intensity.....9 out of 10 Pain Management Goal.....0 0-10 Symptoms And Behaviors Observed...Irritable Rubbing Site Aggravating Factors.....Standing Walking Measures Used To Relieve Pain.....Medication Pain Assessment Comment.....Tramadol not effective							5259900 PHYSICIAN RECORD HA .QSHIPTN PS Document 11/11/15 1520 SS 11/11/15 1524 SS Was Patient Specific Education Provided Identified by CEHRT.....Y This is patient education content provided via the Info Button CEHRT=Certified Electronic Health Record Technology Were the Problems or Medications or Labs Reviewed.....Y Education Pertinence..... MENTAL HEALTH DISEASE AND MEDICATION COMPLIANCE Education Topics.....Disease Process																																								
1750140 Wound Care HA .QADMSHIFTN PS Document 11/11/15 1520 SS 11/11/15 1520 SS Moisture.....Rarely Moist Sensory Perception.....No limitation Activity.....Walks Frequently Mobility.....No limitation Nutrition.....Adequate Friction and Shear.....No Apparent Problem Total Score Skin Risk Assessment...22 score 19-23 = No Risk 15-18 = Low Risk 13-14 = Moderate Risk 10-12 = High Risk Less Than 9 = Very High Risk																																															

Date Range: Beginning - 11/17/15

Referring: MAGSOOD, SAHIL

Activity	Occurred	Recorded	Site	Frequency	Unit	Change
Type	Date	Time	By	Date	Time	By
525900	Teaching	11/11/15 2209	JM	11/11/15 2211	JM	.GSHITPRN
.....Hospital Policy						
.....Medications						
.....Pain Management						
.....Safety						
.....Signs and Symptoms						
.....Stress Management						
.....Treatment Plan						
.....Need for Followup Care						
.....When to Call 911						
Additional Education Topics...						
.. Pain/Measures to relieve pain						
Teach Fall Risk Safety Components.....Orient To Surroundings						
.....Pt Ask For Assistance						
.....Environmental Safety						
Medication Education Topics.....Action						
.....Side Effects						
.....Administration						
.....Frequency						
.....Dosage						
.....Route						
.....Adverse Reaction						
Other Medication Education Topic...						
.. Tylenol, Typraxa, Restoril, Stivan, Risperdal, Vistaril						
Education Packet Given.....SUBSTANCE ABUSE						
Tobacco Use Education.....Patient Declined						
Practical Counseling includes: Recognizing						
dangerous situation, developing coping						
skills, and providing basic information about						
quitting.						
Patient Referred to Outpatient Counseling after Discharge.....Declined Enrollment						
Referred to evidence based outpatient						
counseling, Outline.						
Teaching Recipient.....Patient						
Readiness to Learn.....Expresses Interest						
Barriers to Learning.....Unmotivated						
.....Emotional						
.....Sensory						
.....Cognitive						
Teaching Methods.....Explained						
Response to Teaching.....Reinforcement needed						
Interpreter Required.....N						
Follow Facility Specific Interpreter						
Guidelines						
Date: 11/11/15 2209						
1750030 ADD Assessment						
Document 11/11/15 2209 JM 11/11/15 2211 JM						
Patient Activity.....Up Ab 1ib						
.....Ambulates						
.....COB						
.....BRR						
.....Active ROM						
Activity Ability.....Independent						
Assistive Devices.....None						
Activity Tolerance.....Good						
Eating Ability.....Independent						
Toileting Ability.....Independent						

Activity	Occurred	Recorded	Site	Frequency	Unit	Change
Type	Date	Time	By	Date	Time	By
IN7-1750030	Teaching	11/11/15 2210	JM	11/11/15 2211	JM	.GSHITPRN
Toileting Assistive Devices...Toilet						
Dressing Ability.....Independent						
Care Provided.....Shower						
Bathing Ability.....Independent						
Oral Care Ability.....Independent						
Sleep Assessment.....Normal						
.....Difficulty Falling Asleep						
Sleep Aids.....None						
Additional ADL Comment.....patient dressed in hospital scrubs.						
Date: 11/11/15 2210						
2750001 ADD Assessment						
Document 11/11/15 2210 JM 11/11/15 2211 JM						
Complaint Of Pain.....N						
Pain Location Modifier.....Lower						
Pain Location.....Back						
Pain Description.....Aching						
Does Pain Radiate.....N						
If Yes, Please Describe The Radiation						
Location.						
Pain Scale Used.....Numeric						
Pain Intensity.....9 out of 10						
Pain Management Goal.....0-10						
Symptoms and Behaviors Observed...Irritable						
.....Rubbing Site						
Aggravating Factors.....Standing						
.....Walking						
Measures Used To Relieve Pain....Medication						
Pain Assessment Comment.....Trenadol not effective						
Date: 11/11/15 2210						
3250001 ADD Assessment						
Document 11/11/15 2210 JM 11/11/15 2211 JM						
Diet Type.....REGULAR						
Thickened Liquids.....N						
Feeding.....Self						
Nutrition Breakfast.....76 to 100%						
Nutrition Lunch.....76 to 100%						
Nutrition Dinner.....76 to 100%						
Tube Feed Flushed.....N N/A						
Aspiration Precautions Maintained....Y N/A						
Calorie Count.....N N/A						
Date: 11/11/15 2210						
3750140 ADD Assessment						
Document 11/11/15 2210 JM 11/11/15 2211 JM						
Moisture.....Rarely Moist						
Sensory Perception.....No Limitation						
Activity.....Walks Frequently						
Mobility.....No Limitation						
Nutrition.....Adequate						
Friction and Shear.....No Apparent Problem						
Total Score Skin Risk Assessment...22 score						
19-23 = No Risk						
15-18 = Low Risk						
13-14 = Moderate Risk						
10-12 = High Risk						
Less Than 9 = Very High Risk						
Pressure Inducing Devices in Use.....No Device in Use						
Any response, except No, will trigger a						
suggested problem of High Risk of Pressure						
Ulcer from Devices.						

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Activity										Activity										
Type	Date	Time	By	Time	By	Doc	Unit	Change	From	Type	Date	Time	By	Time	By	Doc	Unit	Change	From	
460065	11/11/15	2210	JM	11/11/15	2211	JM				460065	11/11/15	2210	JM	11/11/15	2211	JM				
Document 11/11/15 2210 JM 11/11/15 2211 JM Presenting Problem.....ALtered Thought Process Mental Status.....Alert Orientation.....Person Place Time Patient Appearance.....Clean Independent ADLs.....Y Eating Independently.....Y Sleep Pattern.....Difficulty falling asleep Attendance to Meetings.....Intermittent Participation in Meetings.....With Encouragement Compliance With Medications...Y Seclusions and or Restraints...N Behavior.....Anxious Appropriate Compliant Depressed Interacting with Peers Intrusive Restless Suspicious Speech.....Low Volume Clear Mood and Affect.....Anxious Apprehensive Appropriate Constricted Dysphoric Frustrated Suspicious Preoccupied Delusions.....N Hallucinations.....None Thought Process.....Loose Associations Flight of Ideas Disorganized Insight and Judgment.....Poor Danger to Self or Others.....N Suicidal Thoughts.....N Does Patient Have a Plan.....N Homicidal Thoughts.....N Contract for Safety.....Y Contract for Nonviolence.....Y Psych Comment..... patient admits he has delusions that "people are following me in here." Court Date.....11/05/15										Document 11/11/15 2211 JM 11/11/15 2211 JM Was Patient Specific Education Provided Identified by CEHRT.....N This is patient education content provided via the info button CEHRT-Certified Electronic Health Record Technology Were the Problems or Medications or Labs Reviewed.....Y										
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Activity	Occurred	Recorded	sts	freq/target	From
Type	Date	Time By	Date	Time By	Doc Units
1750030	ADL Assessment				.OSHIPT
Toileting Assistive Devices...Toilet Dressing Ability.....Independent Bathing Ability.....Independent Oral Care Ability.....Independent Sleep Assessment.....Difficulty Falling Asleep Sleep Aids.....Medication					
2750001	ADL Assessment				.QADNSHIPTRN
Document 11/12/15 0311 SHP 11/12/15 0311 SHP Complaint Of Pains....N					
3250001	ADL Assessment				.OSHIPTRN
Document 11/12/15 0311 SHP 11/12/15 0311 SHP Diet Type.....REGULAR Thickened Liquids...N Feeding.....Self Caloric Count.....N					
3750140	ADL Assessment				.QADNSHIPTRN
Document 11/12/15 0311 SHP 11/12/15 0311 SHP Moisture.....Rarely Moist Sensory Perception.....No Limitation Activity.....Walks Frequently Mobility.....No Limitation Nutrition.....Adequate Friction and Shear.....No Apparent Problem Total Score Skin Risk Assessment...22 score 19-23 = No Risk 15-18 = Low Risk 13-14 = Moderate Risk 10-12 = High Risk Less Than 9 = Very High Risk					
4500065	ADL Assessment				.OSHIPT
Document 11/12/15 0311 SHP 11/12/15 0311 SHP Presenting Problem.....ALIBRED THOUGH PROCESS Independent ADLS.....Y Eating Independently.....Y Sleep Pattern.....Difficulty Falling Asleep Compliance With Medications...Y Seclusions and or Restraints...N					
0500000	Vital Signs				.SID
Document 11/12/15 0705 SHP 11/12/15 0705 SHP Temperature Celsius.....36.2 degrees C Temperature Calculated Fahrenheit.....97.2 degrees F Temperature Source.....Oral Pulse Location Modifier.....Right Pulse Location.....Brachial Pulse Rate Adult 18 And Older.....80 Beats Per Minute Respiratory Rate Adult 18 And Older.....21 Breaths Per Minute Blood Pressure Systolic Adult 18 And Older.....114 mmHg Blood Pressure Diastolic Adult 18 And Older.....75 mmHg					
5500015	ADL Assessment				
Create 11/12/15 1404 RP* 11/12/15 1404 RP* Document 11/12/15 1404 RP* 11/12/15 1404 RP* Information Provided By.....Patient How Will You Get Home.....Taxi					

Activity	Occurred	Recorded	sts	freq/target	From
Type	Date	Time By	Date	Time By	Doc Units
Do You Need Assistance Arranging For Transportation Home...Y Living Situation Prior To Admission Comment.....girlfriend If patient from nursing home, please enter name. Does Anyone Depend Upon You For Care.....Y Current Support System.....Family Support Group.....Child Children Current Support System Additional Information..... mother/stepmother/father/girlfriend and children Physical Barriers in Home Environment.....None Activity Ability Prior to Admission.....Independent Ambulation Assistive Devices Prior to Admission.....None Notes.....N/A Patient Responsibilities Prior to Admission.....Cooking Laundry Bathing Self Care Managing own meds Shopping Yard work Housekeeping					
Services Received Prior to Admission.....None Planning Assistance Required Due To.....Community Resources Behavioral Health Discharge Planning Assistance Required.....home/outpt follow up care Potential Equipment and Services Needs At Discharge.....N/A Discharge Plan Location.....Return to Home Discharge Destination.....home/outpt follow up care Enter Name Of Location For Discharge Home Care Agency Information.....N/A Enter Phone Number and/or Agency Information Home DME Companies.....N/A For Discharge Hold Bod.....N/A Bed Hold Comment.....N/A Contact Person Name and Number... ..father: Mr. Louis Childs 267-600-4409 Please document the best telephone number to contact Power of Attorney, Next of Kin, or Contact Person Discharge Plan Comment..... Discharge address: 20 North 53th Street Phila Pa 19139 267-600-4409. Recovery support as needed in the community: NA meetings at 59th spruce St on Tuesday's from 6:00pm to 7:00pm daily. Daily AA meetings at 4021 Walnut St on Thursday's at 1:00pm daily. Y					
0010012	ADL Assessment				.OSHIPT
Document 11/12/15 1937 JRH 11/12/15 1940 JRH					
1750030	ADL Assessment				.OSHIPT
Document 11/12/15 1937 JRH 11/12/15 1940 JRH Patient Activity.....Up Ab Lib Activity Ability.....Independent Assistive Devices.....None Activity Tolerance.....Good Eating Ability.....Independent Toileting Ability.....Independent Toileting Assistive Devices...Toilet					

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Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0035 Page 35	
REG/SECT 27 M	Referring MAQSOOD, TAHIR, MD	CHILDS, HANEEF A		DIS IN	Admitted 11/03/15 at 0715
DOB 000611175	Account # 7A1303152331				

1750030 <u>ADL ASSESSMENT</u> [A] .OSHIPT [PS] Crossing Ability.....Independent Bathing Ability.....Independent Oral Care Ability.....Independent 2750001 <u>ADL ASSESSMENT</u> [A] .QADMSHIFTPN [PS] Document 11/12/15 1937 JRN 11/12/15 1940 JRN Complaint Of Pain....N 3250001 <u>ADL ASSESSMENT</u> [A] .OSHIPT [PS] Document 11/12/15 1937 JRN 11/12/15 1940 JRN Diet Type.....regular Feeding.....Self Nutrition Dinner...76 to 100% 3750140 <u>ADL ASSESSMENT</u> [A] .QADMSHIFTPN [PS] Document 11/12/15 1937 JRN 11/12/15 1940 JRN Moisture.....Rarely Moist Sensory Perception.....No Limitation Activity.....Walks Frequently Mobility.....No Limitation Nutrition.....Adequate Friction and Shear.....No Apparent Problem Total Score Skin Risk Assessment...22 score 19-23 = No Risk 15-18 = Low Risk 13-14 = Moderate Risk 10-12 = High Risk Less Than 9 = Very High Risk Pressure Inducing Devices in Use.....No Device in Use Any response, except No, will trigger a suggested problem of High Risk of Pressure Ulcer from Devices. 5259900 <u>Teaching Recipient</u> [A] .OSHIPT [PS] Document 11/12/15 1937 JRN 11/12/15 1940 JRN Was Patient Specific Education Provided Identified by CEHRT.....N This is patient education content provided via the Info Burton CEHRT-Certified Electronic Health Record Technology Were the Problems or Medications or Labs Reviewed.....Y Education Topics.....Medications Signs and Symptoms Medication Education Topics.....Action Side Effects Administration Frequency Dosage Route Other Medication Education Topic.....Risperdal Teaching Recipient.....Patient Readiness to Learn.....Denies Need Barriers to Learning.....Emotional Cognitive Teaching Methods.....Explained Response to Teaching... ..Verbalizes Understanding ..Reinforcement needed Reinforcement Needed Comment.....	poor insight into need for treatment Interpreter Required.....N Follow Facility Specific Interpreter Guidelines 4600065 <u>ADL ASSESSMENT</u> [A] .OSHIPT [PS] Document 11/12/15 1937 JRN 11/12/15 1940 JRN Presenting Problem.....paranoia Mental Status.....Alert Orientation.....Person Place Time Patient Appearance.....Clean Independent ADLs.....Y Eating Independently.....Y Sleep Pattern.....Difficulty Falling Asleep Compliance With Medications...Y Seclusions and or Restraints...N Behavior.....Anxious Compliant Interacting with Peers Restless Suspicious Speech.....Low Volume Clear Mood and Affect.....Anxious Apprehensive Blunted Constricted Dysphoric Frustrated Suspicious Preoccupied Delusions.....N Hallucinations.....Auditory Thought Process.....Circumstantial Goal Oriented Insight and Judgment.....Poor Danger to Self or Others.....N Suicidal Thoughts.....N Homicidal Thoughts.....N Contract for Safety.....Y Contract for Nonviolence.....Y Psych Comment..... patient admits he has delusions that "people are following me in here." Court Date.....11/05/15 0010032 <u>ADL ASSESSMENT</u> [A] .OSHIPT [PS] Document 11/13/15 0149 SHP 11/13/15 0150 SHP 4600065 <u>ADL ASSESSMENT</u> [A] .OSHIPT [PS] Document 11/13/15 0149 SHP 11/13/15 0150 SHP Presenting Problem.....PARANOID, PREOCCUPIED Independent ADLs.....Y Eating Independently.....Y Sleep Pattern.....Normal Compliance With Medications...Y Seclusions and or Restraints...N
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Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary		Printed: 11/17/15 at 0033 Page 36	
Age/Sex: 27 M	Referring: RAGSDON, TAYLOR, MD	CHILDS, HANEEF A		Status: DIS IN	Admission: 11/03/15 at 0715
Unit: N000611175	Account: PA1303162321			Location: 3RD20	Room/Bed: 208-1

Document 11/13/15 0150 SHP 11/13/15 0150 SHP Patient Activity.....Up Ab Lib Activity Ability.....Independent Assistive Devices.....None Activity Tolerance.....Good Eating Ability.....Independent Toileting Ability.....Independent Toileting Assistive Devices.....Toilet Dressing Ability.....Independent Bathing Ability.....Independent Oral Care Ability.....Independent Sleep Assessment.....Normal Sleep Aids.....None Document 11/13/15 0150 SHP 11/13/15 0150 SHP Complaint Of Pain.....N Document 11/13/15 0150 SHP 11/13/15 0150 SHP Diet Type.....REGULAR Thickened Liquids.....N Feeding.....Self Calorie Count.....N Document 11/13/15 0150 SHP 11/13/15 0150 SHP Moisture.....Rarely Moist Sensory Perception.....No Limitation Activity.....Walks Frequently Mobility.....No Limitation Nutrition.....Adequate Friction and Shear.....No Apparent Problem Total Score Skin Risk Assessment.....22 score 19-23 = No Risk 15-19 = Low Risk 13-14 = Moderate Risk 10-12 = High Risk Less Than 9 = Very High Risk Document 11/13/15 0647 SY 11/13/15 0647 SY Temperature Celsius.....35.8 degrees C Temperature Calculated Fahrenheit.....96.4 degrees F Pulse Location Modifier.....Right Pulse Location.....Brachial Pulse Rate Adult 18 And Older.....95 Beats Per Minute Respiratory Rate Adult 18 And Older.....19 Breaths Per Minute Blood Pressure Systolic Adult 18 And Older.....118 mmHg Blood Pressure Diastolic Adult 18 And Older.....96 mmHg Document 11/13/15 1330 RP 11/13/15 1332 RP Information Provided By.....Patient How Will You Get Home.....Taxi Do You Need Assistance Arranging For Transportation Home.....Y Living Situation Prior To Admission Comment.....girlfriend	If patient from nursing home, please enter name. Does Anyone Depend Upon You For Care.....Y Current Support System.....Family Support Group Child Children Current Support System Additional Information..... Mother/stepmother/father/girlfriend and children Physical Barriers in Home Environment.....None Activity Ability Prior to Admission.....Independent Amputation Assistive Devices Prior to Admission.....None Notes.....n/a Patient Responsibilities Prior to Admission.....Cooking Laundry Bathing Self Care Managing own meds Shopping Yard work Housekeeping Services Received Prior to Admission.....None Planning Assistance Required Due To.....Community Resources Behavioral Health Discharge Planning Assistance Required.....home/outpt follow up care Potential Equipment and Services Needs At Discharge.....n/a Discharge Plan Location.....Return to Home Discharge Destination.....home/outpt follow up care Enter Name Of Location For Discharge Home Care Agency Information.....n/a Enter Phone Number and/or Agency Information Home DME Companies.....n/a For Discharge Hold Bed.....n/a Bed Hold Comment.....n/a Contact Person Name and Number..... Father: Mr. Louis Childs 267-600-4409 Please document the best telephone number to contact Power of Attorney, Next of Kin, or Contact Person Discharge Plan Comment..... Discharge address: 20 North 53th Street Phila Pa 19139 267-600-4409. Recovery support as needed in the community: NA meetings at 59th Spruce St on Tuesday's from 6:00pm to 7:00pm daily. Daily AA meetings at 4021 Walnut St on Thursday's at 1:00pm daily. You have a follow up appt at the NE2 5301 Chestnut St Phila Pa 19139 215-747-6430 fax 215-747-6432 appt on 11/16/15 at 1:30pm, please make sure that you have your ID and insurance card with you for your intake appt. Document 11/13/15 1352 RP 11/13/15 1353 RP Information Provided By.....Patient Family Member How Will You Get Home.....Taxi Do You Need Assistance Arranging For Transportation Home.....Y Living Situation Prior To Admission Comment.....girlfriend If patient from nursing home, please enter name. Does Anyone Depend Upon You For Care.....Y
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Date Range: Beginning - 11/17/15

Mercy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary

Printed: 11/17/15 at 0035

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11/17/15

Activity	Occurred	Recorded	By	Date	Time	By	Doc Unit	Change
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5500015 Home Independence Assessment Discharge [A] [PS]

Current Support System.....Family
.....Support Group
.....Child Children

Current Support System Additional Information.....
mother/stepmother/father/girlfriend and children

Physical Barriers in Home Environment.....None

Activity Ability Prior to Admission.....Independent

Ambulation Assistive Devices Prior to Admission.....None

Notes.....n/a

Patient Responsibilities Prior to Admission.....Cooking
.....Laundry
.....Bathing
.....Self Care
.....Managing own meds
.....Shopping
.....Yard work
.....Housekeeping

Services Received Prior to Admission.....None

Planning Assistance Required Due To.....Community Resources
.....Behavioral Health

Discharge Planning Assistance Required.....home/outpt follow up care

Potential Equipment and Services Needs At Discharge.....n/a

Discharge Plan Location.....Return to Home

Discharge Destination.....home/outpt follow up care

Enter Name Of Location For Discharge.....n/a

Home Care Agency Information.....n/a

Enter Phone Number and/or Agency Information.....n/a

Home DME Companies.....n/a

For Discharge Hold Bed.....n/a

Bed Hold Comment.....n/a

Contact Person Name and Number...
..father: Mr. Louis Childs 267-600-4409

Please document the best telephone number to
contact Power of Attorney, Next of Kin, or
Contact Person

Discharge Plan Comment.....

Discharge address: 20 North 53th Street Phila Pa 19139 267-600-4409.

Recovery support as needed in the community: NA meetings at 59th Spruce St
on Tuesday's from 6:00pm to 7:00pm daily. Daily AA meetings at 4021 Walnut
St on Thursday's at 1:00pm daily. You have a follow up appt at the NEI
5501 Chestnut St Phila Pa 19139 215-747-6490 fax 215-747-6132 appt on
11/16/15 at 1:30pm, please make sure that you have your ID and Insurance
card with you for your intake appt

Date: 11/17/15 1445
0040004 Discharge [A] [PS]
Create 11/17/15 1445 RP 11/17/15 1445 RP
Date: 11/17/15 1503
1750030 Home Independence Assessment [A] [PS]
Document 11/17/15 1503 LC 11/17/15 1503 LC
Patient Activity.....Up Ab Lib
Activity Ability.....Independent
Assistive Devices.....None
Activity Tolerance.....Good
Eating Ability.....Independent
Toileting Ability.....Independent
Toileting Assistive Devices...Toilet

Dressing Ability.....Independent

Care Provided.....Shower

Bathing Ability.....Independent

Oral Care Ability.....Independent

Sleep Assessment.....Normal

Sleep Aids.....None

Additional ADL Comment.....patient dressed in hospital scrubs.

2750001 Pain Assessment [A] [PS]
Document 11/13/15 1503 LC 11/13/15 1503 LC
Complaint Of Pain.....N
Pain Location Modifier.....Lower
Pain Location.....Back
Pain Description.....Aching
Does Pain Radiate.....N
If Yes, Please Describe The Radiation
Location.
Pain Scale Used.....Numeric
Pain Intensity.....9 out of 11
Pain Management Goal.....0-10
Symptoms And Behaviors Observed...Irritable
.....Rubbing Site
Aggravating Factors.....Standing
.....Walking
Measures Used To Relieve Pain....Medication
Pain Assessment Comment.....Tramadol not effective

3250001 Nutrition Assessment [A] [PS]
Document 11/13/15 1503 LC 11/13/15 1503 LC
Diet Type.....REGULAR
Thickened Liquids.....N
Feeding.....Self
Nutrition Breakfast.....76 to 103%
Nutrition Lunch.....76 to 103%
Tube Feed Flushed.....N N/A
Aspiration Precautions Maintained....Y N/A
Calorie Count.....N

3750140 Pressure Risk Assessment [A] [PS]
Document 11/13/15 1503 LC 11/13/15 1503 LC
Moisture.....Rarely Moist
Sensory Perception.....No Limitation
Activity.....Walks Frequently
Mobility.....No Limitation
Nutrition.....Adequate
Friction and Shear.....No Apparent Problem
Total Score Skin Risk Assessment...22 score
19-23 = No Risk
15-18 = Low Risk
13-14 = Moderate Risk
10-12 = High Risk
Less Than 9 = Very High Risk
Pressure Inducing Devices in Use.....No Device in Use
Any response, except No, will trigger a
suggested problem of High Risk of Pressure
Ulcer from Devices.

4600065 Pressure Risk Assessment [A] [PS]
Document 11/17/15 1503 LC 11/17/15 1503 LC

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Date Range: Beginning - 11/17/15		Mercy Philadelphia Hospital PCS **LIVE** Archived Discharge Summary	
27 M	Extending	HAQSOOD, TANIR, MD	11/17/15
46L0065 Discharge Summary Document 11/13/15 1503 LC 11/13/15 1503 LC Presenting Problem.....PARANOID, PREOCCUPIED Mental Status.....Alert Orientation.....Person Place Time Patient Appearance.....Clean Independent ADLs.....Y Eating Independently.....Y Sleep Pattern.....Normal Attendance to Meetings.....Intermittent Participation in Meetings.....With Encouragement Compliance With Medications.....Y Seclusions and or Restraints...N Behavior.....Anxious Compliant Interacting with Peers Restless Suspicious Speech.....Low Volume Clear Mood and Affect.....Anxious Apprehensive Blunted Constricted Dysphoric Frustrated Suspicious Preoccupied Delusions.....N Hallucinations.....Auditory Thought Process.....Circumstantial Goal Oriented Insight and Judgment.....Poor Danger to self or Others.....N Suicidal Thoughts.....N Does Patient Have a Plan.....N Homicidal Thoughts.....N Contract for Safety.....Y Contract for Nonviolence.....Y Psych Comment..... patient admits he has delusions that "people are following me in here." Court Date.....11/05/15 52E9900 Discharge Summary Document 11/13/15 1503 LC 11/13/15 1503 LC Was Patient Specific Education Provided Identified by CERHT....Y This is patient education content provided via the Info Button CERHT=Certified Electronic Health Record Technology Were the Problems or Medications or Labs Reviewed.....Y Education Pertinence... ..MENTAL HEALTH DISEASE AND MEDICATION COMPLIANCE Education Topics.....Medications Signs and Symptoms Additional Education Topics...			
5500080 Discharge Summary Document 11/13/15 1536 LC 11/13/15 1547 LC Discharge Assessment Discharge Date from Unit.....11/13/15 Discharge Time from Unit.....1530 Discharged To.....Home Transfer Information Sent.....N Report Given to Receiving Facility.....N Name and Title of Person Receiving Report Accompanied By.....Self Discharge Mode.....Walking Transport.....Cab VTE Confirmed.....N If Yes MUST Answer Discharge Questions Below Acute Stroke.....N If Yes MUST answer Stroke Education and Rehab Questions Below Mental Status at Discharge.....Alert Oriented Was Patient Specific Education Provided Identified by CERHT....Y This is patient education content provided via the Info Button CERHT=Certified Electronic Health Record			

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Date Range Beginning 11/13/15

Kerco Philadelphia Hospital PCS **LIVE** Archived Discharge Summary

Printed: 11/17/15 at 0035

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DIS IN

11/03/15 at 0715

Activity	Occurred	Recorded	At	Time/Target	By	Change	Activity	Occurred	Recorded	At	Time/Target	By	Change
Type	Date	Time	By	Date	Time	By	Type	Date	Time	By	Date	Time	By
5500080	Discharge Plan						Ed Status	11/13/15 1551 his	11/13/15 1551 his				
Technology							5500080	Discharge Plan					
Were the Problems or Medications or Labs Reviewed.....Y							Ed Status	11/13/15 1551 his	11/13/15 1551 his				
Was Patient Portal Enrollment Completed.....N													
A No response requires a reason													
Was Patient Portal Accessed and Viewed.....N													
A No response requires a reason													
Was a PHS Printed or Downloaded for the Patient.....Y													
PHS=Patient Health Summary													
Education.....Medications													
.....Plan of Care													
.....Diagnosis													
Understanding of Discharge Instructions...													
..Understands Condition													
..Willing to Follow Up													
..Understands Instructions													
..Patient Educated													
Translator or Translator Phone Used.....N													
Hygiene.....Self													
Toilet.....Self													
Dressing.....Self													
Eating.....Self													
Bathing.....Self													
Pain Free.....Y													
Document 11/13/15 1536 LC 11/13/15 1547 LC DC Tobacco Cessation													
Tobacco Use in Past 30 Days.....Y													
Interest Expressed in Tobacco Cessation Information...N													
Tobacco Cessation Information Provided.....Patient Declined													
Tobacco Cessation Medication Offered at Discharge.....Patient Declined													
Date: 11/13/15 1551													
0010012 Ambulate Up Ad Lib													
Ed Status 11/13/15 1551 his 11/13/15 1551 his													
0040004 Discharge													
Ed Status 11/13/15 1551 his 11/13/15 1551 his													
0255400 Patient Room Registration													
Ed Status 11/13/15 1551 his 11/13/15 1551 his													
0500000 Vitals													
Ed Status 11/13/15 1551 his 11/13/15 1551 his													
0500013 Report Critical Care Refill													
Ed Status 11/13/15 1551 his 11/13/15 1551 his													
1000201 Change of Condition/Status													
Ed Status 11/13/15 1551 his 11/13/15 1551 his													
1750030 Add Assessment													
Ed Status 11/13/15 1551 his 11/13/15 1551 his													
2750001 Pain Assessment													
Ed Status 11/13/15 1551 his 11/13/15 1551 his													
3250001 Medications Assessment													
Ed Status 11/13/15 1551 his 11/13/15 1551 his													
3750140 Health Status													
Ed Status 11/13/15 1551 his 11/13/15 1551 his													
4600065 Medication Assessment													
Ed Status 11/13/15 1551 his 11/13/15 1551 his													
5000510 Care Plan/Assessment/Service													
Ed Status 11/13/15 1551 his 11/13/15 1551 his													
5259900 Change Record													
Ed Status 11/13/15 1551 his 11/13/15 1551 his													
5500080 Care Management Assessment/Discharge Plan													

Monogram	Initials	Name	Care Provider Type
DR	PHOROW	LEONDA BROOKFELDER	MD
DR	PHOROW	DAVID BLUMBERG	MD
DR	PHOROW	JUSTIN CARPENTON	MD
DR	PHOROW	JAMES D. BAKER	MD
DR	PHOROW	JOANNE MCCOLLIN	MD
DR	PHOROW	JAIME JORDAN	MD
DR	PHOROW	JOHN E. BROOKFELDER	MD
DR	PHOROW	KEVIN STEWART	MD
DR	PHOROW	KYDIA CLEMENTS	MD
DR	PHOROW	MARK A. MULLER	MD
DR	PHOROW	MARSHALL MOORE	MD
DR	PHOROW	MOHAMED M. BAK	MD
DR	PHOROW	MADINE PATILANI	MD
DR	PHOROW	PARMEENA KASS	MD
DR	PHOROW	REYNALDO PUSAN	MD
DR	PHOROW	RENKA PALMER	MD
DR	PHOROW	SHARON A. HAYES	MD
DR	PHOROW	SONIA DASH	MD
DR	PHOROW	SHARAF SUWART	MD
DR	PHOROW	SHARIF YOUS	MD
DR	PHOROW	SALAH HOSMAN	MD
DR	PHOROW	SHARON A. HAYES	MD

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CRC
Point of Care Result Form

VITAL SIGNS

TEMP	PULSE	RESP	BP	Staff Signature	Time	Date
98.5	160	20	125/80	Hammel	8:50p	11-2-15

BREATHALYZER (Mandatory for all patients evaluated in the CRC, 8 years or older.)

