

ORIGINAL

THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM GREENVILLE COUNTY
Court of Common Pleas

D. GARRISON HILL, Circuit Court Judge

Case No. 2009-CP-23-2535

Archie Eddie Jones..... Respondent

vs.

3M Corporation.....Employer/Appellant

- and -

Old Republic Insurance Company.....Carrier/Appellant

RECORD ON APPEAL

VOLUME II OF II

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Greenville Psychiatry, P.A.
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 Greenville, South Carolina 29615
 Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Edie Jones

Date	Notes Should Be Signed by Physician
4/3/01	Zol 12.5 Risperidone .5 TID Depakote 375 Prednisone 10 +/- response. ↓ irritability ↑ mood, ↑ interest in school. Speech n/ble mod level. Allt full range ⊕ finger 1 ⊕ primary ⊕ ALV Adox 3 ⊕ S/HI Dr: Bipolar NOS ADD S/P TBI Ph: No change RTC 1 mo
5/2/01	Dex 10 Zol 12.5 } Risperidone .5 TID } ⊕ SF Depakote 375 } Prednisone 10 } ⊕ CF upset Describes episodic anxiety ? associated w/ executive func Episodic recall. Speech n/ble Mod level. Allt full range ⊕ circumst ⊕ No thought cont. Adox 3 ⊕ S/HI Dr: Bipolar NOS ADD S/P TBI Ph: No change

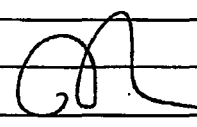
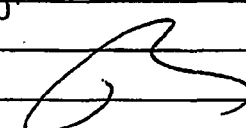
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Patient Name: Edie Jones

Date	Notes Should Be Signed by Physician
6/1/01	Dexedrine 10
	Zol 12.5
	Risperidone 5T10
	Dexedrine 375
	PMS 15
	⑤ response, but episodic depression
	that responds to risperidone
	Zol 25. Cnt. ↑ complicated
	by pulmonary infection. Also
	gastrointestinal. PMS ↑ interest
	in activities → ↑ Risperidone
	about 1000. Speech at rate
	normal level. Fall R/OA
	⑤ to get. O/D thought about
	or present. Addox 3 5/41
	Dex 3.75. Was ADD 5/10 TBI
	PMS ↑ Zol 25 RTC 1mo
	①

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Patient Name: Eddie Jones

Date	Notes Should Be Signed by Physician
7/26/01	Zolpidem 25mg Depakote 375 mg Risperidone 5/5/10 Pethidine 10 S/P TIA - Did well until 3-4 days ago - ? seizure ? ? ? ? ? ? Speech & ? ? ? ? ? ? ? ? ? ? ? ? ? ? Dr. B. has ADD stop TB Ph: POC Liver panel, Blood panel Depakote level. RBC lmo 
10/26/01	Depakote level 16.2 CBC LFT Pethidine 10 POC w/... Does drink... well @ & Depakote level... with dose... Adjust dose based on clinical status 

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Patient Name: Eddie Jones

Date	Notes Should Be Signed by Physician
7/19/01	Phne call - P. reports ↓ energy "↑ sleep" — "patient said it was ok to start Lexapro. Trans S/HT. Discussed options — prais. 100 C. Keep FU. Call pm. Recall usual precautions BU
7/31/01	Prais. 100 Zol. 25 Regal. 375-250 1 kcal 16.2 Risper. 5/5/1.0 Risper. 15 Difficult to eval above 2 ↑ need for prais. & reg thoughts ? hedonic bre. Stage ⊕ delayed sleep phase. Cat on stress. Speech at rate Most kcal affect mind. Thn. chr. & ALU4 A40x3 Dx. Bi-polar NOS AND S/P TRD Plan. ① P/C (Prais.) ② ↑ Zol. 37.5 R/C 1mo CA

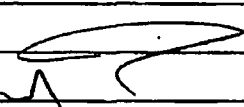
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Patient Name: Ellen Trer

Date	Notes Should Be Signed by Physician
8/5/98	Seen for disability eval. ZPP 37.5 Depth 375-250 Response 51.5/11.0 ↑ Pressure 20 Risk S.
	Alpha Freq
	1. Family Lives 2 @ home ↑ stress son died subarachnoid hemorrhage 2/98 (E) in law arrested living ↑ exposed area → razor
	2. Work - Accident Jan 97 → attempt to return work 11/9998, 2° dizziness, drowsiness, dexamethasone ↓ phosic D/C 3/00. → G't do well 2° "G't go outside" 2° SOB "G't not clean"

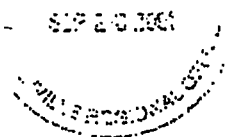
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Patient Name: Edith Jones

Date	Notes Should Be Signed by Physician
8/1/01	d go-no-go "I'm lost"
	WORLD OLROW memory 0/3
	named 8 fruits & veges 15 sec
	" 7 animals 15 sec
	" 9 aces 15 sec
	Able to name, repeat, follow
	2 stage commands
	~~5/14/01~~ ~~Discussed~~ access
	to gms.
	Disability eval. done
9/9/01	Completed 

ROBERT W. RICHARDS, MD

PATIENT: ARCHIE EDDIE JONES
SSN: [REDACTED]
DISABILITY EXAMINER:
DATE OF EXAMINATION: 8-9-01
DATE OF DICTATION: 9-10-01



IDENTIFYING INFORMATION: Mr. Jones is a fifty-eight-year-old married white male, who lives with his wife in Anderson, South Carolina. He was referred to me for a Disability Evaluation.

It is noteworthy that I have been seeing Mr. Jones as an outpatient since April 1999. While this gives me a strong ability to composed a history, it may represent some bias in my conclusions.

HISTORY OF ILLNESS: There is no significant past psychiatric history, until a severe burn and possible brain injury, when he had a cardiac arrest and had to be resuscitated, I understand. In addition, he received intensive care and subsequent multiple operations for repair of damage due to the burn.

I saw him initially on April 20, 1999. My Working Diagnosis was Hypomania Due to Medical Problem and Rule Out Posttraumatic Stress Disorder. His diagnosis has subsequently been changed to Bipolar Disorder, not otherwise specified, Attention-Deficit Disorder, and Traumatic Brain Injury.

He has received multiple medication trials, including Neurontin, Zoloft, Dexadrine, Depakote, Ativan, Celexa, Provigil, and risperidone. Treatment has been complicated by the need for steroids to treat significant respiratory difficulties associated with pneumonitis. In addition, treatment has been complicated by shortness of breath and multiple infections.

In spite of aggressive pharmacotherapy and supportive therapy, Mr. Jones has never achieved remission. Moreover, attempts to expose Mr. Jones to environments which may represent even mild stress usually results in disorganized thinking and racing thoughts. It is difficult to tell, but I suspect the emotional stress may cause a worsening of his medical conditions, and that his medical conditions may exacerbate his emotional distress.

I saw him last on July 31, 2001. At that time, his medications were Provigil 100 mg q.a.m., Zoloft 25 mg q.d., and Depakote 375-250 mg q.a.m. (level is 16.2; target symptoms are racing thoughts, with mild response achieved, but dose was unable to be increased

P.2

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GREENVILLE PSY.

00116876795
Jan 30 07 12:24p

ARCHIE EDDIE JONES

PAGE TWO

due to side effects), risperidone 0.5 mg b.i.d. and 1 mg q.h.s., and prednisone 15 mg q.d. (per pulmonology).

It was difficult to evaluate [redacted] to medications at that time due to the increased need for prednisone and ongoing shortness of breath. There was a reported inability to feel pleasure and substantial delayed sleep phase. He denied other symptoms of affective disorder at that time. He states that he was experiencing ongoing stress due to his inability to do anything without shortness of breath.

PAST MEDICAL HISTORY: Current medications are as above. In addition, the Past Medical History is well-outlined in his Medical Records. The most impressive portion of his past medical history is treatment for his burn and traumatic brain injury. He did have an MRI, which was interpreted and essentially within normal limits. There were one or two small, scattered deep white matter signals present in the para ventricular distribution, consistent with previous ischemic events.

PAST PSYCHIATRIC HISTORY: As above. He has had extensive supportive therapy with Ms. Pat Reardon.

FAMILY PSYCHIATRIC HISTORY: Positive for learning disability, attention-deficit disorder, and a completed suicide. There is no documented family history of bipolar disorder or schizophrenia. I suspect that there may be a family history for severe affective disorder.

SOCIAL HISTORY: This is well-outlined in the Medical Records. I am impressed with a long work history, and what Mr. Jones describes as a strong work ethic. He has attempted to return to work part-time, but he was unable to succeed due to difficulty with complex tasks and shortness of breath. Usually, stressors associated with work result in worsening shortness of breath and disorganized thinking.

The patient lives at home with his wife. He describes high levels of expressed emotion at home, in addition to difficulties organizing his time. He has substantial problems with shortness of breath, organization of thinking, and just generalized levels of wakefulness.

ARCHIE EDDIE JONES

~~250-74-5113~~

PAGE THREE

He has high levels of support from his wife and extended family. He enjoys spending time with his niece. There is no evidence of drug or alcohol abuse.

MENTAL STATUS EXAMINATION: This is a well-developed, slightly overweight, white male, who came willingly to the interview room. He was attentive and cooperative with the process. Speech was mildly rapid, but with normal volume, clear, and easy to understand. Mood was anxious and depressed. Affect was anxious, but full range. Associations were tangential, and at times disorganized and loss. Attempts to redirect were successful, but he would quickly get derailed. There was no clear disorder of thought content or perception at this time. He denied suicidal or homicidal ideation at this time.

He was alert and oriented times three. It was difficult to complete the remainder of the cognitive exam, as Mr. Jones had difficulties with sustained attention. This difficulty was supported by his inability to complete the go, no go task- "I'm lost." He spelled world backwards "dlrow." Short-term memory was zero out of three. He named eight fruits and vegetables in fifteen seconds, seven animals in fifteen seconds, and nine cities in fifteen seconds. He was able to repeat and follow two-stage commands.

DIAGNOSIS:

AXIS I:	1. Bipolar, not otherwise specified, due to traumatic brain, injury.
	2. Cognitive Disorder, not otherwise specified, due to traumatic brain injury.
AXIS II:	No diagnosis.
AXIS III:	Status post severe burn, with traumatic brain injury.
AXIS IV:	Severe.
AXIS V:	GAF 55-65.

CONCLUSIONS: Mr. Jones is totally disabled at this time. My reason for this conclusion is that he has a treatment resistant bipolar disorder, probably due to traumatic brain injury. I cannot rule out a preexisting cyclothymia, with a worsening of symptoms following the traumatic brain injury. The effects of long term prednisone on his injury must also be considered.

Nevertheless, his medical morbidity and bipolar disorder are such that he is not able to complete even simple tasks, as any stress

or physical exertion will result in disorganized thinking and intense anxiety. [REDACTED]

Thank you very much for allowing me to evaluate Mr. Jones. If you have any questions or need additional information, you may reach me at my office, where the telephone number is 864-271-5056.



Robert W. Richards, MD

/wp

This is to certify that the above was transcribed from the recorded voice of Robert W. Richards, MD, on September 13, 2001.

PRN #754
RPT #7706

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Patient Name: Eddie Jones

Date	Notes Should Be Signed by Physician
9/19/01	① seen & discussed - Dr. Richards ② Pt having some anxiety, shaking UE hands every day, ↑ hot flashes, 2 episodes neck stiffness, ↑ angry outbursts toward wife, ↑ itching back of hands. ③ anxiety - concerning shop he owns and car he was working on before TIA 6/2001, has not been able to go complete building on car. ④ UE/hand tremors - all the time & alleviating factors, resting tremor. ⑤ hot flashes - sporadic episodes where need to be hot retained ⑥ neck stiffness - 2-4 episodes "soreness", ↓ facial muscle / tongue spasm ⑦ anger - only takes out anger on wife, ↑ anger & ↑ dose prelmiume 20 mg ⑧ pruritis on hands sleep fine, some ↓ drowsiness during day but nitalin has improved ex., pt. describes mood "real good," ↓ depressed mood, ↓ flashbacks AS/UE Dr. seen degree ALT 37.5 Aspart 375-250 Rispred. 5/5/10 Ritalin 5 ↑ anger → wife verbal assgr ↓ physical assgr & desked at property. For most part "calm" Speech w/ rate. Meal b.k. All at 7:30 Thurs. chn AS/UE ↓ go-no-go 7/3 AP no chng

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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
10/17/01	Ritalin 5/2.5 Zoloft 37.5 Depakote 375 Risperidone 25/25/5 Prozac 10pm Theophylline 300/300 ↑ P ? recall to SOB vs needs COPS & TAD Get stress family illness, SOB, ↓ stamina, "I can't read" Describes alexithymia "I feel things but sleep for (↑ sleep 1st & 2nd dose of Ritalin) Speech at Ritalin Mood level fell Ritalin Thru ch CALVH Aox3 & STHT A/C. More 2nd dose at 4pm Ritalin 4pm to 10pm RTC 1mo. Cough dec Jan 5 ~~note: #~~ BA
11/17/01	Zoloft 25 # 45 Rf2 Depakote 125 # 90 Rf2 A

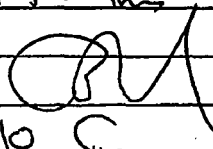
Eddie Jones

MEDICATIONS 10/15/01

Albuterol-USP: 180mg 2to4 times day
Atrovent: 2puffs 2to4 times day-(12/14/01)
Xopene/Nebulizer: 3ml 2to4 times day
Atrovent/Nebulizer: 2.5ml 2to4 times day-(12/14/01)
Serevent: 2 puffs-am/pm
Pulmacort: 2 puffs-am/pm
Singulair: 10mg-pm
Theophylline: 300mg-am/pm-(10/9/01)
Humibid : am/pm
Prednisone: 10mg-pm
Biaxin: 500mg-am (9-15-01)for 7 days
Saline Nasal Spray: 2to4 times day
Sudal DM : 2 pills-am/pm-(8/23/01)
Su-tuss dm cough syrup(as needed)
Flomax: .4 mg pm-(9/14/01)
Risperdal: .25mg-am&noon/.5mg-pm
Depakote: 375mg-pm
Ritalin: 5mg-am-2.5 pm
Plavix: 75mg-am-(9/14/01)
Zoloft: 37.5mg-am
colace: 300mg am/pm

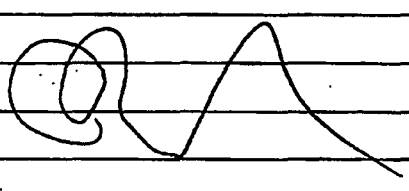
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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
11/14/01	Ritalin 5/2.5 } ~~OSE~~ Zolpidem 37.5 } ~~ORS & TD~~ Dexam. 37.5h. Risperid. 25/25/5 Prochlorperazine 10 Theophylline 300/300 Cal $\uparrow\uparrow$ SOB $\bar{E}$ mild SOB $\uparrow\uparrow$ Pct pain (neoplastic) "No quality of life" Only plea is from visits $\bar{E}$ niece & nephew. Sleep the speed at Bk Motel level $\rightarrow$ sd RA ROA. Thul. ch. CALVIT Axox 3 OSHR Dr. Bupropion 120/120 S/P TBI Ph: Sue on RTC Im. shall see if patient can $\bar{P}$ improve & prognosis $\downarrow$ steroids. RTC Im.
11/24/01	Will OK all  show Deespa S-10, C

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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
1/8/02	Tdpt 37.5 Depakote 375 SL Risperidone .25/.25/X Dec Sun 10 am Thigh 300/300 Pressure 60-50 Peds ↑↑ SOB → ↑ malnutrition 60 ↑ cerebral AP ↑↑ "so agitated" ↑ step "don't care" ↓ memory MSE Speech n/rt. mood but ADL ↓↓↓ "no pleasure" Thigh also ↓ ADL ↓↓ ↓↓ ↓↓ Q: P3-40 Nos ADL ↓↓ P.T.B. Pn ↑ Tdpt 50g R/C 2 weeks. G.I. pr.
	

Patient Name: Archie Tress

F-11 F-800 Attorney, Inc. (864) 225-1298

516

Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Archie Jones

Notes Should Be Signed by Physician

~~QSE~~

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Patient Name: Arche Jones

Date	Notes Should Be Signed by Physician
3/24/02	Zolpidem 50 Doxylamine 375 Risperidone 25/25 Desipramine 10 Theophylline 300/300 Risperidone 10 "I have a serious problem" → Long time periods "Don't get out of bed" Described ↑ sleep & apnea (Sleep apnea to CPAP) Can't breathe when asleep 2 SOB "My mind is clear Speech is clear, Mood is clear Full R/OA, Thinking clear & A/V APOX 3, ES/HT A/P ✓ EKG, R/TIC 1-2m
4/1/02	Doxylamine 375 → Desipramine 10 Urine to H. ↑ dose
	LFT CBC Fine

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Archie Jones

Date _____ Notes Should Be Signed by Physician _____
 5/15/62 Zick 50
 Dye 375
 Respond .25/.25/.5 } Ø SF
 Dec Spr 10
 Redman 2S
 Thigh 300/300
 D. well. Ø dpm Ø m
 "still can't handle stress"
 ⊕ stress @ home. Sleep
 Speech n/r. Rte. Mod. M. Act
 bright. Thinks der Ø S.H.I.
 A/P No Chg Rte 2m
 [Signature]

Patient Name:

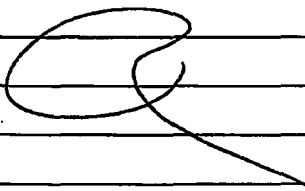
Archie Jones

F-11 FROM Attorney, Inc. (664) 225-1200

PROGRESS NOTES

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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
9/3/00	Zolpidem 50 } Depakote 375 } DSE Dep. Sin 10 } DERS OTO Risperidone .25/.25 Dep. well but frustration / Stress tolerance emphasized by ↑ high pain "nerve entrapment" → Physical Therapy Ref → Start to see ↑ irritability ↑ anxiety Sleep fine Speech not good. Mod aware ↓ irritability APT, assist Think chr CAUT Adox 3 CS/RT Pres: Buprop Nps ANAD S/P TBR Pres: Risperidone .5/.5 Refl presents @ Casert RTC 4-6th 

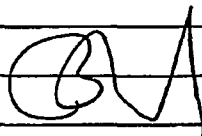
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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
10/18/02	Risperidone .5/1.5 ~~Zoloft~~ 50 ~~Depakote~~ 375 ~~Des~~ 10 ~~Prozac~~ 20 ~~Therapy~~ 300/300 ~~Celebrex~~ 200 Ⓢ response ↓ anxious ↓ irritability "Had fun @ the beach." Concerned about ↓ concentration Speech n/rt. Mood/ADLs bright. Think clear & A/Lt A/Gx3 & S/HK Dr. B. No. Nos ADHD 5/PTOI Ph. No. done ✓ labs R/T 2mo. Call pm <i>[Signature]</i>
10/28/02	Depakote level - 26.9 LFT w/n Pres. call @ 1 level. Urine to tol. 1 dose <i>[Signature]</i>

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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
12/5/02	Risperidone .5/.5 Zolpidem 50 Risperidone 375 Risperidone 375 Dose Spn 10 Therapy in Dietary Exercise Cat. medical complaints w/ly BRBPR popl. Primary stable @ response to meds "really good" ↓ mood ↓ anxiety ↓ more sleep Speech in bed. Mood / Affect bright Thru, clear. Affect ADOX3 & STR DERS & TD Dr: B. J. 12/5 ADHD S/P TBI Ph: No change RTC 2 mo. Call per. 
	* See note TOPAMAX: topiramate/topiramate re: Work. Comp -

re: Work.Comp -

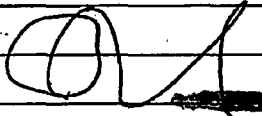
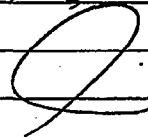
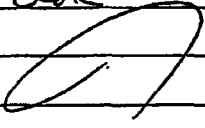
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Patient Name: Andre Jones

Date	Notes Should Be Signed by Physician
1/31/03	Risperidone 16.5 Zolpidem 50 Depakote 375 Doxepin 10 Theophylline Pantoprazole 20 "I'm having a hard time... my lungs" Tried to work around the house → ?"I have diverticulitis" → "Dr. changed my diet" → ↑ Magnesium (↑ 20# 3 weeks) ↑ gabapentin. all exercise "ouch" "my challenge -- I freeze" ⊕ racing thoughts "I can't read" Sleep: Speech 4-5 words. Mood irritability depressed. All at once ↑ Circumstances of ALOT Adox 3 ⊕ SHT ⊕ EPS ⊕ TD Dr. B. al. Nos AD40 SP TBT Pm ↑ Depakote 500mg ↑ Zolpidem 50 ✓ 100% week RTC 1mo. Call pm

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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
2/10/03	Seen with Williams Camp RN. Discal M. M. Medical important part of by COPD + need for steroids. ↑ support 
2/14/03	Letter drafted Crawford Helthorse M.urgent Service. 
2/26/03	LFT Fine Aug 84, Depch 40.5 → Does well @ sp. therapy. Unk to El. J. J. J. 

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248098

Robert W. Richards, M.D.
Vladimir Maletic, M.D.
Amy E. Jones, M.D.

Lynne E. Furey, LISW
Patricia C. Flordan, LMSW
Lynn C. Parsons, L.P.C.
Keith Mundis, L.P.C.
Lawrence J. Belle, LISW

February 20, 2003

Mary Cocke, RN, CCM
Medical Service Consultant
P.O.Box 80430
Simpsonville, South Carolina 29680

Subject: JONES, Archie (Eddie)
Claim # W-1000000000

Dear Ms. Cocke:

Pursuant to our February 5, 2003 meeting I wish to confirm that Mr. Jones has achieved maximum medical improvement of his Bipolar Disorder, NOS and ADHD. This was a difficult conclusion as the maximum medical improvement for Bipolar Disorder and ADHD is usually much higher. Patients usually achieve a higher level of sustained mood stability.

Mr. Jones' chronic obstructive pulmonary disease, recurrent pulmonary infections, and a need for ongoing steroids essentially prevent him from achieving sustained mood stability. I understand that Mr. Jones' medical treatment team believes that he has achieved maximum medical improvement of his chronic obstructive pulmonary disease. He will more likely than not require ongoing treatment with Prednisone, Theophylline and intermittent antibiotics. In addition he will continue to have intermittent exacerbations of his pulmonary status.

In summary, Mr. Jones' chronic obstructive pulmonary disease prevents him from achieving a higher level of medical improvement of his Bipolar Disorder.

Greenville Psychiatry, P.A.

Jones, Eddie
continued...

Thank you for your interest in Mr. Jones' treatment. If you have any questions or need additional information you may reach me at my office where the telephone number is 864-271-5056.

Sincerely,

Robert W. Richards, MD

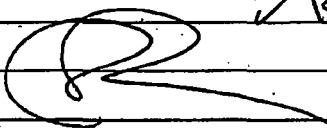
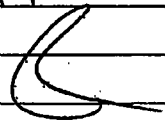
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Patient Name: Archie Eddie Jones

Date	Notes Should Be Signed by Physician
3/1/03	Phne ✓ Improving during in leg. → mood brighter "get out & do things" ~~SE~~ med SE Well should get 2ms B/L
4/1/03	Doc Smile 10 } Zolot MS } ~~SE~~ Risperidone .5/1.5 } Depakote 500 } ⊕ response to ↑ Depakote & Risperidone thoughts & anxiety: Concern about doing "Hard to get some" ⊕ able to feel pleasure sleep less. Speech a little more / All set level than ch CAH4 A+O x 3 ~~SE~~ 5/14E Dr. B. per Ngs ADH40 TBH ↓ response .25/25 ~~SE~~ mood really much Depakote. RTC / 4-6 week

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Patient Name: Archie Eddie Jones

Date	Notes Should Be Signed by Physician
5/16/03	Dec Spn 10 2dpt 75 Risperidol 25/25 Depakote 500 Prozac 15-20 "really jumping" & acc thoughts "big" ↓ motivated Sleep fine 1 stress, 2° inc. L (wand heal on feet) Speech all rite. M. 1/10-11 last thinking clear 2dpt 40x3 05/14 Pk: B. 7th NOS AD40 S/P TRK Ph: 1 2dpt 100 PTC 6-8uh Call pm. ✓/hrs 
5/26/03	Depakote 35.7 

PROGRESS NOTES

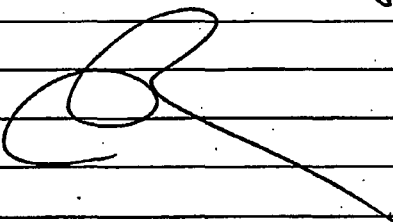
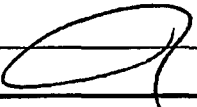
Patient Name: Archie Ellis Jones

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Patient Name: Archie Eddie Jones

Date	Notes Should Be Signed by Physician
9/18/03	Zoloft 75 Risperidone 25/25 Depakote 750 Prozac 150 Steroid 10mg Generally doing well. Periodic depression in stress management problems. SOB complications of prozac. Episodic sleep. Speech at site. Mood level ↑ ROA. Think clear. A/VH. Arox 3. S/HF. CARS. CTD. Dx Bipolar NOS. ADHD. SKTBT. Ph. ✓ LFT CBC Liver panel. RPTC 2mo.
	
9/18/03	Depakote 52.7 LFT CBC RPTC
	

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Patient Name: Arthur Ives

Date	Notes Should Be Signed by Physician
9/17/03	Phn call - reports ↑↑ anxiety ↑ ↑ prednisone 30mg. Also ↑ fatigue. ⊕ metabolic w/c Q Sat 98% H/H w/c MCV 96.8 TSH 4.9. Discuss options: ↑ Discontinue ER 1000hs. Keep. FU call pm. If persistent fatigue ✓ E RP
	(BA)

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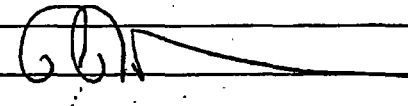
Elle Tres

Date	Notes Should Be Signed by Physician
10/23/03	Phone call - Reports ↓ mood ↓ energy ↓ pleasure ↓ interest + irritable. ↓ mood ↓ risk discussiveness. ↓ SOB. Discussed options will ↑ Zol. from 75mg to 100mg. Keep Fil. Call pm B
11-4-03	Dr. Richards: lab slip mailed for Depakote Level, Liver Panel & CBC ——— Bidwell
12/1/03	Depakote ER 1000 } ↑ lower Risperidone .25/.25 } ⊕ together Zol. 100 Dep. to S Pramoxine ↑ 50mg } → ↓ 15 Reports ↑ stress, ↑ agitated, ↑ appetite + "personal" in crowd, ↓ fear thoughts, ↓ anxiety, ↓ sleep Speed at Rte. Mael level ADT + 1/2 until. Thinking clear ↓ ALH, AOX 3 ↓ SHT. Dr. Bidwell Nos ADH Ph. ↑ dose. Sm 10. RTC Gave

PROGRESS NOTES

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Patient Name: EDDIE JONES

Date	Notes Should Be Signed by Physician
1/8/04	Dex Spn 10
	Depakote ER 1000
	Risperidone 25/25 } @ home
	Zolpid 100 } @ all SE
	Dex Tab 5
	Prednisone 15 } ↑ w/ SSN
	@ baseline. @ Rasmussen deep
	2° "urgency" - m. post-ictal
	(for urology) & depress.
	Able to enjoy family & computer
	games. Difficult to eat
	person in crowd. 2° Not leaving
	house 2° SOB & avoid exposure
	to flu. Speech n/RT
	Mod bright. ↑ ROA @ tangent
	✓ Oculars ✓ ALT A40x3
	✓ SHI ✓ EPS ETO @ home
	Dx: Bi-ph Nos ADHD ? EPS for
	Plan No change RTC 6 wk
	

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Patient Name: Eddie Jones

Date	Notes Should Be Signed by Physician
3/2/04	New Spn 10 } ⊕ lean Depulset ER 100 } ⊕ cut again Respironics .25/.25 Tab 100 Day Tab 5 ↑ stress ~~problem~~ Proclaim 20 ⊕ Response & depress. Empire Sleep impract. Ennis teach niece. Speech at Rte. Mail brought ↑ RoA Thinking clear & ALVA Adox 3 & S/41 Dr Bi-pet was ADHD Min. No change RTC 6-8ul

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Patricia C. Riordan, L.I.S.W. -C.P.
Keith S. Mundis, L.P.C.
Larry Belle, L.I.S.W. -C.P.
Heather M. Ctrellt, L.P.C.

March 19, 2004

Ms. Marcella Wheeler, Claims Adjuster
Liberty Mutual Insurance Company
P. O. Box 31205
Tampa, Florida 33631

Subject: JONES, Archie
Claim # [REDACTED]
DOB: [REDACTED]

Dear Ms. Wheeler:

I have seen Mr. Jones for (7) seven office visits during the time period from February 5, 2003 until March 2, 2004. There has been essentially no change in his condition. As I explained on February 5, 2003 Mr. Jones' maximum medical improvement of his bipolar disorder is prevented by multiple medical conditions including respiratory distress which requires steroid treatment.

He was last seen on March 2, 2004. His current medications were Dexedrine Spansules 10mg in the morning, Depakote ER 1000mg at bedtime, Risperidone .25mg BID, Zoloft 100mg in the morning. He denied significant symptoms of depression or mania. In addition he stated that he enjoys teaching his niece. Nevertheless, functional rehabilitation has been difficult due to recurrent respiratory distress.

My long and short term goals for Mr. Jones are to continue managing his medication, provide supportive therapy from the standpoints of enjoying life with his current disability and functional rehabilitation. I plan to meet with Mr. Jones every six to eight weeks for 15 to 30 minute office visits.

Thank you for supporting Mr. Jones' treatment.

Sincerely Yours,


Robert W. Richards, MD

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Patient Name: Shirley Jones

4/1/04

Dex Spn 10
Depot ER 1000
Risperidone .25/.25
Zol 100
Dex 11 S
Prozac 15 } ⊕ at 5m ↑ Clu
⊕ response ⊕ Depress
⊕ Maria Enjoys work &
niece. ⊕ response in part due
to d long problems. Sleep 7hr.
Speech pl Rte. Mood bright.
↑ QoA Think der ⊕ ALVH
A00K3 ⊕ Shift
Dx Bipol NOS A040 S/P TRT
Pln. No change RTC 2-3mo.
Call pm

Patient Name: Edie Jones

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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
7/18/04	Proctol 9-C TSW 2.453 LOL 109 CBC neg platelet 210 Chk 8C Trig GS HOL SI Q
7/18/04	Zol 100 Depak ER 1000 Risperidone .25/.25 Depo Sp 10 Depo T 5 Depo 20 Cadiz 240 Repts 3mo hr "katharsis" ? related to rectum & sphincter schiz ("I just give me problems") & motivated but no syndrome depression & mania & psychosis ↑ symptoms Speech at rct. Med bright ↑ P/A ⊕ circumvent & O/A thought cont & Alut Adox3 & Slur Dr. Binger Nos Adox3 Slp TBI Pr. No change Rct 3mo Cell

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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
12/15/01	Zol 100 } ⊕ mild depression
	Depak ER 1000 } Ecth. SE
	Risperidone .25/.25
	Dex Sp 10
	Dex Tab 5
	Prochlorperazine 25
	Carisoprodol 240
	Diphenhydramine 25
	"I was doing real good" Reports
	mild depression x 3 weeks ? relapsed
	to URT. ⊕ please "n' back"
	Car. Relapse of Depressive
	Speech at rate. Mood level ↑ ROA
	Thinking der. Zol 100 3000 3000 3000
	Dex. Risperidone 2500 3000 3000 3000
	Ph. No change RCT 300 300 300

[Handwritten signature]

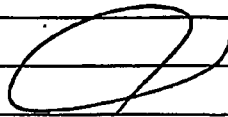
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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
3/14/03	Zolpidem 100
	Doxycycline ER 1000
	Risperidone .25/.25
	Lexapro 10
	Dex Tab 5
	Prochlorperazine 20
	Codeine 240
	Risperidone
	Reports ↑ stress physical problems.
	Main problem is fatigue ? long
	absent. ⊕ interest in activities
	⊕ strong bias ⊕ aggressive
	Episodic irritability. Sleep fine
	Denies ETOH/Drugs.
	Speech n/ok Meal level
	↑ ROA Thinking clear ⊕ AKA
	Axx3 CS/HT.
	⊕ trauma ⊕ other EPS ⊕ TD
	wt. 237
	cont →

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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
3/14/05	cont Des Bipolar NOS due to TBI ADHD
	Plan ① ✓ Alca depole Liver CBC UA
	② Same med
	③ Rtc 3mo. Call per
	
3/21/05	CBC neg platelet 219 UA neg LFT neg Depole 64
	

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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
ddos	Less QOD Zoloft 100 Depote ER 1000 Risperidone .25/25 Dex Spn 10 Dex Tab 5 Prochlorperazine 15-30 Carisizem 240 mild tremor ⊕ tongue ⊖ ERS ⊖ TD
	Reports 2ma hx ↑ SOB (resolves = ↑ prochlorperazine) → ↑ tongue & ↑ irritability & rage? Able to feel pleasure? sleep. ↑ stress. Nephew died Denies ETOH/Drugs
	Speech almost Maud level ↑ RoA Thinking clear @ times circumstantial & ALVH Adox3 & SHIT & ↑ consciousness
	Dx: Bipolar NOS due to TBI ADHD
	Plan: No change RxC 3mo. Call prn



Patient Name:

Archive Index

Date	Notes Should Be Signed by Physician
9/14/05	Zolort 100 Dexdof ER 1000 Risperidone .25/25 Dex-Ser 10 Dex-Ten 5 Prozac 15-30 Greatly day well. ~~Depression~~ ~~more~~ ~~mod~~ ~~recovery~~ ADHD ~~Calmed~~ Sleep fine ~~SHT~~ ~~anger~~ A/P No chage RTC 3-4 mo. Cell pro

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Patient Name: Archie "Eddie" Jones

Date	Notes Should Be Signed by Physician
10/3/06	~~Box Tcb S~~ ~~Box Sp 15~~ ~~TdP 100~~ ~~Depakyl ER 1000~~ ~~Risperidone 25/25~~ ~~Prozac 10-20~~ ~~Levodopa 50mg~~ ~~hydrocodone 20 back pain~~ ~~Reports Gab he a motive~~ ~~disorder - please "Don't enjoy~~ ~~anything" & negative~~ ~~think. Prozac, Levo~~ ~~depression. 1 sleep key~~ ~~↑ cramps @ hs & start~~ ~~hydrocodone & mood~~ ~~↑ pain & SHIT & chrysoem~~ ~~↑ stress level~~ ~~Dr. B. - not NOS due to TBI~~ ~~ADHD~~ ~~Ph: ① ✓ glucose, prolactin, Free~~ ~~testosterone, CBC, platelets, B-D~~ ~~TSH, liver CMP, Lipids → other cell~~ ~~@ RTC 2 weeks apr~~

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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
12/12/05	ZTR 100
	Depakote ER 1000 } ~~SE~~
	Risperidone 25/25 } ~~EPS~~ ~~STD~~
	Dex Spm 10a
	Dex Tab Spm
	Prozac 10
	Levamisole 50mg QD
	Gait baseline. Able to enjoy
	family. ~~Synchronous~~ depression,
	more mood regulated. ADHD
	controlled sleep line. Residual
	lonely & physical/mental strain.
	"don't want to do anything"
	Can external SOB
	MSE Speech at rate. Mood level
	↑ ROR Thinking clear ~~ALH~~
	Adox3 ~~S/NI~~
	Dx: Bipolar NOS due to TRT
	ADHD
	Plan: ↑ Dex spm 15mg
	RJC 3mo. G11 pm

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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
3/14/01	Dex Spn 15am
	Zolof 100
	Depakote ER 1000
	Risperidone .25/25
	Dex Feb Spn Hcr D/C
	Prochlorperazine 10
	Low-threshold Soma EQ
	Report of response to ↑ dex spn,
	but ↑ fatigue & avoidance of
	activities that require effort in
	pm. Denies depression, mania,
	anxiety. Sleep fine. Disagree
	on-going stressors. ☒ ETC/Drugs
	MSE speech nl Rte. Mood bright
	Thinking der ☒ Aket Adox 3
	☒ Sht ☒ ↑ risk of aggression
	Dx: Bipolar NOS due to TBI
	ADHD
	Ph: Ma, Hb dex Hb 5-10
	ms po Q 1-3pm Rte 3mo.
	Call pm

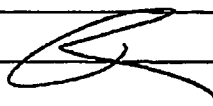
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Patient Name: Archie "Eddie" Jones

Date	Notes Should Be Signed by Physician
6/5/02	Dex 10 Spm
	Dex Spm 15 } ☒ SE
	Zol 100 } ☒ ↑ Thrust
	Depakote ER 1000 } ☒ Curie frequency
	Response 25/25
	Laprox 50mg
	Propranol 10
	☒ response to dex 10 Spm.
	Seen by Dr. Mahan →
	requested sleep study →
	not approved by workers comp.
	↑ stress 2nd p. anxiety about
	economic stress to make
	Cognitive mood test. Able to
	feel place & be optimistic.
	☒ mood relatively ↑ stress.
	☒ mood ↓ psychoses. ↓ restorative
	sleep. ☒ SHT ☒ discourses.
	☒ ER ETO at 22 nd
	Dr. B-prior N05 due to TBI
	ADHD
	Ph: No charge BIC 3mg.
	Call pm ✓ double test ABC
	LFT Close

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Patient Name: Mr. Eddie Jones

Date	Notes Should Be Signed by Physician
9/1/08	~~Dex~~ ~~Tab~~ ~~Spn~~ } ~~↑~~ ~~thrust~~ ~~Dex~~ ~~Spn~~ ~~15~~ } ~~↑~~ ~~wine~~ ~~CDP~~ ~~100~~ } ~~recovery~~ ~~Orally~~ ~~ER~~ ~~1000~~ } ~~DEPS~~ ~~STD~~ ~~Response~~ ~~25/25~~ } ~~wt~~ ~~228~~ ~~Prescribe~~ ~~10~~ - ~~20~~ ~~Levamisole~~ ~~50mg~~ Dr. P. has had complete mental rel. → Psychiatry. II - @ base - line. Able to feel pleasure @ optimum ⊕ spiritual growth. ⊕ ↑ mood reactivity. Thinking clear & ALIVE Adox 3 & SIN 1 & consequences. Disposed of stress: pain, malice, guilt, etc. Dr. Bipolar Now due to TBI ADHP Phs: No change. RIT 3mo dpm 

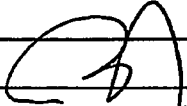
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Patient Name: Archie "Eddie" Jones ~~24-2007~~ ~~25-2007~~

Date	Notes Should Be Signed by Physician
10/31/06	Dec Tcb S } ☒ ↑ Throat Dec Spn 15 } ☒ ↑ June Injury TdRt 100 } ☒ EPS ☒ TD Depch ER 1000 } wt 227 Risperid 25.25 Prochlor 10-20 Leptogen 50mg hydrocodone 20 bich psin Report Gah hix Motivsh dig best ↓ please "Don't enjoy anything" ☒ negativistic think. ☒ dominant behavior ↑ speech. ↑ sleep less ↑ cravls @ hs ☒ sat hydrocodone ☒ mood reschul. ↑ mms ☒ SHIT ☒ dangerous stress noted Dr. Bial Nos de to TBI ADHD Ph: ① ☒ glucose, prolactin, Free testosterone, CBC, ☒ complete panel B-D TSH Liver CMP Lipids → Phn call @ RTC 2 weeks Apr

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Patient Name: Wendie Elsie Jones

Date	Notes Should Be Signed by Physician
11/8/06	CBC neg Platelet 212 LFT neg B-12 1247 TSH 2.452 T4 1.11 Protein 8.4 Testosterone 6.24 Alcohol 63.6 
11-8-06	Left message: Labs WNL, 

Patient Name: Anne "Ellie" Jones

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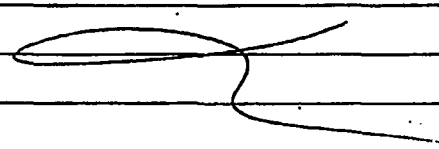
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Patient Name: Archie "Eddie" Jones

Date	Notes Should Be Signed by Physician
12/5/00	Risperidone .5/1.5 } $\emptyset$ ↑ thirst Dex Tab 5 } $\emptyset$ nocturia Acc Spn 15 } Caloric intake Zolpid 100 } Depakote ER 1000qh. kcal 63.6 Levetiracetam 50mg Pt. reports ↑ sleep → meds not approved by weight gain? $\emptyset$ Do not return phone calls. $\emptyset$ missed doses thus far → meds have subsequently been approved. (Care manager is scheduled to come to today's apt. Carel 2° emergency.
	"I'm not doing good" → ↓ response to ↑ risperidone $\oplus$ discomf. $\emptyset$ in crowds → $\uparrow$ ↑ avoid leaving the house ($\emptyset$ symptoms psychophysics) → Also $\uparrow$ ↓ motivation ↑ to be a pleasure ↑ work. ↑ arousal @ night 2° nocturia urgency (urinary consult pending)

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Patient Name: Archie "Eddie" Jones

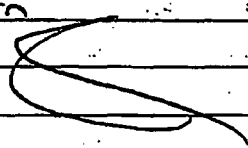
Date	Notes Should Be Signed by Physician
12/5/00	✓ Syncope / minor Spends time working in the shop. ① on repair → some activities re difficult 2nd attention dysed comprehension (✓ Negative delusions over time)
	MDE Speech at Rte. Motel (excl) ↑ ROA ① circumstances ① delusions ✓ ALVH Adox 3 ✓ Slight ✓ delusions ✓ EPS ✓ TD wt 227 Q: ~~Dep~~ ~~to~~ Bipol Nos due to TBIE ADHD
Ph	No change RTC 4-Club 4pm
	

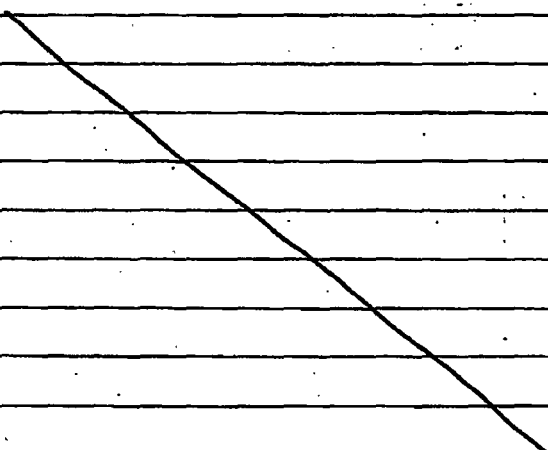
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Patient Name: Adrian Jones

Date _____ Notes Should Be Signed by Physician _____

9/1/85 Total 100
Depakote ER 1000
Risperidone .25/25
Dor Sp 10
Dor Tab 5
Pachira 15-30
Generally does well. ~~Depression~~
~~Mania~~ ~~mod recidivism~~
ADHD Calm. Sleep fine
~~SHT~~ ~~Depression~~
A/P No drug RTC 3-4mo.
Call per





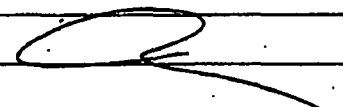
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Archie "Eddie" Jones

Date	Notes Should Be Signed by Physician
10/3/01	~~Dx Tsb S~~ ~~Dx Spn IS~~ ~~TCD 100~~ ~~Depshy ER 1000~~ ~~Risperidone 25/25~~ ~~Pregabalin 10-20~~ ~~Lacosamine 50mg~~ hydrocodone 2° bch psin Reports Gub hix ↓ Motivated in best ↓ please "Don't enjoy anything" ↑ negative thinking. Prolonged lethargy ↓ sleep. ↑ Sleep key ↑ cravels @ hs P start hydrocodone E mod resolute ↑ pain E SLHT E digoxin Stress noted Dx Bipolar Nos due to TBST ADHD Phis ① ✓ Glucose, prolactin, Free testosterone, CBC, Uric acid level B-D Liver CMP Lipids → Phre col @ RTC 2 weeks Apr

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Patient Name: Arthur Jones

Date	Notes Should Be Signed by Physician
12/12/05	Zol 100
	Depak ER 1000 } ~~SE~~
	Risperidone 25/25 } ~~EPS LTD~~
	Dex Spm 10c
	Dep Tab Spm
	Prozac 10
	Levamisole 50mg QD
	Can. baseline. Able to engage
	Remix. ~~Symptoms~~ depression,
	more mood regular. ADHD
	controlled sleep line. Reside
	lonely & physical/mental struggle.
	"don't want to do anything"
	Can. exertial SOB.
	MSE Speech at rate. Moral level
	↑ RoA Thinking clear ~~Alk~~
	Adox 3 ~~SE/HT~~
	Dx: Bi-polar Nos due to TBI
	ADHD
	Ph. ↑ Dex spm 15mg
	RTC 3mo. G 11 pm
	

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Patient Name:

Archie Ines

Date	Notes Should Be Signed by Physician
3/14/06	~~Dep Spm 15am~~ ~~Zolpidem 100~~ ~~Depoite ER 1000~~ ~~Risperidone .25/.25~~ ~~Dep 150 Spm 1hr D/C~~ ~~Prochlorperazine 10~~ ~~Low-thyroxine 50mg EQ~~ Report of response to ↑ Dep Spm, but ↑ fatigue & avoidance of activities that require effort in PM. Denies depression, mania, anxiety. Sleep line. Disagree on-going stressors. ~~ETOH/Drugs~~ MSE good w/ Rte. Mood bright thinking clear. ~~AKH Adox 3~~ ~~Skitt~~ ~~↑ risk~~ ~~discrepancy~~ Dx: Bipolar NOS due to TBI AD/HD. Plan: Max 1hr dex 150 5-10 ms po Q 1-3pm Rte 3mo. GTH pm

Greenville Psychiatry, P.A.
 9-A Caledon Court
 Greenville, South Carolina 29615
 Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Archie "Eddie" Jones

Date	Notes Should Be Signed by Physician
6/5/07	~~Dep 15~~ ~~Zoloft 100~~ ~~Depakote ER 1000~~ ~~Risperidone .25.25~~ ~~Levithyroxine 50mg~~ ~~Prozac 10~~ ~~↑ response to dex 15 Spm.~~ ~~Seen by Dr. Mahan →~~ ~~requested sleep study →~~ ~~not approved by workers comp.~~ ~~↑ stress 2 p. concern about~~ ~~economic stress to med.~~ ~~Gravely mood low. Able to~~ ~~feel place & be optimistic.~~ ~~AD mood reactivity to stress.~~ ~~↑ mood & psychoses. ↓ restorative~~ ~~sleep. ↓ SLEEP ↓ consciousness.~~ ~~↓ ER & TD at 22y~~ ~~Dr. B-prior NAS due to TBI~~ ~~ADHD~~ ~~Ph: No change RIT 3mg.~~ ~~all pm~~ ~~↓ double test ABC~~ ~~LFT clear~~

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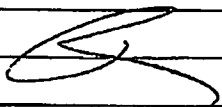
Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
ddos	Less GOD Zoloft 100 Depote ER 1000 Risperidone .25 x 2's Dex Spn 10 Dex Tab 5 Prednisone 15-30 Cadinzem 240 mild trem @ fatigue DERS ETO
	Reports 2mo hx ↑ SOB (resolves - ↑ prednisone) → ↑ fatigue & ↑ irritability & rage? Able to feel pleasure? sleep. ↑ stress. Nephew died Denies ETOH/Drugs
	Speech almost normal level ↑ RoA. Thinking clear @ times circumstantial & ALVH Adox3 & SHIT & ↑ consciousness
	Dx: Bipolar NOS due to TBI ADHD
	Plan: No change RxC 3mo. Call pm



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Patient Name: Archie "Eddie" Jones

Date	Notes Should Be Signed by Physician
1/29/07	Dex Ed Spm } ☒ ↑ Throat Dex Spm 15 } ☒ ↑ Urine Cital 100 } frequently Divalg ER 1000 } ☒ ERPS & TO Risperidone .25/.25 } w/ 228 Prozac 10 - 20 Lasix 50mg Dr. P. has had complete intake (incl. P. → Psychiatry) @ base- line. Able to feel pleasure @ optimum @ skeletal gym. ☒ ↑ mood reactivity. Thinking less @ ALH Adox 3 ☒ SHTG ☒ consequences. Dissect. stress: pain, maln, Gmnl. etc. Dr. Bi-polar NAs due to TBI ADHD Pbs: No change. Rtc 3mo dpm 

October 17, 2008

Health Care Provider's Statement of Disability

Patient's Name: ARCHIE JONES Social Security Number: [REDACTED]

1. Diagnosis: _____

2. Treatment:

a. Date of first treat visit: Month 4 Day 20 Year 1999
 b. Date of last visit: Month 10 Day 31 Year 2008
 c. Frequency of treatment: Weekly ☐ Monthly ☐ Other ☒ 2 weeks - 1 month

3. Progress Recovered ☐ Improved ☐ Unimproved ☒ Regressed ☐

4. Extent of Disability For Any Occupation

a. Is patient now totally disabled? Yes ☒ No ☐
 b. If no, when was patient able to go to work? _____ Month _____ Day _____ Year _____
 c. If yes, when do you think patient will be able to resume any work?
 Approximate Date: _____
 Indefinite ☐
 Never ☒

5. Mental Condition: Frequent cycles of mixed mania & depression.

Remarks: Unable to tolerate stress 20
fragility of mood & need for reassurance
due to SOB

11/10/08 Dr. Chulmo 804-271-5056
 Date Signature (Attending Physician) Degree Telephone No.
9-A Cabela Court Greenville SC 29615
 Street Address City or Town State Zip Code

Return form to:
 3M Disability Program, Building 551-1W-04, PO Box 33116, St. Paul, MN 55133-3116

Telephone: (864) 271-5056 FAX: 271-8043

F-11 R000 Allway, Inc. (224) 225-1200

565

January 4, 2006

Health Care Provider's Statement of Disability

Patient's Name: ARCHIE JONES Social Security Number: [REDACTED]

1/2/3/4/5
are not
his disability
factors
all *

1. Diagnosis: Hypertension, TIA (Transient Ischemic Attack), Small vessel

cerebrovascular ischemia; chronic Pulmonary disease: Hip pain: Shoulder pain

2. Treatment: Insulin resistance; anxiety d/o; alcohol; Depression (5)

a. Date of first treat visit: Month 5 Day 1 Year 1997

b. Date of last visit: Month 02 Day 29 Year 06

c. Frequency of treatment: Weekly ☐ Monthly ☐ Other ☒ 3-6 mths

3. Progress Recovered ☐ Improved ☐ Unimproved ☒ Regressed ☐

4. Extent of Disability For Any Occupation

a. Is patient now totally disabled? Yes ☒ No ☐

b. If no, when was patient able to go to work? _____ Month _____ Day _____ Year

c. If yes, when do you think patient will be able to resume any work?

Approximate Date: _____

Indefinite ☐

Never ☒

5. Mental Condition:

Remarks: Ask his psychiatrist for details he is alert & oriented x 4, pleasant & cooperative; some flight of ideas some what hyperverbal normal affective speech; thought processes

11/9/06 Quinlan MD MD (864) 231-7003
Date Signature (Attending Physician) Degree Telephone No.

2405 N. main St Anderson SC 29621
Street Address City or Town State Zip Code

Return form to:
3M Disability Program, Building 551-1W-04, PO Box 33115, St. Paul, MN 55133-3115

* this patient is disabled from his severe pulmonary disease created by thermal burns in 1997. His secondary disability is from a psychiatric diagnosis: chronic depression anxiety & Adult attention deficit disorder that has remained chronic & unchanged since 1995.

Health Care Provider's Statement of Disability

Patient's Name: ARLIE JONES Social Security Number: 2205 2214

1. Diagnosis: Pulmonary Insufficiency
2. Treatment: 2nd COPD and bronchitis

a. Date of first treat visit: Month 11 Day 7 Year 02
b. Date of last visit: Month 4~~th~~ Day 20 Year 06
c. Frequency of treatment: Weekly ☐ Monthly ☐ Other ☐

3. Progress Recovered ☐ Improved ☒ Unimproved ☐ Regressed ☐

4. Extent of Disability For Any Occupation

a. Is patient now totally disabled? Yes ☒ No ☐
b. If no, when was patient able to go to work? _____ Month _____ Day _____ Year
c. If yes, when do you think patient will be able to resume any work?
Approximate Date: _____
Indefinite ☐
Never ☒

5. Mental Condition:

Remarks:

Has seen a psychiatrist in Greenville.
Currently being actively treated
for pulmonary problem and
sleep problem
MD 225-5667

Date 11-10-06 Signature (Attending Physician) [Signature] Degree MD Telephone No. 225-5667
Street Address 2000 East Greenville Street, Suite 1100 City or Town Anderson State SC Zip Code 29621

Return form to:
3M Disability Program, Building 551-1W-04, PO Box 33115, St. Paul, MN 55133-3115

October 17, 2006

Continuance of Disability Claim Form

Employee Name: ARCHIE JONES Social Security Number: 250-706-1109
Current Address: 1229 SALEM CHURCH ROAD ANDERSON, SC 29625-131
Telephone Number: (864) 271-5056

Attending physician: Name DR. ROBERT RICHARDS
Address 9-A CALEDON COURT GREENVILLE, SC 2961
Phone (864) 271-5056

Dates of Treatment since last report: _____

Have you returned to work? NO

If yes, the date you returned to work: _____

How many hours per week? _____

Name, address, and telephone number of current employer: _____

INCLOSED IS A COPY OF ALL THE DOCTORS AND THE
DATES THAT I SAW THEM.

DEA # 673636202

GREENVILLE PSYCHIATRY, P.A.
ROBERT W. RICHARDS, M.D.
P-A CALEDON COURT
GREENVILLE, SC 29615
864-271-5058 Fax: 864-271-8043

NAME Archie Jones
ADDRESS _____ DATE 3/2/01

B (Please Print) Monthly Update

Relapse of depression
probably due to prednisone
increase.

☒ LABS
OWA M.D.
Discharge As Written
SUBSTITUTION PERMITTED
21-6649-08 66-1962003-7-10542_0002

Health Care Provider's Statement of Disability

Patient's Name: ARCHIE JONES Social Security Number: 1-9-72-5-719

1/2/3/4/5
are not
his disability
factors
see *

1. Diagnosis: Hypertension, TIA (Transient Ischemic Attack), Small vessel cerebrovascular ischemia; chronic Pulmonary disease; Hip pain; Shoulder pain

2. Treatment: Lipitor resistance; anxiety d/o; ADHD + Depression (5)

a. Date of first treat visit: Month 5 Day 1 Year 95
b. Date of last visit: Month 09 Day 29 Year 06
c. Frequency of treatment: Weekly ☐ Monthly ☐ Other ☒ 3-6 mths

3. Progress Recovered ☐ Improved ☐ Unimproved ☒ Regressed ☐

4. Extent of Disability For Any Occupation

a. Is patient now totally disabled? Yes ☒ No ☐
b. If no, when was patient able to go to work? Month _____ Day _____ Year _____
c. If yes, when do you think patient will be able to resume any work?
Approximate Date: _____
Indefinite ☐
Never ☒

5. Mental Condition:

Remarks: Ask his psychiatrist for details he is alert & oriented x 4, pleasant & cooperative; some flight of ideas. Some what hyperverbal normal affect in speech; & thought processes

11/9/06 Quintavon MD MD (864) 231-7003
Date Signature (Attending Physician) Degree Telephone No.
2405 N. Main St Anderson SC 29621
Street Address City or Town State Zip Code

Return form to:
3M Disability Program, Building 551-1W-04, PO Box 33115, St. Paul, MN 55133-3115

* this patient is disabled from his severe pulmonary disease created by thermal burns in 1997. His secondary disability is from a psychiatric diagnosis: chronic depression, anxiety & Adult attention deficit disorder that has remained chronic & unchanged since 1995.

Maintenance updates.doc 01/13/05

October 17, 2006

• Page 3

Health Care Provider's Statement of Disability

Patient's Name: ARCHIE JONES Social Security Number: 252-70-5419

1. Diagnosis: _____

2. Treatment:

a. Date of first treat visit: Month 4 Day 20 Year 1999
 b. Date of last visit: Month 10 Day 31 Year 2006
 c. Frequency of treatment: Weekly ☐ Monthly ☐ Other ☒ 2 weeks - 6 months

3. Progress Recovered ☐ Improved ☐ Unimproved ☒ Regressed ☐

4. Extent of Disability For Any Occupation

a. Is patient now totally disabled? Yes ☒ No ☐
 b. If no, when was patient able to go to work? _____ Month _____ Day _____ Year _____
 c. If yes, when do you think patient will be able to resume any work?
 Approximate Date: _____
 Indefinite ☐
 Never ☒

5. Mental Condition: Frequent cycles of mixed mania & depression.

Remarks: Unable to tolerate stress 20
fragility of mood & need for prednisone
due to SOB

11/10/06 Dr. Chidambaram MD 864-271-5056
 Date Signature (Attending Physician) Degree Telephone No.
9-A Glen Cart Greenville SC 29615
 Street Address City or Town State Zip Code

Return form to:
 3M Disability Program, Building 551-1W-04, PO Box 33115, St Paul, MN 55133-3115

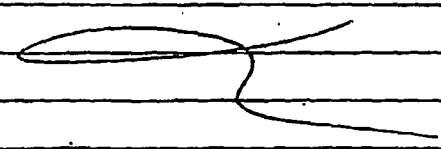
Greenville Psychiatry, P.A.
 9-A Caledon Court
 Greenville, South Carolina 29615
 Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Archie "Eddie" Jones

Date	Notes Should Be Signed by Physician
12/5/00	Risperidone .5 L.S. } $\emptyset$ ↑ thirst Dex Tab 5 } @ nocturnal Dex Spn 15 } Caloric care Zolpidem 100 } Olanzapine ER 1000h bed 63.6 Levetiracetam 500mg P. reports ↑ stress → meds not approved by wages comp.? Did not return phone calls. Missed doses thus far → meds have subsequently been approved. (Care manager was scheduled to care to today's apt. Carel 20 emergency.
	"I'm not doing good" → ↓ response to ↑ risperidone @ discomf. in crowds → ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ the home (↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ psychosis) → Also ↓ ↑ arousal @ night 2° nocturnal urgency (urinary consult pending)

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Patient Name: Archie "Eddie" Jones

Date	Notes Should Be Signed by Physician
12/5/00	✓ syndromal mania Spends time working in the shop. Ⓢ on repeat → some activities are difficult to tolerate ↓ mood compromised (✓ Negative delusion over time)
	MIE Spoke w/ Rpt. Med. Serv. ↑ Rpt. Ⓢ circumstances & obs. ✓ ALN Adox 3 ✓ SHT ✓ dangerousness ✓ EPS ✓ TO w/ 227 D. ~~Adox~~ Bi-pid Nos due to TBIC ADHD
	Ph No change RTC 4-End Apr
	

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Patient Name: Archie "Eddie" Jones

Date	Notes Should Be Signed by Physician
1/15/07	Risperidone .5/1.5 } ↑↑ appetite since D/C dexedrine Dex T6 Spm Dex Spm 15cm Zolpidem 100 Depakote ER 1000mg Levothyroxine 50mcg Reports on-going ↑ stress. ⊕ change working's comp case worker. Also ↑ work on son's house. ⊕ chronic productive cough & mild SOB. → saw PCP HR 110-115 → D/C dexedrine ~ 2 weeks ago → ↓ energy ↓ sustained attention "I sit and read" Sleep fine (intermittent awakenings) MSE good w/ ext. Mood low Thinking clear & ALTH ADOK3 ⊕ SNI ⊕ delirious P78 CPT5 STD wt 233 Dr. B. -sch was due ↓ TBST ADHO Ph: No change. RJC 4-Gale 4pm

Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Archie "Eddie" Jones

[illegible]

P-11 RUBEN Alloway, Inc. (354) 229-1290

PROGRESS NOTES

Greenville Psychiatry, P.A.

9-A Caledon Court

Greenville, South Carolina 29615

Telephone: (864) 271-5056, FAX: 271-8043

Patient Name:

Archie "Eddie" Jones:

Date _____ Notes Should Be Signed by Physician _____

2/22/07 Risperidone .5/.5 P76
Zolpid 100
Dental ER 1000hs Prescribe 10
Lactulose 50mg
Dx Tab Ser: report on own
Cal on-going stress. @w "depressed"
Worries about benefits "ranging out"
Able to feel pleasure @ optimistic
↑↑ pher. & mental fatigue
All p'd step. (seeing urology
for rectitis) Denies ECTH/Psych
MSF Speed of rate. Moral level
↑ APT rate. Thinking der
e ALH Accx3 e SLWT
P 76 BP 140/90 EPOs ETO w/237
Dx: Bipolar Nos due to TBT
ADHD
Ph: No change RxC 4-Gal dpm
HDD sexual.
Will keep P & BP diary
RxC 4-Gal.



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Patient Name: Archie "Eddie" Jones

Date	Notes Should Be Signed by Physician
3/20/07	Responds S.I.S. } MSE w/ 236 Edict 100 } + 1/2 Repeats ER 1000hs } Problems has been 50mg during Prepares 10 @ himself. Able to feel pain @ optimistic. Completed son's house repair. Resident of 2 more 2 more residents. Sleep fine (don't replace for OSA) MSE Speech n1 Rate Moral level AROA Think clear of Alvt Arok 3 of SMT of dangerous. of EPS LTD Bound BP day 121/70 - 155/53 (↓ BP = exercise) Dr. B. not NOS due to TBI ADHD Ph. No phase. RTC G-8 No decrease 2° w/ BP the TID

[Signature]

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Patient Name: Archie "Eddie" Jones

Date	Notes Should Be Signed by Physician
5/16/07	Risperidone .51.5 } ↑↑ self
	Zolpidem 100
	Depak ER 1000mg
	Levothyroxine 50mg
	Prelisone 10
	Reps on say ↓↑ very
	↓ excessive sleep ↓ mood
	but "I feel good" & saying
	things & mood resolved
	Sleep in (dall apnea OSA)
	Surgery pending (wound care)
	MSE good in role. Mood bright
	Think ok. Adex 3 & SHH
	↓ depression. ↓ EPS & TD w/ 240
	Dr. Bishop was due to TBK
	Risperidone .251.5
	RTC 1 mo. GH pa

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 Greenville, South Carolina 29615
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Patient Name: Archie "Eddie" Jones ul 233

Date	Notes Should Be Signed by Physician
5/14/07	Risperidone .25/.5 } +/- ↑ energy Zolpid 100 } ↓ sim dose Depakote ER 1000mg } of risperidone Lexapro 50mg } but significant Prozac 10 } sim fatigue ↑ stress 2° (R) leg graft Like → surgery → recovery requires insensitivity. Concerned about ↓ motivation ↓ pleasure ↑ wish to stay in bed. & thought of death / dying & ↑ anxiety & mania & ETOH / Drugs MSE: Speech not clear Mood depressed Affect congruent Think clear & Alim Adox 3 & Start "World Call" Dr. Bi-ops Nbs due to TBST Rx ↑ Zolpid 150 round precautions. RxC 3-4ul call pm.

Greenville Psychiatry, P.A.

Robert W. Richards, M.D.
246 Adley Way Greenville, SC 29607
(864) 288-0330 Fax (864) 288-0350

1/26/07

July 6, 2007

June Souviron, M.D.
Anderson, SC

Subject: Archie "Eddie" Jones

DOB: 07/15/43

SS#: 233-70-3113

Dear Dr. Souviron:

I saw Mr. Jones for an office visit on July 6, 2007. He was taking his Risperidone .25 in the morning and .5 at bedtime, Zoloft 150 in the morning, Depakote ER 1000 at bedtime, and non-psychotropic medications as prescribed. He reported ongoing fatigue otherwise no problems or side effects. Mr. Jones may be experiencing more motivation since his last visit but he continues to experience significant fatigue, limited pleasure, and frustrations about limitations due to his medical problems. He is able to feel situational pleasure. Sleep is reported as fine "with my CPAP". There is no evidence of hypomania, obsessions, compulsions, or worsening depression.

On examination his speech is normal rate. Mood level. Affect brighter. Associations were tight. No disorder of thought content or perception. He was alert and oriented in all spheres. No evidence of suicidality, homicidality, or dangerous behavior.

Weight 233. No evidence of extrapyramidal side effects of tardive dyskinesia.

My working diagnosis remains Bipolar not otherwise specified due to traumatic brain injury.

Will decrease Depakote by 250mg each month. My reason for this decision is that Mr. Jones exhibits persistent fatigue. In addition he is taking multiple medications which can have side effects that are additive to Depakote. Should he experience a relapse of hypomania, panic, anxiety will consider increasing his Risperidone or increasing

Greenville Psychiatry, P.A.

Archie Jones

Page 2

Depakote back to the original dose. Requested a routine comprehensive metabolic panel, CBC, and fasting lipids.

Sincerely,



Robert W. Richards, M.D.

RWR/dc

Greenville Psychiatry, P.A.
9-A Caledon Court
Greenville, South Carolina 29615
Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Archie "Fido" Jones RCP Jure Sanchez MD

Date	Notes Should Be Signed by Physician
7/6/07	Risperidone .25/1.5 } ↑ TC Zolpidem 150 } "I feel tired" Doxylate ER 1000 } ↑ phos + tach/ Pachisone 10 } discharge Levetiracetam 500mg } No significant change = ↑ zolpidem +/- "a little more motivated" don't sleep as much. Predominant ↑ physical fatigue. Able to feel situational pleasure. Hypomania Sleep fine (RCP) ↑ appetite, but still anorectic MSE Speech not clear. Mood low Affect bright. Associational tight ✓ delirious ✓ ALVN Adox3 ✓ SNI ✓ dangerous ⊕ symptoms ✓ EPS ✓ ETD Di. Bipolar NOS due to TBS Ph. ↓ Dose ER 750 2° ↑ Risperidone & multiple meds ↑ risk SE. If any redupercat hypomania/depression, consider ↑ Risperidone. ✓ RCP, CBC, Lipids RCP MD

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 9-A Caledon Court
 Greenville, South Carolina 29615
 Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Archie "Eddie" Jones

Date	Notes Should Be Signed by Physician
7/1/07	Letter dictated June Sawyers, MD
7/1/07	CBC neg platelet 168 Cholesterol 104
	$\begin{array}{r l} 140 & 104 \\ \hline 3.9 & 2.7 \end{array} < \begin{array}{l} 1.4 \\ 3.6 \end{array}$
	LFT neg
	LDL 103 HDL 39 Trig 150 Chol 172

Greenville Psychiatry, P.A.

Robert W. Richards, M.D.
246 Adley Way Greenville, SC 29607
(864) 288-0330 Fax (864) 288-0350

PROGRESS NOTE

Date of Appointment: August 10, 2007
Start Time: 9:15 A.M.
Finish Time: 9:45 A.M.
Duration of Appointment: 30 minutes

Archie "Eddie" Jones
SS#: 250-77-16119
DOB: 6/7/30/23

SUBJECTIVE: Mr. Jones reports a good response to decreasing his Depakote from 1000mg to 750mg at bedtime. He describes slightly increased energy. Denies symptoms suggestive of panic, depression, or hypomania. His sleep is fine. Continues to experience excessive daytime sleepiness and fatigue associated with decreased structure and demands on his time.

OBJECTIVE: On mental status exam speech normal rate clear and easy to understand. Mood brighter. Nice range of affect. Associations tight. No disorder of thought content or perception. Alert and oriented in all spheres. No suicidal or homicidal thinking. No evidence of dangerousness at this time.

No extrapyramidal side effects or signs of tardive dyskinesia.

Labs from July 2007 CBC negative. Platelet count 168. Glucose 104. Sodium 140. Chloride 104. Potassium 3.9. Bicarb 24. Creatinine 1.4. BUN 36. Liver studies negative. Fasting lipid panel essentially negative.
Diagnosis: Bipolar Disorder not otherwise specified due to traumatic brain injury 296.80.

PLAN:

1. Continue Risperidone .25 in the morning and .5mg at bedtime, Zoloft 150mg in the morning.
2. Decrease Depakote ER to 500mg at bedtime. Discussed slow taper of Depakote due to additive side effects of multiple medications and the long term response to Depakote, Risperidone, and Zoloft. Should Mr. Jones experience a relapse of panic, depression, or mania he will call.
3. Return to the clinic in one month.



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 Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Archie "Edie" Jones

Progress Note dictated by [unclear]

Date	Notes Should Be Signed by Physician
8/10/07	Risperidone .25 b.i.d. } Cal. P.I. Zolpidem 150 } Drowsy all SE Donepezil ER 150 } 2 problems during Risperidone 10 } EPS & TO Levodopa 50 mg ⊕ response to ↓ donepezil dose Not as tired, but ant. ↑ step ↓ fatigue associated c ↓ demands on time & hypomanic expression ↑ ↑ mood, resocial. steps fine MSE Speech n/rt. Mood bright ↑ ROA Think der & Alut ADOX3 & SIFET & disorganized Dr. Bipolar NPS due to TBI Ph. ↓ Donepezil ER 500 RSC Imo. Call pm
8/10/07	Paul medical / metabolic complications / SE mels. Also benefits. Paul has. ↑ mood, resocial. of hypomanic c ↓ donepezil, call.

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 Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Archie "Eddie" Jones

Date	Notes Should Be Signed by Physician
9/12/01	Risperidone .25/5 Zolpidem 150 Depakote ER 750 Prochlorperazine 10 Lorazepam 50mg Col. B. Bogue Call SE Signs TD
	probably never ↓ depth stress due to SOB, gain back-down "I'm really doing good" "don't let things bother me" Express of more anxiety Sleep for 12hr
	MSE Speech w/ at Mod bright Think clear & Alth Adox J & SLUR & dangerous & ERS & TD w/ 234 Dose Biperiden due to TBT Ph: ↓ Depakote ER 500 RTC Im. Call

Progress not dictated

Greenville Psychiatry, P.A.
 9-A Caledon Court
 Greenville, South Carolina 29615
 Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Archie "Eddie" Jones

Date	Notes Should Be Signed by Physician
10/1/07	Risperidone .25/.5 } Signs TD Zolpidem 150 } & problems during Depakote ER 500 Prochlorperazine 10 Levothyroxine 50mcg D.R. to school due to "bone infection" & vertigo due to "hernia" & der problems ↑ ↓ Depakote & ↑ racing thoughts & mood & mood reactivity & Depress. Sleep fine & ↑ daytime sleep. MSE Speech placid. Mood bright ↑ RGA Assoc. tight & ALW ADOX3 & SLWT & Disorientation & EPS & TD Pk 1 hr Qm 120 (? recall to previous Discal report & abuse. Dr. B. at NBS due to TBI Pk & Depakote ER 250 RTC Mo. Call Am.

Greenville Psychiatry, P.A.

Robert W. Richards, M.D.
246 Adley Way Greenville, SC 29607
(864) 288-0330 Fax (864) 288-0350

PROGRESS NOTE

September 12, 2007

Eddie Archie Jones

SS#: 250-705-5119

DOB: 07/07/1958

SUBJECTIVE: Mr. Jones came today for a routine medication check. Reports that he is taking his medications as prescribed but inadvertently ~~attempt~~ to decrease his Depakote ER from 750mg to 500mg. He continues to ~~experience~~ high levels of stress associated with shortness of breath and skin breakdown on his right foot. Regardless "I am doing real good". "I don't let things bother me". Denies symptoms of depression, mania or anxiety. Sleep is fine at approximately twelve hours per day.

OBJECTIVE: On examination speech is normal rate, clear and easy to understand. Mood bright. Increased range of affect. Thinking clear. No disorder of perception. Alert and oriented in all spheres. No thoughts of suicide or homicide. No risk of dangerousness.

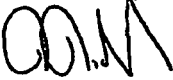
No extrapyramidal side effects or signs of tardive dyskinesia. Weight 234.

ASSESSMENT: Bipolar not otherwise specified due to traumatic brain injury. Well controlled.

PLAN:

1. Decrease Depakote ER to 500mg at bedtime.
2. Continue Risperidone .25mg in the morning and .5mg at bedtime.
3. Continue Zoloft 150mg in the morning.
4. Return to the clinic for a check in one month. Should he experience any difficulties tapering the Depakote he will call.

Respectfully Submitted,



Robert W. Richards, M.D.

RWR/dc

10/30/2007 09:14 KATHRYN WILLIAMS, P.A. + 2880350

NO.714 0003

RE: Patient/Client : A. Eddy Jones
Date of Injury : June 3, 1997
Social Security No. : [REDACTED]
Date of Birth : [REDACTED]

Based on my review of the medical records and notes related to this patient, it is my opinion to a reasonable degree of medical certainty that:

☒ YES

Mr. Jones is permanently and totally disabled as a result of the combination of physical, psychological and physical brain damage suffered in his accident at work on June 3, 1997.

☐ NO

Mr. Jones is not permanently and totally disabled as a result of the combination of physical, psychological and physical brain damage suffered in his accident at work on June 3, 1997.

Robert W. Richards, M.D.
Robert W. Richards, M.D.

10/30/07
Date

September 20, 2007

Continuance of Disability Claim Form

Employee Name: Archie E Jones Employee Number: _____
 Current Address: 1229 Salem Church Rd
Anderson, SC 29625 Telephone Number: 864-224-2009
 Attending physician: Name Robert Richards, MD
 Address: 24C Alley Way Greenville, SC
 Phone: 864-288-0330
 Dates of Treatment since last report: 10/1/07, 9/12/07, 8/10/07, 7/6/07
6/14/07, 5/16/07
 Have you returned to work? 3/20/07, 2/26/07, 1/15/07
 If yes, the date you returned to work No
 How many hours per week? N/A
 Name, address, and telephone number of current employer: N/A

Health Care Provider's Statement of Disability

Patient's Name: Archie Edward Jones Employee Number: _____

1. Diagnosis: Bi-polar Disorder NOS due to TBI

2. Treatment: traumatic brain injury

a. Date of first treat visit: Month 4 Day 20 Year 1999
 b. Date of last visit: Month 10 Day 11 Year 2007
 c. Frequency of treatment: Weekly [] Monthly [☒] Other []

3. Progress Recovered [] Improved [] Unimproved [☒] Regressed []

4. Extent of Disability For Any Occupation

a. Is patient now totally disabled? Yes [☒] No []
 b. If no, when was patient able to go to work? _____ Month _____ Day _____ Year _____
 c. If yes, when do you think patient will be able to resume any work?

Approximate Date: _____

Indefinite []
 Never [☒]

5. Mental Condition: Bi-polar NOS due to TBI
Unstable to stress. Unable to concentrate
for sustained time periods

Remarks:

Must take steroids for management
of lung disease due to injury. It's
permanently cognitive impairment due to
brain injury
refused
Dr. Richard MD 864-288-0330

Date _____ Signature (Attending Physician) _____ Degree _____ Telephone No. _____

246 Adler Way Greenville, SC 29607
 Street Address City or Town State Zip Code

Return form to:
 3M Disability Program, Building 551-1W-04, PO Box 33115, St. Paul, MN 55133-3115

JONES, Archie

5/20/99

INITIAL OFFICE CONSULTATION

HISTORY OF PRESENT ILLNESS: Mr. Jones is a 55-year-old male patient of Dr. Souviron in Anderson. He was sent by Peg Stutsman, a workman's comp case worker at Liberty Mutual. The patient has been seen for a long period by pulmonologist, Dr. Walker, in Anderson. Dr. Walker stopped seeing the patient on the last visit of April 12 of this year.

The patient reports being a lifelong nonsmoker and that he had no previous pulmonary problems, including no history of childhood asthma or shortness of breath. On June 3, 1997, the patient had approximately 40% third-degree burns on his body from an accident at work with hot oils. He also had a report of significant inhalation of the fumes. He, by report, was on a ventilator at MUSC for at least three months and had a trach. The patient has been felt to have bronchospasm and chronic rhinitis and has been treated with inhalers and nasal steroids. He additionally has had speech pathology, barium swallow and EGD in the past. He has had some residual trace pulling in the valleculae. He is on sucralfate and denies present reflux symptoms.

The patient, before his accident, did have significant sinus secretions. He has been on the nasal steroid and is not having the previous sinus symptoms. The patient reports occasional wheezing. He has increased shortness of breath with heat. The patient reports that he is able to go up two flights of steps at times and then, at other times, four flights of steps before he has to stop secondary to shortness of breath. Since his accident, he has at most been able to go on a treadmill for one hour at 2.6 miles per hour at a 3.5% grade.

The patient reports that, in the past, he has felt like the inhalers had helped but, at the present time, cannot notice an improvement with these. The patient reports that he has some daily minimal a.m. phlegm production. In the last two days, he has had significant yellow secretions but he is unsure whether it is sinus drainage or from the lungs. His phlegm is not difficult to expectorate.

Of note, the patient, in March of 1998, had a blood gas of 7.40, pCO₂ of 42 and a PO₂ of 76. Going to the rehab, he at best has a 97% sat. Of recent, he feels that he has had a 93-94% sat.

The patient, near the beginning of this month, was given a cortisone shot and a prednisone taper along with nebulization. He has felt that this helped significantly but that he is starting to have problems again.

ALLERGIES: No known drug allergies.

SOCIAL HISTORY: The patient works at 3M. He now works helping with AUTO CAD. He is a lifelong nonsmoker.

CURRENT MEDICATIONS: Neurontin 100 mg bid, sucralfate 10 mg qid, Cardura 2 mg qhs, hydroxyzine 10 mg qhs, Singulair 10 mg qhs, Duratuss-G bid, Dulcolax 300 mg bid, albuterol two puffs tid-qid, Atrovent two puffs tid-qid, Serevent two puffs qd, Flovent 220 mcg two puffs bid, Flonase two squirts to each nostril qd.

JONES, Archie

5/20/99

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PAST MEDICAL AND SURGICAL HISTORY:

1. Accident with burn, as above.
2. Hypertension.
3. Left knee surgery.
4. Tonsillectomy in 1994.
5. Right sinus surgery with antral window.

FAMILY HISTORY: Negative.

REVIEW OF SYSTEMS: As above and on the attached Review of Systems sheet. The patient does have snoring at night but does not report ever being told he had apnea. He also feels that any daytime sleepiness has been due to his medications and improves when he was off the Neurontin for a period of time.

PHYSICAL EXAMINATION: Male, alert and oriented x three, in no distress. Temperature 98.9, heart rate 80, respirations 12, blood pressure 140/86. Nasal mucosa is minimally gray tinged. Oropharynx has minimal cobblestoning. Oral cavity is without abnormality. Neck is without JVD, lymphadenopathy, stridor or thyromegaly. Lungs are clear to auscultation. Heart has a regular rate and rhythm without S3 or murmur. Abdomen is soft and nontender. Normal bowel sounds. No hepatosplenomegaly. Extremities without clubbing or cyanosis and with trace pedal edema with the patient wearing compression stockings. There is no calf tenderness or cords. There is evidence of his diffuse burns.

Chest x-ray shows consistence with hyperinflation and some lucencies of the apices.

On pulmonary function tests, I had some variability with the patient clamping down during exam. The flow volume loop did show a moderate obstructive ventilatory impairment with a significant postbronchodilator improvement of the FEV1 and a borderline significant improvement in the FVC. Flow volume loop was consistent with an obstructive ventilatory impairment. The inspiratory flow volume loop had some questionable flattening but there was at least curve that did not show any flattening. FEF 50/FIF 50 was significantly less than 1.0 at 0.49.

IMPRESSION:

1. Burn of approximately 40% of his body and three months on the ventilator, as described above.
2. Probable chronic rhinitis with symptoms pre-dating his injury and improved with Flonase.
3. Some difficulty with swallowing, as described above, although this does not seem to be significant. The patient is on sucralfate also.
4. Onset of shortness of breath and bronchitis, after the above burn and for a long period of time on the ventilator. Patient is without inspiratory flow volume loop flattening and does not have stridor on today's exam. The patient is on good regimen of medications with his inhalers. There is little to add to his regimen. Theophylline would likely cause more trouble with his anxiety and not be a

JONES, Archie

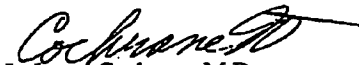
5/20/99

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good idea. We could place him on chronic low dose steroids but this would have the risk of side effects that were discussed in detail with the patient, including aseptic hip necrosis. He would rather not be on steroids, chronically. He is rinsing and spitting out after the use of his inhaled Flovent. Patient has received his flu shot and Pneumococcal vaccine this last year. Therefore, at the present time there is little to add to his regimen. The patient has not been with evidence of hypoxia.

PLAN:

1. Continue present medication.
2. Follow-up in three to four months.


L. James Cochrane, M.D.

LJC/kd/mds

cc: June P. Souviron, M.D.
Peg Stutsman, BS, CRRN

JONES, Archie

8/24/99

OFFICE NOTE

Mr. Jones is a 56-year-old male patient of Dr. Souviron in Anderson. He has previously been followed by a pulmonologist, Dr. Walker, in Anderson but he stopped seeing the patient in April of this year. The patient has a history of a 40% third degree burn of his body from an accident at work with hot oils on 6/3/97. He has reportedly been on a ventilator at MUSC for three months and had a trach, and he was also felt to have bronchospasm and chronic rhinitis. He was seen for the first time in 5/99. The patient was on a good regimen of medications, including Singulair, Duratuss-G, albuterol, Atrovent, Serevent two puffs at night, Flovent 220 mcg two puffs bid and Flonase two sprays to each nostril qd. Flow volume loop had variability but did not show any flattening of the inspiratory flow volume loop. Patient was continued on his present medications.

Since the last visit, the patient reports that he has actually done quite well. He was switched to a nebulizer and feels that this has helped his breathing significantly. He was doing quite well until the last approximately three to four weeks when he had the onset of slight green phlegm, especially in the morning, without fever or chills. He has been without chest pain or other new symptomology. He has not been placed on an antibiotic. Otherwise, he had been undergoing pulmonary rehab until recently, and felt that this was helping his breathing significantly.

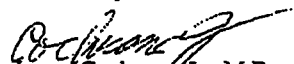
PHYSICAL EXAMINATION: Male, alert and oriented x three, in no distress. Temperature 98.9, heart rate 88, respirations 16, blood pressure 140/88. Oral cavity is without evidence of thrush. Neck is without adenopathy or stridor. Lungs are clear to auscultation. Heart is without S3. Extremities are without pedal edema, calf tenderness or cords.

IMPRESSION:

1. Burn, as described above.
2. Chronic rhinitis that he states is doing well with the Flonase.
3. Shortness of breath and bronchitis, occurring after the above injury and prolonged ventilation. He is on medicines as above, which seem to help him. He feels like the nebulizer has helped significantly.
4. Acute bronchitis. He has increased discolored sputum with increased shortness of breath and will start Z-Pak. Patient denies any drug allergies.

