

THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

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APPEAL FROM THE FULL COMMISSION OF THE SOUTH CAROLINA WORKERS'  
COMPENSTION COMMISSION

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WCC FILE NO.: 1206355  
Appellate Tracking No.: 2013-002666

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FRANCES BARON,

EMPLOYEE, APPELLANT

V.

SANCTUARY HOSPICE

EMPLOYER,

AND

GUARANTEE  
INSURANCE COMPANY C/O  
PATRIOT NATIONAL  
INSURANCE GROUP,

CARRIER,  
RESPONDENTS.

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RECORD ON APPEAL

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SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1206355

FRANCES BARON,

Employee,

Claimant,

vs.

SANCTUARY HOSPICE,

Employer,

AND

GUARANTEE INSURANCE COMPANY  
c/o PATRIOT NATIONAL INSURANCE  
GROUP,

Carrier,

Defendants.

**DECISION AND ORDER**

**DATE OF HEARING:** Hearing held in Yemassee, South Carolina on February 27, 2013.

**APPEARANCES:** Claimant appeared and represented by William G. Jenkins, Jr., Esquire, of Jenkins & Esquivel, P.A. of Hilton Head, South Carolina.

Defendants represented by Kathleen G. Lyall, Esquire of McAngus Goudelock & Courie, L.L.C. of Greenville, South Carolina.

**PURPOSE OF THE HEARING:** To determine all issues as set forth in Forms 50, 51 and 58.

**COMMISSIONER:** Commissioner Gene McCaskill

**FILED:** June 14, 2013



### STIPULATIONS

The parties stipulated at the hearing to the following:

1. All parties received timely and proper notice of the scheduled hearing.
2. There is no objection to venue.

### APA SUBMISSIONS

Without objections, the following medical and documentary evidence was submitted into the record pursuant to the South Carolina Administrative Procedures Act and Regulations for the South Carolina Workers' Compensation Commission.

Claimant's APA Submissions:

| Tab No. | Facility or Physician           | Dates                   | Pages   |
|---------|---------------------------------|-------------------------|---------|
| 1.      | Jasper County EMS               | 5/21/12                 | 1-5     |
| 2.      | Coastal Carolina Medical Center | 5/21/12 to<br>05/23/12  | 6-69    |
| 3.      | Optim Orthopaedics              | 5/24/12 to<br>07/09/12  | 70-82A  |
| 4.      | Palmetto Eye Specialists        | 05/24/12 to<br>06/14/12 | 83-113  |
| 5.      | Coastal Carolina Medical Center | 5/29/12                 | 114-123 |
| 6.      | Dr. Cotter (wound care)         | 05/31/12 to<br>08/02/12 | 124-308 |
| 7.      | Savannah Cardiology             | 09/15/09 –<br>05/25/12  | 309-319 |
| 8.      | Mileage Reimbursement Requests  | 05/24/12 –<br>11/20/12  | 320-327 |

Defendants APA Submissions:

| APA # | DOCTOR           | PRACTICE                        | DATES      | PAGES   |
|-------|------------------|---------------------------------|------------|---------|
| 9.    | Mark Wagner, PhD | MUSC Department of Neurology    | 08/23/2012 | 328-335 |
| 10.   |                  | Coastal Carolina Medical Center | 09/10/2009 | 336     |

**STATEMENT OF THE CASE**

Claimant was involved in a car accident on May 21, 2012 when she was driving from a patient's home back to the office, had a syncopal episode and was involved in a single car automobile accident as the result of the same. A hearing was held before the undersigned Commissioner on February 27, 2013 in Yemassee, South Carolina to determine compensability of the claim.

Claimant alleges she sustained a compensable accident by injury arising out of an in the scope and course of her employment. She requests payment of all causally related medical bills and alleges entitlement to temporary total disability benefits from the date of accident to the present and continuing.

Defendants deny that Claimant sustained a compensable injury under S.C. Code Ann. §42-1-160. Specifically, Defendants stipulate that Claimant was in the course of her employment at the time of the accident, but Defendants deny the accident arose out of employment as the accident was caused by Claimant's syncopal episode and unrelated to her employment. Defendants submitted a detailed Memorandum of Law to support their position, citing numerous cases on point including Edge v. Dunean Mills, 202 S.C. 189; 24 S.E.2d. 268 (1943). Defendants further assert that should the claim be found compensable, Claimant's

compensation rate and entitlement to temporary total disability benefits should be limited as Claimant was not planning on returning to work full-time starting a week following the accident.

A hearing was held before the undersigned Commissioner on February 27, 2013 in Yemassee, South Carolina to evaluate these facts and decide these issues.

### EVIDENCE OF THE CASE

Without objection, the Commission's files and the Commissioner's notes were part of the record of the hearing. Claimant's attorney called Claimant to testify. The Defendants called Penny Abbott to testify on behalf of Sanctuary Hospice.

Claimant testified that she is 71 years old. (Hrg. Trs. p. 11, line 22). She graduated as a Registered Nurse in 1962 and has been working as a Registered Nurse since that time. (Hrg. Trs. p. 12, lines 1-4). Claimant testified that she was injured in an automobile accident on May 21, 2012 on her way back to the office after visiting her last patient of the day. (Hrg. Trs. p. 12, lines 10-16). Claimant testified that she does not remember anything about the accident and the first thing that she remembers is opening her eyes after she hit a tree. She was able to get out of the car and walk several steps before her legs got shaky and she sat down. (Hrg. Trs. p. 13, lines 5-18).

Claimant testified that she hit her head in the accident and now has scars on her forehead and above her eye from the blow that she received to her head. (Hrg. Trs. p. 13, lines 19-25). Claimant testified that she has permanent nerve and muscle damage over the right eye with drooping eye lids that keep her from seeing clearly. (Hrg. Trs. p. 14, lines 8-13). She testified to short term memory loss as a result from the blow to the head. (Hrg. Trs. p. 15, lines 5-8). Further, she testified that she had a fracture of the left ankle that she had surgically repaired, a

large hematoma on her right leg that had to be drained and a scar above her right eye. (Hrg. Trs. P. 16, lines 15-16).

Claimant has not returned to work since the accident in May 2012. (Hrg. Trs. p. 17, lines 7-9). She testified that she would be able to perform the nursing part of her job, but stated that she has not driven since the date of her accident due to her eyesight. (Hrg. Trs. p. 17, lines 12-21). Finally, Claimant testified that she was not planning to retire prior to the accident, but that she was going from a full time to part time position following the vacation she planned to take after the accident. (Hrg. Trs. p. 20, lines 1-6).

On cross-examination, Claimant testified again that she cannot remember anything immediately prior to the accident. (Hrg. Trs. p. 21, lines 15-17). She stated that she was driving down the road and the next thing she knew; she was looking at the sky and the smoke. (Hrg. Trs. p. 22, lines 1-5). Claimant admitted that she was not planning to return to full duty work following the accident. (Hrg. Trs. p. 22, lines 6-9). She testified that she had talked to Sanctuary Hospice about working part time, but they did not have any set hours or set plans for her return to work. (Hrg. Trs. p. 22, lines 15-18).

Claimant again testified that she has been suffering memory loss since the accident. (Hrg. Trs. p. 23, lines 3-5). She indicated that she started noticing memory loss when she stopped taking pain pills. (Hrg. Trs. p. 23, lines 20-23). At this time, Claimant's deposition transcript was submitted into the evidence for purposes of impeachment. (Hrg. Trs. p. 24, lines 1-2). In her deposition, Claimant was asked whether she had any cognitive deficits to which she answered "I hope not. No, not that I know of." (Hrg. Trs. p. 25, lines 14-16). Claimant testified that no treatment has been recommended for her alleged memory loss and that she has not received any treatment for her alleged memory loss. (Hrg. Trs. p. 26, lines 12-15).

With regards to her right leg, Claimant testified that no additional treatment has been recommended. She last received treatment in August 2012 for her right leg. (Hrg. Trs. p. 27, lines 2-8).

Claimant testified that she has not contacted anybody at Sanctuary Hospice about the possibility of returning to work. (Hrg. Trs. p. 27, lines 21-23). She indicated that she did not contact Sanctuary Hospice because she could not drive, but admitted that she does not have any written driving restrictions from doctors. (Hrg. Trs. p. 28, lines 1-4). Claimant next testified that the car accident occurred on a Monday and that she was going to stop working as a full time employee of Sanctuary Hospice the following Friday. (Hrg. Trs. p. 29, lines 7-10). She was planning on taking two weeks of paid vacation and then would discuss with Sanctuary Hospice how many days she was going to work. (Hrg. Trs. p. 29, lines 20-24). Claimant testified that she assumed she would still be covering River Oaks following her return from vacation and that she would have worked three days a week on Mondays, Wednesdays and Fridays. (Hrg. Trs. p. 30, lines 22-25). Claimant testified that she likely would have worked six hours a day for the three days a week equaling a total of 18 hours per week. (Hrg. Trs. p. 34, lines 8-10).

On redirect examination, Claimant again testified that she was not planning to return to work full time following her vacation. However, she was not sure exactly how many hours she would have eventually been working because it would have depended on the number of patients that were admitted or actively dying. (Hrg. Trs. p. 35, lines 16-19).

Penny Abbott testified next on behalf of Sanctuary Hospice. Ms. Abbott testified that she is one of the principal owners and the director of community relations with Sanctuary Hospice. (Hrg. Trs. p. 38, lines 24-25). In that position, she is in charge of a lot of the decision making. (Hrg. Trs. p. 39, lines 1-3). It was her understanding that Claimant was not going to return to

work full time following her vacation, but nothing was determined with regards to her exact schedule following vacation. (Hrg. Trs. p. 39, liens 8-15). At most, it was her understanding that Claimant would be working part time, but more likely she would have been just filling in. (Hrg. Trs. p. 39, lines 23-25). According to Ms. Abbott, the maximum number of hours you can work per week and still be considered part time is 25 hours. (Hrg. Trs. p. 40, lines 1-4). Further, Ms. Abbott stated that the River Oaks position that Claimant indicated she was planning to return to part time would provide between 9 to 10 hours per week at the most. (Hrg. Trs. p. 41, lines 7-12).

On cross-examination, Ms. Abbott again stated that they had not discussed how frequently Claimant would be working following her vacation. (Hrg. Trs. p. 42, lines 1-10). Ms. Abbott admitted that Sanctuary Hospice does not have any part time employees, but that they were going to try to accommodate Claimant's request as she had worked for a long time. (Hrg. Trs. p. 43, lines 16-20). Ms. Abbott finally testified that Claimant was being paid \$25.00 an hour and would still be paid \$25.00 per hour if she worked part time. (Hrg. Trs. p. 45, lines 17-21).

On redirect examination, Ms. Abbott testified that the decision to move to part time was Claimant's decision. (Hrg. Trs. p. 46, lines 8-9). Further, she testified that part time positions are not eligible for medical benefits or paid time off. (Hrg. Trs. p. 46, lines 20-21).

The medical evidence indicates that EMS responded to the scene of Claimant's car accident on May 21, 2012. (APA 1, p. 2). It was noted that Claimant had a Glasgow Coma Scale of 15, a hematoma to above the right eye with bruising, a laceration to the right side above the eye, and no other abnormalities. (APA 1, p. 3). It was noted that there were no abnormalities with her mental status. (APA 1, p. 3).

Claimant was transported to Coastal Carolina Medical Center where she was diagnosed with a syncopal episode. (APA 2, p. 20). It was noted that she had a syncopal episode while driving and lost consciousness. She reported that she does not remember going off the road and believes that she was unconscious for ten minutes. (APA 2, p. 21). On May 23, Claimant was again evaluated and she reported feeling well on the day of the accident when she suddenly lost consciousness and ran off the road into a tree. (APA 2, p. 25). Again, she was diagnosed with a syncopal episode. (APA 2, p. 26).

A CT scan was taken of her head on May 21, 2012 which showed no acute intracranial abnormality. (APA 2, p. 43). A CT scan was taken of her left ankle which showed a minimally displaced fracture of the medial malleolus. (APA 2, p. 52). An MRI of the brain showed no acute cerebral edema or infarct noted. (APA 2, p. 56).

Claimant began treating at Optim Orthopaedics for her left ankle fracture on May 24, 2012. (APA 3, p. 76). She reported that she either fell asleep at the wheel or passed out when she was involved in a motor vehicle accident. (APA 3, p. 76). She was diagnosed with a right ankle hematoma and a left ankle fracture and underwent surgery on May 29, 2012. (APA 3, p. 78-79). Claimant continued to treat with Optim Orthopaedics through September 10, 2012 at which point she was released to return to activities as she tolerates and instructed to return back only if any increased pain or problems. (APA 3, p. 82A).

Claimant treated with Coastal Carolina Hospital for wound care for her right ankle hematoma from May 31, 2012 to August 2, 2012. (APA 6, pgs. 124-308). On August 2, 2012, it was noted that her right ankle would was healed. (APA 6, p. 304).

Claimant was evaluated by Dr. Mark Wagner of the MUSC Department of Neurology on August 23, 2012. (APA 9, pgs. 328-335). Dr. Wagner was able to review all medical records

from Coastal Carolina Medical Center, Jasper County EMS and Palmetto Eye Specialist. Further, Dr. Wagner interviewed and examined Claimant. (APA 9, p. 328). Dr. Wagner opined that Claimant experienced an unexplained syncopal event that was not caused by any condition relating to her employment. (APA 9, p. 335).

### FINDINGS OF FACT

Based upon the testimony, the workers' compensation file and medical evidence submitted, the undersigned Commissioner makes the following findings of fact:

1. The Claimant was in an automobile accident on May 21, 2012. This fact is not in dispute by either party.
2. The Claimant lost consciousness, ran off of the road and hit a tree. This fact is not in dispute by either party.
3. Dr. Scott Condie, the attending physician at Coastal Carolina Medical Center, opined that the Claimant suffered a syncopal event which resulted in the accident. Neither Dr. Condie nor Dr. MacCabe, to whom the Claimant was referred for a consultation, opine as to a cause for this syncopal event.
4. On the Form 58, the Claimant alleges injuries to her head/brain, eyes, face, both legs, both ankles, and both feet.
5. The questions at bar is whether Claimant's injuries are compensable and what benefits, if any, she is entitled to under the Act.
6. The answer to these questions hinges on whether or not Claimant's injuries arose out of and were within the course and scope of her employment.
7. The Defendants have stipulated that the Claimant was in the course of her employment when the accident occurred.



8. That being the case, the question as to compensability rests on whether or not the Claimant's injuries arose out of her employment.
9. It is on whether Claimant's injuries arose out of her employment that Claimant fails to meet her burden of proof under S.C. Code Ann. §42-1-160.
10. The fact that the syncopal event occurred while Claimant was working is not sufficient to meet the burden of proof required under S.C. Code Ann. §42-1-160.
11. The Claimant was evaluated by Mark Wagner, PhD., Clinical Neural Psychologist, Professor of Neurology, MUSC Department of Neurology, at the request of the Defendants on August 23, 2012. Dr. Wagner's report is part of the record at Defendant's APA No. 9, pages 328-335. Dr. Wagner concludes his evaluation by saying, "ultimately, this is an unexplained syncopal event. It does not appear that the syncopal event was caused by any condition related to her employment. Although, the event did occur during her employment when she was traveling from one location to another". This is based on Defendant's APA No. 9, p. 335.
12. The Defendant site Edge v. Dunean Mills as supporting case law. In that case, the Court concluded that Claimant's injuries were caused when he suffered an epileptic seizure at work and fell down a flight of stairs. The Court concluded by saying, "... the only inference to be drawn from all of the testimony is that respondent's injury was caused by an attack of epilepsy."
13. The Court in Edge v. Dunean Mills denied benefits to the claimant where his injuries were caused by an attack of epilepsy.

14. As in Edge where the Claimant fell down the stairs at work, the fact Mrs. Baron suffered the syncopal event while driving to see patients is not sufficient to meet her burden as to "arising out of" under S.C. Code Ann. §42-1-160.

15. The claim is not compensable under S.C. Code Ann. §42-1-160 as it did not arise out of her employment.

16. As a result, the Claimant is not entitled to any benefits under the Act.

### **CONCLUSIONS OF LAW**

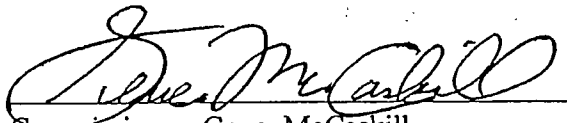
Accordingly, as provided in S.C. Code §42-17-40 and pursuant to other applicable law, it is the determination of this Commissioner that:

1. That under §42-1-160 and other applicable law, the Claimant did not sustain injuries by an accident arising out her employment.
2. That under §42-1-160, Claimant is not entitled to any benefits under the Act.

### **ORDER**

**IT IS HEREBY ORDERED ADJUDGED AND DECREED** that Claimant's claim for workers' compensation benefits is **DENIED**. The Defendants shall not be responsible for making any payment in any form or fashion for the Claimant's workers' compensation benefits.

**AND IT IS SO ORDERED.**



Commissioner Gene McCaskill

### **CERTIFICATE OF SERVICE**

This is to certify the undersigned has this date served this order in the above entitled action upon all parties to this cause by sending an electronic copy hereof by electronic mail addressed to the attorney or attorneys for said parties or by depositing a copy hereof, postage paid, in the United States certified mail addressed to any unrepresented party.  
June 14, 2013

By: Kellie Lindler, Administrative Assistant to Commissioner McCaskill

APPELLATE PANEL DECISION AND ORDER  
OF THE  
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1206355

Frances Baron

EMPLOYEE,  
CLAIMANT/RESPONDENT

VS.

Sanctuary Hospice

EMPLOYER,

AND

Guarantee Insurance Company c/o Patriot National  
Insurance Group

CARRIER,  
DEFENDANTS/APPELLANTS,

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Appellate Panel Review held in Columbia, South  
Carolina, on October 15, 2013 per notices timely  
And properly served upon all parties of interest.

Appellate Panel Decision and Order Filed:

12-12-13

APPEARANCES: Claimant/Appellant represented by William G. Jenkins, Jr., Esquire

Defendants/Respondents represented by Kathleen G. Lyall, Esquire of  
McAngus, Goudelock, and Courie LLC.

### STATEMENT OF THE CASE

Claimant was involved in a car accident on May 21, 2012 when she was driving from a patient's home back to the office, had a syncopal episode and was involved in a single car automobile accident as the result of the same. A hearing was held before the undersigned Commissioner on February 27, 2013 in Yemassee, South Carolina on Forms 50 and 51 to determine compensability of the claim.

Claimant alleged she sustained a compensable accident by injury arising out of an in the scope and course of her employment. She requested payment of all causally related medical bills and alleged entitlement to temporary total disability benefits from the date of accident to the present and continuing.

Defendants denied that Claimant sustained a compensable injury under S.C. Code Ann. §42-1-160. Specifically, Defendants stipulated that Claimant was in the course of her employment at the time of the accident, but Defendants denied the accident arose out of employment as the accident was caused by Claimant's syncopal episode and unrelated to her employment. Defendants submitted a detailed Memorandum of Law to support their position, citing numerous cases on point including Edge v. Dunean Mills, 202 S.C. 189; 24 S.E.2d. 268 (1943). Defendants further asserted that should the claim be found compensable, Claimant's compensation rate and entitlement to temporary total disability benefits should be limited as Claimant was not planning on returning to work full-time starting a week following the accident.

In a Decision and Order dated June 14, 2013, the Single Commissioner found as fact that Claimant was in an automobile accident on May 21, 2012; that Claimant lost consciousness, ran off of the road and hit a tree; that Dr. Scott Condie, the attending physician at Coastal Carolina Medical Center, opined that Claimant suffered a syncopal event which resulted in the accident;

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that neither Dr. Condie nor Dr. MacCabe, to whom Claimant was referred for a consultation, opined as to a cause for this syncopal event; that on the Form 58, Claimant alleges injuries to her head/brain, eyes, face, both legs, both ankles, and both feet; that the question at bar is whether Claimant's injuries are compensable and what benefits, if any, she is entitled to under the Act; that the answer to these questions hinges on whether or not Claimant's injuries arose out of and were within the scope and course of her employment; that the Defendants have stipulated that the Claimant was in the scope and course of her employment when the accident occurred; that Claimant failed to meet her burden of proof under S.C. Code Ann. §42-1-160 as to whether her injuries arose out of her employment; that the fact the syncopal event occurred while Claimant was working is not sufficient to meet the burden of proof required under S.C. Code Ann. §42-1-160; that Dr. Wagner evaluated Claimant and concluded his evaluation by saying, "ultimately, this is an unexplained syncopal event. It does not appear that the syncopal event was caused by any condition related to her employment. Although, the event did occur during her employment when she was traveling from one location to another"; that the Defendants cite Edge v Dunean Mills as supporting case law and that in that case, the Court concluded that Claimant's injuries were caused when he suffered an epileptic seizure at work and fell down a flight of stairs; that the Court in Edge v Dunean Mills denied benefits to the claimant where his injuries were caused by an attack of epilepsy; that as in Edge where the claimant fell down the stairs at work, the fact that Mrs. Baron suffered the syncopal event while driving to see patients is not sufficient to meet her burden as to "arising out of" under S.C. Code Ann. §42-1-160; and that the claim is not compensable under S.C. Code Ann. §42-1-160, thus the Claimant is not entitled to benefits under the Act. This appeal timely was timely filed thereafter.

### EVIDENCE OF THE CASE

At the hearing before the Single Commissioner, the Commission's files and the Commissioner's notes were part of the record of the hearing without objection. Claimant's attorney called Claimant to testify. The Defendants called Penny Abbott to testify on behalf of Sanctuary Hospice.

Claimant testified that she is 71 years old. (Hrg. Trs. p. 11, line 22). She graduated as a Registered Nurse in 1962 and has been working as a Registered Nurse since that time. (Hrg. Trs. p. 12, lines 1-4). Claimant testified that she was injured in an automobile accident on May 21, 2012 on her way back to the office after visiting her last patient of the day. (Hrg. Trs. p. 12, lines 10-16). Claimant testified that she does not remember anything about the accident and the first thing that she remembers is opening her eyes after she hit a tree. She was able to get out of the car and walk several steps before her legs got shaky and she sat down. (Hrg. Trs. p. 13, lines 5-18).

Claimant testified that she hit her head in the accident and now has scars on her forehead and above her eye from the blow that she received to her head. (Hrg. Trs. p. 13, lines 19-25). Claimant testified that she has permanent nerve and muscle damage over the right eye with drooping eye lids that keep her from seeing clearly. (Hrg. Trs. p. 14, lines 8-13). She testified to short term memory loss as a result from the blow to the head. (Hrg. Trs. p. 15, lines 5-8). Further, she testified that she had a fracture of the left ankle that she had surgically repaired, a large hematoma on her right leg that had to be drained and a scar above her right eye. (Hrg. Trs. P. 16, lines 15-16).

Claimant has not returned to work since the accident in May 2012. (Hrg. Trs. p. 17, lines 7-9). She testified that she would be able to perform the nursing part of her job, but stated that

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she has not driven since the date of her accident due to her eyesight. (Hrg. Trs. p. 17, lines 12-21). Finally, Claimant testified that she was not planning to retire prior to the accident, but that she was going from a full time to part time position following the vacation she planned to take after the accident. (Hrg. Trs. p. 20, lines 1-6).

On cross-examination, Claimant testified again that she cannot remember anything immediately prior to the accident. (Hrg. Trs. p. 21, lines 15-17). She stated that she was driving down the road and the next thing she knew; she was looking at the sky and the smoke. (Hrg. Trs. p. 22, lines 1-5). Claimant admitted that she was not planning to return to full duty work following the accident. (Hrg. Trs. p. 22, lines 6-9). She testified that she had talked to Sanctuary Hospice about working part time, but they did not have any set hours or set plans for her return to work. (Hrg. Trs. p. 22, lines 15-18).

Claimant again testified that she has been suffering memory loss since the accident. (Hrg. Trs. p. 23, lines 3-5). She indicated that she started noticing memory loss when she stopped taking pain pills. (Hrg. Trs. p. 23, lines 20-23). At this time, Claimant's deposition transcript was submitted into the evidence for purposes of impeachment. (Hrg. Trs. p. 24, lines 1-2). In her deposition, Claimant was asked whether she had any cognitive deficits to which she answered "I hope not. No, not that I know of." (Hrg. Trs. p. 25, lines 14-16). Claimant testified that no treatment has been recommended for her alleged memory loss and that she has not received any treatment for her alleged memory loss. (Hrg. Trs. p. 26, lines 12-15).

With regards to her right leg, Claimant testified that no additional treatment has been recommended. She last received treatment in August 2012 for her right leg. (Hrg. Trs. p. 27, lines 2-8).

Claimant testified that she has not contacted anybody at Sanctuary Hospice about the possibility of returning to work. (Hrg. Trs. p. 27, lines 21-23). She indicated that she did not contact Sanctuary Hospice because she could not drive, but admitted that she does not have any written driving restrictions from doctors. (Hrg. Trs. p. 28, lines 1-4). Claimant next testified that the ~~car~~ accident occurred on a Monday ~~and~~ that she was going to stop working ~~as~~ a full time employee of Sanctuary Hospice the following Friday. (Hrg. Trs. p. 29, lines 7-10). She was planning on taking two weeks of paid vacation and then would discuss with Sanctuary Hospice how many days she was going to work. (Hrg. Trs. p. 29, lines 20-24). Claimant testified that she assumed she would still be covering River Oaks following her return from vacation and that she would have worked three days a week on Mondays, Wednesdays and Fridays. (Hrg. Trs. p. 30, lines 22-25). Claimant testified that she likely would have worked six hours a day for the three days a week equaling a total of 18 hours per week. (Hrg. Trs. p. 34, lines 8-10).

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Penny Abbott testified next on behalf of Sanctuary Hospice. Ms. Abbott testified that she is one of the principal owners and the director of community relations with Sanctuary Hospice. (Hrg. Trs. p. 38, lines 24-25). In that position, she is in charge of a lot of the decision making. (Hrg. Trs. p. 39, lines 1-3). It was her understanding that Claimant was not going to return to work full time following her vacation, but nothing was determined with regards to her exact schedule following vacation. (Hrg. Trs. p. 39, lines 8-15). At most, it was her understanding that Claimant would be working part time, but more likely she would have been just filling in.

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(Hrg. Trs. p. 39, lines 23-25). According to Ms. Abbott, the maximum number of hours you can work per week and still be considered part time is 25 hours. (Hrg. Trs. p. 40, lines 1-4). Further, Ms. Abbott stated that the River Oaks position that Claimant indicated she was planning to return to part time would provide between 9 to 10 hours per week at the most. (Hrg. Trs. p. 41, lines 7-12).

On cross-examination, Ms. Abbott again stated that they had not discussed how frequently Claimant would be working following her vacation. (Hrg. Trs. p. 42, lines 1-10). Ms. Abbott admitted that Sanctuary Hospice does not have any part time employees, but that they were going to try to accommodate Claimant's request as she had worked for a long time. (Hrg. Trs. p. 43, lines 16-20). Ms. Abbott finally testified that Claimant was being paid \$25.00 an hour and would still be paid \$25.00 per hour if she worked part time. (Hrg. Trs. p. 45, lines 17-21).

On redirect examination, Ms. Abbott testified that the decision to move to part time was Claimant's decision. (Hrg. Trs. p. 46, lines 8-9). Further, she testified that part time positions are not eligible for medical benefits or paid time off. (Hrg. Trs. p. 46, lines 20-21).

The medical evidence indicates that EMS responded to the scene of Claimant's car accident on May 21, 2012. (APA 1, p. 2). It was noted that Claimant had a Glasgow Coma Scale of 15, a hematoma to above the right eye with bruising, a laceration to the right side above the eye, and no other abnormalities. (APA 1, p. 3). It was noted that there were no abnormalities with her mental status. (APA 1, p. 3).

Claimant was transported to Coastal Carolina Medical Center where she was diagnosed with a syncopal episode. (APA 2, p. 20). It was noted that she had a syncopal episode while driving and lost consciousness. She reported that she does not remember going off the road and believes that she was unconscious for ten minutes. (APA 2, p. 21). On May 23, Claimant was

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again evaluated and she reported feeling well on the day of the accident when she suddenly lost consciousness and ran off the road into a tree. (APA 2, p. 25). Again, she was diagnosed with a syncopal episode. (APA 2, p. 26).

A CT scan was taken of her head on May 21, 2012 which showed no acute intracranial abnormality. (APA 2, p. 43). A CT scan was taken of her left ankle which showed a minimally displaced fracture of the medial malleolus. (APA 2, p. 52). An MRI of the brain showed no acute cerebral edema or infarct noted. (APA 2, p. 56).

Claimant began treating at Optim Orthopaedics for her left ankle fracture on May 24, 2012. (APA 3, p. 76). She reported that she either fell asleep at the wheel or passed out when she was involved in a motor vehicle accident. (APA 3, p. 76). She was diagnosed with a right ankle hematoma and a left ankle fracture and underwent surgery on May 29, 2012. (APA 3, p. 78-79). Claimant continued to treat with Optim Orthopaedics through September 10, 2012 at which point she was released to return to activities as she tolerates and instructed to return back only if any increased pain or problems. (APA 3, p. 82A).

Claimant treated with Coastal Carolina Hospital for wound care for her right ankle hematoma from May 31, 2012 to August 2, 2012. (APA 6, pgs. 124-308). On August 2, 2012, it was noted that her right ankle would was healed. (APA 6, p. 304).

Claimant was evaluated by Dr. Mark Wagner of the MUSC Department of Neurology on August 23, 2012. (APA 9, pgs. 328-335). Dr. Wagner was able to review all medical records from Coastal Carolina Medical Center, Jasper County EMS and Palmetto Eye Specialist. Further, Dr. Wagner interviewed and examined Claimant. (APA 9, p. 328). Dr. Wagner opined that Claimant experienced an unexplained syncopal event that was not caused by any condition relating to her employment. (APA 9, p. 335).

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### STANDARD OF REVIEW

Under S.C. Code Ann. § 42-17-50, an Appellate Panel is empowered to review the appealed award, weigh the evidence as presented at the initial hearing, and, if good grounds are shown, make its own ~~separate~~ findings and legal conclusions consistent with or inconsistent with the Hearing Commissioner.

Based upon its review of all the evidence on the record in this case, the Panel hereby affirms the Order of the Hearing Commissioner in full. Accordingly, the Panel makes the following Findings of Fact and Rulings of Law:

### FINDINGS OF FACT

1. The Claimant was in an automobile accident on May 21, 2012. This fact is not in dispute by either party.
2. The Claimant lost consciousness, ran off of the road and hit a tree. This fact is not in dispute by either party.
3. Dr. Scott Condie, the attending physician at Coastal Carolina Medical Center, opined that the Claimant suffered a syncopal event which resulted in the accident. Neither Dr. Condie nor Dr. MacCabe, to whom the Claimant was referred for a consultation, opine as to a cause for this syncopal event.
4. On the Form 58, the Claimant alleges injuries to her head/brain, eyes, face, both legs, both ankles, and both feet.

5. The questions at bar is whether Claimant's injuries are compensable and what benefits, if any, she is entitled to under the Act.
  6. The answer to these questions hinges on whether or not Claimant's injuries arose out of and were within the course and scope of her employment.
  7. The Defendants have stipulated that the Claimant was in the course of her employment when the accident occurred.
  8. That being the case, the question as to compensability rests on whether or not the Claimant's injuries arose out of her employment.
  9. It is on whether Claimant's injuries arose out of her employment that Claimant fails to meet her burden of proof under S.C. Code Ann. §42-1-160.
  10. The fact that the syncopal event occurred while Claimant was working is not sufficient to meet the burden of proof required under S.C. Code Ann. §42-1-160.
  11. The Claimant was evaluated by Mark Wagner, PhD., Clinical Neural Psychologist, Professor of Neurology, MUSC Department of Neurology, at the request of the Defendants on August 23, 2012. Dr. Wagner's report is part of the record at Defendant's APA No. 9, pages 328-335. Dr. Wagner concludes his evaluation by saying, "ultimately, this is an unexplained syncopal event. It does not appear that the syncopal event was caused by any condition related to her employment. Although, the event did occur during her employment when she was traveling from one location to another". This is based on Defendant's APA No. 9, p. 335.
  12. The Defendant site Edge v. Dunean Mills as supporting case law. In that case, the Court concluded that Claimant's injuries were caused when he suffered an epileptic seizure at work and fell down a flight of stairs. The Court concluded by saying, "...
-

the only inference to be drawn from all of the testimony is that respondent's injury was caused by an attack of epilepsy."

13. The Court in Edge v. Dunnean Mills denied benefits to the claimant where his injuries were caused by an attack of epilepsy.
14. As in Edge ~~where~~ the Claimant fell down the stairs at work, the fact Mrs. Baron suffered the syncopal event while driving to see patients is not sufficient to meet her burden as to "arising out of" under S.C. Code Ann. §42-1-160.
15. The claim is not compensable under S.C. Code Ann. §42-1-160 as it did not arise out of her employment.
16. As a result, the Claimant is not entitled to any benefits under the Act.

#### RULINGS OF LAW

Accordingly, as provided in S.C. Code §42-17-50 and pursuant to other applicable law, it is the determination of this Panel that:

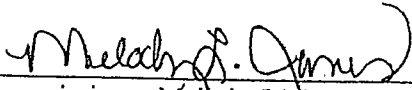
1. That under §42-1-160 and other applicable law, the Claimant did not sustain injuries by an accident arising out her employment.
2. That under §42-1-160, Claimant is not entitled to any benefits under the Act.

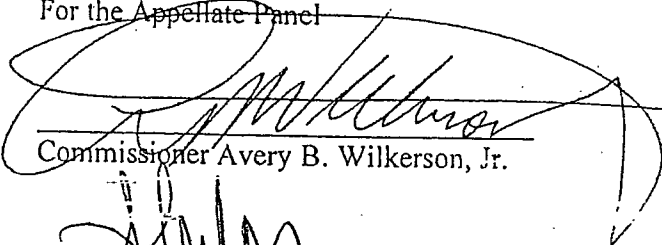
#### ORDER

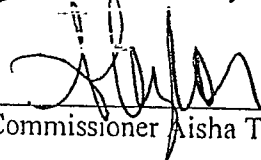
IT IS HEREBY ORDERED ADJUDGED AND DECREED that the Single Commissioner's denial of this claim is **AFFIRMED IN FULL**.

AND IT IS SO ORDERED.

WE CONCUR:

  
Commissioner Melody L. James  
For the Appellate Panel

  
Commissioner Avery B. Wilkerson, Jr.

  
Commissioner Aisha Taylor

#### CERTIFICATE OF SERVICE

This is to certify that the undersigned has on this date served a copy of this order in the above entitled action upon all parties to this case by sending an electronic copy hereof by electronic mail addressed to the attorneys for said parties; or if there is an unrepresented party(ies), by depositing a copy hereof, postage paid in the United States mail, first class, addressed to the unrepresented party(ies) and to the attorney(s) for the represented party(ies).

*By Valerie Deller on December 12, 2013*



WCC File #: 1206355  
Carrier File #: \_\_\_\_\_  
Carrier Code #: \_\_\_\_\_  
Employer FEIN #: \_\_\_\_\_

Claimant's Name: Frances Baron SSN: [REDACTED] Employer's Name: Sanctuary Hospice  
Address: [REDACTED] Address: 10911 B Jacob Smart Boulevard  
City: [REDACTED] State: [REDACTED] Zip: [REDACTED] City: Ridgeland State: SC Zip: 29936  
Home Phone: [REDACTED] Work Phone: \_\_\_\_\_ Insurance Carrier: Guarantee Ins. Co.  
Preparer's Name: William G. Jenkins, Jr. Law Firm: Jenkins & Esquivel, P.A. Preparer's Phone #: 843 785 8800

### REQUEST FOR COMMISSION REVIEW

Request for Commission Review by ☒ claimant ☐ employer (check one) Date of Injury: 05/21/2012

The undersigned makes application for review of the findings of the Commissioner in the above-captioned case. The request for review is based on the following grounds: (State the grounds of your appeal in the form of questions presented. Each question presented must contain a concise statement of one proposition of law or fact. Refer to evidence by title and exhibit number. Use additional pages if necessary).

Did the hearing Commissioner err in finding as matters of fact that the Claimant has failed to meet her burden of proof, that her syncopal event and the injuries resulting from this event, are not compensable under 42-1-60? This appeal addresses findings of fact 14-16 in the hearing Commissioner's Order, as well as, conclusions of law 1-2. In the event that the conclusions of the Hearing Commissioner are found to be in error, Claimant requests that the Full Commission, as the ultimate fact finder in Workers' Compensation cases, determine the applicable average weekly wage and compensation rate.

(Check one) Oral argument ☒ is ☐ is not requested. Appellant's request for oral argument is waived if not indicated on this form.

I certify that I have served this document pursuant to R.67-211 by delivering a copy to Kathleen G. Lyall, Esquire,  
Name  
McAngus, Goudelock & Courie, LLC, P.O. Box 2980, Greenville, SC 29602

on the 18 day of June, 2013 by [Signature] Address ☒ first class mail ☐ personal service ☐ certified mail.

Preparer's Signature [Signature] Esquire Title

Check this box if you are not represented by an attorney. ☐

06/18/2013

SCWCC

SCWCC

JUN 20 2013

JUN 20 2013

JUDICIAL

JUDICIAL

If the claimant appeals and is representing himself or herself, the Judicial Department will prepare the additional copies of this form and serve this form on the opposing party. R.67-701B. Otherwise, file the original and four copies of this form with the Judicial Department. The appeal must be postmarked no later than 14 days from the date of service of the Hearing Commissioner's decision. R.67-701 and R.67-205. Attach the filing fee to this form. Attach a Form 32 if you are required to pay the filing fee. Refer to R.67-701 through R.67-711 for additional information.



WCC File #: 1206355  
Carrier File #: \_\_\_\_\_  
Carrier Code #: 01094  
Employer FEIN #: \_\_\_\_\_

Claimant's Name: Frances Baron SSN: \_\_\_\_\_ Employer's Name: Sanctuary Hospice  
Address: \_\_\_\_\_ Address: P.O. Box 161  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ City: Ridgeland State: SC Zip: 29936  
Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Insurance Carrier: Guarantee Ins. Co.  
Preparer's Name: William G. Jenkins, Jr. Law Firm: Jenkins & Esquivel, P.A. Preparer's Phone #: (843) 785 - 8800

Complete each information block. To request a hearing, check Box 13b, indicate the kinds of benefits claimed by checking the box(es) at lines 6, 7, 8, and 9, and file this form in duplicate.

A claim for workers' compensation benefits is made based on the following grounds:

Date of Injury or Illness: 05/21/2012

☒ Injury ☐ Illness ☐ Repetitive Trauma

- 1a. The claimant sustained an injury to Rt. Ankle/foot, left leg, Rt. Arm, Rt. Eye, face and head (Part(s) of Body Injured) on 05/21/2012 (Month/Day/Year) in Jasper county, state of South Carolina.
- 1b. Body part(s) affected are: Right ankle and foot, left leg, right eye, face and head/brain  
Briefly describe how the accident occurred. Claimant was driving from a patients home back to the office when she was involved in a single car automobile accident
2. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
3. The relationship of employer and employee existed at the time of injury.
4. At the time of the injury the claimant was performing services arising out of and in the course of employment.
5. Notice of the accidental injury was given to the Employer on 05/21/2012 (Month/Day/Year) in the following manner:  
Boss Will Abbott came to the scene of the accident.
6. Due to injury, the claimant is in need of (check one):  
☒ (a) medical examination and treatment for: Right ankle/foot, left leg, right eye face, head and brain  
☒ (b) additional medical examination and treatment for: Right ankle/foot, left leg, right eye, head and brain
7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of: TBD
8. Due to the injury, the Claimant has permanent disability of the following nature and extent (check one):  
☐ (1) General Disability: ☐ Total ☐ (2) Specific Disability: ☐ Total  
☐ (3) Wage Loss ☐ Partial ☐ Partial
9. Due to the injury, the Claimant has a serious bodily disfigurement consisting of: \_\_\_\_\_
- 10a. At the time of the injury, the Claimant was paid weekly wages of \$TBD, and demands accounting of days worked and wages earned as provided by law.
- 10b. Give names and addresses of all employers for whom the Claimant has worked since the date of the accident:  
None
- 11a. Further grounds or unusual aspects of claim: \_\_\_\_\_
- 11b. List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident:  
See Attached
- 11c. To the best of your knowledge, did you have any prior permanent disability? No  
If yes, describe: \_\_\_\_\_
12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.
- 13a. I am filing a claim. I am not requesting a hearing at this time.
- 13b. I am requesting a hearing. A \$25 fee is required.
14. Estimated time needed for hearing: 1 hour

I certify the contents of this form are accurate and true to the best of my knowledge.

Preparer's Signature: William G. Jenkins, Jr. Esquire Title: william@jenkins-esquivel.com Email: 11/06/2012 Date

Refer to R.67-204 through R.67-210 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Claims Department.





**Workers' Compensation Commission**

Main Street, suite 500 • Post Office Box 1715  
 Columbia, South Carolina 29202-1715  
 (737) 737-5723



WCC File #: 1206355

Carrier File #: 319-111-165

Carrier Code #:

Employer FEIN #:

James Baron

Claimant's Name

SSN

Address City State Zip

Home Phone #

Kathleen G. Lyall

Representative's Name

Work Phone #

McAngus Goudelock &amp; Courie

Law Firm

Sanctuary Hospice

Employer's Name

10911B Jacob Smart Boulevard  
 Ridgeland, South Carolina 29936

Address City State Zip

Guarantee Insurance Company c/o Patriot National  
 Insurance Group

Insurance Carrier

(864) 239-4016

Phone Number

Date of Accident: 5/21/12

Complete each information blank. Specify clearly when contentions are admitted in part and denied in part.  
 The employer-insurance carrier in answer to the claim, respectfully shows:

1. It is denied that the employee sustained an injury on or about the date set forth in the application. The reasons for denial are: Defendants deny Claimant sustained a compensable injury.
2. It is denied that both the employer and employee were subject to the Workers' Compensation Act at the time in question. The reasons for denial are: See No. 1 above.
3. It is denied that the relationship of employer and employee existed at the time in question. The reasons for denial are: See No. 1 above.
4. It is denied that at the time in question the employee was performing service growing out of and incidental to his employment. The reasons for denial are: See No. 1 above.
5. It is denied that notice of injury was given to the employer. The reasons for denial are: See No. 1 above.
6. It is denied that the employee needs/is entitled to additional medical care as a result of the injury. The reasons for denial are: Defendants deny Claimant is entitled to additional medical treatment.
7. It is denied that the employee is entitled to temporary total disability for the period(s) of: Defendants deny Claimant is entitled to temporary compensation.
8. It is denied that the employee is permanently disabled. The reasons for denial are: Permanent disability, if any, to be determined by the Commission.
9. It is denied that the employee has a serious disfigurement.
10. It is contended that an average weekly wage of Form 20 to be submitted applies, according to attached accounting of employee's earnings as provided by law.
11. Further contentions or grounds of defense are: See addendum.
12. Estimated time needed for hearing: 60 minutes

I certify that I have served this document pursuant to R.67-211 by delivering a copy to:

William G. Jenkins, Jr., Esquire  
 Jenkins & Esquivel, P.A.  
 Post Office Box 6855  
 Columbia, South Carolina 29928

South Carolina Workers' Compensation Commission  
 PO Box 1715  
 Columbia, South Carolina 29202

On the 5th day of December, 2012 by ☐ first class mail; ☐ personal service; ☒ certified mail.  
 I certify the contents of this form are accurate and true to the best of my knowledge.

*Katie Lyall*  
 Representative's Signature

Attorney for Employer/Carrier  
 Title  
 Email: katie.lyall@mqclaw.com

December 5, 2012  
 Date

Refer to R.67-204 through R.67-210 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Judicial Department. Pursuant to R.67-606, a Form 20 must be filed with the Claims Department at least 30 days from the date of filing this form.

Addendum to Form 51

11. Defendants respectfully reserve the right to amend this Form 51 and claim any and all affirmative and specific defenses should facts be discovered during investigation which allow the defenses to be asserted in good faith, (see Reg. 67-603), including but not limited to Section 42-9-60, fraud in the application for employment, fraud in the inducement to sign Form 15, fraud in the initiation of the claim for benefits, pre-existing disability to allegedly injured members, election of remedies, and intervening trauma, no compensable injury by accident under Section 42-1-160; degree of disability, if any, attributable to this injury needs to be determined; statute of limitations. notice, defendants reserve the right to amend this Answer and plead additional defenses.

BEFORE THE  
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION  
WCC FILE NO. 1206355

|                              |   |                           |
|------------------------------|---|---------------------------|
| Frances Baron,               | ) |                           |
|                              | ) |                           |
| Claimant,                    | ) |                           |
|                              | ) |                           |
| vs.                          | ) |                           |
|                              | ) | TRANSCRIPT OF PROCEEDINGS |
| Sanctuary Hospice, Employer, | ) |                           |
|                              | ) |                           |
| and                          | ) | February 27, 2013         |
|                              | ) |                           |
| Guarantee Insurance Company, | ) |                           |
| Carrier,                     | ) |                           |
|                              | ) |                           |
| Defendants.                  | ) |                           |
|                              | ) |                           |

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This hearing was held before Commissioner Gene McCaskill, reported by Kimberly T. Power, Court Reporter and Notary Public in and for the State of South Carolina; said proceedings were held at the South Carolina Workers' Compensation Commission, Lowcountry Council of Governments, 634 Campground Road, Yemassee, South Carolina, on Wednesday, February 27, 2013.

APPEARANCES

ATTORNEYS FOR THE CLAIMANT

LAW OFFICES OF WILLIAM G. JENKINS, JR.  
BY: WILLIAM G. JENKINS, JR., ESQUIRE  
Post Office Box 1969  
Bluffton, South Carolina 29910

ATTORNEYS FOR THE DEFENDANTS

MCANGUS GOUDELOCK & COURIE, LLC  
BY: KATHLEEN G. LYALL, ESQUIRE  
MARK D. ALLISON, ESQUIRE  
Post Office Box 2980  
Greenville, South Carolina 29602-2980

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WITNESS: PENNY COX ABBOTT

|                                  |    |
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1 THE COURT: Today's date is February 27, 2013.  
 2 This is the case of Frances Baron vs. Sanctuary Hospice.  
 3 The carrier is Guarantee Insurance Company. The Workers'  
 4 Compensation Commission File Number is 1206355. The  
 5 claimant is represented by William G. Jenkins, Jr., and  
 6 the employer/carrier is represented by Kathleen G. Lyall.  
 7 Mark, do you want to be on this case?

8 MR. ALLISON: Sure. Yes, please.

9 THE COURT: And Mark Allison. The date of  
 10 accident is May 21, 2012. And how shall I characterize  
 11 this, as admitted in part, denied in part? Y'all tell me  
 12 what y'all think.

13 MS. LYALL: I think it would have to be fully  
 14 denied.

15 THE COURT: Fully denied?

16 MS. LYALL: Yes, sir.

17 MR. JENKINS: I believe that's right.

18 THE COURT: All right. Fully denied. Fully  
 19 denied. You're just seeking whether the leg is  
 20 compensable?

21 MS. LYALL: It's actually the whole claim is  
 22 denied.

23 THE COURT: I'm just looking at my last note.  
 24 You weren't admitting that.

25 MS. LYALL: No. Right. If the whole claim is

1 found to be compensable, then --

2 THE COURT: Yes. If I scrolled back and sat  
3 here for a minute, I probably would have figured it out.  
4 But in the interest of time, thank you. Date of  
5 accident, May 21, 2012. Are there any objections to  
6 jurisdiction, venue, or APA submissions?

7 MR. JENKINS: None from the claimant.

8 MS. LYALL: None.

9 THE COURT: All right. Without objection, the  
10 Commission file becomes a part of the record with the  
11 exception of self-serving declarations and unstipulated  
12 medical reports.

13 All right. Mr. Jenkins, you're the moving  
14 party. If you would, please, sir, place your client's  
15 position on the record.

16 MR. JENKINS: Commissioner, my client's  
17 position is that she suffered a work-related injury  
18 arising out of -- arising out of and during the course of  
19 her employment on May the 21st, 2012. As a result, she  
20 suffered a fracture of her left ankle, she suffered an  
21 injury to her right tibia, she suffered a closed-head  
22 injury which resulted in a concussion as per the medical  
23 records that have been submitted, as well as an injury to  
24 her -- both her eyes and she has suffered disfigurement  
25 in the form of --



1 THE COURT: Excuse me. Make sure I understood  
2 you to say injury above her eyes or to her eyes?

3 MR. JENKINS: Both. She suffered an injury  
4 to -- above her right eye which has resulted in scarring  
5 in addition to affecting her vision in both of her eyes.  
6 She scheduled for eye surgery at the end of March or the  
7 first part of April with Dr. Diana who is an eye surgeon;  
8 that she has been unable to work since the day of this  
9 accident. That would be May the 21st, 2012. She's  
10 entitled to all medical expenses incurred as a result of  
11 this accident as well as temporary total benefits from  
12 the date of the accident through the present and  
13 continuing into the future until such time as she's able  
14 to return to work if that, in fact, ever occurs, as well  
15 as future medical expenses from the date of this hearing  
16 forward.

17 It's further our position that under the law  
18 that she suffered a compensable injury by virtue of the  
19 fact that she was driving an automobile in route from her  
20 place of business to the home of one of her patients,  
21 that her traveling in that automobile was necessitated by  
22 her employment; that she suffered a syncopal episode  
23 during the course of her driving from her place of  
24 business to the home of the patient as a result of her  
25 driving an automobile. The injuries that she suffered

1 were contributed to by virtue of the fact that she was in  
2 her automobile and that being in an automobile  
3 constituted a condition of her employment which  
4 contributed to her injuries.

5 THE COURT: What else, sir?

6 MR. JENKINS: I think that about covers it.

7 THE COURT: All right. Ms. Lyall.

8 MS. LYALL: It's the defendant's position that  
9 this claim is not compensable as it did not arise out of  
10 the employment. We have denied this claim under South  
11 Carolina case law including the Jennings, Turner, Bagwell  
12 and Edge cases cited in our Memorandum of Law. It's our  
13 position that while we concede she was in the course of  
14 her employment at the time, it was a syncopal episode was  
15 the cause of the car accident. It did not arise out of  
16 her employment. The accident was due to the syncopal  
17 episode.

18 The claimant admittedly under deposition  
19 testimony had a syncopal episode that, in her words, a  
20 light switch went out causing the accident and there are  
21 numerous references under our APA submissions that  
22 indicate that the syncopal episode was the cause of the  
23 accident. Additionally, Dr. Mark Wagner opined that the  
24 accident was caused by the syncopal episode and he  
25 further opined that the syncopal episode did not appear,

1 that there's no evidence relating a syncopal episode to  
2 the accident.

3 Additionally, further, in the alternative, if  
4 this claim is found compensable, it's the defendant's  
5 position that Ms. Baron did not suffer a brain injury and  
6 that medical evidence does not support a finding of brain  
7 injury. Further, we are -- it is our position that she  
8 is not entitled to temporary total disability benefits  
9 from the date of the accident to the present as Ms. Baron  
10 was not planning on returning to work following a  
11 scheduled two week vacation that was to take place four  
12 days following the accident. As Ms. Baron was not  
13 planning on returning to work following the accident, it  
14 is not the accident that has caused her to not work since  
15 May of last year. It was her already made plans of  
16 retiring. Therefore, she is not entitled to temporary  
17 total disability benefits.

18 THE COURT: What else?

19 MR. ALLISON: Commissioner, I would briefly  
20 add to the legal issue of arising out of employment. If  
21 I'm understanding the claimant's position, it is that the  
22 fact that she was operating a motor vehicle at the time  
23 of her syncopal episode which brings this case within the  
24 gamut of arising out of employment. I would submit to  
25 you that there's not any evidence before you that

1 indicates that the fact that she was in a motor vehicle  
2 at the time of the syncopal episode created any greater  
3 injury or caused any greater injury than would have  
4 occurred if she had suffered a syncopal episode outside  
5 of the vehicle. There's not one piece of medical  
6 evidence that suggests that her injuries are worse  
7 because of that. So logically just the incidental fact  
8 that she was in a motor vehicle alone is not sufficient  
9 under any -- any of the cases that have been brought  
10 forward to support a finding that this arose out of  
11 employment and should be compensable.

12 MR. JENKINS: Could I respond to that,  
13 Commissioner?

14 THE COURT: Just give me a second. Anything  
15 else, Mark?

16 MR. ALLISON: No, sir. Thank you.

17 THE COURT: Yes, sir.

18 MR. JENKINS: I would simply say there's no  
19 expert testimony required in any of the cases that I have  
20 handed up to you that the fact that she was in an  
21 automobile caused a greater degree of injury. That's  
22 clearly within the realm of expertise of the ordinary  
23 person or the ordinary reasonable person to determine.  
24 Again, we think it's self-evident on its face that by  
25 your injuries with a syncopal episode are going to be

1 greater while you're driving in an automobile than they  
2 would be sitting in this room or walking from here to  
3 your car.

4 THE COURT: What else?

5 MR. JENKINS: That's it.

6 THE COURT: Anything else from the defense?

7 MR. ALLISON: No, sir.

8 MS. LYALL: No, sir.

9 THE COURT: All right. Mr. Jenkins, are you  
10 ready to call your witness?

11 MR. JENKINS: I am, Your Honor.

12 THE COURT: All right. Ms. Baron, I'm going  
13 to swear you in in just a moment. I've got two requests  
14 for you. The first is I need for you to speak up. We  
15 don't have any amplification, no microphones, and this is  
16 a fairly large room that has carpet which absorbs sound.  
17 It's very important that this young lady who is making  
18 the record of this proceeding hear you, but it's equally  
19 important that all of the attorneys hear you and that I  
20 hear you. Sometimes with folks they start out really  
21 strong. But as we go along because they're, especially  
22 in the beginning having a conversation with their  
23 attorney, they forget that there's a conversation for all  
24 of us. So please remember to speak up loudly and  
25 continually so.

1 And the second is real very simple. If you're  
2 asked a yes or no question, please respond with yes or  
3 no. I have a tendency to shake and nod my head. Well,  
4 if you do that, she has to enter that in the record and  
5 that sometimes can be misunderstood. But if you answer  
6 yes or no, it's clear, it's clean, it's concise, and that  
7 just I think is helpful to all of us. So if you would do  
8 that, I would appreciate it. Okay?

9 THE WITNESS: I'll try very hard.

10 (FRANCES BARON, being duly sworn to tell the  
11 whole truth and nothing but the truth, testified as  
12 follows:)

13 THE COURT: Please state and spell your full  
14 name for the record.

15 THE WITNESS: Frances Albina Baron.  
16 F-R-A-N-C-E-S. Albina, A-L-B-I-N-A. Baron, B-A-R-O-N.

17 THE COURT: All right. Thank you, ma'am.  
18 Mr. Jenkins.

19 DIRECT EXAMINATION

20 BY MR. JENKINS:

21 Q. Ms. Baron, how old are you?

22 A. Seventy-one.

23 Q. And go through very quickly your educational  
24 background.

25 A. I graduated high school. I then entered in a

1 three year diploma school of nursing which was much more  
2 prominent at that time than college. RN from Washington,  
3 Pennsylvania. Graduated in 1962 as a registered nurse.

4 Q. Have you been working as a registered nurse  
5 continuously since 1962 until the present?

6 A. Except for the time my husband was in the Air  
7 Force and we were in Germany for two years and there was  
8 no position available there and we had two children and I  
9 returned a few months after each childbirth.

10 Q. Now, you were injured in an automobile  
11 accident on May 21, 2012; is that right?

12 A. That's correct.

13 Q. What were you doing at the time?

14 A. I had visited my patients in Beaufort and was  
15 on my way back to the office and to visit my last patient  
16 of the day.

17 Q. And does your job require that you travel from  
18 place to place in your automobile to perform your duties?

19 A. Yes, it does. Yes.

20 Q. And you were in route to -- from Beaufort to  
21 another patient at the time this accident happened?

22 A. Well, I was going to go back to the office  
23 first because I had some medicine for the patient that I  
24 was going to see and pick that up, and she was having a  
25 doctor's appointment and I needed to call first to make

1       sure that she was home so that I wouldn't go there and  
2       have her be somewhere else.

3           Q.       Tell us -- tell the Commissioner what you  
4       remember about the accident.

5           A.       Unfortunately there isn't anything I remember.  
6       I don't -- I mean, I know I hit the trees, but I don't  
7       even think I remember the impact. The first thing that I  
8       remember is opening my eyes and I was towards the sky and  
9       I could see trees, and then I looked down a little bit  
10      and I could see smoke or what I perceived to be smoke.  
11      And I looked around and my dashboard was just in  
12      shambles, and I realized that I had an accident. And,  
13      like I said, I saw the smoke and I thought, well, I need  
14      to get out. I looked at my car door and it was jarred a  
15      little bit. I undid my seat belt, pushed the door, and I  
16      was able to walk out and walk several steps. It's a  
17      little null. And just kind of sat down there. My legs  
18      started getting very shaky and I sat down.

19          Q.       Did you receive a head injury in this  
20      automobile accident?

21          A.       Yes. I had blood everywhere on me and in the  
22      car.

23          Q.       Do you have scars on your forehead and above  
24      your eye from the blow you received to the head?

25          A.       Yes, yes.



1 Q. Have you ever been treated anywhere for a head  
2 injury for this accident?

3 A. They examined me in the hospital the day  
4 afterwards. I had a CT scan of my brain, and it showed  
5 that I did not have a stroke. They ruled out a stroke.

6 Q. Did you have a skull fracture or any hematoma  
7 or any bruising on the inside of your skull?

8 A. That's why they sent me to Dr. Diana. As soon  
9 as I was discharged, they were considering I had a blood  
10 clot behind my eye because my eye was so involved, but he  
11 did not find a hematoma there. I have permanent nerve  
12 and muscle damage over the right eye. I have drooping  
13 eyelids which keeps me from seeing clearly, like  
14 everything is just halos here and very blurred. I cannot  
15 read for longer than a sentence or two that it just  
16 doesn't blur all up and I'm guessing at what I'm reading.

17 Q. Now, are you going to have -- in the near  
18 future are you going to have any sort of procedure for  
19 those problems?

20 A. Yes. I have to have -- my left eye just had  
21 an exam last week. My left eye is worsening and the  
22 eyelids both need to be attached or lifted up. And  
23 during the process, he said sometimes they can't tell now  
24 but when they get into surgery that there might be  
25 something on the muscle. If it's not attached or if it's

1 cut or something, then he would repair that at the same  
2 time.

3 Q. Do you have any residual effects from that  
4 blow to the head?

5 A. Unfortunately I do have some short-term memory  
6 loss. I know I have it. And sometimes on new things I  
7 have to repeat it several times or write it down, but I  
8 do know that I didn't have that before the accident. My  
9 long-term memory is pretty good, but my short-term memory  
10 I do have difficulty with.

11 Q. Tell the Commissioner about any other  
12 accidents -- or any other injuries you've had as a result  
13 of this accident?

14 A. Well, of course I had the fracture of the left  
15 ankle and I had to have surgery done. And then I had a  
16 large hematoma on my right leg and they had to drain it  
17 in the office. The doctor removed a large amount of  
18 blood clot -- a large, thick blood clot and I had to have  
19 packing on that daily until it healed and it was  
20 non-healing. So we had to put a wound vac on it and that  
21 finally did heal it, and I still have discoloration  
22 there, a scar there, pain there and my legs get -- like  
23 now they get very cold and numb.

24 Q. If we looked at your leg right now, could we  
25 see where the injury --

1 A. Yes.

2 Q. If you could show that to Commissioner  
3 McCaskill.

4 A. Of course this is the incision for the  
5 fractured ankle and then this is still the -- and the  
6 discoloration and it's about to there and into my ankle  
7 and this went up seven centimeters which needed to be  
8 packed daily.

9 Q. Show him the scars that you have above your  
10 right eye.

11 A. It's that one and then in my brow. And, of  
12 course, it's taken a lot of months for it to kind of fill  
13 in. It was indented and it hasn't been too long since  
14 it's kind of rounded out a little bit when you look at  
15 me. And then you can see my eyebrow. This eyebrow was  
16 pulled up over this eyebrow and that just means, the  
17 doctor said, over-compensating trying to use this eye to  
18 accommodate the injury in my right eye.

19 Q. Now, Ms. Baron, do you have any other injuries  
20 that maybe we haven't spoken of?

21 A. And I didn't tell you, this arm is also I  
22 don't have -- I can't get behind my arm -- behind my back  
23 to fasten my bra. Excuse me. And so I can push up with  
24 it. And then I did -- when I was moving around and until  
25 I was much more active after the doctors released me to

1 start walking, which was over six weeks, then I started  
2 doing other things and I noticed that that was limiting  
3 me. I did show to Dr. Sutherland when I saw him that  
4 last day and he rubbed it and says, yes, you have a knot  
5 there and that was the end of that. But this arm still  
6 limits me.

7 Q. Now, have you gone back to work since this  
8 accident happened in May of last year?

9 A. No. No, I have not.

10 Q. In your opinion would you be able to perform  
11 the tasks that you were performing prior to the injury?

12 A. Well, the nursing part of it, yes, and I would  
13 love to do that. I love my patients, I love my job, I  
14 love my work, and I still feel like I'm capable of  
15 working. But I have not driven since then. I know that  
16 I don't see well. And the thought of injuring somebody  
17 if they would jump out in front of my car, especially a  
18 child, would just be unbearable for me. So, no, I  
19 haven't driven since then. And my endurance is just not  
20 there. I could not work a 40 hour week or even an eight  
21 hour day.

22 Q. Given -- given your problems with the vision,  
23 do you feel like it would be safe for you to drive a car  
24 on the highway?

25 A. No, absolutely not.

1 Q. Now, when are you scheduled to have the  
2 procedure on your eye -- eyes?

3 A. Yes. It will be right after my husband -- he  
4 had to put off his surgery for his right shoulder when I  
5 had my accident, and he's in a lot of pain. So now that  
6 I'm able to get up and move around and can take care of  
7 myself, he's going to have his surgery next week. And  
8 then as soon as he's able and gets over his shoulder  
9 surgery and he can drive me, then I'll schedule my  
10 surgery. Oh, and they have to be two different ones.  
11 Dr. Diana said they can't do them both at the same time.

12 Q. Now, insofar as the head injury is concerned,  
13 do you have issues -- any sort of problems associated  
14 with that blow to the head other than what we talked  
15 about?

16 A. He was -- he was surprised I wasn't having  
17 headaches, and I just recently in the last month been  
18 trying to do more and I play games for hand/eye  
19 coordination and I try to do crossword puzzles to make my  
20 brain work a little bit. I've been starting to get  
21 headaches. So then I have to go ahead and stop -- stop  
22 doing that. Any of that, reading activity or writing  
23 activity or even playing some games on the computer just  
24 to try to improve my hand/eye coordination.

25 Q. I noticed you wear eye glasses.

1 A. I do.

2 Q. Has Dr. Diana -- have you changed your  
3 prescription as a result of this accident?

4 A. He did not, but he said last week that  
5 he wants to do the surgery for --

6 MS. LYALL: Object to hearsay.

7 THE WITNESS: Oh, I'm sorry.

8 THE COURT: You can tell me what you  
9 understand.

10 THE WITNESS: Okay. I understand him to say  
11 that --

12 THE COURT: Not what he said. You can't do  
13 that.

14 BY MR. JENKINS:

15 Q. What is your understanding of why --

16 A. After surgery then we'll readjust the glasses.

17 Q. Has this accident had any effect on your  
18 personality or your tolerance for frustration?

19 A. Yes, yes. I'm much more irritable and  
20 stressful.

21 Q. If you're able to get back your vision and  
22 back to some semblance of normalcy, do you want to go  
23 back to work?

24 A. I'd love to.

25 Q. Was it ever your intention to retire?

1           A.     I was not retiring, but I was going from  
2     full-time to part-time position. I could work the 40  
3     hours a week, but it was the on-call that was in addition  
4     to it that I just -- was getting too much for me. So we  
5     were going to go to from full-time to part-time.

6           Q.     When were you going to do that?

7           A.     After my vacation.

8           MR. JENKINS: Answer any questions Ms. Lyall  
9     may have.

10                           CROSS-EXAMINATION

11 BY MS. LYALL:

12           Q.     Thank you, Ms. Baron. My name is Katie Lyall.  
13     We met a few months ago at your deposition.

14           A.     I almost remember that.

15           Q.     All right. I just want to go back and again  
16     talk about the actual accident. You stated that you  
17     don't remember anything leading up to the accident?

18           A.     Well, the one thing I do remember is I was  
19     driving over the bridge and the speed limit there is 55  
20     and I will put my cruise control on a lot of time and I  
21     had a state police officer go right by me, pass me, you  
22     know. ~~It's a two lane road. And for some reason I~~  
23     looked at my speedometer and I was exactly at 55. So  
24     that was the main thing, and it made me feel good because  
25     I don't like to speed. I don't like looking around. I

1 like to concentrate on what I'm doing. And the fact I  
2 was exactly 55 miles an hour and I was just thinking  
3 about going, you know, to my next patient who was  
4 actively dying and I was concerned because his wife  
5 was -- possibly either had a heart attack or they had  
6 just stopped her from having a heart attack. So I was  
7 thinking about, you know, that next visit, but I was not  
8 distracted by any means. But the state police going by  
9 me and looking, that's really about the last thing that I  
10 can really focus on or visualize right now.

11 Q. And it was like a light switch went out?

12 A. Well, no. This was down the road several  
13 miles.

14 Q. But that's what happened before the accident?

15 A. I just can't remember. There is no memory  
16 whatsoever, that I was just driving. I was thinking  
17 about that. I was thinking about my week of work. I was  
18 thinking about what work I had to have done. There were  
19 two patients. I was working on one of them, and I knew I  
20 was going to work three days that week Monday, Wednesday,  
21 Friday. And I was saying, okay, I have enough time for  
22 this, you know, as long as nothing else came up, I would  
23 have enough time to get everything done and be on my way  
24 for my vacation and not leave the nurses to cover me with  
25 doing anything extra.



1 Q. Okay. So you were just driving and next thing  
2 you know, a light switch went off and you got into an  
3 accident?

4 A. Next thing I know, I was looking at the sky  
5 and the smoke.

6 Q. Okay. You just testified that you're not  
7 planning to return to work full duty following the  
8 accident, correct?

9 A. That's correct.

10 Q. Had you made complete arrangements with  
11 Sanctuary Hospice as to your return to work situation?

12 A. Well, Penny and I had talked about it, and  
13 they just said we would discuss it more fully when I got  
14 back from vacation.

15 Q. So you didn't have any set hours or any set  
16 plans for your return to work?

17 A. Not at that particular time, no. We were  
18 going to discuss it when I came back from vacation.

19 Q. And you would have to wait for, I guess, Penny  
20 Abbott to confirm what hours were available and your  
21 light duty -- or your part-time availability?

22 A. I'm not sure if -- see, there's some -- I just  
23 can't -- I don't know. I can't remember some of the  
24 conversations, but I thought I was still going to cover  
25 River Oaks where I was working. I just can't -- I can't

1 pin that down to a conversation. I just -- that's just  
2 one of the things that just are lacking.

3 Q. Have you been suffering memory loss since your  
4 accident?

5 A. Yes.

6 Q. So all along I guess immediately after the  
7 accident you started noticing memory loss?

8 A. Well, for six weeks I was taking pain pills  
9 and sleeping a lot. So -- oh, yes, and there was some  
10 instances then, yes, that I was having memory loss. But,  
11 of course, I kind of attributed that more to having to  
12 take the pain pills. I had to have surgery on my ankle,  
13 and then my right leg being as painful as it was.

14 Q. When did you quit taking the pain pills?

15 A. Oh, as soon as they stopped packing my wound,  
16 I didn't have to take the pain pills anymore and  
17 evacuated blood clot. But it was after the packing  
18 because that was excruciating pain.

19 Q. Since that time you've suffered memory loss?

20 A. There are things I don't remember, yes. And I  
21 can't -- and I'm not going to say here that I can  
22 remember substances if I can't remember clearly. I'm not  
23 going to say that.

24 MS. LYALL: I'd like to hand up the claimant's  
25 deposition.

1 THE COURT: Do you have any objection to your  
2 client's deposition?

3 MR. JENKINS: No.

4 BY MS. LYALL:

5 Q. Ms. Baron, and for the Commission's record,  
6 I'm referring to Page 72 of claimant's deposition. At  
7 your deposition I questioned you on whether you had  
8 suffered any memory loss as a result of the accident or  
9 any cognitive deficiencies and you denied both.

10 A. Well, I -- when I came -- when we had that  
11 deposition, I was still taking pain pills and I had taken  
12 some pain pills that morning too. And it says Page 72.  
13 I had gone to the wound clinic and had a treatment, then  
14 I did not think the deposition was going to be anywhere  
15 that length of time. I had no idea. And I think a lot  
16 of that was I wasn't having memory loss because I wasn't  
17 doing anything to really notice my memory was gone. I  
18 was mostly sleeping and eating and going to the bathroom  
19 and that was it, you know. And I wasn't doing anything  
20 at that time or that I was still thinking that, you know,  
21 I'm fuzzy because of the pain pills I was still taking.

22 Q. I'm going to read the questions and your  
23 answers to determine whether it was truthful and accurate  
24 at the time of the deposition. I asked, "And since the  
25 accident, have you suffered any memory loss?" And you

1 said, "Well, I've taken pain pills and I can't say memory  
2 loss as much as not having details, dates, well, of  
3 course, has been doing the calendar -- my husband has  
4 been doing the calendar, so I rely on him. I just kind  
5 of check it off and say, okay, what date did you put  
6 down." And you said, "I mean, I know who my family is.  
7 I know where I work. I know all of that."

8 Is that accurate?

9 A. I do. I mean, I know, you know, like you  
10 just -- there's just some things in my memory -- and  
11 anything new that comes up, I sometimes have to repeat it  
12 and I'm good at writing it down. Once I write it down  
13 and it's visual for me, it sticks better.

14 Q. Then I asked, "Do you have any cognitive  
15 deficiencies?" And you said, "I hope not. No, not that I  
16 know of."

17 A. Well, like I said, at that time I was still  
18 taking pain pills and I was hardly doing anything besides  
19 sleeping, getting up, going to the bathroom and going to  
20 the doctors and pain and having my wound dressed every  
21 day and back off to sleep again. So I wasn't doing  
22 bills, I wasn't doing anything that would make me  
23 evaluate.

24 Q. Have you complained of this memory loss to any  
25 doctors?

1           A.     I can't remember. Dr. Trish, I may have  
2 mentioned to her. Oh, Dr. Wagner, of course, we talked  
3 about it when I was up there. And I did tell him, I  
4 says, I know myself that I'm not remembering things. And  
5 we did -- he tested me on it. He said, You did very  
6 well. But on some of the tests that I took, it wasn't so  
7 much that I could remember what was there, I remember  
8 that I didn't see something because there were only two  
9 objects and then I had to pick which one I saw. But some  
10 of it wasn't that I remember seeing it, is remembering I  
11 didn't see the other object.

12           Q.     Has any treatment been recommended?

13           A.     No.

14           Q.     Have you received any treatment?

15           A.     No. I've been doing my own like working, you  
16 know, crossword puzzles and working, you know, doing  
17 things on the computer just to make me think. And I  
18 watch game shows on TV. Jeopardy and Wheel of Fortune  
19 are two of my favorites I never miss just to make me  
20 think.

21           Q.     Okay. When did you -- with regards to your  
22 ~~right leg, when did you last receive treatment for your~~  
23 right leg?

24           A.     I don't remember. It would be in the files.  
25 Once the wound vac came off. I just don't remember the

1 date.

2 Q. Do you think it -- would it be accurate to say  
3 it was in August of 2012, August of last year?

4 A. I'm sorry. Without looking at the date and  
5 the last appointment, I don't know.

6 Q. Okay. Has any additional treatment been  
7 recommended for your right leg?

8 A. No. They just told me to come back if it  
9 started draining again and keep the support on it when it  
10 swells. They gave me stockings and support hose, which I  
11 wear, and keep them elevated as part of it. Warm bath  
12 she said would help it and I've done that.

13 Q. I'm just going to refer the Commission's  
14 attention to APA Page 304. It's the wound care from  
15 August 2, 2012 where they stated that her wound is now  
16 healed.

17 Since this accident, have you had any contact  
18 with Sanctuary Hospice or any employees there?

19 A. I have talked -- I have spoken to some of the  
20 employees.

21 Q. Have you contacted anybody about possibly  
22 returning to work?

23 A. No.

24 Q. Did you ever contact them to discuss returning  
25 to work part-time?

1 A. No, because I haven't been able to drive.

2 Q. Do you have any restrictions from doctors  
3 keeping you from being able to drive?

4 A. I don't have anything written.

5 MR. JENKINS: She can explain her answer, can  
6 she not, Commissioner?

7 THE COURT: Yes.

8 THE WITNESS: Dr. Diana did tell me --

9 MS. LYALL: I'm going to object to --

10 THE COURT: You can't tell me what the doctor  
11 told you.

12 THE WITNESS: He said don't drive. And, I  
13 mean, I know that I can't see properly.

14 MR. JENKINS: Well, didn't she open that up,  
15 Commissioner, by asking if she received any directives?  
16 Read the -- I don't recall exactly what the question was.

17 MS. LYALL: I asked if she had any  
18 restrictions from doctors on her ability to drive.

19 THE WITNESS: And he told me not to drive.

20 MR. ALLISON: Commissioner, I have a few  
21 questions of Ms. Baron.

22 THE COURT: Do you want to ask them now?  
23 Ms. Lyall is still perusing her notes. That way she can  
24 do that. Okay. Thank you, Commissioner.

25 CROSS-EXAMINATION

1 BY MR. ALLISON:

2 Q. Good afternoon, Ms. Baron. I want to ask you  
3 some questions about the changing in your employment  
4 status and what your intentions were about possibly  
5 returning to work. On what day of the week did this  
6 accident occur?

7 A. This was a Monday.

8 Q. And when were you going to stop working as a  
9 full-time employee at Sanctuary Hospice?

10 A. That Friday.

11 Q. And so this was literally the last week that  
12 you were going to work full-time; is that correct?

13 A. That's true.

14 Q. And after that weekend, what was your plan?

15 A. Two weeks of vacation.

16 Q. Is that two weeks of paid vacation --

17 A. Yes.

18 Q. -- by Sanctuary Hospice?

19 A. Yes, my personal time off.

20 Q. So you would be paid for that time you accrued  
21 for a total of two weeks. And then after the expiration  
22 of that two weeks, what was your plan?

23 A. Well, I thought we were going to discuss how  
24 many days I was going to work.

25 Q. Had it been definitely decided that you would



1 in fact work at all or was there still the option that  
2 you would not work in any capacity?

3 A. Oh, no, no. I was part-time. I was going to  
4 go to part-time staff.

5 Q. So is it your testimony that you and Sanctuary  
6 Hospice had established that you would definitely come  
7 back and work part-time?

8 A. Yes.

9 Q. And what was your understanding of how often  
10 you would work?

11 A. That I think was what we were going to  
12 determine when I came back. But I had the impression,  
13 and I can't say from whom or how, that I might still be  
14 covering River Oaks where I had been for well over a  
15 year. But I can't -- I can't --

16 Q. Assuming that what you're stating is true,  
17 that there was an agreement that you would come back to  
18 work part-time, what would be the least amount of time  
19 you would work in a week?

20 MR. JENKINS: You know, I think she's asked  
21 and answered, Your Honor.

22 ~~THE WITNESS:~~ Well, see, I have a patient at  
23 River Oaks who was getting wound care and I was doing a  
24 dressing on Monday, Wednesday, and Fridays. And so my  
25 assumption was that, you know, if I continued there,

1       those would have been my three days.

2 BY MR. ALLISON:

3           Q.       So how many hours per day would you work?

4           A.       Well, that -- that is what we probably would  
5       have been discussing on what they wanted to happen.  
6       Sometimes you would get three, four, or five admissions  
7       in one day and if you only had four nurses and you had  
8       five people to be admitted, then I would gladly go out  
9       and admit another patient and get them all set up for  
10      another nurse to take over. I mean, and I had just done  
11      that the prior two weeks. We had -- we had a lot of  
12      patients -- a lot of admissions and they had asked me to  
13      admit one, and then the very next week to go ahead and if  
14      I can help out and admit a second patient which I did do.

15           MR. ALLISON: Commissioner, what I'm trying to  
16      do to help you out is that if you find this compensable,  
17      there is an issue as to whether or not she's entitled to  
18      temporary compensation; and if so, how much. And the  
19      point being is that if she was going to go back and earn  
20      diminished wages, she would not be entitled to a full  
21      comp rate where she did not even intend to earn anywhere  
22      close to her pre-injury weekly average wage. So what I'm  
23      trying to do is to give you a range of figures which she  
24      may have earned had she gone back so that you can  
25      determine the proper compensation rate for temporary

1 compensation.

2 BY MR. ALLISON:

3 Q. Ms. Baron, what I'm asking you to do is to  
4 give me your best understanding of the least amount of  
5 hours that you would work in a week part-time?

6 MR. JENKINS: If I might respond to that.  
7 She's already testified that that had not yet been  
8 determined, Commissioner, that they were going to talk  
9 about that at some period in time in the future.

10 THE WITNESS: And then I would be available  
11 when we got hit with -- I mean, sometimes you get four or  
12 five admissions at one time and they're scattered all  
13 over the place.

14 THE COURT: It's my understanding that  
15 she's -- her recollection is that had yet to be  
16 determined.

17 MR. ALLISON: Correct. And if you've heard  
18 what you need to hear about that, that's fine. We'll  
19 stop. All I'm trying to do is give you a range of I  
20 could have worked X number of hours a week on the low end  
21 or X numbers on the high end so that you have some way to  
22 derive what her temporary compensation would be.

23 Otherwise, if there's no -- if there is no testimony  
24 about how much she might have worked even if it's not set  
25 in stone and definitive, then there's no way to determine

1       how much she would be paid for TTD.

2               THE COURT: And I appreciate what you're  
3       trying to do. But based on what I'm hearing from her,  
4       that was yet to be determined. I believe in the answer  
5       from her would be purely speculative, would it not, if  
6       that is indeed her understanding that it hadn't been  
7       determined?

8               MR. ALLISON: She has testified that what she  
9       assumed would happen or what had been discussed with some  
10      specifics is returning to River Oaks and taking the  
11      patients at River Oaks.

12              THE COURT: Is that your understanding?

13              THE WITNESS: I thought that that was, yes,  
14      that it would be River Oaks plus I would help out if you  
15      had somebody sick or if we had an influx.

16              THE COURT: I understand. That part I think  
17      would be speculative. If you had River Oaks, how many  
18      hours a week do you think that would involve?

19              THE WITNESS: Well, again, if I had River  
20      Oaks, I had -- they were looking at two other patients to  
21      admit down there. So, you know, all I can tell you is I  
22      ~~had one lady who had a wound three times a week, Monday,~~  
23      Wednesday and Friday, and I had two other ones there and  
24      we were talking about admitting two other patients. That  
25      could be three full days, yes.

1 THE COURT: If you admitted the two other  
2 patients?

3 THE WITNESS: Yes.

4 THE COURT: But we don't know --

5 THE WITNESS: No.

6 THE COURT: -- that to be a fact. So for the  
7 patients you were caring for, what would it be?

8 THE WITNESS: With those three, drive down and  
9 doing those three and seeing them twice -- twice a week,  
10 maybe six hours a day and the drive back.

11 THE COURT: All right. Thank you. Other  
12 questions, Mr. Allison?

13 MR. ALLISON: No, sir. That's all I have.

14 THE COURT: Ms. Lyall, do you have other  
15 questions for this witness?

16 MS. LYALL: No, sir.

17 MR. JENKINS: I've got a couple.

18 THE COURT: I'm coming back to you. It's your  
19 turn. All right. Mr. Jenkins.

20 MR. JENKINS: Thank you.

21 REDIRECT EXAMINATION

22 BY MR. JENKINS:

23 Q. Had you discussed with your employer or  
24 anybody employed by your employer exactly what your work  
25 schedule was going to be after you got back from

1 vacation?

2 A. Penny and I had a discussion about, you know,  
3 I would work that week that I was working and that I  
4 would take two PTO days on Tuesday and Thursday to make  
5 it a full week, full-time, my vacation would be two  
6 full-time weeks, and when I came back it would be  
7 part-time, and then we would be sitting down and  
8 discussing what that would entail.

9 And, of course, you know, I had told them that  
10 I would -- even if it was Monday, Wednesday, and Friday;  
11 but if they had a bunch of admissions like on Tuesday or  
12 Thursday, I'd definitely come in and help them out. I  
13 mean --

14 Q. You don't -- so you don't exactly know how  
15 many hours you would have eventually been working?

16 A. No, because if we admitted those other two  
17 patients there. And you never know when one of your  
18 patients is going to start acutely dying. And if they  
19 are actively dying, then that's a lot more hours.

20 Q. If you were to testify here today about how  
21 many hours -- how many hours you would have been working  
22 when you got back from your vacation, you would just be  
23 guessing, wouldn't you?

24 A. Oh, absolutely. And I was physically able at  
25 that point to work a full 40 hours if I needed to.

1 Q. Why did you want to go back to part-time? Why  
2 were you thinking about going to --

3 A. Well, because in March it was so heavy laden  
4 and the one pay period I had worked like 99 hours plus  
5 had to take call 20 or 30 hours on top of that and that  
6 was just too much. We were hiring somebody, but I didn't  
7 know that at the time. We weren't informed some on-call  
8 people, but that was just too much.

9 Q. So some weeks before you got injured, you were  
10 working 90 hours a week?

11 A. Yes.

12 Q. Plus --

13 A. No, paid. Paid. I'm sorry. Did I say weeks?  
14 It was two weeks. It was for per pay period.

15 Q. Plus an additional 30 hours of being on-call?

16 A. Yeah.

17 Q. And how old were you at the time?

18 A. Seventy.

19 Q. And you felt like that was a little too much  
20 for you?

21 A. Yeah.

22 Q. So you wanted to cut your hours back some  
23 because that was putting too much stress on you?

24 A. Yeah. And I did -- I remember now -- this one  
25 I do remember. I did talk to Will about that because he

1 said, Well, how much can you work? And I said, Will,  
2 truthfully I could work the 40 hour week and on Friday  
3 I'm naturally tired -- normally tired, tired, you know.  
4 Just at the end of 40 hours a week, you're tired, but not  
5 excessively. I said, But it's the on-call and I know I  
6 can't do this job 40 hours a week without taking call  
7 because that's just not how the job came. So I knew I  
8 had to give that up. And I didn't want to, but that's  
9 what I had to do.

10 Q. Could you have worked after you had gotten  
11 back 40 hours a week?

12 A. Oh, sure. Oh, sure.

13 Q. And you had -- at the time you were injured,  
14 you had not reached any concrete agreement with your  
15 employer as to how many hours you were going to be  
16 working?

17 A. No, no.

18 MR. JENKINS: That's all I've got.

19 THE COURT: Ms. Lyall?

20 MS. LYALL: Nothing further.

21 THE COURT: All right. Thank you, ma'am. Do  
22 you have other witnesses?

23 MR. JENKINS: I do not.

24 THE COURT: Is that your case?

25 MR. JENKINS: It is.



1 THE COURT: All right. Ms. Lyall, do you have  
2 witnesses?

3 MS. LYALL: We do. We're going to have Penny  
4 Abbott testify from Sanctuary Hospice.

5 THE COURT: You were present for my  
6 instructions about speak up and --

7 THE WITNESS: Yes.

8 THE COURT: -- answer yes or no so we're not  
9 going to replot that ground, so I'm going to swear you  
10 in.

11 (PENNY COX ABBOT, being duly sworn to tell the  
12 whole truth and nothing but the truth, testified as  
13 follows:)

14 THE COURT: Please state and spell your full  
15 name for the record.

16 THE WITNESS: Penny Cox Abbott. P-E-N-N-Y,  
17 C-O-X, A-B-B-O-T-T.

18 THE COURT: All right. Thank you, ma'am.  
19 Ms. Lyall.

20 DIRECT EXAMINATION

21 BY MS. LYALL:

22 Q. Ms. Abbott, what's your position with  
23 Sanctuary Hospice?

24 A. I'm one of the principal owners and also the  
25 director of community relations.

1 Q. And in that position you are in charge of a  
2 lot of the decision-making?

3 A. Yes.

4 Q. And you're familiar with Ms. Baron here?

5 A. Yes.

6 Q. Okay. What was your understanding about  
7 Ms. Baron's plans following her vacation?

8 A. Well, and as Ms. Baron said earlier,  
9 everything kind of was up in the air. We knew she did  
10 not want to come back full-time. We don't typically have  
11 part-time positions for our RNs. She had been working at  
12 River Oaks and was very familiar with the patients, so  
13 there's a chance we would be able to work with her when  
14 she got back about having her see certain patients. But  
15 nothing was determined.

16 Q. Okay. Was it your understanding that, I  
17 guess -- did you think at any point she was going to  
18 return to work full-time after vacation?

19 A. No. We had had a conversation and it did seem  
20 like she was -- the hours were too much. She was getting  
21 to tire and I knew she would not come back full-time.  
22 That was something she said to me.

23 Q. So at most she would return to work part-time?

24 A. Correct. And I would say more just kind of  
25 filling in.

1 Q. Filling in. At Sanctuary Hospice, what is the  
2 maximum number of hours you could work a week and still  
3 be considered part-time?

4 A. Twenty-five hours.

5 Q. What was your understanding of how many hours  
6 Ms. Baron would likely return to work part-time?

7 MR. JENKINS: You know, I'm going to object to  
8 that. I believe she's testified that there was no  
9 agreement about that.

10 THE COURT: State your question again.

11 MS. LYALL: I asked if Ms. Baron was to return  
12 to work part-time, what would her understanding of her  
13 hours set be?

14 MR. JENKINS: She's testified that she  
15 hadn't -- they hadn't discussed --

16 THE COURT: I understand that. I understand  
17 that. And I'm going to have to agree with Mr. Jenkins.  
18 But if they --

19 MS. LYALL: I can rephrase to get whatever I'm  
20 trying to get to.

21 THE COURT: That's where we're going with  
22 this. If you could rephrase because you are correct,  
23 that was up in the air. I mean, you've said that.

24 BY MS. LYALL:

25 Q. Let me back up and kind of restate. You said

1 that it was possible or maybe even likely that if she was  
2 to return to work part-time, she would return to work at  
3 the River Oaks position?

4 A. Correct.

5 Q. Do you know how many hours a week that  
6 position --

7 A. I believe she had -- as she said, she had one,  
8 possibly three patients there. On a generous scale, I  
9 would say about an hour for each patient, maybe, three  
10 hours a day for three days a week.

11 Q. So maybe nine hours?

12 A. Nine, ten hours at the most.

13 Q. Nine or ten hours. And do you remember how  
14 much Ms. Baron was paid per hour?

15 A. I believe \$25.

16 Q. So the part-time work ten hours, \$25 an hour,  
17 \$250 a week average?

18 A. I would say so.

19 MS. LYALL: That's all I have.

20 CROSS-EXAMINATION

21 BY MR. JENKINS:

22 Q. A couple of follow-up. You had not made --  
23 discussed with Ms. Baron that she was only going to be  
24 working 25 hours a week after she got back, had you?

25 A. Well, as Ms. Baron said, she would -- she

1 would be done working full-time before she left to go on  
2 her vacation. So that was her last week working  
3 full-time that we had established. The amount of hours  
4 exactly that she would work afterwards within this  
5 part-time position, we weren't quite sure. We didn't  
6 know if it would be a fill-in position where she would  
7 maybe work a couple hours here or there per week if  
8 necessary or if she would keep patients at River Oaks.  
9 Again, it was all something we were going to determine  
10 once she got back.

11 Q. Now, if she had decided when she got back from  
12 vacation that she wanted to continue working a full 40  
13 hours a week, you would have been able to accommodate  
14 that, wouldn't you?

15 A. Honestly, I'm not quite sure. We had already  
16 had the discussion that she was not going to come back  
17 full-time. So we were looking to have, number one,  
18 someone cover her position while she on vacation and then  
19 possibly have someone step into a stronger role. Because  
20 we had already determined she was going to be a  
21 part-time, we had already started to plan to have someone  
22 else fill that full-time position.

23 Q. But prior to her accident, she was -- she was  
24 working I think 90 hours a week plus an additional 30 on  
25 call; is that right?

1           A.     I wouldn't say that was average. There were  
2 definitely times where, as in every position, sometimes  
3 things come up especially in Hospice where there's an  
4 admission and you may work a little bit more. That was  
5 definitely not her standard set schedule.

6           Q.     But, once again, you had not reached an  
7 agreement with her as to how much she was going to work  
8 after she got back?

9           A.     Correct. I just knew it would be part-time or  
10 less. Definitely not full-time.

11          Q.     Do you have any part-time employees now?

12          A.     We do not.

13          Q.     Have you had any part-time employees since she  
14 was involved in her accident last -- I think you said  
15 that you don't have part-time employees there?

16          A.     Correct, especially with the RN position.  
17 Ms. Baron had worked for us long enough that we were  
18 going to try to accommodate her if necessary because she  
19 had come to us and said she wasn't able to work a  
20 full-time schedule.

