THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM MARION COUNTY
South Carolina Workers' Compensation Commission

WCC Case Nos. 0123790 and 0824046

Betty Joe Floyd as Personal Representative of the Estate of
Scottie Wayne Floyd and as dependent mother beneficiary of
Scottie W. Floyd, deceased employee, ... Appellant,

v.

Ken Baker Used Cars, Employer, and Legion Insurance Company
In liquidation c/o South Carolina Property & Casualty Insurance
Guaranty Association and Amguard Insurance Company, Carriers, ... Respondents.

RECORD ON APPEAL
VOLUME III

Steve Wukela, Jr.
Wukela Law Firm
Post Office Box 13057
Florence, South Carolina 29504
(843) 669-5634
Attorney for Appellant

Mark D. Cauthen, Esquire
Peter P. Leventis, Esquire
McKay, Cauthen, Settana & Stubley, PA
Post Office Box 7217
Columbia, South Carolina 29202
(803) 256-4645
Attorney for Respondent,
Legion Insurance Company

Edwin P. Martin, Jr., Esquire
Hedrick, Gardner, Kincheloe & Garofalo, LLP
Post Office Box 11267
Columbia, South Carolina 29211
(803) 727-1200
Attorney for Respondent,
Amguard Insurance Company

RECEIVED
SEP 17 2012
SC Court of Appeals

INDEX

Order of Honorable Thomas Russo dated January 4, 2012 and served on March 8, 2012 5
Order of the South Carolina Court of Appeals dated March 25, 2011 21
Appellate Panel Decision and Order of the South Carolina Workers' Compensation Commission dated December 3, 2010 23
Decision and Order of Commissioner G. Bryan Lyndon dated March 1, 2010 39
Decision and Order of Commissioner J. Alan Bass dated December 12, 2007 69
Consent Order of Commissioner J. Alan Bass dated October 8, 2006 82
Consent Order of Commissioner J. Alan Bass dated June 27, 2006 85
Consent Order of Commissioner J. Alan Bass dated April 18, 2006 91
Consent Order of Commissioner J. Michelle Childs dated July 11, 2004 94
Decision and Order of Commissioner J. Michelle Childs dated June 10, 2004 96
Certificate of Appointment for Guardian dated July 14, 2004 112
Order of Appointment of Guardian ad Litem dated April 24, 2002 116
Form 30, Request for Commission Review, of Claimant dated March 12, 2010 119
Form 53 of Amguard Insurance Company dated June 11, 2009 123
Form 53 of Legion Insurance Company dated June 29, 2009 124
Form 52 dated May 30, 2009 126
Form 53 of Legion Insurance Company dated June 29, 2009 127
Form 52 dated May 30, 2009 128
Form 51 dated June 29, 2009 129
Form 50 dated May 30, 2009 130
Form 51 dated February 3, 2006 131
Form 50 dated January 6, 2006 132
Form 51 dated May 8, 2003 133
Form 50 dated April 8, 2003 134
Brief of Defendants, Ken Baker Used Cars and Legion Ins. Co. dated June 1, 2010 135
Brief of Ken Baker Used Cars and Body Shop and Amguard Insurance Company to the Full Commission dated May 19, 2010 164
Brief of Claimant/Appellant dated May 5, 2010 173
Post Trial Memorandum of Defendants, Ken Baker used Cars and Legion Ins. Co. dated October 16, 2009 211
Reply Brief of Defendant Amguard Insurance Company dated October 16, 2009 238
Single Commission Brief of Defendant Amguard Insurance Company dated October 1, 2009 243
Post-Trial Brief of Claimant dated September 30, 2009 251
Notice of Appeal to Circuit Court dated December 29, 2010 274
Notice of Appeal to South Carolina Court of Appeals dated December 29, 2010 278
Motion for Consolidation of Appeals dated February 15, 2011 282
Notice of Appeal to South Carolina Court of Appeals dated March 14, 2012 287

