

224451

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Mark Hayes, II, Circuit Court Judge

Case No. 2013-CP-42-2404
Appellate Case No. 2015-001828

RECEIVED
APR 11 2016
SC Court of Appeals

Lisa McKaughan, Individually
and as Personal Representative
of the Estate of William Farr,

..... Appellant

v.

Upstate Lung and Critical Care
Specialists, P.C. and Sau-Yin
Wan, M.D.

..... Respondents.

RECORD ON APPEAL (VOLUME 4)

Ashby W. Davis
David L. Williford
Davis, Snyder & Williford, P.A.
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Greenville, SC 29615
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J. David Wren, MD PHD, Director

Spartanburg Regional Medical Center
101 E. Wood Street
Spartanburg, South Carolina 29303-3072

-901-
Dept of Laboratory Medicine
864-560-6212

FARR, WILLIAM GAULT
68Y
CRUZ, RAUL B

MR#: S000478684
DOB: [REDACTED]
Location: ENDOSCOPY

ACCT#: S1029200952
Admitted: 10/19/2010
PT Type: ENDOSCOPY

MICROBIOLOGY

CULTURE FUNGUS WITH SMEAR
Accession #MF10292004

Collected: 10/19/2010 13:25
Specimen: BRONCHOALVEOLAR LAVAGE
Source:

Fungal Smear with Culture (Final)
Calcofluor White: no yeast or fungal elements seen

Results: (Final)
Fungus Culture Negative at 2 weeks
SOURCE bal rul

Patient Name: FARR, WILLIAM GAULT
Location: ENDOSCOPY

OUTPATIENT SRMC FINAL DISCHARGE TO

PT Type: ENDOSCOPY

PHYS FAX#: 864 5823750

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3/27/2013

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FARR, WILLIAM GAULT
68Y
CRUZ, RAUL B

MR#: S000478684
DOB: [REDACTED]
Location: ENDOSCOPY

ACCT#: S1029200952
Admitted: 10/19/2010
PT Type: ENDOSCOPY

MICROBIOLOGY

CULTURE FUNGUS WITH SMEAR
Accession #MF10292004

Collected: 10/19/2010 13:25
Specimen: BRONCHOALVEOLAR LAVAGE
Source:

Fungal Smear with Culture (Final)
Calcofluor White: no yeast or fungal elements seen

Results: (Final)
Fungus Culture Negative at 3 weeks
SOURCE bal rul

Patient Name: FARR, WILLIAM GAULT
Location: ENDOSCOPY

OUTPATIENT SRMC FINAL DISCHARGE TO

PT Type: ENDOSCOPY

PHYS FAX#: 864 5823750

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FARR, WILLIAM GAULT
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CRUZ, RAUL B

MR#: S000478684
DOB: [REDACTED]
Location: ENDOSCOPY

ACCT#: S1029200952
Admitted: 10/19/2010
PT Type: ENDOSCOPY

MICROBIOLOGY

CULTURE AFB AND AFB SMEAR
Accession #MT10292006

Collected: 10/19/2010 13:25
Specimen: BRONCHOALVEOLAR LAVAGE
Source:

Acid Fast Smear with Culture (Final)
No Acid Fast Bacilli on Direct Smear

Results: (Final)

S.C. Department of Health and Environmental Control (8231 Parklane Road Columbia, S.C.) Results indicate: Acid (Acid Fast Bacilli) Smear=Negative and No AFB isolated at 7 weeks.

SOURCE bal rul

Patient Name: FARR, WILLIAM GAULT
Location: ENDOSCOPY

OUTPATIENT SRMC FINAL DISCHARGE TO

PT Type: ENDOSCOPY

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SRHS 0048

DATE

3/27/2013

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SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-904-

NAME: FARR, WILLIAM GAULT
ORDERING PHYSICIAN: CRUZ, RAUL MANUEL B
LOC: DIS DOB: [REDACTED]
Pt. Type: OPS OUTPATIENT SURGERY

UNIT #: 000478684
CI#: 2889576
AN#: S1029400218

FINAL

Exam

60379 CT GUIDANCE FOR BX, INJ, ASP, LOCAL Date: 10/26/10 1200

Ord Diag: 786.6-CHEST SWELLING/MASS/LUMP

CT-guided biopsy of right upper lobe mass.

Indication: History of colon cancer in the remote past with history of right upper lobe lesion.

Operator: Dowling.

Medications: IV fentanyl and Versed.

The patient was placed under moderate conscious sedation for approximately 45 minutes of intravenous administration of Versed and fentanyl. Limited CT was performed, which again showed the wedge shaped area of increased density in the right upper lobe. This does not appear significantly changed since the previous study of 10/18/2010.

The region of interest was prepped and draped in sterile fashion and anesthetized with 2% lidocaine. A 20-gauge coaxial Francine needle was then inserted under CT fluoroscopic guidance. Immediate cytopathological review deemed the sample adequate for assessment. Request was made for sample for culture, which was done.

The patient tolerated the procedure well. No pneumothorax was seen post biopsy.

Impression: CT-guided biopsy of right upper lobe mass. Specimen sent for cytology and culture.

Page 1

SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-905-

NAME: FARR, WILLIAM GAULT

ORDERING PHYSICIAN: CRUZ, RAUL MANUEL B

LOC: DIS

Pt. Type: OPS

DOB: [REDACTED]

OUTPATIENT SURGERY

UNIT #: 000478684

CI#: 2889576

AN#: S1029400218

Checkin-Exam Code Summary
2889576-60379

Transcriptionist- MELISSA DALTON
Reading Radiologist- KYRAN DOWLING
Releasing Radiologist- KYRAN DOWLING
Released Date Time- 10/27/10 1122

Page 2

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-906-

NAME: FARR, WILLIAM GAULT

ORDERING PHYSICIAN: DOWLING, KYRAN

LOC: OPS

Pt. Type: OPS

DOB: [REDACTED]

OUTPATIENT SURGERY

UNIT #: 000478684

CI#: 2889691

AN#: S1029400218

FINAL

Exam

50338 XR CHEST PA
71010

Date: 10/26/10 1335
Ord Diag: 786.6

Single AP upright chest x-ray October 26, 2010

Reference exam: 10/19/2010

Indication: Post right lung biopsy

Findings: Hazy opacity remains in the right mid chest, lungs are underexpanded with film taken in a lordotic position. There is no convincing pneumothorax seen.

Impression: No convincing pneumothorax noted.

Transcriptionist- n/a

Reading Radiologist- JEFFREY NEWMAN MD

Releasing Radiologist- JEFFREY NEWMAN MD

Released Date Time- 10/26/10 1426

Page 1



CELLIGENT
DIAGNOSTICS

106 Venture Boulevard, Spartanburg, South Carolina 29306
Phone: 864-583-3850 Toll Free: 888-583-3850 Fax: 864-583-1405
Billing: 704-973-5500 or 866-389-5500
www.celligent.net

CYTOPATHOLOGY REPORT

Patient:	FARR, WILLIAM GAULT	Accession #:	SF10-771
	1032 JONESVILLE LOCKHART HWY, Union, SC, 29379 864-251-0531		
SSN:	[REDACTED]	Date Collected:	26 OCT 2010
DOB/Age:	[REDACTED]	Date Received:	26 OCT 2010
Office ID:	478684	Date Reported:	28 OCT 2010
Practice:			
Physician:	DOWLING, KYRAN - SRMC		
Cc:	SRMC		
	CRUZ, RAUL MANUEL - SRMC		

SPECIMEN:

Specimen Source: Lung (Right middle lobe)

Immediate Assessment:

1. Inflammatory

2. Inflammatory. -GHF

Test(s) Ordered: Fine Needle Aspiration with Immediate Assessment.

Fine Needle Aspiration Cell Block

GROSS DESCRIPTION:

Received are 4 prepared slides (2 fixed, 2 Diff-Quik Stained) and additional specimen received in CytoLyt; 30 mL slightly cloudy pink-tinged fluid. (JA)

Immunohistochemistry testing performed and interpreted by Celligent Diagnostics: TTF-1, CD7, CD20, CEA

SPECIMEN ADEQUACY:

Satisfactory for evaluation.

INTERPRETATION:

BRONCHOALVEOLAR CARCINOMA

COMMENT:

The TTF-1 is positive. The CD20 is negative. The cea is weakly positive. The CD7 is positive.

The tumor is predominantly mucinous and there has been an inflammatory response to this mucus

Electronic Signature: Gist H. Farr, MD October 28, 2010 11:25AM

Point of Service: Celligent Diagnostics - SR, 101 East Wood St, Spartanburg, SC, 29303

HISTORY:

History of colon cancer; smoker; mass found in right middle lobe of lung.

ICD9 CODES:

786.6

END OF REPORT

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101 E. Wood Street
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-908-

Dept of Laboratory Medicine
864-560-6212

FARR, WILLIAM GAULT
68Y
VIDITO, SARAH I

MR#: S000478684
DOB: [REDACTED]
Location: GIBBS INFUSION CENTE

ACCT#: S1029800104
Admitted: 10/25/2010
PT Type: GIBBS INFUSION CENTER-OPT

MICROBIOLOGY

CULTURE FUNGUS WITH SMEAR
Accession #MF10299001

Collected: 10/26/2010 12:50
Specimen: BIOPSY
Source: R LUNG MID LOBE

Fungal Smear with Culture (Final)
Calcofluor White: no yeast or fungal elements seen

Results: (Final)
Fungus Culture Negative at 3 weeks
SOURCE RIGHT LUNG MID LOBE BIOPSY FLUID

Patient Name: FARR, WILLIAM GAULT
Location: GIBBS INFUSION CENTER-PAL

OUTPATIENT SRMC FINAL DISCHARGE TO

PT Type: GIBBS INFUSION CENTER-OPT

PHYS FAX#: 864 5601826

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FARR, WILLIAM GAULT
68Y
VIDITO, SARAH I

MR#: S000478684
DOB: [REDACTED]
Location: GIBBS INFUSION CENTE

ACCT#: S1029800104
Admitted: 10/25/2010
PT Type: GIBBS INFUSION CENTER-OPT

MICROBIOLOGY

CULTURE FUNGUS WITH SMEAR
Accession #MF10299001

Collected: 10/26/2010 12:50
Specimen: BIOPSY
Source: R LUNG MID LOBE

Fungal Smear with Culture (Final)
Calcofluor White: no yeast or fungal elements seen

Results: (Final)
Fungus Culture Negative at 4 weeks
SOURCE RIGHT LUNG MID LOBE BIOPSY FLUID

Patient Name: FARR, WILLIAM GAULT
Location: GIBBS INFUSION CENTER-PAL

OUTPATIENT SRMC FINAL DISCHARGE TO

PT Type: GIBBS INFUSION CENTER-OPT

PHYS FAX#: 864 5601826

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FARR, WILLIAM GAULT
68Y
VEDITO, SARAH I

MR#: S000478684
DOB: [REDACTED]
Location: GIBBS INFUSION CENTE

ACCT#: S1029800104
Admitted: 10/25/2010
PT Type: GIBBS INFUSION CENTER-OPT

MICROBIOLOGY

CULTURE ANAEROBIC, AEROBIC
Accession #: MW10299030

Collected: 10/26/2010 12:50
Specimen: BIOPSY
Source: R LUNG MID LOBE

Gram Stain with Culture (Final)
Few polys seen and No organisms seen

Results: (Final)
No Aerobic and No Anaerobic Growth
SOURCE RIGHT LUNG MID LOBE BIOPSY FLUID

CULTURE AFB AND AFB SMEAR
Accession #MT10299001

Collected: 10/26/2010 12:50
Specimen: BIOPSY
Source: R LUNG MID LOBE

Acid Fast Smear with Culture (Final)
No Acid Fast Bacilli on Direct Smear

Results: (Prelim)
S.C. Department of Health and Environmental Control (8231 Parklane Road Columbia, S.C.) Results indicate: Acid Fast
Bacilli Concentrated Smear=Negative. Final report made after 7 weeks.
SOURCE RIGHT LUNG MID LOBE BIOPSY FLUID

CULTURE FUNGUS WITH SMEAR
Accession #MF10299001

Collected: 10/26/2010 12:50
Specimen: BIOPSY
Source: R LUNG MID LOBE

Fungal Smear with Culture (Final)
Calcofluor White: no yeast or fungal elements seen

Results: (Final)
Fungus Culture Negative at 1 week
SOURCE RIGHT LUNG MID LOBE BIOPSY FLUID

Patient Name: FARR, WILLIAM GAULT
Location: GIBBS INFUSION CENTER-PAL

OUTPATIENT SRMC FINAL DISCHARGE TO

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PT Type: GIBBS INFUSION CENTER-OPT

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SRHS 0052
3/27/2013

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Dept of Laboratory Medicine
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FARR, WILLIAM GAULT
68Y
VIDITO, SARAH I

MR#: S000478684
DOB: [REDACTED]
Location: GIBBS INFUSION CENTE

ACCT#: S1029800104
Admitted: 10/25/2010
PT Type: GIBBS INFUSION CENTER-OPT

MICROBIOLOGY

CULTURE FUNGUS WITH SMEAR
Accession #MF10299001

Collected: 10/26/2010 12:50
Specimen: BIOPSY
Source: R LUNG MID LOBE

Fungal Smear with Culture (Final)
Calcofluor White: no yeast or fungal elements seen

Results: (Final)
Fungus Culture Negative at 2 weeks
SOURCE RIGHT LUNG MID LOBE BIOPSY FLUID

Patient Name: FARR, WILLIAM GAULT
Location: GIBBS INFUSION CENTER-PAL

OUTPATIENT SRMC FINAL DISCHARGE TO

PT Type: GIBBS INFUSION CENTER-OPT

PHYS FAX#: 864 5601826

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3/27/2013

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Dept of Laboratory Medicine
864-560-6212

FARR, WILLIAM GAULT
68Y
VIDITO, SARAH I

MR#: S000478684
DOB: [REDACTED]
Location: GIBBS INFUSION CENTE

ACCT#: S1029800104
Admitted: 10/25/2010
PT Type: GIBBS INFUSION CENTER-OPT

MICROBIOLOGY

CULTURE AFB AND AFB SMEAR
Accession #MT10299001

Collected: 10/26/2010 12:50
Specimen: BIOPSY
Source: R LUNG MID LOBE

Acid Fast Smear with Culture (Final)
No Acid Fast Bacilli on Direct Smear

Results: (Final)

S.C. Department of Health and Environmental Control (8231 Parklane Road Columbia, S.C.) Results indicate: Acid (Acid Fast Bacilli) Smear=Negative and No AFB isolated at 7 weeks.

SOURCE: RIGHT LUNG MID LOBE BIOPSY FLUID

Patient Name: FARR, WILLIAM GAULT
Location: GIBBS INFUSION CENTER-PAL

OUTPATIENT SRMC FINAL DISCHARGE TO

PT Type: GIBBS INFUSION CENTER-OPT

PHYS FAX#: 864 5601826

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DATE

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3/27/2013

Medications

mg tablet, extended release 1 tab(s)

mg enteric coated tablet 1 tab(s) once a

meq 2 cap bid

37.5/25 1 tab QD

g-40 mg tablet 1 tab(s) once a day

List reviewed and reconciled with the

Medical History

History

or colon cancer radiation and chemo tx

History

ceased old age

ased cancer bone

rother, 3 sister

ntive for:, hypertension, cancer.

History

: yes, PPD: 1, years: 50.

is: Married.

vel: 11t.

retired.

in home smoke?: no.

orts, beer.

Primary care Dr Littlefield, Dr Vidito.

of Systems

ORY:

mild. no Day-Time Sleepiness.

wakening sometimes. Trouble

ns.

IONAL:

/Chills. no Night sweats.

ORY:

ness of breath. no Cough, Productive.

no Chest Tightness. no Pleuritic

GY:

na occasionally. no Palpitations.

TEROLOGY:

Reason for Appointment

1. LUNG BX 10/26/10

2. Pt still smokes 1 pk cigarette day.

History of Present Illness

Interim History:

- Followup for copd and st IIa (T3, No, Mo) bronchoalveolar carcinoma
- He still smokes, wants to quit,
- He claims he can climb 2-3 flights of stairs without stopping
- He has moderate to severe obstruction with an FVC=1.98 l
- He is a colon cancer survivor, followed up by Dr Vidito
- He has requested to see Dr Corso for his new cancer
- He also has been started on symbicort and proventil
- He complains of insomnia, requested a sleep aid

Pulmonary Evaluation:

c/o Smoking Yes. c/o Dyspnea at baseline.

Denies : COUGHING. Wheeze. chest congestion. Palpitations. chest pain. fever. hemoptysis.

Vital Signs

Wt 140.2, BP 130/70, HR 87, O2 sat 92%, FIO2 .21.

Physical Examination

GENERAL:

General Appearance: No acute distress. Build: average built.

HEENT:

Head: normocephalic. Pharynx: oropharynx clear. Pupils: symmetric. Sclera: anicteric. EOM: intact. Nose: normal. Nasal septum: midline. Oral cavity: normal.

NECK:

Neck: supple, no jugular venous distention, trachea midline. Cervical lymph nodes: normal. Thyroid: not enlarged.

CHEST:

Shape and expansion: symmetrical chest expansion. Wheezes: no. Rales: no. Rhonchi no.

HEART:

PMI: PMI not displaced. Rhythm: regular. Heart sounds: tones normal. Murmurs: no.

ABDOMEN:

Exam shows: no organomegaly. Tenderness: no. Guarding: no. Liver, Spleen: not palpable.

EXTREMITIES:

Pulses: 2+ bilateral. Clubbing: no. Cyanosis: no. Edema: no.

no Nausea. no Vomiting. no Heartburn.
no Diarrhea.
Reviewed by: Anne Purser.

Assessments

-914-

1. Lung cancer - 162.9 (Primary)
2. Mass in chest NOS - 786.6
3. COPD [Chronic obstructive pulmonary disease] - 496
4. Tobacco abuse - 305.1
5. Insomnia - 780.52

Treatment

1. Lung cancer

radiologic T3 NoMo (IIb) bronchoalveolar type) in the setting of moderate to severe copd. He would benefit from RUL / RML lobectomy and adjuvant chemotherapy. His borderline lung function makes him a moderate risk patient for a high risk procedure. He understands the plan and agrees. His daughter is here and was part of the decision making. He has been referred to Dr Corso and Dr Nguyen. I would recommend that his PFT's and VQ scan be done/ repeated if surgery is decided upon.

2. COPD [Chronic obstructive pulmonary disease]

Start Symbicort 160/4.5, 160/4.5 mg, 2 puffs, bid
Start Proventil HFA aerosol with adapter, CFC free 90 mcg/inh, 2 puff(s), inhaled, 4 times a day, 30 day(s)

3. Tobacco abuse

Start Chantix, Starter Pack 0.5mg-1mg, 1 tab, BID
Start Chantix Continuing Month tab, 1 mg, 1 tab, oral, bid
He denies suicidality. He denies being depressed.

4. Insomnia

Start Ambien tablet, 5 mg, 2 tab(s), orally, once a day (at bedtime), 30 day(s), 60, Refills 1

5. Others

I have spent a total of 1 hour discussing the case with him and his family.

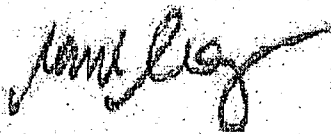
Preventive Medicine

Counseling: Pharmacy CVS Union.

Immunizations: Pneumococcal 2006. Influenza 2010.

Follow Up

6 Weeks



Electronically signed by DR RAUL CRUZ , MD on 03/06/2013 at 10:02 AM EST

Sign off status: Pending

Lung and Chest Medical Associates
2030 North Church Place
Spartanburg, SC 293032799
Tel: 864-582-6858
Fax: 864-542-9043

Patient: FARR, WILLIAM G DOB: [REDACTED] Progress Note: RAUL B CRUZ, MD 11/01/2010

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



Palmetto

Hematology Oncology, P.C.

The Gibbs Cancer Center
380 Serpentine Drive, Suite #200
Spartanburg, South Carolina 29303
(864) 560-7050 FAX: (864) 560-7057

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Eric C. Nelson, M.D.
Asim R. Pati, M.D.
Steven W. Corso, M.D.
Colin P. Curran, M.D.
Sarah I. Vidito, D.O.
Sharmila Mehta, M.D.

Page: 1

PATIENT: FARR, WILLIAM GAULT
MRN: 14160

D.O.B.: [REDACTED]

OFFICE VISIT:

DATE: 11/02/10

DIAGNOSIS:

- 09/12/97: Rectal cancer, T3N0M0 treated with 5-FU infusional treatment concomitant radiotherapy on Protocol 59304
- Erythrocytosis secondary to tobacco abuse.
- Life long tobacco abuse.

SUBJECTIVE: The patient is here for regular follow up of secondary erythrocytosis. He is being treated with intermittent therapeutic phlebotomy with goal for level of hematocrit below 45 volume percent. His last phlebotomy has been 09/14/10. As part of evaluation for secondary erythrocytosis the patient has been referred to Dr. Wan. He has been seen by Dr. Wan in January 2010. The recommendation has been made to follow up in six month intervals with further evaluation. During previous office visit the patient has elicited no significant complaints. Tobacco cessation has been addressed and highly suggested to the patient. During today's office visit the patient reports new presentation of respiratory distress. He has been seen and evaluated by his primary care physician. The imaging study identified new right upper lobe mass consistent with neoplasm. The patient has been referred to Dr. Cruz for further evaluation. Further investigational work up included lung biopsy. During today's office visit, the patient complains of a new presentation of shortness of breath. This has been evaluated as described above. The patient complains of cough with sputum production. There is no hemoptysis. He denies fevers, chills, or night sweats. There is no significant chest pain/chest discomfort. He denies abdominal pain, nausea or vomiting, diarrhea or constipation.



Palmetto

Hematology Oncology, P.C.

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Eric C. Nelson, M.D.
Asim R. Pati, M.D.
Steven W. Corso, M.D.
Colin P. Curran, M.D.
Sarah I. Vidito, D.O.
Sharmila Mehta, M.D.

Page: 2

PATIENT: FARR, WILLIAM GAULT
MRN: 14160

D.O.B.: [REDACTED]

There is no melena, hematochezia or bright red blood per rectum. There is no significant arthralgia or myalgia. The remainder of review of systems has been obtained and is within normal limits and noncontributory to this presentation. Patient maintains good quality of life and functional independence.

ALLERGIES: NKA

TOBACCO: He is smoking one pack of cigarettes per day. He drinks about two beers per day. Patient received appropriate tobacco cessation education.

PAIN: 0/10

FAMILY HISTORY: Reviewed and unchanged since initial office visit.

SOCIAL HISTORY: Reviewed and unchanged since initial office visit.

REVIEW OF SYSTEMS: As above.

Imaging:

- 01/10: As indicated by Dr. Wan's clinical note chest x-ray has been obtained with no pathological findings. 1
- 10/19/10 CXR: Right upper lobe infiltrate
- 10/18/10 PET scan: Moderate level hypermetabolic activity corresponding to opacity in the right upper lobe. Not typical for metastatic disease and probably infectious or inflammatory pneumonic infiltrate. Primary bronchoalveolar cell carcinoma could however have this appearance.

Cytopathology report:

- 10/19/10 Transbronchial: Reactive Bronchial Cells and Atypical Cells Present, Negative for Malignancy in these sections.



Palmetto

Hematology Oncology, P.C.

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PATIENT: FARR, WILLIAM GAULT
MRN: 14160

D.O.B.: [REDACTED]

PHYSICAL EXAMINATION: ECOG PS: 1. HEENT: oral mucosa moist without petechiae. Facial plethora is noted. Mucosal membranes reveal mild cyanosis. There is no cervical, supraclavicular, axillary or inguinal adenopathy. Lungs are clear to auscultation bilaterally. Heart is within normal rate and rhythm. Abdomen is soft, nontender and non-distended, no hepatosplenomegaly. Extremities are without edema, cyanosis and petechiae. Skin is without excessive ecchymosis, petechiae or purpura. Neurologic exam is without focal deficit.

LABORATORY: HCT: 50%

PLAN:

- **Lung neoplasm:** the patient reports recent lung parenchymal biopsy with path report consistent with non-small cell lung carcinoma. Path report currently is not available for my review. I had a lengthy discussion with the patient and his daughter regarding current clinical presentation. The patient has been seen and evaluated in our office for reason of secondary erythrocytosis. He has been followed up in six month intervals for clinical evaluation. The laboratory data including CBC has been obtained. As per ASH recommendations therapeutic phlebotomy has been applied to maintain hematocrit below 45%. The initial evaluation of secondary erythrocytosis included pulmonological evaluation. This has been provided by Dr. Wan. The chest x-ray dated January 2010 revealed no significant lung parenchymal pathology. There was no indication for further evaluation based on stable and asymptomatic patient clinical presentation. I discussed with the patient NCCN and ASCO recommendations. There is no data for prophylactic chest x-ray and CT imaging in a patient with tobacco abuse with goal of early detection of lung neoplasm. As per Dr. Wan's notes, the patient has been advised to follow up in six month intervals. It is not clear if the patient has been followed with medical recommendations. All of the patient's questions have been answered. At this point the patient would like to proceed with further evaluation and



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PATIENT: FARR, WILLIAM GAULT
MRN: 14160

D.O.B.: [REDACTED]

treatment for recently diagnosed non-small cell lung carcinoma. He would like to transfer medical management to Dr. Steve Corso. I will provide immediate assistance to the patient in order to maintain a continuity of care.

- **Secondary erythrocytosis:** current CBC identified hematocrit above 45%. In the view of present diagnosis of lung neoplasm I will withhold therapeutic phlebotomy. I will defer further medical management to Dr. Corso. The patient will follow up with Dr. Corso as per Dr. Corso's discretion and recommendations.
- **Tobacco cessation:** I spent at least 5-10 minutes and discussed with patient appropriate tobacco cessation.
- **Rectal carcinoma:** follow up as per NCCN guidelines.
- **Patient will follow up** with his primary care physician regarding chronic medical conditions.

ELECTRONICALLY APPROVED BY: SARAH VIDITO, DO

DATE/TIME APPROVED: 11/10/10/12:12 PM

TRANSCRIBED BY: jm

cc: Dr. Raul Cruz
Dr. Littlefield
Dr. Wan



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PATIENT: FARR, WILLIAM G.
MRN: 14160

D.O.B: [REDACTED]
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NEW PATIENT CONSULTATION: DATE: 11/08/10

This patient was a patient of Dr. Vidito's who has changed care to Dr. Corso.

HPI: This is a 68 year-old gentleman who has been provided care by Dr. Vidito and Dr. Bearden in the past who is seen today with a recent diagnosis of lung cancer as per family request. The patient states he recently changed primary care physician to Dr. Littlefield and due to his history of COPD requested a chest x-ray they performed to evaluate his lung disease. His chest x-ray showed an infiltrate in the right middle lobe that prompted a CT scan which was performed on the 11th of October revealing atelectasis in the anterior segment of the right upper lobe with adjacent patchy infiltrate. There were also two cysts in the liver noted. Due to these findings, the patient was referred to Dr. Cruz and a PET scan was ordered and performed on the 18th of October revealing a moderate level of hypermetabolic activity that corresponded to the opacity in the right upper lobe. The patient underwent a bronchoscopy on the 19th of October with only reactive bronchial cells noted. Due to the suspiciousness of his PET scan, the patient then underwent a needle biopsy on the 26th of October which revealed a bronchioalveolar carcinoma. It was TTF1 positive and CD20 negative. CD7 was positive. Due to these findings, he is seen today in our office for further evaluation and consultation.

PAST MEDICAL HISTORY:

- Polycythemia Vera with intermittent phlebotomies.
- Rectal cancer in 1997, T3 N0 M0 treated with 5-FU and concomitant radiotherapy.
- Hypertension.



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PATIENT: FARR, WILLIAM G.
MRN: 14160

D.O.B.: [REDACTED]
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- Hypercholesterolemia.

PAST SURGICAL HISTORY:

- Hernia repair.
- Some type of cyst removed.

ALLERGIES: No known drug allergies.

CURRENT MEDICATIONS:

Vytorin 10-40 daily
ASA 81 mg daily
Chlor-con m20 tid
Nifedipine ER 30 mg every day
Triam/HCTZ 37.25 daily

FAMILY HISTORY: The patient's mother is deceased due to old age. The patient's father is deceased with a history of prostate cancer. He does have six living siblings, all in good health, no history of cancer. He had a paternal grandfather with a history of colon cancer and a paternal uncle with a history of esophageal cancer.

SOCIAL HISTORY: The patient is married and has two children that are living and in good health. He smokes approximately a half pack a day and has smoked for the past 55 years. He has approximately three to four beers a day and is of the Methodist faith.

REVIEW OF SYSTEMS: No complaints of headaches, visual changes, paresthesias or focal weakness. No night sweats, fevers, changes in appetite or weight loss. No pruritus, rashes, musculoskeletal pains or bleeding. No problems with shortness of breath, chest pain, cough or palpitations. No problems with nausea, vomiting or changes in bowels. No difficulty with urination. No problems with depression or anxiety.

PHYSICAL EXAMINATION: BP 157/88, P 90, T 98.1, Weight 140. This is an alert and oriented, ambulatory pleasant white gentleman in no acute distress. HEENT: PERRLA. Sclera nonicteric, non-injected without lid lag. Lips, tongue and gums without sores. No caries or inflammation. Oropharynx is without lesions. RESPIRATORY: Normal respiratory effort without accessory muscle use. Breath sounds equal bilaterally without rales or



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PATIENT: FARR, WILLIAM G.
MRN: 14160

D.O.B: [REDACTED]
Page: 1

wheezing. CARDIOVASCULAR: no murmurs, gallops or rubs. No lower extremity edema or varicosities. ABDOMEN: Soft, nontender, without masses or hepatosplenomegaly. Colostomy is present. LYMPH: No cervical, supraclavicular, axillary or inguinal adenopathy. SKIN: No petechiae, rashes or ulcers. No induration or subcutaneous nodules. NEUROLOGICAL: Cranial nerves intact and deep tendon reflexes 2+ without down-going toes.

LABORATORY: Dated today: White count 10.6, hemoglobin 15.4, hematocrit 47.1, platelets 355,000. Chemistries: Potassium 3.5.

ASSESSMENT/PLAN: Lung cancer: Elderly male smoker with recent diagnosis of bronchioalveolar carcinoma of the right upper lobe. Clinically he appears to have a stage II, T2 versus T3 N0 M0 malignancy. I have spoken with him and his family at length about his diagnosis. We have reviewed his PET and CT scans. At this time he appears to have a localized process, one that hopefully will be amenable to surgical resection for curative intent. We talked about his surgical plans with Dr. Nguyen and I have agreed with the current approach. He would like to be as aggressive as possible and I told him at this point surgery really is what is needed to provide him the best opportunity for long term survival. I have told him that after surgery we would get back together to discuss the results and consider whether or not other therapies would be needed.

PLAN:

- Follow up appointment phone call and after the Thanksgiving weekend to see how his treatment/work up is proceeding and make further plans at that point.

ELECTRONICALLY APPROVED BY: Steven W. Corso, M.D.

DATE/TIME APPROVED: 11/15/10/5:33 PM

SWC/jm

cc: Dr. Littlefield
Dr. Cruz
Dr. Nguyen

M.D. SIGNATURE/DATE

DATE: 11-8-10

NEW PATIENT REPORTED HISTORY
GIBBS REGIONAL CANCER CENTER

Dear Patient or Family Member:

We thank you in advance for taking the time to complete this questionnaire. We are aware of how time consuming this is. This information is very useful and helps your doctor and staff document your history in an accurate manner in order to respond to your health problems or issues.

NAME: William H. Jan

DOB: [REDACTED] 68

MR#: [REDACTED] SSN: [REDACTED]

CHIEF COMPLAINT: What is the main reason for your visit today?

Lung Cancer

Referring Physician:

Other Physicians/Dentist you have seen as part of your care:

Surgeon:

Urologist/OB-GYN:

Primary Care:

List and Radiology/Pathology you have had in the last 2 years and location:

PAST MEDICAL HISTORY:

Diabetes
High Blood Pressure
Previous Cancer
Stroke/TIA
Heart Trouble
Arthritis
High Cholesterol/Lipids
Blood Clots
Hepatitis
Neuropathy
Seizures
TB
Pacemaker
Lupus/Scleroderma
Other

Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No

DATE OF ONSET

1997

Any condition for which you take medication: Blood Pressure

NAME: William H. Gurn
MR# _____

PAST SURGERIES INCLUDING YEAR PERFORMED/SURGEONS NAME:

1. 1997 Dr. Kapp
2. 2000 Dr. Kapp
3. 2001 Dr. Orr
4. _____
5. _____
6. _____

Reactions to Surgery:

☐ Problems with Anesthesia

☐ Reactions to surgery, please describe.

Waking up / Hem

Prior Radiation Therapy:

Facility/MD: Dr. Braden Date of Last Treatment: 1997

Prior Chemotherapy:

Facility/MD: Dr. Braden Date of Last Treatment: 1997

Prior Hormonal Treatments:

Facility/MD: _____ Date of Last Treatment: _____

PERSONAL HISTORY:

Marital Status: ☒ Married ☐ Widowed ☐ Single ☐ Divorced

Occupation: Retired

Retired: 1997

With whom do you live: Wife

Education: Can you read? ☒ Yes ☐ No

Can you write? ☒ Yes ☐ No

Finished grammar school ☒ Yes ☐ No

Finished high school ☒ Yes ☐ No

Finished college _____ 2 year _____ 4 year _____ > 4 years

Tobacco Usage: Yes ☐ No ☒ Quit Smoking: Yes ☐ No ☒ When: _____

Cigarettes: How many packs per day: 1 pack How many years: 55 yrs.

Chew/Dip Tobacco: _____ How long: _____

Alcohol: How many drinks per day: 2 drinks What type: Beer / Liquor

Drug Abuse: Marijuana Yes ☒ No ☐ Prescription Pain Meds: Yes ☐ No ☒

Cocaine Yes ☒ No ☐ IV Drug Abuse: Yes ☐ No ☒

Other: _____

Would you like to meet with a social worker: ☐ Yes ☒ No

MILITARY HISTORY: _____

ELIGIBLE FOR VA BENEFITS: Yes ☒ No ☐

NAME: William H. Fenn

MR# _____

EXPOSURE HISTORY:

Please include the approximate period of years, if any that you were exposed to:

Agent Orange: _____ Paints/Benzenes: _____

Insecticides/Pesticides: all the time Radiation: _____

Asbestos: _____ Other: _____

Pets: all the time Rare (Birds/Reptiles, Etc) _____

Have you ever tested positive for Tuberculosis?

Yes ☒ No ☒

Have you worked in the card or weave room of a factory?

Yes ☒ No ☒

Have you ever been exposed to HIV?

Yes ☒ No ☒

Have you ever been exposed to Hepatitis?

Yes ☒ No ☒**FAMILY MEDICAL HISTORY:** The following questions are about your FAMILY, you may or may not know all the information asked. Please answer to the best of your ability.

NAME	LIVING/DECEASED// AGE OF DEATH OR PRESENT AGE:	ANY HEALTH PROBLEMS:	CAUSE OF DEATH:
MOTHER <u>Sarah</u>	<u>91</u>		<u>old age</u>
FATHER <u>William</u>	<u>90</u>		<u>Cancer</u>
BROTHER <u>William</u>	<u>1</u>		
BROTHER <u>Charles</u>	<u>1</u>		
SISTER <u>Ronald</u>	<u>1</u>		
SISTER <u>Paul</u>	<u>1</u>		
CHILDREN			
FIRST <u>John</u>	<u>45</u>		
SECOND <u>Lisa</u>	<u>40</u>		
THIRD <u>David</u>	<u>1</u>		
FOURTH	<u>1</u>		
FIFTH	<u>1</u>		

Please list extended family members with cancer and/or blood disorders:

Father Melanoma

Have you ever been transfused blood?

Yes ☒ No ☒

Are you opposed to receiving blood products?

Yes ☒ No ☒

Do you have a Living Will?

Yes ☒ No ☒**VACCINATION HISTORY:****DATE LAST RECEIVED:**

Childhood Immunizations

Yes ☒ No ☒

Flu Vaccine

Yes ☒ No ☒

Last Received

Pneumovax

Yes ☒ No ☒

Last Received

Hepatitis Vaccine

Yes ☒ No ☒

Last Received

Tetanus

Yes ☒ No ☒

Last Received

Other

Yes ☒ No ☒

Last Received

NAME: _____

MR# _____

*William H. Gar***FEMALE HISTORY:**

Age periods started: _____

Age stopped: _____

How many pregnancies: _____

Live births: _____

Your age at 1st pregnancy _____

Date of last mammogram _____

Last GYN/Pap Exam: _____

Did you ever take any hormone replacement pills/shots? _____

Did you ever take birth control (state how long)? _____

Breast biopsies (include dates/results): _____

MALE HISTORY:Date of last rectal exam: 2008

Have you ever had a PSA drawn and when: _____

HEALTH MAINTENANCE:

Have you ever had your cholesterol or lipids checked & when?

Medicare

Are you being treated for this? _____

Have you ever had a:

Colonoscopy

Yes

No

When

2008

Sigmoidoscopy

Yes

No

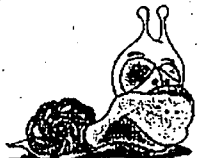
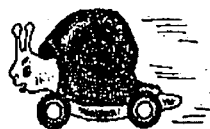
When

Bone Density

Yes

No

When

2010**PLEASE LIST YOUR SYMPTOMS BELOW AS BEST YOU CAN:****Fatigue Scale(Circle How You Feel)**

NO FATIGUE	MILD FATIGUE			MODERATE FATIGUE	EXTREME FATIGUE			THE WORST FATIGUE
0	1	2	3	4 5 6	7	8	9	10

Pain Scale(Circle How You Feel)

0



2



4



6



8



10

NAME: William L. Gann

MR# _____

General:

- ☐ Fevers
☐ Chills
☒ Sweats *Somnolence*
☐ Anorexia (Loss of appetite)
☐ Fatigue (tired)
☐ Weakness
☐ Malaise
☒ Weight loss *Amnesia*
☒ Sleep disorder
☐ Insomnia

- ☐ Excessive sputum
☐ Excessive snoring

Gastrointestinal:

- ☐ Excessive appetite
☐ Excessive sputum
☐ Excessive snoring

- ☐ Vaginal discharge
☐ Pelvic pain

Musculoskeletal:

- ☐ Muscle cramps
☐ Joint pain
☐ Joint swelling
☐ Presence of joint fluid
☐ Back pain
☐ Stiffness
☐ Muscle weakness
☐ Arthritis
☒ Gout
☐ Loss of strength
☐ Muscle aches

Eyes:

- ☐ Vision Loss in 1 eye
☐ Double vision
☐ Eye irritation
☐ Vision Loss in both eyes
☐ Blurring
☐ Eye pain
☐ Halos
☐ Discharge
☐ Light sensitivity

Gastrointestinal:

- ☐ Excessive appetite
☐ Loss of appetite
☐ Indigestion
☐ Vomiting blood
☐ Nausea
☐ Yellowish skin color
☐ Gas
☐ Abdominal pain
☐ Abdominal bloating
☐ Hemorrhoids
☐ Diarrhea
☐ Change in bowel habits
☐ Constipation
☐ Dark tarry stools
☐ Bloody stools

Skin:

- ☐ Excessive perspiration
☒ Night sweats
☐ Suspicious lesions
☐ Changes in nail beds
☐ Dryness
☐ Poor wound healing
☐ Unusual hair distribution
☐ Skin cancer
☐ Itching
☐ Changes in color of skin
☐ Flushing
☐ Rash

Ears/Nose/Throat:

- ☐ Ringing in the ears
☐ Ear discharge
☐ Earache
☐ Decreased hearing
☐ Nasal congestion
☐ Nosebleeds
☐ Difficulty swallowing
☒ Hoarseness
☐ Sore throat
☐ Sinus congestion

Genitourinary/MALE:

- ☐ Dysuria (painful urination)
☐ Hematuria (bloody urine)
☐ Discharge from penis
☐ Urinary frequency
☐ Urinary hesitancy
☐ Nocturia (urination at night)
☐ Incontinence
☐ Genital sores
☐ Decreased libido (decreased desire)
☐ Erectile dysfunction

Cardiovascular:

- ☐ Difficulty breathing at night
☐ Near fainting
☐ Chest pain or discomfort
☐ Racing/skipping heartbeats
☐ Fatigue
☐ Lightheadedness
☐ Shortness of breath with exertion
☐ Palpitations
☐ Swelling of hands or feet
☐ Difficulty breathing while lying down
☐ Fainting
☐ Leg cramps with exertion
☐ Bluish discoloration of lips or nails
☐ Weight gain

Genitourinary/FEMALE:

- ☐ Foul urinary discharge
☐ Blood in urine
☐ Urinary frequency
☐ Inability to empty bladder
☐ Urinary urgency
☐ Kidney pain
☐ Trouble starting urinary stream
☐ Painful urination
☐ Nighttime urination
☐ Inability to control bladder
☐ Genital sores
☐ Lack of sexual drive
☐ Excessive heavy periods

Respiratory:

- ☒ Sleep disturbances due to breathing
☒ Cough
☒ Shortness of breath

- ☒ Coughing up blood
☒ Wheezing
☒ Chest discomfort
☐ Missed periods
☐ Unusual urinary color
☐ Other abnormal vaginal bleeding

NAME: William L. Jan
 MR#: _____

Review of Systems

Please check all that apply over the **LAST MONTH**:

Neurologic:

- ☐ Difficulty with concentration
☐ Poor balance
☐ Headaches
☐ Disturbances in coordination
☐ Numbness
☐ Inability to speak
☐ Falling down
☐ Tingling
☐ Brief paralysis (can't move)
☐ Visual disturbances (can't see)
☐ Seizures
☐ Weakness
☐ Sensation of room spinning
☐ Tremors
☐ Fainting
☐ Excessive daytime sleeping
☐ Memory loss
☐ Dizziness

Psychiatric:

- ☐ Sense of great danger
☐ Anxiety
☐ Thoughts of suicide
☐ Mental problems
☐ Depression
☐ Thoughts of violence
☐ Frightening visions or sounds

Endocrine:

- ☐ Excessive hunger
☐ Cold intolerance
☐ Heat intolerance
☐ Excessive urination
☐ Excessive thirst
☐ Weight change

Heme/Lymphatic:

- ☐ Enlarged lymph nodes (swollen glands)
☐ Bleeding
☐ Skin discoloration
☐ Abnormal bruising
☐ Fevers
☐ Blood Clots

Allergic/Immunologic:

- ☐ Persistent infections
☐ Hives or rash
☐ Seasonal allergies
☐ HIV exposure

Breast:

- ☐ Left breast lump
☐ Right breast lump
☐ Nipple discharge
☐ Bloody discharge from nipple
☐ Breast pain
☐ Abnormal mammogram
☐ Breast enlargement
☐ Breast pain or tenderness

PATIENT SIGNATURE

DATE

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Spartanburg, SC 29303

Phone (864) 560-1900

Fax (864) 560-1925

www.gibbsurgicaloncology.com

CHRISTOPHE NGUYEN, M.D.

OFFICE NOTE

DATE: November 8, 2010

PATIENT: FARR, WILLIAM

DOB:

REQUESTING PHYSICIAN:

Dr. Raul Cruz

REASON FOR EVALUATION:

1. Recently biopsy proven bronchioalveolar lung cancer of the right lung.
2. Previous history of colorectal cancer status post treatment and resection by my partner Dr. Orr approximately 1989.

CHIEF COMPLAINT:

Here because of my lung.

HISTORY OF PRESENT ILLNESS:

Mr. William Farr is a 68 year-old man who presents at the behest of Dr. Cruz and Orr for evaluation of the above. The patient has an extensive cancer history as mentioned above. He was treated for a colorectal cancer approximately 13 years ago. He underwent resection and also received chemotherapy and radiation therapy. He has done quite well from this and is without evidence of disease. He does have a longstanding history of smoking which is ongoing currently. He smokes one pack per day over the last 50 years. The patient underwent a routine chest x-ray in light of his history of cancer and chronic cough and as a smoker. This demonstrated an infiltrate in the right middle lobe which prompted a CT scan. He was eventually seen by Dr. Littlefield and by Dr. Cruz. CT imaging demonstrated abnormal infiltrate in the right middle lobe with some proximity to the pericardium as well as possibly involvement of the basilar segment of the right upper lobe. He ultimately underwent a CT guided biopsy which returned positive for bronchioalveolar lung cancer. He underwent a PET scan which demonstrated activity in this area with an SUV of 5. There was no evidence of any hypermetabolic activity in the hilar or mediastinal region.

He denies any hemoptysis, any weight loss or any new neurologic symptoms. He is still smoking a half a pack of cigarettes a day. He also does drink a beer daily. He denies any exposure to asbestos.

-continued-

DATE: November 8, 2010
PATIENT: FARR, WILLIAM
DOB:
PAGE -2-

ALLERGIES:

Negative.

CURRENT MEDICATIONS:

1. Nifedipine 30 mg po q day.
2. Aspirin 81 mg po q day.
3. Triamterene hydrochlorothiazide 37.5/25 mg 1 tablet po q day.
4. Vytorin 10 mg/40 1 po q day.

PAST MEDICAL HISTORY:

1. COPD with reduced PFTs.
2. Chronic cough.
3. Hypertension.
4. History of previous colorectal cancer.
5. Recently diagnosed lung cancer.

PAST SURGICAL HISTORY:

As above including also hernia repair and nasal surgery.

FAMILY HISTORY:

Father with bone cancer.

SOCIAL HISTORY:

As mentioned above, significant for tobacco use. He is married. He also uses alcohol every day.

REVIEW OF SYSTEMS:

All systems have been reviewed and other than mentioned in the HPI are negative.

PHYSICAL EXAMINATION:

VITAL SIGNS:	Blood pressure is 149/86. Pulse is 83. Temperature is 98.0. Respirations are 20. O2 saturation is 94%.
HEENT:	Sclerae anicteric. Pupils equal and reactive to light and accommodation. Head is normocephalic, atraumatic. The oral cavity is without lesions.
NECK:	No cervical or supraclavicular adenopathy.
CHEST:	Clear to auscultation bilaterally without wheezing.
HEART:	Regular rate and rhythm without murmurs.
ABDOMEN:	Soft, nontender without masses.
EXTREMITIES:	Warm, well perfused without cyanosis.
NEUROLOGIC:	Cranial nerves II-XII are intact. Gait is normal.

-continued-

DATE: November 8, 2010
PATIENT: FARR, WILLIAM
DOB:
PAGE -3-

Pulmonary function intraoffice spirometry performed by Dr. Cruz demonstrated an FEV1 of 1.54 and FEC at 1.96.

IMPRESSION:

1. Biopsy proven bronchioalveolar lung cancer of the right lung possibly right upper lobe and right middle lobe clinical stage T3, N0, M0 with significant obstruction on his pulmonary function tests.
2. History of previous colorectal cancer currently NED.

I spent the majority of an hour and a half visit with the patient as well as discussing with his family the results of his PET scan as well as the biopsy results demonstrating an apparent localized bronchioalveolar lung cancer. I am concerned on his PET scan that he may have extension across the minor fissure into the upper lobe particularly the basilar segment. I see no radiographic evidence to suggest disease in the right lower lobe. He has no significant hilar or mediastinal adenopathy. Nonetheless from a staging perspective I would recommend a mediastinoscopy prior to resection in light of the extent of his process. I have also recommended a brain MRI to complete his staging as he is clinically a stage 2. We did discuss the staging system for lung cancer extensively. I have given him a copy of my lung cancer handout. He understands the importance of mediastinal staging as well as the role of surgery for this process. I am concerned about his capacity to undergo surgery with his reduced pulmonary function tests. I have recommended a differential lung scan as well as repeat pulmonary function tests to more accurately assess his postoperative predicted lung function. It does appear that he would likely require a bilobectomy. I have also asked that he see Dr. Littlefield for a medical clearance for potential surgery.

We focused on the different operative approaches to lung cancer particularly thoracoscopic techniques. In light of his extent of disease of the middle and upper lobes he may not be the ideal minimally invasive candidate. I am also starting to perform robotic assisted surgery and it may be that he could be a candidate for this depending on the pulmonary function assessment.

We had an extensive discussion regarding the overall prognosis for lung cancer as well as the role of surgery and chemotherapy. We will go ahead and expedite these tests. I will see him back for another discussion hopefully within the week. He is also seeing Dr. Corso later today.

PLAN:

As above.


Christophe L. Nguyen, M.D.

CLN/mal

CC: Dr. Richard Orr, Dr. Raul Cruz, Dr. Steve Corso

RONALD H. LITTLEFIELD, M.D., LLC
319 NORTH PINE STREET
SPARTANBURG, SOUTH CAROLINA 29302

PATIENT NAME: WILLIAM FARR
CHART NO.: 091065

DATE OF VISIT: 11/10/2010

This is a preoperative evaluation for Dr. Nguyen.

PRESENT ILLNESS: Mr. Farr was recently diagnosed to have CA of the lung. He recently had a stress test, echocardiogram and carotid B-mode scan, and all of these were very stable. He certainly presents with a very stable cardiac status. He continues to smoke excessively. We filled out the appropriate forms for Dr. Nguyen and feel like he is certainly safe cardiovascular-wise for his operative procedure.

RONALD H. LITTLEFIELD, M.D.

RHL/jm



RONALD H. LITTLEFIELD, MD., LLC
319 NORTH PINE STREET
SPARTANBURG, S.C. 29302
(864) 582-8900 PHONE
(864) 582-8555 FAX

CHART # 091065

PATIENT NAME: William Farr DOB: [REDACTED]

NOTES: _____

DATE: 11-10-10

LBS: _____

TEMP: _____

BP: 130/80

PULSE: 72 RESP: _____

LAB TEST: YES OR NO

NEED NEW RX: YES OR NO

MEDICATIONS:

Klor-Con MD
Vytorin 10/40mg
Nifedipine ER 30mg
Iriamterene 37.5mg
Asa 81mg
Ambien 10mg
Chantix
Symbicort 160/4.5mg
Proventil

SMOKER: Y OR N PKS 1/2 YRS 55

LAST CXR: 2010

LAST GYN: _____

NAME GYN: _____

LAST MAMMOGRAM: _____

LAST BONE DENSITY: _____

LAST PSA: 10/07/10

DIABETIC EYE EXAM: _____

NAME OPTOMETRIST: _____

LAST COLONOSCOPY: 2007

LAST TETANUS: 2006

LAST PNEUMOVAC: 2007

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-934-

NAME: FARR, WILLIAM GAULT

ORDERING PHYSICIAN: NGUYEN, CHRISTOPHE L

LOC: BHC

Pt. Type: BHC

DOB: [REDACTED]

BREAST HEALTH CENTER

UNIT #: 000478684

CI#: 2902067

AN#: S1031300817

FINAL

Exam

04094 MRI HEAD W/O AND W CONTRAST Date: 11/10/10 1034

70553

Ord Diag: 162.9-MAL NEO BRONCH/LUNG NOS

MRI brain with and without contrast November 10, 2010

History: Headaches, history of lung and colon carcinoma

Imaging sequences: Sagittal short TR/short TE, axial short TR/short TE, long TR/long TE, FLAIR, gradient recall, diffusion weighted images and ADC mapping. Axial and coronal short TR/short TE postcontrast images. The study was performed on a 3.0 Tesla magnet utilizing the uneventful administration of 15 cc's of intravenous Optimark in order to better evaluate for intracranial pathology.

Comparison: None.

Findings:

The ventricles and sulci are normal in size and configuration. There are no extra-axial fluid collections. Patchy and discrete foci of T2 prolongation are present within the supratentorial white matter. These are nonspecific findings but would be most compatible with mild chronic small vessel ischemic changes. There are no areas of restricted diffusion to suggest an acute or subacute infarction. No evidence of intraparenchymal hemorrhage or mass effect is identified. Normal flow-voids are present within all of the major intracranial vessels.

No abnormal areas of enhancement are identified following contrast administration.

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SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-935-

NAME: FARR, WILLIAM GAULT

ORDERING PHYSICIAN: NGUYEN, CHRISTOPHE L

LOC: BHC

Pt. Type: BHC

DOB: [REDACTED]

BREAST HEALTH CENTER

UNIT #: 000478684

CI#: 2902067

AN#: S1031300817

Checkin-Exam Code Summary
2902067-04094

The visualized mastoid air cells and paranasal sinuses are well-pneumatized and aerated slight from minor mucosal thickening within the right maxillary sinus

Impression:

1. Findings most compatible with mild chronic small vessel ischemic changes.
2. No evidence of intracranial metastases.

Transcriptionist- n/a

Reading Radiologist- DAVID E PELINO DO

Releasing Radiologist- DAVID E PELINO DO

Released Date Time- 11/10/10 1118

Page 2

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-936-

NAME: FARR, WILLIAM GAULT
ORDERING PHYSICIAN: NGUYEN, CHRISTOPHE L
LOC: OPT DOB: [REDACTED]
Pt. Type: OPT OPT REGISTRATION

UNIT #: 000478684
CI#: 2903230
AN#: S1031500825

FINAL

Exam

70117 NM LUNG DIFFERENTIAL FUNCT SCANDate: 11/11/10 1120

78596

Ord Diag: 162.9-MAL NEO BRONCH/LUNG NOS

Differential Lung Perfusion Scan November 11, 2010

Indication: Right lung cancer

Comparison: Chest x-ray 10/26/2010

Radiopharmaceutical: 4 mCi Tc99-m MAA IV.

Findings: High count perfusion imaging is done. Relative perfusion is calculated utilizing the geometric mean. There is a large perfusion defect in the right upper lobe anteriorly compatible with the abnormal lung associated with the cancerous lesion.

Relative perfusion to the left lung is 27% to the upper lobe region and 32% to the lower lobe region for total of 59%.

Relative perfusion to the right lung is approximately 21% to the upper lobe region and 20% to the lower lobe Region for a total of 41%.

Conclusion: Relative perfusion to the right lung is 41% and to the left lung 59%, as above.

Transcriptionist- n/a

Reading Radiologist- William T Joyce MD

Releasing Radiologist- William T Joyce MD

Released Date Time- 11/11/10 1403

Page 1

SURGICAL ONCOLOGY AT THE GIBBS CANCER CENTER

101 East Wood Street

Spartanburg, SC 29303

Phone (864) 560-1900

Fax (864) 560-1925

www.gibbsurgicaloncology.com

CHRISTOPHE NGUYEN, M.D.

OFFICE NOTE

DATE: November 15, 2010

PATIENT: FARR, WILLIAM

DOB:

DIAGNOSIS:

1. Biopsy proven bronchioalveolar lung cancer involving right upper lobe, right middle lobe, clinical stage T3,N0, M0.
2. Longstanding history of tobacco use which is ongoing with reduced pulmonary function tests.

INTERVAL HISTORY:

Mr. Farr presents for follow up along with his family. At my request he underwent a differential lung scan in order to further assess his lung capacity. This demonstrated an approximate 41% to the right lung perfusion and 59% to the left. Of note 25% was approximately to the right upper and right middle lobes. Repeat pulmonary function tests demonstrated an FEV1 of 1.61 which is 65% predicted. His brain MRI was negative for metastatic disease. Overall Mr. Farr denies any new symptoms. He continues to smoke less than half a pack a day. He has an occasional cough which is nonproductive.

PHYSICAL EXAMINATION:

Physical examination is unchanged.

IMPRESSION/PLAN:

As above. Likely stage 2 non small cell lung cancer involving the right upper and right middle lobes with reduced pulmonary function tests and smoking which is ongoing.

I spent the majority of a 50 minute visit reviewing the results of the above with the patient and his family. We again discussed that his clinical stage is one in which surgery would be recommended. Surgery offers the best chance of cure from his lung cancer. Certainly a mediastinoscopy should be recommended and I would perform this prior to attempting his resection. We discussed the implications of stage 3 disease and he understands that this would likely not translate into him being a surgical candidate. We had a very frank discussion about his smoking and the increased risks of pneumonia after lung surgery in smokers who continue to smoke up to the time of surgery. I strongly recommended he quit before his operation. We discussed also his anticipated postoperative pulmonary function which would be adequate according to our conventional guidelines of 800 cc in over 35% predicted by DLCO and FEV1.

-continued-

DATE: November 15, 2010
PATIENT: FARR, WILLIAM
DOB:
PAGE -2-

He certainly meets those anticipated projections in the event that we take his upper and middle lobe. In regards to the approach of surgery I would begin thoroscopically however the extent of his disease may preclude this and he may require conventional thoracotomy. We discussed all these details today as well as the risks of the operation which include bleeding, infection, risk of bronchopleural fistula and certainly risk of pneumonia in the postoperative setting. He understands the potential for postoperative ventilation and oxygen use. I feel that he has a strong understanding of the seriousness of the situation as does the family. We will go ahead and plan for surgery and he has signed consents today. We will plan for the week after Thanksgiving.

Christophe L. Nguyen, M.D. *NG*
CLN/mal

CC: Dr. Raul Cruz, Dr. Richard Orr

SURGICAL ONCOLOGY

Office Note

patient:

William Fan

NAME AND DATE OF BIRTH VERIFIED: ☒

DATE

1/5/10

BP 139/79 Pulse 76 Temp 97.2 Resp _____ Weight _____ O2 Sat 94%

ALLERGIES REVIEWED ☒ CURRENT MEDICATIONS REVIEWED AND LISTED ☒

CHIEF COMPLAINT: Lung Cancer

3/6/22
39400
32663
32746
28746

Renal, med, (E) VATP, Bilobectomy

pos. thrombosis, in dia

(4 HR)

(Epidural wv)

12/2/10 - 7:30 Am

pre-op 11/24 - 4:00 pm -

(D)
NJ

NOV-17-2010(WED) 10:04

Ronald H. Littlefield, M.D. LLC

(FAX) 864 582 8555

P.001/006

RONALD H. LITTLEFIELD, M.D. LLC

324-N Pine Street • Spartanburg, South Carolina 29302

Phone: 864.582.8900 • Fax: 864.582.8555

TO DR: Christopher NguyenDATE OF SURGERY: 12/2/10PATIENT'S NAME: William Farr

HISTORY: This patient has history of:

1. ☐ Cardiac Disease
2. ☒ Hypertension
3. ☒ Pulmonary Disease
4. ☐ Endocrine Disease
5. ☐ Allergies NKA
6. ☐ Blood Dyscrasia

Code: O - No Abnormality
X - Abnormality (describe)

PHYSICAL EXAM: BP 144/90

7. ☐ Head, Eyes, Ears, Nose, Throat
8. ☒ Heart 2/4
9. ☐ Lungs
10. ☐ Extremities

10/17/11
neg
Candida plus
see COPS

MEDICATIONS: (List)

Klor-Con M20, Vytorin 10/40mg, Nifedipine ER 30mg, Triamterene
37.5mg, Asa 81mg

OTHER MEDICAL

CONDITIONS:

DIAGNOSIS: ① Hxw ② COPD ③ NKA ④ Bx

Lab Work Performed:

EKG INTERPRETATION: normalPatient is cleared for "General" Anesthesia: yes

Patient is cleared for "Local" Anesthesia:

PHYSICIAN'S SIGNATURE: Ronald H. LittlefieldDATE: 11/16/10

Ronald H. Littlefield, M.D.

REF: A1122 SURGICAL ONCOLOGY - MR - 0083

GSO 0083

OP REPORT

PATIENT NAME: FARR, WILLIAM G

DOB: [REDACTED]

MEDICAL RECORD #: 478684

PROCEDURE DATE: 12/02/2010

ACCOUNT NUMBER: 1032100540

ROOM: 8428

PREOPERATIVE DIAGNOSIS

Non-small cell lung cancer right upper lobe/right middle lobe.

POSTOPERATIVE DIAGNOSIS

Non-small cell lung cancer right upper lobe/right middle lobe.

PROCEDURE

1. Bronchoscopy without biopsy.
2. Mediastinoscopy.
3. Right thoracotomy with bilobectomy (right upper lobe/right middle lobe).
4. Mediastinal lymph node dissection.

STAFF SURGEON

Dr. Christophe Nguyen.

ASSISTANT

Dr. Steven Phillips.

ANESTHESIA

General with epidural.

SPECIMENS

1. From mediastinoscopy 4R, 7, 4L lymph nodes - negative for tumor.
2. Bronchial margin for the bilobectomy - negative for tumor.

ESTIMATED BLOOD LOSS

Less than 100 mL.

FINDINGS

No evidence of metastatic disease. Grossly abnormal right upper lobe cancer with invasion into the right middle lobe.

INDICATION FOR PROCEDURE

William Farr is a 68-year-old man who presents with a long-standing history of smoking. He has had a history of colorectal cancer in the past and now presents with a biopsy-proven non-small cell lung cancer. His imaging suggests a stage II cancer. He presents for mediastinoscopy as well as for potential therapeutic resection.

DESCRIPTION OF PROCEDURE

The patient was brought to the operating room, identified, and placed supine on the operating room table. He underwent induction of general endotracheal anesthesia, at which point a Foley catheter was placed. I performed bronchoscopy

through a single-lumen endotracheal tube. The distal carina and trachea appeared normal. The right and left mainstem bronchi were normal down to the subsegmental bronchi. There was no evidence of any endobronchial tumor. The scope was removed. The patient's neck was extended and prepped and draped in standard surgical fashion. A 1 cm incision was made above the sternal notch with a 15 blade scalpel. Electrocautery was used to dissect down to the subcutaneous tissue, dividing the platysma and the strap muscles in the midline. The pretracheal fascia was incised, and the mediastinoscope was introduced down to the level of the carina. We first focused our attention to the left paratracheal space. The left recurrent laryngeal nerve was identified, and all lymphoid tissues lateral to the left portion of the trachea bordered by the AP window were removed; this was 4L lymph nodes. Next, the subcarinal space was explored and all lymphoid tissue removed at level 7. Finally, the right paratracheal space between the azygos vein and the innominate artery was dissected, and all lymphoid tissue removed was 4R. The frozen section returned negative for tumor. Surgicel and gauze compression afforded good hemostasis. The scope was removed. The incision was closed in two layers. The platysma approximated with 3-0 Vicryl suture. The patient's skin closed with 4-0 Monocryl subcuticular. Next, the patient was positioned in the left lateral decubitus position. The right chest was prepped and draped in standard surgical fashion. Single lung ventilation was achieved. A 1 cm incision was made with a 15 blade scalpel at approximately the 7th interspace in the mid axillary line. Electrocautery was used to dissect down to the subcutaneous tissues creating a passage into the right chest. A 5.5 mm trocar was introduced followed by the camera. The lung cavity was surveyed. There was no evidence of any metastatic disease. There were some adhesions that were taken down with electrocautery. Because of the extent of disease, I elected to proceed with thoracotomy. The scope was removed. Again, this was because of extension into the right middle lobe and the bulkiness of the tumor. A 10 blade scalpel was used to create a standard posterolateral thoracotomy incision. Electrocautery was used to dissect down to the subcutaneous tissue, dividing the latissimus as well as the serratus muscles. The 5th interspace was entered and a portion of the 6th rib was removed to provide chest opening. A Tuffier retractor was placed, and the lung cavity was surveyed. We reflected the lung posteriorly exposing the anterior hilum. The pleura between the phrenic nerve and the right superior pulmonary vein was incised with electrocautery. In this fashion, we continued our dissection between the azygos vein and the hilum back to the posterior aspect dissecting along the junction of the right upper lobe and bronchus intermedius. The superior pulmonary vein was identified, and as we were performing the bilobectomy, the main trunk was encircled and dissected away from the pulmonary artery and divided with endovascular stapler device. Next, the truncus off the pulmonary artery was dissected and divided with endovascular stapler device. Next, the right upper lobe bronchus was dissected away from the bronchus intermedius, occluded and then divided with a 4.8 mm stapler device/Duet. Next, we entered the major fissure identifying

the pulmonary artery. The branch to the right middle lobe was identified and divided between 2-0 silk ties. We then identified the right middle lobe bronchus, which was dissected and divided with a 4.8 mm stapler device as well. The anterior fissure was completed as well as the posterior fissure with additional firings of the endovascular stapler device. Next, we had a few remaining branches of the pulmonary artery towards the posterior segment of the upper lobe as well as the middle lobe. These were divided with the endovascular stapler device as well. The specimen was removed en bloc, and frozen section returned, as mentioned above, negative for bronchial margin. The chest was irrigated with saline solution. We then completed our mediastinal lymph node dissection by removing all hilar lymph nodes. We completed our mediastinal lymph node dissection. Several hilar lymph nodes level 10 were removed as well as additional level 4 from the paratracheal mediastinum. Surgicel was placed. The integrity of the bronchial stump was assessed by insufflation of 30 mm of positive pressure under water irrigation. There was no evidence of a leak from the bronchial stumps. Plasmagel was applied. Next, a 24 French Blake chest tube was placed to the apex and secured with 0 Vicryl suture. The ribs were approximated with #2 pericostal sutures. The latissimus and serratus muscles were approximated with 0 Vicryl. Subcutaneous tissues were approximated with 2-0 Vicryl. The patient's skin was closed with a running staple line. The patient was extubated and transferred to recovery in stable condition.