Patient Result	Reference Range	Staff Signature	Time	Date
100	0			
	0			
	0			

ACCU CHEK® GLUCOSE

Patient Result mg/dl	Reference Range	Staff Signature	Time	Date
/	70 - 109 mg/dl			
	70 - 109 mg/dl			
	70 - 109 mg/dl			

URINE PREGNANCY (Mandatory for all female patients admitted to inpatient)

Patient Result	Reference Range	Staff Signature	Time	Date
/	Negative			

URINE DRUG SCREEN (Indicate "+" where results are positive and leave boxes with negative results blank.)

AMPH	BENZ	COC	THC	OPI	TRIC
BARB	PCP	METHADONE	PROPOXY	OXYCODONE	METHAMPH

CHECK HERE IF ALL UDS RESULTS ARE NEGATIVE _____ Staff Initials _____

Tape HCG result here if slip is available.

Mercy Philadelphia Hospital
A member of Mercy Health System

Point of Care Result Form



Page 1 of 1
Form CRC057, Rev. 03/2013
PCS POC.REHAB

CHILDS, HANEEF A

DOB
A
AC



75

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INPATIENT PSYCHIATRIC UNIT TREATMENT PLANS

The problem, goals and interventions in the Preliminary Treatment Plan that guide the care for the first 24 hours are based on the Assessments of the admitting staff. The Master Treatment Plan is completed by the Treatment Team within 72 hours and guides the continuing course of treatment.

(1) Problem Area: Auditory hallucinations saying people are trying to kill his family

Long Term Goal: Upon MC Pt. will be free from auditory hallucinations

Short Term Goal: While on the unit, Pt. will begin to be free from

Specific Interventions: A/H -

- ① Administer med. as ordered, education and plan for A/H -
- ② Encourage Pt. to verbalize his feelings and concerns about his hallucinations to staff.
- ③ Encourage Pt. to attend groups with participation

(2) Problem Area: Non-compliance with medications as evidenced by him not taking his medications for 30 days

Long Term Goal: Upon MC Pt. will be compliant with his medications

Short Term Goal: While on the unit, Pt. will begin to be compliant

Specific Interventions: with his meds -

- ① Educate Pt. on the importance of taking his meds and administer as ordered.
- ② Encourage Pt. to verbalize feelings and concerns to staff.
- ③ Involve Pt. in unit's activity as needed.

(3) Problem Area: 100 Marijuana Use

Long Term Goal: Pt. will attend NA meetings

Short Term Goal: While on the unit Pt. will attend NA group meetings

Specific Interventions:

- ① Encourage Pt. to attend groups with participation
- ② Administer med. as ordered and plan for withdrawal symptoms -

Harriet Chell
Consumer's Signature

[Signature] MD
Physician's Signature

Melvin M. Bohm
Nurse's Signature

[Signature]
Social Worker's Signature

11/3/15
Date

2:10 p
Time

11/3/15
Date

2:10 PM
Time

11/3/15
Date

2PM
Time

11/3/15
Date

8:30 AM
Time

The signature above indicates participation in the development of and agreement with the proposed Preliminary Treatment Plan.

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A member of Mercy Health System

PRELIMINARY AND MASTER TREATMENT PLAN



Page 1 of 6
Form PS342, Rev. 01/2011
PCS, X OTHER

CHILDS, HANEE
DOB: [REDACTED]
Ad: [REDACTED]
Ac: [REDACTED]



Department of Psychiatry

PRELIMINARY AND MASTER TREATMENT PLANS
CONSUMER CONTRIBUTIONS TO TREATMENT PLAN

I feel that I have the following Positive Strengths:

- | | |
|---|---|
| ☐ I have positive/stable relationships. | ☒ I am physically healthy. |
| ☐ I have good social skills. | ☐ I have job or work skills. |
| ☒ I am able to talk about my problems and issues. | ☐ I have a stable place to live. |
| ☐ I am independent. | ☐ I take my medication as prescribed. |
| ☐ I voluntarily asked for help. | ☐ I have had successful treatment in the past. |
| ☐ I have a history of being clean and sober. | ☐ I am motivated for treatment. |
| ☐ My family supports my treatment. | ☐ I have several people in my support system. |
| ☐ My support system includes: | |
| ☒ I need little or no help with my Activities of Daily Living, for example bathing, hygiene, or meal preparation. | |
| ☐ Other strengths: | |

I feel that the following may be barriers or obstacle to my treatment:

- | | |
|---|--|
| ☒ I need better coping skills. | ☒ I have a history of substance abuse. |
| ☒ I am presently homeless. | ☐ I have been unable to work. |
| ☐ I have had mental health problems for a long time. | ☐ I have problems with my health. |
| ☐ I have transportation problems | ☐ I am not able to care for myself. |
| ☐ I have a lack of income. | ☐ I am involved with the legal system. |
| ☐ I have been involuntarily committed to the hospital. | ☒ I do not have much motivation for treatment. |
| ☐ I have a limited support system | ☐ I have not been taking my medications. |
| ☐ I have a history of physical or psychological abuse. | ☐ I have family problems. |
| ☐ I have marriage or relationship problems. | |
| ☐ Other barriers: | |

Reason(s) for My Hospitalization: people were following me

I think that my Treatment Plan should include the following:

Journals

I have had an opportunity to add to my treatment plan.

(If Consumer chooses not to add to the Treatment Plan, they should still initial).

Consumer's Signature: Hameed Chiz Date: 11/3/15

Mercy Philadelphia Hospital
A member of Mercy Health System

PRELIMINARY AND MASTER TREATMENT PLAN



Page 2 of 6
Form PG342, Rev. 01/2011
PCS X OTHER

CHILDS, HANEEF A

DOB: [REDACTED]
Adm: [REDACTED]
Acc: [REDACTED]



407

MASTER TREATMENT PLAN

Reason(s) for Hospitalization: HANEEF IS A REYO SMY ALLIANCE FOR BY KIDNEY FOR OUTPATIENT SYMPTOMS OF PSYCHIATRY
AND DISORDER

Patient Strengths/Assess:

- | | | | |
|--|--|--|---|
| ☒ Has positive/stable relationships | ☐ Physically healthy | ☒ Positive social skills | ☐ Has job skills |
| ☒ History of good response to medication | ☒ Has support system | ☒ Able to verbalize issues | ☒ Stable housing |
| ☐ Needs little or no help with ADL's | ☐ Lives independently | ☐ Medication compliant | ☐ Voluntary patient |
| ☒ History of successful treatment | ☐ History of sobriety | ☐ Motivated for treatment | ☒ Supportive family |
| ☐ Other(s): _____ | | | |

Barriers/Obstacles to Treatment:

- | | | | |
|--|---|--|---|
| ☒ Poor coping skills | ☒ History of substance abuse | ☐ Homeless | ☐ Occupational problem |
| ☒ Chronic mental illness | ☐ Medical/Health Problems | ☐ Transportation problems | ☐ Poor self-care/ADL's |
| ☐ Lack of income | ☒ Involvement with legal system | ☒ Involuntary commitment | ☐ Lack of motivation |
| ☒ Limited support system | ☒ Poor medication compliance | ☐ History of abuse/trauma | ☐ Family problems |
| ☐ Other(s): _____ | | | |

DSM-V/ ICD10:

SMITHSONIAN D/O SCHIZOPHRENIA D/O-BIPOLAR D/O
CAUTION USE MD

Discharge Criteria: HANEEF will be able to independently manage his dual diagnosis symptoms to allow for
fulltime hospital ADL's. INPATIENT level of care

THIS PLAN WILL BE UPDATED IN SEVEN DAYS.

The signatures below reflect the involvement of the consumer and the Multidisciplinary Team Members in the development of the Preliminary and Master Treatment Plans.

Psychiatrist	<u>[Signature]</u>	<u>11-3-15</u>	<u>1:55 PM</u>
Nurse	<u>[Signature]</u>	<u>11/3/15</u>	<u>2 PM</u>
Therapist	<u>U. Albi</u>	<u>11-3-15</u>	<u>2 PM</u>
Case Manager	<u>[Signature]</u>	<u>11/3/15</u>	<u>1 PM</u>
Social Worker	<u>[Signature]</u>	<u>11/3/15</u>	<u>2 PM</u>
Consumer	<u>[Signature]</u>	<u>11/3/15</u>	<u>2 PM</u>

☐ Refused to Sign (Witness/Reason): _____

Mercy Philadelphia Hospital
 A member of Mercy Health System

RELIMINARY AND MASTER TREATMENT PLAN



Page 3 of 6
 Form PS342, Rev. 10/2013
 PGS X.OTHER

CHILDS, HANEEF A
 DOB: 01/10/1988
 Address: [REDACTED]



408

Problem: MANIC EPISODES WITH DOMINANT SYMPTOMS OF PSYCHOTIC DISORGANIZATION

Evidenced by: FOR ALLEGATIONS OF MEDICATED NONCOMPLIANCE, OUTPATIENT PARANOID BELIEFS HE IS BEING FOLLOWED & PEOPLE ARE TRYING TO KILL HIM

Long Term Goal(s): CONTROL OR ELIMINATE PARANOID AND ADDRESS ISSUES OF MEDICATION & TREATMENT COMPLIANCE

Short Term Goal(s): WORK TO STABILIZE MENTAL HEALTH SYMPTOMS, PROMOTE HEALTHY-BASED THOUGHT PROCESSES AND DEVELOP POSITIVE COPING FOR SYMPTOMS

DISCIPLINE	INTERVENTION	FREQUENCY
Physician	<u>Prescribe & Monitor Psychotropic Medication</u> <u>Regular Psychiatric Interviews</u>	<u>Daily</u> <u>Daily</u>
Nurse	<u>Encourage pt. to verbalize his feelings and concerns,</u> <u>Encourage pt. to attend groups with participation</u>	<u>Daily</u>
Therapist	<u>Identify goals for treatment</u> <u>Verbalize barriers to compliance</u>	<u>7-9 AM daily</u> <u>Individual x 2x/week</u>

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RELIMINARY AND MASTER TREATMENT PLAN



Page 4 of 6
Form PS342, Rev. 01/2011
PCS, X OTHER

CHILDS, HANEE D

DOB
A
P



Problem: HANEEF HAS A HISTORY OF SUBSTANCE ABUSE

Evidenced by: SELF-REPORTED HISTORY OF CRACK COCAINE + URSA @ MARIJUANA

Long Term Goal(s): ESTABLISH + MAINTAIN SUBSTANCE-FREE LIFESTYLE

Short Term Goal(s): INITIATE RECOVERY PROCESS, PARTICIPATE IN ADDICTION/RECOVERY GROUPS AND JOIN/LEAD AFTER-SCHOOL PROGRAM PLAN

DISCIPLINE	INTERVENTION	FREQUENCY
Physician	<u>Dx & Education</u>	<u>Daily</u>
Nurse	<u>Allow pt to vent his feelings and concerns - Monitor pt and treat for substance abuse withdrawal</u>	<u>Daily</u>
Therapist	<u>IDENTIFY sources of support in recovery</u>	<u>individual ext out</u>
	<u>IDENTIFY impacts of substance abuse on mental health</u>	<u>group ext out</u>

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PRELIMINARY AND MASTER TREATMENT PLAN



Page 5 of 6
Form PS342, Rev. 01/2011
PCS X OTHER

CHILDS, HANEEF A



Problem: Suicide attempt

Evidenced by: attempting to hang himself with towels standing on the bed with towels anchored through the ceiling vent in Rm 218-bed 3.

Long Term Goal(s): Pt. will practice good coping skills and avoid S/A.

Short Term Goal(s): On the unit, Pt. will begin to practice good coping skills

DISCIPLINE	INTERVENTION	FREQUENCY
Physician	- Continue medication - Risperidone 400	daily daily
Nurse	Encourage Pt. to verbalize feelings and concerns to staff. Monitor Pt. 1:1 on arms length and good eye sight to prevent S/A	daily / continuous
Therapist	- IMEDIATE positive coping for mood related issues - IMEDIATE de-escalation to avoid any harm on person - 1:1 safety	group therapy - individual and

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PRELIMINARY AND MASTER TREATMENT PLAN



Page 8 of 8
Form PS342, Rev. 01/2011
PCS X OTHER

CHILDS, HANEEF A



Department of Psychiatry
Aftercare Plan

I, Hameed Childs have developed the following Aftercare Plan. I give my consent to the Treatment Team to contact the treatment facility I have been referred to for the purpose of making a follow-up contact. I understand that the overall goal and objective of these contacts and the Aftercare Plan is the continuous support for the progress I have already made in my recovery.

Problem Areas: (Family, job, physical, housing, special needs etc).

1. History of mental health
2. History of substance abuse THE
3. _____

Personal Goals/Objectives: (What I need to do to begin working on in reference to the above problems).

1. The pt will be able to make a list of the social work needs
2. to develop his life plan, he will be able to ID all of his med
3. and their side effects. The pt will be able to attend all of his
4. treatment groups in order to gain insight into his situation
5. and 1-2 coping skills in order to manage his mlt condition

My Next Step in Treatment:

I am going to: NET
(Name of Program)

Address: 5501 Chestnut St
25-747-6480

Mercy Philadelphia Hospital
A member of Mercy Health System

Aftercare Plan



Page 1 of 4
Form PS340, Rev. 01/2011
PCS POC.PLANCAR

CHILDS, HAMEED A

DOB: [REDACTED]
Ad: [REDACTED]
Ad: [REDACTED]



412

The length of this next step in treatment is 17 days

My appointment is on 11/16/15 at 1:30 PM

My contact person is Tina

Their telephone number is [REDACTED]

I understand that if I need help with my aftercare, I can call the Inpatient Detoxification staff at Mercy Philadelphia Hospital.

My contact here is:

Renee Blum
Staff Name

Tele [REDACTED]

I may also call or visit Mercy Philadelphia Hospital's Crisis Response Center (CRC) at 215-748-9525.

Harriet Chib
Consumer Signature

11/13/15
Date

3:00 pm
Time

Renee Blum
Counselor Signature

11/13/15
Date

3:00 pm
Time

Mercy Philadelphia Hospital
A member of Mercy Health System

TER CARE PLAN



Page 2 of 4
Form PS310, Rev. 01/2011
PGS POC PLANOR

CHILDS, HANDEE A

DO [REDACTED]
Ad [REDACTED]
Ac [REDACTED]



413

Department of Psychiatry
Discharge Note

Must include:

1. _____ Completion of therapeutic process
2. _____ Consumers behavior and attitude on discharge
3. _____ The consumers satisfaction with Aftercare arrangements
4. _____ Destination and mode of transportation
5. _____ Treatment outcomes (stable, improved, noncompliant)
6. _____ Consumer made aware of follow-up appointment and given copy of Aftercare

*see the social work
discharge note in the
computer*

Bruce Palmer M.D.

Signature

11/13/15

Date

3:00 pm

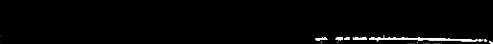
Time

 Mercy Philadelphia Hospital
A member of Mercy Health System

AFTER CARE PLAN



Page 4 of 4
Form PS340, Rev. 1/2011
PCS POC.PLANCAR

CHILDS, HANEEF A
DOB: 
Adm: 
Acc: 



415

Name: Harvey Charles Sex: M Date of Birth: [REDACTED]

☒ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Married/Common Law Number of years: _____

Current living environment: ☐ Lives alone ☒ Lives with family/roommates ☐ Homeless ☐ No ☐ Yes How long: _____

Years at current residence: 3 days ☐ Rented ☐ Owned ☐ Other: mother

Other people residing in the same housing: # _____ Can patient return home: ☐ No ☒ Yes

If children live in the same house: DHS involved ☐ No ☐ Yes DHS Worker's Name: _____

Name	Relationship	Supportive
<u>Amanda Moore</u>	<u>5</u>	☒ No ☐ Yes
<u>Shirley</u>	<u>6 mother</u>	☐ No ☒ Yes
_____	_____	☐ No ☐ Yes
_____	_____	☐ No ☐ Yes
_____	_____	☐ No ☐ Yes

Issues/Concerns with violence/abuse in the household. ☐ No ☐ Yes Details: _____

Current Financial Situation 70 a month food stamp

☒ Unemployed ☐ Welfare ☒ SSI/SSDI Last job: poor work history

Employed: ☒ No ☐ Yes Number of years at current job: 0 Position: 0 Salary: 0

Main occupation/profession: _____

Financial Obligations

☐ Rent ☐ Food ☐ Personal Needs ☐ Child support ☐ No ☐ Yes Amount: _____ Alimony ☐ No ☐ Yes

Amount: _____ Other: _____

Educational/Vocational History

11th grade completed 11th grade

Finished High School. ☒ No ☐ Yes Year of graduation: _____ Currently in school: ☒ No ☐ Yes

Attended College/Vocational School: ☒ No ☐ Yes Degree obtained: _____

Legal History

Ever arrested: ☐ No ☒ Yes If yes number of arrest: 2 times assault, gun charge

Ever incarcerated: ☐ No ☒ Yes Nature of charges leading to incarceration: 15 months

Currently on probation/parole: ☐ No ☒ Yes If yes name of Probation/Parole Officer: VAK

When did probation start: 2009 When will it end: 2010

Any open cases: ☒ No ☐ Yes If yes next court date: 0

Nature of charge: 0

Mercy Philadelphia Hospital
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Social Worker Psycho-Social Evaluation



Page 1 of 2
Form PS345, Rev. 02/2011
PCS X OTHER

CHILDS NUMBER [REDACTED]



4116

Military History

Military Service: ☒ No ☐ Yes If yes duration of Service: _____ Rank: _____

Condition of Discharge: ☐ Honorable ☐ Dishonorable Other than Honorable: _____

VA connected ☒ No ☐ Yes

Treatment History

Age of first treatment: mit 21 DA 7 0 Currently in treatment: ☒ No ☐ Yes Name of Outpatient Provider/ Agency:

KBC First visit: _____ Last visit: _____

Nature of treatment received: _____ Next appointment: _____

Name of Psychiatrist: _____ Phone #: _____

Name of Therapist: _____ Phone #: _____

Name of ICM/Resource Coordinator: _____ Phone #: _____

Other Agencies/Worker involved: ☒ No ☐ Yes Details: _____

Compliant with medication: ☒ No ☐ Yes Compliant with attendance: ☒ No ☐ Yes

Medical Treatment

Primary Care Physician's Name: _____ Phone #: _____

Last visit: _____ Next visit: _____

Specialist I: _____ Phone #: _____

Last visit: _____ Next visit: _____

Specialist II: _____ Phone #: _____

Last visit: _____ Next visit: _____

Specialized Drug and Alcohol treatment: ☐ No ☐ Yes Details: CAR

Contact Name with treatment providers: ☐ No ☐ Yes Consent obtained: ☐ No ☐ Yes

Details/result of contact made: _____

Current supports: mother

Emergency contact: mother

Contact made: ☐ No ☒ Yes Details: mother agree to attend in H court

Tentative Disposition Plan: return home w/ 48 hrs for follow up care

Completed by: Renee Blumstein Date & Time: 11/13/15 3:45 pm

****Please attach all the consents obtained during the treatment.**

 Mercy Philadelphia Hospital
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Social Worker Psycho-Social Evaluation



Page 2 of 2
Form PS345, Rev. 02/2011
PCS X.OTHER

CHILDS, HANDEE



412

NON-RESPONSIBILITY FOR PATIENT VALUABLES,
MONEY, OR PERSONAL BELONGINGS

WE UNDERSTAND AND AGREE THAT MERCY HEALTH SYSTEM IS NOT RESPONSIBLE FOR PATIENT VALUABLES, MONEY, EYEGLASSES, DENTURES OR OTHER PERSONAL BELONGINGS BROUGHT TO THE HOSPITAL AT THE BEGINNING OR DURING THE STAY IN THE HOSPITAL. I RESUME FULL RESPONSIBILITY FOR SUCH ITEMS.

X refused to sign
PATIENT SIGNATURE

11/3/15
DATE

Mercy Philadelphia Hospital
A member of Mercy Health System

NON-RESPONSIBILITY FOR PATIENT BELONGINGS



Page 1 of 1
Form PCS001, Rev. 06/2012
PGS.X OTHER

CHILDS, HANEEF A

DOB: 01/15/1980

A

A



915

- ☐ SP I (Q15 Minute check)
☐ SP II (Continuous 1 - 1 / arms length)
☐ PSP I (Q15 Minute check)
☐ PSP II (Continuous Eyesight Observation)
☐ PSP III (Continuous 1 - 1 / arms length)

- ☐ Elopement Precautions
☐ Arson Precautions
☐ Smoking Precautions
☐ Assault Precautions

SPECIAL PATIENT OBSERVATION RECORD

10/14/15

TIME	08:00 AM				09:00 AM				10:00 AM				11:00 AM				12:00 PM				01:00 PM				02:00 PM				03:00 PM				INT	Date <u>10/14/15</u> Staff Signature	Assigned Time
	00	15	30	45	00	15	30	45	00	15	30	45	00	15	30	45	00	15	30	45	00	15	30	45	00	15	30	45							
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Comments (Document significant behaviors not listed in progress notes)

TIME	04:00 PM				05:00 PM				06:00 PM				07:00 PM				08:00 PM				09:00 PM				10:00 PM				11:00 PM				INT	Date <u>10/14/15</u> Staff Signature	Assigned Time
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Comments (Document significant behaviors not listed in progress notes)

TIME	12:00 AM				01:00 AM				02:00 AM				03:00 AM				04:00 AM				05:00 AM				06:00 AM				07:00 AM				INT	Date <u>10/14/15</u> Staff Signature	Assigned Time
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Comments (Document significant behaviors not listed in progress notes)


 Mercy Philadelphia Hospital
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SPECIAL PATIENT OBSERVATION RECORD



Page 1 of 1
 Form #NS477, Rev. 01/2011
 PCS.F.O.OTRE

CHILDS, HANEEF A
 DOB: [REDACTED]



u/a

- ☐ SP I (Q15 Minute check)
☐ SP II (Continuous 1 - 1 / arms length)
☐ PSP I (Q15 Minute check)
☐ PSP II (Continuous Eyesight Observation)
☐ PSP III (Continuous 1 - 1 / arms length)

- ☐ Elopement Precautions
☐ Arson Precautions
☐ Smoking Precautions
☐ Assault Precautions

SPECIAL PATIENT OBSERVATION RECORD

TIME	08:00 AM				09:00 AM				10:00 AM				11:00 AM				12:00 PM				01:00 PM				02:00 PM				03:00 PM				INT	Date <u>11/5/15</u> Staff Signature 	Assigned Time
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Comments (Document significant behaviors not listed in progress notes)

TIME	04:00 PM				05:00 PM				06:00 PM				07:00 PM				08:00 PM				09:00 PM				10:00 PM				11:00 PM				INT	Date <u>11/12/15</u> Staff Signature <u>[Signature]</u>	Assigned Time
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Comments (Document significant behaviors not listed in progress notes)

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Comments (Document significant behaviors not listed in progress notes)

 Philadelphia Hospital
 A member of Mercy Health System

SPECIAL PATIENT OBSERVATION RECORD



CHILDS, HANEE A

[REDACTED]
 [REDACTED]
 [REDACTED]



- ☐ SP I (Q15 Minute check)
☐ SP II (Continuous 1 - 1 / arms length)
☐ PSP I (Q15 Minute check)
☐ PSP II (Continuous Eyesight Observation)
☐ PSP III (Continuous 1 - 1 / arms length)

- ☐ Elopement Precautions
☐ Arson Precautions
☐ Smoking Precautions
☐ Assault Precautions

SPECIAL PATIENT OBSERVATION RECORD

TIME	08:00 AM				09:00 AM				10:00 AM				11:00 AM				12:00 PM				01:00 PM				02:00 PM				03:00 PM				INT	Date <u>11/21/16</u> Staff Signature	Assigned Time
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Comments (Document significant behaviors not listed in progress notes)

TIME	04:00 PM				05:00 PM				06:00 PM				07:00 PM				08:00 PM				09:00 PM				10:00 PM				11:00 PM				INT	Date <u>11/21/16</u> Staff Signature	Assigned Time
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Agitated																																			

Comments (Document significant behaviors not listed in progress notes)

TIME	12:00 AM				01:00 AM				02:00 AM				03:00 AM				04:00 AM				05:00 AM				06:00 AM				07:00 AM				INT	Date <u>11/21/16</u> Staff Signature	Assigned Time
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Comments (Document significant behaviors not listed in progress notes)

University of Pennsylvania Hospital
 A member of Mercy Health System

SPECIAL PATIENT OBSERVATION RECORD



CHILDS, HANEEF A

DOB: 01/21/1988

Ac

Ac



NR

- ☐ SP I (Q15 Minute check)
☐ SP II (Continuous 1 - 1 / arms length)
☐ PSP I (Q15 Minute check)
☐ PSP II (Continuous Eyesight Observation)
☐ PSP III (Continuous 1 - 1 / arms length)

- ☐ Elopement Precautions
☐ Arson Precautions
☐ Smoking Precautions
☐ Assault Precautions

SPECIAL PATIENT OBSERVATION RECORD

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Comments (Document significant behaviors not listed in progress notes)

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Comments (Document significant behaviors not listed in progress notes)


Mercy Philadelphia Hospital
 A member of Mercy Health System

SPECIAL PATIENT OBSERVATION RECORD



CHILDS, EDWARD

D
 A
 A

MR#: M000611175



22

- ☐ SP I
☐ SP II
☐ PSP I
☐ PSP II
☐ PSP III

(Q15 Minute check)
 (Continuous 1 - 1 / arms length)
 (Q15 Minute check)
 (Continuous Eyesight Observation)
 (Continuous 1 - 1 / arms length)

- ☐ Elopement Precautions
☐ Arson Precautions
☐ Smoking Precautions
☐ Assault Precautions

SPECIAL PATIENT OBSERVATION RECORD

11/8/15

SPECIAL PATIENT OBSERVATION RECORD																																	Date <u>11/1/20</u>	Assignee																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																							
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Comments (Document significant behaviors not listed in progress notes)

11/8/2015

Comments (Document significant behaviors not noted in program notes)																																	Date <u>1/1</u>	Assigne	
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Sleeping																																			
Withdrawn																																			
Active	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Agitated																																			

Comments (Document significant behaviors not listed in progress notes)

Comments (Document significant behaviors not listed in progress)																																	Date / J /	Assigne	
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Active																																			
Agitated																																			

Comments (Document significant behaviors not listed in progress notes)

Mercy Philadelphia Hospital
 A member of Mercy Health System

SPECIAL PATIENT OBSERVATION RECORD



Page 1 of 1
 Form 20S477, Rev. 01/2011
 PCSFLO.OTHER

CHILDS, HANEEF A

DOB: [REDACTED]
 [REDACTED]
 [REDACTED] 175



423

- ☐ SP I
☐ SP II
☐ PSP I
☐ PSP II
☐ PSP III

(Q15 Minute check)
(Continuous 1 - 1 / arms length)
(Q15 Minute check)
(Continuous Eyesight Observation)
(Continuous 1 - 1 / arms length)

- ☐ Elopement Precautions
☐ Arson Precautions
☐ Smoking Precautions
☐ Assault Precautions

SPECIAL PATIENT OBSERVATION RECORD

TIME	08:00 AM				09:00 AM				10:00 AM				11:00 AM				12:00 PM				01:00 PM				02:00 PM				03:00 PM				INT	Date / J / Staff Signature	Assigned Time
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Comments (Document significant behaviors not listed in progress notes)

TIME	04:00 PM				05:00 PM				06:00 PM				07:00 PM				08:00 PM				09:00 PM				10:00 PM				11:00 PM				INT	Date / J / Staff Signature	Assigned Time
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Comments (Document significant behaviors not listed in progress notes)

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Comments (Document significant behaviors not listed in progress notes)

Philadelphia Hospital
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SPECIAL PATIENT OBSERVATION RECORD



Page 1 of 1
Form RNS177, Rev. 01/2011
PCS.FLO.OTHER

CHILDS, HANEEF A

DOB
Adm
Ac



Date of Admission: 11-3-15 Day Update: 7 Date of Next Anticipated Update: 11-12-15

Review of Progress: HANEEF HAS MADE LITTLE PROGRESS SINCE LAST REVIEW OF SYMPTOMS. HANEEF
CONTINUES TO EXHIBIT SYMPTOMS OF PSYCHOTIC + MOOD INSTABILITY (SPRINKLES PARANOID DELUSIONS, CARRYING OUT VIOLENT
ACTIONS BEHAVIORS) IMPAIRING HIS ABILITY TO FUNCTION INDEPENDENTLY OUTSIDE HOSPITAL. (INCLUDING TENDENCY
TO INFLAME SIBLING ARGUMENTS + FIGHTS)

HANEEF CONTINUES TO BECOME PROGRESSIVE FOR MEDICAL + MEDICATION COMPLIANCE

Problem Areas Resolved : ↓ LABILITY + PSYCHOTIC

Newly Identified Problem Area(s): None

Rationale for Continued Hospitalization: Continued exacerbation of psychotic symptoms +
involvement of discharge plans

The Treatment Plan review reflects the progress/lack of progress made towards realization of identified goals. Treatment Plan updates are completed seven (7) days after the development of the Comprehensive Plan. The signatures below reflect the involvement of both the consumer and multi-disciplinary team members.

