VOLUME I OF III

STATE OF SOUTH CAROLINA
IN THE SUPREME COURT

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S.C. Supreme Court

Appeal from Horry County
The Honorable Benjamin H. Culbertson, Circuit Court Judge

Court of Common Pleas Case No. 2011-CP-26-3907
(Capital PCR Action)
Appellate Case No. 2014-000904

LOUIS MICHAEL WINKLER, JR.,

Respondent/Petitioner,

vs.

STATE OF SOUTH CAROLINA,

Petitioner/Respondent.

SUPPLEMENTAL APPENDIX

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Death Penalty Resource & Defense Center
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Louis Michael Winkler, Jr.

Vs.

State of South Carolina

Proffer Related to Neurological and Cognitive Impairments

STATE OF SOUTH CAROLINA COUNTY OF HORRY Louis Michael Winkler Jr. Applicant, v. State of South Carolina, Respondent.	IN THE COURT OF COMMON PLEAS Case No. 2011-CP 26-03907 **PROFFER RELATED TO NEUROLOGICAL AND COGNITIVE IMPAIRMENTS AND CLAIM 10 & 11(b)(1)**

Applicant, Louis M. Winkler, has alleged, *inter alia*, that trial counsel was prejudicially ineffective for failing to "investigate and present evidence of Applicant's neurological and cognitive impairments and/or dysfunction." Second Amended Application for Post-Conviction Relief at 2. On April 10, Applicant moved for a continuance, in part, because additional time was required to follow-up on substantial leads related to Applicant's potential brain damage. Mot. for Cont. at 2. Applicant required additional time to conduct a positron emission tomography (PET), as approved by this Court. Applicant had been unable to obtain the PET because of his previously undiagnosed and untreated diabetes. This Court denied the continuance. Order Denying Cont. at 2. Applicant offers this proffer as a record of the evidence he believes he would have been able to develop and the claims he would have been able to prove had he additional time.

PROFFER

I. Introduction

Brain damage is a well-recognized source of information relevant to a complete investigation and presentation in a capital case. The United States Supreme Court has repeatedly recognized the mitigating force of brain damage. *See, e.g., Jefferson v. Upton*, 130 S. Ct. 2217

(2010) (remanding for considering whether deference of the state court's decision on ineffectiveness of trial counsel was warranted where counsel failed to present evidence of a serious head injury and related brain damage); *Sears v. Upton*, 130 S. Ct. 3259 (2010) (finding counsel ineffective for failing to investigate and present evidence of "significant frontal lobe brain damage . . . as well as drug and alcohol abuse in his teens" causing impairments in cognitive function); *Porter v. McCollum*, 130 S. Ct. 447 (2009) (finding trial counsel ineffective for failing to investigate and present neuropsychological evidence that the defendant "suffered from brain damage that could manifest in impulsive, violent behavior."); *Rompilla v. Beard*, 545 U.S. 374 (2005) (finding counsel ineffective for failing to discover that the defendant "suffers from organic brain damage, an extreme mental disturbance significantly impairing several of his cognitive functions."); *Tennard v. Dretke*, 542 U.S. 274 (2004) (holding evidence of impaired intellectual functioning inherently mitigating in capital penalty phase); *Mills v. Maryland*, 486 U.S. 367 (1988) (finding Maryland jury instruction requiring agreement as to existence of mitigating evidence invalid because it prevented the jury from considering evidence that "[p]etitioner underwent therapy as a child, was diagnosed as having 'minimal brain damage,' and was placed on medication.").

Through the course of their investigation, post-conviction counsel for Applicant discovered he has experienced several significant head injuries dating to his early childhood. In 1967, a child in Applicant's neighborhood struck him in the front of the head with a spear. In addition to requiring stitches, the injury is a potential source of damage to Mr. Winkler's frontal lobe, the seat of executive functioning.

When Applicant was a teenager, he injured his head in the family pool. The pool was not well cleaned and the water was green and opaque. Applicant jumped off of the diving board

head first, only to discover his brother was lurking in the water below. They collided head to head, and Mr. Winkler blacked out.

As an adult, Applicant was struck in the head hard enough to knock him out and cause him to forget the source of the injury. The reports of the injury speculate that he was either hit by a car or hit in the head with a beer bottle. For weeks after the injury, Applicant experienced tingling in his extremities, dizziness, and was foggy. Based on this initial investigation, post-conviction counsel sought and received funding for neuropsychological testing, neuroimaging, and analysis of the testing and imaging.

In light of this information and in light of initial neuropscyhological testing, the neuropsychologist consulting with Applicant recommended neuroimaging and analysis. Ex. 1 (Letter from Kristine Herfkens, Ph.D, Nov. 3, 2011). For the neuroimaging, Applicant retained the services of a local neurologist, David Bachman, M.D. Dr. Bachman was retained to obtain high resolution volumetric magnetic resonance images (MRI) and a PET scan. "[V]olumetric MRI scans are used to produce images of the brain's structure, while PET scans are used to measure the brain's metabolism." Ex. 2 (Letter from Michael Keutmann, June 4, 2012).

Post-conviction counsel requested the services of Dr. Ruben Gur to conduct the analysis of the PET scan and MRI images. Dr. Gur is a Professor of Psychiatry, and the Director of the Brain Behavior Research Laboratory at the Maloney Institute of Neurological Sciences at the University of Pennsylvania School of Medicine. Ex. 3 (Curriculum Vitae of Dr. Gur). His laboratory conducts computerized quantitative analysis of magnetic resonance images and PET scans. Quantitative analysis is by far the most accurate and reliable way in which to determine if an individual has brain abnormalities and minimizes the risk of subjectivity and error by a radiologist in analyzing the MRI and PET images. Additionally, quantitative analysis allows for

the comparison of the MRI and PET data from Applicant with data gathered from other imaging studies in persons with both normal and abnormal brains. This comparison can uncover otherwise difficult to identify abnormalities. Both an MRI and a PET are required for Dr. Gur to conduct his analysis. Ex. 2.

On January 26, 2012, Mr. Winkler was transferred to the Medical University of South Carolina for Dr. Bachman to conduct the PET scan and MRI. The MRI was conducted as planned, and the initial review of the MRI showed some abnormalities. Ex. 4 (Report on MRI Feb. 14, 2012). The PET scan, however, could not be completed.

A PET scan measures the brain's metabolism by injecting fluorodeoxyglucose into the blood stream and observing the brain's metabolism of this sugar. Because the PET images are produced by comparing the measured brain metabolism against norms created in patients with normal blood glucose concentration, "[i]f the patient has an abnormal blood glucose concentration, the imaging will not produce a reliable result." Ex. 5 (Letter from Dr. David Bachman, Feb. 7, 2012). Thus, prior to conducting a PET scan, blood tests are conducted prior to a PET scan to ensure that the patient's blood glucose concentration is in the normal range. *Id.*

When Applicant's blood was tested, it was not in the normal range. Applicant's blood glucose concentration was 272 mg/dl. *Id.* Normal blood glucose would have been no more than 100 mg/dl. *Id.* Because of the abnormal blood glucose concentration, no PET scan was conducted. *Id.*

Dr. Bachman observed that Applicant's "glucose concentration strongly suggests he has untreated diabetes and that he needs treatment. *Id.* Dr. Bachman estimated that with six to eight weeks of closely monitored medication, Applicant's blood sugars would return to normal. *Id.* When counsel for Applicant learned he likely suffered from diabetes, they immediately

contacted the medical personnel at the Department of Corrections. Ex. 6 {Letter to Joan Doudy, Feb. 14, 2012) (referencing conversation last week about Mr. Winkler's likely diabetes). Eventually, the Department of Corrections tested Applicant and confirmed Dr. Bachman's suspicion: Applicant had untreated diabetes.

With treatment, Applicant's blood glucose concentration eventually returned to the normal range. Ex. 7 (Medical Records from Lieber Correctional Institute). Soon thereafter, counsel for Applicant requested and received an order for a PET scan. The PET scan was completed on June 6, 2012.[1]

Once Dr. Gur's laboratory receives the PET scan images and MRI, he requires between six and eight weeks to conduct an analysis. Ex. 2. After completing his analysis, Dr. Gur consults with counsel about what additional steps would be helpful for a more complete analysis. *Id.*

II. Additional Investigation that Would Be Required and Additional Information Applicant Would Have Been Able to Develop and Present.

Had Applicant not been deprived of adequate time to investigate and prepare his case, he would have been able to investigate and present substantial information that would support his current claims for relief.

Had Applicant been given more time, Dr. Gur would have been able to complete his analysis. He, in turn, would have produced a report or provided testimony in support of Applicant's claims. Reports authored by Dr. Gur, as well as a transcript of some of Dr. Gur's testimony, are attached to this proffer as examples of the kind of information Applicant would have been able to present. Ex. 8 (Reports and testimony of Dr. Ruben Gur).

[1] Counsel for Applicant only received this information on Friday, June 15. Thus, they have not yet been provided to or been analyzed by Dr. Gur.

Depending on the information Dr. Gur would have uncovered, it could have dramatically changed the picture the trial jury received. Trial counsel had no strategic reason not to investigate and present evidence of Applicant's brain damage.

Had the analysis been completed, it may have uncovered, for example, frontal lobe damage or damage to the areas of his brain that process and help control emotions. Such damage could provide a basis for concluding that because of his brain abnormalities, Applicant has difficulty responding to stress, controlling impulses, and making decisions. The analysis may have uncovered the long-term effects of substance abuse and the havoc alcohol has wreaked on Applicant's brain. These effects could include dementia, major depression, and damage to the prefrontal cortex, hippocampus, nucleus accumbens, and other parts of the brain.

The information uncovered by Dr. Gur's analysis and investigation stemming from it could help explain many of the unexplained behaviors the state presented at trial. Depending on the outcome of the follow-up investigation, additional evidence may explain—but not excuse—much of the state's penalty phase case against Applicant, including his troubled history with women, his dependence on controlled substances, the dispute with the police in which he allegedly spit on a police officer, the prior incident with the victim, his flight after the incident, and the letter to the victim's daughter. The results may also help explain why Applicant may have acted on the tragic and violent impulse that led to this incident. Such an explanation would have dramatically undermined the state's case against him and created a reasonable probability that the jury would have returned a life verdict.

In addition to undermining the state's case against him, the information and subsequent investigation could also provide the jury with a reason to show Applicant mercy. Brain damage is a reason to return a life verdict, even if there is no direct nexus to the crime or other

aggravating evidence. *See Sears v. Upton*, 130 S. Ct. 3259 (2010); *Porter v. McCollum*, 130 S. Ct. 447 (2009); *Rompilla v. Beard*, 545 U.S. 374 (2005); *Tennard v. Dretke*, 542 U.S. 274 (2004) (holding evidence of impaired intellectual functioning inherently mitigating in capital penalty phase). The independent mitigating force of brain damage would have created a reasonable probability that the jury would have returned a life verdict.

Depending on the results of Dr. Gur's report, additional expert assistance may be required. For example, Dr. Gur's analysis may uncover brain damage that should be verified by additional neuropsychological testing. Such testing would confirm impairments related to the brain damage Dr. Gur may uncover using his quantitative analysis.

Likewise, should Dr. Gur's analysis uncover brain damage, additional investigation into lay witnesses, medical records, and other social history records may be required. Those sources of information could provide the additional factual bases for the underlying brain damage. Depending on what Dr. Gur uncovers, this investigation may require investigation not only into Applicant's history, but additional inquiry into the history of his family members.

For example, if Applicant has a brain abnormality with a genetic basis, information related to his genetic history would be relevant to confirming the existence and etiology of that abnormality. Post-conviction counsel for Applicant have recently uncovered the presence of dementia in his paternal family (Ex. 9 (medical records of Louis Michael Winkler Sr.)), and obtaining additional medical history may become necessary depending on what brain abnormalities Dr. Gur uncovers. Depending on the outcome of the analysis, substantial investigation into lay witnesses and documentary evidence could be necessary.

Had Applicant been given additional time, he could have uncovered substantial evidence that supports his current claims for post-conviction relief.

III. Additional Claims Applicant May Have Been Able to Prove.

Depending on the information uncovered by the PET and MRI, the analysis of the PET and MRI, and the investigation subsequent to it, Applicant may be able to establish additional claims for relief.

For example, a reduced capacity to control Applicant's impulses or emotions could support a lesser included crime or additional defenses, such as heat of passion. The information could be relevant to whether Applicant was able to control his impulses in response to a provocation and whether he acted while still under the heat of passion. If, for example, Applicant suffers from brain abnormalities affecting his ability to control his impulses, he would be more likely to act on an impulse in response to a provocation. Likewise, if he has brain abnormalities affecting ability to process and control emotions, that information would be relevant to whether he was acting while under the heat of passion. Trial counsel has no reasonable strategic reason for failing to investigate and present this information.

CONCLUSION

Had Applicant been given adequate time to prepare for the PCR hearing, he could have uncovered substantial evidence that supports his additional claims for post-conviction relief, as well as other potentially meritorious claims.

Respectfully submitted,

June 16, 2012
DATE

COUNSEL FOR MR. WINKLER

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EXHIBIT 1

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Triangle Neuropsychology Services

Fax

To: John Mills

From: Kristine Herfkens, Ph.D., ABPP

Fax: 237-9254

Pages: 2

Phone:

Date: 11/2/11

Re:

CC:

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TRIANGLE NEUROPSYCHOLOGY SERVICES, PLLC
3310 Croasdaile Drive, Suite 400
Durham, NC 27705

2 November 2011

John. R. Mills
201 W. Main Street
Suite 301
Durham, NC 27701

Dear Mr. Mills:

This letter is in reference to your client, Mr. Louis Michael Winkler. I recommend that you consider consulting with a neurologist or neuropsychiatrist for further information about Mr. Winkler's neurologic status. In addition, it would be very useful to have neuroimaging of Mr. Winkler. A neurologist or neuropsychiatrist would have to refer for and interpret that testing.

If I can provide further information to you, please do not hesitate to call.

Sincerely,

Kristine M. Herfkens, PhD, ABPP
Board Certified in Clinical Neuropsychology

EXHIBIT 2

Perelman School of Medicine
University of Pennsylvania

Department of Psychiatry
Neuropsychiatry Section

June 4, 2012

To whom it may concern:

In December of 2012, the University of Pennsylvania Brian Behavior Laboratory agreed to analyze magnetic resonance imaging (MRI) and positron emission tomography (PET) scans of Louis Michael Winkler and to write a comprehensive report. To conduct a comprehensive neuroimaging evaluation, both an MRI and a PET scan are required. A volumetric MRI scans are used to produce images of the brain's structure, while PET scans are used to measure the brain's metabolism. Both are required for the Brain Behavior Laboratory to conduct a comprehensive analysis of Mr. Winkler's potential brain damage. Without the PET, the analysis will be incomplete because we will have no measure of Mr. Winkler's brain physiology.

It is my understanding that Mr. Winkler had a high-resolution MRI on January 26, 2012. To date we have not received a PET scan study of Mr. Winkler. Once we receive the PET, it takes approximately six to eight weeks to conduct the analysis once the images are received.

After conducting the analysis, it is customary for Dr. Ruben Gur to consult with the attorneys requesting the analysis and report, which can take an additional week or two to arrange.

If you have any questions or concerns, please do not hesitate to contact us.

Sincerely,

Michael Kobel Keutmann

Digitally signed by Michael Kobel Keutmann
DN: cn=Michael Kobel Keutmann, o=University of Pennsylvania, ou=Neuropsychiatry, email=michaelk@upenn.edu, c=US
Date: 2012.06.04 15:00:54 -05'00'

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EXHIBIT 3

UNIVERSITY OF PENNSYLVANIA - SCHOOL OF MEDICINE
Curriculum Vitae

Date: March 2012

Ruben C. Gur, Ph.D.

HOME ADDRESS: [redacted]
Voice/Fax [redacted]

OFFICE ADDRESS: Brain Behavior Laboratory
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10 Gates Building
University of Pennsylvania
Philadelphia, PA 19104-4283
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EDUCATION:

1967-70	B.A. Hebrew University of Jerusalem
1970-71	M.A. Michigan State University
1971-73	Ph.D. Michigan State University
1973-74	Postdoctoral Fellowship, Stanford University

POSTGRADUATE TRAINING AND FELLOWSHIP APPOINTMENTS:

Doctorate:	1971	NIMH Summer Traineeship, Psychiatric Clinic Oakland County Juvenile Court Pontiac, Michigan
	1971-72	Psychology Internship, Psychiatric Clinic State Prison of Southern Michigan Jackson, Michigan
	1972-73	Psychology Internship, Counseling Center Michigan State University East Lansing, Michigan
Postdoctorate:	1973-74	Research Associate, Department of Psychology Stanford University, Stanford, California
	1974-76	Postdoctorate supervised clinical experience Department of Psychiatry University of Pennsylvania

MILITARY SERVICE: 1965-67 Israeli Defense Forces

FACULTY APPOINTMENTS:

1974-81	Assistant Professor Department of Psychology University of Pennsylvania School of Medicine Philadelphia, PA
1981-84	Research Associate Professor of Psychology in Neurology and Psychiatry University of Pennsylvania School of Medicine Philadelphia, PA
1984-88	Associate Professor of Psychology in Psychiatry and Neurology University of Pennsylvania School of Medicine Philadelphia, PA
1988-Present	Professor of Psychology in Psychiatry, Neurology and Radiology University of Pennsylvania School of Medicine Philadelphia, PA

HOSPITAL AND ADMINISTRATIVE APPOINTMENTS:

1974-81	Supervisor, Clinical Training Program Department of Psychology University of Pennsylvania School of Medicine Philadelphia, PA
1982-84	Director of Neuropsychology Department of Neurology The Graduate Hospital Philadelphia, PA
1984-Present	Director of Neuropsychology and the Brain Behavior Laboratory, Department of Psychiatry Hospital of the University of Pennsylvania Philadelphia, PA
2005-Present	Director of the Center for Neuroimaging in Psychiatry Department of Psychiatry Hospital of the University of Pennsylvania Philadelphia, PA
2005-Present	Staff Psychologist Philadelphia Veterans Administration Hospital

Philadelphia, PA

BOARD SPECIALTY CERTIFICATION:

Diplomate in Clinical Neuropsychology
American Board of Professional Psychology

LICENSURE: Licensed Psychologist, Commonwealth of Pennsylvania

AWARDS, HONORS AND MEMBERSHIP IN HONORARY SOCIETIES:

Erickson Award for Scientific Excellence for Writing in Hypnosis - 1976
Member, Sigma Xi
Elected to Fellow status, National Academy of Neuropsychologists, 1986
Elected to Fellow status, American Psychological Association, Divisions 6 & 30, 1987
NAMI Stephen V. Logan Award, 1990
Elected to Fellow status, The Association for Psychological Science, 1992
NARSAD Distinguished Investigator Award - 2007
NARSAD Lieber Prize for Outstanding Achievement in Schizophrenia Research – 2009
American Psychological Association George A. Miller Award - 2009

MEMBERSHIP IN PROFESSIONAL AND SCIENTIFIC SOCIETIES:

American Psychological Association, FELLOW
American Psychological Society, FELLOW
American College of Neuropsychopharmacology, FELLOW
The John Morgan Society
American Association for the Advancement of Science
International Neuropsychological Society
National Academy of Neuropsychologists
The New York Academy of Science
International Society for Neuroimaging in Psychiatry

EDITORIAL/ADVISORY POSITIONS:

Member, NIH Study Section on Clinical Neuroscience and Biological Psychopathology (1993-1996) and Neural Basis of Psychopathology, Addictions and Sleep Disorders (NPAS) -2004-2008), NIH Distinguished Editors Panel, BBBP - Biobehavioral & Behavioral Processes IRG (2009)

Editorial Board: Archives of Clinical Neuropsychology (1985-1997), Journal of Mental Imagery (1984-present), Brain and Cognition (1989-present), Brain and Language (1990-present), Brain Imaging and Behavior (1994-present; founding member), Social Neuroscience (founding member). Schizophrenia Research (2004-present)

Action Editor: Brain and Cognition (2002-present)

Advisory Board: The Greenwall Initiative on Imaging and Treating the Human Brain: Ethical and Social Implications. The Center for Bioethics, University of Pennsylvania; Institute for Strategic Threat Analysis and Response (ISTAR), University of Pennsylvania, (2002-)

The Conte Center on the Neurobiology of Suicide, Columbia University (J Mann, MD, PI), Boston Center for Intervention Development and Applied Research (CIDAR is a NIMH-sponsored program project, "Vulnerability to Progression in Schizophrenia".

Advisor, DSM-5 Work Group on Diagnostic Instrument (2011-present)

ACADEMIC COMMITTEES AT THE UNIVERSITY OF PENNSYLVANIA:

1975-1977	Admissions Committee, Psychology Department
1984-1994	Research Committee, Psychiatry Department
1984-1987	Computer Task Force, Psychiatry Department
1984-1988	Chairman's Council for Planning and Development, Psychiatry Department
1990-1992	Senate Committee on Academic Freedom and Responsibility
1996-1998	Search Committee for Chair of Radiology
2000-2002	Search Committee for fMRI Physicist
2002-Present	Steering Committee Center for Functional Neuroimaging
2005-Present	Project Development Committee Center for Functional Neuroimaging
1999-Present	University Scholars Council

MAJOR TEACHING & CLINICAL RESPONSIBILITIES AT THE UNIVERSITY OF PENNSYLVANIA:

A. Teaching:

1. Co-founder and Advisor, Biological Basis of Behavior Undergraduate Major program
2. Supervisor of postdoctoral Fellows (NIMH Training Grant) and doctoral students
3. Member of dissertation committees
4. Rounds and teaching conferences for Psychiatry residents and Neuropsychology Fellows
5. Supervisor of undergraduate Honors theses
6. Co-Founder and Mentor, International Research Training Grant (IRTG 1328) between University of Pennsylvania and the Jülich-Aachen Research Alliance, Germany

B. Clinical:

1. Director of Neuropsychology, Department of Psychiatry, Hospital of the University of Pennsylvania
2. Supervisor of interns and practicum students in neuropsychology.
3. Director of Forensic Neuropsychiatry Center, Hospital of the University of Pennsylvania
4. Psychologist, Philadelphia Veterans Administration Hospital

PRESENTATIONS & LECTURES BY INVITATION: (Outside Philadelphia, Past 5 years, partial list)

April 20, 2007 "Gender Differences in Cerebral Function and Morphology in Normal Subjects. Advances in Neuroscience Conference, Napoli, Italy.

October 6, 2007 "Brain Function, Gender and Age" ASTAR National Judges' Science School. Baltimore, Maryland.

October 11, 2007 "Neurobiology of Sex Differences: Potential Relevance to Women in Science"

Women's Leadership Board Meeting, Cambridge, Massachusettes.

November 16, 2007 "Brain Imaging" Ohio Association of Criminal Defense Lawyers. Columbus, Ohio.

April 2, 2008 "Cutting Edge Neuroscience" Capital Habeas Corpus Unit Conference, Fort Lauderdale, Florida.

November 7, 2008 "Some Advances in Cognitive and Affective Neuroscience with Potential Legal Relevance: Neuroimaging of Brain and Behavior" Institute for Social Science Faculty Fellows and Law faculty, Cornell University, Ithaca, New York.

November 8, 2008 "Brain Development in Healthy and Vulnerable Populations: Lessons from Neuroimaging and Behavioral Measures", Joint Human Development, Psychology and Center for Behavioral Economics and decision Science Colloquium, Cornell University, Ithaca, New York.

November 19, 2008 "Is Fear Special? Studies on the Affective Neuroscience of Schizophrenia" Grand Rounds at University of Illinois in Chicago, Department of Psychiatry, Chicago, Illinois.

November 11, 2008 "Finding the Right Expert and Using them Effectively" Capital Defense Workshop, Richmond, Virginia.

April 22, 2009 "Evidence for Impairment of Heritability of Neurocognitive Functioning in Families of Schizophrenia Patients" Morehouse School of Medicine, Department of Psychiatry Grand Rounds. Atlanta, Georgia.

June 29, 2009 "Language Deficits in Schizophrenia: Evidence from behavioral, functional and connectivity studies" 9th World Congress of Biological Psychiatry. Paris, France.

October 30, 2009 "How Does Cognition Become Neurocognition?" NARSAD Symposium XII, New York City, New York.

April 12, 2010 "Emotion, Genes and the Brain" 2nd Schizophrenic International Research Society Conference, Florence, Italy.

November 27, 2010 "Understanding Emotion Processing" DGPPN Congress, German Association for Psychiatry and Psychotherapy, Berlin, Germany.

February 3, 2011 "Endophenotypes for Schizophrenia Spectrum Disorders: Evidence from Neurological, Cognitive, and Emotional Findings?" 39th Annual International Neuropsychological Society Meeting, Boston, Massachusetts.

April 5, 2011 "Social Cognition and Social Neuroscience in Schizophrenia" International Congress on Schizophrenia Research, Colorado Springs, Colorado.

June 2, 2011 "Probing Deficits in Processing of Vocal and Facial Affect in Schizophrenia with fMRI" 10th World Congress of Biological Psychiatry, Prague, Czech Republic

July 10, 2011 "Interconnectivity of Cortical and Subcortical Regions" American Association for Justice Annual Convention, Traumatic Brain Injury Litigation Group, New York, New York.

September 13, 2011 "A Lab Rat in the Courtroom? When Neuroscience Weighs in on Life or Death" Law and Neuroscience Speaker Series, Fordham Law School, New York, New York.

December 5, 2011 "Adolescent Brains: The Constancy of Change" ACNP 50th Annual Meeting, Waikoloa, Hawaii.

January 6, 2012 "Neuroimaging genomics: A new agenda for neuropsychology" Grand Rounds at Columbia University, Department of Psychiatry, New York, New York.

ORGANIZING ROLES IN SCIENTIFIC MEETINGS:

Co-Chaired a session at the 9th World Congress of Biological Psychiatry. Paris, France

Co-Chaired a session at the Schizophrenic International Research Society Conference, Florence, Italy.

BIBLIOGRAPHY:

Research Publications, peer reviewed:

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2. Gur RC, Gur RE. Handedness, sex and eyedness as moderating variables in the relation between hypnotic susceptibility and functional brain asymmetry. Journal of Abnormal Psychology, 1974, 83, 635-643.

3. Gur RC. An attention-controlled operant procedure for enhancing hypnotic susceptibility. Journal of Abnormal Psychology, 1974, 83, 635-643.

4. Gur RE, Gur RC, Marshalek B. Classroom seating and functional brain asymmetry. Journal of Educational Psychology, 1975, 67, 151-153.

5. Gur RC, Hilgard ER. Visual imagery and discrimination of differences between altered pictures simultaneously and successively presented. British Journal of Psychology, 1975, 66, 341-345.

6. Gur RE, Gur RC. Defense mechanisms, psychosomatic symptomatology and conjugate lateral eye movements. Journal of Consulting and Clinical Psychology, 1975, 43, 416-420.

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10. Sackeim HA, Packer IK, Gur RC. Hemisphericity, cognitive set and susceptibility to subliminal perception. Journal of Abnormal Psychology, 1977, 86, 624-630.

11. Gur RE, Gur RC. Sex differences in the relations among handedness, sighting-dominance and eye acuity. Neuropsychologia, 1977, 15, 585-590.

12. Sackeim HA, Gur RC, Saucy MC. Emotions are expressed more intensely on the left side of the face. Science, 1978, 202, 434-436.

13. Gur RC, Sackeim HA. Self-confrontation and psychotherapy. Psychotherapy: Theory, Research and Practice, 1978, 15, 258-265.

14. Sackeim HA, Gur RC. Lateral asymmetry in intensity of emotional expression. Neuropsychologia, 1978, 16, 473-481.

15. Sackeim HA, Gur RC. Self-deception, other-deception, and self-reported psychopathology. Journal of Consulting and Clinical Psychology, 1979, 47, 213-215.

16. Gur RC, Sackeim HA. Self-deception: A concept in search of a phenomenon. Journal of Personality and Social Psychology, 1979, 37, 147-169.

17. Sackeim HA, Nordlie JW, Gur RC. A model of hysterical and hypnotic blindness: cognition, motivation and awareness. Journal of Abnormal Psychology, 1979, 88, 474-489.

18. Gur RC, Reivich M. Cognitive task effects on hemispheric blood flow in humans: evidence for individual differences in hemispheric activation. Brain and Language, 1980, 9, 78-92.

19. Gur RC, Packer IK, Hungerbuhler JP, Reivich M, Obrist WD, Amarnek WS,Sackeim HA. Differences in the distribution of gray and white matter in human cerebral hemispheres. Science, 1980, 207, 1226-1228.

20. Sackeim HA, Greenberg MS, Weiman AL, Gur RC, Hungerbuhler JP, Geschwind N. Hemispheric asymmetry in the expression of positive and negative emotions: Neurological Evidence. Archives of Neurology, 1982, 39, 210-218.

21. Gur RC, Sussman NM, Alavi A, Gur RE, Rosen AD, O'Connor M, Goldberg HI, Greenberg JH, Reivich M. Positron emission tomography in two cases of childhood epileptic encephalopathy (Lennox-Gastaut Syndrome). Neurology, 1982, 32, 1191-1194.

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Not tracked.

Research Publications, non-peer reviewed: None.

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12. Gur RC &.McBride, T. Toward a unitary description of neuropsychological functions: a review of Handbook of Clinical and Experimental Neuropsychology Edited by Gianfranco Denes and Luigi Pizzamiglio. Contemporary Psychology, 2000, 45, 682-683.

BOOKS:

Gur RE, Andreasen NA, Asarnow R, Gur RC, Jones P, Kendler K, Matcheri K, Lieberman J, McCarley R, Murray R, Rapoport J, Tamminga C, Tsuang M, Walker E, Weinberger D. Commission on Schizophrenia. In D.L. Evans, E. Foa, R.E. Gur, H. Hendrin, C. O'Brien, M. Seligman, B.T. Walsh, (Eds), Treating and Preventing Adolescent Mental Health Disorders: What We Know and What We Don't Know. New York: Oxford University Press, The Annenberg Foundation Trust at Sunnylands, and the Annenberg Public Policy Center of the University of Pennsylvania, 2005.

RESEARCH SUPPORT

Not tracked.

PATENT:

Gur RC, Gur RE, Trivedi SS. "Behavioral Imaging: Topographic Display of Neuropsychological Data, U.S. Patent No. 4862359.

EXHIBIT 4

Radiology Results

Date Printed: 02/14/12

Name: WINKLER, LOUIS MICH ID: 1845446 SEX:M AGE:51

01/26/12 : 11:47am
RAD - MRI BRAIN W/O CONTRAST
DLB
Accession number: 6567489

EXAMINATION: MRI BRAIN 01/26/12 11:47:00

ACCESSION NUMBER: 6567489

INDICATION: Legal case. 51 year old man with a known history of concussion resulting in possible neuropsychiatric sequelae.

COMPARISON: None

TECHNIQUE: Multi-sequence, multi-planar MR images were obtained of the brain without the administration of IV contrast per limited protocol including two 3-D volumetric sequences and a dual echo T2.

FINDINGS:

There is no gross evidence of intracranial hemorrhage, extra-axial collection, mass, or hydrocephalus. There is patchy subcortical white matter hypodensity, a nonspecific finding, likely the result of microangiopathy.

IMPRESSION:

1. No MR evidence of acute intracranial abnormality on this limited study.

VOICE DICTATED BY: Dr. DONNA ROBERTS

AUTHENTICATING RADIOLOGIST: DONNA ROBERTS

Practice Partner signature acknowledges receipt of results only.

MRI of brain (non contrast). Legal case. (please follow these technical requirements) 1. Include a sequence that is T1-w Legal case. 51 year old man with a known history of concussion resulting in possible neuropsychiatric sequelae.

SIGNED BY DAVID L BACHMAN, (ATTENDING) (DLB) 01/27/2012 12:46PM

EXHIBIT 5

MUSC Health
NEUROSCIENCES

February 7, 2012

John R. Mills
Attorney
201 W. Main Street
Suite 301
Durham, NC 27701

RE: Louis Winkler
DOB [redacted]

Dear Mr. Mills,

As you are aware, we were unable to complete the court-ordered brain PET scan for your client, Mr. Winkler. Prior to performing PET scans, blood tests are performed to ensure that the patient's blood glucose concentration does not interfere with the flurodeoxyglucose used to produce the PET images. If the patient has an abnormal blood glucose concentration, then the imaging will not produce a reliable result.

A test of Mr. Winkler's blood on the morning of the scan showed his blood glucose concentration to be 272 mg/dl. Normal blood glucose concentrations for fasting individuals are usually no more than100 mg/dl. Mr. Winkler's glucose concentration strongly suggests that he has untreated diabetes and that he needs treatment. Such a high concentration is very unlikely to be the result of eating, and Mr. Winkler reported compliance with the dietary restrictions, including fasting.

Assuming that Mr. Winkler immediately starts treatment for diabetes, it normally takes six to eight weeks of attentive treatment for glucose concentration to return to the normal range. After his glucose concentration returns to normal, we would be happy to reschedule him for PET imaging.

Sincerely,

David L. Bachman, MD
Professor of Neurosciences
Medical University of South Carolina
96 Jonathan Lucas St
CSB- Suite 301
Charleston, SC 29425
Office: 843-792-6941

EXHIBIT 6

John R. Mills
201 W. Main Street, Suite 301• Durham, NC 27701
Phone: 919 251 6259 • Fax: 919 237 9254 • E-Mail: john@jrmillslaw.com
Web: jrmillslaw.com

Date: February 14, 2012

VIA FACSIMILE

Ms. Joan Doudy
South Carolina Department of Corrections
803-896-1999

Re: Louis Michael Winkler

Dear Ms. Doudy:

Pursuant to our conversation last week, I am writing to provide you with Dr. David Bachman's letter describing Mr. Winkler's present health.

As we discussed, Mr. Winkler was seen by Dr. Bachman late last month. Dr. Bachman was unable to perform the planned PET scan on Mr. Winkler because Mr. Winkler had elevated sugar levels which strongly suggest he has untreated diabetes. Until Mr. Winkler's diabetes is treated and his sugar levels are returned to the normal range, Dr. Bachman will be unable to perform a PET scan.

I am writing to request that Mr. Winkler receive testing and treatment for his blood sugar treatment as soon as possible.

Please do not hesitate to contact me if you have any questions or concerns.

Sincerely,

John R. Mills
Attorney

Enclosures

cc: Hon. Benjamin Culbertson
Emily Paavola, Esq.

MUSC Health
NEUROSCIENCES

February 7, 2012

John R. Mills
Attorney
201 W. Main Street
Suite 301
Durham, NC 27701

RE: Louis Winkler
DOB [redacted]

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Assuming that Mr. Winkler immediately starts treatment for diabetes, it normally takes six to eight weeks of attentive treatment for glucose concentration to return to the normal range. After his glucose concentration returns to normal, we would be happy to reschedule him for PET imaging.

Sincerely,

David L. Bachman, MD
Professor of Neurosciences
Medical University of South Carolina
96 Jonathan Lucas St
CSB- Suite 301
Charleston, SC 29425
Office: 843-792-6941

Gmail by Google

John Mills <john.r.mills@gmail.com>

Fax Delivery Successful to 18038961999

1 message

MyFax <NoReply@myfax.com> **Tue, Feb 14, 2012 at 4:21 PM**
To: john.r.mills@gmail.com

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Fax Delivery Number:	18038961999
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Pages:	3
Duration:	99
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Tax - GST:	0.0000 USD
Tax - PST:	0.0000 USD
Total Cost:	0.0000 USD
Customer Number:	4756722
Reference Number:	455633922
Billing Code:	4756722
Remote CSID:	8038961999

Thank you for using myfax.

EXHIBIT 7

MDCP881D SOUTH CAROLINA DEPARTMENT OF CORRECTIONS 03/28/12
OMINMDCA SCDC HEALTH SERVICES: MEDICAL SUMMARY C045560

SCDC# 6027 WINKLER,LOUIS MICHAEL PAGE 1

** ENCOUNTER: 223 DIABETIC CLINIC 03/28/12 12:27 LIEBER COMP
NOON BS 192 2 UNITS REGULAR INSULIN TO LEFT ARM.
SIGNED OFF ON 03/28/12 @ 12:28 BY JAMES M BRANDFASS, REGISTERED NURSE I

** ENCOUNTER: 222 DIABETIC CLINIC 03/28/12 6:54 LIEBER COMP
0500 REFUSED FSBS
SIGNED OFF ON 03/28/12 @ 6:55 BY SHARON D GARVIN-SHULER, MEDICAL ASSISTANT T
SIGNED OFF ON 03/28/12 @ 7:43 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 221 MENTAL HEALTH CLINIC 03/27/12 13:12 LIEBER CCC
S: WM WITH A HX OF MOOD D/O NOS AND ANXIETY D/O NOS WHO WAS SEEN AT HIS CEL
L DOOR. IM REPORTS THAT HE IS DOING WELL AND VOICES NO COMPLAINTS AT THIS T
IME. TOLERATING ALL MEDS WELL. NO SIDE EFFECTS. NO SI OR HI ENDORSED.
O: MSE - APPEARS TO HAVE JUST WOKEN UP FROM SLEEP. NAD. MOOD "OK". AFFECT N
ORMAL RANGE
A:
1. MOOD D/O NOS
2. ANXIETY D/O NOS
P:
1. CONT WTIH GABAPENTIN 600 MG PO QAM, 600 MG PO QNOON AND 900 MG PO QPM.
2. RTC 3 MOS
SIGNED OFF ON 03/27/12 @ 13:15 BY PHILIP SINATO, PSYCHIATRIST

** ENCOUNTER: 220 DIABETIC CLINIC 03/27/12 6:47 LIEBER COMP
0500. REFUSED FSBS. STATES HE ONLY TAKES FSBS TWICE DAILY-NOON AND PM.
SIGNED OFF ON 03/27/12 @ 6:49 BY BRENDA F FOGLE, REGISTERED NURSE I
SIGNED OFF ON 03/27/12 @ 7:25 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 219 PPD 03/27/12 6:36 LIEBER COMP
PPD GIVEN IN LEFT ARM ON 3-23-12 AND READ ON 3-26-12 AT 0 MM. LOT #C3764AA
EXPIRES 09.03.13.
SIGNED OFF ON 03/27/12 @ 6:36 BY LUANNE W MAUNEY, REGISTERED NURSE II

** ENCOUNTER: 218 DIABETIC CLINIC 03/26/12 16:55 LIEBER COMP
PM BS 263. 6 UNITS REGULAR INSULIN TO LEFT ARM.
SIGNED OFF ON 03/26/12 @ 16:56 BY JAMES M BRANDFASS, REGISTERED NURSE I
THOMAS E BYRNE MD
SIGNED OFF ON 03/26/12 @ 19:32 BY THOMAS E BYRNE, PHYSICIAN II

** ENCOUNTER: 217 DIABETIC CLINIC 03/26/12 13:03 LIEBER COMP
NOON BS 168. 2 UNITS REGULAR INSULIN TO RIGHT ABD.
SIGNED OFF ON 03/26/12 @ 13:04 BY JAMES M BRANDFASS, REGISTERED NURSE I

** ENCOUNTER: 216 MENTAL HEALTH CLINIC 03/26/12 8:39 LIEBER COMP
3/21/12
INC NOTE;
I/M WAS SCHEDULED TO BE SEEN TODAY FOR I/C SESSION UNABLE TO BE SEEN DUE TO
SECURITY REASON. WILL F/U NEXT WEEK.
TANYA MCCANTS, HSCII
SIGNED OFF ON 03/26/12 @ 8:40 BY TANYA F MCCANTS, HUMAN SERVICES COORD II

** ENCOUNTER: 215 DIABETIC CLINIC 03/25/12 6:33 LIEBER COMP
REFUSED FSBS
SIGNED OFF ON 03/25/12 @ 6:33 BY LOREE PARKER, REGISTERED NURSE I
SIGNED OFF ON 03/25/12 @ 11:18 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 214 DIABETIC CLINIC 03/24/12 6:39 LIEBER COMP
0500 REFUSED FSBS
SIGNED OFF ON 03/24/12 @ 6:39 BY SHARON D GARVIN-SHULER, MEDICAL ASSISTANT T
SIGNED OFF ON 03/24/12 @ 8:46 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 213 DIABETIC CLINIC 03/23/12 6:37 LIEBER COMP
0500 REFUSED FSBS
SIGNED OFF ON 03/23/12 @ 6:38 BY SHARON D GARVIN-SHULER, MEDICAL ASSISTANT T

** ENCOUNTER: 212 DIABETIC CLINIC 03/22/12 6:20 LIEBER COMP
0500 REFUSED FSBS
SIGNED OFF ON 03/22/12 @ 6:20 BY SHARON D GARVIN-SHULER, MEDICAL ASSISTANT T
SIGNED OFF ON 03/22/12 @ 6:33 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 211 DIABETIC CLINIC 03/21/12 15:39 LIEBER COMP
PM BS 332. 8 UNITS REG INSULIN TO LFT ARM.
KOP GLIPIZIDE ISSUED.
SIGNED OFF ON 03/21/12 @ 15:41 BY JAMES M BRANDFASS, REGISTERED NURSE I
SIGNED OFF ON 03/21/12 @ 18:03 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 210 NARRATIVE 03/21/12 12:30 LIEBER COMP
PER NP HOLCOMB, CHANGE KOP STATUS TO YES. WILL ISSUE GLYPIZIDE.
SIGNED OFF ON 03/21/12 @ 12:32 BY JAMES M BRANDFASS, REGISTERED NURSE I

** ENCOUNTER: 209 DIABETIC CLINIC 03/21/12 12:29 LIEBER COMP
NOON BS 395, PC. SANDWICHES SERVED EARLY.
SIGNED OFF ON 03/21/12 @ 12:29 BY JAMES M BRANDFASS, REGISTERED NURSE I
REFUSAL DOCUMENTED.
SIGNED OFF ON 03/21/12 @ 12:32 BY JAMES M BRANDFASS, REGISTERED NURSE I
PLEASE HAVE MEDS AS KOP PLEASE.
SIGNED OFF ON 03/21/12 @ 13:16 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III
NOTED
SIGNED OFF ON 03/21/12 @ 13:56 BY DENISE ARGENTINO, LICENSED PRACTICAL NURS

** ENCOUNTER: 208 DIABETIC CLINIC 03/21/12 6:48 LIEBER COMP
0500 REFUSED FSBS
SIGNED OFF ON 03/21/12 @ 6:48 BY SHARON D GARVIN-SHULER, MEDICAL ASSISTANT T
SIGNED OFF ON 03/21/12 @ 7:30 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 207 DIABETIC CLINIC 03/20/12 6:46 LIEBER COMP
0500 REFUSED FSBS.
SIGNED OFF ON 03/20/12 @ 6:46 BY SHARON D GARVIN-SHULER, MEDICAL ASSISTANT T
SIGNED OFF ON 03/20/12 @ 6:48 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 206 DIABETIC CLINIC 03/19/12 17:06 LIEBER COMP
PM BS 271. 6 UNITS REGUALAR INSULIN TO RIGHT ABD.
SIGNED OFF ON 03/19/12 @ 17:06 BY JAMES M BRANDFASS, REGISTERED NURSE I
SIGNED OFF ON 03/20/12 @ 5:56 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 205 DIABETIC CLINIC 03/19/12 12:56 LIEBER COMP
NOON BS 298. 6 UNITS REGULAR INSULIN TO LEFT ABD.
SIGNED OFF ON 03/19/12 @ 12:56 BY JAMES M BRANDFASS, REGISTERED NURSE I
SIGNED OFF ON 03/19/12 @ 12:59 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 204 DIABETIC CLINIC 03/19/12 8:27 LIEBER COMP
REFUSED FSBS
SIGNED OFF ON 03/19/12 @ 8:28 BY JOSEPHINE G HALL, REGISTERED NURSE I

** ENCOUNTER: 203 DOCTOR'S CLINIC 03/19/12 5:55 LIEBER COMP
D/T I/M RECENTLY HIGH BS AND CONSISTENT COVERAGE WITH REGULAR INSULIN DESPI
TE TAKING METFORMIN, I WILL INITIATE GLIPIZIDE. PLEASE LET HIM KNOW.
P> GLIPIZIDE 5MG
P> SIG:1 PO BID 60/MO
P> SIG:
P> START DATE: 03/19/12 TOTAL DAYS: 180
P> MD:HOLCOMB,ELIZABETH -
SIGNED OFF ON 03/19/12 @ 5:58 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III
MAR UPDATED
SIGNED OFF ON 03/21/12 @ 14:06 BY DENISE ARGENTINO, LICENSED PRACTICAL NURS

** ENCOUNTER: 202 DIABETIC CLINIC 03/18/12 20:26 LIEBER COMP
5A REFUSED FSBS
SIGNED OFF ON 03/18/12 @ 20:27 BY JOSEPHINE G HALL, REGISTERED NURSE I
SIGNED OFF ON 03/19/12 @ 5:54 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 201 DIABETIC CLINIC 03/18/12 18:49 LIEBER COMP
FSBS AT 1600= 342. 8 UNITS OF NOVOLIN R GIVEN.
SIGNED OFF ON 03/18/12 @ 18:50 BY SHENIKA MITCHELL, LICENSED PRACTICAL NURS
SIGNED OFF ON 03/19/12 @ 5:53 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 200 DIABETIC CLINIC 03/18/12 18:48 LIEBER COMP
FSBS AT 1100 = 432. 14 UNITS OF NOVOLIN R ADMINISTERED. RECHECKED AFTER ONE
HOUR, BS= 265. WILL ASSESS I/M AT NEXT PILL PASS.
SIGNED OFF ON 03/18/12 @ 18:49 BY SHENIKA MITCHELL, LICENSED PRACTICAL NURS
SIGNED OFF ON 03/19/12 @ 5:53 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 199 DIABETIC CLINIC 03/18/12 18:43 LIEBER COMP
FSBS AT 1600 ON 03/17/12 = 392. 8 UNITS OF NOVOLIN R GIVEN.
SIGNED OFF ON 03/18/12 @ 18:43 BY SHENIKA MITCHELL, LICENSED PRACTICAL NURS
ERROR IN REGARDS TO NOVOLIN R DOSAGE. 10 UNITS NOVOLIN R ADMINISTERED FOR B
S OF 392.
SIGNED OFF ON 03/18/12 @ 18:47 BY SHENIKA MITCHELL, LICENSED PRACTICAL NURS
SIGNED OFF ON 03/19/12 @ 5:53 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 198 DIABETIC CLINIC 03/18/12 18:42 LIEBER COMP
FSBS AT 1100 ON 03/17/12 = 393. 8 UNITS OF NOVOLIN R GIVEN.
SIGNED OFF ON 03/18/12 @ 18:43 BY SHENIKA MITCHELL, LICENSED PRACTICAL NURS
ERROR IN REGARDS TO NOVOLIN R COVERAGE. FOR FSBS OF 393, 10 UNITS WERE ADMI
NISTERED TO I/M.
SIGNED OFF ON 03/18/12 @ 18:48 BY SHENIKA MITCHELL, LICENSED PRACTICAL NURS
SIGNED OFF ON 03/19/12 @ 5:53 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 197 LAB CLINIC 03/17/12 7:12 LIEBER COMP
REFUSED 0500 FSBS.
SIGNED OFF ON 03/17/12 @ 7:13 BY NIKKI L FOWLER, UNCLASSIFIED
SIGNED OFF ON 03/17/12 @ 10:48 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 196 DIABETIC CLINIC 03/16/12 15:53 LIEBER COMP
PM BS 245. 4 UNITS REG INSULIN.
SIGNED OFF ON 03/16/12 @ 15:53 BY JAMES M BRANDFASS, REGISTERED NURSE I
SIGNED OFF ON 03/16/12 @ 17:59 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 195 DIABETIC CLINIC 03/16/12 15:34 LIEBER COMP
NOON BS 301. 8 UNITS REGULAR INSULIN TO RIGHT ABD.
SIGNED OFF ON 03/16/12 @ 15:34 BY JAMES M BRANDFASS, REGISTERED NURSE I
SIGNED OFF ON 03/16/12 @ 17:59 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 194 DIABETIC CLINIC 03/16/12 5:53 LIEBER COMP
0500 REFUSED FSBS
SIGNED OFF ON 03/16/12 @ 5:54 BY SHARON D GARVIN-SHULER, MEDICAL ASSISTANT T
SIGNED OFF ON 03/16/12 @ 5:54 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 193 DIABETIC CLINIC 03/15/12 6:38 LIEBER COMP
0500 REFUSED FSBS
SIGNED OFF ON 03/15/12 @ 6:38 BY SHARON D GARVIN-SHULER, MEDICAL ASSISTANT T
SIGNED OFF ON 03/15/12 @ 6:45 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 192 DIABETIC CLINIC 03/14/12 17:31 LIEBER COMP
FSBS@1600=347 8U REG COV TO L ABD
SIGNED OFF ON 03/14/12 @ 17:32 BY DENISE ARGENTINO, LICENSED PRACTICAL NURS
SIGNED OFF ON 03/14/12 @ 18:41 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 191 DIABETIC CLINIC 03/14/12 7:06 LIEBER COMP
0500 REFUSED FSBS .
SIGNED OFF ON 03/14/12 @ 7:06 BY SHARON D GARVIN-SHULER, MEDICAL ASSISTANT T
SIGNED OFF ON 03/14/12 @ 7:08 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 190 DIABETIC CLINIC 03/13/12 6:33 LIEBER COMP
0500 REFUSED FSBS.
SIGNED OFF ON 03/13/12 @ 6:33 BY SHARON D GARVIN-SHULER, MEDICAL ASSISTANT T
SIGNED OFF ON 03/13/12 @ 7:07 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 189 DIABETIC CLINIC 03/12/12 3:51 LIEBER COMP
FSBS THIS A.M. WAS 378. INMATE INJECTED SELF WITH 10 UNITS OF REGULAR INSU

LIN IN LEFT ABD.
SIGNED OFF ON 03/12/12 @ 3:53 BY CAROLYN MOORER, LICENSED PRACTICAL NURSE
SIGNED OFF ON 03/12/12 @ 5:56 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 188 DIABETIC CLINIC 03/11/12 15:03 LIEBER COMP
PM BS 315. 8UNITS REGULAR INSULIN TO RIGHT ABD.
SIGNED OFF ON 03/11/12 @ 15:03 BY JAMES M BRANDFASS, REGISTERED NURSE I
SIGNED OFF ON 03/11/12 @ 17:41 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 187 DIABETIC CLINIC 03/11/12 13:54 LIEBER COMP
NOON BS 280. 6 UNITS REGULAR INSULIN GIVEN TO RIGHT ABD.
SIGNED OFF ON 03/11/12 @ 13:54 BY JAMES M BRANDFASS, REGISTERED NURSE I
SIGNED OFF ON 03/11/12 @ 17:41 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 186 DIABETIC CLINIC 03/11/12 7:26 LIEBER COMP
REFUSE FSBS.
SIGNED OFF ON 03/11/12 @ 7:27 BY CAROLYN MOORER, LICENSED PRACTICAL NURSE
THOAMS E BYRNE MD
SIGNED OFF ON 03/11/12 @ 8:41 BY THOMAS E BYRNE, PHYSICIAN II

** ENCOUNTER: 185 DIABETIC CLINIC 03/10/12 17:46 LIEBER COMP
PM BSD 269. 6 UNITS REGULAR INSULIN TO RIGHT ABD PER SELF.
SIGNED OFF ON 03/10/12 @ 17:47 BY JAMES M BRANDFASS, REGISTERED NURSE I
SIGNED OFF ON 03/11/12 @ 9:28 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 184 DIABETIC CLINIC 03/10/12 17:45 LIEBER COMP
NOON BS 382. 10 UNITS REGULAR INSULIN TO RIGHT DELTIOD.
SIGNED OFF ON 03/10/12 @ 17:46 BY JAMES M BRANDFASS, REGISTERED NURSE I
PLEASE ENSURE I/M IS TAKING METFORMIN AS PRESCRIBED, AND IF HIS RX HAS NOT
YET ARRIVED FROM PHARMACY PLEASE ISSUE HIM STARTER PACKS.
SIGNED OFF ON 03/11/12 @ 9:28 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III
INMATE WAS ISSUED METFORMIN ON 3/14/12 BY ARGENTINO LPN
SIGNED OFF ON 03/15/12 @ 14:43 BY SHARON A TISON, REGISTERED NURSE I

** ENCOUNTER: 183 DIABETIC CLINIC 03/10/12 6:07 LIEBER COMP
0500 REFUSED FSBS,STATED TO NURSE HE WILL ONLY TAKE FS AT NOON AND 4:00PM.
SIGNED OFF ON 03/10/12 @ 6:09 BY SHARON D GARVIN-SHULER, MEDICAL ASSISTANT T
SIGNED OFF ON 03/10/12 @ 8:37 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 182 DIABETIC CLINIC 03/09/12 6:40 LIEBER COMP
0500 REFUSED FSBS,AMA SUBMITTED.
SIGNED OFF ON 03/09/12 @ 6:41 BY SHARON D GARVIN-SHULER, MEDICAL ASSISTANT T
THOMAS E BYRNE MD
SIGNED OFF ON 03/09/12 @ 6:44 BY THOMAS E BYRNE, PHYSICIAN II

** ENCOUNTER: 181 DIABETIC CLINIC 03/08/12 8:09 LIEBER COMP
FSBS AT 500 192
SIGNED OFF ON 03/08/12 @ 8:10 BY JOSEPHINE G HALL, REGISTERED NURSE I
SIGNED OFF ON 03/08/12 @ 9:34 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 180 DIABETIC CLINIC 03/07/12 18:26 LIEBER COMP
PM BS 382. UNABLE TO GET TO I/M PRIOR TO CONSUMPTION OF MEAL. I/M REFUSED REGULAR INSULIN. REFUSAL DOCUMENTED AND GIVEN TO MEDICAL RECORDS.
SIGNED OFF ON 03/07/12 @ 18:28 BY JAMES M BRANDFASS, REGISTERED NURSE I
THOMAS E BYRNEDM
SIGNED OFF ON 03/07/12 @ 19:28 BY THOMAS E BYRNE, PHYSICIAN II

** ENCOUNTER: 179 DIABETIC CLINIC 03/07/12 13:54 LIEBER COMP
NOON BS 322. 8 UNITS REGULAR INSULIN TO RIGHT DELTIOD.
SIGNED OFF ON 03/07/12 @ 13:56 BY JAMES M BRANDFASS, REGISTERED NURSE I
SIGNED OFF ON 03/07/12 @ 14:50 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 178 DIABETIC CLINIC 03/07/12 6:38 LIEBER COMP
0500 REFUSED FSBS
SIGNED OFF ON 03/07/12 @ 6:38 BY SHARON D GARVIN-SHULER, MEDICAL ASSISTANT T
SIGNED OFF ON 03/07/12 @ 6:39 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 177 DIABETIC CLINIC 03/06/12 6:32 LIEBER COMP
FSBS @ 0500 = 329.
SIGNED OFF ON 03/06/12 @ 6:32 BY SHARON D GARVIN-SHULER, MEDICAL ASSISTANT T
SIGNED OFF ON 03/06/12 @ 6:52 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 176 DIABETIC CLINIC 03/05/12 19:01 LIEBER COMP
REFUSAL DOCUMENTED FOR NOON INSULIN REFUSAL. PM BS 342. C/O TALKED I/M IN TO TAKING PM REGULAR INSULIN. 8 UNITS REGULAR INSULIN TO RIGHT DELTOID.
SIGNED OFF ON 03/05/12 @ 19:02 BY JAMES M BRANDFASS, REGISTERED NURSE I
THOMAS E BYRNE MD
SIGNED OFF ON 03/05/12 @ 19:26 BY THOMAS E BYRNE, PHYSICIAN II

** ENCOUNTER: 175 NARRATIVE 03/05/12 18:20 LIEBER COMP
I/M REFUSED HIS NOON INSULIN COVERAGE. C/O TALKED I/M INTO TAKING TAKING P M INSULIN.
SIGNED OFF ON 03/05/12 @ 18:21 BY JAMES M BRANDFASS, REGISTERED NURSE I
NOTED.
SIGNED OFF ON 03/05/12 @ 18:24 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 174 DIABETIC CLINIC 03/05/12 12:51 LIEBER COMP
NOON BS 436. NP AT CELL SIDE. I/M REFUSED INSULIN PER AGREEMENT WITH NP. STARTER PACK OF GLUCOPHAGE 500MG, 2 TWICE A DAY GIVEN TO I/M BY NP HOLCOMB.
SIGNED OFF ON 03/05/12 @ 12:53 BY JAMES M BRANDFASS, REGISTERED NURSE I

** ENCOUNTER: 173 LAB CLINIC 03/05/12 12:41 LIEBER COMP
INMATE REFUSE TO HAVE BLOOD WORK DRAWN FOR A HGBA1C LEVEL, A CMP LEVEL, AND A CBC LEVEL. INMATE ALSO REFUSE TO GIVE A SPECIMEN OF URINE FOR A MICRO-ALBUMIN LEVEL, AND A URINALYSIS. INMATE SIGNED A REFUSAL OF MEDICAL ADVICE FORM PAPERWORK. THE REFUSAL OF MEDICAL ADVICE FORM PAPERWORK SIGNED BY TWO NURSES AND THE LT. IN THE SMU - A SIDE OF DEATH-ROW. THE REFUSAL OF MEDICAL ADVICE PAPERWORK, PLACE ON CHART FOR M.D. REVIEW AND SIGNATURE.
SIGNED OFF ON 03/05/12 @ 12:46 BY PAULETTE L SEABROOK, LICENSED PRACTICAL NUR
SPOKE TO THIS I/M AT LENGTH MYSELF TODAY ON DEATH ROW, HE CONTINUES TO REFU

SE ALL BLOOD WORK. STS THE REASON IS THAT THE LAST TIME THEY DREW BLOOD, "T HEY WROTE ME 4 PRESCRIPTIONS AND CHARGED ME $320 OVER 8 MONTHS, AND I ONLY GOT A PORTION OF IT BACK. I AM NOT LETTING THEM DRAW ANY BLOOD FROM ME. I T HOROUGHLY EXPLAINED TO HIM THAT WE NEED THE TESTS TO CHECK ON VITAL ORGANS AND MONITOR HIS TX FOR DM. HE CONTINUES TO REFUSE. HE VERBALIZES FULL UNDER STANDING OF MY EXPLANATIONS. STS HE IS FINE WITH CONTINUING THE FINGERSTICK S.
SIGNED OFF ON 03/05/12 @ 13:10 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III ABOVE NOTED.
SIGNED OFF ON 03/06/12 @ 13:50 BY LUANNE W MAUNEY, REGISTERED NURSE II

** ENCOUNTER: 172 MENTAL HEALTH CLINIC 03/05/12 11:51 LIEBER COMP
2/27/12:
D: I/M SEEN FOR I/C SESSION. I/M REPORTS STABLE ON MEDS, DENIED ANY SIDE EFFECTS. REPORTS SLEEP AND APPETITE IS OK. DENIED A/V HALLUCINATIONS AS WEL L AS H/S THOUGHTS.
A: DX: MOOD D/O NOS
ANXIETY D/O NOS
GAF-70
I/M APPEARED TO BE A/O X3; MOOD APPEARED TO BE NORMAL WITH GOOD EYE CONTACT . MEDICATION COMPLIANT. SPEACH CLEAR.
P: WILL F/U IN 30 DAYS OR PRN.
SIGNED OFF ON 03/06/12 @ 10:24 BY TANYA F MCCANTS, HUMAN SERVICES COORD II

** ENCOUNTER: 171 DIABETIC CLINIC 03/05/12 9:01 LIEBER COMP
05A REFUSED FSBS
SIGNED OFF ON 03/05/12 @ 9:01 BY JOSEPHINE G HALL, REGISTERED NURSE I
THOMAS E BYRNE MD
SIGNED OFF ON 03/05/12 @ 9:14 BY THOMAS E BYRNE, PHYSICIAN II

** ENCOUNTER: 170 DIABETIC CLINIC 03/05/12 1:26 LIEBER COMP
LATE ENTRY OF 3/4/12 AT 5A 500 REFUSED SSRI MD CALLED NO NEW ORDERS
SIGNED OFF ON 03/05/12 @ 1:32 BY JOSEPHINE G HALL, REGISTERED NURSE I
I HAVE ORDERED HIM METFORMIN. HE IS SCHEDULED TO BE SEEN THIS WEEK, PLEASE LET HIM KNOW THE MEDICATION HAS BEEN ORDERED AS WELL.
SIGNED OFF ON 03/05/12 @ 6:40 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III NOTED
SIGNED OFF ON 03/09/12 @ 12:28 BY DENISE ARGENTINO, LICENSED PRACTICAL NURS

** ENCOUNTER: 169 DIABETIC CLINIC 03/04/12 22:40 LIEBER COMP
10:50AM FSBS=328. I/M REFUSED S/S REG. INSULIN COVERAGE.
3:45PM FSBS=330. I/M REFUSED S/S REG. INSULIN COVERAGE.
SIGNED OFF ON 03/04/12 @ 22:42 BY TOBY MARKOWITZ, REGISTERED NURSE I

** ENCOUNTER: 168 DIABETIC CLINIC 03/04/12 22:35 LIEBER COMP
ENTRY INFO SAME CHARTED PAPER VERSION OF 3/3/12.
3/3/12 11:00AM FSBS=320 I/M REFUSED S/S REG INSULIN COVERAGE.
3/3/12 4:00PM FSBS=342 I/M REFUSED S/S REG INSULIN COVERAGE.
SIGNED OFF ON 03/04/12 @ 22:40 BY TOBY MARKOWITZ, REGISTERED NURSE I

** ENCOUNTER: 167 DOCTOR'S CLINIC 03/04/12 12:25 LIEBER COMP
PLEASE PLACE ON NP ROUNDS FOR THIS UPCOMING FRIDAY TO DISCUSS HIS FSBS.
SIGNED OFF ON 03/04/12 @ 12:25 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III
PLACED ON APPOINTMENT BOOK
SIGNED OFF ON 03/05/12 @ 15:35 BY LINDA E JONES, REGISTERED NURSE I

** ENCOUNTER: 166 DIABETIC CLINIC 03/03/12 6:49 LIEBER COMP
0500 REFUSED FSBS.
SIGNED OFF ON 03/03/12 @ 6:50 BY SHARON D GARVIN-SHULER, MEDICAL ASSISTANT T
SIGNED OFF ON 03/03/12 @ 8:59 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 165 DIABETIC CLINIC 03/02/12 19:07 LIEBER COMP
FSBS@1600=316
SIGNED OFF ON 03/02/12 @ 19:07 BY DENISE ARGENTINO, LICENSED PRACTICAL NURS
I HAVE PUT HIM ON FSBS TID WITH SSRI. CONTINUE TO DO FSBS TID WITH COVERAGE
FOR NOW SO A PATTERN OF BS CAN BE ESTABLISHED AND PO MEDS ORDERED.
SIGNED OFF ON 03/03/12 @ 8:57 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III
NOTED ON DIABETIC CARE RECORD AND ON INSULIN ENVELOPE
SIGNED OFF ON 03/03/12 @ 20:31 BY JOSEPHINE G HALL, REGISTERED NURSE I

** ENCOUNTER: 164 DIABETIC CLINIC 03/02/12 6:37 LIEBER COMP
0500 REFUSED FSBS B/C HE ATE PRIOR TO NURSE ARRIVAL.
SIGNED OFF ON 03/02/12 @ 6:38 BY SHARON D GARVIN-SHULER, MEDICAL ASSISTANT T
SIGNED OFF ON 03/02/12 @ 7:14 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III

** ENCOUNTER: 163 NON-FORMULARY RX 03/01/12 9:29 LIEBER COMP
INMATE TAKES GABAPENTIN 600 MG PO QAM, 600 MG PO QNOON AND 900 MG PO QPM. M
EDICATION IS TO EXPIRE. REQUESTING REFILL AT THIS TIME.
P> GABAPENTIN 300MG CAP (NEURONTIN) (NON-FORMULARY)
P> SIG:TAKE TWO PO QAM, TWO PO QNOON AND THREE PO QPM
P> SIG:
P> START DATE: 03/01/12 TOTAL DAYS: 180
P> MD:SINATO,PHILIP -
REQUIRES NON-FORM RX APPROVAL:03/01/12 @ 9:31 BY PHILIP SINATO, PSYCHIATRI
RX APPROVED 03/01/12 @ 9:56 BY BEVERLY A WOOD, PSYCHIATRIST
MEDICATION TRANSMITTED TO KIRKLAND PHARMACY. LIEBER MARS UPDATED.
SIGNED OFF ON 03/08/12 @ 8:57 BY SHARON A TISON, REGISTERED NURSE I

** ENCOUNTER: 162 MENTAL HEALTH CLINIC 03/01/12 9:28 LIEBER COMP
NF REQUEST SUBMITTED FOR GABAPENTIN 600 MG PO QAM, 600 MG PO QNOON AND 900
MG PO QPM. HE NORMALLY TAKES THIS MEDICATION AND IT IS DUE TO EXPIRE.
SIGNED OFF ON 03/01/12 @ 9:29 BY PHILIP SINATO, PSYCHIATRIST
NOTED
SIGNED OFF ON 03/08/12 @ 8:57 BY SHARON A TISON, REGISTERED NURSE I

** ENCOUNTER: 161 NARRATIVE 02/29/12 19:34 LIEBER COMP
NEURONTIN EXP. FORWARDED REQEST FOR RENEWAL TO DR. SINATO.
SIGNED OFF ON 02/29/12 @ 19:35 BY JAMES M BRANDFASS, REGISTERED NURSE I
TAKEN CARE OF TODAY AND RENEWED VIS NF REQUEST.
SIGNED OFF ON 03/01/12 @ 15:32 BY PHILIP SINATO, PSYCHIATRIST

MARS UPDATED
SIGNED OFF ON 03/02/12 @ 1:57 BY RACHEL LADDAGA, REGISTERED NURSE I

** ENCOUNTER: 160 NARRATIVE 02/26/12 11:56 LIEBER COMP
DURING NOON PILL ROUNDS, I/M ASKED ABOUT HIS HIGH BLOOD SUGARS. NOTED PREV OUS ENC THAT LABS ORDERED, NOTIFIED MS SEABROOK.
SIGNED OFF ON 02/26/12 @ 11:57 BY JAMES M BRANDFASS, REGISTERED NURSE I
PLEASE DRAW LABS.
SIGNED OFF ON 02/27/12 @ 6:51 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III
PLEASE OBTAIN BID FSBS ON THIS I/M FOR 1 MONTH.
SIGNED OFF ON 02/27/12 @ 10:40 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III
MARS AND INSULIN BOOK UPDATED. LAB ORDERS PLACED ON LAB SLIP
SIGNED OFF ON 02/29/12 @ 5:48 BY RACHEL LADDAGA, REGISTERED NURSE I

** ENCOUNTER: 159 DOCTOR'S CLINIC 02/08/12 10:58 LIEBER COMP
RECEIVED INFORMATION REGARDING A RECENTLY (COURT ORDERED) PET SCAN THAT COU LD NOT BE DONE B/C HIS BLOOD SUGAR WAS APPARENTLY TOO ELEVATED (WELL OVER 2 00). PLEASE DRAW A1C, CMP, CBC, AND COLLECT U/A.
SIGNED OFF ON 02/08/12 @ 10:59 BY ELIZABETH A HOLCOMB, NURSE PRACTITIONER III
ORDER PLACED IN LAB BOOK FOR COLLECTION
SIGNED OFF ON 02/09/12 @ 1:59 BY RACHEL LADDAGA, REGISTERED NURSE I

** ENCOUNTER: 158 MENTAL HEALTH CLINIC 02/07/12 10:32 LIEBER COMP
INC NOTE;
2/1/12;
TX TEAM APPROVED UPDATE TX PLAN. PLEASE SEE HARD COPY OF TX PLAN IN MEDICA L RECORDS. NEXT UPDATE WILL BE 7/19/12.
SIGNED OFF ON 02/07/12 @ 10:32 BY TANYA F MCCANTS, HUMAN SERVICES COORD II

** ENCOUNTER: 157 MENTAL HEALTH CLINIC 02/07/12 10:29 LIEBER COMP
1/30/12:
D: I/M SEEN FOR I/C SESSION TODAY. I/M REPORTS I AM STABLE ON NEUROTIN WITH NO SIDE EFFECTS. I/M DENIED A/V HALLUCINATIONS AS WELL AS H/S THOUGHTS. I/M DENIED AND ANXIETY AT THE PRESENT. REPORTS SLEEP AND APPETITE IS OK.
A: DX:MOOD D/O NOS
GAF-72
I/M APPEARED TO BE A/O X3; MOOD APPEARED TO BE PLEASANT WITH GOOD EYE CONTA CT. SPEACH CLEAR. MED COMPLIANT.
P: WILL F/U IN 30 DAYS OR PRN.
TX PLAN UPDATED.
SIGNED OFF ON 02/07/12 @ 10:31 BY TANYA F MCCANTS, HUMAN SERVICES COORD II

** ENCOUNTER: 156 DENTAL CLINIC 02/06/12 10:06 LIEBER COMP
EXT, #31 POIG ,REFUSE MEDS
A> NECROSIS OF TOOTH PULP
SIGNED OFF ON 02/06/12 @ 10:06 BY RAMNARINE JAGLAL, DENTIST

** ENCOUNTER: 155 DOCTOR'S CLINIC 01/31/12 11:26 LIEBER COMP
RECEIVED A REQUEST TO STAFF FROM THIS I/M REQUESTING A REFILL ON HIS MOTRIN

EXHIBIT 8

1996 WL 34406970 (M.D.Pa.) (Expert Report and Affidavit)
United States District Court, M.D. Pennsylvania.

USA,

v.

HAMMER.

No. 96CR00239. 1996.

(Report or Affidavit of Ruben C. Gur, Ph.D.)

Case Type: Professional Malpractice >> Other Professional Malpractice
Case Type: Medical Malpractice-Physicians & Health Professionals >>Psychologist
Jurisdiction: M.D.Pa.
Name of Expert: Ruben C. Gur, Ph.D.
Area of Expertise: Health Care-Physicians & Health Professionals >>Psychologist

Representing: Unknown

DECLARATION OF RUBEN C. GUR, PH.D.

I, Ruben C. Gur, Ph.D., do hereby declare and verify as follows:

1. I have been licensed as a psychologist in Pennsylvania since 1976. I received a B.A. from the Hebrew University of Jerusalem and an M.A. and a Ph.D. in Clinical Psychology from Michigan State University. I completed Postdoctoral Fellowships at Stanford University and at the University of Pennsylvania. I am a Professor on the Standing Faculty of the University of Pennsylvania, with a primary appointment in Psychiatry and secondary appointments in Neurology and in Radiology. I am currently the Director of Neuropsychology, Department of Psychiatry at the Hospital of the University of Pennsylvania. I am Principal Investigator (API@) of the Neuropsychology Core and the Functional Imaging Core of the federally funded Schizophrenia Center, Co-PI of the functional MRI project of the Conte Center for Neurosciences, and Co-PI and investigator on several individual NIH grants (RO1s) on brain imaging and psychopathology. I am also member of the Biological Basis of Behavior Undergraduate Major Program at the University of Pennsylvania. I have participated in the diagnosis of hundreds of individuals requiring neuropsychological testing and neuroimaging where issues similar to this case were raised. I am a Diplomate in Clinical Neuropsychology of the American Board of Professional Psychology (ABPP/CN), Fellow in the American Psychological Association (APA), the American Psychological Society (APS), the National Academy of Neuropsychology (NAN) and the American College of Neuropsychopharmacology (ACNP), and member of the Psychiatric Research Society (PRS) and the International Neuropsychological Society (INS). I serve on the Editorial Board of scientific peer-reviewed journals including Brain and Cognition and Brain and Language and on the grant review Panel for the National Institutes of Health. I have been accepted as an expert in state, federal and military courts and testified with respect to my expert opinions in the specialty of Neuroimaging and Neuropsychology. All opinions and conclusions in this Declaration are stated to a reasonable degree of neuropsychological certainty.

2. At the request of Mr. Hammer=s current counsel, I reviewed volumes of background materials provided to previous mental health experts and the results of the neuropsychological testing conducted by Dr. Gelbort and psychiatric evaluations conducted by Drs. Wolfson, and Sadoff.

3. The documents that I reviewed provide a significant probability that Mr. Hammer suffers from an organic brain disorder. The main factors in support of this probability are: (I) Multiple instances of trauma; (2) Performance on psychological

and neuropsychological tests conducted thus far; (3) Behavior descriptions in the records; and (4) his history of childhood neurological and cognitive impairments.

4. I have reviewed Dr. Gelbort's report and data. The battery of tests that he conducted are appropriate and his conclusions properly follow the results of those tests. It is my opinion, to a reasonable degree of neuropsycholgical certainty, that there is sufficient evidence in the available data indicating brain dysfunction, that Mr. Hammer has organic brain damage and that it probably results in neuropsychiatric illness. It is my opinion that, through the following procedures, it would be possible to further determine the nature and extent of Mr. Hammers deficits and the effect these deficits had on Mr. Hammer=s conduct and decision making at the time of the offense, at the time he gave various statements to authorities, at the time of trial and appeal:

a. A high resolution volumetric MRI study, including both dual echo sequences proton density and T2-weighted) for optimal resolution of CSF (particularly sulcal) and 3D SPGR scans for gray-white segmentability; and,

b. A positron emission tomography (PET) scan, including an FDG study of local. glucose metabolism and a study of cerebral blood flow while at rest during activation,

5. Magnetic Resonance Imaging (MRI) has become the major method for assessing the structural integrity of the brain, namely brain anatomy. Many brain disorders, formerly requiring clinical procedures for diagnosis, can now be diagnosed by visual inspection of MRI scans. MRI also permits highlighting of specific features of the brain by changing scan parameters and using contrast agents.

6. Reading of the printed MRJ images is sometimes, unfortunately, insufficient to detect effects of some disorders, particularly those associated with diffuse or subtle loss of tissue. Such disorders require either the use of clinical procedures or reliable methods for soft tissue segmentation and volumetric analysis, which permit accurate quantitation of global and regional gray matter, white matter, and cerebrospinal fluid compartments. For these reasons, the fact that a prior Anegative@ MRI was conducted does not change my opinion that the testing I have recommended will yield results indicating impairments. Clinical MRIs are done to detect injuries rather than the more comprehensive areas of examination I have described. In addition, while some in the field in the past have attempted to run the protocols I have described on films from a previously conducted MRI, the results from such testing are skewed and unreliable. For that reason, the practice standards do not recommended testing from prior MRI film.

6. MRIs are performed under specific protocols. Because of the nature of the scanning protocols, no metal objects can be permitted in the scanner room during the MRI procedure. There is an adjacent observation room, where the technologists operate, and where the individual being scanned can be observed at all times. Security personnel may stay with the inmate inside the scanner room but the personnel cannot have any metal on their person. In addition, no metallic restraints can be used on the patient, although plastic restraints would not hamper the process.

7. Brain activity, a key factor in evaluating brain disorders, is associated with physiologic change, and positron emission tomography (PET) provides the most accurate quantitative measures of several parameters of assessing brain physiology. PET scans were available in 1998. They can assist in evaluating brain anatomy where the brain is intact yet still dysfunctional because of aberrant activity. This is seen in many brain disorders. Although PET is a versatile method enabling the measurement of parameters related to both energy metabolism and neurotransmitter function, most relevant for assessing brain dysfunction is the ability to measure glucose metabolism using F-Flouro-d-2-deoxyglucose (FDO). Normative data are available to detect and document abnormalities. The procedure should include quantitative measurement using arterial or arterialized blood samples. IT is also helpful to perform measurement of cerbral blood flow (CBF) using an appropriate ligand (e.d. OH). CBF should be obtained both at rest and during activation with neurobehavioral probes.

8. While the presence of metal during the PET study is not a problem, the hands of the patient must be free as he will have a catheter in each arm. Guards can be present in the room during the process so long as they do not interfere with the procedures.

9. It should be clarified that while MRI and PET results may help document brain dysfunction, scans that appear normal do not rule out the existence of brain abnormality. Both methods have limitations of sensitivity and resolution, and some disorders require longitudinal follow-up data for documentation.

10. Integration of the clinical neurcanatomic, neurophysiologic and neuropsychological data assists in examining the extent to which brain impairment affected Mr. Hammer=s behavior. I have experience in such integration and would be able to conduct the procedures I recommend in this affidavit at the University of Pennsylvania facility. I have conducted similar procedures and protocols in other criminal cases, including capital appeals, in the Commonwealth of Pennsylvania and in other states including Arizona, California, Colorado, Florida, Virginia and the District of Columbia.

11. The assessment procedures I propose are generally accepted in the medical field for evaluating brain disorders of complex behavior, such as exhibited by Mr. Hammer. Our center evaluates, studies and treats patients with such brain disorders and the evaluation process adheres to accepted standards in the field, including those spelled out in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association.

I hereby certify that the facts set forth above are true and correct to the best of my personal knowledge, information and belief, subject to 28 U.S.C. Section 1746.

End of Document

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Penn Medicine
University of Pennsylvania School of Medicine

Neuropsychiatry Section
Ruben C. Gur, PhD
Professor, Departments of Psychiatry, Neurology, and Radiology
Director, Brain Behavior Laboratory

PATIENT'S NAME: Bobby Wayne Stone
DATE OF BIRTH: [redacted]
DATE OF REPORT: 1/18/2011
INTEGRATION BY: Ruben C. Gur, PhD
REFERRED BY: John Blume, Esq.

DRAFT

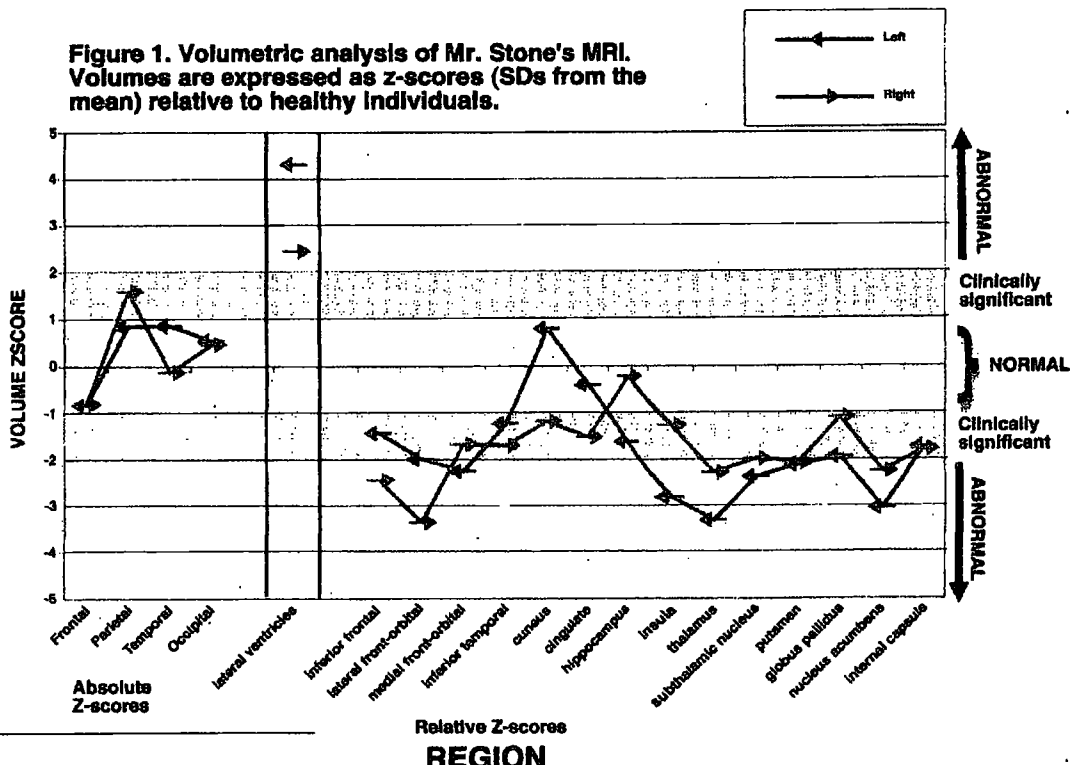
RE: QUANTITATIVE ANALYSIS OF NEUROIMAGING DATA

Mr. Stone was referred for an assessment of brain structure and function. To this end the following neuroimaging studies were performed on Mr. Stone, have been reviewed by me, and will be summarized in this report: magnetic resonance imaging (MRI) and positron emission tomography (PET).

Results of Magnetic Resonance Imaging (MRI): Volumetric structural analysis

The magnetic resonance (MR) images of Mr. Stone were examined by Christos Davatzikos, PhD via delineation of 92 regions of interest (ROI) assisted by a semi-automated template-warping algorithm.[1] **(Figure 1)**

Figure 1. Volumetric analysis of Mr. Stone's MRI. Volumes are expressed as z-scores (SDs from the mean) relative to healthy individuals.



[1] Shen, D. and C. Davatzikos, "HAMMER: Hierarchical attribute matching mechanism for elastic registration". IEEE Trans on Med. Imaging, 2002. 21(11): p. 1421-1439.

The volume of Mr. Stone's brain is in the average to above-average range overall with the exception of the frontal lobe, which is reduced in size to a clinically significant extent. Against this background, abnormalities in the relative volume of several brain structures are observed. Most notably, both of Mr. Stone's lateral ventricles are extremely large for his age. The right ventricle is over 2 standard deviations (SDs) larger than normal and the left ventricle is more than 4 (!) SDs larger. When brain tissue dies, the volume formerly occupied by cells is replaced by cerebrospinal fluid. Large ventricles are therefore an indicator of overall brain atrophy (death of cells) or dystrophy (failure of brain tissue to develop). Examination of specific regions indicates that Mr. Stone's right inferior frontal and right lateral front-orbital, left lateral and medial front-orbital, left insula, bilateral thalamus, subthalamic nuclei, putamen and nucleus accumbens, and left globus pallidus regions are all abnormally small (more than 2 SDs below normal). Additionally, Mr. Stone's left inferior frontal, right medial front-orbital, bilateral inferior temporal, right cuneus, right cingulate, left hippocampus, right insula, and right globus pallidus regions lie in the clinically significant (1 to 2 SD below normal) range.

Results of Positron Emission Tomography (PET)

The PET study examined the regional distribution of cerebral glucose metabolic activity using fluorine-18 labeled deoxyglucose (FDG). The technical quality of the scan was excellent. The study was read clinically by Dr. Andrew Newberg: "The images reveal moderate to severely decreased metabolism in the temporal lobes, particularly the limbic regions, corpus callosum, and midbrain regions. The thalamus and superior parietal regions are somewhat prominent in activity."

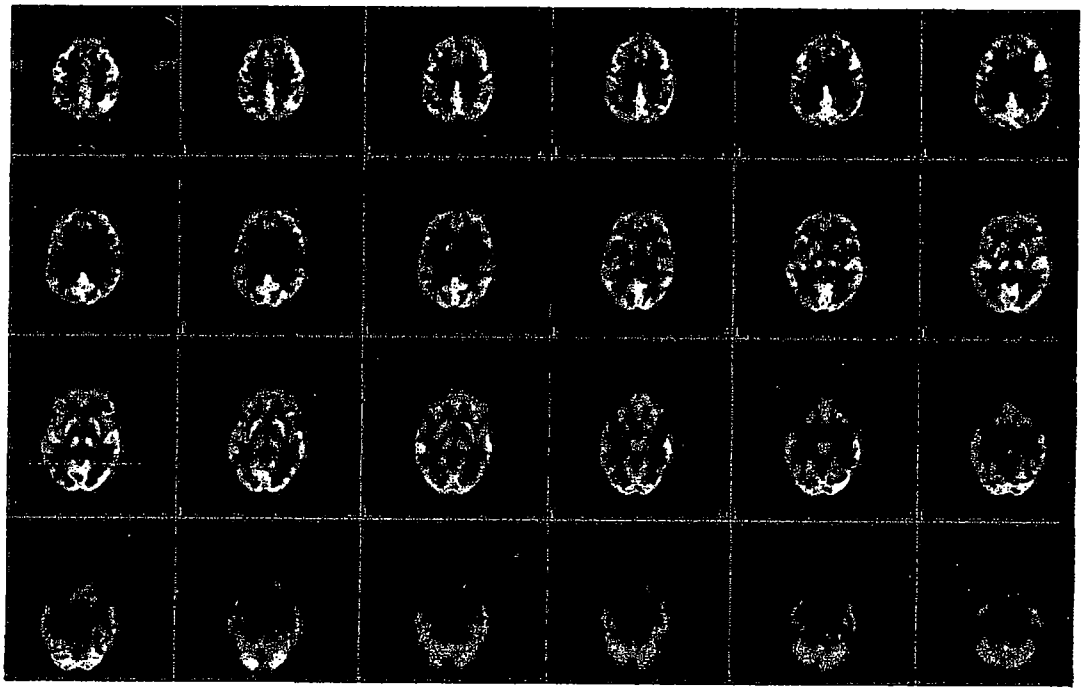
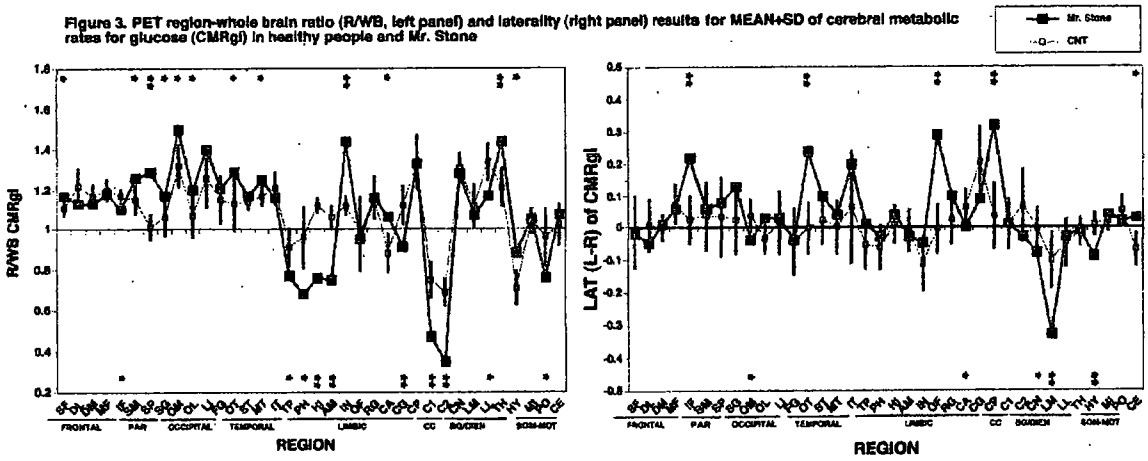


Figure 2. The PET images of Mr. Stone's brain

(Dr. Newberg's report of August 25, 2010). These PET scans are displayed in **Figure 2** below.

The PET study was subjected to a quantitative analysis using a standard regions of interest (ROI) approach.[2] The quantitative analysis of count rates relative to whole brain **(Figure 3, left panel)** support Dr. Newberg's clinical reading and point to more specific sets of regions that show abnormal glucose uptake. The analysis indicated relative *decreases* in ten (10) regions (see key for region abbreviations at bottom of document): IF, TP, PH, HI, AM, CG, C1, C2, LL and PO. Twelve (12) areas show relative *increase* in metabolism: SF, SM, SP, SG, OM, OL, OT, MT, IN, CA, TH, and HY. The laterality index **(Figure 3, right panel)** showed abnormal asymmetries in ten (10) regions, with *higher* than normal relative left activity in IF, OL, OT, OF, and CP and *lower* than normal left activity in OM, CA, CN, LM and HY.

Figure 3. PET region-whole brain ratio (R/WB, left panel) and laterality (right panel) results for MEAN+SD of cerebral metabolic rates for glucose (CMRgl) in healthy people and Mr. Stone



Summary and Conclusions

Results of structural and functional imaging of Mr. Stone's brain converge to show abnormalities indicating brain damage. These abnormalities are in regions that are very important for regulating behavior. Specifically, the kind of structural abnormalities observed in the frontal regions of Mr. Stone's brain interfere with executive functions such as abstraction and mental flexibility, planning, moral judgment, and emotion regulation, moderating limbic arousal and impulse control. The reduced glucose metabolism in the corpus callosum is consistent with toxin exposure or fetal alcohol exposure, but could also reflect a neurodevelopmental abnormality. The abnormally low metabolic activity in the corpus callosum would lead to deficits in integrating verbal reasoning and analytic processing modes of the left hemisphere with intuitive, integrative and affect-related processing modes of the right hemisphere. Such white matter damage would also impair speed of processing. The unusually large size of Mr. Stone's ventricles may indicate loss of limbic tissue or a severe neurodevelopmental disease process.

Probably the most striking finding, however, is the reduced metabolism in the amygdala and both tissue loss and reduced metabolism in hippocampus, combined with tissue loss and hyper-metabolism in cortical regions. Abnormally high metabolism in cortical regions indicates compensatory hypervigilance of the "default brain" state. Reduced activity in limbic regions is often seen in seizure disorders, and could result in "kindling" or sudden hyper-excitability. Abnormally low volume and metabolism in the temporo-limbic system, including hippocampus and

[2] Gur RC, Mozley LH, Mozley PD, Resnick SM, Karp JS, Alavi A, Arnold SE, and Gur RE. (1995). Sex differences in regional cerebral glucose metabolism during a resting state. *Science*. 267:528-531.

amygdala, would lead to severe emotional dysregulation. A damaged amygdala will misinterpret danger signals and when excited it will issue false alarms that require intact frontal components of the limbic system. In Mr. Stone's case, there is reduced volume in orbital frontal regions and the cortex is already at a hyper-activated state. The situation is analogous to a car with weak brakes that are already engaged when it begins to race. When Mr. Stone's amygdala becomes activated, his frontal lobe is unlikely to be capable of exercising control as a normal one would, because his frontal lobe is not only damaged but his cortex is already operating at full capacity in its hyper-vigilant state. The frontal lobe is unable to do its job and act as the brakes on the primitive emotional impulses emanating from the amygdala when the limbic system reaches its activated stage (the Klüver-Bucy syndrome).

The abnormalities in basal ganglia could further impair rational performance under stress because they supply the neurotransmitter dopamine, which is necessary for intact frontal lobe functioning. The resulting behavior of someone with such brain damage could be disorganized, erratic and failing to adjust to situational demands. Notably, such individuals do respond well to structured environments, where the complexity of the surrounding and need for decision-making is reduced.

Thank you for the opportunity to participate in Mr. Stone's evaluation. Please let me know if you have questions or need further elaboration or analysis.

Sincerely,

Ruben C. Gur, PhD

Abbreviations in PET Figures:

SF = Superior Frontal; DL = Dorsal Prefrontal – Lateral; DM = Dorsal Prefrontal – Medial; MF = Mid–Frontal; IF = Inferior Frontal; SM = Sensorimotor; SP = Superior Parietal; SG = Supramarginal Gyrus; OL = Occipital cortex, Lateral; OM = Occipital cortex, Medial; LI = Lingual Gyrus; FG = Fusiform Gyrus; OT = Occipital Temporal; ST = Superior Temporal; MT = Mid–Temporal; IT = Inferior Temporal; TP = Temporal Pole; PH = Parahippocampal Gyrus; HI = Hippocampus; AM = Amygdala; IN = Insula; OF = Orbital Frontal; RG = Rectal Gyrus; CA = Cingulate Gyrus – Anterior; CG = Cingulate Gyrus - genu; CP = Cingulate Gyrus – Posterior; C1 = Corpus Callosum – Anterior; C2 = Corpus Callosum – Posterior; CN = Caudate Nucleus; LM = Lenticular – Medial [Globus Pallidus]; LL = Lenticular – Lateral [Putamen]; TH = Thalamus; HY=Hypothalamus; MI = Midbrain; PO = Pons; CE = Cerebellum.

AFFIDAVIT OF RUBEN C. GUR, PH.D.

I, Ruben C. Gur, Ph.D., being duly sworn upon his oath, do hereby depose and state the following:

1. I am a neuropsychologist, with a special focus on imaging applications to the diagnosis and study of people with behavioral disturbances associated with brain dysfunction. I have been requested by counsel for Kevin Stanford to submit this affidavit in support his request for commutation of his death sentence. My opinion is that the human brain is not fully mature before reaching adulthood, and that furthermore the brain regions that are the most important for regulating impulse control, planning, consideration of consequences, abstract reasoning and, most probably, moral judgment, are the very regions that mature last. This affidavit details my background, identifies the bases for my opinion, and presents my expert opinion.

Synopsis of Curriculum Vitae

2. My Curriculum Vitae is attached to this affidavit. My qualifications for the opinions I state in this affidavit include the following:

a. I have been licensed as a psychologist in Pennsylvania since 1976. I received a B.A. from Hebrew University of Jerusalem and an M.A. and a Ph.D. in Clinical Psychology from Michigan State University. I completed Postdoctoral Fellowships at Stanford University and at the University of Pennsylvania.

b. I am a Diplomat of the American Board of Professional Psychology, with Specialty in Clinical Neuropsychology (ABPP/CN).

c. I am, or have been, a member of the American Psychological Association, Division of Physiological and Comparative Psychology (Fellow status), Division of Neuropsychology (Fellow), the American Psychological Society (Fellow), The American College of Neuropsychopharmacology (Fellow), the American Association for the Advancement of Science, the International Neuropsychological Society, the National Academy of Neuropsychologists, the New York Academy of Science, and the John Morgan Society.

d. Among other honors, I have received the Erikson Award for Scientific Excellence and the 1990 Stephen V. Logan Award from the National Alliance for the Mentally Ill. I have authored or co-authored refereed publications in peer-reviewed journals, made national and international presentations in the field of imaging and brain dysfunction, have served and am serving on Editorial Boards of professional journals, have served on Search Committees for journal Editorship, and have reviewed manuscripts for leading journals in the areas of imaging, brain and behavior, and schizophrenia, have served on Advisory Panels and Study Sections of the National Institutes of Health and currently serve on the NIH Review Group on "Clinical Neuroscience and Biological Psychopathology." I have contributed chapters to textbooks and other scholarly volumes on the topic of brain imaging and neuropsychology.

e. I have the academic rank of Professor (with Tenure) on the Standing Faculty of the University of Pennsylvania, with a primary appointment in Psychiatry and secondary appointments in Neurology and in Radiology. I am currently the Chief of the Brain Behavior Laboratory (BBL) and Director of Neuropsychology, Department of Psychiatry at the Hospital of The University of Pennsylvania. I am Principal Investigator of the Neuropsychology Core and the Functional Imaging Core of the Federally funded Schizophrenia Center, Co-PI of the functional MRI project of the Conte Center for Neurosciences, and PI, Co-PI and investigator on several individual NIH grants (RO1s) on brain imaging and psychopathology. I also supervise interns and practicum students in neuropsychology. I am advisor of the Biological Basis of Behavior Undergraduate Major Program at the University of Pennsylvania. Additionally, I am a supervisor of postdoctoral Fellows and doctoral students in Psychology and Neuroscience and Co-PI of a Federally funded Training Program in the behavioral neurosciences.

f. I have been recognized as an expert and allowed to testify with respect to my expert opinions in the specialty of Neuroimaging and Neuropsychology in state and Federal courts.

The basis for the opinion stated in 1

3. The brain is a complex organ, as could be expected from the complexity of human behavior, and lacking tools for studying the living brain has made scientific progress slow and

laborious. However, methods developed in the '70s and implemented in the '80s have yielded powerful tools for obtaining reliable measures of brain structure, function and behavior. By the mid-'90s these methods have become standard in the assessment of brain structure and function.

a. During the Month of June, 2002, I have reviewed the published literature on the topic of brain maturation in humans. I have reached the opinion stated in point 1 based on that review.

b. The purpose of the review was to summarize current understanding of the process of maturation in human brains during the juvenile period and up to young adulthood. Below I will describe the methods used in such investigations and outline the main findings regarding the course of brain development. Of course there is much that we do not know about brain maturation, but there is congruence of evidence indicating that brain maturation is not complete until young adulthood (about age 21). Furthermore, the main index of maturation, which is rate of myelination, points to large variability in the rate of maturation among brain regions. In general, maturation of association cortex is not complete even by late adolescence and within this cortex the prefrontal regions are last to mature. The review will conclude by discussing the behavioral implications of these findings. The role of myelination is to focus and refine the operation of neural networks regulating behavior, and the frontal lobes specifically modulate and inhibit impulses, shaping behavior in accordance with planned action and long-term goals. Therefore, the brain anatomy data indicate that people are not biologically prepared to exercise mature frontal lobe control until they reach adulthood.

c. The rate at which the human brain matures has been of considerable interest to neuroscientists and knowledge on when different brain regions mature during human development may have profound implications for understanding behavioral development. Although the brain and its structure become well differentiated during fetal development, there is overwhelming evidence that much of the brain maturational process occurs after birth. Indeed, projections from early pioneering work on donated brain tissue have indicated that some brain regions do not reach maturity in humans until adulthood. These projections have been confirmed by more recent studies using neuroimaging with advanced methods for soft tissue segmentation

and regional parcellation. Here I will first describe the initial neuroanatomic methods and results they produced, which gave rise to hypotheses currently being confirmed and further refined. I will proceed to explain the novel methods using structural and functional neuroimaging, and summarize results pertinent to the issue of brain maturation. I will conclude by an attempt to integrate findings from the diverse methods and explain their implications to behavior, focusing on issues pertinent to criminal responsibility.

d. Initial studies: Post-mortem tissue anatomy. While sophisticated methods for preservation and dissection of post mortem brain tissue had been developed in the first decades of the twentieth century, it was not until the 1960's that enough such tissue was available to examine the question of brain maturation in humans. Arguably the largest collection and the most influential work was that of Professor Paul I. Yakovlev and his colleagues at Harvard University. His methods, findings and conclusions have been summarized in a landmark chapter titled "The myelination cycles of regional maturation of the brain" co-authored with Dr. Andre'-Roch Lecours, which was published in a book on Regional Brain Development in Early Life (edited by Prof. Alexandre Minkowski and published by Blackwell Scientific Publications, Oxford, England, 1967).

e. The anatomic work has focused on the process of the creation of fatty tissue surrounding nerve fibers, which is known as "myelogenesis." Myelogenesis is important for assuring efficient transmission of neuronal signals. The fatty tissue called myelin surrounds the nerve fibers that carry information across large distances very much in the same way that rubber is used for insulating cables designed to conduct electricity across distance. The process can be examined by obtaining slices of brain tissue from a wide age range, treated in a way that enables visualization of myelin, and comparing its abundance. Such treatment of tissue is called "staining," and Yakovlev and his colleagues used a staining method developed in the twenties by Loyez. The method relies on the ability to observe both the density of stained fibers and the intensity of coloration (light to dark gray and blue to black), and these can be used to index degree of myelination. (see Figure 1).

f. Yakovlev and his colleagues examined over 200 brains ranging in age from fourth fetal month to one postnatal year, and another large set of brains from the third decade of life on. Unfortunately they had very few brains from the first and second decades of life, and their extrapolations for that phase of development are accordingly more tentative. Nonetheless, They were able to derive some principles and propose hypotheses that were confirmed with remarkable consistency using current techniques.

The main surprise was the much slower progression of the maturational process in the human brain compared to what had been expected from animal studies. Yakovlev and his colleagues have carefully charted the maturational process for a large set of regions and found some that matured very early while others were far from maturation at one year of age. By extrapolating from the sample of adult brains and the few specimens from the period in between, they have produced "maturation charts" for these brain regions (Figure 2). Based on these charts they identified several principles. One of the main principles is illustrated in Figure 3. The brain can be conceptualized architecturally (and phylogenetically) as consisting of three "zones": the median (median thalamus and hypothalamus, septum, hippocampus) the paramedian (limbic) and the supralimbic (mostly cerebral cortex). They noted that maturational rate is fastest for the paramedian zone, where it is complete within the first decade of life, and slowest for the cortical regions where development seems to extend into adulthood.

This principle has rather profound implications for behavior, and is consistent with behavioral data on development. The region that is slowest to mature is the part of the brain that basically serves to inhibit and modulates more primitive, drive related activation of the limbic areas. From phylogenetic perspective, the brain areas that are latest to mature are those areas that have seen the greatest expansion in humans and are associated with faculties such as language comprehension and expression of emotions, impulse control and planning, and aspects of attention and memory (including working memory). Thus, the anatomic data as interpreted by Yakovlev and his colleagues indicated that the very functions that make us uniquely human are the latest to become fully integrated into the workings of the developing brain.

g. Other contributions of anatomic studies for understanding brain development ranged from gross measurement of brain weight in large samples to more detailed measurements of synaptic processes in small samples. For example, Dekaban and Sadowsky (1978) tabulated body and brain weight in nearly 5000 autopsy reports, ranging in age from weeks to 90 years, and plotted these values against age. The most important result from the perspective of this review is that brain weight did not reach its peak until about age 20, and showed steady decline thereafter (see figure 4). This method, of course, could not distinguish myelin from other tissue and hence does not directly examine maturation.

h. Using methods for examining synaptic density, Prof. Peter Hutttenlocher from the University of Chicago was able to uncover another neurodevelopmental phenomenon apparently taking place during adolescence: "pruning." Specifically, he observed a decline in the density of synapses between ages 2 and 16 accompanied by a decrease in neuronal density. His conclusion required a considerable leap of imagination, since he only had one specimen between the ages of 8 and 20 years, however it made theoretical sense and was consistent with animal studies. According to the pruning hypothesis, at some point during adolescence neurons and their connections that have not been consistently used during childhood "shrivel off" and are eliminated, thereby allowing for greater efficiency of remaining neural systems (Huttenlocher, 1979; Huttenlocher et al., 1982).

i. Current anatomic studies: Structural imaging with MRI. The post-mortem tissue studies such as conducted by Yakovlev and his colleagues have contributed important insights into understanding brain maturation, but they have serious limitations. Most importantly, tissue availability depends on sources that may bias the age ranges available; the inability to quantify the measures in an automated fashion limits the number of brains and regions that can be examined; there is large variation introduced by fixation and staining methods; and it is impossible to do repeated studies in the same individual to trace developmental changes.

j. All these difficulties are circumvented by a set of novel techniques developed in the 1970s and fully implemented by the 1990s, and that can be generally referred to as "structural

imaging". These methods permit visualization and volumetric measurement of brain structure in living people without risk. The method that has become state of the art for these studies is based on magnetic resonance imaging (MRI) procedures. The head is placed in a strong magnetic field (current standard is at 1.5 tesla), and the image is based on recording the resonance of molecules after perturbations with radiofrequency (RF) signals using special coils. Recordings are made with antennae, very much like recording of radio waves. What makes MRI particularly amenable for quantitative analysis is that different echo times can highlight different soft tissue contrasts, procedures that have similar effects to those of staining in post mortem studies. The main potential drawback in MRI is the difficulty of maintaining a homogeneous field strength throughout the image brain. Inhomogeneity will produce "shading" effects, which can be sometimes compensated for by the clinician but have to be minimized, or compensated for by complex statistical operation, when trying to implement a computer algorithm to identify the tissue. Several approaches have been developed in the early 90s, and these have now become standard and have been shown to produce reliable results both in phantom and in human studies (e.g. Filipek, Richelme, Kennedy, and Caviness, 1994; Kohn et al, 1991; Yan and Karp 1994). These methods have provided data on the intracranial composition of the three main brain compartments related to cytoarchitecture and connectivity: gray matter (GM) - the somatodenritic tissue of neurons (cortical and deep), white matter (WM)– the axonal compartment of myelinated connecting fibers, and cerebrospinal fluid (CSF). An example of computerized segmentation of MRI into these compartments is provided in Figure 5.

k. It has taken some time to apply these segmentation methods to a sufficiently large sample of healthy people across the age range so as to examine maturational processes. However, several groups have made considerable progress and the results of their efforts, while still tentative with regard to precise charting of developmental trajectories for all brain regions and for all age groups, are nonetheless quite consistent with the post mortem findings and converge to support several conclusions.

l. Among manuscripts in the refereed literature, which by now has reached a considerable number, one can identify seven main groups that pursued issues related to neurodevelopment: 1. The Harvard group under the leadership of Kennedy and Cavines; 2. The NIH group under the leadership of Rapoport and Giedd; 3. The Stanford group under the leadership of Pfefferbaum; 4. The Hopkins group led by Denckla; 5. The UCSD group led by Jernigan; 6. The University of Utah group led by Bigler; 7. The Penn group led by Raquel E. Gur and myself. Contributions from other centers such as Duke, McGill, NYU, UCLA and Toyama University in Japan have also been instrumental.

m. In one of the first studies examining segmented MRI in children and adults, Jernigan and Tallal (1990) have documented the "pruning" process proposed by Huttenlocher's work. They found that children had higher gray matter volumes than adults, indicating loss of GM during adolescence. This group has more recently replicated these results using advanced methods for image analysis (Sowell et al., 1999). Their new study also demonstrated that the pruning is most "aggressive" in prefrontal and temporo-parietal cortical brain regions.

n. The NIH group published a landmark paper in 1996, where they have reported results of a brain volumetric MRI study on 104 healthy children ranging in age from 4-18. While they did not segment the MRI data into compartments, they observed developmental changes that clearly indicated prolonged maturation beyond age 17. In a later report on this sample, where segmentation algorithms have been applied, they were able to pinpoint the greatest delay in myelination, defined as WM volume, for fronto-temporal pathways (Paus et al., 1999). Note that this finding is very consistent with Yakovlev's projections. The NIH group went on to exploit the ability of MRI to obtain repeated measures on the same individuals. Using such long longitudinal data they were able to better pinpoint the timing of pre-adolescent increase in GM that precipitated the pruning process of adolescence. Of importance to the question of maturation as defined by myelogenesis, the results indicated that the volume of WM continued to show increase up to age 22 years (Giedd at al., 1999).

o. The Harvard group developed a sophisticated procedure for MRI analysis (Filipek et al., 1994), which they applied to a sample of children with the age range of 7-11 years and compared to adults (Cavines et al., 1996). They found sex difference suggesting earlier maturation of females, and generally supported the role of WM as an index of maturation. Their results also indicated that WM shows delay in reaching its peak volume until early adulthood.

p. Another landmark study was published by the Stanford group, which examined segmented MRI on a "retrospective" sample of 88 participants ranging in age from 3 months to 30 years and a "prospective" sample of 73 healthy men aged 21 to 70 years (Pfefferbaum et al., 1994). The retrospective sample used scans available from the clinical caseload, although images were carefully selected to include only those with a negative clinical reading, while the prospective sample was recruited specifically for research and medically screened to be healthy. The results demonstrated a clear neurodevelopmental course for GM and WM, the former showing a steady decline during adolescence while the latter shows increased volume until about age 20-22 years (see Figure 6).

q. The Hopkins group used a similar approach in a sample of 85 healthy children and adolescents ranging in age from 5 to 17 years (Reiss et al., 1996). Consistent with the post mortem and the other volumetric MRI studies, they reported steady increase in WM volume with age that did not seem to peak by age 17. Unfortunately, they did not have data on older individuals (Figure 7). Their results are consistent with those of Blatter et al. (1995) from Utah, although the extensive Utah database combines ages 16-25 and therefore does not permit evaluation of changes during late adolescence and early adulthood.

r. In the only study to date that has examined segmented MRI volumes from a prospective sample of 28 healthy children aged 1 month to 10 years, as well as a small adult sample, Matsuzawa et al (2001) have applied the segmentation procedures developed by the Penn group. They have demonstrated increased volume of both GM and WM in the first postnatal months, but whereas GM volume peaked at about two years of age, the volume of WM, which indicates brain maturation, continued to increase into adulthood (Figure 8). Furthermore, consistent with the post mortem and other MRI studies that have examined this issue, the frontal lobe showed the greatest maturational lag and its myelination is unlikely completed before young adulthood.

s. While not directly examining adolescence, several studies of aging may also help shed light on development. The reason is a rather ubiquitous neurodevelopmental principle: whatever "comes on board" last is also first to deteriorate with older age. In this regard, several studies have suggested that frontal and temporal cortex shows the most pronounced age-associated decline, and that this happens earlier for men than for women (e.g., Coffee et al., 1998; Cowell et al., 1994; Gur et al., 1991, 2002; Raz et al., 1997). The possibility of further maturation occurring beyond age 17 is supported in a recent study examining age effects for a prospective sample of 116 healthy adults (57 men and 59 women, age range 18-49). As can be seen in Figure 8, volume of WM showed a positive slope for that age range (Gur et al., 2002). To examine in more detail any effects in young adulthood, defined as between the ages of 18 to 25 (and on which there is probably the least amount of published data), we have selected all

individuals in this age range from that study. As can be seen in Figure 9, there is clear evidence that the maturation process, reflected in WM volume, continues into the early 20s, especially for men.

t. Physiologic studies: Functional imaging. Information on the maturational process can come not only from anatomic studies of brain structure, the focus of this review, but also from studies of brain activity or "function." Few studies have been done to examine brain maturation. Probably the main reason for the paucity of studies is that many of these methods necessitate exposure to ionizing radiation, and therefore are forbidden in healthy children. Another reason is that these studies are expensive and are usually done in very small samples. Nonetheless, several investigators have examined indices of brain maturation using functional imaging (e.g. Chugani et al., 1987; Chiron et al., 1992). These studies concur with the anatomic data. Thus, Chugani et al show that adult values are not reached by age 15 and are delayed in association cortex, while Chiron et al suggest that adult values are reached by about age 20.

u. Summary and conclusions. The review of neuroanatomic studies across methods and approaches, and the few neurophysiologic studies in humans, indicates considerable convergence of findings with respect to brain maturation during childhood, adolescence and early adulthood. The overwhelming weight of the evidence supports the early post mortem studies indicating that the main index of maturation, which is the process called "myelination," is not complete until some time in the beginning of the third decade of life (probably at around age 20-22). Other maturational processes, such as the increase and subsequent elimination ("pruning") in cell number and connectivity, may be completed by late adolescence, perhaps by age 15-17. More data are needed to pinpoint the age at which these latter maturational processes are complete.

v. These results have rather profound implications for understanding behavioral development. The cortical regions that are last to mature, particularly those in prefrontal areas, are involved in behavioral facets germane to many aspects of criminal culpability. Perhaps most relevant is the involvement of these brain regions in the control of aggression and other impulses, the process of planning for long-range goals, organization of sequential behavior, consideration

of alternatives and consequences, the process of abstraction and mental flexibility, and aspects of memory including "working memory." More recent evidence implicates the frontal lobes in processing aspects of morality and moral judgement. If the neural subtrates of these behaviors have not reached maturity before adulthood, it is unreasonable to expect the behaviors themselves to reflect mature thought processes.

w. The brain scan techniques have demonstrated conclusively that the phenomena observed by mental health professionals in persons under 18 that would render them less morally blameworthy for offenses have a scientific grounding in neural substrates. The evidence now is strong that the brain does not cease to mature until the early 20s in those relevant parts that govern impulsivity, judgement, planning for the future, foresight of consequences, and other characteristics that make people morally culpable. Therefore, a presumption arises that someone under 20 should be considered to have a underdeveloped brain. Additionally, since brain development in the relevant areas goes in phases that vary in rate and is usually not complete before the early to mid-20s, there is no way to state with any scientific reliability that an individual 17-year-old has a fully matured brain (and should be eligible for the most severe punishment), no matter how many otherwise accurate tests and measures might be applied to him at the time of his trial for capital murder. This is similar to other physical characteristics such as height. While we know in detail the age at which the average adults reach their maximal height, predictions for individuals are not easy to make. Thus, although 18 is an arbitrary cutoff, given the ongoing development of the brain in most individuals, it must be preferred over 17 as assuring that only the most culpable are punished for capital crimes. Indeed, age 21 or 22 would be closer to the "biological" age of maturity.

x. Having read portions of the *Atkins v. Virginia* decision, I was impressed that the very same reasons applied to mental retardation, with respect to both retribution and deterrence, apply fully to juveniles. This is not a coincidence. Most mentally retarded people have normal physical appearance and fully developed bodies. Their motor skills are intact and they can perform most actions necessary for survival. However, for a variety of reasons their intellectual

capacities, mostly those related to "executive" functions and learning, are not fully developed. These abilities are measurable by standardized tests (IQ tests) and are used to define retardation from the perspective of mental capacity. Indeed, there is a generally acceptable formula for translating IQ scores to "mental age" because the performance of mentally retarded people resembles that of average individuals at that age. Conceptually mental retardation is defined developmentally– as reflected in the term "retarded"– and from a psychometric perspective the statement that individuals are "mentally retarded" is equivalent to the statement that their mental capacity is that of average juveniles. Thus, literally, it can be stated that any juvenile is retarded relative to that juvenile as an adult. To illustrate, if we could build a time machine and take a average 17 year old person 4 years forward, retaining their current mental abilities, and test them, they will score retarded (of course assuming infallibility of psychological testing). While in the case of mental retardation questions regarding fallibility of psychological testing appropriately prompted the Supreme Court to require additional objective criteria for verifying retardation through developmental history, in this case of juveniles all we need is a birth certificate to determine age. Behavioral scientists have long suspected that a major factor contributing to maturation of mental capacity is the development of the brain, which is the organ of mind. Now neuroscientists have been able to demonstrate conclusively that mental maturation follows closely the time course of brain maturation. Thus, juveniles have to rely on the abilities of their still immature brains, and no amount of social intervention or self-motivation can appreciably influence the biological processes involved in brain maturation.

FURTHER AFFIANT SAYETH NAUGHT

I hereby certify that the statements contained in this Affidavit are true and correct to the best of my knowledge and belief.

Ruben C. Gur, Ph.D.

Subscribed and sworn to before me by Ruben C. Gur on November 14, 2002.

NOTARIAL SEAL
GERALDINE PETTEY, Notary Public
City of Philadelphia, Phila. County
My Commission Expires Nov. 29, 2004

My commission expires

Figure captions

Figure 1. Examples of the myelination process as they appear on Yakovlev's stained brain tissue for the spinal cord at lumbar level (left vertical plates) and the corpus callosum (upper horizontal plates). In the spinal cord, note that extensive darkening at dorsal compared to ventral root for a fetus at 25 weeks of gestation (top) and at term (bottom). The corpus callosum is a large body of nerve fibers connecting the two cerebral hemispheres. The corpus callosum is a large body of nerve fibers connecting the two cerebral hemispheres. The leftmost section is from the brain of a baby at 6 postnatal weeks, the center shows a comparable section at one year, and the rightmost picture shows the region at 28 years. Note the increased darkness of the banana-shaped corpus callosum, indicating increased myelination (from Yakovlev and Lecours 1967, Figure 2 and 19, respectively).

Figure 2. Maturational charts for different brain regions based on post mortem tissue (from Yakovlev and Lecours 1967, Figure 1).

Figure 3. The "zones" principle of maturation, showing the late maturation of the corical "supralimbic" region (from Yakovlev and Lecours 1967, Figure 18).

Figure 4. Brain weight (in Kilograms) in relation to age based on about 10,000 autopsy reports (from Dekaban and Sadowsky, 1978, Figure 1; the vertical line indicating age 21 added by the author of this review).

Figure 5. Association of age with the relative volume gray matter (left panel) and white matter (right panel), showing decline for the former and increase for the latter (from Reiss et al., 1996, Figure 3).

Figure 6. Association of age with the cortical white matter volume (top panel) and with relative gray to white matter volume (bottom panel), showing that myelination is incomplete before the age of about 21 (from Pfefferbaum et al., 1994, Figure 3; the vertical line indicating age 21 added by the author of this review).

Figure 7. Illustration of the MRI segmentation process showing an acquired T2 weighted image (left), a proton density image (middle), and the segmented image (right) where GM is depicted in white, WM in light gray and CSF in black (from Gur et al., 1999, Figure 1).

Figure 8. Scatterplots showing the relation between age and compartmental volume (in milliliters) for healthy individuals ranging in age from 18-50 (from Gur et al., 2002).

Figure 9. A scatterplot showing the WM data (relevant to the myelogeneses index of the brain maturation) in the age range of 18-16 from figure 8 above.

Figure 1

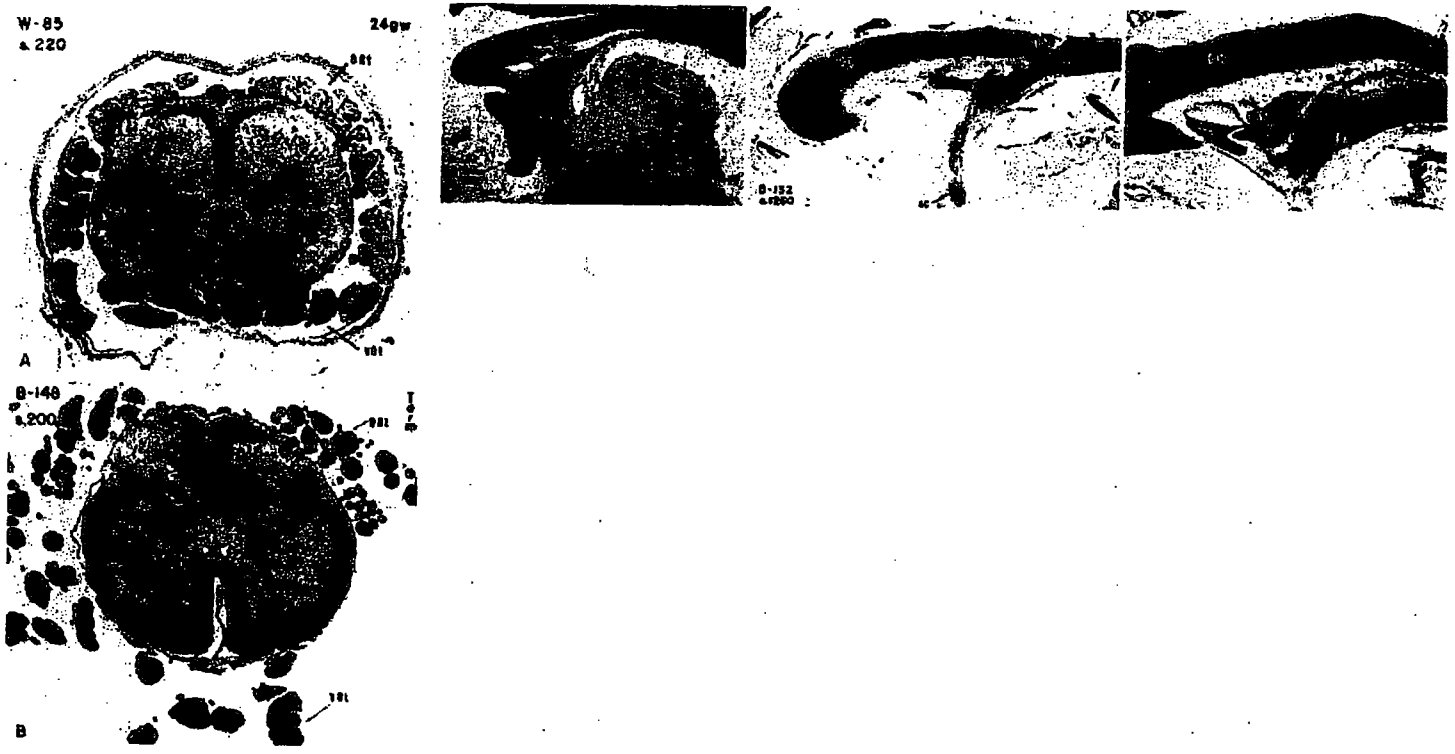


Figure 2

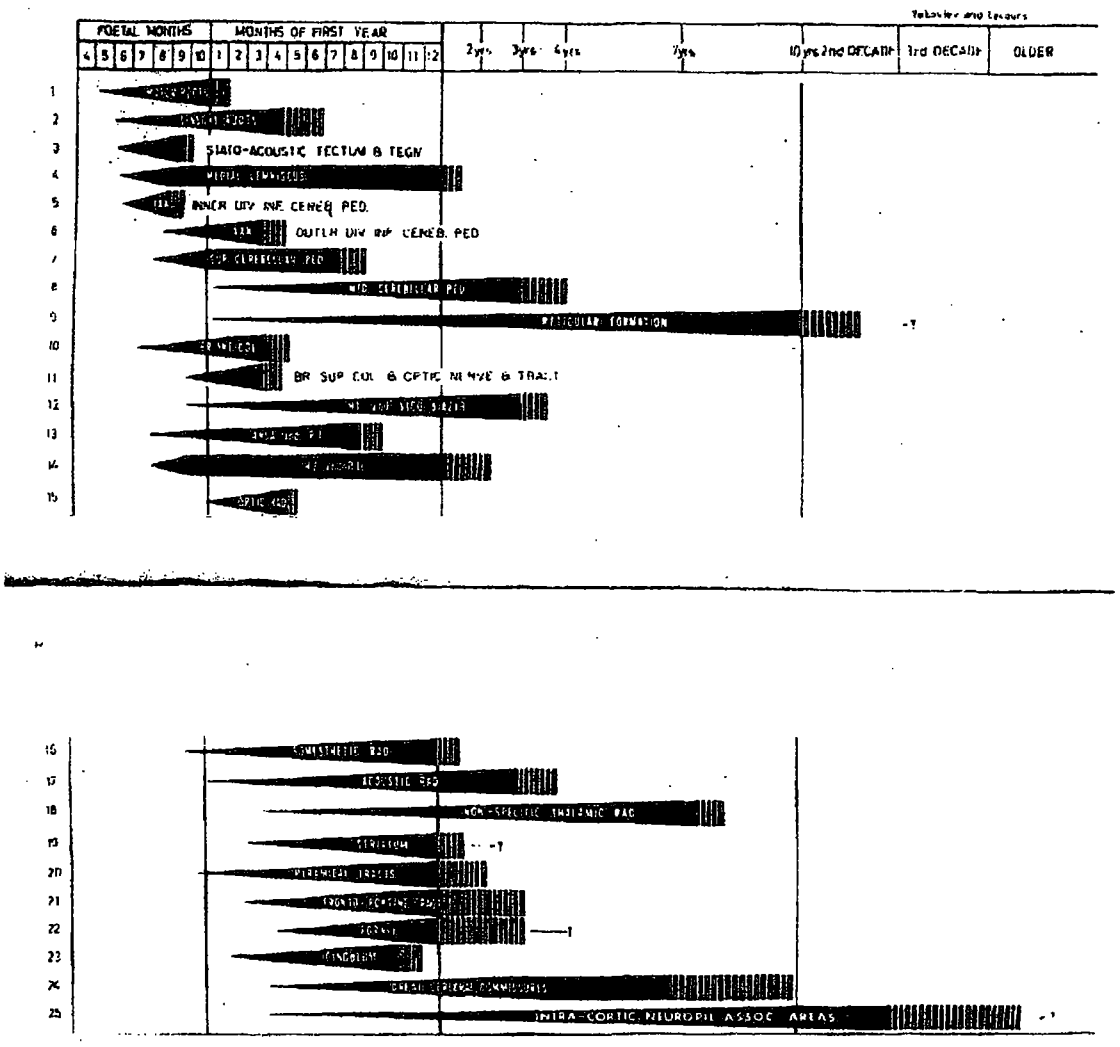
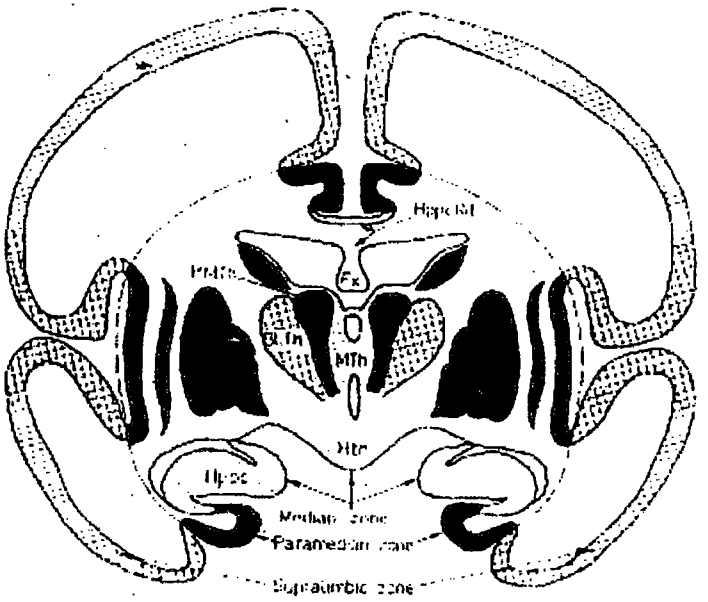
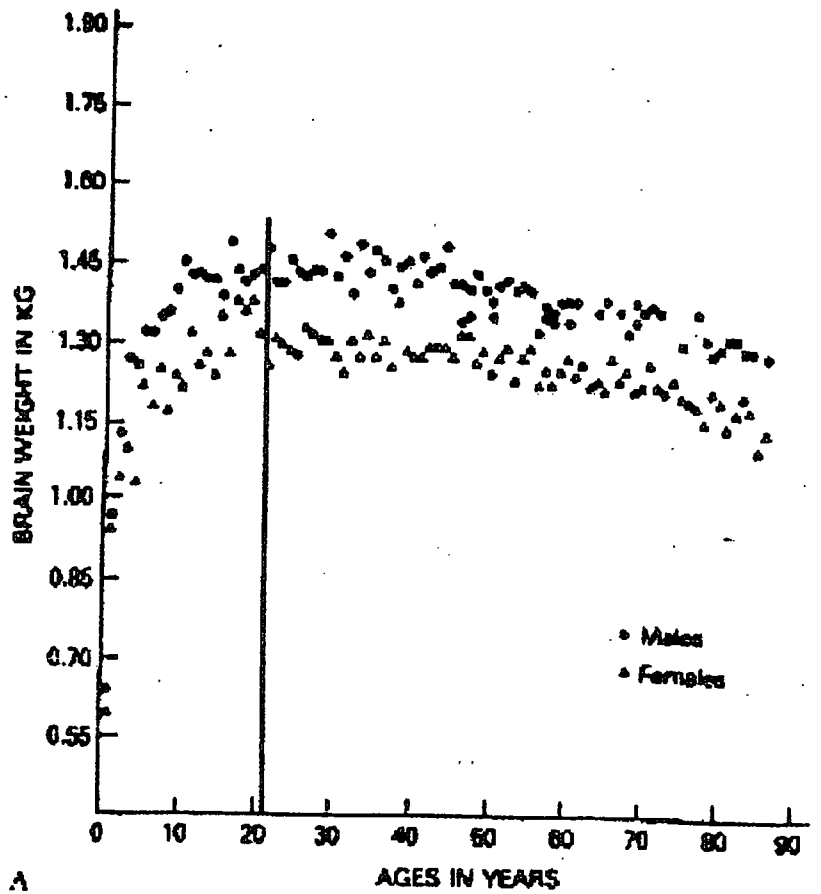

FOETAL MONTHS
MONTHS OF FIRST YEAR
2yrs
3yrs
4yrs
7yrs
10yrs
2nd DECADE
3rd DECADE
OLDER
STATO-ACOUSTIC TECTUM & TEGM
INNER DIV INF. CEREB. PED.
OUTER DIV INF CEREB. PED
PERICOLIAR FORMATION
BR SUP COL & OPTIC NERVE & TRACT
INTRA-CORTIC NEUROPIL ASSOC AREAS

Figure 3



Myelogenetic cycle in	Third foetal	First postnatal	First decade	Older
A The median zone				
B The paramedian limbic zone				
C The supralimbic zone				

Figure 4


1.90
1.75
1.60
1.45
1.30
1.15
1.00
0.85
0.70
0.55
BRAIN WEIGHT IN KG
Males
Females
0
10
20
30
40
50
60
70
80
90
AGES IN YEARS

A

Figure 5

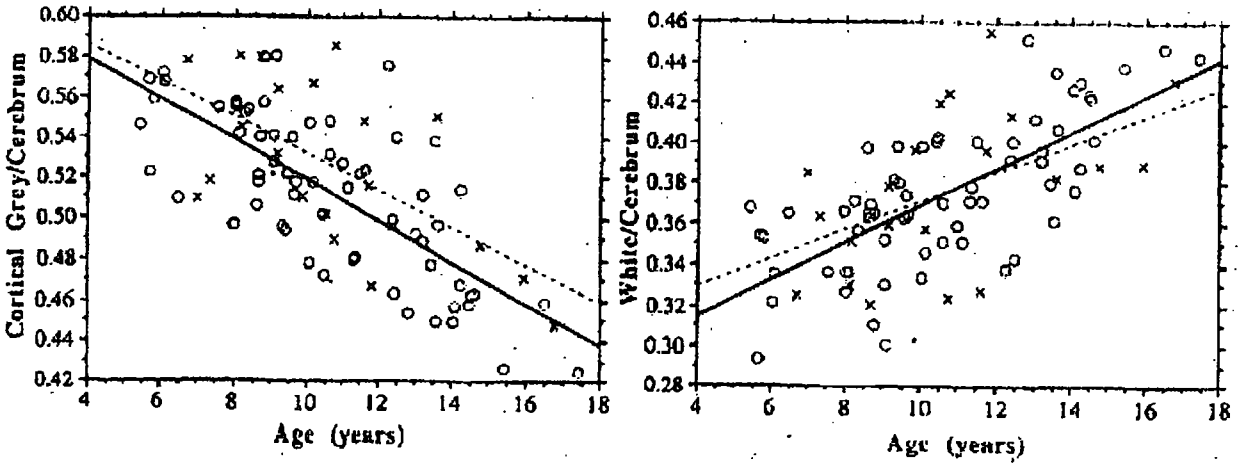

Cortical Grey/Cerebrum
0.60
0.58
0.56
0.54
0.52
0.50
0.48
0.46
0.44
0.42
4
6
8
10
12
14
16
18
Age (years)
White/Cerebrum
0.46
0.44
0.42
0.40
0.38
0.36
0.34
0.32
0.30
0.28
4
6
8
10
12
14
16
18
Age (years)

Figure 6

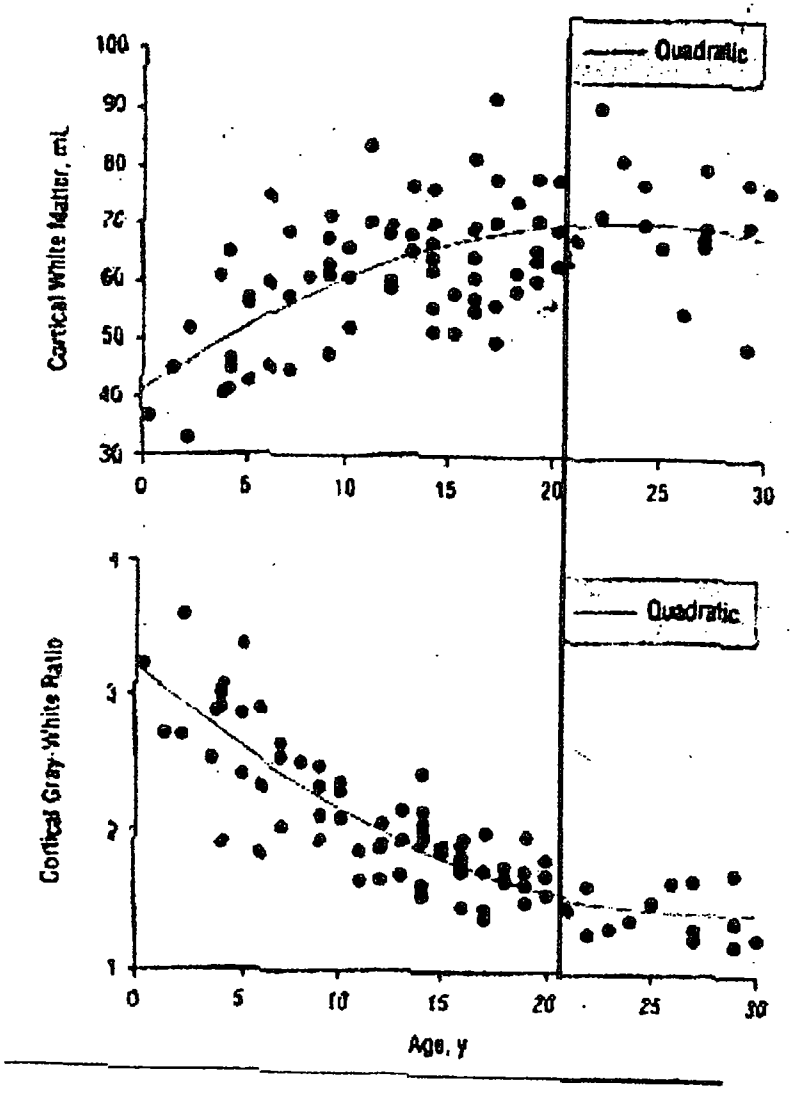

Quadratic
Cortical White Matter, mL
100
90
80
70
60
50
40
30
0
5
10
15
20
25
30
Quadratic
Cortical Gray-White Ratio
4
3
2
1
0
5
10
15
20
25
30
Age, y

Figure 7

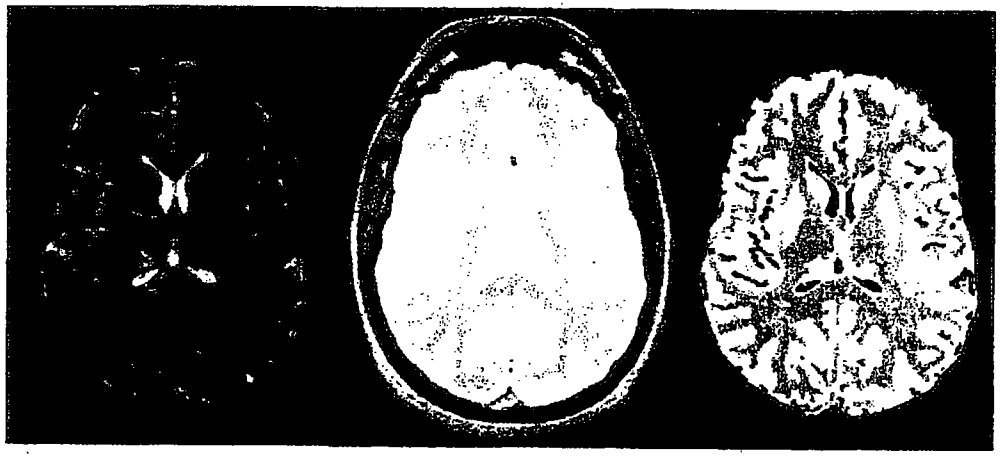


Figure 8

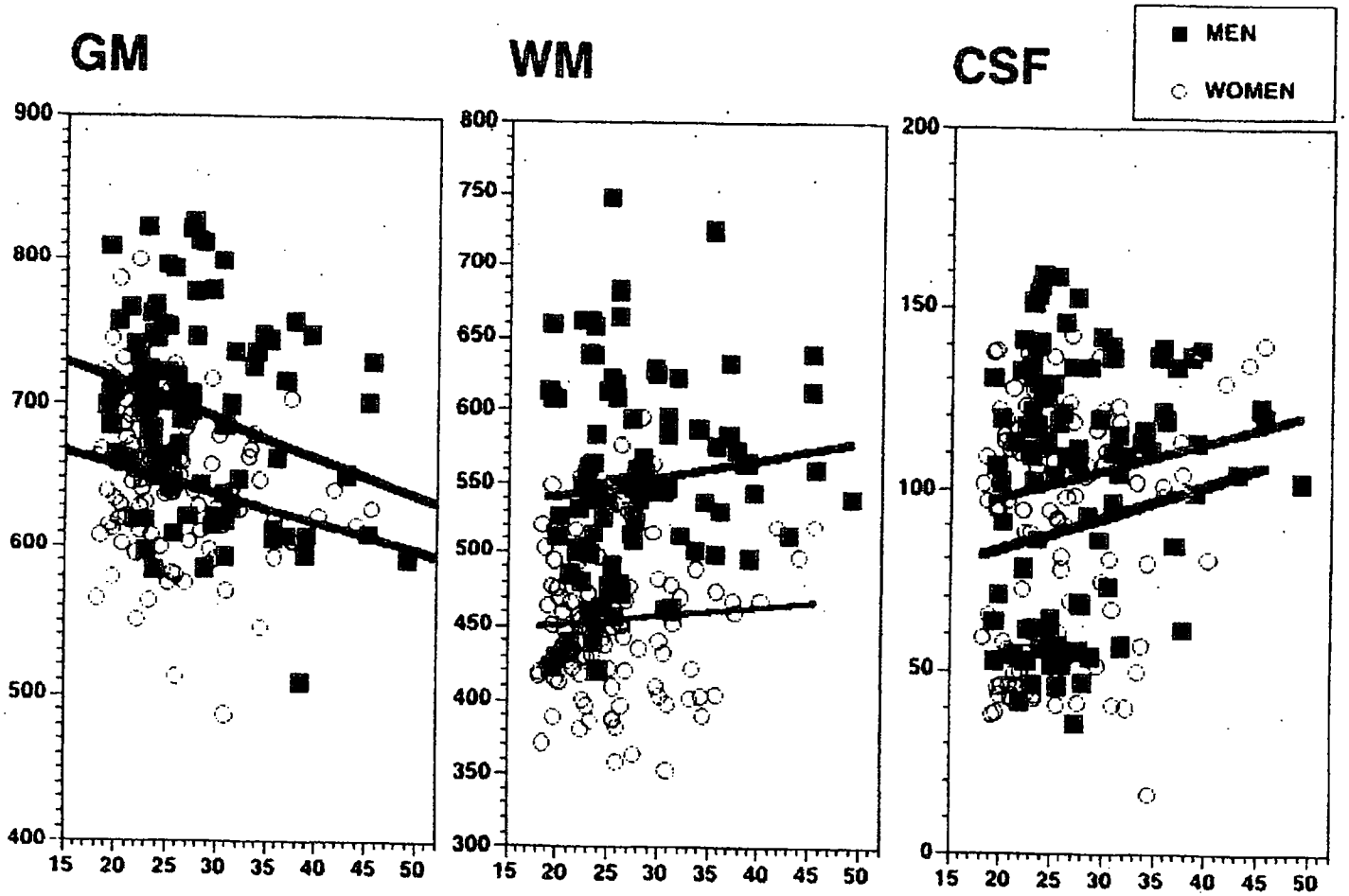
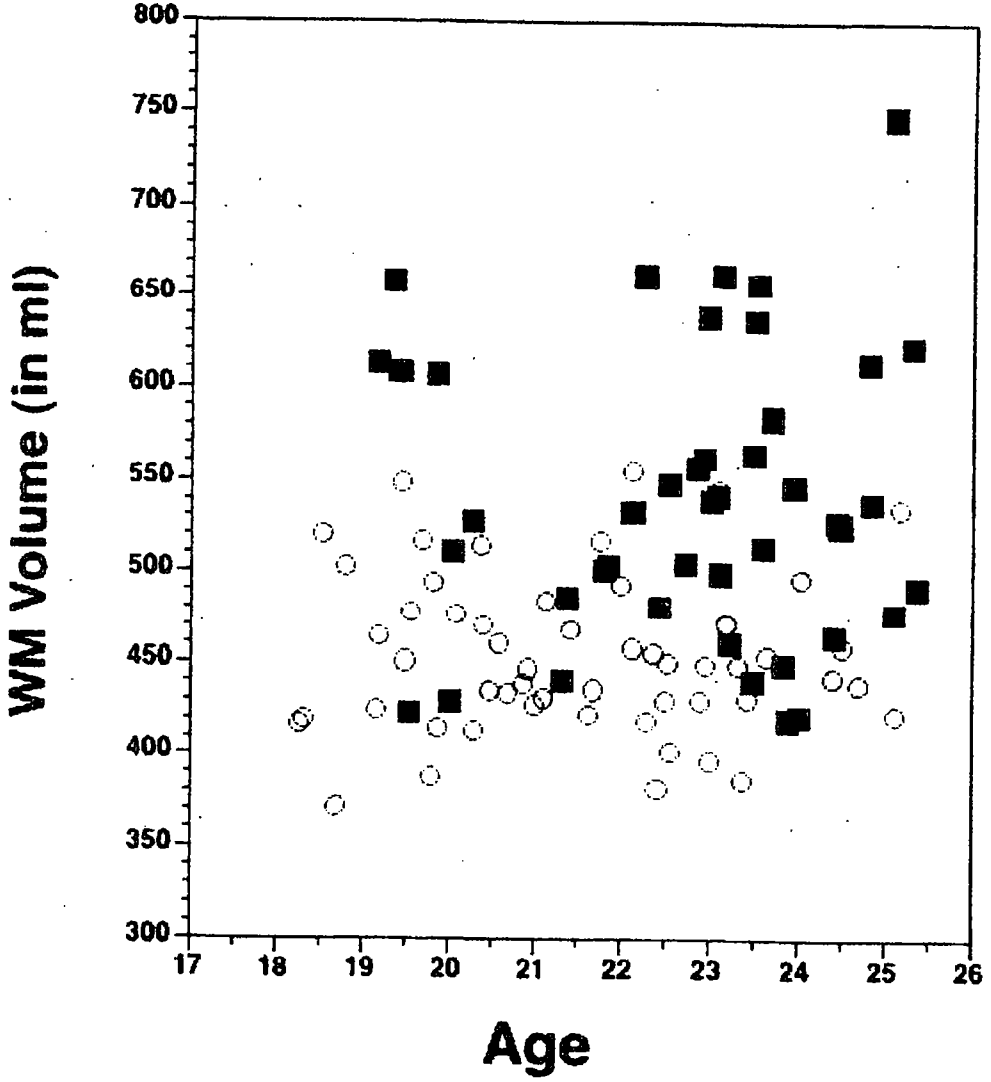

GM
WM
CSF
MEN
WOMEN
900
800
700
600
500
400
800
750
700
650
600
550
500
450
400
350
300
200
150
100
50
0
15 20 25 30 35 40 45 50

Figure 9


WM Volume (in ml)
800
750
700
650
600
550
500
450
400
350
300
17
18
19
20
21
22
23
24
25
26
Age

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[redacted]

QUANTITATIVE FUNCTIONAL BRAIN IMAGING CONSULTATION SUMMARY

Patient's name: **Chadrick E. Fulks**
Date of birth: [redacted]
Date of summary: June 14, 2004
Referring source: John Blume, Esq.