DICTATED BY: CHRISTOPHE NGUYEN, MD

D:12/02/2010 14:53:37
T:12/06/2010 17:22:40/dw
1032394/899318

cc:PAUL PERRY, M.D., Consulting Physician
OP REPORT Page 3 of 3
FARR, WILLIAM G
478684

Note: Document is draft unless signed.<END FOOTER>

Authenticated by Christophe L. Nguyen, MD. On 12/07/2010 07:36:18 AM

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-944-

NAME: FARR, WILLIAM GAULT
ORDERING PHYSICIAN: NGUYEN, CHRISTOPHE L
LOC: OPS
Pt. Type: OPS
DOB: [REDACTED]
OUTPATIENT SURGERY

UNIT #: 000478684
CI#: 2920001
AN#: S1032100540

FINAL

Exam
34005 SU CHEST P**
71010

Date: 12/02/10 1323
Ord Diag: lobectomy

** Portable **

Single portable upright chest x-ray December 2, 2010 at 1352

Reference exam: 10/26/2010

Indication: Post right chest surgery

Findings: Right-sided chest tube is now seen with skin staples and some gas along the right chest wall. Lucencies noted in the right upper chest suggesting a small to moderate pneumothorax. Left lung shows some strandiness.

Impression: May be a right-sided pneumothorax. Chest tube in place.

Transcriptionist- n/a
Reading Radiologist- JEFFREY NEWMAN MD
Releasing Radiologist- JEFFREY NEWMAN MD
Released Date Time- 12/02/10 1358

** Portable **

Page 1

 * SPARTANBURG REGIONAL MEDICAL CENTER DEPARTMENT OF LABORATORY MEDICINE
 * 101 E. WOOD STREET, SPARTANBURG, SOUTH CAROLINA 29303-3072/864-560-6212
 * DRS. WREN, MIMS, LAPHAM, CALDWELL, CAMPBELL, BARUCH AND FARR

 FARR WILLIAM GAULT MR#: (0001)00047-86-84 Fin.No.:1032100540 Admitted: 02DEC10
 68 YRS MALE DOB: [REDACTED] Page: 1
 Dr. NGUYEN CHRISTOPHER Printed: 08DEC10
 Location: 4H 8428-A SURG.POSTCORN.--PCVU 1454
 =====

 SURGICAL PATHOLOGY

PATHOLOGY: S-10-15710 SURGERY: 12/02/10

HISTORY:

Pre-Op: R lung CA
 Past history of CA: Yes, R lung

SPECIMEN:

- A. 4L lymph node
- B. Level 7 lymph node
- C. 4R lymph node
- D. Right upper and middle lobe frozen on bronchial margin - specimen accompanied by Dr. Nguyen to path.
- E. Level 11 lymph node
- F. Level 10 lymph node

GROSS DESCRIPTION:

A. Received fresh for frozen section evaluation labeled with the patient's name, DOB, and "4L lymph node" is a 1.5 x 1 x 0.4 cm aggregate of multiple black anthracotic stained nodal tissues admixed with fibrofatty tissue. The entire specimen is submitted for frozen section evaluation in one frozen block.

FROZEN SECTION DIAGNOSIS: NEGATIVE FOR TUMOR/JAC, GHF.

SUMMARY OF SECTIONS:

AFS - Frozen section control

B. Received in a formalin-filled container labeled with the patient's name, DOB, and "Level 7 lymph node" is a 1.5 x 1.2 x 0.4 cm aggregate of multiple black anthracotic stained nodal tissues admixed with fibrofatty soft tissue. The entire specimen is submitted for frozen section evaluation in one frozen block.

FROZEN SECTION DIAGNOSIS: NEGATIVE FOR TUMOR/JAC.

SUMMARY OF SECTIONS:

BFS - Frozen section control

C. Received fresh for frozen section labeled with the patient's name, DOB, and

Patient Name: FARR WILLIAM GAULT

Location: 4H 8428 SURG.POSTCORN.--PCVU

Page: 1

Cont..

 * SPARTANBURG REGIONAL MEDICAL CENTER DEPARTMENT OF LABORATORY MEDICINE
 * 101 E. WOOD STREET, SPARTANBURG, SOUTH CAROLINA 29303-3072/864-560-6212
 * DRS. WREN, MIMS, LAEHAM, CALDWELL, CAMPBELL, BARUCH AND FARR

 FARR WILLIAM GAULT MR#: (0001)00047-86-84 Fin.No.:1032100540 Admitted: 02DEC10
 68 YRS MALE DOB: [REDACTED] Page: 2
 Dr. NGUYEN CHRISTOPHER Printed: 08DEC10
 Location: 4H 8428-A SURG.POSTCORN.--PCVU 1454
 =====

 SURGICAL PATHOLOGY

PATHOLOGY: S-10-15710 SURGERY: 12/02/10

GROSS DESCRIPTION:

"4R lymph node" is a 2 x 2 x 0.6 cm aggregate of multiple black anthracotic stained nodal tissues admixed with fibrofatty soft tissue. The specimen is entirely submitted for frozen section evaluation in one frozen block.

FROZEN SECTION DIAGNOSIS: NEGATIVE FOR TUMOR/JAC.

SUMMARY OF SECTIONS:

CFS - Frozen section control

D. Received fresh for frozen section labeled with the patient's name, DOB, and "right upper and middle lobes, frozen on bronchial margin" is a 308 g, 18 x 12 x 6.2 cm right upper and middle lung lobes displaying a tan-black, mottled, anthracotic stained pleural surface with scant, focal adhesions. No areas of pleural disruption are noted. Situated within the upper and middle lobes is a well defined, 9 x 8.5 x 5 cm tan, lobulated solid mass lesion, located 3.2 cm from the upper lobe bronchial margin (designated by Dr. Nguyen for frozen section evaluation) and 3.5 cm from the middle lobe bronchial margin. These bronchial margins both appear grossly free of involvement. The hilar bronchioles are unremarkable. The mass abuts and indurates the intact pleural surface. The remaining upper lobe parenchyma is dark red subcrepitant with peripheral apical areas of emphysematous appearing change and a peripheral, 0.9 cm grey consolidated subpleural area creating a mass-like effect. The lower lobe parenchyma is unremarkable and free of an additional lesion. Multiple hilar and intraparenchymal lymph nodes are identified.

FROZEN SECTION DIAGNOSIS: NEGATIVE FOR TUMOR/JAC.

SUMMARY OF SECTIONS:

DFS - Upper lobe bronchial margin, en face shave section/frozen section control (designated by Dr. Nguyen)
 D1 - Middle lobe bronchial margin - en face shave section and hilar nodes
 D2 - Upper lobe component of mass with hilar bronchioles - longitudinal section
 D3 - Mass with pleura
 D4 - Upper lobe intraparenchymal peribronchial nodes
 D5,6 - Mass with middle lobe parenchyma

Patient Name: FARR WILLIAM GAULT

Location: 4H 8428 SURG.POSTCORN.--PCVU

Page: 2

Cont..

 * SPARTANBURG REGIONAL MEDICAL CENTER DEPARTMENT OF LABORATORY MEDICINE
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FARR WILLIAM GAULT	MR#: (0001)00047-86-84	Fin.No.:1032100540	Admitted: 02DEC10
68 YRS MALE	DOB: [REDACTED]		Page: 3
Dr. NGUYEN CHRISTOPHER			Printed: 08DEC10
Location: 4H 8428-A	SURG.POSTCORN.--PCVU		1454

=====

 SURGICAL PATHOLOGY

PATHOLOGY: S-10-15710 SURGERY: 12/02/10

GROSS DESCRIPTION:

- D7 - Apical aspect of upper lobe with peripheral consolidated area/mass-like effect
- D8 - Uninvolved peripheral lower lobe parenchyma

E. Received in a formalin-filled container labeled with the patient's name, DOB, and "Level 11 lymph node" is a 0.4 cm black anthracotic stained nodal tissue, submitted in one cassette labeled E1.

F. Received in a formalin-filled container labeled with the patient's name, DOB, and "Level 10 lymph node" is a 0.7 cm black anthracotic stained nodal tissue that is bisected and entirely submitted in one cassette labeled F1.
 --TB/sj

Tissue handling and fixation:
 Cold ischemic time less than or equal to 1 hour
 Time in 10% phosphate buffered neutral formalin is between 6 and 72 hours

(JDW/AA)12/06/10

MICROSCOPIC DESCRIPTION:

A-F. Slides reviewed.

(JDW/AA)12/06/10

DIAGNOSIS:

- A. LYMPHOID TISSUE (4L), FRAGMENTED BIOPSY:
 BENIGN REACTIVE ANTHRACOTIC LYMPH(S) WITH SINUS HISTIOCYTOSIS AND ANTHRACOSIS;
 NEGATIVE FOR MALIGNANCY (0/1).
- B. TISSUE (LEVEL 7), FRAGMENTED BIOPSY:
 BENIGN REACTIVE LYMPH NODE WITH EXTENSIVE ANTHRACOSIS AND FOCAL SINUS HISTIOCYTOSIS;
 NEGATIVE FOR MALIGNANCY (0/1).
- C. LYMPHOID TISSUE (4R), FRAGMENTED BIOPSY:
 BENIGN REACTIVE LYMPH NODE WITH SINUS HISTIOCYTOSIS AND ANTHRACOSIS;
 NEGATIVE FOR MALIGNANCY (0/1).

Patient Name: FARR WILLIAM GAULT

Location: 4H 8428 SURG.POSTCORN.--PCVU

Page: 3

Cont..

 * SPARTANBURG REGIONAL MEDICAL CENTER DEPARTMENT OF LABORATORY MEDICINE
 * 101 E. WOOD STREET, SPARTANBURG, SOUTH CAROLINA 29303-3072/864-560-6212
 * DRS. WREN, MIMS, LAPHAM, CALDWELL, CAMPBELL, BARUCH AND FARR

 FARR WILLIAM GAULT MR#: (0001)00047-86-84 Fin.No.:1032100540 Admitted: 02DEC10
 68 YRS MALE DOB: [REDACTED] Page: 4
 Dr. NGUYEN CHRISTOPHER Printed: 08DEC10
 Location: 4H 8428-A SURG.POSTCORN.--PCVU 1454
 =====

 SURGICAL PATHOLOGY

PATHOLOGY: S-10-15710 SURGERY: 12/02/10

DIAGNOSIS:

D. Specimen type and laterality: LUNG, RIGHT
 Procedure: UPPER AND MIDDLE LOBECTOMY
 Specimen integrity: INTACT
 Tumor site: PRIMARY TUMOR AT JUNCTION OF RIGHT
 UPPER AND RIGHT MIDDLE LOBE
 ADENOCARCINOMA WITH PAPILLARY FEATURES
 2
 Histologic type: PRIMARY TUMOR 9 CM GREATEST DIMENSION
 Histologic grade: MULTIFOCAL
 Tumor size (greatest dimension):
 Tumor focality: NEGATIVE
 Visceral pleura invasion: NEGATIVE
 Tumor extension: CONFINED TO LUNG
 Margins:
 Bronchial margin: NEGATIVE BUT WITHIN MILLIMETERS AT
 MIDDLE LOBE BRONCHIAL MARGIN
 Vascular margin: NEGATIVE
 Parenchymal margin: NEGATIVE
 Parietal pleural margin: NOT SAMPLED
 Chest wall margin: NOT SAMPLED
 Other attached tissue margin: NOT SAMPLED
 Lymph-vascular invasion: NOT IDENTIFIED
 Treatment effect: NOT IDENTIFIED
 Lymph node status: NEGATIVE 0/13 - SEE DIAGNOSES A-C, E,
 AND F WITH 8 LYMPH NODES PRESENT IN
 SPECIMEN D
 Additional pathologic findings: MULTIFOCAL AREAS OF TUMOR, CHANGES OF
 EMPHYSEMA WITH ANTHRACOSIS
 Pathologic stage: pT4, pN0
 E. LYMPH NODE (LEVEL 11), BIOPSY:
 BENIGN REACTIVE ANTHRACOTIC LYMPH NODE WITH EXTENSIVE ANTHRACOSIS AND
 FOCAL SINUS HISTIOCYTOSIS;
 NEGATIVE FOR MALIGNANCY (0/1).
 F. LYMPH NODE (LEVEL 10), BIOPSY:
 BENIGN REACTIVE ANTHRACOTIC LYMPH NODE WITH EXTENSIVE ANTHRACOSIS AND
 FOCAL SINUS HISTIOCYTOSIS;

Patient Name: FARR WILLIAM GAULT

Location: 4H 8428 SURG.POSTCORN.--PCVU

Page: 4

Cont..

 * SPARTANBURG REGIONAL MEDICAL CENTER DEPARTMENT OF LABORATORY MEDICINE
 * 101 E. WOOD STREET, SPARTANBURG, SOUTH CAROLINA 29303-3072/864-560-6212
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FARR WILLIAM GAULT	MR#: (0001)00047-86-84	Fin.No.:1032100540	Admitted: 02DEC10
68 YRS MALE	DOB: [REDACTED]		Page: 5
Dr. NGUYEN CHRISTOPHER			Printed: 08DEC10
Location: 4H 8428-A	SURG.POSTCORN.--PCVU		1454

 SURGICAL PATHOLOGY

PATHOLOGY: S-10-15710 SURGERY: 12/02/10

DIAGNOSIS: NEGATIVE FOR MALIGNANCY (0/1).

TE RO

88331, 88305
 88331, 88305
 88331, 88305
 88331, 88309
 88305
 88305

T28810, P11400, T09020, M77810, D76100, F40640, T08000, T28100, P00100, M80001,
 D76720, M81403, T01211, T29030, F89050, T28000, T26000, TY2150, T08000,
 M00100, M32800, P00002, P00003

(JDW/AA) verified by J. David Wren, M.D., Pathologist
 12/06/10 08DEC2010 14:54 (electronic signature)
 FINAL VERIFICATION

%%END

 * SPARTANBURG REGIONAL MEDICAL CENTER DEPARTMENT OF LABORATORY MEDICINE
 * 101 E. WOOD STREET, SPARTANBURG, SOUTH CAROLINA 29303-3072/864-560-6212
 * DRS. WREN, MIMS, LAPHAM, CALDWELL, CAMPBELL, BARUCH AND FARR

 FARR WILLIAM GAULT MR#: (0001)00047-86-84 Fin.No.:1032100540 Admitted: 02DEC10
 68 YRS MALE DOB: [REDACTED] Page: 1
 Dr. NGUYEN CHRISTOPHER Printed: 09DEC10
 Location: 4H 8428-A SURG.POSTCORN.--PCVU 0950
 =====

 SURGICAL PATHOLOGY

PATHOLOGY: S-10-15710 SURGERY: 12/02/10

HISTORY:

Pre-Op: R lung CA
 Past history of CA: Yes, R lung

SPECIMEN:

- A. 4L lymph node
- B. Level 7 lymph node
- C. 4R lymph node
- D. Right upper and middle lobe frozen on bronchial margin - specimen accompanied by Dr. Nguyen to path.
- E. Level 11 lymph node
- F. Level 10 lymph node

GROSS DESCRIPTION:

A. Received fresh for frozen section evaluation labeled with the patient's name, DOB, and "4L lymph node" is a 1.5 x 1 x 0.4 cm aggregate of multiple black anthracotic stained nodal tissues admixed with fibrofatty tissue. The entire specimen is submitted for frozen section evaluation in one frozen block.

FROZEN SECTION DIAGNOSIS: NEGATIVE FOR TUMOR/JAC, GHF.

SUMMARY OF SECTIONS:

AFS - Frozen section control

B. Received in a formalin-filled container labeled with the patient's name, DOB, and "Level 7 lymph node" is a 1.5 x 1.2 x 0.4 cm aggregate of multiple black anthracotic stained nodal tissues admixed with fibrofatty soft tissue. The entire specimen is submitted for frozen section evaluation in one frozen block.

FROZEN SECTION DIAGNOSIS: NEGATIVE FOR TUMOR/JAC.

SUMMARY OF SECTIONS:

BFS - Frozen section control

C. Received fresh for frozen section labeled with the patient's name, DOB, and

Patient Name: FARR WILLIAM GAULT Location: 4H 8428 SURG.POSTCORN.--PCVU Page: 1 Cont.,

 * SPARTANBURG REGIONAL MEDICAL CENTER DEPARTMENT OF LABORATORY MEDICINE
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 * DRS. WREN, MIMS, LAPHAM, CALDWELL, CAMPBELL, BARUCH AND FARR

FARR WILLIAM GAULT	MR#: (0001)00047-86-84	Fin.No.:1032100540	Admitted: 02DEC10
68 YRS MALE	DOB: [REDACTED]		Page: 2
Dr. NGUYEN CHRISTOPHER			Printed: 09DEC10
Location: 4H 8428-A	SURG.POSTCORN.--PCVU		0950

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 SURGICAL PATHOLOGY

PATHOLOGY: S-10-15710 SURGERY: 12/02/10

GROSS DESCRIPTION:

"4R lymph node" is a 2 x 2 x 0.6 cm aggregate of multiple black anthracotic stained nodal tissues admixed with fibrofatty soft tissue. The specimen is entirely submitted for frozen section evaluation in one frozen block.

FROZEN SECTION DIAGNOSIS: NEGATIVE FOR TUMOR/JAC.

SUMMARY OF SECTIONS:

CFS - Frozen section control

D. Received fresh for frozen section labeled with the patient's name, DOB, and "right upper and middle lobes, frozen on bronchial margin" is a 308 g, 18 x 12 x 6.2 cm right upper and middle lung lobes displaying a tan-black, mottled, anthracotic stained pleural surface with scant, focal adhesions. No areas of pleural disruption are noted. Situated within the upper and middle lobes is a well defined, 9 x 8.5 x 5 cm tan, lobulated solid mass lesion, located 3.2 cm from the upper lobe bronchial margin (designated by Dr. Nguyen for frozen section evaluation) and 3.5 cm from the middle lobe bronchial margin. These bronchial margins both appear grossly free of involvement. The hilar bronchioles are unremarkable. The mass abuts and indurates the intact pleural surface. The remaining upper lobe parenchyma is dark red subcrepitant with peripheral apical areas of emphysematous appearing change and a peripheral, 0.9 cm grey consolidated subpleural area creating a mass-like effect. The lower lobe parenchyma is unremarkable and free of an additional lesion. Multiple hilar and intraparenchymal lymph nodes are identified.

FROZEN SECTION DIAGNOSIS: NEGATIVE FOR TUMOR/JAC.

SUMMARY OF SECTIONS:

DFS - Upper lobe bronchial margin, en face shave section/frozen section control (designated by Dr. Nguyen)
 D1 - Middle lobe bronchial margin - en face shave section and hilar nodes
 D2 - Upper lobe component of mass with hilar bronchioles - longitudinal section
 D3 - Mass with pleura
 D4 - Upper lobe intraparenchymal peribronchial nodes
 D5,6 - Mass with middle lobe parenchyma

Patient Name: FARR WILLIAM GAULT

Location: 4H 8428 SURG.POSTCORN.--PCVU

Page: 2

Cont..

 * SPARTANBURG REGIONAL MEDICAL CENTER DEPARTMENT OF LABORATORY MEDICINE
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 * DRS. WREN, MIMS, LAHAM, CALDWELL, CAMPBELL, BARUCH AND FARR

 FARR WILLIAM GAULT MR#: (0001)00047-86-84 Fin.No.:1032100540 Admitted: 02DEC10
 68 YRS MALE DOB: [REDACTED] Page: 3
 Dr. NGUYEN CHRISTOPHER Printed: 09DEC10
 Location: 4H 8428-A SURG.POSTCORN.--PCVU 0950
 =====

 SURGICAL PATHOLOGY

PATHOLOGY: S-10-15710 SURGERY: 12/02/10

GROSS DESCRIPTION:

D7 - Apical aspect of upper lobe with peripheral consolidated area/mass-like effect
 D8 - Uninvolved peripheral lower lobe parenchyma

E. Received in a formalin-filled container labeled with the patient's name, DOB, and "Level 11 lymph node" is a 0.4 cm black anthracotic stained nodal tissue, submitted in one cassette labeled E1.

F. Received in a formalin-filled container labeled with the patient's name, DOB, and "Level 10 lymph node" is a 0.7 cm black anthracotic stained nodal tissue that is bisected and entirely submitted in one cassette labeled F1.
 --TB/sj

Tissue handling and fixation:
 Cold ischemic time less than or equal to 1 hour
 Time in 10% phosphate buffered neutral formalin is between 6 and 72 hours

(JDW/AA)12/06/10

MICROSCOPIC DESCRIPTION:

A-F. Slides reviewed.

(JDW/AA)12/06/10

DIAGNOSIS:

- A. LYMPHOID TISSUE (4L), FRAGMENTED BIOPSY:
 BENIGN REACTIVE ANTHRACOTIC LYMPH(S) WITH SINUS HISTIOCYTOSIS AND ANTHRACOSIS;
 NEGATIVE FOR MALIGNANCY (0/1).
- B. TISSUE (LEVEL 7), FRAGMENTED BIOPSY:
 BENIGN REACTIVE LYMPH NODE WITH EXTENSIVE ANTHRACOSIS AND FOCAL SINUS HISTIOCYTOSIS;
 NEGATIVE FOR MALIGNANCY (0/1).
- C. LYMPHOID TISSUE (4R), FRAGMENTED BIOPSY:
 BENIGN REACTIVE LYMPH NODE WITH SINUS HISTIOCYTOSIS AND ANTHRACOSIS;
 NEGATIVE FOR MALIGNANCY (0/1).

Patient Name: FARR WILLIAM GAULT

Location: 4H 8428 SURG.POSTCORN.--PCVU

Page: 3

Cont..

 * SPARTANBURG REGIONAL MEDICAL CENTER DEPARTMENT OF LABORATORY MEDICINE
 * 101 E. WOOD STREET, SPARTANBURG, SOUTH CAROLINA 29303-3072/864-560-6212
 * DRS. WREN, MIMS, LAPEAM, CALDWELL, CAMPBELL, BARUCH AND FARR

 FARR WILLIAM GAULT MR#: (0001)00047-86-84 Fin.No.:1032100540 Admitted: 02DEC10
 68 YRS MALE DOB: [REDACTED] Page: 4
 Dr. NGUYEN CHRISTOPHER Printed: 09DEC10
 Location: 4H 8428-A SURG.POSTCORN.--PCVU 0950
 =====

 SURGICAL PATHOLOGY

PATHOLOGY: S-10-15710 SURGERY: 12/02/10

DIAGNOSIS:

D. Specimen type and laterality: LUNG, RIGHT
 Procedure: UPPER AND MIDDLE LOBECTOMY
 Specimen integrity: INTACT
 Tumor site: PRIMARY TUMOR AT JUNCTION OF RIGHT
 UPPER AND RIGHT MIDDLE LOBE
 Histologic type: ADENOCARCINOMA WITH PAPILLARY FEATURES
 Histologic grade: 2
 Tumor size (greatest dimension): PRIMARY TUMOR 9 CM GREATEST DIMENSION
 Tumor focality: MULTIFOCAL
 Visceral pleura invasion: NEGATIVE
 Tumor extension: CONFINED TO LUNG
 Margins:
 Bronchial margin: NEGATIVE BUT WITHIN MILLIMETERS AT
 MIDDLE LOBE BRONCHIAL MARGIN
 Vascular margin: NEGATIVE
 Parenchymal margin: NEGATIVE
 Parietal pleural margin: NOT SAMPLED
 Chest wall margin: NOT SAMPLED
 Other attached tissue margin: NOT SAMPLED
 Lymph-vascular invasion: NOT IDENTIFIED
 Treatment effect: NOT IDENTIFIED
 Lymph node status: NEGATIVE 0/13 - SEE DIAGNOSES A-C, E,
 AND F WITH 8 LYMPH NODES PRESENT IN
 SPECIMEN D
 Additional pathologic findings: MULTIFOCAL AREAS OF TUMOR, CHANGES OF
 EMPHYSEMA WITH ANTHRACOSIS
 Pathologic stage: pT3, pN0
 E. LYMPH NODE (LEVEL 11), BIOPSY:
 BENIGN REACTIVE ANTHRACOTIC LYMPH NODE WITH EXTENSIVE ANTHRACOSIS AND
 FOCAL SINUS HISTIOCYTOSIS;
 NEGATIVE FOR MALIGNANCY (0/1).
 F. LYMPH NODE (LEVEL 10), BIOPSY:
 BENIGN REACTIVE ANTHRACOTIC LYMPH NODE WITH EXTENSIVE ANTHRACOSIS AND
 FOCAL SINUS HISTIOCYTOSIS;

Patient Name: FARR WILLIAM GAULT Location: 4H 8428 SURG.POSTCORN.--PCVU Page: 4 Cont..

 * SPARTANBURG REGIONAL MEDICAL CENTER DEPARTMENT OF LABORATORY MEDICINE
 * 101 E. WOOD STREET, SPARTANBURG, SOUTH CAROLINA 29303-3072/864-560-6212
 * DRS. WREN, MIMS, LAPHAM, CALDWELL, CAMPBELL, BARUCH AND FARR

 FARR WILLIAM GAULT MR#: (0001)00047-86-84 Fin.No.:1032100540 Admitted: 02DEC10
 68 YRS MALE DOB: [REDACTED] Page: 5
 Dr. NGUYEN CHRISTOPHER Printed: 09DEC10
 Location: 4H 8428-A SURG.POSTCORN.--PCVU 0950
 =====

 SURGICAL PATHOLOGY

PATHOLOGY: S-10-15710 SURGERY: 12/02/10

DIAGNOSIS: NEGATIVE FOR MALIGNANCY (0/1).

TB RO

Note: This report has been corrected in order to correct the pT staging result from pT4 to pT3. There are NO changes to the original diagnoses.

88331, 88305

88331, 88305

88331, 88305

88331, 88309

88305

88305

REPORT REVISED ON 09DEC10 AT 0950 BY LAB199

T28810, P11400, T09020, M77810, D76100, F40640, T08000, T28100, P00100, M80001,
 D76720, M81403, T01211, T29030, F89050, T28000, T26000, T21150, T08000,
 M00100, M32800, P00002, P00003

(JDW/AA) verified by J. David Wren, M.D., Pathologist
 12/06/10 09DEC2010 09:50 (electronic signature)
 REPORT CORRECTION

%%END

J. David Wren, MD PHD, Director

Spartanburg Regional Medical Center
101 E. Wood Street
Spartanburg, South Carolina 29303-3072Dept of Laboratory Medicine
864-560-6212FARR, WILLIAM GAULT
68Y
NGUYEN, CHRISTOPHE LMR#: S000478684
DOB: XXXXXXXXXX
Location: IP IPACCT#: S1032100540
Admitted: 12/02/2010
PT Type: INPATIENTHEMATOLOGY

BLOOD							
Collected	12/13 07:40 ¹	12/12 06:15 ¹	12/11 06:45 ¹	12/10 05:15 ¹	12/09 06:00 ¹		
Released	12/13 07:52	12/12 07:01	12/11 06:49	12/10 05:56	12/09 06:42	Reference	Units
Accession	H103460046	H103450077	H103440226	H103430071	H103420067		
WBC	10.0 H	10.5 H	10.1 H	9.1	10.1 H	3.1-9.7	K/cmm
RBC	4.77	4.78	4.44	4.62	4.09	4.08-5.70	million/cmm
HGB	12.3 L	12.4 L	11.6 L	12.0 L	10.6 L	13.1-16.8	g/dL
HCT	38.6	38.9	36.3 L	37.7 L	33.2 L	38.2-48.4	%
MCV	81.0	81.4	81.7	81.5	81.1	80.1-98.7	fL
MCH	25.7 L	26.1 L	26.2 L	25.9 L	25.8 L	27.5-34.3	pg
MCHC	31.8 L	32.0 L	32.0 L	31.7 L	31.9 L	33.2-35.7	g/dL
RDW	17.7 H	18.0 H	17.7 H	17.6 H	17.7 H	11.7-15.0	%
PLT	486 H	481 H	445 H	447 H	376 H	119-332	K/cmm

BLOOD							
Collected	12/08 05:45 ¹	12/07 05:20 ¹	12/06 09:38 ¹	12/06 06:10 ¹	12/05 06:30 ¹		
Released	12/08 06:20	12/07 06:22	12/06 10:32	12/06 07:32	12/05 07:40	Reference	Units
Accession	H103410094	H103400176	H103400128	H103390123	H103380159		
WBC	9.2	10.2 H	11.5 H	10.5 H	12.2 H	3.1-9.7	K/cmm
RBC	4.35	4.33	4.35	4.58	4.60	4.08-5.70	million/cmm
HGB	11.4 L	11.3 L	11.4 L	11.9 L	12.3 L	13.1-16.8	g/dL
HCT	35.5 L	35.5 L	35.5 L	37.2 L	37.4 L	38.2-48.4	%
MCV	81.8	82.0	81.5	81.4	81.2	80.1-98.7	fL
MCH	26.2 L	26.2 L	26.3 L	26.1 L	26.7 L	27.5-34.3	pg
MCHC	32.1 L	31.9 L	32.2 L	32.0 L	32.9 L	33.2-35.7	g/dL
RDW	17.3 H	17.7 H	17.1 H	17.7 H	17.7 H	11.7-15.0	%
PLT	375 H	332	307	324	281	119-332	K/cmm

BLOOD							
Collected	12/04 05:45 ¹	12/04 05:45 ¹	12/03 04:15 ¹	12/02 13:25 ¹	11/24 16:40 ¹		
Released	12/04 07:03	12/04 07:03	12/03 04:29	12/02 13:38	11/24 17:18	Reference	Units
Accession	H103370056	H103370349	H103360493	H103360385	H103280546		
WBC	16.5 H	16.4 H	9.6	16.6 H	11.1 H	3.1-9.7	K/cmm
RBC	4.82	4.80	4.49	4.99	5.44	4.08-5.70	million/cmm
HGB	12.5 L	12.6 L	12.1 L	13.4	13.9	13.1-16.8	g/dL
HCT	39.5	39.5	36.4 L	41.4	44.6	38.2-48.4	%
MCV	82.1	82.4	81.1	82.9	82.1	80.1-98.7	fL
MCH	25.9 L	26.3 L	27.0 L	26.8 L	25.6 L	27.5-34.3	pg
MCHC	31.5 L	31.9 L	33.3	32.3 L	31.2 L	33.2-35.7	g/dL
RDW	17.7 H	17.4 H	17.2 H	17.2 H	16.9 H	11.7-15.0	%
PLT	305	301	264	321	276	119-332	K/cmm

1...

Patient Name: FARR, WILLIAM GAULT
Location: IP IP
PT Type: INPATIENT

SRMC CUM FINAL DISCHARGE REPORT -

Printed: 12/15/2010 19:05
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SRHS 0072

DP - SRHS - 0072 PRINTED BY: DB30588

DATE 3/27/2013

J. David Wren, MD PHD, Director

Spartanburg Regional Medical Center
101 E. Wood Street
Spartanburg, South Carolina 29303-3072**-956-**Dept of Laboratory Medicine
864-560-6212FARR, WILLIAM GAULT
68Y
NGUYEN, CHRISTOPHE LMR#: S000478684
DOB: [REDACTED]
Location: IP IPACCT#: S1032100540
Admitted: 12/02/2010
PT Type: INPATIENT**COAGULATION STUDIES**

BLOOD Collected	11/24 16:40 ²	11/24 16:40 ²		
Released	11/24 17:21	11/24 17:20		
Accession	O103280197	O103280197		
PT		12.7	11.7-14.3	seconds
INR		1.0 L	2.0-3.0	
PTT	29.4		23.3-36.3	seconds

CHEMISTRY

BLOOD Collected	12/13 07:40 ³	12/12 06:15 ³	12/11 06:45 ³	12/10 05:15 ³	12/09 06:00 ³		
Released	12/13 08:10	12/12 07:20	12/11 07:09	12/10 06:07	12/09 07:03		
Accession	C103460099	C103450186	C103440392	C103430131	C103420163		
Creat	1.11	1.07	1.02	1.10	1.00	0.47-1.35	mg/dL
UN	10	11	7	10	8	6-20	mg/dL
Na	140	139	142	143	140	133-146	mmol/L
Chlor	107	105	109	107	108	100-111	mmol/L
CO2	25.6	25.5	29.0	27.9	26.2	23.0-32.6	mmol/L
K	4.1	3.7	3.7	3.8	3.3 L	3.5-4.9	mmol/L
Gluc	113 H	98	105 H	96	131 H	70-100	mg/dL
Ca	9.0	9.1	8.8 L	9.0	8.5 L	8.9-10.3	mg/dL
Bun/Crea	9	10	7 L	9	8	8-23	
Ani Gap	12	12	8	12	9	6-13	mmol/L
Osmo Cal	279	277	281	284	280	271-318	mOsm/kg
eGFR-AA	>60	>60	>60	>60	>60		mL/min/1.73
eGFR-Oth	>60 ⁴	>60 ⁴	>60 ⁴	>60 ⁴	>60 ⁴		mL/min/1.73

BLOOD Collected	12/08 05:45 ³	12/07 05:20 ³	12/06 09:38 ³	12/06 06:10 ³	12/05 06:30 ³		
Released	12/08 06:36	12/07 07:09	12/06 10:53	12/06 07:57	12/05 07:57		
Accession	C103410202	C103400376	C103400304	C103390258	C103380312		
Creat	1.02	0.96	0.91	0.85	0.84	0.47-1.35	mg/dL
UN	8	8	6	7	4 L	6-20	mg/dL
Na	136	138	139	139	138	133-146	mmol/L
Chlor	103	106	105	109	106	100-111	mmol/L
CO2	26.5	24.9	27.0	24.1	25.9	23.0-32.6	mmol/L
K	3.6	3.2 L	3.0 L	3.4 L	3.2 L	3.5-4.9	mmol/L
Gluc	105 H	108 H	114 H	105 H	107 H	70-100	mg/dL
Ca	8.7 L	8.4 L	8.3 L	8.4 L	8.4 L	8.9-10.3	mg/dL
Bun/Crea	8	8	7 L	8	5 L	8-23	
Ani Gap	10	10	10	9	9	6-13	mmol/L
Osmo Cal	271	275	276	276	273	271-318	mOsm/kg
eGFR-AA	>60	>60	>60	>60	>60		mL/min/1.73
eGFR-Oth	>60 ⁴	>60 ⁴	>60 ⁴	>60 ⁴	>60 ⁴		mL/min/1.73

No hemolysis noted.

Do not use this eGFR calculation for medication dose adjustments.Patient Name: FARR, WILLIAM GAULT
Location: IP IP
PT Type: INPATIENT

SRMC CUM FINAL DISCHARGE REPORT -

Printed: 12/15/2010 19:05
Page: 2 of 11SRHS 0073
3/27/2013

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DATE

J. David Wren, MD PHD, Director

Spartanburg Regional Medical Center
101 E. Wood Street
Spartanburg, South Carolina 29303-3072Dept of Laboratory Medicine
864-560-6212FARR, WILLIAM GAULT
68Y
NGUYEN, CHRISTOPHE LMR#: S000478684
DOB: [REDACTED]
Location: IP IPACCT#: S1032100540
Admitted: 12/02/2010
PT Type: INPATIENT

BLOOD							
Collected	12/04 05:45 ⁸	12/03 04:15 ³	12/02 13:25 ³	12/02 06:43 ⁵	11/24 16:40 ³		
Released	12/04 07:13	12/03 04:53	12/02 14:05	12/02 07:32	11/24 17:34	Reference	Units
Accession	C103370119	C103361011	C103360672	C103360089	C103280951		
ALT					23	8-39	IU/L
Alb					3.9	3.5-4.9	g/dL
Alk Phos					83	36-108	IU/L
Creat	1.00	0.96	1.15		1.06	0.47-1.35	mg/dL
AST					22	12-33	IU/L
UN	7	12	14		13	6-20	mg/dL
Na	140	139	139		137	133-146	mmol/L
Chlor	107	110	110		103	100-111	mmol/L
CO2	25.0	23.5	21.5 L		24.5	23.0-32.6	mmol/L
K	2.9 L	3.2 L	4.1	3.6	2.8 L	3.5-4.9	mmol/L
Gluc	135 H	113 H	125 H		93	70-100	mg/dL
Ca	8.7 L	8.0 L	8.7 L		9.2	8.9-10.3	mg/dL
Bun/Crea	7 L	13	12		12	8-23	
Ani Gap	11	9	12		12	6-13	mmol/L
Osmo Cal	279	278	279		274	271-318	mOsm/kg
T Bili					0.7	0.0-1.5	mg/dL
T Prot					7.6	6.1-8.0	g/dL
A/G Rati					1.1	0.9-2.4	
Glob					3.7	2.0-3.7	g/dL
Mg		1.8	1.9			1.7-2.4	mg/dL
Phos		4.4 H ⁸	4.5 H ³			2.3-4.3	mg/dL
eGFR-AA	>60	>60	>60		>60		mL/min/1.73
eGFR-Oth	>60 ⁴	>60 ⁴	>60 ⁴		>60 ⁴		mL/min/1.73

⁸No hemolysis noted³High dosages of liposomal Amphotericin B therapy may cause falsely elevated results for phosphorus.

Clinical correlation may be necessary.

BLOOD GAS

ARTERIAL BLOOD				
Collected	12/02 14:00			
Released	12/02 14:10		Reference	Units
Accession	EC103360820			
pH	7.36		7.35-7.45	
PCO2	39		35-45	mm/Hg
PO2	101 H		75-85	mm/Hg
Tot CO2	23		23-27	mmol/L
HCO3	22.2		22.0-26.0	mmol/L
BE	-3 L		-2-3	mmol/L
O2 SAT	98		95-100	%
L/min	2			
Type	ARTERIAL			
Allen's	N/A			
DelSys	Nasal Can			
Intubate	No			
Site	Art Line			

BLOOD BANKPatient Name: FARR, WILLIAM GAULT
Location: IP IP
PT Type: INPATIENT

SRMC CUM FINAL DISCHARGE REPORT -

Printed: 12/15/2010 19:05
Page: 3 of 11SRHS 0074
3/27/2013

DP - SRHS - 0074 PRINTED BY: DB30588

DATE

J. David Wren, MD PHD, Director

Spartanburg Regional Medical Center
101 E. Wood Street
Spartanburg, South Carolina 29303-3072Dept of Laboratory Medicine
864-560-6212FARR, WILLIAM GAULT
68Y
NGUYEN, CHRISTOPHE LMR#: S000478684
DOB: [REDACTED]
Location: IP IPACCT#: S1032100540
Admitted: 12/02/2010
PT Type: INPATIENT

Accession No. B103280093

Collection Date	Test Panel	Test	Result
11/24/2010 16:40 Released 11/24/2010 18:30	Extended T/S- Reflex	Group and RH	O Rh Negative
		Antibody Screen	Negative
		Historical AB	No
		Extended T/S	
		Current AB Extended T/S	No
		Previous ABORH Check	No Hist ABORH
		Specimen expiration date	12/04/2010 23:59
11/24/2010 16:40 Released 11/24/2010 16:42	Extended T/S	Transfused in last 3 months?	NO
		Patient pregnant in last 3 months	NO
		Surgery Date	12/02/10

NO NO 12/02/10

Accession No. B103360028

Collection Date	Product	Description	Status
12/02/2010 08:06 Released 12/05/2010 00:10	2 RBC	01 - Product ID	Red Blood Cells
		01 - Product Code	E0424V00
		01 - Unit Number	W121610166289
		01 - Blood Type	O Neg
		01 - Cross Match	Compatible
		01 - Status Info	Canceled
		02 - Product ID	Red Blood Cells
		02 - Product Code	E0424V00
		02 - Unit Number	W121610168131
		02 - Blood Type	O Neg
		02 - Cross Match	Compatible
		02 - Status Info	Canceled

Patient Name: FARR, WILLIAM GAULT
Location: IP IP
PT Type: INPATIENT

SRMC CUM FINAL DISCHARGE REPORT -

Printed: 12/15/2010 19:05
Page: 4 of 11

DP - SRHS - 0075 PRINTED BY: DB30588

DATE 3/27/2013

SRHS 0075

J. David Wren, MD PHD, Director

Spartanburg Regional Medical Center
101 E. Wood Street
Spartanburg, South Carolina 29303-3072

Dept of Laboratory Medicine
864-560-6212

FARR, WILLIAM GAULT
68Y
NGUYEN, CHRISTOPHEL

MR#: S000478684
DOB: [REDACTED]
Location: IP IP

ACCT#: S1032100540
Admitted: 12/02/2010
PT Type: INPATIENT

MICROBIOLOGY

CULTURE RESPIRATORY
Accession #: MU10339018

Collected: 12/05/2010 09:10
Specimen: BRONCHIAL WASHING
Source: R LUNG

Gram Stain with Culture (Final)
Few Polymorphonuclear Leukocytes Seen
Few Gram Positive Cocci In Pairs

Results: (Final)
(Light Growth)
Normal Respiratory Flora Isolated

CULTURE INFECTION CONTROL
Accession #: MW10336019

Collected: 12/02/2010 16:00
Specimen: NASOPHARYNGEAL
Source: NASAL

Results: (Final)
No Methicillin resistant Staphylococcus Aureus isolated

CANCELLED TESTS

Collection Date	Specimen	Test Name	Reason
12/04/2010 05:00 ⁸	BLOOD	BASIC METABOLIC PANEL	Cancelled duplicate by system
12/04/2010 18:00 ⁹	BLOOD	BASIC METABOLIC PANEL	Other
12/12/2010 05:00 ¹⁰	BLOOD	BASIC METABOLIC PANEL	Cancelled duplicate by system
12/12/2010 05:00 ¹¹	BLOOD	COMPLETE BLOOD COUNT	Cancelled duplicate by system
12/13/2010 05:00 ¹²	BLOOD	BASIC METABOLIC PANEL	Cancelled duplicate by system
12/13/2010 05:00 ¹³	BLOOD	COMPLETE BLOOD COUNT	Cancelled duplicate by system
12/14/2010 05:00	BLOOD	BASIC METABOLIC PANEL	Other
12/14/2010 05:00	BLOOD	COMPLETE BLOOD COUNT	Other

BLOOD BANK

Accession No. B103360028

Collection Date	Product	Description	Status
12/02/2010 08:06 Released 12/05/2010 00:10	2 RBC	01 - Product ID	Red Blood Cells

Patient Name: FARR, WILLIAM GAULT
Location: IP IP
PT Type: INPATIENT

SRMC CUM FINAL DISCHARGE REPORT -

Printed: 12/15/2010 19:05
Page: 5 of 11

SRHS 0076
3/27/2013

DP - SRHS - 0076 PRINTED BY: DB30588

J. David Wren, MD PHD, Director

Spartanburg Regional Medical Center
101 E. Wood Street
Spartanburg, South Carolina 29303-3072Dept of Laboratory Medicine
864-560-6212FARR, WILLIAM GAULT
68Y
NGUYEN, CHRISTOPHE LMR#: S000478684
DOB: XXXXXXXXXX
Location: IP IPACCT#: S1032100540
Admitted: 12/02/2010
PT Type: INPATIENT

Collection Date	Product	Description	Status
		01 - Product Code	E0424V00
		01 - Unit Number	W121610166289
		01 - Blood Type	O Neg
		01 - Cross Match	Compatible
		01 - Status Info	Canceled
		02 - Product ID	Red Blood Cells
		02 - Product Code	E0424V00
		02 - Unit Number	W121610168131
		02 - Blood Type	O Neg
		02 - Cross Match	Compatible
		02 - Status Info	Canceled

Accession No. B103280093

Collection Date	Test Panel	Test	Result
11/24/2010 16:40 Released 11/24/2010 16:30 ¹⁴	Extended T/S- Reflex	Group and RH	O Rh Negative
		Antibody Screen	Negative
		Historical AB	No
		Extended T/S	
		Current AB Extended T/S	No
		Previous ABORH Check	No Hist ABORH
		Specimen expiration date	12/04/2010 23:59
11/24/2010 16:40 Released 11/24/2010 16:42	Extended T/S	Transfused in last 3 months?	NO
		Patient pregnant in last 3 months	NO
		Surgery Date	12/02/10

¹⁴NO NO 12/02/10

BLOOD	WBC	RBC	HGB	HCT
	3.1-9.7	4.08-	13.1-	38.2-
		5.70	16.8	48.4
	K/cmm	million/ cmm	g/dL	%

11/24/2010
16:40
Released11/24/2010
17:18¹⁵12/02/2010 16.6 H 4.99 13.4 41.4
13:25Released
12/02/2010
13:38¹⁵12/03/2010 9.6 4.49 12.1 L 36.4 L
04:15Released
12/03/2010
04:29¹⁵12/04/2010 16.5 H 4.82 12.5 L 39.5
05:45Released
12/04/2010¹⁵...Patient Name: FARR, WILLIAM GAULT
Location: IP IP
PT Type: INPATIENT

SRMC CUM FINAL DISCHARGE REPORT -

Printed: 12/15/2010 19:05
Page: 6 of 11SRHS 0077
DATE 3/27/2013

DP - SRHS - 0077 PRINTED BY: DB30588

DATE _____

J. David Wren, MD PHD, Director

Spartanburg Regional Medical Center
101 E. Wood Street
Spartanburg, South Carolina 29303-3072

-962-

Dept of Laboratory Medicine
864-560-6212

FARR, WILLIAM GAULT
68Y
NGUYEN, CHRISTOPHE L

MR#: S000478684
DOB: [REDACTED]
Location: IP IP

ACCT#: S1032100540
Admitted: 12/02/2010
PT Type: INPATIENT

BLOOD WBC RBC HGB HCT
3.1-9.7 4.08- 13.1- 38.2-
5.70 16.8 48.4
K/cmm million/
cmm
12/13/2010 10.0 H 4.77 12.3 L 38.6
07:40
Released
12/13/2010
07:52¹⁵

BLOOD MCV MCH MCHC RDW
80.1- 27.5- 33.2- 11.7-
98.7 34.3 35.7 15.0
fL pg g/dL %

11/24/2010
16:40
Released
11/24/2010
17:18¹⁵
12/02/2010 82.9 26.8 L 32.3 L 17.2 H
13:25
Released
12/02/2010
13:38¹⁵
12/03/2010 81.1 27.0 L 33.3 17.2 H
04:15
Released
12/03/2010
04:29¹⁵
12/04/2010 82.1 25.9 L 31.5 L 17.7 H
05:45
Released
12/04/2010
07:03¹⁵
12/04/2010 82.4 26.3 L 31.9 L 17.4 H
05:45
Released
12/04/2010
07:03¹⁵
12/05/2010 81.2 26.7 L 32.9 L 17.7 H
06:30
Released
12/05/2010
07:40¹⁵
12/06/2010 81.4 26.1 L 32.0 L 17.7 H
06:10
Released
12/06/2010
07:32¹⁵
12/06/2010 81.5 26.3 L 32.2 L 17.1 H
09:38
Released
12/06/2010
10:32¹⁵
12/07/2010 82.0 26.2 L 31.9 L 17.7 H

Patient Name: FARR, WILLIAM GAULT
Location: IP IP
PT Type: INPATIENT

SRMC CUM FINAL DISCHARGE REPORT -

Printed: 12/15/2010 19:05
Page: 8 of 11

SRHS 0079
3/27/2013

DP - SRHS - 0079 PRINTED BY: DB30588

DATE

J. David Wren, MD PHD, Director

Spartanburg Regional Medical Center
101 E. Wood Street
Spartanburg, South Carolina 29303-3072Dept of Laboratory Medicine
864-560-6212FARR, WILLIAM GAULT
68Y
NGUYEN, CHRISTOPHE LMR#: S000478684
DOB: [REDACTED]
Location: IP IPACCT#: S1032100540
Admitted: 12/02/2010
PT Type: INPATIENT

	MCV	MCH	MCHC	RDW
BLOOD	80.1-	27.5-	33.2-	11.7-
	98.7	34.3	35.7	15.0
	fL	pg	g/dL	%

05:20

Released

12/07/2010

06:22¹⁵

12/08/2010

81.8

26.2 L

32.1 L

17.3 H

05:45

Released

12/08/2010

06:20¹⁵

12/09/2010

81.1

25.8 L

31.9 L

17.7 H

06:00

Released

12/09/2010

06:42¹⁵

12/10/2010

81.5

25.9 L

31.7 L

17.6 H

05:15

Released

12/10/2010

05:56¹⁵

12/11/2010

81.7

26.2 L

32.0 L

17.7 H

06:45

Released

12/11/2010

06:49¹⁵

12/12/2010

81.4

26.1 L

32.0 L

18.0 H

06:15

Released

12/12/2010

07:01¹⁵

12/13/2010

81.0

25.7 L

31.8 L

17.7 H

07:40

Released

12/13/2010

07:52¹⁵

BLOOD

PLT
119-332
K/cmm

Scan(y/n

11/24/2010

16:40

Released

11/24/2010

17:18¹⁵

12/02/2010

321

13:25

Released

12/02/2010

13:38¹⁵

12/03/2010

264

04:15

Released

12/03/2010

NO

Patient Name: FARR, WILLIAM GAULT
Location: IP IP
PT Type: INPATIENT

SRMC CUM FINAL DISCHARGE REPORT -

Printed: 12/15/2010 19:05
Page: 9 of 11SRHS 0080
3/27/2013

DP - SRHS - 0080 PRINTED BY: DB30588

DATE

J. David Wren, MD PHD, Director

Spartanburg Regional Medical Center
101 E. Wood Street
Spartanburg, South Carolina 29303-3072Dept of Laboratory Medicine
864-560-6212FARR, WILLIAM GAULT
68Y
NGUYEN, CHRISTOPHE LMR#: S000478684
DOB: [REDACTED]
Location: IP IPACCT#: S1032100540
Admitted: 12/02/2010
PT Type: INPATIENT

	PLT	Scan(y/n)
BLOOD	119-332	
	K/cmm	
04:29 ¹⁵		
12/04/2010	305	
05:45		
Released		
12/04/2010		
07:03 ¹⁵		
12/04/2010	301	
05:45		
Released		
12/04/2010		
07:03 ¹⁵		
12/05/2010	281	
06:30		
Released		
12/05/2010		
07:40 ¹⁵		
12/06/2010	324	
06:10		
Released		
12/06/2010		
07:32 ¹⁵		
12/06/2010	307	
09:38		
Released		
12/06/2010		
10:32 ¹⁵		
12/07/2010	332	
05:20		
Released		
12/07/2010		
06:22 ¹⁵		
12/08/2010	375 H	
05:45		
Released		
12/08/2010		
06:20 ¹⁵		
12/09/2010	376 H	
06:00		
Released		
12/09/2010		
06:42 ¹⁵		
12/10/2010	447 H	
05:15		
Released		
12/10/2010		
05:56 ¹⁵		
12/11/2010	445 H	
06:45		
Released		
12/11/2010		
06:49 ¹⁵		
12/12/2010	481 H	NO
06:15		

Patient Name: FARR, WILLIAM GAULT
Location: IP IP
PT Type: INPATIENT

SRMC CUM FINAL DISCHARGE REPORT -

Printed: 12/15/2010 19:05
Page: 10 of 11

DP - SRHS - 0081 PRINTED BY: DB30588

DATE

SRHS 0081
3/27/2013

J. David Wren, MD PHD, Director

Spartanburg Regional Medical Center
101 E. Wood Street
Spartanburg, South Carolina 29303-3072

-965-

Dept of Laboratory Medicine
864-560-6212

FARR, WILLIAM GAULT
68Y
NGUYEN, CHRISTOPHE L

MR#: S000478684
DOB: XXXXXXXXXX
Location: IP IP

ACCT#: S1032100540
Admitted: 12/02/2010
PT Type: INPATIENT

	PLT	Scan(y/n)
BLOOD	119-332	
	K/cmm	
Released		
12/12/2010		
07:01 ¹⁵		
12/13/2010	486 H	
07:40		
Released		
12/13/2010		
07:52 ¹⁵		

Patient Name: FARR, WILLIAM GAULT
Location: IP IP
PT Type: INPATIENT

SRMC CUM FINAL DISCHARGE REPORT -

Printed: 12/15/2010 19:05
Page: 11 of 11

DP - SRHS - 0082 PRINTED BY: DB30588

DATE

SRHS 0082
3/27/2013

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-966-

NAME: FARR, WILLIAM GAULT
ORDERING PHYSICIAN: NGUYEN, CHRISTOPHE L
LOC: CVR-CVR-04
Pt. Type: IP

DOB: [REDACTED]
INPATIENT

UNIT #: 000478684
CI#: 2920266
AN#: S1032100540

FINAL

Exam

50354 XR CHEST P** 1 VIEW
71010

Date: 12/03/10 0346
Ord Diag: 162.9

** Portable **

Single portable upright chest x-ray December 3, 2010 at 0716

Reference exam: December 2, 2010

Indication: Short of breath

Findings: Right-sided chest tube is again noted, skin staples and soft tissue gas on the right are seen with patient rotated to the right. There is no convincing pneumothorax identified but patient is rotated.

Impression: No convincing pneumothorax seen the patient is rotated.

Transcriptionist- n/a
Reading Radiologist- JEFFREY NEWMAN MD
Releasing Radiologist- JEFFREY NEWMAN MD
Released Date Time- 12/03/10 0823

** Portable **

Page 1

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-967-

NAME: FARR, WILLIAM GAULT
ORDERING PHYSICIAN: NGUYEN, CHRISTOPHE L
LOC: 4H-8428-A
Pt. Type: IP

DOB: [REDACTED]
INPATIENT

UNIT #: 000478684
CI#: 2920929
AN#: S1032100540

FINAL

Exam

50354 XR CHEST P** 1 VIEW
71010

Date: 12/04/10 0203
Ord Diag: 786.50

** Portable **

AP portable chest 12/4/2010 at 5:30 a.m.

The study is done because of chest pain. Postsurgical findings are seen in the right chest. With the volume loss in the right hemithorax, findings are suspected to represent a lobectomy. The mediastinum is shifted to the right. The left lung is under ventilated but clear. The left jugular catheter remains.

Impression: Postsurgical findings in the right chest. Decreased expansion of the left lung.

Transcriptionist- EVALYNN HYRA
Reading Radiologist- Mark Monson MD
Releasing Radiologist- Mark Monson MD
Released Date Time- 12/05/10 1450

** Portable **

Page 1

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-968-

NAME: FARR, WILLIAM GAULT
ORDERING PHYSICIAN: NGUYEN, CHRISTOPHE L
LOC: 4H-8428-A
Pt. Type: IP

DOB: [REDACTED]
INPATIENT

UNIT #: 000478684
CI#: 2921670
AN#: S1032100540

FINAL

Exam

50354 XR CHEST P** 1 VIEW
71010

Date: 12/04/10 1612
Ord Diag: 786.50

** Portable **

1 View portable chest x-ray December 4, 2010

Indication: Followup for right chest surgery

Comparison: December 4, 2010 at 0528

Findings: This portable upright AP chest at 1639 shows the the right chest postsurgical volume loss is persistent. This hemithorax is largely opaque due to cardiac shift and some pleural thickening. No gross pleural air is seen. There is persistence of gas in the right chest walls and the skin staple line is in place. Chest drainage tubes remain in place. The left lung field remains clear and normally inflated, with normal pulmonary vascularity.

IMPRESSION: Stable right chest postsurgery changes with considerable volume loss, as above.

Transcriptionist- n/a
Reading Radiologist- William T Joyce MD
Releasing Radiologist- William T Joyce MD
Released Date Time- 12/04/10 1642

** Portable **

Page 1

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-969-

NAME: FARR, WILLIAM GAULT
ORDERING PHYSICIAN: CLARK, ERICA C
LOC: 4H-8428-A
Pt. Type: IP

DOB: [REDACTED]
INPATIENT

UNIT #: 000478684
CI#: 2921525
AN#: S1032100540

FINAL

Exam

50354 XR CHEST P** 1 VIEW
71010

Date: 12/05/10 0428
Ord Diag: s/p bilobectomy R ** Portable **

AP portable chest 12/5/2010 at 6:15 a.m.

The exam is done following thoracic surgery. A lobectomy has been done on the right. The remaining right lung volume remains small, as on the previous day's exam. The mediastinum remains shifted into the right chest. The left lung is clear. Cardiomegaly is unchanged.

Impression: The surgical findings and volume loss in the right chest. There is more fluid at the right lung base than before. The mediastinum remain shifted from left-to-right.

Transcriptionist- n/a
Reading Radiologist- Mark Monson MD
Releasing Radiologist- Mark Monson MD
Released Date Time- 12/05/10 0812

** Portable **

Page 1

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-970-

NAME: FARR, WILLIAM GAULT
ORDERING PHYSICIAN: BRENDA, DEREK STEVEN
LOC: 4H-8428-A
Pt. Type: IP

UNIT #: 000478684
CI#: 2921982
AN#: S1032100540

DOB: [REDACTED]
INPATIENT

FINAL

Exam

60220 CT LUNG WITHOUT CONTRAST Date: 12/05/10 1449
71250 Ord Diag: effusion

CT scan of the chest without contrast 12/5/2010:

The examination is done to assess fluid in the chest following surgery. Spiral CT scanning was done through the chest. No IV contrast was used, as ordered.

Findings of a thoracotomy are evident on the right side. A chest tube is in place. An anterior pneumothorax is present. There is very little pleural fluid. The remaining portion of the right lung has patchy areas of opacification. The left lung is hyperexpanded and is clear. There is a small amount of pleural fluid at the left lung base. The mediastinum is shifted into the right chest. Surgical clips are evident in the right hilar area. No gross adenopathy is evident, but assessment for hilar nodes is limited without the use of IV contrast. Some subcutaneous emphysema remains in the right chest wall.

Impression:

1. Post surgical findings in the right hemithorax with a right chest tube remaining.
2. Small anterior pneumothorax on the right.
3. The remaining right lung is diffusely opacified, with question of whether this represents compressive atelectasis or any superimposed infectious infiltrate.
4. No significant pleural fluid on the right. Small layer of pleural fluid at the left base.

Transcriptionist- n/a

Page 1

SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-971-

NAME: FARR, WILLIAM GAULT
ORDERING PHYSICIAN: BRENDA, DEREK STEVEN
LOC: 4H-8428-A
Pt. Type: IP

DOB: [REDACTED]
INPATIENT

UNIT #: 000478684
CI#: 2921982
AN#: S1032100540

Checkin-Exam Code Summary
2921982-60220

Reading Radiologist- Mark Monson MD
Releasing Radiologist- Mark Monson MD
Released Date Time- 12/05/10 1611

Page 2

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-972-

NAME: FARR, WILLIAM GAULT
ORDERING PHYSICIAN: NGUYEN, CHRISTOPHE L
LOC: 4H-8428-A
Pt. Type: IP

DOB: [REDACTED]
INPATIENT

UNIT #: 000478684
CI#: 2921858
AN#: S1032100540

FINAL

Exam

50354 XR CHEST P** 1 VIEW
71010

Date: 12/06/10 0203
Ord Diag: 786.50

** Portable **

History: Chest pain.

Portable AP chest dated 12/6/10: Compared with 12/5/10.

Skin staples are seen on the right lateral chest wall. A right-sided chest tubes in place. There is volume loss on the right with hyperexpansion of the left lung. There is air in the pleural space on the right, most likely due to previous lung resection. There appears to be a small amount fluid as well. The left lung is clear. No left-sided pleural effusion is seen.

Impression: Postoperative changes to the right hemithorax. No acute change since the previous study.

Transcriptionist- n/a
Reading Radiologist- LAWRENCE WARRENJR MD
Releasing Radiologist- LAWRENCE WARRENJR MD
Released Date Time- 12/06/10 0827

** Portable **

Page 1

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-973-

NAME: FARR, WILLIAM GAULT

ORDERING PHYSICIAN: NGUYEN, CHRISTOPHE L

LOC: 4H-8428-A

Pt. Type: IP

DOB: [REDACTED]

INPATIENT

UNIT #: 000478684

CI#: 2922323

AN#: S1032100540

FINAL

Exam

50354 XR CHEST P** 1 VIEW
71010

Date: 12/07/10 0328
Ord Diag: 786.50

** Portable **

History: Shortness of breath.

Portable AP chest dated 12/7/10: compared with 12/6/10.

Skin staples overlie the right lateral chest wall. There is volume loss in the right hemithorax with what appears to be a chest tube in place. There is a small right apical pneumothorax. The lung is otherwise clear. Left lung is hyperexpanded and clear. There is no left-sided pleural effusion.

Impression: Changes from partial pneumonectomy on the right. Tiny apical pneumothorax. No acute changes since the previous study.

Transcriptionist- ALICE R ADLER

Reading Radiologist- LAWRENCE WARRENJR MD

Releasing Radiologist- LAWRENCE WARRENJR MD

Released Date Time- 12/07/10 1219

** Portable **

Page 1

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-974-

NAME: FARR, WILLIAM GAULT
ORDERING PHYSICIAN: NICHOLS, WILLIS T
LOC: 4H-8428-A DOB: [REDACTED]
Pt. Type: IP INPATIENT

UNIT #: 000478684
CI#: 2923253
AN#: S1032100540

FINAL

Exam

50354 XR CHEST P** 1 VIEW
71010

Date: 12/08/10 0355
Ord Diag: 786.50

** Portable **

Portable chest, one view, 12/08/2010

Indication: Followup pneumothorax.

Comparison: 12/7/2010.

There is a small right apical pneumothorax that measures about 17 mm at the apex slightly larger than the prior exam. Right-sided chest tube noted. Patient has had a partial pneumonectomy on the right. Some atelectasis or infiltrate at the right lung base appears improved. Left lung clear.

Impression: Post partial pneumonectomy on the right with a small apical pneumothorax marginally larger than the prior exam. The right lung base is clearer.

Transcriptionist- ALICE R ADLER
Reading Radiologist- Peter Ryan MD
Releasing Radiologist- Peter Ryan MD
Released Date Time- 12/08/10 1331

** Portable **

Page 1

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-975-

NAME: FARR, WILLIAM GAULT
ORDERING PHYSICIAN: NICHOLS, WILLIS T
LOC: 4H-8428-A
Pt. Type: IP

UNIT #: 000478684
CI#: 2924256
AN#: S1032100540

DOB: [REDACTED]
INPATIENT

FINAL

Exam

50354 XR CHEST P** 1 VIEW
71010

Date: 12/09/10 0438
Ord Diag: 786.50

** Portable **

Portable chest x-ray 12/09/2010 0632

Since 12/08/2010 at 0644 a 15% right apical pneumothorax is again demonstrated. Heart is enlarged and left lung field is clear. There is an atelectatic-like infiltrate noted at the right lung base.

Transcriptionist- ALICE R ADLER
Reading Radiologist- Neil H Parnes MD
Releasing Radiologist- Neil H Parnes MD
Released Date Time- 12/09/10 1157

** Portable **

Page 1

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-976-

NAME: FARR, WILLIAM GAULT
ORDERING PHYSICIAN: NICHOLS, WILLIS T
LOC: 4H-8428-A DOB: [REDACTED]
Pt. Type: IP INPATIENT

UNIT #: 000478684
CI#: 2925303
AN#: S1032100540

FINAL

Exam

50354 XR CHEST P** 1 VIEW
71010

Date: 12/10/10 0317
Ord Diag: vaas

** Portable **

Portable chest, one view, 12/10/2010 at 0708 hours:

Comparison: 12/9/2010.

Indication: Followup pneumothorax.

A small right apical pneumothorax has not changed significantly over the interval. The patient has had right chest surgery with chest tube/drain with some volume loss on the right, probably a lobectomy. Some minor atelectasis at the right lung base. Left lung clear.

Impression: Stable chest including postsurgical changes on the right with a small right apical pneumothorax.

Transcriptionist- Patricia Licurs
Reading Radiologist- Peter Ryan MD
Releasing Radiologist- Peter Ryan MD
Released Date Time- 12/10/10 1347

** Portable **

Page 1

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-977-

NAME: FARR, WILLIAM GAULT
ORDERING PHYSICIAN: MOSKOWITZ, ROBERT
LOC: 4T-407-A
Pt. Type: IP

UNIT #: 000478684
CI#: 2926450
AN#: S1032100540

DOB: [REDACTED]
INPATIENT

FINAL

Exam

50354 XR CHEST P** 1 VIEW
71010

Date: 12/11/10 0137

Ord Diag: lung surgery

** Portable **

History: Lung surgery.

Comments: Semi upright view of the chest submitted for review and compared to prior exam dated December 10, 2010.

The right apical pneumothorax is present and perhaps slightly increased from the prior exam. A right chest tube/drain is present. Left lung field is clear. Heart and mediastinal contour is unremarkable.

Impression: Perhaps slight increase in the right apical pneumothorax.

Transcriptionist- JACKIE SAMS
Reading Radiologist- RICHARD J HARP MD
Releasing Radiologist- RICHARD J HARP MD
Released Date Time- 12/12/10 1058

** Portable **

Page 1

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-978-

NAME: FARR, WILLIAM GAULT
ORDERING PHYSICIAN: MOSKOWITZ, ROBERT
LOC: 4T-407-A
Pt. Type: IP

UNIT #: 000478684
CI#: 2927202
AN#: S1032100540

DOB: [REDACTED]
INPATIENT

FINAL

Exam

50354 XR CHEST P** 1 VIEW
71010

Date: 12/12/10 0445
Ord Diag: lung surgery

** Portable **

History: Status post lung surgery. Chest tube in place.

Portable AP chest dated 12/12/10: Compared with 12/11/10.

Skin staples overlie the right lateral chest. A right-sided chest tube remains in place. The heart is not enlarged. There still appears to be a right pneumothorax, but the pleural line is difficult to visualize. It is no larger than on the previous study. The left lung is hyperexpanded but clear. No pleural fluid is seen.

Impression: Persistent right-sided pneumothorax following lung surgery. No focal acute changes.