Psychiatrist

Date

Time

Nurse

Date

Time

Counselor

Date

Time

Social Worker

Date

Time

Consumer/Guardian

Date

Time

Refused to Sign (Witness/Reason)

Date

Time

Mercy Philadelphia Hospital
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Treatment Plan Update



Page 1 of 4
Form PS343, Rev. 01/2011
POS X, OTHER

CHILDS, HANEEF A

DOB
A
A



75

475

Problem: HANEEF CONTINUES TO EXHIBIT SYMPTOMS/SYMPTOMS (DISORDER/CONDITION)

Evidenced by: EXPRESSIVE PARANOID BELIEFS (PEOPLE FOLLOWING HIM) + CONTINUED AGGRESSIVE BEHAVIOR, LAYING ON FLOOR

Long Term Goal(s): STABLE MOOD, CONTROL OF CURRENT BEHAVIOR AND ADDRESS ISSUES OF MEDICATION TREATMENT COMPLIANCE

Short Term Goal(s): CONTINUE TO WORK TO STABILIZE MOOD + CURRENT BEHAVIOR SYMPTOMS, ENCOURAGE POSITIVE BEHAVIOR THROUGH REINFORCEMENT AND DEVELOP POSITIVE COPING FOR SYMPTOMS

DISCIPLINE	INTERVENTION	FREQUENCY
Physician	Prescribe + Monitor Psychotropic Medications	Daily
	Regular Psychiatric Interviews	Daily
Nurse	Get firm limits on PB behavior.	Daily
	Administer meds as ordered with observation	
Therapist	Identify supports outside hospital	as needed, 2x/week
	Work on coping skills - relaxation	as needed, daily
	Monitor	as needed, daily

Mercy Philadelphia Hospital
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Payment Plan Update



Page 2 of 4
Form PS343, Rev. 01/2011
PCS X OTHER

CHILDS, HANEEF A

DOB
AC
AC



420

Problem: HANDER has a history of substance abuse

Evidenced by: SELF-REPORTED HISTORY OF MARIJUANA
USE @ MARIJUANA upon admission

Long Term Goal(s): Establish & maintain a substance-free lifestyle

Short Term Goal(s): increase therapy process, participate in individual, group and community.
relapse prevention plan.

DISCIPLINE	INTERVENTION	FREQUENCY
Physician	<u>D & A Education</u>	<u>Daily</u>
Nurse	<u>Monitor Pt. for</u> <u>S/S of substance abuse</u> <u>w/ physical and/or heart</u> <u>as need with med.</u>	<u>Daily</u>
Therapist	<u>Encourage Pt. to</u> <u>attend groups with</u> <u>participation</u>	<u>twice weekly</u> <u>relapse prevention</u> <u>relapse prevention strategies</u> <u>groups - daily</u>

Mercy Philadelphia Hospital
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Treatment Plan Update



Page 3 of 4
Form PS343, Rev. 01/2011
PCS, X, OTHER

CHI
DOB
Adm
Acc



427

REF ID: A66051175

Accounting

PA1303162331

CHILDS, HANEEF A

11452

[illegible]

27 M Appending: MADSOOD, ZAMIR, MD

CHILDS, HANEEF A

ADDITIONAL Interventions	INIT BY	COMP BY	START D/T/M	Frequency	STS
Behavior: Cont. Observation	DOM		11/04/15	Continuous	X
CHAP: Nutritional Care: Solid Cus	DOM		11/05/15	Continuous	X
Vital: Cont. Observation	DOM		11/03/15	Continuous	X
Care Management: Assessment & Plan	DOM		11/12/15	Continuous	X
Discharge	DOM		11/13/15	Continuous	X

Monogram	Initials	Name	Care Provider Type
DR	PHHOCTRD	DAVID HOKTCH	SC
JO	PHOTGJ	JAMIE OGBNS	RN
JRH	PHNAVILLJ	JOHN R HAMILTON	RN
LC	PHCLEMEL	LYDIA CLEMENTS	RN
KAY	CONOVITH	MARK A NOVITSKY	
RE	COPUSSAR	REYNALDO FUSSAN	
RP	PHPALMER	RENEA PALMER	SR
SHR	PHBARKSU	SJN H BARK	RN

629

DE-BRIEFING REPORT FOR LOCKED SECLUSION AND RESTRAINTS

Date: 11/24/15 Time: 3:30 PM

Staff Participants: Ger GARY MHT, James Baker, Todd DAVIS MHT,
George DOVE MHT

Others: Security Staff

(Precipitating Factors)

WHAT LED TO THE INCIDENT?

Pt became very combative, after attempting suicide by trying to
hang himself with towels anchored through the cath vent in room 218.

HOW COULD THIS EVENT HAVE BEEN HANDLED DIFFERENTLY BY THE STAFF?

Pt could have been co-operative with staff and calmed down.

HOW COULD THIS EVENT HAVE BEEN HANDLED DIFFERENTLY BY THE PATIENT?

Pt needed to be calmer

HOW DO YOU FEEL REGARDING THE CARE THAT WAS PROVIDED TO YOU?

Were your needs met? ☒ Yes ☐ No
 Were you treated with respect? ☒ Yes ☐ No
 Was your privacy maintained? ☒ Yes ☐ No

WERE THERE INJURIES TO STAFF? ☐ Yes ☒ No

WERE THERE INJURIES TO PATIENT? ☐ Yes ☒ No

IF YES, HOW COULD INJURIES BEEN AVOIDED?

N/A

DISCUSS THE PATIENTS RESPONSE TO THE PROCEDURE?

Pt asleep at this time

HAVE GOALS AND INTERVENTIONS BEEN ADDED TO THE TREATMENT PLAN TO PREVENT FURTHER EPISODES? ☐ Yes ☐ No

Comments:

Yes

Signatures:

Mohamed M. Bahar
☒ Staff

Pt sleeping at this time
☒ Patient ☐ Family

See progress note for continued documentation

Mercy Philadelphia Hospital
 A member of Mercy Health System

DE-BRIEFING REPORT FOR LOCKED SECLUSION AND RESTRAINTS



Page 1 of 1
 Form PSYQEDR, Rev. 02/2015
 ASA X.BEHAV

DOB: [REDACTED]
 Adm: [REDACTED]
 Acc: [REDACTED]

CHILDS, HANEEF A



DE-BRIEFING REPORT FOR LOCKED SECLUSION AND RESTRAINTS

Date: 11/03/15 Time: PM

Staff Participants: James Baker, MHA, Gary G. MHA,

Others: Security Staff

(Precipitating Factors)
WHAT LED TO THE INCIDENT?

Pt. became very aggressive, started swinging at staff.

HOW COULD THIS EVENT HAVE BEEN HANDLED DIFFERENTLY BY THE STAFF?

Pt. needed to follow redirection and calm down on his own.

HOW COULD THIS EVENT HAVE BEEN HANDLED DIFFERENTLY BY THE PATIENT?

HOW DO YOU FEEL REGARDING THE CARE THAT WAS PROVIDED TO YOU?

Were your needs met? ☒ Yes ☐ No

Were you treated with respect? ☒ Yes ☐ No

Was your privacy maintained? ☒ Yes ☐ No

WERE THERE INJURIES TO STAFF? ☐ Yes ☒ No

WERE THERE INJURIES TO PATIENT? ☐ Yes ☒ No

IF YES, HOW COULD INJURIES BEEN AVOIDED?

DISCUSS THE PATIENTS RESPONSE TO THE PROCEDURE?

Pt. could not verbalize at this time he is asleep.

HAVE GOALS AND INTERVENTIONS BEEN ADDED TO THE TREATMENT PLAN TO PREVENT FURTHER EPISODES? ☐ Yes ☐ No

Comments: (Yes)

Signatures: Melvin P. DeLeon

☐ Staff

☒ Patient

☐ Family

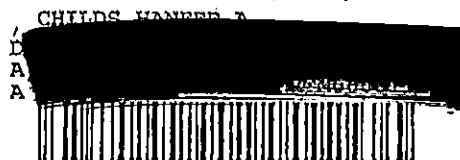
See progress note for continued documentation

Mercy Philadelphia Hospital
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DE-BRIEFING REPORT FOR LOCKED SECLUSION AND RESTRAINTS



Page 1 of 1
Form PSYDEBR, Rev 02/2015
ASIA.X.BEHAV



DE-BRIEFING REPORT FOR LOCKED SECLUSION AND RESTRAINTS

Date: 11/5/15 Time: 3pm

Staff Participants: Marcus Williams, George Dover, Todd Daniel

Others: _____

(Precipitating Factors)
WHAT LED TO THE INCIDENT? MHC Protocol

HOW COULD THIS EVENT HAVE BEEN HANDLED DIFFERENTLY BY THE STAFF? _____

HOW COULD THIS EVENT HAVE BEEN HANDLED DIFFERENTLY BY THE PATIENT? _____

HOW DO YOU FEEL REGARDING THE CARE THAT WAS PROVIDED TO YOU?

Were your needs met? ☒ Yes ☐ No
Were you treated with respect? ☒ Yes ☐ No
Was your privacy maintained? ☒ Yes ☐ No

WERE THERE INJURIES TO STAFF? ☐ Yes ☒ No

WERE THERE INJURIES TO PATIENT? ☐ Yes ☒ No

IF YES, HOW COULD INJURIES BEEN AVOIDED? _____

DISCUSS THE PATIENT'S RESPONSE TO THE PROCEDURE? _____

HAVE GOALS AND INTERVENTIONS BEEN ADDED TO THE TREATMENT PLAN TO PREVENT FURTHER EPISODES? ☒ Yes ☐ No

Comments: yes

Signatures: Mohamed M. Bahar ☐ Staff ☒ Patient ☐ Family

See progress note for continued documentation

 Mercy Philadelphia Hospital
A member of Mercy Health System

BRIEFING REPORT FOR LOCKED SECLUSION AND RESTRAINTS



Page 1 of 1
Form PSYDEBR, Rev. 02/2015
ASM X BEHAV

CHILDS, HANEEF A

DOB: 
Adm: 
Acc: 



432

DE-BRIEFING REPORT FOR LOCKED SECLUSION AND RESTRAINTS

Date: 11/9/15 Time: 2pm

Staff Participants: GARY GEE MHT, Marcus Williams MHT, Camington Justin

Others: Security

(Precipitating Factors)
WHAT LED TO THE INCIDENT? Pt. became violent; very aggressive & combative behavior

Attempted to escape through the exit door

HOW COULD THIS EVENT HAVE BEEN HANDLED DIFFERENTLY BY THE STAFF? Pt. uncooperative, refused to de-escalate

HOW COULD THIS EVENT HAVE BEEN HANDLED DIFFERENTLY BY THE PATIENT? Pt. needed to calm down and be co-operative with staff.

HOW DO YOU FEEL REGARDING THE CARE THAT WAS PROVIDED TO YOU?

Were your needs met? ☒ Yes ☐ No
Were you treated with respect? ☒ Yes ☐ No
Was your privacy maintained? ☒ Yes ☐ No

WERE THERE INJURIES TO STAFF? ☐ Yes ☒ No

WERE THERE INJURIES TO PATIENT? ☐ Yes ☒ No

IF YES, HOW COULD INJURIES BEEN AVOIDED? n/a

DISCUSS THE PATIENT'S RESPONSE TO THE PROCEDURE? Pt. not happy about the restraints

HAVE GOALS AND INTERVENTIONS BEEN ADDED TO THE TREATMENT PLAN TO PREVENT FURTHER EPISODES? ☒ Yes ☐ No

Comments: _____

Signatures: Marcus Williams ☒ Staff ☐ Patient Refer to SOP at this line ☐ Family

See progress note for continued documentation.

Mercy Philadelphia Hospital
A member of Mercy Health System

CHILDS, HANSEN

DE-BRIEFING REPORT FOR LOCKED SECLUSION AND RESTRAINTS



Page 1 of 1
Form PSYDEBR, Rev. 02/2015
ASM X BEHAV



433

Attending: MAGSOD, TAHIR, MD

4344

CHILD, HENEEF &

15 at 0032

525

Sex: 27 M Attending: MAGSOD, TAHIR, MD
ID #: M009511175 Account #: PA133316231

11/04/15 1226 11/04/15 1234 NMB
11/04/15 1603 11/04/15 1638 NMB

Occurrence	Reviewed	Notes	Category
Date Time	Date Time	By	Category
11/04/15 0417	11/04/15 0422	SNP (continued)	Nurse
11/04/15 0455	11/04/15 0455	by SNR	Nurse
11/04/15 1226	11/04/15 1234	NMB	Nurse
11/04/15 1603	11/04/15 1638	NMB	Nurse
11/04/15 2032	11/04/15 2112	JM	Nurse
11/04/15 2135	11/04/15 2143	JM	Nurse
11/04/15 2310	11/04/15 2312	JRH	Nurse

Occurrence	Reviewed	Notes	Category
Date Time	Date Time	By	Category
11/04/15 2310	11/04/15 2312	JRH (continued)	Nurse
11/05/15 0800	11/05/15 1225	JNR	Nurse
11/05/15 0915	11/05/15 0942	JNR	Nurse
11/05/15 1434	11/05/15 1455	JNR	Nurse
11/05/15 1715	11/05/15 1715	JNR	Nurse
11/05/15 1949	11/05/15 2008	JM	Nurse
11/05/15 2009	11/05/15 2014	JM	Nurse
11/05/15 2111	11/05/15 2111	JRH	Nurse
11/05/15 2204	11/05/15 2211	JNR	Nurse

494

Occurred Date Time	Recorded Date Time By	Notes All Categories Category	Occurred Date Time	Recorded Date Time By	Notes All Categories Category
11/11/15 0515	11/10/15 0517 SHP	(continued)	11/11/15 0430	11/11/15 0534 SC	(continued)
NINOSITIVE GUN GIVEN AS REQUESTED			11/11/15 1104	11/11/15 1107 LC	
ADDENDUM 11/10/15 AT 0623 BY SON H PARK RN			11/11/15 1259	11/11/15 1306 JDS	
ANYA TRAPS GIVEN AS DIRECTED					
ADDENDUM 11/10/15 AT 0713 BY SON H PARK RN					
11/10/15 1443	11/10/15 1451 LC				
11/10/15 1521	11/10/15 1546 HMB				
11/10/15 1539	11/10/15 1546 LC				
11/10/15 1800	11/10/15 1800 JWH				
11/10/15 2201	11/10/15 2206 JM				
11/11/15 0430	11/11/15 0534 LC				
11/11/15 1518	11/12/15 1520 HMB				
11/11/15 1659	11/12/15 1700 MMB				
11/12/15 2202	11/12/15 2202 JPH				

Period ending 11/17/15 at 0033

4259

Patient Instructions Signature Page

Date of Birth: [REDACTED]

Guardian Name: CHILDS, HANEEF

The above-named patient and/or guardian has received the following:
Patient Visit Report

Signature Disclaimer

Please make sure you have read through this information before signing.

I have read and understand the instructions given to me by my caregivers.

Haneef Childs

Print Patient Name

Haneef Childs

Patient (or Guardian) Signature

Date

Time

[Signature]

11/13/15

1530

Caregiver/RN/Doctor Signature

Date

Time

CHILDS, HANEEF



440

CONSENT FOR HOSPITAL TREATMENT AND SERVICES

PATIENT NAME: CHILDS, HANEEF A

- I have presented myself for treatment and/or admission on _____ (date). I consent to routine medical care and treatment, including diagnostic procedures and blood tests, and to such emergency or additional care as may be deemed necessary, which will be provided by the Hospital and by my Attending Physician, his/her assistants and/or designees. The use of telemedicine technology may be included in the diagnostic process of my care.
- I understand that, except for emergency situations, this consent does not include operations and non-routine procedures or treatment. I may be asked to consent to such operations and procedures after the risks and alternatives have been explained to me by my Attending Physician or by another physician.
- I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations in the Hospital.
- I realize that I have the right to refuse any drugs, treatment, or procedures to the extent permitted by law. If such treatments or procedures are my reason for hospitalization, refusal may result in discharge.
- I hereby authorize the Hospital to photograph my face for purposes of identification and camera monitoring as indicated. In addition, I authorize the Hospital to take photographs for clinical purposes as part of the diagnostic/treatment documentation process.
- In the event that the results of my diagnostic studies or procedures indicate the need for further coordination of care, the hospital's patient care coordinator may be notified of my results, as deemed appropriate, so as to assist me with further diagnostic and/or treatment options.
- I consent to the release of such information from my medical records as may be required by my health insurance company for the processing of claims for hospital or medical benefits, except for records containing mental health, drug and alcohol information. In these cases a separate written consent will be required. I consent to release medical information to any medical care provider for the purpose of continuity of care/discharge planning. I consent to the use of my medical information for research when federal law allows such use without my specific consent.
- I understand the Hospital will not be liable for loss of or damage to any money or personal property.
- I hereby assign to the Hospital payment of all hospital and insurance benefits otherwise payable to me or for my benefit in connection with my treatment and/or hospitalization.
- In consideration of the care and services to be furnished to me, I undertake and promise to pay for these services (to the extent that the charges are not covered by any insurance benefits) in accordance with Hospital terms and usual and customary charges.
- The professional services of physicians are billed separately from the hospital bill, such as the departments of Anesthesia, Pathology, Emergency, Radiology, Neurology, Cardiology, and Physician Medicine.
- (Managed Care Patients Only) A law was passed in Pennsylvania in 1998 called "Act 68" or the "Quality Health Care Accountability and Protection Act." This law allows you to give the Hospital consent to seek payment from your health insurance company for health care you received for the Hospital if your health insurance company (a) denies payment; (b) limits the scope of services; (c) only pays for a shorter stay in the hospital; or (d) only pays for an alternative service than the one you received. When a hospital seeks payment from a health insurance company it is called a "grievance". I hereby give consent to the Hospital (and/or its designee) to file a grievance on my behalf, including requesting an appeal of any decision by my health insurance company. If the Hospital files a grievance for me, all costs related to the grievance will be paid by the Hospital. I also understand and agree that (1) I will not file a grievance with my health insurance company unless I withdraw my consent in writing; (2) I have the right to rescind this consent at any time during the grievance process; and (3) my consent will be automatically rescinded if the Hospital does not file a grievance.
- (Medicare Patients Only) - Certification, Authorization to Release Information, and Payment Requests. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize the release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I will either assign any such benefits to be paid directly to the Hospital or to the physician or organization furnishing the services or authorize the Hospital or such physician or organization to submit a claim to Medicare on my behalf, for payment.
- I understand that Hospital, including their business associates, may contact me by telephone at any telephone number I have provided or that is associated with my record, including cell phone numbers, which could result in charges to me. Hospital may also contact me by sending text messages or e-mails, using the contact information provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.
I am the patient or the person authorized to give consent for the patient. My signature certifies that I have read and understood this consent and that any questions have been answered to my satisfaction.

Signature of Patient

Date/Time

Witness to Signature

Date/Time

If Patient is a minor or incompetent/unable to give consent

Signature of Person authorized to give consent

Date/Time

Address

Relationship to Patient

Witness

Date/Time

Patient Rights and Responsibilities

☒ I have received the Patient Rights and Responsibilities form (40M)

Hospital Directory

The hospital directory contains your name, room number and general condition. It can be used to direct visitors, flower deliveries and phone callers to you. ☐ I want to be included in the directory ☒ I do not want to be included in the directory

Patient's Email Address: _____

Notice of Privacy Practices

The Notice of Privacy Practices explains how your Protected Health Information (medical and demographic information about you) may be used or disclosed. ☒ I have received the Notice of Privacy Practices.

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgment and the reason you could not obtain it: _____

Mercy Philadelphia Hospital
A member of Mercy Health System

CONSENT FOR HOSPITAL TREATMENT AND SERVICES



Page 1 of 1
Form AD404, Rev. 08/2015
CST.X.TREAT

CHILDS, HANEEF

DO

AD

AC



441

DEPARTMENT OF PSYCHIATRY

AUTHORIZATION AND CONSENT TO RECEIVE MEDICATION

It has been explained to me that the use of medication(s) will be a part of my treatment. It has been further explained that I have the right to refuse my medication(s) prescribed to the extent permitted by law.

My signature below indicates my informed consent to receive the medication(s) deemed necessary by my physician.

X *not refused*
(Patient signature) (Date and Time)

Don L *11.2.15* *8p*
(Witness Signature) (Date and Time)

Mercy Philadelphia Hospital
A member of Mercy Health System

Authorization & consent to receive Medication



Page 1 of 1
Form #CRC032, Rev. 03/2013
CST.X.TREAT

CHILDS, HANEEF A

DOB [REDACTED]
Ad [REDACTED]
AC [REDACTED] 25



442

AUTHORIZATION TO DISCLOSE DRUG AND/OR ALCOHOL ABUSE INFORMATION

I, Haneef Childs hereby authorize MITP
to disclose to CBH my medical record(s) for the purpose of diagnosis and
treatment or obtaining benefits. The information is restricted to whether or not I am receiving treatment, my prognosis, a
brief description of my progress, and/or a short statement as to whether I have relapsed into drug or alcohol abuse and
the frequency of such relapse.
(Pennsylvania Drug and Alcohol Abuse Control Act of 1972- Act 148 Section 7(e).

I understand that I may revoke this consent in writing at any time. I understand that the revocation
will not apply to information that has already been released in response to this authorization. This
authorization will begin on 11.2.15 and end on 1.2.16.
(date) (date)

I understand that treatment may not be conditioned upon my signing this authorization.

[Signature]
Signature of Patient

Time and Date

[Signature]
Witness

Time and Date

Signature of Patient's Health Care Agent/Representative
(if patient is incompetent)

Time and Date

Printed Name of Health Care Agent/ Representative

I have been offered a copy of this Authorization Form ☐ Accept ☒ Refuse
Patient (or agent/ representative) Identification verified ☒ Yes ☐ No
I would like to receive the records requested in an electronic format ☐ Yes ☐ No

Important Note: Records pertaining to drug and/or alcohol abuse may be released only to the patient's health care providers for
purposes of diagnosis and treatment of the patient or (ii) to government or other officials exclusively for the purpose of obtaining benefits
due the patient as a result of his drug or alcohol abuse or drug or alcohol dependence. To release records to any other organization or
individual a court order must be obtained.

 **Mercy Philadelphia Hospital**
A member of Mercy Health System

AUTHORIZATION TO DISCLOSE DRUG AND/OR ALCOHOL ABUSE INFORMATION



Page 1 of 1
Form NS823, Rev. 09/2015
CST, XOTHER

CHILDS, HANEEF A

DOB [REDACTED]
A [REDACTED]
A [REDACTED] - 11-2-2015



443

DATE: 11/19/15 @ 1247		Mercy Philadelphia Hospital ABS *LIVE*		PAGE 1	
USER: COMILLET		ATTESTATION STATEMENT			
NAME: CHITIDS HANSEN A		ACCT #:		PA1303162331	
ADM DATE: [REDACTED]		1175			
ATT: [REDACTED]					
DIS: [REDACTED]					
DIS: [REDACTED]					
LOS: 10		DOB: 01/10/1988			
PT CLASS: IN.MCD		FIN CLASS: MCD			
		ABS STATUS: FINAL			
DIAGNOSES:					
ADMIT: F20.0		PARANOID SCHIZOPHRENIA		POA?	
PRINC: F20.0		PARANOID SCHIZOPHRENIA		Y	
SECOND: F12.10		CANNABIS ABUSE, UNCOMPLICATED		Y	
Z72.0		TOBACCO USE		E	
OPERATIONS:					
CPTS:					
DRG: 885 PSYCHOSES					
STATUS \$ REIMB MIN-LOS MAX-LOS STD-LOS GRP VERS GRP FC					
F 8525.71 5.6 33 MCD					

I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.