PLAN:

1. Z-Pak.
2. Continue present medications.
3. Continue pulmonary rehab.
4. Follow-up in four to five months with PFTs.


L. James Cochran, Jr., M.D.

LJC/kd/mds

cc: June P. Souviron, M.D.

JONES, Archie

10/12/99
OFFICE NOTE

Mr. Jones is a 56-year-old male patient of Dr. Souviron in Anderson. He has an extensive history of third degree burns on 40% of his body related to a work accident with hot oils on 6/3/97, requirement for ventilation at MUSC for three months with a trache and shortness of breath subsequently. The patient was referred to be seen earlier by his case worker due to the patient using a nebulizer at work. The question was whether he required nebulization frequently at work.

The patient reports that the nebulizer had helped him with his breathing significantly. He is using Atrovent and albuterol through the nebulizer. He does have some phlegm after using the nebulization, which is a very small amount of green phlegm. He has phlegm more in the morning when he awakes. This is mainly in the back of his throat and he is able to expectorate this. He does not feel that he has postnasal drip. He is without any new symptomology. The patient reports that the inhaler with spacers caused him to be dizzy but that the nebulizer does not.

PHYSICAL EXAMINATION: Male, alert and oriented x three, in no distress. Temperature 98.2, heart rate 88, respirations 16, blood pressure 170/80. Nasal mucosa is minimally gray tinged. Oropharynx is with slight erythema. Neck is without stridor. Lungs are clear to auscultation. Heart is without S3 or murmurs.

Pulmonary function tests today show a good FVC of 77%. The FEV1 is mildly decreased and the FEV1/FVC ratio is moderately decreased. The FEV1 is 65% of predicted, compared to the previous postbronchodilator value of 66% of predicted, and FEV1/FVC ratio is 60% compared to a previous 56%. Of note, the inspiratory flow volume loop is flat and the FEF50/FIF50 is increased at 1.47. The flow volume loops were all printed and they also basically show the flattening inspiratory flow volume loop.

IMPRESSION:

1. Burn, as described above.
2. Chronic rhinitis with the patient on Flonase and doing relatively well.
3. Shortness of breath and bronchitis after the oil injury and prolonged ventilation. The patient, while at work, should be able to use an MDI with spacer and, if he would like, to use the nebulizer while at home and before and after work. There is no obvious reason that the patient should become dizzy with the MDI and not the nebulizer when the MDI actually is a lower dose than the nebulization. If he would like, he could actually use four puffs of his MDI with his spacer in replacement of the nebulization. My concern is that there is flattening in the inspiratory flow volume loop and the patient has hot oil burn and also a prolonged tracheostomy. There is a possibility that some of his shortness of breath could be due to tracheal narrowing and I feel that an ENT evaluation is indicated.

PLAN:

1. Continue present meds and use of an MDI with spacer at work.
2. Patient to make an appointment back with the ENT physician he has seen in the past, Dr. Hellstrom in Anderson, and should have evaluation for tracheal narrowing.

JONES, Archie

10/12/99

Page 2

3. Keep follow-up in December.



L. James Cochrane, Jr., M.D.

LJC/kd/mds

cc: June P. Souviron, M.D.
Michael Hellstrom, M.D.

JONES, Archie

12/2/99
OFFICE NOTE

Mr. Jones is a 56-year-old male, patient of Dr. Souviron in Anderson who has a history of hot oil burns over 40% of his body and three months of mechanical ventilation at MUSC trach and subsequent shortness of breath. The flow volume loop on the last visit of 10/12/99 had the suspicion of possible variable upper airway obstruction (flattening of the inspiratory loop and a FEF 50/FIF 50 of 1.47). Because of this abnormality the patient was asked to see Dr. Hellstrom, an ENT physician that had seen him in the past.

The patient reports that he has not yet seen his ENT physician and stated that it would help if we made the referral from this office. His breathing is approximately the same except for a recent URI with white sinus drainage and some increased shortness of breath. He is slowly improving from his URI. The patient has also been seen by Dr. Mohan for evaluation of obstructive sleep apnea. He reports that this was positive and he is awaiting a CPAP titration study. Apparently, Dr. Mohan also changed him from Singular to theophylline with a possible slight improvement of his breathing. The patient has had significant psychological problems and states that the sleep study caused him to remember his time in the burn unit at Charleston.

PHYSICAL EXAMINATION: Male, alert and oriented x three in no distress. Temperature - 98.1. Heart rate - 84. Respirations - 12. BP - 116/82. Lungs were clear to auscultation. Heart was without S3 or murmur.

Pulmonary function tests today are with a slight decrease in the vital capacity in FEV1 from October. The inspiratory flow volume loop is still suspicious for flattening. There is slight slope to it today in contrast to October and FEF 50/FIF 50 is 0.8 today.

IMPRESSION:

1. Burn with injuries as described.
2. Chronic rhinitis, on Flonase.
3. Shortness of breath. Patient is on medications for this problem. I think it is important for the patient to be seen by an ENT physician and make sure that there is not tracheal narrowing, which would be treated differently than with medications. We will call and make a referral to Dr. Hellstrom's office.

PLAN:

1. Continue present medications.
2. Referral to ENT.
3. Follow up in three to four months.


L. James Cochrane, M.D.
LJC/jwb/mds

cc: June P. Souviron, M.D.
Michael D. Hellstrom, M.D.

JONES, Archie

12/20/99
OFFICE NOTE

1/14 8

Mr. Jones is a 56 year old male patient of Dr. Souviron in Anderson who has a history of hot oil burns over 40% of his body and 3 months of mechanical ventilation at MUSC with trach an subsequent shortness of breath. Patient has had obstructive ventilatory impairment on pulmonary function test and some questioning of flattening in inspiratory loop for which he has been sent to see Dr. Hellstrom, an ENT physician since the last visit. Patient had been switched from Singular to Theo-Dur 300 mg bid by Dr. Mohan who he was seeing for obstructive sleep apnea. Otherwise, he is on Serevent, Atrovent, Albuterol, Flovent 220 micrograms two puffs bid and Flonase 2 sprays each nostril q day. Note he has been told to stop his Flonase due to slight nasal bleeding and he is using his Serevent only one puff at night.

The patient felt that after his endoscopy by the ENT physician that he had irritation of his nasal and upper airways and has had increased cough, increased thick white phlegm and increased shortness of breath to the point that it has been difficult for him to work. Apparently, his family physician has written for him to be out of work for the present time. He states that he had had a couple of times of low grade fever. His phlegm occasionally will be a minimal yellow in color. He denies sinus problems, diarrhea, but first time today may have had possible slight dysuria. He states that before the worsening last month, he was able to do perform his job at work.

PHYSICAL EXAMINATION: Male, alert and oriented in no distress. Temperature 100.8. Respirations 12. Heart rate 108. Blood pressure 150/94. The sinuses are not tender to percussion. Nasal mucosa was minimally gray tinged. Oropharynx had minimal cobblestoning. Lungs were clear to auscultation without wheezes. Heart was without S3, murmurs. Extremities were without pedal edema.

Chest x-ray showed some slight hyperinflation.

Reports from Dr. Hellstrom's office reports that his erythema above the vocal cords which he felt was due to reflux and he was placed on Prilosec. Also sinus x-rays earlier this month were clear.

IMPRESSION:

1. Probable gastroesophageal reflux by evidence of erythema above the vocal cords. I agree the patient be on Prilosec 20 mg qd.
2. No evidence of upper airway obstruction on recent ENT examination.
3. Moderate obstructive ventilatory impairment.
4. Fever. Increased sputum production that is mainly white and occasionally yellow. I will place the patient on a course of Z-Pak which he states he has no trouble taking and also on a short tapering course of prednisone.
5. Moderate obstructive ventilatory impairment on medications as above. I will check a theophylline level today.
6. Difficulty with patient performing significant exertion at work. It is unclear from his present status how much he can perform. It would be reasonable for the patient to perform light to moderate exertion with limitation from significant dust or chemical exposure.

JONES, Archie

12/20/99

Page Two

The case manager is requesting further clarification. If the insurance company would like a possible objective determination, we can perform a cardiopulmonary stress test looking for any limitation of heart or lungs as long as patient gives good effort.

PLAN:

1. Theophylline level.
2. Continue Prilosec.
3. Z-Pak.
4. Prednisone 25 mg taper 5 mg each day until off.
5. Follow up in 3 to 4 months.


L. James Cochrane, M.D.

LJC/lr/mds

cc: June P. Souvion, M.D.
Michael Hellstrom, M.D.
Liberty Mutual

PIEDMONT ORTHOPAEDIC ASSOC. 35 International Dr. Greenville, SC 29615

Telephone: (864) 234-7654

Name: Archie E. Jones

SS # [REDACTED]

Address: 1229 Salem Church RD

SC 29625

Chart # 157678-10 DOB: [REDACTED]

Page 1

8/26/1999

W. CLARK JERNIGAN, MD

PROGRESS NOTES (WORKERS' COMP)

CC: Painful right 4th toe.

PI: Archie Jones is a gentleman who was burned in hot oil in an industrial accident about 2 years ago. He underwent a very long convalescence but is here today alive with both legs. He has pain on the dorsum of his right 4th toe where it rubs the top of his shoe. He has altered sensation in both feet but clearly the 4th toe is getting a signal through to the brain. He is seen in consultation from Dr. Tim Brown for consideration of treatment recommendations.

PMH: Is per the accompanying patient history form.

EXAM: Shows a cheerful gentleman who has Jobst hose on both lower extremities. When he removes these one can see extensive skin grafting of both lower extremities. The overall contour of both calves and both feet is fairly pleasing. He has ankle dorsiflexion-10, plantar flexion full on the right, subtalar motion full. No midfoot malalignment. His hallux is extremely limited, and I would estimate plantar 10, dorsiflexion-20, IP 0-20. The 2nd and 3rd toe on the right will plantar flex to neutral, the 4th has a dorsiflexion contracture of about 30 degrees. The skin on the dorsum of the toe looks like natural skin at the base of each toe as a delineation between skin graft, and he says that is where his safety shoe helped him. I sense that there is an extensor tendon present on the 4th ray, but I cannot elicit much volitional contraction of it. Sensation to light touch is intact in the 4th toe. He also has pain in the lateral border of the foot where the 5th met head would be (but is not by x-ray). He also has pain on the left foot at the lateral border of the 5th met head. Attention is directed mainly to the right foot today.

An x-ray in the AP and lateral view shows excellent MP joints rays 2, 3, and 4. He has undergone amputation of the distal portion of the metatarsal 5th ray. Lateral shows the contracture.

IMPRESSION: EXTENSION CONTRACTURE RT 4TH TOE.

PLAN: I think this can be helped by extensor tenotomy, capsulotomy, and possible partial phalangectomy. I think it reasonable to go ahead with this under the same surgical anesthetic for which he is going to have revision of a right hand problem by Dr. Tim Brown. The expected benefits of surgery are better posturing of the toe, elimination of rubbing and thereby improved comfort. We have also talked about fitting him with custom arch supports and he says he has tried that before but would be willing to give it a go again.

I thank Dr. Brown for his consultation.

POA COPY
APR 03 2007

WCJ/JWJ

CC: TIM BROWN, MD
3M COMPANY

PIEDMONT ORTHOPAEDIC ASSOC. 35 International Dr. Greenville, SC 29615

Telephone: (864) 234-7654

Name: Archie Jones

SS # [REDACTED]

Address: 1229 Salem Church RD

SC 29625

Chart # 157678-10 DOB: [REDACTED]

Page 2

8/26/1999 W. CLARK JERNIGAN, MD

-CONTINUED-

PROGRESS NOTES (WORKERS' COMP)

LIBERTY MUTUAL W/C

Dictated, not read.

XRAYS

RT FOOT--AP/LAT

CORRESPONDENCE

(LTR) TIMOTHY BROWN, MD

10/19/1999 W. CLARK JERNIGAN, MD

INTEROFFICE NOTES

NO OFFICE APPT

W/C AUTH PENDING

PRE-ASSESS 101399 @ 10:00

LINDA MCALISTER 800-922-3305 X 224

SURG SCHED 101999 @ 8:00

HSC GEN OP

OPERATIVE NOTES

WCJ: PART PHALANGECTOMY RT 4TH TOE @ HSC

SCAN-OP NOTES

Image Ref : ID 00018137 OP NOTES

Scanned 10-22-1999 by AIMAGE

Last Update 10-25-1999 at 09:18 by AIMAGE

Category OP NOTES Cabinet PT CHART Drawer OP NOTES

11/03/1999 W. CLARK JERNIGAN, MD

PROGRESS NOTES (WORKERS' COMP)

Archie Jones's wound is healing well without obvious infection. He is sore in the toe but not unusually so. The alignment shows excellent alignment of the 4th toe with pin in place across the MP joint.

My plan is to remove this pin in about 1-2 weeks and allow him to begin passive stretching in a plantar direction. I also recommend he purchase and use a custom TCI. His foot is too swollen to fit those now, but a prescription for the same is provided.

WCJ/JWJ

CC:

3M COMPANY

LIBERTY MUTUAL W/C

XRAYS

RIGHT FOOT--AP/LAT.

WORK STATUS

WCJ: I RECOMMEND HE REMAIN OUT OF ALL WORK FOR 3 ADDITIONAL WKS, FREQUENTLY ELEVATING LIMB THROUGHOUT DAY.

POA COPY
APR 03 2007

PIEDMONT ORTHOPAEDIC ASSOC. 35 International Dr. Greenville, SC 29615
Telephone: (864) 234-7654

Name: Archie B. Jones

SS # 153 24 57 9

Address: 1229 Salem Church RD

SC 29625

Chart # 157678-10 DOB: 07/30/1932

Page 3

11/03/1999
WORK STATUS

W. CLARK JERNIGAN, MD

-CONTINUED-

11/16/1999 W. CLARK JERNIGAN, MD

PROGRESS NOTES (WORKERS' COMP)

Mr. Jones' right 4th toe wound is healing without obvious infection. There is moderate edema of all of the toes, not unusual considering his known vascular insufficiency on the venous side. I have, today, removed the pin from his right 4th toe uneventfully. I want him to work on AROM and PROM exercises of the toe, and I have shown him how to stretch it into plantar flexion.

WCJ/JWJ

12/02/99 3:25

CC:

3M COMPANY
LIBERTY MUTUAL W/C

WORK STATUS

WCJ: ANTICIPATE HE WILL PROBABLY BE ABLE TO RETURN TO ADMINISTRATIVE, OFFICE TYPE WORK, AFTER THANKSGIVING.

12/02/1999 W. CLARK JERNIGAN, MD

PROGRESS NOTES (WORKERS' COMP)

Mr. Jones' 4th toe looks more dorsiflexed now than when I removed the pin. He is still having pain beneath the 4th met head. He has no callous there. He is picking up his custom TCI's tomorrow. I think that is going to be the solution for his metatarsalgia and I would like to see him back after he has been wearing those for about 1 1/2 weeks.

He has another pain in the right foot that I think is sensitivity of the distal portion of the sural nerve in the lateral border of the foot near the 5th met metaphysis. He may be a candidate some day to excise the end of the sural nerve there.

WCJ/JWJ

12/16/99 3:45

CC:

3M COMPANY
LIBERTY MUTUAL W/C

WORK STATUS

WCJ: NO CHANGE.

POA COPY
APR 03 2007

12/27/1999 W. CLARK JERNIGAN, MD

PROGRESS NOTES (WORKERS' COMP)

Archie Jones has been ill with pulmonary complaints since his last visit. He feels like his toe is about the same position it was before surgery and, indeed, he again has an extension contracture despite the generous proximal

PIEDMONT ORTHOPAEDIC ASSOC. 35 International Dr. Greenville, SC 29615

Telephone: (864) 234-7654

Name: Archie E. Jones

SS # 220 70 5119

Address: 2201 1st Church RD

SC 29625

Chart # 157678-10 DOB: 07/20/63

Page 4

12/27/1999

W. CLARK JERNIGAN, MD

-CONTINUED-

PROGRESS NOTES (WORKERS' COMP)

phalangectomy. He is still tender in the lateral border of the foot in a pattern consistent with a sural nerve injury too.

I think he may require some sural nerve surgery later but he has just gotten and begun using his custom TCI's. I want him to try using this for several more weeks before we decide if anything more is needed.

WCJ/JWJ

01/25/00

4:15

CC:

3M COMPANY

LIBERTY MUTUAL W/C

WORK STATUS

WCJ: NO CHANGE.

1/25/2000

W. CLARK JERNIGAN, MD

PROGRESS NOTES (WORKERS' COMP)

Today his sural nerve on the right foot does not seem unduly tender. I can percuss at the malleolus without undue pain. He complains of pain in the lateral border of the 5th MT where he has basically a skin-on-bone situation. That skin is grafted skin. I am no longer as confident that ablation of the sural nerve would help that pain. He does not have hyperesthesia of the lateral border of the met head like he had had before and in fact I can press it quite firmly with no undue pain.

He complains of left ankle and hindfoot pain. It is made worse with excursion. His most severe pain is posterior to the lateral malleolus. The ankle seems to have full motion as does the subtalar joint on the left. He has extensive burn scarring about the left foot also but clearly his sural nerve is not tender to percussion today.

X-RAYS: A lateral x-ray of the ankle and an AP of same shows no significant ankle arthritis. No destructive lesions are seen. No abnormal calcification about the ankle is appreciated.

I do not think we should intervene with surgery at this point. I would like to recheck in about 3 months.

WCJ/JWJ

CC:

3M COMPANY

LIBERTY MUTUAL W/C

POA COPY
APR 03 2007

PIEDMONT ORTHOPAEDIC ASSOC. 35 International Dr. Greenville, SC 29615

Telephone: (864) 234-7654

Name: Archie E. Jones

SS # 250 70 2122

Address: 1229 Salem Church RD

SC 29625

Chart # 157678-10 DOB: 08/22/45

Page 5

1/25/2000

W. CLARK JERNIGAN, MD

-CONTINUED-

PROGRESS NOTES (WORKERS' COMP)

XRAYS

LT. ANKLE--AP/LATERAL STANDING

WORK STATUS

WCJ: NO CHANGE.

POA COPY
APR 03 2007

PIEDMONT ORTHOPAEDIC ASSOC., P.A., 35 International Dr. Greenville, SC. 29615

Telephone: (864) 234-7654

Name: JONES, ARCHIE E.

yr SS # 250 70 5119

Address: 1229 Salem Church RD

SC 29625

Chart # 157678-10

DOB: 07/30/43

Page 1

6/01/2000

W CLARK JERNIGAN MD

PROGRESS NOTES (WORKERS' COMP)

Mr. Jones has 2 new problems today. Number 1 is the skin graft on the lateral hindfoot is ulcerating and he is concerned about that. Number 2 is that he has pain on the medial aspect of his hallux in the MTP joint of the right foot.

I have seen him before for complications of the severe burns to his right foot. That information is well documented earlier in the chart. He has had no injury to his great toe but did have a twisting injury to the hindfoot about 2 weeks ago while on his deck.

He has 4 toes on the right foot. His hallux is limited in motion and is uncomfortable with the extremes of ROM. He can plantar flex beyond neutral. He is tender to the extremes of motion. His 4th toe seems completely dislocated on the metatarsal. He has with him well fitting orthotics for the right foot. I see no areas of breakdown of the right foot. His sural nerve is not tender to percussion today. He has extensive scarring on the dorsum of the foot. In a portion of his grafted skin on the lateral hindfoot, there is a shallow ulceration without deep infection. I estimate this is about 1 cm in greatest dimension.

X-RAYS: A standing AP and lateral x-ray of his right foot shows a surgical clip in place about the medial hindfoot. He has absence of the 5th met head and the 5th ray. The proximal phalanx of the 4th toe is completely dislocated dorsally on the metatarsal and has undergone a proximal phalangectomy. He has mild osteoarthritis of the MTP joint and an unusual bony prominence of the medial aspect of the distal 1st metatarsal. I do not see any destructive lesions.

DIAGNOSIS: SYMPTOMATIC MP ARTHRITIS, RT FOOT.
ULCER LATERAL HINDFOOT.
EXTENSIVE BURN SCARS.

RECOMMENDATION: I have no more ideas to lessen his foot pain other than the arch supports that he is in. At times past I thought that he might benefit from a sural neurectomy, but today his exam does not support that as the cause of his pain. I recommend that he be referred to his bone surgeon, Dr. Harvey, in Charleston for evaluation of the ulceration of his graft.

WCJ/JWJ

CC:

3M COMPANY
LIBERTY MUTUAL

POA COPY
APR 03 2007

XRAYS

RIGHT FOOT--AP/LAT STD.

PIEDMONT ORTHOPAEDIC ASSOC., P.A., 35 International Dr. Greenville, SC. 29615

Telephone: (864) 234-7654

Name: JONES, ARCHIE E. yr SS # 2 0 0 0 0 0 0 0 0 0

Address: 1229 Salem Church Rd. SC 29625

Chart # 157678-10 DOB: 0 0 0 0 0 0 0 0 0 0 Page 2

6/01/2000

W CLARK JERNIGAN MD

-CONTINUED-

XRAYS

WORK STATUS

WCJ: NO CHANGE.

POA COPY
APR 03 2007

Date: 8-26-97

**PATIENT HISTORY
(PLEASE PRINT)**

MLW
WCS

Clinic No. 157678-10

Patient's Name: First ARCHIE	Middle (EDDIE)	Maiden	Last JONES, JR.	Birthdate: [REDACTED]	Age: [REDACTED]	Sex: MC	Social Security No.: [REDACTED]
Address: 1229 SALEM CHURCH ROAD ANDERSON, SC.				City: ANDERSON	State: SC	Zip: 29625-1310	County: ANDERSON
Patient's Home Phone: 2242669		Patient's Work Phone: 2362014		Marital Status: ☒ Married ☐ Single ☐ Divorced ☐ Widowed			
Patient's Employer or School Name: 3M				Address: 1400 PERIMETER RD GREENVILLE, SC.		City: GREENVILLE	
Spouse's Name: DERRELL V. JONES				Spouse's Birthdate: 8-6-43			
Spouse's Employer: POPE DRIVE BAPTIST CHURCH				Spouse's Work Phone: 2261789			
Nearest Friend or Relative not residing with you: BRETT JONES				Phone No.: 2442501		Relationship to patient: SON	
Have you or any other member of your family been treated by Piedmont Orthopaedic Associates Doctors? If yes, give name of family member.							
IF PATIENT IS A MINOR							
Father's Name:				Address:		Birthdate:	
Father's Employer: Name:				Address:		Work Phone:	
Mother's Name:				Address:		Birthdate:	
Mother's Employer: Name:				Address:		Work Phone:	
MEDICAL INFORMATION							
Family Doctor: DR. JUNE SONNIVON				Address: 2405 N. MAIN ST. ANDERSON, SC 29625			
Referring Doctor: DR. TIM BROWN / DR. BARRY BISHOP				Address: ?			
A. Description of problem: PT FOOT 4TH TOE SCAR TISSUE IS DRAWING TOE UPWARD				If injured, how did this happen? INDUSTRIAL ACCIDENT - HOT OIL SPILL 4ES			
B. Date of injury or onset of problem? JUNE 3, 1997				Was this an on the job injury? INDUSTRIAL ACCIDENT - HOT OIL SPILL 4ES			
C. Was the patient seen in the hospital emergency room? If yes, where? Date: GREENVILLE MEMORIAL JUNE 3, 1997							
D. Was the patient admitted to the hospital? If yes, discharge date: TRANSFERRED TO MUSC - CHARLESTON, SC. OCTOBER 5, 1997							

PAYMENT IS REQUIRED AT THE TIME OF SERVICE.

How will you pay for the visit?

☐ Cash

☐ Check

☐ Credit Card

PAYMENT FOR MEDICAL CARE IS SOLELY THE RESPONSIBILITY OF THE PATIENT OR HIS/HER LEGAL GUARDIAN. Piedmont Orthopaedic Associates, P.A. will provide you with information and assistance in filing your insurance claim. However, the patient or his/her legal guardian remains responsible for the collection of insurance payments.

PRIVATE INSURANCE AND / OR WORKERS' COMPENSATION INSURANCE			
1. Name of Insurance Company & Address: LIBERTY MUTUAL CAPITAL INSURANCE CO. (800-922-3355) 3305 GREEN NO. 150-171944	Policy No.: 3305	Name of Insured & Social Security No: ARCHIE E. JONES - 250-70-530	
2. Name of Insurance Company & Address: FOUR 100154 COLUMBIA, SC 29202	Policy No.: EX-1224	Name of Insured & Social Security No. ARCHIE E. JONES - 250-70-530	
3. Name of Insurance Company & Address:	Policy No.:	Name of Insured & Social Security No.	

*** PLEASE PRESENT I.D. CARD TO THE RECEPTIONIST. ***

APR 03 2007

I hereby authorize Piedmont Orthopaedic Associates, P.A. to furnish information to insurance carriers or other physicians concerning medical information on myself or my dependent. A fee may be charged for this service.

I HEREBY ASSIGN, TRANSFER AND SET OVER TO PIEDMONT ORTHOPAEDIC ASSOCIATES ALL MY RIGHTS, TITLE AND INTEREST TO MY MEDICAL REIMBURSEMENT BENEFITS UNDER MY INSURANCE POLICY(IES).

I HEREBY UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE.

Responsible Party's Signature: Chad E. Jones, Jr.

Insured's Signature: 1. _____

2. _____

3. _____

Piedmont Orthopaedics Patient History Form

Name: ARCHIE (EDDIE) JONES Date: 8-23-99 Updated on: _____

*Current Medications (Please List): see attached list

Drug Allergies (Please List):

Currently using birth control pills? Yes No Calcium? Yes No

Prior surgeries and hospitalizations with dates (Please list): KNEE (L) TORN MENISCUS SUR - 1990, TONSILLOIDECTOMY 1993, ANTRAL WINDOW (R. SINUS) 1978, 40% 5RD DEGREE BURN SKIN GRAFTS 1997

Circle any of the following you have or have had: Heart attack High cholesterol Cancer Diabetes Lung disease

Liver disease Thyroid Blood clots Circulatory problems Excessive bleeding Ulcers Gout

Hepatitis AIDS High blood pressure Are you pregnant? Yes No

Other Medical Problems: ANXIETY

Family history of: Health and ages of parents & siblings (if no longer living give age at death and cause).

Social History: Single Married Have Children Alcohol use Drug use Tobacco use

Occupation: TRUCK DRIVER / MAINTENANCE MECHANIC

Review of Systems: Please Circle any of the following symptoms or problems you presently have:

Constitutional: Fever Weight loss

Eyes: Double vision Blurred vision

ENT & Mouth: Deafness Sinus trouble Dental problems Hoarseness

Cardiovascular: Chest pain Palpitations High blood pressure Irregular beats

Respiratory: Shortness of breath Asthma Cough Trouble breathing at night

GI: Loss of appetite Diarrhea Constipation Abdominal pain Heartburn

GU: Trouble urinating Loss of bladder control Painful urination

MS: Pain in joints or bones Swelling of joints Arthritis Stiffness

Skin-Breast: Rashes Lesions Scars Masses Ulcers

Neuro: Stroke Numbness or tingling Seizures Weakness Balance problems

Psych: Depression Hallucinations Sleep disturbances

Endocrine: Frequent urination Frequent thirst Hyper or hypoactivity Growth or hair changes

Hematologic and Lymphatic: Bleeding tendency Lymph node pain or enlargement Anemia

Allergic Immunologic: Dermatitis Eczema Latex, Drug or other Allergies

For the Nurse:

Pulse: _____ BP: _____ Temp. _____ Max. Lifetime Ht. _____ Ht. _____ Weight: 234 Arm span: _____
Forms patient for 8-26-99 Rev: 5/26/99

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(Medication size/dosage)

Colace	300 mg.	twice Daily	
Duratus G	1200 mg.	twice Daily	
Cardura	1 mg.	once Daily - night	
Citrac	10 mg.	once Daily - night	
Singulair	10 mg.	once Daily - night	
Neurontin	100 mg.	(Varies) 200 mg. AM. 200 mg. night	
Sulfasate	1 gm.	Before meals and bedtime	
Flomase	2 ea. 50 mca	sprays in AM.	(16 G size)
Fluvent	2 ea. 220 mca	sprays in AM. & PM.	(13 G size)
Exersant	1 li.	spray at bedtime	(13 G size)
Albuterol, USP	2 sprays	2 to 4 times daily	(17 G size)
Atrament	2 sprays 18 mca	2 to 4 times daily	(14 G size)
Albuterol	Nebulizer solution	2 to 4 times daily	25 x 3 ml
Atrament	Nebulizer solution	2 to 4 times daily	25 x 2.5 ml

Z. Theomax Z-PAC -

Zolof - { I am not taking these two medications at the present by
 Venadine. } possibly I could start back on ~~venadine~~

OCT 20 '99 01:41PM GREENVILLE SURGERY

P.5/6

157678-10

HEALTHSOUTH SURGERY CENTER OF GREENVILLE
OPERATIVE RECORD

PATIENT: Archie Jones
MEDICAL RECORD #: 87603

DATE OF SURGERY: 10/19/99
PAGE: 1 of 1

7/30/43

SURGEON:	W. Clark Jernigan, M.D.
ANESTHESIA:	General
PREOPERATIVE DIAGNOSIS:	Extensor contracture right 4 th MP joint
POSTOPERATIVE DIAGNOSIS:	Same
OPERATION:	Partial phalangectomy 4 th toe right foot, Capsulotomy and extensor tenotomy

FINDINGS: I was able to get the toe plantar grade with the above procedures.

PROCEDURE: The pt was brought to the OR where general anesthetic was obtained without complication. The foot was prepped and draped in sterile fashion. Using old scar lines, I made an L shaped incision over the dorsum of the MP joint through the dense subcutaneous scar. I estimate the sub-q scar tissue was 6-7mm thick. I identified the extensor tendon and cut it. The proximal phalanx was dorsi flexed about 60 degrees on the mid head. The proximal half of the proximal phalanx was removed with a rongeur. This shortening and extensor tenotomy then allowed plantar flexion to a neutral position. All the dorsal capsule which could be identified was incised. The toe was pinned in a plantar grade position with a smooth pin in retrograde fashion across the MP joint. The wound was irrigated and closed with interrupted Monocril in the sub-q and running Chromic in the skin followed by sterile non-adherent dressing. The pt tolerated the procedure well and left for the RR in good condition after Dr. Brown completed the hand surgery.

WCJ:kmg

WILLIAM CLARK JERNIGAN, M.D.

cc: Piedmont Orthopedic Associates

dd: 10/19/99
dt: 10/19/99

copies sent

int.

SCAN

OCT 23 1999 COPY

APR 03 2007

CAROLINA PULMONARY AND SLEEP CENTER
605 EAST GREENVILLE STREET
ANDERSON, SC 29621
(864) 231-7004

PULMONARY AND SLEEP CONSULTATION

PATIENT: Jones, Archie
CHART #: 250705210
REFERRING PHYSICIAN: Dr. John Pilch
DATE: 10/11/99

CHIEF COMPLAINT: Snoring, observed apneas, excessive day time sleepiness and shortness of breath on exertion.

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant 56-year-old white male with multiple medical problems, significant for exposure to thermal fumes in the past who is here for further work up and management for his sleep and pulmonary problems. Patient was working at the 3M factory on 06/03/97 at which time he suffered a chemical spill burn of thermal 66 which was reported to be greater than 300 degrees F. Patient was initially evaluated at the Greenville Memorial Hospital. He went in to respiratory distress secondary to pulmonary involvement of the thermal injury. He was electively intubated and placed on mechanical ventilation and was flown to MUSC the same day for further evaluation and management. Patient also had second and third degree burns in the anterior thighs, lower legs and in the dorsum of the feet which was very well managed at MUSC with appropriate wound care, skin graft, physical therapy, etc. Patient has bronchoscopy done on 06/04/97 which revealed intense tracheobronchial mucosa secretions. After a long protracted course the patient was extubated and was on tracheostomy collar for significant amount of time. Currently, patient is not on trach collar. He was later followed at Memorial Hospital on an outpatient basis. Patient currently has shortness of breath on exertion for four to five blocks. He takes his medications including the inhalers regular. Minimal cough and sputum production present on and off. Sputum is white in color with no hemoptysis present. No orthopnea present. No symptoms suggestive of PND. No chest pain or dizziness present. Patient was evaluated by Dr. Cochrane at Memorial Hospital for his pulmonary problems. The usual steroids for chronic pulmonary fibrosis secondary to burn injury was discussed. Patient preferred not to be on steroids because of the side effects. Theophylline at that time was decided not to be started because of his anxiety problem. He was last seen by Dr. Cochrane on 05/20/99. Since then, no significant change in medication regimen has been made.

Patient is also a heavy snorer. His snoring severity has worsened within the last 10 years. He snores every night and in all positions. He does not have any complaints of runny nose or sinus congestion. He usually goes to bed around 11:30 p.m. and wakes up around 6:30 a.m. During the weekends he sleeps longer. He rarely sleeps for more than 12 hours. He has never had any hard time trying to fall asleep. He has never had troubled thoughts racing through his mind.

Jones, Archie
Chart # [REDACTED]
GOWDHAMI MOHAN, M.D.
10/11/99
page 2

While trying to fall asleep, patient does not have any uneasy sensation in the legs suggestive of restless legs. He wakes up one time a night to use the bathroom. Patient complains of choking episodes. He has been observed to have apneas by his wife. Occasional episodes of gasping and attacks of shortness of breath have also been noted at night. Patient rarely has complaints of acid reflux symptoms. No nocturnal palpitations. He has nocturnal episodes of cough. He does not have any complaints of sleep walking or sleep talking. No symptoms suggestive of nocturnal enuresis or nocturnal epilepsy. Patient does not give any history suggestive of bruxism.

No symptoms suggestive of hypnagogic or hypnopompic hallucinations. No history of cataplexy or sleep paralysis. His night time and wake times does not vary a great deal from day to day. When he wakes up in the night time he is usually able to fall asleep quickly without any significant problem. Most of the time he is awake during the last 1/3 of the night. He does toss and turn around a lot throughout the night. He suffers from headache in the morning which clears within one to two hours after being awake. No abnormal behavior movement present during sleep.

When he wakes up in the morning, he feels tired and exhausted. He has headache in the morning. Drowsiness is greatest in the afternoon. He does not take naps on a routine basis. Patient states that he feels sleepy while at work, while reading books, while driving and also occasional while in phone conversation. Patient has never dozed off when eating. He has noticed a decrease in sexual interest and function. His thought, memory and mood processes have also changed significantly within the last two years. Patient has decreased memory and has trouble concentrating and remembering things. He does exercise on a regular basis.

PAST MEDICAL HISTORY:

1. History of hypertension.
2. History of obstructive pulmonary disease secondary to thermal injury.
3. Restrictive lung disease present.
4. Chronic anxiety disorder.
5. Allergic rhinitis and sinusitis.
6. Reflux esophagitis.

PAST SURGICAL HISTORY:

1. Left knee surgery.
2. Tonsillectomy done in 1994.
3. Right sinus surgery done.
4. Skin grafting for thermal injury done in 1997.

Jones, Archie

Chart #: 250705019

GOWDHAMI MOHAN, M.D.

10/11/99

page 3

PREVIOUS PFT RESULTS: Done on 03/23/98 reveal FEV1 of 1.62 which is 47% prediction. FVC is 3.27 which is 69% prediction. FEV1/FVC 50. RV was 3.06 which is 145% prediction. Total lung capacity is 6.45 which is 96% prediction. RV by TLC is 133% prediction. This is suggestive of severe obstructive lung disease. PFT done on 10/12/99 reveal FEV1 of 2.27 which is 60% prediction. FVC of 3.46 which is 78% prediction. FEV1/FVC is 62. This is suggestive of significant improvement in his pulmonary function test within the last one year.

SOCIAL HISTORY: Never a smoker. No history of alcoholic or drug abuse.

FAMILY HISTORY: Nonrelevant.

SIGNIFICANT OTHER HISTORY: Has gained about 12 lbs. within the last one year. Has gained about 22 lbs. within the last five years.

ALLERGIES: NKDA.

MEDICATIONS:

1. Colace 100 mg. PO qd.
2. Duratuss 1200 mg. one PO qd.
3. Cardura 1 mg. PO qhs.
4. Atarax 10 mg. one PO qhs.
5. Singulair 10 mg. PO qhs.
6. Neurontin 100 mg. two tabs PO bid.
7. Sucralfate 1 gm. before meals and bed time.
8. Flonase spray, 2 sprays in both nostrils qd.
9. Serevent 2 sprays MDI q 12h.
10. Flovent 220 micrograms 2 puffs q 12h.
11. Albuterol 2 sprays q 6h PRN.
12. Atrovent 2 puffs q 6h.
13. Nebulizer treatment with albuterol q 6-8h
14. Nebulizer treatment with Atrovent q 6-8h
15. Levaquin, finishing up a course of antibiotics 250 mg. PO qd for the next seven days.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is afebrile. Height is 5'10". Weight is 236 lbs. Pulse is 96. Respirations are 22. BP is 140/110. O2 saturation on room air is 97%.

GENERAL: Patient is in no acute distress at rest.

HEENT: No sinus tenderness. Ear exam is normal. Throat is clear. No

Jones, Archie
Chart # [REDACTED]
GOWDHAMI MOHAN, M.D.
10/11/99
page 4

lymphadenopathy or elevated JVD. Carotid upstroke present. Narrowed oropharynx present. No thyromegaly.

LUNGS: Few scattered rhonchi present. Minimal wheezing heard. No bronchial breathing present.

HEART: S1, S2 heard with no murmur or gallop.

ABDOMEN: Soft with bowel sounds present, no organomegaly.

EXTREMITIES: No cyanosis, clubbing or pedal edema. Scars of thermal injury noted in the lower extremities.

NEURO: No deficit present.

ASSESSMENT AND PLAN:

1. Sleep related breathing disorder. Patient has classic symptoms of snoring, observed apneas and excessive day time sleepiness, which strongly suggests obstructive sleep apnea. Obesity related hypoventilation may also be present as an added component. Need to a complete overnight polysomnogram to assess the severity of the problem and hence to manage the patient clinically. Patient does not give any clinical history to suggest PLMS syndrome or narcolepsy. Weight reduction strategies discussed with the patient. Sleep hygienic measures reviewed. Educational materials given. Video presentation on pathophysiology of sleep apnea and treatment of it was also viewed. Medical vs. surgical management discussed with patient.
2. Restrictive and obstructive lung disease secondary to thermal lung injury. Patient's PFT's have shown significant improvement within the last one year as mentioned above. The patient is currently not on steroids and has decided not to be on it. Patient does not give any clinical history to suggest triggering of his symptoms secondary to environmental exposure to allergens, dust, cold, mold, etc. Singulair may not be needed for him, hence I will DC Singulair. His anxiety problems are better and adequately controlled. At this point, I think it is safe to add theophylline though it is a weak bronchodilator in order to improve the sensation of dyspnea along with improvement in diaphragmatic function. Patient to get serum theophylline level done in one week. Theophylline to be started at 200 mg. q 12h. We will arrange for pulmonary rehab once his sleep studies are done and treatment is started for it.

GOWDHAMI MOHAN, M.D.

CC: Dr. John Pilch
Dr. Suverion
Dr. Robert Richards
gm:sps-155 / JOB: 1398

CAROLINA PULMONARY AND SLEEP CENTER

PATIENT: Archie Jones
CHART: 226705-4
REFERRING PHYSICIAN:
DATE: November 15, 1999

FOLLOW UP VISIT

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a 56-year-old gentleman who has multiple medical problems, including history of exposure to thermal lung injury, secondary to that and is here for follow up on his sleep study. The patient has been noted to have heavy snoring, observed apnea, and excessive daytime sleepiness. The patient continues to have the same problems. Sleep study was done at Anderson Memorial Hospital, which showed severe obstructive sleep apnea.

The patient's dyspnea level has much improved after starting on theophylline. The patient has been discontinued off of Singulair since 11/15/99. He is using his inhalers regularly. He uses aerosol treatment 3-4 times a day on a regular basis. The patient has no complaints, no cough, with minimal sputum production in the morning. No hemoptysis present. No paroxysmal nocturnal dyspnea and no pedal edema. No orthopnea. No fever, no chills, no other constitutional changes.

PAST MEDICAL HISTORY:

1. History of thermal injury to the lungs/obstructive and restrictive lung disease, secondary to this.
2. Chronic anxiety disorder.
3. Allergic rhinitis and sinusitis.
4. Reflexes of angitis.
5. Hypertension.

MEDICATIONS:

1. Colace 300 mg po q.d.
2. Duratuss 1 tablet po q.d.
3. Cardura 1 mg po q.h.s.
4. Atarax 10 mg one po q.h.s.
5. Neurontin 200 mg po b.i.d.
6. Sulcrafate 1 gram EC and t.i.d.
7. Flonase 2 sprays in both nostrils q.d.
8. Flovent 220 mcg, 2 puffs MDI q12.
9. Aerosol treatment with albuterol and Atrovent.
10. Theophylline 200 mg po q12h.
11. Serevent 2 puffs MDI q12h.

ALLERGIES: No know drug allergies.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is 98.1. Pulse 78. Respirations are 17. BP is 132/86. Weight is 232 lbs.

GENERAL: Patient is in no acute distress at rest.

Archie Jones
Med Red.# [REDACTED]
Gowdhami Mohan, M.D.
November 15, 1999
Page 2

HEENT: No sinus tenderness present. Ear exam normal.
Throat is clear, no lymphadenopathy. Narrow
oropharynx plus no elevated JVD. Carotid upstroke
LUNGS: Normal breath sounds present. Minimal wheezing
heard on force expiration. No rales, no rhonchi.
HEART: S1, S2 heard. No murmur or gallop.
ABDOMEN: Soft with bowel sounds present. No organomegaly.
EXTREMITIES: No cyanosis or clubbing. No pedal edema.

IMPRESSION AND PLAN:

1. Chronic obstructive pulmonary disease, secondary to chronic bronchitis, after suffering thermal injury to the lungs. The patient is to be continued on the aerosol treatment along with the theophylline and Flovent nasal inhalers. The patient's symptoms are well controlled with the current medication regimen and will continue implement the same. His overall pulmonary function tests have improved significantly from the previous PFTs. The patient is to continue on the cardiac pulmonary rehab program as before.
2. Severe sleep apnea. Sleep study results discussed with the patient. Medical versus surgical management also discussed. The patient opts to go for medical management only. The patient is to be started on continuous positive pressure treatment for optimal medical management. The patient is to have a CPAP titration study done for this. The problems associated with the CPAP treatment, including nasal dryness, nasal stuffiness, upper airway dryness, conjunctivitis discussed with the patient. The patient is to use normal saline nasal spray 2 sprays on both sides every 8 hours if he suffers from increased nasal dryness. The patient is to continue to use the Flonase nasal spray which may tremendously help to improve his nasal complaints. Sleep hygiene measures discussed with the patient. Weight reduction strategies also reviewed.
3. The patient is to return to the clinic one month after CPAP has been initiated.

Gowdhami Mohan, M.D.

cc: Dr. Pilch
Dr. Robert Richards
Dr. Souviron

035-5656.PSC

CAROLINA PULMONARY AND SLEEP CENTER

PATIENT: Archie Jones
CHART: 26055119
REFERRING PHYSICIAN:
DATE: November 15, 1999

FOLLOW UP VISIT

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a 56-year-old gentleman who has multiple medical problems, including history of exposure to thermal lung injury, secondary to that and is here for follow up on his sleep study. The patient has been noted to have heavy snoring, observed apnea, and excessive daytime sleepiness. The patient continues to have the same problems. Sleep study was done at Anderson Memorial Hospital, which showed severe obstructive sleep apnea.

The patient's dyspnea level has much improved after starting on theophylline. The patient has been discontinued off of Singulair since 11/15/99. He is using his inhalers regularly. He uses aerosol treatment 3-4 times a day on a regular basis. The patient has no complaints, no cough, with minimal sputum production in the morning. No hemoptysis present. No paroxysmal nocturnal dyspnea and no pedal edema. No orthopnea. No fever, no chills, no other constitutional changes.

PAST MEDICAL HISTORY:

1. History of thermal injury to the lungs/obstructive and restrictive lung disease, secondary to this.
2. Chronic anxiety disorder.
3. Allergic rhinitis and sinusitis.
4. Reflexes of angitis.
5. Hypertension.

MEDICATIONS:

1. Colace 300 mg po q.d.
2. Duratuss 1 tablet po q.d.
3. Cardura 1 mg po q.h.s.
4. Atarax 10 mg one po q.h.s.
5. Neurontin 200 mg po b.i.d.
6. Sulcrafate 1 gram EC and t.i.d.
7. Flonase 2 sprays in both nostrils q.d.
8. Flovent 220 mcg, 2 puffs MDI q12.
9. Aerosol treatment with albuterol and Atrovent.
10. Theophylline 200 mg po q12h.
11. Serevent 2 puffs MDI q12h.

ALLERGIES: No known drug allergies.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is 98.1. Pulse 78. Respirations are 17. BP is 132/86. Weight is 232 lbs.

GENERAL: Patient is in no acute distress at rest.

Archie Jones
Med Red.# [REDACTED]
Gowdhami Mohan, M.D.
November 15, 1999
Page 2

HEENT: No sinus tenderness present. Ear exam normal.
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1. Chronic obstructive pulmonary disease, secondary to chronic bronchitis, after suffering thermal injury to the lungs. The patient is to be continued on the aerosol treatment along with the theophylline and Flovent nasal inhalers. The patient's symptoms are well controlled with the current medication regimen and will continue implement the same. His overall pulmonary function tests have improved significantly from the previous PFTs. The patient is to continue on the cardiac pulmonary rehab program as before.
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3. The patient is to return to the clinic one month after CPAP has been initiated.

Gowdhami Mohan, M.D.

cc: Dr. Pilch
Dr. Robert Richards
Dr. Souviron

035-5656.PSC

CAROLINA PULMONARY AND SLEEP CENTER
605 EAST GREENVILLE STREET
ANDERSON, SC 29621
(864) 231-7004

27518

FOLLOW UP VISIT

PATIENT: Jones, Archie
CHART #: 253705112
REFERRING PHYSICIAN: Dr. John Pilch
DATE: 01/27/00

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant 46-year-old gentleman with multiple medication problems who has come in for follow up. Patient's major medical problems are COPD secondary to smoke inhalation, lung injury, obstructive sleep apnea, and shortness of breath on exertion. Patient was last seen by me on 11/15/99. Patient had a sleep study done and he is here for follow up on the sleep study results also.

Patient states that his cough and shortness of breath have increased in severity. Sputum production has also increased. Patient is using the nebulizer treatment regularly. No fever or chills present. He does not have any generalized myalgia. Patient is here also to state that he is finding it extremely difficult to work and may apply for disability. He has mixed up feelings about going on disability.

SLEEP STUDY RESULTS: (Done on 11/09/99). Reveals a total of 36 apneas and 84 hypopneas. Patient had a total apnea/hypopnea index of 16.7. Patient noted to have significant desaturations throughout the sleep study with the lowest O2 saturation being recorded at 85%.

PAST MEDICAL HISTORY:

1. History of thermal injury to the lungs. Patient has both obstructive and restrictive lung disease to this.
2. Chronic anxiety disorder.
3. Allergic rhinitis and sinusitis.
4. Reflux esophagitis.
5. Hypertension.

CURRENT MEDICATIONS:

1. Duratuss G 1200 mg. PO qd.
2. Cardura 1 mg. PO qhs.
3. Neurontin 200 mg. PO q 12h.
4. Sucralfate 1 gm. before meals and bed time.
5. Flonase nasal spray, 2 sprays in both nostrils q a.m.
6. Flovent 220 mcg. two sprays both nostrils qd.

MEDICATIONS CONTINUED:

Jones, Archie

Chart # [REDACTED]

GOWDHAMI MOHAN, M.D.

01/27/00

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7. Serevent 2 puffs MDI q 12h.
8. Albuterol 2 puffs q 6h PRN.
9. Atrovent 2 puffs q 6h PRN.
10. Aerosol treatment with albuterol and Atrovent.
11. Theophylline 200 mg. PO q 12h.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature afebrile. Pulse is 84. Respirations are 18. BP is 138/80.
O2 saturation on room air is 96%.

GENERAL: Patient is in no acute distress at rest.

HEENT: Unremarkable except for narrowed oropharynx.

LUNGS: Distant breath sounds present. A few scattered rhonchi present. No wheezing heard.

HEART: S1, S2 heard with no murmur or gallop.

ABDOMEN: Soft with bowel sounds present, no organomegaly.

EXTREMITIES: No cyanosis, clubbing or pedal edema.

ASSESSMENT/PLAN:

1. Chronic obstructive pulmonary disease. Patient is being evaluated for disability. He had his PFT done in the past. Need to reevaluate the severity of this problem with complete PFT's.
2. Pulmonary rehab to be started again.
3. X-ray of the chest also added as a part of follow up.
4. Obstructive sleep apnea. Sleep study results discussed with the patient. Pros and cons of medical vs. surgical management discussed. Since the patient has had extensive thermal injury to the oropharynx and because of his multiple medical problems, patient is an ideal candidate for continuous positive airway pressure treatment only. We will arrange for CPAP titration study to be done for optimal medical management of the sleep apnea. Patient to return to the clinic one month later for follow up.

GOWDHAMI MOHAN, M.D.

CC: Dr. John Pilch

gm:sps-155 / JOB: 6308

ANDERSON AREA MEDICAL CENTER
SLEEP DISORDER CENTER
ANDERSON, S.C.

2/25/00

CPAP TITRATION STUDY

PATIENT: Jones, Archie
CHART #: 257405729
REFERRING PHYSICIAN: Dr. Pilch
DATE: 02/14/00

BRIEF HISTORY AND REASON FOR THE STUDY: Mr. Archie Jones is a pleasant 46-year-old gentleman who has been diagnosed to have obstructive sleep apnea by a previous sleep study who had CPAP titration study done for optimal medical management.

POLYSOMNOGRAM FINDINGS: Complete overnight polysomnogram was performed as per the protocol. Routine PSG montage included EEG, EOG, chin EMG, limb leads, oral and nasal air flow, abdominal and thoracic effort and O2 saturation. The patient was studied for 6.3 hours during which time he slept for only 5.3 hours, thus had a sleep efficiency index of 84%. Patient noted to have a prolonged sleep latency of 18 minutes. This may be secondary to CPAP intolerance. Patient also had REM phase sleep of 83 minutes which falls within the normal range. Patient was started on CPAP pressure of 4 cm. and slowly increased up to 12 cm. to obliterate all the apneas, hypopneas, O2 desaturations, hypoventilation events, transient arousals and snoring. Patient was studied on 12 cm. pressure for nearly half an hour. Patient was noted to have an RDI of only 2 when on 12 cm. pressure. Patient was noted to have a significant amount of REM phase and was in supine position when on 12 cm. of CPAP pressure. Patient appears to have tolerated the CPAP pressure relatively okay with some initial difficulty. Patient noted to have a total respiratory disturbance index of 4.2 for the whole sleep study. Patient had 13 apneas and 9 hypopneas for the whole sleep study. Maximum apnea duration was 18 seconds and maximum hypopnea duration was 60 seconds.

Patient spent majority of the time in stage II sleep, 47% of the total sleep time. He had a reduced percentage of deep sleep, 8.7% of the total sleep time. Patient was noted to have prolonged stage I sleep, 26% of the total sleep time. Patient was also noted to have increased REM phase sleep of 18% of the total sleep time which is also significantly increased. The increase in REM phase sleep is secondary REM rebound phenomenon associated CPAP initiation.

Patient did not have any significant tachyarrhythmias or bradyarrhythmias. The slowest heart rate recorded was 65 and the fastest heart rate recorded was 105. Patient did not have any leg movements suggestive of PLMS syndrome. PLMS index was 0 and PLMS arousal index was also 0. Patient noted to have a total transient arousal index of 9.3. Spontaneous arousal index was 7.4. Patient did not have any EEG evidence for seizures. No abnormal behavior movement noted during this sleep study.

FINAL IMPRESSION:

1. Obstructive sleep apnea.
2. CPAP titration study reveals that Mr. Jones requires an optimal pressure of 12 cm. to adequately manage the respiratory events during sleep. Patient to be started on 12 cm. of CPAP pressure. Patient to return to clinic in one month for follow up.
3. Weight reduction strategies and sleep hygienic measures to be again reinforced.


GOWDHAMI MOHAN, M.D.

CC: Dr. Pilch
Dr. Souviron
Dr. Robert Richards -Greenville
Sleep lab

gm:sps-155 / JOB: 2610

**CAROLINA PULMONARY AND SLEEP CENTER
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(864) 231-7004**

FOLLOW UP VISIT

PATIENT: Jones, Archie
CHART #: 5040919
REFERRING PHYSICIAN: Dr. John Pilch
DATE: 03/02/00

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant 46-year-old, obese, white male with a history of multiple medical problems who is here for follow up. Patient has COPD with restrictive component secondary to thermal injury in the past and recently diagnosed to have sleep apnea also.

Patient has complaints of increasing difficulty to breathe for the last seven to eight days. He also has generalized myalgia. Runny nose and sinus congestion present. Patient states that he has been feeling very fatigued for the last two days. Cough initially was dry but later having increased secretions. No hemoptysis present. His dyspnea level is less than two blocks. No pedal edema present.

Patient not able to wear the CPAP for now because of increasing difficulty to breathe and increased symptoms of sinusitis being present now.

PAST MEDICAL HISTORY:

1. COPD secondary to thermal injury.
2. Restrictive lung disease secondary to thermal injury.
3. Hypertension.
4. Chronic anxiety disorder.
5. Reflux esophagitis.
6. Obstructive sleep apnea.

ALLERGIES: NKDA.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature afebrile. Vital signs stable. O2 saturation on room air is 92%.

GENERAL: Patient is in no acute distress at rest.

HEENT: Unremarkable except for right maxillary sinus tenderness and narrowed oropharynx.

LUNGS: Mild to moderate wheezing present.

HEART: S1, S2 heard with no murmur or gallop.

EXTREMITIES: No cyanosis, clubbing or pedal edema.

Jones, Archie
Chart #: [REDACTED]
GOWDHAMI MOHAN, M.D.
03/02/00
page 2

ASSESSMENT AND PLAN:

1. Mild exacerbation of COPD with bronchitis. Patient started on Augmentin 500 mg. one PO q 12h x 7 days. Patient to continue to use the bronchodilators frequently. If he is not getting significant symptomatic relief, then he is to call me and I will start him on steroids.

GOWDHAMI MOHAN, M.D.

CC: Dr. John Pilch

gm:sps-155 / JOB: 6309

CAROLINA PULMONARY AND SLEEP CENTER
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ANDERSON, SC 29621
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5/8

FOLLOW UP VISIT

PATIENT: Jones, Archie
CHART #: 250705115
REFERRING PHYSICIAN: Dr. John Pilch
DATE: 03/17/00

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant 46-year-old gentleman who has sleep apnea and COPD who is here for follow up. Patient has complaints of cough and sputum production for the last two to three years which is slowly increasing in severity within the last six to seven months. Patient recently had an episode of COPD exacerbation with bronchitis which has been successfully treated with two courses of antibiotics and steroids which has been tapered off. Patient is concerned about his overall worsening respiratory status. No fever or chills. No chest pain. Shortness of breath on exertion present for two to three blocks. No pedal edema or symptoms suggestive of PND. No palpitations or dizziness. Patient has complaints of nocturnal attacks of wheezing on and off. He uses the nebulizer treatment regularly. He is also very compliant with the rest of his medications. Patient is able to use the CPAP machine also on a regular basis.

Patient recently has been suffering from urethral stricture/prostatism and is being followed by a urologist.

PAST MEDICAL HISTORY:

1. Obstructive sleep apnea.
2. COPD.
3. Reflux esophagitis.
4. Chronic anxiety disorder.
5. Chronic sinusitis.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature afebrile. Pulse is 92. Respirations are 18. BP is 162/72. Weight is 236 lbs. O2 saturation on room air is 96-97%.

GENERAL: Patient is in no acute distress at rest.

HEENT: No sinus tenderness. Ear exam normal. Throat is clear. Narrowed oropharynx present.

LUNGS: Mild wheezing present. No rales or rhonchi.

HEART: S1, S2 heard with no murmur or gallop.

ABDOMEN: Soft with bowel sounds present, no organomegaly.

EXTREMITIES: No cyanosis, clubbing or pedal edema.

Jones, Archie

Chart #: 6310

GOWDHAMI MOHAN, M.D.

03/17/00

page 2

ASSESSMENT AND PLAN:

1. COPD. Patient has chronic obstructive pulmonary disease secondary to the thermal injury. The PFT done on 02/01/00 reveals moderate degree of obstructive lung defect with normal lung volumes. This suggests that the patient's lung injury secondary to increased heat fumes must have improved. He may have an added component of restriction which is possibly not evident by PFT's. Continue the patient on nebulizer treatment along with theophylline. Patient does not meet the criteria for O2 supplementation. Patient to be continued on pulmonary rehab as is being done now.
2. Rule out bronchiectasis. Patient has complaints of chronic cough and sputum production on and off with episodes of bronchitis. Because of the previous lung injury, patient will benefit from getting CT of the chest to rule out bronchiectasis. Patient also to be started on Mucomyst along with albuterol and Atrovent aerosol treatment to help to clear the secretions. Add Azmacort MDI q 8h to reduce the airway inflammation. Patient to return to the clinic in one month for follow up.

GOWDHAMI MOHAN, M.D.

CC: Dr. John Pilch
Dr. June Souviron.
Dr. Robert Richards

gm:sps-155 / JOB: 6310

CAROLINA PULMONARY AND SLEEP CENTER
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FOLLOW UP VISIT

PATIENT: Jones, Archie
CHART #: 250705119
REFERRING PHYSICIAN: Dr. John Pilch
DATE: 04/17/00

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant 46-year-old white male with multiple medical problems and is here for follow up. He has a long history of pulmonary complaints which started initially with thermal injury two years back. Patient has been suffering from pulmonary problems since then. Recent PFT reveals moderate obstructive lung defect with possible added restrictive component to it. Patient was last seen on 03/17/00. Because of the patient's worsening pulmonary status for the last nine months, I have ordered CT of the chest to rule out bronchiectasis. Patient has been suffering from increased cough and more sputum production with multiple episodes of bronchitis within the last nine months.

CT OF CHEST: Reveals resolving lingular pneumonia. Right middle lobe minimal atelectasis. No evidence for bronchiectasis present. Upper paratracheal adenopathy of 2 cm. size which may be related to previous pulmonary thermal injury.

Patient is using the CPAP machine regularly. Runny nose and sinus congestion are at minimal. He states that he is short of breath for one to two blocks and feels extremely tired and exhausted. No pedal edema or PND. No nausea, vomiting or altered bowel habits. He continues to have GU problems for which he is being followed by a urologist.

PAST MEDICAL HISTORY:

1. COPD.
2. Status post thermal lung injury.
3. Obstructive sleep apnea.
4. Chronic anxiety disorder.
5. Chronic rhinitis and sinusitis.
6. Esophagitis.
7. History of recurrent attacks of bronchitis with COPD exacerbation.
8. History of pneumonia last month.

ALLERGIES: NKDA.

Jones, Archie
Chart #: ~~060705113~~
GOWDHAMI MOHAN, M.D.
04/17/00
page 2

MEDICATIONS:

1. Theophylline 200 mg. PO q 12h.
2. Nebulizer treatment with aerosol and Atrovent q 4h.
3. CPAP treatment.
4. Serevent 2 puffs MDI q 12h.
5. Flonase 2 sprays both nostrils q a.m.
6. Azmacort 4 puffs MDI q 8h.
7. Cardura 1 mg. PO qhs.
8. Duratuss 1200 mg. PO q 12h.
9. Colace 300 mg. PO q 12h.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is afebrile. Pulse is 96. Respirations are 18. BP is 128/92.
Weight is 236 lbs.

GENERAL: Patient is in no acute distress at rest.

HEENT: No sinus tenderness. Ear exam is normal. Throat clear. Narrowed oropharynx present. No elevated JVD. Carotid upstroke present.

LUNGS: Mild wheezing present. A few scattered rhonchi.

HEART: S1, S2 heard with no murmur or gallop.

ABDOMEN: Soft with bowel sounds present, no organomegaly.

EXTREMITIES: No cyanosis, clubbing or pedal edema.

ASSESSMENT AND PLAN:

1. COPD. Patient complains of increased cough and dyspnea along with sputum production more within the last nine months. Patient has tendency to ruminate about his medical problems to a quite significant degree. These complaints were once again discussed with his wife who also states his overall pulmonary problem has worsened. CAT scan of the chest did not reveal any bronchiectasis. Patient is on optimum bronchodilator treatment. The only other option that is left at this point is to start the patient on small dose of prednisone. We will start the patient on 20 mg. PO qd and try to taper it to 10 mg. PO qd. Patient was made to walk in my office for more than a block. Patient did not desaturate and did not have any shortness of breath.
2. Obstructive sleep apnea. He is to continue on the current amount of CPAP pressure. Sleep hygienic measures discussed with the patient. Weight reduction strategies also reviewed.

Jones, Archie

Chart #: 250705133

GOWDHAMI MOHAN, M.D.

04/17/00

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ASSESSMENT AND PLAN CONTINUED:

3. Disability form to be signed for the patient. Since the patient has multiple medical problems and has extreme difficulty to work, I agree with him applying for disability. Papers will be sent by me once I receive it.

GOWDHAMI MOHAN, M.D.

CC: Dr. Souvion
Dr. John Pilch
Dr. Robert Richards

gm:sps-155 / JOB: 6311

CAROLINA PULMONARY AND SLEEP CENTER
605 EAST GREENVILLE STREET
ANDERSON, SC 29621
(864) 231-7004

8/16/00

FOLLOW UP VISIT

PATIENT: JONES, ARCHIE

CHART#:

REFERRING PHYSICIAN:

Dr. June Souviron

DATE: 08/04/00

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones, a pleasant middle-aged gentleman with multiple medical problems, is here for follow up. The patient's past medical history includes severe thermal injury a few years back, obstructive sleep apnea, chronic obstructive lung disease secondary to bronchiectasis, chronic rhinitis and sinusitis, etc. The patient also has significant psychological trauma since the accident and is being currently seen by a psychiatrist in Greenville (Dr. Robert Richards). The patient's pulmonary problems worsen whenever he is tapered off of prednisone. Currently he has been placed on Prednisone 20 mg a day. The patient states that his symptoms of shortness of breath have improved significantly. His secretions have also decreased.

His is compliant with the rest of his medications. His dyspnea level is 2-3 blocks on his good day. When he has worsening of his symptoms he is dyspneic even at rest. No fever, no chills. Cough and sputum production continue to be present with on-and-off exacerbations. The patient is being evaluated for a dental appliance for his sleep apnea problem.

PAST MEDICAL HISTORY:

1. Status post thermal injury.
2. Obstructive sleep apnea.
3. Psychiatric illness.
4. Chronic rhinitis and sinusitis.
5. Reflux esophagitis.
6. Bronchiectasis.
7. COLD secondary to bronchiectasis.
8. Urological problems/chronic prostatitis.

ALLERGIES: NKDA.

MEDICATIONS:

1. Pulmicort 2 puffs MDI q12h.
2. Serevent 2 puffs MDI q12h.
3. Aerosol treatment with albuterol and Atrovent.
4. Colace 100 mg p.o. b.i.d.

PATIENT: JONES, ARCHIE
CHART#:
REFERRING PHYSICIAN: Dr. June Souviron
DATE: 08/04/00

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5. Prilosec 20 mg p.o. b.i.d.
6. Duratuss-G 1 tablet p.o. b.i.d.
7. Cardura 20 mg p.o. q.d.
8. Theophylline 300 mg p.o. b.i.d.
9. Aspirin 81 mg p.o. q.d.
10. Depakote 250 mg p.o. q.d.
11. Neurontin 200 mg p.o. b.i.d.
12. Prednisone 20 mg a day.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature afebrile, pulse 110, respirations 18, blood pressure 152/86, Weight 245 pounds, height 5' 10".

GENERAL: The patient is not in any acute distress at rest.

HEENT: No sinus tenderness. Ear exam normal. Narrowed oropharynx present. Increased redundant tissue noted in the oropharynx.

NECK: No thyromegaly, no elevated JVD. Carotid upstrokes present.

LUNGS: Distant breath sounds present. Scattered rales with rhonchi present.

HEART: S1, S2 heard. No murmur, no gallop.

ABDOMEN: Soft. Bowel sounds present. No organomegaly.

EXTREMITIES: No cyanosis or clubbing present. No pedal edema.

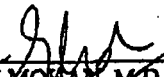
ASSESSMENT AND PLAN:

1. Chronic obstructive lung disease, secondary to bronchiectasis. The patient's symptoms significantly improved on p.o. prednisone 20 mg a day. The patient is also on Pulmicort. We will discontinue that. The patient was initially placed on Pulmicort when prednisone was stopped. Since the plan is to continue on prednisone 20 mg a day, he does not need Pulmicort. Aerosol treatment with albuterol and Atrovent is to be continued. Mucomyst was stopped on the last visit itself. The patient is to continue to use Serevent as prescribed.
2. Obstructive sleep apnea. The patient saw Dr. Harrison for further evaluation since he was not able to tolerate the CPAP machine. He has been scheduled to have a dental appliance made for this problem.
3. Bronchiectasis. Since the patient's exacerbation of chronic obstructive lung disease appears to be more associated with upper respiratory tract infection, it may be beneficial for him to be on antibiotics cyclically every month. This is a controversial issue in the treatment of bronchiectasis. A few authorities state that patients with bronchiectasis

PATIENT: JONES, ARCHIE
 CHART#:
 REFERRING PHYSICIAN: Dr. June Souviron
 DATE: 08/04/00

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will have significant improvement if they take antibiotics one week in a month cyclically. There are some authorities who disagree with it. But given the patient's clinical picture, I strongly feel that this will benefit him. We will rotate three antibiotics for him every month, namely Tequin, Augmentin, and Biaxin. The patient is to return to the clinic four months later for follow-up.


 GOWDHAMI MOJAN, M.D.

GM/DTIvb 789.63

Cc Dr. June Souviron
 Dr. Hellstrom
 Dr. John Pilch
 Dr. Robert Richards
 Sleep lab

CAROLINA PULMONARY AND SLEEP CENTER
605 EAST GREENVILLE STREET
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(864) 231-7004

10/12/00

FOLLOW UP VISIT

PATIENT: Jones, Archie
CHART #: ~~217132~~
REFERRING PHYSICIAN: Dr. Pilch
PRIMARY CARE M.D.: Dr. Souviron
DATE: 10/02/00

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant middle aged gentleman with multiple medical problems and is currently followed by me for his pulmonary and sleep problem. He is here for four month check up. Patient's significant past medical history includes severe thermal injury a few years back with extensive pulmonary damage. Patient has resultant chronic obstructive lung disease secondary to bronchiectasis. Patient also has chronic rhinitis and sinusitis as an added long standing problem. He also has obstructive sleep apnea. CPAP trial was done without any success. Currently, patient is wearing a dental device.

Patient has been placed on cyclic antibiotic therapy one week per month (patient rotates with Biaxin, Augmentin and Tequin). Patient's symptoms of dyspnea has improved significantly within the last four months. Patient is currently on the first week of Biaxin course. Patient's sputum and cough production has decreased significantly. Currently, he is on prednisone 10 mg. PO qd. He occasionally has difficulty to breathe, but overall his symptoms have improved significantly.

Patient continues to have nocturnal awakenings and day time sleepiness problem. The orthodontic device is not working very well according to him. Patient continues to feel sleepy and tired during the day time. No fever or chills. No weight loss or loss of appetite. No other significant problems.

PAST MEDICAL HISTORY:

1. Status post thermal injury affecting the lungs and upper respiratory tract.
2. Obstructive sleep apnea.
3. Psychiatric illness with major depression and anxiety.
4. Chronic rhinitis and sinusitis.
5. Reflux esophagitis.
6. COLD secondary to bronchiectasis.
7. Urological problem- chronic prostatitis.

ALLERGIES: NKDA.

Jones, Archie
Chart # ~~1000000000~~
GOWDHAMI MOHAN, M.D.
10/02/00
page 2

MEDICATIONS:

1. Prednisone 10 mg. PO qd.
2. Neurontin 200 mg. PO bid.
3. Depakote 500 mg. PO qd.
4. Aspirin 81 mg. PO qd.
5. Theophylline 300 mg. PO bid.
6. Cardura 4 mg. PO qd.
7. Prilosec 20 mg. PO bid.
8. Colace 300 mg. PO bid.
9. Aerosol treatment with albuterol and Atrovent.
10. Serevent 2 puffs MDI bid.
11. Flovent 2 puffs MDI bid.
12. Duratuss liquid bid PRN.
13. Biaxin cycling with Augmentin and Tequin.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature afebrile. BP is 150/96. Pulse is 80. Respirations are 18.
Weight is 244 lbs.

GENERAL: Patient is in no acute distress at rest.

HEENT: No sinus tenderness. Ear exam normal. Throat is clear. No lymphadenopathy or elevated JVD. Carotid upstroke present.

LUNGS: Distant breath sounds present. Mild wheezing heard on expiration.

HEART: S1, S2 heard with no murmur or gallop.

ABDOMEN: Soft with bowel sounds present, no organomegaly.

EXTREMITIES: No cyanosis, clubbing or pedal edema.

ASSESSMENT AND PLAN:

1. Bronchiectasis. Patient's clinical symptoms significantly improved overall within the last four months after being on cyclic antibiotic therapy and we will continue the same. Patient to use aerosol treatment along with prednisone and steroid inhalers. Serevent also to be continued along with theophylline. Patient to continue to exercise on regular basis as he is doing now.

Jones, Archie
Chart #: ~~2370519~~
GOWDHAMI MOHAN, M.D.
10/02/00
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ASSESSMENT AND PLAN CON'T:

2. Obstructive sleep apnea. Patient's symptoms not well controlled with dental device. Patient is having some technical difficulties with the orthodontic device but has been continuing to wear it. Patient has already been arranged to have a sleep study done with the dental device on in order to assess the resolution of the sleep related problem. Patient to return to the clinic one week after the sleep study is done.



GOWDHAMI MOHAN, M.D.

CC: Dr. June Souviron
Dr. John Pilch
Dr. Richards
Dr. Hellstrom

gm:sps-155 / JOB: 0467

ANDERSON AREA MEDICAL CENTER
SLEEP DIAGNOSTIC CENTER
ANDERSON, SC 29621

Complete Overnight Polysomnogram

PATIENT: Jones, Archie
CHART#: ~~20000512~~
REFERRING MD: Dr. John Pilch
DATE: 10/26/00

BRIEF HISTORY AND REASON FOR THE STUDY: Mr. Archie Jones is a pleasant middle-aged gentleman with a history of obstructive sleep apnea documented by polysomnogram done on November 9, 2000. Had sleep study done and was on CPAP treatment. The patient could not tolerate the CPAP at all. Patient is currently wearing a dental appliance (mandibular retraction device). Patient has been wearing the oral appliance for the last few months and is here for polysomnography to evaluate the adequacy of treatment.

POLYSOMNOGRAM FINDINGS: Complete overnight polysomnogram was performed as per the protocol. Routine PSG montage included EEG, EOG, EKG, chin EMG, limb leads, oral and nasal air flow, thoracic and abdominal effort and O2 saturation. Patient was studied for nearly 377 minutes, during which time he slept for 345 minutes thus having a slightly reduced sleep efficiency index of 92%. Patient was noted to have a normal sleep latency of 11.5 minutes. REM phase sleep latency falls within the normal range of 61 minutes. Patient was noted to have a snoring throughout the study. Patient had a baseline O2 saturation of 98% while awake at rest. During sleep he was noted to have a significant desaturation with the lowest O2 saturation being recorded at 87%. Patient spent less than 1% of the total study on O2 saturation below 90%. Patient was noted to have 1 apnea and 28 hypopneas during this sleep study. In his baseline study he was noted to have a total of 36 apneas and 84 hypopneas with a total disturbance index of 16.7. In this current study, with the oral appliance, his RDI (number of apneas and hypopneas per hour) is 5.2. Patient was studied in the supine position and in the right lateral position. He spent the majority of the time in the right lateral position.

Patient spent the majority of the time in Stage II sleep, 77% of the total sleep time and reduced to deep sleep 1% of the total sleep time. 21% of the total sleep was in REM phase of sleep. 1.3% of the total sleep was spent in Stage I sleep.

Patient had a total respiratory arousal index of 5.2. Spontaneous arousal index was 5.9. Patient did not have any isolated leg movements. Total PLMS index was 0. Patient did not have any EEG evidence for seizures, no abnormal tachyarrhythmias or bradyarrhythmias present, and no abnormal behavioral movement.

PATIENT: Jones, Archie
CHART#: ~~1000019~~
REFERRING MD: Dr. John Pilch
DATE: 10/26/00
PAGE: 2

During this sleep study.

FINAL IMPRESSION AND PLAN:

1. Obstructive sleep apnea of mild to moderate degree present.
2. Patient's sleep related events are significantly improved with oral appliance. RDI is only 5 when on the oral appliance.
3. Patient has significant improvement and resolution of his problems with the oral appliance and will continue this for now.
4. Sleep hygienic measures and weight reduction strategies will be reinforced during the next office visit.

Gowdhami Mohan
GOWDHAMI MOHAN, M.D.

cc: John Pilch, M.D.
June Souviron, M.D.
Robert Richards, M.D. ✓
Sleep Lab

GM/sps-189/JOB:5774

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FOLLOW UP VISIT

PATIENT: JONES, ARCHIE
CHART #: 260705544
REFERRING PHYSICIAN: DR. JUNE SOUVIRON
DATE: 11/13/00

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant middle aged white male with the history of obstructive sleep apnea, bronchiectasis secondary to thermal injury in the past. He is here for followup. The patient is currently on prednisone for his pulmonary problem. The patient has not had any exacerbation of COPD for the last few months, since he has been on prednisone. His shortness of breath on exertion has improved significantly. No fever, no chills, no chest pain. Cough present, minimal sputum production present on and off. The patient is also taking cyclic antibiotics on a regular basis.

The patient is wearing orthodontic device for his sleep apnea problem. His symptoms of snoring, quality of sleep has improved significantly. The patient does not have any significant symptoms of daytime sleepiness also. The patient had a sleep study done with orthodontic device, done on 10/26/00.

SLEEP STUDY RESULTS: Sleep study results revealed that the patient's respiratory disturbance, namely apneas and hypopneas were much reduced, with the orthodontic device in place. In the past, the patient had an RDI of 16.7 (number of apneas and hypopneas per hour). During the recent study that was done his RDI was found to be around 5. The patient had only 1% of deep sleep.

PAST MEDICAL HISTORY:

1. Status post thermal injury involving the lungs and upper respiratory tract.
2. Obstructive sleep apnea.
3. Psychiatric illness with major depression and anxiety.
4. Chronic rhinitis and sinusitis.
5. Reflux esophagitis.
6. COLD secondary to bronchiectasis.
7. Urological problem secondary to chronic prostatitis.

ALLERGIES: NKDA.

PATIENT: JONES, ARCHIE

CHART #: ~~XXXXXX~~

REFERRING PHYSICIAN: DR. JUNE SOUVIRON

DATE: 11/13/00

PAGE 2

MEDICATIONS:

1. Prednisone 10 mg p.o. q.d.
2. Depakote 500 mg 1 p.o. q.d.
3. Aspirin 81 mg 1 p.o. q.d.
4. Theophylline 300 mg p.o. b.i.d.
5. Cardura 4 mg p.o. q.d.
6. Duratuss 1 tablet p.o. b.i.d.
7. Prilosec 20 mg p.o. b.i.d.
8. Colace 100 mg p.o. b.i.d.
9. Aerosol treatment with albuterol and Atrovent.
10. Serevent 2 puffs MDI p.r.n.
11. Flovent 2 puffs MDI q.12h.
12. Pulmicort 2 puffs MDI b.i.d.
13. Duratuss liquid b.i.d.
14. Biaxin, amoxicillin, Levoquin, in rotation.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature afebrile. Pulse is 100. Respiration 18. Blood pressure 138/80. The patient is not in any acute distress at rest. O2 saturation on room air is 96%.

HEENT: Unremarkable except for a narrow oropharynx.

LUNGS: A few scattered rhonchi present, mild wheezing noted.

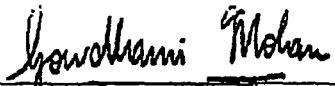
HEART: S1, S2 heard, no murmur, no gallop.

ABDOMEN: Soft. Bowel sounds present. No organomegaly.

EXTREMITIES: No cyanosis, no clubbing, no pedal edema.

ASSESSMENT AND PLAN:

1. COLD secondary to bronchiectasis. The patient is currently on aerosol treatment along with the prednisone. The patient symptomatically is doing much better than in the past. The patient to have his flu vaccine this year. The patient also to be continued on cyclic antibiotics.
2. Obstructive sleep apnea. Sleep study done with the orthodontic device suggests that the patient's sleep related problem are well controlled with orthodontic device. The patient did not want to have CPAP treatment. He was evaluated by Dr. Hellstrom who did not feel he is a surgical candidate. The patient to return to the clinic four months later for followup. Symptoms are well controlled / much better controlled with orthodontic device.


GOVDHAMI MOHAN, M.D.
GM/DTTksa 789.395
cc: Dr. June Souviron

JONES, JR., ARCHIE E. DOB: 7/30/43 ACCT# 4857

12/11/00 Eddie comes in for follow-up. He has a slight amount of distal urethral narrowing following previous hypospadias repair. He's voiding fairly comfortably but still has a splayed stream. Nothing seems to help this as much as we'd like. I think for that reason at this point it's simply best followed. His chief complaint today is erectile dysfunction. He's unable to get an adequate erection. His problems are compounded by significant psychological stress and difficulties in his relationship with his wife. The latter are bascially predicated on problems with an elderly relative and the general issues that have surrounded Eddie's injury. He is, however, recuperating and says his quality of life is much better than it used to be. In the past, he was able to achieve adequate erections however recently says that his erectile maintenance ability is very compromised. He denies recent loss of libido but does complain of stress. He denies visual symptoms any claudication or lightheadedness.

A urine is negative for sugar and albumin with a PH of 6. Microscopic shows only an occasional WBC. Physical reveals a clear chest. The heart has a regular rate and rhythm with no murmur and the abdomen is benign. Neither flank is tender. Penis and scrotal contents showed no gross abnormality.

I'm going to try Eddie a venous flow controller. This was dispensed today in hopes that it will improve his maintenance. He thinks that injections are uncomfortable and that Viagra may be unsafe for him. He's also not been satisfied with his response using the latter agent. We are going to see him in 6 weeks. He has some interest in a penile prosthesis and at some point this may be his only available option.

C. WILLIAM HINNANT, JR., MD, DABU, FCLM/dlc
Copy to Dr. Souvion

CAROLINA PULMONARY AND SLEEP CENTER
605 EAST GREENVILLE STREET
ANDERSON, SC 29621
(864) 231-7004

2/23/01

FOLLOW-UP VISIT

PATIENT: JONES, ARCHIE
PRIMARY CARE PHYSICIAN: DR. JUNE SOUVIRON
DATE: 02/15/01

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant middle-aged gentleman with multiple medical problems, including chronic obstructive lung disease, bronchiectasis, status post respiratory thermal injury, obstructive sleep apnea, who is here with the complaints of dizziness. The patient has been feeling dizzy for the last five days. He also has generalized myalgia and tiredness. The patient had a migraine attack five days back, which is not an active problem now. His symptoms of cough and sputum production are much well controlled, dyspnea level is also not worse. The patient has no fever, no chills, no other significant complaints, takes his medications regularly. Recently, he has been started on Dexedrine.

ALLERGIES: NKDA.

MEDICATIONS:

1. Aerosol treatment with albuterol and Atrovent.
2. Albuterol on a p.r.n. basis
3. Serevent 2 puffs MDI q.12h.
4. Colace 300 mg q.12h.
5. Prilosec 20 mg q.12h.
6. Theophylline 300 mg p.o. q.12h.
7. Cardura 20 mg p.o. q.p.m.
8. Aspirin 81 mg q.a.m.
9. Prednisone 10 mg q.p.m.
10. Normal saline spray 2 sprays in both nostrils two to three times a day.
11. Dexedrine 5 mg q.a.m. - 2 mos
12. Depakote 375 mg q.p.m. - 2 mos
13. Risperdal 15 mg t.i.d. - 2 mos
14. Cyclic course of antibiotics Augmentin, Tequin, and Biaxin.
15. Cough syrup? 1 teaspoon as needed.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is afebrile. Pulse is 80. Respirations 18. Blood pressure on sitting is 146/80, on standing systolic pressure dropped to 120/70. Change in pulse by more than 20 beats was also noted from sitting to standing position.

HEENT: Unremarkable except for narrowed oropharynx.

LUNGS: Distant breath sounds present. A few scattered rhonchi present.

HEART: S1, S2 heard. No murmur, no gallop.

EXTREMITIES: No cyanosis, no clubbing, no pedal edema.

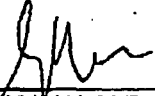
NEUROLOGICAL: No focal neurological deficit present.

PATIENT: JONES, ARCHIE
PRIMARY CARE PHYSICIAN: DR. JUNE SOUVIRON
DATE: 02/15/01

PAGE 2

ASSESSMENT AND PLAN:

1. Syncope. Mr. Archie Jones has multiple medical problems. He is being primarily followed by me for his pulmonary problems. He came in today mainly for his syncopal episodes. The patient's syncopal episodes are not associated with any cardiac events, does not have any chest pain, palpitations, etc. He does not appear to have any focal neurological deficit. The symptoms and orthostatic parameters suggest viral infection with some dehydration. The patient is encouraged to take lot of fluids. The patient is also to take Tylenol on a p.r.n. basis. I have advised the patient to have blood work done as ordered by Dr. Souviron and to make an appointment with Dr. Souviron next week for follow up. The patient is to return to the clinic for his regular routine follow-up three months later.



GOWDHAMI MOHAN, M.D.

GM/DTlakb 789.686

cc: Dr. June Souviron

7/16/01

CAROLINA PULMONARY AND SLEEP CENTER
605 EAST GREENVILLE STREET
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(864) 231-7004

FOLLOW-UP VISIT

PATIENT: JONES, ARCHIE
CHART: ~~250703159~~
PRIMARY CARE PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 08/04/01

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant gentleman with multiple medical problems who is here for his pulmonary and sleep problems. The patient has obstructive sleep apnea, currently doing well on dental appliance. The patient does not have any difficulty in wearing the dental appliance. He wears it for at least seven to eight hours. His snoring is much reduced and his quality of sleep has improved. His daytime sleepiness problem has also improved to a significant degree. He was not able to tolerate CPAP in the past.