Transcriptionist- JACKIE SAMS
Reading Radiologist- LAWRENCE WARRENJR MD
Releasing Radiologist- LAWRENCE WARRENJR MD
Released Date Time- 12/12/10 1005

** Portable **

Page 1

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-979-

NAME: FARR, WILLIAM GAULT
ORDERING PHYSICIAN: NICHOLS WILLIS T
LOC: 4T-407-A
Pt. Type: IP

UNIT #: 000478684
CI#: 2927563
AN#: S1032100540

DOB: [REDACTED]
INPATIENT

FINAL

Exam

50354 XR CHEST P** 1 VIEW
71010

Date: 12/13/10 0038
Ord Diag: 162.9

** Portable **

Portable chest x-ray 12/13/2010 at 6:31:

Since 12/12/2010 at 5:54, a 30% right pneumothorax is again demonstrated. The heart is enlarged and the left lung field is clear.

Transcriptionist- Patricia Licurs
Reading Radiologist- Neil H Parnes MD
Releasing Radiologist- Neil H Parnes MD
Released Date Time- 12/13/10 1000

** Portable **

Page 1

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-980-

NAME: FARR, WILLIAM GAULT
ORDERING PHYSICIAN: NICHOLS, WILLIS T
LOC: 4T-407-A
Pt. Type: IP

DOB: [REDACTED]
INPATIENT

UNIT #: 000478684
CI#: 2928118
AN#: S1032100540

FINAL

Exam

50354 XR CHEST P** 1 VIEW
71010

Date: 12/14/10 0530
Ord Diag: surgery

** Portable **

Single portable semierect chest December 14, 2010 at 0731

Reference exam: December 13, 2010

Indication: Respiratory distress

Findings: Right-sided pneumothorax appears unchanged, right-sided central venous catheters, with skin staples on the right are again noted. Left lung appears clear.

Impression: No significant interval change.

Transcriptionist- n/a
Reading Radiologist- JEFFREY NEWMAN MD
Releasing Radiologist- JEFFREY NEWMAN MD
Released Date Time- 12/14/10 0806

** Portable **

Page 1

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-981-

NAME: FARR, WILLIAM GAULT
ORDERING PHYSICIAN: MOSKOWITZ ROBERT M
LOC: 4T-407-A
Pt. Type: IP

DOB: [REDACTED]
INPATIENT

UNIT #: 000478684
CI#: 2929249
AN#: S1032100540

FINAL

Exam

50354 XR CHEST P** 1 VIEW
71010

Date: 12/14/10 0859
Ord Diag: 162.9

** Portable **

1 View portable chest x-ray December 14, 2010

Indication: Status post right chest surgery now with chest tube removal

Comparison: December 14, 2010 at 0732

Findings: This portable upright chest of 0910 hours shows the patient rotated somewhat toward the right. Skin staples remain in place. The right chest tube has been removed. There continues to be right-sided pneumothorax, the volume of this is not significantly changed and are not radiographic findings of mass effect. The cardiac silhouette is stable. The left lung field is clear.

IMPRESSION: Right chest tube removed, residual pleural air persists and does not appear significantly changed in volume.

Transcriptionist- n/a
Reading Radiologist- William T Joyce MD
Releasing Radiologist- William T Joyce MD
Released Date Time- 12/14/10 0924

** Portable **

Page 1

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-982-

NAME: FARR, WILLIAM GAULT
ORDERING PHYSICIAN: MOSKOWITZ ROBERT M
LOC: 4T-407-A
Pt. Type: IP

UNIT #: 000478684
CI#: 2929264
AN#: S1032100540

FINAL

Exam

50354 XR CHEST P** 1 VIEW
71010

Date: 12/15/10 0413
Ord Diag: 162.9

** Portable **

Chest one view portable, 15 December 2010:

History: Shortness of breath.

Comparison: 14 December 2010.

Technique: Single AP view.

Findings: Right-sided pneumothorax may be slightly smaller than on the prior exam. No new abnormality. No lobar consolidation. There are postoperative changes in the right chest.

Impression: Slight decrease in the right pneumothorax.

Transcriptionist- Patricia Licurs

Reading Radiologist- DAVID STOPPENHAGEN MD

Releasing Radiologist- DAVID STOPPENHAGEN MD

Released Date Time- 12/15/10 0903

** Portable **

Page 1

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

-983-

NAME: FARR, WILLIAM GAULT
ORDERING PHYSICIAN: NGUYEN, CHRISTOPHE L
LOC: OPT DOB: [REDACTED]
Pt. Type: OPT OPT REGISTRATION

UNIT #: 000478684
CI#: 2936299
AN#: S1035600774

FINAL

Exam

50342 XR CHEST PA AND LATERAL
71020

Date: 12/22/10 1135

Ord Diag: 162.9-MAL NEO BRONCH/LUNG NOS

Two-view chest 12/22/2010 at 1137

Reference exam: 12/15/2010

Indication: Lung cancer

Findings: Right-sided pneumothorax is again seen, some scarring is noted in the right lung base, left lung is considered clear. Cardiac silhouette and pulmonary vascularity are normal.

Impression: Right pneumothorax again seen, felt to be unchanged.

Transcriptionist- n/a

Reading Radiologist- JEFFREY NEWMAN MD

Releasing Radiologist- JEFFREY NEWMAN MD

Released Date Time- 12/22/10 1149

Page 1

DISCHARGE SUMMARY

PATIENT NAME: FARR, WILLIAM G

DOB: [REDACTED]

MEDICAL RECORD #: 478684

ACCOUNT NUMBER: 1032100540

ADMISSION DATE: 12/02/2010 DISCHARGE DATE: 12/15/2010

ATTENDING PHYSICIAN: NGUYEN, CHRISTOPHE L

ADMITTING DIAGNOSES

History of chronic obstructive pulmonary disease and tobacco use, with right lung cancer.

DISCHARGE DIAGNOSES

1. History of chronic obstructive pulmonary disease and tobacco use, with right lung cancer, including also status post right thoracotomy with bilobectomy right upper lobe and right middle lobe on 12/2/2010.
2. Prolonged bronchopleural fistula treated conservatively with chest tube management.

HOSPITAL COURSE

Mr. Farr was admitted to the Intensive Care Unit after his surgery as mentioned above. He recovered there for approximately two days, at which point he was transferred to the floor. He required bronchoscopy by pulmonary for some retained secretions and atelectasis. He had advancement of his diet without difficulty as well as his activity. His chest x-ray continued to look stable after the bronchoscopy. He did have a prolonged air leak, which was treated with chest tube drainage. This ultimately sealed and the chest tube was removed. He was discharged from the hospital the next day. The patient was to follow up with me next week in the office with a chest x-ray.

Dictated by: CHRISTOPHE NGUYEN, MD

D:12/27/2010 15:44:27

T:12/27/2010 17:34:11 /abr

1043088/906612

cc:CHRISTOPHE NGUYEN, MD, Admitting Physician

WILSON P SMITH, M.D., Consulting Physician

Authenticated by Christophe L. Nguyen, MD. On 12/28/2010 08:05:29 AM

SURGICAL ONCOLOGY AT THE GIBBS CANCER CENTER

101 East Wood Street

Spartanburg, SC 29303

Phone (864) 560-1900

Fax (864) 560-1925

www.gibbsurgicaloncology.com

CHRISTOPHE NGUYEN, M.D.

OFFICE NOTE

DATE: December 22, 2010

PATIENT: FARR, WILLIAM

DOB: [REDACTED]

DIAGNOSIS:

1. History of previous colorectal cancer treated by my partner, Dr. Orr.
2. Non small cell lung cancer of the right upper and middle lobe, adenocarcinoma with papillary features, stage pT3, N0, M0 (stage 2B) status post resection 12/2/10 with postoperative bronchopleural fistula treated conservatively with chest tube management, resolved prior to discharge.

INTERVAL HISTORY:

Mr. Farr presents for follow up with me now a week after his discharge. He denies any significant shortness of breath except on exertion since being at home. He was discharged on room air. He denies any drainage from his incision or any productive cough. His PA and lateral chest x-ray from today demonstrates clear lung field on the right with near complete expansion of the remaining lower lobe. There is a small residual space from the bilobectomy but otherwise no infiltrates or pneumothorax.

PHYSICAL EXAMINATION:

Blood pressure is 131/79. Pulse is 93. Temperature is 97.4. Respirations are 20. O2 saturation is 95% on room air. Lungs are clear to auscultation bilaterally. Heart has a regular rate and rhythm. Abdomen is soft and nontender. Incision is healing nicely without evidence of infection.

IMPRESSION/PLAN:

As above, stage 2B non small cell lung cancer with negative margins, negative lymph nodes.

Mr. Farr is doing quite well from his surgery and I am pleased that his oxygenation is as good as it is. I was concerned about his capacity to undergo such an operation because of his history of smoking and COPD. Certainly he is on track to make a complete recovery. I am pleased with his chest x-ray and will insure that he has follow up with Drs. Corso, Cruz and Littlefield. I will plan to see him back in a few weeks.

Christophe L. Nguyen, M.D.
CLN/mal

N3

CC: Dr. Raul Cruz, Dr. Richard Orr, Dr. Steve Corso

SURGICAL ONCOLOGY

Office Note

Patient: William Farr

NAME AND DATE OF BIRTH VERIFIED: ☒

DATE

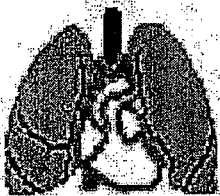
BP 131/79 Pulse 93 Temp 97⁴ Resp 20 Weight _____ O2 Sat 95% RA

ALLERGIES REVIEWED ☒

CURRENT MEDICATIONS REVIEWED AND LISTED ☒

CHIEF COMPLAINT: lung surgery

CP
17



-987-
FARR, WILLIAM G

68 Y old Male, DOB: [REDACTED]

1032 JONESVILLE LOCKHART HWY, UNION, SC-29379

Home: 864-251-0531

Guarantor: FARR, WILLIAM G Insurance: MEDICARE Payer

ID: SMSCo

PCP: RONALD LITTLEFIELD

Appointment Facility: Lung and Chest Medical Associates

01/04/2011

RAUL B CRUZ, MD

Current Medications

nifedipine 30 mg tablet, extended release 1 tab(s) once a day
Aspirin 81 mg enteric coated tablet 1 tab(s) once a day
Klor-Con 20 meq 2 cap bid
Triam/HCTZ 37.5/25 1 tab QD
Vytorin 10 mg-40 mg tablet 1 tab(s) once a day
Symbicort 160 mcg-4.5 mcg/inh aerosol with adapter 2 puff(s) 2 times a day
Proventil HFA CFC free 90 mcg/inh aerosol with adapter 2 puff(s) 4 times a day
zolpidem 5 mg tablet 1 tab(s) 1-2 hs
Klor-Con M20 20 mEq tablet, extended release 2 tabs bid
Medication List reviewed and reconciled with the patient

Past Medical History

Copd
Cough
Hypertension
Colon cancer

Surgical History

hernia repair
colostomy for colon cancer radiation and chemo tx 1989
nasal surgery

Family History

Mother: deceased old age
Father: deceased cancer bone
Siblings: 3 brother, 3 sister
History positive for, hypertension, cancer.

Social History

Tobacco Use: yes, PPD: 1, years: 50.
Marital status: Married.
Education level: 11.
Occupation: retired.
Anyone else in home smoke?: no.
Alcohol: reports, beer.
Other MDs: Primary care Dr Littlefield, Dr Corso.

Allergies

NKDA

Review of Systems

SLEEP HISTORY:

no Day-Time Sleepiness. no Fatigue on Wakening.

CONSTITUTIONAL:

no Fever/Chills. no Night sweats.

RESPIRATORY:

Reason for Appointment

1. 2 mo f/u coughing with clear secretion, occ wheezing, dyspnea more especial when lying down since surgery right bilobectomy Dr Nguyen 12-2-10.
2. Saw Dr Nguyen with cxr last week appt to see Dr Corso next week.
3. Pt still smokes 1-2 daily. Has cut down since last visit.

History of Present Illness

Interim History:

- followup for lung cancer, s/p bilobectomy
- awaiting plans for chemotherapy with Dr Corso
- Shortness of breath with recumbency,
- no cough, wheezing, sputum, hemoptysis
- post op pain acceptable
- still smokes!

Vital Signs

Wt 139.4, BP 144/82, HR 104, O2 sat 94%, FIO2 .21, FVC 2.23, FEV1 1.50, FEV1/FVC% 67%, Ht 64, BMI 23.93.

Physical Examination

GENERAL:

General Appearance: No acute distress. Build: average built.

HEENT:

Head: normocephalic. Pharynx: oropharynx clear. Pupils: symmetric. Sclera: anicteric. EOM: intact. Nose: normal. Nasal septum: midline. Oral cavity: normal.

CHEST:

Shape and expansion: symmetrical chest expansion. Wheezes: no. Rales: no. Rhonchi no. Breath sounds: diminished bilateral wound healing well.

HEENT:

PMI: PMI not displaced. Rhythm: regular. Heart sounds: tones normal. Murmurs: no.

ABDOMEN:

Exam shows: no organomegaly. Tenderness: no. Guarding: no. Liver, Spleen: not palpable.

EXTREMITIES:

Pulses: 2+ bilateral. Clubbing: no. Cyanosis: no. Edema: no.

Assessments

1. Lung cancer - 162.9 (Primary)
2. COPD [Chronic obstructive pulmonary disease] - 496
3. Tobacco abuse - 305.1
4. Restrictive lung disease - 516.8, post bilobectomy

Treatment

1. Lung cancer

c/o Shortness of breath. no Cough, Productive.
no Wheezing. no Chest Tightness. c/o Pleuritic
Chest Pain, at surgery site, right lateral
chest wall.

CARDIOLOGY:

c/o Leg edema. no Palpitations.

GASTROENTEROLOGY:

no Nausea. no Vomiting. no Heartburn.
no Diarrhea.

Reviewed by: Anne Purser.

s/p surgery and plans for chemo per Dr Corso.

-988-

2. COPD [Chronic obstructive pulmonary disease]
continue meds.

3. Tobacco abuse

offered chantix/ wellbutrin, refused at this point. said he is stressed right now.

4. Restrictive lung disease

will monitor with yearly pft's.

5. Others

Refill zolpidem tablet, 5 mg, 1 tab(s), sublingually, 1-2 hs, 30days, 60, Refills 2
Refill Symbicort aerosol with adapter, 160 mcg-4.5 mcg/inh, 2 puff(s), inhaled,
2 times a day, 30 day(s), 1, Refills 11
Refill Proventil HFA aerosol with adapter, CFC free 90 mcg/inh, 2 puff(s),
inhaled, 4 times a day, 30 day(s), 1, Refills 11

Labs

Lab: Spirometry moderately severe obstruction

FVC 2.23/61%

FEV₁ 1.50/51%

%FEV₁ 67%

Anne Purser 1/4/2011 11:02:45 AM > CRUZ, MD, RAUL B 2/9/2011
9:30:00 AM >

Preventive Medicine

Counseling: Pharmacy CVS Union.

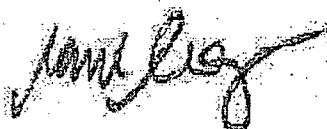
Immunizations: Pneumococcal 2006. Influenza 2010.

Procedure Codes

94010 SPIROMETRY

Follow Up

3 Months



Electronically signed by DR RAUL CRUZ, MD on 03/06/2013 at
10:02 AM EST

Sign off status: Pending

Lung and Chest Medical Associates
2030 North Church Place
Spartanburg, SC 293032799

Patient: FARR, WILLIAM G DOB: [REDACTED] Progress Note: RAUL B CRUZ, MD 01/04/2011

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



Palmetto

Hematology Oncology, P.C.

The Gibbs Cancer Center
380 Serpentine Drive, Suite #200
Spartanburg, South Carolina 29303
(864) 560-7050 FAX: (864) 560-7057

James D. Bearden, III, M.D., F.A.C.P.
Eric C. Nelson, M.D.
Asim R. Pati, M.D.
Steven W. Corso, M.D.
Colin P. Curran, M.D.
Sarah I. Vidito, D.O.
Sharmila Mehta, M.D.

Page: 1

PATIENT: FARR, WILLIAM GAULT
MRN: 14160

D.O.B.: [REDACTED]

OFFICE VISIT:

DATE: 01/17/11

DIAGNOSIS:

- Lung cancer: right upper lobe mass noted October 2010 with FNA revealing bronchioalveolar carcinoma TTF1 positive/CD20 negative/CD7 positive, clinical stage II T2 versus T3 N0 M0; see below.
- Polycythemia vera with intermittent phlebotomies.
- History of rectal cancer in 1997 stage II T3 N0 M0 treated with 5-FU and concomitant radiation.
- Hypertension.
- Hypercholesterolemia.

CURRENT MEDICATIONS:

- Vytarin 10-40 daily
- asa 81 mg daily
- K-Lor-con m20 tid
- nifedipine ER 30 mg every day
- Triamterene/HCTZ 37.25 daily
- Ambien q. h.s.

ALLERGIES: NKDA

TOBACCO: Ongoing use, cessation discussed.

PAIN: 0/0-10

SUBJECTIVE: This is a 68 year-old gentleman seen today for follow up evaluation and discussion. He states he is feeling pretty well since his surgery. He is getting up and moving around without any significant trouble with pain. He does have some dyspnea on exertion. Otherwise there are no new problems.

OBJECTIVE: This is an alert, ambulatory, pleasant white male in no acute distress. Weight 141 pounds. Performance status is 1-2. Temp 99.1, pulse 102 and BP 149/77. Physical exam deferred.



Palmetto

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Sarah I. Vidito, D.O.
Sharmila Mehta, M.D.

Page: 2

PATIENT: FARR, WILLIAM GAULT
MRN: 14160

D.O.B.: [REDACTED]

PATHOLOGY: 12/2/10: right middle and upper lobes with a large 9 cm moderately differentiated adenocarcinoma with papillary features. There are multifocal areas of involvement involving both lobes in 0/13 lymph nodes.

ASSESSMENT/PLAN: Lung cancer: this is an elderly male who is a smoker now status post right upper lobe and middle lobe lobectomies for a moderately differentiated adenocarcinoma. He has a stage III T4 N0 M0 cancer. I spoke with him and his family at length (approximately one hour regarding the surgical results). I explained to them that given the close margins at the right middle lobe bronchial region that radiation may be helpful to maximize local regional control. I recommended radiation evaluation for discussion. We talked about his prognosis and using the adjuvant online tool this estimates about a 33% five year survival rate and an approximately 57% mortality rate from the cancer itself. We talked about the role of adjuvant chemotherapy and three to four cycles of Cisplatin based therapy could reduce the mortality by approximately 7%. We talked about the toxicities involved and I encouraged him to give this some consideration. We will touch base with him in a few weeks regarding his decision.

PLAN:

- Referral to Radiation Oncology.
- Follow up phone call in two weeks.

ELECTRONICALLY APPROVED BY: STEVEN CORSO, MD

DATE/TIME APPROVED: 02/02/11/5:04 PM

TRANSCRIBED BY: PAG

cc: Dr. George Bass
Dr. Christophe Nguyen
Dr. Drew Monitto

RONALD H. LITTLEFIELD, M.D., LLC
319 NORTH PINE STREET
SPARTANBURG, SOUTH CAROLINA 29302

PATIENT NAME: WILLIAM FARR
CHART NO.: 091065

DATE OF VISIT: 01/18/2011

PRESENT ILLNESS: The patient has been hypertensive over a long period of time. Blood pressure has not been ideally controlled recently for no clear reason. The patient really has not been symptomatic.

The patient's dyslipidemia is poorly controlled primarily because of noncompliance and not sticking with the diet as we have instructed the patient to do. There has been a significant increase in the LDL cholesterol.

PAST MEDICAL HISTORY: Was reviewed and there are no changes.

SOCIAL HISTORY: Denies tobacco or alcohol abuse.

ALLERGIES: NO KNOWN ALLERGIES.

REVIEW OF SYSTEMS:

HEAD AND NECK: Denies sore throat or earache. Denies congestion, nasal drainage, and sinus pressure. Denies any problems with eyes. Has occasional headaches.

PULMONARY: Denies shortness of breath, PND (paroxysmal nocturnal dyspnea), or orthopnea. Denies cough, sputum production, or hemoptysis. Denies night sweats.

GASTROINTESTINAL: Denies abdominal pain, nausea, vomiting, hematemesis, constipation, diarrhea, or blood in the stools. Denies any change in bowel habits. Denies rectal pain.

GENITOURINARY: Denies frequency, urgency, or dysuria. Denies change in color of urine.

MUSCULOSKELETAL: Denies arthralgias. Denies swelling or edema. No leg or foot pain. No back pain.

ENDOCRINE: No polyuria, polydipsia, or polyphagia. No weight loss. Denies heat or cold intolerance.

SKIN: Denies recent or chronic rash or irritation. Denies pruritus. Denies easy bruisability.

NEUROLOGICAL: Denies seizure disorder. Denies syncope or pre-syncope. Denies headaches or trouble with speech or walking. No confusion.

PHYSICAL EXAMINATION:

VITAL SIGNS:
Blood Pressure: 132/92
Heart Rate: 76
Respirations: 18
Weight: 137
Height: 65"
BMI: 23

GENERAL: The patient is a well-developed male in no acute distress. Alert, responsive and oriented.

HEENT: ENT inspection is normal. Pupils are equal, round, and reactive to light. Sclerae are nonicteric. No nasal drainage present. Pharynx is without erythema and exudate.

WILLIAM FARR

NECK: Supple. No thyromegaly or lymphadenopathy. Bilateral carotid bruits.

LYMPH NODES: There is no evidence of lymphadenopathy in the axillary or inguinal areas.

PULMONARY: No respiratory distress is noted. AP diameter is normal. Breath sounds are normal.

BREASTS: Deferred.

CARDIOVASCULAR: There is a regular rate and rhythm present. No gallops, lifts or heaves noted. The patient has a 2/6 mitral murmur.

ABDOMEN: The abdomen is nontender. Bowel sounds are normoactive. No organomegaly or masses.

SKIN: Normal turgor. No evidence of rashes, ecchymoses, or petechiae. No cyanosis or pallor.

RECTAL EXAM: Deferred.

EXTREMITIES: Revealed full range of motion without pain or edema.

NEUROLOGICAL EXAM: Alert and oriented times three. Remote and recent memory is intact. Cranial nerves are grossly intact. No evidence of sensory or motor deficits. Mood and affect normal.

ASSESSMENT:

1. Accelerated hypertension.
2. Dyslipidemia.
3. CA of the lung.
4. Nicotine abuse.
5. Mitral regurgitation.
6. Bilateral carotid bruits.

PLAN:

1. The patient's carotid arteries certainly are concerning. Lipids are not well controlled. I placed him on vitamin D and also Niaspan for Lp(a) and ultimately may create cardiovascular problems.
2. His other medical issues discussed today were smoking and his history of CA of the lung, but he is not willing to stop smoking at the present time even though he has CA of the lung.
3. Return to the office in two to three months or p.r.n.

RONALD H. LITTLEFIELD, M.D.

RHL/jm



RHL 0011

RONALD H. LITTLEFIELD, MD., LLC

CHART # 091065DATE: 1-18-11PATIENT NAME: William GarrDOB: [REDACTED]WT: 137 HT: 45" BMI: 23

NOTES: _____

TEMP: _____

BP: 132/82SMOKER: (Y) OR N PKS 3-4 per day YRS 55PULSE: 76 RESP: _____

WELLNESS PHYSICAL: Y OR N

DATE OF PHYSICAL: _____

LAB TEST: YES OR NO

LAST CXR: 2010

NEED NEW RX: YES OR NO

LAST GYN: _____

MEDICATIONS:

NAME GYN: _____

LAST MAMMOGRAM: _____

LAST BONE DENSITY: _____

LAST PSA: 10/07/10

DIABETIC EYE EXAM: _____

DIABETIC FOOT EXAM: _____

NAME OPTOMETRIST: _____

LAST COLONOSCOPY: 2007LAST TETANUS: 2006LAST PNEUMOVAC: 2007LAST FLU SHOT: 10/6/10

Ambien 10mg
 Lorazepam 7.5mg - to 7/96
 Nifedipine 30mg qd
 Vytorin 10/40mg
 Asa 81mg
 Ultracet
 Klor-Con 20mg - TI BID
 Proventil
 Symbicort
 VA 2000

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Spartanburg, SC 29303

Phone (864) 560-1900

Fax (864) 560-1925

www.gibbsurgicaloncology.com

CHRISTOPHE NGUYEN, M.D.

OFFICE NOTE

DATE: January 19, 2011
PATIENT: FARR, WILLIAM
DOB: [REDACTED]

DIAGNOSIS:

1. History of previous colorectal cancer treated by my partner, Dr. Orr, in remission.
2. Non small cell lung cancer right upper lobe, middle lobe adenocarcinoma with papillary features stage pT3, N0, M0, Stage 2B.
3. Status post resection 12/2/10 with postoperative bronchopleural fistula treated with chest tube management now resolved.

INTERVAL HISTORY:

Mr. Farr presents for follow up with me now six weeks out from his operation. He continues to do quite well and is no longer taking any pain medicine. He has resumed his normal activities with full function of his right arm and shoulder. He denies any significant shortness of breath or hemoptysis. His room air saturations today are 96%. He has met with Dr. Corso to discuss possible adjuvant therapy and is confused about the different options. His daughter has researched the potential for Tarceva and at this point they are still debating whether or not to consider any adjuvant therapy.

PHYSICAL EXAMINATION:

Blood pressure is 137/76. Pulse is 77. Temperature is 98.6. Respirations are 26. O2 saturation is 96% on room air. Neck is without cervical or supraclavicular adenopathy. Lungs are clear to auscultation bilaterally. His right thoracotomy incision is completely healed without evidence of infection. Heart has a regular rate and rhythm.

IMPRESSION/PLAN:

As above. Overall Mr. Farr looks quite well and has recovered nicely from his operation. I do feel that he is now in a position where he could receive some therapy depending on his decision on this. As mentioned above, the patient and his family are still confused about the different options and I have offered to present his case at our tumor board to have further insight into his options. They agree with this and I will get back to them after the conference.

Christophe L. Nguyen, M.D.
CLN/mal

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SURGICAL ONCOLOGY

Office Note

Patient: William Farr

NAME AND DATE OF BIRTH VERIFIED: ☒

DATE

BP 137/76 Pulse 77 Temp 98⁶ Resp 26 Weight _____ O2 Sat 96% RA

ALLERGIES REVIEWED ☒ CURRENT MEDICATIONS REVIEWED AND LISTED ☒

CHIEF COMPLAINT: Surry Co - Sick flu

TS
27

WILLIAM FARR 000478684

Radiation Therapy Consultation Note**Date:** January 21, 2011**Dictating Physician:** Drew Monitto, M.D.**Referring Physician:** Christophe Nguyen, M.D./ Steven Corso, M.D.**PATIENT NAME:** Farr, William**SRMC#:** 000478684**Date of Birth:** [REDACTED]**REASON FOR CONSULT:** Lung cancer

~~HISTORY OF PRESENT ILLNESS:~~ The patient is a 68-year-old white male referred by Dr. Corso for consideration of treatment for lung cancer. The patient's primary care physician is Dr. Littlefield. The patient presented in the fall of 2010 with a right middle lobe infiltrate on apparent routine chest x-ray, leading to a CT scan of the chest on October 11, 2010. This revealed atelectasis in the anterior segment of the right upper lobe with adjacent infiltrates. This pattern was suspicious for a possible endobronchial lesion and possibly a lung cancer primary. 2 cysts were seen in the liver. Bronchoscopy was recommended. The patient was referred to pulmonology Dr. Cruz and a PET/CT was performed on October 18, 2010. This showed moderate level hypermetabolic activity corresponding to an opacity in the right upper lobe. Differential diagnosis included infection versus possible bronchioalveolar carcinoma. There were no additional abnormal hypermetabolic foci in the thorax or distantly. The patient then underwent bronchoscopy on October 19, 2010 with biopsies that were nondiagnostic. The patient then underwent a CT-guided needle biopsy of the right upper lobe on October 26, 2010 which showed bronchioalveolar carcinoma, TTF and CD7 positive and CD20 negative. The patient has been seen in the past by Dr. Bearden and Dr. Vidito for polycythemia rubra vera, but they sought out the care of Dr. Corso for the newly diagnosed lung cancer. Dr. Corso evaluated the patient on November 8, 2010. A staging MRI of the brain was recommended and performed on November 10, 2010 which showed no evidence of metastatic disease. Dr. Corso felt that the patient had stage II, T2 versus T3, N0, M0 bronchioalveolar carcinoma of the lung. He felt that the patient was potentially resectable and referred the patient to Dr. Nguyen of thoracic oncologic surgery. After preoperative functional studies, Dr. Nguyen did feel the patient was a surgical candidate. On December 2, 2010 the patient underwent a bronchoscopy, mediastinoscopy and right thoracotomy with bilobectomy (right upper lobe and right middle lobe) by Dr. Nguyen. He also had a mediastinal lymph node dissection. Operative findings were notable for no evidence of metastatic disease. The patient had a grossly abnormal right upper lobe cancer with invasion into the right middle lobe. The patient's surgery was complicated by a prolonged bronchopleural fistula treated conservatively with chest tube management. The patient was hospitalized from December 2 until December 15, 2010. Pathology from the patient's surgery on December 2, 2010 showed a 9 cm grade 2 adenocarcinoma involving the right upper and middle lobe, multifocal and confined to the lung. Margin status was notable for a negative but close margin at the bronchial margin, within millimeters, exact margin with not specified. A total of 13 lymph nodes were dissected and were negative including levels 4L, 7, 4R, 11 and 10. Pathologic stage was actually T4 N0 (stage IIIA) due to presence of cancer in 2 separate lobes. There was no lymphovascular invasion. The patient met back with Dr. Corso on January 17, 2011 for a discussion of adjuvant therapy. The patient reported feeling well following his surgery. The patient has had no major weight loss. Dr. Corso felt that the patient had T4, N0, M0 disease and a significant risk of relapse in mortality from his lung cancer. He discussed the possibility of cisplatin based adjuvant chemotherapy

Electronically Approved By:

Drew Monitto M.D.

January 21, 2011

Def. Prod. Gibbs Surgical Oncology - MR - 0086

GSO 0086

WILLIAM FARR 000478684

and encourage it. He also discussed the possibility of radiation therapy given the close margins of the right middle lobe bronchial margin. Dr. Corso plans to call the patient in approximately a week regarding his decision about chemotherapy. The patient is now referred for radiotherapy opinion.

On questioning, the patient has done quite well after his surgery. He denies any pain or fatigue. He states that overall his exercise capacity is actually improved since his surgery and he has less dyspnea on exertion. He has occasional dry cough. He denies any thoracic pain, hemoptysis or wheezing. He is not on oxygen. He did not lose any weight prior to diagnosis or after surgery. Pain and fatigue scores are 0/10 and 3/10, respectively.

PAST MEDICAL HISTORY:

- COPD-FEV1 in November 2010 prior to surgery and was 1.61 L
- Polycythemia rubra vera treated with phlebotomy
- History of rectal cancer T3, N0, M0 status post treatment for SWOG 9304 with Dr. Bearden and received chemotherapy and radiotherapy and surgery in 1997. Records regarding prior pelvic radiation are being sought
- Hypertension
- Hypercholesterolemia
- History depression
- PRIOR EXTERNAL RADIATION AS DESCRIBED ABOVE

PAST SURGICAL HISTORY:

- Hernia repair
- Abdominoperineal resection with permanent colostomy for rectal cancer
- See history of present illness

MEDICATIONS:

Vytorin 10-40 mg	1 by mouth daily
Aspirin 81 mg	1 by mouth daily
Klor-con m 20	1 by mouth 2 x day
Nifedipine er 30 mg	1 by mouth daily
Triam/ hctz 37/25mg	1 by mouth daily
Ambien	1 by mouth daily as needed for sleep
Multivitamin	1 by mouth daily

ALLERGIES: No known drug allergies

SOCIAL HISTORY: The patient lives in Union. The patient is married and has 2 grown children. He presents with his daughter today who is supportive. The patient is retired. He used to run a convenience store. He smoked one pack a day of cigarettes for 50 years, and currently down to 5 or 6 cigarettes a day. I recommend smoking cessation. He trying to quit on his own and plans to use smokeless cigarettes help him. He drinks 2-4 beers daily. He did not use illicit drugs.

FAMILY HISTORY: Notable for prostate cancer in his father. His father died of prostate cancer at age 88. A paternal grandfather had colon cancer and a paternal uncle had esophageal cancer.

REVIEW OF SYSTEMS: See enclosed review of systems form. All systems have been reviewed. This is notable for mild dyspnea and orthopnea.

Electronically Approved By:

Drew Monitto M.D.

January 21, 2011

WILLIAM FARR 000478684

PHYSICAL EXAMINATION: Vital signs: Blood pressure 145/88, pulse 81, afebrile, 5 foot 5 inches, 139.2 pounds. This is a petite elderly gentleman who appears well-nourished. The patient is alert and oriented and in no acute distress. He is in no respiratory distress. There is no scleral icterus or jaundice. Pupils are equal and reactive to light. Oral exam is clear without lesions in oral cavity. He has native dentition with a partial denture. There is no palpable cervical, supraclavicular or axillary adenopathy. The patient has a well-healed thoracotomy scar on the right. Breath sounds are somewhat distant with evidence of some volume loss on the right as expected. Lungs are clear to auscultation and percussion, and with normal diaphragmatic excursion. No wheezes or rales were noted. Heart has a regular rate and rhythm with distinct S1-S2. Abdomen is soft nontender, positive bowel sounds, without organomegaly. The patient is a well-functioning colostomy. Neurologic exam is nonfocal. Extremities are without clubbing cyanosis or edema.

ADDITIONAL DATA:

Radiographic data: See history of present illness

Laboratory data: November 8, 2010: White blood cell count 10.6 hemoglobin 15.4 and platelet count 355,000.

Pulmonary function tests: November 11, 2010: FEV1 1.61, 65% of predicted with DLCO 51% of predicted. Postoperatively function tests are not available.

ASSESSMENT: This is a 68-year-old white male status post thoracotomy December 2, 2010 for pathologic stage IIIA, T4, N0, M0 (due to multifocal tumor in 2 different lobes) stage IIB non-small cell carcinoma, adenocarcinoma, with a close bronchial margin. The patient has excellent performance status.

RECOMMENDATIONS:

The patient's case will be discussed at the Thoracic Multidisciplinary Conference next week. Final recommendations will be made at that time. The patient has been appropriately offered adjuvant systemic therapy by Dr. Corso. With regards to adjuvant radiotherapy, I would like to review his pathology and margin status. If his bronchial margin were positive, I think there is a role for postoperative adjuvant radiotherapy. However, given the pathology report that the margin was negative although close, I think that radiotherapy is likely not indicated. I discussed this with Dr. Nguyen who is in agreement. I have explained my initial impressions to the patient and his daughter but stated final recommendations will be made after the conference.

PLAN:

- Presentation next week at Thoracic Multidisciplinary Conference
- Full recommendations to follow, see discussion above regarding initial impressions

Thank you very much for referring the patient and allowing me to participate in their care.

Drew Monitto, M.D.

Please send a copy to Dr. Nguyen

Dictated using Dragon Naturally Speaking
Electronically Approved By:

Electronically Approved By:

Drew Monitto M.D.

January 21, 2011

Def. Prod. Gibbs Surgical Oncology - MR - 0088

GSO 0088

WILLIAM FARR 000478684

Drew Monitto M.D.
January 21, 2011

Electronically Approved By:
Drew Monitto M.D.
January 21, 2011

Def. Prod. Gibbs Surgical Oncology - MR - 0089

GSO 0089

SURGICAL ONCOLOGY AT THE GIBBS CANCER CENTER

101 East Wood Street

Spartanburg, SC 29303

Phone (864) 560-1900

Fax (864) 560-1925

www.gibbsurgicaloncology.com

CHRISTOPHE NGUYEN, M.D.

OFFICE NOTE

DATE: February 2, 2011
PATIENT: FARR, WILLIAM
DOB: [REDACTED]

DIAGNOSIS:

1. History of previous colorectal cancer treated by Dr. Orr, in remission.
2. Non small cell lung cancer right upper lobe, right middle lobe adenocarcinoma with papillary features stage pT3, N0, M0 stage 2B negative margins status post resection 12/2/10.

INTERVAL HISTORY:

Mr. Farr presents for follow up with me with his family regarding concerns about adjuvant therapy. He is now approximately two months out from his operation. He has met with Dr. Corso and his case was presented at our multidisciplinary conference. Recommendations were for either observation or for contemporary adjuvant therapy. The issue of Tarceva was raised and thought to be best reserved for situations in which the cancer has returned or is metastatic. The patient has spoken with Dr. Corso and would like to have an additional opinion regarding his adjuvant therapy. Clinically he denies any worsening shortness of breath, any productive cough or any fever or chills.

PHYSICAL EXAMINATION:

Blood pressure is 128/75. Pulse is 79. Temperature is 97.3. O2 saturation is 98%. Lungs are clear to auscultation bilaterally. His incision is completely healed. Heart has a regular rate and rhythm.

IMPRESSION/PLAN:

As above. I spent approximately 30 minutes with the family and also discussed this with Dr. Corso that the best plan of action would be to send Mr. Farr for an opinion to either Duke or MUSC. We will be happy to assist him in whatever capacity we can but it appears that Dr. Corso's office will help with this. From a clinical surgical perspective I feel that he is recovering nicely and we will see him back for follow up in the next few months.

Christophe L. Nguyen, M.D.
CLN/mal

NS

SURGICAL ONCOLOGY

Office Note

nt: William Fan NAME AND DATE OF BIRTH VERIFIED: ☒

BP 128/75 Pulse 79 Temp 97.3 Resp _____ Weight _____ O2 Sat 98%

ALLERGIES REVIEWED ☒ CURRENT MEDICATIONS REVIEWED AND LISTED ☒

CHIEF COMPLAINT: talk to Dr. Nguyen

TO
NS

MUSC
MEDICAL UNIVERSITY
OF SOUTH CAROLINA

MR# 47-86-84

JDW

Department of Pathology and Lab Medicine
165 Ashley Avenue, Suite 309
PO Box 250908
Charleston, SC 294253-1-11
Dr. Nguyen

Page: 1 of 3

560-1925

Req. Physician: Simon, George
Att. Physician: Simon, George
LOC: PCON - Path Consult
Client: Medical University Hospital AuthorityPatient: FARR, WILLIAM
Med Rec: 1798277
DOB: [REDACTED] Age: 68 years
Sex: Male Race: White**S u r g i c a l P a t h o l o g y F i n a l R e p o r t**Date Collected
2/14/2011Date and Time Received
2/14/2011 1:11:00 PMAccession Number
SC-11-03348**Surg Copy To**Spartanburg Regional Medical Center
Department of Pathology
101 East Wood Street
Spartanburg, SC 29303
Phone: (864) 560-6212
Fax: (864) 560-6049**Diagnosis**

OUTSIDE SLIDES (S10-15710)

A. LYMPH NODES, LABELED AS "4L", EXCISION:

- FRAGMENTS OF BENIGN LYMPH NODE TISSUE
- NO CARCINOMA IDENTIFIED

B. LYMPH NODE, LABELED AS "LEVEL 7", EXCISION:

- FRAGMENTS OF BENIGN LYMPHOID TISSUE
- NO CARCINOMA IDENTIFIED

C. LYMPH NODE, LABELED AS "4R", EXCISION:

- FRAGMENTS OF BENIGN LYMPHOID TISSUE
- NO CARCINOMA IDENTIFIED

D. LUNG, LABELED AS "RIGHT UPPER AND MIDDLE LOBES", BILOBECTOMY:

- TUMOR HISTOLOGIC TYPE: ADENOCARCINOMA, PAPILLARY PREDOMINANT HISTOLOGIC SUBTYPE
- HISTOLOGIC GRADE: WELL TO MODERATELY DIFFERENTIATED
- TUMOR SPECIMEN: RIGHT UPPER AND MIDDLE LOBES
- PROCEDURE: BILOBECTOMY
- SPECIMEN INTEGRITY: INTACT
- SPECIMEN LATERALITY: RIGHT
- TUMOR SITE: DOMINANT, 9 CM MASS AT JUNCTION OF UPPER AND MIDDLE LOBE AND INVOLVING PARENCHYMA OF BOTH LOBES
- TUMOR SIZE: 9 CM IN GREATEST DIMENSION (DOMINANT MASS); 0.9 CM SECOND NODULE IN UPPER LOBE
- TUMOR FOCALITY: MULTIFOCAL; SEPARATE NODULES IN DIFFERENT IPSILATERAL LOBES
- VISCERAL PLEURAL INVASION: INDETERMINATE (PLURAL DISCONTINUITY)
- TUMOR EXTENSION: TUMOR CONFINED TO LUNG
- MARGINS:

Department of Pathology and Laboratory Medicine

Chair: Janice M. Lage, M.D.

Director: Janice M. Lage, M.D.

Anatomic Pathology
Phone: 843-792-3821
Fax: 843-792-8974Autopsy Pathology
Phone: 843-792-3556
Fax: 843-792-8974Client Services
Phone: 843-792-0707
Fax: 843-792-4896Clinical Pathology
Phone: 843-792-0707
Fax: 843-792-4896

Patient: FARR, WILLIAM

Medical Record: 1798277

Location: PCON

MUSC
MEDICAL UNIVERSITY
OF SOUTH CAROLINA**Department of Pathology and Lab Medicine**165 Ashley Avenue, Suite 309
PO Box 250908
Charleston, SC 29425

Page: 2 of 3

Req. Physician: Simon, George
Att. Physician: Simon, George
LOC: PCON - Path Consult
Client: Medical University Hospital Authority**Patient: FARR, WILLIAM**

Med Rec: 1798277

DOB: [REDACTED] Age: 68 years

Sex: Male Race: White

S u r g i c a l P a t h o l o g y F i n a l R e p o r tDate Collected
2/14/2011Date and Time Received
2/14/2011 1:11:00 PMAccession Number
SC-11-03348

- **BRONCHIAL MARGIN: UNINVOLVED BY INVASIVE CARCINOMA**
 - **VASCULAR MARGIN: UNINVOLVED BY INVASIVE CARCINOMA**
 - **PARENCHYMAL MARGIN: UNINVOLVED BY INVASIVE CARCINOMA**
 - **TREATMENT EFFECT: NOT APPLICABLE**
 - **LYMPHOVASCULAR INVASION: NOT IDENTIFIED**
 - **LYMPH NODES:**
 - **EIGHT BENIGN PERIBRONCHIAL LYMPH NODES (0/8)**
 - **THIRTEEN TOTAL BENIGN LYMPH NODES (0/13) (SPECIMENS A-F)**
 - **PATHOLOGIC STAGING (pTNM): pT4 pN0 (SEPARATE TUMOR NODULE(S) IN A DIFFERENT IPSILATERAL LOBE)**
 - **ADDITIONAL PATHOLOGIC FINDINGS: EMPHYSEMA**
- E. LYMPH NODE, LABELED AS "LEVEL ELEVEN", EXCISION:**
- **FRAGMENTS OF BENIGN LYMPHOID TISSUE**
 - **NO CARCINOMA IDENTIFIED**
- F. LYMPH NODE, LABELED AS "LEVEL 10", EXCISION:**
- **FRAGMENTS OF BENIGN LYMPHOID TISSUE**
 - **NO CARCINOMA IDENTIFIED**

Comment

This diagnosis essentially correlates with that rendered by the outside pathologist. The only discrepancy is the pathologic TNM designation. Based on the outside report, two distinct nodules are seen: the dominant 9 cm mass located at the junction of the upper and middle lobes and involving parenchyma of both lobes, and a separate 0.9 cm subpleural nodule in the apical aspect of the upper lobe. This area from the apical upper lobe was submitted in cassette D7 for microscopic examination and shows tumor. According to the 7th ed. AJCC Staging Manual, this describes a pT4 lesion.

Slides will be retained.

Tissue Source

A OUTSIDE SLIDE 14slid/S10-15710/MB

Clinical Information

Right lung cancer

Department of Pathology and Laboratory Medicine

Chair: Janice M. Lage, M.D.

Director: Janice M. Lage, M.D.

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Patient: FARR, WILLIAM

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Location: PCON

MUSC
MEDICAL UNIVERSITY
OF SOUTH CAROLINA

Department of Pathology and Lab Medicine
165 Ashley Avenue, Suite 309
PO Box 250908
Charleston, SC 29425

Page: 3 of 3

Req. Physician: Simon, George
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Client: Medical University Hospital Authority

Patient: FARR, WILLIAM
Med Rec: 1798277
DOB: [REDACTED] Age: 68 years
Sex: Male Race: White

S u r g i c a l P a t h o l o g y F i n a l R e p o r t

Date Collected
2/14/2011

Date and Time Received
2/14/2011 1:11:00 PM

Accession Number
SC-11-03348

Gross Description

Received from Spartanburg Regional Medical Center in Spartanburg, South Carolina are fourteen H&E stained slides labeled with the accession number S10-15710 and a corresponding surgical pathology report dated 12/6/10. The slides contain the additional labeling of A FS, B FS, C FS, D FS, D1-D8, E1 and F1.

Masha Bilic, M.D./ RW

Microscopic Description

All microscopic sections with this case were examined, and the result(s) of each examination is/are incorporated in the above diagnosis(es). - Paul Eberts, M. D.

Masha Bilic, M.D./ RW

Certification Statement

I certify that I personally conducted the diagnostic evaluation of the above specimen(s) and have rendered the above diagnosis(es).

Masha Bilic, M.D.
(Electronically signed by)
Verified: 02/21/2011 03:47
MB /RW

Department of Pathology and Laboratory Medicine

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Fax: 843-792-4896

Clinical Pathology
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Fax: 843-792-4896

Patient: FARR, WILLIAM

Medical Record: 1798277

Location: PCON

Progress Notes**Page: 1**

Name: FARR, WILLIAM

Date Printed: 02/15/11

ID: 1798277 SEX:M AGE:68

02/15/11 : 03:19pm

HEMATOLOGY/ONCOLOGY NEW PATIENT VISIT
MEDICAL UNIVERSITY OF SOUTH CAROLINA
g2rDr Christophe Nguyen
101 East Wood Street
Spartanburg, SC 29303
864-560-1925
Dear Dr. Nguyen,

I had the pleasure of seeing your patient Mr Farr, with Dr George Simon today in clinic. He was referred for consideration of adjuvant chemotherapy for his stage IIB lung cancer. Please see my notes below.

CHIEF COMPLAINT/DIAGNOSIS: NSCLC, adenocarcinoma variety, T3N0 stage IIB

HISTORY OF PRESENT ILLNESS: 68 year male with COPD and a history of rectal cancer was undergoing routine chest xray and an infiltrate was seen. He then had a CT scan which showed an abnormal infiltrate in the RML with involvement of the basilar segment of the RUL. PET CT revealed hypermetabolic activity (SUV 5) in this area only. He went to surgery in early 12/2010 and had a RUL and RML with mediastinoscopy. All nodes were negative, the pathology was consistent with an adenocarcinoma 9 x 8.5 x 5 cm with negative margins. The patient has been doing well with no problems since hospital discharge. He is breathing well with some chronic SOB but able to do yard work and walk about one mile. He has minimal cough with clear sputum production. No chest pain, no headaches, no fevers, chills, visual changes. No N/V/D. no bony pains.

PAST MEDICAL HISTORY: COPD
colorectal cancer in the 1990's s/p resection, chemo and XRT
HTN
HLD

FAMILY HISTORY: father with prostate cancer at age 88

SOCIAL HISTORY: 1 ppd for 55 years still smoking, drinks beer, used to own a liquor store, lives in Union, SC
ROS - as per HPI: The patient has been doing well with no problems since hospital discharge. He is breathing well with some chronic SOB but able to do yard work and walk about one mile. He has minimal cough with clear sputum production. No chest pain, no headaches, no fevers, chills, visual changes. No N/V/D. no bony pains.

CURRENT MEDICATIONS:Rx: ASPIRIN 81MG daily
Rx: LISINAPRIL-HYDROCHLOROTHIAZIDE 10MG DAILY
Rx: METFORMIN HCL 1000MG DAILY
Rx: MVI DAILY
Rx: PRAVASTATIN SODIUM 80MG DAILY2/15/11
M**ALLERGIES:**
NKA**PHYSICAL EXAM:**Bp: 125/85, Pulse: 92
Temperature: 97.6 F, Height: 160.5 cm, Weight: 63.9 kg
RESPIRATIONS: 20 on 02/15/2011
Bp: 125/85, Pulse: 92
Temperature: 97.6 F, Height: 160.5 cm, Weight: 63.9 kg
WEIGHT IN LBS: 140.8 lbs on 02/15/2011

Printed using Practice Partner®

Progress Notes

Page: 2

Name: FARR, WILLIAM

Date Printed: 02/15/11

ID: 1798277 SEX:M AGE:68

General: Well appearing, well nourished in no distress. Normal affect.
Skin: Good turgor, no rash or prominent lesions
Head: Normocephalic, atraumatic
Eyes: Conjunctivae clear, sclerae non-icteric
Pharynx: Mucosa non-inflamed, no tonsillar hypertrophy or exudate
Neck: Supple, without lesions or adenopathy
Heart: Regular rate, no murmur or gallop
Lungs: Clear to auscultation
Abdomen: Bowel sounds nl, no tenderness, organomegaly, masses, or umbilical hernia; colostomy in place
Back: Spine normal without deformity or tenderness, no costovertebral angle (CVA) tenderness, no spinous or sacroiliac tenderness
Extremities: No cyanosis, edema or varicosities

LABS:

ASSESSMENT/PLAN: 68 yo WM with NSCLC, adenocarcinoma, T3N0, brain MRI negative, stage IIB. He has had a complete resection of his tumor with negative margins and lymph nodes. At this point, we would recommend adjuvant chemotherapy to improve his 5 yr overall survival. We spent over 30 minutes discussing the role of chemotherapy in this setting. He could be expected to have a 5-15% improvement in his 5 yr overall survival from adjuvant chemotherapy. Since he has adenocarcinoma, we would recommend adjuvant treatment with cisplatin and pemetrexed every 3 weeks for four cycles. Cisplatin and pemetrexed is an accepted adjuvant chemotherapy regimen with ECOG 1505 trial using this regimen as a reference arm. We have reviewed the potential side effects including but not limited to neutropenic sepsis, kidney and hearing damage, nausea vomiting, anemia, fatigue. He and his family report they would like to receive treatment closer to home and would like to have treatment with Dr Bearden. I will fax him a copy of this note as well.

Return to clinic in prn

cc: James D Bearden.

HON CC: Simon

SIGNED BY SARA E ADAMS, MD (FELLOW) (K18) 02/15/2011 03:50PM
REVISED BY SARA E ADAMS, MD (FELLOW) (K18) 02/15/2011 03:51PM



Palmetto

Hematology Oncology, P.C.

The Gibbs Cancer Center
380 Serpentine Drive, Suite #200
Spartanburg, South Carolina 29303
(864) 560-7050 FAX: (864) 560-7057

James D. Bearden, III, M.D., F.A.C.P.
Eric C. Nelson, M.D.
Asim R. Pati, M.D.
Steven W. Corso, M.D.
Colin P. Curran, M.D.
Sarah I. Vidito, D.O.
Sharmila Mehta, M.D.

Page: 1

PATIENT: FARR, WILLIAM GAULT
MRN: 14160

D.O.B.: [REDACTED]

OFFICE VISIT:

DATE: 02/22/11

DIAGNOSIS:

- Lung cancer: right upper lobe mass noted October 2010 with FNA revealing bronchioalveolar carcinoma TTF1 positive/CD20 negative/CD7 positive, clinical stage II T2 versus T3 N0 M0; see below.
- Polycythemia vera with intermittent phlebotomies.
- History of rectal cancer in 1997 stage II T3 N0 M0 treated with 5-FU and concomitant radiation.
- Hypertension.
- Hypercholesterolemia.

CURRENT MEDICATIONS:

- Vytorin 10-40 daily
- ASA 81 mg daily
- Klor-Con m20 tid
- Nifedipine ER 30 mg every day
- Triamterene/HCTZ 37.25 daily
- Ambien q. h.s.

ALLERGIES: NKDA

TOBACCO: Patient has cut down to 7-8 cigarettes a day, cessation discussed. The patient refuses formal smoking cessation program.

PAIN: 0/0-10

SUBJECTIVE: This is a 68 year-old gentleman seen today for follow up of his lung cancer. The patient was previously a patient of Dr. Corso and we are now taking over his care.



Palmetto

Hematology Oncology, P.C.

The Gibbs Cancer Center
380 Serpentine Drive, Suite #200
Spartanburg, South Carolina 29303
(864) 560-7050 FAX: (864) 560-7057

James D. Bearden, III, M.D., F.A.C.P.
Eric C. Nelson, M.D.
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Steven W. Corso, M.D.
Colin P. Curran, M.D.
Sarah I. Vidito, D.O.
Sharmila Mehta, M.D.

Page: 2

PATIENT: FARR, WILLIAM GAULT
MRN: 14160

D.O.B.: [REDACTED]

In the interim, he has recently been to MUSC to see Dr. George Simon who has recommended adjuvant chemotherapy with Cisplatin and Alimta and he is here to discuss that. The patient reports that he is feeling fairly well. He has no new complaints. He states that he has continued to have some mild to moderate pain at the site of his surgery, but otherwise is ambulatory, mobile and feeling quite well. He states that he has had some difficulty sleeping the last two to three days. He has been taking his Ambien, but states that it hasn't been working like it previously had. He otherwise has no new complaints or medical problems.

PAST MEDICAL HISTORY: He has a past medical history of high blood pressure, history of rectal carcinoma and polycythemia.

REVIEW OF SYSTEMS: All systems reviewed and negative except as mentioned per HPI.

OBJECTIVE: Vital signs: Temperature 98.4, blood pressure 122/84, pulse is 101. General: This is a well-developed, well-nourished Caucasian male in no acute distress. HEENT: sclerae anicteric. Oropharynx is clear. His neck is supple. Lung clear to auscultation. He has decreased breath sounds on the right base. Well-healed incision site. Cardiovascular: Regular rate and rhythm. Abdomen: soft, nontender and nondistended. Extremities: No clubbing, cyanosis or edema.

LABS:

- WBC 9.9, hemoglobin 14.4, hematocrit 43.2, platelet count 319.
- Sodium 139, potassium 3.8, BUN 17, creatinine 1.3.

ASSESSMENT/PLAN:

- History of stage IIB non small cell lung cancer status post resection: At this time, the patient is planning on undergoing chemotherapy with Cisplatin and Alimta at the recommendations of Dr. Simon at MUSC.



Palmetto

Hematology Oncology, P.C.

The Gibbs Cancer Center
380 Serpentine Drive, Suite #200
Spartanburg, South Carolina 29303
(864) 560-7050 FAX: (864) 560-7057

James D. Bearden, III, M.D., F.A.C.P.
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Sarah I. Vidito, D.O.
Sharmila Mehta, M.D.

Page: 3

PATIENT: FARR, WILLIAM GAULT
MRN: 14160

D.O.B.: [REDACTED]

Risks, benefits and side effects associated with treatment have been discussed with him and his daughter at length. He has gone ahead and signed chemotherapy consent. I have given him premedications with Phenergan and Decadron to take prior to his chemotherapy. He is to remain on his folic acid and he will get a B12 injection today. I spent greater than 60 minutes with them discussing the risks, benefits and side effects associated with treatment.

- Tobacco abuse: At this time, we did discuss formal smoking cessation. The patient is not interested. He states that he would like to cut down on his own. He has cut down to just 7-8 cigarettes a day. I encouraged him to continue to try to quit. The patient will return to see us in three weeks time, sooner if needed.

ELECTRONICALLY APPROVED BY: SHARMILA MEHTA, MD

DATE/TIME APPROVED: 03/15/11/2:38 PM

TRANSCRIBED BY: LB

cc: Dr. Christophe Nguyen
Dr. Ron Littlefield

OP REPORT

PATIENT NAME: FARR, WILLIAM G
DOB: [REDACTED]
MEDICAL RECORD #: 478684
PROCEDURE DATE: 03/10/2011
ACCOUNT NUMBER: 1106200081
ROOM:

ATTENDING SURGEON
Dr. Nguyen.

RESIDENT PHYSICIAN
Dr. Imbertson

PROCEDURE PERFORMED
Insertion of left internal jugular Port-A-Cath

INDICATION FOR PROCEDURE
Mr. Farr is a 68 year old male with right-sided lung cancer.

ANESTHESIA
MAC and local

SPECIMENS
None.

ESTIMATED BLOOD LOSS
Minimal.

DESCRIPTION OF PROCEDURE

The patient was brought to the operating room, identified and placed in the supine position on the operating room table. The patient underwent MAC and a time-out was performed and the correct patient and procedure were identified. The patient received antibiotics preoperatively. The patient was prepped and draped in the usual sterile fashion exposing the left internal jugular. Using ultrasound guidance the left internal jugular vein was identified and accessed with a 18 gauge needle. Guide wire was introduced down into the superior vena cava. Using the Seldinger technique an introducer sheath was placed over the guide wire and the guide wire was then removed. Afterwards an 8 French catheter was placed into the superior vena cava. Placement was confirmed during fluoroscopy. After this a subcutaneous pocket was created one fingerbreadth below the left clavicle using a 15 blade scalpel and electrocautery a subcutaneous tunneler device was used to tunnel the catheter in the pocket created to site where the guidewire was placed. The catheter was then pulled through this tunnel and brought out to the site of the

OP REPORT

FARR, WILLIAM G
478684
PHYSICIAN COPY

Page 1 of 2

ADMITTING

Note: Document is draft unless signed

port. The port was connected and placed in the pocket. At this time the port was sutured in place with Prolene suture and the port was flushed with heparinized saline and had good blood flow and flushed very easily. Position was then confirmed by fluoroscopy. The subcutaneous pocket of the port chamber was closed in layers and a single stitch was placed over the guidewire insertion site. Dermabond was applied over the incisions. The patient was awakened and transferred to PACU in stable condition.

Dictated by: ERICK IMBERTSON, M.D.

D:03/12/2011 07:40:22
T:03/12/2011 13:48:45/lbr
1075805/934550

cc: CHRISTOPHE NGUYEN, MD, Admitting Physician

OP REPORT
FARR, WILLIAM G
478684
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Page 2 of 2

ADMITTING

Note: Document is draft unless signed.



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Page: 1

PATIENT: FARR, WILLIAM GAULT
MRN: 14160

D.O.B.: [REDACTED]

OFFICE VISIT:

DATE: 03/21/11

DIAGNOSIS:

- Patient status post one cycle of Cisplatin/Alimta for stage II non small cell lung cancer status post resection to receive C#2 3/22/11.
- Lung cancer: right upper lobe mass noted October 2010 with FNA revealing bronchioalveolar carcinoma TTF1 positive/CD20 negative/CD7 positive, clinical stage II T2 versus T3 N0 M0; see below.
- Polycythemia vera with intermittent phlebotomies.
- History of rectal cancer in 1997 stage II T3 N0 M0 treated with 5-FU and concomitant radiation.
- Hypertension.
- Hypercholesterolemia.

ALLERGIES: NKDA

TOBACCO: Patient smokes 7-8 cigarettes a day and not interested in smoking cessation.

PAIN: 0/0-10

SUBJECTIVE: Mr. Farr presents today for follow up. He reports that things are going fairly well. After his first cycle of chemotherapy he did feel overall week and tired. His appetite was decreased. He did have a couple of mouth sores but he denied having any problems with nausea, vomiting or diarrhea. He feels like his energy is almost back to normal. He states he felt the best yesterday he had in a long time although he is not feeling quite as well today. He denies having any fever, chills, coughing, shortness of breath, nausea, vomiting, or diarrhea. He



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Page: 2

PATIENT: FARR, WILLIAM GAULT
MRN: 14160

D.O.B.: [REDACTED]

does have shortness of breath which is unchanged. He is eating and drinking without difficulty. His energy level is fairly good.

FAMILY HISTORY: Reviewed and unchanged from initial consultation.

SOCIAL HISTORY: Reviewed and unchanged from initial consultation.

REVIEW OF SYSTEMS: All systems reviewed and are negative, except as mentioned in HPI.

PHYSICAL EXAM: Generally the patient is a well-developed, well-nourished man in no acute distress. Temp 98.9, BP 121/74, pulse 104, weight 141.4 pounds. Skin: no rash. HEENT: no conjunctival pallor or jaundice. There are no oral ulcers. Lungs are clear to auscultation bilaterally. Heart is S1, S2 without murmur. Abdomen is soft, nontender and nondistended. Extremities are without edema.

LABS: WBC 4.4, hemoglobin 15.4, hematocrit 45.9, platelets 529,000, ANC 3.6. CMP is within normal limits with the exception of an elevated glucose of 141 and decreased carbon dioxide of 22.

ASSESSMENT/PLAN:

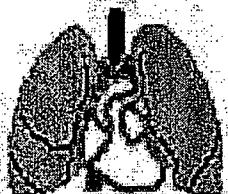
- History of stage IIB non small cell lung cancer currently on treatment with Cisplatin/Alimta given in the adjuvant setting. At this time the patient is tolerating his therapy fairly well. He does get fatigued after therapy. We will proceed with C#2.
- He will return to see us in three weeks or sooner if needed.

ELECTRONICALLY APPROVED BY: SHARMILA MEHTA, MD

DATE/TIME APPROVED: 03/30/11/5:14 PM

TRANSCRIBED BY: PAG

cc: Dr. Christophe Nguyen
Dr. Ron Littlefield



04/04/2011

RAUL B CRUZ, MD

Current Medications

nifedipine 30 mg tablet, extended release 1 tab(s) once a day
Aspir 81 81 mg enteric coated tablet 1 tab(s) once a day
Triam/HCTZ 37.5/25 1 tab QD
Vytarin 10 mg-40 mg tablet 1 tab(s) once a day
Symbicort 160 mcg-4.5 mcg/inh aerosol with adapter 2 puff(s) 2 times a day
Proventil HFA CFC free 90 mcg/inh aerosol with adapter 2 puff(s) 4 times a day
zolpidem 5 mg tablet 1 tab(s) 1-2 hs
Klor-Con M20 20 mEq tablet, extended release 2 tabs bid
dexamethasone 4 mg tablet 2 tabs bid before and after chemo tx
Norco 325 mg-7.5 mg tablet 1 tab(s) every 6 hours
folic acid 1 mg tablet 1 tab(s) once a day
promethazine 50 mg tablet 1 tab(s) every 6 hours
Medication List reviewed and reconciled with the patient

Past Medical History

Copd
Cough
Hypertension
Colon cancer

Surgical History

hernia repair
colostomy for colon cancer radiation and chemo tx 1989
nasal surgery

Family History

Mother: deceased old age
Father: deceased cancer bone
Siblings: 3 brother, 3 sister
History positive for: hypertension, cancer.

Social History

Tobacco Use: yes, PPD: 1, years: 50.
Marital status: Married.
Education level: 11t.
Occupation: retired.
Anyone else in home smoke?: no.
Alcohol: reports, beer.
Other MDs: Primary care Dr Littlefield, Dr Corso.

Allergies

NKDA

Review of Systems

SLEEP HISTORY:

Snoring c/o. no Day-Time Sleepiness.

Reason for Appointment

1. 3 MO F/U W/SPIRO
2. Occ cough with clear secretion and occ wheezing. Dyspnea about same.
3. Pt has 2 more chemo treatment. Pt continues to smoke some.

History of Present Illness

Interim History:

still smoking, wants to quit, 1/2 ppd
- tried chantix, unable to tolerate (bad dreams)
- compliant with medications
- no recent hospitalization for copd
- lung cancer followed by Dr Mehta.

Vital Signs

Wt 141.7, BP 140/80, HR 75, O2 sat 96%, FIO2 .21, FVC 2.49, FEV1 1.51, FEV1/FVC% 61%, Ht 64, Temp 97.9, BMI 24.32.

Physical Examination

GENERAL:

General Appearance: No acute distress.

HEENT:

Head: normocephalic. Pharynx: oropharynx clear. Pupils: symmetric. Sclera: anicteric. EOM: intact. Nose: normal. Nasal septum: midline. Oral cavity: normal.

NECK:

Neck: supple, no jugular venous distention, trachea midline. Cervical lymph nodes: normal. Thyroid: not enlarged.

CHEST:

Shape and expansion: symmetrical chest expansion. Wheezes: no. Rales: no. Rhonchi no.

HEART:

PMI: PMI not displaced. Rhythm: regular. Heart sounds: tones normal. Murmurs: no.

ABDOMEN:

Exam shows: no organomegaly. Tenderness: no. Guarding: no. Liver, Spleen: not palpable.

EXTREMITIES:

Pulses: 2+ bilateral. Clubbing: no. Cyanosis: no. Edema: no.

Assessments

1. COPD [Chronic obstructive pulmonary disease] - 496 (Primary)
2. Lung cancer - 162.9
3. Tobacco abuse - 305.1
4. Restrictive lung disease - 516.8, post bilobectomy

no Fatigue on Wakening.

CONSTITUTIONAL:

no Fever/Chills. no Night sweats.

RESPIRATORY:

c/o Shortness of breath, at baseline. Cough,

Productive clear secretions. no Wheezing.

no Chest Tightness. no Pleuritic Chest Pain.

CARDIOLOGY:

Leg edema occasionally. no Palpitations.