DATE: _____

444

DATE: 11/18/15 @ 0007
USER: MT

Mercy Philadelphia Hospital AOM *LIVE*
Ambulatory Prescriptions and Procedures

PAGE 1

Patient Name: CHILDS, HANEET A
Admission/Registration Date: 11/08/15
Unit Number: 0000001125
Account Number: [REDACTED] MD
Date of Birth: [REDACTED] MD

Prescriptions

Haloperidol (Haloperidol) 5 Mg Tablet
10 MG ORAL TWICE A DAY 30 Days REF 1
Rx# 0000000323 Days: 30 Refills: 1 TABLET
Entered Date: Nov 13, 2015 Compound Med: No
Ordering Provider: PUESRE Location: PH2NE
Diagnosis:

Olanzapine (Olanzapine) 10 Mg Tablet
20 MG ORAL BEDTIME 30 Days REF 1
Rx# 0000000324 Days: 30 Refills: 1 TABLET
Entered Date: Nov 13, 2015 Compound Med: No
Ordering Provider: PUESRE Location: PH2NE
Diagnosis:

Reported Medications

[COLACE 100MG PO] No Conflict Check

Refills: 0 Date: Nov 13, 2015
Location: ph2ne
Diagnosis:
Last Taken Information:
Date/Time: UNKNOWN
Dose: UNKNOWN
Information Source:
Medication Purpose:
Comments:

[MINOCYCLINE 100MG PO] No Conflict Check

Refills: 0 Date: Nov 13, 2015
Location: ph2ne
Diagnosis:
Last Taken Information:
Date/Time: UNKNOWN
Dose: UNKNOWN
Information Source:
Medication Purpose:
Comments:

[OMEPRAZOLE 20MG PO] No Conflict Check

Refills: 0 Date: Nov 13, 2015
Location: ph2ne
Diagnosis:
Last Taken Information:

443

DATE: 11/18/15 @ 0007
USER: MT

Mercy Philadelphia Hospital AOM *LIVE*
Ambulatory Prescriptions and Procedures

PAGE 2

Patient Name: CHILDS, HANDED 11/18/15
Unit Number: [REDACTED]
Account Number: [REDACTED]
Date of Birth: [REDACTED]

Date/Time: UNKNOWN
Dose: UNKNOWN
Information Source:
Medication Purpose:
Comments:

[SENNA 1 TAB] No Conflict Check

Refills: 0

Date: Nov 13, 2015

Location: ph2na

Diagnosis:

Last Taken Information:

Date/Time: UNKNOWN

Dose: UNKNOWN

Information Source:

Medication Purpose:

Comments:

Discontinued/Reported Medications

Abilify (Aripiprazole) 5-Mg Tablet
5 MG ORAL DAILY

Refills: 0

Date: Nov 3, 2015

TABLET

Location: ph2na

Diagnosis:

Last Taken Information:

Date/Time: UNKNOWN

Dose: UNKNOWN

Information Source: chart

Medication Purpose:

Comments:

[marijuana] No Conflict Check

Refills: 0

Date: Nov 3, 2015

Location: ph2na

Diagnosis:

[COGENTIN 1MG PO] No Conflict Check

Refills: 0

Date: Nov 13, 2015

Location: ph2na

Diagnosis:

Last Taken Information:

Date/Time: UNKNOWN

Dose: UNKNOWN

Information Source:

Medication Purpose:

Comments:

DATE: 11/18/15 @ 0007
USER: MT

Mercy Philadelphia Hospital AOM *LIVE*
Ambulatory Prescriptions and Procedures

PAGE 3

Patient Name: CHILDS, HAREEF A
Unit Number: [REDACTED]
Account Number: [REDACTED]
Date of Birth: [REDACTED] Age: 25
Refills: 0
Date: Nov 13, 2015
MD
ND

[CARBAMAZEPINE 200MG] No Conflict Check

Refills: 0 Date: Nov 13, 2015
Location: ph2ne
Diagnosis:
Last Taken Information:
Date/Time: UNKNOWN
Dose: UNKNOWN
Information Source:
Medication Purpose:
Comments:

[HALDOL 5MG PO] No Conflict Check

Refills: 0 Date: Nov 13, 2015
Location: ph2ne
Diagnosis:
Last Taken Information:
Date/Time: UNKNOWN
Dose: UNKNOWN
Information Source:
Medication Purpose:
Comments:

[ZIPRASIDONE 40MG PO] No Conflict Check

Refills: 0 Date: Nov 13, 2015
Location: ph2ne
Diagnosis:
Last Taken Information:
Date/Time: UNKNOWN
Dose: UNKNOWN
Information Source:
Medication Purpose:
Comments:

[ORIENT D&A HX] No Conflict Check

Refills: 0 Date: Nov 13, 2015
Location: ph2ne
Diagnosis:

[UDS +THC 11/12/15] No Conflict Check

Refills: 0 Date: Nov 13, 2015
Location: ph2ne
Diagnosis:

417

STATE OF SOUTH CAROLINA

COUNTY OF MARLBORO

STATE OF SOUTH CAROLINA

vs.

HANEEF AQUIL CHILDS,

Defendant.

IN THE COURT OF GENERAL SESSIONS

FOURTH JUDICIAL CIRCUIT

2017-GS-34-0054/ Murder

2017-GS-34-0055/ Possession of Weapon

TRIAL EXHIBITS

EXHIBIT 3

CareSouth Carolina

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May 25, 2018

Page 1

Office Visit

Haneef Q

Male DOB

495926

Home: (000) 000-0000

Ins: Wellcare

08/25/2016 - Office Visit: check up

Provider: Alexia W McKoy FNP

Location of Care: Bennettsville

Patient Identification Checked

Two Identifiers Checked by Nurse: Patient Name, DOB

Checked By: Sharon Denise Covington CMA (August 25, 2016 10:09 AM)

Two Identifiers Checked by Lab: Patient Name, DOB

Two Identifiers Checked by Provider: Patient Name, DOB

Checked By: Alexia W McKoy FNP (August 25, 2016 11:03 AM)

Past Medical History:

Reviewed history and no changes required:

Anxiety Disorder

Schizophrenia

Past Surgical History:

Reviewed history and no changes required:

Unremarkable

Family History Summary:

Mother (biol.) - Has Family History of Stroke/CVA - Entered On: 8/25/2016

Father (biol.) - Has Family History of Hypertension - Entered On: 8/25/2016

Mother (biol.) - Has Family History of Hypertension - Entered On: 8/25/2016

Social History:

Passive smoke exposure - no

Alcohol Use - no

Drug Use - no

Regular Exercise - no

Smoking History:

Patient currently smokes every day.

PHQ-9 Patient Questionnaire

1. Over the last 2 weeks how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things - Score: 1

Feeling down, depressed, or hopeless - Score: 0

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May 25, 2018

Page 2
Office Visit

H
M

495926

Home: (000) 000-0000
Ins: Wellcare

Trouble falling/staying asleep, sleeping too much - Score: 0
Feeling tired or having little energy - Score: 0
Poor appetite or overeating - Score: 0
Feeling bad about yourself - or that you are a failure or have let yourself or your family down - Score: 0
Trouble concentrating on things, such as reading newspaper or watching television - Score: 3
Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual - Score: 1
Thoughts that you would be better off dead or of hurting yourself in some way - Score: 1
Total PHQ-9 Score 6

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? Not difficult at all

Vital Signs:

Patient Profile: 28 Years Old Male

Height: 68 inches
Weight: 149 pounds
BMI: 22.65
Temp: 98.1 degrees F oral
Pulse rate: 86 / minute
Resp: 18 per minute
BP sitting: 132 / 79
Cuff size: regular

Pt. in pain? no

Vitals Entered By: Sharon Denise Covington CMA (August 25, 2016 10:09 AM)

Medications:

CLONAZEPAM 0.5 MG ORAL TABS (CLONAZEPAM) Take 1 tab by mouth daily

Medications:

Medications were reviewed with the patient during this visit.

Allergies:

No Known Allergies

Allergies:

Allergies were reviewed with the patient during this visit.

Risk Factors:

Smoked Tobacco Use: Current every day smoker
Cigarettes: Yes

D528AF3683184569ABC7, CHILDS, 8

450

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May 25, 2018

Page 3

Office Visit

Ha
Male

495926

Home: (000) 000-0000

Ins: Wellcare

Passive smoke exposure: no
Drug use: no
Caffeine use: <1 drinks per day
Alcohol use: no
Exercise: no
Seatbelt use: 100 %
Sun Exposure: occasionally

Patient Learning Needs

Information Obtain From: Patient

Able to Read: Yes

Communicates in: English

Education Level: High School

Preferred Method of Learning: Visual(Seeing), Auditory(Hearing), Tactile/Kinesthetic(Hands on)

Factors Influencing Learning: No Barriers

Assessed By: Sharon Denise Covington CMA (August 25, 2016 10:18 AM)

Patient Education:**Cardiovascular Counseling:**

Discussed With Patient/Guardian Verbalized Understanding

Exercise/Physical Activity Counseling

Discussed With Patient/Guardian Verbalized Understanding

Medication Education

Discussed With Patient/Guardian Verbalized Understanding

Nutrition/Diet Instructions

Discussed With Patient/Guardian Verbalized Understanding

STD Prevention/Contraception

Discussed With Patient/Guardian Verbalized Understanding

Weight Education

Discussed With Patient/Guardian Verbalized Understanding

..... Sharon Denise Covington CMA August 25, 2016 10:20 AM

CC: check up.

History of Present Illness:

This is a 28 year old AA male here for follow- up . Has past hx of scizophrenia . Recently moved here from Philadelphia. Does not have a doctor here and wants to establish care Says he does hear voices all the time but has learned how to deal with it. Not on any anti-psychotics due to problems and issues with the majority of them. Wants to be referred to Tri- County Mental Health. Denies chest pain , pressure or

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May 25, 2018

Page 4

Office Visit

Haneef, Om

Male

495926

Home: (000) 000-0000

Ins: Wellcare

discomfort. Denies fever or chills.

Review of Systems**General**

Denies fever, chills, fatigue and weakness.

Eyes

Denies double vision and blurring.

ENT

Denies ringing in the ears, nasal congestion and sore throat.

CV

Denies chest pain or discomfort, shortness of breath with exertion, palpitations and swelling of hands or feet.

Resp

Denies cough, chest discomfort and wheezing.

GI

Denies nausea, vomiting, abdominal pain, diarrhea and constipation.

GU

Denies dysuria, urinary frequency and urinary hesitancy.

MS

Denies joint pain, joint swelling, back pain and stiffness.

Derm

Denies itching, flushing and rash.

Neuro

Denies headaches, numbness and tingling.

Psych

Complains of anxiety and mental problems.

History of schizophrenia

Endo

Denies cold intolerance, excessive urination and excessive thirst.

Heme

Denies bleeding, skin discoloration and abnormal bruising.

Allergy

Denies hives or rash and seasonal allergies.

Physical Exam

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May 25, 2018

Page 5

Office Visit

Haneef

Male D

495926

Home: (000) 000-0000

Ins: Wellcare

General:

well developed, well nourished, in no acute distress.

Lungs:

clear bilaterally to auscultation.

Heart:

non-displaced PMI, chest non-tender; regular rate and rhythm, S1, S2 without murmurs, rubs, or gallops

Abdomen:

normal bowel sounds; no hepatosplenomegaly no ventral, umbilical hernias or masses noted.

Msk:

no deformity or scoliosis noted of thoracic or lumbar spine.

Neurologic:

no focal deficits, cranial nerves II-XII grossly intact with normal sensation, reflexes, coordination, muscle strength and tone.

Skin:

intact without lesions or rashes. macular rash.

Psych:

alert and cooperative; normal mood and affect; normal attention span and concentration. history of schizophrenia

In House Labs**Urinalysis (Dipstick)**

UA Dipstick Entered By: Gerturde S McKiver (August 25, 2016 10:44 AM)

Color:	yellow	Normal Value: Yellow
Appearance:	clear	Normal Value: Clear
Leukocytes:	negative	Normal Value: Negative
Nitrates:	negative	Normal Value: Negative
Urobilinogen:	0.2	Normal Value: 0.2 - 1.0
Protein:	negative	Normal Value: Negative
pH:	7	Normal Value: 5.0-7.5
Blood:	TRACE	Normal Value: Negative
Specific Gravity:	1.015	Normal Value: 1.003-1.030
Ketones:	negative	Normal Value: Negative
Bilirubin:	negative	Normal Value: Negative
Glucose:	negative	Normal Value: Negative

Microalbumin

Microalbumin Read by: Gerturde S McKiver (August 25, 2016 10:46 AM)

Color:	yellow	Normal Value: Yellow
Appearance:	clear	Normal Value: Clear
Albumin:	10	Normal Value: <20 mg/l
Creatinine:	200	Normal Value: 10-300 mg/dl
Alb Creatinine:	<30	Normal Value: 0-30 mg/g

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May 25, 2018

Page 6

Office Visit

Haneef Childs

Male DOB: [REDACTED]

495926

Home: (000) 000-0000

Ins: Wellcare

Problem # 1: Anxiety Disorder (ICD-300.00) (ICD10-F41.9)

His updated medication list for this problem includes:

Clonazepam 0.5 Mg Oral Tabs (Clonazepam) Take 1 tab by mouth daily

Problem # 2: Schizophrenia (ICD-295.90) (ICD10-F20.9)

Referred to Sharon Black to refer him to Tri_ county mental health

Medications Added to Medication List This Visit:

1) Clonazepam 0.5 Mg Oral Tabs (Clonazepam) Take 1 tab by mouth daily

Patient Instructions:

- 1) Please schedule a follow-up appointment in 1 month.
- 2) Discussed the hazards of tobacco smoking (use). Smoking cessation recommended and techniques and options to help patient quit were discussed.

Process Orders

Check Orders Results (495926_1):

Laboratory: ABN not required for this insurance.

Tests Sent for requisitioning (August 25, 2016 10:59 AM):

08/25/2016: Laboratory -- CBC With Differential/Platelet [CPT-85025] (signed)

08/25/2016: Laboratory -- Comp. Metabolic Panel (14) [CPT-80053] (signed)

08/25/2016: Laboratory -- Lipid Panel With LDL/HDL Ratio [CPT-80061] (signed)

Prescriptions:

CLONAZEPAM 0.5 MG ORAL TABS (CLONAZEPAM) Take 1 tab by mouth daily #30 Tablet x 1

Entered and Authorized by: Alexia W McKoy FNP

Electronically signed by: Alexia W McKoy FNP on 08/25/2016

Method used: Print then Give to Patient

Indications: ANXIETY DISORDER

RxID: 1787742852233640

Electronically signed by Alexia W McKoy FNP on 08/25/2016 at 10:46 PM

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May 25, 2018

Page 1

Lab Report

H

Male

495926

Home: (000) 000-0000

Ins: Wellcare

08/25/2016 - Lab Report: CBC With Differential/Platelet, Comp. Metabolic Panel (14), ...**Provider: Alexia W McKoy FNP****Location of Care: Bennettsville**

Patient: Haneef Childs

ID: 110

Note: All result statuses are Final unless otherwise noted.

Patient Note: PATIENT NOT FASTING

Tests: (1) CBC With Differential/Platelet (005009)

WBC	6.4 x10E3/uL	3.4-10.8
RBC	4.37 x10E6/uL	4.14-5.80
Hemoglobin	13.7 g/dL	12.6-17.7
Hematocrit	41.1 %	37.5-51.0
MCV	94 fL	79-97
MCH	31.4 pg	26.6-33.0
MCHC	33.3 g/dL	31.5-35.7
RDW	13.4 %	12.3-15.4
Platelets	179 x10E3/uL	150-379
Neutrophils	68 %	
Lymphs	26 %	
Monocytes	6 %	
Eos	0 %	
Basos	0 %	
Neutrophils (Absolute)	4.3 x10E3/uL	1.4-7.0
Lymphs (Absolute)	1.6 x10E3/uL	0.7-3.1
Monocytes (Absolute)	0.4 x10E3/uL	0.1-0.9
Eos (Absolute)	0.0 x10E3/uL	0.0-0.4
Baso (Absolute)	0.0 x10E3/uL	0.0-0.2
Immature Granulocytes	0 %	
Immature Grans (Abs)	0.0 x10E3/uL	0.0-0.1

Tests: (2) Comp. Metabolic Panel (14) (322000)

Glucose, Serum [H]	106 mg/dL	65-99
BUN	8 mg/dL	6-20
Creatinine, Serum	0.99 mg/dL	0.76-1.27
eGFR If NonAfricn Am	103 mL/min/1.73	>59
eGFR If Africn Am	119 mL/min/1.73	>59
BUN/Creatinine Ratio	8	8-19
Sodium, Serum	143 mmol/L	134-144
Potassium, Serum	3.9 mmol/L	3.5-5.2
Chloride, Serum	103 mmol/L	97-108
Carbon Dioxide, Total	23 mmol/L	18-29
Calcium, Serum	9.7 mg/dL	8.7-10.2
Protein, Total, Serum	7.6 g/dL	6.0-8.5
Albumin, Serum	5.3 g/dL	3.5-5.5
Globulin, Total	2.3 g/dL	1.5-4.5
A/G Ratio	2.3	1.1-2.5
Bilirubin, Total	0.3 mg/dL	0.0-1.2
Alkaline Phosphatase, S	58 IU/L	39-117

D528AF3683184569ABC7, CHILDS, 13

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May 25, 2018

Page 2

Lab Report

Haneef, [REDACTED]

Male [REDACTED]

495926

Home: (000) 000-0000

Ins: Wellcare

AST (SGOT)	22 IU/L	0-40
ALT (SGPT)	13 IU/L	0-44

Tests: (3) Lipid Panel With LDL/HDL Ratio (235010)

Cholesterol, Total	164 mg/dL	100-199
Triglycerides	53 mg/dL	0-149
HDL Cholesterol	58 mg/dL	>39

According to ATP-III Guidelines, HDL-C >59 mg/dL is
considered a negative risk factor for CHD.

VLDL Cholesterol Calc	11 mg/dL	5-40
LDL Cholesterol Calc	95 mg/dL	0-99
LDL/HDL Ratio	1.6 ratio units	0.0-3.6

	LDL/HDL Ratio	
	Men	Women
1/2 Avg.Risk	1.0	1.5
Avg.Risk	3.6	3.2
2X Avg.Risk	6.2	5.0
3X Avg.Risk	8.0	6.1

Tests: (4) Cardiovascular Report (910385)

! Interpretation Note
Supplement report is available.

Note: An exclamation mark (!) indicates a result that was not dispersed into
the flowsheet.

Document Creation Date: 08/26/2016 9:30 AM

(1) Order result status: Final

Collection or observation date-time: 08/25/2016 10:35

Requested date-time:

Receipt date-time: 08/25/2016 17:59

Reported date-time: 08/26/2016 09:09

Referring Physician:

Ordering Physician: A McKoy (mckoya)

Specimen Source:

Source: 1100

Filler Order Number: 23807506940 LAB

Lab site: Performed At: BN, LabCorp Burlington 1447 York Court Burlington,
NC 272153361 William F Hancock MD Phone: 8007624344

(2) Order result status: Final

Collection or observation date-time: 08/25/2016 10:35

Requested date-time:

Receipt date-time: 08/25/2016 17:59

Reported date-time: 08/26/2016 09:09

Referring Physician:

Ordering Physician: A McKoy (mckoya)

Specimen Source:

Source: 1100

Filler Order Number: 23807506940 LAB

Lab site: Performed At: BN, LabCorp Burlington 1447 York Court Burlington,
NC 272153361 William F Hancock MD Phone: 8007624344

CareSouth Carolina

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May 25, 2018

Page 3

Lab Report

Name: [REDACTED]

Male

495926

Home: (000) 000-0000

Ins: Wellcare

(3) Order result status: Final

Collection or observation date-time: 08/25/2016 10:35

Requested date-time:

Receipt date-time: 08/25/2016 17:59

Reported date-time: 08/26/2016 09:09

Referring Physician:

Ordering Physician: A McKoy (mckoya)

Specimen Source:

Source: 1100

Filler Order Number: 23807506940 LAB

Lab site: Performed At: BN, LabCorp Burlington 1447 York Court Burlington,
NC 272153361 William F Hancock MD Phone: 8007624344

(4) Order result status: Final

Collection or observation date-time: 08/25/2016 10:35

Requested date-time:

Receipt date-time: 08/25/2016 17:59

Reported date-time: 08/26/2016 09:09

Referring Physician:

Ordering Physician: A McKoy (mckoya)

Specimen Source:

Source: 1100

Filler Order Number: 23807506940 LAB

Lab site: Performed At: LITIL, Litholink Corporation 2250 West Campbell Park
Drive Chicago, IL 606123502 Mitchell Laks PhD Phone: 3122430600

The following lab values were dispersed to the flowsheet
with no units conversion:

WBC, 6.4 X10E3/UL, (F) expected units: 10*3/mm3
RBC, 4.37 X10E6/UL, (F) expected units: 10*6/mm3
Platelets, 179 X10E3/UL, (F) expected units: 10*3/mm3
Neutrophils (Absolute), 4.3 X10E3/UL, (F) expected units: 10*3/mm3
Lymphs (Absolute), 1.6 X10E3/UL, (F) expected units: 10*3/mm3
Monocytes (Absolute), 0.4 X10E3/UL, (F) expected units: 10*3/microliter
Eos (Absolute), 0.0 X10E3/UL, (F) expected units: 10*3/mm3
Baso (Absolute), 0.0 X10E3/UL, (F) expected units: 10*3/mm3
Immature Grans (Abs), 0.0 X10E3/UL, (F) expected units: 10E3/uL

Electronically signed by Alexia W McKoy FNP on 08/27/2016 at 12:04 AM

D528AF3683184569ABC7, CHILDS, 15

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CareSouth Carolina

201 South Fifth Street Hartsville, SC 29550
(843) 857-0111 Fax: (843) 378-9962

May 25, 2018

Page 1

Internal Other

Han
M

495926

Home: (000) 000-0000

Ins: Wellcare

09/26/2016 - Internal Other: Appointment No Show
Provider: Alexia W McKoy FNP
Location of Care: Bennettsville

Appointment status changed to No Show by
Ernestina Bridges on 9/26/2016 2:56 PM

No Show Comments

Appointment Information

Appt Type : Follow Up 15
Date : 9/23/2016
Time : 9:30:00 AM
Made By : bridgese
To Visit : McKoy FNP, Alexia W
Notes : follow up

Electronically signed by Alexia W McKoy FNP on 10/04/2016 at 12:15 AM

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CareSouth Carolina

201 South Fifth Street Hartsville, SC 29550
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May 25, 2018

Page 1

Internal Other

Hanee

Male DOB

495926

Home: (000) 000-0000

Ins: Wellcare

09/12/2016 - Internal Other: Appointment No Show**Provider: Sharon Black LISW-CP****Location of Care: Bennettsville**

Appointment status changed to No Show by
Sierra Shelley on 9/12/2016 4:05 PM

No Show Comments

Appointment Information

Appt Type : Social Work 60
Date : 9/12/2016
Time : 1:00:00 PM
Made By : englishp
To Visit : Black LISW-CP, Sharon
Notes : schizophrenia

Electronically signed by Sharon Black LISW-CP on 09/13/2016 at 8:02 AM

CareSouth Carolina

201 South Fifth Street Hartsville, SC 29550
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May 25, 2018

Page 1

Internal Other

Haneef Childs

Male DOB [REDACTED]

495926

Home: (000) 000-0000

Ins: Wellcare

09/26/2016 - Internal Other: Appointment No Show**Provider: Alexia W McKoy FNP****Location of Care: Bennettsville**

Appointment status changed to No Show by
Ernestina Bridges on 9/26/2016 2:56 PM

No Show Comments
-----Appointment Information

Appt Type : Follow Up 15
Date : 9/23/2016
Time : 9:30:00 AM
Made By : bridgese
To Visit : McKoy FNP, Alexia W
Notes : follow up

Electronically signed by Alexia W McKoy FNP on 10/04/2016 at 12:15 AM

Patient Ledger

Patient ID:
Birthdate:
Phone 1:
Phone 2:

Total Charges: \$224.00

Visit	Company	Provider	Facility	Ticket Number	Units	Fee
Service	Code	Description				
08/26/2016	CareSouth Carolina	McKoy FNP, Alexia W	Bennettville Main	702434		
	Z00.00	Encounter for general adult medical examination without abnormal findings				
	F20.9	Schizophrenia, unspecified				
	F41.9	Anxiety disorder, unspecified				
	Z68.22	Body mass index (BMI) 22.0-22.9, adult				
08/26/2016	99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires three key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making. Counsel			1.00	\$133.00
08/26/2016	36415	Collection of venous blood by venipuncture			1.00	\$15.00
08/26/2016	99000	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory			1.00	\$20.00
08/25/2016	82044	Albumin; urine, microalbumin, semiquantitative (eg, reagent strip assay)			1.00	\$15.00
08/25/2016	81003	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy			1.00	\$16.00
08/25/2016	G8427	List of current medications (includes prescriptions, over-the-counter, herbals, vitamin/minerals/dietary/nutritional supplements) documented by the provider, including drug name, dosage, frequency and route			1.00	\$0.00
08/25/2016	G0444	Annual Depression Screening			1.00	\$25.00
08/25/2016	G8752	Most recent systolic blood pressure < 140 mmHg			1.00	\$0.00
08/25/2016	G8754	Most recent diastolic blood pressure < 90 mmHg			1.00	\$0.00
08/25/2016	G8731	Pain assessment documented as negative, no follow-up plan is required			1.00	\$0.00

UCL

STATE OF SOUTH CAROLINA

COUNTY OF MARLBORO

STATE OF SOUTH CAROLINA

vs.

HANEEF AQUIL CHILDS,

Defendant.

IN THE COURT OF GENERAL SESSIONS

FOURTH JUDICIAL CIRCUIT

2017-GS-34-0054/ Murder

2017-GS-34-0055/ Possession of Weapon

TRIAL EXHIBITS

EXHIBIT 4

INITIAL CLINICAL ASSESSMENT							
Started on: 12/16/2016							
Date: 12/19/2016		Source of Data: ☒ Client		Family:		School	
						Old Records	
Referred by: ☒ Self		Court Order (Type):				Other:	
[REDACTED]							
Name: (Last, First, Middle) [REDACTED]							
Age: [REDACTED] Gender: [REDACTED] Race: [REDACTED]							
Other Information: [REDACTED]							
Section B: Perceptions and History of Presenting Problem(s)							
Documentation should address the source of information and the following:							
☒ Client				Family/Guardian (Specify):			
What brought client here today (px, sx, hx, duration and stressors)?				Collateral Sources (Specify):			
'I need my meds and I need to talk to somebody. (Raldol and something else, I forget what it was called for anxiety) .' What are the possible causes? Why does the client think she/he is having these problems/symptoms? 'I need to talk to somebody before I snap. I usually talk to my wife, but I haven't talked to her.' Who and what area of client's life are affected by this? How does this make client/family member feel about him/herself? 'Everything. I feel like I am being discriminated against. Islam religion. I don't know what the media is saying about Muslims and them being terrorists.' How does client/family think this can be solved? What will help? 'I don't know. If I can get out of this situation and move. I have a family and everything to lose or everything to gain. It wasn't as hard in Philadelphia as it is here.'							
Section C: Urgent Needs/ Risk Assessment							
Suicidal Risk:	Denies	☒ Ideas	Plans	Means	Intent	☒ Hx of attempts	Hx In Family
Homicidal Risk:	☒ Denies	Ideas	Plans	Means	Intent	Hx of attempts	Hx In Family
Self Mutilation:	Denies	Ideas	Plans	Means	Intent	☒ Hx of attempts	Hx In Family
Other Risk Taking Behaviors:	Denies	Driving fast	DUI	Unprotected sex		Gang affiliations	Fire setting
	☒ Hx of violence:	Other (specify):					
Comments: History of self-mutilation - 'banged my head, punched walls' 'I just want to say bye to all'. I don't know about harming someone else because I wouldn't want no one else to do that to me. - One assault charge. Steps taken to address urgent needs: Personal safety plan completed and original given to the clt. Copy imported into the EMR.							
Section D: History of Mental Health Treatment							
A chronological history of all inpatient and outpatient treatment to include location, date of treatment, diagnosis, type of treatment, and how/why ended:							
20 years old - dx in PA with schizophrenia, paranoid type - medication given Seroquel, thorazine, celexa, Risperdal, etc.							
Scotland County Jail received the Raldol 2 mg oral and feels that he responded best to it. in PA admitted to Meroy wellness hospital last year.							
Family Mental Health History:							
Grandmother's brother died and was dx schizophrenia and bipolar, and I think somebody else.							
Two cousins and uncle dx with some mental health disorder.							
Section E: Trauma History							
History of Trauma:	None apparent	Signs/sx present, but denies	☒ Acknowledges	Referred to assessment		See Trauma Assessment	
Type of Trauma:	None	☒ Sexual	☒ Physical	Emotional		Violence	
	Abuse	Neglect	Natural Disaster	Felt self/someone else was going to die/be killed			
	Accident (specify):						
Client was:	☒ Victim	Witness	Perpetrator				
Describe Issues Identified: (nightmares, flashbacks, startle reflex, avoidance):							
Around 12 friends tripped him, held him down, and took his clothes - outside naked but got his clothes back later.							
He and father got into at 16 and Dad pistol whipped him in the head. 3. His mother saw him in a room of a hotel and that has been fulfilled.							
Section F: Substance Use							

ICA (page 1)

Date: 12/19/2016 11:27:29

Substance	Age Started	Frequency/Duration	Method	Last Use
NICOTINE	16	5 a day	smoke	
CANNABIS	16	1 dutch (blount) a day	smoke	
ALCOHOL	16	liquor	drink	weeks

Substance Use Treatment:

Drug program in PA - court ordered in PA because he kept violating probation

Substance Use Experiences:

Experienced blackouts? ☒ No

Withdrawal symptoms (seizures, DT's etc)? ☒ No

Legal environments related to substance use? ☒ No

Is your alcohol/drug use something that needs to be addressed in treatment? Yes, describe: ☒ I do wanna stop smoking

Family history of substance abuse? No ☒

'I don't know I mind my business'

Section G: Medical History and Current Status

C = Current problem H = History of problem

C H

No physical sx/problems

Thyroid

Seizures

Severe headaches/migraines

TB

Cancer (specify):

Lung problems

Diabetes (specify if juvenile or adult onset)

C H

Kidney/bladder problems

☒ Stomach/intestinal problems

☒ Serious body/head injury

Heart problems/Hypertension

Epilepsy

Liver/Hepatitis

Immune disorder

Surgeries (specify)

Allergies (specify):

C H

STDs (specify):

Other (specify):

Females:

Date of last menstrual period:

Pregnant?