The patient's dyspnea also has improved, he is able to walk half-a-mile without any problem. Occasionally, he has episodes of wheezing on exertion, cough is much reduced. His sputum production has also reduced to a significant degree after being on cyclic antibiotic therapy. No fever, no chills, no weight loss, no loss of appetite, no nausea, no vomiting, no altered bowel habits, the patient has some abdominal discomfort for which he is going to be evaluated by a gastroenterologist.

PAST MEDICAL HISTORY:

1. COPD.
2. Bronchiectasis.
3. Status post respiratory thermal injury.
4. Obstructive sleep apnea.
5. Attention deficit disorder.
6. Hypertension.
7. Reflux esophagitis.
8. Manic depressive illness with anxiety.
9. Prostatitis.

ALLERGIES: NKDA.

MFICATIONS: As mentioned in my previous notes.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is afebrile. Vital signs stable. The patient is not in any acute distress at rest.

PATIENT: JONES, ARCHIE
CHART: ~~REDACTED~~
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 08/04/01

7/16/01

PAGE 2

HEENT: Unremarkable except for narrowed oropharynx and increased
redundant tissue noted in the oropharynx.
LUNGS: Breath sounds are much well-heard. Few scattered rhonchi heard
over the right base. Otherwise, no rales, no rhonchi.
HEART: S1, S2 heard. No murmur, no gallop.
ABDOMEN: Soft. Bowel sounds present. No organomegaly.
EXTREMITIES: No cyanosis, no clubbing, no pedal edema.

ASSESSMENT AND PLAN:

1. Chronic obstructive lung disease secondary to bronchiectasis. The patient's symptoms are currently well-controlled. The patient does not have any exacerbation of COLD. The patient is doing well on cyclic antibiotic therapy. We will continue the same medications for now. We will reevaluate in four to six months. Depending upon the resolution of his symptoms, we may discontinue the cyclic antibiotic therapy.
2. Obstructive sleep apnea. The patient is to be continued on the dental appliance for now. Sleep hygienic measures were discussed with the patient, weight reduction strategies also reinforced. The patient is to return to the clinic four months later for follow up.

Gowdhami Mohan

GOWDHAMI MOHAN, M.D.

GM/DTlakb 789.267

cc: Dr. June P. Souviron

CAROLINA PULMONARY AND SLEEP CENTER
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FOLLOW-UP VISIT

PATIENT: JONES, ARCHIE
CHART: 200405009
REFERRING PHYSICIAN: DR. JOHN F. PITCH
PRIMARY CARE PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 06/04/01

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant gentleman with multiple medical problems who has come for follow up. The patient was last seen by me on 02/15/01. The patient has had thermal injury to his respiratory system two years back and was on prolonged mechanical ventilation. He since then has developed significant respiratory problems. Currently, suffers from chronic obstructive lung disease secondary to bronchiectasis. The patient is doing relatively well for the last two to three months. Recently he had a bout of COPD exacerbation and was treated by Dr. June Souviron for this problems with increased dose of prednisone and antibiotics.

The patient has no fever, no chills, no weight loss, no loss of appetite, able to ambulate significantly better than before. Dyspnea level is more than two to three blocks. No pedal edema present. No paroxysmal nocturnal dyspnea present. Minimal cough, no significant sputum production. According to the patient, the quantity of sputum is much less than before. No hemoptysis present. Two pillow orthopnea present. No pedal edema present. Occasional episodes of paroxysmal attacks of wheezing present. No other significant complaints.

PAST MEDICAL HISTORY:

1. Chronic obstructive lung disease.
2. Bronchiectasis.
3. Status post respiratory thermal injury.
4. Obstructive sleep apnea.
5. Attention deficit disorder.
6. Hypertension.
7. Reflux esophagitis.
8. ?Manic depressive illness with anxiety.
9. Chronic prostatitis.

ALLERGIES: NKDA.

MEDICATIONS:

1. Aerosol treatment with albuterol and Atrovent four times a day.

PATIENT: JONES, ARCHIE
CHART: 8842614097
REFERRING PHYSICIAN: DR. JOHN F. PILCH
PRIMARY CARE PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 06/04/01

PAGE 2

2. Serevent 2 puffs MDI twice daily.
3. Pulmicort 2 puffs MDI b.i.d.
4. Theophylline 300 mg p.o. q. 12h.
5. Prilosec 20 mg p.o. q. 12h.
6. Colace 300 mg p.o. q. 12h.
7. Atrovent 2 puffs MDI four times a day.
8. Cardura 20 mg p.o. q. p.m.
9. Aspirin 81 mg p.o. q.d.
10. Prednisone 10 mg p.o. q.d.
11. Normal saline two sprays on both nostrils two or three times a day.
12. Dexedrine 5 mg p.o. q. a.m.
13. Depakote 375 mg q. p.m.
14. Risperdal 15 mg p.o. t.i.d.
15. Alternating Augmentin, Tequin, and Biaxin.
16. Cytotec 200 mg p.o. q.i.d.
17. Sudal 2 tablets p.o. b.i.d.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is 98.7. Pulse is 80. Respirations 18. Blood pressure is 150/80. Weight is 222 pounds. The patient is not in any acute distress at rest.

HEENT: No sinus tenderness. Ear examination normal. Narrowed oropharynx present. No lymphadenopathy. No elevated JVD.

LUNGS: Distant breath sounds present. Occasional wheezing present. No crackles, no rhonchi present.

HEART: S1, S2 heard. No murmur, no gallop.

ABDOMEN: Soft. Bowel sounds present. No organomegaly.

EXTREMITIES: No cyanosis, no clubbing, no pedal edema.

ASSESSMENT AND PLAN:

1. Chronic obstructive lung disease secondary to bronchiectasis. The patient is to be on prednisone 10 mg a day along with Pulmicort inhalers. Cyclic antibiotics has helped tremendously to improve his symptoms. Hence, we will continue the same for the next four months. We will stop these antibiotics on a trial basis later and see his clinical response.

PATIENT: JONES, ARCHIE
CHART: 2107/05 7732
REFERRING PHYSICIAN: DR. JOHN F. PILCH
PRIMARY CARE PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 06/04/01

PAGE 3

2. Obstructive sleep apnea. The patient is to be continued on the dental appliance he has. The patient is able to sleep much better, wakes up feeling fresh and energetic, does not have any daytime sleepiness problem.
3. Sinusitis of chronic nature -- currently well controlled with normal saline nasal spray alone. The patient is to return to the clinic four to six months later for follow up.


GOWDHAMI MOHAN, M.D.

GM/DTlakb 789.201

cc: Dr. June P. Souviron
cc: Dr. John F. Pilch

9/28/01

**CAROLINA PULMONARY AND SLEEP CENTER
605 EAST GREENVILLE STREET
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(864) 231-7004**

FOLLOW UP VISIT

PATIENT: Jones, Archie
CHART #: ~~25075549~~
REFERRING PHYSICIAN: Dr. Souviron
DATE: 09/14/01

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant middle aged white gentleman with multiple medical problems. He is here for follow up. Patient is currently seen by me for obstructive sleep apnea, bronchiectasis secondary to thermal lung injury along with resultant chronic obstructive lung disease.

Patient is currently on CPAP treatment and tolerating it well. He uses it for at least eight hours without any problem. He could not wear the mask and was placed on dental devices. Patient's daytime sleepiness problem was much improved after being on the orthodontic device. He did require a Reglan to keep him alert throughout the daytime. Patient states that 5 mg of Reglan twice a day is not helping him to a significant degree. (Patient does admit that it has helped to some extent.)

He complains of increasing shortness of breath on exertion. He has increased cough and sputum production present for the last two to three weeks. Patient has been taking cyclic antibiotic therapy as prescribed. Patient is currently having no fever. He has occasional episodes of chills noted within the last two to three weeks. He has no other significant problems.

PAST MEDICAL HISTORY: As mentioned above.

MEDICATIONS: See my previous noted.

ALLERGIES: No known drug allergies.

PHYSICAL EXAMINATION:

VITAL SIGNS:	Temperature was 98.6. Pulse is 80. Respirations are 18. Blood pressure 110/80. Weight is 226 pounds. Patient is not in any acute distress at rest.
HEENT:	Unremarkable except for mild narrowing of the oropharynx.
LUNGS:	Distant breath sounds present. Wheezing heard over both the bases. No bronchial breathing present.
HEART:	S1, S2 heard. No murmur or gallop.
ABDOMEN:	Soft with bowel sounds present. No organomegaly.

Jones, Archie

Chart #: 250/05149

9/14/01

page 2

EXTREMITIES: No cyanosis, clubbing or pedal edema.

ASSESSMENT AND PLAN:

1. COPD, mild exacerbation. Mr. Archie Jones has chronic obstructive lung disease secondary to bronchiectasis. He has an exacerbation of his dyspnea secondary to an upper respiratory tract infection. We will start the patient on doxycycline for ten days. Patient is also to take frequent bronchodilator treatments, especially with the Zovirax q.4.h. The patient has been on prednisone for a long period of time, currently on 10 mg of prednisone. We will increase the prednisone dose to 15 mg a day. Patient is to be continued on cyclic antibiotic therapy also.
2. Sleep apnea. Patient is to be continued on the dental appliance every night. Reglan dose will be increased to 10 mg in the morning and 5 mg in the evening. Patient is to return to the clinic in three to four months for follow up.


GOWDHAMI MOHAN, M.D.

cc: Dr. Souviron
Sleep Lab

GM/sps-189/JOB:0333

1/24/4

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FOLLOW-UP VISIT

PATIENT: JONES, ARCHIE
CHART: 268763049
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 01/11/02

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant middle-aged white gentleman with multiple medical problems who is here for follow-up. The patient has been on several medications for his COLD secondary to bronchiectasis and asthma. The patient has recently tapered himself off of prednisone. Since then, his problems have worsened. He had to be placed on a higher dose of prednisone treatment because of worsening of his clinical symptoms. The patient had extreme difficulty to breathe. Increased cough and sputum production was also present. Mr. Jones also has been having significant psychiatric problems lately and is being closely followed by Dr. Robert Richards. Currently, he is using nebulizer treatment three to four times a day.

No fever, no chills, no weight loss, no loss of appetite. Two-pillow orthopnea present. No chest pain, no palpitations, no dizziness, no pedal edema, no other significant problems.

PAST MEDICAL HISTORY: As mentioned above.

ALLERGIES: NKDA.

MEDICATIONS:

1. He is on Aerosol treatment with albuterol and Atrovent three to four times a day.
2. Atrovent 2 puffs MDI q.i.d. p.r.n.
3. Combivent inhalers 2 puffs MDI q.i.d.
4. Pulmicort 2 puffs MDI q.12h.
5. Serevent 2 puffs MDI q.12h.
6. Singulair 10 mg p.o. q.d.
7. Theophylline 300 mg p.o. q.12h.
8. Humibid LA one tablet p.o. q.12h.
9. Cyclic antibiotic therapy with Augmentin, Levaquin, and Bactrim.
10. Risperdal 25 mg p.o. q.12h.
11. Plavix 75 mg p.o. q.d.
12. Dexedrine 5 mg p.o. b.i.d.

1124

PATIENT: JONES, ARCHIE
CHART: 050725103
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 01/11/02

PAGE 2

13. Zolof 50 mg p.o. q.d.
14. Colace 100 mg p.o. t.i.d.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is 99.4. Pulse is 82. Blood pressure is 140/90.
Weight is 243 pounds. O2 saturation on room air is 97 percent.
HEENT: No sinus tenderness. Ear examination is normal. Throat clear.
Narrowed oropharynx present.
LUNGS: Distant breath sounds present. Scattered rhonchi heard bilaterally.
HEART: S1, S2 heard. No murmur, no gallop.
EXTREMITIES: No cyanosis, mild clubbing, no pedal edema.

ASSESSMENT AND PLAN:

1. Sleep-related breathing disorder, currently on CPAP treatment. The patient is to be continued on the same amount of the CPAP pressure, tolerating it fairly well. He does not have any significant evidence of daytime sleepiness problem for the most part.
2. COLD secondary to bronchiectasis and asthma. The patient is to be continued on Pulmicort and nebulizer treatments. The patient is currently on 30 mg of prednisone a day. We will add Foradil one tablet p.o. q. 12h. The patient is to take 20 mg prednisone a day for 15 days and then reduce it to 10 mg a day. Singulair is also to be continued. The patient is to stop Serevent Inhalers. Combivent inhalers are to be taken on a p.r.n. basis. Detailed instructions for all these medications were given to the patient. The goal is to taper the prednisone to 10 mg a day and to maximize other medications. The patient is to return to the clinic four months later for follow up.



GOWDHAMI MOHAN, M.D.

GM/DTIakb 789.331

cc: Dr. June P. Souviron
Anderson Neurological Associates
Dr. Robert W. Richards, Jr.

3/20/02

CAROLINA PULMONARY AND SLEEP CENTER
805 EAST GREENVILLE STREET
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(864) 231-7004

FOLLOW-UP VISIT

PATIENT: JONES, ARCHIE
CHART: 288065889
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 03/12/02

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant middle-aged white gentleman with multiple medical problems, last seen by me on 01/12/02 who is here for follow-up. The patient recently had complaints of increasing cough, sputum production, etc. and was treated with antibiotics along with pulse dose steroids by Dr. Souviron. He was on a higher dose of prednisone before. Currently, he is on 15 mg of prednisone a day. The patient is compliant with all his medications. His dyspnea level is more than two to three blocks. He has no fever, no chills present. Occasionally he has nocturnal attacks of wheezing present. Cough is present, no significant sputum production present. The patient has no hemoptysis present.

No fever, no chills, no weight loss, no loss of appetite. He uses the CPAP machine regularly. He uses it for at least eight hours without any problem. He wakes up feeling fresh and more energetic. He does not have any daytime sleepiness problem. No pedal edema present, no PND present, no nausea, no vomiting, no altered bowel habits, no other significant problems. The patient's psychological status also seems to be stable.

PAST MEDICAL HISTORY:

1. Status post thermal lung injury.
2. Bronchiectasis.
3. COLD.
4. Obstructive sleep apnea.
5. Attention deficit disorder.
6. Hypertension.
7. Reflux esophagitis.
8. Manic depressive illness with anxiety.
9. History of prostatitis.

ALLERGIES: NKDA.

MEDICATIONS: As mentioned in my previous notes. He is taking prednisone at 15 mg a day.

3/20

PATIENT: JONES, ARCHIE
CHART: 250705108
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 03/12/02

PAGE 2

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is 98. Pulse is 100. Respirations 18. Blood pressure is 120/84. Weight is 245 pounds. O2 saturation on room air is 97 percent.

HEENT: No sinus tenderness. Ear examination is normal. Throat clear. No lymphadenopathy. No elevated JVD. Carotid upstroke present.

LUNGS: Distant breath sounds present. No rales, no rhonchi present.

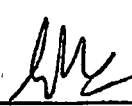
HEART: S1, S2 heard. No murmur, no gallop.

ABDOMEN: Soft. Bowel sounds present. No organomegaly.

EXTREMITIES: No cyanosis, no clubbing, no pedal edema.

ASSESSMENT AND PLAN:

1. Sleep-related breathing disorder. The patient is tolerating the CPAP treatment very well. We will continue the patient on the same amount of the CPAP pressure. Sleep hygienic measures were discussed with the patient, weight reduction strategies also reinforced.
2. COLD secondary to bronchiectasis and asthma. The patient is to be continued on prednisone 15 mg a day. Aerosol treatments are also to be continued. Pulmicort and Serevent are to be continued as prescribed. The patient is taking Singulair on a regular basis.
3. Bronchiectasis. The patient is to be continued on cyclic antibiotic therapy as prescribed before. This seems to be significantly helping him to reduce his airway flare-up. The patient is to return to the clinic three to four months later for follow up.


GOWDHAMI MOHAN, M.D.

GM/DT/akb 789.657

cc: Dr. June P. Souviron
Dr. Robert W. Richards, Jr.
Anderson Neurological Associates

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FOLLOW-UP VISIT

PATIENT: JONES, ARCHIE #715.14
CHART: ~~6270510~~
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 06/25/02

HISTORY OF PRESENT ILLNESS: This is a pleasant 58-year-old white male with a history of thermal lung injury and subsequent bronchiectasis. The patient is here today complaining of an increase in secretions and dry mouth. The patient began Levaquin on 06/10 under the direction of Dr. Souviron and for the past two days he has been on 15 mg of prednisone. He states that he made this appointment before he began to feel better and before he went on the prednisone. Since he went on the steroids, his secretions have decreased considerably and he finds that his shortness of breath has also diminished. He has been using his nebulizers twice a day and only uses his inhalers on a p.r.n. basis when he cannot get his nebulizers. He is always using his Singulair and theophylline, however. At the beginning of over month, he will begin either Augmentin, Biaxin, or Tequin on a rotational basis. The patient admits to occasional headache, no visual disturbance, no epistaxis or hemoptysis, no nausea, vomiting, diarrhea, or constipation, no PND, night sweats, changes in appetite or unusual weight change.

PAST MEDICAL HISTORY:

1. Status post thermal lung injury.
2. Bronchiectasis.
3. COLD.
4. Obstructive sleep apnea.
5. ADD.
6. Hypertension.
7. Reflux esophagitis.
8. Manic depressive illness with anxiety.
9. History of prostatitis.

ALLERGIES: NKDA.**MEDICATIONS:**

1. Albuterol inhaler p.r.n.
2. Atrovent inhaler p.r.n.

PATIENT: JONES, ARCHIE #715.14
CHART: [REDACTED]
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 06/25/02

PAGE 2

3. Combivent inhaler p.r.n.
4. Nebulized Xopenex and Atrovent nebulizers b.i.d.
5. Serevent p.r.n.
6. Pulmicort p.r.n.
7. Singulair 10 mg one tablet p.o. q.a.m.
8. Theophylline 300 mg p.o. b.i.d.
9. Biaxin 500 mg one tablet p.o. q.d. every third month.
10. Prednisone 15 mg one tablet p.o. q.d. p.r.n.
11. Saline spray two to four sprays each nostril q.d.
12. Prevacid 30 mg p.o. q.d.
13. Sudal DM two sprays b.i.d.
14. Flomax 8 mg one tablet p.o. q.d.
15. Risperdal 0.25 mg b.i.d. and 0.5 mg p.o. q.p.m.
16. Depakote 375 mg one tablet p.o. q.p.m.
17. Plavix 75 mg p.o. q.d.
18. Dexedrine 5 mg q.a.m. and 5 mg q.p.m.
19. Zoloft 50 mg p.o. q.a.m.
20. Colace 300 mg p.o. b.i.d.
21. Tequin 400 mg p.o. q.d. every third month.
22. Augmentin 875 mg p.o. q.d. every third month.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is 98.7. Pulse is 96. Blood pressure is 140/78.
Weight is 221 pounds. O2 saturation is 97 percent on room air.
The patient is in no acute distress on room air.

HEENT: No frontal or maxillary sinus tenderness. Ear examination is normal. Throat is without erythema or exudate. No lymphadenopathy, JVD, or carotid bruits.

LUNGS: Distant breath sounds. There are some expiratory wheezes and *fine crackles noted on the right.* There is no egophony or unusual tactile fremitus or whispered soliloquy.

ABDOMEN: Soft. Bowel sounds x 4. It is nontender, nondistended. No organomegaly.

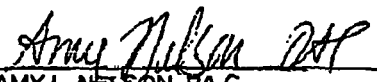
EXTREMITIES: Show no clubbing, cyanosis, or edema.

PATIENT: JONES, ARCHIE #715.14
CHART: [REDACTED]
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 06/25/02

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ASSESSMENT AND PLAN:

1. Sleep-related breathing disorder. The patient is tolerating the CPAP treatment well. We will continue on the same amount of pressure. Sleep hygienic measures and weight reduction strategies were reinforced with this patient.
2. COLD secondary to bronchiectasis and asthma. The patient will continue on his prednisone 15 mg a day for his current exacerbation. I also recommended an increase in his aerosolized treatments to four to six times per day. The patient is also encouraged to take his Pulmicort and Serevent as prescribed and not on a p.r.n. basis. He also should continue with his theophylline and Singulair.
3. Bronchiectasis. The patient is currently not showing any signs of acute infection such as fevers, nausea, vomiting. Therefore, I recommended the patient not to take his antibiotics unless absolutely necessary and he should continue on his cyclic antibiotic therapy as prescribed. The patient is to return to the clinic at his regularly scheduled appointment, which I believe is in two months.


AMY L. NELSON, PA-C


GOWDHAM MOHAN, M.D.

cc: Dr. June P. Souviron
Dr. Robert W. Richards, Jr. ✓
Anderson Neurological Associates ✓

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(864) 231-7004

FOLLOW-UP VISIT

PATIENT: JONES, ARCHIE #789.131
CHART: 259703149
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 07/11/02

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant 58-year-old gentleman with a history of thermal lung injury and subsequent bronchiectasis who is here for follow-up. The patient has chronic obstructive lung disease secondary to this. He has complaints of dry secretions at night. He wears the oral appliance for his sleep apnea. He does not wear the CPAP machine. The patient recently got a course of antibiotics with Levaquin and is doing extremely well.

The patient has been on cyclic antibiotics, which has been given for the last six months. His symptoms of dyspnea are stable. On a good day he could walk more than one mile at a slow pace without any problem. During exacerbations he has extreme difficulty to breathe even for less than half-a-block. The patient has no fever, no chills present. He has lost about 20-30 pounds within the last few months. No loss of appetite present, he is losing weight intentionally. The patient is compliant with all his medications. No other significant problems.

PAST MEDICAL HISTORY: See my previous notes.

ALLERGIES: NKDA.

MEDICATIONS:

1. Albuterol and Atrovent on a p.r.n. basis.
2. Xopenex nebulizer treatment b.i.d.
3. Atrovent nebulizer treatment b.i.d.
4. Serevent ? p.r.n.
5. Prevacid 30 mg p.o. q.d.
6. Sudal DM two tablets p.o. b.i.d.
7. Flomax 8 mg p.o. q.d.
8. Risperdal 0.25 mg p.o. b.i.d. and 0.5 mg q.h.s.
9. Depakote 375 mg p.o. q.a.m.
10. Plavix 75 mg p.o. q.d.
11. Dexedrine 5 mg p.o. q.a.m. and 5 mg q.p.m.
12. Zolof 50 mg p.o. q.a.m.
13. Colace 100 mg p.o. b.i.d.

PATIENT: JONES, ARCHIE #789.131
CHART: [REDACTED]
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 07/11/02

PAGE 2

14. Cyclic antibiotics with Tequin, Augmentin, and Blaxin.
15. Humibid 1200 mg p.o. b.i.d.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is 98.6. Pulse is 80. Respirations 18. Blood pressure is 150/92. Weight is 218 pounds. The patient is not in any acute distress at rest.

HEENT: Unremarkable except for narrowing of the oropharynx.

LUNGS: Distant breath sounds present. Few scattered rales heard over both the lung fields.

HEART: S1, S2 heard. No murmur, no gallop.

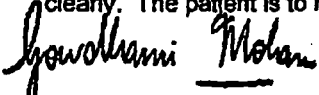
ABDOMEN: Soft. Bowel sounds present. No organomegaly.

EXTREMITIES: No cyanosis, mild clubbing, no pedal edema.

NEUROLOGICAL: No focal neurological deficit present.

ASSESSMENT AND PLAN:

1. COLD secondary to bronchiectasis secondary to thermal lung injury. Mr. Archie Jones is a pleasant 58-year-old gentleman with a history of chronic obstructive lung disease who has come in here for follow-up. The patient is currently on 20 mg of prednisone a day. He is to taper it down to his baseline 15 mg of prednisone a day within the next couple of weeks. He recently had an exacerbation of his respiratory complaints, during which time he increased the dose. The patient is to use nebulizer treatments q.4h. and then p.r.n. Pulmicort is also to be continued.
2. Sleep apnea. The patient is to be continued on oral dental appliance as prescribed.
3. Bronchiectasis. The patient was receiving cyclic antibiotics to prevent exacerbation of his obstructive airways disease. The patient did receive antibiotic courses for breakthrough bronchitis. We will stop the antibiotics on a trial basis and follow the clinical response. This was explained to the patient clearly. The patient is to return to the clinic four to five months later for follow-up.


GOWDHAMI MOHAN, M.D.

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FOLLOW-UP VISIT

PATIENT: JONES, ARCHIE #715.256
CHART: 2507405-13
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 11/07/02

HISTORY OF PRESENT ILLNESS: This is a gentleman with a history of thermal lung injury and subsequent bronchiectasis who is here for complaints of sputum production, wheezing, and shortness of breath x 1 week. He was doing some automobile restoration in an enclosed area with a kerosene heater running last week. Since that time he has complained of sputum production that had begun a kind of blackish color and it is now green. It is increasing in amount becoming copious and thick. He also has increased in cough. He has on his own increased his prednisone from 10 mg to 20 over the last week without a lot of relief of his cough or sputum production. He is still nebulizing three to four times a day as well as using his inhalers as directed. He denies any fever, chills, no nausea, or vomiting, no sinus pain or pressure, no hemoptysis or epistaxis, but fears he may delay too long and resulting in a serious lung infection. He still has dyspnea for less than half-a-block. He denies any changes in weight, loss of appetite, or chest pain at this time.

PAST MEDICAL HISTORY:

1. Status post lung injury.
2. Bronchiectasis.
3. COLD.
4. Obstructive sleep apnea.
5. ADD.
6. Hypertension.
7. Reflux esophagitis.
8. Manic depressive illness with anxiety.
9. History of prostatitis.

ALLERGIES: NKDA.

MEDICATIONS:

1. Albuterol and Atrovent Inhalers p.r.n.
2. Xopenex and Atovent nebulized treatments b.i.d.
3. Serevent 2 puffs b.i.d. q.12h.
4. Prevacid 30 mg p.o. q.d.

PATIENT: JONES, ARCHIE #715.256
CHART: [REDACTED]
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 11/07/02

PAGE 2

5. Sudal DM two tablets b.i.d.
6. Flomax 8 mg p.o. q.d.
7. Risperdal 0.25 mg p.o. b.i.d. and 0.5 mg q.h.s.
8. Depakote 375 mg p.o. q.a.m.
9. Plavix 75 mg p.o. q.d.
10. Dexedrine 5 mg p.o. q.a.m. and 5 mg q.p.m.
11. Zoloft 50 mg p.o. q.a.m.
12. Colace 100 mg b.i.d.
13. Celebrex 200 mg p.o. q.a.m.
14. Humibid 1200 mg p.o. b.i.d.
15. Actonel 35 mg q.week.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is 36.9. Pulse is 80. Blood pressure is 148/88. Weight is 226. O2 saturation is 97 percent on room air. The patient is in no acute distress.

HEENT: Unremarkable except for narrowed oropharynx. No frontal or maxillary sinus tenderness. Ears are clear. Nose is without mucus or erythema. Throat is somewhat erythematous without any exudate.

LUNGS: Distant breath sounds. Few scattered rales over the lung fields.

HEART: Regular rate and rhythm with no murmurs or bruits.

ABDOMEN: Soft. Bowel sounds x 4. It is nontender, nondistended. No organomegaly.

ASSESSMENT AND PLAN:

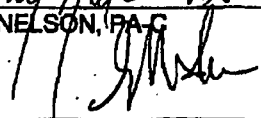
1. COLD secondary to bronchiectasis and thermal lung injury. Mr. Jones is a pleasant 59-year-old male with a history of COLD who is here for a follow-up. He is currently on 20 mg of prednisone for the last week. We will continue this over the next several days and then ask him to subsequently taper off when begins to feel better. I also instructed him to continue his nebulizer treatments every four hours and then p.r.n. when he is doing better. He can also continue his nebulizers as directed.
2. Sleep apnea. The patient is to continue on oral dental appliance as prescribed for treatment of his sleep apnea. This seems to be helping him and he tolerates it well.

PATIENT: JONES, ARCHIE #715.256
CHART: 250705114
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 11/07/02

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3. Bronchiectasis. The patient is currently not on any antibiotics since July. He has done well up until this time. Prescription for Biaxin 500 mg b.i.d. x 10 days is given to the patient. I instructed him to fill the prescription if by tomorrow he is not feeling better or if symptoms had not remitted. I instructed him to look for increased copious amounts of productive sputum, increased cough, fever, chills, or increase in shortness of breath and wheezing. He is to follow up with us at his regular appointment and fill prescription as necessary.


AMY L. NELSON, PA-C


GOWDHAMI MOHAN, M.D.

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~~Dr. Richard Roberts~~
Dr. Robert Richards ✓

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FOLLOW-UP VISIT

PATIENT: JONES, ARCHIE #789.905
CHART: ~~2003-02~~
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 12/12/02

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant middle-aged white gentleman with multiple medical problems who is here for follow-up. The patient has multiple medical problems including COLD secondary to bronchiectasis and asthma. The patient is on chronic prednisone therapy. He had tapered himself off of prednisone in the past, but without much success. The patient is, overall, doing very well. Recently he had left rib fracture and had pleuritic chest pain associated with it, which caused him difficulty to breathe. The patient is taking all his medications regularly. His dyspnea level is about two to three blocks. Sometimes his dyspnea is much improved and he is able to exercise more than a mile. He is not having any frequent COPD exacerbations like in the past.

No fever, no chills, no loss of weight, no loss of appetite. He continues to have symptoms of reflux esophagitis for which he takes Prevacid. The patient is wearing the CPAP treatment regularly. He uses it for at least seven or eight hours. He does not have any trouble in tolerating the pressure. Occasionally he has sinus congestion present. He wakes up feeling fresh and more energetic. He does not feel sleepy during the daytime.

No fever, no chills, no weight loss, no loss of appetite. He takes his Dexedrine regularly in order to keep himself awake. No other significant problems.

PAST MEDICAL HISTORY: As mentioned in my previous notes.

ALLERGIES: NKDA.

MEDICATIONS:

1. Humibid one tablet p.o. q.12h.
2. Celebrex 200 mg p.o. q.d.
3. Colace 300 mg p.o. b.i.d.
4. Zolof 50 mg p.o. q.d.
5. Dexedrine 5 mg p.o. q.12h.
6. Plavix 75 mg p.o. q.d.

PATIENT: JONES, ARCHIE #789.805
CHART: [REDACTED]
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 12/12/02

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7. Depakote 375 mg p.o. q.d.
8. Risperdal 0.25 mg p.o. b.i.d.
9. Flomax 8 mg p.o. q.d.
10. Sudal DM two tablets p.o. b.i.d.
11. Prevacid 30 mg p.o. q.d.
12. Nasal saline spray.
13. Prednisone therapy 20 mg p.o. q.d.
14. Theophylline 300 mg p.o. b.i.d.
15. Singulair 10 mg p.o. q.d.
16. Aerosol treatments with Atrovent and Xopenex.
17. Combivent Inhalers 2 puffs MDI b.i.d.
18. Atrovent 2 puffs MDI q.6h.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is 97.6. Pulse is 88. Respirations 18. Blood pressure is 138/36. The patient is not in any acute distress at rest.

HEENT: No sinus tenderness. Ear examination is normal. Throat clear. Narrowed oropharynx present.

LUNGS: Distant breath sounds present. Occasional wheezing heard during expiration. Few rhonchi present.

HEART: S1, S2 heard. No murmur, no gallop.

ABDOMEN: Soft. Bowel sounds present. No organomegaly.

EXTREMITIES: No cyanosis, no clubbing, no pedal edema.

ASSESSMENT AND PLAN:

1. Sleep apnea. The patient is tolerating the CPAP treatment very well. Currently, he is taking Dexedrine to keep himself fully awake. Sleep hygienic measures and weight reduction strategies were discussed with the patient.
2. Bronchiectasis. The patient is stable. He is able to bring out his secretions adequately with the current medications. The patient is not on cyclic antibiotic therapy. He has not had any COPD exacerbations. He is doing significantly well.

PATIENT: JONES, ARCHIE #789.905
CHART: [REDACTED]
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 12/12/02

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3. Obstructive airways disease. The patient is to be continued on aerosol treatments with albuterol and Xopenex. Combivent is to be used on a p.r.n. basis along with steroid inhalers. I have asked the patient to use Pulmicort 2 puffs everyday.



GOWDHAMI MOHAN, M.D.

cc: Dr. June P. Souviron ✓
Dr. David T. Wortham ✓
Dr. Michael D. Hellstrom ✓

CAROLINA PULMONARY AND SLEEP CENTER

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FOLLOW-UP VISIT

PATIENT: JONES, ARCHIE #715.382

CHART: [REDACTED]

REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON

DATE: 01/30/03

HISTORY OF PRESENT ILLNESS: This is a pleasant 59-year-old white male with multiple medical problems seen by us for COLD secondary to bronchiectasis and asthma. The patient is on chronic prednisone therapy at 20 mg. He is overall doing well. At this point, he complains of three weeks of shortness of breath, a productive yellow cough, and an increase in his nebulizer use. His dyspnea level is about two blocks. He also states that he has had an increase in weight gain, his heaviest since his last visit was 25 pounds. He denies any headache or visual disturbance, no rhinorrhea or epistaxis, no hemoptysis, a yellow productive cough, some wheezing, no PND, no chest pain or palpitations, no nausea, vomiting, diarrhea or constipation, no fever, no chills, no night sweats, orthopnea, edema, no unaccounted for changes in weight, or loss of appetite. He states that he is taking all his medications as prescribed.

PAST MEDICAL HISTORY:

1. Status post lung injury.
2. Bronchiectasis.
3. COLD.
4. Obstructive sleep apnea.
5. ADD.
6. Hypertension.
7. Reflux esophagitis.
8. Manic depression with anxiety.
9. History of prostatitis.

ALLERGIES: NKDA.

MEDICATIONS:

1. Humibid one tablet p.o. q. 12h.
2. Celebrex 200 mg p.o. q.d.
3. Colace 200 mg b.i.d.
4. Zolof 50 mg p.o. q.d.
5. Dexedrine 5 mg q. 12h.

PATIENT: JONES, ARCHIE #715.382
CHART: [REDACTED]
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 01/30/03

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6. Plavix 75 mg p.o. q.d.
7. Depakote 375 mg p.o. q.d.
8. Risperdal 0.25 mg p.o. b.i.d.
9. Flomax 8 mg p.o. q.d.
10. Sudal DM two tablets p.o. b.i.d.
11. Prevacid 30 mg p.o. q.d.
12. Nasal saline spray p.r.n.
13. Prednisone therapy 20 mg p.o. q.d.
14. Theophylline 300 mg p.o. b.i.d.
15. Singulair 10 mg p.o. q.d.
16. Aerosolized treatments with Atrovent and Xopenex q.i.d.
17. Combivent Inhalers 2 puffs b.i.d.
18. Atrovent 2 puffs MDI q.6h. p.r.n.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is 98.3. Pulse is 86. Blood pressure is 130/88.
Weight is 240 pounds. O2 saturation is 97 percent on room air.
The patient is in no acute distress in the office.

HEENT: No frontal or maxillary sinus tenderness. Ear examination is normal. Throat is clear. Narrowed oropharynx is present. No lymphadenopathy, JVD, or carotid bruits.

LUNGS: Distant breath sounds. Expiratory wheezing noted throughout all lung fields. No rales or rhonchi. No egophony or consolidation
on percussory

HEART: Regular rate and rhythm with no murmurs or bruits.

ABDOMEN: Soft. Bowel sounds x 4. It is nontender, nondistended. No organomegaly.

EXTREMITIES: No clubbing, cyanosis, or edema.

ASSESSMENT AND PLAN:

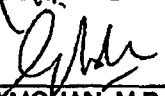
1. Sleep apnea. The patient is currently tolerating the CPAP treatment well and taking his Dexedrine. Sleep hygienic measures and weight reduction strategies were discussed with this patient.

PATIENT: JONES, ARCHIE #715.382
CHART: 257-12519
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 01/30/03

PAGE 3

2. COPD exacerbation. The patient's wheezing and productive cough x 3 weeks 4:30 382 bacterial upper respiratory infection. I recommend that he increase his nebulizer use to four times a day. He is given prescription for Tequin 40 mg one tablet p.o. q.7days. He is to follow up with us or Dr. Souviron during that period if he is not feeling better or if his symptoms have worsened. He can continue taking his prednisone therapy as well as his nebulized medications or inhalers as necessary. Follow up with us at his regular scheduled visit.


AMY L. NELSON, PA-C


GOWDHAMI MOHAN, M.D.

cc: ✓ Dr. June P. Souviron
✓ Dr. David T. Wortham
✓ Dr. Michael D. Hellstrom

faxed 

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FOLLOW-UP VISIT

PATIENT: JONES, ARCHIE #789.482
CHART: 2307031
PRIMARY CARE PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 04/11/03

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant 59-year-old Caucasian gentleman with multiple medical problems who is here for follow-up on his pulmonary and sleep complaints. The patient has chronic obstructive pulmonary disease secondary to bronchiectasis secondary to significant thermal lung injury. The patient also has sleep apnea and is currently on nocturnal dental device. The patient has some daytime sleepiness problem occasionally, but is doing most of the time very well. He takes his Dexedrine also regularly. His dyspnea level is unchanged. He continues to have some sputum production. No hemoptysis present. Occasional cough is present during the nighttime. No pedal edema present. No PND present. He takes all his medications regularly. No other significant complaints.

PAST MEDICAL HISTORY: See my previous notes.

ALLERGIES: NKDA.

MEDICATIONS: See my previous notes.

PHYSICAL EXAMINATION:

VITAL SIGNS:	Temperature is 97.4. Pulse is 80. Blood pressure is 140/98. Weight is 238 pounds. O2 saturation on room air is 96 percent.
HEENT:	Unremarkable except for narrowed oropharynx.
LUNGS:	Distant breath sounds present. Few rhonchi. Otherwise, clear. No rales.
HEART:	S1, S2 heard. No murmur, no gallop.
ABDOMEN:	Soft. Bowel sounds present. No organomegaly.
EXTREMITIES:	No cyanosis, mild clubbing, no pedal edema.

PATIENT: JONES, ARCHIE #789.482
CHART: 250745119
PRIMARY CARE PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 04/11/03

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ASSESSMENT AND PLAN:

1. Sleep apnea. The patient is using dental appliance regularly. He is taking Dexedrine also on a regular basis. This is keeping him fully awake during the daytime. He does not have any snoring or nocturnal awakenings at night. Sleep hygienic measures and weight reduction strategies were discussed with the patient.
2. COPD with asthma component. The patient is symptomatically feeling much better. The patient is to be continued on the bronchodilators along with the steroid inhalers. He is using nebulizer treatments at least four times a day. He has a dyspnea level of more than two or three blocks. No other significant problems.
3. Bronchiectasis. The patient is to be continued on Humibid. Mucomyst is discontinued. The patient is currently not on any cyclic antibiotics and is doing well without any increase in frequency of exacerbation of his symptoms. The patient is to return to the clinic four to five months later for follow-up.


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cc: Dr. June P. Souviron
Dr. Robert W. Richards, Jr.

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FOLLOW-UP VISIT

PATIENT: JONES, ARCHIE #901.46
CHART: [REDACTED]
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 09/11/03

HISTORY OF PRESENT ILLNESS: This is a pleasant 60-year-old white male with a history of multiple medical problems seen in this office for COLD secondary to bronchiectasis and asthma. He is on multiple pulmonary medications including nebulizer treatment and chronic prednisone therapy. He complains now of three weeks of fatigue. He has had a decreased amount of motivation since he is no longer working with his nephews on the garage workshop. His mother also died recently, but he denies any symptoms of depressed mood secondary to grief. He does have a cough productive of clear sputum, but does seem to be at his regular baseline so far as exercise tolerance and dyspnea go. He is able to walk about two blocks before significant dyspnea. He would like to change back to Serevent Inhaler from the Serevent Diskus as he felt like his symptoms did better on that form.

There is no fever or chills, no headache or visual disturbance, no nasal congestion or drainage, no hemoptysis, PND or chest pain, no nausea, vomiting or diarrhea, no significant weight change or loss of appetite.

PAST MEDICAL HISTORY:

1. Status post lung injury.
2. Bronchiectasis.
3. COLD.
4. Obstructive sleep apnea.
5. ADD.
6. Hypertension.
7. Reflux esophagitis.
8. Manic depression with anxiety.
9. History of prostatitis.

ALLERGIES: NKDA.

MEDICATIONS:

1. Xopenex and Atrovent nebulizer treatments two to four times a day.
2. Combivent 2 puffs two to four times a day.

PATIENT: JONES, ARCHIE #901.46
CHART: 250705-22
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 09/11/03

PAGE 2

3. Serevent 1 puff b.i.d.
4. Pulmicort 2 puffs b.i.d.
5. Singulair 10 mg q.d.
6. Theophylline 300 mg b.i.d.
7. Humibid 600 mg b.i.d.
8. Prednisone 30 mg q.d.
9. Prevacid 30 mg b.i.d.
10. Sudal DM two pills b.i.d.
11. Flomax 4 mg p.r.n.
12. Risperdal 0.25 mg b.i.d.
13. Depakote 100 mg q.h.s.
14. Plavix 75 mg q.d.
15. Dexedrine 10 mg q.a.m.
16. Zolof 75 mg q.d.
17. Actonel 35 mg per week.
18. Celebrex 200 mg q.d.
19. Regranex.
20. Lamisil 250 mg p.r.n.
21. Colace 300 mg b.i.d.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is 98.6. Pulse is 72 and regular. Respirations are 18 and nonlabored with an O2 saturation of 88 percent on room air. Blood pressure is 140/88. ^{78/2c}

HEENT: Left TM is clear. Right TM is retracted. Nasal mucosa is pink and moist. Oropharynx is clear without any drainage or exudates present. Neck is supple without lymphadenopathy, JVD, or carotid bruits.

LUNGS: Distant breath sounds and clear bilaterally.

HEART: Audible S1, S2 heard with no murmurs.

ABDOMEN: Nondistended with normal bowel sounds, soft, and nontender.

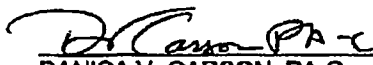
EXTREMITIES: With no clubbing at the fingernails. Feet are obscured by support stockings with 1+ pedal edema bilaterally.

PATIENT: JONES, ARCHIE #901.46
CHART: [REDACTED]
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 09/11/03

PAGE 3

ASSESSMENT AND PLAN:

1. COPD with asthma component. The patient is fairly stable at his baseline today. He is to continue on his Xopenex and Atrovent nebulizer treatments. He is only using these three times a day, although Dr. Mohan had requested that he increase them to four times a day at his last visit in April. I, again, today asked him to increase this to four times a day. We will also keep him on his current inhaled steroids of Serevent and Pulmicort as well as the Singulair, theophylline, and Humibid. His prednisone is currently at ~~40~~³⁰ mg a day, but he has been able to decrease it to 15 mg in the past. He should try tapering this back to 15 mg per day if his symptoms permit. We will see him back in four months for a recheck.


DANICA V. CARSON, PA-C


GOWDHAMI MOHAN, M.D.

cc: Dr. June P. Souviron ✓
Dr. Robert W. Richards, Jr. ✓

CAROLINA PULMONARY AND SLEEP CENTER
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(864) 231-7004

FOLLOW-UP VISIT

PATIENT: JONES, ARCHIE #901.62
CHART: 240111-19
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 09/30/03

HISTORY OF PRESENT ILLNESS: This is a pleasant 60-year-old white male with a history of pulmonary and sleep disorders who presents today complaining of "feeling very bad." His complaints include a cough productive of yellow green sputum, feeling bad, and his right ear popping. He has a mild sore throat, but denies nasal congestion or drainage. He has not noted any fever, chills, rash, headaches, nausea, vomiting, or diarrhea.

PAST MEDICAL HISTORY:

1. Status post lung injury.
2. Bronchiectasis.
3. COLD.
4. Obstructive sleep apnea.
5. ADD.
6. Hypertension.
7. Reflux esophagitis.
8. Manic depression with anxiety.
9. History of prostatitis.

ALLERGIES: NKDA.

MEDICATIONS: See previous dictation.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is 98.6. Pulse is 100 and regular. Respirations are 18 and nonlabored with an O2 saturation of 97 percent on room air. Blood pressure is 132/98. Weight is 235 pounds with a height of 5 feet and 10 inches.

HEENT: Sinuses are nontender to percussion. Left TM is somewhat dull and right TM is injected dull. Nasal mucosa is dark pink and moist with mild edema. Oropharynx is clear without exudates present. Neck is supple without lymphadenopathy.

LUNGS: With faint expiratory wheezes.

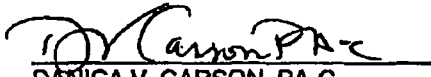
PATIENT: JONES, ARCHIE #901.62
CHART: [REDACTED]
REFERRING PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 09/30/03

PAGE 2

HEART: Regular rate and rhythm. No murmurs or gallops noted.
ABDOMEN: Normal bowel sounds. Soft and nontender.
EXTREMITIES: There is 1+ pedal edema bilaterally with support stockings worn.

ASSESSMENT AND PLAN:

1. COPD with asthma component. The patient does seem to be having some exacerbations starting secondary to an acute otitis media. He is to be very vigilant about keeping up his nebs to a level of four times a day for the next 10 days. We will also be giving him a prescription of Biaxin 500 mg b.i.d. for 10 days.
2. Acute otitis media. He should use some nasal decongestant spray for just two to three days. He is also getting the prescription of Biaxin as noted above.
3. Sleep apnea. We will not be making any changes and he should continue to use his appliance as usual.


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GOWDHAMI MOHAN, M.D.

cc: Dr. June P. Souviron

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FOLLOW-UP VISIT

PATIENT: JONES, ARCHIE #901.82
CHART: 230705113
PRIMARY CARE PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 10/06/03

HISTORY OF PRESENT ILLNESS: This is a pleasant 60-year-old white male with a history of multiple medical problems followed in this office for COLD secondary to bronchiectasis and asthma. He had been having some exacerbation, apparently, triggered by an ear infection. This was treated with a 10-day course of Biaxin 500 mg b.i.d., increased nebulizer treatments, and one week increase of his maintenance prednisone to 30 mg per day. He continues to have a cough, mildly productive of some yellow sputum, but has improved markedly since his last visit. He is also back to his 15 mg dose of prednisone for maintenance. He has diminished his use of nebulizer treatment back to t.i.d.

The patient still complains of having some problems with his dental appliance. He feels that the threads are stripped, but states that it actually still works pretty well for him.

PAST MEDICAL HISTORY: See previous notes.

ALLERGIES: None.

MEDICATIONS: See previous notes, particularly 09/11/03.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is 98.8. Pulse is 88 and regular. Respirations are 18 and nonlabored.

HEENT: TMs are clear bilaterally. Nasal mucosa is pink and moist. Oropharynx is clear. Neck is supple without lymphadenopathy, JVD, or carotid bruits.

LUNGS: Distant breath sounds. Clear bilaterally.

HEART: Regular rate and rhythm with no murmurs or gallops.

ABDOMEN: Nondistended, but normal bowel sounds. Soft and nontender.

EXTREMITIES: No clubbing or cyanosis. Fingernails. Feet are as usual obscured by support stockings with 1+ pedal edema bilaterally.

PATIENT: JONES, ARCHIE #901.82
CHART: [REDACTED]
PRIMARY CARE PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 10/06/03

PAGE 2

ASSESSMENT AND PLAN:

1. COPD with asthma component. The patient was encouraged to use his nebulizer treatment at least four times a day as instructed. He does have a tendency to adjust his own medications at will. He has also continued on his steroid inhalers.
2. Bronchiectasis. The patient is to be continued on Humibid.
3. Sleep apnea. The patient is using his dental appliance regularly. He is also taking Dexedrine 10 mg a day. He reports sleeping fairly well and little problems with daytime drowsiness. He has, however, gained 16 pounds in the past year and is having some maintenance problems with the appliance. I recommended that he take his appliance back to the provider for adjustment or repair.

We will see the patient back for a recheck in three to four months.


DANICA V. CARSON, PA-C


GOWDHAMI MOHAN, M.D.

cc: Dr. June P. Souviron

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FOLLOWUP VISIT

PATIENT: ARCHIE JONES
CHART: 67-70-5113
REFERRING PHYSICIAN:
DATE: 11/03/03
PRIMARY CARE PHYSICIAN: DR. JUNE SOUVIRON
PAGE: 1

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant 60-year-old gentleman with a long history of pulmonary problems secondary to thermal burn injury at his work a few years back who is here for a follow up. The patient has chronic obstructive pulmonary disease secondary to bronchiectasis associated with inhalation lung injury. The patient has on and off exacerbations. Currently, the patient is having increased cough and sputum production. The patient has been coughing more for the last two weeks. Sputum production is minimal. He complains of runny nose and sinus congestion present 10 days back. No hemoptysis is present. The patient is currently on 50 mg of prednisone a day. No fever or chills are present. The patient is compliant with all his medications. Currently, the patient can walk more than a mile without any problem.

No recent travel history and no history of exposure to any unusual chemical fumes, dust, etc. The patient has gained weight. No loss of appetite is present. No complaints of reflux esophagitis. Currently, he is using the oral appliance for sleep apnea very well. He does not have any daytime sleepiness problem. The patient wakes up feeling fresh and more energetic. He takes all his medications including the psychotropic medications.

PAST MEDICAL HISTORY: As mentioned above.

ALLERGIES: NKDA.

MEDICATIONS: As mentioned in our previous notes.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is afebrile, pulse is 92, respirations are 18, blood pressure is 160/108, and weight is 241 pounds. The patient is not in any acute distress. O2 saturation on room air is 98%.

PATIENT: ARCHIE JONES
CHART: [REDACTED]
REFERRING PHYSICIAN:
DATE: 11/03/03
PRIMARY CARE PHYSICIAN: DR. JUNE SOUVIRON
PAGE: 2

HEENT: No sinus tenderness. Ear exam is normal. Throat is clear. No [REDACTED] lymphadenopathy. No elevated JVD. Carotid upstroke is present. Narrowed oropharynx is present.

LUNGS: Distant breath sounds are present. Mild wheezing is heard during expiration.

HEART: S1 and S2 are heard. No murmur and no gallop.

ABDOMEN: Soft. Bowel sounds are present. No organomegaly.

EXTREMITIES: No cyanosis, no clubbing, and no pedal edema.

ASSESSMENT AND PLAN:

1. Bronchitis. The patient is having clinical symptoms and signs indicative of bronchitis. We will start the patient on Biaxin. The patient responds very well to Biaxin. Biaxin XL 500 mg p.o. q.12h. is given for 10 days.
2. Mild COPD exacerbation is present. The patient is started on prednisone pulse dose steroids. Prednisone is to be tapered to 20 mg q.d.
3. Sleep apnea. Dental appliance is to be continued. Sleep hygienic measures and weight reduction strategies are reinforced.

The patient is to return to the clinic three to four months later.



GOWDHAMI MOHAN, M.D.

cc: Dr. June Souviron

C1751900

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FOLLOWUP VISIT

PATIENT: ARCHIE JONES

CHART: 252205119

REFERRING PHYSICIAN: DR. JUNE SOUVIRON

DATE: 01/22/04

PAGE: 1

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant 60-year-old Caucasian white gentleman with multiple medical problems who is here for followup on his pulmonary and sleep complaints. The patient has longstanding chronic obstructive pulmonary disease with associated bronchiectasis secondary to thermal injury to his lungs. The patient is currently on Pulmicort aerosols along with frequent bronchodilators. He was in the past taking cyclic antibiotics with some good relief. Mr. Archie Jones states that he is experiencing more shortness of breath for the last few months. He continues to have some sputum production.

The patient has mild snoring. He uses Dexedrine for daytime alertness and could not tolerate CPAP treatment. He is using the aerosol treatments regularly. He is also compliant with rest of all his other medications.

No fever, no chills, no weight loss, no loss of appetite, no recent travel history, and no history of anyone suffering from respiratory infection.

PAST MEDICAL HISTORY:

1. Status post lung injury.
2. Bronchiectasis.
3. Cold.
4. Obstructive sleep apnea.
5. ADD.
6. Hypertension.
7. Reflux esophagitis.
8. Manic depression with anxiety.
9. History of prostatitis.

ALLERGIES: NKDA.

PATIENT: ARCHIE JONES

CHART: 250-205

REFERRING PHYSICIAN: DR. JUNE SOUVIRON

DATE: 01/22/04

PAGE: 2

MEDICATIONS:

1. Aerosol treatments with Xopenex and Atrovent.
2. Combivent inhalers two puffs MDI q.i.d.
3. Atrovent two puffs MDI q.i.d. p.r.n.
4. Albuterol also p.r.n.
5. Theophylline 300 mg p.o. q. 12h.
6. Singulair 10 mg p.o. q.d.
7. Pulmicort two puffs MDI q. 12h.
8. Mucinex 600 mg p.o. q. 12h.
9. Normal saline spray.
10. Prevacid 30 mg p.o. q. 12h.
11. Sudal DM two pills q.i.d.
12. Cough Syrup DM - p.r.n.
13. Flomax 0.4 mg q.d. p.r.n.
14. Risperdal 0.25 mg q.a.m. and 0.25 q.p.m.
15. Depakote 1000 mg p.m.
16. Plavix 75 mg q.a.m.
17. Dexedrine 10 mg p.o. q.a.m.
18. Zoloft 100 mg p.o. q.a.m.
19. Actonel 35 mg q.d.
20. Celebrex 200 mg q.d.
21. Regranex q.d.
22. Lamisil p.r.n.
23. Vitamin E, C, and D.
24. Calcium supplements.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is 98.8, pulse is 84, respirations are 18, blood pressure is 150/88, and weight is 250 pounds. O2 saturation on room air is 97%.

HEENT: Unremarkable except for narrowed oropharynx.

LUNGS: Mild wheezing heard during forced expiration.

HEART: S1 and S2 are heard. No murmur. No gallop.

ABDOMEN: Soft. Bowel sounds are present. No organomegaly.

EXTREMITIES: No cyanosis, no clubbing, and no pedal edema.

NEUROLOGIC: No focal neurological deficit present.

PATIENT: ARCHIE JONES
CHART: ~~050412517~~
REFERRING PHYSICIAN: DR. JUNE SOUVIRON
DATE: 01/22/04
PAGE: 3

ASSESSMENT AND PLAN:

1. Sleep apnea. The patient is currently using dental device, tolerating it well. ~~The patient does~~ have some daytime sleepiness for which, he takes Dexedrine and is doing well.
2. COPD. The patient is to continue on bronchodilators as prescribed now. The patient is to use Combivent inhalers p.r.n.
3. Bronchiectasis. Mucinex was given to clear the secretions.
4. Asthmatic component to COPD present. The patient does seem to have overall worsening of his pulmonary symptoms. We will discontinue Pulmicort Respules and start the patient on Pulmicort aerosol. I am hoping to increase the steroids aerosol treatments. We will have to improve his pulmonary function.

ADDENDUM: Spirometry done, which did not reveal any worsening of his lung function from his previous spirometry.

The patient is to return to the clinic four months later.



GOWDHAMI MOHAN, M.D.

cc: Dr. June Souviron

C50412517

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FOLLOW-UP VISIT

PATIENT: JONES, ARCHIE #901.299
CHART: 20070503
PRIMARY CARE PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 03/01/04

HISTORY OF PRESENT ILLNESS: This is a pleasant 60-year-old Caucasian gentleman with a history of sleep disorder and pulmonary problems secondary to thermal burn injury at work. His function remains at baseline, but again today he complains of thick, darkened secretions. He has been changed to Mucinex with discontinuation of Humibid from the market. He also complains of nighttime awakening to urinate three to four times a night lately. He did admit to recent use of caffeine. The patient's symptoms remained stable from the time of his last visit two months ago. In addition, he complains of extreme dryness to his mouth with use of the nebulizer treatment whenever he does a combination of Xopenex, Atrovent, and Pulmicort. These three medications do cause the nebulizer treatment to last for an extended period of time approaching an hour.

So far as his sleep complaints go, this patient is using his oral appliance and Dexedrine for management of his sleep apnea and daytime sleepiness.

On review of systems, he has no recent fever, no chills, no loss of appetite, nausea, vomiting, or changes in bowel habits.

ALLERGIES: None.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is 98.5. Pulse is 96 and regular. Respirations are 18 and nonlabored with an O2 saturation of 97 percent on room air. Blood pressure is elevated at 150/96. Current weight is 247 pounds at a height of 5 feet 10 inches.

HEENT: There is no sinus tenderness to percussion. TMs are clear bilaterally. Nasal mucosa is pink and moist. Slight drainage is present on the posterior oropharynx. Neck is supple without lymphadenopathy or carotid bruits.

LUNGS: Single expiratory wheeze in the left that is cleared with deep breathing.

HEART: Regular rate and rhythm with no murmurs or gallops.

EXTREMITIES: No cyanosis and no clubbing. The feet were as usual obscured by support stockings with 1+ pedal edema bilaterally.

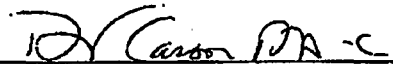
PATIENT: JONES, ARCHIE #901.299
CHART: 2272119
PRIMARY CARE PHYSICIAN: DR. JUNE P. SOUVIRON
DATE: 03/01/04

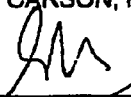
PAGE 2

ASSESSMENT AND PLAN:

1. COPD. This patient's triple medication nebulizer treatment may be contributing to the dryness of his mouth simply because of the duration of the treatment. I suggested that he separate his Xopenex and Atrovent nebulizers from the ~~the~~ Pulmicort and make it a separate treatment. He is again reminded to rinse his mouth after using the Pulmicort. He also has Combivent to use p.r.n.
2. Bronchiectasis. This patient is to continue using Muclnex that clears secretions. He is also reminded to drink plenty of water before 6 p.m. and to avoid caffeine, which he has been using lately.
3. Sleep apnea. This patient is to continue using his dental devices as well as the Dexedrine for daytime sleepiness. No changes made to his current regimen.
4. Hypertension. This patient's blood pressure is 150/96 today. It was 150/88 on 01/22/04, 160/108 on 11/03/03, and 142/92 on 10/06/03. At this point, it is clearly a trend indicating hypertension. We will be starting him on Cardizem 120 mg q.a.m. He is to follow up with Dr. Souviron in three to four weeks to check his response to this therapy and for further blood pressure management.

We will see the patient back in the clinic in two to three months.


DANICA V. CARSON, PA-C


GOWDHAMI MOHAN, M.D.

cc: Dr. June P. Souviron
Dr. James F. Richardson
ROBERT RICHARDS

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FOLLOWUP VISIT

PATIENT: ARCHIE JONES

CHART: [REDACTED]

REFERRING PHYSICIAN: DR. JUNE SOUVIRON

DATE: 05/18/04

PAGE: 1

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant middle-aged Caucasian gentleman with multiple medical problems. He is here for followup. The patient has had chronic bronchiectasis secondary to lung damage associated with thermal lung injury. The patient is currently stable. He takes his bronchodilators regularly. He has dyspnea on and off. He has not had any recent COPD exacerbations. Recently, he was using some cleaning materials, fumes of which caused him to have more cough and shortness of breath. His exacerbation is slowly improving. The patient uses the nebulizer treatments on a regular basis.

No complaints of runny nose or sinus congestion now. Currently, he is using the dental appliance on a regular basis. He also uses CNS stimulants to keep him awake and alert. He has no fever, no chills, no weight loss, no loss of appetite, no nausea, no vomiting, no altered bowel habits, and no other significant problems.

PAST MEDICAL HISTORY: See my previous notes.

ALLERGIES: NKDA.

MEDICATIONS:

1. Cardizem CD 120 mg p.o. q.d.
2. Mucinex one tablet p.o. q. 12h.
3. Normal saline nasal spray.
4. Prevacid 30 mg p.o. q. 12h.
5. Pseudo DM two pills b.i.d.
6. Flomax 0.4 mg p.r.n.
7. Risperdal 0.25 mg a.m. and p.m.
8. Depakote 1000 mg p.m.
9. Plavix 75 mg q.d.
10. Dexedrine 10 mg a.m.
11. Zolof 100 mg p.o. q.d.
12. Actonel 35 mg once a week.
13. Celebrex 200 mg q.a.m.
14. Regranex.

PATIENT: ARCHIE JONES

CHART: 751-1055779

REFERRING PHYSICIAN: DR. JUNE SOUVIRON

DATE: 05/18/04

PAGE: 2

15. Lamisil 250 mg.
16. AmLactin lotion.
17. Colace 300 mg b.i.d.
18. Combivent inhalers two puffs MDI q.i.d.
19. Nebulizer treatments with albuterol and Atrovent q.i.d.
20. Singulair 10 mg q.d.
21. Theophylline 300 mg b.i.d.
22. Prednisone 20 mg q.d.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is 98.4, pulse is 88, respirations are 18, blood pressure is 142/80, and height is 5 feet 10 inches. O2 saturation on room air is 98%.

HEENT: No sinus tenderness. Ear examination is normal. Throat is clear. No lymphadenopathy. No elevated JVD. Narrowed oropharynx is present. Increased redundant tissue is noted in the oropharynx.

LUNGS: Distant breath sounds are present. Occasional wheezing is present.

HEART: S1 and S2 are heard. No murmur or gallop.

ABDOMEN: Soft. Bowel sounds are present. No organomegaly.

EXTREMITIES: No cyanosis, no clubbing, and no pedal edema.

NEUROLOGIC: No focal neurological deficit.

ASSESSMENT AND PLAN:

1. COPD. The patient is doing symptomatically well. The patient is to be continued on aerosols four to five times a day. Steroid inhalers are also to be continued/Pulmicort Respules. The patient takes Pulmicort two puffs q.12h. and currently he is on prednisone 20 mg a day. The patient is encouraged to exercise on a regular basis.
2. Hypersomnia associated with sleep-related breathing disorder. The patient is currently using dental appliance to continue the same. Dexedrine is to be taken 10 mg q.d. This helps to keep him awake and alert throughout the daytime. Sleep hygienic measures are discussed. Weight reduction strategies are reinforced.
3. Allergic rhinitis and sinusitis. Symptoms are well controlled with Singulair and normal saline nasal spray.

PATIENT: ARCHIE JONES

CHART: ~~882-77-5440~~

REFERRING PHYSICIAN: DR. JUNE SOUVIRON

DATE: 05/18/04

PAGE: 3

Thank you for allowing me to participate in the care of this patient.

The patient is to return to the clinic six months later.



GOVDHAMI MOHAN, M.D.

cc: Dr. June Souviron
Sleep Lab

C2338352

A. Hutchison ~~ARCHIE JONES~~
27-8097

Archie Jones
IMA# 31513
8/27/04

WT 227

FOLLOW-UP VISIT

REFERRING PHYSICIAN: June Souvion, MD.

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant 61-year-old Caucasian gentleman with multiple medical problems who is here for follow-up. Patient had apparently been stable until two days back when he began to have increasing shortness of breath after doing yard work and heavy exertion. Occasional cough present. No significant sputum production. No hemoptysis. Currently able to walk 3-4 blocks without any problem. No nocturnal attacks of wheezing present.

Patient is having difficulty to sleep well. Has choking episodes present. Does use the dental appliance at night. Has some daytime sleepiness problem, but currently on Dexedrine, which is helping him to a significant degree. Patient sleeps at least 7-8 hours every night. Occasionally has daytime sleepiness problem. Has no headache present. Has no suicidal ideation. No suicidal thought. Followed by Dr. Richards for his psychiatric complaints. Patient does not have any recent hospitalization for his pulmonary symptoms. Compliant with all of his medications.

No nausea, vomiting. No altered bowel habits. No other significant complaints.

PAST MEDICAL HISTORY:

1. Status post lung thermal injury.
2. Bronchiectasis.
3. Obstructive sleep apnea.
4. ADD.
5. Hypertension.
6. Reflux esophagitis.
7. Depressive illness with anxiety.
8. History of prostatitis.

ALLERGIES: No known drug allergies.

MEDICATIONS: Updated and reviewed.

PHYSICAL EXAMINATION: Vital signs: Blood pressure 140/100, pulse 90, respiration 12. Patient is not in any acute distress at rest. O2 saturation 97%. HEENT: No sinus tenderness. Ear exam is normal. Narrowed oropharynx is present. Lungs: Normal breath sounds present. No rales or rhonchi present. No wheezing present. Heart: S1 and S2 are heard. No murmur, no gallop. Abdomen: Soft. Bowel sounds present. No organomegaly. Extremities: No cyanosis, no clubbing, and no pedal edema. Neurologic: No focal neurological deficit.

ASSESSMENT AND PLAN:

1. COPD secondary to bronchiectasis and asthma as a result of thermal lung injury. Mr. Archie Jones is currently stable with his current medication regimen. Will continue the patient on Singulair 10 mg once a day, along with chronic low-dose Prednisone therapy. Patient is currently on 20 mg a day of Prednisone. Will reduce it to 15 mg a day on a trial basis. Patient to be continued on Pulmicort MDI q 12 hours. Xopenex nebulizer treatments also continued along with the Atrovent.
2. Sleep apnea with hypersomnia. Patient could not tolerate CPAP treatment. Currently on dental device. Patient is taking Dexedrine to improve daytime sleepiness.

(Continued)

(Continued)

RE: Archie Jones

IMA# 31513

8/27/04

Page 2

3. Hypertension, not well controlled. Will increase Cartia XT to 240 mg a day. Blood pressure checkup to be done in one month.
4. Osteoporosis with osteoarthritis. Actonel 35 mg once a day to be continued.

Patient to return to clinic in one month for blood pressure checkup.

Yasmin M. Khan

GM/dtc

cc: Nurse - Workman's Comp

CAROLINA PULMONARY AND SLEEP CENTER
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LETTER OF MEDICAL NECESSITY

RE: ARCHIE JONES
CHART: ~~1504765116~~

Reference to: Archie Jones.

Respected Sir/Madam,

This letter is in reference to Mr. Archie Jones, a patient of mine, who has had lung injury secondary to exposure to thermal fumes. The patient has been disabled for many years secondary to this. For followup on his pulmonary function, I need to have a complete pulmonary function test done to assess his functional status.

If you have any questions regarding this, please feel free to call me.

Yours sincerely,



GOWDHAMI MOHAN, M.D.

C50484385

RE: ARCHIE JONES
IMA # 31513

12-8-04

WL 237

Mr. Jones comes in today for followup. He is followed by Dr. Mohan for S/P lung thermal injury. He has bronchiectasis and obstructive sleep apnea. He does see Dr. Souviron. He has a history of ADD, hypertension, reflux esophagitis and depressive illness with anxiety. He states he has been doing fairly well. He did recently have to increase his Prednisone, but is almost back down to his normal dose. He is not having cough or sputum production. He has not had any hemoptysis. He is sleeping well and is using his dental appliance. He is using Dexedrine. He does also see Dr. Richards for psychiatric problems.

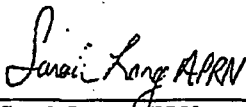
CURRENT MEDICATIONS: See list for 12-8-04.

O - WL 237. BP 112/70. Heart rate 84. CV: RRR. Normal S1, S2. Lungs clear. No forced expiratory wheezing. Abdomen soft, nontender. Lower extremities without edema.

AP:

1. COPD secondary to bronchiectasis and asthma as a result of thermal lung injury. Mr. Jones is stable. He will continue his present treatment. He is on Prednisone. He does state that he has received a bone density test by Dr. Souviron and is on Actonel.
2. Sleep apnea with hypersomnia. He is currently using a dental appliance and is using Dexedrine during the day.
3. Hypertension. Mr. Jones' BP is much better with doubling up on Cartia.
4. Osteoporosis. He is on Actonel.

Mr. Jones will follow up with Dr. Mohan in 4 months.


Sarah Long, APRN


Gowdhgani Mohan, MD

SL/GM/mw

Addendum: Mr. Jones did also have spirometry today. FVC: 4.08. FEV1: 2.28. FEV1/FVC: 0.56. FEF 25/75: 0.91.

248098

INTERNAL MEDICINE ASSOCIATES OF ANDERSON, P.A.
2000 E. Greenville Street, Suite 1100 - Anderson, S.C. 29621

Phone 854-325-8887
Fax 854-716-0110

HENRY C. MARTIN, M.D. DEA No. AM1485584	THOMAS J. SULLIVAN, JR., M.D. DEA No. BS1345774	GOWDHAMI MOHAN, M.D. DEA No. BM2908943
C. WILSON BOFLEY, JR., M.D. DEA No. B53322485	WILLIAM W. WALKER, M.D. DEA No. AH7120819	CHARLES A. THOMPSON, M.D. DEA No. BT4138081
STEPHEN H. HAND, M.D. DEA No. BH2291229	MICHAEL R. KUNDEL, M.D. DEA No. BW4842080	GARLENE P. WILSON, M.D. DEA No. BW7329329
JOSEPH A. FARMER, B. M.D. DEA No. BF148818	CHRISTOPHER E. LECROIX, M.D. DEA No. FL8216362	

FOR Prescription Jones

ADDRESS _____

DATE

12/15/04

R Mr. Archie Jones is a pleasant middle aged male who has bronchitis 2° to bronchectasis 2° to COPD 2° inhalation lung injury. Call me if you have any questions.

D LABEL

REFILL

Times PRN NR

_____, M.D.

_____, M.D.

Signature As Written

INA LAB

Subscribed Permitted

12/15/04 WED 10:48 FAX 8647186134

002

JONES, ARCHIE EDWARD

03/07/05

#31513

310.785

REFERRING PHYSICIAN: Dr. June P. Souvion

FOLLOW-UP VISIT

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant 61-year-old Caucasian gentleman with multiple medical problems who is here for follow-up on his pulmonary and sleep complaints. The patient has chronic obstructive pulmonary disease secondary to bronchiectasis as a result of thermal injury. The patient also has reactive airways disease due to thermal injury. He is on prednisone therapy on a regular basis. He also has COPD exacerbations on and off. The patient is also followed by me for his sleep apnea. The patient was tried on CPAP treatment and could not tolerate it. The patient was referred to Dr. Hellstrom who recommended dental device for him. The patient is currently using the dental device on a regular basis. He sleeps for at least 7-8 hours without any problem. No daytime sleepiness present for the most part after being started on Dexedrine. He takes Dexedrine on a regular basis.

No fever, no chills, no weight loss, no loss of appetite. He has complaints of shortness of breath for the last 2-3 weeks. He had fever and chills initially, but currently no fever and no chills present. Sputum production is present: sputum is minimal in quantity. The patient feels the color of the sputum is lightly darker than his baseline. The patient has dyspnea on exertion. Dyspnea level is less than 1 block. No nocturnal attacks of wheezing present. The patient is using the nebulizer treatments regularly. He has no runny nose and no sinus congestion. No chest pain, no palpitations, no dizziness, and no other significant problems.

PAST MEDICAL HISTORY:

- 1) Status post thermal lung injury.
- 2) Bronchiectasis.
- 3) Reactive airways disease.
- 4) Sleep apnea.
- 5) ADD.
- 6) Hypertension.
- 7) Reflux esophagitis.
- 8) Depression with anxiety.
- 9) History of prostatitis.

ALLERGIES: NKDA.

MEDICATIONS: Updated and reviewed.

JONES, ARCHIE EDWARD

03/07/05

#31513

310.785

3/16/09

Page 2

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is 98.1. Pulse is 86. Respirations 20. Blood pressure is 154/88. Weight is 238 pounds. O2 saturation is 96 percent. The patient is not in any acute distress at rest.

HEENT: No sinus tenderness. Ear examination is normal. Throat is clear. No lymphadenopathy. No elevated JVD. Carotid upstroke present. Narrowed oropharynx present.

HEART: S1, S2 heard. No murmur, no gallop.

LUNGS: Clear.

ABDOMEN: Soft. Bowel sounds present. No organomegaly.

EXTREMITIES: No cyanosis, no clubbing, no pedal edema.

NEUROLOGICAL: No focal neurological deficit present.

ASSESSMENT AND PLAN:

1) Sleep apnea. The patient is using the dental device regularly. Sleep hygienic measures were discussed; weight reduction strategies reinforced. The patient is to be continued on Dexedrine 10 mg twice daily.

2) COPD, mild exacerbation secondary to bronchitis. The patient is to be slowly tapered off of prednisone to his baseline dosage. He takes prednisone 10-20 mg once a day. The patient has symptoms indicative of upper respiratory tract infection. Hence, we will start the patient on Biaxin 500 mg p.o. q.12h. Aerosol treatments are to be continued as directed. The patient is to return to the clinic 6 months later for follow-up.

Gowdhami Mohan

Gowdhami Mohan, M.D.

GM/DTI oper25

cc: Dr. June P. Souviron

JONES, ARCHIE.

10/04/05

#31513

310.769

REFERRING PHYSICIAN: Dr. June P. Souvion

FOLLOW-UP VISIT

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant 62-year-old Caucasian gentleman with multiple medical problems who is here for follow-up. The patient has been followed by me for his pulmonary and sleep problems for more than 5 years. He had thermal injury to his lungs several years' back and had been on prolonged ICU stay. He has developed chronic obstructive pulmonary disease with resultant bronchiectasis secondary to thermal injury. He used to have significant COPD exacerbations in the past and also was requiring frequent bronchodilators. Increased cough and sputum production was also a major problem. Few years back, early morning sputum production was a major problem. At present, these problems are reduced, but still he continues to have dyspnea on exertion with dyspnea level of less than 2 blocks. During winter season/allergy season, his symptoms always get worse. He is having daytime sleepiness and tiredness. He has been diagnosed to have sleep apnea, but could not tolerate CPAP treatment and, hence, has been using dental appliance. He is taking Dexedrine for residual daytime sleepiness. Now, he continues to have significant daytime sleepiness problem despite taking Dexedrine and dental appliance. He is scheduled to have a new dental appliance.

No fever, no chills, no weight loss, no loss of appetite, no nausea, no vomiting, no altered bowel habits, he is compliant with all his medications.

PAST MEDICAL HISTORY:

- 1) COPD.
- 2) Bronchiectasis.
- 3) Attention deficit disorder.
- 4) Asthmatic component to COPD.
- 5) Allergic rhinitis.
- 6) Foot problem. He has had longstanding right foot problem with difficulty to heal (before present).
- 7) Arthritis.
- 8) Depression.

SOCIAL HISTORY: He is not a smoker and not an alcoholic.

ALLERGIES: NKDA.

MEDICATIONS: Reviewed and updated.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is 98. Pulse is 112. Respirations 12. Blood pressure is 140/78. O2 saturation on room air is 97 percent.

JONES, ARCHIE

10/04/05

#31513

310.769

Page 2

HEENT: No sinus tenderness. Ear examination is normal. Throat is clear. No lymphadenopathy. No elevated JVD. Carotid upstroke present. Narrowed oropharynx present. Increased redundant tissue noted in the oropharynx. Short uvula present.
HEART: S1, S2 heard. No murmur, no gallop.
LUNGS: Mild wheezing present. Few rhonchi present.
ABDOMEN: Soft. Bowel sounds present. No organomegaly.
EXTREMITIES: No cyanosis, no clubbing, no pedal edema.

ASSESSMENT AND PLAN:

- 1) Sleep apnea. Mr. Archie Jones is having excessive daytime sleepiness despite being on dental appliance. Though following some sleep hygienic measures, the patient is still feeling continuously sleepy and tired during the daytime. The patient is to be on a new dental appliance. We will follow the clinical response after he is on the new dental appliance. I have asked the patient to call me if he continues to feel very sleepy and tired despite being on the new dental appliance. The patient may need a repeat sleep study with MSLT. The patient is encouraged to sleep at least 7-8 hours without any problem.
- 2) The patient has lost some weight. Sleep hygienic measures were discussed.
- 3) COPD with asthmatic component. The patient is to be continued on Pulmicort 2 puffs MDI once a day. Bronchodilators are to be continued. The patient uses nebulizer treatments and also uses Atrovent 2 puffs MDI q.i.d. The patient is also on Singulair, which will significantly help his problems.
- 4) Insomnia, symptoms are well controlled.
- 5) Reflux esophagitis, well controlled on Nexium.
- 6) The patient used to get cyclic antibiotic therapy every month, which he is not doing now. The patient does seem to be clinically better when compared to the days when he was taking the prednisone on cyclic therapy (more than 15 months back).

Thank you, for allowing me to participate in the care of this patient.

Gowdhami Mohan, M.D.

GM/DTI oper25

cc: Dr. June P. Souviron
Sleep Lab



JONES, ARCHIE

11/30/06

#31513

310.665

REFERRING PHYSICIAN: June P. Souviron, M.D.

FOLLOW-UP VISIT

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant 63-year-old Caucasian gentleman with multiple medical problems who is here for follow-up on his pulmonary and sleep complaints. The patient is having slight increase in dyspnea for the last couple of months. He is taking prednisone regularly. The patient has occasional cough. Sputum production is present. Sputum production is sometimes more and sometimes less. Occasionally, he has difficulty to lay down flat. No hemoptysis present. He does not have any nocturnal attacks of wheezing. No complaints of runny nose or sinus congestion. No symptoms of conjunctivitis.

The patient is using the dental appliance. He is not on CPAP treatment. He is sleeping for at least 7-8 hours. He feels somewhat less sleepy especially after medication adjustment had been made. The patient has not been able to exercise because of the painful feet. The patient is using Lidoderm patch on both the feet. The patient has no nausea and no vomiting. No fever, no chills, and no chest pain. No palpitations present. No other significant problems present.

PAST MEDICAL HISTORY:

- 1) COPD.
- 2) Bronchiectasis.
- 3) Attention deficit disorder.
- 4) Asthmatic component to COPD.
- 5) History of osteomyelitis in both his feet.

SOCIAL HISTORY: He is not a smoker and not an alcoholic.

ALLERGIES: NKDA.

MEDICATIONS: Reviewed and updated.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is 97.9. Pulse is 100. Respirations 20. Blood pressure is 138/96. Weight is 230 pounds. O2 saturation on room air is 93 percent. The patient is not in any acute distress.

HEENT: Narrowed oropharynx present. Increased redundant tissue noted in the oropharynx. No thyromegaly. No elevated JVD.

HEART: S1, S2 heard. No murmur, no gallop.

LUNGS: Distant breath sounds present. No wheezing heard. Few rhonchi heard over the right base.

ABDOMEN: Soft. Bowel sounds present. No organomegaly. Ventral hernia is present.

JONES, ARCHIE

11/30/06

#31513

310.665

Page 2

EXTREMITIES: No cyanosis, mild clubbing present, no pedal edema.
NEUROLOGICAL: No focal neurological deficit present.

ASSESSMENT AND PLAN:

- 1) COPD.
- 2) Bronchiectasis.
- 3) Sleep apnea.
- 4) Asthmatic component to COPD.

The patient is to be continued on the current medications. The patient takes prednisone 20 mg a day. Sometimes he cuts it down to 15 mg a day. I encouraged the patient to exercise regularly. Normal saline spray is to be continued to control rhinitis symptoms. The patient is also on theophylline 300 mg twice daily. Pulmicort aerosols are to be continued along with Serevent and Xopenex aerosols 3-4 times a day on a p.r.n. basis.

The patient is taking Dexedrine in the morning to be more awake and alert. Adjusting the psychiatric medication including Zoloft has helped to improve his symptoms. Mucinex is to be also used on a p.r.n. basis. Dental appliances are to be continued. Better sleep hygienic measures were discussed. The patient may need overnight polysomnography with the dental appliance on if he continues to have more daytime sleepiness and tiredness. The patient is to return to the clinic 6 months later for follow-up.

Thank you for allowing me to participate in the care of this patient.

Gowdhami Mohan, M.D.

GM/DTI oper25

cc: June P. Souviron, M.D.

CERTIFICATE OF MEDICAL NECESSITY

FORM APPROVED
OHS NO. 1007-0075
JWERC 03.02

SECTION A		CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP)	
Certification Type/Date: INITIAL 3/6/00 REVISED 1/1			
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER Archie R. Jones 1234 Salem Church Rd Anderson SC 29625 (864) 231-2469 HICN 250 70 509		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER Christina Oxygen Service 271 W. Jones Rd Greenville SC 29605 (864) 231-0666 NSC # 1188930001	
PLACE OF SERVICE 12 NAME and ADDRESS of FACILITY if applicable (See Reverse)	HPCS CODE E060	PTPOS # 12045; Sex M (M/F); HT 61 (in); WT 25 (lb); PHYSICIAN NAME, ADDRESS (Printed or Typed) Dr. G. M. Jones 105 E. Greenville St. Anderson SC PHYSICIAN'S UPI#: 606540 PHYSICIAN'S TELEPHONE #: (864) 231-7014	
SECTION B Information in this Section May Not Be Completed by the Supplier of the Item/Supplies.			
EST. LENGTH OF NEED (# OF MONTHS): 97 1-99 (99=LIFETIME)		DIAGNOSIS CODES (ICD-9): 280.5 2	
ANSWERS	ANSWER QUESTIONS 12 AND 14 FOR CPAP (Circle Y for Yes, N for No, or D for Does Not Apply, Unless Otherwise Noted)		
	Questions 1 - 11, and 13, reserved for other or future use.		
	12. How many episodes of apnea lasting greater than 10 seconds does the patient have during 6-7 hours of recorded sleep? (Number of episodes) (If greater than 99, enter 99.)		
(Y) N D	14. Does the patient have obstructive sleep apnea?		
NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print): NAME: TITLE: EMPLOYER:			
SECTION C Narrative Description Of Equipment And Cost (1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (See Instructions On Back)			
SECTION D Physician Attestation and Signature/Date I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil and criminal liability. PHYSICIAN'S SIGNATURE: [Signature] DATE: 4/7/02 SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE			

Eddie Jones

MEDICATIONS 12/28/01

Albuterol-USP: 180mg 2to4 times day
Atrovent: 2puffs 2to4 times day
Combivent: 2 puffs 2to4 times day
Xopene/Nebulizer: 3ml 2to4 times day
Atrovent/Nebulizer: 2.5ml 2to4 times day
Serevent: 2 puffs-am/pm
Pulmicort: 2 puffs-am/pm
Singulair: 10mg-pm
Theophylline: 300mg-am/pm
Humibid : am/pm
Augmentin: 875mg-am/pm-start 01/09/02 *4 Biacin*
Prednisone: 80mg-pm *no 73 mg - 15 mg*
Avelox: 400mg-am *no*
Saline Nasal Spray: 2to4 times day
Prevacid: 30mg-am/pm
Sudal DM : 2 pills-am/pm
Su-tuss dm cough syrup(as needed)
Flomax: .4 mg pm
Risperdal: 25mg-am&noon/.5mg-pm
Depakote: 375mg-pm
Ritalin: 8mg-am *2.5 pm D/C*
Plavix: 75mg-am
Dexadrine: 5mg-am/5mg-afternoon
Zolof: 50mg-am
colace: 300mg am/pm

Once a month I alternate antibiotics to counteract the immune suppressant effects of prednisone. They are:

Biacin: 500mg-am for 7 days-1st month
Tequin: 400mg-am for 7 days-2nd month
Augmentin: 875mg am/pm-3rd month

Carolina Pulmonary and Sleep Center

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

605 East Greenville Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Archie Jones DATE: 7/11/02

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

Rx Prednisone 20mg 1 PO QD
Refill 5 -30 days
Smigulami 10mg 1 PO QD
Refill 5 -30 days

DEFENSE AS WRITTEN M.D. [Signature] M.D. _____

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

☐ Label

Date	Notes Should Be Signed by Physician
DATE: 7-11-08	HGT: 5'10" / WGT: 215 lbs
BP: 150/92	TEMP: 98.4 / P: 80
ALLERGIES: NKBA	

7-11-08 4mth Recurrence
 1. ~~fat~~ ^{2/3} ~~thin~~ (Diets)
 2. Dry ~~Acid~~ ^{Acid}
 3. High green excretion
 4. Her Recurrence Arising due
 Antiviral High Eff.
 O/C antileste

The Full Service Pump		For Doctor	Date	Time	AM	PM
 PREVACID LANSOPRAZOLE	Name	Dr M	9/18			
	Telephone	Bilo				
	Medication/Prescription	226-0522				
	Message	Edna Archie Jones				
		Theophylline 300mg 1x12h				
Please See Accompanying Prescribing Information.		☐ Returned your call ☐ Will call again ☒ Please call ☐ Refill ☐ Urgent				

Signature: [Signature] O/C 2 Aug 08

Carolina Pulmonary and Sleep Center

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

605 East Greenville Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Archie Jones DATE: 11/7/02

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

R_x

Bioxin 500mg
1000mg bid x 10 days
#20

M.D. Amy Weismann M.D.