GASTROENTEROLOGY:

no Nausea. no Vomiting.

c/o Heartburn, occasional. no Diarrhea.

Reviewed by: Anne Purser.

Treatment

-1016-

1. COPD [Chronic obstructive pulmonary disease]

Continue Symbicort aerosol with adapter, 160 mcg-4.5 mcg/inh, 2 puff(s), inhaled, 2 times a day

Continue Proventil HFA aerosol with adapter, CFC free 90 mcg/inh, 2 puff(s), inhaled, 4 times a day

2. Lung cancer

LAB: Spirometry moderate to sever obstruction, stable

FVC 2.49/68%

FEV1 1.51/53%

%FEV1 61%

Odom, Jessica 4/4/2011 10:01:30 AM > CRUZ, MD, RAUL B 4/4/2011 11:02:18 AM >

3. Tobacco abuse

Start Wellbutrin SR tablet, extended release, 150 mg, 1 tab(s), orally, 2 times a day, 30 day(s), 60, Refills 2

counselled, will try wellbutrin. Followup in 6 weeks for further counselling and monitoring of response.

Preventive Medicine

Counseling: Pharmacy CVS Union.

Immunizations: Pneumococcal 2006. Influenza 2010.

Procedure Codes

94010 SPIROMETRY

Follow Up

6 Weeks



Electronically signed by DR RAUL CRUZ, MD on 03/06/2013 at 10:02 AM EST

Sign off status: Pending

Lung and Chest Medical Associates
2030 North Church Place
Spartanburg, SC 293032799
Tel: 864-582-6858
Fax: 864-542-9043

Patient: FARR, WILLIAM G DOB: [REDACTED] Progress Note: RAUL B CRUZ, MD 04/04/2011

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

RONALD H. LITTLEFIELD, M.D., LLC
319 NORTH PINE STREET
SPARTANBURG, SOUTH CAROLINA 29302

PATIENT NAME: WILLIAM FARR
CHART NO.: 091065

DATE OF VISIT: 04/11/2011

PRESENT ILLNESS: The patient relates that on occasion there has been some fast heart rates. The patient will feel the heart running away and will feel very lightheaded, almost feels like a butterfly occasionally and it will go away and then come back. It is not associated with chest pain or any additional symptomatology, specifically no syncopal episodes.

The patient complains of episodes of dizziness, lightheadedness and faintness. The episodes seem to be sometimes related to vertigo and sometimes related to just not blacking out but close to blacking out, very dizzy, lightheaded, with pre-syncopal type symptomatology. There were no focal or neurological deficits associated with this.

PAST MEDICAL HISTORY: Was reviewed and there are no changes.

SOCIAL HISTORY: Smokes one pack of tobacco per day. Drinks one alcoholic beverage per day.

ALLERGIES: NO KNOWN ALLERGIES.

REVIEW OF SYSTEMS:

HEAD AND NECK: Denies sore throat or earache. Denies congestion, nasal drainage, and sinus pressure. Denies any problems with eyes. Has occasional headaches.

PULMONARY: Denies shortness of breath, PND (paroxysmal nocturnal dyspnea), or orthopnea. Denies cough, sputum production, or hemoptysis. Denies night sweats.

GASTROINTESTINAL: Denies abdominal pain, nausea, vomiting, hematemesis, constipation, diarrhea, or blood in the stools. Denies any change in bowel habits. Denies rectal pain.

GENITOURINARY: Denies frequency, urgency, or dysuria. Denies change in color of urine.

MUSCULOSKELETAL: Denies arthralgias. Denies swelling or edema. No leg or foot pain. No back pain.

ENDOCRINE: No polyuria, polydipsia, or polyphagia. No weight loss. Denies heat or cold intolerance.

SKIN: Denies recent or chronic rash or irritation. Denies pruritus. Denies easy bruisability.

PHYSICAL EXAMINATION:

VITAL SIGNS:

Blood Pressure: 126/80

Heart Rate: 120

Respirations: 18

Weight: 143

Height: 65"

BMI: 24

GENERAL: The patient is a well-developed male in no acute distress. Alert, responsive and oriented.

HEENT: ENT inspection is normal. Pupils are equal, round, and reactive to light. Sclerae are nonicteric. No nasal drainage present. Pharynx is without erythema and exudate.

WILLIAM FARR

NECK: Supple. No thyromegaly or lymphadenopathy. No carotid bruits.

LYMPH NODES: There is no evidence of lymphadenopathy in the axillary or inguinal areas.

PULMONARY: No respiratory distress is noted. AP diameter is normal. Breath sounds are normal.

BREASTS: Deferred.

CARDIOVASCULAR: There is a regular rate and rhythm present. No gallops, lifts or heaves noted. The patient has a 2/6 mitral murmur present along the apex of the anterior axillary line.

ABDOMEN: The abdomen is nontender. Bowel sounds are normoactive. No organomegaly or masses.

SKIN: Normal turgor. No evidence of rashes, ecchymoses, or petechiae. No cyanosis or pallor.

RECTAL EXAM: Deferred.

EXTREMITIES: Revealed full range of motion without pain or edema.

NEUROLOGICAL EXAM: Alert and oriented times three. Remote and recent memory is intact. Cranial nerves are grossly intact. No evidence of sensory or motor deficits. Mood and affect normal.

ASSESSMENT:

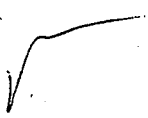
1. PSVT.
2. Syncope.
3. CA of the lung.
4. Mitral regurgitation.
5. Continued nicotine abuse.

PLAN:

1. The patient's PSVT was evaluated with EKG that revealed sinus tachycardia. I changed his Procardia to Verapamil. We will check his blood pressure and heart rate on return.
2. His syncopal episode seemed to be related to vertigo; however, he will have MRI to evaluate that.
3. He continues to smoke in spite of having cancer of the lung that was in the early stages and may be even cured.
4. Return to the office in two to three months or p.r.n.

RONALD H. LITTLEFIELD, M.D.

RHL/jm



RHL 0014

RONALD H. LITTLEFIELD, MD., LLC

CHART # 091065DATE: 4-11-11PATIENT NAME: William SarrDOB: [REDACTED]WT: 143 HT: 65" BMI: 24NOTES: MRI today

TEMP: _____

BP: 126/80SMOKER: Y OR N PKS 34 YRS 55PULSE: 120 RESP: _____WELLNESS PHYSICAL: Y OR N
DATE OF PHYSICAL: _____

LAB TEST: YES OR NO

LAST CXR: 2010

NEED NEW RX: YES OR NO

LAST GYN: _____

MEDICATIONS:

NAME GYN: _____

~~Nifedipine 30mg qd~~

LAST MAMMOGRAM: _____

Ultracet qd

LAST BONE DENSITY: _____

Klorcon 1200 $\dot{\bar{t}}$ BIDLAST PSA: 10/7/10

Asa 81mg

DIABETIC EYE EXAM: _____

Vitorin 10/40mg

DIABETIC FOOT EXAM: _____

Folic Acid 1mg qd

NAME OPTOMETRIST: _____

Dexamethasone 4mg - as dir

LAST COLONOSCOPY: 2007

Prenergan 25mg qd-q

LAST TETANUS: 2006

Preventil

LAST PNEUMOVAC: 2007

Symbricort 160/4.5mg

LAST FLU SHOT: 10/10/10Vera 250
me



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Page: 1

PATIENT: FARR, WILLIAM GAULT
MRN: 14160

D.O.B.: [REDACTED]

OFFICE VISIT:

DATE: 04/11/11

DIAGNOSIS:

- Patient status post two cycles of Cisplatin/Alimta for stage II non small cell lung cancer status post resection
- Lung cancer: right upper lobe mass noted October 2010 with FNA revealing bronchioalveolar carcinoma TTF1 positive/CD20 negative/CD7 positive, clinical stage II T2 versus T3 N0 M0; see below.
- Polycythemia vera with intermittent phlebotomies.
- History of rectal cancer in 1997 stage II T3 N0 M0 treated with 5-FU and concomitant radiation.
- Hypertension.
- Hypercholesterolemia.

ALLERGIES: NKDA

TOBACCO: Patient now smoking one-half pack per day and not in any form of smoking cessation. Has been prescribed what sounds like Chantix by his pulmonologist recently.

PAIN: 0/10

FATIGUE: 0/10.

ECOG PS: 1-2.

SUBJECTIVE: Mr. Farr presents today for follow up. He states that he has had a roaring in his ears essentially constantly since his last treatment. He states that it started with his first cycle of chemotherapy, but has now proceeded to a point where he feels like it is constant and he says it is driving him crazy.



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Page: 2

PATIENT: FARR, WILLIAM GAULT
MRN: 14160

D.O.B.: [REDACTED]

He denies a high-pitched ringing, but does state that there is some component of ringing to this as well. He states that other than that he had one episode of syncope. He states that he came out of the shower at one point and woke up a few minutes later on the floor. He does not know how long he was down. He does not know if there was any seizure activity. It was an unwitnessed event. He states that since that time he has been feeling well. He states that prior to that it was approximately two weeks from his chemotherapy and he was eating and drinking well, felt mildly fatigue, but was not other feeling poorly. He denies any shortness of breath, chest pain, abdominal pain, diarrhea or constipation. He denies any sinusitis or sinus drainage. He denies any sinus pressure, headaches, ear fullness, headaches, visual disturbances, etc.

FAMILY HISTORY: Reviewed and unchanged from initial consultation.

SOCIAL HISTORY: Reviewed and unchanged from initial consultation.

REVIEW OF SYSTEMS: All systems reviewed and are negative, except as mentioned in HPI.

PHYSICAL EXAM: Generally the patient is a well-developed, well-nourished man in no acute distress. Blood pressure 129/77, pulse 97, temperature 98.5, weight 141.8 pounds. HEENT sclerae nonicteric. Examination of both ears reveal gray tympanic membranes with no evidence of otitis media or externa or occlusion of his canal. Nasal canal within normal limits. No excessive rhinorrhea or congestion. Oropharynx clear. Neck is supple. Lungs are with scattered wheezes. Cardiovascular with regular rate and rhythm with no murmurs, rubs or gallops. Abdomen soft, nontender, nondistended. Extremities without clubbing, cyanosis or edema.

LABS: WBC 4.1, hemoglobin 14.8, hematocrit 43.1, platelet count 336, sodium 130, potassium 4.1, BUN 10, creatinine 1.2.



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Page: 3

PATIENT: FARR, WILLIAM GAULT
MRN: 14160

D.O.B.: [REDACTED]

ASSESSMENT/PLAN:

- History of stage IIB non small cell lung cancer currently on treatment with Cisplatin/Alimta: at this time I am concerned that he might be having toxicity related to his Cisplatin. I would like to refer him for formal ENT and hearing assessment. He states that he has had this in the past, but does not recall by who or when. Certainly his symptoms have progressed and I do not wish to be irreversible. I would also like to obtain an MRI of the brain. I do not see that this has been imaged recently.
- Syncope: the patient has had new onset of syncope of unclear etiology. I am going to refer him to get an MRI. I have asked him about cardiology and neurology evaluations. At this time he states that he would like to undergo these tests prior to proceeding with further evaluations.
- Smoking cessation: we have discussed smoking cessation and I have offered him the assistance of Judy Drake, our tobacco cessation counselor. The patient states that he wishes to try to quit on his own. He has been given a prescription for Chantix; however, he has been reluctant to take it and states that he would like to wait until after the completion of his chemotherapy. I have encouraged him to start taking it now. Once again I have counseled him on the importance of quitting smoking in terms of treatment of his lung cancer and he verbalizes understanding.
- I have spent greater than 60 minutes with the patient today discussing the above topics and scheduling the appropriate follow up, as well as following up with his daughter.

ELECTRONICALLY APPROVED BY: SHARMILA MEHTA, MD

DATE/TIME APPROVED: 04/20/11/4:53 PM

TRANSCRIBED BY: KJW

CC:



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Sharmila Mehta, M.D.

Page: 1

PATIENT: FARR, WILLIAM GAULT
MRN: 000478684

D.O.B.: [REDACTED]

OFFICE VISIT:
DATE: 05/10/11

DIAGNOSIS:

- Patient with sensory neural hearing loss secondary to cisplatin diagnosed by hearing test and performed by ENT. Further therapy with cisplatin discontinued secondary to above.
- Patient status post two cycles of Cisplatin/Alimta for stage II non small cell lung cancer status post resection
- Lung cancer: right upper lobe mass noted October 2010 with FNA revealing bronchioalveolar carcinoma TTF1 positive/CD20 negative/CD7 positive, clinical stage II T2 versus T3 N0 M0; see below.
- Polycythemia vera with intermittent phlebotomies.
- History of rectal cancer in 1997 stage II T3 N0 M0 treated with 5-FU and concomitant radiation.
- Hypertension.
- Hypercholesterolemia.

ALLERGIES: NKDA

TOBACCO: Patient continues to smoke one-half pack per day, not interested in any form of smoking cessation. Not taking Chantix.

PAIN: 0/10

FATIGUE: 0/10.

ECOG PS: 1-2.

SUBJECTIVE: Mr. Farr presents today for follow up. He reports that he continues to have the ringing in his ears. He states that it has moved from his head into his ears. He states that some



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Page: 2

PATIENT: FARR, WILLIAM GAULT
MRN: 000478684

D.O.B.: [REDACTED]

days it is absolutely unbearable and some days it seems somewhat tolerable although he states it is present approximately 24 hours a day, seven days a week. He otherwise reports just feeling kind of jittery at times. He states that most of this is when he tries to do something he states that he has a little bit of a tremor that he did not notice previously. He has no numbness or tingling. No neuropathy, shortness of breath, chest pain, abdominal pain, diarrhea. Unfortunately he continues to smoke in spite of recommendations to quit.

FAMILY HISTORY: Reviewed and unchanged from initial consultation.

SOCIAL HISTORY: Reviewed and unchanged from initial consultation.

REVIEW OF SYSTEMS: All systems reviewed and are negative, except as mentioned in HPI.

PHYSICAL EXAM: Vital signs: BP 122/78, P 83, T 98, weight 142.6 pounds. Generally, the patient is a well-developed, well-nourished Caucasian male in no acute distress. HEENT: facial plethora. Sclerae nonicteric. Oropharynx clear. Neck is supple. Lungs are clear to auscultation. Cardiovascular with regular rate and rhythm. Abdomen soft, nontender, nondistended. Extremities without clubbing, cyanosis or edema. Lymph nodes: No palpable cervical, supraclavicular, axillary or inguinal adenopathy.

LABS: WBC 10.3, hemoglobin 15.6, hematocrit 45.0, platelet count 250, sodium 139, potassium 4.6, BUN 13, creatinine 1.2. LFTs are within normal limits.



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James D. Bearden, III, M.D., F.A.C.P.
Eric C. Nelson, M.D.
Asim R. Pati, M.D.
Steven W. Corso, M.D.
Colin P. Curran, M.D.
Sarah I. Vidito, D.O.
Sharmila Mehta, M.D.

Page: 3

PATIENT: FARR, WILLIAM GAULT
MRN: 000478684

D.O.B.: [REDACTED]

ASSESSMENT/PLAN:

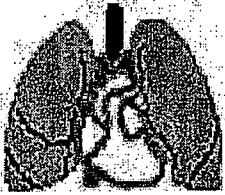
- History of stage IIA non small cell lung cancer: at this time the patient continues to have tinnitus from his cisplatinum and sensory neural hearing loss. At this time I have recommended no further therapy secondary to the adverse effects from his cisplatinum. He was receiving adjuvant chemotherapy. Unfortunately the patient continues to smoke and I have once again expressed to him the greatest factor of his cancer coming back is because he continues to smoke on a regular basis. He verbalizes understanding and states that he will continue to try to cut down. He continues to refuse formal smoking cessation.
- Rib pain: the patient is reporting some rib pain. He states that he fell several weeks ago when he had a syncopal episode. He did have an MRI at that time of the brain which was negative however he states he is slightly sore on that side. We will get a chest x-ray to evaluate this further to make sure that there are no rib fractures. He will otherwise return to see us in approximately three months time with a CT of the lung prior to his return appointment.

ELECTRONICALLY APPROVED BY: SHARMILA MEHTA, MD

DATE/TIME APPROVED: 05/16/11/5:31 PM

TRANSCRIBED BY: JMM

cc: Dr. Christophe Nguyen
Dr. George Bass



05/31/2011

RAUL B CRUZ, MD

Current Medications

nifedipine 30 mg tablet, extended release 1 tab(s) once a day
Aspirin 81 mg enteric coated tablet 1 tab(s) once a day
Triam/HCTZ 37.5/25 1 tab QD
Vytorin 10 mg-40 mg tablet 1 tab(s) once a day
Symbicort 160 mcg-4.5 mcg/inh aerosol with adapter 2 puff(s) 2 times a day
Proventil HFA CFC free 90 mcg/inh aerosol with adapter 2 puff(s) 4 times a day
zolpidem 5 mg tablet 1 tab(s) 1-2 hs
Klor-Con M20 20 mEq tablet, extended release 2 tabs bid
dexamethasone 4 mg tablet 2 tabs bid before and after chemo tx
Norco 325 mg-7.5 mg tablet 1 tab(s) every 6 hours
folic acid 1 mg tablet 1 tab(s) once a day
promethazine 50 mg tablet 1 tab(s) every 6 hours

Past Medical History

COPD
Cough
Hypertension
Colon cancer

Surgical History

hernia repair
colostomy for colon cancer radiation and chemo tx 1989
nasal surgery

Family History

Mother: deceased old age
Father: deceased cancer bone
Siblings: 3 brother, 3 sister
History positive for: hypertension, cancer.

Social History

Tobacco Use: yes, PPD: 1, years: 50.
Marital status: Married.
Education level: 11th.
Occupation: retired.
Anyone else in home smoke?: no.
Alcohol: reports, beer.
Other MDs: Primary care Dr Littlefield, Dr Corso.

Allergies

NKDA

Review of Systems

SLEEP HISTORY:

Snoring c/o, mild. no Day-Time Sleepiness.
Fatigue on Wakening c/o, sometimes.

CONSTITUTIONAL:

Reason for Appointment

1. 6 wk f/u

History of Present Illness

Interim History:

followup for COPD, tobacco abuse, and lung cancer (seeing Dr Mehta)
- did not complete chemotherapy because of ototoxicity (per patient)
already seen by ENT (no reports available)
- some wheezing at night.

Vital Signs

Wt 142.2, BP 148/84, HR 61, O2 sat 93%, FIO2 .21.

Physical Examination

GENERAL:

General Appearance: No acute distress. Build: average built.

HEENT:

Head: normocephalic. Pharynx: oropharynx clear. Pupils: symmetric.
Sclera: anicteric. EOM: intact. Nose: normal. Nasal septum: midline. Oral cavity: normal.

NECK:

Neck: supple, no jugular venous distention, trachea midline. Cervical lymph nodes: normal. Thyroid: not enlarged.

CHEST:

Shape and expansion: symmetrical chest expansion. Wheezes: no. Rales: no. Rhonchi: no.

HEART:

PMI: PMI not displaced. Rhythm: regular. Heart sounds: tones normal. Murmurs: no.

ABDOMEN:

Exam shows: no organomegaly. Tenderness: no. Guarding: no. Liver, Spleen: not palpable.

EXTREMITIES:

Pulses: 2+ bilateral. Clubbing: no. Cyanosis: no. Edema: no.

Assessments

1. COPD [Chronic obstructive pulmonary disease] - 496 (Primary)
2. Lung cancer - 162.9
3. Tobacco abuse - 305.1
4. Restrictive lung disease - 516.8, post bilobectomy
5. Insomnia - 780.52
6. Insomnia disorder related to known organic factor - 780.50

Treatment

1. COPD [Chronic obstructive pulmonary disease]

Continue Symbicort aerosol with adapter, 160 mcg-4.5 mcg/inh, 2 puff(s),

no Fever/Chills. no Night sweats.

RESPIRATORY:

c/o Shortness of breath, occasional.
no Chest congestion. no Cough, Dry. c/o Cough,
Productive, occasional, productive, clear
secretions. Wheezing c/o, Occasional.
no Chest Tightness. c/o Pleuritic Chest Pain,

from old surgical site at times

CARDIOLOGY:

no Angina. c/o Leg edema, bilateral,
occasionally.

GASTROENTEROLOGY:

no Nausea. no Vomiting.
c/o Heartburn, occasional. no Diarrhea.
Reviewed by: Gloria Gann, RN.

inhaled, 2 times a day

Continue Proventil HFA aerosol with adapter, CFC free 90 mcg/inh, 2 puff(s),
inhaled, 4 times a day

2. Lung cancer

Refill zolpidem tablet, 5 mg, 1-2, orally, hs, 5 day(s), 30, Refills 5
Will defer followup to Dr Mehta. Will assist with complications of therapy that
may arise. Per patient, has a ct scan scheduled in a few weeks. I asked him to
request that a copy of the result be sent to us.

3. Tobacco abuse

Start Nicoderm C-Q film, extended release, 14 mg/24 hr, 1 PATCH,
transdermally, once a day, 28 day(s), 28

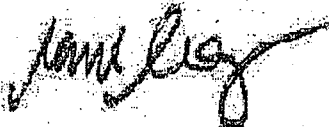
Preventive Medicine

Counseling: Pharmacy CVS Union.

Immunizations: Pneumococcal 2006. Influenza 2010.

Follow Up

3 Months



Electronically signed by DR RAUL CRUZ , MD on 03/06/2013 at
10:02 AM EST

Sign off status: Pending

Lung and Chest Medical Associates
2030 North Church Place
Spartanburg, SC 293032799
Tel: 864-582-6858
Fax: 864-542-9043

Patient: FARR, WILLIAM G DOB: [REDACTED] Progress Note: RAUL B CRUZ, MD 05/31/2011

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Aug-09-2011 10:40 AM DR. Curran SRHS 8645601877

Aug 09, 11:35 EDT (11:36) Page 1 of 2

SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report
North Grove



Spartanburg Regional

NAME: FARR, WILLIAM GAULT
ORDERING PHYSICIAN: MEHTA, SHARMILA
LOC: OPT
Pt. Type: OPT

DOB: [REDACTED]
NORTH GROVE RADIOLOGY

UNIT #: 000478684
CI#: 3115646
AN#: S1122100507

FINAL

Exam

65095 NG CT LUNG W/CONTRAST
71260

Date: 08/09/11 1035

Ord Diag: 162.9=MAL NEO BRONCH/LUNG NOS

CT CHEST WITH INTRAVENOUS CONTRAST dated 8/9/2011

HISTORY: 69-year-old male with history of lung carcinoma

COMPARISON: 12/05/2010

TECHNIQUE: 5 mm axial scans from the apices through the diaphragms following 100 mL Optiray-320 without acute complication.

FINDINGS: Interval placement of left chest IJ portacatheter with tip at the cavoatrial junction. The visualized thyroid is unremarkable. The main pulmonary artery and thoracic aorta are normal in caliber. The heart size is normal. Scattered coronary artery calcifications identified. No pericardial effusion.

AP window node, image 19 again measures 1.2 cm no hilar or axillary lymph node. No interval mediastinal lymph node.

The sequelae of right upper lobectomy noted. There is residual soft tissue along the surgical margin, image 21 measuring 1.3 x 0.9 cm. Superior segment right upper lobe scattered nodularity peripheral tree in bud opacities noted. No pleural effusion. There has been interval increase in left upper lobe, lingular ill-defined ground glass and tree in bud opacities.

Limited evaluation of the upper abdomen again shows hepatic cysts. The adrenal glands are unremarkable. No aggressive osseous lesion

Page 1

petlet
scw 0
SPM
8/9/11

Aug 09, 11:35 EDT (11:36) Page 2 of 2

SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report
North Grove



Spartanburg Regional

NAME: FARR, WILLIAM GAULT

ORDERING PHYSICIAN: MEHTA, SHARMILA

LOC: OPT

DOB: [REDACTED]

Pt. Type: OPT

NORTH GROVE RADIOLOGY

UNIT #: 000478684

CI#: 3115646

AN#: S1122100507

Checkin-Exam Code Summary: _____
3115646-65095

identified.

IMPRESSION:

1. Sequelae of right upper lobectomy with soft tissue seen along the medial suture margin measuring 1.3 x 0.9 cm. This may be postoperative in nature although local recurrence cannot be excluded. PET/CT could be helpful for further evaluation.
2. Increased bilateral peripheral nodular opacities and tree in bud opacities likely represent the sequelae of aspiration and/or pneumonia. If not desired sooner, followup chest CT in 3 months recommended.

Transcriptionist- n/a

Reading Radiologist- KELAN J BROWN MD

Releasing Radiologist- KELAN J BROWN MD

Released Date Time 08/09/11 1118



Palmetto

Hematology Oncology, P.C.

The Gibbs Cancer Center
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Sharmila Mehta, M.D.

Page: 1

PATIENT: FARR, WILLIAM GAULT
MRN: 000478684

D.O.B.: [REDACTED]

OFFICE VISIT:

DATE: 08/10/11

DIAGNOSIS:

- CT scan of the chest on August 9, 2011 shows right upper lobectomy with soft tissue seen along the medial suture margin measuring 1.3 x 0.9 cm. This may be postoperative in nature although local recurrence cannot be excluded. Increased bilateral peripheral nodular opacities and opacities likely representing sequelae of aspiration or pneumonia.
- Patient with sensory neural hearing loss secondary to cisplatin diagnosed by hearing test and performed by ENT. Further therapy with cisplatin discontinued secondary to above.
- Patient status post two cycles of Cisplatin/Alimta for stage II non small cell lung cancer status post resection.
- Lung cancer: right upper lobe mass noted October 2010 with FNA revealing bronchioalveolar carcinoma TTF1 positive/CD20 negative/CD7 positive, clinical stage II T2 versus T3 N0 M0; see below.
- Polycythemia vera with intermittent phlebotomies.
- History of rectal cancer in 1997 stage II T3 N0 M0 treated with 5-FU and concomitant radiation.
- Hypertension.
- Hypercholesterolemia.

SUBJECTIVE: Mr. Farr presents today for follow up. He reports that does feel more short of breath over the last three weeks. This does not limit his mobility. He does not have to stop when he is walking. He does have a cough which is better with clear



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Page: 2

PATIENT: FARR, WILLIAM GAULT
MRN: 000478684

D.O.B.: [REDACTED]

phlegm. He denies having any hemoptysis. He does continue to have pain in his right side. He did get an x-ray done in May which was negative for a fracture after a fall that he had had. He does take Norco one tablet generally after dinner to help with the pain and help him sleep. He had stopped taking the Norco for a while but started having pain again in the ribs within the last several weeks. He did have tinnitus related to his chemotherapy. This seems to be better. It is intermittent and not constant anymore and does not last as long. He denies having any fever or chills, coughing, chest pain, nausea or vomiting, diarrhea. He does have some occasional night sweats. He has not had any recent infections. He had his last phlebotomy in September 2010. He did not notice that this improved how he is feeling. He does continue to smoke a half pack per day. He is eating and drinking without difficulty. His energy level is fair.

ALLERGIES: NKDA

TOBACCO: Patient continues to smoke one-half pack per day, not interested in any form of smoking cessation. Not taking Chantix.

PAIN: 0/10

FATIGUE: 0/10.

ECOG PS: 1-2.

PAST MEDICAL HISTORY/PAST SURGICAL HISTORY: Reviewed and unchanged since initial consultation.

FAMILY HISTORY: Reviewed and unchanged from initial consultation.

SOCIAL HISTORY: Reviewed and unchanged from initial consultation.

REVIEW OF SYSTEMS: All systems reviewed and are negative, except as mentioned in HPI.

PHYSICAL EXAM: Generally, the patient is a well-developed, well-nourished Caucasian male in no acute distress. Vital signs: T 97.7, BP 152/76, P 55, weight 143.4 pounds. Skin: No rashes. HEENT: No conjunctival pallor. No jaundice. There are no oral ulcers. Thorax: Lungs are clear to auscultation bilaterally.



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Page: 3

PATIENT: FARR, WILLIAM GAULT
MRN: 000478684

D.O.B.: [REDACTED]

Heart: S1-S2 without murmur. Abdomen is soft, nontender, and nondistended. Extremities are without edema. Lymph node exam reveals no cervical, supraclavicular, axillary or inguinal adenopathy. Scattered wheezes in bilateral bases.

LABS: WBC 9.6, hemoglobin 17.3, hematocrit 49.2, platelet count 213,000. ANC 6.9. CMP is normal.

ASSESSMENT/PLAN:

- History of clinical stage 2B lung cancer, status post resection: at this time the patient attempted to do adjuvant chemotherapy with cisplatin. Unfortunately he developed quite serious ototoxicity and treatment was stopped prematurely. The patient has had a recent CT scan which shows some evidence of possible scar tissue versus recurrence. We will get a PET scan to further delineate the area and he will return to see us following his PET scan.
- Rib pain: the patient does continue to have some persistent rib pain. We will go ahead and refill his prescription of Norco.
- He will return to see us in approximately 2-3 weeks time after his PET scan has been performed.

ELECTRONICALLY APPROVED BY: SHARMILA MEHTA, MD

DATE/TIME APPROVED: 08/24/11/5:10 PM

TRANSCRIBED BY: JMM

cc: Dr. Christophe Nguyen
Dr. George Bass

3118061 NM PET CT SKULL BASE TO MID THIGH
S000478684 FARR, WILLIAM^GAULT
EXAM Date

Nuclear Medicine Whole Body CT / PET- FDG Study 8/12/2011

INDICATION- History of lung cancer with possible recurrence. Remote history of colorectal cancer

COMPARISONS- PET CT examination October 18, 2010 and chest CT examination August 9, 2011

TECHNIQUE- Radiopharmaceutical- 14.1 mCi F18-FDG IV. This is a whole-body PET- FDG study performed on a dedicated full- ring scanner. Low dose, nondiagnostic CT axial source images are also acquired after oral contrast for PET attenuation correction and are utilized for PET-CT fusion. The patient is not a diabetic and underwent adequate fasting of at least 4 hours. Blood glucose at the time of tracer administration is 105 mg/dl, which is adequate for imaging. Approximately 50-60 minutes after administration of the radiopharmaceutical imaging was initiated covering the skull to the thighs. SUV max. calculated from patient body wt.

FINDINGS- Examination of the 3D tomographic CT and PET images demonstrate a 13 mm long axis hypermetabolic soft tissue abnormality abutting the medial staple line at the right lung indicating recurrent disease at this site. In the more cephalad right upper lung there is a linear strandy hypermetabolic abnormality, I would favor scarring or inflammatory change.

The contralateral left lung shows an ill-defined hazy lingular infiltrate with multiple nodular densities in a tree in bud appearance. The infiltrate and the relatively low level metabolic activity suggests inflammatory cause but short term imaging followup following appropriate medical therapy is recommended to rule out metastatic disease.

There is no active hilar or mediastinal lymphadenopathy and uptake in the neck is normal.

Below the hemidiaphragms there is continued normal tracer biodistribution and excretion. Evidence of previous abdominal perineal

resection again noted. Liver and adrenals demonstrate continued normal activity. 1 cm left lobe hepatic cyst redemonstrated.

IMPRESSION- Evidence of tumor recurrence at the right lung anastomotic staple line.

Findings at the right apex and in the lingula thought to represent inflammation/infection. Short term CT imaging followup is recommended however to exclude metastatic tumor.

Transcriptionist- n/a

Reading Radiologist- Joseph Kavanagh MD

Releasing Radiologist- Joseph Kavanagh MD

Released Date Time- 08/12/11 1040



08/17/2011

RAUL B CRUZ, MD

Current Medications

nifedipine 30 mg tablet, extended release 1 tab(s) once a day
Triam/HCTZ 37.5/25 1 tab QD
Vytorin 10 mg-40 mg tablet 1 tab(s) once a day
Symbicort 160 mcg-4.5 mcg/inh aerosol with adapter 2 puff(s) 2 times a day
zolidem 5 mg tablet 1 tab(s) 1-2 hs
Klor-Con M20 20 mEq tablet, extended release 1 tabs bid
Norco 325 mg-7.5 mg tablet 1 tab(s) every 6 hours
ProAir HFA CFC free 90 mcg/inh aerosol with adapter 2 puff(s) 4 times a day
Vitamin D3 1000 intl units tablet 1 tab(s) once a day
Medication List reviewed and reconciled with the patient

Past Medical History

Copd
Cough
Hypertension
Colon cancer

Surgical History

hernia repair
colostomy for colon cancer radiation and chemo tx 1989
nasal surgery
upper and middle lobectomy 12/2010

Family History

Mother: deceased old age
Father: deceased cancer bone
Siblings: 3 brother, 3 sister
History positive for: hypertension, cancer.

Social History

Tobacco Use: yes, PPD: 1, years: 50. pt states he is down to 1/2-3/4 ppd 8/17/11.
no Military Service.
Marital status: Married.
Education level: 11th.
Occupation: retired.
Anyone else in home smoke?: no.
Alcohol: reports, beer.
no Recreational drug use.
Other MDs: Primary care Dr Littlefield, Oncologist/Hematologist Dr Mehta.
CVS RICE AVE UNION.

Allergies

NKDA

Review of Systems

Reason for Appointment

1. 3 MO F/U
2. Dr Mehta sent pt for possible bronchoscopy to bx area that lit up on PET

History of Present Illness

Interim History:

Mr Farr is sent back from Dr Mehta's office for bronchoscopy after a PET scan showed activity in the RUL stump.

- he denies cough, wheezing, hemoptysis.

Vital Signs

Wt 140.6, BP 120/82, HR 88, O2 sat 95%, FIO2 .21, Ht 64, BMI 24.13.

Physical Examination

GENERAL:

General Appearance: No acute distress. Build: thin.

HEENT:

Head: normocephalic. Pharynx: oropharynx clear. Pupils: symmetric. Sclera: anicteric. EOM: intact. Nose: normal. Nasal septum: midline. Oral cavity: normal.

NECK:

Neck: supple, no jugular venous distention, trachea midline. Cervical lymph nodes: normal. Thyroid: not enlarged.

CHEST:

Shape and expansion: symmetrical chest expansion. Wheezes: no. Rales: no. Rhonchi no.

HEART:

PMI: PMI not displaced. Rhythm: regular. Heart sounds: tones normal. Murmurs: no.

ABDOMEN:

Exam shows: no organomegaly. Tenderness: no. Guarding: no. Liver, Spleen: not palpable.

EXTREMITIES:

Pulses: 2+ bilateral. Clubbing: no. Cyanosis: no. Edema: no.
Nuclear Medicine Whole Body CT / PET- FDG Study 8/12/2011
INDICATION- History of lung cancer with possible recurrence. Remote history of colorectal cancer
COMPARISONS- PET CT examination October 18, 2010 and chest CT examination August 9, 2011
TECHNIQUE- Radiopharmaceutical- 14.1 mCi F18-FDG IV. This is a whole-body PET- FDG study performed on a dedicated full- ring scanner. Low dose, nondiagnostic CT axial source images are also acquired after oral contrast for PET attenuation correction and are utilized for PET-CT fusion. The patient is not a diabetic and underwent adequate fasting of at least 4 hours. Blood glucose at the time of tracer administration is 105 mg/dl, which is adequate for imaging. Approximately 50-60 minutes after administration of the

SLEEP HISTORY:

Snoring c/o. no Day-Time Sleepiness.
no Fatigue on Wakening.

CONSTITUTIONAL:

no Fever/Chills. no Night sweats.

RESPIRATORY:

c/o Shortness of breath, with exertion.
c/o Cough, Productive, clear secretions.
Wheezing c/o. no Chest Tightness. no Pleuritic
Chest Pain.

CARDIOLOGY:

no Angina. c/o Leg edema, ankles.
no Palpitations.

GASTROENTEROLOGY:

no Nausea. no Vomiting.
c/o Heartburn, occasional. no Diarrhea.
Reviewed by: Joan Floyd, RN.

radiopharmaceutical imaging was initiated covering the skull 1036-
thighs. SUV max. calculated from patient body wt.

FINDINGS- Examination of the 3D tomographic CT and PET images demonstrate a 13 mm long axis hypermetabolic soft tissue abnormality abutting the medial staple line at the right lung indicating recurrent disease at this site. In the more cephalad right upper lung there is a linear strandy hypermetabolic abnormality, I would favor scarring or inflammatory change.

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IMPRESSION- Evidence of tumor recurrence at the right lung anastomotic staple line.

Findings at the right apex and in the lingula thought to represent inflammation/infection. Short term CT imaging followup is recommended however to exclude metastatic tumor.

Assessments

1. Lung cancer - 162.9 (Primary)
2. COPD [Chronic obstructive pulmonary disease] - 496

Treatment**1. Lung cancer**

Mr Farr comes for reevaluation for possible completion pneumonectomy of the RLL after a RUL RML lobectomy for 2B lung cancer with moderate COPD. ON review of the PET ct scan, I feel that the lesion is less than 2 cm from the carina, making surgical resection not possible. Will plan for a bronchoscopy to check the stump, measure the distance from the carina, and also sample the L side for cultures. Will schedule the bronch in the next few days. NO aspirin, check coags. discussed with family.

Labs

Lab: CBC normal

WBC	10.0
Lymphs	15.4L
Monos	5.2
GR	79.4H
RBC	4.35
Hemoglobin	16.3H
Hematocrit	44.3
MCV	101.7H
MCH	37.4H
MCHC	36.8H
RDW	12.5
Platelets	258
MPV	6.9L
Blood Sample obtained by	JO

venipuncture

Odom, Jessica 8/17/2011 12:05:28 PM > CRUZ, RAUL B 8/22/2011
12:04:15 PM >

Lab: PT/PTT Send Out
Blood Sample Obtained by
Venipuncture

JO

-1037-

Preventive Medicine

Counseling: Pharmacy CVS Union.

Immunizations: Pneumococcal 2006. Influenza 2010.

Procedure Codes

85025 CBC; COMPLETE W/AUTO DIFF WBC

36415 Venipuncture, routine

Follow Up

Thursday next week



Electronically signed by DR RAUL CRUZ, MD on 03/06/2013 at
10:01 AM EST

Sign off status: Pending

Lung and Chest Medical Associates
2030 North Church Place
Spartanburg, SC 293032799
Tel: 864-582-6858
Fax: 864-542-9043

Patient: FARR, WILLIAM G DOB: [REDACTED] Progress Note: RAUL B CRUZ, MD 08/17/2011

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG, SC 29303

OP REPORT

PATIENT NAME: FARR, WILLIAM G
DOB: 07/06/1942
MEDICAL RECORD #: 478684
PROCEDURE DATE: 08/22/2011
ACCOUNT NUMBER: 1123400810
ROOM:

Raul Man B. Cruz
9-6-11

PROCEDURE

Fiberoptic bronchoscopy with brushing of the right middle lobe stump, right upper lobe stump and transbronchial biopsy using Wang needle of the stump, right upper lobe.

PROCEDURE IN DETAIL

After explaining the risks and benefits, consent was obtained. Time-out was done identifying the right patient and procedure. Total of fentanyl 75 mg, Versed 5 and lidocaine 10 mL was used. Bronchoscope was passed through the right nostril. Vocal cords were mobile. The trachea was clear. Left carina was sharp. Examination of the left upper and lower lobes appeared free of secretions, mass or bleeding. Examination of the right upper and middle lobe stumps were intact. There was no bulging. There was no endobronchial mass. There were no mucosal changes. Wang needle was done and the area was lavaged and brushed. The right lower lobes were clear and free of secretions, mass or bleeding. The patient tolerated the procedure and remained hemodynamically stable. No bleeding was encountered.

POSTOPERATIVE DIAGNOSIS

Impacted right upper lobe and right middle lobe stump with no endobronchial lesion.

DICTATED BY: RAUL MANUEL B. CRUZ, M.D.

D:09/04/2011 16:16:34
T:09/05/2011 04:01:26/an
1145487/998407

cc:

OP REPORT
FARR, WILLIAM G
478684
PHYSICIAN COPY

Page 1 of 1

DICTATING

Note: Document is draft unless signed

CYTOPATHOLOGY REPORT

Patient: FARR, WILLIAM GAULT Accession No: SC11-1733
MRN: 478684 Collected: 22 AUG 2011
DOB: [REDACTED] Received: 22 AUG 2011
Signed Out: 23 AUG 2011
Physician: CRUZ, RAUL MANUEL - SRMC
LOCATION: SPARTANBURG REGIONAL MEDICAL CENTER

TESTING PERFORMED BY: CELLIGENT DIAGNOSTICS
106 VENTURE BLVD, SPARTANBURG, SC 29306
PH: (864) 583-3850 FAX: (864) 583-1405

SPECIMEN:
TYPE: NonGYN Cytology - Thin Prep
SOURCE: Bronchial Brushing
(RML stump)

GROSS DESCRIPTION:
Specimen brush received in CytoLyt; 30 mL clear colorless fluid.

SPECIMEN ADEQUACY:
Satisfactory for evaluation.

INTERPRETATION:
NEGATIVE FOR MALIGNANT CELLS

COMMENT:
Respiratory epithelium present with pulmonary macrophages noted.

ELECTRONIC SIGNATURE: AWC YTR 23 AUG 2011
Alfred W. Campbell, M.D.
Yolanda T. Richardson, Cytotechnologist

HISTORY:
Lung CA with (R) upper lobe and (R) middle lobectomies, Rectal CA
with colostomy

CYTOPATHOLOGY REPORT

Patient: FARR, WILLIAM GAULT Accession No: SF11-624
MRN: 478684 Collected: 22 AUG 2011
DOB: [REDACTED] Received: 22 AUG 2011
Signed Out: 23 AUG 2011
Physician: CRUZ, RAUL MANUEL - SRMC
LOCATION: SPARTANBURG REGIONAL MEDICAL CENTER

TESTING PERFORMED BY: CELLIGENT DIAGNOSTICS
106 VENTURE BLVD, SPARTANBURG, SC 29306
PH: (864) 583-3850 FAX: (864) 583-1405

SPECIMEN:
TYPE: Fine Needle Aspiration - Thin Prep
SOURCE: Wang Needle Biopsy
(RML / RLL cani)

GROSS DESCRIPTION:
Specimen received in CytoLyt; 45 mL slightly cloudy pink tinged fluid.

SPECIMEN ADEQUACY:
Satisfactory for evaluation.

INTERPRETATION:
NEGATIVE FOR MALIGNANT CELLS

COMMENT:
Bronchial epithelium present with alveolar macrophages noted.

ELECTRONIC SIGNATURE: AWC YTR 23 AUG 2011
Alfred W. Campbell, M.D.
Yolanda T. Richardson, Cytotechnologist

HISTORY:
Lung CA with (R) upper lobe and (R) middle lobectomies, \Rectal CA with colostomy



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PATIENT: FARR, WILLIAM G
MRN: 000478684

D.O.B.: [REDACTED]

OFFICE VISIT:

DATE: 08/30/11

DIAGNOSIS:

- Status post bronchoscopy on August 22, 2011 with Dr. Cruz - bronchial brushing and biopsy negative for malignant cells.
- CT scan of the chest on August 9, 2011 shows right upper lobectomy with soft tissue seen along the medial suture margin measuring 1.3 x 0.9 cm. This may be postoperative in nature although local recurrence cannot be excluded. Increased bilateral peripheral nodular opacities and opacities likely representing sequelae of aspiration or pneumonia.
- Patient with sensory neural hearing loss secondary to cisplatin diagnosed by hearing test and performed by ENT. Further therapy with cisplatin discontinued secondary to above.
- Patient status post two cycles of Cisplatin/Alimta for stage II non small cell lung cancer status post resection
- Lung cancer: right upper lobe mass noted October 2010 with FNA revealing bronchioalveolar carcinoma TTF1 positive/CD20 negative/CD7 positive, clinical stage II T2 versus T3 N0 M0; see below.
- Polycythemia vera with intermittent phlebotomies.
- History of rectal cancer in 1997 stage II T3 N0 M0 treated with 5-FU and concomitant radiation.
- Hypertension.
- Hypercholesterolemia.

SUBJECTIVE: Mr. Farr presents today for follow up. He reports that overall things are going fairly well.



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PATIENT: FARR, WILLIAM G
MRN: 000478684

D.O.B.: [REDACTED]

He has no new problems except for that he continues to get short of breath with exertion. He missed his appointment with Dr. Cruz, but did get a phone call and he is here today to discuss what happens next. He does feel somewhat weak at times. He does have a cough with clear phlegm, but no hemoptysis. He continues to have right rib pain, but thinks this is after his fall. This is going away and he has only taken about four Lortab in the last 1 ½ weeks. He had some diarrhea the other day three times, but this has resolved and he has had none since. He denies any fevers or chills. He does have occasional night sweats. He denies any nausea or vomiting.

ALLERGIES: NKDA

TOBACCO: Patient continues to smoke one-half pack per day, not interested in any form of smoking cessation. Not taking Chantix.

PAIN: 0/10

FATIGUE: 0/10.

ECOG PS: 1-2.

PAST MEDICAL HISTORY/PAST SURGICAL HISTORY: Reviewed and unchanged since initial consultation.

FAMILY HISTORY: Reviewed and unchanged from initial consultation.

SOCIAL HISTORY: Reviewed and unchanged from initial consultation.

REVIEW OF SYSTEMS: All systems reviewed and are negative, except as mentioned in HPI.

PHYSICAL EXAM: Generally, the patient is a well-developed, well-nourished Caucasian male in no acute distress. Vital signs: T 98.3, blood pressure 145/80, pulse 80, weight 143.6 pounds.

HEENT: No conjunctival pallor. There are no oral ulcers. Lungs reveal wheeze in the left upper lobe. Heart is S1-S2 without murmur. Abdomen is soft, nontender and nondistended. Extremities are without edema.

LABS: None today.



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PATIENT: FARR, WILLIAM G
MRN: 000478684

D.O.B.: [REDACTED]

ASSESSMENT/PLAN:

- History of stage IIB lung cancer now with questionable recurrence: Fortunately the patient's bronchoscopy did not yield any clear evidence of recurrent disease; however the PET scan remains suspicious. I have discussed the case with Dr. Cruz as well as Dr. Nguyen. We do not feel that there is going to be any safe way to proceed with another biopsy. The question is to do wait and watch versus refer him for possible radiation or stereotactic radiotherapy to his area. I am going to refer him to radiation therapy to at least get their opinion on the matter and to consider possibly treating this area. If this will be difficult to do or the patient decides not to, then I would just recommend watchful waiting process of having him repeat his scans in approximately two months time or if he becomes symptomatic. I have discussed this with him, his sister and his daughter at length today.
- Tobacco abuse: unfortunately the patient does continue to smoke. He is somewhat reluctant to stop. We will go ahead and continue to encourage him. He is refusing help through formal smoking cessation at this time. He will return to see us in approximately three weeks time. In the interim we will set him up to see our colleagues in radiation oncology.

ELECTRONICALLY APPROVED BY: SHARMILA MEHTA, MD

DATE/TIME APPROVED: 09/06/11/8:52 PM

TRANSCRIBED BY: LHB

cc: Dr. Christophe Nguyen
Dr. George Bass



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Page: 1

PATIENT: FARR, WILLIAM G
MRN: 000478684

D.O.B.: [REDACTED]

OFFICE VISIT:

DATE: 09/08/11

DIAGNOSIS:

- Plan for initiation with concurrent chemoradiotherapy with radiation therapy for six weeks with weekly Carbo/Taxol for recurrent lung cancer.
- Status post bronchoscopy on August 22, 2011 with Dr. Cruz - bronchial brushing and biopsy negative for malignant cells.
- CT scan of the chest on August 9, 2011 shows right upper lobectomy with soft tissue seen along the medial suture margin measuring 1.3 x 0.9 cm. This may be postoperative in nature although local recurrence cannot be excluded. Increased bilateral peripheral nodular opacities and opacities likely representing sequelae of aspiration or pneumonia.
- Patient with sensory neural hearing loss secondary to cisplatin diagnosed by hearing test and performed by ENT. Further therapy with cisplatin discontinued secondary to above.
- Patient status post two cycles of Cisplatin/Alimta for stage II non small cell lung cancer status post resection
- Lung cancer: right upper lobe mass noted October 2010 with FNA revealing bronchioalveolar carcinoma TTF1 positive/CD20 negative/CD7 positive, clinical stage II T2 versus T3 N0 M0; see below.
- Polycythemia vera with intermittent phlebotomies.
- History of rectal cancer in 1997 stage II T3 N0 M0 treated with 5-FU and concomitant radiation.
- Hypertension.
- Hypercholesterolemia.



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PATIENT: FARR, WILLIAM G
MRN: 000478684

D.O.B.: [REDACTED]

SUBJECTIVE: Mr. Farr presents today for follow up. He has seen Dr. Monitto of radiation and he is planning on starting his radiation as soon as next week. He states that other than that he is feeling well. He has no new complaints or medical problems. He denies any shortness of breath, chest pain, abdominal pain, diarrhea or constipation. No nausea, vomiting, etc. He states that he is feeling quite well. Unfortunately he continues to smoke, but he states that he is still working on cutting down.

ALLERGIES: NKDA

TOBACCO: Patient continues to smoke one-half pack per day, not interested in any form of smoking cessation. Not taking Chantix.

PAIN: 0/10

FATIGUE: 0/10.

ECOG PS: 1-2.

PAST MEDICAL HISTORY/PAST SURGICAL HISTORY: Reviewed and unchanged since initial consultation.

FAMILY HISTORY: Reviewed and unchanged from initial consultation.

SOCIAL HISTORY: Reviewed and unchanged from initial consultation.

REVIEW OF SYSTEMS: All systems reviewed and are negative, except as mentioned in HPI.

PHYSICAL EXAM: Generally, the patient is a well-developed, well-nourished Caucasian male in no acute distress. Vital signs: T 97.4, pulse 64, blood pressure is 158/87. The rest of his physical exam is deferred secondary to discussion.

LABS: WBC 9.1, hemoglobin 16.1, hematocrit 44.4, platelet count 241. Sodium 141, potassium 3.9, BUN 19, creatinine 1.4.

ASSESSMENT/PLAN:

- Recurrent lung cancer: at this time I have had a long discussion with him and his daughter and sister about further treatment.



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PATIENT: FARR, WILLIAM G
MRN: 000478684

D.O.B.: [REDACTED]

The plan is to give him concurrent chemoradiotherapy. Risks, benefits and side effects associated with Carboplatin/Taxol have been discussed with the patient at length. He has gone ahead and signed chemotherapy consent. We will plan on starting him next week with his concurrent chemoradiation. He will return to see us in approximately three weeks time, sooner if needed. All questions were answered in a satisfactory manner. I spent greater than 45 minutes with the patient and his family today discussing the above topics.

ELECTRONICALLY APPROVED BY: SHARMILA MEHTA, MD

DATE/TIME APPROVED: 09/22/11/11:27 AM

TRANSCRIBED BY: LHB

cc: Dr. Christophe Nguyen
Dr. George Bass



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PATIENT: FARR, WILLIAM G
MRN: 000478684

D.O.B.: [REDACTED]

OFFICE VISIT:

DATE: 09/28/11

DIAGNOSIS:

- Patient status post recent initiation of concurrent chemoradiotherapy for recurrent non-small cell lung cancer with weekly Carbo/Taxol. The patient is status post three weekly treatments thus far.
- Status post bronchoscopy on August 22, 2011 with Dr. Cruz - bronchial brushing and biopsy negative for malignant cells.
- CT scan of the chest on August 9, 2011 shows right upper lobectomy with soft tissue seen along the medial suture margin measuring 1.3 x 0.9 cm. This may be postoperative in nature although local recurrence cannot be excluded. Increased bilateral peripheral nodular opacities and opacities likely representing sequelae of aspiration or pneumonia.
- Patient with sensory neural hearing loss secondary to cisplatin diagnosed by hearing test and performed by ENT. Further therapy with cisplatin discontinued secondary to above.
- Patient status post two cycles of Cisplatin/Alimta for stage II non small cell lung cancer status post resection.
- Lung cancer: right upper lobe mass noted October 2010 with FNA revealing bronchioalveolar carcinoma TTF1 positive/CD20 negative/CD7 positive, clinical stage II T2 versus T3 N0 M0; see below.
- Polycythemia Vera with intermittent phlebotomies.
- History of rectal cancer in 1997 stage II T3 N0 M0 treated with 5-FU and concomitant radiation.
- Hypertension.



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PATIENT: FARR, WILLIAM G
MRN: 000478684

D.O.B.: [REDACTED]

- Hypercholesterolemia.

SUBJECTIVE: Mr. Farr presents today for follow up. He reports that he is doing quite well. He states the only thing he is having is some pain and discomfort with indigestion like feelings in his lower esophagus. He states that he notices this from the radiation therapy. He did try to take some Tums for indigestion but did not feel like this alleviated most of his symptoms. He does continue to smoke approximately the same amount. He denies any other new complaints. He specifically denies having any shortness of breath, chest pain, abdominal pain, diarrhea, constipation, nausea or vomiting, etc. He states that chemotherapy wise he is doing quite well and the treatment does not necessarily feel badly for him.

ALLERGIES: NKDA

TOBACCO: Patient continues to smoke one-half pack per day, not interested in any form of smoking cessation. Not taking Chantix.

PAIN: 0/10

FATIGUE: 0/10.

ECOG PS: 1-2.

PAST MEDICAL HISTORY/PAST SURGICAL HISTORY: Reviewed and unchanged since initial consultation.

FAMILY HISTORY: Reviewed and unchanged from initial consultation.

SOCIAL HISTORY: Reviewed and unchanged from initial consultation.

REVIEW OF SYSTEMS: All systems reviewed and are negative, except as mentioned in HPI.

PHYSICAL EXAM: Vital signs: P 106, weight 140 pounds, T 97.8. Generally, the patient is a well-developed, well-nourished Caucasian male in no acute distress. HEENT: Sclera is anicteric. PERRL. EOMI. Oropharynx is clear. Neck is supple. Lungs are clear to auscultation. Cardiovascular is regular rate and rhythm.



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PATIENT: FARR, WILLIAM G
MRN: 000478684

D.O.B.: [REDACTED]

Abdomen is soft and nontender/nondistended. Extremities are without edema.

LABS: No new laboratory studies from today. From 9/27 WBC 4.0, hemoglobin 13.9, hematocrit 40.6, platelet count 163.

ASSESSMENT/PLAN:

- Recurrent lung cancer with involvement close to the mediastinum at median border of resection site: at this time the patient is undergoing concurrent chemoradiotherapy for this area. He is tolerating it fairly well. He does have some mild esophagitis. I am going to prescribe him some mouthwash with viscous lidocaine as well as Prilosec for his indigestion.
- He will return to see us in approximately three weeks time, sooner if needed.
- I am also going to change his potassium to potassium elixir since he is having trouble swallowing his potassium tablets today.

ELECTRONICALLY APPROVED BY: SHARMILA MEHTA, MD

DATE/TIME APPROVED: 10/04/11/10:07 AM

TRANSCRIBED BY: JMM

cc: Dr. Christophe Nguyen
Dr. George Bass



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PATIENT: FARR, WILLIAM G
MRN: 000478684

D.O.B.: [REDACTED]

OFFICE VISIT:

DATE: 11/14/11

DIAGNOSIS:

- Recent hospital discharge after being admitted from 11/2 to 11/6/11 for dehydration and radiation esophagitis.
- Patient status post recent initiation of concurrent chemoradiotherapy for recurrent non-small cell lung cancer with weekly Carbo/Taxol. The patient is status post three weekly treatments thus far.
- Status post bronchoscopy on August 22, 2011 with Dr. Cruz - bronchial brushing and biopsy negative for malignant cells.
- CT scan of the chest on August 9, 2011 shows right upper lobectomy with soft tissue seen along the medial suture margin measuring 1.3 x 0.9 cm. This may be postoperative in nature although local recurrence cannot be excluded. Increased bilateral peripheral nodular opacities and opacities likely representing sequelae of aspiration or pneumonia.
- Patient with sensory neural hearing loss secondary to cisplatin diagnosed by hearing test and performed by ENT. Further therapy with cisplatin discontinued secondary to above.
- Patient status post two cycles of Cisplatin/Alimta for stage II non small cell lung cancer status post resection
- Lung cancer: right upper lobe mass noted October 2010 with FNA revealing bronchioalveolar carcinoma TTF1 positive/CD20 negative/CD7 positive, clinical stage II T2 versus T3 N0 M0; see below.
- Polycythemia Vera with intermittent phlebotomies.
- History of rectal cancer in 1997 stage II T3 N0 M0 treated with 5-FU and concomitant radiation.
- Hypertension.



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PATIENT: FARR, WILLIAM G D.O.B.: [REDACTED]
MRN: 000478684

- Hypercholesterolemia.

SUBJECTIVE: Mr. Farr presents today for follow up. The last time we saw him we readmitted him for radiation esophagitis, nausea, vomiting and uncontrolled pain. The patient was discharged home after his admission and he was improved. He was feeling better. His nausea and vomiting had subsided. He denies any new complaints. He denies any new shortness of breath or chest pain. He is eating and drinking more. He has gained 2 ½ pounds since his hospital discharge. He has no new complaints or medical problems since he last saw us. During the course of his inpatient stay we did do a CT of the chest to make sure there was no evidence of TE fistula and at that time his previously seen recurrent disease had shrunk in size. He is otherwise doing quite well.

ALLERGIES: NKDA

TOBACCO: Patient continues to smoke one-half pack per day, not interested in any form of smoking cessation. Not taking Chantix.

PAIN: 0/10

FATIGUE: 0/10.

ECOG PS: 1-2.

PAST MEDICAL HISTORY/PAST SURGICAL HISTORY: Reviewed and unchanged since initial consultation.

FAMILY HISTORY: Reviewed and unchanged from initial consultation.

SOCIAL HISTORY: Reviewed and unchanged from initial consultation.

REVIEW OF SYSTEMS: All systems reviewed and are negative, except as mentioned in HPI.

PHYSICAL EXAM: Vital signs: T 98.5, BP 110/70, pulse 102, weight is 127.4 pounds. Generally, the patient is a well-developed, well-nourished Caucasian male in no acute distress. HEENT: Sclera is anicteric. Oropharynx is clear. Neck is supple. Lungs are clear to auscultation. Cardiovascular is regular rate and rhythm.



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Page: 3

PATIENT: FARR, WILLIAM G
MRN: 000478684

D.O.B.: [REDACTED]

Abdomen is soft and nontender/nondistended. Extremities: no clubbing, cyanosis or edema.

LABS: WBC 7.5, hemoglobin 12.8, hematocrit 35.5, platelet count of 316. Sodium 144, potassium 4.1, BUN 14, and creatinine 1.5. LFT's within normal limits.

ASSESSMENT/PLAN:

- History of recurrent non small cell lung cancer: at this time the patient is doing much better. His radiation esophagitis has improved. He is no longer having nausea, vomiting or discomfort. We will plan on rescanning him approximately 6 to 8 weeks after the completion of his therapy which will be in approximately three weeks time. We will go ahead and schedule him for this and have him return to see us at that time.

ELECTRONICALLY APPROVED BY: SHARMILA MEHTA, MD.

DATE/TIME APPROVED: 11/23/11/12:23 PM

TRANSCRIBED BY: LHB

cc: Dr. Christophe Nguyen
Dr. George Bass



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PATIENT: FARR, WILLIAM G
MRN: 000478684

D.O.B.: [REDACTED]

OFFICE VISIT:

DATE: 12/05/11

DIAGNOSIS:

- CT of the chest, abdomen and pelvis from December 1, 2011 shows post surgical changes in the right hemithorax, scarring in the left. He is stable since previous study done one month ago. No significant abnormality in the abdomen and pelvis. There is a previous colostomy but no evidence of metastatic or recurrence colon cancer.
- Recent hospital discharge after being admitted from 11/2 to 11/6/11 for dehydration and radiation esophagitis.
- Patient status post concurrent chemoradiotherapy for recurrent non-small cell lung cancer with weekly Carbo/Taxol completed 5 weeks out of 6, sixth week held secondary to toxicity.
- Status post bronchoscopy on August 22, 2011 with Dr. Cruz - bronchial brushing and biopsy negative for malignant cells.
- CT scan of the chest on August 9, 2011 shows right upper lobectomy with soft tissue seen along the medial suture margin measuring 1.3 x 0.9 cm. This may be postoperative in nature although local recurrence cannot be excluded. Increased bilateral peripheral nodular opacities and opacities likely representing sequelae of aspiration or pneumonia.
- Patient with sensory neural hearing loss secondary to cisplatin diagnosed by hearing test and performed by ENT. Further therapy with cisplatin discontinued secondary to above.
- Patient status post two cycles of Cisplatin/Alimta for stage II non small cell lung cancer status post resection.



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PATIENT: FARR, WILLIAM G D.O.B.: [REDACTED]
MRN: 000478684

- Lung cancer: right upper lobe mass noted October 2010 with FNA revealing bronchioalveolar carcinoma TTF1 positive/CD20 negative/CD7 positive, clinical stage II T2 versus T3 N0 M0; see below.
- Polycythemia Vera with intermittent phlebotomies.
- History of rectal cancer in 1997, stage II T3 N0 M0 treated with 5-FU and concomitant radiation.
- Hypertension.
- Hypercholesterolemia.

SUBJECTIVE: Mr. Farr presents today for follow up. He reports that he is feeling much better. He feels like his energy level is improving every day. His appetite has improved. He has gained 7 pounds from his last office visit. He denies having any fever or chills, night sweats, coughing, shortness of breath, chest pain, nausea, vomiting, diarrhea. He has occasional dizziness. He has shortness of breath which is improved. He stopped his pain medications. He feels like he no longer needs these medications. He is not having any pain. He does have occasional a twinge of discomfort over his port. This has been going on over the last couple of days. He feels like he may have slept wrong. He is not having any redness or tenderness at the port site or along the tunnel.

ALLERGIES: NKDA

TOBACCO: Patient continues to smoke one-half pack per day, not interested in any formal smoking cessation program.

PAIN: 0/10

FATIGUE: 0/10.

ECOG PS: 1-2.

PAST MEDICAL HISTORY/PAST SURGICAL HISTORY: Reviewed and unchanged since initial consultation.

FAMILY HISTORY: Reviewed and unchanged from initial consultation.

SOCIAL HISTORY: Reviewed and unchanged from initial consultation.



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Page: 3

PATIENT: FARR, WILLIAM G
MRN: 000478684

D.O.B.: [REDACTED]

REVIEW OF SYSTEMS: All systems reviewed and are negative, except as mentioned in HPI.

PHYSICAL EXAM: Vital signs: T 97.9, BP 136/73, pulse 96, weight is 134.4 pounds. Generally, the patient is a well-developed, well-nourished Caucasian male in no acute distress. HEENT: Sclera is anicteric. Oropharynx is clear. Neck is supple. Lungs are clear to auscultation. Cardiovascular is regular rate and rhythm. Abdomen is soft and nontender/nondistended. Extremities: no clubbing, cyanosis or edema.

LABS: WBC 7.8, hemoglobin 13, hematocrit 38.4, platelet count of 233,000. ANC 6.0. CMP within normal limits with the exception of a decreased ALT of 11.

ASSESSMENT/PLAN:

- Locally recurrent non small cell lung cancer status post concurrent chemoradiotherapy. At this time his most recent imaging shows no evidence of recurrent disease. Patient still feels somewhat weak and tired post chemotherapy and radiation. His esophagitis is better though is not 100%. We did talk about possibly maintenance chemotherapy with an agent like Tarceva; however, at this time the patient wishes to wait until after the holidays. We will have him return to see us in approximately six weeks or sooner if needed.

ELECTRONICALLY APPROVED BY: SHARMILA MEHTA, MD

DATE/TIME APPROVED: 12/15/11/5:51 PM

TRANSCRIBED BY: JMM

cc: Dr. Christophe Nguyen
Dr. George Bass

SPARTANBURG REGIONAL MEDICAL CENTER

RADIATION ONCOLOGY
FOLLOW-UP NOTESA/E 8/11
N7

PATIENT NAME: Farr, William G

Unit Number: 000478684

DOB: [REDACTED]

Age: 69

Date: 8/31/2011

Mr. Farr is seen today in follow up at the request of Dr. Mehta. Please see my previous consultation from January 21, 2011. After the patient had surgery his case was discussed in the Multidisciplinary Thoracic Conference and radiotherapy was not recommended. He was originally seen by Dr. Corso but has since been followed by Dr. Mehta. The patient did undergo adjuvant Alimta and cisplatin which completed in late April. The patient recently had a PET/CT on August 12, 2011 to follow up on a CT scan from August 9, 2011 where there was some suspicion of recurrence. CT of the chest on August 9, 2011 showed a right upper lobectomy with soft tissue seen along the medial suture margin measuring 1.3 x 0.9 cm. Recurrence could not be excluded, therefore a PET scan was performed at SRMC on August 12, 2011. This showed a 1.3 cm soft tissue abnormality, hypermetabolic, abutting the medial staple line at the right lung suspicious for recurrent disease. More cephalad in the right upper lung there was some linear stranding which was more likely inflammatory change. The contralateral left lung shows some linear infiltrate with multiple nodular densities with low metabolic activity suggesting probable inflammatory. The patient saw Dr. Cruz, his pulmonologist and underwent fiberoptic. The patient did have transbronchial washings and biopsy performed but these were not diagnostic. Repeat attempt at tissue was not recommended according to the patient due to proximity to central vessels. Dr. Cruz apparently discussed the case with Dr. Nguyen who did not feel he was a surgical candidate. The patient was re-referred to Dr. Mehta who saw him recently. Her note is not available at protocol and I discussed the case with her. She has recommended proceeding with radiotherapy. On questioning the patient has not any weight loss. He has had increased dyspnea on exertion over the past several months. No hemoptysis. No increase in wheezing. He has no significant pain.