Summary of PET quantitative analysis for Mr. Chadrick E. Fulks

The PET ^{18}F-FDG study of cerebral metabolic rates for glucose (CMRgl) was deemed technically sound. A quantitative analysis of the PET data was requested to evaluate whether regional activity values deviate statistically from normal.

To perform the quantitative analysis, count data were downloaded electronically to a SUN Microsystems workstation and a standard set of regions of interest (ROIs) was applied using validated procedures[1]. Dr. J. Daniel Ragland performed placement of ROIs and the region-to-whole-brain (R/WB) ratio values were transferred electronically to a Macintosh computer for graphical display using Deltagraph_ (v4.5 for Mac). Two graphs were generated, one to evaluate regional hypo- or hyper-metabolism and the other to focus on any asymmetries.

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[1] Gur RE, Resnick SM, Alavi A, Gur RC, Caroff S, Dann R, Silver F, Saykin AJ, Chawluk JB, Kushner M, Reivich M. Regional brain function in schizophrenia: I. A positron emission tomography study. *Archives of General Psychiatry*, 1987, 44, 119-125.

Gur RC, Mozley LH, Mozley PD, Resnick SM, Karp JS, Alavi A, Arnold SE, Gur RE. Sex differences in regional cerebral glucose metabolism during a resting state. *Science*, 1995, 267, 528-531

Ragland JD, Glahn DC, Gur RC, Censits DM, Smith RJ, Mozley PD, Alavi A, Gur RE. PET regional cerebral blood flow change during working and declarative memory: Relationship with task performance. *Neuropsychology*, 1997, 11, 222-231.

Examination of the R/WB regional values (**Figure PET-1**) showed abnormal relative metabolism in a significant number (12 out of 35, $p < 0.001$) of regions. Notably, marked focal decrease in metabolism was documented in fusiform gyrus (FG) and thalamus (TH), while relative increases were notable in Superior Frontal (SF), Dorsal Prefrontal – Lateral (DL) and Medial (DM), Inferior Frontal (IF), Occipital cortex, Lateral (OL), Mid–Temporal (MT), Cingulate Gyrus – anterior (CA), Cingulate Gyrus – genu (CG), Cingulate Gyrus – Posterior (CP), and Lateral Lenticular nucleus(LL). Reduced fusiform and thalamic activity could be a result of head injuries, most likely a blow to the top of the head. The abnormally increased activity in some temporal, occipital and frontal regions could reflect epileptiform or psychotic process, possibly related to fetal alcohol syndrome that results in aberrant connectivity and over-excitability of affected regions. This could also relate to shearing associated with closed head injury. The findings of cortical hyper-metabolism are worrisome because they may lead to further tissue deterioration, unless there is also increased cerebral blood flow, which we were not able to determine.

Hemispheric asymmetry measures (**Figure PET-2**) indicate that the reduced activity in the fusiform gyrus is in the right, resulting in relatively higher left hemispheric metabolism in this region, while reduced thalamic activity is bilateral. Notably, in all regions showing abnormally increased activity the increase is lateralized to the left, while the lingual gyrus of the occipital lobe (LI) and the medial lenticular (LM), or globus pallidus, show focal decrease in the left. The symmetric activity in cerebellum is also abnormal because it is usually lower in the left in right-handed individuals. Some of these abnormalities can be appreciated by visual inspection of the PET scans (**Figure PET-3**), although knowledge of the normative data is essential to document regional deviations in many parts of the brain where normal metabolism may be asymmetric.

Interpretation

Quantitative examination of the PET data indicates an abnormal shift in regional activity, with hypo-metabolism in regions associated with complex visual processing and signal modulation, and hyper-metabolism of glucose in several cortical regions. Abnormal asymmetries in these regions were also documented. While the abnormalities in regional CMRgl are not themselves diagnostic in that they do not converge to support a specific etiology, they do establish with statistical certainty that Mr. Fulks has abnormal brain function. The extent to which the increased glucose metabolism in cortex, particularly temporal areas, is cause for concern depends of the adequacy of cerebral perfusion. This can be established with a PET study using a tracer such as $^{15}OH_2$ for measuring regional cerebral blood flow (rCBF). The interpretation of all these PET abnormalities also depends strongly on the anatomic analysis (see Dr. Davatzikos report). The etiology of these abnormalities is difficult to ascertain, but they are consistent with long-term effects of fetal alcohol exposure, extensive history of substance abuse and head injuries. The complexity and distribution of these abnormalities likely reflect more than a single cause.

Summary of neuropsychological evaluation for Mr. Chadrick E. Fulks

For preparing this report, I have reviewed the comprehensive neuropsychological testing performed by Drs. James Evans and Jonathan Venn and submitted the results for analysis and display using the Behavioral Imaging (BI) algorithm, I interviewed Mr. Fulks, and administered additional computerized tests and a measure of olfactory functioning to further delineate the nature and extent of deficits. I have also reviewed the screening results performed more recently by Dr. Landis at the Butner facility.

Prior testing and the "Behavioral Image"

In general, all evaluations agree that Mr. Fulks has put forth a good effort and was not trying to feign dysfunction. Therefore, the testing is considered a valid indication of his neurocognitive abilities. The evaluations also point out consistently that Mr. Fulks generally functions at a low level, with specific deficits in executive functions and memory.

The results of traditional neuropsychological testing were entered into the "Behavioral Imaging" algorithm as described in Gur et al.[2] The resulting behavioral image translates the neuropsychological scores into a color scaled presentation of the brain from top and side views, with red and yellow colors representing average or better performance and blue and dark colors representing brain dysfunction. The behavioral image of Mr. Fulks based on Dr. Evans evaluation (**Figure NP-1**, top panel) indicated overall impaired performance, with two notable foci of hypofunction on the left inferior and orbital frontal and, extending to the posterior temporal lobe, and left occipital region. The behavioral image based on Dr. Venn's testing (**Figure NP-1**, bottom panel) is remarkably consistent, also showing reduced left frontal functioning in the identical region and reduced occipito-parietal functioning, albeit more superiorly. The variability in occipital localization likely reflects differences in the sensitivity of visual testing by these evaluators.

Lesions of the kind depicted by the behavioral image are associated with several cognitive and emotional difficulties, in addition to those documented in the testing. In the cognitive domain, individuals with such lesions tend to have visual-perceptual problems, they will be considered "clumsy" and inattentive, they are easily distractible, and they have difficulty "sizing up" situations. Emotionally, people with lesions in the left fronto-temporal areas tend to be anxious, depressed and have poor impulse control.

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[2] Gur RC, Trivedi SS, Saykin AJ, Gur RE. "Behavioral imaging" - a procedure for analysis and display of neuropsychological test scores: I. Construction of algorithm and initial clinical evaluation. Neuropsychiatry, Neuropsychology and Behavioral Neurology, 1988, 1, 53-60.

Gur RC, Saykin AJ, Blonder LX, Gur RE. "Behavioral imaging": II. Application of the quantitative algorithm to hypothesis testing in a population of hemiparkinsonian patients. Neuropsychiatry, Neuropsychology and Behavioral Neurology, 1988, 1, 87-96.

Gur RC, Saykin AJ, Benton A, Kaplan E, Levin H, Kester DB, Gur RE. "Behavioral imaging": III. Inter-rater agreement and reliability of weightings. Neuropsychiatry, Neuropsychology, and Behavioral Neurology, 1990, 3, 113-124.

Clinical interview and Testing

I interviewed Mr. Fulks in a cell provided by the prison. Mr. Fulks was dressed in prison-issued clothing and his handcuffs were removed. He was polite and friendly, and talked almost incessantly unless instructed to respond to specific questions. His speech was slow and somewhat slurred, with minimal prosody. His face had a stare that seemed to reflect efforts to understand what was going on around him. He had a slight tremor in his right hand, especially when he had to use his left hand.

Mr. Fulks described numerous head injuries with LOC. He also reported an extensive history of substance abuse during childhood, adolescence and adulthood, a factor that likely exacerbated a pre-existing brain dysfunction probably related to his mother's use of alcohol during pregnancy.

Mr. Fulks approached the testing confidently and put forth his best effort. He worked diligently, and was cautious and meticulous in his approach. When encountering difficult tasks he talked to himself in an effort to guide his responses. He generally performed in the average to much below average range (**Figure NP-2**). His effort to perform accurately (**Figure NP-2,** top panel) seems to have masked deficits, as his reaction time (speed) was significantly impaired whenever his accuracy was within the normal range (**Figure NP-2,** bottom panel). Notably for executive functioning, he was unable to attain the third category on the PCET even though he was able to discover the firs two categories quite fast, consistent with dorsolateral prefrontal damage. On the attentional test he was able to perform on average for target detection, but this was by using a very liberal strategy that resulted in a highly abnormal rate of false positives. His immediate memory was impaired for words, faces and shapes, although his ability to retain information, once memorized, is less impaired. On the other hand, his accuracy for the intellectual measure was impaired while his speed was normal. For spatial processing he attained performance within the normal range, but at the expense of highly abnormal speed (>4SDs below average). His sensorimotor performance was markedly abnormal for both accuracy and speed.

On the measures of affect processing, his accuracy was within normal limits but his speed was severely compromised. The exception was for recognition of high intensity happy, where he was impaired for accuracy but not speed. Finally, olfactory testing using the UPSIT was in the range of Moderate Microsmia (<5th %tile).

Interpretation of neuropsychological evaluation

The impairments documented in the neuropsychological testing indicate the presence of moderate to severe cerebral dysfunction affecting fronto-temporal and limbic regions, as well as visual and sensorimotor areas. Both cortical and subcortical regions are affected, including the limbic system. This is strongly supported by the affect processing and the olfactory findings.

Individuals with this degree and distribution of cerebral dysfunction have behavioral deficits encompassing both cognition and affect. Probably of greatest relevance to this case are impaired ability to process emotion and the ability to understand emotional expressions on other people's faces. Such difficulties may create paranoid ideation and cause inappropriate responses. The deficits indicate poor ability to abstract and understand

the context of his behavior and control impulses. One should bear in mind that individuals with focal brain lesions might behave in ways that deviate from their "normal" self, ways in which they would not have behaved had they not suffered from brain dysfunction. Therefore, the presence of brain dysfunction such as observed in Mr. Fulks diminishes the ability to assess his environment and control his behavior. The pattern is consistent with an individual having a fetal alcohol spectrum disorder complicated by substance abuse and traumatic head injuries.

Integration across the behavioral and imaging studies

As indicated in the report of Dr. Davatzikos, Mr. Fulks has a highly abnormal brain anatomy with reduced volume in frontal and limbic regions. The PET results indicate focal reduction in neuronal activity in fusiform gyrus and thalamus, areas that are central for complex visual processing and signal modulation. At the same time there is abnormal elevation of activity in several fronto-temporal regions and limbic structures including the entire cingulate gyrus. The elevated metabolic activity in regions of tissue loss indicates an active pathological process that could be epileptogenic if cerebral perfusion is compromised. The pattern of abnormalities is consistent with results of neuropsychological testing, which shows deficits in functions related to these regions. This includes deficits in abstraction, flexibility, attention and impulse control, as well as affect processing and the olfactory deficit. His right hand tremor may relate to relative reduction in cerebellar activity on the right. His deficits in visual sensorimotor functioning likely relates to reduced metabolism in fusiform gyrus and visual sensorimotor areas. Reduced thalamic activity likely interferes with signal modulation and the process of assigning meaning to the environmental cues.

This pattern is consistent with neurodevelopmental aberrations seen in cases suffering from fetal exposure to alcohol, which is characterized by tissue loss in medial and frontal structures. However, the severity and distribution of abnormalities indicate that additional dysfunction was caused by head injuries, where bony structures in the orbital regions produce tissue injury and the force of the blow produces shearing in medially located regions. Other factors may have further exacerbated the deficit including poor prenatal and perinatal conditions and extensive substance abuse. Most substances of abuse affect frontal regions and may add to tissue loss and abnormal physiologic landscape.

Prepared by

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Abbreviations in PET Figures:

SF = Superior Frontal; DL = Dorsal Prefrontal – Lateral; DM = Dorsal Prefrontal – Medial; MF = Mid–Frontal; IF = Inferior Frontal; SM = Sensorimotor; SP = Superior Parietal; SG = Supramarginal Gyrus; OL = Occipital cortex, Lateral ; OM = Occipital cortex, Medial; LI = Lingual Gyrus; FG = Fusiform Gyrus; OT = Occipital Temporal; ST = Superior Temporal; MT = Mid–Temporal; IT = Inferior Temporal; TP = Temporal Pole; PH = Parahippocampal Gyrus; HI = Hippocampus; AM = Amygdala; IN = Insula; OF = Orbital Frontal; RG = Rectal Gyrus; CA = Cingulate Gyrus – Anterior; CG = Cingulate Gyrus - genu; CP = Cingulate Gyrus – Posterior; C1 = Corpus Callosum – Anterior; C2 = Corpus Callosum – Posterior; CN = Caudate Nucleus; LM = Lenticular – Medial [Globus Pallidus]; LL = Lenticular – Lateral [Putamen]; TH = Thalamus; MI = Midbrain; PO = Pons; CE = Cerebellum.

PAR = Parietal
OCC = Occipital
CC = Corpus callosum
BG = Basal ganglia
BS = Brainstem

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
FLORENCE DIVISION

UNITED STATES OF AMERICA,	)	CR. NO. 4:02-992
	)	COLUMBIA, SC
	)	JUNE 16, 2004
VERSUS	)	
	)	
CHADRICK E. FULKS	)	
DEFENDANT.	)	
_____	)	

BEFORE THE HONORABLE JOSEPH F. ANDERSON, JR.,
CHIEF UNITED STATES DISTRICT COURT JUDGE
JURY TRIAL
VOLUME XII

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*** *** *** *** ***

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RUBEN GUR, HAVING BEEN FIRST DULY SWORN, TESTIFIED AS FOLLOWS:

DIRECT EXAM

BY MR. BLUME:

Q. DR. GUR, WHERE ARE YOU CURRENTLY EMPLOYED?

A. UNIVERSITY OF PENNSYLVANIA IN PHILADELPHIA.

Q. AND WHAT DO YOU DO AT THE UNIVERSITY OF PENNSYLVANIA?

A. I AM A PROFESSOR IN THE MEDICAL SCHOOL, PRIMARY APPOINTMENT IN THE DEPARTMENT OF PSYCHIATRY AND SECONDARY APPOINTMENT IN THE DEPARTMENTS OF NEUROLOGY AND RADIOLOGY.

Q. AND DO YOU ALSO WORK AT THE BRAIN BEHAVIOR LABORATORY AT THE UNIVERSITY OF PENNSYLVANIA?

A. YES. I DIRECT THE BRAIN BEHAVIOR LABORATORY.

Q. WHAT IS THE BRAIN BEHAVIOR LABORATORY?

A. IT IS A LABORATORY THAT HAS BEEN WORKING FOR THE PAST OVER 20 YEARS IN THE AREA OF USING IMAGING IN ORDER TO UNDERSTAND THE WAY THE BRAIN REGULATES BEHAVIOR. SO, WE HAVE BEEN INVOLVED IN RESEARCH, BASIC AND CLINICAL RESEARCH, LOOKING AT HOW NORMAL BRAIN FUNCTIONS AND HOW BRAIN DAMAGE CAN INFLUENCE WHAT WE CAN DO, AND HOW WE THINK, AND HOW WE FEEL.

Q. AND SO, YOU SAID YOU HAVE -- YOUR PRIMARY APPOINTMENT IS IN PSYCHIATRY, BUT YOU ARE ALSO APPOINTED IN NEUROLOGY AND APPOINTMENT IN NEUROLOGY RADIOLOGY?

A. YES.

Q. WHAT ARE THE DIFFERENCES BETWEEN PSYCHIATRY,

RADIOLOGY, AND NEUROLOGY?

A. PSYCHIATRY IS THE DISCIPLINE THAT CONCERNS ITSELF WITH DISORDERS OF COMPLEX BEHAVIORS. SO, VARIOUS DISORDERS INVOLVE DISRUPTION OF BEHAVIOR THAT IS MORE COMPLEX THAN SIMPLE REFLEXES.

NEUROLOGY FOCUSES MORE ON HARD-WIRED BEHAVIOR, ALTHOUGH THERE IS A BRANCH OF NEUROLOGY THAT LOOKS AT MORE COMPLEX BEHAVIOR, AS WELL. IN THAT SENSE, THERE IS SOME OVERLAP. TRADITIONALLY, TRADITIONALLY, PSYCHIATRY HAD A BIG PART OF IT DEVOTED TO UNKNOWN BEHAVIORS WITHOUT REALLY ASSUMING OR UNDERSTANDING THAT THERE IS A NEURAL BASIS TO THOSE ABNORMALITIES. MORE AND MORE, THE FIELD HAS BECOME HEAVILY BIOLOGICAL BECAUSE OF THE ADVANCES IN BASIC NEUROSCIENCE. AND, SO, INCREASINGLY, WE LEARN HOW BRAIN ABNORMALITIES REALLY ARE AT THE HEART OF THE MOST SEVERE FORMS OF SO-CALLED MENTAL ILLNESSES.

AND RADIOLOGY IS THE DISCIPLINE THAT CAN USE TOOLS IN ORDER TO STUDY THE BRAIN AND REALLY DOCUMENT THE ANATOMY OF THE BRAIN, AND MORE RECENTLY THE PHYSIOLOGY OF THE BRAIN.

Q. YOU TEACH IN ALL THREE AREAS?

A. YES.

Q. AND SO, I ASSUME THAT, SINCE YOU ARE A PROFESSOR AT THE MEDICAL SCHOOL, MOST OF YOUR TEACHING IS OF MEDICAL STUDENTS?

A. WELL, I TEACH ALSO AT THE COLLEGE, AT THE UNDERGRADUATES, USUALLY BE A SEMINAR. I TEACH MEDICAL

STUDENTS, REGULAR STUDENTS. WE HAVE A FEDERALLY-FUNDED TRAINING GRANT TO TEACH POSTDOCTORATE FELLOWS. SO, AFTER YOU GET YOUR M. D. OR YOUR PH.D., IF YOU WANT TO HAVE A CAREER IN RESEARCH, YOU NEED TO SPEND ANOTHER COUPLE OF YEARS LEARNING A SPECIFIC AREA. AND OUR SPECIFIC AREA IS ON THE USE OF IMAGING IN RESEARCH AND CLINICAL PRACTICE.

Q. BY IMAGING, YOU MEAN CAT SCANS, MRI SCANS, AND BRAIN SCANS?

A. YES.

Q. AND, BRIEFLY, AND I KNOW YOU WILL TALK ABOUT THIS BECAUSE THIS IS WHAT YOU ARE AN EXPERT IN, WHAT IS COGNITIVE NEUROSCIENCE?

A. COGNITIVE NEUROSCIENCE IS A FIELD THAT HAS REALLY MATURED OVER THE PAST DECADE TAKING ADVANTAGE OF ADVANCES IN METHODS FOR STUDYING THE BRAIN AND, IN PARTICULAR, LOOKING AT THE BRAIN CHANGES THAT OCCUR WITH COMPLEX BEHAVIOR. AND SO, WE CAN NOW MAKE DIRECT LINKS BETWEEN CONCEPTS OF COGNITION, THE WAY PEOPLE THINK AND FEEL, AND SPECIFIC SYSTEMS IN THE BRAIN. AND THAT FIELD IS NOW RECOGNIZED AS COGNITIVE NEUROSCIENCE.

Q. SO, COGNITION IS, BASICALLY, IN LAYPERSON'S TERMS OR TO DUMB IT DOWN A LITTLE BIT FOR ME, IS THE WAY PEOPLE THINK?

A. EXACTLY. AND I WOULD INCLUDE FEELING, MORE COMPLEX FEELING AS PART OF COGNITION, ALTHOUGH THERE IS NOW PEOPLE WHO SAY THERE SHOULD BE MORE SO AFFECTIVE NEUROSCIENCE,

NEUROSCIENCE OF EMOTION. BUT MOST PEOPLE, WHEN THEY TALK ABOUT COGNITIVE NEUROSCIENCE, ALSO MEAN TO COVER THE AREA OF EMOTION PROCESSES.

Q. CAN YOU BRIEFLY RELAY YOUR EDUCATIONAL BACKGROUND TO THE JURY, PLEASE?

A. WELL, I GOT MY BACHELOR DEGREE IN PSYCHOLOGY AND PHILOSOPHY FROM THE HEBREW UNIVERSITY IN JERUSALEM IN ISRAEL IN 1970. I GOT MY MASTER DEGREE IN CLINICAL PSYCHOLOGY AT MICHIGAN STATE UNIVERSITY IN 1971. MY PH.D. IN CLINICAL PSYCHOLOGY SAME PLACE, 1973. I DID POSTDOCTORATE TRAINING AT STANFORD UNIVERSITY. AND ANOTHER ONE AT THE UNIVERSITY OF PENNSYLVANIA. AND THEN I, IN ADDITION, DID AN INTERNSHIP IN CLINICAL PSYCHOLOGY, INCLUDING EXPERIENCE WORKING IN PRISON PSYCHIATRIC UNIT IN THE STATE PRISON OF SOUTHERN MICHIGAN IN JACKSON, MICHIGAN.

Q. AND CAN YOU ALSO TELL THE JURY A LITTLE BIT ABOUT, SINCE COMPLETING YOUR FORMAL EDUCATION, POSTDOCTORAL TRAINING, WHAT YOU HAVE BEEN DOING?

A. SINCE COMPLETING MY TRAINING, I HAVE BEEN ENGAGED IN THE THREE PRONGS OF ACTIVITY THAT ACADEMIC MEDICINE IS FOSTERING, WHICH IS RESEARCH; CLINICAL WORK; AND, TEACHING. THE RESEARCH AT THE UNIVERSITY OF PENNSYLVANIA WAS ONE OF THE PLACES WHERE THIS WHOLE IMAGING RESEARCH HAS STARTED. AND SO, PENN HAS ALWAYS BEEN MAKING AN EFFORT TO STAY AT THE FOREFRONT. AND, AS SOMEONE WHO IS TRAINED IN PSYCHOLOGY,

INTERESTED IN BEHAVIOR, I BECAME PART OF A MULTIDISCIPLINARY TEAM THAT PUT TOGETHER THE INSTRUMENTATION AND THE METHODOLOGY IN ORDER TO USE IMAGING TO BETTER UNDERSTAND CONNECTIONS BETWEEN BRAIN INTEGRITY AND BEHAVIOR. SO, MY RESEARCH IN THE CLINICAL WORK HAVE REALLY COMPLIMENTED EACH OTHER.

IN RESEARCH, WE STUDY HEALTH IN PEOPLE AS WELL AS PATIENTS WITH DIFFERENT FORMS OF BRAIN DYSFUNCTION, EITHER SO-CALLED NEUROLOGICAL OR SO-CALLED PSYCHIATRIC. AND A LOT OF THE EFFORT, INITIALLY, WAS TO CHARACTERIZE THE BRAIN DISORDERS. FIND OUT HOW DOES A STROKE LOOK WHEN YOU DO AN IMAGING OF THE BRAIN. HOW DOES ALZHEIMER'S DISEASE LOOK. HOW DOES PARKINSON'S, SCHIZOPHRENIA, BIPOLAR DISORDERS. AND BY STUDYING A LOT OF HEALTHY PEOPLE, WE WERE ABLE TO DOCUMENT THE SPECIFIC ABNORMALITIES THAT YOU CAN SEE WHEN YOU LOOK AT BRAIN IMAGES. AND RELATE THOSE ABNORMALITIES TO THE ABNORMALITIES IN COMPLEX BEHAVIOR THAT YOU SEE IN THOSE PATIENTS. AND, OF COURSE, EVERYTHING WE LEARNED, WE TRY TO TEACH TO THE STUDENTS. AND SO, THE BIG, IMPORTANT PART OF MY ACTIVITY HAS BEEN TEACHING AT THE VARIOUS LEVELS.

Q. AND DO YOU PUBLISH ARTICLES?

A. WELL, YES. THEY SAY PUBLISH OR PERISH IS THE COMMAND IN ACADEMIA. AT PENN IS PUBLISH OR YOU NEVER EXISTED. YOU REALLY HAVE TO PUBLISH AND PUBLISH OF ONE KIND, WHICH IS THE REFEREED PUBLICATIONS. SO, WE ONLY COUNT PAPERS THAT WERE REFEREED BY COLLEAGUES.

Q. BY THAT, YOU JUST MEAN THAT, BEFORE SOMETHING IS PUBLISHED, IT HAS TO BE REVIEWED BY YOUR PEERS OR BY OTHER PEOPLE IN THE FIELD, AND DETERMINED TO BE SCIENTIFICALLY CORRECT?

A. EXACTLY. EVERY PAPER HAS TO GO THROUGH A REVIEW PROCESS WHERE OPINIONS ARE SOLICITED FROM PEERS AND THAT IT GOES TO AN EDITORIAL BOARD THAT MAKES DECISIONS. AND THE PAPER HAS TO BE TECHNICALLY FLAWLESS, BUT, IN ADDITION, ADD SUBSTANTIALLY TO THE LITERATURE BEFORE IT CAN BE PUBLISHED.

Q. AND, APPROXIMATELY, HOW MANY SEPARATE ARTICLES AND STUDIES HAVE YOU PUBLISHED DURING YOUR CAREER?

A. AT THIS POINT, I THINK I JUST PASSED THE 200.

Q. AND ARE YOU BOARD-CERTIFIED IN ANY PARTICULAR AREAS?

A. YES, I AM BOARD-CERTIFIED IN CLINICAL NEUROPSYCHOLOGY BY THE AMERICAN BOARD OF PROFESSIONAL PSYCHOLOGY.

Q. AND DO YOU CURRENTLY DO RESEARCH FOR VARIOUS BRANCHES OF THE FEDERAL GOVERNMENT?

A. YES. THIS RESEARCH THAT WE ARE DOING IS ACTUALLY QUITE EXPENSIVE. YOU CAN'T CONTEMPLATE A SERIOUS STUDY WITHOUT AT LEAST 3, $400,000 FOR THE PROJECT. AND, SO, THE WAY WE OBTAIN FUNDING IS WE HAVE TO DESCRIBE THE IDEA FOR THE STUDY IN DETAIL, SHOW EVIDENCE THAT WE CAN CARRY OUT THE STUDY, CONDUCT PRELIMINARY WORK TO SHOW THAT THE STUDY CAN PRODUCE MEANINGFUL RESULTS, AND THEN WE SEND IT TO WASHINGTON. AND THERE ARE STUDY SECTIONS THAT CONSIST OF

EXPERTS AROUND THE COUNTRY, AND THEY MEET THREE TIMES A YEAR IN WASHINGTON AND REVIEW GRANTS WITHIN THEIR AREAS. SO, EACH ONE OF THOSE PROPOSALS WILL GO TO THE COMMITTEE OF ABOUT 25 PEERS, WHO WILL REVIEW THE IDEAS AND DECIDE WHETHER THE PROJECT IS WORTH FUNDING AND WHAT PRIORITY LEVEL.

SO, WITHIN THAT, WE HAVE SEVERAL INDIVIDUAL PROJECTS THAT ARE CALLED R-1'S, THESE ARE, IN SOME WAYS, THE MOST COVETED GRANTS BECAUSE YOU GET, SAY, FIVE YEARS TO PURSUE A CERTAIN HYPOTHESIS OR SPECIFIC DIRECTION IN YOUR RESEARCH.

ANOTHER MECHANISM IS THE CENTER GRANTS. AND WE HAVE JOINTLY APPLIED WITH DIFFERENT COLLEAGUES FROM DIFFERENT DEPARTMENTS AND CREATED A CENTER FOR BASIC NEUROSCIENCE AT THE UNIVERSITY WHERE PEOPLE COLLABORATED, ALL LEVELS, ALL THE WAY FROM THE VERY BASIC MOLECULAR STUDIES UP TO MORE COMPLEX STUDIES OF COMPLEX BEHAVIOR AND IMAGING.

SO, JUST TO GIVE YOU AN IDEA, AN R-1, AN AVERAGE R-1 THAT I HAVE, WILL HAVE ABOUT $300,000 A YEAR FOR 3 TO 4 TO 5 YEARS. OUR CENTER IS 1.5 MILLION DOLLARS A YEAR FOR FIVE YEARS. AND WE HAVE HAD THE CENTER SINCE 1987. EVERY FIVE YEARS, YOU HAVE TO COME UP FOR COMPETING RENEWAL, AND THE CENTER IS SCRUTINIZED. IN EFFECT, THEY HAVE ASSIGNED VISITS OF THE EXPERTS COMING TO US AND LOOKING OVER OUR SHOULDERS AND MAKING SURE THAT EVERYTHING IS DONE, IS DONE RIGHT. AND THEN, IT IS A LITTLE TOUGH BECAUSE, BASICALLY, YOU ARE ASKING FOR THE MONEY FROM YOUR COMPETITION. ALL OF THOSE COLLEAGUES,

THEMSELVES, APPLY FOR GRANTS, AND THEY LITERALLY SEE THE MONEY AS COMING FROM THEIR OWN POCKET, BOTH AS TAXPAYER AND AS PEOPLE TRYING TO COMPETE FOR THE SAME AMOUNT OF MONEY. SO, THERE IS QUITE A BIT OF SCRUTINY OF OUR WORK FROM ALL STAGES, FROM THE PLANNING, TO THE EXECUTION, TO FINALLY WHEN WE SUBMIT IT FOR PUBLICATION.

Q. DR. GUR, IN THE COURSE OF YOUR CAREER, HAVE YOU RECEIVED ANY AWARDS FOR YOUR WORK IN THE FIELD OF NEUROSCIENCE?

A. YES, I HAVE RECEIVED SEVERAL AWARDS. THE ONE THAT I CONSIDERED MOST HIGHLY IS AN AWARD FROM THE FAMILIES OF PEOPLE WHO SUFFER FROM SEVERE MENTAL ILLNESS. AND THEY GAVE ME THE LOGAN AWARD FOR EXCELLENCE IN RESEARCH IN COMPLEX BEHAVIOR.

Q. AND ARE YOU A MEMBER OF ANY PROFESSIONAL ASSOCIATIONS?

A. YES, I AM A MEMBER, FELLOW STATUS, IN THE AMERICAN PSYCHOLOGICAL ASSOCIATION, AMERICAN PSYCHOLOGICAL SOCIETY, WHICH IS MORE PSYCHOLOGY SORT OF INTERESTED IN BASIC SCIENCE. THE AMERICAN COLLEGE OF NEUROPSYCHOPHARMACOLOGY, THE AMERICAN ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE, AND INTERNATIONAL NEUROPSYCHOLOGICAL SOCIETY. SEVERAL OTHERS, BUT THESE ARE THE MOST IMPORTANT ONES.

Q. AND, DR. GUR, HAVE YOU EVER BEEN QUALIFIED AS AN EXPERT WITNESS BEFORE?

A. YES, I WAS.

Q. AND HAVE YOU EVER BEEN RETAINED BY THE PROSECUTION OR

THE UNITED STATES GOVERNMENT IN A CRIMINAL CASE?
A. YES, I WAS.
Q. AND YOU HAVE ALSO BEEN RETAINED, ON OCCASION, BY ATTORNEYS FOR DEFENSE COUNSEL?
A. THIS IS NOT -- I HAVEN'T DONE A LOT OF IT. MY DAY JOB KEEPS ME PRETTY BUSY. BUT AS PART OF MY APPOINTMENT, I AM ALLOWED ONE DAY SEVEN RULE, WHERE I CAN DO CONSULTATIONS ON VARIOUS ISSUES, INCLUDING MEDICAL LEGAL CONSULTATIONS.
Q. SO, THAT JUST GOES PRIMARILY, YOU ARE AN ACADEMIC AND RESEARCHER. BUT, ON OCCASION, YOU DO SOME CONSULTATION WORK?
A. THAT IS CORRECT.
MR. BLUME: YOUR HONOR, AT THIS TIME, I WOULD MOVE TO QUALIFY DR. GUR AS AN EXPERT IN COGNITIVE NEUROSCIENCE.
THE COURT: ANY VOIR DIRE BY THE GOVERNMENT?
MR. GASSER: NO, SIR.
THE COURT: ALL RIGHT. YOU MAY PROCEED.
BY MR. BLUME:
Q. DR. GUR, AT MY REQUEST, DID YOU REVIEW CERTAIN MATERIALS AND CONDUCT CERTAIN TESTING IN THE CASE OF UNITED STATES OF AMERICA VERSUS CHADRICK FULKS?
A. YES, I DID.
Q. CAN, YOU BRIEFLY, TELL THE JURY WHAT MATERIALS YOU REVIEWED?
A. FIRST, I REVIEWED PREVIOUS TESTING THAT WAS DONE ON MR. FULKS BY DR. EVANS AND DR. VENN: I, THEN, APPLIED SOME

METHODS THAT WERE DEVELOPED FOR INTERPRETING THE TESTS. THEN I REVIEWED -- THEN I TESTED MR. FULKS MYSELF IN ORDER TO PURSUE AREAS THAT SHOWED POTENTIAL DYSFUNCTION AND CHARACTERIZE BETTER THE NATURE OF THE DEFICIT. I REVIEWED ALL OF THE IMAGING STUDIES THAT WERE DONE ON MR. FULKS. THERE WERE TWO SETS OF MRI SCANS, AND TOGETHER WITH MY COLLEAGUE, DR. CHRISTOS DAVITZKOS, APPLIED QUANTITATIVE METHODS TO ANALYZE THE IMAGING DATA. I ALSO REVIEWED THE CAT SCANS AND APPLIED STANDARD METHODS TO EXAMINE THE CAT SCANS QUANTITATIVELY. I ANALYZED THOSE DATA AND REACHED SOME CONCLUSIONS ABOUT THE STATE OF MR. FULKS'S BRAIN AND HOW IT RELATES TO HIS BEHAVIOR.

Q. DR. GUR, WE ARE GOING TO GO THROUGH ALL OF THIS IN SOME DETAIL. AND WE WILL TALK ABOUT WHAT THE DIFFERENT TESTS ARE AND THAT KIND OF THING. BUT JUST AT THE BEGINNING, BEFORE WE SORT OF MARCH THROUGH THIS IN DETAIL, COULD YOU GIVE THE JURY AN OVERALL SUMMARY OF YOUR CONCLUSIONS IN THIS CASE?

A. OVERALL, I FOUND CONSIDERABLE CONSISTENCY AMONG THE NEUROPSYCHOLOGICAL TEST RESULTS, THE IMAGING STUDIES OF BRAIN STRUCTURE OR ANATOMY, AND IMAGING STUDIES OF BRAIN FUNCTION OR PHYSIOLOGY THAT INDICATE THAT MR. FULKS HAS A HIGHLY ABNORMAL BRAIN. AND THE ABNORMALITY IN THE BRAIN STRUCTURE AND FUNCTION EXPLAIN A LOT OF THE BEHAVIORS, AND THE COGNITIVE, AND EMOTIONAL DEFICITS THAT HAVE BEEN DOCUMENTED IN HIS CASE.

Q. YOU SAID HE HAS A HIGHLY ABNORMAL BRAIN. IS IT

ABNORMAL STRUCTURALLY, METABOLICALLY, BEHAVIORALLY, ALL?

A. ALL OF THE ABOVE IS THE CORRECT ANSWER, IF THIS WERE A MULTIPLE CHOICE.

Q. WELL, DR. GUR, WHAT I WANT TO DO NOW IS, SO WE CAN SORT OF GET THE JURY ORIENTED, IF WE COULD TALK A LITTLE BIT ABOUT THE STRUCTURE OF THE BRAIN AND HOW THE BRAIN WORKS AND DEVELOPS, I THINK IT WOULD POTENTIALLY HELP THE JURORS UNDERSTAND YOUR TESTIMONY.

DID YOU BRING -- DID YOU PREPARE, FOR DEMONSTRATIVE PURPOSES FOR THE JURY TO SEE, A SERIES OF SLIDES AND PICTURES ABOUT THE BRAIN?

A. YES. AND I HOPE I WILL BE ABLE TO SHOW THAT BECAUSE I THINK THAT WILL HELP CLARIFY A LOT OF WHAT I WILL BE SAYING. I DID PREPARE A SHORT PRESENTATION THAT EXPLAINS HOW THE DIFFERENT PARTS OF MY EVALUATION ARE CONDUCTED AND WHAT THEY MEAN.

MR. GASSER: I HAVE NO OBJECTION TO WHAT HE PLANS ON DOING WITH GENERALITIES.

THE COURT: OFFERING THIS AS AN EXHIBIT?

MR. BLUME: THERE ARE SEVERAL I WILL OFFER AS EXHIBITS. MOST OF THESE ARE FOR DEMONSTRATIVE USES ALONG THE WAY.

THE COURT: MAKE IT CLEAR WHAT IS DEMONSTRATIVE.

MR. BLUME: IT WILL BE CLEAR WHEN I TRY TO OFFER THE ONES.

BY MR. BLUME:

Q. MR. GUR, CAN YOU SEE WHAT IS ON THE SCREEN? IT SHOULD BE IN FRONT OF YOU.

A. I CAN SEE WHAT IS ON THE SCREEN.

Q. DR. GUR, LET'S TALK A LITTLE BIT ABOUT THE BRAIN, AND THE BRAIN STRUCTURE, AND HOW IT DEVELOPS. AND I THINK, BY NOW, LADIES AND GENTLEMEN, YOU SEE THE SCREEN. WHAT IS THIS? FIRST, TELL US WHAT THIS IS.

A. OKAY.

THE COURT: I AM TOLD WE NEED TO TAKE A BREAK. LET'S TAKE A FIFTEEN MINUTE RECESS AT THIS TIME. PLEASE GO TO YOUR JURY ROOM. RECESS FOR 15 MINUTES.

(WHEREUPON, A SHORT RECESS WAS HELD.)

THE COURT: PLEASE CONTINUE.

BY MR. BLUME:

Q. DR. GUR, CAN YOU SEE THE IMAGE ON YOUR SCREEN?

A. YES.

Q. AND JUST TO LET YOU KNOW, IF THERE ARE THINGS YOU WANT TO POINT OUT, I SHOULD HAVE EXPLAINED THIS TO YOU EARLIER. IF YOU TOUCH THE SCREEN, IT WILL SHOW UP. AND THEN, WE CAN CLEAR IT FROM HERE. SO, IF THERE ARE THINGS YOU WANT TO PULL IN, OR OUTLINE, OR DRAW, OR TOUCH, YOU CAN DO IT ON THE SCREEN.

BUT WHAT I WANT TO DO FOR MY OWN BENEFIT, AND FOR THE JURY'S BENEFIT, IS TO TALK, BEFORE WE SORT OF GO INTO YOUR

TESTIMONY ABOUT THE ABNORMALITIES OF MR. FULKS'S BRAIN, IF WE COULD TALK A LITTLE BIT ABOUT HOW THE BRAIN WORKS AND THE STRUCTURE OF THE BRAIN, SORT OF GET EVERYBODY ON THE SAME PAGE ORIENTED. CAN YOU BRIEFLY DESCRIBE WHAT IS ON THIS SLIDE?

A. WHAT YOU SEE HERE IS A CARTOON, REALLY, OF THE BUILDING BLOCK OF THE BRAIN. AND THIS IS WHAT YOU SEE IS A NERVE CELL CALLED NEURON. AND NO NEURON REALLY LOOKS LIKE THAT, BUT ALL OF THEM HAVE THOSE FEATURES. SO, IT IS LIKE, IF YOU DREW A STICK FIGURE OF A HUMAN, THERE IS NOT A HUMAN THAT LOOKS LIKE THAT, BUT IT IS AN IDEA OF WHAT ARE THE MAIN PARTS OF A HUMAN BEING. HERE YOU SEE THE MAIN PARTS ARE THE CELL BODY THAT ARE RIGHT HERE, THAT IS DISTINGUISHED IN THAT IT HAS A LOT OF THOSE LITTLE PROTRUSIONS COMING OUT THAT ARE CALLED DENDRITES. THESE PROTRUSIONS ARE IN ORDER TO COMMUNICATE WITH THE ADJACENT NEURONS. THEY GET INFORMATION FROM ADJACENT NEURONS, AND THE INFORMATION IS CHEMICAL, BUT THE CHEMICAL INFORMATION CHANGES THE ELECTRICAL POLARITY OF THE MEMBRANE OF THE CELL OR THE SKIN OF THE CELL. AND AFTER ENOUGH INFORMATION GETS IN, THE POLARITY CHANGES ENOUGH SO THAT IT SENDS AN ELECTRICAL PULSE.

THE ELECTRICAL PULSE WORKS LIKE ELECTRICITY IN AN OUTLET OF YOUR HOUSE. IT TRAVELS VERY FAST, AND IT TRAVELS DOWN THIS LONG FIBER THAT YOU SEE COMING OUT, AND THAT IS CALLED AN AXON. WHEN IT TRAVELS THROUGH THAT FIBER, IT TERMINATES HERE

AT THE END WHERE YOU SEE THE TERMINALS OF THAT FIBER. THAT IS WHERE OTHER NERVE CELLS EXIST, OR THERE MAY BE A MUSCLE. AND DEPENDING UPON WHAT IS THERE, IF THERE ARE OTHER NERVE CELLS, THAT MEANS THE INFORMATION GOES FORWARD TO OTHER NEURONS. IF THERE IS A MUSCLE, THEN THE MUSCLE WILL CONTRACT, AND YOU WILL MOVE OR SOMETHING, A MUSCLE WILL MOVE.

THE RED NODE THAT YOU SEE HERE, IN REALITY, THEY ARE NOT RED, THEY ARE WHITE BECAUSE THEY ARE REALLY MADE OF FAT. AND THEY ARE CALLED MYELIN. THIS IS VERY IMPORTANT BECAUSE THIS FAT DOESN'T LET THE ELECTRICAL SIGNAL DISSIPATE AND GO AROUND THE SAME WAY. IF YOU WANT TO SEND ELECTRICITY THROUGH LONG DISTANCE, YOU SHIELD THE CABLES WITH RUBBER. THE BRAIN DOESN'T HAVE RUBBER. WHAT IT USES IS FAT IN ORDER TO INSULATE THOSE FIBERS AND ALLOW THE ELECTRICAL SIGNAL TO GO WHERE IT IS SUPPOSED TO GO.

ONE THING THAT I WILL SHOW YOU IN A MOMENT IS THAT, WHEN YOU ARE BORN, YOU HAVE NO FAT IN YOUR BRAIN. THERE IS, VIRTUALLY, NONE OF THAT RED, NONE OF THESE MYELIN SHEATHS. THEY DEVELOP AS YOU GROW. THAT IS WHY, FOR EXAMPLE, IF YOU TICKLE A BABY IN THE FOOT, THE BABY WILL THROW UP BOTH ARMS AND FEET. THE BABY CAN'T REALLY CONTROL WHERE THE MOVEMENT IS GOING, IT GOES EVERYWHERE. THERE IS NONE OF THAT INSULATION THAT ALLOWS THE COMMAND TO GO WHERE IT IS SUPPOSED TO GO. AND THEN, THIS INSULATION BEGINS TO BUILD UP IN AREAS THAT CONTROL MOVEMENT AND SLOWLY BEGINS TO BUILD UP IN FURTHER AND

FURTHER AREAS UNTIL THE BABY COULD REALLY MOVE AND TOUCH SOMETHING AND EVENTUALLY GET UP AND START WALKING AND START MOVING ABOUT AND CONTROLLING HIMSELF.

Q. NOW, IS THAT ALL ABOUT THAT? I'M SORRY.

A. YEAH, I THINK THAT IS, BASICALLY.

Q. SO, THAT IS THE SMALLEST PART, THAT IS THE NERVE CELL?

A. THAT IS THE SMALLEST PART. ONE NERVE CELL. AND WE JUST HAVE SEVERAL MILLIONS OF THOSE, AND THEY ALL COMMUNICATE WITH EACH OTHER. AND, EVENTUALLY, THE INFORMATION REACHES THE PART OF THE BODY THAT NEED TO MOVE IN ORDER FOR US TO DO SOMETHING. SO, IF IT IS WALKING, IT WILL REACH THE LEG MUSCLES, AND THE LEGS WILL START WALKING. IF IT IS TALKING, IT WILL REACH THE FACE MUSCLES, AND MY MOUTH WILL BE MOVING.

ONE THING I SHOULD NOTE THAT, THOSE NEURONS ARE VERY, VERY SMALL. BUT THE FIBERS, THE AXONS THAT COMMUNICATE TO DISTANCES CAN BE AS LONG AS -- THERE IS ONE THAT CONNECTS ALL THE WAY FROM THE BRAIN TO THE TIP OF YOUR TOE. SO IT CAN BE VERY, VERY LONG.

Q. DOCTOR, IN THIS NEXT SLIDE, WHAT IS IT? CAN YOU EXPLAIN TO THE JURY WHAT YOU HAVE HERE?

A. YES. HERE IT SHOWS JUST THE OVERALL, THE LARGEST STRUCTURES OF THE BRAIN. AT THE BOTTOM HERE, YOU SEE THE PICTURE LOOKING AT THE LEFT SIDE OF THE BRAIN. AND THE TOP SHOWS, IF I SLICE THE BRAIN STRAIGHT DOWN THE MIDDLE AND OPEN IT UP AND IT SHOWS YOU, ESSENTIALLY, THE OTHER SIDE, BUT FROM

INSIDE. SO, IF YOU LOOK OUTSIDE AT THE BOTTOM, OF COURSE, THESE ARE NOT THE COLORS THAT YOU WILL SEE, BUT JUST COLORED THEM FOR YOUR CONVENIENCE.

THE MAJOR PARTS OF THE BRAIN ARE THE FRONTAL LOBE RIGHT HERE, AND THAT IS A BIG CHUNK OF BRAIN. AND THAT IS WHAT YOU SEE HERE IS THE OUTER LAYER OF IT. BEHIND IT, IS THE PARIETAL LOBE, AND BEHIND THAT, IS THE OCCIPITAL LOBE. SORT OF SQUISHED IN THE MIDDLE IN GREEN HERE IS THE TEMPORAL LOBE, WHICH IS THE PART OF THE BRAIN THAT IS RIGHT WHERE YOUR TEMPLES ARE BEHIND THE EARS.

THE WAY INFORMATION WORKS IS THAT, IF YOU LOOK AT SOMETHING, THE FIRST PLACE IT GOES TO IS THE BACK OF YOUR BRAIN IN THE OCCIPITAL LOBE. THE OCCIPITAL REALLY SEES BLOTCHES OF LIGHTS AND LINES AND REALLY DOESN'T MAKE ANY MEANING OUT OF THEM. BUT IT INTERPRETS THEM FOR THEIR SPATIAL LAYOUT AND SENDS INFORMATION FORWARD TO THE PARIETAL LOBE. IN THE PARIETAL LOBE, FOR EXAMPLE, YOU WILL SEE A LOT OF THE HORIZONTAL LINE, VERTICAL LINE, ANOTHER HORIZONTAL, ANOTHER VERTICAL AND SAY, OH, THAT IS A SQUARE. THEN THAT INFORMATION GETS FURTHER AHEAD, AND IT THEN ACQUIRES MEANING, AND SAY, OH, IT IS A WINDOW, IT IS A DOOR. AND THEN, WHEN IT GOES FURTHER, IT SAYS, OH, THIS IS SOMETHING I CAN WALK THROUGH. SO, THE MORE FORWARD IT MOVES, THE MORE IT BECOMES FROM JUST A PURE PERCEPT OF JUST LINES AND SHADES AND COLORS, INTO A MEANINGFUL OBJECT AND, EVENTUALLY, SOMETHING THAT YOU

MAY WANT TO ACT UPON.

NOW THE FRONT OF THE BRAIN IS THE EXECUTIVE. THAT IS THE PART OF YOUR BRAIN THAT SAYS, ALL RIGHT, NOW LET ME GO FORWARD AND MOVE THROUGH THAT DOOR. SO, IF YOU HAVE LESIONS IN THE FRONTAL LOBE, FOR EXAMPLE, IN PARKINSON'S DISEASE, YOU HAVE DIFFICULTIES WITH FRONTAL LOBE FUNCTION, YOU HAVE THE PHENOMENA THAT THESE PEOPLE CANNOT MAKE THE FIRST STEP. THEY WILL STAND IN FRONT OF THE DOOR, AND THEY JUST CAN'T MOVE IN. ONCE THEY START WALKING, THEY WILL WALK. AND ONCE THEY START WALKING, SOMETIMES THEY CAN'T STOP. YOU HAVE TO TELL THEM, OKAY, NOW STOP. SO, THE FRONTAL LOBE IS THE EXECUTIVE THAT DECIDES WHAT TO DO WITH ALL OF THAT INFORMATION THAT COMES FROM THE BACK OF THE BRAIN.

THE TEMPORAL LOBE IN GREEN HERE IS THE -- GETS A LOT OF AUDITORY INFORMATION THE SAME WAY THAT THE OCCIPITAL GETS VISUAL INFORMATION. THE TEMPORAL LOBE GETS THE AUDITORY INFORMATION AND INTEGRATES WHAT YOU HEAR WITH WHAT YOU -- WITH WHAT YOU SEE AND PUTS THAT IN MEMORY. AND THAT IS -- THE TEMPORAL LOBE IS VERY IMPORTANT TO UNDERSTAND MEMORY.

WHEN YOU LOOK AT THE ABOVE, THE BRAIN IS SLICED IN TWO IMPORTANT STRUCTURES. ONE IS THE CEREBELLUM, I WILL BE GOING FROM LEFT TO RIGHT. CEREBELLUM IS THE LITTLE BRAIN TUCKED AWAY RIGHT BEHIND THE VISUAL, THE OCCIPITAL, THE VISUAL VORTEX. AND IT LOOKS AS IF IT IS LIKE ANOTHER LITTLE BRAIN INSIDE OUR BRAIN. AND IT IS CLEAR THAT ITS MAIN FUNCTION IS

CONTROLLING MOVEMENT. SO, IT ALLOWS US TO MAKE FINE MOTOR MOVEMENTS. AND, UNLIKE ALL OF THE OTHER PARTS OF THE BRAIN, IT CONTROLS THE SAME SIDE OF THE BODY. SO, GENERAL RULE, THE LEFT SIDE OF OUR BRAIN CONTROLS THE RIGHT SIDE OF OUR BODY, WHEREAS THE RIGHT SIDE OF OUR BRAIN CONTROLS THE LEFT SIDE OF OUR BODY. AND THAT IS TRUE FOR ALL STRUCTURES EXCEPT FOR THE CEREBELLUM, WHICH CONTROLS THE SAME SIDE OF THE BODY.

ANOTHER IMPORTANT STRUCTURE HERE IN YELLOW IS THE CORPUS CALLOSUM. THAT IS REALLY A BODY OF NERVE FIBERS. THERE ARE NERVE CELLS, THOSE LONG FIBERS THAT YOU REMEMBER FROM THE DRAWING OF THE NEURON THAT THESE ARE THE AXONS, THE LONG FIBERS. AND THE CORPUS CALLOSUM CONNECTS THE TWO SIDES OF THE BRAIN AND ALLOWS INFORMATION TO GO BACK AND FORTH.

ONE REMARKABLE FEATURE OF THE BRAIN IS IT IS ENTIRELY DIVIDED IN TWO. SO, IN SOME WAYS, IT IS ALMOST INCORRECT TO TALK ABOUT OUR BRAIN. WE SHOULD BE TALKING ABOUT OUR BRAINS. WE HAVE TWO OF THEM. IF IT WEREN'T FOR THE CORPUS CALLOSUM, IT WOULD BE FALLING TO THE SIDE. ACTUALLY, TAKE THEM AND SEPARATE THEM, AND YOU HAVE TWO BRAINS. AND SO, THE CORPUS CALLOSUM ALLOWS COMMUNICATION BETWEEN THOSE TWO PARTS OF THE BRAIN.

NOW, WHERE YOU SEE AT THE BOTTOM, IS THE BRAIN STEM. THE BRAIN STEM REALLY CONNECTS THE BRAIN TO THE REST OF OUR BODY, AND THE BRAIN STEM GOES THROUGH OUR SPINAL CORD AND THEN SPREADS TO OUR LEGS. THIS IS HOW THE BRAIN CAN CONTROL ALL

OF OUR REMOTE ORGANS, AND ALSO THAT IS HOW IT REGULATES ALL OF OUR BODY FUNCTIONS SO WE DON'T HAVE TO WORRY ABOUT BREATHING, OR SWEATING, OR ALL OF THOSE OTHER THINGS THAT WE NEED TO DO IN ORDER TO REGULATE OUR BODY FUNCTIONS. WE DON'T REALLY HAVE TO THINK ABOUT, NOW, I BETTER DIGEST THAT FOOD THAT I ATE A MOMENT AGO, SO I NEED TO SPRINKLE SOME CHEMICALS ON IT SO IT GETS DIGESTED. ALL OF THIS IS DONE IN THE SO-CALLED AUTONOMIC NERVE SURFACE, WHICH AUTONOMIC MEANING, WORKS BY ITSELF. FEEDS THROUGH THE BRAIN ON THE BRAIN STEM THAT YOU SEE HERE COLORED IN RED.

NOW, ONE MORE IMPORTANT STRUCTURE IS THE THALAMUS. I WILL BE FOCUSING ON STRUCTURES THAT WILL EXPLAIN SOME OF WHAT WE SEE WITH MR. FULKS. THE THALAMUS IS INDICATED HERE BY THE ARROW. THIS IS SORT OF THE SWITCHBOARD FOR THE BRAIN.

Q. THIS IS RIGHT HERE IN THE MIDDLE?

A. RIGHT HERE. IT IS THE SWITCHBOARD. AND YOU CAN SEE WHY IT IS RIGHT SMACK IN THE MIDDLE OF THE BRAIN. IT GETS ALL INFORMATION FROM THE VARIOUS PARTS OF THE BRAIN AND DECIDES WHERE THE INFORMATION SHOULD GO. SO, IF YOU THINK OF THE FRONTAL LOBE AS THE CHIEF EXECUTIVE OF THE BRAIN, AS THE BIG BOSS, THE SWITCHBOARD IS WHERE THE INFORMATION GETS HANDLED. AND THE THALAMUS DECIDES IF THE INFORMATION NEEDS TO BE, IF THIS IS -- IF IT NEEDS TO BE ACTED UPON OR NOT ACTED UPON, SHOULD IT BE IGNORED. SO, YOU CAN IMAGINE IF YOU TRY, IF SOMEBODY CALLS IN, TRIES TO REACH THE BOSS, IT IS

IMPORTANT THAT THERE BE A GOOD SWITCHBOARD OPERATOR SO YOU KNOW WHERE TO CONNECT AND WHAT DIFFERENT PARTS OF THE ORGANIZATION ARE BEST TO DEAL WITH A PARTICULAR ISSUE. SO, THAT IS REALLY WHAT THE THALAMUS DOES FOR THE BRAIN.

Q. DOCTOR, IN THIS SLIDE, CAN YOU JUST BRIEFLY EXPLAIN WHAT MYELINATION IS?

A. SO, AS I MENTIONED, BABIES ARE BORN WITHOUT ANY FAT IN THE BRAIN. WITHOUT ANY OF THE MYELIN THAT ALLOWS FOR SUFFICIENT TRANSMISSION OF INFORMATION. THE WAY WE LEARN ABOUT BRAIN MATURATION, INITIALLY, WAS THROUGH LOOKING AT POSTMORTEM PEOPLE WHO DIED, AND WE LOOK AT THEIR BRAIN, DONATED THEIR BRAINS TO SCIENCE. THEN THEY ARE COLLECTED, AND THE BIGGEST COLLECTION OVER THE YEARS HAS BEEN OF DR. YAKOVLEV AND HIS COLLEAGUES AT HARVARD. WHAT HE DID WITH THOSE BRAINS WAS TRY TO LOOK AT WHAT CHANGES AS YOU GROW, WHAT DEVELOPS THE SIDE OF THE BRAIN. THEY HAD DECIDED, IF THEY TAKE A SLICE OF BRAIN AND PUT THAT STAIN ON IT, THE STAIN GETS ATTRACTED TO FAT. SO, WHEN THEY STARTED STAINING THOSE BRAINS, IF YOU LOOK AT THE UPPER LINE HERE, A BABY AT FULL TERM, THIS WHAT YOU SEE. HERE IS THE CORPUS CALLOSUM. YOU REMEMBER THAT WAS THE YELLOW PART IN THE CARTOON. AND IN A BABY, AT FULL TERM, IF YOU PUT THE STAIN, YOU DON'T SEE MUCH. YOU GET, BASICALLY, A GRAY APPEARING AREA RIGHT HERE THAT DOESN'T SHOW THAT THERE IS ANY FAT THERE. WHEN YOU DO THE SAME TO A TWO-YEAR-OLD BABY'S BRAIN, UNFORTUNATELY IF HE

DIED AT AGE 2, YOU CAN BEGIN TO SEE BLACK APPEARING HERE IN THE BACK OF THE CALLOSUM, AND THE REST IS GRAY. WHEN YOU DO THE SAME STAINING IN AN ADULT, YOU CAN SEE IT IS PITCH-BLACK HERE. THIS IS NOT COMPLETELY BLACK. SO, THAT WAY, WE LEARN THAT, BY TRACING THE PROCESS OF MYELINATION, THE PROCESS IN WHICH FAT BEGINS TO INSULATE THE TRANSMISSION, WE CAN HAVE AN IMPORTANT IMPACT OF BRAIN DEVELOPMENT. THAT IS HOW WE CAN TRACE THE DEVELOPMENTS OF THE BRAIN.

Q. WHAT DOES THIS FIGURE TELL US?

A. WHAT YAKOVLEV AND HIS COLLEAGUES DID, THEY LOOKED AT THE MYELINATION OF DIFFERENT PARTS OF THE BRAIN AND DISCOVERED, QUITE SURPRISINGLY, THAT DIFFERENT PARTS OF THE BRAIN MYELINATES AT DIFFERENT RATES. SOME OF THEM ARE ALREADY PITCH-BLACK WHERE YOU STAINED THEM BY THE FIRST YEAR OF LIFE. SOME OF THEM BECOME COMPLETELY MYELINATED BY THE SECOND YEAR OF LIFE. BUT SOME OF THEM DO NOT BECOME MYELINATED UNTIL THE THIRD DECADE OF LIFE.

SO, HE TRIED TO MAKE SENSE OF WHAT PARTS MATURE FAST AND WHAT PARTS MATURE MORE SLOWLY. AND CAME UP WITH A CONCLUSION THAT THOSE PARTS ARE RESPONSIBLE FOR SENSING AND MOVING, THEY MATURE FIRST. AND THAT EXPLAINS WHY A BABY CAN SMELL, CAN HEAR, AND THEN, EVENTUALLY, WALK. THEN COME THE PARTS THAT DEAL WITH MORE OF INTEGRATION OF INFORMATION AND UNDERSTANDING OF INFORMATION. AND THEN LAST TO COME ABOARD IS THE FRONTAL PART OF THE BRAIN, THE CHIEF EXECUTIVE. AND THAT RELATES TO

WHY SOME ADOLESCENTS CAN BE, AND THAT REALLY, ACCORDING TO YAKOVLEV'S HYPOTHESIS, DOES NOT BECOME COMPLETELY MYELINATED UNTIL EARLY IN THE THIRD DECADE OF LIFE. SO, SOMETIME AT THE EARLY TWENTIES, IS WHEN THAT PART BECOMES COMPLETELY CONNECTED TO THE REST OF THE BRAIN. AND THAT MAY EXPLAIN, IF ANY OF YOU HAVE EXPERIENCE WITH TEENAGERS OR REMEMBER WHEN YOU WERE A TEENAGER YOURSELF, WHICH THEY ARE VERY SMART, THEY CAN DO A LOT OF VERY, VERY SMART THINGS, BUT SOMETIMES THEY DO SOMETHING THAT LEAVES US WONDERING, WHAT WERE YOU THINKING? AND THEY ARE ABLE TO THINK, BUT THE HIGHWAY THAT CONNECTS THE THINKING PART TO THE BRAIN TO THE CHIEF EXECUTIVE THAT TELLS THEM WHAT TO DO IS ONLY A COUNTRY ROAD. IT IS NOT A HIGHWAY YET. AND THE INFORMATION JUST DOESN'T GET THERE ON TIME.

Q. NEXT?

A. NOW, IF YOU JUST TAKE THE BRAIN AND TAKE THEM OUT AND PUT THEM ON A SCALE AND WEIGH THEM, THIS IS A STUDY THAT LOOKED AT THOUSANDS OF BRAINS AS A FUNCTION OF AGE. AND YOU CAN SEE THAT BRAIN WEIGHT GOES UP FROM BIRTH UP TO AROUND AGE 21 OR 22, AFTER WHICH IT STAYS STABLE. AND THEN, OF COURSE, WHEN AGING BEGINS, BRAIN CELLS BEGIN TO DIE, AND THE BRAIN WEIGHT BEGINS TO GO DOWN AS YOU GROW OLDER.

Q. NOW, WHY DOES THE BRAIN WEIGHT GO UP?

A. WELL, PRESUMABLY, BECAUSE OF THE FAT, REALLY, BECAUSE IT TURNS OUT THAT WHEN YOU ARE BORN, ALL OF THE BRAIN CELLS YOU WILL EVER HAVE ARE ALREADY IN PLACE. SO, THE BRAIN,

ITSELF, IS FULLY FORMED, IT'S TERM. VERY LITTLE KEEPS GROWING AFTER THE BABY IS BORN. AND EVERYTHING THAT GETS ADDED TO IT IS THAT MYELIN THAT ALLOWS FOR SMOOTHER COMMUNICATION OF INFORMATION INSIDE THE BRAIN. AND FAT IS HEAVY. AND SO, THAT IS WHAT EXPLAINS THE INCREASING BRAIN WEIGHT UP TO AGE 21 OR 22.

Q. DOCTOR?

A. WE NOW, FORTUNATELY, DON'T HAVE TO WAIT FOR SOMEONE TO DIE IN ORDER TO STUDY THE BRAIN. THE MAIN METHOD THAT LETS US LOOK AT BRAIN ANATOMY, YOU HAVE TO REMEMBER, TO UNDERSTAND THE BRAIN, WE HAVE TO UNDERSTAND THE BRAIN ANATOMY OF THE STRUCTURE. AND WE ALSO HAVE TO UNDERSTAND THE FUNCTION OF THE BRAIN. SO, IN THE SAME WAY, IF YOU WANT TO BUY A USED CAR, YOU OPEN THE HOOD AND SEE THERE IS AN ENGINE, ALL THE PARTS ARE THERE. YOU ARE NOT GOING TO ASSUME THAT THAT CAR IS STILL RUNNING. IN FACT, THE ANATOMY OF THE BRAIN IS STILL INTACT AFTER AN INDIVIDUAL IS DEAD. IT CAN STAY INTACT FOR QUITE SOME TIME. SO, YOU WANT TO TURN ON THE ENGINE AND SEE IF THE CAR CAN MOVE. AND THAT IS SORT OF THE PHYSIOLOGY OF THE BRAIN, THE ACTIVITY OF THE BRAIN. THEY BOTH NEED TO BE UNDERSTOOD TO KNOW HOW THE BRAIN IS FUNCTIONING. ARE ALL THE PARTS THERE, AND IS THE BRAIN ACTIVE?

NOW, THE MAIN METHOD TO STUDY BRAIN STRUCTURE OR ANATOMY IS CALLED MAGNETIC RESONANCE IMAGING OR MRI. AND THE WAY IT WORKS IS THAT YOU PUT THE HEAD IN A VERY STRONG MAGNETIC

FIELD. SO, WHEN YOU PUT IT IN A STRONG MAGNETIC FIELD, THAT IS MANY TIMES STRONGER THAN THE STRENGTH OF THE MAGNETIC FIELD OF OUR PLANET. IT IS A VERY STRONG MAGNET. ALL OF THE MOLECULES IN YOUR BRAIN ALIGN THEMSELVES WITH THAT MAGNET, AND THEY ALL GO IN LINE WITH THAT FORCE. AND THEN, WHAT WE DO IS, WE SEND PULSE, MAGNETIC PULSE OR RADIO FREQUENCY PULSE THAT IS NOT -- THAT IS AN ANGLE TO THE MAIN MAGNETIC FIELD. ALL OF THE MOLECULES TRY TO ALIGN THEMSELVESS WITH THE NEW BOSS, THE NEW FORCE. BUT THAT FORCE IS ONLY THERE VERY BRIEFLY. THEY ONLY SEND IT FOR 20 MILLISECONDS, TWENTY-THOUSANDS OF A SECOND. YOU CAN BARELY NOTE THAT. AND SO, MOLECULES GET LOST FOR A MOMENT, DON'T KNOW WHERE TO GO, AND THEN THEY REALIGN THEMSELVESS WITH THE MAIN MAGNETIC FIELD.

AND WHAT HAPPENED, WHEN THEY REALIGNED THEMSELVES IS THAT THEY, WHEN IT IS LIKE IF YOU TOOK A PENCIL AND TRIED TO PLAY WITH IT, MOVE IT, YOU WILL SEE IF IT COMES BACK TO POSITION, IT DOESN'T JUST COME BACK, BUT IT RATTLES A LITTLE BIT. THAT RATTLING, WE CAN LISTEN TO USING ANTENNAS, LIKE RADIO ANTENNAS. SO, THERE IS A BIG PRINCIPLE IN BIOLOGY WHICH IS -- WORKS IN LIFE, WHICH IS, BIG BODIES MOVE SLOWLY AND SMALL BODIES MOVE FAST. AND SO, WE HAVE SMALL MOLECULES AND BIGGER MOLECULES. AND SO, THE SMALL MOLECULES RATTLE FIRST.

THE FIRST ECHO THAT WE HEAR FROM THAT PERTURBATION COMES FROM THE SMALL MOLECULES, WHICH IS WATER. THERE IS A LOT OF

WATER MOLECULES IN OUR BRAIN. SO, WE CAN SEE THE WATER COMING FIRST. THEN THE PROTEINS, WHICH ARE BIGGER MOLECULES, RATTLE IN PLACE. AND LAST COME THE BIG, FAT MOLECULES, THEY RATTLE INTO PLACE. DEPENDING UPON WHEN WE LISTEN TO THE ECHO, WE CAN HIGHLIGHT DIFFERENT ASPECTS OF THE BRAIN. SO, THE FIRST IMAGE THAT YOU SEE HERE ON THE LEFT IS OBTAINED VERY QUICKLY AFTER THE ECHO, AND SO, WATER LOOKS VERY BRIGHT. AND WHAT YOU SEE AS WHITE HERE IS REALLY LIQUID. IT IS CALLED CEREBROSPINAL FLUID. AND OUR BRAIN IS REALLY BATHING IN FLUID. IT IS REALLY SITTING IN A POOL OF FLUID WHICH IS FORTUNATE BECAUSE, OTHERWISE, WE WOULD GET BRAIN DAMAGE EVERY TIME WE SNEEZE. WHEN THE BRAIN MOVES INSIDE OUR SKULL, THE BACK OF OUR SKULL IS VERY NICE AND SMOOTH, BUT THE FRONT OF OUR SKULL HAS SOME PRETTY NASTY BONES RIGHT HERE ABOVE THE EYES, THE ORBITAL PART. AND, SO, IF THE BRAIN WOULD HIT THOSE BONES, IT WOULD GET SQUISHED AND DAMAGED. SO, THERE IS LIQUID THAT CUSHIONS THE BLOW. THE LIQUID IS ALSO INSIDE THE BRAIN, AND THE LIQUID INSIDE THE BRAIN IS CALLED VENTRICLES OF THE BRAIN. SO, THAT FLUID SERVES TWO PURPOSES. IN ADDITION TO CUSHIONING THE BRAIN AS IT MOVES AROUND IN OUR SKULL, IT ALSO FEEDS THE BRAIN AND SUPPLIES SOME OF THE NUTRIENTS THE BRAIN NEEDS AS WELL AS SOME OF THE -- IT SUPPLIES A LOT IN ADDITION TO THE BLOOD THAT SUPPLIES THE MAIN SUPPLY OF NUTRIENT IN THE BRAIN.

NOW, IF WE TAKE THE ECHO, TIME IT A BIT LATER, AS YOU SEE

IN THE SECOND IMAGE, WE CAN BEGIN TO BETTER APPRECIATE THE TWO OTHER PARTS, THE TWO OTHER TYPES OF TISSUE THAT WE HAVE IN THE BRAIN THAT WE ALREADY TALKED ABOUT. ONE IS THE GRAY MATTER WHICH ARE THE BRAIN CELLS THEMSELVES WITH THOSE SHORT PROTRUSIONS AROUND THEM THAT ARE DENDRITES. AND WHITE MATTER, WHICH IS THE FAT, THE MYELIN. SO, THE WHITE MATTER ARE THE BUNDLES OF FIBERS THAT ARE NOW SURROUNDEDED BY FAT OR WHAT WE CALL WHITE MATTER. AND SINCE EACH OF THEM HAVE A DIFFERENT CHEMICAL COMPOSITION, IT GIVES A DIFFERENT SIGNAL WHEN WE LISTEN TO THE ECHO. AND SO, WE CAN TELL THE COMPUTER, WE HAVE A LOT OF THOSE, THOSE PICTURES THAT YOU SEE ARE GENERATED BY A COMPUTER, AND THEY JUST, BASICALLY, TELL YOU THAT IN INTENSITY, HOW MANY REVERBERATIONS DID THEY GET FROM THAT PARTICULAR REGION. AND SO, IT TELLS YOU THE INTENSITY OF EACH PICTURE ELEMENT OR PIXEL. AND SINCE THESE ARE SLICES, WE KNOW THEY HAVE A CERTAIN THICKNESS. SO, WE CALL THEM NOT PIXELS, YOU KNOW, PIXEL IS A PICTURE ELEMENT. IF YOU TOOK ANY PICTURE AND YOU BLOW IT UP AND BLOW IT UP AND BLOW IT UP, EVENTUALLY, YOU WILL SEE A BUNCH OF DOTS THAT REALLY COMPOSE THAT PICTURE. HERE, THE PROCESS IS REVERSED. THE COMPUTER GENERATES THOSE DOTS, AND SO FOR THOSE DOTS, WE LOOK, AND WE SEE A PICTURE OF THE BRAIN. SO, EACH ONE OF THOSE DOTS, WE KNOW THE EXACT SIZE OF THIS. AND IN THIS CASE, IT IS ONE CUBIC MILLIMETER, EACH ONE OF THOSE DOTS. AND SO, WE CAN TELL THE COMPUTER IN YOUR INFINITE PATIENCE

NOW, THROW ALL OF THOSE PICTURES INTO THREE PILES. ONE PILE THAT IS GRAY MATTER, ONE PILE THAT IS WHITE MATTER, AND ONE PILE THAT IS CEREBRAL SPINAL FLUID OR CSF. IT USED TO BE THE COMPUTER HAD TO WORK THE WHOLE NIGHT FOR EACH BRAIN, BUT THEY DON'T COMPLAIN. THEY DO THAT, AND WHEN YOU COME IN THE MORNING, YOU FIND EXACTLY THE ANSWER, HOW MANY VOXELS ARE IN EACH PILE, AND THEN KNOWING THE DIMENSION OF THE VOXEL, YOU CAN CALCULATE, PRECISELY, THE VOLUME OF WHAT IS THE VOLUME OF THE GRAY MATTER, WHITE MATTER, AND FLUID.

Q. SO, DOCTOR, AS I UNDERSTAND IT, THERE ARE THREE BASIC COMPONENTS: GRAY MATTER, WHITE MATTER, AND CEREBROSPINAL FLUID?

A. CORRECT.

Q. AND SO, THAT IS SORT OF -- WHAT IS THAT?

A. THAT IS ILLUSTRATED IN THE LAST PICTURE. THE LAST PICTURE IS WHAT THE COMPUTER IS GIVING YOU BACK WHEN YOU COME IN THE MORNING AND IT PAINTS THE GRAY MATTER, YOU CAN SEE HERE IS IN WHITE; WHITE MATTER IS IN GRAY, AND JUST TO CONFUSE YOU A LITTLE; THE FLUID IS IN BLACK. SO WE KNOW EXACTLY WHICH TYPE OF TISSUE IS IN EACH AREA.

SO, WHEN WE APPLIED THIS METHOD, AND WE STARTED LOOKING AT WHAT HAPPENS WITH DEVELOPMENT, IF YOU LOOK AT THE TOP PANEL HERE, YOU CAN SEE THIS IS YEARS, IT TELLS YOU WHAT IS THE -- HOW MUCH GRAY MATTER THERE IS, DEPENDING UPON YEARS FROM ZERO TO 30. YOU CAN SEE THAT THE AMOUNT OF WHITE MATTER

AT THE TOP, AS WHITE MATTER GOES UP STEADILY AND VERY CONSISTENTLY WITH WHAT WE SAW FROM POSTMORTEM STUDY, IT KEEPS GOING UP UNTIL THE AGE OF AROUND 21, AND THEN, IT LEVELS OFF AND BEGINS TO GO DOWN. SO, THAT WAS NOT SURPRISING. WE EXPECTED THAT, FROM THE WORK OF YAKOVLEV THAT, AS THE WHITE MATTER BUILDS, WHITE MATTER BUILDS UP WITH AGE. THE SURPRISING FINDING WAS THAT GRAY MATTER, ACTUALLY, GOES DOWN WITH AGE. THAT LITTLE BABIES HAVE MORE GRAY MATTER THAN ADOLESCENTS, AND ADOLESCENTS HAVE MORE GRAY MATTERS THAN ADULTS.

AND THAT TURNS OUT IS BECAUSE OF THE PROCESS OF PRUNING. IN THE SAME WAY THAT YOU DON'T WANT THE TREE TO GROW WILD AND ALLOW ALL OF THE BRANCHES TO COME OUT, YOU NEED TO TAKE OFF BRANCHES THAT DON'T DO ANYTHING, OUR BRAINS PRETTY MUCH DECIDE IF YOU HAVEN'T USED A PARTICULAR PART, YOU PROBABLY DON'T NEED IT. AND THAT PART SHRIVELS OFF. THAT HAPPENS MOST AGGRESSIVELY DURING EARLY ADOLESCENCE BETWEEN THE AGE OF AROUND 12 AND 18 OR 19. AND THAT IS WHY, FOR EXAMPLE, IF YOU HAVEN'T LEARNED HOW TO PLAY THE VIOLIN WHEN YOU WERE A LITTLE CHILD, YOU CAN'T START NOW. IT JUST WON'T WORK. THAT PART THAT CAN PLAY THE VIOLIN IS GONE. OR LIKE MYSELF, IF YOU DON'T LEARN A FOREIGN LANGUAGE WHEN YOU ARE A CHILD, THEN YOU WILL ALWAYS HAVE AN ACCENT IN THAT LANGUAGE. YOU WILL NEVER REALLY MASTER IT COMPLETELY. OR SKIING, FOR EXAMPLE. YOU CAN LEARN SKIING AT AN OLDER AGE, BUT ON THE

CATWALKS, YOU CAN ALWAYS TELL THOSE WHO LEARN IT AS CHILDREN FROM THOSE WHO LEARN IT A LITTLE BIT LATER. THEY ARE JUST NOT COMPLETELY AT PEACE WITH A SKI.

YOU HAVE TO REMEMBER THAT OUR BRAINS, EVEN THOUGH WE DO A LOT OF FANCY AND WONDERFUL THINGS AND PLAY WITH COMPUTERS AND DRIVE CARS, OUR BRAINS WERE PRETTY MUCH SET IN PLACE AT THE TIME WHEN WE WERE A HUNTER/GATHERER SOCIETY, ROWING THE SAVANNAH. AND THIS IS HOW THEY ARE OPTIMIZED TO OPERATE. AND SO, BY AND LARGE, IF YOU WERE A CHILD GROWING IN THE HUNTER/GATHERER SOCIETY, WHATEVER YOU HAVEN'T LEARNED BY AGE 13, YOU ARE NOT GOING TO LEARN ANY MORE. YOUR EDUCATION WAS COMPLETE BY THAT AGE. AND SO, OUR BRAINS WILL ALLOW THOSE PARTS THAT HAVEN'T BEEN CONSISTENTLY USED TO SHRIVEL OFF, AND THAT IS THE PROCESS OF PRUNING.

SO, THERE ARE TWO MAJOR PROCESSES OF MATURATION, BRAIN MATURATION: ARE MYELINATION AND PRUNING. MYELINATION, THE BUILD-UP OF CONNECTIONS; PRUNING, THE SHRIVELING OFF OF PARTS OF THE BRAIN THAT HAVEN'T BEEN USED.

Q. WHAT DO WE SEE IN THIS NEXT SLIDE?

A. THERE IS ANOTHER PRINCIPLE IN BIOLOGY THAT SAYS, WHATEVER COMES ONBOARD LAST, JUMPS OFFBOARD FIRST. I GUESS IT WORKS IN POLITICS, TOO. SO, HERE YOU SEE THAT THESE ARE ADULTS. ALL ADULTS BETWEEN THE AGES OF 18 AND 45, AND DURING THAT AGE, GRAY MATTER CONTINUES TO GO DOWN, WHITE MATTER CONTINUES TO GO UP, AND WHEN YOU LOOK AT CEREBROSPINAL FLUID,

IT GOES UP. AND THE REASON IT GOES UP IS, EVERY TIME A BRAIN CELL DIES, ITS PLACE IS TAKEN UP BY FLUID. AND SO, WHEN WE SEE MORE FLUID THAN WE EXPECT IN A BRAIN, THEN WE CAN CONCLUDE THAT SOME TISSUE WAS THERE THAT WAS SUPPOSED TO BE THERE IS MISSING.

NOW -- ONCE WE HAVE THE BRAIN -- NOW, I MENTIONED THAT THE MRI ARE ACQUIRED SLICE BY SLICE, BUT OUR COMPUTER EXPERTS ARE PUTTING -- STACKING UP THOSE SLICES ONE ON TOP OF THE OTHER AND MAKING IT INTO A THREE-DIMENSIONAL MRI. AND ONCE WE HAVE A THREE-DIMENSIONAL MRI, WE CAN RESLICE IT IN ANY DIRECTION THAT WE WANT. SO, THIS SLICE SHOWS YOU THE TWO IMPORTANT STRUCTURES THAT ARE RELEVANT TO OUR CASE. ONE IS THE FRONTAL LOBE, WHICH YOU REMEMBER IS OUR CHIEF EXECUTIVE, IT CAN BE DIVIDED INTO TWO PARTS.

Q. DR. GUR, JUST TO MAKE SURE, THE BACK OF THE HEAD IS HERE?

A. THIS IS THE BACK OF THE HEAD.

Q. THIS IS THE FRONT OF THE HEAD?

A. THIS IS THE FRONT.

SO, HERE THE FRONT OF THE BRAIN, THE CHIEF EXECUTIVE, IS DIVIDED INTO TWO PARTS, THE DORSAL AND ORBITAL. THE ORBITAL FRONTAL CORTEX IS RIGHT IN THIS AREA HERE. SO, THAT PART IS RIGHT HERE THAT IS SIGNIFIED BY THE ARROW I PUT IN EARLIER. YOU CAN SEE THAT IT SITS RIGHT ABOVE THE EYES. HERE YOU CAN SEE THE NOSE OF THAT INDIVIDUAL AND THE EYES. AND THAT

ORBITAL PART OF THE BRAIN SITS RIGHT BEHIND THE EYES. AND IT IS CLOSELY CONNECTED TO A REGION THAT YOU CAN'T SEE HERE BECAUSE YOU HAVE TO MOVE OUTWARD MORE, AND YOU SEE IT HERE, THE AMYGDALA, WHICH IS IN THE HEART OF THE BRAIN AND INTERACTS VERY INTIMATELY WITH THE ORBITAL FRONTAL AREA. AND THIS IS WHAT THEIR RELATIONSHIP IS.

AMYGDALA IS THE PART OF THE BRAIN THAT DECIDES WHETHER ANYTHING THAT YOU SEE HAS EMOTIONAL SIGNIFICANCE. IN PARTICULAR, IF IT IS RELEVANT TO WHETHER YOU NEED TO FIGHT OR TO RUN AWAY. SO, THIS IS THE PART THAT DECIDES, IS IT SCARY, OR IS IT -- AM I COMFORTABLE HERE? AND THAT IS WHEN IT KEEPS WORKING. SO, IF YOU ARE LOOKING AT THE FACE, THE AMYGDALA WILL NOT DO ANYTHING UNTIL THERE IS AN EMOTION ON THE FACE. YOU WILL SEE THE AMYGDALA BEGIN TO WORK. MOST OF THE OUTPUT OF THE AMYGDALA RELATES TO FIGHT OR FLEE. IT IS A VERY PRIVATIVE STRUCTURE. IT DOESN'T TALK. IT JUST TELLS YOU, FOR EXAMPLE, SOMEBODY IS AT A COCKTAIL PARTY AND SOMEONE INSULTS YOU. THE AMYGDALA YELLS, "KILL THE BASTARD." THAT INFORMATION, FORTUNATELY, GOES FORWARD INTO THE FRONT -- ORBITAL FRONTAL AREA. THE ORBITAL FRONTAL IS PART OF THE EXECUTIVE. THE EXECUTIVE IS RESPONSIBLE FOR PUTTING THIS IN CONTEXT. COME ON, YOU ARE AT A COCKTAIL PARTY, PEOPLE AROUND, MAYBE YOU CAN DO SOMETHING ELSE LIKE GIVE A NASTY COMMENT IN RESPONSE. IT TAKES THE OUTPUT OF THE AMYGDALA AND COUNTERS IT.

NOW, ANOTHER PART YOU WILL NOTICE ABOUT THE ORBITAL REGION IS THAT IT IS SITTING ON TOP OF BONES. AND SO, IT IS AN AREA THAT IS VERY PRONE TO DAMAGE WITH ANY KIND OF HEAD INJURY. THAT IS WHY WE SEE, A LOT OF TIMES WITH HEAD INJURIES, PEOPLE WHO WERE NORMALLY QUITE CALM AND COOL AND COLLECTED, ALL OF A SUDDEN, GO INTO OUTBURSTS OF UNCONTROLLABLE EMOTIONS THAT MAY INCLUDE EITHER ANGER OR FEAR.

Q. DOCTOR, WHAT DO WE HAVE HERE?

A. ON THE NEXT IS A STUDY WE DID IN COLLABORATION WITH A GROUP AT TOYAMA UNIVERSITY IN JAPAN. THEY WERE ABLE TO STUDY PEOPLE AS SOON AS THEY, BASICALLY, POPPED OUT OF THE WOMB. HERE IS A BABY, A ONE-MONTH-OLD BABY, THREE-MONTHS-OLD BABY, SIX-MONTH-OLD BABY. WHEN YOU DIVIDE THE BRAIN IN GRAY MATTER, WHITE MATTER, CSF, YOU WILL SEE, IN A ONE-MONTH-OLD BABY, THERE IS NO FAT. REMEMBER THE FAT IS IN GRAY. AND YOU BEGIN TO SEE THE FAT DEVELOPING RIGHT HERE IN THE MIDDLE OF THE BRAIN, WHICH IS THE PART THAT IS RESPONSIBLE FOR SENSING AND FOR ACTION. AND THEN THE FAT, THE GRAY CONTINUES TO SPREAD. YOU CAN SEE A ONE YEAR OLD, THREE YEAR OLD, A TEN YEAR OLD, BUT ONLY IN THE 20 YEAR OLD CAN YOU SEE THE, YOU CAN SEE THIS GRAY AREA SPREAD ALL THE WAY TO THE FAR REACHES OF THE FRONTAL LOBE. SO, EVEN A TEN YEAR OLD STILL HAS VERY TENUOUS CONNECTION ALONG THE DIFFERENT PARTS OF THE BRAIN. IT IS STILL NOT WORKING AS A WELL-OILED MACHINE. I GUESS I DON'T NEED TO TELL ANY PARENT.

NOW, THESE ARE THE AVERAGES. THESE ARE THE AVERAGES. ON THE LEFT, YOU SEE FOR THE WHOLE BRAIN OF GRAY MATTER AND WHITE MATTER, AND THE POINT I WANT TO SHOW IS THE BLUE LINES ARE FOR BABIES WHO ARE LESS THAN TWO YEARS OLD, THE GREEN LINE IS CHILDREN BETWEEN TWO YEARS AND TEN YEARS, AND THE RED LINE IS THE ADULTS. SO, IF YOU LOOK AT GRAY MATTER, YOU CAN SEE THAT NEWBORN BABIES HAVE A HIGHER VOLUME OF GRAY MATTER THAN ADULTS OR CHILDREN. BUT IF YOU LOOK AT THE WHITE MATTER DOWN HERE, THEY STILL HAVEN'T REACHED THE AMOUNT OF WHITE MATTER FOR THE WHOLE BRAIN.

NOW, THIS DIFFERENCE IS PARTICULARLY PRONOUNCED FOR THE FRONTAL LOBE HERE THAT YOU SEE THAT THEY ALREADY LOST A LOT OF GRAY MATTER, BUT THEY STILL HAVE A LOT OF WHITE MATTER TO BUILD BEFORE THEY REACH ADULTHOOD. IN THE TEMPORAL LOBE, WHICH IS THE PART THAT RELATES TO MEMORY, THIS PROCESS OF MYELINATION IS NEARLY COMPLETE. THERE IS JUST A LITTLE BIT MORE FOR THE LEFT GRAY MATTER, THE LEFT WHITE MATTER TO GROW. BUT THAT IS WHY CHILDREN HAVE TREMENDOUS MEMORY. THEY CAN LEARN, AND THEY CAN REMEMBER. SO THE MEMORY PART OF THE BRAIN IS ALREADY WORKING. IT IS JUST THE EXECUTIVE THAT NEEDS TO BE, TO GET IMPORTED.

Q. WHAT DO WE HAVE HERE?

A. HERE WE SEE A VERY RECENT STUDY JUST CAME OUT LAST MONTH PUBLISHED IN THE PROCEEDINGS OF NATIONAL ACADEMY OF SCIENCES BY CALIBRATION BETWEEN UCLA, AND NCIH, AND

UNIVERSITY OF MARYLAND. AND THIS, BASICALLY, TAKES ALL OF THE DATA WE HAVE ABOUT DEVELOPMENT AND TURNS THEM INTO A MOVIE. SO, YOU CAN SEE, IF YOU LOOK AT THE LEFT PICTURE HERE, THIS SHOWS YOU A PICTURE OF THE LEFT SIDE OF THE BRAIN TAKEN FROM THE SIDE, AS SOON AS YOU TOUCH, YOU WILL SEE BLUE MEANS MYELINATION. YOU CAN SEE IT STARTED RIGHT IN THIS STRIP HERE, WHICH IS THE SENSORY MOTOR STRIP, AND MOVES FORWARD, AND THE LAST AREA TO BECOME BLUE IS THE FRONT OF THE BRAIN. YOU WILL SEE THAT REPEATED AFTER BEN TOUCHES THE RIGHT SIDE. AND THIS IS A VIEW FROM THE TOP. IF YOU GO HERE FIRST TO VIEW, AND THIS IS A VIEW FROM THE BOTTOM. SO, THIS, BASICALLY, THIS MOVIE IS GENERATED FROM REAL MRI THAT WERE ALL PUT IN THESE THREE-DIMENSIONAL SCALES AND SEGMENTED AND A LOT OF TAPE THAT WERE MADE SO CAN YOU SEE THEM IN A MOVIE. SO, YOU SAW OVER A FEW SECONDS WHAT REALLY TAKES PLACE OVER SEVERAL YEARS.

Q. DOCTOR, YOU HAVE BEEN TALKING ABOUT THE MRI AND HOW IT WORKS. CAN YOU BRIEFLY TALK ABOUT THE PET?

A. YES. OUR NEXT -- NOW, AS I MENTIONED, YOU CANNOT -- YOU CAN'T -- YOU CAN'T UNDERSTAND THE BRAIN JUST FROM LOOKING AT THE ANATOMY ANY MORE THAN, YOU KNOW, IF YOUR CAR IS WORKING BY JUST VERIFYING THAT THERE IS AN ENGINE IN PLACE. SO, YOU NEED TO LOOK AT IT IN ACTION. AND POSITRON EMISSION TOMOGRAPHY, OR PET, IS AN IMAGING TO LET YOU LOOK AT HOW ACTIVE THE BRAIN IS. THE REASON WE CAN LOOK AT HOW ACTIVE THE BRAIN IS IS THAT EVERY TIME ONE OF THOSE BRAIN CELLS

FIRES, IT NEEDS ENERGY BEFORE IT CAN FIRE AGAIN. EACH NEURON GETS REALLY EXHAUSTED AFTER ONE PULSE. AND, IMMEDIATELY, IS LOOKING FOR A WAY TO REGENERATE THE ENERGY TO SEND ANOTHER PULSE. THE BRAIN ONLY EATS SUGAR. OUR MUSCLES CAN EAT PROTEINS, BUT OUR BRAIN DOESN'T GET PROTEINS. THE PROTEINS DON'T GET THROUGH TO THE BRAIN BECAUSE THERE IS A BARRIER THAT STOPS ANY BIG MOLECULE FROM ENTERING FROM THE BLOOD TO THE BRAIN. SO, WHEN THE BRAIN GETS ENERGY BY BREAKING DOWN SUGAR USING OXYGEN, SO IT IS BASICALLY BURNING THE SUGAR WITH OXYGEN, AS SOON AS THE NEURON IS EXHAUSTED, ASKS, SAYS, GIVE ME SOMETHING, I AM HUNGRY, I AM SUFFOCATING, THE BLOOD GUSHES INTO THE AREA, BRINGS WITH IT SUGAR AND OXYGEN, AND THE CELL TAKES THE SUGAR AND THE OXYGEN, BURNS THE SUGAR WITH THE OXYGEN, AND USES WHAT COMES OUT AS THE ENERGY SO IT CAN DO ANOTHER PULSE.

NOW, WHEN SUGAR BREAKS DOWN, IT RELEASES A TOXIC. THESE ARE -- REALLY, THE PRODUCTS OF THIS METABOLISM ARE TOXIC TO THE BRAIN. THEY HAVE -- A SCIENTIST GAVE THEM A NAME, FREE RADICALS. AS SOON AS THEY GET RELEASED, THEY ATTACK THE CELLS. AND WOULD KILL THEM UNLESS THEY GET CARRIED AWAY BY THE BLOOD. SO, OUR BLOOD FLOWING THROUGH THE BRAIN IS BOTH BRINGS THE GROCERIES AND TAKES AWAY THE GARBAGE. AND SO, IT IS IMPORTANT THAT THE BLOOD WILL KEEP FLOWING THROUGH THE BRAIN IN ORDER TO KEEP FEEDING IT AND TAKING AWAY ALL OF THE TOXIC BY-PRODUCTS.

WHAT POSITRON EMISSION TOMOGRAPHY DOES IS A LITTLE FOOLING AROUND WITH THE BRAIN. WE TAKE A MOLECULE THAT LOOKS EXACTLY LIKE SUGAR OR GLUCOSE, BUT IT IS SYNTHETIC. AND IT DOESN'T BREAK DOWN. ONCE IT GETS INTO THE CELL, IT STAYS THERE FOR A LITTLE BIT. AND THAT MOLECULE GETS TAGGED WITH A RADIOACTIVE LABEL. SO, ESSENTIALLY, YOU PUT IN ANOTHER ATOM THAT HAS A LOT MORE POSITIVELY CHARGED PARTS THAN NEGATIVELY CHARGED PARTS. THE NEGATIVELY CALLED CHARGE PARTS ARE POSITRON. WHEN THERE ARE MORE PARTS THAN ANOTHER, THAT IS CALLED ATOMS. THE POSITRONS KEEP FLYING OUT LOOKING FOR A MATE, BASICALLY. THEY ARE LOOKING FOR A NEGATIVELY CHARGED PARTICLE. THESE ARE ABUNDANT IN THE BRAIN, SO THEY WILL USUALLY TRAVEL NO MORE THAN THREE MILLIMETERS BEFORE THEY HIT A NEGATIVELY CHARGED PARTICLE, WHICH IS CALLED AN ELECTRON.

SO, WHEN A POSITRON HITS AN ELECTRON, THEY BOTH EXPLODE, ESSENTIALLY, ANNIHILATE OUT OF THAT EXPLOSION. THERE ARE TWO LIGHT PARTICLES THAT COME OUT OF THAT EXPLOSION, WHICH, FORTUNATELY FOR US, TRAVEL EXACTLY 180 DEGREES FROM EACH OTHER. THEY GO AWAY.

A. WHAT WE DO IS, WE ESSENTIALLY SURROUND THE BRAIN WITH DETECTORS, AND WHEN THE DETECTORS -- TWO DETECTORS THAT LOOK AT EACH OTHER GET TRIGGERED EXACTLY AT THE SAME TIME, WE KNOW THAT SOME SUGAR WAS EATEN UP IN THAT PLANE. AND FROM ALL OF THAT INFORMATION, WE CAN CONSTRUCT THE THREE-DIMENSIONAL PICTURE OF THE BRAIN WHERE THE BRIGHT SPOTS TELL US A LOT OF

SUGAR WENT THERE. IF A LOT OF SUGAR GOES TO THE PART OF THE BRAIN, IT MEANS THAT THAT BRAIN IS WORKING. AND UNLIKE ANATOMY, YOU CAN DO AN MRI TO SOMEONE WHO IS SLEEPING OR SOMEONE WHO IS BEING SCARED TO DEATH IN THE SCANNER, THE ANATOMY IS NOT GOING TO CHANGE. THE MRI WILL LOOK THE SAME. BUT IF YOU DO A PET SCAN, THE RESULTS WILL DIFFER A LITTLE BIT DEPENDING UPON WHAT THE PERSON WAS DOING INSIDE THE SCANNER. AND HERE ARE ILLUSTRATIONS. IF YOU ARE LISTENING, YOU WILL SEE ACTIVATION HERE WHICH IS THE TEMPORAL PART OF THE BRAIN RIGHT BEHIND THE TEMPLE. IF YOU ARE LOOKING, THE ACTIVATION WILL BE MORE IN THE BACK OF THE BRAIN, WHICH IS RIGHT HERE, WHICH IS WHERE THE VISUAL INFORMATION GOES. IF YOU ARE THINKING, THE CHIEF EXECUTIVE GOES UP, THE FRONT OF THE BRAIN RIGHT HERE. SO, CHANGES CAN BE, THEY CAN BE SUBTLE, BUT CLEAR CHANGES DEPENDING UPON WHAT THE PERSON IS DOING.

AND, OF COURSE, IN VARIOUS DISORDERS, EPILEPSY, FOR EXAMPLE, IS CHARACTERIZED BY ABNORMALLY HIGH ACTIVITY IN THE TEMPORAL LOBE, USUALLY IN A PARTICULAR REGION. AND THAT IS WHY THE REASON EPILEPSY HAPPENS IS, WHEN THERE IS A LOT OF SUGAR UPTAKE BUT NOT ENOUGH BLOOD GOING. AND SO, THE FREE RADICALS BEGIN TO KILL THE CELLS AND PRODUCE WHAT IS KNOWN AS AN EPILEPTIC FAULTNESS THAT WILL DISCHARGE ABNORMALLY.

SO, NOW WE ARE DONE WITH EXPLAINING TO YOU THE ANATOMY OF THE BRAIN, THE PHYSIOLOGY OF THE BRAIN AND THE FINAL CHAPTER

IS, BEHAVIOR. AND, ACTUALLY, IT DIDN'T, THE FACT THAT THE BRAIN CONTROLS BEHAVIOR THAT TODAY EVERYBODY SORT OF ASSUMES THIS IS TRUE, I DOUBT THERE ARE MANY PEOPLE WHO THINK DIFFERENTLY. BUT ACTUALLY, IT IS A FAIRLY RECENT DISCOVERY. PLATO, FOR EXAMPLE, THOUGHT THAT COURAGE RESIDES IN THE HEART, REASON RESIDES IN THE HEAD, AND BASE QUALITIES ARE IN THE STOMACH. ALBERTUS MAGNUS CAME CLOSER TO THE SIGHT. HE THOUGHT IT HAPPENED IN THE HEAD, IT DIDN'T HAPPEN IN THE TISSUE. HE THOUGHT IT HAPPENED IN THE VENTRICLES, THE CEREBROSPINAL FLUID IN THE BRAIN. BECAUSE THERE ARE THREE OF THOSE VENTRICLES INSIDE THE BRAIN, IT FIT HIS IDEA OF THREE DIFFERENT ASPECTS OF THE BRAIN. RENE DESCARTES SAID, NO, NO, IT CAN'T BE THE VENTRICLES. ALL I SEE IN THE VENTRICLES IT IS FLUID. IT MUST BE INSIDE THE BRAIN. UNFORTUNATELY, HOW CAN IT BE IN THE BRAIN IF HE ALREADY KNEW WE DON'T HAVE ONE BRAIN, WE HAVE TWO BRAINS? AND SINCE HE WAS CATHOLIC AND BELIEVED STRONGLY THAT, YOU KNOW, THE AFTERLIFE, AND SO ON, IF WE HAVE TWO BRAINS, WE MUST HAVE TWO SOULS, WHAT HAPPENS IF ONE OF THEM IS GOOD AND THE OTHER IS BAD.

LET ME SEARCH, LET ME SEE IF THERE IS ANY STRUCTURE INSIDE THE BRAIN THAT IS NOT SPLIT. THE PINEAL GLAND THAT IS NOT DIVIDED IN TWO, AND HE SAID, AHA, THIS IS THE SEAT OF THE SOUL. THE PINEAL GLAND TURNS OUT IS AN IMPORTANT GLAND, BUT DOES NOTHING RELATED TO WHAT WE THINK OF AS MIND OR SOUL. AND SO THE FIELD WAS A LITTLE BIT IN DISARRAY AND GAVE RISE TO

A FIELD OF PHRENOLOGY, WHERE THESE INVESTIGATORS TRIED TO CULMINATE THE SHAPE OF THE SKULL WITH THESE VARIATIONS. THEY SAID PEOPLE WITH HIGH BROWS TEND TO BE MORE INTELLECTUAL. THEY SAID THIS IS THE SITE OF INTELLECT. SO, THEY ACTUALLY DISCOVERED THE EXECUTIVE, THE ROLE OF THE FRONTAL LOBE PRETTY EARLY. BUT THEY GOT SOMETIMES, FOR EXAMPLE, THEY THOUGHT PEOPLE WHO HAD PROTRUSIONS IN THE BACK OF THE HEAD WOULD BE GREAT MATHEMATICIANS. AND THEY WERE FRENCH, SO THEY THOUGHT ABOUT THE THIRD OF THE BRAIN WAS DEVOTED TO WINE APPRECIATION RIGHT HERE.

BUT IT BECAME CLEAR THAT THIS IS NOT A VERY EFFICIENT WAY TO GO, AND THE FIELD WAS REALLY IN A CRISIS UNTIL FRENCH NEUROSURGEON BY THE NAME OF PAUL BROCA REASONED, AS FOLLOWS. HE SAID, IF THERE IS DIFFERENT PARTS OF THE BRAIN DOING DIFFERENT THINGS, LET'S TAKE VERY IMPORTANT FUNCTION, THE MOST IMPORTANT FUNCTION AND SEE IF THAT HAS A LOCATION IN THE BRAIN. SO, WHAT IS THE MOST IMPORTANT FUNCTION? HE SAID SPEECH. IT IS VERY HARD TO SURVIVE IF YOU CAN'T TALK. SO, HE SAID, LET ME SEE IF I CAN FIND A PATIENT WHO IS NOT DEMENTED, WHO IS VERY NORMAL IN INTELLIGENCE, BUT LOST THE ABILITY TO TALK. AND HE WAS PRESENTED WITH MONSIEUR LELONG, WHO FIT THE BILL EXACTLY.

HE WAS A GENTLEMAN IN HIS FIFTIES, WAS MARRIED, HAD CHILDREN, RAISED A FAMILY, WAS AN UPRIGHT CITIZEN, AND ALL OF A SUDDEN, STARTED TO SPEAK LESS AND LESS AND LESS. AND AT

THE POINT WHERE WHEN BROCA MET HIM, HE HAD ONLY SEVEN WORDS HE COULD USE. THESE WORDS WERE: 1, 2, 3, YES, NO, TOUJOURS, WHICH MEANS ALWAYS AND HIS NAME. BUT BROCA SHOWED THAT HE WASN'T DEMENTED, HE WAS ACTUALLY QUITE SMART, WAS ABLE TO USE THESE WORDS EXACTLY TO COMMUNICATE. WE USED ONE FOR ONE; TWO FOR TWO; AND THREE FOR ANY NUMBER LARGER THAN TWO. BUT WHEN YOU ASKED HIM, SAY, HOW MANY CHILDREN DO YOU HAVE, HE WILL SAY TROIS AND POINT OUT THE CORRECT ANSWER FIVE. HOW OLD ARE YOU? HE WOULD SAY THREE BUT GAVE A COMPLICATED SIGNAL THAT INDICATED HIS CORRECT AGE. AND HE USED YES FOR YES; NO FOR NO; AND TOUJOURS FOR EVERYTHING ELSE.

BUT HE WASN'T AUGMENTED. HE WAS ABLE TO COMMUNICATE THAT WAY. WELL, BROCA, ONCE HE ESTABLISHED THAT, HE, OF COURSE, COULDN'T WAIT FOR POOR MONSIEUR LELONG TO DIE AND, FORTUNATELY, FOR MONSIEUR LELONG, FORTUNATELY FOR OUR FIELD, HE DIED TWO YEARS AFTER BEING EXAMINED BY BROCA. HE OPENED UP THE BRAIN, LOOKED AT THE SKULL, LO AND BEHOLD, THERE WAS A BIG LESION IN THE THIRD FRONTAL CONVOLUTION OF THE LEFT HEMISPHERE. HE PUBLISHED THAT HERE IS THE SEAT OF SPEECH. HE WAS LUCKY, DEAD ON THE MONEY. HE PUBLISHED IN 1864, AND NOW WE ARE 140 YEARS LATER, AND THAT IS VERY FIRMLY ESTABLISHED. A LESION IN THE LEFT FRONT PART OF THE BRAIN PRODUCES DIFFICULTIES SPEAKING.

MOST IMPORTANTLY, HE ALSO ESTABLISHED THE METHOD THAT SERVED US FOR A HUNDRED YEARS, WHICH IS LOOKING FOR PATIENTS

THAT CAN'T DO VARIOUS THINGS AND FINDING OUT WHAT PARTS OF THE BRAIN ARE MISSING. AND THAT IS HOW WE DISCOVERED THAT, IF THE LESION IS MORE IN THE BACK OF THE LEFT, PEOPLE CAN TALK FINE, BUT THEY DON'T UNDERSTAND ANYTHING. AND IF THE LESION IS IN THE RIGHT SIDE IN THE SAME PLACE, THEY CAN TALK, BUT THEY DON'T HAVE ANY EMOTION IN THEIR SPEECH.

SO, THE FIRST CASE PRESENTED WAS A TEACHER WHO CAME IN WITH A COMPLAINT THAT SHE LOST CONTROL OF HER CLASSROOM. AND DURING THE CLINICAL INTERVIEW, THE PHYSICIAN OBSERVED SHE WAS TALKING IN A STRAIGHT VOICE, HAD NO EMOTIONAL INFLECTION. SO, OBVIOUSLY, YOU TAKE A BUNCH OF KIDS, AND YOU TELL THEM, PLEASE, SIT QUIETLY, IT IS NOT GOING TO WORK. YOU HAVE TO PUT EMOTION IN YOUR SPEECH, AND THAT IS WHAT SHE COULDN'T DO. SHE HAD THE LESION IN EXACTLY BROCA'S AREA, BUT ON THE RIGHT SIDE.

OTHER LESIONS ON THE RIGHT HEMISPHERE PRODUCE DIFFICULTIES IN UNDERSTANDING SPATIAL RELATIONS. AND REALLY, THIS IS HOW THE FIELD OF NEUROPSYCHOLOGY WAS DEVELOPED. PSYCHOLOGISTS STARTED TO GET INTO THIS EVALUATION, AND NOW, INSTEAD OF TALKING TO A PATIENT AND TRYING TO FIGURE OUT THEIR FLUENCY, WE HAVE STANDARD TESTS. WE TELL A PATIENT, OKAY, YOU HAVE ONE MINUTE, HOW MANY WORDS CAN YOU SAY THAT START WITH C? AND YOU COUNT HOW MANY, AND YOU COLLECT A LOT OF DATA ON THE HEALTHY PEOPLE ACROSS THE AGE RANGE. YOU KNOW WHAT THE AVERAGE NUMBER OF WORDS THAT THE HEALTHY PERSON WILL GIVE YOU

IS AND WHAT THIS PARTICULAR PATIENT GAVE YOU. AND THEN, YOU GO ON AND YOU LOOK AT VERBAL COMPREHENSION. YOU GIVE A STANDARD SET OF TESTS THAT SAY -- WILL TELL THEM, TAKE THE GREEN CHIP, THE BIG GREEN CHIP, AND PUT IT ON TOP OF THE LITTLE RED CHIP. AND SEE IF THEY CAN UNDERSTAND WHAT YOU ARE INSTRUCTING THEM. SO, IF THERE IS A DIFFICULTY THERE, PEOPLE WITH LESIONS, MORE IN THE LEFT MORE IN THE BACK, WILL HAVE A HARD TIME, THEY WILL GET CONFUSED, THEY WON'T UNDERSTAND WHAT YOU WANT THEM TO DO. AND THAT IS THROUGH THOSE KINDS OF TESTING, LOOKING AT VARIOUS ASPECTS OF EXECUTIVE FUNCTIONS AND MEMORY AND SPATIAL ABILITIES, YOU CAN MAP THE BRAIN AND FIND OUT WHAT PARTS OF THE BRAIN DON'T SEEM TO BE WORKING RIGHT. AND THAT IS DONE MUCH MORE RIGOROUSLY THROUGH STANDARD TESTING THAN NEUROLOGIST OR NEUROSURGEON CAN DO BY JUST TALKING AND TRYING TO GET A FEEL FOR IT.

Q. SO, DR. GUR, AS I UNDERSTAND IT, YOU CAN MEASURE THE BRAIN STRUCTURE. YOU DO THAT WITH AN MRI?

A. YES.

Q. YOU CAN MEASURE THE PHYSIOLOGY OF THE BRAIN, AND YOU DO THAT WITH THE PET SCAN?

A. CORRECT.

Q. AND THEN, YOU CAN MEASURE HOW THE BRAIN IS ACTUALLY WORKING BEHAVIORALLY, HOW IT IS BEHAVING, YOU DO THAT WITH NEUROPSYCHOLOGICAL TESTING?

A. ABSOLUTELY. IN THE SAME WAY THAT THE FUNCTION OF THE

HEART IS TO PUMP BLOOD, THE FUNCTION OF THE BRAIN IS TO BEHAVE. SO, THE SAME WAY WHEN YOU, ULTIMATELY, YOU CAN SCAN THE HEART AND YOU SEE THE HEART IS HEALTHY, YOU MEASURE ITS RATE, AND IT IS FINE, BUT IF IT DOESN'T PUMP BLOOD, IT IS NOT, IT IS NOT DOING ITS JOB. THE JOB OF THE BRAIN IS BEHAVIOR.. SO, ULTIMATELY, THE STATE OF THE BRAIN IS MEASURED BY THE BEHAVIOR.

Q. AND, DR. GUR, IN THIS CASE, MIGHT HELP WE COULD MOVE ON SOME NOW AND TALK ABOUT THAT, MOVE ON TO MR. FULKS'S CASE. IN THIS CASE, DO YOU HAVE ACCESS TO AN MRI?

A. I WAS GOING TO JUST QUICKLY ILLUSTRATE SOME OF THESE MEASURES.

Q. YOU CAN DO IT NOW OR IN THE CONTEXT OF WHAT YOU, ACTUALLY, DISCOVERED IN THIS CASE.

A. WE HAVE IT, MIGHT AS WELL DO IT, BECAUSE I THINK IT WILL --

Q. OKAY. WHAT IS THIS THEN?

A. SO, THIS NOW LOOKS MORE DETAILED AT THE EXECUTIVE. SO, THE TEST THAT YOU SEE CALLED "ATTENTION CPT," YOU SEE THOSE SEVEN SEGMENT DISPLAYS FLASHING VERY RAPIDLY.

Q. JUST TO BE CLEAR, THIS IS AN EXAMPLE OF NEUROPSYCHOLOGICAL TEST, THE THIRD THING YOU WERE TALKING ABOUT?

A. YES.

THE PATIENT IS ASKED TO PUSH A BUTTON EVERY TIME THEY SEE

A NUMBER. SO, THE STRUCTURE HERE IS THE NUMBER 5. SO, WHEREAS, ON THE LEFT, IT IS A MEANINGLESS COMBINATION. SO, YOU ARE ONLY SUPPOSED TO HIT THE BUTTON WHEN YOU SEE AN ACTUAL NUMBER. THE BOTTOM ONE IS LOOKING AT YOUR ABILITY TO COME UP WITH A CONCEPT OF GROUPS. SO YOUR INSTRUCTION IS TO CLICK ON AN OBJECT THAT DOES NOT BELONG. NOW, IF YOU LOOK CAREFULLY, YOU MAY WANT TO CHOOSE THE SQUARE ON THE RIGHT BECAUSE IT IS THE ONLY SQUARE. ON THE OTHER HAND, YOU MAY WANT TO CHOOSE THE LEFT MOST OBJECT BECAUSE IT IS THE ONLY ONE THAT IS SMALL. OR YOU WOULD WANT TO CHOOSE THIS OBJECT, WHICH IS THE ONLY ONE THAT HAS THICK -- THAT IS DRAWN IN THICK LINES. SO, REALLY, NONE OF THOSE OBJECTS BELONG, DEPENDING UPON WHAT RULE YOU WANT TO ADOPT. AND THE COMPUTER KNOWS, BASICALLY, RANDOMLY CHOOSES ONE OF THOSE RULES. AND SO, IF YOU CHOOSE, IF YOU HAPPEN TO CLICK ON THE SQUARE AND THE COMPUTER IS THINKING SIZE, YOU WILL GET ZIP, NO, TRY AGAIN. AND A NEW CARD WILL SHOW UP. AND IF YOU CHOOSE BY SHAPE AGAIN, YOU WILL GET ZIP AGAIN UNTIL YOU SAY, WAIT, MUST BE SOMETHING ELSE. THEN YOU SAY, OH, IT COULD BE SIZE, AND YOU BEGIN TO CHOOSE BY SIZE. THEN YOU GET BINGO, YOU GOT IT. AND THE COMPUTER LETS YOU SIT ON YOUR GLORY FOR 10 TRIES. AND THEN, THE COMPUTER SWITCHES ON YOU.

AND ALL OF A SUDDEN, AS HAPPENS IN LIFE, THE SAME THING THAT ALWAYS WORKED DOESN'T WORK ANYMORE. WHAT DO YOU DO? DO YOU FALL ON YOUR FEET? DO YOU THINK ABOUT ALTERNATIVES? AND

HERE IS WHERE THE FRONTAL EXECUTIVE LOBE GETS AN OPPORTUNITY EITHER TO SHINE OR TO FAIL.

NEXT. AND IN ADDITION, WE LOOK AT THE INTERACTION. YOU RECALL I TALKED ABOUT THE RELATIONSHIP BETWEEN THE TEMPORAL LOBE AND THE EXECUTIVE, AND THAT IS VERY IMPORTANT IN MEMORY. BECAUSE IF YOU WANT TO REMEMBER SOMETHING, IT HELPS IF YOU CAN ORGANIZE IT INTO MEANINGFUL CHUNKS, PARTICULARLY IF YOU WANT TO REMEMBER WORDS. IF I ASK YOU TO REMEMBER A BUNCH OF WORDS, YOU WILL JUST TRY TO REMEMBER, BY THE SOUND OF MY VOICE, IT WILL BE HARD. YOU TRY TO SAY WAIT A MINUTE, SOME OF THESE WERE TOOLS, SOME OF THESE WERE CLOTHING ITEMS, SOME OF THESE WERE NAMES OF CITIES. AND ONCE WE BEGIN TO CHUNK IT, IT IS EASIER BECAUSE THERE WILL BE FEWER THINGS THAT YOU HAVE TO REMEMBER.

AND SO, WE TEST FOR WORD MEMORY, WE TEST FOR FACE MEMORY, WE SHOW THEM 20 FACES, MIX THEM UP WITH 20 OTHER FACES, AND ASK THEM IF THEY HAVE SEEN THAT FACE BEFORE, AS WELL AS SPATIAL MEMORY. WHAT IS INTERESTING, FOR EXAMPLE, IN SPATIAL MEMORY, YOU SEE 20 OF THESE SHAPES AND THEN, WHEN YOU TRY TO DECIDE WHAT I HAVE SEEN AND WHAT I HAVEN'T SEEN, MOST PEOPLE COME OUT SAYING, I ANSWERED COMPLETELY RANDOMLY. I HAVE NO IDEA WHY I WAS ANSWERING AND, ACTUALLY, THE TYPICAL ANSWER IS 80 PERCENT CORRECT. AND THE REASON IS, THIS IS DONE BY YOUR RIGHT HEMISPHERE THAT IS NOT TALKING. YOUR LEFT HEMISPHERE THAT IS THINKING AND TALKING IN WORDS SAYS, I DON'T KNOW WHAT

I AM DOING. BUT THE RIGHT HEMISPHERE SENDS YOUR FINGER TO THE RIGHT ANSWER. AND WE HAVE A FEELING THAT IT IS INTUITION.

ANOTHER IMPORTANT FUNCTION THAT WE ARE MEASURING MORE RECENTLY, BUT IT TURNS OUT TO BE EXTREMELY IMPORTANT TO BEHAVIOR, IS EMOTION. NOT ONLY COGNITION IS IMPORTANT BUT EMOTION. WHEN YOU WANT TO LOOK AT EMOTION PROCESSING, THE MOST IMPORTANT PART IS THE FACE, BECAUSE THE FACE IS WHERE EMOTIONS ARE EXPRESSED MOST CLEARLY, NOT ONLY WITHIN A SPECIES BUT EVEN AT CROSS SPECIES.

SO, HERE, IN THIS PICTURE, YOU SEE THE PEOPLE LYING IN LINE. IF YOU JUST LOOKED AT THE BODY YOU COULDN'T TELL WHERE THEY ARE LYING. IF YOU ZOOM IN TO THE FACE, YOU CAN PRETTY MUCH TELL THEIR POSITION IN THE LINE BY LOOKING AT THE FACE. NUMBER 9 ALREADY SEES THE MOTOR HAS FLOWN OVER HIM, HE IS QUITE HAPPY. NUMBER 12 IS STILL HOLDING A STIFF UPPER LIP, BUT NUMBER 13 LOOKS CONCERNED. SO, WHAT WE HAVE DONE IS, ESSENTIALLY, OBTAINED PICTURES FROM ACTORS AND ACTRESSES WHO DISPLAY DIFFERENT EMOTIONS AT DIFFERENT LEVELS OF INTENSITY. THEN WE SHOW THOSE PICTURES TO HEALTHY PEOPLE AND ASK THEM TO IDENTIFY THE EMOTION AND TELL US THE INTENSITY OF THE EMOTION. AND BASED ON THAT, WE ARE ABLE TO CONSTRUCT TESTS TO FIND OUT IF SOMEBODY UNDERSTANDS EMOTIONAL EXPRESSIONS. AND TO OUR SURPRISE, INITIALLY, BECAUSE IT SEEMS LIKE SOMETHING EVERYBODY SHOULD BE ABLE TO DO, IT TURNS OUT NOT TO BE VERY EASY IF YOU

HAVE BRAIN DAMAGE.

SO, NOW WE ARE TURNING TO MR. FULKS.

Q. WE ARE TURNING TO MR. FULKS. TALKED ABOUT STRUCTURE, TALKED ABOUT PHYSIOLOGY, TALKED ABOUT BEHAVIOR. LET'S FOLLOW THAT SAME PATTERN AND LET'S GO FIRST TO THE MRI AND THE BRAIN STRUCTURE.

A. YES.

Q. WHAT DO WE HAVE ON THIS SLIDE?

A. MRI. I WOULD DEFER GOING INTO THE DETAIL TO DR. DAVITZKOS SINCE HE DID THE COMPLETE ANALYSIS, BUT THE MRI, IF YOU LOOK AT IT, THE BRAIN LOOKS MISSHAPEN. IT IS NOT, IN PARTICULAR, I MEAN, THERE IS THE CLINICAL READING OF SUBARACHNOID OR ARACHNOID CYST, BUT THIS IS ALMOST THE LEAST OF THE TROUBLES.

Q. FIRST, WHAT IS AN ARACHNOID CYST?

A. IT IS LIKE A CYST. IT IS LIKE, REALLY, I GUESS WE CALL IT A ZIT, BUT IT IS INSIDE THE HEAD, AND IT KEEPS GROWING, AND IT CAN, IT IS USUALLY NOT, IT IS NOT MALIGNANT, AND IT JUST -- YOU USUALLY KEEP LEAVE IT THERE UNLESS IT BEGINS TO GROW TO THE POINT WHERE IT COMPRESSES THE BRAIN AND BEGINS TO CAUSE TROUBLE. OTHERWISE, PROBABLY SOME PEOPLE IN THIS ROOM WITH A CYST, AND THEY DON'T EVEN KNOW IT. SO, IT DOESN'T. BUT, I MEAN, DEPENDING UPON THE SIZE, IT CAN BEGIN TO IMPACT, AND THAT IS USUALLY WHEN YOU WILL COME TO THE ATTENTION OF A PHYSICIAN. BUT WE DO, HEALTHY PEOPLE, OCCASIONALLY, WE FIND

TUMORS IN PEOPLE WHO JUST COME IN IN ORDER TO PARTICIPATE AS RESEARCH VOLUNTEERS, AND THESE ARE OPERABLE, AND IT IS GOOD WE DISCOVERED THEM IN TIME AND THE PERSON DIDN'T EVEN NOTICE THAT THERE WAS SOMETHING WRONG. USUALLY, ONCE A TUMOR GETS A CERTAIN SIZE, THEN IT BEGINS TO PUSH BRAIN STRUCTURES, AND THAT IS WHEN YOU BEGIN TO SEE SYMPTOMS.

Q. HE HAS THIS CYST, BUT IN ADDITION TO THAT?

A. THE MAIN THING IS THAT YOU SEE THE WHOLE BRAIN IS MISSHAPEN. YOU CAN SEE THERE ARE AREAS HERE THAT SHOULD BE FILLED. AND THEY ARE FILLED HERE ON THE -- WELL, RADIOLOGIST LIKE TO THINK OF SCANNING SOMEONE FROM THE BOTTOM UP. SO, WHEN THEY SHOW A PICTURE, WHAT IS ON YOUR LEFT IS REALLY THE RIGHT SIDE, AND WHAT IS ON YOUR RIGHT IS THE LEFT SIDE. THAT ARROW IS REALLY POINTING TO THE LEFT PART OF THE BRAIN. AND THE WHOLE BRAIN IS HAS AN ABNORMAL SHAPE TO IT THAT SEEMS TO ALREADY ORIGINATE IN THE BOTTOM, IN THE BASE OF IT, IN THE STRUCTURES THAT REALLY ARE FULLY DEVELOPED DURING PREGNANCY.

Q. AND WHAT IS THE SIGNIFICANCE OF THAT?

A. THIS IS SOMETHING THAT WE MAKE A DISTINCTION BETWEEN DYSTROPHY AND ATROPHY. ATROPHY IS A PART OF THE BRAIN THAT WAS THERE, AND THEN IT DIES OFF. DYSTROPHY IS THE PART THAT NEVER MADE IT. AND THIS LOOKED, THIS BRAIN LOOKS DYSTROPHIC IN THE SENSE THAT IT NEVER REALLY -- IT DOESN'T LOOK LIKE IT IS A FULLY BAKED CAKE. IT IS AS IF SOMETHING, SOMETHING

HAPPENED EARLY ON THAT DISRUPTED THE NORMAL LAYING OUT OF THE DIFFERENT BRAIN STRUCTURES.