Transcript of hearing before Honorable Thomas Russo on September 8, 2011
Oral Argument
Mr. Wukela 294
Mr. Cauthen 314
Mr. Martin 321
Mr. Wukela 325
Transcript of hearing before Appellate Panel on June 22, 2010
Oral Argument
Mr. Wukela 330
Mr. Leventis 338
Mr. Martin 343
Reply
Mr. Wukela 346
Transcript of hearing before Commissioner Bryan Lyndon on September 1, 2009
Examination of Betty Jo Floyd:
Direct Examination by Mr. Wukela 381
Cross Examination by Mr. Cauthen 396
Cross Examination by Mr. Martin 403
Examination by Commissioner Lyndon 406
Transcript of Deposition of R. Joseph Healy, M.D. taken August 25, 2009
Direct Examination by Mr. Wukela 414
Cross Examination by Mr. Cauthen 438
Cross Examination by Ms. Turner 448
Re-direct Examination by Mr. Wukela 454
Transcript of Deposition of Alexander M. Federer, PhD. taken August 21, 2009
Direct Examination by Mr. Wukela 462
Cross Examination by Mr. Cauthen 486
Cross Examination by Mr. Martin 508
Transcript of Deposition of Betty Jo Floyd taken July 24, 2009
Direct Examination by Mr. Cauthen 516
Cross Examination by Ms. Turner 543
Transcript of Deposition of Walter James Evans, M.D. taken March 13, 2007
Direct Examination by Mr. Cauthen 548
Cross Examination by Mr. Wukela 564
Re-direct Examination by Mr. Cauthen 571
Re-cross Examination by Mr. Wukela 575
Re-direct Examination by Mr. Cauthen 576
Transcript of Deposition of Rakesh P. Chokshi, M.D. taken March 12, 2007
Direct Examination by Mr. Goodwyn 582
Cross Examination by Mr. Wukela 598
Exhibits
Defendant's Exhibit #1 612
Defendant's Exhibit #2 613
Defendant's Exhibit #3 614
Transcript of Deposition of Betty Jo Floyd taken February 5, 2007
Direct Examination by Mr. Cauthen 618

Transcript of Deposition of Scottie Floyd taken February 5, 2007
Direct Examination by Mr. Cauthen 669
Transcript of Deposition of Sasha Federer, PhD. Taken February 2, 2007
Direct Examination by Mr. Wukela 720
Cross Examination by Mr. Cauthen 759
Re-direct Examination by Mr. Wukela 804
Re-cross Examination by Mr. Cauthen 812
Re-direct Examination by Mr. Wukela 816
Re-cross Examination by Mr. Cauthen 819
Transcript of Deposition of R. Joseph Healy, M.D. taken April 24, 2006
Direct Examination by Mr. Wukela 825
Cross Examination by Mr. Cauthen 844
Transcript of Deposition of R. Joseph Healy, M.D. taken March 15, 2004
Direct Examination by Mr. Martin 864
Transcript of Deposition of Scottie Floyd taken December 18, 2003
Direct Examination by Mr. Martin 895
Exhibits
Defendant's Exhibit #1 978
Defendant's Exhibit #2 979
Form 58, Pre-Hearing Brief, of Employer/Carrier Legion Insurance Co. dated August 24, 2009 980
Notice of Witnesses and Written Reports of Employer/Carrier Legion Insurance Co. dated August 24, 2009, with attached APA No. 1 981
Form 58, Pre-Hearing Brief, of Employer/Carrier Amguard Insurance Company 992
Form 58, Pre-Hearing Brief, of Claimant, with attachments, dated August 17, 2009 993
Notice of Witnesses and Written Reports of Claimant dated August 17, 2009 1001
Form 58, Pre-Hearing Brief, on behalf of Employer and the S.C. Property & Casualty Insurance Guaranty Association filed on February 6, 2007 1005
Form 58 filed on behalf of Claimant Scottie Floyd on February 1, 2007 1007

APA 1 1010
APA 2 1053
APA 3 1063
APA 5 1084
APA 6 1096
APA 7 1102
APA 8 1139
APA 9 1145
APA 10 1192
APA 11 1199
APA 12 1202
APA 13 1219
APA 14 1225
APA 15 1237
APA 23 1245
APA 24 1263

APA 25 1312
APA 25, pp. 399-401 of the "CD Note Book Report" 1332
APA 26 1335
APA 27 1336
APA 28 1393
APA 29 1409
APA 35 1428
APA 36 1432
APA 37 1434
APA 38 1440
APA 39 1445
APA 40 1446
APA 41 1447
APA 42 1448
APA 43 1449
APA 44 1450
APA 45 1451
APA 46 1452

Certificate of Counsel 1453

South Carolina Workers' Compensation Commission
1333 Main Street, 5th Floor
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5739
www.wcc.sc.gov

PRE-HEARING BRIEF
WCC File No: 0123790
0824046

Claimant's Name: Betty Joe Floyd as Personal Representative of Estate of Scottie Wayne Floyd, and as dependent mother beneficiary of Scottie Wayne Floyd, deceased

Address: _____

City: _____ State: ____ Zip: ____

Home Phone: _____ Work Phone: ( ) -

Preparer's Name: Steve Wukela, Jr.