On exam his weight is up to 143.1, BP 153/81, P 60, he is afebrile. There is no palpable cervical, supraclavicular, axillary or inguinal adenopathy. Lungs reveal distant breath sounds. There is some end-expiratory wheezing on the right which is slight. He is in no respiratory distress. Heart: Regular rate and rhythm with distinct S1 and S2. The abdomen is without mass or organomegaly. Extremities are without clubbing, cyanosis or edema.

Electronically Approved By:

Drew Monitto M.D.

September 01, 2011

CBC on August 10, 2011 showed hemoglobin 17.3, platelets 313,000, WBC 9.6.

IMPRESSION: Clinical picture highly suspicious for local recurrence of non-small cell lung cancer, adenocarcinoma of the right hilum. Biopsy confirmation has not been achieved.

PLAN: I will discuss his case with Dr. Mehta. If his other physicians feel that further attempts at biopsy could potentially be harmful, the patient's clinical scenario is quite compelling and I would be willing to offer him treatment based on clinical grounds and radiographic grounds. I did warn them that if we did this there would be a very small chance that our clinical diagnosis may be an error. He is willing to accept that potential risk and his family members agree as well. Anticipating probable radiotherapy, therefore I will update his baseline pulmonary function tests. I have also referred him for smoking cessation with Judy Drake as he continues to smoke. I will set him up for simulation. He tells me that Dr. Mehta has not discussed further chemotherapy with him but I will discuss with her whether she would consider radiosensitizing chemotherapy which I think will improve our response rate. Upon discussing the potential side effects of treatment, we did discuss that with treatment the patient would be at risk for fatal hemoptysis given the location of his recurrence. He is willing to accept that risk as well. As above, the patient will return for simulation.
DCM/jmm

C: Dr. Mehta
Dr. Cruz
Dr. Nguyen

Electronically Approved By:
Drew Monitto M.D.
September 01, 2011

Electronically Approved By:
Drew Monitto M.D.
September 01, 2011

SPARTANBURG REGIONAL MEDICAL CENTER
SPARTANBURG, SOUTH CAROLINA
HISTORY AND PHYSICAL

Mehra

PATIENT NAME: FARR, WILLIAM G
MEDICAL RECORD #: 478684
DATE OF BIRTH: [REDACTED]
ACCOUNT NUMBER: 1129101546
DATE OF ADMISSION: 10/18/2011
ROOM: 2006

CHIEF COMPLAINT

Recurrent lung cancer, currently undergoing chemoradiotherapy and being admitted for dehydration, nausea, vomiting and pain control.

HISTORY OF PRESENT ILLNESS

The patient is a 69-year-old gentleman who was diagnosed with stage T2 versus T3, N0, M0 lung cancer in October 2010. He underwent treatment with cisplatin and Alimta. Cis-platinum was discontinued secondary to neural hearing loss. He presented with recurrence of his non-small lung cancer in August 2011 with involvement close to the mediastinum at the a median border of the resection site and was started on concurrent chemoradiotherapy with radiation and carbo/Taxol. On September 13, 2011, he has completed 5 weeks of chemoradiotherapy and came in to clinic today, reports that he was

just feeling horribly. He has been unable to eat or drink anything for the past 2 days secondary to burning pain from his throat down to his stomach. He has secretions with coughing, with nausea and vomits small amounts frequently due to the secretions. He has been having some occasional dizziness and headaches and has lost 8 pounds in the past week. He has been taking Lortab for pain, but this has not been helping. He is unable to take some of his medications due to the burning and he is taking his Prilosec at 20 mg twice a day, but this has not helped. He has stopped his radiation therapy this week and canceled his chemotherapy for today and came in secondary to feeling so poorly. He will be admitted for management of his dehydration, nausea, vomiting and pain.

PAST MEDICAL HISTORY

1. History of rectal cancer in 1987, stage II T3, N0, M0, treated with 5-FU and concomitant radiation therapy.
 2. Polycythemia vera with intermittent phlebotomies.
 3. Stage II lung cancer, the right upper lobe, diagnosed in October 2010.
 4. Recurrent non-small cell lung cancer as described in the HPI. Currently receiving combined chemoradiotherapy with weekly carbo/Taxol, completed 5 weeks of treatment, due for week 6, held secondary to toxicity.
- 10/20/11*

PAST SURGICAL HISTORY

H & P
FARR, WILLIAM G
478684

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Page 1 of 3

ATTENDING

Hernia repair.

MEDICATIONS

Dyazide 37.5/25 mg p.o. daily, verapamil 240 mg ER daily and Prilosec 20 mg twice a day.

ALLERGIES

No known drug allergies.

FAMILY HISTORY

The patient's mother is deceased due to old age. The patient's father is deceased with a history of prostate cancer. He does have 6 siblings, all in good health, no one has a history of cancer. He had a paternal grandfather with a history of colon cancer and paternal uncle with a history of esophageal cancer.

SOCIAL HISTORY

The patient is married. He has 2 children, they are living in good health. He smokes approximately 1/2 pack a day and he smokes for the last 55 years. He has approximately 3 to 4 beers a day and he is of Methodist faith.

REVIEW OF SYSTEMS

The patient does have some occasional headaches and dizziness. He has had low grade fevers of 99, but denies any chills or sweats. He does have some shortness of breath and coughing with clear secretions. He has had nausea with some vomiting, mostly secondary to coughing and causing him to vomit. He has not had any diarrhea or constipation. His appetite has been decreased. He has had a positive weight loss of 8 pounds in the last week. He does have some numbness and tingling in his fingers and toes. He does not have any rashes, pruritus, muscle pain, bleeding or difficulty with urination.

PHYSICAL EXAMINATION

GENERAL: The patient is an ill appearing man in no acute distress.

VITAL SIGNS: Temperature 97.6, blood pressure 109/75, pulse 114 and weight 128.6 pounds.

SKIN: No rash.

HEENT: No conjunctival pallor or jaundice. No oral ulcers.

THORAX: Lung sounds are clear to auscultation although scattered expiratory wheezes bilaterally.

HEART: S1, S2. No murmur.

ABDOMEN: Soft, nontender, nondistended. No hepatosplenomegaly.

EXTREMITIES: No cyanosis, clubbing or edema.

LYMPH NODES: There is no cervical, supraclavicular, axillary or inguinal adenopathy.

NEUROLOGIC: Cranial nerves II through XII grossly intact. Muscle strength 5/5 throughout.

LABORATORY DATA

H & P

FARR, WILLIAM G

478684

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Page 2 of 3

ATTENDING

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White blood count 2.4, hemoglobin 13.5, hematocrit 37.6 and platelet count 162,000. ANC 1.7. Comprehensive metabolic panel is within normal limits with exception of a decreased potassium of 3.5, decreased chloride of 96, elevated BUN of 31, elevated creatinine of 2.0, decreased ALT of 17 and decreased AST of 13.

ASSESSMENT AND PLAN

1. Recurrent lung cancer, currently receiving combined chemotherapy and radiation with radiation and carbo/Taxol. The patient is in week 6 of treatment. This is currently being held secondary to toxicity.
2. Esophagitis, secondary to chemoradiotherapy. We will start Carafate 1 g p.o. q.i.d. Change Protonix to 40 mg IV every 12 hours. Start nystatin 1000 units per mL 5 mL 4 times a day. In addition to Magic Mouthwash and fluconazole 200 mg IV daily.
3. Nausea and vomiting. Antiemetics as needed including Zofran and Phenergan or Ativan.
4. Renal insufficiency, likely secondary to dehydration. We will give 0.9 normal saline at 500 mL bolus followed by 0.9 normal saline 100 mL an hour.
5. Gastrointestinal prophylaxis, Protonix and Carafate.
6. Deep vein thrombosis prophylaxis. Lovenox 40 mg daily.

Dictated by: HEATHER M. HINDS, NP

Dictated for (if applicable): 01160 VIDITO, SARAH

D:10/18/2011 17:06:27

T:10/18/2011 20:01:58/sn

1162745/1013635

Cc: SARAH I VIDITO, DO., Attending Physician

H & P
FARR, WILLIAM G
478684
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ATTENDING

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*Mehra*SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG, SC 29303

CONSULT

PATIENT NAME: FARR, WILLIAM G
DOB: [REDACTED]
MEDICAL RECORD #: 478684
ACCOUNT NUMBER: 1129101546
ADMISSION DATE: 10/18/2011
DATE OF SERVICE: 10/20/2011
ATTENDING PHYSICIAN: VIDITO, SARAH I
ROOM: 2006

REASON FOR ADMISSION

1. Esophagitis.
2. Pneumonitis.
3. Lung cancer, status post chemo and radiation.

Consult was requested by Dr. Sarah Vidito.

PRIMARY CARE PHYSICIAN
Dr. Littlefield.

Sony 10/20/11

HISTORY OF PRESENT ILLNESS

Mr. Farr is an unfortunate 69-year-old white male who has a history of non-small cell lung cancer who has gone through cisplatin chemotherapy regimen as well as radiation with 5 treatments of each. He at this time is neutropenic and has an esophageal mucositis, which is common after this type of chemo. He also has coarse breath sounds bilaterally, most likely secondary to a pneumonitis, which is also common after these types of chemo. The patient denies any fevers, sweats or chills. He has not really been coughing anything up, but he says his throat is very sore and he feels somewhat short of breath.

PAST MEDICAL HISTORY

Significant for hypertension. The patient also has had a history of colon cancer.

CURRENT MEDICATIONS

Are as follows:

1. Albuterol 180 mcg inhaled p.r.n.
2. Aquaphor and Aloe vera 1 application gel topically q. 12 hours.
3. Carboplatin 1 mg IV on demand.
4. Ceftriaxone 1 g IV q. day.
5. Dexamethasone 20 mg IV on demand.
6. Lovenox 40 mg subcu q. day.

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ADMITTING

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7. Famotidine 20 mg on demand.
8. Fentanyl 100 mcg buccally p.r.n.
9. BLM mouthwash 5 mL orally q. 3 hours p.r.n.
10. Fluconazole 200 mg q. day, which actually has been discontinued. As it was oral, it has been changed to IV, 200 mg IV daily.
11. Lorazepam 0.5 mg IV q. 4 hours p.r.n. and oral q. 4 hours p.r.n.
12. Maxzide 25/37.5, 1 tablet q. day.
13. Morphine 2 to 4 mg IV q. 6 hours p.r.n.
14. Nicotine patch topically q. day.
15. Nystatin 500,000 units suspension every 6 hours.
16. Ondansetron 8 mg q. 8 hours p.r.n. IV as well as p.o.
17. Paclitaxel 85 mg IV on demand.
18. Palonosetron 0.25 mg on demand.
19. Protonix 40 mg IV q. 12 hours.
20. Potassium 20 mEq p.o. q. 6 hours.
21. Promethazine 25 mg p.o. q. 6 hours as needed as well as IV q. 6 hours as needed as well as PR.
22. Senna 8.6 p.o. q. 12 hours as needed.
23. Sucralfate 1 g p.o. q.a.c. and at bedtime.
24. Verapamil 240 mg p.o. q. day.

ALLERGIES

The patient has got no known drug allergies.

SOCIAL HISTORY

He smokes. He does not drink or use any drugs. He used to drink a beer almost daily, but quit 11 weeks ago.

FAMILY HISTORY

Significant for colon cancer and bone cancer.

REVIEW OF SYSTEMS

Entire review of systems covered this patient. Pertinent positives are mentioned in his present illness. Please refer to it.

STUDIES PERFORMED

Magnesium is 1.4 and phosphorus 2.5. Sodium 136, potassium 2.9, chloride 104, CO2 is 22, glucose is 81, BUN is 13, creatinine is 1.03 and calcium is 8.2. White count is 1200 with 600 absolute granulocytes. The white count has 50% segmented neutrophils, 20% lymphocytes and 30% monocytes. Hemoglobin 10.1, hematocrit 28.4, MCV 95.4 and platelet count 134,000.

CONSULT

FARR, WILLIAM G

478684

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ADMITTING

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PHYSICAL EXAMINATION

VITAL SIGNS: The patient's temperature is 97.6, pulse 75, respirations 24, blood pressure 106/66 and O2 saturation is 97% on 2 L.

GENERAL: The patient appears in no acute distress. He is alert and oriented x3.

HEENT: His head is normocephalic and atraumatic. Extraocular muscles are intact. Pupils are equal, round and react to light. Oropharynx is clear of erythema or exudate.

NECK: Supple. There are no carotid bruits. No jugular venous distention. No thyromegaly. No lymphadenopathy.

LUNGS: Coarse to auscultation bilaterally.

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

ABDOMEN: Soft and nontender. Positive bowel sounds are present. There is no guarding or rebound.

EXTREMITIES: Full range of motion without edema. Cranial nerves II through XII are within normal limits. There are no focal neuro deficits.

SKIN: Intact.

ASSESSMENT

1. Neutropenia.
2. Non-small cell lung cancer.
3. Status post chemotherapy and radiation.
4. Esophagitis.
5. Pneumonitis.
6. Hypokalemia.
7. Hypomagnesemia.

PLAN

We will follow along with oncology, who will manage the patient's chemo issues. We agree with replacing magnesium and potassium, which has already been ordered. The patient is on ceftriaxone. We are going to change that to cefepime since the patient is neutropenic. We will follow along on the patient's white count. Continue the esophagitis swish and swallows as well as the patient's blood pressure management. At this time, I would like to thank Dr. Vidito for the opportunity to take part in the care of this unfortunate gentleman.

Dictated by: JAMES G. BOTTS, M.D.

Dictated for (if applicable):

D:10/20/2011 10:11:03

T:10/21/2011 03:45:59/sn

1163425/1014642

cc: SARAH I VIDITO, DO., Admitting Physician

CONSULT

FARR, WILLIAM G

478684

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ADMITTING

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JAMES G. BOTTS, M.D., Consulting Physician
RONALD H LITTLEFIELD, M.D.

CONSULT
FARR, WILLIAM G
478684
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Page 4 of 4

ADMITTING

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MRN - 000478684, Patient Name - FARR, WILLIAM
CT CHEST WITHOUT INTRAVENOUS CONTRAST 11/2/2011

HISTORY- Lung cancer, tracheoesophageal fistula symptoms

COMPARISON- CT chest dated August 9, 2011 and PET CT examination
August 12, 2011

TECHNIQUE- Helical scans performed without contrast.

FINDINGS- There are no CT findings suspicious for tracheoesophageal fistula. There is no focal soft tissue mass adjacent to the esophagus and no abnormal fluid within the mediastinum. There may be mild wall thickening of the upper and mid esophagus, nonspecific but most likely esophagitis. The small local soft tissue recurrence at the anastomotic staple line on the right measures smaller, currently 9 mm x 6 mm, previously 13 x 9 mm. There is no evidence of hydropneumothorax. Small scattered nodules in the posterior right upper lung are unchanged as are areas of patchy and somewhat coarse infiltrates in the left mid and lower lung. Central venous port tip terminates in the lower SVC. Surgical changes noted in the right chest and chest wall. In the upper abdomen the adrenals remain normal size. Hepatic cysts are unchanged.

IMPRESSION- No evidence of tracheoesophageal fistula.
The small local recurrence at the anastomotic staple line in the right lung is decrease in size from the comparison exam and no significant new findings demonstrated elsewhere in the chest.

Transcriptionist- n/a
Reading Radiologist- Joseph Kavanagh MD
Releasing Radiologist- Joseph Kavanagh MD
Released Date Time- 11/02/11 1711

<<Unsupported data from the interface message was omitted from the document>>

MRN - 000478684, Patient Name - FARR, WILLIAM
History- Lung cancer. Colon cancer.

CT of the chest dated 12/1/2011- Compared with 11/2/11.

Spiral images were obtained through the chest during bolus IV contrast administration. 100 mL of 320 were administered intravenously without adverse patient reaction. Contrast was given for optimal opacification of vascular structures and solid organs.

Findings- The thyroid is unremarkable. There is no significant axillary, mediastinal, or hilar adenopathy. There is volume loss in the right hemithorax from previous partial lung resection. There are some chronic appearing changes in the right lung, but no pulmonary mass is seen to suggest recurrent tumor.

On the left, there is some strandy scarring in the left upper lobe extending into the perihilar region. This is unchanged from the previous study. More nodular areas also appear to be essentially unchanged. No significant abnormalities are noted in the lung bases. There are no pleural effusions.

CT abdomen.

Spiral images were obtained through the abdomen with oral and IV contrast.

Findings- There is a cyst in the left lobe of liver similar to that noted on the previous study. A calcified granuloma is present in the right lobe of the liver, also unchanged. The gallbladder is contracted but contains no obvious stones. The spleen has a small accessory splenule adjacent to the lower pole. The pancreas, adrenals, and kidneys show no significant abnormality. There is a small cyst on lower pole of left kidney, of no significance clinically. The aorta is not aneurysmal. Atherosclerotic calcification is present. No retroperitoneal adenopathy is seen. Bowel is unremarkable. There is no inflammation or fluid in the abdomen.

CT pelvis.

Spiral images were obtained through the pelvis with oral and IV contrast.

Findings- A colostomy is seen in the left lower quadrant. Bowel is otherwise unremarkable in the pelvis. No significant distention is seen. The bladder is smooth in contour. No pelvic masses or abnormal fluid collections are seen. Atherosclerotic calcification is present in the iliac arteries.

Bone windowed images of the chest, abdomen, and pelvis demonstrate mild degenerative spinal changes. No bony lesions suggestive of metastatic disease are seen.

Impression- Postsurgical changes to the right hemithorax and scarring on the left. These are stable since the previous study done one month ago. No significant abnormality in the abdomen and pelvis. There is a previous colostomy, but no evidence of metastatic or recurrent colon cancer is seen.

Transcriptionist- n/a

Reading Radiologist- LAWRENCE WARRENJR MD

Releasing Radiologist- LAWRENCE WARRENJR MD

Released Date Time- 12/01/11 1111

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J. David Wren, M.D., PhD
Rosanna L. Lapham, M.D.
William W. Mims, M.D.
John A. Caldwell, M.D.
Alfred W. Campbell, M.D.



Spartanburg Regional

101 E. Wood Street
Spartanburg, SC 29303
864-560-8212

Amy C. Baruch, M.D.
Gist H. Farr, M.D.
Jared G. Block, M.D.
E. Travis Smith, M.D.
Keith J. Kaplan, M.D.

Name: FARR, WILLIAM G.

DOB: [REDACTED]

Provider: SHARMILA MEHTA MD

Encounter: S1135400712

Location: SPARTANBURG REGIONAL HOSPITAL

MRN: S000478684

Sex: M

Age: 69

Accession #: S11-16430

Collection Date: 12/20/2011

Date Received: 12/20/2011

Date Reported: 12/27/2011

SURGICAL PATHOLOGY REPORT

DIAGNOSIS

EGFR MUTATION ANALYSIS PERFORMED ON SRMC/ACCESSION S10-15710, BLOCK D3, DATED 12/2/2010, SPECIMEN FROM RIGHT UPPER AND MIDDLE LOBES LUNG.

EGFR MUTATION ANALYSIS: NO EGFR ALTERATION DETECTED.
GENOTYPE RESULT: WILD-TYPE (NO EGFR ALTERATION DETECTED).

COMMENT

Tumor was identified by SRMC pathologist and marked to optimize DNA yield in the microdissection process for molecular testing.

The EGFR Mutation Analysis was performed and interpreted by Clariant Diagnostic Services, Aliso Viejo, CA (refer to Clariant report #MBE11-014639). The Genotype result is wild-type (no EGFR alteration detected). The EGFR mutation analysis by real-time PCR is able to detect the wild-type sequence and 29 known mutations, deletions and insertions found in codons 18-21 of the EGFR tyrosine kinase domain.

Electronically Signed 12/27/2011 8:34 AM
ROSANNA LAPHAM MD

Clinical history

Pre-operative diagnosis: Request for molecular testing (EGFR)

History of malignancy: Yes - right lung

Specimen(s)

Request for molecular testing (EGFR)

Gross description

Microscopic slides and original pathology report reviewed by the pathologist from SRMC case #S10-15710; representative block(s) as required for studies is retrieved from archive on 12/19/11 and submitted to Clariant Diagnostic Services.

The original H-and-E slides are reviewed and block selected for unstained baked sections which are matched to a new last cut H-and-E, and cell section of tumor is performed.

Point of Service 101 East Wood St., Spartanburg, SC 29303

Medical diagnosis code(s) as provided: 162.3

Sam
1/5/12

Case ID: S11-16430/1
END OF REPORT (FINAL)

Page 1

Patient: FARR, WILLIAM G

MRN: 000478684

Encounter: 1135400712

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SPARTANBURG REGIONAL MEDICAL CENTER
SPARTANBURG, SOUTH CAROLINA
HISTORY AND PHYSICAL

PATIENT NAME: FARR, WILLIAM G
MEDICAL RECORD #: 478684
DATE OF BIRTH: [REDACTED]
ACCOUNT NUMBER: 1136301165
DATE OF ADMISSION: 12/29/2011
ROOM: 411

James J. Ayres
1-2-12

Admitted to 4-Tower, room 411.

PRESENT ILLNESS

This is a 69-year-old white male with a history of recent diagnosis of lung cancer, done on routine chest x-ray.

He has long history of continued cigarette abuse with at least 50 pack-year. Nevertheless, in the last 24 to 48 hours, had an increasing cough productive of yellow-greenish sputum and generalized fatigability. Because of the increased respiratory distress, brought to the office. He did have a sinus tachycardia and significant respiratory difficulty. O2 saturation on room air was 91%.

PAST MEDICAL HISTORY

1. History of CA lung.
2. History of CA of the colon, status post colectomy 12 years ago. Last colonoscopy was in 2007.
3. History of hypertension.
4. Dyslipidemia.
5. COPD.
6. Secondary polycythemia.

FAMILY HISTORY

His father died at 88 years of age with carcinoma of the lung, questionable metastatic. Mother died at 94 years of age of old age. Three sisters, one is diabetic, one is hypertensive and the other is in relatively good health.

SOCIAL HISTORY

He smoked 1 pack for 50 years and continues to smoke, despite of his recent diagnosis of lung cancer. He drinks 6 beers a day _____. He is married, 2 children and they are in good health.

ALLERGIES

NO KNOWN DRUG ALLERGY.

H & P

FARR, WILLIAM G
478684

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REVIEW OF SYSTEMS

Denies recurrent or chronic headache. Denies change in vision acuity. Denies any change in auditory perception. Denies chest pain or palpitations. Denies shortness of breath, PND or orthopnea. Denies epigastric pain, pyrosis or dyspepsia. Denies hematemesis, melena or hematochezia. Denies urgency, frequency or dysuria. Denies change in color of urine. Denies any change in arthralgias. Denies weight gain or loss. Denies any neuropsych changes.

MEDICAL REGIMEN

Include Dyazide 37.5/25 one daily; Prilosec 20 twice daily; ProAir HFA p.r.n.; simvastatin 40 mg daily and Symbicort twice daily.

PHYSICAL EXAMINATION

GENERAL: This is an ill-appearing white male who appeared to be in moderate distress.

VITAL SIGNS: Blood pressure 123/82, respirations were 20 per minute, temperature 99.4.

HEENT: Head is normocephalic. Pupils equal in size and reactive to light and accommodation.

NECK: Supple. No lymphadenopathy or carotid bruits.

CHEST: Revealed rhonchi throughout both lung fields. Revealed inspiratory and expiratory wheezes. No evidence of consolidation can be clearly identified. There was scarring in the posterior right thorax.

CARDIOVASCULAR: Revealed a sinus tachycardia. No gallop present. No new murmurs present.

ABDOMEN: Flat and nontender. Bowel sounds present and normoactive. No organomegaly or masses.

EXTREMITIES: Free range of motion without pain or edema.

IMPRESSION

1. Bronchitis with acute exacerbation.
2. History of cancer of the lung.
3. Continued nicotine abuse, in spite of counseling and Chantix.
4. History of cancer of the colon, status post resection.
5. History of chronic obstructive pulmonary disease.
6. Hypertension.
7. Secondary polycythemia.
8. _____
9. History of recurrent epistaxis.

PLAN

Admit to the hospital for IV antibiotics, seems very toxic at this point in time. Blood cultures and sputum cultures will be obtained. He is certainly immunocompromised for treatment for his lung cancer and very aggressively treated. Pulmonology will be consulted with Dr. Raul Cruz for any additional recommendation. He will be placed on IV steroids, IV antibiotics, DVT and GI prophylaxis. Hand-held nebulizers for improvement of his overall situation. Atypical will be checked for. Start on atypical until the results of those are in.

H & P

FARR, WILLIAM G
478684

Page 2 of 3

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Dictated by: RONALD H LITTLEFIELD, M.D.
Dictated for (if applicable):

D:12/29/2011 15:43:28
T:12/29/2011 21:29:07/vn
1190788/1038729

Cc: RONALD H LITTLEFIELD, M.D., Attending Physician
RAUL MANUEL B. CRUZ, M.D.

H & P
FARR, WILLIAM G
478684

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Note: Document is draft unless signed

RONALD H. LITTLEFIELD, MD., LLC

CHART # 091065DATE: 12-29-11PATIENT NAME: William FarrDOB: [REDACTED]WT: 143 HT: 5'7" BMI: 25.7NOTES: Work in - Fever-SOBTEMP: 99.402 SAT - Temp @ home 100.4 - I hadBP: 123/81SMOKER: Y OR N PKS YRS PULSE: 118 RESP: WELLNESS PHYSICAL: Y OR N
DATE OF PHYSICAL: LAB TEST: YES OR NO LAST CXR: NEED NEW RX: YES OR NO LAST GYN:

MEDICATIONS:

NAME GYN: Dyazide 37.5-253 T qdLAST MAMMOGRAM: Omeprazole 20mg T BidLAST BONE DENSITY: Klor-Con M 20 T BidLAST PSA: ProAir HFA T puffs qidDIABETIC EYE EXAM: Simvastatin 40mg T qdDIABETIC FOOT EXAM: Symbicort 160/4.5 T puffs BidNAME OPTOMETRIST: LAST COLONOSCOPY: LAST TETANUS: LAST PNEUMOVAC: LAST FLU SHOT:



Palmetto

Hematology Oncology, P.C.

The Gibbs Cancer Center
380 Serpentine Drive, Suite #200
Spartanburg, South Carolina 29303
(864) 560-7050 FAX: (864) 560-7057

James D. Bearden, III, M.D., F.A.C.P.
Eric C. Nelson, M.D.
Asim R. Pati, M.D.
Steven W. Corso, M.D.
Colin P. Curran, M.D.
Sarah I. Vidito, D.O.
Sharmila Mehta, M.D.

Page: 1

PATIENT: FARR, WILLIAM G
MRN: 000478684

D.O.B.: [REDACTED]

OFFICE VISIT:

DATE: 01/16/12

DIAGNOSIS:

- Recent hospitalization for bronchitis. The patient was admitted from 12/29/11 to 12/31/2011. Patient treated with antibiotic therapy. Chest x-ray during course of admission did not show any evidence of recurrent lung cancer.
- CT of the chest, abdomen and pelvis from December 1, 2011 shows post surgical changes in the right hemithorax, scarring in the left. He is stable since previous study done one month ago. No significant abnormality in the abdomen and pelvis. There is a previous colostomy but no evidence of metastatic or recurrence colon cancer.
- Recent hospital discharge after being admitted from 11/2 to 11/6/11 for dehydration and radiation esophagitis.
- Patient status post concurrent chemoradiotherapy for recurrent non-small cell lung cancer with weekly Carbo/Taxol completed 5 weeks out of 6, sixth week held secondary to toxicity.
- Status post bronchoscopy on August 22, 2011 with Dr. Cruz - bronchial brushing and biopsy negative for malignant cells.
- CT scan of the chest on August 9, 2011 shows right upper lobectomy with soft tissue seen along the medial suture margin measuring 1.3 x 0.9 cm. This may be postoperative in nature although local recurrence cannot be excluded. Increased bilateral peripheral nodular opacities and opacities likely representing sequelae of aspiration or pneumonia.
- Patient with sensory neural hearing loss secondary to cisplatin diagnosed by hearing test and performed by ENT. Further therapy with cisplatin discontinued secondary to above.



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Page: 2

PATIENT: FARR, WILLIAM G
MRN: 000478684

D.O.B.: [REDACTED]

- Patient status post two cycles of Cisplatin/Alimta for stage II non small cell lung cancer status post resection
- Lung cancer: right upper lobe mass noted October 2010 with FNA revealing bronchioalveolar carcinoma TTF1 positive/CD20 negative/CD7 positive, clinical stage II T2 versus T3 N0 M0; see below.
- Polycythemia Vera with intermittent phlebotomies.
- History of rectal cancer in 1997 stage II T3 N0 M0 treated with 5-FU and concomitant radiation.
- Hypertension.
- Hypercholesterolemia.

SUBJECTIVE: Mr. Farr presents today for follow up. He reports that he is doing much better than he was at the end of December when he was admitted for shortness of breath and acute bronchitis. He states that since that time he has been feeling much better. He does report that every once in a while he feels like things may be stuck up or hung up in his throat. He has not had any significant dysphagia or odynophagia, but just feels like it takes him a minute to swallow it and it gets hung up there for a few seconds in the interim. He denies any pain, although he states that every once in a while he feels a fullness in his right upper quadrant. He states that it is not really pain where he is requiring to take any pain medicine. He denies any abdominal pain, shortness of breath, chest pain, diarrhea, constipation, etc.

ALLERGIES: NKDA

TOBACCO: Patient continues to smoke one-half pack per day, not interested in any formal smoking cessation program.
Counseled at length today.

PAIN: 0/10

FATIGUE: 0/10.

ECOG PS: 1-2.



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Page: 3

PATIENT: FARR, WILLIAM G
MRN: 000478684

D.O.B.: [REDACTED]

PAST MEDICAL HISTORY/PAST SURGICAL HISTORY: Reviewed and unchanged since initial consultation.

FAMILY HISTORY: Reviewed and unchanged from initial consultation.

SOCIAL HISTORY: Reviewed and unchanged from initial consultation.

REVIEW OF SYSTEMS: All systems reviewed and are negative, except as mentioned in HPI.

PHYSICAL EXAM: Vital signs: T 97.5, blood pressure 137/75, pulse 90 and weight is 135.2 pounds. Generally, the patient is a well-developed, well-nourished Caucasian male in no acute distress. HEENT: Sclera is anicteric. Oropharynx is clear. Neck is supple. Lungs are clear to auscultation. Cardiovascular is regular rate and rhythm. Abdomen is soft and nontender/nondistended. Extremities: no clubbing, cyanosis or edema.

LABS: WBC 7.8, hemoglobin 14.8, hematocrit 42.9, platelet count of 236. Sodium 140, potassium 4.0, BUN 14, creatinine 1.3. ALT 14, AST 19, total bili 0.6, ALP of 110.

ASSESSMENT/PLAN:

- Locally recurrent non small cell lung cancer status post concurrent chemoradiotherapy: At this time we will plan on reimaging the patient in approximately three months from his most recent previous scan. He is otherwise doing fairly well. We did talk about maintenance therapy and the patient is somewhat reluctant to do so at this time. We have continued to encourage him to quit smoking and we have told him that this is his greatest risk of recurrence in his disease coming back. He verbalizes understanding. He will return to see us in approximately two months time, sooner if needed.



Palmetto

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Page: 4

PATIENT: FARR, WILLIAM G D.O.B.: [REDACTED]
MRN: 000478684

ELECTRONICALLY APPROVED BY: SHARMILA MEHTA, MD

DATE/TIME APPROVED: 01/30/12/11:33 AM

TRANSCRIBED BY: LHB

cc: Dr. Christophe Nguyen
Dr. George Bass

RONALD H. LITTLEFIELD, M.D., LLC
319 NORTH PINE STREET
SPARTANBURG, SOUTH CAROLINA 29302

PATIENT NAME: WILLIAM FARR
CHART NO.: 091065

DATE OF VISIT: 01/09/2012

WELL PHYSICAL

PRESENT ILLNESS: This is a 69-year-old white male with a long history of CA of the ~~lung~~ ^{colon} history of recent admission to the hospital with bronchitis. He had some persistent cough with productivity.

CHRONIC ILLNESSES:

1. COPD.
2. History of non-small cell cancer of the lung.
3. History of CA of the colon, continuing chemotherapy status post treatment for his colon cancer with a history of surgery.
4. History of hernia repair.
5. Colectomy.
6. Right upper lobe lobectomy for his lung cancer.

SOCIAL HISTORY: The patient is married and has two children. He continues to smoke one pack per day. He drinks occasionally. No substance abuse.

ALLERGIES: NO KNOWN ALLERGIES.

REVIEW OF SYSTEMS:

CARDIOVASCULAR: Denies chest pain, palpitations, or PND (paroxysmal nocturnal dyspnea). Denies peripheral edema. Denies prior history of heart murmur or heart attack.

GASTROINTESTINAL: Denies abdominal pain, nausea, vomiting, hematemesis, constipation, diarrhea, or blood in the stools. Denies any change in bowel habits. Denies rectal pain.

GENITOURINARY: Denies frequency, urgency, or dysuria. Denies change in color of urine.

MUSCULOSKELETAL: Denies arthralgias. Denies swelling or edema. No leg or foot pain. No back pain.

ENDOCRINE: No polyuria, polydipsia, or polyphagia. No weight loss. Denies heat or cold intolerance.

SKIN: Denies recent or chronic rash or irritation. Denies pruritus. Denies easy bruisability.

NEUROLOGICAL: Denies seizure disorder. Denies syncope or pre-syncope. Denies headaches or trouble with speech or walking. No confusion.

PHYSICAL EXAMINATION:

VITAL SIGNS:

Blood Pressure: 112/70

Heart Rate: 92

Respirations: 18

Weight: 136

GENERAL: The patient is a well-developed male in no acute distress. Alert, responsive and oriented.

WILLIAM FARR

HEENT: ENT inspection is normal. Pupils are equal, round, and reactive to light. Sclerae are nonicteric. Purulent nasal drainage present. Pharynx is with erythema and exudate.

NECK: Supple. No thyromegaly or lymphadenopathy. No carotid bruits.

LYMPH NODES: There is no evidence of lymphadenopathy in the axillary or inguinal areas.

PULMONARY: No respiratory distress is noted. AP diameter is normal. Bilateral wheezing, rales and rhonchi.

BREASTS: Deferred.

CARDIOVASCULAR: There is a regular rate and rhythm present. No gallops, lifts or heaves noted.

ABDOMEN: The abdomen is nontender. Bowel sounds are normoactive. No organomegaly or masses.

SKIN: Normal turgor. No evidence of rashes, ecchymoses, or petechiae. No cyanosis or pallor.

RECTAL EXAM: Deferred.

EXTREMITIES: Revealed full range of motion without pain or edema.

NEUROLOGICAL EXAM: Alert and oriented times three. Remote and recent memory is intact. Cranial nerves are grossly intact. No evidence of sensory or motor deficits. Mood and affect normal.

ASSESSMENT:

1. Bronchitis, resolving.
2. Continued nicotine abuse.
3. CA of the colon, treated.
4. CA of the lung, status post lobectomy.

PLAN:

1. The patient's bronchitis is not completely cured. We will place him on antibiotics for that. We will give him 7 more days of Avelox.
2. The patient's colostomy in the left lower quadrant area seems to be stable. Considering the rectal carcinoma, he will not be able to have this reversed.
3. Return to the office in two to three months or p.r.n.

RONALD H. LITTLEFIELD, M.D.

RHL/jm



RHL 0018

RONALD H. LITTLEFIELD, MD., LLC.

CHART # 091065DATE: 1-9-12PATIENT NAME: William Jarr DOB: [REDACTED]WT: 136 HT: BMI: NOTES: hosp flnTEMP: Still coughing - finishedBP: 112/70SMOKER: Y OR N PKS YRS PrednisonePULSE: 92 RESP: ~~WELLNESS PHYSICAL~~: Y OR N

LAB TEST: YES OR NO

DATE OF PHYSICAL:

NEED NEW RX: YES OR NO

LAST CXR: 12-22-11

MEDICATIONS:

LAST GYN:

Dyzide 37.5-25mg TID
 Simvastatin 40mg
 Omeprazole 20mg BID
 Clonidine 0.1mg BID
 Prochlor HFA 11 puffs BID
 Symbicort 160/4.5
 11 puffs BID

NAME GYN: LAST MAMMOGRAM: LAST BONE DENSITY: LAST PSA: 10-7-10DIABETIC EYE EXAM: DIABETIC FOOT EXAM: NAME OPTOMETRIST: LAST COLONOSCOPY: 2007LAST TETANUS: 2006LAST PNEUMOVAC: 2007LAST FLU SHOT:

MRN - 000478684, Patient Name - FARR, WILLIAM
CT chest dated 3/12/2012

Clinical Information- Lung cancer. History of right middle lobectomy.

Comparison CT scan dated 12/1/2011

Axial images of the chest were obtained during intravenous injection of 100 cc Multihance intravenous contrast.

CT chest

There are changes from right middle lobectomy as per history there is mild bronchiectasis in the left upper lobe. Ill-defined areas of infiltrate are present left upper lobe and right lower lobe. These were not present on the prior study. Also, there are several very small nodular densities scattered in the lungs, less than 1 cm in size. These are mainly in the left lung. A few are present on the right. These are not calcified. No mediastinal or hilar adenopathy. A small amount of fluid is present in the anterior mediastinum. Very small right pleural effusion.

Impression-

1. Several subcentimeter nodular densities present in the lungs.
2. Bilateral infiltrates.
3. Postoperative and chronic appearing changes

Transcriptionist- n/a
Reading Radiologist- MICHAEL ENRIGHT MD
Releasing Radiologist- MICHAEL ENRIGHT MD
Released Date Time- 03/12/12 1048

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MRN - 000478684, Patient Name - FARR, WILLIAM
CT of the Abdomen dated 3/12/2012

INDICATION- Lung carcinoma

COMPARISON- 12/01/2011

TECHNIQUE- Multiple axial images were obtained through the abdomen after intravenous injection of 100 mL Isovue 370.

FINDINGS-

Left hepatic lobe low-density lesion again measures 2 cm image 51 and likely represents a cyst. Similar low-density lesion is unchanged in the caudate lobe and lateral segment left hepatic lobe. No new liver lesions identified to suggest metastases. The portal veins are patent.

The adrenal glands, kidneys, spleen, gallbladder, pancreas are unchanged without interval lesion.

Visualized bowel is grossly unremarkable. There is partial visualization of left lower quadrant colostomy. No free fluid, free air, or pathologic adenopathy. No acute or aggressive osseous lesion. There are atherosclerotic calcifications noted within the aorta and its branches.

IMPRESSION-

1. No discrete evidence for metastases in the abdomen.

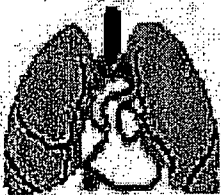
Transcriptionist- n/a

Reading Radiologist- KELAN J BROWN MD

Releasing Radiologist- KELAN J BROWN MD

Released Date Time- 03/12/12 1105

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**-1082-
FARR, WILLIAM G**

69 Y old Male, DOB: [REDACTED]
1032 JONESVILLE LOCKHART HWY, UNION, SC-29379

Home: 864-251-0531

Guarantor: FARR, WILLIAM G Insurance: MEDICARE Payer
ID: SMSCo

PCP: RONALD LITTLEFIELD

Appointment Facility: Lung and Chest Medical Associates

03/13/2012

RAUL B CRUZ, MD

Current Medications

Symbicort 160 mcg-4.5 mcg/inh aerosol with adapter 2 puff(s) 2 times a day
ProAir HFA CFC free 90 mcg/inh aerosol with adapter 2 puff(s) 4 times a day
Triam/HCTZ 37.5/25 1 tab QD
Klor-Con M20 20 mEq tablet, extended release 2tab bid
Norco 325 mg-7.5 mg tablet 1 tab(s) every 6 hours
Vitamin D3 1000 intl units tablet 1 tab(s) once a day
simvastatin 40 mg tablet 1 tab(s) once a day (at bedtime)
Medication List reviewed and reconciled with the patient.

Past Medical History

Copd
Cough
Hypertension
Colon cancer

Surgical History

hernia repair
colostomy for colon cancer radiation and chemo tx 1989
nasal surgery
upper and middle lobectomy 12/2010

Family History

Mother: deceased old age
Father: deceased cancer bone
Siblings: 3 brother, 3 sister
History positive for: hypertension, cancer.

Social History

no Military Service.
Smoking Patient is a: current smoker PPD1 down to 1/2, years:50, Are you interested in quitting
No, Patient was counseled on the dangers of smoking and urged to quit. 03/13/2012.
Marital status: Married.
Education level: 11th.
Occupation: retired.
Anyone else in home smoke?: no.
Alcohol: reports, beer.
no Recreational drug use.
Other MDs: Primary care Dr Littlefield, Oncologist/Hematologist Dr Mehta.
CVS RICE AVE UNION.

Allergies

NKDA

Review of Systems

Reason for Appointment

1. med refills Pt staes Dr Littlefield admitted to SRMC pneumonia 12-11. He had chest ct yesterday and Dr Mehta called pt antibiotic thought may have pneumonia and he will pick up today.
2. Coughing with clear secretion, occ wheezing and dyspnea.
3. Pt ran out of Symbicort and has been using cousin extra Advair 250mg.

History of Present Illness

Interim History:

- called in for medication refills
- incidentally, he had a routine ct visit with Dr Mehta yesterday (ct reviewed: R fibrosis and volume loss post RUL, RML lobectomy and XRT to R lung field
- last december, admitted for pneumonia per DR Littlefield, ct done showed nodular infiltrates L lung
- repeat ct shows progression of that infiltrates
- increased SOB, cough about the same
- no hemoptysis.

Vital Signs

Wt 136.9, BP 130/80, HR 83, O2 sat 96%, FIO2 .21, FVC 2.01, FEV1 1.21, FEV1/FVC% 60%, Ht 64, BMI 23.50.

Physical Examination

GENERAL:

General Appearance: No acute distress. Build: thin.

HEENT:

Head: normocephalic. Pharynx: oropharynx clear. Pupils: symmetric. Sclera: anicteric. EOM: intact. Nose: normal. Nasal septum: midline. Oral cavity: normal.

NECK:

Neck: supple, no jugular venous distention, trachea midline. Cervical lymph nodes: normal. Thyroid: not enlarged.

CHEST:

Shape and expansion: symmetrical chest expansion. Wheezes: no. Rales: no. Rhonchi no.

HEART:

PMI: PMI not displaced. Rhythm: regular. Heart sounds: tones normal. Murmurs: no.

ABDOMEN:

Exam shows: no organomegaly. Tenderness: no. Guarding: no. Liver, Spleen: not palpable.

EXTREMITIES:

Pulses: 2+ bilateral. Clubbing: no. Cyanosis: no. Edema: no.

Assessments

SLEEP HISTORY:

Snoring mild. no Day-Time Sleepiness.
Fatigue on Wakening c/o.

CONSTITUTIONAL:

no Fever/Chills. no Night sweats.

RESPIRATORY:

c/o Shortness of breath. Cough,
Productive Green secretions.
Wheezing Occasional. no Chest Tightness.
Pleuritic Chest Pain OCC.

CARDIOLOGY:

no Leg edema. no Palpitations.

GASTROENTEROLOGY:

no Nausea. no Vomiting. no Heartburn.
no Diarrhea.

Reviewed by: Anne Purser.

1. Lung cancer - 162.9 (Primary)
2. COPD [Chronic obstructive pulmonary disease] - 496
3. Pneumonia NOS - 486

-1083-**Treatment****1. Lung cancer**

LAB: Spirometry moderately severe obstruction, no change

FVC	2.01/55%
FEV1	1.21/42%
%FEV1	60%

Gaffney, Jamie 3/13/2012 8:31:32 AM > CRUZ, RAUL B 3/13/2012 9:21:26 AM >

L nodules are concerning for recurrence given they have been there since December and have grown since. Agree with Dr Mehta for empiric levaquin therapy but will schedule for a bronchoscopy early next week, will check coagulation parameters today. he is not asa. He is told that this could be PNA or cancer recurrence.

2. COPD [Chronic obstructive pulmonary disease]

Refill Symbicort aerosol with adapter, 160 mcg-4.5 mcg/inh, 2 puff(s), inhaled, 2 times a day, 30 day(s), 1; Refills 11
Refill ProAir HFA aerosol with adapter, CFC free 90 mcg/inh, 2 puff(s), inhaled, 4 times a day, 30 day(s), 1; Refills 11
Eprescribe Rx to pharmacy.

3. Pneumonia NOS

as above, on levaquin.

LabsLab: CBC

WBC	9.3
Lymphs	10.8L
Monos	7.1
GR	82.1H
RBC	4.93
Hemoglobin	16.1H
Hematocrit	47.9H
MCV	97.0
MCH	32.6
MCHC	33.6
RDW	15.1H
Platelets	260
MPV	6.6L

Blood Sample obtained by
venipuncture JO

Odom, Jessica 3/13/2012 9:45:23 AM >

Lab: PT/PTT Send Out

Blood Sample Obtained by
Venipuncture JO

Preventive Medicine

Counseling: Pharmacy CVS Union.

Immunizations: Pneumococcal 2006. Influenza 2010, 2011.

Procedure Codes

94010 SPIROMETRY

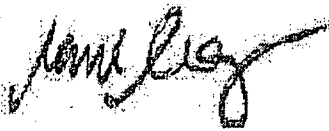
85025 CBC; COMPLETE W/AUTO DIFF WBC

36415 Venipuncture, routine

-1084-

Follow Up

2 Weeks



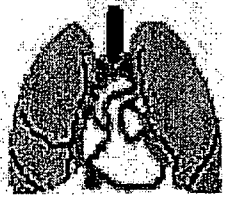
Electronically signed by DR RAUL CRUZ , MD on 03/06/2013 at
10:01 AM EST

Sign off status: Pending

Lung and Chest Medical Associates
2030 North Church Place
Spartanburg, SC 293032799
Tel: 864-582-6858
Fax: 864-542-9043

Patient: FARR, WILLIAM G DOB: [REDACTED] Progress Note: RAUL B CRUZ, MD 03/13/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



03/23/2012

RAUL B CRUZ, MD

Current Medications

Symbicort 160 mcg-4.5 mcg/inh aerosol with adapter 2 puff(s) 2 times a day
ProAir HFA CFC free 90 mcg/inh aerosol with adapter 2 puff(s) 4 times a day
Triam/HCTZ 37.5/25 1 tab QD
Klor-Con M20 20 mEq tablet, extended release 2tab bid
Norco 325 mg-7.5 mg tablet 1 tab(s) every 6 hours
Vitamin D3 1000 intl units tablet 1 tab(s) once a day
simvastatin 40 mg tablet 1 tab(s) once a day (at bedtime)

Past Medical History

Copd
Cough
Hypertension
Colon cancer

Surgical History

hernia repair
colostomy for colon cancer radiation and chemo tx 1989
nasal surgery
upper and middle lobectomy 12/2010

Family History

Mother: deceased old age
Father: deceased cancer bone
Siblings: 3 brother, 3 sister
History positive for: hypertension, cancer.

Social History

no Military Service.
Smoking Patient is a: current smoker PPD1 down to 1/2, years: 50, Are you interested in quitting No, Patient was counseled on the dangers of smoking and urged to quit. 03/13/2012.
Marital status: Married.
Education level: 11th.
Occupation: retired.
Anyone else in home smoke?: no.
Alcohol: reports, beer.
no Recreational drug use.
Other MDs: Primary care Dr Littlefield, Oncologist/Hematologist Dr Mehta.
CVS RICE AVE UNION.

Allergies

NKDA

Review of Systems

SLEEP HISTORY:

no Day-Time Sleepiness. Fatigue on Wakening

Reason for Appointment

1. Bronch f/u

History of Present Illness

Interim History:

- followup post bronch, showing atypical cells but negative pathology
- no fever, sputum, hemoptysis
- cultures so far are negative (but done on antibiotics).

Vital Signs

Wt 132.1, BP 134/91, HR 94, O2 sat 94%, FIO2 .21, Ht 64, BMI 22.67.

Physical Examination

GENERAL:

General Appearance: No acute distress. Build: thin.

HEENT:

Head: normocephalic. Pharynx: oropharynx clear. Pupils: symmetric. Sclera: anicteric. EOM: intact. Nose: normal. Nasal septum: midline. Oral cavity: normal.

NECK:

Neck: supple, no jugular venous distention, trachea midline. Cervical lymph nodes: normal. Thyroid: not enlarged.

CHEST:

Shape and expansion: symmetrical chest expansion. Wheezes: no. Rales: no. Rhonchi no.

HEART:

PMI: PMI not displaced. Rhythm: regular. Heart sounds: tones normal. Murmurs: no.

ABDOMEN:

Exam shows: no organomegaly. Tenderness: no. Guarding: no. Liver, Spleen: not palpable.

EXTREMITIES:

Pulses: 2+ bilateral. Clubbing: no. Cyanosis: no. Edema: no.

Assessments

1. Lung cancer - 162.9 (Primary)
2. COPD [Chronic obstructive pulmonary disease] - 496
3. Pneumonia NOS - 486

Treatment

1. Lung cancer

Start Ativan tablet, 1 mg, 1-2 tab(s), orally, once, 1d, 2 as above, highly suspicious for recurrence (although pneumonia is possible) will refer to IR for assessment for Core needle bX of the LUL lesions. he will get his ct scan pre procedure with IR and a decision to needle will be made that day. I will opt to wait a few weeks to allow for possible radiologic lag clearance if it

c/o, sometimes.

CONSTITUTIONAL:

no Fever/Chills. no Night sweats.

RESPIRATORY:

c/o Shortness of breath. c/o Cough,
Productive, clear secretions.

Wheezing Occasional. no Chest Tightness.
no Pleuritic Chest Pain.

CARDIOLOGY:

no Leg edema. no Palpitations.

GASTROENTEROLOGY:

no Nausea. no Vomiting. no Heartburn.
no Diarrhea.

Reviewed by: Anne Purser.

was a pneumonia.

-1086-

Addendum: spoke with IR, unable to do needle biopsy. Will refer to Dr Nguyen for vats lung biopsy. Suspicious for cancer recurrence.

2. COPD [Chronic obstructive pulmonary disease]

Continue Symbicort aerosol with adapter, 160 mcg-4.5 mcg/inh, 2 puff(s),
inhaled, 2 times a day

Continue ProAir HFA aerosol with adapter, CFC free 90 mcg/inh, 2 puff(s),
inhaled, 4 times a day

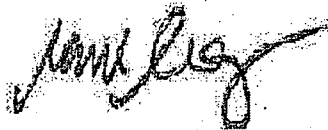
Preventive Medicine

Counseling: Pharmacy CVS Union.

Immunizations: Pneumococcal 2006. Influenza 2010,2011.

Follow Up

5 Weeks, mopve appt



Electronically signed by DR RAUL CRUZ , MD on 03/06/2013 at
10:01 AM EST

Sign off status: Pending

Lung and Chest Medical Associates
2030 North Church Place
Spartanburg, SC 293032799
Tel: 864-582-6858
Fax: 864-542-9043

Patient: FARR, WILLIAM G DOB: [REDACTED] Progress Note: RAUL B CRUZ, MD 03/23/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

CYTOPATHOLOGY REPORT

Patient: FARR, WILLIAM G Accession No: SC12-498
MRN: 478684 Collected: 19 MAR 2012
DOB: [REDACTED] Received: 19 MAR 2012
 Signed Out: 21 MAR 2012
Physician: CRUZ, RAUL MANUEL - SRMC
LOCATION: SPARTANBURG REGIONAL MEDICAL CENTER

TESTING PERFORMED BY: CELLIGENT DIAGNOSTICS
106 VENTURE BLVD, SPARTANBURG, SC 29306
PH: (864) 583-3850 FAX: (864) 583-1405

SPECIMEN:
TYPE: NonGYN Cytology - Thin Prep
Non-Gyn Cell Block
SOURCE: Bronchial Lavage
(LUL)

GROSS DESCRIPTION:
Specimen received in CytoLyt; 40mL slightly cloudy colorless fluid.

SPECIMEN ADEQUACY:
Satisfactory for evaluation.

INTERPRETATION:
ATYPICAL CELLS PRESENT (SEE COMMENT)

COMMENT:
See also concurrent surgical biopsy (SRMC #S12-3805) and bronchial brushing results (SC12-499). There is insufficient cellularity present to perform any further diagnostic/predictive studies on this material.

ELECTRONIC SIGNATURE: ACB jmb 21 MAR 2012
Amy C. Baruch, M.D.
Jean Barrow; Cytotechnologist

CLINICAL DIAGNOSIS/HISTORY:

162.9; History of lung CA, possible pneumonia. Malignancy: rectal,
(R) lung

Some tests may have been performed that were developed with performance characteristics determined by Celligent Diagnostics. These tests have not been cleared or approved by the US Food and Drug Administration. The FDA does not require these tests to go through premarket FDA review. The testing is used for clinical purposes and should not be regarded as investigational or for research. This laboratory is certified under the Clinical Laboratory Improvement Amendments (CLIA) as qualified to perform high complexity clinical laboratory testing. Reference laboratories performing these tests are approved by Celligent Diagnostics and are certified as CLIA laboratories, with test development in their laboratory.

----- END OF REPORT -----

CYTOPATHOLOGY REPORT

Patient: FARR, WILLIAM G Accession No: SC12-499
MRN: 478684 Collected: 19 MAR 2012
DOB: [REDACTED] Received: 19 MAR 2012
 Signed Out: 21 MAR 2012
Physician: CRUZ, RAUL MANUEL - SRMC
LOCATION: SPARTANBURG REGIONAL MEDICAL CENTER

TESTING PERFORMED BY: CELLIGENT DIAGNOSTICS
106 VENTURE BLVD, SPARTANBURG, SC 29306
PH: (864) 583-3850 FAX: (864) 583-1405

SPECIMEN:
TYPE: NonGYN Cytology - Thin Prep
SOURCE: Bronchial Brushing
(LUL)

GROSS DESCRIPTION:
Specimen brush received in CytoLyt; 30mL clear colorless fluid.

SPECIMEN ADEQUACY:
Satisfactory for evaluation.

INTERPRETATION:
ATYPICAL CELLS PRESENT (SEE COMMENT)

COMMENT:
See also concurrent surgical biopsy (SRMC #S12-3805) and bronchial lavage results (SC12-498). There is insufficient material present to perform any further diagnostic/predictive studies.

ELECTRONIC SIGNATURE: ACB jmb 21 MAR 2012
Amy C. Baruch, M.D.
Jean Barrow; Cytotechnologist

CLINICAL DIAGNOSIS/HISTORY:
162.9; History lung CA, possible pneumonia. Malignancy: rectal, (R)

lung

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----- END OF REPORT -----



Palmetto

Hematology Oncology

Gibbs Cancer Center
380 Serpentine Drive, Suite #200
Spartanburg, South Carolina 29303
(864) 560-7050 FAX: (864) 560-7057

Page: 1

James D. Bearden, III, M.D., F.A.C.P.
Eric C. Nelson, M.D.
Asim R. Pati, M.D.
Steven W. Corso, M.D.
Colin P. Curran, M.D.
Sarah I. Vidito, D.O.
Sharmila Mehta, M.D.
Charles E. Bowers, M.D.
Samuel K. Wood, M.D.

PATIENT: FARR, WILLIAM G
MRN: 000478684

D.O.B.: [REDACTED]

OFFICE VISIT:

DATE: 03/27/12

DIAGNOSIS:

- March 19, 2012 bronchoscopy with brushings showing atypical cells. Left lower lung biopsy, histology unremarkable.
- CT of the chest on March 12, 2012 shows several subcentimeter nodular densities present in the lungs, bilateral infiltrates postoperative and chronic appearing changes.
- Recent hospitalization for bronchitis. The patient was admitted from 12/29/11 to 12/31/2011. Patient treated with antibiotic therapy. Chest x-ray during course of admission did not show any evidence of recurrent lung cancer.
- CT of the chest, abdomen and pelvis from December 1, 2011 shows post surgical changes in the right hemithorax, scarring in the left. He is stable since previous study done one month ago. No significant abnormality in the abdomen and pelvis. There is a previous colostomy but no evidence of metastatic or recurrence colon cancer.
- Recent hospital discharge after being admitted from 11/2 to 11/6/11 for dehydration and radiation esophagitis.
- Patient status post concurrent chemoradiotherapy for recurrent non-small cell lung cancer with weekly Carbo/Taxol completed 5 weeks out of 6, sixth week held secondary to toxicity.
- Status post bronchoscopy on August 22, 2011 with Dr. Cruz - bronchial brushing and biopsy negative for malignant cells.
- CT scan of the chest on August 9, 2011 shows right upper lobectomy with soft tissue seen along the medial suture



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PATIENT: FARR, WILLIAM G
MRN: 000478684

D.O.B.: [REDACTED]

margin measuring 1.3 x 0.9 cm. This may be postoperative in nature although local recurrence cannot be excluded. Increased bilateral peripheral nodular opacities and opacities likely representing sequelae of aspiration or pneumonia.

- Patient with sensory neural hearing loss secondary to cisplatin diagnosed by hearing test and performed by ENT. Further therapy with cisplatin discontinued secondary to above.
- Patient status post two cycles of Cisplatin/Alimta for stage II non small cell lung cancer status post resection
- Lung cancer: right upper lobe mass noted October 2010 with FNA revealing bronchioalveolar carcinoma TTF1 positive/CD20 negative/CD7 positive, clinical stage II T2 versus T3 N0 M0; see below.
- Polycythemia Vera with intermittent phlebotomies.
- History of rectal cancer in 1997 stage II T3 N0 M0 treated with 5-FU and concomitant radiation.
- Hypertension.
- Hypercholesterolemia.

SUBJECTIVE: Mr. Farr presents today for follow up. He reports that since his last visit and his recent CT scan showing nodular densities in the lungs and bilateral infiltrates he was treated with an antibiotic. He felt better after receiving the antibiotic and he also was seen by Dr. Cruz and had a bronchoscopy approximately one week ago and as this was nondiagnostic Dr. Cruz will be setting him up for an additional scan to evaluate the pulmonary nodules seen earlier this month. These are still present and the patient will be scheduled for another biopsy. The patient did have one low grade fever of 99.4 earlier in the week and some chills, but denies otherwise having any fever, chills, night sweats, nausea, vomiting, diarrhea or headaches. No dizziness or neuropathy. He does have some pain in his chest which is unchanged. He does take Norco as needed which does help



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PATIENT: FARR, WILLIAM G
MRN: 000478684

D.O.B: [REDACTED]

with the pain. He does continue to have shortness of breath and coughing, which is unchanged. His appetite is fair. He has lost 2 pounds from his last visit. His energy level is somewhat better after the recent antibiotic.

ALLERGIES: NKDA

TOBACCO: Patient continues to smoke one-half pack per day, not interested in any formal smoking cessation program. Counseled at length today.

PAIN: 0/10

FATIGUE: 0/10.

ECOG PS: 1-2.

PAST MEDICAL HISTORY/PAST SURGICAL HISTORY: Reviewed and unchanged since initial consultation.

FAMILY HISTORY: Reviewed and unchanged from initial consultation.

SOCIAL HISTORY: Reviewed and unchanged from initial consultation.

REVIEW OF SYSTEMS: All systems reviewed and are negative, except as mentioned in HPI.

PHYSICAL EXAM: T 98.4, blood pressure 124/84, pulse 109, weight 133.2 pounds. Generally, the patient is a well-developed, well-nourished man in no acute distress. HEENT: No conjunctival pallor. There are no oral ulcers. Lungs are clear to auscultation bilaterally. Heart is S1-S2 without murmur. Abdomen is soft, nontender and nondistended. Extremities are without edema.

LABS: WBC 13.1, hemoglobin 15.8, hematocrit 46.2, platelet count 260,000. ANC 10.8. Comprehensive metabolic panel is within normal limits with the exception of a decreased ALT of 7.

ASSESSMENT/PLAN:

- History of locally recurrent non small cell lung cancer status post concurrent chemoradiotherapy: the most recent



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Samuel K. Wood, M.D.

PATIENT: FARR, WILLIAM G
MRN: 000478684

D.O.B.: [REDACTED]

CT scan from March 12, 2012 did show some subcentimeter nodular densities and bilateral infiltrates. The patient has been treated with antibiotics and has seen Dr. Cruz and had a bronchoscopy on 3/19/12 which was nondiagnostic. The patient is currently waiting to hear from Dr. Cruz's office regarding reimaging of his chest with plans for rebiopsy if subcentimeter nodules are still present.

- Smoking cessation: I did counsel the patient today regarding smoking cessation. He reports that he has been trying to quit and trying to cut down although he is not willing to speak with our smoking cessation counselor at this time.
- The patient will return to the clinic in one month, sooner if needed.

ELECTRONICALLY APPROVED BY: SHARMILA MEHTA, MD

DATE/TIME APPROVED: 04/16/12/10:37 AM

TRANSCRIBED BY: LHB

cc: Dr. Raul Cruz

Dr. George Bass

Dr. Christoph Nguyen

SURGICAL ONCOLOGY AT THE GIBBS CANCER CENTER

101 East Wood Street

Spartanburg, SC 29303

Phone (864) 560-1900

Fax (864) 560-1925

www.gibbsurgicaloncology.com

CHRISTOPHE NGUYEN, M.D.

OFFICE NOTE

DATE: April 11, 2012
PATIENT: FARR, WILLIAM
DOB: [REDACTED]

DIAGNOSIS:

History of stage 2B non small cell lung cancer of the right lung status post resection, upper lobectomy and right middle lobectomy in December 2010.

INTERVAL HISTORY:

Mr. Farr presents for follow up with me now approximately a year and several months after his operation. He has been followed by his oncologist and has received chemotherapy as of just a few months ago. He developed a possible pneumonia characterized by bilateral pulmonary infiltrates. He has been seen by Dr. Cruz as well and underwent a vigorous workup to assess the etiology of this. He has been on multiple rounds of antibiotics without resolution. His most recent PET scan demonstrates interval increase in bilateral infiltrates worse on the left with a reticular pattern. He clinically has occasional shortness of breath but otherwise denies any significant weight loss, productive cough, hemoptysis or any new neurologic symptoms.

PHYSICAL EXAMINATION:

Blood pressure is 130/88. Pulse is 101. Temperature is 97.6. O2 saturation is 97% on room air. Neck is without adenopathy. Lungs are clear to auscultation bilaterally. Heart has a regular rate and rhythm. Abdomen is soft and nontender. His previous incision on the right is well healed.

IMPRESSION/PLAN:

As above, history of stage 2 cancer now with worsening infiltrates concerning for either refractory infectious process versus cancer recurrence.

I spent the majority of a 45 minute visit with the patient and his family reviewing the results and recommending a lung biopsy. We would target the left side and hopefully it would be fairly quick of an operation for him. He understands the risk of bleeding, infection, bronchopleural fistula and the use of a chest tube after surgery. We will go ahead and plan for this next week and he agrees.

Christophe L. Nguyen, M.D. *NY*

CLN/mal

CC: Dr. Sharmila Mehta, Dr. Raul Cruz

SURGICAL ONCOLOGY

Office Note

Patient: William FarrNAME AND DATE OF BIRTH VERIFIED: ☒

DATE

BP 130/88 Pulse 101 Temp 97.4 Resp _____ Weight _____ O2 Sat 97% RAALLERGIES REVIEWED ☒CURRENT MEDICATIONS REVIEWED AND LISTED ☒CHIEF COMPLAINT: lung biopsy / ? VATSref track: lungH/o NSC lung CA RUL/RML s/p RUL/ML obstructions. Had recent admission for pneumonia & had had some SOB since.Recent PET shows b/l lung infiltrates. No O2 but yes infiltrates. @n/v. Doubt significant int change since stopping chemo in December.VSSAFRPR, mildly labored breathing. Lungs sound clear.Had cough RTExt 2+ pleurapp: h/o (lung CA & colorectal CA- PET ? for infiltrate vs. PNA- Plan @ VATS biopsyOKAS no ERRORSB/N

OP REPORT

PATIENT NAME: FARR, WILLIAM G
DOB: [REDACTED]
MEDICAL RECORD #: 478684
PROCEDURE DATE: 04/17/2012
ACCOUNT NUMBER: 1210301383
ROOM: 8405

PREOPERATIVE DIAGNOSES

History of right lung cancer, status post resection and chemotherapy.

POSTOPERATIVE DIAGNOSES

History of right lung cancer, status post resection and chemotherapy and pulmonary infiltrates.

PROCEDURE

Left thoracoscopic lung biopsy, robotic assisted (left upper lobe).

STAFF SURGEON

Christophe Nguyen, MD

ASSISTANT

Brian Dalton, MD

ANESTHESIA

General with local.

SPECIMENS

As above.

ESTIMATED BLOOD LOSS

Minimal.

FINDINGS

Abnormal medial left upper lobe portion.

INDICATION FOR PROCEDURE

William Farr is a 69-year-old man who presents with the above history.