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL) ☒ SUBSTITUTION PERMITTED ☐ Allegro 40

Date	Notes Should Be Signed by Physician		
	DATE: 11-7-08	HGT: 5'10"	WGT: 200 lb
	BP: 128/88	TEMP: 96.9	P: 80
	ALLERGIES: NADA		
11-7-08	Coughing up Black sputum, wheezing SOB		
	↑ cough	0% 0/1/1	Loose heat last black → green copious
	10mg → Prednisone 20mg 1 week		
	Neb 3-4		
	Biaxin 7 Neb 3.		
PROGRESS NOTES			

Notes Should Be Signed by Physician

HGT: 6'

WGT:

BP: 12

TEMP:

P. 

ALLERGIES:

12K5A

9057

not sleeping well, had rectal bleeding.
Tired all the time.

① int # $\rightarrow$ 1st Dec

Hed diff to ~~the~~

②

✓ DR Helldorn

✓ Dr. Waltham

✓ 5

day

PROGRESS NOTES

HEALTH CARE MANAGEMENT
SERVICES

William B. Bivens
Branch Manager

December 31, 2002

Gowdhami Mohan, MF
1209 B. North Fant Street
Anderson, SC 29621

RE: CLAIMANT : Archie (Eddie) Jones
EMPLOYER : 3M
DOI : 6/3/97
CLAIM NO. : ~~VCSS-24803~~
OUR FILE NO. : 531-4400

Dear Dr. Mohan:

I am a Nurse Case Manager with Crawford & Company Healthcare Management and have been requested by the Workers Compensation Insurance Carrier, Liberty Mutual, to assist Mr. Jones during his recovery from his workers compensation burns and pulmonary difficulties.

Mr. Jones reportedly developed pulmonary difficulties at the time of his injury in 1997, which has required ongoing treatment. Since that time, he has been on multiple medications including Prednisone. Reportedly, he has not been able to reduce the dosage of the Prednisone below 10mg without becoming symptomatic. At the time of my visit with you and Mr. Jones on 11/13/00, you stated that Mr. Jones had attained maximum medical improvement (MMI) regarding his pulmonary disorder.

The workers compensation insurance carrier is requesting your documentation regarding Mr. Jones' status and MMI.

Yes. Mr. Jones has attained MMI regarding his pulmonary disorder only.

Comments: Mr. Jones is currently on multiple ~~as~~ pulmonary medications to maintain his current quality of life.

Please assign an impairment rating or document the claimant is permanently disabled due to lung function. He can carry out his day to day activities for his life. May not be able to return to work.

5- mailed
1-7-02

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Archie Jones DATE: 1/30/03
ADDRESS: _____
CITY _____ STATE _____ ZIP _____

Rx Please provide nebulizer tubing.

DISPENSE AS WRITTEN M.D. Amy Nelson, P.A.C. M.D.
SUBSTITUTION PERMITTED
Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL) ☐ Label

Date	Notes Should Be Signed by Physician		
	DATE: 1-30-03	HGT: 5'10"	WGT: 240lbs
	BP: 130/88	TEMP: 98.3	P: 86
	ALLERGIES: NKDA		

O2 sat 97%
on RA.

1-30-03 Patient is here because he is very short of breath.

7/5/38

3 weeks

Pud 20mg

SOB

productive cough.

Neb 2-3

exp wheezing

↑ Neb
Teguin

8-11-03 Xopenex 1.25mg called in to BilD
w/ Refill (5)

Archie Jones
Patient's Name

Age

Nature of Illness or Injury

Please describe any other disease or infirmity affecting the present condition

None

Is the patient still under your care for this condition?

☒ Yes ☐ No

If discharged, give date

Give dates of treatment:

since 6/03

Office: 6/03, 7/11/03, 11/7/03, 12/12/03 Hospital

Date of Last Office Visit 1-30-03

Please complete if the patient was hospitalized since the last report:

No Hospital

Address

Date Admitted

Date Discharged

Is the condition or illness or injury due to the patient's employment?

☒ Yes ☐ No

If yes, please explain

Patient had thermal injury to the lungs

When was or will the patient be able to return to work?

☐ Full Time

☐ Part Time

If the date is undetermined, please estimate

☐ 1 - 3 Months

☐ 3 - 6 Months

☐ 6 - 12 Months

☐ 1 - 2 Years

☒ Never

Signature

Gowdham Mohan

M.D.

Date

1/31/03

Physician's Name (Printed or Typed)

Gowdham Mohan

Telephone

8611-231-7004

Address

1209 B.N. Faint Street, Anderson SC 29621

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Archie Jones DATE: 1/30/03

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

R_x

*Teguin 400mg
÷ tab po qd for 7 days
7*

M.D.

Army Nilsen D.O.

DISPENSE AS WRITTEN

SUBSTITUTION PERMITTED

Refills ☒ 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

11004 Label

Preferred Works

DISABILITY PROGRESS REPORT

3M LTD Plan

Claimant's Statement

[To be completed and returned by 2/6/03 if still disabled]

☒ If checked, your Physician must complete the reverse portion of this form by the date above

Archie James Jr.
Name

Telephone

Address

Are you still medically incapable of performing your own occupation?

☐ Yes ☐ No

Could you perform another occupation? ☐ Yes ☐ No

If yes, please elaborate on a separate sheet of paper.

If you are receiving disability income benefits from any source other than this Plan, or compensation of any kind, please indicate name and address of payor.

SS Disability
Source

Address

\$ SAME AS
Amount BEFORE

Your current attending Physician DR. G. MOHAN, DR. ROBERT RICHARDS, DR. JUNE SOLVIRON

Physician's Address

Please Sign the Following Authorization

I authorize any health care provider (e.g., hospital, clinic, physician, pharmacy), insurance company, claims administrator, case management company or Employer to release to Preferred Works, my Employer or their attorneys, agents, representatives, consultants or insurance carriers, any information relating to my physical or mental condition. This includes my medical history (including diagnosis, prognosis, prescriptions or medication, psychiatric, drug or alcohol abuse treatment) and copies of all records which may be requested. Information about my claim will be kept confidential, except for the purposes allowed by law.

I understand that this information will be used to determine my eligibility for, and to compute the proper amount of benefits under the Short Term Disability, Statutory/Voluntary Disability, Salary Continuation, Pension/Retirement Disability, FMLA, Long Term Disability or Workers' Compensation Plans.

This Authorization expires two years from the date shown below. A photocopy of this form shall be as valid as the original. I acknowledge my right to receive a copy of this Authorization.

Archie E. James Jr.
Signature

1-5-03
Date

If you are signing on behalf of Employee/Claimant, what is your relationship to him/her? _____

3280 E. Foothill Blvd. • Suite 250 • Pasadena, CA 91107 • 626-568-1415 • 800-939-4911 • Fax 626-568-1440

Archie Jones
Patient's Name

Age

Nature of Illness or Injury

Please describe any other disease or infirmity affecting the present condition

None

Is the patient still under your care for this condition?

☒ Yes ☐ No

If discharged, give date

Give dates of treatment:

since 6/02

Office: 6/05/02, 7/11/02, 11/7/02, 12/19/02 Hospital

Date of Last Office Visit 1-30-03

Please complete if the patient was hospitalized since the last report:

No Hospital

Address

Date Admitted

Date Discharged

Is the condition or illness or injury due to the patient's employment?

☒ Yes ☐ No

If yes, please explain

Patient had thermal injury to the lungs

When was or will the patient be able to return to work?

☐ Full Time

☐ Part Time

If the date is undetermined, please estimate

☐ 1 - 3 Months

☐ 3 - 6 Months

☐ 6 - 12 Months

☐ 1 - 2 Years

☒ Never

Signature

G. Mohan

M.D.

Date

1/31/03

Physician's Name (Printed or Typed)

Gowdham Mohan

Telephone

864-231-7004

Address

1209 B N. Faint Street, Anderson SC 29621

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7804

PATIENT'S NAME:

Richie Jones

DATE:

5/11/03

ADDRESS:

CITY

STATE

ZIP

Rx

Dexedrine 5mg po q 7.00am.
5mg po q 12noon
#60 Tablets - 3 days

DEPENDENCE AS WRITTEN

M.D.

SUBSTITUTION PERMITTED

M.D.

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILLS)

☐ Label

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME:

Richie Jones

DATE:

6/11/03

ADDRESS:

CITY

STATE

ZIP

Rx

Dexedrine 5mg @ po q 7.00am.
5mg @ po q noon
#60 Tablets - 3 days

DEPENDENCE AS WRITTEN

M.D.

SUBSTITUTION PERMITTED

M.D.

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILLS)

☐ Label

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME

Archie Jones

DATE

7/11/03

ADDRESS

CITY

STATE

ZIP

Rx

Dexedrine 5mg $\odot$ po q 7.00am

" 5mg $\odot$ po q 12 noon

60 Tablets

— 30 days
G. Mohan

M.D.

M.D.

DISPENSE AS WRITTEN

SUBSTITUTION PERMITTED

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILLS)

☐ Label

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Eddie Jones DATE: 7-25-03

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

Rx Celecox 200mg + BID
Refill @ -30 days

DISPENSE AS WRITTEN M.D.

hmr
SUBSTITUTION PERMITTED M.D.

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

☐ Label

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Eddie Jones DATE: 7-25-03

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

Rx Colace tit tabs BID
Refill @ -30 days

DISPENSE AS WRITTEN M.D.

hmr
SUBSTITUTION PERMITTED M.D.

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

☐ Label

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Eddie Jones DATE: 7-22-03

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

Rx Actonel 50mg + 8 weeks
Refill (6) - 30 days

DISPENSE AS WRITTEN M.D. [Signature] M.D.
SUBSTITUTION PERMITTED

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

☐ Label

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Eddie Jones DATE: 7-22-03

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

Rx Albuterol 2p 84-whr PRN
Refill (6) - 30 days

DISPENSE AS WRITTEN M.D. [Signature] M.D.
SUBSTITUTION PERMITTED

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

☐ Label

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Eddie Jones DATE: 7-22-08

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

Rx Atrovent 2p q4-6hrs prn
Refill @ -30 days

DISPENSE AS WRITTEN M.D.

[Signature]
SUBSTITUTION PERMITTED M.D.

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

☐ Label

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Eddie Jones DATE: 7-22-08

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

Rx Atrovent ~~2p q4-6hrs~~ 2.5ml T BID
Refill @ -30 days

DISPENSE AS WRITTEN M.D.

[Signature]
SUBSTITUTION PERMITTED M.D.

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

☐ Label

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Eddie Jones DATE: 7-22-03

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

R Pulmicort 2p BID
Refills (10) -30 days

DISPENSE AS WRITTEN M.D. [Signature] M.D.
SUBSTITUTION PERMITTED

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

☐ Label

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Eddie Jones DATE: 7-22-03

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

R Senerent Diskus 1p BID
Refill (1) -30 days

DISPENSE AS WRITTEN M.D. [Signature] M.D.
SUBSTITUTION PERMITTED

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

☐ Label

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 281-7004

PATIENT'S NAME: Eddie Jones DATE: 7-22-03

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

Rx Prevacid 30mg + 60 BID
Refill @ -30 days

DISPENSE AS WRITTEN M.D. [Signature] M.D.
SUBSTITUTION PERMITTED

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

☐ Label

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 281-7004

PATIENT'S NAME: Eddie Jones DATE: 7-22-03

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

Rx Humabid 60mg + BID
Refill @ -30 days

DISPENSE AS WRITTEN M.D. [Signature] M.D.
SUBSTITUTION PERMITTED

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

☐ Label

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Eddie Jones DATE: 7-22-03

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

Rx Sudal 40/500 CR + BID
Refill 10 -30 days

DISPENSE AS WRITTEN

M.D.

SUBSTITUTION PERMITTED

M.D.

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

☐ Label

Date	Notes Should Be Signed by Physician		
	DATE: 4-11-03	HGT: 5'10"	WGT: 235
	BP: 140/98	TEMP: 97.4	P: 80
	ALLERGIES: NKDA		

4-11-03 4-5 mths Recheck. No new problems

1 week prior to 4-5 mths Recheck
John P. Jones
Dr. P. Jones

189/482

 Prescribe powerful 24-hour relief CLARINET Rx Tracker™ 2002C	TELEPHONE Rx REFILL		☐ Hosp ☐ Nursing Home	Formedica Action Taken Rx called in ☐ ☐ ☐ ☐ ☐ patient notified ☐ make app't ☐ post to chart ☐ ☐ Dr ☐ PA ☐ NP
	Dr. Moha	Caller Archie		
	Patient & age 2242669	Ph (H) Jones		
	Rx & Prescription #	dosage	last refill date	
	Theophyllin 300mg 2XID			
	Refill (3)			
	BID 226-0164			
	See reverse for additional Rx's			
Allergies				
Insurance				
Pharmacy				
Phone				
Call taken by	Date 6/13	Time	Date Time	

PROGRESS NOTES

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Archie Jones DATE: 8/11/03

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

Rx Dexedrine 5 mg po q 7.00 am.
5 mg po q 12 noon
#60 Tablets - 30 days.

DISPENSE AS WRITTEN M.D. G. Mohan M.D.
SUBSTITUTION PERMITTED

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILLS)

☐ Label

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Archie Jones DATE: 4/11/03

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

Rx Dexedrine 5mg po q 7.00 am
5mg po q 12 noon
#60 Tablets - 30 days

DISPENSE AS WRITTEN M.D. G. Mohan M.D.
SUBSTITUTION PERMITTED

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILLS)

☐ Label

Eddie Jones

MEDICATIONS 08/08/03

- Albuterol-USP: 180mg 2to4 times day
- Atrovent: 2puffs 2to4 times day
- Combivent: 2 puffs 2to4 times day
- Xopenex/Nebulizer: 3ml 2to4 times day
- Atrovent/Nebulizer: 2.5ml 2to4 times day
- Serevent: 1 puff-(powder disk)am/pm
- Pulmacort: 2 puffs-am/pm
- Singulair: 10mg-pm
- Theophylline: 300mg-am/pm
- Humibid: 600mg-am/pm
- Prednisone: 15mg-pm/increase when needed 30mg-pm & 20mg
- Saline Nasal Spray: 2to4 times day
- Prevacid: 30mg-am/pm
- Sudal DM : 2 pills-am/pm
- Su-tuss DM cough syrup(as needed)
- Flomax: .4 mg pm
- Risperdal: .25mg-am/.25mg-pm
- Depakote: 750mg-pm 1000mg-pm
- Plavix: 75mg-am
- Dexamethasone: 10mg-am
- Zolof: 75mg-am 100mg-qam
- Actonel: 35mg am/weekly
- Celebrex: 200mg-am
- Regranex: Apply once a day(Rt. foot)
- Lamisil: 250mg-pm
- Amlectin Lotion : daily on donor areas
- Colace: 300mg am/pm

(Daily)

Multi-vitamin
500mg Vitamin C
400 IU Vitamin E
1200mg Calcium

Once a month I alternate antibiotics to help remove secretions, counteract the immune suppressant effects of prednisone and the hardening of my lungs from thermal and chemical burns.

They are:

Biaxin: 500mg-am for 7 days—1st month
Tequin: 400mg-am for 7 days—2nd month
Augmentin: 875mg am/pm—3rd month

I have been able to leave off the antibiotics recently. I only take them when I need them instead of taking them as a preventive.

Cardizem CD 120mg 1 QD

mucinep

Mucimax 120 120

Marcella

1-800-628-6215
282-6218

ANMED HEALTH
OUTPATIENT PHYSICIAN'S ORDER

APPT. DATE _____ TIME: _____
TODAY'S DATE 8-11-03
PRECERT NO. (if required
by insurance company): _____
☐ STAT ☐ CALL REPORT ☐ FAX ☐ ROUTINE

PATIENT NAME: Eddie Jones
PATIENT COMPLAINT: SDB
(Do not list probable, history of, questionable, rule out, status post or possible as part of the medical complaint.)

OUTPATIENT PROCEDURE(S): ☐ ANDERSON AREA MEDICAL CENTER ☐ ANMED HEALTH CAMPUS

CXR PA
LAT

G. Mohan, M.D. PHONE 281-7004 FAX: 281-0552
STREET _____ CITY _____ STATE/ZIP _____

Anderson Area Medical Center 281-1000
OSC Fax for Orders 281-1911
Rehab (P.T., O.T., Speech) 281-1198
AnMed FirstCall
To schedule appointment 281-2255
To pre-register for scheduled procedure 281-1492

AnMed Health Campus 281-1000
LifeChoice 718-8847
(Cardiac Rehab, Pulm. Rehab, Wellness)
See other side for locations of outpatient facilities.

PATIENT: You must bring this order with you at time of service

FORM 8143

Notes Should Be Signed by Physician		
DATE	MO	YR
HP	TR	PR
		
For Doctor: <u>Mohan</u> Date: <u>7/11</u> Time: <u>AM</u> Name: <u>Eddie Jones</u> Telephone: <u>222-0164</u> Pharmacy: <u>Bilo</u> Medication/Prescription: <u>needs Prednisone</u> Message: <u>20mg QD refilled</u>		
Please See Accompanying Prescribing Information. ☐ Returned your call ☐ Will call again ☐ Please call ☐ Refill ☐ Urgent		

8-11-03 Singular and Sudad called in for pt w/ @ Bezels on both. Pt also informed we can not call anything in for the fungus b/c it is not her specialty Per Dr. Mohan

		For Doctor: <u>Dr M</u> Date: <u>8/13</u> Time: <u>AM</u> Patient: <u>Archie Jones</u> Pharmacy Tel.: Caller Tel.: Allergies:
MESSAGE		
<u>Needs refill for 3</u>		
<u>Zopenex - 1.25 3 milligrams</u>		
<u>2000000</u>		
<u>Bilo - 226 0164</u>		
☐ Returned Call ☐ Please Call ☐ Will Call Again	☐ Refill ☐ Urgent	Received By:
Before prescribing VIOXX®, please read the accompanying full Prescribing Information.		

PROGRESS NOTES

P

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Archie Jones DATE: 9/11/03

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

Rx Serevent INHALER
11 puffs BID
120 puff canister
Refill x 5

DISPENSE AS WRITTEN

M.D.

SUBSTITUTION PERMITTED

M.D.

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

ALG 80 Puff ☐ Label

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Archie Jones DATE: 9/11/03

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

Rx Xopenex 125mg / 3ml
TQ 6x via nebulizer
30 day supply
refill x 5

DISPENSE AS WRITTEN

M.D.

SUBSTITUTION PERMITTED

M.D.

Refills: 0 1 2 3 5 PRN (WHEN NOT INDICATED, NO REFILL)

ALG 80 Puff ☐ Label

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Archie Jones DATE: 9/11/03

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

Rx Atroneumt .02% / 2.5 mL
TQB in nebulizer
30 day supply
Refill x 5

DISPENSE AS WRITTEN M.D. Dr. Carson PA-C M.D.
SUBSTITUTION PERMITTED
Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL) A680 Pm ☐ Label

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Archie Jones DATE: 9/11/03

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

Rx Theophylline 300mg
q BID
60
Refill x 5

DISPENSE AS WRITTEN M.D. Dr. Carson PA-C M.D.
SUBSTITUTION PERMITTED
Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL) A680 Pm ☐ Label

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Archie Jones DATE: 9/11/03

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

Rx Dexadrine 10mg
i QAm
#30

DISPENSE AS WRITTEN _____ M.D. [Signature] M.D. SUBSTITUTION PERMITTED _____

Refills: 0 2 3 4 5 (WHEN NOT INDICATED, NO REFILLS)

☐ Label

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Archie Jones DATE: 10/11/03

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

Rx Dexadrine 10mg
i QAm
#30

DISPENSE AS WRITTEN _____ M.D. [Signature] M.D. SUBSTITUTION PERMITTED _____

Refills: 0 2 3 4 5 (WHEN NOT INDICATED, NO REFILLS)

☐ Label

Date	Notes Should Be Signed by Physician		
	DATE 9-11-03	HGT: 5'10"	WGT: 285
	BP: 140/88	TEMP: 97.5	P: 100
	ALLERGIES: NKDA		

9-11-03 45mth Recheck. Feeling bad for
 3 wks, SOB, tired all the time, wheezing,
 Stomach burning, bad Pleurisy (ok for
 not sleeping soundly, Hands shaking
 Occas cough - prod of clear sputum. (KmJ)
 tired lately / denies depression + / no recheck
 due to mother's death
 A back to Serenent INH 70.46

Blood Group	DATE	HGT	WGT
high?	9-18-03	5'10"	235 lbs
	BP: 138/98	TEMP: 98.6	P: 100
	ALLERGIES: NKDA		

9-19-03 Pt is here because he is SOB. Says he feels
 very bad.
 cough prod yellow-green sputum @ear popping
 @throat's media
 Nebbs 1 QID
 Biaxin 500 BID x 10 d

PROGRESS NOTES

Date	Notes Should Be Signed by Physician		
	DATE: 10/6/03	HGT: 5'10"	WGT: 242
	BP: 142/94	TEMP: 98.8	P: 92
	ALLERGIES:		

10/6/03 FU 2wk recheck.

St. n having some problems w appliance
 Cough mildly prod of yellow sputum maintenance
 Back to 15mg prednisone
 -use nebs QID
 -watch diet

Spirometry
 901.82

OSA
 Chronic COPD

Am > 11m
 can walk slowly

DATE: 11-5-03	HGT: 5'10"	WGT: 241
BP: 140/108	TEMP: 97.8	P: 95
ALLERGIES:		
NKDA		

Q Sat 9:30p
 on O2

① HTN →
 FHL
 ↑ heart giv

11-5-03 SOB, congestion

195/100

Neural arm
 Numbness
 4 mm/day

No further

Now 7-20-04
 prednis 15

PROGRESS NOTES

Carolina Pulmonary and Sleep Center

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

605 East Greenville Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Archie Jones DATE: 11/3/03

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

Rx Biaxin XL 500mg PO q 12h
- 10 days.

DISPENSE AS WRITTEN M.D. [Signature] M.D.
SUBSTITUTION PERMITTED

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL) ☐ Label

Carolina Pulmonary and Sleep Center

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

605 East Greenville Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Archie Jones DATE: 11/3/03

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

Rx Prozac 50mg PO q 1x2 days,
fol 40mg PO q 1x3 days,
" 30mg PO " 1x3 days,
" 20mg PO " 1x3 days.

DISPENSE AS WRITTEN M.D. [Signature] M.D.
SUBSTITUTION PERMITTED

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL) ☐ Label

Date	Notes Should Be Signed by Physician									
	<table border="1"> <tr> <td>DATE:</td> <td>HGT:</td> <td>WGT:</td> </tr> <tr> <td>BP:</td> <td>TEMP:</td> <td>P:</td> </tr> <tr> <td colspan="3">ALLERGIES:</td> </tr> </table>	DATE:	HGT:	WGT:	BP:	TEMP:	P:	ALLERGIES:		
DATE:	HGT:	WGT:								
BP:	TEMP:	P:								
ALLERGIES:										
11-13-03	Augmentin 1000mg + 9180 x10 days called into Bilo Pharmacy 220-01109									
	Archie 220-01109/11/16 Singulair 10mg Refill 5 BID 30 days Sudal 1000 CR TI BID - 30 days									

WHILE YOU WERE AWAY

FOR <u>Eddie Jones</u>	DATE <u>11/16/14</u>	TIME <u>5:00</u>	A.M. P.M.
M <u>discolored sputum</u>			
OF <u>and coughing. wheezing</u>			
PHONE ☐ FAX ☐ <u>224-2669</u>	PHONED		
AREA CODE <u>224</u> NUMBER <u>2669</u> EXTENSION	RETURNED YOUR CALL		
MESSAGE <u>Augmentin XL 1000</u>	PLEASE CALL		
<u>see Rednison (mainline)</u>	WILL CALL AGAIN		
<u>to Bilo Pharmacy</u>	CAME TO SEE YOU		
SIGNED <u>[Signature]</u>	WANTS TO SEE YOU		

FORM 4002

PROGRESS NOTES

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Archie Jones DATE: 11/11/03

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

Rx Dexadrine 10mg
7 QAM
30

DISPENSE AS WRITTEN M.D. JMh SUBSTITUTION PERMITTED M.D.

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILLS)

☐ Label

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943- SC LICENSE NO. 17935

1209 B North Fant Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Archie Jones DATE: 12/11/03

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

Rx Dexadrine 10mg
7 QAM
30

DISPENSE AS WRITTEN M.D. JMh SUBSTITUTION PERMITTED M.D.

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILLS)

☐ Label

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943 - SC LICENSE NO. 17935

1403 East Greenville Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Archie Jones

ADDRESS: _____

DATE: 12-16-03

Rx Guafenesin 600mg + PO BID

- 30 days

Refill: 5

DISPENSE AS WRITTEN

M.D.

SUBSTITUTION PERMITTED

M.D.

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

☐ Label

MSD 1103

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943 - SC LICENSE NO. 17935

1403 East Greenville Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Archie Jones

ADDRESS: _____ DATE: 1/22/04

R Pulmicort 0.5mg unit, Aerosol
refill 9/12
Doxycycline 100mg PO
30 days
7 days

DISPENSE AS WRITTEN M.D. SUBSTITUTION PERMITTED M.D.

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL) ☐ Label

MSD 1103

Date	Notes Should Be Signed by Physician			
	DATE: 1-22-04	HGT: 5'10"	WGT: 250	O ₂ SAT 97%
	BP: 150/88	TEMP: 98.8	P: 84	ON R/A
	ALLERGIES: NKDA			

1-22-04 Having Thick Greenish Sputum
w/ Dyspnea.

D/c pulmonary edema

Reason: pulmonary edema

Revised

104/125/17

Other
Signs
of
CHF
Bronchitis

2/19/04 (226-0164) (Bilo Pharmacy "John") refilled script for Albuterol inhaler 2 puffs every 4 hrs as needed (~~226-0164~~) Tr

DATE: 3-1-04	HGT: 5'10"	WGT: 249	O ₂ SAT 97%
BP: 150/96	TEMP: 98.5	P: 96	ON R/A
ALLERGIES: NKDA			

PROGRESS NOTES

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943 - SC LICENSE NO. 17935

1403 East Greenville Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Eddie Jones

ADDRESS: _____ DATE: 2-12-04

Rx Prednisone 20mg ti po qd
Refill ⑤ - 30 days

Actonel 35mg ti qwk
Refill ⑤ - 30 days

DISPENSE AS WRITTEN M.D. _____ SUBSTITUTION PERMITTED M.D.

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

☐ Label

8880 1103

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943 - SC LICENSE NO. 17935

1403 East Greenville Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Eddie Jones

ADDRESS: _____ DATE: 2-12-04

Rx Celebrex 200mg ti po qd
Refill ⑤ - 30 days

Docusate 300mg ti po qd
Refill ⑤ - 30 days

DISPENSE AS WRITTEN M.D. _____ SUBSTITUTION PERMITTED M.D.

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

☐ Label

8880 1103

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943 - SC LICENSE NO. 17935

1403 East Greenville Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Eddie Jones

ADDRESS: _____ DATE: 2-12-04

R. Prevacid 30mg + PO BID

Refill ⑤ - 30 days

Singulair 10mg + PO qd

Refill ⑤ - 30 days

DISPENSE AS WRITTEN M.D. _____ M.D.
SUBSTITUTION PERMITTED

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

☐ Label

6880 11/03

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943 - SC LICENSE NO. 17935

1403 East Greenville Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Eddie Jones

ADDRESS: _____ DATE: 2-12-04

R. Dexadrine 10mg + qam

- 30 days

Sudaf 40/600 + PO BID

Refill ⑤ - 30 days

DISPENSE AS WRITTEN M.D. _____ M.D.
SUBSTITUTION PERMITTED

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

☐ Label

6880 11/03

February 19, 2004

Health Care Provider's Statement of Disability

Patient's Name: Archie E. Jones Social Security Number: 250-70-5119

1. Diagnosis: COPD, Bronchietum

2. Treatment:

a. Date of first treat visit: Month 11 Day 01 Year 02
 b. Date of last visit: Month 03 Day 01 Year 04
 c. Frequency of treatment: Weekly ☐ Monthly ☐ Other ☐

3. Progress Recovered ☐ Improved ☐ Unimproved ☒ Regressed ☐

4. Extent of Disability For Any Occupation

a. Is patient now totally disabled? Yes ☒ No ☐
 b. If no, when was patient able to go to work? Month _____ Day _____ Year _____
 c. If yes, when do you think patient will be able to resume any work?
 Approximate Date: _____
 Indefinite ☐
 Never ☒

5. Mental Condition:

Has significant anxiety and psychological problem

1. Is the Patient competent to endorse checks and direct the use of the proceeds thereof?

Yes ☒ No ☐

Remarks:

Art is not medically + psychologically fit to work.
Continues to have significant COPD

Date _____ Signature (Attending Physician) _____ Degree _____ Telephone No. 864-231-7004

1403 E. Greenville St Anderson, SC 29621
 Street Address City or Town State Zip Code

Return form to:
 3M Disability Program, Building 551-1W-04, PO Box 33115, St. Paul, MN 55133-3115

February 19, 2004

Continuance of Disability Claim Form

Employee Name: Archibald Jones Social Security Number: 250-70-5119

Current Address: 1529 Salem Church Rd

Anderson, SC 29625 Telephone Number: 864-224-2669

Attending physician: Name Gandhiani, Mohan, M.D.

Address 1403 E. Greenville St, Anderson, SC 29621

Phone 864-231-7004

Dates of Treatment since last report: 4-11-03, 9-11-03, 9-18-03, 10-6-03, 11-3-03
1-22-04, 3-1-04

Have you returned to work? No

If yes, the date you returned to work None

How many hours per week? _____

Name, address, and telephone number of current employer: _____

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943 - SC LICENSE NO. 17935

1403 East Greenville Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME:

Archie Jones

ADDRESS:

DATE:

3/1/04

Rx Cardizem CD 120mg 1 Po qam
-30 days

DISPENSE AS WRITTEN

M.D.

G. Mohan

M.D.

SUBSTITUTION REQUESTED

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

☐ Label

MSD 1103

Date

Notes Should Be Signed by Physician

DATE: 3/1/04	HGT:	WGT:
BP:	TEMP:	P:
ALLERGIES:		

3-1-04 Nebulizer is drying out mouth & tongue - pt has dark, green secretions

Xopenex / Albuterol nebs

separate from Pulmatort - rinse mouth

drink plenty of fluid & P 6pm

Caffeine

Casady 1200 AM
may try B mg prednisone

707.293

3/1/04

Mycelis

Trache - 1 1/2

times a day

x 14 days

lhr

WHILE YOU WERE AWAY

FOR: Dr. M.	DATE: 3/5/04	TIME: 9:30 A.M.
M: Mycelis Trache		
OF: 1	5 times a day	PHONED
PHONE: ☐ FAX ☐ VOICE	day x 14 days	RETURNED YOUR CALL
MESSAGE: pt states has much from nebulizer would like Rx		PLEASE CALL
called to Bldg 226-0164		WILL CALL AGAIN
SIGNED: Debbie	called 3/1/04	CAME TO SEE YOU
		WANTS TO SEE YOU

3-24-04 found 3-1-04 office note to Mary (caseworker) 864 228-1697

PROGRESS NOTES

AUTHORIZATIONS REFERRALS

3-10-04 | It scheduled for PET's on 3/10/04.

| Marcella Wheeler from Liberty Mutual

| called due to no ins prior-authorization.

| Requests medical Documentation to

| support medical necessity. Need to fax

| to 603-834-8050. ^{Attn: Marcella Wheeler} Liberty Mutual

| authorized PET's. Ordered by Dr. Mohan.

| to determine breathing /lung capacity per

| Dr. Mohan via phone conversation on 3/10/04.

(PB)

3-22-04 | Saved letter of medical necessity to

| Liberty Mutual Attn: Marcella Wheeler.

ANMED  HEALTH

OUTPATIENT PHYSICIAN'S ORDER

APPT. DATE: 3-10-04 TIME: 9:00am

TODAY'S DATE _____
PRECERT NO. (if required
by insurance company): _____

☐ STAT ☐ CALL REPORT ☐ FAX ☐ ROUTINE

PATIENT NAME: Annie Jones

PATIENT COMPLAINT: CPED
(Do not list probable, history of, questionable, rule out, status post or possible as part of the medical complaint.)

OUTPATIENT PROCEDURE(S): ☐ ANDERSON AREA MEDICAL CENTER ☒ ANMED HEALTH CAMPUS

Complete PFT

G. Mohan, M.D. PHONE: 261-7001 FAX: 261-0552

STREET _____ CITY _____ STATE/ZIP _____

Anderson Area Medical Center 261-1000
OSC Fax for Orders 261-1911
Rehab (P.T., O.T., Speech) 261-1198

AnMed FirstCall
To schedule appointment 261-2255
To pre-register for scheduled procedure 261-1482

AnMed Health Campus 261-1000
LifeChoice 716-6847
(Cardiac Rehab, Pulm. Rehab, Wellness)

See other side for locations of outpatient facilities.

FORM #143

PATIENT: You must bring this order with you at time of service

**CAROLINA PULMONARY AND SLEEP CENTER
1403 E. GREENVILLE STREET
ANDERSON, SC 29621
(864) 231-7004**

LETTER OF MEDICAL NECESSITY

RE: ARCHIE JONES
CHART: 200000000

3-22-04

Reference to: Archie Jones.

Respected Sir/Madam,

This letter is in reference to Mr. Archie Jones, a patient of mine, who has had lung injury secondary to exposure to thermal fumes. The patient has been disabled for many years secondary to this. For followup on his pulmonary function, I need to have a complete pulmonary function test done to assess his functional status.

If you have any questions regarding this, please feel free to call me.

Yours sincerely,



GOWDHAMI MOHAN, M.D.

C50484385

Eddie Jones (Archie)

MEDICATIONS 03/22/04

- Albuterol-USP: 180mg 2to4 times day (as needed, when away from nebulizer)
- Atrovent Inhaler: 2puffs-2to4 times day (as needed when away from nebulizer)
- Atrovent: (Nebulizer solution): 2.5ml 4 times day
- Pulmacort Inhaler: 2 puffs-am/pm (usual medicine)
- Pulmacort (nebulizer solution) every 12 hours as needed.
- Xopenex: (Nebulizer solution): 3ml 4 times day
- Combivent Inhaler: 2 puffs-2to4 times day (as needed)
- Serevent: 1 puff (powder disk) am/pm
- Singulair: 10mg-pm
- Theophylline: 300mg-am/pm
- Humibid (Mucinex): 600mg-am/pm
- Prednisone: 20mg-pm (increase as needed)
- Biaxin XL: 1000mg am (7days-end 1/23/04) ←
- Doxycycline Hyc: 100mg am/pm (start 1/27/04)
- Saline Nasal Spray: 2 to 4 times day
- Liquid Tears: 2 drops each eye-4 times day (with hot compresses)
- Prevacid: 30mg-am/pm
- Sudal DM: 2 pills-am/pm
- Su-tuss DM cough syrup (as needed)
- Risperdal: 25mg-am/.25mg-pm
- Depakote: 1000mg-pm
- Plavix: 75mg-am
- Aspirin: 81mg-am
- Cartia XT: 40mg-am (as needed)
- Mycellex Troche: 10mg-5 times a day
- Dexadrine: 10mg-am
- Zolof: 100mg-am
- Actonel: 35mg-weekly/am
- Celebrex: 200mg-am/pm
- Regranex: Apply twice a day (Rt. foot)
- Silicone bandage (Rt. foot)
- Lamisil: 250mg-pm
- Amlactin Lotion: daily on skin donor
- Colace: 300mg am/pm

(Daily)

- Multi-vitamin
- 100mg Vitamin C
- 400 IU Vitamin E
- 1200mg Calcium

(Once a month I alternate antibiotics to counteract the immune suppressant effect of prednisone and the hardening of my lungs from thermal and chemical burn. They are:

- Biaxin: 500mg-am for 7 days—1st r
- Tequin: 400mg-am for 7 days—2nd r
- Augmentin: 875mg am/pm—3rd r

I have been able to leave off the antibiotics recently. I only take them when I need instead of taking them as a preventive

DR. MOTTAL 12-8-04
12/21/04 called to
Belle
Theophylline 300mg SR-60TAS
TAKE ONE TABLET BY MOUTH TWICE DAILY

② Singulair 60-500 CR - 120 TABLETS
TAKE TWO TABLETS BY MOUTH TWICE DAILY

③ DEXTROAMPHETAMINE-10 SR 30 CAPS
TAKE ONE CAPSULE ONCE DAILY

④ SINGULAIR 10MG-ORAL TABLET-30 TAB
TAKE ONE TABLET DAILY

⑤ PREDNISONE-20MG 30 TABS
TAKE ONE TABLET BY MOUTH ONCE DAILY

⑥ MUCINEY ER 600MG 60 TABS M
TAKE ONE TABLET TWICE DAILY

⑦ CELEBREX 200MG 60 CAP
TAKE TWO CAPSULES BY MOUTH DAILY

⑧ Pulmacort TURBO INHALER

Date _____ Notes Should Be Signed by Physician

3-30-04 pt called requesting refill for Prednisone 20 mg. 1 tab per Dr Moham. called in Rx to Bilo 226-0164 @ 1st for Prednisone 20 mg 100 30 tabs x 5 refills. spoke to Julie informed pt @ LM on volcarin

7-30-43

WHILE YOU WERE AWAY

FOR <u>Dr M</u>	DATE <u>3/30</u>	TIME _____	A.M. P.M.
M. <u>Bilo Pharmacy</u>			
OF _____			
PHONE ☐ FAX ☐ <u>226 0522</u>			
AREA CODE <u>226</u>	NUMBER <u>0522</u>	EXTENSION _____	
MESSAGE <u>Archie Jones needs</u>			
<u>Refill - Prednisone 20 mg 100</u>			
<u>Refill 5 - 30 days</u>			
SIGNED _____			

FORM 4002

WHILE YOU WERE AWAY

FOR <u>Dr M</u>	DATE <u>3/9</u>	TIME _____	A.M. P.M.
M. <u>Mary lat nurse case manager</u>			
OF _____			
PHONE ☐ FAX ☐ <u>864 228 9679</u>			
AREA CODE <u>864</u>	NUMBER <u>228</u>	EXTENSION <u>9679</u>	
MESSAGE <u>re Archie Jones</u>			
<u>needs given for HBP - this</u>			
<u>has not been approved - they</u>			
<u>Need documentation related to loss of</u>			
SIGNED <u>Workless Comp</u>			

FORM 4002

PROGRESS NOTES

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943 - SC LICENSE NO. 17935

1403 East Greenville Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME:

Archie. Jones.

ADDRESS:

DATE:

4/6/04

Rx Doxamine 10mg. $\text{O} \text{P} \text{Q} \text{D}$
- 30 days.

DEPENDENT AS WRITTEN

M.D.

SUBSCRIPTION INITIALED

M.D.

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

☐ Label

MSD 11/03

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943 - SC LICENSE NO. 17935

1403 East Greenville Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Eddie Jones
ADDRESS: _____ DATE: 4/23/04

Rx Please provide
New dental appliance

DISPENSE AS WRITTEN M.D. G. Mohan M.D.
SUBSTITUTIONS PERMITTED

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILLS)

☐ Label

6030 11/03

			
Please see accompanying full prescribing information.			
For Doctor	<u>Dr. M.</u>	Returned	☐
Patient	<u>Archie Jones</u>	Call	☐
Caller Tel.	<u>224-2109</u>	Please Call	☐
Date	<u>5/4</u>	Will Call Again	☐
Time	<u>AM</u>	Refill	☐
Pharmacy Tel.		Urgent	☐
Allergies		Message	<u>Needs Script for Dexadrine</u>
		Received By	

Carolina Pulmonary and Sleep Center, P.A.

Govdhami Mohan, M.D.

DEA NO. BM2908943 - SC LICENSE NO. 17935

1403 East Greenville Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME: Archie Jones DATE: 5-4-04

ADDRESS: _____
 Rx Dexadrine 10mg q 8 AM 30 days

 DISPENSE AS WRITTEN M.D. _____ M.D.
 Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED NO REFILL) ☐ Label

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943 - SC LICENSE NO. 17935

1403 East Greenville Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME:

Rehmi Jones

ADDRESS:

DATE:

5/18/04

Rx

Dexedrine 10mg

QD

- 30 days

#30 Tablets

DISPENSE AS WRITTEN

M.D.

[Signature]

M.D.

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

SUBSTITUTION PERMITTED

☐ Label

MSD 11/03

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943 - SC LICENSE NO. 17935

1403 East Greenville Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME:

Rehmi Jones

ADDRESS:

DATE:

6/18/04

Rx

Dexedrine 10mg

QD

- 30 days

#30 Tablets

DISPENSE AS WRITTEN

M.D.

[Signature]

M.D.

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

SUBSTITUTION PERMITTED

☐ Label

MSD 11/03

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943 - SC LICENSE NO. 17935

1403 East Greenville Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME:

Archie Jones

ADDRESS:

DATE:

5/18/04

R Lacosate Na 100mg Capsule
#(3) PO q12h
- 30 days

#180 Tablets

M.D.

G. Mohan

M.D.

DISPENSE AS WRITTEN

SUBSTITUTION PERMITTED

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

☐ Label

8880 11/03

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943 - SC LICENSE NO. 17935

1403 East Greenville Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME:

Archie Jones

ADDRESS:

DATE:

7/10/04

Rx

Dexedrine 10mg ① PO q.d.
- 30 days

#30 Tablets

DISPENSE AS WRITTEN

M.D.

SUBSTITUTION REQUESTED

M.D.

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

☐ Label

8880 1100

Carolina Pulmonary and Sleep Center, P.A.

Gowdhami Mohan, M.D.

DEA NO. BM2908943 - SC LICENSE NO. 17935

1403 East Greenville Street, Anderson, SC 29621 (864) 231-7004

PATIENT'S NAME:

Archie Jones

ADDRESS:

DATE:

8/10/04

Rx

Dexedrine 10mg ① PO q.d.
- 30 days

#30 Tablets

DISPENSE AS WRITTEN

M.D.

SUBSTITUTION REQUESTED

M.D.

Refills: 0 1 2 3 4 5 PRN (WHEN NOT INDICATED, NO REFILL)

☐ Label

8880 1100

Universal Medication Information

Patient's Name: <u>Archie Jones</u>
Social Security #: <u>950-70-3112</u>
Birthdate: <u>7-30-43</u>

Phone Number: <u>224-26009</u>
Address: <u>1829 Salem Church Rd</u> <u>Anderson, SC 29625</u>

Allergic To: (Include Medications, Foods, or anything else): <u>NBDA</u>	Description of Reaction:

Medications: Include all prescription and over-the-counter (non-prescription) medications such as vitamins, Aspirin, Tylenol, and herbals (examples: Ginseng, Ginkgo biloba, St. John's Wort)

Name of Medications Presently Taking/Strength:	Directions:	Prescribing Physician:	Date Started:	Date Stopped:	Confirmed by/ Date: (Doctor's office use only)
Example: Zantac 150mg	Two times a day	Dr. Smith	6/7/00		
1. Albuterol	prn	Dr. Mohan			
2. Albuterol	prn	Dr. Mohan			
3. Combivent	prn	Dr. Mohan			
4. Xopenex - neb	BID	Dr. Mohan			
5. Albuterol - neb	BID	Dr. Mohan			
6. Serevent	prn	Dr. Mohan			
7. Pulmicort	prn	Dr. Mohan			
8. Singulair 10mg	+ qam	Dr. Mohan			
9. Theophylline 800mg	+ BID	Dr. Mohan			
10. Biaxin 500mg	+ qd	Dr. Souriron			
11. Prednisone 5mg	+ qd	Dr. Mohan			
12. Saline spray	2-4 qd	Dr. Souriron			
13. Prevacid 30mg	+ qd	Dr. Souriron			
14. Sudal DM	+ BID	Dr. Souriron			
15. Flomax 10mg	+ qd	Dr. Souriron			
16. Risperdal 0.5mg BID	+ qam	Dr. Souriron			
17. Depakote 500mg	+ qam	Dr. Souriron			
18. Plavix 75mg	+ qd	Dr. Souriron			
19. Dexam. 0.5mg qam	+ 5mg qam	Dr. Mohan			
20. Zolof 50mg	+ qam	Dr. Souriron			
21. Colace 300mg	+ q BID	Dr. Souriron			
22. Teguin 400mg	+ qd	Dr. Souriron			
23. Augmentin 800mg	+ qd	Dr. Souriron			
24. Celebrex 200mg	+ qam	Dr. Souriron			
25. Amitri	+ qam	Dr. Souriron			

#31513

Eddie Jones (Archie)

MEDICATIONS 09/18/04

Albuterol-USP: 180mg 2to4 times day (as needed, when away from nebulizer) INHALER

Atrovent: 2puffs 2to4 times day (as needed when away from nebulizer)

Combivent: 2 puffs 2to4 times day (as needed)

SMZ TMP DS 800-160 (BACTRIM) TWICE DAILY (924-06)

Xopenex: (Nebulizer solution): 3ml. 4 times day

Flomax: .4mg ONCE A DAY

Atrovent: (Nebulizer solution): 2.5ml. 4 times day

FUROSEMIDE: 20mg EVERY OTHER DAY

Serevent: 2 puff-(powder disk) am/pm

Pulmacort: 2 puffs-am/pm (usual medicine)

Pulmacort (nebulizer solution) every 12 hours as needed.

Singulair: 10mg-pm

Theophylline: 300mg-am/pm

Humibid (Mucloax): 800mg-am/pm

Prednisone: 20mg-pm (increase as needed) (15)

Saline Nasal Spray: 2 to 4 times day

Liquid Tears: 2 drops each eye-4 times day (with hot compresses)

Prevacid: 30mg-am/pm

~~200mg-2 pills am/pm~~ GUAFEN/PSEPHED SR: 1120mg 2 TIMES A DAY

Su-tuss DM cough syrup (as needed)

Risperdal: .25mg-am/.25mg-pm .50am/.50pm 11/30/06

Depakote: 1000mg-pm

Plavix: 75mg-am

Cartia XT: 240mg-am

~~Aspirin: 81mg-8 times a day when needed~~

Aspirin: 81mg-am

Dexadrine: 10mg-am

Zolof: 100mg-am

Actonel: 35mg-weekly/am

Celebrex: 200mg-am/pm

Regranex: Apply once a day (Rt. foot).

Silicone bandage (Rt. foot) 2 places

Lamisil: 250mg-pm

Amlactin Lotion: daily on skin donor areas

Colace: 300mg am/pm

(Daily)

Multi-vitamin, B12, Potassium, GLUCOSAMINE CHONDROITIN

200mg Vitamin C

1000 IU Vitamin E

1200mg Calcium

(Once a month I alternate antibiotics to counteract the immune suppressant effects of prednisone and the hardening of my lungs from thermal and chemical burns.)

They are:

Biaxin: 500mg-am for 7 days—1st month

Tequin: 400mg-am for 7 days—2nd month

Augmentin: 875mg am/pm—3rd month

I have been able to leave off the antibiotics recently. I only take them when I need them

INSTEAD OF TAKING THEM AS A

PREVENTIVE.

Levothyroxine
Mucinex EA

8th Page 1

10/6/03

4/28/06

INTERN. MEDICINE ASSOCIATES OF ANDERSON, P.A.

2000 East Greenville Street • Suite 1100 • Anderson, SC 29621 • (864) 225-5667 • FAX (864) 716-6116

NAME: Ricki (Eddie) Jones
 DATE: 8/27/07 AGE: [redacted] WT: 227 BP: 140/100 PULSE 90
 DOCTOR: Mohan ACCT# 31513 RESP. 12
 (OV) Temp 98.0
 O2 sat 97%
 Not seen

✓ 12-8-04

wt: 837

Oral Aug Monday - off Plavix -

Actonel -

11/2/10

12/15/04 (call in)

coughing up green slem - streaks of blood
 no fever start antibiotics
 Bill Mann
 Levoquin 750mg po qd
 7 days

Internal Medicine / Cardiology
 JOHN B. MARTIN, JR., M.D., F.A.C.P.
 Diagnostic and Invasive Cardiology
 THOMAS J. SULLIVAN, JR., M.D., F.A.C.C., F.A.C.P.
 RHONDA L. DUNCAN, M.D.

General Internal Medicine
 HENRY C. MARTIN, M.D. JOSEPH A. FARAIER II, M.D.
 C. WILSON SOFLEY, JR., M.D. MICHAEL R. KUNKEL, M.D.
 Gastroenterology/Hepatology
 DAVID T. WORTHAM, M.D.

Pulmonary and Critical Care
 WILLIAM W. WALKER, M.D., F.A.C.P.
 STEPHEN H. HAND, M.D.
 Nurse Practitioner
 ANGELA REEVES, R.N., F.N.P.
 SARAH B. LONG, R.N., F.N.P.

Eddie Jones(Archie)

MEDICATIONS 12/08/04

Albuterol-USP: 180mg 2to4 times day (as needed,when away from nebulizer)

Atrovent: 2puffs 2to4 times day (as needed when away from nebulizer)

Combivent: 2 puffs 2to4 times day (as needed)

Xopenex:(Nebulizer solution): 3ml. 4 times day

Atrovent: (Nebulizer solution): 2.5ml. 4 times day

Serevent: 2 puff-(powder disk) am/pm

Pulmacort: 2 puffs-am/pm (usual medicine)

Pulmacort (nebulizer solution) every 12 hours as needed.

Singulair: 10mg-pm

Theophylline: 300mg-am/pm

Humibid (Mucinex) : 800mg-am/pm

Prednisone: 20mg-pm (increase as needed)

Saline Nasal Spray: 2 to 4 times day

Liquid Tears: 2 drops each eye-4 times day(with hot compresses)

Prevacid: 30mg-am/pm

Sudal DM : 2 pills-am/pm

Su-tuss DM cough syrup(as needed)

Risperdal: .25mg-am/.25mg-pm

Depakote: 1000mg-pm

Plavix: 75mg-am(Omitting for oral surgery 12/13/04)

Cartia.XT: 240mg-am

Mycelax Troche: 10mg- 5 times a day-when needed

Aspirin: 81mg-am(Omitting for oral surgery 12/13/04)

Dexadrine: 10mg-am

Zoloft: 100mg-am

Actonel: 35mg-weekly/am

Celebrex: 200mg-am/pm

Regranex: Apply once a day(Rt. foot).

Silicone bandage (Rt. foot) 2 places

Lamisil: 250mg-pm

Amiactin Lotion : daily on skin donor areas

Colace: 300mg am/pm

(Daily)

Multi-vitamin

200mg Vitamin C

1000 IU Vitamin E

1200mg Calcium

(Once a month I alternate antibiotics to counteract the immune suppressant effects of prednisone and the hardening of my lungs from thermal and chemical burns.)

They are:

Blaxin: 500mg-am for 7 days—1st month

Tequin: 400mg-am for 7 days—2nd month

Augmentin: 875mg am/pm—3rd month

I have been able to leave off the antibiotics recently. I only take them when I need them

E. Greenville Street, Suite 1100 - Anderson, S.C. 29621
Phone 864-223-6667
Fax 864-716-8116

HENRY C. MARTIN, M.D. DEA No. AM1485564	THOMAS J. SULLIVAN, JR., M.D. DEA No. BS1346774	GOWDHAMI MOHAN, M.D. DEA No. BM2908943
C. WILSON BOFLEY, JR., M.D. DEA No. BS3322469	WILLIAM W. WALKER, M.D. DEA No. AW7120619	CHARLES A. THOMPSON, M.D. DEA No. BT4135061
STEPHEN H. HAND, M.D. DEA No. BH2091229	MICHAEL R. KUNKEL, M.D. DEA No. BK4842080	CARLENE P. WILSON, M.D. DEA No. BW7395559
JOSEPH A. FARMER, III, M.D. DEA No. BF1438167	CHRISTOPHER E. LACROIX, M.D. DEA No. BL4216382	

FOR Archie Jones

ADDRESS _____ DATE 12/15/04

R Mr. Archie Jones is a pleasant middle
aged male who has bronchitis 2° to
bronchiectasis 2° to COPD 2° inhalation
lung injury. Call me if you
have any questions.

_____, M.D. _____, M.D.
Dispense As Written Substitution Permitted

THIS PRESCRIPTION IS THE PROPERTY OF THE PHARMACY AND IS NOT TO BE REPRODUCED OR COPIED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE PHARMACY.

THANK YOU

ADDITIONAL NOTES AND ROUTING INSTRUCTIONS

THIS PRESCRIPTION IS THE PROPERTY OF THE PHARMACY AND IS NOT TO BE REPRODUCED OR COPIED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE PHARMACY.

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February 3, 2005

Health Care Provider's Statement of Disability

Patient's Name: ARCHIE E. JONES Social Security Number: 250-11-5511

1. Diagnosis: COPD; bronchiectasis

2. Treatment:

a. Date of first treat visit: Month 11 Day 07 Year 02
 b. Date of last visit: Month 12 Day 10 Year 04
 c. Frequency of treatment: Weekly ☐ Monthly ☐ Other ☐

3. Progress Recovered ☐ Improved ☐ Unimproved ☒ Regressed ☐

4. Extent of Disability For Any Occupation

a. Is patient now totally disabled? Yes ☒ No ☐
 b. If no, when was patient able to go to work? _____ Month _____ Day _____ Year _____
 c. If yes, when do you think patient will be able to resume any work?
 Approximate Date: _____
 Indefinite ☐
 Never ☒

5. Mental Condition: patient has significant anxiety and psychological problems

Remarks: patient is not medically able to work

2-11-05 [Signature] M.D. (864) 825-5667
 Date Signature (Attending Physician) Degree Telephone No.
200 E. Greenville St. Anderson SC 29621
 Street Address City or Town State Zip Code

Return form to:
 3M Disability Program, Building 551-1W-04, PO Box 33115, St. Paul, MN 55133-3115

INTERNAL MEDICINE ASSOCIATE/ ANDERSON, P.A.
2000 E. Greenville Street, Suite 1100 - Anderson, S.C. 29621
Phone 854-225-5667
Fax 854-715-6118

HENRY C. MARTIN, M.D. DEA No. AM1485584	THOMAS J. SULLIVAN, JR., M.D. DEA No. BS1346774	GOWDHAMI MOHAN, M.D. DEA No. BM2908943
C. WILSON SORLEY, JR., M.D. DEA No. BS3522489	WILLIAM W. WALKER, M.D. DEA No. AW7120619	CHARLES A. THOMPSON, M.D. DEA No. BT4135061
STEPHEN H. HAND, M.D. DEA No. BH2091229	MICHAEL R. KUNKEL, M.D. DEA No. BK4842080	CARLENE P. WILSON, M.D. DEA No. BW7396559
JOSEPH A. FARMER, III, M.D. DEA No. BF1439187	CHRISTOPHER E. LACROIX, M.D. DEA No. BL8215382	SARAH B. LONG, APRN, BC DEA No. MB0366751

FOR Chick Jones DATE 3/2/05

R Serevent Inhaler
1
Sig: 2 puffs 2-4 x's qd
Q LABEL 5 times PRN NR
REFILL 5
Dispense As Written, M.D. Substitution Permitted

STEPHEN H. HAND, M.D. DEA No. BH2091229	MICHAEL R. KUNKEL, M.D. DEA No. BK4842080	CHRISTOPHER E. LACROIX, M.D. DEA No. BL8215382
JOSEPH A. FARMER, III, M.D. DEA No. BF1439187		

FOR Chick Jones DATE 3/2/05

R Zoloft 100mg
30
Sig: qd
Q LABEL 5 times PRN NR
REFILL 5
Dispense As Written, M.D. Substitution Permitted

HENRY C. MARTIN, M.D. DEA No. AM1485584	THOMAS J. SULLIVAN, JR., M.D. DEA No. BS1346774	GOWDHAMI MOHAN, M.D. DEA No. BM2908943
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JOSEPH A. FARMER, III, M.D. DEA No. BF1439187	CHRISTOPHER E. LACROIX, M.D. DEA No. BL8215382	SARAH B. LONG, APRN, BC DEA No. MB0366751

FOR Chick Jones DATE 3/2/05

R Prevacid 30mg
60
Sig: qd B1D
Q LABEL 5 times PRN NR
REFILL 5
Dispense As Written, M.D. Substitution Permitted

U.S. DEPT. OF JUSTICE
DEA No. BH2091229
JOSEPH A. FARMER, III, M.D.
DEA No. BF1439187
CHRISTOPHER E. LACROIX, M.D.
DEA No. BL8215382
SARAH B. LONG, APRN, BC
DEA No. MB0366751
DATE 3-2-05
FOR Chick Jones
ADDRESS _____
DATE 3-2-05
R Acetaminophen 325mg
4
Sig: qd
L

www C. Greenville Street, Suite 1100 - Anderson, S.C. 29521
Phone 864-225-5657
Fax 864-718-6118

HENRY C. MARTIN, M.D. DEA No. AM1485584	THOMAS J. SULLIVAN, JR., M.D. DEA No. BS1346774	GOWDHARI MOHAN, M.D. DEA No. BM2908943
C. WILSON SOFLEY, JR., M.D. DEA No. BS3522489	WILLIAM W. WALKER, M.D. DEA No. AW7120619	CHARLES A. THOMPSON, M.D. DEA No. BT4135081
STEPHEN H. HAND, M.D. DEA No. BH2091229	MICHAEL R. KUNKEL, M.D. DEA No. BK4542080	CARLENE P. WILSON, M.D. DEA No. BW7398559
JOSEPH A. FARMER, III, M.D. DEA No. BF1439187	CHRISTOPHER E. LACROIX, M.D. DEA No. BL8215382	SARAH B. LONG, APRN, BC DEA No. MB0366751

FOR Archie Jones DATE 3/2/05
ADDRESS _____

R

albuterol Inhaler
#1
Sig: 2 puffs 2-4x qd

Q LABEL 5
REFILL _____ times PRN NR

Dispense As Written _____, M.D. Substitution Permitted _____, M.D.
JOSEPH A. FARMER, III, M.D. CHRISTOPHER E. LACROIX, M.D. SARAH B. LONG, APRN, BC
DEA No. BF1439187 DEA No. BL8215382 DEA No. MB0366751

FOR Archie Jones DATE 3/2/05
ADDRESS _____

R

lorazepam N/A USP
100mg # 180
Sig: 3 BID

Q LABEL 5
REFILL _____ times PRN NR

Dispense As Written _____, M.D. Substitution Permitted _____, M.D.
DEA No. BH2091229 DEA No. BK4542080 SARAH B. LONG, APRN, BC
JOSEPH A. FARMER, III, M.D. CHRISTOPHER E. LACROIX, M.D. DEA No. MB0366751
DEA No. BF1439187 DEA No. BL8215382

FOR Archie Jones DATE 3/2/05
ADDRESS _____

R

Nexadrine Transpules #30
10mg
Sig: 1 qd

Q LABEL
REFILL _____ times PRN NR

Dispense As Written _____, M.D. Substitution Permitted _____, M.D.

2000 E. Greenville Street, Suite 1100 - Anderson, S.C. 29621
Phone 854-225-8887
Fax 854-718-6118

FOR Alchis Jones
ADDRESS _____ DATE 4/12/05

Sig: gl #30

Q. LABEL
REPL. times PRN NR

Disburse As Written

Substitution Permitted

~~Charles Egan Jr~~

INTERNAL MEDICINE ASSOCIATES OF ANDERSON, P.A.
 2000 E. Greenville Street, Suite 1100 - Anderson, S.C. 29621
 Phone 804-225-5837
 Fax 804-716-8118

HENRY C. MARTIN, M.D. DEA No. AM1485564	THOMAS J. SULLIVAN, JR., M.D. DEA No. BS1346774	GOWDHAMI MOHAN, M.D. DEA No. BM2908943
C. WILSON BOFLEY, JR., M.D. DEA No. BS3522489	WILLIAM W. WALKER, M.D. DEA No. AW7120818	CHARLES A. THOMPSON, M.D. DEA No. BT4135061
STEPHEN H. HAND, M.D. DEA No. BH2091229	MICHAEL R. KUNKEL, M.D. DEA No. BX4642089	CARLENE P. WILSON, M.D. DEA No. BW7399359
JOSEPH A. FARMER, III, M.D. DEA No. BF1439187	CHRISTOPHER E. LACROIX, M.D. DEA No. BL2153682	

FOR Rescue Jones DATE 5/11/05
 ADDRESS _____

B Dexamethasone 10mg #30
 Sig: po q am

[Signature]
 _____, M.D.
 Dispense As Written

☐ LABEL
 REFILL _____ times PRN NR

Substitution Permitted _____, M.D.

X [Signature]
 picked up
 Date

ANAL MEDICINE ASSOCIATES OF ANDERS
 2000 E. Greenville Street, Suite 1100 • Anderson, S.C. 29611
 Phone 864-225-5667
 Fax 864-718-6118

HENRY C. MARTIN, M.D. DEA No. AM1485664	THOMAS J. BULLMAN, JR., M.D. DEA No. BS1346774	GOWDHAMI MOHAN, M.D. DEA No. BM2008943
C. WILSON SOFLEY, JR., M.D. DEA No. BS3522489	WILLIAM W. WALKER, M.D. DEA No. AW7180810	CHARLES A. THOMPSON, M.D. DEA No. BT4135081
STEPHEN H. HAND, M.D. DEA No. BM2091323	MICHAEL R. KUNKEL, M.D. DEA No. BK41842080	CARLENE R. WILSON, M.D. DEA No. BW7306559
JOSEPH A. FARMER, III, M.D. DEA No. BF1488187	CHRISTOPHER E. LACROIX, M.D. DEA No. BL8215382	SARAH B. LONG, APRN, BC DEA No. MBG866737

FOR Archie Jones DATE 6/17/05

R Dexadrene 10mg #30
 Sig: i po q Am

Dispense As Written . M.D. [Signature] times PRN NR

Sign X Archer E Jones Jr

INTERNAL MEDICINE ASSOCIATES OF ANDERSON, P.A.

2000 E. Greenville Street, Suite 1100 • Anderson, S.C. 29621

Phone 864-225-6867

Fax 864-716-6116

HENRY C. MARTIN, M.D. DEA No. AM1485584	THOMAS J. SULLIVAN, JR., M.D. DEA No. BS1348774	GOWDHAMI MOHAN, M.D. DEA No. BM2908843
C. WILSON SOFLEY, JR., M.D. DEA No. BS3522489	WILLIAM W. WALKER, M.D. DEA No. AW7120819	CHARLES A. THOMPSON, M.D. DEA No. BT4135081
STEPHEN H. HAND, M.D. DEA No. BH2091229	MICHAEL R. KUNKEL, M.D. DEA No. BK4642080	CARLENE P. WILSON, M.D. DEA No. BW7396559
JOSEPH A. FARMER, III, M.D. DEA No. BF1439187	CHRISTOPHER E. LeCROIX, M.D. DEA No. BL8215382	SARAH B. LONG, APRN, BC DEA No. MB0368751

FOR Archie Jones

ADDRESS _____ DATE _____

R Dexadrine SR Spanules
10mg #30
Sig: i po qd

☒ LABEL
times PRN NR
4/1/04
Substitution Permitted

Dispense As Written _____, M.D. _____, M.D.

Sign X Archie Jones, Jr.
7-20-05

NAME	Archie Jones	DATE	9-20-05	PEAR	Bilo
PHONE		TIME		INIT	mp
ALLERGIES					
CALL	Rx says 10mg tid last dictation says bid Dt / Pharmacy says bid ? <u>TID</u>				
RECEIVED	once daily <u>TID</u>				
DATE		TIME		INITIALS	

HENRY C. MARTIN, M.D.
DEA No. AM1485564
G. WILSON SOFLEY, JR., M.D.
DEA No. B53322489
STEPHEN H. HAND, M.D.
DEA No. B12081229
JOSEPH A. FARMER, III, M.D.
DEA No. BF1429187
THOMAS J. SULLIVAN, JR., M.D.
DEA No. B51348774
WILLIAM W. WALKER, M.D.
DEA No. AW7120819
MICHAEL R. KUNKEL, M.D.
DEA No. BK4042080
CHRISTOPHER E. LACROIX, M.D.
DEA No. BL215362
GONDHANI, M.D.
DEA No. B42208943
CHARLES A. THOMPSON, M.D.
DEA No. BT4135061
CARLENE R. WILSON, M.D.
DEA No. BW7295539
SARAH B. LONG, APRN, BC
DEA No. MB5368751

FOR Archie Jones DATE 9-15-05
ADDRESS _____

R Dexadriene 10mg POTID
#30

[Signature]
M.D.

PRESCRIPTIONS

PATIENT'S FULL NAME Archie Jones

CHART NO. 31513

DATE	MEDICATION	PHARMACY	DR.
12/15/04	Levragin 750 mg /gl #7 ^{refill}	226-0522 Belle Mall	Moham/13
1/5/05	Xopenex 1.25mg 26 Pulmicort 5 Respiules 212	226-0522 Belle Mall	Gm/CS
ARCHIE E. JONES			
① CARTIA XT - 200 mg - TAKE ONE BY MOUTH DAILY			
② DEXADRINE - 10 SR - TAKE ONE CAPSULE BY MOUTH DAILY			
③ ZOLOFT - 100 mg - TAKE ONE TABLET BY MOUTH DAILY			
④ PREVACID - 30 mg - TAKE ONE CAPSULE TWICE DAILY			
⑤ DUCASATE SOD - 100 mg - TAKE THREE CAPSULES TWICE A DAY			
⑥ ACTONEL - 25 mg - TAKE ONE TABLET BY MOUTH WEEKLY			
Rx written REFILL 8/17/05			

PRESCRIPTIONS

PATIENT'S FULL NAME Archie Jones

CHART NO. 31513

DATE	MEDICATION	PHARMACY	DR.
9-15-05	Dexadrine 10mg po tid #30	Waffle	Jm/mb
9-16-05	Clarified Pseudoephedrine bid x 14yr	Belo mall vrm	Jm/mb
9-20-05	Dexadrine instructions corrected 1008	Belo Mall Billy	Jm/mb
11-15-05	Dexadrine #30 po qd	Waffle	Jm/mb
1-20-06	Pulmicort 2P gl ² x 14r	Belo-mall vrm	Jm/mb
3-23-06	Acetaminophen 325mg q 4hr	Belo mall	Jm
	Zolof 100mg qd x 14r		
	Xopenex as directed		
	Atropine " as directed		mb
8-17-06	Pseudoephedrine bid x 6 mo	Belo mall	Jm/mb
9-2-06	Atrovent neb	Belo	Jm
	Albuterol mdi 2 x bid for		
	Atrovent nb	/ mall	mb
3-19-07	Pseudoephedrine bid x 6 mos	Belo-mall - vrm	Jm/mb

January 4, 2006

Health Care Provider's Statement of Disability

Patient's Name: Archie Jones Social Security Number: 250-720119

1. Diagnosis: Thermal Lung Injury, COPD, OSA

2. Treatment:

a. Date of first treat visit: Month 11 Day 7 Year 02
 b. Date of last visit: Month 10 Day 04 Year 05
 c. Frequency of treatment: Weekly ☐ Monthly ☐ Other ☐

3. Progress Recovered ☐ Improved ☐ Unimproved ☒ Regressed ☐

4. Extent of Disability For Any Occupation

a. Is patient now totally disabled? Yes ☒ No ☐
 b. If no, when was patient able to go to work? _____ Month _____ Day _____ Year _____
 c. If yes, when do you think patient will be able to resume any work?
 Approximate Date: _____
 Indefinite ☒
 Never ☐

5. Mental Condition:

Has. 1st depression, followed by a psychiatrist.

Remarks:

1/27/06 [Signature] 2255667.
 Date Signature (Attending Physician) Degree Telephone No.
2000 E Greenville St Anderson SC 29621
 Street Address City or Town State Zip Code

Return form to:
 3M Disability Program, Building 551-1W-04, PO Box 33115, St. Paul, MN 55133-3115

INTERNAL MEDICINE ASSOCIATES OF ANDERSON, P.A.

2000 East Greenville Street • Suite 1100 • Anderson, SC 29621 • (864) 225-5667 • FAX (864) 716-6116

April 26, 2008

Re: JONES, ARCHIE

To Whom It May Concern:

Mr. Archie Jones is a pleasant 62-year-old patient of mine followed by me for his pulmonary symptoms who was last seen by me on 04/20/08. The patient has chronic lung damage secondary to thermal injury. The patient has been suffering from obstructive airways disease with resultant bronchiectasis. He is on multiple medications for this problem including aerosols, prednisone therapy, etc. Chronic prednisone therapy can cause significant damage to his body. Hence, I plan to decrease the prednisone therapy. Before we do that, we will do a complete pulmonary function test for follow-up and then decide on any further medication adjustments.

Thank you, if you have any questions please feel free to call me.

Yours sincerely,


Gowdhami Mohan, M.D.

GM/DTlakb 310.701

General Internal Medicine

HENRY C. MARTIN, M.D. JOSEPH A. FARMER II, M.D.
C. WILSON SOFLEY, JR., M.D. MICHAEL R. KUNKEL, M.D.

Diagnostic and Invasive Cardiology

THOMAS J. SULLIVAN, JR., M.D.

Nurse Practitioner

SARAH B. LONG, APRN, BC

Pulmonary and Critical Care/Sleep Medicine

WILLIAM W. WALKER, M.D. STEPHEN H. HAND, M.D.
GOWDHAMI MOHAN, M.D. CHARLES A. THOMPSON, M.D.

31513
Archie Edward Jones, Jr
11:00 PFT's

She would not
approved.

She was ~~very~~ ^{very} rude
Attn: Reba McFarland
Fax 1-803-772-6361

Regina Called - pt per
Dr Mohan -

4/26/06 ^{Asked} Dr Mohan to do addendum
to these records. Need to fax
info to Reba McFarland. once
I have it back. Pt had to
reschedule his PFT's.

12:32
5/17/06 Spoke to pt he
is still trying to work
things out with
workers Comp bdy.
He will call for
PFT ^{+ sleep study} appt once he
gets this W/C situation
taken care of.

INVAZ
INDEPENDENT SOCIALITY IV-VA

Need an addendum
done for 4/20/06
OK. Need reasons
for having PFT's

done 7/10/06

MESSAGE CONFIRMATION

06/26/2006 13:54

ID=Internal Medicine Assoc of And.

DATE	S.R-TIME	DISTANT STATION ID	MODE	PAGES	RESULTS
06/26	01:58"	918037726361	CALLING	005	OK 0000

4:12 P.M.
7/5/06 Per Reba
Approved given for
7/10/06 PFT's.

06/26/2006 13:52 Internal Medicine Assoc of And. → 918037726361

NO.576 0001

INTERNAL MEDICINE ASSOCIATES OF ANDERSON, P.A.

2000 East Greenville Street Anderson, S.C. 29621 (864) 225-5667 Fax (864) 716-6116

FAX TRANSMITTAL COVER SHEET

DATE: 6/26/06

TO: _____

ATTENTION: Reba McFarland

FROM: Virginia

SUBJECT: Needing Approval for 7/10/06

Functions Test being done in our office

SENT TO FAX NO. 1-803-772-6361

SENT FROM FAX NO. (864) 716-6116

NUMBER OF PAGES TO FOLLOW: 4

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INTERNAL MEDICINE ASSOCIATES OF ANDERSON, P.A.

2000 East Greenville Street Anderson, S.C. 29621 (864) 225-5667 Fax (864) 716-6116

FAX TRANSMITTAL COVER SHEET

DATE: 6/26/06
TO: _____
ATTENTION: Reba McFarland
FROM: Virginia
SUBJECT: Needing Approval For 7/10/06 Pulmonary
Functions Test being done in our office
SENT TO FAX NO. 1-803-772-6361
SENT FROM FAX NO. (864) 716-6116
NUMBER OF PAGES TO FOLLOW: 4

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If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited by law. If you have received this telecopy in error, please notify us by telephone to arrange for return of the documents. PLEASE CALL US IMMEDIATELY IF THE TELECOPY YOU RECEIVED IS INCOMPLETE OR ILLEGIBLE.

ADDITIONAL NOTES AND ROUTING INSTRUCTIONS:

Patient: Archie Edward Jones, Jr.
~~SSN: 250-12-0000~~
~~DOB: 7/31/43~~
I.F. additional records are need please let
THANK YOU Virginia (864) 716-6122 ne Know.

General Internal Medicine
HENRY C. MARTIN, M.D. JOSEPH A. FARMER, III, M.D. MICHAEL R. KUNKEL, M.D.
C. WILSON SOFLEY, JR., M.D.

Pulmonary and Critical Care
WILLIAM W. WALKER, M.D., F.A.C.P.
STEPHEN H. HAND, M.D.
GOWDHAMI MOHAN, M.D.
CHARLES THOMPSON, M.D.

Diagnostic and Invasive Cardiology
THOMAS J. SULLIVAN, JR., M.D., F.A.C.C., F.A.C.P.
Nurse Practitioner
SARAH B. LONG, R.N. FNP

Internal Medicine Associates
2000 East Greenville Street
Anderson, SC, 29621

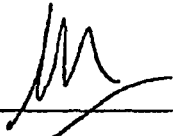
Name: JONES, ARCHIE E	ID: 31513	BSA: 1.29	Date: 07/10/2006
Tech:	Height: 70.00	Age: 62	Room:
Doctor: Mohan, Gowdhami	Weight: 65.00	Sex: Male	Race: Caucasian

The FVC, FEV1, FEV1/FVC ratio and FEF25-75% are reduced indicating airway obstruction. The normal airway resistance and decreased specific conductance indicate a peripheral or small airway disease. The SVC is reduced, but the TLC is within normal limits. Following administration of bronchodilators, there is no significant response. The reduced diffusing capacity indicates a mild loss of functional alveolar capillary surface. However, the diffusing capacity was not corrected for the patient's hemoglobin.

Conclusions: Although there is moderately severe airway obstruction and a diffusion defect suggesting emphysema, the absence of overinflation indicates a concurrent restrictive process which may account for the diffusion defect. A clinical trial of bronchodilators may be beneficial in view of the airway obstruction.

Pulmonary Function Diagnosis:
Moderately severe Obstructive Airways Disease
Restriction -Probable
Mild Diffusion Defect

This preliminary report should not be used clinically unless reviewed and signed by a physician.



M.D.

Dear Dr. Gowdhami Mohan,

Progressive Medical, Inc. has been providing your patient with medications related to his/her Worker's Compensation Injury. The claim is currently pending a Letter of Medical Necessity (LMN) from the prescribing physician.

Please fax this completed form to:

ATTN: Dawnetta Metzger
A/R Specialist
Progressive Medical, Inc.
FAX-614-923-7660

Letter of Medical Necessity Request

Date: DOI 06/03/1997

Patient: Archie (Eddy) Jones

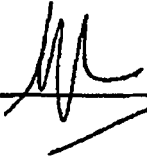
Claim: WC555248098

Please be sure to state the relationship between the medications provided and the injury.

Medications:

Relationship to claim:

①	Clobrimazole Tro 10mg	
2.	Prevacid Cap 30mg	stress ulcer prophylaxis
3.	Prednisone Tab 20mg	for lung problems assoc w injury
4.	Celebrex Cap 200mg	for chronic pain
⑤	Docusate Sod Cap 100mg	

SIGNATURE : 

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FAX-614-923-7660

Letter of Medical Necessity Request

Date: DOI 06/03/1997

Patient: Archie (Eddy) Jones

Claim: WC555248098

Please be sure to state the relationship between the medications provided and the injury.

Medications:

Relationship to claim:

6. Dextromphetam Sulfate 15mg

related To depression / lethargy

7. Guaifensin/Pseudoephedri 12hr

for lung problem assoc w/

8. Lidoderm Dis 5%

for chronic pain

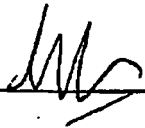
9. Mucinex Tab 600mg

for lung problem 2nd to injury

10. Singulair Tab 10mg

" " " " " "

SIGNATURE :



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FAX-614-923-7660

Letter of Medical Necessity Request

Date: DOI 06/03/1997

Patient: Archie (Eddy) Jones

Claim: WC555248098

Please be sure to state the relationship between the medications provided and the injury.

Medications:	Relationship to claim:
11. Albuterol Aro 0.09 mg/inh	related to lung damage around injury
12. Pulmicort RespSus 0.	" "
13. Xopenex 1.25mg/3ml solution	" " "
14. Serevent Diskus 50mcg	" " "
15.	"

SIGNATURE: 

INTERNAL MEDICINE ASSOCIATES OF ANDERSON, P.A.

2000 East Greenville Street • Suite 1100 • Anderson, SC 29621 • (864) 225-5667 • FAX (864) 716-6116

October 30, 2006

Re: JONES, ARCHIE

To Whom It May Concern:

Mr. Archie Jones is a pleasant 63-year-old gentleman who is followed by me for his pulmonary problems for the last 6-7 years. Currently, he is also being treated by me for sleep apnea. Although, his lung injury is not a direct cause for sleep apnea, increase in body mass index and reduced lung function might have contributed as predisposing factors to cause sleep apnea.

If you have any further questions on this, you can feel free to call me.

Thank you.

Yours sincerely,



Gowdhami Mohan, M.D.

GM/DTlakb 310.520

Original Mailed 11/3/06

General Internal Medicine		Diagnostic and Invasive Cardiology	Pulmonary and Critical Care/Sleep Medicine	
HENRY C. MARTIN, M.D.	JOSEPH A. FARMER JR., M.D.	THOMAS J. SULLIVAN, JR., M.D.	WILLIAM W. WALKER, M.D.	STEPHEN H. HAND, M.D.
C. WILSON SOFLEY, JR., M.D.	MICHAEL R. KUNKEL, M.D.	Nurse Practitioners	GOWDHAMI MOHAN, M.D.	CHARLES A. THOMPSON, M.D.
		SARAH B. LONG, R.N., APRN, BC		

January 4, 2006

Health Care Provider's Statement of Disability

Patient's Name ARCHIE JONES Social Security Number: 978-72-2044

1. Diagnosis: Pulmonary Insufficiency
2. Treatment: 2nd Lt COPD and bronchitis

a. Date of first treat visit: Month 11 Day 7 Year 02
b. Date of last visit: Month 4~~th~~ Day 20 Year 06
c. Frequency of treatment: Weekly ☐ Monthly ☐ Other ☐

3. Progress Recovered ☐ Improved ☒ Unimproved ☐ Regressed ☐

4. Extent of Disability For Any Occupation

a. Is patient now totally disabled? Yes ☒ No ☐
b. If no, when was patient able to go to work? _____ Month _____ Day _____ Year
c. If yes, when do you think patient will be able to resume any work?
Approximate Date: _____
Indefinite ☐
Never ☒

5. Mental Condition:

Has seen a psychiatrist in Greenville.

Remarks:

Currently being actively treated for pulmonary problem and sleep problem

11-10-06 Date [Signature] Signature (Attending Physician) MD Degree 225-5667 Telephone No.
2000 E. Greenville Street, Suite 1100 Street Address Anderson City or Town SC State 29621 Zip Code

Return form to:
3M Disability Program, Building 551-1W-04, PO Box 33115, St. Paul, MN 55133-3115

DATE: 11-30-06 ACCOUNT #: 31613

NAME: A. Eddie Jones

WT: 230.2 BP: 138/96 P: 105 R: 20

AGE: 63 NECK SIZE:

T: 97° O2: 93% RA

DOCTOR: Shoben

Heart &

80% slowly worn

✓ E-T. Ask.

Not able to exercise
became of leg
Both feet

Lidoderm

or

Both feet

orthomyxins

✓ Dental appliances/

Not the machine

310.669

medication less sleepy

Lower to 10/10

Eddie Jones (Archie)

MEDICATIONS 01/23/07

- 1) Albuterol-USP: 180mg 2to4 times day (as needed, away from nebulizer) Dr. Mohan
- 2) Atrovent: 2puffs 2to4 times day ~~(as needed)~~ when away from nebulizer) Dr. Mohan
- 3) Combivent: 2 puffs 2to4 times day (as needed) Dr. Mohan (use very rarely)
- 4) Xopenex:(Nebulizer solution): 3ml. 4 times day Dr. Mohan
- 5) Atrovent: (Nebulizer solution): 2.5ml. 4 times day Dr. Mohan
- 6) Pulmacort (nebulizer solution) every 12 hours as needed. Dr. Mohan
- 7) Pulmacort: 2 puffs-am/pm Dr. Mohan
- 8) Serevent: 2 puffs- (powder disk) am/pm Dr. Mohan
- 9) Singulair: 10mg-pm Dr. Mohan
- 10) Humibid (Mucinex): 600mg-am/pm Dr. Mohan (stopped 01/16/07)
- 11) Prednisone: 20mg-pm (increase as needed) Dr. Mohan
- 12) Furosemide: 10mg-am Dr. Souviron
- 13) Theophylline: 300mg-am/pm DR. Mohan
- 14) Guaifen/Psephed sr:1120mg-am Dr. Mohan (stopped 01/16/07-substitute Guaifenisen)
- 15) Su-tuss DM cough syrup (as needed) Dr. Hellstrom
- 16) Mycelex Troche: 10mg- 5 daily as needed for thrush Dr. Souviron
- 17) Risperdal: .5mg-am-pm Dr.Richards
- 18) Depakote: 1000mg-pm Dr. Richards
- 19) Dexadrine: 15mg-am Dr. Richards (temporary stop due to increased heart rate)
Dexadrine: 5mg-noon Dr. Richards (temporary stop due to increased heart rate)
- 20) Zoloft: 100mg-am Dr. Richards
- 21) Actonel: 35mg-weekly/am Dr. Mohan (Stopped 8/15/06 due to stomach erosion)
- 22) Lamisil: 250mg-pm Dr. Souviron
- 23) Colace: 300mg am/pm Dr. Mohan
- 24) Prevacid: 30mg-am/pm Dr. Mohan
- 25) Celebrex: 200mg-am/pm Dr. Mohan
- 26) Diltiazem cd: 240mg-am Dr. Souviron
- 27)Levothyroxine: .05mg-noon
- 28)Flomax: .4 mg-noon
- 29)Plavix: 75mg-am
- 30)Aspirin: 81mg-am
- 31) Lidoderm 4x4 Patch: 9:00 AM til 9:00 PM (Right Foot) Dr. Oliver
- 31) Allewyn 4x4 Bandages (Rt. foot) am/pm (AnMed Wound Care) Dr. Souviron
- 33) 1" paper surgical tape (Rt. Foot)(AnMed Wound Care) Dr. Souviron
- 34) 2x2 gauze sponges (Rt. Foot) (AnMed Wound Care) Dr. Souviron
- 35) Sterile 0.9 sodium chloride wash (Rt. Foot) (AnMed Wound Care) Dr. Souviron
- 36) Amlactin Lotion : daily on skin donor areas (on back) Dr. Souviron
- 37) Duoderm Patch (Rt. Knee) Dr. Souviron

(Once a month I alternated antibiotics to counteract the immune suppressant effects of prednisone and the hardening of my lungs from thermal and chemical burns.)
They were: Biaxin: (500mg-am for 7 days-1st month), Tequin: (400mg-am for 7 days-
2nd month). Augmentin: (875mg am/pm-3rd month)

I have been able to leave off the antibiotics recently. I only take them as needed instead of taking them as a preventive.