Q. AND WOULD THAT BE CONSISTENT OR INCONSISTENT WITH FETAL ALCOHOL EXPOSURE?

A. THAT IS PROBABLY THE MOST LIKELY CAUSE FOR SOMETHING LIKE THAT BECAUSE THAT MEANS THAT THE CONDITIONS WEREN'T RIGHT THROUGHOUT THE TIME WHEN THE FETUS WAS DEVELOPING. IT WAS A PERSISTENT, CHRONIC CONDITION THAT JUST DIDN'T ALLOW THE BRAIN TO GET THE NORMAL SHAPE THAT YOU WOULD EXPECT FROM THE BRAIN. I MEAN, IT IS THERE. ALL OF THE PARTS ARE THERE, BUT SOME PARTS ARE BIGGER THAN THEY SHOULD BE. SOME PARTS ARE SMALLER THAN THEY SHOULD BE. AND IT JUST DOESN'T LOOK LIKE A NORMAL BRAIN THAT YOU -- THAT YOU WOULD SEE WHEN YOU LOOK AT THAT ORIENTATION.

Q. ANYTHING ELSE ON THIS?

A. DR. DAVITZKOS WAS ABLE TO, THROUGH HIS SOFTWARE, SHOW EXACTLY WHAT ARE THE REGIONS THAT SEEM TO BE MOST PROBLEMATIC. YOU WILL NOTE THAT INVOLVES, ESPECIALLY, THE INFERIOR FRONTAL PART. THE LOWER FRONTAL PART THAT WE DESCRIBE AS THE ORBITAL FRONTAL AREA. THE ONE THAT TELLS YOU TO STOP, THINK ABOUT ALTERNATIVES, PARTICULARLY IN RELATION TO EMOTIONAL SITUATIONS.

Q. IT SAYS HERE, "LOSS OF BRAIN TISSUE."

A. IT MEANS THAT HE EXPECTED, WHEN HE COMPARED IT TO A LARGE SET OF NORMAL BRAINS, HE EXPECTED TO SEE TISSUE THERE,

AND THERE WASN'T.

Q. AND WITHOUT GOING BACK OVER WHAT WE TALKED ABOUT EARLIER, THAT WOULD MEAN THERE IS AN ABSENCE OF GRAY MATTER?

A. YES. IT IS MOSTLY IN GRAY MATTER. AND THAT IS ANOTHER REASON WHY IT HAS PROBABLY HAPPENED, MOST OF THE MISCHIEF HAPPENED BEFORE BIRTH. AS I MENTIONED, THE WHITE MATTER FORMS AFTER BIRTH. THERE IS SOME WHITE, BUT NOT AS MUCH AS GRAY MATTER.

Q. WHAT ARE THE ABNORMALITIES OF THE WHITE MATTER, JUST BRIEFLY?

A. I THINK DR. DAVITZKOS WILL PROBABLY BE ABLE TO CHARACTERIZE IT A LOT BETTER.

Q. YES, I WILL JUST DEAL WITH THAT WITH HIM. OKAY. GO TO THE NEXT SLIDE.

A. YEAH. THIS IS AGAIN FROM, YOU WILL SEE MORE DETAIL OF THAT FROM DR. DAVITZKOS. WHERE THIS METHOD, AS I MENTIONED, WE CAN MEASURE EACH STRUCTURE AND FIND OUT THE VOLUME OF THAT STRUCTURE. AND HE IS, BASICALLY, TRANSLATING IT INTO STANDARD DEVIATION UNITS. STANDARD DEVIATION. SO, IF I MEASURED THE HEIGHT OF EVERYBODY IN THIS ROOM, I WILL GET AN AVERAGE, SAY, 5 FEET 11 INCHES. THAT REALLY DOESN'T TELL US MUCH BECAUSE YOU COULD HAVE THAT MEASURE, COME IN THE ROOM WHERE HALF THE ROOM OF MIDGETS AND HALF ARE NBA PLAYERS. YOU WANT TO GET ANOTHER ESTIMATE OF HOW MUCH VARIATION WAS THERE AROUND THE MEAN. AND THE WAY WE DO IT, WE CALCULATE WHAT WE CALL A

STANDARD DEVIATION, WHICH IS, ESSENTIALLY, THE AVERAGE OF THE DIFFERENCES FROM THE AVERAGE. NOW, WE KNOW, MATHEMATICALLY, THAT THE STANDARD DEVIATION IS HELPFUL BECAUSE, IF THE DISTRIBUTION, LIKE MOST DISTRIBUTION ARE WHAT WE CALL BELL SHAPE OR NORMAL DISTRIBUTION, MOST PEOPLE ARE, ON THE AVERAGE, AND AS YOU GET AWAY FROM THE AVERAGE, YOU GET FEWER AND FEWER PEOPLE HAVING THAT VALUE. SO, STANDARD DEVIATION TELLS YOU, WITHIN ONE STANDARD DEVIATION FROM THE MEAN, YOU WILL FIND TWO-THIRDS OF THE PEOPLE. SO, IF I KNOW THAT THE AVERAGE HEIGHT IN THIS ROOM IS FIVE FEET EIGHT INCHES, AND THE STANDARD DEVIATION IS THREE INCHES, THEN I KNOW THAT TWO-THIRDS OF YOU WILL BE BETWEEN FIVE-FIVE AND SIX -- FIVE ELEVEN. I AM NOT VERY GOOD WITH ARITHMETIC. AND THE TWO STANDARD DEVIATION WOULD BE 99 -- 98 PERCENT OF YOU WILL BE WITHIN TWO STANDARD DEVIATION. AND THAT IS A RULE THAT APPLIES TO EVERYTHING THAT HAS A DISTRIBUTION THAT LOOKS LIKE A BELL, THE NORMAL DISTRIBUTION. YOU CAN SEE SOME REGIONS. HE HAS STATED THEM IN STANDARD DEVIATION UNITS. MINUS ONE MEANS ONE STANDARD DEVIATION; MINUS TWO, MINUS THREE IS THREE STANDARD DEVIATION FROM THE MEAN. YOU WILL SEE IN THE BAR THERE ARE SEVERAL REGIONS WHERE THE VOLUME IS ALMOST THREE STANDARD DEVIATION LOWER THAN THE AVERAGE, AND SOME AT THE SAME INDIVIDUAL. FOR SOME REGIONS IN SOME OTHER AREAS, THE VOLUME IS THREE STANDARD DEVIATION LARGER THAN YOUR AVERAGE BRAIN. THAT IS HIGHLY UNUSUAL. SO, AGAIN, THIS CHART

DR. DAVITZKOS WILL TALK ABOUT IT WHEN HE COMES IN, IN MORE DETAIL, JUST SHOWS -- SUMMARIZES, IN A BAR GRAPH, THE ABNORMALITIES IN VARIOUS BRAIN IMAGES.

Q. NEXT.

A. HERE IS MR. FULKS'S PET SCAN. THESE LOOK LIKE THE MRI ARE SIMILAR, BUT THEY ARE FUZZIER, THEY ARE FUZZIER BECAUSE THE RESOLUTION IS NOT QUITE AS GOOD. YOU RECALL, WITH MRI, WE CAN GET THE PIXEL DOWN TO ONE MILLIMETER. WITH PET, BECAUSE THE POSITRON WIGGLES A LITTLE BIT BEFORE IT HITS AN ELECTRON, POSSIBLE RESOLUTION IS ABOUT THREE MILLIMETERS. IT IS VERY HARD TO GET THE BETTER THAN THREE MILLIMETER. SO, IF I PUT ONE POINT IN THE MIDDLE OF THE MRI SCANNER, I AM NOT GOING TO SEE A POINT, I AM GOING TO SEE A BALL THAT WILL BE ABOUT THREE MILLIMETERS IN SIZE, AND THAT IS THE BEST I CAN DO. I CAN'T IMPROVE ON THAT. THEY ARE FUZZIER. THEY DON'T TELL US THE ANATOMY. THEY TELL US HOW MUCH SUGAR WENT INTO DIFFERENT PARTS.

WHAT YOU SEE HERE ARE SLICES STARTING FROM THE TOP WHERE THERE IS ALMOST NO BRAIN AND BEGINNING TO SLICE THE BRAIN DOWN FURTHER DOWN. AND EVERYTHING LOOKS QUITE NORMAL AND A LITTLE BIT LOW AT THE TOP. NOW, THE MRI, THE PET, WAS READ BY A CLINICAL RADIOLOGIST WHO READS THEM AND WAS READ AS HAVING ABNORMALLY LOW CORTICLE UPTAKE RELATIVE TO BASAL GANGLIA.

Q. WHAT DOES THAT MEAN?

A. WHAT THAT MEANS IS, THERE ARE TWO KINDS OF PET SCANS

YOU CAN DO. ONE OF THEM IS QUANTITATIVE, WHERE YOU ACTUALLY KNOW HOW MUCH SUGAR WAS TAKEN UP FOR EACH HUNDRED GRAM OF TISSUE EVERY MINUTE. SO, YOU CAN ACTUALLY MEASURE THAT, BUT IT IS A PROCEDURE THAT REALLY NEEDS A MAJOR ACADEMIC CENTER TO DO BECAUSE YOU NEED TO PUT A CATHETER IN AN ARTERY, AND THAT IS A COMPLICATION. MR. FULKS DID NOT GET THE QUANTITATIVE SCAN. HE GOT -- HE DIDN'T GET AN ARTERIAL SAMPLING, SO ALL WE KNOW IS HOW MANY COUNTS, POSITRONS DID WE GET FROM EACH PART OF THE BRAIN. THIS IS FINE. IT IS VERY CLOSELY RELATED TO METABOLISM, BUT IT DOESN'T TELL US WHETHER ANYTHING IS ABNORMALLY HIGH OR ABNORMALLY LOW, ONLY HOW IT IS RELATIVE TO THE AVERAGE.

SO, WHAT THE COMPUTER DOES IS, IT TAKES THE HIGHEST NUMBER THAT HE SEES IN THE WHOLE BRAIN AND GIVES IT -- MAKES IT WHITE, STRONG WHITE. TAKES THE LOWEST NUMBER, MAKES IT BLACK. AND ALL OF THE NUMBERS IN BETWEEN GETS VALUES IN BETWEEN. SO, WHEN YOU SEE A VERY HOT AREA, YOU DON'T, YOU KNOW IT IS RELATIVE TO EVERYTHING ELSE. SOMETHING IN A RELATIVE STATE HERE. YOU CAN'T SAY WHETHER, ABSOLUTELY, IT IS HIGH, OR ABSOLUTELY, IT IS LOW.

NOW, WHAT HAPPENS HERE IS, WHEN WE BEGIN TO SLICE, AND ON HERE, I TRIED TO SHOW HOW THE SLICES ARE MOVING DOWN THE BRAIN. WHEN WE COME TO THE THALAMUS, YOU MAY OR MAY NOT RECALL, YOU MAY RECALL IS THE SWITCHBOARD OPERATOR, USUALLY THE THALAMUS, AS WE GO DOWN THE BRAIN, YOU SEE WE GET THROUGH,

THESE SLICES ARE PRETTY HOT UP TO THE THIRD PANEL FROM THE TOP WHEN YOU BEGIN TO SEE THE MIDDLE BEING COLD. THE HOT PART IS THE SINGULAR GYRUS, WHICH IS IN THE MIDDLE OF THE BRAIN, AND THEN, RIGHT AFTER THAT, IT COMES TO THE CALLOSUM, WHICH IS WHITE MATTER, FAT, AND WHITE MATTER DOESN'T TAKE A LOT OF SUGAR. IT ALMOST DOESN'T METABOLIZE. SO, YOU CAN SEE PITCH-BLACK. BUT RIGHT AFTER THE WHITE MATTER COMES FLUID WHICH HAS ZERO METABOLISM. NO METABOLISM. AND THEN, AS SOON AS YOU PASS THE FLUID, YOU SHOULD BE HITTING THE THALAMUS. AND WHAT THE RADIOLOGIST DID NOT NOTICE IS THAT YOU DON'T SEE A THALAMUS THERE. IT IS SO -- IT IS STILL DARK. AND YOU BEGIN TO SEE BRIGHT SPOTS. ONLY IF YOU SEE TWO LINES FROM THE BOTTOM HERE, YOU BEGIN TO SEE WHAT YOU ARE BEGINNING TO SEE ARE THE BASAL GANGLIA.

THE BASAL GANGLIA ARE VERY, VERY HIGH IN HIS CASE. AND, AGAIN, WHEN YOU GET FURTHER DOWN TO THE CEREBELLUM, IT SEEMS TO BE ASYMMETRIC AND LOW. AND SO, BASAL GANGLIA ARE REALLY THE PLACE THAT PRODUCES THE NEUROTRANSMITTERS THAT GET ATTACKED BY ALCOHOL. ESSENTIALLY, GET MODIFIED BY ALCOHOL. AND THEY PROJECT TO THE FRONT OF THE THE BRAIN. SO THE FAVORITE PLACE WHERE ALCOHOL GOES OR TWO PLACES. ONE IS THE FRONT OF THE BRAIN, AND THE OTHER IS THE CEREBELLUM. AND THAT IS WHY TWO THINGS HAPPEN WHEN YOU ARE DRUNK IS YOU ARE NOT A VERY GOOD EXECUTIVE. IN FACT, YOU DON'T MAKE VERY GOOD DECISIONS. AND THE OTHER IS THE CEREBELLUM, YOUR

MOVEMENT IS NOT STEADY. YOU CAN'T WALK A STRAIGHT LINE. ALL OF THOSE KINDS OF THINGS ARE CEREBELLUM FUNCTIONS. AND WHEN YOU DRINK CHRONICALLY, YOU GET THE TREMORS. AND THE TREMORS, AGAIN, ARE RELATED TO THE CEREBELLUM BEING IMPAIRED. AND SO, BY VISUAL INSPECTION, BECAUSE THE BASAL GANGLIA ARE SO HOT IN MR. FULKS, IT IS VERY DIFFICULT TO SAY WHAT THE REST IS, AND THAT IS WHY I THINK THE RADIOLOGIST MAY HAVE MISSED THE LOW UPTAKE IN THE THALAMUS.

Q. WHAT IS THE SIGNIFICANCE IN THE LOW UPTAKE IN THE THALAMUS?

A. THAT MEANS YOUR SWITCHBOARD IS NOT OPERATING, IT IS NOT OPERATING WELL. A MESSAGE IS MISINTERPRETED, SENT TO THE WRONG PLACE. THINGS THAT SHOULD GO TO THE LABOR DEPARTMENT GO TO THE JUSTICE DEPARTMENT. THINGS THAT SHOULD GO TO THE PRESIDENT GO TO THE, YOU KNOW, TO HIS, I DON'T KNOW, THE PERSON RESPONSIBLE FOR CLEANING THE STAIRS. THOSE THINGS ARE JUST NOT SENT TO WHERE THEY ARE SUPPOSED TO GO.

THE NEXT SLIDE WILL SHOW THE ACTUAL PET RESULTS. SO, THE IMAGE IS SORT OF A REPRESENTATION OF THE RESULTS. IT LOOKS COMPLICATED. I THINK I CAN EXPLAIN THAT. WHAT WE DO IS, WE TAKE HOW MANY COUNTS YOU GET FOR EACH REGION, AND WE APPLY A STANDARD SET OF 35 REGIONS TO THE BRAIN. WE PUSH A BUTTON. WE GET HOW MANY PHOTONS WORK IN THIS AREA. HOW MANY PHOTONS DO WE DETECT FROM COMING FROM THAT AREA. WE TAKE THAT NUMBER, WE DIVIDE IT BY THE TOTAL NUMBER OF PHOTONS WE GOT IN

THE TOTAL BRAIN. THAT TELLS US WHETHER EACH REGION GIVES US A VALUE. WHERE THE VALUE IS ONE, IF IT IS ABOVE ONE, IT MEANS THAT MORE SUGAR WENT TO THAT AREA. IF IT IS BELOW ONE, IT MEANS THAT LESS SUGAR WENT TO THIS AREA.

WE APPLIED THE SAME TEMPLATE TO MR. FULKS THAT WE ALREADY HAVE DATA ON FOR A LARGE SAMPLE OF HEALTHY PEOPLE, IN THIS CASE, HEALTHY MEN, SO WE CAN, THERE ARE INTERESTING SEX DIFFERENCES. MEN AND WOMEN HAVE SOMEWHAT DIFFERENT PATTERN OF BRAIN ACTIVITY. WE ARE COMPARING MR. FULKS TO MEN. SO, THE GREEN LINE YOU SEE IS THE HEALTHY PEOPLE, AND THE LINES THAT YOU SEE COMING UP AND DOWN FROM THE GREEN LINES GIVE YOU THE STANDARD DEVIATION.

THE THICK BLUE LINE IS MR. FULKS. AND STARS WERE PLACED IN AREAS WHERE MR. FULKS SHOWS VALUES THAT ARE MORE THAN THE STANDARD DEVIATION AWAY FROM THE AVERAGE. SO, THE TOP PANEL SHOWS THE REGION TO ALL BRAIN RATIOS. YOU WILL SEE THERE ARE TWO REGIONS THAT ARE HIGHLY ABNORMAL IN TERMS OF HAVING VERY LOW METABOLISM. ONE IS PART OF THE OCCIPITAL, WHICH IS THE BACK OF THE BRAIN. AS YOU REMEMBER, THAT IS THE PART THAT ANALYZED VISUAL INFORMATION. IN THAT PART, THAT ONE REGION IS CALLED FG, FUSIFORM GYRUS RIGHT HERE IS THE PART THAT RELATES TO MORE COMPLEX SHAPES. AND SOME PEOPLE THOUGHT THAT JUST THIS PART IS SPECIALIZED FOR FACES. BUT IT IS A HUGE CHUNK OF REAL ESTATE IN THE BRAIN, AND IT IS UNLIKELY THAT FACES IS THE ONLY THING THAT IT DOES. AND THERE IS MORE AND

MORE EVIDENCE THAT IT IS NOT JUST FACES, BUT IT ALSO VERY COMPLICATED THINGS THAT HAVE PERSONAL MEANING.

Q. DR. GUR, LET ME MAKE SURE I UNDERSTAND. ONE WAY TO READ A PET SCAN OR A COMMON WAY IS A RADIOLOGIST WOULD JUST LOOK AT THE FILM OF THE INDIVIDUAL, AND BASED UPON THEIR CLINICAL EXPERIENCE AND TRAINING, SORT OF WHAT A NORMAL ONE LOOKS LIKE, LOOKS AT IT AND SAYS, OKAY, I THINK THIS IS NORMAL OR ABNORMAL; IS THAT CORRECT?

A. YES. THAT WORKS QUITE WELL FOR MRI. BUT IS NOT A VERY GOOD PRACTICE FOR PET.

Q. BUT THEN THE OTHER WAY, WHICH YOU HAVE BEEN TALKING ABOUT, YOU CAN ALSO -- THE TEST GENERATES, ESSENTIALLY, A LOT OF DATA THAT CAN BE ANALYZED BY A COMPUTER. SO, A QUANTITATIVE ASSESSMENT YOU ARE TALKING ABOUT HERE IS COMPARING THE RESULTS OF AN INDIVIDUAL PERSON'S PET SCAN WITH THAT OF A NUMBER OF OTHER NORMAL INDIVIDUALS?

A. YES. AND THIS IS REALLY THE WAY IT SHOULD BE DONE BECAUSE THERE ARE, AS YOU CAN SEE, IF YOU LOOK AT THE GREEN LINES HERE, YOU CAN SEE MORE, ACTUALLY, IN THE -- IF YOU LOOK AT THAT SYMMETRY, BECAUSE RADIOLOGISTS ARE TRAINED TO LOOK AT THE SYMMETRIES. THERE ARE A LOT OF NO TWO BRAINS LOOK EXACTLY THE SAME. SO, WHEN A RADIOLOGIST LOOKS AT THE BRAIN SCAN, GOES SLICE BY SLICE, HE IS PARTICULARLY TUNED TO SEE, IT SHOULD BE SYMMETRIC. AND THAT IS TRUE FOR ANATOMY. BUT IT IS NOT TRUE FOR PET. PET, A NORMAL PET IS NOT SYMMETRIC.

IT DOESN'T LOOK SYMMETRIC. THERE ARE SUBTLE DIFFERENCES BETWEEN THE TWO SIDES. AND IT IS VERY DIFFICULT IN ANY, I MEAN, WE HAVE SOME RADIOLOGISTS WHO HAVE BEEN READING PET SCANS EVER SINCE THE PET SCAN WAS CREATED. BEEN READING IT SINCE 1983 OR '83, AND STILL WOULD MISS THINGS THAT WE CAN SEE QUANTITATIVELY.

WHAT YOU SEE QUANTITATIVELY, THIS IS THE PET SCAN. THIS IS REALLY THE RESULT OF THE PET SCAN. THE IMAGE THAT YOU LOOK AT IS A WAY, CONVENIENTLY, TO TRY TO APPRECIATE WHAT THE PET SCAN SHOWS.

Q. OKAY.

A. WE NEED TO LOOK AT A COUPLE MORE. THE OTHER REGION THAT SHOWS ABNORMALLY LOW METABOLISM IS THE THALAMUS. YOU CAN SEE THAT IS THE FOURTH REGION FROM THE RIGHT. AND YOU CAN SEE THAT THIS ONE IS ABOUT THREE OR FOUR STANDARD DEVIATIONS LESS THAN NORMAL. IN FACT, I WENT BACK TO OUR DATA SCAN, DATA SET TO SEE, AND THERE IS NOBODY, NOBODY IN OUR ENTIRE SAMPLE OF HEALTHY PEOPLE WE STUDIED, THAT HAS SUCH LOW METABOLISM IN THE THALAMUS. SO, IT IS HIGHLY ABNORMAL.

IN CONTRAST, THERE ARE SOME REGIONS, PARTICULARLY IN THE FRONTAL LOBE, ONE IN THE OCCIPITAL, AND THE BASAL GANGLIA THAT WERE SO ASTUTELY NOTED BY THE CLINICIAN THAT ARE ABNORMALLY HIGH. THESE ARE REGIONS THAT RELATE, I THINK, QUITE TELLINGLY, THEY RELATE TO THE EFFECT OF, RELATE TO WHAT ALCOHOL DOES. IT INCREASES, BY ITS ACTION OF THE ADULT

SYSTEM, INCREASES, AT THIS TIME, ABNORMALLY IN THE FRONT PART OF THE BRAIN. AND THE OTHER ABNORMALITIES, IF YOU LOOK AT THE BOTTOM BAR, THE BOTTOM BAR TAKES THE SAME VALUE AND DOES SOMETHING SIMPLE. IT TAKES LEFT MINUS RIGHT. AND WHAT YOU CAN SEE HERE, THIS ILLUSTRATES THAT EVEN DEGREES ARE NOT SYMMETRIC. THERE IS NO STRUCTURE IN THE BRAIN THAT HAS SYMMETRIC METABOLISM.

BY AND LARGE, MR. FULKS'S BRAIN FOLLOWS THE SAME PATTERN AS THE HEALTHY BRAINS, BUT WITH NOTABLE EXCEPTIONS. MOST NOTABLE IS THAT REDUCED ACTIVITY IN THE BASAL GANGLIA ON THE LEFT. SO, THIS IS LEFT MINUS RIGHT. SO, IF A POINT IS ABOVE THE ZERO, IT MEANS THERE IS MORE ACTIVITY TO THE LEFT. IF IT IS BELOW THE ZERO, THERE IS MORE ACTIVITY TO THE RIGHT. AND YOU CAN SEE TWO REGIONS THAT ARE ABNORMALLY LOW ON THE LEFT SIDE, AND A BUNCH OF THEM THAT ARE ABNORMALLY HIGH ON THE LEFT SIDE.

AND THE OTHER WORRISOME REGION IS THE MID TEMPORAL LOBE, BECAUSE WHEN YOU HAVE TOO HIGH A METABOLISM IN THE TEMPORAL LOBE, THIS IS THE SITUATION THAT WE SAW THAT MAY, EVENTUALLY, GIVE RISE TO SEIZURES UNLESS THERE IS ENOUGH, ENOUGH BLOOD SUPPLY TO TAKE AWAY THE EXCESS HIGH ALCOHOLISM.

Q. ARE EXCESSES IN BASAL GANGLIA AN ABNORMALITY THAT IS ASSOCIATED WITH FETAL ALCOHOL EXPOSURE?

A. VERY MUCH SO. THEN THE FINAL ABNORMALITY IS IN THE CEREBELLUM, WHICH IS THE LAST POINT ON THE BOTTOM PART.

NOTE, THAT IN HEALTHY PEOPLE, THESE ARE ALL RIGHT-HANDERS BECAUSE MR. FULKS IS RIGHT-HANDED AND COMPARED HIM TO RIGHT-HANDERS, IN RIGHT-HANDERS, THE RIGHT CEREBELLUM IS MORE ACTIVE THAN THE LEFT. AND SO, THAT POINT IS BELOW THE ZERO LINE. AND YOU RECALL, THE CEREBELLUM IS THE DISSECTION, ALL PARTS OF THE BRAIN CONTROL THE OPPOSITE SIDES THAT THE CEREBELLUM CONTROLS THE SAME SIDE. AND IN MR. FULKS'S CASE, THE CEREBELLUM IS SYMMETRIC, WHICH TELLS US THAT IT DOES NOT HAVE ENOUGH ACTIVITY ON THE RIGHT SIDE, AND THAT IS ANOTHER REGION THAT YOU SEE AFFECTED BY ALCOHOL.

ESSENTIALLY, WHAT YOU GET WITH ALCOHOL FETAL SYNDROME, YOU GET A PICTURE OF A BRAIN OF SOMEBODY WHO IS A CHRONIC ALCOHOLIC. WHO WAS BORN WITHOUT FETAL ALCOHOL SYNDROME BUT BECAME CHRONICALLY ALCOHOLIC. ESSENTIALLY, A BABY WITH FETAL ALCOHOL SYNDROME IS BORN DRUNK, HAS TO SPEND THE FIRST FEW MONTHS GOING THROUGH WITHDRAWAL.

THIS HIGHLIGHTS THE PART THAT IS MISSING HERE, THE THALAMUS. IF YOU LOOK IN THE MIDDLE LINE, YOU CAN SEE WHERE SLICING OUR WAY DOWN THE BRAIN AND THIS, THE PLACE WHERE YOU SEE A STRAIGHT LINE GOING DOWN THE MIDDLE IS THE SINGULAR GYRUS, YOU SEE ALL OF THE SLICES HERE, HERE, BUT HERE IS WHERE YOU GET TO THE CORPUS CALLOSUM. YOU CAN SEE, FAINTLY UNDER IT, THERE IS FLUID, BUT HERE IS WHERE YOU EXPECT TO SEE THE THALAMUS. AND USUALLY, IT COMES OUT VERY NICELY AS A HEART SHAPE, AND HERE IT IS NOT SEEN, BARELY SEEN. I MEAN,

I CAN IMAGINE IT THERE BECAUSE I KNOW WHAT TO LOOK FOR. BUT NOT UNTIL YOU GET TO THE BASAL GANGLIA AND BEGIN TO SEE THE HOT FLAMING BASAL GANGLIA IN THE MIDDLE OF THE BRAIN RIGHT HERE.

Q. SO, WE HAVE NOW LOOKED AT MR. FULKS'S MRI, WHICH IS THE STRUCTURE. LOOKED AT MR. FULKS'S PET SCAN, WHICH IS, ESSENTIALLY, THE PHYSIOLOGY OF HIS BRAIN. AND NOW, AS I UNDERSTAND IT, WE ARE GOING TO LOOK AT BRAIN BEHAVIOR THROUGH OTHER NEUROPSYCHOLOGICAL TESTINGS?

A. THE FIRST FIGURE HERE, ESSENTIALLY, SHOWS WHAT HAPPENS IF YOU TAKE THE NEUROPSYCHOLOGICAL TEST THAT MR. VENN GAVE, AND THEN YOU TAKE THE NEUROPSYCHOLOGICAL TEST THAT MR. EVANS GAVE, AND PUT THEM INTO A FORMULA THAT IS BASED ON THE CLINICAL EXPERIENCE, AND REALLY USES THE REASON FOR WHY THOSE TESTS WERE GIVEN. SO, IF YOU RECALL, THE REASON WE ARE MEASURING VERBAL FLUENCY IS BECAUSE, IF WE FIND A DEFICIT IN FLUENCY, WE THINK THERE IS A LESION IN THE LEFT FRONT. IF WE LOOK AT -- WE LOOK AT MEMORY, WE ARE WONDERING IF THERE IS A LESION IN THE TEMPORAL LOBE.

WHEN WE STUDY SPATIAL ABILITIES, WE LOOK TO SEE HOW THE RIGHT HEMISPHERE IS DOING. ALL OF THIS INFORMATION HAS BEEN FROZEN AS A SET OF WEIGHTS, AND THERE IS AN ALGORITHM THAT LETS US PUT IN THE NEUROPSYCHOLOGICAL TEST RESULTS AND GET A PICTURE OF THE BRAIN THAT INTERPRETS IT. AND THE PICTURE IS BASED ON EXPERTS. IT IS CALLED AN EXPERT SYSTEM. THOSE

EXPERTS, THE REASON I LIKE TO USE IT, ESPECIALLY IN MEDICAL/LEGAL CASES IS, THOSE EXPERTS DON'T KNOW FROM FULKS,. DON'T KNOW FROM TRIALS, THEY HAVE NO INVOLVEMENT IN THIS. THEY JUST SAID, IF YOU SEE A SCORE LIKE THIS, AND A TEST LIKE THIS, IT MEANS THIS.

AND SO, WE TAKE AND WE PUT THEM THROUGH, PUT THE TEST COURSE THROUGH THE ALGORITHM AND SEE WHAT THE EXPERT SYSTEM TELLS US. AND WHEN WE TAKE MR. VENN'S TESTING, DR.VENN'S TESTING AND DR. EVANS' TESTING, WE GET EXACTLY THE SAME ANSWER WHICH IS IN THIS PICTURE. WHEN IT IS YELLOW, IT MEANS RELATIVELY -- AGAIN, WE ARE ALL RELATIVE HERE, YOU NOTICE THAT EVEN THE YELLOW IS MORE THAN ONE STANDARD DEVIATION WORSE THAN NORMAL. SO, IT DOESN'T MEAN THAT. I MEAN, OUR CLIENT IS REALLY NOT, YOU KNOW, A VERY BRIGHT INDIVIDUAL. BUT AGAINST THAT BACKGROUND, YOU HAVE, ESPECIALLY, DIFFICULTIES IN THIS FRONTAL PART THAT I JUST PUT AN ARROW ON, AND IT IS EXACTLY THE SAME PART THAT IS SHOWING UP IN DR. EVANS, AND THAT IS THE ORBITAL FRONTAL PART OF THE BRAIN. IT IS THE ONE THAT SITS RIGHT ABOVE THE EYES THAT IS SUSCEPTIBLE BOTH TO THE EFFECT OF ALCOHOL AND TO THE EFFECTS OF HEAD INJURIES.

NOW, WE ALSO SEE AN ABNORMALITY FURTHER BACK IN THE TEMPORAL PARIETAL JUNCTURE WHICH IS IN THE FACE AREA OF THE VISUAL SYSTEM OR THE AREA THAT MAKES INTERPRETATION OF MORE COMPLEX, MORE COMPLEX INFORMATION. THESE IMAGES WERE GENERATED ON THE TRADITIONAL NEUROPSYCHOLOGICAL TESTING THAT

WERE DONE BY DR. VENN AND EVANS, AND I UNDERSTAND THAT THEY, THEMSELVES, WILL OFFER THEIR OWN INTERPRETATIONS OF THOSE TESTS LATER ON.

Q. BUT THE BOTTOM LINE ON THIS IS, THE BLUE THAT YOU SEE, IS IN THE SAME BASIC REGION OF THE BRAIN IN BOTH PLACES?

A. YEAH.

Q. AND THE INTENSITY MARKS THAT, I GUESS, THE INTENSITY OF THE COLOR MARKS THE SEVERITY OF THE ABNORMALITY.

A. THE BLUE COLORS MEAN BAD; RED COLOR MEANS OKAY; YELLOW COLORS MEAN, YOU KNOW, RELATIVELY EXCELLENT.

Q. NOW, IN ADDITION TO REVIEWING THE TESTING OF DR. VENN AND DR. EVANS, DID YOU ALSO, YOURSELF, CONDUCT SOME NEUROPSYCHOLOGICAL TESTING?

A. YES. I CONDUCTED MY OWN TEST IN ORDER TO TRY TO BETTER CHARACTERIZE THE EXACT NATURE OF THE DEFICITS. THE DIFFERENCE BETWEEN THE TEST I GAVE AND TRADITIONAL TEST IS THAT THE TESTS I GAVE WERE COMPUTERIZED, AND THEY WERE BASED ON EXPERIENCE WITH IMAGING. SO, THE TRADITIONAL NEUROPSYCHOLOGICAL TESTS ARE BASED ON EXPERIENCE WITH PATIENTS WHO HAD DIFFERENT TYPE OF BRAIN LESIONS AND WERE TESTED, AND THAT IS HOW WE CAN LINK A PARTICULAR PERFORMANCE TO A PARTICULAR BRAIN LESION.

OUR TESTS WERE DONE DIFFERENTLY. WE TAKE HEALTHY PEOPLE, STICK THEM IN A SCANNER, AND GIVE THEM TESTS, AND SEE WHICH PARTS OF THE BRAIN BECOME ACTIVE FOR EACH TEST. SO, THESE

TESTS CAN MORE -- CAN HIT THE TARGET MORE CLEARLY, BECAUSE WITH LESIONS, IT IS RARE YOU GET THE NICE LESION IN ONE AREA. USUALLY, LESIONS WILL BE IN MORE THAN ONE AREA, BE MORE DEFUSED. WITH OUR TESTS, WE CAN PINPOINT A MORE DIRECT LINK BETWEEN PARTICULAR BEHAVIOR AND A PARTICULAR BRAIN SYSTEM.

Q. AND THESE ARE TESTS THAT YOU AND YOUR COLLEAGUES AT THE UNIVERSITY OF PENNSYLVANIA DEVELOPED?

A. YES. WE DEVELOPED OTHER TESTS LIKE THAT. WE DEVELOPED ELSEWHERE. OUR TESTS WERE PUBLISHED IN THE REFEREE LITERATURE AND ARE BEING USED RIGHT NOW AROUND THE COUNTRY AND REALLY AROUND THE WORLD IN MULTIPLE STUDIES AND CLINICAL APPLICATIONS.

Q. OKAY. IS THERE ANY OTHER ADVANTAGE OF COMPUTER-GENERATED TESTS?

A. YES. THE OTHER ADVANTAGE IS THAT, WITH A TRADITIONAL TEST, YOU CAN ONLY LOOK AT PERFORMANCE. YOU CAN ONLY TELL HOW WELL SOMEONE DOES. BUT, AS EVERYONE KNOWS, OR AT LEAST WILL REALIZE, IF YOU THINK ABOUT IT, PERFORMANCE RULE IS TWO HORNS. ONE IS CALLED ACCURACY; THE OTHER IS CALLED SPEED. IN PRINCIPLE, ANYBODY COULD BUILD THE TAJ MAHAL IF GIVEN ENOUGH TIME. YOU WOULD GO VERY, VERY SLOWLY, AND YOU END UP DOING A PERFECT JOB. OR EVEN IF YOU ARE VERY GOOD AT SOMETHING, IF YOU ARE PUSHED TO DO IT VERY QUICKLY, YOU WILL MAKE MISTAKES. SO, WHENEVER WE ARE ASKED TO DO SOMETHING, WE SORT OF HAVE TO JUGGLE, ARE WE GOING TO GO FOR SPEED, OR

ARE WE GOING TO GO FOR ACCURACY, AND USUALLY WE FIND SOME SORT OF A HAPPY MEDIUM, AT LEAST WE ARE HAPPY WITH, THE BOSS MAY SAY, GEE, I WISH YOU WOULD HAVE TAKEN MORE TIME AND DONE IT MORE ACCURATELY OR THE BOSS MAY SAY, I WISH YOU, YOU KNOW, I DON'T MIND YOU MAKING MISTAKES, BUT I NEEDED IT YESTERDAY. NOW THAT YOU BRING ME A PERFECT PRODUCT TODAY, IT IS NO GOOD FOR ME. SO, DEPENDING UPON THE SITUATION, YOU ALWAYS HAVE TO JUGGLE, YOU WANT TO WORK FAST, YOU WANT TO WORK ACCURATELY. WITH A COMPUTERIZED TESTING, WE, LITERALLY, HAVE HOW MUCH TIME THE PERSON SPENT ON EACH ITEM, ITEM BY ITEM, ACCURATE TO THE MILLISECOND. SO, WE CAN LOOK AT THAT BULL HOLDING BOTH HORNS, AND WE KNOW IN WHAT WE OFTEN SEE IS SOMETIMES PEOPLE TRY TO HIDE A DIFFICULTY BY FOCUSING AND TRYING TO PERFORM WITHOUT A MISTAKE, BUT THEN WE SEE THAT THEIR SPEED GOES BELOW NORMAL. OR ON THOSE ITEMS WHERE THEY GO FAST, WE SEE THEIR ACCURACY DROP. SO, WE CAN CALCULATE REALLY WHAT WE CALL EFFICIENCY, WHICH IS ACCURACY DIVIDED BY TIME. YOU KNOW, HOW WELL DO YOU DO GIVEN THE AMOUNT OF TIME.

Q. SO, DR. GUR, IS THIS SLIDE THAT THE JURY IS NOW SEEING, DOES THAT SUMMARIZE THE RESULTS OF YOUR TESTING?

A. YES. THIS SLIDE SUMMARIZES THE RESULTS OF MY TESTING. AND THE TOP PART SHOWS THE ACCURACY. AND THE BOTTOM PART SHOWS THE SPEED. AND YOU CAN SEE THAT IN AREAS WHERE, I MEAN, IN GENERAL, MR. FULKS WORKED VERY DILIGENTLY AND REALLY,

VISIBLY, WAS TRYING TO PERFORM WELL. BUT WHEN HE WAS TRYING TO DO THINGS THAT HE WASN'T GOOD AT, PARTICULARLY FRONTAL LOBE STUFF, HIS ACCURACY CAME AT THE EXPENSE OF SPEED. SO, IF HE WANTS TO DO -- TO BE A GOOD EXECUTIVE, HE NEEDS TIME.

IN TERMS OF ACCURACY, ONE VERY ABNORMAL PERFORMANCE WE SAW FOR THAT TEST WHERE I SHOWED YOU WHERE YOU HAVE TO PICK OUT THE ONE THAT DOESN'T BELONG, HE GOT THE FIRST ONE, PROBABLY HE WAS LUCKY VERY QUICKLY WITH THE VERY FIRST IDEA, AND HE WORKED ON THAT. BUT THEN, ONCE IT CHANGED, HE GOT LOST, AND HE CONTINUED LONGER THAN FOR ANYBODY I HAVE SEEN TRYING TO FIGURE OUT THE PRINCIPLE. SO, WHEN HE DISCOVERED A PRINCIPLE, HE WAS ABLE TO FOLLOW IT. BUT WHEN THAT PRINCIPLE WASN'T WORKING ANYMORE, HE STILL KEPT TRYING TO DO THE SAME THING. REPEATING, AND REPEATING, AND REPEATING. AND THAT IS SOMETHING THAT YOU SEE VERY RARELY, BUT YOU DO SEE IN CASES OF FRONTAL LOBE DAMAGE. THEY WILL KEEP TRYING THE SAME STRATEGY AGAIN AND AGAIN.

IN TERMS OF MEMORY, YOU KNOW, THE MOST REMARKABLE PART IS THAT HIS IMMEDIATE MEMORY IS POOR, EXTREMELY POOR FOR WORD, FOR FACES, LESS SO FOR SHAPES; BUT HIS LONG-TERM MEMORY IS ACTUALLY QUITE NORMAL. HE HAS A HARD TIME LEARNING NEW INFORMATION, BUT WHATEVER CAME IN STAYS THERE. IF HE LEARNS SOMETHING HE WILL REMEMBER IT QUITE NORMALLY.

HIS INTELLECTUAL ABILITIES ARE BELOW AVERAGE FOR ACCURACY, ALTHOUGH HE WAS WORKING QUITE NORMALLY INTERPRETING FOR SPEED.

SPATIAL ABILITIES ARE NORMAL FOR ACCURACY, BUT HE WORKED VERY SLOWLY. SO, HIS SPEED WAS ABNORMAL. AND HIS SENSORY MOTOR FUNCTION, WHICH IS THE TEST MOST SENSITIVE TO ALCOHOL EFFECTS, I MEAN, HAD I NOT KNOWN THAT HE IS IN PRISON AND DOESN'T HAVE ALCOHOL AVAILABLE TO HIM BEFORE TESTING, HIS PERFORMANCE IS WHAT YOU GET FROM PEOPLE WITH ALCOHOLISM.

MOST REMARKABLY, I THOUGHT, WAS HIS PERFORMANCE ON EMOTION DISCRIMINATION. HIS ACCURACY WAS AVERAGE, BUT HE, IT WAS REALLY A CHALLENGE FOR HIM TO TELL THE EMOTIONAL EXPRESSION AS YOU CAN SEE BY THE HIGHLY ABNORMAL SPEED. THE ONE EXCEPTION IS RECOGNIZING HAPPY WHERE HE WAS IMPAIRED IN HIS ACCURACY AS WELL AS IN SPEED. SO, EVEN THOUGH HE SLOWED DOWN, HE STILL HAS A HARD TIME RECOGNIZING THAT EMOTION.

THE COURT: MR. BLUME, WE NEED TO BREAK FOR LUNCH SOMEWHERE WHEN YOU GET TO A GOOD STOPPING POINT.

MR. BLUME: I THINK NOW IS A GOOD TIME.

THE COURT: LET'S BREAK FOR LUNCH AT THIS TIME. BE BACK AT 2:00 O'CLOCK. THAT WILL GIVE YOU AN HOUR AND A HALF. HAVE A NICE LUNCH. SEE YOU BACK AT 2:00 O'CLOCK.

(WHEREUPON, THE FOLLOWING WAS HEARD OUTSIDE THE PRESENCE OF THE TRIAL JURY.)

THE COURT: QUICK QUESTION. DID THE GOVERNMENT FILE A MOTION IN REGARD TO THE MALINGERING?

MR. SCHOOLS: WE HAVE NOT FILED A RESPONSE.

THE COURT: WANTED TO MAKE SURE WE DIDN'T MISPLACE

IT.

MR. SCHOOLS: I THINK WE NEED TO TALK ABOUT IT.

THE COURT: WE WILL DO IT, WHATEVER IS APPROPRIATE. I HAVEN'T HEARD HIM SAY ANYTHING YET THAT BRINGS THAT INTO ISSUE YET. BUT MAYBE HE HAS.

MR. SCHOOLS: I THINK, YOUR HONOR --

THE COURT: WHY DON'T WE WAIT UNTIL WE FINISH HIS DIRECT.

MR. SCHOOLS: MR. BLUME HAS INDICATED HE WANTS TO SOFTEN THE BLOW COMING IN. WE NEED TO RESOLVE IT BEFORE HE GETS OFF DIRECT.

MR. BLUME: EXCUSE THE WITNESS, YOUR HONOR?

THE COURT: YOU CAN STEP DOWN. ALL RIGHT.

MR. SCHOOLS: IN 1998, THE DEFENDANT WAS ARRESTED ON A FEDERAL CHARGE ON INTERSTATE TRANSPORTATION, STOLEN MOTOR VEHICLE. AS A RESULT OF THAT ARREST, HE WAS SENT OFF TO THE FEDERAL MEDICAL CENTER IN LEXINGTON, KENTUCKY, FOR EVALUATION TO DETERMINE HIS MENTAL COMPETENCY TO ASSIST HIS COUNSEL IN HIS DEFENSE AND ALSO TO DETERMINE HIS MENTAL STATE AT THE TIME OF THE OFFENSE.

THE FINDINGS OF THE EXAMINER AT LEXINGTON WERE THAT THE DEFENDANT WAS MALINGERING, AND AMONG THE THINGS THAT THE DEFENDANT WAS MALINGERING ABOUT WAS THAT HE WAS EXHIBITING INVOLUNTARY PHYSICAL MOVEMENTS, INCLUDING THE SHAKING OF HIS HAND, AND EYE TWITCHING, AND MOVEMENTS SUCH AS THAT. THE

DIAGNOSIS WAS BASED ON THE FACT THAT DOCTORS AND OTHER PERSONNEL IN LEXINGTON MEDICAL CENTER OBSERVED HIM WITH THESE SUPPOSED INVOLUNTARY MOVEMENTS WHEN HE WAS BEING QUESTIONED BY MEDICAL PERSONNEL OR IN THE PRESENCE OF MEDICAL PERSONNEL. BUT WHEN HE WAS BEING OBSERVED BY OTHER INDIVIDUALS WITHIN THE FACILITY WHEN HE WAS NOT ACTUALLY BEING DIAGNOSED, WHEN HE WAS INTERACTING WITH OTHER INMATES, WHEN HE WAS IN RECREATION, OR THOSE TYPE OF THINGS, THOSE INVOLUNTARY MOVEMENTS WENT AWAY. ONE OF THE THINGS THAT THIS, AND ALL OF THESE WITNESSES WHO I THINK WILL TESTIFY FOR THE DEFENSE, A COUPLE OF SORT OF BASIC PREMISES ABOUT THE FACT THAT THIS PREVIOUS EVALUATION TOOK PLACE, THE MOST IS MR. FULKS HAD THE EVALUATION. IF THE EVALUATION IS CORRECT, HE WOULD HAVE LEARNED OF IT. I THINK THAT IS --

THE COURT: IF THE EVALUATION HAD BEEN CORRECT?

MR. SCHOOLS: HE HAS LEARNED FROM HIS PRIOR MISTAKES. THE DEFENDANT FIGURED OUT AFTER BEING EVALUATEED IN 1998 THAT, IF HE IS GOING TO EXHIBIT INVOLUNTARY MOVEMENTS OR OVERREPRESENT, BASED ON HIS PERFORMANCE ON TESTS OF ANY PARTICULAR MENTAL ILLNESS, THAT HE HAS TO DO A BETTER JOB OF IT. I THINK THAT IS ONE OF THE MOST IMPORTANT THINGS ABOUT THIS.

THIS WITNESS JUST TESTIFIED THAT, BASED ON THIS DEFENDANT'S BRAIN FUNCTION, IF SOMETHING ENTERS HIS BRAIN, IT STAYS IN THERE, HE REMEMBERS IT. IN 1998, HE WAS EVALUATED

BY LEXINGTON. HE ATTEMPTED, ACCORDING TO THE REPORT, TO FEIGN CERTAIN INVOLUNTARY MOVEMENTS, TO FEIGN MENTAL ILLNESS BASED ON HIS PERFORMANCE ON TESTS. I THINK THAT PROCESS EDUCATED HIM AND WOULD, CERTAINLY, FORM THE BASIS OF AN EVALUATION. OTHER RELEVANT CIRCUMSTANCES WITH RESPECT TO THIS EVAL IS WHETHER OR NOT ANY OF THESE EXPERTS HAVE SEEN IT. BECAUSE, OBVIOUSLY, WE HAD A MEDICAL RECORD WHERE A DOCTOR HAD EXAMINED MR. FULKS'S BRAIN AND DETERMINED THAT IT PERFORMED PERFECTLY NORMALLY. THEY DID AN MRI, HAD THESE IMAGES FROM SOMEONE WHO TOOK THESE IMAGES PRIOR TO EVEN THIS CASE ARISING. IT WAS TOTALLY NORMAL. A DOCTOR CAME IN AND TESTIFIED, WELL, I BELIEVE X ABOUT HIS BRAIN, WHO HAD NOT CONSIDERED THAT PREVIOUS -- THAT PREVIOUS REPORT, THAT WOULD BE INFORMATION THAT WOULD IMPEACH, NOT THE CREDIBILITY OF THE WITNESS SO MUCH AS TO THE VALUE OF HIS OPINION.

AND HERE, IT IS THE SAME THING. WE THINK, IF A WITNESS OR AN EXPERT'S OPINION IS IN ANY WAY DEPENDENT ON OR RELYING ON INTERVIEWS WITH MR. FULKS, OBSERVATIONS OF MR. FULKS, OR REPORTS WHERE OTHER PEOPLE HAVE INTERVIEWED MR. FULKS, OR OBSERVED MR. FULKS, THEN THE FACT THAT MR. FULKS HAD BEEN THROUGH THIS PREVIOUS MENTAL EVALUATION, HAS HAD THIS DIAGNOSIS IS RELEVANT TWICE. IT IS RELEVANT BECAUSE HE HAD BEEN EDUCATED BY THE PROCESS. HE HAS LEARNED, ARGUABLY, TO DO IT BETTER. AT LEAST THAT IS A VALID ARGUMENT, WE THINK, BASED ON THE REPORT AND THE OTHER ANALYSIS, THAT HERE IS A

REPORT THAT THE DEFENDANTS SHOULD HAVE BEEN AWARE ABOUT.

MAYBE THESE WITNESSES SAW IT. I DON'T KNOW BECAUSE WE DON'T HAVE ANY IDEA WHAT THESE WITNESSES SAW, AT THIS POINT. BUT I THINK IT IS A VALID METHOD OF CROSS-EXAMINATION TO SAY, WERE YOU AWARE THAT, IN 1998, THIS DEFENDANT WAS PRESENTED FOR EVALUATION AT THE LEXINGTON MEDICAL CENTER, AND HE WAS DIAGNOSED AS HAVING ANTISOCIAL PERSONALITY DISORDER AND MALINGERING, AND THE MALINGERING DIAGNOSED WAS BASED ON HIS, ALLEGEDLY, FEIGNING INVOLUNTARY MOVEMENTS IN THE PRESENCE OF MEDICAL PERSONNEL THERE. AND IN ADDITION TO MAKING REPRESENTATIONS TO MEDICAL PERSONNEL THAT SEEMED INCONSISTENT WITH SOMEONE OF HIS INTELLIGENCE, AMONG THE THINGS THEY SAID IN THE FORENSIC EVAL DONE IN 1998 WAS THAT MR. FULKS CLAIMED NOT TO KNOW HIS MOTHER'S PHONE NUMBER, NOT TO KNOW WHY HE WAS INCARCERATED. HE THOUGHT HE WAS IN JAIL BECAUSE HE HAD BROKEN INTO A CAR. WHEN, IN FACT, IT WAS A MONTH AFTER HE HAD ENGAGED IN THIS ENTIRE USE WITH MS. LEE IN MYRTLE BEACH, WHEREIN HE HAD FEIGNED THE INJURY TO HIS CHILD THAT RESULTED IN HIM ACTUALLY STEALING A CAR.

SO, I THINK IT IS EXTREMELY RELEVANT TO ESTABLISH MR. FULKS'S MOTIVATION IN THE PRESENCE OF DOCTORS WHO ARE EVALUATING HIM FOR THE PURPOSE OF PRESENTING A MEDICAL OPINION IN A DEATH PENALTY CASE THAT, WHEN PRESENTED WITH THAT SAME OPPORTUNITY IN A MUCH LESS SEVERE CIRCUMSTANCE, HE WAS CHARGED IN 1998 WITH AN OFFENSE FOR WHICH HE WAS SENTENCED TO

ONE YEAR IN PRISON, AND HE FACES THE DEATH PENALTY TO THIS CASE. I THINK IT IS CRITICAL THAT THIS JURY UNDERSTAND THAT HE HAS BEEN THROUGH THIS PROCESS BEFORE. HE LEARNED FROM IT. AND TO THE EXTENT THIS DIAGNOSIS HAS ANY WEIGHT, THAT THE EXPERTS WHO ARE TESTIFYING, BASED ON HISTORICAL INFORMATION PROVIDED BY MR. FULKS, ARE AWARE OF --

THE COURT: MOST OF WHAT THIS WITNESS HAS TESTIFIED ABOUT HAS COME FROM OBJECTIVE BRAIN SCREENINGS, THOUGH, RIGHT?

MR. SCHOOLS: HIS REPORT INDICATES HE INTERVIEWED MR. FULKS. I PRESUME HE WILL SAY THE OBSERVATION OF MR. FULKS AND CONVERSATION WITH MR. FULKS ARE CONSISTENT WITH HIS BRAIN SCAN. AND I THINK HE DID SAY THAT. THAT HE HAD A CONVERSATION WITH MR. FULKS, AND HE EXHIBITED SYMPTOMS THAT WERE CONSISTENT WITH THE BRAIN ANALYSIS THAT HE HAS DEDUCTED. I THINK, OBVIOUSLY, MR. FULKS'S SINCERITY AND MOTIVATION IN THIS PROCESS IS CRITICAL. I WOULD IMAGINE THAT, ANY INDIVIDUAL WHO IS MOTIVATED TO FEIGN SOME SORT OF MENTAL ILLNESS OR TO PRESENT SOME SORT OF SYMPTOM THAT IS NOT REAL, CAN DO SO. AND DOCTORS HOPE THAT THEY CAN TEASE THAT OUT. I THINK THAT ANY DOCTOR WHO IS WORTH HIS WEIGHT WOULD TESTIFY THAT AN INDIVIDUAL WHO HAS BEEN THROUGH THAT PROCESS ONCE, WHO HAS FIGURED OUT THAT THE PATTERN AND ACTIVITIES HE ENGAGED IN DURING THAT PREVIOUS INCIDENT WERE INSUFFICIENT TO DEMONSTRATE WHATEVER TRADE IT WAS HE WAS TRYING TO DEMONSTRATE, WOULD BE

BETTER AT IT THE SECOND TIME AROUND.

I THINK THAT IS CRITICAL INFORMATION TO THIS JURY'S ANALYSIS OF ALL OF THIS TESTIMONY. WHILE I UNDERSTAND THE DEFENDANTS WOULD WANT TO KEEP IT OUT, I HONESTLY CAN'T FATHOM A REASON WHY THIS EVIDENCE IN THIS REPORT IS NOT VALUABLE INFORMATION TO THAT JURY'S ANALYSIS OF THE VALUE OF EACH OF THESE EXPERT OPINIONS.

THE COURT: WHAT ABOUT BASIC HEARSAY PROBLEM WITH, THIS IS A STATEMENT BY A PRIOR TREATING DOCTOR OR PRIOR EXAMINING DOCTOR?

MR. SCHOOLS: THE DOCTOR WILL TESTIFY, ULTIMATELY. BUT AS FAR AS HEARSAY GOES, WHAT AN EXPERT RELIES ON --

THE COURT: THE DOCTOR WHO GAVE THIS MALINGERING ANALYSIS WILL TESTIFY IN THIS CASE?

MR. SCHOOLS: IF YOUR HONOR PERMITS IT, WE INTEND HIM TO TESTIFY, YES, SIR. THE ISSUE IS NOT NECESSARILY WHETHER, WE ARE NOT, AT THIS POINT, OFFERING IT FOR ITS TRUTH. THE QUESTION IS, ARE YOU AWARE OF IT. ARE YOU AWARE THE DEFENDANT WENT THROUGH THIS PROCESS? ARE YOU AWARE OF THIS DIAGNOSIS? ARE YOU AWARE THAT, IN A PRIOR CLINICAL SETTING, THE DEFENDANT WAS DEEMED TO HAVE BEEN FAKING SYMPTOMS? AND I THINK ALL OF -- WHAT IS IN THIS DOCTOR'S SCOPE OF KNOWLEDGE, PRIOR TO MAKING AN EVALUATION AND AN OPINION, IS CRITICAL. IT IS -- THE RULES OF EVIDENCE ALLOW IT. WE ARE NOT OFFERING IT. THE DOCTOR RELIES ON INFORMATION AS HEARSAY. THE RULES

OF EVIDENCE ALLOW, IF THE EVIDENCE IS NOT MORE PREJUDICIAL THAN PROBATIVE, FOR THAT TO BE ADMITTED. IT IS A BASIS FOR THE DOCTOR'S OPINION.

CERTAINLY, THE CONTRARY HAS TO BE TRUE THAT WE CAN ASK THE DOCTOR THINGS ABOUT THE DEFENDANT THAT HE MAY NOT HAVE CONSIDERED TO DETERMINE HOW THOSE THINGS WOULD EFFECT HIS OPINION, OR WHETHER THEY WOULD EFFECT HIS OPINION. AND THAT IS WHY WE ARE SEEKING --

THE COURT: MR. BLUME, WHAT IS YOUR RESPONSE?

MR. BLUME: WELL, I MEAN, OUR POSITION IS, YOUR HONOR, THAT WE THINK IT SHOULD BE EXCLUDED. OBVIOUSLY, THAT IS THE REASON WE HAVE FILED THE MOTION AND THE PLEADING. I THINK, OVERALL, CERTAINLY, THE PEOPLE AT BUTNER, THEY WERE AWARE OF THE FACT THAT HE HAD PREVIOUSLY BEEN DETERMINED TO BE MALINGERING IN 1998. IN FACT, THEY GAVE HIM, AT BUTNER, EVERY TEST OF MALINGERING KNOWN TO THE UNIVERSE. THE PRIMARY FOCUS OF THEIR EVALUATION AT BUTNER IN 2000 -- LAST YEAR WAS TO DETERMINE WHETHER MR. FULKS WAS MALINGERED, AND THERE WAS NO EVIDENCE OF MALINGERING IN THEIR EVALUATION.

THE COURT: WELL, MR. SCHOOLS WILL STAND BACK UP AND SAY, THAT JUST SHOWS HE LEARNED WELL THE FIRST TIME.

MR. BLUME: IT JUST CAN'T. I MEAN, IT REALLY CAN'T BE DONE. I MEAN, YOU CAN'T, THERE IS NOBODY, CERTAINLY NOBODY WITH HIS IQ, EVEN WITH SOMEBODY -- OVERALL, MOST EXPERTS SAY, YOU KNOW, THEY COULDN'T MALINGER. THEY

COULDN'T SURVIVE A LOT OF THESE. IF YOU KNOW HOW TO TAKE THEM AND CERTAINLY GET THE CONSISTENCY OF SCORES THAT YOU SEE BETWEEN WHAT THE BUTNER PEOPLE GOT, WHAT DR. EVANS GOT, WHAT DR. VENN GOT, WHAT DR. GUR GOT, ALL OF THE EXPERTS, INCLUDING THE GOVERNMENT, OF HIS COGNITIVE FUNCTIONING, IS WITHIN ONE POINT OF EACH OTHER. AND ON NONE OF THOSE TESTS WAS THERE ANY INDICATION THAT MR. FULKS WAS MALINGERED OR FAKING.

SO, I MEAN, I THINK THAT, TO ME, THE PREJUDICIAL VALUE OF ALLOWING THAT, SURE, I WILL NOT SIT HERE AND DISPUTE THAT, IN 1998 THEY EVALUATED HIM IN LEXINGTON AND THEY DETERMINED HE WAS MALINGERING, THAT IS A HISTORICAL FACT. THEY DID DETERMINE THAT. BUT THE QUESTION IS, SHOULD THAT BE INJECTED IN THIS PROCEEDING AT THIS POINT? AND I THINK, ON BALANCE, WHEN YOU LOOK AT THE CONSISTENCY OF THE PRESENT EVALUATIONS, EVERYONE'S OBSERVATIONS, AND PUT FORTH HIS BEST EFFORT, THE BUTNER REPORT FROM THE PSYCHOLOGISTS INDICATE IT WAS THEIR IMPRESSION, THEIR FEELING, NOT ONLY FROM THE RESULTS OF THE TESTING, BUT THEIR OBSERVATION OF MR. FULKSM THAT HE WAS PUTTING FORTH HIS BEST EFFORT. THEN, YOU KNOW, I WOULD THINK THAT THE PREJUDICIAL VALUE OF THAT OUTWEIGHS ITS PROBATIVE VALUE.

MR. SCHOOLS: I THINK THAT IS ENTIRELY A WEIGHT ISSUE, YOUR HONOR. IN 1998, THE REPORT PREPARED BY DR. SIMXOC AT LEXINGTON STATES THAT MR. FULKS CLAIMED NOT TO

KNOW WHY HE WAS INCARCERATED OTHER THAT SAYING HE HAD BROKEN A CAR WINDOW, WAS IN THE SEAT. HE ALSO SAID HE DID NOT KNOW IF HE GRADUATED FROM HIGH SCHOOL, WHAT TOWN HE GREW UP IN, IF HE WAS PRESENTLY MARRIED, OR WHAT HIS MOTHER'S PHONE NUMBER WAS, DESPITE HAVING WRITTEN HIS MOTHER'S PHONE NUMBER AND ADDRESS ON FORMS. MR. FULKS CLAIMS TO HAVE BEEN TREATED FOR PSYCHIATRIC PROBLEMS IN THE PAST BUT COULD NOT RECALL WHERE, WHEN, WHAT HIS DIAGNOSIS WERE, OR WHAT TYPE OF TREATMENT HE RECEIVED. WHEN ASKED --

THE COURT: SLOW DOWN JUST A LITTLE BIT.

MR. SCHOOLS: WHEN ASKED IF HE HEARD VOICES OR EXPERIENCED VISUAL HALLUCINATIONS, MR. FULKS, INITIALLY, SAID HE DID NOT. LATER, HE SAID HE RECEIVED MESSAGES FROM THE TELEVISION. STAFF NOTED MR. FULKS DID NOT BEHAVE STRANGELY WHEN INTERACTING WITH HIS PEERS WHILE IN RECREATION AREAS OR OTHER TIMES WHEN HE WAS UNAWARE STAFF WERE OBSERVING HIM. DURING THESE TIMES, STAFF REPORTED MR. FULKS LAUGHED AND TALKED APPROPRIATELY TO PEERS. HOWEVER, WHEN INTERVIEWED BY PSYCHOLOGY AND SOCIAL WORK STAFF, MR. FULKS, AGAIN, DISPLAYED MANY OF THE ODD BEHAVIORS MENTIONED.

HE WAS ADMINISTERED AN EEG DURING A PROCEDURE. MR. FULKS CONTINUOUSLY MOVED. HE WAS INSTRUCTED BY MEDICAL STAFF OF THE IMPORTANCE OF KEEPING STILL IN ORDER FOR THE TEST RESULTS TO BE ACCURATE. HE RESPONDED THAT HIS MOVEMENTS WERE INVOLUNTARY.

IT IS JUST --

THE COURT: TO BE SURE I UNDERSTAND. YOU INTEND TO CALL THE DOCTOR LATER IN YOUR CASE AT SOME POINT, EITHER CASE-IN-CHIEF OR REBUTTAL, THAT MADE THAT ANALYSIS?

MR. SCHOOLS: YES.

THE COURT: WON'T BE ANY CROSS-EXAMINATION PROBLEM?

MR. SCHOOLS: NO, SIR. IT IS NOT A QUESTION OF CONFRONTATION ISSUE. AND I DON'T THINK IT IS A CONFRONTATION CLAUSE ISSUE ANYWAY, BECAUSE WITH RESPECT TO THE PRESENTATION WITH THIS WITNESS, THE CROSS-EXAMINATION REPORT IS NOT BEING OFFERED FOR ITS TRUTH, IT IS BEING OFFERED AS THE POTENTIAL BASES UPON WHICH AN EXPERT OR SOMETHING UPON WHICH AN EXPERT MIGHT RELY TO FORM AN OPINION. THE DOCTOR MIGHT SAY, NO, IT DOESN'T MEAN ANYTHING TO ME, IT WAS TOO LONG AGO. ONE THING FOR SURE, YOUR HONOR, THIS IS THE SAME -- I BELIEVE IT IS THE SAME PROBLEM WE HAVE CONFRONTED IN THE DISQUALIFICATION MOTION ON MR. BASHAM. IF MR. FULKS HAD BEEN DIAGNOSED IN 1998 WITH A DIAGNOSIS THAT IS CONSISTENT WITH WHAT THESE DOCTORS WERE SAYING, THE DEFENSE WOULD BE THE FIRST ONE TO BE OFFERING THIS AND SUGGESTING IT WAS PURELY RELEVANT. AND SO, I DON'T KNOW WHY, BECAUSE IT IS NOT FAVORABLE TO THEIR CLIENT, IT BECOMES NOT RELEVANT AND TOO PREJUDICIAL. I THINK ALL OF THAT GOES TO WEIGHT. AND I THINK IT IS A CRITICAL PIECE OF EVIDENCE THE JURY NEEDS TO HEAR TO BE EVALUATED. NOT ONLY IS MR. FULKS'S CREDIBILITY CRITICAL TO EVERYTHING IN THIS CASE,

IT IS CRITICAL TO THEIR ENTIRE DEFENSE, WHICH IS BASED ON STATEMENTS HE MADE TO LAW ENFORCEMENT. AND IT IS, LIKEWISE, CRITICAL TO THEIR DOCTOR'S EVALUATIONS OF HIM. IF HE IS LYING TO THEM, IF HE IS MAKING UP SYMPTOMS, IF HE IS FAKING IT, THEN THEIR DIAGNOSISES ARE NOT ACCURATE.

THE COURT: THERE IS A FAMOUS STUDY THAT WAS DONE -- MY DAUGHTER, WHO MAJORED IN SOCIOLOGY TOLD ME ABOUT IT, I HAVE A COPY OF IT IN MY LIBRARY, WHERE THEY STUDIED ALL OF THESE SOURCES. THEY TOOK EIGHT PEOPLE WHO WERE PERFECTLY NORMAL AND SENT THEM TO EIGHT DIFFERENT PHYSICIANS TO BE EVALUATED TO DETERMINE IF THEY WERE COMPETENT. THEY TRIED TO TRICK THE PHYSICIANS. THEY WERE SUCCESSFUL IN TRICKING THE PHYSICIANS. DON'T QUOTE ME TO IT, I THINK IN ALL EIGHT CASES. I MEAN, DEMONSTRATING THAT THIS IS NOT AN EXACT SCIENCE. WHICH IS, I GUESS, SOMEWHAT OF A REASON TO LET IT IN. SO, WHAT I AM SAYING --

MR. SCHOOLS: THAT IS OUR POSITION. I THINK IF AN INDIVIDUAL -- IF THOSE EIGHT INDIVIDUALS HAD BEEN THROUGH THE PROCESS BEFORE AND NOT GOTTEN IT RIGHT, I THINK, INFERENTIALLY COMMON-SENSICALLY THEY WOULD BE BETTER AT IT THE SECOND TIME. I THINK THAT IS IMPORTANT. AND, YOU KNOW, ONE OF THE THINGS, WE HAVEN'T CROSS-EXAMINED THESE DOCTORS YET. ONE OF THE THINGS I WOULD THINK THAT IS CRITICAL TO THE PSYCHOANALYSIS OF ANY INDIVIDUAL IS THE PATIENT'S MOTIVATION. AND THERE IS NO QUESTION THAT MR. FULKS'S MOTIVATION IN THIS

INSTANCE IS HIGH TO DEMONSTRATE SOME SORT OF MENTAL IMPAIRMENT OR FEIGN SOME SORT OF MENTAL IMPAIRMENT SO THIS JURY WILL ATTRIBUTE THE HORRIBLE THINGS THAT HE HAS ADMITTED HE HAS DONE TO SOME BRAIN ABNORMALITY OR MENTAL ILLNESS.

I MEAN, IN 1998, HIS MOTIVATION WAS VERY LOW. AND DESPITE THAT LOW MOTIVATION IN 1998, HE STILL ATTEMPTED TO GAIN THE DOCTOR. I THINK THAT IS ALL RELEVANT TO THE ASSESSMENT IN PSYCHIATRIC TESTING.

THE COURT: I WILL DENY THE MOTION IN LIMINE AND ALLOW CROSS-EXAMINATION OF THE WITNESS ABOUT THE 1998 EVALUATION AT BUTNER. WE WILL TAKE IT A QUESTION AT A TIME. I DON'T KNOW HOW FAR I WILL LET YOU GO. BUT I THINK IT IS FAIR GAME. CREDIBILITY IS A BIG ISSUE IN THIS CASE. THE WITNESS MAY HAVE WAYS TO EXPLAIN THE EARLIER ANALYSIS, I DON'T KNOW. AND, CERTAINLY, THE DEFENDANT IS GOING TO BE GIVEN THE OPPORTUNITY TO SHOW THAT, IN THE MOST RECENT BUTNER EVALUATION, THERE WAS NO MALINGERING FOUND BY THE FEDERAL AUTHORITIES. THAT IS, CERTAINLY, PROPERLY ADMISSIBLE EVIDENCE. WITH THAT, WE WILL BREAK FOR LUNCH. WE WILL SEE YOU BACK AT 2:00 O'CLOCK.

MR. SCHOOLS: THE DONNA WARD INCIDENT, WE RAISED THE ISSUE THE OTHER DAY. WE HAVE SOME DEVELOPMENTS ON THAT WE CAN TALK ABOUT NOW.

THE COURT: TELL ME ABOUT THEM.

MR. SCHOOLS: MS. WARD ARRIVED IN COLUMBIA YESTERDAY.

AND WE ALSO PURSUED SOME ADDITIONAL RECORDS WITH RESPECT TO THIS MATTER, CONDUCTED SOME ADDITIONAL INVESTIGATION. THIS IS WHAT WE HAVE DETERMINED, AT THIS POINT. MS. WARD, INITIALLY, INDICATED THAT SHE BELIEVED THE PHONE CALL THAT SHE GOT FROM THE UNKNOWN INDIVIDUAL ALL ON THE 17TH OCCURRED AT 4:15 IN THE AFTERNOON BECAUSE SHE REMEMBERED SHE WAS AT SEARS AND AN ANNOUNCEMENT CAME ON THE OVERHEAD -- ON THE LOUDSPEAKER THE STORE WAS ABOUT TO CLOSE. I ASKED AGENT BRUNING TO CONTACT THE SEARS STORE IN CHILLICOTHE, OHIO TO DETERMINE WHAT THEIR HOURS WERE ON NOVEMBER 17TH OF 2002, AND HE FOUND OUT THEIR HOURS WERE TWO TO NINE P.M.

THE COURT: I WONDERED ABOUT IT WHEN YOU SAID THAT. THE QUESTION MARK POPPED IN MY HEAD WHEN YOU SAID THAT.

MR. SCHOOLS: THAT WAS MY THOUGHT, AS WELL. THAT IS WHY I ASKED HIM TO CALL. MR. BRUNING HAD SOME ADDITIONAL CONVERSATIONS WITH THE FOLKS AT SPRINT. THEY WERE, ACTUALLY, ABLE TO DEVELOP A RECORD THAT SHOWS THE TIME OF THE PHONE CALLS ON THR 17TH. AND IF I COULD JUST SHOW THE COURT GOVERNMENT'S EXHIBIT NUMBER 355 IS THE RECORD WITH THE TIME ON IT. AND I CAN BLOW UP THE RELEVANT PORTION OF THREE -- SEE, THREE PHONE CALLS ON THE 17TH, ONE REPRESENTED AT 7:36:26, ONE AT 20:11:29, AND ANOTHER ONE AT 7:38:29. SPRINT CELLULAR IS LOCATED IN OVERLAND -- EXCUSE ME, SHAWNEE MISSION, KANSAS, WHICH IS CENTRAL TIME. THE TIMES REFLECTED IN THIS RECORD ARE, ACTUALLY, CENTRAL TIME. WE HAVE OBTAINED FROM MS. DONNA

WARD THE PHONE NUMBERS FOR HER CELLPHONE AND THE PHONE NUMBER FOR THEIR HOME PHONE.

IF THE COURT LOOKS AT THE FIRST CALL THAT WAS PLACED ON NOVEMBER 17TH, 2002, IT APPEARS TO BE A MISDIALED OF HER HOME PHONE. THERE IS INSERTED A ZERO AFTER THE AREA CODE, BUT OTHERWISE, THE PHONE NUMBER MATCHES THE HOME PHONE NUMBER OF DONNA WARD, [redacted]. THREE MINUTES LATER OR TWO MINUTES LATER, AT 19:38:29, WHICH IS A PHONE CALL PLACED AT [redacted], WHICH IS MS. WARD'S CELLULAR TELEPHONE. SO, THAT CALL IS REFLECTED TO, ACTUALLY, HAVE OCCURRED AT 7:38:29 CENTRAL TIME, WHICH IN CHILLICOTHE, OHIO, WOULD BE 8:38 EASTERN STANDARD TIME.

MS. WARD'S PHONE RECORDS REFLECT THAT AT 8:38 P.M., ON NOVEMBER 17TH, 2002, SHE RECEIVED AN INCOMING PHONE CALL AT THAT TIME. BECAUSE OF THE CENTRAL TIME/EASTERN TIME VARIATION, MEANS THAT THE PHONE CALL WAS PLACED USING THE SPRINT PREPAID CARD CALLED MS. WARD AT 8:38. ALL OF THAT, COMBINED WITH THE SEARS, FINDING THEY DIDN'T CLOSE UNTIL 9:00 O'CLOCK P.M., ON THE 17TH, IN REALITY, NOT AT FOUR, MEANS THAT SHE WAS CORRECT ABOUT HAVING HEARD THE ANNOUNCEMENT THAT SEARS WAS ABOUT TO CLOSE. SHE WAS JUST WRONG ABOUT WHAT TIME IT WAS.

WE HAVE TALKED WITH MS. WARD ABOUT THAT. SHE NOW RECALLS THERE WAS SOME SORT OF MIDNIGHT MADNESS GOING ON. IT WAS NIGHTTIME. WHAT SHE REMEMBERED, THE ANNOUNCEMENT CAME ON THE

LOUD SPEAKER INDICATING THE STORE WAS ABOUT TO CLOSE PRIOR TO HER RECEIVING THE PHONE CALL OR ABOUT THE SAME TIME.

THE COURT: TIME IS MORE SIGNIFICANT NOW BECAUSE, ARGUABLY, MR. BASHAM AND MR. FULKS WEREN'T TOGETHER THAT LATE.

MR. SCHOOLS: THEY WERE NOT TOGETHER AT THAT POINT. MR. BASHAM WAS IN THE OHIO RIVER. MR. FULKS WOULD HAVE PLACED THIS PHONE CALL WITH THE CALLING CARD.

THE COURT: SO, IT IS MUCH MORE DAMAGING TO THE DEFENDANT THAN IT MIGHT HAVE BEEN.

MR. SCHOOLS: YES, SIR.

THE COURT: BECAUSE OF THE TIME DELAY.

MR. SCHOOLS: YES, SIR. WHILE WE DON'T HAVE THE TOLL RECORD FROM THE PHONE FROM WHICH THAT CALL WAS PLACED, WE HAVE CONFIRMED IT WAS A PAY PHONE IN PORTSMITH, OHIO, WHICH IS IN THE VICINITY OF WAVERLY, ASHLAND, THAT WHOLE KENTUCKY, WEST VIRGINIA, OHIO, THREE STATE AREA.

THE OTHER CONCERN THAT WAS RAISED BY THE DEFENSE WAS ONE OF NOTICE AND ABILITY TO BE PREPARED TO RESPOND TO THIS EVIDENCE. MS. WARD WAS IN OUR OFFICE YESTERDAY AFTERNOON. SHE ADVISED US THAT, ON MAY 21ST, SHE WAS VISITED BY PETE SKIDMORE, THE INVESTIGATOR FOR THE DEFENSE, WHO WAS THERE PUTATIVELY TO INTERVIEW AMY WARD. MS. WARD WAS PRESENT FOR THE INTERVIEW, AND SHE ADVISED US THAT SHE TOLD MR. SKIDMORE ABOUT THIS PHONE CALL SHE HAD RECEIVED ON NOVEMBER 17TH, INDICATING IT WAS SOMETHING ABOUT WHICH SHE HAD CONCERN.

SO, THE REALITY IS, I HAVE MADE THIS POINT BEFORE TO THE COURT, ONCE AGAIN, AND I AM NOT PROUD OF THIS EITHER, BUT THE DEFENSE INVESTIGATOR WAS AHEAD OF US ON THIS, AND THEY WERE AWARE OF THE PHONE CALL, NOT ONLY BEFORE WE WERE, BUT BEFORE OPENING STATEMENTS IN THE CASE. AT LEAST, CONSTRUCTIVELY, AWARE THROUGH MR. SKIDMORE.

THE COURT: I THOUGHT THIS WAS GOING TO BE A HARD CALL TO MAKE. NOW, IT DOESN'T LOOK SO HARD, UNLESS THE DEFENDANT CAN TELL ME SOMETHING PRETTY POWERFUL. YOUR INVESTIGATOR HEARD ABOUT THIS CALL WAY BACK THERE.

MR. BLUME: WAIT. THAT IS NOT AN ACCURATE CHARACTERIZATION OF THIS. I DO WANT TO -- I FOUND OUT, ACTUALLY, YESTERDAY WHEN I CALLED HIM ABOUT THIS, THAT HE HAD INTERVIEWED HER. HE DIDN'T REALLY MAKE ANY BIG DEAL ABOUT ANYTHING BECAUSE THERE WAS NO INDICATION ANY OF THIS WAS CONNECTED TO THIS CASE. OR THAT THEY COULD TIE ANY OF THIS TO US. AND THERE WAS NO INDICATION OF THAT, WHATSOEVER. I MEAN, THE ONLY TIME, THE FIRST TIME I EVER HEARD ANYTHING ABOUT THIS AT ALL, MYSELF, WAS LAST WEEK MR. GASSER SAID SOMETHING TO ME ABOUT IT. AND HE SAID, BOY, MS. WARD TOLD ME THIS THING AND, YOU KNOW, HE SAID, ISN'T IT AN UNUSUAL COINCIDENCE. WE ARE NOT GOING TO DO ANYTHING WITH IT BECAUSE I GUESS, AT THAT POINT, THEY DIDN'T HAVE ANYTHING TO KNOW ABOUT IT.

SO, I MEAN, THAT IS JUST NOT ACCURATE. WE HAVE DONE NO

INVESTIGATION OF THIS. WE HAD NO KNOWLEDGE OF THIS BEING SIGNIFICANT. WE HAD NO INDICATION OF THIS LINK TO OUR CASE.

THE COURT: DO YOU ACKNOWLEDGE MS. WARD'S MOTHER TOLD YOUR INVESTIGATOR ABOUT THIS MYSTERIOUS CALL TO GO TO THE HARDWARE STORE? I UNDERSTAND YOU DIDN'T CONNECT THE DOTS. THAT INFORMATION WAS MADE KNOWN TO YOUR INVESTIGATOR?

MR. BLUME: YES. SHE ALSO TOLD HIM SHE TOLD LAW ENFORCEMENT POLICE OFFICERS MONTHS AGO. THE MAIN POINT, IN MY OPINION, IF YOU DO THIS, YOU ARE DIRECTING A DEATH VERDICT. WE HAVE MADE ALL OF OUR DECISIONS ABOUT THIS CASE BASED ON WHAT WE PERCEIVE TO BE A KNOWN UNIVERSE OF FACTS, WHICH ARE BAD ENOUGH, IN AND OF THEMSELVES. AND WE HAVE DEVELOPED A STRATEGY, IN LIGHT OF WHAT THE KNOWN UNIVERSE OF FACTS WAS. WE HAVE STOOD UP IN FRONT OF THIS JURY, AND WE HAVE GIVEN AN OPENING STATEMENT ABOUT THIS CASE BASED ON WHAT THE KNOWN UNIVERSE OF FACTS WERE TO US. WE HAVE CROSS-EXAMINED EVERY WITNESS WHO HAS TESTIFIED ABOUT WHAT THEY WERE DOING ON THE 17 DAYS, BASED ON THE KNOWN UNIVERSE OF FACTS.

IF THIS COMES IN AT THIS POINT, WE STILL HAVEN'T HAD ANY TIME TO INVESTIGATE IT AND DETERMINE WHETHER IT IS ADDITIONAL INVESTIGATION TO BE DONE. WE LOSE ANY CREDIBILITY WE HAVE WITH THIS JURY. THERE IS NO WAY YOU CAN CURE THAT. THEY ARE GOING TO BELIEVE WE TRIED TO DO THIS TO YOU. WE WILL LOSE OUR CASE IN MITIGATION. WE HAVE BEEN DEPRIVED OF THE RIGHT TO EFFECTIVELY CROSS-EXAMINE THE WITNESSES AND DEVISE A STRATEGY

WHICH MAKES SENSE IN LIGHT OF THIS.

THE GOVERNMENT -- THIS GOES BACK TO BASIC FACTS. THEY KNEW ABOUT AMY WARD NOVEMBER 2002 ON. THEY COULD HAVE GONE AND INTERVIEWED THEM. APPARENTLY, THERE WAS A DISCUSSION WITH SOMEBODY IN LAW ENFORCEMENT. THIS INFORMATION NEVER CAME OUT, WAS NEVER PROVIDED TO US. THEY KNEW THAT THEY HAD THAT SPRINT CARD FROM THE BEGINNING. YOU WOULD THINK THEY WOULD HAVE HAD SOME MOTIVATION TO DETERMINE WHAT CALLS WERE MADE, WHAT THEY WERE. NONE OF THAT WAS DONE. I HAD ABSOLUTELY NO INDICATION IN THE WORLD, UNTIL THIS THING CAME UP, THAT ANYTHING ON THAT CARD COULD LINK, YOU KNOW, THAT CALL TO MR. FULKS.

THE COURT: LET ME ASK YOU THIS. DID THE GOVERNMENT DISCLOSE THAT MS. WARD -- THAT THE THEFT OF MS. WARD'S POCKETBOOK WOULD BE BROUGHT OUT AT TRIAL?

MR. SCHOOLS: YES, SIR.

THE COURT: THAT WAS IN THE TRIAL BRIEF?

MR. SCHOOLS: IN THE TRIAL BRIEF. I KNOW WE HAD PROVIDED INFORMATION ABOUT MS. WARD PRIOR TO THE TRIAL BRIEF.

THE COURT: SHE WAS LISTED AS A WITNESS?

MR. SCHOOLS: YES, SIR.

THE COURT: AND WAS THE DEFENSE TEAM AWARE THAT, WHEN MR. FULKS WAS ARRESTED, HE HAD HER CELLPHONE, AND ID, AND DRIVER'S LICENSE?

MR. SCHOOLS: YES, SIR. PRESUMABLY, THAT IS WHY

THEY SENT THEIR INVESTIGATOR TO INTERVIEW AMY WARD. THEY UNDERSTOOD SHE WOULD BE A WITNESS. WHAT MS. WARD TELLS US, NO REASON FOR MR. BLUME AND I TO GET INTO A CONTEST ABOUT WHAT TOOK PLACE DURING OUR CONVERSATION. BUT MS. WARD TELLS US THAT SHE TALKED WITH MR. SKIDMORE. SHE TOLD HIM ABOUT THE PHONE CALL. SHE TOLD HIM THAT SHE WAS AWARE THAT THE INDIVIDUALS WHO HAD STOLEN HER PURSE WOULD HAVE HAD ACCESS TO HER PHONE NUMBER BECAUSE OF THE CELLPHONE CALL. IT SCARED HER. SHE CONNECTED THOSE DOTS. MR. SKIDMORE ADVISED HER, ACCORDING TO MR. WARD, I WAS NOT THERE, HE WOULD MAKE IT KNOWN TO DEFENSE COUNSEL. NOT SAYING HE DID THAT. THAT IS WHAT HE TOLD MS. WARD.

AT THAT POINT, YOUR HONOR, NOT KNOWING WHEN THE PHONE CALL WAS PLACED OR BY WHOM, IT IS POSSIBLE THAT PHONE CALL COULD HAVE BEEN PLACED BY BRANDON BASHAM. WE NOW KNOW, FROM THE RECORDS, IT WASN'T PLACED BY MR. BASHAM. YOU KNOW, YOUR HONOR, IF MR. FULKS GOES BACK TO COLUMBIA CARE TONIGHT AND CONFESSES TO HIS CELLMATE, THAT WOULD, LIKEWISE, BLOW THE DEFENSE STRATEGY. I KNOW THAT. IT DOESN'T MEAN IT WOULD BE INADMISSIBLE. OR, IF HIS CELLMATE FROM RICHLAND COUNTY GETS MOTIVATED TO COME TELL US, SOMEHOW, A VERY COMPELLING STORY IN THE MIDDLE OF THIS TRIAL THAT WE DIDN'T ANTICIPATE AND DIDN'T KNOW TO GO SEE THAT THE DEFENDANT HAD CONFESSED TO HIM, IT IS INCONCEIVABLE THAT THE COURT WOULD KEEP THAT OUT.

I MEAN, ULTIMATELY, THIS IS A TRUTH-SEEKING FUNCTION.

AND THE ONE PERSON IS, AND, YOUR HONOR, I THINK IT IS WEEKS VERSUS UNITED STATES SUPREME COURT CASE, IT IS THE RARE DEFENSE ATTORNEY THAT GETS THE WHOLE TRUTH FROM HIS CLIENT. THE ONE PERSON WHO HAD THIS INFORMATION SINCE NOVEMBER 19TH OF 2002 IS CHAD FULKS. SO, WHILE I UNDERSTAND THE DEFENDANT'S CONCERN ABOUT THE MIDTRIAL DEVELOPMENT OF THIS EVIDENCE, THERE ARE CASES THAT, AND WE CAN CITE THEM TO YOUR HONOR THIS AFTERNOON, THAT TALK ABOUT THE ADMISSIBILITY OF EVIDENCE DISCOVERED DURING THE COURSE OF THE TRIAL WHEN THERE HAS BEEN NO NEGLIGENCE ON THE PART OF THE GOVERNMENT IN DISCOVERING INFORMATION.

I HAVE TALKED -- I TALKED TO AMY WARD ON THE PHONE AT LEAST TWICE. I TALKED TO HER DAD ON THE PHONE THREE OR FOUR TIMES. I DIDN'T KNOW TO ASK THEM WHETHER THEY HAD RECEIVED ANY PHONE CALLS FROM A SUSPECT ON THE 17TH OF NOVEMBER. IN RETROSPECT, IT IS SURPRISING TO ME THEY DIDN'T TELL ME. THEY DIDN'T TELL ME. IT IS NOT AS IF WE NEVER TALKED TO AMY WARD BEFORE SHE SHOWED UP HERE. SHE HAD BEEN INTERVIEWED, TALKED ON THE PHONE, AGREED TO COME TESTIFY. TALKED TO HER DAD ABOUT THE ARRANGEMENTS. THEY HAD NEVER MENTIONED IT. I CERTAINLY DIDN'T KNOW TO ASK BECAUSE I HAD NO REASON TO THINK THAT THAT PHONE CALL HAD BEEN PLACED.

MR. BLUME: JUDGE, WE ARE AT THE THIRD WEEK, ALMOST THE END OF A CAPITAL TRIAL IN THE GOVERNMENT'S CASE. YOU ARE TALKING ABOUT DROPPING A PIECE -- I DON'T USUALLY TALK --

DROPPING A PIECE OF INFORMATION INTO THIS THAT TOTALLY GUTS EVERYTHING -- THAT MIGHT TOTALLY DEGUT EVERYTHING WE HAVE.

THE COURT: IN YOUR OPENING STATEMENT, HELP ME WITH THAT. IS IT MR. BASHAM DID ALL OF THE BAD ACTS, HE HAD THE GUN, ET CETERA, ET CETERA? YOU SAY THIS UNDERMINES YOUR OPENING STATEMENT.

MR. BLUME: UNDERMINES CREDIBILITY. WE HAD NO IDEA. LIKE, WE WILL TRY TO DRAW OUT THE DISTINCTIONS, TALK ABOUT THE DEFENDANT'S LIFE AND BACKGROUND, YOU KNOW. WE ARE GOING TO TRY AND TELL YOU THE TRUTH ABOUT THIS. GOING TO LET THIS COME IN IT DROPS, ESSENTIALLY, A COMPLETELY OTHER -- WHAT THEY ARE GOING TO PORTRAY, AS ANOTHER ATTEMPTED, YOU KNOW, LURING SOMEBODY OUT TO CARJACK. A COMPLETELY, YOU KNOW -- I'M SORRY. COMPLETELY NEW AND SEPARATE ASPECT IN THIS AFTER, I MEAN, I WOULD HAVE PLANNED TONS OF THINGS DIFFERENTLY. CROSS-EXAMINED WITNESSES DIFFERENTLY. I AM NOT ATTRIBUTING ANY BAD FAITH TO THEM. THEY HAD PLENTY OF MOTIVATION TO IT. THEY HAD ACCESS.

WE DIDN'T RUN DOWN EVERY SINGLE LEAD. ENOUGH BAD THINGS ANYWAY. WE WERE DEVELOPING A CASE, DEVELOPING A STRATEGY. WE HAVE HAD OUR EXPERTS EVALUATE THEM IN LIGHT OF A CERTAIN WAY. AND IT IS JUST, YOU KNOW, TWO SPORTS ANALOGIES. ONE, THERE IS TIME WHEN THE REFEREE THROWS THE PILE IT ON FLAG. THIS IS PILING ON. THERE IS ALSO, YOU KNOW, A TIME WHERE, YOU KNOW, LIKE THE BASEBALL TEAM, IT HAS TO HAVE THE ROSTER.

AFTER THAT, YOU CAN'T MAKE ADDITIONS, YOU KNOW, OR DELETIONS. THE THIRD WEEK OF A CAPITAL TRIAL IS NOT THE TIME, WHERE WE HAVE ALREADY OPENED, ALL THE MAIN WITNESSES HAVE BEEN CALLED, WE HAVE CROSS-EXAMINED, TO THROW THAT INTO THIS. I CANNOT IMAGINE ANYTHING MORE PREJUDICIAL. AND IT TOTALLY DEGUTS US.

THE COURT: YOUR POINT THE OTHER DAY THAT YOU MADE, YOU SAID IT IS UNFAIR, YOU HAVE ALREADY MADE YOUR OPENING STATEMENT AND STRUCTURED IT IN A CERTAIN WAY. AND YOUR EXPERTS HAD PREPARED FOR THIS CASE ON A KNOWN UNIVERSE OF FACTS. I UNDERSTAND YOUR ARGUMENT REGARDING THE OPENING STATEMENT. I DON'T UNDERSTAND HOW IT WOULD REALLY AFFECT YOUR EXPERT'S TESTIMONY.

MR. BLUME: NOW IT WOULD AFFECT OUR OPENING STATEMENT. ALSO WOULD AFFECT, CONCEIVABLY, WE WOULD HAVE HAD A DIFFERENT APPROACH TO LOTS OF THIS. CONCEIVABLY, WE WOULD HAVE, AND I WOULD IMAGINE WE WOULD HAVE CROSS-EXAMINED ALL OF THE WITNESSES THAT WERE WITH THEM, MS. SEVERANCE, MS. RODDY, AND ALL OF THE OTHER PEOPLE, POTENTIALLY, IN DIFFERENT WAYS ABOUT WHAT HAS HAPPENED. AND, YOU KNOW, POTENTIALLY, HAD A DIFFERENT TAKE ON THIS.

THE EXPERTS, I MEAN, THE KNOWN UNIVERSE OF FACTS, WE ARE NOT GOING TO ASK TO GET THEM BACK IN -- SEVERAL BACK IN TO SEE MR. FULKS ABOUT THIS, OR BE ABLE TO INCORPORATE THIS, AT LEAST SOME OF THE LATER ONES. I THINK, IN THIS CIRCUMSTANCE, THAT ONE REASON YOU HAVE A NOTICE REQUIREMENT UNDER REMAINING

CIRCUMSTANCES IN CAPITAL CASES IS THAT -- SO YOU WILL HAVE NOTICE. YOU WILL BE ABLE TO RESPOND AND MEET THE CHARGES AGAINST YOU AND BE ABLE TO DEVELOP IT IN A COHERENT FASHION. WE CAN'T DO IT AT THIS POINT.

I JUST THINK THAT, YOU KNOW, IT WOULD BE INCREDIBLY PREJUDICIAL. IF THEY WANT TO GET THIS OUT, THE TIME AND PLACE TO DO IT, IF THEY THINK IT IS A REALLY IMPORTANT CRITICAL FACT, THERE WILL BE ANOTHER TRIAL IN WEST VIRGINIA AFTER THIS. THEY ARE GOING TO TRY -- A FEDERAL TRIAL IS SCHEDULED THERE, CHARGED WITH THAT. THE TIME IS TO LET THIS BE INVESTIGATED, LET THE DEFENSE LAWYERS UP THERE, WHETHER IT IS ME AND MS. NEWBERGER, SOMEBODY ELSE AND MS. NEWBERGER, LET THEM TAKE IT INTO ACCOUNT, DEAL WITH IT IN A COHERENT, RATIONAL MANNER. WE, IN WEEK THREE OF A CAPITAL CASE IN THE GOVERNMENT'S TRIAL, I CAN'T IMAGINE ANYTHING MORE PREJUDICIAL, ANYTHING MORE DEVASTATING.

THE COURT: I DON'T, FOR A SECOND, DOUBT THE SIGNIFICANCE OF THE EVIDENCE BECAUSE IT PUTS, ARGUABLY, PUTS YOUR CLIENT OF LURING IN A POTENTIAL VICTIM WHEN HE WAS APART FROM MR. BASHAM. I REALIZE HOW POWERFUL IT IS.

MR. BLUME: NOT BEING ABLE TO SAY ANYTHING ABOUT HOW WE CROSS-EXAMINED WITNESSES, HOW WE FORMULATED OUR CASE. TO DEAL WITH IT IN THE OPENING STATEMENT. IT WOULD TOTALLY UNDERMINE OUR CREDIBILITY IN EVERY RESPECT, AND I THINK IT IS THE LEGAL EQUIVALENT, IN THE THIRD WEEK OF A CAPITAL TRIAL, OF

DIRECTING A DEATH VERDICT.

THE COURT: LET ME THINK ABOUT IT OVER LUNCH.

MR. SCHOOLS: I WOULD WANT TO RAISE ONE OTHER ISSUE WITH RESPECT TO THAT WHOLE ISSUE, YOUR HONOR. YOU KNOW, UNFORTUNATELY, SOMETIMES FACTS GET IN THE WAY OF THE DEFENSE. AND, I THINK, IN SOME WAYS, THAT IS WHAT HAS HAPPENED HERE. THROUGH NO -- I DON'T INTEND TO CAST ASPERSIONS ON ANYBODY ON THE DEFENSE TEAM AT ALL. I DON'T INTEND TO DO THAT. SOMETIMES, THE FACTS GET IN THE WAY OF OF THE DEFENSE AND REALITY. THE TWO ISSUES IS, DOES THE JURY GET TO KNOW ABOUT THESE FACTS THAT ARE SQUARELY IN THE WAY OF THE DEFENSE? WHAT ARE THE DEFENSE ATTORNEYS GOING TO ARGUE NOW? I MEAN, THEY NOW HAVE THIS INFORMATION. IT IS IN THE PUBLIC DOMAIN. ARE THEY GOING TO -- IT IS IN THEIR DOMAIN ANYWAY. ARE THEY GOING TO BE ALLOWED TO STAND UP IN FRONT OF THIS JURY AND ARGUE THAT MR. FULKS DIDN'T INTEND THAT ANDREA FRANCIS AND DEANNA FRANCIS BE VICTIMS OF HE AND MR. BASHAM WHEN THE REALITY IS, APPEARS TO BE THAT, AFTER MR. BASHAM BOTCHED THE ATTEMPT TO KIDNAP DEANNA FRANCIS AT 7:21 P.M. ON NOVEMBER 17TH, 2002, MR. FULKS, UNSATISFIED, SOUGHT ANOTHER VICTIM FOR HIS PURPOSES. AND I THINK THAT IS CLEARLY CONTRARY TO ANY ARGUMENT THAT THE DEFENSE ATTORNEYS MIGHT MAKE TO THIS JURY THAT THIS DEFENDANT DID NOT INTEND THAT AS A CRIME, DID NOT INTEND DEANNA FRANCIS, AND DID NOT INTEND ALICE DONOVAN, AND SAMANTHA BURNS AS VICTIMS.

SO, THERE ARE TWO ISSUES HERE. ONE IS, DOES THE JURY HEAR ABOUT IT? WE THINK THAT ABSENT, BASED ON THE WAY IT WAS DEVELOPED, THAT THE JURY DOESN'T HEAR ABOUT IT, THEN THEIR VERDICT IS LESS LIKELY TO BE JUST. AND SECOND OF ALL, EVEN IF THE JURY DOESN'T HEAR ABOUT IT, THAT THE ABILITY OF THE DEFENSE COUNSEL TO ARGUE TO A JURY BASED ON THIS EVIDENCE, THIS DEFENDANT WAS SOMEHOW BRANDON BASHAM'S DUPE, SHOULD BE INHIBITED.

THE COURT: ALL RIGHT. I WOULD LIKE TO THINK ABOUT IT OVER LUNCH. WE TOLD THE JURY TO BE BACK AT TWO. WHY DON'T WE BE BACK AT 2:15. WE WILL TELL THE MARSHALS TO TELL THE JURORS WE WILL BE A LITTLE LATE STARTING. TAKE THEM OUT FOR SOME FRESH AIR, IF YOU WANT TO, WHEN THEY GET BACK AT TWO. ALL RIGHT. ANYTHING ELSE?

MR. SCHOOLS: NO, SIR.

THE COURT: BE IN RECESS UNTIL 2:15.

(WHEREUPON, A LUNCH RECESS WAS HELD.)

THE COURT: ON THE MATTER WE WERE DEBATING BEFORE LUNCH, I WOULD LIKE TO HOLD THAT UNDER ADVISEMENT FOR A LITTLE WHILE. I WANT MY LAW CLERK TO RESEARCH THE STATUTE REQUIRING THREE DAYS ADVANCE NOTICE OF THE WITNESS LIST OF A CAPITAL CASE. I WANT TO SEE IF THERE IS ANY CASE LAW ON THAT. I AM ASSUMING THAT THE WITNESS, MS. WARD'S MOTHER, WAS NOT LISTED AS A WITNESS?

MR. SCHOOLS: THAT'S CORRECT. WE HAVE LOOKED AT

THAT CASE LAW, AS WELL, YOUR HONOR. I WILL BE HAPPY TO ADDRESS IT.

THE COURT: YOU HAVE LOOKED AT IT?

MR. SCHOOLS: LOOKED AT SOME. THERE IS ONE CASE, I BELIEVE IT IS OUT OF THE CENTRAL DISTRICT OF CALIFORNIA, THAT IMPOSES A HEAVIER BURDEN ON THE GOVERNMENT UNDER THESE CIRCUMSTANCES THAN THE OTHER CASES. BUT, GENERALLY, THE CASE LAW SEEMS TO INDICATE THAT, WHERE INFORMATION CAME TO THE GOVERNMENT'S ATTENTION AFTER THE COMMENCEMENT OF THE TRIAL, THE VIOLATION OF THE THREE-DAY STATUTE IS INTENDED TO GIVE THE DEFENDANT THREE DAYS NOTICE AND ABILITY TO CONDUCT ANY INVESTIGATION IT MAY NEED TO CONDUCT. IF THE DEFENDANT OR THE COURT, GENERALLY, THAT SAME BASIC ACCOMMODATION OF THE EVIDENCE COMING IN.

THE COURT: ALL RIGHT. WELL, DID THEY MAKE ANY DISTINCTION BETWEEN GUILT PHASE AND PENALTY PHASE? PROBABLY NOT.

MR. SCHOOLS: NO, SIR. NOT THAT I RECALL. ONE OF OUR LAWYERS PULLED THE CASE. I READ THROUGH THEM BRIEFLY YESTERDAY AFTERNOON.

MR. BLUME: I DON'T WANT TO KEEP DOING THE SAME THING. THE THREE-DAY THING HERE WILL DO NOTHING FOR US. WE HAD STAKED OUT A POSITION. WE HAVE WAITED OUT --

THE COURT: YOU ARE SAYING, THE THREE DAYS RUNNING RIGHT NOW WON'T DO YOU ANY GOOD?

MR. BLUME: NOT A BIT.

THE COURT: THREE DAYS BEFORE THE TRIAL BEGAN DEADLINE MIGHT SAVE YOU, IS WHAT YOU ARE SAYING.

NOW, ANOTHER JUROR ISSUE. A JUROR APPROACHED MS. FLOYD YESTERDAY TO SAY THAT HER OR HIS SON, I GUESS IT IS, IS BEING DEPLOYED TO IRAQ THIS WEEKEND. THE JUROR WANTED TO SEE IF WE COULD ADJOURN FRIDAY BECAUSE THE CHILD WAS GOING TO LEAVE ON SATURDAY, AND HE WANTED TO BE WITH HIM TO HAVE DINNER AND ALL THE NIGHT BEFORE. WE LEARNED TODAY THE CHILD, ACTUALLY, SHIPS OUT AT NOONTIME ON FRIDAY, NOT SATURDAY. SO, WE NEED TO MAKE A DECISION WHETHER WE LOSE ANOTHER JUROR, OR STOP EARLY, OR TELL THEM HE WILL JUST HAVE TO SEE HIS CHILD AT HOME. HE HAS BEEN COMMUTING. ANY THOUGHTS?

MR. SCHOOLS: GENERAL THOUGHTS, ARE, YOUR HONOR, WE HAVE KIND OF BOGGED DOWN THIS WEEK, TO BE CANDID WITH THE COURT. WE HAVE A LOT OF WITNESSES THAT ARE HERE WE HOPE CAN GET TO TESTIFY TO GET OUT OF HERE. NOT TRYING TO STOP EARLY IF HE IS A LOCAL. IF HE IS A LOCAL OR, AT LEAST, A COMMUTING JUROR, CLOSE ENOUGH TO MAKE IT HOME AT NIGHT, HE STICK AROUND AND PERSEVERE.

THE COURT: ALL RIGHT. MR. BLUME, DO YOU HAVE A POSITION ONE WAY OR THE OTHER?

MR. BLUME: NO, I LEAVE IN IT THE COURT'S DISCRETION.

THE COURT: AS I WAS SAYING, I WILL SAY THAT, IN DISCUSSING THIS MATTER OVER LUNCH WITH MY LAW CLERKS, REALLY

AND TRULY HAVEN'T MADE UP MY MIND, BUT I SUGGESTED TO MY LAW CLERKS, IF I DECIDE TO ADMIT THE EVIDENCE, I MIGHT OFFER -- I MIGHT ADMIT IT UNDER CERTAIN CONTINGENCIES. THAT IS, IT BE A FULL DEVELOPMENT TO THE JURY IT WAS NOT DISCLOSED TO THE DEFENDANT UNTIL AFTER THE TRIAL BEGAN. AND, SECONDLY, OFFER THE DEFENDANT A TWO-DAY HIATUS IN THE TRIAL, WHICH I WOULD BLAME ON MYSELF IN FRONT OF THE JURY. I WOULD JUST BLAME IT ON MY SCHEDULE TO PERMIT THE DEFENDANT TWO UNFETTERED DAYS TO DO WHATEVER INVESTIGATION NEEDS TO BE DONE.

NOW, THAT MIGHT, IF THE DEFENDANT WANTED TO DO THAT, THAT MIGHT DOVETAIL WITH THE JUROR'S DESIRE TO FINISH EARLY THIS WEEK. ANYWAY, LET ME LOOK AT THESE AUTHORITIES, AND WE WILL DECIDE THAT LATER.

MR. GASSER: BEFORE THE JURY IS BROUGHT UP, I DON'T KNOW IF YOU HAVE MADE THE RULING ON THE '98 REPORT. WHEN WE PUT THE DOCTOR BACK UP ON THE STAND, I DON'T KNOW HOW MUCH MR. BLUME WILL REFERENCE THIS, BUT HE MADE REFERENCE IN HIS ARGUMENT TO YOU, HE KEEPS REFERRING TO THE BOP DOCTORS AT BUTNER AS GOVERNMENT DOCTORS. AND WHILE, TECHNICALLY, THAT IS TRUE, THEY ARE NOT PROSECUTION DOCTORS. THEY ARE NOT U. S. ATTORNEY DOCTORS. AND I KNOW, WHEN I PROSECUTED IN THE STATE SYSTEM, THE DOCTORS, PSYCHOLOGISTS, PSYCHIATRISTS AT THE HALL INSTITUTE, THE SOUTH CAROLINA STATE CIRCUIT COURT JUDGE WOULD SIGN A COMPETENCY OR ORDER A MENTAL EVALUATION, AND THAT IS WHERE THEY WOULD GO TO. I KNOW ALL OF THOSE DOCTORS AND

PSYCHOLOGISTS AND SOCIAL WORKERS. THEY DIDN'T CONSIDER THEMSELVES AS PROSECUTION WITNESSES. THEY CONSIDERED THEMSELVES, IN FACT, WITNESSES FOR THE COURT. THEY CONSIDERED THEMSELVES COMPLETELY OBJECTIVE. THEY WEREN'T FOR ONE SIDE OR THE OTHER.

I AM ASSUMING, THE EMPLOYEES AT THESE FEDERAL MEDICAL FACILITIES, I WOULD BE SHOCKED IF THESE PSYCHOLOGISTS, AND PSYCHIATRISTS, AND SOCIAL WORKERS CONSIDER THEMSELVES AN ARM OF THE PROSECUTION.

THE COURT: CAN'T YOU EXPLORE THAT WITH THE WITNESS WHEN HE IS ON THE STAND? I MEAN, RATHER THAN ME LIMIT MR. BLUME?

MR. GASSER: I DON'T HAVE A PROBLEM. THE INFERENCE THAT HE DRAWS IS WE HAVE --

THE COURT: I UNDERSTAND. WHAT I AM SAYING, RATHER THAN LIMIT MR. BLUME IN HIS CHOICE OF ADJECTIVES, I WOULD LIKE YOU TO DEVELOP IT THROUGH TESTIMONY.

MR. GASSER: THAT IS FINE.

THE COURT: ALL RIGHT. BRING IN THE JURY, PLEASE.

(WHEREUPON, THE FOLLOWING WAS HEARD IN THE PRESENCE OF THE TRIAL JURY.)

THE COURT: IF THE WITNESS WILL RESUME THE STAND. MR. BLUME, YOU CAN RESUME YOUR DIRECT EXAMINATION.

BY MR. BLUME:

Q. DR. GUR, BEFORE THE LUNCH BREAK, WE WERE TALKING ABOUT

YOUR TESTING THAT YOU CONDUCTED IN THIS CASE. AND PREVIOUS TO THAT, WE WERE TALKING ABOUT THE DIFFERENT TYPES OF TESTS WHICH HAVE BEEN DONE ON MR. FULKS. WE TALKED ABOUT THE MRI SCAN. THEN WE TALKED ABOUT THE PET SCAN. AND THEN WE TALKED ABOUT THE NEUROPSYCHOLOGICAL TESTING. AND ONE ISSUE I WOULD LIKE TO ADDRESS, BEFORE WRAPPING UP HERE, IS WHAT IS KNOWN AS THE QUESTION OR SOMETIMES WHAT IS REFERRED TO AS MALINGERING. OR ANOTHER WORD FOR IT, MORE COMMONSENSE WORD, IS FAKING.

NOW, AS I UNDERSTAND IT, AND CORRECT ME IF I AM WRONG, THAT THE MRI SCAN IS, BASICALLY, A TYPE OF A PICTURE OF THE BRAIN?

A. YOU ARE RIGHT.

Q. SO, I MEAN, NOBODY, NO MATTER WHAT THEIR MOTIVATION, NO MATTER WHAT THEIR DESIRE, CAN FAKE WHAT IS ON AN MRI SCAN?

A. THAT IS CORRECT. THE ONLY THING THAT ONE CAN DO, IF THEY DON'T WANT TO COOPERATE, IS MOVE WHEN THE SCAN IS DONE. AND THAT WILL CREATE MOTION ARTIFACTS. IF THEY ARE VERY SEVERE, MAKE THE SCAN DIFFICULT TO INTERPRET.

Q. BUT THAT, OBVIOUSLY, DID NOT HAPPEN HERE?

A. NO, NO.

Q. THERE IS NO INDICATION OF MOVEMENT IN THIS MRI SCAN?

A. NO, NO, NO. YOU CAN SEE MOVEMENT VERY EASILY ON MRI. THERE IS NO MOVEMENT.

Q. AND IS THE SAME TRUE WITH THE PET SCAN?

A. THE SAME IS TRUE FOR THE PET SCAN, YES.
Q. I MEAN, IN OTHER WORDS, IT IS A DIFFERENT TYPE OF IMAGE OR PICTURE OF THE BRAIN, AND, YOU KNOW, YOU CAN'T FAKE IT. WHAT IS THERE IS THERE?
A. NO, YOU CAN'T.
Q. OKAY. WELL, THEN, THAT BRINGS US TO THE THIRD COMPONENT OF YOUR TESTIMONY, WHICH IS THE NEUROPSYCHOLOGICAL TESTING. AND IN THE TESTING OF THAT, YOU WERE AWARE OF, IN THIS CASE THAT YOU REVIEWED, YOU REVIEWED THE RAW DATA OF DR. VENN'S TESTING?
A. CORRECT.
Q. YOU REVIEWED THE RAW DATA OF DR. EVANS' TESTING?
A. YES.
Q. AND WAS THERE ANY INDICATION OF MALINGERING OR FAKING IN THAT TEST DATA?
A. WELL, AS YOU CAN IMAGINE, IT IS POSSIBLE TO FAKE, MALINGER, AND, THEREFORE, BOTH DR. VENN AND DR. EVANS USED SPECIAL TESTS THAT ARE DESIGNED TO DETECT MALINGERING OR FAKING. AND ALL OF THOSE TESTS INDICATED, CLEARLY, THAT THERE WAS NO FAKING OF THOSE TESTS.
Q. I MEAN, THE REASON I ASK, AND JUST TO CUT TO THE CHASE, ARE YOU AWARE OF THE FACT THAT, IN 1998, MR. FULKS WAS EVALUATED BY, FOR A DIFFERENT OFFENSE, WAS EVALUATED BY MENTAL HEALTH PROFESSIONALS AT THE FEDERAL BUREAU OF PRISONS, YOU ARE AWARE OF THAT?

A. YES, I SAW THAT REPORT.
Q. AND YOU ARE AWARE OF THE FACT, ARE YOU NOT, THAT AT LEAST AT THAT TIME, IN 1998, THEY DETERMINED THAT HE WAS -- THEY SAID MALINGERING, BUT JUST IN LAY TERMS, THAT MEANS HE WAS FAKING; IS THAT RIGHT?
A. YES, THAT'S RIGHT.
Q. IN OTHER WORDS, THAT HE WAS TRYING TO, THAT HE -- HE TOOK THE TEST, AND WHEN THEY SCORED THE TEST, THEY DETERMINED THAT THE TEST RESULTS WERE INCONSISTENT WITH WHAT THEY SAW?
A. THEY ALSO CONCLUDED A TEST THAT WAS DESIGNED TO DETECT MALINGERING, AND THE TEST INDICATED THAT HE WAS NOT MALINGERING.
Q. OKAY. AND ALTHOUGH -- SO THAT JUST RAISED THE QUESTION. I UNDERSTAND YOU CAN'T FAKE THE MRI, YOU CAN'T FAKE THE PET. THAT IS WHAT IT IS. SO, YOU CAN IMAGINE HOW IT WOULD RAISE A QUESTION IN A JUROR'S MIND, WELL, IF HE FAKED IN 1998, AND HE TOOK SOME OF THESE TESTS THAT HE TRIED TO FAKE IT, HOW CAN WE BE SURE HE IS NOT FAKING THIS?
A. THAT IS PERFECTLY UNDERSTANDABLE.
Q. WELL, IT IS AN UNDERSTANDABLE QUESTION. WHAT IS YOUR RESPONSE TO IT?
A. I THINK IT IS A VERY IMPORTANT CONCERN, PARTICULARLY WHEN, IN THE MEDICAL/LEGAL CONTEXT, WHEN SOMEONE IS PRESENTED WITH A SITUATION WHERE, IF THEY DON'T PERFORM WELL, THEY MAY COME OUT WITH A BETTER RESULT. SO, THERE IS MOTIVATION TO

FAKE, AND THAT IS WHY IT IS IMPORTANT TO INCLUDE MEASURES THAT ARE SENSITIVE TO EFFORTS TO FAKE.

BOTH DR. VENN AND DR. EVANS WERE SENSITIVE TO THAT ISSUE AND, THEREFORE, INCORPORATED MEASURES OF FAKING. AND UNLIKE 1998, WHERE THE MEASURES OF FAKING INDICATED THAT HE WAS, IN THE RECENT EVALUATION, THERE WAS CLEAR INDICATION THAT HE WASN'T.

Q. ARE YOU ALSO AWARE THAT, IN 2003, HE WAS EVALUATED, NOT ONLY BY DR. VENN AND DR. EVANS, BUT ALSO BY PSYCHOLOGISTS AT ANOTHER FEDERAL BUREAU OF PRISONS FACILITY IN BUTNER, NORTH CAROLINA?

A. YES, I SAW THAT REPORT.

Q. AND, BASED UPON YOUR REVIEW OF THAT REPORT, DID THE MENTAL HEALTH PROFESSIONALS AT BUTNER DETECT ANY MALINGERING WHEN THEY EVALUATED HIM IN 2003?

A. NO. THEY THREW AT HIM THE BEST, NEWEST TEST MEASURES OF MALINGERING. AND FROM HIS PERFORMANCE, AGAIN, IT IS CLEAR THAT HE WAS NOT MALINGERING WHILE BEING TESTED AT BUTNER.

Q. AND WHEN YOU EVALUATED MR. FULKS THIS YEAR, I ASSUME THAT, IN ADDITION, I MIGHT BE WRONG, BUT I ASSUME THAT, IN ADDITION TO SPECIFIC TESTS FOR MALINGERING, SOME OF IT IS ALSO BASED UPON YOUR EXPERIENCE?

A. WELL, ULTIMATELY, THE JUDGMENT OF MALINGERING IS A CLINICAL JUDGMENT. THE TESTS GIVE YOU AN INDICATION AND

SOMETIMES GIVE YOU A VERY STRONG AND CLEAR INDICATION. BUT, ULTIMATELY, IT IS BASED ON YOUR EXPERIENCE AND LOOKING AT THE PERFORMANCES. AND HIS PERFORMANCE, WHEN I TESTED HIM, IT WAS QUITE APPARENT THAT HE WAS MAKING AN EFFORT TO DO THE BEST HE CAN, AND HE WAS FRUSTRATED WHEN HE WAS NOT ABLE TO PERFORM WELL. AND HE DID PERFORM WELL IN SEVERAL TESTS.

SO, THE DEFICIT IS, WHAT YOU GET WITH MALINGERERS IS, BECAUSE THEY DON'T KNOW WHAT TESTS MIGHT BE IMPORTANT AND WHAT MIGHT NOT BE IMPORTANT, THEY WOULD TEND TO JUST DO MORE POORLY ACROSS-THE-BOARD. AND THAT IS PART OF THE RATIONALE FOR MALINGERING TESTS. ESSENTIALLY, YOU GIVE PEOPLE A TEST THAT EVEN SOMEONE WITH ADVANCE ALZHEIMER'S WOULD DO WELL ON. IT IS DISGUISED AS BEING MORE DIFFICULT THAN IT REALLY IS. AND SO, ONE WHO IS TRYING TO FAKE WOULD DO POORLY ON A TEST THAT EVEN PEOPLE WITH SEVERE BRAIN DAMAGE DO WELL ON. AND THAT -- NONE OF THAT HAPPENED IN MR. FULKS'S TESTING, EITHER IN MY -- THE TESTING THAT I DID, OR THE TESTING DONE AT BUTNER, OR THE TESTING DONE BY DOCTORS EVANS AND VENN.

Q. AND SO, JUST TO SORT OF SUMMARIZE, IS WHAT YOU ARE SAYING IS THAT, BASED UPON YOUR REVIEW OF THE TESTING BY DR. VENN AND DR. EVANS, BY THE MENTAL HEALTH PROFESSIONALS AT BUTNER, AND IN YOUR CLINICAL JUDGMENT, MR. FULKS IS NOT MALINGERING IN TAKING THESE NEUROPSYCHOLOGICAL TESTS?

A. THAT IS CORRECT.

Q. IS IT ALSO ACCURATE TO SAY, THE RESULTS FROM THE

NEUROPSYCHOLOGICAL TESTING WERE CONSISTENT WITH THE DEFICITS AND THE ABNORMALITIES FOUND ON THE MRI SCAN AND THE PET SCAN?

A. YES. AND THAT IS REALLY WHAT CONVINCES ME MORE THAN ANYTHING ELSE. HE WOULD HAVE HAD TO KNOW QUITE A BIT OF MY FIELD. HE WOULD HAVE TO TAKE A COUPLE OF COURSES TO BE ABLE TO GENERATE A PATTERN OF BEHAVIORAL DEFICIT THAT WILL FIT THE PATTERN OF ABNORMALITIES THAT WE SEE ON THE BRAIN IMAGES. AS FAR AS I KNOW, HE DOESN'T HAVE THAT KNOWLEDGE.

Q. BUT, AGAIN, NO MATTER HOW SORT OF MOTIVATED YOU ARE TO HELP YOURSELF, YOU CAN'T FAKE WHAT IS ON THE MRI, YOU CAN'T FAKE WHAT IS ON THE PET?

A. THAT'S CORRECT. YOU CAN'T FAKE EITHER OF THOSE.

Q. DR. GUR, WHAT I WANTED TO MOVE TO NOW IS SORT OF, I GUESS, WHAT I WOULD CALL THE BOTTOM LINE. WE TALKED ABOUT THE ABNORMALITIES IN MR. FULKS'S BRAIN; WE TALKED ABOUT THE ABNORMALITIES WE SAW ON THE MRI; TALKED ABOUT THE ABNORMALITIES ON THE PET SCAN; TALKED ABOUT THE ABNORMALITIES FOUND IN THE NEUROPSYCHOLOGICAL TESTING. AND, SO, I GUESS THE REAL QUESTION IS, OKAY, HE HAS GOT AN ABNORMAL BRAIN. IT IS ABNORMAL IN ALL OF THESE DIFFERENT AREAS. SO, WHAT DOES IT MEAN?

A. ONE OTHER POINT, IF I MADE IT, WE DIDN'T GET INTO IT WHEN I SAW THE ORBITAL FRONTAL SIGNS. AS YOU KNOW, I ASKED FOR ONE MORE TEST TO BE ADMINISTERED TO HIM, WHICH IS AN OLFACTORY TEST. THE REASON IS THAT THE OLFACTORY BULB IS

RIGHT UNDER THE ORBITAL LOBE, SO IT IS IMPOSSIBLE TO GET -- DAMAGE THE ORBITAL CORTEX WITHOUT DAMAGING SOMEWHAT OF THE OLFACTORY BULB. THAT TEST INDICATED THAT HE HAS DIFFICULTIES SMELLING, WHICH IS EXACTLY WHAT YOU WOULD EXPECT, BASED ON THAT SPECIFIC REGION.

SO, WHEN YOU PUT ALL OF IT TOGETHER, IT IS CLEAR THAT HE HAS AN ABNORMAL ANATOMY. AND THE MAIN REGIONS THAT ARE INVOLVED ARE THE FRONTAL EXECUTIVE PART, THE TEMPORAL MEMORY PART, THE CORPUS CALLOSUM, WHICH IS AN AREA THAT DR. BOOKSTEIN WILL FOCUS ON. HE HAS ABNORMAL PHYSIOLOGY AND, AGAIN, WE SEE IN THE SAME REGIONS, IN THE FRONTAL, TEMPORAL, AND THEN THE PHYSIOLOGY SHOWS, ALSO, REDUCED ACTIVITY IN THE THALAMUS, THE SWITCHBOARD, THE FUSIFORM GYRUS, THE PART THAT LOOKS AT FACES AND COMPLEX FACIAL ASPECTS, AND THE RIGHT CEREBELLUM, WHICH IS RESPONSIBLE FOR THE TREMOR, FOR THE RIGHT HAND TREMOR, AND THOSE KINDS OF SIGNS.

MR. GASSER: YOUR HONOR, MAY WE APPROACH, PLEASE?

(WHEREUPON, A BENCH CONFERENCE WAS HELD.)

MR. GASSER: WE HAD, SPECIFICALLY, ON THE RECORD, MR. SCHOOLS AND MR. THURMOND AND I, WE HAD SPECIFICALLY DISCUSSED WHEN WE WERE DISCUSSING ALL OF THESE MENTAL HEALTH ISSUES WHETHER THEY WOULD HAVE ANY EXPERTS COME IN HERE TALKING ABOUT MENTAL RETARDATION.

MR. BLUME: I WILL NOT SAY HE IS MENTALLY RETARDED.

THE COURT: YOU THOUGHT HE WAS HEADING IN?

MR. BLUME: I'M SORRY. I WILL HAVE HIM AFFIRMATIVELY SAY HE IS NOT.

(WHEREUPON, THE BENCH CONFERENCE CONCLUDED.)

MR. GASSER: THANK YOU, YOUR HONOR.

THE WITNESS: AND IF YOU LOOK AT THE BEHAVIORAL ABNORMALITIES, THE DEFICITS ARE EXACTLY WHAT YOU WOULD EXPECT IF YOU PUT THESE IN EXECUTIVE FUNCTIONING MEMORY, IN THE VIGILANTS, THAT IS THE SWITCHBOARD PART, AND SENSORY MOTOR FUNCTION.

Q. SO, BASICALLY, THAT IS REAFFIRMING YOUR POINT ANATOMICALLY, PHYSIOLOGY, AND BEHAVIORALLY, HIS BRAIN IS BAD?

A. AND IN ABOUT THE SAME PLACES.

Q. AND SO, THEN YOU PREVIOUSLY DISCUSSED, AS I UNDERSTAND IT, THAT HIS BRAIN IS DAMAGED IN WAYS WHICH ARE CONSISTENT WITH FETAL EXPOSURE TO ALCOHOL?

A. YES. YOU CAN TRY TO GAUGE THE AGE AT WHICH DAMAGE OCCURRED. THE DIFFERENT STAGES OF DEVELOPMENT, THE DAMAGE WOULD RESULT IN A DIFFERENT WAY OF ADJUSTING. AS THE BRAIN IS GROWING, IN SOME WAYS, IT IS GOOD IF THE DAMAGE OCCURS TO A YOUNG BRAIN BECAUSE THE SAME DAMAGE OCCURRED TO A YOUNG AND ELDERLY BRAIN COULD KILL THE ELDERLY, AND THE YOUNG WOULD STILL SURVIVE. BUT THE FLIP SIDE OF THAT SAME COIN IS THAT, THE EARLIER THE DAMAGE, THE MORE THERE WILL BE ABNORMALITIES DOWN THE STREET, AND THE BRAIN WILL JUST LOOK MISSHAPED.

IT IS THE SAME WAY IF YOU TAKE THE ANALOGY OF A TREE THAT

GETS STRUCK BY LIGHTNING. IF IT IS AN OLD TREE, YOU WILL SEE THE SIGN OF THE LIGHTNING, YOU WILL SEE THE BURNING, YOU WILL ALWAYS LOOK AT THE TREE AND SAY, THIS IS A TREE HIT BY LIGHTNING. IF THE TREE IS HIT WHEN IT IS YOUNG, IT WILL STILL GROW TO FULL SIZE, MAY LIVE AS LONG AS A NORMAL TREE. BUT BECAUSE OF IT, IT WOULD BE MISSHAPEN. THE TRUNK WILL NOT BE QUITE WHERE IT SHOULD BE. THE BRANCHES WILL COME OUT BEFORE THEY ARE SUPPOSED TO, OR AFTER THEY ARE SUPPOSED TO, AND YOU WILL SEE THAT THERE IS SOMETHING SERIOUSLY MISSHAPEN ABOUT THAT TREE. AND YET, THE TREE HAS SURVIVED.

THE BRAIN IS THE SAME WAY. IT KEEPS TRYING TO REPAIR ITSELF. AND IN THAT PROCESS, PRODUCES ANOMALIES, SOME SUGGEST BEING LARGE, SOME BEING SMALL FOR THE KIND OF ENERGY THAT HAPPENS VERY EARLY. THE REASON I AM THINKING OF FETAL ALCOHOL IS BECAUSE THE REGIONS ARE EXACTLY THOSE REGIONS THAT YOU SEE AFFECTED BY ALCOHOL. THESE ARE PARTS OF THE BRAIN THAT ALCOHOL LIKES TO GO TO, AND ACTIVATE, AND DESTROY.

Q. AND THEN AS I TAKE IT, BUT THERE WERE ALSO ABNORMALITIES, AS I UNDERSTAND YOUR TESTIMONY, ABOVE AND BEYOND WHAT YOU WOULD, NECESSARILY, EXPECT FROM FETAL EXPOSURE TO ALCOHOL?

A. YES.

Q. AND THEN I BELIEVE YOU INDICATED THE TWO MOST LIKELY CAUSES OF THAT ARE HEAD INJURIES AND SUBSTANCE ABUSE?

A. CORRECT.

Q. I MEAN, HEAD INJURIES WOULD RESULT IN LOSS OF CONSCIOUSNESS OR -- I GUESS ANY TYPE OF HEAD INJURY COULD CONCEIVABLY AFFECT THE BRAIN?

A. WE USED TO THINK THERE IS NO LOSS OF CONSCIOUSNESS, THEN THERE WAS NO STRUCTURAL DAMAGE. BUT THAT IS, CLEARLY, INCORRECT. THERE ARE SOME, DEPENDING UPON WHERE YOU GET THE BLOW, SOME BLOWS WILL PRODUCE LOSS OF CONSCIOUSNESS MORE THAN OTHERS. AS A RULE, IT IS, YOU DON'T GET A LOT OF TISSUE DAMAGE IF THERE IS NO LOSS OF CONSCIOUSNESS, BUT THERE HAVE BEEN DOCUMENTED CASES WHERE NO LOSS OF CONSCIOUSNESS OCCURRED AND YET, THERE IS STRUCTURAL DAMAGE.

IN THE CASE OF MR. FULKS, THERE WERE NUMEROUS INSTANCES OF HEAD INJURIES WITH LOSS OF CONSCIOUSNESS. AND THOSE THAT ARE MOST WORRISOME ARE THOSE THAT WERE HIT STRAIGHT ON TOP OF HIS HEAD BECAUSE THEY WOULD AFFECT THE VERY SAME REGIONS THAT WERE ALREADY SUSCEPTIBLE BECAUSE OF THE FETAL ALCOHOL EXPOSURE.

Q. BUT, AGAIN, THE BOTTOM LINE IS, BASED UPON THE MRI AND THE PET SCAN, YOU CAN CLEARLY SEE ABNORMALITIES IN THE BRAIN ABOVE AND BEYOND WHAT YOU WOULD EXPECT FROM FETAL ALCOHOL?

A. YES.

Q. AND YOU ALSO HAVE IMPOVERISHED, STRESSFUL ENVIRONMENT. WHY IS THAT AN ELEMENT?

A. WE USED TO THINK THE ENVIRONMENT DOESN'T REALLY CHANGE THE BRAIN. BUT THERE IS MORE AND MORE EVIDENCE THAT SOME

BRAIN STRUCTURES ARE HIGHLY SENSITIVE TO ENVIRONMENTAL STRESS. AND EVEN PEOPLE NOW THAT WE CAN LOOK AT PEOPLE WHEN THEY ARE ALIVE, PEOPLE WERE STUDIED BEFORE AND AFTER STRESSFUL EVENTS, WAS A JAPANESE STUDY ON PEOPLE, WITH FLOOD AND EARTHQUAKES. YOU CAN ACTUALLY SEE STRUCTURAL CHANGES AND, PARTICULARLY, SEE THEM IN THEIR REGION CALLED THE HIPPOCAMPAL. PROLONGED STRESS DOES ALSO IMPACT THE BRAIN, THE BRAIN FUNCTION.

Q. WHAT IS THE BOTTOM LINE. HE HAS A HIGHLY ABNORMAL BRAIN?

A. THAT IS VERY CLEAR.

Q. AND AREAS THAT ARE MOST AFFECTED, THE EXECUTIVE FUNCTIONING AND, AGAIN, JUST BRIEFLY, WHAT IS THE EXECUTIVE FUNCTIONING?

A. IT IS THE PART THAT TELLS YOU STOP, THINK ABOUT THE CONTEXT, THINK ABOUT YOUR LONG-TERM GOALS, AND ACT IN ACCORDANCE WITH WHAT IS GOOD FOR YOU.

Q. SO, THAT WOULD AFFECT THINGS LIKE JUDGMENT, IMPULSE CONTROL?

A. MOSTLY IMPULSE CONTROL, BECAUSE THAT IS THE PART THAT HOLDS THE ANALAGOUS LINE IN CHECK, AS WELL AS JUDGMENT.

Q. DECISION MAKING?

A. DECISION MAKING.

Q. THAT IS ONE AREA THAT IS AFFECTED. THEN YOU TALK ABOUT SWITCHBOARD. AGAIN, WHAT IS THAT?

A. THAT IS THE THALAMUS. THE THALAMUS, IN ORDER FOR THE

EXECUTIVE TO MAKE GOOD DECISIONS, THEY NEED TO HAVE THE INFORMATION COME FROM THE RIGHT PLACES. AND WHEN THE SWITCHBOARD IS SENDING INFORMATION TO THE WRONG PLACES, IT IS HARD FOR THE EXECUTIVE TO GAUGE, EVEN IF THE EXECUTIVE WAS INTACT, IT IS HARD FOR THE EXECUTIVE TO COME UP WITH APPROPRIATE DECISIONS. AND SO, ALONG WITH THE EXECUTIVE IS IMPAIRED, AND IT IS WORKING ON BAD INFORMATION THAT, INEVITABLY, WILL LEAD TO A LOT OF BAD DECISIONS.

Q. THAT IS A DOUBLE WHAMMY TO THE THINKING PROCESS?

A. YES.

Q. AFFECT?

A. THAT IS THE ABILITY TO UNDERSTAND AND COMMUNICATE EMOTION. WE MEASURE THE VERY NARROW FACET OF THAT IS THE ABILITY TO INTERPRET FACIAL EXPRESSIONS OF EMOTION. HE WAS IMPAIRED IN THAT.

Q. NOW, JUST TO MAKE CLEAR HERE, YOU ARE NOT SAYING THAT MR. FULKS IS LEGALLY INSANE? IN OTHER WORDS, THAT HE DIDN'T KNOW THE DIFFERENCE BETWEEN RIGHT AND WRONG?

A. NO. HE IS MORE LIKE THAT ADOLESCENT. IF YOU ASKED HIM, AFTER THE FACT, DID YOU KNOW THAT WHAT YOU DID WAS WRONG? YEAH. THEY CAN EXPLAIN BETTER THAN YOU CAN EXPLAIN WHAT IS RIGHT AND WHAT IS WRONG, EXCEPT AT THE MOMENT THE BRAIN DOESN'T WORK EFFICIENTLY ENOUGH TO RELAY THAT INFORMATION TO THE EXECUTIVE AND ALLOW THE EXECUTIVE TO MAKE AN INFORMED DECISION OF THAT TOPIC.

Q. AND YOU ARE NOT SAYING THAT MR. FULKS IS MENTALLY RETARDED?

A. WELL, NO, I DON'T. I AM NOT SAYING HE IS RETARDED. HE IS CLEARLY NOT A VERY BRIGHT INDIVIDUAL. HE IS LESS INTELLIGENT THAN THE AVERAGE PERSON.