DESCRIPTION OF PROCEDURE

The patient was brought to the operating room, identified and placed supine on the operating room table. He underwent induction of general endotracheal anesthesia at which point a double-

OP REPORT

FARR, WILLIAM G

478684

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Page 1 of 2

DICTATING

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lumen endotracheal tube was positioned. His left lung was isolated. He was placed in the right lateral decubitus position. The left chest was prepped and draped in a standard surgical fashion. I entered the chest at approximately the 8th interspace in the posterior axillary line with a 5-mm trocar and CO2 insufflation. Under direct vision, 2 additional trocars were placed, 15-mm working port and an 8-mm robotic port. Next, the da Vinci robot was docked to the patient and assumed control with surgeon consult. Using a blunt grasper, there was _____ fissure as well as the left upper lobe, there was an area of induration medially. Using a tri-stapler device, we were able to obtain a biopsy along the lateral edge of the upper lobe. This was placed into an Endobag and removed. There was excellent hemostasis. The chest tube was introduced to the apex and secured with 0 Vicryl suture. Chest tube was connected to -20 wall suction. The robotic instruments were then removed. The trocars removed as well and the remaining incisions were closed in 2 layers, 3-0 Vicryl for the subcutaneous tissues and 4-0 Monocryl for the skin. The patient was extubated and transferred to recovery room in stable condition.

DICTATED BY: CHRISTOPHE NGUYEN, MD

DICTATED FOR (IF APPLICABLE):

D:04/17/2012 14:03:03

T:04/18/2012 03:09:02/pn

1235487/1078585

cc: DANIEL SCOTT GRAVES, MD, Consulting Physician

OP REPORT
FARR, WILLIAM G
478684
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Page 2 of 2

DICTATING

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J. David Wren, M.D., PhD
Rosanna L. Lapham, M.D.
William W. Mims, M.D.
John A. Caldwell, M.D.
Alfred W. Campbell, M.D.

Spartanburg Regional

101 E. Wood Street
Spartanburg, SC 29303
864-560-6212

-1099-
Amy C. Baruch, M.D.
Gist H. Farr, M.D.
Jared G. Block, M.D.
E. Travis Smith, M.D.
Keith J. Kaplan, M.D.

Name: **FARR, WILLIAM G.**

DOB: [REDACTED]

Provider: CHRISTOPHE NGUYEN MD

Encounter: S1210301383

Location: SURGERY/RECOVERY

MRN: S000478684

Sex: M

Age: 69

Accession #: S12-05235

Collection Date: 4/17/2012

Date Received: 4/17/2012

Date Reported: 4/20/2012

SURGICAL PATHOLOGY REPORT

DIAGNOSIS

A. LUNG, LEFT UPPER LOBE, WEDGE RESECTION:

- WELL DIFFERENTIATED ADENOCARCINOMA, LIPIDIC PREDOMINANT AND WITH ACINAR PATTERN
(SEE TUMOR SYNOPTIC REPORT).

B. LUNG, LEFT UPPER LOBE, WEDGE RESECTION:

- WELL DIFFERENTIATED ADENOCARCINOMA, LIPIDIC PREDOMINANT AND WITH ACINAR PATTERN
(SEE TUMOR SYNOPTIC REPORT).

COMMENT

Tumor shows a predominant lipidic pattern with areas of acinar pattern of infiltration. Within the random sections of the lung parenchyma there are multiple minute foci of lipidic in situ adenocarcinoma.

Electronically Signed 4/20/2012 11:51 AM
ROSANNA LAPHAM MD

Tumor synoptic report

Specimen type and laterality: LEFT LUNG, UPPER LOBE

Procedure: WEDGE RESECTION

Specimen integrity: RECEIVED IN TWO PARTS (A AND B)

Tumor site: LEFT UPPER LOBE

Histologic type: INVASIVE ADENOCARCINOMA

Histologic grade: GRADE 1

Tumor size - greatest dimension(s): 3.5 CM IN AGGREGATE

Tumor focality: MULTIFOCAL (SEE COMMENT)

Visceral pleura invasion: PRESENT

Tumor extension: INVOLVES VISCERAL PLEURA

Margins:

- Parenchymal margin: APPEARS POSITIVE

Lymph-vascular invasion: NOT IDENTIFIED

Treatment effect: NOT IDENTIFIED

Regional lymph node status: NOT APPLICABLE

Additional pathologic findings: EMPHYSEMATOUS CHANGE

Pathologic stage: pT2a, pNX

4/20/12
b1
N3

Clinical history

Pre-operative diagnosis: Abnormal pet/ct. Inflamm vs recurrence b/l mostly on LLL

Post-operative diagnosis: Same

History of malignancy: Yes; RML/RLL resect for NSC lung cancer

Specimen(s)

A. Lung, left upper lobe, wedge resection

B. Lung, wedge resection

Frozen section diagnosis:

A. ADENOCARCINOMA. --R. L. LAPHAM, MD

Gross description

A. Received fresh for frozen section labeled with the patient's name, DOB, and "left upper lobe" is an ill defined gray-white, indurated nodule, 1 x 1 x 0.3 cm. The entire specimen is submitted for frozen section diagnosis. One cassette.

Tissue handling and fixation:

Cold ischemic time less than or equal to 1 hour

Time in 10% phosphate buffered neutral formalin is between 6 and 72 hours

B. Received in a formalin-filled container labeled with the patient's name, DOB and "lung left upper lobe" is a wedge resection of lung, 16 g and 6 x 3.5 x 1.6 cm. The pleura is pink and smooth with a staple line along one edge. The periphery at one end of the specimen contains an ill defined gray-white, indurated nodule measuring 2.5 x 1.7 x 1.1 cm. The nodule is exposed at one surface and also extends less than 0.1 cm from the nearest staple line. The area in which the nodule is exposed is marked black and the tissue immediately subjacent to the nearest staple line is marked yellow. The nodule extends to and distorts the overlying pleura. The remainder of the parenchyma is tan-pink, spongy and poorly aerated. Representative sections are submitted as follows.

Summary of sections

B1 - Nodule including staple line (yellow)

B2 - Nodule including area at which it is exposed (marked black)

B3 - Representative lung

Tissue handling and fixation:

Cold ischemic time less than or equal to 1 hour

Time in 10% phosphate buffered neutral formalin is between 6 and 72 hours

Point of Service 101 East Wood St, Spartanburg, SC 29303

Medical diagnosis code(s) as provided. 518.89 518.89

DISCHARGE SUMMARY

PATIENT NAME: FARR, WILLIAM G
DOB: [REDACTED]
MEDICAL RECORD #: 478684
ACCOUNT NUMBER: 1210301383
ADMISSION DATE: 04/17/2012 DISCHARGE DATE: 04/20/2012
ATTENDING PHYSICIAN: NGUYEN, CHRISTOPHE L

ATTENDING SURGEON
Dr. Nguyen.

ADMITTING DIAGNOSIS
Primary malignant neoplasm of the lung.

HOSPITAL COURSE

The patient was admitted on 04/17/2012 by Dr. Nguyen and taken to the operative suite that day for a left thoracoscopic lung biopsy, robot-assisted, of the left upper lobe. The patient tolerated the procedure well, recovered in PACU and was transferred to the floor for further recovering. The patient had couple of episodes of vomiting. Nausea and vomiting were controlled via medication. The patient's oxygenation was supplemented with O2. Chest tube was discontinued. The patient tolerated procedure well, was ambulating on approximately 5 liters nasal cannula with sats in the 88% to 90% range. Per the patient's pulmonologist, the patient will be discharged with prednisone as well as home oxygen. The patient today is tolerating regular diet, desiring to go home in agreement with following up in the office with Dr. Nguyen as well as Dr. Cruz.

DISCHARGE MEDICATIONS

The patient will be sent home on previous home medications as well as appropriate pain medications, nicotine patch and Senokot-S. Pain medications; Norco 10/325 one 2 p.o. q. 4 hours p.r.n. for pain.

DISCHARGE INSTRUCTIONS

The patient has been given appropriate instructions on how to taper steroid dose and to use oxygen when ambulating or as needed for shortness of breath when not ambulating.

DISCHARGE FOLLOWUP

The patient will follow up with Dr. Cruz in 1 to 2 weeks and with Dr. Nguyen next week.

DICTATED BY: WILLIAM JACOBS RIVERS III, MD
DICTATED FOR:

DISCHARGE SUMMARY
FARR, WILLIAM G
478684

Page 1 of 2

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ADMITTING

D:04/20/2012 12:52:42
T:04/21/2012 07:55:59 /hn
1236928/1079930

cc: CHRISTOPHE NGUYEN, MD, Admitting Physician
DANIEL SCOTT GRAVES, MD, Consulting Physician
RAUL MANUEL B. CRUZ, M.D.

DISCHARGE SUMMARY
FARR, WILLIAM G
478684
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Page 2 of 2

ADMITTING

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SPARTANBURG REGIONAL MEDICAL CENTER
SPARTANBURG, SOUTH CAROLINA
HISTORY AND PHYSICAL

PATIENT NAME: FARR, WILLIAM G
MEDICAL RECORD #: 478684
DATE OF BIRTH: [REDACTED]
ACCOUNT NUMBER: 1211401433
DATE OF ADMISSION: 04/23/2012
ROOM: 822

ATTENDING SURGEON
Christophe Nguyen, MD

Reason FOR ADMISSION
Pneumothorax and subcutaneous air in the left chest.

HISTORY OF PRESENT ILLNESS

Mr. Farr is a gentleman who was recently discharged from the hospital subsequent to a left lung biopsy. The patient was discharged home on home oxygen. He comes back today with a large amount of subcutaneous air in the chest wall, back and upper arm on the left side. The patient is having shortness of breath as well. In the ER, the patient was imaged which shows small pneumothorax as well as air in subcutaneous tissues.

PAST MEDICAL HISTORY

COPD, hypertension, colon cancer and lung cancer.

SURGICAL HISTORY

Hernia repair, nasal surgery, upper middle lobectomy on the right and left lung biopsy.

MEDICATIONS

1. Klor-Con 20 mEq twice a day.
2. Multivitamins daily.
3. Nicotine patch 14 mg daily.
4. Omeprazole 20 mg twice a day.
5. Prednisone 10 mg daily.
6. Senna 8.6 mg twice a day.
7. Simvastatin 40 mg at bedtime.
8. Symbicort 160/4.5 mcg twice a day.
9. Triamterene 50/25 mg at bedtime.
10. Lortab 7.5 mg p.r.n.
11. ProAir p.r.n.

4/24/12
N3

PHYSICAL EXAMINATION

H & P
FARR, WILLIAM G
478684

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Page 1 of 2

ATTENDING

GENERAL: The patient is alert, awake and oriented x3.

CARDIAC: Regular rate and rhythm. No murmurs, gallops or rubs appreciated.

LUNGS: Clear to auscultation bilaterally. Large amount of subcutaneous air. The patient is having some inspiratory effort issues.

ABDOMEN: Soft, nontender and no distention.

NEUROLOGIC: Moves all extremities.

ASSESSMENT AND PLAN

A 70-year-old gentleman with subcutaneous air and small pneumothorax on the left side, status post surgical changes. We will insert chest tube on the left side to evacuate the pneumothorax and admit the patient for observation.

DICTATED BY: WILLIAM JACOCKS RIVERS III, MD

DICTATED FOR (IF APPLICABLE):

D:04/24/2012 05:55:50

T:04/24/2012 06:28:54/sn

1238179/1080802

Cc: CHRISTOPHE NGUYEN, MD, Attending Physician

H & P

FARR, WILLIAM G

478684

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ATTENDING

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CONSULT

PATIENT NAME: FARR, WILLIAM G
DOB: [REDACTED]
MEDICAL RECORD #: 478684
ACCOUNT NUMBER: 1211401433
ADMISSION DATE: 04/23/2012
DATE OF SERVICE:
ATTENDING PHYSICIAN: NGUYEN, CHRISTOPHE L
ROOM: 410

REFERRAL FROM

Dr. Cruz.

REASON FOR REFERRAL

Discussion of goals of care.

ASSESSMENT

This is a 69-year-old white male with a history of non-small lung cancer with recurrence, stage IV, here for pneumothorax diagnosed in 10/10 and treated with chemoradiation. The patient is very realistic concerning his prognosis and effectiveness of chemotherapy.

SYMPTOMS

Right now, mainly severe dyspnea at rest but no pain, complains of fatigue and anorexia.

PROGNOSIS

I think, 3 to 6 months if he continues to decline. With chemo, could offer a survival management with PPS 50% premorbid condition. He has had some loss of ADLs and was declining. He is living at home independently.

GOALS OF CARE

1. He wants to improve enough to receive chemotherapy if offered.
2. Improve shortness of breath and dyspnea.
3. Go home to see his garden.
4. Wants his daughter and son to be his health care power of attorney.
5. We will make decision on code status over the weekend when he talks to his family.

ADVANCED CARE PLANNING

He is a full code. At this time, he has no living will. He is decisional. Wife right now is his power of attorney.

CONSULT

FARR, WILLIAM G
478684
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Page 1 of 3

ADMITTING

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RECOMMENDATIONS

1. I will get chaplain here to help with health care power of attorney and documents.
2. I have recommended the team to start him on MS Contin 15 mg p.o. b.i.d. to help with dyspnea. I am going to leave this to the primary team to write the order.
3. We will start him on some Tessalon Perles p.o. t.i.d. for cough.
4. I am going to follow up ____ I would recommend for DNR status based on his advanced disease.
5. The patient is very realistic about his current condition. Obviously, he is not very excited about it but has good expectations of what chemotherapy may offer.

HISTORY OF PRESENT ILLNESS

Mr. Farr is a 69-year-old gentleman diagnosed with non-small cell lung cancer in October of 2010 and had surgery in November of 2010 and had a recurrence in August of 2011. He has received chemotherapy and radiation which he said he was unable to finish all of it previously. The patient was just recently in the hospital from 04/17 to 04/20 for a lung biopsy. Unfortunately, he came back and had a pneumothorax _____. He had been in the ICU, and today, he has done pretty well except that he feels weak, fatigued and very short of breath. I had a very long conversation today _____ his daughter and himself. We discussed his goals which were to try to get better enough to get chemotherapy but he understands that there is a little possibility that may not happen. Also, would like to get home to see his garden. We did briefly discuss about his code status which is a decision _____ going to think up over the weekend. I did not give any recommendations at this time but I did tell him that there may be very little benefit for him if he coded and once on the ventilator, the decision _____ be made to withdraw a code by his family. He did tell me that he wanted his family, his daughter and his son to be his power of attorneys.

PAST MEDICAL HISTORY

Significant for hypertension, colon cancer, COPD and non-small cell lung cancer.

PAST SURGICAL HISTORY

Middle lobe lobectomy and hernia repair.

MEDICATIONS

Reviewed.

SOCIAL HISTORY

He has got 2 children. He worked in the mills most of his life and then he owned an ABC convenience store. He likes to garden. He has continued to smoke but he has cut down, I understand.

ALLERGIES

No known drug allergies.

CONSULT

FARR, WILLIAM G

478684

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Page 2 of 3

ADMITTING

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REVIEW OF SYSTEMS

- 12-point review of systems is positive for anorexia, fatigue and the pain as noted above.

PHYSICAL EXAMINATION

GENERAL: Today, the patient is a frail white male lying in the bed. Obviously, dyspneic with just minimal conversation.

VITAL SIGNS: Temperature 97.8, pulse 109, respirations 16 and blood pressure 127/76. He is on 6 L.

HEENT: Sclerae are nonicteric.

NECK: Supple.

LUNGS: Show some rhonchi in both lung fields. There is still some subcutaneous crepitus noted on the left side.

ABDOMEN: Soft and nontender. He has got good bowel sounds. No hepatosplenomegaly.

EXTREMITIES: Warm and dry.

I spent from 0915 this morning to 0950 today reviewing the chart and again today from 1530 to 1640, greater than 50% of the time counseling with the family and discussing goals of care.

DICTATED BY: BRIAN WAYNE BELL, M.D.

DICTATED FOR (IF APPLICABLE):

D:05/04/2012 16:31:43

T:05/05/2012 06:07:24/rn

1242783/1084964

Cc: CHRISTOPHE NGUYEN, MD, Admitting Physician
WILLIAM JACOCKS RIVERS III, MD, Consulting Physician
Health Informatics

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SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG, SC 29303

CONSULT

PATIENT NAME: FARR, WILLIAM G
DOB: [REDACTED]
MEDICAL RECORD #: 478684
ACCOUNT NUMBER: 1211401433
ADMISSION DATE: 04/23/2012
DATE OF SERVICE: 04/24/2012
ATTENDING PHYSICIAN: NGUYEN, CHRISTOPHE L
ROOM: 822

REASON FOR CONSULTATION

The patient known to us for his chronic obstructive pulmonary disease and with spontaneous pneumothorax.

HISTORY OF PRESENT ILLNESS

Mr. Farr is a 69-year-old Caucasian male with a history of recurrent non-small cell lung cancer, has had a history of a right middle lobe, right upper lobectomy bilobectomy for non-small cell lung cancer in December 2010. He has had recurrence in the fall of last year and has undergone chemo when he presents to Dr. Cruz for evaluation again of some nodules. Abnormal PET scan suggested possible infection. Dr. Cruz did a bronchoscopy, was nondiagnostic, sent to Dr. Nguyen for further evaluation. He underwent a VATS procedure. Lung biopsy and resection of the left upper lobe, which did confirm recurrent non-small cell lung CA in the left upper lobe with invasive adenocarcinoma of the visceral pleura. prior to discharge, a repeat chest x-ray did show a small pneumothorax. The patient was stable, discharged home. States that he woke up during the night with pain in his chest and shortness of breath. He is on home O2 prior to his resection. His FEV1 was around 42% of predicted. He also continues to smoke, unfortunately. States he has not had a fever or chills at home, has been coughing productively on occasion of yellow sputum. Chest x-ray prior to discharge after his resection did show left chest infiltrate. White count though slightly elevated. He presents now in the ER with increasing subcutaneous air over the left chest with no identifiable pneumothorax noted. He was seen by staff medicine, staff surgery and Dr. Nguyen _____ on chest tube was placed. The patient does state since that time he has had improved work of breathing, less short of breath. He does have some pain. He is on supplemental O2. Subcutaneous air has improved as well. Due to the fact that the patient is known to Dr. Cruz for his COPD, he has been asked to assist with his care.

PAST MEDICAL AND SURGICAL HISTORY

Significant for the following;

1. History of colon cancer, status post colectomy in 1987.
2. GERD.
3. Continued tobacco use.
4. COPD.

4/25/12
N7

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5. History of a right middle lobe and right upper lobe bilobectomy for non-small cell in December 2010.
6. Recurrent non-small cell lungs CA in the right chest in October 2011, status post chemotherapy.
7. Hypertension.
8. History of hernia repair.

ALLERGIES

No known allergies.

MEDICATIONS

1. Morphine as needed.
2. Norco as needed.
3. Potassium chloride 40 mEq q.12.
4. Nicotine patch 14 mg daily.
5. Protonix 40 mg daily.
6. Prednisone 10 mg daily.
7. Senokot 17.2 mg daily.
8. Symbicort 160/4.5 mcg 2 puffs q.12.
9. Albuterol MDI q.6 as needed.
10. Lovenox 20 mg subcutaneous q.12.
11. Simvastatin 40 mg daily.
12. Maxzide 37.5/25 mg 1 tablet at bedtime.

SOCIAL HISTORY

The patient resides at home with his wife. He has cut back on his smoking. He is down to about 1/2 pack per day. He does have beer on occasion. No recreational drug use.

FAMILY HISTORY

Positive for bone cancer in his father.

FAMILY HISTORY

Positive for hypertension.

REVIEW OF SYSTEMS

At present time states shortness of breath is much better; uses his inhaler.

MEDICATIONS

Medications at home on a regular basis, but has not used them since admission here.

Sputum production covered above. Denies any significant chest pain prior to the chest tube insertion. He denies any palpitations, history of heart disease, states heartburn is controlled with

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his p.o. medications. Denies nausea, vomiting or diarrhea. Denies any prostate issues. Denies any lower extremity swelling or lower extremity pain.

DIAGNOSTIC WORKUP

Is the following: FEV1 done in our office March 2012 shows moderately severe obstruction, FEV1 is around 1.21 or 42% of predicted. BMP is essentially normal. Glucose slightly bumped at 105. CBC also is essentially normal. Platelet count is 344. Chest x-ray shows done last night at 0600 hours shows left chest tube inserted with some improvement in the shift of mediastinal structures to the right, but on the previous chest x-ray states worsening right basilar air space changes. No pneumothorax identifiable, but extensive gas in the left chest wall. His INR was 1.0.

PHYSICAL EXAMINATION

GENERAL: This is a Caucasian male appearing stated age. No obvious distress.

VITAL SIGNS: Temperature is 97.9 maximum, heart rate 76, respiratory rate 18, blood pressure 131/71 and oxygen saturation is 92% on supplemental O2 at 2 L.

HEENT: His head is normocephalic. His pupils are equal. His oropharynx is with his own teeth, fair condition. No obvious caries noted. No obvious lesions.

NECK: With no appreciable JVD. No palpable lymphadenopathy.

CHEST: Palpable subcutaneous air is present on the left chest almost to the mediastinal area anteriorly and posteriorly only up to about the scapula.

LUNGS: His breath sounds on the right, he does have some coarse breath sounds with a faint wheeze. On the left, he has decreased. Chest tube is intact. No appreciable air leak or drainage on the dressing.

CARDIAC: S1, S2, regular rhythm.

ABDOMEN: Soft, nontender and nondistended.

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

IMPRESSION

His impression and plan of care has been reviewed and discussed in detail with Dr. Cruz:

1. Status post spontaneous pneumothorax.
2. Status post video-assisted thoracic surgery procedure and lung biopsy with resection of left upper lobe showing _____ invasive adenocarcinoma involving the visceral pleura on 04/17 by Dr. Nguyen and group.
3. Chronic obstructive pulmonary disease with continued tobacco use.
4. History of rectal cancer in 1987 with a colectomy.
5. History of gastroesophageal reflux disease.
6. History of therapeutic phlebotomies.

PLAN

At present time, Mr. Farr has been admitted by Dr. Nguyen and group. His home medication, bronchodilators, Symbicort and albuterol metered dose inhaler have been restarted according to

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FARR, WILLIAM G

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the computer. The patient states he has not had them as of yet. We will follow his chest x-ray. He does need pulmonary toiletry, maintenance of his continued supplemental O2, nutrition needs to be encouraged and he also needs to encourage ambulation and maintaining activity. Further medical workup will be obtained as indicated. We thank you for this opportunity to participate in the care of this patient.

DICTATED BY: CHARLENE MCCRAW, NP
DICTATED FOR (IF APPLICABLE): 30502 CRUZ, RAUL MANUEL B.
D:04/24/2012 11:15:38
T:04/25/2012 05:25:02/sn
1238346/1081220

cc: CHRISTOPHE NGUYEN, MD, Admitting Physician
WILLIAM JACOCKS RIVERS III, MD, Consulting Physician

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FARR, WILLIAM G
478684
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CYTOPATHOLOGY REPORT

Patient: FARR, WILLIAM G Accession No: SC12-783
MRN: 478684 Collected: 03 MAY 2012
DOB: [REDACTED] Received: 03 MAY 2012
 Signed Out: 03 MAY 2012
Physician: CRUZ, RAUL MANUEL - SRMC
LOCATION: SPARTANBURG REGIONAL MEDICAL CENTER

TESTING PERFORMED BY: CELLIGENT DIAGNOSTICS
106 VENTURE BLVD, SPARTANBURG, SC 29306
PH: (864) 583-3850 FAX: (864) 583-1405

SPECIMEN:
TYPE: NonGYN Cytology - Thin Prep
SOURCE: Bronchial Lavage
(RLL)

GROSS DESCRIPTION:
Specimen received in CytoLyt; 40mL slightly cloudy pink tinged.

SPECIMEN ADEQUACY:
Satisfactory for evaluation.

INTERPRETATION:
NEGATIVE FOR MALIGNANT CELLS
MARKED ACUTE INFLAMMATION

ELECTRONIC SIGNATURE: AWC jmb 03 MAY 2012
Alfred W. Campbell, M.D.
Jean Barrow; Cytotechnologist

CLINICAL DIAGNOSIS/HISTORY:
512.89

Some tests may have been performed that were developed with
performance characteristics determined by Celligent Diagnostics.
These tests have not been cleared or approved by the US Food and Drug

Administration. The FDA does not require these tests to go through premarket FDA review. The testing is used for clinical purposes and should not be regarded as investigational or for research. This laboratory is certified under the Clinical Laboratory Improvement Amendments (CLIA) as qualified to perform high complexity clinical laboratory testing. Reference laboratories performing these tests are approved by Celligent Diagnostics and are certified as CLIA laboratories, with test development in their laboratory.

----- END OF REPORT -----

SPARTANBURG REGIONAL MEDICAL CENTER

CONSULTING MD

ATTENDING PHYSICIAN				CONSULTING PHYSICIAN				ICD-9-CM							
PRINCIPAL DIAGNOSIS															
ADDITIONAL DIAGNOSES															
PRINCIPAL SURGERY															
ADDITIONAL SURGERY															
DATE															
OTHER SIGNATURE								ACCOMMODATION							
OTHER SIGNATURE								☐ C.C.U. ☐ I.C.U. ☐ NEURO. ☐ POST C.C.U.							
ASSEMBLED				CODED				ANALYZED							
				FINAL CHECK				CORPORATE ID 00348263							
SPARTANBURG REGIONAL MEDICAL CENTER															
DISCHARGED				DISCHARGE DISPOSITION				UNIT NUMBER							
DATE				TIME				000-478884							
☐ ALIVE ☐ AUTOPSY ☐ DEATH +48 ☐ DEATH -48 ☐ STILLBORN ☐ TRANSFERRED															
ACCOUNT NO.		ADMISSION DATE / TIME		FC	DATE OF BIRTH	AGE	SEX	RACE	MS	SERVICE	STATION	ROOM NO.	ACC	PAT. TYPE	
8 1215200150		05/31/12 1717		MC		89Y	M	1	M	MED	5H	8527-A	T	IP	
RESIDENT / REFERRING DOCTOR				ADMITTING DOCTOR				ACCIDENT / WORK RELATED				ACCIDENT DATE / TIME		ADM. TYPE / SOURCE	
PALADUGU, RAJA				PALADUGU, RAJA				NO						1 7	
PATIENT INFORMATION				SOC. SEC. NO.				PATIENT EMPLOYER				TELEPHONE NO.			
FARR, WILLIAM G								RETIRED							
1032 JONESVILLE LOCKHART				TELEPHONE NO.											
HWY UNION SC 29379				(884)251-0531											
GUARANTOR NAME AND ADDRESS				SOC. SEC. NO.				GUARANTOR EMPLOYER				TELEPHONE NO.			
FARR, WILLIAM G								RETIRED							
1032 JONESVILLE LOCKHART				TELEPHONE NO.								OCCUPATION			
HWY UNION SC 29379				(884)251-0531								RETIRED			
RELATION SELF															
RELATIVE 1				(884)426-8788				RELATIVE EMPLOYER							
FARR, DELORIS				SPOUSE								UNEMPLOYED			
1032 JONESVILLE LOCKHART															
UNION SC 29379															
INSURANCE 1				INSURANCE 2				INSURANCE 3				INSURANCE 4			
MEDICARE				MEDICARE 1500 F/C MC				AARP MED SUPP							
2300 SPRINGDALE DRIVE				2300 SPRINGDALE DRIVE				UHC/CLAIMS DIVISION							
CAMDEN SC 29020				CAMDEN SC 29020				ATLANTA GA 30374-0818							
FARR, WILLIAM G				FARR, WILLIAM G				AARP PLAN F							
PRESENTING COMPLAINT				ARRIVAL MODE		FEB / VAL		ADV. DIR.		PAT. CLA.		DECOM		ADM. BY	
486-PNEUMONIA, ORGANISM NOS				EMS		N		NO				BAP		KMB	
STAFF ALERT:				OBSERVATION: ☐ YES ☐ NO											
PREVIOUS ENCOUNTER NAME / DATE / TYPE				GIC											
FARR, WILLIAM G				05/10/12											

SPARTANBURG REGIONAL MEDICAL CENTER
SPARTANBURG, SOUTH CAROLINA
HISTORY AND PHYSICAL

PATIENT NAME: FARR, WILLIAM G
MEDICAL RECORD #: 478684
DATE OF BIRTH: [REDACTED]
ACCOUNT NUMBER: 1215200150
DATE OF ADMISSION: 05/31/2012
ROOM: 8527 54

CHIEF COMPLAINT

This is a patient with chief complaint of shortness of breath.

He is a 69-year-old male, patient of Dr. Littlefield, with a 2-week history of shortness of breath. Four weeks ago, the patient relates he was in the hospital for a left lower lobe biopsy. He had a small pneumothorax associated with it and had to stay in-house for treatment with chest tube. Discharged home, did not really feel good. No fevers or chills. The cough is productive of scant clear sputum. No leg swelling. No chest pain noted. Now, he is in today because he simply is more short of breath.

ALLERGIES

He has no known drug allergies.

PAST MEDICAL HISTORY

Past history for colon cancer and non-small cell lung cancer with a right upper and middle lobe lobectomy. He states he also had a left lobe lobectomy, although I do not see it in the records. He has COPD, hypertension, an extensive history of smoking and hypokalemia.

CURRENT MEDICATIONS

To the best of his knowledge are potassium 20 b.i.d., omeprazole 20 b.i.d., prednisone 20 a day, Zocor 40 a day, Symbicort 160, Maxzide 50/25 and Lortab as needed.

SOCIAL HISTORY

Reformed smoker.

FAMILY HISTORY

Noncontributory.

REVIEW OF SYSTEMS

Done in full. Notable for weakness, dyspnea and cough. No fevers. No chills. Constitutional issues as noted above, but no frank chest pain, jaw pain or left arm pain noted.

PHYSICAL EXAMINATION

H & P

FARR, WILLIAM G

478684

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CHART COPY

VITAL SIGNS: Currently, his systolic blood pressure is 116 over diastolic 85, pulse 115, respiratory rate 22 and saturation 98% on 15 L mask, now down to 4 L nasal cannula at 97%.

GENERAL: Emaciated, weak white male, dyspneic but conversant. Nasal cannula in place. Oropharynx is clear.

NECK: Supple. No thyromegaly. No lymphadenopathy.

HEART: Rhythm tachycardic.

LUNGS: Wheezes and rhonchi.

ABDOMEN: Soft and nontender.

EXTREMITIES: No cyanosis, clubbing or edema.

LABORATORIES

Lab was reviewed. White count slightly elevated. Chest x-ray, possible infiltrations.

ASSESSMENT AND PLAN

1. Shortness of breath with possible infiltrate. Alerted Dr. Cruz for consultation. Check a BNP. CTA with _____. Maxipime. A CT scan with contrast. Nebulizers and steroids.
2. Non-small cell cancer. Consult Dr. Mekita.
3. The patient wishes to be a full code. We will honor that request, although discussion with Dr. Cruz, he feels that his long-term outlook is very bleak with a very poor prognosis.
4. Hypertension. Continue Maxzide.
5. Chronic obstructive pulmonary disease. Stable. No chest pain for now, but given slightly elevated troponin, we will check a troponin in the morning and an EKG now. We will _____ this patient over to Dr. Littlefield in the morning who knows this patient.

Dictated by: Maximillian Cortez Finch, M.D.

Dictated for (if applicable):

D:05/31/2012 11:45:22

T:05/31/2012 21:56:09/rn

1252991/1093920

Cc: RAJA PALADUGU, M.D., Attending Physician

H & P
FARR, WILLIAM G
478684

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12/12

2012-Jun-05 11:10 AM Shear 8645608055



FORM: 1080

MD Progress Notes - FARR, WILLIAM G - 06/04/12 08:47
(SUMMARIZED PATIENT DATA ONLY, COMPLETE DATA ONLINE.)

PROG NOTES TOTAL Most recent value for 06/04 (Range for past 24 hrs excluding most recent value)

Temp 1 (P) 98.62 07:21	(97P Gr1-97.9P 0) Resp	16 Viss 021	(18 Visual)	Oxygen L 32 No 021	(32 No)
Pulse #1 92 Brea 021	(84 Chm-99 021) BP #1	130/80 021	(110-116/60-72)	O2 Saturat 99% Sup 021	(91% Sup-98% Sup)

INTAKE Summary values for past 24 hours

Oral 460 ml IVPA 100 ml

OUTPUT Summary values for past 24 hours

Urine 250 ml Urine Occu 2 cc

ALL LABS Most recent value for 06/04 (Range for past 24 hrs excluding most recent value)

BASIC METABOLIC PANEL	EST. GFR A >60	Neutrophil 77.60 06:15
Sodium 138 06:15	EST. GFR O >60	Lymphocyte 10.20 06:15
Potassium 3.9 06:15	COMPLETE BLOOD COUNT WITH AUTOMA	Monocyte P 21.40 06:15
Chloride 105 06:15	White Blec 9.4 06:15	Eosinophil 0.30 06:15
Carbon Dio 25.9 06:15	Red Blec 3.95 06:15	Basophil P 0.50 06:15
Glucose 89 06:15	Hemoglobin 12.4 L 06:15	Nucleated 0.0 06:15
Urea Nitro 14 06:15	Hematocrit 28.1 L 06:15	Absolute L 1.0 06:15
Creatinine 1.02 06:15	Mean Corpus 91.8 06:15	Absolute M 1.1 06:15
Bun/Creat 14 06:15	Mean Corpus 31.3 06:15	Absolute H 7.3 06:15
Anion Gap 12 06:15	Mean Corpus 34.2 06:15	Absolute E 0.0 06:15
Osmolality 275 06:15	Red Cell D 18.3 06:15	Absolute S 0.0 06:15
Calcium 8.6 06:15	Platelet 203 06:15	Nucleated 0.00 06:15

Echo - EF 55%

No further chest pain. Would not pursue.
will sign off but please call if needed



PATIENT ID: 1215200150



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PROGRESS NOTES

DATE/TIME	NOTES
6/4/12	Pt. arrives on 52 highs - "dents" to ambulation ↓ 30%"
7:40 PM	comes to cough clear phlegm. X-rays cont smoking
10:40	states Dr. Nelson said this is not cancer & Dr. Littlefield says they are going to get this cured.
	T98% HR 92 RR 16 SpO ₂ 89% on mt
	Client: ↓ trachea with air exchange to lungs / veins what
	AB: hr
	Cal: ⊕ P3
	Ext: redness 9.4
	MPO acute/chronic neutrophil
	(2) Bilat infiltrates - on broad spectrum #6 Cefepime
	(3) recurrent NCC lung Ca.
	(4) MI 2011
	Procalcitonin 0 - don't
	viper
	- SpO ₂ ex ⊕
	- DAs of Cefepime
	- scheduled for bronchoscopy
	- only growth on BAL (S-HF 12) was
	Candida Tritoma (?) identified, 8 pcy's
	→ onc / Px believe it is viper
	→ ID consult - called Dr. [unclear] refers
	→ when scheduled for [unclear] [unclear]
	→ DOUBT PNA
	→ after tot of [unclear] is to
	be treated.
	→ add [unclear]?

Patient Lab

1215200150 000-478684 05/31/12
FARR, WILLIAM G
ADM: PALADUGU, RAJA
REF: PALADUGU, RAJA



1080 (Rev. 05-09)



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PROGRESS NOTES

DATE/TIME	NOTES
6/4/12	<u>Palliative care</u>
	ID seen - will file tomorrow
6/5/12	from Mr. [unclear] [unclear] PA & [unclear] [unclear] Mr. [unclear] [unclear] Ref: 127 152 p 76 Chr [unclear] & [unclear] for [unclear] [unclear] as [unclear] Ref: ① Ce long [unclear] ② SP - [unclear] [unclear] ③ [unclear] Ref: [unclear] to [unclear] & [unclear] Mr. [unclear] [unclear] come in [unclear] [unclear]

Patient L# 1216200150 000 478684 05/31/12
 FARR, WILLIAM G
 ADM: PALADUGU, RAJA
 REF: PALADUGU, RAJA



1080 (Rev. 05-09)



FORM: 1080
MD Progress Notes - FARR, WILLIAM G - 06/05/12 08:44
(SUMMARIZED PATIENT DATA ONLY; COMPLETE DATA ONLINE.)



PROG NOTES VITAL		Most recent value for 06/05 (Range for past 24 hrs excluding most recent value)			
Temp	97.4F 0728	(97.3F-97.5F) 0728	20	Vital 0728	(18-22) Vital 02 saturat 95% 0728 (90% Sup-Pit Sup)
Pulse	88 Cmm 0728	(75-100) 0728	BP	122/82 0728	(110-130/60-80)

INTAKE Summary values for past 24 hours
Oral 1060 ml IVPB 200 ml

OUTPUT Summary values for past 24 hours
Urine 950 ml Urine Osm 4000 Stool Osm 1000

At times he feels about his spine. Location not worse but
not significantly better. No new medical issues.
Vitals - 97.4, 88, 20, 122/82
He well dressed well matched arm in mid range of motion
20 to 80s
Heart - normal, no chest pain - 4.5 in all day folds
Chest - Right - abd - right RT
Ext - Pedal
Labs - 2 more tests
HPI: ASC by ca - consensus that is his cancer
pt is motivated, feels to work for treatment. I
am in agreement. AGG 2-3 currently
agreeable to have w/ respect
35 minutes spent bedside. 45 min: coordinating
care
J. Miller



PATIENT ID: 1215200150



SPARTANBURG

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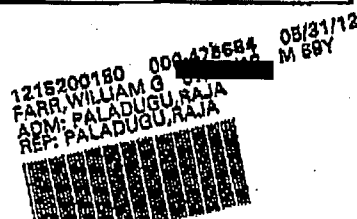
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PROGRESS NOTES

DATE/TIME	NOTES
060517	Palliative Medicine Consult--Full consult to follow
0940	<u>Assessment:</u> 69yo w/ Recurrent NSCLC. Admitted
10:45	for suspected PNA vs Tumor. Grogg None today in hosp
	<u>Symptoms:</u> unable to communicate
	Pain= 1/10 Dyspnea ~~severe~~ ^{mod} Fatigue Anorexia
	Depression Anxiety Sleep difficulties Constipation
	Other
	<u>Prognosis:</u> ☐ Expect Continued Decline ☐ In Hospital death likely
	☐ Gradual Improvement ☐ Days to weeks ☐ Weeks to months
	☒ 3-6 months ☐ <4y year ☐ Depends on goals
	<u>Expected Disability:</u> ☐ Mild ☐ Moderate ☒ Severe ☐ Total care
	<u>PPS score:</u> 60%
	<u>PC Screen revealed problems in these areas:</u>
	☐ Child care ☐ Housing ☐ Insurance ☐ Transportation ☐ Work/school
	☐ Finances ☐ Family Problems ☐ Cultural issues with care
	☐ Spiritual concerns/problems ☐ Caregiver Breakdown
	☐ Communication problems with Medical providers
	<u>Goals of care:</u>
	1. Desired disposition plan ☒ Home with ☒ Hospice or ☐ Home health
	☐ SNF/ALF ☐ LTACH ☐ Hospice Home ☐ Unknown
	2. Code Status ☒ Full code ☐ DNR ☐ Comfort care only
	☐ Limited low burden treatments:
	3) Wants to improve to the point he can receive chemo therapy → Feels to well @ the time.
	4) Improve dyspnea

Patient Label

1080 (Rev. 05-09)



2012-Jun-05 11:10 AM Sheart 8645608055

6/12

PRINTED BY: DB30588

DATE 7/18/2013

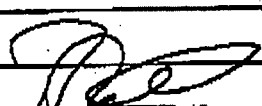


SPARTANBURG

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PROGRESS NOTES

DATE/TIME	NOTES
060517	ACP: Code status DNR <u>full code</u> Living With yes <u>no</u> Decisional capacity: <u>yes</u> no HCPOA/proxy decision maker Brian Fenn is HCPAN Recommendations: 1) Continue to Fortang for discharge -> 2) Agree to Hospice at discharge I suspect he has a low probability that he may improve enough to return home to household ECOG score (2-3) 3) Continued discussion about Code Status to hospice organization would remain for DNR/DNI Follow Up: ☐ Daily ☐ 2-3x Week ☐ Weekly to assist with: ☐ Symptom management ☐ Psychosocial support ☐ Complex decision making ☐ Transitions of Care ☐ Goals of Care ☐ Clinical updates to family Refer: ☐ Chaplain for spiritual support/ HCPOA documents ☐ Social Work for psychosocial support ☐ Hospice referral  Brian W. Bell, MD #706-6288 Thanks for letting us care for this patient.

Patient Label

1216200150 000-478684 08/31/12
FARR, WILLIAM G. M 65Y
ADM: PALADUGU, RAJA
REF: PALADUGU, RAJA



1080 (Rev. 05-09)


SPARTANBURG
 Regional Healthcare System
☐ SRMC☐ SHRC☐ VH

Use Ball Point Pen and Press Firmly

REQUIRED FOR ADMISSION

Height:

Weight:

Allergies:

CHECK
OFF EACH
ORDER AS
TRANSCRIBED**PHYSICIANS ORDER FORM**

TIME

DATE

6/5/12

Diagnosis:

①

Case management to set up home hospice today

Done

②

Please send home on tapering prednisone.

(a)

Lorazepam 3 days

(b)

Alprazolam po x 3 days

20mg

po x 3 days

10mg

po x 3 days

then stop

Please give pt appt w/ Dr. McArthur 6/20/12
at time of d/c Home

TIME NOTED

TELEPHONE/VERBAL ORDER RECEIVED BY:



REMINDER: VERIFY & READ BACK

PHYSICIAN PRINTED NAME

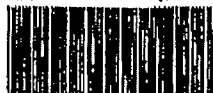
SMC/h

RECORD FINAL DIAGNOSIS ON THE FACE SHEET

PHYSICIAN SIGNATURE

Date/Time 6/5/12

Patient Label

 1215200150 000475684 05/31/12
 FARR, WILLIAM G M 69Y
 ADM: LITTLEFIELD, RONALD
 REP: LITTLEFIELD, RONALD


1108 (Rev. 08-10)

2/12

2012-Jun-05 11:10 AM Sheet 8645608055

PRINTED BY: DB30588

DATE

7/18/2013

Hospice

SPARTANBURG

Regional Healthcare System
Home Care Referral Form

Date: 06-05-2012

MR# U-3293

Account # 1215200150

☐ HHS☒ HOSPICE☐ SRMC☐ SHRC☐ MD office

From: YVONNE GATH Case Manager SPARTANBURG REGIONAL MEDICAL CENTER 101 EAST WOOD STREET Spartanburg, SC 29303 Phone: (864) 560-6926 Mobile: (864) 641-9239		Name: WILLIAM G FARR Birth Date: Address: 1032 JONESVILLE LOCKHART HWY City & State: UNION, SC Zip Code: 29379 Phone: (864) 251-0531 Nearest Relative/Emergency Contact/Primary Caregiver (if different person): DELORIS FARR Phone: (864) 426-5765	
To: Regional Hospice		Primary Insurance Name: MEDICARE INP OUTP SEC P/C MC Primary Insurance#: Secondary Insurance Name: MEDICARE 1500 P/C MC Secondary Insurance#: Other Insurance Information: AARP med supp	
Admitting Physician: RONALD H LITTLEFIELD		Follow-Up MD: Dr. Littlefield	
Diagnosis: Lung Cancer		DME Provider/Infusion Co.:	
Home Health Services Needed: ☒ RN Visit ☐ Speech Therapy ☐ Physical Therapy ☐ Occupational Therapy ☐ Home Health Aide ☐ Nutrition Consult ☐ Medical Social Worker ☐ PATH Referral		Date First Home Visit Needed: ☐ Today ☒ Next Day Visit ☐ 48 Hours ☐ Specific Date	
MRSA: ☐ Yes ☒ No		6/6/12	
Admit date: 05-31-2012		D/C date: 06-05-2012	
MD Orders:			
Comments:			

1215200150 000-478584 05/31/12
 FARR, WILLIAM G 576374 M 69Y
 ADM: LITTLEFIELD, RONALD
 REF: LITTLEFIELD, RONALD

1245-SR Revised 4/2008

ORDER: 939168**PICK UP LOCATION:**

SRMC
101 E WOOD ST
rm 8527
SPARTANBURG, SC 29303

DROP OFF LOCATION

RESIDENCE
1032 jonesville lockhart hwy
UNION, SC 29379

PATIENT
WILLIAM FARR
SERVICE:
BLS NON EMERGENCY
SCHEDULED PICK UP
6/6/2012 10:30:06 AM

UNIT09

BILLY COMPTON
ZACHARY LANGSTON

Notes

CALL CAME IN 6/6 @ 9:35
PT IS ON 02

Status Date/Time	Status	Address	City	State	Zip
06/6/12 10:00 AM	DISPATCHED	188 DEWEY AVE	SPARTANBURG	SC	29303
06/6/12 10:43 AM	ON SCENE	362 SERPENTINE DR	SPARTANBURG	SC	29303
06/6/12 10:54 AM	TRANSPORTING	924 S PINE ST [US-176/SC-9]	SPARTANBURG	SC	29302
06/6/12 11:26 AM	AT DESTINATION	JONESVILLE LOCKHART HWY [SC-9]	JONESVILLE	SC	29353
06/6/12 11:29 AM	CLEAR CALL	JONESVILLE LOCKHART HWY [SC-9]	JONESVILLE	SC	29353
06/6/12 11:29 AM	CALL COMPLETE	JONESVILLE LOCKHART HWY [SC-9]	JONESVILLE	SC	29353

DATE 7/18/2013

PRINTED BY: DB30588

SPARTANBURG REGIONAL MEDICAL CENTER

(DUPLICATE) NURSING UNIT

ATTENDING PHYSICIAN		CONSULTING PHYSICIAN		ICD-9-CM	
PRINCIPAL DIAGNOSIS					
ADDITIONAL DIAGNOSES					
PRINCIPAL SURGERY					
ADDITIONAL SURGERY					
DATE					
OTHER SIGNATURE				ACCOMMODATION	
OTHER SIGNATURE				☐ C.C.U. ☐ I.C.U. ☐ NEURO. ☐ POST C.C.U.	
ASSEMBLED	CODED	ANALYZED	FINAL CHECK	CORPORATE ID	
SPARTANBURG REGIONAL MEDICAL CENTER				00348263	
DISCHARGED		DISCHARGE DISPOSITION			UNIT NUMBER
DATE	TIME	☐ ALIVE ☐ AUTOPSY ☐ DEATH +48 ☐ DEATH -48 ☐ STILLBORN ☐ TRANSFERRED	000-478684		
ACCOUNT NO.	ADMISSION DATE / TIME	FC	DATE OF BIRTH	AGE	SEX RACE MS SERVICE STATION ROOM NO. ACC PAT. TYPE
S 1215200150	05/31/12 1717	MC		69Y	M 1 M MED 5H 8527-A T IP
RESIDENT / REFERRING DOCTOR		ADMITTING DOCTOR		ACCIDENT / WORK RELATED	
LITTLEFIELD, RONALD		LITTLEFIELD, RONALD		NO	
PATIENT INFORMATION		SOC. SEC. NO.		PATIENT EMPLOYER	
FARR, WILLIAM G				RETIRED	
1032 JONESVILLE LOCKHART		TELEPHONE NO.		TELEPHONE NO.	
HWY UNION SC 29379		(864)251-0531			
GUARANTOR NAME AND ADDRESS		SOC. SEC. NO.		GUARANTOR EMPLOYER	
FARR, WILLIAM G				RETIRED	
1032 JONESVILLE LOCKHART		TELEPHONE NO.		OCCUPATION	
HWY UNION SC 29379		(864)251-0531		RETIRED	
RELATIVE 1		RELATIVE EMPLOYER		UNEMPLOYED	
FARR, DELORIS		(864)426-5765			
1032 JONESVILLE LOCKHART		SPOUSE			
UNION SC 29379					
INSURANCE 1		INSURANCE 2			
MEDICARE 1		MEDICARE 1500 F/C MC 1			
2300 SPRINGDALE DRIVE		2300 SPRINGDALE DRIVE			
CAMDEN SC 29020		CAMDEN SC 29020			
MEDICARE FARR, WILLIAM G		MEDICARE FARR, WILLIAM G			
250680627A					
INSURANCE 3		INSURANCE 4			
AARP MED SUPP 1					
UHC/CLAIMS DIVISION P O BOX 7408					
ATLANTA GA 30374-0819					
AARP FARR, WILLIAM					
PLAN F 32853635011					
PRESENTING COMPLAINT		ARRIVAL MODE	PUB / VAL	ADV. DIR.	PAT CLA
486-PNEUMONIA, ORGANISM NOS		EMS	N	NO	DENOM
STAFF ALERT:		OBSERVATION: ☐ YES ☐ NO		ADM. BY	
PREVIOUS ENCOUNTER NAME / DATE / TYPE		GIC		KMB	
FARR, WILLIAM G		05/10/12			

T09

121590341

INPATIENT

PRINTED BY: DB30588

DATE

7/18/2013



Physician Certification Statement for Ambulance Transportation

Section I - Patient Information

Last Name:

FARR

Date(s) of Service

First Name:

William

Date

6/6/11

to

Patient transported from:

SRMC 8527

Patient transported to:

1032 Jonesville Lockhart Hwy

Union SC 29379

Section II - Qualifying documentation supporting presumptive reasons that non-emergency ground transport by any other means than ambulance is contraindicated. Supporting documentation for any boxes checked must be maintained in the patient's medical records.

Check all that apply

- ☐ Bed Confined *All three below must be met to qualify for bed confinement
- Unable to ambulate *
 - Unable to get out of bed without assistance *
 - Unable to safely sit up in a wheelchair *
 - ☐ Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate muscular weakness and de-conditioning.
 - ☐ Unable to sit in chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks.
- ☒ Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route
- ☐ I.V. medications/fluids required during transport
- ☐ Cardiac/Hemodynamic monitoring required during transport
- ☐ Special Handling en route - Isolation
- ☐ Contractures
- ☐ Non-healed fractures
- ☐ Moderate to severe pain on movement
- ☐ DVT requires elevation of lower extremity
- ☐ Morbid Obesity requires additional personnel/equipment to handle
- ☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling in transit
- ☐ Severe muscular weakness and de-conditioned state precludes any significant physical activity
- ☐ Restraints (physical or chemical) anticipated or used during transport
- ☐ Danger to self or others - monitoring
- ☒ Risk of falling off wheelchair or stretcher while in motion (not related to obesity)
- ☐ Danger to self or others - seclusion (flight risk)
- ☐ Confused, combative, lethargic, comatose

1215200150 000-478684 05/31/12
 FARR, WILLIAM G M 69Y
 ADM: LITTLEFIELD, RONALD
 REF: LITTLEFIELD, RONALD



Section III - Physician's Authorization

I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date of service.

Littlefield
 (Signature of Attending Physician)

R. Littlefield
 (Attending Physician's Name Printed)

Date

6/6/11

This authorization must be completed and signed by the attending physician for scheduled repetitive transports. For unscheduled or scheduled non-repetitive transport the authorization may be signed by the attending physician, physician assistant, clinical nurse special, nurse practitioner, registered nurse or discharge planner (employed by the facility where the beneficiary is being treated) who has personal knowledge of the beneficiary's condition at the time ambulance transport is ordered or furnished.

Version 03/2009

1215901341

FINAL**Patient Care Report****SRMC Transportation**

101 EAST WOOD STREET
SPARTANBURG, SC 29303
(864) 560-4118 Ext.

Run Number: 939168

Patient Number: 1 of 1

Date of Service: 06/06/2012

Patient Name: WILLIAM FARR

Medical Record #

Account #

CREW INFO	RESPONSE INFO	DISPOSITION	TIMES
Vehicle: 17909 Call Sign: Unit 9 Crew #1: LANGSTON, ZACHARY Crew #2: COMPTON, WILLIAM Doc'd By: LANGSTON, ZACHARY Assisted By: 0 0 0	Med/Trauma: Medical Response Priority: Pre-Scheduled Nature Of Call: Transfer Start Mileage: 64,379.7 Resp. Delay: No Delay Trans. Delay: No Delay Call Taken by: Transport Dispatch Resp. with: Location: Spartanburg Regional Medical Center Dept: In-Patient 101 E. WOOD ST RM 8527 SPARTANBURG, SC 29303 Pt. Found: In Bed	Outcome: Hospital Dest. Reason: Patient Choice Transport Priority: Non-Emergency At Scene Mileage: 64,385.2 At Dest. Mileage: 64,408.4 Condition at Dest.: Unchanged Level of care: BLS Barriers to Care: None Pt. Transported: Semi-Fowlers - Main Stretcher Scene Delay: No Delay Destination: 1032 JONESVILLE LOCKHART HIGHW Union, SC 29379 Recv Doctor: Transporting Agency: SRHS Transport	Recvd: 10:00 06-06-12 Dispatch: 10:01 06-06-12 En route: 10:09 06-06-12 At scene: 10:24 06-06-12 At patient: 10:33 06-06-12 Transport: 10:44 06-06-12 At dest.: 11:20 06-06-12 In service: 11:27 06-06-12

- PATIENT INFORMATION

Name: WILLIAM FARR	Phone: (864) 251-0531	DL Info:
SSN: [REDACTED]	DOB: [REDACTED]	Weight: 165 lbs
Sex: Male		
Race: Caucasian	Home Addr.: 1032 JONESVILLE LOCKHART HYW UNION, SC 29379	Mailing Addr.: 1032 JONESVILLE LOCKHART HYW UNION, SC 29379
Marital Status: Married		
Doctor:	Marital Status: Married	
Doctor:		

NEXT OF KIN

Name:	Phone:	Relationship:
SSN:	DOB:	
Sex:	Home Addr.:	

Charges

Account #	Admitted Yes / No
Base Charge	Amb. Svc, Non-Emergency, BLS A0428
Mileage Type	Mileage A0425 Miles 23.20
Origin Modifier H - Hospital	Destination Modifier R - Residence

1215901341

FINAL**Patient Care Report****SRMC Transportation**

101 EAST WOOD STREET
SPARTANBURG, SC 29303
(864) 660-4118 Ext.

Run Number: 939168

Patient Number 1 of 1

Date of Service: 06/06/2012

Patient Name: WILLIAM FARR

Medical Record #

Account #

Medicare Questions**Retirement Date**

Pt on Dialysis? No

Pt receive VA benefits? No

Pt in Black Lung Program? No

Pt had Kidney Transplant? No

INSURANCE

Work Related: No

Payor Info:

Company: Medicare

Policy #: [REDACTED]

Name:

Address:

SSN:

Phone:

Date of Birth:

HISTORY**Allergies**

No Known Drug Allergies

Chief Complaint

Transfer - Non Emergency

Medications

Other - Not Listed -

Note: SEE PATIENT PACKET

Past Medical History

Hypertension

Cancer - Lung

Cancer - Colon

Respiratory Problems - COPD

ASSESSMENTS

06/06/2012 10:44:46 By: LANGSTON, ZACHARY

<u>Body Area</u>	<u>Assessment</u>	<u>Body Area</u>	<u>Assessment</u>
Airway	Patent	Breathing	Normal Respirations
	Patent		Normal Respirations :
Circulation	Pulses - Radial - Normal (2+)	LOC	A & O to person, place, time, event
	Pulses - Radial - Normal (2+)		A & O to person, place, time, event :
Central Nervous System	Neuro Intact	Blood/Fluid Loss	None Noted
	Neuro Intact :		None Noted :

IMPRESSIONS**Primary Impression:** Short Of Breath 788.09**Secondary Impressions:** C.O.P.D. 496.**TRAUMA**

no trauma entered

1215901341

FINAL

Patient Care Report



SRMC Transportation

101 EAST WOOD STREET
SPARTANBURG, SC 29303
(864) 560-4118 Ext.

Run Number: 939168

Patient Number 1 of 1

Date of Service: 06/06/2012

Patient Name: WILLIAM FARR

Medical Record #

Account #

VITAL SIGNS

Time	BP	Pulse	Respiratory	SPO2	EtCO2	Glucose	GCS
10:45	119/84 NIBP Machine	95, Strong, Regular	18 Normal, Regular	97%, Source: Supplemental			E4 + V5 + M6 = 15
Skin Temp=Normal Skin Color=Normal Skin Moisture=Normal Cap. Refill=Normal Level of Consciousness: Alert; Pain Scale=0;							
Taken by: LANGSTON, ZACHARY							

TRAUMA SCORES

no trauma scores entered

Comments:

TREATMENT SUMMARY

Time	PTA	Treatment	Who performed	Comments
10:47		Oxygen	LANGSTON, ZACHARY	
		Complication	Complication Narrative	
		None		
		Device=Adult Cannula	LPM=6 LPM	Result=No Change
		Response=Unchanged	Route=Inhalation	Indication=Continued from Facility/Home

NARRATIVE

69 YEAR OLD MALE TRANSPORTED FROM SRMC RM 8527 TO RESIDENCE. PATIENT FOUND IN BED AND WAS ABLE TO WALK TO STRETCHER THEN SECURED WITH TWO STRAPS AND RAILS. PATIENT IN NEED OF AMBULANCE TRANSPORT DUE TO SHORTNESS OF BREATH, COPD, AND HISTORY OF LUNG CANCER. VITALS TAKEN AND RECORDED ABOVE. ABC's MONITORED DURING TRANSPORT AND NO PROBLEMS OCCURRED. OXYGEN DELIVERED BY ADULT CANNULA AT 6 LPM. PATIENT ABLE TO WALK TO COUCH AT RESIDENCE WITH MINIMAL ASSISTANCE AND LEFT IN CARE OF FAMILY.

1215901341

FINAL

Patient Care Report



SRMC Transportation

101 EAST WOOD STREET
SPARTANBURG, SC 29303
(864) 560-4118 Ext.

Run Number: 939168

Patient Number 1 of 1

Date of Service: 06/06/2012

Patient Name: WILLIAM FARR

Medical Record #

Account #

SIGNATURES

Time	Type	Who signed	Why patient did not sign
06/06/2012 10:47	Responsible Party	Self - FARR, WILLIAM	<Not applicable>

X 10:47

WILLIAM FARR or the patient's lawful representative or surrogate for consent to treatment acknowledges that the medical care which (was) (is about to be) furnished to the patient (was) (will be) limited solely to emergency transportation and treatment. The Undersigned authorizes such medical treatment and transportation as being considered medically necessary. I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to Spartanburg Regional Medical Center EMS for any services provided to me by Spartanburg Regional Medical Center EMS now or in the future. I understand that I am financially responsible for the services provided to me by SRMC EMS, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to Spartanburg Regional Medical Center any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Spartanburg Regional Medical Center. I authorize Spartanburg Regional Medical Center to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or documentation about me to release such information to Spartanburg Regional Medical Center and its billing agents, and/or the Centers for Medicare and Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by Spartanburg Regional Medical Center - EMS, now or in the future. A copy of this form is as valid as an original.

Witness

ZACH LANGSTON

x Zach Langston

CREW INFORMATION

Start Date/Time: 06/06/2012 10:00

Crew #	Name
273	LANGSTON, ZACHARY

Crew #	Name
296	COMPTON, WILLIAM

x

x Will R. Compton

1215901341



Spartanburg Regional

HOSPICE

PATIENT NAME: William FarrPATIENT ID: 38224HOSPICE ELECTION EFF. DATE: 6/7/12

ADDRESS:

INSTRUCTIONS: This form is used to acknowledge receipt of our Orientation Booklet and confirm your understanding and agreement with its contents. Your signature below indicates your approval.

PATIENT RIGHTS & RESPONSIBILITIES

I acknowledge that I have been provided with a written copy of my rights and responsibilities as a patient. A hospice representative has discussed them with me and I understand them. The State home health hotline number has been provided and explained to me. I acknowledge that I have chosen this agency to provide hospice care. No employee of this agency has solicited or coerced my decision in selecting a home care agency.

CONSENT FOR TREATMENT

I hereby give my permission for authorized personnel of your agency to perform all necessary procedures and treatments as prescribed by my physician for the delivery of hospice care. I understand the following hospice care and services may be provided to me during the course of illness: physician, nursing, social work, therapy services, counseling services (bereavement, spiritual, dietary), hospice aide/homemaker, volunteers, durable medical equipment, pharmaceuticals, medical supplies, respite care, short term inpatient care and continuous care. I understand that I may refuse treatment or terminate services at any time and the hospice may terminate their services to me as explained in my orientation. I agree and consent to the care plan and payment as outlined in this admission booklet.

CONSENT TO FILM OR RECORD

I hereby consent for the agency to record or film my care, treatment and services and allow the agency to use the photographs/recordings for their internal use, for documenting my medical condition or for insurance providers to document my condition for payment purposes.

CONSENT FOR HIV/HEPATITIS TESTING

If any employee of this agency is exposed to my blood or other body fluids, I hereby consent for hospice to test my blood for Hepatitis B, C and HIV (the virus that causes AIDS). If required, this testing will be done at no cost to me.

RELEASE OF INFORMATION

I hereby consent for your agency to release to or receive from hospitals, physicians or other agencies involved in my care all medical records and information pertinent to my care. I hereby give permission for the review of my medical record by the agencies accrediting and/or other regulatory bodies.

NOTICE OF PRIVACY PRACTICES

I/We have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. The Notice of Privacy Practices may be accessed at www.srhc.com.

AUTHORIZATION FOR PAYMENT/ELECTION OF HOSPICE CARE

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 all records required to act on this request. I request that payment of authorized benefits from Medicare, Medicaid or other responsible payor be made in my behalf to Spartanburg Regional Hospice. I understand that I am responsible for all amounts not paid by my insurance. If I am a Private Pay patient, I agree to pay for all services rendered by the hospice. I have been provided a full understanding of hospice care and understand that certain benefits are waived by election of the hospice Medicare benefit if applicable. I hereby elect to participate in hospice care under the following program checked:

☐ Hospice Medicare Benefit (Section 11.1)☐ Hospice Medicaid Benefit☐ Private Insurance Hospice Benefit (Section 11.2)☐ Private Pay

If I have Medicare Part A benefits, I understand that Medicare payments will be accepted as payment in full and I have no financial liability, unless I have been notified in writing that service(s) will not be covered by Medicare and wish to receive the care or service.

If I have other insurance, I may be responsible for the co-payment, deductible and any charges that my insurance will not cover. Medicare, Medicaid or Insurance will cover _____ % and patient's responsibility _____ % ☐ Amounts Unavailable

The specific amounts to be determined by your insurance company.

☐ We have contacted your insurance company. Your co-payment deductibles; reasonable and customary charges are pending. You will be contacted by our Home Care billing office when these specific amounts are available to us.

OTHER MEDICARE SERVICES/SUPPLIES

I understand that while I am under the agency's plan of care, the agency will coordinate all medically necessary services and medical supplies for me. Should I arrange for these services or supplies on my own, I understand that Medicare will not reimburse me or my supplier and I will be responsible for their cost.

ADVANCE DIRECTIVES

I understand that the Federal Patient Self-Determination Act of 1990 requires that I be made aware of my right to make healthcare decisions for myself. I understand that I may express my wishes in a document called an Advance Directive (Living Will/Durable Power of Attorney for Health Care) so that my wishes may be known when I am unable to speak for myself.

1. I have made a Living Will

☐ No ☐ Yes

2. I have made a Durable Power of Attorney for Health Care

☐ No ☐ Yes (If yes, provide a copy to the agency)

(If yes, write the name & phone number of the person given power of attorney)

William Farr
Patient's Signature

Date

Monica Chalk, RN
Witness Signature/Agency Representative

Date

Responsible Person or Legal Guardian Signature

Printed Name & Relationship of Person above



Spartanburg Regional

HOSPICE

**-1133-
ELECTION OF HOSPICE
MEDICARE BENEFIT**

PATIENT NAME: William Farr MEDICARE #: _____ HOSPICE ELECTION EFF. DATE: 6/7/12

THROUGH MY PARTICIPATION IN THIS ADMISSION PROCESS I UNDERSTAND THAT I AM REQUESTING ADMISSION TO THE SPARTANBURG REGIONAL HOSPICE PROGRAM. I HAVE BEEN ADVISED BY MY PHYSICIAN OF MY DIAGNOSIS, PROGNOSIS AND LIFE-LIMITING ILLNESS.