Supplements:

- 1) Omega 3 Fish Oil
- 2) Saline Nasal Spray: 4-a-day
- 3) Liquid Tears: 4 times a day
- 4) (Daily): 7) Multi-vitamin
- 5) 400mg Vitamin C
- 6) 400 IU Vitamin E
- 7) 1200mg Calcium
- 8) B12
- 9) Chondroitin Glucosamine
- 10) Potassium

September 20, 2007

Continuance of Disability Claim Form

Employee Name: Archie Edward Jones Employee Number: _____
Current Address: 1229 Salem Church Rd Anderson SC 29625

Telephone Number: 864-224-2669

Attending physician: Name Gowdhani Mohan MD

Address 2000 E Greenville St Suite 1100

Phone 864-224-5667 Anderson SC 29621

Dates of Treatment since last report: 10/15/07 - 11/30/07

Have you returned to work? NO

If yes, the date you returned to work _____

How many hours per week? 0

Name, address, and telephone number of current employer: _____

Health Care Provider's Statement of Disability

Patient's Name: Archie Edward Jones Employee Number: 252 10 1119

1. Diagnosis: COPD Bronchiectasis Thermal Lung Injury

2. Treatment:

a. Date of first treat visit: Month 11 Day 7 Year 02
 b. Date of last visit: Month 10 Day 15 Year 07
 c. Frequency of treatment: Weekly ☐ Monthly ☐ Other ☐

3. Progress Recovered ☐ Improved ☐ Unimproved ☒ Regressed ☐

4. Extent of Disability For Any Occupation

a. Is patient now totally disabled? Yes ☒ No ☐
 b. If no, when was patient able to go to work? _____ Month _____ Day _____ Year _____
 c. If yes, when do you think patient will be able to resume any work?
 Approximate Date: _____
 Indefinite ☒
 Never ☐

5. Mental Condition: Being treated by a psychiatrist

Remarks: Being treated for pulmonary + sleep apnea problems.

10/23/07 [Signature] MD 864-225-5667
 Date Signature (Attending Physician) Degree Telephone No.
2000 E Greenville St Anderson SC 29621
 Street Address City or Town State Zip Code

Return form to:
 3M Disability Program, Building 551-1W-04, PO Box 33115, St. Paul, MN 55133-3115

**THE HAND SURGERY CENTER, P.A.
1120 GROVE ROAD, SUITE A
GREENVILLE, SC 29605**

DATE: JULY 21, 1999
PATIENT: JONES, ARCHIE
SS#: 2-0-710-5119
DATE OF BIRTH: 10-27-1943
EMPLOYER: 3M

CHIEF COMPLAINT: Burns to his hands.

HISTORY: Mr. Jones is a 56 year old right hand dominant white male seen at the request of Dr. Bishop for evaluation of his right hand, particularly his little finger. He reports that he was involved in an industrial accident where 600 degree oil was poured on his hands, forearms and body. He was initially evaluated at Greenville Memorial Hospital and then treated at the Medical University in Charleston. He underwent extensive surgical procedures, including skin grafting along the right forearm and essentially had urologic procedures secondary to long term Foley catheterization. He has recently seen Dr. Barry Bishop who injected several hypertrophic scars. He has reported some contraction of the right little finger and feels it is drawing in a flexed fashion.

PAST MEDICAL HISTORY: Reviewed with him in the medical history form in the chart dated 7/21/99. Previous medical records from Dr. Bishop's office, Dr. A. C. Harvey's office, as well as medical records from the Medical University of South Carolina were reviewed.

PHYSICAL EXAM: He has multiple scars about his forearms and hands. Predominantly what he complains about today is on the ulnar aspect of his hand with some extension into the little finger. He has a hypertrophic scar dorsally over the middle finger which is longitudinal over the MP and PIP joints. He is able to fully flex his finger, but does have some dorsal pain with this. When attempting to extend his finger he has some tightness in the skin on the ulnar side of his finger extending from the scar on the ulnar side of the hand to approximately the middle phalanx. There are no significant cords palpated. There is not a linear scar in this area. There is no subcutaneous nodules or cords palpated. With the finger flexed there does not appear to be any tightness to the volar side of the finger. On the dorsal side of the finger terminal flexion does produce some tightness in the scar with some blanching of the scar. His sensation over the pulp of the little finger has decreased on the radial and ulnar sides. He has good capillary refill. He does have some hooking of the fingernail and what appears to be some atrophy of the distal portion of the fingers, particularly of the little finger on the right side.

THE HAND SURGERY CENTER, P.A.

PATIENT: JONES, ARCHIE
SS# 250 70 5119

~~CONFIDENTIAL~~

JULY 21, 1999

CONTINUATION - PAGE TWO

IMPRESSION:

little finger.

Burns to his right hand with skin tightness of the right

DECISION MAKING:

He has several complaints including numbness and pain in his finger, changes in his fingernail, as well as the tightness when he attempts to extend his little finger. The tightness appears to be related to the more proximal scar in the hand. I discussed the treatment options with him. I have recommended against performing procedures on the volar and dorsal sides simultaneously, as it may lead to some compromise of the skin. I briefly discussed a local flap coverage or a Z-plasty on the volar side with him, as this side appears to bother him the most. He would like to consider this and will re-contact us if he has any further questions. I would like to thank Dr. Bishop for this referral.

Timothy R. Brown, M.D.

TRB/lsl

cc: WC
John B. Bishop, M.D.
Liberty Mutual Ins. Co. (Attn: Lori Rose)

B

OCTOBER 14, 1999

Mr. Jones is seen here for his preoperative appointment. He is continuing to have problems with the right hand and tightness of the right little finger. I discussed the risks, benefits and alternatives with him. I plan to proceed with release of the little finger contracture. This will be performed in conjunction with the procedure with Dr. Jernigan. His questions are answered to his satisfaction. I plan to proceed.

TRB/jeg

cc: WC
John B. Bishop, M.D.
Liberty Mutual Ins. Co., Attn: Lori Rose

B

THE HAND SURGERY CENTER, P.A.

PATIENT: JONES, ARCHIE

SS# [REDACTED]

OCTOBER 21, 1999

Mr. Jones returns. He is two days out from his Z-plasty of his right little finger. His wounds are healing nicely with no signs of infection. He is pleased with the ability to extend the finger and I can hyperextend it slightly. His splint is removed and he is placed into a hand base extension splint for his little finger. He will wear this six hours a day and at night. I will see him back next week for suture removal and I anticipate night splinting after that.

TRB/lsl

cc: WC

THE HAND SURGERY CENTER, P.A.
PATIENT: JONES, ARCHIE
SS#

OCTOBER 28, 1999

Mr. Jones returns. He is nine days out from his Z-plasty. He is doing very well. He has good extension present. I plan to allow him just wear his splint at night and follow up in approximately 4-6 weeks for recheck.

TRB/lsl

CB

NOVEMBER 29, 1999

Mr. Jones is approximately six weeks out from his Z-plasty of his right little finger. He is doing well. He does not have any changes in his preoperative numbness. He is able to hyperextend the MP joint and is pleased with the result of this. I do not see any scar contractures at this time. I plan to follow him if he has any further difficulties.

TRB/lsl

CB

Updated: _____

Date 7-21-99

Patient ARCHIE E. JONES

THE HAND SURGERY CENTER, P.A.
AND
THE HAND THERAPY CENTER

MEDICAL HISTORY

Do you have a personal physician? ☒ Yes ☐ No

Physician's Name: JUNE ~~SENEZ~~ SOUVIRON

Phone # 221-7003 Date of Last Visit 6-23-99

Are you currently under the care of a physician? ☒ Yes ☐ No

If yes, please explain DR. DONALDSON, DR. PILCH, DR. R. RICHARDS, DR. COCHRANE

Are you taking prescription/over-the-counter drugs? ☒ Yes ☐ No

Please list each one: ATRAK, NEURONTIN, SINGULAR, SABONRA, SUBOXONE, DUBATUS, COLACE, FLOXID, ALBUTEROL, ATRUBAT, SEREVENT, FLOWVENT

Are you allergic to any medications? If yes, please list: _____

Have you ever had any of the following diseases or medical problems?

Y N Anemia	Y N Fever Blisters/Herpes
Y N Artificial Bones/Joints	Y N Heart Attack/Stroke
Y N Artificial Valves	Y N Heart Murmur
Y N Asthma	Y N Heart Surgery/Pacemaker
40 units ☒ N Blood Transfusion	Y N Hemophilia/Abnormal Bleeding
Y N Cancer/Chemotherapy	Y N Hepatitis
Y N Congenital Heart Defect	H ☒ N High/Low Blood Pressure
Y N Diabetes	Y N HIV /AIDS
Y N Tuberculosis (TB)	Y N Kidney Problems
10 ☒ N Difficulty Breathing	Y N Mitral Valve Prolapse
Y N Drug/Alcohol Abuse	☒ N Psychiatric Problems
Y N Emphysema	Y N Rheumatic/Scarlet Fever
Y N Epilepsy/Seizures/Fainting	Y N Ulcers/Colitis

Please list any serious medical condition(s) that you have ever had: _____

Past Surgeries & Hospitalizations: L. KNEE, SINUS, TONSILS, SKIN GRAFTS for 3RD DEGREE BURNS

Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Family History: Health & age (or cause of death) of parents, brothers, sisters _____

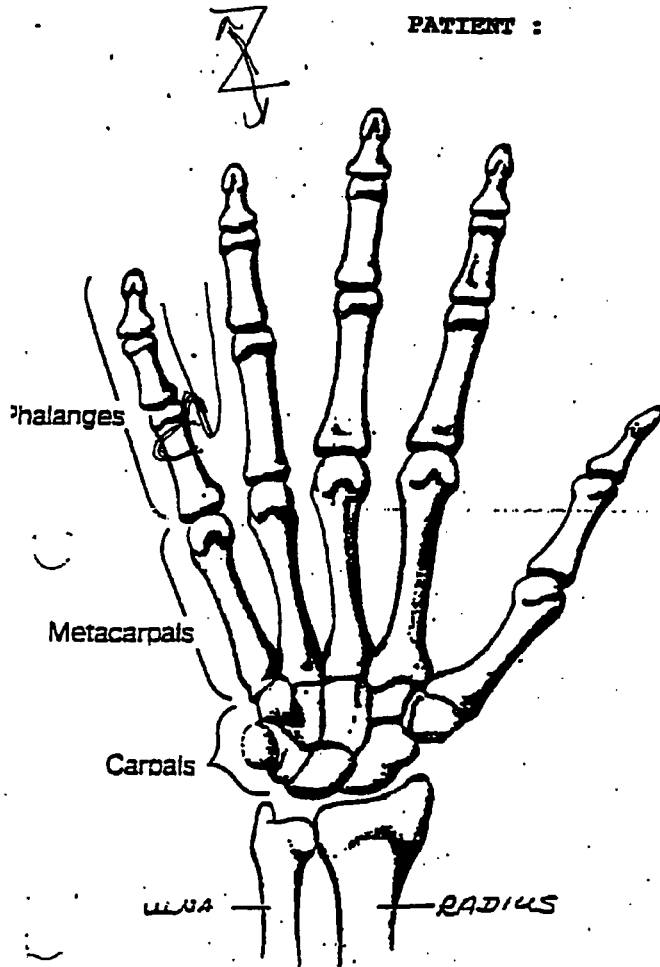
Social History: ☐ Single ☐ Married; # children _____

Do you use any of the following? ☐ Alcohol ☐ Drugs ☐ Tobacco

Occupation: DRAFTSMAN / MARINE MECH

THE HAND SURGERY CENTER

PATIENT :



Bones of the Hand and Wrist

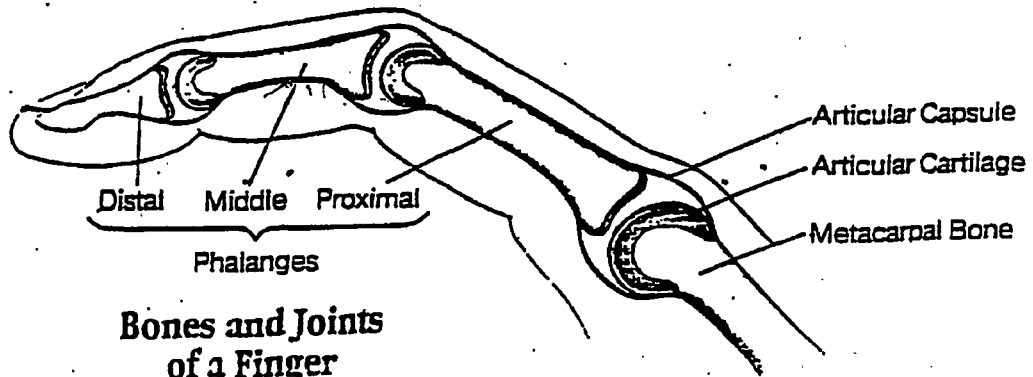
7/21/99 - Burnhard
Notes
56 RMD

2 yrs ago 600° oil
Industrial Accident

GTH → MUSE
grafts R forearm

R Little finger drawing
getting better.

↓ sensation to little pulp
devised scars



Bones and Joints of a Finger

Circle below if you currently have any of the following symptoms:

General: Fever, weight loss, malaise

Eyes: Double vision, blurred vision, trauma, glasses

Ears, Nose, Throat: Deafness, ringing in the ears, hoarseness, dizziness, sinus problems

Heart, Vascular: Chest pain, irregular beats, shortness of breath with activity, difficulty breathing when lying flat, swelling in legs

Lungs: Shortness of breath, asthma attacks, cough, coughing up blood

Intestines: Loss of appetite, diarrhea, constipation, abdominal pain

Urinary: Difficulty urinating, incontinence, painful urination

Skeletal: Joint swelling, joint pain, muscle atrophy, arthritis, fracture

Skin: Rashes, skin lesions, skin ulcers

Neurologic: Speech/swallowing difficulty, numbness, seizures, weakness, visual changes, abnormal balance, poor memory

Psychiatric: Depression, hallucinations, sleep problems, mood swings, crying spells

Endocrine: Increased thirst, increased appetite, growth changes, hair changes, hyperactivity, hypoactivity

Blood: Abnormal bleeding, painful lymph nodes, enlarged nodes

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the medical staff to perform any necessary medical service that I may need during diagnosis and treatment with my informed consent.

Richard E. Jones, Jr.
Signature

7-21-99
Date

Date: 9-3-99

Patient: ARCHIE Jones

Dr. OR Lemigan's office called
and would like to schedule appt
with Mr. Jones at the same time
you would do so. MD

Date: _____

Date: _____

Date: _____

Date: _____

OCT 20 '99 01:33PM GREENVILLE SURGERY

P.2/2

10/19/99

HEALTHSOUTH SURGERY CENTER OF GREENVILLE
OPERATIVE RECORD

PATIENT: Archie Jones

DATE OF SURGERY:

MEDICAL RECORD #: 87603

PAGE: 1 of 1

SURGEON:

Tim Brown, M.D.

ASSISTANT:

Haycock

ANESTHESIA:

General

COMPLICATIONS:

None

PREOPERATIVE DIAGNOSIS:

Right little finger scar contracture

POSTOPERATIVE DIAGNOSIS:

Same

OPERATION:

Z-plasty right little finger and palin

PROCEDURE: After consent was obtained, the pt was taken to the OR and placed in the supine position and underwent general anesthetic. The right upper extremity had the tourniquet placed proximally and was prepped and draped in sterile fashion. The tourniquet was inflated for 17 minutes. A single limb Z-plasty was placed on the volar ulnar aspect of the little finger over the scar contracture from the PIP joint to the distal palmar crease. Full thickness flaps were elevated and the digital nerve and artery were identified and deep to the flaps. The finger was able to be hyper extended at the MP joint while the PIP joint was fully extended. The limbs were sutured into position, the tourniquet let down and all flaps were seen to be pink and viable. The wound was dressed sterilely and placed in an ulnar gutter splint with the MP and IP joint extended.

DISPOSITION: Pt will be discharged to home. Follow up in approximately 3 days. Pt was given a prescription for Lortab.

TB:kmg

TIM BROWN, M.D.

c: Hand Surgery Center

dd: 10/19/99

dt: 10/19/99

copies sent

int.

CARDIOLOGY ASSOCIATES OF ANDERSON, P.A.

CONSULTATIVE AND INVASIVE CARDIOLOGY

John D. Ware, III, M.D., F.A.C.C.

105 BUFORD AVENUE
ANDERSON, S.C. 29621

224-2669

12/14

No apparently
significant heart
problem

OFFICE: (864) 375-9090
FAX: (864) 260-0194

TRANSTHORACIC ECHOCARDIOGRAM REPORT

Patient Name : Archie Jones

Date : 11/23/99

DOB : 07/30/43

SSN : ~~XXXXXXXXXX~~

Clinical Hx : Dyspnea. HTN.

The aortic, mitral, tricuspid and pulmonic valves appear anatomically unremarkable on 2-D echo. Color flow doppler shows no significant hemodynamic abnormality involving the valves.

Cardiac chamber size evaluation shows mild enlargement of the left ventricle. Left ventricular diastolic dimension is 6.5 mm. Systolic dimension 4.1 mm. No segmental wall motion deficits are seen.

There is left ventricular diastolic dysfunction present.

No pericardial effusion is seen.

IMPRESSION:

1. Mild enlargement of the left ventricle noted with normal left ventricular systolic function.
2. LV diastolic dysfunction is noted.
3. No significant valve disease is seen.

John D. Ware, III, MD
JDW:kk

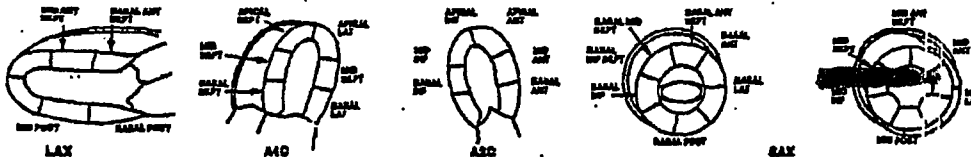
PHYSICIAN'S DIAGNOSTIC SERVICES INC.

ECG CARDIOLOGICAL WORKSHEET

Patient Name: Jones, Archie E. Date: 11/23/99 Age: 56
 Type: 22 Previous Exam: — Sonog: KSU Ref MD: Southern
 Indication(s): SOB, HTN.
 2D ☒ Doppler ☒ Color ☒

Measurements
 Ao Root 32 mm AoV 30 mm LA 33 mm
 IVS (d) 1 mm LVID (d) 45 mm LVID (s) 41 mm PW (d) 8 mm

REGIONAL LEFT VENTRICULAR WALL MOTION ABNORMALITIES



Estimated Left Ventricular Ejection Fraction: 30-35% 20-30% 20-30% 20-30%
☒ Normal (>55%) ☒ Mildly Reduced (40-55%) ☐ Moderately Reduced (25-40%) ☐ Severely Reduced (<25%)
 Fractional Shortening: 36%

AORTIC VALVE/LVOT

LVOT diam _____ mm LVOT max _____ m/sec LVOT max grad _____ mmHg

AOV Tricuspid _____ Bicuspid _____ Thickened _____ AVR _____ Prosthesis Type _____
 Ao v max 2.4 m/sec Ao max grad 2.8 mmHg Ao mean grad _____ mmHg AVA continuity _____ cm²
 Aortic Insufficiency: None ☒ Trace ☐ Mild ☐ Moderate ☐ Severe ☐ AI (p/0) _____ mmHg

MITRAL VALVE

MV Thickened ☐ Prolapse ☐ MMR ☐ Fall ☐ SAM ☐ Apical Displacement M/A Apparatus ☐ T/A 61
 MV v max _____ m/sec MV max grad _____ mmHg MV mean grad _____ mmHg MVA (p/20) _____ cm² MVA (planimetry) _____ cm²
 Mitral Regurgitation: None ☒ Trace ☐ Mild ☐ Moderate ☐ Severe ☐ MVR _____ Prosthesis Type _____

TRICUSPID VALVE

TV Thickened ☐ Prolapse ☐ TVR ☐ Prosthesis Type: _____
 TR v max _____ m/sec TR max grad + RA pressure _____ mmHg Tricuspid Regurgitation: _____ mmHg Trace ☐ Mild ☒ Moderate ☐ Severe ☐

PULMONIC VALVE

PV Thickened ☐ Doming ☐ PVR ☐ Prosthesis Type: _____
 PV v max _____ m/sec PV max grad _____ mmHg PV mean grad _____ mmHg PVA _____ cm²
 Pulmonic Regurgitation: None ☐ Trace ☐ Mild ☐ Moderate ☐ Severe ☐

PERICARDIUM

Thickened _____ mm Effusion: Small ☐ Moderate ☐ Large ☐ (94) RA Collapse ☐
 RV Diastolic Collapse ☐ Resp Variation (>20-25%) _____

SEPTAL DEFECTS/SHUNTS

Atrial ☐ Ventricular ☐ PDA ☐ Shunt Ratio _____ / _____
 Max Velocity _____ m/sec Max Grad _____ mmHg Mean Grad _____ mmHg

Handwritten notes:
 mild LV enlargement
 LV dysfunction present
 no valve disease seen

Signature: J. M. [unclear]

ARMED HEALTH SYSTEM
Radiology Consult Report

Attending MD: MOHAN, GOWDHAMI
REQUEST DATE/TIME:
ORDERING PHYS : MOHAN, GOWDHAMI
ORDER PHYS PH#: (864) 231-7004

JONES, ARCHIE EDWARD
MR#
IDX Acc #
Acct#
Patient Loc: 04
Status: O

Sex: M Age: 56 Years DOB: 07-20-1943

Exam: (81)210100 Completed: 03-02-2000 12:47 PM

Clinical History:

JONES CHEST

CLINICAL HISTORY: Shortness of breath.

PA and lateral views of the chest are compared to a previous exam dated 7-7-98. There has been no appreciable significant change. The lungs appear clear. There is a slight decrease in pulmonary vascular markings in the upper lobe suggesting possible obstructive airway disease. The lungs are otherwise unremarkable. The cardiac silhouette and mediastinum are remarkable only for mild atherosclerotic changes of the aorta.

IMPRESSION:

POSSIBLE COPD. NO ACUTE CARDIOVASCULAR OR PULMONARY PROCESS OR SIGNIFICANT CHANGE FROM 7-7-98.

Reading Physicians:
David Harrison Holt Jr M.D.

Dictated on: 03-03-2000 9:03 AM
Transcribed on: 03-03-2000 11:37 AM by Linda Harper
Finalized on: 03-03-2000 1:39 PM by David Harrison Holt Jr M.D.

Page: 1

05/27/99 07:07:57
05/26/99 19:37

973.257 44(2)-> 164 576 4473
ONE CALL MEDICAL → 973.257.0044(1)

Page 002
NO. 238 P003/006

Anderson Radiology

1011 Ella Street, Anderson, South Carolina 29621
Telephone (864) 225-6286 • Fax (864) 231-6738

Exam Date: 05/18/99

Physician: Robert Richards, M.D.
Patient Name: Jones, Archie
DOB: [REDACTED] Age: 55 Sex: M
Acct: # [REDACTED]

CRANIAL MRI

History: 55-year-old male who was burned in a fire and subsequently presented with some mental changes.

T1, proton density and fast spin-echo T2-weighted axial, in addition to T1-weighted sagittal, images were obtained. A gradient echo axial sequence was carried out. T1-weighted axial images following gadolinium administration were acquired.

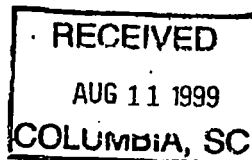
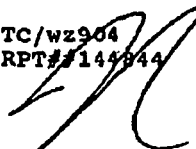
The calvarium is intact. The midline is normally located. The ventricular system has a normal appearance. There are one or two small scattered deep white matter signals present in a paraventricular distribution consistent with previous ischemic events. The most prominent of these is seen on image 111 of the T2-weighted axial sequence. The brainstem and sella turcica are normal. No axial or extra-axial collections of fluid can be seen. The cerebellopontine angles are normal. A little bit of right mastoiditis is noticed with some increased signal being noted in the right mastoids on the T2-weighted axial sequence. Gadolinium administration produces no unusual enhancement.

IMPRESSION: Cranial MRI essentially within normal limits for a patient of this age. Please see above comments regarding the deep white matter. Incidentally noted is a little bit of right mastoiditis.

Thank you for this consultation.

Terence M. Clark, M.D.

TC/wz904
RPT#144844



1-864-230-6730
FOR MRI OF
BRAIN 5/18

GREENVILLE PSYCHIATRY, P.A.
ROBERT W. RICHARDS, M.D.

9-A CALEDON COURT
GREENVILLE, S.C. 29615

(864) 271-6066
FAX (864) 271-6043

SC LIC. # 18540
DEA # BR3636202

NAME Archie Jones AGE 41
ADDRESS _____ DATE 4/30/99

B

MRI
w/ no toxic injury
E persistent mental
status change

Refill _____ times
☐ Label
CR

DISPENSE AS WRITTEN

SUBSTITUTION PERMITTED

Radiologist:
Please call Dr
Richards prior to
doing this MRI
if you can.

RECEIVED
AUG 11 1999
COLUMBIA, SC

ANMED HEALTH SYSTEM
Radiology Consult Report

3/15/00

Attending MD: SOUVIRON, JUNE PETRYSZN
REQUEST DATE/TIME:
ORDERING PHYS :SOUVIRON, JUNE PETRYSZN
ORDER PHYS PH#:(864) 231-7003

JONES, ARCHIE EDWARD
MR# :000000000
IDX Acc # :45104
Acct# :000000000
Patient Loc: 04
Status: O

Sex: M Age: [REDACTED] DOB: [REDACTED]

Exam: (81)210100 Completed:03-09-2000 3:34 PM

Clinical History: FEVER, COUGH

JONES CHEST, TWO VIEWS

HISTORY: 56-year-old male with fever and cough. A comparison is made with a previous study from 3-2-00.

The lungs are hyperexpanded consistent with COPD. The central pulmonary arteries are slightly prominent which may represent pulmonary hypertension. The heart size is within normal limits.

Compared to the prior exam from 1998, the patient does appear to have some focal infiltrate in the left infrahilar region, most likely in the region of the lingula.

IMPRESSION:

COPD. THERE IS A FOCAL INFILTRATE IN THE LEFT INFRAHILAR REGION PROBABLY REPRESENTING LINGULAR PNEUMONIA.

*I discuss
Dr. [unclear]
more*

Reading Physicians:
Paige Skinner Huber M.D.

Transcribed on: 03-10-2000 2:44 PM by Linda Harper
Finalized on: 03-10-2000 3:35 PM by Paige Skinner Huber M.D.

Page: 1

ARMED HEALTH SYSTEM
Radiology Consult Report

Attending MD: MOHAN, GOWDHAMI
REQUEST DATE/TIME: 03-17-2000 1519
ORDERING PHYSICIAN: MOHAN, GOWDHAMI
ORDER PHYS PH#: (864) 231-7004

JONES, ARCHIE EDWARD
MR# [REDACTED]
IDX Acc # [REDACTED]
Acct# [REDACTED]
Patient Loc: 04
Status: 0

Sex: M Age: 56 YEARS DOB: 07-20-1943

Exam: (81)260401 Completed: 03-30-2000 1024

Clinical History: BRONCHIECTASIS, LUNGS BURNED IN AN INDUSTRIAL ACCIDENT NO SUR
PT USES A NEBULIZER AND INHALERS CONSTANTLY ALL DAY NO IV PER DR.
MOHAN

JONES CT CHEST WITHOUT CONTRAST 3-30-2000

CLINICAL HISTORY: This is a 56-year-old male patient with bronchiectasis and previous lung burning incident due to an industrial accident with hot oil inhalation who presents for follow-up and continued shortness of breath. There are no previous CTs for comparison but comparison is made to the most recent chest x-ray dated 3-9-2000.

TECHNIQUE: Multiple helical images were obtained at 7.5mm/11.25HQ from the level of the thoracic inlet through the adrenal glands without administration of intravenous contrast.

FINDINGS: There is very mild atelectasis and/or scarring seen in the right middle lobe. There is minimal residual atelectasis in the lingula, but no evidence of pneumonia or mass lesion. There is no evidence of focal alveolar consolidation, mass lesion or definite bronchiectasis or interstitial disease seen on this exam. The lungs appear mildly well aerated. There is superior mediastinal adenopathy at the level of the brachiocephalic vein in the upper paratracheal region with lymph nodes measuring up to 2 cm in greatest diameter. There is shotty axillary adenopathy with no lymph node seen measuring larger than 1 cm and fatty hila bilaterally. No additional significant mediastinal adenopathy is seen. The hila are incompletely assessed due to lack of intravenous contrast. There is no evidence of pericardial or pleural disease. No focal lytic or sclerotic lesions are seen in the thoracic spine. The superior portions of the liver, spleen and adrenal glands are all within normal limits.

IMPRESSION: 1. RESOLVING LINGULAR PNEUMONIA; THE AREA OF CONSOLIDATION SEEN ON CHEST X-RAY ON THE 9TH NOW APPEARS TO HAVE MINIMAL RESIDUAL DISCOID ATELECTASIS. THERE IS ADDITIONAL DISCOID ATELECTASIS AND/OR SCARRING IN THE RIGHT MIDDLE LOBE WHICH IS NOT WELL APPRECIATED ON CHEST X-RAY. THERE IS NO EVIDENCE OF ADDITIONAL FOCAL MASS LESION, OR DEFINITE BRONCHIECTASIS SEEN ON TODAY'S EXAM.

2. UPPER PARATRACHEAL ADENOPATHY; CLINICAL CORRELATION RECOMMENDED; THIS MAY BE INFLAMMATORY WITH A LYMPH NODE MEASURING UP TO 2 CM IN

[Continued On Next Page]

Page: 1

**ARMED HEALTH SYSTEM
Radiology Consult Report**

Attending MD: MOHAN, GOWDHAMI
REQUEST DATE/TIME: 03-17-2000 1519
ORDERING PHYS: MOHAN, GOWDHAMI
ORDER PHYS REF: 231-7004

JONES, ARCHIE EDWARD
MR# : 0000000000
IDX Acc # : 062719
Acct# : 00000000
Patient Loc: 04
Status: O

Sex: M Age: 56 Years DOB: 03-30-1943

Exam: (81)260401 Completed: 03-30-2000 1024

.....
THIS AREA ONLY.

Reading Physicians:
Kyle Bryans

Dictated on: 03-30-20001051
Transcribed on: 03-30-20001259
Last Edited on: 03-30-20001438
Finalized on: 03-30-20001439

by Pauline Walters
by Kyle Coreen Bryans M.D.
by Kyle Coreen Bryans M.D.

Page: 2

APR-02-2007 08:28AM FROM-PLASTIC SURGERY ASSOCIATES

8642950445

T-157 P.002/002 F-802

PLASTIC SURGERY ASSOCIATES OF GREENVILLE, P.A.

Archie Jones

4-20-00

Mr. Jones is doing well. He has some concern about a lesion that appears to me to be benign. We will follow along.

J. Barry Bishop, M.D./sf

ARMED HEALTH SYSTEM
Radiology Consult Report

Attending MD: SOUVIRON, JUNE PETRYSZN
REQUEST DATE/TIME:
ORDERING PHYS : SOUVIRON, JUNE PETRYSZN
ORDER PHYS PH#: (864) 231-7003

5/24/04
JONES, ARCHIE EDWARD
MR# : 000066441
IDX Acc # : 232742
Acct# : 2367057
Patient Loc: 04
Status: 0

Sex: M Age: 56 DOB: 07-27-1947

Exam: (81)210508 Completed: 05-18-2000 0952

Clinical History:

JONES TWO VIEWS RIGHT LOWER LEG

CLINICAL HISTORY: This is a 56-year-old male patient who fell with swelling and pain over the lateral malleolus. He had previous surgery of the ankle.

FINDINGS: AP and lateral views of the tibia and fibula show no evidence of acute fracture or dislocation; there is chronic posttraumatic change seen, particularly of the medial and lateral tibia with osteophyte formation, deformity, and overgrowth and healing of both the tibia and fibula. There are vascular clips seen in the medial proximal calf and distal medial ankle from previous surgery. No focal lytic or sclerotic lesions are seen. There is cartilage space narrowing of both the knee and ankle joint. A full report will follow of coned-down views of the ankle as well.

IMPRESSION: 1. CHRONIC POSTTRAUMATIC CHANGES OF THE ANKLE WITH HEALING AND DEFORMITY AND SECONDARY SEVERE OSTEOARTHRITIS. THERE IS NO EVIDENCE OF DEFINITE ACUTE FRACTURE OR DISLOCATION.

2. MILD OSTEOARTHRITIS OF THE KNEE.

Reading Physicians:
Kyle Bryans

Dictated on: 05-18-20001033
Transcribed on: 05-18-20001236
Last Edited on: 05-18-20001242
Finalized on: 05-18-20001242

by Linda Harper
by Kyle Coreen Bryans M.D.
by Kyle Coreen Bryans M.D.

Page: 1

ANMED HEALTH SYSTEM
Radiology Consult Report

Attending MD: SOUVIRON, JUNE PETRYSZN
REQUEST DATE/TIME:
ORDERING PHYS : SOUVIRON, JUNE PETRYSZN
ORDER PHYS PH#: (864) 231-7003

JONES, ARCHIE EDWARD
MR# 00000041
IDX Acc # 492751
Acct# 0067057
Patient Loc: 04
Status: 0

Sex: M Age: 56 Years DOB: 07-30-1944

Exam: (81)210500/RIGHT Completed: 05-18-2000 0953

Clinical History:

JONES THREE VIEW RIGHT ANKLE 5-18-2000

CLINICAL HISTORY: This is a 56-year-old male patient who fell with pain. He has a previous history of ankle surgery in 1962. Findings were compared and correlated with views of the tibia and fibula from the same day.

FINDINGS: There is some soft tissue swelling over the lateral malleolus with no acute fractures or dislocations. There is severe deformity of the ankle which appears to be due to chronic post-traumatic change, particularly of the lateral and medial tibia. The ankle mortise is well maintained although there is cartilage thinning seen throughout. In addition there is a focal lucency in the lateral dome of the talus and overgrowth of the fibula in the region of the tibiofibular syndesmosis. There is a small ankle joint effusion. No focal lytic or sclerotic lesions are seen. There is degenerative spurring seen of the posterior calcaneus.

IMPRESSION:

1. CHRONIC POST-TRAUMATIC CHANGE WITH HEALING AND DEFORMITY OF THE ANKLE; THERE IS SOFT TISSUE SWELLING OVER THE LATERAL MALLEOLUS AND SMALL ANKLE EFFUSION BUT NO ACUTE FRACTURES OR DISLOCATIONS ARE SEEN.

2. QUESTION OF OSTEOCHONDRAL DEFECT VERSUS SUBCHONDRAL CYST OF THE LATERAL TALAR DOME; IF CLINICALLY INDICATED, MRI COULD PROVIDE FURTHER EVALUATION OF THIS AREA.

3. DEGENERATIVE ENTHESOPATHY OF THE CALCANEUS WITH NO EVIDENCE OF EROSION OR INFLAMMATORY CHANGE.

Faxed on 5-18-2000 at 10:45 by pdw.

Reading Physicians:
Kyle Bryans

Dictated on: 05-18-20001037
Transcribed on: 05-18-20001041
Finalized on: 05-18-20001235

by Pauline Walters
by Kyle Coreen Bryans M.D.

Page: 1

248098

Archie Jones

6/12/00: Archie comes in today for evaluation. He is a gentleman who sustained severe burns. He has burn contractures extending down both legs. He has now developed symptomatology especially with the webbing of his foot. This webbing has resulted in continuous pain and discomfort and difficulty in wearing shoes.

I discussed with him that until he gets his steroid dosage reduced, we do not want to proceed with any surgical intervention. At the same time we will try to address his right leg.

Tracy S. Harvey, M.D./cbc

Ronald E. Tysl, D.D.S.

P.O. BOX 128
121 RIVER STREET
BELTON, SOUTH CAROLINA 29627

TELEPHONE (864) 338-8521

Ref. Eddie "Archie" Jones,

The oral sleep appliance is to treat
obstructive sleep apnea. Its function
is to help maintain a patent airway
facilitating proper breathing and
adequate intake of oxygen.

10-12-05

Ronald E. Tysl, D.D.S.

P.O. BOX 128
121 RIVER STREET
BELTON, SOUTH CAROLINA 29627
TELEPHONE (864) 338-8521

Don,

Ref. Archie Jones (SS # 250-10-111)

We spoke this morning ref. a new Apnea Appliance. At that time you gave us the O.K. Later today we will begin this treatment. The appliance that Mr. Jones has at this time is broken & can not be repaired. We will begin constructing the appliance today & plan to have it back from our lab completed & ready for patient in approximately two weeks.

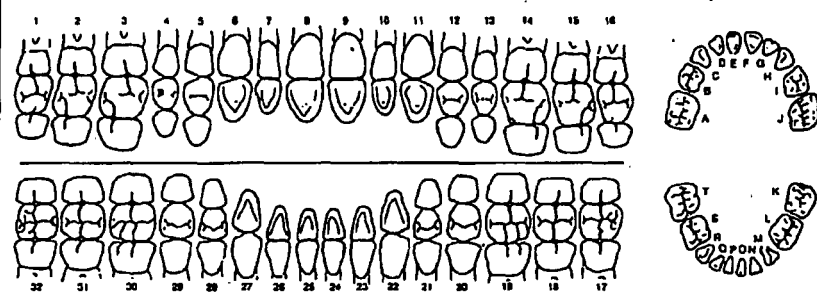
Sincerely,
Ronald E Tysl DDS

NAME Jones, Arch (EDDIE) TELEPHONE 222-2222

ADDRESS 1229 Salem Ch Rd BUSINESS ADDRESS Liberty Mutual

CHARGE TO 8514 McAlpine Rd ESTIMATE 514

REMARKS 1-2022 1:00 - 3:00 To do 1st 1st



ITEM 6421 COLWELL SYSTEMS 1 800 837 1140

DATE	TOOTH	SERVICE RENDERED	CHARGE	PAID	BALANCE
7-19-00		Sleep Appliance Consult	40-		
		Pt. born victim of Ref by Dr. Kellstrom for sleep appliance. Pt. has been Dx'd OSA. Covered by Workers Comp?			
7-31-00		Imp. for Klear-Way			
8-24-00		ins sleep appliance / Klear-Way			
		Check in 2 weeks. No screw adj.			
9-19-00		Ch. Sleep Appl. Pt. to turn screws twice / week. Check again in four weeks. Pt. has no more headaches upon awaking.			
10-17-00		Check appliance. Adj labial of 23 & 26. Pt. to leave sleep study Oct 28 & will call us with results.			
		Adj screw measures 3.5 mm opening			

DATE	TOOTH	SERVICE RENDERED	CHARGE	PAID	BALANCE
7-17-01		Imp. Sleep Apnea lightening wires Advance screw 4 turns (1 MM)			
6-9-03		Advance screw to reestablish proper MB advancement.			
10-22-03		Lock down screw & ligature wire and acrylic resin. R/C			
4-19-04		Imp. FAX Klearway Appl.			
11-26-04		Bite Reg			
5-12-04		ins. sleep appl.			
6-14-04		appl. adv.			
8-31-04	30	wire clasp removed, sleep appl. only in same area.			
6-1-05		Apnea appliance broken. Rt. post palatal wire broken @ acrylic interface. MB facial acrylic cracked around #6, 25, 26, MX buccal acrylic cracked @ #15. Rec. either new appliance or repair present one. if new is made, rec. repair present one later, to keep as "spare".			
10-12-05		Spoke to ANN Hutchison (Archie's case worker) she gave verbal OK over phone & ask that we FAX her note of work to be done & why - Spoke to Archie & he wants to try to get Appl. before Doc has Surg.			
10-12-05		Imp. for sleep Appl. FAX info to caseworker			
10-24-05		Klearway appliance ins. No turn for 1st 2 weeks. Dr. Hapray will be in 24th			

NAME <u>Jones, Archie</u>		DATE	AGE
ADDRESS		TELEPHONE	
E-MAIL		CELL PHONE	
BUSINESS ADDRESS		TELEPHONE	
CHARGE TO		ADDRESS	
ESTIMATE		REFERRED BY	
REMARKS			

DATE	TOOTH	SERVICE RENDERED	CHARGE	PAID	BALANCE
11-7-05		1/4 turn, appliance tried in mouth of patient. Decided to turn 1/4 more turn. Patient states, appl. is better with 2 turns. Will try & re-v in 2 wks.			
11-16-05		FXed information to ANN HUTCHINSON (case worker) ref why INS only. Paid \$28.00			
11-21-05		Patient states, he ~~do~~ has not felt well. Also appl. is not quite right yet. Dr. Hapnew adjust 2 turns. Patient to try 2 wks.			

*These notes were
sent to Sedgewick 4-26-06*

Clinical Notes for Archie Jones

6/1/2005 Apnea appliance broken. Right posterior palatal wire broken at acrylic interface. Mandibular facial acrylic cracked around tooth #'s 25-26. Maxillary buccal acrylic cracked at tooth # 15. Recommend new appliance be made and, if possible, repair present appliance later to be kept as "spare". Dr. Tysl

10/12/2005 Staff spoke with Ann Hutchison (patient's case worker) who gave verbal OK over phone and asked that we FAX her a note of work to be done and why. Spoke with Archie (patient) and he wants to try to get appliance before Dr. Tysl has his shoulder surgery.

10/12/2005 Impression for KlearWay sleep appliance and proper bite registrations taken. FAX info to caseworker.

10/24/2005 KlearWay appliance inserted. No turns for first two weeks. Dr. Hapney will check patient in two weeks.

11/16/2005 FAX info to case worker to seek payment.

12/6/2005 Mailed info to Liberty Mutual. Have had no response from caseworker.

12/18/2005 Patient office visit. Turned screw two turns. Check again in two weeks. Total of eight turns so far. Dr. Hapney

1/3/2006 Patient office visit. Measurement of two mm. Turned screw two turns. Will check again in two weeks. Dr. Hapney

1/18/2006 Patient office visit. Turned screw two turns. Will check again in two weeks. Dr. Hapney.

2/1/2006 Patient office visit. Patient states that his snoring has stopped. No further turns of screw. Dr. Hapney.

* REPRINT *

Acct.: 15004 Pat.: AJ -JONES, JR., ARCHIE PData: V-Date: 03/01/01
TS-Id: 71623 TS-Dt: 03/01/01 Doc#: 6 S/R: M/ Age: 57

ARCHIE E. JONES
HISTORY AND PHYSICAL
MARCH 1, 2001

REFERRING PHYSICIAN: DR. JUNE SOUVIRON

HISTORY: Mr. Jones is a 57 year old male who presents for colon screening. He has a history of having bleeding per rectum approximately once every six weeks which he thinks are associated with internal hemorrhoidal disease. He has lost weight recently, although he states he has been trying to lose weight.

His past medical history is significant for a 45 percent, third degree burn for which he was in the burn center at MUSC for approximately four months and he has had multiple surgeries since then. He has had one colonoscopy in the distant past greater than 10 years ago. He does not recall the results of this. He does not have any history of colon polyps or colon cancer and he does not have any family history of colon cancer.

MEDICAL HISTORY: 1. High blood pressure. 2. Rectal bleeding as above.
3. Multiple skin grafting procedures after extensive burn injury. 4.
Psychiatric disorders secondary to burn injury.

MEDICATIONS: Please see attached list.

PHYSICAL EXAMINATION: Patient is found to be in no distress. Lungs are clear. Abdomen is benign with extensive skin grafting. There is no hepatomegaly. On rectal exam, he has good tone. Stool is brown and heme negative. There is no significant hemorrhoidal disease appreciated.

IMPRESSION: Fifty-seven year old male with bleeding per rectum for the past six weeks. At this time, we will schedule him for a diagnostic colonoscopy. The risks and the benefits of the procedure have been discussed with him and he wishes to proceed.

SCOTT W. BEMAN, M.D./jd

c: Dr. Souviron

Dictated But Not Read

ANDERSON AREA MEDICAL CENTER

ANDERSON, S. C.

MEDICAL RECORD

JONES, ARCHIE EDWARD

SCOTT W. BEMAN, M.D.

3810261 7E- 0000-

03/16/2001

3/23/2001

PROCEDURE NOTE

Date of procedure: 3/16/01

Preoperative diagnosis: Bleeding per rectum

Postop diagnosis: Mild internal hemorrhoidal disease

Procedure: Colonoscopy to the cecum

Surgeon: Beman

Sedation: 5 mg Versed, 100 mcg Fentanyl

Complications: None

Procedure: The patient was brought to the endoscopy suite and identified as Archie Jones. After adequate sedation was provided, digital rectal exam was performed. There were no masses appreciated. The colonoscope was placed into the rectum and under direct visualization was advanced around to the level of the cecum. There was a very suboptimal prep and in particular the cecum was not well visualized, however, there were no large masses appreciated. The colonoscope was withdrawn as the mucosa was visualized. There were no large masses identified but this was a suboptimal prep and small mucosal detail could not be appreciated. There was noted to be a mild to moderate internal hemorrhoidal disease upon removal of the scope.

The patient tolerated the procedure well. He was awake and sent to regular rate and rhythm in stable condition.

SWB: ljw

SCOTT W. BEMAN, M.D.

CC: Piedmont Surgical (faxed 10:52)

<Page> 1 of 1

Authenticated by Scott W. Beman, MD On 3/26/01 3:36:56 PM

Re: ARCHIE EDWARD JONES
IMA # 31513

6/10/88

6.04.01

Wt 222 lbs.

Mr Jones comes on FU today. I have seen him before for dysphagia. I performed an upper endoscopy with him back in June of 1998. He has a history of burns and has lung disease related to this. He has had a fairly recent colonoscopy with Dr Beman back in March which was normal. He has been having some problems with epigastric burning, a significant amount and no significant dysphagia symptoms. No reflux symptoms. He described epigastric burning. He has been on multiple medications including aspirin and chronic steroid use and other medications as well. He started on some Cytotec which has been somewhat beneficial. He is on long term Prilosec 20mgs twice a day. He denies any fevers or chills. He has not had any vomiting. No history of peptic ulcer disease. He had an endoscopy in 1998. His stomach looked normal.

PHYSICAL EXAMINATION: His weight today is 222 lbs. BP 142/90. HEENT exam is within normal limits. Chest is clear to auscultation. Abdomen soft, nontender, positive bowel sounds. No hepatosplenomegaly.

IMPRESSION:

1. Epigastric burning. Probably a combination of medications and diet.

PLAN: We would like to switch him from Prilosec to Prevacid 30mgs twice a day. I have asked him to hold his aspirin for at least a week. He will try to minimize his steroid use and avoidance of acid containing foods and soft drinks. I have given him samples of Prevacid and a Rx. He is to call back if he has continued symptoms in which case he may need an upper endoscopy.

David Wortham

DTW/dlg

CC: Dr June Souviron



Anderson Area Medical Center
ADMISSION FORM

Am Am

DISCHARGE DIAGNOSIS		CODE
PRINCIPAL DIAGNOSIS (DESIGNATED AND DEFINED AS THE CONDITION ESTABLISHED AFTER STUDY TO BE CHIEFLY RESPONSIBLE FOR OCCASIONING THE ADMISSION OF THE PATIENT TO THE HOSPITAL FOR CARE)		
SECONDARY DIAGNOSIS (CONDITIONS THAT COEXIST AT THE TIME OF ADMISSION, THAT DEVELOP SUBSEQUENTLY, OR THAT AFFECT TREATMENT RECEIVED AND OR LENGTH OF STAY)		
PRINCIPAL PROCEDURE (PROCEDURE THAT WAS PERFORMED FOR DEFINITIVE TREATMENT RATHER THAN ONE PERFORMED FOR DIAGNOSTIC OR EXPLORATORY PURPOSES OR WAS NECESSARY TO TAKE CARE OF A COMPLICATION)		
DATE	PROCEDURE	
SECONDARY PROCEDURES		
DATE	PROCEDURE	
DISCHARGE DATE <u>6/11/01</u>		
DISCHARGE STATUS ☒ HOME ☐ DEATH + 48 ☐ DEATH - 48 ☐ AUTOPSY ☐ P.O. ☐ O.R. TIME OF DEATH AM PM DISC. SUM. DICT. ☐ TRANSFER ☐ AMA ☐ HOME HEALTH ☐		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. <i>June Petry</i> 6/11/01 SIGNATURE OF ATTENDING PHYSICIAN DATE
MEDICAL RECORD # 66441	PATIENT NAME AND ADDRESS JR ARCHIE EDWARD 1229 SALEM CHURCH ROAD ANDERSON SC 29625	ADMISSION DATE TIME 6/09/01 23:05 PR. ADMT/OPRY DATE 7/24/93 ACCOUNT # 3889154
BIRTHDATE 11/30/43	TEL 864 224-2669 COUNTY 004	BRV. CD. SOCIAL SECURITY # MED 30-2113 ROOM 415 BED 1 ACCL. ISO. RELIGION P N BP
ADMIT DIAG. TIA	PHYSICIAN NAME ATT. SOUVIRON, JUNE PETRY REF. SOUVIRON, JUNE PETRY ADM. SOUVIRON, JUNE PETRY	ST. LIC. # 1572420 1572420 1572420 DR. # 725 725 725
IN CASE OF EMERGENCY CONTACT DERRELL JONES WORK NUMBER ANDERSON SC 29621 TEL 864 226-1789 REL SPOUSE		PATIENT EMPLOYER NAME AND ADDRESS DISABLED 1229 SALEM CHURCH ROAD ANDERSON SC 29625 TEL 864 224-2669
GUARANTOR NAME AND ADDRESS ARCHIE EDWARD JONES 1229 SALEM CHURCH RD ANDERSON SC 29625 TEL 864 224-2669 REL PATIENT IS I		GUARANTOR EMPLOYER NAME AND ADDRESS DISABLED 1229 SALEM CHURCH ROAD ANDERSON SC 29625 TEL 864 224-2669
INSURANCE SUBSCRIBER NAME MEDICARE PART A JONES, ARCHIE E JR MINNESOTA BCBS JONES, ARCHIE E WORKMENS COMPENSATIO JONES, ARCHIE EDWARD		REL POLICY # GROUP # PT 250705119A PT MM2507051190 3MNL111 PT 250705119 COMP. CO PLAN CO 618 4 90 1 622 1
DOB MOTHER DOB FATHER POA: 1 LW: 1 VET: ADM. BY: DMAR		
CONSENT/NEED COPY MEDICARE/BC CARDS/PT WANTS FILED ON WC AND MEDICARE LATER/WC FORM SIGNED/DCMBEE CNE PATIENT CHART		

ANDERSON AREA MEDICAL CENTER ASSESSMENT SHEET EMERGENCY DEPARTMENT 800 NORTH FANT STREET, ANDERSON, SC 29621 (864) 261-1333		MR # 000066441 Sex: Male DOB: XXXXXXXXXX Name: Jones, Archie Edward E Phone: (864) 224-2669 Address: 1229 SALEM CHURCH ROAD, ANDERSON, SC 29625-0000 Unit Code: TCC Account # 3889154 Age: 57																																																																									
Complaint: Tera/ile Arrival Date/Time: 19:53 06/09/2001 Arrived by: Private Vehicle, Private Vehicle, Private Vehicle, Private Vehicle Mobility: Wheelchair, Wheelchair, Wheelchair, Wheelchair Accompanied By: Friend/Family, Friend/Family, Friend/Family, Friend/Family		Acuity: 2 - Urgent Fin Class: M Insurance: MEDICARE PART A Amb/Helicopter: Referring Facility: Emergency Physician: GRIER, Dr. John Primary Care: SOUVIRON, Dr. Jane																																																																									
Complaint Code: Neurologic Treatment PTA:		Triage Nurse: SOUTHERN-RN, Amy																																																																									
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ANDERSON AREA MEDICAL CENTER ASSESSMENT SHEET EMERGENCY DEPARTMENT 800 NORTH FANT STREET, ANDERSON, SC 29621 (864) 261-1333	MR # 00006641 Sex: Male DOB: 07/30/1943 Name: Jones, Archie Edward E Phone: (864) 224-2669 Address: 1129 SALEM CHURCH ROAD, ANDERSON, SC 29625-0000 Unit Code: TCC Account: XXXXXXXXXX A/C: XXXX

Orders 06/09/2001 20:00 - ER Physician Eval. - Dr. John GRIER, MD Evaluate Patient - Dr. John GRIER, MD at 06/09/2001 20:00 06/09/2001 20:01 - ORDER CANCELLED FOR ER Physician Eval. - Marie ASHLEY-RN 06/09/2001 20:22 - CT Head Neuro to read - Dr. John GRIER, MD Prepare Patient for Xray - Amy SOUTHERN-RN at 06/09/2001 20:24 06/09/2001 20:22 - EKG - Dr. John GRIER, MD 06/09/2001 20:22 - Saline Lock - Dr. John GRIER, MD 06/09/2001 20:22 - Oxygen - Dr. John GRIER, MD 06/09/2001 20:22 - Blood Sugar - Dr. John GRIER, MD 06/09/2001 20:22 - CBC - Dr. John GRIER, MD Obtain Specimen - Amy SOUTHERN-RN at 06/09/2001 20:23 06/09/2001 20:22 - PT - PROTHROMBIN TIME - Dr. John GRIER, MD Obtain Specimen - Amy SOUTHERN-RN at 06/09/2001 20:23 06/09/2001 20:22 - PTT - Dr. John GRIER, MD Obtain Specimen - Amy SOUTHERN-RN at 06/09/2001 20:24 06/09/2001 20:22 - URINALYSIS DIAGNOSTIC - Dr. John GRIER, MD Obtain Specimen (completion not documented) 06/09/2001 20:22 - CHESTPA/LAT/LORDOTIC - Dr. John GRIER, MD Prepare Patient for Xray - Amy SOUTHERN-RN at 06/09/2001 20:24 Triage/Initial Assessment 20:00 06/09/2001 - Vital Signs - Marie ASHLEY-RN Temp: 97.1 Oral BP: 145/87, Manual, Sitting, Left Arm, Regular cuff HR: 104, Regular Resp: 18, Regular, - Easy 20:10 06/09/2001 - Initial Triage Info - Amy SOUTHERN-RN Duration: 30, minutes Quick Assessment: Denies neck pain, Denies back pain, Denies LOC, AIRWAY intact, BREATHING no respiratory distress, BREATHING speaking complete sentences, BEHAVIOR cooperative, BEHAVIOR calm, NEURO alert & oriented x3, NEURO LOC - negative, NEURO weakness, SKIN warm & dry, SKIN coloration WNL, TRAUMA CMS intact, AMBULATES - without assistance Chief Complaint: 70v/10v Initial Triage Acuity: 2 - Urgent Complaint Category: Neurologic Presenting Complaints: Headache, Weak Trauma Yes / No: No 20:11 06/09/2001 - Past Medical History - Amy SOUTHERN-RN PMH-Medical history: Burns Social history: Lives with family Immunization History: Tetanus < 5 years Additional Note: pt. has had sinus, ankle, and knee surgeries along with tonsillectomy 20:11 06/09/2001 - Allergy Information - Amy SOUTHERN-RN Allergy A: -Codine 20:12 06/09/2001 - Medicine - Amy SOUTHERN-RN Medication A: Albuterol MDI Dosage A: 180mg Frequency A: BID Medication B: Alavert Dosage B: 2 puffs Frequency B: BID Medication C: Albuterol Neb Dosage C: 3ml Frequency C: BID 20:14 06/09/2001 - Medicine - Amy SOUTHERN-RN Medication A: Sorovont Dosage A: 2 puffs Frequency A: BID Medication B: Theophylline Dosage B: 300mg Frequency B: BID	Medication C: Prednisone Dosage C: 10mg Frequency C: QD Additional Note: pt. also takes pulmacort-2 puffs BID 20:17 06/09/2001 - Medicine - Amy SOUTHERN-RN Medication A: Prevacid Medication B: Risperdal Dosage B: 25mg Frequency B: BID Medication C: Depakote Dosage C: 375mg Frequency C: QD Additional Note: PL also takes saline nasal spray and lequin 400mg, and Sudal. 20:19 06/09/2001 - Medicine - Amy SOUTHERN-RN Medication A: Decadine Dosage A: 5mg Frequency A: Q AM Medication B: Zolof Dosage B: 12.5mg Frequency B: Q AM Medication C: Cardura Dosage C: 20mg Frequency C: Q PM 20:19 06/09/2001 - Medicine - Amy SOUTHERN-RN Medication A: Celecox Dosage A: 300mg Frequency A: BID Medication B: Aspirin Dosage B: 81mg Frequency B: Q AM 20:22 06/09/2001 - Subjective/HPI - Amy SOUTHERN-RN Additional Note: PL presents with c/o right sided weakness, slurred speech, and facial drooping lasting approx. 15 minutes today. PL states no previous neurological problems. PL is alert and oriented upon arrival. Denies visual disturbances or any cognitive problems during this episode. PL in bed upon arrival. Bilateral pupils equal, pupils equal and reactive to light. 20:23 06/09/2001 - Neuro - Amy SOUTHERN-RN Historian: patient Onset: last several hours Duration: less than 30 minutes Symptoms: aphasia, weakness Quality: moderate Reflexes and Strengths: Grip equal bilaterally Additional Note: PL took 1 ASA PTA. 22:28 06/09/2001 - Vital Signs - Kathleen CHALK, RN BP: 134/91, Automatic, Sitting, Left Arm, Regular cuff HR: 75, Regular Resp: 20, Regular, - Easy Nursing Documentation 20:21 06/09/2001 - Reassessment - Allison JACKSON, RN Additional Note: # 18 INT PLACED IN LAC X 1 ATTEMPT LABS DRAWN PT TOLD WELL WILL CONT TO MONITOR AJRN Assessment 19:53 06/09/2001 - Change Room - Sandra RICHIEY Change Room: Critical Care Wait 19:55 06/09/2001 - Change Room - Misty RICHARDSON Change Room: Critical Care Room 6 Occ 20:23 06/09/2001 - Document IV Placement - Amy SOUTHERN-RN Site #: 1 Catheter size: 18g Solution Amount: Heparin Site: AC, Right 21:29 06/09/2001 - Oximetry - Amy SOUTHERN-RN Pulse Oximetry %: 99 Oxygen Therapy: Nasal Cannula Concentration: 2 Units: L/min 21:44 06/09/2001 - Blood Sugar - Jean DYAR ED (mg/dl): 109

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ED - Treated by: One Touch 23:29 06/09/2001 - Family Notification - Allison JACKSON, RN Notification: Present, Notified	

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ANDERSON AREA MEDICAL CENTER

ASSESSMENT SHEET

EMERGENCY DEPARTMENT
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MR # 00006641 Sex: Male DOB: 07/30/1943
Name: Jones, Archie Edward E
Phone: (864) 224-2669
Address: 1229 SALEM CHURCH ROAD, ANDERSON, SC 29625-0000
Unit Code: TCC Account # 00000000000000000000

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Evaluate Patient - Dr. John GRIER, MD at 06/08/2001 20:00
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06/08/2001 20:22 - CT Head Neuro to read - Dr. John GRIER, MD
Prepare Patient for Xray - Amy SOUTHERN-RN at 06/08/2001 20:24
06/08/2001 20:22 - EKG - Dr. John GRIER, MD
06/08/2001 20:22 - Saline Lock - Dr. John GRIER, MD
06/08/2001 20:22 - Oxygen - Dr. John GRIER, MD
06/08/2001 20:22 - Blood Sugar - Dr. John GRIER, MD
06/08/2001 20:22 - CBC - Dr. John GRIER, MD
Obtain Specimen - Amy SOUTHERN-RN at 06/08/2001 20:23
06/08/2001 20:22 - PT - PROTHROMBIN TIME - Dr. John GRIER, MD
Obtain Specimen - Amy SOUTHERN-RN at 06/08/2001 20:23
06/08/2001 20:22 - PTT - Dr. John GRIER, MD
Obtain Specimen - Amy SOUTHERN-RN at 06/08/2001 20:24
06/08/2001 20:22 - URINALYSIS DIAGNOSTIC - Dr. John GRIER, MD
Obtain Specimen (completion not documented)
06/08/2001 20:22 - CHESTPA/LAT/LORDOTIC - Dr. John GRIER, MD
Prepare Patient for Xray - Amy SOUTHERN-RN at 06/08/2001 20:24

Triage/Initial Assessment

20:00 06/08/2001 - Vital Signs - Marie ASHLEY-RN
Temp: 97.1 Oral
BP: 142/87, Manual, Sitting, Left Arm, Regular cuff
HR: 104, Regular
Resp: 18, Regular, -, Easy
20:10 06/08/2001 - Initial Triage Info - Amy SOUTHERN-RN
Duration: 30, minutes
Quick Assessment: Denies neck pain, Denies back pain, Denies LOC, AIRWAY intact, BREATHING no respiratory distress, BREATHING speaking complete sentences, BEHAVIOR cooperative, BEHAVIOR calm, NEURO alert & oriented x3, NEURO LOC - negative, NEURO weakness, SKIN warm & dry, SKIN coloration WNL, TRAUMA CMS intact, AMBULATES - without assistance
Chief Complaint: Tinnitus
Initial Triage Acuity: 2 - Urgent
Complaint Category: Neurologic
Presenting Complaints: Headache, Weak
Trauma Yes / No: No
20:11 06/08/2001 - Past Medical History - Amy SOUTHERN-RN
PMH-Medical history: Burns
Social history: Lives with family
Immunization History: Tetanus < 5 years
Additional Note: pt. has had elbow, ankle, and knee surgeries along with tonsilectomy
20:11 06/08/2001 - Allergy Information - Amy SOUTHERN-RN
Allergy A: -Codeine
20:12 06/08/2001 - Medication - Amy SOUTHERN-RN
Medication A: Albuterol MDI
Dosage A: 180mg
Frequency A: BID
Medication B: Alvevent
Dosage B: 2 puffs
Frequency B: BID
Medication C: Albuterol Neb
Dosage C: 3ml
Frequency C: BID
20:14 06/08/2001 - Medication - Amy SOUTHERN-RN
Medication A: Borevent
Dosage A: 2 puffs
Frequency A: BID
Medication B: Theophylline
Dosage B: 300mg
Frequency B: BID

Medication C: Prednisone
Dosage C: 10mg
Frequency C: QD
Additional Note: pt. also takes pulmacort-2 puffs BID
20:17 06/08/2001 - Medication - Amy SOUTHERN-RN
Medication A: Prevacid
Medication B: Risperdal
Dosage B: 25mg
Frequency B: BID
Medication C: Depakote
Dosage C: 375mg
Frequency C: QD
Additional Note: Pt. also takes saline nasal spray and lequin 400mg, and Sudal.
20:19 06/08/2001 - Medication - Amy SOUTHERN-RN
Medication A: Decadron
Dosage A: 6mg
Frequency A: Q AM
Medication B: Zolof
Dosage B: 12.5mg
Frequency B: Q AM
Medication C: Cardura
Dosage C: 20mg
Frequency C: Q PM
20:19 06/08/2001 - Medication - Amy SOUTHERN-RN
Medication A: Celecox
Dosage A: 300mg
Frequency A: BID
Medication B: Aspirin
Dosage B: 81mg
Frequency B: Q AM
20:22 06/08/2001 - Subjective/HPI - Amy SOUTHERN-RN
Additional Note: Pt. presents with r/o right sided weakness, slurred speech, and facial drooping lasting approx. 15 minutes today. Pt. states no previous neurological problems. Pt. is alert and oriented upon arrival. Denies visual disturbances or any cognitive problems during this episode. Pt. in need upon arrival. Bilateral pupils equal, pupils equal and reactive to light.
20:23 06/08/2001 - Neuro - Amy SOUTHERN-RN
History: patient
Onset: last several hours
Duration: less than 30 minutes
Symptoms: aphasia, weakness
Quality: moderate
Reflexes and Strengths: Grip equal bilaterally
Additional Note: Pt. took 1 ASA PTA.
22:28 06/08/2001 - Vital Signs - Kathleen CHALK, RN
BP: 134/91, Automatic, Sitting, Left Arm, Regular cuff
HR: 75, Regular
Resp: 20, Regular, -, Easy
Nursing Documentation
20:21 06/08/2001 - Reassessment - Allison JACKSON, RN
Additional Note: # 18 INT PLACED IN LAC X 1 ATTEMPT LASS DRAWN PT TOL WELL WILL CONT TO MONITOR. AJRN
ASSESSMENT
19:53 06/08/2001 - Change Room - Sandra RICHIEY
Change Room: Critical Care Wait
19:55 06/08/2001 - Change Room - Misty RICHARDSON
Change Room: Critical Care Room 6
20:22 06/08/2001 - Document IV Placement - Amy SOUTHERN-RN
Site #: 1
Catheter size: 18g
Solution Amount: Heparin
Site: AC, Right
21:30 06/08/2001 - Oximetry - Amy SOUTHERN-RN
Pulse Oximetry %: 99
Oxygen Therapy: Nasal Cannula
Concentration: 2
Unit: L/min
21:44 06/08/2001 - Blood Sugar - Jean DYAR
ED (mg/dl): 109

ANDERSON AREA MEDICAL CENTER ASSESSMENT SHEET EMERGENCY DEPARTMENT 800 NORTH FANT STREET, ANDERSON, SC 29621 (864) 261-1333	MR # 000066441 Sex: Male DOB: 07/30/1943 Name: Jones, Archie Edward E Phone: (864) 224-2669 Address: 1229 SALEM CHURCH ROAD, ANDERSON, SC 29625-0000 Unit Code: TCC ~~Assess Unit 536-015~~ ~~Age 67~~
ED - Tested by: One Touch 23:29 06/09/2001 - Family Notification - Allison JACKSON, RN Notification: Present, Notified	

ANDERSON AREA MEDICAL CENTER
ANDERSON, S.C.
MEDICAL RECORD
66441

JONES, ARCHIE
JOHN GRIER, M.D.
3889154
06/09/01

EMERGENCY DEPARTMENT -- PRIORITY --

DATE: 06/09/01

CHIEF COMPLAINT: Could not talk.

DATE OF BIRTH: 07/30/43

HISTORY OF PRESENT ILLNESS: Mr. Jones is a 57-year-old white male. He comes to the Emergency Department accompanied by his wife and daughter. He was at home. He says he bent over to tie his shoe and very suddenly he lost the ability to speak. He said he did not have confusion, he knew exactly what he wanted to say but he could not make the words come out right. He says he could make sounds but they were very guttural, unintelligible sort of sounds that he was making. The patient's wife apparently observed this and agreed that he was not able to speak. She also noticed that he had a left facial droop. He says he had some tingling and incoordination of the right arm during this episode. The symptoms lasted 20 to 30 minutes and began to resolve. By the time the patient arrived in the Emergency Department, he was speaking normally to my exam although his wife says he is still not quite normal.

PAST MEDICAL HISTORY: The patient has never had a stroke, he does not have any heart disease and no diabetes. Four years ago he apparently suffered very severe burns and was at the Burn Unit and on the ventilator. He has COPD as a result of his burns or smoke inhalation or something related to the burns.

SOCIAL HISTORY: The patient is not a cigarette smoker, he is disabled from his burns, he lives with his wife.

FAMILY HISTORY: Negative for strokes, negative for heart disease.

ALLERGIES: The patient is allergic to CODEINE.

CURRENT MEDICATIONS: His current medicines are Atrovent inhaler, albuterol inhaler, Serevent, theophylline, prednisone, Prevacid, Risperdal, Depakote, Dexedrine, Zolof, Cardura, Colace and aspirin. The patient said he took an aspirin immediately after the symptoms began this evening.

REVIEW OF SYSTEMS: The patient has not had a headache but he does say he has felt somewhat unsteady on his feet today. He has had no
Continued

Page 2
EMERGENCY DEPARTMENT

JONES, ARCHIE
JOHN GRIER, M.D.

weight loss, no fevers or chills. He has had a roaring sound in his ears. He says he has tinnitus and often has a noise in his ears but today the roaring sound is something different. He has had no palpitations, no fevers or chills, no skin rash, no swelling of the feet or ankles, no nausea or vomiting.

PHYSICAL EXAMINATION:

VITAL SIGNS: Vital signs are stable. Temperature 97.1 degrees, respiratory rate 18, heart rate 104, blood pressure 145/87. The O2 saturation is 99% on two liters of oxygen per nasal cannula.

GENERAL: The patient is alert and oriented times three.

HEENT: The patient's speech sounds normal to me. Fundi have flat discs. Cranial nerves II through XII are intact. No facial droop is observed. Motor and sensory cerebellar exams appear normal.

NECK: Supple.

CHEST: Clear.

HEART: Regular rate and rhythm without murmur.

ABDOMEN: Soft and non-tender.

EXTREMITIES: There is no peripheral edema or calf tenderness.

INTERPRETATIONS:

EKG: EKG shows a sinus rhythm. There is a normal EKG.

DIFFERENTIAL DIAGNOSIS: Sounds to me like the patient had a transient ischemic attack. He could have had some type of arrhythmia or could have a tumor I suppose.

EMERGENCY DEPARTMENT COURSE: IV access is established. The patient has labs drawn.

DIAGNOSTIC STUDIES: A CT scan of the brain is done, it is interpreted by the neurologist, Dr. Oliver, as normal.

LABORATORY DATA: CBC is normal. CMP is essentially normal. The blood sugar is slightly elevated at 127, potassium slightly low at 3.4. PT and PTT are normal. Cardiac enzymes are negative.

DISPOSITION: The patient is reexamined at 9:30. At this point the patient's speech is normal, he says he feels back to normal.

DIAGNOSIS:

1. Transient ischemic attack.

Continued

Page 3
EMERGENCY DEPARTMENT

JONES, ARCHIE
JOHN GRIER, M.D.

PLAN: I have consulted with Dr. June Souviron. She and I agree hospitalization is indicated and she is arranging hospitalization for this patient. His condition is serious but stable.

JG/938:167971
ADMIT

JOHN GRIER, M.D.

Time Dictated: 9:57 pm
Time Transcribed: 10:08 pm
Authenticated by John Grier, MD On 6/21/2001 7:35:03 AM

ANDERSON AREA MEDICAL CENTER

ANDERSON, S. C.
MEDICAL RECORD

JUNE V. SOUVIRON, M.D.

3889154

4N- 0416- 1

06/10/2001

6/11/2001

6/13/01

HISTORY AND PHYSICAL

Date of admission: 6/9/01

Chief complaint: Aphasia and right arm numbness x 20-30 minutes prior to arrival in the Emergency Room at apparently 8:27 p.m.

This very pleasant 57 year old white male, disabled secondary to thermal induced COPD and extensive burns sustained four years ago this month in a chemical fire at work, also has marked secondary psychiatric related disorders, (sees a psychiatrist in Greenville, and his exact diagnosis is unknown to me). He reports on 6/9 in the afternoon while working under his car in the supine position had an episode of vertigo. This is common for him when he is supine and changes positions primary to the left side. He has discussed this previously with Dr. Hellstrom, his ENT physician, who he had seen initially for sleep apnea, and then later for recurrent sinus disorders, and Dr. Hellstrom assured him that this was related to his four month immobility and supine position four years ago during his stay at the burn unit in Charleston. Therefore, this did not worry him much at all yesterday when it occurred. Several hours after that he also was under the house fixing a water leak, came back upstairs and was showering and changing and dressing, when he suddenly began experiencing an episode of right arm numbness and minimal weakness, and when he wanted to tell his wife about it - he was unable to speak. He had no facial numbness or tingling. He did say that he had some worsening tinnitus on the left. No associated vision changes. No headache, no nausea, vomiting, diarrhea, chills, no loss of consciousness, no falls, no trauma and basically no other complaints. His wife immediately became alarmed. He took an aspirin on the way to the Emergency Room. Once he arrived here his symptoms had essentially ceased. There was nothing specifically focal on exam by the Emergency Room physician. He was impressed by the fact that the patient's wife had noted his difficulty with speech.

The patient reports that it is not uncommon for him to have numbness in his right arm. He has had this episodically but primarily associates it with cough spasm and also associated with a left-sided headache, neither of which were present today. He never had any speech difficulty in the past. He reports he has been emotionally quite upset for the last few days after receiving a letter from Medicare in reference to his disability on Friday.

As far as the patient's overall cardiovascular and cerebrovascular risk factors, he has never smoked, he has no diabetes, no known lipid disorders. He had an essentially normal echo approximately two years ago. There is no family history of any cerebrovascular or cardiovascular events. The patient has no known seizure disorder.

He sees Dr. Hellstrom periodically for ENT complaints, and began his association with him several years ago for sleep apnea, secondarily went on to see Dr. Mohan, local pulmonologist, who cares for him as far as his COPD is concerned. He recently began complaining of unrelenting gastroesophageal reflux symptoms and despite very high doses of PPIs. I sent him to Dr. David Wortham, who apparently did not do any interventional studies, did change his PPI, however. He is better now.

<Page> 1 of 3

Order

HISTORY AND PHYSICAL

JONES, ARCHIE EDWARD
JUNE V. SOUVIRON, M.D.

The patient has had long history of prostate difficulty, primarily prostatism from BPH and he sees Dr. Hinnant for that. He has always been controlled essentially with Cardura, but also seems to have a positive impact on some previously slightly elevated blood pressures. He has not had any blood pressure problems for years now. He has been kept on his Cardura by Dr. Hinnant. He has a history of migraine headaches, which he had not had for many years now.

Allergies: No known drug allergies.

Medication: Albuterol/Atrovent nebulizers or metered dose inhalers. Serevent two puffs b.i.d. Pulmicort two puffs b.i.d. Theophylline 300 mg q.a.m. and p.m. Prednisone 10 mg q.d. Sudal 2 tabs p.o. b.i.d. Saline spray. Prevacid 30 mg b.i.d. Risperdal .25 mg a.m. and noon and .5 in the p.m., Depakote 375 mg q.p.m. Dexedrine 5 mg q.a.m. Zolof 12.5 mg q.a.m. Cardura 20 mg q.p.m. Colace 300 mg b.i.d. Aspirin q.d.

Past medical and surgical history: Primarily as noted above. The patient also sees a burn specialist, who I think may also do some plastic surgery periodically for him in Charleston. Probably also has generalized anxiety disorder.

Social history: He is married, disabled draftsman. He had one son who has been deceased for approximately five years - I am not sure from an accidental death or a suicide. He has never used tobacco, alcohol or drugs.

Family history: There is no cardiovascular, cerebrovascular, diabetes, or hypertension. His father died at age 78 from a staph infection. His mother is alive and well. He has nine siblings, who I hear reportedly are generally healthy.

His review of systems is as above. No palpitations, no chest pain, no new shortness of breath, no nausea, no trauma, no lower extremity complaints, no falls, and otherwise as per HPI.

Physical examination: Temperature 96.7, pulse 72, respirations 16, blood pressure 120/70. Weight 99 kg. Height 5'10". He is tearful, alert, and oriented x 4, normal speech, no abnormal thought processes. No focal neurologic deficits at this time. Gross cerebellar testing was not done. He was able to do finger to nose, rapid alternating movements without difficulty. The cranial nerves are intact. Motor strength 5/5 in all groups. Sensory testing is normal for him. There may be some desensitization of light touch or hypersensitivity secondary to his burns. He has normal hair. Skin is per the usual with multiple graft sites. Nails are normal for him. He has pupils which are equal, round and reactive to light and accommodation. The extraocular muscles are intact. Conjunctivae are clear. Mucous membranes of the nose and throat are clear. Currently he has a mouth piece in place that he uses for sleep apnea. Neck is supple with no nodes, JVD, thyromegaly, masses, bruit or adenopathy. Heart regular rate and rhythm without murmur, gallop or rub. He has been in sinus rhythm throughout his hospital stay. Normal S1 and S2. PMI fifth intercostal space, +2 carotid, brachial, radial, femoral, posterior tibial, and dorsalis pedis pulses were not palpable at this time, have been present up to the last two weeks and he is without complaints in that area. I did not remove his Jobst hose. His lungs have good air movement. They are clear at this time. No wheezes, crackles or rhonchi. Abdomen is soft, nontender, no organomegaly or masses or guarding. GU and rectal exams deferred. Extremities: Good range of motion. No joint or bony abnormalities. Jobst hose were not removed.

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HISTORY AND PHYSICAL

JONES, ARCHIE EDWARD
JUNE V. SOUVIRON, M.D.

PHYSICIAN'S COPY

EKG is a sinus rhythm. White count 6.8. H&H 13.5 and 39. Platelets 231. PT, INR, PTT: 10.8, 0.8 and 30.7. Sodium 142, potassium 3.4, chloride 108, CO2 25, BUN 22, creatinine 1.2, and glucose 127, normal liver panel and proteins. CT of the head was negative per the Emergency Room physician. Lipid profile, TSH and theophylline level are pending.

Assessment and plan: Right arm numbness and aphasia, very transient in nature, preceded by an episode yesterday afternoon of vertigo. We will ask neurology to consult. He had been off his aspirin for about a week. It has been restarted. I have also added some Plavix since I am not sure that he did have a TIA, it would not have been considered to have been on aspirin therapy. An MRI will probably be negative for thoroughness. Carotids are pending. Lipids, TSH pending.

In view of the fact that the patient has unspecified psychiatric disorder and recently has had a lot of stress, I am not sure that role that may have played here. I am continuing his current psychiatric drugs except for the Dexedrine and I will contact his psychiatrist about that on Monday.

COPD. Continue routine meds. Theophylline level pending.

Prostatism. I am holding Cardura. I will ask Dr. Hinnant about changing his Cardura to possibly Flomax or other more specified alpha blocker and then we can just continue to monitor his blood pressures.

JVS/rjw

JUNE V. SOUVIRON, M.D.

ANDERSON AREA MEDICAL CENTER
ANDERSON, S. C.
MEDICAL RECORD

JONES, ARCHIE EDWARD
FRANK E. OLIVER, M.D.
3889154 4N- 0416- 1
06/10/2001
6/11/2001

CONSULTATION NOTE

REQUEST FOR CONSULTATION TO: FRANK E. OLIVER, M.D.

ATTENDING PHYSICIAN:

JUNE V. SOUVIRON, M.D.

DATE: 6/10/01

ASSESSMENT: Probable transient ischemic attack, reflecting an approximate 15 minute episode of speech disturbance with right upper extremity numbness and with some weakness

RECOMMENDATIONS: Antiplatelet therapy (Plavix 75 mg. q.day). If there is a recurrent event or if significant large vessel disease is determined, one might consider anticoagulation with Coumadin.

MRI scan of the brain with contrast. MRA of the circle of Willis. Noninvasive vascular examination to include carotid artery to transcranial Doppler, echocardiogram, chemistry/hematological screen.

HISTORY: Mr. Jones is a 57 year old Caucasian gentleman, right-handed, who states that just prior to admission he experienced an episode of numbness that started in his right upper extremity in the hand and progressed to involve the whole arm. The arm also felt heavy although he could move it some. He also at that time noted that he could not speak. Prior to arrival in the emergency room, the patient had resolved his deficit and has had no recurrence. He had no prior history of this. With the exception of that, he says about 29 years ago he had an episode of right upper extremity numbness. I will assume that is nongermane.

MEDICAL HISTORY: Is significant for second and third degree burns, for which he spend an extensive period of time in the burn unit; that was approximately 4 years ago. Also in that accident he experienced chemical-smoker inhalation and developed some significant chronic obstructive pulmonary disease. He denies a history of diabetes mellitus or organic heart disease, GI disturbances or blood dyscrasias. He has no history of kidney problems. He has no history of cancer. Dr. Souviron says his lipid panel is normal.

At the time of this dictation, he was taking aspirin.

Related to his accident and burns, patient is under psychiatric care on a considerable amount of medicine.

A PT, PTT and INR are normal. CBC is normal. General chemistry is normal other than a marginal decrease in potassium to 3.4, BUN of 22 and a random glucose of 127.

EKG on the chart shows normal sinus rhythm.

Unenhanced CT scan of the brain was interpreted as normal.

<Page> 1 of 2

CONSULTATION NOTE

PHYSICIAN'S COPY

JONES, ARCHIE EDWARD
FRANK E. OLIVER, M.D.

Clinically, the patient is awake, alert, and oriented with normal cognition. Sleep pattern is normal.

Reflexes are symmetrical. Plantar reflexes are downgoing. Motor examination reveals symmetrical strength, bulk and tone. No positional drift is noted.

Fine motor skills and finger-to-nose testing of the extremities are symmetrical and normal.

Facial motor is normal. Tongue protrudes in the midline. Bulbar function is good.

Extraocular movements are full. Pupils are equal and reactive. Fundoscopic examination normal. Visual fields are intact to confrontation.

Romberg is negative. His natural gait looks normal.

No carotid bruits are auscultated. Admission blood pressure in the normotensive range. Heart has a regular rhythm.

FEO: smr

FRANK E. OLIVER, M.D.

ANDERSON AREA MEDICAL CENTER
ANDERSON, S.C.
MEDICAL RECORD

JONES, ARCHIE E.
JUNE SOUVIRON, M.D.
3889154
06/11/01
06/26/01

DISCHARGE SUMMARY

DATE OF ADMISSION: 06/09/01
DATE OF DISCHARGE: 06/11/01

PRINCIPAL DIAGNOSIS: 1. Probable transient ischemic attack.