Employer's Name: Ken Baker Used Cars

Address: 2066 N. Hwy. 501 By-Pass

City: Marion State: SC Zip: 29571

Carrier: **0123790** – Legion Insurance Co. c/o SC Insurance Guaranty Assoc.
0824046 - Legion Insurance Co. c/o SC Insurance Guaranty Assoc. AND Amguard Insurance Company

Preparer's Phone #: (843) 669 -5634

A claim for workers' compensation benefits is made based on the following grounds:
☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: $ 211.77 2. AWW: $ 375.36 **Date of Injury:** 0123790 – 09/13/2001
0824046 – 09/05/2008
3. Type of injury and body part(s): brain and back
4. Facts in controversy: This is an admitted case. Scottie Wayne Floyd, deceased claimant, had work experience as an automotive parts puller, pulling parts off of cars. On September 13, 2001, while removing a control arm under tension off of a Mercedes, it struck the deceased claimant across the left forehead, . . . (continued on page 2 of 8)
5. Legal issues involved: See attached statement.
6. Unusual aspects: See attached statement.
7. Witnesses (designate if expert):* Betty Joe Floyd
8. Exhibits: See attached APA Submissions.
9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance):
See attached APA Submissions.
10. Name, address, and specialty, if any, of the treating physician: Dr. Keith Stewart, Dr. Charles Heath, Dr. Ross Fulcher, Dr. Eric Weinbaum, Dr. Joseph Healy, Dr. Grant Breazeale, Dr. Howard Farrell, Dr. Dora Windsorova, Dr. Timothy Malone, Dr. Wesley Wallis, Dr. Sasha Federer, Dr. Walter J. Evans, Dr. Rakesh Chokshi,
11. Impairment rating(s); body part(s); physician and date of opinion: (Back) whole person impairment -15% – Dr. Healy, 4/24/06
Brain - TBA
12. I am amending my Form 50/51 in the following manner: _____

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

Signature: _____ Date: August 17, 2009 Email: steve@wukelalaw.com
Steve Wukela, Jr.

Date of hearing: September 1, 2009 Time needed for hearing: 1 hour

On behalf of ☒ Claimant ☐ Employer

File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports.
* Commissioners reserve the right to admit expert witnesses at hearings.

. . . nose, and cheek, breaking his nose and causing a closed head injury.

The deceased claimant was taken to Marion Medical Center Emergency Room and received stitches in his forehead and cursory x-rays, and was sent to Dr. Keith Stewart, his family physician. Over the next four months, Dr. Stewart treated the deceased claimant conservatively for concussion. Deceased claimant was nauseated for approximately two weeks after the accident. Dr. Stewart then ordered a CT scan on January 9, 2002, which detected "appearance consistent with infarct ... atypical post-traumatic fluid collection cannot be excluded." (APA #1, pg. 16). During that period of time, the deceased claimant experienced severe headaches to the point wherein he took a pistol to McLeod Regional Medical Center Emergency Room demanding help to stop the pain.

While at McLeod Regional Medical Center Emergency Room, a "CT Scan showed a decreased attenuation in the right frontal lobe and a fracture of the left frontoethmoidal complex." (APA #5, pg. 42). The deceased claimant was sent to Three Rivers Center for Behavioral Health for psychological evaluation. When he returned from Columbia, deceased claimant was referred to Dr. R. Joseph Healy, a neurologist who treated him

conservatively for psychological and mood disorders and emotional outrages consistent with brain injury.

Deceased claimant had severe headaches, photophobia, and uncontrolled emotional rages. Dr. Healy recommended deceased claimant be referred to Tangram Rehabilitation Facility. The employer/carrier contested the referral to Tangram, which resulted in a hearing before Commissioner Childs on January 7, 2004 and an Order dated June 10, 2004, which, among other things, found:

> "2. I find that the claimant sustained an injury to his brain, head, nose, and psyche on September 13, 2001 when while removing a control arm under tension off a Mercedes, a spring came loose and the control arm struck the claimant across the left forehead, nose and cheek, breaking his nose and causing a closed heard injury."
>
> * * * * *
>
> "3. I find claimant has not reached maximum medical improvement and is in need of additional psychological treatment and behavioral modification, specifically at Tangram Premier in Texas."
>
> * * * * *
>
> "4. I find that based on the fact that the claimant has not reached maximum medical improvement and is in need of treatment in Tangram Premier that the issue of the extent of the claimant's disability is held in abeyance."