Q. AS I UNDERSTAND, HIS OVERALL IQ FALLS IN THE HIGH SEVENTIES, WHICH PUTS IT IN THE SORT OF THE BORDERLINE RANGE?

A. JUST AT THE BORDERLINE. A FEW MORE POINTS -- LESS POINTS, HE WOULD HAVE PASSED THE THRESHOLD; A FEW MORE POINTS, HE WOULD BE IN THE NORMAL RANGE. THE IQ, ITSELF, IS SORT OF A FRUIT SALAD. YOU TAKE ALL OF THE ABILITIES, YOU MEASURE AND MIX THEM TOGETHER AND COME UP WITH ONE NUMBER. WHEN REALLY, AS WE ALL KNOW, THERE ARE DIFFERENT THINGS THAT WE HAVE TO DO FOR OUR INTELLIGENCE. AND EVERYBODY HAS SOME STRENGTH AND SOME WEAKNESSES.

AND SO, IN SOME AREAS, HE IS WEAK ENOUGH TO BE WELL BELOW WHAT WE WOULD CALL A THRESHOLD FOR RETARDATION. IF YOU DIVIDE THE INTELLIGENCE INTO THE DIFFERENT COMPONENTS, WELL ONLY ONE OF THEM IS EXECUTIVE, ANOTHER ONE IS MEMORY. ANOTHER ONE IS VISUAL SPATIAL PROCESSING. IN A REGULAR IQ MEASURE, YOU HAVE ALL OF THOSE MEASURES. YOU COME UP WITH ONE NUMBER. THAT ONE NUMBER, WHEN YOU DO IT WITH MR. FULKS, COMES UP ON THE BORDERLINE SLIGHTLY ABOVE THE CUT OF RETARDATION. BUT A LOT OF THE MEASURES THAT GO INTO THAT FRUIT SALAD ARE BELOW THAT, WELL BELOW THAT THRESHHOLD.

Q. SOME ARE ABOVE AND SOME ARE BELOW?
A. YES.
Q. THE OVERALL COMPONENT PUTS HIM IN THE BORDERLINE?
A. EXACTLY.
Q. NOW, IF YOU -- I JUST WANTED TO SORT OF ASK YOU ONE MORE THING, WHICH I FORGOT TO ASK ABOUT AND GO BACK. NOW, YOU WERE TALKING ABOUT THE EFFECTS OF THE STRESSFUL ENVIRONMENT. IF MR. FULKS, LET'S SAY, HAD BEEN, YOU KNOW, BORN JUST LIKE HE WAS AND ADOPTED, AND JUST, HYPOTHETICALLY, ADOPTED AND PUT IN A LOVING, SUPPORTING, NURTURING FAMILY, WOULD HE LIKELY HAVE THE SAME BRAIN FUNCTION THAT HE DOES TODAY?
A. IT IS UNLIKELY THAT IT WOULD BE ANYTHING DIFFERENT ABOUT THESE MRI OR HIS PET SCAN. BUT BEHAVIOR IS, TOO, A LARGE EXTENT SHAPED BY YOUR UPBRINGING. IT IS NOT ALL BIOLOGY. YOU CAN TAKE THE SAME KID AND USE THE ENVIRONMENT IN ORDER TO GIVE HIM A BETTER EXECUTIVE. WHEN THE EXECUTIVE IS NOT WORKING WELL, THEN, IN FACT, THOSE INDIVIDUALS TEND TO BE EVEN MORE LIKELY TO ACCEPT DIFFERENT STRUCTURES. THEY LIKE STRUCTURE, AND THEY REALIZE THERE IS SOMETHING WRONG IN THEIR OWN EXECUTIVE, SO THEY ARE LOOKING FOR GUIDANCE. IF YOU GUIDE THEM WELL, THEY CAN TURN OUT BEING FINE. IF THEY ARE GUIDED OTHERWISE, THEY CAN TURN OUT TO BE VERY DIFFICULT.
Q. JUST TO MAKE SURE I UNDERSTAND YOUR LAST STATEMENT. EVEN ASSUMING HE HAD BEEN, YOU KNOW, BORN IN AN ADOPTIVE

FAMILY, HE WOULD STILL HAVE DIFFICULTIES?

A. YES.

Q. THEY JUST PROBABLY WOULDN'T BE THE SAME MAGNITUDE THAT THEY ARE NOW?

A. THAT IS EXACTLY WHAT I AM TRYING TO SAY.

MR. BLUME: I OFFER DEFENDANT'S EXHIBIT 8.

MR. GASSER: NO OBJECTION.

THE COURT: ALL RIGHT. WITHOUT OBJECTION.

MR. BLUME: DR. GUR, IF YOU WOULD PLEASE ANSWER ANY QUESTIONS THAT MR. GASSER MAY HAVE.

THE COURT: CROSS-EXAMINATION.

CROSS EXAM

BY MR. GASSER:

Q. GOOD AFTERNOON, DR. GUR.

A. GOOD AFTERNOON.

Q. MY NAME IS JOHNNY GASSER. I WORK IN THE U. S. ATTORNEY'S OFFICE HERE IN COLUMBIA, SOUTH CAROLINA. AND YOU AND I HAVE NOT HAD AN OPPORTUNITY TO MEET; IS THAT CORRECT?

A. THAT'S CORRECT. NICE TO MEET YOU.

Q. WE JUST HAD, ACTUALLY, WHEN WE GOT BACK FROM WORK YESTERDAY AFTER INTERVIEWING SOME WITNESSES, ME AND MY COLLEAGUES LOOKED ON MR. SCHOOLS'S COMPUTER, AND WE JUST GOT YOUR REPORT E-MAILED TO US LAST NIGHT OR YESTERDAY MORNING, BUT WE DIDN'T GET TO LOOK AT IT UNTIL LAST NIGHT. SO, I WANT YOU TO BEAR WITH ME. I MIGHT NOT BE UNDERSTANDING SOME

OF THE THINGS THAT IS INCLUDED IN YOUR REPORT. ANYTIME YOU WANT TO CLARIFY A POINT, FEEL FREE TO DO SO, OKAY, SIR?

A. SURE.

Q. WHEN WERE YOU RETAINED IN THIS MATTER, DR. GUR?

A. AS I RECALL, IT WAS TOWARD THE END OF 2003.

Q. WOULD YOU AGREE WITH ME THAT HUNDREDS OF THOUSANDS, IF NOT MILLIONS, OF AMERICANS THAT ARE ALIVE TODAY, HAVE SOME SORT OF BRAIN ABNORMALITY?

A. YES.

Q. INCLUDING, FROM THE LOWEST DEGREE TO THE HIGHEST DEGREE, IS THAT A FAIR STATEMENT?

A. I THINK, YEAH. I MEAN, WE SOMETIMES EVEN FIND IT IN COLLEGE UNDERGRADUATES WHO VOLUNTEER FOR AN EXPERIMENT.

Q. EPILEPSY, THAT INVOLVES A BRAIN ABNORMALITY?

A. YES.

Q. DO YOU EVEN KNOW THE NUMBER OF EPILEPTICS THAT LIVE IN THE UNITED STATES. COULD YOU FATHOM A GUESS?

A. I UNDERSTAND THE PREVALENCE IS QUITE HIGH. IT IS CLOSE TO ALMOST ONE PERCENT.

Q. YOU MENTIONED ALMOST ONE PERCENT OF THE POPULATION, WHICH IS APPROACHING 290 MILLION?

A. YES. NO. I MEAN, OUR POPULATION DOES.

Q. ABOUT ONE PERCENT?

A. OUT OF 290 MILLION, RIGHT.

Q. ONE PERCENT OF THE POPULATION HAS EPILEPSY?

A. SOME FORM OF EPILEPSY.

Q. SOME FORM OF EPILEPSY. IF MY MATH IS CORRECT, THAT IS CLOSE TO 3 MILLION PEOPLE?

A. YES.

Q. YOU MENTIONED ALZHEIMER'S DISEASE. OF COURSE, AT THE EARLY STAGES, PEOPLE CAN BE DIAGNOSED WITH ALZHEIMER'S DISEASE, AND FOR SOME PEOPLE, FOR SEVERAL YEARS, CONTINUE TO, AT LEAST, BE ABLE TO INTERACT WITH THEIR FAMILY, THEIR LOVED ONES, PEOPLE IN THE COMMUNITY; IS THAT CORRECT, SIR?

A. THAT IS CORRECT, YES.

Q. PEOPLE CAN HAVE A SLIGHT PARALYSIS OR SOME SORT OF PARALYSIS IN A PORTION OF THEIR BODY, WHICH, OBVIOUSLY, IS A DIRECT RESULT OF SOME SORT OF BRAIN ABNORMALITY; IS THAT CORRECT, DR. GUR?

A. WELL, IT DEPENDS IF IT IS CHILDREN OR ELDERLY PEOPLE. IF IT IS DYSTROPHY OR STROKE, BUT, YES, THE ANSWER IS YES.

Q. I, MYSELF, HAD A BAD STUTTERING PROBLEM AS A CHILD. AND THAT HAD SOMETHING TO DO WITH, APPARENTLY, SOME SORT OF ABNORMALITY THAT HAS, AT LEAST, BETTERED ITSELF. BUT PEOPLE WHO STUTTER, THAT CAN BE DIRECTLY?

A. WELL, STUTTERING HAS BEEN STUDIED, AND AS FAR AS I KNOW, THERE IS NO STRUCTURAL DAMAGE IN STUTTERERS.

Q. MY COLLEAGUES TELL ME I HAVE A TWITCH. AND SOME PEOPLE HAVE NERVOUS TWITCHES OR BODY MANNERISMS CAN BE DIRECTLY RELATED TO POSSIBLY, NO MATTER HOW SLIGHT, SOME SORT

OF BRAIN ABNORMALITY, OR SOME CONDITION, OR SOMETHING GOING ON IN THE BRAIN?

A. SOME OF IT COULD BE, SOME OF IT COULD BE LEARNED. IN SEVERE CASES, LIKE TOURETTE SYNDROME, THEN IT WOULD BE MORE THAN A TWITCH. IF YOU FIND YOURSELF CURSING WITHOUT MEANING TO, THEN MAYBE.

Q. WELL, I AM GLAD YOU WEREN'T IN MY OFFICE LAST NIGHT. I COULD GO ON AND ON. EYE PROBLEMS. MANY EYE PROBLEMS THAT ARE ASSOCIATED. PEOPLE WHO HAVE PROBLEMS WITH SIGHT CAN BE ASSOCIATED WITH BRAIN ABNORMALITIES?

A. THAT IS LESS FREQUENT, BUT, YES.

Q. HEARING IMPAIRMENT?

A. WELL, HEARING IMPAIRMENT IS USUALLY PERIPHERAL, SO THERE IS SOMETHING WRONG WITH THE MACHINERY IN THE EARS. BUT IT CAN GET, FOR EXAMPLE, HEARING IMPAIRMENT WITH A TUMOR GROWING RIGHT ON THE NERVE THAT SUPPLIES THE TEMPORAL LOBE.

Q. WOULD YOU ALSO AGREE THAT MANY PEOPLE THAT HAVE SOME OF THE BRAIN ABNORMALITIES, I KNOW THERE ARE MANY, MANY, MANY MORE THAT I DON'T NEED TO GET INTO, THEN THERE ARE SECONDARY AFFECTS. PEOPLE THAT -- THERE MAY BE EMOTIONAL OR MENTAL AFFECTS AS A RESULT OF THAT. PEOPLE GET DEPRESSED, OR PEOPLE DEVELOP OTHER CONDITIONS BECAUSE THEY LOST THE USE OF THEIR RIGHT ARM, OR THEY HAVE PROBLEMS WITH VERTIGO, OR THEIR EPILEPTIC CONDITION HAS CREATED OTHER BEHAVIORAL AND EMOTIONAL PROBLEMS. YOU WOULD AGREE WITH THAT, WOULD YOU NOT, SIR?

A. I AM AFRAID I CAN'T ANSWER IT IN A SIMPLY "YES" OR "NO," BECAUSE THERE IS A DIFFERENCE. FOR EXAMPLE, IF YOU LOSE AN ARM, AND YOU GO THROUGH A PERIOD OF DEPRESSION BECAUSE OF WHAT HAPPENED TO YOU, AND YOU ARE MOURNING THE LOSS OF YOUR ARM. INTERESTINGLY, IF YOU HAVE A BRAIN LESION, IT REALLY DEPENDS ON WHERE THE LESION IS. AND IN SOME CASES, THE SIGNS THAT SOMETHING IS ABNORMAL IS THAT YOU ARE SICK. IN FACT, SOME PEOPLE, AFTER A STROKE, THEY ARE PARALYZED, AND RIGHT AFTER THEN, THEY BECOME HAPPIER THAN THEY EVER WERE BEFORE. AND PART OF THAT IS THAT THE PART OF THE BRAIN THAT MAKES YOU SAD WAS GONE. AND SO, YOU HAVE ABNORMALLY JOVIAL PEOPLE WHO HAVE JUST SUFFERED A STROKE, AND YOU ASK THEM WHY ARE YOU SO HAPPY, AND YOU GET STRANGE ANSWERS. LIKE, IF I DIDN'T HAVE A STROKE, I WOULDN'T HAVE MET SUCH A WONDERFUL DOCTOR LIKE YOU. SO, IT DEPENDS.

Q. AND, OF COURSE, PEOPLE REACT EMOTIONALLY, AND MENTALLY, AND EVEN PHYSICALLY, PEOPLE REACT DIFFERENTLY, DEPENDING UPON THE CIRCUMSTANCES. AND WHAT I MEAN BY THAT IS, SOMEBODY MIGHT HAVE A MAJOR -- A SOLDIER IN IRAQ MAY LOSE BOTH OF HIS LEGS AND COME BACK HERE AND NEVER -- BE IN A WHEELCHAIR WITH NO LEGS FOR THE REST OF HIS LIFE. BUT THAT PERSON MAY HAVE AN INCREDIBLE POSITIVE OUTLOOK ON LIFE, EVEN THOUGH, DESPITE THE FACT, THEY LOST TWO LEGS. AS OPPOSED TO SOMEBODY ELSE WHO MAY HAVE A MINOR CONDITION PHYSICALLY OR MINOR CONDITION -- BRAIN ABNORMALITY, FOR WHATEVER REASON, WHATEVER ELSE IS

GOING ON IN THEIR LIFE, THEY HAVE SIGNIFICANT, OR CLINICAL DEPRESSION, OR MENTAL PROBLEMS, OR OTHER THINGS. YOU WOULD AGREE WITH THAT, WOULDN'T YOU? IT ALL DEPENDS ON THE PERSON?

A. I WOULD AGREE TO YOUR LAST STATEMENT. I AGREE, ABSOLUTELY, YOU SEE, PARADOXICALLY, PEOPLE ARE SLIGHTLY INJURED REACT IN A CATASTROPHIC WAY. PEOPLE SEVERELY INJURED MAINTAIN VERY GOOD MORALE, HELP THEM OVERCOME IT. A LOT OF IT DEPENDS ON THEIR PERSONALITY MAKEUP.

Q. YOU SAID IT BETTER THAN I DID, SIR. I APPRECIATE THAT. I GUESS THE POINT I AM TRYING TO MAKE, I GUESS, IS OF THE HUNDREDS OF THOUSANDS IF NOT MILLIONS, AS YOU SAY, PEOPLE THAT HAVE BRAIN ABNORMALITIES, INCLUDING PEOPLE THAT HAVE THE BRAIN ABNORMALITY THAT YOU CLAIM THAT MR. FULKS HAS, 99.9 PERCENT OF THEM DON'T RAPE WOMEN, DO THEY?

A. I AM NOT SURE ABOUT THE STATISTICS ON THAT. BUT I HAVEN'T SEEN A BRAIN QUITE AS ABNORMAL AS THAT OF MR. FULKS.

Q. IN ALL OF YOUR YEARS, YOU ARE TELLING THIS JURY, IN ALL OF YOUR YEARS OF STUDY AND RESEARCH, THAT YOU HAVEN'T SEEN A BRAIN AS ABNORMAL AS MR. FULKS? YOU JUST VOLUNTEERED THAT INFORMATION ON CROSS-EXAMINATION?

A. WELL, I THINK I SAID THAT BEFORE, THAT THAT PARTICULAR CONFIGURATION OF ABNORMALITIES I HAD NOT SEEN BEFORE.

Q. AND MUCH OF WHAT YOU HAVE DISCUSSED HERE TODAY IS YOUR SUBJECTIVE OPINION, BASED ON YOUR EXPERIENCE, AND YOUR INTERPRETATION OF THE IMAGING THAT YOU HAVE DESCRIBED TO THE

JURY, IS THAT A FAIR STATEMENT?

A. HOPEFULLY. AT LEAST, I TRIED TO SEPARATE WHAT I DESCRIBED AS EVIDENCE AS FINDINGS FROM MY OPINION REGARDING THOSE FINDINGS.

Q. IN OTHER WORDS, DOCTORS, MANY, MANY DOCTORS, WELL-EDUCATED, WELL-RESEARCHED, WELL-EXPERIENCED PHYSICIANS AND PSYCHIATRISTS, WHEN I SAY "PHYSICIANS," I MEAN BOTH MEDICAL DOCTORS AND PH.D.'S, SUCH AS YOURSELF, THEY CAN LOOK AT THE SAME IMAGING, THEY CAN TAKE THE SAME CLINICAL HISTORY, AND THEY CAN DISAGREE AS TO A DIAGNOSIS AND A TREATMENT PROCEDURE; ISN'T THAT THE TRUTH?

A. IT USED TO BE TRUE. I DON'T THINK IT IS TRUE ANY LONGER. I WOULD BE SURPRISED IF PEOPLE WITH THE SAME KIND OF BACKGROUND, AND EDUCATION, AND EXPERIENCE AS MYSELF, WOULD LOOK AT THE DATA THAT I HAVE BEEN LOOKING AT AND ARRIVE AT VERY DIFFERENT CONCLUSIONS.

Q. YOU ARE SURE ABOUT THAT?

A. YEAH, I AM SURE. I WOULD BE SURPRISED, YES.

Q. WELL, LET ME ASK YOU THIS. AND I WANT TO BE AS FAIR TO YOU AND MR. FULKS AS POSSIBLE, SO I PICKED AN ORGANIZATION THAT I WOULD ASSUME THAT YOU WOULD AGREE WITH IS AN ORGANIZATION THAT IS WELL-KNOWN IN THIS FIELD AND IS MOST DEFINITELY NOT A PRO LAW ENFORCEMENT ORGANIZATION. DID YOU HAVE AN OPPORTUNITY -- HAVE YOU EVER HEARD OF THE NATIONAL COALITION TO ABOLISH THE DEATH PENALTY?

A. I HAVEN'T SPECIFICALLY HEARD ABOUT THEM, NO.
Q. YOU WERE QUOTED BY THEM TWO DAYS BEFORE THIS JURY WAS SELECTED IN AN UNDERLYING ARTICLE. YOU DON'T REMEMBER TALKING TO SOMEBODY FROM THE NATIONAL COALITION TO ABOLISH THE DEATH PENALTY SOME TIME PRIOR TO MAY 8TH, 2004?
A. I DON'T REMEMBER TALKING TO SOMEBODY.
Q. LET ME GIVE YOU A COPY OF THE ARTICLE TO SEE IF THAT WILL REFRESH YOUR MEMORY. I BELIEVE ONE OF YOUR QUOTES IS RIGHT SMACK DAB THERE ABOUT THE ONE, TWO, THREE, FOUR, FIVE, SIXTH PARAGRAPH?
A. OKAY. I SEE WHAT THIS ARTICLE IS REPORTING. IT WAS A CONFERENCE THAT WAS ORGANIZED BY THE AMERICAN BAR ASSOCIATION.
Q. RIGHT.
A. AND INCLUDED FOUR PEOPLE. I WAS ONE OF THEM. AND I WAS ASKED TO MEET WITH THE PRESS AND, I GUESS, IN PREPARATION TO THE SUPREME COURT GOING TO RULE ABOUT EXECUTING JUVENILES.
Q. JUVENILES. I AM TALKING ABOUT, I WANT TO USE THIS ARTICLE, BASED UPON YOUR OPINION THAT, IN YOUR FIELD, IN YOUR OVERALL FIELD, YOU THINK THAT EXPERTS AREN'T -- MY QUESTION TO YOU WAS THAT, DON'T YOU AGREE, THAT THERE ARE RESEARCHERS AND PEOPLE THAT ARE EXPERIENCED IN YOUR FIELD, PHYSICIANS, PH.D. DOCTORS THAT CAN LOOK AT CLINICAL INFORMATION, LOOK AT BRAIN IMAGING, SUCH AS YOURSELF, AND DISAGREE ON A PARTICULAR DIAGNOSIS? AND YOUR TESTIMONY, IN FRONT OF THIS JURY, PRIOR

TO ME GIVING YOU THAT ARTICLE, YOU SAY, NO, THAT MOST PEOPLE, WITH YOUR EXPERIENCE AND EDUCATION, WOULD TEND TO AGREE WITH YOUR OPINION THAT YOU HAVE RENDERED TO THIS JURY, DO YOU RECALL THAT TESTIMONY?

A. YES.

Q. NOW, JUST TO PUT THIS ARTICLE, AGAIN, YOU WOULD AGREE WITH ME THAT THE NATIONAL COALITION TO ABOLISH THE DEATH PENALTY IS CERTAINLY NOT A CONSERVATIVE PRO LAW ENFORCEMENT, PRO JUSTICE ORGANIZATION, THAT IS FAIR TO SAY; IS IT NOT?

A. I AM NOT FAMILIAR WITH THIS ORGANIZATION. I JUST HEARD ABOUT THEM TODAY. I MEAN, I WOULD BE HAPPY TO CHECK OUT WHAT THEY ARE FOR.

Q. DR. GUR, GIVEN YOUR EDUCATIONAL BACKGROUND, THE NAME, ITSELF, THE "NATIONAL COALITION TO ABOLISH THE DEATH PENALTY?"

A. I AM EMBARRASSED TO SAY, I DO READ THE PAPERS, BUT MOST OF WHAT I READ, I MAY BE REALLY A LITTLE BIT OUT OF CONTACT WITH EVERYTHING THAT HAPPENS.

Q. I WANTED TO MAKE SURE I GOT AN ARTICLE THAT YOU WERE QUOTED IN. AND SO, THAT IS THE REASON WHY WE WERE ABLE TO FIND THIS ARTICLE. IT IS MAY 8TH. I KNOW YOU DON'T KNOW THE JURY PROCESS SELECTION BEGAN MAY 10TH, 2004. THIS ARTICLE DEALT WITH THE ISSUE, AS YOU SAID, OF WHETHER OR NOT, FROM A MEDICAL PERSPECTIVE, THE EXECUTING OF 16 AND 17-YEAR-OLDS. THAT IS WHAT THIS ARTICLE DEALS WITH, IN GENERAL; IS THAT CORRECT?

A. THAT IS WHAT IT SEEMS LIKE FROM WHAT I WAS ABLE TO READ.

Q. AND AS YOU WELL KNOW, THE UNITED STATES GOVERNMENT, THE FEDERAL GOVERNMENT, IN WHICH EVERY ONE OF THESE JURORS WAS TOLD DURING JURY SELECTION, THE FEDERAL DEATH PENALTY BARS THE SEEKING OR IMPOSITION OF THE DEATH PENALTY AGAINST ANYBODY WHO IS 16 OR 17 YEARS OLD. I KNOW THIS HAS NOTHING TO DO WITH THIS PROCESS. YOU UNDERSTAND THAT, DON'T YOU SIR?

A. I AM NOT SURE I UNDERSTAND YOUR QUESTION.

Q. YOU KNOW THE FEDERAL DEATH PENALTY STATUTE, THE GOVERNMENT CAN'T SEEK THE DEATH PENALTY AGAINST ANYONE UNDER THE AGE OF 18 YEARS OLD. DID YOU KNOW THAT, BASED ON YOUR EXPERIENCE; I BELIEVE, IN RESPONSE TO MR. BLUME, THAT YOU HAVE TESTIFIED BEFORE IN COURTS ON THESE MATTERS?

A. NOT ON THAT SPECIFIC ISSUE, BUT I THINK YOU ARE RIGHT. I AM PRETTY SURE YOU ARE RIGHT. I AM NOT A LAWYER. I DON'T KNOW.

Q. ONE OF THE THINGS THAT THEY ASKED YOUR OPINION ABOUT DURING THIS ARTICLE DEALT WITH THIS WHOLE ISSUE THAT YOU BROUGHT UP BEFORE THE JURY DEALING WITH INTERPRETING BRAIN IMAGING AND TO EXPLAIN HUMAN BEHAVIOR. THAT IS THE CRUX THEY WERE ASKING YOU ABOUT, THE REPORTER, WHOEVER WAS WITH THIS ORGANIZATION; WAS IT NOT?

A. I THINK THE REPORTER MUST HAVE SAT IN THE ROOM BECAUSE I NEVER GAVE AN INTERVIEW, AN INDIVIDUAL INTERVIEW.

Q. WOULD YOU AGREE WITH ME THAT, WHEN YOU WERE SITTING IN THE ROOM, YOU KNOW JEROME KAGAN, A NOTED HARVARD UNIVERSITY PSYCHOLOGIST?

A. YES.

Q. YOU KNOW DR. KAGAN. WHILE YOU WERE SITTING IN THE ROOM AND THAT THIS ARTICLE REFERENCES, HE INDICATED THAT HE WAS PART OF THAT CAMP THAT ARGUES THAT BRAIN SCIENCE DOESN'T BELONG IN COURT BECAUSE THERE IS NO EVIDENCE LINKING SPECIFIC CHARACTERISTICS OF TEENS' BRAINS TO ANY LEGALLY RELEVANT CONDITION SUCH AS IMPAIRED MORAL JUDGMENT OR INABILITY TO CONTROL MURDEROUS IMPULSES. THAT WAS -- HE WAS IN ONE CAMP SAYING THAT THIS WHOLE BRAIN IMAGING THAT YOU HAVE DISCUSSED FOR ABOUT THREE TO FOUR HOURS WITH THIS JURY DOESN'T BELONG IN A COURT OF LAW BECAUSE IT IS NOT RELIABLE. I KNOW YOU MAY BE FRIENDS, BUT I TAKE IT YOU DISAGREE WITH MR. KAGAN?

A. YEAH, KAGAN HAS NOT DONE A SINGLE IMAGING STUDY IN HIS WHOLE LIFE. HE IS A PSYCHOLOGIST, A VERY, VERY EXCELLENT PSYCHOLOGIST. HIS ENTIRE LIFE WORK HAS BEEN ON BEHAVIOR. IT USED TO BE THAT COGNITIVE PSYCHOLOGISTS ARGUED THEY COULD BUILD WHOLE SCIENCE WITHOUT KNOWING ANYTHING FROM THE BRAIN. HE COMES FROM THAT TRADITION. AND IT IS CHANGING VERY RAPIDLY.

Q. OKAY. LET'S NOT STOP AT DR. KAGAN. LET'S BE FAIR AND MOVE ON. I GUESS YOU, IN ONE OF THE EXHIBITS THAT MR. BLUME AND YOU WENT OVER IN FRONT OF THE JURY, I CAN'T REMEMBER

WHICH ONE IT WAS, IT HAD SOMETHING TO DO WITH, I BELIEVE, ONE OF YOUR COLLEAGUES TOUCHED A BUTTON, AND THERE WERE FOUR SCREENS, AND THE BRAIN ALL TURNED TO BLUE, DO YOU REMEMBER THAT EXHIBIT?

A. YES.

Q. YOU SAID IT CAME FROM PEOPLE IN UCLA, AND MARYLAND, AND NIH, I BELIEVE?

A. CORRECT.

Q. SITTING IN THAT SAME ROOM, SOME TIME PRIOR TO MAY 8TH THIS YEAR WHEN YOU WERE DISCUSSING THE RELIABILITY OF THIS TYPE OF INTERPRETING BRAIN IMAGERY, IT WASN'T SIMPLY DR. KAGAN, BUT YOU KNOW DR. ELIZABETH SOWELL, ANOTHER PROMINENT BRAIN DEVELOPMENT RESEARCHER FROM UCLA, WHO, IN THAT VERY CONFERENCE, TOOK A DIM VIEW OF THE MOVEMENT TO APPLY NEUROSCIENCE TO THE LAW:

"DELAYED FRONTAL-LAB MATURATION MAY EVENTUALLY BE SHOWN TO AFFECT TEENAGER'S CAPACITY TO MAKE LONG-TERM PLANS AND CONTROL THEIR IMPULSES, SHE SAYS, BUT NO CURRENT RESEARCH CONNECTS SPECIFIC BRAIN TRAITS OF TYPICAL TEENAGERS TO ANY MENTAL OR BEHAVIORAL PROBLEMS. THE SCIENTIFIC DATA AREN'T READY TO BE USED BY THE JUDICIAL SYSTEM, SHE

REMARKS. THE HARDEST THING FOR NEUROSCIENTISTS TO DO IS TO BRING BRAIN RESEARCH INTO REAL-LIFE CONTEXTS."

I TAKE IT YOU DISAGREE WITH HER. THAT IS FINE IF YOU DO. YOU DISAGREE WITH DR. SOWELL WHEN SHE SAYS -- YOU WOULD AGREE, YOU CALL YOURSELF A NEUROSCIENTIST? THAT IS WHAT YOU ARE?

A. YES.

Q. YOU DISAGREE WITH HER, "THE HARDEST THING FOR A NEUROSCIENTIST TO DO IS TO BRING BRAIN RESEARCH INTO REAL-LIFE CONTEXTS." YOU DISAGREE WITH HER?

A. I DON'T DISAGREE WITH HER. WE DISAGREE ON SOME ISSUES, BUT I -- SHE IS A FAIRLY -- SHE IS IS A NEUROLOGIST, AND SHE HAS DONE A COUPLE OF STUDIES WITH IMAGING. I THINK IT IS HER OPINION. I THINK THE STATEMENT, AS YOU QUOTED TO ME, IS TOO GENERAL EVEN TO KNOW WHAT TO AGREE OR DISAGREE. I AM SURE THERE ARE SOME AREAS THAT, WHERE THE KNOWLEDGE IS MORE TENUOUS THAN OTHERS. I THINK SHE IS WAY OFF SAYING THAT THERE ARE NO LINKS THAT HAVE BEEN ESTABLISHED. I MEAN, EITHER SHE IS IGNORANT OF OR IGNORING A FAIRLY SIZABLE BODY OF LITERATURE.

Q. SHE IS IGNORANT OR IGNORING CERTAIN INFORMATION THAT YOU BELIEVE IS APPLICABLE?

A. BECAUSE -- YES, DEFINITELY.

Q. HOW ABOUT DR. B. J. CASEY OF CORNELL UNIVERSITY WEILL MEDICAL COLLEGE IN NEW YORK CITY, WHO WAS IN THAT SAME CONFERENCE WITH YOU?

A. INCIDENTALLY, NONE OF THESE PEOPLE WERE THERE. AT LEAST, I DIDN'T SEE THEM THERE. THERE WERE FOUR OF US. THEY MAY HAVE BEEN INTERVIEWED. I HAVE NO IDEA HOW THEY CAME INTO IT, BUT I AM PRETTY SURE I WOULD HAVE RECOGNIZED THEM IF THEY WERE THERE.

Q. DO YOU AGREE OR DISAGREE WITH DR. B. J. CASEY OF THE WEILL MEDICAL COLLEGE OF NEW YORK WHEN HE SAYS THAT:

"IT IS AMAZING HOW LITTLE WE KNOW
ABOUT THE DEVELOPING BRAIN."

WOULD YOU AGREE WITH THAT STATEMENT?

A. IT IS SHE.

Q. SHE?

A. I WOULD ENDORSE IT. IT IS AMAZING HOW LITTLE WE KNOW. EVERYTHING I TOLD YOU TODAY REALLY JUST PRETTY MUCH SUMS UP WHAT WE KNOW, YOU KNOW, A BIT MORE THAN WHAT I SAID. I CAN'T CONVEY EVERYTHING IN THIS SHORT TIME. BUT IN THE SAME TIME, I AGREE THAT THERE IS A LOT. WE ARE JUST NOW DONE SCRATCHING THE SURFACE AND GETTING INTO MUCH FIRMER CONNECTIONS.

Q. AND DR. CASEY, SHE, WOULD YOU AGREE OR DISAGREE, THIS WAS ONE OF THE THINGS THAT YOU DEMONSTRATED TO THIS JURY, I BELIEVE? YOU TALKED ABOUT THE MRI AND BRAIN SCANNING TECHNIQUES. YOU TALKED ABOUT THAT IN FRONT OF THIS JURY, DID

YOU NOT, DR. GUR?

A. YES.

Q. DO YOU AGREE WITH DR. CASEY WHEN SHE SAYS:

"BRAIN-SCANNING TECHNIQUES, INCLUDING THE POPULAR MRI, REMAIN A 'CRUDE LEVEL OF ANALYSIS.' AT BEST, BLOOD-FLOW MEASUREMENTS INDIRECTLY TAP INTO BRAIN-CELL ACTIVITY AS PEOPLE PERFORM A TASK, SUCH AS IDENTIFYING EMOTIONS IN POSED FACES, THAT MAY SUPERFICIALLY STIMULATE A REAL-WORLD ENDEAVOR. WHAT IS MORE, MANY CRITICAL BRAIN-CELL RESPONSES ARE TOO FAST FOR THE MRI TO TRACK."

THAT IS ONE OF THE THINGS THAT YOU EVEN TALKED ABOUT IN FRONT OF THIS JURY WHEN YOU SHOWED UP WITH SOME OF THE FACES IN THE BRAIN IMAGING, DID YOU NOT?

A. YES. I HOPED THAT I EXPLAINED THAT EACH ONE OF THOSE MEASURES HAS AN INDICATION. I MEAN, YOU ARE BASICALLY CRITICIZING A RULER FOR NOT MEASURING THE TEMPERATURE. SO THAT THESE METHODS DON'T MEASURE WHAT THEY ARE DESIGNED TO MEASURE. AND I THINK WE HAVE LEARNED A LOT MORE WHEN WE CAN STUDY THE MOLECULAR LEVEL. WHAT WE DESCRIBED TODAY TAKES PLACE IN LARGE REGIONS. I DON'T -- SHE IS NOT QUESTIONING THE VALIDITY OF THE MRI. BUT SHE IS SAYING, WITH AN MRI, YOU

CANNOT STUDY, YOU CANNOT REALLY SEE A MOLECULE. YOU CAN'T GO DOWN TO THE MOLECULAR LEVEL OF THE BRAIN. YOU CAN'T EVEN GO TO THE CELL. YOU CAN'T SEE CELLS WITH MRI'S. BUT WHAT YOU DO SEE IS A REFLECTION OF THE INTEGRITY OF THE MOLECULES IN THE CELLS.

Q. I GUESS WHAT I AM TRYING TO SAY WHEN I ASK YOU, ISN'T IT TRUE, MANY PEOPLE IN YOUR PROFESSION WITH LIKE EDUCATIONAL EXPERIENCES, RESEARCH EXPERIENCE, ON-THE-JOB TRAINING, PHYSICIANS, AND DOCTORS DISAGREE AT TIMES OVER LOOKING AT SCANS, CAT SCANS, MRI'S ABOUT WHAT THEY ARE LOOKING AT, THERE ARE DISAGREEMENTS?

A. MAYBE I MISUNDERSTOOD YOUR QUESTION. I THOUGHT YOU ASKED ME WHETHER A GROUP OF PEOPLE WITH MY BACKGROUND WOULD DISAGREE ABOUT THE BRAIN OF MR. FULKS. ABOUT IF THEY HAD ALL OF THE DATA THAT I HAD ON MR. FULKS, WOULD THEY COME OUT WITH A DIFFERENT CONCLUSION. I AM NOT TRYING TO SAY THAT OUR FIELD IS LOVEY-DOVEY, HUNKY-DORY. NOBODY DISAGREES WITH ANYBODY. IN FACT, THERE ARE LOTS OF AREAS OF DISAGREEMENT.

Q. ONE AREA OF DISAGREEMENT THAT I RECENTLY DISCUSSED WITH SOME OF YOUR COLLEAGUES, AS YOU KNOW, IS THIS WHOLE IDEA OF WHAT YOU JUST DID IN FRONT OF THE JURY, THAT YOU COULD SOMEHOW INTERPRET BRAIN IMAGING TO OFFER SOME SORT OF EXPLANATION FOR HUMAN BEHAVIOR. THERE IS SIGNIFICANT DISAGREEMENT IN USING THIS BRAIN IMAGING THAT YOU ARE DESCRIBING TO INTERPRET WHY MR. FULKS ACTED THE WAY HE DID. I MEAN, I JUST NAMED THREE

PEOPLE IN ONE ARTICLE.

A. I MEAN, IT IS DISAGREEMENT THEY HAVE ARE VERY SPECIFIC AND LEGITIMATE. I THINK SOME OF THEM ARE LEGITIMATE. I THINK SOME OF THE -- AT LEAST PART OF WHAT YOU QUOTED TO ME FROM BARBARA SOWELL'S -- EXCUSE ME, ELIZABETH SOWELL'S STATEMENT, I WOULD LIKE TO TALK TO HER ABOUT IT. I DON'T THINK SHE WILL REALLY -- WHAT CAN I DO? SHE IS NOT HERE.

Q. LET ME MOVE ON. I NOTICED, IN SOME OF THE PUBLICATIONS, I WAS ABLE TO READ, THAT WE GOT OFF THE INTERNET, THAT YOU HAD PUBLISHED, ONE OF THE THINGS THAT YOU APPEAR TO BE PRETTY CONSISTENT IN, DR. GUR, IT IS YOUR OPINION. I HAVE SEEN DIFFERENT AGES, DEPENDING UPON WHAT ARTICLE YOU ARE QUOTED IN, IT IS YOUR OPINION, IS IT NOT, UNTIL SOMEBODY IS 21 OR 22 OR 23, IN THAT RANGE, UNTIL THE BRAIN IS FULLY DEVELOPED; IS THAT CORRECT, SIR?

A. YES.

Q. AND MUCH OF YOUR INTERPRETING THIS BRAIN IMAGING THAT YOU HAVE DESCRIBED AND SHOWN TO THE JURY AND TALKED ABOUT, IT IS SUBJECTIVE AND NOT, NECESSARILY, EXACT. DO YOU KNOW WHAT I MEAN BY THAT? YOU CAN'T SAY, SCIENCE IS NOT EXACT; ISN'T THAT TRUE?

A. THE INTERPRETATION IS AS GOOD AS I CAN MAKE IT. AND, OF COURSE, EVEN THE NUMBERS ARE NOT EXACT. THEY EACH CONTAIN SOME ELEMENT OF ERROR.

Q. THAT IS THE REASON WHY -- DO YOU HAVE A COPY OF YOUR

REPORT? IF NOT, I CAN GIVE YOU ONE. DO YOU HAVE A COPY?

A. I DON'T HAVE ONE IN FRONT OF ME.

Q. OKAY. I WILL GIVE YOU ONE. SHOWING YOU AT THE TOP OF PAGE 2 WHEN YOU WRITE IN YOUR REPORT, RIGHT AT THE TOP OF THE PAGE I WILL PUBLISH IT:

"REDUCED FUSIFORM AND THALAMIC ACTIVITY COULD BE," YOUR WORDS, "COULD BE A RESULT OF HEAD INJURIES, MOST LIKELY A BLOW TO THE TOP OF THE HEAD. THE ABNORMAL INCREASED ACTIVITY IN SOME TEMPORAL, OCCIPITAL, FRONTAL REGIONS COULD REFLECT" --

AND HOW DO YOU PRONOUNCE THAT NEXT WORD?

A. "EPILEPTIFORM."

Q. THANK YOU.

"OR PSYCHOTIC PROCESS, POSSIBLY RELATED TO FETAL ALCOHOL SYNDROME." NEXT SENTENCE. "THIS COULD ALSO RELATE THE FINDINGS, THEY MAY LEAD TO FURTHER TISSUE DETERIORATION."

AND ARE YOU SURE YOU DON'T HAVE A LAW DEGREE, DR. GUR. YOU DON'T HAVE A LOT HERE. IT SEEMS TO ME THAT YOU ARE NOT BEING SPECIFIC BECAUSE YOU CAN'T BE SPECIFIC BECAUSE SCIENCE IS INEXACT.

A. THIS IS EXACTLY WHAT I TRIED TO EXPLAIN, WHICH IS, I AM TRYING TO SEPARATE EFFECT FROM MY INTERPRETATION OF IT. SO, THE FACT THAT FUSIFORM AND THALAMIC ACTIVITY IS REDUCED IS THE DATA. AND WHEN I SAID I COULD BE MORE TENTATIVE, IT IS BECAUSE I CAN'T BE ABSOLUTELY SURE ABOUT THE CAUSE FOR THAT ABNORMALITY. SO, I HOPE YOU DON'T INTERPRET THE "COULD" THAT RELATES TO THE INTERPRETATION OF THE FINDING TO INDICATE THAT I DON'T -- THAT I DON'T -- THAT I HAVE ANY DOUBTS ABOUT THE FINDING ITSELF.

Q. ONE OF THE THINGS THAT YOU TRY DO IN YOUR FIELD, I THINK YOU HAVE, OBVIOUSLY, DEDICATED YOUR ENTIRE PROFESSIONAL AND ADULT LIFE TO, IS THAT YOU TRY AND FIGURE OUT WHY PEOPLE COMMIT VIOLENT CRIMES. THAT IS ONE OF THE THINGS YOU TRY AND FIGURE OUT; IS THAT CORRECT?

A. THAT IS CORRECT.

Q. YOU FEEL, BASED ON YOUR RESEARCH, YOU CAN TAKE BRAIN IMAGING, OF COURSE, YOU NEED CLINICAL HISTORY AS WELL, DO YOU AGREE WITH THAT?

A. YES.

Q. YOU ARE LOOKING FOR, IN ORDER TO KIND OF PUT YOUR FINGER ON TO AS TO WHY SOMEBODY WOULD CARJACK ANOTHER HUMAN BEING, KILL ANOTHER HUMAN BEING, RAPE ANOTHER HUMAN BEING, IS THAT A FAIR STATEMENT?

A. THAT IS A VERY FAIR STATEMENT.

Q. DO YOU TAKE IN THE FACT, DOCTOR, SOME PEOPLE ARE JUST

PLAIN MEAN OR EVIL?

A. I HAVE LIVED TOO LONG TO BE ABLE TO SAY THAT I DON'T BELIEVE SUCH PEOPLE EXIST. THERE ARE SOME MEAN PEOPLE OUT THERE.

Q. AND THAT IS A VERY HONEST ANSWER. I APPRECIATE THAT ANSWER. COUPLE OF POINTS BEFORE I GO ONTO THE NEXT SUBJECT MATTER, AND I AM NOT GOING TO BE -- I WILL TRY TO MAKE THIS AS BRIEF AS POSSIBLE. WHEN YOU WERE DISCUSSING YOUR QUALIFICATIONS, I WANTED TO BE SURE ON THIS. NOT NECESSARILY YOUR QUALIFICATIONS, BUT WHAT YOU DO, BASICALLY, DURING A WORKING DAY. YOU INDICATED THAT YOU TEACH STUDENTS AND ALSO LECTURED AT SEMINARS; IS THAT CORRECT?

A. YES.

Q. YOU RESEARCH, AND WRITE, PUBLISH?

A. YES.

Q. YOU HAVE A PRACTICE, THAT IS WHAT, DIRECTOR OF BRAIN BEHAVIOR LAB? I WOULD CONSIDER YOU ARE A PRACTICING PSYCHOLOGIST?

A. YES. BUT IT IS WITHIN THE MEDICAL SCHOOL. I DON'T HAVE A PRIVATE PRACTICE.

Q. AND HOW LONG HAVE YOU BEEN AN EXPERT WITNESS?

A. ACTUALLY, I CAN ALMOST PINPOINT THE DAY THE FIRST TIME I WAS INVITED, IT WAS AROUND 1990.

Q. SO, ABOUT 14 YEARS YOU HAVE BEEN HIRED TO CONSULT, BY LAWYERS, AS AN EXPERT WITNESS IN THE AREAS THAT YOU HAVE,

BASICALLY, TESTIFIED TO BEFORE THIS JURY; IS THAT CORRECT?
A. AT DIFFERENT RATES. I MEAN, BETWEEN 1990 AND THE NEXT CASE, A COUPLE OF YEARS. AND THEN, SOMETIMES, I GET TWO OR THREE CASES IN A YEAR, AND SOMETIMES A YEAR WILL GO BY. I AM NOT LOOKING FOR THEM. BUT IF A CASE IS PRESENTED TO ME THAT I FEEL I HAVE TIME TO WORK ON AND SOUNDS INTERESTING, I WILL TAKE IT ON.
Q. AND THAT IS NOT SIMPLY TESTIFYING. HOW MANY CASES DO YOU THINK YOU HAVE WORKED ON WITH REGARD TO CRIMINAL CASES, ANY TYPE OF CONSULTATION?
A. SINCE 1990?
Q. TO INCLUDE REVIEWING SOMEBODY ELSE'S MATERIAL, NOT NECESSARILY MEETING WITH ANY DEFENSE LAWYERS?
A. I CAN LOOK AT THE EXACT NUMBER. RIGHT NOW I WOULD SAY IT IS IN THE NEIGHBORHOOD A BIT OVER 20.
Q. YOU INDICATED TO MR. BLUME THAT YOU HAD, AT ONE TIME, OR A TIME BEEN HIRED BY A PROSECUTION ENTITY?
A. YES.
Q. WHEN WAS THAT?
A. THAT WAS IN A CASE OF FORMER CONGRESSMAN WHO WAS ACCUSED OF EMBEZZLING ABOUT 10 MILLION DOLLARS FROM HIS FRIENDS -- FORMER FRIENDS, I SUPPOSE. AND ARGUED THAT IT WAS CAUSED BY THE INTAKE OF ANTIMALARIA DRUG. HE HAD A PET SCAN AND MRI THAT I SUBMITTED TO THE SAME KIND OF ANALYSIS THAT YOU SAW TODAY.

Q. SO, YOU HAVE BEEN HIRED BY THE PROSECUTION ENTITY ONE TIME?

A. NO.

Q. YOU DON'T HAVE TO DESCRIBE THE WHOLE --

A. MAYBE THREE TIMES TOTAL.

Q. HOW MANY?

A. MAYBE THREE.

Q. SO, OUT OF EVERY 20, YOU HAVE BEEN HIRED BY PROSECUTION THREE TIMES, AND THE REST OF THE TIME, 17 PLUS, BY THE CRIMINAL DEFENSE TEAM; IS THAT CORRECT?

A. THAT WOULD BE ABOUT RIGHT, YEAH.

Q. AND WERE YOU EVER HIRED BY THE PROSECUTION IN A CASE INVOLVING A HOMICIDE?

A. NO.

Q. SO, IF YOU HAVE TESTIFIED IN FRONT OF JURIES ACROSS THE COUNTRY IN MURDER CASES, IT HAS ALWAYS BEEN FOR THE DEFENSE?

A. I MEAN, THAT IS CARRYING IT FAR ACROSS THE COUNTRY. I MAY HAVE TESTIFIED -- THIS IS PROBABLY MY FOURTH OR FIFTH TIME. USUALLY, THE PROSECUTION IS NOT ALL THAT EAGER TO FIND OUT IF THE BRAIN IS ABNORMAL.

Q. OR DISAGREES WITH YOU. JUST DISAGREES WITH YOU?

A. I'M SORRY?

Q. OR THEY DISAGREE WITH YOU?

A. YEAH.

Q. LET'S GO TO WHAT YOU USED TO DEVELOP THIS OPINION THAT YOU HAVE PROVIDED TO THE JURY. MY UNDERSTANDING IS THAT, BASED UPON YOUR REPORT AND YOUR TESTIMONY IS THAT YOU REVIEWED THE COMPREHENSIVE NEUROPSYCHOLOGICAL TESTING PERFORMED BY DR. JAMES EVANS AND JONATHAN VENN. AND THAT INCLUDED THE PET SCANS, THE MRI SCANS, THE CAT SCANS; IS THAT CORRECT?

A. I REVIEWED THEM. YEAH. I REVIEWED. ARE YOU ASKING IS IT CORRECT? I REVIEWED THE VENN DATA.

Q. I AM GOING TO MAKE SURE WHAT YOU REVIEWED BEFORE YOU TENDERED YOUR OPINION TO THE JURY.

A. YES.

Q. OF COURSE, DR. EVANS AND DR. VENN WERE HIRED BY MR. FULKS, AS WELL, WERE THERE TO DIRECT MR. FULKS'S DEFENSE?

A. YES.

Q. YOU SAID SOMETHING ABOUT, YOU TOOK THE RESULTS, YOU KIND OF APPLIED YOUR OWN FORMULAS AND DID SOMETHING WITH THEM. DO YOU REMEMBER SAYING THAT?

A. YEAH. WELL, NO -- YES.

Q. AND YOU ADMINISTERED ADDITIONAL COMPUTERIZED TESTS TO MR. FULKS, YOU, YOURSELF?

A. YES.

Q. ADMINISTERED NEUROPSYCHOLOGICAL TESTS TO MR. FULKS?

A. YES.

Q. AND YOU CONDUCTED INTERVIEWS?

A. YES.

Q. THOSE ARE THE THREE THINGS YOU USED TO COME TO YOUR CONCLUSIONS OR YOUR OPINIONS. THE TESTING BY THE TWO OTHER DEFENSE DOCTORS, YOUR INTERVIEW WITH MR. FULKS, AND THE TESTING THAT YOU -- COGNITIVE TESTING THAT YOU PROVIDED MR. FULKS, THOSE THREE THINGS?

A. FOR THE BEHAVIORAL PART, YES.

Q. AND HOW LONG DID YOU INTERVIEW MR. FULKS? OVER HOW MANY PERIOD OF DAYS?

A. I HAD ONE INTERVIEW WITH HIM FOR ABOUT AN HOUR AND A HALF.

Q. ONE NINETY-MINUTE INTERVIEW WITH CHAD FULKS?

A. BEFORE I STARTED THE TESTING, THE WHOLE SESSION TOOK ABOUT THREE AND A HALF HOURS, INCLUDING THE TESTING.

Q. YOU NEVER MET MR. FULKS BEFORE?

A. NO.

Q. YOU INTERVIEWED HIM FOR 90 MINUTES AND THEN GAVE HIM A SERIES OF TESTS THAT LASTED APPROXIMATELY THREE AND A HALF HOURS?

A. YES. THE WHOLE, YES.

Q. DO YOU THINK YOU GOT MR. FULKS'S WHOLE LIFE STORY IN NINETY MINUTES, DR. GUR?

A. I WASN'T TRYING TO. I HAD THE BENEFIT OF HAVING MATERIAL ABOUT HIS PREVIOUS TESTING AND INTERVIEWS, AND I JUST WENT AFTER SPECIFIC ISSUES THAT I THOUGHT NEEDED FURTHER CLARIFICATION.

Q. WELL, THAT IS WHY I ASKED YOU WHAT YOU HAD. I APOLOGIZE IF MY QUESTION WAS WHAT MATERIALS YOU USED TO FORM YOUR OPINION. I DON'T KNOW IF THE JURY WAS FOLLOWING IT. I WROTE DOWN, BASICALLY, THE THREE THINGS YOU TOLD ME ON CROSS-EXAMINATION. SO, YOU ARE NOW SAYING THAT YOU DID HAVE -- YOU WERE PROVIDED ACCESS TO THE POLICE REPORTS, AND DOCUMENTS, AND STATEMENTS, AND LETTERS, AND PRIOR PSYCHOLOGICAL TESTING, AND PRIOR MENTAL HEALTH EXPERTS OPINION'S/REPORTS, YOU WERE PROVIDED ALL OF THAT INFORMATION?

A. WELL, NOT ALL OF IT. I WAS PROVIDED A SUMMARY OF THE CASE. I AM SORRY IF I MAYBE MISUNDERSTOOD YOUR QUESTIONING. I REVIEWED THOSE THREE THINGS YOU MENTIONED. I DIDN'T TRY TO IMPLY THAT I DIDN'T SEE ANYTHING ELSE. I DID SEE MORE MATERIAL. I CAN PROVIDE YOU WITH A WHOLE LIST OF WHAT I HAVE.

Q. SUMMARIZE FOR US.

A. I HAD, AS I RECALL, I SAW A SYNOPSIS OF THE CASE. I SAW SOME OF THE REPORTS FROM THE PRISON. I SAW THE INTERVIEW MATERIAL AND THE TESTING MATERIAL FROM DR. VENN AND EVANS.

Q. THE TWO?

A. I SAW SOME LETTERS THAT HE WROTE. I SAW THE BUTNER REPORT MORE RECENTLY.

Q. THE TWO -- YOU SAY YOU SAW SOME REPORTS FROM DR. EVANS AND DR. VENN YOU HAVE ALREADY TALKED ABOUT, THOSE ARE THE TWO EXPERTS FOR MR. FULKS?

A. RIGHT.

Q. THE SUMMARY, WAS THAT SOME SORT OF SUMMARY PROVIDED BY DEFENSE COUNSEL TO YOU?

A. I DON'T REMEMBER EXACTLY. SOME OF IT WAS THAT. THERE WERE SOME COPIES OF SOME COPIES OF REPORTS. I MEAN, I WILL BE HAPPY TO GIVE YOU THE EXACT LIST.

Q. LET ME ASK IT THIS WAY. YOU ARE A PH.D. DOCTOR. YOU WOULD AGREE WITH ME THAT, A PH.D. PSYCHOLOGIST OR A MEDICAL DOCTOR, WHEN REACHING A DIAGNOSIS OR A CONCLUSION OR WHEN WANTING TO RENDER AN OPINION ABOUT AN IMPORTANT MATTER, THEY NOT ONLY WANT TO ORDER TESTING DONE AND THEN SUBJECTIVELY, ANALYZE THAT TESTING, THEY WANT TO GET AS MUCH CLINICAL INFORMATION AS POSSIBLE, MEANING THEY WANT TO INTERVIEW THE SUBJECT MATTER, IF THAT IS POSSIBLE. THEY WANT ACCESS TO ALL MATERIAL WITNESSES, IF THERE ARE WITNESSES, ALL MATERIAL THAT RELATE TO THE SUBJECT MATTER SO THAT YOU CAN HAVE AS MUCH INFORMATION AS POSSIBLE ON THE CLINICAL END BECAUSE, THAT IS JUST AS IMPORTANT AS THE TESTING AND INTERPRETING THE TESTING. WOULD YOU AGREE WITH THAT AS A DOCTOR, WOULD YOU NOT?

A. IN THE DAY OF MANAGED CARE, DO YOU THINK DOCTORS HAVE TIME FOR THAT? I MEAN, YOU HAVE TO RELY BY -- RELY ON WHAT IS THERE. CLINICALLY, I WOULDN'T SURVIVE IF I SPENT THE WHOLE DAY WITH EVERY PATIENT GOING OVER THEIR HISTORY. I GO OVER WHAT OTHER PEOPLE HAVE DONE, AND UNLESS I HAVE REASON TO DOUBT, I ACCEPT WHAT IS IN THE FILE. I THINK EVERY

PSYCHOLOGIST OR PHYSICIAN DOES THAT.

Q. YOU, AS A PROFESSIONAL, AS YOU ARE IN RUNNING THIS BRAIN CENTER AND HAVING TESTIFIED IN COURT BEFORE, YOU WANTED TO MAKE SURE THAT YOU HAD ALL OF THE INFORMATION AVAILABLE THAT WOULD ALLOW YOU TO MAKE YOUR OWN INFORMED, OBJECTIVE OPINION AS TO THE CREDIBILITY OF CHAD FULKS BEFORE YOU CAME INTO THIS COURTROOM, DID YOU NOT? TO OFFER YOUR OPINION TO THE 16 PEOPLE, 12 OF WHICH ARE GOING TO DECIDE WHETHER OR NOT MR. FULKS LIVES OR DIES, I MEAN, THAT IS IMPORTANT TO YOU, IS IT NOT?

A. VERY IMPORTANT.

Q. AND, BASICALLY, YOU ARE ALMOST A PRISONER OF WHAT IS PROVIDED TO YOU BY THE DEFENSE ATTORNEYS, ARE YOU NOT? IF THEY DON'T PROVIDE YOU DOCUMENTATION, YOU CAN'T SEE IT?

A. THAT IS CORRECT.

Q. YOU TOLD THIS JURY THAT PART OF THE BASIS -- AN IMPORTANT PART OF THE BASIS OF YOUR OPINION TO THIS JURY IS YOUR INTERVIEW WITH MR. FULKS, YOUR TESTING OF MR. FULKS, AND THE VERACITY OR THE CREDIBILITY OF THAT INTERVIEW AND THAT TESTING; ISN'T THAT TRUE?

A. I DIDN'T SAY IT, BUT IT IS TRUE.

Q. SO, THE CREDIBILITY OF MR. FULKS IS NOT AN IMPORTANT FACTOR IN YOUR ANALYSIS?

A. THE CREDIBILITY IS, AND THERE ARE STANDARD WAYS OF ASSESSING IT. SO, I WAS VERY INTERESTED IN FINDING OUT THE

RESULTS OF THE MALINGERING TESTS THAT DR. VENN GAVE HIM. BUT HAVING HAD THOSE RESULTS, I SAW NO REASON TO RE-EXAMINE AGAIN THAT ISSUE.

Q. YOU WOULD AGREE WITH ME THAT IS A -- YOU WOULD AGREE WITH THE COMMON PREMISE THAT A GOOD INDICATOR OF FUTURE CONDUCT IS PAST BEHAVIOR, WOULD YOU AGREE WITH THAT STATEMENT?

A. I THINK THAT IS, BY AND LARGE, A GOOD RULE. IT HAS ITS LIMITS, BUT IT IS A FAIR SUMMARY.

Q. SO, IF THERE WERE -- YOU SAY YOU ARE LOOKING AT TESTS FROM DR. VENN AND DR. EVANS CONCERNING THIS MALINGERING ISSUE. THE BOTTOM LINE IS, THAT YOU ARE STILL, YOU AND THE TWO DOCTORS THAT WORK FOR MR. FULKS, YOU ARE LOOKING AT SUBJECTIVELY INTERPRETING THOSE RESULTS, ARE YOU NOT?

A. THE INTERPRETATION WOULD BE, WOULD HAVE AN ELEMENT OF SUBJECTIVITY TO IT.

Q. SO, IF THERE WERE DOCUMENTS OUT THERE, AND WITNESSES OUT THERE, AND PEOPLE OUT THERE THAT COULD PROVIDE YOU OBJECTIVE INFORMATION AS TO ALL OF THE LIES, AND THE MANIPULATIONS, AND DECEIT OF MR. CHAD FULKS SINCE THE TIME HE WAS 16 YEARS OLD, TO THE TIME HE WAS 26 YEARS OLD, WHEN YOU MET HIM, WOULDN'T YOU WANT THAT INFORMATION IN ORDER TO REACH AN INFORMED DECISION BEFORE THIS GROUP OF PEOPLE?

A. THERE WAS A LOT OF INFORMATION OF THAT KIND THAT I DID GET. I MEAN, I REALIZE GOING IN THAT MR. FULKS IS NOT, YOU

KNOW, HOW DO YOU CALL THEM --

Q. BELIEVABLE?

A. AN ALL-AMERICAN SOMEONE THAT WE CAN ALL BE PROUD OF AND SO ON. I MEAN --

Q. I AM NOT TALKING ABOUT THAT, SIR. I AM NOT TALKING ABOUT PAST CRIMINAL BEHAVIOR.

A. I THOUGHT YOU WERE.

Q. THE DEFENSE ATTORNEYS PROVIDED YOU -- I AM TALKING ABOUT INFORMATION, WITNESSES, AND STATEMENTS, AND POLICE REPORTS OVER THE PAST TEN YEARS WHICH CLEARLY INDICATE MR. FULKS WAS A MANIPULATOR, A LIAR, A DECEIVER. AND THE PEOPLE THAT HE MANIPULATED, LIED, AND DECEIVED BELIEVED HIM, AT THAT POINT IN TIME, AS WELL. WOULDN'T YOU WANT THAT INFORMATION IN ORDER FOR YOU TO MAKE AN INFORMED OPINION AS TO THE CREDIBILITY OF MR. FULKS FROM YOUR INTERVIEWING HIM AND GIVING HIM THESE TESTS?

A. AS I WAS SAYING, I DID GET QUITE A BIT OF INFORMATION. AND IF YOU ASK ME, BEFORE GOING TO INTERVIEW HIM IS HE A LIAR, MANIPULATOR, A THIEF, AND ALL THAT, I KNEW HE WAS. I AM NOT SITTING HERE BEING SHOCKED BY WHAT YOU ARE TELLING ME.

Q. HIS MOTIVATION, YOU WOULD AGREE WITH ME THAT ONE WHO IS FACING EXECUTION, HAS NO GREATER MOTIVE TO FAKE BAD OR TO LIE, YOU WOULD AGREE WITH THAT?

A. SURE.

Q. SELF-PRESERVATION?

A. SURE.

Q. YOU INDICATE IN YOUR REPORT, I BELIEVE IT IS ON PAGE 3, AND YOU ALSO TESTIFIED TO THIS THAT, "IN GENERAL, ALL OF THE EVALUATIONS," I GUESS THAT INCLUDES DR. EVANS AND VENN, "AGREE MR. FULKS HAS PUT FORTH A GOOD EFFORT AND WAS NOT TRYING TO FEIGN DYSFUNCTION; THEREFORE, THE TESTING IS CONSIDERED A VALID INDICATION OF HIS NEUROCOGNITIVE ABILITIES." THAT IS WHAT YOU PUT IN YOUR REPORT AND, OF COURSE, YOU HAVE ALREADY SAID THAT IS YOUR OPINION, AS WELL AS THE OTHER TWO DOCTORS' OPINIONS; IS THAT CORRECT?

A. YES.

Q. AND YOU COULD BE WRONG?

A. YES, THAT IS AN OPINION.

Q. YOU COULD BE RIGHT. I MEAN, TO BE FAIR TO YOU, YOU COULD BE RIGHT?

A. ABSOLUTELY. I COULD BE WRONG.

Q. NOW, UNDER THE PRIOR TESTING IN THE BEHAVIORAL IMAGE PORTION OF YOUR REPORT WHEN YOU DESCRIBE THE LESIONS, LESIONS OF THE KIND -- LESIONS OF THE KIND DEPICTED BY BEHAVIORAL IMAGE, ASSOCIATED WITH SEVERAL COGNITIVE AND EMOTIONAL DEFICIENCIES, DOCUMENTED IN THE TESTING IN THE COGNITIVE DOMAIN -- THIS IS YOUR RESULTS, I GUESS -- IN THE COGNITIVE DOMAIN, INDIVIDUALS WITH SUCH LESIONS TEND TO HAVE VISUAL PERCEPTION PROBLEMS. THEY WILL BE CONSIDERED CLUMSY AND INATTENTIVE, AND THEY ARE EASILY DISTRACTIBLE. THEY HAVE

DIFFICULTY SIZING UP SITUATIONS IN THE COGNITIVE DOMAIN. IS THAT YOUR OPINION OF MR. FULKS?

A. THIS IS WHAT MOST PEOPLE WHO HAVE THAT KIND OF LESION WOULD LOCK LIKE. I WASN'T ABLE TO VERIFY THAT MR. FULKS HAS ALL OF THESE CHARACTERISTICS. BUT I BELIEVE HE HAS MOST.

Q. LET ME OFFER YOU A COUPLE OF PIECES OF EVIDENCE THAT THIS JURY HAS SEEN TO SEE IF THAT MIGHT SWAY YOUR OPINION ONE WAY OR THE OTHER. I BELIEVE ONE OF YOUR QUOTES EARLY ON IN YOUR DIRECT TESTIMONY WAS, QUOTE, YOU NEED TO LOOK AT THE BRAIN IN ACTION. DO YOU REMEMBER MAKING THAT STATEMENT?

A. YES.

Q. SO, VISUAL?

A. WITH REFERENCE TO LOOKING AT PHYSIOLOGICAL INSTEAD OF PHYSICAL.

Q. WERE YOU PROVIDED WITH A COPY OF THE VIDEOTAPE SHOWING MR. FULKS DRIVING AN AUTOMOBILE AT 130 MILES PER HOUR, IN AND OUT OF TRAFFIC, WITH HIS LIGHTS OFF, WHILE BEING CHASED, WERE YOU PROVIDED WITH THAT?

A. NO. HE TOLD ME IN THE INTERVIEW THINGS LIKE THAT HAPPENED.

Q. YOU WOULDN'T EXPECT SOMEBODY TO DRIVE AN AUTOMOBILE 130 MILES PER HOUR, OUTRUN MULTIPLE POLICE OFFICERS WHO ARE TRAINED AT THEIR RESPECTIVE ACADEMIES, TO HAVE, QUOTE, VISUAL PERCEPTUAL PROBLEMS, WOULD YOU, DOCTOR?

A. I THINK HE IS. HE STARTED DRIVING AT AN AGE THAT YOU

WOULDN'T WANT TO KNOW. HE WAS A CHILD WHEN HE STARTED DRIVING. AND I PROBABLY -- ABOUT HALF OF HIS BRAIN IS DEVOTED TO DRIVING. I MEAN, THAT IS REALLY WHAT HE WAS DOING A LOT. THAT WOULD BE AN EXAMPLE OF THAT INDIVIDUAL WHO LEARNED TO SKI AS A CHILD.

Q. YOU MENTIONED THE LESIONS THAT YOU CLAIM, THAT YOU SAY ARE ON THE BRAIN SCAN-- THE LESIONS THAT ARE ON THE BRAIN SCAN OF MR. FULKS. I AM NOT QUESTIONING YOUR DIAGNOSIS OF THESE LESIONS ON THE BRAIN SCAN, I DON'T WANT YOU TO THINK THAT. BUT ALSO, PEOPLE MAY BE CLUMSY OR INATTENTIVE. WERE YOU PROVIDED WITH EITHER NOTES, OR THE TESTIMONY, OR THE FBI 302 OF AN INDIVIDUAL BY THE NAME OF JAMES HAWKINS, WHO WAS KIDNAPED AND CARJACKED, AND WHO TESTIFIED AND PROVIDED A STATEMENT INDICATING THAT IT WAS MR. FULKS THAT TOOK OVER THE LEAD ROLE, IT WAS MR. FULKS THAT MARCHED HIM TO A TREE, MR. FULKS VIOLENTLY TIED HIM TO A TREE WITH DUCT TAPE, WERE YOU PROVIDED WITH THAT INFORMATION?

A. I THINK THAT WAS INCLUDED IN THE MATERIAL.

Q. NOTHING CLUMSY OR INATTENTIVE ABOUT THAT CONDUCT, IS THERE, SIR?

A. IT IS HARD TO KNOW, IF YOU ARE NOT THERE. BUT IT SOUNDS LIKE HE ACCOMPLISHED DOING THAT.

Q. HIS GOAL. OKAY. AND YOU ALSO SAY THAT THESE PEOPLE WHO HAVE LESIONS AT TIMES MIGHT HAVE DIFFICULTY SIZING UP SITUATIONS. ARE YOU AWARE, BASED ON YOUR REVIEW OF OR MAYBE

THE SUMMARY OF THIS CASE, AS YOU DESCRIBED, THAT THE AFTERNOON OF THURSDAY, NOVEMBER 14TH, MR. FULKS AND HIS COHORT DROVE INTO A WAL-MART IN CONWAY, SOUTH CAROLINA. AND WHEN, SAY, GIVEN AN OPPORTUNITY TO APPROACH TWO GUYS OF GOOD SIZE TO CARJACK THEM, THEY DIDN'T DO THAT. THEY CHOSE A WOMAN WHO IS FIVE FOOT SEVEN AND 150 POUNDS BY HERSELF, ARE YOU AWARE OF THAT INFORMATION?

A. YEAH. ACTUALLY, MR. FULKS, HIMSELF, TOLD ME ABOUT THAT INCIDENT.

Q. AND THEY -- HE SIZED UP THE SITUATION, YOU WOULD AGREE WITH ME. AND YOU GO AFTER THE WOMAN, WHO IS MORE VULNERABLE THAN MEN?

A. YES. I MEAN, I GUESS FROM THAT PERSPECTIVE HE SIZED THE SITUATION UP WELL.

Q. AGAIN, I AM JUST CITING EXAMPLES, BASED ON YOUR NEEDING TO LOOK AT THE BRAIN IN ACTION. I AM TRYING TO SEE WHAT EXAMPLES YOU WERE PROVIDED IN WHICH THE JURY HAS BEEN PROVIDED. THEY HAVE SEEN MR. FULKS BRAIN IN ACTION.

A. I MEAN, THERE ARE MANY INSTANCES WHERE HE, OBVIOUSLY, DID NOT SIZE UP THE SITUATION WELL AND GOT INTO A LOT OF TROUBLE FOR IT.

Q. OR HE CHOSE?

A. IT DOESN'T MEAN THAT. WHEN SOMEBODY IS CLUMSY, IT DOESN'T MEAN THAT THEY SPILL WATER EVERY TIME THEY GIVE TESTIMONY IN COURT, BUT --

Q. ANOTHER RATIONAL EXPLANATION IS, HE CHOSE TO ACT THAT WAY. HE CHOSE?

A. YEAH. I AM NOT MAKING -- GIVING OPINION ON --

Q. WHEN YOU INTERVIEWED MR. FULKS, YOU INDICATED YOU WERE IN A CELL DURING THIS 90-MINUTE INTERVIEW. AND YOU SAY THAT "HIS SPEECH WAS SLOW AND SOMEWHAT SLURRED, WITH MINIMAL PROSODY"; IS THAT CORRECT?

A. YES.

Q. WHAT DOES "PROSODY" MEAN?

A. PROSODY IS THE INTONATION THAT YOU PUT ON YOUR VOICE IN ORDER TO PUT EMPHASIS IN THE RIGHT PLACE. SO, SAY, I WENT UP TO THE BOSS, HE GAVE ME THE NEWS. YOU CAN SAY THE SAME THING AND SAY, I WENT UP TO THE BOSS, HE GAVE ME THE NEWS. TOTALLY DIFFERENT THINGS.

Q. "HIS FACE HAD A STARE THAT SEEMED TO REFLECT EFFORTS TO UNDERSTAND WHAT WAS GOING ON AROUND HIM." DO YOU REMEMBER WRITING THAT IN YOUR REPORT?

A. YES.

Q. DID YOU WANT TO INTERVIEW, VIRTUALLY, I DON'T KNOW IF YOU NEEDED TO INTERVIEW ALL OF THEM, JUST, RANDOMLY, A DOZEN PEOPLE THAT MR. FULKS CAME INTO CONTACT WITH, FROM THE TIME HE ESCAPED ON NOVEMBER 4TH, 2002, UNTIL THE TIME HE WAS APPREHENDED ON NOVEMBER 20TH, DID YOU WANT TO RANDOMLY SELECT MAYBE 12 TO 15 PEOPLE AND ASK THEM IF HIS SPEECH WAS SLOW AND SOMEWHAT SLURRED, HIS FACE HAD A STARE THAT SEEMED TO REFLECT

EFFORTS TO UNDERSTAND WHAT WAS GOING ON AROUND HIM, DID YOU WANT TO DO THAT?

A. WELL, I ONLY COMMENTED ON WHAT I SAW.

Q. THAT IS THE POINT I AM TRYING TO MAKE. WHEN ONE OF HIS EXPERTS THAT CAME INTO HIS CELL TO INTERVIEW HIM IN PREPARATION TO DO A REPORT TO OFFER OPINIONS IN FRONT OF THE PEOPLE THAT ARE GOING TO DECIDE WHETHER HE LIVES AND DIES, HIS SPEECH WAS SLOW AND SOMEWHAT SLURRED, AND HIS FACE HAD A STARE THAT SEEMED TO REFLECT EFFORTS TO SEEM TO UNDERSTAND WHAT WAS GOING ON AROUND HIM. THE REALITY, DR. GUR, YOU WOULD BE SURPRISED THAT NOT ONE PERSON THAT WAS AROUND CHAD FULKS, NOT ONE PERSON DURING THIS ENTIRE 17-DAY CRIME SPREE, EVER DESCRIBED CHAD FULKS IN THAT MANNER. WOULD THAT SURPRISE YOU?

MR. BLUME: YOUR HONOR, THAT IS A MISSTATEMENT OF THE EVIDENCE.

THE COURT: I'M SORRY?

MR. BLUME: MISSTATING THE EVIDENCE.

BY MR. GASSER:

Q. PUT IT THIS WAY, ABSENT DRUG AND ALCOHOL INDUCEMENT, BECAUSE YOU SAID HE WASN'T UNDER THE INFLUENCE OF ALCOHOL WHEN YOU SAW HIM.

A. WHEN I SAW HIM. IT WOULD BE SOMEWHAT SURPRISING, BUT NOT ENTIRELY, BECAUSE PEOPLE MAY BE ONE WAY ONE SITUATION AND ANOTHER WAY IN ANOTHER. WHEN YOU ARE UNDER TREMENDOUS

EMOTIONAL UPHEAVAL, THEN EVEN PEOPLE WHO SPEAK WITHOUT MUCH INTONATION, THEY CAN BECOME VERY ANIMATED. IN FACT, THE PEOPLE WITH FRONTAL BRAIN DAMAGE, THEY VACILATE BETWEEN SOMETIMES SEEMING TOTALLY APATHETIC, AND THEN, ALL OF A SUDDEN, SOMETHING GOES OFF, AND THEY BECOME VIOLENT AND GO INTO OUTBURSTS OF SCREAMING AND VIOLENT BEHAVIOR.

SO, WHAT YOU ARE TELLING ME IS, I SUGGEST THAT HE DOES HAVE PROBLEMS IN REGULATING HIS AFFECT. IT COULD BE EITHER ABSENT OR BE VERY, VERY VIOLENT. AND THAT IS NOT ATYPICAL. NOT BE SURPRISING FOR FRONTAL LOBE DAMAGE.

Q. OR, HE COULD BE FAKING. HE COULD BE PURPOSEFULLY ALTERING HIS SLURRED SPEECH, STARING AROUND THE ROOM?

A. ANY BEHAVIOR CAN BE FAKED.

Q. AND YOU SAW HIM. HE WAS IN A SOMEWHAT SIGNIFICANT ALTERED STATE PHYSICALLY FROM THIS CRIME SCENE, YOU ARE AWARE OF THAT, AREN'T YOU?

A. WHEN I SAW HIM, HE HAD A TUBE COMING OUT OF HIS BELLY AND --

Q. HE WAS PHYSICALLY DIFFERENT?

A. YES.

Q. LET ME SHOW YOU WHAT IS MARKED GOVERNMENT'S EXHIBIT 302 AND ASK IF YOU WERE PROVIDED THIS PHOTOGRAPH?

A. EXCUSE ME. IF I APPEAR NERVOUS, A BIG PART OF IT IS I DON'T KNOW IF MY FLIGHT IS THE LAST FLIGHT. IF I MISS MY PLANE, I HAVE TO GET UP 7:00 O'CLOCK TOMORROW MORNING AND BE

IN HARRISBURG, PENNSYLVANIA BY AROUND TEN.

MS. JOHNSON: IF I CAN INTERRUPT. THERE IS A LATER FLIGHT OUT.

THE WITNESS: OKAY. THANK YOU.

BY MR. GASSER:

Q. WERE YOU PROVIDED WITH THIS PHOTOGRAPH TO SHOW CHAD FULKS AND THE PHYSICAL CONDITION -- PHYSICALLY, MEANING HIS BODY'S PHYSICAL CONDITION THE DAY HE WAS ARRESTED ON NOVEMBER 20TH, 2002, DID YOU EVER SEE THAT PICTURE BEFORE?

A. NO, I DIDN'T.

Q. AND, AS A PSYCHOLOGIST, BEFORE YOU INTERVIEWED HIM, GAVE HIM THESE TESTS, DID YOU WANT TO KNOW ALL OF THE DRUGS THAT HE WAS ON THAT SOME OTHER PSYCHIATRIST, PSYCHOLOGIST, WORKING ON BEHALF OF THE DEFENSE TEAM, HAD BEEN PROVIDING HIM? DID YOU WANT TO KNOW THAT?

A. I ASKED FOR HIS HISTORY OF SUBSTANCE ABUSE.

Q. THAT IS NOT WHAT I AM TALKING ABOUT. ARE YOU AWARE THAT, DURING THE PENDENCY OF HIS INCARCERATION, THAT HE HAS BEEN ON MEDICATION?

A. YES.

Q. AND SOME OF THE MEDICATION INCLUDES TRANQUILIZING AGENTS?

A. YES.

Q. SEDATIVES, OBVIOUSLY, AND SOME SORT OF TRANQUILIZER, YOU WILL APPEAR A LOT MORE CALMER, SAY, IN AN INTERVIEW ROOM

OR IN A COURTROOM THAN YOU WOULD IF YOU WERE NOT ON A TRANQUILIZER OR SEDATIVE?

A. YES.

Q. WHAT IMPACT DID YOU TAKE TO DETERMINE WHAT LEVELS OF SEDATION OR TRANQUILIZERS HE MAY OR MAY NOT HAVE BEEN ON? WERE YOU CONCERNED ABOUT THAT WHEN YOU WERE INTERVIEWING HIM OR DURING THIS NEUROLOGICAL TESTING?

A. I WAS CONCERNED. I WANTED TO HAVE THIS INFORMATION. SURPRISINGLY, TRANQUILIZERS DON'T HAVE MUCH IMPACT, POSITIVE OR NEGATIVE, ON THE NEUROPSYCHOLOGICAL PERFORMANCE. SO, IF YOU GIVE -- LET ME EXPLAIN THAT. IF YOU GIVE THE SAME TEST TO THE SAME INDIVIDUAL TWICE, ONCE WHEN THEY ARE MEDICATED, ONCE WHEN THEY ARE UNMEDICATED, YOU MAY SEE SOME CHANGES IN ONE TEST SCORE OR THE OTHER. BUT ONE OF THE FINDINGS THAT WAS QUITE SURPRISING WHEN IT SHOWED UP 15 YEARS AGO WAS THAT THOSE AFFECTS ARE VERY SMALL. AND, REALLY, THE PROFILE IS NOT SUBSTANTIALLY AFFECTED BY THE PRESENCE OF MEDICATION ON BOARD.

WE STUDIED PATIENTS WITH SCHIZOPHRENIA WHERE WE ADMINISTERED A BATTERY OF TEST. THEY WERE HALLUCINATING, THEY WERE ACUTELY ILL, AND THEN WE TREATED THEM AND TESTED THEM AGAIN, AND I WOULD CHALLENGE ANYBODY TO SEE THERE IS ANYTHING ABNORMAL ABOUT THEM. SO, THE SYMPTOMS IMPROVED VERY DRAMATICALLY. THE NEUROCOGNITIVE PERFORMANCE, THIS PROFILE IS VERY BOTCHED.

Q. OKAY. I WILL TALK ABOUT THREE OTHER AREAS, JUST SO,

YOU KNOW, THE JURY KNOWS I WILL GO TO THE END AS QUICK AS POSSIBLE. I KNOW THIS HAS BEEN LONG. I WANT TO TALK ABOUT THIS SOLE ISSUE OF POTENTIAL FETAL ALCOHOL SYNDROME. I WANT TO GO INTO THE 1998 REPORT AND THEN A FEW OTHER QUESTIONS ABOUT YOUR REPORT, OKAY? SO, THREE SUBJECT MATTERS.

YOU ARE NOT SAYING THAT MR. FULKS -- YOU HAVE NOT DIAGNOSED MR. FULKS WITH FETAL ALCOHOL SYNDROME. YOU ARE SAYING THAT, WHAT YOU ARE SEEING ON THE BRAIN SCAN OR IMAGING, IS CONSISTENT WITH FETAL ALCOHOL SYNDROME?

A. YES.

Q. WERE YOU PROVIDED WITH ANY MEDICAL REPORTS AND HOSPITAL REPORTS FROM WHEN CHAD FULKS WAS BORN IN MAY OF 1977?

A. I WAS PROVIDED WITH SOME HOSPITAL RECORDS.

Q. DID THEY INDICATE THAT THE DOCTORS AND THE NURSES NOTED THAT THE MOTHER WAS DRUNK, I MEAN, IS THAT IN THERE?

A. I BELIEVE THAT IS WHERE I SAW THAT. THERE WERE SEVERAL SOURCES INCLUDING -- A LOT OF TIMES I KNOW SOMETHING AND YOU ASK ME WHERE DID I LEARN IT. I HAVE A HARD TIME REMEMBERING. I BELIEVE THERE WERE OTHER INDICATIONS THAT SHE WAS DRUNK WHEN SHE DELIVERED HIM.

Q. WOULD IT BE FAIR TO SAY, THAT THERE ARE NO REPORTS OF ANY DOCTOR'S OFFICE WHERE MR. FULKS WAS BORN INDICATING THAT THE MOTHER, NO BLOOD REPORTS, NOTHING TO SHOW THE MOTHER WAS DRUNK OR INTOXICATED, AT THE TIME MR. FULKS WAS BORN?

A. I AM NOT SURE EXACTLY WHERE THE SOURCE OF THAT

INFORMATION WAS. BUT I RECALL MAYBE ONE OF THE -- I CAN CHECK, BUT I RECALL -- WHAT I DO WITH IS WITH A PIECE OF INFORMATION, I REMEMBER THE PIECE, AND I REMEMBER WHETHER I BELIEVED THE SOURCE OF IT. AND IF I BELIEVE THE SOURCE OF IT, I PUT IT IN ONE CORNER OF MY MIND; IF I DON'T BELIEVE THE SOURCE OF IT, I PUT IT IN ANOTHER CORNER. AND THAT PIECE OF INFORMATION THAT HIS MOTHER WAS USING ALCOHOL HEAVILY, WAS DRUNK WHEN SHE GOT THERE, I CAN'T QUOTE YOU THE SOURCE RIGHT NOW, BUT I REMEMBER CHECKING IT OFF AS THAT SOUNDS LIKE A PROBLEM.

Q. WAS IT HIS MOTHER?

A. NO, I DID NOT TALK TO HIS MOTHER.

Q. DID YOU --

A. I MAY HAVE READ SOME MATERIAL FROM --

Q. DID YOU ASK ANYBODY? MS. THOMPSON? ANYBODY TALK TO MS. THOMPSON? SHE HAS BEEN TALKED TO BY ALL PARTIES INVOLVED IN THIS. DID YOU TALK TO HER?

A. I DID NOT TALK TO HER.

Q. SO, YOU DIDN'T ASK THE MOTHER, WHO GAVE BIRTH TO CHAD FULKS, IF SHE WAS DRUNK OR HEAVILY USING DRUGS AT THE TIME OF CHAD'S BIRTH?

A. NO.

Q. THAT IS NOT SOMETHING YOU WOULD WANT TO KNOW BEFORE DIAGNOSING FETAL ALCOHOL SYNDROME?

A. IF I HAD DOUBTS, I MIGHT HAVE WANTED TO CHECK THEM.

AS I REMEMBER, I CLASSIFIED THE SOURCE AS BEING RELIABLE. I AM SORRY, I CAN'T PINPOINT WHAT THE SOURCE WAS.

Q. WHAT YOU ARE DESCRIBING IN THESE BRAIN SCANS IS ALSO CONSISTENT, IS IT NOT, WITH THE FACT THAT CHAD FULKS, HIMSELF, PERSONALLY, HIS OWN CHOICE, ABUSED ALCOHOL AND MULTIPLE DRUGS DURING HIS ADULT LIFE, CORRECT?

A. A LOT OF WHAT WE SEE LOOKS LIKE IT MAY HAVE BEEN EXACERBATED BY SUBSTANCE ABUSE. I WOULDN'T CARE TO COMMENT ON WHETHER SUBSTANCE ABUSE IS BEHAVIOR OF CHOICE. THERE IS A LOT OF CONTROVERSY ON THAT ISSUE IN THE FIELD. IT IS, FOR EXAMPLE, HIGHLY GENETIC, IT RUNS IN FAMILIES. AND IT HAPPENS EVEN WHEN CHILDREN ARE ADOPTED AWAY. IF THEIR PARENTS WERE DRUG ADDICTS, THEY CAN GROW UP IN A VERY NICE ENVIRONMENT. AND THEN, ALL OF THE NICE ADOPTING PARENTS DON'T UNDERSTAND WHY THEIR KID IS ADDICTED.

Q. DO YOU HAVE A COPY OF THE 1998 REPORT THAT YOU REFERENCED AT THE END OF YOUR DIRECT EXAMINATION?

A. I'M SORRY, I DON'T.

Q. WHEN WAS IT THAT YOU BECAME AWARE THAT THIS REPORT EXISTED?

A. I THINK IT WAS -- MAYBE I HEARD SOME ALLUSION TO IT, BUT THE FIRST TIME I SAW IT WAS YESTERDAY.

Q. YESTERDAY?

A. (WITNESS NODS HEAD AFFIRMATIVELY.)

Q. WELL, LET ME ASK YOU THIS. SOMEBODY THAT IS A

TEACHER AT THE ESTEEMED UNIVERSITY OF PENNSYLVANIA, DO YOU TEACH YOUR STUDENTS TO BE OBJECTIVE, DR. GUR?

A. YES.

Q. SIMPLE QUESTION.

A. YES, SURE.

Q. AND WHEN YOU ARE BROUGHT IN FOR CONSULTATION, DO YOU BELIEVE THAT YOU ARE OBJECTIVE COMING INTO THE MATTER?

A. YES.

Q. AND DO YOU EXPECT THE PECPLE THAT HIRE YOU TO EXPECT YOU TO BE OBJECTIVE?

A. YES.

Q. AND AS AN OBJECTIVE DOCTOR PH.D., AND AN OBJECTIVE PSYCHOLOGIST, ISN'T ONE OF THE MOST CRITICAL PIECES OF INFORMATION THAT YOU WOULD WANT TO HAVE BEFORE EVEN STARTING ANY TYPE OF INTERVIEW WITH A PATIENT, OR ANY TYPE OF TESTING, IS ALL OTHER REPORTS OF COLLEAGUES IN THE AREA OF MENTAL HEALTH?

MR. BLUME: YOUR HONOR, CAN WE APPROACH ON THIS?

(WHEREUPON, A BENCH CONFERENCE WAS HELD.)

MR. BLUME: I THINK I OBJECT TO THIS. I THINK THIS IS UNFAIR. IT WAS AN OUTSTANDING MOTION.

THE COURT: WHAT?

MR. BLUME: IT WAS AN OUTSTANDING MOTION IN LIMINE PENDING.

MR. GASSER: THAT IS NOT THE QUESTION. THAT IS NOT

THE QUESTION, WHETHER IT IS ADMISSIBLE OR NOT ADMISSIBLE. WHAT HE WAS SAYING IS, WHETHER THE MALINGERING WAS ADMISSIBLE, NOT WHETHER THE REPORT AND EVERYTHING ELSE WOULD BE ADMISSIBLE.

THE COURT: I THINK IT IS A FAIR QUESTION. THE WITNESS HAS TO FORM HIS OPINION BASED ON PROFESSIONAL EXPERTISE.

MR. GASSER: NO QUESTION ABOUT IT.

MR. BLUME: SO, IF YOU GRANTED THE MOTION IN LIMINE, HE STILL COULD HAVE DONE THIS.

MR. GASSER: THE MOTION IN LIMINE WAS NOT TO GET IN THE OPINION IT WAS MALINGERING. THE MOTION IN LIMINE -- I CAN STILL ASK HIM IF HE REVIEWED ALL THE TESTING IN 1998.

THE COURT: ALL RIGHT. OVERRULE THE OBJECTION.

(WHEREUPON, THE BENCH CONFERENCE CONCLUDED.)

BY MR. GASSER:

Q. AS AN OBJECTIVE PH.D. DOCTOR, TEACHER, ISN'T SOMEBODY IN THE FIELD THAT YOU ARE, BEFORE MEETING WITH AND TESTING A PATIENT TO DETERMINE THEIR CREDIBILITY, YOU WOULD WANT TO KNOW IF OTHER COLLEAGUES, OTHER MENTAL HEALTH EXPERTS, OTHER PSYCHOLOGISTS HAVE HAD AN OPPORTUNITY TO PROVIDE TESTING TO THAT PARTICULAR PATIENT, AND THE OPPORTUNITY TO OBSERVE THAT PARTICULAR PATIENT, AND THE OPPORTUNITY TO RENDER OPINIONS TO THAT PARTICULAR PATIENT JUST SO YOU WOULD HAVE THAT INFORMATION, IS THAT A FAIR STATEMENT, SIR?

A. YES.

Q. YOU ARE TELLING THIS JURY THAT THERE WAS A -- YOU RECEIVED FROM A FEDERAL MEDICAL CENTER IN LEXINGTON, KENTUCKY A FORENSIC REPORT BY A FORENSIC PSYCHOLOGIST THAT HAD AN OPPORTUNITY, HIM AND HIS TEAM, TO EVALUATE MR. FULKS FOR A PERIOD OF 43 DAYS IN 1998, AND YOU NEVER GOT THE REPORT UNTIL YESTERDAY?

A. YEAH.

Q. BUT YOU HEARD OF THE REPORT?

A. I HEARD THAT THERE WAS SOME REPORT. I WAS TOLD IT WASN'T A NEUROPSYCHOLOGICAL TESTING. I ASKED TO LOOK AT PREVIOUS NEUROPSYCHOLOGICAL TESTING. I DIDN'T THINK IT WAS EXTENSIVE ENOUGH TESTING, AND IT WAS A WHILE BACK. SO, I DIDN'T THINK IT WAS ALL THAT RELEVANT, SO I DIDN'T FEEL PRESSED TO GET IT. I WAS VERY HAPPY WITH THE VERY COMPREHENSIVE TESTING THAT WAS DONE MORE RECENTLY. I GOT SOME SUMMARY OF SCHOOL PERFORMANCE, THOSE KINDS OF THINGS.

YOU ARE RIGHT. MAYBE I SHOULD HAVE DEMANDED EVERYTHING, BUT, FRANKLY, I FIGURED THE TESTING OF HIM NOW, WE HAVE ALL OF THE STUDIES ON HIM. I HAVE VERY COMPREHENSIVE MEASURES. I WAS MORE CONCERNED WITH HIS CURRENT INTELLECTUAL AND COGNITIVE ABILITIES. SO, EVEN THOUGH I JUST SAW IT RECENTLY, THE REPORT IS REALLY NOT ALL THAT RELEVANT TO ANYTHING THAT I WAS CONCLUDING.

Q. DR. GUR, YOU ARE TELLING THIS JURY, THIS REPORT IN

1998, DIDN'T CORROBORATE AND, BASICALLY, COME TO THE SAME CONCLUSIONS THAT YOU CAME TO HERE SIX YEARS LATER? ISN'T IT TRUE THAT IF THIS REPORT CAME WITH SOME OF THE SAME CONCLUSIONS THAT YOU CAME TO, YOU WOULD HAVE TALKED ABOUT THIS REPORT UP AND DOWN THIS MORNING AND ALL INTO THIS AFTERNOON, WOULDN'T YOU, SIR?

A. I WOULDN'T. FIRST OF ALL, IT DOESN'T MEASURE THE SAME THINGS THAT I MEASURED IN THAT IT GIVES A PERSONALITY INVENTORY AND MALINGERING TESTS. MALINGERING ARE RELEVANT TO NOW. I MEAN, THE FACT THAT HE MALINGERED SIX YEARS AGO, WHENEVER, IS REALLY NOT RELEVANT. MALINGERING, AS THE REPORT, ITSELF, INDICATES, IT IS NOT A MENTAL CONDITION THAT YOU NEED TO DIAGNOSE. IT IS SOMETHING THAT MAY INTERRUPT WITH SOMETHING YOU ARE DOING RIGHT NOW. WHAT YOU WANT TO KNOW IS, WHETHER THEY ARE MALINGERING ON THE TEST YOU ARE GIVING NOW.

Q. DR. GUR, YOU SAID THE REPORT IS SIX YEARS OLD. SO, MR. FULKS WAS 21-YEARS-OLD. AND SO, YOU MENTION THE FACT THAT THERE WAS SOME AGE TO THE REPORT. THAT IS WHAT YOU TOLD THE JURY JUST A FEW MINUTES AGO, CORRECT?

A. DO WHAT?

Q. THE REPORT WAS SIX YEARS OLD, AND YOU PUT LESS SIGNIFICANCE ON THE INFORMATION CONTAINED IN IT BECAUSE IT IS SIX YEARS OLD?

A. WITH REGARD TO THE SPECIFIC ISSUE OF MALINGERING.

Q. YET -- SO, JUST ISOLATED TO THAT ISSUE?

A. YES.

Q. ALL INFORMATION ABOUT MR. FULKS WHEN HE WAS IN UTERO, WHEN HE WAS IN GRADE SCHOOL, WHEN HE WAS AN ADOLESCENT, ALL INTO HIS ADULT YEARS, YOU WANT TO GET AHOLD OF ALL OF THAT INFORMATION?

A. IF I HAD ALL OF THE TIME IN THE WORLD, I WOULD HAVE DONE IT.

Q. THERE IS A REPORT OUT THERE BY A BOP MENTAL HEALTH TEAM IN 1998, AND YOU DIDN'T SEE IT. YOU HEARD ABOUT IT, BUT YOU DIDN'T ASK TO SEE IT?

A. I HEARD. I ASKED TO SEE IT, AND I SAW IT YESTERDAY. I UNDERSTOOD FROM THE DISCUSSION THAT IT -- HE DID NOT HAVE NEUROPSYCHOLOGICAL TESTS. AND WHEN I SAW IT YESTERDAY, I AGREED, THERE WERE NO PSYCHOLOGICAL TESTS IN THERE.

Q. IT DESCRIBES, IN DETAIL, THE MANIPULATIVE BEHAVIOR AND DECEIT OF MR. FULKS DURING THIS 43-DAY PERIOD?

A. IT DESCRIBES THE IMPRESSION OF THE PERSON THAT WROTE IT THAT, FRANKLY, I THINK HE PROBABLY WAS A LITTLE BIT TAINTED, BECAUSE HE GOT THE POSITIVE FINDING ON THE MALINGERING THAT SO TAINTED HIS WHOLE INTERPRETATION. IT WOULD HAVE TAINTED MINE. IT IS LIKE CRYING WOLF. IF YOU KNOW SOMEBODY IS MALINGERING, EVEN IF YOU KNOW, I HAVE HAD CASES OF PEOPLE THAT I KNEW HAD REAL BRAIN DAMAGE, WHEN THEY MALINGERED, YOU CAN'T TELL WHAT IS REAL AND WHAT IS NOT REAL. THAT IS WHY YOU WANT TO KNOW IF THEY ARE MALINGERING RIGHT NOW WHEN YOU ARE TESTING THEM.

Q. DR. ANDREW SIMCOX IS A PH.D. IN FORENSIC -- PH.D. IN FORENSIC PSYCHOLOGY. HE AND HIS TEAM OF OTHER PSYCHOLOGISTS AND SOCIAL WORKERS SPENT 43 DAYS EVALUATING MR. FULKS'S CONDUCT, AND EVALUATING TESTS AND MRI'S, AND ALL THAT SORT OF STUFF. AND IT WASN'T JUST ONE PERSON'S OPINION, AS YOU WELL KNOW, THIS METHODOLOGY, IT WAS EVERYBODY'S OPINION GOING INTO THIS REPORT AFTER HAVING AN OPPORTUNITY TO LOOK AT ALL OF THE MATERIAL; ISN'T THAT TRUE?

A. NOTHING ABOUT MRI.

Q. WELL, THERE IS NOTHING ABOUT -- I AM SORRY, NOT MRI. THEY TRIED TO DO A TEST, I BELIEVE, AS PART OF HIS MEDICAL EVALUATION, HE WAS ADMINISTERED AN EEG DURING THE PROCEDURE. MR. FULKS CONTINUOUSLY MOVED. HE WAS INSTRUCTED BY MEDICAL STAFF OF THE IMPORTANCE OF KEEPING STILL IN ORDER FOR THE TEST RESULTS TO BE ACCURATE. HE RESPONDED HIS MOVEMENTS WERE INVOLUNTARY. MR. FULKS DID NOT EXHIBIT THE SAME TYPE OF BODY MOVEMENTS AT TIMES WHEN HE WAS UNAWARE THAT STAFF WAS WATCHING HIM. DOESN'T THAT FALL INTO WHAT YOU TOLD THE JURY AT THE END OF YOUR DIRECT EXAMINATION, A PATIENT DOESN'T WANT TO COOPERATE, ALL HE HAS TO DO IS MOVE AROUND WHEN YOU DO SOME OF THIS TESTING?

A. YES. YES. HE SEEMS TO HAVE BEEN, CLEARLY, MALINGERING IN 1998.

Q. AND LET'S GET IT CLEAR, SO THE JURY UNDERSTANDS. THIS WAS A 43-DAY STAY AT A FEDERAL MEDICAL FACILITY IN KENTUCKY.

AND MR. FULKS WAS CHARGED WITH THE MOST HEINOUS CRIME OF INTERSTATE TRANSPORTATION OF A STOLEN MOTOR VEHICLE, CORRECT?

A. WITH THE MOST HEINOUS?

Q. THE MOST HEINOUS CRIME OF STEALING A CAR AND DRIVING IT ACROSS LINES?

A. YOU THREW ME OFF THERE A MOMENT. YES. NO, I WAS -- I UNDERSTAND THAT. AND, OBVIOUSLY, HE WASN'T VERY SUCCESSFUL. HE WAS PICKED UP RIGHT AWAY AS MALINGERING.

Q. SO, MR. FULKS SPENDS 43 DAYS IN A FACILITY. AND HE DECEIVES AND MANIPULATES THE PEOPLE IN THAT FACILITY, FAKES BAD BOTH MENTALLY, PHYSICALLY TESTING-WISE WHEN HE IS UNDER THE CHARGE OF STEALING A CAR. AND, IT IS YOUR OPINION, AS YOU ALREADY STATED, THAT WHEN THE DEATH PENALTY IS ON THE TABLE, YOU DON'T GET ANY MORE SERIOUS THAN THAT. AND IT IS MORE LIKELY SOMEBODY WOULD MALINGER OR FAKE BAD WHEN SOMEBODY IS FACING DEATH THAN FACING, SAY, A PROPERTY CRIME, DO YOU AGREE WITH THAT?

A. WHAT ARE YOU ASKING?

Q. THAT IT IS MORE LIKELY THAT SOMEBODY WOULD FAKE BAD --

A. SURE.

Q. -- WHEN THEY ARE FACING THE DEATH PENALTY THAN THEY WOULD WHEN THEY ARE FACING A PROPERTY CRIME?

A. THAT'S RIGHT.

Q. LET ME USE, SO I AM EXACT, ONE OF THE RESULTS THAT YOU WERE PRETTY EMPHATIC ABOUT. AND YOU HAVE HAD AN OPPORTUNITY

TO REVIEW THIS REPORT. YOU SAID YOU LOOKED AT IT YESTERDAY. IT IS A PRETTY THOROUGH NINE-PAGE REPORT. IT IS NINE PAGES. YOU WOULDN'T DISPUTE THAT, WOULD YOU, SIR?

A. YEAH, NINE PAGES.

Q. AND IN THIS REPORT, YOU KNOW, BECAUSE YOU HAVE REVIEWED IT, AT LEAST YOU REVIEWED IT YESTERDAY, THAT THE CONCLUSIONS THAT I AM DISCUSSING WERE MADE BY THE STAFF AS FAR AS HE WAS MALINGERING, AND HE WAS FAKING BAD AND THAT WE WAS MANIPULATIVE, THAT WAS WHAT THE STAFF'S CONCLUSIONS WERE AND THE FORENSIC PSYCHOLOGISTS CONCLUSIONS WERE, CORRECT?

A. YES.

Q. DO YOU EVEN KNOW, AS A RESULT, A JUDGE FOUND HIM COMPETENT TO STAND TRIAL. HE PLED GUILTY TO THESE CHARGES IN FEDERAL COURT. DID YOU KNOW THAT?

A. I DID NOT.

Q. YOU DON'T DISPUTE MY WORD ON THAT?

A. NO. I PUT IT IN THAT CORNER OF RELIABLE SOURCES.

Q. I APPRECIATE THAT.

YOU MENTIONED SOMETHING AT THE END OF YOUR DIRECT EXAMINATION. YOU SAID YOU HAD A VERY STRONG OPINION DURING THE TESTING THAT YOU GAVE MR. FULKS THAT WHATEVER -- WITH REGARD TO HIS BRAIN, HIS ABILITY TO ABSORB INFORMATION, FOR LACK OF A BETTER PHRASE, WHATEVER COMES IN, STAYS THERE. IF HE LEARNS SOMETHING, HE WILL REMEMBER IT. DO YOU RECALL TESTIFYING IN THAT REGARD, SIR?

A. THAT IS WHAT THE DATA SUGGESTS.

Q. SO, IN 1998, MR. FULKS TRIED TO FAKE BAD, LEARNED THAT STAFF MEMBERS WERE WATCHING HIM WHEN HE DIDN'T KNOW THAT THEY WERE WATCHING HIM, LEARNED THE TESTS HE WOULD BE GIVEN, AND THE QUESTIONS THAT PSYCHOLOGISTS AND SOCIAL WORKERS WOULD BE PROVIDED, AND EVEN, IN YOUR OWN WORDS, HE IS THE TYPE OF PERSON THAT, WHATEVER COMES IN, STAYS THERE. AND WHEN HE LEARNS SOMETHING, HE WILL REMEMBER IT. ISN'T IT FAIR, A FAIR STATEMENT, A FAIR CONCLUSION, DOCTOR, THAT MR. FULKS KNEW EXACTLY WHAT YOU AND YOUR FELLOW COLLEAGUES WERE GOING TO DO WITH REGARDS TO TESTING AND INTERVIEWS BECAUSE HE WENT THROUGH THE SAME PROCESS IN 1998? ISN'T THAT A FAIR CONCLUSION TO MAKE?

A. NOT ENTIRELY BECAUSE THE TEST THAT HE GOT MORE RECENTLY ARE TESTS THAT WEREN'T AVAILABLE AT THE TIME.

Q. DESPITE THAT FACT --

A. THESE ARE THE MALINGERING TESTS.

Q. WHICH ARE NOT CONCLUSIVE. IT IS IMPOSSIBLE TO DETERMINE WHETHER OR NOT SOMEBODY IS TELLING THE TRUTH OR FAKING BAD OR NOT. IT IS IMPOSSIBLE?

A. I GUESS, YEAH -- NO -- YEAH. I AM THINKING ABOUT POLYGRAPHY. AND THERE ARE SOME USE OR FUNCTION TO LOOK AT THAT. YOU ARE RIGHT. IF SOMEBODY WANTS TO FAKE BAD, THEY CAN FAKE BAD. BUT IT IS VERY DIFFICULT TO FAKE BAD AND NOT BE CAPTURED BY ONE OF THOSE NEW MALINGERING TESTS. AND THEY

USE SOME OLD MALINGERING TESTS THAT CAUGHT HIM. AND I WOULD BE VERY SURPRISED IF HE WOULD BE ABLE TO PERFORM IN A WAY THAT WOULDN'T BE CAPTURED ON THE NEWER MALINGERING TESTS THAT ARE MUCH STRONGER, MUCH BETTER CONSTRUCTED.

Q. JUST A FEW MORE QUESTIONS IN THIS REPORT AND I WILL MOVE ON TO MY LAST MATTER. YOU NOTICE IN THIS REPORT, THIS FORENSIC PSYCHOLOGIST DIDN'T JUST RELY ON AN INTERVIEW WITH MR. FULKS OR TESTING. HE ACTUALLY WENT OUT AND WANTED TO INTERVIEW PEOPLE, HIMSELF, THAT HAD INFORMATION ABOUT MR. FULKS'S LIFE, HIS UPBRINGING, HIS PERSONALITY, AND THE CIRCUMSTANCES SURROUNDING THE CRIME FOR WHICH HE WAS CHARGED. DID YOU NOTICE THAT?

A. YEAH. IN THE VERSION I SAW, THE NAMES WERE TAKEN OUT.

Q. ROBERT LEE AND NELLIE LEE, WHO THE JURY WILL HEAR FROM LATER ON IN THE WEEK; AMBER FOWLER, WHO THE JURY WILL HEAR FROM; HIS MOTHER, DIAN THOMPSON. THIS FORENSIC PSYCHOLOGIST DIDN'T WANT TO RELY ON AN INTERVIEW WITH THE SUSPECT AND TESTING AND WHATEVER KIND OF -- WHEN I SAY "TESTING," BOTH COGNITIVE TESTING AND MEDICAL TESTING, BUT HE WANTED TO, ACTUALLY, INTERVIEW PEOPLE THAT KNEW CHAD FULKS OR KNEW SOMETHING ABOUT THE CRIME. IS THAT SOMETHING THAT YOU DO IN OTHER EVALUATIONS, SIR?

A. FRANKLY, I, USUALLY, WHEN SOMEBODY COMES TO ME AND WANTS TO RETAIN ME TO TESTIFY, I TRY TO MAKE SURE THAT THEY ALSO RETAIN A REGULAR CLINICAL NEUROPSYCHOLOGIST LIKE DR. VENN

AND DR. EVANS. AND I JUST CAN'T AFFORD TO DO THE THOROUGH EVALUATION MYSELF OF FAMILY MEMBERS AND SO ON. BUT I EMPHASIZE AND CONSULT TO THE PERSON RETAINING ME THAT THEY SHOULD GET SOMEBODY LIKE THAT. AND GET THE VERY THOROUGH INFORMATION. AND, UNFORTUNATELY, I HAVE TO RELY ON OTHER PEOPLE TO RELAY TO ME. I AGREE THAT IT WOULD HAVE BEEN -- I WOULD HAVE BEEN HAPPIER IF I COULD TALK TO ALL OF THOSE PEOPLE, BUT I DON'T USUALLY DO THAT.

Q. THIS REPORT INDICATED, ACCORDING TO THE PEOPLE ON THIS TEAM, MR. FULKS WAS VIEWED AS EXTREMELY VAGUE AND UNRELIABLE AS FAR AS HIS HISTORY. DID YOU CONSIDER HIM TO BE EXTREMELY VAGUE AND UNRELIABLE, OR WAS HE COOPERATIVE WITH YOU?

A. HE WAS COOPERATIVE WITH ME. FROM WHAT I COULD TELL, HE WAS MAKING EVERY EFFORT TO GIVE ME THE INFORMATION I ASKED FOR.

Q. YOU NOTED IN THIS REPORT, YOU MAY HAVE NOTED, I GUESS, PROBABLY, IN YOUR INTERVIEW WITH HIM, IN A JUVENILE FACILITY, HE GOT HIS HIGH SCHOOL EQUIVALENCY, GED; EARNED A CERTIFICATE AS A WELDER. SO, HE HAD A TRADE. DID HE TELL YOU THAT, AS WELL?

A. YES.

Q. JUST TO BE SPECIFIC, SINCE YOU INDICATED YOU HAD AN OPPORTUNITY TO REVIEW THIS REPORT, BUT YOUR TESTIMONY IS THIS REPORT DOESN'T CHANGE YOUR FINDINGS THAT YOU DESCRIBED TO THE JURY; IS THAT TRUE, SIR?

A. THAT IS TRUE, YES.

Q. SO, THE FACT THAT, WHEN YOU READ IN THE REPORT THAT MR. FULKS ALSO PRESENTED WITH VARIOUS ODD MANNERISMS, SUCH AS DRAMATIC EYE BLINKING, HEAD WITCHING, HAND RUBBING, ROCKING BACK AND FORTH WHEN INTERVIEWED, HE CLAIMED TO HAVE BEEN TREATED FOR PSYCHIATRIC PROBLEMS IN THE PAST. COULD NOT RECALL WHEN, WHERE, WHAT HIS DIAGNOSIS WAS, OR WHAT TYPE OF TREATMENT HE RECEIVED. WHEN ASKED IF HE HEARD VOICES OR EXPERIENCED VISUAL HALLUCINATIONS, MR. FULKS, INITIALLY, SAID HE DID NOT. LATER, HE SAID HE RECEIVED MESSAGES FROM THE TELEVISION. HE THEN REPORTED HE WAS HEARING THE VOICES OF HIS DECEASED UNCLE AND SON CALLING HIM STUPID, WHICH HE REPORTED KEPT HIM AWAKE AT NIGHT.

I KNOW YOU READ THAT IN THE REPORT. BUT I GUESS HE DIDN'T SAY ANY OF THAT STUFF TO YOU, HEARING VOICES IN THE TELEVISION. THAT WOULD HAVE BEEN IN YOUR REPORT, WOULD IT NOT?

A. YES. I ASKED HIM ABOUT HALLUCINATIONS.

Q. AND ONE OF THE REASONS THEY KNEW HE WAS MALINGERING WAS BECAUSE THEY HAD STAFF MEMBERS, DURING THIS TIME PERIOD WHEN HE WASN'T BEING TESTED OR INTERVIEWED, TO MONITOR HIM, AND THROUGHOUT THE ENTIRE 43 DAYS, HE HAD ABSOLUTELY NORMAL INTERACTION WITH ALL OF THE OTHER INMATES OR PATIENTS AT THAT FACILITY; ISN'T THAT TRUE?

A. THAT IS TRUE.

Q. NEVER DISPLAYED ANY OF THE HEAD TWITCHING, AND HAND RINGING, AND ALL OF THE STUFF THAT IS DESCRIBED IN THE REPORT WHEN HE WASN'T IN A CONTROLLED ENVIRONMENT WITH ONE OF THE EVALUATORS; ISN'T THAT TRUE, SIR?

A. YES.

Q. I BELIEVE YOU EVEN MENTIONED SOMETHING ABOUT THE HAND TWITCHING IN YOUR REPORT?

A. NO, I AM TALKING ABOUT SOMETHING ELSE. I AM TALKING ABOUT A SLIGHT TREMOR THAT DOESN'T -- IS NOT PRESENT ALL THE TIME. PRESENT, ESPECIALLY, WHEN HE IS WORKING WITH THE OTHER HAND. SO, AND THAT IS A SIGN. IF HE LEARNS SOMEWHERE ABOUT THAT SIGN, I AM IMPRESSED.

Q. THEY ALSO NOTED IN THEIR REPORT, AS YOU NOTED IN YOUR REPORT, THAT HIS SPEECH WAS DIFFERENT WHEN HE WAS BEING INTERVIEWED BY CLINICIANS AS OPPOSED TO WHEN HE WAS INTERMINGLING WITH OTHER PATIENTS AND STAFF MEMBERS, DID THEY NOT?

A. YES, I NOTICED THAT WAS NOTED.

Q. MALINGERING IS NOT A MENTAL ILLNESS, DO YOU AGREE?

A. YES.

Q. INTENTIONAL PRODUCTION OF FALSE OR GROSSLY EXAGGERATED PHYSICAL OR PSYCHOLOGICAL SYMPTOMS MOTIVATED BY OBVIOUS EXTERNAL INCENTIVES, SUCH AS AVOIDING --

A. YOU ARE REPORTING FROM THE DIAGNOSTIC STATISTICAL MANUAL.

Q. DSM-IV?

A. YES.

Q. AND YOU WOULD ALSO AGREE WITH ME THAT ANTISOCIAL PERSONALITY DISORDER IS NOT A MENTAL ILLNESS?

A. WE CAN SPEND AN HOUR ON THAT ONE, I'M AFRAID. BUT I THINK -- IT IS NOT ONE THAT I CLASSIFY WITH THE SEVERE FORMS OF MENTAL ILLNESS OF THE KIND THAT WOULD QUALIFY AS AN AXIS-I DSM DIAGNOSIS.

Q. DOES THE DSM-IV DEFINE ANTISOCIAL PERSONALITY DISORDER AS:

> "A CLUSTER OF ABHORRENT PERSONALITY TRAITS CHARACTERIZED BY PERVASIVE PATTERN OF DISREGARD FOR AND VIOLATION OF THE RIGHTS OF OTHERS. THIS PATTERN BEGINS IN EARLY ADOLESCENCE AND CONTINUES INTO ADULTHOOD AND IS CHARACTERIZED BY DECEPTION, IMPULSIVE AND IRRESPONSIBLE BEHAVIOR, AGGRESSION, AND LACK OF REMORSE."

IS THAT A FAIR DEFINITION OF ANTI-SOCIAL PERSONALITY DISORDER?

A. THIS IS, AGAIN, THE DEFINITION OF -- THE CURRENT DEFINITION IN THE DSM-IV. I BELIEVE THE DSM-V WOULD BE A LITTLE DIFFERENT. THIS IS WHAT DSM-IV SAYS.

Q. THE PSYCHOLOGICAL TEAM IN 1998 CLEARLY DIAGNOSED MR. FULKS AS HAVING AN ANTI-SOCIAL PERSONALITY DISORDER, DID THEY NOT?

A. THAT IS WHAT THEY DID, YES.

Q. YOU WOULD AGREE WITH THAT, BASED ON EVEN JUST A REVIEW OF THE REPORT, BASED ON WHAT YOU KNOW ABOUT MR. FULKS, HE CLEARLY HAS ANTISOCIAL PERSONALITY DISORDER?

A. I BELIEVE IT IS PROBABLY AN AXIS TO AN APPROPRIATE DIAGNOSIS.

Q. I DON'T KNOW HOW MUCH YOU HAVE SEEN --

A. BY DEFINITION, HE HAS DONE A LOT OF BAD THINGS.

Q. THAT IS THE POINT.

A. THAT IS THE SHORT WAY OF DESCRIBING WHAT IS SAYS HERE.

Q. FROM THE TIME OF THIS REPORT IN 1998, TO THE TIME THAT YOU SAW HIM, THIS PATTERN, CHARACTERIZED BY DECEPTION, IMPULSIVE AND IRRESPONSIBLE BEHAVIOR, AGGRESSION, AND LACK OF REMORSE, I MEAN, FITS HIM TO A T BASED ON WHAT YOU KNOW; DOES IT NOT?

A. IT DOES.

Q. LAST COUPLE OF POINTS. YOUR REPORT ON THE PART OF INTERPRETATION OF NEUROPSYCHOLOGICAL EVALUATION. DO YOU SEE THAT SECTION OF YOUR REPORT? TOWARDS THE END, I BELIEVE?

A. YES.

Q. WHERE YOU WRITE ON THE SECOND PARAGRAPH THERE SECOND SENTENCE:

"PROBABLY OF GREATEST RELEVANCE TO THIS CASE ARE MR. FULKS'S IMPAIRED ABILITY TO PROCESS EMOTION AND THE IMPAIRED ABILITY TO UNDERSTAND EMOTIONAL EXPRESSIONS ON OTHER PEOPLE'S FACES."

DO YOU SEE THAT?

A. YES. UH-HUH (AFFIRMATIVE RESPONSE).

Q. YOU SAY THAT ONE OF THE GREATEST RELEVANCES OF THIS CASE IS HE HAD AN IMPAIRED ABILITY TO UNDERSTAND THE EMOTIONAL EXPRESSION ON OTHER PEOPLE'S FACES. YOU EVEN HIGHLIGHT THAT AS SAYING, PROBABLY ONE OF THE GREATEST RELEVANCIES TO THIS CASE IN YOUR REPORT; IS THAT TRUE, DOCTOR?

A. YES.

Q. ARE YOU TELLING THIS JURY THAT, ON NOVEMBER 14TH, 2002, AS CHAD FULKS STRADDLED ALICE DONOVAN AND RAPED HER, AND LOOKED AT HER FACE, HE HAD AN IMPAIRED ABILITY TO UNDERSTAND HER EMOTIONAL EXPRESSION AS HE WAS RAPING HER? IS THAT WHAT YOU MEAN BY THAT?

A. YES.

Q. HE IS ON TOP OF A WOMAN WHO HAD JUST BEEN RAPED. HE IS AS CLOSE AS A MAN CAN GET TO A WOMAN. HE IS PENETRATING HER. AND IT IS YOUR OPINION THAT CHAD FULKS DID NOT UNDERSTAND THE EMOTIONAL EXPRESSION ON ALICE DONOVAN'S FACE?.

A. I THINK IT IS REALLY HARD TO BELIEVE, BUT BASED ON THE

TESTING, HE JUST DOES NOT INTERPRET EMOTIONAL EXPRESSIONS NORMALLY.

Q. LET ME SHOW YOU. SO, I TAKE IT, BASED ON THAT ANSWER, THREE DAYS BEFORE THAT, ON NOVEMBER 11TH OF 2002, WHEN CHAD FULKS DECKED OUT IN CAMOUFLAGE, INCLUDING THIS TURKEY MASK, PARTICIPATED IN THE CARJACKING AND KIDNAPPING OF A 19-YEAR-OLD COED IN WEST VIRGINIA, HE HAD AN IMPAIRED ABILITY TO SEE THE ABSOLUTE FEAR OF GOD ON SAMANTHA BURNS'S FACE? HE WAS IMPAIRED? HE COULDN'T SEE THAT FEAR?

A. WELL, ACCORDING TO THE TESTING, HE HAS A VERY DIFFICULT TIME DETECTING EMOTIONS ON THE FACE AND INTERPRETING THEM. NOW, IT COULD BE, IN HER CASE, WHEN EMOTION IS VERY EXTREME IT COULD BE -- YOU KNOW, WHENEVER WE TEST SOMEONE, WE TAKE A SAMPLE OF WHAT COULD HAPPEN IN LIFE. IT COULD BE, UNDER CERTAIN CONDITIONS, THAT HE DOES -- SOMETHING DOES COME THROUGH. IT IS VERY HARD FOR ME TO INTERJECT. BUT THE TEST CLEARLY SHOWS THAT HE REALLY HAS A VERY DIFFICULT TIME UNDERSTANDING EMOTIONS.

Q. LAST QUESTION OR TWO. WOULD YOU AGREE WITH ME THAT, ABSENT A SEVERE PSYCHOTIC DISORDER MAKING SOMEONE INSANE, WOULD YOU AGREE WITH ME THAT, MOST ADULT MINDS, EVEN THE MIND OF CHAD FULKS, THAT THEY UNDERSTAND THE SIMPLEST THINGS TO GET THROUGH, TO GET THROUGH THE DAY. FOR INSTANCE, WHEN THEY ARE THIRSTY, YOU DRINK. WHEN YOU ARE HUNGRY, YOU EAT. WHEN YOU ARE TIRED, YOU SLEEP. WHEN YOU ARE COLD, YOU PUT

ON A COAT OR A BLANKET. WHEN YOU ARE DIRTY, YOU BATHE. THE BASIC HUMAN FUNCTIONING, YOU WOULD AGREE WITH ME, THAT THE OVERWHELMING MAJORITY OF PEOPLE IN THIS COUNTRY, ABSENT A SEVERE AND SIGNIFICANT PSYCHOLOGICAL OR MENTAL DISORDER, THOSE COME NATURAL, DO THEY NOT, DR. GUR?

A. YEAH.

Q. AND TO THOSE SAME PEOPLE, YOU WOULD AGREE, THAT AS NATURAL AS EATING WHEN ARE YOU HUNGRY OR DRINKING WHEN YOU ARE THIRSTY, YOU DON'T RAPE WOMEN, YOU DON'T CARJACK WOMEN, YOU DON'T KIDNAP WOMEN, AND YOU DON'T KILL WOMEN. THAT IS AS BASIC AN UNDERSTANDING OF HUMAN RATIONALE AS EATING WHEN YOU ARE HUNGRY, DRINKING WHEN YOU ARE THIRSTY, PUTTING A COAT ON WHEN YOU ARE COLD; IS IT NOT, DR. GUR?

A. WELL, YOU HAVE JUST, IN THOSE FUNCTIONS THAT YOU MENTIONED, AS STRANGE AS IT MAY SEEM, THERE ARE SEVERE FORMS OF MENTAL ILLNESS THAT ARE SEVERE WHERE PEOPLE DON'T DO THAT. SCHIZOPHRENIA, THEY MAY STOP BATHING FOR MONTHS. THEY WILL NEGLECT TO EAT. THEY WILL KEEP -- THEY WILL WALK AROUND WITH HEAVY COATS IN THE HEAT OF THE SUMMER, AND THEY WILL DIE OF DEHYDRATION NOT NOTICING THAT THEY ARE HOT.

SO, WHEN THE BRAIN IS DAMAGED, A LOT OF STRANGE THINGS HAPPEN. IT IS JUST NOT THE SAME AS WHEN YOU ARE OPERATING WITH A FULL DECK AND ALL OF THE PIECES ARE IN PLACE. AND I AGREE WITH YOU, FORTUNATELY, THANKS TO THE GOOD LORD, MOST PEOPLE DON'T GO AROUND RAPING AND KILLING AND DOING THOSE

THINGS. BUT WHEN YOUR BRAIN IS DAMAGED AS BADLY AS THAT, YOU MAY BE ABLE TO DO A LOT OF THE BASIC THINGS, AND YOU MAY BE ABLE TO DO A LOT OF THINGS THAT ARE NOT NORMAL.

Q. IS IT YOUR OPINION, ON NOVEMBER 11TH, 2002, AND NOVEMBER 14TH, 2002, THAT CHAD FULKS DIDN'T HAVE ANY CHOICES?

A. I AM SURE HE HAD CHOICES.

Q. AND HE MADE THOSE CHOICES?

A. THAT IS WHAT I AM QUESTIONING. HE MADE THE CHOICES. THE QUESTION IS, WHETHER HIS EXECUTIVE WAS WORKING IN ON BEING INTACT WHEN HE MADE THEM.

MR. GASSER: BEG THE COURT'S INDULGENCE. YOUR HONOR, I APPRECIATE THE TIME YOU GAVE ME.

MR. BLUME: I HAVE ABOUT TEN OR FIFTEEN MINUTES. GO AHEAD AND DO IT?

THE COURT: YEAH. I THINK IT WOULD BE BEST.

REDIRECT EXAM

BY MR. BLUME:

Q. DR. GUR, IT WON'T BE THAT LONG. I WANT TO START AND TALK ABOUT AND MAKE CLEAR, JUST TO BE FAIR TO YOU, WHAT YOU WERE ASKED TO DO AND WHAT YOU WEREN'T ASKED TO DO, AND PUT THAT INTO CONTEXT OF SOMETIMES DIFFERENT TYPES OF EVALUATIONS. YOU WEREN'T ASKED, FOR EXAMPLE, IN THIS CASE, TO RENDER AN OPINION ON WHETHER MR. FULKS WAS COMPETENT TO STAND TRIAL?

A. NO. NO.

Q. YOU WEREN'T ASKED TO RENDER AN OPINION ON WHETHER HE

WAS LEGALLY INSANE AT THE TIME OF THE OFFENSE?

A. NO.

Q. YOU WEREN'T ASKED TO REALLY DO A BROAD-BASED PSYCHOLOGICAL EVALUATION OR SOCIAL HISTORY FROM MR. FULKS; IS THAT CORRECT?

A. THAT'S CORRECT.

Q. WHAT YOU WERE ASKED TO DO, WHAT I ASKED YOU TO DO WAS, TO DETERMINE SOLELY, BASED UPON YOUR TESTING, AND BASED UPON THE IMAGING DATA WHICH WAS AVAILABLE, AND THE OTHER NEUROPSYCHOLOGICAL TESTING, I ASKED YOU COULD YOU TRY AND DETERMINE FOR ME HOW MR. FULKS'S BRAIN WORKS; IS THAT CORRECT?

A. THAT IS PRETTY MUCH WHAT THE REFERRAL QUESTION WAS.

Q. AND I DIDN'T ASK YOU EVEN TO RENDER A DIAGNOSIS?

A. THAT'S CORRECT.

Q. IN OTHER WORDS, TO SAY -- TO TELL ME, YOU KNOW, DOES HE --

MR. GASSER: YOUR HONOR, I HATE TO OBJECT. BUT HOW AM I TO CROSS-EXAMINE MR. BLUME? I MEAN, I OBJECT TO THE FORM OF THE QUESTION. THERE IS NO WAY WE CAN ADEQUATELY GO INTO THIS. IF HE WANTS TO KNOW WHAT HE WAS ASKED TO DO, THAT IS FINE. BUT SAYING MR. BLUME WAS ASKING HIM OR ANYONE ELSE WAS ASKING HIM.

THE COURT: REWORD YOUR QUESTION JUST A BIT AND SOLVE THE PROBLEM.

MR. BLUME: TRYING TO CUT TO THE CHASE. HE WAS ASKED

TO DO A LIMITED EVALUATION AND NOT BROAD-BASED.

THE COURT: I UNDERSTAND.

BY MR. BLUME:

Q. WELL, DR. GUR, YOU WEREN'T ASKED TO RENDER EVEN A DIAGNOSIS?

A. I WAS NOT ASKED.

Q. AND, IS IT ACCURATE TO SAY THEN THAT, AGAIN, YOU WERE JUST ASKED TO DETERMINE, BASED UPON ALL OF THE AVAILABLE DATA, WHETHER MR. FULKS HAD ANY ABNORMALITY OF THE STRUCTURE OF HIS BRAIN, ANY ABNORMALITY OF THE PHYSIOLOGY OF HIS BRAIN, OR ANY ABNORMALITY ON HOW HIS BRAIN FUNCTIONS?

A. YES.

Q. AND SO, BECAUSE OF THE LIMITED -- IS IT ACCURATE OR IS IT FAIR TO SAY, IF IT IS NOT, YOU KNOW, PLEASE TELL THE JURY THAT, BECAUSE, YOU KNOW, WHAT YOU WERE ASKED TO DO WAS MORE LIMITED, THEREFORE, THE INFORMATION THAT YOU WOULD NEED WOULD BE MORE LIMITED?

A. YES.

Q. I WANT TO TALK ABOUT -- OKAY. NOW, YOU HAVE TESTIFIED, PREVIOUSLY, AND I BELIEVE YOU ALSO TESTIFIED ON CROSS-EXAMINATION, THAT THE IMAGING STUDIES, THE MRI AND THE PET SCAN, SHOW INDICATIONS OF WHAT YOU CALL THE NEURODEVELOPMENTAL DISORDER?

A. YES.

Q. AND AS I UNDERSTAND IT, WHAT THAT MEANS IS, YOU CAN

JUST SEE ON THE MRI, SEE ON THERE, THAT THERE IS DAMAGE IN THE PARTS OF THE BRAIN WHICH -- OR THE WAY THE DAMAGE LOOKS IS THAT IT IS NOT SOMETHING THAT HAS BEEN THERE SINCE BIRTH?

A. YES.

Q. SO, IF IT IS CLEAR THAT THE DAMAGE HAS BEEN THERE SINCE BIRTH, IN SOME WAYS IT DOESN'T MATTER WHAT ANYBODY SAYS, THE PICTURE IS THERE, AND THE DAMAGE HAS BEEN THERE SINCE BIRTH?

A. YES.

Q. I MEAN, IT IS SORT OF LIKE IF SOMEBODY SAYS, WELL, YOU KNOW, THERE IS NOTHING THIS CHILD WAS COMPLETELY, YOU KNOW, IN UTERO, NOTHING EVER HAPPENED. AND, YOU KNOW, NOTHING EVER HAPPENED; THE MOTHER NEVER DRANK; THE MOTHER NEVER FELL. THERE WERE NEVER ANY TOXINS, WHATEVER IT IS, ANY NUMBER OF EXPOSURES. IT DOESN'T MATTER WHAT THEY SAID. THE FACT IS, THERE IS NEURODEVELOPMENTAL DISORDER?

A. I MEAN, HAD I BEEN TOLD THAT HE HAD A PERFECTLY HEALTHY PREGNANCY, AND DELIVERY, AND SO ON, I JUST WOULD HAVE SCRATCHED MY HEAD LONGER WONDERING HOW COME.

Q. BECAUSE, WHAT IS IN THE FILM, IS WHAT IS IN THE FILM?

A. YEAH.

Q. NOW, I WANT TO ASK YOU TO JUST GO BACK TO THE LEXINGTON EVALUATION IN 1998 JUST TO MAKE CLEAR ON THAT. NOTHING WAS DONE IN 1998. THEY DIDN'T DO ANY MRI SCANS? THEY DID NOT DO A PET SCAN; IS THAT CORRECT?

A. THAT'S CORRECT.
Q. THEY DIDN'T DO ANY NEUROPSYCHOLOGICAL TESTING?
A. NO.
Q. SO, THEY DIDN'T, ESSENTIALLY, THEY DIDN'T REALLY, AT THAT TIME, THEY DID NOT?
A. THEY HAD ONE, AS I RECALL. THERE WAS ONE OR TWO TESTS THAT A -- PSYCHOLOGICAL TESTS, BUT YOU COULD USE THEM AS A NEUROPSYCHOLOGICAL. BUT THE SAME TESTS WERE REPEATED BY BOTH, I BELIEVE, BOTH VENN AND EVANS, SO THEY WOULD NOT HAVE HAD THAT INFORMATION.
Q. BUT NO ASSESSMENT WAS MADE, AT THAT TIME, OR ATTEMPT TO MAKE AN ASSESSMENT OF HOW HIS BRAIN FUNCTIONED?
A. CORRECT.
Q. AND, UNQUESTIONABLY, AS WE TALKED ABOUT DURING YOUR DIRECT EXAMINATION, HE TRIED TO FAKE DURING THAT EVALUATION?
A. YES.
Q. AND THEY CAUGHT HIM?
A. YES. THEY CAUGHT HIM.
Q. BUT THE TEST HE WAS GIVEN THEN, OTHER THAN, I THINK, THE SIRS YOU ARE THINKING OF?
A. THE SIRS, THEY RELATE TO --
Q. HE DIDN'T GET ANY OF THE BATTERY OF TESTS WHICH DR. VENN GAVE HIM, DR. EVANS GAVE HIM, OR YOU GAVE HIM?
A. THAT'S CORRECT.
Q. SO HE WOULD HAVE HAD NO, WHEN HE TOOK THOSE TESTS

WOULD HAVE BEEN TAKING THEM, ESSENTIALLY, FOR THE FIRST TIME, WOULDN'T HAVE HAD ANY PRIOR EXPERIENCE WITH THEM?

A. THAT'S RIGHT.

Q. NO IDEA, REALLY, HOW TO FAKE, EVEN IF HE TRIED TO DO SO?

A. I MEAN, IF HE WANTED TO FAKE, MOST PEOPLE TRY TO FAKE JUST SAYING I DON'T KNOW, WHETHER THEY KNOW THE ANSWER, OR THEY GIVE THE WRONG ANSWER WHEN THEY KNOW THE RIGHT ANSWER.

Q. NOW?

A. THERE ARE WAYS OF DETECTING FAKING JUST BASED ON THE PERFORMANCE IN SPECIFIC TESTS. BUT THIS IS REALLY WHAT THE SPECIAL -- THE SO-CALLED VALIDITY TESTS ARE HERE TO -- THAT IS WHAT THEY WERE DESIGNED TO DO. IN OTHER WORDS, NO MATTER HOW MOTIVATED YOU ARE TO FAKE, NO MATTER HOW HARD YOU TRY, YOU CAN'T FAKE THE MRI OR THE PET SCAN.