21          Q.     But you really don't have any part-time  
22 employees?

23          A.     We don't at the moment, no.

24          Q.     And you haven't had any part-time employees  
25 since May of 2012; is that correct?

1 A. Not in the RN position, no.

2 Q. So you really don't know how many hours a week  
3 she would have worked, do you?

4 A. We really didn't know for sure if she was  
5 going to come back to fill that schedule. Just we  
6 weren't sure.

7 Q. I mean, she could have come back to full  
8 schedule or she could have -- you just don't know?

9 A. She could not have come back to full --

10 MR. ALLISON: Objection, Commissioner. He's  
11 asked the question three times and she's answered it the  
12 same way three times.

13 BY MR. JENKINS:

14 Q. Go ahead. I'm sorry.

15 A. She would not have been able to come back  
16 full-time because she had already told us that she was  
17 finished with her full-time position. She would work  
18 part-time or less. So we already started to look for  
19 someone to fill that part-time role. As she said, if she  
20 was working 90 hours every two weeks, we definitely would  
21 need someone to fill that position.

22 Q. Had you hired somebody at that time to replace  
23 her?

24 A. No, this was a relatively new conversation.  
25 So we knew that her full-time was going to end, we were

1 looking to have someone fill that position. We had an RN  
2 that was filling in while she was gone. We were going to  
3 look to, again, have that conversation with her and see  
4 what we needed to fill.

5 Q. So really to say exactly how many hours she  
6 would be working when she got back would be kind of  
7 guessing, wouldn't it?

8 A. Again, it just wasn't determined. We knew it  
9 would not be a full-time schedule.

10 THE COURT: I think we've plowed this road  
11 long enough.

12 MR. JENKINS: All right. That's all I've got.

13 THE COURT: Any other questions, Ms. Lyall?

14 MR. ALLISON: Yes, Commissioner, I do have --

15 THE COURT: Mr. Allison.

16 MR. ALLISON: -- some follow-up on that.

17 THE COURT: Before you do, let me ask a  
18 question. She was getting paid \$25 an hour?

19 THE WITNESS: Yes, sir.

20 THE COURT: If she worked part-time, would she  
21 still be making \$25 an hour?

22 ~~THE WITNESS: She would.~~

23 THE COURT: Okay. Go ahead, Mr. Allison.

24 MR. ALLISON: Thank you.

25 CROSS-EXAMINATION



1 BY MR. ALLISON:

2 Q. You were asked a lot of questions about hours.  
3 I think we've established that there was no agreement  
4 about hours, but this -- but this is what the agreement  
5 was, she was not going to work full-time anymore; is that  
6 correct?

7 A. Correct.

8 Q. Whose decision was that?

9 A. Ms. Baron.

10 Q. She came to you with that decision, correct?

11 A. Yes.

12 Q. And the full-time/part-time distinction is not  
13 only important for hours and assigning tasks, but for  
14 benefits as well; is that correct?

15 A. Correct.

16 Q. Does a part-time -- would a part-time employee  
17 or a employee on the schedule that you contemplated for  
18 her enjoy the same employee benefits as a full-time  
19 worker?

20 A. Part-time positions, they're not eligible for  
21 medical benefits or voluntary benefits or paid time off.

22 Q. Was Ms. Baron aware of that? Did you ever  
23 discuss that with her?

24 A. Yes.

25 Q. So she knew --

1           A.     It was in our employee handbook. It's just a  
2     general regulation.

3           Q.     So it's not just about hours working, but  
4     she's -- it's about the benefits that she would be  
5     entitled to as an employee as well?

6           A.     Correct.

7           Q.     And those benefits were changing no matter  
8     what when she came back from vacation?

9           A.     Correct.

10          MR. ALLISON: That's all I have.

11          THE COURT: Anything else, Ms. Lyall?

12          MS. LYALL: No, sir.

13          THE COURT: Anything else, Mr. Jenkins.

14          MR. JENKINS: Nothing further.

15          THE COURT: All right. Thank you, ma'am. Do  
16     you have other witnesses?

17          MS. LYALL: We do not.

18          THE COURT: Is that your case?

19          MS. LYALL: Yes, sir.

20          THE COURT: That concludes this hearing.

21                 (The hearing was concluded.)  
22  
23  
24  
25

## CERTIFICATE OF REPORTER

I, Kimberly T. Power, Court Reporter and Notary Public for the State of South Carolina at Large, do hereby certify:

That the foregoing transcript of proceedings was taken before me on the date and at the time and location stated on page 1 of this transcript; that the witness was duly sworn to testify to the truth, the whole truth, and nothing but the truth; that the testimony of the witness and all objections made at the time of the proceeding were recorded stenographically by me and were thereafter transcribed; that the foregoing transcript of proceedings as typed is a true, accurate and complete record of the testimony and of all objections made at the time to the best of my ability.

I further certify that I am neither related to nor counsel for any party to the cause pending or interested in the events thereof.

Witness my hand, I have hereunto affixed my official seal this 1st day of June, 2013, at Richland County, South Carolina.

---

Kimberly T. Power, Court Reporter  
Notary Public, State of South Carolina  
My Commission Expires: 07/22/2015

STATE OF SOUTH CAROLINA  
BEFORE THE  
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION  
WCC No. 1206355

Frances Baron,  
Claimant,  
v.  
Sanctuary Hospice,  
Employer,  
and  
Guarantee Insurance Company  
C/O Patriot National  
Insurance Group,  
Carrier/Defendants.

COPY

**FULL COMMISSION PANEL HEARING**

\*\*\*\*\*

**Tuesday, October 15, 2013**  
10:30 a.m. - 11:57 a.m.

The Full Commission Panel Hearing before the South Carolina Workers' Compensation Commission, was taken at the South Carolina Workers' Compensation Commission, 1333 Main Street, Suite 500, Columbia, South Carolina, on the 15th day of October, 2013 before Jill H. Vickers, Certified Court Reporter and Notary Public in and for the State of South Carolina, pursuant to Notice of Deposition.



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EXHIBITS

(There were no exhibits marked during this hearing.)



1 COURT REPORTER: Today is October 15, 2013. This is  
2 South Carolina Workers' Compensation Case  
3 Number 1206355. This is the case of Frances  
4 Baron, Claimant, versus Sanctuary Hospice,  
5 Employer, and Guarantee Insurance Company C/O  
6 Patriot National Insurance Group, is the  
7 Carrier. The Appellant is the Claimant  
8 represented by William G. Jenkins, Jr. The  
9 Respondent is represented by Kathleen G. Lyall.  
10 Each side is allowed ten minutes for oral  
11 argument and three minutes in reply. You are  
12 requested to argue the grounds of exception and  
13 stay within the record.

14 MR. JENKINS: This case involves what is called an  
15 idiopathic -- an accident that resulted from an  
16 idiopathic condition, and that means an  
17 unexplained condition that is personal to the  
18 employee, such as -- in this case, it was what  
19 they -- and I didn't know this word before I  
20 had this case -- a "syncopal episode", which is  
21 just a fancy word for a fainting spell. My  
22 client was driving a car in Jasper County on  
23 May 21st, 2012, and by all accounts in the  
24 medical evidence, she suffered a fainting spell  
25 while operating this automobile. She suffered



1 numerous injuries to the head, the leg. She  
2 had some eye issues, also. The principal issue  
3 here is the construction of 42-1-168, whether  
4 or not this accident arose out of her  
5 employment. I think defendants will stipulate  
6 that she was in the course of her employment,  
7 driving an automobile at the time of the  
8 accident. What they're contesting is, did this  
9 accident arise out of her employment. The  
10 question is, is an idiopathic injury  
11 compensable under the Act. And the law has  
12 evolved going back to the Edge case in 1943.  
13 That case involved a mill worker going outside  
14 to get a breath of fresh air and suffered an  
15 epileptic seizure. Again, that's idiopathic  
16 injury personal to the employee. The employee  
17 fell down the steps, injured himself. The  
18 Supreme Court said that that is not a  
19 compensable injury. They said that in dicta --  
20 they decided the case based on the fact the  
21 claim wasn't timely filed, and then they  
22 volunteered a bunch of other information, and  
23 they said, you know, "Epilepsy doesn't arise  
24 out of your employment". This issue was next  
25 addressed by Bagwell versus Burwell, 1955, and



1 that called into question the 1943 decision in  
2 Edge -- they called the discussion of whether  
3 or not that was a compensable injury, that is  
4 the epileptic seizure was a compensable injury  
5 and called it "dicta", and they said that, in  
6 the Edge case, the attorney for the claimant  
7 never attempted to show that the conditions of  
8 the employment aggravated or exacerbated the  
9 injury. After Bagwell, in 1969, the Supreme  
10 Court took up the case of Turner versus  
11 Campbell Soup. That's a lady -- this lady was  
12 working, suffered an unexplained fall, passed  
13 out. The Supreme Court heard the case and  
14 remanded it back to the full commission to  
15 determine whether or not the pipes that the  
16 lady hit her head on contributed to the  
17 severity of her injuries. In 1998, Crosby  
18 versus Wal-Mart adopted the section from  
19 Larson. It says "Where an employee suffers an  
20 idiopathic or unexplained fall while standing  
21 on a level surface, and in the course of the  
22 fall, hits no machinery, furniture or other  
23 objects such as would contribute to the effects  
24 of the fall, the majority of the jurisdictions  
25 deny compensation". That is, in fact, correct.





1 What we're dealing with here is not a flat  
2 floor fall, but a lady who is driving an  
3 automobile and suffers a seizure. The question  
4 then would be, would the act of driving an  
5 automobile, incident to her employment, as is  
6 the case in this case, would that fact  
7 aggravate the consequences of her syncopal  
8 episode or idiopathic blacking out. I would  
9 further point out that the full commission in  
10 2012 last year has, in fact, adopted what is  
11 called the "Increased Danger Rule". That rule  
12 is set forth in Larson 9.01 as follows: "As a  
13 general rule, injuries attributable to risks or  
14 conditions personal to the employee do not  
15 arise out of the employment, unless the  
16 employment contributes to the risk or  
17 aggravates the injury. When the employment  
18 places the employee in a position of increased  
19 danger such as working above ground, near  
20 operating machinery, sharp objects or in a  
21 moving vehicle and the injury is aggravated or  
22 worsened by the increased danger, then the  
23 resulting injury may deem compensable. That  
24 was adopted by the full commission last year.  
25 It's called the "Increased Danger Rule".



1 That's pretty uniformly across the country been  
2 adopted. The case is Thomas versus Five Star.  
3 There's some additional issues outside the  
4 idiopathic compensability question. The issue  
5 of the compensation rate, we have a Form 20  
6 which is filed in this case. Before this lady,  
7 Mrs.

8 Baron was injured, she had discussed with her  
9 employer the prospect of, after she got back  
10 from vacation, going part-time. They hadn't  
11 come to any concrete agreement about that. I  
12 have -- in the transcript, the transcript has  
13 numerous references by both the claimant and  
14 the employer that say how many hours she was  
15 supposed to work when she got back from  
16 vacation was up in the air. I would direct  
17 your attention to the transcript of record,  
18 Page 22, Lines 10 through 18. The claimant  
19 testified that she had no set plans for how  
20 many hours she would be working, and that she  
21 was going to discuss that with the employer  
22 when she got home from vacation. Page 29,  
23 Lines 23 through 24, they were going to discuss  
24 how many hours she was going to be working when  
25 she got back from her vacation. And Page 35,



1 Lines 14 through 24, if she were to testify how  
2 many hours she would be working when she got  
3 back from vacation, she'd just be guessing.  
4 Page 37, Lines 10 through 17, the employer and  
5 employee had reached no concrete agreement as  
6 to how many hours she was going to work when  
7 she got back from vacation. Of particular  
8 note, and I would stress this particular entry,  
9 Page 39, the employer is testifying, and if you  
10 look at Line 6 through 9, the employer herself  
11 says everything was up in the air. We were  
12 supposed to talk about it when Ms. Baron got  
13 back. They had come to no decision as to how  
14 many hours she was going to be working. Look  
15 at Page 42, Line 3 through 5, "We weren't sure  
16 how many hours she was going to work. It was  
17 something we were going to discuss when she got  
18 back." Page 43, Lines 5 through 12 and 21  
19 through 23, they had not reached an agreement  
20 on hours. Now, they were going to discuss the  
21 prospect of Ms. Baron coming back to work  
22 ~~part-time at some time in the future.~~

23 COMMISSIONER WILKERSON: Is there a finding of  
24 anything in there about that?

25 MR. JENKINS: No.



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1 COMMISSIONER WILKERSON: That's what -- when you  
2 mentioned that, I saw it last night, but I  
3 thought, "Wait a minute, there isn't even a  
4 finding in here."

5 MR. JENKINS: He didn't get to that, because he  
6 found the injury was not compensable, so he  
7 never got to that, but I think the full  
8 commission would be able to make a finding on  
9 that as the ultimate arbiter of questions of  
10 fact, and that's why I put it in my brief. A  
11 couple of more points. At the time Ms. Baron  
12 was injured, all the way through the hearing,  
13 which took place this year, the employer  
14 testified she didn't have any part-time  
15 employees. She hadn't hired anybody to fill  
16 the spot, and the inescapable conclusion from  
17 all these entries in the transcript is, they  
18 hadn't reached any definite agreement as to the  
19 amount of hours that Ms. Baron was going to be  
20 working after she got from that vacation, and  
21 in fact, after the injury. It's certainly our  
22 position that the compensation rate shouldn't  
23 be based on speculation, conjecture or  
24 guessing, and that's all we would be doing  
25 here.



1 COMMISSIONER TAYLOR: Mr. Jenkins, I was going to  
2 let you finish your final thought, but you're  
3 going into a new thought now. Your time has  
4 expired. Okay.

5 MR. JENKINS: Yeah, I'll -- last sentence. And to  
6 find the compensation rate based on future  
7 earning capacity when no agreement had been  
8 reached as to hours would be speculation.  
9 Thank you;

10 COMMISSIONER TAYLOR: Ms. Lyall.

11 MS. LYALL: May it please the Commission. Mr.  
12 Jenkins is correct in that we are stipulating  
13 to the fact that this accident was in the  
14 course of her employment, and really the only  
15 issue we're here for today is to determine  
16 whether the injuries in the accident arose out  
17 of her employment under 42-1-160. There are no  
18 factual issues in dispute. They have even  
19 stipulated that the syncopal episode was the  
20 cause of her accident, and that the syncopal  
21 episode was idiopathic in nature. The doctors  
22 at the hospital evaluated her and could not  
23 come up with a reason as to why she passed out  
24 at the wheel. She testified in her deposition  
25 that she was driving down the road, a light



1 switch went out, she swerved off the road and  
2 hit a tree. We sent her to Dr. Wagener at MUSC  
3 in Charleston. He evaluated her, went through  
4 all the medical records and opined that there's  
5 no cause -- he said "There's nothing relating  
6 to her employment that caused her to run off  
7 the road at the time, and the only relation is  
8 that she was driving in the course of her  
9 employment". And again, Mr. Jenkins, he  
10 accurately depicted the history of the caselaw  
11 dealing with idiopathic injuries dating back to  
12 Edge. Again, Edge involved a claimant that  
13 fell down the stairs and hit his head, and it  
14 was denied, and the cause of the accident was  
15 personal in nature. It was due to an epileptic  
16 seizure and nothing related to work. The Court  
17 further evaluated this matter in Bagwell versus  
18 Burwell, again, as Mr. Jenkins indicated. This  
19 one involved a claimant that was talking to one  
20 of his co-workers, for no apparent reason,  
21 passes out, falls back, faints and hits his  
22 head on the concrete. He ends up actually  
23 dying two days later, and the Supreme Court in  
24 great detail looked at this case and looked at  
25 all the facts surrounding it, and it ended up



1 determining that it was not a compensable claim  
2 because his employment did not have anything to  
3 do with, again, the cause of the fact, and that  
4 it did not bear any relation to the resulting  
5 injury, and that one of the main points that  
6 they had to evaluate was whether the concrete  
7 floor that caused his resulting injuries and  
8 caused his death was something that was common  
9 to the neighborhood, or was it specific to the  
10 employment, and they held that they could not  
11 find the concrete floor to having any special  
12 relationship to employment, because how many  
13 times a day does everybody come across a  
14 concrete floor, it happens frequently. So, in  
15 the end, they ended up saying that they could  
16 not award benefits as his accident did not  
17 arise out of work or out of the employment.  
18 And again, in Turner versus Campbell Soup, they  
19 again outlined the law in this, and they  
20 applied Bagwell and Edge's finding and came up  
21 with a rule for the modern day, how to test  
22 whether an idiopathic injury arises out of the  
23 employment. And so, they determined that you  
24 had to -- they opined that you had to determine  
25 whether the fall bore such consequences as



1 would not have occurred except for the  
2 employment. In other words, they must inquire  
3 whether the employment contributed to the  
4 effects of the fall, and again, in this case,  
5 it was a fall. And then they say that the  
6 employment has subject to the workman to a  
7 special danger which in fact resulted in an  
8 injury. So, when those three cases are applied  
9 to the facts of the present case, there is no  
10 relation, again, between -- similar to the  
11 concrete floor, there is nothing that can point  
12 to an automobile as being not common to the  
13 neighborhood. Everybody drives every day. In  
14 fact, in this case, the claimant was driving on  
15 the road that she would have been driving on to  
16 go home. She's near her house, same road that  
17 she drove on frequently, as she testified in  
18 her deposition.

19 **COMMISSIONER WILKERSON:** If she had run into the  
20 back of a car, would it be compensable?

21 **MS. LYALL:** Yes, it probably would be, but the  
22 difference is that it was something -- the  
23 cases in Larson actually states that -- and in  
24 Bagwell versus Burwell, and one of the main  
25 differences is that the cause of the accident





1 when it's idiopathic in nature is personal.  
2 It's completely a personal issue, and what they  
3 -- how they outline it.

4 **COMMISSIONER WILKERSON:** So, your argument is, the  
5 proximate cause of the accident is her passing  
6 out?

7 **MS. LYALL:** Exactly, and that's what -- and I think  
8 even claimant's attorney will stipulate to the  
9 fact that the proximate cause was the accident.  
10 You know, she indicated she was driving along  
11 feeling great and then fell over and passed  
12 out. And in Bagwell versus Burwell, which is  
13 still good law in South Carolina, they cited  
14 Larson where he stated -- when he's talking  
15 about the class of idiopathic cases, he states  
16 "What is to be done about ..." -- "What, then,  
17 is to be done about this class of cases? One  
18 thing is certain. The statute will not prevent  
19 the scrapping of the principal that the  
20 employee must contribute something to the  
21 hazard of the fall, especially since the injury  
22 stems originally from such an overwhelmingly  
23 personal source as internal weakness or  
24 disease".

25 **COMMISSIONER JAMES:** There are some other



1 jurisdictions that do use the transportation,  
2 truck drivers, any -- and because it increases  
3 the resulting injury.

4 **MS. LYALL:** Right. And that is one thing that they  
5 pointed out in their brief. And North Carolina  
6 is one that does, and obviously, South Carolina  
7 does look to North Carolina in some instances.  
8 However, North Carolina relies on the Increased  
9 Risk Doctrine, and so North Carolina has  
10 adopted the Increased Risk Doctrine. And I  
11 know the Commission is all well aware, less  
12 than a month ago, South Carolina Court of  
13 Appeals, they did not decline, or they did not  
14 refuse the Increased Risk Doctrine, but they  
15 did have the opportunity to adopt it in South  
16 Carolina, and that, at this time, have not yet.  
17 So, when you look at South Carolina Law, that  
18 is an existence ---

19 **COMMISSIONER JAMES:** And I'm just trying to figure  
20 all this along with y'all. The pipe would be  
21 an Increased Risk of that particular  
22 employment?

23 **MS. LYALL:** Right.

24 **COMMISSIONER JAMES:** So, how is the car different?

25 **MS. LYALL:** The really distinguishing line in, I



1 think all of these cases, is it can't be  
2 something common to the neighborhood, and  
3 that's a phrase used all the time, and so  
4 that's why maybe a pipe if you're working in a  
5 company that deals with pipes and has pipes  
6 there, that's not something -- if I fell right  
7 now, I'm going to hit my head on a pipe. I  
8 don't deal with exposed pipes frequently. It's  
9 not common to the neighborhood. But something  
10 like cement floors would be completely common  
11 to the neighborhood. Every day when you're  
12 walking, you're walking past cement, so that's  
13 not something specific to the employment, and  
14 again, the phrase that they used is that the  
15 employment itself must subject the workman to  
16 special danger, and it has to have -- the  
17 employment must contribute to effect. And so,  
18 again, in this case, driving would not be  
19 something that would be -- or it is common to  
20 the neighborhood. It's not something specific  
21 to the employment. Everybody drives. And  
22 there was a full commission case that did and  
23 relatively similar facts apply the Increased  
24 Danger Rule. South Carolina Appellant Courts  
25 have not specifically adopted that. That was



1 something done by the full commission, and it  
2 does not hold complete precedential value  
3 today, but the difference in that one was, that  
4 was a bus driver who was employed as a bus  
5 driver and driving a bus, and the driving of  
6 the bus did increase his injury. Driving a bus  
7 is not common to the neighborhood. I've never  
8 driven a bus. It's not something I do on  
9 day-to-day basis or something I'm normally  
10 exposed to.

11 **COMMISSIONER JAMES:** So, a truck driver, in your  
12 analogy, could be different because it's not a  
13 common thing?

14 **MS. LYALL:** Right, but driving a vehicle would be  
15 something commonplace, and something everybody  
16 over the age of 16 does daily, and there's no  
17 evidence whatsoever that, you know, there was  
18 any increase because -- you know, any  
19 difference in the accident had she been driving  
20 to the grocery store versus somewhere else,  
21 where a truck driver, obviously, if he runs off  
22 the road in his truck compared to a day-to-day  
23 car, there probably will be a difference in the  
24 resulting injuries, and that's really what  
25 needs to be shown is that there bears a



1 consequence in the resulting injury. So,  
2 again, the North Carolina cases that I relied  
3 on heavily in the Appellant's Brief do deal  
4 with the Increased Risk Doctrine, and that is  
5 the law in North Carolina. So, that's  
6 something a little bit different than with  
7 South Carolina, and again, Larson's and North  
8 Carolina cases under another jurisdiction are  
9 persuasive and can be looked at, but they do  
10 not hold precedential value in this claim.  
11 What holds precedential value is the line of  
12 cases, Bagwell, Edge and Turner, which all  
13 culminate in saying that "The employment must  
14 contribute to the fall and bears special -- or  
15 contribute to injury and bears a special  
16 relationship to the injury, and it cannot be  
17 common to the neighborhood", and when you apply  
18 that law which is the existing juris prudence  
19 in the state of South Carolina, then I believe  
20 the full commission should affirm the single  
21 commissioner's ruling. With regards to the  
22 compensation and average weekly wage issue,  
23 there's one thing that both sides agree on, is  
24 that she was not going to return to work full  
25 time. We had different numbers come up.



1 Ms. Baron, the claimant, testified that she  
2 might work three days a week, three hours a  
3 day. We kind of came up with a figure of 18.  
4 The employer testified, at max, under their  
5 handbook, the most she could work is 25. So,  
6 we're asserting that somewhere between 18 and  
7 25, even given the 25, that's an average weekly  
8 wage of \$625, and as Sellers versus Pinedale  
9 Residential Center held, the wage calculation  
10 should be based on future earning capacity.  
11 Thank you.

12 **COMMISSIONER TAYLOR:** Mr. Jenkins.

13 **MR. JENKINS:** Yes. Let me very quickly address,  
14 counsel for tempoyer is saying, if you're  
15 driving a bus incident to your employment and  
16 you get in a -- have an idiopathic fainting  
17 spell, syncopal episode, whatever you want to  
18 have, that's compensable, but if you're a  
19 registered nurse going from place to place to  
20 people's homes to care for them driving a  
21 vehicle, that is not compensable? That does  
22 not make any sense. I mean, that distinction  
23 has no rational basis to it, and therefore, I  
24 would contend it should be disregarded.

25 **COMMISSIONER WILKERSON:** Is she paid for her



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1 driving, or is she paid once she arrives?

2 MR. JENKINS: Well, she was paid mileage for going  
3 from place to place. I believe that's correct.  
4 But they're ---

5 COMMISSIONER JAMES: They're not contesting course,  
6 though?

7 MR. JENKINS: No, they're not contesting course. I  
8 mean, that's a given.

9 COMMISSIONER JAMES: And whether you agree with her  
10 or not, she gives a reason for the distinction.

11 COMMISSIONER TAYLOR: And it's my understanding,  
12 she's talking about a distinction in other

13 jurisdictions anyway. South Carolina hasn't  
14 commented on either one.

15 MR. JENKINS: Well, yes, they have.

16 COMMISSIONER TAYLOR: Haven't adopted it.

17 MR. JENKINS: They haven't specifically adopted  
18 Larson, but if you look at the Bagwell case,  
19 the Court quoted a New York called Connolly  
20 versus Samaritan which says, "In saying that  
21 if, except for the employment, the fall, though  
22 due to a cause not related to the employment  
23 would not have carried the consequences it did  
24 but for the conditions of employment, then  
25 causal connection is established between the



1 injury and the employment, and the incidental  
2 injury arose out of the employment". That's  
3 the functional equivalent of adopting the  
4 Increased Danger Rule that's set forth in  
5 Larson. Now, here's another point. She quotes  
6 what is something called the "Increased Risk  
7 Doctrine". That's not -- that's what was  
8 addressed very recently by the South Carolina  
9 Supreme Court. That's not the same as the  
10 Increased Danger Rule. And if you look at  
11 Larson, and I brought some copies of that with  
12 me, and I can hand that up of Larson 9.01. May

13 I approach?

14 **COMMISSIONER WILKERSON:** Sure.

15 **COMMISSIONER TAYLOR:** You're going to use up your  
16 time. You can finish your argument and give it  
17 to us afterwards.

18 **MR. JENKINS:** Okay. Anyway, in Larson 9.01 which is  
19 the discussion of the Increased Danger Rule, if  
20 you go down and look at 9.14(B), they explain  
21 that this is not the same thing as the  
22 Increased Risk Rule which the South Carolina  
23 Court has rejected. These are not the -- those  
24 two are not the same thing. The Increased  
25 Danger Rule is unique to the idiopathic injury



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1 cases. Additionally, every court in this  
2 country that I have been able to find that  
3 passed on whether or not an idiopathic passing  
4 out while driving a vehicle incident to your  
5 employment is compensable has ruled it  
6 compensable. Counsel can't show me one case in  
7 any jurisdiction where, if you're driving in a  
8 car while you're working, that it hasn't been  
9 ruled compensable, and I've listed many many  
10 cases from jurisdictions all over the country  
11 in my brief on that, particularly North  
12 Carolina.

13 COMMISSIONER TAYLOR: Okay. Thank you.

14 (Whereupon, the Full Commission Panel Hearing  
15 concluded at 11:57 o'clock a.m.)  
16  
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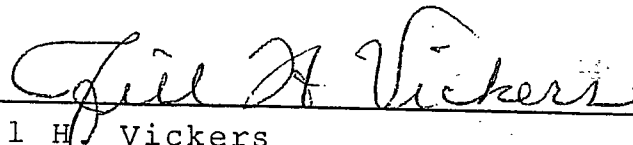


**CERTIFICATE**

This is to certify that the within hearing consisting of twenty-two (22) pages, is a true and correct transcript of the testimony given by said witnesses after being duly sworn; said hearing was reported by the method of Stenotype with Backup.

I further certify that I am neither employed by nor related to any of the parties in this matter or their counsel; nor do I have any interest, financial or otherwise, in the outcome of same.

IN WITNESS WHEREOF I have hereunto set my hand and seal on November 21, 2013.



Jill H. Vickers  
Certified Court Reporter

Notary Public for South Carolina  
My Commission Expires: July 5, 2016

BEFORE THE SOUTH CAROLINA  
WORKERS' COMPENSATION COMMISSION

FRANCES BARON,  
Employee,

vs.

WCC NO. 1206355

SANCTUARY HOSPICE,  
Employer,

and

GUARANTEE INSURANCE COMPANY C/O  
PATRIOT NATIONAL INSURANCE GROUP,  
Insurer.

DEPOSITION OF: FRANCES BARON

DATE: July 2, 2012

TIME: 1:05 PM

COPY

LOCATION: Jenkins & Esquivel, PA.  
114 Executive Center  
Hilton Head Island, SC

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A. WILLIAM ROBERTS, JR., & ASSOCIATES

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14 ALSO PRESENT:

15 Edward J. Baron  
16  
17

18 (INDEX AT REAR OF TRANSCRIPT)  
19  
20  
21  
22  
23  
24  
25

[illegible]

\* \* \* \* \*

being first duly sworn, testified as follows:

BY MS. LYALL:

A. Okay.

A. No, ma'am.

A. Okay.

1 Q. -- so she can take down everything you  
2 say. Also if I ask you a question that requires a  
3 yes or a no, I'm going to ask that you say yes or  
4 no and not uh-huh or huh-uh.

5 A. Okay.

6 Q. If at any time if you'd like to take a  
7 break just let me know --

8 A. All right.

9 Q. -- and we'll be glad to do that. And  
10 if you have any questions, I'm not here trying to  
11 trick you or mislead you, I'm just trying to figure  
12 out exactly what's going on.

13 A. Okay.

14 Q. So let me know any questions. And if  
15 you answer my question, I'm going to assume that  
16 you understood and that you're telling the truth --

17 A. Okay.

18 Q. -- is that fair?

19 A. Uh-huh.

20 Q. Okay.

21 MR. JENKINS: Yes?

22 THE WITNESS: Yes.

23 MS. LYALL: Thank you.

24 BY MS. LYALL:

25 Q. And could you please state your full

1 name for the record.

2 A. My full name?

3 Q. Yes.

4 A. Frances Albina Baron. I guess that's  
5 what you want.

6 Q. That is. And have you ever gone by a  
7 different name?

8 A. No. My maiden name.

9 Q. And what was your maiden name?

10 A. Murm, M-U-R-M.

11 Q. Okay. And how old are you today?

12 A. 70.

13 Q. And what's your birthday?

14 A. [REDACTED]

15 Q. And what's your current address?

16 A. [REDACTED]  
17 [REDACTED]

18 Q. And how long have you lived there?

19 A. Three, four years.

20 Q. Have you always lived in [REDACTED]  
21 [REDACTED]?

22 A. No.

23 Q. Where else have you lived?

24 A. [REDACTED]

25 Q. Anywhere else?

6

1 A. I was born and raised in [REDACTED].  
2 My husband was military.

3 Q. Okay.

4 A. So we have 18 other stops if you want  
5 to...

6 Q. That's okay. And what's your home  
7 phone number?

8 A. ([REDACTED]) [REDACTED].

9 Q. Do you have a cell phone?

10 A. I do.

11 Q. And what's your cell phone number?

12 THE WITNESS: Did you bring the blue  
13 thing in? I -- I have it taped to the back. I  
14 never do remember my cell phone number.

15 MR. BARON: I'll look it up for you. I  
16 don't remember it. When you have a cell phone, you  
17 don't have to worry about it. I'm getting there.

18 THE WITNESS: Did you bring the blue  
19 bag in? I have it in there.

20 MR. BARON: Phone number  
21 ([REDACTED]) [REDACTED].

22 MS. LYALL: Thank you.

23 BY MS. LYALL:

24 Q. And this is your husband here with you  
25 today?



1 A. Yes.

2 Q. And how long have y'all been married?

3 A. 50 years.

4 MR. BARON: And ten months.

5 MS. LYALL: Not that he's counting.

6 MR. BARON: Matter of fact is today the  
7 2nd? Today's the 2nd?

8 THE WITNESS: Uh-huh.

9 MR. BARON: 10 months -- 50 years and  
10 10 months today.

11 MS. LYALL: Wow. Congratulations.

12 BY MS. LYALL:

13 Q. And this might cause some more having  
14 to look up. Do you know your husband's cell phone  
15 number?

16 A. [REDACTED]...

17 MR. BARON: ([REDACTED]) [REDACTED].

18 THE WITNESS: It's listed under Ed in  
19 the menu.

20 BY MS. LYALL:

21 Q. And does your husband currently work?

22 A. No.

23 Q. Okay. And what's your social security  
24 number?

25 A. Oh, goody. [REDACTED].

1 Q. Do you have a South Carolina driver's  
2 license?

3 A. Yes.

4 Q. Do you know that number?

5 A. No, because in [REDACTED] it was your  
6 social security number so I -- and it's not the  
7 same here.

8 Q. Right.

9 A. Yeah.

10 Q. Did you drive here today?

11 A. No.

12 Q. Do you have any children?

13 A. Two.

14 Q. How old are they?

15 A. My son may turn [REDACTED] and my daughter is  
16 [REDACTED]

17 Q. What's your daughter's name?

18 A. [REDACTED].

19 Q. Do either of them live with you?

20 A. I -- we live with her.

21 Q. How long have you lived with her?

22 A. Well, we put an apartment onto the  
23 garage and it was part time and then my son-in-law  
24 went to Iraq and we came down to help with the  
25 children and -- four -- four years primarily.

1 MR. BARON: Three to four years.

2 THE WITNESS: Yeah, three to four  
3 years.

4 BY MS. LYALL:

5 Q. How many children does she have?

6 A. Two.

7 Q. How old are they?

8 A. A 14-year old girl and a 21-year old  
9 boy.

10 Q. And do the both live in the house with  
11 you?

12 A. They do.

13 Q. Does anybody else live in the house  
14 with you?

15 A. No.

16 MR. BARON: Two dogs.

17 THE WITNESS: Yeah, the dogs.

18 BY MS. LYALL:

19 Q. Is your daughter's family and her  
20 children, are they dependent on you for support?

21 A. No. My son-in-law is a lieutenant at  
22 the police department in Hardeeville.

23 Q. Okay.

24 A. And my daughter just got a job about  
25 four a half months ago. She was off for quite a

10

1 while. She worked for a construction company.

2 And my son -- grandson works between  
3 Pizza Hut and Olive Garden.

4 Q. Great. Is there anybody else that's  
5 dependent on you for support?

6 A. No.

7 Q. Okay.

8 A. Nope.

9 Q. Great. We're going to get into your  
10 background a little bit.

11 A. Uh-huh.

12 Q. Where did you graduate high school?

13 A. [REDACTED]. We joined that year.  
14 It used to be [REDACTED] but the last year it  
15 was [REDACTED] in [REDACTED]  
16 [REDACTED].

17 Q. And you graduated from there?

18 A. Yes.

19 Q. When did you graduate?

20 A. [REDACTED]

21 Q. Did you attend any school after high  
22 school?

23 A. Washington School of Nursing,  
24 Washington, Pennsylvania. Three-year diploma. RN  
25 program.

1 Q. And when did you complete that?

2 A. '62.

3 Q. Do you have any other certificates or  
4 licenses?

5 A. No.

6 Q. Any other formal education?

7 A. No, just on what they call CEUs and on  
8 the jobs and...

9 Q. CEUs, like continuing education?

10 A. Yeah, yeah. And no matter where you  
11 worked there's so many in-services that they  
12 provide for you per year and so forth.

13 Q. Okay.

14 A. Yeah.

15 Q. Do you have a computer?

16 A. Yes.

17 Q. Are you able to surf the web --

18 A. No.

19 Q. -- and check your e-mail?

20 A. No. I have no e-mail. I play games.

21 Q. What games do you like to play?

22 A. Bejeweled and Spider Solitaire and  
23 Password. Very little do I do on the computer. I  
24 can do one or two things, but...

25 Q. Okay. And have you ever been charged

12

1 with or convicted of a crime?

2 A. No.

3 Q. Any military experience?

4 A. No. My husband was in the military.

5 Q. Have you ever filed a lawsuit before?

6 A. No.

7 Q. Have you ever been sued?

8 A. No. I don't think so.

9 Q. Is this your first workers'  
10 compensation claim?

11 A. Yes.

12 Q. Without filing a claim, have you ever  
13 been injured on the job?

14 A. No. No. I haven't been injured on the  
15 job. Sometimes, you know, when you pull patients  
16 and so forth like that over the years that has an  
17 accumulative effect, you know, transferring and  
18 everything. But you try to use good body mechanics  
19 and always get somebody to help you. But not  
20 injured injured.

21 Q. Okay.

22 A. And I think for 71, my body is still  
23 doing pretty well.

24 Q. Have you ever been involved in a car  
25 wreck before?

1 A. Yes.

2 Q. Have you been involved in a car wreck  
3 prior to the accident we're here for today?

4 A. Uh-huh.

5 Q. And when was that?

6 THE WITNESS: Do you remember the year  
7 Edward?

8 MR. BARON: When mom died.

9 THE WITNESS: Yeah. His mother -- we  
10 were in Pennsylvania and his mother had a stroke.

11 Eight years -- ten years?

12 MR. BARON: No.

13 THE WITNESS: Eight?

14 MR. BARON: Six to eight years ago.

15 THE WITNESS: Yeah.

16 BY MS. LYALL:

17 Q. And just -- just I guess to clarify,  
18 when I ask a question we're going to have to not  
19 rely on your husband --

20 A. Oh, I'm sorry.

21 Q. -- for the answers. It's okay. It's  
22 okay. I should have clarified that from the  
23 beginning.

24 A. Okay.

25 Q. We'll just -- we'll just need to --

14

1 A. Yeah.

2 Q. -- just with us talking and everything.

3 A. Yeah.

4 Q. But -- so you were involved in an  
5 accident about eight years ago?

6 A. Yeah. Uh-huh.

7 Q. Were you injured?

8 A. No. I -- I got jerked with my seatbelt  
9 but I didn't even go to the hospital.

10 Q. And were you driving?

11 A. No.

12 Q. Was there any settlement? Any money  
13 received for that accident?

14 A. I don't remember any.

15 Q. Okay. Is that the only accident you've  
16 been involved in?

17 A. Yes. That's enough.

18 Q. Okay. Who is your family doctor?

19 A. Trish Etheridge.

20 Q. You said Etheridge?

21 A. Yes.

22 Q. And where -- where is that?

23 A. Ridgeland.

24 Q. Ridgeland. Do you know the name of the  
25 practice?



1           A.    I think it's family medicine or family  
2 medical practice.

3           Q.    Okay.  Do you have any other family  
4 doctors?

5           A.    Well, no, I don't have any other family  
6 doctors.  I mean, I'm going to a variety of doctors  
7 now because of the accident, but...

8           Q.    Were you seeing any other doctors  
9 before the accident?

10          A.    No.

11          Q.    Prior to the -- prior to the accident,  
12 what medications were you on?

13          A.    I take luck Glucophage.

14          Q.    Could you spell that?

15          A.    G-L-U-O-P-H-A-G-E (sic).

16          Q.    And what do you take that for?

17          A.    Sugar.

18          Q.    Okay.

19          A.    Okay.  And then I take calcium with  
20 Vitamin D.  And I had part of my thyroid removed  
21 two years ago and that's with the parathyroid part  
22 that was removed.  And I take Lisinopril.

23          Q.    And what do you take that for?

24          A.    Blood pressure.  It's -- it's a dual  
25 one.  It's for kidneys because of being a diabetic

16

1 it makes your kidneys work better.

2 Q. And any other medications?

3 A. Oh, yes. Don't ask me to spell this  
4 one. Xalatan, they're eye drops. I never quite  
5 got to glaucoma. A few pressures behind. But I am  
6 being treated with that. And I take a multivitamin  
7 a day. And I do take CoQ10.

8 Q. And what is that for?

9 A. It's -- it's something that enhances  
10 your heart. Makes you help -- health -- heart  
11 healthy.

12 Q. Is that a prescription?

13 A. No, it's over the counter.

14 Q. Okay. Were you taking all of those  
15 medications on May 21st --

16 A. Uh-huh.

17 Q. -- when you were involved in the  
18 accident?

19 A. Uh-huh.

20 Q. So those were all daily?

21 A. Those are daily but I take half of them  
22 at bedtime.

23 Q. Okay. So half in the morning and half  
24 at bed time?

25 A. Uh-huh. Uh-huh.

1 Q. Okay. Have you worked since May 21st?

2 A. No.

3 Q. Okay. We're going to talk about your  
4 employment history starting with your most recent  
5 job for Sanctuary Hospice. When did you start  
6 there?

7 A. It'll be two years in August.

8 Q. And what was your job title?

9 A. I'm an RN.

10 Q. And what were your duties there?

11 A. You visited patients on a daily basis  
12 and help facilitate in the dying process. We have  
13 a team that we work with, CNAs, nurse, pastor, and  
14 social worker.

15 Q. Okay. And is that the same position  
16 you've held the whole two years?

17 A. Uh-huh.

18 Q. And how many days per week did you  
19 work?

20 A. I was working five days a week, seven  
21 sometimes, but I was -- was considered a full-time  
22 employee.

23 Q. And how many hours a day did you work?

24 A. They just changed -- they just  
25 averaged, but, you know 8, 9, sometimes 12.

1 MR. JENKINS: How many days a week did  
2 you say?

3 THE WITNESS: Five days a week. And  
4 then we took on-call so there was Saturdays and  
5 Sundays you would go out and make visits for.

6 BY MS. LYALL:

7 Q. And what was your schedule, your daily  
8 schedule while working? You said you visited  
9 different houses?

10 A. Uh-huh.

11 Q. How many houses a day would you visit?

12 A. I was primary at River Oaks which is an  
13 assisted living facility. And then I -- it  
14 depended on our census if I picked up other  
15 patients, you know, in the community. And at that  
16 time I had two patients, one they gave to another  
17 nurse because she lived in Beaufort and the other  
18 one I did keep, the one he was in Ridgeland. And I  
19 had three at the assisted living facility.

20 Q. What was your typical routine from  
21 leaving your house in the morning throughout work?  
22 Would you typically go to River Oaks first thing in  
23 the morning?

24 A. It -- it depended on the patients. I  
25 had an actively dying patient at that time, so I

1 went to visit him first. He lived right there in  
2 Ridgeland. And then from Ridgeland I went on to  
3 River Oaks and saw the other three patients and  
4 then was returning back to the office. And  
5 every -- every day is different. It just -- yeah.

6 Q. Would you typically go into the office  
7 before work?

8 A. Since I lived so close, most of the  
9 days I would probably start in the office.

10 Q. By most of the days, approximately how  
11 many days a week do you think?

12 A. Five.

13 Q. What about going to the office after  
14 work?

15 A. Yes. Yeah, we tried to end up --  
16 because they wanted our time sheets, so whenever  
17 possible we would go back to the office and put in  
18 our time sheets for the day. You don't always get  
19 a chance to do that, but that was your objective.

20 Q. How many days a week would you go into  
21 the office after work?

22 A. Probably close to all five of them.

23 Q. Were you instructed to come into the  
24 office after work?

25 A. Well, they -- they wanted our time

1 sheets, yeah. They wanted our sheets as quickly as  
2 possible. And if not then, very first thing in the  
3 next morning.

4 Q. Did anybody in particular request the  
5 time sheets to be brought in at -- at the end of  
6 the shift?

7 A. Yeah, the one -- the girls in the  
8 office. And I think it came from Penny, you know,  
9 who was doing payroll. Will also asked for it.  
10 I'm not sure who generated it. But, you know, they  
11 wanted us to get it in -- get it in in a timely  
12 manner.

13 Q. Were you paid mileage?

14 A. Yes.

15 Q. And for -- for what were you paid  
16 mileage? Were you paid mileage I guess from your  
17 home to the office?

18 A. No.

19 Q. But once you were out of the office --

20 A. Yes.

21 Q. And were you paid mileage from your  
22 last stop back home?

23 A. Not if you went to the office. You --  
24 you were paid mileage from your last point back to  
25 the office, but once you left the office at the end

1 of the day and went home, no, you didn't get  
2 mileage.

3 Q. What were your typical working hours  
4 during a day?

5 A. Well, we started in the office about  
6 8:30. On Mondays we had a staff meeting there all  
7 the time and they -- we tried to keep Mondays as  
8 paperwork day where you got all your paperwork and  
9 everything done. But I had a -- a lady who needed  
10 dressing changes on Mondays, Wednesdays, and  
11 Fridays so that didn't turn out to be my paperwork  
12 day. After my meeting, I just go on and do my  
13 visits.

14 Q. And what time would you typically leave  
15 River Oaks in the afternoon?

16 A. There's never a typical time. There --  
17 I don't know that we ever have any same days. Like  
18 on a Monday, I would just get there late.  
19 Sometimes I didn't leave until 4:00. On the other  
20 days I could be leaving by 11:00, 12:00.

21 Q. So you didn't have set hours --

22 A. Oh, no.

23 Q. -- you were -- you were required to  
24 work?

25 A. No. I mean, no, no set time.

1 Q. Right.

2 A. Like I said, if they called you and  
3 said this man fell, well, then you changed  
4 everything and that's where you went, you went to  
5 go check him out. Because hospice is primarily  
6 designed to keep the persons from going back into  
7 the hospital.

8 Q. Right.

9 A. So -- and our care is -- is geared to  
10 that. So if you have a fall or if you have someone  
11 throwing up or if you have somebody vomiting or  
12 whatever, then they go to the top and that's the  
13 first visit you go and make.

14 Q. Okay.

15 A. Yeah.

16 Q. If you were finished making your rounds  
17 and finished at River Oaks early --

18 A. Yes.

19 Q. -- would you return to the office?

20 A. I was going back to the office, yes.

21 Q. Routinely would you --

22 A. Yes. Yeah.

23 Q. And what -- what would you do at the  
24 office?

25 A. Well, you have to do your time sheets.



1 Of course you can't do that until the end of the  
2 day. But also if there were any changes in your  
3 patients, you have to update your nursing care  
4 plan. And if you have to call a doctor for orders.  
5 If you have to call other agencies for anything.

6 Sometimes you have messages on your  
7 desk, the family member wants you to call on  
8 something so you return that phone call.

9 Q. Do you have a personal desk in your  
10 office?

11 A. Uh-huh. Yes.

12 Q. Did you use your own personal car?

13 A. Yes.

14 Q. What time would you typically get home  
15 every day?

16 A. See, nothing is typical, but a lot --  
17 after 5:00. Between 5:00 and 6:00 I'd say.

18 Q. How many people work out of the office?

19 A. People or -- you have the two  
20 secretaries. Now, Will and Penny are there so  
21 that's four. One, two, three, four -- five of the  
22 nurses, our chaplain, and our social worker. And  
23 then our aides come in at the end of the day also  
24 to do their charting.

25 Q. Are they required to come in at the end

1 of the day?

2 A. Required? Preferred. You'd have to  
3 ask the aides that one exactly, because I don't  
4 know.

5 Q. But it's your understanding that  
6 they're preferred to come in, not required?

7 A. Do -- yeah, do their time sheets and do  
8 their charts -- their patient's charts.

9 Q. On the days you would go into the  
10 office, would you see other people and talk to  
11 other people after -- at the end of your -- after  
12 leaving River Oaks and coming to the office, would  
13 you typically see Penny and Will and talk to them?

14 A. Oh, yeah. It just -- yeah, that varied  
15 from day to day if they were there.

16 Q. But you usually would see somebody?

17 A. Yes. We have the two secretaries  
18 there. One is a -- is a personal assistant. She's  
19 going to kill me for calling her a secretary.

20 Q. I won't tell her.

21 A. Okay. The two ladies are there.

22 Q. So routinely you would go from River  
23 Oaks back to the office?

24 A. Uh-huh. Uh-huh.

25 Q. And you estimated five days a week?

1           A.    It could be as many as five days a  
2 week. The minimum was three days a week if nothing  
3 else was going on Monday, Wednesday and Friday,  
4 because I had one patient that had dressing changes  
5 and I could see my other patients while I was  
6 there, so usually I wouldn't go Tuesdays and  
7 Thursdays if I didn't have to.

8           But, see, the census there changed  
9 rapidly on me because at the turn of the year I had  
10 almost 14 patients and I was down now to 3, so...

11          Q.    Prior to the accident, you were working  
12 full time?

13          A.    Yes.

14          Q.    Were you planning on continuing to work  
15 full time?

16          A.    No, we had made arrangements after my  
17 vacation I was going to go on call.

18          Q.    And when was that going to take effect?

19          A.    You told me not to look at my husband.  
20 Okay. The week I had the accident was the 20 --  
21 was that Monday. I was going on vacation that  
22 Saturday. Friday was my last -- Monday, Wednesday,  
23 and Friday I was going to work that week and  
24 Saturday I was going to start a two-week vacation.

25          Q.    Did you have set hours or days that you

1 would be on call?

2 A. No. We hadn't really talked too much  
3 about that. It was going to transition to --  
4 depending on the census when I got back and  
5 everything.

6 Q. Okay.

7 A. So that would -- that was to be worked  
8 out. Yep.

9 Q. And who was your direct supervisor at  
10 the time of the accident?

11 A. Steve Gerald is our clinical director.

12 Q. Was he over River Oaks?

13 A. No.

14 Q. Or the -- over --

15 A. He works for hospice.

16 Q. Okay. Did you have a supervisor at  
17 River Oaks?

18 A. Not truly. The administrator and his  
19 wife that were in charge, we would report to each  
20 other and talk to each other. Of course, Dr.  
21 LaCavera would -- I mean, he's the doctor that I  
22 saw the patients with so, of course, you know, he  
23 would be over me giving me orders and so forth.

24 Q. And what was his name?

25 A. Dr. Richard LaCavera, L-A capital

1 C-A-V-E-R-A.

2 Q. How many people were employed in the  
3 same position as you as an RN?

4 A. Let's see. We have Wanda, Kathy,  
5 Catherine, Eva, Chris, five -- oh, and Margaret  
6 came on as our weekend RN. So five and she's the  
7 sixth one that was just hired.

8 Q. And all those people you just named  
9 were all at River Oaks with you?

10 A. Oh, no.

11 Q. Those --

12 A. I was the only one that ever went to  
13 River Oaks.

14 Q. Would you please repeat all those  
15 names?

16 A. Wanda.

17 Q. Do you know Wanda's last name?

18 A. Gervoy. I can't spell it. Kathy  
19 Perez, Catherine Kennedy, Eva Brown, and Chris.  
20 She works at the other office. What is her name?  
21 I can't think of it right now. It's C-H-R-I-S.

22 Q. Okay. But you were the only one that  
23 would go to River Oaks?

24 A. Uh-huh.

25 Q. Would you usually check in or would you

1 sometimes check in with people from the office  
2 throughout the day?

3 A. Would I call them?

4 Q. Yes.

5 A. Almost no for any reason. If I had a  
6 problem, I'd call the doctor, tell them and then I  
7 would let Steve know as to what would be going on  
8 with the patients if it would change the condition,  
9 if somebody was really, you know, deteriorating  
10 very quickly.

11 Q. Okay.

12 A. Something like that. But just to call  
13 back into the office, no.

14 Q. Did -- did you ever update anybody with  
15 your schedule or where you would be?

16 A. No, because I was the one that went to  
17 River Oaks and that's -- when I left -- when we  
18 leave the office in the morning we usually told the  
19 girls, the ladies, you know, going to -- well, me  
20 since I'd almost primarily went to River Oaks, but  
21 when I told them I was going to this other  
22 patient's first and then to River Oaks we usually  
23 told them that.

24 Q. Okay.

25 A. Just out of courtesy to let them know

1 where we were. But, of course, they called us on  
2 our cell phones, so...

3 Q. On the day of the accident, had you  
4 talked to anybody on the telephone?

5 A. I don't believe I did. Are you -- can  
6 you explain that again?

7 Q. Sure.

8 A. Just in the part of working or...

9 Q. Sure.

10 A. Before the accident you said?

11 Q. Right. Before the accident --

12 A. Yeah.

13 Q. -- had you talked to anybody from your  
14 office or anybody related to work?

15 A. I don't -- I don't think I spoke to  
16 anybody that day.

17 Q. Okay. Had you talked to your husband?

18 A. That day?

19 Q. Yes, that day.

20 A. I call him very often -- very little.

21 No, I did not.

22 But what I did do after the accident  
23 when I -- I got out of the car and came up and sat  
24 down and there was a lady there helping me and I  
25 did take my cell phone out and I did call Vicky.

1 Well, she -- I called the office number. Vicky is  
2 the one that answered. She was up in the Hampton  
3 office.

4 Q. Okay. Before we get too much into the  
5 accident --

6 A. Uh-huh.

7 Q. -- I'm going to go over your medical  
8 history just a little bit.

9 A. Okay.

10 Q. Have you ever had any surgeries prior  
11 to this accident?

12 A. Yes, I had my thyroid removed and  
13 parathyroid. And, like I said, it was two years  
14 ago this June.

15 Q. And where did you have that done?

16 A. I'm still having some trouble with  
17 names. Lake Norman Hospital.

18 I had my gallbladder removed when I was  
19 like 30. And that was at Union Town Hospital.

20 And I had part of my ovaries and my  
21 appendectomies (sic) removed when I was about 24,  
22 6.

23 Q. Are those all of your surgeries?

24 A. I think so.

25 Q. Got to stay over here.



1 A. Yeah. I think so.

2 Q. Okay.

3 A. I don't think I had any other  
4 surgeries.

5 Q. Other than for this accident and for  
6 those surgeries you just mentioned, have you ever  
7 been hospitalized any other times?

8 A. For what reason? Okay. I'm not  
9 remembering -- oh, oh, when I was pregnant with  
10 my -- see, I have to go back many years. When I  
11 was pregnant with my son I had pernicious vomiting  
12 so I was hospitalized with IVs on him. And, of  
13 course, I was hospitalized for two child births.

14 Q. Okay.

15 A. Funny how that works, huh? I plopped  
16 out those kids somewhere.

17 Q. Hey, some people don't make it to the  
18 hospital.

19 A. That's true. I don't think I was  
20 admitted for anything else. I -- I can't remember  
21 right now. It'd be something like child births or  
22 something -- no, I don't really think so.

23 Q. Okay. If you think anything throughout  
24 you --

25 A. Yeah, I --

1 Q. -- can just let me know.

2 A. Yeah.

3 Q. Have you ever had any kind of  
4 outpatient procedure where you've gone in in the  
5 morning and been released that same day?

6 A. I'm not remembering any of it right now  
7 if I did have anything.

8 Q. Okay.

9 A. No, I think I've been a pretty healthy  
10 chick.

11 Q. Have you ever broken any bones?

12 A. No. Well, probably my little toe. You  
13 know how you stub it between the sofa, they don't  
14 do anything now. They tape it to the next toe and  
15 that's all so I think I've done that before.

16 Q. I think I actually did that last night.

17 A. Yeah, you go ow for a couple weeks but,  
18 yeah, that's the only other one.

19 Q. Okay. Have you ever been treated for  
20 any kind of illness where you would follow up with  
21 a doctor regularly? I know earlier you mentioned  
22 diabetes.

23 A. Yeah. Yeah, I do follow up with her.

24 Q. Okay. And when were you diagnosed with  
25 diabetes?

1 A. Probably five or six years ago.

2 Q. Have you been treating with your family  
3 doctor?

4 A. With Dr. Trish, yeah.

5 Q. Dr. Trish.

6 A. Yeah.

7 Q. Okay. Have you treated with anybody  
8 else for your diabetes?

9 A. Huh-uh. Oh, I'm sorry, when we were  
10 living up in Virginia I did start out with -- oh  
11 yeah -- his name is not Dr. Doogie, we just called  
12 him that. That's terrible. Now I'm not going to  
13 remember his name. I started out with a doctor up  
14 there. He was considered our family and, boy, I'll  
15 tell you, he looked just like Dr. Doogie. Yeah,  
16 it'll take me a while before I think of his name.

17 Q. Okay. I'll mark that and we can come  
18 back to that.

19 A. Yeah. Dr. Doogie. I can't remember  
20 his name. Yeah, that's where I was first  
21 diagnosed.

22 Q. And how were you initially diagnosed  
23 with diabetes? Were you having symptoms?

24 A. Yeah, I knew what they were. I had  
25 excessive thirst.

1 Q. Were you having any other symptoms?

2 A. No, primarily just the thirst.

3 Q. And have you been on the same  
4 medication for the diabetes the entire time?

5 A. Primarily, yes.

6 Q. Other than diabetes, have you been  
7 treated with any -- for any other kind of illness  
8 or health condition?

9 A. No. I'm being treated for the  
10 glaucoma -- it's pre-glaucoma is actually what it's  
11 diagnosed as. And I do see Dr. Diana regularly,  
12 about every three months.

13 Q. And how long has that been going on?

14 A. Probably a good four years also.

15 Q. Are there any other health conditions  
16 other than the pre-glaucoma and the diabetes?

17 A. Huh-uh.

18 MR. JENKINS: Can we take just like a  
19 second so I can run to the restroom?

20 MS. LYALL: Sure.

21 MR. JENKINS: Do you mind?

22 (A recess transpired.)

23 BY MS. LYALL:

24 Q. Okay. We're going to continue with  
25 your medical history. Just a few more questions.

1 A. Uh-huh.

2 Q. Do you have a history of headaches or  
3 migraines?

4 A. No.

5 Q. Have you ever had any treatment for  
6 headaches or migraines?

7 A. No.

8 Q. Have you ever had any accidents where  
9 you've bumped your head or been knocked  
10 unconscious?

11 A. No.

12 Q. Have you ever had any syncopal  
13 episodes?

14 A. No, I can't remember any syncopal  
15 episodes.

16 Q. So no --

17 A. I got to go back 50 years. In nurses  
18 training I did pass out twice. Yes, I did. I'll  
19 go all the way back to that.

20 Yeah, the orderlies were student nurses  
21 and they took us in, they were rounding up some  
22 students to go in and watch a procedure. They did  
23 not tell us what it was. We walked through the  
24 door and there was a dead man laying naked on the  
25 bed. And, I'm sorry, but we grew up in a different

1 time. I don't think it was so much dead, it was  
2 that he was naked. And I went right down the wall.  
3 So, yes, I did have a syncopal episode. I was 17.

4 Q. Okay.

5 A. Yes, I did.

6 Q. And other than that, have you had any?

7 A. No.

8 Q. So no -- no blackouts?

9 A. No.

10 Q. No fainting?

11 A. No.

12 Q. No dizzy spells?

13 A. No.

14 Q. Loss of consciousness?

15 A. No. I'm always goofy, but no.

16 Q. Have you ever had a concussion?

17 A. No.

18 Q. Prior to this accident?

19 A. Yes. Oh, joy.

20 Q. Had you ever had an MRI or CT scan of  
21 your brain?

22 A. No. Afterwards, but not before.

23 Q. Have you ever received any treatment  
24 for any psychological issues, any kind of  
25 counseling?

1           A.    I've been married too long to one man.  
2   No. I'm sorry. No.

3           Q.    So -- so no treatment for any  
4   psychological issues?

5           A.    No.

6           Q.    Any medication for any psychological  
7   issues?

8           A.    No.

9           Q.    Antidepressants? Anxiety?

10          A.    No.

11          Q.    Prior this accident and what we've  
12   already discussed, have you had to go to the  
13   emergency room for any reason?

14          A.    I just got to think back now. Don't  
15   remember. Don't remember going to the emergency  
16   room for anything. Let's see...

17          Q.    Have you ever filed for unemployment  
18   benefits?

19          A.    No.

20          Q.    Have you ever filed for social security  
21   disability?

22          A.    No.

23          Q.    Are you currently on Medicare?

24          A.    Yes.

25          Q.    We're going to talk about your job

1 history now. Prior to working for Sanctuary  
2 Hospice, where were you employed?

3 A. Hilton Head Life Care Center.

4 Q. And what was your job title there?

5 A. I was a staff nurse and I was wound  
6 care nurse.

7 Q. And how long did you work there?

8 A. I knew you were going to do that. Two  
9 and a half, maybe three years.

10 Q. Was this immediately before your being  
11 hired at Sanctuary Hospice?

12 A. Actually, no, I was working both jobs  
13 at the same time before I stopped at Hilton Head  
14 and came with Sanctuary full time.

15 Q. Okay. And what was your reason for  
16 leaving Hilton Head Life Care Center?

17 A. The mileage.

18 Q. By mileage, do you just mean --

19 A. Travel -- yes, traveling. It took an  
20 hour to get there and it took an hour to get back.  
21 And Sanctuary just happened to be in my hometown.  
22 I'm less than a mile to drive to the hospital.

23 Q. Okay. Did you have any injuries while  
24 working at Hilton Head?

25 A. No.



1 Q. And who was your supervisor there?

2 A. The director of nurses.

3 Q. Do you remember her name?

4 A. Nabell was one. And then they had an  
5 interim RN and another one that came after that.  
6 No, I don't remember their names.

7 Q. Okay. Prior to working for Hilton Head  
8 Life Care Center, where were you employed?

9 A. Ridgeland Nursing Home.

10 Q. And how long were you working there?

11 A. I don't know. At least three years, I  
12 think.

13 Q. Have you ever had any jobs outside of  
14 the nursing field?

15 A. No. No. I -- mostly always nursing.  
16 Oh, we went to Germany. I'm sorry. See, I knew  
17 there was going to be one. When we went to Germany  
18 I couldn't work as a nurse because of the national  
19 requirements and we weren't on a base where I would  
20 work as a United States Citizen, so I worked at PX.

21 Q. And what did you do there?

22 A. You had a department you stocked and  
23 took care of the department. Ran a cash register.

24 Q. Okay. Have you ever had to leave a job  
25 due to any illness?

1           A.    The one at Hilton Head, I -- I had to  
2    leave the job, yes. And they were trying to find  
3    out what was wrong with me, I was having all kinds  
4    of symptoms and I couldn't work the hours. It  
5    wound up being the thyroid and I had a nodule which  
6    I -- that was cancerous but it was encapsulated, so  
7    there was no growth or anything. But I did have to  
8    stop that job until we found out what was wrong  
9    with me.

10          Q.    What kind of symptoms were you having  
11    at that time?

12          A.    I was very tired and very short of  
13    breath. Most of the time it was shortness of  
14    breath.

15          Q.    Okay. All right. We're going to talk  
16    about the actual accident now. So on May 21st --

17          A.    Yes.

18          Q.    -- what time did you leave River Oaks?

19          A.    It was -- it was right around 3:00 I  
20    think. My watch that day happened to be messing up  
21    and so it was telling me one time and I was writing  
22    it down and it wasn't the correct time. So, I  
23    mean, I -- I was sure that, you know, it was a  
24    little bit right before 3:00.

25          Q.    We're actually going to back up just a

1 little bit. What time did you leave for -- for  
2 work that morning?

3 A. Leave where?

4 Q. Your house.

5 A. Oh, leave my house? Probably 25 after  
6 8:00.

7 Q. Did you go into the office that  
8 morning?

9 A. Yes.

10 Q. What time did you leave your office?

11 A. Without looking at my timesheet, I  
12 don't know.

13 Q. Okay. How many stops did you make?

14 A. Well, I went first to the patient's --  
15 patient's home that was dying. And I made my visit  
16 there. And then I left there and went straight to  
17 River Oaks.

18 Q. And River Oaks was your last stop?

19 A. Yes.

20 Q. And from River Oaks...

21 A. I was going back to the office.

22 Q. And what were you going to do at the  
23 office?

24 A. Well, there was several things I was  
25 going to do. Being that I was getting ready to go

1 on vacation, I had to get all my paperwork in  
2 order. But also my dying man when I went there  
3 that day, we use a medicine called hyoscyamine for  
4 extra fluid -- secretions and he had a lot of them  
5 and I used the last one that day so I had to obtain  
6 some and I was going back to the office to get  
7 them.

8 He also had problems with his suction  
9 machine. They had let it get too full and it was  
10 clogging up the filter. And I did work on it a  
11 little bit. And I called the -- the -- the  
12 equipment company responsible for that and wanted  
13 them to come in and give him a new suction  
14 apparatus.

15 Q. And when did you call them?

16 A. From the house. And so whenever I left  
17 I was going to go back and pick up the medicine and  
18 go back and see him again that day.

19 And his wife, they thought had either  
20 just staged (sic) off a heart attack and she had  
21 just had one and she went to the doctors that day  
22 and I wanted to check on her too. And since he  
23 lived right there in town, it wasn't going to add  
24 that much more time, but I needed to take the  
25 medicine back down and check and make sure the

1 equipment got there.

2 Q. And what was that patient's name?

3 A. Am I allowed to give that name?

4 MR. JENKINS: Maybe not. I don't know  
5 the answer to that question. Is that covered by  
6 HIPAA?

7 THE WITNESS: That's what I was going  
8 to say. That's a HIPAA...

9 MR. JENKINS: Y'all want to talk about  
10 that or...

11 MR. ALLISON: Yeah, let's go off the  
12 record.

13 (Off-the-record conference.)

14 THE WITNESS: His name was Mr. [REDACTED]

15 BY MS. LYALL:

16 Q. And what was Mr. [REDACTED] first name?

17 A. [REDACTED].

18 Q. I'm sorry, to get back to what you were  
19 saying before, you were going to return to  
20 Mr. Wilson's --

21 A. Uh-huh.

22 Q. -- house?

23 A. Uh-huh. Uh-huh.

24 Q. Were you going to go from River Oaks to  
25 Mr. [REDACTED] house?

1           A.    No.  I had to go back to the office to  
2   pick up the hyoscyamine that I had gotten for him.

3           Q.    Were Mr. [REDACTED] and his wife aware that  
4   you would be coming back to the house?

5           A.    I told the aides when I was there that  
6   I would be bringing it -- you know, that I'd check  
7   back in in the afternoon.  The wife was not there.  
8   She was having a doctor's appointment and that's  
9   why -- one of the reasons I wanted to go and see  
10  what they had told her about her.

11          Q.    Right.

12          A.    We -- I mean, I work with hospice  
13  patients before where you lose the caregiver before  
14  you lose the patients --

15          Q.    Uh-huh.

16          A.    -- so I was quite concerned about it.

17          Q.    Do you remember the name of the aides  
18  that were working at Mr. [REDACTED]?

19          A.    Ms. Sarah Williams.  Now, she just got  
20  married last weekend so I don't know her married  
21  name.

22          Q.    Is it -- was she the only one?

23          A.    He had somebody on weekends but I'm not  
24  really too sure.  Sarah I think took one weekend  
25  and I'm not sure if anybody else had taken any

1 weekend there with him.

2 Q. But on this day it was Sarah --

3 A. Oh, it was Sarah.

4 Q. -- Williams that was there?

5 A. Yeah. Uh-huh.

6 Q. How far was the drive from River Oaks  
7 to your office?

8 A. 28 miles.

9 Q. Did you take the same way every time?

10 A. Yeah. Almost. If you had a patient on  
11 the other side, then I'd go up 21. But if all I  
12 was doing was going up to the hospital or River  
13 Oaks, yes.

14 Q. So you would sometimes take a different  
15 way, but most of the time the same?

16 A. Most of the time -- and unless I had a  
17 patient I had to go see somewhere else that -- you  
18 know, up 21 and then you get on exit 33 and come  
19 down.

20 Q. And how far is River Oaks from your  
21 house?

22 A. Well, I'd add another mile. 29 miles.  
23 Now we're talking approximately. It's probably  
24 27.8 or something like 28.3 or -- but you always  
25 go -- you just round it off to the next mile, so...

1 Q. So you lived approximately a mile, from  
2 your office?

3 A. Yes. Like six-tenths of a mile.

4 Q. Did you have to drive past your office  
5 to get to your house?

6 A. Depends on who I was leaving but most  
7 generally, yes.

8 Q. Would you take the same way to get from  
9 River Oaks to your house as you would from River  
10 Oaks to your office?

11 A. Uh-huh.

12 Q. I'm sorry, was that a yes?

13 A. Oh, I'm sorry, yes.

14 Q. Thank you. Okay. So you were involved  
15 in an accident after leaving River Oaks. How far  
16 approximately from River Oaks were you?

17 A. I don't know if it was half or just  
18 under halfway. I never checked the mileage to  
19 there.

20 Q. And do you know exactly where the  
21 accident occurred?

22 A. By way of...

23 Q. I guess like maybe at an intersection  
24 near where it happened or...

25 A. My husband took me back past it and,



1       yes, I recognized the area. I mean, yeah.

2               Q.     Is there a way that you could describe  
3       it to me, I mean, like with an intersection --

4               A.     No.

5               Q.     -- or a street or --

6               A.     No, it was like a -- I can't say  
7       severe, but it was more like a left curve going  
8       down the road.

9               Q.     And what road were you on?

10              A.     Snake Road.

11              Q.     Does Snake Road have any other name?

12              A.     I'm not aware of that.

13              Q.     Okay.

14              A.     No, there's two signs there that say  
15     Snake Road.

16              Q.     Okay. Some -- some highways are --  
17     also have names of roads --

18              A.     Yeah.

19              Q.     -- so I didn't know if it had anything  
20     else.

21              A.     It probably has a number to it, but I  
22     don't know what that would be.

23              Q.     Okay. So you're between River Oaks and  
24     where -- you're about halfway between River Oaks  
25     and where your home and your office were?

1 A. Right. Right. Correct. Yes.

2 Q. Did you have any plans the evening of  
3 the 21st --

4 A. No.

5 Q. -- sometimes --

6 No dinner with your husband?

7 A. No.

8 Q. Cooking with your daughter?

9 A. No.

10 Q. What did you typically do in the  
11 evenings?

12 A. I love to garden. And I probably get  
13 out of my car and go around and pull weeds and get  
14 the mail and walk into the house.

15 Q. Okay. Did you usually eat dinner at  
16 home?

17 A. Usually we do, yeah.

18 Q. Okay. So tell me about the accident on  
19 Snake Road. Exactly what happened?

20 A. I do not remember a thing. I was  
21 driving. I was alert. I had nothing particularly  
22 on my mind. I mean, I had had three pretty decent  
23 visits with those three patients. And it was just  
24 like a light switch just went off and I can't  
25 remember a thing. I don't even remember going off

1 the road onto the grass.

2 Q. Were you wearing a seatbelt at the time  
3 of the accident?

4 A. Oh, yes. Yes.

5 Q. Do you know approximately how fast you  
6 were going?

7 A. No.

8 Q. What is the first thing you remember  
9 after the accident?

10 A. I was in the vehicle and I could see  
11 smoke all around. And I kind of looked to my side  
12 and my door seemed to be halfway open and I  
13 unsnapped my seatbelt and opened the door and  
14 walked back. I only went a few feet then kind of  
15 stumbled down onto the ground.

16 Q. Did you notice any cars around? Was --  
17 was anybody -- did anybody witness the accident?

18 A. I don't know if they witnessed it but  
19 there was a lady there and she came across the  
20 street. She had already stopped her car. And she  
21 had told me that she would call 911. I don't even  
22 know who she was.

23 ~~And there was a man behind me and he~~  
24 was talking but I couldn't see him or anything.  
25 And I don't know if he walked or if he had a truck,

1 if he had a car, what, but he was behind me.

2 Q. So the lady called 911?

3 A. That's what she said, yes.

4 Q. Were you aware of approximately what  
5 time it was at this point?

6 A. (Shaking head from side to side.) No.  
7 No.

8 Q. Thank you. So let's go back  
9 immediately before you ran off the road. You lost  
10 consciousness?

11 A. I didn't seem that I -- I mean, not to  
12 my recollection. I mean, I don't know what  
13 happened. Like I said, yeah, I was driving and  
14 felt fine and no problems and the next thing I was  
15 looking up at -- at the smoke.

16 Q. Throughout the day on the 21st, did you  
17 have any dizzy spells?

18 A. No. And I had eaten lunch.

19 Q. And where were you immediately  
20 experiencing pain?

21 A. You're talking about the accident?

22 Q. Yes..

23 A. I think my head. This thing, the big  
24 gash. (Indicating.)

25 Q. You're pointing to the scar above your

1 right eye?

2 A. Uh-huh. And I could feel blood  
3 dropping -- or dripping. (Gesturing.)

4 Q. Were you experiencing pain anywhere  
5 else?

6 A. No. They put me on a backboard.

7 Q. We'll -- we'll get back to --

8 A. Oh.

9 Q. -- when the EMS came.

10 A. Okay.

11 Q. But before even the EMS got there.

12 A. No, I was just -- I was just sitting on  
13 the ground just -- I'm sure more dazed than  
14 anything. And like I said, I knew I was bleeding  
15 here because I could feel it dripping.

16 Q. Had you ever had any other injuries  
17 before this accident where any part of your head  
18 was bleeding?

19 A. Prior to this accident?

20 Q. Uh-huh.

21 A. No.

22 Q. And you did not -- you said you did not  
23 know the name of either of the people that were  
24 there on the scene?

25 A. No, I did not.

1                   Now, whether the EMT people or the  
2 police when they got there got their names, I  
3 really don't know.

4                   Q.    Okay. And earlier you said you'd  
5 called Vicky.

6                   A.    Yeah. Don't ask me why. They asked me  
7 about who could they notify and stuff and I had my  
8 cell phone in my pocket and I had a hard time  
9 trying to get the number out because we have such a  
10 crazy office number, but I guess eventually I did  
11 get the right numbers out. And I did let her know  
12 that we had an accident and I really wanted  
13 somebody to come -- because we carry HIPAA  
14 important information on our patients, you know,  
15 personal, and I wanted to make sure somebody --  
16 they got into the right hands, that they weren't  
17 going to be laying there for anybody to come look  
18 at them. I was -- I was just really emphatic on  
19 trying to get those records out of my car and into  
20 the proper hands so that...

21                  Q.    Okay.

22                  A.    Now somebody told me I said I didn't  
23 know where I was, but I don't remember saying that.

24                  Q.    Okay. And did Vicky send somebody to  
25 get the stuff from your car?

1 A. The owner did show up, yes.

2 Q. And what did you tell Vicky about the  
3 accident?

4 A. I don't think I told Vicky anything  
5 other than I had an accident on Snake Road.

6 Q. Okay.

7 A. I would -- the lady took the phone from  
8 me.

9 Q. Okay.

10 A. I think she was talking.

11 Q. And the police showed up?

12 A. Yes.

13 Q. And as far as you're aware, did they  
14 take a report?

15 A. Not from me.

16 Q. Do you know approximately how long it  
17 took for the EMS to get to the scene?

18 A. No. It seemed like they were there  
19 pretty quickly.

20 Q. What did you do while you waited for  
21 them?

22 A. I just sat there. And the lady was in  
23 front of me and she was just talking to me. And  
24 there was a man behind me. I don't remember what  
25 he was saying. He was talking, but I just don't

1 remember what he was saying.

2 Q. Typical man talk?

3 A. I don't know.

4 Q. Was there anybody else there other than  
5 the man, the lady, and yourself?

6 A. That's all. And then I think one of  
7 the responders came from Callawassie in his own  
8 vehicle and he was checking me out. And he was the  
9 one that I kept sending back trying to get the  
10 information out of the car, the personal  
11 information on the patients.

12 Q. Did the police or the EMS show up  
13 first?

14 A. I don't know.

15 Q. Okay. Okay. Let's talk about the  
16 treatment you received by the EMS. What did they  
17 do for you?

18 A. What did they do first, they checked my  
19 back and asked me if I hurt and they told me no.  
20 And they said, well, you know, we're going to have  
21 to do this anyway. And I said, yeah. So they put  
22 a collar on me and put me on a backboard.

23 Then I don't even remember getting into  
24 the ambulance. But they put something on my head.  
25 And, like I said, I knew I was bleeding. And they



1 took my blood pressure. And they were -- they  
2 didn't move me right away. It was a while, because  
3 they were waiting for clearance. I think I heard  
4 them say, they were waiting for clearance from one  
5 of the two emergency rooms, which one to take me  
6 to. So we just kind of sat on the side of the  
7 road. I think they started an IV on me there.  
8 They started one somewhere, but I think it was  
9 there. And, like I said, they just monitored me.  
10 And put an ice pack on my head. And I don't  
11 remember anything else.

12 Q. So that's about all?

13 Which hospital did they take you to?

14 A. Coastal.

15 Q. Did the EMS perform any tests to  
16 determine any possible causes of the accident or  
17 your loss of consciousness?

18 A. I -- I know that it's just routine.  
19 I'm a nurse. I know it's routine in an accident to  
20 draw blood and run it for alcohol level and  
21 probably some standard of drugs and things like  
22 that. I mean, that -- I think that's pretty  
23 standard.

24 Q. Right. Other than testing for alcohol  
25 in blood, are you aware of any other test

1 performed?

2 A. I don't -- I'm not even aware that they  
3 did that. I just said I -- I know that that's the  
4 standard --

5 Q. Right.

6 A. -- with an accident.

7 Q. Did you tell the EMS workers what had  
8 happened with the accident?

9 A. No, I just told them I -- I didn't  
10 know. That every -- you know, it was just like a  
11 light switch just went off.

12 Q. Once you were at Coastal Hospital --

13 A. Uh-huh.

14 Q. -- what treatment did they provide?

15 A. Oh, gee, I had CTs. I had chest x-rays  
16 because of the pain and the bruising there.

17 (Indicating.) I know I had an IV, but, like I  
18 said, I don't know where that came from. I was  
19 sure it probably was from the ambulance.

20 They put stuff on my -- they didn't  
21 have to suture it up, they kind of glued it. A lot  
22 of that, I don't even remember. I must have gone  
23 back to sleep or I just wasn't aware of a lot of  
24 that.

25 Q. Did they give you pain medication?

1           A.    I'm sure they didn't. I can't say yay  
2           or nay. It was a head injury and when I was  
3           admitted I was only allowed to have Tylenol and  
4           that didn't work and then we went to Toradol IV.  
5           So no narcotics with a head injury. And I'm sure  
6           that was the protocol that they followed, but I  
7           don't know.

8           Q.    Once you were at the hospital, did --  
9           did you tell any of the doctors how the accident  
10          happened or what you thought had happened?

11          A.    He asked me and I said I didn't  
12          remember. I said, I just -- just like a light  
13          switch, it just went off.

14          Q.    At any point did you tell any, I guess,  
15          anybody involved in your medical treatment that you  
16          had fainted or had a --

17          A.    (Shaking head from side to side.)  
18          Because I didn't know that I had fainted.

19          Q.    Okay. What about the syncopal episode?

20          A.    I had nothing prior to that that would  
21          make me think that I had a syncopal episode. I had  
22          no pain in my head, no dizziness, no blurriness, no  
23          nothing.

24          Q.    What other treatment have you received  
25          from Coastal Hospital?

1           A.    From the hospital. Okay. Now, wait a  
2           minute. We have -- we have different departments  
3           here now and I -- I guess I'll be more typical  
4           because I'm a nurse. I went to the office for Dr.  
5           Sutherland for my left ankle. And I did have a  
6           reduction done at Coastal Hospital as an  
7           outpatient.

8                    I am seeing the people at the wound  
9           clinic for this hematoma wound on my right leg.  
10          And I was admitted for probably more like  
11          observation for three days, Monday to Tuesday to  
12          Wednesday.

13          Q.    And that was immediately following the  
14          accident?

15          A.    Yes, and -- and tests. Because I did  
16          the CTs down in the ER, did the MRI the next day.  
17          I think I was on a cardiac monitor. I think I was  
18          on a cardiac monitor.

19          Q.    And do you know why they had you on a  
20          cardiac monitor?

21          A.    I asked them if they saw anything and  
22          they said no.

23          Q.    Do you know what they were looking for?

24          A.    Well, probably any kind of an irregular  
25          heartbeat or something that would cause you to pass

1 out would be my guess. I used to work ICU, so  
2 heart block, you know, any -- anything like that.  
3 So I asked them, I said -- and they said, no, they  
4 didn't see anything abnormal.

5 Q. So they were looking for a possibility  
6 as to why you might have passed out before --

7 A. Yes.

8 Q. -- before the accident?

9 A. If I passed out or what happened, yeah.

10 Q. And you said you were currently  
11 treating with Dr. Sutherland?

12 A. Yes.

13 Q. And he performed surgery?

14 A. Yes.

15 Q. And when was that surgery,  
16 approximately?

17 A. I think we had a holiday in there. It  
18 was Memorial Day holiday. And I think it was  
19 Tuesday which would have been the 29th. I'm not  
20 sure.

21 Q. And when did you last treat with him?

22 A. I saw him two weeks later, so whenever  
23 he put me in the boot. Took the cast -- the cast  
24 off and put me in the boot. And I will see him  
25 Monday.

1 Q. Has he told you anything about your  
2 condition? How -- how your leg is healing?

3 A. No, not -- he didn't say anything when  
4 we were there. He looked at the x-rays. He said  
5 the pins were good. Just no weight bearing until  
6 he saw me again.

7 Q. And how frequently are you treating  
8 with the wound clinic?

9 A. I was once -- I was once a week, but  
10 over the weekend this just got very inflamed and  
11 painful again so now that we have the wound back on  
12 it's going to be twice a week, Monday and Thursday.

13 Q. Are you treating with any other doctors  
14 right now?

15 A. Well, Dr. Diana. It's a follow up with  
16 my eyes. Of course they thought I had a hematoma  
17 back here, but when he got to look at it he said it  
18 wasn't. Just a lot of swelling. So my eye doctor.

19 I went back to Dr. Trish because my  
20 blood -- because of all the anxiety, my blood  
21 pressure was going high so she had to increase my  
22 Lisinopril. She actually doubled it. And she gave  
23 me some sleeping pills because I haven't been  
24 able -- and I don't like to take a lot of pain  
25 pills, so she gave me some sleeping pills to help

1 me rest.

2 Q. What sleeping pills did she give you?

3 A. Restoril 15. And I take one or two a  
4 night.

5 Okay. Who did we do now?

6 Q. We did Dr. Sutherland, the wound  
7 clinic, Dr. Diana and Dr. Trish.

8 A. Dr. Trish. That's it, I think.

9 Q. And do you -- do you have follow up  
10 appointments scheduled with all of these doctors?

11 A. Yes.

12 Q. Do you know when you're following up  
13 next with Dr. Diana?

14 A. The middle of September.

15 MR. BARON: 19th.

16 THE WITNESS: The 19th. It's on his  
17 calendar.

18 BY MS. LYALL:

19 Q. And when is your next appointment with  
20 Dr. Trish? That's okay if you don't remember.

21 A. No, it's three months from when I saw  
22 her last week.

23 Q. Okay.

24 A. I find a calendar...

25 Q. Have you had any physical therapy?

1           A.    We did have a physical therapist come  
2   to the house and give me a -- a set for range of  
3   motion, but it was still very limited on what I  
4   could do. And so she only came twice. And, of  
5   course, you know, I'm a nurse and I do fall  
6   directions and so I did my own therapy. I mean, it  
7   wasn't really necessary to have her keep coming  
8   back. I'd rather save it until after I have to  
9   start bearing weight if I need to have more  
10   physical therapy or doing what she wanted me at  
11   home --

12           Q.    Okay.

13           A.    -- I could do myself.

14           Q.    And I notice you're in a wheelchair  
15   today. Has that been --

16           A.    Since the accident because I'm non  
17   weight bearing on my left and the wound on my  
18   right, they really want me non-weight bearing on  
19   that one too, but if I can't bear weight on either  
20   one of my feet I'm in trouble.

21           Q.    Did the doctor prescribe you the  
22   wheelchair or did anybody specifically tell you to  
23   be in a wheelchair?

24           A.    No.

25           Q.    Okay.



1 A. Yeah.

2 Q. And where did you get the wheelchair?

3 A. Oh, from a friend.

4 Q. Okay. Are you able to move around at  
5 all without the wheelchair?

6 A. Oh, yes. I can. You know, and I had  
7 my seatbelt on and I have this very, very bad  
8 contusion here too. So that, you know, doing  
9 anything like with a walker with my arms, didn't  
10 allow me to do that those first almost four weeks.  
11 I -- it's gotten a lot a better now. So, you  
12 know -- but I transfer myself. I go to the  
13 bathroom, I go sit in the chair. (Indicating.)

14 Q. And the contusion you're talking about  
15 is in your right rib area?

16 A. Yeah. (Indicating.)

17 Q. And do you have any other appointments  
18 scheduled that we have not talked about?

19 A. Eye, wound care, Sutherland, and Dr.  
20 Trish. I think those are the four.

21 Q. Okay. And have you seen any other  
22 doctors we have not talked about?

23 A. Oh, gosh, I -- no.

24 Q. What medications are you currently  
25 taking?

1           A.    The Glucophage, the Lisinopril.  Oh, I  
2   am taking a hydrocodone for pain.  Multivitamins,  
3   CoQ10.  Same things except for the hydrocodone.

4           Q.    So the -- the same medications --

5           A.    Uh-huh.

6           Q.    -- you just added on hydrocodone?

7           A.    Uh-huh.

8           Q.    Does the hydrocodone help with the  
9   pain?

10          A.    Not when they're dressing or packing  
11   the wound it doesn't.  And that's any time I take  
12   it, I'll take the two of them before I have --  
13   before they pack my wound and -- and I try not to  
14   take it any other time.  I'll take an Advil but not  
15   a -- not a narcotic.

16          Q.    Have you had any other injuries or  
17   accidents since May 21st?

18          A.    Oh, no.  That's a terrible thing.

19          Q.    All right.  We're going to talk about  
20   what problems you're currently having today.

21          A.    Okay.

22          Q.    You mentioned your right leg.

23          A.    Uh-huh.  That's my biggest one.

24          Q.    Okay.  And is it specifically your  
25   ankle?

1 A. No, it's my calf.

2 Q. Right calf.

3 A. Mid -- midleg. No, it's not my calf  
4 either. I guess it's your calf. (Indicating.)

5 MR. JENKINS: That's your shin it looks  
6 like. Maybe.

7 THE WITNESS: It's the middle part of  
8 the bone, yeah.

9 MR. JENKINS: Yeah.

10 BY MS. LYALL:

11 Q. Okay.

12 A. Yeah.

13 Q. And that -- was it a burn?

14 A. It was a large bruise that had a crust  
15 as an opening and when he opened it up it was a  
16 large hematoma. He evacuated the blood out of  
17 there and that was a month ago.

18 Q. On a scale from one to ten with ten  
19 being equivalent to the worst pain --

20 A. 20. I'm sorry. When they pack it,  
21 it's a 20. But, yeah, it's extremely painful.

22 Q. What has the doctor told you about this  
23 condition and the hematoma?

24 A. He -- that's why they stopped me with  
25 the packing to this wound care. And he looked at

1 it today, didn't think it was infected. It was  
2 red, raised again, very painful into the bone. He  
3 wants to wait a week, and then they said that they  
4 might have to do an MRI. Because of the bone  
5 hardening, I know the condition, what I'm concerned  
6 about is getting an infection into that bone and  
7 it's called osteomyelitis and that's a very bad...

8 Q. Okay. What other problems are you  
9 having today?

10 A. A little bit with my vision. Even  
11 though I have glasses on, I don't always can see  
12 properly.

13 Q. So your vision has decreased?

14 A. Yes.

15 Q. Did you wear glasses before the  
16 accident?

17 A. Yes.

18 Q. Has your prescription changed?

19 A. No. We refilled the prescription the  
20 same. But like Dr. Diana said, it's because my  
21 right eyelid is just drooping down. (Indicating.)

22 Q. And what other problems are you having?

23 A. Well, my -- my left ankle I'm not going  
24 to -- you know, until I start walking on it I don't  
25 have significant pain in there. About a two or

1 three when I do my range of motion exercises.

2 I have pain still in my head. I can't  
3 do anything like even wash my head without it  
4 hurting, let alone putting curlers in it.

5 Q. Where in your head are you having pain?

6 A. Right there. (Indicating.)

7 Q. And that's above your right eyebrow?

8 A. Uh-huh. Yeah. Now, it doesn't hurt  
9 but if I touch it. And so, you know, I can't do  
10 anything like curl my hair or -- and I certainly  
11 don't want to go back and color my hair or get a  
12 perm or anything. I don't want to put anything in  
13 my hair right now just as a precaution, you know, I  
14 just don't want to add insult to injury.

15 Q. Are you still receiving any treatment  
16 for your head?

17 A. No.

18 Q. Has any treatment been recommended?

19 A. No. Just to heal, I'm sure.

20 Q. Right.

21 A. Give it time.

22 Q. Is there anywhere else you're  
23 experiencing pain or discomfort right now?

24 A. Just that little bit. It'll catch me  
25 sometimes much less now. The other night I rolled

1 over to try to sleep and it made me move again, but  
2 it's minimal.

3 Q. Overall do you feel like you're  
4 improving since the accident?

5 A. I am, but I'm not too sure about my  
6 leg.

7 Q. Your right leg?

8 A. Uh-huh. Like I said, I've very  
9 concerned about it.

10 Q. Is the pain in your right leg constant?

11 A. It has varied in the last four weeks  
12 but over the weekend it was throbbing and I  
13 couldn't sleep very well. I had to take a couple  
14 of Advil. And it was just getting longer lengths  
15 of time. Friday night was starting, Saturday  
16 was -- I was up for quite a few hours with the pain  
17 and the throbbing. And Sunday was -- last night  
18 was worse, yeah.

19 Q. I know you mentioned packing is very  
20 uncomfortable, other than that --

21 A. You -- you have no idea.

22 Q. -- other than that is there anything  
23 else that makes it -- the pain worse?

24 A. No. No. The packing is the worst.  
25 But then, like I said, during the night because

1 it's been getting red and inflamed again, it's just  
2 been like throbbing constantly. Very hard to  
3 reposition so that -- to get comfortable.