1. I understand that the hospice program is not curative, but is palliative in its care and services. I understand that the focus of the care provided by the hospice program is to alleviate my pain and other symptoms, and that no extreme medical or surgical measures or artificial life support systems will be used. I understand that hospice will not play a role in assisted suicide. I have been given ample opportunity to ask questions in accordance with the hospice plan of care.
2. I understand that my hospice care will be coordinated and managed by the hospice interdisciplinary group. Hospice services provided to me will be in accordance with my plan of care. Hospice services provided to me in my home may include:
 - a. Intermittent visits by the team members providing medical, nursing, counseling, social work, pastoral and personal care.
 - b. Intermittent visits and/or consultation, by auxiliary team members providing dietary, physical and personal care.
 - c. Management of my related physical symptoms.
 - d. Instructions for myself and my caregivers for managing my care.
 - e. Counseling and emotional support for my family/caregiver.
 - f. Hospice-trained volunteers to augment the professional services.
 - g. Durable medical equipment and supplies for a medical crisis.
 - h. Continuous home care services for a medical crisis.
 - i. Prescriptions and biologicals as needed for pain and symptom control.
 - j. Inpatient Care:
 1. As the patient/family, I understand that Regional Hospice provides inpatient services in Spartanburg Regional Hospice Home when deemed necessary for **acute pain or symptom control**, or occasionally in Spartanburg Regional Medical Center.
 2. As the patient/family, I understand that Regional Hospice Home may also be authorized for short-term **respite care** for relief for my caregivers.
 3. As the patient/family I understand that Regional Hospice Home is not able to provide long-term hospitalization, custodial or nursing home care, but is designed for short term stays which have as their goal to help me and my family become emotionally and physically stable enough for me to go home.
 4. As the patient/family I understand that all inpatient admissions must be to Spartanburg Regional Hospice Home or Spartanburg Regional Medical Center. If another hospital is utilized, I understand that I will be billed and responsible for all costs related to the admission.
 5. I understand that while I am receiving inpatient hospice services I may have unlimited contact with visitors; keep and use personal belongings; an environment that preserves dignity and contributes to a positive self image.
 - k. I understand that my own attending physician will provide medical care. Consultation with the Hospice Medical Director is available.
3. I understand that all hospice services will be provided as needed directly by Spartanburg Regional Hospice (nursing service, social work, spiritual counseling, volunteers, hospice aide/homemaker services, therapy services, dietary counseling).
4. I understand a nurse is available to respond to my needs by phone or a visit on a 24-hour basis.
5. I understand that I or my family must seek pre-approval for all treatments not on the plan of care; hospice must approve any change in the plan of care, including all inpatient admissions, emergency room and ambulance services.
6. I understand that I will be billed and responsible for all costs of any treatments/procedures not pre-approved by hospice.
7. By choosing the Hospice Medicare Benefit, I understand that I am giving up all rights for regular Medicare benefits to pay for treatment of my life-limiting illness.
8. Under the Hospice Medicare Benefit, Medicare will provide for the following benefit periods:
First Benefit Period = 90 days Second Benefit Period = 90 days Unlimited number of 60 day benefit periods
9. I also understand that I may revoke my election of hospice care any time during an election period and thereby resume the Medicare coverage of the benefits I waived. To revoke this election, I understand I must file a revocation statement with Spartanburg Regional Hospice. At a later date, I may elect to again receive hospice coverage for any of the remaining election periods.
10. If I revoke my Hospice Medicare Benefit in the middle of a benefit period, I give up the remaining days in the benefit period. For example, if I revoke my benefit after the first 10 days, I give up the remaining 80 days in the first benefit period.

William Farr
Patient's Signature

6/7/12
Date

Mamada Chale, RN
Witness Signature/Agency Representative

6/7/12
Date

Responsible Person or Legal Guardian Signature

Printed Name & Relationship of Person above

☐ Patient unable to sign due to: _____

**[WC IS PRIMARY PAYOR ONLY FOR CLAIMS
RELATED TO WORK RELATED INJURIES OR
ILLNESS.]**

7. Was your illness/injury due to a non-work
related accident?

☐ Yes; Date of accident: _____

State in which accident occurred: _____

☒ No. Skip to question 9.

8. What type of accident caused the
illness/injury?

☐ Automobile

☐ Non-automobile

Name and address of non-fault or liability
insurer: _____

Insurance claim number: _____

**[NO-FAULT INSURER IS PRIMARY PAYOR
ONLY FOR THOSE CLAIMS RELATED TO
THE ACCIDENT]**

9. Are you entitled to Medicare based on
disability?

☐ Yes;

☒ No.

10. Are you receiving Black Lung (BL) Benefits?

☐ Yes; Date benefits began: _____

**[BL BENEFITS ARE PRIMARY ONLY FOR
CLAIMS RELATED TO BL.]**

☒ No.

11. Have you received a kidney transplant?

☐ Yes; Date of transplant: _____

☒ No.

12. Have you received maintenance dialysis
treatments for End Stage Renal Disease (ESRD)?

☐ Yes; Date dialysis began: _____

☒ No.

13. Are you within the 30-month coordination period
for ESRD Medicare benefits?

☐ Yes;

☒ No.

Home Care representative Monica Chalk Date 10/7/12

Spartanburg Regional Home Care

Medicare Secondary Payor Questionnaire

This questionnaire helps identify other payors which may be primary to Medicare. Please answer each question (both sides of page) in sequence and comply with any instructions that follow an answer. If the instructions direct you to go to another question, please go directly to that question. After completing the form, please return the form to the Referral center if payor discrepancies are identified.

PATIENT'S NAME William FowrEPISODE NUMBER 38224

1. Are you currently employed?

☐ Yes;☒ No. Date of retirement: _____

If no, skip to question 4

2. Does your present or former employer offer health insurance?

☐ Yes;☐ No. Skip to question 4.

3. Does the employer that sponsors your Group Health Plan (GHP) employ 20 or more employees?

☐ Yes; [GROUP HEALTH PLAN IS PRIMARY]

Name and address of your employer:

Employer's Work Telephone:

Patient's Work Telephone:

Patient's Occupation:

Name and address of GHP

Policy identification number:

Group identification number:

4. Do you have group health plan (GHP) coverage based on your spouse's or parent's current or former employment?

☐ Yes;☒ No. Skip to question 6

5. Does the employer that sponsors your spouse's or parents GHP employ 20 or more employees?

☐ Yes; [GROUP HEALTH PLAN IS PRIMARY]

Name and address of GHP:

Policy identification number: _____

Group identification number: _____

Name of policy-holder: _____

Relationship to patient: _____

☐ No.

6. Was your illness/injury due to a work related accident/condition?

☐ Yes; Date of injury/illness: _____☒ No. Skip to question 7.

Name and address of Worker's Compensation (WC) plan:

Policy or identification number:

Name and address of your employer:



OXYGEN SAFETY CONTRACT

Regional Hospice is committed to patient and family safety. This contract is provided to ensure that our patients and caregivers understand their responsibility in complying with oxygen safety measures.

- *Post No Smoking sign to alert others that oxygen is in use.*
- *No Smoking when oxygen is in use and do not allow others to smoke.*
- *Do Not use oils, alcohol or petroleum based products on your face. (For example: Vaseline, baby oil)*
- *Oxygen concentrator/cylinder should be stored in an open well-ventilated area. Do Not store the concentrator/cylinder in closets or near a heat source.*
- *Do Not use oxygen near open flames or heaters. (For example: fireplace, electric heater, striking matches)*
- *Do Not use oxygen near electrical appliances or other sources of electrical sparks. (For example: stove, cooking appliances)*
- *Oxygen cylinders currently in use should always be secured in the cart holder or stand and kept in an upright position.*
- *Extra oxygen cylinders are secured in a cart holder or stand and kept in an upright position. If a cart holder or stand is not available, the extra cylinder(s) should be stored lying flat on the floor.*
- *Do not store oxygen cylinders under a bed unless the bed is a hospital bed.*
- *Do Not store cylinders in the trunk of your car. Contact a representative from your equipment company for safety instructions when traveling with extra cylinders.*

I understand the safety information provided and agree to comply with oxygen safety precautions. Regional Hospice will not be responsible for any injury or damages due to unsafe use of oxygen.

X William Fero 6/7/12
Patient Signature Date

Caregiver Signature

Date

Mmanda Chalk, RN
Regional Hospice Representative Signature

6/7/12
Date





Request for Change of Hospice Provider
(Transfer of Hospice Provider)

Patient Name William G. Farr MR# 000-478684

Effective date of change 6/16/12 Benefit Period 1st 90 day

Certification dates: From: 6/12/12 To: 9/9/12

Beneficiary Address 1032 Jonesville Rockport Hwy Union SC 29379

Phone 864-251-0531

Medicare # [REDACTED] SS# [REDACTED]

Attending Physician Sharnika Mehta Phone: 864-560-7050

Transferring Hospice: Spartanburg Regional Hospice
120 Heywood Avenue Suite 300
Spartanburg, SC 29302
Phone: 1 (864) 560-3900
Fax: 1 (864) 560 3998

Receiving Hospice Hospice CARE of South Carolina
408 North Duncan Bypass Union SC 29379
Phone 864-429-4827

The patient's Hospice benefits have been explained. The coordination for continued Hospice care has been completed.

Hospice Representative [Signature] Date 6/16/12

Each Hospice should maintain a copy of this change request in the patient's medical record

TIME RECEIVED June 16, 2012 3:16:55 PM EDT
REMOTE CSID 8645605625
DURATION 57
PAGES 1
STATUS Received

INBOUND NOTIFICATION : FAX RECEIVED SUCCESSFULLY

To: HOSPISCRIPT: FAX: 800-616-2479 TEL: 800-227-0848

To: Pharmacy: Fax: _____ Tel: _____

Date: ____/____/____

Pages: _____ including this cover sheet.



HospiceScript

Circle all that apply: admit transfer profile update mail order other

• Member ID#:	SRH + episode number
• Eligible Prescriptions:	ALL HOSPICE-COVERED MEDS
•  Pharmacy Services Group A HealthExtras Company BIN#:	011891
• Account #:	3074
• Hospice Name:	Spartanburg Regional Hospice
• Days Supply:	15
• Pharmacy Help Desk:	1-800-427-4893
• Pharmacy Help Desk Hours:	24 / 7 / 365
• Generic Substitution:	MANDATORY GENERIC SUBSTITUTION

Please select one:

☐ HOME CARE☐ FACILITY☐ IPU

Facility Name _____

Patient Name: William G Farr☐ New patient: Effective Date: 6/17/12Patient ID: SRH 38224☐ Re-admit patient (new med. list required)
Effective Date: ____/____/____Patient Address: 1032 Jonesville Lockhart Hwy☐ Update medication profile:
Effective Date: ____/____/____City: Union State: SC Zip: 29379Diagnosis: Bronchus/Lung CATerminate coverage: Effective date: ____/____/____
☐ Discharged ☐ Expired ☐ RevokedDate of birth: 7/6/42

If transferring a patient circle what applies:

Gender: ☒ M ☐ F

Transfer from: Hospice Facility IPU Branch _____

Co-Pay: ☐ Yes ☒ No

Transfer to: Hospice Facility IPU Branch _____

Hospice RN / Authorized Party _____

Phone Number _____

SPARTANBURG REGIONAL HEALTHCARE SYSTEM

"This facsimile transmission is intended for the use of the individual or entity to which it is addressed. It may contain information that is privileged, or Protected Health Information (PHI), as defined by the Health Insurance Portability and Accountability Act. This information is confidential and exempt from disclosure under applicable law. If the reader of this facsimile message is not the intended recipient or the employee or agent responsible for delivering the message to the recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited and may be a violation of Federal or State law. If you have received this communication in error, please notify the sender immediately and return the original message to us at the above address via U.S. Mail, or destroy this material immediately."

To: *Regional HHS*

From: Yvonne Gath, RN, BSN

Fax: *# 63867*

Phone: 864-550-8580 office, 864-841-9239 cell

Phone: *560-3867*

Pages: 5 Heart Case Manager

Fax 864-580-8055

Re: *1*

Date:

☐ Urgent ☒ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

• **Comments:**

2012-Jun-05 11:10 AM Sheart 8645608055

1/12

PRINTED BY: DB30588

DATE 7/18/2013

Spartanburg Regional Medical Center Home Health

Coverage Detail Report

Provider#: 421500

Date Requested : 06-05-2012

User Name: Ashley Amaker

BatchID : Web120805-219

Date Printed: 6/5/2012 1:32:09 pm (CST)

Verification Type: CWF/HH Look Up

The Following Information was used to perform the lookup:

Patient Name: FARR, WILLIAM
Per Medicare: FARR.WILLIAM.G

HICN: 250680627A

Birth Date: [REDACTED]

Sex: M

The Following Sections have been suppressed:

Preventive Services

Benefit Information

Part A Effect : 10-01-1998	Part B Effect : 04-01-1999	PAP	PAP	Lifetime	ESRD				
Part A Term :	Part B Term :	Risk	Date	Rsrv	Psych	CD1	Date	CD2	Date
Date of Death :				60	190				

First Bill Date	Last Bill Date	Hospital		Amount	SNF		Ded	Blood
		Full Days	Coins Days		Full Days	Coins Days		
Current 04-17-2012	05-07-2012	43	30	0	20	80	0	\$0.00 0
Prior 10-18-2011	12-31-2011	48	30	0	20	80	0	\$0.00 0

DI 0000020000

Part B Year: 12	TBM:	\$0.00	3	PT TBM: \$1880.00	OT TBM: \$1880.00
Part B Year: 11	TBM:	\$0.00	3		

Pos.6 - Representative Payee Indicator - Representative payee does apply

Medicare Advantage

NO MEDICARE ADVANTAGE PLAN DATA AVAILABLE

NO TRANSPLANT DATA AVAILABLE

Screening Data

HCPSC	Tech	Risk	Recent	Recent	Recent
Code	Prof		DOS 1	DOS 2	DOS 3
G0103	PROF		12/26/2008		

Rehabilitation Sessions

Pulmonary Remaining (HCPC G0424):

Cardiac Applied (HCPC 93797, 93798):

ICR Applied (HCPC G0422, G0423):

Tech:72 / Prof:72

Tech:0 / Prof:0

Tech:0 / Prof:0

Hospice

NO HOSPICE DATA AVAILABLE

Home Health

NO HOME HEALTH DATA AVAILABLE

Home Health Certification

NO HOME HEALTH CERTIFICATION DATA AVAILABLE

PPS Episodes

NO PPS EPISODE DATA AVAILABLE - HIGH

Based on PPS Episode data currently available, an episode beginning on the date of this eligibility verification would be designated as a

FIRST EARLY EPISODE

Disclaimer: There is no guarantee that the designation provided is accurate. Actual Episode designation is only determined when the claim is received by Medicare.

(H)ospice and (P)PS Provider Information

MSP Insurer Information

NO MSP INSURER DATA AVAILABLE

Spartanburg Regional Allstar Patient Page Processor

No. 000478684 Name FARR, WILLIAM G Sex M BD [REDACTED] Room [REDACTED] Tue Jun 05, 2012 03:24 pm Physician SVC ICD St.

1 Name FARR, WILLIAM G 2 Entitle 3 Sex MALE

4 Birthdate [REDACTED] Age 69Y 5 Birthplace 6 DOD

7 Marital Status M MARRIED 8 Address Line 1 1032 JONESVILLE LOCKHART 9 Address Line 2 HWY

10 City UNION 11 St 12 ZIP Code SC 29379 13 County 044 UNION SC 14 Country US UNITED S'

15 Phone (864)251-0531 16 Ext 17 Phone Msg Yes 18 Geo.Cd/Census Tr.

19 Residence Type 20 Since 21 Addl No 22 Alt&Confidential Add-Ph No

23 Invalid Address/Phone 24 Soc Sec Number [REDACTED]

25 Race 1 WHITE / CA 26 Ethnicity 2 NOT HISPANIC/LAT 27 Nationality 1 AMERICAN 28 Language E ENGLISH

Press NL--

Spartanburg Regional Allstar Insurance Process Processor

No.	Name	Sex	BD	Room	Tue Jun 05, 2012 03:24 pm	
000478684	FARR, WILLIAM G	M			Physician	SVC ICD St.
Page:01		Master Insurance				
1 Carrier-Plan			2 Same As	3 Insured Address.		
MEDICARE			Patient			
4 Insured Name	5 Entitle		6 Sex	7 Relation to Insured		
FARR, WILLIAM G			MALE	1 PATIENT IS INSUR		
8 Insured's Birthdate	9 Claim Number		10 Group Phone	11 Ext.		
			(877)567-9249			
12 Enrollment State	13 Mail To		14 Mail to Person			
SC SOUTH CAROLINA	Plan					
15 Mail To Company			16 Address Line 1			
MEDICARE			2300 SPRINGDALE DRIVE			
17 Address Line 2	18 City		19 St	20 ZIP Code	21 C	
	CAMDEN		SC	29020	U	
22 Comment						

Press NL--

next screen(/) or previous screen(/P) [/]

Patient: **Farr, William G**
Arrival: **6/10/2012 1106**
Pt Acct: **1216200102**
Med Rcd: **000478684**

ED RECORD

Patient: **Farr, William G**
Home Address: **1032 Jonesville Lockhart**
Hwy
City: **Union**
State: **SC** Zip: **29379**
Home Ph: **(864) 251-0531**

DOB: [REDACTED]
Age: **69yr**
Sex: **M**

Insurance Companies

Insurance Company

MEDICARE
MEDICARE
MEDICARE SUPPLEMENT F/C MS

Acuity: **2**
Mode of Departure: **Non Emergency Transport**
Disposition: **Admit**
Condition at Dispo: **Stable**

Arrival: **6/10/2012 1106**
EMS Agency: **union co ems**

Time Left ED:

Pt Weight: **54.9 kg (121**
lbs)

BMt: **20.7**

Pt Height: **5'4" (163cms**
)

BSA: **1.58 m2**

CC / Curr Imp: **Shortness of Breath, Chest Pain Nos**

Nature of EMS Call: **SOB**

RN Triage: **Adams, John F R.N. (E.C.)**
RN Primary: **John A.**
RN Dispo: **John A.**
Provider: **Roy, Micah J M.D.**

PCP: **Littlefield, Ron M.D.**
PCP Ph: **864-582-8900**
Admit Phys: **Alexander, Omar B M.D.**
Admit Phys Phone: **864-254-9330**
Referring Phys:
Referring Phys Ph:
Consult Phys:
Cnslt Phys Ph:

Admit Info

Admitting Dx: **Pneumonia, Bacterial (Not Otherwise Specified)**

Dx/Instr

Dx 1: Pneumonia, Bacterial (Not Otherwise Specified)	ICD-9 1: 482.9
Dx 2: Tachycardia (Unspecified)	ICD-9 2: 785.0
Dx 3: Hypoxemia	ICD-9 3: 799.02

Created and Electronically Authenticated By: **Roy, Micah J M.D.** Created: **6/10/2012 1121** Last Entry: **1125**

PHYSICIAN H&P SHORT OF BREATH

Patient seen at: **6/10/2012 1111.**

HPI:

Short of breath -Onset last night ago.mild cough productive clear phlegm, no fever, (-)pain-with inspiration, ()relief with self interventions prior to arrival.

CONTEXT:

Increased cough/SOB since last pm. Mild pain on right side of chest feels tight.

QUALITY:

PRINTED BY: **DB30588**

DATE: **7/18/2012**

Patient: Farr, William G
Arrival: 6/10/2012 1106
Pt Acct: 1216200102
Med Rcd: 000478684

TIMING:

SEVERITY:

MODIFIERS:

ASSOCIATED SYMPTOMS:

COMPLICATING FACTORS:

ROS:

CONST(System): (+)fatigue, (+)weakness.

ENT(System):

EYES(System):

CV(System):

RESP(System): (+)dyspnea on exertion, (+)difficulty breathing, (+)cough, (+)sputum production, (+)SOB, (+)PND.

GI(System):

GU(System):

MS(System):

SKIN(System):

NEURO(System):

LYMPH(System):

ENDO(System):

PSYCH(System):

ALLERGIC/IMMUNOLOGIC(System):

FEMALE(System):

PSYCH(System):

yes - Except as marked positive, all systems above reviewed and found negative.

History not limited.

yes - Nursing chart reviewed, vitals noted, home medications reviewed and verified, allergies reviewed.

SH: quit smoking 1mo ago, no alcohol, no drugs, lives with family.

IMMUNIZATIONS:

Tetanus: immunization status:.

Influenza (flu): immunization status:.

PREHOSPITAL CARE: None

PMH List (See PMH Table) **PSH List** (See PSH Table)

(+)Reviewed and agree with or personally modified the table above.

FH: ()CAD, ()DM, ()HTN

PHYSICAL EXAM:

GENERAL APPEARANCE: well nourished, alert, cooperative, cachecticresp distressmod

VITALS: reviewed as documented by nurse.

EYES: conjunctiva clear

EARS:

THROAT: no airway obstruction

NECK: supple, no neck tenderness.

RESPIRATORY: (-)prolonged expiratory phase, good air exchange bilateral, mild wheezing, mild rhonchi, mild rales.

CVS: rapid rate, normal rhythm, no murmur.

ABDOMEN\GI: soft, normal BS, no abd tenderness, no abd masses, (-)distended.

SKIN: no rash, dry, warm, good color.

EXTREMITIES: (-)erythema, no swelling\tenderness. no edema

NEURO: (-)facial droop, cranial nerves 2 - 12 intact as examined, motor intact, sensory intact

MENTAL STATUS: speech clear, oriented X 3, responds appropriately to questions.

CLINICAL DECISIONING:

PROVIDER NOTE:

After obtaining the patient's history and performing the physical examination initial considerations based on the presenting problem included but were not limited to these Diagnosis:

CLINICAL IMPRESSION:

DATA REVIEWED:

CARDIAC MONITOR:

PRINTED BY: DB30588

DATE 7/18/201:

Patient: Farr, William G
Arrival: 6/10/2012 1106
Pt Acct: 1216200102
Med Rcd: 000478684

(+) EKG interpreted by ED Physician See Pyramis.

COUNSELING:

CRITICAL CARE TIME: critical care time none. Critical care time includes time spent with the patient and/or family, reviewing past medical charts, discussions with consultants and admitting physicians, review of diagnostic testing, and active treatment and assessment of response to treatments. Total critical care time does not include time spent on separately billed procedures.

Created and Electronically Authenticated By: Roy, Micah J M.D. Created: 6/10/2012 1138 Last Entry: 1138

Results Reviewed by ED Provider:

CBC WITH DIFF

White Blood Cell Count	20.1	High	K/cmm	3.1-9.7

Created and Electronically Authenticated By: Roy, Micah J M.D. Created: 6/10/2012 1141 Last Entry: 1141

Results Reviewed by ED Provider:

EC TROPONIN

Troponin I	0.10	High	ng/mL	0.00-0.07

EC CK-MB

Creatine Kinase MB Isoenzyme	8.4	High	ng/mL	0.0-6.0

Created and Electronically Authenticated By: Roy, Micah J M.D. Created: 6/10/2012 1203 Last Entry: 1203

Results Reviewed by ED Provider:

BMP

No hemolysis noted

Urea Nitrogen	29	High	mg/dL	7-25
Sodium	133	Norm	mmol/L	133-146
Potassium	4.5	Norm	mmol/L	3.5-5.2
Chloride	103	Norm	mmol/L	100-111
Carbon Dioxide	21.1	Low	mmol/L	23.0-32.6
Glucose	121	High	mg/dL	70-100
Creatinine	0.93	Norm	mg/dL	0.47-1.35
Calcium	9.6	Norm	mg/dL	8.9-10.3
Bun/Creat Ratio	31	High		8-23
Osmolality Calculation	273	Norm	mOsm/kg	270-350
Anion Gap	13	Norm	mmol/L	6-13
Estimated GFR-African American	>60		mL/min/1.73 m ²	

XR CHEST PORTABLE

Report: Impression- Extensive parenchymal lung densities bilaterally, a little
Report: more pronounced than on the previous study. Findings most compatible
Report: with pneumonia. Pulmonary edema would be a clinical consideration as
Report: well.

Created and Electronically Authenticated By: Roy, Micah J M.D. Created: 6/10/2012 1205 Last Entry: 1205

Results Reviewed by ED Provider:

BNP-CHF

B Natriuretic Peptide	85.3	Norm	pg/mL	0.0-100.0

Created and Electronically Authenticated By: Roy, Micah J M.D. Created: 6/10/2012 1215 Last Entry: 1215

Results Reviewed by ED Provider:

CBC WITH DIFF

Created and Electronically Authenticated By: Roy, Micah J M.D. Created: 6/10/2012 1224 Last Entry: 1225

Provider Note:

ADMIT - After completion of initial emergency department evaluation, it has been determined that the patient requires further evaluation and treatment in an inpatient setting. The case was discussed with Alexander, Omar B M.D. and their service has agreed to assume care of this patient at this time. The patient has been informed of their initial diagnosis and agrees to further evaluation and treatment in an inpatient setting. The patient is admitted in stable condition.

CONSULT (general) - Dr. Alexander, Omar B M.D. was consulted at 6/10/2012 1215. Case was discussed

Patient: Farr, William G
Arrival: 6/10/2012 1106
Pt Acct: 1216200102
Med Rcd: 000478684

and consultant directive.

Created and Electronically Authenticated By: Roy, Micah J M.D. Created: 6/10/2012 1227 Last Entry: 1227

Provider Note:

CRITICAL CARE TIME: 30-74min Critical care time includes time spent with the patient and/or family, reviewing past medical charts, discussions with consultants and admitting physicians, review of diagnostic testing, and active treatment and assessment of response to treatments. Total critical care time does not include time spent on separately billed. Pt given IV, Avelox, Lovenox due to elevated cardiac enzymes suspect secondary to hypoxia/TACHYCARDIA.

Created and Electronically Authenticated By: Roy, Micah J M.D. Created: 6/10/2012 1421 Last Entry: 1421

Results Reviewed by ED Provider:

CT LUNG FOR PE W/CONTRAST

Report: Impression- Negative for pulmonary embolus, aortic aneurysm, or report: dissection. Extensive parenchymal lung densities bilaterally, largely Report: chronic. More confluent density in the right lower lung which could report: represent superimposed pneumonia. No acute changes since the previous report: study done 2 weeks ago.

Created and Electronically Authenticated By: Roy, Micah J M.D. Created: 6/10/2012 1444 Last Entry: 1444

Results Reviewed by ED Provider:

BLOOD GAS

pH, Blood Gas	7.41	Norm		7.35-7.45
PCO2	30	Low	mm/Hg	35-45
PO2	64	Low	mm/Hg	75-85
Total CO2	20	Low	mmol/L	23-27
HCO3	19.2	Low	mmol/L	22.0-26.0
Base Excess	-4	Low	mmol/L	-2-3
O2 Saturation, Calculated	93	Low	%	95-100
Liters per Min	12			
Sample Type	ARTERIAL			
Allen's Test	Pass			
Delivery System	Oxymizer			
Intubated? Y/N	No			
Site	R Radial			

Clinical Decision Support

Alert	CPT II	Compliance
Pneumonia - Vital Signs (BP, P, R, T)		performed and completed
Pneumonia - O2 Sat		performed and completed
Pneumonia - Blood Culture Before First Antibiotic Dose		performed and documented
Pneumonia - Antibiotics Within 4 Hrs		performed and documented

Vital Signs

Sys	Dia	Pulse	Resp	SAT	O2 Delivered	Temp (F)	Route	Pain Scale	Comment	Taken at	User Name
118	94	108	28	94%	6L-NC	97.5F	oral		Triage Vitals	6/10/2012 1149	Adams, John F R.N. (E.C.)
		112	26	99%	neb tx					6/10/2012 1127	Whitfield, Walter, R.C.P.
		116	22	99%	neb tx					6/10/2012 1137	Whitfield, Walter, R.C.P.
136	96	109		92%						6/10/2012 1233	Henderson, Catherine W

PRINTED BY: DB30588

DATE 7/18/2012

Patient: Farr, William G
Arrival: 6/10/2012 1106
Pt Acct: 1216200102
Med Rcd: 000478684

Vital Signs (continued)

Sys	Dia	Pulse	Resp	SAT	O2 Delivered	Temp (F)	Route	Pain Scale	Comment	Taken at	User Name
140	103	114	30	93%	12L- 10-12 oxygenizer					6/10/2012 1409	(E.S.T.) Adams, John F.R.N. (E.C.)

Home Medications

Arrival Medication	Indication	Last Dose	Comments
Prednisone 20mg by mouth; emergency use, take 2 tabs for SOB pt takes Unknown BP, cholesterol and cancer med Albuterol			PRN

Allergies

Allergic Substance	Reaction
NKDA none	

Input & Output

Fluid Type	Intake	Output	I/O Time
AVELOX IVPB (moxifloxacin hcl)	250 mL		6/10/2012 1228
=== TOTAL ===	250 mL		

PMH

Condition
Lung CA
Smoker
Hypertension
Hypokalemia
Colon cancer
COPD
Cancer
Hypertension

Patient: Farr, William G
Arrival: 6/10/2012 1106
Pt Acct: 1216200102
Med Rcd: 000478684

PSH

Procedure

R lung lobes removed
Colostomy
partial colectomy
Colostomy
Lobectomy

Orders

Order	Sched D/T	Comp D/T	Provider Sig
TELEMETRY	6/10/2012 1121	6/10/2012 1112	Roy, Micah J.M.D. 6/10/2012 1121
PULSE OXIMETRY on Room Air or home O2	6/10/2012 1121	6/10/2012 1112	Roy, Micah J.M.D. 6/10/2012 1121
OXYGEN - supplementation at 2L/min. or to keep pulse oximetry > 92%.	6/10/2012 1121	6/10/2012 1112	Roy, Micah J.M.D. 6/10/2012 1121
INT	6/10/2012 1121	6/10/2012 1116	Roy, Micah J.M.D. 6/10/2012 1121
CBC WITH DIFF	6/10/2012 1121	6/10/2012 1136	Roy, Micah J.M.D. 6/10/2012 1121
BMP	6/10/2012 1121	6/10/2012 1155	Roy, Micah J.M.D. 6/10/2012 1121
CK-MB BEDSIDE	6/10/2012 1121	6/10/2012 1141	Roy, Micah J.M.D. 6/10/2012 1121
TROPONIN BEDSIDE	6/10/2012 1121	6/10/2012 1141	Roy, Micah J.M.D. 6/10/2012 1121
HOLD BLOOD CULTURES	6/10/2012 1121	6/10/2012 1118	Roy, Micah J.M.D. 6/10/2012 1121
BNP-CHF	6/10/2012 1121	6/10/2012 1203	Roy, Micah J.M.D. 6/10/2012 1121
RT HHN	6/10/2012 1121	6/10/2012 1152	Roy, Micah J.M.D. 6/10/2012 1121
XR CHEST PORTABLE	6/10/2012 1121	6/10/2012 1153	Roy, Micah J.M.D. 6/10/2012 1121
EKG-12 Lead	6/10/2012 1140	6/10/2012 1126	Roy, Micah J.M.D. 6/10/2012 1140
EC TROPONIN	6/10/2012 1126	6/10/2012 1140	Roy, Micah J.M.D. 6/10/2012 1226
EC CK-MB	6/10/2012 1126	6/10/2012 1140	Roy, Micah J.M.D. 6/10/2012 1226
BLOOD CULTURE	6/10/2012 1204		Roy, Micah J.M.D. 6/10/2012 1204
BLOOD CULTURE	6/10/2012 1204		Roy, Micah J.M.D. 6/10/2012 1204
Medication Verification, Verified_At: 6/10/2012_1214, Med_Verified: Lovenox, Verified_For: Sharon	6/10/2012 1209	6/10/2012 1214	Roy, Micah J.M.D. 6/10/2012 1209
CT LUNG FOR PE W/CONTRAST	6/10/2012 1209	6/10/2012 1417	Roy, Micah J.M.D. 6/10/2012 1209
BLOOD GAS	6/10/2012 1425	6/10/2012 1435	

Orders (Meds)

Order	Sched D/T	Administered D/T
SOLU-MEDROL IV (methylPREDNISolone sodium) 60mg (1.5mL of 40mg/mL) IV once - Gave 60mg	6/10/2012 1121	6/10/2012 1134
DUONEB (albuterol-ipratropium) 3mL by inhalation once - Gave 3mL	6/10/2012 1121	6/10/2012 1127
AVELOX IVPB (moxifloxacin hcl) 400mg (250mL of 400mg/250mL) IVPB once - Gave 400mg	6/10/2012 1209	6/10/2012 1228
LOVENOX SQ (enoxaparin sodium) 55mg (0.55mL of 100mg/mL) subcutaneous once - Gave 55mg	6/10/2012 1209	6/10/2012 1223

Patient: Farr, William G
Arrival: 6/10/2012 1106
Pt Acct: 1216200102
Med Rcd: 000478684

TIMI Scale

Criteria	Present

Age >= 65	
>= 3 CAD risk factors	
Known coronary stenosis >= 50%	
Aspirin use in past 7 days	
2 angina episodes in prior 24 hours	
Elevated serum cardiac markers	
ST deviation >= 0.5mm on admission ECG	
===== TOTAL TIMI Score	
===== Mortality/Ischemia RISK	
===== Date/Time Performed	
===== User Name	

Pneumonia Scale

Pneumonia Criteria	Present	Points

Age	yes	+1/year
Female		-10
Nursing Home Resident		+10
Neoplastic Disease History		+30
Liver Disease		+20
Congestive Heart Failure		+10
Cerebrovascular disease		+10
Renal Disease		+10
Altered Mental Status		+20
Respiratory Rate > 29/min		+20
Systolic Blood Pressure < 90 mmHg		+20
Temperature < 95F or > 103.8F		+15
Pulse > 124 beats/min		+10
pH < 7.35		+30
BUN > 29mg/dl		+20
Sodium < 130 mmol/liter		+20
Glucose > 250mg/dL		+10
Hematocrit < 30%		+10
Oxygen saturation < 90%		+10
Pleural Effusion on X-ray		+10
===== TOTAL Score	69	
===== MORTALITY RISK	0.6%	Low
===== Performed on	6/10/2012 1112	
===== User Name	Ed Hall	

Patient: Farr, William G
Arrival: 6/10/2012 1106
Pt Acct: 1216200102
Med Rcd: 000478684

NIH Stroke Scale

LOC	Questions Comman	Gaze	Visual Fl	Paresis	RA Motor	LA Motor	RL Motor	LL Motor	Ataxia	Sensory	Language	Dysarthria	Extl
No Entries													

Procedures

Procedure	Performed By	Quantity Entered	Billing No.
No Entries			

Created and Electronically Authenticated By: Henderson, Catherine W (E.S.T.) Created: 6/10/2012 1119 Last Entry: 1119

Clinical Note:

EKG SHOWN TO MD - 6/10/2012 1117. EKG shown to Roy, Micah J M.D..

Created and Electronically Authenticated By: Adams, John F.R.N. (E.C.) Created: 6/10/2012 1123 Last Entry: 1123

Order(s) performed by "Task":

- TELEMETRY
- PULSE OXIMETRY on Room Air or home O2
- OXYGEN - supplementation at 2L/min. or to keep pulse oximetry > 92%.
- INT
- HOLD BLOOD CULTURES

Created and Electronically Authenticated By: Adams, John F.R.N. (E.C.) Created: 6/10/2012 1135 Last Entry: 1135

Orders Performed by Nurse:

- SOLU-MEDROL IV (methylPREDNISolone sodium) 60mg (1.5mL of 40mg/mL) IV once - Gave 60mg.
- Verified: 2 patient IDs and allergies, IV Med Site: forearm left, Given At: 6/10/2012 1134

Created and Electronically Authenticated By: Adams, John F.R.N. (E.C.) Created: 6/10/2012 1137 Last Entry: 1145

Clinical Note: Pt states increased SOB today beginning last PM states producing clear mucus. Pt noted to have increased RR on exam hx of lung CA on home O2 at 4 lpm O2 sat 87% on this increased to 6 lpm via oxymizer with O2 sat increasing to 93%. Pt aox3 noted to have increased WOB breathing and dyspnea with exertion. Bilat rales/ronchi noted on auscultation. ED MD Roy in immediately of patient arrival for exam.

Denies NV and fever and chills.

Portable CXR being done at this time.

ASSESS RESPIRATORY: Assessment performed at 6/10/2012 1131.

Roy, Micah J M.D. at bedside at 6/10/2012 1116

SALINE-LOCK INSERTED - PTA per UCEMS 20ga left forearm following with labs drawn. Porta-cath noted in L chest.

PMH List (See PMH Table) PSH List (See PSH Table)

SH: no alcohol, drug usage

PHYSICAL EXAM:

AIRWAY: (+)patent, (-)obstructed.

BREATHING: no breathing compromise. (+)accessory muscle use, good air exchange bilateral.

CIRCULATION: no circulatory compromise, capillary refill <2 seconds.

MENTAL STATUS: speech clear, oriented X 3, normal affect, responds appropriately to questions, alert, cooperative.

RESPIRATORY: Onset 12hrs ago while exercising. nothing improves symptoms, nothing makes it worse. no fever, (-)chills, (+)congestion, (+)SOB, (-)chest pain no cough, (-)labored breathing, (-)nasal flaring.

HEART: normal rate, normal rhythm, no murmur, no rub

EXPOSURE: Clothing removed, Hospital gown provided. Family at bedside.

DATE 7/18/201:

Patient: Farr, William G
Arrival: 6/10/2012 1106
Pt Acct: 1216200102
Med Rcd: 000478684

SAFETY: Call light at bedside, Use of call bell explained to patient. Side rails raised for patient safety.

FALLS ASSESSMENT ADULT:

FALL HISTORY: No history of falling 0

SECONDARY DIAGNOSIS: No secondary diagnosis 0

IV ACCESS: IV Access 20

AMBULATORY AID: None\bed rest\nurse assist 0

GAIT: Gait Normal bed rest or wheelchair 0

MENTAL STATUS: Oriented to own ability 0

FALL RISK SCORE:

Plan of Care to Decrease Fall Risk: High Risk Interventions include - ()yellow bracelet, (+)room near nursing station, (+)Instruct to call for help/call bell within reach, (+)Bed in low position, (+)Bed/stretchers brakes on, (+)Bed rails up.

Created and Electronically Authenticated By: Adams, John F.R.N. (E.C.) Created: 6/10/2012 1148 Last Entry: 1148

NURSING TRIAGE (Adult)

HPI:

PREHOSPITAL CARE: Monitoring and Albuterol Tx and INT saline lock

Support System: lives w family or significant other.

Special Considerations: None Identified.

LEARNING BARRIERS: None Identified.

TRIAGE DATA:

History obtained from: patient

Tetanus: immunization status:.

LMP:

PHYSICAL EXAM:

AIRWAY: oral, (-)obstructed.

BREATHING: no breathing compromise.

CIRCULATION: no circulatory compromise, capillary refill <2 seconds.

GENERAL APPEARANCE: (adult) - well nourished, alert, oriented X 3, no acute distress, no obvious discomfort.

SKIN: warm, dry, good color, no rash.

NURSING INTERVENTION: None

Created and Electronically Authenticated By: Adams, John F.R.N. (E.C.) Created: 6/10/2012 1151 Last Entry: 1151

Order(s) performed by "Task":

- EKG-12 Lead

- CK-MB BEDSIDE

- TROPONIN BEDSIDE

Created and Electronically Authenticated By: Whitfield, Walter, R.C.P. Created: 6/10/2012 1152 Last Entry: 1152

Orders Performed By RT:

- DUONEB (albuterol-ipratropium) 3mL by inhalation once - Gave 3mL, Verified: 2 patient IDs and allergies

- RT HHN

Order Notes:

RT RESPIRATORY TREATMENT - 6/10/2012 1127

Before Treatment - Left LUNG: no wheezing, no rhonchi, no rales, Right LUNG: no wheezing, no rhonchi, no rales

Pre VS TABLE See Table

HHN of Duoneb 2.5mg/0.5mg given, tolerated well by patient

Post Treatment - Left LUNG: no wheezing, no rhonchi, no rales, Right LUNG: no wheezing, no rhonchi, no rales

Post VS TABLE See Table

The patient was instructed on the use of respiratory meds and respiratory treatment using the following methods,

demonstration with returned demonstration with no learning barriers. Family was not involved in teaching.

Created and Electronically Authenticated By: Adams, John F.R.N. (E.C.) Created: 6/10/2012 1205 Last Entry: 1206

Clinical Note: Notified ED MD Roy of elevated cardiac enzymes now new orders received.

Created and Electronically Authenticated By: Adams, John F.R.N. (E.C.) Created: 6/10/2012 1228 Last Entry: 1228

DATE 7/18/201

Patient: Farr, William G
Arrival: 6/10/2012 1106
Pt Acct: 1216200102
Med Rcd: 000478684

Orders Initiated by Nurse.

- AVELOX IVPB (moxifloxacin hcl) 400mg (250mL of 400mg/250mL) IVPB once - Gave 400mg.
Verified: 2 patient IDs and allergies, IV Med Site: L FA, Start: 6/10/2012 1222, End: 6/10/2012 1228,
Volume Given: 250 mL

Orders Performed by Nurse:

- LOVENOX SQ (enoxaparin sodium) 55mg (0.55mL of 100mg/mL) subcutaneous once - Gave 55mg,
Verified: 2 patient IDs and allergies, Verified By: Sharon, SQ Site: R lateral ABD wall, Given At:
6/10/2012 1223

- AVELOX IVPB (moxifloxacin hcl) 400mg (250mL of 400mg/250mL) IVPB once - Gave 400mg,
Verified: 2 patient IDs and allergies, IV Med Site: L FA, Start: 6/10/2012 1222, End: 6/10/2012 1228,
Volume Given: 250 mL

Created and Electronically Authenticated By: Adams, John F.R.N. (E.C.) Created: 6/10/2012 1228 Last Entry: 1228

Order(s) performed by "Task":

- Medication Verification, Verified At: 6/10/2012 1214, Med Verified: Lovenox, Verified For: Sharon

Created and Electronically Authenticated By: Adams, John F.R.N. (E.C.) Created: 6/10/2012 1239 Last Entry: 1240

Clinical Note: Awaiting IV team for access of L chest porta-cath.

Created and Electronically Authenticated By: Adams, John F.R.N. (E.C.) Created: 6/10/2012 1251 Last Entry: 1252

Clinical Note: Blood cultures drawn prior to antibiotics. IV team here now for porta-cath access.

Created and Electronically Authenticated By: Adams, John F.R.N. (E.C.) Created: 6/10/2012 1252 Last Entry: 1252

Clinical Note:

PORT-A-CATH ACCESS PERFORMED - by IV team nurse 6/10/2012 1252 Strict sterile technique used throughout procedure. The area was prepped with chlorhexidine for 30sec. The Port A Cath device was accessed using a 20ga 1inch huber needle setup. 3mL of blood was withdrawn without difficulty, then discarded. Port was flushed with 300units. The lab specimens were collected, labeled at bedside, and given to ED Nurse. Site was marked with time and date and secured with dressing according to hospital policy. Patient tolerated procedure well.

Created and Electronically Authenticated By: Scruggs, Rhonda R.N. Created: 6/10/2012 1254 Last Entry: 1256

Clinical Note:

CENTRAL LINE ACCESS - 6/10/2012 1253 Strict sterile technique used throughout procedure. The area was prepped with chlorhexidine for 2min. Th single lumen catheter was accessed using a huber needle 20 gauge 3/4 inch setup per Rachel Bryant RN. Site was marked with time and date and secured with dressing according to hospital policy. Patient tolerated procedure well.

Created and Electronically Authenticated By: Adams, John F.R.N. (E.C.) Created: 6/10/2012 1309 Last Entry: 1309

Clinical Note: Admitting provider Alexander, Omar B M.D. at bedside for admission assessment.

Created and Electronically Authenticated By: Adams, John F.R.N. (E.C.) Created: 6/10/2012 1314 Last Entry: 1314

Clinical Note: Awaiting completion of admission orders.

Created and Electronically Authenticated By: Adams, John F.R.N. (E.C.) Created: 6/10/2012 1339 Last Entry: 1340

Clinical Note: Patient up to urinate acutely more dyspneic. MD Alexander informed and in for reassessment of patient and order for ABG received. Notified RRT of ABG orders awaiting CT of chest at this time. Dyspnea improved with rest and increased O2 via oxymixer at 10 lpm.

Created and Electronically Authenticated By: Adams, John F.R.N. (E.C.) Created: 6/10/2012 1405 Last Entry: 1407

Clinical Note:

MEDICATION GIVEN - 6/10/2012 1350 SoluMedrol 125 mg IV per admission orders. verified 2 patient ID's and allergies.

Patient transported to CT.

Patient returned to ED from CT.

Created and Electronically Authenticated By: Adams, John F.R.N. (E.C.) Created: 6/10/2012 1407 Last Entry: 1408

Clinical Note: Patient acutely dypneic with minmial exertion. Patient now on O2 via at 10-12 lpm.

Created and Electronically Authenticated By: Whitfield, Walter, R.C.P. Created: 6/10/2012 1431 Last Entry: 1432

Clinical Note:

ABG DONE; RESULTED TO DR. ALEXANDER

Created and Electronically Authenticated By: Adams, John F.R.N. (E.C.) Created: 6/10/2012 1432 Last Entry: 1435

Clinical Note: Paged MD Alexander to notify of ABG results. Called results to Tyler NP from Alliance no new orders received.

Patient: Farr, William G
Arrival: 6/10/2012 1106
Pt Acct: 1216200102
Med Rcd: 000478684

Lotze, Christina M (Cust Svc) Created: 6/10/2012 1046 Last Entry: 1052

Other Note:

per union co ems medic 5 69yom that is c/o shortness of breath. pt has been given 5 of albuterol. pt has hx of lung cancer with top portion of lungs removed and is home o2 and his initial o2 sat was 84% . at this time vitals are bp 136/98 hr 122st spo2 91% on 5-6lpm. pt states that normal o2 sat for him is 90-92% and he is a pt of dr littlefield's

Wellsoft Interface Created: 6/10/2012 1136 Last Entry: 1136

Patient: FARR, WILLIAM G ; Date/Time: 6/10/2012 1121 ; 10000032437

----- COMPLETE BLOOD COUNT WITH AUTOMATED DIFF (PRELIMINARY RESULTS) -----

Source: BLOOD

White Blood Cell Count	20.1	High	K/cmm	3.1-9.7
Red Blood Cell Count	4.84	Norm	million/cmm	4.08-5.70
Hemoglobin	14.7	Norm	g/dL	13.1-16.8
Hematocrit	44.9	Norm	%	38.2-48.4
Mean Corpuscular Volume	92.9	Norm	fL	80.1-98.7
Mean Corpuscular Hemoglobin	30.4	Norm	pg	27.5-34.3
Mean Corpuscular Hemoglobin Concentration	32.7	Low	g/dL	33.2-35.7
Red Cell Distribution Width	16.6	High	%	11.7-15.0
Platelet	320	Norm	K/cmm	119-332

The above 9 analytes were performed by SPARTANBURG REGIONAL LABORATORY
101 EAST WOOD STREET, SPARTANBURG, SC 29303

NOTE: Additional Information is Available in the Sections Below.

Wellsoft Interface Created: 6/10/2012 1140 Last Entry: 1140

Patient: FARR, WILLIAM G ; Date/Time: 6/10/2012 1126 ; 1944296

----- EC TROPONIN -----

Source: BLOOD

Troponin I	0.10	High	ng/mL	0.00-0.07

The above 1 analytes were performed by SPARTANBURG REGIONAL LABORATORY
101 EAST WOOD STREET, SPARTANBURG, SC 29303

Wellsoft Interface Created: 6/10/2012 1140 Last Entry: 1140

Patient: FARR, WILLIAM G ; Date/Time: 6/10/2012 1126 ; 1944293

----- EC CK-MB -----

Source: BLOOD

Creatine Kinase MB Isoenzyme	8.4	High	ng/mL	0.0-6.0

The above 1 analytes were performed by SPARTANBURG REGIONAL LABORATORY
101 EAST WOOD STREET, SPARTANBURG, SC 29303

Wellsoft Interface Created: 6/10/2012 1155 Last Entry: 1155

Patient: FARR, WILLIAM G ; Date/Time: 6/10/2012 1121 ; 10000032438

----- BASIC METABOLIC PANEL -----

Source: BLOOD

No hemolysis noted

Urea Nitrogen	29	High	mg/dL	7-25
Sodium	133	Norm	mmol/L	133-146
Potassium	4.5	Norm	mmol/L	3.5-5.2
Chloride	103	Norm	mmol/L	100-111
Carbon Dioxide	21.1	Low	mmol/L	23.0-32.6
Glucose	121	High	mg/dL	70-100
Creatinine	0.93	Norm	mg/dL	0.47-1.35
Calcium	9.6	Norm	mg/dL	8.9-10.3
Bun/Creat Ratio	31	High		8-23
Osmolality Calculation	273	Norm	mOsm/kg	270-350
Anion Gap	13	Norm	mmol/L	6-13
Estimated GFR-African American	>60		mL/min/1.73 mS\2	
Estimated GFR-Other	>60		PRINTED BY: 1155	

Patient: Farr, William G
Arrival: 6/10/2012 1106
Pt Acct: 1216200102
Med Rcd: 000478684

Do not use this eGFR calculation for medication dose adjustments.

The above 13 analytes were performed by SPARTANBURG REGIONAL LABORATORY
101 EAST WOOD STREET, SPARTANBURG, SC 29303

Wellsoft Interface Created: 6/10/2012 1203 Last Entry: 1203

Patient: FARR, WILLIAM G ; Date/Time: 6/10/2012 1121 ; 10000032439

----- B NATRIURETIC PEPTIDE -----

Source: BLOOD

B Natriuretic Peptide 85.3 Norm pg/mL 0.0-100.0

The above 1 analytes were performed by SPARTANBURG REGIONAL LABORATORY
101 EAST WOOD STREET, SPARTANBURG, SC 29303

Wellsoft Interface Created: 6/10/2012 1213 Last Entry: 1213

Patient: FARR, WILLIAM G ; Date/Time: 6/10/2012 1121 ; 10000032437

----- COMPLETE BLOOD COUNT WITH AUTOMATED DIFF -----

Source: BLOOD

White Blood Cell Count 20.1 High K/cmm 3.1-9.7

Red Blood Cell Count 4.84 Norm million/cmm 4.08-5.70

Hemoglobin 14.7 Norm g/dL 13.1-16.8

Hematocrit 44.9 Norm % 38.2-48.4

Mean Corpuscular Volume 92.9 Norm fL 80.1-98.7

Mean Corpuscular Hemoglobin 30.4 Norm pg 27.5-34.3

Mean Corpuscular Hemoglobin Concentration 32.7 Low g/dL 33.2-35.7

Red Cell Distribution Width 16.6 High % 11.7-15.0

Platelet 320 Norm K/cmm 119-332

Neutrophil Percent 91.60 High % 37.60-73.50

Lymphocyte Percent 2.60 Low % 16.80-46.20

Monocyte Percent 5.30 Norm % 4.60-13.10

Eosinophil Percent 0.00 Norm % 0.00-7.70

Basophil Percent 0.50 Norm % 0.10-1.30

Absolute Neutrophil 18.4 High /cmm 0.9-6.3

Absolute Lymphocyte 0.5 Low /cmm 0.8-3.1

Absolute Monocyte 1.1 High /cmm 0.2-0.9

Absolute Eosinophil 0.0 Norm /cmm 0.0-0.6

Absolute Basophil 0.1 Norm /cmm 0.0-0.1

Nucleated RBC Percent 0.0 Norm % 0.0-0.0

Nucleated RBC Absolute 0.00 Norm /cmm 0.00-0.00

Scan Peripheral smear scanned to verify automated differential.

The above 22 analytes were performed by SPARTANBURG REGIONAL LABORATORY
101 EAST WOOD STREET, SPARTANBURG, SC 29303

Wellsoft Interface Created: 6/10/2012 1435 Last Entry: 1435

Patient: FARR, WILLIAM G ; Date/Time: 6/10/2012 1425 ; 1944400

----- BLOOD GAS -----

Source: ARTERIAL BLOOD

pH, Blood Gas 7.41 Norm 7.35-7.45

PCO2 30 Low mm/Hg 35-45

PO2 64 Low mm/Hg 75-85

Total CO2 20 Low mmol/L 23-27

HCO3 19.2 Low mmol/L 22.0-26.0

Base Excess -4 Low mmol/L -2-3

O2 Saturation, Calculated 93 Low % 95-100

Liters per Min 12

Sample Type ARTERIAL

Allen's Test Pass

Delivery System Oxymizer

Intubated? Y/N No

Site R Radial

The above 13 analytes were performed by SPARTANBURG REGIONAL LABORATORY

Patient: Farr, William G
Arrival: 6/10/2012 1106
Pt Acct: 1216200102
Med Rcd: 000478684

101 EAST WOOD STREET, SPARTANBURG, SC 29303

Wellsoft Interface Created: 6/10/2012 1153 Last Entry: 1153

Patient: FARR, WILLIAM G ; Date/Time: 6/10/2012 1122 ; 10000032441

----- ER CHEST P** -----

Read By: LAWRENCE WARRENJRMD

Report: History- Shortness of breath and congestion.

Report:

Report: Portable AP chest dated 6/10/2012- Compared with 6/4/2012.

Report:

Report: A left-sided Port-A-Cath is unchanged. The heart is not enlarged.

Report: Parenchymal lung densities are noted bilaterally most typical of

Report: pneumonia. Pulmonary edema would be a possibility as well. These

Report: appear to have progressed, and there is a small amount of associated

Report: right pleural effusion.

Report:

Report: Impression- Extensive parenchymal lung densities bilaterally, a little

Report: more pronounced than on the previous study. Findings most compatible

Report: with pneumonia. Pulmonary edema would be a clinical consideration as

Report: well.

Report:

Report: Transcriptionist- n/a

Report: Reading Radiologist- LAWRENCE WARRENJR MD

Report: Releasing Radiologist- LAWRENCE WARRENJR MD

Report: Released Date Time- 06/10/12 1152

Report:

Released By: LAWRENCE WARRENJRMD

Wellsoft Interface Created: 6/10/2012 1417 Last Entry: 1417

Patient: FARR, WILLIAM G ; Date/Time: 6/10/2012 1348 ; 10000032479

----- CT LUNG WWO CONTRAST FOR PE -----

Read By: LAWRENCE WARRENJRMD

Report: History- Shortness of breath. History of lung cancer.

Report:

Report: CT of the chest with pulmonary embolus protocol dated 6/10/2012-

Report: Compared with 5/31/2012.

Report:

Report: Spiral images were obtained through the chest during bolus IV contrast

Report: administration. 100 mL of Isovue-370 were administered intravenously

Report: without adverse patient reaction. Contrast was given for optimal

Report: opacification of vascular structures and solid organs.

Report:

Report: Findings- There is excellent opacification of the pulmonary arteries.

Report: No pulmonary emboli are seen. There is no evidence of aortic aneurysm

Report: or dissection. Extensive parenchymal lung densities are noted

Report: bilaterally. These are largely chronic, but there is more confluent

Report: density in the right lower lung similar to that seen on the previous

Report: study. Superimposed pneumonia cannot be excluded. There is no

Report: significant adenopathy in the mediastinum or hila. No significant

Report: pleural effusion is seen. There is a tiny amount of right pleural

Report: effusion, unchanged.

Report:

Report: No significant abnormality is seen in the upper abdomen. A cyst in the

Report: left lobe of the liver is unchanged.

Report:

Report: Impression- Negative for pulmonary embolus, aortic aneurysm, or

DATE 7/18/2012

Patient: Farr, William G
Arrival: 6/10/2012 1106
Pt Acct: 1216200102
Med Rcrd: 000478684

Report: dissection. Extensive parenchymal lung densities bilaterally, largely
Report: chronic. More confluent density in the right lower lung which could
Report: represent superimposed pneumonia. No acute changes since the previous
Report: study done 2 weeks ago.

Report:
Report: Transcriptionist- n/a
Report: Reading Radiologist- LAWRENCE WARRENJR MD
Report: Releasing Radiologist- LAWRENCE WARRENJR MD
Report: Released Date Time- 06/10/12 1416
Report:
Released By: LAWRENCE WARRENJRMD

Prescription / Rx

Disposition

Signatures

Electronically Authenticatc Roy, Micah J M.D. 6/10/2012 1239

Electronically Authenticatc

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-1157-

SPARTANBURG REGIONAL MEDICAL CENTER

(DUPLICATE) NURSING UNIT

ATTENDING PHYSICIAN				CONSULTING PHYSICIAN				ICD-9-CM								
PRINCIPAL DIAGNOSIS																
ADDITIONAL DIAGNOSES																
PRINCIPAL SURGERY																
ADDITIONAL SURGERY																
DATE																
OTHER SIGNATURE								ACCOMMODATION								
OTHER SIGNATURE								☐ C.C.U. ☐ I.C.U.								
ASSEMBLED <i>6/14</i>				CODED				☐ NEURO. ☐ POST C.C.U.								
ANALYZED				FINAL CHECK				CORPORATE ID								
SPARTANBURG REGIONAL MEDICAL CENTER																
DISCHARGED				DISCHARGE DISPOSITION				UNIT NUMBER								
DATE <i>6/12/12</i> TIME				☐ ALIVE ☐ AUTOPSY ☐ DEATH +48 ☐ DEATH -48 ☐ STILLBORN ☐ TRANSFERRED				000-478684								
ACCOUNT NO.		ADMISSION DATE / TIME		FC	DATE OF BIRTH	AGE	SEX	RACE	MS	SERVICE	STATION	ROOM NO.	ACC	PAT. TYPE		
S 1216200102		06/10/12 1457		MC		69Y	M	1	M	MED	5H	8528-A	T	IP		
PATIENT	RESIDENT / REFERRING DOCTOR				ADMITTING DOCTOR				ACCIDENT / WORK RELATED		ACCIDENT DATE / TIME		ADM. TYPE / SOURCE			
	LITTLEFIELD, RONALD				LITTLEFIELD, RONALD				NO				1 7			
GUARANTOR	PATIENT INFORMATION				SOC. SEC. NO.				PATIENT EMPLOYER				TELEPHONE NO.			
	FARR, WILLIAM G 1032 JONESVILLE LOCKHART HWY UNION SC 29379				[REDACTED] TELEPHONE NO. (864)251-0531				RETIRED							
RELAT	GUARANTOR NAME AND ADDRESS				SOC. SEC. NO.				GUARANTOR EMPLOYER				TELEPHONE NO.			
	FARR, WILLIAM G 1032 JONESVILLE LOCKHART HWY UNION SC 29379				[REDACTED] TELEPHONE NO. (864)251-0531 RELATION SELF				RETIRED				OCCUPATION RETIRED			
INSURANCE	RELATIVE 1				(864)426-5765				RELATIVE EMPLOYER				UNEMPLOYED			
	FARR, DELORIS 1032 JONESVILLE LOCKHART UNION SC 29379 SPOUSE															
INSURANCE	INSURANCE 1				INSURANCE 2				INSURANCE 3				INSURANCE 4			
	MEDICARE 1 2300 SPRINGDALE DRIVE CAMDEN SC 29020 MEDICARE FARR, WILLIAM G				MEDICARE 1500 F/C MC 1 2300 SPRINGDALE DRIVE CAMDEN SC 29020 MEDICARE FARR, WILLIAM G				AARP MED SUPP 1 UHC/CLAIMS DIVISION P O BOX 7408 ATLANTA GA 30374-0819 AARP FARR, WILLIAM PLAN F 32853635011							
MISC	PRESENTING COMPLAINT				ARRIVAL MODE		PUB / VAL		ADV. DIR.		PAT CLA		DENOM		ADM. BY	
	786.50-CHEST PAIN NOS				EMS		N		NO				BAP		DBG	
STAFF ALERT:												OBSERVATION: ☐ YES ☐ NO				
PREVIOUS ENCOUNTER NAME / DATE / TYPE												FARR, WILLIAM G 06/07/12 TRS				



HT2

PRINTED BY: INPATIENT DB30588

DATE 7/18/2013

Patient: FARR, WILLIAM G

Address: 1032 JONESVILLE LOCKHART

DOB: [REDACTED] Fin Class: MEDICARE

UNION

Sex: MALE Ins. Plan: MEDICARE

SC, 29379

SS#: [REDACTED] Guarantor: SELF

Phone #: (864) 251-0531

-5 Adm Date: 06/10/12

Adm Source: 7 EMERGENCY DEPT

Acct. #: 1216200102

Adm Time: 14:57

Adm Type: 1 EMERGENCY

Unit. #: 000478684

Dis Date: 06/12/12

Trans From:

Pt. Type: INPATIENT

Dis Time: 15:09

Service: INTERNAL MEDICINE

Trans To:

LOS: 2

Dis Status: L-HOSPICE FACILITY, HOUSE, IP HOSPICE

Coder: LMB

Admitting DR: LITTLEFIELD, RONALD H

Referring DR: LITTLEFIELD, RONALD

Attending DR: LITTLEFIELD, RONALD H

Discharge DR: LITTLEFIELD, RONALD

ER Physician:

Primary DR:

ORG: 193 SIMPLE PNEUMONIA & PLEURISY W MCC

Admit Diagnosis: 786.50 CHEST PAIN NOS

Principal Diagnosis: 486 *PNEUMONIA, ORGANISM NOS

POA: Y

Secondary Diagnoses/POA:

518.84 ACUTE & CHRONC RESP FAIL/Y

V10.05 HX OF COLONIC MALIGNANC/E

162.3 MAL NEO UPPER LOBE LUNG/Y

785.0 TACHYCARDIA NOS/Y

496 CHR AIRWAY OBSTRUCT NEC/Y

V49.86 DO NOT RESUSCITATE STATU/Y

401.9 HYPERTENSION NOS/Y

305.1 TOBACCO USE DISORDER/Y

272.4 HYPERLIPIDEMIA NEC/NOS/Y

305.01 ALCOHOL ABUSE-CONTINUOU/Y

Reason for Visit:

Principal Procedure:

Date:

Primary Surgeon:

Secondary Procedures:

Consultants:

CLARK, J DOUGLAS

Date:

06/10/12

Specialty:

PULMONARY

End of Report

PATIENT NAME: FARR, WILLIAM G
MEDICAL RECORD #: 478684
DATE OF BIRTH: [REDACTED]
ACCOUNT NUMBER: 1216200102
DATE OF ADMISSION: 06/10/2012
ROOM:

8528

SERVICE

Alliance Inpatient Medicine.

ATTENDING PHYSICIAN

Dr. Omar Alexander.

PRIMARY CARE PHYSICIAN

Dr. Ronald Littlefield.

ONCOLOGIST

Dr. Mehta.

PULMONOLOGIST

Dr. Cruz.

CHIEF COMPLAINT

Chest tightness, shortness of breath.

HISTORY OF PRESENT ILLNESS

Mr. Farr is an unfortunate 69-year-old male who has a past medical history significant for non-small cell lung cancer, status post right upper lobe and right middle lobe lobectomy, COPD, hypertension and dyslipidemia who was recently discharged from the hospital 6 days ago for acute respiratory failure which was thought secondary to the patient's progressing non-small cell lung cancer. However, the patient states that he did go home, thought everything was _____, on the day of discharge; however, he continued to deteriorate in his respiratory status requiring more and more oxygen. The patient states that his cough frequency has not changed. He also states he is still coughing a still clear sputum. The patient stated that he has had no sick contacts since; however, he just states that he has kept getting worse and worse with his shortness of breath.

PAST MEDICAL HISTORY

Significant for history of colon cancer, non-small cell lung cancer, COPD, hypertension and dyslipidemia.

PAST MEDICAL HISTORY

Right upper lobe and right middle lobe lobectomy.

ALLERGIES

No known drug allergies.

MEDICATIONS

The patient is unsure of his medications and there were none stated on the discharge summary; however, from his

last admission on May 30, 2012, the patient was on potassium 20 mEq p.o. b.i.d., omeprazole 20 mg p.o. b.i.d., prednisone 20 mg p.o. q. day, Zocor 40 mg p.o. q. day, Symbicort 160 one puff inhaled q. 4 hours, Maxzide 50/25 one pill p.o. q. day and Lortab dose is unknown q. 4 hours p.r.n. pain.

SOCIAL HISTORY

The patient has a past history of tobacco abuse, states he has quit. Denies alcohol or drugs.

FAMILY HISTORY

Noncontributory.

REVIEW OF SYSTEMS

Currently at this time, the patient still complains of chest tightness. All other 10-point review of systems is currently negative.

PHYSICAL EXAMINATION

VITAL SIGNS: Temperature is 97 degrees Fahrenheit, blood pressure 104/78, pulse of 104, respiratory rate 20 and saturations 97% on 4-L nasal cannula.

GENERAL: The patient in mild distress, but alert and oriented x3.

LUNGS: Bilateral coarse.

CARDIOVASCULAR: Tachy.

GASTROINTESTINAL: Nontender to palpation, nondistended and positive bowel sounds.

EXTREMITIES: No clubbing, cyanosis or edema.

LABORATORIES

Starting with BNP is 85.3. BMP is sodium 133, potassium 4.5, chloride 103, bicarbonate 21.1, BUN 29, creatinine 0.93, glucose 121 and calcium 9.6. CBC: White blood cell count is 20.1, hemoglobin 14.7, hematocrit 44.9 and platelets 320. CK-MB is 8.4 and troponin 0.10.

Chest x-ray showed bilateral infiltrates.

ASSESSMENT AND PLAN

1. Dyspnea/acute respiratory failure. This is probably likely secondary to the patient's ongoing evolution of his non-small cell lung cancer or possible acute exacerbation of chronic obstructive pulmonary disease, difficult to tell which at this time. However, we will treat the patient as a healthcare-associated pneumonia with broad-spectrum antibiotics. We will consult pulmonary, also to rule out possible pulmonary embolus, we will get a CT/PE protocol of the lung. We will also place the patient on Lovenox weight base to ensure that if he does have pulmonary embolus, he is already treated for it.

2. Non-small cell lung cancer. We will re-consult pulmonary once again and we will just follow the recommendations at this point in time.

3. Chronic obstructive pulmonary disease. We will add p.r.n. nebs. Continue the patient on his inhalers. We will treat with IV steroids for his acute respiratory failure.

4. Hypertension. We will continue the patient on his p.o. medications.
5. Dyslipidemia. We will continue the patient on his statin.
6. Leukocytosis. The patient is currently afebrile, does have chronic steroid use as p.o. We will monitor for now and we would repeat CBC in a.m. We will have the patient on IV antibiotics.
7. Elevated troponin. We will follow up cardiac enzymes x3, place on a monitored bed. Also, we will check repeat EKG in the a.m.
8. Prophylaxis. For deep vein thrombosis, we will place the patient on weight-based prophylaxis. For gastrointestinal prophylaxis, we will place the patient on Protonix bring.