A. THAT'S CORRECT.

Q. WOULD IT BE CONSISTENT OR INCONSISTENT WITH YOUR TESTING IF VARIOUS WITNESSES DESCRIBE MR. FULKS AS BEING QUIET?

A. QUIET?

Q. NOT TALKING MUCH, STARING OUT THE WINDOW?

A. IT IS HARD TO SAY. IT WOULD BE EITHER CONSISTENT OR NONCONSISTENT WHEN PEOPLE ARE TOGETHER. I WOULD OBSERVE ANYBODY HERE. I WOULD FIND THEM SOMETIMES QUIET, SOMETIMES RAMBUNCTIOUS, HOPEFULLY FROLICKING IN THE SUN. PEOPLE DO

VARIOUS THINGS UNDER DIFFERENT CONDITIONS.

Q. NO, I MUST HAVE MISUNDERSTOOD THE LINE OF CROSS-EXAMINATION. I WILL MOVE ON TO SOMETHING ELSE. I MUST HAVE MISUNDERSTOOD THE POINT.

FINALLY, I WANT TO GET TO SOMETHING THAT YOU TALKED ABOUT AT THE END AND JUST TO MAKE CLEAR. YOU ARE NOT SAYING -- YOU ARE NOT SAYING THAT MR. FULKS DOES NOT KNOW THE DIFFERENCE BETWEEN RIGHT AND WRONG?

A. I AM NOT SAYING THAT.

Q. AND, CLEARLY, HE ALSO WOULD KNOW THAT IT IS WRONG TO CARJACK SOMEBODY?

A. YES.

Q. AND, CLEARLY, KNOW IT IS WRONG TO RAPE SOMEBODY?

A. YES.

Q. AND HE WOULD HAVE THE ABILITY TO KNOW IF HE WERE COMMITTING THE ACT OF RAPE, OBVIOUSLY, THIS WAS AGAINST THE PERSON'S WILL?

A. YES.

Q. AND SO, AGAIN, YOUR TESTIMONY IS, NOT THAT HE IS TOTALLY DEPRIVED OF THE ABILITY TO MAKE A CHOICE OR TO DECIDE?

A. CORRECT.

Q. JUST AS I UNDERSTAND IT, THE ESSENCE OF YOUR TESTIMONY IS THAT, HIS ABILITY TO MAKE GOOD DECISIONS, CORRECT DECISIONS, APPROPRIATE DECISIONS IS IMPAIRED BY HIS NEUROLOGICAL DYSFUNCTION?

A. AND MOST IMPORTANT, CONTROL OF IMPULSES.

MR. BLUME: THANK YOU.

THE COURT: ANYTHING FURTHER? MEMBERS OF THE JURY, LET'S TAKE A 20-MINUTE RECESS. GO TO YOUR JURY ROOM. TAKE OUR AFTERNOON RECESS AT THIS TIME.

(WHEREUPON, A SHORT RECESS WAS HELD.)

THE COURT: COUPLE OF THINGS. THE JUROR'S SON WHO IS REPORTING TO IRAQ ASKED MS. FLOYD, IN THE PRESENCE OF THE OTHER JURORS, UNLIKE THE FIRST JUROR THAT I EXCUSED THIS MORNING, WHO CALLED MS. FLOYD ASIDE. THIS JUROR SPOKE TO MS. FLOYD IN THE PRESENCE OF THE OTHERS AND SAID HIS SON WILL BE LEAVING FROM FORT BRAGG. HE DID NOT WANT TO BE EXCUSED FROM THE JURY. HE DID NOT WANT TO TAKE A WHOLE DAY OFF. HE JUST WANTED TO LEAVE A LITTLE BIT EARLY ON THE DAY BEFORE HIS SON IS TO REPORT. WELL, HIS SON HAS TO REPORT OR DEPART RATHER AT LUNCHTIME ON FRIDAY. WHICH MEANS, THIS JUROR WOULD LIKE US TO BREAK TWO OR THREE HOURS EARLY TOMORROW; IS THAT CORRECT?

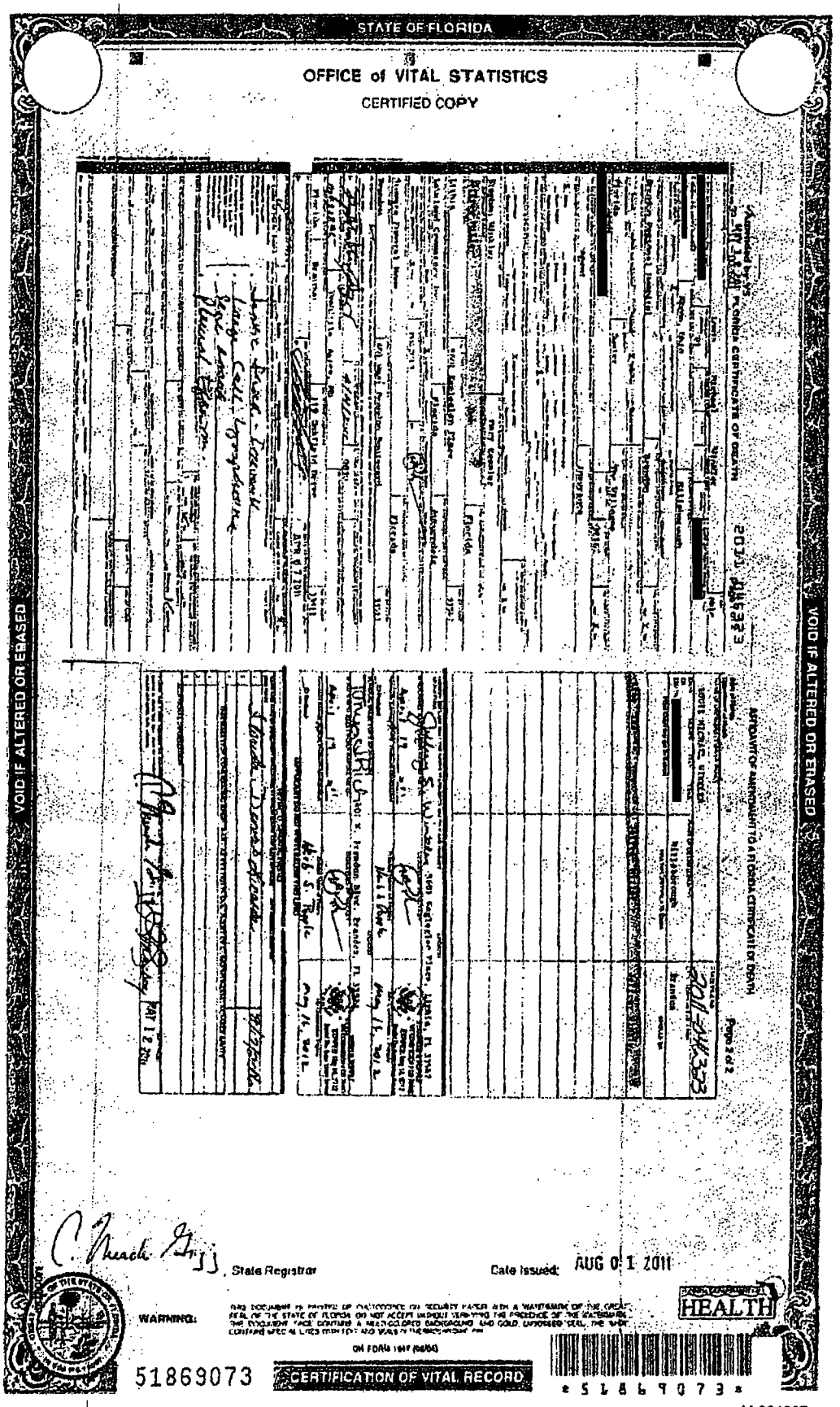
THE CLERK: NO, SIR. HE WANTED TO -- THAT IS NOT MY UNDERSTANDING AT ALL. HE WANTED TO BE WITH HIM ON FRIDAY BEFORE HE LEFT.

THE COURT: I THOUGHT YOU SAID HE WANTED TO LEAVE A LITTLE BIT EARLY.

THE CLERK: THAT WAS HIS ORIGINAL REQUEST.

THE COURT: OKAY. HE WANTS TO BE WITH HIM. IN

EXHIBIT 9



:MyFax - John Mills To:Hinkler Brandon Region (17277734950) 16:18 04/10/12 EST Pg 3-7

Patient	Unit#	Service/Location	Status	Date	Account #
WINKLER,LOUIS	[redacted]	SURGICAL INTENSIVE C 015	IN	03/30/11	[redacted]

PATIENT

Soc Sec No: [redacted] DOB: [redacted] Age: 81 Sex: M MS: D Race: W Religion: CATHOLIC
Address: [redacted]
Home Ph: [redacted] County: HILLSBOROUGH
Language: English Email:

EMPLOYER/SCHOOL

RETIRED
Work Phone:
Occupation: RETIRED

GUARANTOR

WINKLER,LOUIS
SS#: [redacted]
Address: [redacted]
Home Ph: [redacted] County: HILLSBOROUGH
Relationship to Patient: SELF

GUARANTOR EMPLOYER/SCHOOL

RETIRED
Work Phone:
Occupation: RETIRED

NEXT OF KIN / OTHER

WINKLER,SANDY
[redacted]
Hm: [redacted] Wk: (999)999-9999
Rel to Patient: DAUGHTER IN LAW

EMERGENCY CONTACT

WINKLER,JEFF
[redacted]
Hm: [redacted] Wk: (999)999-9999 Ph: Thru:
Rel to Patient: SON Note:

INSURANCE #1

FREEDOM HLTH PLAN MCR HMO
CLAIMS DEPARTMENT
TAMPA, FL 33684
Phone (800)401-2740
Contact

Policy#: [redacted]
Patient ID [redacted]
Coverage #
Subscriber WINKLER,LOUIS
Rel to Pt SELF
Eff. 01/01/11 to Rel Y Assign Y
Group [redacted] Trencr

AUTHORIZATION/REFERRAL

Treat/Precert [redacted]
Ins Verif
Pro Review Not Required
Ins. Name FREEDOM HLTH PLAN MCR HMO
Ins. Mnemonic FREMCR
Insured DOB [redacted]

INSURANCE #2

Phone
Contact

Policy#:
Patient ID
Coverage #
Subscriber
Rel to Pt
Eff. to Rel Assign
Group

AUTHORIZATION/REFERRAL

Treat/Precert
Ins Verif
Pro Review
Ins. Name
Ins. Mnemonic
Insured DOB

INSURANCE #3

Phone
Contact

Policy#:
Patient ID
Coverage #
Subscriber
Rel to Pt
Eff. to Rel Assign
Group

AUTHORIZATION/REFERRAL

Treat/Precert
Ins Verif
Pro review
Ins. Name
Ins. Mnemonic
Insured DOB

ACCIDENT/ONSET/HOSPITALIZATION/PATIENT DATES

Code Type	Date	Time	Code Type	Code	From	Thru
11 ONSET OF SYMPTOMS/ILLNESS	03/29/11					
				Code	From	Thru
				Special Program		

Last Hospitalization

Admission Comment: 195 | CP 1-10 DUE BH ER/IP

Financial Class: 12

PROVIDERS

Attending Physician	HCIS	Admitting Physician	HCIS	Emergency Room Physician	HCIS
Agzew,Yeshitila MD	1735	Agzew,Yeshitila MD	1735	Bennett,Roderick MD	2319
Prim Care Physician	HCIS	Family Physician	HCIS	Other Physician	
No Primary or Family Physician	7943			Self Referred	

ADMISSION/REGISTRATION

Date	Time	Source/Priority	Rm/Bed	Arrival	Principal Admitting Diagnosis/Reason for Visit	Admitted By
03/30/11	0245	TRANSFER FROM DIFFER EMERGENCY	A539/1	AMB	UROSEPSIS RD LYMPHOMA	IRSCBP4395

Brandon Regional Hospital
119 Oakfield Drive, Brandon FL 33511 (813) 681-5551

FACE

04/03/11 1908 By HMEJMS

Acct# [redacted] Unit# [redacted]

M 001372

Conditions of Admission

BRANDON REGIONAL HOSPITAL

WINKLER,LOUIS MR#: [redacted] Serv: EMERGENCY Status: PRE ER Date: Acct #: [redacted]

1. **Consent to Treatment.** I consent to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services rendered to me as ordered by my physician or other healthcare professional on the hospital's medical staff. I understand that as part of their training, students in health care education may participate in the delivery of my medical care and treatment or be observers while I receive medical care and treatment at the Hospital, and that these students will be supervised by instructors and hospital staff. I further consent to the hospital conducting blood borne infectious disease testing, including but not limited to testing for hepatitis, Acquired Immune Deficiency Syndrome (AIDS), and Human Immunodeficiency Virus (HIV), if a physician orders such tests or if ordered by protocol. I understand that the potential side effects and complications of this testing are generally minor and are comparable to the routine collection of blood specimens, including discomfort from the needle stick and/or slight burning, bleeding or soreness at the puncture site. The results of this test will become part of my confidential medical record.

2. **Financial Agreement.** In consideration of the services to be rendered to me, or to the patient for whom I am accepting responsibility, I individually promise to pay the patient's account at the rates stated in the hospital's price list (known as the Charge Master) effective on the date the charge is processed for the service provided, which rates are hereby expressly incorporated by reference as the price term of this agreement to pay the patient's account. Some special items will be priced separately if there is no price listed on the Charge Master, or if the charge is listed as zero. An estimate of the anticipated charges for service to be provided to the patient is available upon request from the hospital. Estimates may vary significantly from the final charges based on a variety of factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

The hospital will provide a medical screening examination as required to all patients who are seeking medical services to determine if there is an emergency medical condition, without regard to the patient's ability to pay. If there is an emergency medical condition, the hospital will provide stabilizing treatment within its capacity. However, patients who do not qualify under the hospital's charity care policy or other applicable policy are not relieved of their obligation to pay for these services.

If supplies and services are provided to a patient who has coverage through a governmental program or through certain private health insurance plans, the hospital may accept a discounted payment for those supplies and services. In this event, any payment required from the undersigned will be determined by the terms of the governmental program or private health insurance plan. If the patient is uninsured and not covered by a governmental program, the patient may be eligible to have his or her account discounted or forgiven under the hospital's uninsured discount or charity care programs in effect at the time of treatment. I understand that I may request information about these programs from the hospital.

I also understand that as a courtesy to me, the hospital may bill my insurance company, but is not obligated to do so. Regardless, I agree that except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I agree to pay any services that are not covered and covered charges not paid in full by my insurance company. This includes, but is not limited to, coinsurance, deductibles, non-covered benefits due to policy limits or policy exclusions as well as failure to comply with insurance plan requirements. I also agree that if the hospital must initiate collection efforts to recover amounts owed by me, then in addition to amounts incurred for the the services rendered I will pay, to the extent permitted by law: (a) any and all costs incurred by the hospital in pursuing collection, including, but not limited to, reasonable attorneys' fees and (b) any court costs or other costs of litigation incurred by the hospital that applicable rules or statutes permit the hospital to recover.

3. **Consent to Wireless Telephone Calls.** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls (including autodialed calls and prerecorded messages) at that wireless number from the hospital, its successors and assigns, and their affiliates, agents and independent contractors, including servicers and collections agents, of each of them regarding the hospitalization, the services rendered, or my related financial obligations.

4. **Release of Information.** I permit the hospital and the physicians or other health professionals involved in the inpatient or outpatient care to release the healthcare information for purposes of treatment, payment or healthcare operations. Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA affiliated admitting facilities to coordinate patient care for case management purposes. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation. If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions

COA

Conditions of Admission

BRANDON REGIONAL HOSPITAL

WINKLER, LOUIS MRN: [redacted] Serv: EMERGENCY Status: PRE ER Date: Acct #: [redacted]

and/or infectious diseases including, but not limited to, blood borne diseases, such as Hepatitis, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

5. **Assignment of Benefits.** In executing this assignement of benefits, I am directing the health insurance carrier or other health benefit plan providing my coverage (including, but not limited to, any employer, employer group or trust sponsored or offered plan) to pay the hospital and/or hospital-based physicians directly for the services the hospital and/or hospital-based physicians provided to the patient during this admission. If the insurance carrier providing my coverage fails to pay the hospital or hospital-based physicians directly, as they are hereby directed to do, I acknowledge that it is my duty and responsibility to immediately pay any such benefits received by me to the hospital and/or hospital-based physicians. I hereby irrevocably assign and transfer to the hospital and/or hospital-based physicians all right, title, and interest in all payments for the healthcare rendered, which are paid pursuant to any and all insurance policies and health benefit plans from which I am entitled to services or I am entitled to recover. I understand that any payment received from these policies and/or plans will be applied to the amount that I have agreed to pay for services rendered during this admission, as further described under section 2. I further hereby irrevocably assign and transfer to the hospital and/or hospital-based physicians an independent, non-exclusive right of recovery against my insurer or health benefit plan, but this assignment shall not be construed as an obligation of the hospital and/or hospital-based physicians to pursue and such right of recovery. I acknowledge and understand that I maintain my right of recovery against my insurer or health benefit plan and the foregoing assignment does not divest me of such right. In no event will the hospital and/or benefits in excess of the amount owed to the hospital and/or hospital-based physicians for the care and treatment rendered hospital-based physicians retain benefits in excess of the amount owed to the hospital and/or hospital-based physicians for the care and treatment rendered during the admission. If a third party (such as an insurance company or employer group or trust sponsored or offered plan) may be obligated to pay some or all of these charges, I agree to take all actions necessary to assist the hospital and or hospital-based physicians in collecting payment from such third party payer. Should the hospital or hospital-based physicians elect to collect such payment. In the event the hospital and/or hospital based physicians elect to exercise its independent, non exclusive right of recovery against the patients insurer or health plan, I hereby appoint the hospital as my authorized representative to pursue, any administrative remedies, claims and/or lawsuits on my behalf and at the hospital's election, against any responsible third party, medical insurer, or employer sponsored medical benefit plan for the purposes of collecting any and all hospital benefits due me for the payment of the charges referred to in section 2 above. If the hospital elects to pursue a claim or lawsuit against a third party payor as authorized representative, I agree to execute a special power of attorney, if requested, authorizing the hospital to take all actions necessary or appropriate in pursuit of such claim or lawsuit, including allowing the hospital to bring suit against the third party payer in my name. I agree to pay over to the hospital immediately all sums recovered in in and claim or lawsuit brought on my behalf by the hospital (up to the amount of the hospital's charges, plus expenses and attorney's fees). I have read and been given the opportunity to ask questions about this assignment of benefits, and I have signed this document freely and without inducement, other than the rendition of services by the hospital and or hospital based physicians.

**Hospital-based physicians include but are not limited to: Emergency Department Physicians, Pathologists, Radiologists, and Anesthesiologists, Psychiatrists, Psychologists or other Behavioral Health Providers. These service are rendered by independent contractors and are not part of your hospital bill. These services will be billed for separately by each physician's company.*

6. **Private Room.** I understand and agree that I or the party responsible for payment for hospital and medical services is responsible for any additional charges associated with the request and use of a private room.

7. **Communications About My Healthcare.** I authorize my healthcare information to be disclosed for purposes of communicating results, findings, and care decisions to my family members and others responsible for my care or designated by me. I will provide these individuals with a password or other verification needs specified by the hospital.

8. **Medicare Patient Certification and Assignment of Benefit.** I certify that any information I provide in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the hospital or hospital-based physician by the Medicare or Medicaid program.

9. **Other Acknowledgements.**

a. Personal Valuables. I understand that the hospital maintains a safe for the safekeeping of money and valuables, and and the hospital shall not be liable for the loss of or the damage to any money, jewelry, documents, furs, fur coats and fur garments, or other articles of unusual value and small size, unless placed in the safe, and shall not be liable for the loss or damage to any other personal property, unless deposited with the hospital for safekeeping the liability of the hospital for loss of any personal property that is deposited with the hospital for safekeeping is limited to the greater of five hundred dollars ($500.00) or the maximum required by law, unless a written receipt for a greater amount has been obtained from the hospital by the patient.

b. Weapons/Explosives/Drugs. I understand and agree that if the hospital at any time believes there may be a weapon,

Conditions of Admission

BRANDON REGIONAL HOSPITAL

WINKLER,LOUIS MRN: [redacted] Serv: EMERGENCY Status: PRE ER Date: Acct #: [redacted]

explosive device, illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the hospital may search my room and my belongings, confiscate any of the above items that are found, and dispose of them as appropriate, including delivery of any item to law enforcement authorities.

c. Additional Provision for Admission of Minors I, the undersigned, acknowledge and verify that I am the legal guardian or custodian of the minor/incapacitated patient.

d. Legal Relationship Between Hospital and Physicians Most or all of the health care professionals performing services in the hospital are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions and the hospital shall not be liable for the acts or omissions of any such independent contractors.

I understand that physicians or other health care professionals may be called upon to provide care of services to me or on my behalf, but that I may not actually see, or be examined by, all physicians or health care professionals participating in my care; for example, I may not see physicians providing radiology, pathology, EKG interpretation and anesthesiology services. I understand that, in most instances, there will be a separate charge for professional services rendered by physicians to me or on my behalf, and that I will receive a bill for those professional services that is separate from the bill for hospital services.

e. Patient Visitation Rights. I understand that I have the right to receive the visitors whom I or my support person designates, without regard to my relationship to these visitors. I also have the right to withdraw or deny such consent at any time. I will not be denied visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation or disability. All visitors I designate will enjoy full and equal visitation privileges that are no more restrictive than those that my immediate family members would enjoy. Further, I understand that the hospital may need to place clinically necessary or reasonable restrictions or limitations on my visitors to protect my health and safety in addition to the health and safety of other patients. The hospital will clearly explain the reason for any restrictions or limitations if imposed. If I believe that my visitation rights have been violated, I or my representative has the right to utilize the hospital's complaint resolution system.

CDW

Conditions of Admission

BRANDON REGIONAL HOSPITAL

WINKLER,LOUIS MR#: [redacted] Serv: EMERGENCY Status: PRE ER Date: Acct #: [redacted]

I have been given the opportunity to read and ask questions about the information contained in this form as well as this section of the form, and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

Acknowledge: JW (Initial)

10. Patient Self Determination Act.
I have been furnished information regarding Advance Directives (such as durable power of attorney for healthcare and living will's). I have also been furnished with written information regarding patient rights and responsibilities and other information related to my stay. Please initial or place a mark next to ONE of the following applicable statements:

JW	I executed an Advance Directive and have been requested to supply a copy to the hospital	I have not executed an Advance Directive, wish to execute one and have received information on how to execute an Advance Directive	I have not executed an Advance Directive and do not wish to execute one at this time

11. Notice of Privacy Practices I acknowledge that I have received the hospital's Notice of Privacy Practices, which describes the ways in which the hospital may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Hospital Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the hospital's Notice of Privacy Practices.

Acknowledge: JW (Initial)

Date: 3/30/11

Time: 0000

I, the undersigned, as the patient or legal agent of the patient, hereby certify I have read and fully and completely understand this Conditions of Admission and Authorization for Medical Treatment, and that I have signed this Conditions of Admission and Authorization for Medical Treatment knowingly, freely, voluntarily and agree to be bound by its terms. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services. If insurance coverage is insufficient, denied altogether, or otherwise unavailable, the undersigned agrees to pay all charges not paid by the insurer.

Patient/Authorized Representative Signature:

X Jeff Winkler

If you are not the patient, please identify your relationship to the patient.
(Circle or mark relationship(s) from list below):

Spouse Parent Legal Guardian
Neighbor/Friend Sibling
Healthcare Power of Attorney
Other (please specify)_____

Witness Signature and Title:

X registrar

Additional Witness Signature and Title:
(required for patients unable to sign without a representative or patients who refuse to sign)

X_____

CIA

ITEM	YES	NO	COMMENTS
1. Attending physician notified:	X		
a) Will he/she sign the death certificate?	X		
b) Next-of-kin notified? [illegible]	X		Name: Phone #: By whom:
c) Will family be in to view body? [illegible]	X		
2. Medical Examiner Case? See Criteria – next page		X	
a) Notify M.E. if patient meets criteria (#914-4587)		X	
b) All tubes and lines left in place?		X	
c) Copy of chart sent with body: H&P, progress notes, labs, consults?		X	
3. Autopsy requested by physician?		X	
a) Autopsy Consent form completed?		X	
b) Risk Management notified @ Ext. 12347		X	
c) Autopsy entered in Meditech? (Req for Service – Path – Autopsy)		X	
d) Copy of chart sent with body: H&P, progress notes, labs, consults?		X	
e) Copy of order for Autopsy sent to Nursing Supervisor?		X	
4. Nursing Supervisor notified of expiration and/or autopsy? Spectralink 6013 or Ext. 5109	X	X	
a) Facesheet with date/time of death sent to Nursing Supervisor? (mark if M.E. or Autopsy)	X		
5. Patient in restraints within the last 24 hours?		X	
a) If yes, message with patient information called to Ext. 1234		X	
6. If patient is a Hospice Patient –Hospice notified? (#877-2200)		X	
7. Consulting physicians or answering services notified? [Document in Meditech]	X		
8. Funeral Home notified? Stowers | "Herb"	X		Name: Herb Phone #: 689-1211
9. Consent for Disposition of Body signed? (2 witnesses required if done by phone)	X		
10. Organ Donation (LifeLink/Lions) notified? NO EXCEPTIONS (1-800-643-6667 or 932-8808)			
a) Will organs be donated?			Name of Rep:
11. Dentures: Given to Family X Left in place			
12. Expiration entered in Meditech (D.EXP)			
13. Expiration Checklist & Disposition of Body completed and sent with body to Morgue (if no funeral home, send to Nursing Supervisor – copy left with body on door in morgue)	X		
14. Any implantable devices (i.e. pain pump to empty and disable, notify Pain MD)?		X	
15. If implantable device (i.e. pain pump, AICD, pacemaker) Funeral Home notified?		X	
16. Post Mortem care provided?	X		
17. Indigent Patient – UM Notified?		X	

Expiration Checklist



Patient Identification / Label
WINKLER, LOUIS R.A539-1 3359
[redacted] 03/30/11 0245
DOB [redacted] 81 M IN
Agzcv, Yeshicila MD MRN 1000742583
BRANDON REGIONAL HOSPITAL BRANDON,FL



"DEATH" MNEMONIC rev 12/09

Send to Nursing Supervisor:

- Face Sheet with date and time of death

Send with body to morgue:

- Face Sheet with date and time of death
- Original, signed Disposition of Body form
- Copy of Chart (if M.E. or Autopsy case) – N/A

MEDICAL EXAMINER CRITERIA

a. By criminal violence.

b. By accident, fall or trauma (which results in a traumatic injury, no matter how remote if original injury contributes to decline or cause of death (i.e. patient is never returned to normal base line prior to injury).

c. By suicide.

d. Suddenly, when in apparent good health.

e. Unattended by a practicing physician or other recognized practitioners.

f. In any prison or penal institution.

g. In police custody.

h. In suspicious or unusual circumstance.

i. By criminal abortion prior to admission.

j. By poison, or when drug overdose is suspected. (Police involvement must be requested and if possible, pre-admission blood needs to be obtained and provided to Medical Examiner).

k. By disease, constituting a threat to public health.

l. By disease, injury, or toxic agent resulting from employment (i.e. Asbestosis, Mesothelioma, Black Lung, Pesticide Exposure, etc).

Expiration Checklist

WINKLER, LOUIS [redacted] M A539-L 3359
03/30/11 0245
DOB: [redacted] 81 M DR#
Agnew, Yeshteria MD MR# H00074583
BRANDON REGIONAL HOSPITAL BRANDON, FL

'DEATH' MNEMONIC rev 12/08

CONSENT FOR DISPOSITION OF BODY

DATE OF EXPIRATION: 4/3/11 TIME OF EXPIRATION: 0830

CONSENT:

Brandon Regional Hospital is hereby given permission to release the body of: Louis Winkler

To: Stowe (name of Funeral Home designated) Phone: 689-1211

Designated by: Jeff Winkler Relationship: Son

Funeral Home notified: ☐ YES ☐ NO

To the best of my knowledge, the deceased during their lifetime made no indications contrary to the permission I have given for disposition of the body of the deceased by any person who is a member of a class in priority consent prior to the class of which I am a member (see Priority of Consent below)

Signature: Jeff Winkler Relationship: Son (POA) Date/Time: 4/3/11

Or Name (by Proxy): _____ Relationship: _____

Address: _____

Witness: _____ Date/Time: _____

Witness: _____ Date/Time: _____

DISPOSITION OF PERSONAL BELONGINGS

☒ No belongings

The property listed below was delivered by the hospital to:

☐ The funeral home listed below ☐ Medical Examiner ☐ Family representative

Property sent to: ☐ Safe ☐ Lost & Found ☐ With body

PROPERTY DESCRIPTION:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Person releasing property: _____ Person receiving property: _____

Date: _____

FUNERAL HOME RELEASE

Autopsy Case: ☐ YES ☒ NO (Copy of chart H&P, progress notes, labs, consults must accompany body)

Medical Examiner Case: ☐ YES ☒ NO (Copy of chart H&P, progress notes, labs, consults must accompany body)

Funeral Home: _____

Body Released to: Isabelle Per Morgan Brutts Date/Time: 4/3/11 @ 1350

Witness: _____ Date/Time: _____

MEDICAL EXAMINER RELEASE

M.E. special instructions: N/A

Body Released to: _____ Date/Time: _____

SIGNATURE: _____ DATE/TIME: 4/3/11 0965

Patient Identification Label

WINKLER, LOUIS [redacted]

DOB: [redacted] 81 M JR

Acct#: [redacted] MD MRN# H0007425B3

BRANDON REGIONAL HOSPITAL BRANDON, FL

A539-[illegible] 1359

03/30/11 0245

Consent for Disposition of Body

"TREAT" MNEMONIC rev 12/09

BRANDON REGIONAL HOSPITAL
119 OAKFIELD DRIVE
BRANDON, FLORIDA 33511

********** DISCHARGE SUMMARY

Patient Name: WINKLER,LOUIS DOB: [redacted]
Account #: [redacted] MRN: [redacted]
Admit Date: 03/30/11 AGE: 81
Attending Physician: Agzew,Yeshitila MD

DATE OF DISCHARGE: 04/03/2011

PRIMARY DIAGNOSIS: Acute metabolic acidosis.

OTHER DIAGNOSES: Include:
1. Non-Hodgkin lymphoma.
2. Anemia.
3. DNR status.

CONSULTATION: Oncology, Dr. Auerbach.
Pulmonary, Dr. Lorch and his group.

HOSPITAL COURSE: This is an 81-year-old male patient who came with urinary tract infection. CT was found to have lymphadenopathy, and the patient was seen and evaluated by oncologist. The patient came with acute change in mentation, and he is out of state from Pittsburgh. Past medical history is significant for hypertension, benign prostatic hypertrophy, dementia, and recent back surgery. The patient with above complaint seen in the Emergency Department and admitted with sepsis, rule out sepsis, rule out urosepsis, and after admission, he also had CT angio which showed numerous enlarged lymph nodes in the supraclavicular as well as in the hilar and mediastinal region. He was admitted for lymphoma rule-out, and after admission, he was seen and evaluated by the Pulmonary physician as well as by the oncologist, evidence of lymphoma. The patient condition deteriorated, and he was made DNR, and the patient expired.

Yeshitila Agzew, MD
YA/MedQ

DD: 06/16/2011 18:38
DT: 06/17/2011 14:21
Job #: 673028/470289236
Revision #:
Authenticated by Yeshitila Agzew, MD On 06/17/2011 02:38:39 PM

Electronically Signed by Yeshitila Agzew, MD on 06/17/11 at 1439

PATIENT NAME: WINKLER,LOUIS ACCOUNT #: [redacted]

BRANDON REGIONAL HOSPITAL
119 OAKFIELD DRIVE
BRANDON, FLORIDA 33511

********** EMERGENCY ROOM REPORT

Patient Name: WINKLER,LOUIS
Account #: [redacted]
Admit Date: 03/30/11
Attending Physician: Agzew,Yeshitila MD

DOB: [redacted]
MRN:
AGE: 81

Clinical Report - Physicians/Mid Levels
Brandon Regional Hospital
119 Oakfield Drive, Brandon, FL 33511 813-571-5150
03/29/2011 22:41

Patient: WINKLER, LOUIS
MRN: [redacted]
Acct#: [redacted]
Age: 81y

Time Seen: 22:55 Mar 29 2011; initial patient contact, initial documentation. Arrived- By ambulance. Historian- son. History limited by altered mental status.

HISTORY OF PRESENT ILLNESS
Chief Complaint: CHANGED MENTAL STATUS. This started today and is still present. He has been disoriented. Nursing home resident. (Per pt's son, pt fell 5 weeks ago breaking his right arm and hitting his head. He was released from hospital and placed in a rehab center for a few days, but he again had a decline in his mental status and was admitted to the Leesburg Hospital for a UTI and dehydration. He was released to a rehabilitation facility yesterday and again has had a decline in his mental status. The rehab facility also reported possible low O2 saturations).

Usually is alert and oriented X3 and usually has normal mobility.

Similar symptoms previously: Patient has not had similar symptoms previously.

Recent medical care: The patient was seen recently and hospitalized (see above). (PCP: Young).

REVIEW OF SYSTEMS
Unobtainable due to patient's altered mental status. The patient has had fever of 100.3 F. All systems otherwise negative, except as recorded above.

PAST HISTORY
See nurses notes. Hypertension. Diabetes mellitus. Heart murmur. Dementia.

Surgeries: (Artificial left eye. Right forearm.).

Medications:

See Nurses Notes..
Allergies:
NKDA..

SOCIAL HISTORY
Nonsmoker. Is a local resident. Resides in an assisted living center.

ADDITIONAL NOTES
The nursing notes have been reviewed.

PHYSICAL EXAM
Appearance: No acute distress. The patient is somnolent.
Vital Signs: Have been reviewed- tachycardic; tachypneic (100.3 - P 114 - P 32 - R 128 / 59 - BP 95 % - O2 sat).
Eyes: Pupils equal, round and reactive to light.
ENT: Airway intact. Dry mucous membranes present.
Neck: Neck supple. No meningeal signs.
CVS: Tachycardia. Pulses normal.
Respiratory: No respiratory distress. Breath sounds normal.
Abdomen: Soft and nontender.
Back: Normal inspection. (small wound from back surgery without signs of infection).
Skin: Skin warm and dry. Normal skin color. No rash.
Extremities: Bilateral 2+ edema of the lower extremities involving both feet, both ankles and both lower legs.
Neuro: The patient is disoriented to time and place. Cranial nerves normal (as tested). Moves all extremities equally.

LABS, X-RAYS, AND EKG
EKG: EKG time (23:14). Rate: 114. Tachycardia. Sinus tachycardia. Normal QRS complex. Normal axis. Non-specific ST segment / T wave abnormalities. No ST elevation. The study has been interpreted contemporaneously by me.
Chest X-ray: (BRANDON EMERGENCY ROOM Name: WINKLER,LOUIS
[redacted] Phys: Bennett,Roderick MD
DOB: [redacted] Age: 81 Sex: M
Acct: [redacted] Loc: H.ED
PHONE #: [redacted] Exam Date: 03/29/2011 Status: REG ER
FAX #: [redacted] Radiology No: 00630589
Unit No: H000747583

EXAMS: Reason for Exam::
020374480 CHEST PORTABLE AMS

Exam Description: - CHEST PORTABLE

Exam Complete Date: 3/29/2011 11:35:00 PM
History: Altered mental status

Comparison: None

Findings:

PATIENT NAME: WINKLER,LOUIS ACCOUNT #: [redacted]

The aorta is tortuous.The cardiomediastinal silhouette and pulmonary vascular markings are within normal limits. The lungs are clear. There is no pleural effusion, pneumothorax or hyperinflation. Regional skeleton and soft tissues are unremarkable.

Impression:

1. No acute cardiopulmonary disease.

** Electronically Signed by BRET NEIDERMAN M.D **
** on 03/30/2011 at 0001 **
Reported and signed by: BRET NEIDERMAN M.D). The X-rays were independently viewed by me and interpreted by the radiologist and contemporaneously by me.
CT Head: (BRANDON HOSPITAL Name: WINKLER,LOUIS
[redacted] Phys: Bennett,Roderick MD
DOB: [redacted] Age: 81 Sex: M
ACCT: [redacted] LOC: H.ED
PHONE #: [redacted] Exam Date: 03/29/2011 Status: REG ER
FAX #: [redacted] Radiology No: 00630589
Unit No: HC00747583

EXAMS: Reason for Exam::
020374479 CT BRAIN W/O CONTRAST AMS

Exam Description: - CT BRAIN W/O CONTRAST

Exam Complete Date: 3/30/2011 1:15:00 AM
History: Altered mental status

Comparison: None

Technique:

Serial axial CT images were acquired from the base of the skull through the vertex at 5 mm collimation. No IV contrast was administered.

Findings:

The ventricles, sulci and cisterns are of a normal size and configuration for chronologic age. There is global cerebral atrophy. There is no intracranial mass lesion, mass effect or midline shift. There are no abnormal intra-axial or extra-axial fluid collections. There is no evidence of acute intracranial hemorrhage.

Bilateral periventricular and centrum semiovale white matter hypodensity is noted likely due to demyelination from chronic small vessel ischemic changes.

Gray white differentiation is otherwise intact.

PATIENT NAME: WINKLER,LOUIS ACCOUNT #: [redacted]

visualized portions of the paranasal sinuses and mastoid air cells are clear.

The bones of the calvaria and skull base are intact without evidence of depressed or displaced fracture.

There is a probable left globe prosthesis.
Impression:

1. No acute intracranial abnormality noted.
2. White matter chronic small vessel ischemic changes.

** Electronically Signed by BRET NEIDERMAN M.D **
** on 03/30/2011 at 0138 **
Reported and signed by: BRET NEIDERMAN M.D). The study was interpreted by the radiologist.
CTA Pulmonary Arteries: BRANDON HOSPITAL Name: WINKLER,LOUIS
[redacted] Phys: Bennett,Roderick MD
DOB: [redacted] Age: 81 Sex: M
Acct: [redacted] Loc: H.ED
PHONE #: [redacted] Exam Date: 03/29/2011 Status: REG ER
FAX #: [redacted] Radiology No: 00630589
Unit No: H000747583

EXAMS: Reason for Exam::
020374486 CT ANGIO CHEST WITH CONTR TACHYCARDIA, PROLONGED BEDREST

Exam Description: - CT ANGIO CHEST WITH CONTRAST

Exam Complete Date: 3/30/2011 1:15:00 AM
History: Tachycardia

Comparison: None

Technique:

Serial axial 2.5 mm slice images of the chest were obtained from the thoracic inlet to the upper abdomen after intravenous contrast administration tailored as a pulmonary artery embolus protocol. Multiplanar reconstructions were obtained for additional evaluation of the pulmonary arteries after post-processing the axial angiographic images using special software.

Findings:

Evaluation of the post segmental pulmonary arteries is limited due to significant motion degradation. There are no filling defects seen to the segmental level.

There is no thoracic aortic aneurysm or dissection.

PATIENT NAME: WINKLER,LOUIS ACCOUNT #: [redacted]

Impression:

1. Study limited by respiratory motion with no filling defects seen to the segmental level. Post segmental pulmonary arteries are poorly evaluated.

CT Chest with contrast

Findings:
There are numerous enlarged lymph nodes seen within the supraclavicular regions. On the left, conglomerate lymph nodes measure up to 5.5 x 3.3 cm. On the right, a large lymph node measures up to 3.1 x 2.9 cm. There are no enlarged axillary lymph nodes. There are multiple soft tissue masses seen medial to the aorta, abutting the esophagus. These likely represent enlarged lymph nodes. The largest is noted on image 128 measuring up to 2.4 x 2.4 cm. There is a large lymph nodes seen within the azygoesophageal recess measuring up to 1.9 x 2.2 cm.

The heart is normal in size. There is no pericardial effusion.

There are small bilateral effusions which layer freely. There is compressive atelectasis of the lower lobes.

Lung windows demonstrate respiratory motion artifact. However, there are no infiltrates seen.

There are no pulmonary nodules or masses. Partial imaging of the upper abdomen demonstrates surgical absence of the gallbladder. There are no acute findings demonstrated.

Evaluation of the bone windows demonstrates no destructive abnormality.
Impression:

1. Extensive supraclavicular lymphadenopathy noted bilaterally. There are also numerous enlarged lymph nodes seen within the posterior mediastinum abutting the esophagus and aorta as well as within the azygoesophageal recess. Recommend clinical correlation. Consider PET imaging.
2. Small bilateral pleural effusions with compressive lower lobe atelectasis.

** Electronically Signed by BRET NEIDERMAN M.D **
** on 03/30/2011 at 0156 **
Reported and signed by: BRET NEIDERMAN M.D. The study was interpreted by the radiologist.
Laboratory Tests: Laboratory tests have been ordered, with results reviewed and considered in the medical decision making process. 0329:BR:C01217R:
(COLL: 03/29/2011 23:20) (MsgRcvd 03/30/2011 02:07) Final results

PATIENT NAME: WINKLER,LOUIS ACCOUNT #: [redacted]

Laboratory Test	Value
GLUCOSE POC	208

0329;BR;C01197S: (COLL: 03/29/2011 23:00) (MsgRcvd 03/29/2011 23:47)
Final results

Laboratory Test	Value
B TYPE NATRIURETIC PEPTIDE	119

0329;BR;C01181S: (COLL: 03/29/2011 23:00) (MsgRcvd 03/30/2011 00:00)
Final results

Laboratory Test	Value
TROPONIN I	0.05

0329;BR;C01180S: (COLL: 03/29/2011 23:00) (MsgRcvd 03/30/2011 00:40)
Final results

Laboratory Test	Value
SODIUM	144
POTASSIUM	4.3
CL	109
CO2	19
ANION GAP	16
GLUCOSE	162
BUN	38
CREATININE	1.5
BUN/CREAT RATIO	25
GLOMERULAR FILTRATION RATE	48
TOTAL PROTEIN	6.0
ALBUMIN	2.2
GLOBULIN	3.8
ALBUMIN/GLOBULIN RATIO	0.6
CALCIUM	9.3
BILIRUBIN TOTAL	0.6
SGOT/AST	132
SGPT/ALT	16
ALKALINE PHOSPHATASE TOTAL	91
PHOSPHOROUS	2.5
CREATINE KINASE (CK)	30
MAGNESIUM	2.1
CK	30
CKMB	< 0.5
CK ISOENZYME COMMENT	NO REL% CALCULATED

0330;BR;U00007S: (COLL: 03/30/2011 00:34) (MsgRcvd 03/30/2011 00:49)
Final results

Laboratory Test	Value
UA COLOR	AMBER
UA APPEARANCE	sl hazy
UA GLUCOSE	NEG
UA BILIRUBIN DIPSTICK	NEG

PATIENT NAME: WINKLER,LOUIS ACCOUNT #: [redacted]

UA KETONE DIPSTICK	1+
UA SPECIFIC GRAVITY	1.020
UA BLOOD DIPSTICK	5+
UA PH DIPSTICK	5.0

UA PROTEIN DIPSTICK	2+
UA UROBILINOGEN DIPSTICK	<0.2 mg/dl
UA NITRITE DIPSTICK	NEGATIVE
UA LEUKOCYTE ESTERASE DIPSTICK	3+
UA RBC	10-25
UA WBC	2-5
UA BACTERIA	2+(FEW)
UA SQUAMOUS CELLS	2-5
UA MUCUS	1+(RARE)
UA AMORPHOUS SEDIMENT	3+(MODERATE)

0329:BR:CG00208S: (COLL: 03/29/2011 23:00) (MsgRcvd 03/30/2011 00:11)
Final results

Laboratory Test	Value
PROTHROMBIN TIME	12.7
INTERNATIONAL NORMAL RATIO	1.2
PTT	27.7

0329:BR:H00484S: (COLL: 03/29/2011 23:00) (MsgRcvd 03/30/2011 00:50)
Correction to results

Laboratory Test	Value
WHITE BLOOD CELL	10.8
RED BLOOD CELL	2.99
HEMOGLOBIN	9.3
HEMATOCRIT	29.9
MEAN CELL VOLUME	100.0
MEAN CELL HGB	31.1
MEAN CELL HGB CONCENTRATION	31.1
RED CELL DISTRIBUTION WIDTH	20.6
PLATELET COUNT	95
MEAN PLATELET VOLUME	10.0
NEUTROPHIL %	62.2
LYMPHOCYTE %	25.5
MONOCYTE %	11.5
EOSINOPHIL %	0.4
BASOPHIL %	0.4
NEUTROPHIL #	6.7
LYMPHOCYTE #	2.7
MONOCYTE #	1.2
EOSINOPHIL #	0.0
BASOPHIL #	0.0

Pulse Oximetry: O2 saturation- 95% (FIO2 - room air). Interpretation: normal.

PROGRESS AND PROCEDURES
Course of Care: Documented by Cristina Jones acting as scribe for Dr. Bennett. R. Bennett, MD: This document accurately reflects all work, treatment, procedures and medical decision-making performed by me.

PATIENT NAME: WINKLER,LOUIS ACCOUNT #: [redacted]

Ordered at 22:56. IV fluids given (saline lock) 1 liter. Acetaminophen 650 mg PO.

Ordered at 01:52. Rocephin 1gm IVPB.

02:12 Call placed to Dr. Agzew for admission.

02:43. Consult obtained from internal medicine. Dr. Agzew, will admit. Case discussed. Agree with treatment plan. Patient disposition per consultant..

Patient counseled in person regarding the patient's condition, test results and diagnosis.

Disposition: Admitted. Condition: fair.

CLINICAL IMPRESSION
Changed mental status.
Sepsis.
Dehydration.
Urinary tract infection.
Possible malignant lymphoma.

(Electronically signed by Bennett, Roderick, M.D. 03/30/2011 4:14)

Any laboratory data incorporated in this document has been entered by the emergency clinician and may have been summarized or otherwise modified. The original full report is available in Meditech. Please refer to PCI for the Performing site information.

PATIENT NAME: WINKLER,LOUIS ACCOUNT #: [redacted]

RUN DATE: 03/30/11
RUN TIME: 0603
RUN USER: IPF.FEED

Brandon Regional Hospital EDR **LIVE**
EMERGENCY PATIENT RECORD

PAGE 1

Patient: WINKLER,LOUIS
LOA Provider: Bennett,Roderick MD

Age/Sex: 61,M

Acct: [redacted]
MRN: [redacted]

ED Physician: Bennett,Roderick MD, FACEP
Practitioner:
Nurse: Brownley,Ashlie M

Arrival Date/Time: 03/29/11 - 2241
Triage Date/Time: 03/29/11 - 2245
Date of Birth: [redacted]

Stated Complaint: SEPSIS RD LYMPHOMA
Chief Complaint: Change Mental/Neuro Status
Status Event History:
03/29/11 2241 Reception
2254 Triaged
2256 Room Placement
03/30/11 0208 Disposition
0251 ADM - RAU
0304 Admit

Priority: 3

Ambulance/Fire Rescue

Allergy/Adverse Reaction	Type/Category	Severity	Ver
No Known Allergies	Allergy/Drug		N

RAPID INITAL ASSESSMENT

Occurred			Recorded	
Date	Time	User	Date	Time User
03/29/11	2248	Brownley,Ashlie M, RN	03/29/11	2254 Brownley,Ashlie M, RN

First Point of Contact: Yes
Enter/Edit Allergies? Yes
Arrived By: EMS
EMS service: Americare
Subjective Assessment:
PT ARRIVED VIA EMS, FROM HH STATED PT ALTERED, AND LOW O2 SAT
Objective Assessment:
PT ACOX1. PINK, HOT, DRY. 99% ON RA.
See next page
Neuro WDP? No
Cardiovascular WDP? Yes
Respiratory WDP? Yes
Pain scale: Numeric
Intensity: 0
OB/GYN History: (if noted below)
See next page
Smoking status for patients 13 years old or older: Unknown if ever smoked
Onset of Symptom Date: 03/29/11
Onset of Symptoms Time: 1600
Flowsheet: Yes
Chief Complaint: CHEMOTAL
Priority: 3
ESP? N
Facility ESP status:

ESP Enabled
See next page
Last page
Is Patient Present? Y
Able to perform TB & Contagious Respiratory Infection Point of Entry Screen Y
Is patient currently experiencing any of following in last 7 days:
Fever greater than 100.4? N
(37.8 C)
Cough? N
(not related to
allergy or COPD)
Sore Throat? N
Night sweats? N
Unexplained weight loss? N
Fatigue? N
Body Aches? N
Rash? N
Nasal Congestion (not related to allergies or sinus infections)? N
Pt reports prior history of TB or positive TB skin test? N
Close contact with a person who has TB? N
Close contact with any person having an Influenza-like Illness? N
TB Point of Entry Screen: NEGATIVE
Contagious Respiratory Infection Point of Entry Screen- NEGATIVE
** FLACC Pain Assessment - Less than Age 3 or Sleeping **
Score of 4 or More, Consider Intervention
** Neonatal / Infant Pain Scale (NIPS) **
Temp-F: 100.3
Temp Source: AXILLARY
Pulse: 114
Resp: 32
BP: 128/59
BP Source: ARM, LEFT
Pulse Ox: 96
Airway adjunct: Room air
Feet: 6
Inches: 1.0
Cm: 185.42
Lbs: 180
Kgs: 81.647
Weight Source: ESTIMATED WEIGHT
Body Mass Index (BMI): 23.8
: Normal
Evaluate Glasgow Coma Scale: Yes
Glasgow Coma Scale: (if noted below)
Eye Opening: 4
Best Verbal Response: 4
Best Motor Response: 6

Change Mental/Neuro Status

Occurred			Recorded	
Date	Time	User	Date	Time User
03/29/11	2254	Brownley,Ashlie M, RN	03/29/11	2259 Brownley,Ashlie M, RN

Initial Onset of Signs & Symptoms: Today
Symptoms Constant or Intermittent: Unknown
Onset of Current Episode: Today
Symptom Onset Gradual or Sudden: Unknown

RUN DATE: 03/30/11
RUN TIME: 0609
RUN USER: PF.FELD

Brandon Regional Hospital EDM **LIVE**
EMERGENCY PATIENT RECORD

Patient: WINKLER,LOUIS — Age/Sex: 61,M — Acct No: [redacted]
EDM Provider: Arnett,Anne Rae MD — Unit No: [redacted]

CMA Must Document Exact Time of Onset of Sign/Symptom.
When Was the Patient Last Seen Normal?: Unknown
Present Trauma: Unable to Assess
Any Precipitating Factors Prior to Noted Change: UTI
Level of Consciousness: Confused
Behavior: Calm
Recent Head Injury: Unable to Assess
Altered Mental Status Potentially Due to Pulm Unknown Etiology: N
Cardiac Rhythm: Sinus Tachycardia
EMS/Esquire Patient? N
Does Patient Have a Pacemaker: N
Implantable Defibrillator: No
Loss of Consciousness: Unable to Assess
Witnessed Seizure: Unable to Assess
Associated Signs & Symptoms: NS
Breath Sounds Clear & Equal Bilaterally All Lobes: N
Glasgow Coma Scale:(If noted below)
Pupils PERLA: Y
Eye Opening: 3
Best Motor Response: 6
Best Verbal Response: 4
GCS Total: 13
Numbness or Tingling: Unable to Assess
Weakness: Yes
Weakness Location: GEN WEAKNESS
Hand Grips & Leg Strength Equal & Strong: No
Grip Strength Left: Weak
Grip Strength Right: Strong
Leg Strength Left: Weak
Leg Strength Right: Weak
Skin Color: Pale
Skins Hot, Dry
Assess Pain Now: N
Balance/Gait: Unable to Assess
Assess Vital Signs Now: N
RUL Breath Sounds: Rhonchi
RML Breath Sounds: Rhonchi
LUL Breath Sounds: Diminished
LLL Breath Sounds: Diminished
Bilat BP for Potential Sepsis, Hypovolemia, Congenital Heart, Cardiac Meds,
Chest Pain (Age 30+) & Abdominal Pain (Age 15+): (If noted below)
Orthostatic Vital Signs: (If noted below)
LIST ALL PRECAUTIONS UTILIZED

DETAIL ASSESSMENT

Occurred Date	Time	User	Recorded Date	Time	User
03/29/11	0254	Brownley,Ashlie N, RN	03/29/11	2312	Brownley,Ashlie N, RN

Suicide screenings: No
In the Past 30 days have you:
Evidence of physical and/or psychological abuse: No
Does the patient feel safe at home: Yes
See next page
Previous Medical History: Yes
Previous Surgeries: ARTIFICIAL LEFT EYE, L THUMB AND FIRST 2 DIGIT, AMPUTATED
Last Tetanus Shot: Unknown

See next page
Nutritional Assessment WDP? Yes
Functional Assessment WDP? No
Explain Variance:
PT FELL 5 YRS AGO, UNABLE TO AMBULATE
Living arrangements: Assisted Living/Skill Nur
See next page
Tobacco history: No
Alcohol history: No
Drug use history: No
See next page
Are there cultural,religious,language,developmental or behavioral factors to consider in planning care: Yes
Describe:
AMS
Any barriers to learning identified: Yes
Barriers to learning: Acute medical/mental cond
Readiness to learn: Unable to assess
Preferred method of learning: Discussion
See next page
OB/GYN History: (If noted below)
See next page
Do you feel a sense of hopelessness or helplessness that affects the care
See next page
Body Mass Index (BMI): 23.8
: Normal
See next page
Last page
"Modified SAD Person Scale is a SCREENING TOOL"
Interpretation of Scores:
Less Than 6 = May be Safe to Discharge (Depending on Circumstances)
6-8 = Probably Requires Psychiatric Consultation
Greater than 8 - Probably Requires Hospital Admission
Respiratory: No
Heart: No
GU: No
Neurological: No
Mental Health: Yes
: Other
Cancer: No
Chronic/Other: Yes
: Diabetes
Risk Factors: Yes
: Hypo/Hypertension
Comments:
DENTURA

PAIN ASSESSMENT/REASSESSMENT

Occurred Date	Time	User	Recorded Date	Time	User
03/29/11	2312	Brownley,Ashlie N, RN	03/29/11	2322	Brownley,Ashlie N, RN

Acceptable pain level: 0
Assessment Type: Ongoing Monitoring
Pain scale: Numeric
Intensity: 0
See next page

Patient:WINKLER, LOUIS [redacted] Sex/Race: M/W Acct No: [redacted]
EDN Provider: Ahmet Jeanrick, MD Unit No: 001[redacted]

See next page
Last page

Physical Findings

Observed		Recorded	
Date	Time User	Date	Time User
03/29/11	2302 Bromley,Ashlie N, RN	03/29/11	2304 Bromley,Ashlie N, RN

Neurological Assessment WDP: N
Documented via Chief Complaint: Y
ENT Assessment WDP: Y
Respiratory Assessment WDP: Y
Cardiovascular Assessment WDP: N
Documented via Chief Complaint: N
Circulatory Assessment WDP: N
Documented via Chief Complaint: N
Musculoskeletal Assessment WDP: Y
Gastrointestinal Assessment WDP: Y
Genitourinary Assessment WDP: Y
Integumentary Assessment WDP: Y
Psychosocial Assessment WDP: Y
Glasgow Coma Scale:(If noted below)
Heart Status: Normal
Cardiac Rhythm: Sinus Tachycardia
Skin Color: Pale
Skin: Cool
Associated Signs & Symptoms: ANS
Does Patient Have a Pacemaker: N
Implantable Defibrillator: No
Is this a Reassessment: N
Altered Circulatory Site: Lower Extremity, Left, Lower Extremity, Right
Amount of Edema Noted Proximal to Affected Site: 1+ Pitting
Capillary Refill Proximal to Affected Site: <2 Seconds
Skin Proximal to Affected Site: Warm, Dry
Skin Color Proximal to Affected Sites Pale
Sensation Proximal to Affected Sites Intact
Distal Pulse to Affected Site Evaluated: Dorsalis Pedal, Left, Dorsalis Pedal, Right
Distal Pulse Character: Weak
Amount of Edema Noted Distal to Affected Site: 1+ Pitting
Capillary Refill Distal to Affected Site: <2 Seconds
Skin Distal to Affected Sites Warm, Dry
Skin Color Distal to Affected Sites Pale
Sensation Distal to Affected Site: Intact
Is this a Reassessment: N

Change Mental/Neuro Status POC

Observed		Recorded	
Date	Time User	Date	Time User
03/29/11	2304 Bromley,Ashlie N, RN	03/29/11	2304 Bromley,Ashlie N, RN

Problem / Goals	Priority
Alteration in Neurological Function	
: 1	
- Pt will maintain adequate neuro functions awake, responsive, easily aroused, or return of baseline for patient.	
Impaired Circulation	
: 2	
- Pt will show evidence of adequate circulation/perfusion.	
Pain:	
: 3	
- Pt will verbalize a decrease or tolerable level of pain.	
- Comfort measures and/or medications for pain will be provided in collaboration with physician.	
Education:	
: 4	
- Pt will demonstrate an adequate knowledge level of follow-up care/resources.	
Anxiety:	
: 5	
- Pt will verbalize a decrease or relief of tension.	
- Patient will verbalize use of appropriate coping mechanisms.	
High Risk for Falls/Injury:	
: 6	
- Pt will not have any falls and/or injuries during hospital stay.	

Change Mental/Neuro St Reassat

Observed		Recorded	
Date	Time User	Date	Time User
03/30/11	0417 Bromley,Ashlie N, RN	03/30/11	0419 Bromley,Ashlie N, RN

Level of Consciousness: Confused, Calm
Behavior: Calm
Cardiac Rhythm: Sinus Tachycardia
Associated Signs & Symptoms: ANS
Breath Sounds Clear & Equal Bilaterally All Lobes: N
Glasgow Coma Scale:(If noted below)
Pupils PERLA: Y
Eye Openings: 4
Best Motor Response: 6
Best Verbal Response: 4
GCS Total: 14
Numbness or Tingling: No
Weakness: Yes
Weakness Location: GEN WEAKNESS
Balance/Gait: Unable to Assess
Hand Grips & Leg Strength Equal & Strong: No
Grip Strength Left: Weak
Grip Strength Right: Strong
Leg Strength Left: Weak
Leg Strength Right: Weak
Skin Color: Pale
Skin: Warm, Dry
Assess Pain Now: Y
Pulse: 108
Respirations: 23
Blood Pressure: 116/85
SaO2: 97
Pain Relief Measures Provided: Dark & Quiet Room, Repositioning, Medication
Were Pain Relief Measures Effective: Y
Severity Pain Scale Used: 0-10

Brenton Regional Hospital EDM **LIVE**
EMERGENCY PATIENT RECORD

PRINT DATE: 03/31/11
PRINT TIME: 0509
PRINT USER: HPF.USER

Patient: WINKLER, LOUIS — Age/Sex: 41/M — Acct: MR: [redacted]
ED Provider: Barnett,Rebecca MD — Arrived: 03/29/11 2241

Pain/Discomfort Severity: 0
Has Quality & Characteristics of Pain Worsened Since Previous Assessment: N
RUL Breath Sounds: Diminished
RLL Breath Sounds: Diminished
LUL Breath Sounds: Diminished
LLL Breath Sounds: Diminished

Change Mental/Neuro St Reassmt — ** EDIT **

Occurred Date	Time	User	Recorded Date	Time	User
03/30/11	0117	Brownley,Ashlie N, RN	03/30/11	0140	Brownley,Ashlie N, RN

Temperature: 98.4

Change Mental/Neuro St Reassmt

Occurred Date	Time	User	Recorded Date	Time	User
03/30/11	0230	Brownley,Ashlie N, RN	03/30/11	0233	Brownley,Ashlie N, RN

Level of Consciousness: Confused, Calm
Behavior: Calm
Cardiac Rhythm: Sinus Tachycardia
Associated Signs & Symptoms: ANS
Breath Sounds Clear & Equal Bilaterally: All Lobes: N
Glasgow Coma Scale: (If noted below)
Pupils PERLA: Y
Eye Opening: 4
Best Motor Response: 6
Best Verbal Response: 4
GCS Total: 14
Numbness or Tingling: No
Weakness: Yes
Weakness Location: GEN WEAKNESS
Balance/Gait: Unable to Assess
Hand Grips & Leg Strength Equal & Strong: No
Grip Strength Left: Weak
Grip Strength Right: Strong
Leg Strength Left: Weak
Leg Strength Right: Weak
Skin Color: Pale
Skin: Warm, Dry
Assess Pain Now: Y
Pulse: 103
Respirations: 14
SpO2%: 100
Pain Relief Measures Provided: Dark & Quiet Room, Repositioning, Medication
Were Pain Relief Measures Effective: Y
Severity Pain Scale Used: 0-10
Pain/Discomfort Severity: 0
Has Quality & Characteristics of Pain Worsened Since Previous Assessment: N
RUL Breath Sounds: Diminished
RLL Breath Sounds: Diminished
LUL Breath Sounds: Diminished
LLL Breath Sounds: Diminished

Change Mental/Neuro St Reassmt — ** EDIT **

Occurred Date	Time	User	Recorded Date	Time	User
03/30/11	0230	Brownley,Ashlie N, RN	03/30/11	0234	Brownley,Ashlie N, RN

Blood Pressure: 109/58

Disposition-DC, TX,ADM,LPT

Occurred Date	Time	User	Recorded Date	Time	User
03/30/11	0206	Brownley,Ashlie N, RN	03/30/11	0208	Brownley,Ashlie N, RN

Patient Disposition: Admission
LPNSE
Last page
Transported via : Stretcher
Transported with the following: Oxygen, Monitor, Tech
Arrival Date: 03/29/11
Arrival Time: 2241
Triage Date: 03/29/11
Triage Time: 2245
Triage Level: ESI-3/Urgent
Placed in Bed Date: 03/29/11
Placed in Bed Time: 2242
MD/RN/PA/NP Initiates Contact/Greets Patient Date: 03/29/11
MD/RN/PA/NP Initiates Contact/Greets Patient Time: 2249
MD/RN/PA/NP Writes Disposition Order Date: 03/30/11
MD/RN/PA/NP Writes Disposition Order Time: 0200
Elapsed Time from Disposition to Depart:
0200
ESPF N
Patient Left
See next page
See next page
See next page

Change Mental/Neuro St Reassmt

Occurred Date	Time	User	Recorded Date	Time	User
03/30/11	0409	Brownley,Ashlie N, RN	03/30/11	0409	Brownley,Ashlie N, RN

Level of Consciousness: Confused, Calm
Behavior: Calm
Cardiac Rhythm: Sinus Tachycardia
Associated Signs & Symptoms: ANS
Breath Sounds Clear & Equal Bilaterally: All Lobes: N
Glasgow Coma Scale: (If noted below)
Pupils PERLA: Y
Eye Opening: 4
Best Motor Response: 6
Best Verbal Response: 4
GCS Total: 14
Numbness or Tingling: No
Weakness: Yes
Weakness Location: GEN WEAKNESS
Balance/Gait: Unable to Assess
Hand Grips & Leg Strength Equal & Strong: No

Patient: WINKLER, LOUIS Age/Sex: 61/M; Facility: [redacted]
ED# Provider: Arnett,Alaina Joy MD Unit #: ED/75581

Grip Strength Left: Weak
Grip Strength Right: Strong
Leg Strength Left: Weak
Leg Strength Right: Weak
Skin Color: Pale
Skin: Warm, Dry
Assess Pain Now: Y
Pulse: 102
Respirations: 14
Blood Pressure: 118/61
SpO2%: 97
Pain Relief Measures Provided: Rest & Quiet Room, Repositioning, Medication
Were Pain Relief Measures Effective: Y
Severity Pain Scale Used: 0-10
Pain/Discomfort Severity: 0
Has Quality & Characteristics of Pain Worsened Since Previous Assessment: N
RUL Breath Sounds: Diminished
RML Breath Sounds: Diminished
LLL Breath Sounds: Diminished
LUL Breath Sounds: Diminished

Flowsheet Detail

Occurred Date	Time User	Recorded Date	Time User
03/29/11 2250	Brownley,Ashlie N, RN	03/30/11 0141	Brownley,Ashlie N, RN

Temp: 100.4
Temp Source: RECTAL
See next page
Orthostatic Vital Signs: (If noted below)
See next page
Glasgow Coma Scale: (If noted below)
Last page

Teaching Education

Occurred Date	Time User	Recorded Date	Time User
03/29/11 2304	Brownley,Ashlie N, RN	03/29/11 2304	Brownley,Ashlie N, RN

Learner: Family
Readiness to Learn: Cooperative, Eager to Learn, Asks Questions
Barriers to Learning: None
Patient Rating of Current Knowledge Level: Fair
Teaching Method: Verbal
Patient/Family Education Subject Items: Medications, Disease Process, Safety, Community Resources, Procedures, MFD Status, ED After Care & Follow Up, Hygiene, Nutrition, Food/Drug Interactions
Learner(s) Verbalized Understanding and/or Return Demonstration of Items: Y
Pt/Family Encouraged Verbalize Anxieties & Reassurance Given: Y
Pt/Family/Significant Other Informed of Condition & Treatment Plan: Y
Pt/Family/Significant Other Encouraged Give Input & Participate in Tx: Y

EKG - 12 LEAD

Occurred Date	Time User	Recorded Date	Time User
03/29/11 2315	Brownley,Ashlie N, RN	03/29/11 2315	Brownley,Ashlie N, RN

Opponent Exit Y
Time IDE Performed: 2314
EKG Provided for
OR BOTHETT
Bilat LE for Potential Sepsis, Hypovolemia, Congenital Heart, Cardiac Meds.
Chest Pain (Age 30+) & Abdominal Pain (Age 15+): (If noted below)
Orthostatic Vital Signs: (If noted below)

Blood Sugar

Occurred Date	Time User	Recorded Date	Time User
03/29/11 2327	Brownley,Ashlie N, RN	03/29/11 2327	Brownley,Ashlie N, RN

Fingerstick Blood Sugar (Mg/Dl):
208
MD Notified of Low/High Result: Not Applicable

Foley Catheter

Occurred Date	Time User	Recorded Date	Time User
03/29/11 2327	Brownley,Ashlie N, RN	03/29/11 2327	Brownley,Ashlie N, RN

Site of Insertion: Urethra
Condition of Meatus Prior to Insertion: WNL
Size of Catheter: 16 FR
Catheter Type: Foley
Initial Amount of Urine Obtained:
0
Foley Connected To: Bedside Drainage Bag
Foley Secured To Leg With: Not Secured

URINE SPECIMEN COLLECTION

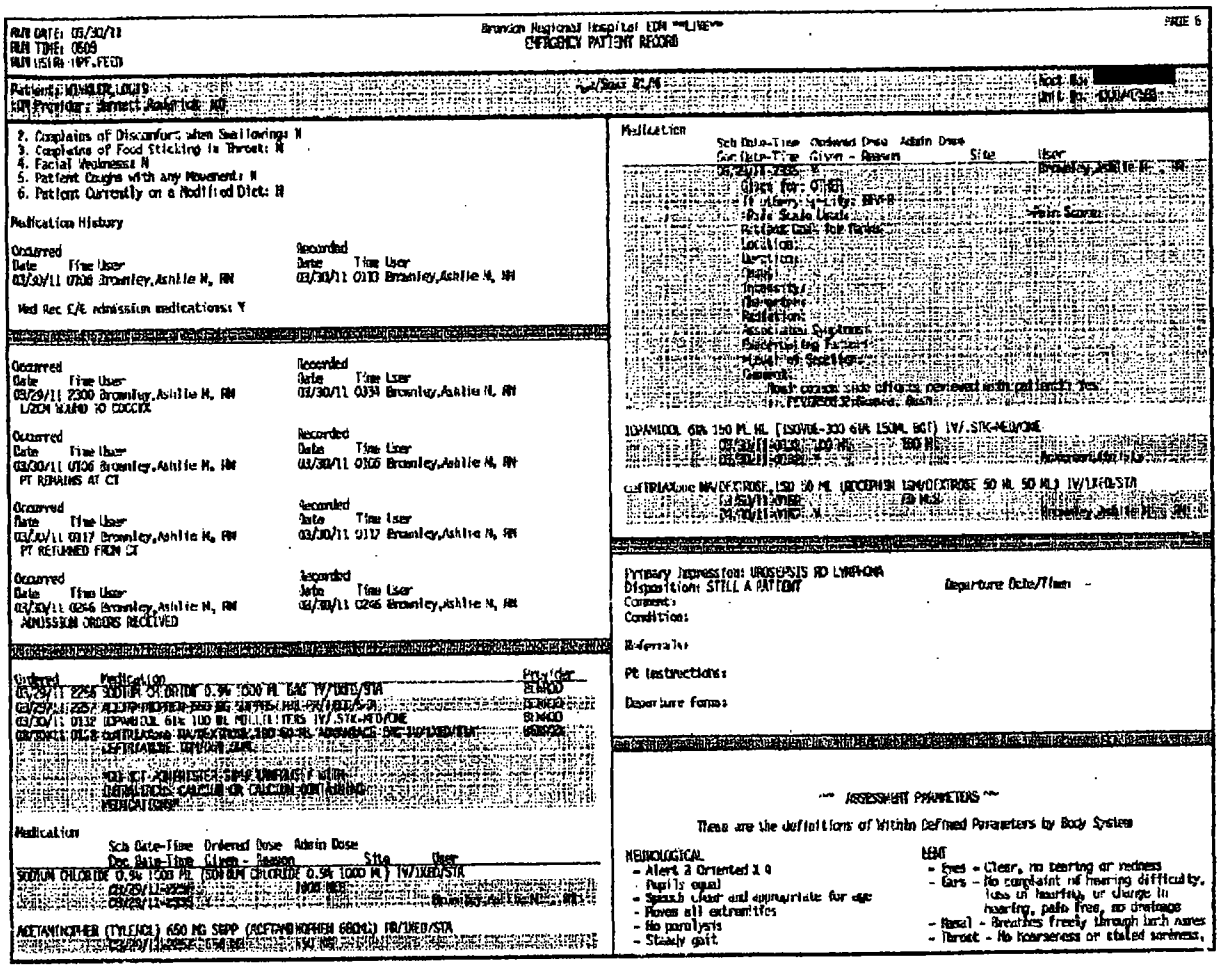
Occurred Date	Time User	Recorded Date	Time User
03/30/11 0101	Hubbard,Dawn, RN	03/30/11 0101	Hubbard,Dawn, RN

Specimen Collected #1: Voided Urine
Specimen #1 Sent To: Lab
Additional Findings:
NO

Swallow Screening

Occurred Date	Time User	Recorded Date	Time User
03/30/11 0105	Brownley,Ashlie N, RN	03/30/11 0105	Brownley,Ashlie N, RN

< SWALLOW SCREEN >
1. Drooling: N



2. Complains of Discomfort when Swallowing: N
3. Complains of Food Sticking in Throat: N
4. Facial Weakness: N
5. Patient Coughs with any Movement: N
6. Patient Currently on a Modified Diet: N

Medication History

Occurred Date	Time	User	Recorded Date	Time	User
03/30/11	0706	Bromley,Ashlie N, RN	03/30/11	0710	Bromley,Ashlie N, RN

Med Rec E/R admission medications: Y

Occurred Date	Time	User	Recorded Date	Time	User
03/29/11	2300	Bromley,Ashlie N, RN	03/30/11	0359	Bromley,Ashlie N, RN
LIZOX WAND TO COCCIX					
03/30/11	0706	Bromley,Ashlie N, RN	03/30/11	0709	Bromley,Ashlie N, RN
PT REMAINS AT CT					
03/30/11	0817	Bromley,Ashlie N, RN	03/30/11	0917	Bromley,Ashlie N, RN
PT RETURNED FROM CT					
03/30/11	0256	Bromley,Ashlie N, RN	03/30/11	0245	Bromley,Ashlie N, RN
ADMISSION ORDERS RECEIVED					

Ordered	Medication	Provider
03/29/11 2256	SODIUM CHLORIDE 0.9% 1000 ML BAG IV/UKED/STA	BRANCO
03/29/11 2257	ACETAMINOPHEN 650 MG SUPP (ACETAMINOPHEN 650MG) PR/UKED/STA	BRANCO
03/30/11 0132	IBUPROFEN 600 MG TABLET	BRANCO
03/30/11 0148	CEFTRIAXone IN/DEXTROSE, ISO 50 ML (RECEPHIN ISM/DEXTROSE 50 ML 50 ML) IV/ULED/STA	BRANCO

Medication

Sch Date-Time	Ordered Dose	Admin Dose
Doc Date-Time	Given - Reason	Site	User

SODIUM CHLORIDE 0.9% 1000 ML (500 NM CHLORIDE 0.9% 1000 ML) IV/UKED/STA

03/29/11-2256 1000 ML
03/29/11-2355 IV

ACETAMINOPHEN (TYLENOL) 650 MG SUPP (ACETAMINOPHEN 650MG) PR/UKED/STA

03/29/11-2257 650 MG

Medication

Sch Date-Time	Ordered Dose	Admin Dose
Doc Date-Time	Given - Reason	Site	User

03/29/11-2256 1000 ML
03/29/11-2355 IV

IBUPROFEN 600 MG TABLET

03/30/11-0132 600 MG
03/30/11-0148 PO

CEFTRIAXone IN/DEXTROSE, ISO 50 ML (RECEPHIN ISM/DEXTROSE 50 ML 50 ML) IV/ULED/STA

03/30/11-0148 50 ML/HR
03/30/11-0245 IV

Primary Impression: UROSEPSIS RD LYMPHOMA
Disposition: STILL A PATIENT
Departure Date/Time: -
Comment:
Condition:
Referrals:
Pt Instructions:
Departure Forms:

*** ASSESSMENT PARAMETERS ***

These are the definitions of Within Defined Parameters by Body System

NEUROLOGICAL
- Alert & Oriented X 0
- Pupils equal
- Speech clear and appropriate for age
- Moves all extremities
- No paralysis
- Steady gait

ENT
- Eyes - Clear, no tearing or redness
- Ears - No complaint of hearing difficulty, loss of hearing, or change in hearing, pain free, no drainage
- Nasal - Breathes freely through both nares
- Throat - No hoarseness or stated soreness,

RUN DATE: 03/30/11
RUN TIME: 0509
RUN USER: IPF.FEED

Brandon Regional Hospital CDN **LIVE**
EMERGENCY PATIENT RECORD

PAGE 7

Patient: WINKLER, LOUIS
CDR Provider: Bennett,Roderick MD

Age/Sex: 81,M

Med Rec #: [redacted]
Unit #: 0004/5383

- Ambulates independently

no cough

RESPIRATORY
- No respiratory distress
- No cough
- No O2 or assistive devices
- No nasal flaring or pursed lip breathing
- Respirations even & unlabored
- Skin pink & warm to touch

CARDIAC
- No stated calf tenderness
- No history of pacemaker or implanted defibrillator
- Denies current cardiac complaint
- Skin pink & warm to touch - no cyanosis, mottling, diaphoresis or flushing of skin

CIRCULATORY
- Oral mucosa pink and moist
- Skin color appropriate to ethnic color
- Denies sensory complaints
- No edema noted

MUSCULOSKELETAL
- Moves all extremities
- Ambulates independently

GASTROINTESTINAL
- Denies GI complaints

GENITO-URINARY
- Denies GU complaints

INTEGUMENTARY
- Skin warm, dry & intact
- No complaints of lesions, rash, wounds, bruises, petechiae or abrasions

PSYCHOSOCIAL
- With regards to cultural influences mood/affect is appropriate
- Patient demonstrates effective coping skills/patterns for situation

These are the definitions of Within Defined Parameters for the Nutritional and Functional Screenings:

NUTRITIONAL
- No swallowing/chewing impairments
- No nausea and/or vomiting and/or diarrhea for 3 or more days
- No reported unintentional weight loss > 10 lbs in last 3 months
- No reported decrease in intake > 50% of usual in last two weeks

FUNCTIONAL
- No unexplained alteration in movement/mobility in last four weeks
- No recent limitation performance of ADLs
- No recent alteration in ADLs that require assistance

This is the definition for the evidence of Physical and/or Psychological Abuse question:

ABUSE HISTORY TO INCLUDE, BUT NOT LIMITED TO:
PT DOES NOT REPORT/NO EVIDENCE OF ANY OF THE FOLLOWING: abuse/neglect, hx. of abuse/neglect, withdrawn/fearful behavior, Unexplained or suspicious bruises/wounds, Patient/Caregiver story changes, Defensive about injuries, Undernourished despite good appetite, Recurrent/Suspicious injuries, Fear of return to previous arrangements, Injuries do not match event history.

Home Medications

03/29/11 0106 Medication History
Med Rec E/E admission medications: Y

Brownley,Jashlie M, RN

Ordered	Order	Ordering Provider	E-Signed
03/29 2256	DNR	Bennett,Roderick MD	Y 03/29 2256

03/29 2256	CBC WITH DIFFERENTIAL	Bennett,Roderick	MD	Y	03/29 2256
03/29 2256	COMPREHENSIVE METABOLIC PANEL	Bennett,Roderick	MD	Y	03/29 2256
03/29 2256	PROTHROMBIN TIME PROFILE	Bennett,Roderick	MD	Y	03/29 2256
03/29 2256	PTT PROFILE	Bennett,Roderick	MD	Y	03/29 2256
03/29 2256	TROPONIN I	Bennett,Roderick	MD	Y	03/29 2256
03/29 2256	B TYPE NATRIURETIC PEPT	Bennett,Roderick	MD	Y	03/29 2256
03/29 2256	CPK-MB PROFILE	Bennett,Roderick	MD	Y	03/29 2256
03/29 2256	MAGNESIUM	Bennett,Roderick	MD	Y	03/29 2256
03/29 2256	PHOSPHORUS	Bennett,Roderick	MD	Y	03/29 2256
03/29 2256	CHEST PORTABLE	Bennett,Roderick	MD	Y	03/29 2256
03/29 2256	CT BRAIN W/O CONTRAST	Bennett,Roderick	MD	Y	03/29 2256
03/29 2256	URINALYSIS COMPLETE	Bennett,Roderick	MD	Y	03/29 2256
03/29 2256	CULTURE BLOOD	Bennett,Roderick	MD	Y	03/29 2256
03/29 2256	URINE SPECIMEN COLLECTION	Bennett,Roderick	MD	Y	03/29 2256
03/29 2256	SODIUM CHLORIDE 0.9% 1000 ML IV INFD	Bennett,Roderick	MD	Y	03/29 2256
03/29 2257	ACETAMINOPHEN 650MG 650 MG Dose: 650 MG PR 1	Bennett,Roderick	MD	Y	03/29 2253
03/29 2314	CT ANG CHEST W/WO CONTRAST	Bennett,Roderick	MD	Y	03/29 2314
03/30 0152	ROCEPHIN 1GM/DEXTROSE 50 ML 1 GM/50 ML IV 1	Bennett,Roderick	MD	Y	03/30 0152

BRANDON REGIONAL HOSPITAL
119 OAKFIELD DRIVE
BRANDON, FLORIDA 33511

********** HISTORY AND PHYSICAL

Patient Name: WINKLER,LOUIS DOB: [redacted]
Account #: [redacted] MRN:
Admit Date: 03/30/11 AGE: 81
Attending Physician: Agzew,Yeshitila MD

DATE OF ADMIT: 03/30/2011

PRIMARY CARE PHYSICIAN: Out of state.

CHIEF COMPLAINT: Altered mentation.

HISTORY OF PRESENT ILLNESS: This is an 81-year-old male patient, out of state, recently in nursing home, came with change in mentation. The patient came to this 5 weeks ago to live with his son. The patient is not verbally communicating. History obtained from medical record and from medical staff. He was recently admitted at Pittsburgh Hospital for urinary tract infection and IV hydration. He was released to rehab facility where he had been declining the mental condition and low saturation of oxygen where he was sent to the Brandon emergency room and the patient admitted for further workup.

PAST MEDICAL HISTORY: Significant for hypertension, degenerative joint disease, recent benign prostatic hypertrophy, dementia, recent back surgery, recent fracture in the right forearm. The patient had been on chemotherapy in the past for unknown condition.

ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: Include Hydrea 500 mg t.i.d., Lactinex 1 b.i.d., NovoLog insulin sliding scale, Prinivil 5 mg daily, Protonix 40 daily, Synthroid 0.1 daily, Tylenol 650 q.6 p.r.n., Vicodin 5/500 one q.12 h. p.r.n.

SOCIAL HISTORY: Could not be obtained.

REVIEW OF SYSTEMS:
Could not be done.

PHYSICAL EXAMINATION:
GENERAL: Lethargic patient, opens his eyes by command. Otherwise, not communicating adequately verbally, in no acute distress.
VITAL SIGNS: Blood pressure 145/81, respiratory rate 22, pulse 105, and temperature 99.
HEAD, EYES, EARS, NOSE, AND THROAT: Sclerae not icteric. Conjunctivae not pale.
NECK: Supple.
CHEST: Symmetrical movement. Good air entry bilaterally. No rhonchi. No wheezing.
CARDIOVASCULAR: S1 and S2 heard. No murmur. No gallop.
ABDOMEN: Soft and nontender.

GUS: No flank tenderness. No suprapubic tenderness.
EXTREMITIES: No joint swelling. No leg edema. There is a splint in the right forearm, right wrist.
NEUROLOGICAL: Proper neurological examination could not be done. The patient is not verbally communicating.

LABORATORY FINDINGS: Potassium 4.3, BUN 38, creatinine 1.5. Sodium 144, glucose 162. CK 30. Troponin 0.05. INR 1.2, PT 12. BNP 119. WBC 10, hemoglobin 9.3, hematocrit 29, platelets 95. SGOT 132, SGPT 16, bilirubin total 0.6. Urine, positive with a ketone positive and esterase positive, wbc 2 to 5, and bacteria positive. CT angio, numerous enlarged lymph nodes in the supraclavicular as well as in the hilar and mediastinal region. There is also multiple soft tissue mass seen medial to the aorta, nothing in the esophagus, representing probably lymph nodes.

ASSESSMENT AND PLAN:
1. Sepsis, rule out urosepsis. Rule out other courses of sepsis as well. The patient started on broad-spectrum IV antibiotics and blood culture done.
2. Rule out lymphoma or lung mass malignancy. Pulmonary consulted and also Hematology/Oncology consulted for the numerous lymph nodes in the mediastinum in the supraclavicular region. The patient on Hydrea. We may request further medical record, because the patient in the previous history and medical record was mentioned that he was getting chemotherapy and we need to know the possible cause of condition for the chemotherapy.
3. Degenerative joint disease.
4. Dementia.
5. Benign prostatic hypertrophy.

PLAN: IV antibiotics. IV fluids. Blood culture. Urine culture. GI/DVT prophylaxis. We will follow the patient. The patient's at this time condition is weak and not communicating. We will follow closely.

Yeshitila Agzew, MD

YA/MedQ
DD: 03/30/2011 11:36
DT: 03/30/2011 16:34
Job #: 536279/459934159
Revision #:
Authenticated by Yeshitila Agzew, MD On 04/03/2011 12:52:05 PM

Electronically Signed by Yeshitila Agzew, MD on 04/03/11 at 1253

PATIENT NAME: WINKLER,LOUIS ACCOUNT #: [redacted]

BRANDON REGIONAL HOSPITAL
119 OAKFIELD DRIVE
BRANDON, FLORIDA 33511

********** CONSULTATION

Patient Name: WINKLER,LOUIS DOB: [redacted]
Account #: [redacted] MRN: [redacted]
Admit Date: 03/30/11 AGE: 81
Attending Physician: Agzew,Yeshitila MD

DATE OF CONSULTATION: 03/30/2011

ADMITTING PHYSICIAN: Yeshitila Agzew, MD

CONSULTING PHYSICIAN: Rasha Beg, MD

REASON FOR CONSULTATION: Lymphadenopathy.

HISTORY OF PRESENT ILLNESS: The patient is an 81-year-old male, who was admitted for urinary tract infection. On CT scan, he was found to have lymphadenopathy and we are consulted for further management.

He is unable to give me any of the history, so most of the history was obtained from the chart and from his the daughter-in-law. He is an 81-year-old gentleman, who has otherwise been healthy prior to a couple of months ago when he has been in and out of the hospital for different reasons. At one time, he fell. He has also had a urinary tract infection in the past. He was in a nursing home in Ocala and currently he is in a nursing home in Plant City. Yesterday his daughter-in-law saw him and felt that he looks very ill. He was therefore brought to the emergency room where he was found to have a urinary tract infection. He is being admitted for the same.

On review of the old records, the patient has been on some sort of anti-chemotherapeutic agent. I spoke to the daughter-in-law and son-in-law and they both have no idea about his previous oncological history. They do not know what type of an anti-chemotherapeutic agent he has been on, nor did they have any information about the doctor who has been prescribing him with the medication. Again, the patient is unable to give any history whatsoever.

REVIEW OF SYSTEMS:
Unable to be obtained secondary to the patient's clinical condition.

PAST MEDICAL HISTORY: Hypertension, DJD, back surgery, BPH, some dementia.

PAST SURGICAL HISTORY: Back surgery.

FAMILY HISTORY: No significant family history of cancer or another hematological or oncological disorders.

SOCIAL HISTORY: Prior to getting ill, he was actually quite well. Currently, he is in a nursing home. There is no alcohol or tobacco abuse reported.

MEDICATIONS: Apparently some of his home medications include Colace, Lortab,

Protonix, Tylenol and folic acid. He is not on regular prescription medications. He currently is on Rocephin, Hydrea, Lactinex, Novolin, Prilosec, Prinivil, Synthroid, dextrose, water and p.r.n. medications. He is on Hydrea 500 mg tablets 3 times a day.

PHYSICAL EXAMINATION:
GENERAL: This patient was seen in the RAU. The patient is resting comfortably. He is in no acute distress though he is a ill looking.
VITAL SIGNS: Currently temperature 99.3, on admission his temperature was 100.3, pulse 105, blood pressure 145/81.
HEENT: Eyes, some pallor. PERRL. Mild dry mucous membranes. Some dental caries
NECK: There are left supraclavicular palpable lymph nodes. Trachea midline. No thyromegaly.
RESPIRATORY: The lungs are clear to auscultation anteriorly with normal inspiratory effort.
CARDIOVASCULAR: Heart rhythm is regular, trace bilateral lower extremity edema.
GASTROINTESTINAL: Soft and nontender. There is a palpable mass near the left lower quadrant.
LYMPHATICS: As I stated, the left supraclavicular lymph nodes are palpable. No inguinal adenopathy.
PSYCHIATRIC: The patient is alert and oriented x0.

LABORATORY DATA: CBC shows a white count of 10.8, hemoglobin of 9.3, platelet count of 95,000. CMP, creatinine is 1.5, BUN is 38, globulin is 3.8, albumin is 2.2.

RADIOLOGICAL DATA: He had a CT angiogram of the chest with contrast, which revealed numerous and large lymph nodes within the supraclavicular regions both on the left and on the right. There are multiple soft tissue masses seen medial to the aorta, abutting the esophagus.

ASSESSMENT:
1. Lymphadenopathy.
2. Questionable hematological disorder as the patient is on Hydrea.
3. Urinary tract infection.
4. Change in mental status, most likely related to the urinary tract infection.

PLAN:
1. The patient is on Hydrea and the family is unaware of who is prescribing the Hydrea and why he is on. I think it is imperative to get old records. He was admitted to be the Villages Regional Hospital and we are attempting to get the records today. For the time being, we will discontinue the Hydrea given his pancytopenia. Until further records are available, I feel uncomfortable continue the Hydrea at least for now.
2. He needs a CT scan of the abdomen and pelvis.
3. I will order anemia workup though his pancytopenia may be related to the Hydrea.
4. Continue antibiotics for urinary tract infection.

All of this was discussed in length with the patient's daughter-in-law who verbalized understanding.

PATIENT NAME: WINKLER,LOUIS ACCOUNT #: [redacted]

Thank you again for allowing us to participate in care this patient.

Rasha Beg, MD

RB/MedQ
DD: 03/30/2011 09:08
DT: 03/30/2011 13:59
Job #: 492985/459907490
Revision #:
Authenticated by Rasha Beg, MD On 05/04/2011 01:55:29 PM

Electronically Signed by Rasha Beg, MD on 05/04/11 at 1357

PATIENT NAME: WINKLER,LOUIS ACCOUNT #: [redacted]

BRANDON REGIONAL HOSPITAL
119 OAKFIELD DRIVE
BRANDON, FLORIDA 33511

********** CONSULTATION

Patient Name: WINKLER,LOUIS
Account #: [redacted]
Admit Date: 03/30/11
Attending Physician: Agzew,Yeshitila MD

DOB: [redacted]
MRN: [redacted]
AGE: 81

DATE OF CONSULTATION: 03/30/2011

ADMITTING PHYSICIAN: Yeshitila Agzew, MD

CONSULTING PHYSICIAN: Enid Klauber-Choephe, MD

The patient is seen at the request of attending physician.

REASON FOR CONSULTATION: Sepsis.

IMPRESSION:
1. Abnormal CT scan of the chest with a diffuse lymphadenopathy in the supraclavicular and paraesophageal lymph nodes suspicious for malignant process.
2. History of taking urea for malignant process, data unknown.
3. History of urinary tract infection.
4. Fever, this could be part of the malignant process versus a separate process.
5. No pyuria at this time.

PLAN:
1. IV with Rocephin. We will continue that.
2. Follow up culture results.
3. Serial physical examination.
4. Follow up Hematology/Oncology recommendations.

HISTORY OF PRESENT ILLNESS: This is an 81-year-old gentleman who was brought to the emergency room from his nursing home with a chief complaint of being disoriented. The facility reported possibly low oxygen saturations. Evaluation in the emergency room revealed an 81-year-old gentleman who was disoriented x3, but moved all extremities equally. He had recently fractured his arm and that was a known problem. The patient had mental status had returned to baseline following the fracture and the patient had known to be taken the medication called hydroxyurea, but the exact reason was not able to be elicited at this time. The patient had been taking hydroxyurea, but the reason for taking that drug as well as any other data is not available at the time of this dictation. The patient is totally unable to contribute to the history. He does not answer any questions at all.

PAST MEDICAL HISTORY: Significant for hypertension, degenerative joint disease, back surgery, and BPH.

PAST SURGICAL HISTORY: Includes back surgery.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS:
Unable to be performed.

SOCIAL HISTORY: The patient formerly was living in a nursing home. No drinking, tobacco, or drug use. However, according to some of the notes, the patient's mental status was fairly normal. He had been able to be alert and oriented x3. At this time, that is not the case.

MEDICATIONS: List is reviewed.

PHYSICAL EXAMINATION:
GENERAL: Reveals an 81-year-old gentleman who looks to be at his stated age. The patient will give single word answers, but does not answer anything beyond yes or no to very simple questions. He was recently had an outlying institution discharged March 22 with oral antibiotics for a history of UTI. At this time, his UA is negative for pyuria and cultures are pending that are negative today.
VITAL SIGNS: T-max is 100.4 and T-current is 98.6.
HEENT: Reveals anicteric sclerae. Oral cavity, no thrush.
NECK: Not vigorously manipulated.
LUNGS: Quiet anteriorly.
HEART: Rate and rhythm. S1 and S2. No S3 or 4.
ABDOMEN: Soft and nontender.
EXTREMITIES: Pt is missing 2nd and 3rd digit left hand. No peripheral edema of lower extremities

SKIN: Very pale with no suspicious lesions. He has a peripheral IV. NEUROLOGIC: The patient is obtunded.

LABORATORY DATA: Reveals BUN is 38 and creatinine 1.5. White count is 10.8, hemoglobin 9.3, and platelets of 95. The differential reveals elevated monocytes and no blasts. Additional data will be reviewed as it becomes available. The CAT scan reveals diffuse lymphadenopathy that was previously described.

Thank you very much for this interesting consultation. I will follow the patient with you.

_____
Enid Klauber-Choephe, MD

EK/MedQ
DD: 03/30/2011 16:19
DT: 03/30/2011 19:24
Job #: 494315/459996551
Revision #:
Authenticated and Edited by Enid Klauber Choephel, MD On 3/31/11 3:56:09 PM

PATIENT NAME: WINKLER,LOUIS ACCOUNT #: [redacted]

Electronically Signed by Enid Klauber Choephel, MD on 03/31/11 at 1557

PATIENT NAME: WINKLER,LOUIS ACCOUNT #: [redacted]

BRANDON REGIONAL HOSPITAL
119 OAKFIELD DRIVE
BRANDON, FLORIDA 33511

********** CONSULTATION

Patient Name: WINKLER,LOUIS
Account #: [redacted]
Admit Date: 03/30/11
Attending Physician: Agzew,Yeshitila MD

DOB: [redacted]
MRN: [redacted]
AGE: 81

DATE OF CONSULTATION: 03/30/2011

ADMITTING PHYSICIAN: Yeshitila Agzew, MD

CONSULTING PHYSICIAN: Suketu K Shah, MD

REASON FOR CONSULTATION: Possible lymphoma, lymph nodes on CT scan.

HISTORY OF PRESENT ILLNESS: The patient is an 81-year-old white male. He definitely has some confusion. He tells me that he does not smoke. He cannot really tell me, which hospital he was in, but says he was in the hospital. He cannot really give me much in the way of details as far as history. I did call and speak with his son. His son, Mr. Jeff Winkler at cell phone number [redacted]. His son was able to tell me in a little bit better as far as his history. He said the patient is essentially a nonsmoker having quit in his early 30s. He said his father did not have any asthma nor COPD history. His father used to live alone until about 2 to 2-1/2 months ago. Around that time, he started to decline. He was certainly having some weakness issues and his son put his house up for sale to get him to moved down this way. He said the patient had fallen and bumped his head when he had gone to the post office and ended up being hospitalized. While in the hospital up in Leesburg, there was a question of possible malignancy. He said he told there was some masses on scans that were done there, but then they performed a bone marrow biopsy that was negative and basically gave him a clean bill of health and sent him to the rehab. From the rehab facility, he did not do well, was getting weaker and worse, went to different hospital, did not do well, went back to different rehab facility, again was just continued to decline mentation changes, fevers and now he ends up here in Brandon. His son said he has had a urinary tract infection along the way that was treated. He has a fever of 100.4 here currently and does have an abnormal urinalysis. However, the more impressive thing on this patient, who has declined is that he has significant lymphadenopathy. His CT angiogram of the chest shows marked lymphadenopathy. There is bilateral supraclavicular lymphadenopathy, left greater than right. Left side is 5.5 x 3.3 cm, right supraclavicular 3.1 x 2.9 cm. There is mediastinal lymphadenopathy. The patient has azygoesophageal recess. He has small bilateral pleural effusions. No significant pericardial effusion. The lung parenchyma itself looks okay; however, without any mass or any nodule. He is status post a cholecystectomy. No destructive lesions within the bones. The patient's BNP was 119. His chest x-ray, which I visualized pretty clear looking lung fields in retrospect may have some prominence in the hilar mediastinal area. There was also some blunting of the left costophrenic angle greater than the right costophrenic angle.

REVIEW OF SYSTEMS:
Difficult to obtain from the patient, but according to the son he had fevers. No specific cough or phlegm. There has been mild dyspnea and no specific chest pain. He does not know if any bruising or bleeding. He has been getting evaluate for questionable lymphoma, had a pulmonary biopsy, which he said was told as normal or has been evaluated for possible masses. No lymph node masses. Cerebellar biopsy, which shows normal. No complaints of any diarrhea or melena the son is aware of, and just progressive weakness and progress failure to thrive issues.

FAMILY HISTORY: The son was unaware of any lymphoma in the family. The patient did live alone until a couple months ago and is going to be living with the son once he is out of rehab facilities.

SOCIAL HISTORY: He quit smoking in his around 30-year-old. The son says, there has been no alcohol use recently that he is aware of, no illicit drug use that he is aware of.

MEDICATIONS LIST: Includes Rocephin and did include Hydrea, but that has been stopped by Oncology (of note, the son says he was told that there might have been chemotherapeutic type medicines over the last 15 years being given to the patient, but he is not sure of the details of such), Prinivil 5 mg b.i.d., Prilosec.

DATABASE: Rest of his database, CBC; his white blood cell count was 10.8 with a hemoglobin of 9.3 and platelets of 95. The patient's CMP; his sodium 144, potassium of 4.3, BUN 38, creatinine 1.5, bicarbonate 19, anion gap 16, albumin 2.2, phosphorus 2.5. The patient's BNP was 119. His INR was 1.2 with a PTT of 27.7. The patient's CT scan of the brain had no specific mass, nor nodule, nor bleed, nor shift. He had just some chronic white matter changes.

PHYSICAL EXAMINATION:
GENERAL: He is a white male. He is week. He is arousable with mild lethargy. Able to answer some questions. He was in no respiratory distress, but he is slightly tachypneic.
VITAL SIGNS: The patient's T-max was 100.4, the last temperature 99.3, heart rate 105, respiratory rate 20 to 26, blood pressure 145/80.
LUNGS: Sounds were clear bilaterally. No wheezes. No crackles. Just slightly decreased in the extreme lung base.
CARDIAC: Slightly tachycardic, regular. No JVD.
NECK: Supple. His trachea is midline. He has marked supraclavicular lymphadenopathy in the left side bulging out the left supraclavicular area, at least a few centimeters in size, it is firm. There is slight right supraclavicular lymphadenopathy to the deeper inspection and palpation.
EXTREMITIES: He has 2+ femoral pulses bilateral, 2+ radial pulses, 1+ dorsalis pedis pulses. No edema. No clubbing. No cords. No cyanosis.
ABDOMEN: Soft and nontender. No definitive hepatosplenomegaly, but difficult to assess.
SKIN: Had no rash. He is able to move all extremities.

IMPRESSION:
1. Lymph gland enlargement especially supraclavicular, most worrisome for primary lymphoma.
2. Failure to thrive over 60 weeks, possibly related to the lymphoma.

PATIENT NAME: WINKLER,LOUIS ACCOUNT #: [redacted]

3. Pleural effusion bilateral, small.
4. Anemia and thrombocytopenia, suspect related to the lymphoma issue. Recent bone marrow biopsy negative per the son at the outside hospital.
5. Fever, possibly related to urosepsis given the abnormal urinalysis, but may be a lymphoma related fever.

RECOMMENDATIONS:
1. Surgical biopsy of the left supraclavicular lymph gland enlargement to make a definitive diagnosis.
2. Oncology evaluation has already seen the patient.
3. Empiric antibiotics while awaiting urine culture to return.
4. We will follow up chest x-ray to see if there is any other change.
5. Would avoid empirically diuresing as the BNP is just slightly elevated and his creatinine is 1.5.
6. Check echocardiogram.
7. Discontinuation of the Prinivil, the renal insufficiency is more of a new issue, but we are going to leave that to his internist.

Thank you very much. Will follow with you.

Suketu K Shah, MD

SKS/MedQ
DD: 03/30/2011 11:05
DT: 03/30/2011 16:37
Job #: 536167/459927620
Revision #:
Authenticated by Suketu K Shah, MD on 04/01/2011 02:27:15 PM

Electronically Signed by Suketu K Shah, MD on 04/01/11 at 1429

PATIENT NAME: WINKLER,LOUIS ACCOUNT #: [redacted]

To: Consulting Service or Physician
Klauber 681-6474

From:
Agzive

☐STAT ☐ Today ☐ Routine | Date: 3/30/11 | Time: 1400

Service Requested
- ☐ Impression Only
- ☐ Impression & Recommendation
- ☐ Assume Concurrent Care
- ☐ Assume Total Care
- ☐ Accept Transfer
- ☐ History & Physical
- ☐ Other:

Reason for Consultation/Brief History:
Sepsis

Signature of Attending Physician | Date & Time

Notified ☐ Consultant ☐ Consultant's Office | Signature | Date & Time
Office Contact: Amanda | Morton | 3/30/11 1400

Consultation Report:

last — 9a 7-
1 ① Abd CT check
② ? lymphoma
③ Heal for fever wk? last — 9a 7-
④ No pagers after 5p
⑤ Onc appt for PO
⑥ ID Fellowship Date
⑦ No Diarrhea - Thanks

Chart Reviewed ☐ Yes ☐ No | Date: 3/30/11 | Time: 4p | Signature of Consultant
Dictated ☐ Yes ☐ No

Consultation Request/Report

WINKLER, LOUIS
[redacted] 03/30/11 0245
008 [redacted] AI M IN
Agzew, Yesmicila MD 1966 #000747583
BRANDON REGIONAL HOSPITAL BRANDON,FL

"CONS" BRH07514 rev 08/09

To: Consulting Service or Physician
Pauls

From:
Agzen

☐STAT ☐ Today ☐ Routine | Date: | Time:

Service Requested
- ☐ Impression Only
- ☐ Impression & Recommendation
- ☐ Assume Concurrent Care
- ☐ Assume Total Care
- ☐ Accept Transfer
- ☐ History & Physical
- ☐ Other:

Reason for Consultation/Brief History:
CW biopsy
Sig. & Gabriel for w.s. & lymph
Some cervical sympathetic & brachial

Signature of Attending Physician | Date & Time

Notified ☐ Consultant ☐ Consultant's Office | Signature | Date & Time

Office Contact: Lymphadenopathy

Consultation Report:
Thx. H.TN. Am. Interview Lt U 77
AM: MCAT Past Lt cervical
7 mo SCC ↓ cervical Pt Area of Pain
R/L ENT symptoms Lt. Pharynx & Lt. post
Lt. Cervical Lymphadenopathy Lt. Carotid Lt.
Thx. Paul
FOS 53-CST 12.7/22.7 Hgb 4.1/12.2

A/P Infiltrative lymphadenopathy of unknown
- will ph for core needle biopsy of
Lt. supraclavicular LN at Lt. 77 through
operative area will proceed if open
biopsy in OR
- discussed DDx Sim.
- Thks

Chart Reviewed ☐ Yes ☐ No | Date 3/30/11 | Time | Signature of Consultant
Dictated ☐ Yes ☐ No

Consultation Request/Report

WINKLER, LOUIS
[redacted] SI M
Agzew, Yesuzeiha MD
BRANDON REGIONAL HOSPITAL
M A539-1 336594
03/30/11 0205
IR
MRN# 1000747583
BRANDON FL

"CONS" BRH07514 rev 08/09

M 001409

N5201BC

To: Consulting Service or Physician: Gorch

From: Agrew

☐ STAT ☐ Today ☑ Routine | Date: 3/30 | Time: 0755 ☑ AM ☐ PM

Service Requested
- ☐ Impression Only
- ☐ Impression & Recommendation
- ☐ Assume Concurrent Care
- ☐ Assume Total Care
- ☐ Accept Transfer
- ☐ History and Physical
- ☐ Other

Reason for Consultation/Brief History

Hilar lymphnodes in lung
~~biopsies~~

Signature of Attending Physician

Notified ☐ Consultant ☑ Consultants Office | Date: 3/30 | Time: 0755 ☐ AM ☐ PM | Signature: Michelle B

Office Contact: Susan

Consultation Report

Consulted for Angel Risky (1) Lobectomy

(2) Fever - Antibiotics

Sputum Gram Stain Negative

Pend. Chemotherapy - Oncologist

(3) Urinalysis

Chest Pain

EKG

(1) Biopsy (2) Supraclavicular Mass

Also Enlarged Prostate

(2) Urine culture sent Results

Chart Reviewed ☑ Yes ☐ No | Date: 3/30/11 | Time: ☐ AM ☐ PM | Signature of Consultant

Dictated ☑ Yes ☐ No

"CONS"

PATIENT IDENTIFICATION

WINKLER, LOUIS [redacted] 03/29/11 0000 M ER

Bennett, Roderick MD MR# H00824733 BRANDON REGIONAL HOSPITAL BRANDON, FL

Consultation Request/Report

N5201BC (Rev. 6/10)

CHART

N5201BC

To: Consulting Service or Physician: Robbins

From: Hazen

☐ STAT ☐ Today ☑ Routine | Date: 3/30 | Time: 0300 ☑ AM ☐ PM

Service Requested
- ☐ Impression Only
- ☐ Impression & Recommendation
- ☐ Assume Concurrent Care
- ☐ Assume Total Care
- ☐ Accept Transfer
- ☐ History and Physical
- ☐ Other

Reason for Consultation/Brief History

F/O Lymphnode

Signature of Attending Physician

Notified ☐ Consultant ☐ Consultants Office | Date: 3/30 | Time: 0300 ☑ AM ☐ PM | Signature: Michelle

Office Contact: Erika

Consultation Report

992785

A/: CAD

? on thyroid

pancytopenia

P/: D/c thyroid

CT abd pelvis

Old records

anemia w/u Greenwald asap

Chart Reviewed ☐ Yes ☐ No | Date | Time ☐ AM ☐ PM | Signature of Consultant

Dictated ☐ Yes ☐ No

CONS

PATIENT I

WINKLER, LOUIS [redacted] 81 M | 3359[illegible] | 03/29/17 0060 | ER

Bennett, Roderick MD | HRN H00074758[illegible]

BRANDON REGIONAL HOSPITAL | BRANDON, FL

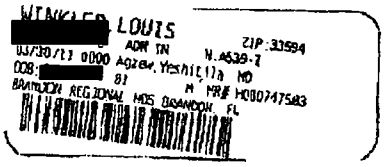
Consultation Request/Report

N5201BC (Rev. 8/10)

CHART

Date	Time	Each Entry Requires Physician's Signature, Date and Time
4/2/11	12P	TM
		S.
		O.N T98 P111 R28 AP 120/60
		AAO Lab
W/		Osc. nl.
282		Hct, tech 11.4 10.8 (50)
237		Sod, K 95 146 | 116 | 37 (237)
153		Alb 4.7 | (13) | 1.4
		Lactic acid (8.5)
146 CT		ABG 7.39 | (8) | 82 | 95 2. yesterday
CXR		a 2L NC
		AP
		(1) Notify MD of chem results
		(2) Antibiotic resistance of Lactic acid
		esp in context / hospice
		called MD made - see order
		Discuss family
		James Abraham, MD #12421 813-468-5722
4/3/11		Time of death 820
JM		Spoke to family

Physician's Progress Notes





"HNS" 8AH02160_Rev.11/09

Date	Time	Each Entry Requires Physician's Signature, Date and Time
		DA
8/2/11		Lymph / path noted afeb.
		All ex ⊖ 145/137 1.4
		Bcell lymphoma 11.4/247
		confirmed (50)
		Mesna / Ifex ex'd ⊖
		started by pathology
		A - Lymphoma
		P - Wide excision

Physician's Progress Notes

WINKLER, LOUIS [redacted] ZIP: 33594
ACN: [redacted] A: A539-E
DOB: [redacted] 01 M MRN: H008747583
BRANDON REGIONAL HOS BRANDON FL

Date	Time	Each Entry Requires Physician's Signature, Date and Time
4/2/11		Rounding
	10:12	S: Fatigued, no pain, dyspnea
		O: 98° HR 22 118/61 147/114/37 97/72/14 283
		Chest - clear
		WBRT - s/c tmt
		Abd - soft/NT
		Ext - no c/c/e
		7.34/45/62/65% 2L NC
		path: neutrop Ly B-cell lymphoma
		Onc
		A/P: Anemia - no prbc
		2/2 protein loss secondary to tumor burden
		probably Type 1 & 3 - not
		eligible for hypofractionation
		2/2 Anemia
		2/2 poor prognosis
		Spoke c family
		DNR

Physician's Progress Notes

WINKLER, LOUIS ZIP:33594
[redacted] ADM IN H.A539-1
03/30/11 0000 Agzew,Yeshitila MD
DOB [redacted] 81 M MR# H000747583
BRANDON REGIONAL HOS BRANDON, FL

Date	Time	Each Entry Requires Physician's Signature, Date and Time
		4/2/11
		dtr
		ill in ICU
		s/p PBC
		B & LN – NHL (DLCL-B)
		pt in no shape for
		Ant. Neoplastic Rx
		dtr
		Plan - supportive
		Case

Physician's Progress Notes

WINKLER, LOUIS ZIP: 33594
[redacted] ADM IN H.A539-1
03/30/11 0000 Agzev, Yeshitila MD
DOB: [redacted] 81 M MR# (H00747583)
BRANDON REGIONAL HOS BRANDON, FL

On DRAGE

Date	Time	Each Entry Requires Physician's Signature, Date and Time
4/11		S. NP comm
4/11	1600	O 2 nasal cann,
		BP 126/60 a RA 24h R ~ 106 [illegible]
		comf, LBS 2.4/17/79/14.
		LUQ - [illegible]
		Abd - Soft
		Ext, 4+4/3+ 1+ 1.7 38
		148/1.4 85.
		A ① Anion metabolic acidosis
		② RD c Dm / uroseps
		③ RD hypoalbum.
		④ Anemia - / Immunosupp
		⑤ DNR.
		P ① Lasix D Tue
		② TPN, PICC
		Dispo: SNF vs Home c HH

Physician's Progress Notes

WINKLER, LOUIS
[redacted] 91 M IN
BRANDON REGIONAL HOSPITAL BRANDON, FL

Date	Time	Each Entry Requires Physician's Signature, Date and Time
		PMD
		MMonnieeen
9/1		
		- Long disc ē son present
		- Random
		- prosande equals
		. DNR
		- ICU
		Au

Physician's Progress Notes

WINKLER.LOUIS
[redacted] BJ M IN
Agizaw, Yeshitila MD MR# H0000747583
BRANDON REGIONAL HOSPITAL BRANDON,FL

*PNS*_BRHOSP60_Rev_11/09

Date	Time	Each Entry Requires Physician's Signature, Date and Time
		Ruby
		elderly NAD AA 24
Adm		Cervical LN, CLD, prox. LUE tenderness
		Large firm mass (R) neck base.
		enhancing.
		CBC grossly clear Bilat
		effusions BS fd Benign
	A	· Lymphoma
		· Anemia
		· Mild dehydrated, resp. insuff
		· Anemia, lymphoma
		· Workup for sepsis
		- V A/G
	P	- Cont O2, RT, home BP, CM.
		· Sev en route - clarify code status - ?
		home Tx. Discussed c DTR

Physician's Progress Notes

WINKLER, LOUIS
DOB: [redacted] 81 M IN
Age: [illegible] MD HR# H0007247583
BRAWARD REGIONAL HOSPITAL BRAWLIN, FL
H 8318-1 33594
03/30/11 0245

Date	Time	Each Entry Requires Physician's Signature, Date and Time
		TAO
3/31/11		2 RT w/o wounds D 0 970 V85
		PE NAD CT ordered
		A ① Lymphoma ② Advanced age
		P ① D/c prophylaxis 4-7-11 ② CBC ③ Wean fent prn
4/1/11		Surg: Bx [illegible] clavicular mass rt clavicle & thyroid Pain - ① mask bag ventilate no complications

Physician's Progress Notes

WINKLER, LOUIS
DOB: [redacted] 61 M
Agzew, Yeshitila MD
BRANDON REGIONAL HOSPITAL
H.A539-1 33594
03/30/11 0245
IN
MRN: M00747583
BRANDON, FL

Dan M Aglio

Date	Time	Each Entry Requires Physician's Signature, Date and Time
3/31/11		S- not consuf - weak O 2 - no distress, but SOB on exertion BP-140/69 and 69-0 CVP Cont: WBS CVS & RS WNL Abd-Soft Labs 4.7/31 Ca 8.4 11 8.2 ↓ 26 149/1.3 A(1) Rule Complication P/o pancreatic metastasis P(2) Anemia / Transfusion P(3) bx(P)

Physician's Progress Notes

WINKLER, LOUIS [redacted] 81 M 33694 03/29/11 0000 ER
Bennett, Roderick MD PRI HUUU747582
BRANDON REGIONAL HOSPITAL BRANDON, FL

Date	Time	Each Entry Requires Physician's Signature, Date and Time
3/31/11	1015	Patient has a pressure ulcer:
		Stage I
		Stage II COCCYX
		Stage III
		Stage IV
		Unstageable
		Deep Tissue Injury
		Pressure ulcer protocol initiated.
		**See additional notes and description under wound care "tab" in this patient's chart.

PRESSURE ULCER ALERT

Dr. Agzew

Your patient currently has:

- ☐ Stage I
- ☐ Stage II
- ☐ Stage III
- ☐ Stage IV
- ☐ Unstageable
- ☐ Deep Tissue Injury

- Please document skin conditions in your H&P of this patient.
- Please give orders.

MD Acknowledgement: _____

Date/Time: _____

Physician's Progress Notes

WINKLER, LOUIS [redacted] 81 F IN
Agzew, Yeshitila MD MR# H00074583
BRANDON REGIONAL HOSPITAL BRANDON, FL
H.8018-1 33594 03/30/11 0245

PNS BRH01120 rev.02/10

M 001421

Date	Time	Each Entry Requires Physician's Signature, Date and Time
3/31	11	PMS Ok benefited not SOB 97° 145 18 140/68 Abdomen NT Dull Lg Clear Extremities free of edema CN Grossly Intact AAOx3 PERRLA LOH 6614 11 Hgb 13 Hospital Provided IV Potassium NHL Lymphoma - Suspected relapse 4 Fine Path (P) 99 37 9.7 15 13 ② Hypercalcemia ③ Anemia/Febrile Neutropenia - Hgb from Endocrinology ④ Severe Asthma ⑤ Atypical Final Path ⑥ AFB Pending ⑦ Fungal Culture Pending ⑧ Cord Compression

Physician's Progress Notes

WINKLER, LOUIS
[redacted] 81 M
Asthma HD MRN# H00074683
BRANDON REGIONAL HOSPITAL BRANDON, FL
H.8318-1 3356 03/30/11 0245 IN

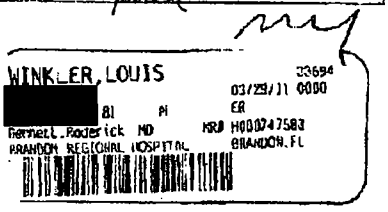
"HNS" BRH02160 Rev 11/09

Dr. Dr. Agler

Date	Time	Each Entry Requires Physician's Signature, Date and Time
3/30/11		Dictation # 536279
		Discussed Dr. Agler
3/31/11		Home Onc - Beag
		Pt a bit more awake, but still lethargic.
		Unable to communicate much.
		96 101 140/72 NAD
		AAOx1
		S1+S2 + RRR
		CTA, ↑ resp effort
		⊖ BS, NT
		⊖ edema
		11.7 / 35.2 / 63 LDH: 6694 Ferritin: 8320
		Folic acid 3.71
		Af: LAD Pt obtained pharmacy and
		U71 to get more info today he is
		? hematological disorder on nucleus
		↓ Folic acid Awaiting bx results
		↓ Folic acid
		Hold bypass

Physician's Progress Notes





DO NOT USE ABBREVIATIONS: QD, QOD, U, IU, MS, $MgSO_4$, MSO_4
Never a zero after a decimal point (Xmg) – Always a zero before a decimal point (0.Xmg)

Authorization is hereby given to dispense the generic equivalent unless otherwise indicated by the physician

Date	Time	Each Entry Requires Physician's Signature, Date and Time
		1. Admitting Physician: _____
		2. Level of Care (please check one): ☐ Admit to necessary certified hospital inpatient services. ☐ Assign to outpatient Observation services. ☐ Place in Outpatient services (i.e. SDC /diagnostic testing/ infusion).
		3. Bed type (please check one): ☐ M/S ☐ Tele ☐ PCU ☐ ICU
4/2/11	2100	Vitals in Triage [illegible]
		prn [illegible]
4/2/11	2345	Give Cardizem 5mg bolus x1 stat
		If HR [illegible] >140, start Cardizem gtt 2.5-5mg/hr
		prn [illegible]

STAT

Physician's Orders

WINKLER, LOUIS ZIP: 33594
[redacted] ADM IN H_A539-1
03/30/[redacted] 0600 Aqzew, Yeshitla MD
DOB [redacted] 81 M RRF H080/47563
BRANDON REGIONAL HOS BRANDON FL

"POS" BRH01072 rev 09/09

DO NOT USE ABBREVIATIONS: QD, QOD, U, IU, MS, $MgSO_4$, MSO_4

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Date	Time	Each Entry Requires Physician's Signature, Date and Time

1. Admitting Physician: _____
2. Level of Care (please check one): ☐ Admit to necessary certified hospital inpatient services.
   ☐ Assign to outpatient Observation services.
   ☐ Place in Outpatient services (i.e. SDC /diagnostic testing/ infusion)
3. Bed type (please check one): ☐ MS ☐ Tele ☐ PCU ☐ ICU

4/2/11

① D/C Lovenox

② Ablated 2.5 mg SO 0 AM

③ CBC

④ HIT Test 4/3 AM

⑤ PT/PTT 4/3 AM

Scanned 4/2/11

⑥ Morphine 2-4 mg IV q 2° PRN pain

⑦ Topical cream

Physician's Orders

WINKLER, LOUIS [redacted] ZIP: 33594
ACH TN H.A539-1
07/30/11 0000 Agzew, Yeshitila MD
DOB: [redacted] 81 M HR# H000747583
BRANDON ADDITIONAL HOS BRANDON, FL

"POS" BRH01072 rev 09/09

Page 1 of 1

Patient:WINKLER, LOUIS MRN: [redacted] Encounter:H00718392715 Page 2 of 20

M 001425

DO NOT USE ABBREVIATIONS: QD, QOD, U, IU, MS, $MgSO_4$, MSO_4
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This study intervention has met all criteria for waiver of documented patient consent (Code of Federal Regulations 45 CFR part 46)

Inclusion Criteria – ALL criteria must be present to include patient in study interventions.

- Age ≥13 years
- Patient admitted or readmitted to ICU

Exclusion Criteria - Selection of ANY one of the criteria listed below excludes patient from study interventions.

- Age < 13 years

FOR PATIENTS MEETING INCLUSION CRITERIA, INITIATE THE FOLLOWING:

Skin Cleaning – Bathing
1. 2% Chlorhexidine gluconate (CHG) bathing cloths for all bathing needs (below jaw line) for the entire duration of ICU stay.

2. Discontinue 2% Chlorhexidine (CHG) bathing when patient is discharged or transferred out of the ICU

3. Exclude from CHG bathing intervention patient with known allergy to Chlorhexidine gluconate (CHG). Document bathing exclusion reason in MEDITECH.

Nasal Medication
1. Mupirocin (Bactroban) nasal ointment 2%, ½ of the contents of a 1 gram tube applied to each nostril twice a day for 5 days. Massage nostrils gently for approximately 1 minute. **Do not substitute with generic medication**

2. Discontinue Mupirocin (Bactroban) nasal ointment when patient is discharged or transferred out of the ICU

3. *Exclude from Mupirocin (Bactroban) nasal ointment intervention if patient has known allergy to Mupirocin (Bactroban).*

4/2/11 — Date
4/2/11 — Time
Physician's Signature

Reduce MRSA Intervention 3 Protocol

[redacted] LOUIS
ADM IN ZIP:33594
DOB: [redacted] AI H MRN H00071847583
BRANDON REGIONAL FOS BRANDON FL

"POS" BACNASALSO rev 02/10

DO NOT USE ABBREVIATIONS: [redacted] QD, QOD, U, IU, MS, $MgSO_4$, MSO_4
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Central line bundle: hand hygiene, maximal barrier precautions upon insertion (full body patient drape, sterile gown, sterile gloves, cap and mask/face shield), chlorhexidine skin antisepsis and daily review of line necessity with prompt removal of unnecessary lines.

Reason for placement

- ☐ Intravenous medication is a vesicant and requires hemodilution in a large central vein (e.g. vasoactive medications, extreme pH or osmolarity)
- ☐ Total parenteral nutrition containing more than 10% dextrose or 5% protein
- ☐ High volume fluid infusions for resuscitation
- ☐ Infusion of multiple blood products
- ☐ Long term venous access/lack of sustainable peripheral access
- ☐ Other _____



PRE INSERTION

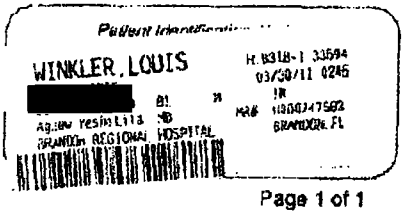
1. Ensure that physician has explained risks and benefits for PICC insertion and informed consent obtained.
2. Lidocaine 1% 0.2 ml with each intradermal injection for PICC insertion.

POST INSERTION

1. 4 / 5 / 6 French SINGLE / DOUBLE / TRIPLE lumen Power PICC placed.
2. Stat portable chest x-ray or fluoroscopy report from Radiology to confirm placement of PICC.
3. May use PICC once tip placement confirmed by Radiology.
4. No blood pressures in RIGHT / LEFT arm.
5. Do not draw blood from RIGHT / LEFT arm unless from PICC.
6. Notify MD if temperature > 101.5 or pain or swelling at site.
7. X-pad to the RIGHT / LEFT arm for redness, pain, or swelling.
8. Initial gauze dressing should be changed within 24 hours after insertion. Apply antimicrobial sponge and occlusive, transparent dressing. Then change every seven (7) days or when damp, loose or soiled. If gauze dressings are used, they must be changed every 48 hours.
9. PICC care.
   a) For intermittent catheter use – Flush catheter with NS 10ml after each use.
   b) If blood drawn – Obtain sample then flush with NS 10ml.
   c) For PICC not in use - Flush catheter with NS 10ml per lumen every 8 hours.
   d) For line occlusion – Cathflo Activase 2mg vial prn. Platelets must be greater than or equal to 40,000 to use. Dilute with 2.2 ml Sterile Water for Injection, USP by directing stream into the powder. If slight foaming occurs, let vial stand undisturbed to allow large bubbles to dissipate. Swirl vial gently until contents are completely dissolved DO NOT SHAKE. Reconstituted solution should be colorless or pale yellow and transparent. Inspect the solution for foreign matter and discoloration. [Reconstituted final concentration = 1mg/ml.] Using a 10 ml syringe, withdraw 2 ml of solution and instill into occluded catheter. After 30 minutes of dwell time assess catheter function by attempting to aspirate blood. If not functional, re-check after 120 minutes dwell time. If catheter function is restored: Aspirate 4-5 ml of blood to remove Cathflo and residual clot. Irrigate catheter gently with 0.9% NS. If catheter is still occluded, a second dose may be instilled repeating above sequence.
   NOTE: Cathflo Actlyase should be reconstituted immediately prior to use. The solution may be used within 8 hours if stored at 2-30° C (36-86F).

04/01/11 — Date
1525 — Time
[signature] — Physician's Signature

PICC Insertion / Maintenance Orders



POS PICC rev 02/11

DO NOT USE ABBREVIATIONS: QD, QOD, U, IU, MS, $MgSO_4$, MSO_4

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1. **Diet:** 1800 Calorie Carbohydrate Controlled diet Regular (NPO P.S.T.)
2. a. HgbA1C (if not done in the past 3 months)
   b. Lipid profile (if not done this admission)
3. **Consults:** ☐ Endocrinologist: Dr. _____ ☐ Dietitian: Diet (as above) teaching
   *Present Basic Survival Guide for Diabetes Management for patient education
4. **Education:** Nurse will present **Basic Survival Guide for Diabetes Management** for patient education
5. **Glucose Monitoring/Corrective Subcutaneous Insulin Dosing Schedule:** Check one
   ☐Before meals and at bedtime ☐Before meals only
   ☑Every 6 hours (NPO, Tube feeding, TPN) ☐ 2am -3 am (nocturnal hypoglycemia)
   ☐Every 4 hours ☐Other: ____
   Call for Blood Glucose > 400 or > _____ or for recurring hypoglycemia (< 70)
6. **NPO patients must have IV fluids containing Dextrose-** ☐D5W at _____ml/hr OR ☐ Other _____ml/hr
7. **Scheduled Insulin:** check required amount * see reference page 2 for insulin requirement calculations

Insulin	Breakfast	Lunch	Dinner	Bedtime
Basal Insulin NPO pt will need dose adjustment	Give ____units ☐Levemir ☐ NPH ☐ Other			Give ____units ☐Levemir ☐ NPH ☐ Other
Prandial/Bolus Mealtime insulin/not NPO patients **Give insulin before meal**	☐ Novolog ____units ☐ Other _____ OR ____ unit(s)/ CHO	☐ Novolog ____ units ☐ Other _____ OR ____ unit(s)/ CHO	☐ Novolog ____units ☐ Other _____ OR ____ unit(s)/ CHO	**Note: 1 Carbohydrate choice (CHO) = 15gm of carbohydrate**

8. ☐ **A. Corrective Subcutaneous Insulin:** Check either low, medium, high, individualized scale, OR insulin formula #6B.
   To be added to & given with Prandial/Bolus dose ** see reference page 2 for Corrective Insulin dose Check timing above in order #4

Blood Glucose BG must be pre-meal < 70mg/dl call physician	☑ Low dose scale Regular Novolog units (Insulin sensitive)	☐ Medium dose scale Novolog units	☐ High dose scale Novolog units (resistant/steroid)	☐ Individualized scale ☐Novolog units ☐Other _____
150 – 199mg/dl	2	2	3	
200 - 249mg/dl	3	4	5	
250 - 299mg/dl	4	6	8	
300 - 349mg/dl	5	8	10	
>349mg/dl	6	10	12	

OR

☐ **B. Corrective Subcutaneous Insulin using Insulin Formula:** Novolog *** see reference page for formula
(Current BG - BG target of _____) divided by the sensitivity factor of _____ = number of units of insulin to be given.
Maximum dose of _____units *** see reference page 2 for insulin formula

9. **Hypoglycemia Protocol for BG <70mg/dl or signs and symptoms present**

4/1/11 — Date
1400 — Time
TO Dr Lorch LCRD — Physician's Signature

Insulin Subcutaneous Preprinted Order Set

Used 10:14 FAXED

WINKLER, LOUIS [redacted] 61 M
Agzew, Yeshitila MD
BRANDON REGIONAL HOSPITAL
H 5318-1 33594 03/30/11 0245 IN
MR# H00074583 BRANDON, FL

"POS" DM SQINS rev 12/09

DO NOT USE ABBREVIATIONS: QD, QOD, U, IU, MS, $MgSO_4$, MSO_4

Never a zero after a decimal point (X.mg) - Always a zero before a decimal point (0.Xmg)

Authorization is hereby given to dispense the generic equivalent unless otherwise indicated by the physician

Date	Time	Each Entry Requires Physician's Signature, Date and Time

1. *Admitting Physician:* _____
2. Level of Care (please check one): ☐ Admit to necessary certified hospital inpatient services.
   ☐ Assign to outpatient Observation services.
   ☐ Place in Outpatient services (i.e. SDC /diagnostic testing/ infusion).
3. Bed type (please check one): ☐ M/S ☐ Tele ☐ PCU ☐ ICU

46 Transfer to ICU - Sepsis
PICC
- IV - NS @ 200 cc/hr x 2 hours then 100 cc/hr
- $NaHCO_3$ 2 amps IV now
- Meropenem 1 gm IV 500 q 8 hr
- Zyvox 600 mg IV q 12 hr
- Notify MD if pt status
- ABG, O_2, sputum culture if able, and CBS
- Hydrocortisone 50 mg IV q 8 hr
- O_2 prn sats
- BBS albuterol 2.5 mg q 6 hr prn
- q 6 hr accucheck, sliding scale to keep regular insulin
- Ekg, ASA, Cardiac enzymes now
- DNR

FAXED

STAT

Physician's Orders

WINKLER, LOUIS
[redacted] 61 M
MD
BRANDON REGIONAL HOSPITAL
MRN: H00718392715
BRANDON, FL

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3. Bed type (please check one): ☐ M/S ☐ Tele ☐ PCU ☐ ICU

4/11 1319 speech therapy consult for bedside swallow study. If pt passes start full liq diet
Verbal Dr Agnew
4/11/11
325
Verbal
APS

4/11 Lactic acid level now
portable CXR at bed side
ABG bypap
FAXED 4/11/11 1345 CT
Clear log etc to blm
q4h x 3 then qam
Hemoccult for occult blood

Physician's Orders

WINKLER, LOUIS
[redacted] SI M 18
Agnew, Yeshitila MD MR# H00047583
BRANDON REGIONAL HOSPITAL BRANDON, FL
H 8318-1 33594
33/30/11 0245

"POS" BRH01072 rev 09/09

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2. Level of Care (please check one): ☐ Admit to necessary certified hospital inpatient services.
   ☐ Assign to outpatient Observation services.
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3. Bed type (please check one): ☐ M/S ☐ Tele ☐ PCU ☐ ICU

4/1/11 0900 If pt agrees, transfuse 2 units PRBC
PO To Dr Averbach | ECRN
H/O

4/1/11 0900 Consent signed

noted 1600 TOD

4/1/11 @ 1600
O/R 96

Physician's Orders

WINKLER, LOUIS [redacted] 81 M IN
Agzaw Yeshitila MD MRN# H00074583
BRANDON REGIONAL HOSPITAL BRHDOM,FL
H.8318-1 30594 03/30/11 0245

POS BRH01072 rev 09/09

DO NOT USE ABBREVIATIONS QD, QOD, U, IU, MS, $MgSO_4$, MSO_4
Never a zero after a decimal point (X.mg) – Always a zero before a decimal point (0.Xmg)

Authorization is hereby given to dispense the generic equivalent unless otherwise indicated by the physician

Date	Time	Each Entry Requires Physician's Signature, Date and Time
		1. Admitting Physician: _____
		2. Level of Care (please check one): ☐ Admit to necessary certified hospital inpatient services. ☐ Assign to outpatient Observation services. ☐ Place in Outpatient services (i.e. SDC /diagnostic testing/ infusion).
		3. Bed type (please check one): ☐ M/S ☐ Tele ☐ PCU ☐ ICU
3/31/11		CEA, CA 19-9, AFP. CA, bmet tn
		FAXED 1035pm UC 3/31/11 Noted 3/31/11 1pm
3/31/11		Dr Seraphin 7-2-11
		FAXED 1350 3/31/11 JG Noted 3/31/11 Seraphin

Physician's Orders

3/31/11 120 chart

WINKLER, LOUIS [redacted] 03/29/11 22:41 Bennett L. Roderick MD BRANDON REGIONAL HOSPITAL H00747583 BRANDON, FL

"POS" BRH01072 rev 09/09

DO NOT USE ABBREVIATIONS: QD, QOD, U, IU, MS, $MgSO_4$, MSO_4

Never a zero after a decimal point (Xmg) – Always a zero before a decimal point (0.Xmg)

Authorization is hereby given to dispense the generic equivalent unless otherwise indicated by the physician

Date	Time	Each Entry Requires Physician's Signature, Date and Time

1. Admitting Physician: _____
2. Level of Care (please check one): ☐ Admit to necessary certified hospital inpatient services.
   ☐ Assign to outpatient Observation services.
   ☐ Place in Outpatient services (i.e. SDC /diagnostic testing/ infusion)
3. Bed type (please check one): ☐ M/S ☐ Tele ☐ PCU ☐ ICU

3/31/11 Folic acid 1mg po Qday

FAXED 9:23 am JC 3/31/11

3/31/11 1:15pm IVF 1/2NS @ 100 cc/hr x 4 hrs

Then 70 cc/hr

Keep Pt's K+ > 4.0

Given 30 meq KCl FAXED @ 4 PM 1445pm JC 3/31/11

Physician's Orders

2 units 04/01/11 @ 7:00 hr

WINKLER, LOUIS [redacted] 61 M 03/29/11 1000 ER
Bennett, Roderick MD MRN H000747583
BRANDON REGIONAL HOSPITAL BRANDON, FL

'POS' BRH01072 rev 09/09

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*** The Floor RN/LPN will initiate the interventions upon admission and obtain any additional physician orders. DO NOT wait for the wound care nurse to start treatment. ***

☐ Consult wound care nurse to evaluate and photograph the wound and evaluate patient for specialty bed.
☐ Consult Dietician for dietary work-up to assess general nutrition.
☐ Obtain twice-weekly weights.
☐ Surgical consult to _____
☐ Infectious disease consult to: _____
☐ Physical therapy consult to. _____
☐ Wound culture: culture wound(s) for ☐ aerobic ☐ anaerobic organisms
Add: _____

1. Initiate prevention protocol.
   - Turn Patient at least q2 hours and position using a foam wedge, rotating to a 30 degree lateral position from RT>LT>Flat.
   - Encourage use of bathroom/bedside commode as appropriate
   - Use draw/lift sheet at all time for lifting and turning
   - Keep HOB at 30 degrees or less unless medically contraindicated and at mealtimes
   - Heels: Float to keep from touching the bed at ALL times (even on specialty beds).
2. Measure all wounds in cm (length x width x depth) upon discovery and discharge.
3. All wounds will be cleansed/or irrigated with Normal Saline, Wound Cleanser or prescribed cleanser with each dressing change.
   ☐ Other _____
4. All dressings will be labeled with date applied and initials of treating staff member
5. Notify primary physician with any signs of infection (including but not limited to redness, warmth, increase in pain, boggy tissue, purulent drainage).
6. If patient has wounds on 2 turning surfaces: Contact/Consult wound care nurse for specialty bed.
   Specialty Bed ordered_____ (NO plastic chux on air flow beds).
7. Wounds with a necrotic base CANNOT be staged, document as un-stageable.