4 Q. All right. And the injury above your  
5 right eye --

6 A. Uh-huh.

7 Q. -- is that a constant pain?

8 A. No, not unless I touch it.

9 Q. And what kind of pain is that?

10 A. I -- what kind of pain?

11 Q. Like a stinging pain or --

12 A. Oh, yeah, that's a good one. Stinging.  
13 It hurts. (Gesturing.)

14 Q. How long does it hurt once you touch  
15 it?

16 A. It -- as soon as I take my fingers off  
17 of it then it doesn't. But I tried curling my  
18 hair -- you know, doing something with my hair and  
19 it was just -- no way. I couldn't even do it. I  
20 had to take the curlers right back out.

21 So for some dignity I've ordered a wig.

22 Q. It'll save time and -- and I'm sure  
23 it'll look beautiful. You mentioned earlier that  
24 you like gardening?

25 A. Yes.

1 Q. Do you have any other hobbies?

2 A. Swimming, boating. I like going to  
3 church.

4 Q. Are you currently able to garden?

5 A. No. No, I can't. I have bent over and  
6 pulled up one or two weeds, but not to garden.

7 Q. Who is taking care of your garden right  
8 now?

9 A. (Indicating.)

10 Q. You're looking at your husband?

11 A. Yeah.

12 Q. Is he doing a good job?

13 A. No.

14 MR. ALLISON: That's not nice.

15 BY MS. LYALL:

16 Q. What's the typical day for you like  
17 right now?

18 A. Oh, absolutely bored out of my mind.  
19 Oh, I usually get up and have breakfast and  
20 transfer to the chair and look out because I  
21 have -- my couple of flowers that are blooming are  
22 blooming right outside my window. So I have to  
23 check those out first.

24 I do some range of motion and stuff  
25 like that and I'll watch my church programs on TV.



1 And not too much after that. Sometimes play a game  
2 or two on the computer.

3 I have -- some of the girls have  
4 written to me and I've tried to get a card back to  
5 them. Do an occasional bill or two.

6 Q. Who does the grocery shopping for your  
7 family?

8 A. Everybody does. My grandson will pass  
9 Walmart on the way home. My daughter -- my husband  
10 will go into town and -- and do shopping.

11 Q. Are you able to do grocery shopping  
12 right now?

13 A. No, I haven't.

14 Q. Are you able to drive right now?

15 A. No. I wouldn't even attempt it. Not  
16 with my eyes anyway. Not with my right leg. I  
17 don't have any legs that work.

18 And, like I said, I mean, you know,  
19 there's some dignity to it. I -- I look like a  
20 battered wife I guess. And, no, I just don't even  
21 want to go out. And I love fireworks and I just  
22 didn't even have Ed take me out to the fireworks  
23 Saturday, so...

24 MS. LYALL: We are almost finished.

25 If y'all don't mind, we're going to

1 take a quick break.

2 MR. JENKINS: Sure.

3 (A recess transpired.)

4 BY MS. LYALL:

5 Q. And this is just to clarify what we've  
6 already been over earlier. Right before the  
7 accident, you don't recall swerving to avoid an  
8 animal?

9 A. Can't remember. Nope, nothing.

10 Q. So --

11 A. That's just the biggest zero. And I  
12 have thought and thought and thought, but there was  
13 no.

14 Q. There was just like a light switch and  
15 that's that?

16 A. Yes, ma'am.

17 Q. Okay. And since the accident, have you  
18 suffered any memory loss?

19 A. Well, I'm taking pain pills and I can't  
20 say memory loss as much as not having details. The  
21 dates -- well, of course, Ed's been doing the  
22 calendar, my husband has been doing the calendar,  
23 so, you know, I rely on him. I just kind of check  
24 it off and say, okay, what date did you put down  
25 for that and what are we doing the next day.

1 But, I mean, I know who my family is, I  
2 know where I work, I know all of that, but it's --  
3 it's some of that date and time. Names, sometimes  
4 I get stuck on a name for no apparent reason.

5 Q. And do you associate that memory loss  
6 with the pain medication?

7 A. I think so. Yeah.

8 Q. Do you have any other cognitive  
9 deficits?

10 A. I hope not. No, not that I know of.

11 MS. LYALL: Okay. I think that's all  
12 the questions I have. I appreciate your time.

13 THE WITNESS: Oh, you're very welcome.

14 (The deposition was concluded at 2:48  
15 PM.)

16

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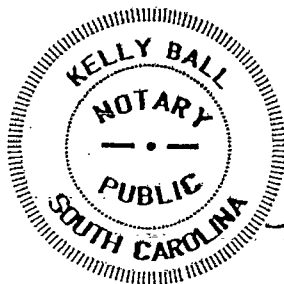
25

1 CERTIFICATE OF REPORTER  
2

3 I, Kelly A. Ball, Court Reporter and  
4 Notary Public for the State of South Carolina at  
5 Large, do hereby certify that the foregoing  
6 transcript is a true, accurate, and complete  
7 record.

8 I further certify that I am neither  
9 related to nor counsel for any party to the cause  
10 pending or interested in the events thereof.

11 Witness my hand, I have hereunto  
12 affixed my official seal this 2nd day of July, 2012  
13 at Charleston, Charleston County, South Carolina.  
14  
15  
16  
17  
18  
19



24 Kelly A. Ball  
25 My Commission expires  
November 19, 2017



Claimant's Name: Frances Baron Employer's Name: Sanctuary Hospice  
Address: [REDACTED] Address: 10911B Jacob Smart Boulevard  
City: [REDACTED] State: [REDACTED] Zip: [REDACTED] City: Ridgeland State: SC Zip: 29936  
Home Phone: ( [REDACTED] ) [REDACTED] Work Phone: ( ) -  Carrier: Guarantee Ins. Co./Patriot National Ins. Group  
Preparer's Name: William G. Jenkins, Jr. Preparer's Phone #: ( 843 ) 785-8800

**A claim for workers' compensation benefits is made based on the following grounds:**

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: 725.47 2. AWW: \$1095.15 Date of Injury: 05/21/2012
3. Type of injury and body part(s): Head/brain, eyes, face, both legs, both ankles, both feet,
4. Facts in controversy: Whether claimant is entitled to past and future medical care and attention. Whether claimant is entitled to Temporary Total Disability. Whether claimant is entitled to mileage reimbursement for travel to and from physicians.
5. Legal issues involved: Same as number 4 above
6. Unusual aspects: None anticipated  
Witnesses (designate if expert):\* Frances Baron, claimant, Ed Baron, claimant's husband.
8. Exhibits: Photographs of claimant's vehicle
9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance):  
See attached
10. Name, address, and specialty, if any, of the treating physician: See attached medical records.
11. Impairment rating(s); body part(s); physician and date of opinion: None to date.
12. I am amending my Form 50/51 in the following manner:

I verify the contents of this form are accurate and true to the best of my knowledge.

Signature: [Signature] Email: william@jenkins-esquivel.com  
Date of hearing: February 27, 2012 Time needed for hearing: 1 hour

**RECEIVED**

FEB 14 2013

of ☒ Claimant ☐ Employer

S.C. WORKERS' COMP. COMM.  
OFFICE OF COMMISSIONER

File this form and proof of service on the opposing party according to R.67-611 and R.67-612. Do not send medical reports. Commissioners reserve the right to admit expert witnesses at hearings.

STATE OF SOUTH CAROLINA )  
COUNTY OF BEAUFORT )  
FRANCES BARON, )  
Claimant, )  
vs. )  
SANCTUARY HOSPICE, )  
Employer, )  
and )  
GUARANTEE INS. CO./PATRIOT NATIONAL )  
Carrier, )

BEFORE THE SOUTH CAROLINA  
WORKERS' COMPENSATION  
COMMISSION

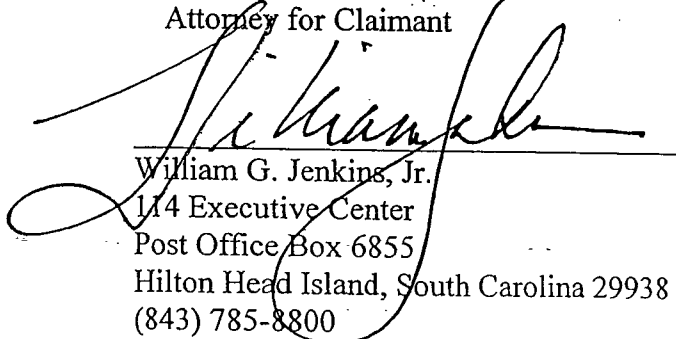
W.C.C. FILE NO.: 1206355

**CLAIMANT'S INDEX OF APA SUBMISSIONS**

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|---------|---------------------------------|----------------------|---------|
| 1       | Jasper County EMS               | 05/21/12             | 1-5     |
| 2       | Coastal Carolina Medical Center | 05/21/12 to 05/23/12 | 6-69    |
| 3       | Optim Orthopedics               | 05/24/12 to 07/09/12 | 70-82A  |
| 4       | Palmetto Eye Specialists        | 05/24/12 to 06/14/12 | 83113   |
| 5       | Coastal Carolina Medical Center | 05/29/12             | 114-123 |
| 6       | Dr. Cotter (wound care)         | 05/31/12 to 08/02/12 | 124-308 |
| 7.      | Savannah Cardiology             | 09/15/09-05/25/12    | 309-319 |
| 8.      | Mileage Reimbursement Requests  | 05/24/12 – 11/20/12  | 320-327 |

JENKINS LAW FIRM, P.A.

Attorney for Claimant

  
William G. Jenkins, Jr.  
114 Executive Center  
Post Office Box 6855  
Hilton Head Island, South Carolina 29938  
(843) 785-8800

Hilton Head Island, South Carolina  
February 12, 2013

# JASPER COUNTY EMS

P O BOX 1509  
RIDGELAND, SC 29936  
(843)726-7816  
Federal Tax ID: 57-6000366

Patient Name: FRANCES BARON

Insurance: ANSI MEDICARE ELECTRI  
BCBS FEDERAL  
TRICARE CLAIMS REGION

FRANCES BARON  
[REDACTED]

Patient Number: [REDACTED]  
Call Number: [REDACTED]  
Date Of Call: 05/21/2012  
Call Time: 02:54 PM  
Caller: Police/Fire/911  
From Location: SNAKE ROAD  
To Location: COASTAL CAROLINA MEDICAL

Reason(s) 873.40  
For 959.9  
Transport 784.0

| <u>DESCRIPTION OF CHARGES</u> | <u>HCPC</u> | <u>QUANTITY</u> | <u>UNIT PRICE</u> | <u>AMOUNT</u> |
|-------------------------------|-------------|-----------------|-------------------|---------------|
| ALS/BLS MILEAGE               | A0425       | 15.0            | 9.50              | 142.50        |
| BLS EMERGENCY TRANSPORT       | A0429       | 1.0             | 360.00            | 360.00        |
| RESEARCH FEE ATTORNEY         | A0999       | 1.0             | 15.65             | 15.65         |

Total Charges 518.15

Total Credits 0.00

PLEASE PAY THIS AMOUNT => \$518.15

-----  
^DETACH ALONG ABOVE LINE AND RETURN STUB WITH YOUR PAYMENT^

Patient Name: BARON, FRANCES  
Patient Number: [REDACTED]

Call Number: [REDACTED]  
Current Date: 06/04/2012

Amount Due: \$518.15

Amount  
Enclosed \$ \_\_\_\_\_



Name: BARON, FRANCES

Incident #: 12-1338

Date: 05/21/2012

Patient 1 of 1

| Patient Information |                          |           |  | Clinical Impression  |                                                                                        |
|---------------------|--------------------------|-----------|--|----------------------|----------------------------------------------------------------------------------------|
| last                | BARON                    | Address   |  | Primary Impression   | Traumatic Injury                                                                       |
|                     | FRANCES                  | Address 2 |  | Secondary Impression |                                                                                        |
|                     |                          | City      |  | Protocol Used        | Spinal Cord Trauma                                                                     |
|                     | Female                   | State     |  | Anatomic Position    | Head                                                                                   |
| DOB                 |                          | Zip       |  | Chief Complaint      | HEAD TRAUMA                                                                            |
| age                 | 70 Yrs, 7 Months, 3 Days | Country   |  | Duration             | 15 Units Minutes                                                                       |
| Weight              | 155lbs - 70kg            | Race      |  | Secondary Complaint  |                                                                                        |
| SN                  |                          | Physician |  | Duration             | Units                                                                                  |
| Advanced Directive  |                          |           |  | Signs & Symptoms     | Laceration - Face<br>Pain - Head                                                       |
| Resident Status     |                          |           |  | Injury               | Motorized Vehicle Accident - Auto vs. Fixed<br>Object - Street or Highway - 05/21/2012 |
|                     |                          |           |  | Medical/Trauma       | Medical & Trauma                                                                       |
|                     |                          |           |  | Barriers of Care     | None                                                                                   |
|                     |                          |           |  | Alcohol/Drugs        | None                                                                                   |

| Medication/Allergies/History |                        |
|------------------------------|------------------------|
| Medications                  | Glucophage, Lisinopril |
| Allergies                    | NKDA                   |
| History                      | Diabetes               |

| Vital Signs |      |      |     |           |       |      |      |       |    |     |      |      |       |
|-------------|------|------|-----|-----------|-------|------|------|-------|----|-----|------|------|-------|
| Time        | AVPU | Site | POS | BP        | Pulse | RR   | SP02 | ETCO2 | CO | BG  | Temp | Pain | GCS   |
| 15:15       | A    | L    | Lay | 230/106 M | 126 R | 18 R | 98   |       |    |     |      | 6    | 15/NQ |
| 15:25       | A    | L    | Lay | 224/100 M | 124 R | 18 R | 99   |       |    | 216 |      | 6    | 15/NQ |
| 15:35       | A    | L    | Lay | 210/98 M  | 122 R | 18 R | 100  |       |    |     |      | 6    | 15/NQ |
| 15:45       | A    | L    | Lay | 198/90 M  | 122 R | 18 R | 100  |       |    |     |      | 6    | 15/NQ |

| ECG   |                   |             |  |
|-------|-------------------|-------------|--|
| Time  | 3-Lead ECG        | 12-Lead ECG |  |
| 15:25 | Sinus Tachycardia |             |  |
| 15:35 | Sinus Tachycardia |             |  |
| 15:45 | Sinus Tachycardia |             |  |

| Flow Chart |                       |                                                                                         |                   |
|------------|-----------------------|-----------------------------------------------------------------------------------------|-------------------|
| Time       | Treatment             | Description                                                                             | Provider          |
| 15:11      | Spinal Immobilization | Patient Response: Unchanged                                                             | FERGUSON, REBECCA |
| 15:12      | Spinal Immobilization | Patient Response: Unchanged                                                             | FERGUSON, REBECCA |
| 15:14      | Bleeding Control      | Patient Response: Unchanged                                                             | FERGUSON, REBECCA |
| 15:28      | IV Therapy            | 18 ga; Hand-Right; Saline Lock; Total Fluid 10; Patient Response: Unchanged; Successful | FERGUSON, REBECCA |





| Initial Assessment |                  |
|--------------------|------------------|
| Category           | Comments         |
| Status             | Mental Status    |
| HEENT              | No Abnormalities |
|                    | ⊕ Other          |
|                    | ⊕ Swelling       |
|                    | No Abnormalities |
| EENT               | No Abnormalities |
|                    | No Abnormalities |
|                    | No Abnormalities |
|                    | No Abnormalities |
| Chest              | No Abnormalities |
|                    | No Abnormalities |
|                    | No Abnormalities |
|                    | No Abnormalities |
| Abdomen            | No Abnormalities |
|                    | No Abnormalities |
|                    | No Abnormalities |
|                    | No Abnormalities |
| Back               | No Abnormalities |
|                    | No Abnormalities |
|                    | No Abnormalities |
|                    | No Abnormalities |
| Pelvis/GU/GI       | No Abnormalities |
|                    | No Abnormalities |
|                    | No Abnormalities |
|                    | No Abnormalities |
| Extremities        | No Abnormalities |
|                    | No Abnormalities |
|                    | No Abnormalities |
|                    | No Abnormalities |
| Vital              | Not Assessed     |
|                    | Not Assessed     |
|                    | No Abnormalities |
|                    | No Abnormalities |

Print Time: 05/21/2012 15:10



| Ongoing Assessment |                                                                                                                                                             |                  |                                       |
|--------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------|
| Category           | Comments                                                                                                                                                    | Abnormalities    |                                       |
| Status             |                                                                                                                                                             | Mental Status    | No Abnormalities                      |
|                    | LACERATION TO ABOVE RIGHT EYE HAS BLEEDING CONTROLLED WITH DRESSING AND SLIGHT PRESSURE APPLIED                                                             | Skin             | ⊕ Other                               |
| HEENT              |                                                                                                                                                             | Head/Face        | No Abnormalities                      |
|                    |                                                                                                                                                             | Eyes             | No Abnormalities                      |
|                    |                                                                                                                                                             | Neck             | No Abnormalities                      |
| Chest              |                                                                                                                                                             | Chest            | No Abnormalities                      |
|                    |                                                                                                                                                             | Heart Sounds     | No Abnormalities                      |
|                    |                                                                                                                                                             | Lung Sounds      | No Abnormalities                      |
| Abdomen            |                                                                                                                                                             | General          | No Abnormalities                      |
|                    |                                                                                                                                                             | Left Upper       | No Abnormalities                      |
|                    |                                                                                                                                                             | Right Upper      | No Abnormalities                      |
|                    |                                                                                                                                                             | Left Lower       | No Abnormalities                      |
|                    |                                                                                                                                                             | Right Lower      | No Abnormalities                      |
| Back               |                                                                                                                                                             | Cervical         | No Abnormalities                      |
|                    |                                                                                                                                                             | Thoracic         | No Abnormalities                      |
|                    |                                                                                                                                                             | Lumbar/Sacral    | No Abnormalities                      |
| Extremities/GU/GI  |                                                                                                                                                             | Pelvis/GU/GI     | No Abnormalities                      |
| Extremities        | PT HAS ABRASION AND BRUISING WITH SLIGHT SWELLING NOTED TO THE LOWER MEDIAL LEG, AND TO LOWER RIGHT ARM WITH NO BLEEDING CREPITUS OR OTHER OBVIOUS INJURIES | Left Arm         | No Abnormalities                      |
|                    |                                                                                                                                                             | Right Arm        | ⊕ Other                               |
|                    |                                                                                                                                                             | Left Leg         | No Abnormalities                      |
|                    |                                                                                                                                                             | Right Leg        | ⊕ Other                               |
|                    |                                                                                                                                                             | Pulse            | ⊕ Pedal: 2+ Normal, Radial: 2+ Normal |
|                    |                                                                                                                                                             | Capillary Refill | Not Assessed                          |
| Neurological       |                                                                                                                                                             | Neurological     | No Abnormalities                      |

Assessment Time: 05/21/2012 15:45

**Narrative**  
EDIC 82 RESPONDED TO ABOVE LOCATION FOR MVA VEHICLE V/S TREE. U/A FOUND 70 Y/O FEMALE CAOx4 SITTING ON SIDE OF ROAD STATING THAT SHE WAS THE RESTRAINED DRIVER OF SEDAN CAR WITH MODERATE TO HEAVY FRONT END DAMAGE, AIRBAG DEPLOYMENT. PT FULLY IMOBILIZED ON LSB WITH C-COLLAR IN PLACE. PE SHOWS HEMATOMA OVER THE RIGHT EYE AND 2 LACERATIONS TO THE RIGHT SIDE OF HER FACE 1 JUST OVER HER RIGHT EYE APPROX 1/2 INCH IN SIZE AND 1 TO THE RIGHT SIDE OF EYE ALSO APPROX 1/2 INCH WITH SLIGHT BLEEDING, DRESSING APPLIED AND ICE PACK FOR SWELLING. PT ALSO HAS ABRASION WITH SLIGHT SWELLING AND BRUISING NOTED TO THE LOWER RIGHT LEG AND LOWER RIGHT ARM. PT DENIES ANY NECK OR BACK PAIN AND ALSO DENIES ANY LOSS OF CONSCIOUSNESS BUT IS FULLY IMOBILIZED DUE TO THE HEMATOMA ABOVE EYE. PT REMAINS CAOx4 DURING TRANSPORT AND ANSWERS ALL QUESTIONS APPROPRIATELY. VS BGL 216 AND PERRL, LUNG SOUNDS CLEAR AND EQUAL AND IV EST AS NOTED. PRIOR TO TRANSPORT WHILE VITALS OBTAINED PTS BP NOTED TO BE VERY HIGH PER PTS STATED NORMAL. CCH CONTACTED WITHOUT ANY QUESTIONS OR ORDERS. PT TRANSPORTED WITHOUT FURTHER CHANGE. U/A PT CARE AND REPORT TURNED OVER TO ER STAFF BED 5

| Specialty Patient - Motor Vehicle Collision |            |                        |                         |  |  |
|---------------------------------------------|------------|------------------------|-------------------------|--|--|
| Patient Injured                             | Yes        | Law Enforcement Case # |                         |  |  |
| Vehicle Type                                | Automobile | Collision Indicators   | Windshield Spider/Star  |  |  |
| Position in Vehicle                         | Driver     | Damage Location        | Center Front            |  |  |
| Seat Row                                    | 1          | Airbag Deployment      | Front Deployed          |  |  |
| Weather                                     | Overcast   | Safety Devices         | Lap Belt, Shoulder Belt |  |  |
| Extrication Required                        | No         | Extrication Comments   |                         |  |  |
| Estimated Speed                             | 45mph      | Extrication Time       |                         |  |  |

| Specialty Patient - Spinal Immobilization |                       |                                     |                    |                    |                        |
|-------------------------------------------|-----------------------|-------------------------------------|--------------------|--------------------|------------------------|
| Immobilization Recommended?               | Altered Mental Status | Evidence of Alcohol/Drug Impairment | Distracting Injury | Neurologic Deficit | Spinal Pain/Tenderness |
| No                                        | No                    | No                                  | No                 | No                 | No                     |



Name: BARON, FRANCES

Incident #: 12-1338

Date: 05/21/2012

Patient 1 of 1

| Patient Details  |                          | Destination Details      |                             | Incident Times |          |
|------------------|--------------------------|--------------------------|-----------------------------|----------------|----------|
| Location         | 170 SIDE OF SNAKE ROAD   | Disposition              | Transported No Lights/Siren | Call Received  | 14:54:00 |
| Address          | SNAKE ROAD               | Transport Due To         | Patient                     | Dispatched     | 14:56:00 |
|                  | Ridgeland                | Transported to           | Coastal Carolina Hospital   | En Route       | 14:57:00 |
| State            | SC                       | Requested By             | Patient                     | Response Scene | 15:07:00 |
| Zip              | 29936                    | Destination              | Hospital ER                 | On Scene       | 15:08:00 |
| Medic Unit       | Medic 82                 | Address                  | 1000 Medical Center Drive   | At Patient     | 15:09:00 |
| Unit Type        | 911 Response (Emergency) | Address 2                |                             | Depart Scene   | 15:35:00 |
| Priority Score   | Lights/Sirens            | City                     | Hardeeville                 | At Destination | 15:52:00 |
| Shift            | B Shift                  | State                    | SC                          | En Route       | 15:54:00 |
| Line             | 82                       | Zip                      | 29927                       | Incident Close | 16:10:00 |
| Level of Service |                          | Zone                     | 81                          | In District    | 16:10:00 |
|                  |                          | Condition at Destination | Unchanged                   |                |          |
|                  |                          | Destination Record #     |                             |                |          |

| Crew Members     |        |                         |
|------------------|--------|-------------------------|
| Personnel        | Role   | Certification Level     |
| REGUSON, REBECCA | Lead   | EMT-Paramedic-SC011383; |
| TTLES, THERESA   | Driver | EMT-Basic-SC018354;     |

| Insurance Details       |              |                   |                    |
|-------------------------|--------------|-------------------|--------------------|
| Insured's Name          | EDWARD BARON | Primary Payer     | Dispatch Nature    |
| Relationship To Patient | Spouse       | Medicare          | Response Urgency   |
| Insured SSN             |              | Medicaid          | Job Related Injury |
| Insured DOB             |              | Primary Insurance | Employer           |
| Address 1               |              | Policy #          | Contact            |
| Address 2               |              | Group #           | Phone              |
| Address 3               |              | Secondary Ins     |                    |
| City                    |              | Policy #          |                    |
| State                   |              | Group #           |                    |
| County                  |              |                   |                    |

| Mileage      |      | Delays             |        | Additional Agencies                                        |  |
|--------------|------|--------------------|--------|------------------------------------------------------------|--|
| Scene        | 40.0 | Category           | Delays | Hardeeville Fire Department, South Carolina Highway Patrol |  |
| Destination  | 55.0 | Dispatch Delays    | None   |                                                            |  |
| Loaded Miles | 15.0 | Response Delays    | None   |                                                            |  |
| Arrive       | 28.0 | Scene Delays       | None   |                                                            |  |
| Loaded Miles | 66.0 | Transport Delays   | None   |                                                            |  |
| Arrive Miles | 38.0 | Turn Around Delays | None   |                                                            |  |

| Next of Kin             |              |           |         |
|-------------------------|--------------|-----------|---------|
| Next of Kin Name        | EDWARD BARON | Address 1 | City    |
| Relationship to Patient | Spouse       | Address 2 | State   |
| Phone                   |              | Address 3 | Zip     |
|                         |              |           | Country |

| Personal Items |                   |         |
|----------------|-------------------|---------|
| Item           | Given To          | Comment |
| Purse/Wallet   | GIVEN TO PT AT ER |         |

| Transfer Details  |                         |  |
|-------------------|-------------------------|--|
| IN                | Sending Physician       |  |
| SS                | Sending Record #        |  |
| ON                | Receiving Physician     |  |
| VS/Service Level  | Condition Code          |  |
| D-9 Code          | Condition Code Modifier |  |
| Transfer Reason   |                         |  |
| Ref/Services      |                         |  |
| Medical Necessity | Immobilized-            |  |

ISSUE DATE: 6/27/12  
ISSUE TIME: 17:29:42

PATIENT CHARGE DETAIL BY SERVICE DATE  
FOR FACILITY: CDD

PROGRAM-ID: NC2651  
PAGE NUMBER: 1

| PATIENT<br>ACCT# | PATIENT NAME  | SERVICE<br>DATE | POST<br>DATE | POST<br>BY | CHARGE<br>ITEM | REV<br>CODE       | DESCRIPTION     | HCPCS<br>CODE | QTY | CHARGE AMT | ACCU<br>TOTAL CHARGE |
|------------------|---------------|-----------------|--------------|------------|----------------|-------------------|-----------------|---------------|-----|------------|----------------------|
| ████████         | BARON FRANCES | 5/21/12         | 5/22/12      | HL7P       | 41001116       | 0300              | COMP METABLC PH | 80051         | 1   | 250.59     | 250.59               |
|                  |               | 5/22/12         | HL7P         | 41025503   | 0300           | CPK TOTAL         | 82550           |               | 1   | 102.38     | 352.97               |
|                  |               | 5/22/12         | HL7P         | 41025537   | 0300           | CK MB FRAC        | 82553           |               | 1   | 136.02     | 488.99               |
|                  |               | 5/22/12         | HL7P         | 41029620   | 0300           | GLUC BLD MNT DV   | 82962           |               | 1   | 9.59       | 498.58               |
|                  |               | 5/22/12         | HL7P         | 41037359   | 0300           | MAGNESIUM         | 83735           |               | 1   | 55.43      | 554.01               |
|                  |               | 5/22/12         | HL7P         | 41044363   | 0300           | THYROXIN TOTAL    | 84436           |               | 1   | 119.76     | 672.77               |
|                  |               | 5/22/12         | HL7P         | 41044439   | 0300           | TSH               | 84443           |               | 1   | 219.50     | 892.27               |
|                  |               | 5/22/12         | HL7P         | 41044843   | 0300           | TROPONTIN         | 84484           |               | 1   | 237.93     | 1,130.20             |
|                  |               | 5/22/12         | HL7P         | 41050287   | 0300           | CBC/DIFF&PLATLT   | 85025           |               | 1   | 143.90     | 1,274.10             |
|                  |               | 5/22/12         | HL7P         | 41056102   | 0300           | PROTHROM TIME     | 85610           |               | 1   | 97.30      | 1,371.40             |
|                  |               | 5/22/12         | HL7P         | 41057001   | 0300           | PTT               | 85730           |               | 1   | 83.13      | 1,454.53             |
|                  |               | 5/22/12         | HL7P         | 41087818   | 0300           | MRAA SCREEN       | 87081           |               | 1   | 35.27      | 1,549.80             |
|                  |               | 5/22/12         | HL7P         | 46030003   | 0730           | EKG               | 93005           |               | 1   | 262.60     | 1,812.40             |
|                  |               | 5/22/12         | HL7P         | 46030003   | 0730           | EKG               | 93005           |               | 1   | 262.60     | 2,075.00             |
|                  |               | 5/22/12         | HL7P         | 49010101   | 0320           | CHBST SINGLE VW   | 71010           |               | 1   | 329.33     | 2,404.33             |
|                  |               | 5/22/12         | HL7P         | 50504505   | 0350           | CT HD/BRW WO CM   | 70450           |               | 1   | 1,863.50   | 4,267.83             |
|                  |               | 5/22/12         | HL7P         | 50504869   | 0350           | CT FACIAL WO CM   | 70486           |               | 1   | 1,783.62   | 6,051.45             |
|                  |               | 5/22/12         | HL7P         | 50512506   | 0350           | CT THORAX WO CM   | 71250           |               | 1   | 2,267.14   | 8,318.59             |
|                  |               | 5/22/12         | HL7P         | 50521251   | 0350           | CT SP CERV W/O    | 72125           |               | 1   | 2,713.11   | 11,031.70            |
|                  |               | 5/22/12         | HL7P         | 53000170   | 0637           | APAP 325MG TB     | A9150           |               | 2   | 6.52       | 11,038.22            |
|                  |               | 5/22/12         | HL7P         | 53204186   | 0636           | ENOXAPARIN 101J   | J1650           |               | 1   | 61.94      | 11,100.16            |
|                  |               | 5/25/12         | BYOU         | 53204186   | 0636           | ENOXAPARIN        | J1650           |               | 4   | 247.76     | 11,347.92            |
|                  |               | 5/25/12         | BYOU         | 53204186   | 0636           | ENOXAPARIN        | J1650           |               | 1   | 61.94      | 11,285.98            |
|                  |               | 5/22/12         | HL7P         | 61005278   | 0450           | HR VISIT LVL V    | 99285           |               | 1   | 1,433.49   | 12,719.46            |
|                  |               | 5/22/12         | THAD         | 62406145   | 0762           | OBS 23LMS 1/HR    | 99218           |               | 1   | 268.06     | 12,987.52            |
|                  |               | 5/22/12         | THAD         | 62406152   | 0762           | OBS 23LMS AD HR   | 99218           |               | 4   | 108.92     | 13,095.84            |
|                  |               | 5/22/12         | HL7P         | 80220007   | 0272           | ADHES DERMA       |                 |               | 1   | 119.81     | 13,215.65            |
|                  |               | 5/24/12         | THAD         | 82030040   | 0270           | ELCTRD ECG PACE   |                 |               | 1   | 5.26       | 13,220.91            |
|                  |               | 5/24/12         | THAD         | 82030040   | 0270           | ELCTRD ECG PACE   |                 |               | 1   | 5.26       | 13,226.17            |
|                  |               | 5/23/12         | HL7P         | 41000621   | 0300           | LIPID PANEL       | 80061           |               | 1   | 189.04     | 13,415.21            |
|                  |               | 5/23/12         | HL7P         | 41001660   | 0300           | BSC METABLC PNL   | 80048           |               | 1   | 156.26     | 13,571.47            |
|                  |               | 5/23/12         | HL7P         | 41025503   | 0300           | CPK TOTAL         | 82550           |               | 1   | 102.38     | 13,673.85            |
|                  |               | 5/23/12         | HL7P         | 41025503   | 0300           | CPK TOTAL         | 82550           |               | 1   | 102.38     | 13,776.23            |
|                  |               | 5/23/12         | HL7P         | 41025537   | 0300           | CK MB FRAC        | 82553           |               | 1   | 136.02     | 13,912.25            |
|                  |               | 5/23/12         | HL7P         | 41025537   | 0300           | CK MB FRAC        | 82553           |               | 1   | 136.02     | 14,048.27            |
|                  |               | 5/23/12         | HL7P         | 41029620   | 0300           | GLUC BLD MNT DV   | 82962           |               | 1   | 9.59       | 14,057.86            |
|                  |               | 5/23/12         | HL7P         | 41029620   | 0300           | GLUC BLD MNT DV   | 82962           |               | 1   | 9.59       | 14,067.45            |
|                  |               | 5/23/12         | HL7P         | 41029620   | 0300           | GLUC BLD MNT DV   | 82962           |               | 1   | 9.59       | 14,077.04            |
|                  |               | 5/23/12         | HL7P         | 41029620   | 0300           | GLUC BLD MNT DV   | 82962           |               | 1   | 9.59       | 14,086.63            |
|                  |               | 5/23/12         | HL7P         | 41044843   | 0300           | TROPONTIN         | 84484           |               | 1   | 237.93     | 14,324.56            |
|                  |               | 5/23/12         | HL7P         | 41044843   | 0300           | TROPONTIN         | 84484           |               | 1   | 237.93     | 14,562.49            |
|                  |               | 5/23/12         | HL7P         | 41050287   | 0300           | CBC/DIFF&PLATLT   | 85025           |               | 1   | 143.90     | 14,706.39            |
|                  |               | 5/23/12         | HL7P         | 46030003   | 0730           | EKG               | 93005           |               | 1   | 262.60     | 14,968.99            |
|                  |               | 5/23/12         | HL7P         | 46333068   | 0480           | CARD ECHO 2D      | 93306           |               | 1   | 2,123.07   | 17,092.06            |
|                  |               | 5/23/12         | HL7P         | 50665413   | 0921           | DUPLX CARTD BI    | 93880           |               | 1   | 1,119.63   | 18,211.69            |
|                  |               | 5/23/12         | HL7P         | 52506011   | 0610           | MRA HD W/O        | 70544           |               | 1   | 1,963.08   | 20,174.77            |
|                  |               | 5/23/12         | HL7P         | 52506086   | 0610           | MRA NBCK WO/W     | 70549           |               | 1   | 2,248.61   | 22,423.38            |
|                  |               | 5/23/12         | HL7P         | 52508165   | 0610           | MRI BRAIN WO/W    | 70553           |               | 1   | 2,248.61   | 24,671.99            |
|                  |               | 5/23/12         | HL7P         | 53000170   | 0637           | APAP 325MG TB     | A9150           |               | 2   | 6.52       | 24,678.51            |
|                  |               | 5/23/12         | HL7P         | 53011136   | 0637           | ASA 325MG TB      | A9150           |               | 1   | 3.79       | 24,682.30            |
|                  |               | 5/23/12         | HL7P         | 53066346   | 0637           | LYSINOPR 2.5MG TB | J8499           |               | 2   | 10.06      | 24,692.36            |

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Coastal Carolina Medical Center  
1000 Medical Center Drive  
Hatterasville, S.C. 29927

Jun. 27. 2012 5:33PM Coastal Carolina Hospital PFS

No. 9966 P. 2

ISSUE DATE: 6/27/12  
ISSUE TIME: 17:29:42

PATIENT CHARGE DETAIL BY SERVICE DATE  
FOR FACILITY: CCD

PROGRAM-ID: NC2651  
PAGE NUMBER: 2

PATIENT  
ACCT# PATIENT NAME

| SERVICE<br>DATE | POST<br>DATE | POST<br>BY | CHARGE<br>ITEM | REV<br>CODE | DESCRIPTION     | HCPCS<br>CODE | QTY | CHARGE AMT | ACCOM<br>TOTAL CHARGE |
|-----------------|--------------|------------|----------------|-------------|-----------------|---------------|-----|------------|-----------------------|
| 5/23/12         | HL7P         | 53073607   | 0637           | 0637        | METFORMIN500TB  | J1650         | 2   | 7.92       | 24,700.28             |
| 5/23/12         | HL7P         | 53204186   | 0636           | 0636        | EROSAPARIN 101J | J1650         | 1   | 61.94      | 24,762.22             |
| 5/25/12         | NYOU         | 53204186   | 0636           | 0636        | EROSAPARIN      | J1650         | 4   | 247.76     | 25,009.98             |
| 5/25/12         | NYOU         | 53204186   | 0636           | 0636        | EROSAPARIN      | J1650         | 1-  | 61.94-     | 24,948.04             |
| 5/23/12         | HL7P         | 53206611   | 0250           | 0250        | PANOTIDIN20MG1J | S0028         | 1   | 26.25      | 24,974.29             |
| 5/23/12         | HL7P         | 53206611   | 0250           | 0250        | PANOTIDIN20MG1J | S0028         | 1   | 26.25      | 25,000.54             |
| 5/23/12         | HL7P         | 53216339   | 0636           | 0636        | KETOROLAC 15MG  | J1885         | 1   | 25.00      | 25,025.54             |
| 5/23/12         | HL7P         | 53216339   | 0636           | 0636        | KETOROLAC 15MG  | J1885         | 1   | 4.86       | 25,030.40             |
| 5/25/12         | NYOU         | 53216339   | 0636           | 0636        | KETOROLAC       | J1885         | 2   | 4.86       | 25,035.26             |
| 5/25/12         | NYOU         | 53216339   | 0636           | 0636        | KETOROLAC       | J1885         | 2   | 9.72       | 25,044.98             |
| 5/25/12         | NYOU         | 53216339   | 0636           | 0636        | KETOROLAC       | J1885         | 2   | 9.72       | 25,054.70             |
| 5/25/12         | NYOU         | 53216339   | 0636           | 0636        | KETOROLAC       | J1885         | 1-  | 4.86-      | 25,049.84             |
| 5/25/12         | NYOU         | 53216339   | 0636           | 0636        | KETOROLAC       | J1885         | 1-  | 4.86-      | 25,044.98             |
| 5/23/12         | HL7P         | 53246187   | 0636           | 0636        | TELAMINE100MG1J | J3411         | 1   | 68.90      | 25,113.88             |
| 5/23/12         | HL7P         | 53582417   | 0636           | 0636        | MR CONTRAST 1ML | A9579         | 30  | 165.40     | 25,479.28             |
| 5/23/12         | HL7P         | 57052029   | 0424           | 0424        | PT EVAL INT     | 97001         | 1   | 177.89     | 25,657.17             |
| 5/24/12         | THAD         | 62406152   | 0762           | 0762        | OBS 23LMS AD HR | 99218         | 24  | 649.92     | 26,307.09             |
| 5/24/12         | HL7P         | 41010042   | 0300           | 0300        | UR NO MICRO AUT | 81003         | 1   | 52.03      | 26,359.12             |
| 5/24/12         | HL7P         | 41026113   | 0300           | 0300        | VIT B12         | 82607         | 1   | 153.03     | 26,512.15             |
| 5/24/12         | HL7P         | 41029620   | 0300           | 0300        | GLUC BLD MNT DV | 82962         | 1   | 9.59       | 26,521.74             |
| 5/24/12         | HL7P         | 41029620   | 0300           | 0300        | GLUC BLD MNT DV | 82962         | 1   | 9.59       | 26,531.33             |
| 5/24/12         | HL7P         | 41029620   | 0300           | 0300        | GLUC BLD MNT DV | 82962         | 1   | 9.59       | 26,540.92             |
| 5/24/12         | HL7P         | 41044439   | 0300           | 0300        | TSE             | 84443         | 1   | 219.50     | 26,760.42             |
| 5/24/12         | HL7P         | 41056532   | 0300           | 0300        | SED RATE AUTO   | 85652         | 1   | 91.57      | 26,851.99             |
| 5/24/12         | HL7P         | 41070863   | 0300           | 0300        | CULT URIN CNT   | 87086         | 1   | 158.04     | 27,010.03             |
| 5/24/12         | HL7P         | 41090093   | 0300           | 0300        | VENIPUNCTURE    | 36415         | 1   | 20.18      | 27,030.21             |
| 5/24/12         | HL7P         | 49036106   | 0320           | 0320        | ANKLE 3 VNS MIN | 73610         | 1   | 406.55     | 27,436.76             |
| 5/25/12         | HL7P         | 49036106   | 0320           | 0320        | ANKLE 3 VNS MIN | 73610         | 1   | 406.55     | 27,843.31             |
| 5/24/12         | HL7P         | 53064580   | 0637           | 0637        | LEVOTRY.125MG1B | J8499         | 1   | 3.88       | 27,847.19             |
| 5/24/12         | HL7P         | 53064580   | 0637           | 0637        | LEVOTRY.125MG1B | J8499         | 2   | 10.04      | 27,857.25             |
| 5/24/12         | HL7P         | 53073607   | 0637           | 0637        | METFORMIN500TB  | J1650         | 2   | 7.92       | 27,865.17             |
| 5/24/12         | HL7P         | 53204186   | 0636           | 0636        | EROSAPARIN 101J | J1650         | 1   | 61.94      | 27,927.11             |
| 5/29/12         | THAD         | 53204186   | 0636           | 0636        | EROSAPARIN      | J1650         | 1-  | 61.94-     | 27,865.17             |
| 5/29/12         | THAD         | 53204186   | 0636           | 0636        | EROSAPARIN      | J1650         | 4   | 247.76     | 28,112.93             |
| 5/24/12         | HL7P         | 53206611   | 0250           | 0250        | PANOTIDIN20MG1J | S0028         | 1   | 26.25      | 28,139.18             |
| 5/24/12         | HL7P         | 53246187   | 0636           | 0636        | TELAMINE100MG1J | J3411         | 1   | 68.90      | 28,208.08             |
| 5/24/12         | HL7P         | 57053126   | 0420           | 0420        | THERPTC ACTEALS | 97530         | 1   | 82.49      | 28,290.51             |
| 5/24/12         | HL7P         | 57056566   | 0420           | 0420        | GAIT/STR TRN 15 | 97116         | 1   | 67.56      | 28,358.07             |
| 5/24/12         | THAD         | 62406152   | 0762           | 0762        | OBS 23LMS AD HR | 99218         | 12  | 324.96     | 28,683.03             |
| 5/24/12         | HL7P         | 72562572   | 0300           | 0300        | LYME DISEASE    | 86618         | 1   | 136.34     | 28,819.37             |

TOTAL CHARGES FOR ACCT:

28,819.37

Coastal Carolina Medical Center  
1030 Medical Center Drive  
Harrisville, S.C. 29927

ISSUE DATE: 6/27/12  
ISSUE TIME: 17:29:42

PATIENT CHARGE DETAIL BY SERVICE DATE  
FOR FACILITY: CDD

PROGRAM-ID: NC2651  
PAGE NUMBER: 3

PATIENT  
ACCT# PATIENT NAME

| SERVICE DATE | POST DATE | POST BY | CHARGE ITEM | REV CODE | DESCRIPTION      | RCPCS CODE | QTY | CHARGE AMT | ACCUH TOTAL CHARGE |
|--------------|-----------|---------|-------------|----------|------------------|------------|-----|------------|--------------------|
| 5/29/12      | 5/31/12   | KL7P    | 32135527    | 0360     | SURG LVII INT30  |            | 1   | 3,246.18   | 3,246.18           |
|              | 5/31/12   | HL7P    | 32135535    | 0360     | SURG LVII BAL5   |            | 4   | 3,515.36   | 6,761.54           |
|              | 5/31/12   | HL7P    | 32235707    | 0710     | RECOVERY INT 30  |            | 1   | 671.37     | 7,432.91           |
|              | 5/31/12   | HL7P    | 32235715    | 0710     | RECOVERY HA 15M  |            | 2   | 405.56     | 7,838.47           |
|              | 5/31/12   | HL7P    | 32235715    | 0710     | RECOVERY HA 15M  |            | 7   | 1,419.46   | 9,257.93           |
|              | 5/31/12   | HL7P    | 37035607    | 0370     | ANESTH INT 10M   |            | 1   | 693.98     | 9,951.91           |
|              | 5/31/12   | HL7P    | 37035615    | 0370     | ANESTH HA ADD15  |            | 4   | 953.28     | 10,905.19          |
|              | 5/30/12   | HL7P    | 41029620    | 0300     | CLUC BLD MNT DV  | 82962      | 1   | 9.59       | 10,914.78          |
|              | 5/30/12   | HL7P    | 49036007    | 0320     | ANKLE 2 VWS      | 73600      | 1   | 398.81     | 11,313.59          |
|              | 5/30/12   | HL7P    | 49036106    | 0320     | ANKLE 3 VWS MEM  | 73610      | 1   | 406.55     | 11,720.14          |
|              | 5/30/12   | HL7P    | 50669605    | 0402     | OS GUIDANCE      | 76942      | 1   | 461.98     | 12,182.12          |
|              | 5/30/12   | HL7P    | 53189734    | 0636     | CEFAZOL500PBIV   | J0690      | 2   | 54.24      | 12,236.36          |
|              | 5/30/12   | HL7P    | 53221008    | 0636     | MEPIVACAINHLIV   | J0670      | 1   | 14.18      | 12,250.54          |
|              | 5/30/12   | HL7P    | 53224549    | 0636     | MIDAZOLAM IMGLJ  | J2250      | 1   | 2.93       | 12,253.47          |
|              | 6/01/12   | THAD    | 53224549    | 0636     | MIDAZOLAM        | J2250      | 2   | 5.86       | 12,259.33          |
|              | 6/01/12   | THAD    | 53224549    | 0636     | MIDAZOLAM        | J2250      | 1   | 2.93       | 12,262.40          |
|              | 5/30/12   | HL7P    | 532240529   | 0636     | ROPIVACAINIMGLJ  | J2795      | 1   | 2.53       | 12,264.93          |
|              | 5/30/12   | HL7P    | 532275012   | 0636     | PENTANYL IMG IJ  | J3010      | 1   | 6.48       | 12,271.41          |
|              | 5/31/12   | HL7P    | 532275921   | 0636     | HYDROMORPHMG IJ  | J1170      | 1   | 19.44      | 12,290.85          |
|              | 5/31/12   | HL7P    | 54125505    | 0636     | L RINGERS ILIVP  | J7120      | 2   | 110.64     | 12,401.49          |
|              | 5/31/12   | HL7P    | 54141452    | 0270     | NACL .9 500 EBR  | A4217      | 2   | 7.54       | 12,409.03          |
|              | 5/31/12   | HL7P    | 54200209    | 0270     | ST PRIM CRTPLN   |            | 1   | 43.05      | 12,452.08          |
|              | 5/31/12   | HL7P    | 54203187    | 0270     | LINE IV INFUS    |            | 1   | 17.94      | 12,469.02          |
|              | 5/31/12   | HL7P    | 54204334    | 0270     | CATH IV JELCO    |            | 1   | 9.20       | 12,478.22          |
|              | 5/31/12   | HL7P    | 55007009    | 0270     | OXYGEN INITIAL   |            | 1   | 140.80     | 12,619.02          |
|              | 5/31/12   | HL7P    | 80240468    | 0270     | END BLST A/S     |            | 2   | 33.84      | 12,652.86          |
|              | 5/31/12   | HL7P    | 80242019    | 0270     | END WEBERIL A/S  |            | 3   | 107.07     | 12,759.93          |
|              | 5/31/12   | HL7P    | 80242019    | 0270     | END WEBERIL A/S  |            | 2   | 71.38      | 12,831.31          |
|              | 5/31/12   | HL7P    | 80243009    | 0270     | DRS AED PD       |            | 2   | 1.36       | 12,832.67          |
|              | 5/31/12   | HL7P    | 80243876    | 0272     | DRS COBAN 6XN    |            | 1   | 22.68      | 12,855.35          |
|              | 5/31/12   | HL7P    | 80249774    | 0270     | DRS XEROFORM A/S |            | 1   | 3.92       | 12,859.27          |
|              | 5/31/12   | HL7P    | 80730609    | 0272     | GN               | C1769      | 3   | 280.23     | 13,139.50          |
|              | 5/31/12   | HL7P    | 80931306    | 0270     | PD GROUNDING BIO |            | 1   | 34.77      | 13,174.27          |
|              | 6/01/12   | THAD    | 81360307    | 0278     | SCOW CANN        | C1713      | 2   | 1,669.86   | 14,844.13          |
|              | 5/31/12   | HL7P    | 81651002    | 0272     | PK EXTREMITY     |            | 1   | 76.15      | 14,920.28          |
|              | 5/31/12   | HL7P    | 81711251    | 0271     | CIRC BREATH      |            | 1   | 36.22      | 14,956.50          |
|              | 5/31/12   | HL7P    | 81740508    | 0272     | DRILL BIT CANNL  |            | 1   | 1,679.58   | 16,636.08          |
|              | 5/30/12   | HL7P    | 81754616    | 0272     | NDL STIMULAT     |            | 1   | 43.57      | 16,679.65          |
|              | 5/31/12   | HL7P    | 81826103    | 0270     | IMPERVUS STOCKIN |            | 1   | 19.30      | 16,698.95          |
|              | 5/31/12   | HL7P    | 81850083    | 0270     | SCALPEL          |            | 2   | 17.60      | 16,716.55          |
|              | 5/31/12   | HL7P    | 83941452    | 0272     | SUT CLOS ETHLON  |            | 2   | 29.72      | 16,746.27          |
|              | 5/31/12   | HL7P    | 82011206    | 0270     | AW ORAL          |            | 1   | 1.70       | 16,747.97          |
|              | 5/31/12   | HL7P    | 82030040    | 0270     | ELECTRD DCS PAGE |            | 1   | 5.26       | 16,753.23          |

TOTAL CHARGES FOR ACCT:

16,728.23

-184-

Coastal Carolina Medical Center  
1000 Medical Center Drive  
Hartsville, S.C. 29327

Jun. 27. 2012 5:33PM Coastal Carolina Hospital PFS

No. 9966 P. 4

ISSUE DATE: 6/27/12  
ISSUE TIME: 17:29:42

PATIENT  
ACCT# PATIENT NAME  
[REDACTED] BARON FRANCES

TOTAL CHARGES FOR ACCT:

PATIENT CHARGE DETAIL BY SERVICE DATE  
FOR FACILITY: CCD

| SERVICE<br>DATE | POST<br>DATE | POST<br>BY | CHARGE<br>ITEM | REV<br>CODE | DESCRIPTION      |
|-----------------|--------------|------------|----------------|-------------|------------------|
| 5/31/12         | 6/02/12      | KL7P       | 69004026       | 0510        | WDC SURG LVL III |
|                 | 6/02/12      | KL7P       | 69010049       | 0510        | BLX-WF LVL IV    |

| HCPCS<br>CODE | QTY |
|---------------|-----|
| 99204         | 1   |

PROGRAM-ID: NC2651  
PAGE NUMBER: 4

| CHARGE AMT | ACCOM<br>TOTAL CHARGE |
|------------|-----------------------|
| 775.39     | 775.39                |
| 232.62     | 1,008.01              |
| 1,008.01   |                       |

Coastal Carolina Medical Center  
1000 Medical Center Drive  
Hartsville, S.C. 29527

Jun. 27. 2012 5:33PM

Coastal Carolina Hospital PFS

No. 9966 P. 5

STMT DATE: 06/20/12

S T A T E M E N T \* \* \* S T A T E M E N T \* \* \* S T A T E M E N T

ADDRESS CORRECTION REQUESTED

FRANCES BARON

ACCT#: [REDACTED]

INSUR CO: AUTO ACCIDENT INSURANCE

PATIENT: FRANCES BARON

## ACCOUNT DETAIL BELOW

| D.O.S.   | DX    | SERVICE DESC              | CPT   | CHARGE |
|----------|-------|---------------------------|-------|--------|
| 05/21/12 | 780.2 | 12 Lead Electrocardiogram | G8704 | .00    |
| 06/20/12 |       | TRANSFERRED BILLED INS    |       | .00    |
| 05/21/12 | 780.2 | E/M Level 5               | 99285 | 506.00 |
| 06/20/12 |       | TRANSFERRED BILLED INS    |       | .00    |
| 05/21/12 | 780.2 | EKG interpretation and re | 93010 | 25.00  |
| 06/20/12 |       | TRANSFERRED BILLED INS    |       | .00    |

TOTAL BALANCE DUE: 531.00

Returned checks subject to \$30.00 service charge.

You may contact us, MBI Solutions, by calling 1-800-875-7374  
during normal working hrs of 8:00AM - 4:30PM, Mon-Fri.

Service(s) rendered at:

By Emergency Room Physician: ZORCH PAUL MD  
Tax Id #200495416

This is the ED doctors' bill, NOT the hospital's.

Mail your payment to:

HILTON HEAD EMERG PHYS  
PO BOX 634125  
CINCINNATI, OH 45263

Mark on your check, "For ED acct # 693750842 "



1500

SOUTH CAROLINA MEDIC 0002  
PO BOX 100190

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

COLUMBIA

SC 29202-3190

CA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

| <input type="checkbox"/> MEDICARE<br>(Medicare #)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                     | <input type="checkbox"/> MEDICAID<br>(Medicaid #) |                                                                                         | <input type="checkbox"/> TRICARE<br>CHAMPUS<br>(Sponsor's SSN) |               | <input type="checkbox"/> CHAMPVA<br>(Member ID#) |                   | <input type="checkbox"/> GROUP<br>HEALTH PLAN<br>(SSN or ID) |                             | <input type="checkbox"/> FECA<br>BLK/LUNG<br>(SSN) |  | <input type="checkbox"/> OTHER<br>(ID) |  | PICA <input type="checkbox"/>                   |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------|-----------------------------------------------------------------------------------------|----------------------------------------------------------------|---------------|--------------------------------------------------|-------------------|--------------------------------------------------------------|-----------------------------|----------------------------------------------------|--|----------------------------------------|--|-------------------------------------------------|---------------------|--------|-----------------------------------------------------------------------------------------|----------------------|---------------|------------------|-------------------|--------------|-----------------------------|-----------------------|----|--|----------|---|-------|---|--|-----|-----------|-----------------------|----|--|----------|---|-------|---|--|-----|-----------|--|--|--|--|--|--|--|--|-----|--|--|--|--|--|--|--|--|--|-----|--|--|--|--|--|--|--|--|--|-----|--|--|--|--|--|--|--|--|--|-----|--|--|--|--|--|--|--|--|--|-----|--|--|--|--|--|--|--|--|--|-----|--|--|--|--|--|--|--|--|--|-----|--|
| 1. INSURED'S ID NUMBER (For Program in Item 1)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)<br>ARON FRANCES A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 3. PATIENT'S BIRTH DATE MM DD YY<br>4. INSURED'S NAME (Last Name, First Name, Middle Initial)<br>ARON FRANCES A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 5. PATIENT'S ADDRESS (No., Street)<br>CITY STATE ZIP CODE TELEPHONE (Include Area Code)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 6. PATIENT RELATIONSHIP TO INSURED<br>Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 7. INSURED'S ADDRESS (No., Street)<br>CITY STATE ZIP CODE TELEPHONE (Include Area Code)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 8. PATIENT STATUS<br>Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)<br>ARON EDWARD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 10. IS PATIENT'S CONDITION RELATED TO?<br>a. EMPLOYMENT? (Current or Previous)<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 11. INSURED'S POLICY GROUP OR FECA NUMBER<br>a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| b. EMPLOYER'S NAME OR SCHOOL NAME<br>c. INSURANCE PLAN NAME OR PROGRAM NAME<br>SOUTH CAROLINA MEDICARE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| d. IS THERE ANOTHER HEALTH BENEFIT PLAN?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete item 9 a-d.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.<br>SIGNATURE ON FILE 06 04 2012<br>SIGNED DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.<br>SIGNATURE ON FILE<br>SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)<br>2012                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY<br>17a. 17b. 17c. 17d. N1730179979                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION<br>FROM MM DD YY TO MM DD YY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE<br>JUL ZORCH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES<br>FROM MM DD YY TO MM DD YY<br>05 21 2012                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 19. RESERVED FOR LOCAL USE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 20. OUTSIDE LAB? \$ CHARGES<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)<br>1922 1<br>2920                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.<br>23. PRIOR AUTHORIZATION NUMBER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| <table border="1"> <thead> <tr> <th>A. DATE(S) OF SERVICE From MM DD YY To MM DD YY</th> <th>B. PLACE OF SERVICE</th> <th>C. EMG</th> <th>D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER</th> <th>E. DIAGNOSIS POINTER</th> <th>F. \$ CHARGES</th> <th>G. DAYS OR UNITS</th> <th>H. 800T FARM PLAN</th> <th>I. JD. QUAL.</th> <th>J. RENDERING PROVIDER ID. #</th> </tr> </thead> <tbody> <tr> <td>02/12/2012 05/21/2012</td> <td>23</td> <td></td> <td>71010 26</td> <td>1</td> <td>25 00</td> <td>1</td> <td></td> <td>NPI</td> <td>508819970</td> </tr> <tr> <td>02/12/2012 05/21/2012</td> <td>23</td> <td></td> <td>70486 26</td> <td>2</td> <td>59 58</td> <td>1</td> <td></td> <td>NPI</td> <td>508819970</td> </tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td><td></td></tr> </tbody> </table> |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  | A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. \$ CHARGES | G. DAYS OR UNITS | H. 800T FARM PLAN | I. JD. QUAL. | J. RENDERING PROVIDER ID. # | 02/12/2012 05/21/2012 | 23 |  | 71010 26 | 1 | 25 00 | 1 |  | NPI | 508819970 | 02/12/2012 05/21/2012 | 23 |  | 70486 26 | 2 | 59 58 | 1 |  | NPI | 508819970 |  |  |  |  |  |  |  |  | NPI |  |  |  |  |  |  |  |  |  | NPI |  |  |  |  |  |  |  |  |  | NPI |  |  |  |  |  |  |  |  |  | NPI |  |  |  |  |  |  |  |  |  | NPI |  |  |  |  |  |  |  |  |  | NPI |  |  |  |  |  |  |  |  |  | NPI |  |
| A. DATE(S) OF SERVICE From MM DD YY To MM DD YY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | B. PLACE OF SERVICE | C. EMG                                            | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER                                           | F. \$ CHARGES | G. DAYS OR UNITS                                 | H. 800T FARM PLAN | I. JD. QUAL.                                                 | J. RENDERING PROVIDER ID. # |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 02/12/2012 05/21/2012                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 23                  |                                                   | 71010 26                                                                                | 1                                                              | 25 00         | 1                                                |                   | NPI                                                          | 508819970                   |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 02/12/2012 05/21/2012                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 23                  |                                                   | 70486 26                                                                                | 2                                                              | 59 58         | 1                                                |                   | NPI                                                          | 508819970                   |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
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| 24. FEDERAL TAX I.D. NUMBER SSN EIN 25. PATIENT'S ACCOUNT NO. 26. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 27. TOTAL CHARGE \$ 84 58 28. AMOUNT PAID \$ 0 00 29. BALANCE DUE \$ 84 58                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 30. BILLING PROVIDER INFO & PH # 912 629 0457                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 31. SERVICE FACILITY LOCATION INFORMATION<br>COASTAL CAROLINA ER<br>1000 MEDICAL CENTER DR<br>HARDEEVILLE SC 29927                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 32. BILLING PROVIDER INFO & PH # 912 629 0457<br>COASTAL EMPIRE IMAGING<br>PO BOX 15479<br>SAVANNAH GA 31416-2179                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 33. BILLING PROVIDER INFO & PH # 912 629 0457<br>COASTAL EMPIRE IMAGING<br>PO BOX 15479<br>SAVANNAH GA 31416-2179                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |
| 34. BILLING PROVIDER INFO & PH # 912 629 0457<br>COASTAL EMPIRE IMAGING<br>PO BOX 15479<br>SAVANNAH GA 31416-2179                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                     |                                                   |                                                                                         |                                                                |               |                                                  |                   |                                                              |                             |                                                    |  |                                        |  |                                                 |                     |        |                                                                                         |                      |               |                  |                   |              |                             |                       |    |  |          |   |       |   |  |     |           |                       |    |  |          |   |       |   |  |     |           |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |     |  |

1500

SOUTH CAROLINA MEDIC 0002  
PO BOX 100190

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

COLUMBIA

SC 29202-3190

CA

PICA 11

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

|                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                           |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/> |  | 1a. INSURED'S I.D. NUMBER (For Program in Item 1)                                                                                                                                                                                                                                                                                                         |  |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)<br>BARON FRANCES A                                                                                                                                                                                                                                                                    |  | 3. PATIENT'S BIRTH DATE MM DD YY<br>SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                  |  |
| 5. PATIENT'S ADDRESS (No., Street)<br>CITY<br>STATE<br>ZIP CODE<br>TELEPHONE (Include Area Code)                                                                                                                                                                                                                                                |  | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)<br>BARON FRANCES A<br>7. INSURED'S ADDRESS (No., Street)<br>CITY<br>STATE<br>ZIP CODE<br>TELEPHONE (Include Area Code)                                                                                                                                                                          |  |
| 8. PATIENT STATUS<br>Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/><br>Employee <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>                                                                                                 |  | 11. INSURED'S POLICY GROUP OR FECA NUMBER                                                                                                                                                                                                                                                                                                                 |  |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)<br>BARON EDWARD                                                                                                                                                                                                                                                                 |  | 10. IS PATIENT'S CONDITION RELATED TO:<br>a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>b. AUTO ACCIDENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____<br>c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.<br>SIGNATURE ON FILE<br>SIGNED _____ DATE 06 04 2012                                   |  | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.<br>SIGNATURE ON FILE<br>SIGNED _____                                                                                                                                                        |  |
| 14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)<br>2012                                                                                                                                                                                                                                                     |  | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY<br>17a. 17b. N/A 1730179979                                                                                                                                                                                                                                                      |  |
| 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION<br>FROM MM DD TO MM DD YY<br>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES<br>FROM MM DD TO MM DD YY<br>19. RESERVED FOR LOCAL USE                                                                                                                                               |  | 20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> \$ CHARGES<br>21. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO<br>22. PRIOR AUTHORIZATION NUMBER                                                                                                                                                                      |  |
| 23. NAME OF REFERRING PROVIDER OR OTHER SOURCE<br>AUL ZORCH                                                                                                                                                                                                                                                                                     |  | 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMO D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPBOT Form Plan I. IN OUAL J. RENDERING PROVIDER ID #                                                                       |  |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN<br>3804260                                                                                                                                                                                                                                                                                                  |  | 26. PATIENT'S ACCOUNT NO. 06220 27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                |  |
| 28. TOTAL CHARGE \$ 142 14 29. AMOUNT PAID \$ 0 00 30. BALANCE DUE \$ 142 14                                                                                                                                                                                                                                                                    |  | 31. BILLING PROVIDER INFO & PH # 912 629 0457                                                                                                                                                                                                                                                                                                             |  |
| 32. SERVICE FACILITY LOCATION INFORMATION<br>COASTAL CAROLINA ER<br>1000 MEDICAL CENTER DR<br>HARDEEVILLE SC 29927<br>9162472431                                                                                                                                                                                                                |  | 33. BILLING PROVIDER INFO & PH #<br>COASTAL EMPIRE IMAGING<br>PO BOX 15479<br>SAVANNAH GA 31416-2179<br>4417900556 EC0549                                                                                                                                                                                                                                 |  |

1500

SOUTH CAROLINA MEDIC 0002  
PO BOX 100190

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08'05

COLUMBIA

SC 29202-3190

|                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                  |  |  |  |  |                                                                                                                                                                   |  |  |  |  |                                                                                |  |  |  |  |                    |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                                                                                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|--------------------------------------------------|--|--|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--------------------------------------------------------------------------------|--|--|--|--|--------------------|--|--|--|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|----------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER<br>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (BLK/LUNG SSN) (ID)          |  |  |  |  |  |  |  |  |  | 1a. INSURED'S ID. NUMBER (For Program in Item 1) |  |  |  |  |                                                                                                                                                                   |  |  |  |  |                                                                                |  |  |  |  |                    |  |  |  |  |                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                                                                                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)<br>ARON FRANCES A                                                                              |  |  |  |  |  |  |  |  |  |                                                  |  |  |  |  | 3. PATIENT'S BIRTH DATE MM DD YY SEX M F<br>[REDACTED] M F                                                                                                        |  |  |  |  |                                                                                |  |  |  |  |                    |  |  |  |  | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)<br>ARON FRANCES A                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                                                                                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 5. PATIENT'S ADDRESS (No., Street)<br>[REDACTED]                                                                                                         |  |  |  |  |  |  |  |  |  |                                                  |  |  |  |  | 6. PATIENT RELATIONSHIP TO INSURED<br>Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> |  |  |  |  |                                                                                |  |  |  |  |                    |  |  |  |  | 7. INSURED'S ADDRESS (No., Street)<br>[REDACTED]                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                                                                                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| CITY<br>[REDACTED]                                                                                                                                       |  |  |  |  |  |  |  |  |  | STATE<br>SC                                      |  |  |  |  | 8. PATIENT STATUS<br>Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>                                              |  |  |  |  |                                                                                |  |  |  |  | CITY<br>[REDACTED] |  |  |  |  | STATE<br>SC                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                                                                                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ZIP CODE<br>[REDACTED]                                                                                                                                   |  |  |  |  |  |  |  |  |  | TELEPHONE (Include Area Code)<br>[REDACTED]      |  |  |  |  |                                                                                                                                                                   |  |  |  |  | 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)<br>ARON EDWARD |  |  |  |  |                    |  |  |  |  | 10. IS PATIENT'S CONDITION RELATED TO:<br>a. EMPLOYMENT? (Current or Previous)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____<br>c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                                                                                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 11. INSURED'S POLICY OR GROUP NUMBER<br>SOUTH CAROLINA MEDICARE                                                                                          |  |  |  |  |  |  |  |  |  |                                                  |  |  |  |  | 12. INSURED'S DATE OF BIRTH MM DD YY SEX M F<br>[REDACTED] M F                                                                                                    |  |  |  |  |                                                                                |  |  |  |  |                    |  |  |  |  | 13. EMPLOYER'S NAME OR SCHOOL NAME<br>[REDACTED]                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                                                                                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14. OTHER INSURED'S POLICY OR GROUP NUMBER<br>[REDACTED]                                                                                                 |  |  |  |  |  |  |  |  |  |                                                  |  |  |  |  | 15. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F<br>[REDACTED] M F                                                                                              |  |  |  |  |                                                                                |  |  |  |  |                    |  |  |  |  | 16. EMPLOYER'S NAME OR SCHOOL NAME<br>[REDACTED]                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                                                                                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 17. INSURANCE PLAN NAME OR PROGRAM NAME<br>RICARE FOR LIFE                                                                                               |  |  |  |  |  |  |  |  |  |                                                  |  |  |  |  | 18. RESERVED FOR LOCAL USE                                                                                                                                        |  |  |  |  |                                                                                |  |  |  |  |                    |  |  |  |  | 19. IS THERE ANOTHER HEALTH BENEFIT PLAN?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d                                                                                                                                                                                                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                                                                                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.                                                                                                 |  |  |  |  |  |  |  |  |  |                                                  |  |  |  |  |                                                                                                                                                                   |  |  |  |  |                                                                                |  |  |  |  |                    |  |  |  |  | 20. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.<br>SIGNATURE ON FILE 06 04 2012 SIGNED                                                                                                                                                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                                                                                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21. NAME OF CURRENT DOCTOR<br>2012                                                                                                                       |  |  |  |  |  |  |  |  |  |                                                  |  |  |  |  | 22. ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP)<br>[REDACTED]                                                                                 |  |  |  |  |                                                                                |  |  |  |  |                    |  |  |  |  | 23. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY<br>17a. [REDACTED]<br>17b. NPI 1730179979                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 24. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION<br>FROM MM DD YY TO MM DD YY<br>FROM 05 21 2012 TO [REDACTED] |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 25. NAME OF REFERRING PROVIDER OR OTHER SOURCE<br>AUL ZORCH                                                                                              |  |  |  |  |  |  |  |  |  |                                                  |  |  |  |  | 26. RESERVED FOR LOCAL USE                                                                                                                                        |  |  |  |  |                                                                                |  |  |  |  |                    |  |  |  |  | 27. MEDICAID RESUBMISSION CODE<br>ORIGINAL REF. NO.                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                                                                                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 28. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)<br>1. 922.1                                                 |  |  |  |  |  |  |  |  |  |                                                  |  |  |  |  | 29. MEDICAID RESUBMISSION CODE<br>ORIGINAL REF. NO.                                                                                                               |  |  |  |  |                                                                                |  |  |  |  |                    |  |  |  |  | 30. PRIOR AUTHORIZATION NUMBER                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                                                                                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 31. DATE(S) OF SERVICE<br>From MM DD YY To MM DD YY<br>5212012 05212012 23 71250 26 1                                                                    |  |  |  |  |  |  |  |  |  |                                                  |  |  |  |  | 32. PLACE OF SERVICE<br>EMG CPT/HCPB MODIFIER                                                                                                                     |  |  |  |  |                                                                                |  |  |  |  |                    |  |  |  |  | 33. DIAGNOSIS POINTER<br>\$ CHARGES 76 44 1                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 34. G. DAYS OR UNITS 1                                                                                               |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 35. H. EP301 FORTN. PAY      |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 36. I. ID. QUAL NPI 1508819970 |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 37. J. RENDERING PROVIDER ID. # |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 38. FEDERAL TAX ID. NUMBER<br>3804260                                                                                                                    |  |  |  |  |  |  |  |  |  |                                                  |  |  |  |  | 39. SSN EIN<br>[REDACTED]                                                                                                                                         |  |  |  |  |                                                                                |  |  |  |  |                    |  |  |  |  | 40. PATIENT'S ACCOUNT NO.<br>06220                                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 41. ACCEPT ASSIGNMENT?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                        |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 42. TOTAL CHARGE<br>\$ 76 44 |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 43. AMOUNT PAID<br>\$ 0 00     |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 44. BALANCE DUE<br>\$ 76 44     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 45. SIGNATURE OF PHYSICIAN OR SUPPLIER<br>I certify that the statements on the reverse of this bill are made a part thereof.<br>30275<br>DAN V MOESCH MD |  |  |  |  |  |  |  |  |  |                                                  |  |  |  |  | 46. SERVICE FACILITY LOCATION INFORMATION<br>COASTAL CAROLINA ER<br>1000 MEDICAL CENTER DR<br>HARDEEVILLE SC 29927                                                |  |  |  |  |                                                                                |  |  |  |  |                    |  |  |  |  | 47. BILLING PROVIDER INFO & PH #<br>912 529 0457<br>COASTAL EMPIRE IMAGING<br>PO BOX 15479<br>SAVANNAH GA 31416-2179                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 48. SIGNATURE<br>06 04 2012 DATE                                                                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 49. 1962472431               |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 50. 4417900556                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 51. 1C8549                      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|      | PHYSICIAN OR SUPPLIER INFORMATION | PATIENT AND INSURED INFORMATION |
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SOUTH CAROLINA MEDIC 0002  
PO BOX 100190

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

COLUMBIA

SC 29202-3190

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

|                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID) |  | 1a. INSURED'S I.D. NUMBER (For Program in Item 1)                                                                                                                                                                                                                                                                                                            |  |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)<br>ARON FRANCES A                                                                                                                                                                                                                                                   |  | 3. PATIENT'S BIRTH DATE MM DD YY 01 05 11 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>                                                                                                                                                                                                                                               |  |
| 5. PATIENT'S ADDRESS (No., Street)<br>[REDACTED]                                                                                                                                                                                                                                                                              |  | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)<br>ARON FRANCES A                                                                                                                                                                                                                                                                                  |  |
| 6. CITY [REDACTED] STATE [REDACTED]                                                                                                                                                                                                                                                                                           |  | 7. INSURED'S ADDRESS (No., Street)<br>[REDACTED]                                                                                                                                                                                                                                                                                                             |  |
| 8. ZIP CODE [REDACTED] TELEPHONE (Include Area Code) [REDACTED]                                                                                                                                                                                                                                                               |  | 8. CITY [REDACTED] STATE [REDACTED]                                                                                                                                                                                                                                                                                                                          |  |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)<br>ARON EDWARD                                                                                                                                                                                                                                                |  | 10. IS PATIENT'S CONDITION RELATED TO:<br>a. EMPLOYMENT? (Current or Previous)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____<br>c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 11. INSURED'S POLICY OR GROUP NUMBER                                                                                                                                                                                                                                                                                          |  | 11. INSURED'S POLICY GROUP OR FECA NUMBER                                                                                                                                                                                                                                                                                                                    |  |
| 12. OTHER INSURED'S DATE OF BIRTH MM DD YY 01 05 11 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>                                                                                                                                                                                                      |  | 12. INSURED'S DATE OF BIRTH MM DD YY 01 05 11 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>                                                                                                                                                                                                                                           |  |
| 13. EMPLOYER'S NAME OR SCHOOL NAME                                                                                                                                                                                                                                                                                            |  | 13. EMPLOYER'S NAME OR SCHOOL NAME                                                                                                                                                                                                                                                                                                                           |  |
| 14. INSURANCE PLAN NAME OR PROGRAM NAME<br>RICARE FOR LIFE                                                                                                                                                                                                                                                                    |  | 14. INSURANCE PLAN NAME OR PROGRAM NAME<br>SOUTH CAROLINA MEDICARE                                                                                                                                                                                                                                                                                           |  |
| 15. IS THERE ANOTHER HEALTH BENEFIT PLAN?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete Item 9 and 10                                                                                                                                                                 |  | 15. IS THERE ANOTHER HEALTH BENEFIT PLAN?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete Item 9 and 10                                                                                                                                                                                                |  |
| 16. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.<br>SIGNATURE ON FILE<br>SIGNED _____ DATE 06 04 2012   |  | 16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.<br>SIGNATURE ON FILE<br>SIGNED _____                                                                                                                                                           |  |
| 17. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)<br>MM DD YY 05 11 11                                                                                                                                                                                                                      |  | 17. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY<br>17a. GCB3315<br>17b. N1922034859                                                                                                                                                                                                                                                 |  |
| 18. NAME OF REFERRING PROVIDER OR OTHER SOURCE<br>COTT D CONDIE                                                                                                                                                                                                                                                               |  | 18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION<br>FROM MM DD YY 05 22 2012 TO MM DD YY 05 22 2012                                                                                                                                                                                                                                                    |  |
| 19. RESERVED FOR LOCAL USE                                                                                                                                                                                                                                                                                                    |  | 19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES<br>FROM MM DD YY 05 22 2012 TO MM DD YY 05 22 2012                                                                                                                                                                                                                                                     |  |
| 20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 20E by Line)<br>B50 11                                                                                                                                                                                                                        |  | 20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES                                                                                                                                                                                                                                                              |  |
| 21. MEDICAID RESUBMISSION CODE                                                                                                                                                                                                                                                                                                |  | 21. MEDICAID RESUBMISSION CODE                                                                                                                                                                                                                                                                                                                               |  |
| 22. PRIOR AUTHORIZATION NUMBER                                                                                                                                                                                                                                                                                                |  | 22. PRIOR AUTHORIZATION NUMBER                                                                                                                                                                                                                                                                                                                               |  |
| 23. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 05 11 11 To 05 11 11                                                                                                                                                                                                                                                      |  | 23. B. PLACE OF SERVICE EMG                                                                                                                                                                                                                                                                                                                                  |  |
| 23. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER                                                                                                                                                                                                                                |  | 23. E. DIAGNOSIS POINTER                                                                                                                                                                                                                                                                                                                                     |  |
| 23. F. \$ CHARGES                                                                                                                                                                                                                                                                                                             |  | 23. G. DAYS OR UNITS                                                                                                                                                                                                                                                                                                                                         |  |
| 23. H. EPSON Family Plan                                                                                                                                                                                                                                                                                                      |  | 23. I. IC QUAL                                                                                                                                                                                                                                                                                                                                               |  |
| 23. J. RENDERING PROVIDER ID. #                                                                                                                                                                                                                                                                                               |  | 23. J. RENDERING PROVIDER ID. #                                                                                                                                                                                                                                                                                                                              |  |
| 24. FEDERAL TAX ID NUMBER SSN EIN 3804260                                                                                                                                                                                                                                                                                     |  | 24. PATIENT'S ACCOUNT NO. 06220                                                                                                                                                                                                                                                                                                                              |  |
| 25. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                    |  | 25. TOTAL CHARGE \$ 280 00                                                                                                                                                                                                                                                                                                                                   |  |
| 26. SERVICE FACILITY LOCATION INFORMATION<br>COASTAL CAROLINA IP<br>1000 MEDICAL CENTER DR<br>HARDEEVILLE SC 29927                                                                                                                                                                                                            |  | 26. AMOUNT PAID \$ 0 00                                                                                                                                                                                                                                                                                                                                      |  |
| 27. BILLING PROVIDER INFO & PH # 912 629 0457<br>COASTAL EMPIRE IMAGING<br>PO BOX 15479<br>SAVANNAH GA 31416-2179                                                                                                                                                                                                             |  | 27. BALANCE DUE \$ 280 00                                                                                                                                                                                                                                                                                                                                    |  |
| 28. DATE 06 04 2012                                                                                                                                                                                                                                                                                                           |  | 28. DATE 06 04 2012                                                                                                                                                                                                                                                                                                                                          |  |
| 29. 1962472431                                                                                                                                                                                                                                                                                                                |  | 29. 1417900556                                                                                                                                                                                                                                                                                                                                               |  |
| 30. 190-                                                                                                                                                                                                                                                                                                                      |  | 30. PC8549                                                                                                                                                                                                                                                                                                                                                   |  |

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SOUTH CAROLINA MEDIC 0002  
PO BOX 100190

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08-05

COLUMBIA

SC 29202-3190

|                                                                                                                                                                                                                                                                                                                                                  |  |                                                   |  |                                                     |  |                                                                                                                                                                   |  |                                                                                                                 |  |                                                                                    |  |                                                                                                                                                                                           |  |                                                        |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|--|-----------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|--|
| <input type="checkbox"/> MEDICARE<br>(Medicare #)                                                                                                                                                                                                                                                                                                |  | <input type="checkbox"/> MEDICAID<br>(Medicaid #) |  | <input type="checkbox"/> TRICARE<br>(Sponsor's SSN) |  | <input type="checkbox"/> CHAMPVA<br>(Member ID)                                                                                                                   |  | <input type="checkbox"/> GROUP<br>HEALTH PLAN<br>(SSN or ID)                                                    |  | <input type="checkbox"/> FECA<br>BLX (LUNG<br>SSN)                                 |  | <input type="checkbox"/> OTHER<br>(ID)                                                                                                                                                    |  | 1a. INSURED'S I.D. NUMBER<br>(For Program in Item 1)   |  |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)<br><b>ARON FRANCES A</b>                                                                                                                                                                                                                                                               |  |                                                   |  |                                                     |  | 3. PATIENT'S BIRTH DATE<br>MM DD YY <b>06 04 2012</b>                                                                                                             |  | SEX<br>M <input type="checkbox"/> F <input checked="" type="checkbox"/>                                         |  | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)<br><b>ARON FRANCES A</b> |  |                                                                                                                                                                                           |  |                                                        |  |
| 5. PATIENT'S ADDRESS (No., Street)<br><b>ARON FRANCES A</b>                                                                                                                                                                                                                                                                                      |  |                                                   |  |                                                     |  | 6. PATIENT RELATIONSHIP TO INSURED<br>Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> |  | 7. INSURED'S ADDRESS (No., Street)<br><b>ARON FRANCES A</b>                                                     |  |                                                                                    |  |                                                                                                                                                                                           |  |                                                        |  |
| CITY<br><b>ARON FRANCES A</b>                                                                                                                                                                                                                                                                                                                    |  |                                                   |  |                                                     |  | STATE<br><b>ARON FRANCES A</b>                                                                                                                                    |  | CITY<br><b>ARON FRANCES A</b>                                                                                   |  | STATE<br><b>ARON FRANCES A</b>                                                     |  | ZIP CODE<br><b>ARON FRANCES A</b>                                                                                                                                                         |  | TELEPHONE (Include Area Code)<br><b>ARON FRANCES A</b> |  |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)<br><b>ARON EDWARD</b>                                                                                                                                                                                                                                                            |  |                                                   |  |                                                     |  | 10. IS PATIENT'S CONDITION RELATED TO<br>a. EMPLOYMENT? (Current or Previous)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO              |  | 11. INSURED'S POLICY GROUP OR FECA NUMBER<br><b>SOUTH CAROLINA MEDICARE</b>                                     |  |                                                                                    |  |                                                                                                                                                                                           |  |                                                        |  |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER<br><b>ARON EDWARD</b>                                                                                                                                                                                                                                                                                  |  |                                                   |  |                                                     |  | b. AUTO ACCIDENT?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                          |  | a. INSURED'S DATE OF BIRTH<br>MM DD YY <b>06 04 2012</b>                                                        |  |                                                                                    |  |                                                                                                                                                                                           |  |                                                        |  |
| b. OTHER INSURED'S DATE OF BIRTH<br>MM DD YY <b>06 04 2012</b>                                                                                                                                                                                                                                                                                   |  |                                                   |  |                                                     |  | c. OTHER ACCIDENT?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                         |  | b. EMPLOYER'S NAME OR SCHOOL NAME<br><b>ARON EDWARD</b>                                                         |  |                                                                                    |  |                                                                                                                                                                                           |  |                                                        |  |
| d. EMPLOYER'S NAME OR SCHOOL NAME<br><b>ARON EDWARD</b>                                                                                                                                                                                                                                                                                          |  |                                                   |  |                                                     |  | 10d. RESERVED FOR LOCAL USE                                                                                                                                       |  | c. INSURANCE PLAN NAME OR PROGRAM NAME<br><b>SOUTH CAROLINA MEDICARE</b>                                        |  |                                                                                    |  |                                                                                                                                                                                           |  |                                                        |  |
| d. INSURANCE PLAN NAME OR PROGRAM NAME<br><b>RICARE FOR LIFE</b>                                                                                                                                                                                                                                                                                 |  |                                                   |  |                                                     |  | 10d. RESERVED FOR LOCAL USE                                                                                                                                       |  | d. IS THERE ANOTHER HEALTH BENEFIT PLAN?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |                                                                                    |  |                                                                                                                                                                                           |  |                                                        |  |
| READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.<br>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.<br><b>SIGNATURE ON FILE</b> |  |                                                   |  |                                                     |  |                                                                                                                                                                   |  |                                                                                                                 |  |                                                                                    |  | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.<br><b>SIGNATURE ON FILE</b> |  |                                                        |  |
| SIGNED <b>06 04 2012</b><br>DATE                                                                                                                                                                                                                                                                                                                 |  |                                                   |  |                                                     |  |                                                                                                                                                                   |  |                                                                                                                 |  |                                                                                    |  | SIGNED<br>DATE                                                                                                                                                                            |  |                                                        |  |
| 14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)<br>DO YY <b>06 04 2012</b>                                                                                                                                                                                                                                   |  |                                                   |  |                                                     |  | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE<br>MM DD YY <b>06 04 2012</b>                                                                     |  |                                                                                                                 |  |                                                                                    |  |                                                                                                                                                                                           |  |                                                        |  |
| 16. NAME OF REFERRING PROVIDER OR OTHER SOURCE<br><b>COTT D CONDIE</b>                                                                                                                                                                                                                                                                           |  |                                                   |  |                                                     |  | 17. NPI <b>1746033315</b>                                                                                                                                         |  |                                                                                                                 |  |                                                                                    |  |                                                                                                                                                                                           |  |                                                        |  |
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES<br>FROM <b>05 23 2012</b> TO <b>06 04 2012</b>                                                                                                                                                                                                                                             |  |                                                   |  |                                                     |  | 19. RESERVED FOR LOCAL USE                                                                                                                                        |  |                                                                                                                 |  |                                                                                    |  |                                                                                                                                                                                           |  |                                                        |  |
| 20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                             |  |                                                   |  |                                                     |  | 21. MEDICAID REBUBMISSION CODE<br><b>0240</b>                                                                                                                     |  |                                                                                                                 |  |                                                                                    |  |                                                                                                                                                                                           |  |                                                        |  |
| 22. PRIOR AUTHORIZATION NUMBER<br><b>0240</b>                                                                                                                                                                                                                                                                                                    |  |                                                   |  |                                                     |  | 23. PRIOR AUTHORIZATION NUMBER                                                                                                                                    |  |                                                                                                                 |  |                                                                                    |  |                                                                                                                                                                                           |  |                                                        |  |
| 24. A. DATE(S) OF SERVICE<br>From To<br>MM DD YY MM DD YY                                                                                                                                                                                                                                                                                        |  |                                                   |  |                                                     |  | B. PLACE OF SERVICE<br>EMG                                                                                                                                        |  |                                                                                                                 |  |                                                                                    |  |                                                                                                                                                                                           |  |                                                        |  |
| C. D. PROCEDURES, SERVICES, OR SUPPLIES<br>(Explain Unusual Circumstances)<br>CPT/HCPCS MODIFIER                                                                                                                                                                                                                                                 |  |                                                   |  |                                                     |  | E. DIAGNOSIS<br>POINTER                                                                                                                                           |  |                                                                                                                 |  |                                                                                    |  |                                                                                                                                                                                           |  |                                                        |  |
| 25. DATE(S) OF SERVICE<br>From To<br>MM DD YY MM DD YY                                                                                                                                                                                                                                                                                           |  |                                                   |  |                                                     |  | 26. PATIENT'S ACCOUNT NO.<br><b>06220</b>                                                                                                                         |  |                                                                                                                 |  |                                                                                    |  |                                                                                                                                                                                           |  |                                                        |  |
| 27. ACCEPT ASSIGNMENT?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                    |  |                                                   |  |                                                     |  | 28. TOTAL CHARGE<br><b>8 91</b>                                                                                                                                   |  |                                                                                                                 |  |                                                                                    |  |                                                                                                                                                                                           |  |                                                        |  |
| 29. AMOUNT PAID<br><b>0 00</b>                                                                                                                                                                                                                                                                                                                   |  |                                                   |  |                                                     |  | 30. BALANCE DUE<br><b>8 91</b>                                                                                                                                    |  |                                                                                                                 |  |                                                                                    |  |                                                                                                                                                                                           |  |                                                        |  |
| 31. BILLING PROVIDER INFO & PH #<br><b>912 629 0457</b>                                                                                                                                                                                                                                                                                          |  |                                                   |  |                                                     |  | 32. SERVICE FACILITY LOCATION INFORMATION<br><b>COASTAL CAROLINA IP</b>                                                                                           |  |                                                                                                                 |  |                                                                                    |  |                                                                                                                                                                                           |  |                                                        |  |
| 33. BILLING PROVIDER INFO & PH #<br><b>COASTAL EMPIRE IMAGING</b>                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                     |  | 34. BILLING PROVIDER INFO & PH #<br><b>PO BOX 15479</b>                                                                                                           |  |                                                                                                                 |  |                                                                                    |  |                                                                                                                                                                                           |  |                                                        |  |
| 35. BILLING PROVIDER INFO & PH #<br><b>SAVANNAH</b>                                                                                                                                                                                                                                                                                              |  |                                                   |  |                                                     |  | 36. BILLING PROVIDER INFO & PH #<br><b>GA 31416-2179</b>                                                                                                          |  |                                                                                                                 |  |                                                                                    |  |                                                                                                                                                                                           |  |                                                        |  |
| 37. BILLING PROVIDER INFO & PH #<br><b>1417900556</b>                                                                                                                                                                                                                                                                                            |  |                                                   |  |                                                     |  | 38. BILLING PROVIDER INFO & PH #<br><b>AC8549</b>                                                                                                                 |  |                                                                                                                 |  |                                                                                    |  |                                                                                                                                                                                           |  |                                                        |  |