Dictated by: OMAR ALEXANDER, MD
Dictated for (if applicable):

D:06/10/2012 13:12:56
T:06/10/2012 18:56:46/sn
1256646/1097034

Cc:RONALD H LITTLEFIELD, M.D., Attending Physician
Dr. Mehta
RAUL MANUEL B. CRUZ, M.D.
Health Informatics
H & P Page 3 of 3
FARR, WILLIAM G
478684

Note: Document is draft unless signed.<END FOOTER>

Authenticated by Alexander, Omar B., MD On 06/13/2012 02:49:11 PM

CONSULT

PATIENT NAME: FARR, WILLIAM G

DOB: [REDACTED]

MEDICAL RECORD #: 478684

ACCOUNT NUMBER: 1216200102

ADMISSION DATE: 06/10/2012

DATE OF SERVICE:

ATTENDING PHYSICIAN: LITTLEFIELD, RONALD H

ROOM: 8528

PULMONARY CONSULTATION

Dr. Omar Alexander.

REASON FOR CONSULTATION

Respiratory failure.

IMPRESSION

1. Right lower lobe pneumonia.
2. End-stage chronic obstructive pulmonary disease.
3. Acute on chronic respiratory failure.
4. History of lung cancer with history of right upper lobe and right middle lobectomies.
5. History of colon cancer with colectomy.
6. Hypertension.

RECOMMENDATION

1. Decrease steroids.
2. Continue antibiotics.
3. Continue nebulizer treatments.
4. Consider bronchoscopy.
5. Consider hospice.

HISTORY OF PRESENT ILLNESS

This is a 69-year-old male who was recently discharged after an admission with chest tightness and shortness of breath. He has end-stage lung cancer, which is recurrent. He has had right upper lobe and right middle lobectomies apparently in the past, but has recurrence of his cancer. He underwent a CT scan of the chest, which showed progression of densities in his lungs and no PE. He does have a semi-productive cough.

PAST MEDICAL HISTORY

Significant for lung cancer and colon cancer. He had spontaneous pneumothorax, hypertension, COPD and dyslipidemia.

MEDICATIONS

At home apparently included aspirin, Maalox, clonidine, Zofran, Lovenox, cefepime, Norco and Solu-Medrol. He is now also on Zosyn and vancomycin.

ALLERGIES

No known drug allergies.

SOCIAL HISTORY

Long past history of tobacco use, apparently continues to smoke. Daily alcohol intake. No known occupational or environmental exposure.

FAMILY HISTORY

Noncontributory.

REVIEW OF SYSTEMS

Noted above. No known significant nausea, vomiting, diarrhea, constipation, melena, hematochezia, hematuria, dysuria, hemoptysis, hematemesis, fever, chills, night sweats or weight loss.

PHYSICAL EXAMINATION

VITAL SIGNS: Are in the computer.

GENERAL: A well-developed thin male, alert and oriented x3, in minimal distress.

HEENT: TMs and oropharynx clear. Fair dentition. Normal gums.

NECK EXAM: No JVD, adenopathy, bruits or thyromegaly. Trachea is midline.

CHEST: Symmetric excursion. Decreased breath sounds. Mild diffuse wheeze and rhonchi.

CARDIOVASCULAR: Regular rate and rhythm. Tachycardia without murmur, rub or gallop.

ABDOMEN: Soft. Positive bowel sounds. Nondistended and nontender. No hepatosplenomegaly or hepatjugular reflux. No masses.

EXTREMITIES: No cyanosis, clubbing or edema. No edema, erythema or tenderness of the calves or thighs.

RECTAL: Exam is deferred.

LABORATORY

CT scan is as noted above, which is negative for PE, but did show bilateral lung infiltrates or densities. Arterial blood gas; pH 7.41, pCO2 of 30 and pO2 of 64 on 12 L. Sodium 133, potassium 4.5, chloride 103, total CO2 of 21, glucose 121, BUN 29 and creatinine 0.9. CHF-BNP is 85. White blood count 9.4, hemoglobin 12.4, hematocrit 36.1 and platelet count 203,000.

DISCUSSION

Again, I will consider bronchoscopy, but hospice might be a better option and would consider consulting hematology for that.

Dictated by: J DOUGLAS CLARK, M.D.

Dictated for (if applicable):

D:06/10/2012 20:21:02

T:06/11/2012 05:16:05/sn

1256758/1097185

cc:RONALD H LITTLEFIELD, M.D., Admitting Physician

J DOUGLAS CLARK, M.D., Consulting Physician

Authenticated by J. Douglas Clark, M. D. On 06/25/2012 11:06:42 AM

#16

Regional Healthcare System

SHRC

☐ YH

Consulting Physician and/or Service

Reason for Request

☒ At convenience of consultant

Urgent, today if possible

Opinion and recommendation only

_____ Evaluate and manage condition in
your specialty

Accept in transfer, if you will

_____ Write diagnostic orders and
re-evaluate as indicated

Surgical procedure only

Date: 6-10-12

Attending Physician: Alexander, O, M.D.

Date and Time Consultant Notified 10-10-12 1600 ^{NOTIFIED} _{Dr. Clark}

Signed April O. Nichols

Report

Impressi:

- (1) RUL PMA
- (2) ESCOP
- (3) Alp. Heights Table
- (4) Jm. ^{3/p} RUL, RM Lecton
- (5) H/O color ^{at}
- (6) H. n

Recommen^d

- ① Sterile
- ② control ABZ
- ③ Control brachycephalus
- ④ Control Karyol
- ⑤ control HZN

Date _____

Signed

, M.D.

Patient's Address:

Patient Label

1216200102 000-478684 06/10/12
FARR, WILLIAM G [REDACTED] M 69Y
ADM: LITTLEFIELD, RONALD
REF: LITTLEFIELD, RONALD



8528



SPARTANBURG

Regional Healthcare System

☒ SRMC

☐ SHRC

☐ VH

Use Ball Point Pen and Press Firmly

REQUIRED FOR ADMISSION

Height:

Weight:

Allergies:

CHECK
OFF EACH
ORDER AS
TRANSCRIBED

PHYSICIANS ORDER FORM

TIME

1323

DATE

06/10/12

Diagnosis:

ABC now on 2050/15

Done in
ERAdmitted
1526
6-10-122400
6/11/12 0100
Physician SignatureContinued
6/10/12
1526

TIME NOTED

TELEPHONE/VERBAL ORDER RECEIVED BY:

MD OMAR ALEXANDER / JMW

REMINDER: VERIFY & READ BACK

PHYSICIAN PRINTED NAME

RECORD FINAL DIAGNOSIS ON THE FACE SHEET

PHYSICIAN SIGNATURE

Authenticated by
Alexander, Omar B., MD
On 06/18/2012 02:39:11 PM

Patient Label

1216200102 000-478684
FARR, WILLIAM G DOB
ADM: PHYSICIANS, ED
ADM DATE/TIME: 06/10/12 1112

Date/Time

1106 (Rev. 09-10)

PRINTED BY: DB30588

DATE

7/18/2013



SPARTANBURG

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Use Ball Point Pen and Press Firmly

REQUIRED FOR ADMISSION

Height:

Weight:

Allergies:

CHECK
OFF EACH
ORDER AS
TRANSCRIBED

PHYSICIANS ORDER FORM

Extended Infusion Piperacillin/Tazobactam and Doripenem

TIME 1800
DATE 6-10-12

Diagnosis:

Inclusion Criteria: Patient's CrCl $\geq$ 20 mL/min and patient weight $<$ 100 kgWeight: 61.3 kg CrCl: 60.5 mL/min

Piperacillin/tazobactam

Discontinue piperacillin/tazobactam if previously ordered

Start:

For weight $<$ 60 kg or CrCl 20-39 mL/min, use piperacillin/tazobactam 3.375 gmFor weight $\geq$ 60 kg and $<$ 100 kg and CrCl $\geq$ 40 mL/min, use piperacillin/tazobactam 4.5 gm☒ Piperacillin/tazobactam ☐ 3.375 gm OR ☒ 4.5 gm IV every 8 hours to be infused over 4 hours

Doripenem

Discontinue doripenem if previously ordered

Start:

For CrCl $>$ 50 mL/min, use 500 mg every 8 hours

For CrCl 30-49 mL/min, use 250 mg every 8 hours

For CrCl 20-29 mL/min, use 250 mg every 12 hours

☐ Doripenem ☐ 250 mg OR ☐ 500 mg IV every ☐ 8 hours OR ☐ 12 hours to be infused over 4 hours

TIME NOTED

TELEPHONE/VERBAL ORDER RECEIVED BY:



REMINDER: VERIFY & READ BACK

PHYSICIAN PRINTED NAME

RECORD FINAL DIAGNOSIS ON THE FACE SHEET

PHYSICIAN SIGNATURE

Authenticated by
Alexander, Omar B., MD
On 06/18/2012 02:39:13 PM

Date/Time

Patient Label

Farr, W.

1216206

1216200102 000-478684 06/10/12
FARR, WILLIAM G. M 69Y
ADM: LITTLEFIELD, RONALD
REF: LITTLEFIELD, RONALD

1106-425 (11-10)

PRINTED BY: DB30588

DATE

7/18/2013



SPARTANBURG

Regional Healthcare System

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Use Ball Point Pen and Press Firmly

REQUIRED FOR ADMISSION

Height:

Weight:

Allergies:

CHECK
OFF EACH
ORDER AS
TRANSCRIBED

VACCINATION ORDER FORM

Standing Orders Protocol for all ELIGIBLE PATIENTS

TIME

DATE

6/18/12

PNEUMOCOCCAL VACCINE (PPV23)

☐ If patient is under age 6 years, you may stop here.

☐ Pneumococcal polysaccharide vaccine 0.5 milliliters intramuscularly on DAY 3 or sooner if being discharged

If patient's temperature is >38 degrees Celsius / 100.4 degrees Fahrenheit, hold vaccine until patient is afebrile.

Note:

All pediatric patients, age 6-17 with a high risk condition of diabetes, nephritic syndrome, ESRD, CHF, COPD, HIV, or asplenia i.e., Sickie Cell, are a candidate for the vaccine unless they meet one of the Exclusion Criteria.

Exclusion Criteria for Pneumococcal Vaccine

- ☐ 1. Less than 6 years old
- ☒ 2. Has had in the past
- ☐ 3. Patient/caregiver refusal
- ☐ 4. Severe allergy to vaccine or its components
- ☐ 5. Bone Marrow transplant within the past 12 months
- ☐ 6. Received Chemo/Radiation in the past 2 weeks
- ☐ 7. Received Shingles vaccine (Zostavax) in past 4 weeks
- ☐ 8. Age 6 and older received conjugate vaccine in past 8 weeks
- ☐ 9. Pregnancy

INFLUENZA VACCINE

☐ If patient is under age 6 months, you may stop here.

☐ Influenza vaccine 0.5 milliliters intramuscularly on DAY 3, or sooner if being discharged

☐ Age 6-35 months - Influenza vaccine 0.25 milliliters intramuscularly on DAY 3, or sooner if being discharged

If patient's temperature is > 38 degrees Celsius/100.4 degrees Fahrenheit, hold vaccine until patient is afebrile.

Exclusion Criteria for Influenza Vaccine

- ☐ 1. Less than 6 months old
- ☐ 2. Already had THIS flu season.
- ☐ 3. Patient/Caregiver refusal
- ☐ 4. Severe ALLERGY to EGGS, vaccine or components of the vaccine (documented by physician)
- ☐ 5. Bone Marrow transplant within past 6 months
- ☐ 6. History of Guillain-Barre or neurological reaction to vaccine
- ☐ 7. Severe latex allergy (documented by physician)

TIME NOTED

VERIFYING NURSE:

Wang

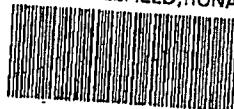
MD Signature not required per Federal Register

(Volume 67, 191) 42 CFR, Sub-part C, 482.23 (81814).

PATIENT NAME:

Patient Label

1216200102 000-478684 06/10/12
FARR, WILLIAM G
ADM: LITTLEFIELD, RONALD
REF: LITTLEFIELD, RONALD



1106-260 (Rev. 01-12)

PRINTED BY: DB30588

DATE

7/18/2013


SPARTANBURG
 Regional Healthcare System

☒ SRMC

☐ SHRC

☐ VH

Use Ball Point Pen and Press Firmly

REQUIRED FOR ADMISSION

Height:

Weight:

Allergies:

 CHECK
 OFF EACH
 ORDER AS
 TRANSCRIBED
PHYSICIANS ORDER FORMTIME 0130DATE 6/11/12

Diagnosis:

Lasix 40mg IV now xT

ABG xT Stat

Call results to Dr. Clark

BiPAP 10/5 100% Now
 over night

FAXED

24°/11. km RN
 6/12 9:00

TIME NOTED

TELEPHONE/VERBAL ORDER RECEIVED BY:

Stephen G. Dillen



REMINDER: VERIFY & READ BACK

x2

PHYSICIAN PRINTED NAME

D. Clark, MD

RECORD FINAL DIAGNOSIS ON THE FACE SHEET

PHYSICIAN SIGNATURE

Authenticated by
 J. Douglas Clark, M. D.
 On 06/25/2012 11:26:44 AM

P 1216200102 000-478684 06/10/12
 FARR, WILLIAM G M 69Y
 ADM: LITTLEFIELD, RONALD
 REF: LITTLEFIELD, RONALD



Date/Time

1106 (Rev. 09-10)

PRINTED BY: DB30588

DATE

7/18/2013


SPARTANBURG
 Regional Healthcare System

☒ SRMC

☐ SHRC

☐ VH

Use Ball Point Pen and Press Firmly

REQUIRED FOR ADMISSION

Height:

Weight:

Allergies:

CHECK
OFF EACH
ORDER AS
TRANSCRIBED**PHYSICIANS ORDER FORM**
 TIME 0200
 DATE 6/11/12

Diagnosis:

Do not intubate

9/4 V/H - Hines RN
6/12 900

TIME NOTED

TELEPHONE/VERBAL ORDER RECEIVED BY:

REMINDER: VERIFY & READ BACK

0200

Stephen A. Jones RN and Jorge Weatherly RN / Fran Wise, NP

PHYSICIAN PRINTED NAME

RECORD FINAL DIAGNOSIS ON THE FACE SHEET

PHYSICIAN SIGNATURE

Patient Label

 1216200102 000-478684 06/10/12
 FARR, WILLIAM G M 69Y
 ADM: LITTLEFIELD, RONALD
 REF: LITTLEFIELD, RONALD

Date/Time



1106 (Rev. 09-10)

PRINTED BY: DB30588

DATE

7/18/2013



SPARTANBURG
Regional Healthcare System

☐ SRMC☐ SHRC☐ VH

Use Ball Point Pen and Press Firmly

REQUIRED FOR ADMISSION

Height:

Weight:

Allergies:

CHECK
OFF EACH
ORDER AS
TRANSCRIBED

PHYSICIANS ORDER FORM

TIME 0250
DATE 6/11/12

Diagnosis:

Morphine 2-4mg IV q 2^h PRN
respiratory distress & pain.

Ativan 1mg IV q 6^h PRN for anxiety

FAXED

24 V/H Vmed RN
6/12/12

TIME NOTED

TELEPHONE/VERBAL ORDER RECEIVED BY:

REMINDER: VERIFY & READ BACK

0250

Stephen A. Jiles RN / Fran Wise RNP

V2

PHYSICIAN PRINTED NAME

Dr. Alexander

RECORD FINAL DIAGNOSIS ON THE FACE SHEET

PHYSICIAN SIGNATURE

[Signature]

Date/Time

1216200102 000-478684 06/10/12
FARR, WILLIAM G M 69Y
ADM: LITTLEFIELD, RONALD
REF: LITTLEFIELD, RONALD



1106 (REV. 05-10)

VH

REQUIRED FOR ADMISSION

Weight:

Allergies:

CHECK
OFF EACH
ORDER AS
TRANSCRIBED

PHYSICIANS ORDER FORM

TIME

DATE _____

Diagnosis:

① Paracalcitonin Receptor

D. Nolas D. R. Cruz
MS cabinet

③ D.N.R. - R.M.N.

④ Common to both sets is

Trans. or 123pm hours

6-11-12
1115

247/1. Line 811
6/12 900

TIME NOTED

TELEPHONE/VERBAL ORDER RECEIVED BY:

REMINDER: VERIFY & READ BACK

PHYSICIAN PRINTED NAME _____

RECORD FINAL DIAGNOSIS ON THE FACE SHEET

PHYSICIAN SIGNATURE _____

Patient Label

Date/Time

1216200102 000-478684 06/10/12
FARR, WILLIAM G [REDACTED] M 69Y
ADM: LITTLEFIELD, RONALD
REF: LITTLEFIELD, RONALD





SPARTANBURG
Regional Healthcare System

☐ SRMC

☐ SHRC

☐ VH

Use Ball Point Pen and Press Firmly

REQUIRED FOR ADMISSION

Height:

Weight:

Allergies:

CHECK
OFF EACH
ORDER AS
TRANSCRIBED

PHYSICIANS ORDER FORM

TIME
DATE

Diagnosis:

As - Chronic Heart ref. to

Frank to Bryan to

Dr. Vancomycin



#104
Howard OS
10/12/12
840

TIME NOTED

TELEPHONE/VERBAL ORDER RECEIVED BY:



REMINDER: VERIFY & READ BACK

PHYSICIAN PRINTED NAME

Emr

RECORD FINAL DIAGNOSIS ON THE FACE SHEET

PHYSICIAN SIGNATURE

[Signature]

Patient Label

1216200102 000-478684 06/10/12
FARR, WILLIAM G M 69Y
ADM: LITTLEFIELD, RONALD
REF: LITTLEFIELD, RONALD



Date/Time

1106 (Rev. 09-10)

PRINTED BY: DB30588

DATE

7/18/2013



SPARTANBURG
Regional Healthcare System

☐ SRMC☐ SHRC☐ VH

Use Ball Point Pen and Press Firmly

REQUIRED FOR ADMISSION

Height:

Weight:

Allergies:

CHECK
OFF EACH
ORDER AS
TRANSCRIBED

PHYSICIANS ORDER FORMTIME 1123DATE 6-12-12

Diagnosis:

Nicotine 21 mg Patch Q24h

EXED

TIME NOTED

TELEPHONE/VERBAL ORDER RECEIVED BY:

REMINDER: VERIFY & READ BACK

PHYSICIAN PRINTED NAME

RECORD FINAL DIAGNOSIS ON THE FACE SHEET

PHYSICIAN SIGNATURE

Authenticated by
Ronald H. Littlefield, M.D.
On 06/22/2012 10:02:16 AM

Patient Lab 1216200102 000-478684 06/10/12
FARR, WILLIAM G M 69Y
ADM: LITTLEFIELD, RONALD
REF: LITTLEFIELD, RONALD



Date/Time

FARR, WILLIAM G
SPARTANBURG REGIC
FROM: 06/09/12 13:15 TO: 06/10/12 13:15
ROOM: CP30-A ADM: 06/10/12 11:12
AGE: 65Y SEX: M M.D.: PHYSICIANS, ED
ID: 1216200102 MR: 000478684
REQUESTED: 06/10/12 13:15 (OA)
OPT OUT:

Order Confirmation Report - FARR, WILLIAM G
DEPT: ECH ROOM: CP30-A MR: 000478684
Ordered by: MD ALEXANDER, OMAR
Authenticated by: MD ALEXANDER, OMAR - 06/10/12 13:15
Order mode: Direct - Session Id: 18933746

ALLERGY				
Charted	Allergy name	Type	Reaction	Severity Comment
03/23 13:22 NKA	(NEEDS REVIEW)	Drug Allergy		

AMS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
14	Started	ADMIT AS ADMIT AS: INPATIENT	ONCE	ROUTINE	1 Time	06/10 13:05	06/10 13:05
15	Started	ADMIT TO ADMIT TO: TELEMETRY UNIT	ONCE	ROUTINE	1 Time	06/10 13:05	06/10 13:05

HEODEPT

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
12	started	DIAGNOSIS: Category: Medical Enter a diagnosis search (part of a name or an ICD9 code): Adenocarcinoma of lung (162.9)	CONTIN	ROUTINE		06/10 13:05	Indefinite
13	started	DIAGNOSIS: Category: Medical Enter a diagnosis search (part of a name or an ICD9 code): Dyspnea (786.09)	CONTIN	ROUTINE		06/10 13:05	Indefinite
16	started	DIAGNOSIS: Category: Medical Enter a diagnosis search (part of a name or an ICD9 code): Dyspnea (786.09)	CONTIN	ROUTINE		06/10 13:05	Indefinite
17	started	CONDITION: Condition: Serious	CONTIN	ROUTINE	1 Occr	06/10 13:05	06/10 13:05
42	started	CHECKBOX MAIN MENU IFORM USED	ONCE	ROUTINE	1 Time	06/10 13:06	06/10 13:06
60	started	DIAGNOSIS: Category: Medical Enter a diagnosis search (part of a name or an ICD9 code): Primary malignant neoplasm of lung (162.9)	CONTIN	ROUTINE		06/10 13:05	Indefinite

LMC

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
28	started	CPK LMC: Specimen Source: BLOOD NURSE COLLECT: No Ordering Diagnosis: acute coronary syndrome	Q6H	TIMED	3 Occrs	06/10 13:05	06/11 01:05
29	started	CK-MB LMC: Specimen Source: BLOOD NURSE COLLECT: No Ordering Diagnosis: acute coronary syndrome	Q6H	TIMED	3 Occrs	06/10 13:05	06/11 01:05
30	started	TROPONIN I ULTRA LMC: Specimen Source: BLOOD NURSE COLLECT: No Ordering Diagnosis: acute coronary syndrome	Q6H	TIMED	3 Occrs	06/10 13:05	06/11 01:05
39	Active	CBC LMC: Specimen Source: BLOOD NURSE COLLECT: No	IN AM	ROUTINE	1 Time	06/11 05:00	06/11 05:00
40	Active	BASIC METABOLIC PANEL LMC: Specimen Source: BLOOD NURSE COLLECT: No	IN AM	ROUTINE	1 Time	06/11 05:00	06/11 05:00
50	Started	RESPIRATORY CULTURE W/ GRAM STAIN LMC: Specimen Source: SPUTUM NURSE COLLECT: Yes	ONCE	ASAP	1 Time	06/10 13:10	06/10 13:10
51	Started	BLOOD CULTURE	ONCE	ROUTINE	1 Time	06/10 13:11	06/10 13:11

CONTINUED

Page 1

PERM

PRINTED BY: DB30588

DATE

7/18/2013

FARR, WILLIAM G
SPARTANBURG REGIC
FROM: 06/09/12 13:15 TO: 06/10/12 13:15
ROOM: CP30-A ADM: 06/10/12 11:12
AGE: 69Y SEX: M M.D.: PHYSICIANS, ED
ID: 1216200102 MR: 000478684
REQUESTED: 06/10/12 13:15 (OA)
OPT OUT:

Order Confirmation Report - FARR, WILLIAM G
DEPT: ECH ROOM: CP30-A MR: 000478684
Ordered by: MD ALEXANDER, OMAR
Authenticated by: MD ALEXANDER, OMAR - 06/10/12 13:15
Order mode: Direct - Session Id: 18933746

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
		BOTTLE TYPE: AEROBIC AND ANAEROBIC BOTTLES					
		LMC: Specimen Source: BLOOD					
		NURSE COLLECT: No					
52	Active	BLOOD CULTURE	ONCE	ROUTINE	1 Time	06/10 13:21	06/10 13:21
		BOTTLE TYPE: AEROBIC AND ANAEROBIC BOTTLES					
		LMC: Specimen Source: BLOOD					
		NURSE COLLECT: No					
53	Started	CHF BNP	ONCE	STAT	1 Time	06/10 13:10	06/10 13:10
		LMC: Specimen Source: BLOOD					
		NURSE COLLECT: No					

NS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
56	Active	CARDIAC DIET	M	DINNER		06/10 16:30	Indefinite
		DIET MODIFIER #1: CARDIAC PRECAUTIONS					
		DIET MODIFIER #2: NO DIET MODIFIER					
		DIET MODIFIER #3: NO DIET MODIFIER					

NSG

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
18	Started	CODE STATUS:	QS	ROUTINE		06/10 13:05	Indefinite
		CODE STATUS CATEGORIES: Cat 1 - Full Code					
19	Started	VITAL SIGNS	PRN	ROUTINE		06/10 13:05	Indefinite
		q 30 min until stable, then q 4 hr and prn					
20	Started	CARDIAC MONITORING	CONT	ROUTINE		06/10 13:05	Indefinite
21	Started	NOTIFY MD IF ST SEGMENT CHANGES	PRN	ASAP		06/10 13:05	Indefinite
22	Started	NOTIFY MD FOR SYSTOLIC BP	PRN	ASAP		06/10 13:05	Indefinite
		< 90					
23	Started	NOTIFY MD IF SYMPTOMATIC RHYTHM	PRN	ASAP		06/10 13:05	Indefinite
		CHANGE					
24	Started	NOTIFY MD IF SYMPTOMATIC CHANGE	PRN	ASAP		06/10 13:05	Indefinite
		IN RESPIRATIONS					
25	Started	NOTIFY MD IF PROGRESSIVE CHEST	PRN	ASAP		06/10 13:05	Indefinite
		DISCOMFORT					
26	Started	NOTIFY MD IF O2 SAT <	PRN	ASAP		06/10 13:05	Indefinite
		90					
27	Started	NSG: O2 PER NASAL CANNULA	CONT	ASAP		06/10 13:05	Indefinite
		START O2 AT 2 L/MIN; THEN FOLLOW PROTOCOL					
31	Started	INTAKE AND OUTPUT	Q8H	ROUTINE		06/10 13:05	Indefinite
32	Started	BEDREST WITH BRP	QS	ROUTINE		06/10 13:05	Indefinite
33	Started	FALL PRECAUTIONS	QS	ROUTINE		06/10 13:05	Indefinite
34	Started	IV ACCESS	ONCE	ROUTINE	1 Time	06/10 13:05	06/10 13:05
54	Started	CONSULT:	ONCE	ROUTINE	1 Time	06/10 13:11	06/10 13:11
		Dr. Cruz et al for acute resp failure/copd.					
55	Started	MESSAGE TO NURSING:	ONCE	ROUTINE	1 Time	06/10 13:11	06/10 13:11
		Dr. Littlefield will take over in the am. Please update him to pt location.					
57	Started	MESSAGE TO NURSING:	ONCE	ROUTINE	1 Time	06/10 13:14	06/10 13:14
		need a correct weight for wt based lovenox					
58	Started	MESSAGE TO NURSING:	ONCE	ROUTINE	1 Time	06/10 13:15	06/10 13:15
		please find out home meds and call alliance to restart.					
59	Started	NSG: MAY-TRAVEL FROM EC-TO	PER PROTOCOL	ROUTINE	Time	06/10 13:15	
		INPATIENT UNIT W/O MONITOR					

CONTINUED

FARR, WILLIAM G
 SPARTANBURG REGIC
 FROM: 06/09/12 13:15 TO: 06/10/12 13:15
 ROOM: CP30-A ADM: 06/10/12 11:12
 AGE: 69Y SEX: M M.D.: PHYSICIANS, ED
 ID: 1216200102 MR: 000478684
 REQUESTED: 06/10/12 13:15 (OA)
 OPT OUT:

Order Confirmation Report - FARR, WILLIAM G
 DEPT: ECH ROOM: CP30-A MR: 000478684
 Ordered by: MD ALEXANDER, OMAR
 Authenticated by: MD ALEXANDER, OMAR - 06/10/12 13:15
 Order mode: Direct - Session Id: 18933746

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop

PMS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
35	Started	ACETAMINOPHEN for pain/headache Dose: 325 - 650 MG Route: PO	Q6H PRN	ROUTINE		06/10 13:05	Indefinite
36	Started	MAALOX PLUS EXTRA STRENGTH SUSP for indigestion Dose: 15 ML Route: PO	Q6H PRN	ROUTINE		06/10 13:05	Indefinite
37	Started	CLONIDINE [CATAPRES] for systolic bp > 180 mmHg or diastolic bp > 100 mmHg Dose: 0.1 MG Route: PO	Q4H PRN	ROUTINE		06/10 13:05	Indefinite
38	Started	ONDANSETRON INJ [ZOFTRAN] for nausea unrelieved by promethazine Dose: 4 - 8 MG Route: IV	Q6H PRN	ROUTINE		06/10 13:05	Indefinite
41	Started	MESSAGE TO PHARMACY Dose: 0 Route: MISC Comments: lovenox 1mg/kg sq q12h	ONCE	ROUTINE	1 Time	06/10 13:05	06/10 13:05
43	Started	ALBUTEROL - IPRATROPIUM SOLN INH Q4HPRNRESP sob/wheezing; IPPB treatment(s) Dose: 3 ML Route: INHALATN	Q4H PRN	ROUTINE		06/10 13:06	Indefinite
45	Started	VANCOMYCIN INJ ; ask kinetics pharmacist to follow and order levels as appropriate Dose: 1500 mg Route: IV	ONCE	NOW	1 Time	06/10 13:07	06/10 13:07
46	Started	PIPERACILLIN-TAZOBACTAM INJ [ZOSYN] Dose: 3.375 G Route: IV	Q6H	NOW		06/10 13:09	Indefinite
47	Started	METHYLPREDNISOLONE INJ Dose: 125 MG Route: IV	ONCE	NOW	1 Time	06/10 13:09	06/10 13:09
48	Active	METHYLPREDNISOLONE INJ Dose: 60 MG Route: IV	Q6H	NEXT SCH		06/10 18:00	Indefinite
49	Active	PANTOPRAZOLE [PROTONIX] Dose: 40 MG Route: PO	DAILY AC	NEXT SCH		06/11 06:00	Indefinite

RT

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
44	Active	IPPB TRANSPORTATION METHOD: BEDSIDE/PORTABLE ENTER ORDER UNDER INSTRUCTIONS INSTRUCTIONS: sob/wheezing; IPPB treatment(s); med: duonebi 3 ml Q4H PRN Ordering Diagnosis: copd	PRN	ROUTINE		06/10 18:00	Indefinite

FARR, WILLIAM G
 SPARTANBURG REGIONAL
 FROM: 06/09/12 15:16 TO: 06/10/12 15:16
 ROOM: 8528-A ADM: 06/10/12 14:57
 AGE: 69Y SEX: M MD: LITTLEFIELD, RONALD H
 ID: 1216200102 MR: 000478684
 REQUESTED: 06/10/12 15:16 (ALH2)
 OPT OUT:

Order Confirmation Report - FARR, WILLIAM G
 DEPT: 5H ROOM: 8528-A MR: 000478684
 Ordered by: MD ALEXANDER, OMAR
 Entered by: PCT HICKS, APRILL - 06/10/12 15:16
 Order mode: Written - Session Id: 18934276

Charted	Allergy name	Type	Reaction	Severity	Comment
03/23 13:22 NKA	(NEEDS REVIEW)	Drug Allergy			

HEODEPT

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
69	Started	CHECKBOX MAIN MENU IFORM USED	ONCE	ROUTINE	1 Time	06/10 15:14	06/10 15:14
73	Started	CHECKBOX MAIN MENU IFORM USED	ONCE	ROUTINE	1 Time	06/10 15:15	06/10 15:15

LMC

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
28	D/C'd	CPK	Q6H	TIMED	3 Occrs	06/10 13:05	06/11 01:05

v2 Reason for action: ORDER CHANGED

LMC:Specimen Source: BLOOD

NURSE COLLECT: No

Ordering Diagnosis: acute coronary syndrome

29	D/C'd	CK-MB	Q6H	TIMED	3 Occrs	06/10 13:05	06/11 01:05

v2 Reason for action: ORDER CHANGED

LMC:Specimen Source: BLOOD

NURSE COLLECT: No

Ordering Diagnosis: acute coronary syndrome

30	D/C'd	TROPONIN I ULTRA	Q6H	TIMED	3 Occrs	06/10 13:05	06/11 01:05

v2 Reason for action: ORDER CHANGED

LMC:Specimen Source: BLOOD

NURSE COLLECT: No

Ordering Diagnosis: acute coronary syndrome

70	Active	CPK	Q6H	TIMED	2 Times	06/10 17:26	06/10 23:26

LMC:Specimen Source: BLOOD

NURSE COLLECT: No

Ordering Diagnosis: CHEST PAIN

71	Active	CK-MB	Q6H	TIMED	2 Times	06/10 17:26	06/10 23:26

LMC:Specimen Source: BLOOD

NURSE COLLECT: No

Ordering Diagnosis: CHEST PAIN

72	Active	TROPONIN I ULTRA	Q6H	TIMED	2 Times	06/10 17:26	06/10 23:26

LMC:Specimen Source: BLOOD

NURSE COLLECT: No

Ordering Diagnosis: CHEST PAIN

NOU

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
75	Started	SEND TRAY NOW	ONCE	ASAP	1 Time	06/10 15:15	06/10 15:15

Enter Diet in Instruction Box

INSTRUCTIONS (Enter diet): : cardiacdiet

NS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
56	D/C'd	CARDIAC DIET	M	DINNER		06/10 16:30	

v2 Reason for action: ORDER CHANGED

DIET MODIFIER #1: CARDIAC PRECAUTIONS

DIET MODIFIER #2: NO DIET MODIFIER

DIET MODIFIER #3: NO DIET MODIFIER

74	Active	CARDIAC DIET	M	DINNER		06/10 16:30	Indefinite

DIET MODIFIER #1: NO DIET MODIFIER

DIET MODIFIER #2: NO DIET MODIFIER

DIET MODIFIER #3: NO DIET MODIFIER

FARR, WILLIAM G
 SPARTANBURG REGIONAL
 FROM: 06/09/12 16:17 TO: 06/10/12 16:17
 ROOM: 8528-A ADM: 06/10/12 14:57
 AGE: 68Y SEX: M MD: LITTLEFIELD, RONALD H
 ID: 1216200102 MR: 000478684
 REQUESTED: 06/10/12 16:17 (CAM)
 OPT OUT:

Order Confirmation Report - FARR, WILLIAM G
 DEPT: 5H ROOM: 8528-A MR: 000478684
 Ordered by: MD ALEXANDER, OMAR
 Entered by: RX MESSINGER, CHAD A - 06/10/12 16:17
 Order mode: Written - Session Id: 18934506

ALLERGY				
Charted	Allergy name	Type	Reaction	Severity Comment
03/23 13:22	NKA	Drug Allergy		

HEODEPT

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
77	Started	PATIENT SPECIFIC DATA	CONTIN	ROUTINE		06/10 16:07	Indefinite
		Patient's weight (kgs or lbs): 55.701098					
		Instructions: weight: 55.701kg/122.81lb;					
78	Started	PATIENT SPECIFIC DATA	CONTIN	ROUTINE		06/10 16:07	Indefinite
		Patient's height (cms or ins): 165.100000					
		Instructions: height: 165.10cm/65.0in;					

PMS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
79	Active	VANCOMYCIN INJ	Q18H VAR	ROUTINE		06/11 09:00	Indefinite
		Dose: 1250 mg					
		Route: IV					

Abdis
1749
6-10-12

242
6/11/12 0100
Prophen Admitted

FARR, WILLIAM G
SPARTANBURG REGIONAL
FROM: 06/09/12 20:28 TO: 06/10/12 20:28
ROOM: 8528-A ADM: 06/10/12 14:57
AGE: 69Y SEX: M MD: LITTLEFIELD, RONALD H
ID: 1216200102 MR: 000478584
REQUESTED: 06/10/12 20:28 (JDC)
OPT OUT:

Order Confirmation Report - FARR, WILLIAM G
DEPT: 5H ROOM: 8528-A MR: 000478684
Ordered by: MD CLARK, J DO
Authenticated by: MD ALEXANDER, OMAR - 06/10/12 20:28
Order mode: Direct - Session Id: 18935678

ALLERGY				
Charted	Allergy name	Type	Reaction	Severity Comment
03/23 13:22 NKA		Drug Allergy		

PMS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
48	Modified	METHYLPREDNISOLONE INJ	Q12H	NEXT SCH		06/10 20:28	Indefinite
v3		MONITOR BLOOD PRESSURE-ELECTROLYTES.					
		Dose: 40 MG					
		Route: IV					

24w
6/11/12 01:00
Daphne A. [Signature]

FARR, WILLIAM G
SPARTANBURG REGIONAL
FROM: 06/10/12 12:12 TO: 06/11/12 12:12
ROOM: 8528-A ADM: 06/10/12 14:57
AGE: 69Y SEX: M MD: LITTLEFIELD, RONALD H
ID: 1216200102 MR: 000478684
REQUESTED: 06/11/12 12:13 (STB1)
OPT OUT:

Order Confirmation Report - FARR, WILLIAM G
DEPT: 5H ROOM: 8528-A MR: 000478684
Ordered by: MD LITTLEFIELD, RONALD H
Entered by: RX BAILEY, SUZZANE T - 06/11/12 12:12
Order mode: Written - Session Id: 18940156

ALLERGY				
Charted	Allergy name	Type	Reaction	Severity Comment
03/23 13:22 NKA		Drug Allergy		

PMS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
80	D/C'd	VANCOMYCIN INJ 1250 MG	Q18H	ROUTINE		06/11 09:00	
v2		Reason for action: ORDER CHANGED					
		NORMAL SALINE BOLUS 250 ML					
		Route: IV					
99	Active	VANCOMYCIN INJ	Q24H VAR	ROUTINE		06/11 16:00	Indefinite
		Dose: 1250 mg					
		Route: IV					

K. Howard, US
6/11/12
1249

24 H. King
6/12 0200

FARR, WILLIAM G
SPARTANBURG REGIONAL
FROM: 06/11/12 09:19 TO: 06/12/12 09:19
ROOM: 8528-A ADM: 06/10/12 14:57
AGE: 69Y SEX: M MD: LITTLEFIELD, RONALD H
ID: 1216200102 MR: 000478684
REQUESTED: 06/12/12 09:19 (KMH1)
OPT OUT:

Order Confirmation Report - FARR, WILLIAM G
DEPT: 5H ROOM: 8528-A MR: 000478684
Ordered by: MD LITTLEFIELD, RONALD H
Entered by: US HOWARD, KERA M - 06/12/12 09:19
Order mode: Written - Session Id:18947725

ALLERGY				
Charted	Allergy name	Type	Reaction	Severity Comment
03/23 13:22 NKA		Drug Allergy		

CNS							
Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
104	Started	HMS CONSULT FOR HOSPICE transfer to hospice house	ONCE	ROUTINE	1 Time	06/12 09:19	06/12 09:19



FORM: 1080

MD Progress Notes - FARR, WILLIAM G - 06/10/12 12:25
(SUMMARIZED PATIENT DATA ONLY, COMPLETE DATA ONLINE.)

FARR, WILLIAM G
SPARTANBURG REGIONAL
FROM: 06/09/12 12:25 TO: 06/10/12 12:25
ROOM: CP30-A ADM: 06/10/12 11:12
AGE: 69Y SEX: M M.D.: PHYSICIANS, ED
D: 1216200102 MR: 000478684
REQUESTED: 06/10/12 12:25 (OA)
OPT OUT:

ALL LABS Most recent value for 06/10 (Range for past 24 hrs excluding most recent value)

B Natriuretic Peptide	EST. GFR O >60	Eosinophil 0.00 11:21
B Natriure 85.3 11:21	COMPLETE BLOOD COUNT WITH AUTOMA	Basophil P 0.50 11:21
BASIC METABOLIC PANEL	White Bloo 20.1 H 11:21	Nucleated 0.0 11:21
Sodium 133 11:21	Red Blood 4.84 11:21	Absolute L 0.5 L 11:21
Potassium 4.5 11:21	Hemoglobin 14.7 11:21	Absolute M 1.1 H 11:21
Chloride 103 11:21	Hematocrit 44.9 11:21	Absolute N 18.4 H 11:21
Carbon Dio 21.1 L 11:21	Mean Corpu 92.9 11:21	Absolute E 0.0 11:21
Glucose 121 H 11:21	Mean Corpu 30.4 11:21	Absolute B 0.1 11:21
Urea Nitro 29 H 11:21	Mean Corpu 32.7 L 11:21	Nucleated 0.00 11:21
Creatinine 0.93 11:21	Red Cell D 16.6 H 11:21	Scan Comme Periphe
Bun/Creat 31 H 11:21	Platelet 320 11:21	EC CK-MB
Anion Gap 13 11:21	Neutrophil 91.60 11:21	Creatinine 8.4 H 11:26
Osmolality 273 11:21	Lymphocyte 2.60 11:21	EC TROPONIN
Calcium 9.6 11:21	Monocyte P 5.30 11:21	Troponin I 0.10 11:26
EST. GFR A >60		

PP: Littlefield
Hem/oc: Nuka
Pulse: Cruz.
All: NKA.

Assurance Inpatient Medicine
HPI: 69yo male recent dx
now back for chest tightness

PP: Hx Colon CA
NSCLCA
COPD
HTN
DMP

- ① Dyspnea/Hx
 - ② NSCLCA RSP failure
 - ③ COPD
 - ④ HTN
 - ⑤ DMP
 - ⑥ Leukocytosis
- ppx: lovenax w/ based / prolonix

PP:
SP & RUL+ML
lobectomy

SF: Hx Tob abuse

12566400

FF: g. amb

[Signature]
D. Alexander

ME DS: 280
M.A.R.



PATIENT ID: 1216200102



SPARTANBURG
Regional Healthcare System

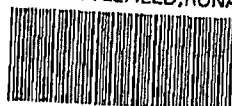
☐ SRMC ☐ SHRC ☐ VH

PROGRESS NOTES

DATE/TIME	NOTES
6/11/12 0356	<i>Am</i> I work Anti Recp duties - End of the am - attending RN community T.D. Clark - David 147.4/30/61/128 92% sat. placed on BIPAP. Discharge patient per RN - and confirmed by myself & son D.V. Keep computer & monitor at work - more & H. & B. from 40/1000 - family @ bedside for discussion & son who confirms D.V. who tells. <i>Am</i>

Patient La'

1216200102 000-478684 06/10/12
FARR, WILLIAM G [REDACTED] M 69Y
ADM: LITTLEFIELD, RONALD
REF: LITTLEFIELD, RONALD





SPARTANBURG

Regional Healthcare System

☐ SRMC ☐ SHRC ☐ VH

PROGRESS NOTES

DATE/TIME	NOTES
6/11/12	ent med pt Dr. & O'Brien & Miller & + met to review on 1/12 & → 1/12 on 1/12 Ppt 1 2nd pt 2nd MR Chm & BLS Cm in gk a 2nd ASC meta Ca COPD ① 1st + ② last admt & Q Kalya - 1st admt Bx in P - 1st E final - 45 min + Dr. → 1/12 on 1/12 MR

Patient Label

1216200102 000 478684 06/10/12
FARR, WILLIAM G M 69Y
ADM: LITTLEFIELD, RONALD
REF: LITTLEFIELD, RONALD



1080 (Rev. 05-09)

PRINTED BY: DB30588

DATE

7/18/2013



SPARTANBURG
Regional Healthcare System

☐ SRMC

☐ SHRC

☐ VH

PROGRESS NOTES

DATE/TIME	NOTES
6/11/12	Pharmacy Agreeing with Assessing AP - J. J. J. Coen McRae's File Agree to have evaluated - ~~not~~ ~~not~~ ~~not~~ Calcareum Chronic
6/11/12	Pharmacy consulted to dose Vancomycin for this patient. Wt = 61 Kg Scr = 1.13 Est Crcl $\approx$ 46-50 ml/min WBC = 14.9 ① Vancomycin 1500mg IV x 1 given 6/10/12 @ 1554, then ② Vancomycin 1250mg IV @ 24h ③ Pharmacy will follow along with you. Thank You Suzanne Bailey PharmD 809-9533

Patient Label

1216200102 000 06/10/12
FARR, WILLIAM G M 69Y
ADM: LITTLEFIELD, RONALD
REF: LITTLEFIELD, RONALD



1080 (Rev. 05-09)

PRINTED BY: DB30588

DATE

7/18/2013



SPARTANBURG
Regional Healthcare System

☐ SRMC

☐ SHRC

☐ VH

PROGRESS NOTES

DATE/TIME	NOTES
6/12/11	Just met pt on 6 PM I left for room care pt from (Bum - sm) which pt is going to be with him for comparison Wangue & 201 RA
6/12/12	Hospice Social Worker: Just visit to room a hospice SW. Admin. Discuss early leading to hospitalization. Pt admitted to home hospice on 6/7 with significant decline. Spouse & Brothers in the room. Pt stated wanted to verbalize desire to go home but also agreeable to hospice home to get symptoms under control. Will follow up soon & agreed. (Ch. Keener, LBS) Dr Bell given report and gave okay to follow Dr Littlefield's order to transfer to hospice home before palliative consult. Hospice Supervisor S. Carr made aware. (Adrian Allen RN)

Patient 1216200102 000 478684 06/10/12
 FARR, WILLIAM G M 69Y
 ADM: LITTLEFIELD, RONALD
 REF: LITTLEFIELD, RONALD



1080 (Rev. 05-09)

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

NAME: FARR, WILLIAM G
ORDERING PHYSICIAN: ROY, MICAH J
LOC: ECH-CP30-A
Pt. Type: ER
DOB: [REDACTED]
EMERG DEPT

UNIT #: 000478684
CI#: 3358938
AN#: S1216200102

FINAL

Exam

10052 ER CHEST P**
71010

Date: 06/10/12 1121
Ord Diag: sob

** Portable **

History: Shortness of breath and congestion.

Portable AP chest dated 6/10/2012: Compared with 6/4/2012.

A left-sided Port-A-Cath is unchanged. The heart is not enlarged. Parenchymal lung densities are noted bilaterally most typical of pneumonia. Pulmonary edema would be a possibility as well. These appear to have progressed, and there is a small amount of associated right pleural effusion.

Impression: Extensive parenchymal lung densities bilaterally, a little more pronounced than on the previous study. Findings most compatible with pneumonia. Pulmonary edema would be a clinical consideration as well.

Transcriptionist- n/a
Reading Radiologist- LAWRENCE WARRENJR MD
Releasing Radiologist- LAWRENCE WARRENJR MD
Released Date Time- 06/10/12 1152

** Portable **

Page 1

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

NAME: FARR, WILLIAM G
ORDERING PHYSICIAN: ROY, MICAH J
LOC: ECH-CP30-A
Pt. Type: ER
DOB: [REDACTED]
EMERG DEPT

UNIT #: 000478684
CI#: 3358963
AN#: S1216200102

FINAL

Exam

60221 CT LUNG FOR PE W/CONTRAST Date: 06/10/12 1210

71270

Ord Diag: hypoxia/cancer/tachy---

History: Shortness of breath. History of lung cancer.

CT of the chest with pulmonary embolus protocol dated 6/10/2012:
Compared with 5/31/2012.

Spiral images were obtained through the chest during bolus IV contrast administration. 100 mL of Isovue-370 were administered intravenously without adverse patient reaction. Contrast was given for optimal opacification of vascular structures and solid organs.

Findings: There is excellent opacification of the pulmonary arteries. No pulmonary emboli are seen. There is no evidence of aortic aneurysm or dissection. Extensive parenchymal lung densities are noted bilaterally. These are largely chronic, but there is more confluent density in the right lower lung similar to that seen on the previous study. Superimposed pneumonia cannot be excluded. There is no significant adenopathy in the mediastinum or hila. No significant pleural effusion is seen. There is a tiny amount of right pleural effusion, unchanged.

No significant abnormality is seen in the upper abdomen. A cyst in the left lobe of the liver is unchanged.

Impression: Negative for pulmonary embolus, aortic aneurysm, or dissection. Extensive parenchymal lung densities bilaterally, largely chronic. More confluent density in the right lower lung which could represent superimposed pneumonia. No acute changes since the previous

Page 1

SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

NAME: FARR, WILLIAM G

ORDERING PHYSICIAN: ROY, MICAH J

LOC: ECH-CP30-A

Pt. Type: ER

DOB: [REDACTED]

EMERG DEPT

UNIT #: 000478684

CI#: 3358963

AN#: S1216200102

Checkin-Exam Code Summary
3358963-60221

study done 2 weeks ago.

Transcriptionist- n/a

Reading Radiologist- LAWRENCE WARRENJR MD

Releasing Radiologist- LAWRENCE WARRENJR MD

Released Date Time- 06/10/12 1416

Page 2

J. David Wren, MD PHD, Director

Spartanburg Regional Medical Center
101 E. Wood Street
Spartanburg, South Carolina 29303-3072

Dept of Laboratory Medicine
864-560-6212

FARR, WILLIAM GAULT
69Y
LITTLEFIELD, RONALD H

MR#: S000478684
DOB: XXXXXXXXXX
Location: 5H 8528A

ACCT#: S1216200102
Admitted: 06/10/2012
Pt. Type: INPATIENT

CHEMISTRY

BLOOD	06/10	06/10	06/10	06/10	06/10		
Collected	23:50 ¹	23:50 ¹	17:40 ¹	17:40 ¹	17:40 ¹		
Released	06/11	06/11	06/10	06/10	06/10	Reference	Units
	00:33	00:25	18:43	18:42	18:35		
Accession	C121620642	C121620640	C121620641	C121620641	C121620639		
CK		37			35	30-223	IU/L
CKMB	7.0 H		6.5 H			0.0-6.0	ng/mL
Trop Ult	0.072 H			0.067 H		0.000-0.040	ng/mL

BLOOD	06/11						
Collected	11:26						
Released	06/11					Reference	Units
	11:26						
Accession	EC121630655						

J. David Wren, MD PHD, Director

Spartanburg Regional Medical Center
101 E. Wood Street
Spartanburg, South Carolina 29303-3072Dept of Laboratory Medicine
864-560-6212FARR, WILLIAM GAULT
69Y
LITTLEFIELD, RONALD HMR#: S000478684
DOB: [REDACTED]
Location: 5H 8528AACCT#: S1216200102
Admitted: 06/10/2012
Pt. Type: INPATIENT

BLOOD			
Collected	06/11 11:26		
Released	06/11 11:26	Reference	Units
Accession	EC121630655		
FS Glu	143 H ²	70-100	mg/dL

BLOOD GAS

ARTERIAL BLOOD			
Collected	06/11 01:59		
Released	06/11 01:59	Reference	Units
Accession	EC121630173		
pH	7.44	7.35-7.45	
PCO2	30 L	35-45	mm/Hg
PO2	61 L	75-85	mm/Hg
Tot CO2	21 L	23-27	mmol/L
HCO3	19.8 L	22.0-26.0	mmol/L
BE	-3 L	-2-3	mmol/L
O2 SAT	92 L	95-100	%
L/min	15		
Type	ARTERIAL		
Allen's	Pass		
DelSys	NFB Msk		
Intubate	No		
Site	R Radial		

²Fingerstick glucose levels greater than 500 mg/dL must be sent to the laboratory for confirmation.

Patient Name: FARR, WILLIAM GAULT
Location: 5H 8528A
PT Type: INPATIENT

SRMC CUM DAILY REPORT - TO PRINT, A

Printed: 06/11/2012 21:58
Page: 2 of 2

PRINTED BY: DB30588

DATE 7/18/2013

J. David Wren, MD PHD, Director

Spartanburg Regional Medical Center
101 E. Wood Street
Spartanburg, South Carolina 29303-3072Dept of Laboratory Medicine
864-560-6212FARR, WILLIAM GAULT
69Y
LITTLEFIELD, RONALD HMR#: S000478684
DOB: [REDACTED]
Location: 5H 8528AACCT#: S1216200102
Admitted: 06/10/2012
PT Type: INPATIENTHEMATOLOGY

BLOOD				
Collected	06/11	06/10		
	05:20	11:21		
Released	06/11	06/10	Reference	Units
	05:32	12:13		
Accession	H121620411	H121620355		
WBC	14.9 H	20.1 H	3.1-9.7	K/cmm
RBC	4.63	4.84	4.08-5.70	million/cmm
HGB	14.2	14.7	13.1-16.8	g/dL
HCT	42.5	44.9	38.2-48.4	%
MCV	91.6	92.9	80.1-98.7	fL
MCH	30.6	30.4	27.5-34.3	pg
MCHC	33.4	32.7 L	33.2-35.7	g/dL
RDW	16.4 H	16.6 H	11.7-15.0	%
PLT	276	320	119-332	K/cmm
Neut %		91.60 H	37.60-73.50	%
Lymph %		2.60 L	16.80-46.20	%
Mono %		5.30	4.60-13.10	%
Eos %		0.00	0.00-7.70	%
Baso %		0.50	0.10-1.30	%
NE#		18.4 H	0.9-6.3	/cmm
LY#		0.5 L	0.8-3.1	/cmm
MO#		1.1 H	0.2-0.9	/cmm
EO#		0.0	0.0-0.6	/cmm
BA#		0.1	0.0-0.1	/cmm
NRBC %		0.0	0.0-0.0	%
NRB #		0.00	0.00-0.00	/cmm
Scan		See Note ¹		

CHEMISTRY

BLOOD

¹Peripheral smear scanned to verify automated differential.Patient Name: FARR, WILLIAM GAULT
Location: 5H 8528A
PT Type: INPATIENT

SRMC CUM FINAL DISCHARGE REPORT -

Printed: 06/13/2012 02:04
Page: 1 of 4

PRINTED BY: DB30588

DATE 7/18/2013

J. David Wren, MD PHD, Director

Spartanburg Regional Medical Center
101 E. Wood Street
Spartanburg, South Carolina 29303-3072Dept of Laboratory Medicine
864-560-6212FARR, WILLIAM GAULT
69Y
LITTLEFIELD, RONALD HMR#: S000478684
DOB: [REDACTED]
Location: 5H 8528AACCT#: S1216200102
Admitted: 06/10/2012
PT Type: INPATIENT

Collected	06/11 05:20 ²	06/10 23:50 ³	06/10 23:50 ³	06/10 17:40 ³	06/10 17:40 ³		
Released	06/11 05:57	06/11 00:33	06/11 00:25	06/10 18:43	06/10 18:42	Reference	Units
Accession	C121620570	C121620642	C121620640	C121620641	C121620641		
Creat	1.13					0.47-1.35	mg/dL
UN	30 H					7-25	mg/dL
Na	139					133-146	mmol/L
Chlor	102					100-111	mmol/L
CO2	25.3					23.0-32.6	mmol/L
K	3.7					3.5-5.2	mmol/L
Gluc	166 H					70-100	mg/dL
Ca	9.3					8.9-10.3	mg/dL
Bun/Crea	27 H					8-23	
Ani Gap	15 H					6-13	mmol/L
Osmo Cal	287					270-350	mOsm/kg
CK			37			30-223	IU/L
CKMB		7.0 H		6.5 H		0.0-6.0	ng/mL
Trop Ult		0.072 H			0.067 H	0.000-0.040	ng/mL
eGFR-AA	>60						mL/min/1.73
eGFR-Oth	>60 ⁴						mL/min/1.73

BLOOD							
Collected	06/10 17:40 ³	06/10 11:21	06/10 11:21 ²				
Released	06/10 18:35	06/10 12:03	06/10 11:54			Reference	Units
Accession	C121620639	C121620468	C121620467				
Creat			0.93			0.47-1.35	mg/dL
BNP		85.3				0.0-100.0	pg/mL
UN			29 H			7-25	mg/dL
Na			133			133-146	mmol/L
Chlor			103			100-111	mmol/L
CO2			21.1 L			23.0-32.6	mmol/L
K			4.5			3.5-5.2	mmol/L
Gluc			121 H			70-100	mg/dL
Ca			9.6			8.9-10.3	mg/dL
Bun/Crea			31 H			8-23	
Ani Gap			13			6-13	mmol/L
Osmo Cal			273			270-350	mOsm/kg
CK	36					30-223	IU/L
eGFR-AA			>60				mL/min/1.73
eGFR-Oth			>60 ⁴				mL/min/1.73

BLOOD							
Collected	06/11 11:26	06/10 11:26	06/10 11:26				
Released	06/11 11:26	06/10 11:26	06/10 11:26			Reference	Units
Accession	EC121630655	EC121620407	EC121620408				

²No hemolysis noted³...
⁴**Do not use** this eGFR calculation for medication dose adjustments.Patient Name: FARR, WILLIAM GAULT
Location: 5H 8528A
PT Type: INPATIENT

SRMC CUM FINAL DISCHARGE REPORT -

Printed: 06/13/2012 02:04
Page: 2 of 4

PRINTED BY: DB30588

DATE 7/18/2013

J. David Wren, MD PHD, Director

Spartanburg Regional Medical Center
101 E. Wood Street
Spartanburg, South Carolina 29303-3072Dept of Laboratory Medicine
864-560-6212FARR, WILLIAM GAULT
69Y
LITTLEFIELD, RONALD HMR#: S000478684
DOB: [REDACTED]
Location: 5H 8528AACCT#: S1216200102
Admitted: 06/10/2012
PT Type: INPATIENT

BLOOD					
Collected	06/11	06/10	06/10		
	11:26	11:26	11:26		
Released	06/11	06/10	06/10	Reference	Units
	11:26	11:26	11:26		
Accession	EC121630655	EC121620407	EC121620408		
FS Glu	143 H ⁵			70-100	mg/dL
CKMB			8.4 H	0.0-6.0	ng/mL
TNI		0.10 H		0.00-0.07	ng/mL

BLOOD GAS

ARTERIAL BLOOD					
Collected	06/11	06/10			
	01:59	14:25			
Released	06/11	06/10	Reference	Units	
	01:59	14:25			
Accession	EC121630173	EC121620490			
pH	7.44	7.41	7.35-7.45		
PCO2	30 L	30 L	35-45	mm/Hg	
PO2	61 L	64 L	75-85	mm/Hg	
Tot CO2	21 L	20 L	23-27	mmol/L	
HCO3	19.8 L	19.2 L	22.0-26.0	mmol/L	
BE	-3 L	-4 L	-2-3	mmol/L	
O2 SAT	92 L	93 L	95-100	%	
L/min	15	12			
Type	ARTERIAL	ARTERIAL			
Allen's	Pass	Pass			
DelSys	NRB Msk	Oxymizer			
Intubate	No	No			
Site	R Radial	R Radial			

⁵Fingerstick glucose levels greater than 500 mg/dL must be sent to the laboratory for confirmation.Patient Name: FARR, WILLIAM GAULT
Location: 5H 8528A
PT Type: INPATIENT

SRMC CUM FINAL DISCHARGE REPORT -

Printed: 06/13/2012 02:04
Page: 3 of 4

PRINTED BY: DB30588

DATE 7/18/2013

J. David Wren, MD PHD, Director

Spartanburg Regional Medical Center
101 E. Wood Street
Spartanburg, South Carolina 29303-3072Dept of Laboratory Medicine
864-560-6212FARR, WILLIAM GAULT
69Y
LITTLEFIELD, RONALD HMR#: S000478684
DOB: [REDACTED]
Location: 5H 8528AACCT#: S1216200102
Admitted: 06/10/2012
PT Type: INPATIENTMICROBIOLOGY**CULTURE BLOOD**

Accession #: MB12162039

Specimen: BLOOD
Source:Collected: 06/10/2012 11:30
Released: 06/12/2012 07:48Results: (Prelim)
No Growth At 24 Hours
SOURCE=

L FA

CULTURE BLOOD

Accession #: MB12162040

Specimen: BLOOD
Source:Collected: 06/10/2012 11:20
Released: 06/12/2012 07:48Results: (Prelim)
No Growth At 24 Hours
SOURCE=

L FA

CANCELLED TESTS

Collection Date	Specimen	Test Name	Reason
06/10/2012 13:05	BLOOD	B NATRIURETIC PEPTIDE	Cancelled duplicate by system
06/10/2012 13:05 ⁶	BLOOD	CREATINE KINASE	Nurse requested test cancellation
06/10/2012 13:05 ⁷	BLOOD	CREATINE KINASE MB FRACTION	Nurse requested test cancellation
06/10/2012 13:05	BLOOD	CULTURE BLOOD	Cancelled duplicate by system
06/10/2012 13:05	BLOOD	CULTURE BLOOD	Cancelled duplicate by system
06/10/2012 13:05 ⁸	BLOOD	TROPONIN ULTRA	Nurse requested test cancellation
06/10/2012 19:05	BLOOD	CREATINE KINASE	Other
06/10/2012 19:05	BLOOD	CREATINE KINASE MB FRACTION	Other
06/10/2012 19:05	BLOOD	TROPONIN ULTRA	Other
06/11/2012 01:05	BLOOD	CREATINE KINASE	Other
06/11/2012 01:05	BLOOD	CREATINE KINASE MB FRACTION	Other
06/11/2012 01:05	BLOOD	TROPONIN ULTRA	Other

⁶per Kim
⁷per Kim
⁸per KimPatient Name: FARR, WILLIAM GAULT
Location: 5H 8528A
PT Type: INPATIENT

SRMC CUM FINAL DISCHARGE REPORT -

Printed: 06/13/2012 02:04
Page: 4 of 4

PRINTED BY: DB30588

DATE 7/18/2013

J. David Wren, MD PHD, Director

Spartanburg Regional Medical Center
101 E. Wood Street
Spartanburg, South Carolina 29303-3072

Dept of Laboratory Medicine
864-560-6212

FARR, WILLIAM GAULT
69Y
LITTLEFIELD, RONALD H

MR#: S000478684
DOB: [REDACTED]
Location: 5H 8528A

ACCT#: S1216200102
Admitted: 06/10/2012
PT Type: INPATIENT

MICROBIOLOGY

CULTURE BLOOD

Accession #: MB12162039

Specimen: BLOOD

Collected: 06/10/2012 11:30

Source:

Released: 06/13/2012 07:16

Results: (Prelim)

No Growth At 48 Hours

SOURCE=

L FA

CULTURE BLOOD

Accession #: MB12162040

Specimen: BLOOD

Collected: 06/10/2012 11:20

Source:

Released: 06/13/2012 07:16

Results: (Prelim)

No Growth At 48 Hours

SOURCE=

L FA

J. David Wren, MD PHD, Director

Spartanburg Regional Medical Center
101 E. Wood Street
Spartanburg, South Carolina 29303-3072

Dept of Laboratory Medicine
864-560-6212

FARR, WILLIAM GAULT
69Y
LITTLEFIELD, RONALD H

MR#: S000478684
DOB: [REDACTED]
Location: 5H 8528A

ACCT#: S1216200102
Admitted: 06/10/2012
PT Type: INPATIENT

MICROBIOLOGY

CULTURE BLOOD

Accession #: MB12162039

Specimen: BLOOD
Source:

Collected: 06/10/2012 11:30
Released: 06/14/2012 07:34

Results: (Prelim)
No Growth At 72 Hours
SOURCE=

L FA

CULTURE BLOOD

Accession #: MB12162040

Specimen: BLOOD
Source:

Collected: 06/10/2012 11:20
Released: 06/14/2012 07:34

Results: (Prelim)
No Growth At 72 Hours
SOURCE=

L FA

CANCELLED TESTS

Collection Date Specimen
06/10/2012 13:10 SPUTUM

Test Name
CULTURE RESPIRATORY

Reason
Specimen not received in lab
after 4 days.

J. David Wren, MD PHD, Director

Spartanburg Regional Medical Center
101 E. Wood Street
Spartanburg, South Carolina 29303-3072

Dept of Laboratory Medicine
864-560-6212

FARR, WILLIAM GAULT
69Y
LITTLEFIELD, RONALD H

MR#: S000478684
DOB: [REDACTED]
Location: 5H 8528A

ACCT#: S1216200102
Admitted: 06/10/2012
PT Type: INPATIENT

MICROBIOLOGY

CULTURE BLOOD

Accession #: MB12162039

Specimen: BLOOD

Collected: 06/10/2012 11:30

Source:

Released: 06/15/2012 07:18

Results: (Prelim)

No Growth After 4 Days

SOURCE=

L FA

CULTURE BLOOD

Accession #: MB12162040

Specimen: BLOOD

Collected: 06/10/2012 11:20

Source:

Released: 06/15/2012 07:18

Results: (Prelim)

No Growth After 4 Days

SOURCE=

L FA

J. David Wren, MD PHD, Director

Spartanburg Regional Medical Center
101 E. Wood Street
Spartanburg, South Carolina 29303-3072

Dept of Laboratory Medicine
864-560-6212

FARR, WILLIAM GAULT
69Y
LITTLEFIELD, RONALD H

MR#: S000478684
DOB: [REDACTED]
Location: 5H 8528A

ACCT#: S1216200102
Admitted: 06/10/2012
PT Type: INPATIENT

MICROBIOLOGY

CULTURE BLOOD

Accession #: MB12162039

Specimen: BLOOD
Source:

Collected: 06/10/2012 11:30
Released: 06/16/2012 07:41

Results: (Final)
No Growth After 5 Days
SOURCE=

L FA

CULTURE BLOOD

Accession #: MB12162040

Specimen: BLOOD
Source:

Collected: 06/10/2012 11:20
Released: 06/16/2012 07:41

Results: (Final)
No Growth After 5 Days
SOURCE=

L FA

SPARTANBURG REGIONAL

06/12/2012 21:10

Page 1 of 1

Imaging Services Report

From 06/10/2012 11:21 To 06/12/2012 15:09

NO DATA FOUND FOR MODULE: 1. narrative

Name: FARR, WILLIAM G.

Age: 69 yr

Acct: 1216200102

Opt Out:

Gender: M

MRN: 000478684

Physician: Littlefield, Ronald H., MD

Rm-Bed: 8528 - A

Admit Dt: 06/10/2012 14:57

PRINTED BY: DB30588

DATE

7/18/2013