1. Deep Tissue Injury: A pressure related injury to subcutaneous tissues under intact skin. Initially it appears like a deep bruise, which may herald the development of a Stage III or IV ulcer even with optimal treatment.
   Location: _____

☐ N/A
☐ INITIATE a.☐ Apply "MAJIK BUTT CREAM" (Zinc Oxide/Nystatin/Mineral Oil/Petrolatum/Mag Hydrox/Al Hydrox/Simeth) (from pharmacy) ☐ BID & PRN as needed. DO NOT vigorously massage.

(IF ON FOOT, HEEL OR ANKLE, GO TO #6.

2. Stage I: Observable pressure-related alteration of intact skin, whose indicators (as compared to adjacent or opposite side) may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy), and/or change in sensation (increased pain or itching).
   Location: _____

☐ N/A
☐ INITIATE a.☐ Apply "MAJIK BUTT CREAM" (Zinc Oxide/Nystatin/Mineral Oil/Petrolatum/Mag Hydrox/Al Hydrox/Simeth) (from pharmacy) ☐ BID & PRN as needed. DO NOT vigorously massage.

(IF ON FOOT, HEEL OR ANKLE, GO TO #6)

Date _____ Time _____ Physician's Initial or Signature _____

Pressure Ulcer Treatment

WINKLER,LOUIS [redacted] 81 M 16
Agzaw, Yeshitila MD KRF H0007475B3
BRANDON REGIONAL HOSPITAL
H.8318.1 3359C
03/30/11 0245
BRANDON,FL

"POS" WC PRULCER rev 02/09

Placed in Chart by Wound Care nurse on 3-31-11 @ 1015

M 001434

DO NOT USE ABBREVIATIONS: QD, QOD, U, IU, MS, $MgSO_4$, MSO_4

Never a zero after a decimal point (Xmg) – Always a zero before a decimal point (0.Xmg)

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Date	Time	Each Entry Requires Physician's Signature, Date and Time

1. Admitting Physician: _____
2. Level of Care (please check one): ☐ Admit to medically necessary certified hospital inpatient services.
   ☐ Assign to outpatient Observation services.
   ☐ Place in Outpatient services (i.e. SDC /diagnostic testing/ infusion).
3. Bed type (please check one): ☐ M/S ☐ Tele ☐ PCU ☐ ICU

3/30/11 – Cirbacume 1% I Bpi
- Consent for L&R sigmoid colon resection
- Lymphadenectomy, peritoneal biopsy, possible ileostomy

3/30/11
- Stool to continue
- NS
- Heparin -

3/30/11 noted

3/30/11 1220 Send bx for frozen section to path. To Dr Pak's room RLC

3/30/11 noted

STAT

Physician's Orders

WINKLER, LOUIS
[redacted] 81 M
Bennett, Roderick MD
BRANDON REGIONAL HOSPITAL
33594
03/29/11 0000
ER
MR# H000747583
BRANDON, FL

noted 1550

3/30/11 120 Chart

"POS" BRN:01072 rev 09/09

Page 1 of 1

03/31/11 0000

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Date	Time	Each Entry Requires Physician's Signature, Date and Time

1. Admitting Physician: _____
2. Level of Care (please check one): ☐ Admit to necessary certified hospital inpatient services.
   ☐ Assign to outpatient Observation services.
   ☐ Place in Outpatient services (i.e. SDC /diagnostic testing/ infusion).
3. Bed type (please check one): ☐ MS ☐ Tele ☐ PCU ☐ ICU

3/30/11

CBC, Renal Function Panel – ASAP

LDH – ASAP

Consult Dr Rocco re: Bx (L) Supraclavicular Mass

CT Chest W

Esophagogram – Barium Meal

3/30/11 Noted by

CBC, Basic Metabolic Panel

PO Consult Dr Klauber for

FAXED 1120

Revlimid 40mg PO Daily

Tylenol 650mg PR Q6hr PRN

Physician's Orders

3/30/11 called Dr Klauber's office and left message for him to call me back regarding orders

WINKLER, LOUIS
[redacted] 61 M
Bennett, Roderick MD
BRANDON REGIONAL HOSPITAL
33594
03/29/11 0000
ER
MRN# H00074783
BRANDON, FL

4th Mar 03/31/11 0230

'POS' BRH01072 rev 09/09

Run Date/Time: 03/30/11 0113

BRANDON REGIONAL HOSPITAL
Admit - Physician Order

Printed By: HEDANG

Height: 185.42 cm (73 inches)
Weight: 81.65 Kg (180 lbs)

WINKLER, LOUIS

Acct#: [redacted]
MRN: [redacted]

ALLERGIES: No Known Allergies
ADRS: *** No ADR's Entered ***

HOME MEDICATIONS

As documented in medication history during admission

CHK TO CONT/STOP	GENERIC NAME FREQUENCY	DOSE	ROUTE / INDICATION	LAST DOSE DATE/TIME
ACE INHIBITORS				
☐ ☐	LISINOPRIL***** TWICE DAILY *** CHANGE ***	5MG	ORAL	03/29/11 2200
ANALGESICS AND ANTIPYRETICS M				
☐ ☒	ACETAMINOPHEN EVERY 4 HOURS AS NEEDED *** CHANGE ***	650MG	ORAL FEVER	Unknown
ANTIDIARRHEA AGENTS				
☐ ☐	ACIDOPHILUS/BULGARICUS BID X 10 DAYS *** CHANGE ***	1 TAB	ORAL	03/29/11 1000
ANTINEOPLASTIC AGENTS				
☐ ☐	HYDROXYUREA THREE TIMES DAILY *** CHANGE ***	1 TAB	ORAL	03/29/11 1000
ANTIULCER AGENTS AND ACID SUPP				
☐ ☒	PANTOPRAZOLE DAILY *** CHANGE ***	40MG	ORAL	03/29/11 1000
INSULINS				
☐ ☒	INSULIN ASPART S/S	S/S	SUBCUTANE.	Unknown

Dose Inst: 0-120 0 UNITS
121-180 2 UNITS
181-240=4 UNITS
241-300=6 UNITS
301-350= 8 UNITS
351 400= 10 UNITS
>400=12 UNITS CALL MD

*** CHANGE ***

FAXED

WINKLER, LOUIS
Acct#: [redacted]
MRN: [redacted]
Adm/Svc: 03/29/11
Attend MD:
Age: 81 DOB: [redacted] Sex: M

Toro De Arzew / A. Brownlee 3/30/11 0815
Physician Signature Date/Time

H00718392715A

**** This form is a part of the PERMANENT MEDICAL RECORD. Place in PHYSICIAN'S ORDER SECTION ****

PHYSICIAN'S ORDERS

Page: 1 (See Page 2)

M 001437

Run Date/Time: 03/30/11 0113

BRANDON REGIONAL HOSPITAL
Admit - Physician Order

Printed By: HEDRMB

Height: 185.42 cm (73 inches)
Weight: 81.65 Kg (180 lbs)

WINKLER, LOUIS

Acct# [redacted]
MR# [redacted]

ALLERGIES: No Known Allergies
ADRS: *** No ADR's Entered ***

HOME MEDICATIONS

As documented in medication history during admission

CHK TO CONT/STOP	GENERIC NAME FREQUENCY	DOSE	ROUTE / INDICATION	LAST DOSE DATE/TIME
OPIATE AGONISTS				
☐ ☐	HYDROCODONE BITARTRATE/APAP EVERY 12 HOURS AS NEEDED *** CHANGE ***	5/500MG	ORAL	Unknown
THYROID AGENTS				
☑ ☐	LEVOTHYROXINE SODIUM DAILY *** CHANGE ***	25MCG	ORAL	03/29/11 1090

VACCINATION HISTORY

*** No Vaccines History Found ***

ADDITIONAL MEDICATION ORDERS

*** *** ***

The medications listed above comprise the patient's home medication list. The medication dose/rate, route and frequency should be clarified above prior to a continuation order

*** *** ***

FAXED

WINKLER, LOUIS
Acct# [redacted]
MR# [redacted] Adm/Svc: 03/29/11
Attend MD:
Age: 81 DOB: [redacted] Sex: M

Physician Signature

Date/Time

PHS

H00718392715A

This form is a part of the PERMANENT MEDICAL RECORD. Place in PHYSICIAN'S ORDER SECTION

PHYSICIAN'S ORDERS

Page: 2 (FINAL PAGE)

DO NOT USE ABBREVIATIONS: QD, QOD, U, IU, MS, $MgSO_4$, MSO_4

Never a zero after a decimal point (Xmg) – Always a zero before a decimal point (0.Xmg)

Authorization is hereby given to dispense the generic equivalent unless otherwise indicated by the physician

Date	Time	Each Entry Requires Physician's Signature, Date and Time

1. Admitting Physician: _____
2. Level of Care (please check one): ☐ Admit to necessary certified hospital inpatient services.
   ☐ Assign to outpatient Observation services.
   ☐ Place in Outpatient services (i.e. SDC /diagnostic testing/ infusion).
3. Bed type (please check one): ☐ M/S ☐ Tele ☐ PCU ☐ ICU

3/30/11 D/c Hydrea

MRI C-Spine ordered & pended with contrast - re: L AD

gm

gm saline lock

Tylenol

Percocet

Ativan

Zofran

MMA

Hypercoagulable panel

CBC

today

3/30/11 noted K

Scanned 3/30/11 @ 0913

3/30/11

T.O. Dr. Berg C 092!

per Wilson Pharmacy & Primary MD faxed copy Dr. Berg

Clarification - MMA - Methyl Malonic Acid to be drawn today

Order faxed back Dr. Berg

Physician's Orders

noted dcpw 1500

WINKLER, LOUIS [redacted] 01 M 33504 03/29/11 0000 EK

Bennett, Roderick MD MR# H00074583

BRANDON REGIONAL HOSPITAL BRANDON, FL

POS BRH01072 rev 09/08

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1. DIet: Kosher Calorie Carbohydrate Controlled diet
2. a. HgbA1C (if not done in the past 3 months)
   b. Lipid profile (if not done this admission)
3. Consults: ☐ Endocrinologist: Dr. _____ ☐ Dietitian: Diet (as above) teaching
   *Present Basic Survival Guide for Diabetes Management for patient education
4. Education: Nurse will present Basic Survival Guide for Diabetes Management for patient education
5. Glucose Monitoring/Corrective Subcutaneous Insulin Dosing Schedule: Check one
   ☑ Before meals and at bedtime ☐ Before meals only
   ☐ Every 6 hours (NPO, Tube feeding, TPN) ☐ 2am -3 am (nocturnal hypoglycemia)
   ☐ Every 4 hours ☐ Other: ___
   Call for Blood Glucose > 400 or > _____ or for recurring hypoglycemia (< 70)
6. NPO patients must have IV fluids containing Dextrose- ☐D5W at _____ml/hr OR ☐ Other _____ml/hr
7. Scheduled Insulin: check required amount * see reference page 2 for insulin requirement calculations

Insulin	Breakfast	Lunch	Dinner	Bedtime
Basal Insulin: NPO pt will need dose adjustment	Give ____units ☐Levemir ☐ NPH ☐ Other			Give ____units ☐Levemir ☐ NPH ☐ Other
Prandial/Bolus Mealtime insulin/not NPO patients Give insulin before meal	☐ Novolog ____units ☐ Other_____ OR _____ unit(s)/ CHO	☐ Novolog____ units ☐ Other_____ OR _____ unit(s)/ CHO	☐ Novolog ____units ☐ Other_____ OR _____ unit(s)/ CHO	Note: 1 Carbohydrate choice (CHO) = 15gm of carbohydrate

8A. Corrective Subcutaneous Insulin. Check either low, medium, high, individualized scale, OR insulin formula #8B
To be added to A given with Prandial/Bolus dose ** see reference page 2 for Corrective Insulin dose. Check timing above in order #4

Blood Glucose BG must be pre-meal < 70mg/dl call physician	☐ Low dose scale Novolog units (insulin sensitive)	☑ Medium dose scale ~~Novolog units~~ Regular	☐ High dose scale Novolog units (resistant/septic/steroid)	☐ Individualized scale ☐Novolog units ☐Other_____
150 – 199mg/dl	2	2	3	
200 - 249mg/dl	3	4	5	
250 - 299mg/dl	4	6	8	
300 - 349mg/dl	6	8	10	
>349mg/dl	8	10	12	

OR

☐ 8. Corrective Subcutaneous Insulin using Insulin Formula: Novolog *** see reference page for formula
(Current BG – BG target of _____) divided by the sensitivity factor of _____ = number of units of insulin to be given.
Maximum dose of _____units *** see reference page 2 for insulin formula

9. Hypoglycemia Protocol for BG <70mg/dl or signs and symptoms present

FAXED

3/30/11 Date | 0245 Time | TCB Dr. Agzaw/A. Brantley Physician's Signature

Insulin Subcutaneous Preprinted Order Set

WINKLER, LOUIS [redacted] 81 M 03/29/11 2241 ER
MRN H0007475B3 BRANDON REGIONAL HOSPITAL BRANDON, FL

"POS" DM SQINS rev 12/09

Page 1 of 1

M 001440

DO NOT USE ABBREVIATIONS: QD, QOD, U, IU, MS, $MgSO_4$, MSO_4
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Date	Time	Each Entry Requires Physician's Signature, Date and Time
		1. Admitting Physician: Agzew
		2. Level of Care (please check one): ☒ Admit to necessary certified hospital inpatient services. ☐ Assign to outpatient Observation services. ☐ Place in Outpatient services (i.e. SDC /diagnostic testing/ infusion).
		3. Bed type (please check one): ☒ M/S ☐ tele ☐ PCU ☐ ICU
3/30/11	0025	Dx Urosepsis/ R/O lymphoma
		Condition: stable
		Diet 1800 ADA ✓
		VS routine ✓
		O_2 @ 2L NC
		Rocephin 1gm IV q24h
		NS @ 100cc/hr
		PO Tylenol 650mg q6h PRN
		Pulmonary Consult: Cavitary Hilar lymph Nodes in LUL
		Hem/Oncology Consult: Robinson Central Outreach ; R/O lymphoma
		SCD's DVT Prophylaxis ✓
		Zofran 4mg IV q6h PRN
		Nexium 40mg PO Daily
		SQ S moderate Regular Insulin ✓
		AC HS Accu ✓
		Tolls DR. Agzew /A. Brownley RN
		3/30/11 noon

FAXED

Physician's Orders

WINKLER, LOUIS
[redacted] 87 M
03/25/11 2241
ER
MRN: H300747583
BRAYDON REGIONAL HOSPITAL
BRANDON, FL

3/30/11

"POS" BRH01072 rev 09/09

Page 1 of 1

M 001441

DO NOT USE ABBREVIATIONS: QD, QOD, U, IU, MS, $MgSO_4$, MSO_4

~~Never a zero after a decimal point (X.mg)~~ Always a zero before a decimal point (0.Xmg)

All medications are hereby given to dispense the patient equivalent unless otherwise indicated by the physician

Date	Time	Each Entry Requires Physician's Signature, Date and Time
		1. Admitting Physician: _____
		2. Level of Care (please check one): ☐ Admit to necessary certified hospital inpatient services. ☐ Assign to outpatient Observation services. ☐ Place in Outpatient services (i.e. SDC /diagnostic testing/ infusion).
		3. Bed type (please check one): ☐ M/S ☐ Tele ☐ PCU ☐ ICU
	2307	Old Records from Lee Surg Physical

Physician's Orders

WINKLER, LOUIS
[redacted] 81 M
03/29/11 2241
ER
MRN# H00047563
BRANDON REGIONAL HOSPITAL
BRANDON, FL

"POS" BRH01072 rev 09/09

Page 1 of 1

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Date	Time	Each Entry Requires Physician's Signature, Date and Time
		1. Admitting Physician: _____
		2. Level of Care (please check one): ☐ Admit to necessary certified hospital inpatient services. ☐ Assign to outpatient Observation services. ☐ Place in Outpatient services (i.e. SDC /diagnostic testing/ infusion)
		3. Bed type (please check one): ☐ M/S ☐ Tele ☐ PCU ☐ ICU
4/3/11	0400	(1) Give 250 mL NS bolus now
		(2) Repeat 250 mL NS bolus if SBP remains < 80
		(3) If after NS bolus x2 SBP remains < 80, start Levophed gtt
		(4) If HR remains sustained > 130, Consult BAC. ☐
		TOAMV. IDR Azzeu / Levo IV (Transfer Orders)
		SCAmed Over VS
4/3/11	0452	Please Make pt CMO per family/power of attorney's wishes.
		D/c labs, Cxrays/tests
		D/c Meds, continue Morphine
		D/c Ancef/abx
		SCAmed
		TOAMV IDR Azzeu / Levo

Physician's Orders

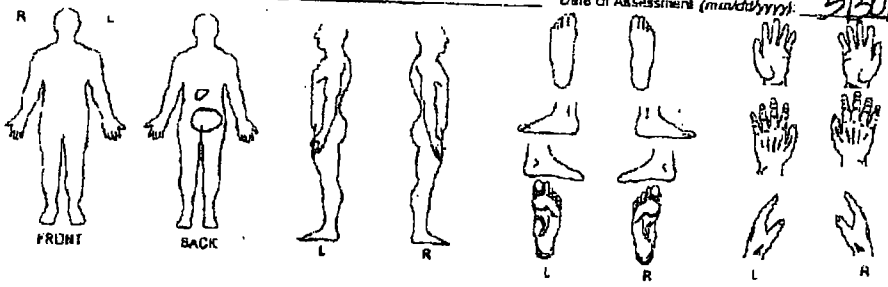
4/3/11 0730 12 Chris Azzeu

WINKLER, LOUIS ZIP:33594
[redacted] NOH LN H A639-1
03/30/[redacted] 0000 Azzeu, Yeshitila MD
[redacted] 61 M MRN H000747583
BRANDON REGIONAL HOS BRANDON, FL

"POE" BRHD1072 rev 09/09

WOUND/SKIN ANATOMICAL LOCATION

Site: _____ Date of Assessment (mm/dd/yyyy): 3/30/11



Nursing Notes- Wound/Skin Description (size, drainage amount, color, wound bed and periwound skin):
BILE - discoloration
Coccyx - pressure ulcer
Laceration to lumbar spine
Ulceration to tip of tongue

Check all that apply
- [x] Patient has been undressed completely and had a complete skin assessment
- [ ] No pressure ulcer noted
- [x] Patient has skin integrity issue (described above - not pressure ulcer)
- [ ] Wound care consult entered in Meditech (if needed)
- [ ] Pictures taken and placed on chart
- [ ] Patient refused consent for pictures

Nurse Signature X _____ Date/Time 3/30/11 0720

(PLACE IN PHYSICIAN PROGRESS NOTES – SEE PHYSICIANS ORDERS FOR WOUND ORDERS AND/OR TREATMENT)

PHYSICIAN PROGRESS NOTE:

NOTES: _____

Physician Signature X _____ Date/Time _____

I have reviewed the above nursing assessment and have addressed any skin integrity findings requiring treatment orders

WINKLER, LOUIS
[redacted] 03/29/11 0000
Bennett, Roderick MD ER
BRANDON REGIONAL HOSPITAL MRN# H00074583 BRANDON, FL

Admission Wound / Skin Assessment Tool

"WC" BRH02671 rev'02/11

Patient:WINKLER, LOUIS MRN:[redacted] Encounter:H00718392715 Page 1 of 1

POOR ORIGINAL

Patient Initials:

JW I understand that my (the patient's) physician has ordered a Peripherally Inserted Central Catheter (PICC Line) or Midline to be placed in a vein in my (the patient's) arm in order to have venous access for my (the patient's) medical care. I understand that the catheter tip will be placed in my arm and the tip will come to rest near my heart if it is a PICC line and the catheter tip will come to rest in my upper arm if it is a Midline.

JW I understand that a PICC Line / Midline is a thin flexible tube that is inserted in a vein. I understand that the indications for the placement of a PICC Line / Midline are long term IV therapies.

JW I understand that there are several benefits to having a PICC Line / Midline. Some of the benefits include the long term administration of direct fluids and medications, pain medications and antibiotics, hyperalimentation, blood transfusions and chemotherapy drugs. A PICC Line / Midline also can be accessed for taking blood samples. PICC Lines / Midlines also can be left in an arm for several weeks.

JW I also fully understand that there are known risks or complications associated with all invasive procedures such as a PICC Line / Midline. Some of the risks include infection; bleeding and bruising; incorrect placement of the catheter tip; breakage of catheter; catheter blockage/leakage; accidental puncture of an artery; collapsed lung; irritation or injury to an adjacent vessel or nerve; irregular heart beat; blood clots; air embolus and death. It is impossible to list all the risks of any invasive procedure.

JW I understand that the medically acceptable alternatives to a PICC Line / Midline would be a central line that would be placed in my neck or having individual needle sticks, if feasible.

JW I fully understand that the ordering physician will not be the person inserting the PICC Line / Midline.

JW I fully understand that a professionally trained and certified non-physician health care provider will be inserting the peripherally inserted catheter in my arm.

JW I have had the opportunity to discuss the PICC Line / Midline with my physician. All of my questions have been answered to my satisfaction.

JW My physician has explained this procedure, the benefits, substantial risks and alternatives listed above. I have read this form or I have had this form read to me and I understand its contents.

I HEREBY VOLUNTARILY CONSENT to the placement of a Peripherally Inserted Central Catheter (PICC Line or Midline).

Jeff Winkler (POA)
Patient or Patient Representative's Signature

Date&Time: 4/1/11 2:10pm

Witness Signature

Date&Time:

Consent for Peripherally Inserted Central Catheter (PICC Line) or Midline

WINKLER, LOUIS
[redacted] M
MRN: [redacted]
BRANDON REGIONAL HOSPITAL BRANDON, FL

"TREAT" MNEMONIC rev 09/10

Page 1 of 1

Jeff Winkler

POOR ORIGINAL

Your physician has ordered blood and/or blood components. Blood components may include, but are not limited to: packed cells, washed packed cells, whole blood, white cells, platelets and fresh frozen plasma. Blood and/or blood components used for transfusion purposes have been tested by an outside laboratory, which has declared that the blood and/or blood components are negative for certain infectious diseases. Blood testing is not one-hundred percent (100%) effective.

Prior to administration, blood is tested for serological compatibility with your blood, however, occasions may arise where it may not be possible to complete the pre-transfusion tests and in an emergency, it may require the use of existing stocks of blood which may not include the most compatible types.

The administration of blood and/or blood components is not always successful in producing desired results and there are possible risks. These risks include, but are not limited to, acquiring HIV or AIDS, hepatitis, West Nile Virus, malaria, other viral and bacterial infections, fever, allergic reactions, anemia, lung dysfunction, hypothermia, myocardial infarction, renal failure, graft versus host disease (GVHD), anaphylactic reactions, shock, hypotension and circulatory overload. It is impossible to list all of the inherent risks and potential hazards that could potentially occur.

I acknowledge that no guarantees are made about the quality of the blood.

I acknowledge that I have been given an explanation of the available alternative forms of treatment, which may include, but not be limited to, directed donation and autologous donation. I acknowledge that alternative forms of treatment and risk have been explained to me.

I am advised that I have the option of refusing the administration of blood and/or blood components.

I acknowledge that: 1) I have read and understand the information on this form; 2) that I am aware of alternative treatments and associated risks; 3) that I have had the opportunity to ask questions; 4) that I have received all of the information that I desire in order to make an informed decision, and 5) that I authorize and consent to the transfusion of blood and/or blood products. All my questions have been answered to my satisfaction.

Verbal consent from son Jeff Winkler

Patient or Legal Representative — Date 4/1/11 0905

Witness — Date

PHYSICIAN'S DECLARATION

___ I hereby certify that I have explained fully the risks, benefits, side effects related to the proposed procedure listed above & alternatives, such as not having proposed procedure, the likelihood of achieving goals as result of procedure, any potential problems that may occur during recuperation, and have answered fully all of the questions posed by the patient or the patient's representative. I understand that there may be neurological impairment related to positioning for procedures performed in the [illegible]

___ Emergency medical condition is present. Consent is implied.

Physician Signature — Date — Time

Consent for Administration of Blood and/or Blood Components

WINKLER, LOUIS [redacted] M 8018-1 33594 03/30/11 0245 81 M GW Assoc. Yes/No/n/a ND MRN# H000747583 BRANDON REGIONAL HOSPITAL BRANDON, FL

"TREAT" MNEMONIC rev'09/09

I, the undersigned, consent to the following operation(s) and/or procedure(s): Left Supraclavicle Lymph node BOPSy - Percutaneous Possible open

To be performed by Dr. Park and his/her associates and assistants with knowledge that the attending physician will have primary responsibility for my care specific to the stated procedure. Dr. _____ has explained to me the nature, purpose and possible consequences of each operation(s) and/or procedure(s) as well as the substantial risks and possible complications involved the benefits and the possible alternative methods of treatment. I understand that it is impossible to list all the risks of any invasive procedure

The Inherent Risks of General Surgery Include But Are Not Limited To:

Patient Initials:

_____Bleeding that may require further surgery or blood translusions; worsening of pre-operative conditions and/or failure of procedure to be successful requiring further surgeries; infection; wound separation; adhesions; missing diagnosis of cancer or incomplete removal; excessive or unusual scarring; blood clots; myocardial infarction; cardiac arrhythmias; perforation and/or injury to adjacent blood vessels, nerves or organs; inability to complete procedure due to complications or equipment failure; protracted recovery from the use of local or general anesthesia; death; inadvertent puncture, laceration or tearing of other organs requiring additional surgery to repair. It is impossible to list all the risks of any invasive procedure.

_____If my doctor discovers a different, unexpected or unforeseen medical condition during my surgery, I consent and authorize him/her to performs additional or different procedures as deemed medically necessary and advisable in his/her professional opinion. This includes remedying conditions that are not known at the time of the procedure. If such a situation occurs, I request and authorize my doctor to perform the remedying procedure. I do not want to be woken up from anesthesia to discuss the unforeseen findings.

In addition to the above listed risks, there are risks associated with different procedures. The below procedures list additional risks and complications for your consideration. As stated above, it is impossible to list every potential known complication or risk.

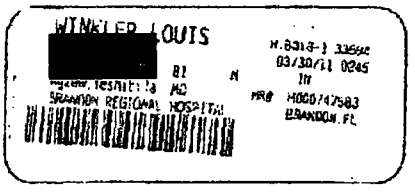
General/Endoscopic Surgery: Injury to colon and small bowel such as perforation or punctures, and cuts to organs and tissues including but not limited to the esophagus, chest, trachea, ureter; kidneys; gallbladder; common bile duct; liver; stomach; uterus; fallopian tubes; ovaries; vascular structures; anastamotic leaks; incisional hernia; impotence; lymphadema; bladder; urinary retention; aspiration, electrocautery burns, infection and in rare cases even death.

Urology: As listed in general surgery consent, and deterioration of testes; impotency; urinary extravasation; stricture formation; incontinence of urine, urinary retention; chronic pain; retrograde ejaculation; recurrence of stones; recurrence of cancer; hemiation or erosion; inability to insert device; leakage of urine; need for urinary catheter.

Gynecology: As listed in general surgery as well as injuries to the vagina, vulva, bladder; perforation of the uterus; infertility; premature delivery; scarring of the uterus and cervix; abnormal fluid or air collections in chest and abdomen; pre-nature menopause; urinary leakage; inability to urinate; nerve damage causing weakness, pain and numbness in the legs and thighs.

Head & Neck: Injury to nerves and vessels; cerebral spinal fluid leak; vision problems or blindness; worsening or loss of hearing; change in voice or loss of voice.

Informed Consent for Operative or Invasive Procedure(s)



TREAT MNEMONIC rev'08/09

Orthopedics: In addition to the general surgery risks, specific risks include failure of fractures to heal, damage to arteries, nerves and tendons; stiffness and swelling of the arm(s)/leg(s); nerve damage resulting in nerve injury; tendon rupture; pain; weakness, numbness, tingling, reflex sympathetic dystrophy, fractures or breaks of the bones of the arm(s)/leg(s); changes in the length of the arm(s)/leg(s); poorly healing wounds; need for future surgery and blood transfusions, prolonged illness and permanent deformity; injury to intra-abdominal organs; alteration of ambulation; stiffness; immobilization; recurrence of deformity; prolonged swelling; numbness; mechanical failure of an artificial joint and possible need for revision; infections; blood clots in the arms, legs, or lungs; strokes; heart attacks; allergic reactions; personality changes and mental difficulties; and rarely even death.

Neurosurgery: Numbness; reflex sympathetic dystrophy; dislodgement of catheters from the spinal fluid either from the ventricular or from the lumbar subarachnoid space from the abdomen; blockage of the shunt at both places, cerebral spinal fluid leak; premature rupture of aneurysm with massive stroke or uncontrollable bleeding when surgery cannot be completed; coma; weakness; seizures; nerve injury; no improvement of pain; recurrence of disc in about 5% of cases; paralysis; kyphotic spine or subluxation of the spine when one bone moves over the other bone; air embolism; movement of cages; extrusion of the disc space after ambulation; non-union; pseudoarthritis; injury to the esophagus, laryngeal nerve, vertebral artery; graft extrusion with plate placement with screws; misalignment of screw position.

Vascular Surgery: As listed in general surgery consent as well as injuries such as renal failure requiring dialysis; colon ischemia resulting in colon resection; graft failure; pulmonary failure requiring prolonged intubation or tracheotomy; recurrent stenosis; carotid thrombosis; stroke; thrombosis formation; pulmonary embolism; malplacement or migration of stent or filter; spinal cord ischemia; ventral hernia formation; steal syndrome, hematoma.

Thoracic Surgery: As listed in the general and vascular surgery consent as well as injuries such as lung collapse, puncture of esophagus or trachea, injury of the larynx; leadreleclrode heart perforation or scarring; damage to blood vessels near the heart.

Plastic Surgery: Formation of undesirable scar tissue; persistent pain, redness, or swelling near area of surgery; fat embolism; skin graft or tissue flap loss; decrease or loss of sensation in the area of procedure; loss of nipple; loss of nipple sensation; infection or deflation of breast implant or expanders; asymmetry; inability to correct facial fractures; incomplete correction of ptosis.

Other:_____

Patient Initials

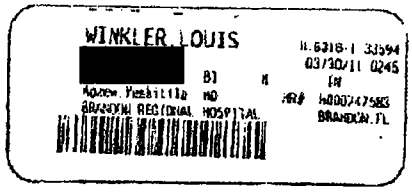
_____ My doctor has provided me with the opportunity to ask questions about the proposed procedure. All of my questions have been answered to my satisfaction.

_____ I fully understand that there are inherent and substantial risks and complications associated with all surgical and invasive procedures. I fully understand that cuts, punctures, perforations or burns to surrounding internal organs, tissues, blood vessels, and nerves are known surgical complications that may require me to undergo additional surgical or invasive procedures, returns to surgery or treatments to repair any injury or damage resulting from these types of complications. It is impossible to list every potential known complication or risk.

_____ I consent to the administration of blood or blood products as deemed necessary by my doctor(s). I understand that there are risks inherent in every blood transfusion, and these risks, benefits and alternatives have been explained to me.

_____ I consent to the use of anesthetics and/or sedation as may be considered for my pain and anxiety.

Informed Consent for Operative or Invasive Procedure(s)



_____ I understand that the hospital may dispose of any tissues or parts surgically removed during my procedure.

_____ I consent to the use of medical photography during my procedure; the release of my social security number for the purpose of tracking any implantable device; to the presence of technical representatives or qualified observers during my procedure as deemed appropriate between my doctor and the hospital.

_____ I understand that in the event of unforeseen mechanical/equipment failure the procedure will be cancelled or terminated for health and safety reasons.

_____ The content of this consent form has been explained to me. I have read it or have had it read to me and I understand its contents.

_____ My initials indicate whether manufacturer's representative, observers, students, or health care professionals to meet continuing education requirements, may be present during my procedure, in accordance with my physician's approval and hospital policy.

I voluntarily consent and authorize my doctor and his/her associates to perform this surgery or procedure. I have been advised that _____ will be assisting my doctor. I further authorize my doctor to arrange additional services such as anesthesia, pathology and imaging as deemed necessary for my care. I also authorize my doctor to administer any anesthetics or contrast materials deemed medically necessary.

Patient Signature	Date	Time
Jeff Winkler / Son / POA phone consent Signature of: Parent/Guardian/Proxy/ Surrogate	3/30/11 Date	12 noon Time
Loretta RN / Dr. Park Witness Signature	3/30/11 Date	12 noon Time

Physician's Declaration:

I hereby certify that I have explained fully the risks, benefits, side effects related to the proposed procedure listed above & alternatives, such as not having proposed procedure, the likelihood of achieving goals as result of procedure, any potential problems that may occur during recuperation, and have answered fully all of the questions posed by the patient or the patient's representative.

Signature of Physician	3/30/11 Date	Time

Informed Consent for Operative or Invasive Procedure(s)

WINKLER, LOUIS [redacted] M 8318-1 32534 03/30/11 0245 IR MRN# H000747563 BRANDON, FL

"TREAT" MNEMONIC rev'04/09

1) Modern anesthesia is relatively safe and uneventful so that virtually everyone can be offered its benefits. Most operations / procedures can be performed utilizing general anesthesia, regional anesthesia (such as epidural, saddle block, spinal, bier block), sedation/analgesia or a combination of these methods of anesthesia. Your anesthesia provider will decide the type of anesthetic drug(s) and techniques and the choice and the medically acceptable alternatives will be discussed with you. In the case of sedation / analgesia given for a procedure, the physician responsible for the procedure will decide the drugs. Every type of anesthesia and sedation/analgesia has certain types of risks and hazards that are known by your anesthesia provider/physician. Unexpected reactions and complications may occur, however, and vary between patients where medical conditions appear otherwise similar.

2) ANESTHESIA – Risks and hazards which are recognized by anesthesiologist as substantial and which can occur regardless of experience, care and skill of the anesthesia provider include, but are not limited to: broken teeth, allergic reactions, sore throat, awareness under anesthesia, hoarseness, pneumonia, phlebitis (inflammation and infection of the veins), nerve injury or paralysis, damage to or failure of the heart, liver, kidneys and/or brain, and death. In most cases these risks and hazards are rare. Your anesthesia provider will do his/her best to protect you from such risk and hazards, but no guarantees as to the outcome of anesthesia can be made.

3) SEDATION/ANALGESIA FOR PROCEDURES – It is common for a patient to experience one or more of the following short term side effects from sedation/analgesia: nausea, vomiting, slurred speech, amnesia, itching, agitation and confusion. With any sedation/analgesia procedure there is always the possibility of unexpected side effects or complications such as allergic reaction, increase or decrease in blood pressure or decrease in heart rate, decreased respirations, respiratory arrest, and cardiac arrest.

4) Due to a nature of the particular surgery, blood transfusions may be required. Some hazards of the infusion include, but not limited to: diseases transmitted through blood products, such as hepatitis, AIDS, and allergic reactions.

5) I understand that the anesthesia provider who administers the anesthetic or sedation will choose the type of anesthesia/sedations/analgesia, and it may be changed if necessary, except as specified by patient.

Exception: ☐ None ☐ Spinal ☐ Epidural ☐ Other_____

I (we) have read the above statements _____ Date _____ Time _____

I (we) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia or sedation/analgesia and treatment, risk of non-treatment, the procedures to be used, and the risk and hazards involved, and I (we) have sufficient information to given this informed consent. I request that I be given anesthesia or sedation/analgesia for my operation/procedure.

Patient's Signature _____ Date _____ Time _____

Person giving consent if other than Patient Jeff Winkler/Son/POA Relationship _____

Signature of Witness Pharm Consent Beverly RN / Dr. Park Date 3/30/11 Time 12 noon

I have explained and discussed the risks and benefits of anesthesia &/or sedation/analgesia and alternative forms of treatments with the patient.

Physician's Signature _____ Date _____ Time _____

Consent for Anesthesia and Sedation / Analgesia

WINKLER, LOUIS [redacted] 81 M LN
Acct: 169004583 BRANDON REGIONAL HOSPITAL
R 6318-1 13594 03/30/11 0245
MR# 169004583 BRANDON, FL

'TREAT' BRH00077 – Revision Date: 09/09

Page 1 of 1

M 001450

BRANDON REGIONAL HOSPITAL
119 OAKFIELD DRIVE
BRANDON, FLORIDA 33511

********** OPERATIVE REPORT

Patient Name: WINKLER,LOUIS
Account #: [redacted]
Admit Date: 03/30/11
Attending Physician: Agzew,Yeshitila MD

DOB: [redacted]
MRN:
AGE: 81

DATE OF PROCEDURE: 03/30/2011

SURGEON: In Soon Park, MD

PREOPERATIVE DIAGNOSES: Enlarged left supraclavicular lymph node, rule out lymphoma.

POSTOPERATIVE DIAGNOSES: Enlarged left supraclavicular lymph node, rule out lymphoma.

PROCEDURE PERFORMED: Percutaneous core needle left supraclavicular lymph node biopsy.

METHOD OF ANESTHESIA: Lidocaine 1% and epi.

COMPLICATIONS: None.

DESCRIPTION OF PROCEDURE: The patient was sitting semi upright in his bed. The left neck and chest wall were then prepped and draped in usual sterile surgical fashion. A small skin incision was made with an 11-blade. Through this opening, several passes with the 16-gauge needle were performed through the obvious enlarged lymph node in the supraclavicular region. Several specimens of the lymph node were obtained. Pressure was held directly over the puncture site. Once good hemostasis was achieved, the skin was closed with Dermabond. The specimen was placed in sterile cup with gauze soaked in saline and sent directly to pathology for frozen section. The patient tolerated the procedure well.

In Soon Park, MD
ISP/MedQ

DD: 03/30/2011 13:56
DT: 03/30/2011 21:23
Job #: 493856/459964479
Revision #:
Authenticated by In Soon Park, MD On 04/06/2011 08:31:00 AM

PATIENT NAME: WINKLER,LOUIS ACCOUNT #: [redacted]

Electronically Signed by In Soon Park, MD on 04/06/11 at 0833

PATIENT NAME: WINKLER,LOUIS ACCOUNT #: [redacted]

Consulting MD: D. Fanck
Date of Consult: 4/1/11
Room Number:
Reason for Consulting:

- ☑ PICC Line
- ☐ PICC Declot
- ☐ MidLine
- ☐ MidLine Declot
- ☐ PICC Repair
- ☐ Site Check
- ☐ MidLine Repair
- ☐ Other:
- ☐ PICC Exchange

Reason for Insertion:

- ☑ Venous Access
- ☑ Long Term IV ABT
- ☐ Vasoactive Drips
- ☐ Home IV ABT
- ☑ Other:
- ☐ Hydration
- ☐ TPN
- ☐ PPN
- ☐ Chemo Tx

Discharge Date:

Pre Insertion Work Up:			
Allergies?	☑ Yes ☐ No	Hx Chest Lines?	☐ Yes ☑ No
Consent Signed?	☑ Yes ☐ No	Temperature > 100?	☐ Yes ☑ No
Pos. / Pending Bld Cx	☑ Yes ☐ No	ID Consultation?	☐ Yes ☐ No

NKA
Dr Klauke

Post Insertion

Line Insertion

- ☑ PICC Line ☐ MidLine # Attempts: 1
- ☑ Right Arm ☐ Left Arm
- ☐ Cephalic ☐ Basilic
- Line Threaded 40 cm pulled back to 42 cm
- Line Exposed 1 cm 50 cm
- Upper Arm Circumference 29 cm Repeat q week

Blood Return	☑ Positive	☐ Negative	
Guidewire D/C	☑ Yes	☐ No	
PCXR Ordered	☑ Yes	☐ No	☐ N/A
Ultrasound	☑ Yes	☐ No	

PICC Insertion referred to:

- ☐ Interventional Radiology
- ☐ Other Access Recommended

Reason:

Declot

Line Declot

- ☐ PICC ☐ MidLine ☐ Other
- ☐ Right ☐ Left
- Drug:
- Total Dwell Time:
- ☐ Cleared ☐ Not Cleared
- Dressing Change? ☐ Yes ☐ No

PICC Exchange / Repair

- ☐ Exchange ☐ Repair ☐ Other
- ☐ PICC ☐ MidLine
- ☐ Right ☐ Left

Reason:

Site Check – See Comments

Comments:

1500 - 1525

Lot #

L Sanderson 4/1/11 1515

RN Signature Date / Time

Discharge Information given? ☐ Yes ☐ No

REF 32751080
LOT REUL0267

Patient Identification / Label
WINKLER LOUIS
[redacted] 81 M IN
Age: Yesterday HD HOSP HOO074583
BRANDON REGIONAL HOSPITAL BRANDON, FL

OPS BRH00234 IV Consultation Rev. 01/10

☐ **Emergency Procedures (Life Threatening) – Boarding Pass NOT Required**

All signatures must be in place before surgical/invasive procedures begin.

CHECK ONE	INITIALS		Comments
☐ NO ☐ YES		Beta Blocker addressed	
☐ NO ☐ YES		Patient identified (ask the patient to state their name and date of birth; compare the two identifiers to the chart)	
☐ NO ☑ YES		Informed consent verified and signature witnessed (physician and patient)	
☐ NO ☑ YES		Surgical / invasive procedure in Physician Orders	
☐ NO ☑ YES		Patient's statement of correct procedure site(s) & side(s).	
☐ NO ☐ YES		Surgical schedule / invasive, if applicable	
☐ NO ☐ YES		History & Physical / Impression and Plan (Must be < 30 days and updated on day of procedure)	
☐ NO ☐ YES		Surgeon's/Proceduralist's credentials for proposed procedure (Must be checked by O.R. / Procedural Nurse)	

Signature: _____ 4/1/11 1500
RN/LPN, Technologist Date/Time

Signature: LSanderson 04/01/11 1500
RN, RN 1ST Assistant, Physician Date/Time

Site Marked: Required as per policy.

☐ Patient Refused Site Marking

Physician's Signature & Date/Time

Time-Out occurred prior to the incision and included the following:

- IV Preop Antibiotic given?
- Correct patient identity?
- Identifiers match consent?
- Any antibiotics / fluids for irrigation?
- Verbal agreement on procedure?
- Any implants / special equipment?
- Correct side / site marked?
- Any safety precautions for history / med use?
- Correct position for procedure?
- Images labeled / displayed?
- Diagnostic results available?

The above requirements have been verified to be correct. Time Out was observed by the following team members:

_____ 4/1/11 1500
Surgical/Invasive Procedure RN/LPN/Tech

_____
Physician/Surgeon

_____
Anesthesia Provider (if applicable)

PICC
Name of Procedure

4/01/11 1500 LSanderson
Date & Time RN Signature

Boarding Pass & Time Out Verification Procedure Record
for Surgical & Other Invasive Procedures

Patient Identification / Label

WINKLER, LOUIS [redacted]
H 8318-1 33594
03/30/11 0245
AGZ84, Yeshitla MD 81 M IN
BRANDON REGIONAL HOSPITAL H000747583 BRANDON, FL

"ORS" BRH00039 – Revision Date: 07/10

PRINT DATE: 04/04/11
PRINT TIME: 0306

Brandon Regional Hospital
Clinical Laboratory
119 Oakfield Drive
Brandon, FL 33511
(813) 571-5190

HPF Pathology Specimen Report

PATIENT: WINKLER,LOUIS
ACCT #: [redacted] LOC: H.SSIC U #: [redacted]
AGE/SX: 61/M ROOM: H.AS39 REG: 03/30/11
REQ DR: Agzew,Yeshitila MD STATUS: DIS INx BED: 1 DIS: 04/03/11

Specimen: BR:HS11-2455 Received: 03/30/11-1336 Status: SCUT Req#: 07704443
Spec Type: SURGICAL Subm Dr: Park,In Soon MD

TISSUES:
LYMPH NODE, NOS - (FLOW)-SUPRACLAVICULAR LYMPH NODE BX

PREOPERATIVE DIAGNOSIS:
R/O LYMPHOMA

POSTOPERATIVE DIAGNOSIS:
R/O LYMPHOMA

GROSS DESCRIPTION:
Received fresh labeled with the patient's hospital ID and "left supraclavicular lymph node biopsy" are multiple tan-pink irregular fragments of soft tissue aggregating 0.5 x 0.5 x 0.1cm. Touch preparations are performed. Representative portions of the specimen are placed in transport media and sent to Clarient for flow cytometry. The remaining tissue is submitted in one cassette.

Dictated by: Richmond,Shawn
Entered: 03/30/11 - 1529 HLBKLY

PRELIMINARY SMEAR IMPRESSION:
(TP) "Suspicious for lymphoma." (KBP)

Dictated by: Richmond,Shawn
Entered: 03/30/11 - 1529 HLBKLY

MICROSCOPIC DIAGNOSIS:
Necrotic large B-cell lymphoma (see comment), left supraclavicular lymph node biopsy.

88305, 88342 x 4, 88333

Dictated by: Pautler,Keith
Entered: 04/01/11 - 1223 HLBAKL

Patient: WINKLER,LOUIS Age/Sex: 61/M Acct#[redacted] Unit#[redacted]

Patient:WINKLER, LOUIS MRN:[redacted] Encounter:H00718392715 Page 1 of 2

PRINT DATE: 04/04/11
PRINT TIME: 0306

Brandon Regional Hospital
Clinical Laboratory
119 Oakfield Drive
Brandon, FL 33511
(813) 571-5190

HPF Pathology Specimen Report

Patient: WINKLER,LOUIS #[redacted] (Continued)

COMMENT:

Immunoperoxidase stains for CD20 and BCL2 are positive within neoplastic lymphocytes and the stains for CD3 and CD43 are negative. The morphologic findings and immunophenotypic findings are diagnostic of a large cell lymphoma with B-cell immunotype.

Flow Cytometry performed at Clarient Laboratories is interpreted as having mainly debris and is not optimal for detection of the lymphoma due to extensive necrosis.

COPIES TO:

Agzew,Yeshitila MD
PO Box 48165
Tampa, FL 33646-0119
(813)931-2955

Park,In Soon MD
519 Medical Oaks Avenue
Brandon, FL 33511
(813)685-7995

Ruffolo,Robert F DO
5751 Hoover Blvd
Tampa, FL 33634-5340
(813)886-8334

Signed _____(signature on file)_____ Pautler,Keith 04/01/11 1600

74-7583 43

Brandon Regional Hospital
119 Oakfield Drive
Brandon, Florida 33511
Phone 813.571.5193
Fax 813.571.5169

5 of 12

Flow Cytometry

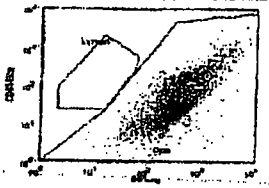
Patient Name	Winkler,Louis	Facility Name	Brandon Regional Hospital-HCA Facility
DOB	[redacted]	Facility ID	100681-B
Gender	Male	Ordering Physician	Parkin Soon
Medical Record #		Treating Physician	
Master Accession:	[redacted]	Date/Time Collected	3/30/2011 12:21 PM
Case No	FI11-009583	Date/Time Received	3/31/2011 12:21 AM

Lymph Node Supraclavicular (HS11-2455)

Interpretation: MAINLY DEBRIS, NOT OPTIMAL FOR DETECTION OF LYMPHOMA (SEE COMMENT).

COMMENTS

This specimen has low cell yield with large quantities of debris, which is not optimal for detection of lymphoma. Cells of certain non-Hodgkin lymphomas such as large cell lymphoma may not survive processing or transit. Correlation with histologic findings is necessary for definitive assessment.



VIABILITY

2

FLOW DIFFERENTIAL

Lymphs (%) 0 Myeloid (%) 0 Monos (%) 0 Debris (%) 100

POPULATION ANALYSIS

Lymphoid Cells:

0% lymphoid events were detected. Evaluation of these cells is not reliable due to the low number of events and high proportion of debris.

Debris:

Only nonspecific immunoreactivity is noted.

ANTIBODIES USED

CD10, CD11c, CD14, CD16, CD19, CD2, CD20, CD22, CD23, CD3, CD38, CD4, CD45, CD5, CD56, CD7, CD8, FMC7, Kappa, Lambda. 20 Antibodies

Electronically Signed by Julie Vitko M.D. on 03/31/2011

Julie Vitko M.D.

These tests were developed and the performance characteristics determined by Clarient Diagnostic Services. They have not been cleared or approved by the US Food and Drug Administration (FDA). The FDA has determined that such clearance or approval is not necessary. These tests are used for clinical purposes. Prognostic and predictive testing should be interpreted in the context of additional clinical and/or histopathologic findings.

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MR# 7415583 [redacted]

FI11-009583, Winkler, Louis

Patient:WINKLER, LOUIS MRN [redacted] Encounter:H00716392715 Page 1 of 1

M 001457

PRINT DATE: 04/06/11
PRINT TIME: 0307

Brandon Regional Hospital
Clinical Laboratory
119 Oakfield Drive
Brandon, FL 33511
(813) 571-5190

HPF LAB Discharge Summary Report w/o Pathology

PATIENT: WINKLER,LOUIS
ACCT #: [redacted]
AGE/SX: 81/M
STATUS: DIS INx
LOC: H.SSIC
ROOM: H.A539
BED: 1
U #: H000747583
REG: 03/30/11
DIS: 04/03/11

REG DR: Agzev,Yashitila MD

********** HEMATOLOGY **********

COMPLETE BLOOD COUNT

Date / Time	04/02/11 0423		04/01/11 0720		Reference	Units
>>WBC	11.4(a)	H	11.3(b)	H	(4.0-10.5)	10^3/uL
>>RBC	3.40	L	2.51	L	(4.00-5.70)	10^6/uL
>>HGB	10.5	DL	7.7	L	(13.0-17.0)	G/DL
>>HCT	32.1	DL	25.1	L	(38.0-51.0)	%
>>MCV	94.4(c)	D	100.0	H	(80.0-98.0)	FL
>>MCH	30.9		30.7		(27.0-32.0)	PG
>>MCHC	32.7		30.7	L	(32.0-36.0)	G/DL
>>RDW	21.7	H	21.6	H	(11.5-15.1)	%
>>PLT	50	L	58	L	(136-400)	10^3/uL
>>MPV	11.0		10.1		(8.80-12.80)	FL
>>NEUT %	85.2		55.9		(42.2-76.2)	%
>>LYMPH %	28.7		27.3		(16.3-46.0)	%
>>MONO %	14.9	H	15.5	H	(2.9-10.4)	%
>>EOS %	0.7		0.7		(0.0-5.0)	%
>>BASO %	0.5		0.6		(0.0-2.0)	%
>>NEUT #	6.3		6.3		(1.3-7.1)	K/MM3
>>LYMPH #	3.3		3.1		(1.10-4.80)	K/MM3
>>MONO #	1.7	H	1.7	H	(0.2-0.9)	K/MM3
>>EOS #	0.1		0.1		(0.0-0.6)	K/MM3
>>BASO #	0.1		0.1		(0-0.3)	K/MM3

NOTES: (a) SMEAR REVIEW CONFIRMS AUTOMATED CBC FLAG OF NRBCS,ANISOCYTOSIS,THROMBOCYTOPENIA,IG
Previous reported result: 11.4 10^3/uL
Edited by: HLB2F on 04/02/11:0649
****
* Amended Report *
****

(b) IMMATURE CELLS AND NRBCS NOTED. MEGALOBLASTIC CHANGES SEEN.CLINICAL CORRELATION IS SUGGESTED PER DR.PAUTLER, PATHOLOGIST.
Previous reported result: 11.3 10^3/uL
Edited by: HLEGH01 on 04/01/11:1636

(c) POST TRANSFUSION

PRINT DATE: 04/06/11
PRINT TIME: 0307

Brandon Regional Hospital
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HPF LAB Discharge Summary report w/o Pathology

Patient: WINKLER,LOUIS #[redacted] (Continued)

**********HEMATOLOGY (continued)**********

COMPLETE BLOOD COUNT (continued)

Date Time	03/31/11 0437		03/30/11 1515		Reference	Units
>>WBC	11.7(d)	H	10.2		(4.0-10.5)	10^3/uL
>>RBC	2.64	L	2.65	L	(4.00-5.70)	10^6/uL
>>HGB	8.2	L	8.2	L	(13.0-17.0)	G/DL
>>HCT	26.9	L	26.5	L	(38.0-51.0)	%
>>MCV	101.9	H	100.0	H	(80.0-98.0)	FL
>>MCH	31.1		30.9		(27.0-32.0)	PG
>>MCHC	30.5	L	30.9	L	(32.0-36.0)	G/DL
>>RDW	21.4	H	21.0	H	(11.5-15.1)	%
>>PLT	63	L	72	L	(136-400)	10^3/uL
>>MPV	9.8		9.7		(8.80-12.80)	FL
>>NEUT %	60.5		61.9		(42.2-76.2)	%
>>LYMPH %	25.6		24.3		(16.3-46.0)	%
>>MONO %	13.0	H	13.0	H	(2.9-10.4)	%
>>EOS %	0.4		0.5		(0.0-5.0)	%
>>BASO %	0.5		0.3		(0.0-2.0)	%
>>NEUT #	7.1		6.3		(1.3-7.1)	K/MM3
>>LYMPH #	3.0		2.5		(1.10-4.80)	K/MM3
>>MONO #	1.5	H	1.3	H	(0.2-0.9)	K/MM3
>>EOS #	0.1		0.1		(0.0-0.5)	K/MM3
>>BASO #	0.1		0.0		(0-0.3)	K/MM3

Date Time	03/29/11 2300		Reference	Units
>>WBC	10.8(e)	H	(4.0-10.5)	10^3/uL
>>RBC	2.99(f)	L	(4.00-5.70)	10^6/uL
>>HGB	9.3	L	(13.0-17.0)	G/DL
>>HCT	29.9	L	(38.0-51.0)	%
>>MCV	100.0	H	(80.0-98.0)	FL

NOTES: (d) SMEAR REVIEW CONFIRMS AUTOMATED CBC FLAG OF LEFT SHIFT
Previous reported result: 11.7 10^3/uL
Edited by: HLBJLL on 03/31/11:0728

(e) SMEAR REVIEW CONFIRMS AUTOMATED CBC FLAG OF FEW IMMATURE GRANULOCYTES, ATYPICAL LYMPHOCYTES
Previous reported result: 10.8 10^3/uL
Edited by: HLBLAV on 03/30/11:0048

(f) SMEAR REVIEW CONFIRMS AUTOMATED CBC FLAG OF ANISOCYTOSIS, RARE BASOPHILIC STIPLING AND FEW STOMATOCYTES PRESENT
Previous reported result: 2.99 10^6/uL
Edited by: HLBLAV on 03/30/11:0050

Patient: WINKLER,LOUIS Age/Sex: 81/M Acct#[redacted] Unit[redacted]

PRINT DATE: 04/06/11
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BPF LAB Discharge Summary report w/o Pathology

Patient: WINKLER,LOUIS #[redacted] (Continued)

**********HEMATOLOGY (continued)**********
COMPLETE BLOOD COUNT (continued)

Date Time	03/29/11 2300		Reference	Units
>>MCH	31.1		(27.0-32.0)	PG
>>MCHC	31.1	L	(32.0-36.0)	G/DL
>>RDW	20.6	H	(11.5-15.1)	%
>>PLT	95	L	(136-400)	10^3/uL
>>MPV	10.0		(5.80-12.80)	FL
>>NEUT %	62.2		(42.2-76.2)	%
>>LYMPH %	25.5		(16.3-46.0)	%
>>MONO %	11.5	H	(2.9-10.4)	%
>>EOS %	0.4		(0.0-5.0)	%
>>BASO %	0.4		(0.0-2.0)	%
>>NEUT #	6.7		(1.3-7.1)	K/MM3
>>LYMPH #	2.7		(1.10-4.80)	K/MM3
>>MONO #	1.2	H	(0.2-0.8)	K/MM3
>>EOS #	0.0		(0.0-0.6)	K/MM3
>>BASO #	0.0		(0-0.3)	K/MM3

PRINT DATE: 04/06/11
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HBF LAB Discharge Summary report w/o Pathology

Patient: WINKLER,LOUIS #[redacted] (Continued)

**********COAGULATION **********

Date / Time	03/29/11 2300		Reference	Units
>>PROTHROMBIN TIME	12.7	H	(9.3-12.5)	SECONDS
>>INTERNATIONAL NORMAL R	1.2(g)	H	(0.9-1.1)	
>>PTT	27.7		(23-38)	SECONDS

NOTES: (g) ***SUGGESTED INR GUIDELINES FOR WARFARIN***
ANTICOAGULANT THERAPY

INR VALUE	INTERPRETATION
2.0-3.0	PATIENTS WITH VENOUS THROMBOSIS, PULMONARY EMBOLISM, ATRIAL FIBRILLATION, OR VALVULAR HEART DISEASE.
2.5-3.5	PATIENTS WITH INTRACARDIAC THROMBI OR MECHANICAL HEART VALVES.

THE MEAN NORMAL POPULATION PROTHROMBIN TIME IS 10.9 SECONDS.
THE INR SYSTEM IS STANDARDIZED ONLY FOR PATIENTS ON STABLE ORAL ANTICOAGULANT THERAPY.

Patient: WINKLER,LOUIS Age/Sex: 81/M Acct[redacted] Unit[redacted]

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HPF LAB Discharge Summary report w/o Pathology

Patient: WINKLER,LOUIS #[redacted] (Continued)

********** URINALYSIS **********

	Date / Time		Reference	Units
	03/30/11 0034			
>>UA COLOR	AMBER			
>>UA APPEARANCE	sl hazy		(CLEAR)	
>>UA GLUCOSE	NEG		(NEG)	
>>UA BILIRUBIN	NEG		(NEGATIVE)	
>>UA KETONES	1+	H	((NEGATIVE))	
>>UA SPECIFIC GRAVITY	1.020		(1.001-1.035)	
>>UA BLOOD	5+	H	(NEGATIVE)	
>>UA PH	5.0		(5.0-8.0)	
>>UA PROTEIN	2+	H	(NEG/TRACE)	
>>UA UROBILINOGEN	<0.2 mg/dl		(<0.2 mg/dl)	
>>UA NITRITE	NEGATIVE		(NEGATIVE)	
>>UA LEUKOCYTE ESTERASE	3+	H	(NEGATIVE)	
>>UA RBC	10-25	H	(0-2)	/HPF
>>UA WBC	2-5	H	(0-2)	
>>UA BACTERIA	2+(FEW)		(NONE SEEN)	/HPF
>>UA SQUAMOUS CELLS	2-5		(0-5)	/HPF
>>UA MUCUS	1+(RARE)			/LPF
>>UA AMORPHOUS	3+(MODERATE)			/HPF

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HPF LAB Discharge Summary Report w/o Pathology

Patient: WINKLER,LOUIS #[redacted] (Continued)

**********CHEMISTRY**********

ROUTINE CHEMISTRY

Date / Time	04/02/11 2147		04/02/11 1602		Reference	Units
>>GLUCOSE POC	244	H	217	H	(70-140)	mg/dL

Date / Time	04/02/11 1148		04/02/11 0420		Reference	Units
>>SODIUM			149	H	(136-145)	mmol/L
>>POTASSIUM			4.7		(3.5-5.1)	mmol/L
>>CHLORIDE			114	H	(98-107)	mmol/L
>>CARBON DIOXIDE			12	L	(21-32)	mmol/L
>>ANION GAP			23	H	(6-16)	
>>GLUCOSE			293	H	(74-106)	mg/dL
>>GLUCOSE POC	282	H			(70-140)	mg/dL
>>BLOOD UREA NITROGEN			37	H	(7-18)	mg/dL
>>CREATININE			1.4	H	(0.6-1.3)	mg/dL
>>BUN/CREAT RATIO			26	H	(6-20)	
>>GLOMERULAR FILTRATION			52(h)	L	(>90)	
>>TOTAL PROTEIN			5.3	L	(6.4-8.2)	gm/dL
>>ALBUMIN			1.5	L	(3.4-5.0)	gm/dL
>>GLOBULIN			3.8	H	(2.3-3.5)	GM/DL
>>ALBUMIN/GLOBULIN RATIO			0.4	L	(1.1-1.8)	
>>CALCIUM			8.2	L	(8.8-10.5)	mg/dL
>>BILIRUBIN TOTAL			0.8		(0-1.0)	mg/dL
>>SGOT/AST			114	H	(15-37)	Units/L
>>SGPT/ALT			13(i)		(12-78)	Units/L
>>ALKALINE PHOSPHATASE T			87		(50-136)	Units/L

NOTES: (h) Units of measure: mL/min/1.73 square meters

Estimated Glomerular Filtration Rate (eGFR) is calculated using the Modification of Diet in Renal Disease (MDRD) equation for adult serum creatinine tests.

Reference Range:
Healthy Adults >90 mL/min/1.73 m2

Chronic Kidney Disease:

Stage II	Mild Decrease in GFR	60-90 mL/min/1.73m2
Stage III	Moderate Decrease in GFR	30-59 mL/min/1.73m2
Stage IV	Severe Decrease in GFR	15-29 mL/min/1.73m2
Stage V	Kidney Failure	<15 ml/min/1.73m2

(i) NEW REFERENCE RANGE EFFECTIVE 10/1/10

Patient: WINKLER,LOUIS Age/Sex: 81/M Acct[redacted] Unit#[redacted]

PRINT DATE: 04/06/11
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HDF LAB Discharge Summary report w/o Pathology

Patient: WINKLER,LOUIS [redacted] (Continued)

**********CHEMISTRY**********

ROUTINE CHEMISTRY (continued)

Date			04/01/11			
Time	2225		1647		Reference	Units
>>GLUCOSE POC	233	H	153	H	(70-140)	mg/dL

Date			04/01/11			
Time	1118		0720		Reference	Units
>>SODIUM			148	H	(136-145)	mmol/L
>>POTASSIUM			4.4		(3.5-5.1)	mmol/L
>>CHLORIDE			116	H	(98-107)	mmol/L
>>CARBON DIOXIDE			15	L	(21-32)	mmol/L
>>GLUCOSE			119	H	(74-106)	mg/dL
>>GLUCOSE POC	137				(70-140)	mg/dL
>>BLOOD UREA NITROGEN			31	H	(7-18)	mg/dL
>>CREATININE			1.4	H	(0.6-1.3)	mg/dL
>>BUN/CREAT RATIO			22	H	(6-20)	
>>GLOMERULAR FILTRATION			52(j)	L	(>90)	
>>ALBUMIN			1.8	L	(3.4-5.0)	gm/dL
>>CALCIUM			8.7	L	(8.8-10.5)	mg/dL
>>PHOSPHORUS			2.6		(2.5-4.9)	mg/dL

Date	04/01/11		03/31/11			
Time	0529		2134		Reference	Units
>>GLUCOSE POC	141	H	175	H	(70-140)	mg/dL

NOTES: (j) Units of measure: mL/min/1.73 square meters

Estimated Glomerular Filtration Rate (eGFR) is calculated using the Modification of Diet in Renal Disease (MDRD) equation for adult serum creatinine tests.

Reference Range:
Healthy Adults >90 mL/min/1.73 m2

Chronic Kidney Disease:

Stage II	Mild Decrease in GFR	60-90 mL/min/1.73m2
Stage III	Moderate Decrease in GFR	30-59 mL/min/1.73m2
Stage IV	Severe Decrease in GFR	15-29 mL/min/1.73m2
Stage V	Kidney Failure	<15 ml/min/1.73m2

Patient: WINKLER,LOUIS Age/Sex: 81/M Acct#[redacted] Unit#[redacted]

PRINT DATE: 04/06/11
PRINT TIME: 0307

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HPF LAB Discharge Summary Report w/o Pathology

Patient: WINKLER,LOUIS #[redacted] (Continued)

**********CHEMISTRY**********

ROUTINE CHEMISTRY (continued)

Date / Time	03/31/11 1602		03/31/11 1300		Reference	Units
>>GLUCOSE POC	186	H	199	H	(70-140)	mg/dL

Date / Time	03/31/11 0527		03/31/11 0437		Reference	Units
>>SODIUM			149	H	(136-145)	mmol/L
>>POTASSIUM			4.7		(3.5-5.1)	mmol/L
>>CHLORIDE			117	H	(98-107)	mmol/L
>>CARBON DIOXIDE			15	L	(21-32)	mmol/L
>>GLUCOSE			155	H	(74-106)	mg/dL
>>GLUCOSE POC	202	H			(70-140)	mg/dL
>>BLOOD UREA NITROGEN			31	H	(7-18)	mg/dL
>>CREATININE			1.3		(0.6-1.3)	mg/dL
>>BUN/CREAT RATIO			24	H	(6-20)	
>>GLOMERULAR FILTRATION			56(k)	L	(>90)	
>>ALBUMIN			1.9	L	(3.4-5.0)	gm/dL
>>CALCIUM			8.4	L	(8.8-10.5)	mg/dL
>>PHOSPHORUS			2.8		(2.5-4.9)	mg/dL
>>LACTIC DEHYDROGENASE(L			6694(1)	H	(87-241)	Units/L

NOTES: (k) Units of measure: mL/min/1.73 square meters

Estimated Glomerular Filtration Rate (eGFR) is calculated using the Modification of Diet in Renal Disease (MDRD) equation for adult serum creatinine tests.

Reference Range:
Healthy Adults >90 mL/min/1.73 m2

Chronic Kidney Disease:

Stage II	Mild Decrease in GFR	60-90 mL/min/1.73m2
Stage III	Moderate Decrease in GFR	30-59 mL/min/1.73m2
Stage IV	Severe Decrease in GFR	15-29 mL/min/1.73m2
Stage V	Kidney Failure	<15 mL/min/1.73m2

(1) NEW METHOD/REFERENCE RANGE IN USE 8/13/10
METHOD STANDARDIZED TO THE IFCC LD PRIMARY REFERENCE METHOD

Patient: WINKLER,LOUIS Age/Sex: 81/M Acct#[redacted] Unit#[redacted]

PRINT DATE: 04/06/11
PRINT TIME: 0307

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BPF LAB Discharge Summary report w/o Pathology

Patient: WINKLER,LOUIS [redacted] (Continued)

**********CHEMISTRY**********

ROUTINE CHEMISTRY (continued)

Date / Time	03/30/11 2133		03/30/11 1515		Reference	Units
>>SODIUM			149	H	(136-145)	mmol/L
>>POTASSIUM			4.2		(3.5-5.1)	mmol/L
>>CHLORIDE			116	H	(98-107)	mmol/L
>>CARBON DIOXIDE			18	L	(21-32)	mmol/L
>>ANION GAP			15		(6-16)	
>>GLUCOSE			124	H	(74-106)	mg/dL
>>GLUCOSE POC	144	H			(70-140)	mg/dL
>>BLOOD UREA NITROGEN			30	H	(7-18)	mg/dL
>>CREATININE			1.3		(0.6-1.3)	mg/dL
>>BUN/CREAT RATIO			23	H	(6-20)	
>>GLOMERULAR FILTRATION			56(n)	L	(>90)	
>>CALCIUM			8.6	L	(8.8-10.5)	mg/dL

Date / Time	03/30/11 1221		03/30/11 1125		Reference	Units
>>GLUCOSE POC	178	H			(70-140)	mg/dL
>>LACTIC DEHYDROGENASE(L			6670(n)	H	(87-241)	Units/L

Date / Time	03/30/11 1125		03/30/11 0736		Reference	Units
>>GLUCOSE POC			218	H	(70-140)	mg/dL

NOTES: (m) Units of measure: mL/min/1.73 square meters

Estimated Glomerular Filtration Rate (eGFR) is calculated using the Modification of Diet in Renal Disease (MDRD) equation for adult serum creatinine tests.

Reference Range:
Healthy Adults >90 mL/min/1.73 m2

Chronic Kidney Disease:

Stage II	Mild Decrease in GFR	60-90 mL/min/1.73m2
Stage III	Moderate Decrease in GFR	30-59 mL/min/1.73m2
Stage IV	Severe Decrease in GFR	15-29 mL/min/1.73m2
Stage V	Kidney Failure	<15 ml/min/1.73m2

(n) NEW METHOD/REFERENCE RANGE IN USE 8/13/10
METHOD STANDARDIZED TO THE IFCC LD PRIMARY REFERENCE METHOD

Patient: WINKLER,LOUIS Age/Sex: 81/M Acct[redacted] Unit#[redacted]

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HPF LAB Discharge Summary report w/o Pathology

Patient: WINKLER,LOUIS #[redacted] (Continued)

**********CHEMISTRY**********

ROUTINE CHEMISTRY (continued)

Date	03/30/11		03/29/11			
Time	1125		0736	2320	2300	Reference	Units
>>TRIGLYCERIDES	457	H				(0-150)	mg/dL
>>CHOLESTEROL	128(o)					(0-200)	mg/dL
>>IRON	111(p)					(65-175)	mcg/dL
>>SODIUM					144	(136-145)	mmol/L
>>POTASSIUM					4.3	(3.5-5.1)	mmol/L
>>CHLORIDE					109 H	(98-107)	mmol/L
>>CARBON DIOXIDE					19 L	(21-32)	mmol/L
>>ANION GAP					16	(6-16)	
>>GLUCOSE					162 H	(74-106)	mg/dL
>>GLUCOSE POC	208	H				(70-140)	mg/dL
>>BLOOD UREA NITROGEN					38 H	(7-18)	mg/dL
>>CREATININE					1.5 H	(0.6-1.3)	mg/dL
>>BUN/CREAT RATIO					25 H	(6-20)	
>>GLOMERULAR FILTRATION					48(q) L	(>90)	
>>TOTAL PROTEIN					6.0 L	(6.4-8.2)	gm/dL
>>ALBUMIN					2.2 L	(3.4-5.0)	gm/dL
>>GLOBULIN					3.8 H	(2.3-3.5)	GM/DL
>>ALBUMIN/GLOBULIN RATIO					0.6 L	(1.1-1.8)	

NOTES: (o) Desirable: Less than 200 mg/dL
Borderline: 200 - 240 mg/dL
High Risk: Greater than 240 mg/dL
(p) *****NEW METHOD/NEW REFERENCE RANGE*****
(q) Units of measure: mL/min/1.73 square meters

Estimated Glomerular Filtration Rate (eGFR) is calculated using the Modification of Diet in Renal Disease (MDRD) equation for adult serum creatinine tests.

Reference Range:
Healthy Adults >90 mL/min/1.73 m2

Chronic Kidney Disease:

Stage II	Mild Decrease in GFR	60-90 mL/min/1.73m2
Stage III	Moderate Decrease in GFR	30-59 mL/min/1.73m2
Stage IV	Severe Decrease in GFR	15-29 mL/min/1.73m2
Stage V	Kidney Failure	<15 ml/min/1.73m2

Patient: WINKLER,LOUIS Age/Sex: 81/M Acct#[redacted] Unit#[redacted]

PRINT DATE: 04/06/11
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HPF LAB Discharge Summary report w/o Pathology

Patient: WINKLER,LOUIS #[redacted] (Continued)

**********CHEMISTRY**********

ROUTINE CHEMISTRY (continued)

Date / Time	2320	2300		Reference	Units
		03/29/11			
>>CALCIUM		9.3		(8.8-10.5)	mg/dL
>>PHOSPHOROUS		2.5		(2.5-4.9)	mg/dL
>>BILIRUBIN TOTAL		0.6		(0-1.0)	mg/dL
>>SGOT/AST		132	H	(15-37)	Units/L
>>SGPT/ALT		16(r)		(12-78)	Units/L
>>ALKALINE PHOSPHATASE T		91		(50-136)	Units/L
>>CREATINE KINASE (CK)		30	L	(39-308)	Units/L
>>MAGNESIUM		2.1		(1.8-2.4)	mg/dL

NOTES: (r) NEW REFERENCE RANGE EFFECTIVE 10/1/10

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HPF LAB Discharge Summary report w/o Pathology

Patient: WINKLER,LOUIS [redacted] (Continued)

BLOOD GASES
ARTERIAL BLOOD GASES

Date / Time	04/02/11 0400		04/01/11 1223		Reference	Units
>>ARTERIAL BLOOD GAS PH	7.39		7.430		(7.35-7.45)	
>>ABG PCO2	18(s)	CL	17.3(t)	CL	(35-45)	MMHG
>>ABG PO2	82		79.2	L	(80-104)	MMHG
>>ABG HCO3	10.9	L	11.2	L	(20-28)	MEQ/L
>>ABG BASE EXCESS	-12.1	L	-12.0	L	(-3.0-3.0)	
>>ABG TEMPERATURE	37.0		36.8	L	(37.0-37.5)	C
>>ABG O2 SATURATION	97.4				(90-)	%
>>CO-OX O2 SATURATION	95.1		97.6		(80-)	%
>>CO-OX METHEMOGLOBIN	0.5		0.6		(0-6.0)	%
>>CO-OX O2 CONTENT			8.3		(8.0-41.0)	% VOL
>>BAROMETRIC PRESSURE			760			
>>ABG L/M	2		2			L/MIN
>>ABG DELIVERY	N/C		N/C			
>>ARTERIAL BLOOD GAS SIT	L RADIAL(u)		L RADIAL(v)			

Test	Date	Time	Result		Reference	Units	Ver Da
>>HDL CHOLESTEROL	03/30/11	1125	6(w)	L	(40-60)	mg/dL	03/30/

NOTES:
(s) RESULTS REPORTED TO DR. LORCH AT 0509 BY RCPRCT ON 04/02/11. Critical results were acknowledged.
(t) RESULTS REPORTED TO DR. LORCH AT 1233 BY HRTKNC ON 04/01/11. Critical results were acknowledged.
(u) PASSED MODIFIED ALLEN'S TEST
PUNCTURE SITE HELD UNTIL BLEEDING STOPPED
(v) PASSED MODIFIED ALLEN'S TEST
PUNCTURE SITE HELD UNTIL BLEEDING STOPPED
(w) HDL REFERENCE INTERVAL:

Less than 35 mg/dL: Major risk factor for CHD
Greater than or equal to 60 mg/dL: Negative risk factor for CHD

Patient: WINKLER,LOUIS Age/Sex: 81/M Acct# [redacted] Unit# [redacted]

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HPF LAB Discharge Summary Report w/o Pathology

Patient: WINKLER,LOUIS #[redacted] (Continued)

Test	Date	Time	Result		Reference	Units	Ver Da
>>LDL CHOLESTEROL	03/30/11	1125	56(x)		(0-100)	mg/dL	03/30/
>>CHOLESTEROL/HDL RATIO	03/30/11	1125	21.33(y)				03/30/
>>TOTAL IRON BINDING CAPACI	03/30/11	1125	144	L	(250-450)	mcg/dL	03/30/
>>UIBC	03/30/11	1125	33	L	(260-445)	mcg/dL	03/30/
>>IRON SATURATION	03/30/11	1125	77	H	(20-50)	%	03/30/
>>VITAMIN B12	03/30/11	1125	715(z)		(211-911)	pg/mL	03/30/
>>FOLIC ACID	03/30/11	1125	3.71(aa)	L	(5.38-24.0)	ng/mL	03/30/

NOTES: (x) ****LDL Interpretation****

OPTIMAL	< 100 mg/dL
NEAR OPTIMAL	100 - 129 mg/dL
BORDERLINE HIGH	130 - 159 mg/dL
HIGH	160 - 189 mg/dL
VERY HIGH	Greater than or equal to 190 mg/dL

(y) **CHOLESTEROL TO HDL RATIO INTERPRETATIONS**

	RELATIVE RISK	RATIO
MALE:	1/2 AVERAGE	3.43
	AVERAGE	4.97
	2X AVERAGE	9.55
	3X AVERAGE	23.39
FEMALE:	1/2 AVERAGE	3.27
	AVERAGE	4.44
	2X AVERAGE	7.05
	3X AVERAGE	11.04

(z) NEW METHOD/REFERENCE RANGE EFFECTIVE 9/21/09
(aa) NEW METHOD/REFERENCE RANGE EFFECTIVE 9/21/09
See also (ab)
(ab) ******FOLATE INTERPRETATION******

NORMAL:	>5.38 ng/mL
INDETERMINATE:	3.38 - 5.38 ng/mL
DEFICIENT:	0.35 - 3.37 ng/mL

****

Patient: WINKLER,LOUIS Age/Sex: 81/M Acct#[redacted] Unit#[redacted]

PRINT DATE: 04/06/11
PRINT TIME: 0307

Brandon Regional Hospital
Clinical Laboratory
119 Oakfield Drive
Brandon, FL 33511
(813) 571-5190

HDF LAB Discharge Summary report w/o Pathology

Patient: WINKLER,LOUIS #[redacted] (Continued)

Test	Date	Time	Result		Reference	Units	Ver Da
>>AG CARCINOEMBRYONIC	03/31/11	0437	2.5(ac)		(0-5.0)	ng/mL	03/31/
>>TROPONIN I	03/29/11	2300	0.05(ae)		(0-0.06)	ng/mL	03/29/
>>CK	03/29/11	2300	30	L	(95-232)	Units/L	03/30/
>>CKMB	03/29/11	2300	< 0.5		(0-5.0)	ng/mL	03/30/
>>CK COMMENT	03/29/11	2300	(af)				03/30/
>>ALPHA FETOPROTEIN	03/31/11	0437	< 1.3(@ag)		(0.0-8.0)	ng/mL	04/01/
>>CA 19-9	03/31/11	0437	6.7(@ag)		(0.00-30.90)	InU/mL	04/01/
>>LACTIC ACID	04/01/11	1730	8.9	H	(0.4-2.0)	mmol/L	04/01/
>>METHYLMALONIC ACID	03/30/11	1125	507(ah)	H	(73-376)	nmol/L	04/02/
>>HOMOCYSTEINE	03/30/11	1125	9.2(aj)		(3.7-13.9)	umol/L	03/30/

NOTES: (ac) **CEA INTERPRETATION**

NON SMOKERS: 0 - 5.0 ng/mL
SMOKERS: 0 - 10.0 ng/mL
See also (ad)

(ad) NEW METHOD/REFERENCE RANGE EFFECTIVE 9/17/09

(ae) Elevation of Troponin I - Suggestive of Myocardial Ischemia and/or injury. Other causes may be Trauma, Hypertension, Hypotension, Acute Neurologic Disease, Rhabdomyolysis, Renal Failure, Post-Op Recovery, Critically Ill, Hypothyroidism, Myocarditis, Post PCI, Pulmonary Embolism, Sepsis, Amyloidosis and Vital Exhaustion.

A delta change of 100% or more between Troponin I serial draws are abnormal and highly suggestive of myocardial infarction.

(af) NO REL% CALCULATED
No Relative Index % can be calculated if the Total CK <120 or the CKMB <0.5 ng/ml.

(@ag) TEST PERFORMED AT: Integrated Regional Laboratories
5361 N.W. 33rd Ave Fort Lauderdale FL 33309

(ah) The reference range for methylmalonic acid has been set at +3sd above the mean for healthy blood bank donors. In the clinical assessment of patients with megaloblastic anemias a cutoff of +3sd provides greater specificity in the diagnosis of the vitamin deficiency states, despite the sacrifice of some sensitivity.
Performed At: BN, LabCorp Burlington
1447 York Court, Burlington, NC, 272153361
William F Hancock, MD, Phone: 8007624344
See also (@ai)

(@ai) Tampa,FL

(aj) NEW METHOD/REFERENCE RANGE EFFECTIVE 9/21/09

Patient: WINKLER,LOUIS Age/Sex: 81/M Acct#[redacted] Unit#[redacted]

PRINT DATE: 04/06/11
PRINT TIME: 0307

Brandon Regional Hospital
Clinical Laboratory
119 Oakfield Drive
Brandon, FL 33511
(813) 571-5190

HPF LAB Discharge Summary report w/o Pathology

Patient: WINKLER,LOUIS #[redacted] (Continued)

Test	Date	Time	Result		Reference	Units	Ver Da
>>B TYPE NATRIURETIC PEPTID	03/29/11	2300	119(ak)	H	(0-100)	pg/mL	03/29/
>>FERRITIN	03/30/11	1125	8320(al)	H	(26-388)	ng/mL	03/30/

NOTES: (ak) New Method effective 12/07. Same reference range.
(al) NEW METHOD/REFERENCE RANGE EFFECTIVE 9/21/09

Patient: WINKLER,LOUIS Age/Sex: 81/M Acct#[redacted] Unit#[redacted]

Brandon Regional Hospital
Clinical Laboratory
119 Oakfield Drive
Brandon, FL 33511
(813) 571-5190

EPF LAB Discharge Summary Report w/o Pathology

Patient: WINKLER,LOUIS [redacted] (Continued)

********** BACTERIOLOGY **********

MICRO SUMMARY REPORT

11:BR:B0012587R Coll: 03/30/11 0046 Source: URINE\CATHETER

> URINE CULTURE Final 04/01/11
CULTURE RESULTS: LESS THAN 10,000 CFU/ML MIXED ORGANISMS

11:BR:B0012604R Coll: 03/30/11 0734 Source: NASAL\LEFT AND R

> Chromagar:MRSA Surveillance Sc Final 03/31/11
MRSA Surveillance Screen MRSA ChromAgar Screen Negative

Screen performed per MRSA/VRE and Other Resistant Organisms policy and procedure approved by the Medical Executive Committee.

11:BR:BC00061088 Coll: 03/29/11 2300 Source: BLOOD\BLOOD CULT

> BLOOD CULTURE Final 04/03/11
NO GROWTH AFTER 5 DAYS

11:BR:BC00062978 Coll: 04/01/11 1520 Source: BLOOD\BLOOD CULT

> BLOOD CULTURE Final 04/02/11
BLOOD CULTURE RESULT SEEN ON GRAM STAIN
GRAM POSITIVE COCCI IN CLUSTERS

CALLED RESULTS TO JEN AT 2104 BY HLBMLS01 ON 04/02/11. Were the critical results read back to the tech? Y

> SUBCULTURES(BLOOD) Final 04/04/11
Organism 1 STAPHYLOCOCCUS HOMINIS
QUANTITATION NP
GROWTH IN VIAL: AEROBIC ONLY
CULTURE POSITIVE ON DAY: 1
COMMENTS NO COMMENT

BLOOD CULTURE RESULT COAGULASE NEGATIVE STAPHYLOCOCCUS

INDUCIBLE CLINDAMYCIN RESISTANCE - POSITIVE

Patient: WINKLER,LOUIS Age/Sex: 81/M Acct#[redacted] Unit[redacted]

PRINT DATE: 04/06/11
PRINT TIME: 0307

Brandon Regional Hospital
Clinical Laboratory
119 Oakfield Drive
Brandon, FL 33511
(813) 571-5190

HPF LAB Discharge Summary report w/o Pathology

Patient: WINKLER,LOUIS [redacted] (Continued)

********** BACTERIOLOGY (continued) **********
MICRO SUMMARY REPORT

11:BR:BC00062978 (continued) Coll: 04/01/11 1520 Source: BLOOD\BLOOD CULT

SUBCULTURES(BLOOD) (continued)
1. STAPHYLOCOCCUS HOMINIS

	INTERP	M.I.C.
TETRACYCLINE	R	>=16
GENTAMICIN	S	<=0.5
PENICILLIN	R	>=0.5
OXACILLIN	R	>=4
CLINDAMYCIN	R	<=0.25
ERYTHROMYCIN	R	>=8
VANCOMYCIN	S	1
RIFAMPIN	S	<=0.5
LEVOFLOXACIN	I	4
CIPROFLOXACIN	R	4

11:BR:BC00062988 Coll: 04/01/11 1520 Source: BLOOD\BLOOD CULT

> BLOOD CULTURE Final 04/03/11
BLOOD CULTURE RESULT SEEN ON GRAM STAIN
GRAM POSITIVE COCCI IN CLUSTERS
GRAM POSITIVE RODS

CALLED RESULTS TO JEN AT 2334 BY HLBDCR ON 04/02/11. Were the critical results read back to the tech? Y
CALLED RESULTS TO CAMMIE,RN AT 1730 BY HLBJRG ON 04/03/11. Were the critical results read back to the tech? Y

Final Verified Result Edit Comment
****
* This is a corrected result. *
****
A prior result that was reported as final has been changed.
****
* This is a corrected result. *
****
A prior result that was reported as final has been changed.
> SUBCULTURES(BLOOD) Final 04/05/11

Patient: WINKLER,LOUIS Age/Sex: 81/M Acct#[redacted]

Brandon Regional Hospital
Clinical Laboratory
119 Oakfield Drive
Brandon, FL 33511
(813) 571-5190

RPF LAB Discharge Summary report w/o Pathology

Patient: WINKLER,LOUIS #[redacted] (Continued)

********** BACTERIOLOGY (continued) **********
MICRO SUMMARY REPORT

11:BR:BC00062988 (continued) Coll: 04/01/11 1520 Source: BLOOD\BLOOD CULT

SUBCULTURES(BLOOD) (continued)

Organism 1	STAPHYLOCOCCUS EPIDERMIDIS
QUANTITATION	Not Applicable to this culture type
GROWTH IN VIAL:	ANAEROBIC ONLY
CULTURE POSITIVE ON DAY:	1
COMMENTS	NO COMMENT
Organism 2	CORYNEBACTERIUM SPECIES
GROWTH IN VIAL:	AEROBIC ONLY
CULTURE POSITIVE ON DAY:	2
COMMENTS	CORYNEBACTERIUM AFERMENTANS
BLOOD CULTURE RESULT	ANAEROBIC BOTTLE^ COAGULASE NEGATIVE STAPHYLOCOCCUS AEROBIC BOTTLE ^ GRAM POSITIVE RODS IDENTIFIED AS: CORYNBACTERIUM AFERMENTAN MICS NOT PERFORMED ON THIS ISOLATE

INDUCIBLE CLINDAMYCIN RESISTANCE - NEGATIVE (ST.EPIDERMIDIS)

1. STAPHYLOCOCCUS EPIDERMIDIS

	INTERP	M.I.C.
TETRACYCLINE	S	2
GENTAMICIN	S	<=0.5
PENICILLIN	R	>=0.5
OXACILLIN	R	>=4
CLINDAMYCIN	S	<=0.25
ERYTHROMYCIN	R	>=8
VANCOMYCIN	S	2
RIFAMPIN	S	<=0.5
LEVOFLOXACIN	R	>=8
CIPROFLOXACIN	R	>=8

Patient: WINKLER,LOUIS Age/Sex: 81/M Acct#[redacted] Unit[redacted]

Brandon Regional Hospital
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HPF LAB Discharge Summary report w/o Pathology

Patient: WINKLER,LOUIS [redacted] (Continued)

**********BLOOD TRANSFUSION SERVICE**********

COLLECTED: Apr 1, 2011 10:35am

> PREV HIST CHECK	NO PREVIOUS HISTORY	04/01/11 1306
> BLOOD TYPE	O POS	04/01/11 1304
> ABSC	NEGATIVE	04/01/11 1306
CROSSMATCH		
PACKED CELLS	W035511978533 RBC E0332 O POS Comp? Y	04/01/11 1306
PACKED CELLS	W036511967586 RBC E0332 O POS Comp? Y	04/01/11 1306

ISSUED AND TRANSFUSED PRODUCTS

Product	Unit#	Blood Type	Status	Volume	Transfused Date	Transfused Begin-End
RBC E0332	W036511967586	O POS	TRANSFUSED	04/01/11 350 ML		1808 2101

UNIT(S) APPEARANCE? NORMAL
CLERICAL CHECK? YES
Issuing to Monitored System? None
Time: 1823
Temp-C: 36.4 Temp-F: 97.5 Pulse: 100
Resp: 24 BP: 158/73 Pulse Ox: 98
Signs & Symptoms of Possible Transfusion Reaction: N
Has Transfusion been stopped?
Please Explain why not:
Time: 1808
Temp-C: 36.9 Temp-F: 98.5 Pulse: 109
Resp: 30 BP: 137/65 Pulse Ox: 98
Signs & Symptoms of Possible Transfusion Reaction: N
Has Transfusion been stopped?
Please Explain why not:
Time: 2101
Temp-C: 37.4 Temp-F: 99.4 Pulse: 104
Resp: 25 BP: 130/60 Pulse Ox: 99
Signs & Symptoms of Possible Transfusion Reaction: N
Has Transfusion been stopped?
Please Explain why not:

RBC E0332	W035511978533	O POS	TRANSFUSED	04/01/11 350 ML		1402 1700

UNIT(S) APPEARANCE? NORMAL
CLERICAL CHECK? YES
Issuing to Monitored System? None
Time: 1400
Temp-C: 37.7 Temp-F: 99.9 Pulse: 107
Resp: 24 BP: 127/65 Pulse Ox: 98
Signs & Symptoms of Possible Transfusion Reaction:
Has Transfusion been stopped?

PRINT DATE: 04/06/11
PRINT TIME: 0307

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(813) 571-5190

HPF LAB Discharge Summary Report w/o Pathology

Patient: WINKLER,LOUIS [redacted] (Continued)

ISSUED AND TRANSFUSED PRODUCTS

Product	Unit#	Blood Type	Status	Volume	---Transfused--- Date	Begin-End

Please Explain why not:
Time: 1417
Temp-C: 38.1 Temp-F: 100.5 Pulse: 63
Resp: 24 BP: 127/56 Pulse Ox: 99
Signs & Symptoms of Possible Transfusion Reaction: N
Has Transfusion been stopped?
Please Explain why not:

Patient: WINKLER,LOUIS Age/Sex: 61/M Acc[redacted] Unit#[redacted]

PRINT DATE: 04/06/11
PRINT TIME: 0307

Brandon Regional Hospital
Clinical Laboratory
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Brandon, FL 33511
(813) 571-5190

HPF LAB Discharge Summary report w/o Pathology

Patient: WINKLER,LOUIS [redacted] (Continued)

**********CANCELLED SPECIMENS**********

0401:BR:C00179R CAN, Coll: 04/01/11-0300 Recd: - (R#07707727) Agzew,Yeshitila
Ordered: BASIC METABOLIC
Comment: CXL SEE C178
0401:BR:H00107R CAN, Coll: 04/01/11-0400 Recd: - (R#07707726) Shah,Suketu K
Ordered: CBC W/DIFF
Comment: CXL SEE H106
0402:BR:C00076T CAN, Coll: 04/02/11-0400 Recd: - (R#07709910) Agzew,Yeshitila
Ordered: BASIC METABOLIC
Comment: DUP
0403:BR:CG00045R CAN, Coll: 04/03/11-0400 Recd: - (R#07711881) Agzew,Yeshitila
Ordered: PLAT HEP DEP AB
Comment: PT EXPIRED PER RN PETER
0403:BR:H00068R CAN, Coll: 04/03/11-0500 Recd: - (R#07711803) Agzew,Yeshitila
Ordered: CBC W/DIFF
Comment: PT EXPIRED PER RN PETER
0403:BR:CG00024R CAN, Coll: 04/03/11-0500 Recd: - (R#07711803) Agzew,Yeshitila
Ordered: PT, PTT
Comment: PT EXPIRED PER RN PETER

BRANDON HOSPITAL
119 OAKFIELD DRIVE
BRANDON FLA 33511

PHONE #: 813-571-5280
FAX #: 813-571-5288

Name: WINKLER,LOUIS
Phys: Beg,Rasha MD
DOB: [redacted] Age: 81 Sex: M
Acct: [redacted] Loc: H.8518 1
Exam Date: 03/31/2011 Status: ADM IN
Radiology No: 00630309
Unit No: H000747563

EXAMS:
020374593 CT ABDOMEN PELVIS W/CON RE:LAO

Reason for Exam::

CT abdomen and pelvis with contrast

3/31/2011 12:46:00 PM

History: Urosepsis, lymphoma

Comparison: CTA chest from 03/30/2011

Technique: Serial axial 5 MM slice images of the abdomen and pelvis were obtained from the lung bases to the ischial tuberosities after intravenous and oral contrast administration. Delayed images through the kidneys, ureters, and bladder were obtained.

CT abdomen findings:

Partial imaging of the lung bases demonstrate small bilateral pleural effusions with mild posterior bilateral lower lobe atelectasis, unchanged. Bilateral distal paraesophageal lymphadenopathy is noted with largest lymph node on the left measuring approximately 2.9 cm, likely stable. There is no pericardial effusion.

Images of the abdomen demonstrate hepatomegaly measuring 22 cm. There is splenomegaly measuring 19 cm. Right upper quadrant surgical clips are noted due to cholecystectomy. A right adrenal gland approximately 1.4 cm hypodense nodule is noted, indeterminate. Posterior right renal cortical exophytic approximately 3.8 cm benign cortical cyst is noted. There is an approximately 1.8 cm distal pancreatic body/tail the superior enhancing nodule, indeterminate. Metastatic disease or primary pancreatic malignancy cannot be excluded. There is evidence of severe ill-defined central mesenteric and retroperitoneal confluent lymphadenopathy eccentric to the left measuring up to approximately 10 cm with multiple cystic components within likely related to lymphoma/metastatic disease. There is evidence of lymphadenopathy surrounding the left renal vein and artery in addition to the mid to proximal left ureter with associated moderate left hydroureteronephrosis. Abdominal aortic wall calcific changes are present without evidence of aneurysm. There is no free air in the abdomen. Left paracolic gutter scattered soft tissue nodules and ill-defined soft tissue is noted likely due to lymphoma/metastatic disease. Bilateral anterior

abdominopelvic wall subcutaneous fat nodular densities are noted, indeterminate.

Impression:
1. Malignancy/metastatic disease as described above.

BRANDON HOSPITAL
119 OAKFIELD DRIVE
BRANDON,FLA 33511

PHONE #: 813-571-5280
FAX #: 813-571-5286

Name: WINKLER,LOUIS
Phys: Beg,Rasha MD
DOB: [redacted] Age: 81 Sex: M
Acct: [redacted] Loc: E.ED18 1
Exam Date: 03/31/2011 Status: ADM IN
Radiology No: 00630585
Unit No: EDD0747583

EXAMS:
020374293 CT ABDOMEN PELVIS W/CON Reason for Exam::
<Continued> RE:LAD

2. Mild left hydroureteronephrosis.

CT pelvis findings:

Images of the pelvis demonstrate mild pelvic free fluid. Proximal edema is noted. Mild bilateral pelvic arterial wall calcific changes are present. There is fusiform aneurysmal dilation of the distal left common iliac artery measuring 2.4 cm. There is a non-obstructing bowel loop pattern. Foley balloon catheter is present within an empty decompressed bladder. Left pelvic retroperitoneal lymphadenopathy is noted extending from the abdomen. Left inguinal nodular densities are noted, indeterminate. The appendix is not visualized.

Impression:
1. Pelvic free fluid.

2. Left inguinal nodular densities, indeterminate. Metastatic disease cannot be excluded.

** Electronically Signed by HUGO MONTES M.D on 03/31/2011 at 1310 **
Reported and signed by: HUGO MONTES M.D

CC: No Primary or Family Physician; Self Referred: Rasha Beg MD

Dictated Date/Time: 03/31/2011 (1301)
Technologist: STEPHEN MOLINOWSKI
Transcribed Date/Time: 03/31/2011 (1301)
Transcriptionist: RAD.VR
Electronic Signature Date/Time: 03/31/2011 (1310)
Printed Date/Time: 03/31/2011 (1311; BATCH NO: N/A

PAGE 2

Signed Report

BRANDON HOSPITAL
119 OAKFIELD DRIVE
BRANDON,FLA 33511

PHONE #: 813-871-5200
FAX #: 813-871-5288

Name: WINKLER,LOUIS
Phys: Bennett,Roderick MD
DOB: [redacted] Age: 61 Sex: M
Acct: [redacted] Loc: E.ED
Exam Date: 03/29/2011 Status: RSH AR
Radiology No: 00630569
Unit No: H0003747683

EXAMS:
0203744486 CT ANGIO CHEST WITH CONTR

Reason for Exam:: TACHYCARDIA, PROLONGED BEDREST

Exam Description: - CT ANGIO CHEST WITH CONTRAST

Exam Complete Date: 3/30/2011 1:15:00 AM

History: Tachycardia

Comparison: None

Technique:

Serial axial 2.5 mm slice images of the chest were obtained from the thoracic inlet to the upper abdomen after intravenous contrast administration tailored as a pulmonary artery embolus protocol. Multiplanar reconstructions were obtained for additional evaluation of the pulmonary arteries after post-processing the axial angiographic images using special software.

Findings:

Evaluation of the post segmental pulmonary arteries is limited due to significant motion degradation. There are no filling defects seen to the segmental level.

There is no thoracic aortic aneurysm or dissection.

Impression:

1. Study limited by respiratory motion with no filling defects seen to the segmental level. Post segmental pulmonary arteries are poorly evaluated.

CT Chest with contrast

Findings:

There are numerous enlarged lymph nodes seen within the supraclavicular regions. On the left, conglomerate lymph nodes measure up to 5.5 x 3.3 cm. On the right, a large lymph node measures up to 3.1 x 2.0 cm. There are no enlarged axillary lymph nodes. There are multiple soft tissue masses seen medial to the aorta, abutting the esophagus. These likely represent enlarged lymph nodes. The largest is noted on image 128 measuring up to 2.8 x 2.4 cm. There is a large lymph nodes seen within the azygoesophageal recess measuring up to 1.9 x 2.2 cm.

Signed Report (CONTINUED)

BRANDON HOSPITAL
119 OAKFIELD DRIVE
BRANDON,FLA 33511

PHONE #: 813-571-5280
FAX #: 813-571-5288

Name: WINKLER,LOUIS
Phys: Bennett,Roderick MD
DOB: [redacted] Age: 91 Sex: M
Acct: [redacted] Loc: S.SP
Exam Date: 03/29/2011 Status: RAD ER
Radiology No: 00630889
Unit No: HD00747583

EXAMS:
020374486 CT ANGIO CHEST WITH CONTR
<Continued>

Reason for Exam:
TACHYCARDIA, PROLONGED RECOVERY

The heart is normal in size. There is no pericardial effusion.

There are small bilateral effusions which layer freely. There is compressive atelectasis of the lower lobes.

Lung windows demonstrate respiratory motion artifact. However, there are no infiltrates seen.

There are no pulmonary nodules or masses. Partial imaging of the upper abdomen demonstrates surgical absence of the gallbladder. There are no acute findings demonstrated.

Evaluation of the bone windows demonstrates no destructive abnormality.

Impression:

1. Extensive supraclavicular lymphadenopathy noted bilaterally. There are also numerous enlarged lymph nodes seen within the posterior mediastinum abutting the esophagus and aorta as well as within the azygoesophageal recess. Recommend clinical correlation. Consider PET imaging.
2. Small bilateral pleural effusions with compressive lower lobe atelectasis.

** Electronically Signed by BRET NEIDERMAN M.D **
** on 03/30/2011 at 0156 **
Reported and signed by: BRET NEIDERMAN M.D

CC: Roderick Bennett MD

Dictated Date/Time: 03/30/2011 (0148)
Technologist: CHRISTY ACKERMAN
Transcribed Date/Time: 03/30/2011 (0148)
Transcriptionist: RAE.VR
Electronic Signature Date/Time: 03/30/2011 (0156)
Printed Date/Time: 03/30/2011 (0156) BATCH NO: N/A

PAGE 2

Signed Report

BRANDON HOSPITAL
119 OAKFIELD DRIVE
BRANDON,FLA 33511

PHONE #: 813-571-5280
FAX #: 813-571-5288

Name: WINKLER,LOUIS
Phys: Bennett,Roderick MD
DOB: [redacted] Age: 61 Sex: M
Acct: [redacted] Loc: B.ED
Exam Date: 03/29/2011 Status: REG ER
Radiology No: 00630589
Unit No: H000749583

EXAMS:
020376479 CT BRAIN W/O CONTRAST

Reason for Exam::
AMS

Exam Description: - CT BRAIN W/O CONTRAST

Exam Complete Date: 3/30/2011 1:15:00 AM

History: Altered mental status

Comparison: None

Technique:

Serial axial CT images were acquired from the base of the skull through the vertex at 5 mm collimation. No IV contrast was administered.

Findings:

The ventricles, sulci and cisterns are of a normal size and configuration for chronologic age. There is global cerebral atrophy. There is no intracranial mass lesion, mass effect or midline shift. There are no abnormal intra-axial or extra-axial fluid collections. There is no evidence of acute intracranial hemorrhage.

Bilateral periventricular and centrum semiovale white matter hypodensity is noted likely due to demyelination from chronic small vessel ischemic changes.

Gray white differentiation is otherwise intact.

Visualized portions of the paranasal sinuses and mastoid air cells are clear.

The bones of the calvaria and skull base are intact without evidence of depressed or displaced fracture.

There is a probable left globe prosthesis.

Impression:

1. No acute intracranial abnormality noted.
2. White matter chronic small vessel ischemic changes.

Signed Report

(CONTINUED)

BRANDON HOSPITAL
119 OAKFIELD DRIVE
BRANDON,FLA 33511

PHONE #: 813-371-5280
FAX #: 813-571-5288

Name: WINKLER,LOUIS
Phys: Bennett,Roderick MD
DOB: [redacted] Age: 61 Sex: M
Acct: [redacted] Loc: E.ED
Exam Date: 03/29/2011 Status: REG ER
Radiology No: 00630589
Unit No: E000747883

EXAMS:
020374479 CT BRAIN W/O CONTRAST
<Continued>

Reason for Exam::
AMS

** Electronically Signed by BRET NEIDERMAN M.D **
** on 03/30/2011 at 0138 **
Reported and signed by: BRET NEIDERMAN M D

CC: Roderick Bennett MD

Dictated Date/Time: 03/30/2011 (0135)
Technologist: CHRISTY ACKERMAN
Transcribed Date/Time: 03/30/2011 (0135)
Transcriptionist: RAD VH
Electronic Signature Date/Time: 03/30/2011 (0138)
Printed Date/Time: 03/30/2011 (0136) BATCH NO: N/A

PAGE 2
Signed Report

BRANDON HOSPITAL
119 OAKFIELD DRIVE
BRANDON,FLA 33511

PHONE #: 813-571-5200
FAX #: 813-571-8288

Name: WINKLER,LOUIS
Phys: Agnew,Venkatila MD
DOB: [redacted] Age: 81 Sex: M
Acct: [redacted] Loc: H.A539 1
Exam Date: 04/02/2011 Status: ADM IN
Radiology No: 00630569
Unit No: H0000747563

EXAMS:
020372801 CHEST PORTABLE

Reason for Exam::
COMPARISON

History: Followup per

Comparison 04/01/2011

Right PICC line in unchanged position. No pneumothorax. Lung fields are well-aerated. Improved basilar aeration.

summary:

Improved basilar aeration since 04/01/2011.

Findings otherwise unchanged.

No evidence of acute cardiopulmonary abnormality

** Electronically Signed by RONALD STENGEL DO on 04/02/2011 at 0948 **
Reported and signed by: RONALD STENGEL, DO

CC: No Primary or Family Physician; Self Referred

Dictated Date/Time: 04/02/2011 (0946)

Technologist: BRIAN COOPER; DIANE SMITH
Transcribed Date/Time: 04/02/2011 (0946)
Transcriptionist: KAD.VM
Electronic Signature Date/Time: 04/02/2011 (0948)
Printed Date/Time: 04/02/2011 (0949) BATCH NO: N/A

PAGE 1

Signed Report

BRANDON HOSPITAL
119 OAKFIELD DRIVE
BRANDON,FLA 33511

PHONE #: 813-571-5280
FAX #: 813-571-5286

Name: WINKLER,LOUIS
Phys: Agzew,Yashitila MD
DOB: [redacted] Age: 61 Sex: M
Acct: [redacted] Loc: E.A599 1
Exam Date: 04/01/2011 Status: ADM IN
Radiology No: 006304S9
Unit No: H0007475S3

EXAMS:
020375791 CHEST PORTABLE

Reason for Exam::
SOB

Exam: - CHEST PORTABLE

Exam Date: 4/1/2011 5:33:00 PM

History: Shortness of breath

Comparison: 04/01/2011

Findings:

Cardiomediastinal silhouette and pulmonary vascular markings are within normal limits. Atherosclerotic calcification is noted within the aortic arch. No acute consolidation is noted. There is hazy opacity noted the left lung base which may represent effusion versus atelectasis. The left hemidiaphragm is elevated. Right upper extremity PICC is in place with tip overlying the SVC. Degenerative changes are present within the thoracic spine.

Impression:

Left basilar opacity which may represent small pleural effusion versus atelectasis.

** Electronically Signed by ANDRE PRINCE MD on 04/01/2011 at 1806 **
Reported and signed by: ANDRE PRINCE, MD

CC: No Primary or Family Physician; Self Referred

Dictated Date/Time: 04/01/2011 (1803)

Technologist: MARK MOORE
Transcribed Date/Time: 04/01/2011 (1803)
Transcriptionist: RAD.VR
Electronic Signature Date/Time: 04/01/2011 (1806)
Printed Date/Time: 04/01/2011 (1807) BATCH NO: N/A

PAGE 1

Signed Report

BRANDON HOSPITAL
119 OAKFIELD DRIVE
BRANDON,FLA 33511

PHONE #: 813-571-5280
FAX #: 813-571-5288

Name: WINKLER,LOUIS
Phys: Agnew,Yashitila MD
DOB: [redacted] Age: 81 Sex: M
Loc: H.BSIS 1
Exam Date: 04/01/2011 Status: ADM IN
Radiology No: 00630589
Unit No: H0000747683

EXAMS:
020375841 CHEST PORTABLE

Reason for Exam:
POST-PICC INSERTION 46CM

Portable chest radiograph

4/1/2011 3:45:00 PM

POST-PICC INSERTION 46CM

Comparison: 03/29/2011

Findings:

Cardiomediastinal silhouette and pulmonary vascular markings are within normal limits. Lungs are clear. There is no pleural effusion or pneumothorax. Regional skeleton is unremarkable. Right upper extremity PICC is noted with tip overlying the mid SVC. Cardiac monitor leads are noted overlying the patient's chest.

Impression:
1. No acute cardiopulmonary disease.

** Electronically Signed by HUGO MONTES M.D on 04/01/2011 at 1551 **
Reported and signed by: HUGO MONTES M.D

CC: No Primary or Family Physician; Self Referred

Dictated Date/Time: 04/01/2011 (1549)

Technologist: JOVELDA BYRD
Transcribed Date/Time: 04/01/2011 (1548)
Transcriptionist: RAD.VK
Electronic Signature Date/Time: 04/01/2011 (1551)
Printed Date/Time: 04/01/2011 (1552) BATCH NO: N/A

PAGE 1

Signed Report

BRANDON EMERGENCY ROOM
115 OAKFIELD DR
BRANDON,FLA 33511

PHONE #: 813-371-5200
FAX #: 813-371-5288

Name: WINKLER,LOUIS
Phys: Bennett,Roderick MD
DOB: [redacted] Age: 61 Sex: M
Acct: [redacted] Loc: E.ED
Exam Date: 03/29/2011 Status: MSG RR
Radiology No: 00630589
Unit No: H000747683

EXAMS:
020394480 CHEST PORTABLE

Reason for Exam::
AMS

Exam Description: - CHEST PORTABLE

Exam Complete Date: 3/29/2011 11:35:00 PM

History: Altered mental status

Comparison: None

Findings:

The aorta is tortuous. The cardiomediastinal silhouette and pulmonary vascular markings are within normal limits. The lungs are clear. There is no pleural effusion, pneumothorax or hyperinflation. Regional skeleton and soft tissues are unremarkable.

Impression:

1. No acute cardiopulmonary disease.

** Electronically Signed by BRET NEIDERMAN M.D **
** on 03/30/2011 at 0001 **
Reported and Signed by: BRET NEIDERMAN M.D

CC: Roderick Bennett MD

Dictated Date/Time: 03/29/2011 (2359)

Technologist: KEISHA MAHER
Transcribed Date/Time: 03/29/2011 (2359)
Transcriptionist: RAD.VR
Electronic Signature Date/Time: 03/30/2011 (0001)
Printed Date/Time: 03/30/2011 (0002) BATCH NO: N/A

PAGE 1

Signed Report

BRANDON REGIONAL HOSPITAL
119 OAKFIELD DRIVE
BRANDON, FLORIDA 33511

********** ECHO REPORT
Patient Name: WINKLER,LOUIS
Account #: [redacted] DOB: [redacted]
Admit Date: 03/30/11 MRN: [redacted]
Attending Physician: Agzew,Yeshitila MD AGE: 81

DATE OF PROCEDURE: 03/31/2011

PROCEDURE: Echocardiogram with Doppler.

CLINICAL INDICATION: Tachycardia.

M-MODE AND 2-D INTERPRETATION:
1. The study is technically limited, only parasternal views were obtained, as the patient refused to complete the test, uncooperative.
2. The left ventricular chamber does not appear to be dilated. The wall motion in the parasternal views appears hyperdynamic with an ejection fraction that would appear to be at least 60%.
3. The mitral valve was mildly thickened, and there was mild annular calcification with normal mitral valve opening.
4. The left atrium in the parasternal views, did not appear to be dilated.
5. The aortic valve appeared mildly sclerotic with normal leaflet opening.
6. The right atrium and right ventricle were not enlarged. They are seen poorly. Tricuspid valve is seen poorly.
7. Trace pericardial effusion.

DOPPLER INTERPRETATION:
1. A very technically limited Doppler study, without gross evidence of mitral regurgitation or aortic insufficiency in the parasternal views.
2. Suggestion of trace tricuspid regurgitation.

SUMMARY:
1. Technically limited study.
2. Hyperdynamic left ventricle, normal to increased ejection fraction.
3. Mitral and aortic valve sclerosis.
4. Suggestion of trace tricuspid insufficiency.
5. Trace pericardial effusion.

Rolando D Rodriguez, MD
RDR/MedQ

DD: 03/31/2011 17:27
DT: 03/31/2011 18:28
Job #: 539797/460176216

PATIENT NAME: WINKLER,LOUIS ACCOUNT #: [redacted]

Revision #:
Authenticated by Rolando D Rodriguez, MD On 04/07/2011 08:54:38 AM

Electronically Signed by Rolando D Rodriguez, MD on 04/07/11 at 0856

PATIENT NAME: WINKLER,LOUIS ACCOUNT #: [redacted]

B318-1

Date: 3/31/11 ☐ Out Pt. Ref. Phy.: Cardiologist: BAR

Bolded measurements and information need to be completed on every patient!

Patient History

A-fib CABG CAD CHF CMO COPD CVA/TIA DM Dyslipidemia
HTN MI Murmur PACER PALP SOB Syncope ETOH R.Fever Smoker
Other:

Indication: tachy.