Number of pregnancies:

Number of living Children 5

Comments:

Thinks he was rushed to the hospital a few months ago for intestinal swelling (eating a lot of candy and woke up sick? - couldn't stop throwing up and couldn't stop running to the bathroom).

Pistol whipped (see trauma)

Significant Family History:

-N - mother

Mental Health Medication		Current Medication		Purpose/ Effectiveness
Dosage	Frequency			
No current MHC medication				
Physical Healthcare Medication		Current Medication		Purpose/ Effectiveness
Dosage	Frequency			
No current medication				
Other: OTC, Herbs, Vitamins, etc.		Current Medication		Purpose/ Effectiveness
Dosage	Frequency			
No current medication				
Allergies				
Seroquel - green stuff coming Risperdal - growing male breasts Thorazine - almost blind				
Primary Care Physician: Care South		Phone num:		Date Last Seen:
If none, community resources provided?				

Section H: Social, Economic, Cultural

1. Where were you born and raised?

Born in Philadelphia and raised there.

2. Describe your family of origin (who raised you, how many sibling(s), quality of relationships then and now):

Mother raised him, Dad was in and out. 'I dead, I have 5 siblings' I don't talk to my little brother, he cut us off he's too good for us. Me and my sister are tight. Me and my older brother are cool. My older sister - we fine too.

3. Describe current family/significant relationships (significant other? children? quality of relationships?):

11, 9, 8, 2 year old daughter and 11 month old baby - 3 different baby mothers (has the two oldest and the youngest here with him).

4. Describe past significant relationships (marriages, divorces, separations, etc.):

Married for almost 2 years. Previously married for a week. Divorced.

5. Describe any significant losses/separations of any family members/significant others

(Including loss of pets, physical functions, limbs, property/possessions, etc.):

Brother got shot - in 2010 (March 17) - Affects him because he thinks about all the time, that was my heart, we were born a day apart and he died one day before my son's birthday.

Cousin killed (3) uncle died on a motorcycle.

ICA (page 2)

Date: 12/19/2016 11:27:29

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6. Describe current housing situation (house, mobile home, boarding homes, shelter, homeless, etc.): Any needs?

Currently incarcerated

7. Any problems/issues/changes with sex/sexuality? No

None

Describe current social involvement (activities that you enjoy with others):

I don't I don't trust nobody. People have broke into my house.'

9. Describe current spiritual/religious involvement:

'I am in tune with my religion and can't nothing mess with my faith. My religion is only reason why I feel I can gain my sanity back. I understand everything is already written. I practice my faith.'

10. Describe educational background (how far in school, tech school, college, special ed., special programs, highest level completed):

'I went to the 11th grade and I quit. I passed the 1st part of the GED which was reading.'

11. Describe current and past employment (how long at each job, if on disability, include any military service/type of discharge, etc.):

'I have mainly worked with food. Since I have been growing my beard, it has been kind of hard. My beard is part of my faith - the longer the beard, the longer your knowledge, if it is on your face it is supposed to grow. I trim my mustache'

If you could work now, what would you be interested in doing?

'I would do anything. If I could be a cop, I would be a cop.'

12. History of legal involvements (DJJ, charges, jail/prison time, number of arrests and number of convictions, as well as any current legal problems):

'I was adjudicated but didn't finish the program. Arrested altogether about 8 times. convicted 3 times - aggravated assault, carrying an illegal firearm, simple possession.

Incarcerated now for murder - around the 3rd of December.'

Section I: Strengths, Needs, Abilities and Preferences

Strengths: (Family, social, spiritual support, hobbies, and attitudes that have helped overcome past crises)

Family, prayer

Needs: (Client's expression of current needs emotional, physical, social, environmental)
therapy

Abilities: (Client's ability to follow up with treatment, understand instructions, participate in treatment)
Clt is able to communicate and participate fully.

Preferences: (appt., day/times, therapist, treatment modality, etc.)
outpatient

Client is currently receiving services from other providers/agencies? ☒ No

Section J: View of Treatment and Discharge:

Documentation should include the source and the following:

☒ Client Family (specify):

What are your expectations?

'The proper help - proper medicine, proper therapy, family helping me, judge, cops, y'all helping me. As long as God will send the help I will be fine.'

What is your commitment and motivation to treatment?

'Family'

How will you know when you will be ready for discharge?

'When God says'

Section K: Mental Status Examination

	Meticulous	Neat	Clean	☒ Disheveled	Bizarre
Appearance & Hygiene	Body Odor				
	Comments:				
	In jail attire, cuffed.				
Motor Activity	☒ Appropriate to situation	Over-active	Tremor/tics	Poor coordination	Repetitive
	Lethargic				
	Comments:				
	None				
Attitude During Interview	☒ Cooperative	Oppositional	Hostile	Dramatic	Guarded
	Irritable	Withdrawn			
	Comments:				
	None				
Affect	☒ Appropriate to situation	Blunted	Flat		
	Expansive	Labile			
	Comments:				
	None				
Mood	Happy	Euthymic	Anxious	☒ Depressed	Angry
	Hopeless	Suspicious	Passive		

ICA (page 3)

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Date: 12/19/2016 11:27:29

uhs

Speech	Comments: Haven't been talking to my wife Normal rate and tone Slow Fast ☒ Soft Loud Pressured Stuttered Stuttering Atlogla				
	Comments: None				
Thought Process	☒ Normal, appropriate, coherent, relevant Loose associations Flight of ideas Blocking Racing Circumstantial Tangential Indecisive Disorganized Concrete				
	Comments: None				
Thought Content	Normal Phobias Obsessions Ideas of hopelessness Ideas of worthlessness ☒ Paranoid ☒ Persecutory Suicidal Homicidal (Note: If suicidal or homicidal, see risk assessment)				
	Comments: 'I don't trust nobody. I had someone try to break into my house - someone trying to kill me and my wife and unborn child.'				
Hallucinations	☒ No evidence ☒ Auditory ☒ Command ☒ Visual Olfactory Tactile Denies				
	Comments: Hear voices - hear voices now telling me to calm down it's not that bad. Sometimes I see the evil in people, see demons, see an angel in somebody. I may see faces on the wall, shadows				
Delusions	No evidence ☒ Persecutory Grandeur Reference Influence Somatic Denies				
	Comments: Feels that people are out to get him 'because of his religion and because he has a beautiful wife and kids.'				
Orientation/Level of Consciousness	☒ Alert Oriented to ☒ Person ☒ Place ☒ Time ☒ Situation Clouded Confused				
	Comments: None				
Judgement	Able to make sound decisions ☒ Usually able to make sound decisions ☒ Poor decision making, adversely affects self Poor decision-making, adversely affects others				
	Comments: 'Good ones for my family, bad decisions for myself.'				
Insight/Adjustment to Problems/Illness, Disabilities, Disorders	Denies problems/illness Blames others Minimizes ☒ Acknowledges & understands Acknowledges but fails to understand				
	Comments: None				
Memory (use example)	☒ Intact Poor remote Poor recent Poor immediate Comments: fifth grade - Barry elementary first meal yesterday - cereal 3 things: clock, pencil, and coffee - pencil, clock, and coffee				
	Concentration & Calculations (use example) ☒ Able to concentrate ☒ Able to do simple math Easily distracted Daydreams				
Fund of Knowledge (use example)	Above average Average ☒ Below average Comments: President - I don't know Capital of South Carolina - I don't know Capital of PA - Pittsburgh				
	Other Pertinent Information: None				

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447

Revision Reason: decrease frequency

SC DEPARTMENT OF MENTAL HEALTH
PLAN OF CARE

Date:
2016

POC Level of Care: 3 - Moderate Symptoms/Problems

Start Date: 07/24/2017

End Date: 07/24/2018

Primary Diagnosis Addressed in TX.: Code and Description:

Active primary diagnosis:
295.90 Schizophrenia

Other Diagnosis Addressed in TX.: Code and Description:

Active secondary diagnosis:
309.0 Adjustment disorder, With depressed mood

Identified Problems/Needs:

anger
patience/anxiety
having a sound mind (voices)/paranoia

Goals, Objectives and Interventions

Services

Frequency

Provider

Goal # 1

'I may just lose it sometimes (anger).'

IND TX

1xMonth

MHP

Objective # 1.1

Clt will identify three triggers that cause his anger within the same week.

Intervention # 1.1.1

Clinician will assist the clt in identifying his triggers for anger through an exploration of the past events that have resulted in aggressive actions.

Target Date: 06/05/2017

Objective # 1.2

Clt will be able to utilize three different coping skills to control his outbursts of anger (either verbal or physical).

Intervention # 1.2.1

Clinician and clt will explore coping skills and their effectiveness in order to determine which are more effective for the clt and identify alternatives as needed.

Target Date: 09/05/2017

Goal # 2

'My anxiety makes me pace back and forth, makes me angry or sad because I don't like dealing with it.'

Objective # 2.1

Clt will utilize coping skills such as deep breathing, guided imagery, or alternative techniques to assist him in managing anxiety effectively.

Intervention # 2.1.1

Clinician will foster a working knowledge of different skills the clt has that can be used to deter anxiety attacks as needed.

Target Date: 08/05/2017

Discharge Plan

Clt will be able to transition into his home community from individual treatment when he is able to control his anger and hallucinations where he is neither incarcerated or hospitalized for anger outbursts or deviant and odd behavior for 3 months. Clt will have supports in place in the community such as family and friends to assist in maintaining progress and a PCP who will write his medications for continuity of medications. Clt is anticipated to discharge 08/05/2017.

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2. Disclosure to other parties is prohibited.
3. This document is the property of the Department of Mental Health and has been filed.

CLIENT/FAMILY MEMBER SIGNATURE AND DATE

PROVIDER SIGNATURE AND DATE

PHYSICIAN'S SIGNATURE AND DATE

Emilia Bell, MSW 07/24/2017

Edmond Higgins, MD

24 Jul 2017 12:32:32 PM

Reason Revision: POC revision from PMA/dx changed

SC DEPARTMENT OF MENTAL HEALTH
PLAN OF CARE

Client Name:
HANEEF CHILDS

CID:
10390

Admit Date:

Primary Diagnosis Addressed:

Description:

Active primary diagnosis:
295.90 Schizophrenia

Other Diagnosis Addressed in TX-Ord:

Description:

Active secondary diagnosis:
309.0 Adjustment disorder, With depressed mood

Identified Problems/Needs:

anger
patience/anxiety
having a sound mind (voices)/paranoia

Goals, Objectives and Interventions

Services

Frequency

Provider

Goal # 1

'I may just lose it sometimes (anger).'

IND TX

2xWeek

MHP

Objective # 1.1

Clt will identify three triggers that cause his anger within the same week.

Intervention # 1.1.1

Clinician will assist the clt in identifying his triggers for anger through an exploration of the past events that have resulted in aggressive actions.

Target Date:08/05/2017

Objective # 1.2

Clt will be able to utilize three different coping skills to control his outbursts of anger (either verbal or physical).

Intervention # 1.2.1

Clinician and clt will explore coping skills and their effectiveness in order to determine which are more effective for the clt and identify alternatives as needed.

Target Date:08/05/2017

Goal # 2

'My anxiety makes me pace back and forth, makes me angry or sad because I don't like dealing with it.'

Objective # 2.1

Clt will utilize coping skills such as deep breathing, guided imagery, or alternative techniques to assist him in managing anxiety effectively.

Intervention # 2.1.1

Clinician will foster a working knowledge of different skills the clt has that can be used to deter anxiety attacks as needed.

Target Date:08/05/2017

Discharge Plan

Clt will be able to transition into his home community from individual treatment when he is able to control his anger and hallucinations where he is neither incarcerated or hospitalized for anger outbursts or deviant and odd behavior for 3 months. Clt will have supports in place in the community such as family and friends to assist in maintaining progress and a PCP who will write his medications for continuity of medications. Clt is anticipated to discharge 08/05/2017.

CLIENT/FAMILY MEMBER SIGNATURE AND DATE

PROVIDER SIGNATURE AND DATE:

Eunice Bell, MSW
10 Jan 2017 8:24:32 AM

Edmund Higgins, MD
01/09/17 11:04:00 AM

PROGRESS SUMMARY

(Due at transfer, discharge, and no less often than every 90 days)

Name: HANEEF CHILDS

CAF:	Current CAFAS (optional):	Other Rating: [REDACTED]
1-None 2-Limited 3-Some 4-Significant 5-Accomplished		

Summary: 1. A review of the appropriateness of services and their frequency 2. Progress on each goal & tx. Objective (outcome rating). 3. Clinical justification of the need for continuing treatment by clearly stating how the continuation of services is necessary to treat the disorder or prevent decompensation (the benefit or impact of the services) and/or criteria for discharge to another program or from Center. 4. Plan/recommendation for future treatment, include client and family feedback; integration of client into the community and changes in treatment planning. For transfer or discharge, list medication/efficacy.

[illegible]

Eunece Bell
03/09/17 12:45:08 PM

Date:

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PROGRESS SUMMARY
(Due at transfer, discharge, and no less often than every 90 days)

Name:	ID #:
HANEEF CHILDS	[REDACTED]

Check All Services Received: ☒ PMA ☐ PMA-APRN ☐ Mod Adm ☐ NS ☐ GI ☒ ASSMT ☐ SPD ☒ IND. Tx. ☐ Fm. Tx.
☐ Gp. Tx. ☐ CCS ☐ PRS ☐ FS ☐ PSS ☐ BMod ☐ BHS

[illegible]

Clinician's Signature and Title:	Eunice Bell, MSW	Date:	06/16/17 3:18:24 PM
----------------------------------	------------------	-------	---------------------

DMH FORM
1, 2004 C-102

1. Use of the above information is restricted to the specific authority authorized.

2. The least restrictive conditions are preferred.

3. This document will be removed from the record once it has been fulfilled.

421

Revision reason:

PROGRESS SUMMARY

08/14/17 to 09/12/17

(Due at transfer, discharge, and inpatient 90 days)

Name: HANEEF CHILDS

SAF: Current CAFAS (optional): Other Rating: Outcome Rating Scale: 1- None 2- Limited 3- Some 4- Significant 5- Accomplished

Check All Services Received: ☒ PMA ☐ PMA-APRN ☐ Med Adm ☐ NS ☐ CI ☐ ASSMT ☐ SPD ☒ IND. Tx. ☐ Fm. Tx.
☐ Gp. Tx. ☐ CCS ☐ PRS ☐ FS ☐ PSS ☐ BMed ☐ BHS

Summary: 1. A review of the appropriateness of services and their frequency 2. Progress on each goal & tx. Objective (outcome rating). 3. Clinical justification of the need for continuing treatment by clearly stating how the continuation of services is necessary to treat the disorder or prevent decompensation (the benefit or impact to the services) and/or criteria for discharge to another program or from Center. 4. Plan/recommendation for future treatment, include client and family feedback; integration of client into the community and changes in treatment planning. For transfer or discharge, list medications/efficacy.

Object Num	Outcom Rating	Target Date	Rating Hist	
1.1	3	08/05/2017	..	Review of POC services and frequencies: A review of the appropriateness of services indicates client has made some progress with her overall treatment. Client has complied with treatment during the progress quarter. During the last PMA client's frequency was decreased to once a month. No other barriers to treatment identified at this time. Progress on each goal and objective: Objective 1.1, 1.2, 2.1- Client has made some progress with his overall treatment. No incidents or referrals have been made while incarcerated during the progress quarter. Clinical justification for continued treatment/services: Client will benefit from ongoing treatment for medication management and monitoring of symptoms. No additional goals or objectives will be added at this time. Recommendations for continued treatment/services: Therapy 2x monthly and PMA every 2-3 months or as needed.
1.2	3	09/05/2017	..	
2.1	3	08/05/2017	..	

Clinician's Signature and Title: Eunice Bell, MSW Date: 09/12/17 4:08:18 PM

972

TRI-COUNTY MENTAL HEALTH This form is being used to : Transfer to another program			
Client Name: HANBEF CHILDS [REDACTED]			
Reason for Discharge/Transition: ~~None and no signs of mental illness present.~~ CODE 4			
Diagnosis at Admission: 295.90 Schizophrenia 301.7 Antisocial Personality Disorder		Diagnosis at Discharge/Transition: 295.90 - Schizophrenia 309.0 - Adjustment disorder, With depressed mood	
GAF at Admission:		GAF at Discharge/Transition:	
Strengths:	Needs:	Abilities:	Preferences:
Current medications (list medications, dosages):			
Medication	Dosage		
COGENTIN	1mg		
HALDOL	5mg		
Will the client be discharged/transferred on medication? ☒ Yes Explain: Will be followed and monitored by nurse, RN			
Presenting Condition/Problem(s)/Symptom(s): Mild depression Vague A/H What services were provided and what were the results of services/progress on recovery at the time of discharge/transition. (Include the following: Were goals/objectives met? Gains achieved? Progress in his/her recovery?): Client is doing well. Maintaining and management symptoms well.			
Date of Last Contact: 10/09/2017 Client Status at Last Contact: Stable			
Recommendations for Follow-up/Support (include information about referrals to other agencies): 1) If symptoms re-appear you may return to the mental health center for further evaluation and treatment. 2) Referred to: Contact name & phone number:			
Program Transfer Information: Sending Staff: Eune'ce Bell, MSW Receiving Staff: Lacey Lee, RN Transferred From: Adult Outpatient Program Transferred To: Medication Management Program Admission Date to Currently Assigned Program: 10/18/2017 Person participating in Discharge Summary/ Transition Plan: Client received a copy of the Discharge Summary/ Transition Plan: ☒ No			

Eune'ce Bell, MSW Eunece Bell
 18 Oct 2017 10:45:57 AM

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Balance: Query View Info Look Print Exit

Query Client/Payment
Client ID [REDACTED] C 3N
Medicaid [REDACTED] Bus No [REDACTED]
Medicare [REDACTED] Ins Code [REDACTED]
Location 800 Office 26 Cost Center 3N8 Percent Accur 0
Fee Elig 02 Serv Dates 12/16/2016 to 01/21/2018 Seric D
Balance [REDACTED] Current Diag: 295.90
PayID [REDACTED]

Org Trn	Cur Trn	Date	JCode	Rcpt#	Serv Sub	Staff	Time	Amount	Type
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curdue _____ Current Balance 6

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FOLLOW-UP PSYCHIATRIC MEDICAL ASSESSMENT ORDERS AND SERVICE NOTES (PMA)

Name: HANEFF ACHIL CHILDS

DOB: [REDACTED]

ID: [REDACTED]

Place of Service: 58 COMMUNITY-MHC

Modifier:

Medicare Authorized Provider: NONE

Time	Staff ID	Staff Name
30	602	EDMUND HIGGINS

HISTORY

Chief Complaint/Reason for Visit

29 yo bm here for med check. Last PMA was with me about 3 mos ago. Pt remains in jail, but team rpts he could move to MMO until case resolved.

History of Present Illness

Pt rpts the meds help - "voices are down to a minimum" but rpts he still hear some. c/o anxiety and would like better sleep. Energy is low. Not suicidal. Doesn't know much about his case or what is happening next. Not having any side effects.

Psychiatric Med Trials

Med	Dosage	Sig	Amount	Refills	Start Date
COGENTIN	1mg	qhs		0	
HALDOL	5mg	one qhs	-	-	04/10/2017

Allergies

nkda

Substance/Alcohol Use

Service	Last Update	Substance	Frequency/Quantity	Date of Last Use
H052	10/09/2017	CANNABIS	daily	dec '16

Comments 10/09/2017: Was in drug court prior to arrest

EXAMINATION

Vital Signs and Measurements

Service	Date	Weight	Blood Pressure	Pulse
H012	01/09/2017	148Lbs	132/88	72
H052	04/10/2017	179Lbs	116/72	88
H052	07/10/2017	19208Lbs	132/91	89
H052	10/09/2017	203Lbs	128/82	87

Musculoskeletal

Abnormal Movements: None; Date of last assessment of abnormal movements: 10/09/2017; Gait & Station: WNL; alms=0

Cuffed - escorted by officer who stood outside room

Psychiatric

Appearance: WNL; Attitude: Cooperative; Behavior: Calm; Delusions: Denies; Suicidal Ideation: Denies; Homicidal Ideation: Denies; Obsessions: Denies; Hallucinations: Denies; Affect: Flat; Sensorium: Alert; Language: Below Average; Judgment: Poor; Insight: Poor; Fund of Knowledge: Unable to assess at this time;

MEDICAL DECISION MAKING

Diagnosis

296.90 Schizophrenia (Prim Dx)
309.0 Adjustment disorder, With depressed mood
R/O ASPD R/O malingering

Tx Goal(s)

Medication adherence;

Current and New DMH Rx List

Med	Dosage	Sig	Amount	Refills	Start Dt
COGENTIN	1mg	qhs		0	
HALDOL	5mg	one qhs	-	-	04/10/17

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Date: 10/09/2017 15:32:11

48

Medication Education/Counseling Provided

Present for counseling: Client;

Discussion: Medication dose & time to take, purpose/expected benefits/risks, common side effects;

Neuroleptic Consent

A paper consent form was last obtained: 01/09/2017

Recommendations and Referrals

Follow up with: MD, requires monitoring of response to medication, requires monitoring of medication side effects;

Time until next PMA and/or NS: 3 month(s);

Follow up with MH clinician: N/A;

Referral: None;

Emergency admission to inpatient psychiatric care: N/A;

MMO Status and Client Goal

MMO since 10/09/2017

MMO: Remain in MMO

Patient agrees to continue this level of care and requests new goal.

Goal: would like to stay on medication

Other Comments

Pt with both symptoms of psychosis and malingering. Stable with this medication. Would like more sedation at night, but not appropriate for jail setting.

Cont Haldol and Cogentin

Change to MMO

//u with Doc in 3 mos

//U with nurse in between.

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Edmund S. Higgins

Edmund Higgins, MD

09 Oct 2017 3:32:14 PM

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CDMH

Date: 10/09/2017 15:32:11

276

FOLLOW-UP PSYCHIATRIC MEDICAL ASSESSMENT ORDERS AND SERVICE NOTES (PMA)

Name: HANEEF ACHU

TIN: 48992007

Place of Service: 53 COMMUNITY

Medicare Authorized Provider: NONE

Time	Staff ID	Staff Name
30	602	EDMUND HIGGINS

HISTORY

Chief Complaint/Reason for Visit

29 yo bm here for med check. Last PMA was with me about 3 mos ago at which time Haldol was increased from 2mg qhs to 5mg qhs.

History of Present Illness

"I'm fine". no changes noted, but now rpts he's better able to ignore the voices with the increased dose. also rpts visions - sees "stuff before it happens". Also rpts "I some times feel the devil is chasing me". These do not sound like typical hallucinations. Sleeping a lot, energy is fair. some depression (seems situational), appetite good and not suicidal.

Psychiatric Med Trials

Med	Dosage	Sig	Amount	Refills	Start Date
COGENTIN	1mg	qhs	-	0	
HALDOL	5mg	one qhs	-	-	04/10/2017

Allergies

nkda

Substance/Alcohol Use

Reviewed no change 07/10/2017.

Service	Last Update	Substance	Frequency/Quantity
H012	01/09/2017	CANNABIS	1 mos
Method/Comments: daily			

EXAMINATION

Vital Signs and Measurements

Service	Date	Weight	Blood Pressure	Pulse
H012	01/09/2017	148Lbs	132/86	72
H052	04/10/2017	179Lbs	116/72	88
H052	07/10/2017	19208Lbs	132/91	89

Musculoskeletal

Abnormal Movements: None; Date of last assessment of abnormal movements: 07/10/2017; Gait & Station: WNL; alms=0

Psychiatric

Appearance: WNL; Attitude: Cooperative; Behavior: Calm; Speech: Normal for Client, soft spoken; Associations: Intact; Delusions: Denies; Suicidal Ideation: Denies; Homicidal Ideation: Denies; Obsessions: Denies; Hallucinations: Auditory, visual; Affect: Flat; Sensorium: Alert; Language: Average; Judgment: Poor; Insight: Fair; Fund of Knowledge: Unable to assess at this time;

MEDICAL DECISION MAKING

Diagnosis

296.90 Schizophrenia (Prim Dx)
309.0 Adjustment disorder, With depressed mood
R/O ASPD R/O malingering

TxGoal(s)

Medication adherence, maintain therapeutic gains;

Current and New DMH Rx List

Med	Dosage	Sig	Amount	Refills	Start Dt
COGENTIN	1mg	qhs	-	0	
HALDOL	5mg	one qhs	-	-	04/10/17

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C

Date: 07/10/2017 10:59:26

472

Medication Education/Counseling Provided

Present for counseling: Client;

Discussion: Medication dose & time to take, purpose/expected benefits/risks, common side effects;

Neuroleptic Consent

A paper consent form was last obtained: 01/09/2017

Recommendations and Referrals

Follow up with: MD, requires monitoring of response to medication, requires monitoring of medication side effects;

Time until next PMA and/or NS: 3 month(s);

Follow up with MH clinician: Supportive/rehabilitative interventions, monitoring to prevent decompensation/hospitalization;

Referral: None;

Emergency admission to inpatient psychiatric care: N/A;

Other Comments

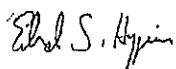
Pt rpts improvement c/w schizophrenia and antipsychotic response. However, he also pushes forward symptoms that appear to be exaggerations or even malingering. Will continue medication but will not increase.

Continue 6mg Haldol qhs and 1mg Cogentin qhs

f/u with doc in 3 mos

f/u with counselor as planned - not clear he will get much benefit from psychotherapy.

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Edmund Higgins, MD

10 Jul 2017 10:59:28 AM

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CID: 10

Date: 07/10/2017 10:59:26

2-178

STATE OF SOUTH CAROLINA

COUNTY OF MARLBORO

STATE OF SOUTH CAROLINA

vs.

HANEEF AQUIL CHILDS,

Defendant.

IN THE COURT OF GENERAL SESSIONS

FOURTH JUDICIAL CIRCUIT

2017-GS-34-0054/ Murder

2017-GS-34-0055/ Possession of Weapon

TRIAL EXHIBITS

EXHIBIT 5

FOLLOW-UP PSYCHIATRIC MEDICAL ASSESSMENT ORDERS AND SERVICE NOTES (PMA)

Name: HANEEF AQUIL CHILDS

Service Dates: 07/25/2018

Medicare Authorized Provider: NONE

Time	Staff ID	Staff Name
30	872	MARIANO RAZON

HISTORY

Chief Complaint/Reason for Visit

For psychiatric follow up - "Not so good."

History of Present Illness

Client presents to the clinic in orange jumpsuit from Marlboro Detention Center/secured by hand-body cuffs/accompanied by police officer for scheduled follow up. He reports he is still taking Haldol & it is not working for him- he continues to report VH- 'seeing people' & AH- 'hearing voices' that are not there. Sleep is poor with difficulty staying asleep/early am awakening/occasional nightmares. States this morning he was aggressive- "I punch the wall." Denies SI/HI/delusions/paranoia/hallucinations. Anxiety is rated at (8/10)/depression (8/10). Energy is low/denies hyperactivity/interacts with other inmates/denies any current conflicts with other inmates/warden. Reports able to meet self-care needs/functional /no current threat to self or to others. Denies muscle rigidity/tremors/stiffness/ involuntary movements/restlessness/confusion with current medication regimen. States he used to take Seroquel but had it stopped due to heavy sedation effect/ Risperidone stopped due to chest pains. Explained same side effects with Haldol can occur with trial Abilify/ accepts treatment proposal/ verbalized understanding. Will taper both Haldol discontinuation & Abilify initiation. No medical issues reported except hyperacidity post meal.

Psychiatric Med Trials

Med	Dosage	Sig	Amount	Refills	Start Date
COGENTIN	1mg	qhs	0		
HALDOL	5mg	one qhs	-	-	04/10/2017

Allergies

Seroquel = heavy sedation; Risperidone = chest pains;

Substance/Alcohol Use

Reviewed no change 07/25/2018.