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

1500

SOUTH CAROLINA MEDIC 0002  
PO BOX 100190

COLUMBIA

SC 29202-3190

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

|                                                                                                                                                                                                                                                                                                                           |  |                                                   |  |                                                                |  |                                                                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                     |  |                                                                                                         |  |                                                     |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|--|----------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|--|--|--|
| <input type="checkbox"/> MEDICARE<br>(Medicare #)                                                                                                                                                                                                                                                                         |  | <input type="checkbox"/> MEDICAID<br>(Medicaid #) |  | <input type="checkbox"/> TRICARE<br>CHAMPUS<br>(Sponsor's SSN) |  | <input type="checkbox"/> CHAMPVA<br>(Member ID#)                                                                                                                                                     |  | <input type="checkbox"/> GROUP<br>HEALTH PLAN<br>(SSN or ID)                                                                                                |  | <input type="checkbox"/> FECA<br>BLK LUNG<br>(SSN)                                  |  | <input type="checkbox"/> OTHER<br>(ID)                                                                  |  | 1a. INSURED'S ID, NUMBER<br>(For Program in Item 1) |  |  |  |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)<br><b>BARON FRANCES A</b>                                                                                                                                                                                                                                       |  |                                                   |  |                                                                |  | 3. PATIENT'S BIRTH DATE<br>MM DD YY<br><b>11 11 11</b>                                                                                                                                               |  | SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                     |  | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)<br><b>BARON FRANCES A</b> |  |                                                                                                         |  |                                                     |  |  |  |
| 5. PATIENT'S ADDRESS (No., Street)<br><b>[REDACTED]</b>                                                                                                                                                                                                                                                                   |  |                                                   |  |                                                                |  | 6. PATIENT RELATIONSHIP TO INSURED<br><input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other                         |  | 7. INSURED'S ADDRESS (No., Street)<br><b>[REDACTED]</b>                                                                                                     |  |                                                                                     |  |                                                                                                         |  |                                                     |  |  |  |
| CITY<br><b>[REDACTED]</b>                                                                                                                                                                                                                                                                                                 |  |                                                   |  |                                                                |  | STATE<br><b>SC</b>                                                                                                                                                                                   |  | 8. PATIENT STATUS<br><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other                                        |  | CITY<br><b>[REDACTED]</b>                                                           |  | STATE<br><b>[REDACTED]</b>                                                                              |  | ZIP CODE<br><b>[REDACTED]</b>                       |  |  |  |
| TELEPHONE (Include Area Code)<br><b>[REDACTED]</b>                                                                                                                                                                                                                                                                        |  |                                                   |  |                                                                |  | Employee <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>                                                                              |  | ZIP CODE<br><b>[REDACTED]</b>                                                                                                                               |  | TELEPHONE (Include Area Code)<br><b>[REDACTED]</b>                                  |  | 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)<br><b>BARON EDWARD</b>                  |  |                                                     |  |  |  |
| 10. IS PATIENT'S CONDITION RELATED TO:<br>a. EMPLOYMENT? (Current or Previous)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                     |  |                                                   |  |                                                                |  | b. AUTO ACCIDENT?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                             |  | c. OTHER ACCIDENT?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                   |  | 11. INSURED'S POLICY GROUP OR FECA NUMBER<br><b>SOUTH CAROLINA MEDICARE</b>         |  |                                                                                                         |  |                                                     |  |  |  |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.<br><b>SIGNATURE ON FILE</b><br>SIGNED <b>06 04 2012</b><br>DATE |  |                                                   |  |                                                                |  | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.<br><b>SIGNATURE ON FILE</b><br>SIGNED |  | 14. IS THERE ANOTHER HEALTH BENEFIT PLAN?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete Item 8 a-d. |  |                                                                                     |  |                                                                                                         |  |                                                     |  |  |  |
| 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY<br>17a <b>GC83315</b><br>17b <b>NP1922034859</b>                                                                                                                                                                                                 |  |                                                   |  |                                                                |  | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION<br>FROM MM DD YY TO MM DD YY<br><b>05 23 2012</b>                                                                                             |  |                                                                                                                                                             |  |                                                                                     |  | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES<br>FROM MM DD YY TO MM DD YY<br><b>05 23 2012</b> |  |                                                     |  |  |  |
| 19. RESERVED FOR LOCAL USE                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 20. OUTSIDE LAB? \$ CHARGES<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                   |  |                                                                                                                                                             |  |                                                                                     |  | 21. MEDICAID RESUBMISSION CODE<br>ORIGINAL REF NO.                                                      |  |                                                     |  |  |  |
| 22. PRIOR AUTHORIZATION NUMBER                                                                                                                                                                                                                                                                                            |  |                                                   |  |                                                                |  | 23. DATE(S) OF SERVICE<br>From MM DD YY To MM DD YY<br><b>05232012 05232012</b>                                                                                                                      |  |                                                                                                                                                             |  |                                                                                     |  | 24. B. PLACE OF SERVICE<br><b>21</b>                                                                    |  |                                                     |  |  |  |
| 25. C. EMO<br><b>73610</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 26. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)<br><b>26</b>                                                                                                                |  |                                                                                                                                                             |  |                                                                                     |  | 27. E. DIAGNOSIS POINTER<br><b>1</b>                                                                    |  |                                                     |  |  |  |
| 28. F. \$ CHARGES<br><b>8 91</b>                                                                                                                                                                                                                                                                                          |  |                                                   |  |                                                                |  | 29. G. DAYS OR UNITS<br><b>1</b>                                                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                     |  | 30. H. EXPECT Family Pay<br><b>1</b>                                                                    |  |                                                     |  |  |  |
| 31. I. ID QUAL<br><b>NPI</b>                                                                                                                                                                                                                                                                                              |  |                                                   |  |                                                                |  | 32. J. RENDERING PROVIDER ID #<br><b>1508819970</b>                                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                     |  | 33. K. NPI<br><b>NPI</b>                                                                                |  |                                                     |  |  |  |
| 34. L. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                  |  |                                                   |  |                                                                |  | 35. M. NPI<br><b>NPI</b>                                                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                     |  | 36. N. NPI<br><b>NPI</b>                                                                                |  |                                                     |  |  |  |
| 37. O. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                  |  |                                                   |  |                                                                |  | 38. P. NPI<br><b>NPI</b>                                                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                     |  | 39. Q. NPI<br><b>NPI</b>                                                                                |  |                                                     |  |  |  |
| 40. R. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                  |  |                                                   |  |                                                                |  | 41. S. NPI<br><b>NPI</b>                                                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                     |  | 42. T. NPI<br><b>NPI</b>                                                                                |  |                                                     |  |  |  |
| 43. U. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                  |  |                                                   |  |                                                                |  | 44. V. NPI<br><b>NPI</b>                                                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                     |  | 45. W. NPI<br><b>NPI</b>                                                                                |  |                                                     |  |  |  |
| 46. X. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                  |  |                                                   |  |                                                                |  | 47. Y. NPI<br><b>NPI</b>                                                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                     |  | 48. Z. NPI<br><b>NPI</b>                                                                                |  |                                                     |  |  |  |
| 49. AA. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                 |  |                                                   |  |                                                                |  | 50. AB. NPI<br><b>NPI</b>                                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                                     |  | 51. AC. NPI<br><b>NPI</b>                                                                               |  |                                                     |  |  |  |
| 52. AD. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                 |  |                                                   |  |                                                                |  | 53. AE. NPI<br><b>NPI</b>                                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                                     |  | 54. AF. NPI<br><b>NPI</b>                                                                               |  |                                                     |  |  |  |
| 55. AG. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                 |  |                                                   |  |                                                                |  | 56. AH. NPI<br><b>NPI</b>                                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                                     |  | 57. AI. NPI<br><b>NPI</b>                                                                               |  |                                                     |  |  |  |
| 58. AJ. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                 |  |                                                   |  |                                                                |  | 59. AK. NPI<br><b>NPI</b>                                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                                     |  | 60. AL. NPI<br><b>NPI</b>                                                                               |  |                                                     |  |  |  |
| 61. AM. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                 |  |                                                   |  |                                                                |  | 62. AN. NPI<br><b>NPI</b>                                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                                     |  | 63. AO. NPI<br><b>NPI</b>                                                                               |  |                                                     |  |  |  |
| 64. AP. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                 |  |                                                   |  |                                                                |  | 65. AQ. NPI<br><b>NPI</b>                                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                                     |  | 66. AR. NPI<br><b>NPI</b>                                                                               |  |                                                     |  |  |  |
| 67. AS. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                 |  |                                                   |  |                                                                |  | 68. AT. NPI<br><b>NPI</b>                                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                                     |  | 69. AU. NPI<br><b>NPI</b>                                                                               |  |                                                     |  |  |  |
| 70. AV. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                 |  |                                                   |  |                                                                |  | 71. AW. NPI<br><b>NPI</b>                                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                                     |  | 72. AX. NPI<br><b>NPI</b>                                                                               |  |                                                     |  |  |  |
| 73. AY. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                 |  |                                                   |  |                                                                |  | 74. AZ. NPI<br><b>NPI</b>                                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                                     |  | 75. BA. NPI<br><b>NPI</b>                                                                               |  |                                                     |  |  |  |
| 76. BB. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                 |  |                                                   |  |                                                                |  | 77. BC. NPI<br><b>NPI</b>                                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                                     |  | 78. BD. NPI<br><b>NPI</b>                                                                               |  |                                                     |  |  |  |
| 79. BE. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                 |  |                                                   |  |                                                                |  | 80. BF. NPI<br><b>NPI</b>                                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                                     |  | 81. BG. NPI<br><b>NPI</b>                                                                               |  |                                                     |  |  |  |
| 82. BH. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                 |  |                                                   |  |                                                                |  | 83. BI. NPI<br><b>NPI</b>                                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                                     |  | 84. BJ. NPI<br><b>NPI</b>                                                                               |  |                                                     |  |  |  |
| 85. BK. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                 |  |                                                   |  |                                                                |  | 86. BL. NPI<br><b>NPI</b>                                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                                     |  | 87. BM. NPI<br><b>NPI</b>                                                                               |  |                                                     |  |  |  |
| 88. BN. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                 |  |                                                   |  |                                                                |  | 89. BO. NPI<br><b>NPI</b>                                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                                     |  | 90. BP. NPI<br><b>NPI</b>                                                                               |  |                                                     |  |  |  |
| 91. BQ. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                 |  |                                                   |  |                                                                |  | 92. BR. NPI<br><b>NPI</b>                                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                                     |  | 93. BS. NPI<br><b>NPI</b>                                                                               |  |                                                     |  |  |  |
| 94. BT. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                 |  |                                                   |  |                                                                |  | 95. BU. NPI<br><b>NPI</b>                                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                                     |  | 96. BV. NPI<br><b>NPI</b>                                                                               |  |                                                     |  |  |  |
| 97. BW. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                 |  |                                                   |  |                                                                |  | 98. BX. NPI<br><b>NPI</b>                                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                                     |  | 99. BY. NPI<br><b>NPI</b>                                                                               |  |                                                     |  |  |  |
| 100. BZ. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 101. CA. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 102. CB. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 103. CC. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 104. CD. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 105. CE. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 106. CF. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 107. CG. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 108. CH. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 109. CI. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 110. CJ. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 111. CK. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 112. CL. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 113. CM. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 114. CN. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 115. CO. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 116. CP. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 117. CQ. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 118. CR. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 119. CS. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 120. CT. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 121. CU. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 122. CV. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 123. CW. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 124. CX. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 125. CY. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 126. CZ. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 127. DA. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 128. DB. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 129. DC. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 130. DD. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 131. DE. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 132. DF. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 133. DG. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 134. DH. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 135. DI. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 136. DJ. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 137. DK. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 138. DL. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 139. DM. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 140. DN. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 141. DO. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 142. DP. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 143. DQ. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 144. DR. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 145. DS. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 146. DT. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 147. DU. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 148. DV. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 149. DW. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 150. DX. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 151. DY. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 152. DZ. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 153. EA. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 154. EB. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 155. EC. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 156. ED. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 157. EE. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 158. EF. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 159. EG. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 160. EF. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 161. EH. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 162. EI. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 163. EJ. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 164. EK. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 165. EL. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 166. EM. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 167. EN. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 168. EO. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 169. EP. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 170. EQ. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 171. ER. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 172. ES. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 173. ET. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 174. EU. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 175. EV. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 176. EW. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 177. EX. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 178. EY. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 179. EZ. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 180. FA. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 181. FB. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 182. FC. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 183. FD. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 184. FE. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 185. FF. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 186. FG. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 187. FF. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 188. FH. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 189. FI. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 190. FJ. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 191. FK. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 192. FL. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 193. FM. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 194. FN. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 195. FO. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 196. FP. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 197. FQ. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 198. FR. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 199. FS. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 200. FT. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 201. FU. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 202. FV. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 203. FW. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 204. FX. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 205. FY. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 206. FZ. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 207. GA. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 208. GB. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 209. GC. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 210. GD. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 211. GE. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 212. GF. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 213. GH. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 214. GF. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 215. GI. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 216. GJ. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 217. GK. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 218. GL. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 219. GM. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 220. GN. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 221. GO. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 222. GP. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 223. GQ. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 224. GR. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 225. GS. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 226. GT. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 227. GU. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 228. GV. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 229. GW. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 230. GX. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 231. GY. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 232. GZ. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 233. HA. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 234. HB. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 235. HC. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 236. HD. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 237. HE. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 238. HF. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 239. HG. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 240. HH. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 241. HF. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 242. HI. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 243. HJ. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 244. HK. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 245. HL. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 246. HM. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 247. HN. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 248. HO. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 249. HP. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 250. HQ. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 251. HR. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 252. HS. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 253. HT. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 254. HU. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 255. HV. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 256. HW. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 257. HX. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 258. HY. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 259. HZ. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 260. IA. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 261. IB. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 262. IC. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 263. ID. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 264. IE. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 265. IF. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 266. IG. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 267. IH. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 268. IF. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 269. II. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 270. IJ. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 271. IK. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 272. IL. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 273. IM. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 274. IN. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 275. IO. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 276. IP. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 277. IQ. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 278. IR. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 279. IS. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 280. IT. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 281. IU. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 282. IV. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 283. IW. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 284. IX. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 285. IY. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 286. IZ. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 287. JA. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 288. JB. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 289. JC. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 290. JD. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 291. JE. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 292. JF. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 293. JG. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 294. JH. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 295. JF. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 296. JI. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 297. JJ. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 298. JK. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 299. JL. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 300. JM. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 301. JN. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 302. JO. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 303. JP. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 304. JQ. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 305. JR. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 306. JS. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 307. JT. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 308. JU. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 309. JV. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 310. JW. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 311. JX. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 312. JY. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 313. JZ. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 314. KA. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 315. KB. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 316. KC. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 317. KD. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 318. KE. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 319. KF. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 320. KG. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 321. KH. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 322. KF. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 323. KI. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 324. KJ. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 325. KK. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 326. KL. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 327. KM. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 328. KN. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 329. KO. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 330. KP. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 331. KQ. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 332. KR. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 333. KS. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 334. KT. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 335. KU. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 336. KV. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 337. KW. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 338. KX. NPI<br><b>NPI</b>                                                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                     |  | 339. KY. NPI<br><b>NPI</b>                                                                              |  |                                                     |  |  |  |
| 340. KZ. NPI<br><b>NPI</b>                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                |  | 341. LA. NPI                                                                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                     |  |                                                                                                         |  |                                                     |  |  |  |

1500

SOUTH CAROLINA MEDIC 0002  
PO BOX 100190

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

COLUMBIA

SC 29202-3190

|                                                                                                                                                                                                                                                                                                                             |  |                                                   |  |                                                                                                                                                                                                           |  |                                                  |  |                                                                                                                                                                                                                                                  |  |                                                              |  |                                                                                    |  |                                                      |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------|--|------------------------------------------------------------------------------------|--|------------------------------------------------------|--|
| <input type="checkbox"/> MEDICARE<br>(Medicare #)                                                                                                                                                                                                                                                                           |  | <input type="checkbox"/> MEDICAID<br>(Medicaid #) |  | <input type="checkbox"/> TRICARE<br>CHAMPUS<br>(Sponsor's SSN)                                                                                                                                            |  | <input type="checkbox"/> CHAMPVA<br>(Member ID#) |  | <input type="checkbox"/> GROUP<br>HEALTH PLAN<br>(SSN or ID)                                                                                                                                                                                     |  | <input type="checkbox"/> FECA<br>BLK (LUNG)<br>(SSN)         |  | <input type="checkbox"/> OTHER<br>(ID)                                             |  | 1a. INSURED'S I.D. NUMBER<br>(For Program in Item 1) |  |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)<br><b>ARON FRANCES A</b>                                                                                                                                                                                                                                          |  |                                                   |  |                                                                                                                                                                                                           |  |                                                  |  | 3. PATIENT'S BIRTH DATE<br>MM DD YY<br><b>MM DD YY</b>                                                                                                                                                                                           |  | SEX<br><input type="checkbox"/> M <input type="checkbox"/> F |  | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)<br><b>ARON FRANCES A</b> |  |                                                      |  |
| 5. PATIENT'S ADDRESS (No., Street)<br><b>CITY</b>                                                                                                                                                                                                                                                                           |  |                                                   |  |                                                                                                                                                                                                           |  |                                                  |  | 6. PATIENT RELATIONSHIP TO INSURED<br><input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other                                                                                                   |  | 7. INSURED'S ADDRESS (No., Street)<br><b>CITY</b>            |  |                                                                                    |  |                                                      |  |
| 8. PATIENT STATUS<br>Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>                                                                                                                                                                                                        |  |                                                   |  | 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)<br><b>ARON EDWARD</b>                                                                                                                     |  |                                                  |  | 10. IS PATIENT'S CONDITION RELATED TO:<br>a. EMPLOYMENT? (Current or Previous)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                            |  |                                                              |  | 11. INSURED'S POLICY GROUP OR FECA NUMBER<br><b>SOUTH CAROLINA MEDICARE</b>        |  |                                                      |  |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.<br><b>SIGNATURE ON FILE</b><br>SIGNED _____ DATE <b>06 04 2012</b> |  |                                                   |  | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.<br><b>SIGNATURE ON FILE</b><br>SIGNED _____ |  |                                                  |  | 14. IS THERE ANOTHER HEALTH BENEFIT PLAN?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 8 a-d.                                                                                      |  |                                                              |  |                                                                                    |  |                                                      |  |
| 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY<br>17a. <b>17b. NPI 1518177559</b>                                                                                                                                                                                                                 |  |                                                   |  |                                                                                                                                                                                                           |  |                                                  |  | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION<br>FROM MM DD YY TO MM DD YY<br><b>FROM 05 29 2012 TO</b>                                                                                                                                 |  |                                                              |  |                                                                                    |  |                                                      |  |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE<br><b>GEORGE B. SUTHERLAND MD</b>                                                                                                                                                                                                                                            |  |                                                   |  |                                                                                                                                                                                                           |  |                                                  |  | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES<br>FROM MM DD YY TO MM DD YY<br><b>FROM 05 29 2012 TO</b>                                                                                                                                  |  |                                                              |  |                                                                                    |  |                                                      |  |
| 19. RESERVED FOR LOCAL USE                                                                                                                                                                                                                                                                                                  |  |                                                   |  |                                                                                                                                                                                                           |  |                                                  |  | 20. OUTSIDE LAB? \$ CHARGES<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                               |  |                                                              |  |                                                                                    |  |                                                      |  |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by line)<br><b>1. 824 0</b>                                                                                                                                                                                                             |  |                                                   |  |                                                                                                                                                                                                           |  |                                                  |  | 22. MEDICAID RESUBMISSION<br>CODE ORIGINAL REF. NO.                                                                                                                                                                                              |  |                                                              |  |                                                                                    |  |                                                      |  |
| 23. PRIOR AUTHORIZATION NUMBER                                                                                                                                                                                                                                                                                              |  |                                                   |  |                                                                                                                                                                                                           |  |                                                  |  | 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY<br>B. PLACE OF SERVICE<br>C. EMO<br>D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER<br>E. DIAGNOSIS POINTER<br><b>5292012 05292012 22 73610 26 1</b> |  |                                                              |  |                                                                                    |  |                                                      |  |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN<br><b>13804260</b>                                                                                                                                                                                                                                                                      |  |                                                   |  |                                                                                                                                                                                                           |  |                                                  |  | 26. TOTAL CHARGE \$ <b>8 91</b>                                                                                                                                                                                                                  |  |                                                              |  |                                                                                    |  |                                                      |  |
| 27. ACCEPT ASSIGNMENT? (For gov't claims, see back)<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                  |  |                                                   |  |                                                                                                                                                                                                           |  |                                                  |  | 29. AMOUNT PAID \$ <b>0 00</b>                                                                                                                                                                                                                   |  |                                                              |  |                                                                                    |  |                                                      |  |
| 28. PATIENT'S ACCOUNT NO.<br><b>06220</b>                                                                                                                                                                                                                                                                                   |  |                                                   |  |                                                                                                                                                                                                           |  |                                                  |  | 30. BALANCE DUE \$ <b>8 91</b>                                                                                                                                                                                                                   |  |                                                              |  |                                                                                    |  |                                                      |  |
| 31. BILLING PROVIDER INFO & PH # <b>912 629 0457</b><br><b>COASTAL EMPIRE IMAGING</b><br><b>PO BOX 15479</b><br><b>SAVANNAH GA 31416-2179</b>                                                                                                                                                                               |  |                                                   |  |                                                                                                                                                                                                           |  |                                                  |  | 32. SERVICE FACILITY LOCATION INFORMATION<br><b>COASTAL CAROLINA OP</b><br><b>1000 MEDICAL CENTER DR</b><br><b>HARDEEVILLE SC 29927</b>                                                                                                          |  |                                                              |  |                                                                                    |  |                                                      |  |
| 33. BILLING PROVIDER INFO & PH # <b>912 629 0457</b><br><b>COASTAL EMPIRE IMAGING</b><br><b>PO BOX 15479</b><br><b>SAVANNAH GA 31416-2179</b>                                                                                                                                                                               |  |                                                   |  |                                                                                                                                                                                                           |  |                                                  |  | 34. BILLING PROVIDER INFO & PH # <b>912 629 0457</b><br><b>COASTAL EMPIRE IMAGING</b><br><b>PO BOX 15479</b><br><b>SAVANNAH GA 31416-2179</b>                                                                                                    |  |                                                              |  |                                                                                    |  |                                                      |  |
| 35. SIGNATURE OF PHYSICIAN OR SUPPLIER<br>(The signature must be on the reverse of this bill and are made a part thereof.)<br><b>10275</b><br><b>IAN V MOESCH MD</b><br>SIGNED <b>06 04 2012</b> DATE                                                                                                                       |  |                                                   |  |                                                                                                                                                                                                           |  |                                                  |  | 36. SIGNATURE OF PHYSICIAN OR SUPPLIER<br>(The signature must be on the reverse of this bill and are made a part thereof.)<br><b>10275</b><br><b>IAN V MOESCH MD</b><br>SIGNED <b>06 04 2012</b> DATE                                            |  |                                                              |  |                                                                                    |  |                                                      |  |

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

1500

SOUTH CAROLINA MEDIC 0002  
PO BOX 100190

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 01/05

COLUMBIA

SC 29202-3190

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|
| <input type="checkbox"/> MEDICARE<br><input type="checkbox"/> (Medicare B)                                                                                                                                                                                                                            |  | <input type="checkbox"/> MEDICAID<br><input type="checkbox"/> (Medicaid A) |  | <input type="checkbox"/> TRICARE<br><input type="checkbox"/> CHAMPUS<br><input type="checkbox"/> (Sponsor's SSN) |  | <input type="checkbox"/> CHAMPVA<br><input type="checkbox"/> (Member ID#) |  | <input type="checkbox"/> GROUP<br><input type="checkbox"/> HEALTH PLAN<br><input type="checkbox"/> (SSN or ID) |  | <input type="checkbox"/> FECA<br><input type="checkbox"/> BLX (LNO)<br><input type="checkbox"/> (SSN) |  | <input type="checkbox"/> OTHER<br><input type="checkbox"/> (ID) |  | <input type="checkbox"/> PICA<br><input type="checkbox"/> (For Program in Item 1) |  |
| 1. PATIENT'S NAME (Last Name, First Name, Middle Initial)<br><b>ARON FRANCES A</b>                                                                                                                                                                                                                    |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 2. PATIENT'S ADDRESS (No. Street)<br><b>[REDACTED]</b>                                                                                                                                                                                                                                                |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 3. CITY<br><b>[REDACTED]</b>                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 4. STATE<br><b>SC</b>                                                                                                                                                                                                                                                                                 |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 5. ZIP CODE<br><b>[REDACTED]</b>                                                                                                                                                                                                                                                                      |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 6. TELEPHONE (Include Area Code)<br><b>[REDACTED]</b>                                                                                                                                                                                                                                                 |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 7. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)<br><b>ARON EDWARD</b>                                                                                                                                                                                                                 |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 8. OTHER INSURED'S POLICY OR GROUP NUMBER<br><b>[REDACTED]</b>                                                                                                                                                                                                                                        |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 9. OTHER INSURED'S DATE OF BIRTH<br><b>[REDACTED]</b>                                                                                                                                                                                                                                                 |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 10. OTHER INSURED'S SEX<br><b>[REDACTED]</b>                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 11. EMPLOYER'S NAME OR SCHOOL NAME<br><b>[REDACTED]</b>                                                                                                                                                                                                                                               |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 12. INSURANCE PLAN NAME OR PROGRAM NAME<br><b>TRICARE FOR LIFE</b>                                                                                                                                                                                                                                    |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 13. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.<br>I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.<br><b>SIGNATURE ON FILE</b> |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 14. SIGNED<br><b>[REDACTED]</b>                                                                                                                                                                                                                                                                       |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 15. DATE<br><b>06 04 2012</b>                                                                                                                                                                                                                                                                         |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 16. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)<br><b>[REDACTED]</b>                                                                                                                                                                                              |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 17. DATE OF REFERRING PROVIDER OR OTHER SOURCE<br><b>GEORGE B SUTHERLAND MD</b>                                                                                                                                                                                                                       |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 18. RESERVED FOR LOCAL USE                                                                                                                                                                                                                                                                            |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| <b>B24 0</b>                                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 20. DATE(S) OF SERVICE<br><b>5/29/2012</b>                                                                                                                                                                                                                                                            |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| <b>05/29/2012</b>                                                                                                                                                                                                                                                                                     |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| <b>22</b>                                                                                                                                                                                                                                                                                             |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| <b>76942</b>                                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| <b>26</b>                                                                                                                                                                                                                                                                                             |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| <b>1</b>                                                                                                                                                                                                                                                                                              |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| <b>35 09</b>                                                                                                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| <b>1</b>                                                                                                                                                                                                                                                                                              |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| <b>NPI</b>                                                                                                                                                                                                                                                                                            |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| <b>508819970</b>                                                                                                                                                                                                                                                                                      |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 21. FEDERAL TAX I.D. NUMBER<br><b>3804260</b>                                                                                                                                                                                                                                                         |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 22. PATIENT'S ACCOUNT NO.<br><b>06220</b>                                                                                                                                                                                                                                                             |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 23. ACCEPT ASSIGNMENT?<br><b>[REDACTED]</b>                                                                                                                                                                                                                                                           |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 24. TOTAL CHARGE<br><b>\$ 35 09</b>                                                                                                                                                                                                                                                                   |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 25. AMOUNT PAID<br><b>\$ 0 00</b>                                                                                                                                                                                                                                                                     |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 26. BALANCE DUE<br><b>\$ 35 09</b>                                                                                                                                                                                                                                                                    |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 27. SIGNATURE OF PHYSICIAN OR SUPPLIER<br><b>AN V MOESCH MD</b>                                                                                                                                                                                                                                       |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 28. SERVICE FACILITY LOCATION INFORMATION<br><b>COASTAL CAROLINA OP</b>                                                                                                                                                                                                                               |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| <b>1000 MEDICAL CENTER DR</b>                                                                                                                                                                                                                                                                         |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| <b>HARDEEVILLE SC 29927</b>                                                                                                                                                                                                                                                                           |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| <b>2962472431</b>                                                                                                                                                                                                                                                                                     |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| 29. BILLING PROVIDER INFO & PH#<br><b>COASTAL EMPIRE IMAGING</b>                                                                                                                                                                                                                                      |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| <b>PO BOX 15479</b>                                                                                                                                                                                                                                                                                   |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| <b>SAVANNAH GA 31416-2179</b>                                                                                                                                                                                                                                                                         |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| <b>1417900556</b>                                                                                                                                                                                                                                                                                     |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |
| <b>DC8549</b>                                                                                                                                                                                                                                                                                         |  |                                                                            |  |                                                                                                                  |  |                                                                           |  |                                                                                                                |  |                                                                                                       |  |                                                                 |  |                                                                                   |  |

CARRIER →

**PATIENT AND INSURED INFORMATION**

PHYSICIAN OR SUPPLIER INFORMATION



SOUTHEAST REIMBURSEMENT  
23 PLANTATION PARK DRIVE BLDG 400  
BLUFFTON, SC 29910-9909

PRINTED BY: 57-05 Jan 21 Aug 2012  
BY: FMT110R-AR CB11101  
PAGE 1  
TAX ID# 263342341

FRANCES BARON (2575)

Patient..... Seq Date..... Type Code..... Description..... Prov FCL Diagnosis Original... Link... Refer. Charges... Adjust....

|      |   |          |       |                      |   |       |         |        |        |  |
|------|---|----------|-------|----------------------|---|-------|---------|--------|--------|--|
| 2575 | 1 | 05/22/12 | 99223 | INITIAL HOSP. DED 1  | 2 | 700.2 | 264.00  | 11867. | 11867. |  |
|      | 3 | 06/18/12 | 16    | F185.71 ALLOWED 1    | 2 |       | 0.00    | 11867. | 801614 |  |
|      | 4 | 06/18/12 | 20    | F37.14 COINSURANCE 1 | 2 |       | 0.00    | 11867. | 801614 |  |
|      | 5 | 06/18/12 | 2.2   | MEDICARE PBT 1       | 2 |       | -149.57 | 11867. | 801614 |  |
|      | 6 | 06/18/12 | 4.2   | MEDICARE ADJ REL 1   | 2 |       | -78.29  | 11867. | 801614 |  |
|      | 8 | 07/01/12 | 3.8   | TRICARE PBT WK 1     | 2 |       | -37.14  | 11867. | 700122 |  |
|      | 2 | 06/05/12 | Insur | ECS-MEDICARE         |   |       |         |        | 8237   |  |
|      |   |          |       | Balance              |   |       | 0.00    |        |        |  |
|      |   |          |       | Total                |   |       |         | 264.00 | -78.29 |  |
|      |   |          |       |                      |   |       | 0.00    |        |        |  |

DOCTOR..... TAX-ID..... FINANCIAL CLASS

1 GEORGE V WARMER, MD 263342341 2 MEDICARE

|                         |               |                |                   |
|-------------------------|---------------|----------------|-------------------|
| ENT NO. 2575            | FRANCES BARON | DUB=10/18/1941 | SEX=F 189-32-2746 |
| Insurance Company Group |               | Id Number      | Insured           |
| MEDICARE                |               | 189-32-2746A   | 2575              |
| TRICARE-SOUTH           |               | 189-32-2746    | 2575              |
| PATIENT NO.             |               | DUB=           | SEX=              |

6/11/12  
4:52:24

COASTAL CAROLINA MED CNTR  
1000 MEDICAL CENTER DR HARDEEVILLE

REGISTRATION  
SC 29927 RECORD-F01

PATIENT NO: [REDACTED]  
NS/ROOM/BED: [REDACTED]

ADMIT DT/TIME: 5/21/12 18:50 M/R NO: [REDACTED]  
CLINICS: MO RESISTANT ORG:

PNT NAME: BARON, FRANCES

BY: ACOP

TITLE:

MAILING ADDR: [REDACTED]

SOCIAL SECURITY: [REDACTED]

CITY/STATE: [REDACTED]

PHONE: [REDACTED]

PHYSICAL ADR: [REDACTED]

NPP: 2.0 DATE: 12/08/03

CITY/STATE: [REDACTED]

00000 0000

PHONE: ( )

OCCUPATION: RN

LANGUAGE: EN

FC: 05

POB: XX

ADMT PHYS:

42- CONDIE, SCOTT

HSV: 58

DOB: [REDACTED]

ADMT PHYS PHONE:

(843) 757-5966

PAR:

AGE: 70 Y RACE: WHI

ATTEND PHYS:

42- CONDIE, SCOTT

MS: M

SEX: F REF PHY:

42-CONDIE, SCOTT

PHN: 843 757-5966

SMK:

PCP PHY: -

PHN:

VAL: PT: 2

ETHNICITY: NON FLAG:

FATHER'S DOB:

MOTHER'S DOB:

EMER CONTACT: EDWARD BARON

REL: SPOUSE

ADDRESS: [REDACTED]

PHONE: [REDACTED]

CITY/STATE: [REDACTED]

NEAREST RELT: EDWARD BARON

REL: SPOUSE

ADDRESS: [REDACTED]

PHONE: [REDACTED]

CITY/STATE: [REDACTED]

RESEARCH ID:

GUARANTOR: BARON, FRANCES A

REL: SELF

ADDRESS 1: [REDACTED]

PHONE: [REDACTED]

ADDRESS 2: [REDACTED]

SOCIAL SECURITY: [REDACTED]

CTY/STE/ZIP: [REDACTED]

OCC: RN

AF:

PAYOR NAME 1: NATIONWIDE INS

INS. PLAN ID: Q9701 SRV/TYPE: ALLOP

PLAN NAME: AUTO INSURANCE/600

IPA:

VO NAME:

AUTH #:

ADDRESS: 1 NATIONWIDE

CERT-SSN-HIC-ID#: CL# [REDACTED]

Y/STE/CNTRY: DES MOINES

IA 50391 0000

BILL PHONE: (919) 278-9080

BILLING NAME:

GP #:

INSURED: BARON, FRANCES

SEX/REL: F SELF

EMPLOYER:

MSP:

TRACKING#:

ADDRESS:

EMP PHONE: ( ) 000-0000

CITY/STATE:

00000 0000

ESC:

PAYOR NAME 2: MEDICARE

INS. PLAN ID: [REDACTED]

PLAN NAME:

LL C/O NAME:

AUTH #:

ILL ADDRESS: P O BOX 1602

CERT-SSN-HIC-ID#: [REDACTED]

Y/STE/CNTRY: OMAHA

NE 68101 0000

BILL PHONE: (866) 580-5981

BILLING NAME:

GP #: NONE

INSURED: BARON, FRANCES A

SEX/REL: SELF

EMPLOYER: SANCTUARY HOSPICE

TRACKING#:

ADDRESS: 10911 N JACOB SMART BLVD

EMP PHONE: (843) 645-6540

CITY/STATE: RIDGELAND

00000 0000

ESC: 1

SPAN CODE:

PRIOR VISIT: 6/07/12

FROM/TO DATE:

PRIOR HOSPITAL:

CONDITION CD

CONDITION CD

OCCURRENCE CD/DATE

OCCURRENCE CD/DATE

02

5/21/12

35

5/22/12

11

5/21/12

29

5/22/12

COMPLAINT DESCRIPTION:

CHIEF COMPLAINT CODE: 850.11

/NOPE, MVA, DMII, GLAUCOMA, THYROID NODULE

COMMENTS:

PRINTED BY: TARABLOOM

DATE: 08/17/2012

COASTAL CAROLINA MEDICAL CENTER  
1000 Medical Center Drive  
Hardeeville, SC 29927

Name: BARON, FRANCES

Scott Condie, MD

ADM: 05/21/2012

MRN: [REDACTED]  
UPT: [REDACTED]

History and Physical

-----  
ADMITTING DIAGNOSES: Syncope, motor vehicle accident, diabetes mellitus type 2 without insulin use, glaucoma and thyroid nodule.

HISTORY OF PRESENT ILLNESS: This 70-year-old Caucasian female RN presented to the Emergency Room by ambulance after a motor vehicle accident. Patient was a driver of the car, she was restrained. The vehicle was impacted on the front and by a tree. Apparently, the patient had a syncopal episode while driving. She lost consciousness. She does not remember going off the road, but she does have some recollection of the airbag going off. States she was unconscious for perhaps 10 minutes, although I am not sure how she knows that.

She presented to the Emergency Room where she was evaluated by Jennifer Fralick, PA. She has multiple superficial lacerations. She has had a CT scan of the head and neck with no fractures. States that she is a diabetic, but that she had just eaten, so her sugars should not have been low. I do not have EMS run sheet to review glucoses in the field, but in the Emergency Room, her glucose was 211.

I have discussed in detail our evaluation with both patient and spouse. Obviously syncopal episodes tend to be more cardiovascular than neurological; however, we will trigger both evaluations during this hospital stay.

Site count 7800, H&H 13.1 and 37.6 respectively with a platelet count 302,000. CK-MB slightly elevated at 5.65, total CK 116. Chem-12 was abnormal only with glucose of 211. INR normal. Troponin less than 0.01. A CT of the head shows generalized mild cerebral atrophy with some periventricular white matter disease. There is a right frontal scalp hematoma, but no frontal bone fracture. A CT of the chest shows no pulmonary contusion, pleural effusion or pneumothorax. There is no evidence of thoracic aortic aneurysm, but there is a large hiatal hernia, which the patient is asymptomatic for. C-spine CT revealed no acute cervical spine fracture or subluxation noted. No bony encroachment in the cervical spine or canal. A CT maxillofacial bone shows a right frontal scalp hematoma and laceration, but no frontal bone fractures. There is no definitive facial bone fracture noted.

We will admit the patient, to telemetry, outpatient observation, sliding scale insulin, CBC, BMP in a.m., hemoglobin Alc, fasting lipids, cardiac enzymes every 8 hours x 3, EKG in a.m., 2-dimensional echocardiogram, carotid ultrasound, MRA with gadolinium, MRA, both intra and extracranial vessels, 2-dimensional echocardiogram, we will begin Lovenox for DVT prophylaxis, aspirin 325 mg daily, Pepcid 20 mg IV b.i.d. for GI prophylaxis, Tylenol, Zofran and the aspirin as mentioned. We will continue her home medications as outlined below. If all other workup is negative, we will discharge tomorrow, otherwise, if we have any positive findings we will obviously adjust those individually.

Work Type: History and Physical

T001

Work Type Code: HYP

Page: 1

PRINTED BY: TARABLOOM

DATE: 08/17/2012

COASTAL CAROLINA MEDICAL CENTER  
1000 Medical Center Drive  
Hardeeville, SC 29927

Name: BARON, FRANCES  
RN: [REDACTED]  
SCT: [REDACTED]

Scott Condie, MD  
ADM: 05/21/2012

History and Physical

---

ALLERGIES: MANGO FLAVOR.

HOME MEDICATIONS: Lisinopril 5 mg daily, multivitamin daily, Glucophage 1000 mg twice a day, calcium and vitamin D daily, Motrin 800 mg as needed p.r.n., Xalatan 0.05% one drop both eyes daily and Synthroid 125 mcg daily.

CHRONIC ILLNESSES: Diabetes mellitus type 2 without insulin use, glaucoma, hypothyroidism.

PAST SURGICAL HISTORY: Appendectomy, cholecystectomy, right thyroid lobectomy for thyroid nodules.

IMMUNIZATIONS: States that she does not remember when her last tetanus was, we will give that today. Pneumovax and influenza are up-to-date.

SOCIAL HISTORY: Tobacco, none. Alcohol, minimal. Drugs, none. Educated to a 3-year, RN degree. Employed at Sanctuary Hospice, married for 50 years, +7 months, has 2 children. No armed services time. She has 2 pet dogs lives in Ridgeland with her spouse. One story home with minimal steps.

PHYSICIANS: Primary care physician: Dr. Etheridge. She does not see any local consultants.

FAMILY HISTORY: Father died from MI at 74. Mother died from Parkinson's at age 78. Has 1 brother and 1 sister, both in good health. She did have a maternal grandmother with diabetes and a father with skin cancer. She does have a grandmother who did have a stroke in her 80s.

REVIEW OF SYSTEMS:

GENERAL: No weight loss, polyuria, polydipsia, heat or cold intolerance.

HEENT: Negative except for thyroid disease.

CARDIOVASCULAR: No chest pain, palpitations, PND, orthopnea or edema.

RESPIRATORY: Negative for shortness of breath, pleurisy, sputum production, PND, orthopnea.

NECK: Negative.

CHEST: Pain in the right lower chest wall anteriorly.

LUNGS: No cough or shortness breath, wheeze, pleurisy or hemoptysis.

HEART: No chest pain, palpitations, PND, orthopnea or edema.

ABDOMEN: No nausea, vomiting, diarrhea, constipation, black or bloody stools.

GENITOURINARY: No dysuria, hematuria, polyuria or frequency.

SKIN: Multiple abrasions from the accident, otherwise, negative. She has not noted any new lesions.

NEUROLOGIC: No prior history of seizure, migraine or lateralizing neurological symptomatology.

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Work Type: History and Physical  
T001

Work Type Code: HYP  
Page: 2

PRINTED BY: TARABLOOM  
DATE: 08/17/2012

COASTAL CAROLINA MEDICAL CENTER  
1000 Medical Center Drive  
Hardeeville, SC 29927

Name: BARON, FRANCES

Scott Condie, MD

DN: [REDACTED]

ADM: 05/21/2012

CT: [REDACTED]

History and Physical

PHYSICAL EXAMINATION:

VITAL SIGNS: Height 65 inches, weight 157 pounds, pulse ox 97%, temperature 97.8, respirations 20, pulse 122 initially, dropping to 105, blood pressure 200/113, on admission 160/102 at 5:16, when I saw her it was closer to 150/90.

HEAD: Head normocephalic, multiple cranial abrasions and small lacerations from glass shards.

EYES: Pupils are equally round and reactive to light and accommodation. Extraocular movements are intact. Funduscopy exam is benign. Pupils are approximately 3 mm bilaterally.

ENT: Nares patent. Negative Battle sign. Tympanic membranes are normal. Pharynx is pink. No exudate, ulcerations or suspicious lesions. She does have some dental repair that needs to be done.

NECK: Supple, nontender. A CT scan negative. No adenopathy. Carotids are 2/4 without bruit. Thyroid palpates with an enlarged left-sided nodularity, scar present. Trachea midline. No adenopathy.

HEART: Regular rhythm without murmur, rub or click. No S3 or S4. PMI is at the MCL.

CHEST: Lungs clear to A&P. No wheeze, rhonchi or rales. Tenderness over the right lower anterior chest wall.

ABDOMEN: ~~Soft and nontender without mass, megaly or abnormal bowel sounds.~~

GENITALIA AND RECTAL: Deferred.

EXTREMITIES: Full passive range of motion without deformity or edema. No tenderness, no pain. Distal pulses 2/4. No edema. Negative Homans'.

SKIN: Warm, dry, color normal, turgor normal.

NEUROLOGICAL: Grossly intact including cranial nerves II-XII, reflexes, strength and sensation.

ADMITTING DIAGNOSES: Syncope, motor vehicle accident with head trauma (concussion, loss of conscious is less than 15 minutes), diabetes mellitus type 2, glaucoma, thyroid nodule, historically and currently.

PLAN: Admit as above, pretty much already as outlined in the history of present illness of what we will be doing.

Scott Condie, MD

cc: Tricia Etheridge MD

TR:SC/HN

DD:05/21/2012 20:06 EDT

DT:05/21/2012 22:10 EDT

Work Type: History and Physical  
T001

Work Type Code: HYP  
Page: 3

PRINTED BY: TARABLOOM  
DATE: 08/17/2012

COASTAL CAROLINA MEDICAL CENTER  
1000 Medical Center Drive  
Hardeeville, SC 29927

Name: BARON, FRANCES  
RN: [REDACTED]  
JCT: [REDACTED]

Scott Condie, MD  
ADM: 05/21/2012

History and Physical

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Dictation ID: 6450925/Confirmation #: 2386195  
R:

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Work Type: History and Physical  
T001

Work Type Code: HYP  
Page: 4

Authenticated by SCOTT CONDIE, MD On 05/25/2012 11:21:36 AM  
PRINTED BY: PARABLOOM  
DATE: 08/17/2012

COASTAL CAROLINA MEDICAL CENTER  
1000 Medical Center Drive  
Hardeeville, SC 29927

Name: BARON, FRANCES  
N: [REDACTED]  
CT: [REDACTED]

Jonathan MacCabe, MD  
ADM: 05/21/2012

Consultation

---

DATE OF SERVICE: 05/23/2012

REFERRING PHYSICIAN: Scott Condie, MD

REASON FOR REFERRAL: Syncope.

HISTORY: Ms. Baron is a 70-year-old nurse who presented to the Emergency Room after an automobile accident. She reports she was feeling well when she suddenly lost consciousness apparently ran off the road and drove into a tree. She woke with the airbag deployed. She has no recollection of running off the road. She reports no antecedent palpitations, chest pain, shortness of breath, dizziness or lightheadedness. She has a history of arrhythmias, diagnosed with PACs and PVCs in the past, but reports occasional "heart racing" which she can terminate with cough or Valsalva. These arrhythmias have never been documented by Holter monitoring over telemetry. She had a cardiac evaluation 3 years ago including a stress echocardiogram showing normal left ventricular systolic function and no evidence of ischemia. She has no history of recurrent syncope or near syncope in the past.

~~PAST MEDICAL HISTORY:~~ Significant for a history of diabetes, hypertension, hypothyroidism and glaucoma.

HOME MEDICATIONS: Include lisinopril 5 mg daily, Glucophage 1000 mg twice daily, Xalatan eye drops daily, Synthroid 125 mcg daily, calcium and vitamin D daily, multivitamin daily and Motrin as needed for aches and pains.

ALLERGIES: She has no significant drug allergies.

SOCIAL HISTORY: She is a nonsmoker who very rarely drinks alcohol. She is married and currently works as a nurse in hospice. She lives in Ridgeland with her husband.

FAMILY HISTORY: There is a paternal history of cardiovascular disease. Her father died of myocardial infarction at age 74. Her mother had Parkinson disease before her death at age 78.

REVIEW OF SYSTEMS:

CONSTITUTIONAL: She reports no recent fever, chills or unexplained changes in weight.

CARDIAC: She denies chest pain or angina. She has a history of intermittent palpitations as described in the history of present illness. No history of previous syncope or near syncope prior to the current event.

RESPIRATORY: She denies shortness of breath, cough, wheezing, hemoptysis, orthopnea or PND. Remainder of 12-system review is unremarkable.

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Work Type: Consultation  
T001

Work Type Code: CON  
Page: 1

PRINTED BY: TARABLOOM  
DATE: 08/17/2012

COASTAL CAROLINA MEDICAL CENTER  
1000 Medical Center Drive  
Hardeeville, SC 29927

Name: BARON, FRANCES  
N: [REDACTED]  
SUBJECT: [REDACTED]

Jonathan MacCabe, MD  
ADM: 05/21/2012

Consultation

---

PHYSICAL EXAMINATION:

GENERAL: She is a well-developed, well-nourished female in no acute distress.  
HEENT: She has marked ecchymosis and swelling about the face. There is no scleral icterus or conjunctivitis. Extraocular movements are intact. Nares and oropharynx are unremarkable.  
NECK: Supple. There is no cervical lymphadenopathy or thyromegaly.  
LUNGS: Clear to auscultation bilaterally. There is no accessory muscle use or respiratory difficulty.  
HEART: Regular in rate and rhythm with a normal S1 and S2. No murmurs, gallops or rubs are appreciated.  
ABDOMEN: Flat, soft, nontender and nondistended with normoactive bowel sounds. No organomegaly.  
EXTREMITIES: There is no clubbing, cyanosis or edema of the extremities.  
NEUROLOGIC: She is alert and oriented x3. There is no focal strength or sensory deficits.

Electrocardiogram shows a sinus rhythm without significant ST changes, her conduction intervals are normal. Chemistry and CBC are both unremarkable. Cardiac enzymes have been within normal limits.

---

ASSESSMENT:

1. Syncope.
2. Diabetes.

PLAN: Ms. Baron has a history of recent syncopal event concerning for cardiac dysrhythmia. She had a bedside echocardiogram performed in the hospital showing normal left ventricular systolic function without significant valvular stenosis or regurgitation. She has had no significant arrhythmias since her admission. There is no evidence of an acute ischemic event; however, given her history of diabetes, outpatient stress testing will be arranged to exclude any ischemia. I discussed her case with Dr. Mark Jenkins, electrophysiologist in Savannah who will see her in consultation as an outpatient. Medications will remain unchanged.

---

Jonathan MacCabe, MD

TR:JM/IN  
DD:05/23/2012 17:37 EDT  
DT:05/23/2012 23:52 EDT

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Work Type: Consultation  
T001

Work Type Code: CON  
Page: 2

PRINTED BY: TARABLOOM  
DATE: 08/17/2012



COASTAL CAROLINA MEDICAL CENTER  
1000 Medical Center Drive  
Hardeeville, SC 29927

Name: BARON, FRANCES  
N: [REDACTED]  
CT: [REDACTED]

Jonathan MacCabe, MD  
ADM: 05/21/2012

Consultation

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Dictation ID: 6468549/Confirmation #: 2830764  
R:

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rk Type: Consultation  
T001

Work Type Code: CON  
Page: 3

Authenticated by JONATHAN MAC CABB, MD On 06/11/2012 03:09:00 PM  
PRINTED BY: PARABLOM  
DATE: 08/17/2012

**PROGRESS NOTE:** 5/22/12

**History of Present Illness**

The patient is a 70 year old female being seen for routine hospital rounds. This is hospital day number 2. Overall status is improved. Condition is stable. Note for "Progress note": Patient is a 70 year old white female who was involved in a MVA yesterday. She apparently passed out at the wheel (out for 10-15 minutes) and hit a tree sustaining multiple lacerations on face and contusions on face and extremities and abdomen. Today patient does have a slight headache and slightly dizzy when she moves some. She has no chest or abdominal pain except from the contusions. No shortness of breath or cough. No N, V, or D. No urinary symptom.

Labs: CBC 5100/11.9/34.1/262,000 BMP 139/3.9/103/0.6/13/164 Ca 8.8 Lipids 286/573/31 ratio 9.2 TSH 2.62 T4 6.1  
Cardiac enzymes: CKMB 5.65, 5.19, 3.90 Troponin <0.01 x 3 CK 116, 124, 99 LFT's nl CT chest revealed lg hiatal hernia; no pulmonary contusion, pleural effusion, or pneumothorax; no thoracic aortic aneurysm. CT C-spine normal; CT face: right frontal scalp hematoma with no frontal bone fracture CT head revealed mild generalized cerebral atrophy with mild periventricular white matter disease. MRA of brain

Physical exam: General alert and oriented x 3; Skin: multiple small lacerations, ecchymosis, and hematomas on face with swollen right upper lid and swollen left eye lids; HEENT: nystagmus, right eye deviated to the nose; Neck: no bruit; thyroid: small left thyroid nodule 8mm per U/S. Lungs: rales RLL; Heart: RRR with soft murmur audible in all areas. Abdomen: small hematoma right upper quadrant near rib cage size of apricot, no other abdominal tenderness, BS active. Extremities: multiple contusions, one on left knee anteriorly and a few scrapes on the shins, and entire right arm. Neuro: nystagmus, deviated right eye toward nose, and questionably positive right babinski. Reflexes 3-4+ symmetrical of upper and lower extremities.

**History**

**Vitals** (Josleann M Eccles; 05/22/2012 01:33 PM)

05/22/2012 01:32 PM

**Weight:** 157 lb **Height:** 68 in

**Body Surface Area:** 1.85 m<sup>2</sup> **Body Mass Index:** 23.87 kg/m<sup>2</sup>

**Temp.:** 98.2 °F (Oral) **Pulse:** 74 (Regular) **Resp.:** 1898 (Unlabored)

**P:** 150/73 Manual

**Assessment & Plan**

**BRAIN INJURY WITHOUT OPEN INTRACRANIAL WOUND AND WITH UNSPECIFIED CONCUSSION (854.09)**

Current Plans:

**SYNCOPE, NOS (780.2)**

Current Plans:

**DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED (250.00)**

Current Plans:

**UNSPECIFIED GLAUCOMA (365.9)**

Current Plans:

**THYROID NODULE (241.0)**

Current Plans:

BARON, FRANCES  
ADM INO 124-1  
05/21/12 Condie. Scott  
DOB: 70 F MR#  
Coastal Carolina

124

Frances Baron

**History of Present Illness**

The patient is a 70 year old female who char(39)s recent hospitalization is summarized as follows.

The patient has been hospitalized at Coastal Carolina Hospital. Hospital Dates include an Admission date (05/21/2012) and Discharge Date (05/23/2012). The hospital diagnoses include an Discharge Diagnosis (Syncope, MVA resulting in multiple contusions; NIDDMII; Glaucoma; Thyroid nodule; Left ankle fracture). Narrative summaries include Current stay (The patient is a 70 year old female being seen for discharge. This is hospital day number 3. Overall status is improved.

Condition is stable. Note for "Progress note": Patient is a 70 year old white female who was involved in a MVA yesterday.

She apparently passed out at the wheel (out for 10-15 minutes) and hit a tree sustaining multiple lacerations on face and contusions on face and extremities and abdomen. Yesterday patient did have a slight headache and slightly dizzy when she moved some. Today she was complaining of left ankle pain and bruising on face. She has no chest or abdominal pain except from the contusions. No shortness of breath or cough. No N,V, or D. No urinary symptom. Dr. MacCabe was consulted Labs: CBC 5100/11.9/34.1/262,000 BMP 139/3.9/103/0.6/13/164 Ca 8.8 Lipids 286/573/31 ratio 9.2 TSH 2.62 T4 6.1 Cardiac enzymes: CKMB 5.65, 5.19, 3.90 Troponin <0.01 x 3 CK 116, 124, 99 LFT's nl CT chest revealed lg hiatal hernia; no pulmonary contusion, pleural effusion, or pneumothorax; no thoracic aortic aneurysm. CT C-spine normal; CT face: right frontal scalp hematoma with no frontal bone fracture CT head revealed mild generalized cerebral atrophy with mild periventricular white matter disease. MRA/MRI of brain showed no fractures or hemorrhages. No masses or tumors seen. X-ray of the left ankle revealed a transverse, minimally displaced fracture of the medial malleolus. Right ankle was also taken and this did not show any acute fractures. The patient's physicians include: Consulting Physician (Dr. MacCabe, Dr. Sutherland). Hospital Complications include none. Surgery performed during this hospitalization includes none.

**Past Medical History**

BARON, FRANCES

ADM INo 124.1

05/21/12 Condie, Scott

DOB 70 F MR#

Coastal Carolina

**Vital Signs**

| Temp.   | Pulse | Resp. Rate | P. Ox. | BP Syst. | BP Diast. | Wt.    | Ht    | Pain |
|---------|-------|------------|--------|----------|-----------|--------|-------|------|
| 98.3 °F | 81    | 16         | 96%    | 118      | 51        | 157 lb | 68 in | /10  |

**Physical Exam****General**

**Mental Status** - Alert. **General Appearance** - Cooperative and Consistent with stated age. **Build & Nutrition** - Well nourished. **Hydration** - Well hydrated.

**Skin**

**General: Color** - Normal color. **Moisture** - Normal Moisture. **Temperature** - Warm. **Texture** - Normal texture. **Thickness** - Normal thickness. **Mobility & Turgor** - Normal turgor.

**Neck**

**Carotid Arteries** - normal upstroke and No Bruits. **Neck** - Full range of motion. Non Tender. No Abnormal movements, Masses or Nuchal rigidity. **Trachea** - Midline. **Thyroid: Gland** - Normal size and consistency.

**Chest and Lung Exam****Inspection:**

**Chest Wall:** Inspection of the chest wall reveals - No Scars.

**Shape** - Normal. **Movements** - Symmetrical. **Accessory muscles** - No use of accessory muscles in breathing.

**Palpation:** Palpation of the chest reveals - Non-tender.

**Auscultation:**

**Breath sounds:** - Normal.

**Adventitious sounds:** - No Adventitious sounds.

**Cardiovascular**

**Palpation/Perussion:** Hepatojugular Reflux - Absent.

**Auscultation: Rhythm** - Regular. **Heart Sounds** - S1 WNL and S2 WNL. No S3 or S4.

**Murmurs & Other Heart Sounds:** Auscultation of the heart reveals - No Murmurs, No Systolic Clicks, No Opening Snaps and No Pericardial Friction Rubs.

**Abdomen**

**Inspection: Contour** - Normal. **Incisional scars** - No incisional scars.

**Palpation/Perussion:** Palpation and Percussion of the abdomen reveal - Soft.

**Liver:** - Normal.

**Spleen:** - Normal. **Other Characteristics** - No Costovertebral angle tenderness - Left or Costovertebral angle

tenderness - Right.

**Auscultation:** Auscultation of the abdomen reveals - Bowel sounds normal.

**Peripheral Vascular**

**Lower Extremity: Inspection - Bilateral - Inspection Normal.**

**Palpation: Tenderness - Bilateral - Non Tender. Homan's sign - Bilateral - Negative (normal). Dorsalis pedis pulse - Bilateral - 2+. Edema - Bilateral - No edema.**

**Neurologic**

**Mental Status: Affect - normal. Speech - Fluid. Thought content/perception - Normal. Cognitive function - Normal.**

**Neuropsychiatric**

**Orientation - oriented X3. The patient's mood and affect are described as - not anxious and not agitated.**

**Musculoskeletal**

**General**

**Movements - Full range of motion in all joints. Joints and Muscles - Normal joints and muscles.**

**Assessments & Plans**

- **BRAIN INJURY WITHOUT OPEN INTRACRANIAL WOUND AND WITH UNSPECIFIED CONCUSSION (854.09)**

**Medications**

Pepcid 20MG, 1 Tablet two times daily, 10 days starting 05/23/2012, No Refill. Active.

Thiamine HCl 100MG/ML, 1 ml IV Solution daily, 30 days starting 05/23/2012, No Refill. Active.

Xalatan 0.005%, 1 qtt OU Solution daily, 30 days starting 05/23/2012, No Refill. Active.

Lisinopril 5MG, 1 Tablet daily, 30 days starting 05/23/2012, No Refill. Active.

Glucophage 1000MG, 1 Tablet daily, 30 days starting 05/23/2012, No Refill. Active.

Aspirin EC 325MG, 1 (one) Tablet DR Daily, #100, 30 days starting 05/23/2012, No Refill. Active.

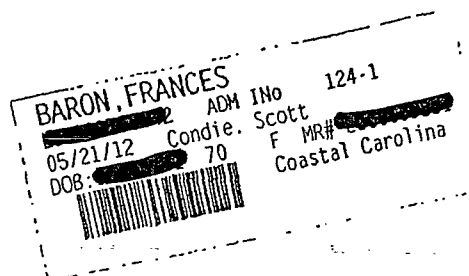
Tylenol 325MG, 2 (two) Tablet q 6 h prn fever/pain, 30 days starting 05/23/2012, No Refill. Active.

- **DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED (250.00)**
- **SYNCOPE, NOS (780.2)**
- **THYROID NODULE (241.0)**
- **UNSPECIFIED GLAUCOMA (365.9)**
- **FX CLOSED ANKLE NOS (824.8)**

*Assessment/Plan Note: Appt. with Dr. Sutherland at 9 am 5/24/12, To see pthamologist Thursday (Dr Dianne), Nuclear stress test next week, Follow up with Dr Jenkins after the stress test.*

*Scott D Condle RA*

Dr. Scott D Condle



RUN DATE: 05/23/12  
RUN TIME: 1827  
RUN USER: 0.

Coastal Carolina Med. Ctr. NUR \*LIVE\*  
PATIENT INTERVENTION ACTIVITY

PAGE 1

Patient: BARON, FRANCES  
Account #:   
Admit Date: 05/21/12  
Status: ADM INO  
Attending: Condie, Scott

Age/Sex: 70 F  
Unit #:   
Location: MS  
Room/Bed: 124-1

| Number | Description                      | Status | Source |
|--------|----------------------------------|--------|--------|
| 501006 | DISCHARGE: Summary/ Instructions | A      | PS     |
|        | Date Time Directions             |        |        |
| 1      | 05/23/12 1822 On Discharge       |        |        |

Documented at 05/23/12 1822 by MXB

\*\*\*DISCHARGE INSTRUCTIONS\*\*\*

Diagnosis: SYNCOPAL EPISODE

Diet: DIABETIC DIET

Fluid Restriction: N Limit all fluids to: 00 glasses per day.  
\*For CHF\*Eat a well balanced diet. Do not put a salt shaker on the table.  
Use frozen vegetables instead of canned vegetables, limit fast foods and processed foods (hot dogs or deli meals).

\*\*\*\*WEIGHT MONITORING\*\*IS MANDATORY\*\*FOR ALL\*\*CHF Patients\*\*\*\*

Weight Monitoring: Y Weight at discharge in lbs.: 157  
If daily wt. needed, weigh self daily at same time and without clothing.  
Notify MD if you gain more than 2 lbs. in 24 hrs. or 5 lbs. in one week.

Heart Failure pt education

packet has been received: N/A

Activities: AS TOLERATED

\*\*CHF PATIENTS\*\* Only resume your usual activity if you have a normal pulse rate (60-100) and are not short of breath or very tired \*\*

Limitations: AS TOLERATED

Wound Care: KEEP CLEAN AND DRY

Smoking Education Offered: Y

Education Materials Provided: Smoking Education

Stroke patient education

packet has been received: N/A

Patient/Family Understand Information: Y

Prescriptions Given: Y

Food/Drug Interaction Info Provided: Y

Support Services: N/A

Follow Up Appointments Needed: Y

Follow Up Appointments Made: Y

Physician:

Date:

Time:

Physician:

Date:

Time:

\*\*\* Call Physician or go to the Emergency Dept for any of the following \*\*\*

\* Increased difficulty breathing \* Shortness of Breath \* Chest Pain \*

\* Increased swelling in the feet, ankles or abdomen \* Fever \* Cough \*

\* Frequent dizziness (not just when first standing up)\*Worsening Symptoms\*

\*\*\* Bleeding that will not stop \*\*\*\*\* Waking up with shortness of breath \*\*\*

\*\*\* Contact your Primary Care Physician for additional instructions \*\*\*  
related to medications that you were not taking before this admission.

RUN DATE: 05/23/12  
RUN TIME: 1827  
RUN USER: 0

Coastal Carolina Med. Ctr. NUR \*LIVE\*  
PATIENT INTERVENTION ACTIVITY

PAGE 2

Patient: BARON, FRANCES  
Account #: [REDACTED]  
Admit Date: 05/21/12  
Status: ADM INO  
Attending: Condie, Scott

Age/Sex: 70 F  
Unit #: [REDACTED]  
Location: MS  
Room/Bed: 124-1

Additional Instructions: SAVANNAH CARDIOLOGY, WED,  
5/30/12 AT 9:15 AM.

NO CAFFIENE FOR 24 HRS PRIOR  
TO STRESS TEST.

NOTHING TO EAT OR DRINK 4  
HOURS PRIOR TO STRESS TEST.

DR MARK JENKINS OFFICE WILL  
CALL YOU WITH AN APPOINTMENT  
TO EVALUATE YOUR SYNCOPAL  
EPISODE.

NO DRIVING UNTIL CLEARED BY DR  
JENKINS.

PATIENT'S COPY OF THE  
MEDICATION RECONCILIATION GIVEN: Y.

Mode of Discharge: Wheelchair

Accompanied By: Spouse

Pneumonia Vaccine Status: Up to date when Admitted

Influenza Vaccine Status: N/A Due to Season

I acknowledge receipt of the instructions above and understand my  
discharge plan of care. I understand if my symptoms should return or  
worsen, I should see my physician or go to the Emergency Department.

All personal items on the valuables list have been returned to me.

Nurse Signature: LNURMXB BASS, MARYLYNN

Date: 05/23/12 Time: 1827

Pt./Guardian Signature: *X Frances Baron*

Date: 05/23/12 Time: 1827

| Date                              | Time | By  | Monogram | Initials       | Name | Nurse Type |
|-----------------------------------|------|-----|----------|----------------|------|------------|
| Occurred: 05/23/12                | 1822 | MXB | LNURMXB  | BASS, MARYLYNN |      | RN         |
| Recorded: 05/23/12                | 1827 | MXB | LNURMXB  | BASS, MARYLYNN |      | RN         |
| Recorded at terminal: CCARMSG03.1 |      |     |          |                |      |            |

Physician Documentation  
Coastal Carolina Hospital  
Name: Frances Baron  
Age: 70 years  
Sex: Female  
DOB: [REDACTED]  
RN: [REDACTED]  
Arrival Date: 05/21/2012  
Time: 16:05  
Account#: [REDACTED]  
Bed 5a  
Private MD:

HPI:

05/21 This 70 years old Caucasian Female presents to ER via Ambulance with jf2  
16:24 complaints of MVC.  
16:24 The patient was a driver of a car. The patient was restrained The jf2  
vehicle was impacted on front end, and was traveling at moderate  
speed, The vehicle did not rollover, the patient was not ejected  
from the vehicle, extrication of the patient from vehicle was not  
required, the patient was ambulatory at the scene, the force of  
impact was moderate.  
16:25 Associated signs and symptoms: Pertinent negatives: confusion, jf2  
numbness, weakness, Loss of consciousness: the patient experienced  
loss of consciousness. Severity of symptoms: At their worst the  
symptoms were moderate, in the emergency department the symptoms are  
unchanged. PATIENT STATES THAT SHE WAS DRIVING AND LOST  
CONSCIOUSNESS. SHE RAN OFF THE ROAD AND HIT A TREE. THE PATIENT HAS  
MULTIPLE SUPERFICIAL LACS AND BRUISING. SHE STATES THAT SHE IS  
DIABETIC BUT DID NOT FEEL LIKE THE CRASH WAS DUE TO HER BLOOD SUGAR.

Historical:

Allergies: mango flavor (bulk);  
- Home Meds:  
1. Lisinopril Oral 5 mg daily  
2. multivitamin Oral 1 capsule daily  
3. Glucophage Oral 1000 mg twice a day for Diabetes  
4. Calcium-Vitamin D Oral Unknown daily  
5. Motrin Oral 800 mg as needed  
6. Xalatan Opht 1-2 drops both daily  
7. Synthroid Oral 125 mcg daily  
- PMHx: diabetes; Right Thyroid Nodule; Glaucoma;  
- PSHx: Appendectomy; Cholecystectomy; Partial Thyroidectomy;  
- Immunization history:: Last tetanus immunization: up to date.  
Pneumococcal vaccine given in the past. Influenza vaccine up to date  
this flu season per patient/family.  
- Social history:: The patient lives with family, Tobacco info:  
Denies tobacco use and denies tobacco use in home.  
- The history from nurses notes was reviewed: and I agree with what  
is documented.

ROS:

16:25 Eyes: Negative for injury, pain, redness, and discharge. jf2

Name: Frances Baron

MRN: [REDACTED]

Account#: [REDACTED]

Page 1 of 7

PRINTED BY: TARABLOOM  
DATE: 08/17/2012

Physician Documentation  
Coastal Carolina Hospital  
Name: Frances Baron  
Age: 70 years  
Sex: Female  
DOB: 1/1/1942  
RN: 00000000  
Arrival Date: 05/21/2012  
Time: 16:05  
Account#: 00000000  
Bed 5a  
Private MD:

Cardiovascular: Negative for chest pain, palpitations, and edema,  
Respiratory: Negative for shortness of breath. ENT: Positive for  
nose bleed. Neck: Negative for pain with movement, pain at rest.  
Back: Negative for injury or acute deformity, acute changes.  
MS/extremity: Negative for acute changes, injury or acute deformity.  
Skin: Positive for abrasion(s), ecchymosis, laceration(s),  
diffusely. Neuro: Positive for loss of consciousness. All other  
systems reviewed and are negative, except as noted.

Exam:

16:25 Neuro: Awake and alert, GCS 15, oriented to person, place, time, and jf2  
situation. Cranial nerves II-XII grossly intact. Motor strength 5/5  
in all extremities. Sensory grossly intact. Cerebellar exam normal.  
Normal gait. Eyes: Pupils equal round and reactive to light,  
extra-ocular motions intact. Lids and lashes normal. Conjunctiva and  
sclera are non-icteric and not injected. Cornea within normal  
limits. Periorbital areas with no swelling, redness, or edema. ENT:  
Nares patent. No nasal discharge, no septal abnormalities noted.  
Tympanic membranes are normal and external auditory canals are  
clear. Oropharynx with no redness, swelling, or masses, exudates, or  
evidence of obstruction, uvula midline. Cardiovascular: Regular rate  
and rhythm with a normal S1 and S2. Respiratory: Lungs have equal  
breath sounds bilaterally, clear to auscultation and percussion. No  
rales, rhonchi or wheezes noted. No increased work of breathing, no  
retractions or nasal flaring. Constitutional: The patient appears  
alert, awake, non-toxic. Neck: External neck: is normal, no acute  
changes, C-spine: C-collar placed PTA, Back board PTA. Chest/axilla:  
Inspection: ecchymosis, that is mild, of the right lateral anterior  
chest Palpation: tenderness, that is mild. Back: pain, is absent,  
ROM is normal. Musculoskeletal/extremity: Extremities: all appear  
grossly normal, with no appreciated pain with palpation, ROM: no  
acute changes, Sensation intact. Skin: Appearance: normal except for  
affected area, injury.

Vital Signs:

16:05 BP 200 / 113; Pulse 122; Resp 20; Temp 97.8; Pulse Ox 97% on R/A; cb  
Weight 157 lbs / 71.21 kg; Height 5 ft. 5 in. (165.10 cm); Pain 6/10;  
16:21 Pulse 112; cb  
17:16 BP 160 / 102; Pulse 105; Resp 20; Pulse Ox 99% on 2 lpm NC; Pain 7/10; cb  
18:45 BP 185 / 92; Pulse 95; Resp 16; Pulse Ox 96% ; jll  
19:19 BP 183 / 89; Pulse 90; Resp 20; Pulse Ox 99% on 2 lpm NC; Pain 4/10; cb

Name: Frances Baron

MRN: 00000000

Account#: 00000000

Page 2 of 7

PRINTED BY: TARABLOOM  
DATE: 08/17/2012



Physician Documentation  
Coastal Carolina Hospital  
Name: Frances Baron  
Age: 70 years  
Sex: Female  
DOB: [REDACTED]  
N: 0 [REDACTED]  
Arrival Date: 05/21/2012  
Time: 16:05  
Account#: [REDACTED]  
Bed 5a  
Private MD:

MDM:

16:13 Patient medically screened. jf2  
17:20 ECG:. jf2  
17:22 ECG:. ECG:. jf2  
17:36 Data reviewed: vital signs, nurses notes, lab test result(s), EKG, radiologic studies. jf2  
18:11 Attestation: The patient's history, exam findings, diagnostics, and a summary of any interventions or procedures was reviewed in detail with Jennifer Fralix PA-C All diagnostic studies were reviewed and discussed. I confirm diagnosis as documented by the NP/PA. My conclusion is that the patient requires in-patient care. We will notify an admitting physician. pz  
  
16:24 Order name: CBC AUTO DIFF; Complete Time: 18:17 jf2  
16:24 Interpretation: Normal: WBC 7.8; RBC 4.22; HGBT 13.1; HCTT 37.6; PLT 302.  
16:24 Order name: CK; Complete Time: 18:38 jf2  
~~16:24 Order name: CK-MB; Complete Time: 18:38 jf2~~  
16:24 Order name: CMP; Complete Time: 18:38 jf2  
16:24 Order name: PT; Complete Time: 18:38 jf2  
16:24 Order name: PTT; Complete Time: 18:38 jf2  
16:24 Order name: TROPONIN; Complete Time: 18:38 jf2  
18:38 Order name: MAGNESIUM; Complete Time: 22:41 jf2  
18:39 Order name: TSH jf2  
18:39 Order name: T4 jf2  
19:24 Order name: MRSA Culture cb  
16:24 Order name: CT BRAIN W/O CONTRAST; Complete Time: 18:02 jf2  
16:24 Interpretation: NO ACUTE INTRACRANIAL ABNORMALITIES; INT BY RADS.  
16:24 Order name: Portable CXR jf2  
16:25 Order name: CT CHEST WITHOUT CONTRAST; Complete Time: 18:02 jf2  
16:25 Interpretation: NO ACUTE CHEST FINDINGS; INT BY RADS.  
16:25 Order name: CT C-SPINE WO/CONTRAST; Complete Time: 18:02 jf2  
16:25 Interpretation: no acute cervical abnormalitites noted; int by RADS.  
16:25 Order name: CT MAXILLOFACIAL WO CONTRAST; Complete Time: 18:02 jf2  
16:25 Interpretation: soft tissue injury noted; NO ACUTE ABNORMALITY; INT BY RADS.  
16:24 Order name: EKG.; Complete Time: 16:55 jf2  
16:24 Order name: IV Saline Lock x 2; Complete Time: 17:16 jf2  
16:24 Order name: NPO; Complete Time: 16:39 jf2  
16:24 Order name: O2 @ 2L/min via NC; Complete Time: 16:39 jf2  
16:24 Order name: Place patient on monitors; Complete Time: 16:39 jf2

Name: Frances Baron  
MRN: [REDACTED]  
Account#: [REDACTED]  
Page 3 of 7

Physician Documentation  
Coastal Carolina Hospital  
Name: Frances Baron  
Age: 70 years  
Sex: Female  
DOB: [REDACTED]  
RN: [REDACTED]  
Arrival Date: 05/21/2012  
Time: 16:05  
Account#: [REDACTED]  
Bed 5a  
Private MD:

16:24 Order name: Undress to gown; Complete Time: 16:39 jf2  
16:24 Order name: EKG; Complete Time: 17:16 jf2  
16:24 Order name: Bedside Glucose; Complete Time: 17:56 jf2

ECG:  
17:22 Rate is 106 beats/min. Rhythm is irregular, Sinus tachycardia. QRS jf2  
Axis is Normal. PR interval is normal. ST Segment is elevated in  
lead II, 2-5mm.

Dispensed Medications:  
19:18 Drug: DERMABOND 1 application; Route: Topical; Duration: 20 mins; cb.  
Site: right eye;  
19:19 Follow up: Response: No adverse reaction cb

Disposition:  
05/21/12 17:36 Admit ordered for Condie, Scott. Preliminary diagnosis are Syncop  
Unknown Cause, Abrasion of Multiple Sites.  
- Bed requested for Med/Surg.  
Condition is Stable.  
Problem is new.  
- Symptoms have improved.

Orders:  
Order: IV Saline Lock x 2; Ordered: 05/21 16:24; By: jf2; For: jf2;  
Completed 05/21 17:16 By: Bible, Charity, RN; Order Method:  
Electronic  
Order: NPO; Ordered: 05/21 16:24; By: jf2; For: jf2; Completed 05/21  
16:39 By: Bible, Charity, RN; Order Method: Electronic  
Order: O2 @ 2L/min via NC; Ordered: 05/21 16:24; By: jf2; For: jf2;  
Completed 05/21 16:39 By: Bible, Charity, RN; Order Method:  
Electronic  
Order: Place patient on monitors; Ordered: 05/21 16:24; By: jf2;  
For: jf2; Completed 05/21 16:39 By: Bible, Charity, RN; Order  
Method: Electronic  
Order: Undress to gown; Ordered: 05/21 16:24; By: jf2; For: jf2;  
Completed 05/21 16:39 By: Bible, Charity, RN; Order Method:  
Electronic  
Order: CBC AUTO DIFF; Ordered: 05/21 16:24; By: jf2; For: jf2;

Name: Frances Baron  
MRN: [REDACTED]  
Account#: [REDACTED]  
Page 4 of 7

Physician Documentation  
Coastal Carolina Hospital  
Name: Frances Baron  
Age: 70 years  
Sex: Female  
DOB: [REDACTED]  
RN: [REDACTED]  
Arrival Date: 05/21/2012  
Time: 16:05  
Account#: [REDACTED]  
Bed 5a  
Private MD:

Reviewed 05/21 18:17 By: Fralix, Jennifer, PA-C; Order Method: Electronic; Interpretation: Normal: WBC 7.8; RBC 4.22; HGB 13.1; HCT 37.6; PLT 302.; Isolation: (OEISO1): ; MN Check (UCR.CHECK): ; Collected by Nurse/RT? (OECBN): No; Collected by: (INIT) (OECOLBY): ; Comment: (YOECM):

Order: CK; Ordered: 05/21 16:24; By: jf2; For: jf2; Reviewed 05/21 18:38 By: Fralix, Jennifer, PA-C; Order Method: Electronic; Isolation: (OEISO1): ; MN Check (UCR.CHECK): ; Collected by Nurse/RT? (OECBN): No; Collected by: (INIT) (OECOLBY): ; Comment: (YOECM):

Order: CK-MB; Ordered: 05/21 16:24; By: jf2; For: jf2; Reviewed 05/21 18:38 By: Fralix, Jennifer, PA-C; Order Method: Electronic; Isolation: (OEISO1): ; MN Check (UCR.CHECK): ; Collected by Nurse/RT? (OECBN): No; Collected by: (INIT) (OECOLBY): ; Comment: (YOECM):

Order: CMP; Ordered: 05/21 16:24; By: jf2; For: jf2; Reviewed 05/21 18:38 By: Fralix, Jennifer, PA-C; Order Method: Electronic; Isolation: (OEISO1): ; MN Check (UCR.CHECK): ; Collected by Nurse/RT? (OECBN): No; Collected by: (INIT) (OECOLBY): ; Comment: (YOECM):

Order: PT; Ordered: 05/21 16:24; By: jf2; For: jf2; Reviewed 05/21 18:38 By: Fralix, Jennifer, PA-C; Order Method: Electronic; IF PREVIOUS ANSWER WAS NO, WAS PATIENT RECENTLY ON ANTICOAGULANTS? (LABCOAGP): ; IS PATIENT ON ANTICOAGULANT THERAPY? (LABCOAG): No; IS PATIENT PRE-OP? (LABQPO): NO; Isolation: (OEISO1): ; MN Check (UCR.CHECK): ; Collected by Nurse/RT? (OECBN): No; Collected by: (INIT) (OECOLBY): ; Comment: (YOECM):

Order: PTT; Ordered: 05/21 16:24; By: jf2; For: jf2; Reviewed 05/21 18:38 By: Fralix, Jennifer, PA-C; Order Method: Electronic; IF PREVIOUS ANSWER WAS NO, WAS PATIENT RECENTLY ON ANTICOAGULANTS? (LABCOAGP): ; IS PATIENT ON ANTICOAGULANT THERAPY? (LABCOAG): No; IS PATIENT PRE-OP? (LABQPO): NO; Isolation: (OEISO1): ; MN Check (UCR.CHECK): ; Collected by Nurse/RT? (OECBN): No; Collected by: (INIT) (OECOLBY): ; Comment: (YOECM):

Order: TROPONIN; Ordered: 05/21 16:24; By: jf2; For: jf2; Reviewed 05/21 18:38 By: Fralix, Jennifer, PA-C; Order Method: Electronic; Isolation: (OEISO1): ; MN Check (UCR.CHECK): ; Collected by Nurse/RT? (OECBN): No; Collected by: (INIT) (OECOLBY): ; Comment: (YOECM):

Order: CT BRAIN W/O CONTRAST; Ordered: 05/21 16:24; By: jf2; For: jf2; Reviewed 05/21 18:02 By: Fralix, Jennifer, PA-C; Notes: Bed Name: 5a; Order Method: Electronic; Interpretation: NO ACUTE

Name: Frances Baron  
MRN: [REDACTED]  
Account#: [REDACTED]  
Page 5 of 7

Physician Documentation  
Coastal Carolina Hospital  
Name: Frances Baron  
Age: 70 years  
Sex: Female  
DOB: [REDACTED]  
MRN: [REDACTED]  
Arrival Date: 05/21/2012  
Time: 16:05  
Account#: [REDACTED]  
Bed 5a  
Private MD:

INTRACRANIAL ABNORMALITIES; INT BY RADS.; HOW IS THE PATIENT TRANSPORTED? (ABOETRANS): PORTABLE; IS PATIENT A FALL RISK? (RAD FALL): Yes; IS THE PATIENT PREGNANT? (ABOEPREG): No; REASON FOR EXAM? (RAD REASON): Pain  
Order: Portable CXR; Ordered: 05/21 16:24; By: jf2; For: jf2; In Process Unspecified 05/21 17:03 By: Dispatcher MedHost; Notes: Bed Name: 5a; Order Method: Electronic; HOW IS THE PATIENT TRANSPORTED? (ABOETRANS): PORTABLE; IS PATIENT A FALL RISK? (RAD FALL): Yes; IS THE PATIENT PREGNANT? (ABOEPREG): No; REASON FOR EXAM? (RAD REASON): Pain  
Order: EKG.; Ordered: 05/21 16:24; By: jf2; For: jf2; Completed 05/21 16:55 By: Sticht, Lorenz; Order Method: Electronic  
Order: EKG; Ordered: 05/21 16:24; By: jf2; For: jf2; Completed 05/21 17:16 By: Bible, Charity; RN; Order Method: Electronic  
Order: Bedside Glucose; Ordered: 05/21 16:24; By: jf2; For: jf2; Completed 05/21 17:56 By: Bible, Charity, RN; Order Method: Electronic  
Order: CT CHEST WITHOUT CONTRAST; Ordered: 05/21 16:25; By: jf2; For: jf2; Reviewed 05/21 18:02 By: Fralix, Jennifer, PA-C; Notes: Bed Name: 5a; Order Method: Electronic; Interpretation: NO ACUTE CHEST FINDINGS; INT BY RADS.; HOW IS THE PATIENT TRANSPORTED? (ABOETRANS): STRETCHER; IS PATIENT A FALL RISK? (RAD FALL): Yes; IS THE PATIENT PREGNANT? (ABOEPREG): No; REASON FOR EXAM? (RAD REASON): Pain  
Order: CT C-SPINE WO/CONTRAST; Ordered: 05/21 16:25; By: jf2; For: jf2; Reviewed 05/21 18:02 By: Fralix, Jennifer, PA-C; Notes: Bed Name: 5a; Order Method: Electronic; Interpretation: no acute cervical abnormalities noted; int by RADS.; HOW IS THE PATIENT TRANSPORTED? (ABOETRANS): STRETCHER; IS PATIENT A FALL RISK? (RAD FALL): Yes; IS THE PATIENT PREGNANT? (ABOEPREG): No; REASON FOR EXAM? (RAD REASON): Pain  
Order: CT MAXILLOFACIAL WO CONTRAST; Ordered: 05/21 16:25; By: jf2; For: jf2; Reviewed 05/21 18:02 By: Fralix, Jennifer, PA-C; Notes: Bed Name: 5a; Order Method: Electronic; Interpretation: soft tissue injury noted; NO ACUTE ABNORMALITY; INT BY RADS.; HOW IS THE PATIENT TRANSPORTED? (ABOETRANS): STRETCHER; IS PATIENT A FALL RISK? (RAD FALL): Yes; IS THE PATIENT PREGNANT? (ABOEPREG): No; REASON FOR EXAM? (RAD REASON): Pain  
Order: DERMABOND 1 application Topical once; Ordered: 05/21 17:25; By: jf2; For: jf2; Administered: 05/21 19:18 By: cb; Frequency: once; Order Method: Electronic Administration: DERMABOND 1 application Topical in right eye over 20 mins Follow Up: Response:

Name: Frances Baron  
MRN: [REDACTED]  
Account#: [REDACTED]  
Page 6 of 7

Physician Documentation  
Coastal Carolina Hospital  
Name: Frances Baron  
Age: 70 years  
Sex: Female  
DOB: [REDACTED]  
RN: [REDACTED]  
Arrival Date: 05/21/2012  
Time: 16:05  
Account#: [REDACTED]  
Bed 5a  
Private MD:

No adverse reaction

Order: MAGNESIUM; Ordered: 05/21 18:38; By: jf2; For: jf2; Reviewed  
05/21 22:41 By: Fralix, Jennifer, PA-C; Order Method: Electronic;  
Isolation: (OEISO1): ; MN Check (UCR.CHECK): ; Collected by  
Nurse/RT? (OECBN): No; Collected by: (INIT) (OECOLBY): ; Comment:  
(YOECM):

Order: TSH; Ordered: 05/21 18:39; By: jf2; For: jf2; In Process  
Unspecified 05/21 18:40 By: Dispatcher MedHost; Order Method:  
Electronic; Isolation: (OEISO1): ; MN Check (UCR.CHECK): ; Collected  
by Nurse/RT? (OECBN): No; Collected by: (INIT) (OECOLBY): ; Comment:  
(YOECM):

Order: T4; Ordered: 05/21 18:39; By: jf2; For: jf2; In Process  
Unspecified 05/21 18:40 By: Dispatcher MedHost; Order Method:  
Electronic; Isolation: (OEISO1): ; MN Check (UCR.CHECK): ; Collected  
by Nurse/RT? (OECBN): No; Collected by: (INIT) (OECOLBY): ; Comment:  
(YOECM):

Order: MRSA Culture; Ordered: 05/21 19:24; By: cb; For: jf2; In  
Process Unspecified 05/21 19:26 By: Dispatcher MedHost; Order  
Method: Verbal - Read back; Sign Off: Fralix, Jennifer, PA-C - 05/21  
22:44; Isolation: (OEISO1): ; MN Check (UCR.CHECK): ; Collected by  
Nurse/RT? (OECBN): No; Collected by: (INIT) (OECOLBY): ; Comment:  
(YOECM): ; SOURCE: (MICGRMRSa): NASOPHARYNGEAL

Order Signatures:

Fralix, Jennifer, PA-C, PA-C, jf2;  
Bible, Charity, RN, RN, cb;

Signatures:

|                        |          |
|------------------------|----------|
| Dispatcher MedHost     | EDMS     |
| Sticht, Lorenz         | ls       |
| Zorch, Paul, MD        | MD pz    |
| Fralix, Jennifer, PA-C | PA-C jf2 |
| Bible, Charity, RN     | RN cb    |

Corrections: (The following items were deleted from the chart)

|                                                                           |     |
|---------------------------------------------------------------------------|-----|
| 17:23 17:20 Rate is 106 beats/min. Rhythm is regular. QRS Axis is Normal. | jf2 |
| PR interval is normal. QRS interval is normal. QT interval is             |     |
| normal. Q waves are Absent. Interpreted by me. Reviewed by me.            | jf2 |
| 17:35 16:05 Home Meds: Glucophage Oral Unknown daily for Diabetes; cb     | jf2 |
| 17:35 16:05 Home Meds: Lisinopril Oral Unknown; cb                        | jf2 |
| 17:54 17:34 Home Meds: Glucophage Oral 1000 mg daily for Diabetes; jf2    | cb  |

Name: Frances Baron  
MRN: [REDACTED]  
Account#: [REDACTED]  
age 7 of 7

PRINTED BY: TARABLOOM  
DATE: 08/17/2012

PHYSICIAN / SPECIALITY TO BE CONSULTED:

Neurology

URGENCY: ☐ STAT ☐ Same Day ☒ Routine  
(STAT requires Physician to Physician Communication)CONSULTANT TO CALL ATTENDING PHYSICIAN AFTER CONSULT: ☐ Yes ☐ No

REASON FOR CONSULTATION (BY ATTENDING PHYSICIAN):

Syncope with MVA

DATE / TIME NOTIFICATION CONFIRMED:

BY:

WITH:

DATE / TIME OF CONSULTATION:

(2000) 5/22/2012

FINDINGS (BY CONSULTANT):

70yo WFE w/10 diabetes (Type II), thyroid nodule, claustrum into presented to emergency as syncope spell while driving. Pt was driver of car (seat belts / plus hit tree. Car stopped deployed along with car & pulled to minutes. Pt experienced multiple focal clonic convulsions but no reported fractures (RT head & C-spine 3 fr). No reported seizures (phenytoin, CO2 etc). ROS - 10+ ROS in dent removed. PMHx - Abuse + Appendicitis, claustrum, STx - 8 smoky, GERD abuse, Mucous, RA. @ the collection 2 nodules, no PT. STx - (PT) Mucous, MUI, claustrum, VtD, Mucous, claustrum; syncope, ALL-NHSA. = VS: BP (11/68) HR (85) TC (98) RR (17) O2 - 97% Fat - Padum. - moderate to severe aortic stenosis. CN - sym intact / pupil, RWT + eye sym. / RT full. Exam complete, facial asymmetry, no clonus / sym. / RT full. ASSESSMENT: Motor sym B/T (17/95) Denerv - sym LTP + RT parietal. Cor. / RT full. DVT - sym 3 long tract signs. Red - signs but. C. / RT full. / RT full.

1) Syncope - suggest cardiogenic possible - 210 PR's + clonus but cardiac aut. / RT full.  
2) Post-concussive SK's - elevated & Cor. / RT full.  
3) 210 - DM; cardiac arrhythmia; some hyperlipidemia

RECOMMENDATIONS: 1) T Hb 300, Weiss VSO 40, fall + begin precaution.

2) Thiamine 100mg IV daily  
3) Daily ASA - p. burning stabilizer (8mg/day) - RT full.  
4) Oph. / RT full. ASA (1000 mg) / RT full.  
5) Cardiac consultation - more detailed w/ RT full for cardiogenic potential source.  
6) MUI - B. / RT full. U. / RT full.

DICTATION #:

D. / RT full. / RT full.

Signature of Consulting Physician

Date 5-22-2012 (210)

Consultation Record

BARON, FRANCES

ADM Ino 124-1

05/21/12 Condie, Scott

DOB: 70

F MR#

Coastal Carolina

PRINTED BY: TARABLOOM

DATE: 08/17/2012

Coastal Carolina Hospital

\*CCH1PN\*

CCH1PN CCD0377 03/12

ATTENDING PHYSICIAN

UNIT / ROOM NO.

DATE / TIME

NOTES MUST BE SIGNED, DATED, AND TIMED BY PHYSICIAN

Cardiology

Consult note dictated

Mr. (i) Syncope -

PROGRESS NOTES

BARON, FRANCES

ADM INo 124-1  
05/21/12 Condie. Scott  
DOB 70 F MR#  
Coastal Carolina

ient Label



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Coastal Carolina Hospital

\*CCH1PN\*

CCH1PN CCD0377 03/12

ATTENDING PHYSICIAN

UNIT / ROOM NO.

DATE / TIME

NOTES MUST BE SIGNED, DATED, AND TIMED BY PHYSICIAN

5/22/2012  
2140

*Neuro*  
See completed consult sheet -  
\* Care reviewed & brother (ER physician) as requested  
who agrees & will & plans in progress.  
\* Add ASA as pt & I concerned  
for cement bandages? *performed*  
Rec - ASA 8mg/day After bandages  
\* swelling improved -  
\* Auditory evaluation for repeat audiologic region.