IVSd	0.9	cm	(.6 - 1.1cm)	FS	29	% (25% - 40%)
LVPWd	1.0	cm	(.6 - 1.1cm)	EF	60	% (55% - 75%)
LVEdD	4.9	cm	(3.5 - 5.6cm)			
LVEsD	3.3	cm	(2.1 - 4.0cm) ↑ HR			
AOR	4.0	cm	(2.4 - 3.7cm)			
LA	3.5	cm	(2.5 - 4.0cm)			

Pericardial Effusion Yes No trace

Pleural Effusion Yes (No)

Heart Valves

Aortic Valve
Comments:
Regurgitation: None Trace Mild Mod Sev
Aortic Pk Velocity ____ m/s Peak mmHg ____ P1/2t ____ DT (<200m/s) ____ Mean mmHg ____
Blind Probe: Apex ____ m/s SSN: ____ m/s RSB: ____ m/s
LVOT Dia. ____ cm LVOT Velocity ____ m/s Valve Area ____ cm²

Mitral Valve
Comments:
Regurgitation: None Trace Mild Mod Sev
Mitral Peak mmHg ____ Mean mmHg ____ P1/2t ____ Valve Area ____ cm²
E/A Ratio: ____ E/E': ____ E Velocity = ____ cm/s Lateral Septal

Tricuspid Valve
Regurgitation: None (Trace) Mild Mod Sev
TR Velocity 1.5 m/s TR Pk mmHg 10 + RA Est. mmHg 10 = 20 mmHg

Pulmonic Valve
Regurgitation: None Trace Mild Mod Sev
Pulmonic Pk Velocity ____ Pk mmHg ____ Mean mmHg ____

Sonographer Notes: Technically Difficult? (Yes) No

Pt sitting up / Pt refuse to finish test

Cardiologist Impression: tech difficult
hyperdynamic LV
EF 60%
for pericardial effusion
for TR
mild MR/AR/TR
#539797

Adult Echocardiography Preliminary Report

WINKLER, LOUIS H.8318 1 3365
[redacted] 03/30/11 0241
DOB: [redacted] 80 M IN
Agzew, Yesfiet Tsa MD MRN: MD[redacted]
BRANDON REGIONAL HOSPITAL BRANDON, FL

'ECHS' BRH00011 – Revision Date: 03/10

Patient: WINKLER, LOUIS MRN [redacted] Encounter: H00718392715 Page 1 of 1

M 001491

BRANDON REGIONAL HOSPITAL
119 OAKFIELD DRIVE
BRANDON, FLORIDA 33511

********** EKG REPORT
Patient Name: WINKLER,LOUIS
Account #: [redacted]
Admit Date: 03/30/11
Attending Physician: Agzew,Yeshitila MD

DOB: 09/14/29
MRN: [redacted]
AGE: 81

Test Reason : CP
Blood Pressure : ***/*** mmHG
Vent. Rate : 114 BPM
P-R Int : 000 ms
QT Int : 472 ms
QTc Int : 650 ms
Atrial Rate : 117 BPM
QRS Dur : 082 ms
P-R-T Axes : 000 -07 050 degrees

Sinus rhythm
No previous ECGs available
Confirmed by KHANT MD, RANCHOD (18) on 3/30/2011 5:51:10 PM

Referred By: Self.Referred
Overread By: RANCHOD KHANT MD

PATIENT NAME: WINKLER,LOUIS
ACCOUNT #: [redacted]

WINKLER, LOUIS ID [redacted] 29-MAR-2011 23:14:44 BRANDON REGIONAL HOSPITAL-ER ROUTINE RECORD

14 SEP-1929 (81 yr) Male
Room:B318
Loc:3

Vent. rate	114	BPM
PR interval	*	ms
QRS duration	82	ms
QT/QTc	472/650	ms
P-R-T axes	* -7	50

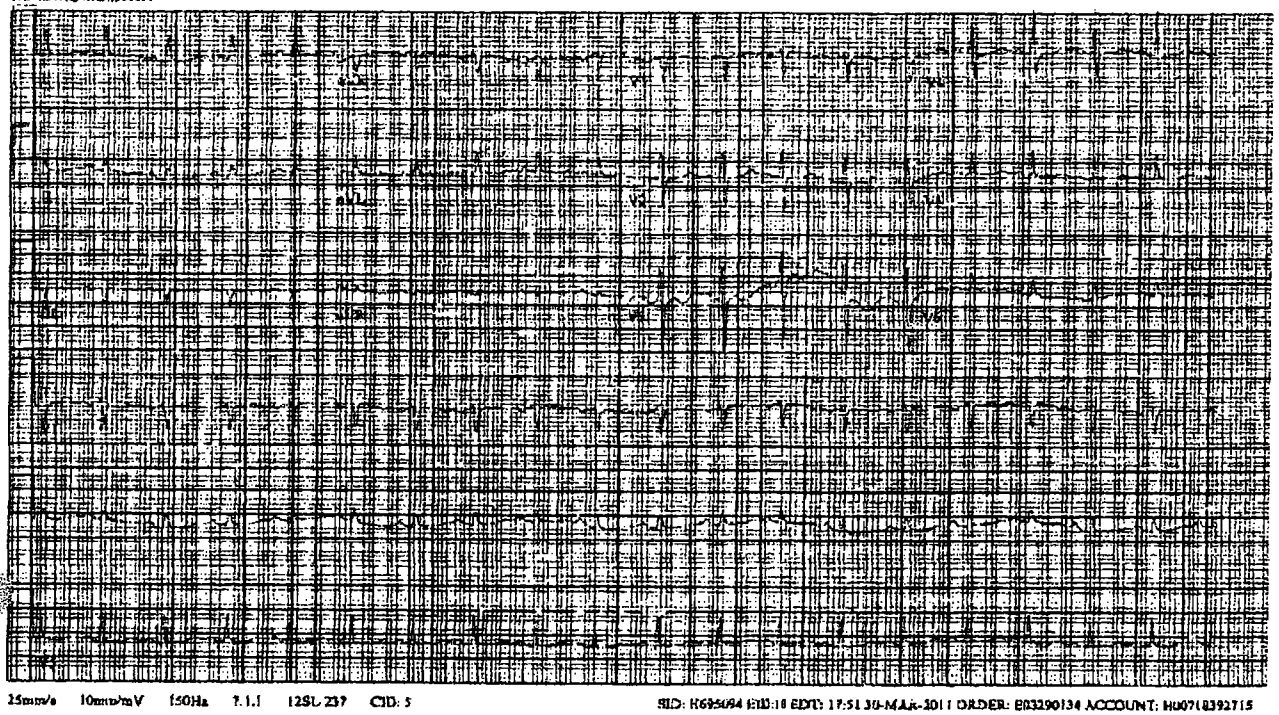
Sinus rhythm
No previous ECGs available
Confirmed by KHANT MD, RANCHOD (18) on 3/30/2011 5:51:10 PM

Technician: STEPHENSON
Test ind:CP

READING MD:STAFF

Referred by: Self Referred

Confirmed By: RANCHOD KHANT MD



25mm/s 10mm/mV 150Hz ?.1.1 12SL 237 CID: 5

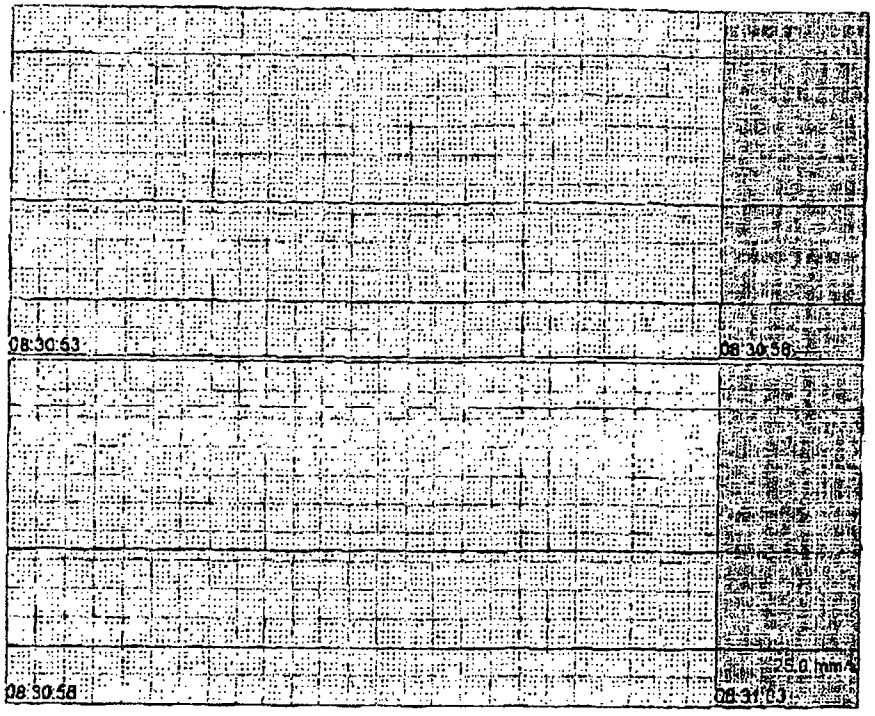
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Page 1 of 1

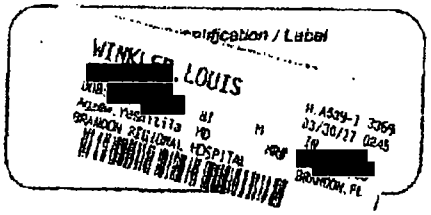
Patient:WINKLER, LOUIS MRN: [redacted] Encounter:H00718392715 Page 1 of 1

WINKLER, LOUIS Medical Record Number: [redacted] A539

Strip Report 4/3/2011 08:30:43



Telemetry Record



"TELE" DRH02673 rev 07/10

Page 2 of 2

Page 1 of 1

ICU5

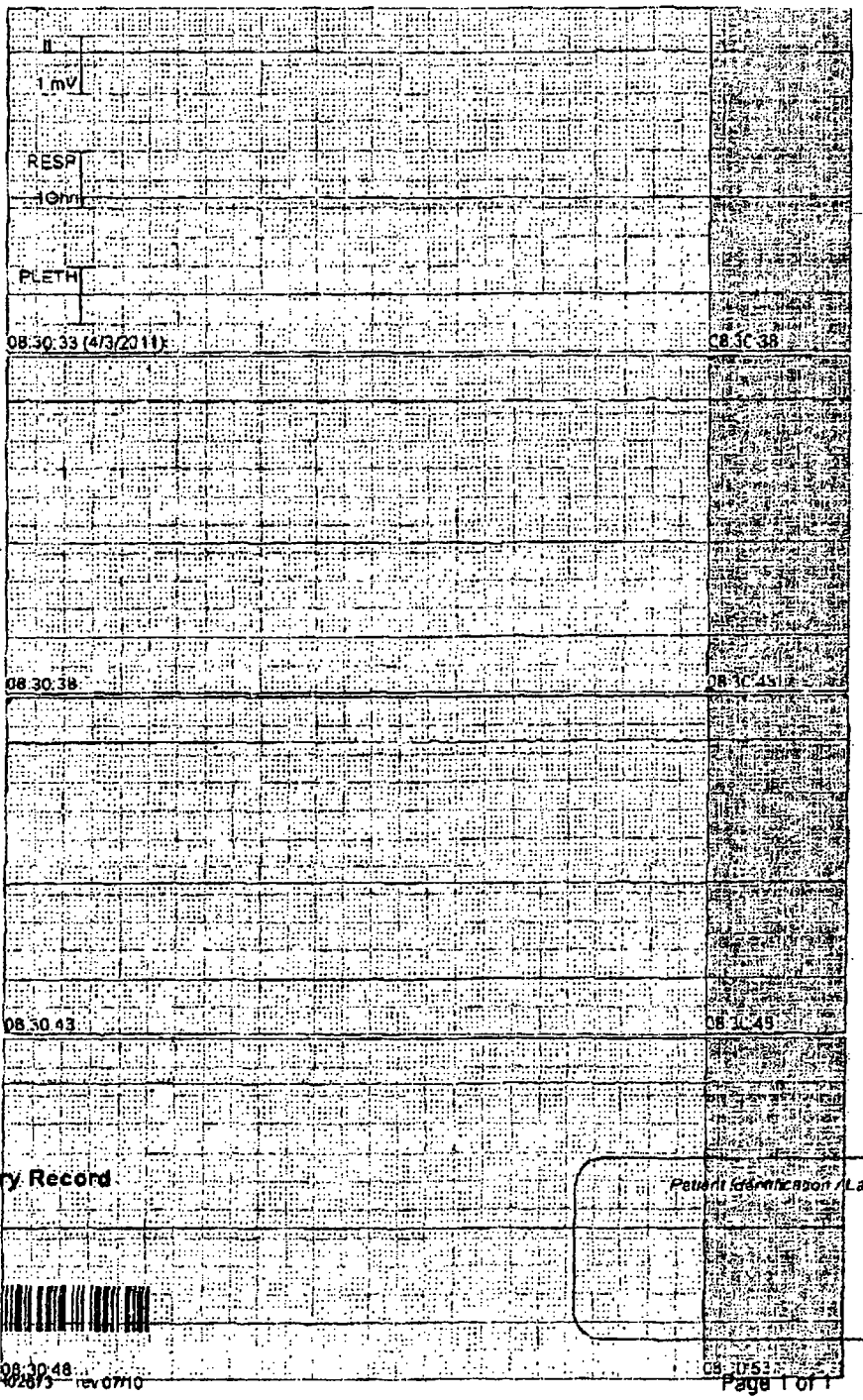
Patient:WINKLER, LOUIS MRN: [redacted] Encounter:H00718392715 Page 1 of 9

M 001494

WINKLER, LOUIS Medical Record Number: [redacted] A539

Strip Report 4/3/2011 08:30:43

HR 0 PVC 0 RESP 0



Telemetry Record

Patient Identification / Label

'TELE' BRH02673 rev 07/10

Page 1 of 2

ICU5

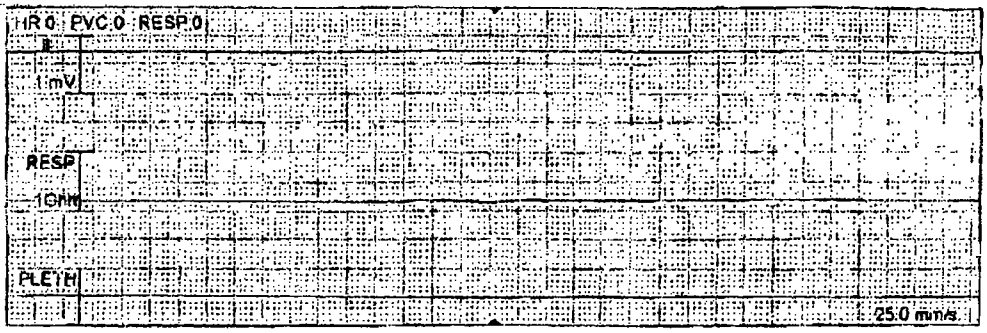
Page 1 of 1

M 001495

WINKLER, LOUIS Medical Record Number: H00710392715 A539

Strip Report

4/3/2011 08:30:43



Telemetry Record

Patient Identification / Label

"TELE" BRH02873 rev 07/10

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Page 1 of 1

ICU5

Patient:WINKLER, LOUIS MRN:[redacted] Encounter:H00710392715 Page 3 of 9

M 001496

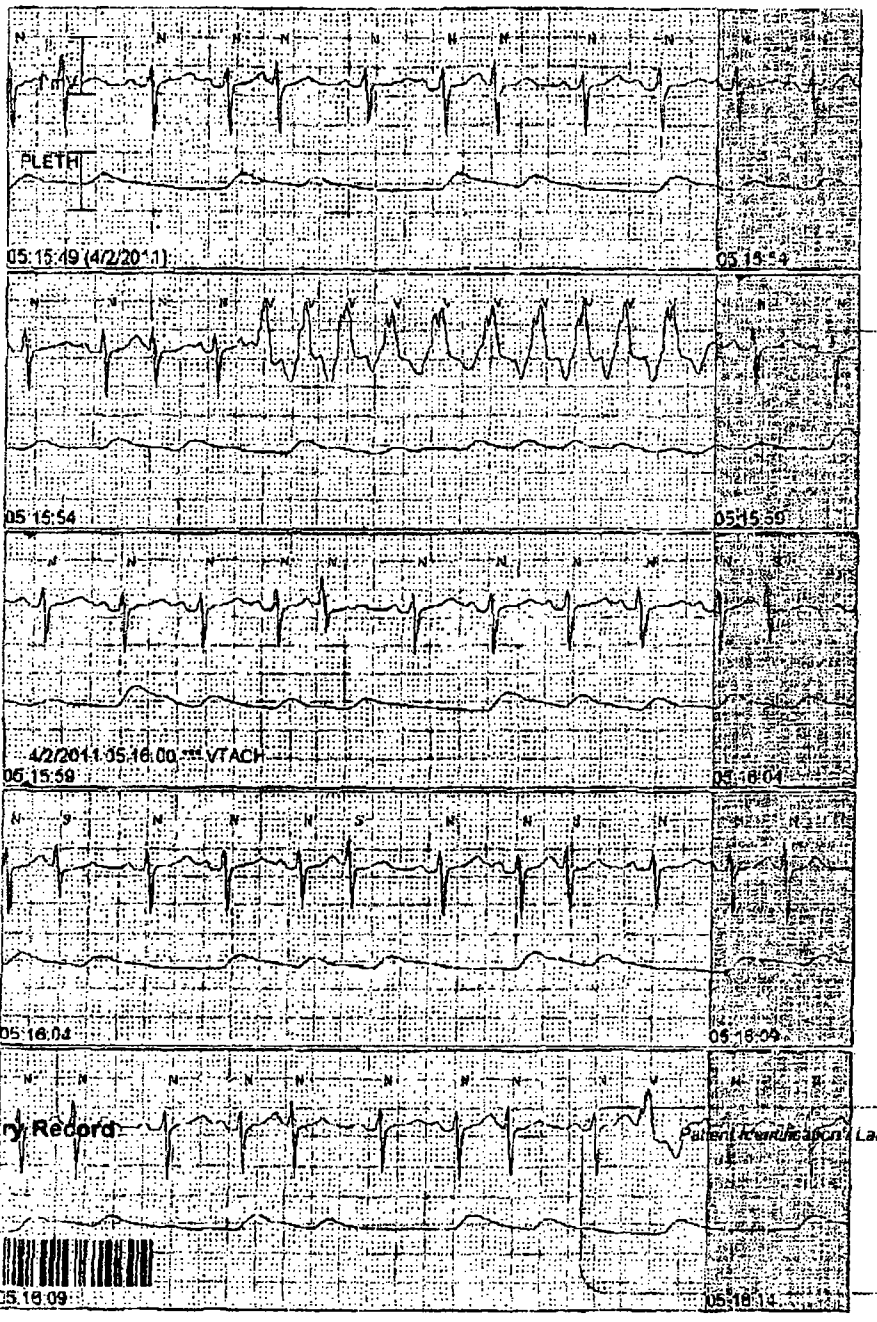
WINKLER, LOUIS Medical Record Number: [redacted] A539

Alarm Review

4/2/2011 05:16:00 *** VTACH

HR 140 %SpO2 98 NBP ?/?(?) PULSE 117 PVC 8

RESP 24



Telemetry Record

Patient Identification Label

TELE BRH02673 rev 07/10

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ICU5

ICU5

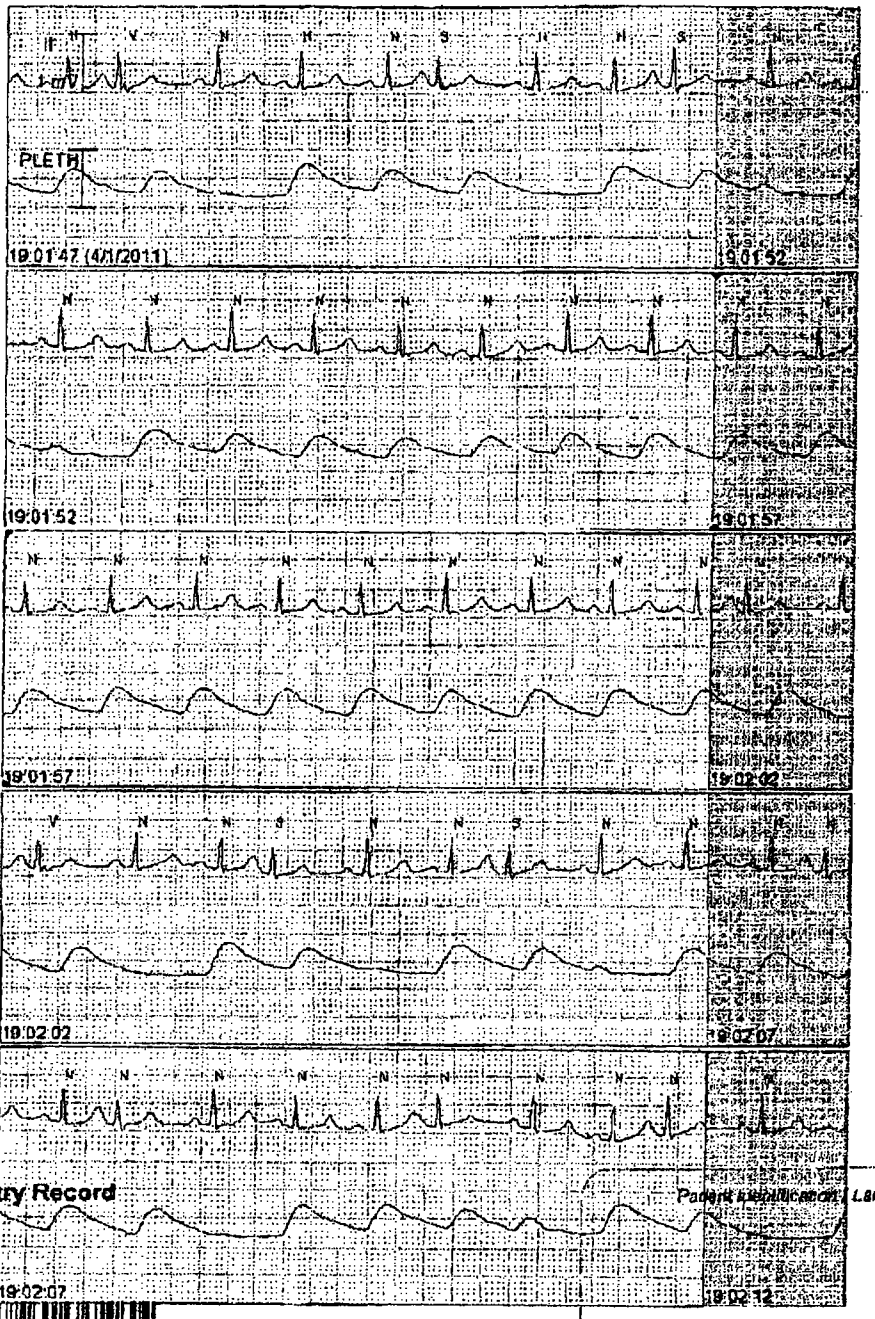
Patient:WINKLER, LOUIS MRN:[redacted]3 Encounter:H00718392715 Page 4 of 9

M 001497

WINKLER, LOUIS Medical Record Number: [redacted] A539

Strip Report. 4/1/2011 19:01:56

HR 108 %SpO2 97 PULSE 105 PVC 7 RESP 26



Telemetry Record

Patient Identification Label

'TELE' BRH02673 rev 07/10

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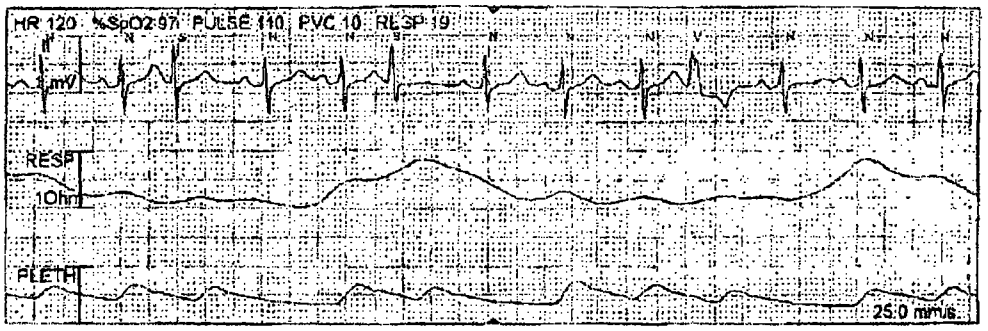
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M 001498

WINKLER, LOUIS Medical Record Number: [redacted] A539

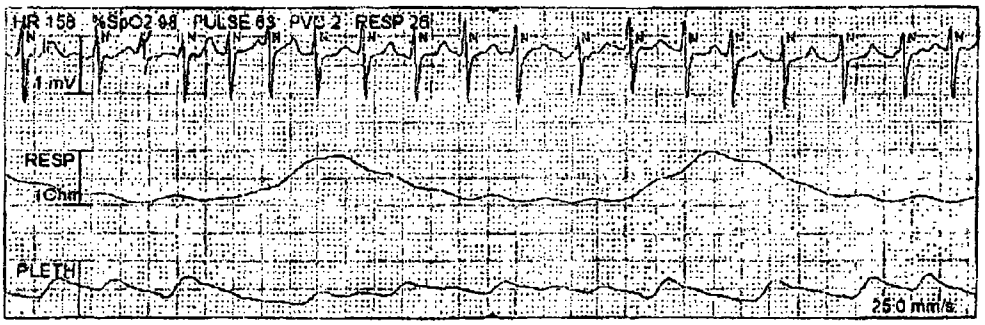
Strip Report

4/2/2011 19:58:00



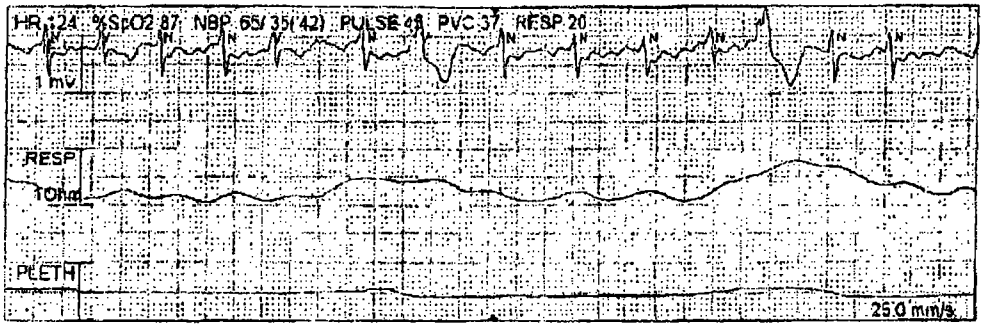
ST ↑ PVC'S

4/2/2011 23:58:00



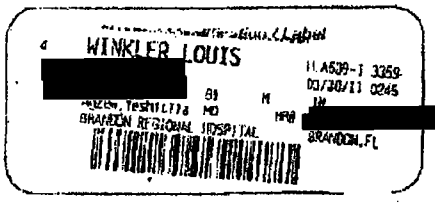
SVT

4/3/2011 03:58:00



SVT PVC's/PAC's

Telemetry Record



'TELE' BRH02673 rev 07/10

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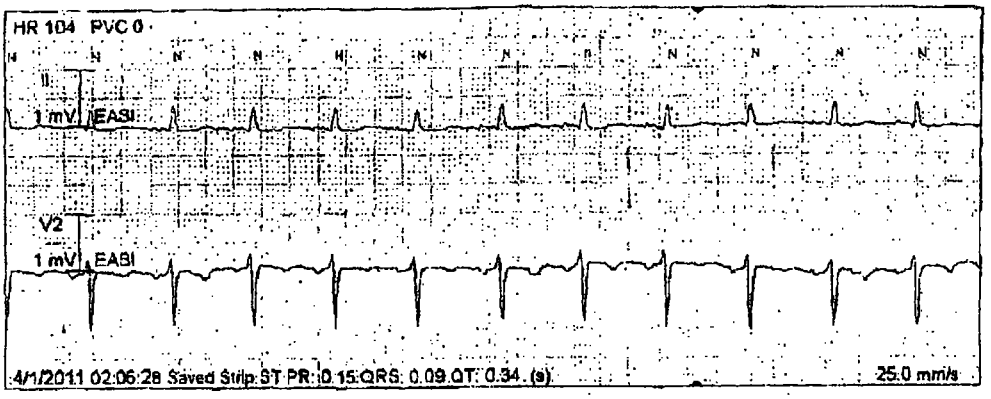
ICU5

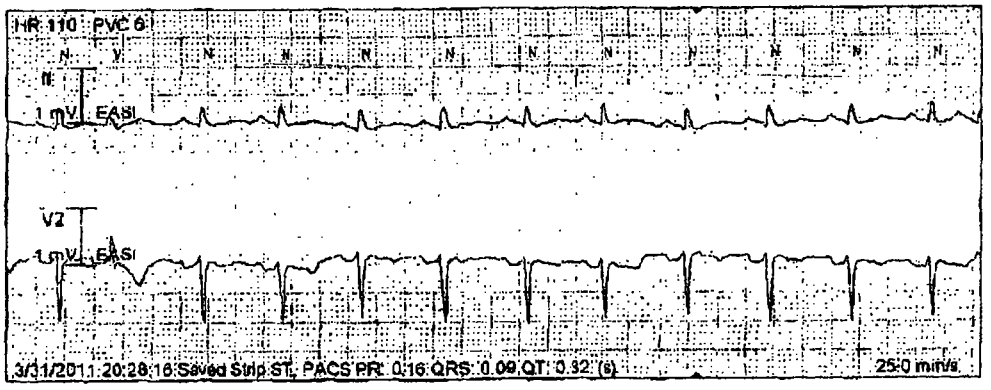
M 001499

318-1

WINKLER, LOUIS Medical Record Number: [redacted] TEL102

Alarm Review





Telemetry Record

Patient Identification / Label

'TELE' BRH02673 rev 07/10
Page 1 of 1

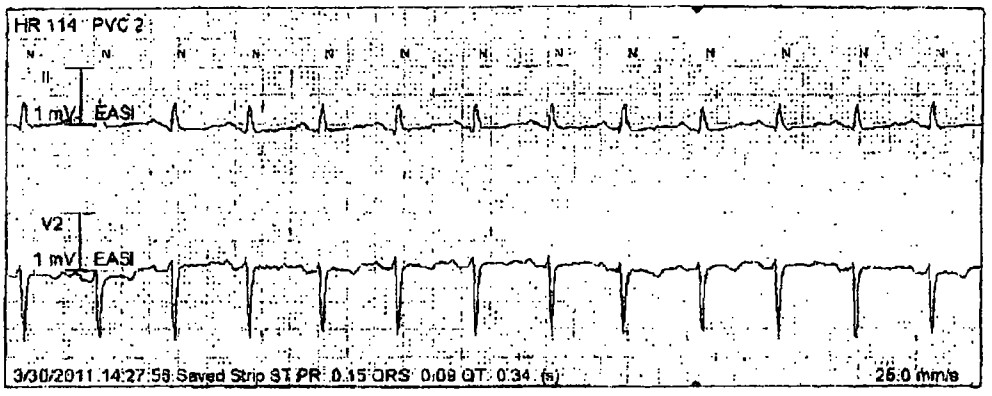
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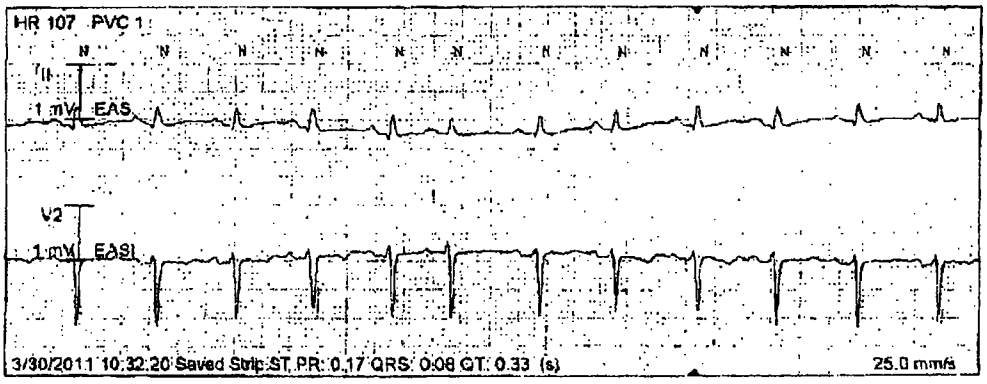
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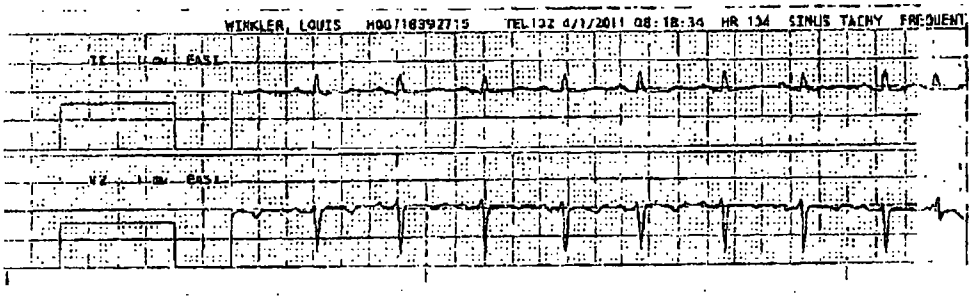
M 001500

WINKLER, LOUIS Medical Record Number: [redacted] TEL102

Alarm Review







Telemetry Record

Patient identification / Label

"TELE" BRH02673 rev 07/10

Page 1 of 1

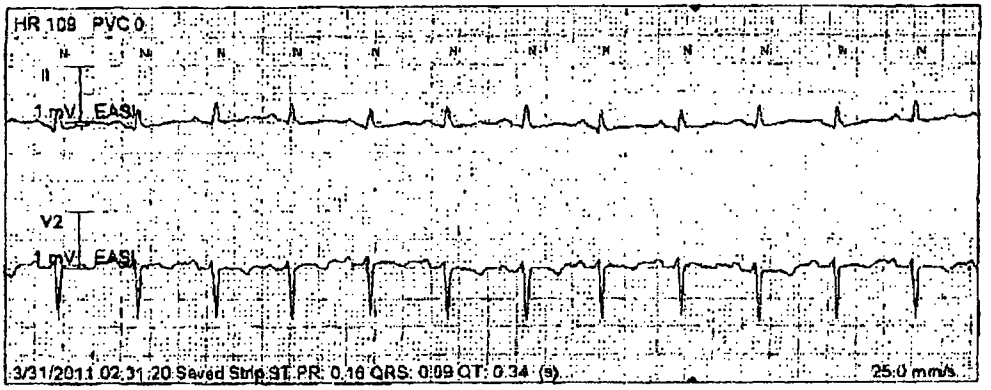
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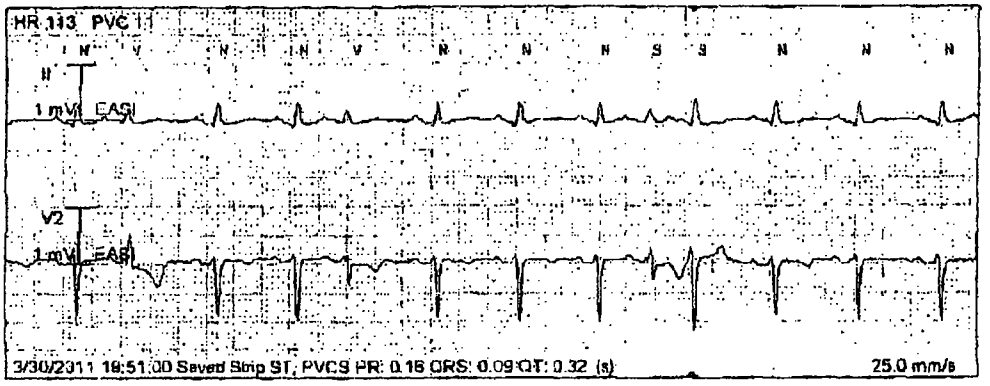
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318-1

WINKLER, LOUIS Medical Record Number: [redacted] TEL102

Alarm Review





Telemetry Record

Patient Identification / Label

"TELE" BRH02673 rev 07/10

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PCU

M 001502

04/12/11 0536 MEDICATION DISCHARGE SUMMARY PAGE: 1

NAME: WINKLER,LOUIS ADMIT DATE: 03/30/11 AGE: 81
UNIT #: DISCHARGE DATE: 04/03/11 SEX: M
ACCT #: STATUS: DIS Tbx
PHA ALLERGIES: No Known Allergies
ALLERGIES: No allergies recorded

ADMINISTRATION PERIOD: (0001 03/29/11 to 0000 03/30/11)	START / STOP	
SODIUM CHLORIDE 0.9% 1000 ML (SODIUM CHLORIDE 0.9% 1000 ML BAG) WD IV KI IN CD/STA RX #: 11733284	03/29/11 03/30/11	2256 HEDAMB at 2335 GAVE: 1000 MLS NDC/DIN: (SOURCE: eMAR) 0409795309 SODIL.938 - Sodium Chloride 0.9% 1000 Ml Ba Most common side effects reviewed with patient?: Yes :: SODIL.938:Peripheral Edema 03/29/11-2335 File Document by HEDAMB 2256 Order Entry PHDDR01 2320 Nursing Acknowledged Order HEDAMB
ACETAMINOPHEN 650MG (ACETAMINOPHEN (TYLENOL) 650 MG SUPP) 650 MG PR KI IN CD/STA RX #: 11733795	03/29/11 03/29/11	2357 HEDAMB at 2335 GAVE: 650 MG NDC/DIN: (SOURCE: eMAR) 59939973052 FEVERS6602 - Acetaminophen (Tylenol) 650 M.. Most common side effects reviewed with patient?: Yes :: FEVERS6602:Nausea, Rash Given for:: OTHER If other, specify:: FEVER 03/29/11-2335 File Document by HEDAMB 2357 Order Entry PHDDR01 2358 Pharmacy Discontinue SCHEDULER 2358 Nursing Acknowledged Order HEDAMB

ADMINISTRATION PERIOD: (0001 03/30/11 to 0000 03/31/11)	START / STOP	
SODIUM CHLORIDE 0.9% 1000 ML (SODIUM CHLORIDE 0.9% 1000 ML BAG) WD IV KI IN CD/STA RX #: 11733284	03/29/11 03/30/11	0455 Pharmacy Discontinue SCHEDULER

*** CONTINUED ON PAGE 2 ***
This document is part of the legal medical record.

ADMINISTRATION PERIOD	START/STOP		
GOAL: 03/30/11 to 0000 03/31/11 (CONTINUOUS)			
ISOVUE-300 61% 150ML BOT (ISOPAQUE 61% 156 ML ML) 100 ML IV .STR-MED/ONE RX #: 11733597	03/30/11 03/30/11	0132 HRDPCA at 0132 GAVE: 100 ML NDC/DIN: 02730131550 Most common side effects reviewed with patient?: Yes .. ISOVIV61:Refer to Clinical Pharmacology or contact Pharmacy 03/30/11-0134 File Document by HRDPCA 0132 Order Entry HRDPCA 0132 Pharmacy Discontinue STK MED	ISOVIV61 - Iopamidol 61% 150 Ml Ml
ROCEPHIN 1GM/DEXTROSE 50 ML 50 ML (ceftRIAXone NA/DEXTROSE,ISO 1 GM/50 ML ADVANTAGE) 200 MLS/HR IV XT 18 FD/STA Comments: CEFTRIAXONE 1GM/DEXW 50ML "DO NOT ADMINISTER SIMULTANEOUSLY WITH INTRAVENOUS CALCIUM OR CALCIUM CONTAINING MEDICATIONS" RX #: 11733636	03/30/11 03/30/11	0152 HMDAM8 at 0160 GAVE: 50 MLS NDC/DIN: (SOURCE: eMAR) 04987933018 Most common side effects reviewed with patient?: Yes .. CEFTIPM150:Na, rash, nausea/vomiting/diarrhea 03/30/11-0157 File Document by HMDAM8 0152 Order Entry ZHBBR01 0154 Warning Acknowledged Order HMDAM8 0205 Pharmacy Discontinue SCHEDULER	CEFTIPM150 - ceftRIAXone NA/DEXTROSE,ISO 1...
ROCEPHIN 1GM/DEXTROSE 50 ML 50 ML (ceftRIAXone NA/DEXTROSE,ISO 1 GM/50 ML ADVANTAGE) 100 MLS/HR IV 0240 RX #: 11733699	03/30/11 04/02/11	0259 Order Entry HRBDLG 0730 Nursing Acknowledged Order HEDHSB 2300 HNSBA04 at 2237 GAVE: 50 MLS NDC/DIN: (SOURCE: eMAR) 04987933304 03/30/11-2241 File Document by HNSBA04	CEFTIPM150 - ceftRIAXone NA/DEXTROSE,ISO 1...
SODIUM CHLORIDE 0.9% 1000 ML (SODIUM CHLORIDE 0.9% 1000 ML BAG) 100 MLS/HR IV AS DIRECTED RX #: 11733698	03/30/11 05/29/11	0259 Order Entry HRBDLG 0730 Nursing Acknowledged Order HEDHSB 0801 HEDHSB at 0801 GAVE: 1000 MLS NDC/DIN: (SOURCE: eMAR) 04999988309 03/30/11-0802 File Document by HEDHSB	SODIL.9SB - Sodium Chloride 0.9% 1000 Ml Bag
PRILOSEC 40MG CAPSULE (OMEPRAZOLE (PRILOSEC) 40 MG CAPSULE) 40 MG PO DAILY Comments: THERAPEUTIC INTERCHANGE TO OMEPRAZOLE Drug Ordered (Drug Dispensed Nexium (esomeprazole) 40 mg PO-omeprazole 40 mg PO RX #: 11733701	03/30/11 05/29/11	0259 Order Entry HRBDLG 0730 Nursing Acknowledged Order HEDHSB 1400 Not Administered HNSKAN02 at 1253 N APD .. 03/30/11-1253 File Document by HNSKAN02 1349 Pharmacy Discontinue HPENHR	

*** CONTINUED ON PAGE 3 ***
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04/12/11 0636 MEDICATION DISCHARGE SUMMARY PAGE: 3

NAME: WINKLER,LOUIS UNIT #: [redacted] ACCT #: [redacted]

ORDERS FOR THIS PERIOD	START/ STOP	
NovoLOG R 100 UNITS/ML VIAL (Insulin reg 100 UNITS/ML VIAL) See Dose Ins. SQ BEFORE MEALS AND AT BEDTIME Dose for: MEDIUM DOSE ALGORITHM BS 150 - 199 = 2 UNITS BS 200 - 249 = 4 UNITS BS 250 - 299 = 6 UNITS BS 300 - 349 = 8 UNITS BS > 349 = 10 UNITS PLEASE COORDINATE MEDICATION ADMINISTRATION TIME TO MEAL DELIVERY SCHEDULE RX #: 11713702	03/30/11 04/29/11	0759 Order Entry HRXULG 0700 MEDICATED at 0801 CO-SIGNED: HRSATO6 SITE: LUA - Left Upper Arm GAVE: 4 UNITS NDC/DIN: (SOURCE: eMAR) 0169103311 NOVOIV1001 - Insulin reg 100 UNITS/ML VIAL Glucose:: 218 Method:: FINGERSTICK Most common side effects reviewed with patient?: Yes :: NOVOIV1001:Hypoglycemia. Injection Site RXN. Pruritus. Weight Gain 03/30/11-0902 File Document by MEDTAB DOSE changed from UNITS to 4 UNITS 0758 Nursing Acknowledged Order MEDTAB 1130 HRSKAM02 at 1202 CO-SIGNED: HRUDOC L/E COMMENTS SITE: LUA - Left Upper Arm GAVE: 2 UNITS NDC/DIN: (SOURCE: eMAR) 0169103311 NOVOIV1001 - Insulin reg 100 UNITS/ML VIAL Glucose:: 170 Method:: FINGERSTICK DR PARK IN ROOM DOING DIGPSY 03/30/11-1233 File Document by HRSKAM02 DOSE changed from UNITS to 2 UNITS 1630 HRSKAM02 at 1719 CO-SIGNED: HRUDOC L/E COMMENTS SITE: LUA - Left Upper Arm GAVE: 4 UNITS Glucose:: 277 Method:: FINGERSTICK GIVEN AND SCANNED ALREADY 03/30/11-1711 File Document by HRSKAM02 DOSE changed from UNITS to 4 UNITS 2200 Not Administered HRSBMO4 at 2238 N FLPARAM Glucose:: 144 Method:: FINGERSTICK 03/30/11-2241 File Document by HRSBMO4
PRINIVIL 5MG (LISINOPRIL (PRINIVIL) 5 MG ORTAB) 5 MG PO TWICE DAILY RX #: 11713704	03/30/11 05/29/11	0306 Order Entry HRXULG 0731 Nursing Acknowledged Order MEDTAB 1000 Not Administered HRSKAM02 at 1233 N APO 03/30/11-1234 File Document by HRSKAM02 2200 HRSBMO4 at 2238 GAVE: 5 MG NDC/DIN: (SOURCE: eMAR) 68084080811 PRIMPI5100 - Lisinopril (Prinivil) 5 MG Ortab Most common side effects reviewed with patient?: Yes :: PRINOT5100:Pnfl Total bone or mortality. Angioedema (head / neck). Cough 03/30/11-2241 File Document by HRSBMO4

*** CONTINUED ON PAGE 4 ***
This document is part of the legal medical record.

04/12/11 0535 MEDICATION DISCHARGE SUMMARY PAGE: 4

NAME: WINKLER,LOUIS UNIT #: [redacted] ACCT #: [redacted]

ADMINISTRATION PERIOD. BEGIN: 03/30/11 715 LOCAL 04/01/11 TODAY'S DATE	START/ STOP	
LACTINEX TABLET CHEWABLE (ACIDOPHILUS/BULGARICUS) 1 TAB TAB.CHEW) 1 TAB PO TWICE DAILY RX #: 11733705	03/30/11 04/09/11	0305 Order Entry HRXOLG 0711 Nursing Acknowledged Order HEDIGB 1020 Not Administered HNSKAN02 at 1252 # NPO 03/30/11-1238 File Document by HNSKAN02 2200 HNSHN04 at 2241 GAVE: 1 TAB NDC/DIN: (SOURCE: eMAR) 49281056 Most common side effects reviewed with patient: Yes .: ACIDOP50:Flatulence, nausea/vomiting 03/30/11-2241 File Document by HNSBN04 ACIDOP50 - Acidophilus/Bulgaricus 1 Tab ...
HYDREA 500MG (HYDROXYUREA (HYDREA) 500 MG CAP) 500 MG PO THREE TIMES DAILY Comments: **CAUTION CHEMOTHERAPY** DO NOT CUT OR CRUSH HEALTHCARE WORKERS SHOULD WEAR GLOVES TO ADMINISTER RX #: 11733708	03/30/11 04/29/11	0306 Order Entry HRXOLG 0537 Nursing Acknowledged Order HEDAHB 0600 HEDMPP at 0604 GAVE: 500 MG NDC/DIN: (SOURCE: eMAR) 66993811 Most common side effects reviewed with patient?: Yes .: HYDROC500:Nausea, vomiting 03/30/11-0604 File Document by HEDMPP 1024 Nursing DC HRSEPN ORDER FAXED TO PHARM 1056 Nursing DC HRXHSB 1096 Pharmacy Discontinue HRXHSB 1544 Nursing Acknowledged Order HNSCHH HYDROC500 - Hydroxyurea (Hydrea) 500 MG Cap
SYNTHROID 0.025MG (LEVOTHYROXINE SODIUM (SYNTHROID) 0.025 MG ORTAB) 0.025 MG PO DAILY RX #: 11733708	03/30/11 04/29/11	0307 Order Entry HRXOLG 0537 Nursing Acknowledged Order HEDAHB 0600 HEDMPP at 0604 GAVE: 0.025 MG NDC/DIN: (SOURCE: eMAR) 51079044401 Most common side effects reviewed with patient?: Yes .: LEVOOT.025:Headache, sweating, increased pulse rate 03/30/11-0604 File Document by HEDMPP LEVOOT.025 - Levothyroxine Sodium (Synthrd...
XYLOCAINE/EPI 1%-1:100000 (LIDOCAINE HCL 1% W/EPIN 30 ML VIAL) See Dose Inc. NOTE AS DIRECTED Dose Ins. AS DIRECTED Comments: FOR PROCEDURE RX #: 11714602	03/30/11 03/30/11	1206 Order Entry HRXOLG 2050 Pharmacy Discontinue SCHEDULER

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ADMINISTRATION INSTRUCTIONS ORDER STATUS/ORDERING CLINICIAN (DOCTOR/NURSE)	START/STOP	
BETASEPT 4% LIQUID (CHLORHEXIDINE GLUCONATE 4 OZ LIQUID) See Dose Ins. TOPICAL AS DIRECTED Dose Ins: AS DIRECTED RX #: 11734603	03/30/11 03/30/11	1209 Order Entry HRXHR 1210 Canceled Order HREKER
BETADINE 10% SOLUTION (POVIDONE-IODINE 10% 120 ML BOTT) See Dose Ins. TOPICAL AS DIRECTED Dose Ins: AS DIRECTED RX #: 11734604	03/30/11 03/30/11	1211 Order Entry HRXHR 1216 Canceled Order HRXHR
PROTONIX (PANTOPRAZOLE (PROTONIX IV) 40 MG/VIAL) 40 MG IV DAILY RX #: 11734970	03/30/11 05/29/11	1440 HANSKAM02 at 1501 I/F RTN ORDER GAVE: 40 MG ROC/DIN: (SOURCE: eMAR) 00068092351 PROTOR(IV40 - Pantoprazole (Protonix IV) 40.. Most common side effects reviewed with patient?: Yes :: PROTONIV40:Headache, Diarrhea 03/30/11-1522 File Document by HNSKAM02 1350 Admin Criteria Entered HRXHR 1350 Order Entry HRXHR 1452 Nursing Acknowledged Order HNSKAM02
CLARIFY ORDER-MEDICATION (CLARIFY ORDER-MEDICATION) See Dose Ins. NOTE TWICE DAILY Dose Ins: TYLENOL Comments: CLARIFY ORDR: TYLENOL INDICATION? RX #: 11734972	03/30/11 05/29/11	1450 Order Entry HRXHR 2208 Not Administered HNSBM04 at 03/31/11 - 0236 N COMMENTS TB SCANNED 03/31/11-0237 File Document by HNSBM04
TYLENOL 325MG (ACETAMINOPHEN 325 MG CDTAB) 650 MG PO EVERY 4H AS NEEDED/PRN PRN Reason: PRN PAIN/TEMP RX #: 11733699	03/30/11 04/29/11	0258 Order Entry HRXDLG 0738 Nursing Acknowledged Order HEIDOB 2237 HNSBM04 at 2237 GAVE: 650 MG ROC/DIN: (SOURCE: eMAR) 63739440601 ACETOT3224 - Acetaminophen 325 MG Uitab Given for:: PAIN If other, specify:: 6 03/30/11-2241 File Document by HNSBM04
ZOFRAN 2MG/ML (ONDANSETRON HCL (ZOFRAN) 4 MG/2 ML VIAL) 4 MG IV EVERY 6H AS NEEDED/PRN PRN Reason: NAUSEA RX #: 11733700	03/30/11 05/29/11	0258 Order Entry HRXDLG 0738 Nursing Acknowledged Order HEIDOB

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ADMINISTRATION PERIOD: (DATE ADMINISTERED OR ANTICIPATED)	START/STOP	
DEXTROSE 50%/WATER ADD-VANTAGE (DEXTROSE 50% WATER 50 ML SYR) See Dose Ins. IV AS DIRECTED/PRN PRN Reason: DAILY @ AS NEEDED Dose Ins: *** SEE COMMENTS *** Comments: HYPOGLYCEMIA PROTOCOL: FOR BG < 70 OR SIGNS AND SYMPTOMS PRESENT A. IF PATIENT CAN TAKE PO GIVE 15 GMS FAST ACTING CARBS (E.G. 4OZ JUICE REG SODA). B. IF PATIENT IS NPO AND MAKE GIVE 25 ML OF D50 IV PUSH. C. IF PATIENT IS NOT RESPONSIVE GIVE 50 ML OF D50 IV PUSH. D. IF NO IV ACCESS GIVE GLUCAGON 1 MG SQ. MAY REPEAT IN 15 MINUTES PRN. E. CHECK FINGER STICK BLOOD GLUCOSE EVERY 15 MINUTES AND REPEAT TREATMENT IF BLOOD GLUCOSE IS <80. F. CALL PHYSICIAN FOR POSSIBLE INSULIN ADJUSTMENT. RX #: 11733763	03/10/11 05/28/11	0259 Order Entry HRXLG 0730 Nursing Acknowledged Order HECOXB
HYDROCODONE BITARTRATE/APAP (VICODIN 5/500) 1 EA (1 TAB) 1 EA PO EVERY 12HOURS AS NEEDED/PRN PRN Reason: PRN PAIN Comments: **MAX DOSE 8 TABS PER 24 HOUR PERIOD** CHART EXACT DOSE GIVEN FOR ALL DOSAGE RANGES RX #: 11733707	03/30/11 04/29/11	0307 Order Entry HRXLG 0731 Nursing Acknowledged Order HECOXB
ACETAMINOPHEN 650MG (ACETAMINOPHEN (TYLENOL) 650 MG SUPP) 650 MG PR EVERY 4H AS NEEDED/PRN PRN Reason: FEVER RX #: 11734993	03/30/11 04/29/11	1350 Order Entry HRXLR 1519 Nursing Acknowledged Order HNSKAM02 1522 HNSKAM02 at 1522 GAVE: 650 MG NDC/BIN: (SOURCE: eMAR) 07134016506 (FEVER6502 - Acetaminophen (Tylenol) 650 M... Given for:: OTHER If other, specify:: TEMP 03/30/11-1522 File Document by HNSKAM02
ADMINISTRATION PERIOD: (DATE ADMINISTERED OR ANTICIPATED)	START/STOP	

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ADMINISTRATION DETAILS	START/STOP	
0401 04/12/11 ro 0700 (PRN/PCA) (continued)	STOP:	
ROCEPHIN 1GM/DEXTROSE 50 ML 50 ML (ceFTRIAXone HA/DEXTROSE.ISO 1 GM/50 ML ADVANTAGE) 100 MLS/HR IV Q24H RX #: 11273897	03/30/11 04/02/11	1650 Pharmacy Edit or Verification COMPLT 1822 Nursing Acknowledgment Order HNSKAM02 2320 HNSBM04 at 2246 GAVE: 50 MLS MDC/DIN: (SOURCE: eMAR) 01409733304 CEFTI/PM150 - ceftRIAXone HA/DEXTROSE.ISO 1... 03/31/11-2247 File Document by HNSBM04
NovoLIN R 100 UNITS/ML VIAL (Insulin reg 100 UNITS/ML VIAL) See Dose Inv, SQ BEFORE MEALS AND AT BEDTIME Dose Ins: MEDIUM DOSE ALGORITHM BS 150 - 199 = 2 UNITS BS 200 - 249 = 4 UNITS BS 250 - 299 = 6 UNITS BS 300 - 349 = 8 UNITS BS > 349 = 10 UNITS PLEASE COORDINATE MEDICATION ADMINISTRATION TIME TO MEAL DELIVERY SCHEDULE RX #: 11733702	03/30/11 04/29/11	0700 HNSBM04 at 0701 CO-SIGNER: HNSMCT SITE: LUA - Left Upper Arm GAVE: 2 UNITS MDC/DIN: (SOURCE: eMAR) 01693983311 NOVOIV1001 - Insulin reg 100 UNITS/ML VIAL Glucose:: 202 Method:: FINGERSTICK 03/31/11-0702 File Document by HNSBM04 DOSE changed from UNITS to 2 UNITS 1130 HNSKAP02 at 1309 CO-SIGNER: HNLUIP L/C OFF UNIT SITE: LUA - Left Upper Arm GAVE: 2 UNITS MDC/DIN: (SOURCE: eMAR) 01693983311 NOVOIV1001 - Insulin reg 100 UNITS/ML VIAL Glucose:: 198 Method:: FINGERSTICK AT CAT SCAN 03/31/11-1310 File Document by HNSKAP02 DOSE changed from UNITS to 2 UNITS 1630 HNSKAP02 at 1637 CO-SIGNER: HNLUIP SITE: LUA - Left Upper Arm GAVE: 2 UNITS Glucose:: 176 Method:: FINGERSTICK 03/31/11-1637 File Document by HNSKAM02 DOSE changed from UNITS to 2 UNITS 2300 HNSBM04 at 2246 CO-SIGNER: HNSIEB SITE: LUA - Left Upper Arm GAVE: 2 UNITS MDC/DIN: (SOURCE: eMAR) 01693983311 NOVOIV1001 - Insulin reg 100 UNITS/ML VIAL Glucose:: 125 Method:: FINGERSTICK 03/31/11-2247 File Document by HNSBM04 DOSE changed from UNITS to 2 UNITS

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ORDERS FOR PERIOD: 03/31/11 TO 04/12/11	START/ STOP		
PRINIVIL 5MG (LISINOPRIL (PRINIVIL) 5 MG ORTAB) 5 MG PO TWICE DAILY RX #: 11733764	03/30/11 05/29/11	1000 HNSKAM02 at 1055 GAVE: 5 MG NDC/DIN: (SOURCE: eMAR) 68084060211 03/31/11-1057 File Document by HNSKAM12 2100 HNSBH04 at 2245 GAVE: 5 MG NDC/DIN: (SOURCE: eMAR) 68084060211 03/31/11-2247 File Document by HNSBH04	PRIOOT5100 - Lisinopril (Prinivil) 5 MG ORTab PRIOOT5100 - Lisinopril (Prinivil) 5 MG ORTab
LACTIBEX TABLET CHEWABLE (ACIDOPHILUS/BULGARICUS 1 TAB TAB.CHEW) 1 TAB PO TWICE DAILY RX #: 11733705	03/30/11 04/08/11	1000 HNSKAM02 at 1056 L/E COMMENTS GAVE: 1 TAB MONT SCAN 03/31/11-1057 File Document by HNSKAM02 2200 HNSBH04 at 2246 GAVE: 1 TAB NDC/DIN: (SOURCE: eMAR) 49000129501 03/31/11-2247 File Document by HNSBH04	ACIDOT50 - Acidophilus/Bulgaricus 1 Tab ...
SYNTHROID 0.025MG (LEVOTHYROXINE SODIUM (SYNTHROID) 0.025 MG ORTAB) 0.025 MG PO DAILY RX #: 11733708	03/30/11 04/29/11	0600 HNSBH04 at 0701 L/E SLEEPING GAVE: 0.025 MG NDC/DIN: (SOURCE: eMAR) 51079044401 03/31/11-0702 File Document by HNSBH04	LEVOOT.025 - Levothyroxine Sodium (Synthro...
PROTONIX (PANTOPRAZOLE (PROTONIX IV) 40 MG/VIAL) 40 MG IV DAILY RX #: 11734970	03/30/11 05/29/11	1000 HNSKAM02 at 1055 GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 00008023611 03/31/11-1057 File Document by HNSKAM02	PROTONIV40 - Pantoprazole (Protonix IV) 40...
CLARIFY ORDER-MEDICATION (CLARIFY ORDER-MEDICATION) See Dose Ins. NOTE TWICE DAILY Dose Ins: TYLENOL Comments: CLARIFY ORDER: TYLENOL (MEDICATION) RX #: 11734972	03/30/11 05/29/11	0236 Nursing Acknowledged Order HNSBH04 1000 Not Administered HNSKAM02 at 1056 R COMMENTS WAITING FOR CLARIFICATION 03/31/11-1057 File Document by HNSKAM02 2200 Not Administered HNSBH04 at 2247 L/E COMMENTS for fever 03/31/11-2247 File Document by HNSBH04	

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ADMINISTRATION PERIOD ORDER EFFECTIVE DATE/TIME (Continued)	START/ STOP	
READI-CAT 2 (BARIUM SULFATE (READI-CAT 2) 460 MG ORAL SUSP) 225 ML PO NS DIRECTED Comments: READICAT 225 ML PO EVERY 30 MINUTES X 4 DOSES DOSES DUE AT 0900, 1300, 1930, AND 2100. EXAM SCHEDULED FOR 1130. PLEASE NOTIFY RADIOLOGY/PHARMACY OF ANY CHANGE IN SCHEDULED TIMES. RX #: 11737142	03/31/11 04/02/11	0914 Order Entry CDETHT
FOLIC ACID 1MG (FOLIC ACID 1 MG UNITAB) 1 MG PO DAILY RX #: 11737741	03/31/11 04/30/11	0947 Order Entry CDETHT 1008 HNSEAH02 at 1055 GAVE: 1 MG NDC/BIN: (500/OF: uNAB) 62584869716 FOLIO11104 - Folic Acid 1 MG UnitAb Most common side effects reviewed with patient?: Yes :: FOLIO11104:Fleming, Malaise, Pruritus, Rash 03/31/11-1057 File Document by HNSEAH02 1055 Nursing Acknowledged Order HNSEAH02
ISOVUE-300 61% 150ML BOT (IOPAMIDOL 61% 150 ML ML) 100 ML IV STK-MED/CONE RX #: 11737744	03/31/11 03/31/11	1300 HRESMM at 1301 GAVE: 100 ML NDC/BIN: 02/0301600 ISOVI161 - Iopamidol 61% 150 Ml Mf ADMIN CONFLICTS: Duplicates reviewed. 03/31/11-1301 File Document by HRESMM 1301 Order Entry RWUSMM 1301 Pharmacy Discontinue STK MED

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ADMINISTRATION PERIOD: ORDER DESCRIPTION AND ORDER COMMENTS	START/ STOP	
LOVENOX 30MG (ENOXAPARIN (LOVENOX) 30 MG/0.3 ML SYR) 30 MG SQ Q24H Comments: do not administer while on epidural **** ADMINISTER DEEP SC INJECTION INTO ANTEROLATERAL/POSTEROLATERAL (LOVENOX) ABDOMINAL WALL *ALTERNATE SITES DAILY* *TO AVOID LOSS OF DOSE, DO NOT EXPEL AIR BUBBLE BEFORE INJECTION* *DO NOT ADMINISTER IM* *DO NOT RUB OR ASPIRATE AFTER INJECTION* RX #: 11737981	03/31/11 04/30/11	1428 Admin Criterion Entered HRXCNF 1420 Order Entry HRXCNF 1618 Nursing Acknowledged Order HNSKAM02 1600 HNSKAM02 at 1616 SITE: LAB - Left Abdomen GAVE: 30 MG NDC/DIN: (SOURCE: eMAR) 67457331963 LOVE0030.3 - Enoxaparin (Lovenox) 30 MG/0... PT/FM UNDERSTANDS:COMPLIANCE,ADR/INTER,DIET,F/U INFO: Y Most common side effects reviewed with patient?: Yes :: LOVE0030.3rash, fever, injection site reaction, bruising 03/31/11-1637 File Document by HNSKAM02
SODIUM CHLORIDE 0.45% SOLN 1000ML, 1000 ML (SODIUM CHLORIDE 0.45% 1000 ML BAG) 100 MLS/HR IV AS DIRECTED RX #: 11737982	03/31/11 04/01/11	1428 Order Entry HRXCNF 1532 Nursing Acknowledged Order HNSKAM02 1617 HNSKAM02 at 1637 GAVE: 1000 MLS NDC/DIN: (SOURCE: eMAR) 00409708509 SODI0L.45 - Sodium Chloride 0.45% 1000 ML... 03/31/11-1637 File Document by HNSKAM02
SODIUM CHLORIDE 0.45% SOLN 1000ML 1000 ML (SODIUM CHLORIDE 0.45% 1000 ML BAG) 70 ML/HR IV AS DIRECTED RX #: 11737983	03/31/11 05/30/11	1428 Order Entry HRXCNF
ACETAMINOPHEN 650MG (ACETAMINOPHEN (TYLENOL) 650 MG SUPP) 650 MG PR EVERY 6H AS NEEDED/PRN PRN Reason: FEVER RX #: 11734971	03/30/11 04/29/11	1052 HNSKAM02 at 1057 GAVE: 650 MG NDC/DIN: (SOURCE: eMAR) 67130716506 FEVER6502 - Acetaminophen (Tylenol) 650 M... Given for:: OTHER If other, specify:: FEVER 03/31/11-1057 File Document by HNSKAM02
ADMINISTRATION PERIOD: ORDER DESCRIPTION AND ORDER COMMENTS	START/ STOP	
0001 04/01/11 to 0859 04/02/11		

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04/12/11 0855	MEDICATION DISCHARGE SUMMARY	PAGE: 11
NAME: WINKLER,LOUIS	UNIT #: [redacted]	ACCT #: [redacted]

ADMINISTRATION PERIOD 9301 04/01/11 thru 0000 04/12/11 (Continued)	START / STOP	
SODIUM CHLORIDE 0.9% 1000 ML (SODIUM CHLORIDE 0.9% 1000 ML BAG) WO IV X1 IN ED/STA RX #: 11733384	03/29/11 03/30/11	1931 Nursing Acknowledged Order HNSRP03
ISOVUE-300 0.LE 150ML BOT (IOPAMIDOL 61% 150 ML ML) 100 ML IV .STK-MED/ONE RX #: 11733597	03/30/11 03/30/11	1931 Nursing Acknowledged Order HNSRP03
ROCEPHIN 1GM/DEXTROSE 50 ML 50 ML (ceFTRIAXone NA/DEXTROSE,ISO 1 GM/50 ML ADVANTAGE) 207 MLS/HR IV X1 IN ED/STA Comments: CEFTRIAXONE 1GM/DEX 50ML *DO NOT ADMINISTER STERILTANEOUSLY WITH INTRAVENOUS CALCIUM OR CALCIUM CONTAINING MEDICATIONS* RX #: 11735606	03/30/11 03/30/11	1931 Nursing Acknowledged Order HNSRP03
ROCEPHIN 1GM/DEXTROSE 50 ML 50 ML (ceFTRIAXone NA/DEXTROSE,ISO 1 GM/50 ML ADVANTAGE) 103 MLS/HR IV Q24H RX #: 11733699	03/30/11 04/02/11	2000 HNSRP03 at 2233 GAVE: 50 PLS NDC/DIN: (SOURCE: eMAR) 11409733204 CEFTIAM150 - ceFTRIAXone NA/DEXTROSE,ISO 1.. 04/01/11-2233 File Document by HNSRP03
PRILOSEC 40MG CAPSULE (OMEPRAZOLE (PRILOSEC) 40 MG-CAPSULE) 40 MG PO DAILY Comments: THERAPEUTIC INTERCHANGE to OMEPRAZOLE Drug Ordered Drug Dispensed Nexium (esomeprazole) 40 mg PO-omeprazole 40 mg PO RX #: 11733701	03/30/11 05/29/11	1932 Nursing Acknowledged Order HNSRP03

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ADMINISTRATION PERIOD	START/ STOP	
Novol IN U IGO UNITS/ML VIAL (Insulin reg 100 UNITS/ML VIAL) See Dose Ins. SQ BEFORE MEALS AND AT BEDTIME Dose Ins: MEDIUM DOSE ALGORITHM BS 150 - 199 = 2 UNITS BS 200 - 249 = 4 UNITS BS 250 - 299 = 6 UNITS BS 300 - 349 = 8 UNITS BS > 349 = 10 UNITS PLEASE COORDINATE MEDICATION ADMINISTRATION TIME TO MEAL DELIVERY SCHEDULE RX #: 11733702	03/30/11 04/29/11	0700 Not Administered HNSBM04 at 0608 W CLPARAM Glucose:: 141 Method:: FINGERSTICK 04/01/11-0608 File Document by HNSBM04 1130 Not Administered HNSCMP04 at 1301 W GLUMDP Glucose:: 137 Method:: FINGERSTICK 04/01/11-1201 File Document by HNSCMP04 1411 Pharmacy Discontinue HNUCMF 1932 Nursing Acknowledged Order HNSRP03	
PROBIOTIC SMG (LISINOPRIL (PRINIVIL) 5 MG ORTAB) 5 MG PO TWICE DAILY RX #: 11733704	03/30/11 05/29/11	1000 HNSCMP04 at 1202 W SLEEPING GAVE: 5 MG 04/01/11-1203 File Document by HNSCMP04 2200 HNSRP03 at 2233 GAVE: 5 MG NDC/DIN: (SOURCE: uMAR) 60505486011 04/01/11-2251 File Document by HNSRP03	PROBIOTIC - Lisinopril (Prinivil) 5 MG Ortab
LACTIMEX TABLET CHEWABLE (ACIDOPHILUS/BULGARICUS 1 TAB TAB.CHEW) 1 TAB PO TWICE DAILY RX #: 11733705	03/30/11 04/08/11	1000 Not Administered HNSCMP04 at 1202 W SLEEPING 04/01/11-1201 File Document by HNSCMP04 2200 Not Administered HNSRP03 at 2234 E PT REFUSED 04/01/11-2234 File Document by HNSRP03	
SYNTHROID 0.025MG (LEVOTHYROXINE SODIUM (SYNTHROID) 0.025 MG UDTAB) 0.025 MG PO DAILY RX #: 11733708	03/30/11 04/29/11	0600 HNSBM04 at 0608 GAVE: 0.025 MG NDC/DIN: (SOURCE: uMAR) 51079044401 04/01/11-0609 File Document by HNSBM04	LEVOOT.025 - Levothyroxine Sodium (Synthro..
XYLOCAINE/EPI IN-1:100000 (LIDOCAINE HCL IN W/EPIN 30 ML VIAL) See Dose Ins. MIXI AS DIRECTED Dose Ins. AS DIRECTED Comments FOR PROCEDURE RX #: 11734602	03/30/11 03/30/11	1932 Nursing Acknowledged Order HNSRP03	

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ADMINISTRATION PERIOD ORDER DESCRIPTION AND ADDITIONAL COMMENTS	START/ STOP	
BETASEPT 4% LIQUID (CHLORHEXIDINE GLUCONATE 4 OZ LIQUID) See Dose Ins. TOPICAL AS DIRECTED Dose Ins: AS DIRECTED RX #: 11734603	03/30/11 03/30/11	1932 Nursing Acknowledged Order HNSRP03
BETADINE 10% SOLUTION (POVIDONE-IODINE 10% 120 ML BOT) See Dose Ins. TOPICAL AS DIRECTED Dose Ins: AS DIRECTED RX #: 11734604	03/30/11 03/30/11	1932 Nursing Acknowledged Order HNSRP03
PROTONIX (PANTOPRAZOLE (PROTONIX (R)) 40 MG/VIAL) 40 MG IV DAILY RX #: 11734970	03/31/11 05/29/11	1600 HNSCMP04 at 1201 GMT: 40 MG ROC/DIN: (SOURCE: eMAR) 00069031353 PROTONIX40 - Pantoprazole (Protonix IV) 40 . 04/01/11-1203 File Document by HNSCMP04
CLARIFY ORDER-MEDICATION (CLARIFY ORDER-MEDICATION) See Dose Ins. NOTE TWICE DAILY Dose Ins: TYLENOL Comments: CLARIFY ORDER. TYLENOL INDICATION? RX #: 11734972	03/30/11 05/29/11	1600 Not Administered HNSRP03 at 2030 R COMMENTS 04/01/11-2039 File Document by HNSRP03 2200 Not Administered HNSRP03 at 2039 R COMMENTS 04/01/11-2039 File Document by HNSRP03
READI-CAT 2 (BARIUM SULFATE (READI-CAT 2) 460 ML ORAL SUSP) 225 ML PO AS DIRECTED Comments: READI-CAT 225 ML PO EVERY 30 MINUTES X 4 DOSES DOSES DUE AT 0930, 1000, 1030, AND 1100. EXAM SCHEDULED FOR 1130. PLEASE NOTIFY RADIOLOGY/PHARMACY OF ANY CHANGE IN SCHEDULED TIMES. RX #: 11737142	03/31/11 04/02/11	1932 Nursing Acknowledged Order HNSRP03
FOLIC ACID 1MG (FOLIC ACID 1 MG UDTAB) 1 MG PO DAILY RX #: 11737241	03/31/11 04/30/11	1600 Not Administered HNSCMP04 at 1803 R SLEEPING 04/01/11-1203 File Document by HNSCMP04
ISOVUE-300 61% 150ML BOT (IOPAMIDOL 61% 150 ML ML) 100 ML IV STAT-MEDICINE RX #: 11737744	03/31/11 03/31/11	1932 Nursing Acknowledged Order HNSRP03

*** CONTINUED ON PAGE 14 ***

This document is part of the legal medical record.

NAME: WINKLER,LOUIS UNIT #: [redacted] ACCT #: [redacted]

ADMINISTRATION PERIOD: FROM: 04/01/11 to 0000 04/13/11 (continued)	START	
LOVENOX 30MG (ENOXAPARIN (LOVENOX) 30 MG/0.3 ML SYR) 30 MG SQ Q24H Comments: do not administer while on epidural ****** ADMINISTER DEEP SC INJECTION INTO ANTEROLATERAL/POSTEROLATERAL (LOVENOX(R)) ABDOMINAL WALL *ALTERNATE SITES DAILY* *TO AVOID LOSS OF DRUG, DO NOT EXPEL AIR BUBBLE BEFORE INJECTION* *DO NOT ADMINISTER IM* *TO NOT RUB OR ASPIRATE AFTER INJECTION* RX #: 11737983	03/31/11 04/30/11	1600 CSS.ZA at 1654 SITE: L AB - Left Abdomen GAVE: 30 MG NDC/DIN: (SOURCE: eMAR) 378831961 LOVE1030.1 - Enoxaparin (Lovenox) 30 MG/0... PT/FAM UNDERSTANDS:COMPLIANCE_ADV/INTER.DIET.F/U INFO: Y 04/01/11-1658 File Document by CSS.ZA
SODIUM CHLORIDE 0.45% SOLN 1000ML, 1000 ML (SODIUM CHLORIDE 0.45% 1000 ML BAG) 100 MLS/HR IV AS DIRECTED RX #: 11737982	03/31/11 04/01/11	0354 HNSBM04 at 0354 GAVE: 1000 MLS NDC/DIN: (SOURCE: eMAR) 10409793509 SODI0L.45 - Sodium Chloride 0.45% 1000 Ml... 04/01/11-0354 File Document by HNSBM04 1358 Pharmacy Discontinue HPOTOMF 1932 Nursing Acknowledged Order HNSRP03
SODIUM CHLORIDE 0.45% SOLN 1000ML, 1030 ML (SODIUM CHLORIDE 0.45% 1000 ML BAG) 70 MLS/HR IV AS DIRECTED RX #: 11737983	03/31/11 05/30/11	1358 Pharmacy Discontinue HPOTOMF 1932 Nursing Acknowledged Order HNSRP03
SODIUM CHLORIDE 0.9% 1000 ML (SODIUM CHLORIDE 0.9% 1000 ML BAG) 200 MLS/HR IV AS DIRECTED RX #: 11741213	04/01/11 05/31/11	1400 Order Entry HNXIOMF 1932 Nursing Acknowledged Order HNSRP03
SODIUM CHLORIDE 0.9% 1000 ML (SODIUM CHLORIDE 0.9% 1000 ML BAG) 100 MLS/HR IV AS DIRECTED RX #: 11741214	04/01/11 05/31/11	1400 Order Entry HNXIOMF 1932 Nursing Acknowledged Order HNSRP03

*** CONTINUED ON PAGE 15 ***
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ADMINISTERED/ORDER FROM WARD ORDER DATE/TIME AND DOSAGE FORM/ROUTE/COMMENTS	START/ STOP	
SODIUM BICARB 8.4% ABBOJECT (SODIUM BICARBONATE 8.4% 50 ML SYR) 100 ML IV 1400 RX #: 11241219	04/02/11 04/09/11	1401 Order Entry HSKOF 1654 Pharmacy Discontinue (PD565 1932 Nursing Acknowledged Order HNSAP03
MERREM I SW/NS 100ML 100 ML (MEROPENEM 1000 MG/100 ML NS) 200 ML/HR IV Q8H Comments: INFUSE OVER 30MIN ***INCOMPATIBLE WITH IV POTASSIUM*** RX #: 11241221	04/01/11 05/01/11	1403 Order Entry HSKOF 1435 Nursing Acknowledged Order CSS.YBM 1500 CSS.ZA at 1627 I/C PT AVAIL CAVE: 300 MLS HOC/DIN: (SOURCE: eMAR) 0409350601 MERREM - Meropenem 1000 MG/100 ML Ns Most common side effects reviewed with patient?: Yes :: MERREM:headache, nausea/vomiting/diarrhea, rash 04/01/11-1631 File Document by CSS.ZA 2100 HNSAP03 at 2039 GAVE: 300 MLS HOC/DIN: (SOURCE: eMAR) 0409350601 MERREM - Meropenem 1000 MG/100 ML Ns 04/01/11-2039 File Document by HNSAP03
ZYVOX 600MG/300ML PREMIX 300 ML (LINEZOLID (ZYVOX) 600 MG/300 ML PIGGYBACK) 200 ML/HR IV Q12H Comments: ZYVOX 600MG IN 300ML PREMIX INFUSE OVER 60 MINUTES PLEASE DOCUMENT TEACHING ON FOOD/DRUG INTERACTION FORM RX #: 11241231	04/01/11 05/01/11	1405 Order Entry HSKOF 1435 Nursing Acknowledged Order CSS.YBM 1500 CSS.ZA at 1640 I/C NEW ORDER GAVE: 300 MLS HOC/DIN: (SOURCE: eMAR) 0009514081 ZYVOX - Linezolid (Zyvox) 600 MG/300 .. Most common side effects reviewed with patient?: Yes :: ZYVOX:headache, nausea/vomiting/diarrhea, insomnia 04/01/11-1654 File Document by CSS.ZA

*** CONTINUED ON PAGE 16 ***

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ADMINISTRATION PERIOD ORDER 04/01/11 to 1000 CATEGORY: CONTINUOUS	STRTY STAT
CLARIFY ORDER-MEDICATION (CLARIFY ORDER-MEDICATION) See Done Ins. NOTE THESE DAILY Done Ins: CLARIFY ORDER PT ON RECEIPEN NEW ORDER FOR MERGEN PROFILED IS RECEIPEN NEEDED Comments: CLARIFY ORDER: MEDICATION ORDER PLEASE CLARIFY MEDICATION PLEASE CLARIFY DOSE PLEASE CLARIFY ROUTE PLEASE CLARIFY FREQUENCY PLEASE CLARIFY TIME PLEASE CLARIFY INDICATION "PLACE IN "PHYSICIAN ORDERS" SECTION OF CHART" NON-FORMULARY MEDICATION: NON-FORMULARY MEDICATION ORDERED 1. PLEASE SEE IF PATIENT HAS THEIR OWN MED. IF SO, EMAIL PHYSICIAN TO GET AUTHORIZATION TO USE PATIENT'S OWN MED AND WRITE ORDER "OK FOR PATIENT TO TAKE OWN " AND SCAN ORDER TO PHARMACY, OR 2. SEE IF PHYSICIAN CAN USE A FORMULARY MED SUGGESTED FORMULARY ALTERNATIVES: "PLACE IN "PHYSICIAN ORDERS" SECTION OF CHART" RX #: 11741245	04/01/11 1408 Order Entry HRIONF 05/31/11 1532 Nursing Acknowledged Order (NSRP03 2208 Not Administered (HSRP03 at 2039 N COMMENTS 04/01/11-2039 File Document by (HSRP03
Solu-CORTEF 100MG (HYDROCORTISONE SOD SUCCINATE 100 MG/2 ML VIAL) 50 MG IV EVERY 6H RX #: 11741262	04/01/11 1408 CSS.ZA at: 1607 I/F NEW ORDER GAVF: 50 MG NDC/DIN: (SOURCE: eMAR) 00090011A3 SOLUIV1004 - Hydrocortisone Sod Succinate .. Most common side effects reviewed with patient?: Yes :: SOLUIV1004:muscle/bone weakness, increased blood glucose, increased BP 04/01/11-1630 File Document by CSS.ZA 1410 Order Entry HRIONF 1435 Nursing Acknowledged Order CSS.YRK 2208 (HSRP03 at 2233 CARE: 50 MG NDC/DIN: (SOURCE: eMAR) 00090011A3 SOLUIV1004 - Hydrocortisone Sod Succinate ... 04/01/11-2233 File Document by (HSRP03

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ADMINISTRATION PERIOD: 0301 04/01/11 to 0000 04/12/11 (Continued)	START/ STOP	
NovoLOG (INSULIN ASPART 100 UNITS/ML ML) See Dose Ins. SQ EVERY 6H Dose Ins: LOW DOSE ALGORITHM BS 150 - 199 = 2 UNITS BS 200 - 249 = 3 UNITS BS 250 - 299 = 4 UNITS BS 300 - 349 = 5 UNITS BS > 349 = 6 UNITS PLEASE COORDINATE MEDICATION ADMINISTRATION TIMES TO MEAL DELIVERY SCHEDULE RX #: 11741266	04/01/11 05/31/11	1411 Order Entry HAXCHF 1418 Pharmacy Discontinue HRXCHF 1932 Nursing Acknowledged Order HNSAP03
NovoLIN R 100 UNITS/ML VIAL (Insulin reg 100 UNITS/ML VIAL) See Dose Ins. SQ EVERY 6H Dose Ins: LOW DOSE ALGORITHM BS 150 - 199 = 2 UNITS BS 200 - 249 = 3 UNITS BS 250 - 299 = 4 UNITS BS 300 - 349 = 5 UNITS BS > 349 = 6 UNITS PLEASE COORDINATE MEDICATION ADMINISTRATION TIME TO MEAL DELIVERY SCHEDULE RX #: 11741286	04/01/11 05/01/11	1412 Order Entry HAXCHF 1655 Nursing Acknowledged Order CSS.ZA 1700 Not Administered CSS.ZA at 1656 N HPO Glucose:: 151 Method:: 04/01/11-1658 File Document by CSS.ZA 2330 HNSAP03 at 2233 CO-SIGNER: HNSCAH SITE: LUA - Left Upper Arm SAVE: 3 UNITS NDC/DIN: (SOURCE: eMAR) 01692833 ADVCIVI001 - Insulin reg 100 UNITS/ML VIA. Glucose:: 233 Method:: FINGERSTICK 04/01/11-2233 File Document by HNSAP03 OSSN changed from UNITS to 3 UNITS
LASIX 20MG INJ (FUROSEMIDE (LASIX) 20 MG/2 ML VIAL) 20 MG IV AS DIRECTED Rx #: 11741314	04/01/11 04/02/11	1461 Order Entry HAXCHF 1932 Nursing Acknowledged Order HNSAP03
SODIUM BICARB 8.4% ADD/JECT (SODIUM BICARBONATE 8.4% 50 ML SYR) 100 ML IV 1656 Comments. NOTE. 2 AMPS BICARB = 100 MEQ/100 MLS RX #: 11741344	04/01/11 04/06/11	1654 Order Entry HAXSGS 1656 Nursing Acknowledged Order CSS.ZA 1656 CSS.ZA at 1808 SAVE: 100 ML NDC/DIN: (SOURCE: eMAR) 00409637 SODIIB8.43 - Sodium Bicarbonate 8.4% 50 ML... Most common side effects reviewed with patient?: Yes -- SODIIB8.43:Flatulence, Gastric Distention, Edema 04/01/11-1658 File Document by CSS.ZA 2359 Pharmacy Discontinue SCHEDULER 0000 Nursing Acknowledged Order HNSAP03

*** CONTINUED ON PAGE 18 ***
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ADMINISTRATION PERIOD	START / STOP		
2301 04/01/11 thru 0001 04/12/11 (CONTINUED)			
TYLENOL 325MG (ACETAMINOPHEN 325 MG UDTAB) 650 MG PO EVERY 6H AS NEEDED/PRN PRN Reason: PRN PAIN/TEMP RX #: 11728690	03/30/11 04/29/11	2232 HNSRP03 RE 2232 GAVE: 650 MG NDC/DIN: (SOURCE: eMAR) 63739440001 Given for:: OTHER If other, specify:: T 04/01/11-2233 File Document by HNSRP03	ACETOT2234 - Acetaminophen 325 MG Udtab
ACETAMINOPHEN 650MG (ACETAMINOPHEN (TYLENOL) 650 MG SUPP) 650 MG PR EVERY 6H AS NEEDED/PRN PRN Reason: FEVER RX #: 11734971	03/30/11 04/29/11	1056 HNSCP04 at 1058 GAVE: 650 MG NDC/DIN: (SOURCE: eMAR) 67130116506 Given for:: OTHER If other, specify:: FEVER 04/01/11-1060 File Document by HNSCP04	FEVERS6502 - Acetaminophen (Tylenol) 650 M..
DEXTROSE 50%/WATER ADD0JECT (DEXTROSE 50%-WATER 50 ML SYR) See Comm Ins. IV AS NEEDED/PRN PRN Reason: DAILY Q AS NEEDED Dose Inq: *** SEE COMMENTS *** Comments: HYPOGLYCEMIA PROTOCOL: FOR BG < 70 OR SIGNS AND SYMPTOMS PRESENT A. IF PATIENT CAN TAKE PO GIVE 15 GMS FAST ACTING CARBS (E.G. 4OZ JUICE,REG SODA). B. IF PATIENT IS NPO AND AWAKE GIVE 25 ML OF D50 IV PUSH. C. IF PATIENT IS NOT RESPONSIVE GIVE 50 ML OF D50 IV PUSH. D. IF NO IV ACCESS GIVE GLUCAGON 1 MG SQ. MAY REPEAT IN 15 MINUTES PRN. E. CHECK FINGER STICK BLOOD GLUCOSE EVERY 15 MINUTES AND REPEAT TREATMENT IF BLOOD GLUCOSE IS <80. F. CALL PHYSICIAN FOR POSSIBLE INSULIN ADJUSTMENT. RX #: 11741965	04/01/11 05/31/11	1411 Order Entry HSIOHF 1412 Pharmacy Discontinue HSIOHF 1932 Nursing Acknowledged Order HNSRP03	

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NAME: WINKLER,LOUIS UNIT #: [redacted] ACCT #: [redacted]

ADMINISTRATION PERIOD: CODE 04/07/11 to 0000 04/08/11 [illegible]	START: STOP:	
DEXTROSE 50%/WATER ANSOJECT (DEXTROSE 50%-WATER 50 ML SYR) See Dose Ins. IV AS NEEDED/PRN PRN Reason: DAILY @ AS NEEDED Dose Ins: *** SEE COMMENTS *** Comments. HYPOGLYCEMIA PROTOCOL: FOR BG < 70 OR SIGNS AND SYMPTOMS PRESENT A. IF PATIENT CAN TAKE PO GIVE 16 GMS FAST ACTING CARBS (E.G. 4OZ JUICE,REG SODA). B. IF PATIENT IS NPO AND AWAKE GIVE 25 ML OF D50 IV PUSH. C. IF PATIENT IS NOT RESPONSIVE GIVE 50 ML OF D50 IV PUSH. D. IF NO IV ACCESS GIVE GLUCAGON 1 MG SQ. MAY REPEAT IN 15 MINUTES PRN. E. CHECK FINGER STICK BLOOD GLUCOSE EVERY 15 MINUTES AND REPEAT TREATMENT IF BLOOD GLUCOSE IS <80. F. CALL PHYSICIAN FOR POSSIBLE INSULIN ADJUSTMENT. RX #: 11741257	04/01/11 05/31/11	1412 Order Entry HRXONF 1932 Nursing Acknowledged Order INSRP03	
ALBUTEROL (ALBUTEROL SULFATE 2.5 MG/0.5 ML UDENF) 2.5 MG INHALATION EVERY 6 HOURS RT/PRN PRN Reason: BRONCHOSPASM Comments. **RT TO ADMINISTER** RX #: 11741288	04/01/11 05/01/11	1413 Order Entry HRXONF 1932 Nursing Acknowledged Order INSRP03	
ADMINISTRATION PERIOD: CODE 04/08/11 to 0000 04/09/11	START: STOP:		
ROCEPHIN 1GM/DEXTROSE 50 KL 50 ML (ceFTRIAXone NA/DEXTROSE,ISO 1 GM/50 ML ADVANTAGE) 133 ML/HR IV OVER RX #: 11733869)	03/30/11 04/02/11	2300 CSS.JASH at 2200 GAVE: 50 ML ROC/DIR: (SOURCE: eMAR) 140972304 04/02/11-2253 File Document by CSS.JASH 2359 Pharmacy Discontinue SCHEDULER	CEFTRIA150 - ceFTRIAXone NA/DEXTROSE,ISO 1..
SODIUM CHLORIDE 0.9% 1000 ML (SODIUM CHLORIDE 0.9% 1000 ML BAG) 103 ML/HR IV AS DIRECTED RX #: 11733898	03/30/11 05/29/11	1405 CSS.ZA at 1405 GAVE: 1000 ML ROC/DIR: (SOURCE: eMAR) 140979W209 04/02/11-1405 File Document by CSS.ZA	SODIR.9%B - Sodium Chloride 0.9% 1000 Ml Ba

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ADMINISTRATION PERIOD (DOSE ORDERED) (ROUTE) (ADDITIONAL)	START-STOP		
PRIMIVIL 5MG (LISINOPRIL (PRINIVIL) 5 MG ORTAB) 5 MG PO TWICE DAILY RX #: 11735704	03/30/11 04/29/11	1000 CSS,ZA at 0900 GAVE: 5 MG MDC/DIN: (SOURCE: eMAR) 60093406011 04/02/11-0901 File Document by CSS,ZA 2200 Not Administered CSS,JASH at 2156 N ROUTE 04/12/11-2203 File Document by CSS,JASH	PRIMOTE100 - Lisinopril (Prinivil) 5 MG Ortа
LACTIMEX TABLET CHEWABLE (ACIDOPHILUS/BULGARICUS 1 TAB TAB,CHEW) 1 TAB PO TWICE DAILY RX #: 11733706	03/30/11 04/08/11	1000 Not Administered CSS,ZA at 0900 N NPO 04/02/11-0901 File Document by CSS,ZA 2200 Not Administered CSS,JASH at 2156 N ROUTE MDC/DIN: (SOURCE: eMAR) 49001/950 04/02/11-2203 File Document by CSS,JASH	ACIDOT50 - Acidophilus/Bulgaricus 1 Tab ..
SYNTHROID 0.025MG (LEVOTHYROXINE SODIUM (SYNTHROID) 0.025 MG ORTAB) 0.025 MG PO DAILY RX #: 11733708	03/30/11 04/29/11	0600 HMSRP03 at 0459 L/E REQUEST GAVE: 0.025 MG MDC/DIN: (SOURCE: eMAR) 51079044401 04/02/11-0459 File Document by HESRF03	LEVOOT.025 - Levothyroxine Sodium (Synthro..
PROTONIX (PANTOPRAZOLE (PROTONIX (R)) 40 MG/VIAL) 40 MG IV DAILY RX #: 11734970	03/30/11 05/29/11	1000 CSS,ZA at 0900 GAVE: 40 MG MDC/DIN: (SOURCE: eMAR) 00008-5235 04/02/11-0901 File Document by CSS,ZA	PROTONI40 - Pantoprazole (Protonix (R)) 40..
CLARIFY ORDER-MEDICATION (CLARIFY ORDER-MEDICATION) See Dose Ins. NOTE TWICE DAILY Dose Ins: TYLENOL Comments: CLARIFY ORDER: TYLENOL INDICATION? RX #: 11734972	03/30/11 05/30/11	1000 1438 Nursing Id: CSS,ZA CM TYLENOL 2200 2355 Pharmacy Discontinue HYDROCOL 2355 Nursing Request Removed HYDROCOL	
READY-CAT 2 (BARIUM SULFATE (READI-CAT 2) 450 ML ORAL,SUSP) 225 ML PO AS DIRECTED Comments: READICAT 225 ML PO EVERY 30 MINUTES X 4 DOSES DOSES DUE AT 0930, 1000, 1030, AND 1100. EXAM SCHEDULED FOR 1130. PLEASE NOTIFY RADIOLOGY/PHARMACY OF ANY CHANGE IN SCHEDULED TIMES. RX #: 11737142	03/31/11 04/02/11	0910 Pharmacy Discontinue REFILL LIST	

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04/12/11 0535 MEDICATION DISCHARGE SUMMARY PAGE: 21

NAME: WINKLER,LOUIS UNIT #: [redacted] ACCT #: [redacted]

ADMISSION PERIOD: 0001 04/02/11 to 0000 04/12/11 (Continuing)	START/ STOP	
FOLIC ACID 1MG (FOLIC ACID 1 MG UDTAB) 1 MG PO DAILY RX #: 11737241	03/31/11 04/30/11	1000 CSS.ZA at 0900 GAVE: 1 MG NDC/DIN: (SOURCE: <HAR) 62269469711 FOLIOTIL04 - Folic Acid 1 MG Udtab 04/02/11-0901 File Document by CSS.ZA
LOVENOX 30MG (ENOXAPARIN (LOVENOX) 30 MG/0.3 ML SYR) 30 MG SQ Q24H Comments: do not administer while on epidural **** ADMINISTER DEEP SC INJECTION INTO ANTEROLATERAL/POSTEROLATERAL (NONDOMINANT) ABDOMINAL WALL *ALTERNATE SITES DAILY* *TO AVOID LOSS OF DRUG, DO NOT EXPEL AIR BUBBLE BEFORE INJECTION* *DO NOT ADMINISTER IM* *DO NOT RUB OR ASPIRATE AFTER INJECTION* RX #: 11737081	03/31/11 04/30/11	1420 Pharmacy Discontinue COENPR
SODIUM CHLORIDE 0.9% 1000 ML (SODIUM CHLORIDE 0.9% 1000 ML BAG) 100 ML/HR IV AS DIRECTED RX #: 11741214	04/01/11 05/31/11	2150 Pharmacy Discontinue HEPCOL

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04/12/11 0636 MEDICATION DISCHARGE SUMMARY PAGE: 22

NAME: WINKLER,LOUIS UNIT #: [redacted] ACCT #: [redacted]

ADMINISTRATION PERIOD ORDER 04/02/11 to 2010 CHANGE/DISCONTINUED	START/ STOP		
MERREM I GM/NS 100ML 100 ML (MEROPENEM 1000 MG/100 ML MS) 200 ML/HR IV DSH Comments: INFUSE OVER 30MIN ***INCOMPATIBLE WITH IV POTASSIUM*** RX #: 11741221	04/01/11 05/01/11	0200 HMSRP03 at 0208 GAVE: 100 ML NDC/DIN: (SOURCE: eMAR) 04093502601 MERREN - Meropenem 1000 MG/100 ML Ns 04/02/11-0208 File Document by HMSRP03 0940 CSS.ZA at 0950 GAVE: 100 ML NDC/DIN: (SOURCE: eMAR) 04093502601 MERREN - Meropenem 1000 MG/100 ML Ns 04/02/11-0859 File Document by CSS.ZA 1340 CSS.ZA at 1405 GAVE: 100 ML NDC/DIN: (SOURCE: eMAR) 04093502601 MERREN - Meropenem 1000 MG/100 ML Ns 04/02/11-1403 File Document by CSS.ZA 2100 CSS.DASH at 2155 GAVE: 100 ML NDC/DIN: (SOURCE: eMAR) 04093502601 MERREN - Meropenem 1000 MG/100 ML Ns 04/02/11-2203 File Document by CSS.DASH	
ZYVOX 600MG/300ML PREMIX 300 ML (LINEZOLID (ZYVOX) 600 MG/300 ML P(BOTTLE)) 200 ML/HR IV DISH Comments: ZYVOX 600MG IN 300ML PREMIX INFUSE OVER 90 MINUTES PLEASE DOCUMENT FLUSHING OF FOOD/DRUG INTERACTION FORM RX #: 11741233	04/01/11 06/01/11	0300 HMSRP03 at 0307 GAVE: 300 ML NDC/DIN: (SOURCE: eMAR) 09951400 ZYVOX - Linezolid (Zyvox) 200 MG/300 .. 04/02/11-0308 File Document by HMSRP03 1400 CSS.ZA at 1405 GAVE: 300 ML NDC/DIN: (SOURCE: eMAR) 09951400 ZYVOX - Linezolid (Zyvox) 600 MG/300 .. 04/02/11-1406 File Document by CSS.ZA	

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ADMINISTRATION PERIOD: 04/01/11 05:35 to 05/05/11 [illegible]	START/STOP	
CLARIFY ORDER-MEDICATION (CLARIFY ORDER-MEDICATION) See Dose Ins. NOTE THICC DAILY Dose Ins: CLARIFY ORDER PT ON ROCEPHIN NEW ORDER FOR MORRIN PROFILED IS ROCEPHIN NEEDED Comments: CLARIFY ORDER: MEDICATION ORDER PLEASE CLARIFY MEDICATION PLEASE CLARIFY DOSE PLEASE CLARIFY ROUTE PLEASE CLARIFY FREQUENCY PLEASE CLARIFY TIME PLEASE CLARIFY INDICATION "PLACE IN "PHYSICIAN ORDERS" SECTION OF CHART" NON-FORMULARY MEDICATION: NON-FORMULARY MEDICATION CHECKED 1. PLEASE SEE IF PATIENT HAS THEIR OWN MED. IF SO, CALL PHYSICIAN TO GET AUTHORIZATION TO USE PATIENT'S OWN MED AND WRITE ORDER "OK FOR PATIENT TO TAKE OWN " AND SCAN ORDER TO PHARMACY, OR 2. SEE IF PHYSICIAN CAN USE A FORMULARY MED SUGGESTED FORMULARY ALTERNATIVES: "PLACE IN "PHYSICIAN ORDERS" SECTION OF CHART" RX #: 11741745	04/01/11 05/05/11	1000 1437 Nursing Of CSS,ZA OK MORRIN 2200
Solu-CORTEF 100MG (HYDROCORTISONE SOD SUCCINATE 100 MG/2 ML VIAL) 50 MG IV EVERY 8H RX #: 11741762	04/01/11 05/31/11	0400 HBSPP03 ok 0458 I/F REQUEST GAVE: 50 MG NDC/DIN: (SOURCE: eMAR) 00009001103 S0LU1V1004 - Hydrocortisone Sod Succinate .. 04/02/11-0459 File Document by HBSPP03 1440 CSS,ZA at 1358 GAVE: 50 MG NDC/DIN: (SOURCE: eMAR) 00009001103 S0LU1V1004 - Hydrocortisone Sod Succinate ... 04/02/11-1358 File Document by CSS,ZA 2200 CSS,JASH at 2157 GAVE: 50 MG NDC/DIN: (SOURCE: eMAR) 00009001103 S0LU1V1004 - Hydrocortisone Sod Succinate ... 04/02/11-2203 File Document by CSS,JASH

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04/12/11 0935	MEDICATION DISCHARGE SUMMARY	PAGE: 24
NAME: WINKLER,LOUIS	UNIT #: [redacted]	ACCT #: [redacted]

ADMINISTRATION PERIOD: DATE: 04/07/11 to 04/10/11 (continued)	START/STOP	
NovoLIN R 100 UNITS/ML VIAL (insulin reg 100 UNITS/ML VIAL) See Dose Ins. SQ CYCRY CI Dose Ins: LOW DOSE ALGORITHM BS 150 - 199 = 2 UNITS BS 200 - 249 = 3 UNITS BS 250 - 299 = 4 UNITS BS 300 - 349 = 5 UNITS BS > 349 = 6 UNITS PLEASE COORDINATE MEDICATION ADMINISTRATION TIME TO MEAL DELIVERY SCHEDULE RX #: 11241256	04/01/11 05/01/11	0600 HNSRP03 at 0458 CO-SIGNER: HNSCAN SITE: LUA - Left Upper Arm GAVE: 3 UNITS MDC/DIN: (SOURCE: eMAR) 01691883311 HOVOIV1001 - insulin reg 100 UNITS/ML VIAL Glucose:: 233 04/02/11-0458 File Document by HNSRP03 DOSE changed from UNITS to 3 UNITS 1100 CSS.ZA at 1220 CO-SIGNER: HNSHIP01 LIFE COMMENTS SITE: LUA - left Upper Arm GAVE: 4 UNITS MDC/DIN: (SOURCE: eMAR) 01691883311 HOVOIV1001 - insulin reg 100 UNITS/ML VIAL Glucose:: 282 Method:: FINGERSTICK PT UNAVAILABLE 04/09/11-1221 File Document by CSS.ZA DOSE changed from UNITS to 4 UNITS 1700 HNSKJY at 1616 CO-SIGNER: HNSHIP01 SITE: LAB - Left Abdomen GAVE: 3 UNITS MDC/DIN: (SOURCE: eMAR) 01691883311 HOVOIV1001 - insulin reg 100 UNITS/ML VIAL Glucose:: 302 Method:: FINGERSTICK 04/02/11-1618 File Document by HNSKJY DOSE changed from UNITS to 3 UNITS 2300 CSS.JASH at 2200 CO-SIGNER: HNSMCOP SITE: LUA - Left Upper Arm GAVE: 3 UNITS MDC/DIN: (SOURCE: eMAR) 01691883311 HOVOIV1001 - insulin reg 100 UNITS/ML VIAL Glucose:: 244 Method:: FINGERSTICK 04/07/11-2203 File Document by CSS.JASH DOSE changed from UNITS to 3 UNITS
LASIX 20MG INJ (FUROSEMIDE (LASIX) 20 MG/2 ML VIAL) 20 MG IV AS DIRECTED RX #: 11241514	04/01/11 04/02/11	2300 Pharmacy Discontinue SCHEDULER

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ANTICIPATED DISCHARGE PERIOD: 04/01 04/03 13:26 (0100 04/03/11) (Continued)	START / STOP	
MUPIROCIN NASAL OINTMENT (MUPIROCIN 0.9 GM OINT..BRAND NAME STUDY DRUG) One Dose Ins: NASAL THICE DAILY Dose Ins: SEE LABEL COMMENTS Comments: HOSA TRIAL BACTRORAN UNIT DOSE NASAL FOR ICU PATIENTS ONLY!! TO BE DISCONT'D/HELD ON PATIENT TRANSFER FROM ICU. 1/2 OF THE CONTENTS OF A 1 GRAM TUBE APPLIED TO EACH NOSTRIL THICE DAILY RX #: 11743645	04/02/11 04/07/11	0819 Order Entry HRK/HM 0050 Nursing Acknowledged Order CSS.ZA 1000 CSS.ZA at 0900 SITE: EN - Each Nare GAVE: 0.9 GM NDC/DIN: (SOURCE: eMAR) 00295152603 BACNASALSD - Mupirocin 0.9 Gm Oint..brand .. Most common side effects reviewed with patient?: Yes :: BACNASALSD:Itching, burning sensation 04/02/11-0901 File Document by CSS.ZA DOSE changed from GM to 0.9 GM r200 CSS.JASH at 2157 SITE: EN - Each Nare GAVE: 0.9 GM NDC/DIN: (SOURCE: eMAR) 00295152603 BACNASALSD - Mupirocin 0.9 Gm Oint..brand ... 04/03/11-2203 File Document by CSS..JASH DOSE changed from GM to 0.9 GM
ARIXTRA (FUNDAPARINUX SODIUM (ARIXTRA) 2.5 MG/0.5 ML SYR) 2.5 MG SQ DAILY Comments: MEDICALLY NECESSARY RX #: 11744088	04/02/11 05/02/11	1430 HMSKJY at 1547 L/E COMMENTS SITE: LAB - Left Abdomen GAVE: 2.5 MG NDC/DIN: (SOURCE: eMAR) 00073020601 AR(22.5D - Fondaparinux Sodium (Arixtra).. PT/FAM UNDERSTANDS:COMPLIANCE,ADV/SIDE,DIET,F/U INFO: Y NEW ORDER. FIRST DOSE. PLUS. JUST PICKED UP PT AT 1515 04/02/11-1540 File Document by HMSKJY 1430 Order Entry CDEKMA 1430 Pharmacy Edit or Verification CDEKMA 1450 Pharmacy Edit or Verification CDEKMA 1547 Nursing Acknowledged Order HMSKJY
CARDIZEM 125MG/5ML (DILTIAZEM HCL (CARDIZEM) 25 MG/5 ML VIAL) 5 MG IV BOLUS Comments: "HIGH ALERT DRUG" **PER HOSPITAL POLICY DOCUMENT DOUBLE CHECK PROCESS OR PUMP** RX #: 11744935	04/03/11 04/03/11	2354 Order Entry HRKDDL 0000 CSS..JASH at 0010 GAVE: 5 MG NDC/DIN: (SOURCE: eMAR) 04091201 CARDIV5S - Diltiazem HCl (Cardizem) 25 M.. Drug/Dose verified by: HDDLRM Double check required?: Y Most common side effects reviewed with patient?: Yes :: CARDIV5S.Constipation, Dizziness, Hypotension, Headache, Edema 04/03/11-0010 File Document by CSS.JASH

*** CONTINUED ON PAGE 26 ***
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04/12/11 0535 MEDICATION DISCHARGE SUMMARY PAGE: 26

NAME: WINKLER,LOUIS UNIT #: [redacted] ACCT #: [redacted]

ADMINISTRATION PERIOD:
0301 04/02/11 ED ADULT OBSERVATION (CONFIRMED)

CARDIZEM 100MG/100 ML NS PIGGYBACK 100 ML (DILTIAZEM 100 MG/100 ML NS PIGGYBACK) ASDIRECTED IV AS DIRECTED Comments: FINAL CONC = 1MG/ML RATE = MG/HR = ML/HR TO BE USED ONLY FOR PATIENTS IN MONITORED TELEMETRY OR ICU BEDS ****** HIGH ALERT DRUG ****** ** PER HOSPITAL POLICY DOCUMENT DOUBLE CHECK PROCESS ** RX #: 11744936	04/02/11 05:08/11	2057 Admin Criterion Entered FAXCOL 2057 Order Entry UNIDOL
VICODIN 5/500 (HYDROCODONE BITARTRATE/APAP (VICODIN 5/500) 1 EA ORTAB) 1 EA PO EVERY 12HOURS AS REIDID/PRN PRN Reason: PRN PAIN Comments: **MAX DOSE 8 TABS PER 24 HOUR PERIOD** CHART EXACT DOSE GIVEN FOR ALL DOSAGE RANGES RX #: 11733707	03/30/11 04/29/11	0004 HASSPO1 at 0004 GAVE: 1 EA ROC/DIN: (SOURCE: eMAR) 62584729811 HYDROTB117 - Hydrocodone Bitartrate/Apap (... >Pain Score:: 5 Patient Goal for Pain:: 3 Most common side effects reviewed with patient?: Yes (. HYDROTB117:Drowsiness, Sedation, nausea/vomiting, Constipation >Pain Scale Used:: 04/02/11-0004 File Document by HASSPO1 0104 REASSESS by HASSPO1 at 0104 >Pain Scale Used: NUMBERS 0-10 >Pain Score: 0 Location: >Level of Sedation: Comment: 0859 CSS.ZA at 0859 GAVE: 1 EA ROC/DIN: (SOURCE: eMAR) 62584729811 HYDROTB117 - Hydrocodone Bitartrate/Apap (... >Pain Score:: 5 Patient Goal for Pain:: 0 Location:: ALL OTER >Pain Scale Used:: NUMBERS 0-10 >Level of Sedation:: Awake and alert 04/02/11-0859 File Document by CSS.ZA 0959 REASSESS by CSS.ZA at 0959 >Pain Scale Used: NUMBERS 0-10 >Pain Score: 0 Location: >Level of Sedation: Frequently drowsy Comment:

*** CONTINUED ON PAGE 27 ***
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04/12/11 0535 MEDICATION DISCHARGE SUMMARY PAGE: 27

NAME: WINKLER,LOUIS UNIT #: [redacted] ACCT #: [redacted]

ADMIN: AS FOR PERIOD: 0901 04/07/11 TO 0700 04/12/11 (CURRENT)	START / STOP	
ACETAMINOPHEN 650MG (ACETAMINOPHEN (TYLENOL) 650 MG SUPP) 650 MG PR EVERY 6 HOURS AS NEEDED/PRN PRN Reason: FEVER RX #: 11734971	03/30/11 04/29/11	2155 Pharmacy Edit or Verification HRLOOL
MORPHINE 2MG/ML SYRINGE (morphine SULFATE 2 MG/ML SYR) See Dose Ins. IV EVERY 2 HOURS AS NEEDED/PRN PRN Reason: FOR PAIN Dose Ins. 2-4MG Comments: **** IF ORDERED IV **** RECOMMEND FOR IV ADMINISTRATION TO OPIOID NAIVE PATIENTS *** DILUTE TO A FINAL CONC OF 1 MG/ML WITH NS * *** PUSH SLOWLY IV INCREMENTS OF 2 MG *** *** PAIN REASSESSMENT RECOMMENDED *** CHART EXACT DOSE GIVEN FOR ALL DOSAGE RANGES RX #: 11744007	04/02/11 04/09/11	1429 Order Entry COEKAR 1548 Nursing Acknowledged Order HNSKJY 1549 HNSKJY at 1549 GAVE: 2 MG NDC/DIN: (SOURCE: eMAR) 0409176230 MORPHI2I 2 - morphine SULFATE 2 MG/ML SYR >Pain Score: 5 Patient Goal for Pain: 3 >Pain Scale Used:: NUMBERS 0-10 Exacerbating Factors:: MOVEMENT >Level of Sedation:: Slightly drowsy Given for:: PAIN 04/02/11-1549 File Document by HNSKJY DOSE changed from .5MG to 2 MG 1649 REASSESS by HNSKJY at 1649 >Pain Scale Used: NUMBERS 0-10 >Pain Score: 0 Location: >Level of Sedation: Slightly drowsy Comment: 2214 CSS.JASH at 2214 GAVE: 1 MG NDC/DIN: (SOURCE: eMAR) 0409176230 MORPHI2I 2 - morphine SULFATE 2 MG/ML SYR >Pain Score : 6 >Pain Scale Used:: WONG BAKER/FACES >Level of Sedation:: Somnolent Given for:: PAIN 04/02/11-2215 File Document by CSS.JASH DOSE changed from .5MG to 1 MG 2114 REASSESS by CSS.JASH at 2309 >Pain Scale Used: WONG BAKER/FACES >Pain Score: 0 Location: >Level of Sedation: Somnolent Comment:
ADMINISTRATION HISTORY: 0001 04/07/11 TO 0000 04/12/11	START / STOP	

*** CONTINUED ON PAGE 28 ***
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ADMINISTRATION PERIOD (VOL 04/03/11 to 2200 04/04/11 (CONTINUED))	STARTED STOP	
SODIUM CHLORIDE 0.9% 1000 ML (SODIUM CHLORIDE 0.9% 1000 ML BAG) 100 MLS/HR IV AS DIRECTED RX #: 11733698	03/30/11 05/29/11	0247 CSS.JASH at 0247 GAVE: 1000 MLS ADDITN: (CHANGE: CHAN) 04096798309 04/03/11-0247 File Document by CSS.JASH 0510 Pharmacy Discontinue HRXOOL SOD1L.9SB - Sodium Chloride 0.9% 1000 Ml Ba
PRINIVIL 5MG (LISINOPRIL (PRINIVIL) 5 MG UDTAB) 5 MG PO TWICE DAILY RX #: 11733704	03/30/11 05/29/11	0510 Pharmacy Discontinue HRXOOL
LACTINEX TABLET CHEWABLE (ACIDOPHILUS/BULGARICUS 1 TAB TAB.CHEW) 1 TAB PO TWICE DAILY RX #: 11733705	03/30/11 04/08/11	0510 Pharmacy Discontinue HRXOOL
SYNTHROID 0.025MG (LEVOTHYROXINE SODIUM (SYNTHROID) 0.025 MG UDTAB) 0.025 MG PO QSUN RX #: 11733709	03/30/11 04/29/11	0510 Pharmacy Discontinue HRXOOL 0640 Not Administered CSS.JASH at 0502 M DC 04/03/11-0503 File Document by CSS.JASH
PROTONIX (PANTOPRAZOLE (PROTONIX (N) 40 MG/VIAL) 40 MG IV DAILY RX #: 11734970	03/30/11 05/29/11	0509 Pharmacy Discontinue HRXOOL
FOLIC ACID 1MG (FOLIC ACID 1 MG UDTAB) 1 MG PO DAILY RX #: 11737741	03/31/11 04/30/11	0409 Pharmacy Discontinue HRXOOL
SODIUM CHLORIDE 0.9% 1000 ML (SODIUM CHLORIDE 0.9% 1000 ML BAG) 200 MLS/HR IV AS DIRECTED RX #: 11741813	04/01/11 05/31/11	0509 Pharmacy Discontinue HRXOOL

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ADMINISTER FOR PERIOD: 24HR Period(FIRST 24HRS OF ADMIT) Continuous	START: STOP:			
MERREM 1 GM/NS 100ML 100 ML (MEROPENEM 1000 MG/100 ML NS) 200 MG/HR IV Q8H Comments: DISEASE OVER 30MIN ****INCOMPATIBLE WITH IV POTASSIUM**** RX #: 11741221	04/01/11 05/01/11	0300 CSS.JASH at 0247 GAVE: 100 ML/S MDC/DIN: (SOURCE: eMAR) 00409588601 04/03/11-0247 File Document by CSS.JASH 0509 Pharmacy Discontinue HONEDL	MERREM	- Meropenem 1000 MG/100 ML NS
ZYVOX 600MG/300ML PREMIX 300 ML (LINEZOLID (ZYVOX) 600 MG/300 ML PIGGYBACK) 200 ML/HR IV Q12H Comments: ZYVOX DOSING IN 300ML PREMIX DISEASE OVER 90 RESULTS PLEASE DOCUMENT REACHING ON FOOD/DRUG INTERACTION FORM RX #: 11741231	04/01/11 05/01/11	0300 CSS.JASH at 0247 GAVE: 300 ML/S MDC/DIN: (SOURCE: eMAR) 00009834001 04/03/11-0247 File Document by CSS.JASH 0509 Pharmacy Discontinue HONEDL	ZYVOX	- Linezolid (Zyvox) 600 MG/300 ..

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04/12/11 0535 MEDICATION DISCHARGE SUMMARY PAGE: 30

NAME: WINKLER,LOUIS UNIT #: [redacted] ACCT #: [redacted]

ADMINISTRATION PERIOD: 04/01/11 to 04/03/11 (48:00 duration) (Continued)	START/STOP	
CLARIFY ORDER-MEDICATION (CLARIFY ORDER-MEDICATION) See Dose Ins. KEEP TAKE DAILY Dose Ins: CLARIFY ORDER PT ON ROCEPHIN NEW ORDER FOR HERPEN PROFILED IS ROCEPHIN NEEDED Comments: CLARIFY ORDER: MEDICATION ORDER PLEASE CLARIFY MEDICATION PLEASE CLARIFY DOSE PLEASE CLARIFY ROUTE PLEASE CLARIFY FREQUENCY PLEASE CLARIFY TIME PLEASE CLARIFY INDICATION "PLACE IN "PHYSICIAN ORDERS" SECTION OF CHART" NON-FORMULARY MEDICATION: NON-FORMULARY MEDICATION ORDERED 1. PLEASE SEE IF PATIENT HAS THEIR OWN MED, IF SO, CALL PHYSICIAN TO GET AUTHORIZATION TO USE PATIENT'S OWN MED AND WRITE ORDER "OK FOR PATIENT TO TAKE OWN " AND SCAN ORDER TO PHARMACY, OR 2. SEE IF PHYSICIAN CAN USE A FORMULARY MED. SUGGESTED FORMULARY ALTERNATIVES: "PLACE IN "PHYSICIAN ORDERS" SECTION OF CHART" RX #: 11741245	04/01/11 05/31/11	0018 Nursing Request Removed HALLMP 0010 Pharmacy Discontinue HALLMP
Solu-CORTEF 100MG (HYDROCORTISONE SOD SUCCINATE 100 MG/2 ML VIAL) 60 MG IV EVERY 8H RX #: 11741262	04/01/11 05/31/11	0569 Pharmacy Pharmacist HALTO 0680 Not Administered CSS.JASH at 0600 8 D2 04/03/11-0503 File Document by CSS.JASH

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ADMINISTRATION PERIOD ORDER DATE/STATUS/ORDERABLE/COMMENTS	START/STOP	
NovoLIN R 100 UNITS/ML VIAL (insulin reg 100 UNITS/ML VIAL) See Dose Ins. SQ DAILY AC Dose Ins. LOW DOSE ALGORITHM BS 150 - 199 = 2 UNITS BS 200 - 249 = 3 UNITS BS 250 - 299 = 4 UNITS BS 300 - 349 = 5 UNITS BS > 349 = 6 UNITS PLEASE COORDINATE MEDICATION ADMINISTRATION TIME TO MEAL DELIVERY SCHEDULE RX #: 11741866	04/01/11 05/01/11	0500 Not Administered CSS.JASH at 0502 W COMMENTS PT CHO 04/03/11-0508 File Document by CSS.JASH 0509 Pharmacy Discontinue MEDCOL
MUPIROCIN NASAL OINTMENT (MUPIROCIN 0.9 GM OINT, BRAND NAME STUDY DRUG) See Dose Ins. NASAL TWICE DAILY Dose Ins: SEE LABEL COMMENTS Comments: MRSA TRIAL-BACTROBAN UNIT DOSE NASAL FOR ICU PATIENTS ONLY!! TO BE DISCONTINUED ON PATIENT TRANSFER FROM ICU. 1/2 OF THE CONTENTS OF A 1 GRAM TUBE APPLIED TO EACH NOSTRIL TWICE DAILY RX #: 11743445	04/02/11 04/07/11	0509 Pharmacy Discontinue MEDCOL
ARIXTRA (FONDAPARINUX SODIUM (ARIXTRA) 2.5 MG/0.5 ML SYR) 2.5 MG SQ DAILY Comments: MEDICALLY NECESSARY RX #: 11744026	04/02/11 05/02/11	0509 Pharmacy Discontinue MEDCOL
CARDIZEM 25MG/5ML (DILTIAZEM HCL (CARDIZEM) 25 MG/5 ML VIAL) 5 MG IV Q8HR Comments: "HIGH ALERT DRUG" --PER HOSPITAL POLICY DOCUMENT DOUBLE CHECK PROCESS ON MAR-- RX #: 11744935	04/03/11 04/03/11	0508 Nursing Acknowledged Order CSS.JASH 0208 Pharmacy Discontinue SCHEDULER

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ADMINISTRATION PERIOD	START/STOP	
CARDIZEM 100MG/100 ML NS PIGGYBACK 100 ML (DILTIAZEM 100 MG/100 ML NS PIGGYBACK) ASSINJECTED IV AS DIRECTED Comments: FINAL CONC = 1MG/ML RATE = MG/HR = ML/HR TO BE USED ONLY FOR PATIENTS IN MONITORED TELEMETRY OR ICU BEDS **** HIGH ALERT DRUG **** ** PER HOSPITAL POLICY DOCUMENT DOUBLE CHECK PROCESS ** RX #: 11744935	04/02/11 05/06/11	0033 Nursing Acknowledged Order CSS.JASH 0034 CSS.JASH at 0034 GAVC, 100 ML'S Drug/Dose verified by: HAMSCAE Double check required?: Y 04/03/11-0034 File Document by CSS.JASH 0509 Pharmacy Discontinue HENDEL
SODIUM CHLORIDE 0.9% 250 ML (SODIUM CHLORIDE 0.9% 500 ML BAG) ASSINJECTED IV AS DIRECTED Comments: ** IF SBP < 80 ** RX #: 11745205	04/03/11 04/03/11	0403 Order Entry ISMITH 0509 Pharmacy Discontinue HENDEL
TYLENOL 325MG (ACETAMINOPHEN 325 MG CAPTAB) 650 MG PO EVERY 6H AS NEEDED/PRN PRN Reason: HAH PAIN/TEMP RX #: 11731699	03/30/11 04/29/11	0510 Pharmacy Discontinue HENDEL
ZOFRAN 2MG/ML (ONDANSETRON HCL (ZOFRAN) 4 MG/2 ML VIAL) 4 MG IV EVERY 6H AS NEEDED/PRN PRN Reason: NAUSEA RX #: 11738700	03/30/11 05/29/11	0510 Pharmacy Discontinue HENDEL

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MEDICATION PERIOD	START STOP	
DEXTROSE 50%/WATER AMBOJECT (DEXTROSE 50%-WATER 50 ML SYR) Sig: Dose Inc. IV AS NEEDED/PRN PRN Reason: DAILY @ AS NEEDED Dose Inc: *** SEE COMMENTS *** Comments: HYPOGLYCEMIA PROTOCOL: FOR BG < 70 OR STORS AND SYMPTOMS PRESENT A. IF PATIENT CAN TAKE PO GIVE 15 GMS FAST ACTING CARBS (E.G. 4OZ JUICE,REG SODA). B. IF PATIENT IS NPO AND HAVE GCVE 25 ML OF D50 IV PUSH. C. IF PATIENT IS NOT RESPONSIVE GIVE 50 ML OF D50 IV PUSH. D. IF NO IV ACCESS GIVE IM GLACAGON 1 MG SQ. MAY REPEAT IN 15 MINUTES PRN. E. CHECK FINGER STICK BLOOD GLUCOSE EVERY 15 MINUTES AND REPEAT TREATMENT IF BLOOD GLUCOSE IS <80. F. CALL PHYSICIAN FOR POSSIBLE INSULIN ADJUSTMENT. RX #: 11733765	03/30/11 05/29/11	0510 Pharmacy Discontinue (RXDCD)
VICODIN 5/500 (HYDROCODONE BITARTRATE/APAP (VICODIN 5/500) 1 EA (DTAB) 1 EA PO EVERY 12HOURS AS NEEDED/PRN PRN Reason: FOR PAIN Comments: **MAX DOSE 8 TABS PER 24 HOUR PERIOD** CHART EXACT DOSE GIVEN FOR ALL DOSAGE RANGES RX #: 11733707	03/30/11 04/29/11	0510 Pharmacy Discontinue (RXDCD)
ACETAMINOPHEN 650MG (ACETAMINOPHEN (TYLENOL) 650 MG SUPP) 650 MG PR EVERY 4H AS NEEDED/PRN PRN Reason: FEVER RX #: 11734973	03/30/11 04/29/11	0509 Pharmacy Discontinue (RXDCD)

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ADMINISTRATION PERIOD: 0001 04/01/11 TO 0000 04/12/11 (EMETHUBER)	START
DEXTROSE 50%/WATER ABBOJECT (DEXTROSE 50%-WATER 50 ML SYR) See Dose Ins, IV AS DIRECTED/PRN PRN Reason: DAILY @ AS NEEDED Dose Ins: *** SEE COMMENTS *** Comments: HYPOGLYCEMIA PROTOCOL: FOR BG < 70 OR SIGNS AND SYMPTOMS PRESENT A. IF PATIENT CAN TAKE PO GIVE 15 GMS FAST ACTING CARBS (E.G. 4OZ JUICE,REG SODA). B. IF PATIENT IS NPO AND AWAKE GIVE 25 ML OF D50 IV PUSH. C. IF PATIENT IS NOT RESPONSIVE GIVE 50 ML OF D50 IV PUSH. D IF NO IV ACCESS GIVE GLUCAGON 1 MG SQ. MAY REPEAT IN 15 MINUTES PRN. E CHECK FINGER STICK GLUCOSE EVERY 15 MINUTES AND REPEAT TREATMENT IF BLOOD GLUCOSE IS <80. F. CALL PHYSICIAN FOR POSSIBLE INSULIN ADJUSTMENT. RX #: 11741287	04/01/11 0509 Pharmacy Discontinue HSKEDL 05/01/11
ALBUTEROL CALBUTEROL SULFATE 2.5 MG/0.5 ML UDAMP) 2.5 MG INHALATION EVERY 6 HOURS RT/PRN PRN Reason: BRONCOSPASM Comments: **RT TO ADMINISTER** RX #: 11741288	04/01/11 0509 Pharmacy Discontinue HSKEDL 05/01/11
MORPHINE 2MG/ML SYRINGE (morphine SULFATE 2 MG/ML SYR) See Dose Ins, IV EVERY 2 HOURS AS NEEDED/PRN PRN Reason: FOR PAIN Dose Ins: 2-4MG Comments: **** IF ORDERED IV **** RECOMMEND FOR IV ADMINISTRATION TO OPIOID NAIVE PATIENTS *** DILUTE TO A FINAL CONC OF 1 MG/ML WITH NS * *** PUSH SLOWLY IN INCREMENTS OF 2 MG *** **** PAIN REASSESSMENT RECOMMENDED **** CHART EXACT DOSE GIVEN FOR ALL DOSAGE RANGES RX #: 11744007	04/03/11 0017 CSS.JASH at 0017 GIVE: 2 MG 04/09/11 NDC/DIN: (SOURCE: uMARS) 00409762301 MORFI021 2 - morphine SULFATE 2 MG/ML SYR >Pain Score:: 5 >Pain Scale Used:: WONG BAKER/FACES >Level of Sedation:: Somnolent Given for:: PAIN 04/03/11-0017 File Document by CSS.JASH DOSE changed from MG to 2 MG 0117 REASSESS by CSS.JASH at 0117 >Pain Scale Used: WONG BAKER/FACES >Pain Score: 0 location: >Level of Sedation: Somnolent Comment: IMED Pharmacy Discontinue DISCHARGE

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04/12/11 2535 MEDICATION DISCHARGE SUMMARY PAGE: 18

NAME: WINKLER,LOUIS UNIT #: [redacted] ACCT #: [redacted]

ADMINISTRATION PERIOD:	START/ STOP
3551 04/03/11 to 0000 04/04/11 (Continuing)	

LEVOPHED 4MG/250ML 250 ML CHOROPTIMIZATION DRIP 4 MG/250 ML IV SOLN ASDIRECTED IV AS NEEDED/PRN PRN Reason: IF SBP ALWAYS < 80 Comments: LEVOPHED 4MG/250 ML 2SW PREMIXED DRIP *** CONC=16 MCG/ML (0.01) MG/ML) RX #: 11745206	04/03/11 04/02/11	0403 Order Entry HRADOL 0437 Nursing Acknowledged Order INSCAE 0442 INSCAE at 0442 JD:SIGN:R; CSS.JASH GAVE: 250 MLS Drug/Dose verified by: CSS.JASH Double check required?: Y Most common side effects reviewed with patient?: Yes :: NONEPIN:nausea/vomiting, sweating, restlessness 04/03/11-0442 File Document by INSCAE 0509 Pharmacy Discontinue HRADOL

ADMINISTRATION PERIOD:	START/ STOP
3551 04/04/11 to 0000 04/05/11	

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This document is part of the legal medical record.

ORDERS FOR PERIOD:	STAT/
2007-04/04/11 to 2007-04/30/11 (CONTINUED)	STOP

LEGEND

READING CODES
L/C COMMENTS - LATE/EARLY SEE COMMENTS
L/E NEW ORDER - LATE/EARLY NEW ORDER
L/E OFF UNIT - LATE/EARLY OFF UNIT
L/E PT AVAIL - LATE/EARLY PT NOT AVAILABLE
L/E REQUEST - LATE/EARLY PT REQUEST
L/E SLEEPING - LATE/EARLY PT SLEEPING
CLPARM - NOT GIVN CLINICAL PARAMETERS
COMMENTS - NOT GIVN SEE COMMENTS
DC - NOT GIVN ORDER DISCONTINUED
GLUMOP - NOT GIVN GLUCOSE MAIN OFF PARA
HPO - NOT GIVN HPO
PT REFUSED - NOT GIVN PT REFUSED
ROUTE - NOT GIVN ROUTE NOT AVAILABLE
SLEEPING - NOT GIVN SLEEPING

SITE CODES
EB - Each Nare
LAB - Left Abdomen
LUA - Left Upper Arm

ADMINISTERED BY

USER	USER NAME/TYPE	USER	USER NAME/TYPE	USER	USER NAME/TYPE	USER	USER NAME/TYPE
CSS.JASH	SHIPLEY,JENNIFER A RN	CSS.YAN	MOHAMMAD,YOLENE RN	CSS.ZA	ACOSTA,ZAYDEE RN	HEDAMB	Brownley,Ashlie M RN
HEDHWB	Brightwell,Heather J RN	HEDMPP	Pring,Mary P RN	HMLDAC	Caldas,Deborah RN	HMLDNP	Pullappally,Jasmin RN
HNSAT05	Thomas,Anna RN	HNSPM04	MallSWAMY,RABU RN	HNSCAE	Evans,Cherrie A RN	HNSCAN	Mase,Carol A RN
HNSCHM04	Pasquini,Candace M LPN	HNSJDM	Carter,Erin M RN	HNSIBB	Bobiera,Imelda E. RN	HNSGAN02	Hansen,Kelly A RN
HNSKJY	Yost,Kami J. RN	HNSMC07	Chellappan,Merina RN	HNSKCT	Hawk,Melissa C RN	HNSNIP01	Patham,Mariamma I RN
HNSRP03	Privs,Robert RN	HNSPMA	Ackerman,Christy M	HRSPAM	Malinowski,Stephen M MT		

OTHER USERS

USER	USER NAME/TYPE	USER	USER NAME/TYPE	USER	USER NAME/TYPE	USER	USER NAME/TYPE
CDEDNR	Roberts,Korrie M	CTETMT	Tran,Julie M.	CSS.ZA	ACOSTA,ZAYDEE	HNSEDM	Carter,Erin M
HNSPCA	Ackerman,Christy	HNSMM	Malinowski,Stephen M	HRSCAF	Casilla,Carl N	HNSDBL	Daniels-Lee,Darsra
HRSDJ	John,Oberendat	HRSDGS	Groenwall,Dina	HRSENK	Kassem,Gamal M.	HRSDHR	Ross,Keonna M
HRSLMP	Presciaski,Lynn M.	HRSMSB	Bodtee,Melody S	HRSSCS	Smith,Suzanne G.	HNSEPR01	Bennett,Roderick B

PHA ALLERGY HISTORY

DATE	PHA	USER	ALLERGEN/REACTION	
03/29/11 2250	N	HEDAMB - Brownley,Ashlie M	ADDED No Known Allergies CLR: NEW: No Known Allergies added.	by HEDAMB
03/30/11 0739	N	HRTHBR - Brightwell,Heather J	FIFO	by HFDHBR

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ADMINISTRATION PERIOD:
DOS: 04/05/11 to 04/05/11 (continued)

		START/STOP	
			TEXT: User filed without changing allergy record.
03/30/11 0745 N	HEIWRD - Bright Swell,Heather J	FILED	by HEIWRD
			TEXT: User filed without changing allergy record.
04/01/11 1733 N	WES0001 - Jetson Berkys	FILED	by WES0001
			TEXT: User filed without changing allergy record.

Adm/Bdc: [redacted] Attending: Agzew,Yeshitila MD
Unit #: Account #: [redacted]
Admitted: 03/30/11 at 0245 Location: Nursing
Status: DIS Jhb Room/Bed: [redacted]

WINKLER,LOUIS

Brandon Regional Hospital Nursing *Live*
EVOLUTION PLAN OF CARE HPF

Printed 04/12/11 at 0319

Problem/Goal/Intervention Description	Activity Type	Date	Time	by	Date	Time	by	Comment	Unit	Charge
Activity Date: 03/30/11 Time: 0752										
Problem: PROB: Impaired Cardiovascular Function										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Goal: GOAL: Maintain/Impr Cardiovasc Function										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Problem: Care Guidelines										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Goal: SOC: Will Receive Care Per Guidelines										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Problem: Standard of Care Telemetry-Medical										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Goal: SOC: Will Receive Standard of Care										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Problem: PROB: Potential/Actual Altered Mental St										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Goal: ID Altered Mental Status/Maintain Safety										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Problem: PROB: Impaired EENT Function										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Goal: GOAL: Maintain/Improve EENT Function										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Problem: PROB: Impaired GI Function										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Goal: GOAL: Maintain/Improve GI Function										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Problem: PROB: Impaired Neuro Function										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Goal: GOAL: Maintain/Improve Neuro Function										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Problem: PROB: Impaired GU Function										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Goal: GOAL: Maintain/Impr Genitourinary Function										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Problem: PROB: Impaired Musculoskeletal										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Goal: GOAL: Maint/Impr Musculoskeletal Function										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Problem: PROB: Impaired Respiratory Function										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Goal: GOAL: Maintain/Improve Respiratory Func										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Problem: PROB: Impaired Skin Integrity										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Goal: GOAL: Maintain/Improve Condition of Skin										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Problem: FALL: Precautions-Fall										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			

Problem/Goal/Intervention Description	Activity Type	Date	Time	by	Date	Time	by	Comment	Unit	Charge
Activity Date: 03/30/11 Time: 0752										
Goal: GOAL: Maintain Precautions-FALL										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Problem: Age Guidelines: Adult 65+ Years										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Goal: ADL: Primarily manages discharge process in response to staff addressing age-specific communication, treatment, safety, anxiety, and education needs.										A
Create		03/30/11	0752	HJB	03/30/11	0752	HJB			
Activity Date: 03/30/11 Time: 1147										
Problem: Advance Directives										A
Create		03/30/11	1147	JMM	03/30/11	1147	JMM			
Goal: ADV: Respect Advance Directive Choices										A
Create		03/30/11	1147	JMM	03/30/11	1147	JMM			
Activity Date: 03/31/11 Time: 1246										
Problem: PROB: Impaired Hydration/Nutrition										A
Create		03/31/11	1246	AM	03/31/11	1246	AM			
Goal: GOAL: Optimize Hydration/Nutrition										A
Create		03/31/11	1246	AM	03/31/11	1246	AM			
Activity Date: 04/01/11 Time: 1744										
Problem: Standard of Care: Critical Care-Medical										A
Create		04/01/11	1744	ZA	04/01/11	1744	ZA			
Goal: SOC: Will Receive Standard of Care										A
Create		04/01/11	1744	ZA	04/01/11	1744	ZA			
Activity Date: 04/01/11 Time: 1958										
Problem: PROB: Potential/Actual Altered Mental St										A
Ed Status		04/01/11	1958	RP	04/01/11	1958	RP			A → C
Goal: ID Altered Mental Status/Maintain Safety										C
Ed Status		04/01/11	1958	RP	04/01/11	1958	RP			A → C
Problem: PROB: Impaired EENT Function										C
Ed Status		04/01/11	1958	RP	04/01/11	1958	RP			A → C
Goal: GOAL: Maintain/Improve EENT Function										C
Ed Status		04/01/11	1958	RP	04/01/11	1958	RP			A → C
Problem: PROB: Impaired GI Function										C
Ed Status		04/01/11	1958	RP	04/01/11	1958	RP			A → C
Goal: GOAL: Maintain/Improve GI Function										C
Ed Status		04/01/11	1958	RP	04/01/11	1958	RP			A → C

Age/Sex: [redacted]
Unit #: [redacted]
Admitted: 03/30/11 at 0845
Status: DIS INx

Attending: Agnew,Yeshitila MD
Account #: [redacted]
Location: R ESTC
Room/Bed: R A219-1

WINKLER, LOUIS

Brandon Regional Hospital Nursing Flow
EVOLUTION PLAN OF CARE HSF

Printed 04/12/11 at 0139

Problem/Goal/Intervention Description	Activity Type	Occurred Date	Occurred Time	By	Sec Interaction Comment	Documented Date	Time	Done
Activity Date: 04/02/11 Time: 2017								
Problem: PROB: Impaired Cardiovascular Function	A							
Problem: Care Guidelines	A							
- Resequence	04/02/11 2017 JAS	04/02/11 2017 JAS						12 => 10
Problem: Standard of Care: Telemetry-Medical	A							
Problem: Advance Directives	A							
- Resequence	04/02/11 2017 JAS	04/02/11 2017 JAS						14 => 12
Problem: Standard of Care: Critical Care-Medical	A							
Problem: PROB: Potential/Actual Altered Mental St	C							
- Resequence	04/02/11 2017 JAS	04/02/11 2017 JAS						1 => 14
Problem: PROB: Impaired ENT Function	C							
Problem: PROB: Impaired GU Function	C							
- Resequence	04/02/11 2017 JAS	04/02/11 2017 JAS						4 => 16
Problem: PROB: Impaired Neuro Function	A							
Problem: PROB: Impaired Hydration/Nutrition	A							
- Resequence	04/02/11 2017 JAS	04/02/11 2017 JAS						16 => 3
Problem: PROB: Impaired GI Function	A							
Problem: PROB: Impaired Musculoskeletal	A							
- Resequence	04/02/11 2017 JAS	04/02/11 2017 JAS						6 => 5
Problem: PROB: Impaired Respiratory Function	A							
Problem: PROB: Impaired Skin Integrity	A							
- Resequence	04/02/11 2017 JAS	04/02/11 2017 JAS						9 => 7
Problem: PREC: Precautions-Fall	A							
Problem: Age Guidelines: Adult 80+ years	A							
- Resequence	04/02/11 2017 JAS	04/02/11 2017 JAS						11 => 9
Activity Date: 04/03/11 Time: 1139								
Problem: PROB: Impaired Cardiovascular Function	D							
Goal: GOAL: Maintain/Impr Cardiovasc Function	D							
- Ed Status	04/03/11 1139 hrs	04/03/11 1139 hrs						A => D
Problem: Care Guidelines	D							
Goal: SOC: Will Receive Care Per Guidelines	D							
- Ed Status	04/03/11 1139 hrs	04/03/11 1139 hrs						A => D
Problem: Standard of Care: Telemetry-Medical	D							

Problem/Goal/Intervention Description	Activity Type	Occurred Date	Occurred Time	By	Sec Interaction Comment	Documented Date	Time	Done
Activity Date: 04/03/11 Time: 1139								
Goal: SOC: Will Receive Standard of Care	D							
- Ed Status	04/03/11 1139 hrs	04/03/11 1139 hrs						A => D
Problem: Advance Directives	D							
Goal: ADV: Respect Advance Directive Choices	D							
- Ed Status	04/03/11 1139 hrs	04/03/11 1139 hrs						A => D
Problem: Standard of Care: Critical Care-Medical	D							
Goal: SOC: Will Receive Standard of Care	D							
- Ed Status	04/03/11 1139 hrs	04/03/11 1139 hrs						A => D
Problem: PROB: Impaired Neuro Function	D							
Goal: GOAL: Maintain/Improve Neuro Function	D							
- Ed Status	04/03/11 1139 hrs	04/03/11 1139 hrs						A => D
Problem: PROB: Impaired Hydration/Nutrition	D							
Goal: GOAL: Optimize Hydration/Nutrition	D							
- Ed Status	04/03/11 1139 hrs	04/03/11 1139 hrs						A => D
Problem: PROB: Impaired GU Function	D							
Goal: GOAL: Maintain Genitourinary Function	D							
- Ed Status	04/03/11 1139 hrs	04/03/11 1139 hrs						A => D
Problem: PROB: Impaired Musculoskeletal	D							
Goal: GOAL: Maintain Musculoskeletal Function	D							
- Ed Status	04/03/11 1139 hrs	04/03/11 1139 hrs						A => D
Problem: PROB: Impaired Respiratory Function	D							
Goal: GOAL: Maintain/Improve Respiratory Func	D							
- Ed Status	04/03/11 1139 hrs	04/03/11 1139 hrs						A => D
Problem: PROB: Impaired Skin Integrity	D							
Goal: GOAL: Maintain/Improve Condition of Skin	D							
- Ed Status	04/03/11 1139 hrs	04/03/11 1139 hrs						A => D
Problem: PREC: Precautions-Fall	D							
Goal: GOAL: Maintain Precautions-FALL	D							
- Ed Status	04/03/11 1139 hrs	04/03/11 1139 hrs						A => D
Problem: Age Guidelines: Adult 80+ years	D							
Goal: AGE: Pt/Family manages disease process in response to staff addressing age-specific communication, treatment, safety, anxiety, and education needs.	D							
- Ed Status	04/03/11 1139 hrs	04/03/11 1139 hrs						A => D

Age/Sex: 81 M
MRN: [redacted]
Admitted: 03/30/11 at 0245
Status: DIS INa

Attending: Agiew, Yeshitila MD
Account #: [redacted]
Location: M-SSIC
Room/Bed: M.A539-1

WINKLER, LOUIS

Brandon Regional Hospital Nursing Flow
EXHIBITION PLAN OF CARE HPF

Page: 3
Printed 04/12/11 at 0329

Assigned Initials	Name	Role
AM	MORAM	Manserrato, Angeliael	RD
DMH	MAGDMH02	Mullins, Donna M	PR
HJB	HEIGHXB	Brightwell, Heatner J	RN
JAS	CSS.JASH	SHIPLEY, JENNIFER A	RN
RP	MAGRP01	Price, Robert	RN
ZA	CSS.ZA	ACOSTA, ZAYDEE	RN
This		automatic by progress	

Admitted: 03/30/11 at 0246
Status: DIS IRx

Attending: Agnew,Yeshitila MD
Account #: [redacted]
Location: H.5S1C
Room/Bed: H.5339-1

WINKLER,LOUIS

Brandon Regional Hospital Nursing "Live"
PLAN OF CARE RPT

Page: 1
Printed 04/12/11 at 0340

Problem/Goal/Intervention Description	Sta	Direction	Freq	Activity Date	Entered	Recorded	Achieved	Discontinued

Activity Date: 03/30/11 Time: 0252

Problem: PROB: Impaired Cardiovascular Function A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: GOAL: Maintain/Impr Cardiovasc Function A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Problem: Care Guidelines A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: SOC: Will Receive Care Per Guidelines A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
450600 Plan of Care Review A QSWIFT CP
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Problem: Standard of Care: Telemetry-Medical A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: SOC: Will Receive Standard of Care A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Problem: PROB: Potential/Actual Altered Mental St A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: IC Altered Mental Status/Maintain Safety A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Problem: PROB: Impaired GI/GU Function A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: GOAL: Maintain/Improve GI/GU Function A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Problem: PROB: Impaired Neuro Function A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: GOAL: Maintain/Improve Neuro Function A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Problem: PROB: Impaired GU Function A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: GOAL: Main/Imp Genitourinary Function A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Problem: PROB: Impaired Musculoskeletal A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: GOAL: Main/Impr Musculoskeletal Function A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Problem: PROB: Impaired Respiratory Function A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: GOAL: Maintain/Improve Respiratory Func A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Problem: PROB: Impaired Skin Integrity A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: GOAL: Maintain/Improve Condition of Skin A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB

Problem/Goal/Intervention Description	Sta	Direction	Freq	Activity Date	Entered	Recorded	Achieved	Discontinued

Activity Date: 03/30/11 Time: 0252

Problem: PRECS: Precautions-Fall A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: GOAL: Maintain Precautions-FALL A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Problem: Age Guidelines: Adult 80+ years A
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: ADE: Patfamly manages disease process A
in response to staff addressing age-specific communication, treatment, safety, orality, and education needs.
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB

Activity Date: 03/30/11 Time: 0310

450600 Plan of Care Review A QSWIFT CP
- Create 03/30/11 0752 HJB 03/30/11 0752 HJB
< PLAN OF CARE REVIEW >

Link to Plan of Care: [redacted]
Care plan reviewed and/or individualized and reprioritized: [redacted]

Nurse signature: [redacted]

Activity Date: 03/30/11 Time: 1140

450600 Plan of Care Review A QSWIFT CP
- Create 03/30/11 1140 HJB 03/30/11 1140 HJB
< PLAN OF CARE REVIEW >

Link to Plan of Care: [redacted]
Care plan reviewed and/or individualized and reprioritized: [redacted]

Nurse signature: [redacted]

Activity Date: 03/30/11 Time: 1147

Problem: Advance Directives A
- Create 03/30/11 1147 DMH 03/30/11 1147 DMH

Problem/Goal/Intervention Description | Activity Type | Acquired Date | Acquired Time | By | Activity/Event | Site Direction / Comments | Units | Freq / Charge

Activity Date: 03/30/11 Time: 1147

Qual. ADs: Respect Advance Directive Choices A
Create 03/30/11 1147 [redacted] 03/30/11 1147 [redacted]

Activity Date: 03/31/11 Time: 2000

450600 Plan of Care Review A QSHIFT CP
[redacted]
< PLAN OF CARE REVIEW >

Link to Plan of Care: Y
Care plan reviewed and/or individualized and reprioritized: Y
Nurse signature: [redacted]

Activity Date: 04/01/11 Time: 0400

450600 Plan of Care Review A QSHIFT CP
[redacted]
< PLAN OF CARE REVIEW >

Link to Plan of Care: Y
Care plan reviewed and/or individualized and reprioritized: Y
Nurse signature: [redacted]

Activity Date: 04/01/11 Time: 1240

Problem: PROB: Impaired Hydration/Nutrition A
- Create 03/31/11 1246 AM 03/31/11 1246 AM
Goal: GOAL: Optimize Hydration/Nutrition A
- Create 03/31/11 1246 AM 03/31/11 1246 AM

Activity Date: 04/01/11 Time: 2000

450600 Plan of Care Review A QSHIFT CP
[redacted]
< PLAN OF CARE REVIEW >

Link to Plan of Care: Y
Care plan reviewed and/or individualized and reprioritized: Y

Activity Date: 04/01/11 Time: 1700

450600 Plan of Care Review (continued)
Nurse signature: [redacted]

Activity Date: 04/01/11 Time: 1700

450600 Plan of Care Review A QSHIFT CP
[redacted]
< PLAN OF CARE REVIEW >

Link to Plan of Care: Y
Care plan reviewed and/or individualized and reprioritized: Y
Nurse signature: [redacted]

Problem: Standard of Care Critical Care-Medical A
- Create 04/01/11 1744 ZA 04/01/11 1744 ZA
Goal: SOC: Will Receive Standard of Care A
- Create 04/01/11 1744 ZA 04/01/11 1744 ZA

Problem: PROB: Potential/Actual Altered Mental St C
- Ed Status 04/01/11 1958 RP 04/01/11 1958 RP A ⇒ C
Goal: GOAL: Altered Mental Status/Maintain Safety C
- Ed Status 04/01/11 1958 RP 04/01/11 1958 RP A ⇒ C
Problem: PROB: Impaired CENT Function C
- Ed Status 04/01/11 1958 RP 04/01/11 1958 RP A ⇒ C
Goal: GOAL: Maintain/Improve CENT Function C
- Ed Status 04/01/11 1958 RP 04/01/11 1958 RP A ⇒ C
Problem: PROB: Impaired GI Function C
- Ed Status 04/01/11 1958 RP 04/01/11 1958 RP A ⇒ C
Goal: GOAL: Maintain/Improve GI Function C
- Ed Status 04/01/11 1958 RP 04/01/11 1958 RP A ⇒ C

Problem/Goal/Intervention Description	Sig	Direction Documented	Error Status
Activity Type: Date: Occurred Time: By: Location:			
Activity Date: 04/02/11 Time: 1823			
460600 Plan of Care Review A CBAUFT CP			
Document: 04/02/11 0023 JAS 04/02/11 0023 JAS			
< PLAN OF CARE REVIEW >			
Link to Plan of Care:			
Care plan reviewed and/or individualized and reprioritized:			
Nurse signature: [redacted]			
Activity Date: 04/02/11 Time: 2000			
460600 Plan of Care Review A CBAUFT CP			
Document: 04/02/11 2000 JAS 04/02/11 2000 JAS			
< PLAN OF CARE REVIEW >			
Link to Plan of Care:			
Care plan reviewed and/or individualized and reprioritized:			
Nurse signature: [redacted]			
Activity Date: 04/02/11 Time: 2017			
460600 Plan of Care Review A CBAUFT CP			
Document: 04/02/11 2017 JAS 04/02/11 2017 JAS			
< PLAN OF CARE REVIEW >			
Link to Plan of Care:			
Care plan reviewed and/or individualized and reprioritized:			
Nurse signature: [redacted]			
Activity Date: 04/02/11 Time: 2017			
Problem: PROB: Impaired Cardiovascular Function	A		
Resequence 04/02/11 2017 JAS 04/02/11 2017 JAS			2 ⇒ 1
Problem: Care Guidelines	A		
Resequence 04/02/11 2017 JAS 04/02/11 2017 JAS			10 ⇒ 9
Problem: Standard of Care: Telemetry-Medical	A		
Resequence 04/02/11 2017 JAS 04/02/11 2017 JAS			13 ⇒ 11
Problem: Advance Directives	A		
Resequence 04/02/11 2017 JAS 04/02/11 2017 JAS			14 ⇒ 12
Problem: Standard of Care: Critical Care-Medical	A		
Resequence 04/02/11 2017 JAS 04/02/11 2017 JAS			16 ⇒ 13
Problem: PROB: Potential/Actual Altered Mental St	A		
Resequence 04/02/11 2017 JAS 04/02/11 2017 JAS			17 ⇒ 14
Problem: PROB: Impaired ENT Function	C		
Resequence 04/02/11 2017 JAS 04/02/11 2017 JAS			3 ⇒ 15
Problem: PROB: Impaired GI Function	A		
Resequence 04/02/11 2017 JAS 04/02/11 2017 JAS			18 ⇒ 16
Problem: PROB: Impaired Neuro Function	A		
Resequence 04/02/11 2017 JAS 04/02/11 2017 JAS			7 ⇒ 2
Problem: PROB: Impaired Hydration-Nutrition	A		
Resequence 04/02/11 2017 JAS 04/02/11 2017 JAS			19 ⇒ 17
Problem: PROB: Impaired GU Function	A		
Resequence 04/02/11 2017 JAS 04/02/11 2017 JAS			5 ⇒ 4
Problem: PROB: Impaired Musculoskeletal	A		
Resequence 04/02/11 2017 JAS 04/02/11 2017 JAS			20 ⇒ 18
Problem: PROB: Impaired Respiratory Function	A		
Resequence 04/02/11 2017 JAS 04/02/11 2017 JAS			8 ⇒ 6
Problem: PROB: Impaired Skin Integrity	A		
Resequence 04/02/11 2017 JAS 04/02/11 2017 JAS			21 ⇒ 19
Problem: PROB: Precautions-Fall	A		
Resequence 04/02/11 2017 JAS 04/02/11 2017 JAS			10 ⇒ 8
Problem: Age Guidelines: Adult 864 years	A		
Resequence 04/02/11 2017 JAS 04/02/11 2017 JAS			22 ⇒ 20
Activity Date: 04/03/11 Time: 1139			
Problem: PROB: Impaired Cardiovascular Function	B		
Ed Status 04/03/11 1139 hrs 04/03/11 1139 hrs			A ⇒ D
Goal: GOAL: Maintain/Impr Cardiovasc Function	B		
Ed Status 04/03/11 1139 hrs 04/03/11 1139 hrs			A ⇒ D
Problem: Care Guidelines	B		
Ed Status 04/03/11 1139 hrs 04/03/11 1139 hrs			A ⇒ D
Goal: SOC: Will Receive Care Per Guidelines	B		
Ed Status 04/03/11 1139 hrs 04/03/11 1139 hrs			A ⇒ D
460600 Plan of Care Review	B	CBAUFT	CP
Co-Sign 04/03/11 1139 hrs 04/03/11 1139 hrs			A ⇒ D
Problem: Standard of Care: Telemetry-Medical	B		
Ed Status 04/03/11 1139 hrs 04/03/11 1139 hrs			A ⇒ D

Ward: 4I 9 | Attending: Anjaw,Yeshitila MD | WINKLER, LOUIS | Page: 4
Unit: [redacted] | Account #: [redacted]
Admitted: 03/30/11 At 0246 | Location: M,SSIC | Brandon Regional Hospital Nursing Flow Sheet | Printed 04/12/11 at 0340
Status: DIS INP | Room/Bed: M,A039-1

Problem/Goal/Intervention Description	Ed. Status	Direction	Error
Activity Type	Entered Date Time	Performed By Date	Time Or Comment	Values	Charge

Activity Date: 04/03/11 Time: 1139

Goal: SOC: Will Receive Standard of Care 0
Ed Status 04/03/11 1139 hls 04/03/11 1139 hls A => D
Problem: Advance Directives 0
Ed Status 04/03/11 1139 hls 04/03/11 1139 hls A => D
Goal: ADV: Respect Advance Directive Choices 0
Ed Status 04/03/11 1139 hls 04/03/11 1139 hls A => D
Problem: Standard of Care: Critical Care-Medical 0
Ed Status 04/03/11 1139 hls 04/03/11 1139 hls A => D
Goal: SOC: Will Receive Standard of Care 0
Ed Status 04/03/11 1139 hls 04/03/11 1139 hls A => D
Problem: PROB: Impaired Neuro Function 0
Ed Status 04/03/11 1139 hls 04/03/11 1139 hls A => D
Goal: GOAL: Maintain/Improve Neuro Function 0
Ed Status 04/03/11 1139 hls 04/03/11 1139 hls A => D
Problem: PROB: Impaired Hydration/Nutrition 0
Ed Status 04/03/11 1139 hls 04/03/11 1139 hls A => D
Goal: GOAL: Optimize Hydration/Nutrition 0
Ed Status 04/03/11 1139 hls 04/03/11 1139 hls A => D
Problem: PROB: Impaired GU Function 0
Ed Status 04/03/11 1139 hls 04/03/11 1139 hls A => D
Goal: GOAL: Male/Fem Genitourinary Function 0
Ed Status 04/03/11 1139 hls 04/03/11 1139 hls A => D
Problem: PROB: Impaired Musculoskeletal 0
Ed Status 04/03/11 1139 hls 04/03/11 1139 hls A => D
Goal: GOAL: Main/Impr Musculoskeletal Function 0
Ed Status 04/03/11 1139 hls 04/03/11 1139 hls A => D
Problem: PROB: Impaired Respiratory Function 0
Ed Status 04/03/11 1139 hls 04/03/11 1139 hls A => D
Goal: GOAL: Maintain/Improve Respiratory Func 0
Ed Status 04/03/11 1139 hls 04/03/11 1139 hls A => D
Problem: PROB: Impaired Skin Integrity 0
Ed Status 04/03/11 1139 hls 04/03/11 1139 hls A => D
Goal: GOAL: Maintain/Improve Condition of Skin 0
Ed Status 04/03/11 1139 hls 04/03/11 1139 hls A => D
Problem: PREC: Precautions-Fall 0
Ed Status 04/03/11 1139 hls 04/03/11 1139 hls A => D
Goal: GOAL: Maintain Precautions-FALL 0
Ed Status 04/03/11 1139 hls 04/03/11 1139 hls A => D
Problem: Age Guidelines: Adult 80+ years 0
Ed Status 04/03/11 1139 hls 04/03/11 1139 hls A => D
Goal: AGE: PT/Family manages disease process 0
In response to staff addressing age-specific communication, treatment, safety, quality, and education needs.
Ed Status 04/03/11 1139 hls 04/03/11 1139 hls A => D

Modified Initials	Name	Nurse Title
AM	MDFAM	Monserrate,Angelsel	RD
BM	HNSBM04	MUNISAMY,BABU	RN
DMM	HNSDM02	Molina,Donna M	RN
HJB	NEDHJB	Brightwell,Heather J	RN
JAS	CSS.JASH	SHIPLEY,JENNIFER A	RN
KAM	HNSKAM02	Morran,Kelly A	RN
RD	HDCRD03	Price,Robert	RN
ZA	CSS.ZA	ACOSTA,JAYDEE	RN
hls		automatic by program	

Age/Sex: 81 M
DOB: [redacted]
Admitted: 03/30/11 at 0246
Status: DIS INP

Attending: Ajeen,Yemitib MD
Account: [redacted]
Location: M.SSIC
Room/Bed: M.A539-1

WINKLER, LOUIS

Brendan Regional Hospital Nursing Flow*
CLINICAL DOCUMENTATION RECORD HPF

Printed 04/12/11 at 1802

Problem/Goal/Intervention Description | SCS Intervention | Init

Activity Type	Occurred Date	Recorded Time by Date	Time on Current	Documented Entity	Status

Activity Date: 03/29/11 Time: 2250

ORI Allergies: 03/29/11 2250 AMB 03/29/11 2250 AMB
Sterling Values
No allergy record on file.
Edited and Verified
Order Allergies/Adverse Reactions

Activity Name	Category Type	Severity Vert	Init Activity
Reaction			
ADD No Known Allergies	Drug Allergy	N 03/29/11 2250 AMB	

Activity Date: 03/29/11 Time: 2300

Patient Notes: EMERGENCY DEPARTMENT
- Create 03/29/11 2303 AMB 03/30/11 0134 AMB

1/2ON WOUND TO COCCYX
Note Type Description
No Type None

Activity Date: 03/30/11 Time: 0100

LOG-E EDM - MEDICATION HISTORY A AS
- Create 03/30/11 0105 AMB 03/30/11 0105 AMB
- Document 03/30/11 0105 AMB 03/30/11 0113 AMB
Med Rec E/E admission medications: Y
Patient Notes: EMERGENCY DEPARTMENT
- Create 03/30/11 0105 AMB 03/30/11 0106 AMB

PT ADMAINS AT CT
Note Type Description
No Type None

Activity Date: 03/30/11 Time: 0117

Patient Notes: EMERGENCY DEPARTMENT
- Create 03/30/11 0117 AMB 03/30/11 0117 AMB

PT RETURNED FROM CT
Note Type Description
No Type None

Problem/Goal/Intervention Description | SCS Intervention | Init

Activity Type	Occurred Date	Recorded Time by Date	Time on Current	Documented Entity	Status

Activity Date: 03/30/11 Time: 0246

Patient Notes: EMERGENCY DEPARTMENT
- Create 03/30/11 0246 AMB 03/30/11 0246 AMB

ADMISSION ORDERS RECEIVED
Note Type Description
No Type None

Activity Date: 03/30/11 Time: 0300

540000 Patient Care Orders A USHIFT OE
YS HF
ADLS AS HS
SLDS DAY PROGRAM ASLS
Create 03/30/11 0302 HJB 03/30/11 0302 AMB

Activity Date: 03/30/11 Time: 0315

LOG016 Admit History A WS Admission AS
Create 03/30/11 0315 HJB 03/30/11 0315 HJB
- Document 03/30/11 0730 HJB 03/30/11 0745 HJB
<< ADMISSION HISTORY >>
- ARRIVAL INFORMATION -
Arrival From: ADULT LIVING FACILITY
Mode of Arrival: EMS TRANSPORT
Accompanied By: CHILD(REN)
Unable to take Rx due to: DEMENTIA, DISORIENTED
Admit Dx: UNSEPSIS R/O LYMPHOMA
Present Symptoms/Complaints: PER NH REPORT PT RETURNED FROM ROMAD AND A SEVERE DECLINE IN MENTAL STATUS WAS NOTED WITH SOB
Are you currently participating in a research study? N NO
Instruct Patient not to take any medications in the Hospital unless ordered by a physician.
Takes Daily Medications, Vitamins, Herbal or OTC Medications Y
- Y
Core Measure/Stroke Tracking: Not Applicable
Height
Feet: 6
Inches: 1.0
Cm: 185.42
Weight
Lb: 180
Kg: 81.63
BMI: 23.7
- ADVANCE DIRECTIVES -
Do you have an advance directive: Y
Do You Have a Durable Medical Power of Attorney: YES
Copy Placed on Chart: N
Name: JEFFERY WINKLER

[redacted] Attending: Andrea Yehiilis MD | WINKLER, LOUIS | Page: 2

Admitted: 03/30/11 at 0245 Location: H.ESIC | Brandon Regional Hospital Nursing *Live* | Printed 04/12/11 at 1002
Status: DIS Inp Room/Bed: H.A539-1 | CLINICAL DOCUMENTATION RECORD MPF

Problem/Goal/Intervention Description — Sig Intervention — Event

Activity Type | Ordered Date Time | By | Role | Accepted Date Time | By | Role | Documented Date Time | By | Comment | Entity | Change

Activity Date: 03/30/11 — Type: OTHER (continued)

ICD015 Admit: History* (continued)
Do You Have a Health Care Surrogate: YES
Copy Placed on Chart: N
Name: JEFFREY WINKLER
Does pt have order for comfort measures/palliative care: N
- PREVIOUS SURGERIES/PROCEDURES -
Previous Surgeries: LT PROSTHETIC EYE
RT ARM
Problems with Prior Anesthesia: UNKNOWN
Family History of Anesthesia Problems: UNKNOWN
- COMMUNICABLE DISEASE HISTORY -
Drug Resistant Organism: UNKNOWN
Hepatitis: UNKNOWN
TB/Respiratory Screening: Y
Communicable Disease: UNKNOWN
TB Point of Entry Screen: NEGATIVE
Contagious Respiratory Infection Point of Entry Screen: NEGATIVE
Vaccine Screening: Y
MRSA SCREENING - FIRST POINT OF CONTACT: NURSING
Patient admitted/transferred from: Nursing Home
Name of facility: THE VILLAGES
Reported/Visualized open or draining wound: Yes
Is reason for visit Ortho/Joint Replacement, Spine, or Open Heart Surgery? N
Is this a dialysis patient? N
Is patient an ICU Admit? N
Does patient meet criteria? Y
Nasal swab obtained? Y
- SOCIAL HISTORY -
Smoking status for patients 13 years old or older: Unknown if ever smoked
Adult cigarette smoking history within last year: UNABLE TO DETERMINE
Smoking Cessation Information Given: Y
- ABUSE HISTORY -
Comment: UNABLE TO ASSESS
- MEDICAL HISTORY -
Neuro/Psych Hx: DEMENTIA
Endocrine Hx: DM
EENT Hx: ARTIFICIAL LT EYE
GI Hx: UNABLE TO ASSESS
Cardiovascular Hx: HYPERTENSION
Respiratory Hx: UNABLE TO ASSESS
Musculoskeletal Hx: WEAKNESS
Integumentary Hx: ULCER ON COCCYX
DISCOLORATION ON LOWER
EXTREMITIES
Hematological Hx: UNABLE TO ASSESS
Genitourinary Hx: UROSEPSIS
Reproductive Hx: CHILDREN
History of Cancer: UNABLE TO ASSESS

Problem/Goal/Intervention Description — Sig Intervention — Event

Activity Type | Ordered Date Time | By | Role | Accepted Date Time | By | Comment | Entity | Change

Activity Date: 03/30/11 — Type: OTHER (continued)

ICD015 Admit: History* (continued)
Bone Marrow or Stem Cell Transplant: UNABLE TO ASSESS
History of Blood Transfusion: UNABLE TO ASSESS
Self Testicular Exam: N
Last Prostate Exam (Date): UTA
< ADVANCE DIRECTIVE INTENT >
The intent of my Advance Directive/Living Will is to have the following:
Is patient currently experiencing any of following in last 7 days:
Fever greater than 100.4? N
(37.8 C)
Cough? N
(not related to
allergy or COPD)
Sore Throat? N
Night sweats? N
Unexplained weight loss? N
Fatigue? N
Body Aches? N
Rash? N
Nasal Congestion (not related to allergies or sinus infections)? N
Pt reports prior history of TB or positive TB skin test? N
Close contact with a person who has TB? N
Close contact with any person having an Influenza-like Illness? N
Patient or caregiver refuses to receive Pneumococcal Vaccine: Y
Patient or caregiver refuses to receive Influenza Vaccine: Y
Vaccine Status: NOT A CANDIDATE
Pneumococcal vaccination status- Pt or caregiver : refusal

Activity Date: 03/30/11 — Type: DIS

LZ0000 Admit: Assessment* — A — On admission — AS
A physical evaluation will be performed per policy. The following parameters are considered a normal evaluation, whose results are "within defined parameters" (WDP). If a patient falls within defined parameters for a system, user may answer "Y" to the "WDP" query and move on to the next system. Alternatively, if the user answers "N" he/she must complete the system specific evaluation, addressing all appropriate queries before moving onto the next system.