Finally on July 24, 2004, the deceased claimant was admitted to Tangram/ResCare Premier in San Marco, Texas, where he stayed from July 27, 2004 until June 1, 2006. Between the time of the hearing before Commissioner Childs on January 7, 2004 and the Order of June 10, 2004, the deceased claimant was admitted to McLeod Regional Medical Center as a result of severe epileptic seizures and the deceased claimant sustained two compression fractures and injury to his spine, which was a result of the brain injury. For

whatever reason, the carrier denied an injury to the spine. They had been providing medical treatment, which is not an admission of compensability. In addition to APAs 1-22, which were submitted at a prior hearing, medical records from Tangram/ResCare Premier were also submitted by virtue of a CD as APA 25, consisting of 1700 pages, and APAs 23-34.

The deceased claimant was returned to South Carolina on a trial basis for a one week period in March 2006, where he was evaluated by Dr. Healy and returned to Tangram Premier. The deposition of Dr. Healy was taken on March 15, 2004 and again on April 24, 2006. As a result of the second deposition of Dr. Healy of April 24, 2006, the parties agreed to a Consent Order, signed by Commissioner Bass on June 27, 2006, requiring the employer/carrier to provide continuing medical care for the deceased claimant when he returned to Florence on June 1, 2006. Among other things provided for in the Order was a weekly allowance of $400.00 a week to be paid to the deceased claimant's mother, Betty Joe Floyd, so that she could stay at home with the deceased claimant as his caregiver.

When the deceased claimant returned, he was significantly improved. However, over a period of a month or so, his condition deteriorated and his episodes of violence increased. Dr. Healy refused to continue to treat the deceased claimant because of his violence. Dr. Walter James Evans of Comprehensive Neurological Services, P.C., by agreement of the parties, commenced treatment of the deceased claimant. The deceased claimant was unable to control his rage during this entire period of time. After a period of time, Dr. Evans also refused to continue treating the deceased claimant. Dr. Sasha Federer, a neuro-psychologist, undertook the continuing psychological treatment of the

deceased claimant, and the deceased claimant's condition was stabilized. The deceased claimant still needed treatment for his back injuries by Dr. Rakesh Chokshi, an orthopaedic doctor, and for his brain injury by a neurologist.

It has been asserted that the condition of the deceased claimant was permanent; that his brain injury resulted in him being permanently totally disabled and required closely supervised medical attention, as well as the continued use of a caregiver 24 hours a day. The deceased claimant was entitled to lifetime disability benefits pursuant to 42-9-10, arising out of his physical brain damage and injury to his spine, along with lifetime medical benefits.

A hearing was conducted before the Commission on February 16, 2007, approximately five and one-half years after deceased claimant's accident, resulting in an Order dated December 12, 2007, which among other things, determined that the deceased claimant had a physical brain injury from which he had not reached maximum medical improvement. That Order further found that as a result of convulsions arising out of his brain injury, the deceased claimant had also sustained a back injury, resulting in compression of the vertebrae at levels T3, T7, T8, and T9.

Because of the nature of deceased claimant's brain injury, he was combative, unruly, and threatening. He was receiving continuing treatment from Dr. Healy, notwithstanding his physical threats to Dr. Healy and his staff. He was also receiving psychological treatment from Dr. Federer in an attempt to socialize the deceased claimant in hopes that he would not have to be re-institutionalized.

Upon his release from Tangram/ResCare Premier on June 1, 2006, Betty Joe Floyd, the deceased claimant's mother and sole dependent, provided the deceased claimant with a residence and mentorship in an effort to keep him from having to be re-institutionalized.

On September 5, 2008, Betty Joe Floyd, the deceased claimant's mother, went into the bedroom in an attempt to arouse the deceased claimant for supper, and discovered that he was dead.

The Claimant herein, Betty Joe Floyd, as Personal Representative of the Estate of Scottie Wayne Floyd and as dependent mother beneficiary of Scottie Wayne Floyd, deceased, is informed and believes that the employer has conducted a dependency investigation, which will demonstrate that she was the deceased claimant's sole dependent.

The Claimant herein, Betty Joe Floyd, as Personal Representative of the Estate of Scottie Wayne Floyd and as dependent mother beneficiary of Scottie Wayne Floyd, deceased, is also informed and believes that as a result of the autopsy performed on the body of the deceased claimant on September 6, 2008, (APA #37, pg. 396-401), and the toxicology study performed on September 16, 2008, (APA # 38, pg. 402-406), that at the time of his death, the deceased claimant had a significant, permanent impairment to his brain and a permanent, significant impairment to his back, to which he was entitled to a permanent award, to which the Claimant herein, Betty Joe Floyd, as Personal Representative of the Estate of Scottie Wayne Floyd and as dependent mother beneficiary of Scottie Wayne Floyd, deceased, is now entitled to the balance of 2681.64 weeks, as if he had lived, based on his life expectancy. (Deceased claimant's life expectancy at the time of injury was 51.57 years, or 2681.64 weeks.) Between September 13, 2001, the

date of the accident, and September 5, 2008, the date of his death, the deceased claimant received 363 weeks of benefits, leaving a balance of 2318.64 weeks remaining on his permanent award.