*W. A. [Signature]*

PROGRESS NOTES

BARON, FRANCES

REG ER

05/21/12 ZORCH, PAUL MD

DOB: 1 [redacted] 70 F MR# [redacted]

Coastal Carolina

124

nt Label

PRINTED BY: TARABLOOM

DATE: 08/17/2012



Coastal Carolina Medical Center  
1000 Medical Center Drive  
Hardeeville, SC 29927

Phone #: 843-784-8042  
Fax #: 843-784-8094

Name: BARON, FRANCES  
Attending Dr: ZORCH, PAUL MD  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: L.ED  
Exam Date: 05/21/2012 Status: REG ER  
Radiology No:  
Unit No: [REDACTED]

Exams: 000148868 CT HEAD/BRAIN WO CONTRAST

History: 7-year-old female trauma, MVA .

CT brain scan.

TECHNIQUE: This study was performed without IV contrast administration. 5 mm scans were obtained through the posterior fossa and cerebral hemispheres.

DOSE: Total exam DLP: 1072.1

FINDINGS: No subdural, epidural or acute intraparenchymal hemorrhage is noted. No large subarachnoid hemorrhage is seen. No mass effect, midline shift or acute cerebral edema is noted. No posterior fossa mass is noted. There is mild generalized cerebral atrophy with ~~periventricular white matter disease noted. No acute cerebral edema is~~ seen. There is prominent right frontal scalp hemorrhage noted. Soft tissue injury is noted. No frontal bone fracture is noted.

**IMPRESSION:**

1. Mild generalized cerebral atrophy with mild periventricular white matter disease.
2. No acute intracranial abnormality observed.
3. Right frontal scalp hematoma with no frontal bone fracture.

Thank you for this referral.

\*\* Electronically Signed by MOESCH DEAN on 05/21/2012 at 1736 \*\*  
Reported and Signed by: MOESCH DEAN

CC: Tricia Etheridge; JENNIFER PA FRALIX; PAUL MD ZORCH

Dictated Date/Time: 05/21/2012 (1736)  
Technologist: LAO DAN  
Transcribed Date/Time: 05/21/2012 (1736)  
Transcriptionist: RAD.VR  
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Orig Print D/T:--S: 05/21/2012 (1733) Batch No: N/A

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1000 Medical Center Drive  
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Phone #: 843-784-8042  
Fax #: 843-784-8094

Name: BARON, FRANCES  
Attending Dr: ZORCH, PAUL MD  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: L.ED  
Exam Date: 05/21/2012 Status: REG ER  
Radiology No:  
Unit No: [REDACTED]

Exams: 000148871 CT C-SPINE WO/CONTRAST

History: 70-year-old female neck pain, MVA

CT scan of the cervical spine with sagittal and coronal reformatted imaging.

TECHNIQUE: This study was performed utilizing axial 2.5 mm imaging with bone and soft tissue algorithms. Sagittal and coronal reformatted imaging was performed.

DOSE: Total exam DLP: 1119.6

FINDINGS: The cervical vertebral bodies demonstrate no acute compression fracture or subluxation. No prevertebral soft tissue swelling is noted. The odontoid process appears to be intact. The C1-C2 relationship is normal. There is no bony encroachment on the cervical spinal canal. There is degenerative disc space narrowing noted at C3-C4. The pedicles and posterior elements appear intact. No acute facet joint abnormality is noted.

**IMPRESSION:**

1. No acute cervical spine fracture or subluxation noted.
2. No bony encroachment on the cervical spinal canal observed.

Thank you for this referral.

**\*\* Electronically Signed by MOESCH DEAN on 05/21/2012 at 1739 \*\***  
Reported and Signed by: MOESCH DEAN

CC: Tricia Etheridge; JENNIFER PA FRALIX; PAUL MD ZORCH

Dictated Date/Time: 05/21/2012 (1739)  
Technologist: LAO DAN  
Transcribed Date/Time: 05/21/2012 (1739)  
Transcriptionist: RAD.VR  
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1000 Medical Center Drive  
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Phone #: 843-784-8042  
Fax #: 843-784-8094

Name: BARON, FRANCES  
Attending Dr: ZORCH, PAUL MD  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: L.ED  
Exam Date: 05/21/2012 Status: REG ER  
Radiology No:  
Unit No: [REDACTED]

Exams: 000148872 CT MAXILLOFACIAL W/O CONTRAST

History: 70-year-old female trauma, MVA. Facial pain.

CT scan of the facial bones.

Technique: This study was performed utilizing axial 2.5 mm imaging through the facial bone region. Sagittal and coronal reformatted imaging was obtained.

Dose: Total exam DLP 967.8

Findings: The frontal bone region demonstrates prominent right frontal scalp hematoma with laceration. The frontal bone and frontal sinus appear intact. The zygomatic arches appear intact. Unfortunately, there is significant motion artifact in the nasal bone region. I see ~~no definite acute nasal bone fracture. The orbital floors and lateral orbital margins appear intact.~~ No maxillary sinus air-fluid level is noted. Small mucous retention cyst are noted. The temporomandibular joints appear intact. No definite maxillary or mandibular fracture is noted.

**Impression:**

1. Right frontal scalp hematoma and laceration with no frontal bone fracture noted.
2. No definite facial bone fracture noted.

**\*\* Electronically Signed by MOESCH DEAN on 05/21/2012 at 1745 \*\***  
Reported and Signed by: MOESCH DEAN

CC: Tricia Etheridge; JENNIFER PA FRALIX; PAUL MD ZORCH

Dictated Date/Time: 05/21/2012 (1745)  
Technologist: LAO DAN  
Transcribed Date/Time: 05/21/2012 (1745)  
Transcriptionist: RAD.VR  
Electronic Signature Date/Time: 05/21/2012 (1745)  
Orig Print D/T: S: 05/21/2012 (1742) Batch No: N/A

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Coastal Carolina Medical Center  
1000 Medical Center Drive  
Hardeeville, SC 29927

Phone #: 843-784-8042  
Fax #: 843-784-8094

Name: BARON, FRANCES  
Attending Dr: ZORCH, PAUL MD  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: L.ED  
Exam Date: 05/21/2012 Status: REG ER  
Radiology No:  
Unit No: [REDACTED]

Exams: 000148870 CT CHEST NON CONTRAST (HIRES)

History: 70-year-old female trauma, MVA.

CT scan of the chest.

Technique: This study was performed without IV contrast administration. Axial 5 mm imaging was obtained through the chest and upper abdomen. Coronal reformatted imaging was obtained.

Dose: Total exam DLP 467.9.

Findings: The trachea is midline. The trachea and mainstem bronchi demonstrate no intrinsic lesion or extrinsic compression. No superior mediastinal hematoma is noted. There is an 8mm nodule in the left lobe of the thyroid gland. The thoracic aorta demonstrates no aneurysm. ~~There is dense vascular calcium in the LAD coronary artery. No~~ pericardial effusion is noted. A large hiatal hernia is noted with approximately one half of the stomach above the diaphragm. Evaluation of the lungs demonstrates no pulmonary contusion, pleural effusion or pneumothorax. No sternal fracture is noted. No retrosternal hematoma is noted. No displaced rib fracture is noted. The visualized portions of the upper abdomen demonstrate no acute abnormality.

**Impression:**

1. No pulmonary contusion, pleural effusion or pneumothorax is noted.
2. Large hiatal hernia.
3. No evidence for thoracic aortic aneurysm.

Coastal Carolina Medical Center  
1000 Medical Center Drive  
Hardeeville, SC 29927

Phone #: 843-784-8042  
Fax #: 843-784-8094

Name: BARON, FRANCES  
Attending Dr: ZORCH, PAUL MD  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: L.ED  
Exam Date: 05/21/2012 Status: REG ER  
Radiology No:  
Unit No: [REDACTED]

Exams: 000148870 CT CHEST NON CONTRAST (HIRES)  
<Continued>

4. No sternal fracture or retrosternal hematoma noted.
5. 8mm nodule left lobe of the thyroid gland

\*\* Electronically Signed by MOESCH DEAN on 05/21/2012 at 1758 \*\*  
Reported and Signed by: MOESCH DEAN

CC: Tricia Etheridge; JENNIFER PA FRALIX; PAUL MD ZORCH

Dictated Date/Time: 05/21/2012 (1758)  
Technologist: LAO DAN  
Transcribed Date/Time: 05/21/2012 (1758)  
Transcriptionist: RAD.VR  
Electronic Signature Date/Time: 05/21/2012 (1758)  
Orig Print D/T: S: 05/21/2012 (1755) Batch No: N/A

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Coastal Carolina Medical Center  
1000 Medical Center Drive  
Hardeeville, SC 29927

Phone #: 843-784-8042  
Fax #: 843-784-8094

Name: BARON, FRANCES  
Attending Dr: Condie, Scott  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: 124 1  
Exam Date: 05/21/2012 Status: ADM INO  
Radiology No: [REDACTED]  
Unit No: [REDACTED]

Exams: 000148869 CHEST ONE VIEW

History: 70-year-old female, trauma, MVA.

Portable one view chest, 5/21/2012, 5:01 p.m. This image was obtained through a backboard. The trachea is midline. Cardiac size is normal. No hilar or mediastinal lesion is noted. No pulmonary contusion, pleural effusion or pneumothorax is noted.

**Impression:**

1. No acute cardiopulmonary disease observed.

\*\* Electronically Signed by MOESCH DEAN on 05/22/2012 at 1709 \*\*  
Reported and Signed by: MOESCH DEAN

CC: Tricia Etheridge; JENNIFER PA FRALIX; PAUL MD ZORCH

Dictated Date/Time: 05/22/2012 (1709)  
Technologist: JANE OUIMETTE  
Transcribed Date/Time: 05/22/2012 (1709)  
Transcriptionist: RAD.VR  
Electronic Signature Date/Time: 05/22/2012 (1709)  
Orig Print D/T: S: 05/22/2012 (1706) Batch No: N/A

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MEDICAL RECORDS COPY

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DATE: 08/17/2012

Coastal Carolina Medical Center  
1000 Medical Center Drive  
Hardeeville, SC 29927

Phone #: 843-784-8042  
Fax #: 843-784-8094

Name: BARON, FRANCES  
Attending Dr: Condie, Scott  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: 124 1  
Exam Date: 05/22/2012 Status: ADM INO  
Radiology No:  
Unit No: [REDACTED]

Exams: 000148908 CAROTID BILATERAL/COMPLTE

History: 70-year-old female, syncopal episode. Trauma secondary to MVA.

Duplex Carotid Sonogram.

TECHNIQUE: This study was performed utilizing extensive real time sonographic imaging. Doppler analysis and color flow imaging were utilized.

FINDINGS: Evaluation of the right carotid system demonstrates mild plaque in the right common carotid artery and carotid bulb. There is moderate plaque in the proximal right ICA. The right ICA is tortuous. Increased velocity within the right ICA is noted to 1.64 m/sec. The right ECA is tortuous with a velocity of 1.8 m/sec. Antegrade flow within the right external carotid artery and right vertebral artery are noted.

Left carotid system demonstrates moderate plaque involving the distal left common carotid artery. There is increased velocity within the distal left ICA to 1.3 m/sec. The left ICA and ECA vessels are tortuous with no significant plaque or stenosis observed. Antegrade flow within the left vertebral artery is noted.

**Impression:**

1. Bilateral tortuous carotid system as outlined above.
2. Mild to moderate diffuse plaque involving the right carotid system with no hemodynamically significant stenosis observed.
3. Patent, antegrade flow within both external carotid arteries and vertebral arteries.
4. Moderate plaque in the distal left common carotid artery with estimated 30% left common carotid stenosis. No high-grade left carotid system stenosis observed.

**CRITERIA FOR ESTIMATING INTERNAL CAROTID STENOSIS:**

ICA-PSV:

Normal - 125 cm/sec

Coastal Carolina Medical Center  
1000 Medical Center Drive  
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Phone #: 843-784-8042  
Fax #: 843-784-8094

Name: BARON, FRANCES  
Attending Dr: Condie, Scott  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: 124 1  
Exam Date: 05/22/2012 Status: ADM INO  
Radiology No:  
Unit No: [REDACTED]

Exams: 000148908 CAROTID BILATERAL/COMPLTE  
<Continued>

50% - 125 cm/sec  
50 to 69% - 125 to 230 cm/sec  
>70% - 230 cm/sec ,  
Near occlusion - Variable  
Total occlusion - No Flow

ICA/CCA PSV Ratio:  
Normal - 2.0  
50% - 2.0  
50 to 69% - 2.0 to 4.0  
>70% - 4.0  
Near occlusion - Variable  
Total occlusion - No Flow

---

ICA - EDV:  
Normal - 40 cm/sec  
50% - 40 cm/sec  
50 to 69% - 40 to 100 cm/sec  
>70% - 100 cm/sec  
Near occlusion - Variable  
Total occlusion - No Flow

Grant EG, Benson CD, Monet GL, et al: Society of Radiologists in  
Ultrasound Consensus Conference on Ultrasound and Doppler Diagnosis of  
Carotid Stenosis, Radiology, Nov 2003.



Coastal Carolina Medical Center  
1000 Medical Center Drive  
Hardeeville, SC 29927

Phone #: 843-784-8042  
Fax #: 843-784-8094

Name: BARON, FRANCES  
Attending Dr: Condie, Scott  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: 124 1  
Exam Date: 05/22/2012 Status: ADM INO  
Radiology No:  
Unit No: [REDACTED]

Exams: 000148908 CAROTID BILATERAL/COMPLTE  
<Continued>

*Thank you for this referral.*

\*\* Electronically Signed by MOESCH DEAN on 05/22/2012 at 1725 \*\*  
Reported and Signed by: MOESCH DEAN

CC: Scott Condie; Tricia Etheridge

Dictated Date/Time: 05/22/2012 (1725)  
Technologist: PAYNE, MALLORY  
Transcribed Date/Time: 05/22/2012 (1725)  
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Coastal Carolina Medical Center  
1000 Medical Center Drive  
Hardeeville, SC 29927

Phone #: 843-784-8042  
Fax #: 843-784-8094

Name: BARON, FRANCES  
Attending Dr: Condie, Scott  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: 124 1  
Exam Date: 05/23/2012 Status: ADM INO  
Radiology No:  
Unit No: [REDACTED]

Exams: 000149028 ANKLE LEFT 3 VIEWS

History: 70-year-old female, trauma, MVA pain with weight-bearing.

Left ankle: 3 views of the left ankle are submitted for evaluation. There is a transverse, minimally displaced fracture of the medial malleolus. The tibiotalar articulation appears intact. The talar dome is unremarkable. No lateral malleolar fracture is noted. The base of the fifth metatarsal appears intact.

**Impression:**

1. Transverse, minimally displaced fracture of the medial malleolus.
2. No lateral malleolar fracture noted.

~~Report called to Dr. Condie, 10/23/2012, 10:30 a.m.~~

**\*\* Electronically Signed by MOESCH DEAN on 05/23/2012 at 1035 \*\***  
Reported and Signed by: MOESCH DEAN

CC: Scott Condie

Dictated Date/Time: 05/23/2012 (1035)  
Technologist: LAO DAN  
Transcribed Date/Time: 05/23/2012 (1035)  
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Name: BARON, FRANCES  
Attending Dr: Condie, Scott  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: 124 1  
Exam Date: 05/23/2012 Status: DIS INO  
Radiology No:  
Unit No: [REDACTED]

Exams: 000149061 ANKLE RIGHT 3 VIEWS

History 7-year-old female, trauma, ankle pain .

Right ankle: 3 views of the right ankle are submitted for evaluation. The tibia and talar articulation is intact. No medial and lateral malleolar fracture is noted. The talus, calcaneus and base of the fifth metatarsal appear intact. No ankle joint effusion is seen.

**IMPRESSION:**

1. No acute right ankle abnormality observed.

Thank you for this referral.

\*\* Electronically Signed by MOESCH DEAN on 05/23/2012 at 1446 \*\*

~~Reported and Signed by: MOESCH DEAN~~

CC: Scott Condie

Dictated Date/Time: 05/23/2012 (1446)  
Technologist: LAO DAN  
Transcribed Date/Time: 05/23/2012 (1446)  
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Phone #: 843-784-8042  
Fax #: 843-784-8094

Name: BARON, FRANCES  
Attending Dr: Condie, Scott  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: 124 1  
Exam Date: 05/22/2012 Status: DIS INO  
Radiology No:  
Unit No: [REDACTED]

Exams: 000148906 MRA BRAIN W/O CONTRAST

History: 70-year-old female, syncopal episode, MVA.

Intracranial magnetic resonance angiography.

Technique: This study was performed utilizing 3-D time-of-flight technique. A diagnostic study was obtained.

Findings: The distal right internal carotid artery and terminus appear patent. The right anterior and middle cerebral artery vasculature is unremarkable. There is atheromatous disease in the left carotid siphon region and terminus. The left anterior and middle cerebral artery vasculature is patent.

A dominant right vertebral artery is noted. A small distal left vertebral artery is noted. The basal artery appears intact. There is atheromatous disease involving the proximal left posterior cerebral artery as well as the origin of the right posterior cerebral artery.

**Impression:**

1. Atheromatous disease in the carotid siphon region bilaterally greater on the left side.
2. Patent anterior and middle cerebral artery vasculature.
3. Significant regions of stenosis observed involving the origin of

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Name: BARON, FRANCES  
Attending Dr: Condie, Scott  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: 124 1  
Exam Date: 05/22/2012 Status: DIS INO  
Radiology No:  
Unit No: [REDACTED]

Exams: 000148906 MRA BRAIN W/O CONTRAST  
<Continued>

*the right posterior cerebral artery and P1 segment of the left  
posterior cerebral artery.*

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CC: Scott Condie; Tricia Etheridge

Dictated Date/Time: 05/24/2012 (1526)  
Technologist: MCCANTS PATRICK  
Transcribed Date/Time: 05/24/2012 (1526)  
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Fax #: 843-784-8094

Name: BARON, FRANCES  
Attending Dr: Condie, Scott  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: 124 1  
Exam Date: 05/22/2012 Status: DIS INO  
Radiology No:  
Unit No: [REDACTED]

Exams: 000148905 MRI BRAIN WWO CONTRAST

History: 70-year-old female, syncopal episode while driving.

Magnetic resonance imaging of the with gadolinium enhancement

TECHNIQUE: This study was performed utilizing sagittal T1-weighted imaging followed by axial T1 and T2 imaging of the brain. Axial diffusion and FLAIR imaging was obtained followed by coronal T2 imaging. Axial diffusion imaging was performed. Following IV gadolinium administration, axial and coronal T1-weighted imaging was obtained.

FINDINGS: Diffusion imaging of the brain demonstrates no acute cerebral edema or infarct. No neoplastic edema is noted. No subpleural, epidural or acute intraparenchymal hemorrhage is noted. There is no mass effect, midline shift or focus of acute cerebral edema. No brainstem or cerebellar lesion is noted. The fourth ventricle is midline. The periventricular white matter is normal. The pituitary and parasellar region demonstrates no abnormality. The gadolinium-enhanced images demonstrate no primary or metastatic lesion. No enhancing intracranial lesion is seen.

**Impression:**

1. No acute cerebral edema or infarct noted.
2. No significant cerebral atrophy or periventricular white matter disease.
3. No enhancing intracranial lesion noted. No intracranial neoplasm is observed.

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Attending Dr: Condie, Scott  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: 124 1  
Exam Date: 05/22/2012 Status: DIS INO  
Radiology No:  
Unit No: [REDACTED]

Exams: 000148905 MRI BRAIN WWO CONTRAST  
<Continued>

Thank you for this referral.

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Technologist: MCCANTS PATRICK  
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Name: BARON, FRANCES  
Attending Dr: Condie, Scott  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: 124 1  
Exam Date: 05/21/2012 Status: ADM INo  
Radiology No: [REDACTED]  
Unit No: [REDACTED]

Exams: 000148869 CHEST ONE VIEW

History: 70-year-old female, trauma, MVA.

Portable one view chest, 5/21/2012, 5:01 p.m. This image was obtained through a backboard. The trachea is midline. Cardiac size is normal. No hilar or mediastinal lesion is noted. No pulmonary contusion, pleural effusion or pneumothorax is noted.

**Impression:**

1. No acute cardiopulmonary disease observed.

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Reported and Signed by: MOESCH DEAN

CC: Tricia Etheridge; JENNIFER PA FRALIX; PAUL MD ZORCH

Dictated Date/Time: 05/22/2012 (1709)

Technologist: JANE OUIMETTE

Transcribed Date/Time: 05/22/2012 (1709)

Transcriptionist: RAD.VR

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Name: BARON, FRANCES  
Attending Dr: Condie, Scott  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: 124 1  
Exam Date: 05/22/2012 Status: ADM INO  
Radiology No:  
Unit No: [REDACTED]

Exams: 000148908 CAROTID BILATERAL/COMPLTE

History: 70-year-old female, syncopal episode. Trauma secondary to MVA.

Duplex Carotid Sonogram.

TECHNIQUE: This study was performed utilizing extensive real time sonographic imaging. Doppler analysis and color flow imaging were utilized.

FINDINGS: Evaluation of the right carotid system demonstrates mild plaque in the right common carotid artery and carotid bulb. There is moderate plaque in the proximal right ICA. The right ICA is tortuous. Increased velocity within the right ICA is noted to 1.64 m/sec. The right ECA is tortuous with a velocity of 1.8 m/sec. Antegrade flow within the right external carotid artery and right vertebral artery are noted.

Left carotid system demonstrates moderate plaque involving the distal left common carotid artery. There is increased velocity within the distal left ICA to 1.3 m/sec. The left ICA and ECA vessels are tortuous with no significant plaque or stenosis observed. Antegrade flow within the left vertebral artery is noted.

**Impression:**

1. Bilateral tortuous carotid system as outlined above.
2. Mild to moderate diffuse plaque involving the right carotid system with no hemodynamically significant stenosis observed.
3. Patent, antegrade flow within both external carotid arteries and vertebral arteries.
4. Moderate plaque in the distal left common carotid artery with estimated 30% left common carotid stenosis. No high-grade left carotid system stenosis observed.

**CRITERIA FOR ESTIMATING INTERNAL CAROTID STENOSIS:**

ICA-PSV:

Normal - 125 cm/sec

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Attending Dr: Condie, Scott

DOB: [REDACTED] Age: 70 Sex: F

Acct: [REDACTED] Loc: 124 1

Exam Date: 05/22/2012 Status: ADM INo

Radiology No:

Unit No: [REDACTED]

Exams: 000148908 CAROTID BILATERAL/COMPLTE  
<Continued>

50% - 125 cm/sec

50 to 69% - 125 to 230 cm/sec

>70% - 230 cm/sec ,

Near occlusion - Variable

Total occlusion - No Flow

ICA/CCA PSV Ratio:

Normal - 2.0

50% - 2.0

50 to 69% - 2.0 to 4.0

>70% - 4.0

Near occlusion - Variable

Total occlusion - No Flow

ICA - EDV:

Normal - 40 cm/sec

50% - 40 cm/sec

50 to 69% - 40 to 100 cm/sec

>70% - 100 cm/sec

Near occlusion - Variable

Total occlusion - No Flow

Grant EG, Benson CD, Monet GL, et al: Society of Radiologists in  
Ultrasound Consensus Conference on Ultrasound and Doppler Diagnosis of  
Carotid Stenosis, Radiology, Nov 2003.

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Name: BARON, FRANCES  
Attending Dr: Condie, Scott  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: 124 1  
Exam Date: 05/22/2012 Status: ADM INO  
Radiology No:  
Unit No: [REDACTED]

Exams: 000148908 CAROTID BILATERAL/COMPLTE  
<Continued>

Thank you for this referral.

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CC: Scott Condie; Tricia Etheridge

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Technologist: PAYNE, MALLORY  
Transcribed Date/Time: 05/22/2012 (1725)  
Transcriptionist: RAD.VR  
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Name: BARON, FRANCES  
Attending Dr: Condie, Scott  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: 124 1  
Exam Date: 05/22/2012 Status: DIS INO  
Radiology No:  
Unit No: [REDACTED]

Exams: 000148907 MRA NECK WWO CONTRAST

History: 70-year-old female, syncope.

Extracranial magnetic resonance angiography.

Technique: This study was performed utilizing 2-D time-of-flight technique a a diagnostic study was obtained.

Findings: The right common carotid artery demonstrates mild atheromatous disease with no significant right common carotid stenosis is observed. There is very mild plaque in the proximal right internal and external carotid arteries with no significant stenosis noted. The right vertebral artery is patent and unremarkable. The left common carotid artery is unremarkable throughout its course. The left carotid bulb and proximal left internal and external carotid arteries demonstrate no significant stenosis. The left vertebral artery is unremarkable.

**Impression:**

1. Mild plaque involving the carotid bulb regions bilaterally with no dominant focal plaque or hemodynamically significant stenosis within either carotid system.

2. Patent vertebral arteries bilaterally.

\*\* Electronically Signed by MOESCH DEAN on 06/11/2012 at 2123 \*\*  
Reported and Signed by: MOESCH DEAN

CC: Scott Condie; Tricia Etheridge

Dictated Date/Time: 06/11/2012 (2123)  
Technologist: MCCANTS PATRICK  
Transcribed Date/Time: 06/11/2012 (2123)  
Transcriptionist: RAD.VR  
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Savannah Cardiology  
8 Okatie Center Blvd South  
Suite 101  
Okatie, SC 29909  
843-705-9350  
FAX 843-707-0220

### EXERCISE STRESS ECHOCARDIOGRAM

|                                             |                                   |                              |
|---------------------------------------------|-----------------------------------|------------------------------|
| Name: BARON, FRANCES                        | Study Date: 09/17/2009 01:38 PM   | MRN: [REDACTED]              |
| Age: 67 yrs                                 | Gender: Female                    | Height: 65 in                |
| DOB: [REDACTED]                             |                                   | Weight: 164 lb               |
| Reason For Study: Abnormal EKG              |                                   | BSA: 1.8 meters <sup>2</sup> |
| Ordering Physician: Kenneth R. Hardigan, MD | Performed By: Ashley Merritt, RCS |                              |
| Referring Physician: Dr. Tricia Etheridge   |                                   |                              |
| Medications: Lisinopril, ASA                |                                   |                              |

#### Interpretation Summary

No signs of provokable coronary ischemia by stress echo criteria. Overall probability of significant provokable ischemia Low. Moderate workload achieved. Normal resting wall motion and no stress-induced wall motion abnormality. **PROCEDURE:** Stress echocardiogram 2D (93351).

**COMPLICATIONS:** No stress complications. **IMAGE WINDOW:** Post stress acoustic windows were good. Good acoustic windows at rest.

#### Stress Results

Protocol: Bruce Maximum Predicted HR: 153 bpm  
Target HR: 130 bpm % Maximum Predicted HR: 100 %

| Stage                 | Duration<br>(mm:ss) | Heart Rate<br>(bpm) | BP     | Comment  |
|-----------------------|---------------------|---------------------|--------|----------|
| Rest                  |                     | 77                  | 156/60 |          |
| Stage 1               | 3:00                | 142                 | 198/90 |          |
| Stage 2               | 3:00                | 153                 | 226/90 | mild sob |
| Recovery <sup>R</sup> | 5:00                | 91                  | 138/80 |          |

Stress Duration: 6:00 mm:ss Recovery Time: 5:00 mm:ss  
Maximum Stress HR: 153 bpm METS: 7

#### INTERPRETATION:

**EXERCISE CAPACITY:** Good.

**HR AND BP RESPONSE:** The patient exhibited a hypertensive response with stress.

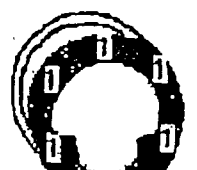
**CHEST PAIN:** No focal chest discomfort. Test terminated secondary to increased blood pressure.

**ST CHANGES:** There was no new ST segment depression.

**ARRHYTHMIAS:** Occasional PVCs.

**ECHOCARDIOGRAM ANALYSIS:** Post stress imaging reveals normal augmentation of left ventricular contractility. No inducible regional wall motion abnormalities noted. Normal LV global systolic function at rest with normal increase in LV global systolic function post exercise.

BARON, FRANCES  
ADM Ino 124-1  
05/21/12 Condie. Scott  
DOB [REDACTED] 70 F MR# [REDACTED]  
Coastal Carolina

|                                        | LAX                                                                               | SAX                                                                               | 4C                                                                                 | 2C                                                                                  |
|----------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| Rest<br>WMSI 1.00<br>% Normal 100      |  |  |  |  |
| Stress<br>WMSI 1.00<br>% Normal 100    |  |  |  |  |
| X - Cannot Interpret<br>5 - Aneurysmal | 1 - Normal                                                                        | 2 - Hypokinetic                                                                   | 3 - Akinetic                                                                       | 4 - Dyakinetic                                                                      |

Reading Physician: Kenneth R. Hardigan, MD 09/17/2009 06:22 PM

BARON, FRANCES  
ADM Ino 124-1  
05/21/12 Condie, Scott  
DOB: 70 F MR#  
Coastal Carolina



Savannah Cardiology  
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Suite 101  
Okatie, SC 29909  
843-705-9350  
FAX 843-707-0220

### ADULT ECHOCARDIOGRAM

|                                         |                                           |                                   |
|-----------------------------------------|-------------------------------------------|-----------------------------------|
| Name: BARON, FRANCES                    | Study Date: 11/06/2009 01:31 PM           | MRN: [REDACTED]                   |
| Age: 68 yrs                             | Gender: Female                            | Height: 65 in                     |
| DOB: [REDACTED]                         |                                           | Weight: 164 lb                    |
| Reason For Study: Dyspnea               |                                           | BSA: 1.8 meters <sup>2</sup>      |
| Ordering Physician: Randall Evans, M.D. | Referring Physician: Dr. Tricia Etheridge | Performed By: Ashley Merritt, RCS |

**Procedure Notes:** Complete 2D/ M-Mode TTE with spectral/ CFD (93306). **Image Window:** Good.  
**Rhythm:** Sinus. **ICD-9 Codes** 786.05 Shortness of Breath.

#### 2-D Measurements:

|                                |                         |                          |
|--------------------------------|-------------------------|--------------------------|
| Ao root diam: 3.4 cm (2.0-3.7) | IVSd: 1.2 cm (0.6-1.1)  | LVIDd: 4.5 cm (3.7-5.5)  |
| LA dimension: 3.9 cm (1.9-4.0) | LVPWd: 1.2 cm (0.6-1.1) | LVIDs: 2.9 cm (variable) |
| LVOT diam: 2.2 cm (1.9-4.0)    | RVDd: 1.4 cm (1.9-3.8)  | EF (est.): (> 55%)       |

#### Interpretation Summary

Normal left ventricle structure and size  
Left ventricular systolic function is normal.  
Proximal septal thickening is noted.  
There is mild concentric left ventricular hypertrophy.  
The right ventricle is normal in size and function.  
Mild aortic regurgitation.  
The left atrium is at the upper limits of normal size  
There is trace mitral regurgitation.  
The mitral valve is normal in structure and function.  
There is trace tricuspid regurgitation.  
Right ventricular systolic pressure is normal.

BARON, FRANCES

ADM INo 124-1  
05/21/12 Condie, Scott  
DOB: [REDACTED] 70 F MR# [REDACTED]  
Coastal Carolina



#### VALVES

##### Aortic Valve

The aortic valve is trileaflet. The aortic valve opens well. Mild aortic regurgitation.

##### Mitral Valve

The mitral valve is normal in structure and function. There is no evidence of mitral valve prolapse.  
There is trace mitral regurgitation.

##### Tricuspid Valve

The tricuspid valve is normal in structure and function. There is no tricuspid valve prolapse. There is trace tricuspid regurgitation. Right ventricular systolic pressure is normal.

##### Pulmonic Valve

The pulmonic valve is not well seen, but is grossly normal. There is no pulmonic valvular stenosis.  
Trace pulmonic valvular regurgitation.

#### CHAMBERS

##### Left Ventricle

Normal left ventricle structure and size. Left ventricular systolic function is normal. Ejection Fraction 60-65%. There is mild concentric left ventricular hypertrophy. Proximal septal thickening is noted. The

left ventricular wall motion is normal. There is no thrombus.

Right Ventricle

The right ventricle is normal in size and function. There is normal right ventricular wall thickness. No regional wall motion abnormalities are noted.

Atria

The left atrium is at the upper limits of normal size. Right atrial size is normal. The interatrial septum is intact with no evidence for an atrial septal defect.

Great Vessels

The aortic root is normal size. The pulmonary artery is normal size.

Pericardium/Pleural

The pericardium appears normal. There is no pleural effusion.

Reading Physician: Kenneth R. Hardigan, MD 11/10/2009 01:52 PM

BARON, FRANCES

ADM Ino 124-1  
05/21/12 Condie, Scott  
DOB 70 F MR#  
Coastal Carolina

FRANCES BARON 11/6/2009

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DATE: 08/17/2012

Page 2 of 2



**BARON, FRANCES**

Date of visit: 03/30/2010  
Date of birth: [REDACTED]  
Age: 68 years old  
Medical record number: [REDACTED]

**CURRENT DIAGNOSES**

1. Dyspnea, 788.05
2. Abnormal EKG, 794.31
3. Aortic Valve Disorders, 424.1

**ALLERGIES**

Antihyperlipidemic - HMG CoA Reductase Inhibitors, Immobility severe  
mangos

**MEDICATIONS**

1. Lisinopril 5 mg Tablet, 1 po qd
2. Glucophage 1,000 mg Tablet, 1 po qd
3. Aspirin 81 mg Tablet, 1 po qd
4. Coenzyme Q10 100 mg Capsule, 1 po qd
5. Lovaza 1-gram Capsule, 1 po tid
6. Trilipix 135 mg Capsule, Delayed Release(E.C.), 1 po qd

**CHIEF COMPLAINTS**

Followup of Abnormal EKG

**HISTORY OF PRESENT ILLNESS**

Patient presents in follow-up. Happily, the echocardiogram shows no significant valvular leak, mild aortic insufficiency and MR noted. Left ventricular mechanics were preserved in November. She stated that after we saw her in September, by the end of October she was starting to have a clearance of dyspnea and exercise intolerance and she is now back to work this week with some degree of fatigue but nonetheless slowly building up. We have no evidence of perfusion deficits. Her stress echo study was normal. She has no evidence of significant valvular pathology that should cause hemodynamic distress. Left ventricular mechanics are preserved. We did not see any evidence of pulmonary hypertension.

She has no chest pain. There is no orthopnea, PND or dependent edema.

She is totally intolerant of statins but is on a dual drug regimen which includes Lovaza and Trilipix. She also takes CoQ10.

**PAST HISTORY**

Past Medical Illnesses: DM-non-insulin dependent, hyperlipidemia, hypertension; Past Cardiac Illnesses: no previous history of cardiac disease; Infectious Diseases: no history of infectious diseases; Surgical Procedures: appendectomy, gallbladder; Trauma History: no history of trauma

**CARDIO PULMONARY TEST DATES**

Stress Echo Date: 09/17/2009

Echocardiography Date: 11/09/2009

**FAMILY HISTORY**

Father - Age 74, deceased and Heart Attack; Mother - Age 76, deceased and Parkinsons;

**CARDIAC RISK FACTORS**

Tobacco Abuse: negative; Family History of Heart Disease: positive; Hyperlipidemia: positive; Hypertension: negative; Diabetes Mellitus: positive; Prior History of Heart Disease: negative

**SOCIAL HISTORY**

Alcohol Use - drinks occasionally; Smoking - denies tobacco use; Diet - low cholesterol and diabetic diet; Lifestyle - married; Exercise - exercises daily; Occupation - retired and nurse; Illicit Drug Use - denies substance abuse;

**REVIEW OF SYSTEMS****GENERAL**

denies recent weight loss, weight gain, fever or chills or change in exercise tolerance.

**INTEGUMENTARY**

denies any change in hair or nails, rashes, or skin lesions.

**EYES**

denies diplopia, history of glaucoma or visual field defects.

BARON, FRANCES

ADM INO 124-1  
05/21/12 Condie. Scott  
DOB [REDACTED] 70 F MR# [REDACTED]  
Coastal Carolina

Patient: BARON, FRANCES MRNO: [REDACTED] DOB: [REDACTED] - Continued  
EARS, NOSE, THROAT, MOUTH

denies any hearing loss, epistaxis, hoarseness or difficulty speaking.

**RESPIRATORY**

denies dyspnea, cough, wheezing or hemoptysis.

**CARDIOVASCULAR**

please review HPI

**ABDOMINAL**

denies ulcer disease, hematochezia or melena.

**MUSCULOSKELETAL**

denies any history of venous insufficiency, arthritic symptoms or back problems.

**NEUROLOGICAL**

denies any history of recurrent strokes, TIA, or seizure disorder.

**PSYCHIATRIC**

denies any history of depression, substance abuse or change in cognitive functions.

**ENDOCRINE**

denies any history of weight change, heat/cold intolerance, polydipsia, or polyuria

**HEMATOLOGICAL/IMMUNOLOGIC**

denies any food allergies, seasonal allergies, bleeding disorders.

**PHYSICAL EXAMINATION**

*Vital Signs*

Blood Pressure:

112/71 Sitting, Right arm, regular cuff

Pulse: 68/min.

Weight: 166.00 lbs.

Height: 65"

BMI: 26

**CONSTITUTIONAL**

cooperative, alert and oriented, well developed, well nourished, in no acute distress

**SKIN**

warm and dry to touch

**HEAD**

normocephalic, no tenderness

**EYES**

EOMS intact, PERRL, conjunctivae and lids unremarkable, Funduscopic exam and visual fields not performed

**ENT**

ears, nose and throat reveal no gross abnormalities, no pallor or cyanosis, dentition good

**NECK**

JVP normal, no carotid bruit, thyroid not enlarged, carotid pulses are full and equal bilaterally

**CHEST**

clear to auscultation bilaterally with good inspiratory effort, normal respiratory excursion, no use of accessory muscles

**CARDIAC**

regular rhythm, S1 normal, S2 normal, No S3 or S4, Apical impulse not displaced, no murmurs, gallops or rubs detected

**ABDOMEN**

abdomen soft, bowel sounds normoactive, no masses, no hepatosplenomegaly, non-tender, no bruits

**PERIPHERAL PULSES**

pulses full and equal in all extremities

**EXTREMITIES & BACK**

no spinal abnormalities noted, no clubbing, cyanosis or edema

**PSYCHIATRIC**

no difficulties with speech or language

**NEUROLOGICAL**

oriented to time, person and place, affect appropriate, no ataxia present

**MEDICATIONS UPDATED TODAY**

<

**IMPRESSIONS/PLAN**

Overall impression is dyspnea, exercise intolerance. No clear cardiovascular etiology. Slowly abating and improving at present. Would encourage continued effort at an exercise regimen with a gradual increase in activity with follow-up with Dr. Etheridge in regard to cholesterol. We will see her happily back in a years time to reassess and consider serial echocardiography on the mild valvular regurgitation that was seen. However, at present she does not appear to need further

BARON, FRANCES

ADM INO 124-1

05/21/12 Condie. Scott

DOB [REDACTED] 70 F MR# [REDACTED]

Coastal Carolina

Patient: BARON, FRANCES MRNO: [REDACTED] DOB: [REDACTED] - Continued  
cardiovascular workup.

**TODAYS ORDERS**

Return Visit 1 year  
12 Lead EKG 1 year

*Referring Physician: ETHERIDGE, TRICIA*

Kenneth R. Hardigan, MD

KRH/vmw

cc: Dr. Tricia Etheridge

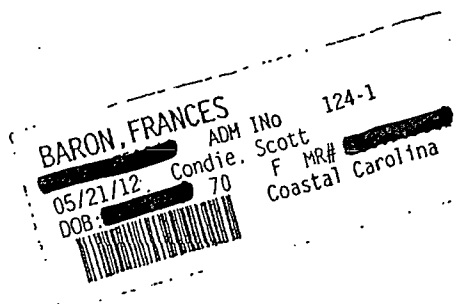
D: 03/30/10

T: 03/30/10

Job #34880

KH/vw

Electronically signed by Kenneth R. Hardigan, MD 8/19/2010 19:53:14



OPTIM ORTHOPEDICS  
210 E DERENNE AVENUE  
SAVANNAH, GA 31405  
(912) 644-5353

TAX ID: 58-1245278

PATIENT:  
FRANCES BARON  
[REDACTED]  
[REDACTED]

GUARANTOR:  
FRANCES BARON  
[REDACTED]  
[REDACTED]

ACCOUNT # [REDACTED]

| DATE OF<br>SERVICE | PROVIDER   | CPT   | TRANSACTION DESCRIPTION  | DX    | AMOUNT |
|--------------------|------------|-------|--------------------------|-------|--------|
| 05/24/12           | SUTHERLAND | 99203 | OFFICE OUTPT NEW LEVEL 3 | 824.0 | 276.00 |
| 05/24/12           | SUTHERLAND | E0135 | WALKERS                  | 824.0 | 154.00 |
| 05/24/12           | SUTHERLAND | L4396 | NIGHT SPLINT             | 824.0 | 336.00 |

TOTAL ACCOUNT BALANCE: 766.00  
INSURANCE PENDING: 766.00  
PLEASE PAY THIS AMOUNT: .00

PAGE 1

OPTIM ORTHOPEDICS  
210 E DERENNE AVENUE  
SAVANNAH, GA 31405  
(912) 644-5353

TAX ID: 58-1245278

PATIENT:  
FRANCES BARON  
[REDACTED]  
[REDACTED] 6  
  
ACCOUNT # [REDACTED]

GUARANTOR:  
FRANCES BARON  
[REDACTED]  
[REDACTED] 6

| DATE OF SERVICE    | PROVIDER   | CPT                         | TRANSACTION DESCRIPTION   | DX    | AMOUNT  |
|--------------------|------------|-----------------------------|---------------------------|-------|---------|
| *****              |            |                             |                           |       |         |
| 06/11/12           | SUTHERLAND | 99024                       | PO F-UP VST RELATED TO OR | 824.0 | .00     |
| 05/24/12           | SUTHERLAND | CORRECTCORRECTION - POSTING |                           | 824.0 | .00     |
| 06/25/12           |            | MEDICARE                    |                           |       | 55.85-  |
| COINSURANCE AMOUNT |            |                             |                           |       |         |
| 05/24/12           | SUTHERLAND | CORRECTCORRECTION - POSTING |                           | 824.0 | .00     |
| 06/28/12           |            | MEDICARE                    |                           |       | 78.52-  |
| 05/24/12           | SUTHERLAND | L4396                       | NIGHT SPLINT              | 824.0 | 336.00  |
| 05/24/12           | SUTHERLAND | 99203                       | OFFICE OUTPT NEW LEVEL 3  | 824.0 | 276.00  |
| 05/24/12           | SUTHERLAND | E0135                       | WALKERS                   | 824.0 | 154.00  |
| 05/29/12           | SUTHERLAND | 27766                       | OPTX MEDIAL MALLS FX +-IN | 824.0 | 2500.00 |
| 05/29/12           | SUTHERLAND | 11042                       | DBRDMT SKN&SUBQ TISS      | 891.1 | 343.00  |
| 06/11/12           | SUTHERLAND | 73610                       | RADEX ANKLE COMPL MINIMUM | 824.0 | 157.00  |

TOTAL ACCOUNT BALANCE: 3631.63  
INSURANCE PENDING: 134.37-  
PLEASE PAY THIS AMOUNT: .00

OPTIM ORTHOPEDICS  
210 E DERENNE AVENUE  
SAVANNAH, GA 31405  
(912) 644-5353

TAX ID: 58-1245278

PATIENT:  
FRANCES BARON  
[REDACTED]  
[REDACTED]  
ACCOUNT # [REDACTED]

GUARANTOR:  
FRANCES BARON  
[REDACTED]  
[REDACTED]

| DATE OF<br>SERVICE | PROVIDER   | CPT   | TRANSACTION DESCRIPTION   | DX    | AMOUNT |
|--------------------|------------|-------|---------------------------|-------|--------|
| *****              |            |       |                           |       |        |
| 07/09/12           | SUTHERLAND | 99024 | PO F-UP VST RELATED TO OR | 824.0 | .00    |
| 07/09/12           | SUTHERLAND | 73610 | RADEX ANKLE COMPL MINIMUM | 824.0 | 157.00 |

TOTAL ACCOUNT BALANCE: 755.04  
INSURANCE PENDING: 128.24-  
PLEASE PAY THIS AMOUNT: 117.28  
PAGE 1

Name: **BARON, FRANCES**Chart: **██████████**Date: **5/24/2012**Provider: **George B. Sutherland, M.D.**

\* 7 3 6 9 4 6 - 1 1 \*

# Patient History & Physical

Today's Date: **5/24/2012**Patient Name: **BARON, FRANCES**Age: **70 Years**

Last

First

Middle

What is the reason for today's visit? **Fracture @ Ankle**Date symptoms first started: **Mon May**

Was this job-related?

☒ YES☐ NO

Was this due to an auto accident?

☒ YES☐ NODate of Accident: **Mon May**

Have x-rays pertaining to your injury been made?

☒ YES☐ NOWhere and When? **Yesterday Coastal Hwy**List all past hospitalizations and surgeries: **Thyroidectomy JUNE 2010****GB 40 yrs Ago****AP? Left oophorectomy 50 yrs Ago (63 or 64)**What medical problems run in your family? **D.M. Heart**Do you have any allergies? ☒ YES☐ NO

If Yes, please list:

**C.I. Contrast Mangoes**

| Current Medications         | Dose                 | Current Medications | Dose |
|-----------------------------|----------------------|---------------------|------|
| <b>Glipizide</b>            | <b>500mg 2 L 2x2</b> |                     |      |
| <b>Atorvastatin 500/400</b> | <b>T 2x Day</b>      |                     |      |
| <b>Thyroid L 2.5 mg</b>     | <b>pm 1-25 g.d.</b>  |                     |      |
| <b>Vit E</b>                | <b>800 U g.d.</b>    |                     |      |
| <b>Lianidipine</b>          | <b>5 mg g.d.</b>     |                     |      |
| <b>ACE</b>                  | <b>T g.d.</b>        |                     |      |

Pharmacy Name: **Natural Base**

Address

City

State

**SC**

Phone Number

Do you drink alcohol? (circle one)

**Yes**

No

If Yes, how much? **1/ Month**

How often?

Do you smoke? (circle one)

Yes

**No**

If Yes, how many packs per day?

How many years?

Please indicate any conditions which you have ever or are currently having by checking the appropriate boxes below:

| PULMONARY                                                 | CARDIOVASCULAR                                           | NEUROLOGICAL                                         | ABDOMEN                                              | OTHER                                                                          |
|-----------------------------------------------------------|----------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------------------|
| <input type="checkbox"/> Pulmonary Embolism               | <input type="checkbox"/> Peripheral Edema                | <input type="checkbox"/> CVA                         | <input type="checkbox"/> Hiatal Hernia               | <input type="checkbox"/> Arthritis <input type="checkbox"/> Skin Disease       |
| <input type="checkbox"/> Emphysema                        | <input type="checkbox"/> High Blood Pressure             | <input type="checkbox"/> Neurostimulator             | <input type="checkbox"/> Stomach Ulcers              | <input type="checkbox"/> Fractures <input checked="" type="checkbox"/> Glasses |
| <input type="checkbox"/> Bronchitis                       | <input type="checkbox"/> Heart Attack (MI)               | <input type="checkbox"/> Epilepsy (Seizures)         | <input type="checkbox"/> Liver Disease               | <input type="checkbox"/> Diabetes                                              |
| <input type="checkbox"/> Asthma                           | <input type="checkbox"/> Rheumatic/Scarlet Fever         | <input type="checkbox"/> Syncope (Fainting)          | <input type="checkbox"/> GI Disease                  | <input type="checkbox"/> Contact Lenses                                        |
| <input type="checkbox"/> COPD                             | <input type="checkbox"/> Heart Murmur                    | <input type="checkbox"/> Depression                  | <input type="checkbox"/> Acid Reflux                 | <input type="checkbox"/> Thyroid Disease                                       |
| <input checked="" type="checkbox"/> Sleep apnea <b>SC</b> | <input type="checkbox"/> Heart Disease                   | <input type="checkbox"/> Anxiety                     | <input type="checkbox"/> Kidney/Bladder Problems     | <input type="checkbox"/> Blood History                                         |
| <input type="checkbox"/> Pneumonia                        | <input checked="" type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Emotional Problems          | <input type="checkbox"/> Bowel Incontinence          | <input type="checkbox"/> Bleeding Disorders                                    |
| <input type="checkbox"/> Shortness of Breath              | <input type="checkbox"/> Phlebitis                       | <input type="checkbox"/> Head/Spinal Injury          | <input type="checkbox"/> Nausea                      | <input type="checkbox"/> Glaucoma                                              |
| <input type="checkbox"/> Frequent Colds                   | <input type="checkbox"/> Heart Stent                     | <input type="checkbox"/> Myasthenia Gravis           | <input type="checkbox"/> Vomiting                    | <input type="checkbox"/> HIV Test ( +/- )                                      |
| <input type="checkbox"/> ENT Disorders                    | <input type="checkbox"/> Pacemaker                       | <input type="checkbox"/> Paralysis                   | <input type="checkbox"/> Vomiting Blood              | <input type="checkbox"/> Implants                                              |
| <input type="checkbox"/> Negative History                 | <input type="checkbox"/> Heart Valve                     | <input type="checkbox"/> Polio                       | <input type="checkbox"/> Rectal Bleeding             | <input type="checkbox"/> Metal in eyes                                         |
|                                                           | <input type="checkbox"/> Heart Failure                   | <input type="checkbox"/> Brain aneurysm              | <input type="checkbox"/> Pregnant/Lactating          | <input type="checkbox"/> Recent Weight Loss                                    |
|                                                           | <input type="checkbox"/> Recent Chest Pain               | <input type="checkbox"/> Chronic Headaches           | <input checked="" type="checkbox"/> Negative History | <input type="checkbox"/> Pain in legs after walking                            |
|                                                           | <input type="checkbox"/> Negative History                | <input checked="" type="checkbox"/> Negative History |                                                      | <input type="checkbox"/> Anesthesia Problems                                   |
|                                                           |                                                          |                                                      |                                                      | <input type="checkbox"/> Negative History                                      |

Please list any other medical problems you have:

Name: **BARON, FRANCES**

Chart: **[REDACTED]**

Date: **5/24/2012**

Provider: **Georgia B. Sutherland, M.D.**



\* 7 3 6 9 4 6 - 1 1 \*

**OPTIM HEALTHCARE - PATIENT INFORMATION & HISTORY FORM**

Patient Name **BARON, FRANCES**

Sex **F**

LAST

FIRST

MIDDLE

Patient's Date of Birth

Age

**70 Years**

Patient's Social Security #

Month

Day

Year

Home Address

Apt#

Lot#

Street

City

State

Zip

Mailing Address

**Same**

City

State

Zip

Is this address: ☐ Permanent ☐ Temporary. (check one) Patient's Marital Status ☐ Single ☐ Widowed ☐ Divorced ☐ Married.

Home Phone

**[REDACTED]**

Work Phone

Cell Phone

E-Mail address

Race

Ethnicity

☐ Hispanic

☐ Non Hispanic

☐ Unknown

If Patient Lives in a Nursing Home or Assisted Living Facility, please provide below:

Primary Language

Name of Facility

Address

Phone

**EMERGENCY INFORMATION**

EMERGENCY CONTACT NAME

**Husb Edward J**

RELATIONSHIP TO PATIENT

Phone

**Same**

NEAREST FRIEND NOT LIVING WITH YOU

**STEVE Murphy**

Phone

**MEDICARE/MEDICAID**

MEDICARE NO.

MEDICAID NO.

EFFECTIVE DATE

**1**

**1**

DATE OF MONTH ELIGIBLE

STATE/ISSUED

**PRIMARY Insurance Information**

Name of Insurance Company

**MEDICARE SC-PART B**

Name of Insurance Company

**TRICARE FOR LIFE**

Address of Insurance Co

Address of Insurance Co

Policy #

Group #

Policy #

Group #

SUBSCRIBER'S NAME

(as on insurance card)

SUBSCRIBER'S NAME

(as on insurance card)

Relationship to Patient

☐ Self

☐ Spouse

☐ Child

☐ Other

Relationship to Patient

☐ Self

☐ Spouse

☐ Child

☐ Other

SUBSCRIBER'S ADDRESS

SUBSCRIBER'S ADDRESS

CITY, STATE

ZIP

CITY, STATE

ZIP

PHONE

PHONE

DATE OF BIRTH

**1**

**1**

SEX

☐ Male

☐ Female

DATE OF BIRTH

**July 17**

**1940**

SEX

☐ Male

☐ Female

Social Security # of Insured

**1**

**1**

Social Security # of Insured

**1**

**1**

**SPOUSE OR GUARDIAN INFORMATION**

Name **Edward J. Baron**

SSN

DOB

Address of Spouse or Guardian

City

State

Zip

Spouse or Guardian's Employer

Employer's Address

City

State

Phone

If Patient is under 18 years of age, please state your relationship to the patient:

WHO IS YOUR FAMILY PHYSICIAN?

**Trish Ehnidge**

WHOM MAY WE THANK FOR REFERRING YOU TO US?

**Dr. Cnais**

WHAT IS YOUR OCCUPATION?

**RA**

NAME OF PATIENT'S EMPLOYER

**SANCTUARY Hospice**

EMPLOYER'S ADDRESS

CITY, STATE

**Ridge/MD**

EMPLOYER'S PHONE

**58**



Name: BARON, FRANCES

Chart: [REDACTED]

Date: 5/24/2012

Provider: George B. Sutherland, M.D.



### ACCIDENT DETAILS

PATIENT'S NAME BARON, FRANCES

DATE OF BIRTH [REDACTED]

Is your visit today the result of a work-related or auto accident? ☒ YES ☐ NO

If YES, which one? ☐ Work-Related ☐ AUTO ACCIDENT

Signature of patient or guardian Frances Baron Date \_\_\_\_\_

If YES, please complete the following:

1. What happened? AA Driving From Pt's Place to office
2. Where did the accident occur? SNAKE Road
3. When did the accident occur? (DATE) Mon May
4. Is there any other insurance coverage (such as a homeowner's policy, school insurance, worker's compensation, etc.) that will pay this bill? ☐ YES ☐ NO

a. If YES, please give us the information in the space provided for that insurance company:

NAME OF COMPANY \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_

INSURANCE COMPANY ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

PHONE \_\_\_\_\_

POLICY # \_\_\_\_\_

CLAIM # \_\_\_\_\_

ATTORNEY'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

IF WORK RELATED:

EMPLOYER NAME \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_

WAS INJURY REPORTED TO EMPLOYER? ☐ YES ☐ NO

If YES, list the name of the person you spoke with \_\_\_\_\_ PHONE \_\_\_\_\_

### AUTO ACCIDENT/OTHER ACCIDENT

When your injuries are the result of an accident and an attorney will be handling your case in court or another party's insurance company is presumed responsible for your charges, the patient is still responsible for payment of the bill. Optim Healthcare cannot be expected to wait for the conclusion of long-term court case or settlement of a disputed insurance claim before being paid. You will be required to make a payment of \$250 before being seen and with each visit that follows. You also are responsible for payment of the balance of your bill should charges exceed the \$250 you pay at each visit.

### WORKER'S COMPENSATION

Patients who are injured on the job should report the injury directly to their employer. The employer will be responsible for directing the employee to a doctor who is listed on their Panel of Physicians. Before we will be able to see you as a patient, we will require you to fax or bring in a letter verifying that your employer will be responsible for your charges. If a patient comes in for a visit without this information, we will have to reschedule the appointment. This information is necessary to avoid the patient being responsible for the bill.

Signature of patient or guardian Frances Baron Date \_\_\_\_\_

Rev 8/1/11

FC64



OKATIE

FRANCES BARON

DOB: 05/24/2012

WHAT: Left ankle.  
HOW: MVA.  
WHEN: Monday.  
WHERE: Jasper County.

CHIEF COMPLAINT: Left ankle pain.

HISTORY OF PRESENT ILLNESS: This is a 70-year-old female who is a hospice nurse who was traveling from work and apparently either fell asleep at the wheel or passed out and was involved in a motor vehicle accident. She was sent to Coastal Carolina Hospital where she was evaluated and admitted to the hospital for a workup for syncope. While in the hospital, they did an x-ray of bilateral ankles showing a normal ankle on the right side but a medial malleolus fracture on the left side. She was sent to me for followup. She complains of pain in both. She is able to walk. She actually came in on a walker today in a boot. She has multiple ecchymosis about her head and about her arms but complains of really no other sites other than mentioned above. No numbness, tingling or other neurologic symptoms.

PAST MEDICAL HISTORY: I have reviewed the patient's medical history sheet, including the complete review of systems, past family and social history. This has been initialed and dated by me and is in the chart. Please refer to the history sheet for further details. It has been reviewed, signed by myself, and placed in the chart as part of the permanent medical record.

PHYSICAL EXAMINATION: On physical examination today, this is a very pleasant female who is awake and oriented x3 in no acute distress. No audible breath sounds. Hearing and vision are intact. Skin is warm and dry to touch.

Observation of both legs shows her to be swollen in the tibia on the left side and about the ankle on the right side. She has limited range of motion of the left ankle and tenderness to palpation at the medial malleolus. Moderate tenderness to palpation at the ATFL but not over the lateral malleolus. She is otherwise neurologically intact. Palpable pulse and less than 2 second capillary refill and a supple calf bilaterally. She does have a large hematoma on the anterior right tibia but no evidence of a fracture.

RADIOGRAPHS: I have reviewed both films from an outside facility. There are 3 views of each ankle, AP, lateral and oblique, which demonstrate no fractures or dislocations. Normal views of the right ankle; however, the left ankle demonstrates a moderately displaced medial malleolus fracture and no evidence of a lateral malleolus fracture.

ASSESSMENT: Right ankle hematoma and left ankle medial malleolus fracture.



optimhealthcare

FRANCES BARON

Page 2

DOB: [REDACTED]

05/24/2012

PLAN: We have talked about percutaneous fixation. I have gone over the risks and benefits of the procedure, and due to recent syncope and diabetes, I would like to do this all under a local block. She understands this. I have actually talked to her brother who is a physician, and he agrees with this. We have her set up at Coastal Carolina Hospital next week.

George Sutherland, MD

GS/wz910ah

D: 5/25/2012 9:03:00 AM T: 05/25/2012

Job ID:490077

Coastal Carolina Hospital  
1000 Medical Center Drive  
Hardeeville, SC 29927  
(843) 784-8000

Name: BARON, FRANCES

MRN: [REDACTED]

ACCT: [REDACTED]

ROOM:

01566: George Sutherland, Jr., MD

ADMIT DATE: 05/29/2012

DATE OF BIRTH: [REDACTED]

### Operative Report

Page 1 of 3

DATE OF PROCEDURE: 05/29/2012

#### PREOPERATIVE DIAGNOSES:

1. Left medial malleolus fracture, closed.
2. Right leg hematoma with wound.

#### POSTOPERATIVE DIAGNOSES:

1. Left medial malleolus fracture, closed.
2. Right leg hematoma with wound.

#### PROCEDURES PERFORMED:

1. Open reduction internal fixation, left medial malleolus fracture.
2. Debridement superficial wound, right leg.

SURGEON: George Sutherland, MD

ASSISTANT: None.

ESTIMATED BLOOD LOSS: Minimal.

ANESTHESIA: General augmented with popliteal block.

IMPLANTS USED: Times 2 36 x 4 mm partially threaded cannulated AO screws.

DRAINS PLACED: None.

SPECIMEN SENT: None.

FINDINGS: Medial malleolus fracture, transverse in nature and a 3 cm x 3 cm x 2 cm x 4 cm wound over the medial tibial above the hematoma with central necrosis.

COMPLICATIONS: None.

INDICATIONS FOR PROCEDURE: This is a 70-year-old female who was involved in a motor vehicle accident sustaining a medial malleolus fracture. We had talked about open reduction and internal fixation and she agreed due to greater than 2 mm of displacement. Upon arrival today, I noted that

## Coastal Carolina Hospital

Name: BARON, FRANCES  
MRN: [REDACTED]  
ACCT: [REDACTED]  
ROOM:

01566:George Sutherland, Jr., MD  
ADMIT DATE: 05/29/2012

## Operative Report

Page 2 of 3

the hematoma over her left leg had some areas of necrosis. I consulted Dr. Jason Cotter for evaluation and he recommended debridement of the fibrous tissue.

**PROCEDURE IN DETAIL:** After obtaining informed consent, the patient receiving preop dose of antibiotics, patient was brought back to the operating room, placed in supine position, sterilely draped and prepped about the left lower extremity. Her sterile drape and prepping, a time-out procedure was performed verifying the correct operative site and the correct patient. After this was performed, the Esmarch dressing was used to exsanguinate the leg and tourniquet taken up to 300 mmHg. After this was performed, 2 small incisions were made above the fracture site at the tip of the anterior colliculus of the medial malleolus. The small incision sites were just stab incisions, reduction forceps were placed through stab incision, a percutaneous reduction was attempted; however, this was unsuccessful, so small hockey-stick incision was made through these 2 previously made incisions, taken down to the medial malleolus bone. Periosteum was reflected medially and laterally. Under direct visualization, the medial malleolus was reduced and held with forceps. Two threaded guide pins were then placed through the inferior tip of the medial malleolus parallel to one another, roughly 1 cm to one another and passed into the tibial shaft. This was confirmed on AP and lateral views with reduction of the fracture site. The cannulated drill bit was then placed crossing the fracture site and two 36 x 4 mm AO partially threaded screws were then placed across the fracture site holding it in an anatomic reduction. They were toggled back and forth as being tightened down and not to displace the fracture. The pins were removed. AP, lateral and mortise all demonstrated anatomic reduction with no evidence of medial widening and obliteration of the fracture site. After this was performed, the wound was irrigated with copious amounts of sterile saline. Tourniquet was taken down and any bleeding was taken care with Bovie electrocautery. The periosteum was closed with 2-0 Vicryl in an interrupted fashion followed by 3-0 nylon in a mattress-type fashion on the skin. She was placed in a sterile double sugar-tong splint. After this was performed, we took our dressings down and then addressed the opposite leg. The opposite leg was debrided. In the areas mentioned above, there was a 3 x 3 x 2 x 4 areas of necrosis with fibrinous exudate, which was scraped with a #10 blade and perpendicular to the skin and removing as much exudate as possible. There were some adhesions to the fat in the middle and I felt that this was better left for enzymatic debridement. She will see the wound care specialist this afternoon. We then dressed it with sterile gauze followed by Kerlix followed by an Ace wrap. She tolerated both procedures well, was taken to PACU stably.

---

George Sutherland, Jr., MD

GS/FI/2402723  
D: 05/29/2012 11:42 EDT

## Coastal Carolina Hospital

Name: BARON, FRANCES  
MRN: [REDACTED]  
ACCT: [REDACTED]  
ROOM:

01566:George Sutherland, Jr., MD  
ADMIT DATE: 05/29/2012

## Operative Report

Page 3 of 3

T: 05/29/2012 17:05 EDT  
E:  
DOCUMENT #: 6508255



OKATIE

FRANCES BARON

DOB: 06/11/2012

**HISTORY OF PRESENT ILLNESS:** Ms. Baron comes in today. She is 13 days out status post open reduction/internal fixation of a medial malleolus fracture. She is doing quite well. Her only issue is the opposite leg where she has had a debridement from Dr. Cotter for a contusion of the tibia with a resulting hematoma. Other than that, she shows no signs of infection.

**PHYSICAL EXAMINATION:** On physical examination today, her incision looks well. She is neurologically intact. Calf is supple. There is some mild swelling about the ankle.

**RADIOGRAPHS:** Three views are submitted, AP, lateral and mortise view, which show anatomically reduced medial malleolus fracture with 2 AO screws. No other fractures or dislocations are noted.

**ASSESSMENT:** Status post open reduction/internal fixation left medial malleolus fracture.

**PLAN:** She is nonweightbearing. We have put her back into a short boot with swelling control, physical therapy at home. I have given her a prescription for 5/325 Lortab q. 4 to 6 hours p.r.n. pain. She will be back in 4 weeks.

George Sutherland, MD

GS/wz910ah

D: 6/11/2012 12:07:00 PM T: 06/13/2012

Job ID:498876



OKATIE

FRANCES BARON

DOB: 07/09/2012

**CHIEF COMPLAINT:** Followup of open reduction internal fixation of left medial malleolar ankle fracture done 05/29/2012.

**HISTORY OF PRESENT ILLNESS:** Ms. Baron reports back today for routine postoperative visit. All in all she is doing well. She complains of some numbness and tingling in the toes of her foot. She continues to use the short walking boot and has been nonweightbearing and compliant with that.

**PHYSICAL EXAMINATION:** Today, she is seated in a wheelchair just for ease of getting around. She is alert and oriented x3, answers questions appropriately. Examination of her left ankle reveals well healed medial incision. There is minimal swelling, redness, warmth. No signs of infection. Gentle passive and active range of motion is well tolerated in her ankle.

**RADIOGRAPHS:** Three views, AP, lateral and oblique of her left ankle were obtained in the office today and interpreted by me. Technique is satisfactory. This reveals a healed medial malleolar fracture transfixed with two medial AO screws. Everything looks good. Hardware in place.

**ASSESSMENT:** Status post open reduction internal fixation of left medial malleolar fracture six weeks postop.

**RECOMMENDATIONS:** At this point, we discussed the next step which would be weaning herself from the boot. She can weight bear as tolerated, use of assistive devices as necessary, although she does not require those. We gave her a prescription for physical therapy and to transition to a home program eventually and a prescription for Lidoderm patches which she found to be very helpful for some pain over the top of the foot. We will see her back in six weeks with three views of her left ankle.

Nick Evangelista, PA-C

Donald Sutherland, MD

NE/wz928pp

D: 7/9/2012 11:03:00 AM T: 07/11/2012

Job ID:513805





OKATIE

FRANCES BARON

DOB: 09/10/2012

CHIEF COMPLAINT: Followup of medial malleolar open reduction internal fixation, 05/29/2012.

HISTORY OF PRESENT ILLNESS: Ms. Baron returns today for followup in regards to her left ankle. She is doing fine. She is ambulating with the use of a single-point cane.

PHYSICAL EXAMINATION: Exam of her left ankle reveals a well-healed surgical incision. There is very minimal pain over the ankle itself. Ankle motion is well preserved. No evidence of laxity.

RADIOGRAPHS: AP, lateral, and oblique of her left ankle were taken and reviewed by myself and Dr. Sutherland. Technique is satisfactory. This reveals a well-healed medial malleolar fracture with two screws transfixing it. The hardware is intact.

ASSESSMENT: Medial malleolus fracture, improved.

RECOMMENDATIONS: At this point, we are going to continually allow her to ambulate as tolerated. We will increase her activities to tolerance. We will see her back only if any increased pain, problems, or questions were to develop.

A handwritten signature in dark ink, appearing to read "G. B. Sutherland".

Nick Evangelista, PA-C

George B. Sutherland, MD

NE/wz992sc

D: 9/10/2012 5:19:00 PM T: 09/11/2012

Job ID:549088

**PATIENT BILLING HISTORY**

Palmetto Eye Specialists, PA  
220 Pembroke Dr.  
Suite 100

Hilton Head Island, SC 29926-6200  
Phone: 843-785-2525

Patient: Frances A. Baron

Guarantor: Frances A. Baron

Account #: [REDACTED]

DOB: [REDACTED]

Home Phone: [REDACTED]

Work Phone: [REDACTED]

5/24/2012 Provider: Diana, Jr. MD, Perin W. (EIN: 57-1084072, UPIN: D02794)  
Procedure: 92014 (Eye Exam, Established) Diagnosis: 921.2

131.00

Payments: 07/10/2012 Medicare SC  
07/23/2012 Tricare Regions 3 & 4 - Humana Military  
Adjustments: 07/10/2012 Medicare Adjustment

88.00  
22.17  
20.14

Balance: 0.00

5/24/2012 Provider: Diana, Jr. MD, Perin W. (EIN: 57-1084072, UPIN: D02794)  
Procedure: 92225-LT (Ophthalmoscopy, extended with p Diagnosis: 379.21

88.00

Payments: 07/10/2012 Medicare SC  
07/23/2012 Tricare Regions 3 & 4 - Humana Military  
Adjustments: 07/10/2012 Medicare Adjustment

19.48  
4.87  
41.65

Balance: 0.00

5/24/2012 Provider: Diana, Jr. MD, Perin W. (EIN: 57-1084072, UPIN: D02794)  
Procedure: 92225-RT (Ophthalmoscopy, extended with p Diagnosis: 379.21

88.00

Payments: 07/10/2012 Medicare SC  
07/23/2012 Tricare Regions 3 & 4 - Humana Military  
Adjustments: 07/10/2012 Medicare Adjustment

19.48  
4.87  
41.65

Balance: 0.00

5/24/2012 Provider: Diana, Jr. MD, Perin W. (EIN: 57-1084072, UPIN: D02794)  
Procedure: 92395 (Supply of spectacles) Diagnosis: 379.21

495.00

Payments: 05/24/2012 Baron, Frances A  
06/05/2012 Baron, Frances A

227.70  
267.30

Balance: 0.00

5/24/2012 Provider: Diana, Jr. MD, Perin W. (EIN: 57-1084072, UPIN: D02794)  
Procedure: TAX (TAX ON OPTICAL) Diagnosis: 379.21

39.60

Payments: 05/24/2012 Baron, Frances A

39.60

Balance: 0.00

6/14/2012 Provider: Diana, Jr. MD, Perin W. (EIN: 57-1084072, UPIN: D02794)  
Procedure: 92014 (Eye Exam, Established) Diagnosis: 921.2

131.00

Payments: 07/23/2012 Medicare SC  
08/06/2012 Tricare Regions 3 & 4 - Humana Military  
Adjustments: 07/23/2012 Medicare Adjustment

88.00  
22.17  
20.14

Balance: 0.00

Balance From 05/24/2012 To 08/16/2012: 0.00

Total Due: 0.00

**PATIENT BILLING HISTORY**

Palmetto Eye Specialists, PA  
900 Pembroke Dr.  
Suite 100  
Hilton Head Island, SC 29926-6200  
Phone: 843-785-2525

**Patient:** Frances A. Baron**Guarantor:** Frances A. Baron**Account #:** [REDACTED]**DOB:** [REDACTED]**Home Phone:** [REDACTED]**Work Phone:** [REDACTED]

5/24/2012 Provider: Diana, Jr. MD, Perin W. (EIN: 57-1084072, UPIN: D02794)  
Procedure: 92014 (Eye Exam, Established) Diagnosis: 276.32

**Balance:** 131.00

5/24/2012 Provider: Diana, Jr. MD, Perin W. (EIN: 57-1084072, UPIN: D02794)  
Procedure: 92225-LT (Ophthalmoscopy, extended with p Diagnosis: 379.21

**Balance:** 66.00

5/24/2012 Provider: Diana, Jr. MD, Perin W. (EIN: 57-1084072, UPIN: D02794)  
Procedure: 92225-RT (Ophthalmoscopy, extended with pDiagnosis: 379.21

**Balance:** 66.00**Balance From 05/24/2012 To 06/07/2012:** 263.00**Total Due:** \$263.00

MEITO OPTICAL RIDGELAND  
N JACOB SMART BLVD  
RIDGELAND SC 29936  
843-726-6509

Merchant ID: 0007004147  
PA ID: 0223

Sale

try Method: Swiped

prvd: Online Batch#: 000003  
/05/12 13:32:59

v#: 00000001 Appr Code: 73565Z

tal: \$ 267.30

Customer Copy

THANK YOU!

Palmetto Eye  
Specialists, PC

Clear Choice

|                              |       |          |      |
|------------------------------|-------|----------|------|
| Name:                        |       | Date:    |      |
| Frances Bacon                |       | 05/24/12 |      |
| PHONE:                       |       | CONF:    |      |
|                              |       | SP11NS63 |      |
| INSURANCE:                   |       |          |      |
|                              |       |          |      |
| OD                           | -1.25 | +1.25    | 170  |
| OS                           | -0.50 | +1.00    | 150  |
| OD                           | 2.50  | 19       | 28.5 |
| OS                           | 2.50  | 19       | 31.0 |
| Verilux<br>Cont 2            |       | CR-39    |      |
| Written 8.80<br>Correct 2.00 |       | Metal    |      |
| 53.19                        |       | 37       |      |
| 53                           |       | 140      |      |
| FRAMES:                      |       |          |      |
| 85.00                        |       |          |      |
| LENS:                        |       |          |      |
| 265.00                       |       |          |      |
| ADDITIONAL:                  |       |          |      |
| 125.00                       |       |          |      |
| 20.00                        |       |          |      |
| 495.00                       |       |          |      |
| 39.60                        |       |          |      |
| TOTAL:                       |       |          |      |

5/24/12 PA 534.60 Balance 267.30  
267.30 6/4/12 267.30  
Balance 0

Frances Baron

DATE:

05/24/12

Bruising from Motor Vehicle Accident  
3 days

CC Assisted Check List

- ☐ blurry ☐ burning  
☐ dryness ☐ eye pain  
☐ flashes ☐ floaters  
☐ glare ☐ irritation  
☐ redness ☐ tearing

⊕ Pain ⊕ Bruising ⊖ Redness  
⊕ Floaters  
N/A N/A

IH: ☐ reviewed and is negative

SOCIAL HISTORY:

☐ negative

ACTIVITY: ☐ full

arthritis osteo rheumatoid  
ASHD ☐ asthma  
cancer  
DVA ☐ diabetes  
hypertension ☐ MI  
hyroid hypo hyper  
cholesterol  
other

☐ cigarettes  
☐ alcohol  
☐ drugs

SYSTEMIC MEDS: ☐ none

mre / head unrecognizable  
mra

ALLERGIES: ☐ no known allergies

CENT HOSPITALIZATION:

☐ reviewed and is negative

REVIEW OF SYSTEMS: ☐ all ROS listed were asked and found negative

amblyopia  
blindness  
cataract  
na  
cornea detachment  
ASHD  
diabetes  
hypertension  
cancer  
other

GENERAL

- ☐ fatigue  
☐ fever  
☐ weight loss

NEURO

- ☐ headache  
☐ dizziness  
☐ gait disorder

ENT

- ☐ sore throat  
☐ hoarseness  
☐ ringing ears

RESPIRATORY

- ☐ cough  
☐ SOB  
☐ wheezing

CARDIOVASC.

- ☐ chest pain  
☐ difficulty/stairs  
☐ leg pain/walking

GU

- ☐ dysuria  
☐ frequency

GI

- ☐ change in bowel habits  
☐ blood in stools

MUSC/SKEL

- ☐ muscle aches  
☐ joint pain/swell.  
☐ PT being followed by MD for these issues

SKIN

- ☐ rash  
☐ itching

HEMAT

- ☐ anemia  
☐ bruising

PSYCHOL

- ☐ anxiety  
☐ depression  
☐ PT advised to seek attn. for these issues

No change in all history  
Since 9/29/11 except as noted above

E HISTORY: ☐ negative

EYE MEDS: ☐ none

macular degen ☐ cataract  
diabetic/back ☐ cat ext  
diabetic/prolif ☐ laser surgery glau  
laser surgery diabetes

☒ glau/open on  
☐ glau/narrow  
☐ other

PHYSICAL EXAM: BP pulse

ANCILLARY TESTS

FACE

pro Mood  
oriented T/P/P ☒ normal  
obtunded ☐ depressed  
disoriented ☐ unresponsive  
mental retardation ☐ combative

Dvorine color  
Amsler grid  
stereopsels

OD OS

- ☒ WNL  
☐ Swelling  
☐ Rash  
☐ Rosacea  
☐ Abrasion  
☐ Ecchymosis

CONTACT LENSES

Brand:  
B.C. Dia.  
OD OS

OD OS

OD OS

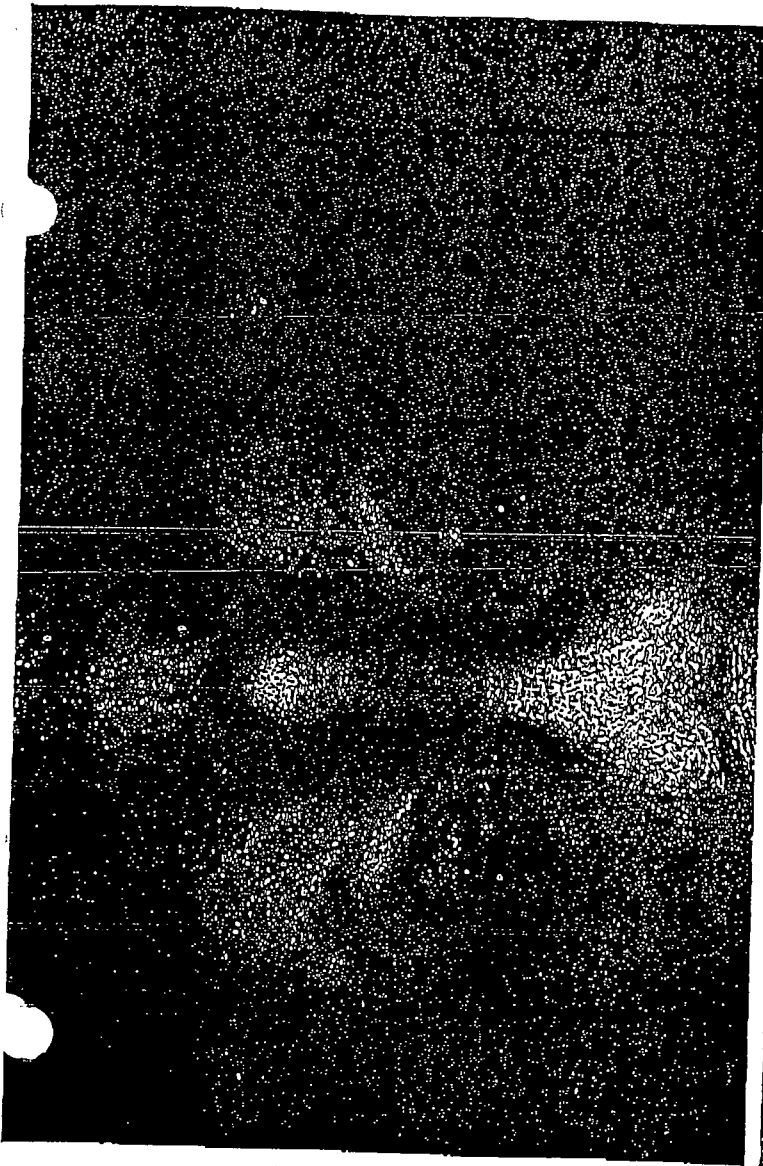
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F/M

Add + - 263 -

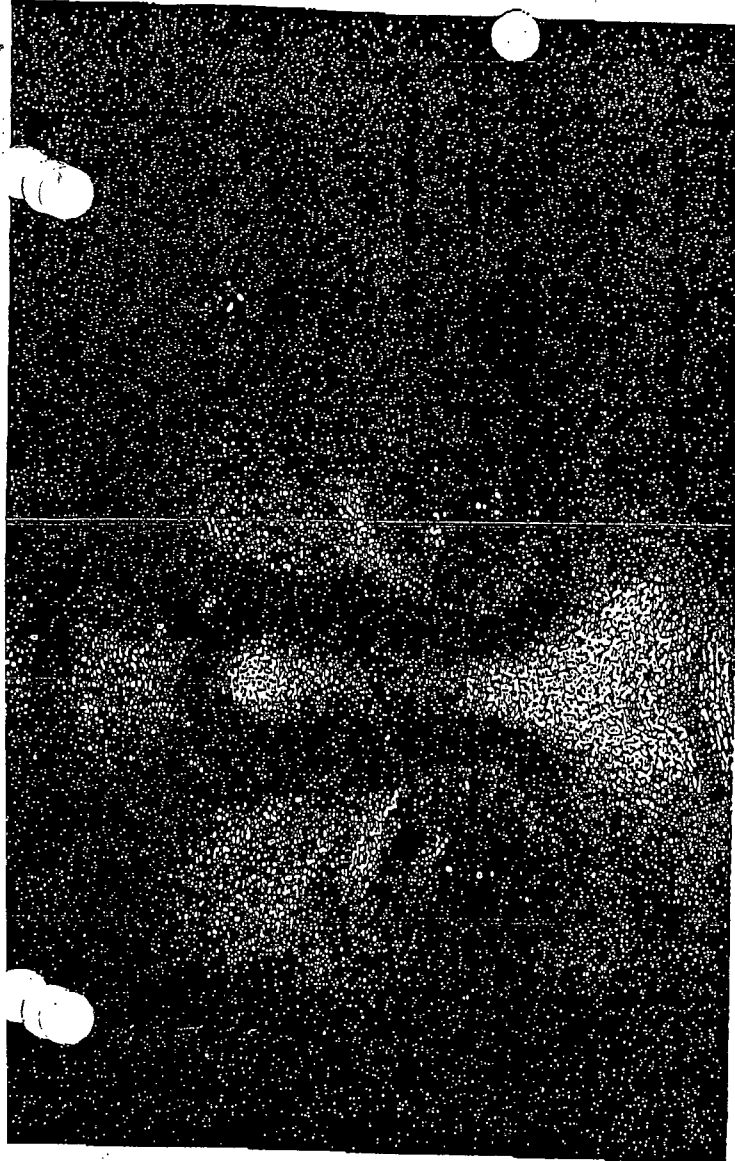
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PALMETTO EYE SPECIALISTS PA  
09/DA/12

*[Handwritten signature]*

-271-



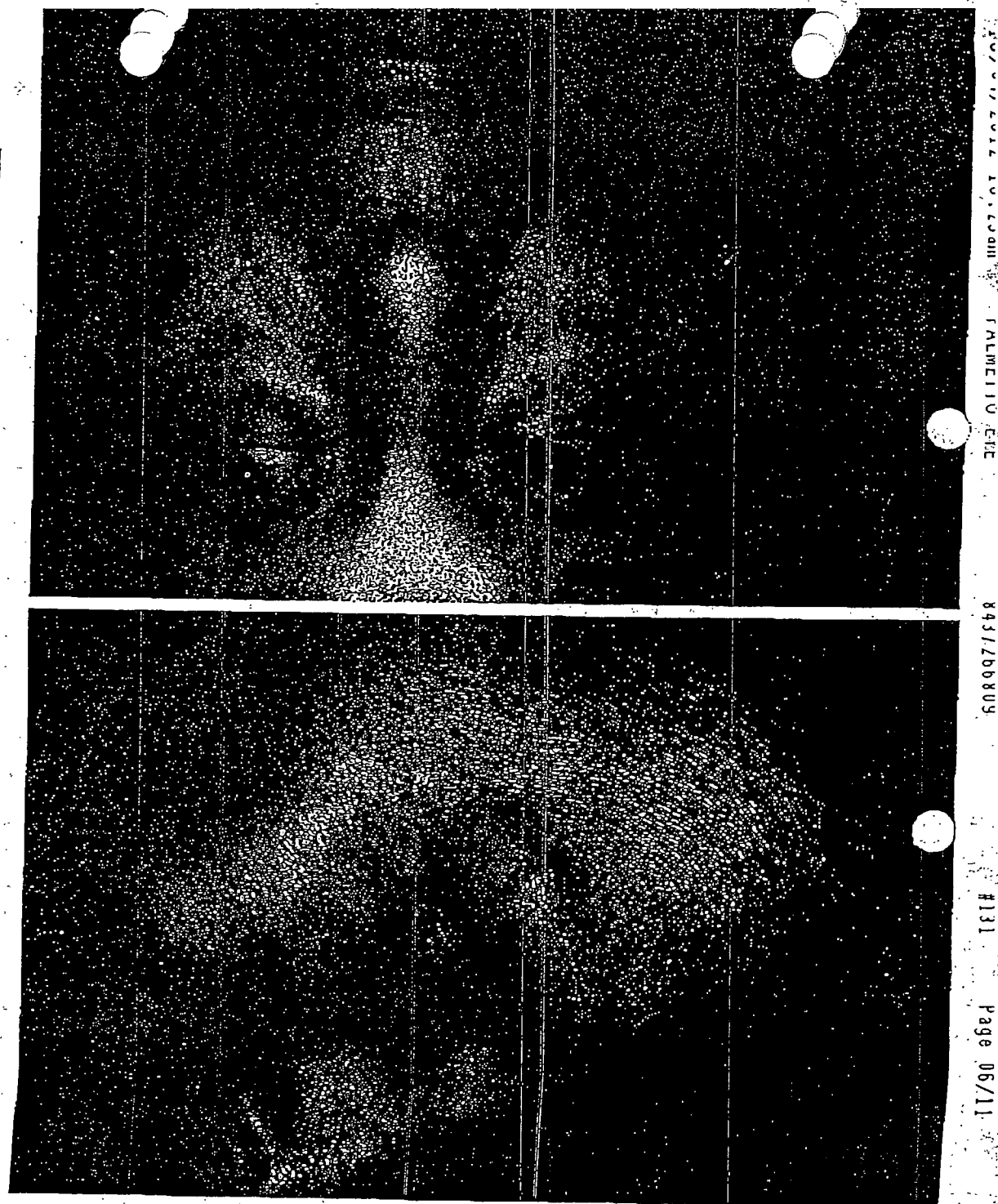
PALMETTO EYE SPECIALISTS PA

09/09/12

PALMETTO EYE SPECIALISTS PA

09/09/12

-269-



09/09/12 10:10:00

PALMETTO EYE

843/200803

#131

Page 06/11





E

CC:

HPI:

Frances Basan

Hit in the Right

DATE:

06/14/12

CC Assisted Check List

☐ blurry☐ dryness☐ flashes☐ glare☐ redness☐ burning☐ eye pain☐ floaters☐ irritation☐ tearingPMH: ☐ reviewed and is negative☐ arthritis osteo rheumatoid☐ ASHD ☐ asthma☐ cancer☐ CVA ☐ diabetes☐ hypertension ☐ MI☐ thyroid hypo hyper☐ cholesterol☐ other

SOCIAL HISTORY:

☐ cigarettes☐ alcohol☐ drugsSYSTEMIC MEDS: ☐ none☐ negativeACTIVITY: ☐ full☐ limited

ALLERGIES:

☐ no known allergies

RECENT HOSPITALIZATION:

FH: ☐ reviewed and is negativeREVIEW OF SYSTEMS: ☐ all ROS listed were asked and found negative☐ amblyopia☐ blindness☐ cataract☐ glaucoma☐ retinal detachment☐ HD☐ diabetes☐ hypertension☐ cancer☐ other☒ No change in all history

Since 8/24/12

GENERAL

☐ fatigue☐ fever☐ weight loss

CARDIOVASC.

☐ chest pain☐ difficulty/stairs☐ leg pain/walking

MUSC/SKEL

☐ muscle aches☐ joint pain/swell.☐ PT being followed by MD for these issues

NEURO

☐ headache☐ dizziness☐ gait disorder

GU

☐ dysuria☐ frequency

SKIN

☐ rash☐ itching

ENT

☐ sore throat☐ hoarseness☐ ringing ears

GI

☐ change in bowel habits☐ blood in stools

RESPIRATORY

☐ cough☐ SOB☐ wheezing

HEMAT

☐ anemia☐ bruising☐ PT advised to seek attn. for these issues

PSYCHOL

☐ anxiety☐ depressionEYE HISTORY: ☐ negative☐ macular degen☐ diabetic/back☐ diabetic/prolif☐ laser surgery diabetes☐ cataract☐ cat ext☐ laser surgery glau☐ glau/open☐ glau/narrow☐ otherEYE MEDS: ☐ none

PHYSICAL EXAM: BP pulse

Neuro

☐ oriented T/P/P☐ obtunded☐ disoriented☐ mental retardation

Mood

☒ normal☐ depressed☐ unresponsive☐ combative

ANCILLARY TESTS

Dvorine color

Amesler grid

stereopels

OD

OS

FACE

☐ WNL☐ Swelling☐ Rash☐ Rosacea☐ Abrasion☐ Ecthymoids

CONTACT LENSES

Brand:

B.C.

Dia.