Service	Last Update	Substance	Frequency/Quantity	Date of Last Use
H082	10/09/2017	CANNABIS	daily	dec '16

Review of Systems — Psychiatric

Appetite: Poor; Sleep: Difficulty with early morning awakening, frequent or prolonged awakenings, nightmares;

EXAMINATION

Vital Signs and Measurements

Service	Date	Height	Weight	Blood Pressure	Pulse	BMI
H052	07/10/2017		192.0 Lbs	132/91	89	
H052	10/09/2017		203 Lbs	128/82	97	
H021	06/18/2018	5 FT 7	197.0 Lbs	118/80	96	31
H053	07/25/2018		196.4 Lbs	128/93	98	

Musculoskeletal

Muscle Strength and Tone: WNL; Abnormal Movements: None; Evaluation of Abnormal Movements: N/A; Date of last assessment of abnormal movements: 07/25/2018; Gait & Station: WNL; AIMS = 0

Psychiatric

Appearance: WNL, wearing orange jumpsuit with Marlboro Detention Center; Attitude: Cooperative, guarded; Behavior: Calm; Eye Contact: WNL; Speech: Normal for Client, articulate, spontaneous; Associations: Intact; Thought Process: Logical/Goal Directed; Delusions: Denies; Suicidal Ideation: Denies; Homicidal Ideation: Denies; Obsessions: Denies; Hallucinations: Auditory, visual, see hpi; Mood: Depressed, anxious; Affect: Appropriate; Sensorium: Alert; Oriented: Time, place, person, circumstance; Recent Memory: Intact; Remote Memory: Intact; Attention: Intact; Concentration: Intact; Language: Average; Judgment: Good; Insight: Good; Fund of Knowledge: Average;

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CID

Date: 07/25/2018 15:49:13

480

MEDICAL DECISION MAKING**Diagnosis**

295.90 Schizophrenia (Prim Dx)
 300.0 Adjustment disorder, With depressed mood
 R/O ASPD R/O malingering

TxGoal(s)

Symptom reduction, medication adherence, maintain therapeutic gains, restore level of functioning;

Labs and Review of Medical Records

Labs Reviewed, review of other pertinent medical/history information;

Current and New DMH Rx List

Med	Dosage	Sig	Amount	Refills	Type	Start Dt	Archive Dt
COGENTIN	1mg	qhs		0			07/25/18
	Note: refill						
	Reason for Archive: DC-Completion of Therapy						
HALDOL	5mg	one qhs				04/10/17	07/25/18
	Note: titration to qhs						
	Reason for Archive: DC-Completion of Therapy						
HALDOL (N)	2 mg	po daily x 1 month then 1 mg then D/C		0	Rx	07/25/18	
ABILIFY (N)	10 mg	po daily x 2 weeks then 15 mg thereafter		1	Rx	07/25/18	
COGENTIN (N)	1 mg	po daily at bedtime		1	Rx	07/25/18	

Physical Health / Other Meds**Medication Education/Counseling Provided**

Present for counseling: Client;

Discussion: Medication dose & time to take, purpose/expected benefits/risks, common side effects, lab monitoring required/reason, expected length of treatment, alternatives to medication, risk of no treatment;

Neurolaptic Consent

A paper consent form was last obtained: 01/09/2017

Recommendations and Referrals

Follow up with: MD, nurse, aprn, requires monitoring of response to medication, requires monitoring of medication side effects;

Time until next PMA and/or NS: 6 week(s);

Follow up with MH clinician: Improve level of functioning, monitoring to prevent decompensation/hospitalization, symptoms unstable (worsening or failing to change as expected), monitoring to maintain therapeutic gains, symptoms improving (resolving and controlled);

MMO Status and Client Goal

MMO since 10/08/2017

Intervening Service since last PMA: Nursing Services;

MMO: Remain in MMO

Patient agrees to continue this level of care and agrees to continue current goal.

Goal: would like to stay on medication

Other Comments

Reports Haldol not working for him- depression & hallucinations. Will discontinue via titration 2 months.

Will trial treatment with Abilify.

Nursing to follow up medication compliance/tolerance/side effects.

Clinic to continue therapeutic relationship/gains- call for psychiatric issues.

Next PMA in 6 weeks for follow up.

Counseled adequate rest/sleep hygiene/hydration/avoid hard to digest foods/

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Mariano Razon
 APRN - C

25 Jul 2018 3:48:18 PM

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C

Date: 07/25/2018 15:49:13

461

FOLLOW-UP PSYCHIATRIC MEDICAL ASSESSMENT ORDERS AND SERVICE NOTES (PMA)

Name: HANEEF AQUIL CHILDS

DOB: [REDACTED]

Referral: [REDACTED]

Medicare A: [REDACTED] NONE

Time	Staff ID	Staff Name
30	674	NIKUNJKUMAR MODI

HISTORY

Chief Complaint/Reason for Visit

"hearing voices, seeing things"

History of Present Illness

Last seen in clinic on July 25, 2018 for medication management and Haldol was stopped and he was prescribed aripiprazole which was not available in detention center and put back on haloperidol.

He reports he has been hearing voices telling him that "he will stay in jail for forever, tell me to do stuff, kill myself". He says he is seeing demons on the wall. He says he was hearing voices from childhood but never asked for any help. He says he does not know any of his family member has any psychiatric issues. He says he is in jail for 2 years for murder and possession of weapon.

He reports he has variable sleep and he sleeps in night and sometimes during the daytime. He reports he does not have any abnormal involuntary movement. He reports he sometimes feels sluggish. He mentions he is participating in group activities and not getting into any altercation.

He mentions he sometimes he has anxiety and pace back and forth.

Taking medications as prescribed; Denies medication side effects; Denies depressive symptoms; Denies manic symptoms; Denies SI/HI;

Review of Systems — Psychiatric

General/Skin: WNL; Sleep: Disturbed/Restless; Interest: WNL; Energy: Decreased energy; Concentration: WNL; Appetite: Erratic/Variable; Psychomotor: WNL;

Psychiatric Medications (DMH)

Med	Dosage	Sig
COGENTIN	1 mg	po daily at bedtime
HALDOL	10mg	qhs

Allergies

Seroquel = heavy sedation; Risperidone = chest pains;

Review of Systems — Medical

Head/Eyes: Denies Problems; ENT: Denies Problems; Cardiovascular: Denies Problems; Respiratory: Denies Problems; Gastrointestinal: Denies Problems; Genitourinary: Denies Problems; Musculoskeletal: Denies Problems; Neurologic: Denies Problems; Endocrine: Denies Problems; Hematologic/Lymphatic: Denies Problems; Allergic/Immunologic: Denies Problems;

Substance/Alcohol Use

All reviewed/updated 11/09/2018.

Service	Last Update	Substance	Frequency/Quantity	Date of Last Use
H052	11/09/2018	CANNABIS	daily	dec '16

Family History

reports his uncle has some psychiatric issues

Social History

Current legal and/or probation;

EXAMINATION

Vital Signs and Measurements

Service	Date	Height	Weight	Blood Pressure	Pulse	Temp
H052	11/09/2018	5FT7	197lbs	133/68	70	98.6

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Date: 11/09/2018 10:23:31

482

Musculoskeletal

Muscle Strength and Tone: WNL; Abnormal Movements: None; Evaluation of Abnormal Movements: Correct and no updates are required; Date of last assessment of abnormal movements: 07/26/2018; Gait & Station: WNL;

Mental Status Examination

Appearance: WNL, wearing orange jumpsuit, hand cuffed, grown beard; Attitude: Cooperative; Behavior: Calm; Speech: Normal for Client; Associations: Intact; Thought Process: Logical/Goal Directed; Suicidal Ideation: Denies; Homicidal Ideation: Denies; Obsessions: Denies; Hallucinations: Auditory, visual; Mood: Euthymic; Affect: Appropriate; Sensorium: Alert; Oriented: Time, place, person, circumstance; Recent Memory: Intact; Remote Memory: Intact; Attention: Intact; Concentration: Intact; Language: Average; Judgment: Good; Insight: Good; Fund of Knowledge: Average;

MEDICAL DECISION MAKING**Diagnosis**

309.0 Adjustment disorder, With depressed mood (Prim Dx)
R/O malingering

TxGoal(s)

Symptom reduction, medication adherence, maintain therapeutic gains, restore level of functioning;

Labs and Review of Medical Records

Review of other pertinent medical/history information;

Current and New DMH Rx List

Med	Dosage	Sig	Refills	Type	Start Dt	Archive Dt
COGN-NTN	1 mg	po daily at bedtime	1	Rx	07/25/18	11/09/18
	Reason for Archive: DC-Completion of Therapy					
HALDOL	10mg	qhs	0	Rx	07/26/18	11/09/18
	Reason for Archive: DC-Completion of Therapy					
HALDOL (N)	5 mg	po qam	0	Rx	11/09/18	
HALDOL (N)	10 mg	po qhs	0	Rx	11/09/18	
COGENTIN (N)	1 mg	po daily at bedtime	0	Rx	11/09/18	

Physical Health / Other Meds**Medication Education/Counseling Provided**

Present for counseling: Client;
Discussion: Medication dose & time to take, purpose/expected benefits/risks, common side effects, lab monitoring required/reason, expected length of treatment, alternatives to medication, risk of no treatment, neuroleptic consent;

Neuroleptic Consent

A paper consent form was last obtained: 01/09/2017

Recommendations and Referrals

Follow up with: MD, requires monitoring of response to medication, requires monitoring of medication side effects;
Time until next PMA and/or NS: 4 month(s);
Follow up with MH clinician: Improve level of functioning, monitoring to prevent decompensation/hospitalization, symptoms unstable (worsening or failing to change as expected), monitoring to maintain therapeutic gains, symptoms improving (resolving and controlled);
Referral: None;
Emergency admission to inpatient psychiatric care: N/A;

MMO Status and Client Goal

MMO since 10/09/2017
MMO: Remain in MMO
Patient agrees to continue this level of care and agrees to continue current goal.
Goal: would like to stay on medication

Other Comments

Patient claims auditory and visual hallucination and says he had it from childhood and did not received any treatment. He becomes vague when asked about hallucinations. He feels Haldol does not help him enough so I will increase dose of Haldol to 5 mg po qam and 10mg po qhs. will continue benztropine 1 mg po qhs for EPS. Nurse will contact detention center and update medications.



Nikunj Kumar Modi

09 Nov 2018 10:23:33 AM

(page 2)

CID: 1000000000

Date: 11/09/2018 10:23:31

FOLLOW-UP PSYCHIATRIC MEDICAL ASSESSMENT ORDERS AND SERVICE NOTES (PMA)

Name: HANEEF AQUIL CHILDS

Service Date: 02/01/2019

DOB: 01/16/1985

Ref: 02/01/2019

Medicare Authorized Provider: NONE

Time	Staff ID	Staff Name
30	074	NIKUNJ KUMAR MODI

HISTORY

Chief Complaint/Reason for Visit

"Medication is not working"

History of Present Illness

"I am still hearing voices" "I can't describe" "They tell me I am a messiah over and over" They don't tell me to hurt myself.

Reports he is has sleep 50-50, says "I sleep but I can't sleep" when asked to explain he replies "I don't know what it mean". He mentions he is getting 5 hours of sleep. He says he has trouble staying into sleep. He reports he has good appetite.

He mentions he is walking back and forth and after that he feels tightness in his chest. He reports it lasts for an hour. He says it happens sometimes. He denies for having radiating pain, nausea, vomiting, trouble breathing.

He reports he is denial of a bond. He denies for having SI, HI. He reports his cousin "Anwar" and his mother comes to visit him every few months.

Taking medications as prescribed; Denies medication side effects; Denies depressive symptoms; Denies anxiety symptoms; Denies manic symptoms; Denies SI/HI;

Review of Systems — Psychiatric

General/Skin: WNL; Sleep: WNL; Interest: WNL; Energy: WNL; Concentration: WNL; Appetite: WNL; Psychomotor: WNL;

Psychiatric Medications (DMH)

Med	Dosage	Sig
HALDOL	5 mg	po qam
HALDOL	10 mg	po qhs
COGENTIN	1 mg	po daily at bedtime

Allergies

Seroquel = heavy sedation; Risperidone = chest pains;

Review of Systems — Medical

Head/Eyes: Denies Problems; ENT: Denies Problems; Cardiovascular: Denies Problems; Respiratory: Denies Problems; Gastrointestinal: Denies Problems; Genitourinary: Denies Problems; Musculoskeletal: Denies Problems; Neurologic: Denies Problems; Endocrine: Denies Problems; Hematologic/Lymphatic: Denies Problems; Allergic/Immunologic: Denies Problems;

Substance/Alcohol Use

All reviewed/updated 02/01/2019.

Service	Last Update	Substance	Frequency/Quantity	Date of Last Use
H052	02/01/2019	CANNABIS	daily	dec '16

EXAMINATION

Vital Signs and Measurements

Service	Date	Height	Weight	Blood Pressure	Pulse	BMI
H052	02/01/2019	5FT7	200Lbs	149/105	90	31

Musculoskeletal

Muscle Strength and Tone: WNL; Abnormal Movements: None; Evaluation of Abnormal Movements: Correct and no updates are required; Date of last assessment of abnormal movements: 07/25/2018; Gait & Station: WNL;

Mental Status Examination

Appearance: Disheveled, unkempt, in orange jumpsuit, hand cuffed, escorted by Law enforcement; Attitude: Guarded; Behavior: Calm; Eye Contact: Intermittent; Speech: Normal for Client; Associations: Intact; Thought Process: Concrete; Delusions: Denies; Suicidal Ideation: Denies; Homicidal Ideation: Denies; Obsessions: Denies;

(page 1)

CID:

Date: 02/01/2019 14:29:21

cm

Hallucinations; Auditory; Mood; Euthymic; Affect: Appropriate; Sensorium: Alert; Oriented: Time, place, person, circumstance; Recent Memory: Intact; Remote Memory: Intact; Attention: Intact; Concentration: Intact; Language: Average; Judgment: Fair; Insight: Fair; Fund of Knowledge: Average;

MEDICAL DECISION MAKING

Diagnosis

309.0 Adjustment disorder, With depressed mood (Prim Dx)

R/O malingering

TxGoal(s)

Symptom reduction, medication adherence, maintain therapeutic gains, restore level of functioning;

Lab and Review of Medical Records

Review of other pertinent medical/history information;

Current and New DMH Rx List

Med	Dosage	Sig	Refills	Type	Start Dt
HALDOL	5 mg	po qam	0	Rx	11/09/18
HALDOL	10 mg	po qhs	0	Rx	11/09/18
COGENTIN	1 mg	po daily at bedtime	0	Rx	11/09/18
TRAZODONE (N)	50 mg	po bedtime as needed for sleep	0	Rx	02/01/19

Physical Health / Other Meds

Medication Education/Counseling Provided

Present for counseling: Client;

Discussion: Medication dose & time to take, purpose/expected benefits/risks, common side effects, lab monitoring required/reason, expected length of treatment, financial availability, alternatives to medication, risk of no treatment, neuroleptic consent;

Neuroleptic Consent

A paper consent form was last obtained: 01/09/2017

Recommendations and Referrals

Follow up with: MD, requires monitoring of response to medication, requires monitoring of medication side effects;

Follow up with MH clinician: Improve level of functioning, monitoring to prevent decompensation/hospitalization, symptoms unstable (worsening or failing to change as expected), monitoring to maintain therapeutic gains, symptoms improving (resolving and controlled);

Referral: None;

Emergency admission to inpatient psychiatric care: N/A;

MMO Status and Client Goal

MMO since 10/09/2017

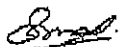
MMO: Remain in MMO

Patient agrees to continue this level of care and agrees to continue current goal.

Goal: would like to stay on medication

Other Comments

Patient claims to have hallucinations but when asked in detail he becomes more vague, reports having auditory hallucination of hearing voice of calling him messiah, says he has trouble staying into sleep, will continue above meds (haloperidol 5 mg po qam and 10 mg po qhs, Cogentin 1 mg po qhs) and add trazodone 50 mg po qhs PRN for sleep. Nurse will inform that detention center about the changes.



Nikunj Kumar Modi

01 Feb 2019 2:29:23 PM

(page 2)

CID: [REDACTED]

Date: 02/01/2019 14:28:21

FOLLOW-UP PSYCHIATRIC MEDICAL ASSESSMENT ORDERS AND SERVICE NOTES (PMA)

Name: HANEEF AQUIL CHILDS

Service Date: 03/15/2019

DOB: 04/11/1981

MHC

ID:

M:

Medicare Authorized Provider: NONE

Time	Staff ID	Staff Name
30	674	NIKUNJKUMAR MODI

HISTORY

Chief Complaint/Reason for Visit

"I am alright now"

History of Present Illness

He says he is doing well. He says he is not hearing any voice now. He reports he feels people are trying to get him and does not know who they are. He says he had dream last night that he has been shot.

He mentions he is waiting for a next hearing. He reports he is sleep okay, wake in the middle of night, reports he did not received trazodone. He says he has good appetite. He reports his mood is "fine". He says he play cards and watch TV in detention center. He denies for having any sl, hi, avh.

Taking medications as prescribed; Denies medication side effects; Denies depressive symptoms; Denies anxiety symptoms; Denies manic symptoms; Denies AVH; Denies SI/HI;

Review of Systems — Psychiatric

General/Skin: WNL; Sleep: WNL; Interest: WNL; Energy: WNL; Concentration: WNL; Appetite: WNL; Psychomotor: WNL;

Psychiatric Medications (DMH)

Med	Dosage	Sig
HALDOL	5 mg	po qam
HALDOL	10 mg	po qhs
TRAZODONE	60 mg	po bedtime as needed for sleep
COGENTIN	1 mg	po daily at bedtime

Allergies

Seroquel = heavy sedation; Risperidone = chest pains;

Review of Systems — Medical

Head/Eyes: Denies Problems; ENT: Denies Problems; Cardiovascular: Denies Problems; Respiratory: Denies

Problems; Gastrointestinal: Denies Problems; Genitourinary: Denies Problems; Musculoskeletal: Denies Problems;

Neurologic: Denies Problems; Endocrine: Denies Problems; Hematologic/Lymphatic: Denies Problems;

Allergic/Immunologic: Denies Problems;

Substance/Alcohol Use

Service	Last Update	Substance	Frequency/Quantity	Date of Last Use
H052	02/01/2019	CANNABIS	daily	dec '18

Social History

Incarcerated

EXAMINATION

Vital Signs and Measurements

Service	Date	Height	Weight	Blood Pressure	Pulse	BMI
H052	03/15/2019	5FT7	202.8Lbs	133/92	80	32

Musculoskeletal

Muscle Strength and Tone: WNL; Abnormal Movements: None; Date of last assessment of abnormal movements: 07/25/2018; Gait & Station: WNL;

Mental Status Examination

Appearance: Disheveled, unkempt, in orange jumpsuit with handcuff, grown beard, multiple tattoos; Attitude: Cooperative; Behavior: Calm; Eye Contact: WNL; Speech: Normal for Client; Associations: Intact; Thought Process: Logical/Goal Directed; Delusions: Denies; Suicidal Ideation: Denies; Homicidal Ideation: Denies; Obsessions: Denies; Hallucinations: Denies; Mood: Euthymic; Affect: Appropriate; Sensorium: Alert; Oriented: Time, place, person, circumstance; Recent Memory: Intact; Remote Memory: Intact; Attention: Intact; Concentration: Intact; Language: Average; Judgment: Fair; Insight: Fair; Fund of Knowledge: Average;

419

MEDICAL DECISION MAKING**Diagnosis**

309.0 Adjustment disorder, With depressed mood (Prim Dx)
R/O malingering

Tx Goal(s)

Symptom reduction, medication adherence, maintain therapeutic gains, restore level of functioning;

Labs and Review of Medical Records

Review of other pertinent medical/history information;

Current and New DMH Rx List

Med	Dosage	Sig	Refills	Type	Start Dt	Archive Dt
HALDOL	5 mg	po qam	0	Rx	11/09/18	
HALDOL	10 mg	po qhs	0	Rx	11/09/18	
TRAZODONE	30 mg	po bedtime as needed for sleep	0	Rx	02/01/19	03/15/19
Reason for Archive: DO Consultation of Therapy						
COGENTIN	1 mg	po daily at bedtime	0	Rx	11/09/18	
TRAZODONE (N)	50	PO BEDTIME for SLEEP	0	Rx	03/15/19	

Physical Health / Other Meds**Medication Education/Counseling Provided**

Present for counseling: Client;

Discussion: Medication dose & time to take, purpose/expected benefits/risks, common side effects, lab monitoring required/reason, expected length of treatment, financial availability, alternatives to medication, risk of no treatment;

Neuroleptic Consent

A paper consent form was last obtained: 01/09/2017

Recommendations and Referrals

Follow up with: MD, requires monitoring of response to medication, requires monitoring of medication side effects;

Time until next PMA and/or NS: 3 month(s);

Follow up with MH clinician: Psychotherapy interventions, improve level of functioning, monitoring to prevent decompensation/hospitalization, symptoms unstable (worsening or failing to change as expected), monitoring to maintain therapeutic gains, symptoms improving (resolving and controlled);

Referral: None;

Emergency admission to inpatient psychiatric care: N/A;

MMO Status and Client Goal

MMO since 10/09/2017

MMO: Remain in MMO

Patient agrees to continue this level of care and agrees to continue current goal.

Goal: would like to stay on medication

Other Comments

Doing well, says mood is stable, report did not receive trazodone, will change it from PRN to scheduled at bedtime, continue other meds as above. Nurse will call detention center to update meds.



Nikunj Kumar Modi

15 Mar 2019 1:51:04 PM

The form has been signed 2 time(s). Reason: change in code, patient is incarcerated (page 2)

CID: 10380595

Date: 03/15/2019 10:51:01

487

FOLLOW-UP PSYCHIATRIC MEDICAL ASSESSMENT ORDERS AND SERVICE NOTES (PMA)

Name: HANEEF

DOB:

ID:

Modifier:

Medicare Authorized Provider: NONE

Time	Staff ID	Staff Name
30	674	NIKUNJKUMAR MODI

HISTORY

Chief Complaint/Reason for Visit

"I am sleeping better now. Waiting for my hearing"

History of Present Illness

Last PMA on 03/15/2019, doing well, had some paranoia, had nightmares, seen for Nurse visit in May and reported improvement in sleep.

Today he reports he is sleeping better after trazodone has been started. says he has nightmares but he does not remember in the morning. He says his mood is "okay". He says he has good appetite. He mentions he talks with other inmates and his family over the phone. He says he speak with his mother, father, sister, wife and his children.

He says he does not have fixed date of next hearing. says he has charges of murder and possession of a weapon,

now he hears voices which tells him "you are a piece of shit, you should die", says voices laugh at him.

denies for having any sl, hl or paranoia.

Taking medications as prescribed; Denies medication side effects; Denies depressive symptoms; Denies anxiety symptoms; Denies manic symptoms; Denies AVH; Denies SI/HI;

Review of Systems — Psychiatric

General/Skin: WNL; Sleep: WNL; Interest: WNL; Energy: WNL; Concentration: WNL; Appetite: WNL;

Psychomotor: WNL;

Psychiatric Medications (DMH)

Med	Dosage	Sig
HALDOL	5 mg	po qam
HALDOL	10 mg	po qhs
TRAZODONE	50	PO BEDTIME for SLEEP
COGENTIN	1 mg	po daily at bedtime

Allergies

Seroquel = heavy sedation; Risperidone = chest pains;

Review of Systems — Medical

Head/Eyes: Denies Problems; ENT: Denies Problems; Cardiovascular: Denies Problems; Respiratory: Denies Problems; Gastrointestinal: Denies Problems; Genitourinary: Denies Problems; Musculoskeletal: Denies Problems; Neurologic: Denies Problems; Endocrine: Denies Problems; Hematologic/Lymphatic: Denies Problems; Allergic/Immunologic: Denies Problems;

Substance/Alcohol Use

All reviewed/updated 06/14/2019.

Service	Last Update	Substance	Frequency/Quantity	Date of Last Use
H052	06/14/2019	CANNABIS	daily	dec '18

EXAMINATION

Vital Signs and Measurements

Service	Date	Height	Weight	Blood Pressure	Pulse	BMI
H052	06/14/2019	5FT7	200Lbs	147/105	78	31

(page 1)

G: [REDACTED] Date: 06/14/2019 11:29:17.

4/28

Musculoskeletal

Muscle Strength and Tone: WNL; Abnormal Movements: None; Date of last assessment of abnormal movements: 07/25/2018; Gait & Station: WNL;

Mental Status Examination

Appearance: hand cuffed, in orange jumpsuit, with LEO sitting outside the office; Attitude: Cooperative; Behavior: Calm; Eye Contact: WNL; Speech: Normal for Client; Associations: Intact; Thought Process: Logical/Goal Directed; Delusions: Denies; Suicidal Ideation: Denies; Homicidal Ideation: Denies; Obsessions: Denies; Hallucinations: Auditory; Mood: Euthymic; Affect: Appropriate; Sensorium: Alert; Oriented: Time, place, person, circumstance; Recent Memory: Intact; Remote Memory: Intact; Attention: Intact; Concentration: Intact; Language: Average; Judgment: Good; Insight: Good; Fund of Knowledge: Average;

MEDICAL DECISION MAKING**Diagnosis**

309.0 Adjustment disorder, With depressed mood (Prm Dx)
R/O malingering

TxGoal(s)

Symptom reduction, medication adherence, maintain therapeutic gains, restore level of functioning;

Labs and Review of Medical Records

Review of other pertinent medical/history information;

Current and New DMH Rx List

Med	Dosage	Sig	Refills	Type	Start Dt
HALDOL	5 mg	po qam	0	Rx	11/09/18
HALDOL	10 mg	po qhs	0	Rx	11/09/18
TRAZODONE	50	PO BEDTIME for SLEEP	0	Rx	03/15/19
COGENTIN	1 mg	po daily at bedtime	0	Rx	11/09/18

Physical Health / Other Meds**Medication Education/Counseling Provided**

Present for counseling: Client;
Discussion: Medication dose & time to take, purpose/expected benefits/risks, common side effects, lab monitoring required/reason, expected length of treatment, financial availability, alternatives to medication, risk of no treatment;

Neuroleptic Consent

A paper consent form was last obtained: 01/09/2017

Recommendations and Referrals

Follow up with: MD, requires monitoring of response to medication, requires monitoring of medication side effects;

Referral: None;

Emergency admission to Inpatient psychiatric care: N/A;

MMO Status and Client Goal

MMO since 10/08/2017

MMO: Remain in MMO

Patient agrees to continue this level of care and agrees to continue current goal.

Goal: would like to stay on medication

Other Comments

He is stable on current meds. says he occasionally hears voices as mentioned in HPI. will continue above meds. Staff nurse will contact nurse at the detention center about him medication. If his blood pressure stays elevated then he might require an appointment with PCP.

[Signature] Nikunj Kumar Modi
14 Jun 2019 11:29:18 AM

(page 2)

[Faint, illegible text stamp]

[Redacted signature] Date: 06/14/2019 11:29:17

LR9

FOLLOW-UP PSYCHIATRIC MEDICAL ASSESSMENT ORDERS AND SERVICE NOTES (PMA)

Name: HANEEF ACHIL CHUNNI Date: 01/21/2020

DOB: [REDACTED]

Medicare Authorized Provider: NONE

Time	Staff ID	Staff Name
30	874	NIKUNJKUMAR MODI

HISTORY

Chief Complaint/Reason for Visit

"Doing well, has trouble with sleep"

History of Present Illness

Seen via telepsychiatry from Florence, SC. He is currently in jail for charges for murder. Reported having AVH during his nurse visit. He no showed last month because of transportation issues.

He reports that he has trouble with sleep and not able to rest well at night. He says he has nightmares, he mentions having trouble staying into sleep. reports hallucinations are under control. denies for having having any sl, hl, says sometimes feels people wants him dead, reports his cousin comes to meet him every week and his mother every 3-4 months and he feels good about it. denies any abnormal involuntary movements.