SECONDARY DIAGNOSIS: 1. Prostatism.
2. Chronic obstructive pulmonary disease.
3. Mild hypertension.
4. Anxiety and depression.
5. Post-traumatic stress disorder secondary to multiple thermal burns.

DISCHARGE MEDICATIONS: Plavix 75 milligram 1 every day, aspirin 1 p.o. every day, prednisone 10 milligram every day, Theo-Dur 300 milligram b.i.d., Proventil MDI in aerosol and Atrovent MDI in aerosol, Serevent inhaler 2 puffs b.i.d., Pulmicort inhaler 2 puffs b.i.d., Risperdal .25 milligram every a.m. at noon and 0.5 milligram q.h.s., Depakote sprinkle 375 1 dose every p.m., Colace, Zolof 25 milligram every day.

CONDITION ON DISCHARGE: Stable.

DIET: Regular.

FOLLOW-UP: Follow-up with Dr. Oliver if right arm numbness persists and with Dr. Souviron in one week. Monitor home blood pressures b.i.d. to t.i.d. and record, bring to the office.

Mr. Jones is a 57 year old white male who is disabled secondary to thermal induced chronic obstructive pulmonary disease and burn sustained four years' ago in a chemical fire at work with marked secondary psychiatric problems. He is a patient of Dr. Souviron's Family Practice, Dr. Mohan of pulmonary, and psychiatry in Greenville. He reportedly had a 15 to 20 minute episode of aphasia with right arm numbness on the evening of 6/09/01. He was brought immediately to the emergency room, had an aspirin in route. He reports that he had been off of his aspirin therapy for about a week prior to this as he had been having some epigastric/GI problems and Dr. Wortham asked him to stop his aspirin temporarily and he had been doing well with his Prevacid therapy. The patient had had no previous TIA's, no seizure activity. He reportedly that he had had a very busy day. He was very nervous and anxious about some dealings recently with Medicare. He had over done it that day to some extent working on his car and repairing plumbing under his

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JUNE SOUVIRON, M.D.
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06/11/01
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DISCHARGE SUMMARY

Page Two

house. He says that in the past he has had some occasional right arm numbness when he has had spasms of cough and occasionally a left sided headache but never any associated speech difficulty. He has never smoked. He does not have diabetes. He has had wonderful lipid profile and a normal echo several years ago. There is no family history of stroke. However, his son was in his late 20's and died with a subarachnoid hemorrhage about five years' ago. He was asymptomatic and no focal findings on arrival to the emergency room. His admission CT was negative. In view of the fact that this was what appeared to a first TIA the emergency room physician felt that he should at least be admitted for inpatient observation and some evaluation.

For details of the history and physical, social, family history, review of systems, past medical history, surgical history please refer to that history and physical document.

On physical examination he appeared his normal self, cheerful, alert, and oriented x 4. Skin changes consistent with multiple skin grafts and burn sites. Mucous membranes were clear. There were no focal central nervous system findings. His heart had a regular rate and rhythm. His lungs were clear.

His EKG was sinus. His white count was 6.8, hemoglobin and hematocrit 13.5 and 39, platelets 231,000. Normal liver. Normal coagulation studies. CT of the head was negative. His glucose was slightly elevated at 127 with potassium of 3.4, sodium 142, chloride 108, BUN 22, creatinine 1.2 and CO2 of 25.

He was admitted to a monitored bed on 4 North and started on some Plavix therapy, continued on aspirin. Noninvasive vasculars were ordered. An MRI was ordered. Dr. Oliver was kind enough to consult. He was continued on his routine psychiatric drugs except for his Dexedrine and I weaned his Cardura in view of some recent cardiovascular studies showing this could possibly be linked to increased stroke and MI and spoke with Dr. Hinnant who agreed that we could wean this and start him on a more specific Alpha blocker like Flomax instead.

Throughout the hospital stay the patient continued to have stable vital signs and no aphasia events. He has been in sinus rhythm throughout his stay. His heart rates remained in the 70's, respiratory rate was 20, blood pressure 120/70, on the morning of

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3889154
06/11/01
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DISCHARGE SUMMARY

Page Three

discharge, 6/11/01. The patient had a negative MRA circle of Willis, negative MRI today except for a T1-T2 hyperdensity in the right parietal white matter that Dr. Oliver felt was probably not related to this event. Carotids and transcranial duplexes were negative. A Holter monitor is still pending. He has had some complaints of some atypical right arm numbness only with certain movements that at this point Dr. Oliver felt was probably unrelated and that we could monitor. He will see him as an outpatient for some EMG type studies if that persisted. On 6/11/01 he was cheerful, again had no events, no chest pain, no shortness of breath, no palpitations, no speech abnormalities, no headaches, no vision changes, no tinnitus, no neck or shoulder pain, occasional cough, some transient right upper extremity numbness only with writing or holding his arm a certain way. No nausea, vomiting, diarrhea. No chest pain. His chronic obstructive pulmonary disease has remained stable. The patient is alert and oriented. He is cheerful and pleasant. He is normocephalic. Mucous membranes are clear. Pupils are equal, round, and reactive to light and accommodation. Extraocular muscles intact. Neck is supple with no JVD. No thyromegaly, masses, or bruit, +2 carotids, midline trachea. Heart shows a regular rate and rhythm without murmur, gallop or rub. Normal S1 and S2. +2 peripheral pulses. Lungs have a few expiratory coarse breath sounds. No wheezes. No crackles. His abdomen is soft and nontender. No organomegaly or masses. Extremities--Jobst hose are in place. He has calluses and some soft tissue deformities consistent with his old burn. He has full range of motion of both upper and lower extremities. No joint or bony abnormalities. No effusion. Neurologically the patient is grossly intact. He has been up and about without difficulty. He is being discharged to home with a diagnosis of a probable TIA. He is being continued on his routine medications except the addition of Plavix 75 milligram every day as samples for home. Continue his aspirin. Will switch from Cardura to Flomax. Dr. Hinnant has some samples for him at his office. I will follow him up in a week. He is to record some home blood pressures. He is to let me know if his arm numbness persists at all and we will have him back in to see Dr. Oliver. At this point he has had no

ANDERSON AREA MEDICAL CENTER
ANDERSON, S.C.
MEDICAL RECORD

JONES, ARCHIE E.
JUNE SOUVIRON, M.D.
3889154
06/11/01
06/26/01

DISCHARGE SUMMARY

Page Four

recurrence of any TIA's and he is quite stable for discharge. His theophylline level on 6/10/01 was 6.6, TSH was 2, triglycerides 88, cholesterol 135, LDL 74, HDL 43. The patient reports he is ready and anxious for discharge. His urine was clear and he has follow-up with me as indicated above.

Authenticated by
June P. Souviron, MD
On 7/8/01 2:35:19 PM

JS/43ms

JUNE SOUVIRON, M.D.

Anderson Area Medical Center
X-Ray Report

NAME:
JONES, ARCHIE EDWARD

DOB DOCTOR
07/30/1943 GRIER, JOHN

Room/Bed
4N4161

DATE: 06/09/2001 TIME: 20:40
VISIT #: 3889154

JONES CT HEAD WITHOUT CONTRAST

This unenhanced CT scan of the brain is accomplished in a 57 y/o with slurred speech and right arm weakness.

The ventricular system is normally configured midline. The third and fourth ventricles are visualized. The pineal recess is midline. The basal cisterns appear normal. No parenchymal abnormalities are appreciated.

IMPRESSION:

NORMAL UNENHANCED CT SCAN OF THE BRAIN.

D: 06/10/2001
T: 06/10/2001
F: 06/10/2001

OLIVER M.D., FRANK

/00246

250-705119
01-chart
ANMED HEALTH
Radiology Consult Report

REQUEST DATE/TIME: 06-10-2001 0917
REQUESTING PHY: SOUVIRON, JUNE PETRYSZN
EQ PHYS PH#: (864) 231-7003
ATTENDING PHY: SOUVIRON, JUNE PETRYSZN

JONES, ARCHIE EDWARD
MR# : 000066441
IDX Acc # : 678269
Acct# : 3889154
Patient Loc:
Status: D

ex: M Age: 57 Years DOB: 07-30-1943

xam: (AH)290101 Completed: 06-11-2001 1445

linical History: TIA NEURO

JONES MRI SCAN OF BRAIN W/NO CONTRAST

INDICATION: TIA.

TECHNIQUE: MRI scan of the brain is obtained using the head coil. Spin echo T1W sagittal and axial sequences as well as heavily T2W axial and coronal sequences with a spin density coronal and a FLAIR axial sequence as well as diffusion-weighted imaging in the axial plane are all completed through the calvarium. After Magnevist contrast administration spin echo T1W sagittal, axial and coronal data sets are obtained.

FINDINGS: The study is of good quality. The paranasal sinuses are well aerated and retro-orbital spaces are unremarkable. The optic chiasm-pituitary region and cranio-cervical junction regions are unremarkable. There is symmetric signal flow void within the internal carotid arteries at the level of the siphon and also within the basilar artery. In the posterior fossa the fourth ventricle has a normal size and position and with unremarkable cerebellum and brain stem structures. In the supratentorial compartment the ventricular system is symmetrical and of normal size and cortical markings normal. There is a solitary T2 hyperintensity of just a few mm in diameter, involving the right mid parietal lobe adjacent to the body of the right lateral ventricle superiorly. This does not show high signal on the diffusion-weighted study. No abnormal contrast enhancing region of the brain is detected.

IMPRESSION:

THIS MRI SCAN OF THE BRAIN WITH CONTRAST SHOWS:

1. A SOLITARY, SMALL T2 HYPERINTENSITY OF THE DEEP WHITE MATTER OF THE RIGHT PARIETAL LOBE ADJACENT TO THE BODY OF THE RIGHT LATERAL VENTRICLE. THIS IS A NONSPECIFIC FINDING WHICH COULD REPRESENT A CHRONIC MICROVASCULAR INFARCT OR A SMALL AREA OF DEMYELINATION. NO EVIDENCE OF ACUTE INFARCT IS SEEN.
2. NO ABNORMAL CONTRAST ENHANCING REGION OF THE BRAIN IS IDENTIFIED.

[Continued On Next Page]

Page: 1

ANMED HEALTH
Radiology Consult Report

REQUEST DATE/TIME: 06-10-2001 0917
REQUESTING PHY: SOUVIRON, JUNE PETRYSN
REQ PHYS PH#: (864) 231-7003
ATTENDING PHY: SOUVIRON, JUNE PETRYSN

JONES, ARCHIE EDWARD
MR# : 000066441
IDX Acc # : 678269
Acct# : 3889154
Patient Loc:
Status: D

Sex: M Age: 57 Years DOB: 07-30-1943

Exam: (AH)290101 Completed: 06-11-2001 1445

.....

Reading Physicians:
John Francis Pilch M.D.

Dictated on: 06-11-20011538
Transcribed on: 06-11-20011557
Finalized on: 06-12-20010915

by Pauline Walters
by John Francis Pilch M.D.

Page: 2

ANMED HEALTH
Radiology Consult Report

REQUEST DATE/TIME: 06-10-2001 2321
REQUESTING PHYS: SOUVIRON, JUNE PETRYSZN
REQ PHYS PH# 231-7003
ATTENDING PHY: SOUVIRON, JUNE PETRYSZN

JONES, ARCHIE EDWARD
MR# :000066441
IDX Acc # :678435
Acct# :3889154
Patient Loc:
Status: D

Sex: M Age: 57 Years DOB: 07-30-1943

Exam: (AH)290110 Completed:06-11-2001 1445

Clinical History: TIA NEURO

JONES

MRA OF THE CIRCLE OF WILLIS

TECHNIQUE: 3D time of flight MR angiography of the Circle of Willis vasculature is obtained with rotation about two axes.

The normal appearing basilar artery gives rise to left and right posterior cerebral arteries which are normal in appearance. The distal internal carotid, middle and anterior cerebral arteries are normal in appearance.

IMPRESSION:

NORMAL MR ANGIOGRAPHY OF THE CIRCLE OF WILLIS VASCULATURE.

Reading Physicians:
John Francis Pilch M.D.

Dictated on: 06-11-20011540
Transcribed on: 06-11-20011605
Finalized on: 06-12-20010915

by Betsy Phillips
by John Francis Pilch M.D.

Page: 1

ARMED HEALTH
Radiology Consult Report

REQUEST DATE/TIME: 06-10-2001 0917
REQUESTING PHY: SOUVIRON, JUNE PETRYSZN
REQ PHYS PH#: (864) 231-7003
ATTENDING PHY: SOUVIRON, JUNE PETRYSZN

6/13/01
JONES, ARCHIE EDWARD
MR# 000066441
IDX Acc # 672267
Acct# 0000154
Patient Loc:
Status: D

Sex: M Age: 57 Years DOB: 02-28-1943

Exam: (AH)280304 Completed: 06-11-2001 1445

Clinical History:

TECHNOLOGIST: ML

BP: RT 120/70 LT --

BRUITS: RT - LT -

PULSE: 79

CAROTID		TEMPORAL		FACIAL	
RT -	LT -	RT -	LT -	RT -	LT -

PROCEDURE DATE: 06-11-01

CLINICAL ASSESSMENT: Generalized weakness; hypertension; COPD.

JONES TRANSCRANIAL DOPPLER 6/11/01

INDICATION: Dizziness.

FINDINGS: Right Anterior Window: The distal internal carotid, middle cerebral, anterior cerebral and posterior cerebral arteries demonstrate antegrade flow with normal waveforms and normal mean velocities. There is no evidence of focal stenosis seen in any of these vessels.

Left Anterior Window: The distal internal carotid, middle cerebral, anterior cerebral and posterior cerebral arteries demonstrate antegrade flow with normal waveforms and normal mean velocities. There is no evidence of focal stenosis seen in any of these vessels.

Posterior Window: The basilar artery and both vertebral arteries demonstrate antegrade flow with normal waveforms and normal mean velocities. There is no evidence of focal stenosis seen in these vessels.

IMPRESSION:

NORMAL TRANSCRANIAL DOPPLER.

End Report

Continued On Next Page]

Page: 1

ARMED HEALTH
Radiology Consult Report

REQUEST DATE/TIME: 06-10-2001 0917
REQUESTING PHY: SOUVIRON, JUNE PETRYSZN
REQ PHYS PH#: (864) 231-7003
ATTENDING PHY: SOUVIRON, JUNE PETRYSZN

JONES, ARCHIE EDWARD
MR# 80 0068141
IDX Acc # 618266
Acct# 3189154
Patient Loc:
Status: D

Sex: M Age: 57 years DOB: 07-20-1943
Exam: (AH)280300 Completed: 06-11-2001 1445

Clinical History:

TECHNOLOGIST: ML

BP: RT 120/70 LT -

BRUITS: RT - LT -

PULSE: 79

CAROTID		TEMPORAL		FACIAL	
RT -	LT -	RT -	LT -	RT -	LT -

PROCEDURE DATE: 06-11-01

CLINICAL ASSESSMENT: Generalized weakness; hypertension; COPD.

JONES NONINVASIVE 6/11/01

VELOCITIES IN METERS/SECOND: Right Common Carotid: 0.59. Internal Carotid Artery: 0.52. External Carotid Artery 0.53.

Left Common Carotid: 0.60. Internal Carotid Artery: 0.52. External Carotid Artery: 0.46.

RIGHT CAROTID: The common carotid, the bulb and internal carotid artery level is visually normal to gray color scale. Pulse-gated Doppler is normal.

LEFT CAROTID: The common carotid, the bulb and internal carotid artery level is visually normal to gray color scale. Pulse-gated Doppler is normal.

VERTEBRAL ARTERIES: Both vertebral arteries are visualized in the cervical neck region to gray color scale. Pulse-gated Doppler is normal.

IMPRESSION:

NORMAL NONINVASIVE VASCULAR EXAMINATION.

Continued On Next Page]

Page: 1

End Report

Anderson Radiology

1011 Ella Street ♦ Anderson, South Carolina 29621
Telephone (864) 225-6286 ♦ Fax (864) 231-6738

JONES, ARCHIE E.

MRN: [REDACTED]

DOB: [REDACTED]

Sex: Male

Ordering MD:

Referring MD: JUNE SQUIVRON

Attending MD:

Consulting MD:

call benz are

*showing
only little
loss but
over all*

Study Date	Accession #	Procedure Code	Procedure/Reason For Study
09/05/2001	1020904858	1	DEXA SCAN

BONE DENSITOMETRY--BASELINE ANALYSIS

Clinical indications: Assess bone mineralization. 58 year-old male patient with long-term steroid use.

Bone mineral density was performed with the Lunar dual energy bone densitometry device. Bone mineral density at L1 is 0.9 standard deviation below young adult reference (T-score). Bone mineral density at the neck of the left femur is 1.2 standard deviation below young adult reference (T-score).

Impression: Low bone mass (osteopenia) according to World Health Organization standards. Follow-up in 2 years advised.

Thank you for this consultation.

Edward Warren, III, M.D.



Dictated on:	09/05/2001 4:43:07PM
Interpreted by:	Edward Warren, III, M.D.
Transcribed by:	PowerScribe
Signed by:	Edward Warren, III, M.D.

General Radiology ♦ Fluoro ♦ 09/05/2001 4:43:39PM ♦ Mammography ♦ CT ♦ MRI

Anderson Diagnostic Imaging, Inc.

EDWARD C. MATTISON, M.D., P.A.
1118 CORNELIA ROAD
P.O. BOX 1847
ANDERSON, SOUTH CAROLINA 29622
TELEPHONE: 224-0028

6/6/4

Edward C. Mattison, M.D.
June 6, 2002

Boris A. P. Ilg, M.D.

June Souviron, M. D.
2405 North Main Street
Anderson, SC 29621

Re: Archie E. Jones

Dear Dr. Souviron:

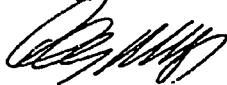
Thank you very much for your referral of Archie Jones for evaluation of his eyes secondary to history of severe burns in the past as well as chronic steroid usage for respiratory difficulties. He complains of occasional floaters OU for several years and sometimes has difficulty focusing. He also has mild glare problems.

His uncorrected vision is 20/30 and 20/20 best corrected to 20/20 and 20/20. His intraocular pressures are normal and his cup to disc ratio is 0.3 OU. He has a posterior vitreous detachment OU and mild cataracts OU. The remainder of his exam is unremarkable.

I gave him a glasses prescription to help with near and distance vision. He has mild senile cataracts which are not visually significant and I will be following these. His posterior vitreous detachments are chronic and stable and I discussed retinal detachment precautions with him. I discussed warm compresses and artificial tears for his mild blepharitis. I could find no ocular affect of his oral Prednisone use.

Thank you again for your referral and for allowing me to participate in the care of this delightful patient. Please do not hesitate to call me with any thoughts or questions.

Sincerely,



Boris A. Ilg, M. D.

BAI/sr

cc: Mary Cocke, RN, CCM
Crawford & Company

Anderson Radiology

1011 Ella Street ♦ Anderson, South Carolina 29621
Telephone (864) 225-6286 ♦ Fax (864) 231-6738

JONES, ARCHIE E.
MRN: 50599
DOB: 07/30/1943
Sex: Male

Ordering MD:
Referring MD: JUNE SOUVIRON
Attending MD:
Consulting MD:

7/22/07
Barney
are ok
exapt
actant

Study Date	Accession #	Procedure Code	Procedure/Reason For Study
07/22/2002	1020919414	1	THORACIC SPINE, LUMBAR SPINE, AND LEFT HI

THORACIC SPINE:

Clinical Information: Back pain when standing.

The thoracic vertebral bodies are normal in height. The curvature is normal. Pedicles are intact. There are small anterior degenerative spurs.

Conclusion: Degenerative disease.

LUMBAR SPINE:

There is narrowing of the L 2-3, 3-4, and 4-5 interspaces. There are relatively large anterior degenerative changes at these levels. The lumbar vertebral bodies remain normal in height. The sacroiliac joints are normal.

Conclusion: There is degenerative disease as described above.

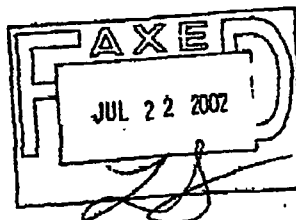
LEFT HIP:

The left hip is normally articulated. The joint space is normal. There are no significant degenerative changes identified. There are large phleboliths in the pelvis.

Conclusion: The left hip is within normal limits.

Thank you for this consultation,

Carl C. Bailey, M.D.



Dictated on: 07/22/2002 1:33:49PM
Interpreted by: Carl Bailey, MD
Transcribed by: PowerScribe
Signed by: Carl Bailey, MD

07/22/2002 1:40:21PM

General Radiology ♦ Fluoro ♦ Ultrasound ♦ Mammography ♦ CT ♦ MRI ♦ Bone Densitometry

Ho

Acct No.: 58882

Patient...: FL -Archie Jones

Doctor...: Douglas A Reeves MD

Visit Date: 8/8/2002

SUBJECTIVE: Mr. Jones is a 59-year-old male who comes today for evaluation of low back pain. Mr. Jones has been having back pain for about four months now. He remembers an episode where he slipped and had to catch himself and felt a jar in his lower back. He has had some pain in the left hip and a little bit down in the back of the left leg. He does not remember significant back injury at any other time in the past. He reports mainly having pain first thing in the morning getting out of bed. He loosens up some during the day and then has some pain in the evenings. No new bowel or bladder dysfunction is noted. No saddle anesthesia.

REVIEW OF SYSTEMS: No significant change in his health status has been noted recently.

PAST MEDICAL HISTORY: He suffered a severe burn about five years ago. He reports 45% body surface area with third degree burns. He was in the burn unit for several months. He has had multiple skin grafts. He also reports burning of the lungs. Because of this he is on multiple medications. He does not have significant health problems otherwise.

CURRENT MEDICATIONS: Include albuterol, Atrovent, Combivent, along with nebulizer, Serevent and Pulmicort, Singulair, theophylline. He is also on Humibid, Provacid, and multiple antitussive medications. He is on Flomax, Risperdal, Depakote, Plavix, Dexedrine, Zolof, and Colace. He is also on chronic prednisone therapy 10 mg a day for the last three years and he is on Celebrex 200 mg to 400 mg a day and he was recently started on Actonel because of the bone scan that apparently showed lowering of his bone density. He was also on frequent antibiotics which he alternates each month. He is also on multiple vitamins and supplements.

PHYSICAL EXAMINATION: Well developed, well nourished, in no acute distress. Inspection does show diffuse burn scars most of the body, particularly lower legs. He does have multiple donor sites on his back. The patient does tell me he has lost light sensation in the legs, but still has pressure sensation. He cannot tell that, but his legs feel little numb on occasion. On palpation he has some tenderness along the midline at the lumbar vertebra L2 down to S1. He has very well maintained flexion and has some pain riding himself. He does have some pain with hyperextension and pain with lateral or rotational movement, although, his range of motion is well maintained. No tenderness currently over the posterior gluteal muscles or hip area. Hips have well maintained range of motion. He has negative straight leg raise. He has normal patella and Achilles reflexes. He has excellent dorsiflexion of the left great toe. He has no dorsiflexion of the right great toe because he has had the extensor hallucis longus tendon removed because of the burn complication. His pressure sensation is intact, but light touch is difficult to assess because of his other problems.

ASSESSMENT AND PLAN: Low back pain. Suspect that this is all related to an aggravation of his degenerative changes. He does have some pain about the left leg and we may need to consider an MRI scan if he does not resolve with fairly conservative treatment. We are going to keep him on his home exercise program. Add icing and heating regimen. I talked to him about Glucosamine, but not sure he is on that any more or supplements at this time. I will continue him on the Celebrex. We talked about formal physical therapy and perhaps the need for MRI scan. We will readdress and this on his return visit in three weeks.

ks. 

Acct No.: 58882

Patient...: Archie Jones

Doctor...: Douglas A. Reeves, MD

Visit Date: 8/29/2002

Mr. Jones is here for recheck. His back is starting to calm down some. He is not having the stinging burning pain in the left leg. He is just having more soreness in the back. It is worse in the morning. He has been doing range of motion exercises. Really does not have any new complaints.

On examination today, he has less tenderness in the lumbar area. He has improved range of motion without significant pain. Otherwise examination is unchanged.

ASSESSMENT AND PLAN: Doing some better. We would like to send him over to physical therapy and have them see if they can finish getting this pain to calm down. If not, we may need to consider an MRI scan. See him back in a few weeks.

Douglas A. Reeves, MD

cc Dr. Souvion

Print Encounter

Blue Ridge Orthopaedic A
1011 Tiger Blvd.
Suite 200
Clemson, SC 29631
Phone: 864-654-4747
Fax: 1-864-653-6567

Archie Jones
1229 Salem Church Road
Anderson, SC 29625

Account Number: 58882
MRN:

Printed: 10/3/2002
Patient Name: Archie Jones
SSN: [REDACTED]
DOB: [REDACTED]
Age: 67
Provider: Douglas

September 19, 2002

Chart Note

Acct No.: 58882
Doctor.: Douglas A. Reeves, MD

Patient.: Archie Jones
Visit Date: 9/19/2002

HISTORY: Mr. Jones is here for a recheck. He still feels like his back is starting to calm down. Notes some problem with work compensation approving his therapy, so he has just been doing his exercises at home. He feels like he is continuing to improve. He is not having to take any pain medicine. He did have a question as to some exposed nerves on his foot from his bone and what will be best to do about that.

PHYSICAL EXAMINATION: Examination of his back shows improvement and tenderness in the lumbar area. Range of motion also improved. Negative straight leg raise bilaterally.

ASSESSMENT AND PLAN: Continue to slowly improve. Continue his home exercises and pain medicines as needed. He me that he has seen a foot and ankle specialist before who felt like the pain in the foot would best be treated by his plastic surgeon and I agree with this. He is going to looking to going back to Charleston and have a visit with his plastic surgeon. If not, we may refer him someone locally.

Douglas A. Reeves, MD

Not Signed Off

Dr Douglas A Reeves

Acct No.: 58882

Patient...: Archie Jones

Doctor...: Douglas A. Reeves, MD

Visit Date: 2/4/2003

-2/16

SUBJECTIVE: Mr. Jones comes in today with a new problem. He was doing some crawling under his home, which is something he is not used to yesterday morning and felt like he had a sharp pain in front of his knee. He did not notice anything wrong right at that time. About 4 to 5 minutes later, he had some swelling around his kneecap. He also noticed some erythema. This morning when he awoke, his swelling was worse. He had some erythema down on the anterior shin and reports that he feels like there is some weight in his leg. He has some chronic decreased sensation because of his prior burn injury. He has not had a fever. He does not feel ill otherwise. He is currently cycling through his Tequin antibiotic and he continues on his other chronic medications.

PHYSICAL EXAMINATION: Examination of the knee shows the chronic scarring and decreased hair that he has always had. There is mild erythema and moderate warmth to touch over the patella as well as over the anterior shin just distal to the patella. There is moderate soft-tissue swelling in the same area. No crepitus is noted. The knee joint itself does not appear to have an effusion and is fairly stable on examination. There is no streaking of erythema above the leg.

RADIOGRAPHS: X-rays of tib-fib showed some soft-tissue swelling but no subcutaneous air was noted.

ASSESSMENT AND PLAN: Cellulitis of the shin, likely related to small injury from crawling under the house. It does not appear he sustained a bite at this time. Dr. Hensarling also examined the patient today. The margins of erythema were marked with a Sharpie. We will have him stop Tequin and start Augmentin 875 mg b.i.d. for 12 days. He is going to follow up in two days with Dr. Hensarling. If he gets any worse, he is to notify us immediately as he may need some IV antibiotics at that point.

Douglas A. Reeves, MD _____
cc Dr. Souviron

Acct No.: 58882

Patient...: Archie Jones

Doctor...: Kirk Hensarling, M.D.

Visit Date: 2/6/2003

2/16/03

HISTORY OF PRESENT ILLNESS: Mr. Jones returns for followup of his right lower extremity cellulitis. He has been on Augmentin for the past several days and actually clindamycin was added recently as well.

PHYSICAL EXAMINATION: Examination demonstrates the erythema and warmth to be much improved. He does have some ecchymosis along the lateral aspect of his knee. There is no significant swelling or pain.

PLAN: It appears that the cellulitis is resolving, but I would like to see him back in a few days for recheck. He will continue his antibiotics.

Kirk Hensarling, M.D. _____

cc Dr. Souvion

350-300-5119
Acct No.: 58882

Patient... Archie Jones

Doctor.: Kirk Hensarling, M.D.

Visit Date: 2/11/2003
B. Flynn
SSS 248098

HISTORY OF PRESENT ILLNESS: Mr. Jones returns for followup of his right lower extremity cellulitis. He has been wearing his compressive stockings and taking his antibiotics.

PHYSICAL EXAMINATION: Examination demonstrates no significant swelling in his lower extremity other than some prepatellar bursitis with a palpable collection of fluid in that bursa. He has good knee range of motion. The erythema is diminished, but more diffuse.

PLAN: Overall, I believe his cellulitis is improving. I have explained that I would not drain fluid off of the prepatellar bursa in face of this cellulitis. I am going to see him back in a week for a recheck. He is to continue his antibiotics.

Kirk Hensarling, M.D. _____
cc Dr. Souviron

Acct No.: 58882

Patient...: Archie Jones

Doctor...: Kirk Hensarling, M.D.

Visit Date: 2/26/2003

3/10

HISTORY OF PRESENT ILLNESS: Mr. Jones returns for followup of his right lower extremity cellulitis and prepatellar bursitis. The fluid that was drawn out last week demonstrates no evidence of bacteria on Gram stain and a few white blood cells. He notes that he has been wearing his Ace wrap and the fluid in his prepatellar bursa will remain low. When he has stopped his Ace wrap, the fluid seems to reaccumulate. Unfortunately, he notes that when he wears his Ace wrap and his prepatellar bursa is less swollen, he has increased swelling in his ankle and foot and he is concerned about what the swelling could do to his many skin grafts.

PHYSICAL EXAMINATION: Examination demonstrates no erythema over his prepatellar bursas. He has no fluid in the bursa today. He has a good knee range of motion without pain. There is no erythema over the anterolateral aspect of his calf where he had cellulitis in the past. He does have some increased edema in his foot and ankle specifically over the medial aspect of his ankle and heel.

PLAN: I am going to have him discontinue his antibiotics in light of the fact that the fluid aspirated from his bursa demonstrated no evidence of infection and his cellulitis has resolved. I will see him back in a couple of weeks for a recheck.

Kirk Hensarling, M.D. _____

cc Dr. Souviron

Acct No.: 58882

Patient...: Archie Jones

Doctor...: Kirk Hensarling, M.D.

Visit Date: 3/11/2003



Hutchinson

248098

HISTORY OF PRESENT ILLNESS: Mr. Jones returns for followup of his right knee prepatellar bursitis. He has stopped his antibiotics and had no recurrence of the prepatellar bursitis. He actually used the kneepad and crawled on his knees yesterday without any subsequent problems.

PHYSICAL EXAMINATION: Examination demonstrates his knee to have no swelling. Good range of motion. There is no erythema and no palpable fluid in his prepatellar bursa.

PLAN: I am going to see him back on an as-needed basis.

Kirk Hensarling, M.D. _____

cc Dr. Souviron

ANMED HEALTH
Radiology Consult Report

REQUEST-DATE/TIME:
REQUESTING PHY: LOVETT, JAMES E.
REQ PHYS PH#: (864) 968-0168
ATTENDING PHY: LOVETT, JAMES E.
Sex: M Age: 59 Years DOB: 07-30-1943

JONES, ARCHIE EDWARD
MR# : 000066441
IDX Acc # : 1028662
Acct# : 4475354
Patient Loc: 04
Status: 0

Exam: (81)210515/RIGHT Completed: 04-23-2003 0945

Clinical History: S/P BURN W/ CHRONIC WOUND OVER MEDIAL ASPECT OF MPJ

JONES TWO VIEWS RIGHT FOOT 04/23/03

CLINICAL HISTORY: S/P burn with a chronic wound.

FINDINGS: Examination demonstrates osteopenia. There are degenerative changes seen about the first metatarsal phalangeal joint. The patient is S/P amputation of the distal 5th metatarsal and phalanges of the 5th digit. There is what appears to be callus formation overlying the base of the proximal phalanx of the 4th digit. There is ossific density measuring 3 x 1mm adjacent to the head of the 1st metatarsal. A spur projection on the posterior aspect of the calcaneus from the dorsal aspect of the talus. There is narrowing of the tibiotalar joint with an anterior osteophyte present. No definite acute periosteal reaction is identified. We do not have a prior plain film available for comparison to assess the chronicity of the findings of the proximal phalanx of the 4th digit. If these could be made available, these may be useful for further evaluation. Clinical correlation as to trauma of this area is also recommended.

Reading Physicians:
Monica H. Grier M.D.

Dictated on: 04-23-20030957
Transcribed on: 04-23-20031509
Finalized on: 04-23-20031524

by Fene Nixon
by Monica Hoies Grier M.D.

Page: 1

ARCHIE JONES

CHART #13635

Mr. Jones returns for interval evaluation of his right foot. The open wound along the medial aspect of the first metatarsal head has closed. On the lateral aspect, overlying the head of the fifth metatarsal, there is a small opening. I have recommended that he have his shoe reevaluated that he reinstitute use of Regranex in this area and continue the Denduaderm to cover the area. He has been given a prescription for new compression garments. I will see him back in a month.

JEL/kcf

1/10/03

NO CLW

wound all closed

Tissue Care reviewed

Pt is Cx skin GEL Study / Jobst

Activity Modification

Specialized shoe

surveys for

① Sk. Lubricant

② Jobst

③ Skin GEL

ARCHIE JONES

CHART #13635

4/16/04

Mr. Jones returns without complaints. He has had minor breakdown along the edge of the first metatarsal head. He was playing soccer with the children when this opened. He said it is healing nicely with the use of DuoDerm and moisturizer. Otherwise, he is doing well. We have given him a prescription for more AmLactin, DuoDerm and for a new set of Jobst garments. I will see him back in six months.

JEL/kcf

Update Plastic Surgery

Kevin M. Keller, M.D.
S.C. License #16137
DEA# BK 2787537

Stolica: St. Onofre, 1882

301 THE PARKWAY
GREEN, SC 29650
(864) 968-0168

James F. Lovell III M.D.
S.C. License # 72384
DEA# BL3680483

Elizabeth Dohman, M.D.
S.C. LICENSE # 23482
DEA# BR541064R

For JONES, Archie Age _____
Address _____ Date 8/11/03

R Compression GARMENT of
Lower Extremity
SIP Burns of Lower Ext.
M.D.

M.D.

M.D.

Dispense as Written **Substitution Permissible**
 This prescription will be filled generically, unless physician signs on the line listing "dispense as written".

7/25
**START EDN EDNOTE AAMC 4755972 1393 03/21/2004 22:52 1393 **
ANDERSON AREA MEDICAL CENTER JONES, ARCHIE E.
ANDERSON, S.C. JEANETTE KINSEY, M.D.
MEDICAL RECORD 4755972
066441 04/21/04
03/21/04

EMERGENCY DEPARTMENT -- PRIORITY --

DATE: 03/21/04

CHIEF COMPLAINT: Tinnitus, weakness with dysarthria and difficulty talking.

DATE OF BIRTH: 07/13/43

HISTORY OF PRESENT ILLNESS: This is a 60-year-old born July 13, 1943 who has come to the Emergency Department at 0155 hours on March 21, 2004 brought by his wife because of a transient episode of tinnitus and weakness with dysarthria and difficulty talking. Distribution a little unusual. He has, apparently, tinnitus in the right ear. His left ear, he said, developed tinnitus. The ringing was loud that he could hardly hear himself talking. He found his right arm, although it did work, he could not control it and his speech, he had difficulty enunciating. He immediately called his wife and she said the episode lasted about five minutes. She brought him an aspirin and he had taken the aspirin. She said he was profusely diaphoretic during this period. He had a very similar episode two years ago and was hospitalized for two nights. Extensive work-up revealed nothing. He said this episode is very similar, but not as severe as it was two years ago.

PAST MEDICAL HISTORY: He see a psychiatrist every month for post traumatic stress syndrome. He has anxiety disorder, a history of hypertension. He was very severe burned in 1997 with 45% burns over his body. He wears Ted hose midway up thigh on both legs because of it. At the same time that he was severe burned, he also suffered very severe inhalation injury and consequently has permanent lung damage.

SOCIAL HISTORY: He lives with his wife, does not smoke, does not drink alcohol, does not use drugs.

CURRENT MEDICATIONS: His medications include Singulair, Cartia-XT, Celebrex, theophylline. He also takes Zolof, Depakote, Risperdal and he takes Plavix 75 mg daily. In addition to that, he takes DepoCyt Sodium.

ALLERGIES: He has no known drug allergies.

REVIEW OF SYSTEMS: He denies a headache associated with this. He Continued

2004 7:47PM

2004 7:47PM

No 0454 P. 2

SSS 248058

Kevin M. Koller, M.D.
S.C. License #16137
DEAN BK 2787337

Upstate Plastic Surgery
Part of Decompressive Surgery
301 THE PARKWAY
GREEN, SC 29650
(864) 968-0168

James E. Lovell, III M.D.
S.C. License # 22384
DEAN BL3680483

Elizabeth Dolbow, M.D.
S.C. License # 23482
DEAN BR3410648

For Archie Jones Age 7-28-04
Address _____ Date _____

R CUSTOM BURN GARMENT
Thigh Length
RFX4

M.D. [Signature] M.D.

Dispense as Written Substitution Permissible
This prescription will be filled generically unless physician signs on the line stating "dispense as written".

Kevin M. Koller, M.D.
S.C. License #16137
DEAN BK 2787337

Upstate Plastic Surgery
Part of Decompressive Surgery
301 THE PARKWAY
GREEN, SC 29650
(864) 968-0168

James E. Lovell, III M.D.
S.C. License # 22384
DEAN BL3680483

Elizabeth Dolbow, M.D.
S.C. License # 23482
DEAN BR3410648

For Archie JONES Age 7-28-04
Address _____ Date _____

R Silicone GEL Sheeting
Use as directed
RFX4

M.D. [Signature] M.D.

Dispense as Written Substitution Permissible
This prescription will be filled generically unless physician signs on the line stating "dispense as written".

Page 2
EMERGENCY DEPARTMENT

JONES, ARCHIE E.
JEANETTE KINSEY, M.D.

denies any chest pain. There has been no feeling of irregularity. He has no history of irregular heart beat. He has had no fever. No neck pain. No chest pain, no shortness of breath. He denies exertional dyspnea. There is no nausea or vomiting. No diarrhea. He does have problems with constipation.

PHYSICAL EXAMINATION:

VITAL SIGNS: He is afebrile with a temperature of 97.4 degrees. He has a normal blood pressure of 130/80, a pulse is 80, good volume and synchronous pulses, respirations 18. He has been placed on a cardiac monitor when he arrived and was in normal sinus rhythm.

NEUROLOGICAL: His cranial nerves II through XII are intact.

GENERAL: He is bright, alert plus three, oriented to person, place and time, talks without any difficulty.

CHEST: Clear.

COR: S1, S2, no murmurs, no gallops.

ABDOMEN: His abdomen is soft and nontender with normal bowel sounds.

EXTREMITIES: Unremarkable. He does have the Ted hose on. No more swelling than usual.

IMPRESSION:

1. Possibly a transient ischemic attack, although the distribution with the left ear and right arm is a little unusual.

LABORATORY STUDIES: His comprehensive metabolic panel shows some slight increase of his glucose at 153. He has renal insufficiency with a BUN of 29 and creatinine of 1.6. His potassium is a little diminished and marginally down at 3.4 and his protein is slightly diminished at 6.2. Otherwise, it is normal. His albumin is 3.7, globulin 2.5. Sodium 137, chloride 102, CO2 of 27, anion gap of 8. Liver function is normal. Total bilirubin is 0.26, alkaline phosphatase 76, ALT or SGPT 48, AST or SGOT is 24. His calcium is 8.9. The PT and PTT is normal and his CBC is normal. His red blood cells is slightly diminished at 419 million. Absolute white count is 6100 which is normal a normal differential, neutrophils 44.9%, lymphocytes 36.4%, his monocytes slightly increased at 13%. Eosinophils are normal. His hemoglobin normal at 13.8 and platelet count normal at 202,000.

EKG INTERPRETATION: Normal.

DIAGNOSTIC STUDIES: A CT scan was done and read as normal.

EMERGENCY DEPARTMENT COURSE/DISPOSITION: I contacted his physician, Dr. Souviron. We discussed the patient. Since he has been evaluated in the last two years for the same problem and she feels it would be reasonable for him to go home tonight and she will continue the work-
Continued

Page 3
EMERGENCY DEPARTMENT

JONES, ARCHIE E.
JEANETTE KINSEY, M.D.

up as an outpatient on Monday, March 22, 2004. The patient and his wife are comfortable with this. He has remained asymptomatic in the Emergency Department. He has remained on the monitor without any evidence of ectopy and is released.

JK/991:508833

JEANETTE KINSEY, M.D.

Time Dictated: 10:48 pm
Time Transcribed: 11:15 pm
CC FAXED TO: Dr. June Souviron

[1m
[1m

ANMED HEALTH [0m
Radiology Consult Report[0m

REQUEST DATE/TIME: 03-21-2004 0303
REQUESTING PHY: KINSEY, JEANETTE C.
REQUESTING PHY: PH#: (864) 261-1333
ATTENDING PHY: KINSEY, JEANETTE C

JONES, ARCHIE EDWARD
MR# : 880006441
IDX Acc # : 128849
Acct# : 275572
Patient Loc: ED
Status: E

Sex: M Age: 60 Years DOB: 07-01-1943

Exam: (AH)260102 COMPLETED: 03-21-2004 0330
CT HEAD SCAN W/O CONTRAST ONLY

Clinical History: CALL REPORT NEURO TO READ CT1 GH POSS TIA, LEFT EAR RING
ARM WEAKNESS

JONES CT SCAN OF THE HEAD WITHOUT CONTRAST

REFERRED BY: Jeanette Kinsey, M.D.

PRIOR HISTORY: This is a 60 y/o male with possible stroke, TIA,
left ear ringing, right arm weakness.

TECHNIQUE: CT scan of the head without contrast was performed with
serial axial images of 5mm from the base of the skull to the
midbrain and 10mm from the midbrain to the vertex.

FINDINGS: No prior study for comparison. The bony structures,
soft tissue structures, retro-orbital spaces, paranasal sinuses are
unremarkable. The posterior fossa structures are normal with no
lesions identified. The fourth ventricle is normal size and
configuration. The supratentorial structures show no
extra-axial fluid collections and are normal. No lesions are
normal. The lateral ventricles, third ventricle, aqueduct of
Sylvius are of normal size and configuration with no hydrocephalus.
There is no shift of midline structures.

IMPRESSION:

NORMAL CT SCAN OF THE HEAD WITHOUT CONTRAST WITH NO LESIONS NOTED.

Reading Radiologists:

Jason Soriano M.D. /signed by/ HAROLD DEAN REEVES M.D.

Transcribed on: 03-22-20040840
Finalized on: 03-22-20041133

by Vickie Burden
by Harold Dean Reeves M.D.

ANMED HEALTH
Radiology Consult Report

REQUEST DATE/TIME: 03-29-2004 1236
REQUESTING PHY: SOUVIRON, JUNE PETRYSZN
REQ PHYS PH#: (864) 231-7003
ATTENDING PHY: SOUVIRON, JUNE PETRYSZN

JONES, ARCHIE EDWARD

MR# : 000000000000
IDX Acc # : 1212514
Acct# : 4766205
Patient Loc: 04
Status: Outpatient

Sex: M Age: 68 Marital: DOB: 10-1948

Exam: (81)280304 Completed: 04-01-2004 1000

Clinical History:

TECHNOLOGIST: ML

BP: RT 128/78 LT 128/78

BRUITS: RT - LT

PULSE: -

CAROTID		TEMPORAL		FACIAL	
RT	LT	RT	LT	RT	LT

PROCEDURE DATE: 4/1/04

CLINICAL ASSESSMENT: Hypertension; COPD; TIA

JONES TRANSCRANIAL DOPPLER

INDICATION: TIA.

FINDINGS: RIGHT ANTERIOR WINDOW: The distal, internal carotid, middle cerebral, anterior cerebral, and posterior cerebral arteries demonstrate antegrade flow with normal waveforms and normal mean velocities. There is no evidence of focal stenosis seen within any of these vessels.

LEFT ANTERIOR WINDOW: The distal, internal carotid, middle cerebral, anterior cerebral, and posterior cerebral arteries demonstrate antegrade flow with normal waveform and normal mean velocities. There is no evidence of focal stenosis seen within any of these vessels.

POSTERIOR WINDOW: Both vertebral arteries demonstrate antegrade flow with normal waveforms and normal mean velocities. There is no evidence of focal stenosis seen in any of these vessels.

IMPRESSION:

NORMAL TRANSCRANIAL DOPPLER STUDY.

Continued On Next Page]

Page: 1

Radiology Consult Report

REQUEST DATE/TIME: 03-29-2004 1236
REQUESTING PHY: SOUVIRON, JUNE PETRYSZN
REQ PHYS PH#: (864) 231-7003
ATTENDING PHY: SOUVIRON, JUNE PETRYSZN

JONES, ARCHIE EDWARD

MR# : 000065445
IDX Acc # : 1202614
Acct# : 1705205
Patient Loc: 04
Status: O

Sex: M Age: 60 YEARS DOB: 07-30-1943

Exam: (81)280304 Completed: 04-01-2004 1000

Reading Physicians:
Harold Dean Reeves M.D.

Transcribed on: 04-04-20040822
Finalized on: 04-05-20041021

by Jane Jordan
by Harold Dean Reeves M.D.

Page: 2

Radiology Consult Report

REQUEST DATE/TIME: 03-29-2004 1236
 REQUESTING PHY: SOUVIRON, JUNE PETRYSZN
 IO PHYS PH#: (864) 231-7003
 ATTENDING PHY: SOUVIRON, JUNE PETRYSZN

JONES, ARCHIE EDWARD

MR# : 000066443
 IDX Acc # : 1212613
 Acct# : 4765205
 Patient Loc: 04
 Status: O

Sex: M Age: 69 Years DOB: 07-20-1943

cam: (81)280300 Completed: 04-01-2004 0930

Clinical History:

TECHNOLOGIST: ML

BP: RT 128/78 LT 128/78

	RIGHT	LEFT
CCA psv (m/s)	0.850	0.780
CCA edv (m/s)	0.200	0.230
ICA Prox psv (m/s)	0.590	0.630
ICA Prox edv (m/s)	0.160	0.230
ICA Mid psv (m/s)	0.740	0.580
ICA Mid edv (m/s)	0.350	0.250
ICA Dist psv (m/s)	0.690	0.530
ICA Dist edv (m/s)	0.270	0.210
ECA (m/s)	0.886	1.230
Vert (m/s)	0.460	0.490

INTERNAL/Common CAROTID RATIO

	RIGHT	LEFT
IC/CC	0.871	0.808

PROCEDURE DATE: 4-1-04

CLINICAL ASSESSMENT: HYPERTENSION; COPD; TIA

JONES BILATERAL CAROTID ULTRASOUND

FINDINGS: The right carotid system demonstrates antegrade flow with normal waveforms and normal velocities. There is no significant plaque formation. There is no significant stenosis. The right vertebral artery is insonated in the cervical course demonstrating antegrade flow.

The left carotid system demonstrates antegrade flow with normal waveforms and normal velocities. There is no significant plaque formation. There is no significant stenosis.

[Continued On Next Page]

Page: 1

ARMED HEALTH
Radiology Consult Report

REQUEST DATE/TIME: 03-29-2004 1236
REQUESTING PHYS: SOUVIRON, JUNE PETRYSZN
REQ PHYS PH# (854) 231-7003
ATTENDING PHY: SOUVIRON, JUNE PETRYSZN

JONES, ARCHIE EDWARD
MR# : 00000004
IDX Acc # : 1212613
Acct# : 4765205
Patient Loc: 04
Status: O

Sex: M Age: 60 Years DOB: 07-30-1943

Exam: (81)280300 Completed: 04-01-2004 0930

.....
IMPRESSION:

NORMAL BILATERAL CAROTID ULTRASOUND.

Reading Physicians:
Harold Dean Reeves M.D.

Transcribed on: 04-04-20041607
Finalized on: 04-05-20041021

by Betsy Phillips
by Harold Dean Reeves M.D.

Page: 2

ANMED HEALTH
Radiology Consult Report

REQUEST DATE/TIME:
REQUESTING PHYS: SOUVIRON, JUNE PETRYSZN
REQ PHYS (864) 231-7003
ATTENDING PHYS: SOUVIRON, JUNE PETRYSZN

JONES, ARCHIE EDWARD
MR# 1000066441
IDX Acc # 812147101
Acct# 442552105
Patient Loc: 04
Status: 0

Sex: M Age: 60 Years DOB: 07-16-1943

Exam: (81)290101 Completed: 04-01-2004 1302

Clinical History: SMALL HYPERDENSITY DEEP WHITE MATTER OF RT PARIETAL LOBE BY MR
RECURRENT TIAMRI BRAIN W/NO NEURO TO READ- 20CC MAG

JONES MRI OF THE BRAIN W/NO CONTRAST

HISTORY: This is a 60 y/o described as having a small hyperintensity in the white matter of the right parietal on previous scans. The patient has had a recent TIA.

TECHNIQUE: This MRI scan of the brain was accomplished with the head coil. Sagittal and axial coronal acquisitions were obtained using T1 proton density T2 weighted formats and the FLAIR technique. Axial acquisitions and diffusion weighted imaging were accomplished. Sagittal, axial, and coronal T1 weighted images were repeated postcontrast enhancement.

FINDINGS: The ventricular system is normally configured and midline. The third and fourth ventricles are visualized. The pineal recess is midline. The basilar cisterns appear normal. Normal cortical sulci markings for age. There is a solitary small T2-FLAIR hyperintensity in the right parietal region. No old films for comparative purposes. Diffusion weighted imaging is negative. Contrast enhancement is negative.

The sella/parasellar region is normal. The cervicomedullary junction level is normal. The upper cervical cord is normal. The VIII nerve complexes are normal. The vascular structures present shows a normal echovoid. Orbital structures are normal. The paranasal sinuses are normal.

IMPRESSION:

MRI SCAN OF THE BRAIN WITH AND WITHOUT CONTRAST DEMONSTRATING A SOLITARY RIGHT PARIETAL T2-FLAIR HYPERINTENSITY. IN THIS AGE GROUP, MOST LIKELY A SMALL VESSEL ISCHEMIC AREA. IT IS NOT ACUTE.

[Continued On Next Page]

Page: 1

ARMED HEALTH
Radiology Consult Report

REQUEST DATE/TIME:
REQUESTING PHY: SOUVIRON, JUNE PETRYSZN
REQ PHYS PH#: (864) 231-7003
ATTENDING PHY: SOUVIRON, JUNE PETRYSZN

JONES, ARCHIE EDWARD

MR# 366441
IDX Acc # 24704
Acct# 475205
Patient Loc: 04
Status: 0

Sex: M Age: 60 DOB: 07-30-1943

Exam: (81)290101 Completed: 04-01-2004 1302

Reading Physicians:
Frank Oliver M.D.

Dictated on: 04-01-20041536
Transcribed on: 04-02-20040956
Finalized on: 04-02-20041149

by Vickie Burden
by Frank Oliver M.D.

Page: 2

2000 EAST GREENVILLE STREET
ANDERSON, SC 29621

JONES, ARCHIE E.

RIGHT FOREARM BONE DENSITY

Attendant: [REDACTED]

Measured: 04/01/2004 9:42:31 AM (2.15)

Birth Date: 07/07/1940 60.7 years

Analyzed: 04/01/2004 9:42:55 AM (2.15)

70.0 in. 231.0 lbs. White Male

Printed: 04/01/2004 9:43:08 AM (2.15)

Physician: SOUVIRON, JUNE

JONESA_HW_527s5.dfa

ANCILLARY RESULTS

Region	^{1,9} BMD (g/cm ³)	² Young-Adult (%) T-Score	³ Age-Matched (%) Z-Score	^{4,9} Est. BMC (g)	⁴ Est. Area (cm ²)
Radius UD	0.405	96 -0.5	99 -0.1	2.0	4.8
Ulna UD	0.309	- -	- -	1.0	3.1
Radius 33%	0.812	101 0.1	105 0.5	3.0	3.7
Ulna 33%	0.872	- -	- -	2.5	2.8
Both UD	0.367	- -	- -	2.9	7.9
Both 33%	0.838	- -	- -	5.5	6.6
Radius Total	0.642	105 0.5	109 0.9	14.1	22.0
Ulna Total	0.602	- -	- -	8.9	14.8
Both Total	0.626	- -	- -	23.0	36.7

1 - Statistically 98% of repeat scans fall within 1SD (± 0.016 g/cm³ for Radius Total)

2 - USA, Forearm Reference Population, Ages 20-40

3 - Matched for Age, Ethnic

4 - Results for investigational use only.

9 - SPA calibration in use: (SPA values are 10% lower than Comac values.)

LUNAR Prodigy
10085

2000 EAST GREENVILLE STREET
ANDERSON, SC 29621

JONES, ARCHIE E

Attendant:

Birth Date: 07/30/1949 60.7 (years)

70.0 in. 231.0 lbs. White Male

Physician: SOUVIRON, JUNE

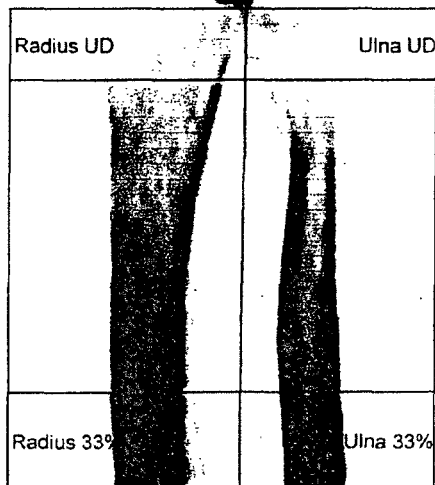
RIGHT FOREARM BONE DENSITY

Measured: 04/01/2004 9:42:31 AM (2.15)

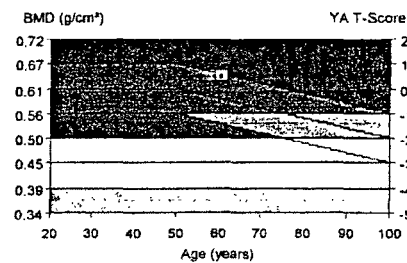
Analyzed: 04/01/2004 9:42:55 AM (2.15)

Printed: 04/01/2004 9:43:08 AM (2.15)

JONESA_hvhy527s5.dfa



Reference: Radius Total



Region	^{1,9} BMD (g/cm ³)	² Young-Adult T-Score	³ Age-Matched Z-Score
Radius Total	0.642	0.5	0.9

COMMENTS:

Image not for diagnosis

78.0.15.50.00.12.0.0.00:6.20.0.60x1.05.6.1.%Fat=28.2%
0.00.0.00.0.00.0.00
Forearm Length: 28.6 cm

- 1 - Statistically 68% of repeat scans fall within 1SD (± 0.016 g/cm³ for Radius Total)
- 2 - USA, Forearm Reference Population, Ages 20-40
- 3 - Matched for Age, Ethnic
- 9 - SPA calibration in use: (SPA values are 10% lower than Comac values.)
- 11 - WHO has defined for white women that: > -1.0 SD = normal; -1.0 to -2.5 SD = osteopenia; < -2.5 SD = osteoporosis

LUNAR Prodigy
10085

2000 EAST GREENVILLE STREET
ANDERSON, SC 29621

JONES, ARCHIE E

Attendant:

Birth Date: 09/09/24 87 (years)

70.0 in. 231.0 lbs. White Male

Physician: SOUVIRON, JUNE

DUALFEMUR BONE DENSITY

Measured: 04/01/2004 9:37:44 AM (2.15)

Analyzed: 04/01/2004 9:39:36 AM (2.15)

Printed: 04/01/2004 9:39:55 AM (2.15)

JONESA_hvhxvt7s5.dfe

ANCILLARY RESULTS

Region	BMD ¹ (g/cm ³)	Young-Adult ^{2,7} (%) T-Score	Age-Matched ³ (%) Z-Score	Est. BMC ⁴ (g)	Est. Area ⁴ (cm ²)
Neck Left	0.908	85 -1.2	89 -0.8	5.2	5.7
Neck Right	0.836	78 -1.8	82 -1.4	4.7	5.6
Neck Mean	0.872	81 -1.5	86 -1.1	5.0	5.7
Neck Diff.	0.072	7 0.6	7 0.6	0.5	0.1
Wards Left	0.605	63 -2.7	72 -1.9	2.2	3.6
Wards Right	0.571	60 -3.0	68 -2.1	2.0	3.5
Wards Mean	0.588	61 -2.9	70 -2.0	2.1	3.6
Wards Diff.	0.034	4 0.3	4 0.3	0.2	0.1
Troch Left	0.908	98 -0.2	95 -0.4	18.1	20.0
Troch Right	0.872	94 -0.5	92 -0.7	16.6	19.1
Troch Mean	0.890	96 -0.4	94 -0.6	17.4	19.5
Troch Diff.	0.036	4 0.3	4 0.3	1.5	0.9
Shaft Left	1.296	- -	- -	19.3	14.9
Shaft Right	1.238	- -	- -	18.9	15.3
Shaft Mean	1.267	- -	- -	19.1	15.1
Shaft Diff.	0.058	- -	- -	0.4	0.4
Total Left	1.050	96 -0.3	98 -0.2	42.6	40.5
Total Right	1.007	92 -0.6	94 -0.5	40.3	40.0
Total Mean	1.029	94 -0.5	96 -0.3	41.4	40.3
Total Diff.	0.044	4 0.3	4 0.3	2.3	0.5

1 - Statistically 68% of repeat scans fall within 1SD (± 0.020 g/cm³ for Total)

2 - USA, Femur Reference Population, Ages 20-40

3 - Matched for Age, Weight (males 25-100 Kg), Ethnic

4 - Results for investigational use only.

7 - Total T-Score difference is 0.3. Asymmetry is None.

LUNAR Prodigy
10085

2000 EAST GREENVILLE STREET
ANDERSON, SC 29621

JONES, ARCHIE E

Attendant:

Birth Date: 07/30/1943 (60.7 years)

70.0 in. 231.0 lbs. White Male

Physician: SOUVIRON, JUNE

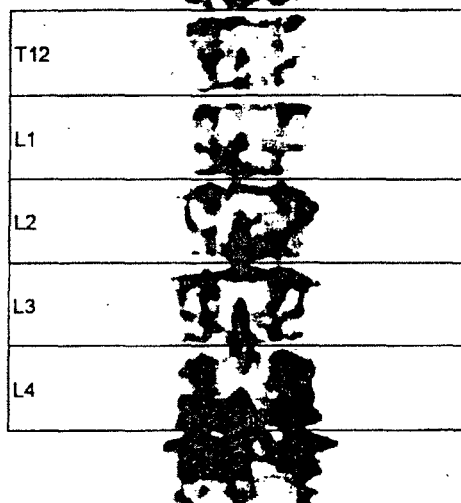
AP SPINE BONE DENSITY

Measured: 04/01/2004 9:34:26 AM (2.15)

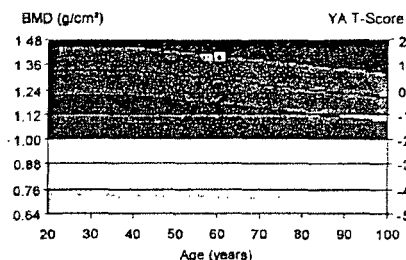
Analyzed: 04/01/2004 9:34:42 AM (2.15)

Printed: 04/01/2004 9:35:35 AM (2.15)

JONESA_hvhxom7s5.dfs



Reference: L2-L4



Region	BMD ¹ (g/cm ³)	Young-Adult ² T-Score	Age-Matched ³ Z-Score
L2-L4	1.394	1.3	0.9

COMMENTS:

Image not for diagnosis

76.3.00:22.20:27.0 0.00:10.44 0.60x1.05 23.3.%Fat=30.8%
0.00:0.00 0.00:0.00

1 - Statistically 68% of repeat scans fell within 1SD (± 0.010 g/cm³ for L2-L4)

2 - USA, AP Spine Reference Population, Ages 20-40

3 - Matched for Age, Weight (males 25-100 Kg), Ethnic

11 - WHO has defined for white women that ≥ -1.0 SD = normal; -1.0 to -2.5 SD = osteopenia, < -2.5 SD = osteoporosis

LUNAR Prodigy
10085

**2000 EAST GREENVILLE STREET
ANDERSON, SC 29621**

JONES, ARCHIE E

AP SPINE BONE DENSITY

Attendant:

Measured: 04/01/2004 9:34:26 AM (2.15)

Birth Date: 01/01/1933 (62.7 years)

Analyzed: 04/01/2004 9:34:42 AM (2.15)

70.0 in. 231.0 lbs. White Male

Printed: 04/01/2004 9:35:35 AM (2.15)

Physician: SOUVIRON, JUNE

JONESA_hvhxom7s5.dfs

ANCILLARY RESULTS

Region	¹ BMD (g/cm ³)	² Young-Adult (%) T-Score	³ Age-Matched (%) Z-Score	⁴ Est. BMC (g)	⁴ Est. Area (cm ²)	⁴ Est. Width (cm)	⁴ Est. Height (cm)
T12	0.924	-	-	14.7	15.9	5.0	3.1
L1	0.973	84 -1.6	81 -1.9	15.0	15.4	4.9	3.1
L2	1.221	98 -0.2	95 -0.5	19.4	15.9	5.0	3.2
L3	1.290	104 0.4	100 0.0	21.2	16.4	5.2	3.1
L4	1.653	133 3.4	129 3.1	28.6	17.3	5.5	3.1
L1-L2	1.099	92 -0.8	88 -1.2	34.4	31.3	5.0	6.3
L1-L3	1.165	96 -0.4	93 -0.8	55.6	47.7	5.1	9.4
L1-L4	1.295	106 0.6	102 0.2	84.2	65.0	5.2	12.6
L2-L3	1.256	101 0.1	98 -0.3	40.6	32.3	5.1	6.3
L2-L4	1.394	112 1.3	108 0.9	69.2	49.6	5.3	9.4
L3-L4	1.476	119 2.0	115 1.6	49.8	33.8	5.4	6.3

Z-Score for Vertebral Height (L2-L4)

Compared to young adult (Z-Score): -3.3
Adjusted for stature (Z-Score): -3.4

1 - Statistically 68% of repeat scans fall within 1SD (± 0.010 g/cm³ for L2-L4)

2 - USA, AP Spine Reference Population, Ages 20-40

3 - Matched for Age, Weight (males 25-100 Kg), Ethnic

4 - Results for investigational use only.

ALMED HEALTH SYSTEM

2000 EAST GREENVILLE STREET
ANDERSON, SC 29621

JONES, ARCHIE E

Attendant: [REDACTED]

Birth Date: 07/30/1943 60.7 (years)

70.0 in. 231.0 lbs. White Male

Physician: SOUVIRON, JUNE

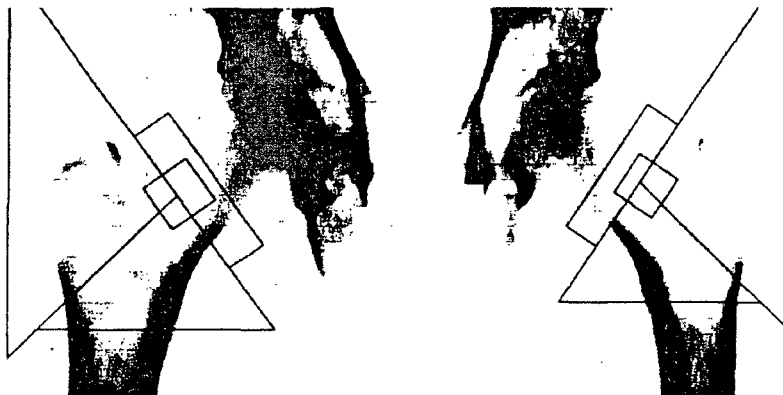
DUAL FEMUR BONE DENSITY

Measured: 04/01/2004 9:37:44 AM (2.15)

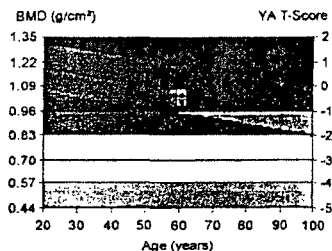
Analyzed: 04/01/2004 9:39:36 AM (2.15)

Printed: 04/01/2004 9:39:55 AM (2.15)

[REDACTED] JONESARCHIE@xvt7s5.dfe



Reference: Total



Region	BMD ¹ (g/cm ³)	Young-Adult ^{2,7} T-Score	Age-Matched ³ Z-Score
Total			
Left	1.050	-0.3	-0.2
Right	1.007	-0.6	-0.5
Mean	1.029	-0.5	-0.3
Difference	0.044	0.3	0.3

COMMENTS:

Image not for diagnosis

76.3.00.50 00:12.0 0.00:11.22 0.60x1.05 16.5.%Fat=24.9%

0 00:0.00 0.00:0.00

Neck Angle (deg) = Right:54 Left:56

1 - Statistically 68% of repeat scans fall within 1SD (± 0.020 g/cm³ for Total)

2 - USA, Femur Reference Population, Ages 20-40

3 - Matched for Age, Weight (males 25-100 Kg), Ethnic

7 - Total T-Score difference is 0.3. Asymmetry is None.

11 - WHO has defined for white women that: >-1.0 SD = normal; -1.0 to -2.5 SD = osteopenia; <-2.5 SD = osteoporosis

LUNAR Prodigy
10065

ARMED HEALTH
Radiology Consult Report

REQUEST DATE/TIME: 03-29-2004 1302
REQUESTING PHY: SOUVIRON, JUNE PETRYSZN
REQ PHYS PH#: (864) 231-7003
ATTENDING PHY: SOUVIRON, JUNE PETRYSZN

JONES, ARCHIE EDWARD
MR# [REDACTED]
IDX Acc # [REDACTED]
Acct# [REDACTED]
Patient [REDACTED]
Status: O

Sex: M Age: 60 Years DOB: 07-30-1943

Exam: (81)212000 Completed: 04-01-2004 0930

Clinical History:

JONES BONE DENSITY/WHOLE BODY

HISTORY: Long term steroid use. 733.90

FINDINGS: Imaging of the skeletal structure is accomplished with DEXA scanning with results as follows:

	BMD gm/cm2	T-SCORE
Lumbar Spine:	1.394	1.3
Left Proximal Neck:	1.050	-0.3
Right Proximal Neck:	1.007	-0.6
Right Radius:	0.642	0.5

The T-Score is the industry standard to interpret DEXA results. The World Health Organization has classified patients with a T-Score above -1 as normal; those with a T-Score of -1 to -2.5 as osteopenic. Subjects with T-Score below -2.5 are considered osteoporotic.

IMPRESSION:

THE PATIENT'S BONE MINERAL DENSITY IS WITHIN THE NORMAL RANGE.

Reading Physicians:
Joseph W. Yon Jr M.D.

Dictated on: 04-01-20041058
Transcribed on: 04-01-20041925
Finalized on: 04-02-20040845

by Rene Nixon
by Joseph W. Yon Jr M.D.

Page: 1

**ANMED HEALTH
Radiology Consult Report**

REQUEST DATE/TIME: 03-29-2004 1236
REQUESTING PHYS: SOUVIRON, JUNE PETRYSZN
REQ PHYS PH#: (864) 231-7003
ATTENDING PHY: SOUVIRON, JUNE PETRYSZN

JONES, ARCHIE EDWARD
MR# [REDACTED]
IDX Acc # [REDACTED]
Acct# [REDACTED]
Patient Loc: 04
Status: 0

Sex: M Age: 60 YEARS DOB: 07-10-1943

Exam: (81)280400 Completed: 04-01-2004 0844

Clinical History:

*Call Eddie
we have
to keep
his BP
controlled
on heart
ESS
OK
Verbal*

**ECHOCARDIOGRAM REPORT
B.S.A.**

Patient Values	Dimensions	Adult Normal Values
38	Aortic Root	< 2.2 cm/M2
47	LV Dias Dimen Dd	< 3.2 cm/m2 (3.5-5.6)
35	LV Sys Dimen Ds	cm/m2
50-55%	Ejection Fraction	55 - 70%

JONES ECHOCARDIOGRAM

CLINICAL HISTORY: TIA, diabetes, hypertension.

RESULTS: The aortic, mitral, tricuspid and pulmonic valves appear anatomically unremarkable on 2D echo.

Color flow Doppler shows no significant hemodynamic abnormality involving the valves.

Cardiac chamber size evaluation shows no significant enlargement of the chambers.

LV wall thickness measurements indicate moderate hypertrophy of the left ventricle.

LV wall motion is normal. EF is 55%. No segmental wall motion deficit seen. There is LV diastolic dysfunction.

IMPRESSION:

1. MODERATE CONCENTRIC HYPERTROPHY WITH LV DIASTOLIC DYSFUNCTION.
2. NORMAL LV SYSTOLIC FUNCTION, WALL MOTION AND EF.
3. NO CHAMBER ENLARGEMENT.
4. NO SIGNIFICANT VALVE DISEASE OR DYSFUNCTION.

[Continued On Next Page]

Page: 1

Radiology Consult Report

REQUEST DATE/TIME: 03-29-2004 1236
REQUESTING PHY: SOUVIRON, JUNE PETRYSZN
REQ PHYS PH# (862) 231-7003
ATTENDING PHY: SOUVIRON, JUNE PETRYSZN

JONES, ARCHIE EDWARD

MR# : 000000000
IDX Acc # : 000000000
Acct# : 000000000
Patient Loc: 04
Status: 0

Sex: M Age: 50 Years DOB: 07-30-1954

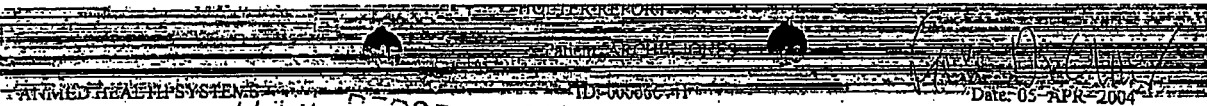
Exam: (81)280400 Completed: 04-01-2004 0844

Reading Physicians:
John Ware M.D.

Dictated on: 04-02-20041847
Transcribed on: 04-05-20041344
Finalized on: 04-06-20041502

by Vickie Burden
by John D Ware M.D.

Page: 2



REPORT

DoB/Age: 30-JUL-1943 (60 yr)
Sex: Male

Date: 05-APR-2004
Hook-up Date: 01-APR-2004
Time: 13:35:00
Duration: 24:00:00

Indications: TIA
Medications: LISTED
Referred by: JUNE P. SOUVIRON, M.D.

*Call Holter ok
C/S
Verbal*

SUMMARY

138356 QRS complexes
5 Ventricular ectopics which represent <1 % of total QRS complexes
21 Supraventricular ectopics which represent <1 % of total QRS complexes
0 Paced QRS complexes which represent <1 % of total QRS complexes

VENTRICULAR ECTOPY

5 Isolated
0 Bigeminal Cycles
0 Couplets
0 Runs
0 Beats in Runs
Beats LONGEST at BPM at
Beats FASTEST at BPM at

SUPRAVENTRICULAR ECTOPY

17 Isolated
2 Couplets
0 Runs
0 Beats in Runs
Beats LONGEST at BPM at
Beats FASTEST at BPM at

HEART RATES

60 MIN at 02:20:55 02-APR-2004
97 AVG
153 MAX at 08:46:07 02-APR-2004

LONGEST RR 1.080 sec at 02:20:50 02-APR-2004

INTERPRETATION

*PATIENT NAME: JONES, ARCHIE

ACCT#4763816

BASELINE ECG: SINUS RHYTHM, RATE IS 75 BPM.

AMBULATORY ECG RECORDED FOR 24 HOURS. DURING THIS TIME THE AVERAGE HEART WAS 97 BPM, MINIMUM OF 60 BPM, AND MAXIMUM OF 153 BPM. THE LONGEST RR INTERVAL WAS 1.1 SECOND.

VENTRICULAR ECTOPY NOTED BY THE COMPUTER AS 5 ISOLATED PREMATURE VENTRICULAR CONTRACTIONS AND 17 SUPRAVENTRICULAR CONTRACTIONS.

THE DIARY INDICATES NO CARDIAC TYPE SYMPTOMS.

REVIEW OF THE RHYTHM STRIPS SHOWS NO SIGNIFICANT ARRHYTHMIAS SEEN.

Read: JOHN D. WARE, M.D.

Date: 05-APR-2004

Jones, Archie (Eddie)

7-26-05 This 61 year old man presents on referral from Dr. Souviron with a possible abdominal wall hernia. This man had a burn some years ago and has been through a lot of rehab and skin grafts and had Pfannensteil type incision in the past for excision some keloids. He has now developed what appears to be a possible hernia in the upper abdomen. He did demonstrate this for us and it is clear that this just represents a diathesis recti. This is a condition that normally does not require surgery and results from the gradual weakening of the rectus fascia. He has also discussed some of his other problems including problems with his feet. At this point, however, I think we can be pretty reassuring about the upper abdominal situation that this does not need any surgical intervention at this point. We will be glad to see him further on a prn basis.

John R. Hunt, M. D./ss

CC:Dr. Souviron

JRHunt

WOUND ASSESSMENT FORM

Anderson Area Medical Center

Annie
Eddie Jones

TREATMENT:

9/11/05 - Cleanse area at (1) lateral foot. have upper and lower open areas surrounded by erythema. Cleanse with NS applied Acticoat for fowens in area / covered with Allevyn - cut to size than spandex and cohen to hold in place - Applied - Skin prep around area before applying dressing. This area not open on medial aspect of (2) big toe. Erythema with erythema - consulted pt. to be seen by MD for ABX Therapy - Also pt. was consulted in probability of needing X-ray at (2) foot. Patient and wife stated will call themselves to get order from MD. - Plans to see MD in one week

9/21/05 - Called Workmen's Compensation and National Rehab to coordinate dressing for patient. Order was put in - National Rehab will call back for any problems

9-28-05 Pt. states he is taking oral antibiotics - Old dressing removed - wound cleaned & sterile K.O. Acticoat 7 cut to fit inside wound - Mepilex - sat for 40 cover. Pt. to change dressing every 2 days and return to clinic in one week.

Pt. states did not receive dressing from National Rehab. will follow up and determine status of order - Barbara Weaver

9/29/05 - Spoke with Dr. Souvion in concerns for pt. - explained was not able to get wound supplies through National Rehab due to litigation with the Workmen's Compensation - Liberty Mutual. Also recommended that pt. needs X-ray to his elbow/shoulder. - states pt. is taking oral ABX at present. Explained to MD that family had found nurse practitioner to call clinic in reference to pt's records - Explained was given that information could not be given. Also if medical records are needed the family needs to speak with medical records of Andler. - MD states for us to continue to follow up pt. in the clinic.

2042 (8/01)

Page 2 of 2

Archie,
Eddie Jones

WOUND ASSESSMENT FORM

Anderson Area Medical Center

TREATMENT:

called company for wound care supplies - that wife had requested to -
Dover, OH, CUBEN. - Penicillin - spoke with Tina Garcia - information
given to her in reference to what pt needs. Called Dr. James
Sommer's office in reference to ordering - needing prescription
sent to company - Scott took message to have MD call and fax in
orders. XLP drugs made pt's wife aware that company had
Dr. Sommer has been called.

10-5-05 To see Dr. Toller (Sister Dr.) in Greenville soon. Had x-ray yesterday
no fracture of foot. Shows clear signs of wound debridement to remove
callus to some Escharosis noted - thick underlying tissue. Wounds cleaned
& Sterile H₂O - Silver dressing impregnated in Sterile H₂O -
applied to wounds & covered in Allergan. - To return in
2 weeks

10/15/05 - Cleanse areas bilaterally with NS - conservatively debrided
both areas gently - had to use O. silver nitrate to small areas of
skin to debride. Healing - pt. is on ASA and Plavix - cut
to 825 mg to both areas - covered with 2x2 then
paper tape. Areas were both skin prepped before application
of dressing - pt. to follow up in one week

10/24/05 - Removed old dressings - Cleanse areas with NS - conservatively
debrided lateral/medial of (R) foot. Cleanse areas - applied skin
prep, 825 mg to open areas cover with 2x2 square - then
paper tape - pt. to follow up in 2 weeks in reference to pt's return
November 9, 2005



Anderson Area Medical Center

WOUND ASSESSMENT FORM

Archie Jones
Eddie

PATIENT NAME

Archie Jones

PHYSICIAN

Dr. Gene Saviron

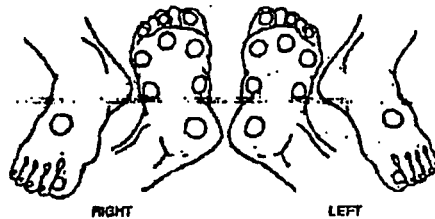
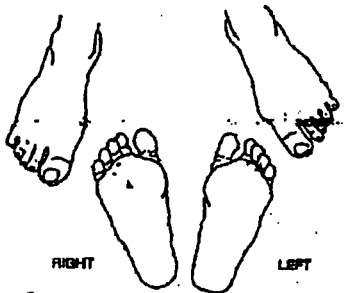
DATE 1st EVALUATED

9-21-05

DATE 1st NOTIFIED BY PT/CAREGIVER

LOCATION OF WOUND

Protective Sensation: #5.07 Monofilament
(+) PRESENT (-) ABSENT



DATE/TIME	9/21/05	9/21/05	9/28/05	9/28/05		
Initials*	SWH	SWH	SWH	SWH		
Type of Wound	Scrub	Scrub	Scrub	Scrub		
Location	Right foot	Right foot	Right foot	Right foot		
Width/Length (cm)	0.5 x 0.7	1.0 x 1.0	1 x 1	0.2 x 0.1		
Depth (cm)						
Appearance:						
Pink Yellow Black Red Gray	Pink	Pink	Pink	Pink		
Drainage Amount:						
None Scant Moderate Copious	Scant	Scant	Scant	Scant		
Type of Drainage:						
None Serous sanguinous Serous	Serous	Serous	Serous	Serous		
Purulent						
Odor: None Mild Foul	N	N	N	N		
Necrotic Tissue: Yes or No	N	N	N	N		
Tunnelling: Yes or No	N	N	N	N		
Undermining: Yes or No	N	N	N	N		
Pain: (J-O-10 T)	0	0	0	0		
Periwound Skin Condition:						
WNL Erythema Macerated Indurated	Erythema	Erythema	mild erythema	mild erythema		

DOCUMENT TREATMENT AND COMMENTS ON REVERSE SIDE

SIGNATURE

Gene Saviron

INITIALS

SWH



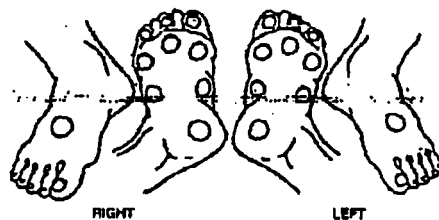
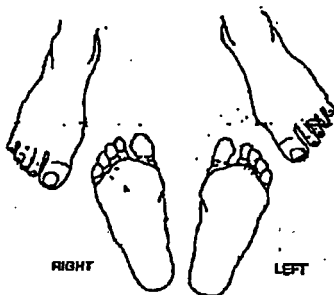
Anderson Area Medical Center
WOUND ASSESSMENT FORM

#2
Archie Jones
Eddie Jones

PATIENT NAME Archie Jones PHYSICIAN Dr. June Sorenson
DATE 1st EVALUATED 9/24/05 DATE 1st NOTIFIED BY PT/CAREGIVER _____

LOCATION OF WOUND

Protective Sensation: #5.07 Monofilament
(+) PRESENT (-) ABSENT



DATE/TIME	2/20/05	10/15/05	10/15/05	10/19/05	10/19/05	10/26/05	10/26/05
Initials	AK	AK	AK	AK	AK	AK	AK
Type of Wound	Lat	Lat	Lat	Lat	Lat	Lat	Lat
Location	Lat	Lat	Lat	Lat	Lat	Lat	Lat
Width/Length (cm)	0.6 x 0.8	0.5 x 0.5	0.5 x 0.5	0.4 x 0.5	0.3 x 0.4	0.1 x 0.1	0.1 x 0.1
Depth (cm)	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Appearance:							
Pink	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yellow	No	No	No	No	No	No	No
Black	No	No	No	No	No	No	No
Red	No	No	No	No	No	No	No
Gray	No	No	No	No	No	No	No
Drainage Amount:							
None	Scant	Moderate	Copious	Scant	Moderate	Copious	Scant
Type of Drainage:							
None	Serosanguinous	Serous	Purulent	Serosanguinous	Serous	Purulent	Serosanguinous
Odor:	None	Mild	Foul	None	Mild	Foul	None
Necrotic Tissue:	Yes	No	No	Yes	No	No	Yes
Tunneling:	Yes	No	No	Yes	No	No	Yes
Undermining:	Yes	No	No	Yes	No	No	Yes
Peri: (1-10)	1	2	3	1	2	3	1
Periwound Skin Condition:							
WNL	Erythema	Macerated	Indurated	Callus	Callus	Callus	Callus

DOCUMENT TREATMENT AND COMMENTS ON REVERSE SIDE

SIGNATURE June Sorenson
June Sorenson RN

INITIALS AK
AK

ANMED HEALTH

Radiology Consult Report

PT NAME: ARCHIE EDWARD JONES
DOB: 07/30/1943
SEX: M LOCATION: X-RAY / 0000 /
ORDERING: JUNE PETRYSZN SOUVIRON
DOS: 09/28/2005 10:50 AM
EXAM ID#: 3128718

MRN: 000066441
STATUS: OP
Acct #: 5212502
PHONE: (864)231-7003
EXAM CODE: AH - 4210414

9/30/05
change
in elbow
just
sug
of otc
No fat
Lack of
soft
Swelling
consist
with
his
injury
injury

JONES RIGHT ELBOW SERIES

INDICATIONS: Hematoma right elbow laterally. Patient was hit by a coil spring.

Three views of the right elbow were performed. There is severe soft tissue swelling involving the lateral aspect of the right elbow. All aspects of the radial head appear intact. Within the shaft of the proximal radius is periosteal reaction and subchondral lucencies. There is a spur seen off of the posterior olecranon and also at the level of the lateral malleolus are multiple corticated bony densities, the largest one measures .8 x .6 cm. No fat pad sign is identified.

IMPRESSION:

1. NO ACUTE FRACTURE NOTED.
2. SEVERE SOFT TISSUE SWELLING ALONG THE LATERAL ASPECT OF THE RIGHT ELBOW. CORTICATED BONY DENSITIES AND PERIOSTEAL REACTION ALONG THE RADIAL HEAD ALL SUGGESTIVE OF POSSIBLE OLD INJURY.