OD

OS

OD

OS

OD

OS

W Add +

F/M

Add +

F/cvc

Patient: Baron, Frances A

Address: [REDACTED]

Home Phone: [REDACTED]

Date of Birth: [REDACTED]

SSN: [REDACTED]

Account Number: [REDACTED]

Primary Covera Medic SC ([REDACTED])

06/05/2012 14:35:04

Secondary Cov Tricare Regions 3 & 4 - Humana Military [REDACTED]

Account Balance \$263.00

Appointment: 06/05/2012, 2:45 pm : Short-Diana

Last 5 Primary 379.21, 276.32, 385.10, 366.16



|            |               |       |          |
|------------|---------------|-------|----------|
| Name:      | Frances Brown | Date: | 05/24/12 |
| PHONE:     |               | CONF# | SP11NS63 |
| INSURANCE: |               |       |          |

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|--------------------------------------------------------------|-------|-------|------|-----------------------|--|
| OD                                                           | -1.25 | +1.25 | 170  |                       |  |
| OS                                                           | -0.50 | +1.00 | 150  |                       |  |
| OD                                                           | 2.50  | 19    | 28.5 |                       |  |
| OS                                                           | 2.50  | 19    | 31.0 |                       |  |
| Verilux<br>Coat 2                                            |       | CR-39 |      | Crizal Sapphire<br>UV |  |
| <del>Written</del> 8.80<br><del>Coat 2</del> <del>guri</del> |       | Match |      | Violet                |  |
| 53.19                                                        |       | 37    |      | 53                    |  |
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5/24/12 Pd 534.60 Balance 267.30  
 267.30 6/4/12 267.30  
 Balance 0

Patient:

Frances P. Mon

Date:

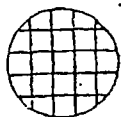
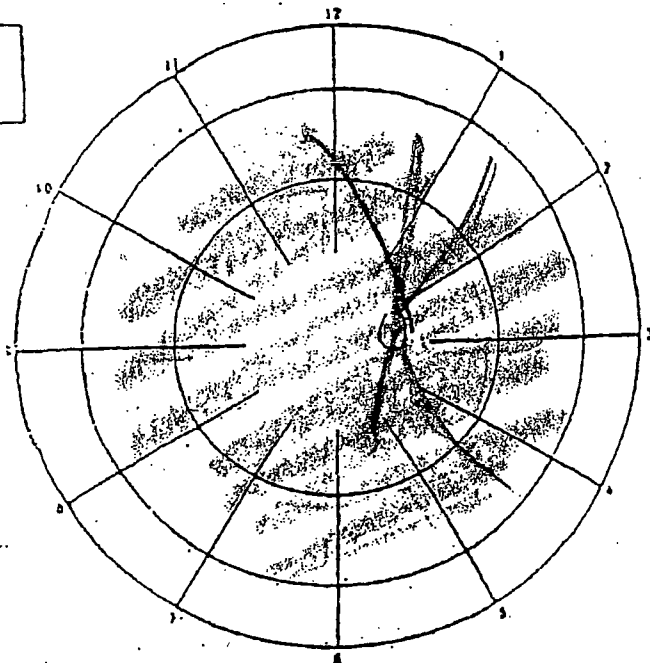
05/24/12

Address:

## EXTENDED OPHTHALMOSCOPY

**RED:** arteries, heme, attached retina**BLUE:** veins, detached retina**YELLOW:** exudate, edema**PURPLE:** flat neovasc.**ORANGE:** Elevated Neovasc.**BROWN:** RPE pigment, vasc occlusion**BLUE filled w/red:** retinal break**Black outline w/ black lattice:** lattice of attached retina**Blue outline w/ blue lattice:** lattice of detached retina**Blue lines (short):** retinal tufts/folds**Green outline filled with red:** red blood in vitreous**GREEN:** opacities in vitreous

OD:



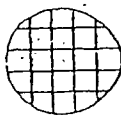
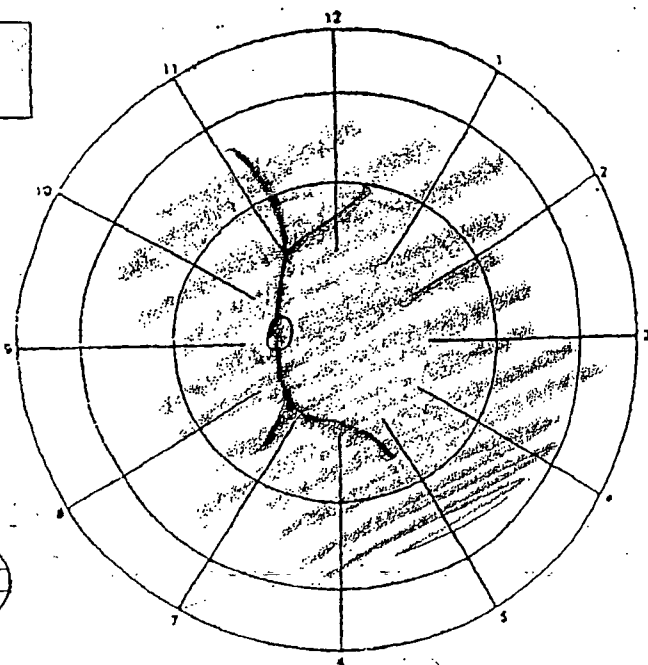
OD:

LENS USED: 20D / 28D / 30D / 2.2D / 78D  
CONTACT LENS /SCLERAL DEPRESSION: ☒ YES ☐ NO

FINDINGS:

PVD  
w RD or  
retinal tear

OS:



OS:

LENS USED: 20D / 28D / 30D / 2.2D / 78D  
CONTACT LENS /SCLERAL DEPRESSION: ☒ YES ☐ NO

FINDINGS:

PVD  
w RD or  
retinal tear

☒ The above findings were discussed at length with the patient. All features of Retinal Detachment, as well as, all associated consequences were discussed, reviewed, emphasized to the patient. The patient understands return time factors in the event of any signs of a retinal detachment.

Return:

2017

Dr.:

Pupils: ☒ PERRL \_\_\_\_\_ APD: ☒ (neg.) ☐ (pos.) \_\_\_\_\_ ☐ NYSTAGMUS

Muscles: (primary gaze) Orthotropia ☒ ☐ ET Orthophoria ☒ ☐ XT Rotations: full OU ☒ Ductions \_\_\_\_\_ Versions \_\_\_\_\_ NPC (if abn) \_\_\_\_\_ NPA (if abn) \_\_\_\_\_

Lids (upper/lower or the lid position) ☒ Abn: ectropion / lid edema RUL ☐ Rosacea ☐ Crusting ☐ Blepharitis ☐ Meibomitis ☐ Dermatochal ☐ Lid Laxity ☐ Entrop. ☐ Ectrop. ☐ Ptosis ☐ Edema ☐ Papilloma ☐ Xanthelasma ☐ Lid Lesion

Lacrimal Glands & Drainage (OU) ☒ Abn: \_\_\_\_\_ Preauric. Nodes: absent ☒ present: ☐ Right ☐ Left Conjunctiva NL OU (bulbar/palpeb) ☐

Cornea ☒ tear film abnormality ☐ ping. ☐ ptery. ☐ concret. ☐ FB ☐ lesion

Anterior Chamber (angle & deep OCT) ☒ Abn: \_\_\_\_\_ Lens (Clear-OCT) ☒ Abn: \_\_\_\_\_

Lens (Clear-OCT) ☒ Abn: \_\_\_\_\_

Vitreous (Clear-OCT) ☒ PVD ☐ VH ☐ synchysis

Fundi: ☒ Dilated ☒ Direct ☒ Indirect ☒ Depress ☒ 78/SF66 ☒ 28/30D ☒ Contact

DX: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

☐ ref. error ☐ asthenopia ☐ strabismus ET/XT ☐ blepharitis ☐ conj/viral/bact/allergic ☐ lid lesion benign/malig ☐ ptosis ☐ ectrop/cic ☐ entropion ☐ iritis ☐ corneal/conj FB ☐ pterygium/ping ☐ narrow < ☐ open < glau. ☐ narrow < glau. ☐ pseudophakia ☐ floater ☐ cat ☐ vitreous hemorrh. ☐ optic neuritis/isch ☐ PVD ☐ papilledema ☐ pseudopapilledema ☐ ret vasc disease ☐ BDR ☐ prolif DR ☐ MD ☐ BRVO ☐ choroidal nevus ☐ retinal tear ☐ macular hole/fib ☐ macular edema ☐ lattice degen

GROSS VISUAL FIELD: ☒ wnl ☒ su

palp fissure mm mm MRD 2.0 mm 4.5 mm lev. function mm mm

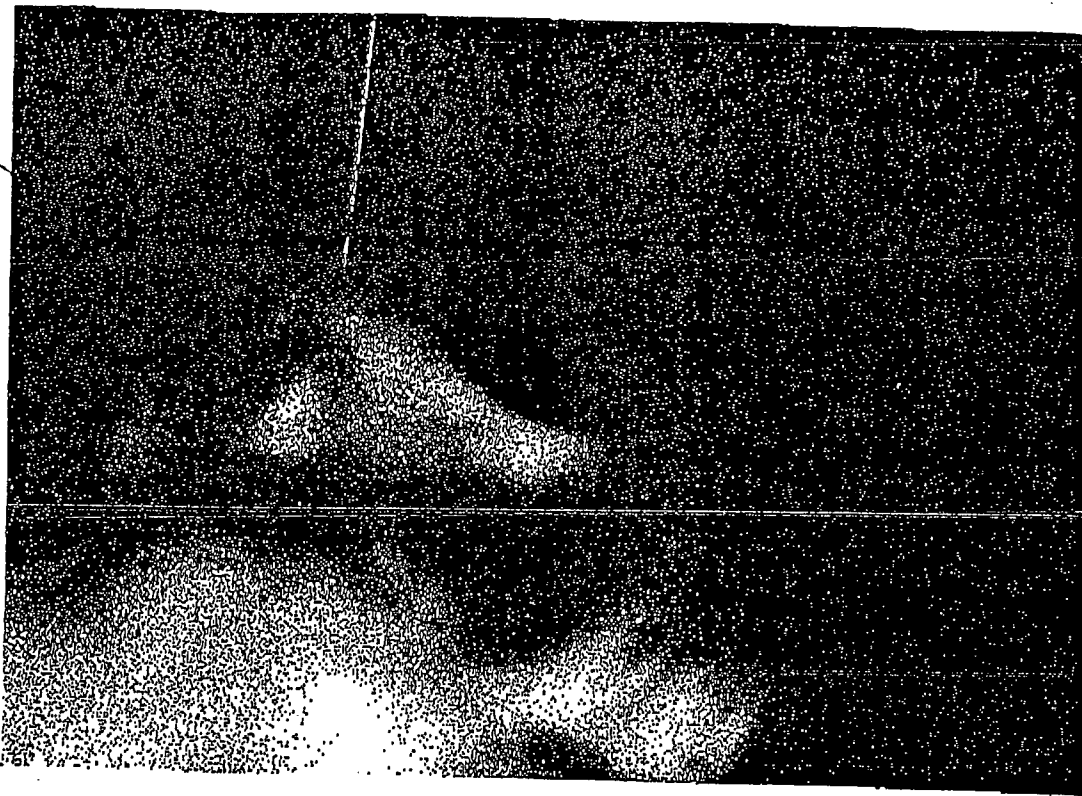
GONIO: OD OS PAS Pigment

no bony sbn. no hyposthenia in clefts brow ptosis 20 photo RUL (? due to edema of lid)

Plan: D/w patient &/or companion in detail 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. ☐ Tears prn ☐ lid hygiene ☐ Rx-F/M

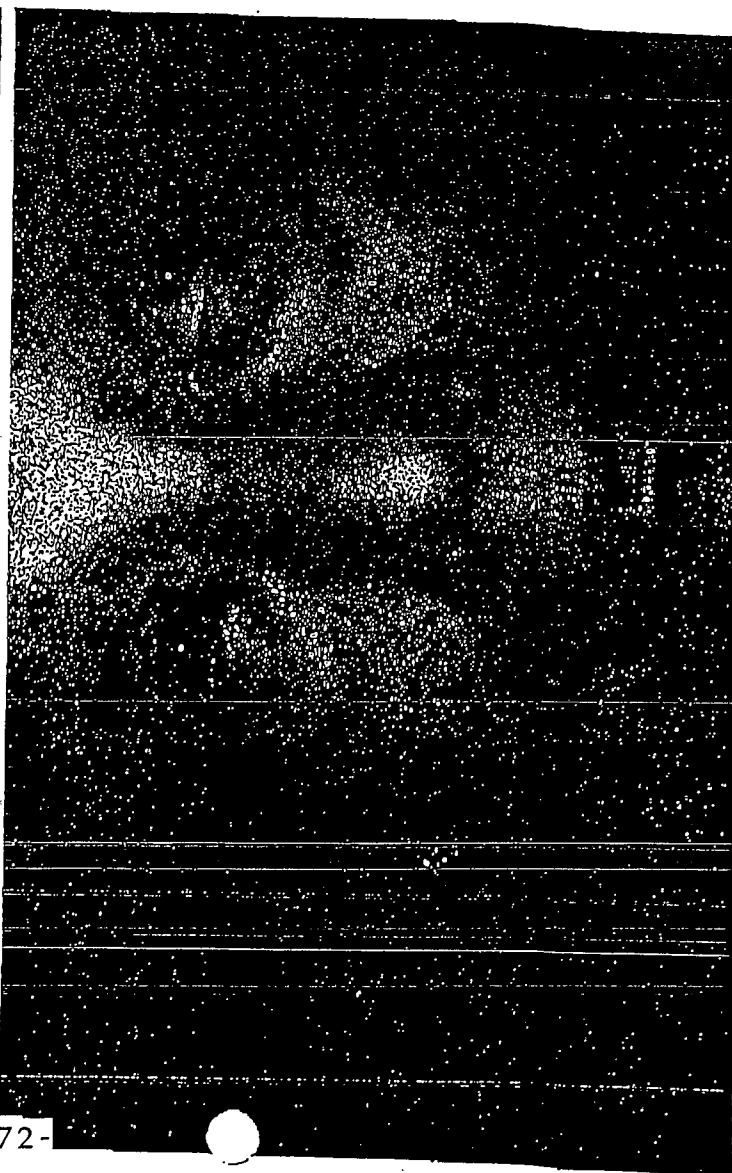
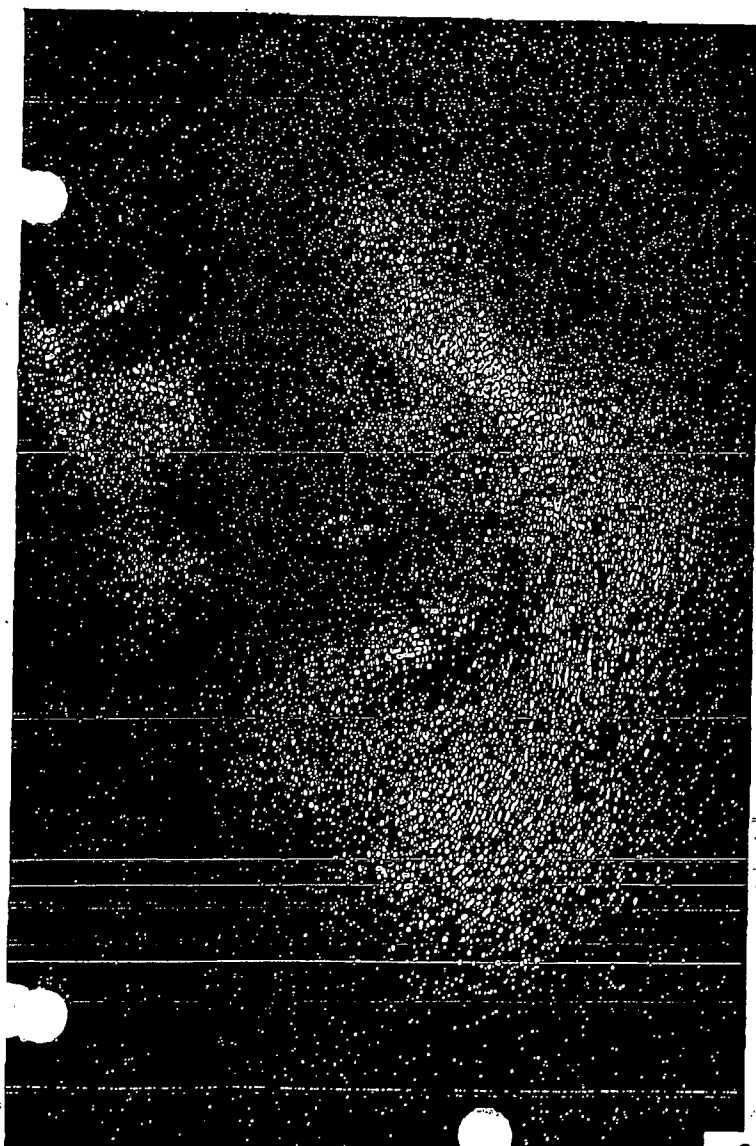
☐ cataract issues/sx ☐ eye safety ☐ glauc./meds/side effects ☐ signs of RD & precautions ☐ ASHD +/- HTN effect on eyes ☐ DM & effects on eyes ☐ monocular precautions ☐ R/B/A of surgery ☐ Driving restrictions due to Va ☐ sun issues ☐ AMD/Vit ☐ letter sent to: Dr. \_\_\_\_\_ ☐ All questions answered

Return: \_\_\_\_\_ Signature: \_\_\_\_\_



PALMETTO EYE SPECIALISTS PA

09.09.12



-272-

IE:

CC:

HPJ:

DATE:

CG Assisted Check List

PMH: ☐ reviewed and is negative

☐ arthritis osteo rheumatoid  
☐ ASHD ☐ asthma  
☐ cancer  
☐ CVA ☐ diabetes  
☐ hypertension ☐ MI  
☐ thyroid hypo hyper  
☐ cholesterol  
☐ other

SOCIAL HISTORY:

☐ cigarettes  
☐ alcohol  
☐ drugs

SYSTEMIC MEDS:

☐ negativeACTIVITY: ☐ full☐ limited☐ none

ALLERGIES:

☐ no known allergies

RECENT HOSPITALIZATION:

FH: ☐ reviewed and is negativeREVIEW OF SYSTEMS: ☐ all ROS listed were asked and found negative

☐ amblyopia  
☐ blindness  
☐ cataract  
☐ glaucoma  
☐ retinal detachment  
☐ ID  
☐ diabetes  
☐ hypertension  
☐ cancer  
☐ other

GENERAL

☐ fatigue  
☐ fever  
☐ weight loss

CARDIOVASC.

☐ chest pain  
☐ difficulty/stairs  
☐ leg pain/walking

MUSC/SKEL

☐ muscle aches  
☐ joint pain/swell.  
☐ PT being followed by MD for these issues

NEURO

☐ headache  
☐ dizziness  
☐ gait disorder

GU

☐ dysuria  
☐ frequency

SKIN

☐ rash  
☐ itching

ENT

☐ sore throat  
☐ hoarseness  
☐ ringing ears

GI

☐ change in bowel habits  
☐ blood in stools

HEMAT

☐ anemia  
☐ bruising

RESPIRATORY

☐ cough  
☐ SOB  
☐ wheezing

PSYCHOL

☐ anxiety  
☐ depression  
☐ PT advised to seek attn. for these issues

EYE MEDS: ☐ noneEYE HISTORY: ☐ negative

☐ macular degen ☐ cataract  
☐ diabetic/back ☐ cat ext  
☐ diabetic/prolf ☐ laser surgery glau  
☐ laser surgery diabetes

☐ glau/open ON☐ glau/narrow☐ other

Trauma OD

PHYSICAL EXAM: BP pulse

leuro  
oriented T/P/P  
obtunded  
disoriented  
mental retardation

Mood

☒ normal  
☐ depressed  
☐ unresponsive  
☐ combative

ANCILLARY TESTS

Dvorina color

Amsler grid

stereopsis

OD

OS

LAME

LAME

FACE

☒ WNL  
☐ Swelling  
☐ Rash  
☐ Rosacea  
☐ Abrasion  
☐ Ecchymosis

CONTACT LENSES

Brand:

B.C.

Dia.

OD

OS

OD

OS

is

T Add +

P/M

Add + 2.00

-273-

F cvc

- 274 -



# Visual Field Documentation and Interpretation

Patient Name: Frances Baur Chart # \_\_\_\_\_ Date: 10/23/12

Test Ordered By: ☐ Dr. Farr ☒ Dr. Diana  
☐ Dr. Meier

Test Performed By: M Smith

Field Ordered: ☒ 30-2 ☐ 24-2 ☐ Macula ☒ Superior 64 (Piosis/Bleph)  
☐ 10-2 Red (Plaquenil) ☐ FF 120 ☐ Other \_\_\_\_\_  
☐ OD ☐ OS ☐ OU ☐ OD first(default)  
+2.00 +2.75 ☐ OS first

## Test Reliability:

☐ High ☐ Moderate ☐ Low ☐ Unreliable  
 If unreliable, secondary to: ☐ Increased fixation losses ☐ False Pos. ☐ False Neg. ☐ Other (see comments)

## VF Interpretation:

| OD                                                | OS                                                |
|---------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Normal                   | <input checked="" type="checkbox"/> Normal        |
| <input type="checkbox"/> Nasal Step               | <input type="checkbox"/> Nasal Step               |
| <input type="checkbox"/> Arcuate Scotoma          | <input type="checkbox"/> Arcuate Scotoma          |
| <input type="checkbox"/> Paracentral Scotoma      | <input type="checkbox"/> Paracentral Scotoma      |
| <input type="checkbox"/> Temporal Wedge           | <input type="checkbox"/> Temporal Wedge           |
| <input type="checkbox"/> Indeterminant Scotoma(s) | <input type="checkbox"/> Indeterminant Scotoma(s) |
| <input checked="" type="checkbox"/> Artifact      | <input type="checkbox"/> Artifact                 |
| <input checked="" type="checkbox"/> Lid           | <input type="checkbox"/> Lid                      |
| <input type="checkbox"/> Ring                     | <input type="checkbox"/> Ring                     |
| <input type="checkbox"/> Homonymous Hemianopia    |                                                   |
| <input type="checkbox"/> Right                    | <input type="checkbox"/> Left                     |
| <input type="checkbox"/> Other                    |                                                   |
| <input type="checkbox"/> Stable                   | <input type="checkbox"/> Stable                   |
| <input type="checkbox"/> Progressed               | <input type="checkbox"/> Progressed               |
| <input checked="" type="checkbox"/> New           | <input type="checkbox"/> New                      |

Plan: ☐ Re-evaluate ☐ OU ☐ OD ☐ OS  
☐ 1 year (routine standard of care) ☐ \_\_\_\_\_ wk(s) ☐ \_\_\_\_\_ mos  
 Indication: ☐ New ☒ Progressed ☐ Unreliable ☐ OD first(default)  
 (if less than 1 year) ☐ OS first

Comments: irregular Piosis RUL Pt wants  
it was reported by

Farr, M.D. / Meier, M.D.

Bollin, O.D. / Amoroso, O.D.

Diana, M.D.

Next Appt 10/29 Cont VF

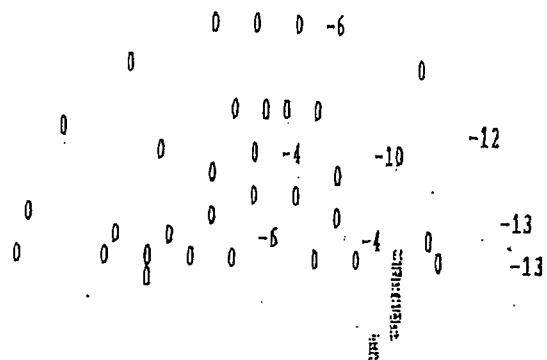
11/14 OCT DCA

Untaped

|                 |               |                |             |                      |
|-----------------|---------------|----------------|-------------|----------------------|
| Patient         | Francis Brown | RIGHT EYE TEST | Date        | 10/23/12             |
| Stimulus...     | Automatic     | Pattern.....   | PTOSIS      | Total Points... 41   |
| Duration..      | 1.6 Sec.      | Strategy....   | FAST THRESH | Presentations.. 99   |
| Interval..      | 0.7 Sec.      | Options.....   | None        | False Posit.... 0/0  |
| Backgrnd..      | 31.5 Asb.     | DB Offset...-  | 3           | False Negat.... 0/0  |
| Patient Age.... | 71            | Correction     | +2.00       | Fix. Losses.... 0/4  |
| IOP             |               | Pupil Size     |             | Elpsd Time: 3 m 53 s |

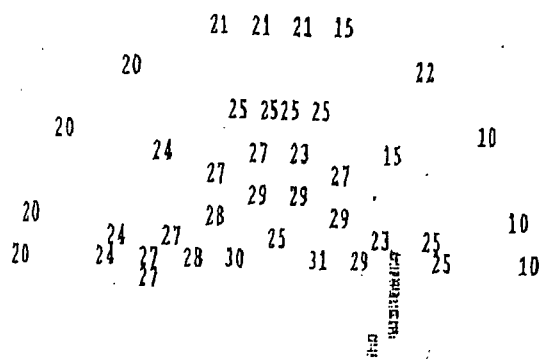
COMPARE TO NORMAL - RIGHT EYE

COMPARISON GRAYSCALE - RIGHT EYE



NUMERIC - RIGHT EYE

STATISTICS - RIGHT EYE



| QUADRANT    | MS      | MD      | LV    |
|-------------|---------|---------|-------|
| Upper Right | 2 1 . 8 | - 3 . 4 | 4 . 9 |
| Upper Left  | 2 4 . 7 | + 0 . 0 | 0 . 0 |
| Lower Left  | 0 . 0   | + 0 . 0 | 0 . 0 |
| Lower Right | 0 . 0   | + 0 . 0 | 0 . 0 |
| Field Total | 2 3 . 4 | - 1 . 7 | 3 . 8 |

CUSTOM PRINT 3 (COMPROM KEY)

BENICIA, CA 94510  
OPTIFIELD I V2.25

SYNEMED INC.

-276-

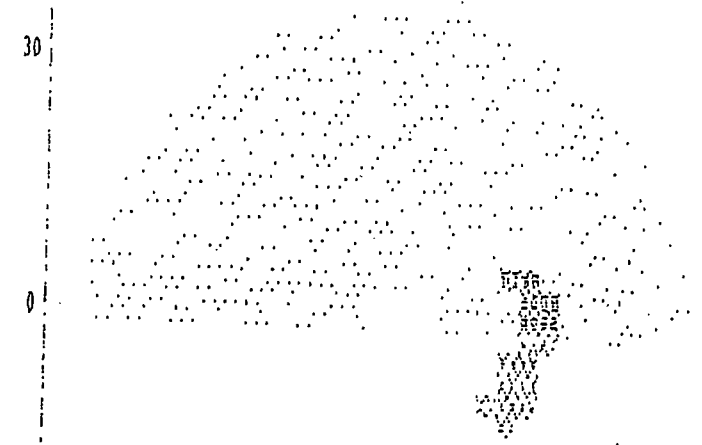
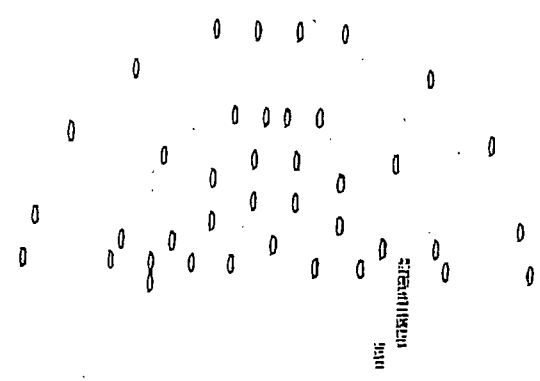
Taped

Patient Frances Baron  
Stimulus... Automatic  
Duration... 1.6 Sec.  
Interval... 0.7 Sec.  
Backgrnd... 31.5 Asb.  
Patient Age... 71  
IOP \_\_\_\_\_  
Pattern... PTOSIS  
Strategy... FAST THRESH  
Options... None  
DB Offset... -3  
Correction +2w  
Pupil Size \_\_\_\_\_

Date 10/23/12  
Total Points... 41  
Presentations... 55  
False Posit... 1/3  
False Negat... 0/0  
Fix. Losses... 1/2  
Elpsd Time: 1 m 53 s

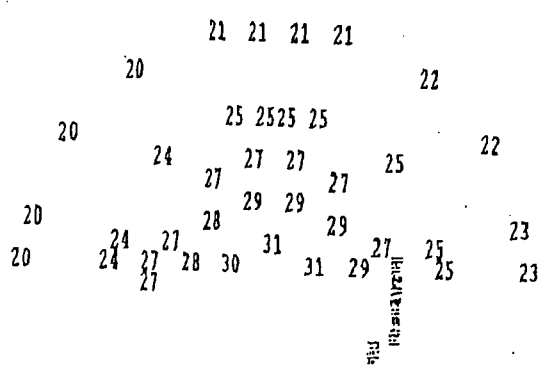
COMPARE TO NORMAL - RIGHT EYE

COMPARISON GRAYSCALE - RIGHT EYE



NUMERIC - RIGHT EYE

STATISTICS - RIGHT EYE



| QUADRANT    | MS   | MD    | LV  |
|-------------|------|-------|-----|
| Upper Right | 25.3 | + 0.0 | 0.0 |
| Upper Left  | 24.7 | + 0.0 | 0.0 |
| Lower Left  | 0.0  | + 0.0 | 0.0 |
| Lower Right | 0.0  | + 0.0 | 0.0 |
| Field Total | 25.1 | + 0.0 | 0.0 |

CUSTOM PRINT 3 (COMENORM KEY)

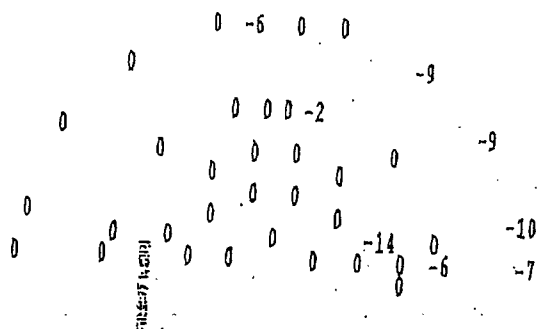
BENICIA, CA 94510  
OPTIFIELD I V2.25  
--277--

SYNEMED INC.

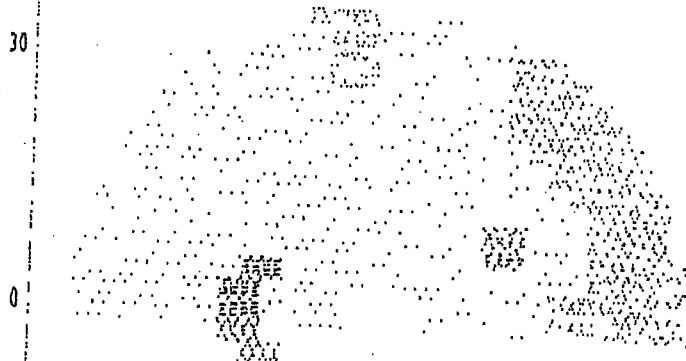
Patient Frances Barron Untaped

|                       |                           |                      |          |
|-----------------------|---------------------------|----------------------|----------|
| Stimulus... Automatic | Pattern.... LEFT EYE TEST | Date                 | 10/23/12 |
| Duration... 1.6 Sec.  | Strategy.... PTOSIS       | Total Points...      | 41       |
| Interval... 0.7 Sec.  | Options..... FAST THRESH  | Presentations..      | 101      |
| Backgrnd... 31.5 Asb. | DB Offset... -3           | False Posit....      | 0/0      |
| Patient Age.... 71    | Correction                | False Negat....      | 0/0      |
| IOP                   | Pupil Size                | Fix. Losses....      | 4/4      |
|                       |                           | Elpsd Time: 3 m 49 s |          |

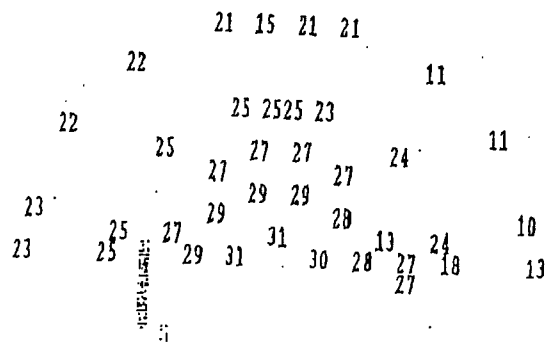
COMPARE TO NORMAL - LEFT EYE



COMPARISON GRAYSCALE - LEFT EYE



NUMERIC - LEFT EYE



STATISTICS - LEFT EYE

| QUADRANT    | MS   | MD    | LV  |
|-------------|------|-------|-----|
| Upper Right | 21.8 | - 2.8 | 4.3 |
| Upper Left  | 25.0 | - 0.3 | 1.3 |
| Lower Left  | 0.0  | + 0.0 | 0.0 |
| Lower Right | 0.0  | + 0.0 | 0.0 |
| Field Total | 23.5 | - 1.6 | 3.5 |

CUSTOM PRINT 3 (COMPNORM KEY)

BENICIA, CA 94510

SYNEMED INC.

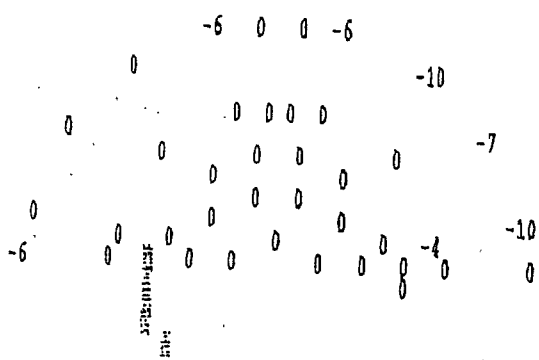
OPTIFIELD I V2.25

Taped

Patient Francis Bacon LEFT EYE TEST  
Stimulus... Automatic Pattern... PTOSIS  
Duration... 1.6 Sec. Strategy... FAST THRESH  
Interval... 0.7 Sec. Options... None  
Backgrnd... 31.5 Asb. DB Offset... -3  
Patient Age... 71 Correction +2.75  
IOP \_\_\_\_\_ Pupil Size \_\_\_\_\_

Date 10/23/12  
Total Points... 41  
Presentations... 78  
False Posit... 0/1  
False Negat... 0/1  
Fix. Losses... 3/3  
Elpsd Time: 2 m 49 s

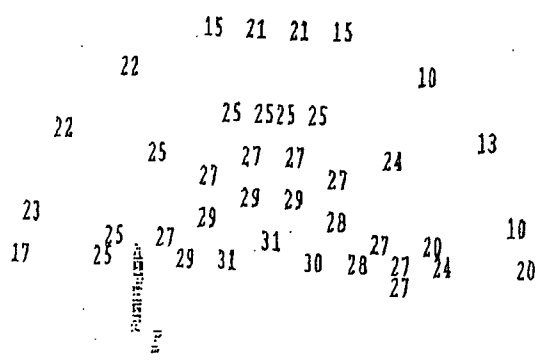
COMPARE TO NORMAL - LEFT EYE



COMPARISON GRAYSCALE - LEFT EYE



NUMERIC - LEFT EYE



STATISTICS - LEFT EYE

| QUADRANT    | MS   | ND    | LV  |
|-------------|------|-------|-----|
| Upper Right | 22.8 | - 1.8 | 3.4 |
| Upper Left  | 24.6 | - 0.6 | 1.8 |
| Lower Left  | 0.0  | + 0.0 | 0.0 |
| Lower Right | 0.0  | + 0.0 | 0.0 |
| Field Total | 23.8 | - 1.2 | 2.8 |

CUSTOM PRINT 3 (COMPNORM KEY)

BENICIA, CA 94510  
OPTIFIELD I V2.25  
--279--

SYNEMED INC.

## CONSENT TO TREATMENT FOR FUNDUS PHOTOS OR EXTERNAL PHOTOS

*The Clear Choice*

Kenneth D. Farr, M.D.  
Walter C. Meler, M.D.  
Emily C. Bollin, O.D.  
Deborah M. Amoroso, OD  
Perin W. Diana, Jr., MD

Patient Frances Baron Date 11/04/12

I hereby authorize D. Diana or whomever he may designate to take pictures of me and / or my eyes. The pictures will be used to evaluate my medical condition. They will not be sent to any other individuals without my consent.

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

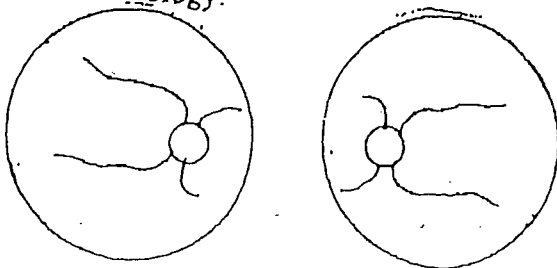
Perin W. Diana, Jr., M.D. \_\_\_\_\_

*external*  
**FUNDUS PHOTOS**

Eye meds for test: Tropicamide 1%, Phenylephrine 2.5% adm. OU

Primary Eye: OD OS OU

Pathology:



*ptau RUL*  
*brow photo (R)*

*photo R. wants to*  
*wait re: surgery*

Indigo Run  
2200 Pembroke Dr.  
Suite 100  
Hilton Head Island, SC 29926  
843.785.2525  
843.785.5394 fax

Sun City  
40 Okatie Center Blvd.  
Suite 302  
Okatie, SC 29909  
843.713.2676  
843.705.2671 fax

id  
4201 East Main Street  
Jageland, SC 29936  
843.726.6509  
843.726.6809 fax

NAME:

CC:

HPI:

Frances Baron

Here to 1 IOP

DATE:

CC Assisted Check List

11/14/12

Cataract on  
 Pain on Right eye  
 Blurred vision on both eyes

PMH: ☐ reviewed and is negative

- ☐ arthritis      osteo      rheumatoid  
☐ ASHD      ☐ asthma  
☐ cancer  
☐ CVA      ☐ diabetes  
☐ hypertension      ☐ MI  
☐ thyroid      hypo      hyper  
☐ cholesterol  
☐ other

SOCIAL HISTORY:

- ☐ cigarettes  
☐ alcohol  
☐ drugs

SYSTEMIC MEDS:

☐ none

- ☐ blurry  
☐ dryness  
☐ flashes  
☐ glare  
☐ redness

☐ negative

ACTIVITY:

☐ full

- ☐ burning  
☐ eye pain  
☐ floaters  
☐ irritation  
☐ tearing

ALLERGIES:

☐ no known allergies

RECENT HOSPITALIZATION:

FH: ☐ reviewed and is negative

- ☐ amblyopia  
☐ blindness  
☐ cataract  
☐ glaucoma  
☐ retinal detachment  
☐ ASHD  
☐ diabetes  
☐ hypertension  
☐ cancer  
☐ other

☒ No change in all history  
 Since 10/23/12

REVIEW OF SYSTEMS: ☐ all ROS listed were asked and found negative

GENERAL

- ☐ fatigue  
☐ fever  
☐ weight loss

CARDIOVASC.

- ☐ chest pain  
☐ difficulty/stairs  
☐ leg pain/walking

MUSC/SKEL

- ☐ muscle aches  
☐ joint pain/swell.  
☐ PT being followed by MD for these issues

NEURO

- ☐ headache  
☐ dizziness  
☐ gait disorder

GU

- ☐ dysuria  
☐ frequency

SKIN

- ☐ rash  
☐ itching

ENT

- ☐ sore throat  
☐ hoarseness  
☐ ringing ears

GI

- ☐ change in bowel habits  
☐ blood in stools

RESPIRATORY

- ☐ cough  
☐ SOB  
☐ wheezing

HEMAT

- ☐ anemia  
☐ bruising

PT advised to seek attn. for these issues

PSYCHOL

- ☐ anxiety  
☐ depression

EYE MEDS: ☐ noneEYE HISTORY: ☐ negative

- ☐ macular degen  
☐ diabetic/back  
☐ diabetic/prolif  
☐ laser surgery diabetes  
☒ cataract on  
☐ cat ext  
☐ laser surgery glau

- ☒ glau/open on  
☐ glau/narrow  
☐ other

Kataract

glau on

PHYSICAL EXAM: BP \_\_\_\_\_ pulse \_\_\_\_\_

Neuro

- ☒ oriented T/P/P  
☐ obtunded  
☐ disoriented  
☐ mental retardation

Mood

- ☒ normal  
☐ depressed  
☐ unresponsive  
☐ combative

ANCILLARY TESTS

Dvorine color

Amsler grid

stereopsis

OD

OS

FACE

- ☒ WNL  
☐ Swelling  
☐ Rash  
☐ Rosacea  
☐ Abrasion  
☐ Ecchymosis

CONTACT LENSES

Brand:

B.C.

Dia.

OD

OS

OD

OS

F<sub>cvc</sub>

F/M

Add +

-281-

Pupils: ☒ PERRL \_\_\_\_\_ APD: ☒ (neg.) ☐ (pos.) ☐ NYSTAGMUS

Muscles: (primary gaze)

Orthotropia ☒ ☐ ET

Orthophoria ☐ ☐ XT

Rotations: full OU ☐

Ductions \_\_\_\_\_

NPC (if abn) \_\_\_\_\_

Versions \_\_\_\_\_

NPA (if abn) \_\_\_\_\_

Lids: (upper/lower) \_\_\_\_\_

☐

Abn: Grave's hyperthyroidism R

Lacrimal Glands

☐

Abn: \_\_\_\_\_

& Drainage (ou)

Orbit (no palpation - bony) (no touch)

☐

Abn: \_\_\_\_\_

Preauric. Nodes: absent ☐

present: ☐ Right ☐ Left

Conjunctiva

ML OU (bulbar/palpebral)

☐

|     | Bulb. | OD | OS | Palp | OD | OS |
|-----|-------|----|----|------|----|----|
| inj |       |    |    |      |    |    |
| fol |       |    |    |      |    |    |
| per |       |    |    |      |    |    |

- ☐ Rosacea
- ☐ Blepharitis
- ☐ Dermatochal
- ☐ Entrop.
- ☐ Ptochia
- ☐ Papilloma
- ☐ Xanthelasma
- ☐ Lid Lesion
- ☐ Crusting
- ☐ Meibomitis
- ☐ Lid Laxity
- ☐ Entrop.
- ☐ Edema

- ☐ ping.
- ☐ ptery.
- ☐ conjunct.
- ☐ FB
- ☐ lesion

Cornes

(at least one of cornea, sclera)

☐

|    | Inter | film | abnormality |
|----|-------|------|-------------|
| OD |       |      |             |
| OS |       |      |             |

- ☐ FB
- ☐ micropan
- ☐ gullae
- ☐ pign.
- ☐ furrow
- ☐ SPK
- ☐ opacity

Ant. Chamber

(wide in deep eye)

☐

Abn: \_\_\_\_\_

Iris (post-op)

☐

Abn: \_\_\_\_\_

Lens (post-op)

☐

|    | NS | Cont | PSC | IOL | PCO | Pseudo subfol. |
|----|----|------|-----|-----|-----|----------------|
| OD |    |      |     |     |     |                |
| OS |    |      |     |     |     |                |

T 1/2 Time 1/2

Vitreous (post-op)

☐

☐ PVD ☐ VH ☐ dyscrasia

Fundr:

- ☒ Dilated
- ☐ Direct
- ☐ Indirect
- ☐ Dystopia
- ☐ 180/360
- ☐ Contact

- macula ☐ wnl ☐ rpa ☐ drusen ☐ hem ☐ edema ☐ hole/fibrosis
- retina ☐ wnl ☐ rpa ☐ ven. dil ☐ hem ☐ microvasc
- periph. ☐ wnl ☐ lattice ☐ rpa ☐ ret. tear ☐ RD
- ☐ peripap. atrophy ☐

OD

OS

wnl/color, NPL

wnl/color, NPL

C/D: 0.3 0

C/D: 0.3 0

good mm o

DX: 1. Grave's hyperthyroidism (H)  
2. Grave's ophthalmopathy  
3. \_\_\_\_\_  
4. \_\_\_\_\_

Plan: D/w patient &/or companion in detail

1. Cont. glaucoma  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. ☐ Tarsal pin ☐ lid hygiene ☐ Rx-P/M

- ☐ ref. error
- ☐ blepharitis
- ☐ ptosis
- ☐ iris
- ☐ narrow
- ☐ cat
- ☐ PVD
- ☐ opt atrophy
- ☐ ret vasc disease
- ☐ BRAO
- ☐ ARMD
- ☐ RD
- ☐ anisotropia
- ☐ conj/viral/bact/allergic
- ☐ ectropion/scler
- ☐ corneal/conj FB
- ☐ open < glau.
- ☐ pseudophakia
- ☐ vitreous hemorrh.
- ☐ papilledema
- ☐ BDR
- ☐ BRVO
- ☐ macular hole/fib
- ☐ retinal tear
- ☐ strabismus ET/XT
- ☐ lid lesion benign/malign
- ☐ entropion
- ☐ pterygium/ping
- ☐ narrow < glau.
- ☐ floater
- ☐ optic neuritis/isch
- ☐ pseudopapillary edema
- ☐ prolif DR
- ☐ choroidal neov.
- ☐ macular edema
- ☐ lattice degen

- ☐ Cataract issues/ex
- ☐ eye safety
- ☐ glove/mask/side effects
- ☐ signs of RD & precautions
- ☐ ASHD +/- HTN effect on eyes
- ☐ DM & effects on eyes
- ☐ monocular precautions
- ☐ R/B/A of surgery
- ☐ Driving restrictions due to Va
- ☐ sun issues
- ☐ AMD/Vit
- ☐ letter sent to: Dr. \_\_\_\_\_
- ☐ All questions answered

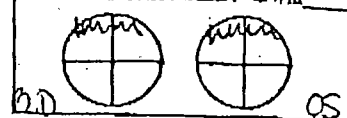
Return:

do  
at  
1/2

Signature:

[Signature]

GROSS VISUAL FIELD: ☐ wnl



|               | OD     | OS     |
|---------------|--------|--------|
| palp fissure  | mm     | mm     |
| MRD           | 0.5 mm | 2.0 mm |
| lev. function | mm     | mm     |

GONIO: OD OS

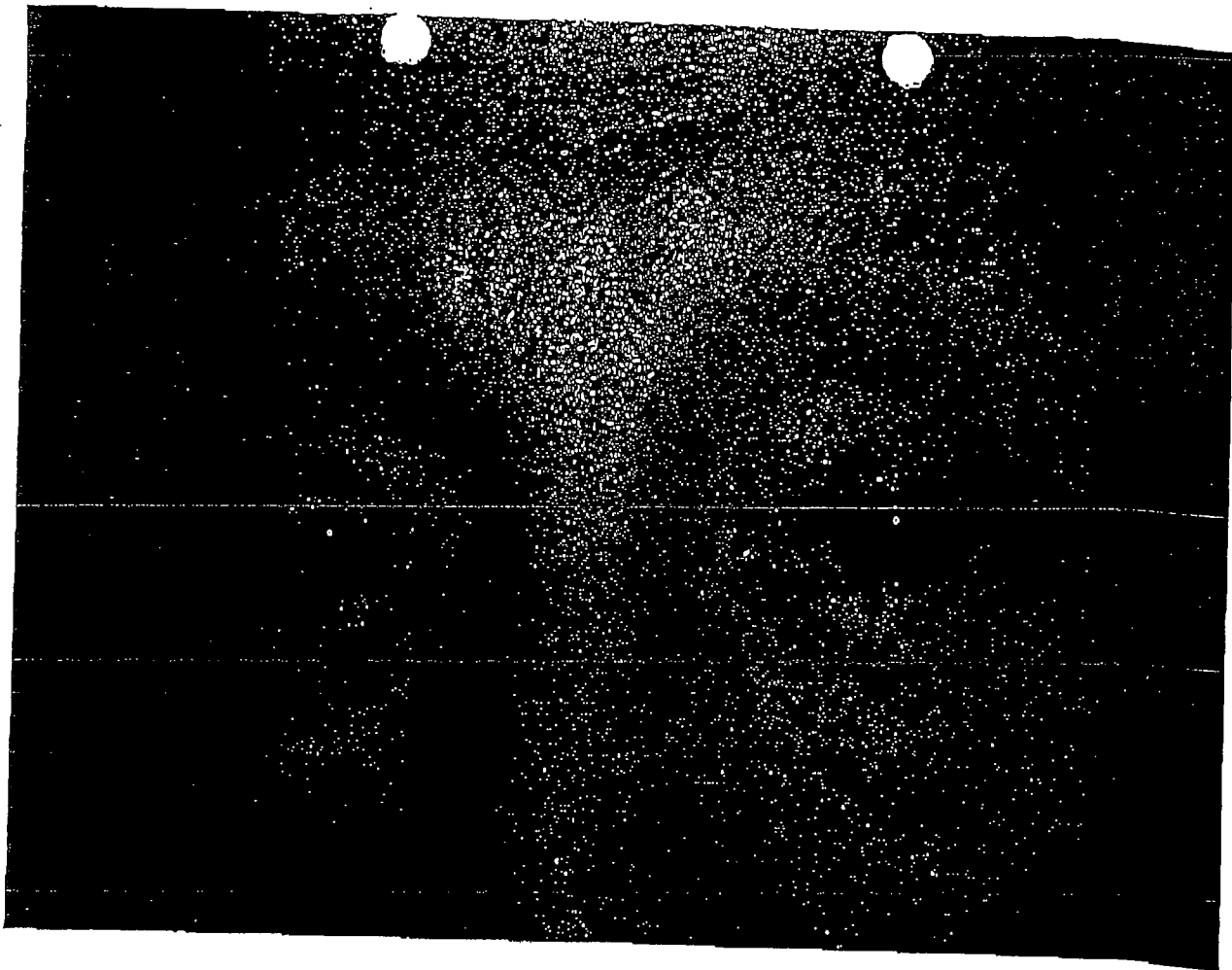
[X] [X]

PAS

Pigment

note: ? some constriction of pupil in the L





Frances Barru 11/14/12

*[Handwritten signature]*

SPECIAL TESTING

Date: 11/14/12

Name: Frances Baren

Tests:

☐ VF

Type: ☐ 30-2 ☐ 24-2 ☐ 120 PV/FT ☐ OD ☐ OS ☐ OU ☐ Ptosis/Bleph

☐ A-Scan

☐ OD ☐ OS ☐ OU

☐ External Photos

☐ OD ☐ OS ☐ OU

☐ Fundus Photography

☐ OD ☐ OS ☐ OU

☒ HRT / OCT

☐ OD ☐ OS ☒ OU Nerve

☐ Corneal Topography

☐ OD ☐ OS ☐ OU

☐ Corneal Pachymetry

☐ OD ☐ OS ☐ OU

Testing ordered by: Dr. Diana

Testing performed by: M. Smith

Interpretation and Report:

POCV SCAN NO - optic nerve unchanged  
as in 11/14/12 - 90237

next appt 11/20/12 (VF)

Farr, MD / Meier, MD / Bollin, OD / Diana, MD / Amoroso, OD

\*\* Results given to pt in office / by phone.

STRATUS OCT  
RNFL Thickness Average Analysis Report - 4.0.7 (0132)

BARON. FRANCES

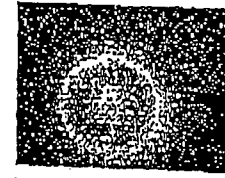
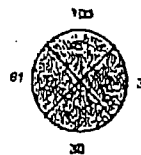
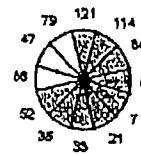
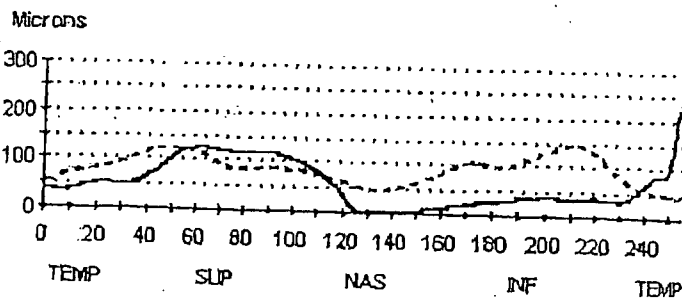
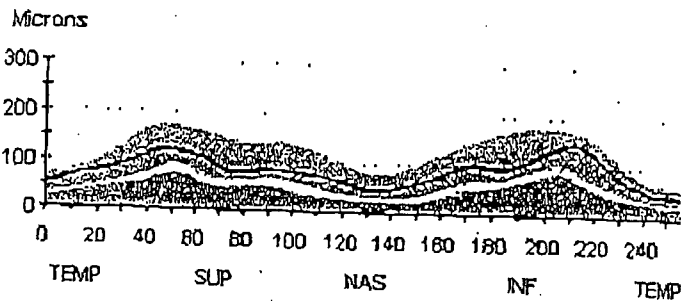
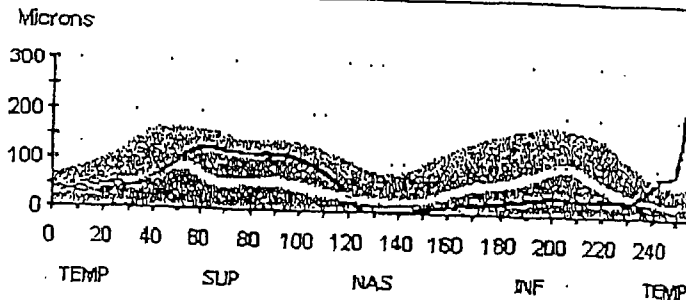


DOB: [REDACTED] ID: NA, Female

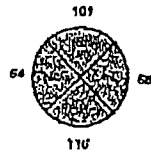
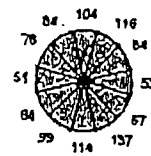
Scan Type: Fast RNFL Thickness (3,4)

Scan Date: 11/14/2012

Scan Length: 10.87 mm

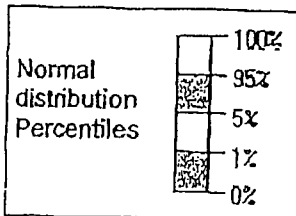


|                          |   |
|--------------------------|---|
| Signal Strength (Max 10) | 3 |
| Analysis Confidence Low  |   |



|                          |   |
|--------------------------|---|
| Signal Strength (Max 10) | 6 |
|                          |   |

|    |            |         |
|----|------------|---------|
| OD | Scans used | 1, 2, 3 |
| OS | Scans used | 1, 2, 3 |



|           | OD (N=3) | OS (N=3) | OD-OS   |
|-----------|----------|----------|---------|
| ImaxSmax  | 0.29     | 1.21     | -0.92   |
| SmaxImax  | 3.48     | 0.83     | 2.63    |
| SmaxTavg  | 2.04     | 1.80     | 0.24    |
| ImaxTavg  | 0.59     | 2.17     | -1.58   |
| SmaxNavg  | 3.83     | 1.92     | 1.91    |
| Max-Min   | 231.00   | 04.00    | 127.00  |
| Smax      | 25.00    | 22.00    | 3.00    |
| Imax      | 38.00    | 48.00    | -112.00 |
| Savg      | 105.00   | 101.00   | 4.00    |
| Iavg      | 30.00    | 16.00    | -86.00  |
| Avg.Thick | 57.24    | 87.41    | -30.17  |

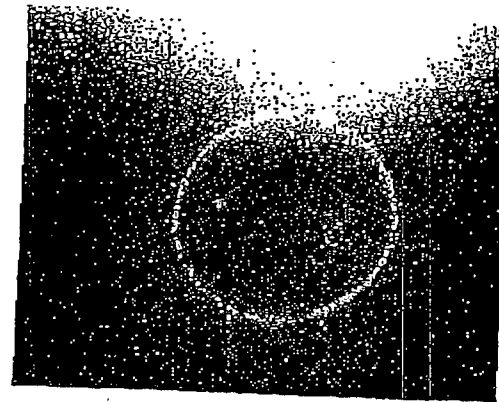
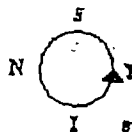
Signature: \_\_\_\_\_

Physician: PERIN DIANA JR, MD

BARON  
FRANCES  
DOB: [REDACTED], ID: NA, Female

Scans to process: 6  
Total Scans 6

11/14/2012 12:04:41 PM OD Fast RNFL Thickness (3.4)  
11/14/2012 12:05:20 PM OS Fast RNFL Thickness (7.3)



Brightness Contrast

[Vertical sliders for brightness and contrast]

Save comment for the selected scan

3 ☒ Grayscale ☐ Default

☐ Log Abs. Refl.

Level Window % Zoom

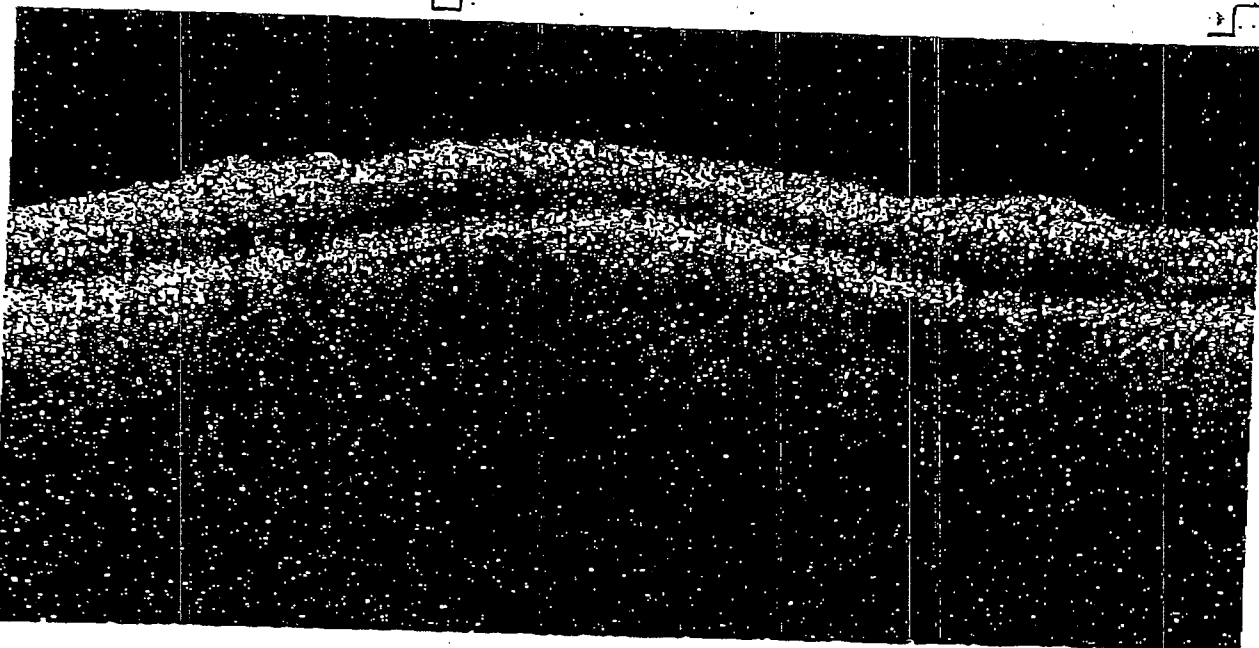
[Vertical sliders for level, window, and zoom]

Width: 10.87 (mm) 256 (scans)  
Depth: 2 (mm) 1024 (pixels)

Analyze

Export JPEG

Cancel



-286-

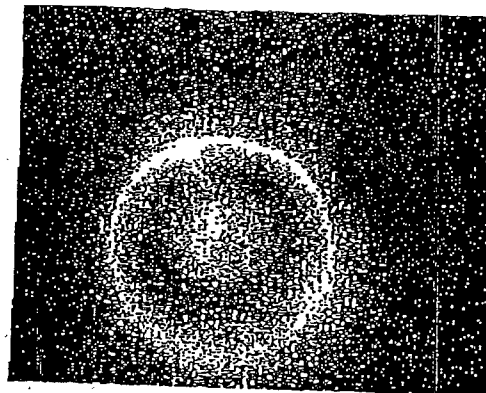
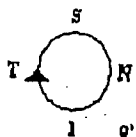
FRANCES

DOB: [REDACTED], ID: NA, Female

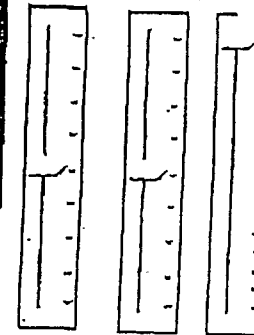
Scans to process: 6

Total Scans 6

11/14/2012 12:05:20 PM OS Fast RNFL Thickness (3.4)



Brightness Contrast %



Save comment for the selected scan

GrayScale

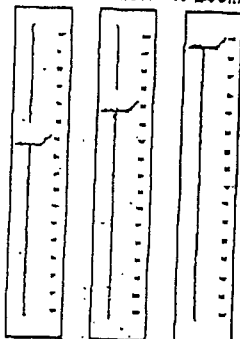
Default

Log Abs. Refl.

Signal Strength (Max 10)

3

Level Window % Zoom

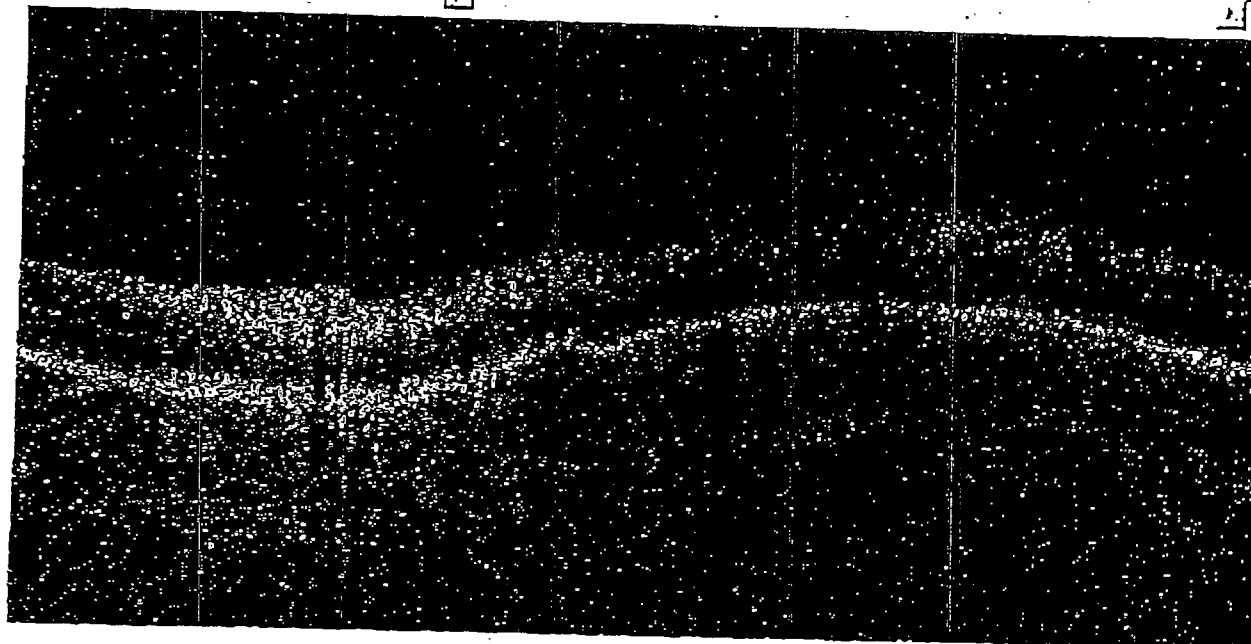


Width: 10.87 (mm) 256 (scans)  
Depth: 2 (mm) 1024 (pixels)

Analyze

Export JPEG

Cancel



-287-

# Visual Field Documentation and Interpretation

Patient Name: Frances Brion Chart # \_\_\_\_\_ Date: 11/20/12

Test Ordered By: ☐ Dr. Farr ☒ Dr. Diana

Test Performed By: K. Smith

Field Ordered: ☒ 30-2 ☐ 24-2 ☐ Macula ☐ Superior 64 (Ptois/Bleph)  
☐ 10-2 Red (Plaquenil) ☐ HF 120 ☐ Other \_\_\_\_\_

☐ OD ☐ OS ☐ OU ☐ OD first(default)  
+2.00 +2.75 ☐ OS first

Test Reliability: ☐ High ☒ Moderate ☐ Low ☐ Unreliable

If unreliable, secondary to: ☐ Increased fixation losses ☐ False Pos. ☐ False Neg. ☐ Other (see comments)

VF Interpretation:

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Normal<br><input type="checkbox"/> Nasal Step<br><input type="checkbox"/> Arcuate Scotoma<br><input type="checkbox"/> Paracentral Scotoma<br><input type="checkbox"/> Temporal Wedge<br><input type="checkbox"/> Indeterminant Scotoma(s)<br><input type="checkbox"/> Artifact<br><input type="checkbox"/> Lid <input type="checkbox"/> Ring<br><input type="checkbox"/> Homonymous Hemianopia<br><input type="checkbox"/> Right <input type="checkbox"/> Left<br><input checked="" type="checkbox"/> Other <u>? too close to follow</u> | <input type="checkbox"/> OS<br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Nasal Step<br><input type="checkbox"/> Arcuate Scotoma<br><input type="checkbox"/> Paracentral Scotoma<br><input type="checkbox"/> Temporal Wedge<br><input type="checkbox"/> Indeterminant Scotoma(s)<br><input type="checkbox"/> Artifact<br><input type="checkbox"/> Lid <input type="checkbox"/> Ring |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

☐ Stable ☐ Progressed ☒ New

Plan: ☒ Re-evaluate ☐ OU ☐ OD ☐ OS  
☐ 1 year (routine standard of care) ☐ \_\_\_\_\_ wk(s) 3 mos  
 Indication: (If less than 1 year) ☐ New ☐ Progressed ☐ Unreliable ☐ OD first(default)  
☐ OS first

Comments: CVT Med  
CVT Med 2-14-13 (Nv)

Farr, M.D. / Meier, M.D.

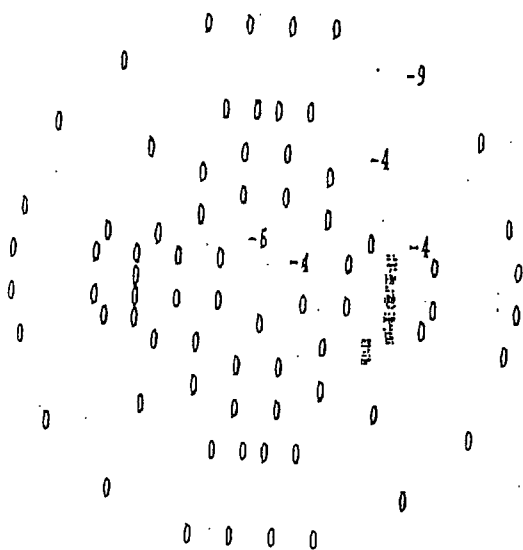
Bollin, O.D. / Amoroso, O.D.

Diana, M.D.

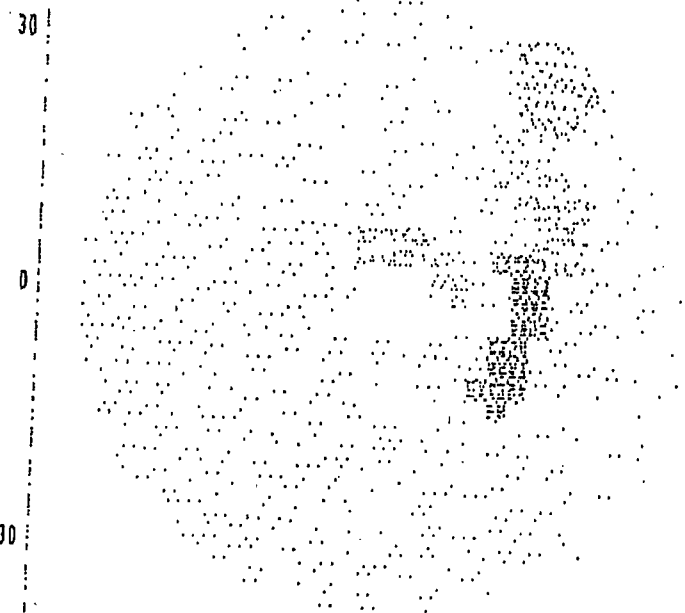
Automatic  
 Duration.. 1.6 Sec.  
 Interval.. 0.7 Sec.  
 Backgrnd.. 31.5 Asb.  
 Patient Age.... 71  
 IOP  
 Pattern.....CENT 30  
 Strategy....FAST THRESH  
 Options.....None  
 DB Offset...-3  
 Correction  
 Pupil Size

Date 11/20/12  
 Total Points... 82  
 Presentations... 125  
 False Posit..... 0/5  
 False Negat..... 0/0  
 Fix. Losses..... 0/5  
 Elpsd Time: 4 m 25 s

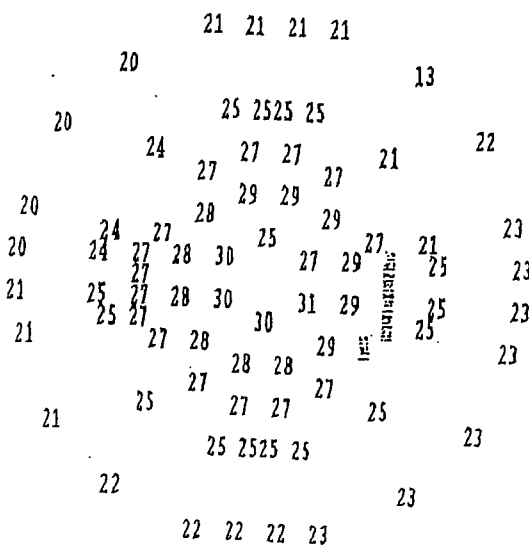
COMPARE TO NORMAL - RIGHT EYE



COMPARISON GRAYSCALE - RIGHT EYE



NUMERIC - RIGHT EYE



STATISTICS - RIGHT EYE

| QUADRANT    | MS   | MD    | LV  |
|-------------|------|-------|-----|
| Upper Right | 24.1 | - 1.1 | 2.4 |
| Upper Left  | 24.7 | + 0.0 | 0.0 |
| Lower Left  | 25.1 | + 0.0 | 0.0 |
| Lower Right | 25.4 | + 0.0 | 0.0 |
| Field Total | 24.9 | - 0.3 | 1.4 |

CUSTOM-PRINT 3-(COMPNORM KEY)

BENICIA, CA 94510  
 OPTIFIELD I V2.25

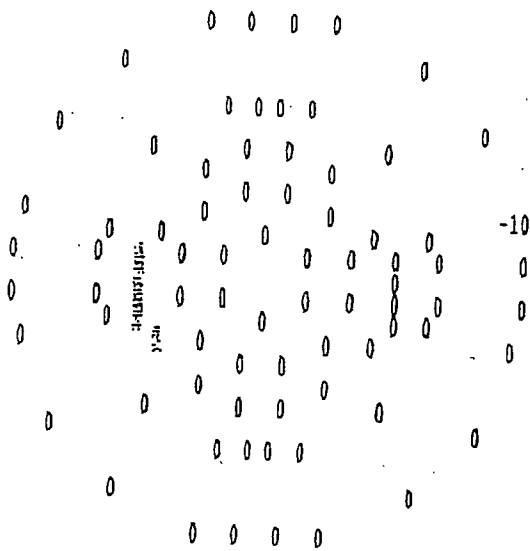
SYNEMED INC.

10 given by phone 11/28/12 (DN)

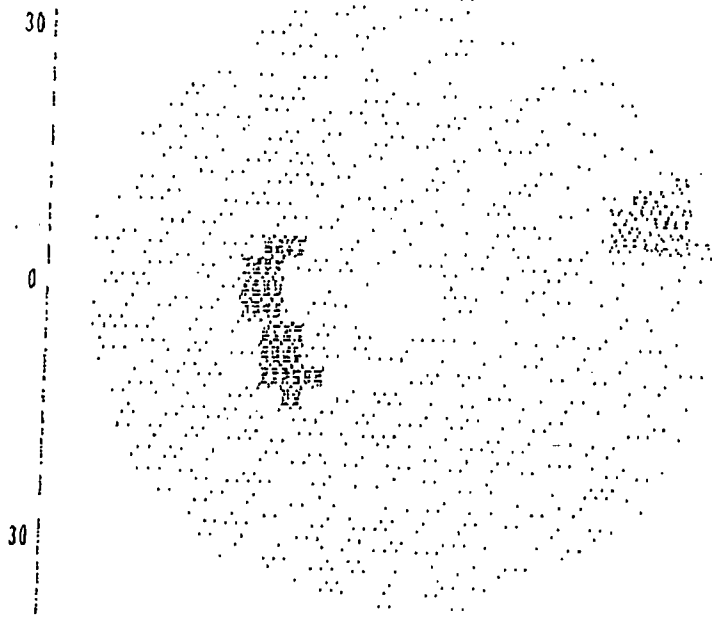
Duration... 1.8 Sec.  
 Interval... 0.7 Sec.  
 Backgrnd... 31.5 Asb.  
 Patient Age... 71  
 IOP  
 Strategy... FAST THRESH  
 Options... None  
 DB Offset... -3  
 Correction  
 Pupil Size

Total Points... 82  
 Presentations... 103  
 False Posit... 0/6  
 False Negat... 0/0  
 Fix. Losses... 2/4  
 Elpsd Time: 3 m 20 s

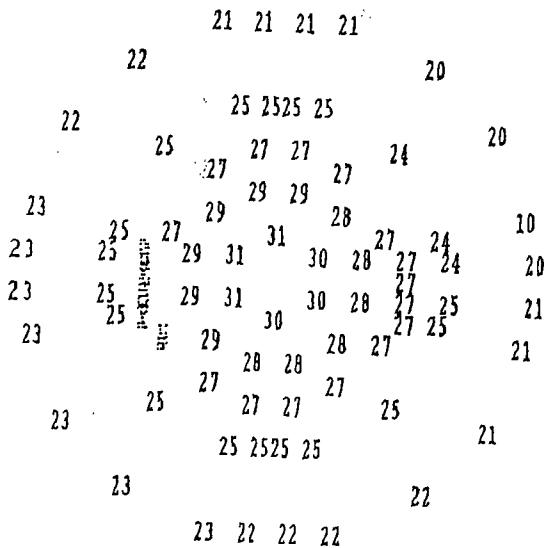
COMPARE TO NORMAL - LEFT EYE



COMPARISON GRAYSCALE - LEFT EYE



NUMERIC - LEFT EYE



STATISTICS - LEFT EYE

| QUADRANT    | MS   | MD    | LV  |
|-------------|------|-------|-----|
| Upper Right | 24.2 | - 0.5 | 2.1 |
| Upper Left  | 25.3 | + 0.0 | 0.0 |
| Lower Left  | 25.4 | + 0.0 | 0.0 |
| Lower Right | 25.1 | + 0.0 | 0.0 |
| Field Total | 25.1 | - 0.1 | 1.1 |

CUSTOM PRINT 3 (COMPNORM KEY)

BENICIA, CA 94510  
 OPTIFIELD I V2.25

SYNEMED INC.



NAME:

CC:

HPI:

Frances Baron

Here to ✓ IOP, Cataracts

DATE:

2/21/13

CC Assisted Check List

☐ blurry☐ dryness☐ flashes☐ glare☐ redness☐ burning☐ eye pain☐ floaters☐ irritation☐ tearingPMH: ☐ reviewed and is negative☐ arthritis osteo rheumatoid☐ ASHD ☐ asthma☐ cancer☐ CVA ☐ diabetes☐ hypertension ☐ MI☐ thyroid hypo hyper☐ cholesterol☐ other

SOCIAL HISTORY:

☐ negativeACTIVITY: ☐ full☐ cigarettes☐ alcohol☐ drugs☐ limitedSYSTEMIC MEDS: ☐ none

ALLERGIES:

☐ no known allergies

RECENT HOSPITALIZATION:

FH: ☐ reviewed and is negativeREVIEW OF SYSTEMS: ☐ all ROS listed were asked and found negative☐ amblyopia☐ blindness☐ cataract☐ glaucoma☐ retinal detachment☐ ASHD☐ diabetes☐ hypertension☐ cancer☐ other

GENERAL

☐ fatigue☐ fever☐ weight loss

CARDIOVASC.

☐ chest pain☐ difficulty/stairs☐ leg pain/walking

MUSC/SKEL

☐ muscle aches☐ joint pain/swell.☐ PT being followed by MD for these issues

NEURO

☐ headache☐ dizziness☐ gait disorder

GU

☐ dysuria☐ frequency

ENT

☐ sore throat☐ hoarseness☐ ringing ears

GI

☐ change in bowel habits☐ blood in stools

RESPIRATORY

☐ cough☐ SOB☐ wheezing

HEMAT

☐ anemia☐ bruising☐ PT advised to seek attn. for these issues

PSYCHOL

☐ anxiety☐ depression☒ No change in all history  
Since 1/20/12EYE HISTORY: ☐ negative☐ macular degen☐ diabetic/back☐ diabetic/prolif☐ laser surgery diabetes☒ cataract on☐ cat ext☐ laser surgery glau☒ glau/open on☐ glau/narrow☐ otherEYE MEDS: ☐ none

Xalatan gls on

PHYSICAL EXAM: BP pulse

Neuro

☒ oriented T/P/P☐ obtunded☐ disoriented☐ mental retardation

Mood

☒ normal☐ depressed☐ unresponsive☐ combative

ANCILLARY TESTS

Dvorine color

Amsler grid

stereopsis

OD

OS

FACE

☒ WNL☐ Swelling☐ Rash☐ Rosacea☐ Abrasion☐ Ecchymosis

CONTACT LENSES

Brand:

B.C.

Dia.

OD

OS

OD

OS

SC D V A

☐ CL / ☒ CC

D V A

N V A

OD

OS

OD

OS

Add +

F/M

Add + 2.00

411

F<sub>cvc</sub>

Pupils: ☒ PERRL

APD: ☒ (neg.) ☐ (pos.)

☐ NYSTAGMUS

Muscles: (primary gaze)

Orthotropia ☒ ☐ ET

Orthophoria ☒ ☐ XT

Rotations: full OU ☒

Ductions

Versions

Lids (palpebral fissure or skin lid position)

☐

Abn:

brow ptosis

NPC (if abn)

NPA (if abn)

Lacrimal Glands

(as swelling/erythema)

& Drainage (ou)

Orbit (as complete/secondary/ocular) (OU)

☐

Abn:

Preauric. Nodes: absent ☒

present: ☐ Right ☐ Left

Conjunctiva

NL OU (bulbar/palpeb)

☐

Abn:

|     | Bulb. OD | OS | Palp OD | OS |
|-----|----------|----|---------|----|
| inj |          |    |         |    |
| fol |          |    |         |    |
| pap |          |    |         |    |

☐ ping.  
☐ ptery.  
☐ concret.  
☐ FB  
☐ lesion

Cornea

(if clouded or of shape, size) OU

☒

Abn:

|    | tear film | abnormality |
|----|-----------|-------------|
| OD |           |             |
| OS |           |             |

☐ FB  
☐ micropan.  
☐ guttae  
☐ pign.  
☐ furrow ☐ SPK  
☐ opacity

Ant. Chamber (depth & comp OU)

☐

Abn:

Iris (color, size)

☐

Abn:

Lens (size, color)

☐

Abn:

|    | NS       | Cort | PSC | IOL | PCO | Pseudo exfol. |
|----|----------|------|-----|-----|-----|---------------|
| OD | <u>+</u> |      |     |     |     |               |
| OS | <u>+</u> |      |     |     |     |               |

K<sup>20</sup>  
19

Vitreous (color, op)

☒

Abn:

☐ PVD ☐ VH ☐ synchysis

Fundi:

☐ Dilated  
☒ Direct  
☐ Indirect  
☐ Depress  
☐ 78/SF66  
☐ 28/30D  
☐ Contact

macula ☐ wnl ☐ rpe's ☐ drusen ☐ hem ☐ edema ☐ hole/fibrosis

vessels ☐ wnl ☐ v.a. ☐ ven. dil. ☐ hem ☐ microaneu

periph. ☐ wnl ☐ lattice ☐ sen. ☐ ret. tear ☐ RD

☐ peripap. atrophy

☐ wnl ☐ rpe's ☐ drusen ☐ hem ☐ edema ☐ hole/fibrosis

☐ wnl ☐ v.a. ☐ ven. dil. ☐ hem ☐ microaneu

☐ wnl ☐ lattice ☐ sen. ☐ ret. tear ☐ RD

☐ tilted disc

DX: 1.

2.

3.

4.

☐ ref. error ☐ asthenopia ☐ strabismus ET/XT  
☐ blepharitis ☐ conj/viral/bact/allergic ☐ lid lesion benign/malg  
☐ ptosis ☐ ectrop/cic ☐ entropion  
☐ initis ☐ corneal/conj FB ☐ pterygium/ping  
☐ narrow ☐ open ☐ glau. ☐ narrow ☐ glau.  
☐ lat ☐ pseudophakia ☐ floater  
☐ PVD ☐ vitreous hemorr. ☐ optic neuritis/isch  
☐ opt atrophy ☐ papilledema ☐ pseudopapilledema  
☐ ret vasc disease ☐ BDR ☐ prolifer DR  
☐ BRAO ☐ BRVO ☐ choroidal nevus  
☐ ARMD ☐ macular hole/fib ☐ macular edema  
☐ RD ☐ retinal tear ☐ lattice degen

Plan: D/w patient &/or companion in detail

1.

2.

3.

4.

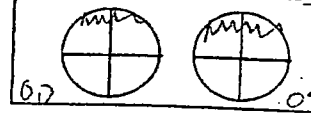
☐ contact issues/sx ☐ eye safety  
☐ glauc./meds/side effects  
☐ signs of RD & precautions  
☐ ASHD +/- HTN effect on eyes  
☐ DM & effects on eyes  
☐ monocular precautions  
☐ R/B/A of surgery  
☐ Driving restrictions due to Va  
☐ sun issues  
☐ AMD/Vit  
☐ letter sent to: Dr.  
☐ All questions answered

Return:

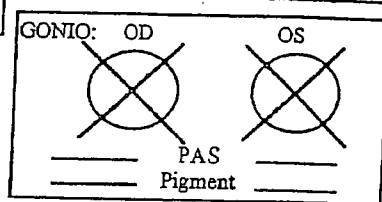
3 m.

Signature:

GROSS VISUAL FIELD: ☐ wnl



|               | OD    | OS     |
|---------------|-------|--------|
| palp fissure  | mm    | mm     |
| MRD           | 0 mm  | 1.0 mm |
| lev. function | 15 mm | 15 mm  |



CONSENT TO TREATMENT FOR  
FUNDUS PHOTOS OR EXTERNAL PHOTOS

*The Clear Choice*

Kenneth D. Farr, M.D.  
Walter C. Meier, M.D.  
Emily C. Bollin, O.D.  
Deborah M. Amoroso, OD  
Perin W. Diana, Jr., MD

Patient Fence Baron Date 2/21/13

I hereby authorize D. Diana or whomever he may designate to take pictures of me and / or my eyes. The pictures will be used to evaluate my medical condition. They will not be sent to any other individuals without my consent.

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Perin W. Diana, Jr., M.D. \_\_\_\_\_

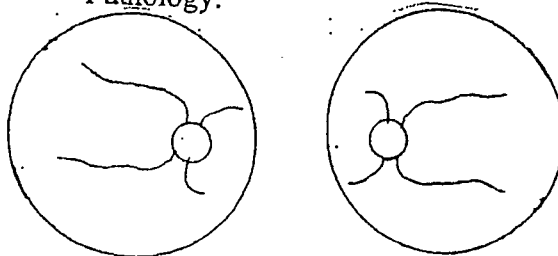
FUNDUS PHOTOS

Eye meds for test: Tropicamide 1%, Phenylephrine 2.5% adm. OU

Primary Eye: OD OS OU

C/O 0.3 JZ

Pathology:



good fund JZ

no D JZ

A. 1. P.O. JZ  
P/Ant. - cont Meds  
2 ✓ in 3rd

Indigo Run  
220 Pembroke Dr.  
Suite 100  
Hilton Head Island, SC 29926  
343.785.2525  
343.785.5394 fax

Jun City  
10 Okatie Center Blvd.  
Suite 302  
Okatie, SC 29909  
43.703.2678  
43.705.2671 fax

Ir id  
2200 East Main Street  
Georgetown, SC 29936  
43.726.6509  
43.726.6809 fax

MAKE CHECKS PAYABLE TO:  
 LIGHTHOUSE ANESTHESIA LLC  
 PO BOX 102681  
 ATLANTA GA 30368

DATE  
 06/14/2012

BALANCE DUE  
 \$.00

ACCOUNT #

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Card

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Signature Code: \_\_\_\_\_

Signature: \_\_\_\_\_

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 BARON, FRANCES  
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 \_\_\_\_\_

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STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

KEEP THIS PORTION FOR YOUR RECORDS

**IMPORTANT - Bill for Anesthesia and/or Pain Management Services**

PROFESSIONAL SERVICES

PRIMARY INSURANCE

NATIONWIDE/CLM  
 PO BOX 100190GM220 COLUMBIA SC 29202  
 POLICY: \_\_\_\_\_

SECONDARY INSURANCE

GROUP: POLICY: GROUP:  
 UNDER REVIEW WITH INSURANCE - \$2,605.00

| DATE       | CODE  | DESCRIPTIONS                                     | CHARGES | CREDITS | BALANCE |
|------------|-------|--------------------------------------------------|---------|---------|---------|
| 05/29/2012 | 27814 | ANESTHESIA SERVICE                               | 960.00  |         |         |
| 05/29/2012 | 76942 | US GUID NDLE PLCMT IMAGING SUPERVIS&INTEPR       | 605.00  |         |         |
| 05/29/2012 | 64445 | INJECTION ANESTHETIC AGENT; SCIATIC NERVE SINGLE | 560.00  |         |         |
| 05/29/2012 | 64450 | INJECTION ANES AGT; OTH PERIPH NERVE/BRANCH      | 400.00  |         |         |
| 05/29/2012 | 99100 | ANES-PATIENT EXTREME AGE UNDER 1 YEAR & OVER 70  | 80.00   |         |         |

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\$0.00

BARON, FRANCES LASA-11182

To pay on-line please visit <https://paynow.anesthesiallc.com>

PATIENT NO: [REDACTED] ADMIT DT/TIME: 5/29/12 08:05 M/R NO: [REDACTED]  
NS/ROOM/BED: CLINICS: OR RESISTANT ORG:  
BY: AUTO  
TENT NAME: BARON, FRANCES TITLE:  
ING ADDR: [REDACTED] SOCIAL SECURITY: [REDACTED]  
CITY/STATE: [REDACTED] PHONE: ( [REDACTED] )  
PHYSICAL ADR: NPP: 2.0 DATE: 12/08/03  
CITY/STATE: [REDACTED] PHONE: ( )  
OCCUPATION: RN LANGUAGE: EN FC: 05  
POB: XX ADMT PHYS: 1566- SUTHERLAND, GEORG HSV: 56  
DOB: [REDACTED] ADMT PHYS PHONE: (843) 705-9401 RLG: PAR:  
AGE: 70 Y RACE: WHI ATTEND PHYS: 1566- SUTHERLAND, GEORG MS: M  
SEX: F REF PHY: 1566-SUTHERLAND, GEORG PHN: 843 705-9401 SMK: N  
PCP PHY: - PHN: VAL: PT: 2  
ETHNICITY: NON FLAG: FATHER'S DOB: MOTHER'S DOB:

EMER CONTACT: EDWARD BARON REL: SPOUSE  
ADDRESS: [REDACTED] PHONE: [REDACTED]  
CITY/STATE: [REDACTED]  
NEAREST RELT: EDWARD BARON REL: SPOUSE  
ADDRESS: [REDACTED] PHONE: [REDACTED]  
CITY/STATE: [REDACTED] RESEARCH ID:

GUARANTOR: BARON, FRANCES A REL: SELF  
ADDRESS 1: [REDACTED] PHONE: [REDACTED]  
ADDRESS 2: [REDACTED] SOCIAL SECURITY: [REDACTED]  
CTY/STE/ZIP: [REDACTED] 9842 OCC: RN AF: USA  
PAYOR NAME 1: ENCRO INS. PLAN ID: Q9701 SRV/TYPE: ALLOP  
PLAN NAME: AUTO INSURANCE/600 IPA:  
C/O NAME: AUTH #: [REDACTED]  
ADDRESS: 1 NATIONWIDE CERT-SSN-HIC-ID#: 6139C050369  
TY/STE/CNTRY: DEMOINE IA 50391 BILL PHONE: (919) 278-9080  
BILLING NAME: GP #: NONE  
INSURED: BARON, FRANCES SEX/REL: F SELF  
EMPLOYER: SANCTUARY HOSPICE MSP: Y TRACKING#:  
ADDRESS: 10911 N JACOB SMART BLVD EMP PHONE: (843) 645-6540  
CITY/STATE: RIDGELAND SC 29936 ESC: 1  
PAYOR NAME 2: MEDICARE INS. PLAN ID: [REDACTED]  
PLAN NAME: MEDICARE/[REDACTED]  
ILL C/O NAME: AUTH #:  
BILL ADDRESS: P O BOX 1602 CERT-SSN-HIC-ID#: [REDACTED]  
TY/STE/CNTRY: OMAHA NE 68101 BILL PHONE: (866) 580-5981  
BILLING NAME: GP #: NONE  
INSURED: BARON, FRANCES A SEX/REL: F SELF  
EMPLOYER: SANCTUARY HOSPICE TRACKING#:  
ADDRESS: 10911 N JACOB SMART BLVD EMP PHONE: (843) 645-6450  
CITY/STATE: RIDGELAND SC 29936 ESC: 1

SPAN CODE: PRIOR VISIT: 5/21/12  
FROM/TO DATE: PRIOR HOSPITAL:  
CONDITION CD CONDITION CD OCCURRENCE CD/DATE OCCURRENCE CD/DATE  
09 01 5/29/12

CHIEF COMPLAINT DESCRIPTION: CHIEF COMPLAINT CODE:  
ANKLE FX  
MENTS: ORIF ANKLE

PRINTED BY: TARABLOOM  
DATE: 08/17/2012

## SECTION 1 ASSESSMENT OF CURRENT ILLNESS

Chief Complaint: Left ankle pain  
 History of Present Illness: Right foot s/p Metatarsal fx after MVA  
 Pre-Procedure Diagnosis: Left Metatarsal fx  
 Planned Procedure: (L) Metatarsal US guided ORIF of Metatarsal fx  
 Drug Allergies: NK.OA

## SECTION 2 PRE-PROCEDURE EVALUATION

Section 2 can be omitted if History and Physical on Chart  
☐ Refer to H&P dated

Past Medical History: DMII, Irregular Heartbeat, Sleep apnea  
 Surgical History: \_\_\_\_\_  
 Relevant Social History: ☐ Non-Contributory Smoking ☐ Yes ☒ No ETOH History: ☒ Yes ☐ No Drug Use: ☐ Yes ☒ No  
 Relevant Family History: ☒ Non-Contributory  
 Current Medications: (L) Lasix, Tylenol, Vioxx, Lisinopril, etc.  
 Physical:  
 Vital Signs: BP \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ Temp: \_\_\_\_\_ HR: \_\_\_\_\_ Wt: \_\_\_\_\_ Pregnant: ☐ Yes ☒ No  
 HEENT: ☒ Normal per eye exam Neck: ☒ Normal  
 Chest: ☒ Normal Lungs: ☒ Normal  
 Heart: ☒ Normal Abdomen: ☒ Normal  
 General: \_\_\_\_\_  
 Skin: ☐ Normal ☐ Deferred Multifocal  
 Back: ☒ Normal ☐ Deferred  
 Musculoskeletal: ☐ Normal ☒ Deferred TTP from motor vehicle  
 Genitalia/Rectal: ☐ Normal ☒ Deferred  
 Extremities: ☐ Normal ☒ Deferred swelling, erythema  
 Neurological: ☒ Normal ☐ Deferred  
 Breast: ☐ Normal ☒ Deferred  
 Mental Status: Alert ☒ Yes ☐ No AND Oriented to: Person? ☒ Yes ☐ No Place? ☒ Yes ☐ No Time? ☒ Yes ☐ No  
 If no, explain: \_\_\_\_\_

Review of Systems: ENT Systems Negative

HEENT ☐ Negative ☐ Positive  
 Respiratory ☐ Negative ☐ Positive  
 Cardiovascular ☒ Negative ☐ Positive

GI/Hepatic ☐ Negative ☐ Positive  
 GU/Renal ☐ Negative ☐ Positive  
 Neurological ☐ Negative ☐ Positive

Date: 5/24/12 Time: 1340

Physician Signature: \_\_\_\_\_

## SECTION 3 POST PROCEDURAL NOTE

Procedure: ORIF of L Metatarsal + (L) Leg Wound  
 Postoperative Diagnosis: Metatarsal fx, Leg Wound  
 Significant Findings: Ankle Pain, Redness  
 Specimen(s) Removed: φ  
 Complications: φ

Physician Notes and Description of Procedure:

Pat. has new wound (leg) - will proceed w/ above + add, debrided (L) leg wound. 5/24/12 1000

Anesthesia Used: Conscious sedation Estimated Blood Loss: φ  
 Physician: Seetharam Assistant(s): None  
 Dictation Job #: \_\_\_\_\_

Implant: (place label here)

X 2 36 mm, 4.0mm A.D. Pauld Cann. Screws

## SECTION 4 PATIENT DISCHARGE INSTRUCTIONS

Diet: Regular Activity: WOB OLE  
 Medications: Cortel 5/350 + 946 hrs Follow-Up: 6/11/12 1030 in OR later  
 Patient Name: \_\_\_\_\_ Physician Signature: \_\_\_\_\_ Date: 5/29/12 Time: 1139

Surgical / Procedural / Physician Note  
 (Short Stay Form)

BARON, FRANCES

PRE SDC  
 05/29/12 SUTHERLAND, GEORGE JR MD  
 DOB: 70 F MR# 500000000  
 Coastal Carolina

Patient Label

COASTAL CAROLINA MEDICAL CENTER  
1000 Medical Center Drive  
Hardeeville, SC 29927

Name: BARON, FRANCES

George Sutherland, Jr., MD

ADM: 05/29/2012

MRN: [REDACTED]

ICD: [REDACTED]

Operative Report

DATE OF PROCEDURE: 05/29/2012

PREOPERATIVE DIAGNOSES:

1. Left medial malleolus fracture, closed.
2. Right leg hematoma with wound.

POSTOPERATIVE DIAGNOSES:

1. Left medial malleolus fracture, closed.
2. Right leg hematoma with wound.

PROCEDURES PERFORMED:

1. Open reduction internal fixation, left medial malleolus fracture.
2. Debridement superficial wound, right leg.

SURGEON: George Sutherland, MD

ASSISTANT: None.

