EXHIBIT

7-1-430

1A 9211

NAME

GREENVILLE HOSPITAL SYSTEM
GREENVILLE, S. C. 29605

1-7

MEDICAL RECORD

BROWN, HASHAWSAN | ROOM NO. 7A | HOSPITAL NO. [redacted]

1/31/94

4152

Mr. Brown was admitted to Traumatic Brain Injury Unit at Roger Peace on 12/22/93 for a final discharge diagnosis of rehabilitation for a traumatic brain injury secondary to a gunshot wound.

Secondary diagnosis responsible in part for the patient's stay include a right subdural hematoma, gunshot wound to the temporal lobes, depression, right hemiparesis, status post gastrointestinal bleed, status post right craniotomy, seizure prophylaxis.

HISTORY OF PRESENT ILLNESS: This is a 19 year old black male with no significant past medical history, who was admitted to the Greenville Memorial Hospital by the ER on 11/28/93 after he suffered a self-inflict gunshot wound to the right temple following an apparent argument with his girlfriend. The patient was brought to the ER for the small caliber bullet wound and where no exit wound was found. CAT scan revealed an evolving hematoma with a right hypodense subdural hematoma in the right frontal lobe. The patient was admitted and managed initially on the neurosurgery service by Dr. Ottis M. Ballenger. When the patient did not appear to be making sufficient recovery, he was taken to the OR by Dr. Ballenger on 12/14/93 and underwent a right frontotemporal craniotomy with evacuation of a chronic subdural hematoma and debridement of frontal gunshot wound to the brain.

Postoperatively the patient became more alert and was evaluated by the psychiatric service. Seen by Dr. Galvarino who felt the patient was not currently psychotic or suicidal and he was subsequently transferred to Roger Peace on 12/22/93 to begin therapy on the Traumatic Brain Injury Unit.

At the time of the patient's admission to Roger Peace, he had the following labs. His white count was 6.3. His hgb. was 10.9, hct. 31.4, platelet count 415. The patient is being maintained on Dilantin, subtherapeutic range. His potassium was 4.0, sodium 144, chloride 106, CO2 32, glucose 108, BUN 7, and creatinine 0.6. Albumin was 2.7, total protein was 5.6. The patient's urinalysis was unremarkable.

HOSPITAL COURSE: The patient was admitted to the Traumatic Brain Injury Unit at Roger Peace and begun on daily physical, occupational, recreational therapies as well as daily physiatric nursing and medical care, psychological services, case management, and speech therapies. On the service the patient did very well. He was converted from Dilantin to Tegretol and maintained Tegretol in the the normal range. He was stopped from his Carafate and had no episodes of upset stomach or GI disturbances. The patient physically improved rather quickly on the service and did fairly well.

The patient was seen by Dr. Galvarino on the psychiatry service while at Roger Peace and was felt to no longer be suicidal. At the time of discharge he was 100% continent of bladder and bowel. He was ambulating

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greater than 150 feet with supervision. His mat bed and mat mobility was independent. Occupational Therapy found him to be oriented to person, place, and circumstance, but inconsistent with time. He still requires standby assistance when shower secondary to balance. His spatial orientation problems were noted with self-care, advanced ADL's, and ambulation. In Recreational Therapy the patient was found to be alert for an entire treatment session daily. He reported some sleep problem later in the week due to being preoccupied with visions of the suicide attempt and at times needed prompting and cues to use as a memory log. In Speech, the patient continues no deficits in deductive reasoning and memory, and continuing with any moderately complex or difficult task. However, he showed progress and recall of recent information. The patient had improved in delayed recall to the location of 5 items on the moderately impaired to the average range. He continued to have significant deficits in recall for names, recall for sentences and visual auditory learning. In psychology the patient was followed by psychology service and denied any suicidal ideation. His mood was bright, although his affect remains puerile. He reported that he was thinking about his suicide attempt more frequently and was currently feeling confident about his discharge plan.

The patient went home on a pass and this went well. Referral was made to the outpatient programmatic Traumatic Brain Injury Services at Cross Creek and at the time of the patient's discharge, he was sent home on the following medications: Tegretol 200 mg. p.o. t.i.d., Trazodone 150 mg. p.o. q.h.s.

He has a follow-up appointment to see Dr. Galvarino, of the psychiatry service 2 to 3 weeks after discharge. He has a follow-up appointment to see me 4 weeks after discharge and to see Dr. Ottis Ballenger in 3 weeks after discharge.

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Discharge

SIGNED
Dennis Hollins, M.D./par
M.D.


CC: Mario Galvarino, M.D.; O. M. Ballenger, M.D.
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