DICTATED: VEENA M. CHANDLER, M.D. Sep 28, 2005 10:50
ELECTRONICALLY VERIFIED: VEENA M. CHANDLER, M.D. Sep 29, 2005 10:09

TRANSCRIBED BY: PAULINE WALTERS Sep 28, 2005 12:07

*****END OF REPORT 3128718*****

Anderson Orthopaedic Clinic, P.A.
2000 E. Greenville Street, Suite 3700
Anderson, South Carolina 29621

JONES, JR., ARCHIE E. 90.944
DOB: 07/03/43
DOS: 10/03/05

Mr. Jones is a 62-year-old gentleman who is seen today regarding his right elbow. He suffered an injury to the elbow approximately 2 weeks ago, receiving a contusion and he has a hematoma on the lateral aspect. He is recommended orthopedic followup for this. He also has a history of nonhealing wound of the right foot following multiple previous procedures on the foot related to initial burn injuries. It sounds he underwent several-layer tenotomy and/or fusion procedures as well to the foot.

PHYSICAL EXAMINATION: On exam of the right elbow, he has full range of motion with no discomfort, and resolving small hematoma over the lateral aspect of the elbow.

X-RAYS: X-rays from September 28 from the AnMed show no evidence of fracture. We do note a small medial loose body which appears old and does not seem to be symptomatic.

IMPRESSION

- 1) Hematoma of the right elbow, resolving.
- 2) Right foot with burn scars, previous flap placements, nonhealed chronic wounds.

PLAN: I am unable to explain to him I am certainly untrained and unqualified to take on further care of his foot. I do suggest that he needed to be seen by foot and ankle specialist regarding any further surgery or intervention that might be performed there. I would recommend we refer him on to Dr. Michael Tollison in Greenville for evaluation as to what if anything needs further to be done regarding the right foot. We will see him back on an as-needed basis only.

Samuel W. Capra, Jr., M.D.

SWC/DTI oper21

ANMED HEALTH

Radiology Consult Report

PT NAME: ARCHIE EDWARD JONES

DOB: 07/30/1943

SEX: M LOCATION: AHC AREA 4 GEN RADIO/CT / 0000 /

ORDERING: JUNE PETRYSZN SOUVIRON

DOS: 10/04/2005 12:41 PM

EXAM ID#: 3131309

MRN: 000066441

STATUS: OP

Acct #: 5217439

PHONE: (864)231-7003

EXAM CODE: 81 - 4210503

JONES

THREE VIEWS OF THE RIGHT FOOT

CLINICAL HISTORY: Ulcer, skin graft breaking down.

The patient is status post amputation of the fifth digit distal to the metatarsal. There are erosions involving the head of the first metatarsal. No change since the previous exam from 2003.

Dictated: PAIGE SKINNER HUBER, M.D. Oct 04, 2005 13:26

Electronically Verified: PAIGE SKINNER HUBER, M.D. Oct 04, 2005 13:53

Transcribed by: PAULINE WALTERS Oct 04, 2005 13:39

*****END OF REPORT 3131309*****

16-15
rule wound
He needs
to go to
ortho
& I do
this
is a
obvious
but
don't
know
what
else to
suggest
come for
visit
in the
next
few days
or so

ANMED HEALTH**Radiology Consult Report**

PT NAME: **ARCHIE EDWARD JONES**
DOB: **07/30/1943**
SEX: **M** LOCATION: **AHC AREA 4 GEN RADIO/CT / 0000 /**

MRN: **000066441**

STATUS: **OP**

Acct #: **5225136**

ORDERING: **JUNE PETRYSZN SOUVIRON**
DOS: **10/13/2005 11:39 AM**

PHONE: **(864)231-7003**

EXAM ID#: **3135413**

EXAM CODE: **81 - 4210100**

JONES 2-VIEW CHEST

CLINICAL HISTORY: Cough, muscle weakness, fatigue, elevated glucose.

Frontal and lateral views of the chest without prior films for comparison.

The lungs are normally expanded bilaterally and clear. The cardiomedastinum is normal in size. Soft tissue and bony structures are unremarkable.

IMPRESSION: NORMAL CHEST.

DICTATED: CARRIE D. COUSAR, M.D. Oct 13, 2005 11:54

ELECTRONICALLY VERIFIED: KYLE COREEN BRYANS, M.D. Oct 13, 2005 17:32

TRANSCRIBED BY: MYRA WHITE Oct 13, 2005 16:45

*****END OF REPORT 3135413*****

RIGHT PAGE

12/15/2005 11:10

PAGE 0001002

12/15/2005

000 NORTH SAINT JOHNS
ANDERSON SC 29621

RADIOLOGY REPORT

Pat. Name: JONES, ARCHIE EDWARD
Address: 1229 SALEM CHURCH RD.
ANDERSON, SC 29625
Unit/Room: 04/0000
DOB: 30-Jul-1943
Sex: M

MR#: 000066441
Ord. Phys.: FRANK OLIVER
Service Date/Time: 12/14/2005 2:37 PM
Order#: E-03159185
PROC: MRI BRAIN W/VO
Attend. Prov.: FRANK OLIVER

JONES MRI OF THE BRAIN WITH AND WITHOUT CONTRAST

INDICATION: Vertigo with TIA.

TECHNIQUE: This MRI is accomplished using the head coil. Images are obtained in the axial plane in a T1, T2, diffusion-weighted, and FLAIR sequences. They are obtained in the coronal plane and a proton density in T2 format and in a sagittal plane in a T1 format. After infusion of Magnevist contrast, images were repeated in the axial, sagittal and coronal plane in a T1 format.

FINDINGS: The study is of fair to good quality. The orbital and retro-orbital structures are unremarkable. The paranasal sinuses are clear. The pituitary glands are visually normal in size and signal on postcontrast enhancement pattern. The patient has normal appearing midline and fourth ventricle.

Within the posterior fossa the cerebellum and brainstem structures appear largely unremarkable. There is some mild diffuse cerebellar atrophy. The VII and VIII nerve complexes appear normal bilaterally. There is normal flow void seen in the basilar and both vertebral arteries.

Supratentorially, there are a few T2 and FLAIR hyperintensities in the subcortical white matter with a minimal degree of microischemic disease. There are no other focal lesions identified within the brain parenchyma. There is normal flow void seen in the internal artery and carotid artery. There is no abnormal diffusion weighted or postcontrast enhancement signal seen on this study. There is mild diffuse atrophy appropriate for the patient's stated age.

IMPRESSION:

THIS ENHANCED AND UNENHANCED MRI OF THE BRAIN DEMONSTRATING:

1. MILD DIFFUSE ATROPHY LIKELY APPROPRIATE FOR THE PATIENT'S STATED AGE OF 62 YEARS.
2. FEW SUBCORTICAL WHITE MATTER T2 AND FLAIR HYPERINTENSITIES MOST CONSISTENT WITH A

*** report continues next page ***

Dictated Date/Time: 12/14/2005 3:10 PM
Transcr. By: VBURDEN
Transcr. Date/Time: 12/15/2005 09:19 AM

Dictated By: HAROLD DEAN REEVES, M.D.
Reviewed By:
Approved Date/Time: 12/15/2005 09:33 AM

Page 1

ACCT:5273100

RADIOLOGY REPORT (Continued)

Pat. Name: JONES, ARCHIE EDWARD
DOB: 30-Jul-1943

MR#: 000066441
Order#: E-03159185

MINIMAL DEGREE OF MICROISCHEMIC DISEASE.

3. NO ACUTE LESION IDENTIFIED.

APPROVED BY: JASON SORIANO, M.D.

Dictated Date/Time: 12/14/2005 3:10 PM
Transcr. By: VBURDEN
Transcr. Date/Time: 12/15/2005 09:19 AM

Dictated By: HAROLD DEAN REEVES, M.D.
Reviewed By:
Approved Date/Time: 12/15/2005 09:33 AM
Page 2

ANMED HEALTH
ANDERSON, S.C.
MEDICAL RECORD

JONES, ARCHIE
Gowdhami Mohan, MD

5/49

Thu Apr 20 13:14:27 2006
Thu Apr 20 14:36:41 2006

HISTORY AND PHYSICAL

DATE SEEN: 04/20/06

FOLLOW UP VISIT: The patient is a scheduled to have outpatient sleep study done at AnMed sleep lab _____.

REFERRING PHYSICIAN: June Souviron, MD.

HISTORY OF PRESENT ILLNESS: Mr. Archie Jones is a pleasant 62-year-old Caucasian gentleman with multiple medical problems who is here for follow up on his pulmonary and sleep complaints. The patient has a longstanding history of pulmonary problems secondary to terminal injury to his lungs many years back at his job. The patient has had prolonged hospitalization at MUSC and was treated for this problem. He suffers from significant obstructive airway disease with bronchiectasis.

Currently on chronic prednisone therapy. He uses prednisone anywhere between 3 mg to 30 mg a day depending upon his clinical symptoms. Occasional cough present. No sputum production present. No hemoptysis present. The patient has dyspnea level of 1 to 2 blocks on a bad day and sometimes can walk up to 1/2 mile to 1 mile a day at a slow pace on a good day. The patient is compliant with all his medications.

No fever, no chills, no weight loss, no loss of appetite present. He has no symptoms of reflux esophagitis. Continues to have pain in his right foot.

Currently using Dexedrine for hypersomnia. He has been diagnosed to have sleep apnea, but could not tolerate CPAP treatment and hence was switched over to dental appliance. Currently he has a new dental appliance and he is using it regularly. Despite this, he continues to have excessive daytime

CONTINUED

<Page> 1 of 3

sleepiness and tiredness. Recently the Dexedrine dose was increased, but still this does not seem to help him. Frequent nocturnal awakenings also present. He does not have any complaints of hypnagogic or hypnopompic hallucinations. No history suggestive of cataplexy or sleep paralysis present.

PAST MEDICAL HISTORY:

1. COPD.
2. Bronchiectasis.
3. Attention deficit disorder.
4. Asthmatic component of COPD.
5. Allergic rhinitis.

SOCIAL HISTORY: Not a smoker and a not an alcoholic.

ALLERGIES: NKDA.

MEDICATIONS: Reviewed and updated.

PHYSICAL EXAMINATION: Temperature is 98.2 degrees, pulse is 86, respirations 16, blood pressure is 128/82, and O2 sat on room air is 97%. Head/ENT: No sinus tenderness. Ear examination: Normal. Throat: Clear. No lymphadenopathy. No elevated JVD. Narrowed oropharynx present. Lungs: Distant breath sounds present. Few scattered rales heard over the right lung field. Few rhonchi heard during expiration. Heart: S1 and S2 heard. No murmur and no gallop. Abdomen: Soft. Bowel sounds present. No organomegaly. Extremities: No cyanosis. Clubbing present. No pedal edema. No focal neurological deficit present.

ASSESSMENT AND PLAN:

1. Chronic obstructive pulmonary disease with bronchiectasis. The patient is symptomatically doing much better currently not using any antibiotics on a regular basis. The patient is to be continued on low dose prednisone therapy along with other bronchodilators. The patient is using Pulmicort inhalers 2 puffs MDI once a day. Also uses Pulmicort nebulizer treatments on a p.r.n. basis. The patient is to be continued on Singulair along with theophylline and Humibid.
2. Reflux esophagitis symptoms well controlled on Prevacid 30 mg once a day.
3. Sleep apnea. The patient continues to have significant sleep-related complaints despite being on dental device and Dexedrine. Prefers to consider CPAP treatment at this

CONTINUED

HISTORY AND PHYSICAL
<Page> 2 of 3

JONES, ARCHIE
Gowdhami Mohan, MD

time. We will do overnight polysomnography to assess the severity of sleep apnea. The patient is to stop Dexedrine for 2 weeks prior to the sleep study. The patient is also not to use dental appliance when he goes for the sleep study.

4. The patient will return to the clinic 2 weeks after the sleep study.

Gowdhami Mohan, MD

MLS: 95550
62430319 /62430319

cc: Dr. Robert Richards, June Souviron MD

COPY for June Souviron, MD

HISTORY AND PHYSICAL
<Page> 3 of 3

JONES, ARCHIE
Gowdhami Mohan, MD

Radiology Consult Report

PT NAME: **ARCHIE EDWARD JONES**
DOB: **07/30/1943**
SEX: **M** LOCATION: **AHC AREA 4 GEN RADIO/CT / 0000 /**
ORDERING: **JUNE PETRYSZN SOUVIRON**
DOS: **08/08/2006 11:40 AM**
EXAM ID#: **3270052**

MRN: **000066441**
STATUS: **OP**
Acct #: **5467336**
PHONE: **(864)231-7003**
EXAM CODE: **81 - 4210722**

JONES UPPER GI

CLINICAL HISTORY: Left upper quadrant abdominal pain.

Barium was ingested by the patient under fluoroscopic control without difficulty. The appearance of the esophagus, stomach, duodenum, and proximal jejunum was normal. No constricting or obstructing lesions, mucosal abnormalities, or filling defects were identified. There was no evidence of hiatal hernia. Gastroesophageal reflux was not demonstrated.

IMPRESSION: NEGATIVE UPPER GI SERIES.

DICTATED: DAVID HARRISON HOLT, JR., M.D. Aug 08, 2006 11:28

ELECTRONICALLY VERIFIED: BRUCE MALLORY BURNS, M.D. Aug 08, 2006 17:48

TRANSCRIBED BY: MYRA WHITE Aug 08, 2006 13:04

*****END OF REPORT 3270052*****

ANIMED HEALTH
Radiology Consult Report

PT NAME: **ARCHIE EDWARD JONES**
DOB: **07/30/1943**
SEX: **M** LOCATION: **AHC AREA 4 GEN RADIO/CT / 0000 /**
ORDERING: **JUNE PETRYSZS SOUVIRON**
DOS: **08/14/2006 10:10 AM**
EXAM ID#: **3270031**

MRN: **000066441**
STATUS: **OP**
Acct #: **5467336**
PHONE: **(864)231-7003**
EXAM CODE: **81 - 4212000**

*Call Burton
are ok
se lets
stop the
Actonel
for*

JONES BONE DENSITY

HISTORY: Previous fracture, steroid therapy B58.69, and osteoporotic therapy B58.69, osteopenia.

Patient had an upper GI last week and there is some density projecting over the spine which could be falsely elevating the bone mineral density of the spine.

DEXA scanning demonstrates the following:

	BMD g/c2	T-SCORE
RADIUS	0.64	0.6 (previous 0.5)
SPINE	1.548	2.6 (again this could be falsely elevated due to
overlying Barium.)		
L3	1.224	-0.1
LEFT FEMUR	1.044	-0.4 (previous left -0.3)
RIGHT FEMUR	1.002	-0.7 (previous right -0.6)

IMPRESSION:

NORMAL BONE MINERAL DENSITY.

Dictated: **PAIGE SKINNER HUBER, M.D.** Aug 14, 2006 11:12
Electronically verified: **PAIGE SKINNER HUBER, M.D.** Aug 14, 2006 16:04

Transcribed by: **PAIGE BURTON** Aug 14, 2006 13:48

*****END OF REPORT 3270031*****

*Now
Verbal*

ANMED HEALTH**Radiology Consult Report**

PT NAME: ARCHIE EDWARD JONES
DOB: 07/30/1943
SEX: M LOCATION: AHC AREA 3 MRI NM US / 0000 /
ORDERING: JUNE PETRYSZN SOUVIRON
DOS: 12/11/2006 01:18 PM
EXAM ID#: 3331288

MRN: 000066441
STATUS: OP
Acct #: 5577830
PHONE: (864)231-7003
EXAM CODE: 81 - 4230600

JONES SCROTAL ULTRASOUND

CLINICAL HISTORY: Moderate sized scrotal swelling.

Multiple sonographic images of the scrotum were obtained. There are no prior studies available for comparison.

The testicles are normal in size, shape and echogenicity. No testicular mass is noted. Doppler signal appears normal in the right and left testicles. There is a moderate sized right and small left hydrocele and a small left varicocele noted.

IMPRESSION:

NO TESTICULAR ABNORMALITIES ARE IDENTIFIED.

MODERATE SIZED RIGHT AND SMALL LEFT HYDROCELES. SMALL LEFT VARICOCELE.

DICTATED: DAVID HARRISON HOLT, JR., M.D. Dec 11, 2006 12:21

ELECTRONICALLY VERIFIED: DAVID HARRISON HOLT, JR., M.D. Dec 11, 2006 15:26

TRANSCRIBED BY: JANE JORDAN Dec 11, 2006 13:52

*****END OF REPORT 3331288*****

ANMED HEALTH
Radiology Consult Report

PT NAME: ARCHIE EDWARD JONES
DOB: 07/30/1943
SEX: M LOCATION: AHC AREA 4 GEN RADIO/CT / 0000 /
ORDERING: JUNE PETRYSZN SOUVIRON
DOS: 01/26/2007_12:37_PM
EXAM ID#: 3355015

MRN: 000066441
STATUS: OP
Acct #: 5618547
PHONE: (864)231-7003
EXAM CODE: 81 - 4210150

1126
Nothing
on X-ray
OL

*** Notice: PRELIMINARY REPORT. NOT APPROVED BY A PHYSICIAN/RADIOLOGIST. ***

JONES UNILATERAL LEFT RIBS

CLINICAL HISTORY: Left flank pain.

Unilateral left ribs are compared to an old chest film from October 13, 2005.

There is no evidence of a displaced rib fracture, lytic or sclerotic bony lesion. There is an asymmetric density in the left lower lobe of the lung which is unchanged since October 2005. The remainder of the left ribs are unremarkable.

IMPRESSION: A SOMEWHAT SPICULATED DENSITY OVERLYING THE LEFT LOWER LOBE WHICH IS UNCHANGED SINCE OCTOBER 13, 2005 BUT CONTINUED FOLLOWUP IS RECOMMENDED UNTIL OCTOBER 2007 TO DOCUMENT A 2 YEAR STABILITY.

DICTATED: CARRIE D. COUSAR, M.D. Jan_26,_2007_12:42

*****END OF REPORT 3355015*****

Has spot right
under ribs cage
(L) side 3in above
navel
Numb C when
it hurt it
burns +
very bad pain
off + on
when moves
very sore
Not
constant
now

ANMED HEALTH**Radiology Consult Report**PT NAME: **ARCHIE EDWARD JONES**DOB: **07/30/1943**SEX: **M** LOCATION: **AHC AREA 4 GEN RADIO/CT / 0000 /**ORDERING: **JUNE PETRYSZN SOUVIRON**DOS: **01/26/2007 12:37 PM**EXAM ID#: **3355017**MRN: **000066441**STATUS: **OP**Accl #: **5618547**PHONE: **(864)231-7003**EXAM CODE: **81 - 4210312****JONES****THORACIC SPINE**CLINICAL HISTORY: **Left flank pain.**FINDINGS: **Multipa views of the thoracic spine show marked osteopenia. There are degenerative changes throughout the thoracic spine. No evidence of a compression fracture.**

IMPRESSION:

DEGENERATIVE CHANGES MOST SEVERE AT T12-L1. NO EVIDENCE OF AN ACUTE COMPRESSION FRACTURE.DICTATED: **CARRIE D. COUSAR, M.D. Jan 26, 2007 12:39**ELECTRONICALLY VERIFIED: **CARRIE D. COUSAR, M.D. Jan 28, 2007 11:03**TRANSCRIBED BY: **RENE NIXON Jan 26, 2007 16:21*********END OF REPORT 3355017*******

ANMED HEALTH

Radiology Consult Report

PT NAME: **ARCHIE EDWARD JONES**
DOB: **07/30/1943**
SEX: **M** LOCATION: **AHC AREA 4 GEN RADIO/CT / 0000 /**
ORDERING: **JUNE PETRYSZN SOUVIRON**
DOS: **05/10/2007 05:17 PM**
EXAM ID#: **3408828**

MRN: **000066441**
STATUS: **OP**
Acct #: **5716029**
PHONE: **(864)231-7003**
EXAM CODE: **81 - 4210508**

JONES RIGHT LOWER LEG

INDICATIONS: Nonhealing wound of right tib fib.

Two views of the right lower leg were performed. Two skin staples are seen along the lower medial and mid medial right leg. The tibia and fibula demonstrate osteopenia without fracture. No erosions are noted.

IMPRESSION:

TWO SKIN STAPLES IN THE SOFT TISSUES OF THE MEDIAL RIGHT LEG. CLINICAL CORRELATION IS RECOMMENDED. NO FRACTURE IS IDENTIFIED.

Dictated: **VEENA M. CHANDLER, M.D.** May 10, 2007 17:17
Electronically Verified: **VEENA M. CHANDLER, M.D.** May 14, 2007 15:50
Transcribed by: **LISA VINSON** May 10, 2007 23:08

*****END OF REPORT 3408828*****

ANMED HEALTH**Radiology Consult Report**

PT NAME: **ARCHIE EDWARD JONES**
DOB: **07/30/1943**
SEX: **M** LOCATION: **AHC AREA 3 MRI NM US / 0000 /**
ORDERING: **JUNE PETRYSZN SOUVIRON**
DOS: **05/11/2007 10:56 AM**
EXAM ID#: **3408793**

MRN: **000066441**
STATUS: **OP**
Acct #: **5716272**

PHONE: **(864)231-7003**

EXAM CODE: **81 - 424Q100**

5/14/07
Good
No Bone
Infect
Dr. Harrison
done
cs

JONES**REGIONAL BONE SCAN**

CLINICAL HISTORY: Nonhealing wound in the distal anterior right calf.

Following the IV administration of 25 mCi of technetium-99m MDP, dynamic, blood pool, and delayed static images of the lower legs were obtained in multiple views.

The dynamic and blood pool images demonstrate minimal hyperemia in the region of the distal, medial right calf. Delayed static images demonstrate a physiologic distribution of radiotracer throughout the skeletal structures.

IMPRESSION:

1. NO SCINTIGRAPHIC FINDINGS SUGGESTING OSTEOMYELITIS.
2. EARLY IMAGES DEMONSTRATE MINIMAL HYPEREMIA IN THE DISTAL MEDIAL RIGHT CALF.

DICTATED: DAVID HARRISON HOLT, JR., M.D. May 11, 2007 11:27

ELECTRONICALLY VERIFIED: DAVID HARRISON HOLT, JR., M.D. May 11, 2007 13:23

TRANSCRIBED BY: LINDA HARPER May 11, 2007 11:50

*****END OF REPORT 3408793*****



Piedmont Surgical Associates, P.A.

General, Thoracic, Vascular, Advanced Laparoscopic Surgery and Endoscopy

William S. Blum, M.D.

James G. Foster, III, M.D.

Paul M. Frassinelli, M.D.

David W. Strathern, M.D.

5/20

May 14, 2007

Dr. June Souviron
AAMC

Re: Archie Jones

Dear June:

Thank you for referring Mr. Jones. He has a somewhat chronic right leg wound. There is a cavity with a small sinus up to the skin. I would like to unroof the cavity and I may excise this chronic wound. He is on Plavix and I plan to stop this for several days prior to the procedure.

I thank you for the referral and I will be certain to let you know if there are any problems.

Sincerely,

Paul M. Frassinelli, M.D.

jd

ANMED HEALTH
MEDICAL RECORD
ANDERSON, S.C.

JONES, ARCHIE
Paul Frassinelli, MD

Sat May 12 17:08:06 2007
Sat May 12 17:40:03 2007

HISTORY AND PHYSICAL

DATE OF SURGERY: Thursday, May 17, 2007

DATE OF BIRTH: 07/30/1943

CHIEF COMPLAINT: Chronic right leg wound.

HISTORY OF PRESENT ILLNESS: This 63-year-old male with history of extensive burn injury to his abdomen and right leg presents with a chronically draining sinus. Examination reveals a cavity under the sinus. The wound has been refractory to conservative therapy.

PAST MEDICAL HISTORY:

1. Hypertension.
2. History of transient ischemic attack.
3. Inhalation injury.

PAST SURGICAL HISTORY: Extensive skin grafting and the patient has had foot and finger surgery.

MEDICATIONS: Albuterol, Atrovent, Combivent, Xopenex, Pulmicort, Serevent, prednisone, Lasix, theophylline, Risperdal, Depakote, Zoloft, Actonel, Lamisil, Colace, Prevacid, Celebrex, diltiazem, Synthroid, Flomax, Plavix, and aspirin.

REVIEW OF SYSTEMS: As documented in detail in his medical information sheet. Aside from joint pain and varicose veins, as well as anxiety and depression, it is negative.

FAMILY HISTORY: Negative for colorectal malignancy or inflammatory bowel disease.

CONTINUED

SOCIAL HISTORY: The patient is married and does not drink or smoke.

PHYSICAL EXAMINATION: Blood pressure is 150/100, pulse 72, temperature 97.1. HEENT exam reveals anicteric sclera. Cardiac is regular. Examination of the right lower extremity reveals extensive changes of skin grafting, which essentially look well healed. There is some edema of the leg. The patient has a small sinus, which when probed, reveals a 1.5 cm cavity under the skin.

IMPRESSION: Chronic right leg wound.

PLAN: I would like to proceed with unroofing of the deeper cavity. I will explore it at that time and possibly excise the chronic wound if indicated. I will stop the patient's Plavix in the interim.

Paul Frassinelli, MD

MLS: 95459
63451915 / 63451915

Authenticated by Paul M. Frassinelli, MD On 05/29/2007 09:06:30 AM

ANMED HEALTH
ANDERSON, S.C
MEDICAL RECORD

JONES, ARCHIE
Paul Frassinelli, MD
5721616
Thu May 17 12:01:24 2007
Thu May 17 13:27:13 2007

PROCEDURE NOTE

DATE OF PROCEDURE: 05/17/2007

PREOPERATIVE DIAGNOSIS: Right leg wound.

POSTOPERATIVE DIAGNOSIS: Right leg wound with necrotic subcutaneous tissue.

PROCEDURE: Excisional debridement of right leg.

SURGEON: Paul Frassinelli, MD

ANESTHESIA: Local..

DESCRIPTION OF PROCEDURE: The patient was taken to the operating room, and the right leg was prepped and draped. Marcaine was used to infiltrate the skin and subcutaneous tissues, and an elliptical incision was made encompassing the patient's chronic wound. There was necrotic subcutaneous tissue under the wound, which was fully excised. A little dead fascia was also excised, and the wound was irrigated and packed open with saline-soaked gauze. A sterile dressing was applied, and the patient was returned to his room in stable condition, having tolerated the procedure well.

Paul Frassinelli, MD
MLS: 96025
63464686 /63464686

cc: June Souviron, MD

Authenticated by Paul M. Frassinelli, MD On 05/29/2007 09:06:33 AM



Piedmont Surgical Associates, P.A.

General, Thoracic, Vascular, Advanced Laparoscopic Surgery and Endoscopy

William S. Buice, M.D.
James G. Foster, III, M.D.
Paul M. Frassinelli, M.D.
David W. Strathern, M.D.

JONES, ARCHIE EDWARD
MR: 66441
ATT:
ADM: FRASSINELLI, PA 688
AC: 5721616 DOB: 7/30/43
083YMC

William S. Buice, M.D., F.A.C.S.
James G. Foster, III, M.D., F.A.C.S.
Paul M. Frassinelli, M.D., F.A.C.S.
David W. Strathern, M.D., F.A.C.S.

HISTORY AND PHYSICAL

(Please do not separate these forms.)

Piedmont Surgical Associates
Medical Information Sheet

Patient Name: Archie E Jones Jr.

Date: 5-11-07

Date of birth: 12-12-33 Age: 73

Referred by: Dr. June Fournier

Reason for seeing doctor: Wound on RT leg

Family doctor: Dr. June Fournier

Related symptoms: _____

Past Medical History:

ALLERGIC TO: NKA

Do you take blood thinners: Yes ☐ No ☒

Medications: Brought Over

JONES, ARCHIE EDWARD

MR: 66441

ATT:

ADM: FRASSINELLI, PA 698

AC: 5721616

DOB: 7/30/43

063YMC

Previous surgeries and dates: Breast grafting (97-98), Foot (2000), Fungus (2000)

Major Medical:

Heart disease/attack

Yes ☐ No ☒

Diabetes

Yes ☐ No ☒

Stroke

Yes ☐ No ☒

(do you have a history of):

High blood pressure

Yes ☒ No ☐

Emphysema

Yes ☐ No ☒

714

Review of Systems: (do you now have any of the following: please circle)

Gastrointestinal

Heartburn Yes ☐ No ☒
Nausea Yes ☐ No ☒
Vomiting Yes ☐ No ☒
Diarrhea Yes ☐ No ☒
Constipation Yes ☐ No ☒
Hemorrhoids Yes ☐ No ☒
Rectal bleeding Yes ☐ No ☒
Peptic ulcer disease Yes ☐ No ☒
Colon cancer Yes ☐ No ☒
Colon polyps Yes ☐ No ☒
Inflammatory bowel disease Yes ☐ No ☒
Change in bowel habits Yes ☐ No ☒

Cardiovascular

Chest pain Yes ☐ No ☒
Heart murmur Yes ☐ No ☒
Pacemaker Yes ☐ No ☒
Irregular heartbeat Yes ☐ No ☒
Heart catheterization Yes ☐ No ☒

Endocrine

Thyroid problem Yes ☒ No ☐

Constitutional

Weight loss Yes ☐ No ☒
Fatigue Yes ☐ No ☒
Fever Yes ☐ No ☒
Chills/night sweats Yes ☐ No ☒

Genitourinary

Kidney disease Yes ☐ No ☒
Blood in urine Yes ☐ No ☒

Musculoskeletal

Joint pain Yes ☐ No ☒
Back pain Yes ☐ No ☒
Arthritis Yes ☐ No ☒
Varicose veins Yes ☐ No ☒
Immunology Yes ☐ No ☒
AIDS Yes ☐ No ☒
Hepatitis Yes ☐ No ☒

Skin/Breast

Jaundice Yes ☐ No ☒
Eczema Yes ☐ No ☒
Breast lumps Yes ☐ No ☒
Breast cancer Yes ☐ No ☒
Nipple bleeding or discharge Yes ☐ No ☒

Psychiatric

Anxiety disorder Yes ☐ No ☒
Depression Yes ☐ No ☒
Insomnia Yes ☐ No ☒

Neurological

Numbness Yes ☐ No ☒
Muscle weakness Yes ☐ No ☒
Dizziness Yes ☐ No ☒
Seizures Yes ☐ No ☒

ENT/Mouth

Blurred vision Yes ☐ No ☒
Hearing loss Yes ☐ No ☒
Hoarseness Yes ☐ No ☒
Difficulty swallowing Yes ☐ No ☒

Hematology

Anemia Yes ☐ No ☒
Bruise easily Yes ☐ No ☒
Swollen lymph nodes Yes ☐ No ☒

Respiratory

Tuberculosis Yes ☐ No ☒
Asthma Yes ☐ No ☒

Do you have a FAMILY history of:

Breast cancer Yes ☐ No ☒
Colorectal cancer Yes ☐ No ☒
Colon polyps Yes ☐ No ☒
(relative)

Bleeding disorders Yes ☐ No ☒
Inflammatory bowel disease Yes ☐ No ☒
(relative)

Social History:

Married Single - Separated - Divorced - Widowed (please circle)

Do you drink: Yes ☐ No ☒ How Much? _____

Do you smoke: Yes ☐ No ☒ How Much? _____

Vital Signs: (staff use) Resp _____ BP 150/100 Pulse 72 Temp 97.1



WOUND CARE PROGRAM
PHYSICAL HISTORY FORM

5701162

ADDRESSOGRAPH

Name ARCHIE E. JONES JR. Age 63 Date 4-26-07
Family Physician DR. JUNE SOUVIRON
Referring Physician SAME

Please check if you have any of these conditions:

☐ Kidney Disease	☐ Heart
☐ Arthritis	☐ Congestive Heart Failure
☐ Cancer	☒ High Blood Pressure
☐ Diabetes	☐ Stroke
☒ Breathing Problems	☐ Poor circulation
☐ Other illnesses not listed above	

Explain any above illness:

Please list current medications:

Medication

How taken:

PLAVIX
81MG ASPIRIN
PREDNISONE 10MG
THEOPHYLLINE
LEVOTHYROXINE
VALPROATE

RISPERDAL
ASAP

Allergies (Drug/Food/Latex)

Please list prior operations:

Procedure:

Date:

GRAFTING 46% 3RD DEGREE Burns 6-3-97



AnMed Health

**WOUND CARE PROGRAM
PHYSICAL HISTORY FORM**



ACCT: 5807567
DR - 96725 SOUVIRON, JUNE

JONES, ARCHIE EDWARD

DOB - 06-03-42
AGE - 62
DOS - 06-03-02



IR: 96866441

ADDRESSOGRAPH

Name Jones, Archie Age _____ Date _____

Family Physician _____

Referring Physician _____

Please check if you have any of these conditions:

☐ Kidney Disease	☐ Heart
☐ Arthritis	☐ Congestive Heart Failure
☐ Cancer	☒ High Blood Pressure <i>2 med</i>
☐ Diabetes	☒ Stroke <i>TIA. 5 or 6 yrs ago</i>
☒ Breathing Problems <i>lung burn</i>	☐ Poor circulation
☐ Other illnesses not listed above	

Explain any above illness:

Please list current medications:

Medication

How taken:

<u>To bring a list</u>	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies (Drug/Food/Latex)

Please list prior operations:

Procedure:

Date:

_____	_____
_____	_____
_____	_____
_____	_____



ANMED HEALTH
PATIENT ASSESSMENT
PRE-POST PROCEDURE RECORD
LOCAL ANESTHESIA/MODERATE SEDATION

JONES, ARCHIE EDWARD

MR: 66441

ATT:

ADM: FRASSINELLI, PA 698

AC: 8721618



DOB: 1/10/50

083YMC

PROPOSED PROCEDURE Debridement DATE OF PROCEDURE 5/17/07

DOES PATIENT HAVE LIVING WILL? ☐ YES ☒ NO HEALTH CARE POWER OF ATTORNEY? ☐ YES ☒ NO

Medical History inhalation injury lungs (Not related to) Pain status ☐ YES ☒ NO

DIABETES ☐ YES ☒ NO HYPERTENSION ☐ YES ☒ NO

HEART DISEASE ☐ YES ☒ NO STROKE TIA ☐ YES ☒ NO

TUBERCULOSIS ☐ YES ☒ NO SEIZURES ☐ YES ☒ NO

LUNG DISEASE Yes ☒ YES ☐ NO GLAUCOMA ☐ YES ☒ NO

RENAL DISEASE ☐ YES ☒ NO CANCER skin ☐ YES ☒ NO

REFLUX/HiATAL HERNIA ☐ YES ☒ NO HEPATITIS ☐ YES ☒ NO

CHICKEN POX ☐ YES ☒ NO SHINGLES ☐ YES ☒ NO

HEIGHT 5'10" WEIGHT 230 KG/LBS ☒

Allergies/Sensitivities LATEX YES ☐ NO ☒

Nice

Medications (listed on Universal Medication Information Record)

Previous Surgery Extremity amputation, foot and hand

Blow hand 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 10th

Res.

DAY OF PROCEDURE ☒ PATIENT RIGHTS AND RESPONSIBILITIES

REVIEWED - BROCHURE GIVEN TO PATIENT

DATE OF ARRIVAL 5/17/07 TIME OF ARRIVAL 0500

MODE: ☒ AMBULATORY ☐ STRETCHER ☐ WHEELCHAIR ☐ ARMS

MENTAL STATUS: ☐ ALERT/ORIENTED ☐ CONFUSED ☐ LETHARGIC

☐ UNRESPONSIVE ☐ OTHER

VITAL SIGNS: T 95.4 P 77 R 19 BP 107/64 O2 Sat 94%

RESPONSIBLE PARTY Wendell RELATIONSHIP wife

PATIENT IDENTIFICATION: SURGICAL SITE/PROCEDURE VERIFIED BY:

☒ NAME ☐ PATIENT

☒ MEDICAL RECORD # ☐ OTHER

☒ ID BAND (ARM/LEG) ☐ RN INITIALS

R or L R

PAIN ASSESSMENT

PAIN/DISCOMFORT ☐ YES ☒ NO LOCATION:

QUALITY: ☐ BURNING ☐ PRESSURE ☐ HEAVY ☐ SHARP ☐ CRAMPING

☐ ACHING ☐ TINGLING ☐ NUMB ☐ DULL

INTENSITY (0-10) _____ DURATION: ☐ CONSTANT ☐ INTERMITTENT

RELIEVED BY: ☐ REST ☐ HEAT ☐ COLD ☐ MEDICATION ☐ OTHER:

NURSING DIAGNOSIS: PLAN/IMPLEMENTATION:

1. POTENTIAL FOR ANXIETY ☐ PT. CONCERNS COMMUNICATED

☐ COMFORT MEASURES PROVIDED

2. POTENTIAL FOR INJURY ☐ SIDERAILS UP POST MEDICATION

☐ CALL LIGHT WITHIN REACH

☐ INSTRUCTED TO CALL FOR ASSISTANCE

3. POTENTIAL FOR PAIN ☐ POSITIONED FOR COMFORT

☐ PAIN RATING SCALE REVIEWED

4. KNOWLEDGE DEFICIT ☒ SEQUENCE OF EVENTS EXPLAINED

☒ EXPRESSES UNDERSTANDING OF PROCEDURE

TIME TO PROCEDURE ROOM _____

2041 (1/05)

LOCATION:

QUALITY: ☐ BURNING ☐ PRESSURE ☐ HEAVY ☐ SHARP

☐ ACHING ☐ TINGLING ☐ NUMB ☐ DULL

INTENSITY (0-10) _____ DURATION: ☐ CONSTANT

☐ INTERMITTENT

RELIEVED BY: ☐ REST ☐ HEAT ☐ COLD ☐ MEDICATION

☐ OTHER:

Psycho/Social Profile

OCCUPATION Disabled

RELIGION Baptist

If Jehovah's Witness, are consent forms signed? ☐ YES ☒ NO

☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

Home Phone: 224-2669

Work Phone: 958-1483

Patient informed to have someone accompany patient to the unit

and drive patient home after the procedure ☐ Yes ☐ No ☐ N/A

DATE 5/16/07 TIME 1705 RN (Initials)

PRE-PROCEDURE CHECKLIST

HISTORY & PHYSICAL ON CHART

CONSENT FORM(S) SIGNED

PATIENT AUTHORIZATION SIGNED

ID BAND (ARM/LEG - R OR L)

YELLOW ID BAND (IF INDICATED)

DENTURES REMOVED partial

GLASSES/CONTACTS REMOVED

JEWELRY REMOVED

CHEWING GUM/TOBACCO REMOVED

PROSTHESIS REMOVED

NO FOOD/DRINK PAST

INITIALS MM

TIME

TREATMENTS

IV / INT ORDERED: ☒ YES ☐ NO

AMT./SOLUTION: _____ mL

SITE:

RATE: _____ mL/HR ☐ KVO

CATH SIZE: _____ TYPE: ☐ PROT PLUS

☐ OTHER:

STERILE DRESSING APP: ☐ YES ☐ NO

INITIALS

TIME

NURSES NOTES

RN (INITIALS)
Page 1 of 2

ANMED HEALTH
POST PROCEDURE RECORD
LOCAL ANESTHESIA / MODERATE SEDATION

JONES, ARCHIE EDWARD MR: 68441

ATT: FRASSINELLI, PA 698
 AC: 6721618

063YMC

DATE 5-12-87 TIME OF ARRIVAL 9:00
 PROCEDURE (1) Leg Nerve Block

☒ ID BRACELET / MRI VERIFIED
☒ IV ☐ INT ON ARRIVAL ☐ NO IV

AMT. / TYPE 1% 2 mL / 500 NO
 SITE / COND. Neuro

QC'd AT Neuro AMT ABSORBED IV site mL
 RN INITIALS MAV

TYPE OF ANESTHESIA:

☒ LOCAL
☐ MODERATE (CONSCIOUS) SEDATION
 REVERSAL AGENT? ☐ YES ☐ NO

TYPE
 TIME

		ADM	15'	30'	45'	60'	75'	90'
CONSCIOUSNESS	FULLY AWAKE AROUSABLE ON CALLING NOT RESPONDING	2 1 0	2					
RESPIRATION	ABLE TO BREATHE DEEPLY AND COUGH FREELY DYSPNEIC, SHALLOW OR LIMITED BREATHING APNEIC	2 1 0	2					
ACTIVITY	ABLE TO MOVE 4 EXTREMITIES VOLUNTARILY OR ON COMMAND ABLE TO MOVE 2 EXTREMITIES VOLUNTARILY OR ON COMMAND ABLE TO MOVE NO EXTREMITIES VOLUNTARILY OR ON COMMAND	2 1 0	2					
CIRCULATION	BP WITHIN 20MM OF PRE-ANESTHESIA LEVEL BP WITHIN 20 TO 50MM OF PRE-ANESTHESIA LEVEL BP MORE THAN LESS THAN 50MM OF PRE-ANESTHESIA LEVEL	2 1 0	2					
OXYGEN SATURATION	ABLE TO MAINTAIN SpO ₂ ABOVE 92% ON ROOM AIR NEEDS SUPPLEMENTAL O ₂ TO MAINTAIN SpO ₂ GREATER THAN 92% SpO ₂ LESS THAN 92% EVEN WITH OXYGEN SUPPLEMENT	2 1 0	2					
TOTAL		10						

VITAL SIGNS				PATIENT ASSESSMENT				PAIN			
TIME	B/P	P	R	O ₂ SAT	DRESS	NAUS	DRNG	LOCATION	QUALITY	INTENSITY	INIT
1:30	87	67	20	98	R Foot	-	✓	Rt Foot with ankle			JW

GUIDELINES FOR ASSESSMENT (See Nurses Notes for Comments)
 Dress - Dressing dry and intact
 Naus. - NAUSEA Yes or No
 Drng. - DRAINAGE Type and Amount Explained in Nurse's Notes

PAIN
 Location - Area of Pain
 Quality - S-sharp D-dull TH-throbbing A-aching C-cramping B-burning H-heavy
 T-tingling N-numb
 Intensity - 0-10

TIME	NURSES NOTES	DISCHARGE CRITERIA	YES	NO	N/A
	☒ SIDE RAILS UP ☐ N/A	Modified Aldrete Score of 8 or Greater (or Pre-procedure score)	✓		
	☒ BED IN LOW POSITION AND LOCKED	Verbalizes Understanding of Discharge Instructions	✓		
	☒ CALL LIGHT WITHIN REACH	Discharged in Care of Responsible Adult Driver or Caregiver	✓		
	<u>Circle calling No distress</u>	Nausea / Vomiting Minimal			
		NURSING DIAGNOSIS			
		☒ Potential for anxiety			
		☒ Potential for injury			
		☒ Potential for pain			
		☒ Knowledge deficit			
		OUTCOME GOALS			
		☒ Verbalizes positive experience			
		☒ No sustaining injury			
		☒ Pain is controlled			
		☒ Family understand discharge instructions			
		☒ Written instructions to caregiver			
		<u>Archie Jones</u> (Initials)			
		Time			
		MODE OF DISCHARGE:			
		☒ AMBULATORY			
		☐ STRETCHER			
		☒ WHEELCHAIR			
		☐ CARRIED BY PARENTS			



ATT: ADM:FRASSINELLI, PA 898
AC: 5721816 DOB: [REDACTED]
[REDACTED] 063Y

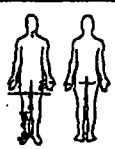
1407 (S/DG)

ANIMED HEALTH
PERIOPERATIVE PLAN OF CARE
 Local Anesthesia/Conscious Sedation

JONES, ARCHIE EDWARD MR: 66441

ATTN: FRASSINELLI, PA 698
 AC: 5721618
 063YMC

ADDRESSOGRAPH

NURSING DX # 3: Potential for Injury ☐ N/A OUTCOME GOAL: Pt. Free From Injury ☒ Met ☐ Not Met PLAN & IMPLEMENTATION: ☒ Bony Prominence Padded ☒ Safety Strap Secure ☒ Alignment Maintained ☐ Legs uncrossed ☐ Other _____																												
POSITION: ☒ Supine ☐ Prone ☐ Lateral R/L ☐ Jack Knife ☐ Semi-Fowlers ☐ Sitting ☐ Lithotomy ☒ Arm secure, arm board ☐ Arm secured @ side R/L AIDES: ☒ Safety belt ☐ Pillow(s) _____ Tape ☐ Axillary Roll R/L ☐ Roll _____ ☐ Stirrups _____ Pressure Paddings: ☐ Heels ☐ Elbows ☐ Knees ☐ Sacral ☐ Popliteal ☐ Other _____ ☐ TED _____																												
CODES Applied by: _____ Ground Pad: <u>MA</u> Tourniquet: _____ Safety Strap: <u>MA</u> Site: _____ Pre Op: _____ Post OP: _____ Bruise: _____ Rash: _____ Abrasion: _____ Pressure Sore: _____ Reddened area: _____ Laceration: _____		EQUIPMENT ID # ESU # <u>51470</u> ☐ N/A Scalpel: <u>30</u> Coag <u>30</u> Cut Bipolar: _____ ☐ N/A Tourniquet: _____ ☐ N/A Up: _____ Up: _____ Down: _____ Down: _____ mm/Hg: _____ mm/Hg: _____ Harmonic Scalpel # _____	DRESSING: ☐ Bioactive ☐ Telfa ☐ Sponges ☐ Star-Strip ☐ Tape ☐ Silk ☐ Paper ☐ Transpore ☐ Microfoam ☐ Hypofix ☐ Other _____ ☐ Cast ☐ Xeroform ☐ Adaptic ☐ Pluflis ☒ Other <u>Kerney roll</u>																									
NURSING DIAGNOSIS # 5: Potential for Injury, related to retained objects OUTCOME: Absence of retained objects ☒ Met ☐ Not Met PLAN & IMPLEMENTATION: ☒ Sponge, Sharp, Instrument (as indicated) Count Maintained																												
ITEMS COUNTED Baseline Count: _____ Closing Count: _____ Final Closing Count: _____ Sponges: ☒ Sponges ☒ Sharps ☐ Instruments Sponges: ☐ Sponges ☒ Sharps ☐ Instruments Sponges: ☐ Sponges ☐ Sharps ☐ Instruments		Scrub Personnel: <u>Rutha Wells CST</u> Circulator Signature: <u>Michelle</u> Surgeon Signature: <u>Antony Ph</u> IF INCORRECT: ☐ Sponges ☐ Sharps ☐ Instruments X-RAY DONE: ☐ Yes ☒ No X-RAY Positive for foreign body: ☐ Yes ☒ No																										
Fluids: _____ Meds: <u>Morphine 0.25/0.125</u> Drains: _____ _____		SPECIMENS: <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>Formalin</th> <th>Frozen</th> <th>C/S - Source</th> <th>Pathology</th> <th>X-ray</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>		Formalin	Frozen	C/S - Source	Pathology	X-ray																				
Formalin	Frozen	C/S - Source	Pathology	X-ray																								
☐ Specimen verified by RN ☒ Specimen discarded per surgeon order ☐ No Specimen ☐ Implants: See Implants Info Sheet																												
NURSE'S NOTES <u>report to OPS Nurse Graham</u>																												
NURSING DX # 7: Potential for Infection ☐ N/A OUTCOME GOAL: Asepsis maintained/restored ☒ Met ☐ Not Met PLAN & IMPLEMENTATION: ☒ Monitor environment ☒ Interventions as appropriate to maintain/restores asepis																												
NURSING DX # 8: POSTOPERATIVE PHASE Post-Op Condition: ☒ Satisfactory ☐ Stable ☐ Pain Rating _____ Patient Awareness: ☒ Awake, alert ☐ Awakening ☐ Responsive to stimuli ☐ Critical ☐ Expired ☐ Sedated ☐ Unresponsive ☐ Other _____ Wound Class: ☐ Clean I ☒ Clean-Contaminated II ☐ Contaminated III ☐ Infected IV Case Classification: ☒ Elective ☐ Emergency ☐ Trauma ☐ Urgent Transported: ☒ Stretcher ☐ Patient Bed ☐ Intubated ☐ AMBU ☐ O2 Monitor Discharged to: ☐ PACU ☐ ICU ☐ CCU ☐ NICU ☐ Pl. Room ☒ OPS ☐ Morgue ☐ Other _____ Transported by: <u>M. Graham</u> In that section																												



JONES, ARCHIE EDWARD
ATT: MR: 66441

ATT: ADM: FRASSINELLI, PA 698
AC: 5721616
MR: 88441
063YMC

[illegible]



JONES, ARCHIE EDWARD

MR: 88441

ATT:

ADM: FRASSINELLI, PA 698

AC: 5721616

063YMC

[illegible]



ADDRESSOGRAPH

Page 1 of 2



ANMED HEALTH
PHYSICIAN'S ORDERS
Local Anesthesia / Sedation Procedures

JONES, ARCHIE EDWARD MR: 65441

ATT:
ADM: FRASSINELLI, PA 898
AC: 5721616

7/18/07

083YMC

Date 5/17/07 Time 900 A.M./P.M.

- ☒ AMBULATORY SURGICAL PROCEDURE
☐ PROVIDE OUTPATIENT OBSERVATION SERVICES
☐ ADMIT TO INPATIENT SERVICES

☐ Saline Lock (INT) on arrival

☐ 500mL Normal Saline IV to KVO on arrival

☒ Other NO IV Site

Archie Edward Jones
SIGNATURE
Dr. Frassinelli

Authenticated by
Paul M. Frassinelli, MD
On 05/29/2007 09:06:56 AM

Post-Procedure Orders:

☐ Discharge

☐ Other _____

Archie Edward Jones

Authenticated by
Paul M. Frassinelli, MD
On 05/29/2007 09:06:42 AM

SIGNATURE



ANMED HEALTH
DISCHARGE INSTRUCTIONS
Outpatient Surgery

JONES, ARCHIE EDWARD

ATT: MR: 68441

ADM: FRASSINELLI, PA 688
AC: 5721616



063YMC

You are urged to carefully follow the instructions checked on this sheet.

- ☒ Progress slowly to regular diet as tolerated. It is better to start with liquids, such as ginger ale or apple juice, then soup and crackers and gradually, solid foods.
- ☒ Certain anesthetics and pain medications may produce nausea and vomiting in certain individuals. If nausea becomes a problem at home, call your physician. In the meantime, rest or sleep on your side to avoid accidentally inhaling material that you may vomit.
- ☒ Anesthetics and other medications will be in your body for 24 hours, so you may feel sleepy or experience dizziness and light-headedness following surgery - DO NOT STAY ALONE. This feeling will slowly wear off, but for the next 24 hours, the patient should not:
 - Drive a car or operate machinery or power tools.
 - Drink any alcoholic beverages (including beer).
 - Make any important decisions, such as signing legal documents.
- ☒ Observe the operative area for signs of excessive bleeding. (Slow general oozing that saturates the dressing completely or frank bright red bleeding. In either case, apply pressure to the area, elevate if possible, and contact your physician at once!)
- ☒ Observe operative area for signs of infection:
 - Increased pain
 - Swelling
 - Foul odor to drainage
 - Fever 101° or higherThese signs and symptoms usually become apparent in 36-48 hours.

- ☒ See the Universal Medication Information Record for a complete list of medications to be taken at home after discharge.
- ☒ Take the Universal Medication Information Record with you to all follow up appointments.
- ☒ See Patient Education Sheet(s) for side effects and more details of medications.
- ☒ Observe affected extremity for circulation or nerve impairment:
 - Change in color
 - Numbness or tingling
 - Coldness
 - Increased painIf these symptoms are present, call your physician at once.
- ☒ Keep operative site elevated for the next 12-24 hours.
- ☒ Apply ice to operative site as directed.
- ☒ May bathe or shower. Pat operative area dry.
- ☒ Keep operative areas clean and dry. Do not remove the dressing unless instructed to do so by your physician.
- ☒ May change dressing as needed and as demonstrated.
- ☒ Avoid stress to suture line (such as pulling, pushing, lifting, etc.)
- ☒ You may experience frequency and burning or you may pass a few drops of blood the first few times you empty your bladder. Report gross bleeding or difficulty urinating to your physician.

☐ Copy of _____ printed instructions given to patient.

☐ Other Instructions: _____

Follow up Care:

OFFICE PHONE

1055 Dr. Frassinelli

☐ APPOINTMENT WITH DR.

See Dr. Jones

ON

AT

☒ KEEP RETURN APPOINTMENT AS PREVIOUSLY SCHEDULED

☐ OTHER

I understand and have received a copy of the above instructions:

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

Archie E. Jones
Jared Shaw RN
DATE 5-17-07 TIME 9:00

Archie
Jones
Reg. No. _____

TREATMENT RECORD

SINGLE FAMILY LEDGER

Anderson Periodontics Associates

Date: 10/09/2007

Page: 1

Guar Name: Archie E Jones 1229 Salem Church Rd. Anderson, SC 29625	Chart Number: Billing Type: 1

DATE	TEETH	DESCRIPTION	PATIENT	CHARGE	PAYMENT	BALANCE
05/24/2007		Balance Forward		0.00		0.00
* 05/25/2007		Maintenance of pharyngeal	Archie	695.00		695.00
* 07/23/2007		Repair/Reline of occlusal guard	Archie	0.00		695.00

TOTAL FAMILY BALANCE AS OF 10/09/2007:	695.00
YTD Finance Charges:	0.00
YTD Late Charges:	0.00
YTD Family Payments:	0.00
YTD Insurance Payments:	0.00

Procedures that have been placed in History.

Patient Information

Name ARCHIE E. JONES Home Phone 252-1166
 Birthdate 7-30-43 Mobile Phone 668-1483
 SS# 250-70-5119 Work Phone 277-8276
 Mailing Address 1229 SALEM CHURCH RD. Pager _____
 City ANDERSON Employer 3 M
 State SC
 Zipcode 29425-1310 Work Address 1400 PERIMETER RD.
GREENVILLE, SC 29605

Primary Dental Insurance _____
 Insured's name _____ Time to call _____
 Relationship to patient _____ Referred By: _____
 Insurance Address _____
 Group or I.D. number _____ Person Responsible for Bill: _____
 Phone number _____

Additional Dental Insurance _____
 Insured's name _____
 Relationship to patient _____ Method of Payment: check one
 Insurance Address _____ Credit Card _____
 Group or I.D. number _____ Cash _____
 Phone number _____ Check _____
 Care Credit _____

Spouse's Name _____
 Birthdate _____
 SS# _____
 Employer _____

HEALTH HISTORY

Patient's Name ARCHIE (EDDIE) JONES

1. Are you being treated for any condition by a physician now? ☒ Yes ☐ No 2. Have you ever experienced a bad reaction to a dental anesthetic? Yes ☒ No ☐ 3. Do you bleed for a long time when you cut yourself? ☒ Yes ☐ No 4. Have you ever had surgery or X-ray treatment for a tumor, growth or other condition in your mouth or on your lips? Yes ☒ No ☐ 5. Are you taking any medicines now? ☒ Yes ☐ No 6. Have you been examined by your physician within the last year? ☒ Yes ☐ No 7. Have you had any of the following: Rheumatic Fever ☐ Yes ☒ No Inflammatory Rheumatism ☐ Yes ☒ No Jaundice (hepatitis) ☒ Yes ☐ No Diabetes (sugar disease) ☐ Yes ☒ No High Blood Pressure ☒ Yes ☐ No Tuberculosis ☐ Yes ☒ No Veneral Disease ☐ Yes ☒ No Heart Attack ☐ Yes ☒ No Stroke <u>TIA</u> ☐ Yes ☒ No Heart Murmur ☐ Yes ☒ No Other Health Problems ☒ Yes ☐ No	8. Do you have AIDS or have you ever tested positive for the AIDS (HIV) Virus? Yes ☐ No ☒ 9. Have you ever experienced a bad reaction to any of the following drugs? Yes ☐ No ☒ Aspirin ☐ Yes ☒ No Penicillin ☐ Yes ☒ No Iodine ☐ Yes ☒ No Sulfonamides (sulfa) ☐ Yes ☒ No Barbiturates (sleeping pills) ☐ Yes ☒ No Other Medicines ☐ Yes ☒ No <u>CODING BURIS EMPTY STOMACH</u> 10. Do you have any sensitive teeth? ☒ Yes ☐ No 11. Have you had a toothache recently? Yes ☐ No ☒ 12. Do you have bleeding gums? Yes ☐ No ☒ 13. Is it difficult for you to open your mouth as wide as you would like? Yes ☐ No ☒ 14. Does your jaw click when you chew? Yes ☐ No ☒ 15. Do you ever have fits or convulsions? Yes ☐ No ☒ 16. Do you have a tendency to faint? Yes ☐ No ☒ 17. Do you have any blood disorder such as anemia (thin blood)? Yes ☐ No ☒ 18. Are you excessively nervous? Yes ☐ No ☒ 19. WOMEN - Are you pregnant at the present time? Yes ☐ No ☒

HEALTH UPDATE:

Date: year _____ / month _____ / day _____ Patient's Signature _____

Patient: JONES, ARCHIE EDWARD
ANMED HEALTH MRN: 000-06-6441 ACCT #: 5768260
800 North Fant DOB: 02/22/1962 Age: 45 Sex: Male
Street Patient Loc: 01
Anderson SC 29621 Admit Provider: Richards, Robert W

7/10/2007 08:42:00 A/G Ratio, Globulin, LDL, Creatinine, eGFR (African American), eGFR, RISK RATIO, VLDL, Alkaline Phosphatase, Albumin, Triglycerides, Glucose, Cholesterol, HDL, Anion CHEMISTRY

GENERAL BLOOD CHEMISTRY

Gap, Sodium, Calcium, Potassium, BUN, Total Protein, ALT (SGPT), CO2, AST (SGOT), Chloride, Total Bilirubin:
Test(s) performed at AnMed Health Women's & Children's Hospital, E Greenville St, Anderson, SC 29621

Legend: L= Low H= High f= footnote C=Critical c= corrected
Report Creation Date/time: 7/10/2007 11:56

Patient: JONES, ARCHIE EDWARD
 ANMED HEALTH MRN: 000-06-6441 ACCT #: 5768260
 800 North Fant ~~0000 01/10/2007 11:56~~ Sex: Male
 Street Patient Loc: 01 ~~0000 01/10/2007 11:56~~
 Anderson SC 29621 Admit Provider: Richards, Robert W

CHEMISTRY

GENERAL BLOOD CHEMISTRY

Date 7/10/2007
 Time 08:42:00
 Day of Stay Tue

Procedure		Units	Ref Range
Total Protein	6.6	g/dL	6.6-8.2
Albumin	4.0	g/dL	3.3-4.9
Globulin	2.6	g/dL	
A/G Ratio	1.5		
Glucose	104	mg/dL	70-110
BUN	36 Hf	mg/dL	5-23
Creatinine	1.4	mg/dL	0.5-1.5
Calcium	8.7	mg/dL	8.5-10.3
Sodium	140	mmol/L	135-146
Potassium	3.9	mmol/L	3.5-5.2
Chloride	104	mmol/L	96-109
CO2	27	mmol/L	22-34
Anion Gap	9	mmol/L	4-15
Total Bilirubin	0.50	mg/dL	0.00-1.00
Alkaline Phosphatase	86	units/L	50-135
ALT (SGPT)	38	units/L	0-60
AST (SGOT)	13	units/L	0-40
Triglycerides	150	mg/dL	0-150
Cholesterol	172	mg/dL	0-200
HDL	39 L	mg/dL	40-60
LDL	103	mg/dL	
VLDL	30	mg/dL	0-30
RISK RATIO	4.4		
eGFR	54		
eGFR (African American)	>60		

Legend: L- Low H- High f- footnote C-Critical c- corrected
 Report Creation Date/time: 7/10/2007 11:56

Patient: JONES, ARCHIE EDWARD
 ANMED HEALTH MRN: 000-06-6441 ACCT #: 5768260
 800 North Fant Street ~~7/30/2006~~ Sex: Male
 Patient Loc: 01
 Anderson SC 29621 Admit Provider: Richards, Robert W

HEMATOLOGY

PERIPHERAL BLOOD COUNTS

Date 7/10/2007
 Time 08:42:00
 Day of Stay Tue

Procedure		Units	Ref Range
WBC	5.90	K/microL	3.50-10.80
RBC	4.12 L	M/microL	4.20-5.80
HGB	13.8	g/dL	13.0-17.0
HCT	38.7	%	38.5-52.0
MCV	93.8	fL	80.0-100.0
MCH	33.5	PG	25.9-34.9
MCHC	35.7	g/dL	32.0-36.0
RDW	13.4	%	11.0-15.0
PLT	168	K/microL	150-450
MPV	8.1	fL	7.4-10.4
Neutrophil %	59.5	%	43.0-75.0
Lymphocyte %	29.0	%	18.0-46.0
Monocyte %	8.6	%	2.0-12.0
Eosinophil %	2.7	%	0.0-6.0
Basophil %	0.2	%	0.0-2.0
Neutrophil #	3.50	K/microL	1.50-8.10
Lymphocyte #	1.70	K/microL	0.60-5.00
Monocyte #	0.50	K/microL	0.10-1.30
Eosinophil #	0.20	K/microL	0.00-0.65
Basophil #	0.00	K/microL	0.00-0.20
Manual Differential	Not Indicated		

7/10/2007 08:42:00 Manual Differential, MCV, HGB, RBC, WBC, Monocyte
 #, Lymphocyte #, Neutrophil #, Basophil %, Eosinophil %, Monocyte %, Lymphocyte
 %, Neutrophil %, MPV, PLT, RDW, MCHC, MCH, Basophil #, Eosinophil #, HCT:
 Test(s) performed at AnMed Health Women's & Children's Hospital, E
 Greenville St, Anderson, SC 29621

Legend: L= Low H= High f= footnote C=Critical c= corrected
 Report Creation Date/time: 7/10/2007 11:56

CT CHEST W/O

ANMED HEALTH
800 NORTH FANT STREET
ANDERSON SC 29621

RADIOLOGY REPORT

Pat. Name: JONES, ARCHIE EDWARD
Address: 1229 SALEM CHURCH RD
ANDERSON, SC 29625
Unit/Room: CT/0000
DOB: 30-Jul-1943
Sex: M

MR#: 000066441
Ord. Phys.: JUNE PETRYSEN SOUVIRON
Service Date/Time: 09/05/2007 11:30 AM
Order#: E-03460125
PROC: CT CHEST W/O
Attend. Prov.: JUNE PETRYSEN SOUVIRON

JONES CT CHEST WITHOUT CONTRAST

CLINICAL HISTORY: Pulmonary fibrosis, severe asthma, shortness of breath, and atypical chest pain.

TECHNIQUE: Multiple helical images were obtained at 5mm from the level of the thoracic inlet through the adrenal glands without injection of intravenous contrast. Additional sagittal and coronal 2D reconstructions were performed after axial helical acquisition.

FINDINGS: CT examination demonstrates symmetry of the thyroid lobes.

There is a nodular density in the anterior mediastinum which measures 1.5 x 1.4 cm. There is a right paratracheal lymph node which measures 9.2 x 5.9 mm. There is no significant hilar adenopathy.

There is no evidence for pleural or pericardial effusion.

Parenchymal lung windows demonstrate mild coarsening of the interstitial markings anteriorly within the upper lobes of the lungs bilaterally. There is mild coarsening of the interstitial markings anteriorly within the right middle lobe. There is no evidence for pleural or pericardial effusion.

Examination demonstrates the liver to be of normal size and density. Small stones are identified in the gallbladder. No pancreatic abnormality is identified. The spleen is within normal limits. The adrenal glands are of normal size and morphology. The kidneys are unremarkable.

IMPRESSION:

1. CHANGES OF PULMONARY FIBROSIS.
2. THERE IS A 1.5 X 1.4 CM LYMPH NODE IN THE ANTERIOR MEDIASTINUM. NO SIGNIFICANT ADENOPATHY IS IDENTIFIED ELSEWHERE ABOUT THE MEDIASTINUM.

*** report continues next page ***

Dictated Date/Time: 09/05/2007 11:58 AM Dictated By: MONICA HOIER GRIER, M.D.
Transcr. By: FWALTERS Reviewed By:
Transcr. Date/Time: 09/05/2007 12:10 PM Approved Date/Time: 09/05/2007 12:16 PM
Page 1

XR FOOT (MIN 3 VIEWS)

ARMED HEALTH
800 NORTH FANT STREET
ANDERSON SC 29621

RADIOLOGY REPORT

Pat. Name: JONES, ARCHIE EDWARD
Address: 1229 SALEM CHURCH RD
ANDERSON, SC 29625
Unit/Room: XR/0000
DOB: 30-Jul-1943
Sex: M

MR#: 000066441
Ord. Phys.: JUNE PETRYSZN SOUVIRON
Service Date/Time: 09/21/2007 3:35 PM
Order#: E-03474524
PROC: XR FOOT (MIN 3 VIEWS)
Attend. Prov.: JUNE PETRYSZN SOUVIRON

JONES RIGHT FOOT THREE VIEWS

HISTORY: Ulcer first MTP region rule out osteomyelitis.

Three views of the right foot demonstrate old erosion of the first metatarsal head with degenerative change of the metatarsal joint. Findings very similar to 10-4-05 study. Old amputation deformity of the right fifth toe is noted with old fracture of proximal phalanx of the fourth toe, unchanged from the past study. There is soft tissue swelling adjacent to the first MTP joint, but no gas collection is seen and unchanged soft tissue calcification is seen. No acute appearing erosion or new bone formation or gas collection is seen that would indicate osteomyelitis.

IMPRESSION:

CHRONIC BONE AND JOINT CHANGES SIMILAR TO 10-4-05. SOFT TISSUE SWELLING OF THE FIRST TOE AND MTP JOINT IS NEW IN THE INTERVAL. NO RADIOGRAPHIC EVIDENCE FOR OSTEOMYELITIS.

APPROVED BY: JOSEPH W. YON, JR., M.D.

Dictated Date/Time: 09/21/2007 3:49 PM
Transcr. By: VWEBBER
Transcr. Date/Time: 09/21/2007 3:57 PM

Dictated By: JOSEPH W. YON, JR., M.D.
Reviewed By:
Approved Date/Time: 09/21/2007 5:08 PM
Page 1

Patient: JONES, ARCHIE EDWARD
 ANMED HEALTH MRN: 000-06-6441 ACCT #: 5851793
 800 North Fant Street DOB: 10/30/1936 Age: 70 Sex: Male
 Patient Loc: 01
 Anderson SC 29621 Admit Provider: Souviron, June Petryszn

CHEMISTRY

GENERAL BLOOD CHEMISTRY

Date 10/8/2007
 Time 11:35:00
 Day of Stay Mon

Procedure		Units	Ref Range
Glucose	120 H	mg/dL	70-110
BUN	38 H	mg/dL	5-23
Creatinine	1.8 H	mg/dL	0.5-1.3
Calcium	9.6	mg/dL	8.5-10.3
Sodium	140	mmol/L	135-146
Potassium	4.5	mmol/L	3.5-5.2
Chloride	104	mmol/L	96-109
CO2	27	mmol/L	22-34
Anion Gap	9	mmol/L	4-15
ALT (SGPT)	41	units/L	0-60
AST (SGOT)	15	units/L	0-40
eGFR	41		
eGFR (African American)	49		

10/8/2007 11:35:00 eGFR:

The NKDEP recommends that eGFR readings of greater than 60 mL/min not be reported due to potential inaccuracies.
 eGFR should be correlated with the patient's clinical status.
 Chronic kidney disease is defined as either kidney damage or GFR less than 60 mL/min/1.73 m² for at least three months.

Stages of Chronic Kidney Disease:

Stage	Description	eGFR (mL/min/1.73m ²)
1	Kidney damage with normal or increased GFR	greater than 90
2	Kidney damage with mild decreased GFR	60-89
3	Moderate decreased GFR	30-59
4	Severe decreased GFR	15-29
5	Kidney Failure	less than 15 (or dialysis)

NOTE: The MDRD formula as used above for eGFR is not recommended for drug dosage calculations.

10/8/2007 11:35:00 Creatinine, eGFR (African American), eGFR, Glucose, Anion Gap, Sodium, Calcium, Potassium, BUN, ALT (SGPT), AST (SGOT), CO2, Chloride:

Legend: L= Low H= High f= footnote C=Critical c= corrected
 Report Creation Date/time: 10/8/2007 15:48

Patient: JONES, ARCHIE EDWARD
ANMED HEALTH MRN: 000-06-6441 ACCT #: 5851793
800 North Fant DOB: [REDACTED] Age: [REDACTED] Sex: Male
Street Patient Loc: 01
Anderson SC 29621 Admit Provider: Souviron, June Petryszn

CHEMISTRY

GENERAL BLOOD CHEMISTRY

Test(s) performed at AnMed Health Women's & Children's Hospital, E
Greenville St, Anderson, SC 29621

Legend: L- Low H- High f- footnote C-Critical c- corrected
Report Creation Date/time: 10/8/2007 15:48

Patient: JONES, ARCHIE EDWARD
 ANMED HEALTH MRN: 000-06-6441 ACCT #: 5851793
 800 North Fant DOB: 7/29/1928 Age: 79 Sex: Male
 Street Patient Location: 800 North Fant
 Anderson SC 29621 Admit Provider: Souviron, June Petryszn

HEMATOLOGY

PERIPHERAL BLOOD COUNTS

Date 10/8/2007
 Time 11:35:00
 Day of Stay Mon

Procedure		Units	Ref Range
WBC	7.40	K/microL	3.50-10.80
RBC	4.57	M/microL	4.20-5.80
HGB	15.3	g/dL	13.0-17.0
HCT	43.2	%	38.5-52.0
MCV	94.4	fL	80.0-100.0
MCH	33.4	PG	25.9-34.9
MCHC	35.4	g/dL	32.0-36.0
RDW	13.1	%	11.0-15.0
PLT	248	K/microL	150-450
MPV	7.9	fL	7.4-10.4
Morphology	Normal		
Segmented Neutrophil	68	%	43-75
Lymphocyte	22	%	18-46
Monocyte	7	%	2-12
Eosinophil	3	%	0-6

10/8/2007 11:35:00 MCV,HGB,RBC,WBC,MPV,PLT,RDW,MCHC,MCH,HCT:
 Test(s) performed at AnMed Health Women's & Children's Hospital, E
 Greenville St, Anderson, SC 29621
 10/8/2007 11:35:00 Monocyte,Morphology,Eosinophil,Lymphocyte,Segmented
 Neutrophil:
 Test(s) performed at AnMed Health Women's & Children's Hospital, E
 Greenville St, Anderson, SC 29621

Legend: L= Low H= High f= footnote C=Critical c= corrected
 Report Creation Date/time: 10/8/2007 15:48

ANMED HEALTH Patient: JONES, ARCHIE EDWARD
 800 North Fant MRN: 000-000644377 ACCT# 11445852793
 Street DOB: 4/28/1936 Age: 68 years Sex: Male
 Anderson SC 29621 Patient Loc: 01
 Admit Provider: Souviron, June Petryszn

URINALYSIS

ROUTINE URINALYSIS

Date	10/8/2007		
Time	11:35:00		
Day of Stay	Mon		
Procedure		Units	Ref Range
U Appearance	Clear		Clear
U Color	Straw		Straw
U Specific Gravity	1.020		1.002-1.035
U pH	6.0		5.0-7.5
U Glucose	Negative	mg/dL	Negative
U Bilirubin	Negative		Negative
U Ketones	Negative	mg/dL	Negative
U Protein	Negative	mg/dL	Negative
U Urobilinogen	0.2	EU/dL	0.2-1.0
U Blood	Negative		Negative
U Nitrite	Negative		Negative
U Leukocyte Esterase	Negative		Negative
Micro Indicated	Not Indicated		Not Indicated

10/8/2007 11:35:00 Micro Indicated, U Ketones, U Bilirubin, U Glucose, U
 Color, U Urobilinogen, U Protein, U Blood, U pH, U Specific Gravity, U
 Appearance, U Leukocyte Esterase, U Nitrite:
 Test(s) performed at AnMed Health Women's & Children's Hospital, E
 Greenville St, Anderson, SC 29621

Legend: L= Low H= High f= footnote C=Critical c= corrected
 Report Creation Date/time: 10/8/2007 15:48

ANMED HEALTH**Radiology Consult Report**

PT NAME: **ARCHIE EDWARD JONES**
DOB: **07/30/1955**
SEX: **M** LOCATION: **CT CLINIC CODE / 0000 /**
ORDERING: **JUNE PETRYSZN SOUVIRON**
DOS: **09/05/2007 11:30 AM**
EXAM ID#: **3460125**

MRN: **000066441**
STATUS: **OR**
Acct #: **5811216**
PHONE: **(864)231-7003**
EXAM CODE: **AH - 4260401**

JONES**CT CHEST WITHOUT CONTRAST**

CLINICAL HISTORY: Pulmonary fibrosis, severe asthma, shortness of breath, and atypical chest pain.

TECHNIQUE: Multiple helical images were obtained at 5mm from the level of the thoracic inlet through the adrenal glands without injection of intravenous contrast. Additional sagittal and coronal 2D reconstructions were performed after axial helical acquisition.

FINDINGS: CT examination demonstrates symmetry of the thyroid lobes.

There is a nodular density in the anterior mediastinum which measures 1.5 x 1.4 cm. There is a right paratracheal lymph node which measures 9.2 x 5.9 mm. There is no significant hilar adenopathy.

There is no evidence for pleural or pericardial effusion.

Parenchymal lung windows demonstrate mild coarsening of the interstitial markings anteriorly within the upper lobes of the lungs bilaterally. There is mild coarsening of the interstitial markings anteriorly within the right middle lobe. There is no evidence for pleural or pericardial effusion.

Examination demonstrates the liver to be of normal size and density. Small stones are identified in the gallbladder. No pancreatic abnormality is identified. The spleen is within normal limits. The adrenal glands are of normal size and morphology. The kidneys are unremarkable.

IMPRESSION:

1. CHANGES OF PULMONARY FIBROSIS.
2. THERE IS A 1.5 X 1.4 CM LYMPH NODE IN THE ANTERIOR MEDIASTINUM. NO SIGNIFICANT ADENOPATHY IS IDENTIFIED ELSEWHERE ABOUT THE MEDIASTINUM.
3. THERE IS COARSENING OF THE INTERSTITIAL MARKINGS ANTERIORLY WITHIN THE RIGHT MIDDLE LOBE.

ARMED HEALTH

Radiology Consult Report

PT NAME: **ARCHIE EDWARD JONES**

DOB: **[REDACTED]**

SEX: **M** LOCATION: **CT CLINIC CODE / 0000 /**

MRN: **000066441**

STATUS: **OP [REDACTED]**

Acct #: **5811216**

ORDERING: **JUNE PETRYSZN SOUVIRON**

DOS: **09/05/2007 11:30 AM**

PHONE: **(864)231-7003**

EXAM ID#: **3460125**

EXAM CODE: **AH - 4260401**

4. NO FOCAL PARENCHYMAL LUNG MASS, HOWEVER, IS IDENTIFIED.

DICTATED: **MONICA HOIER GRIER, M.D. Sep 05, 2007 11:58**

ELECTRONICALLY VERIFIED: **MONICA HOIER GRIER, M.D. Sep 05, 2007 12:16**

TRANSCRIBED BY: **PAULINE WALTERS Sep 05, 2007 12:10**

*****END OF REPORT 3460125*****

ANMED HEALTH**Radiology Consult Report**

PT NAME: **ARCHIE EDWARD JONES**
DOB: **09/21/1945**
SEX: **M** LOCATION: **X-RAY / 0000 /**
ORDERING: **JUNE PETRYSZN SOUVIRON**
DOS: **09/21/2007 03:35 PM**
EXAM ID#: **3474524**

MRN: **000066441**
STATUS: **OP**
Acct #: **5837035**
PHONE: **(864)231-7003**
EXAM CODE: **AH - 4210503**

JONES RIGHT FOOT THREE VIEWS

HISTORY: Ulcer first MTP region rule out osteomyelitis.

Three views of the right foot demonstrate old erosion of the first metatarsal head with degenerative change of the metatarsal joint. Findings very similar to 10-4-05 study. Old amputation deformity of the right fifth toe is noted with old fracture of proximal phalanx of the fourth toe, unchanged from the past study. There is soft tissue swelling adjacent to the first MTP joint, but no gas collection is seen and unchanged soft tissue calcification is seen. No acute appearing erosion or new bone formation or gas collection is seen that would indicate osteomyelitis.

IMPRESSION:

CHRONIC BONE AND JOINT CHANGES SIMILAR TO 10-4-05. SOFT TISSUE SWELLING OF THE FIRST TOE AND MTP JOINT IS NEW IN THE INTERVAL. NO RADIOGRAPHIC EVIDENCE FOR OSTEOMYELITIS.

Dictated: **JOSEPH W. YON, JR., M.D. Sep 21, 2007 15:49**
Electronically verified: **JOSEPH W. YON, JR., M.D. Sep 21, 2007 17:08**

Transcribed by: **VERONICA WEBBER Sep 21, 2007 15:57**

*****END OF REPORT 3474524*****

Center for Emotional Restructuring®**Robert A. Moss, Ph.D., ABPP**
Clinical Psychologist**NEUROPSYCHOLOGICAL EVALUATION**

NAME: Eddie (Archie) Jones, Jr.
DATE OF EVALUATION: 6/29/07
EDUCATION: 13
DOB: [REDACTED]
HANDEDNESS: Right

REASON FOR EVALUATION: Mr. Jones was referred by Kathryn Williams, Esquire, for a neuropsychological evaluation tied to his work injury. Specifically, there is a question as to whether neuropsychological testing would be consistent with Dr. Richards' diagnosis of a brain injury from that injury.

EVALUATION CONTENT: The present evaluation is based on a clinical interview, a review of medical records, and the administration of the following tests: Wechsler Adult Intelligence Test-III (WAIS-III), Wechsler Memory Scale-III (WMS-III), Wechsler Test of Adult Reading (WTAR), California Verbal Learning Test-II (CVLT-II), Symbol Digit Modality Test (SDMT), Dot Counting Test (DCT), Test of Memory Malingering (TOMM), hand dynamometer, finger tapping, Luria-Nebraska Neuropsychological Battery Items, Boston Naming Test (BNT), Delis-Kaplan Executive Function System (D-KEFS), Wisconsin Card Sorting Test (WCST), Rey Complex Figure Test (RCFT), Frontal Systems Behavior Scale (FrSBe), and Personality Assessment Inventory (PAI).

MEDICAL RECORDS: The medical records indicate he suffered a severe (40% of his body) chemical burn injury on 6/3/97. He had lung damage and critical respiratory status. He was discharged from the burn unit at MUSC on 9/25/97. Dr. Richards' records indicate a diagnosis of bipolar disorder due to TBI and cognitive disorder NOS due to TBI. In his report on Mr. Jones of 8/9/01, mental status examination revealed anxious and depressed mood and tangential associations. He notes problems with Mr. Jones' sustained attention with an inability to complete a "go, no go task" and poor recall. The described category fluency would seem consistent with an average level. He considered Mr. Jones totally disabled due to the brain injury. Based on Dr. Richards' records, he made the original diagnosis of a brain injury in 1999.

There are several CT scans, MRIs, and MRAs of the brain that have been essentially normal. Two were done at the time he was believed to have TIAs, once in 2001 and again in 2004. Thus, no permanent vascular effects were identified. The last MRI I saw was in 2005.

INTERVIEW DATA: Mr. Jones indicates that he was injured in a chemical fire. He notes he was trapped in a room and had to run through the hot chemical to escape. He was in ICU in the MUSC burn unit for 3.5 months and hospitalized a total of 4 months. He now has 46% of his lung capacity and estimates having had about 40 surgeries.

Mr. Jones has memory and concentration problems, indicating Dr. Richardson diagnosed him with brain damage. He reports changes in reading and receptive language

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Page 2

comprehension. He notes a change in his spelling ability. He admits to changes in calculation abilities. He has had changes in his ability to organize and plan. He spontaneously reports great difficulty in making decisions. He reports no change in mechanical abilities and getting lost. He denies any change in music appreciation. He admits to word finding problems, but rarely has paraphasic errors.

Mr. Jones sleeps well with his medication. His appetite is high and his energy level is low. He denies crying spells and suicidal thoughts. He denies dysphoric mood. He finds decreased enjoyment in activities. He has experienced panic attacks but denies any recently. He denies problems being irritable since he started Risperdal. He reports corner of the eye illusions but no hallucinations.

Mr. Jones' medications include: Albuterol, Atrovent, Combivent, Xopenex, Pulmacort, Serevent, Singulair, Humibid, Prednisone, Furosemide, Theophylline, Mycelex, Risperdal, Zolof, Lamisil, Colace, Prevacid, Celebrex, Diltiazem, Levothyroxine, Flomax, Plavix, aspirin, Lidoderm patch, and Duoderm patch. He denies any history of mental health treatment prior to his injury. He was briefly seen by the 3M EAP prior to seeing Dr. Richardson. He saw a counselor in Dr. Richards' office about 4 to 5 years ago. He does not drink alcohol. He denies the use of street drugs. He denies prior legal problems.

Mr. Jones is from South Carolina, being reared by both parents. Both are deceased. Her father farmed and later worked in textiles. He demonstrated no physical affection. He used fair corporal punishment, but was verbally abusive. He is unsure if his father drank alcohol.

His mother was a nurse. She demonstrated no physical affection. She used little punishment and was not verbally abusive. She drank no alcohol. Mr. Jones has 9 siblings.

Mr. Jones graduated high school and had one year of college. He reports having made A's until the 9th grade. He lost interest at that time, but believes he still made A's through C's. He was outgoing and denied being picked on. He got in trouble for mischievous acts.

Mr. Jones only marriage has been for 45 years. He indicates things improved when he started the Risperdal. He notes that he was gone a lot while he was working. He had 2 sons. One died at the age of 34 due to a subarachnoid hemorrhage. He has a positive relationship with his 44 year old son. He has no grandchildren.

Mr. Jones last worked for 3M in 1998. He was placed into a position initially using AutoCAD, though he had problems in learning to do it. He "had no short term memory" and a short attention span. Dr. Richards finally took him out of work due to Mr. Jones being unable to cope.

Mr. Jones denies any history of head injuries or serious MVAs.

Mr. Jones resides in a house with his wife. She does the cleaning. He does the cooking. They both do laundry and shopping. He mows the lawn with a riding mower. He leaves the television on, though he rarely watches it. He listens to little music. He does little reading. Old cars are his hobby. He occasionally visits his niece and nephew. His nephew spends Wednesday nights with him. A friend visits about twice a week. He occasionally visits his friend. He goes out to eat about twice a week. He attends no

Page 3

movies. He has not attended church for about a year. He attends a car event about twice a year in Tennessee.

MENTAL STATUS: Mr. Jones arrived at 7:25 am and left at 3:05 pm. He took 1 short break during the course of the evaluation, but no lunch break. He had taken his Furosemide, Risperdal, Zoloft, Colace, Celebrex, Plavix, and aspirin the morning of the evaluation. He took no other medications during the time of the evaluation, commenting that he had forgotten to bring his noontime medication. He demonstrated good perseverance during testing despite his reporting he was fatigued.