~~WOUND~~ BLOOD LOSS: Minimal.

ANESTHESIA: General augmented with popliteal block.

IMPLANTS USED: Times 2 36 x 4 mm partially threaded cannulated AO screws.

DRAINS PLACED: None.

SPECIMEN SENT: None.

FINDINGS: Medial malleolus fracture, transverse in nature and a 3 cm x 3 cm x 2 cm x 4 cm wound over the medial tibial above the hematoma with central necrosis.

COMPLICATIONS: None.

INDICATIONS FOR PROCEDURE: This is a 70-year-old female who was involved in a motor vehicle accident sustaining a medial malleolus fracture. We had talked about open reduction and internal fixation and she agreed due to greater than 2 mm of displacement. Upon arrival today, I noted that the hematoma over her left leg had some areas of necrosis. I consulted Dr. Jason Cotter for evaluation and he recommended debridement of the fibrous tissue.

PROCEDURE IN DETAIL: After obtaining informed consent, the patient receiving preop dose of antibiotics, patient was brought back to the operating room, placed in supine position, sterilely draped and prepped about the left lower extremity. Her sterile drape and prepping, a time-out procedure was performed

rk Type: Operative Report  
r001

Work Type Code: OPT  
Page: 1

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DATE: 08/17/2012

COASTAL CAROLINA MEDICAL CENTER  
1000 Medical Center Drive  
Hardeeville, SC 29927

Name: BARON, FRANCES

George Sutherland, Jr., MD

MRN: [REDACTED]

ADM: 05/29/2012

DOCT: [REDACTED]

Operative Report

-----

verifying the correct operative site and the correct patient. After this was performed, the Esmarch dressing was used to exsanguinate the leg and tourniquet taken up to 300 mmHg. After this was performed, 2 small incisions were made above the fracture site at the tip of the anterior colliculus of the medial malleolus. The small incision sites were just stab incisions, reduction forceps were placed through stab incision, a percutaneous reduction was attempted; however, this was unsuccessful, so small hockey-stick incision was made through these 2 previously made incisions, taken down to the medial malleolus bone. Periosteum was reflected medially and laterally. Under direct visualization, the medial malleolus was reduced and held with forceps. Two threaded guide pins were then placed through the inferior tip of the medial malleolus parallel to one another, roughly 1 cm to one another and passed into the tibial shaft. This was confirmed on AP and lateral views with reduction of the fracture site. The cannulated drill bit was then placed crossing the fracture site and two 36 x 4 mm AO partially threaded screws were then placed across the fracture site holding it in an anatomic reduction. They were toggled back and forth as being tightened down and not to displace the fracture. The pins were removed. AP, lateral and mortise all demonstrated ~~anatomic reduction~~ with no evidence of medial widening and obliteration of the fracture site. After this was performed, ~~the wound~~ irrigated with copious amounts of sterile saline. Tourniquet was taken down and any bleeding was taken care with Bovie electrocautery. The periosteum was closed with 2-0 Vicryl in an interrupted fashion followed by 3-0 nylon in a mattress-type fashion on the skin. She was placed in a sterile double sugar-tong splint. After this was performed, we took our dressings down and then addressed the opposite leg. The opposite leg was debrided. In the areas mentioned above, there was a 3 x 3 x 2 x 4 areas of necrosis with fibrinous exudate, which was scraped with a #10 blade and perpendicular to the skin and removing as much exudate as possible. There were some adhesions to the fat in the middle and I felt that this was better left for enzymatic debridement. She will see the wound care specialist this afternoon. We then dressed it with sterile gauze followed by Kerlix followed by an Ace wrap. She tolerated both procedures well, was taken to PACU stably.

George Sutherland, Jr., MD

TR:GS/HN

DD:05/29/2012 11:42 EDT

DT:05/29/2012 17:05 EDT

Work Type: Operative Report  
T001

Work Type Code: OPT  
Page: 2

PRINTED BY: TARABLOOM  
DATE: 08/17/2012



COASTAL CAROLINA MEDICAL CENTER  
1000 Medical Center Drive  
Hardeeville, SC 29927

Name: BARON, FRANCES

MRN: [REDACTED]

George Sutherland, Jr., MD

ADM: 05/29/2012

UJT: [REDACTED]

Operative Report

---

Dictation ID: 6508255/Confirmation #: 2402723

R:

---

Work Type: Operative Report

Work Type Code: OPT

1001

Page: 3

Authenticated by George Sutherland, MD On 06/05/2012 06:23:41 PM

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DATE: 08/17/2012

Coastal Carolina Medical Center  
1000 Medical Center Drive  
Hardeeville, SC 29927

Phone #: 843-784-8042  
Fax #: 843-784-8094

Name: BARON, FRANCES  
Attending Dr: SUTHERLAND, GEORGE JR  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: L.OR  
Exam Date: 05/29/2012 Status: DEP SDC  
Radiology No:  
Unit No: [REDACTED]

Exams: 000149494 US GUIDANCE

History: 70-year-old female, left side block.

Ultrasound guidance for anesthetic block.

Ultrasound was utilized to localize anatomic structures within the left thigh region. The procedure was performed by the department of anesthesia.

\*\* Electronically Signed by MOESCH DEAN on 05/30/2012 at 1414 \*\*  
Reported and Signed by: MOESCH DEAN

CC: GEORGE JR MD SUTHERLAND

Dictated Date/Time: 05/30/2012 (1414)  
Technologist: NEWMAN KIMBERLY  
Transcribed Date/Time: 05/30/2012 (1414)  
Transcriptionist: RAD.VR  
Electronic Signature Date/Time: 05/30/2012 (1414)  
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MEDICAL RECORDS COPY

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1000 Medical Center Drive  
Hardeeville, SC 29927

Phone #: 843-784-8042  
Fax #: 843-784-8094

Name: BARON, FRANCES  
Attending Dr: SUTHERLAND, GEORGE JR  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: L.OR  
Exam Date: 05/29/2012 Status: DEP SDC  
Radiology No:  
Unit No: [REDACTED]

Exams: 000149511 ANKLE LEFT 2 VIEW

History: 70-year-old female, medial malleolar fracture.

Intraoperative left ankle: A series of 5 intraoperative images demonstrate surgical fixation of the medial malleolus. Two surgical screws are noted in place with anatomic reduction of the medial malleolus. No lateral malleolar fracture is noted.

**Impression:**

1. Anatomic surgical screw reduction of medial malleolar fracture.

\*\* Electronically Signed by MOESCH DEAN on 05/30/2012 at 1313 \*\*  
Reported and Signed by: MOESCH DEAN

CC: GEORGE JR MD SUTHERLAND

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Technologist: ABBY GORMAN  
Transcribed Date/Time: 05/30/2012 (1313)  
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Name: BARON, FRANCES  
Attending Dr: SUTHERLAND, GEORGE JR  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: L.OR  
Exam Date: 05/29/2012 Status: DEP SDC  
Radiology No:  
Unit No: [REDACTED]

Exams: 000149510 ANKLE LEFT 3 VIEWS

History: 70-year-old female postop ankle fracture.

Postoperative left ankle: 3 images are submitted through cast material. There are 2 surgical screws traversing the medial malleolar fracture with anatomic reduction noted. No other definite abnormality is noted.

*Impression:*

1. *Anatomic surgical reduction of medial malleolar fracture.*

\*\* Electronically Signed by MOESCH DEAN on 05/31/2012 at 1427 \*\*  
Reported and Signed by: MOESCH DEAN

CC: GEORGE JR MD SUTHERLAND

Dictated Date/Time: 05/31/2012 (1427)  
Technologist: EDGARDO FLORES  
Transcribed Date/Time: 05/31/2012 (1427)  
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Phone #: 843-784-8042  
Fax #: 843-784-8094

Name: BARON, FRANCES  
Attending Dr: SUTHERLAND, GEORGE JR  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: L.OR  
Exam Date: 05/29/2012 Status: DEP SDC  
Radiology No:  
Unit No: [REDACTED]

Exams: 000149510 ANKLE LEFT 3 VIEWS

History: 70-year-old female postop ankle fracture.

Postoperative left ankle: 3 images are submitted through cast material. There are 2 surgical screws traversing the medial malleolar fracture with anatomic reduction noted. No other definite abnormality is noted.

**Impression:**

1. Anatomic surgical reduction of medial malleolar fracture.

\*\* Electronically Signed by MOESCH DEAN on 05/31/2012 at 1427 \*\*  
Reported and Signed by: MOESCH DEAN

CC: GEORGE JR MD SUTHERLAND

Dictated Date/Time: 05/31/2012 (1427)  
Technologist: EDGARDO FLORES  
Transcribed Date/Time: 05/31/2012 (1427)  
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**Amount Due:**

06/11/12  
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\$371.00



### ***Patient Statement***

| Date     | Description                  | Provider        | Patient | Amount   | Insurance Balance | Patient Balance |
|----------|------------------------------|-----------------|---------|----------|-------------------|-----------------|
| 05/31/12 | OFFICE/OUTPATIENT VISIT, NEW |                 |         |          |                   |                 |
| 05/31/12 | DEBRIDE SKIN/TISSUE          | JASON COTTER MD | FRANCES | \$216.00 | \$0.00            | \$216.00        |
|          | Visit Total                  |                 |         | \$155.00 | \$0.00            | \$155.00        |
|          |                              |                 |         | \$371.00 | \$0.00            | \$371.00        |

**Total Patient Balance:** \$371.00

Business Hours: 8:00 - 5:00 EST

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|                |                |              |
|----------------|----------------|--------------|
| Account Number | Statement Date | Due Date     |
| ██████████     | 06/11/12       | upon receipt |

**Amount Due**  
\$371.00

PLEASE WRITE YOUR ACCOUNT  
NUMBER ON YOUR CHECK

AMOUNT  
PAID

\$

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**XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX**

FRANCES BARON

OKATIE SURGICAL PARTNERS  
PO BOX 405820  
ATLANTA GA 30384-5820



OKATIE SURGICAL PARTNERS  
P. O. BOX 405820  
ATLANTA GA 30384-5820

## Account Information

Account Number:

Statement Date:

Due Date:

Amount Due:

07/02/12  
upon receipt  
\$954.00

## Patient Statement

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| Date     | Description                  | Provider        | Patient | Amount   | Insurance Balance | Patient Balance |
|----------|------------------------------|-----------------|---------|----------|-------------------|-----------------|
| 05/31/12 | OFFICE/OUTPATIENT VISIT, NEW | JASON COTTER MD | FRANCES | \$216.00 | \$0.00            | \$216.00        |
| 05/31/12 | DEBRIDE SKIN/TISSUE          |                 |         | \$155.00 | \$0.00            | \$155.00        |
|          | Visit Total                  |                 |         | \$371.00 | \$0.00            | \$371.00        |
| 06/07/12 | OFFICE/OUTPATIENT VISIT, EST | JASON COTTER MD | FRANCES | \$145.00 | \$0.00            | \$145.00        |
|          | Visit Total                  |                 |         | \$145.00 | \$0.00            | \$145.00        |
| 06/14/12 | OFFICE/OUTPATIENT VISIT, EST | JASON COTTER MD | FRANCES | \$219.00 | \$0.00            | \$219.00        |
|          | Visit Total                  |                 |         | \$219.00 | \$0.00            | \$219.00        |
| 06/21/12 | OFFICE/OUTPATIENT VISIT, EST | JASON COTTER MD | FRANCES | \$219.00 | \$0.00            | \$219.00        |
|          | Visit Total                  |                 |         | \$219.00 | \$0.00            | \$219.00        |

Total Patient Balance: \$954.00

## OR PAYMENT AND BILLING QUESTIONS

Phone: 888-650-3117

Business Hours: 8:00 - 5:00 EST

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OKATIE SURGICAL PARTNERS  
P. O. BOX 405820  
ATLANTA GA 30384-5820

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We accept these credit cards.



Account Number: [REDACTED] Statement Date: 07/02/12 Due Date: upon receipt

Amount Due: \$954.00

PLEASE WRITE YOUR ACCOUNT NUMBER ON YOUR CHECK

AMOUNT PAID \$

MAKE CHECKS PAYABLE TO AND MAIL TO:

[Barcode]

OKATIE SURGICAL PARTNERS  
PO BOX 405820  
ATLANTA GA 30384-5820



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PO Box 405820

Atlanta, GA 30384-5820

ENCOUNTER INVOICE 6852

ADDRESSEE:

Baron, Frances

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| 283776567                                |                          |                          |                          |

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PAGE: 1

14:30:13

1000 MEDICAL CENTER DR HARDEEVILLE

SC 29927

REGISTRATION  
RECORD-F01PATIENT NO: 093761724  
NS/ROOM/BED:ADMIT DT/TIME: 5/31/12 13:00 M/R NO: 000109861  
CLINICS: WC RESISTANT ORG:

PATIENT NAME: BARON, FRANCES

BY: AUTO

ING ADDR:

TITLE:

ITY/STATE:

SOCIAL SECURITY:

PHYSICAL ADR:

PHONE:

CITY/STATE:

NPP: 2.0 DATE: 12/08/03

OCCUPATION: RN

PHONE: ( )

POB: XX

LANGUAGE: EN

FC: 40

DOB:

ADMT PHYS: 1202- COTTER, JASON WIL HSV: 60

AGE: 70 Y RACE: WHI

ADMT PHYS PHONE: (843) 705-8888 RLG: PAR:

SEX: F REF PHY: 1202-COTTER, JASON WIL PHN: 843 705-8888 MS: M

PCP PHY: -

PHN:

VAL: PT: 2

ETHNICITY:NON FLAG:

FATHER'S DOB:

MOTHER'S DOB:

EMER CONTACT: EDWARD BARON

REL: SPOUSE

ADDRESS:

PHONE:

CITY/STATE:

NEAREST RELT: EDWARD BARON

REL: SPOUSE

ADDRESS:

PHONE:

CITY/STATE:

RESEARCH ID:

GUARANTOR: BARON, FRANCES A

REL: SELF

ADDRESS 1:

PHONE:

ADDRESS 2:

SOCIAL SECURITY:

CTY/STE/ZIP:

9842 OCC:RN

AF: USA

PAYOR NAME 1: MEDICARE/618

INS. PLAN ID: 53544 SRV/TYPE: ALLOP

PLAN NAME: MEDICARE/618

IPA:

C/O NAME:

AUTH #:

ADDRESS: P O BOX 1602

CERT-SSN-HIC-ID#:

TY FE/CNTRY: OMAHA

NE 68101

BILL PHONE: (866) 580-5981

BILLING NAME:

GP #: NONE

INSURED: BARON, FRANCES

SEX/REL: F SELF

EMPLOYER: SANCTUARY HOSPICE

MSP: Y TRACKING#:

ADDRESS: 10911 N JACOB SMART BLVD

EMP PHONE: (843) 645-6540

CITY/STATE: RIDGELAND

ESC: 1

PAYOR NAME 2: TRICARE STANDARD

INS. PLAN ID: FR911

PLAN NAME: TRICARE FOR LIFE

ILL C/O NAME:

AUTH #:

BILL ADDRESS: PO BOX 7890

CERT-SSN-HIC-ID#:

TY/STE/CNTRY: MADISON

WI 53707 7890

BILL PHONE: (888) 363-5433

BILLING NAME:

GP #: NONE

INSURED: BARON, EDWARD

SEX/REL: M SPOUSE

EMPLOYER: SANCTUARY HOSPICE

TRACKING#:

ADDRESS: 10911 N JACOB SMART BLVD

EMP PHONE: (843) 645-6450

CITY/STATE: RIDGELAND

ESC: 5

SPAN CODE:

PRIOR VISIT: 5/29/12

FROM/TO DATE:

PRIOR HOSPITAL:

CONDITION CD

CONDITION CD

OCCURRENCE CD/DATE

OCCURRENCE CD/DATE

10

11

5/31/12

CHIEF COMPLAINT DESCRIPTION:

CHIEF COMPLAINT CODE:

WOUND CARE NEW PATIENT

ENTS:

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Visit Report for 5/31/2012

**COASTAL CAROLINA  
HOSPITAL**

Hilton Head Regional Healthcare

**Vital Signs Details**Patient Name: Baron, Frances  
Patient Date of Birth: [REDACTED]Date: 5/31/2012  
RN/LPN: Cole, Lori  
Physician / Extender: Cotter, Jason**Vital Signs Values**Height (in):  
Weight (lbs):  
Body Mass Index (BMI):**Electronic Signature(s)**Signed By:  
Cole, Lori RN  
Cole, Lori RNDate:  
06/06/2012 9:02:08 AM  
06/06/2012 9:02:24 AM

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**COASTAL CAROLINA  
HOSPITAL**

Hilton Head Regional Healthcare

**Arrival Information Details**

Patient Name: Baron, Frances

Date: 5/31/2012

Patient Date of Birth: [REDACTED]

RN/LPN: Cole, Lori

Physician / Extender: Cotter, Jason

**Visit Information**

|                                                 |            |
|-------------------------------------------------|------------|
| Arrival Condition:                              | Stable     |
| Ambulatory Status:                              | Wheelchair |
| Accompanied By:                                 | spouse     |
| Reason for today's visit:                       | MD visit   |
| Patient Identification Verified:                | Yes        |
| Secondary Verification Process Completed:       | Yes        |
| Patient Is in Isolation Precaution?             | No         |
| Is patient oriented to person, place, and time? | Yes        |

**Electronic Signature(s)**

Signed By:

Cole, Lori RN

Cole, Lori RN

Date:

06/06/2012 9:02:08 AM

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# COASTAL CAROLINA HOSPITAL

Minimizing Pain, Maximizing Health

## Pain Assessment Details

Patient Name: Baron, Frances  
Patient Date of Birth: ( )

Date: 5/31/2012  
RN/LPN: Cole, Lori  
Physician / Extender: Cotter, Jason

### Location of Pain

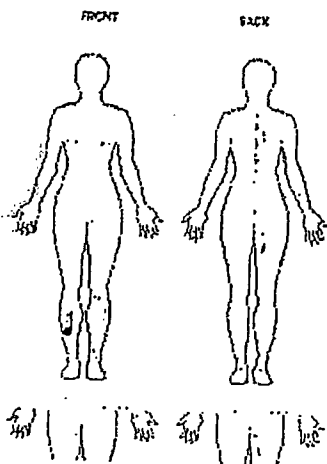


### Severity and Temporal Description of Pain

Patient Has Pain? Yes

Duration of the Pain.  
Constant / Intermittent? Constant

Rate the pain.  
Current Pain Level: 5



### Character of Pain

Describe the Pain: Aching, Tender

### Pain Management and Medication

#### Current Pain Management:

|             |     |                                          |          |
|-------------|-----|------------------------------------------|----------|
| Medication: | Yes | Is the Current Pain Management Adequate: | Adequate |
| Rest:       | Yes |                                          |          |
| Activity:   | Yes |                                          |          |

### Electronic Signature(s)

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Cole, Lori RN

Date:  
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**COASTAL CAROLINA  
HOSPITAL**

Hilton Head Regional Healthcare

**Lower Extremity Assessment Details**

Patient Name: Baron, Frances

Patient Date of Birth: ( )

Date: 5/31/2012

RN/LPN: Cole, Lori

Physician / Extender: Cotter, Jason

**Edema Assessment**

Edema:

Compression Device In Use:

Device Used Correctly:

Left:

Right:

Yes

Yes

Yes

Foot

Point of Measurement: cm

From: cm

cm

**Electronic Signature(s)**

Signed By:

Cole, Lori RN

Cole, Lori RN

Date:

06/06/2012 9:02:08 AM

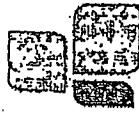
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**COASTAL CAROLINA  
HOSPITAL**

Milton Road Regional Healthcare

**Patient/Caregiver Education Details**

|                        |                |                       |               |
|------------------------|----------------|-----------------------|---------------|
| Patient Name:          | Baron, Frances | Date:                 | 5/31/2012     |
| Patient Date of Birth: |                | RN/LPN:               | Cole, Lori    |
|                        |                | Physician / Extender: | Cotter, Jason |

**Patient/Caregiver Education Items**

Teaching Provided To: Patient

|              |                         |
|--------------|-------------------------|
| Compression: | Yes                     |
| Methods:     | Explain/Verbal          |
| Responses:   | State content correctly |

|            |                         |
|------------|-------------------------|
| Dressing:  | Yes                     |
| Methods:   | Explain/Verbal          |
| Responses: | State content correctly |

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|               |                       |
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**COASTAL CAROLINA  
HOSPITAL**

Wilson Head Regional Healthcare

**Visit Discharge Information Details**

Patient Name: Baron, Frances

Patient Date of Birth: [REDACTED]

Date: 5/31/2012

RN/LPN: Cole, Lori

Physician / Extender: Cotter, Jason

**Visit Discharge Information Items**

|                                                     |            |
|-----------------------------------------------------|------------|
| Discharge Condition:                                | Stable     |
| Ambulatory Status:                                  | Wheelchair |
| Discharge Destination:                              | Home       |
| Transportation:                                     | Private    |
| Accompanied By:                                     | Auto       |
| Schedule Follow-up Appointment:                     | spouse     |
| Medication Reconciliation completed and provided to | Yes        |
| Patient/Care Provider:                              | No         |
| Clinical Summary of Care Provided:                  | No         |

**Electronic Signature(s)**

Signed By:

Cole, Lori RN

Cole, Lori RN

Date:

06/06/2012 9:02:08 AM

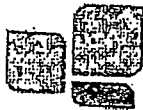
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**COASTAL CAROLINA  
HOSPITAL**

Hilton Head Regional Healthcare

**Educational Needs Assessment/Barriers to Learning Details**

|                                 |                |                                      |               |
|---------------------------------|----------------|--------------------------------------|---------------|
| Patient Name:                   | Baron, Frances | Date:                                | 5/31/2012     |
| Patient Date of Birth:          | ( )            | RN/LPN:                              | Cole, Lori    |
|                                 |                | Physician / Extender:                | Cotter, Jason |
| Cultural / Religious Practices: | No             | Immunization:                        | No            |
| Disease Prevention:             | No             | Lifestyle Changes Needed:            | No            |
| Emotional Disability:           | No             | Patient Rights and Responsibilities: | No            |
| How do you learn best:          | Explain/Verbal | Physical Disability:                 | No            |

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|---------------|-----------------------|
| Signed By:    | Date:                 |
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**COASTAL CAROLINA  
HOSPITAL**

Mission: Meet Regional Healthcare

**Patient/Caregiver Educational Goals Details**Patient Name: Baron, Frances  
Patient Date of Birth: Date: 5/31/2012  
RN/LPN: Cole, Lori  
Physician / Extender: Cotter, Jason**Education Goals Items****Short Term Goals**

- X - Patient wound status will improve/maintain without exacerbation, infection, or deterioration.
- X - Patient/Caregiver will have knowledge of disease process and skills necessary for self care.
- X - Patient/Caregiver will have knowledge of the treatment options.
- X - Patient/Caregiver will have knowledge of risk factors, and interventions to address.
- X - Patient/Caregiver will have the ability to make healthcare treatment decisions.
- X - Patient/Caregiver will have the self management skills necessary to maintain the individual plan of care.
- X - Patient/Caregiver promotes and maintains optimal pain control.

[ ] - Hyperbaric oxygen therapy will continue for the prescribed time and treatments without any untoward effects.

**Long Term Goals**

- X - Patient/Caregiver understands need for continued care when health problems are identified.
- X - Patient/Caregiver will have knowledge to live a healthy lifestyle.

**Notes****Electronic Signature(s)**Signed By:  
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**COASTAL CAROLINA  
HOSPITAL**

Highland Regional Healthcare

**Fall Risk Assessment Details**Patient Name: Baron, Frances  
Patient Date of Birth: [REDACTED]Date: 5/31/2012  
RN/LPN: Cole, Lori  
Physician / Extender: Cotter, Jason**Fall Risk Assessment Items**

| Group1                | Score | Assessment                 |
|-----------------------|-------|----------------------------|
| • History of falling  | 0     | No                         |
| • Secondary diagnosis | 0     | No                         |
| • Ambulatory aid      | 0     | No                         |
| • IV or IV access     | 0     | None/bed rest/nurse assist |
| • Gait                | 0     | No                         |
| • Mental Status       | 20    | Impaired                   |
|                       | 0     | Oriented to own ability    |

Risk Level: Low Risk Score: 20

**Notes****Electronic Signature(s)**Signed By:  
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05/06/2012 9:02:24 AM

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## COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

### Risk for Nutritional Deficit Details

Patient Name: Baron, Frances

Patient Date of Birth:

Date: 5/31/2012

RN/LPN: Cole, Lori

Physician / Extender: Cotter, Jason

Height (in):

Weight (lbs):

Body Mass Index (BMI):



### Risk for Nutritional Deficit Items

| Screening                                                                                                                        | Score | Assessment                |
|----------------------------------------------------------------------------------------------------------------------------------|-------|---------------------------|
| Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties? | 2     | no loss of appetite       |
| Weight loss during the last 3 months.                                                                                            | 3     | no weight loss            |
| Mobility                                                                                                                         | 2     | goes out                  |
| Has suffered psychological stress or acute disease in the past 3 months.                                                         | 2     | no                        |
| Neuropsychological Problems.                                                                                                     | 2     | no psychological problems |
| Body Mass Index (BMI) (weight in kg) / (height in m <sup>2</sup> )                                                               | 3     | BMI 23 or greater         |
| Screening Score:                                                                                                                 |       |                           |
| Is Screening score 12 points or greater? (Patient is not at Risk.)                                                               | 12    | Yes                       |
| Assessment:                                                                                                                      |       |                           |
| Lives Independently (not in a nursing home or hospital)                                                                          |       |                           |
| Takes more than 3 prescription drugs per day.                                                                                    |       |                           |
| Pressure sores or skin ulcers.                                                                                                   |       |                           |
| How many full meals does the patient eat daily?                                                                                  |       |                           |
| Selected consumption markers for protein intake:                                                                                 |       |                           |
| At least one serving of dairy products (milk, cheese, yogurt) per day                                                            |       |                           |
| Two or more servings of legumes or eggs per week                                                                                 |       |                           |
| Meat, fish or poultry every day                                                                                                  |       |                           |
| Consumes two or more servings of fruits or vegetables per day?                                                                   |       |                           |
| How much fluid (water, juice, coffee, tea, milk, . . .) is consumed per day?                                                     |       |                           |
| Mode of Feeding.                                                                                                                 |       |                           |
| Self view of nutritional status.                                                                                                 |       |                           |
| In comparison with other people of the same age, how does the patient consider his/her status?                                   |       |                           |
| Mid-arm circumference (MAC) in cm.                                                                                               |       |                           |
| Calf circumference (CC) in cm.                                                                                                   |       |                           |

Risk Level: Not at Risk Score: 26

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Cole, Lori RN

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# COASTAL CAROLINA HOSPITAL

Wound Healing Regional Healthcare

## Wound Assessment Details

|                        |                |                       |               |
|------------------------|----------------|-----------------------|---------------|
| Patient Name:          | Baron, Frances | Date:                 | 5/31/2012     |
| Patient Date of Birth: | ( )            | RN/LPN:               | Cole, Lori    |
|                        |                | Physician / Extender: | Cotter, Jason |

### Wound Status

|                 |                                     |               |            |
|-----------------|-------------------------------------|---------------|------------|
| Wound Number:   | 1                                   | Wound Status: | Not Healed |
| Wound Location: | Right, Proximal, Anterior Lower Leg |               |            |
| Wound Type:     | Trauma                              |               |            |
| Date Acquired:  | 5/21/2012                           |               |            |

### Wound Measurements

|                                            |      |              |    |
|--------------------------------------------|------|--------------|----|
| Length: (cm)                               | 3.2  | Tunnelling:  | No |
| Width: (cm)                                | 1    | Undermining: | No |
| Depth: (cm)                                | 0.2  | Sinus Tract: | No |
| Hypergranulated:                           | No   |              |    |
| Area: (sq cm) based on L*W                 | 3.2  |              |    |
| Volume: (cm <sup>3</sup> ) based on Area*D | 0.64 |              |    |

### Wound Description

|                              |                       |                   |    |
|------------------------------|-----------------------|-------------------|----|
| Thickness:                   | Full Thickness        | Exposed Structure |    |
| Exudate Amount:              | Small                 | Tendon Exposed:   | No |
| Exudate Type:                | Sero-sanguineous      | Muscle Exposed:   | No |
| Pain:                        | 5                     | Joint Exposed:    | No |
| Less than 20% slough/fibrin? | No                    | Bone Exposed:     | No |
| Slough:                      | Percentage<br>75-100% |                   |    |

### Peripheral Skin Appearance

|                     |          |     |                     |                  |     |
|---------------------|----------|-----|---------------------|------------------|-----|
| Normal For Patient: | Texture  | Yes | Normal For Patient: | Color            | Yes |
| Normal For Patient: | Moisture | Yes | Temperature:        | Temperature      | WNL |
|                     |          |     | S/S Present:        | S/S of Infection | No  |

### Treatment Notes

#### Wound #1 (Right, Proximal, Anterior Lower Leg)

##### Wound Treatment Note

- Pt ID by name and photo, correct site ID.
- Assessed patient's pain status and effectiveness of pain management plan
- Removed old dressing, taking care to avoid trauma to the wound bed
- Cleansed wound and periwound with non-cytotoxic agent using Wound cleanser (1)
- Obtained wound photo
- Applied topical anesthetic for procedural pain control per physician order using Lidocaine 4% Topical (1)
- Debridement.
- Applied enzymatic debriding agent to wound bed. using Santyl (1)
- Applied primary wound dressing using normal saline gauze (1)

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- Applied Secondary Wound Dressing using Gauze (1)
- Dressing secured dressing in place using Tape (1)
- Applied Compression device using Tubigrip (1)

**Electronic Signature(s)**

Signed By:  
Cole, Lori RN  
Cole, Lori RN

Date:  
06/06/2012 9:02:08 AM  
06/06/2012 9:02:24 AM

Entered By: Cole, Lori on 05/31/2012 1:43:54 PM

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DATE: 08/17/2012

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# COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

## Wound Assessment Details

|                        |                |                       |               |
|------------------------|----------------|-----------------------|---------------|
| Patient Name:          | Baron, Frances | Date:                 | 5/31/2012     |
| Patient Date of Birth: | ( )            | RN/LPN:               | Cole, Lori    |
|                        |                | Physician / Extender: | Cotter, Jason |

## Wound Status

|                 |                                   |               |            |
|-----------------|-----------------------------------|---------------|------------|
| Wound Number:   | 2                                 | Wound Status: | Not Healed |
| Wound Location: | Right, Distal, Anterior Lower Leg |               |            |
| Wound Type:     | Trauma                            |               |            |
| Date Acquired:  | 5/21/2012                         |               |            |

## Wound Measurements

|                                            |     |              |    |
|--------------------------------------------|-----|--------------|----|
| Length: (cm)                               | 1.5 | Tunneling:   | No |
| Width: (cm)                                | 2   | Undermining: | No |
| Depth: (cm)                                | 0.2 | Sinus Tract: | No |
| Hypergranulated:                           | No  |              |    |
| Area: (sq'cm) based on L*W                 | 3   |              |    |
| Volume: (cm <sup>3</sup> ) based on Area*D | 0.6 |              |    |

## Wound Description

|                 |                       |                   |    |
|-----------------|-----------------------|-------------------|----|
| Thickness:      | Full Thickness        | Exposed Structure |    |
| Exudate Amount: | Small                 | Tendon Exposed:   | No |
| Exudate Type:   | Sero-sanguineous      | Muscle Exposed:   | No |
| Pain:           | 6                     | Joint Exposed:    | No |
|                 |                       | Bone Exposed:     | No |
| Slough:         | Percentage<br>76-100% |                   |    |

## Peripheral Skin Appearance

|                     |          |     |                     |                  |     |
|---------------------|----------|-----|---------------------|------------------|-----|
| Normal For Patient: | Texture  | Yes | Normal For Patient: | Color            | Yes |
| Normal For Patient: | Moisture | Yes | Temperature:        | Temperature      | WNL |
|                     |          |     | S/S Present:        | S/S of Infection | No  |

## Electronic Signature(s)

|               |                       |
|---------------|-----------------------|
| Signed By:    | Date:                 |
| Cole, Lori RN | 06/06/2012 9:02:08 AM |
| Cole, Lori RN | 06/06/2012 9:02:24 AM |

Entered By: Cole, Lori on 05/31/2012 1:44:28 PM

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DATE: 08/17/2012

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**Treatment Notes Summary****Wound #1 (Right, Proximal, Anterior Lower Leg)****Wound Treatment Note**

- Pt ID by name and photo, correct site ID.
- Assessed patient's pain status and effectiveness of pain management plan
- Removed old dressing, taking care to avoid trauma to the wound bed
- Cleansed wound and periwound with non-cytotoxic agent using Wound cleanser (1)
- Obtained wound photo
- Applied topical anesthetic for procedural pain control per physician order using Lidocaine 4% Topical (1)
- Debridement.
- Applied enzymatic debriding agent to wound bed, using Santyl (1)
- Applied primary wound dressing using normal saline gauze (1)
- Applied Secondary Wound Dressing using Gauze (1)
- Dressing secured dressing in place using Tape (1)
- Applied Compression device using Tubigrip (1)

**Wound #2 (Right, Distal, Anterior Lower Leg)****Wound Treatment Note**

- Pt ID by name and photo, correct site ID.
- Assessed patient's pain status and effectiveness of pain management plan
- Removed old dressing, taking care to avoid trauma to the wound bed
- Cleansed wound and periwound with non-cytotoxic agent using Wound cleanser (1)
- Obtained wound photo
- Applied topical anesthetic for procedural pain control per physician order using Lidocaine 4% Topical (1)
- Debridement.
- Applied enzymatic debriding agent to wound bed, using Santyl (1)
- Applied primary wound dressing using normal saline gauze (1)
- Applied Secondary Wound Dressing using Gauze (1)
- Dressing secured dressing in place using Tape (1)
- Applied Compression device using Tubigrip (1)



## COASTAL CAROLINA HOSPITAL

Myers Head Regional Healthcare

**Debridement Details**

Patient Name: Baron, Frances  
Patient Date of Birth:

Date: 5/31/2012  
RN/LPN: Cole, Lori  
Physician / Extender: Cotter, Jason

Debridement Performed for Assessment:

Performed By:

Debridement:

Time-Out Taken:

Pain Control:

Wound #1 Right, Proximal, Anterior Lower Leg  
Physician Cotter, Jason ; MD  
Surgical  
Yes  
4% Lido

**Post Debridement Measurements**

|              |     |                              |      |
|--------------|-----|------------------------------|------|
| Length: (cm) | 3.2 | Area: (cm <sup>2</sup> )     | 3.2  |
| Width: (cm)  | 1   | Percent Debrided:            | 100  |
| Depth: (cm)  | 0.2 | Total Area Debrided: (sq cm) | 3.2  |
|              |     | Volume: (cm <sup>3</sup> )   | 0.64 |

Level:

Tissue and other material debrided:

Instrument:

Bleeding:

Hemostasis Achieved:

Procedural Pain:

Skin/Subcutaneous Tissue

Necrotic/Eschar, Fibrin, Exudate, Subcutaneous, Slough

Curette, Scissors

Minimal

Pressure

2

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**COASTAL CAROLINA  
HOSPITAL**

High Level Regional Healthcare

**History and Review of Systems Details**Patient Name: Baron, Frances  
Patient Date of Birth: ( )Date: 5/31/2012  
RN/LPN: Cole, Lori  
Physician / Extender: Cotter, Jason**Chief Complaint**

wound right lower leg

**History of Present Illness**

Location: right lower leg

Severity: moderate

Timing: 1 week

Context: car accident

Modifying Factors: diabetes, venous hypertension

Associated Signs and Symptoms: denies nausea, vomiting, fever, or chills

70-year old female who was in a car accident suffering a left lower leg fracture and right lower leg wounds. Her right lower leg x-rays were negative. She has been using Santyl on this wound daily. There have been no improving or worsening factors. Her risk factors for wound healing include diabetes and venous hypertension. She denies nausea, vomiting, fever, or chills.

**Allergies****Active Allergies**

mango

**Allergy Notes****Family and Social History**

Heart Disease, Alcohol Use - denies, Tobacco Use - denies

**Constitutional Symptoms (General Health)**

Complaints and Symptoms:

No Complaints or Symptoms

**Eyes**

Complaints and Symptoms:

No Complaints or Symptoms

**Cardiovascular (Central)**

Complaints and Symptoms:

No Complaints or Symptoms

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**Respiratory**

Complaints and Symptoms:  
No Complaints or Symptoms

**Gastrointestinal (GI)**

Complaints and Symptoms:  
No Complaints or Symptoms

**Musculoskeletal**

Complaints and Symptoms:  
Muscle Pain - right leg fx, Muscle Weakness

**Neurological**

Complaints and Symptoms:  
No Complaints or Symptoms

**Psychiatric**

Complaints and Symptoms:  
No Complaints or Symptoms

**Hematologic/Lymphatic**

Complaints and Symptoms:  
No Complaints or Symptoms

**Past Medical/Surgical History**

**Surgical Hx:**

Past Medical/Surgical History - hypothyroidism, HTN, DM, chole, appy, left leg surgery

**Electronic Signature(s)**

**Signed By:**

Cole, Lori RN

Cole, Lori RN

Cotter, Jason

**Date:**

06/06/2012 9:02:08 AM

06/06/2012 9:02:24 AM

06/11/2012 3:14:39 PM

Entered By: Cotter, Jason on 05/31/2012 8:50:47 PM



**COASTAL CAROLINA  
HOSPITAL**

Wilton Medical Regional Healthcare

**Physical Exam Details**Patient Name: Baron, Frances  
Patient Date of Birth: ( )Date: 5/31/2012  
RN/LPN: Cole, Lori  
Physician / Extender: Cotter, Jason**Constitutional:**

Sitting Blood Pressure < 130/86 and within normal limits.. Supine Blood Pressure < 130/86 and within normal limits.. Pulse regular and within target range of 88.. Respirations regular, non-labored and within the target range of 24.. Temperature normal and within the target range of 98.6. Height: Appearance neat and clean. Appears in no acute distress. Well nourished and well developed.. Weight appropriate for height. .

**Eyes:**

+ ecchymosis present. No scleral icterus. Pupils equal, symmetric, and react to light. .

**Neck:**

Neck supple and symmetrical. No masses or crepitus. . Thyroid WNL, without enlargement, tenderness, or masses. .

**Respiratory:**

Respiratory rate is normal at rest and on room air w/normal respiratory effort. . Bilateral breath sounds are clear and equal in all lobes w/ no wheezes, rales or rhonchi..

**Cardiovascular:**

Heart rhythm and rate regular, no murmur or gallop. S1/S2 no mrg.. Carotids WNL, no bruits..

**Gastrointestinal (GI):**

Abdomen is soft and non-distended without masses or tenderness. Bowel sounds active.. No liver or spleen enlargement or tenderness.. No inguinal or umbilical hernias..

**Lymphatic:**

Palpation of lymph nodes in neck WNL. No lymphadenopathy or glandular swelling noted.. Palpation of lymph nodes in axillae WNL. No lymphadenopathy or glandular swelling noted.. Palpation of lymph nodes in other areas WNL. No lymphadenopathy or glandular swelling noted..

**Musculoskeletal:**

+ edema, palpable DP/PT pulses. + cast present.

**Integumentary (Hair, Skin):**

see wound description. see wound description.

**Psychiatric:**

Judgement and Insight Intact.. Alert and oriented times 3.. Short and long term memory intact.. No evidence of depression, anxiety, or agitation. Calm, cooperative, and communicative. .

**Electronic Signature(s)**Signed By:  
Cotter, JasonDate:  
06/11/2012 3:14:39 PM

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DATE: 08/17/2012

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## COASTAL CAROLINA HOSPITAL

Wilmington Regional Healthcare

### Physician Orders Details

Patient Name: Baron, Frances

Patient Date of Birth: ( )

Date: 5/31/2012

RN/LPN: Cole, Lori

Physician / Extender: Cotter, Jason

Verbal / Phone Orders: No

### Follow-Up Appointments

- Return Appointment in 1 week.

### Anesthetic

- Topical Xylocaine to wound bed prior to debridement. - 4%

### Wound Cleansing & Dressings

- Enzymatic Debriding Agent - santyl each day

### Compression /Edema Control/ Off-Loading

- Elevate leg(s) above the level of the heart when sitting.
- Avoid prolonged standing in one place.
- Single Layer Compression Wrap - tubigrip

### Dietary

- Increased protein
- Supplement with multi-vitamin

### Notes

### Electronic Signature(s)

Signed By:

Cotter, Jason

Date:

06/11/2012 3:14:39 PM

Entered By: Cotter, Jason on 05/31/2012 8:52:55 PM

**COASTAL CAROLINA  
HOSPITAL**

Hilton Head Regional Healthcare

**Progress Note Details****Patient Name:** Baron, Frances  
**Patient Date of Birth:** (REDACTED)**Date:** 5/31/2012  
**RN/LPN:** Cole, Lori  
**Physician / Extender:** Cotter, Jason**Subjective****Chief Complaint**

wound right lower leg

**Allergies**

mango

**HPI**

The following HPI elements were documented for the patient's wound:

Location: right lower leg

Severity: moderate

Timing: 1 week

Context: car accident

Modifying Factors: diabetes, venous hypertension

Associated Signs and Symptoms: denies nausea, vomiting, fever, or chills

70 year old female who was in a car accident suffering a left lower leg fracture and right lower leg wounds. Her right lower leg x-rays were negative. She has been using Santyl on this wound daily. There have been no improving or worsening factors. Her risk factors for wound healing include diabetes and venous hypertension. She denies nausea, vomiting, fever, or chills.

**Family History**

Heart Disease.

**Social History**

Alcohol Use - denies, Tobacco Use - denies.

**Surgical History****Past Medical/Surgical History**

Has A Surgical History of Past Medical/Surgical History - hypothyroidism, HTN, DM, chole, appy, left leg surgery.

**Review of Systems (ROS)****Constitutional Symptoms (General Health)**

The patient has no complaints or symptoms.

**Eyes**

The patient has no complaints or symptoms.

**Cardiovascular (Central)**

The patient has no complaints or symptoms.

**Respiratory**

The patient has no complaints or symptoms.

**Gastrointestinal (GI)**

The patient has no complaints or symptoms.

**Musculoskeletal**

Complains or has symptoms of Muscle Pain - right leg fx, Muscle Weakness.

**Neurological**

The patient has no complaints or symptoms.

**Psychiatric**

The patient has no complaints or symptoms.

**Hematologic/Lymphatic**

The patient has no complaints or symptoms.

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DATE: 08/17/2012

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**Objective****Constitutional**

Sitting Blood Pressure < 130/86 and within normal limits.. Supine Blood Pressure < 130/86 and within normal limits.. Pulse regular and within target range of 88.. Respirations regular, non-labored and within the target range of 24.. Temperature normal and within the target range of 98.6. Height: Appearance neat and clean. Appears in no acute distress. Well nourished and well developed.. Weight appropriate for height. Height: 65 in, Weight: 156 lbs, BMI: 26.

**Psychiatric:**

Judgement and insight Intact.. Alert and oriented times 3.. Short and long term memory intact.. No evidence of depression, anxiety, or agitation. Calm, cooperative, and communicative..

**Eyes:**

+ ecchymosis present. No scleral icterus. Pupils equal, symmetric, and react to light..

**Neck:**

Neck supple and symmetrical. No masses or crepitus.. Thyroid WNL, without enlargement, tenderness, or masses..

**Respiratory:**

Respiratory rate is normal at rest and on room air w/normal respiratory effort.. Bilateral breath sounds are clear and equal in all lobes w/ no wheezes, rales or rhonchi..

**Cardiovascular:**

Heart rhythm and rate regular, no murmur or gallop. S1/S2 no mrg.. Carotids WNL, no bruits..

**Gastrointestinal (GI):**

Abdomen is soft and non-distended without masses or tenderness. Bowel sounds active.. No liver or spleen enlargement or tenderness.. No inguinal or umbilical hernias..

**Lymphatic:**

Palpation of lymph nodes in neck WNL. No lymphadenopathy or glandular swelling noted.. Palpation of lymph nodes in axillae WNL. No lymphadenopathy or glandular swelling noted.. Palpation of lymph nodes in other areas WNL. No lymphadenopathy or glandular swelling noted..

**Musculoskeletal:**

+ edema, palpable DP/PT pulses. + cast present.

**Integumentary (Hair, Skin)**

see wound description. see wound description.

Wound #1 presents as a Full Thickness Trauma located on the Right, Proximal, Anterior Lower Leg and measures 3.2cm length x 1cm width x 0.2cm depth; 3.2cm<sup>2</sup> area and 0.64cm<sup>3</sup> volume, calculated based on L\*W and Area\*D, respectively. There is no tunnelling, undermining, or sinus tract noted. There is a small amount of sero-sanguineous drainage noted. The wound pain is a level 5. There is 76-100% slough within the wound bed.

Wound #2 presents as a Full Thickness Trauma located on the Right, Distal, Anterior Lower Leg and measures 1.5cm length x 2cm width x 0.2cm depth; 3cm<sup>2</sup> area and 0.6cm<sup>3</sup> volume, calculated based on L\*W and Area\*D, respectively. There is no tunnelling, undermining, or sinus tract noted. There is a small amount of sero-sanguineous drainage noted. The wound pain is a level 6. There is 76-100% slough within the wound bed.

**Assessment****Diagnoses**

250.00: Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled  
891.0: Open wound knee, leg, ankle (not thigh)- w/o complication

**Procedures****Wound #1**

Wound #1 is a Trauma located on the Right, Proximal, Anterior Lower Leg. There was a Surgical debridement performed by Cotter, Jason, MD. with the following instrument(s): Curette and Scissors to remove Exudate, Fibrin, Necrotic/Eschar, Subcutaneous, and Slough after achieving pain control using 4% Lido. A time out was conducted prior to the start of the procedure. A Minimal amount of bleeding was controlled with Pressure. The procedure was tolerated well with a pain level of 2 throughout and a pain level of 0 following the procedure. Skin/Subcutaneous Tissue were removed with a total area debrided of 3.2 sq cm. Post Debridement Measurements: 3.2cm length x 1cm width x 0.2cm depth; 3.2cm<sup>2</sup> area and 0.64cm<sup>3</sup> volume, calculated based on L\*W and Area\*D, respectively.

**Plan**

Follow-Up Appointments:  
Return Appointment in 1 week.  
Anesthetic:

Topical Xylocaine to wound bed prior to debridement. - 4%

**Wound Cleansing & Dressings:**

Enzymatic Debriding Agent - santyl each day

**Compression/Edema Control/ Off-Loading:**

Elevate leg(s) above the level of the heart when sitting.

Avoid prolonged standing in one place.

Single Layer Compression Wrap - tubigrip

**Dietary:**

Increased protein

Supplement with multi-vitamin

**Follow-Up Appointments:**

A follow-up appointment should be scheduled.

Large amount of fibrinous exudate present. Santyl each day. Begin tubigrip. If edema were to worsen, consider venous ultrasound. Follow up in one week. May be future Apligraf candidate.

**Electronic Signature(s)**

Signed By:

Cotter, Jason

Date:

06/11/2012 3:14:39 PM.

Entered By: Cotter, Jason on 05/31/2012 8:54:16 PM



# COASTAL CAROLINA HOSPITAL

Milton H. Ford Regional Healthcare

## Clinic Level Of Care Assessment Details

Patient Name: Baron, Frances  
Patient Date of Birth: [REDACTED]

Date: 5/31/2012  
RN/LPN: Cole, Lori  
Physician / Extender: Cotter, Jason

## Clinic Level Of Care Assessment Items

|                                     |                                            | Quantity | Score |
|-------------------------------------|--------------------------------------------|----------|-------|
| <b>Admission / AMA</b>              |                                            |          |       |
| <input type="checkbox"/>            | Hospital Admission (Inpatient Observation) |          | 0     |
| <input type="checkbox"/>            | AMA or LWBS                                |          | 0     |
| <b>Interventions</b>                |                                            |          |       |
| <input type="checkbox"/>            | Specimen Collection # of                   |          | 0     |
| <input type="checkbox"/>            | Hematocult / Glucostix                     |          | 0     |
| <input type="checkbox"/>            | Glucose Scan / Urine Dipstick              |          | 0     |
| <input checked="" type="checkbox"/> | Elastic Wrap                               | 1        | 10    |
| <input type="checkbox"/>            | Compression Therapy Single Extremities     |          | 0     |
| <input type="checkbox"/>            | Compression Therapy Multiple Extremities   |          | 0     |
| <b>Assisting / Monitoring</b>       |                                            |          |       |
| <input type="checkbox"/>            | Ankle, Brachial Index                      |          | 0     |
| <input type="checkbox"/>            | Doppler                                    |          | 0     |
| <input type="checkbox"/>            | Monitoring - Extensive                     |          | 0     |
| <input checked="" type="checkbox"/> | Nursing Assessment - Initial               | 1        | 30    |
| <input type="checkbox"/>            | Nursing Assessment - Subsequent Partial    |          | 0     |
| <b>Wound Care</b>                   |                                            |          |       |
| <input type="checkbox"/>            | Simple Suture Removal                      |          | 0     |
| <input type="checkbox"/>            | Complex Suture Removal                     |          | 0     |
| <input checked="" type="checkbox"/> | Wound Assessment                           | 1        | 10    |
| <input type="checkbox"/>            | Wound Measurement                          |          | 0     |
| <input checked="" type="checkbox"/> | Wound Measurement - Extensive              | 1        | 10    |
| <input type="checkbox"/>            | Wound Cleansing - Simple                   |          | 0     |
| <input checked="" type="checkbox"/> | Wound Cleansing - Complex                  | 1        | 15    |
| <input checked="" type="checkbox"/> | Photography                                | 1        | 10    |
| <input type="checkbox"/>            | Extremity                                  |          | 0     |

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|                                                                                                                               |   |    |
|-------------------------------------------------------------------------------------------------------------------------------|---|----|
| <input type="checkbox"/> Tissue Expander Injection (Episodes of: )                                                            |   | 0  |
| <input type="checkbox"/> Dressing - Simple                                                                                    |   | 0  |
| <input type="checkbox"/> Dressing - Moderate                                                                                  |   | 0  |
| <input type="checkbox"/> Dressing - Moderately Complex                                                                        |   | 0  |
| <input type="checkbox"/> Dressing - Complex                                                                                   |   | 0  |
| <input checked="" type="checkbox"/> Dressing - Extensive                                                                      | 1 | 30 |
| <input type="checkbox"/> Dressing - Extensive Complex (VAC)                                                                   |   | 0  |
| <b>Special Needs</b>                                                                                                          |   |    |
| <input type="checkbox"/> Special Teaching Needs                                                                               |   | 0  |
| <input type="checkbox"/> Special Emotional Needs                                                                              |   | 0  |
| <input type="checkbox"/> Special Service Needs (Each needs episode of: )                                                      |   | 0  |
| <input type="checkbox"/> Coordination of Care                                                                                 |   | 0  |
| <input type="checkbox"/> Combative Patient                                                                                    |   | 0  |
| <b>Medications</b>                                                                                                            |   |    |
| <input checked="" type="checkbox"/> Medications - PO Suppository Topical                                                      | 1 | 5  |
| <input type="checkbox"/> IV Preexisting                                                                                       |   | 0  |
| <b>Education Discharge (Instructions)</b>                                                                                     |   |    |
| <input checked="" type="checkbox"/> Discharge Instructions                                                                    | 1 | 5  |
| <input type="checkbox"/> Discharge:Instructions                                                                               |   | 0  |
| <input type="checkbox"/> Extensive Education / Counseling                                                                     |   | 0  |
| Is this the patient's first visit: Yes      Total Score: 125      Level Of Care: New / Est Patient Level 4 - Moderate to High |   |    |

**Electronic Signature(s)**

Signed By:

Cole, Lori RN

Cole, Lori RN

Date:

06/06/2012 9:02:08 AM

06/06/2012 9:02:24 AM

Entered By: Cole, Lori on 05/31/2012 5:44:30 PM





# COASTAL CAROLINA HOSPITAL

Winston-Salem Regional Healthcare

## SuperBill Details

|                        |                |                       |               |
|------------------------|----------------|-----------------------|---------------|
| Patient Name:          | Baron, Frances | Date:                 | 5/31/2012     |
| Patient Date of Birth: | (REDACTED)     | RN/LPN:               | Cole, Lori    |
|                        |                | Physician / Extender: | Cotter, Jason |

## ICD9 Coding

| Code   | Description                                                                                                |
|--------|------------------------------------------------------------------------------------------------------------|
| 250.00 | Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled |
| 891.0  | Open wound knee, leg, ankle (not thigh)- w/o complication                                                  |

## Facility Procedures

| CPT4 Code | Description                                                                                                                    | Modifier | Quantity |
|-----------|--------------------------------------------------------------------------------------------------------------------------------|----------|----------|
| 760165    | 99204 New Patient Level 4 - Moderate to High                                                                                   |          | 1        |
| 760042    | 11042 Excisional Debride; skin & sub-Q tissue Level III                                                                        |          | 1        |
|           | Diagnosis: 250.00 - Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled |          |          |

## Physician Procedures

| CPT4 Code | Description                                                                                                                    | Modifier | Quantity |
|-----------|--------------------------------------------------------------------------------------------------------------------------------|----------|----------|
| 99203     | New Patient Level 3 - Moderate                                                                                                 |          | 1        |
| 11042     | Excisional Debride; skin & sub-Q tissue Level III                                                                              |          | 1        |
|           | Diagnosis: 250.00 - Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled |          |          |

## Electronic Signature(s)

| Signed By:    | Date:                 |
|---------------|-----------------------|
| Cole, Lori RN | 06/06/2012 9:02:08 AM |
| Cole, Lori RN | 06/06/2012 9:02:24 AM |
| Cotter, Jason | 06/11/2012 3:14:39 PM |

Entered By: Cotter, Jason on 05/31/2012 8:44:32 PM

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<https://nhs.woundexpert.com/DocumentationView.aspx?VisitID=r6...> 6/12/2012

**1. Consent to Medical and Surgical Procedures.** I consent to the procedures which may be performed during this hospitalization or while I am an outpatient or emergency department patient. These may include, but are not limited to, emergency treatment or services, laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, anesthesia, or hospital services provided to me under the general and special instructions of my physician or surgeon. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment in this hospital. I also consent to the use of removed organs, tissues, and/or fluids for research or education purposes.

**2. Nursing Care.** This hospital provides only general nursing care and care ordered by the physician(s). If I want a private duty nurse, I agree to make such arrangements. The hospital is not responsible for failure to provide a private duty nurse and is hereby released from any and all liability arising from the fact that the hospital does not provide this additional care.

**3. Teaching.** Students, residents, postgraduate fellows, nursing and other clinical students may participate in my care as a part of the clinical education or research program of the hospital under appropriate supervision. I agree that unless I notify this hospital to the contrary in writing, I agree to participate in the educational or research programs at this hospital.

**4. PHYSICIANS ARE NOT EMPLOYEES OR AGENTS OF THE HOSPITAL.** All physicians, surgeons and various allied healthcare professionals furnishing services to the patients, including but not limited to emergency department physicians, radiologists, pathologists, anesthesiologists, and all physicians and other independent practitioners who are consulted or otherwise participate in the care of the patient, are independent contractors with the patient and are not employees or agents of the hospital. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of all physicians. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered for the patient under the general and special instructions of the physician.

Emergency department physicians and other physicians caring for the patient may hire physician assistants and nurse practitioners to assist them in the performance of medical care and diagnosis. Such physician assistants and nurse practitioners are usually employed by the physicians alone, and are not employees or agents of the hospital.

My initials at the end of this paragraph or my signature at the end of this form confirms that I have read the two paragraphs above, received a copy thereof, understand and agree to the terms of these paragraphs, and am the patient, the patient's legal representative,

am duly authorized by the patient as the patient's general agent to execute the above and accept its terms. Patient Initials: BARON

**5. Maternity Patients.** If I deliver an infant(s) while a patient of this hospital, I agree that this same Condition of Services apply to the infant(s).

**6. Personal Belongings.** As a patient, I am encouraged to leave personal items at home. The hospital maintains a fireproof safe for the safekeeping of money and valuables. The hospital is not liable for the loss or damage to any money, jewelry, documents, fur, fur coats, fur garments, dentures, eye glasses, hearing aids, prosthetics, or other articles of unusual value and small size, unless placed in the safe, and shall not be liable for loss or damage to any other personal property unless deposited with the hospital for safekeeping. Hospital's maximum liability for loss of any personal property deposited with the hospital for safekeeping is limited by law to five hundred dollars (\$500.00) unless I receive a written receipt for a greater amount from the hospital.

**7. Consent to Photograph/Videotaping.** The hospital is permitted to take pictures of the medical or surgery progress involving patients and to use same for scientific, educational or research purposes. I consent to photograph during medical and surgical procedures and the use of same for scientific, educational or medical research purposes. I further consent to routine photography related to patient care, including newborns. The term "photograph" as used herein includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

**8. Emergency or Laboring Patients.** In accordance with federal law, I understand my right to receive an appropriate medical screening examination performed by a doctor, or other qualified medical professional, to determine whether I am suffering from an emergency medical condition and, if such a condition exists, stabilizing treatment within the capabilities of the hospital's staff and facilities, even if I cannot pay for these services, do not have medical insurance or I am not entitled to Medicare or Medicaid.

**9. Financial Obligations.** Notwithstanding paragraph 8, I agree to promptly pay all hospital bills in accordance with the regular rates and terms of the hospital, including its charity care and discount payment policies, if applicable. I understand that all physicians and surgeons, including the radiologists, pathologists, emergency physicians, anesthesiologists, and others, will bill separately for their services. Should any account be referred to an attorney or collection agency for collection, I will pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law. I understand the hospital may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options. Patient Initials: BARON

## Conditions of Services

Page 1 of 2

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DATE: 08/17/2012

BARON, FRANCES

05/31/12 PRE CLI

DOB: [REDACTED] 70

MR# [REDACTED]

Coastal Carolina

JASON WILLIAM MD

F MR# [REDACTED]

Coastal Carolina

# Coastal Carolina Hospital

CCD2ADM TRC1134(12-08) 10/09

**10. Assignment of Insurance or Health Plan Benefits to Hospital.** I assign and hereby authorize direct payment to the hospital of all insurance and plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurance company's or health plan's payment to the hospital pursuant to this authorization shall discharge the insurance company's or health plan's obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment.

**11. Medicare Patient's Release of Information.** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made in my behalf. I assign payment for the unpaid charges of the physician(s) for whom the hospital is authorized to bill in connection with its services. I understand I am responsible for any remaining balance not covered by other insurance.

**12. The Additional Facility Specific Addendums Have Been Offered To The Patient:** Notice of Privacy Practices and Patient Information Guide which includes information on:

- Patient Rights and Responsibilities
- Lewis Blackman Act
- Smoking Cessation
- Information regarding Advance Directives
  - ☐ Patient has not executed Advance Directives
  - ☐ Patient has executed Advance Directives – copy may be obtained from:

**13. Release of Information.** The hospital will obtain my consent and authorization to release medical information, except in those circumstances when the hospital is permitted or required by law to release information. I consent to the release of my information to third parties for education or research activities. I consent to the release of medical information to entities that provide care in post-acute settings. In accordance with the Safe Medical Device Act of 1990, I agree that in the event a permanent medical device is implanted, I authorize the hospital to notify the manufacturer of my name, address, telephone number and social security number, if available, as well as other information about the implantation.

I authorize the hospital to disclose all or any part of my record to any entity which is or may be liable to the hospital or me for all or part of the hospital's or hospital-based physicians' charges for the services provided to me, including, without limitation, hospital or insurance companies, workers' compensation carriers, welfare funds, my employer, or medical utilization review organization designated by the foregoing.

**14. Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative.** I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Obligations (Paragraph 9) and Assignment of Insurance Health Plan Benefits (Paragraph 10).

Date

Time

Financially Responsible Party

Witness

**TRANSLATOR:** I have accurately and completely read the foregoing document to \_\_\_\_\_ (name of patient/person legally authorized to give consent) in \_\_\_\_\_, the patient's or patient's representative's primary language. He/She understood all the terms and conditions and acknowledges his/her agreement thereto by signing this document in my presence.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and am the patient, the patient's legal representative, or am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

I confirm that I have read and understood and accepted the terms of this document, received a copy thereof, and am the patient, the patient's legal representative, or am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

5/31/12  
Date

1:30 am/pm  
Time

Signature

Patient / Parent / Guardian / Conservator / Responsible Party

Witness Signature / Witness Print Name

Translator Signature / Translator Print Name

If signed by other than patient, indicate relationship

**A COPY OF THIS DOCUMENT SHOULD BE GIVEN TO THE PATIENT AND ANY OTHER PERSON WHO SIGNS THIS DOCUMENT.**

Conditions of Services

Page 2 of 2

PRINTED BY: TARABLOOM

DATE: 08/17/2012

BARON, FRANCES

05/31/12

DOB: 70

PRE CLI

COTTER

JASON WILLIAM MD

F MR#

Coastal Carolina



6/07/12  
17:32:49

COASTAL CAROLINA MED CNTR  
1000 MEDICAL CENTER DR HARDEEVILLE

REGISTRATION  
SC 29927 RECORD-F01

PATIENT NO: [REDACTED] ADMIT DT/TIME: 6/07/12 13:30 M/R NO: [REDACTED]  
NS/ROOM/BED: [REDACTED] CLINICS: WC RESISTANT ORG: [REDACTED]

PATIENT NAME: BARON, FRANCES BY: AUTO  
NG ADDR: [REDACTED] TITLE: [REDACTED]  
CITY/STATE: [REDACTED] SOCIAL SECURITY: [REDACTED]  
PHONE: (843) 726-6774  
PHYSICAL ADR: [REDACTED] NPP: 2.0 DATE: 12/08/03  
CITY/STATE: [REDACTED] PHONE: ( )  
OCCUPATION: RN LANGUAGE: EN FC: 05  
POB: XX ADMT PHYS: 1202- COTTER, JASON WIL HSV: 60  
DOB: [REDACTED] ADMT PHYS PHONE: (843) 705-8888 RLG: PAR:  
AGE: 70 Y RACE: WHI ATTEND PHYS: 1202- COTTER, JASON WIL MS: M  
SEX: F REF PHY: 1202-COTTER, JASON WIL PHN: 843 705-8888 SMK: N  
PCP PHY: - PHN: [REDACTED] VAL: PT: 2  
ETHNICITY: NON FLAG: FATHER'S DOB: MOTHER'S DOB:

EMER CONTACT: EDWARD BARON REL: SPOUSE  
ADDRESS: [REDACTED] PHONE: [REDACTED]  
CITY/STATE: [REDACTED]  
NEAREST RELT: EDWARD BARON REL: SPOUSE  
ADDRESS: [REDACTED] PHONE: [REDACTED]  
CITY/STATE: [REDACTED] RESEARCH ID: [REDACTED]

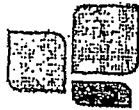
GUARANTOR: BARON, FRANCES A REL: SELF  
ADDRESS 1: [REDACTED] PHONE: [REDACTED]  
ADDRESS 2: [REDACTED] SOCIAL SECURITY: [REDACTED]  
CTY/ST/ZIP: [REDACTED] 9842 OCC:RN AF: USA  
AYOR NAME 1: NATIONWIDE MUTUAL IN INS. PLAN ID: Q9701 SRV/TYPE: ALLOP  
PLAN NAME: AUTO INSURANCE/600 IPA:  
C/O NAME: AUTH #:  
ADDRESS: 1 NATIONWIDE PLZ CERT-SSN-HIC-ID#: [REDACTED]  
Y/STE/CNTRY: COLUMBUS OH 43215 BILL PHONE: ( ) 000-0000  
BILLING NAME: GP #: NONE  
INSURED: BARON, FRANCES SEX/REL: F SELF  
EMPLOYER: SANCTUARY HOSPICE MSP: Y TRACKING#:  
ADDRESS: 10911 N JACOB SMART BLVD EMP PHONE: (843) 645-6540  
CITY/STATE: RIDGELAND ESC: 1  
AYOR NAME 2: MEDICARE/618 INS. PLAN ID: [REDACTED]  
PLAN NAME: MEDICARE/618  
LL C/O NAME: AUTH #:  
BILL ADDRESS: P O BOX 1602 CERT-SSN-HIC-ID#: [REDACTED]  
Y/STE/CNTRY: OMAHA NE 68101 BILL PHONE: (866) 580-5981  
BILLING NAME: GP #: NONE  
INSURED: BARON, FRANCES SEX/REL: F SELF  
EMPLOYER: SANCTUARY HOSPICE TRACKING#:  
ADDRESS: 10911 N JACOB SMART BLVD EMP PHONE: (843) 645-6450  
CITY/STATE: RIDGELAND ESC: 1

SPAN CODE: PRIOR VISIT: 5/31/12  
FROM/TO DATE: PRIOR HOSPITAL:  
CONDITION CD CONDITION CD OCCURRENCE CD/DATE OCCURRENCE CD/DATE  
01 5/21/12

CHIEF COMPLAINT DESCRIPTION: CHIEF COMPLAINT CODE:  
WOUND CARE  
COMMENTS:

PRINTED BY: TARABLOOM  
DATE: 08/17/2012

## Visit Report for 6/7/2012

COASTAL CAROLINA  
HOSPITAL

Norton Miami Regional Healthcare

## Arrival Information Details

Patient Name: Baron, Frances  
Patient Number: [REDACTED]  
Patient Date of Birth: [REDACTED]

Date: 6/7/2012  
RN/LPN: Cole, Lori  
Physician / Extender: Cotter, Jason

## Visit Information

Arrival Condition: Stable  
Ambulatory Status: Wheelchair  
Accompanied By: spouse  
Reason for today's visit: MD visit  
Patient Identification Verified: Yes  
Secondary Verification Process Completed: Yes  
Patient Is In Isolation Precaution? No  
Is patient oriented to person, place, and time? Yes

## History Since Last Visit

Added or deleted any medications: No  
Any new allergies or adverse reactions: No  
Added any significant procedures or medical diagnosis: No  
Experienced change in activities of daily living that may affect risk of falls: No  
Experienced any changes in pain level or management: No  
Signs or symptoms of abuse/neglect since last visit? No

## Electronic Signature(s)

Signed By:  
Cole, Lori RN  
Cole, Lori RN

Date:  
06/12/2012 4:21:07 PM  
06/12/2012 4:21:15 PM

Entered By: Cole, Lori on 06/07/2012 1:36:33 PM

**COASTAL CAROLINA  
HOSPITAL**

Wilson Head Regional Healthcare

**Pain Assessment Details**

Patient Name: Baron, Frances  
Patient Number: ( )  
Patient Date of Birth: ( )

Date: 6/7/2012  
RN/LPN: Cole, Lori  
Physician / Extender: Colter, Jason

**Location of Pain**

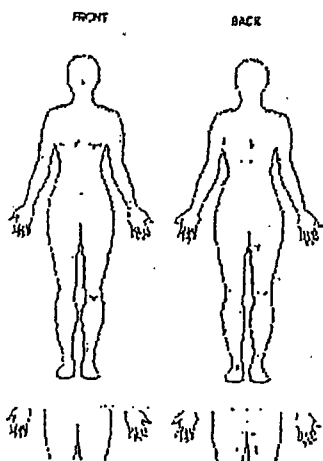
( )

**Severity and Temporal Description of Pain**

Patient Has Pain? Yes

Duration of the Pain.  
Constant / Intermittent? Constant

Rate the pain.  
Current Pain Level: 6  
Worst Pain Level: 10  
Least Pain Level: 4  
Tolerable Pain Level: 4

**Character of Pain**

Describe the Pain: Aching, Splitting, Throbbing

**Pain Management and Medication****Current Pain Management:**

Medication: Yes  
Rest: Yes  
Activity: Yes

**Notes**

Pt states R leg wounds hurt more than anything on her body

**Electronic Signature(s)**

Signed By:  
Cole, Lori RN  
Cole, Lori RN

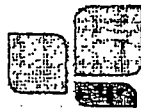
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06/12/2012 4:21:15 PM

Entered By: Cole, Lori on 06/07/2012 1:37:47 PM

PRINTED BY: TARABLOOM

DATE: 08/17/2012

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**COASTAL CAROLINA  
HOSPITAL**

Wilton Field Regional Healthcare

**Lower Extremity Assessment Details**

|                        |                |                       |               |
|------------------------|----------------|-----------------------|---------------|
| Patient Name:          | Baron, Frances | Date:                 | 6/7/2012      |
| Patient Number:        | [REDACTED]     | RN/LPN:               | Cole, Lori    |
| Patient Date of Birth: | [REDACTED]     | Physician / Extender: | Cotter, Jason |

**Edema Assessment**

|                            | Left: | Right:               |
|----------------------------|-------|----------------------|
| Edema:                     |       | Yes                  |
| Compression Device In Use: |       | Yes                  |
| Device Used Correctly:     |       | Yes                  |
| Compression Device Used:   |       | Tubigrip or Tubifast |

**Foot**

|                          |       |    |    |
|--------------------------|-------|----|----|
| Point of Measurement: cm | From: | cm | cm |
|--------------------------|-------|----|----|

**Vascular Assessment**

|                                                | Left: | Right:   |
|------------------------------------------------|-------|----------|
| Pulses:                                        |       |          |
| Popliteal:                                     |       |          |
| Dorsalis Pedis:                                |       | Palpable |
| Extremity colors, hair growth, and conditions: |       |          |
| Extremity Color:                               |       | Red      |
| Erythema:                                      |       | Yes      |

**Electronic Signature(s)**

|               |                       |
|---------------|-----------------------|
| Signed By:    | Date:                 |
| Cole, Lori RN | 06/12/2012 4:21:07 PM |
| Cole, Lori RN | 06/12/2012 4:21:15 PM |

Entered By: Cole, Lori on 06/07/2012 1:38:20 PM



**COASTAL CAROLINA  
HOSPITAL**

Wilton Head Regional Healthcare

**Adherence to Plan of Care Details**

|                        |                  |                       |               |
|------------------------|------------------|-----------------------|---------------|
| Patient Name:          | Baron, Frances   | Date:                 | 6/7/2012      |
| Patient Number:        | (b)(6)(b)(7)(C)) | RN/LPN:               | Cole, Lori    |
| Patient Date of Birth: | (b)(6)(b)(7)(C)) | Physician / Extender: | Cotter, Jason |

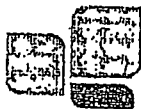
**Adherence to Plan of Care Items**

|                   |     |                |     |
|-------------------|-----|----------------|-----|
| Wound Visits:     | Yes | Umb Elevation: | Yes |
| Dressing Changes: | Yes |                |     |

**Notes****Electronic Signature(s)**

|               |                       |
|---------------|-----------------------|
| Signed By:    | Date:                 |
| Cole, Lori RN | 06/12/2012 4:21:07 PM |
| Cole, Lori RN | 06/12/2012 4:21:15 PM |

Entered By: Cole, Lori on 06/07/2012 1:38:46 PM

**COASTAL CAROLINA  
HOSPITAL**

Milton Road Regional Healthcare

**Patient/Caregiver Education Details**

|                        |                |                       |               |
|------------------------|----------------|-----------------------|---------------|
| Patient Name:          | Baron, Frances | Date:                 | 6/7/2012      |
| Patient Number:        |                | RN/LPN:               | Cole, Lori    |
| Patient Date of Birth: |                | Physician / Extender: | Cotter, Jason |

**Patient/Caregiver Education Items**

Teaching Provided To: Patient

|              |                         |
|--------------|-------------------------|
| Compression: | Yes                     |
| Methods:     | Explain/Verbal          |
| Responses:   | State content correctly |

|            |                         |
|------------|-------------------------|
| Dressing:  | Yes                     |
| Methods:   | Explain/Verbal          |
| Responses: | State content correctly |

**Electronic Signature(s)**

|               |                       |
|---------------|-----------------------|
| Signed By:    | Date:                 |
| Cole, Lori RN | 06/12/2012 4:21:07 PM |
| Cole, Lori RN | 06/12/2012 4:21:15 PM |

Entered By: Cole, Lori on 06/07/2012 1:39:11 PM

**COASTAL CAROLINA  
HOSPITAL**

Wilmington Regional Healthcare

**Visit Discharge Information Details**

|                        |                |                       |               |
|------------------------|----------------|-----------------------|---------------|
| Patient Name:          | Baron, Frances | Date:                 | 6/7/2012      |
| Patient Number:        |                | RN/LPN:               | Cole, Lori    |
| Patient Date of Birth: |                | Physician / Extender: | Cotter, Jason |

**Visit Discharge Information Items**

|                                                                            |            |
|----------------------------------------------------------------------------|------------|
| Discharge Condition:                                                       | Stable     |
| Ambulatory Status:                                                         | Wheelchair |
| Discharge Destination:                                                     | Home       |
| Transportation:                                                            | Private    |
| Accompanied By:                                                            | Auto       |
| Schedule Follow-up Appointment:                                            | spouse     |
| Medication Reconciliation completed and provided to Patient/Care Provider: | Yes        |
| Clinical Summary of Care Provided:                                         | No         |

**Facility Notification**

|                |                      |
|----------------|----------------------|
| Facility Type: | Home Health Services |
| Telephoned:    | Yes                  |
| Spoke With:    | Laura                |
| Orders Sent:   | Yes                  |

**Electronic Signature(s)**

|               |                       |
|---------------|-----------------------|
| Signed By:    | Date:                 |
| Cole, Lori RN | 06/12/2012 4:21:07 PM |
| Cole, Lori RN | 06/12/2012 4:21:15 PM |

Entered By: Cole, Lori on 06/07/2012 4:27:20 PM



## COASTAL CAROLINA HOSPITAL

Weldon Health Regional Healthcare

### Wound Assessment Details

|                        |                |                       |               |
|------------------------|----------------|-----------------------|---------------|
| Patient Name:          | Baron, Frances | Date:                 | 6/7/2012      |
| Patient Number:        |                | RN/LPN:               | Cole, Lori    |
| Patient Date of Birth: |                | Physician / Extender: | Cotter, Jason |

### Wound Status

|                 |                                     |               |            |
|-----------------|-------------------------------------|---------------|------------|
| Wound Number:   | 1                                   | Wound Status: | Not Healed |
| Wound Location: | Right, Proximal, Anterior Lower Leg |               |            |
| Wound Type:     | Trauma                              |               |            |
| Date Acquired:  | 5/21/2012                           |               |            |

### Photos

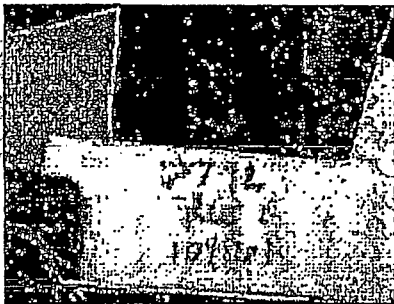


Photo Uploaded By: Sisson LPN, Sally on 6/11/2012

### Wound Measurements

|                                            |     |              |    |
|--------------------------------------------|-----|--------------|----|
| Length: (cm)                               | 2.5 | Tunneling:   | No |
| Width: (cm)                                | 1   | Undermining: | No |
| Depth: (cm)                                | 0.2 | Sinus Tract: | No |
| Hypergranulated:                           | No  |              |    |
| Area: (sq cm) based on L*W                 | 2.5 |              |    |
| Volume: (cm <sup>3</sup> ) based on Area*D | 0.5 |              |    |

### Wound Description

|                              |                  |                   |    |
|------------------------------|------------------|-------------------|----|
| Thickness:                   | Full Thickness   | Exposed Structure |    |
| Exudate Amount:              | Small            | Tendon Exposed:   | No |
| Exudate Type:                | Sero-sanguineous | Muscle Exposed:   | No |
| Pain:                        | 6                | Joint Exposed:    | No |
| Less than 20% slough/fibrin? | No               | Bone Exposed:     | No |
| Slough:                      | Percentage       |                   |    |
| Granulation:                 | 26-50%           |                   |    |
| Granulation Texture:         | Firm             |                   |    |
| Pink:                        | Yes              |                   |    |

PRINTED BY: TARABLOOM

DATE: 08/17/2012

<https://nhs.woundexpert.com/DocumentationView.aspx?VisitID=6R...> 6/13/2012

Peripheral Skin Appearance

|                     |          |     |                                                                     |                  |        |
|---------------------|----------|-----|---------------------------------------------------------------------|------------------|--------|
| Normal For Patient: | Texture  | No  | Normal For Patient:                                                 | Color            | Yes    |
| Edema:              |          | Yes |                                                                     |                  |        |
| Induration:         |          | Yes | Temperature:                                                        | Temperature      | Warm   |
| Normal For Patient: | Moisture | Yes | S/S Present:                                                        | S/S of Infection | Yes    |
|                     |          |     | Confirmation Description & Treatment Plan: Signs & Symptoms Present |                  |        |
|                     |          |     | Local Pulse:                                                        | Local Pulse      | Normal |

Treatment NotesWound #1 (Right, Proximal, Anterior Lower Leg)Wound Treatment Note

- Pt ID by name and photo, correct site ID.
- Assessed patient's pain status and effectiveness of pain management plan.
- Removed old dressing, taking care to avoid trauma to the wound bed
- Cleansed wound and periwound with non-cytotoxic agent using Wound cleanser (1)
- Obtained wound photo
- Applied topical anesthetic for procedural pain control per physician order using Lidocaine 4% Topical (1)
- Debridement.
- Applied enzymatic debriding agent to wound bed. using Santyl (1)
- Applied primary wound dressing using normal saline gauze (1)
- Applied Secondary Wound Dressing using Gauze (1)
- Dressing secured dressing in place using Tape (1)
- Applied Compression device using Tubigrip (1)

Electronic Signature(s)

Signed By:  
Cole, Lori RN  
Cole, Lori RN

Dates  
06/12/2012 4:21:07 PM  
06/12/2012 4:21:15 PM

Entered By: Cole, Lori on 06/07/2012 1:35:50 PM



# COASTAL CAROLINA HOSPITAL

Wilson Road Regional Healthcare

## Wound Assessment Details

|                        |                |                       |               |
|------------------------|----------------|-----------------------|---------------|
| Patient Name:          | Baron, Frances | Date:                 | 6/7/2012      |
| Patient Number:        | (REDACTED)     | RN/LPN:               | Cole, Lori    |
| Patient Date of Birth: | (REDACTED)     | Physician / Extender: | Cotter, Jason |

## Wound Status

|                 |                                   |               |           |
|-----------------|-----------------------------------|---------------|-----------|
| Wound Number:   | 2                                 | Wound Status: | Converted |
| Wound Location: | Right, Distal, Anterior Lower Leg |               |           |
| Wound Type:     | Trauma                            |               |           |
| Date Acquired:  | 5/21/2012                         |               |           |

## Photos



Photo Uploaded By: Slisson LPN, Sally on 6/11/2012

## Wound Measurements

|                                            |       |              |    |
|--------------------------------------------|-------|--------------|----|
| Length: (cm)                               | 1.1   | Tunneling:   | No |
| Width: (cm)                                | 1.3   | Undermining: | No |
| Depth: (cm)                                | 0.1   | Sinus Tract: | No |
| Hypergranulated:                           | No    |              |    |
| Area: (sq cm) based on L*W                 | 1.43  |              |    |
| Volume: (cm <sup>3</sup> ) based on Area*D | 0.143 |              |    |

## Wound Description

|                 |                    |                   |    |
|-----------------|--------------------|-------------------|----|
| Thickness:      | Eschar covered     | Exposed Structure |    |
| Exudate Amount: | None               | Tendon Exposed:   | No |
| Pain:           | 6                  | Muscle Exposed:   | No |
|                 |                    | Joint Exposed:    | No |
|                 |                    | Bone Exposed:     | No |
| Slough:         | Percentage 75-100% |                   |    |

## Peripheral Skin Appearance

|                     |         |     |                     |             |      |
|---------------------|---------|-----|---------------------|-------------|------|
| Normal For Patient: | Texture | No  | Normal For Patient: | Color       | Yes  |
| Edema:              |         | Yes |                     |             |      |
| Induration:         |         | Yes | Temperature:        | Temperature | Warm |

PRINTED BY: TARABLOOM

DATE: 08/17/2012

<https://nhs.woundexpert.com/DocumentationView.aspx?VisitID=6R...> 6/13/2012

|                     |                 |              |                                                                     |        |
|---------------------|-----------------|--------------|---------------------------------------------------------------------|--------|
| Normal For Patient: | <b>Moisture</b> | Yes          | <b>S/S of Infection</b>                                             | Yes    |
|                     |                 |              | S/S Present:                                                        |        |
|                     |                 |              | Confirmation Description & Treatment Plan: Signs & Symptoms Present |        |
|                     |                 |              | <b>Local Pulse</b>                                                  | Normal |
|                     |                 | Local Pulse: |                                                                     |        |

**Electronic Signature(s)**

|                   |                       |
|-------------------|-----------------------|
| <b>Signed By:</b> | <b>Date:</b>          |
| Cole, Lori RN     | 06/12/2012 4:21:07 PM |
| Cole, Lori RN     | 06/12/2012 4:21:15 PM |

Entered By: Cole, Lori on 06/07/2012 4:24:30 PM



## COASTAL CAROLINA HOSPITAL

Hilton Head Regional Healthcare

### Wound Assessment Details

|                        |                |                       |               |
|------------------------|----------------|-----------------------|---------------|
| Patient Name:          | Baron, Frances | Date:                 | 6/7/2012      |
| Patient Number:        | REDACTED       | RN/LPN:               | Cole, Lori    |
| Patient Date of Birth: | REDACTED       | Physician / Extender: | Cotter, Jason |

### Wound Status

|                 |                            |               |            |
|-----------------|----------------------------|---------------|------------|
| Wound Number:   | 3                          | Wound Status: | Not Healed |
| Wound Location: | Distal, Anterior Lower Leg |               |            |
| Wound Type:     | Trauma                     |               |            |

### Photos



Photo Uploaded By: Sisson LPN, Sally on 6/11/2012

### Wound Measurements

|                                            |    |                              |     |
|--------------------------------------------|----|------------------------------|-----|
| Length: (cm)                               | 1  | Tunneling:                   | Yes |
| Width: (cm)                                | 1  | Position (o'clock):          | 12  |
| Depth: (cm)                                | 1  | Maximum Distance: (cm)       | 7   |
| Hypergranulated:                           | No |                              |     |
| Area: (sq cm) based on L*W                 | 1  | Undermining:                 | Yes |
| Volume: (cm <sup>3</sup> ) based on Area*D | 1  | Starting Position (o'clock): | 1   |
|                                            |    | Ending Position (o'clock):   | 11  |
|                                            |    | Maximum Distance: (cm)       | 3.5 |
|                                            |    | Sinus Tract:                 | No  |

### Wound Description

|                 |                 |                   |    |
|-----------------|-----------------|-------------------|----|
| Thickness:      | Full Thickness  | Exposed Structure |    |
| Exudate Amount: | Copious         | Tendon Exposed:   | No |
| Exudate Type:   | Other           | Muscle Exposed:   | No |
| Odor:           | None            | Joint Exposed:    | No |
| Pain:           | 6               | Bone Exposed:     | No |
| Wound Margin:   | Flat and Intact |                   |    |

Percentage

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**Peripheral Skin Appearance**

|                     |          |     |                                                                     |             |        |
|---------------------|----------|-----|---------------------------------------------------------------------|-------------|--------|
| Normal For Patient: | Texture  | Yes | Normal For Patient:                                                 | Color       | Yes    |
| Normal For Patient: | Moisture | Yes | Temperature:                                                        | Temperature | Warm   |
|                     |          |     | S/S of Infection                                                    |             |        |
|                     |          |     | S/S Present:                                                        |             | Yes    |
|                     |          |     | Confirmation Description & Treatment Plan: Signs & Symptoms Present |             |        |
|                     |          |     | Local Pulse:                                                        | Local Pulse | Normal |

**Assessment Notes**

wound converted after debridement and evacuation of hematoma

**Treatment Notes****Wound #3 (Distal, Anterior Lower Leg)****Wound Treatment Note**

- Pt ID by name and photo, correct site ID.
- Assessed patient's pain status and effectiveness of pain management plan
- Removed old dressing, taking care to avoid trauma to the wound bed
- Cleansed wound and periwound with non-cytotoxic agent using Wound cleanser (1)
- Obtained wound photo
- Applied topical anesthetic for procedural pain control per physician order using Lidocaine 1% Injectable (1)
- Debridement.
- Assured hemostasis
- Applied primary wound dressing using Iodoform (1)
- Applied Secondary Wound Dressing using Gauze (1), Kerlix (1)
- Dressing secured dressing in place using Netting (1)
- Applied Compression device using Tubigrip (1)

**Electronic Signature(s)**

Signed By:

Cole, Lori RN

Cole, Lori RN

Date:

06/12/2012 4:21:07 PM

06/12/2012 4:21:15 PM

Entered By: Cole, Lori on 06/07/2012 4:29:54 PM

**Treatment Notes Summary****Wound #1 (Right, Proximal, Anterior Lower Leg)****Wound Treatment Note**

- Pt ID by name and photo, correct site ID.
- Assessed patient's pain status and effectiveness of pain management plan
- Removed old dressing, taking care to avoid trauma to the wound bed
- Cleansed wound and periwound with non-cytotoxic agent using Wound cleanser (1)
- Obtained wound photo
- Applied topical anesthetic for procedural pain control per physician order using Lidocaine 4% Topical (1)
- Debridement.
- Applied enzymatic debriding agent to wound bed, using Santyl (1)
- Applied primary wound dressing using normal saline gauze (1)
- Applied Secondary Wound Dressing using Gauze (1)
- Dressing secured dressing in place using Tape (1)
- Applied Compression device using Tubigrip (1)

**Wound #3 (Distal, Anterior Lower Leg)****Wound Treatment Note**

- Pt ID by name and photo, correct site ID.
- Assessed patient's pain status and effectiveness of pain management plan
- Removed old dressing, taking care to avoid trauma to the wound bed
- Cleansed wound and periwound with non-cytotoxic agent using Wound cleanser (1)
- Obtained wound photo
- Applied topical anesthetic for procedural pain control per physician order using Lidocaine 1% Injectable (1)
- Debridement.
- Assured hemostasis
- Applied primary wound dressing using Iodoform (1)
- Applied Secondary Wound Dressing using Gauze (1), Kerlix (1)
- Dressing secured dressing in place using Netting (1)
- Applied Compression device using Tubigrip (1)

**COASTAL CAROLINA  
HOSPITAL**

Hilton Head Regional Healthcare

**Physician Orders Details**

Patient Name: Baron, Frances

Patient Number: [REDACTED]

Patient Date of Birth: [REDACTED]

Date: 6/7/2012

RN/LPN: Cole, Lori

Physician / Extender: Cotter, Jason

Verbal / Phone Orders: No

**Follow-Up Appointments**

- Return Appointment in 1 wee k.