Taking medications as prescribed; Denies medication side effects;

Review of Systems — Psychiatric

General/Skin: WNL; Sleep: Disturbed/Restless; Interest: WNL; Energy: WNL; Concentration: WNL; Appetite: WNL; Psychomotor: WNL;

Psychiatric Medications (DMH)

Med	Dosage	Sig
HALDOL	5 mg	po qam
HALDOL	10 mg	po qhs
COGENTIN	1 mg	po daily at bedtime
TRAZODONE	60	PO BEDTIME for SLEEP

Allergies

Seroquel = heavy sedation; Risperidone = chest pains;

Review of Systems — Medical

Head/Eyes: Denies Problems; ENT: Denies Problems; Cardiovascular: Denies Problems; Respiratory: Denies Problems; Gastrointestinal: Denies Problems; Genitourinary: Denies Problems; Musculoskeletal: Denies Problems; Neurologic: Denies Problems; Endocrine: Denies Problems; Hematology/Lymphatic: Denies Problems; Allergic/Immunologic: Denies Problems;

Substance/Alcohol Use

Service	Last Update	Substance	Frequency/Quantity	Date of Last Use
H062	08/14/2019	CANNABIS	daily	dec '18

Social History

Incarcerated

EXAMINATION

Vital Signs and Measurements

Service	Date	Height	Weight	Blood Pressure	Pulse	BMI
H062	01/21/2020	5FT7	203Lbs	142/97	85	32

Musculoskeletal

Muscle Strength and Tone: WNL; Abnormal Movements: None; Evaluation of Abnormal Movements: N/A; Date of last assessment of abnormal movements: 01/21/2020; Gait & Station: WNL;

Mental Status Examination

Appearance: Disheveled, unkempt, in shackles, in orange jumpsuit; Attitude: Cooperative; Behavior: Calm; Eye Contact: WNL; Speech: Normal for Client; Associations: Intact; Thought Process: Logical/Goal Directed; Delusions: Denies; Suicidal Ideation: Denies; Homicidal Ideation: Denies; Obsessions: Denies; Hallucinations: Denies; Mood: Euthymic; Affect: Appropriate; Sensorium: Alert; Oriented: Time, place, person, circumstance; Recent Memory: Intact; Remote Memory: Intact; Attention: Intact; Concentration: Intact; Language: Average; Judgment: Fair; Insight: Fair; Fund of Knowledge: Above Average;

(page 1)

Date: 01/21/2020 12:04:04

MA

MEDICAL DECISION MAKING**Diagnosis**

309.0 Adjustment disorder, With depressed mood (Prim Dx)

R/O malingering, h/o AVH and paranoia

TxGoal(s)

Symptom reduction, medication adherence, maintain therapeutic gains, restore level of functioning;

Labs and Review of Medical Records

Review of other pertinent medical/history information;

Current and New DMH Rx List

Med	Dosage	Sig	Refills	Type	Start Dt	Archive Dt
HALDOL	5 mg	po qam	0	Rx	11/09/18	
HALDOL	10 mg	po qhs	0	Rx	11/09/18	
COGENTIN	1 mg	po daily at bedtime	0	Rx	11/09/18	
TRAZODONE	50 mg	PO BEDTIME for SLEEP	0	Rx	03/16/19	01/21/20
Reason for Archive: DC: Completion of Therapy						
TRAZODONE (N)	100 mg	PO Bedtime for sleep	0	Rx	01/21/20	

Physical Health / Other Meds**Medication Education/Counseling Provided**

Present for counseling: Client;

Discussion: Medication dose & time to take, purpose/expected benefits/risks, common side effects, lab monitoring required/reason, expected length of treatment, financial availability, alternatives to medication, risk of no treatment;

Neuroleptic Consent

An electronic consent form was last obtained: 01/21/2020

Recommendations and Referrals

Follow up with: MD, nurse, requires monitoring of response to medication, requires monitoring of medication side effects;

Time until next PMA and/or NS: 3 month(s);

Follow up with MH clinician: Psychotherapy interventions, supportive/rehabilitative interventions, improve level of functioning, monitoring to prevent decompensation/hospitalization, symptoms unstable (worsening or failing to change as expected), monitoring to maintain therapeutic gains, symptoms improving (resolving and controlled);

Referral: None;

Emergency admission to inpatient psychiatric care: N/A;

MMO Status and Client Goal

MMO since 10/09/2017

MMO: Remain in MMO

Patient agrees to continue this level of care and agrees to continue current goal.

Goal: would like to stay on medication

Other Comments

He reports doing well on meds so will continue Haldol and Cogentin, has trouble with sleep so will increase trazodone to 100 mg po qhs from 50 mg po qhs. agrees with the change.

Emad and Nikunj Kumar Modi
21 Jan 2020 12:04:06 PM

(page 2)

CID: [REDACTED] Date: 01/21/2020 12:04:04

FOLLOW-UP PSYCHIATRIC MEDICAL ASSESSMENT ORDERS AND SERVICE NOTES (PMA)

Name: HANEEF AGUIL CHILDS Service Date: 04/13/2020

[REDACTED]

Medicare Authorized Provider: NONE

No-charge reason: COVID-19 Telephone Service

Time	Staff ID	Staff Name
30	074	NIKUNJUMAR MODI

HISTORY

Chief Complaint/Reason for Visit

"Medication management follow up"

History of Present Illness

Talked to patient via telephone. "Patient informed that service provided is a non-HIPAA compliant platform." Patient agreed to proceed.

today he reports he still has AH, he is hearing laughter sounds, voices telling him "I am shit" and other lots of things, says he sometimes sees shadows, reports he does not have any thoughts to hurt himself or others, reports having good sleep and appetite, denies for having any side effects, reports he does not feel depressed, reports haloperidol is not helping him enough and he wants to increase it.

Taking medications as prescribed; Denies medication side effects; Denies depressive symptoms; Denies anxiety symptoms; Denies manic symptoms; Denies AVH; Denies SI/HI;

Review of Systems — Psychiatric

General/Skin: WNL; Sleep: WNL; Interest: WNL; Energy: WNL; Concentration: WNL; Appetite: WNL;

Psychomotor: WNL;

Psychiatric Medications (DMH)

Med.	Dosage	Sig
HALDOL	5 mg	po qam
HALDOL	10 mg	po qhs
TRAZODONE	100 mg	PO Bedtime for sleep
COGENTIN	1 mg	po daily at bedtime

Allergies

Seroquel = heavy sedation; Risperidone = chest pains;

Review of Systems — Medical

Head/Eyes: Denies Problems; ENT: Denies Problems; Cardiovascular: Denies Problems; Respiratory: Denies Problems; Gastrointestinal: Denies Problems; Genitourinary: Denies Problems; Musculoskeletal: Denies Problems; Neurologic: Denies Problems; Endocrine: Denies Problems; Hematologic/Lymphatic: Denies Problems; Allergic/Immunologic: Denies Problems;

Substance/Alcohol Use

Service	Last Update	Substance	Frequency/Quantity	Date of Last Use
H052	08/14/2010	CANNABIS	daily	dec '18

Social History

Current legal and/or probation;

EXAMINATION

Musculoskeletal

Date of last assessment of abnormal movements: 01/21/2020;

Mental Status Examination

Appearance: unable to comment on it as it was a telephone interview; Attitude: N/A; Eye Contact: N/A; Speech: Normal for Client; Associations: Intact; Thought Process: Logical/Goal Directed; Delusions: Denies; Suicidal Ideation: Denies; Homicidal Ideation: Denies; Obsessions: Denies; Hallucinations: Auditory, Visual; Mood: Euthymic; Affect: Appropriate; Sensorium: Alert; Oriented: Time, place, person, circumstances; Recent Memory: Intact; Remote Memory: Intact; Attention: Intact; Concentration: Intact; Language: Average; Judgment: Fair; Insight: Fair; Fund of Knowledge: Average;

MEDICAL DECISION MAKING

Diagnosis

308.0 Adjustment disorder, With depressed mood (Prim Dx)

(page 1)

C [REDACTED] 04/13/2020 18:25:25

992

R/O malingering, h/o AVH and paranoia

TxGoal(s)

Symptom reduction, medication adherence, maintain therapeutic gains, restore level of functioning;

Labs and Review of Medical Records

Review of other pertinent medical/history information;

Current and New DMH Rx List

Med	Dosage	Sig	Refills	Type	Start Dt	Archive Dt
HALOPERIDOL	5 mg	po BID	0	Rx	11/09/18	04/13/20
Reason for Archive: DC-Completion of Therapy						
HALOPERIDOL	10 mg	po qhs	0	Rx	11/09/18	04/13/20
Reason for Archive: DC-Completion of Therapy						
TRAZODONE	100 mg	PO Bedtime for sleep	0	Rx	01/21/20	
COGENTIN	1 mg	po daily at bedtime	0	Rx	11/09/18	
haloperidol (N)	10 mg	PO BID	0	Rx	04/13/20	

Physical Health / Other Meds

Medication Education/Counseling Provided

Present for counseling; Client:

Discussion: Medication dose & time to take, purpose/expected benefits/risks, common side effects, lab monitoring required/reason, expected length of treatment, alternatives to medication, risk of no treatment;

Neuroleptic Consent

An electronic consent form was last obtained: 01/21/2020

Recommendations and Referrals

Follow up with: MD, requires monitoring of response to medication, requires monitoring of medication side effects;

Time until next PMA and/or NS: 3 month(s);

Follow up with MH clinician: Psychotherapy Interventions, supportive/rehabilitative interventions, improve level of functioning, monitoring to prevent decompensation/hospitalization, symptoms unstable (worsening or failing to change as expected), monitoring to maintain therapeutic gains, symptoms improving (resolving and controlled);

Referral: None;

Emergency admission to inpatient psychiatric care: N/A;

MMO Status and Client Goal

MMO since 10/09/2017

MMO: Remain in MMO

Patient agrees to continue this level of care and agrees to continue current goal.

Goal: would like to stay on medication

Other Comments

He reports he still has Auditory or visual hallucinations so will increase it to 10 mg po BID, will continue trazodone and Cogentin as above.

Smal and Nikunj Kumar Modi
13 Apr 2020 6:25:27 PM

(page 2)

Date: 04/13/2020 16:25:25

FOLLOW-UP PSYCHIATRIC MEDICAL ASSESSMENT ORDERS AND SERVICE NOTES (PMA)

Name: HANEEF AQUIL CHILDS

Service Date: 07/07/2020

ID:

Med:

Medication Authorized Provider: NONE

No-charge reason: COVID-19 Telephone Service

Time	Staff ID	Staff Name
30	674	NIKUNJKUMAR MODI

HISTORY

Chief Complaint/Reason for Visit

"I have trouble with sleep, sometimes hearing voices that tells me "I am shit" and not able to get out of the jail"

Service was provided today via telephone since video capability was not available. Identification/location of the patient were confirmed, name/credentials of this practitioner were provided, and emergency procedures were reviewed. The patient was briefed that the session is not recorded, and that notes taken from the session would become part of the medical record. Patient consented to care. The electronic nature of this clinical encounter is necessitated by the current COVID-19 emergency.

History of Present Illness

Patient is incarcerated.

Reports he has trouble with sleep and sometimes wakes up in the middle of night and not able to go back to sleep again. Denies for having side effects from meds, says he is taking it as he is prescribed. He mentions sometimes he hears voices or may be its his own voices which tells him that "I am shit and I am not able to get out of the jail". Denies any command hallucinations. He says he has good appetite. Reports because of corona virus his outside activities has been limited, denies for having SI, HI, AVH or paranoia.

Taking medications as prescribed; Denies medication side effects; Denies depressive symptoms; Denies anxiety symptoms; Denies manic symptoms; Denies AVH; Denies SI/HI;

Review of Systems — Psychiatric

General/Skin: WNL; Sleep: Disturbed/Restless; Interest: WNL; Energy: WNL; Concentration: WNL; Appetite: WNL; Psychomotor: WNL;

Psychiatric Medications (DMH)

Med	Dosage	Sig
TRAZODONE	100 mg	PO Bedtime for sleep
COGENTIN	1 mg	po daily at bedtime
haloperidol	10 mg	PO BID

Allergies

Seroquel = heavy sedation; Risperidone = chest pains;

Review of Systems — Medical

Head/Eyes: Denies Problems; ENT: Denies Problems; Cardiovascular: Denies Problems; Respiratory: Denies Problems; Gastrointestinal: Denies Problems; Genitourinary: Denies Problems; Musculoskeletal: Denies Problems; Neurologic: Denies Problems; Endocrine: Denies Problems; Hematologic/Lymphatic: Denies Problems; Allergic/Immunologic: Denies Problems;

Substance/Alcohol Use

All reviewed/updated 07/07/2020.

Service	Last Update	Substance	Frequency/Quantity	Date of Last Use
H052	07/07/2020	CANNABIS	daily	dec '18

EXAMINATION

Musculoskeletal

Date of last assessment of abnormal movements: 01/21/2020;

Mental Status Examination

Appearance: N/A; Attitude: N/A; Eye Contact: n/a; Speech: Normal for Client; Associations: Intact; Thought Process: Logical/Goal Directed; Delusions: Denies; Suicidal Ideation: Denies; Homicidal Ideation: Denies; Obsessions: Denies; Hallucinations: Auditory; Mood: Euthymic; Affect: Appropriate; Sensorium: Alert; Oriented: Time, place, person, circumstance; Recent Memory: Intact; Remote Memory: Intact; Attention: Intact; Concentration: Intact; Language: Average; Judgment: Good; Insight: Good; Fund of Knowledge: Average;

(page 1)

Date: 07/07/2020 12:02:43

494

MEDICAL DECISION MAKING**Diagnosis**

309.0 Adjustment disorder, With depressed mood (Prim Dx)
R/O malingering, h/o AVH and paranoia

TxGoal(s)

Symptom reduction, medication adherence, maintain therapeutic gains, restore level of functioning;

Labs and Review of Medical Records

Review of other pertinent medical/history information;

Current and New DMH Rx List

Med	Dosage	Sig	Refills	Type	Start Dt	Archive Dt
TRAZODONE	100 mg	PO Bedtime for sleep	0	Rx	01/21/20	07/07/20
Reason for Archive: D/C Completion of Therapy						
COGENTIN	1 mg	po daily at bedtime	0	Rx	11/09/18	
haloperidol	10 mg	PO BID	0	Rx	04/13/20	
TRAZODONE (N)	150 mg	PO BEDTIME for SLEEP	0	Rx	07/07/20	

Physical Health / Other Meds**Medication Education/Counseling Provided**

Present for counseling: Client;

Discussion: Medication dose & time to take, purpose/expected benefits/risks, common side effects, lab monitoring required/reason, expected length of treatment, financial availability, alternatives to medication, risk of no treatment;

Neuroleptic Consent

An electronic consent form was last obtained: 01/21/2020

Recommendations and Referrals

Time until next PMA and/or NS: 4 month(s);

Follow up with MH clinician: Psychotherapy interventions, supportive/rehabilitative interventions, improve level of functioning, monitoring to prevent decompensation/hospitalization, symptoms unstable (worsening or failing to change as expected), monitoring to maintain therapeutic gains, symptoms improving (resolving and controlled);

MMO Status and Client Goal

MMO since 10/09/2017

MMO: Remain in MMO

Patient agrees to continue this level of care and agrees to continue current goal.

Goal: would like to stay on medication

Other Comments

His mood is stable, has trouble with sleep so will increase trazodone to 150 mg po qhs, will continue haloperidol 10 mg po bid, Cogentin 1 mg po bid.

Signed By
Nikunj Kumar Modi, MD
07 Jul 2020 12:02:46 PM

(page 2)

07/07/2020 12:02:43

FOLLOW-UP PSYCHIATRIC MEDICAL ASSESSMENT ORDERS AND SERVICE NOTES (PMA)

Name: HANEEF AQUIL CHILDS

Service Date: 10/28/2020

DOB: [REDACTED]

Medicare Authorized Provider: NONE

No-charge reason: COVID-19 Telephone Service

Time	Staff ID	Staff Name
30	674	NIKUNJKUMAR MODI

HISTORY

Chief Complaint/Reason for Visit

Up for adjustment disorder with depressed mood

History of Present Illness

reports feeling stable, says sometimes he has hallucination but not able to describe, reports mood is stable, has good concentration, focus, has good appetite, says he sometimes has trouble with sleep, reports he is given haloperidol only once a day, denies for having alh, avh or paranoia. Taking medications as prescribed; Denies medication side effects; Denies depressive symptoms; Denies anxiety symptoms; Denies manic symptoms;

Review of Systems — Psychiatric

General/Skin: WNL; Sleep: WNL; Interest: WNL; Energy: WNL; Concentration: WNL; Appetite: WNL; Psychomotor: WNL;

Psychiatric Medications (DMH)

Med	Dosage	Sig
COGENTIN	1 mg	po daily at bedtime
haloperidol	10 mg	PO BID
TRAZODONE	150 mg	PO BEDTIME for SLEEP

Allergies

Seroquel = heavy sedation; Risperidone = chest pains;

Review of Systems — Medical

Head/Eyes: Denies Problems; ENT: Denies Problems; Cardiovascular: Denies Problems; Respiratory: Denies Problems; Gastrointestinal: Denies Problems; Genitourinary: Denies Problems; Musculoskeletal: Denies Problems; Neurologic: Denies Problems; Endocrine: Denies Problems; Hematologic/Lymphatic: Denies Problems; Allergic/Immunologic: Denies Problems;

Substance/Alcohol Use

All reviewed/updated 10/28/2020.

Service	Last Update	Substance	Frequency/Quantity	Date of Last Use
H062	10/28/2020	CANNABIS	daily	dec '16

EXAMINATION

Musculoskeletal

Date of last assessment of abnormal movements: 01/21/2020;

Mental Status Examination

Appearance: N/A; Attitude: N/A; Eye Contact: n/a; Speech: Normal for Client; Associations: Intact; Thought Process: Logical/Goal Directed; Delusions: Denies; Suicidal Ideation: Denies; Homicidal Ideation: Denies; Obsessions: Denies; Hallucinations: Denies; Mood: Euthymic; Affect: Appropriate; Sensorium: Alert; Oriented: Time, place, person, circumstance; Recent Memory: Intact; Remote Memory: Intact; Attention: Intact; Concentration: Intact; Language: Average; Judgment: Fair; Insight: Fair; Fund of Knowledge: Average;

MEDICAL DECISION MAKING

Diagnosis

309.0 Adjustment disorder, With depressed mood (Prim Dx)
R/O malingering, h/o AVH and paranoia

Tx Goal(s)

Symptom reduction, medication adherence, maintain therapeutic gains, restore level of functioning;

Labs and Review of Medical Records

Review of other pertinent medical/history information;

Current and New DMH Rx List

(page 1)

Date: 10/28/2020 16:55:05

SCDMH Electronic Medical Record

Page 2 of 2

Med	Dosage	Sig	Refills	Type	Start Dt
COGENTIN	1 mg	po daily at bedtime	0	Rx	11/09/18
haloperidol	10 mg	PO BID	0	Rx	04/13/20
TRAZODONE	150 mg	PO BEDTIME for SLEEP	0	Rx	07/07/20

Physical Health / Other Meds**Medication Education/Counseling Provided**

Present for counseling: Client;

Neuroleptic Consent

An electronic consent form was last obtained: 01/21/2020

Recommendations and Referrals

Follow up with: MD, requires monitoring of response to medication, requires monitoring of medication side effects;

Time until next PMA and/or NS: 4 month(s);

Referral: None;

Emergency admission to inpatient psychiatric care: N/A;

MMQ Status and Client Goal

MMQ since 10/09/2017

MMQ: Remain in MMQ

Patient agrees to continue this level of care and agrees to continue current goal.

Goal: would like to stay on medication

Other Comments

stable on meds, continue as prescribed.

INCARCERATED, SEEN IN CLINIC

Signed By
Nikunj Kumar Modi, MD
28 Oct 2020 4:55:08 PM

(page 2)

Date: 10/28/2020 16:56:05

497

SCDMH Electronic Medical Record

FOLLOW-UP PSYCHIATRIC MEDICAL ASSESSMENT ORDERS AND SERVICE NOTES (PMA)

Name: HANEEF AGH

DOB: [REDACTED]

ID: [REDACTED]

Sex: [REDACTED]

S: [REDACTED]

Physician Location: Physician/NP/PA Home Office

No-charge reason: INCARCERATED, SEEN IN CLINIC

Time	Staff ID	Staff Name
30	874	NIKUNJ KUMAR MODI

HISTORY

Chief Complaint/Reason for Visit

"I am doing good, I am going to be released on the bonds"

The patient was seen this date via video tele-conferencing technology. Identification/location of the patient were confirmed, name/credentials of this practitioner were provided, and emergency procedures were reviewed. The patient was briefed that the session is not recorded and that notes taken from the session would become part of the medical record. Patient consented to care.

History of Present Illness

says his mood is better, excited about being released on bonds, says he is planning to stay in the area, may be go to chasterfield, mentions his mother is coming down from Philly to stay with him, says he does not have any hallucinations anymore, He reports having good sleep, says his appetite is good, denies having any SEs, denies having any AVH, Paranoia, SI or HI. He is agreeable to start Haldol decanoate injection. Denies depressive symptoms; Denies anxiety symptoms; Denies manic symptoms; Denies AVH; Denies SI/HI;

Review of Systems — Psychiatric

General/Skin: WNL; Sleep: WNL; Interest: WNL; Energy: WNL; Concentration: WNL; Appetite: WNL; Psychomotor: WNL;

Psychiatric Medications (DMH)

Med	Dosage	Sig.
COGENTIN	1 mg	po daily at bedtime
haloperidol	10 mg	PO BID
TRAZODONE	150 mg	PO BEDTIME for SLEEP

Allergies

Seroquel = heavy sedation; Risperidone = chest pains;

Review of Systems — Medical

Head/Eyes: Denies Problems; ENT: Denies Problems; Cardiovascular: Denies Problems; Respiratory: Denies Problems; Gastrointestinal: Denies Problems; Genitourinary: Denies Problems; Musculoskeletal: Denies Problems; Neurologic: Denies Problems; Endocrine: Denies Problems; Hematologic/Lymphatic: Denies Problems; Allergic/Immunologic: Denies Problems;

Substance/Alcohol Use

All reviewed/updated 03/02/2021.

Service	Last Update	Substance	Frequency/Quantity	Date of Last Use
H082	03/02/2021	CANNABIS	daily	dec '16

EXAMINATION

Musculoskeletal

Abnormal Movements: None; Evaluation of Abnormal Movements: N/A; Date of last assessment of abnormal movements: 01/21/2020;

Mental Status Examination

Appearance: WNL; Attitude: Cooperative; Behavior: Calm; Eye Contact: WNL; Speech: Normal for Client; Associations: Intact; Thought Process: Logical/Goal Directed; Delusions: Denies; Suicidal Ideation: Denies; Homicidal Ideation: Denies; Obsessions: Denies; Hallucinations: Denies; Mood: Euthymic; Affect: Appropriate; Sensorium: Alert; Oriented: Time, place, person, circumstance; Recent Memory: Intact; Remote Memory: Intact; Attention: Intact; Concentration: Intact; Language: Average; Judgment: Fair; Insight: Fair; Fund of Knowledge: Average;

MEDICAL DECISION MAKING

(page 1)

C: [REDACTED] Date: 03/02/2021 13:28:49

998

SCDMH Electronic Medical Record

Page 2 of 2

Diagnosis

309.0 Adjustment disorder, With depressed mood (Prim Dx)
R/O malingering, h/o AVH and paranoia

TxGoal(s)

Symptom reduction, medication adherence, maintain therapeutic gains, restore level of functioning;

Labs and Review of Medical Records

Review of other pertinent medical/history information;

Current and New DMH Rx List

Med	Dosage	Sig	Amount	Refills	Type	Start Dt	Archive Dt
COGENTIN	1 mg	po daily at bedtime		0	Rx	11/09/18	
haloperidol	10 mg	PO BID		0	Rx	04/13/20	03/02/21
Reason for Archive: DC Completion of Therapy							
TRAZODONE	150 mg	PO BEDTIME for SLEEP		0	Rx	07/07/20	
HALDOL DECANOATE (N)	75 mg	IM q4weeks	1	11	Rx	03/02/21	

Physical Health / Other Meds**Medication Education/Counseling Provided**

Present for counseling: Client;

Discussion: Medication dose & time to take, purpose/expected benefits/risks, common side effects, lab monitoring required/reason, expected length of treatment, financial availability, alternatives to medication, risk of no treatment;

Neuroleptic Consent

An electronic consent form was last obtained: 01/21/2020

Recommendations and Referrals

Follow up with: MD, nurse, requires monitoring of response to medication, requires monitoring of medication side effects;

Time until next PMA and/or NS: 2 M with MD and 1 M with Nurse;

Follow up with MH clinician: Psychotherapy Interventions, supportive/rehabilitative Interventions, Improve level of functioning, monitoring to prevent decompensation/hospitalization, symptoms unstable (worsening or failing to change as expected), monitoring to maintain therapeutic gains, symptoms improving (resolving and controlled);

Referral: None;

Emergency admission to inpatient psychiatric care: N/A;

MMO Status and Client Goal

MMO since 10/09/2017

MMO: Remain in MMO

Patient agrees to continue this level of care and agrees to continue current goal.

Goal: would like to stay on medication

Other Comments

stable on meds, agreeable to change Haldol to LAI. will stop haloperidol and start Haldol decanoate 75 mg IM q4weeks. He will receive first injection today. will continue trazodone and Cogentin.

Signed By

Nikunj Kumar Modi, MD

02 Mar 2021 1:26:52 PM

(page 2)

Date: 03/02/2021 13:26:49

Patient ID: 10390589 Name: HANSEN, CHILDS DMH Facility: 3N

Medicaid No: 0782164612

Ne

Loc: [REDACTED] Center: 3NARA Patient: [REDACTED]

[REDACTED] 04/01/2021 to 04/27/2021

Org Trn	Cur Trn	Date	Code	Serv	Subcode	Staff	Time	Fullch	Amount	Type
54095559	54095559	04/13/2020	99214	H052		674	30	265.00	265.00	C
54512635	54512635	07/07/2020	99214	H052		674	30	265.00	265.00	C
55095369	55095369	10/28/2020	99213	H052		674	30	133.00	133.00	C
55614819	55614819	02/09/2021	99211	H021	M	675	23	96.00	96.00	C

Curdue 759.00 Current Balance 759.00

THIS INFORMATION IS TAKEN FROM THE PATIENT'S MEDICAL RECORD.
1. Use of this information is prohibited without express or implied authorization.
2. Disclosure to other parties is prohibited.
3. This material shall be destroyed when stated need has been fulfilled.

STATE OF SOUTH CAROLINA
COUNTY OF MARLBORO
STATE OF SOUTH CAROLINA,

vs.

HANEEF AQUIL CHILDS,

Defendant.

IN THE COURT OF GENERALSESSIONS
FOURTH JUDICIAL CIRCUIT

INDICTMENT NOS.: 2017-GS-34-0054;
2017-GS-24-0055;

**MOTION TO WITHDRAW PLEA
AND/OR
MOTION FOR RECONSIDERATION**

COMES NOW THE DEFENDANT, HANEEF AQUIL CHILDS, by and through his undersigned counsel and within the prescribed period by Rule 29 of the South Carolina Rules of Court, files this motion to withdraw his Guilty But Mentally III plea entered May 19, 2021 for the following reasons:

The Defendant was notified on March 11, 2021 that the State intended to proceed with his trial during the May 17, 2021 term of Court. Between the dates of March 24, 2021 and April 20, 2021, the State presented Defendant's counsel with voluminous new evidence that was not provided during the pendency of this case.

During the week of May 3, 2021, the State and Defense engaged in negotiations to reach a plea deal. The terms discussed between the State and Defense was not introduced to the Court as discussed during the plea negotiations. The Defendant waived his right to a jury trial and to assert his affirmative defense of Not Guilty by Reason of Insanity contingent upon the terms reached by the State and his Defense's counsel. The State failed to uphold their part of the plea deal and thereby resulting in the Defendant waiving his constitutional right to proceed with his affirmative defense relying on the State's offer made in writing on May 4, 2021. The Defendant had fully considered the affirmative defense of Not Guilty by Reason of Insanity and retained an expert in the field of forensic psychology to offer evidence during his trial. Defendant's decision

to enter a Guilty But Mentally III was directly related to the terms reached between the State and his counsel and the sole reason he waived his constitutional right to a jury trial. Further, Defendant's counsel acknowledged herein that once the Solicitor failed to state the terms of the plea deal to the Court, the undersigned should have ended all proceedings.

In Smith vs. State of South Carolina, Smith was indicted for murder. Pursuant to a negotiated plea agreement, Smith pled guilty to the lesser included offense of voluntary manslaughter in exchange for testifying against his codefendant. As part of the plea agreement, the State agreed to remain silent as to sentencing. Because Mr. Smith's sentencing was deferred until after his codefendants' trial, the part of the plea agreement relating to sentencing was not placed on the record. During the plea colloquy, Smith stated he understood the sentence for voluntary manslaughter and that the offense was classified as a most serious. Additionally, the plea court judge asked Mr. Smith whether anyone promised him anything to plea guilty and Mr. Smith only indicated the reduction in the offense from murder to voluntary manslaughter. At the subsequent hearing for Mr. Smith's sentencing, the solicitor placed the negotiated plea agreement between the State and Smith on the record. The Solicitor acknowledged that Mr. Smith suffered drug related memory impairment which made his testimony against the codefendant concerning. The Solicitor informed the Court that they could not proceed against Smith's codefendant for murder because Smith failed to truthfully articulate his role in the murder. As a result, the State was forced to mitigate the codefendant's charge to accessory after the fact of murder. The Solicitor then requested the sentencing judge impose the maximum sentence upon Smith. Smith's counsel did not object to the Solicitor's sentencing request nor withdrew Smith's guilty plea. Smith was originally sentenced to twenty-seven years. Smith's counsel moved for the sentencing court to reconsider the sentence and Smith's sentence was reduced to twenty-four

years' imprisonment. *Smith v. State*, 407 S.C. 270, 754 S.E.2d 900 (S.C. App. 2014)

Smith appealed his conviction and the appeal was dismissed. Smith then filed an application for post-conviction relief alleging ineffective assistance of counsel. Smith's application for PCR was denied. Smith filed a motion pursuant to Rule 59 (e), SCRCP, which the PCR court denied. Counsel for Smith filed a petition for writ of certiorari. The Court of Appeals granted Smith's petition to consider whether the PCR court erred in failing to find plea counsel was ineffective for not objecting when the solicitor recommended Smith be sentenced to the maximum term of imprisonment in violation of the negotiated plea agreement with the State.

The Court of Appeals found that the plea counsel's failure to object to the Solicitor's recommendation on the record fell below prevailing professional norms. Plea counsel also acknowledged that she did not object when questioned by the sentencing court as to whether the solicitor had correctly and completely stated the plea agreement. The Court also found that the solicitor's promise to remain silent at sentencing was a material term of the plea agreement and that likewise there was enough evidence to demonstrate Smith would not have pled guilty if he had known the solicitor was going to make a sentencing recommendation.