NEUROLOGICAL

Procedure/Intervention Description				Site Indication		Prov
Activity Type	Occurred Date	Time	Recorded by Date	Time	Documented by Content	Units	Charge

Procedure/Intervention Description				Site Indication		Prov
Activity Type	Occurred Date	Time	Recorded by Date	Time	Documented by Content	Units	Charge

120000 Admit. Assessment (continued)

Alert and oriented
Follows commands
Moves all extremities
Communicates effectively; speech clear
Facial symmetry noted
Sensation intact
Recent and remote memory intact
Thought processes intact; Logical appropriate sequence; Coherent and relevant to topic
No complaint of dizziness/vertigo; Syncope/fainting

CARDIOVASCULAR
Heart rate normal for age
Heart rhythm regular
No edema
Peripheral pulses palpable
No loss of sensation
No chest pain/pressure
Not on a cardiac monitor
No implanted devices within 6 months.

RESPIRATORY
Respirations even and unlabored
Respiratory rate normal for age
Lung sounds clear bilaterally
Chest expansion symmetrical
No cough, sputum, or secretions noted
No supplemental oxygen

GASTROINTESTINAL
Abdomen soft, non tender, without distention
Bowel sounds present all 4 quadrants
Bowel movements are within own normal pattern
Tolerating diet without nausea and vomiting

GENITOURINARY/REPRODUCTIVE
Voiding without discomfort, difficulty, or incontinence
Frequency and amount within own normal pattern
Clear, yellow urine
No reported/observed bladder distention
No urinary catheter, stents or dialysis

120000 Admit. Assessment (continued)

No reported/observed abnormal vaginal/penile discharge

MUSCULOSKELETAL
No skeletal deformities noted
No weakness in extremities
No use of Mobility aids
Range of motion/within own normal pattern

INTEGUMENTARY
Skin warm, dry and intact without redness
Turgor appropriate for age
Skin color appropriate for patient's ethnicity
** ANSWER NO TO MDP's IF USING ANY THERAPEUTIC SKIN CARE DEVICES/MEASURES**

EENT
Eyes have no discharge or redness
No complaint of impaired vision with or without glasses or contacts in place
Able to hear sounds with or/and without hearing aids
Mucosa pink, moist, and smooth
No nasal discharge or complaints
No throat complaints

PSYCHOSOCIAL
Mood appropriate for situation with regards to cultural influences and/or life events
Effective coping skills/patterns with regard to cultural influences and/or life events (i.e., Post-traumatic response, abusive behavior to self, threats of self harm, suicidal thoughts, or violent behavior)
No delusions, hallucinations, or delirium tremors

[redacted]
Document 03/30/11 0745 HJG 03/30/11 0752 HJG
<< ADMISSION ASSESSMENT >>
Patient identification verified and ID bracelet applied: Y
Allergies identified and allergy bracelet applied: Y
Neurological WDP: N
EENT WDP: N
Cardiovascular WDP: N

[redacted] Attending: Agrow,Yeshitila MD | WINKLER,LOUIS | Page: 4
Admitted: 03/30/11 at 0246 Account #: [redacted]
Status: OIS IAA Location: B.A509-1
Brandon Regional Hospital Nursing *Live*
CLINICAL DOCUMENTATION RECORD HPF
Printed 04/12/11 at 1802

Problem/Goal/Intervention Description | Sub Interactive | Flwsht
Activity | Required | Recorded | Documented | Value | Comment

Problem/Goal/Intervention Description | Sub Interactive | Flwsht
Activity | Required | Recorded | Documented | Value | Comment

Activity Date/Time(s) | Time (cont'd)

Activity Date/Time(s) | Time (cont'd)

120000 Admit: Assessment (continued)
Respiratory WDP: N
GI/Nutrition WDP: N
Integumentary WDP: N
Musculoskeletal WDP: N
GU/Reproductive WDP: N
Psycho-social WDP: Y
Foley catheter insertion: Facility Emergency Dept
Mode of Transport: Stretcher
Venous Access: Peripheral
Skin Risk Evaluation: Y
FALL RISK ASSESSMENT: Y
NHS Screening: N
Functional Screening: Y
Venous Thromboembolism Eval: Y
- VITAL SIGNS -
Temp-F: 99.1
Temp-C: 37.4
Temp Source: AXILLARY
Pulse: 108
Pulse Source: MONITOR
Resp: 22
Resp Type: REGULAR
BP: 145/81
BP Source: NON-INVASIVE BP CUFF
Patient Position: Lying
MAP: 102
- PAIN EVALUATION -
Does Patient Currently Have Pain: N
#Pain Scale Used: NON-VERBAL PAIN SCALE
>Pain Score: 0
Code Status: FULL
- ISOLATION PRECAUTIONS -
Isolation Type: NONE
- EDUCATIONAL NEEDS -
Pt/Family Motivational Level: EAGER TO LEARN
Barriers to Learning: COGNITIVE LIMITATION
: VISUAL IMPAIRMENT
Infection control and transmission prevention information provided to patient/family/visitors and questions answered: N
Do You Have Traditions, Values, and/or Beliefs Related to Health Practices: N
Would you object to a visit by a representative of your faith while you are in the hospital: N
Personal Property: N
< DISCHARGE NEEDS EVALUATION >
Condition Causing Hospitalization Results in a Change in Functional Level: N
Psychological or Family Issues May Affect the Patient's Discharge: N
Services Needed at Discharge: N

120000 Admit: Assessment (continued)
< NEUROLOGICAL EVALUATION >
LOC DROWSY
Oriented: N
Disoriented to: PLACE
TIME
SITUATION/EVENT
Speech: APPROPRIATE FOR AGE
Sensation-RUE: WITHDRAWS FROM PAIN
RLE: WITHDRAWS FROM PAIN
LUE: WITHDRAWS FROM PAIN
LLE: WITHDRAWS FROM PAIN
Motor Skill Eval: Y
Right Arm: SPONTANEOUS MOVEMENT
Right Leg: SPONTANEOUS MOVEMENT
Left Arm: SPONTANEOUS MOVEMENT
Left Leg: SPONTANEOUS MOVEMENT
Impaired Memory: DISTANT & RECENT PAST
Behavior: CONFUSED
Right Eye(OD) mm: 2
Reaction: REACTIVE
Reaction: NONREACTIVE
, ARTIFICIAL
Pupils Equal, Round, React to Light, and Accomodation: Y
Eye Movement Without Deficit: Y
Cranial Nerves Intact: Y
< EENT EVALUATION >
Right Eye/OD: VISION IMPAIRMENT
Left Eye/OS: PROSTHETIC EYE
Do you use any assistive devices for vision or hearing: Y
What do you use: ARTIFICAL LT EYE
< CARDIOVASCULAR EVALUATION >
Is Patient on Cardiac Monitoring: Y
Heart Sounds: NORMAL
Rhythm: REGULAR
Cap Refill Eval: Y
RUE: ARISE < 3 SECONDS
LUE: ARISE < 3 SECONDS
RLE: ARISE < 3 SECONDS
LLE: ARISE < 3 SECONDS
Peripheral Pulse Eval: Y
R Radial: 2+ NORMAL
L Radial: 2+ NORMAL
R Dorsal Pedis: 2+ NORMAL
L Dorsal Pedis: 2+ NORMAL
Edema: Y
Edema Location: LOWER EXTREMITIES
Edema Type: 2+ 1 MINUTE

Age/Sex: 81 M
Unit #: [redacted]
Admitted: 03/30/11 at 0245
Status: DIS IN

Attending: Agzew,Yeshitila MD
Account #: [redacted]
Location: M.SSIC
Room/Bed: M.A539-1

WINKLER, LOUIS

Brandon Regional Hospital Nursing Home
CLINICAL DOCUMENTATION RECORD MAR

Printed 04/12/11 at 1002

Problem/Goal/Intervention Description | Site/Direction | Activity | Occurred | Recorded | Documented | Type | Data | Type | By | Value | Type | By | Comment | Units | Charge

Activity Date: 03/30/11 Time Class (continued)

120000 Admit: Assessment (continued)
Human's Sign: NEGATIVE
Chest Pain: N
<< TELEMETRY EVALUATION >>
EKG Rhythm: SINUS TACHYCARDIA
Rate: 102
Tele Box Number: 38
< RESPIRATORY EVALUATION >
Depth: DEEP
Effort: UNLABORED
Cough: NONE
Chest Shape: SYMMETRICAL
Chest Movement: SYMMETRICAL
Retractions: N
Self Suction at Bedside: N
O2 Therapy: Y
Incentive Spirometry: N
Intubated/Trach/Ventilated: N
Breath Sounds Eval: Y
R Upper Anterior: DIMINISHED
L Upper Anterior: DIMINISHED
R Mid Anterior: DIMINISHED
R Lower Anterior: DIMINISHED
L Lower Anterior: DIMINISHED
< RETRACTIONS >
< OXYGEN THERAPY >
O2 Device: NASAL CANNULA
O2 Flow (LPM): 2
< INCENTIVE SPIROMETRY >
< GI/NUTRITION EVALUATION >
Abdomen: SOFT
Nausea: N
Vomiting: N
Bowel Sounds Eval: Y
RUQ: HYPOACTIVE
RLQ: HYPOACTIVE
LUQ: HYPOACTIVE
LLQ: HYPOACTIVE
Last BM: UNK
Current Diet: 1800 ADA
Last Meal: UNKNOWN
Feeding: ASSIST FEED
Ostomy: N
Ostomy: N
Fluid Restriction: N
Do any of the following conditions pertain to the patient
Currently on TPN/Tube Feedings: N
Unintended Weight Loss > 10 lbs in 2 mos: N

Activity Date: 03/30/11 Time Class (continued)

120000 Admit: Assessment (continued)
Currently has Pressure Ulcer: Y
< INTEGUMENTARY EVALUATION >
Skin Appearance: PALE
Skin Temp: WARM
Skin Moisture: DRY
Skin Turgor: FAIR
Mucous Membrane: MOIST
Wounds/Ulcers: Y
Incisions: N
< WOUND/ULCER EVALUATION >
Type #1: LACERATION
Location: TIP OF TONGUE
Wound Eval: OPEN
Surround Tissue Eval: RED
Wound Bed: RED
Dressing: NONE
Drainage Amt: NONE
Type #2: ULCER
Location: COCCYX
Wound Eval: OPEN
Surround Tissue Eval: NORMAL
Wound Bed: PINK
Dressing Changed: Y
Dressing Change Date: 03/20/11
Dressing: DRY & INTACT
Drainage Amt: SCANT
Drainage Type: SEROSANGUINEOUS
Type #3: LACERATION
Location: LUMBAR SPINE
Wound Eval: UNABLE TO ASSESS
Surround Tissue Eval: NORMAL
Dressing Changed: Y
Dressing: TAPE, SMALL GAUZE
Drainage Amt: NONE
< INCISION EVALUATION >
< MUSCULOSKELETAL EVALUATION >
ROM R Arm: WEAKNESS
Sensation R Arm: WITHDRAWS FROM PAIN
ROM L Arm: WEAKNESS
Sensation L Arm: WITHDRAWS FROM PAIN
ROM R Leg: WEAKNESS
Sensation R Leg: WITHDRAWS FROM PAIN
ROM L Leg: WEAKNESS
Sensation L Leg: WITHDRAWS FROM PAIN
< GENITOURINARY/REPRODUCTIVE EVALUATION >
Urinary Elimination: CATHETER-INDWELLING
Secured with: STABILIZATION DEVICE

Problem/Goal/Intervention Description | Activity Type | Occurred Date | Occurred Time | Recorded By | Recorded Date | Recorded Time | Site/Direction/Amount/Lot/Exp | Value | Charge | Discipline | Documented By | Flow Sheet

Activity Date: 03/30/11 Time: 0245 (continued)

12000 Admit: Assessment+ (continued)
Consider catheter removal based on criteria: N
Penile Discharge: N
< PSYCHOSOCIAL EVALUATION >
Event/Issue:
Taken:
<Suicide Risk Assessment, Modified SAD PERSONS>
Sensory perception- Very limited
Moisture- Occasionally moist
Activity- Chairfast
Mobility- Very limited
Nutrition- Probably inadequate
Friction and shear- Potential problem
Braden Skin Score: 13
Braden Risk Level- Medium
Skin risk interventions- Manage moisture, Avoid drying the skin
Manage nutrition, Maintain good hydration
Manage friction and shear
No massage of reddened bony prominences
Reposition Q2hrs and PRN
Offer toileting when turning
Pericare PRN
Use moisture barrier, body wash and lotion routinely
Maximal remobilization-up in chair for meals when appropriate
Protect (offload) heels
Use foam sheets to reduce friction/shear
HOB < 30 degrees unless medically contraindicated
Consider pressure relieving surface (if bed or chair bound)
Provide education on pressure ulcers to patient and family
Assess nutrition status, obtain nutrition consult prn
Use foam wedges for 30 degree lateral positioning
Consider trapeze if indicated
Monitor all body folds for moisture, yeast, rash, irritation
<< TEACHING & EDUCATION >>
Education Content:
< FUNCTIONAL SCREENING >
Related to this Admission, is there a:
NEW Decline in the Pt's Ability to Transfer or Ambulate: N
NEW Decline in the Pt's Ability to Feed, Bathe, and/or Dress Self: N
NEW Decline in the Pt's Ability to Communicate: N
INEFFECTIVE Cough/Unable to Clear Secretions: N
Coughs/Struggles/Holds P.O. in Mouth when Eating or Drinking: N
< SWALLOW SCREEN >
Keep Patient NPO until Swallow Screen performed.
Pt has 3 or more meds in drug classes known to
be indicator of fall risk: N
Is patient Responsive: Yes
Is patient following fall prevention directions: Y

Problem/Goal/Intervention Description | Activity Type | Occurred Date | Occurred Time | Recorded By | Recorded Date | Recorded Time | Site/Direction/Amount/Lot/Exp | Value | Charge | Discipline | Documented By | Flow Sheet

Activity Date: 03/30/11 Time: 0245 (continued)

12000 Admit: Assessment+ (continued)
Fall Risk Comment: PREVIOUS FALLS, CONFUSED
High Risk for Falls: Y
Fall Precautions: Alert: Signage (i.e. Armband, chart, door)
Non-slip footwear
Assist: Mobility
Assist: ADLs
Assist: Toilet program
Tethered devices: Have poles to exit side of bed, secure tubes
Is patient currently on anticoagulation medication? N
Body Mass Index (BMI): 23.7
BMI is in normal range: Y
Is patient ambulating in hallway: N
Pharmacological Prophylaxis due to:
Mechanical prophylaxis in place INT PNEUMATIC COMP DEVICE
- PERSONAL PROPERTY RECORD -
Disposition
Pt/family/significant other verbalize understanding that the hospital

Activity Date: 03/30/11 Time: 0752

10012 Admit: Adult Guidelines+ A on admission AS
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Document 03/30/11 0752 HJB 03/30/11 0752 HJB
<< CARE GUIDELINES >>
Location: TELEMETRY-MEDICAL
Age Group: ADULT 60+ YEARS
Problem: PROB: Impaired Cardiovascular Function A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: GOAL: Maintain/Improve Cardiovascular Function A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
16010 Focused Care: Cardiac A CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Problem: Care Guidelines A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: GOAL Will Receive Care per Guidelines A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
10004 Home Med List Clarification A PRN CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
e0306 Discharge Instructions A on discharge CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
10010 Height A on admission CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
10020 Weight A on admission and PRN CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB

[redacted] MD | WINKLER,LOUIS | Page: 7

Brandon Regional Hospital Nursing *Live*
CLINICAL DOCUMENTATION RECORD HPF

Printed 04/12/11 at 1002

Problem/Goal/Intervention Description	Activity	Occurred	Recorded	Documented	Units	Comment
Activity Date: 03/30/11 Time: 0752						
1100C0 Intake and Output (IXOT BCTA)	A	Q12H				CP
Created: 03/30/11 0752 HJB 03/30/11 0752 HJB						
210060 Eval: Suicide Risk*	A	on admission				CP
Created: 03/30/11 0752 HJB 03/30/11 0752 HJB						
- Document 03/30/11 0752 HJB 03/30/11 0752 HJB						
< SUICIDE RISK SCREEN >						
Do You Have Feelings of Worthlessness, Hopelessness,						
With Recurrent Thoughts of Death? N						
Have You Ever Considered Suicide or Attempted Suicide in the Past? N						
Are You Feeling Suicidal Now? N						
Do You Have a Plan to Commit Suicide? N						
Yes to 1 or More of the Above? N						
Is Patient a Baker Act: N						
<Suicide Risk Assessment, Modified SAD PERSONS>						
210061 Eval: Elopement Risk*	A	on admission				CP
Created: 03/30/11 0752 HJB 03/30/11 0752 HJB						
- Document 03/30/11 0752 HJB 03/30/11 0752 HJB						
ELOPEMENT RISK EVALUATION						
Is Patient Confused/Disoriented? Y						
>Does Patient Take Antipsychotics? N						
>Does Patient Take Antidepressants? N						
>Does Patient Take MAOI Inhibitors? N						
>Does Patient Take Antianxieties? N						
>Is Patient Receiving High Dose IV Steroids? N						
Does Patient Have Mobility? N						
Symptoms/Behaviors Being Exhibited Suggesting Elopement? N						
Patient at Risk for Elopement? N						
ELOPEMENT RISK LEVEL MAINTAIN STD SAFETY PRCCA						
210065 Eval: Fall Risk*	A	PRN				CP
Created: 03/30/11 0758 HJB 03/30/11 0758 HJB						
210062 Eval: Venous Thromboembolism*	A	on admission + QSHIFT				CP
Created: 03/30/11 0752 HJB 03/30/11 0753 HJB						
- Document 03/30/11 0752 HJB 03/30/11 0753 HJB						
Is patient currently on anticoagulation medication? N						
Body Mass Index (BMI): 23.7						
BMI is in normal range: Y						
Is patient ambulating in hallway: N						
Pharmacological Prophylaxis due to:						
Mechanical prophylaxis in place (MT PNEUMATIC COMP DEVICE						
210270 ADLs*	A	Q12H				CP
Created: 03/30/11 0752 HJB 03/30/11 0752 HJB						
210090 Pain Management*	A	with VS and PRN				CP
Created: 03/30/11 0752 HJB 03/30/11 0752 HJB						
1PP005 CVC/PICC Insertion*	A	per standard				Cr
Document both CVC/PICC insertions AND						
Lines placed prior to arrival HERE						
Created: 03/30/11 0756 HJB 03/30/11 0762 HJB						

Problem/Goal/Intervention Description	Activity	Occurred	Recorded	Documented	Units	Comment
Activity Date: 03/30/11 Time: 0752						
320010 Invasive Line Management*	A	E,QSHIFT+PRN				CP
Created: 03/30/11 0752 HJB 03/30/11 0752 HJB						
- Document 03/30/11 0762 HJB 03/30/11 0753 HJB						
<< INVASIVE LINES >>						
Peripheral IV: Y						
PICC/CVC Catheter: N						
Midline: N						
Femoral Access Port: N						
Arterial Catheter: N						
Intracranial Catheter: N						
Pulmonary Artery Catheter: N						
Sheath: N						
Intra-Aortic Balloon Pump: N						
Vascular Assist Device: N						
Dialysis Access: N						
Peripheral Site #1: Y						
Peripheral Site #2: N						
Peripheral Site #3: N						
Peripheral Site #4: N						
<< PERIPHERAL LINE >>						
Insertion: N						
Monitor/Manage: Y						
Location: LEFT ANTECUBITAL						
Insertion Date: 03/30/11						
IV Type: MAGLOCATH						
Size: 18 GAUGE						
Removal: N						
Saline Lock: N						
Fluid Infusing: Y						
Tubing Changed: N						
IV Site Appearance: CLEAN,DRY,INTACT						
<< PERIPHERAL LINE >>						
<< PERIPHERAL LINE >>						
<< PERIPHERAL LINE >>						
< MIDLINE >						
<< ARTERIAL LINE >>						
<< INTRACRANIAL PRESSURE CATHETER >>						
<< PULMONARY ARTERY CATHETER >>						
PRESSURES:						
<< SHEATH-PERCUTANEOUS INTRODUCER >>						
PULSES:						
<< INTRAAORTIC BALLOON PUMP >>						
Condition:						
PULSES						
<< VENTRICULAR ASSIST DEVICE >>						

Age/Sex: 81 M
DOB: [redacted]
Admitted: 03/30/11 at 0246
Status: OIS INs

Attending: Agzew,Yeshitila MD
Account #: [redacted]
Location: H.SSTC
Room/Bed: H.A509-1

WINKLER, LOUIS

Brandon Regional Hospital Nursing *Live*
CLINICAL DOCUMENTATION RECORD MPF

Printed 04/12/11 at 1802

Problem/Goal/Intervention Description | Site/Direction | Freq
Activity Type | Occurred Date | Occurred Time or Date | Recorded Time or Current | Documented User | Charge

Activities Date: 03/30/11 Time: User2

330020 Tubes & Drains Management+ A E.O/SHIFT+PRN CP
Document Foley Insert/Discontinue Pers.
Document Foley Monitor/Manage in Shift
Eval QI Components of Focus Care: QI
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
330025 Special Equipment Management+ A QSHIFT CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
330028 Interdisciplinary Team Conference+ A as going CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
450103 Education, Interdisciplinary+ A Shift CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
450409 Education, Interdisciplinary Media+ A QSHIFT CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
450603 Plan of Care Review+ A QSHIFT CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
450708 Physician Notification/Response+ A PRN CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
450808 Personal Property Record+ A ON TRANSF OR D/C CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Problem: Standard of Care: Telemetry-Medical A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: SOC: Will Receive Standard of Care A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
160117 Standards of Care: Telemetry-Medical A QSHIFT CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
160308 Isolation: Standard Precautions A QSHIFT CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
160611 Shift Evaluation A QSH CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
160150 Shift Recital Verification+ A QSHIFT CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
191008 Vital Signs: (NOT RETA) A QSH CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
191068 CLINICAL MONITORING+ A (PT ACTIVITY) CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
210018 Monitor: EKG Rhythm Strip+ A QSHIFT CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
210012 Monitor: Incentive Spirometry+ A QSHIFT CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Problem: PROB: Potential/Actual Altered Mental St A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: [0 Altered Mental Status/Maintain Safety A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
210052 Eval: Mental Status A PRN CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB

Activities Date: 03/30/11 Time: User2

Problem: PROB: Impaired EENT Function A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: QOAL: Maintain/Improve EENT Function A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
160276 Focused Care: EENT+ A CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Problem: PROB: Impaired GI Function A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: QOAL: Maintain/Improve GI Function A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
160320 Focused Care: GI+ A CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Problem: PROB: Impaired Neuro Function A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: QOAL: Maintain/Improve Neuro Function A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
160300 Focused Care: Neuro+ A CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
210035 Eval: Glascow Coma Scale+ A QSHIFT CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Problem: PROB: Impaired GU Function A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: QOAL: Maintain Genitourinary Function A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
160225 Focused Care: GU+ A CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Problem: PROB: Impaired Musculoskeletal A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: QOAL: Maintain Musculoskeletal Function A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
160230 Focused Care: MusSkel+ A CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Problem: PROB: Impaired Respiratory Function A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: QOAL: Maintain/Improve Respiratory Func A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
160206 Focused Care: Resp+ A CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Problem: PROB: Impaired Skin Integrity A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: QOAL: Maintain/Improve Condition of Skin A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
160236 Focused Care: Integumentary+ A CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
210046 Eval: Wound & Skin+ A QSHIFT CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB

Age/Sex: 81 M
Unit #: [redacted]
Admitted: 03/30/11 at 0245
Service: OIS INx

Attending: Agzew,Yesmitia MD
Account #: [redacted]
Location: R.ASSTC
Room/Bed: R.A539-1

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Brandon Regional Hospital Nursing Alive
CLINICAL DOCUMENTATION RECORD VPF

Printed 04/12/11 at 1602

Problem/Goal/Intervention Description | SEQ | Interaction | Prod
Activity Type | Occurred Date | Occurred Time | By | Recorded Date | Recorded Time | By | Documented Type | Documented By | Documented Status | Units | Charge

Activity Date: 03/30/11 Time: 0752

Problem: PREC: Precautions-Fall A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: SCAL: Maintain Precautions-FALL A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Z0116 Precautions: Fall A H QSHIFT CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Problem: Age Guidelines: Adult 80+ years A
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
Goal: ACG: Pt/Family manages disease process A
in response to staff addressing age-
specific communication, treatment,
safety, anxiety, and education needs.
Create 03/30/11 0752 HJB 03/30/11 0752 HJB
D0008 Age Guidelines: 80 Years, Adult/Elderly A H QSHIFT CP
Create 03/30/11 0752 HJB 03/30/11 0752 HJB

Activity Date: 03/30/11 Time: 0800

L0015 Focused Care: Integumentary* A CP
Document 03/30/11 0804 HJB 03/30/11 0804 HJB
< INTEGUMENTARY EVALUATION >
Wounds/Ulcer: Y
< INCISION EVALUATION >
< WOUND/ULCER EVALUATION >
Type #1: LACERATION
Location: TIP OF TONGUE
Type #2: ULCER
Location: COCCYX
Type #3: LACERATION
Location: LUMBAR SPINE
Type #4: SCAR
Location: FIRST 2 FINGERS LT HAND
Wound Eval: NON-OPEN
Surround Tissue Eval: NORMAL
Wound Bed: PINK
Dressing: NONE
Drainage Amt: NONE
Comment: ALL 2 FINGERS APPROXIMATED

Activity Date: 03/30/11 Time: 0805

Z0015 Monitor: Blood Glucose* A QS CP
Document 03/30/11 0805 HJB 03/30/11 0805 HJB
< BLOOD SUGAR RESULTS >
Glucose: 218
Method: FINGERSTICK
Medication: REGULAR INSULIN

Activity Date: 03/30/11 Time: 0800 (continued)

Z0015 Monitor: Blood Glucose* (continued)
Dose: 4 UNITS
Site: LT ARM
Self Admin: N

Activity Date: 03/30/11 Time: 0824

92000 Intake and Output* (NOT BCMA) A QLIH CP
Document 03/30/11 0826 HJB 03/30/11 0826 HJB
< INTAKE AND OUTPUT >
Intake: Y
<< INTAKE >>
Breakfast %: 0
Diet: SOLID FOOD
<< OUTPUT >>
Patient Notes: NURSES NOTES
Create 03/30/11 0826 HJB 03/30/11 0826 HJB
AM RECEIVED CALL FROM DR. REG AT 0810, ON THE WAY TO SEE PT.
Note Type Description
No Type None

Activity Date: 03/30/11 Time: 0845

540000 Patient Care Orders* A QSHIFT OE
WHEN PHARMACY AND PRIMARY MD FOUND CALL
DR. REG
Create 03/30/11 0849 HJB 03/30/11 0849 HJB

Activity Date: 03/30/11 Time: 0849

Patient Notes: NURSES NOTES
Create 03/30/11 0849 HJB 03/30/11 0849 HJB
PLS DR REG INDICATES INFORMATION RELEASE FAXED TO THE VILLAGES REGIONAL HOSPITAL
IN CEALA. AWAITING RETURN FAX
Note Type Description
No Type None

Activity Date: 03/30/11 Time: 0910

450800 Plan of Care Review* A QSHIFT CP
Document 03/30/11 0910 HJB 03/30/11 0910 HJB
< PLAN OF CARE REVIEW >
Link to Plan of Care: Y
Care plan reviewed and/or individualized and reprioritized: Y
Nurse signature: Moresh,Kelly A - RN

Age/Sex: 81 M
Unit #: [redacted]
Acct/Bed: 0718392715 ac 0246
Status: DIS INP

Attending: Anzaa,Yashitla MD
Assigned: [redacted].5
Location: H ESTC
Room/Bed: H A539-1

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Brandon Regional Hospital Nursing *Live*
CLINICAL DOCUMENTATION RECORD HOF

Printed 04/12/11 at 1002

Problem/Goal/Intervention Description	Site/Laterality	Freq	Activity/ Type	Ordered Date	Ordered Time	By	Discontinued Reason	Discontinued Time	By	Comment	Documented First	Documented Cosign

Activity Date: 3/30/11 Time: 1015

130117 Standards of Care: Telemetry-Medical A 0SHIFT CP
Document 03/30/11 1021 SHW 03/30/11 1021 KAM
Y
By signing off on this intervention, the nurse verifies that
the Facility and Care Area Standard of Care has been met.
Untoward events or care outside of the Standards of Care
must be documented in supplemental interventions or notes.
Nurse signature: Morran,Kelly A - RN
130160 Isolation: Standard Precautions A 0SHIFT CP
Document 03/30/11 1015 KAM 03/30/11 1015 KAM
160011 Shift Evaluation A 0SH CP
Document 03/30/11 1015 KAM 03/30/11 1015 KAM
<< SHIFT EVALUATION >>
Neurological WDP: N
EENT WDP: Y
Cardiovascular WDP: N
Respiratory WDP: N
Gastrointestinal WDP: Y
Integumentary WDP: N
Musculoskeletal WDP: N
Genitourinary WDP: N
Psycho-social WDP: Y
Mode of Transport: Stretcher
W/O2
W/Monitor
Code Status: FULL
Skin Risk Evaluation: Y
FALL RISK ASSESSMENT: Y
~ PAIN EVALUATION ~
Does Patient Currently Have Pain: N
>Pain Scale Used: NUMBERS 0-10
>Pain Score: 0
~ ISOLATION PRECAUTIONS ~
Isolation Type: CONTACT
Infection control and transmission prevention information provided to
patient/family/visitors and questions answered: Y
Special Equipment: Y
Invasive Line Management: Y
Tubes & Drains Management: Y
Education (Interdisciplinary): N
Venous Thromboembolism Eval: Y
< NEUROLOGICAL EVALUATION >
LOC: LETHARGIC
Oriented: N
Disoriented to: PLACE
TIME
Speech: CLEAR
Behavior: COOPERATIVE

Activity Date: 3/30/11 Time: 1015 (Continued)

160011 Shift Evaluation (Continued)
Comment: EASY TO AROUSE
< CENT EVALUATION >
< CARDIOVASCULAR EVALUATION >
Is Patient on Cardiac Monitoring: Y
Pacer/Defibrillator: N
Heart Sounds: REGULAR
Cap Refill Eval: Y
RUE: BRISK < 3 SECONDS
LUE: BRISK < 3 SECONDS
RLE: BRISK < 3 SECONDS
LLE: BRISK < 3 SECONDS
Peripheral Pulse Eval: Y
R Radial: 2+ NORMAL
L Radial: 2+ NORMAL
R Dorsal Pedis: 2+ NORMAL
L Dorsal Pedis: 2+ NORMAL
Homan's Sign: NEGATIVE
Edema: N
Chart Pedi: N
<< TELEMETRY EVALUATION >>
EKG Rhythm: SINUS TACHYCARDIA
Rate: 110
< PACER EVALUATION SCREEN >
< RESPIRATORY EVALUATION >
Effort: UNLABORED
Chest Shape: SYMMETRICAL
Chest Movement: SYMMETRICAL
O2 Therapy: Y
Breath Sounds Eval: Y
R Upper Anterior: CLEAR
L Upper Anterior: CLEAR
R Mid Anterior: CLEAR
R Lower Anterior: DIMINISHED
L Lower Anterior: DIMINISHED
R Upper Posterior: CLEAR
L Upper Posterior: CLEAR
R Lower Posterior: DIMINISHED
L Lower Posterior: DIMINISHED
< RETRACTIONS >
< OXYGEN THERAPY >
O2 Device: NASAL CANNULA
O2 Flow (L/M): 2
< INCENTIVE SPIROMETRY >
< GASTROINTESTINAL EVALUATION >
< INTEGUMENTARY EVALUATION >
Skin Appearance: PALE
Skin Temp: WARM

Problem/Goal/Intervention Description

Activity Type	Occurred Date	Time	Location	Documented by	Signed	Site/Direction	Dose	Route	Frequency	Documented Date/Time	Entered by	Cosign Required	Cosigned by	Cosigned Date/Time	Charge

Activity Date/Time Type Details Comments

I60011 Shift Evaluation (continued)
Skin Moisture: DRY
Skin Turgor: FAIR
Mucous Membrane: DRY
Wounds/Ulcer: Y
Incisions: N
New Onset Skin Breakdown: N
< WOUND/ULCER EVALUATION >
Type #1: LACERATION
Location: TIP OF TONGUE
Wound Eval: NON-OPEN
Surround Tissue Eval: DRY/SCALY
Wound Bed: BROWN
Drainage Amt.: NONE
Type #2: ULCER
Location: COCCYX
Wound Eval: UTA
Surround Tissue Eval: NORMAL
Wound Bed: UTA
Dressing Changed: N
Dressing: TEGADERM
Drainage Amt: NONE
Type #3: LACERATION
Location: LUMBAR SPINE
Wound Eval: UTA
Surround Tissue Eval: NORMAL
Wound Bed: UTA
Dressing Changed: N
Dressing: GAUZE
Drainage Amt: NONE
Type #4: SCAB
Location: FIRST 3 FINGERS LT HAND
Wound Eval: HEALED
Surround Tissue Eval: NORMAL
Wound Bed: PINK
Dressing: NO DRESSING
Drainage Amt: NONE
Comment: HEALED AMPUTEE
< INCISION EVALUATION >
Sensory perception- Slightly limited
Moisture- Occasionally moist
Activity- Bedfast
Mobility- Slightly limited
Nutrition- Adequate
Friction and shear- No apparent problem
Braden Skin Score: 16
Braden Risk Level- Low
Skin risk interventions: Manage moisture, Avoid drying the skin

I60011 Shift Evaluation (continued)
Manage nutrition, Maintain good hydration
Manage friction and shear
No massage of reddened bony prominences
Reposition Q2hrs and PRN
Offer toileting when turning
Pericare PRN
Use moisture barrier: body wash and lotion routinely
Maximal remobilization-up in chair for meals when appropriate
Protect (offload) heels
Use turn sheets to reduce friction/shear
HOB < 30 degrees unless medically contraindicated
Consider pressure relieving surface (if bed or chair bound)
Provide education on pressure ulcers to patient and family
Assess nutrition status, obtain nutrition consult prn
< MUSCULOSKELETAL EVALUATION >
ROM R Arm: WEAKNESS
ROM L Arm: WEAKNESS
ROM R Leg: WEAKNESS
ROM L Leg: WEAKNESS
Comment: BEDREST
< GENITOURINARY >
Urinary Elimination: CATHETER-INDWELLING
Secured with: LEG STRAP
Female Discharge: N
< PSYCHOSOCIAL EVALUATION >
Event/Issue:
Taken:
<Suicide Risk Assessment, Modified SAD PERSONS>
Pt has 3 or more meds in drug classes known to
be indicator of fall risk: N
Is patient Responsive: Yes
Is patient following fall prevention directions: Y
Add'l fall risk elements: Unsteady Gait
Fall Risk Comment: BEDREST
High Risk for Falls: Y
Fall Precautions: Alert: Signage (i.e. Armband, chart, door)
Non-slip footwear
Assist: Mobility
Assist: ADLs
Assist: Toilet program
Tethered devices: Move poles to exit side of bed, secure tubes
Fall Precautions Comment: BEDREST AT PRESENT
< SPECIAL EQUIPMENT >
Special Equip: IVP
Special Equip: CALL BELL
Special Equip: TELE
Special Equip: O2

Age/Sex: 84 M
Unit: 8[redacted]
Acuity: 3 Status: 015 IMs
Admitted: 03/30/11 at 0246
Attending: Ruben,Yesmilla MD
Account #: [redacted]
Location: M.3SIC
Room/Bed: M.A335-1

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Brandon Regional Hospital Nursing "Live"
CLINICAL DOCUMENTATION RECORD HDF

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Problem/Goal/Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Location	Units	Comments	Signature Indicator	Flowsheet

Activity Date: 03/30/11 Time: 0245 (continued)

16A011 Shift Evaluation (continued)
<< INVASIVE LINES >>
Peripheral IV: Y
Peripheral Site #1: Y
<< PERIPHERAL LINE >>
Insertion: N
Monitor/Manage: Y
Location: LEFT ANTECUBITAL
Insertion Date: 03/30/11
IV Type: ANGIOCATH
Size: 18 GAUGE
Removal: N
Saline Lock: N
Fluid Infusing: Y
Tubing Changed: N
IV Site Appearance: CLEAN,DRY,INTACT
<< PERIPHERAL LINE >>
< MIDLINE >
<< ARTERIAL LINE >>
<< INTRACRANIAL PRESSURE CATHETER >>
<< PULMONARY ARTERY CATHETER >>
PRESSURES:
<< SHEATH-PERCUTANEOUS INTRODUCER >>
PULSES:
<< INTRAORTIC BALLOON PUMP >>
Condition:
PULSES
<< VENTRICULAR ASSIST DEVICE >>
< INDWELLING CATHETER / TUBES & DRAINS >
Indwelling Catheter Insertion: N
Indwelling Catheter Removal: N
< TUBES AND DRAINS >
Insert: N
Manage: N
Remove: N
< INDWELLING CATHETER REMOVAL >
<< TEACHING & EDUCATION >>
Education Content:
Is patient currently on anticoagulation medication? N
Body Mass Index (BMI): 23.7
BMI is in normal range: Y
Is patient ambulating in hallway: N
Pharmacological prophylaxis due to:
Mechanical prophylaxis in place NONE
191000 Vital Signs (NOT BCTA) A Q4H CP
[redacted]
<< VITAL SIGNS >>
Temp-F: 99.7

Activity Date: 03/30/11 Time: 0245 (continued)

191000 Vital Signs (NOT BCTA) (continued)
Temp Source: ORAL
Pulse: 110
Pulse Source: BRACHIAL
Resp: 18
Resp Type: REGULAR
BP: 135/73
BP Source: LEFT
Patient Position: Sitting
MAP: 92
Pulse Ox: 96
Oxygen @: 2L
192100 Age Guidelines: 60 Years, Adult-Elderly A Q(SHIFT CP
[redacted]

Activity Date: 03/30/11 Time: 0425

Patient Notes: NURSES NOTES
Created: 03/30/11 0425 HCB 03/30/11 0426 HCB
FAX FROM THE VILLAGES RECIEVED. PRIMARY MD AT NURSING HOME- LAKE HARRIS WAS DR CLARK, 352-728-3366.
Note Type Description
No Type None

Activity Date: 03/30/11 Time: 0500

540000 Patient Care Orders A QSHIFT OE
3/30-31 HC CE
[redacted]

Activity Date: 03/30/11 Time: 0537

Patient Notes: NURSES NOTES
Created: 03/30/11 0537 HCB 03/30/11 0538 HCB
Cal. BCA CALLED WITH UPDATE. NO NEW ORDERS RECIEVED. FAMILY ENCOURAGED TO TRY TO FIGURE OUT WHO PRIMARY MD WAS IN OHIO SO MD CAN FIGURE OUT WHY PT HAS BEEN TAKING HYDROMORPHA. FAX DELIVERED TO FLOOR BY RN.
Note Type Description
No Type None

Activity Date: 03/30/11 Time: 1145

150600 Plan of Care Review A Q8H(FT CD
[redacted]
< PLAN OF CARE REVIEW >
Nurse signature: Molina,Donna M - RN

[redacted] Attending: Andres Kabbaliie MD
[redacted] Account #: [redacted]
Admitted: 03/30/11 at 0245 Location: 8.5STC
Status: DIS INN Room/Bed: N.A559-1

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Branson Regional Hospital Nursing *Live*
CLINICAL DOCUMENTATION RECORD HOF

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Problem/Goal/Intervention Description | Activity Type | Occurred | Recorded | Start Direction | Initiated | Discontinued | Ord By | Sig | Cosign | Q-Life | Format | Charted | Units | License

Activity Date: 03/30/11 Time: 1147

Problem: Advance Directives A
Create 03/30/11 1147 CDT 03/30/11 1147 CDT
Goal: ADV: Respect Advance Directive Choices A
Create 03/30/11 1147 CDT
300030 Advance Directives A CLIN CP
Create 03/30/11 1147 CDT 03/30/11 1147 CDT

Activity Date: 03/30/11 Time: 1500

540000 Patient Care Orders* A CSHIFT OE
3/30-ENCS, 03 2PM AM LABS
Create 03/30/11 1504 CDT 03/30/11 1504 CDT

Activity Date: 03/30/11 Time: 1603

540000 Patient Care Orders* A CSHIFT OE
3/30-OBTAIN SUPPLIES/CONSENTS FOR
BEDSIDE SWPAN CLAVICULAR LYMPH NODE BX
Create 03/30/11 1603 CDT 03/30/11 1603 CDT

Activity Date: 03/30/11 Time: 1610

450700 Physician Notification/Response* A PRM CP
Document 03/30/11 1610 CDT 03/30/11 1621 CDT
< PHYSICIAN NOTIFY/RESPONSE >
Notification: Y
Response: Y
Physician Called: ENRJU Enriquez,Julio A MD
Person Notified: MD
Method of Notification: ANSWERING SERVICE
Reason: ITCHING
Physician Spoken to: ENRJU Enriquez,Julio A MD
Notification Results: BENEDRYL IF DOESNT WORK THEN SOLUMEDROL
40MG IV NOW AND IN 12HR MORS
Verbal Orders are to be written in Chart, Read Back, and Verified.
Physicians are to Read-Back Critical Lab Values/Test Results

Activity Date: 03/30/11 Time: 1800

191000 Vital Signs* (NOT BCTA) A CHN CP
Document 03/30/11 1803 CDT 03/30/11 1803 CDT
<< VITAL SIGNS >>
Temp-F: 99.2
Temp Source: AXILLARY
Pulse: 106
Pulse Source: BRACHIAL
Resp: 20
Resp Type: REGULAR

Problem/Goal/Intervention Description | Activity Type | Occurred | Recorded | Start Direction | Initiated | Discontinued | Ord By | Sig | Cosign | Q-Life | Format | Charted | Units | License

Activity Date: 03/30/11 Time: 1800 (Continued)

191000 Vital Signs* (NOT BCTA) (Continued)
BP: 130/88
BP Source: CUFF
Patient Position: Lying
MAP: 99
Pulse Ox: 96
Oxygen @ 2L

Activity Date: 03/30/11 Time: 1935

Patient Nurse: NURSES NOTES
Created 03/30/11 1949 CDT 03/30/11 1949 CDT
BENEDRYL RELIEVING PTS ITCHING, SOL-MEDROL NOT GIVEN.ORDER FAXED TO PHARMALY
Note Type Description
Key Type Scope

Activity Date: 03/30/11 Time: 2000

192000 Intake and Output* (NOT BCTA) A CLIN CP
Document 03/30/11 2046 CDT 03/30/11 2046 CDT
< INTAKE AND OUTPUT >
Intake Y
<< INTAKE >>
IV Fluids: 900
<< OUTPUT >>

Activity Date: 03/30/11 Time: 2100

240070 ADLs* A CLIN CP
Document 03/30/11 2140 CDT 03/30/11 2151 CDT
< ADL ASSISTANCE >
ACTIVITY
Assistance Required: Y
Assisted By: 1 STAFF ASSIST
Type: BEDREST
Toileting, BSC
TOILETING
Assistance Required: Y
Assisted By: 1 STAFF ASSIST
Type: BEDPAN
ORAL CARE
Assistance Required: Y
Assisted By: 1 STAFF ASSIST
Type: PROVIDE TOOLS
EATING
Assistance Required: Y
Assisted By: 1 STAFF ASSIST

Age/Sex: 81 M
MRN: [redacted]
Acct#: [redacted]
Admitted: 03/30/11 at 0246
Status: DIS INP
Physician: [redacted] MD
Account: [redacted]
Location: M.SSIC
Room/Bed: M.A539-1

WINKLER,LOUIS

Brandon Regional Hospital Nursing "Live"
CLINICAL DOCUMENTATION RECORD WF

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Problem/Goal/Intervention Description	Start Direction Indicated	Type
Activity Type	Occurred Date	Occurred Time

Problem/Goal/Intervention Description	Start Direction Indicated	Type
Activity Type	Occurred Date	Occurred Time

Activity Date: 03/30/11 Time: 0246 (continued)

210270 ADLs* (continued)
Type: FULL FEED
PERSONAL HYGIENE
Assistance Required: Y
Assisted By: 1 STAFF ASSIST
Type: COMPLETE BED BATH
LINEN CHANGED
Was Linen Changed: Y
Type: COMPLETE LINEN CHANGE
DRESSING

Activity Date: 03/30/11 Time: 0246

195000 Intake and Output (ADI BCIA) A Q12N CP
Documented: 03/30/11 0300 by [redacted] RN Q12N/03/30/11 0300 RN
< INTAKE AND OUTPUT >
Intake: Y
Output: Y
<< INTAKE >>
PO: 840
Lunch #: 0
Diet: SOLID FOOD
Dinner #: 0
Diet: SOLID FOOD
<< OUTPUT >>
Foley: 500
Stools #: 0

Activity Date: 03/30/11 Time: 0300

210062 Eval: Venous Thromboembolism A on admission + QSHIFT CP
Documented: 03/30/11 0300 by [redacted] RN QSHIFT/03/30/11 0300 RN
Is patient currently on anticoagulation medication? N
Body Mass Index (BMI): 23.7
BMI is in normal range: Y
Is patient ambulating in hallway: N
Pharmacological Prophylaxis Due To:
Mechanical prophylaxis in place FOOT PUMP
410610 Plan of Care Review A QSHIFT CP
Documented: 03/30/11 0300 by [redacted] RN QSHIFT/03/30/11 0300 RN
< PLAN OF CARE REVIEW >
Link to Plan of Care: Y
Care plan reviewed and/or individualized and reprioritized: Y
Nurse signature: MURISWAMY,BABU - RN
Y

Activity Date: 03/30/11 Time: 0300

160117 Standards of Care: Telemetry-Medical A QSHIFT CP
Documented: 03/30/11 0300 by [redacted] RN QSHIFT/03/30/11 0300 RN
: Y
By signing off on this intervention, the nurse verifies that
the facility and Care Area Standard of Care has been met.
Untoward events or care outside of the Standards of Care
must be documented in supplemental interventions or notes.
Nurse signature: MURISWAMY,BABU - RN
130300 Isolation: Standard Precautions A QSHIFT CP
Documented: 03/30/11 0300 by [redacted] RN 03/30/11 0300 RN
160011 Shift Evaluation A Q8H CP
Documented: 03/30/11 0300 by [redacted] RN Q8H/03/30/11 0300 RN
<< SHIFT EVALUATION >>
Neurological WDP: N
ENT WDP: Y
Cardiovascular WDP: N
Respiratory WDP: N
Gastrointestinal WDP: Y
Integumentary WDP: N
Musculoskeletal WDP: N
Genitourinary WDP: N
Psycho-social WDP: Y
Mode of Transport: Stretcher
Code Status: FULL
Skin Risk Evaluation: Y
FALL RISK ASSESSMENT: Y
- PAIN EVALUATION -
Does Patient Currently Have Pain: N
>Pain Scale Used: NUMBERS 0-10
>Pain Score: 0
- ISOLATION PRECAUTIONS -
Infection control and transmission prevention information provided to
Special Equipment: Y
Invasive Line Management: Y
< NEUROLOGICAL EVALUATION >
LOC: ALERT/AWARE
Oriented: Y
Speech: SLOW
Sensation-RUE: WITHDRAWS FROM PAIN
RLE: WITHDRAWS FROM PAIN
LUE: WITHDRAWS FROM PAIN
LLE: WITHDRAWS FROM PAIN
Motor Skill Eval: Y
Right Grip: RIGHT GRIP WEAK
Right Arm: RT DORSIFLEXION WEAK
Right Leg: RT DORSIFLEXION WEAK
Left Grip: LEFT GRIP WEAK
Left Arm: LT DORSIFLEXION WEAK

Age/Sex: 81 M
Attending: Agtes,Yeamtilk MD
WINKLER,LOUIS
Page: 15
Admitted: 03/30/11 at 0246
Brandon Regional Hospital Nursing Mgmt
Printed 04/12/11 at 1602
Status: DIS INP
CLINICAL DOCUMENTATION RECORD MAR

Protocol/Intervention Description	Site/Direction	From	Problem/Goal/Intervention Description	Site/Direction	Prob
Activity Type	Occurred Date	Occurred Time	Recorded By	Recorded Date	Recorded Time	Documented By	Comment	Units	Charge	Activity Type	Occurred Date	Occurred By	Recorded Date	Recorded Time	Documented By	Comment	Units	Charge

Activity Date: 03/30/11 Time Code Treatments

160011 Shift Evaluation (continued)
Left Leg: LT DORSIFLEXION WEAK
Impaired Memory: UNABLE TO ASSESS
Behavior: COOPERATIVE
Pupils Equal, Round, React to Light, and Accomodation: Y
< EENT EVALUATION >
< CARDIOVASCULAR EVALUATION >
Is Patient on Cardiac Monitoring: Y
<< TELEMETRY EVALUATION >>
EKG Rhythm: SINUS TACHYCARDIA
Rate: 111
Tele Box Number: 102
Zone Number: 611
< PACER EVALUATION SCREEN >
< RESPIRATORY EVALUATION >
Depth: DEEP
Effort: UNLABORED
Chest Shape: SYMMETRICAL
Chest Movement: SYMMETRICAL
O2 therapy: Y
Breath Sounds Eval: Y
R Upper Anterior: COARSE
L Upper Anterior: COARSE
R Mid Anterior: COARSE
R Lower Anterior: DIMINISHED
L Lower Anterior: DIMINISHED
R Upper Posterior: COARSE
L Upper Posterior: COARSE
R Lower Posterior: CLEAR
L Lower Posterior: CLEAR
< RETRACTIONS >
< OXYGEN THERAPY >
O2 Device: NASAL CANNULA
O2 Flow (L/M): 2
FIO2 % : 97
< INCENTIVE SPIROMETRY >
< GASTROINTESTINAL EVALUATION >
< INTEGUMENTARY EVALUATION >
Skin Appearance: PALE
Skin Temp: WARM
Skin Moisture: DRY
Skin Turgor: FAIR
Mucous Membrane: MOIST
Wounds/Ulcer: Y
Incisions: Y
New Onset Skin Breakdown: N
< WOUND/ULCER EVALUATION >
Type #1: LACERATION

Activity Date: 03/30/11 Time Code Treatments (continued)

160011 Shift Evaluation (continued)
Location: TIP OF TONGUE
Type #2: ULCER
Location: COCCYX
Wound Eval: OPEN
Surround Tissue Eval: PINK
Wound Bed: PINK
Dressing Changed: N
Dressing Change Date: 03/30/11
Dressing: TELADERM
Type #3: LACERATION
Location: LUMBAR SPINE
Type #4: WOUND
Location: FIRST 3 FINGERS LT HAND
Comment: HEALED
< INCISION EVALUATION >
Type #1: INCISION
Location: LT CLAVICLE
Incision Eval: WELL APPROXIMATED
Dressing Changed: N
Dressing: OPEN TO AIR
Comment: BIOPSY SITE
Sensory perception- No impairment
Moisture- Rarely moist
Activity- Bedfast
Mobility- Very limited
Nutrition- Probably inadequate
Friction and shear- Potential problem
Braden Skin Score: 15
Braden Risk Level- Low
Skin risk interventions: Manage moisture. Avoid drying the skin
Manage nutrition. Maintain good hydration
Manage friction and shear
No massage of reddened bony prominences
Reposition Q2hrs and PRN
Offer toileting when turning
Pericare PRN
Use moisture barrier: body wash and lotion routinely
Maximal rehabilitation-up in chair for meals when appropriate
Protect (offload) heels
Use turn sheets to reduce friction/shear
HOB < 30 degrees unless medically contraindicated
Consider pressure relieving surface (if bed or chair used)
Provide education on pressure ulcers to patient and family
Assess nutrition status, obtain nutrition consult prn
< MUSCULOSKELETAL EVALUATION >
ROM R Arm: LIMITED ROM
ROM L Arm: LIMITED ROM

[redacted] ALM [redacted] #0 WINKLER,LOUIS Page: 16

Admitted: 03/30/11 at 0245 Location: M.CSTC
Doctor: DIS IMs Room/Bed: M.A539-1

Brandon Regional Hospital Nursing *Live*
CLINICAL DOCUMENTATION RECORD MPF

Printed 04/12/11 at 1002

Problem/Intervention Description	Site/Direction	Add'l
Activity Type	Occurred Date	Recorded Time By Comment

Problem/Goal/Intervention Description	Self Completed	Copy
Activity Type	Occurred Date	Recorded Time By Comment	Occurred Units	Occurs

Activity Date: 03/31/11 Time: 2000 (continued)

160011 Shift Evaluation (continued)
RUA R Log: LIMITED ROM
WEAKNESS
RUA L Log: LIMITED ROM
WEAKNESS
< GENITOURINARY >
Urinary Elimination: CATHETER-INDWELLING
Insert date: 03/30/11
Secured with: TAPE
Urine Color: YELLOW
Urine Clarity: CLOUDY
Consider catheter removal based on criteria: Y
Penile Discharge: N
< PSYCHOSOCIAL EVALUATION >
Events/Issue:
Taken:
<SUICIDE Risk Assessment, Modified SAD PERSONS>
Pt has 3 or more meds in drug classes known to be indicator of fall risk. N
Is patient Responsive: Yes
Is patient following fall prevention directions: Y
Fall Risk Elements: No Risk Elements Noted
Add'l Fall Risk Elements: Unsteady Gait
High Risk for Falls: N
< SPECIAL EQUIPMENT >
Special Equip: IV PUMP
<< INVASIVE LINES >>
Peripheral IV: Y
Peripheral Site #1: Y
<< PERIPHERAL LINE >>
Monitor/Manage: Y
Location: LEFT ANTECUBITAL
Insertion Date: 03/30/11
IV Type: ANGIOCATH
Size: 18 GAUGE
Removal: N
Saline Lock: Y
Fluid Infusing: Y
Tubing Changed: N
<< PERIPHERAL LINE >>
< HEPARIN >
<< ARTERIAL LINE >>
<< INTRACRANIAL PRESSURE CATHETER >>
<< PULMONARY ARTERY CATHETER >>
PRESSURES:
<< SHEATH-PERCUTANEOUS INTRODUCER >>
PULSES:
<< INTRAORTIC BALLOON PUMP >>

Activity Date: 03/31/11 Time: 2000 (continued)

(60011 Shift Evaluation (continued)
Condition:
PULSES
<< VENTRICULAR ASSIST DEVICE >>
< INDWELLING CATHETER / TUBES & DRAINS >
< TUBES AND DRAINS >
< INDWELLING CATHETER REMOVAL >
<< TEACHING & EDUCATION >>
Education Content:
Pharmacological Prophylaxis due to:
:91000 Vital Signs (NOT BETA) A OAH CP
[redacted]
<< VITAL SIGNS >>
Temp-F: 97.2
Temp Source: ORAL
Pulse: 100
Pulse Source: MONITOR
Resp: 18
Resp Type: REGULAR
BP: 136/98
BP Source: CUFF-RIGHT
Patient Position: Lying
MAP: 85
Pulse Ox: 97
Oxygen A: 2L
:99026 Age Guidelines: 60 Years, Addl (Elderly) A d OAH CP
[redacted]

Activity Date: 03/31/11 Time: 2100

480016 RT: Respiratory Therapy Treatment A Per order PS
[redacted]
- Document 03/30/11 2128 JPJ 03/30/11 2128 JPJ
- RESPIRATORY THERAPY TREATMENT -
Oxygen Therapy: Y
- RT BSN TREATMENT -
Pre-treatment breath sounds
Post-treatment breath sounds
- RT IPN TREATMENT -
Pre-treatment breath sounds
Post-treatment breath sounds
- OXYGEN FLOW SHEET -
O2 Flow: 2
l/pm
%
O2 Type: NASAL CANNULA
- CPT TREATMENT/POSTURAL DRAINAGE -
Minutes

[redacted] WINKLER,LOUIS Page: 17

Admitted: 03/30/11 at 0245 Location: R.SSIC Printed 04/12/11 at 1602
Status: DIS IN Room/Bed: R.A539-1

Bradon Regional Hospital Nursing *Live*
CLINICAL DOCUMENTATION RECORD IPF

Problem/Goal/Intervention Description	SLP Interdisc	From
Activity Occurred Recorded Documented		
Type Date Time By Date Time In Comment Units Cause		

Activity Date: 04/10/11 Time: 0128 (continued)

480016 RT: Respiratory Therapy Treatment (continued)
- OMITTED TREATMENT -
- SUCTIONING -
< INCENTIVE SPIROMETRY >
-PULSE OXIMETRY -
$
X

Activity Date: 04/10/11 Time: 0[illegible]

191000 Vital Signs (NOT BCMA) A CMA CP
Document: [redacted]
<< VITAL SIGNS >>
Temp-F: 96.0
Temp Source: AXILLARY
Pulse: 101
Pulse Source: NON-INVASIVE MONITOR
Resp: 22
Resp Type: REGULAR
BP: 148/72
BP Source: NON-INVASIVE BP CUFF
Patient Position: Lying
MAP: 94
Pulse Ox: 96

Activity Date: 04/10/11 Time: 0[illegible]

210720 ADLs A QSEN CP
Document: [redacted]
< ADL ASSISTANCE >
ACTIVITY
Assistance Required: Y
Assisted By: STAFF
Type: WALKS
Patient Response: COOPERATIVE
Tolerance: WITHOUT DISTRESS
TOILETING
Assistance Required: Y
Assisted By: STAFF
Type: DURABLE MEDICAL EQUIPMENT
ORAL CARE
Assistance Required: Y
Assisted By: FAMILY MEMBER
Type: BRUSH TEETH/DENTURES
EATING
Assistance Required: Y
Assisted By: STAFF
Type: PROVIDE FRESH WATER

Problem/Goal/Intervention Description	SLP Interdisc	From
Activity Occurred Recorded Documented		
Type Date Time By Date Time By Comment Units Cause		

Activity Date: 04/11/11 Time: 0500 (continued)

210720 ADLs (continued)
PERSONAL HYGIENE
Assistance Required: Y
Assisted By: STAFF
Type: WASH OF SLEEP CARE
FOLEY CARE
LINEN CHANGED
Was Linen Changed: N
MISSING

Activity Date: 04/11/11 Time: 0500

192000 Intake and Output (NOT BCMA) S QLSN CP
Document: [redacted]
< INTAKE AND OUTPUT >
Intake: Y
<< INTAKE >>
IV Fluids: 1200
IVPB: 50
<< OUTPUT >>
100300 Shift Re-Eval Verification S QSHIFT CP
Document: [redacted]
< SHIFT RE-EVALUATION >
By signing off on this intervention, I verify I have completed a Shift
Re-evaluation and have noted no change from my previous evaluation or have
noted changes and have documented said changes appropriately.
Nurse signature: MANJUNATH BABU - SW
Y

Activity Date: 04/11/11 Time: 0[illegible]

Patient Notes: NURSES NOTES
Created: [redacted]
ON TELE, STABLE TACH, ON FOLEY, ON O2 2L, SATURATING AROUND 94%, VITALS STABLE, ON IV
ABX TO BE FOLLOWED UP.
Note Type Description
No Type NONE

Activity Date: 04/11/11 Time: 0[illegible]

192000 Intake and Output (NOT BCMA) A QLSN CP
Document: [redacted]
< INTAKE AND OUTPUT >
Intake: Y
Output: Y
<< INTAKE >>
PO: 0

Age/Sex: 81 M
Unit #: [redacted]
Admitted: [redacted]
Status: DIS IN

Attending: Agaw, Yeshitila MD
Account #: [redacted]
Location: R.5STC
Room/Bed: R A539-1

WINKLER, LOUIS

Brandon Regional Hospital Nursing Flow*
CLINICAL DOCUMENTATION RECORD

Printed 04/12/11 at 1002

Problem/Goal/Intervention Description	Activity Type	Occurred Date	Occurred Time	By	Ordered/ Documented	Site/ Interaction/ Comment	Units	From/ Charge

Activity Date: 03/31/11 Time: 0001 (continued)

192008 Intake and Output (NOT BCMA) (continued)
<< OUTPUT >>
Foley: 425
Stools #: 0

Activity Date: 03/31/11 Time: 0800

450408 Plan of Care Review A 0SHIFT CP
[redacted]
< PLAN OF CARE REVIEW >
Link to Plan of Care: Y
Nurse signature: Morran,Kelly A - RN
130117 Standards of Care: Telemetry Medical A 0SHIFT CP
[redacted]
: Y
By signing off on this intervention, the nurse verifies that
the Facility and Care Area Standard of Care has been met
Untoward events or care outside of the Standards of Care
must be documented in supplemental interventions or notes.
Nurse signature: Morran,Kelly A - RN
193306 Isolation: Standard Precautions A 0SHIFT CP
[redacted]
160011 Shift Evaluation A 0SH CP
[redacted]
<< SHIFT EVALUATION >>
Neurological WDP: N
EENT WDP: Y
Cardiovascular WDP: N
Respiratory WDP: N
Gastrointestinal WDP: Y
Integumentary WDP: N
Musculoskeletal WDP: N
Genitourinary WDP: N
Psycho-social WDP: ?
Mode of Transport: Stretcher
W/O2
W/Monitor
Code Status: FULL
Skin Risk Evaluation: Y
FALL RISK ASSESSMENT: Y
- PAIN EVALUATION -
Does Patient Currently Have Pain: N
>Pain Scale Used: NUMBERS 0-10
>Pain Score: 0
- ISOLATION PRECAUTIONS -
Isolation Type: CONTACT
Infection Control and transmission prevention information provided to
patient/family/visitors and questions answered: Y

Problem/Goal/Intervention Description	Activity Type	Occurred Date	Occurred Time	By	Ordered/ Documented	Site/ Interaction/ Comment	Units	From/ Charge

Activity Date: 03/31/11 Time: 0001 (continued)

160011 Shift Evaluation (continued)
Special Equipment: Y
Invasive Line Management: Y
Tubes & Drains Management: N
Education (Interdisciplinary): N
Venous Thromboembolism Eval: Y
< NEUROLOGICAL EVALUATION >
LOC: DROWSY
Oriented: N
Disoriented to: PLACE
Speech: CLEAR
Sensation-RUE: WITHDRAWS FROM PAIN
RLE: WITHDRAWS FROM PAIN
LUE: WITHDRAWS FROM PAIN
LLE: WITHDRAWS FROM PAIN
Behavior: COOPERATIVE
Comment: AROUSES EASILY
< EENT EVALUATION >
< CARDIOVASCULAR EVALUATION >
Is Patient on Cardiac Monitoring: Y
Pacer/Defibrillator: N
Heart Sounds: REGULAR
Cap Refill Eval: Y
RUE: BRISK < 3 SECONDS
LUE: BRISK < 3 SECONDS
RLE: BRISK < 3 SECONDS
LLE: BRISK < 3 SECONDS
Peripheral Pulse Eval: Y
R Radial: 2+ NORMAL
L Radial: 2+ NORMAL
R Dorsal Pedis: 2+ NORMAL
L Dorsal Pedis: 2+ NORMAL
Homan's Sign: NEGATIVE
Edema: Y
Edema Location: GENERALIZED
Edema Type: GENERALIZED
Chest Pain: N
<< TELEMETRY EVALUATION >>
EKG Rhythm: SINUS TACHYCARDIA
Rate: 105
< PACER EVALUATION SCREEN >
< RESPIRATORY EVALUATION >
Effort: UNLABORED
Cough: NON-PRODUCTIVE
Chest Shape: SYMMETRICAL
Chest Movement: SYMMETRICAL
O2 Therapy: Y
Breath Sounds Eval: Y

Problem/Goal/Intervention Description	SOR Intervention	From
Activity	Occurred	Recorded	Documented		
Type	Date	Time by	Date	Time by	Comment	Units	Source

Activity Date: 03/31/11 Time: 0001 (continued)

160011 Shift Evaluation (continued)
R Upper Anterior: CLEAR
L Upper Anterior: CLEAR
R Mid Anterior: CLEAR
R Lower Anterior: DIMINISHED
L Lower Anterior: DIMINISHED
R Upper Posterior: CLEAR
L Upper Posterior: CLEAR
R Lower Posterior: DIMINISHED
L Lower Posterior: DIMINISHED
< RETRACTIONS >
< OXYGEN THERAPY >
O2 Device: NASAL CANNULA
O2 Flow (L/M): 2
< INCENTIVE SPIROMETRY >
< GASTROINTESTINAL EVALUATION >
< INTEGUMENTARY EVALUATION >
Skin Appearance: PALE
Skin Temp: WARM
Skin Moisture: DRY
Skin Turgor: FAIR
Mucous Membranes: DRY
Wounds/Ulcer: Y
Incisions: N
New Onset Skin Breakdown: N
Comment: TURN Q 2
< WOUND/ULCER EVALUATION >
Type #1: LACERATION
Location: TIP OF TONGUE
Wound Eval: SCABBED
Surround Tissue Eval: DRY/SCALY
Wound Bed: BROWN
Dressing: NO DRESSING
Drainage Amt: NONE
Type #2: ULCER
Location: COCCYX
Wound Eval: OPEN
Surround Tissue Eval: NORMAL
Wound Bed: UTA
Dressing Changed: N
Dressing: TEGADERM
Drainage Amt: NONE
< INCISION EVALUATION >
Sensory perception- Very limited
Moisture- Occasionally moist
Activity- Bedfast
Mobility- Slightly limited
Nutrition- Probably inadequate

160011 Shift Evaluation (continued)
Friction and shear- Potential problem
Braden Skin Score: 13
Braden Risk Level- Medium
Skin risk interventions: Manage moisture. Avoid drying toe skin
Manage nutrition. Maintain good hydration
Manage friction and shear
No massage of reddened bony prominences
Reposition Q2hrs and PRN
Offer toileting when turning
Perineare PRN
Use moisture barrier: body wash and lotion routinely
Maximal reambilization up in chair for meals when appropriate
Protect (offload) heels
Use turn sheets to reduce friction/shear
HOB < 30 degrees unless medically contraindicated
Consider pressure relieving surface (if bed or chair bound)
Provide education on pressure ulcers to patient and family
Assess nutrition status, obtain nutrition consult prn
Use foam wedges for 30 degree lateral positioning
Consider trapeze if indicated
Monitor all body folds re moisture, yeast, rash, irritation
< MUSCULOSKELETAL EVALUATION >
ROM R Arm: LIMITED ROM
ROM L Arm: WEAKNESS
ROM R Leg: WEAKNESS
ROM L Leg: WEAKNESS
Comment: BRACE ON R ARM
< GENITOURINARY >
Urinary Elimination: CATHETER-INDWELLING
Secured with: LEG STRAP
Urine Color: YELLOW
Consider catheter removal based on criteria: N
Penile Discharge: N
< PSYCHOSOCIAL EVALUATION >
Event/Issue:
Taken:
<Suicide Risk Assessment, Modified SAD PERSONS>
Pt has 3 or more meds in drug classes known to
be indicator of fall risk: N
Is patient Responsive: Yes
Is patient following fall prevention directions: Y
Add'l Fall Risk Elements: Unsteady Gait
Fall Risk Comment: BEDREST
High Risk for Falls: Y
Fall Precautions: Alert: Signage (i.e. Armband, chart, door)
Non-slip footwear
Assist: Mobility

Age/Sex: 81 M
MRN: [redacted]
Acct/Bed: 03/30/11 ec 6245
Status: DIS INA

Attending: Adam Yamulla MD
Support #: [redacted]
Location: M.ESIC
Room/Bed: M.A529-1

WINKLER, LOUIS

Brandon Regional Hospital Nursing "Live"
CLINICAL DOCUMENTATION RECORD HPF

Printed 04/12/11 at 1802

Problem/Goal/Intervention Description | Type: Ordered/INA | User

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Comment | Units | Charge

Activity Date: 03/30/11 Time: 0800 Continued

160911 Shift Evaluation (continued)
Assist: ADLs
Assist: Toilet program
Tethered devices: Move poles to exit side of bed, secure tubes
Fall Precautions Comment: BEDREST
< SPECIAL EQUIPMENT >
Special Equip: IVP
Special Equip: O2
<< INVASIVE LINES >>
Peripheral IV: Y
Peripheral Site #1: Y
Peripheral Site #2: N
<< PERIPHERAL LINE >>
Insertion: N
Monitor/Manage: Y
Location: LEFT ANTECUBITAL
Insertion Date: 03/30/11
IV Type: ANGIOCATH
Size: 18 GAUGE
Removal: N
Saline Lock: N
Fluid Infusing: Y
Tubing Changed: N
IV Site Appearance: CLEAN,DRY,INTACT
<< PERIPHERAL LINE >>
< MIDLINE >
<< ARTERIAL LINE >>
<< INTRACRANIAL PRESSURE CATHETER >>
<< PULMONARY ARTERY CATHETER >>
PRESSURES:
<< SHEATH-PERCUTANEOUS INTRODUCER >>
PULSES:
<< INTRAORTIC BALLOON PUMP >>
Condition:
PULSES
<< VENTRICULAR ASSIST DEVICE >>
< INDWELLING CATHETER / TUBES & DRAINS >
< TUBES AND DRAINS >
< INDWELLING CATHETER REMOVAL >
<< TEACHING & EDUCATION >>
Education Contents:
Is patient currently on anticoagulation medication? N
Body Mass Index (BMI): 23.7
BMI is in normal range. Y
Is patient ambulating in hallway: N
Pharmacological Prophylaxis due to:
Mechanical prophylaxis in place NONE

Activity Date: 03/30/11 Time: 0800

191000 Vital Signs (NOT BCTA) A 0411 CP
Document: 03/31/11 0400 EDT [redacted] 03/31/11 0407 EDT
<< VITAL SIGNS >>
Temp-F: 97.6
Temp Source: AXILLARY
Pulse: 105
Pulse Source: BRACHIAL
Resp: 18
Resp Type: REGULAR
BP: 140/69
BP Source: CUFF
Patient Position: Sitting
MAP: 92
Pulse Ox: 98
Oxygen @: 2
130028 Age Guidelines: 80 Years, Adult-Elderly A 0411 CP
Document: 03/31/11 0400 EDT [redacted] 03/31/11 0407 EDT

Activity Date: 03/30/11 Time: 1012

460015 RT: Respiratory Therapy Treatment A per order PS
Document: 03/31/11 0400 EDT [redacted] 03/31/11 0407 EDT
- RESPIRATORY THERAPY TREATMENT -
Oxygen Therapy: Y
- RT INH TREATMENT -
Pre-treatment breath sounds
Post-treatment breath sounds
- RT INH TREATMENT -
Pre-treatment breath sounds
Post-treatment breath sounds
- OXYGEN FLOW SHEET -
O2 Flow: 2
l/pm
%
O2 Type: NASAL CANNULA
- CPT TREATMENT/POSTURAL DRAINAGE -
Monitor
- OMITTED TREATMENT -
- SUCTIONING -
< INCENTIVE SPIROMETRY >
-PULSE OXIMETRY -
%
%

Age/Sex: 81 M
Unit #: [redacted]
Admitted: 03/30/11 at 0240
Service: DIS INN

Attending: Agnes Kosmalla MD
Account #: [redacted]
Location: M.SSIC
Room/Bed: M.A539-1

WINKLER, LOUIS

Grandon Regional Hospital Nursing "Live"
CLINICAL DOCUMENTATION RECORD HSF

Printed 04/12/11 at 1042

Problem/Goal/Intervention Description	Site/Direction	Flow
Activity Type	Occurred Date	Recorded Time by	Documented Time by	Comment	Units	Charge

Problem/Goal/Intervention Description	Site/Direction	Flow
Activity Type	Occurred Date	Recorded Time by	Documented Time by	Comment	Units	Charge

Activity Date: 03/31/11 Time: 1022

165000 Wound Care Evaluation A per standard PS
Created: 03/31/11 1022 PCD 03/31/11 1633 PCD
- Document 03/31/11 1022 PCD 03/31/11 1633 PCD
<< WOUND CARE INITIAL EVALUATION >>
Admission DX: UROSEPSIS R/O LYMPHOMA
Isolation Type: CONTACT
< Past Medical History >
Height
Feet: 6
Inches: 1.0
Cm: 185.42
Weight
Lb: 180
Kg: 81.63
BMI: 23.7
Smoking History
HGB: 8.2
HCT: 26.9
WBC: 11.7
GLUCOSE: 156
BUN: 31
CRF: 1.3
PLT: 63
ALBUMIN: 1.9
Wounds/Ulcer: Y
Incisions: N
New Coast Skin Breakdown: N
Function of Bed/Mattress: PRESSURE REDISTRIBUTION
PLACED ACCUMAX NC CONTROL
UNIT W/O SET AT 5
ALTERNATING PRESSURE
Document Education: Y
Clinical Assessment: PALE MALE WITH LEFT ARM SWOLLEN. BOTH
ARM SPLINT IN PLACE. FI CAD LEGS CROSSED
WITH FOLEY TUBING CAUGHT IN BETWEEN.
FOLEY STAT LOCK IN PLACE. BILATERAL
HEELS OFFLOADED ON PILLOWS.
COCCYX STAGE II NOTED. ALSO APPEARS TO
BE INCISION TO LOWER LUMBAR.
RECOMMENDATIONS: MAXIK BUTT CREAM BID AND PRN WITH
MEPILEX BORDER SACRUM. TURN/RN. OFFLOAD
HEELS. ELEVATE LEFT ARM ON 2 PILLOWS.
PRESSURE ULCER ORDER SET PLACED ON
CHART. PRIMARY NURSE AWARE OF FINDINGS
TX AND RECOMMENDATIONS.
INCISION TO LOWER BACK. CLEANSE DAILY
APPLY BACTROBAN AND DRY DRSG
< WOUND/ULCER EVALUATION >

Activity Date: 03/31/11 Time: 1022 (continued)

165000 Wound Care Evaluation (continued)
Type #1: LACERATION
Location: TIP OF TONGUE
Wound Eval: UNABLE TO ASSESS
Type #2: ULCER
Location: COCCYX
Wound Eval: OPEN
Surround Tissue Eval: RED
Wound Bed: RED
Dressing Changed: N
Drainage Amt: SMALL
Drainage Type: SEROSANGUINEOUS
Stage: II
Length(cm): 3
Width(cm): 2
Depth(cm): 0.3
Tunneling/Undermining: N
Odor: N
Type #3: LACERATION
Location: LUMBAR SPINE
Wound Eval: OPEN
Surround Tissue Eval: PINK
Wound Bed: PINK
Dressing Changed: N
Drainage Amt: SMALL
Drainage Type: SEROUS
Length(cm): 3
Width(cm): 0.1
Depth(cm): 0.2
Tunneling/Undermining: N
Odor: N
Type #4: SCAR
Location: FIRST 3 FINGERS LT HAND
Wound Eval: HEALED
Surround Tissue Eval: SWOLLEN
WHITE
Wound Bed: WHITE
Dressing Changed: N
Drainage Amt: NONE
Tunneling/Undermining: N
<< TEACHING & EDUCATION >>
Department: WOUND CARE
Setting: BEDSIDE
Learner: PATIENT
Readiness to Learn: WILLING TO LEARN
Preferred Method: EXPLANATION
WRITTEN
Barriers: NONE

[redacted] MD | WINKLER,LOUIS | Page: 72

Brandon Regional Hospital *Live*
CLINICAL DOCUMENTATION RECORD HPF

Printed 04/12/11 at 1002

Activity Type	Occurred Date	Recorded Time	by	Documented Comment	Units	Signed

Activity Date: 03/31/11 Time: 1000 (continued)

16500B Wound Care Evaluation* (continued)
Education Content:
Hospital Care: Wound Care
Strategies: EXPLANATION
WRITTEN
LITERATURE
Outcome: STATES UNDERSTANDING

Activity Date: 03/31/11 Time: 1000

2102/B ADLs* A Q12H CP
Document: [redacted]
< ADL ASSISTANCE >
ACTIVITY
Assistance Required: Y
Assisted By: 1 STAFF ASSIST
Type: BEDREST
Patient Response: COOPERATIVE
Tolerance: WELL
TOILETING
Assistance Required: Y
Assisted By: 1 STAFF ASSIST
Type: DIAPER
ORAL CARE
Assistance Required: Y
Assisted By: 1 STAFF ASSIST
Type: SWAB MOUTH
CARING
Assistance Required: Y
Assisted By: 1 STAFF ASSIST
Type: FULL BED
PERSONAL HYGIENE
Assistance Required: Y
Assisted By: 1 STAFF ASSIST
Type: COMPLETE BED BATH
LINEN CHANGED
Was Linen Changed: Y
Type: COMPLETE LINEN CHANGE
DRESSING

Activity Date: 03/31/11 Time: 1004

192008 Intake and Output* (NOT BCMA) A Q12H CP
Document: [redacted]
< INTAKE AND OUTPUT >
Intake: Y
<< INTAKE >>
PO: 480

Activity Date: 03/31/11 Time: 1000 (continued)

192008 Intake and Output* (NOT BCMA) (continued)
Breakfast #: 10
Diet: SOLID FOOD
<< OUTPUT >>

Activity Date: 03/31/11 Time: 1230

S10000 Nutrition: Assessment* A per standard AS
Order: 03/31/11 Date: AM 03/31/11 1244 AM
- Document 03/31/11 1232 AM 03/31/11 1244 AM
~ ADULT NUTRITION ASSESSMENT ~
Reason for Visit: Wound Care Referral*
~ FOOD AND NUTRITION RELATED HISTORY ~
Nutrition Orders: PUREE DIET WITH THICK LIQUIDS*
BARIATRIC SHAKES TID*
Food & Nutrient Intake: PT WITH 0% PO INTAKE. PT OFF THE FLOOR AT TIME OF VISIT. RECOMMENDATIONS TO BE PLACED IN CHART. *
Medication & Herbal Supplements: NACL, FOLIC ACID, NOVOLIN INSULIN, PROTONIX,* SYNTHROID, ZOFRAN*
Client History: DX: HTN, DVD, DEMENTIA, CHEMOTHERAPY, BRN, BACK* SURGERY*
Biochemical Data: NA 149, CL 117, CO2 15, GLU 155, ALB 1.9, CA 8.9, WBC* 11.7, H/H 8.2-26.9, MCV 101.9, LDH 6694*
Nutrition-Focused Physical Findings: L/O: 2680/900, DMAE 100.4, HYPOACTIVE BS, BRADEN* SCORE 13-PER WD EVAL STAGE II PU TO COCCYX.*
~ ANTHROPOMETRIC MEASUREMENTS ~
Weight
Feet: 6
Inches: 1.8
Cm: 185.42
Weight
Lb: 180
Kg: 81.63
BMI: 23.7
BMI Eval: 18.6-24.9 NORMAL
Ideal/Reference Body Wt Lb: 184.8
184 kg: 83.46
%IBW: 97
~ Comparative Standards ~
~ Methods for Estimating Needs ~
Estimated Energy Needs (Kcals): 2454-1963
: 30-35KCAL/KG
: 2 FU
Estimated Protein Needs (Grams): 98-123
: 1.26-1.5 g/kg
: 2 FU
Estimated Fluid Needs (Mls): 2045-2454
: 25-30ML/KG

Problem/Goal/Intervention Description | Sys Direction | Prob
Activity | Date | Time by Nurse | Time by Computer | Units | Charge

Activity Date: 03/31/11 Time: 1247

S1000 Nutrition: Assessment* (continued)
- NUTRITION DIAGNOSIS -
Problem
Related To
As Evidenced By
1. Inadequate Protein Intake
1. Wound Healing*
1 Pressure Ulcer*
: PT IS AT MODERATE/HIGH NUTRITIONAL RISK SECONDARY TO*
IMPAIRED SKIN. PT WT IS NORMAL. VISCERAL PROTEIN IS SEVERELY*
DEPRESSED. CURRENT DIET WITH ORAL SUPPLEMENT IS ADEQUATE/*
APPROPRIATE TO MEET PTS NEEDS. EDUCATION NOT INDICATED AT*
THIS TIME.*
Nutrition Intervention
Goal
1. VITAMINS
: SUGGEST DAILY THERAPEUTIC MULTI-VITAMINS
2. Medical Food Supplements
: CHANGE ORAL SUPPLEMENT TO ENSURE PLUS TID
- NUTRITION MONITORING AND EVALUATION -
Indicator
Criteria
1. Total Energy Intake
: Meets >75% Assessed Needs
: MONITOR PO INTAKE/LABS*
- REQUESTED PHYSICIAN ORDERS -
: 1.SUGGEST DAILY THERAPEUTIC MULTI-VITAMINS*
2.CHANGE ORAL SUPPLEMENT TO ENSURE PLUS TID*
Document Education: N
User: Monserrate,Angrisel - RD
Date: 03/31/11
Time: 1248
<< TEACHING & EDUCATION >>
Location Comment:
: PT IS AT MODERATE/HIGH NUTRITIONAL RISK SECONDARY TO
IMPAIRED SKIN. PT WT IS NORMAL. VISCERAL PROTEIN IS SEVERELY
DEPRESSED. CURRENT DIET WITH ORAL SUPPLEMENT IS ADEQUATE/
APPROPRIATE TO MEET PTS NEEDS. EDUCATION NOT INDICATED AT
THIS TIME. PT WITH POOR PO INTAKE. [7413 TYPE.]

Activity Date: 03/31/11 Time: 1248

Problem: PROB: Impaired Ingestion/Nutrition A
Create 03/31/11 1245 AM 03/31/11 1246 AM

Activity Date: 03/31/11 Time: 1246

Goal : GOAL: Optimize Hydration/Nutrition 1
Create 03/31/11 1246 AM 03/31/11 1246 AM

Activity Date: 03/31/11 Time: 1247

13100 Shift Re-Eval Verification* A SHIFT CP
Documented: 03/31/11 1247 AM 03/31/11 1247 AM
< SHIFT RE-EVALUATION >
By signing off on this intervention, I verify I have completed a Shift
Re-evaluation and have noted no change from my previous evaluation or have
noted changes and have documented said changes appropriately.
Nurse signature: Morgan,Kelly A - RN
Y

Activity Date: 03/31/11 Time: 1248

460700 Physician Notification/Response* A PRN CP
Documented: 03/31/11 1249 AM 03/31/11 1249 AM
< PHYSICIAN NOTIFY/RESPONSE >
Notification: Y
Response: Y
Physician Called: SHASUK, Shah,Sukeshi K MD
Person Notified: SERVICE
Method of Notification: PAGED
Reason: PT REFUSED 1ST HALF OF
ECHO
Physician Spoken to: SHASUK,Shah,Sukeshi K MD
Notification Results: MD AWARE WILL HAVE THEM READ WHAT THEY
GOT.
Verbal Orders are to be written to Chart, Read Back, and Verified.
Physicians are to be Read Back Critical Lab Values/Test Results

Activity Date: 03/31/11 Time: 1445

197000 Vital Signs* (NOT PCA) A CHI CP
Documented: 03/31/11 1445 PM 03/31/11 1445 PM
<< VITAL SIGNS >>
Temp-F 98.2
Temp Source: AXILLARY
Pulse: 102
Pulse Source: BRACHIAL
Resp: 18
Resp Type: REGULAR
BP: 133/64
BP Source: CUFF
Patient Position: Lying
MAP: 87
Pulse Ox: 96

Age/Sex: 83 M
Unit #: [redacted]
Admitted: 03/30/11 at 0246
Status: OIS Inp

Attending: Ayzen,Yeshitila MD
Account #: [redacted]
Location: H.5STC
Room/Bed: H.A509-1

WINKLER, LOUIS

Brandon Regional Hospital Nursing Home
CLINICAL DOCUMENTATION RECORD 10F

Printed 04/12/11 at 1802

Problem/Goal/Intervention Description | Via | Direction | Freq | Activity Type | Occurred Date | Occurred Time | Recorded by User | Recorded Time | Documentation Type | Documentation Date | Documentation Time | Charge

Activity Date: 03/31/11 Time: 2340 (continued)

191000 Vital Signs (NOT BCTA) (continued)
Oxygen @: 2

Activity Date: 03/31/11 Time: 1649

540060 Patient Care Orders 3/31/11 D/C BGENERIN 4/2/11 — A QSHIFT — UE

Activity Date: 03/31/11 Time: 1751

192000 Intake and Output (NOT BCTA) — A Q12H — CP
Document: 03/31/11 1751 EDT by [redacted]
< INTAKE AND OUTPUT >
Intake: Y
<< INTAKE >>
IV Fluids: 1200
<< OUTPUT >>

Activity Date: 03/31/11 Time: 1755

192060 Intake and Output (NOT BCTA) — A Q12H — CP
Document: 03/31/11 1754 EDT by [redacted]
< INTAKE AND OUTPUT >
Intake: Y
Output: Y
<< INTAKE >>
PO: 600
Lunch #: 0
Diet: SOLID FOOD
Dinner #: 0
Diet: SOLID FOOD
<< OUTPUT >>
Voley: 500
Stools #: 0

Activity Date: 03/31/11 Time: 1900

710062 Eval: Venous Thromboembolism — A on admission + QSHIFT — CA
Document: 03/31/11 2003 EDT by [redacted]
Is patient currently on anticoagulation medication? Y
Pharmacological Prophylaxis due to:
Comment: LOVENOX
SCD'S

150600 Plan of Care Review — A QSHIFT — CP
Document: 03/31/11 2003 EDT by [redacted]
< PLAN OF CARE REVIEW >
Link to Plan of Care: Y

Problem/Goal/Intervention Description | Via | Direction | Freq | Activity Type | Occurred Date | Occurred Time | Recorded by User | Recorded Time | Documentation Type | Documentation Date | Documentation Time | Charge

Activity Date: 03/31/11 Time: 2005 (continued)

150600 Plan of Care Review (continued)
Nurse signature: MUNISWAMY,BABU - RN
: Y
150117 Standards of Care: Telemetry Medical — A QSHIFT — CP
Document: 03/31/11 2008 EDT by [redacted]
: Y
By signing off on this intervention, the nurse certifies that
the Facility and Care Area Standard of Care has been met.
Untoward events or care outside of the Standards of Care
must be documented in supplemental interventions or notes.
Nurse signature: MUNISWAMY,BABU - RN
130300 Isolation: Standard Precautions — A QSHIFT — CP
Document: 03/31/11 2008 EDT by [redacted]
160011 Shift Evaluation — A QSH — CP
Document: 03/31/11 2008 EDT by [redacted]
<< SHIFT EVALUATION >>
Neurological WDP: Y
ENT WDP: Y
Cardiovascular WDP: N
Respiratory WDP: N
Gastrointestinal WDP: Y
Integumentary WDP: N
Musculoskeletal WDP: N
Genitourinary WDP: N
Psycho-social WDP: Y
Mode of Transport: Stretcher
Code Status: FULL
Skin Risk Evaluation: Y
FALL RISK ASSESSMENT: Y
- PAIN EVALUATION -
Does Patient Currently Have Pain: N
>Pain Scale Used: NUMBERS 0-10
>Pain Score: 0
- ISOLATION PRECAUTIONS -
Infection control and transmission prevention information provided to
Special Equipment: Y
Invasive Line Management: Y
< NEUROLOGICAL EVALUATION >
LOC: ALERT/AWAKE
Oriented: N
Disoriented to: SITUATION/EVENT
TIME
REASON
Speech: SLOW
Sensation-RUE: WITHDRAWS FROM PAIN
RLE: WITHDRAWS FROM PAIN
LUE: WITHDRAWS FROM PAIN
LLE: WITHDRAWS FROM PAIN

Age/Sex: 81 M
MRN #: [redacted]
Admitted: 03/30/11 at 0245
Status: DIS IN

Attending: [redacted] MD
Account #: [redacted]
Location: M.ESIC
Room-Bed: M.A539-1

WINKLER,LOUIS

Brandon Regional Hospital Nursing *Live*
CLINICAL DOCUMENTATION RECORD HDF

Printed 04/12/11 at 1802

Problem/Goal/Intervention Description	Activity Type	Occurred Date	Recorded Time by Date	Recorded Time of Current	STG Unrelated Documented Intervention Date	Comments Cosign

Problem/Goal/Intervention Description	Activity Type	Occurred Date	Recorded Time by Date	Recorded Time of Current	S-B Unrelated Documented Intervention Units	Comments Cosign

Activity Date: 03/30/11 Time: 0300 (continued)

160011 Shift Evaluation (continued)
Motor Skill Eval: N
Impaired Memory: UNABLE TO ASSESS
Behavior: COOPERATIVE
Pupils Equal, Round, React to Light, and Accomodation: Y
< CENT EVALUATION >
< CARDIOVASCULAR EVALUATION >
Is Patient on Cardiac Monitoring: Y
<< TELEMETRY EVALUATION >>
EKG Rhythm: SINUS TACHYCARDIA
Rate: 114
Zone Number: 611
< PACER EVALUATION SCREEN >
< RESPIRATORY EVALUATION >
Depth: DEEP
Effort: UNLABORED
Chest Shape: SYMMETRICAL
Chest Movement: SYMMETRICAL
O2 Therapy: Y
Breath Sounds Eval: Y
R Upper Anterior: DIMINISHED
L Upper Anterior: DIMINISHED
R Mid Anterior: DIMINISHED
R Lower Anterior: DIMINISHED
L Lower Anterior: DIMINISHED
R Upper Posterior: DIMINISHED
L Upper Posterior: DIMINISHED
R Lower Posterior: DIMINISHED
L Lower Posterior: DIMINISHED
< RETRACTIONS >
< OXYGEN THERAPY >
O2 Device: NASAL CANNULA
O2 Flow (L/M): 2
I/O Q 8 : SY
< INCENTIVE SPIROMETRY >
< GASTROINTESTINAL EVALUATION >
< INTEGUMENTARY EVALUATION >
Skin Appearance: PALE
Skin Temp: WARM
Skin Moisture: DRY
Skin Turgor: FAIR
Mucous Membrane: DRY
Wounds/Ulcer: Y
Incisions: Y
< WOUND/ULCER EVALUATION >
Type #1: LACERATION
Location: TIP OF TONGUE
Dressing: NO DRESSING

Activity Date: 03/30/11 Time: 0300 (continued)

160011 Shift Evaluation (continued)
Type #2: ULCER
Location: COCCYX
Wound Eval: OPEN
Surround Tissue Eval: RED
Wound Bed: RED
Dressing Changed: Y
Dressing Change Date: 03/31/11
Dressing: MEPILEX
Drainage Amt: NONE
< INCISION EVALUATION >
Type #1: INCISION
Location: LT CLAVICLE
Incision Eval: WELL APPROXIMATED
Dressing: NO DRESSING
Type #2: INCISION
Location: LUMBAR SPINE
Incision Eval: WELL APPROXIMATED
Dressing Changed: Y
Dressing: NO DRESSING
Sensory perception- No impairment
Moisture- Rarely moist
Activity- Bedfast
Mobility- Very limited
Nutrition- Probably inadequate
Friction and shear- Potential problem
Braden Skin Score: 16
Braden Risk Level- Low
Skin prot interventions: Manage moisture, Avoid drying the skin
Manage nutrition, Maintain good hydration
Manage friction and shear
No massage of reddened bony prominences
Reposition Q2hrs and PRN
Offer toileting when turning
Pericare PRN
Use moisture barrier; body wash and lotion routinely
Maximal repositi/ation-up in chair for meals when appropriate
Protect (offload) heels
Use turn sheets to reduce friction/shear
HOB < 30 degrees unless medically contraindicated
Consider pressure relieving surface (if bed or chair bound)
Provide education on pressure ulcers to patient and family
Assess nutrition status, obtain nutrition consult prn
< MUSCULOSKELETAL EVALUATION >
ROM R Arm: LIMITED ROM
ROM L Arm: LIMITED ROM
ROM R Leg: LIMITED ROM
WEAKNESS

Problem/Goal/Intervention Description	Site	Interactor	Frequency
Activity Type	Ordered Date	Ordered Time	by	Discontinued Date	Discontinued Time	by	Documented Comment	Documented Value	Charge

Activity Date: 03/31/11 Time: 2000 (continued)

160011 Shift Evaluation (continued)
RGHT Leg: LIMITED ROM
WEAKNESS
< GENITOURINARY >
Urinary Elimination: CATHETER-INDWELLING
Insert date: 03/30/11
Secured with: TAPE
Urine Color: YELLOW
Urine Clarity: CLEAR
Consider catheter removal based on criteria: Y
Penile Discharge: N
< PSYCHOSOCIAL EVALUATION >
Event/Issue:
Taken:
<Suicide Risk Assessment, Modified SAD PERSONS>
Pt has 3 or more meds in drug classes known to
be indicator of fall risk: N
Is patient Responsive: Yes
Is patient following fall prevention directions: Y
Fall Risk Elements: No Risk Elements Noted
High Risk for Falls: N
< SPECIAL EQUIPMENT >
Special Equip: IV PUMP
<< INVASIVE LINES >>
Peripheral IV: Y
Peripheral Site #1: Y
<< PERIPHERAL LINE >>
Monitor/Manage: Y
Location: LEFT ANTECUBITAL
Insertion Date: 03/30/11
IV Type: ANGIOCATH
Size: 20 GAUGE
Saline Lock: N
Fluid Infusing: Y
Tubing Changed: N
<< PERIPHERAL LINE >>
< MIDLINE >
<< ARTERIAL LINE >>
<< INTRACRANIAL PRESSURE CATHETER >>
<< PULMONARY ARTERY CATHETER >>
PRESSURES:
<< SHEATH-PERCUTANEOUS INTRODUCER >>
PULSES:
<< INTRAORTIC BALLOON PUMP >>
Condition:
PULSES
<< VENTRICULAR ASSIST DEVICE >>
< INDWELLING CATHETER / TUBES & DRAINS >

Problem/Goal/Intervention Description	Site	Interactor	Frequency
Activity Type	Ordered Date	Ordered Time	by	Discontinued Date	Discontinued Time	by	Documented Comment	Documented Value	Charge

Activity Date: 03/31/11 Time: 2000 (continued)

160011 Shift Evaluation (continued)
< TUBES AND DRAINS >
< INDWELLING CATHETER REMOVAL >
<< TEACHING & EDUCATION >>
Education Content:
Pharmacological Prophylaxis dvm to:
91000 Vital Signs (NOT BCTA) A SHH CP
Documented: 03/31/11 2000 BY [redacted] 03/31/11 2000 By:
<< VITAL SIGNS >>
Temp-F: 97.6
Temp Source: AXILLARY
Pulse: 107
Pulse Source: MONITOR
Resp: 20
Resp Type: REGULAR
BP: 123/67
BP Source: CUFF-RIGHT
Patient Position: Lying
MAP: 86
Pulse Ox: 97
Oxygen @: RA
99428 Age Attributes: 80 Years, Acuity Level: A CONSULT CP
Documented: 03/31/11 2000 BY: [redacted] 04/01/11 0005 BY:

Activity Date: 03/31/11 Time: 2000

Z1070 ADLs CP
[redacted]
< ADL ASSISTANCE >
ACTIVITY
Assistance Required: Y
Assisted By: 2 STAFF ASSIST
Type: BEDREST
TOILETING
Assistance Required: Y
Assisted By: 2 STAFF ASSIST
Type: DIAPER
Comment: FOLEY
ORAL CARE
Assistance Required: Y
Assisted By: STAFF
Type: BRUSH TEETH/DENTURES
EATING
Assistance Required: Y
Assisted By: STAFF
Type: FULL FEED
PERSONAL HYGIENE
Assistance Required: Y

[redacted] WINKLER,LOUIS Page: 27

Admitted: 03/30/11 at 0745 Attending: M.SIC
Status: DIS Inp Room/Bed: M.A539-1

Brandon Regional Hospital Nursing "Live"
CLINICAL DOCUMENTATION RECORD 16F

Printed 04/12/11 at 1002

Problem/Goal/Intervention Description	Site/Dtl/Amt/Lot/Exp	Freq
Activity Type	Occurred Date Time	By	Required Date Time	By	Documented Date Time	By	Context	Info	Charge

Activity Date: 04/01/11 Time: 0100

210270 ADLs+ (continued)
Assisted By: STAFF
Type: TOILET CARE
LINEN CHANGED
Bed Linen Changed: N
DRESSING
Was Patient Assisted with Choosing Clothes: N

Activity Date: 04/01/11 Time: 0500

192000 Intake and Output (NOT BCMA) A Q12H CP
Document 04/01/11 0005 CDT 04/01/11 0456 CDT
< INTAKE AND OUTPUT >
Intake: Y
<< INTAKE >>
IV Fluids: 1150
IVPB: 60
<< OUTPUT >>

160100 Shift Re-Eval Verification+ A QSHIFT CP
Document 04/01/11 0000 CDT 04/01/11 0456 CDT
< SHIFT RE-EVALUATION >
By signing off on this intervention, I verify I have completed a Shift
Re-evaluation and have noted no change from my previous evaluation or have
noted changes and have documented said changes appropriately.
Nurse signature: MUNISWAMY,BABU - RN
Y

Activity Date: 04/01/11 Time: 0800

152000 Intake and Output (NOT BCMA) A Q12H CP
Document 04/01/11 0001 CDT 04/01/11 0746 CDT
< INTAKE AND OUTPUT >
Intake: Y
Output: Y
<< INTAKE >>
PO: 150
<< OUTPUT >>
Foley: 550
Stools: 0

Activity Date: 04/01/11 Time: 0800

210665 Eval: Fall Risk+ A PRN CP
Document 04/01/11 0800 CDT 04/01/11 1200 CDT
Is patient Responsive: Yes
Is patient following fall prevention directions: Y
Add'l Fall Risk Elements: Unsteady Gait
High Risk for Falls: N

Activity Date: 04/01/11 Time: 0900

210662 Eval: Venous Thromboembolism+ A on admission + QSHIFT CP
Document 04/01/11 0800 CDT 04/01/11 1200 CDT
Is patient currently on anticoagulation medication? Y
Pharmacological Prophylaxis due to:
320010 Invasive Line Management+ A E,Q/SHIFT+PRN CP
Document 04/01/11 0800 CDT 04/01/11 1200 CDT
<< INVASIVE LINES >>
Peripheral LN: Y
Peripheral Site #1: Y
<< PERIPHERAL LINE >>
Monitor/Manage: Y
Location: LEFT ANTECUBITAL
Insertion Date: 03/30/11
IV Type: ANGIOCATH
Size: 18 GAUGE
Fluid Infusing: Y
<< PERIPHERAL LINE >>
<< PERIPHERAL LINE >>
<< PERIPHERAL LINE >>
< MIDLINE >
<< ARTERIAL LINE >>
<< INTRACRANIAL PRESSURE CATHETER >>
<< PULMONARY ARTERY CATHETER >>
PRESSURES:
<< SHEATH-PERCUTANEOUS INTRODUCER >>
PULSES:
<< INTRAAORTIC BALLOON PUMP >>
Condition:
PULSES
<< VENTRICULAR ASSIST DEVICE >>
320020 Tubes & Drains Management+ A E,Q/SHIFT+PRN CP
Document Foley Insert/Discontinue here.
Document Foley Monitor/Manage in Shift
Lvl: (1) Observation or Focus Lines: ON
Document 04/01/11 0800 CDT 04/01/11 1200 CDT
< INDWELLING CATHETER / TUBES & DRAINS >
< TUBES AND DRAINS >
< INDWELLING CATHETER INSERTION >
< INDWELLING CATHETER REMOVAL >
130117 Standards of Care: Telemetry Medical A QSHIFT CP
Document 04/01/11 0800 CDT 04/01/11 1200 CDT
By signing off on this intervention, the nurse verifies that
the Facility and Care Area Standard of Care has been met.
Untoward events or care outside of the Standards of Care
must be documented in supplemental interventions or notes.
Nurse signature: Pasquini,Candace M - LPN

Problem/Qualification/Intervention Description	SCN	Unplanned	Error
Activity Type	Occurred Date	Recorded Time	By	Date	Time	In	Comment	Recorded Units	Dosage

Problem/Qualification/Intervention Description	SCN	Unplanned	Error
Activity Type	Occurred Date	Recorded Time	By	Date	Time	In	Comment	Recorded Units	Dosage

Activities Performed/Verified Time Added

160011 Shift Evaluation A CBH CB
Documents: [redacted]
<< SHIFT EVALUATION >>
Neurological WDP: N
CENT WDP: Y
Cardiovascular WDP: N
Respiratory WDP: N
Gastrointestinal WDP: N
Integumentary WDP: N
Musculoskeletal WDP: N
Genitourinary WDP: N
Psycho-social WDP: Y
Mode of Transport: Stretcher
Code Status: FULL
Skin Risk Evaluation: Y
FALL RISK ASSESSMENT: Y
- PAIN EVALUATION -
Does Patient Currently Have Pain: N
>Pain Scale Used: NUMBERS 0-10
>Pain Score: 0
- ISOLATION PRECAUTIONS -
Isolation Type: NONE
Infection control and transmission prevention information provided to
Special Equipment: Y
< NEUROLOGICAL EVALUATION >
LOC: AROUSABLE
Oriented: N
Disoriented to: TIME
Speech: CLEAR
Sensation-RUE: WITHDRAWS FROM PAIN
RLE: WITHDRAWS FROM PAIN
LUE: WITHDRAWS FROM PAIN
LLE: WITHDRAWS FROM PAIN
Motor Skill Eval: Y
Right Grip: RIGHT GRIP WEAK
Left Grip: LEFT GRIP WEAK
Right Eye(OD) mm: 4
Reaction: REACTIVE
Left Eye(OS) mm: 4
Reaction: REACTIVE
Pupils Equal, Round, React to Light, and Accomodation: Y
< EENT EVALUATION >
< CARDIOVASCULAR EVALUATION >
Is Patient on Cardiac Monitoring: Y
Heart Sounds: REGULAR
Cap Refill Eval: Y
RUE: SLUGGISH > 3 SECONDS
LUE: SLUGGISH > 3 SECONDS

Activities Performed/Verified Time Added (continued)

160011 Shift Evaluation (continued)
RLE: SLUGGISH > 3 SECONDS
LLE: SLUGGISH > 3 SECONDS
Peripheral Pulse Eval: Y
R Radial: 2+ NORMAL
L Radial: 2+ NORMAL
R Dorsal Pedis: 1+ WEAK
L Dorsal Pedis: 1+ WEAK
R Post Tibial: 1+ WEAK
L Post Tibial: 1+ WEAK
Edema: Y
Edema Location: GENERALIZED
Edema Type: 4+ PITTING
Chest Pain: N
<< TELEMETRY EVALUATION >>
EKG Rhythm: SINUS TACHYCARDIA
Rate: 105
< PACER EVALUATION SCREEN >
< RESPIRATORY EVALUATION >
Depth: SHALLOW
Efforts: UNLABORED
Chest Shape: SYMMETRICAL
Chest Movement: SYMMETRICAL
O2 Therapy: Y
Breath Sounds Eval: Y
R Upper Anterior: CLEAR
L Upper Anterior: CLEAR
R Mid Anterior: CLEAR
R Lower Anterior: DIMINISHED
L Lower Anterior: DIMINISHED
< RETRACTIONS >
< OXYGEN THERAPY >
O2 Device: NASAL CANNULA
O2 Flow (L/MM): 2
< INCENTIVE SPIROMETRY >
< GASTROINTESTINAL EVALUATION >
Abdomen: ROUND
SOFT
Nausea: N
Vomiting: N
Bowel Sounds Eval: Y
RUQ: HYPOACTIVE
RLQ: HYPOACTIVE
LUQ: HYPOACTIVE
LLQ: HYPOACTIVE
< INTEGUMENTARY EVALUATION >
Wounds/Ulcer: Y
< WOUND/ULCER EVALUATION >

Problem/Goal/Intervention Description	Activity Type	Occurred Date	Occurred Time	By	Secured Date	Secured Time	By	Site/Direction/Amount	Documented Units	From Charge

Problem/Goal/Intervention Description	Activity Type	Occurred Date	Occurred Time	By	Required Date	Required Time	By	Site/Direction/Amount	Documented Units	From Charge

Activity Date: 04/01/11 Time: 0000 (Continued)

160011 Shift Evaluation (continued)
Type #1: LACERATION
Location: TIP OF TONGUE
Type #2: ULCER
Location: COCCYX
Wound Eval: OPEN
Dressing Changed: N
Dressing Change Date: 03/31/11
Dressing: MEPILEX
Drainage Amt: NONE
Type #3: LACERATION
Location: LUMBAR SPINE
Wound Eval: OPEN
Surround Tissue Eval: RED
Wound Bed: RED
Dressing Changed: N
Drainage Amt: NONE
Type #4: SCAR
Location: FIRST 3 FINGERS (L HAND)
Wound Eval: NON-OPEN
< INCISION EVALUATION >
Sensory perception- Slightly limited
Moisture- Rarely moist
Activity- Bedfast
Mobility- Very limited
Nutrition- Probably inadequate
Friction and shear- Problem
Braden Skin Score: 13
Braden Risk Level- Medium
Skin risk interventions: Manage moisture, Avoid drying the skin
Manage nutrition, Maintain good hydration
Manage friction and shear
No massage of reddened bony prominences
Reposition Q2hrs and PRN
Offer toileting when turning
Perineare PRN
Use moisture barrier, body wash and lotion routinely
Maximal reambilization-up in chair for meals when appropriate
Protect (offload) heels
Use turn sheets to reduce friction/shear
HOB < 30 degrees unless medically contraindicated
Consider pressure relieving surface (if bed or chair bound)
Provide education on pressure ulcers to patient and family
Assess nutrition status, obtain nutrition consult prn
Use foam wedges for 30 degree lateral positioning
Consider trapeze if indicated
Monitor all body folds for moisture, yeast, rash, irritation
< MUSCULOSKELETAL EVALUATION >

Activity Date: 04/01/11 Time: 0000 (Continued)

160011 Shift Evaluation (continued)
ROM R Arm: WEAKNESS
ROM L Arm: WEAKNESS
ROM R Leg: WEAKNESS
ROM L Leg: WEAKNESS
< GENITOURINARY >
Urinary Elimination: CATHETER-INDWELLING
Secured with: STABILIZATION DEVICE
Urine Color: YELLOW
Urine Clarity: CLOUDY
Consider catheter removal based on criteria: N
Remote Discharge: N
< PSYCHOSOCIAL EVALUATION >
Event/Issue:
Taken:
<Suicide Risk Assessment, Modified SAD PERSONS>
Pt has 3 or more meds in drug classes known to
Behavioral indicator of fall risk: N
Is patient responsive: Yes
Is patient following fall prevention directions: Y
Add'l Fall Risk Elements: Unsteady Gait
High Risk for Falls: N
< SPECIAL EQUIPMENT >
Special Equip: IV PUMP
<< INVASIVE LINES >>
<< PERIPHERAL LINE >>
<< PERIPHERAL LINE >>
< MIDLINE >
<< ARTERIAL LINE >>
<< INTRACRANIAL PRESSURE CATHETER >>
<< PULMONARY ARTERY CATHETER >>
PRESSURES:
<< SHEATH-PERCUTANEOUS INTRODUCER >>
PULSES:
<< INTRAORTIC BALLOON PUMP >>
Condition:
PULSES
<< VENTRICULAR ASSIST DEVICE >>
< INDWELLING CATHETER / TUBES & DRAINS >
< TUBES AND DRAINS >
< INDWELLING CATHETER REMOVAL >
<< TEACHING & EDUCATION >>
Education Content:
Pharmacological Prophylaxis due to:
120429 Age Guidelines: 50 Years, Adult-Elderly A M,CBH,KT CP
[redacted]

Problem/Goal/Intervention Description | SCR Interaction | Initials

Activity Type | Required Date | Required Time | By | Date | Time | In Context | Documented Date | Documented Time | Charted

Activity Date: 04/01/11 Time: 0000

191060 Vital Signs* (NOT BCTA) A Q4H CP
Document: 04/01/11 0500 CHR 04/01/11 0500 CHR
<< VITAL SIGNS >>
Temp-F: 99.1
Temp Source: ORAL
Pulse: 94
Resp: 26
BP: 135/62
MAP: 86
Pulse Ox: 95
Oxygen A: 2L

Activity Date: 04/01/11 Time: 0000

210010 Monitor: EKG Rhythm Strip* A QSHIFT CP
Document: 04/01/11 0800 CHR 04/01/11 0800 CHR
<< TELEMETRY EVALUATION >>
EKG Rhythm: SINUS TACHYCARDIA
Rate: 104
PR Interval: 0.24
QRS Interval: 0.11
QT Interval: 0.28
Tele Box Number: 102
< 12 LEAD ECG EVALUATION >

Activity Date: 04/01/11 Time: 0500

190060 Intake and Output* (NOT BCTA) A Q12H CP
Document: 04/01/11 0500 CHR 04/01/11 0500 CHR
< INTAKE AND OUTPUT >
Intake: Y
<< INTAKE >>
PO: 100
Breakfast %: 50
Diet: SOLID FOOD
<< OUTPUT >>

210270 ADLs* A Q12H CP
Document: 04/01/11 0905 CHR 04/01/11 0905 CHR
< ADL ASSISTANCE >
ACTIVITY
Assistance Required: Y
Assisted By: 2 STAFF ASSIST
Type: TURNED TO RIGHT SIDE
TOILETING
ORAL CARE
EATING
Assistance Required: Y
Assisted By: 1 STAFF ASSIST

Problem/Goal/Intervention Description | SCR Interaction | Initials

Activity Type | Required Date | Required Time | By | Date | Time | In Context | Documented Date | Documented Time | Charted

Activity Date: 04/01/11 Time: 0400 (continued)

210270 ADLs* (continued)
Type: FULL FEED
PERSONAL HYGIENE
Assistance Required: Y
Assisted By: 2 STAFF ASSIST
Type: COMPLETE BED BATH
LINEN CHANGED
Was Linen Changed: Y
Type: COMPLETE LINEN CHANGE
DRESSING
Was Patient Ambulated with Ongoing Order: Y

Activity Date: 04/01/11 Time: 0501

540000 Patient Care Orders* A QSHIFT OE
4/1-IP PT AGREES . TRANSFUSE 2 UNITS
PRBC
Order: 04/01/11 0901 EDT (04/01/11 1900 EDT)

Activity Date: 04/01/11 Time: 0500

191060 Vital Signs* (NOT BCTA) A 24H CP
Document: 04/01/11 1000 CHR 04/01/11 0500 CHR
<< VITAL SIGNS >>
Temp-F: 100.8
Temp Source: AXILLARY
Pulse: 106
Resp: 24
BP: 126/80
BP Source: ARM, RIGHT
Patient Position: Lying
MAP: 82
Pulse Ox: 97
Oxygen A: 2L

Activity Date: 04/01/11

210015 Monitor: Blood Glucose* A D6 CP
Document: 04/01/11 1754 CHR 04/01/11 1754 CHR
< BLOOD SUGAR RESULTS >
Glucose: 137
Method: FINGERSTICK
Medication: NOT MEDICATED

Admitted: 03/30/11 at 0245
Status: DIS IN

Attending: Agbaw,Fecunditia MD
Account #: [redacted]
Location: B SSTC
Room/Bed: B A559-1

Brandon Regional Hospital Nursing Clinic
CLINICAL DOCUMENTATION RECORD IPF

Procedure/Code/Intervention Description	Activity Type	Occurred Date/Time	Recorded Date/Time	Qty	Content	Ref#	Comment
Activity Date: 04/01/11 Time: 0347							
540000 Patient Care Orders* 4/: ABG	A	02SHIFT					OE
Activity Date: 04/01/11 Time: 0400							
191000 Vital Signs (HOT BCTA)	A	Q4H					CE
Document 04/01/11 0205 CMP 04/01/11 0208 CMP							
<< VITAL SIGNS >>							
Temp-F: 98.3							
Temp Source: AXILLARY							
Activity Date: 04/01/11 Time: 0425							
540000 Patient Care Orders* 4/1/11-DERANGE SMALL/LOW EVEN IF PT PASSES MAY HAVE REG LIQUID DIET	A	02SHIFT					OE
Order 04/01/11 1325 CMP 04/01/11 1325 CMP							
Activity Date: 04/01/11 Time: 1349							
540000 Patient Care Orders* 4/: STE 30, AM LABS, PORT CXR. STAT LACTIC ACID	A	02SHIFT					OE
Order 04/01/11 1349 CMP 04/01/11 1349 CMP							
Activity Date: 04/01/11 Time: 1400							
195000 BCTA: Transfusion Documentation*	A	per standard					PS
Created 04/01/11 1400 OC 04/01/11 1400 OC							
Document 04/01/11 1400 OC 04/01/11 1400 OC							
Temp-C: 37.7							
Temp-F: 99.9							
Pulse: 107							
Resp: 24							
BP: 127/68							
Pulse Ox: 98							
Activity Date: 04/01/11 Time: 1402							
159001 BCTA: Blood Bank Product I&O*	A	per standard					PS
Created 04/01/11 1402 OC 04/01/11 1402 OC							
Document 04/01/11 1402 OC 04/01/11 1402 OC							
Normal Saline Volume (ml): 500							
540000 Patient Care Orders* 4/1-IS TO CO,PICC. NOTIFY MD OF PT STATUS.ULD CX # 2. SPUTUM CS IF ABLE. UA CS, QD PRN. KEEP SATS>90..CXR/LABS IN	A	0SHIFT					OE

Procedure/Code/Intervention Description	Activity Type	Occurred Date/Time	Recorded Date/Time	Qty	Content	Ref#	Comment
540000 Patient Care Orders* (continued) AM, IMP							
Create 04/01/11 1402 CMP 04/01/11 1402 CMP							
540000 Patient Care Orders* 4/1: FOR ACCUCHECK, SS TO COVE R/S IAS,	A	0SHIFT					OE
Create 04/01/11 1402 CMP 04/01/11 1402 CMP							
Activity Date: 04/01/11 Time: 1417							
540000 BCTA: Transfusion Documentation*	A	per standard					PS
Document 04/01/11 1417 CMP 04/01/11 1418 CMP							
Temp-C: 36.1							
Temp-F: 100.5							
Pulse: 89							
Resp: 24							
BP: 127/56							
Pulse Ox: 99%							
Signs & Symptoms of Possible Transfusion Reaction: N							
Activity Date: 04/01/11 Time: 1524							
100017 Admit: Adult Guidelines*	C	on admission					AS
Created 04/01/11 1523 CA 04/01/11 1523 CA							
100015 Admit: History*	C	on admission					AS
Created 04/01/11 1523 CA 04/01/11 1523 CA							
100000 Admit: Assessment* A physical evaluation will be performed per policy. The following parameters are considered a normal evaluation whose results are "within defined parameters"(WDP). If a patient falls within defined parameters for a system, user may answer "Y" to the "WDP" query and move on to the next system. Alternatively, if the user answers "N" he/she must complete the system specific evaluation, addressing all appropriate queries before moving onto the next system.	C	on admission					AS
NEUROLOGICAL Alert and oriented Follows commands Moves all extremities Communicates effectively; speech clear Facial symmetry noted Sensation intact Recent and remote memory intact Thought processes intact: Logical appropriate sequence; Coherent and relevant to topic							

Problem/Goal/Intervention Description	Activity Date	Occurred Date	Occurred Time or Date	Recorded Time or Comment	Site/Direction/Dose/Initials	Documented Initials	Documented Cosign	Key

120008 Admit; Assessment (continued)
No complaint of dizziness/vertigo; Syncope/fainting

CARDIOVASCULAR
Heart rate normal for age
Heart rhythm regular
No edema
Peripheral pulses palpable
No loss of sensation
No chest pain/pressure
Not on a cardiac monitor
No implanted devices within 6 months

RESPIRATORY
Respirations even and unlabored
Respiratory rate normal for age
Lung sounds clear bilaterally
Chest expansion symmetrical
No cough, sputum, or secretions noted
No supplemental oxygen

GASTROINTESTINAL
Abdomen soft, non tender, without distention
Bowel sounds present all 4 quadrants
Bowel movements are within own normal pattern
Tolerating diet without nausea and vomiting

GENITOURINARY/REPRODUCTIVE
Voiding without discomfort, difficulty, or incontinence
Frequency and amount within own normal pattern
Clear, yellow urine
No reported/observed bladder distention
No urinary catheter, stents or dialysis
No reported/observed abnormal vaginal/penile discharge

MUSCULOSKELETAL
No skeletal deformities noted
No weakness in extremities
No use of mobility aids
Range of motion/within own normal pattern

Problem/Goal/Intervention Description	Activity Date	Occurred Date	Occurred Time or Date	Recorded Time or Comment	Site/Direction/Dose/Initials	Documented Initials	Documented Cosign	Key

120008 Admit; Assessment (continued)
INTEGUMENTARY
Skin warm, dry and intact without redness
Turgor appropriate for age
Skin color appropriate for patient's ethnicity
** ANSWER NO TO NOP'S IF USING ANY THERAPEUTIC SKIN CARE DEVICES/MEASURES**

EENT
Eyes have no discharge or redness
No complaint of impaired vision with or without glasses or contacts in place
Able to hear sounds with or/and without hearing aids
Mucosa pink, moist, and smooth
No nasal discharge or complaints
No throat complaints

PSYCHOSOCIAL
Mood appropriate for situation with regards to cultural influences and/or life events
Effective coping skills/patterns with regard to cultural influences and/or life events (i.e., Post-traumatic response, abusive behavior to self, threats of self harm, suicidal thoughts, or violent behavior)
No delusions, hallucinations, or delirium tremors

C/I Start: 04/01/11 1542 C/I End: 04/01/11 1542 A

Activity Name/Activity	Time	Sig

340006 CVC/PICC Insertion* A per standard CP
Document both CVC/PICC insertions AND Lines placed prior to arrival HERE.
Prior to the insertion of the CVC/PICC the patient, and their families as needed, are educated about central line-associated bloodstream infection prevention. Y
Document CVC/PICC insertion now: Y
Line present on admission? N
Consent obtained? Y
Timeout done by team discussion of universal protocol- Yes
Performed hair removal- No
Skin prep used- Chlorhexidine + Alcohol
Provider(s) inserting line