**Anesthetic**

- Topical Xylocaine to wound bed prior to debridement. - 4%

**Wound Cleansing & Dressings**

- Enzymatic Debriding Agent - santyl each day to proximal wound.
- Pack wound - 1/4 inch iodoform BID to distal wound

**Compression/Edema Control/ Off-Loading**

- Elevate leg(s) above the level of the heart when sitting.
- Avoid prolonged standing in one place.
- Single Layer Compression Wrap - tubigrip

**Dietary**

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- Increased protein
- Supplement with multi-vitamin

Ancillary Services

- Home Health Services - SN for wound care daily x 1 week, pack distal wound to tunnel at 12 and undermining 1-11

Notes

Electronic Signature(s)

Signed By:

Cotter, Jason

Cole, Lori RN

Cole, Lori RN

Date:

06/11/2012 3:14:39 PM

06/12/2012 4:21:07 PM

06/12/2012 4:21:15 PM

Entered By: Cole, Lori on 06/07/2012 4:39:03 PM

**COASTAL CAROLINA  
HOSPITAL**

J Hilton Head Regional Healthcare

**Progress Note Details**

Patient Name: Baron, Frances  
Patient Number: [REDACTED]  
Patient Date of Birth: [REDACTED]

Date: 6/7/2012  
RN/LPN: Cole, Lori  
Physician / Extender: Cotter, Jason

**Subjective**

Allergies:  
mango

70 year old female who was in a car accident suffering a left lower leg fracture and right lower leg wounds. Her right lower leg x-rays were negative. She has been using Santyl on this wound daily. There have been no improving or worsening factors. Her risk factors for wound healing include diabetes and venous hypertension. She denies nausea, vomiting, fever, or chills. She has been receiving wound care for one week. She seems to think that her pain over her right leg is worse than she would expect. This area feels like there is fluid under the skin.

**Objective****Integumentary (Hair, Skin)**

Wound #1 presents as a Full Thickness Trauma located on the Right, Proximal, Anterior Lower Leg and measures 2.5cm length x 1cm width x 0.2cm depth; 2.5cm<sup>2</sup> area and 0.5cm<sup>3</sup> volume, calculated based on L\*W and Area\*D, respectively. There is no tunneling, undermining, or sinus tract noted. There is a small amount of sero-sanguineous drainage noted. The wound pain is a level 6. There is 26-50% slough and 26-50% \*\*pink, firm granulation within the wound bed.

Wound #2 has been Converted. There is no tunneling, undermining, or sinus tract noted. There was no drainage noted. The wound pain is a level 6. There is \*\*76-100% slough within the wound bed.

Wound #3 presents as a Full Thickness Trauma located on the Distal, Anterior Lower Leg and measures 1cm length x 1cm width x 1cm depth; 1cm<sup>2</sup> area and 1cm<sup>3</sup> volume, calculated based on L\*W and Area\*D, respectively. There is no sinus tract, however, tunneling has been noted at 12:00 with a maximum distance of 7cm. Undermining begins at 1:00 and ends at 11:00 with a maximum distance of 3.5cm. There is a copious amount of other drainage noted which has no odor. The wound pain is a level 6. The wound margin is flat and intact.

**Assessment****Diagnoses**

250.00: Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled  
891.0: Open wound knee, leg, ankle (not thigh) - w/o complication  
459.33: Chronic venous hypertension with ulcer and inflammation  
729.92: Nontraumatic hematoma of soft tissue

**Procedures****Plan**

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**Follow-Up Appointments:**

Return Appointment in 1 week.

**Anesthetic:**

Topical Xylocaine to wound bed prior to debridement. - 4%

**Wound Cleansing & Dressings:**

Enzymatic Debriding Agent - santyl each day to proximal wound

Pack wound - 1/4 Inch Iodoform BID to distal wound

**Compression/Edema Control/ Off-Loading:**

Elevate leg(s) above the level of the heart when sitting.

Avoid prolonged standing in one place.

Single Layer Compression Wrap - tubigrip

**Dietary:**

Increased protein

Supplement with multi-vitamin

**Ancillary Services ordered were:**

Home Health Services - SN for wound care daily x 1 week, pack distal wound to tunnel at 12 and undermining 1-11

**Follow-Up Appointments:**

A follow-up appointment should be scheduled.

Area injected with local using sterile technique. Large amount of blood and fluid aspirated. Necrotic tissue from inferior wound removed. Moderate amount of blood clots manually removed from wound. Will continue santyl to proximal wound and begin packing distal wound with Iodoform. Return for follow up visit in one week.

**Electronic Signature(s)**

Signed By:

Cotter, Jason

Date:

06/11/2012 3:14:39 PM

Entered By: Slisson LPN, Sally on 06/07/2012 5:39:33 PM



## COASTAL CAROLINA HOSPITAL

Wilson Medical Regional Healthcare

### Clinic Level Of Care Assessment Details

Patient Name: Baron, Frances  
 Patient Number:   
 Patient Date of Birth:

Date: 6/7/2012  
 RN/LPN: Cole, Lori  
 Physician / Extender: Cotter, Jason

### Clinic Level Of Care Assessment Items

| Admission / AMA                                                             | Quantity | Score |
|-----------------------------------------------------------------------------|----------|-------|
| <input type="checkbox"/> Hospital Admission (Inpatient Observation)         |          | 0     |
| <input type="checkbox"/> AMA or LWBS                                        |          | 0     |
| <b>Interventions</b>                                                        |          |       |
| <input type="checkbox"/> Specimen Collection # of                           |          | 0     |
| <input type="checkbox"/> Hematocult / Glucostix                             |          | 0     |
| <input type="checkbox"/> Glucose Scan / Urine Dipstick                      |          | 0     |
| <input type="checkbox"/> Elastic Wrap                                       |          | 0     |
| <input checked="" type="checkbox"/> Compression Therapy Single Extremities  | 1        | 15    |
| <input type="checkbox"/> Compression Therapy Multiple Extremities           |          | 0     |
| <b>Assisting / Monitoring</b>                                               |          |       |
| <input type="checkbox"/> Ankle, Brachial Index                              |          | 0     |
| <input type="checkbox"/> Doppler                                            |          | 0     |
| <input type="checkbox"/> Monitoring - Extensive                             |          | 0     |
| <input type="checkbox"/> Nursing Assessment - Initial                       |          | 0     |
| <input checked="" type="checkbox"/> Nursing Assessment - Subsequent Partial | 1        | 10    |
| <b>Wound Care</b>                                                           |          |       |
| <input type="checkbox"/> Simple Suture Removal                              |          | 0     |
| <input type="checkbox"/> Complex Suture Removal                             |          | 0     |
| <input checked="" type="checkbox"/> Wound Assessment                        | 1        | 10    |
| <input type="checkbox"/> Wound Measurement                                  |          | 0     |
| <input checked="" type="checkbox"/> Wound Measurement - Extensive           | 1        | 10    |
| <input type="checkbox"/> Wound Cleansing - Simple                           |          | 0     |
| <input checked="" type="checkbox"/> Wound Cleansing - Complex               | 1        | 15    |
| <input checked="" type="checkbox"/> Photography                             | 1        | 10    |
| <input type="checkbox"/> Extremity                                          |          | 0     |

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|                                           |                                                 |   |    |
|-------------------------------------------|-------------------------------------------------|---|----|
| <input type="checkbox"/>                  | Tissue Expander Injection (Episodes of: )       |   | 0  |
| <input type="checkbox"/>                  | Dressing - Simple                               |   | 0  |
| <input type="checkbox"/>                  | Dressing - Moderate                             |   | 0  |
| <input type="checkbox"/>                  | Dressing - Moderately Complex                   |   | 0  |
| <input type="checkbox"/>                  | Dressing - Complex                              |   | 0  |
| <input checked="" type="checkbox"/>       | Dressing - Extensive                            | 1 | 30 |
| <input type="checkbox"/>                  | Dressing - Extensive Complex (VAC)              |   | 0  |
| <b>Special Needs</b>                      |                                                 |   |    |
| <input type="checkbox"/>                  | Special Teaching Needs                          |   | 0  |
| <input type="checkbox"/>                  | Special Emotional Needs                         |   | 0  |
| <input type="checkbox"/>                  | Special Service Needs (Each needs episode of: ) |   | 0  |
| <input type="checkbox"/>                  | Coordination of Care                            |   | 0  |
| <input type="checkbox"/>                  | Combative Patient                               |   | 0  |
| <b>Medications</b>                        |                                                 |   |    |
| <input checked="" type="checkbox"/>       | Medications - PO Suppository Topical            | 1 | 5  |
| <input type="checkbox"/>                  | IV Preexisting                                  |   | 0  |
| <b>Education Discharge (Instructions)</b> |                                                 |   |    |
| <input checked="" type="checkbox"/>       | Discharge Instructions                          | 1 | 5  |
| <input type="checkbox"/>                  | Discharge Instructions                          |   | 0  |
| <input type="checkbox"/>                  | Extensive Education / Counseling                |   | 0  |

Is this the patient's first visit: No    Total Score: 110    Level Of Care: New / Est Patient Level 4 - Moderate to High

### Electronic Signature(s)

Signed By:  
Cole, Lori RN  
Cole, Lori RN

Date:  
06/12/2012 4:21:07 PM  
06/12/2012 4:21:15 PM

Entered By: Cole, Lori on 06/07/2012 4:37:13 PM

**COASTAL CAROLINA  
HOSPITAL**

Sharon Health Regional Healthcare

**SuperBill Details**

|                        |                |                       |               |
|------------------------|----------------|-----------------------|---------------|
| Patient Name:          | Baron, Frances | Date:                 | 6/7/2012      |
| Patient Number:        | [REDACTED]     | RN/LPN:               | Cole, Lori    |
| Patient Date of Birth: | [REDACTED]     | Physician / Extender: | Cotter, Jason |

**ICD9 Coding**

| Code   | Description                                                                                                |
|--------|------------------------------------------------------------------------------------------------------------|
| 250.00 | Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled |
| 891.0  | Open wound knee, leg, ankle (not thigh)- w/o complication                                                  |
| 459.33 | Chronic venous hypertension with ulcer and inflammation                                                    |
| 862.92 | Nontraumatic hematoma of soft tissue                                                                       |

**Facility Procedures**

| CPT4 Code | Description                                   | Modifier | Quantity |
|-----------|-----------------------------------------------|----------|----------|
| 760171    | 99214 Est. Patient Level 4 - Moderate to High |          | 1        |

**Physician Procedures**

| CPT4 Code | Description                     | Modifier | Quantity |
|-----------|---------------------------------|----------|----------|
| 99213     | Est. Patient Level 3 - Moderate |          | 1        |

**Electronic Signature(s)**

| Signed By:    | Date:                 |
|---------------|-----------------------|
| Cotter, Jason | 06/11/2012 3:14:39 PM |
| Cole, Lori RN | 06/12/2012 4:21:07 PM |
| Cole, Lori RN | 06/12/2012 4:21:15 PM |

Entered By: Slsson LPN, Sally on 06/07/2012 5:38: 24 PM





6/14/12

4:22:12

COASTAL CAROLINA MED CNTR  
1000 MEDICAL CENTER DR HARDEEVILLE

REGISTRATION  
SC 29927 RECORD-F01

PATIENT NO:  
NS/ROOM/BED:

ADMIT DT/TIME: 6/14/12 13:30 M/R NO:  
CLINICS: WC RESISTANT ORG:

PATIENT NAME: BARON, FRANCES

BY: AUTO  
TITLE:

NG ADDR:

SOCIAL SECURITY:

CITY/STATE:

PHONE:

PHYSICAL ADR:

NPP: 2.0 DATE: 12/08/03

CITY/STATE:

PHONE:

OCCUPATION: RN

LANGUAGE: EN

FC: 05

POB: XX

ADMT PHYS: 1202- COTTER, JASON WIL HSV: 60

DOB:

ADMT PHYS PHONE: (843) 705-8888 RLG: PAR:

AGE: 70 Y RACE: WHI

ATTEND PHYS: 1202- COTTER, JASON WIL MS: M

SEX: F REF PHY: 1202-COTTER, JASON WIL PHN: 843 705-8888 SMK: N

PCP PHY: 74-ETHERIDGE, TRICIA PHN: 843 726-6773 VAL: PT: 2

ETHNICITY: NON FLAG:

FATHER'S DOB:

MOTHER'S DOB:

MER CONTACT: BARON, EDWARD

REL: SPOUSE

ADDRESS:

PHONE:

CITY/STATE:

EAREST RELT: BARON, EDWARD

REL: SPOUSE

ADDRESS:

PHONE:

CITY/STATE:

RESEARCH ID:

GUARANTOR: BARON, FRANCES A

REL: SELF

ADDRESS 1:

PHONE:

ADDRESS 2:

SOCIAL SECURITY:

CTY/STE/ZIP:

9842 OCC: RN

AF: USA

AYOR NAME 1: NATIONWIDE MUTUAL INSURAN INS. PLAN ID: Q9701 SRV/TYPE: ALLOP

PLAN NAME: AUTO INSURANCE/600

IPA:

C/O NAME:

AUTH #:

ADDRESS: 1 NATIONWIDE PLAZA

CERT-SSN-HIC-ID#:

Y/STE/CNTRY: COLUMBUS OH 43215

BILL PHONE: ( ) 000-0000

BILLING NAME:

GP #: NONE

INSURED: BARON, FRANCES

SEX/REL: F SELF

EMPLOYER: SANCTUARY HOSPICE

MSP: Y TRACKING#:

ADDRESS: 10911 N JACOB SMART BLVD

EMP PHONE: (843) 645-6540

CITY/STATE: RIDGELAND

ESC: 1

AYOR NAME 2: MEDICARE/618

INS. PLAN ID:

PLAN NAME: MEDICARE/618

LL C/O NAME:

AUTH #:

ILL ADDRESS: P O BOX 1602

CERT-SSN-HIC-ID#:

Y/STE/CNTRY: OMAHA NE 68101

BILL PHONE: (866) 580-5981

BILLING NAME:

GP #: NONE

INSURED: BARON, FRANCES

SEX/REL: F SELF

EMPLOYER: SANCTUARY HOSPICE

TRACKING#:

ADDRESS: 10911 N JACOB SMART BLVD

EMP PHONE: (843) 645-6450

CITY/STATE: RIDGELAND

ESC: 1

SPAN CODE:

PRIOR VISIT: 6/07/12

ROM/TO DATE:

PRIOR HOSPITAL:

NDITION CD

CONDITION CD

OCCURRENCE CD/DATE

OCCURRENCE CD/DATE

11

6/14/12

CHIEF COMPLAINT DESCRIPTION:

CHIEF COMPLAINT CODE:

WOUND CARE / ULTRASOUND / LAB

MENTS:

PRINTED BY: TARABLOOM

DATE: 08/17/2012

# SCHEDULED OUTPATIENT RADIOLOGY

(To Schedule Exams Call 784-8230)

Appt. Date: \_\_\_\_\_

Time: \_\_\_\_\_

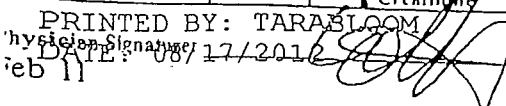
|                                                    |                                                                                   |
|----------------------------------------------------|-----------------------------------------------------------------------------------|
| Patient Name (Print)                               | Patient Address:<br>City, State, Zip Code                                         |
| Patient Photo                                      | Date of Birth: Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Ordering Ph (Print)                                | Ordering physician's phone number & fax number:<br>Phone: Fax:                    |
| Insurance (Print)                                  | Insurance Company Phone Number                                                    |
| History, Signs, Symptoms (Required for each test): |                                                                                   |
| Diagnosis Code (ICD9) 250.00 891.0 459.33 729.92   |                                                                                   |

PHYSICIAN: Please check the requested exams below mark appropriately with left / right and Contrast type (Oral or IV Contrast or both.) Please schedule appointment at (843) 784-8230 and fax completed orders to 784-8094. Please circle the appropriate preparation instructions printed on the back of this form. Patients should present the original order to registration upon arrival.

PATIENT: Please review your orders and preparation instructions on back of this form; any questions please call (843) 784-8230 Mon-Fri, 8AM-5 PM. Please bring your original order form, driver's license (or picture ID) and insurance information.

Please arrive 30 minutes prior to your appointment to assure that there is little or no delay for your scheduled procedure.

| FLOURO                   | CODE  | <input checked="" type="checkbox"/> | ULTRASOUND (cont.)               | CODE        | <input checked="" type="checkbox"/> | NUCLEAR MED                            | CODE  | <input checked="" type="checkbox"/> | NUCLEAR MED              | CODE  | <input checked="" type="checkbox"/> |
|--------------------------|-------|-------------------------------------|----------------------------------|-------------|-------------------------------------|----------------------------------------|-------|-------------------------------------|--------------------------|-------|-------------------------------------|
| Arthrogram               | 73-   |                                     | Abdomen                          | 76700       |                                     | Bone Scan Limited                      | 78300 |                                     | Meckles                  |       |                                     |
| Esophogram / BASW        | 74220 |                                     | Abdomen Limited "Gallbladder"    | 76705       |                                     | Bone Scan- Whole Body                  | 78306 |                                     | WBC Scan                 | 78806 |                                     |
| Barium Swallow Modified  | 74230 |                                     | Aorta                            | 93978       |                                     | Bone Scan-3 Phase                      | 78315 |                                     | MUGA/Gated Heart         | 78472 |                                     |
| Upper GI Series          | 74241 |                                     | Retroperitoneum (Kidney)         | 76770       |                                     | Bone Scan-SPECT                        | 78320 |                                     | Parathyroid Scan         | 78070 |                                     |
| UGI w/ SBFT              | 74245 |                                     | Renal Arterial                   | 93975       |                                     | Cardiac rest/stress Type- Exer. / Lexi | 78452 |                                     | Renal Scan w/ lasix      | 78708 |                                     |
| Small Bowel Series       | 74250 |                                     | Pelvic                           | 76856       |                                     | Cardiac Viability                      | 78452 |                                     | Renal Scan w/o           | 78707 |                                     |
| BE - single contrast     | 74270 |                                     | Trans Vaginal                    | 76830       |                                     | Lung Scan VQ                           | 78580 |                                     | Renal with Captopril     | 78708 |                                     |
| BE - double contrast     | 74280 |                                     | OB <14 weeks (TV)                | 76817       |                                     | Lung Quantitative                      | 78596 |                                     |                          |       |                                     |
| Cystogram voiding (VCUG) | 74430 |                                     | OB <14 weeks (TA)                | 76801       |                                     | Gallium Scan                           | 78802 |                                     | Thyroid Scan Only        | 78010 |                                     |
| ogram                    | 74430 |                                     | OB Complete >14 weeks            | 76805       |                                     | Gastric Emptying                       | 78264 |                                     | Thyroid w/ Uptake & Scan | 78007 |                                     |
| IVP                      | 74400 |                                     | OB Limited                       | 76816       |                                     | HIDA w/ CCK w/o CCK                    | 78223 |                                     | Thyroid Mets Scan        | 78018 |                                     |
| IVP with tomos           | 74415 |                                     | Biophysical Profile              | 76818       |                                     | Lymphoscintigraphy - area:             | 78195 |                                     | Thyroid Therapy          | 79005 |                                     |
| CT cervical Myelogram    | 72240 |                                     | Carotids                         | 93880       |                                     | Lympho (Indicate area)                 | 78195 |                                     |                          |       |                                     |
| CT Thoracic Myelogram    | 72255 |                                     | Chest                            | 76604       |                                     |                                        |       |                                     |                          |       |                                     |
| CT Lumbar Myelogram      | 72265 |                                     | PADE                             | 93923       |                                     |                                        |       |                                     |                          |       |                                     |
| PICC Line Insertion      | 36569 |                                     | Breast RT / LT / BILAT           | 76645       |                                     |                                        |       |                                     |                          |       |                                     |
| PICC line check          | 36598 |                                     | Venous Duplex Scan - Bilat       | 93970       |                                     |                                        |       |                                     |                          |       |                                     |
|                          |       |                                     | UPPER / LOWER - Unilat RT / LT   | 93971       | Y                                   |                                        |       |                                     |                          |       |                                     |
|                          |       |                                     | Duplex Arterial Bilat (or graft) | 93925       |                                     |                                        |       |                                     |                          |       |                                     |
| <b>MAMMOGRAM</b>         |       |                                     |                                  |             |                                     |                                        |       |                                     |                          |       |                                     |
| Ultrasound               |       |                                     | Thyroid/ Soft Tissue Neck        | 76536       |                                     | Screening                              | G0202 |                                     | Needle Loc Area RT / LT  | 77032 |                                     |
| AAA Screening            | G0389 |                                     | Biopsy: Area:                    |             |                                     | Diagnostic Bilat                       | G0204 |                                     | Ductogram (Galactogram)  | 77053 |                                     |
| Thoracentesis            | 76942 |                                     | Scrotum w/doppler                | 76870 93976 |                                     | Diagnostic Unilat. RT / LT             | G0206 |                                     | Additional / Spot Views  | G0206 |                                     |
| Paracentesis             | 76942 |                                     | Misc.                            |             |                                     | Ultrasound if Indicated                | 76645 |                                     | Bone Density             | 77080 |                                     |
| BUN                      | 84520 |                                     | LABS - Creatinine                | 82565       |                                     |                                        |       |                                     |                          |       |                                     |

PRINTED BY: TARABLOM  
Physician Signature:   
DATE: 06/17/2012

Date: 6/14/12  
CCH/Rad#3A



Notice: Bills will be submitted for payment to Medicare, Medicaid, all other governmental programs, and third party payors based upon the diagnostic information provided by the treating physician.

1000 Medical Center Dr.  
Hardeeville, SC 29927  
Laboratory  
Phone 843-784-8088

|                                                                                                                   |  |                                            |     |                                                                                                             |     |
|-------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------|-----|-------------------------------------------------------------------------------------------------------------|-----|
| PATIENT NAME: LAST N,                                                                                             |  | MI                                         | SEX | DATE OF BIRTH                                                                                               | SS# |
| REQUESTING PHYSICIAN                                                                                              |  | PHYSICIAN FAX:                             |     |                                                                                                             |     |
| BILL TO:                                                                                                          |  | Initial                                    |     | Relationship                                                                                                |     |
| <input type="checkbox"/> Patient<br><input type="checkbox"/> Medicare<br><input type="checkbox"/> Other 3rd Party |  | Phone                                      |     | Routine<br>STAT<br>Standing order:<br>Date started: _____<br>Date ending: _____<br>(not to exceed 6 months) |     |
| ALL INSURANCE AND DEMOGRAPHIC INFORMATION MUST BE COMPLETED                                                       |  | Ins. Phone                                 |     | DATE DRAWN                                                                                                  |     |
| Insurance Co. Name/Coverage (Attach Copy of Card)                                                                 |  | DOB                                        |     | TIME DRAWN                                                                                                  |     |
| Insurance Co. Address                                                                                             |  | Date of Injury if Workers Comp. ICD 9 Code |     | : AM/PM                                                                                                     |     |
| Certificate#/Pol #/Group #/Medicare #/Medi-Cal ID#                                                                |  |                                            |     | DRAWN BY:                                                                                                   |     |
| Employer                                                                                                          |  |                                            |     |                                                                                                             |     |

| Organ or Disease Oriented Panels            |       |
|---------------------------------------------|-------|
| <i>See reverse side for included tests.</i> |       |
| _____ Acute Hepatitis Panel                 | 80074 |
| _____ Basic Metabolic Panel                 | 80048 |
| _____ Comprehensive Metabolic Panel         | 80053 |
| _____ Electrolyte Panel                     | 80051 |
| _____ Hepatic Function Panel                | 80076 |
| _____ Lipid Panel                           | 80061 |
| _____ Renal Function Panel                  | 80069 |

ICD-9-CM REQUIRED 782.3 729.5  
(see reverse side for Medicare regulations)

|               |               |
|---------------|---------------|
| 250.00        | 891.0         |
| <u>459.33</u> | <u>729.92</u> |

|                            |       |
|----------------------------|-------|
| — Albumin                  | 82045 |
| — Alk. Phos.               | 84075 |
| — Amylase                  | 82150 |
| — ANA                      | 86038 |
| — AST/SGOT                 | 84450 |
| — Billirubin, Direct       | 82248 |
| — Billirubin, Total        | 82247 |
| — BUN                      | 84520 |
| — Calcium                  | 82310 |
| X CBC w/o diff             | 85027 |
| — CBC w/autodiff           | 85025 |
| — Chloride                 | 82435 |
| — Cholesterol              | 82465 |
| — CK total (CPK)           | 82550 |
| — CKMB                     | 82553 |
| — CO2                      | 82374 |
| — Cortisol                 | 82533 |
| — Creatinine               | 82565 |
| — CRP                      | 86140 |
| — Digoxin                  | 80162 |
| — Diltantin                | 80185 |
| — Ferritin                 | 82728 |
| — Folate                   | 82746 |
| — Glucose                  | 82947 |
| — HCG-Serum (quantitative) | 84702 |
| — HCG Serum (qualitative)  | 84703 |
| — HCG Urine                | 81025 |
| — HDL Direct Meas          | 83718 |
| — Hep A Ab (HAAb)IgM       | 86709 |
| — Hep B Surface Ab         | 86706 |
| — Hep B surface Ag (HBsAg) | 87340 |
| — HepCAb                   | 86803 |

|                             |              |
|-----------------------------|--------------|
| ___ Hgb A1C                 | 83036        |
| ___ HIV Ab Sc               | 86701        |
| ___ Iron                    | 83540        |
| ___ Iron Study              | 83540, 83550 |
| ___ LD (LDH)                | 83615        |
| ___ Lipase                  | 83690        |
| ___ Lithium                 | 80178        |
| ___ Magnesium               | 83735        |
| ___ Mono test               | 86308        |
| ___ Phenobarbital           | 80184        |
| ___ Phosphorous Inorganic   | 84100        |
| ___ Potassium (serum)       | 84132        |
| ___ Protein, Total          | 84155        |
| ___ PSA (Total)             | 84153        |
| ___ PSA Free                | 84154        |
| ___ PSA, <u>Screening</u>   | G0103        |
| ___ PT/INR                  | 85610        |
| ___ PTH Intact              | 83970        |
| ___ PTT                     | 85730        |
| ___ RA Factor (qualitative) | 86430        |
| ___ Retic                   | 85045        |
| ___ RPR                     | 86592        |
| ___ Sed Rate                | 85652        |
| ___ SGOT (AST)              | 84450        |
| ___ SGPT (ALT)              | 84460        |
| ___ Sodium                  | 84295        |
| ___ Testosterone (total)    | 84403        |
| ___ T3 Free                 | 84481        |
| ___ T3 Uptake               | 84479        |
| ___ T4 (Thyroxine).total    | 84436        |
| ___ T4 Free                 | 84439        |
| ___ Triglycerides           | 84478        |
| ___ Troponin                | 84484        |
| ___ TSH                     | 84443        |
| ___ Uric Acid               | 84450        |
| ___ Urinalysis              | 81003, 81001 |
| ___ Vancomycin              | 80202        |
| ___ Vitamin B12             | 82607        |

Other Tests (CPT code required)

| MICROBIOLOGY        |  |
|---------------------|--|
| SOURCE OF SPECIMEN: |  |

• CULTURES

|                                     |             |
|-------------------------------------|-------------|
| _____ Urine                         | 87006       |
| collection method: _____            |             |
| _____ Wound/Abscess                 | 87070       |
| _____ Sputum                        | 87070,87205 |
| _____ Blood                         | 87040,87025 |
| _____ Body Fluid                    | 87070,87205 |
| _____ Genital                       | 87070       |
| _____ Throat                        | 87070       |
| _____ Anaerobic                     | 87075       |
| _____ Gram Stain                    | 87205       |
| _____ Viral                         | 87252       |
| _____ Acid Fast Bacilli             | 87118       |
| _____ Fungus                        | 87102       |
| _____ Tissue: _____                 | 87070,87178 |
| _____ Stool (salm/shig/camp/esc)    | 87045,87046 |
| _____ Stool for vibrio              | 87046       |
| _____ Stool for yersinia            | 87046       |
| _____ Other (please specify): _____ |             |

• **RAPID TESTING**

|                                 |       |
|---------------------------------|-------|
| _____ Rapid Strep A             | 86403 |
| _____ RSV Antigen Screen        | 87420 |
| _____ C. Difficile Toxin Screen | 87324 |
| _____ Stool for WBC             | 87025 |
| _____ OVA & Parasites (stool)   | 87177 |
| _____ Occult Blood              | 82270 |
| _____ Other (please specify):   |       |

| TRANSFUSION SERVICES  |       |
|-----------------------|-------|
| Blood Transfusion:    |       |
| Date Required         | _____ |
| Type of Component     | _____ |
| Number of Units       | _____ |
| Blood Type            |       |
| _____ ABO             | 86900 |
| _____ Rh: _____       | 86901 |
| _____ Antibody Screen | 86850 |
| _____ Coombs Direct   | 86880 |

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*Authorized Signature / Signature requires the signature of a licensed health care practitioner operating within the scope of their practice (i.e. nurse practitioner).*

004 4/10

# SCHEDULED OUTPATIENT RADIOLOGY

(To Schedule Exams Call 784-8230)

Appt. Date: \_\_\_\_\_

Time: \_\_\_\_\_

|                                                    |                                                                                   |
|----------------------------------------------------|-----------------------------------------------------------------------------------|
| Patient Name (Print)                               | Patient Address:<br>City, State, Zip Code                                         |
| Patient Phone                                      | Date of Birth: Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Ordering Ph (Print)                                | Ordering physician's phone number & fax number:<br>Phone: Fax:                    |
| Insurance                                          | Insurance Company Phone Number                                                    |
| History, Signs, Symptoms (Required for each test): |                                                                                   |
| Diagnosis Code (ICD9)                              |                                                                                   |

PHYSICIAN: Please check the requested exams below mark appropriately with left / right and Contrast type (Oral or IV Contrast or both.)  
Please schedule appointment at (843) 784-8230 and fax completed orders to 784-8094. Please circle the appropriate preparation instructions printed on the back of this form. Patients should present the original order to registration upon arrival.  
PATIENT: Please review your orders and preparation instructions on back of this form; any questions please call (843) 784-8230 Mon-Fri, 8AM-5 PM.  
Please bring your original order form, driver's license (or picture ID) and insurance information.  
Please arrive 30 minutes prior to your appointment to assure that there is little or no delay for your scheduled procedure.

| FLOURO                   | CODE           | ULTRASOUND (cont.)               | CODE           | NUCLEAR MED                            | CODE  | NUCLEAR MED              | CODE  |
|--------------------------|----------------|----------------------------------|----------------|----------------------------------------|-------|--------------------------|-------|
| Angiogram                | 73-            | Abdomen                          | 76700          | Bone Scan Limited                      | 78300 | Meckles                  |       |
| Esophogram / BASW        | 74220          | Abdomen Limited "Gallbladder"    | 76705          | Bone Scan-Whole Body                   | 78306 | WBC Scan                 | 78806 |
| Barium Swallow Modified  | 74230          | Aorta                            | 93978          | Bone Scan-3 Phase                      | 78315 | MUGA/Gated Heart         | 78472 |
| Upper GI series          | 74241          | Retroperitoneum (Kidney)         | 76770          | Bone Scan-SPECT                        | 78320 | Parathyroid Scan         | 78070 |
| UGI w/ SBFT              | 74245          | Renal Artery                     | 93975          | Cardiac rest/stress Type- Exer. / Lexi | 78452 | Renal Scan w/ lasix      | 78708 |
| Small Bowel Series       | 74250          | Pelvic                           | 76856          | Cardiac Viability                      | 78452 | Renal Scan w/o           | 78707 |
| BE - single contrast     | 74270          | Trans Vaginal                    | 76830          | Lung Scan VQ                           | 78580 | Renal with Captopril     | 78708 |
| BE - double contrast     | 74280          | OB <14 weeks (TV)                | 76817          | Lung Quantitative                      | 78596 |                          |       |
| Cystogram voiding (VCUG) | 74430          | OB <14 weeks (TA)                | 76801          | Gallium Scan                           | 78802 | Thyroid Scan Only        | 78010 |
| Cystogram                | 74430          | OB Complete >14 weeks            | 76805          | Gastric Emptying                       | 78264 | Thyroid w/ Uptake & Scan | 78007 |
|                          | 74400          | OB Limited                       | 76816          | HIDA w/ CCK w/o CCK                    | 78223 | Thyroid Met Scan         | 78018 |
| IVP with tomos           | 74415          | Biophysical Profile              | 76818          | Lymphoscintigraphy - area              | 78195 | Thyroid Therapy          | 79005 |
| CT cervical Myelogram    | 72240<br>72126 | Carotids                         | 93880          | Lympho (Indicate area)                 | 78195 |                          |       |
| CT Thoracic Myelogram    | 72255<br>72129 | Chest                            | 76604          |                                        |       |                          |       |
| CT Lumbar Myelogram      | 72265<br>72132 | PADE                             | 93923          |                                        |       |                          |       |
| PICC Line Insertion      | 36569          | Breast RT / LT / BILAT           | 76645          |                                        |       |                          |       |
| PICC line check          | 36598          | Venous Duplex Scn. - Bilat.      | 93970          |                                        |       |                          |       |
|                          |                | UPPER LOWER - Unilat RT/ LT      | 93971          |                                        |       |                          |       |
|                          |                | Duplex Arterial Bilat (or graft) | 93925          | <b>MAMMOGRAM</b>                       |       |                          |       |
|                          |                |                                  |                |                                        |       |                          |       |
| Ultrasound               |                | Thyroid/ Soft Tissue Neck        | 76536          |                                        |       |                          |       |
| AAA Screening            | G0389          | Biopsy Area:                     |                | Screening                              | G0202 | Needle Loc Area RT / LT  | 77032 |
| Thoracentesis            | 76942          | Scrotum w/doppler                | 76870<br>93976 | Diagnostic Bilat                       | G0204 | Ductogram (Galactogram)  | 77053 |
| Paracentesis             | 76942          | Misc.                            |                | Diagnostic Unilat RT / LT              | G0206 | Additional / Spot Views  | G0206 |
|                          |                |                                  |                | Ultrasound if Indicated                | 76645 | Bone Density             | 77080 |
|                          | 84520          | LABS - Creatinine                | 82565          |                                        |       |                          |       |

PRINTED BY: TARABLOOM

Feb 11

Date: 6/4/12

CCH/Rad#3A

## INSTRUCTIONS FOR RADIOLOGY EXAMS

Thank for choosing Coastal Carolina Hospital (CCH). We strive to provide you with not only a state-of-the-art Imaging Services Department, but with the compassionate quality care you deserve. Below you will find instructions to help you in preparing for your diagnostic exam. If you have any questions about these instructions, please feel free to ask your physician or contact CCH at (843)784-8042. If you are on Glucophage, Glucovance, and blood thinners (aspirin) notify our department in advance for special instructions.

### Ultrasound Exam

- Abdomen (Gallbladder, Kidneys, Aorta)- please do not drink or eat after midnight or least 6-8 hours prior to exam.
- Exception: Children must have a full bladder for kidney ultrasounds.
- Pelvic must drink a minimum of 36 oz of water 1 hour prior to exam to ensure a full bladder.
- Paracentesis, thoracentesis, drainages and biopsies require lab work (PT & PTT) within 7-days prior to exam
- All other exams – no preparation required.

### CT/Cat Scan

- Notify your physician if you are allergic to iodine, shell fish or strawberries prior to scheduling the exam.
- Abdomen / Pelvis, (with oral &/or IV contrast):  
Please do not eat or drink after midnight or at least 4-6 hours prior to exam.
- Please pick up oral contrast prior to your exam; contrast can be picked at CCH pharmacy 8:30am-5:00pm daily. To receive the contrast you must bring your order with you.
- MRI, CT's and Angiograms of Head, Neck, Chest, Abdomen, Pelvis, and Extremities with IV contrast; NPO for at least 4-6 hours prior to exam.
- Oral contrast, please drink contrast:  
1<sup>st</sup> bottle, 2-hours prior & 2<sup>nd</sup> bottle, 1-hour prior to arrival.

### Exams with IV Contrast (CT, & IVP)

- Do not take Glucophage for 48 hours after the exam.
- Patients 65 years of age and over must have labs completed (Creatinine & BUN) within last 30 days
- Patients that are being treated for diabetes, renal or cardiovascular disease should have labs completed (Creatinine & BUN) within the last 7 days.
- If results are not available in advance, labs will be drawn day of exam. This could delay your procedure.
- CT's and Angiograms of Head, Neck, Chest, Abdomen, Pelvis, and Extremities with IV contrast; Nothing to eat or drink for at least 4-6 hours prior to exam.
- CT's Abdomen and Pelvis for Stone Protocol and ALL CT's without IV or Oral contrast: NO PREP REQUIRED

### Biopsies / Drainages

- History and Physical (H&P) must be sent by your ordering physician prior to procedure being performed.

- Please bring your films to CCH if initial study was performed at another facility.
- Please complete any necessary labs work (PT, PTT) within 24 hours prior to your exam.
- Please stop all blood thinners (aspirin) as advised by your physician. The radiologist recommends stopping blood thinners 7-days prior to biopsy.
- After registration the patient will be escorted to the Ambulatory Surgery department prior to exam.

### Nuclear Medicine

- Please contact (843)784-8230 for procedure specific instructions prior to exam. Notify technologist if you are pregnant or breast feeding.

### Mammogram

- Do not wear any perfume/cologne, powder or deodorant. You may want to bring them with you.
- If possible please bring any previous exams with you to eliminate any delay for comparison readings.
- If unable, please request your last facility to send your last mammogram to:
- Coastal Carolina Hospital  
Attention Imaging Services  
1000 Medical Center Drive  
Hardeeville, SC 29927

### Bone Density

- No Prep is necessary. Please wear clothing without buttons or zippers.

### UGI, Barium Swallow & Small Bowel Follow Through

- Nothing to eat after midnight (infants withhold last feeding).

### Barium Enema or IVP (IV CONTRAST),

- Fleet #1 bowel prep kits must be purchased at your local pharmacy or can be picked up at CCH pharmacy.
- Prep must be started 1-day prior to exam.  
Please follow instruction enclosed.

### X-RAYS:

- Routine, No prep

### MRI:

- Routine, No prep
- MRCP 4 –hours NPO
- Gallbladder 4 –hours NPO

For any further questions please call Imaging Services at (843)784-8042.

**Thank You for Choosing Coastal Carolina Hospital**



# OUTPATIENT LABORATORY REQUISITION FORM FAX FORM TO REGISTRATION (843) 784-8094

Notice: Bills will be submitted for payment to Medicare, Medicaid, all other governmental programs, and third party payors based upon the diagnostic information provided by the treating physician.

1000 Medical Center Dr.  
Hardeeville, SC 29927  
Laboratory  
Phone 843-784-8088

PATIENT NAME: LAST N

REQUESTING PHYSICIAN

BILL TO:

Patient

Medicare

Other 3rd Party

ALL INSURANCE AND  
DEMOGRAPHIC  
INFORMATION MUST  
BE COMPLETED

BARON, FRANCES

PRE CLI

06/14/12 COTTER, JASON WILLIAM MD

DOB: [REDACTED] F MR# [REDACTED]

Coastal Carolina

Address

Insurance Co. Name/Coverage (Attach Copy of Card)

Insurance Co. Address

Certificate#/Pol #/Group #/Medicare #/Medi-Cal ID#

Employer

MI

SEX

DATE OF BIRTH

SS#

PHYSICIAN FAX:

st

Initial

Relationship

Phone

Routine

STAT

Standing order:

Date started:

Date ending:

(not to exceed 6 months)

DATE DRAWN

TIME DRAWN

AM/PM

DRAWN BY:

Date of Injury if Workers Comp. ICD 9 Code

## Organ or Disease Oriented Panels

See reverse side for included tests.

Acute Hepatitis Panel 80074  
Basic Metabolic Panel 80048  
Comprehensive Metabolic Panel 80053  
Electrolyte Panel 80051  
Hepatic Function Panel 80078  
Lipid Panel 80061  
Renal Function Panel 80069

Albumin 82040  
Alk. Phos. 84075  
Amylase 82150  
ANA 86038  
AST/SGOT 84450  
Bilirubin, Direct 82248  
Bilirubin, Total 82247  
BUN 84520  
Calcium 82310  
CBC w/o diff 85027  
CBC w/autodiff 85025  
Chloride 82435  
Cholesterol 82465  
CK total (CPK) 82550  
CKMB 82553  
CO2 82374  
Cortisol 82533  
Creatinine 82565  
CRP 86140  
Digoxin 80162  
Dilantin 80185  
Ferritin 82728  
Folate 82746  
Glucose 82947  
HCG Serum (quantitative) 84702  
HCG Serum (qualitative) 84703  
HCG Urine 81025  
HDL Direct Meas 83718  
Hep A Ab (HAAb)IgM 86709  
Hep B Surface Ab 86706  
Hep B surface Ag (HBsAg) 87340  
HepCAb 86803

ICD-9-CM REQUIRED 782.3 729.5  
(see reverse side for Medicare regulations)

250.00 891.0  
459.33 729.92

Hgb A1C 83036  
HIV Ab Sc 86701  
Iron 83540  
Iron Study 83540, 83550  
LD (LDH) 83615  
Lipase 83690  
Lithium 80178  
Magnesium 83735  
Mono test 86308  
Phenobarbital 80184  
Phosphorous Inorganic 84100  
Potassium (serum) 84132  
Protein, Total 84155  
PSA (Total) 84153  
PSA Free 84154  
PSA, Screening G0103  
PT/INR 85610  
PTH Intact 83970  
PTT 85730  
RA Factor (qualitative) 86430  
Retic 85045  
RPR 86592  
Sed Rate 85652  
SGOT (AST) 84450  
SGPT (ALT) 84460  
Sodium 84295  
Testosterone (total) 84403  
T3 Free 84481  
T3 Uptake 84479  
T4 (Thyroxine) total 84436  
T4 Free 84439  
Triglycerides 84478  
Troponin 84484  
TSH 84443  
Uric Acid 84450  
Urinalysis 81003, 81001  
Vancomycin 80202  
Vitamin B12 82607

Other Tests (CPT code required)

## MICROBIOLOGY

### SOURCE OF SPECIMEN:

### CULTURES

Urine 87086  
collection method:  
Wound/Abscess 87070  
Sputum 87070, 87205  
Blood 87040, 87025  
Body Fluid 87070, 87205  
Genital 87070  
Throat 87070  
Anaerobic 87075  
Gram Stain 87205  
Viral 87252  
Acid Fast Bacilli 87118  
Fungus 87102  
Tissue: 87070, 87176  
Stool (salm/shig/camp/esc) 87045, 87046  
Stool for vibrio 87046  
Stool for yersinia 87046  
Other (please specify):

### RAPID TESTING

Rapid Strep A 86403  
RSV Antigen Screen 87420  
C. Difficile Toxin Screen 87324  
Stool for WBC 87025  
OVA & Parasites (stool) 87177  
Occult Blood 82270  
Other (please specify):

### TRANSFUSION SERVICES

Blood Transfusion:  
Date Required  
Type of Component  
Number of Units  
Blood Type  
ABO 86900  
Rh 86901  
Antibody Screen 86850  
Coombs Direct 86880

PRINTED BY: [Signature]

DATE: 08/17/2012  
Authorized signature of a health care practitioner operating within the scope of their practice (i.e. nurse practitioner).

Organ or Disease oriented panels contain the following tests:

**ACUTE HEPATITIS PANEL**  
 Hep AAb (HAAb) IgM  
 Hep B core Ab (HBcAb), IgM  
 Hep B surface Ag (HBsAg)  
 Hep C Av

80074

**ELECTROLYTE PANEL**

80051

Sodium  
 Potassium  
 Chloride  
 CO2

**BASIC METABOLIC PANEL**

80048 (C7)

**HEPATIC FUNCTION PANEL**

80076

Calcium  
 CO2  
 Chloride  
 Creatinine  
 Glucose  
 Potassium  
 Sodium  
 BUN

Albumin  
 Bilirubin, Total  
 Bilirubin, Direct  
 Phosphatase, Alkaline  
 Protein, Total  
 ALT/SGPT  
 AST/SGOT

**COMP. METABOLIC PANEL**

80053 (C12)

**LIPID PANEL**

80061

Albumin  
 Bilirubin, Total  
 Calcium  
 CO2  
 Chloride  
 Creatinine  
 Glucose  
 Phosphatase, Alkaline  
 Potassium  
 Protein, Total  
 Sodium  
 ALT/SGPT  
 AST/SGOT  
 BUN

Cholesterol  
 Triglycerides  
 HDL Direct Meas

**RENAL FUNCTION PANEL**

80069

Albumin  
 Calcium  
 CO2  
 Chloride  
 Creatinine  
 Glucose  
 Phosphorous Inorganic  
 Potassium  
 Sodium  
 BUN

Medicare regulations require the tests to be medically necessary for the diagnosis and treatment of the patient to qualify for reimbursement from the program. The physician must be treating the patient in connection with the diagnosis or complaints listed and this information must accurately reflect the medical reasons for requesting these tests. The medical necessity of each test ordered on this requisition must be documented in the patient's medical record. Tests ordered for the purpose of screening, or which the physician believes to be appropriate even if the payor may not allow reimbursement, may not be billed to Medicare except for the purpose of receiving a denial. An Advance Beneficiary Notice (ABN) must be signed by the beneficiary or authorized person indicating his/her willingness to assume financial responsibility for the testing. General Instructions: Please provide diagnostic information in the form of a valid ICD-9CM code that is documented in the patient's medical record.



DATE: 06/15/12

COASTAL CAROLINA MEDICAL CENTER  
1000 MEDICAL CENTER DRIVE  
HARDEEVILLE, SC 29927  
(843)784-8088  
MEDICAL DIRECTOR: CHARLES T. LUCAS, MD

PAGE:1

|                               |                     |                  |                 |
|-------------------------------|---------------------|------------------|-----------------|
| PATIENT: BARON, FRANCES       | ACCT # [REDACTED]   | LOC: I-WG        | U # [REDACTED]  |
| REG DR: COTTER, JASON WILLIAM | AGE/SEX: [REDACTED] | ROOM: [REDACTED] | REG: 06/14/12   |
|                               | DOB: [REDACTED]     | BED: [REDACTED]  | DIS: [REDACTED] |
|                               | STATUS: DEP GLI     | TLOC: [REDACTED] |                 |

\*\*\*\*\*HEMATOLOGY\*\*\*\*\*

| Date<br>Time | JUN 14<br>1440 |  |  |  | Reference   | Units |
|--------------|----------------|--|--|--|-------------|-------|
| WBC          | 5.9            |  |  |  | (4.0-11.0)  | K/uL  |
| RBC          | 4.44           |  |  |  | (4.0-5.40)  | M/uL  |
| HGB          | 13.4           |  |  |  | (12.0-16.0) | gm/dL |
| HCT          | 39.3           |  |  |  | (36.0-48.0) | %     |
| MCV          | 89             |  |  |  | (80-100)    | fL    |
| MCH          | 30.1           |  |  |  | (26.0-34.0) | pg    |
| MCHC         | 34.0           |  |  |  | (31.0-37.0) | g/dL  |
| RDW          | 12.7           |  |  |  | (11.5-14.5) | %     |
| PLT          | 437            |  |  |  | (140-440)   | K/uL  |
| MPV          | 5.6 L          |  |  |  | (7.1-10.4)  | fL    |

|                         |               |                                     |
|-------------------------|---------------|-------------------------------------|
| Patient: BARON, FRANCES | Age/Sex: 70/F | Acct# L00093775245 Unit# L000109861 |
|-------------------------|---------------|-------------------------------------|

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DATE: 08/17/2012

Coastal Carolina Medical Center  
1000 Medical Center Drive  
Hardeeville, SC 29927

Phone #: 843-784-8042  
Fax #: 843-784-8094

Name: BARON, FRANCES  
Attending Dr: COTTER, JASON WILLIAM  
DOB: [REDACTED] Age: 70 Sex: F  
Acct: [REDACTED] Loc: L.WC  
Exam Date: 06/14/2012 Status: REG CLI  
Radiology No:  
Unit No: [REDACTED]

Exams: 000150791 DUPLEX VENOUS LOWER EXT RT

History: 70-year-old female, right calf wound.

Duplex Venous Sonogram of the right Lower Extremity.

TECHNIQUE: This study was performed utilizing extensive real-time sonographic imaging. Doppler analysis and color-flow imaging were utilized. Compression sonography and augmentation analysis was performed.

FINDINGS: There is no sonographic evidence for deep vein thrombosis of the right lower extremity to the level of the knee. Normal venous flow, compressibility and augmentation is noted.

**IMPRESSION:**

1. No sonographic evidence for deep vein thrombosis involving the right lower extremity.

Thank you for this referral.

\*\* Electronically Signed by MOESCH DEAN on 06/14/2012 at 1451 \*\*  
Reported and Signed by: MOESCH DEAN

CC: JASON WILLIAM MD COTTER

Dictated Date/Time: 06/14/2012 (1451)  
Technologist: HAUCK CARLIE  
Transcribed Date/Time: 06/14/2012 (1451)  
Transcriptionist: RAD.VR  
Electronic Signature Date/Time: 06/14/2012 (1451)  
Orig Print D/T: S: 06/14/2012 (1446) Batch No: N/A

PAGE 1

MEDICAL RECORDS COPY

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DATE: 08/17/2012

--372--

## Visit Report for 6/14/2012

COASTAL CAROLINA  
HOSPITAL

Milton Hand Regional Healthcare

## Arrival Information Details

|                        |                |                       |               |
|------------------------|----------------|-----------------------|---------------|
| Patient Name:          | Baron, Frances | Date:                 | 6/14/2012     |
| Patient Number:        |                | RN/LPN:               | Cole, Lori    |
| Patient Date of Birth: |                | Physician / Extender: | Cotter, Jason |

## Visit Information

|                                                 |            |
|-------------------------------------------------|------------|
| Arrival Condition:                              | Stable     |
| Ambulatory Status:                              | Wheelchair |
| Accompanied By:                                 | spouse     |
| Reason for today's visit:                       | MD visit   |
| Patient Identification Verified:                | Yes        |
| Secondary Verification Process Completed:       | Yes        |
| Patient is in Isolation Precaution?             | No         |
| Is patient oriented to person, place, and time? | Yes        |

## History Since Last Visit

|                                                                                 |    |
|---------------------------------------------------------------------------------|----|
| Added or deleted any medications:                                               | No |
| Any new allergies or adverse reactions:                                         | No |
| Added any significant procedures or medical diagnosis:                          | No |
| Experienced change in activities of daily living that may affect risk of falls: | No |
| Experienced any changes in pain level or management:                            | No |
| Signs or symptoms of abuse/neglect since last visit?                            | No |

## Electronic Signature(s)

|               |                        |
|---------------|------------------------|
| Signed By:    | Date:                  |
| Cole, Lori RN | 06/15/2012 11:55:21 AM |
| Cole, Lori RN | 06/15/2012 11:55:25 AM |

Entered By: Cole, Lori on 06/15/2012 10:25:04 AM

**COASTAL CAROLINA  
HOSPITAL**

Wilton Medical Regional Healthcare

**Pain Assessment Details**

Patient Name: Baron, Frances

Patient Number: [REDACTED]

Patient Date of Birth: [REDACTED]

Date: 6/14/2012

RN/LPN: Cole, Lori

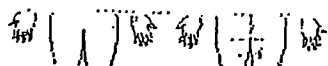
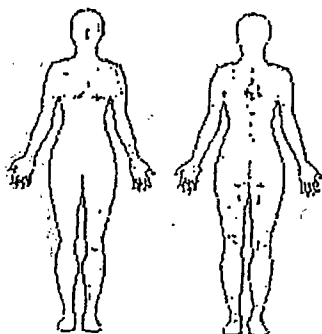
Physician / Extender: Cotter, Jason

**Location of Pain**

[REDACTED]

FRONT

BACK

**Severity and Temporal Description of Pain**

Patient Has Pain? Yes

Duration of the Pain.  
Constant / Intermittent? IntermittentRate the pain.  
Current Pain Level: 2  
Worst Pain Level: 6  
Least Pain Level: 2  
Tolerable Pain Level: 2**Character of Pain**

Describe the Pain: Tender, Throbbing

**Pain Management and Medication****Current Pain Management:**Medication: Yes  
Rest: Yes  
Activity: Yes

Is the Current Pain Management Adequate: Adequate

**Electronic Signature(s)**

Signed By:

Cole, Lori RN

Cole, Lori RN

Date:

06/15/2012 11:55:21 AM

06/15/2012 11:55:25 AM

Entered By: Cole, Lori on 06/15/2012 10:26:27 AM

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**COASTAL CAROLINA  
HOSPITAL**

Horton Heard Regional Healthcare

**Lower Extremity Assessment Details**

|                        |                |                       |               |
|------------------------|----------------|-----------------------|---------------|
| Patient Name:          | Baron, Frances | Date:                 | 6/14/2012     |
| Patient Number:        | (REDACTED)     | RN/LPN:               | Cole, Lori    |
| Patient Date of Birth: | (REDACTED)     | Physician / Extender: | Cotter, Jason |

**Edema Assessment**

|                            | Left: | Right:               |
|----------------------------|-------|----------------------|
| Edema:                     |       | Yes                  |
| Compression Device In Use: |       | Yes                  |
| Device Used Correctly:     |       | Yes                  |
| Compression Device Used:   |       | Tubigrip or Tubifast |

**Foot**

|                          |       |    |    |
|--------------------------|-------|----|----|
| Point of Measurement: cm | From: | cm | cm |
|--------------------------|-------|----|----|

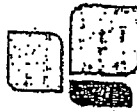
**Vascular Assessment**

|                                                | Left: | Right: |
|------------------------------------------------|-------|--------|
| Pulses:                                        |       |        |
| Popliteal:                                     |       |        |
| Extremity colors, hair growth, and conditions: |       |        |
| Extremity Color:                               |       | Red    |
| Erythema:                                      |       | Yes    |

**Electronic Signature(s)**

|               |                        |
|---------------|------------------------|
| Signed By:    | Date:                  |
| Cole, Lori RN | 06/15/2012 11:55:21 AM |
| Cole, Lori RN | 06/15/2012 11:55:25 AM |

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**COASTAL CAROLINA  
HOSPITAL**

Morton Head Regional Healthcare

**Adherence to Plan of Care Details**

|                        |                |                       |               |
|------------------------|----------------|-----------------------|---------------|
| Patient Name:          | Baron, Frances | Date:                 | 6/14/2012     |
| Patient Number:        |                | RN/LPN:               | Cole, Lori    |
| Patient Date of Birth: |                | Physician / Extender: | Cotter, Jason |

**Adherence to Plan of Care Items**

|                   |     |                 |     |
|-------------------|-----|-----------------|-----|
| Wound Visits:     | Yes | Limb Elevation: | Yes |
| Dressing Changes: | Yes |                 |     |

**Notes****Electronic Signature(s)**

|               |                        |
|---------------|------------------------|
| Signed By:    | Date:                  |
| Cole, Lori RN | 06/15/2012 11:55:21 AM |
| Cole, Lori RN | 06/15/2012 11:55:25 AM |

Entered By: Cole, Lori on 06/15/2012 10:28:41 AM

**COASTAL CAROLINA  
HOSPITAL**

Alton Head Regional Healthcare

**Patient/Caregiver Education Details**

|                        |                |                       |               |
|------------------------|----------------|-----------------------|---------------|
| Patient Name:          | Baron, Frances | Date:                 | 6/14/2012     |
| Patient Number:        |                | RN/LPN:               | Cole, Lori    |
| Patient Date of Birth: |                | Physician / Extender: | Cotter, Jason |

**Patient/Caregiver Education Items**

Teaching Provided To: Patient

|                               |                         |
|-------------------------------|-------------------------|
| Compression:                  | Yes                     |
| Methods:                      | Explain/Verbal          |
| Responses:                    | State content correctly |
| Dressing:                     | Yes                     |
| Methods:                      | Explain/Verbal          |
| Responses:                    | State content correctly |
| Sign & Symptoms of Infection: | Yes                     |
| Methods:                      | Explain/Verbal          |
| Responses:                    | State content correctly |

**Electronic Signature(s)**

|               |                        |
|---------------|------------------------|
| Signed By:    | Date:                  |
| Cole, Lori RN | 06/15/2012 11:55:21 AM |
| Cole, Lori RN | 06/15/2012 11:55:25 AM |

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**COASTAL CAROLINA  
HOSPITAL**

Wound Management Healthcare

**Visit Discharge Information Details**

|                        |                  |                       |               |
|------------------------|------------------|-----------------------|---------------|
| Patient Name:          | Baron, Frances   | Date:                 | 6/14/2012     |
| Patient Number:        | (b)(6)(b)(7)(C)) | RN/LPN:               | Cole, Lori    |
| Patient Date of Birth: | (b)(6)(b)(7)(C)) | Physician / Extender: | Cotter, Jason |

**Visit Discharge Information Items**

|                                                                            |            |
|----------------------------------------------------------------------------|------------|
| Discharge Condition:                                                       | Stable     |
| Ambulatory Status:                                                         | Wheelchair |
| Discharge Destination:                                                     | Home       |
| Schedule Follow-up Appointment:                                            | Yes        |
| Medication Reconciliation completed and provided to Patient/Care Provider: | Yes        |
| Clinical Summary of Care Provided:                                         | No         |

**Electronic Signature(s)**

|               |                        |
|---------------|------------------------|
| Signed By:    | Date:                  |
| Cole, Lori RN | 06/15/2012 11:55:21 AM |
| Cole, Lori RN | 06/15/2012 11:55:25 AM |

Entered By: Sisson LPN, Sally on 06/15/2012 10:49:40 AM





## COASTAL CAROLINA HOSPITAL

Hixon Maud Regional Healthcare

### Wound Assessment Details

|                        |                |                       |               |
|------------------------|----------------|-----------------------|---------------|
| Patient Name:          | Baron, Frances | Date:                 | 6/14/2012     |
| Patient Number:        | ( )            | RN/LPN:               | Cole, Lori    |
| Patient Date of Birth: | ( )            | Physician / Extender: | Cotter, Jason |

### Wound Status

|                 |                                     |               |            |
|-----------------|-------------------------------------|---------------|------------|
| Wound Number:   | 1                                   | Wound Status: | Not Healed |
| Wound Location: | Right, Proximal, Anterior Lower Leg |               |            |
| Wound Type:     | Trauma                              |               |            |
| Date Acquired:  | 5/21/2012                           |               |            |

### Photos

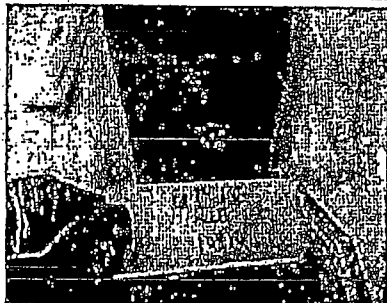


Photo Uploaded By: Slisson LPN, Sally on 6/15/2012

### Wound Measurements

|                                            |      |              |    |
|--------------------------------------------|------|--------------|----|
| Length: (cm)                               | 1    | Tunneling:   | No |
| Width: (cm)                                | 0.5  | Undermining: | No |
| Depth: (cm)                                | 0.1  | Sinus Tract: | No |
| Hypergranulated:                           | No   |              |    |
| Area: (sq cm) based on L*W                 | 0.5  |              |    |
| Volume: (cm <sup>3</sup> ) based on Area*D | 0.05 |              |    |

### Wound Description

|                              |                  |                   |    |
|------------------------------|------------------|-------------------|----|
| Thickness:                   | Full Thickness   | Exposed Structure |    |
| Exudate Amount:              | Small            | Tendon Exposed:   | No |
| Exudate Type:                | Sero-sanguineous | Muscle Exposed:   | No |
| Pain:                        | 6                | Joint Exposed:    | No |
| Less than 20% slough/fibrin? | No               | Bone Exposed:     | No |
|                              | Percentage       |                   |    |
| Slough:                      | 26-50%           |                   |    |
| Granulation:                 | 26-50%           |                   |    |
| Granulation Texture:         | Firm             |                   |    |
| Pink:                        | Yes              |                   |    |

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**Peripheral Skin Appearance**

|                     |     |                                                                     |        |
|---------------------|-----|---------------------------------------------------------------------|--------|
| <b>Texture</b>      |     | <b>Color</b>                                                        |        |
| Normal For Patient: | No  | Normal For Patient:                                                 | Yes    |
| Edema:              | Yes |                                                                     |        |
| Induration:         | Yes | <b>Temperature</b>                                                  | Warm   |
|                     |     | <b>S/S of Infection</b>                                             |        |
| Normal For Patient: | Yes | S/S Present:                                                        | Yes    |
|                     |     | Confirmation Description & Treatment Plan: Signs & Symptoms Present |        |
|                     |     | <b>Local Pulse</b>                                                  |        |
|                     |     | Local Pulse:                                                        | Normal |

**Electronic Signature(s)**

|                   |                        |
|-------------------|------------------------|
| <b>Signed By:</b> | <b>Date:</b>           |
| Cole, Lori RN     | 06/15/2012 11:55:21 AM |
| Cole, Lori RN     | 06/15/2012 11:55:25 AM |

Entered By: Cole, Lori on 06/14/2012 4:51:53 PM



## COASTAL CAROLINA HOSPITAL

Wound Care Regional Healthcare

### Wound Assessment Details

|                        |                |                       |               |
|------------------------|----------------|-----------------------|---------------|
| Patient Name:          | Baron, Frances | Date:                 | 6/14/2012     |
| Patient Number:        | [REDACTED]     | RN/LPN:               | Cole, Lori    |
| Patient Date of Birth: | [REDACTED]     | Physician / Extender: | Cotter, Jason |

### Wound Status

|                 |                            |               |            |
|-----------------|----------------------------|---------------|------------|
| Wound Number:   | 3                          | Wound Status: | Not Healed |
| Wound Location: | Distal, Anterior Lower Leg |               |            |
| Wound Type:     | Trauma                     |               |            |

### Photos

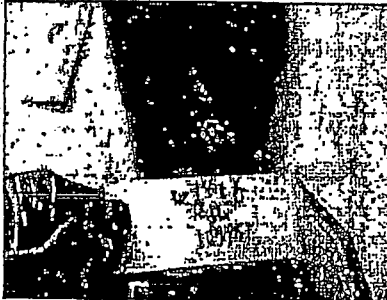


Photo Uploaded By: Sisson LPN, Sally on 6/15/2012

### Wound Measurements

|                                            |    |                        |     |
|--------------------------------------------|----|------------------------|-----|
| Length: (cm)                               | 1  | Tunnelling:            | Yes |
| Width: (cm)                                | 1  | Position (o'clock):    | 12  |
| Depth: (cm)                                | 1  | Maximum Distance: (cm) | 3.5 |
| Hypergranulated:                           | No |                        |     |
| Area: (sq cm) based on L*W                 | 1  | Undermining:           | No  |
| Volume: (cm <sup>3</sup> ) based on Area*D | 1  | Sinus Tract:           | No  |

### Wound Description

|                 |                  |                   |    |
|-----------------|------------------|-------------------|----|
| Thickness:      | Full Thickness   | Exposed Structure |    |
| Exudate Amount: | Large            | Tendon Exposed:   | No |
| Exudate Type:   | Sero-sanguineous | Muscle Exposed:   | No |
| Odor:           | None             | Joint Exposed:    | No |
| Pain:           | 6                | Bone Exposed:     | No |
| Wound Margin:   | Flat and Intact  |                   |    |

Percentage

### Peripheral Skin Appearance

|          |     |             |     |
|----------|-----|-------------|-----|
| Texture  | Yes | Color       | Yes |
| Moisture |     | Temperature |     |

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Normal For Patient:

Yes

Temperature:

Warm

S/S Present:

S/S of Infection

Yes

Confirmation Description &amp; Treatment Plan: Signs &amp; Symptoms Present, Systemic Antibiotics Prescribed

Local Pulse

Local Pulse:

Normal

Treatment NotesWound #3 (Distal, Anterior Lower Leg)Wound Treatment Note

- Pt ID by name and photo, correct site ID.
- Assessed patient's pain status and effectiveness of pain management plan
- Removed old dressing, taking care to avoid trauma to the wound bed
- Cleansed wound and periwound with non-cytotoxic agent using Wound cleanser (1)
- Obtained wound photo
- Applied primary wound dressing using Iodoform (1)
- Applied Secondary Wound Dressing using Gauze (1), Kerlix (1)
- Dressing secured dressing in place using Netting (1)
- Applied Compression device using Tubigrip (1)

Electronic Signature(s)

Signed By:

Cole, Lori RN

Cole, Lori RN

Date:

06/15/2012 11:55:21 AM

06/15/2012 11:55:25 AM

Entered By: Cole, Lori on 06/14/2012 4:51:12 PM

**Treatment Notes Summary****Wound #1 (Right, Proximal, Anterior Lower Leg)****Wound Treatment Note**

- Pt ID by name and photo, correct site ID.
- Assessed patient's pain status and effectiveness of pain management plan
- Removed old dressing, taking care to avoid trauma to the wound bed
- Cleansed wound and periwound with non-cytotoxic agent using Wound cleanser (1)
- Obtained wound photo
- Applied topical anesthetic for procedural pain control per physician order using Lidocaine 4% Topical (1)
- Debridement.
- Applied enzymatic debriding agent to wound bed, using Santyl (1)
- Applied primary wound dressing using normal saline gauze (1)
- Applied Secondary Wound Dressing using Gauze (1)
- Dressing secured dressing in place using Tape (1)
- Applied Compression device using Tubigrip (1)

**Wound #3 (Distal, Anterior Lower Leg)****Wound Treatment Note**

- Pt ID by name and photo, correct site ID.
- Assessed patient's pain status and effectiveness of pain management plan
- Removed old dressing, taking care to avoid trauma to the wound bed
- Cleansed wound and periwound with non-cytotoxic agent using Wound cleanser (1)
- Obtained wound photo
- Applied primary wound dressing using Iodoform (1)
- Applied Secondary Wound Dressing using Gauze (1), Kerlix (1)
- Dressing secured dressing in place using Netting (1)
- Applied Compression device using Tubigrip (1)

**COASTAL CAROLINA  
HOSPITAL**

Wilton Reed Regional Healthcare

**Physician Orders Details**

Patient Name: Baron, Frances

Date: 6/14/2012

Patient Number: [REDACTED]

RN/LPN: Cole, Lori

Patient Date of Birth: [REDACTED]

Physician / Extender: Cotter, Jason

Verbal / Phone Orders: No

**Follow-Up Appointments**

- Return Appointment in 1 week.

**Anesthetic**

- Topical Xylocaine to wound bed prior to debridement. - 4%

**Wound Cleansing & Dressings**

- Enzymatic Debriding Agent - santyl each day to proximal wound
- Pack wound - 1/4 inch iodoform BID to distal wound

**Compression/Edema Control/ Off-Loading**

- Elevate leg(s) above the level of the heart when sitting.
- Avoid prolonged standing in one place.
- Single Layer Compression Wrap - tubigrip

**Dietary**

- Increased protein
- Supplement with multi-vitamin

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Ancillary Services

- Home Health Services - SN for wound care daily x 1 week, pack distal wound to tunnel at 12 and undermining 1-11

Cardiovascular

- Venous Ultrasound

Laboratory

- CBC

Patient Medications

|               |                                                          | Allergies: mango |           |     |
|---------------|----------------------------------------------------------|------------------|-----------|-----|
| Notifications | Medication                                               | Indication       | Start     | End |
|               | ▶ Bactrim DS<br>DOSE 1 - Oral 800 mg-160 mg Tablet - BID |                  | 6/14/2012 |     |

NotesElectronic Signature(s)Signed By:

Cole, Lori RN

Cole, Lori RN

Cotter, Jason

Cotter, Jason

Date:

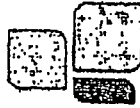
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06/25/2012 8:23:50 AM

06/25/2012 8:23:57 AM

Entered By: Cole, Lori on 06/15/2012 10:48:41 AM

**COASTAL CAROLINA  
HOSPITAL**

Horton Head Regional Healthcare

**Prescription****6/14/2012**

Patient Name: Baron, Frances  
Date of Birth:   
Gender: F  
Phone #:

Physician: Cotter, Jason MD  
NPI#: 1801859640  
DEA#: BC7837618

Coastal Carolina Center for Hyperbarics and Wound Healing  
1000 Medical Center Drive  
Hardeeville, SC 29927  
843-784-8210

**Allergies**

mango

**Medication**

|                                                 |                          |                                  |                                 |
|-------------------------------------------------|--------------------------|----------------------------------|---------------------------------|
| Medication:<br>Bactrim DS                       | Route:<br>Oral           | Strength:<br>800 mg-160 mg       | Form:<br>Tablet                 |
| Class:<br>ABSORBABLE SULFONAMIDES               |                          |                                  |                                 |
| Dose:<br>1                                      | Frequency / Time:<br>BID |                                  | Indication:                     |
| Number of Refills:<br>0                         |                          | Number of Units:<br>20 Tablet(s) |                                 |
| Generic Substitution:<br>Substitution Permitted | Start Date:<br>6/14/2012 | End Date:                        | Administered at Facility:<br>No |
| Note to Pharmacy:                               |                          |                                  |                                 |

**Electronic Signature(s)**

Signed By:  
Cole, Lori  
Cole, Lori  
Cotter, Jason

Date:  
6/15/2012 11:55:21 AM  
6/15/2012 11:55:25 AM  
6/25/2012 8:23:50 AM

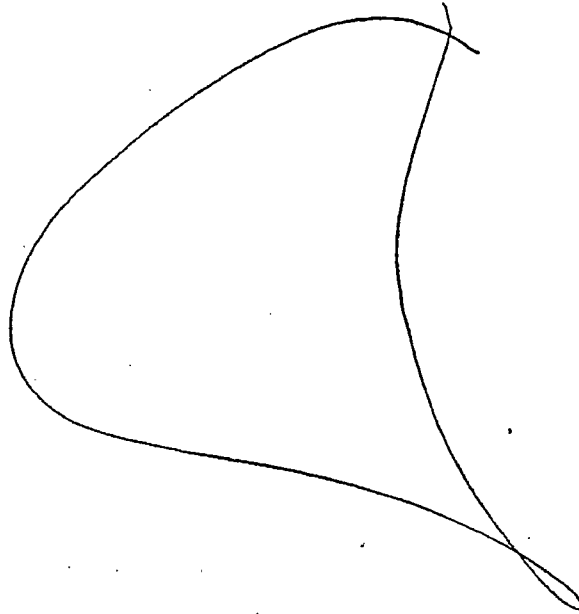
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Cotter, Jason

6/25/2012 8:23:57 AM

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**COASTAL CAROLINA  
HOSPITAL**

Milton Head Regional Healthcare

**Progress Note Details**

Patient Name: Baron, Frances  
Patient Number:   
Patient Date of Birth:

Date: 6/14/2012  
RN/LPN: Cole, Lori  
Physician / Extender: Cotter, Jason

**Subjective**

Allergies:  
mango

70 year old female who was in a car accident suffering a left lower leg fracture and right lower leg wounds. Her right lower leg x-rays were negative. She has been using Santyl on her proximal wound, and packing her distal wound with Iodoform twice daily. There have been no improving or worsening factors. Her risk factors for wound healing include diabetes and venous hypertension. She has had nausea, but denies vomiting, fever, or chills. She has been receiving wound care for 2 weeks. She seems to think that her pain over her right leg is worse than she would expect. The skin surrounding her wound is fairly erythematous or ecchymotic.

**Objective****Integumentary (Hair, Skin)**

Wound #1 presents as a Full Thickness Trauma located on the Right, Proximal, Anterior Lower Leg and measures 1cm length x 0.5cm width x 0.1cm depth; 0.5cm<sup>2</sup> area and 0.05cm<sup>3</sup> volume, calculated based on L\*W and Area\*D, respectively. There is no tunnelling, undermining, or sinus tract noted. There is a small amount of sero-sanguineous drainage noted. The wound pain is a level 6. There is 26-50% slough and 26-50% \*\*pink, firm granulation within the wound bed.

Wound #3 presents as a Full Thickness Trauma located on the Distal, Anterior Lower Leg and measures 1cm length x 1cm width x 1cm depth; 1cm<sup>2</sup> area and 1cm<sup>3</sup> volume, calculated based on L\*W and Area\*D, respectively. There is no sinus tract or undermining noted, however, there is tunnelling at 12:00 with a maximum distance of 3.5cm. There is a large amount of sero-sanguineous drainage noted which has no odor. The wound pain is a level 6. Systemic antibiotics prescribed - refer to new medications prescribed. The wound margin is flat and intact.

**Assessment****Diagnoses**

250.00: Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled  
891.0: Open wound knee, leg, ankle (not thigh)- w/o complication  
459.33: Chronic venous hypertension with ulcer and inflammation  
729.92: Nontraumatic hematoma of soft tissue

**Procedures****Plan**

Follow-Up Appointments:

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Return Appointment in 1 week.

**Anesthetic:**

Topical Xylocaine to wound bed prior to debridement. - 4%

**Wound Cleansing & Dressings:**

Enzymatic Debriding Agent - santyl each day to proximal wound

Pack wound - 1/4 inch Iodoform BID to distal wound

**Compression/Edema Control/ Off-Loading:**

Elevate leg(s) above the level of the heart when sitting.

Avoid prolonged standing in one place.

Single Layer Compression Wrap - tubigrip

**Dietary:**

Increased protein

Supplement with multi-vitamin

**Ancillary Services ordered were:**

Home Health Services - SN for wound care daily x 1 week, pack distal wound to tunnel at 12 and undermining 1-11

**Cardiovascular ordered were:**

Venous Ultrasound

**Laboratory ordered were:**

CBC

The following medications were prescribed: Bactrim DS Oral 800 mg-160 mg Tablet 1 BID starting 6/14/2012

**Follow-Up Appointments:**

A follow-up appointment should be scheduled.

Medication Reconciliation completed and provided to Patient/Care Provider.

Wound itself looks fairly healthy and has actually gotten smaller. I will obtain a venous ultrasound of the area because of her pain. I have given her a prescription for Bactrim, and I will check a CBC. She will continue santyl and packing her distal wound. She will return for a follow up visit in one week.

Addendum: WBC 5.9, venous ultrasound negative

**Electronic Signature(s)**

Signed By:

Cotter, Jason

Cotter, Jason

Date:

06/25/2012 8:23:50 AM

06/25/2012 8:23:57 AM

Entered By: Sisson LPN, Sally on 06/15/2012 10:49:58 AM



## COASTAL CAROLINA HOSPITAL

Wilton Head Regional Healthcare

### Clinic Level Of Care Assessment Details

Patient Name: Baron, Frances

Patient Number: ( )

Patient Date of Birth: ( )

Date: 6/14/2012

RN/LPN: Cole, Lori

Physician / Extender: Cotter, Jason

### Clinic Level Of Care Assessment Items

| Admission / AMA                     |                                            | Quantity | Score |
|-------------------------------------|--------------------------------------------|----------|-------|
| <input type="checkbox"/>            | Hospital Admission (Inpatient Observation) |          | 0     |
| <input type="checkbox"/>            | AMA or LWBS                                |          | 0     |
| Interventions                       |                                            |          |       |
| <input type="checkbox"/>            | Specimen Collection # of                   |          | 0     |
| <input type="checkbox"/>            | Hematoctrit / Glucostix                    |          | 0     |
| <input type="checkbox"/>            | Glucose Scan / Urine Dipstick              |          | 0     |
| <input type="checkbox"/>            | Elastic Wrap                               |          | 0     |
| <input type="checkbox"/>            | Compression Therapy Single Extremities     |          | 0     |
| <input type="checkbox"/>            | Compression Therapy Multiple Extremities   |          | 0     |
| Assisting / Monitoring              |                                            |          |       |
| <input type="checkbox"/>            | Ankle, Brachial Index                      |          | 0     |
| <input type="checkbox"/>            | Doppler                                    |          | 0     |
| <input type="checkbox"/>            | Monitoring - Extensive                     |          | 0     |
| <input type="checkbox"/>            | Nursing Assessment - Initial               |          | 0     |
| <input checked="" type="checkbox"/> | Nursing Assessment - Subsequent Partial    | 1        | 10    |
| Wound Care                          |                                            |          |       |
| <input type="checkbox"/>            | Simple Suture Removal                      |          | 0     |
| <input type="checkbox"/>            | Complex Suture Removal                     |          | 0     |
| <input checked="" type="checkbox"/> | Wound Assessment                           | 1        | 10    |
| <input type="checkbox"/>            | Wound Measurement                          |          | 0     |
| <input checked="" type="checkbox"/> | Wound Measurement - Extensive              | 1        | 10    |
| <input type="checkbox"/>            | Wound Cleansing - Simple                   |          | 0     |
| <input checked="" type="checkbox"/> | Wound Cleansing - Complex                  | 1        | 15    |
| <input checked="" type="checkbox"/> | Photography                                | 1        | 10    |
| <input type="checkbox"/>            | Extremity                                  |          | 0     |

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DATE: 08/17/2012

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|                                                                                                                             |   |    |
|-----------------------------------------------------------------------------------------------------------------------------|---|----|
| <input type="checkbox"/> Tissue Expander Injection (Episodes of: )                                                          |   | 0  |
| <input type="checkbox"/> Dressing - Simple                                                                                  |   | 0  |
| <input type="checkbox"/> Dressing - Moderate                                                                                |   | 0  |
| <input type="checkbox"/> Dressing - Moderately Complex                                                                      |   | 0  |
| <input type="checkbox"/> Dressing - Complex                                                                                 |   | 0  |
| <input checked="" type="checkbox"/> Dressing - Extensive                                                                    | 1 | 30 |
| <input type="checkbox"/> Dressing - Extensive Complex (VAC)                                                                 |   | 0  |
| <b>Special Needs</b>                                                                                                        |   |    |
| <input type="checkbox"/> Special Teaching Needs                                                                             |   | 0  |
| <input type="checkbox"/> Special Emotional Needs                                                                            |   | 0  |
| <input type="checkbox"/> Special Service Needs (Each needs episode of: )                                                    |   | 0  |
| <input type="checkbox"/> Coordination of Care                                                                               |   | 0  |
| <input type="checkbox"/> Combative Patient                                                                                  |   | 0  |
| <b>Medications</b>                                                                                                          |   |    |
| <input checked="" type="checkbox"/> Medications - PO Suppository Topical                                                    | 1 | 5  |
| <input type="checkbox"/> IV Preexisting                                                                                     |   | 0  |
| <b>Education Discharge (Instructions)</b>                                                                                   |   |    |
| <input checked="" type="checkbox"/> Discharge Instructions                                                                  | 1 | 5  |
| <input type="checkbox"/> Discharge Instructions                                                                             |   | 0  |
| <input type="checkbox"/> Extensive Education / Counseling                                                                   |   | 0  |
| Is this the patient's first visit: No      Total Score: 95      Level Of Care: New / Est Patient Level 4 - Moderate to High |   |    |

**Electronic Signature(s)**

Signed By:

Cole, Lori RN

Cole, Lori RN

Date:

06/15/2012 11:55:21 AM

06/15/2012 11:55:25 AM

Entered By: Cole, Lori on 06/15/2012 10:24:33 AM



# COASTAL CAROLINA HOSPITAL

Wilson Head Regional Healthcare

## SuperBill Details

|                        |                |                       |               |
|------------------------|----------------|-----------------------|---------------|
| Patient Name:          | Baron, Frances | Date:                 | 6/14/2012     |
| Patient Number:        | [REDACTED]     | RN/LPN:               | Cole, Lori    |
| Patient Date of Birth: | [REDACTED]     | Physician / Extender: | Cotter, Jason |

## ICD9 Coding

| Code   | Description                                                                                                |
|--------|------------------------------------------------------------------------------------------------------------|
| 250.00 | Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled |
| 891.0  | Open wound knee, leg, ankle (not thigh)- w/o complication                                                  |
| 459.33 | Chronic venous hypertension with ulcer and inflammation                                                    |
| 729.92 | Nontraumatic hematoma of soft tissue                                                                       |

## Physician Procedures

| CPT4 Code | Description                             | Modifier | Quantity |
|-----------|-----------------------------------------|----------|----------|
| 99214     | Est. Patient Level 4 - Moderate to High |          | 1        |

## Electronic Signature(s)

| Signed By:    | Date:                  |
|---------------|------------------------|
| Cole, Lori RN | 06/15/2012 11:55:21 AM |
| Cole, Lori RN | 06/15/2012 11:55:25 AM |
| Cotter, Jason | 06/25/2012 8:23:50 AM  |
| Cotter, Jason | 06/25/2012 8:23:57 AM  |

Entered By: Cotter, Jason on 06/14/2012 9:48:20 PM

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DATE: 08/17/2012

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1. **Consent to Medical and Surgical Procedures.** I consent to the procedures which may be performed during this hospitalization or while I am an outpatient or emergency department patient. These may include, but are not limited to, emergency treatment or services, laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, anesthesia, or hospital services provided to me under the general and special instructions of my physician or surgeon. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment in this hospital. I also consent to the use of removed organs, tissues, and/or fluids for research or education purposes.
2. **Nursing Care.** This hospital provides only general nursing care and care ordered by the physician(s). If I want a private duty nurse, I agree to make such arrangements. The hospital is not responsible for failure to provide a private duty nurse and is hereby released from any and all liability arising from the fact that the hospital does not provide this additional care.
3. **Teaching.** Students, residents, postgraduate fellows, nursing and other clinical students may participate in my care as a part of the clinical education or research program of the hospital under appropriate supervision. I agree that unless I notify this hospital to the contrary in writing, I agree to participate in the educational or research programs at this hospital.
4. **PHYSICIANS ARE NOT EMPLOYEES OR AGENTS OF THE HOSPITAL.** All physicians, surgeons and various allied healthcare professionals furnishing services to the patients, including but not limited to emergency department physicians, radiologists, pathologists, anesthesiologists, and all physicians and other independent practitioners who are consulted or otherwise participate in the care of the patient, are independent contractors with the patient and are not employees or agents of the hospital. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of all physicians. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered for the patient under the general and special instructions of the physician. Emergency department physicians and other physicians caring for the patient may hire physician assistants and nurse practitioners to assist them in the performance of medical care and diagnosis. Such physician assistants and nurse practitioners are usually employed by the physicians alone, and are not employees or agents of the hospital.
- My initials at the end of this paragraph or my signature at the end of this form confirms that I have read the two paragraphs above, received a copy thereof, understand and agree to the terms of these paragraphs, and am the patient, the patient's legal representative, or duly authorized by the patient as the patient's general agent to execute the above and accept its terms. Patient Initials: JS
5. **Maternity Patients.** If I deliver an infant(s) while a patient of this hospital, I agree that this same Condition of Services apply to the infant(s).
6. **Personal Belongings.** As a patient, I am encouraged to leave personal items at home. The hospital maintains a fireproof safe for the safekeeping of money and valuables. The hospital is not liable for the loss or damage to any money, jewelry, documents, fur, fur coats, fur garments, dentures, eye glasses, hearing aids, prosthetics, or other articles of unusual value and small size, unless placed in the safe, and shall not be liable for loss or damage to any other personal property unless deposited with the hospital for safekeeping. Hospital's maximum liability for loss of any personal property deposited with the hospital for safekeeping is limited by law to five hundred dollars (\$500.00) unless I receive a written receipt for a greater amount from the hospital.
7. **Consent to Photograph/Videotaping.** The hospital is permitted to take pictures of the medical or surgery progress involving patients and to use same for scientific, educational or research purposes. I consent to photograph during medical and surgical procedures and the use of same for scientific, educational or medical research purposes. I further consent to routine photography related to patient care, including newborns. The term "photograph" as used herein includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.
8. **Emergency or Laboring Patients.** In accordance with federal law, I understand my right to receive an appropriate medical screening examination performed by a doctor, or other qualified medical professional, to determine whether I am suffering from an emergency medical condition and, if such a condition exists, stabilizing treatment within the capabilities of the hospital's staff and facilities, even if I cannot pay for these services, do not have medical insurance or I am not entitled to Medicare or Medicaid.
9. **Financial Obligations.** Notwithstanding paragraph 8, I agree to promptly pay all hospital bills in accordance with the regular rates and terms of the hospital, including its charity care and discount payment policies, if applicable. I understand that all physicians and surgeons, including the radiologists, pathologists, emergency physicians, anesthesiologists, and others, will bill separately for their services. Should any account be referred to an attorney or collection agency for collection, I will pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law. I understand the hospital may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options. Patient Initials: JS

## Conditions of Services

Page 1 of 2

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DATE: 08/17/2012

BARON, FRANCES

PRE CLI  
06/14/12 COTTER, JASON WILLIAM MD  
DOB: F MR#  
Coastal Carolina

10. Assignment of Insurance or Health Plan Benefits to Hospital. I assign and hereby authorize direct payment to the hospital of all insurance and plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurance company's or health plan's payment to the hospital pursuant to this authorization shall discharge the insurance company's or health plan's obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment.

11. Medicare Patient's Release of Information. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made in my behalf. I assign payment for the unpaid charges of the physician(s) for whom the hospital is authorized to bill in connection with its services. I understand I am responsible for any remaining balance not covered by other insurance.

12. The Additional Facility Specific Addendums Have Been Offered To The Patient: Notice of Privacy Practices and Patient Information Guide which includes information on:

- Patient Rights and Responsibilities
- Lewis Blackman Act
- Smoking Cessation

- Information regarding Advance Directives

☐ Patient has not executed Advance Directives

☐ Patient has executed Advance Directives - copy may be obtained from:

13. Release of Information. The hospital will obtain my consent and authorization to release medical information, except in those circumstances when the hospital is permitted or required by law to release information. I consent to the release of my information to third parties for education or research activities. I consent to the release of medical information to entities that provide care in post-acute settings. In accordance with the Safe Medical Device Act of 1990, I agree that in the event a permanent medical device is implanted, I authorize the hospital to notify the manufacturer of my name, address, telephone number and social security number, if available, as well as other information about the implantation.

I authorize the hospital to disclose all or any part of my record to any entity which is or may be liable to the hospital or me for all or part of the hospital's or hospital-based physicians' charges for the services provided to me, including, without limitation, hospital or insurance companies, workers' compensation carriers, welfare funds, my employer, or medical utilization review organization designated by the foregoing.

14. Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative. I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Obligations (Paragraph 9) and Assignment of Insurance Health Plan Benefits (Paragraph 10).

Date

Time

Financially Responsible Party

Witness

TRANSLATOR: I have accurately and completely read the foregoing document to \_\_\_\_\_ (name of patient/person legally authorized to give consent) in \_\_\_\_\_, the patient's or patient's representative's primary language. He/She understood all the terms and conditions and acknowledges his/her agreement thereto by signing this document in my presence.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and am the patient, the patient's legal representative, or am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

I confirm that I have read and understood and accepted the terms of this document, received a copy thereof, and am the patient, the patient's legal representative, or am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

6-14-12

1:30

am/pm

Signature

Frances Baron

Patient / Parent / Guardian / Conservator / Responsible Party

Date

Time

am/pm

Translator Signature / Translator Print Name

Witness Signature / Witness Print Name

If signed by other than patient, indicate relationship

A COPY OF THIS DOCUMENT SHOULD BE GIVEN TO THE PATIENT AND ANY OTHER PERSON WHO SIGNS THIS DOCUMENT.

Conditions of Services

Page 2 of 2

PRINTED BY: TARABLOOM

DATE: 06/17/2012

BARON, FRANCES

PRE CLI

06/14/12 COTTER, JASON WILLIAM MD

DOB: [REDACTED]

F MR# [REDACTED]

Coastal Carolina