He was oriented in all spheres. He answered questions in a relevant and coherent fashion, being detailed in information he conveyed. He demonstrated some tangentiality as he recounted details. He related in a pleasant and friendly fashion, at times having a rather robust laugh. Affect was generally appropriate. Memory for recent and remote events appears grossly intact. He appears clean and well groomed. He was cooperative. I see no evidence of hallucinations, delusions or any psychotic thought processes. He appears capable of recognizing and avoiding hazards. Insight tied to psychological factors appears fair.

TEST RESULTS:

TEST OF EFFORT: On the TOMM, he had a score of 38 and 49 on the first and second trials, respectively. This is consistent with sufficient effort. On the forced choice recognition task of the CVLT-II, he had 81% (13 of 16) accuracy. This is below what was expected, though it is well above chance level. On the DCT, he had an E-score of 17, falling below the cutoff score of 20 for head injury patients. This is indicative of sufficient effort. His reliable digit span of 11 is in a range suggesting sufficient effort. On the Rarely Missed index of the WMS-III, he had a score of 226 and is consistent with sufficient effort. Thus, on the basis of measures of effort, it is felt that testing is valid and interpretable.

INTELLECTUAL FUNCTIONS: On the WAIS-III he obtained a Verbal IQ of 115, a Performance IQ of 100, and a Full Scale IQ of 109. These results indicate he is functioning in the average to high average range of functioning. There is a significant difference between the verbal and performance IQs. This is largely explained on the basis of his poorer than expected performance on Digit Symbol. His verbal IQ is felt to be the best indicator of pre-morbid functioning and is used as the point of comparison for other results.

READING TEST: On the WTAR, he obtained a standard score of 113. There is no significant difference on any of the IQ scores based on this test.

MEMORY FUNCTIONS: On the CVLT-II he recalled 4 out of 16 words on the first trial of list A, falling in the borderline range. On Trial B he recalled 5 of 16 words, which is in the average range. Such a discrepancy often occurs due to anxiety on the initial

Page 4

presentation of the list. On the fifth learning trial, he recalled 8 words, falling in the low average range. His total recall of words across the five learning trials was in the low average range ($T = 38$). Based on his Verbal IQ, this would be significantly lower than expected (i.e., 2 standard deviations). Across learning trials, he showed an average learning curve. The use of semantic clustering, the most effective learning strategy, was in the low average range. In the short delay free and cued recall, he fell in the average range. He was in the low average range for long delay free recall, and the borderline range for long delay cued recall. His across trial consistency was in the significantly low range, indicating trouble developing an effective learning strategy. Total recall and recognition discriminability was in the average range, though his total recognition hits was in the low average range.

On the WMS-III, he obtained indexes of 77 for auditory-immediate, 91 for visual-immediate, 80 for immediate memory, 80 for auditory-delayed, 100 for visual-delayed, 85 for auditory recognition-delayed, 86 for general memory, and 102 for working memory. There is a significant difference between auditory immediate and visual immediate, auditory delayed and visual delayed, immediate memory and working memory, and general memory and working memory. When considering the predicted memory index scores based on his full scale IQ, auditory immediate, immediate memory, auditory delayed, auditory recognition delayed, and general memory indexes are significantly below that expected. The immediate and general memory indexes are significantly lower than expected on the basis of the WTAR results. His recall of logically related information (scaled score of 8) was much better than on logically unrelated words (scaled score of 4). The overall results are suggestive of verbal memory problems that are worse on unrelated words versus sensible stories.

On the RCFT, he fell in the average range for copying the figure and the time required to complete it. He was in the average range for immediate recall, delayed recall, and recognition total correct. The profile best fits a normal pattern. This is consistent with the WMS-III visual memory results. Thus, there are no indications of problems in visual memory.

ATTENTION: On the WAIS-III, simple attention for digit repetition fell in the average range, consistent with the auditory attention span results on Trial B of the CVLT-II. Thus, he appears to have intact simple auditory span.

On Trail Making for numbers he was in the average range. His performance on the letters condition was in the high average range. This would be consistent with intact simple attention.

On the written SDMT, he obtained a score of 23, falling in the significantly impaired range (-2.5 SDs) average range. He did better on the Digit Symbol, though this was significantly lower than expected (scaled score of 6). These results are suggestive of problems in divided attention and processing speed.

EXECUTIVE FUNCTIONS: On Trail Making, he was in the average range for all conditions, including number-letter sequencing. He was in the average range for category switching accuracy on verbal fluency. These results suggest intact cognitive flexibility.

Page 5

On the D-KEFS Color-Word Interference Test he had lower than expected scores on color naming (scaled score of 4) and word reading. This would be consistent with slower processing speed. He was in the average range for the inhibition-switching condition, and the low average range for inhibition/switching. Thus, there would appear to be no difficulties in his inhibiting pre-potent verbal responses.

On the D-KEFS Tower Test, he obtained a total achievement score in the average range. This suggests intact spatial problem solving ability.

On the WCST, he achieved 4 categories for 124 cards and had 39 perseverative errors. The number of perseverative errors is significantly higher than expected based on the Rhodes data (2004).

MOTOR FUNCTIONS: His best of two grip strength trials was 36 kg. on the right hand and 42 for the left hand. The right hand grip strength is lower than expected. Peripheral factors likely play a role. Finger tapping average for 10 seconds was 58 for the right and 54 for the left, falling in the expected range. There were no signs of ideational or ideomotor apraxia.

TACTILE FUNCTIONS: The ability to identify objects by touch alone is intact bilaterally.

VISUAL FUNCTIONS: Visual fields were grossly full as assessed by confrontation. He shows an intact ability to recognize objects and pictures. He did well with embedded figures. Trail Making scanning ability falls in the average range.

LANGUAGE FUNCTIONS: Receptive and expressive language functions appear intact for both phonemes and words. Relational speech is basically intact. Phonemic (letter) fluency was in the borderline range and is consistent with his reported word finding difficulties. Semantic (category) fluency was in the average range. Confrontation naming on the BNT was in the expected range (59).

PSYCHOLOGICAL TESTING: The PAI Positive Impression Management and Negative Impression Management Scales indicate the profile is valid. In reference to the clinical scales, he only shows a marked elevation on the somatic scale. Given his severe physical problems, this is expected. Notably, there are no indications of a depressive or anxiety disorder.

BEHAVIORAL SCALES: On the Self Rating of the FrSBe, he notes no significant problems before his injury. He does have significant ratings at the current time for Apathy (T = 87), Disinhibition (T = 78), Executive Dysfunction (T = 74), and Total (T = 87). These results are in a range consistent with a brain injury, and would not be attributable to depression or anxiety based on his denial of significant symptoms of anxiety and depression both in the interview and on the PAI.

Page 6

DIAGNOSTIC IMPRESSIONS:

Axis 1. Cognitive Disorder due to brain injury

Personality Change due to brain injury

Axis 2. No diagnosis

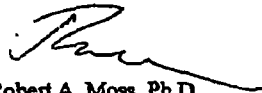
Axis 3. Pulmonary problems; hypertension; history of suspected TIAs

Axis 4. Financial concerns

Axis 5. GAF = 60

CONCLUSIONS: On the basis of the present examination, it appears that Mr. Jones has verbal memory impairment, divided attention problems, problems with phonemic fluency, and problems in some areas of executive functioning (FrSBe and WCST results). These test results are consistent with the problems reported by Mr. Jones in the clinical interview. Based on the medical records, these results are also consistent with Dr. Richards' observations and diagnosis made in 1999. The most probable cause is hypoxia. I am unfamiliar with the chemical involved in his burns, and as a result cannot rule out the possibility of brain damage from a toxic substance. His normal imaging results have ruled out the possibility that vascular events would account for the current evaluation results. In conclusion, it is my opinion that Mr. Jones' work injury resulted in a brain injury.

I have scheduled an appointment to discuss the evaluation results with Mr. Jones. I want to thank you for your referral of this gentleman and feel free to contact me if I can provide further information.



Robert A. Moss, Ph.D
Clinical Psychologist

Diplomate, American Board of Professional Neuropsychology
Diplomate in Clinical Psychology, American Board of Professional Psychology

GREENVILLE UROLOGY, P.A.

52 Bear Drive Greenville, SC 29605 Ph (864)295-2131 F (864)269-8035

*Charlton P. Armstrong, III, MD ~ Michael S. Mathers, MD ~ J. David Rice, MD ~ J. Robert Monroe, MD
Thomas E. Hamilton, MD ~ Andrew R. Bullock, MD ~ L. Allyson Curry, ANP
Charlton P. Armstrong, Jr., MD (1919-1999) ~ Mordecai Nachman, MD (1907-1970)*

PatientID: 41026AJ

Patient Name: ARCHIE E JONES, JR

Date of Birth: 05/20/1943 SSN: 288-78-1022

Date of Service: 08/08/2007

REFERRED BY: Mr. Jones, Jr is referred for consultation by June Souviron, MD.

CHIEF COMPLAINT: Archie Jones, Jr is a 64 Y old M. Patient is seen as a new patient to the practice. Patient c/o ED, frequency and urgency. PSA 2/07 = 1.8.

HISTORY OF PRESENT ILLNESS:

ERECTILE DYSFUNCTION: The patient complains of difficulty with erections for greater than 5 years.

LOWER URINARY TRACT OBSTRUCTION: Need to urinate during the night occurs 4 to 5 times.

The symptoms began several years ago. The urine stream is moderate. There is a history of trauma.

PAST MEDICAL HISTORY:

MEDICAL: Chronic lung disease, hypertension, melanoma, hypothyroidism, TIA.

SURGICAL: Numerous skin grafts due to chemical accident at 3M, 46% of body burned.

SURGICAL-UROLOGIC: TUMT (transurethral microwave therapy) 2006. Urethra repair.

CURRENT ALLERGY LIST:

NKDA

CURRENT MEDICATION LIST:

ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT,
ALBUTEROL-IPRATROPIUM INHALATION AEROSOL 103-18 MCG/ACT,
SEREVENT DISKUS INHALATION AEROSOL POWDER 50 MCG/DOSE,
PULMICORT TURBUHALER INHALATION AEROSOL POWDER 200 MCG/INH,
SINGULAR,

PREDNISOLONE SODIUM PHOSPHATE ORAL TABLET DISPERSIBLE 10 MG,

THEOPHYLLINE CR ORAL TABLET 12 HR 100 MG,

DEPAKOTE ORAL TABLET ENTERIC COATED 500 MG,

ZOLOFT ORAL TABLET 25 MG,

RISPERDAL ORAL TABLET 2 MG,

FUROSEMIDE ORAL TABLET 20 MG,

LEVOTHYROXINE SODIUM ORAL TABLET 100 MCG,

FLOMAX ORAL CAPSULE 24 HR 0.4 MG,

PLAVIX ORAL TABLET 75 MG,

GUAIFENEX PSE 120 ORAL TABLET 12 HR 120-600 MG,

DOCUSATE SODIUM ORAL TABLET 100 MG,

PREVACID ORAL CAPSULE DELAYED RELEASE 30 MG,

CELEBREX ORAL CAPSULE CONVENTIONAL 200 MG

SOCIAL HISTORY:

MARITAL STATUS: Married, living with spouse.

SMOKING: No smoking history.

ALCOHOL: No significant history of usage.

REVIEW OF SYSTEMS:

GREENVILLE UROLOGY, P.A.

52 Bear Drive Greenville, SC 29605 Ph (864)295-2131 F (864)269-8035

*Charlton P. Armstrong, III, MD ~ Michael S. Mathers, MD ~ J. David Rice, MD ~ J. Robert Monroe, MD
Thomas E. Hamilton, MD ~ Andrew R. Bullock, MD ~ L. Allyson Curry, ANP
Charlton P. Armstrong, Jr., MD (1919-1999) ~ Mordecai Nachman, MD (1907-1970)*

PatientID: 41026AJ

Patient Name: ARCHIE E JONES, JR

Date of Birth: 07/30/1963 SSN: 346670-5500

Date of Service: 08/08/2007

GU: Notes nocturia five times per night, INCREASE IN FREQUENCY OF URINATION, URINARY URGENCY. Urethral stenosis.

PHYSICAL EXAM:

CONSTITUTIONAL:

VITAL SIGNS:

VS-WEIGHT: 232lbs

VS-TEMPERATURE: 97.6°F Tympanic

VS-BLOOD PRESSURE: 130/80 Left Arm Sitting

GENITOURINARY:

SCROTUM: Normal in appearance with no cysts, rashes, tenderness, swelling, or ulcerations.

EPIDIDYMIDES: The epididymides are unremarkable.

TESTES: Right testicle descended with no swelling or tenderness, RIGHT TUNICA

VAGINALIS HYDROCELE PRESENT THAT IS 2-5 CM IN SIZE.

PHALLUS: Meatal stenosis. Mild.

PROSTATE: No enlargement, smooth, soft, symmetrical, no nodules.

SKIN: Extensive abdominal burn scars.

TESTS:

URINALYSIS MICROSCOPIC: Negative for WBC's, RBC's, bacteria, or abnormal cells.

URINALYSIS DIPSTICK: Clear, yellow, and negative for leukocyte esterase, nitrite, protein, glucose, ketones, or blood.

PVR:

PVR BY ULTRASOUND: - 40 ml

ASSESSMENT/PLAN:

600.00-HYPERTROPHY BENIGN OF PROSTATE W/O OBSTRU

599.89-UNSPECIFIED DISORDER OF URETHRA Comments: BX of Urethral catheter trauma.
1998

607.84-IMPOTENCE

MEDICATIONS:

TRIMIX PENILE INJECTION, one daily prn, 1 Dispensed, status: NEW

PRESCRIPTION, 08/08/2007. Does not work.

PATIENT EDUCATION: Patient given information sheet on vacuum erection therapy. Penile implant.

788.41-URINARY FREQUENCY

MEDICATIONS:

SANCTURA ORAL TABLET 20 MG, ONE ORAL TWICE DAILY PRN, 28

Dispensed, 28 samples given, status: NEW PRESCRIPTION, 08/08/2007.

PATIENT EDUCATION: Education sheet given to the patient.

INSTRUCTIONS/INFORMATION: Instructions/information given to patient. VED & penile implant.

RETURN VISIT: Patient instructed to return in a month.

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Charlton P. Armstrong, Jr., MD (1919-1999) ~ Mordecai Nachman, MD (1907-1970)*

PatientID: 41026AJ

Patient Name: ARCHIE E JONES, JR

Date of Birth: ~~07/08/1942~~ ~~SSN 230-34-5019~~

Date of Service: 08/08/2007

J. David Rice, M.D.

JDR/bm

CC: June Souviron, MD.

Electronically Signed by: J. David Rice, MD on Friday, August 24, 2007

GREENVILLE UROLOGY, P.A.

52 Bear Drive Greenville, SC 29605 Ph (864)295-2131 F (864)269-8035

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Thomas E. Hamilton, MD ~ Andrew R. Bullock, MD ~ L. Allyson Curry, ANP
Charlton P. Armstrong, Jr., MD (1919-1999) ~ Mordecai Nachman, MD (1907-1970)*

PatientID: 41026AJ

Patient Name: ARCHIE E JONES, JR

Date of Birth: 07/30/1942 SSN: 258-70-5112

Date of Service: 09/10/2007

REFERRED BY: Mr. Jones, Jr is referred by June Souviron, MD.

CHIEF COMPLAINT: Archie Jones, Jr is a 64 Y old M. Patient is seen for follow up of erectile dysfunction. Frequency.

PAST MEDICAL HISTORY:

MEDICAL: Chronic lung disease, hypertension, melanoma, hypothyroidism, TIA.

SURGICAL: Numerous skin grafts due to chemical accident at 3M, 46% of body burned.

SURGICAL-UROLOGIC: TUMT (transurethral microwave therapy) 2006. Urethra repair.

CURRENT ALLERGY LIST:

NKDA

MEDICATIONS:

TRIMIX PENILE INJECTION, one daily pm, 1 Dispensed, status: DISCONTINUED, 09/10/2007.

ASA 81 MD QD, status: NEW HISTORY, 09/10/2007.

COMBIVENT INHALATION AEROSOL 103-18 MCG/ACT, status: NEW HISTORY, 09/10/2007.

XOPENEX CONCENTRATE INHALATION NEBULIZATION SOLUTION 1.25 MG/0.5ML, status: NEW HISTORY, 09/10/2007.

PULMACORT, status: NEW HISTORY, 09/10/2007.

MYCELEX TROCHE, status: NEW HISTORY, 09/10/2007.

LAMISIL ORAL TABLET 250 MG, status: NEW HISTORY, 09/10/2007.

ACTONEL ORAL TABLET 35 MG, status: NEW HISTORY, 09/10/2007.

COLACE ADULT RECTAL SUPPOSITORY 3 GM, status: NEW HISTORY, 09/10/2007.

PREVACID ORAL PACK 30 MG, status: NEW HISTORY, 09/10/2007.

DILTIAZEM HCL COATED BEADS ORAL TABLET 24 HR 240 MG, status: NEW HISTORY, 09/10/2007.

LIDODERM EXTERNAL PATCH 5 %, status: NEW HISTORY, 09/10/2007.

OMEGA 3 ORAL CAPSULE CONVENTIONAL 120-180 MG, status: NEW HISTORY, 09/10/2007.

VIT C, status: NEW HISTORY, 09/10/2007.

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Thomas E. Hamilton, MD ~ Andrew R. Bullock, MD ~ L. Allyson Curry, ANP
Charlton P. Armstrong, Jr., MD (1919-1999) ~ Mordecai Nachman, MD (1907-1970)*

PatientID: 41026AJ

Patient Name: ARCHIE E JONES, JR

Date of Birth: 08/30/49 SSN: 250-40-5112

Date of Service: 09/10/2007

VIT E400MG, status: NEW HISTORY, 09/10/2007.

CALCIUM 1200, status: NEW HISTORY, 09/10/2007.

B12 500MG, status: NEW HISTORY, 09/10/2007.

POTASSIUM & MAGNESIUM ASPARTAT ORAL CAPSULE CONVENTIONAL 250-250 MG,
status: NEW HISTORY, 09/10/2007.

CHONDROITIN GKLUCOSAMINE, status: NEW HISTORY, 09/10/2007.

PHYSICAL EXAM:

CONSTITUTIONAL:

VITAL SIGNS:

VS-HEIGHT: 226R0in

VS-TEMPERATURE: 97.6°F Tympanic

VS-BLOOD PRESSURE: 140/70 Left Arm Sitting

ASSESSMENT/PLAN:

600.00-HYPERTROPHY BENIGN OF PROSTATE W/O OBSTRU

MEDICATIONS:

FLOMAX ORAL CAPSULE 24 HR 0.4 MG, status: NEW HISTORY, 08/08/2007.

607.84-IMPOTENCE

MEDICATIONS:

PGE1, pm, 1 Dispensed, status: NEW PRESCRIPTION, 09/10/2007.

PATIENT EDUCATION: Instructions/information given to patient. VED & penile implant.

788.41-URINARY FREQUENCY

MEDICATIONS:

SANCTURA ORAL TABLET 20 MG, ONE ORAL TWICE DAILY, 180 Dispensed, 3
Fills, status: NEW PRESCRIPTION, 09/10/2007, Comment: for Bladder Symptoms.

ACCOMPANIED BY: his wife.

RETURN VISIT: Patient is to return on an as needed basis.

J. David Rice, M.D.

JDR/bm

CC: June Souvion, MD.

ANMED HEALTH

Radiology Consult Report

*1:16 PM
OS CHART*

PT NAME: ARCHIE EDWARD JONES

DOB: 07/30/1943

SEX: M LOCATION: AHC AREA 4 GEN RADIO/CT / 0000 /

MRN: 000068441

STATUS: OP

Acct #: 5273100

ORDERING: FRANK OLIVER

DOS: 12/14/2005 02:37 PM

EXAM ID#: 3159185

PHONE: (864) 228-7636

EXAM CODE: 81 - 4290101

JONES MRI OF THE BRAIN WITH AND WITHOUT CONTRAST

INDICATION: Vertigo with TIA.

TECHNIQUE: This MRI is accomplished using the head coil. Images are obtained in the axial plane in a T1, T2, diffusion-weighted, and FLAIR sequences. They are obtained in the coronal plane and a proton density in T2 format and in a sagittal plane in a T1 format. After infusion of Magnevist contrast, images were repeated in the axial, sagittal and coronal plane in a T1 format.

FINDINGS: The study is of fair to good quality. The orbital and retro-orbital structures are unremarkable. The paranasal sinuses are clear. The pituitary glands are visually normal in size and signal on postcontrast enhancement pattern. The patient has normal appearing midline and fourth ventricle.

Within the posterior fossa the cerebellum and brainstem structures appear largely unremarkable. There is some mild diffuse cerebellar atrophy. The VII and VIII nerve complexes appear normal bilaterally. There is normal flow void seen in the basilar and both vertebral arteries.

Supratentorially, there are a few T2 and FLAIR hyperintensities in the subcortical white matter with a minimal degree of microischemic disease. There are no other focal lesions identified within the brain parenchyma. There is normal flow void seen in the internal artery and carotid artery. There is no abnormal diffusion weighted or postcontrast enhancement signal seen on this study. There is mild diffuse atrophy appropriate for the patient's stated age.

IMPRESSION:

THIS ENHANCED AND UNENHANCED MRI OF THE BRAIN DEMONSTRATING:

1. MILD DIFFUSE ATROPHY LIKELY APPROPRIATE FOR THE PATIENT'S STATED AGE OF 62 YEARS.

2. FEW SUBCORTICAL WHITE MATTER T2 AND FLAIR HYPERINTENSITIES MOST CONSISTENT WITH A MINIMAL DEGREE OF MICROISCHEMIC DISEASE.

RECEIVED

FEB 21 2006

SEBOWICK CMS
COLUMBIA, SC

ExamID: E-03159185 Approved

JONES, ARCHIE EDWARD

ANMED HEALTH
Radiology Consult Report

PT NAME: ARCHIE EDWARD JONES

DOB: 07/30/1943

SEX: M LOCATION: AHC AREA 4 GEN RADIO/CT / 0000 /

MRN: 000066441

STATUS: OP

Acct #: 5273100

ORDERING: FRANK OLIVER

DOS: 12/14/2005 02:37 PM

PHONE: (864) 226-7636

EXAM ID#: 3159185

EXAM CODE: 81 - 4290101

3. NO ACUTE LESION IDENTIFIED.

DICTATED: HAROLD DEAN REEVES, M.D. Dec 14, 2005 15:10

ELECTRONICALLY VERIFIED: JASON SORIANO, M.D. Dec 15, 2005 09:33

TRANSCRIBED BY: VICKIE BURDEN Dec 15, 2005 08:19

*****END OF REPORT 3159185*****

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FEB 21 2006

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COLUMBIA, SC

ExamID: E-03159185 Approved

JONES, ARCHIE EDWARD

Page 2

ANMED HEALTH

Radiology Consult Report

PT NAME: ARCHIE EDWARD JONES

DOB: 07/30/1943

SEX: M LOCATION: AHC AREA 4 GEN RADIO/CT / 0000 /

ORDERING: FRANK OLIVER

DOS: 12/14/2005 02:38 PM

EXAM ID#: 3163167

MRN: 000066441

STATUS: OP

Acct #: 5273100

PHONE: (864) 226-7638

EXAM CODE: 81 - 4290110

JONES MRA OF THE HEAD WITHOUT CONTRAST

INDICATION: Vertigo. TIA.

TECHNIQUE: This MRA was of the circle of Willis was accomplished using 3D Time-Of-Flight technique. Images were rotated around two axis. No IV contrast was administered.

FINDINGS: The study is of fair to good quality. Anteriorly the intracranial portion of the carotid arteries is seen dividing into the middle anterior cerebral arteries bilaterally. These vessels appear to be normal in size and signal without evidence of focal narrowing or dilatation.

Posteriorly two vertebral arteries are seen forming a single basilar artery which then divides into posterior cerebral arteries bilaterally. These vessels appear to be normal in size and signal without evidence of focal narrowing or dilatation. There appears to be a patent posterior communicating artery on the right side and none on the left which is a normal anatomical variant.

IMPRESSION:

NORMAL UNENHANCED MRA OF THE CIRCLE OF WILLIS.

Dictated: HAROLD DEAN REEVES, M.D. Dec 14, 2005 15:13

ELECTRONICALLY VERIFIED: HAROLD DEAN REEVES, M.D. Dec 15, 2005 14:38

TRANSCRIBED BY: VICKIE BURDEN Dec 15, 2005 09:33

*****END OF REPORT 3163167*****

RECEIVED

FEB 21 2006

SEDGWICK CMS
COLUMBIA, SC

ExamID: E-03163167 Approved

JONES, ARCHIE EDWARD

Page 1

NAME: Archie E. Jones
DATE: 12-06-05
REFERRED BY: Dr. June Souviron

Mr. Jones is a 61-year-old Caucasian gentleman who I have seen in the past on several occasions most recently in April 2004 for what possibly was a TIA in the posterior circulation. He has been on Plavix and aspirin subsequently without any recurrence.

He comes today being referred for some pain in his feet. As previously stated in his records, he has had an extensive burn injury over the legs and feet and also has some organic as well as secondary psychiatric issues with the burn and rather severe pulmonary problems.

He is describing a trigger point on the right lateral foot area. He had a toe amputated and it is kind of at the base of where that toe would have been. If you press on it he gets intense pain. He states the biggest issue is when he is wearing shoes and walking especially on uneven ground and his foot has pressure from the shoe applied to that area. He has a lot of pain which he describes as burning. He has a similar but lesser involved trigger point on the left foot.

Obviously sensation in the foot is altered by the burn and the skin grafts. He has got good pulses there. I don't see any ulcers although he has multiple pressure points where he has them bandaged up with padding on both feet and toes.

His motor examination is good in terms of dorsiflexion and plantar flexion and the reflexes at the ankle level are good.

After much discussion and consideration, I think what we will do is let him cut one of his Lidoderm patches into small squares and place it over one of those trigger points (right foot) and see whether that benefits. A secondary consideration is whether we would inject that trigger point with some steroids.

He then brings another issue up in regards to sensation of vertigo, nausea and diaphoresis with certain positional movements. He best describes it as saying when he is working on his car and he slides under it and looks up he gets this feeling. He can also get it infrequently changing positions in bed. It sounds peripheral vestibular.

Hanging head maneuver produces an ill but vague sensation of discomfort with left ear down and right ear down. However, when coming back to the seated position it sets off a brief but intense sensation that he really doesn't describe as vertigo or movement but nausea and then he gets a little diaphoretic.

He states this may occur once or twice a month just under normal conditions. He is no longer sliding under his car to work on it and I encouraged that.

Anderson Neurological Associates, P. A.
2000 East Greenville Street
Suite 2800
Anderson, South Carolina 29621

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FEB 21 2006
SEDGWICK CMS
COLUMBIA, SC

Archie E. Jones

12-06-03

Page 2

In the past, as I stated, he has had a TIA that we thought was in the posterior circulation. I would like to look at an MRI scan of his 7th and 8th nerve complexes and the posterior fossa at large. I would also like to do an MRA of the Circle of Willis to see the basilar artery.

I will review this with him in a couple of weeks.

For the record, I have interviewed him twice for neurologic consults in the past. I will not reiterate all his past history in detail since it is available. I have also got a copy of his drug list which is significantly extensive. The majority of the medication is pulmonary and psychiatric.



Frank E. Oliver, M.D.

FEO/jbw

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FEB 21 2006

SEDGWICK CMS
COLUMBIA, SC

Anderson Neurological Associates, P. A.
2000 East Greenville Street
Suite 2800
Anderson, South Carolina 29621

210 015
ANMED HEALTH
Radiology Consult Report

250-705119 WC21453
01-Chart

JONES, ARCHIE EDWARD
MR# [REDACTED]
IDX Acc # [REDACTED]
Acct# [REDACTED]
Patient Loc:
Status: D

REQUEST DATE/TIME: 06-10-2001 0917
REQUESTING PHY: SOUVIRON, JUNE PETRYSZN
REQ PHYS PH#: (864) 231-7003
ATTENDING PHY: SOUVIRON, JUNE PETRYSZN

Sex: M Age: 57 Males DOB: 07-30-1943

Exam: (AH)290101 Completed: 06-11-2001 1445

Clinical History: TIA NEURO

JONES MRI SCAN OF BRAIN W/NO CONTRAST

INDICATION: TIA.

TECHNIQUE: MRI scan of the brain is obtained using the head coil. Spin echo T1W sagittal and axial sequences as well as heavily T2W axial and coronal sequences with a spin density coronal and a FLAIR axial sequence as well as diffusion-weighted imaging in the axial plane are all completed through the calvarium. After Magnevist contrast administration spin echo T1W sagittal, axial and coronal data sets are obtained.

FINDINGS: The study is of good quality. The paranasal sinuses are well aerated and retro-orbital spaces are unremarkable. The optic chiasm-pituitary region and cranio-cervical junction regions are unremarkable. There is symmetric signal flow void within the internal carotid arteries at the level of the siphon and also within the basilar artery. In the posterior fossa the fourth ventricle has a normal size and position and with unremarkable cerebellum and brain stem structures. In the supratentorial compartment the ventricular system is symmetrical and of normal size and cortical markings normal. There is a solitary T2 hyperintensity of just a few mm in diameter involving the right mid parietal lobe adjacent to the body of the right lateral ventricle superiorly. This does not show high signal on the diffusion-weighted study. No abnormal contrast enhancing region of the brain is detected.

IMPRESSION:

THIS MRI SCAN OF THE BRAIN WITH CONTRAST SHOWS:

1. A SOLITARY, SMALL T2 HYPERINTENSITY OF THE DEEP WHITE MATTER OF THE RIGHT PARIETAL LOBE ADJACENT TO THE BODY OF THE RIGHT LATERAL VENTRICLE. THIS IS A NONSPECIFIC FINDING WHICH COULD REPRESENT A CHRONIC MICROVASCULAR INFARCT OR A SMALL AREA OF DEMYELINATION. NO EVIDENCE OF ACUTE INFARCT IS SEEN.
2. NO ABNORMAL CONTRAST ENHANCING REGION OF THE BRAIN IS IDENTIFIED.

[Continued On Next Page]

Page: 1

ARMED HEALTH
Radiology Consult Report

REQUEST TIME: 06-10-2001 0917
REQUESTING PHY: SOUVIRON, JUNE PETRYSZN
REQ PHYS (H# 864) 231-7003
ATTENDING PHY: SOUVIRON, JUNE PETRYSZN

JONES, ARCHIE EDWARD

MR#

IDX Acc #

Acct#

Patient Loc:

Status: Doctor

Sex: M Age: 57 Years DOB: 07-30-1943

Exam: (AH)290101 Completed: 06-11-2001 1445

Reading Physicians:
John Francis Pilch M.D.

Dictated on: 06-11-20011538
Transcribed on: 06-11-20011557
Finalized on: 06-12-20010915

by Pauline Walters
by John Francis Pilch M.D.

Page: 2

ARMED HEALTH
Radiology Consult Report

REQUEST DATE/TIME: 06-10-2001 2321
REQUESTING PHYS: SOUVIRON, JUNE PETRYSZN
REQ PHYS: (864) 231-7003
ATTENDING PHYS: SOUVIRON, JUNE PETRYSZN

JONES, ARCHIE EDWARD

MR#

IDX Acc #

Acct#

Patient Loc:

Status: D

Sex: M Age: 57 YEARS DOB: 07-30-1944

Exam: (AH)290110 Completed: 06-11-2001 1445

Clinical History: TIA NEURO

JONES

MRA OF THE CIRCLE OF WILLIS

TECHNIQUE: 3D time of flight MR angiography of the Circle of Willis vasculature is obtained with rotation about two axes.

The normal appearing basilar artery gives rise to left and right posterior cerebral arteries which are normal in appearance. The distal internal carotid, middle and anterior cerebral arteries are normal in appearance.

IMPRESSION:

NORMAL MR ANGIOGRAPHY OF THE CIRCLE OF WILLIS VASCULATURE.

Reading Physicians:
John Francis Pilch M.D.

Dictated on: 06-11-20011540
Transcribed on: 06-11-20011605
Finalized on: 06-12-20010915

by Betsy Phillips
by John Francis Pilch M.D.

Page: 1

Archie Jones
9-20-99

C-171941 REG

421

SUBJECTIVE: Mr. Jones returns today for follow up.

Unfortunately the history of his present illness on his initial consultation was partially lost on the tape.

This gentleman was involved in a severe burn accident in 1997 and apparently suffered cardio-pulmonary arrest a few times during his long hospitalization. He has been experiencing daytime sleepiness and decreased attention which has affected his work performance. His wife has stated he snores loudly at night and has apneas. He also has a very complex respiratory situation.

We had discussed possibly changing some of his medication and he continues on Neurontin 200 mgs twice a day and also on a dose of Atarax at night. He has really had no significant change in his function.

OBJECTIVE: This gentleman is alert, entirely appropriate in complex conversation, with good attention today. He is not obviously drowsy though does appear just slightly sluggish.

ASSESSMENT: Syndrome of excessive daytime sleepiness with some apneas at night and a complex respiratory situation. Medications such as Atarax and Neurontin could contribute. He feels Neurontin is somewhat sedating but he feels he needs the medicine. I don't think these medications could entirely explain his entire situation and suspect he may have a significant disruption of sleep. We discussed the situation at length and agreed to the following plan.

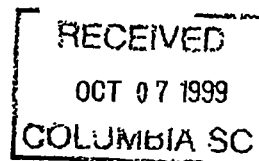
RECOMMENDATIONS: 1. We agreed to a visit with Dr. Mohan. She has recently come to town and has training in both pulmonary medicine and sleep medicine. I think she is better suited for this situation due to this gentleman's difficulty in terms of respiratory disease.

2. He will follow up with me pending that evaluation if needed. No definite appointment was made.

John. F. Pilch, M.D.

JFP/jbw

cc: Dr. June Souviron
Dr. Gowdhami Mohan
(dictated not signed to speed transmission)



FILE

AUG 23

NAME: Archie Jones
DATE: 7-1-99
REFERRED BY: Dr. June Souviron

510-171941 N.D. 421

He feels not quite as mentally sharp though he is working.

He is somewhat more overweight than he used to be as he was an avid exerciser prior to this accident but his weight has been fairly stable fluctuating about 5-10 pounds over the last year.

The past medical history includes before his accident trouble with sinusitis as well as left knee surgery. Sinus surgery, tonsillectomy and hypertension. He also had a urethra repair which apparently was a complication of having chronic Foley catheter.

CURRENT MEDS: Include Neurontin 100 mgs in the morning and 200 mgs at night as well as Colace, Duratuss, Flonase, Flovent, Serovent, Sucralfate, Cardura and also multiple inhalers. He is taking Atarax 10 mgs at bedtime which has been reduced from 40 mgs. He was on Zolofl but this seemed to contribute to sleepiness and it was stopped.

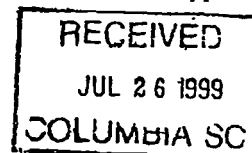
ALLERGIES: None.

SOCIAL HISTORY: He does not smoke or drink alcohol.

FAMILY HISTORY: A son died with subarachnoid hemorrhage. A son age 36 has an unusual glycogen storage disease but apparently has no weakness from this. A sister had epilepsy but she was asphyxiated as a child and it was felt secondary to this. His father died with kidney disease and his mother is 82.

REVIEW OF SYSTEMS: He has no history of cancer, heart disease, diabetes, meningitis or encephalitis. An MRI scan of brain was done in May and reports some subcortical vascular disease but was felt to be essentially normal. No obvious changes of hypoxia to gray matter structures was noted.

EXAMINATION GENERAL: This is a somewhat sleepy appearing white male moderately overweight with scarred skin over much of his body though his skin appears intact. The blood pressure is 152/84 with pulse 80 and regular. This gentleman's posterior pharynx appears fairly clear and in fact his uvula appears a bit small.



Lungs are clear to auscultation. Heart exam reveals regular rate and rhythm. The neck is supple without bruit or mass.

NEUROLOGIC: He is alert and appropriate in complex conversation. He appears entirely appropriate with normal language content detailing his past history. His visual fields are intact to finger counting. Extraocular movements are full without nystagmus. The pupils are equally round and reactive to light. The fundi show sharp discs and normal vessels. The face is symmetric with normal strength and sensation and tongue and palate move in midline.

The motor exam shows normal tone, bulk and strength. Deep tendon reflexes are 1+ throughout. Toes are downgoing.

The sensory exam shows patchy reduction of temperature on multiple areas of the body usually in areas of scarred skin. Vibratory sense is relatively intact though perhaps slightly reduced in the toes bilaterally more on the right. Position sense appears intact. Coordination shows normal finger-to-nose. His gait is normal.

ASSESSMENT: 1. Syndrome of excessive daytime sleepiness which is associated with some apneas as noted by his wife but this is a complex situation including significant respiratory disease which could contribute significantly. This gentleman's sleep by his sleep log is never restful and while he seems rather convinced that medication is the main cause I think that his low dose of Atarax and Neurontin are unlikely to fully explain his lack of restful sleep.

2. By MRI scan the suggestion of subcortical vascular disease. This gentleman is taking an aspirin a day.

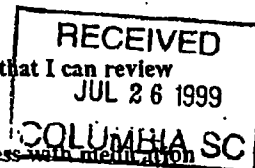
3. Mild numbness which I think is predominantly related to his burns and is multifocal. He does appear to have some decreased vibratory sense in the toes raising a question perhaps of neuropathy.

4. History of hallucination during his hospitalization and some degree of depression and he continues to be followed by Dr. Richards in Greenville.

RECOMMENDATIONS: 1. After much discussion we agreed that he would at his appointment with Dr. Richards tomorrow consider weaning off of Neurontin and stopping his Atarax as this gentleman very much wishes to try and see whether medication may be the main cause of his difficulties.

2. He will obtain more detailed records which he forgot today so that I can review them regarding his past illness.

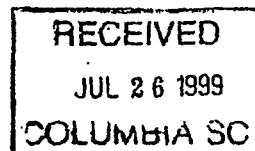
3. This gentleman will call in 1 month to update me on his progress with medication changes and we will make additional plans at that time. I suspect this gentleman will need a sleep study in order to really adequately sort out this problem.



[Handwritten signature]
PILCH #621

John F. Pilch, M.D.

JFP/jbw



Archie Jones
9-20-99

C-171941 REG

421

SUBJECTIVE: Mr. Jones returns today for follow up.

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OBJECTIVE: This gentleman is alert, entirely appropriate in complex conversation, with good attention today. He is not obviously drowsy though does appear just slightly sluggish.

ASSESSMENT: Syndrome of excessive daytime sleepiness with some apneas at night and a complex respiratory situation. Medications such as Atarax and Neurontin could contribute. He feels Neurontin is somewhat sedating but he feels he needs the medicine. I don't think these medications could entirely explain his entire situation and suspect he may have a significant disruption of sleep. We discussed the situation at length and agreed to the following plan.

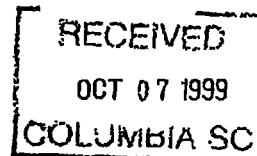
RECOMMENDATIONS: 1. We agreed to a visit with Dr. Mohan. She has recently come to town and has training in both pulmonary medicine and sleep medicine. I think she is better suited for this situation due to this gentleman's difficulty in terms of respiratory disease.

2. He will follow up with me pending that evaluation if needed. No definite appointment was made.

John. F. Pilch, M.D.

JFP/jbw

cc: Dr. June Souviron
Dr. Gowdhami Mohan
(dictated not signed to speed transmission)



**Speech Pathology
Initial Evaluation**

Name: Archie Jones
Address: 1229 Salem Church Rd.
Anderson, SC 29625
Physician: William Walker
DOB: [REDACTED]
DOE: 4/21/98
Referral: Swallowing consultation.

History: Mr. Jones is a 53 y/o w/m who suffered 3rd degree burns over 40% of his body in a work-related accident on 6/3/97. Mr. Jones reports that in addition to the burns on his body, his lungs were "burned" due to inhalation of toxic chemicals and smoke. He reports that his lungs are only functioning at 46% of their capacity. Mr. Jones was treated at the burn center at MUSC. He has undergone numerous surgeries to graft skin during and following the initial hospitalization. He was hospitalized for approximately four months. He was ventilator and trach dependent for 3 1/2 months. After he was weaned from the ventilator he continued to require a trach for another 2 weeks.

He reports he has had difficulty swallowing since he began eating solid foods. Although his swallowing is somewhat better than it has been in the past, he feels that by now this problem should have resolved itself. His main concern is difficulty with frequent lung infections. He believes that they may be related to aspiration. He reports that he frequently has choking episodes during meal. He stated that he has more problems with solids than liquids, and he has particular problems with foods that have a granular texture. He indicated that he usually gets choked after the swallow or sometimes after the meal. He has observed food particles in the sputum.

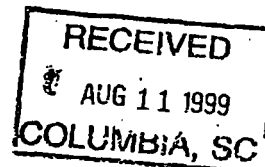
Mr. Jones also has some concerns about the quality of his voice. He indicated that since the accident his voice has not been the same. He reports that the pitch is significantly lower than it was prior the accident and that his voice is hoarse all the time. He was referred to Dr. Hellstrom, ENT for evaluation. Mr. Jones indicated that he was examined by Dr. Hellstrom but not through endoscopic evaluation. Mr. Jones stated that Dr. Hellstrom noticed "some redness" which he attributed to GERD. Dr. Hellstrom prescribed Prilosec to treat symptoms. Mr. Jones reports that his vocal quality has not improved.

Evaluation:

Oral motor: Structures are symmetrical and lingual/labial strength, precision, ROM and endurance are well within functional limits.

Swallowing:

- anticipatory phase-within functional limits.
- oral phase-within functional limits.



ANDERSON-UROLOGY ASSOCIATES, P.A.

C. WILLIAM HINNANT, Jr., M.D.
112 Essex Drive
Anderson, South Carolina 29621
Telephone: (864) 226-6131

October 19, 2001

Mary Cocke, RN, CCM
P. O. Box 80430
Simpsonville, SC 29680

Dear Ms. Cocke,

In response to your letter of 10/8/01, this update concerns your claimant, Mr. Archie Jones (Claim # W-655-228068, Your file #152-24009). As you correctly note, the patient has received urological treatment here. As you are well aware, he suffered a work related accident in the past which led to a significant total body surface area burn. The patient had an indwelling Foley catheter for sometime which led to dramatic erosion of his distal urethra and also to a urethral stricture. The urethra has been repaired and he has undergone dilation on occasion for the stricture although the latter is mild and only requires a couple of visits each year. There is no question that this initial injury and his subsequent requirement for treatment were proximally and factorially caused by his work related injury. The patient's long-term prognosis is good and at this point his long-term treatment plan would include visits on a biannual basis for potential dilation of his stricture and periodic urinalysis. It's very unlikely that he would require any aggressive therapy for this problem in the near future that would entail significant cost.

The patient does suffer from some symptoms that are related to prostatism, however, at present these are mild. Should they worsen there is certainly some possibility that they might require treatment in the future, however, this particular problem would not necessarily bear any causal relationship to the injury necessitating his Workman's Compensation Claim.

I hope that this clarifies the patient's present situation. Please contact me at the above address if there are any questions.

Sincerely,

C. William Hinnant, Jr., MD
CWH/dlc

250-705119 NC2453
44-Char-

ANMED HEALTH
Radiology Consult Report

REQUEST DATE/TIME: 06-09-2001 2016
REQUESTING PHY: GRIER, JOHN
REQ PHYS PH#: (864) 261-1333
ATTENDING PHY: SOUVIRON, JUNE PETRYSEN

JONES, ARCHIE EDWARD
MR# : 0003363247
IDX Acc # : 070184
Acct# : 0000152
Patient Loc: 4N4161
Status: I

Sex: M Age: 57 Years DOB: 07-22-1944

Exam: (AH) 260102 Completed: 06-09-2001 2040

Clinical History: SLURRED SPEECH/ RT. ARM WEAKNESS
NEURO TO READ

JONES CT HEAD WITHOUT CONTRAST

This unenhanced CT scan of the brain is accomplished in a 57 y/o with slurred speech and right arm weakness.

The ventricular system is normally configured midline. The third and fourth ventricles are visualized. The pineal recess is midline. The basal cisterns appear normal. No parenchymal abnormalities are appreciated.

IMPRESSION:

NORMAL UNENHANCED CT SCAN OF THE BRAIN.

Reading Physicians:
Frank Oliver M.D.

Dictated on: 06-10-20010902
Transcribed on: 06-10-20010927
Finalized on: 06-10-20011133

by Teri Polen
by Frank Oliver M.D.

Page: 1

ANDERSON AREA MEDICAL CENTER
ANDERSON, S.C.
MEDICAL RECORD

JONES, ARCHIE E.
JUNE SOUVIRON, M.D.
~~06/09/01~~
06/11/01
06/26/01

DISCHARGE SUMMARY

DATE OF ADMISSION: 06/09/01
DATE OF DISCHARGE: 06/11/01

PRINCIPAL DIAGNOSIS: 1. Probable transient ischemic attack.

SECONDARY DIAGNOSIS: 1. Prostatism.
2. Chronic obstructive pulmonary disease.
3. Mild hypertension.
4. Anxiety and depression.
5. Post-traumatic stress disorder secondary to multiple thermal burns.

DISCHARGE MEDICATIONS: Plavix 75 milligram 1 every day, aspirin 1 p.o. every day, prednisone 10 milligram every day, Theo-Dur 300 milligram b.i.d., Proventil MDI in aerosol and Atrovent MDI in aerosol, Serevent inhaler 2 puffs b.i.d., Pulmicort inhaler 2 puffs b.i.d., Risperdal .25 milligram every a.m. at noon and 0.5 milligram q.h.s., Depakote sprinkle 375 1 dose every p.m., Colace, Zolof 25 milligram every day.

CONDITION ON DISCHARGE: Stable.

DIET: Regular.

FOLLOW-UP: Follow-up with Dr. Oliver if right arm numbness persists and with Dr. Souviron in one week. Monitor home blood pressures b.i.d. to t.i.d. and record, bring to the office.

Mr. Jones is a 57 year old white male who is disabled secondary to thermal induced chronic obstructive pulmonary disease and burn sustained four years' ago in a chemical fire at work with marked secondary psychiatric problems. He is a patient of Dr. Souviron's Family Practice, Dr. Mohan of pulmonary, and psychiatry in Greenville. He reportedly had a 15 to 20 minute episode of aphasia with right arm numbness on the evening of 6/09/01. He was brought immediately to the emergency room, had an aspirin in route. He reports that he had been off of his aspirin therapy for about a week prior to this as he had been having some epigastric/GI problems and Dr. Wortham asked him to stop his aspirin temporarily and he had been doing well with his Prevacid therapy. The patient had had no previous TIA's, no seizure activity. He reportedly that he had had a very busy day. He was very nervous and anxious about some dealings recently with Medicare. He had over done it that day to some extent working on his car and repairing plumbing under his

ANDERSON AREA MEDICAL CENTER
ANDERSON, S.C.
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JONES, ARCHIE B.
JUNE SOUVIRON, M.D.
3889154
06/11/01
06/26/01

DISCHARGE SUMMARY

Page Two

house. He says that in the past he has had some occasional right arm numbness when he has had spasms of cough and occasionally a left sided headache but never any associated speech difficulty. He has never smoked. He does not have diabetes. He has had wonderful lipid profile and a normal echo several years ago. There is no family history of stroke. However, his son was in his late 20's and died with a subarachnoid hemorrhage about five years' ago. He was asymptomatic and no focal findings on arrival to the emergency room. His admission CT was negative. In view of the fact that this was what appeared to a first TIA the emergency room physician felt that he should at least be admitted for inpatient observation and some evaluation.

For details of the history and physical, social, family history, review of systems, past medical history, surgical history please refer to that history and physical document.

On physical examination he appeared his normal self, cheerful, alert, and oriented x 4. Skin changes consistent with multiple skin grafts and burn sites. Mucous membranes were clear. There were no focal central nervous system findings. His heart had a regular rate and rhythm. His lungs were clear.

His EKG was sinus. His white count was 6.8, hemoglobin and hematocrit 13.5 and 39, platelets 231,000. Normal liver. Normal coagulation studies. CT of the head was negative. His glucose was slightly elevated at 127 with potassium of 3.4, sodium 142, chloride 108, BUN 22, creatinine 1.2 and CO2 of 25.

He was admitted to a monitored bed on 4 North and started on some Plavix therapy, continued on aspirin. Noninvasive vasculars were ordered. An MRI was ordered. Dr. Oliver was kind enough to consult. He was continued on his routine psychiatric drugs except for his Dexedrine and I weaned his Cardura in view of some recent cardiovascular studies showing this could possibly be linked to increased stroke and MI and spoke with Dr. Hinnant who agreed that we could wean this and start him on a more specific Alpha blocker like Flomax instead.

Throughout the hospital stay the patient continued to have stable vital signs and no aphasia events. He has been in sinus rhythm throughout his stay. His heart rates remained in the 70's, respiratory rate was 20, blood pressure 120/70, on the morning of

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06/26/01

DISCHARGE SUMMARY

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discharge, 6/11/01. The patient had a negative MRA circle of Willis, negative MRI today except for a T1-T2 hyperdensity in the right parietal white matter that Dr. Oliver felt was probably not related to this event. Carotids and transcranial duplexes were negative. A Holter monitor is still pending. He has had some complaints of some atypical right arm numbness only with certain movements that at this point Dr. Oliver felt was probably unrelated and that we could monitor. He will see him as an outpatient for some EMG type studies if that persisted. On 6/11/01 he was cheerful, again had no events, no chest pain, no shortness of breath, no palpitations, no speech abnormalities, no headaches, no vision changes, no tinnitus, no neck or shoulder pain, occasional cough, some transient right upper extremity numbness only with writing or holding his arm a certain way. No nausea, vomiting, diarrhea. No chest pain. His chronic obstructive pulmonary disease has remained stable. The patient is alert and oriented. He is cheerful and pleasant. He is normocephalic. Mucous membranes are clear. Pupils are equal, round, and reactive to light and accommodation. Extraocular muscles intact. Neck is supple with no JVD. No thyromegaly, masses, or bruit, +2 carotids, midline trachea. Heart shows a regular rate and rhythm without murmur, gallop or rub. Normal S1 and S2. +2 peripheral pulses. Lungs have a few expiratory coarse breath sounds. No wheezes. No crackles. His abdomen is soft and nontender. No organomegaly or masses. Extremities--Jobst hose are in place. He has calluses and some soft tissue deformities consistent with his old burn. He has full range of motion of both upper and lower extremities. No joint or bony abnormalities. No effusion. Neurologically the patient is grossly intact. He has been up and about without difficulty. He is being discharged to home with a diagnosis of a probable TIA. He is being continued on his routine medications except the addition of Plavix 75 milligram every day as samples for home. Continue his aspirin. Will switch from Cardura to Flomax. Dr. Hinnant has some samples for him at his office. I will follow him up in a week. He is to record some home blood pressures. He is to let me know if his arm numbness persists at all and we will have him back in to see Dr. Oliver. At this point he has had no

ANDERSON AREA MEDICAL CENTER
ANDERSON, S.C.
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DISCHARGE SUMMARY

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recurrence of any TIA's and he is quite stable for discharge. His theophylline level on 6/10/01 was 6.6, TSH was 2, triglycerides 88, cholesterol 135, LDL 74, HDL 43. The patient reports he is ready and anxious for discharge. His urine was clear and he has follow-up with me as indicated above.

Authorized by
June P. Souvion, MD
On 7/6/01-23518 RM

JS/43ms

JUNE SOUVIRON, M.D.



William B. Bivens
Branch Manager

April 28, 2003

Jane Souviron, MD
2405 N. Main Street
Anderson, SC 29621

RE: CLAIMANT : Archie E. Jones
EMPLOYER : 3M
DOI : 6/3/97
CLAIM NO. : ~~WC555-246098~~
OUR FILE NO. : 531-5134



Dear Dr. Souviron:

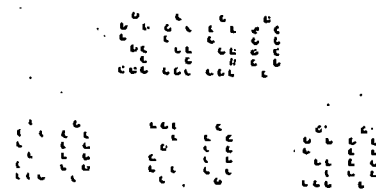
I am a Nurse Case Manager with Crawford & Company Healthcare Management and have been working with the above named during his recovery and treatment of his burn injury. When I met with Mr. Jones on 2/15/03, he reported that a couple of days prior he was kneeling down outside his home on the ground repairing a door under his house. Later that day he was kneeling and discovered his right knee to be swollen. He went to his orthopedic physician who reportedly referred him to you for treatment. Mr. Jones reported he was placed on antibiotics and was referred to another physician to rule out a clot.

The workers compensation insurance carrier has reported receiving charges for treatment from Dr. Kirk Hensarling for treatment of Mr. Jones' right lower extremity cellulitis and prepatellar bursitis.

The workers compensation insurance carrier, Liberty Mutual, is requesting your documentation regarding the treatment of the cellulitis and the causal relationship to Mr. Jones' workers compensation burn injury.

A copy of your report should be sent to:

Ann Hutchinson
Liberty Mutual Insurance Company
PO Box 31205
Tampa, FL 33631



810 Dutch Square Boulevard, Suite 140 ■ Columbia, SC 29210 ■ (803) 716-0491 ■ Fax (803) 716-0491 ■ www.crawfordandcompany.com

Archie Jones
April 28, 2003
Page 2 of 2

Please send a copy to me at Crawford & Company, Healthcare Management, PO Box 80430, Simpsonville, SC 29680.

Should you have any questions, please do not hesitate to contact me at 864-228-9679. I look forward to your response regarding the above information.

Sincerely,

Crawford & Company
Healthcare Management

Mary Cooke

Mary Cooke, RN, CCM
Medical Services Consultant

MC/pbm

C: Ann Hutchinson ✓
Liberty Mutual Insurance
PO Box 31205
Tampa, FL 33631



William B. Bivens
Branch Manager

Claim #:	WC556-248098	Date of Assignment:	4/9/03
SSN:	~~253-745-172~~	Duration of Visit:	1.9 hours
RN Name:	Mary Cocke, RN, CCM	Travel Time:	0.8 hour
Our File No.:	531-5134	Mileage/Expense:	30 mi./\$12.00

Ann Hutchinson
Liberty Mutual Insurance Co.
P.O. Box 31205
Tampa, Florida 33631

Claimant: Archie Jones

Report Date: 4/28/03

Target RTW Date: NA

Medical Information:

Treating Providers:

James E. Lovett, III, MD, Plastic Surgeon
Jane Souviron, MD
Dr. G. Mohan, Pulmonologist
Dr. Robert Richards, Psychiatrist

Diagnosis: Second and third degree burns – 60% of total body surface to chest, back and bilateral lower extremities
Bronchiostasis
Bipolar disorder

ICD-9 Code: 310.8

Treatment History: DOI: 6/3/97. The claimant sustained third degree burns over 45% of his body, and was hospitalized for three months at Charleston Medical Center. He has had extensive grafting over the burned areas on his trunk, arms, legs and feet. He has been treated for multiple difficulties, including Bronchiostasis, which requires treatment with Prednisone steroid medication. Other difficulties requiring treatment include sleep apnea and bipolar disorder. He has been placed at maximum medical improvement by Dr. Mohan and Dr. Richards.

Medications: Albuterol, Atrovent, Combivent, Xopenex Nebulizer, Serevent, Pulmacort, Singulair, Theophylline, Humibid, Prednisone, Prevacid, Sudafed GM, Sy-Tuss DM Cough Syrup, Flomax, Risperdal, Depakote, Plavix, Dexadrine, Zoloft, Actonil, Celebrex, Arulacin, Colace,

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Archie Jones
April 28, 2003
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Multiple Vitamins, Biaxin, Tequin, Augmentin (the last three antibiotics are taken on a rotating basis for seven days once a month)

Current Medical Status: At the request of the claims adjuster, this file was reopened with instructions to schedule an appointment for the claimant with a plastic surgeon to evaluate complaints of bleeding from the claimant's foot. Also, to write to Dr. Souviron regarding the claimant's treatment for cellulitis of his right leg.

The claimant was contacted and advised of case management involvement. The claimant reported that he has had problem with bleeding on both feet, especially on his right big toe. The claimant also reported that he has found some nodules on his neck, chin and arm. He also reported that his skin has been itchy a lot and he is now using Amalactin, Keri Lotion and Coca Butter. He reported that Dr. Hensarling treated him for an infection in his right knee. The claimant was informed that an appointment was to be set up with a plastic surgeon for an evaluation of his foot complaints.

I contacted the office of Plastic Surgeon, Dr. James Lovett, III and an appointment was scheduled for 4/28/03. Medical records were requested and provided by the claims adjuster. A letter of introduction and medical records were copied and sent to Dr. Lovett. A call was received from the claimant on 4/17/03 and requested if an earlier appointment could be made with Dr. Lovett since his foot has been bleeding and draining. Dr. Lovett's office was contacted and the appointment was rescheduled for 4/22/03.

Provider Treatment Plan: I met with the claimant on 4/22/03 at the office of Dr. Lovett. After his examination Dr. Lovett stated that the claimant may have a spur prosteophyte of his right great toe and recommended a plain x-ray film of the foot. Dr. Lovett stated that if there is a spur then surgical intervention may become necessary, however, he would prefer doing conservative treatment before any surgical procedure is done. Because the claimant is on Prednisone, doctor stated that even though the surgery is generally straightforward that this would be a significant procedure for the claimant in order to get a good blood supply to the area due to the grafts on his foot. Doctor trimmed the rough area around the skin irritation. Doctor recommended growth hormone ointment to apply to the area. A prescription was given for Regranex. Doctor stated that the claimant should have his shoes checked to be sure that they were not rubbing on his foot.

The claims adjuster was advised of doctor's recommendation and authorization was obtained for the x-ray. The x-ray was obtained at ANMED in Anderson, SC. The claimant reported on 4/24/03 that the ointment was helping and that the area already looked good. He stated that he was staying off his foot so that it would heal.

A letter has been written to Dr. Souviron requesting her documentation regarding the claimant's treatment for cellulitis and the causal relationship to his workers compensation burn injury.

Archie Jones
April 28, 2003
Page 3 of 3

Case Management Action Plan:

1. I will meet with Dr. Lovett on 5/7/03 for an update on the claimant's status and any additional treatment recommendations. A report will be obtained regarding the plain film x-rays taken of the foot.

Case Management Activity/Outcome

Professional Time: 8.1 hours

1. Maintain contact with the claimant to remain apprised of his status and any other difficulties that may require physician intervention.
2. Determine through evaluation if the claimant's orthotic shoes are causing the skin irritation on his foot.

Crawford & Company
Healthcare Management

Mary Cocke
Mary Cocke, RN, CCM
Medical Services Consultant

MC/pbm

2003
00 00 00
00 00 00



William B. Bivens
Branch Manager

Claim #:	WC555-248098	Date of Assignment:	6/1/00
SSN:	[REDACTED]	Duration of Visit:	1.9 hours
RN Name:	Mary Cocke, RN, CCM	Travel Time:	0.8 hour
Our File No.:	531-4400	Mileage/Expense:	30 mi./\$12.00

Becky Flynn
Liberty Mutual Insurance Co.
P.O. Box 31204
Tampa, Florida 33631-3204

Claimant: Archie Jones

Report Date: 2/27/03

Target RTW Date: NA

Medical Information:

Treating Providers:

Gowdhami Mohan, MD, Pulmonologist
Robert Richards, MD, Psychiatrist
Jane Souviron, MD, Family Practice
C. William Hinnant, Jr., MD, Urologist
Tracy Harvey, MD, Plastic Surgeon
Dr. Altman, Podiatrist
Boris Ilg, Opthamologist

Diagnosis: Third Degree Burns Over 45% of Body
Bipolar Disorder
Pulmonary Disorder/Bronchiostasis
Sleep Apnea
Urethral Stricture
Possible TIA

ICD-9 Code: 310.8

Treatment History: DOI: 6/3/97. The claimant sustained third degree burns over 45% of his body, which required hospitalization for three months at Charleston Medical Center. He has had extensive grafting over the burned areas on his trunk, both arms, legs and feet. Since his burns, he has been treated extensively for multiple difficulties, including Bronchiostasis, which requires treatment with Prednisone steroid medication. He was treated for sleep apnea and is presently wearing a special mouthpiece at night. He has been diagnosed with bipolar disorder since his

810 Dutch Square Boulevard, Suite 140 ■ Columbia, SC 29210 ■ (803) 750-0488 ■ Fax (803) 750-0491 ■
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Archie Jones
February 27, 2003
Page 2 of 2

injury and is being treated with medication. He has been placed at maximum medical improvement by ENT Specialist, Dr. Hellstrom and by Dr. Mohan for his pulmonary disorder. Mr. Jones was hospitalized at Anderson Area Medical Center on 6/11/01 and discharged on 6/26/01 with a probable diagnosis of transient ischemic attack.

Medications: Albuterol, Atrovent and Combivent (these are to be taken as needed), Xopenex Nebulizer, Atrovent, Serevent (to be taken as needed), Pulmicort (to be taken as needed), Singulair, Theophylline, Biaxin, Prednisone, Saline Spray, Prevacid, Sudal DM, Flomax, Risperadal, Depakote, Plavix, Dexadrine, Zolof, Colace, Tequin, Augmentin, Actinil

Current Medical Status: I met with the claimant at Dr. Richards' office on 2/5/03. The claimant was thirty minutes late for the appointment. He stated that he had been at Dr. Souviron's office. He stated that two days prior he was kneeling down outside his home on the ground fixing a door under his house. He stated he went to the garage where his car is being fixed and was kneeling down and thought that there was something on his right knee. After looking at his knee he saw that it was swollen. He said that he thought that he may possibly have an orthopedic injury and went to see the orthopedic doctor. He stated that doctor x-rayed the knee and told him it was not an orthopedic problem and suggested that he see his family physician. He was given an antibiotic prescription. After seeing Dr. Souviron he said that she had changed his antibiotic medication to Levaquin and was to have some blood work done. He was to return to her office that day.

Provider Treatment Plan: I met with Dr. Richards and the claimant. It was explained to Dr. Richards the reason for the visit was to determine if the claimant had plateaued or reached maximum medical improvement. Dr. Richards stated that if the claimant would be able to come off of his Prednisone medication that his condition should improve. However, because of the Prednisone, it continues to cause difficulties with his bipolar disorder. As long as he is on the medication doctor stated that he does not anticipate any changes in the claimant. Dr. Richards stated that he increased the claimant's dosage on his anti-depressant medication, Zolof, and his Depakote. This had helped. The claimant will need to continue to be monitored as long as he is on Prednisone. Doctor stated that he would do a written report stating that the claimant is at maximum medical improvement. A copy of doctor's report was received on 2/27/03. Doctor's report did document that the claimant is at maximum medical improvement. A copy of the report was faxed to the claims adjuster as requested.

Case Management Action Plan:

Professional Time: 4.2 hours

1. As directed by the claims adjuster my file will be closed. Should additional activity become necessary this file can be reopened

Thank you for this referral and I look forward to working with you in the future.

Crawford & Company
Healthcare Management
Mary Cooke
Mary Cooke, RN, CCM
Medical Services Consultant

248098



William R. Bivens
Branch Manager

January 9, 2003

Robert A. Richards, MD
9A Caledone Court
Greenville, SC 29615

RE: CLAIMANT : Archie (Eddie) Jones
EMPLOYER : 3M
DOI : 6/3/97
CLAIM NO. : [REDACTED]
OUR FILE NO. : [REDACTED]

Dear Dr. Richards:

I am a Nurse Case Manager with Crawford & Company Healthcare Management and have been assisting Mr. Jones during his recovery from his workers compensation burn injury of 6/3/97.

Mr. Jones has received psychological counseling and medication for treatment of his bipolar disorder, which is reported to be causally related to his workers compensation burn injury. It has now been several years since his injury and the initial evaluation with treatment for his psychological disorder. At the request of the workers compensation insurance carrier, Liberty Mutual, the following information is being requested:

1. Has Mr. Jones attained MMI (Maximum Medical Improvement) regarding his psychological disorder? Yes No Don't know
Has not reached expected degree of disability
If yes, please assign an impairment rating or document if the claimant is permanently disabled regarding his psychological difficulty.

If no, please comment on anticipated length of time to attain MMI and what additional treatment would be recommended to achieve MMI.

Don't know 2-3 months
if steroids & primary
problems



William B. Bivens
Branch Manager

Claim #:	WC555-248098	Date of Assignment:	6/1/00
SSN:	██████████	Duration of Visit:	NA
RN Name:	Mary Cocke, RN,CCM	Travel Time:	NA
Our File No.:	531-4400	Mileage/Expense:	NA

Karen Gamlin
Liberty Mutual Insurance Co.
P.O. Box 31204
Tampa, Florida 33631-3204

Claimant: Archie Jones

Report Date: 11/8/02

Target RTW Date: Undetermined

Medical Information:

Treating Providers:

Gowdhami Mohan, MD, Pulmonologist
Robert Richards, MD, Psychiatrist
Jane Souviron, MD, Family Practice
C. William Hinnant, Jr. MD, Urologist
Tracy Harvey, MD, Plastic Surgeon
Dr. Altman, Podiatrist
Boris Ilg, Ophthalmologist

Diagnosis: Third Degree Burns Over 45% of Body
Bipolar Disorder
Pulmonary Disorder/Bronchiostasis
Sleep Apnea
Urethral Stricture
Possible TIA

ICD-9 Code: 310.8

Treatment History: DOI: 6/3/97. The claimant sustained third degree burns over 45% of his body, which required hospitalization for three months at Charleston Medical Center. He has had extensive grafting over the burned areas on his trunk, both arms, legs and feet. Since his burns, he has been treated extensively for multiple difficulties, including Bronchiostasis, which requires treatment with Prednisone steroid medication. He was treated for sleep apnea and is presently

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Archie Jones
November 8, 2002
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wearing a special mouthpiece at night. He has been diagnosed with bipolar disorder since his injury and is being treated with medication. He has been placed at maximum medical improvement by ENT Specialist, Dr. Hellstrom and by Dr. Mohan for his pulmonary disorder. Mr. Jones was hospitalized at Anderson Area Medical Center on 6/11/01 and discharged on 6/26/01 with a probable diagnosis of transient ischemic attack.

Medications: Albuterol, Atrovent and Combivent (these are to be taken as needed), Xopenex Nebulizer, Atrovent, Serevent (to be taken as needed) Pulmicort (to be taken as needed), Singulair, Theophylline, Biaxin, Prednisone, Saline Spray, Prevacid, Sudal DM, Flomax, Risperadal, Depakote, Plavix, Dexadrine, Zolof, Colace, Tequin, Augmentin, Actinil

Current Medical Status: The claims adjuster requested that the claimant's shoes be evaluated by the manufacturing company and document whether or not there has been a problem with the soles of the shoes that the claimant is wearing causing people to slip and fall. This information needs to be obtained before back treatment is authorized. I contacted Upstate Podarthic to follow up if the claimant has scheduled an appointment for an evaluation of his shoes. I was informed that the claimant had an appointment scheduled that day (10/28/02) but did not show. I was informed that the claimant had made two other appointments in May 2002 but did not show for those appointments either. It was explained that workers compensation insurance carrier needed a statement from the manufacturing company regarding any other problems with the shoe causing people to slip. She stated that they needed to see the shoes and the claimant to determine if there is a defect. She stated that most people do not wear the type of shoes the claimant is wearing. She stated that they had issued only three pairs of that type of shoe this year. There have been no other reports of problems. She would be able to write the manufacturing company only after inspecting the shoes. The claimant was contacted on 10/9/02 and informed that he needed to reschedule his appointment with the orthotist. The claimant stated that he had an appointment the previous day but was sick and did not attend. He said that his lungs are bad and he had increased his Prednisone. The claimant stated that he was leaving town the next day with his family and would return after the weekend. He would schedule his appointment on return home. I contacted Upstate Podarthic on 10/30/02 and was informed that the claimant has not rescheduled his appointment. A call was placed to the claimant's home on 10/31/02 with no answer and a message was left regarding his scheduling an appointment. I contacted the claimant on 11/8/02 and he stated that he had not been out and that his lungs were bad. He also stated that he had seen Dr. Souviron for rectal bleeding. He stated that his medication was causing this. He also stated that he had seen Dr. Mohan on 11/7/02 and was prescribed the antibiotic, Cipro for his lungs. This was to be taken for seven days only.

Case Management Action Plan:

1. I will contact the claims adjuster to discuss the claimant's status and reported difficulties. It may become necessary to obtain written documentation from the treating physician as to the causal relationship of the claimant's reported symptoms to his workers compensation injury.

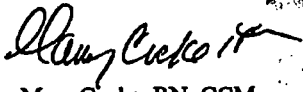
Archie Jones
November 8, 2002
Page 3 of 3

Case Management Activity/Outcome

Professional Time: 2.2 hours

1. Determine if the claimant is going to follow through with the orthotist for his shoe evaluation.

Crawford & Company
Healthcare Management



Mary Cocke, RN, CCM
Medical Services Consultant

MC/pbm

2002

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Mary Ann Osmos
Liberty Mutual
Page 2
March 29, 2001

CURRENT MEDICAL STATUS

Mr. Jones continues on the Prednisone medication, as prescribed by Dr. Mohan. He continues to see a Psychiatrist, Dr. Richards, and medication has been adjusted and changed frequently. Mr. Jones continues to complain of multiple difficulties, including breathing difficulty, painful feet, fatigue and difficulty with coping. Mr. Jones stated that he had a cap, which was pulled loose by his mouth appliance which he uses at night for sleep apnea. The cap had to be replaced by his dentist. He also complained of feeling fatigue and stated that Dr. Richards suggested that he see Dr. Mohan to rule out any pulmonary difficulties. Mr. Jones stated that Dr. Mohan then referred him to his family physician for a physical to rule out any physiological problems.

Mr. Jones stated that his physical exam was good and it was thought that his medication, Dexadrene, prescribed by Dr. Richards was possibly causing his fatigue. Mr. Jones stated that when placed on the medication, Dexadrene, he felt good for approximately 3-1/2 weeks and his mind seemed clearer. However, he said that his concentration was not good and he had difficulty coping.

Mr. Jones also stated that he had to be treated for two infections that were reportedly caused from exposure to odor from a kerosene heater in a car shop. Mr. Jones said that he felt that a portable powered air purifier might be helpful when he has to be in any area that would cause breathing difficulties and/or infection. He said that a portable powered air purifier from 3M costs \$400.00. He was advised that Dr. Mohan would need to write a letter of medical necessity and a prescription for the purifier.

Mr. Jones also stated that he was told by Dr. Harvey that he would need to be on the Prednisone, 5 mgs. daily before any surgical invasion could be done on his feet. Mr. Jones continues to complain about difficulty with his feet.

EXPECTED LENGTH OF DISABILITY/PROJECTED DATE OF MMI

Mr. Jones is at maximum medical improvement regarding the sleep apnea and pulmonary disorders. He continues treating for his psychological order.

EMPLOYER CONTACT

Mr. Jones remains out of work.

Mary Ann Osmos
Liberty Mutual
Page 3
March 29, 2001

RECOMMENDATIONS

1. Contact with Claimant. I will maintain contact with Mr. Jones for an update on his status and treatment.
2. Conference with Psychiatrist. I will meet with the Psychiatrist to obtain an update on Mr. Jones' treatment and to determine if he has attained maximum medical improvement.

CRAWFORD & COMPANY
Healthcare Management Services

Mary Cocke RN
Mary Cocke, RN, CCM
Medical Services Consultant

9999

1-004

0.040



William B. Bivens
Branch Manager

Claim #:	WC555-248098	Date of Assignment:	6/1/00
SSN:	[REDACTED]	Duration of Visit:	
RN Name:	Mary Cocke, RN, CM	Travel Time:	
Our File No.:	531-4400	Mileage/Expense:	

Karen Gamlin
Liberty Mutual Insurance Co.
P.O. Box 31204
Tampa, Florida 33631-3204

Claimant: Archie Jones

Report Date: August 24, 2001

Target RTW Date: Undetermined.

Medical Information:

Diagnosis: Third Degree Burns Over 45% of Body
Bipolar Disorder,
Pulmonary Disorder/Bronchiostasis
Sleep Apnea

Treating Provider:

Gowdhami Mohan, M.D., Pulmonologist
Robert Richards, M.D., Psychiatrist
Jane Souviron, M.D., Family Practice
Dr. Hinnett, Urologist
Tracy Harvey, M.D., Plastic Surgeon
Dr. Altman, Podiatrist

ICD-9 Code: 310.8

Treatment History: DOI: 6/3/97. The claimant sustained third degree burns over 45% of his body, which required hospitalization for three months at Charleston Medical Center. He has had extensive grafting over the burned areas on his trunk, both arms, legs and feet. Since his burns, he has been treated extensively for multiple difficulties, including Bronchiostasis, which requires treatment with Prednisone steroid. He is presently on a maintenance dose of 10 mg per day. He

Archie Jones

Page 2

August 24, 2001

was treated for sleep apnea and is presently wearing a special mouthpiece at night. He has been diagnosed with bipolar disorder since his injury and is being treated on medication.

Due to the extensive grafting on both feet and toes, he has difficulty with webbing of the toes. He wears orthotic shoes due to the grafts. Pulmonologist, Dr. Mohan, has stated the claimant is at maximum medical improvement regarding his pulmonary disorder. ENT Specialist, Dr. Hellstrom, has also placed the claimant at maximum medical improvement. The claimant also has difficulty with ingrown toenails as a result of the grafts. Treatment is on an "as needed" basis. The claimant is being seen by Urologist, Dr. Hinnett, on an "as needed" basis due to urethral stricture.

Medications: Prednisone, 10 mg, Nebulizer and Inhaler. Medications, including Albuterol, Atrovent, Serovent, anti-depressant medication Zoloft, Depakote, Respadal, antibiotic medication to be taken the first week of each month, Cloace, Aspirin daily, and Cytotec.

Current Medical Status: I met with the claimant at Dr. Richards's office on 7-31-01. He reported that he was not doing well. His Prednisone had to be increased to 20-mg. He stated that he has no motivation and continues to complain of congestion and discomfort in his right foot. The claimant stated that the time that he had his TIA that it affected his speech. He stated that he still has some numbness in his right arm. He presently does not have any difficulty with speech or memory impairment.

Provider Treatment Plan:

Dr. Richards stated that he is not at MMI regarding his psychiatric treatment. He increased his anti-depressant medication and discontinued the Provigil. He stated that he felt that the claimant could continue to improve. Other treatments that may be considered in the future with medication include Geodine and Aerosept.

I met with Dr. Souviron on 8-22-01. Dr. Souviron stated that the hospital report at the time of the claimant's TIA did not confirm that he had a TIA. There was only a probability of the TIA. Dr. Oliver was treating the claimant in the hospital and stated that he did not need to see the claimant unless he had increased difficulties. Dr. Souviron requested a bone density test due to the Prednisone medication. This is to be scheduled at Anderson Radiology in Anderson, SC. The claimant reported that Dr. Mohan had prescribed the medication Ritalin since he had to discontinue the Dexedrine. He stated the Ritalin would help to elevate his mood. The Dexedrine had to be discontinued because it may contribute to TIA.

Next Provider Appointment:

Dr. Richards, Psychiatrist, is scheduled for 9-5-01.

Dr. Souviron, to be scheduled in 3 months.

Archie Jones
Page 3
August 24, 2001

Job Information:

Current Position:

Current Work Status: Out of Work.

Physical Requirements of Regular Job:

Modified Duty Available? It is not anticipated that Mr. Jones will return to work at 3M.

Case Management Action Plan:

1. Continue to obtain medical updates from the physician's on the claimant's status and medication.
2. ~~Maintain contact with the claimant for an update on his status and any difficulties that~~
may require physician intervention.

CM Activity/Outcome:

Professional Time: 8.1 hours

1. Obtain hospital medical records for review.
2. Determine if the claimant is at maximum medical improvement.
3. Determine if the claimant will have an impairment rating.

CRAWFORD & COMPANY
HEALTHCARE MANAGEMENT

Mary Cocke, RN, CCM
Medical Services Consultant

MC/pls

09/24/99

14:15

3M BLDG 12 - 864 455 850

NO. 221

081

To: Dr. Cochran
Attention: Cindy

From: Jo Henrich, JIM
Telephone - 864-299-4207
Fax: 864-299-4105

Please evaluate the following task as appropriate for Eddie Jones, and respond if they are appropriate for his condition. If appropriate, please issue a script for a functional capacity evaluation.

Tasks:

1. OPE wire winder - Stand and sit at workbench. Light lifting. 10 - 20 hours per week.
2. Metal, pipe, and nut & bolt inventory and stock man. - Standing and some lifting, 1- 2 hours per week.
3. Electrical and Mechanical shop clean up. - Standing, pushing broom, and some lifting, 3 - 4 hours per week.
4. Card board and pallet disposal. - Drive fork truck. 1 hour per week.
5. Parts gopher - Drive truck. 1 - 4 hours per week.
6. Misc. rebuilds, etc.

Work hours 7:00 am and 3:30 am.

O.K.

Cochran

248098-M

CORE
Peer Review Analysis

Case Report for
LIBERTY MUTUAL NATIONAL MARKET

To:	MARILYN SCHEINKER	Case Number:	10471541
Company:	TAMPA, FL	Office:	TAMPA, FL
Review Type:	W/C-MED SU	Referred:	11/30/2001
Service:	RETROSPECTIVE	Admit Date:	/ /
Sub Service:	RECORD REVIEW	Discharged:	/ /
Patient:	JONES, ARCHIE	Patient SSN:	[REDACTED]
Policy:	555-248098	Employee SSN:	[REDACTED]

REASON FOR REFERRAL:

Is the TIA incident related to the original injury of 06/03/1997 in which he sustained 3rd degree burns over 40 percent of his body and permanent lung damage?

REVIEW DATA:

LMMC referral form and the submitted clinical data. A call was placed to 864-226-7636 on 12/04/2001 at 08:40. I spoke with the answering service, the attending physician was not available. A call was placed on 12/06/2001 at 09:13. I spoke with the answering service, the attending physician was not available. A call was placed on 12/07/2001 at 09:27. I spoke with the receptionist, the attending physician was not available. Two calls were placed on 12/10/2001 at 14:46 and 14:47, there was a hang up with each call. A call was placed on 12/11/2001 at 08:40, the attending physician was not available. I left a message on the office voice mail. Contact with the attending physician was unsuccessful. The recommendation and the appeals process were left on the office voice mail on 12/11/2001 at 08:40.

RECOMMENDATION:

The TIA incident is not related to the original injury of 06/03/1997 in which he sustained 3rd degree burns over 40 percent of his body and permanent lung damage.

RATIONALE:

This claimant had an episode of aphasia and right arm numbness for 20-30 minutes. This was thought to be related to a TIA. No specific etiology was identified. He has received medical care following the burn injury and had no increased risk factors for stroke related to that injury. There is no indication in the records received that there is an association between the TIA and the burn injury.

CLINICAL SUMMARY:

This claimant is a 58 year old male who sustained a burn injury on 06/03/1997. He does not smoke. He has no significant history of hypertension. He had a normal echocardiogram two years ago. There are no specific risk factors identified for stroke other than age and male sex. He had a 20-30 minute episode of aphasia and right arm numbness, thought to represent a TIA. No specific etiology for the TIA was identified.

CORE

Peer Review Analysis
Peer Review Case #10471541

Page: 2

CONFLICT OF INTEREST STATEMENT:

I certify that I have no past or present relationship with the Member and no significant past or present relationship with the Attending Physician. I further certify that there is no professional, familial, financial or other affiliation, relationship or interest with the developer or manufacturer of the principle drug, device, procedure or other therapy being recommended for the Member whose treatment is the subject of this review. Any affiliation that I may have with this client, or as a participating physician in this client's network, at no time constituted more than ten percent of my gross annual income.

Bruce R. LeForce, M.D.
Neurology/Clinical Neurophysiology
License# TX-J3533
12/11/2001

THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM GREENVILLE COUNTY
Court of Common Pleas

D. GARRISON HILL, Circuit Court Judge

Case No. 2009-CP-23-2535

Archie Eddie Jones..... Respondent

vs.

3M Corporation.....Employer/Appellant

- and -

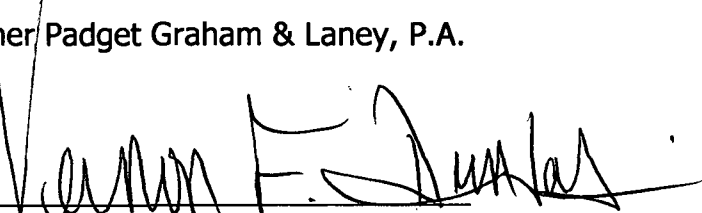
Old Republic Insurance Company.....Carrier/Appellant

CERTIFICATE OF COMPLIANCE

The undersigned hereby certifies this **Record on Appeal** contains all material proposed to be included by any of the parties and not any other material.

The undersigned also certifies that this **Record on Appeal** complies with the South Carolina Supreme Court's Order dated August 13, 2007, concerning personal data identifiers and other sensitive information.

Turner Padgett Graham & Laney, P.A.

By: 

VERNON F. DUNBAR

Post Office Box 1509 (29602)
200 East Broad Street, Suite 250
Greenville, SC 29601
ATTORNEYS FOR APPELLANTS
Telephone: 864-552-4600

THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM GREENVILLE COUNTY
Court of Common Pleas

D. GARRISON HILL, Circuit Court Judge

Case No. 2009-CP-23-2535

Archie Eddie Jones..... Respondent

vs.

3M Corporation.....Employer/Appellant

- and -

Old Republic Insurance Company.....Carrier/Appellant

CERTIFICATE OF SERVICE

I certify that I have served the ***Record on Appeal and Certificate of Service*** on Archie Eddie Jones, Respondent, by depositing a copy of it in the United States Mail, postage prepaid, on June 27, 2012, addressed to the attorney of record, Kathryn L. Williams, Esquire, Post Office Box 10693, Greenville, SC 29603:

Kathryn Williams, Esquire
Attorney at Law
Post Office Box 10693
Greenville, SC 29603

- and -

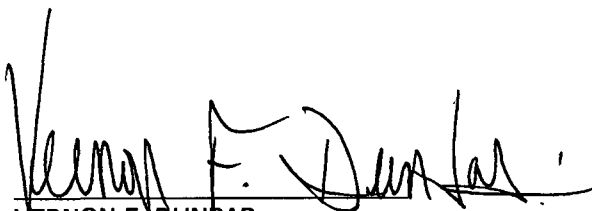
The Honorable Jenny Abbott Kitchings
South Carolina Court of Appeals
1015 Sumter Street
Columbia, SC 29201

June 27, 2012

RECEIVED

JUN 28 2012

SC Court of Appeals


VERNON F. DUNBAR