The Court of Appeals REVERSED the PCR court's denial of relief, VACATED Smith's sentence for voluntary manslaughter and REMANDED for resentencing on the charge consistent with the original plea agreement.

In the Defendant's case, the undersigned acknowledges that she had an obligation to object to the Solicitor's rendition of the plea deal because the terms were incomplete or in the alternative withdraw the Defendant's Guilty But Mentally Ill plea before sentencing was imposed in accordance with *Smith vs. State*.

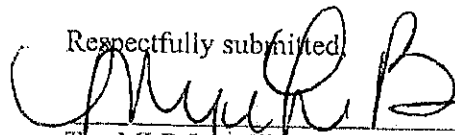
As such, the Defendant respectfully requests that the Court allow him to withdraw his

plea of Guilty But Mental III entered on May 19, 2021 and allow him to proceed with a jury trial with a plea of Not Guilty by Reason of Insanity.

In the alternative, Defendant by and through his undersigned counsel, hereby moves for a reconsideration of his sentence of twenty-five (25) years to the charge of Voluntary Manslaughter imposed on May 19, 2021. Defendant filed this motion based on the Solicitor's failure to recite the full and complete plea agreement terms to the Court as referenced above. Additionally, Defendant files this motion based on the inability to present a clear and concise testimony by his expert, Dr. L. Randolph Waid. Dr. Waid appeared electronically and there were significant interruptions during his testimony. The Defendant had no reason to believe technical difficulties would have significantly impacted Dr. Waid's testimony as it did due to the poor internet connectivity at the courthouse. Most of Dr. Waid's presentation was difficult to hear and understand. Dr. Waid's testimony and the importance of his expertise involving mental illness, and the issue of recidivism and compliance by the Defendant is essential to a court's decision relating to the sentence. In addition to the technical difficulties with the mitigating evidence presented by Dr. Waid, the Court did not have the benefit of the State's position during the plea stage, which too could have influenced the outcome of the case.

For the reasons listed above, the Defendant respectfully requests that the Court reconsider the sentence imposed of twenty-five (25) years to a sentence that allows a cap of twenty (20) years based on the State and Defendant's plea terms.

Respectfully submitted,



The MLB Law Firm, LLC
Myesha L. Brown, Esq.
712 North Cedar Street

May 27, 2021
Summerville, South Carolina

Summerville, South Carolina 29483
Office: (843) 420-1191
Fax: (843) 755-4130
mbrown@them1blawfirm.com
ATTORNEY FOR DEFENDANT

FILED
2021 MAY 28 A 9:37
ANTHONY J. BROWN
CLERK OF COURT
JULY 1, 2021

STATE OF SOUTH CAROLINA
COUNTY OF MARLBORO

IN THE COURT OF GENERAL SESSIONS
FOURTH JUDICIAL CIRCUIT

STATE OF SOUTH CAROLINA

2017GS34-54, 55

vs.

STATE'S RESPONSE TO DEFENDANT'S
MOTION to Withdraw Plea and/or Motion
For Reconsideration

Haneef Childs

The above-captioned Defendant by and through his attorney, Myesha Brown, has moved this Court to withdraw his plea and/or reconsider his sentence. The State respectfully requests the Defendant's motion be denied and sentencing remain in place.

The Defense maintains that the State did not uphold their part of the "plea deal." The State would deny that it failed to do this. Attached hereto is the email sent by the undersigned to Defense counsel on May 4, 2021, confirming the agreement on behalf of the State as to the Defendant's plea deal. The email specifically states the undersigned's understanding of the plea deal as follows: "This will confirm that I have agreed to accept a plea of guilty but mentally ill (GBMI) to Voluntary Manslaughter in the above referenced matter with an exposure of 0-30 years. Please be advised that the siblings of Jackie Purvis will most assuredly be asking for a sentence at or near the higher end of the sentencing spectrum. Under the circumstances, I will not object to a sentence of 20 years and will explain this to the Judge in chambers. However, we will not place on the record a cap. The sentence, as always, will be left up to the Judge." Per this offer, we did talk briefly with the Judge in chambers who indicated he did not wish to discuss sentence there unless it included a recommendation and therefore there was no other discussion as to sentence in chambers. At sentencing, the state did not take a stand as to sentencing and essentially remained silent and simply asked the Court to hear from the members of the victim's family as to sentence. The state would point out that only one of the two family members who spoke actually specifically addressed sentence by asking for "the max."

The State argues the Defendant had every opportunity to stop the hearing prior to the acceptance of his guilty plea. As to the claim regarding the testimony of Dr. Randolph Waid, the State admits that there were some

technical issues intermittently. However, the State maintains problems were overcome by re-questioning or asking the witness to restate his response.

The State maintains that it did everything it had offered to do under the "plea deal." Therefore, the State respectfully asks this Court to deny Defendant's motion.

June 1, 2021.


Elizabeth R. Munnerlyn
Assistant Solicitor
Fourth Judicial Circuit

ANITA H. WILLIAMS
CLERK OF COURT
MARLBORO COUNTY, S.C.
2021 JUN -2 P 3:20

FILED

507

STATE OF SOUTH CAROLINA)
COUNTY OF MARLBORO) COURT OF GENERAL SESSIONS

STATE OF SOUTH CAROLINA)

STATE,)

TRANSCRIPT OF RECORD

v.)

17-GS-34-0054

17-GS-34-0055

HANEEF A. CHILDS,)

DEFENDANT.)

June 18, 2021
Conway, South Carolina

B E F O R E :

THE HONORABLE BENJAMIN H. CULBERTSON, JUDGE

A P P E A R A N C E S:

ELIZABETH R. MUNNERLYN, ESQ. (VIA WEBEX)
Assistant Solicitor

MYESHA L. BROWN, ESQ. (VIA WEBEX)
Attorney for Defendant

FRANCES B. RAY, RPR
Circuit Court Reporter

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1 THE COURT: All right. This is State
2 of South Carolina v. Haneef Aquil Childs regarding
3 indictments 2017-GS-34-0054, 2017-GS-34-0055. The
4 matter is before the Court on a motion to withdraw
5 plea and/or a motion for reconsideration. Please
6 give the court reporter your names and who you
7 represent.

8 MS. BROWN: Good morning, Your Honor.
9 My name is Myesha Brown. I represent the
10 defendant Haneef Childs.

11 THE COURT: All right.

12 MS. MUNNERLYN: Good morning, Your
13 Honor. Elizabeth Munnerlyn, I am with the
14 Solicitor's Office here in Marlboro County.

15 THE COURT: All right. And, sir, you
16 are Mr. Haneef Childs?

17 THE DEFENDANT: Yes.

18 THE COURT: Okay. All right,
19 Ms. Brown, this is your motion?

20 MS. BROWN: Thank you, Your Honor.
21 Good morning, again, and may it please the Court.
22 Your Honor, Mr. Childs appeared before you on May
23 13th, 2020, in the Marlboro County General
24 Sessions courthouse. He entered a plea of guilty
25 but mentally ill to a charge of voluntary

1 manslaughter. Following that hearing he was
2 sentenced to 25 years. A motion to withdraw the
3 guilty plea and a motion for reconsideration of
4 the 25 year sentence was filed on May 28th, 2021,
5 in accordance with Rule 29 of the South Carolina
6 Rules of Civil Procedure, and it was also served
7 appropriately.

8 Mr. Childs, as you've indicated, is
9 present and he's appearing remotely from the
10 Kirkland Reception and Evaluation Center. I
11 believe also, Your Honor, that his mother Brenda
12 Maggert was trying to participate in these --
13 proceeding on these ---

14 THE COURT: All right.

15 MS. BROWN: --- for the proceeding.

16 THE COURT: She's there. I can make
17 her -- let me add her.

18 MS. BROWN: Thank you.

19 THE COURT: All right. Go ahead.

20 MS. BROWN: Your Honor, -- thank you,
21 Your Honor. Your Honor, before we begin with my
22 argument, I would like to place something on the
23 record. On yesterday, June 17th, 2021, I had an
24 opportunity to speak with Mr. Childs via over the
25 phone. As a result of those discussions, it's my

1 understanding that Mr. Childs would not like me to
2 move forward with a motion to withdraw his guilty
3 but mentally plea that was entered on May 19th,
4 2021. I would ask the Court to please inquire
5 directly with Mr. Childs to insure that he
6 understands that if I do not proceed with that
7 part of motion today, he is unable to withdraw his
8 guilty but not --- but mentally ill plea in the
9 future, and also, that he has instructed me to
10 abandon that motion at this time.

11 THE COURT: All right. Now I
12 understand this was a plea to -- it was voluntary
13 manslaughter; is that correct? And that was ---

14 MS. BROWN: That's correct.

15 THE COURT: --- a lesser included
16 offense of what he was indicted for?

17 MS. BROWN: That is correct, Your
18 Honor.

19 THE COURT: Okay. And he was indicted
20 for murder; is that correct?

21 MS. BROWN: Yes, sir.

22 THE COURT: Okay. So you just want --
23 it's your understanding that your client just
24 wants you to proceed on a motion for
25 reconsideration; is that correct?

1 MS. BROWN: That is my -- that is
2 correct, but I just want to make sure that's on
3 the record and that is my understanding how he
4 wants me to proceed today.

5 THE COURT: Well, let me ask you this.
6 Is that how you want to proceed? I mean,
7 certainly he has the right to determine whether or
8 not to plead guilty or not plead guilty; and if he
9 went to trial, he has the right to decide whether
10 he wants to testify or not testify. Other than
11 that, these legal decisions are, you know, left up
12 to the attorney on to how you wish to defend him.
13 Do you wish to withdraw the plea? I mean, ---

14 MS. BROWN: Well, Your Honor, Your
15 Honor, certainly as relates to this decision, he
16 understands that if he withdraw this plea he's now
17 going to be facing that murder charge and that if
18 Your Honor were to grant the withdrawal and
19 certainly the risk associated with proceeding with
20 the murder charge. And obviously, I can't force
21 him to enter a particular plea; that has to be his
22 decision. And I've talked with him extensively
23 about just the potential consequences of both
24 decisions, and I just want to make sure that I
25 understand him correctly. He understood that I

1 filed his motion after talking with him, after
2 serious deliberations with his family, and he
3 wanted me to file it at that time. But as of
4 yesterday, when I spoke with him, I was instructed
5 that he did not want to proceed with that part of
6 the motion that's before you today.

7 THE COURT: All right. All right,
8 Mr. Childs, your attorney has filed, really, two
9 motions in one. Number one is a motion to
10 withdraw your guilty plea and number two is a
11 motion to reconsider your sentence. And according
12 to her, you do not want her to proceed on a motion
13 to withdraw the guilty plea; is that correct?

14 THE DEFENDANT: Yes.

15 THE COURT: Okay. And why don't you
16 want her to go forward on that motion?

17 THE DEFENDANT: I mean, I just don't
18 want her to. Like, I want to accept
19 responsibility for the situation.

20 THE COURT: Well, I mean, put it this
21 way, if I -- this is the legal consequences. If I
22 grant the motion to withdraw your plea, your plea
23 will be withdrawn, the indictment for murder will
24 stand, and you could face your trial on the murder
25 charges. You would still have the presumption of

1 innocence. You have the right to remain silent.
2 You could have your guilt or innocence decided by
3 a jury trial of your peers. The State would have
4 to prove your guilt beyond a reasonable doubt.
5 You could cross-examine anybody who testified
6 against you. So it will more or less be back to
7 ground one. But, you would not have the voluntary
8 manslaughter offer from the State to let you plead
9 to that lesser included offense. Do you
10 understand that?

11 THE DEFENDANT: Yes.

12 THE COURT: And is that why you want
13 to withdraw that motion?

14 THE DEFENDANT: I don't want to
15 withdraw it no more.

16 THE COURT: Do what? Do you want to
17 withdraw your motion to withdraw your plea?

18 THE DEFENDANT: Yes. Yes.

19 THE COURT: Okay. All right.

20 THE DEFENDANT: I -- I was -- also, I
21 was confused. I mean, ---

22 THE COURT: Okay. Now -- so in other
23 words, all you want me to do is to reconsider the
24 sentence, not your guilt for voluntary
25 manslaughter; is that correct?

1 THE DEFENDANT: Yes. Yes, sir.

2 THE COURT: Okay. All right, Ms.
3 Brown, anything further you want on the record in
4 that regard?

5 MS. BROWN: No, Your Honor. Thank you
6 so much for doing that.

7 THE COURT: All right. Ms. Munnerlyn,
8 anything you want on the record with regard to
9 that?

10 MS. MUNNERLYN: No, Your Honor.

11 THE COURT: All right. So we'll
12 withdraw the motion to withdraw plea.

13 All right, Ms. Brown, let me hear from
14 you on the reconsideration.

15 MS. BROWN: Thank you so much, Your
16 Honor. Your Honor, I was informed on March the
17 11th of 2021, that the State had intended to
18 proceed with Mr. Childs' trial the week of May
19 17th of this year. Prior to that notice, at all
20 times it was understood that this was a case that
21 would be a trial on the affirmative defense of not
22 guilty by reason of insanity to the charge of
23 murder. Two years prior to notice of the hearing,
24 I've engaged in extensive communication with
25 Ms. Munnerlyn in an effort to reach a resolution

1 with a sentence no greater of 20 years based on
2 the evidence that we had and also the medical
3 information from health care professionals
4 involved in this case. For more than two years
5 now, the defense has never moved from that
6 position. Through the week of May the 3rd, 2021,
7 Ms. Munnerlyn and I spoke several times in an
8 effort to resolve this case without a trial. My
9 position never changed and refer to the deal of a
10 plea deal that allowed my client to waive his
11 right to a trial, waiving his right to assert his
12 affirmative defense of not guilty by reason of
13 insanity. In exchange for that, Ms. Munnerlyn was
14 to notify the Court that she did not object or
15 oppose a cap of 20 years and would remain silent
16 on the sentence itself.

17 I refer to you in my motion the 2014
18 Court of Appeals case which is Gerald Smith v.
19 State of South Carolina that I believe is very
20 similar to the case that we have in front of us.
21 And I will say, Your Honor, I did a lot of
22 research to see whether or not I had even a ground
23 to come back in front of you. In Smith v. State
24 of South Carolina, Mr. Smith appealed a PCR order
25 denying him relief based on ineffective assistance

1 of counsel during his guilty plea. The Court of
2 Appeals reversed the trial court order denying
3 relief, vacated Mr. Smith's sentence, and remanded
4 the case for resentencing. In Mr. Smith's case,
5 he was indicted for murder. He pled guilty to the
6 lesser included offense of voluntary manslaughter
7 in exchange for testifying against his
8 co-defendant. As part of the plea agreement, the
9 State agreed to remain silent during the
10 sentencing phase. During the plea hearing
11 Mr. Smith told the court that he understood the
12 sentence, he understood the range from 2 to 30
13 years; and when he was asked if anyone promised
14 him anything in exchange for his guilty plea, he
15 informed the court no more other than a lesser
16 included charge. His plea counsel confirmed that.
17 Same as a trial when he appeared before you, Your
18 Honor, he told you he understood the sentence
19 range. He also acknowledged that there was no
20 promise of anything in exchange for his plea
21 except that we then informed the court that
22 there'll be a dismissal of the companion gun
23 charge and that would be the lesser included
24 voluntary manslaughter.

25 In Mr. Smith's case, the sentencing

1 hearing was deferred because his co-defendant's
2 trial had to happen first. After subsequent
3 hearing for the sentencing, the solicitor
4 indicated that there was an agreement to reduce
5 the charge and, also, that Mr. Smith's sentence
6 was deferred until the trial for the co-defendant.
7 The State also informed the court at the
8 sentencing phase that Mr. Smith had suffered a
9 drug related memory impairment and that his
10 co-defendant's counsel had filed a motion to
11 disqualify him from testifying. The State was
12 concerned about using Mr. Smith's testimony
13 against the co-defendant and elected not to
14 proceed with the trial against the co-defendant
15 for murder. They had to mitigate the charge to
16 accessory after the fact to murder. The lesser
17 charge then at the time at the sentencing hearing
18 request that the court impose a maximum sentence
19 upon. The plea counsel for Mr. Smith did not
20 object, nor did he withdraw the plea at the time.
21 Instead, the plea counsel asked that the court
22 give him credit for the time that he had served
23 and asked that he impose a ten year sentence. Mr.
24 Smith was sentenced to 27 years. There was a
25 motion to reconsider and it was reduced to 24

1 years.

2 Now, in Mr. Childs' case,
3 Ms. Munnerlyn and I attempted to provide the Court
4 with the terms of the plea agreement, but was
5 informed that it had to be on the record. When
6 the terms of the plea agreement could not be
7 established, it is clear from the Smith case that
8 it was my responsibility to decline moving forward
9 with a guilty but mentally ill until such time as
10 the terms of the plea that we had reached could,
11 in fact, be matched. Although Mr. Childs
12 understood that the Court had the full authority
13 to sentence him up to 30 years, we all agree that
14 court could be influenced by a recommendation or
15 position offered by the Solicitor, especially when
16 this had a case for more than five years, such as
17 this, once it reviews the evidence, the weight of
18 the evidence, concern the potential for conviction
19 based on the State's verdict, as well as the
20 defenses that could potentially be raised during a
21 trial. We also understand that the solicitor
22 objective is and should always be to serve justice
23 because they're familiar with that case. And
24 Ms. -- in this case, Ms. Munnerlyn did not inform
25 the court that she had no objection to a cap of

1 20, which were the terms of the plea deal. I
2 understand that the basis for why she didn't say
3 that statement; but nevertheless, it was part of
4 the agreement itself, Your Honor. Mr. Childs'
5 decision to enter a guilty but mentally ill was
6 directly and solely related to the State taking a
7 position that it did not oppose a cap of 20 years.
8 Since that did not occur, I was required to file
9 this motion.

10 When I looked at Thompson v. State,
11 which is a 2000 state supreme court case, the
12 Supreme Court stated that there was a reasonable
13 probability that Thompson would not have pled
14 guilty but for his attorney's ineffective
15 assistance because he entered his guilty plea and
16 reliant on the sentencing range at the solicitor's
17 agreement not to make a sentencing
18 recommendations. In the Smith case the court
19 relied on the Thompson case, and it made its
20 ruling. The court concluded that the State's
21 promise to remain silent in the sentencing hearing
22 was a material term of the plea agreement and that
23 there is enough evidence to demonstrate that Smith
24 would not have pled guilty if he had known the
25 Solicitor was going to make a recommendation and,

1 as such, Smith plea counsel should have withdrawn
2 the plea or bring it to the court's attention, and
3 that the failure to do so was ineffective
4 assistance of counsel.

5 In our case, Your Honor, for nearly
6 two years Ms. Munnerlyn was informed that our
7 decision to waive a jury and to waive his right to
8 his affirmative defense has always been based on a
9 sentence no greater than 20 years. It's always
10 been the basis of any plea terms and also resulted
11 in why Mr. Childs pled guilty. I fully understand
12 from the cases that I just talked to you about,
13 the Thompson and the Smith case, it was my duty to
14 inform the court of the discussions of the 20 year
15 cap. I fully accept responsibility for not doing
16 that, Your Honor, and this motion is my attempt to
17 correct my responsibility to Mr. Childs as I
18 totally understand that the rulings in Thompson
19 and State requires me to do so. In the Smith
20 case, again, that case determined from the PCR
21 hearing that this case should be remanded for
22 resentencing. And for those reasons, I have and I
23 fall on the mercy of the court and ask that you
24 reconsider a sentence that's consistent with the
25 discussions of a cap of no more than 20.

1 The court has already heard the
2 mitigating evidence in this case of former Dr.
3 Randall Wade. You've also heard from the victim's
4 wife Meredith Purvis that testified during that
5 proceeding. You also heard from Brenda Maggert,
6 which is my client's mother, and you've also had
7 the benefit and we've introduced hundreds of
8 medical records that talk about my client's mental
9 state years leading up to the event of December of
10 2016. And, Your Honor, considering all of that, I
11 think that that is why, and I'm hoping that's why,
12 the State took the position that they were not
13 gonna object to a cap of 20 and I would just ask
14 that there be a ruling or a reconsideration of the
15 sentence consistent with those plea negotiations.

16 And again, Your Honor, I just -- I
17 just have to accept responsibility because I
18 understand from the case that I should have just
19 withdrawn or decided not to go forward.

20 THE COURT: Well, see, and that's --
21 that's the problem I'm having is that the standard
22 by which I am to review your motion is whether or
23 not your client would have gone forward with the
24 guilty plea. Well, the fact of the matter is he
25 doesn't want to withdraw his guilty plea. So, I

1 mean, so you're asking me to determine whether or
2 not it was critical to him entering a guilty plea
3 and he's standing in front of me now saying I
4 don't want that plea withdrawn.

5 MS. BROWN: Your Honor, may I respond
6 to that?

7 THE COURT: Yes.

8 MS. BROWN: Okay. Certainly, we are
9 now 2020 obviously behind -- after the event has
10 happened. There is no doubt for five years that
11 the four-and-a-half, three-and-a-half years I've
12 been involved in this case that we got to the
13 point that we did on May 19th based on the
14 communications and the reliance of -- with
15 Munnerlyn informing the Court that she did not
16 oppose a cap of 20 years. That ---

17 THE COURT: And I --

18 MS. BROWN: --- is why I'm here.

19 THE COURT: And I understand that.
20 And excuse me for interrupting, but basically,
21 under the Smith and the Thompson case it says --
22 if I've -- correct me if I'm wrong -- but doesn't
23 that say that had your client -- I'm trying to
24 think how to phrase this. The standard I go by is
25 had we done what we were supposed to do, he would

1 enter his guilty plea; but because I did not know
2 that the State did not oppose a cap of 20 years,
3 then Mr. Childs would not have proceeded with his
4 guilty plea.

5 MS. BROWN: And if -- and if you're
6 saying whether or not Mr. Childs relied on the
7 plea negotiations and if those negotiations were
8 not in place, he would not have entered the guilty
9 plea on that day, my understanding is, yes, that
10 is the case. He would not have entered the guilty
11 plea. We would have proceeded with a trial.

12 THE COURT: Then why isn't he asking
13 to withdraw his plea?

14 MS. BROWN: Your Honor, I have to --
15 again, I just spoke with him yesterday for the
16 first time, explained to him procedurally what to
17 expect today; and obviously, I can't tell you
18 what's happened from May 19th up until today.

19 THE COURT: Well, I mean, I ---

20 MS. BROWN: June 18th was 30 days.

21 THE COURT: I think it's a case -- and
22 correct me if I'm wrong. The perception I'm
23 getting is that he wants the benefit of having the
24 charge reduced to voluntary manslaughter and he
25 wants the benefit of having a 20 year cap; but at

1 the time he entered his guilty plea, he did not
2 want the Court to know that the State was not
3 opposed to a 20 year cap because he thought he
4 would get the 20 year, the 20 years then. And so
5 he's wanting the benefit of a negotiations that he
6 didn't want the Court to know about at the time of
7 his guilty plea.

8 MS. BROWN: Your Honor, no. We wanted
9 the Court -- we wanted the Court to know that
10 there was a cap of 20. Ms. Munnerlyn did not
11 provide the Court with that information; but at
12 all times, we wanted the Court to know there was a
13 cap of 20. I think from my understanding of the
14 reading of the cases, the fact that Ms. Munnerlyn
15 did not provide that information and it was
16 material to our negotiations, I had the obligation
17 and responsibility to stop the proceedings at the
18 point that the Court was not informed of a cap of
19 20 years. So certainly we wanted the Court at all
20 times to know there was a cap of 20 years. And
21 Your Honor may not recall, but we were attempting
22 to provide that information in chambers and Your
23 Honor told us we could not, we had to put it on
24 the record.

25 THE COURT: Yeah, and as I understand

1 that meeting it was -- y'all said you did not want
2 it on the record.

3 MS. BROWN: Which means, which means
4 that at that point it was my responsibility to
5 make a decision and let Mr. Childs know that she
6 was not probably going to put on the record, and
7 we need to move forward with a trial or ask him at
8 that point if he still wanted to proceed.

9 THE COURT: All right. Ms. Munnerlyn,
10 let me hear from you.

11 MS. MUNNERLYN: Thank you, Your Honor.
12 I just -- I want to be clear on what our agreement
13 actually was 'cause, I mean, I know she's
14 saying -- I know what she's saying but. I want to
15 be clear that I never swayed from what I said I
16 was gonna do. And I -- and I included in my
17 response to her motion my email that I actually
18 sent her which set forth what my agreement was
19 gonna be with regard to this plea, and I just want
20 to read that into the record. Or it is final. I
21 just want to read that first portion of it. And
22 it says, "This will confirm that I have agreed to
23 accept a plea of guilty but mentally ill to
24 voluntary manslaughter in the above referenced
25 matter, State v. Childs, with an exposure of 30

1 years. Please be advised that the siblings of
2 Jackie Purvis will most assuredly be asking for a
3 sentence at or near the higher end of the
4 sentencing spectrum. Under the circumstances, I
5 will not object to a sentence of 20 years and will
6 explain this to the judge in chambers. However,
7 we will not place on the record a cap. The
8 sentence, as always, will be left up to the
9 judge." So there was never an agreement by me to
10 recommend a cap. I was just gonna simply remain
11 silent on that issue should she ask for it. In
12 other words, I wasn't gonna object but I wasn't
13 gonna argue for the max, which I did not. And I
14 did not do any of those things. And I did exactly
15 as I said I was gonna do and ask the family
16 members to present their positions to the Court
17 and they did so. There were two that addressed
18 the Court, one which did not ask for a specific
19 sentence and the other asked for the max. But
20 never during that time and during the plea did I
21 on behalf of the State ask for a specific
22 sentence. And so I -- I think I -- I did exactly
23 as and I acted in accordance with what we had
24 agreed upon. In fact, when we went back in
25 chambers and Your Honor indicated that you did not

1 wish to discuss the case if it was not gonna be
2 anything that was gonna be put on the record, I
3 indicated at that time, you know, well, to Ms.
4 Brown, do you wish to proceed. And then, of
5 course, we did proceed. So, you know, I -- I just
6 feel like, you know, he had that option at that
7 point. We're beyond that, and I think the
8 sentence that Your Honor gave was appropriate
9 under the circumstances of the plea, and I -- I
10 think it should remain as it is.

11 THE COURT: All right. Ms. Brown,
12 anything in reply?

13 MS. BROWN: Yes, Your Honor. I would
14 just say that the terms of the agreement had
15 always been that she would communicate it to the
16 Court; and at the point that it was not
17 communicated to the Court, that is in itself made
18 the agreement unfulfilled. That is the only
19 position I have here. We all understand, Your
20 Honor, that even though you were provided that
21 information, it's your decision; but I do believe
22 that a solicitor has the influence or her
23 influence, especially since they've had the
24 opportunity to handle the evidence with the case,
25 and in this case that did not happen. The

1 information was not communicated. And again, I
2 understand that Mr. Childs is not withdrawing the
3 plea. I am certainly proceeding with just asking
4 the Court to reconsider the sentence under the
5 circumstances by which I've already provided to
6 you just looking at these cases and the fact that
7 it appears that in Smith there was a resentencing
8 that was done based on the terms not being fully
9 manifested ---

10 THE COURT: Okay.

11 MS. BROWN: --- between the Defense
12 and the State, Your Honor. And thank you, again,
13 for even considering this motion.

14 THE COURT: All right. I'm gonna deny
15 the motion. I don't know that there was an
16 agreement of a cap of 20 years. That's why it was
17 not put on the record. I remember coming back and
18 saying I'm not gonna consider anything unless
19 y'all are willing to put it on the record and so
20 we knew at that time. I think the sentence is
21 appropriate. He's not asking to withdraw his
22 guilty plea so it did not influence his decision
23 to plead guilty; otherwise, he'd want to proceed
24 with the withdrawal of his guilty plea at this
25 time. So, I'm gonna deny your motion. All right?

1 MS. BROWN: Thank you, Your Honor.

2 MS. MUNNERLYN: Thank you.

3 THE COURT: Thank you.

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5 * * * END OF REQUESTED TRANSCRIPT OF RECORD * * *

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C E R T I F I C A T E O F R E P O R T E R

STATE OF SOUTH CAROLINA)
COUNTY OF FLORENCE)

I, FRANCES B. RAY, Registered
Professional Reporter (RPR), court reporter for
the State of South Carolina, Third Judicial
Circuit, do hereby certify that the foregoing
proceeding is a stenographic report and was
transcribed through computer-aided transcription;
that the foregoing transcript contains a true
record of the proceedings.

I further certify that I am neither
counsel for, nor related to nor employed by any of
the parties connected to the action, nor am I
financially interested in the action.

Witness my hand at Florence, South
Carolina, this 23rd day of May, 2022.

Frances B. Ray

FRANCES B. RAY, RPR