That pursuant to 42-9-30(20), for total or partial loss of use of the brain, and pursuant to R67-1101, as amended by 42-9-10 (3rd paragraph), the Claimant herein, Betty Joe Floyd, as Personal Representative of the Estate of Scottie Wayne Floyd and as dependent mother beneficiary of Scottie Wayne Floyd, deceased, is entitled to an award of 2318.64 weeks, pursuant to 42-9-280. (Deceased claimant was injured on 09/13/01 and received benefits through his death on 09/05/08, 363 weeks - - 2681.64 total weeks of life expectancy from date of injury, minus 363 weeks of compensation, equals 2318.64 weeks.)

Additionally, the Claimant herein, Betty Joe Floyd, as Personal Representative of the Estate of Scottie Wayne Floyd and as dependent mother beneficiary of Scottie Wayne Floyd, deceased, is entitled to 500 weeks of benefits due to a greater than 50% loss of use of back pursuant to 42-9-30(19).

Additionally, the Claimant herein, Betty Joe Floyd, as Personal Representative of the Estate of Scottie Wayne Floyd and as dependent mother beneficiary of Scottie Wayne Floyd, deceased, asserts that the deceased claimant's death on September 5, 2008 was the result of a third accident which occurred on September 5, 2008. (WCC File No. 0824046). The first accident having occurred on 09/13/01 when the deceased claimant was struck by a control arm under tension off of a Mercedes; the second accident having occurred on April 10, 2004, when due to convulsions, the deceased claimant sustained injury to his spine; and, the third accident arising out of convulsions on September 5, 2008,

while submitting to medical treatment required by the first and second accidents. Claimant herein is entitled to 500 weeks of benefits from that accident pursuant to 42-9-290.

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Betty Joe Floyd as Personal Representative of the Estate of Scottie Wayne Floyd and as dependent mother beneficiary of Scottie W. Floyd, deceased, Claimant, vs. Ken Baker Used Cars and Body Shop, Employer, and Legion Insurance Co. c/o SC Insurance Guaranty Assn., Carrier, Defendants.	WCC FILE NO. 0123790
AND Betty Joe Floyd as Personal Representative of the Estate of Scottie Wayne Floyd and as dependent mother beneficiary of Scottie W. Floyd, deceased, Claimant, vs. Ken Baker Used Cars and Body Shop, Employer, and Legion Insurance Co. c/o SC Insurance Guaranty Assn. **AND** Amguard Insurance Company, Carrier, Defendants.	**NOTICE OF WITNESSES AND WRITTEN REPORTS/PHYSICIAN OR OTHER EVIDENCE TO BE INTRODUCED AS DIRECT EVIDENCE ON BEHALF OF CLAIMANT** WCC FILE NO. 0824046

TO: THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION; MARK D. CAUTHEN, ESQUIRE, ATTORNEY FOR EMPLOYER/CARRIER, LEGION INSURANCE CO.; AND EDWIN P. MARTIN, JR., ESQUIRE, ATTORNEY FOR THE EMPLOYER/CARRIER, AMGUARD INSURANCE COMPANY:

YOU ARE HEREBY NOTIFIED THAT THE CLAIMANT, Betty Joe Floyd, pursuant to the provisions of Rule 67-30 of the South Carolina Workers' Compensation Commission and Chapter 23, Article 1, Section 1-23-330(1), Code of Laws of South Carolina, 1976, as

amended, herewith submits the following reports/physician or other evidence as direct evidence on behalf of the deceased Claimant, to-wit:

APA	PHYSICIAN	FACILITY	SERVICE DATES	PAGES
APAs previously submitted at hearing of January 7, 2004				
1	Emergency Room	Marion County Medical Center	09/13/01 01/06/02 05/09/03 05/10/03 05/14/03	1 - 8 9 - 16 17 - 21 22 - 27 28 - 31
2	Keith Stewart, MD	Marion Medical Group	09/18/01 - 01/10/02	32 - 41
3		McLeod Regional Medical Center	01/13/02	41a - 41u
4	Attorneys' Dictionary of Medicine and Word Finder			41v - 41y
5	Charles Heath, MD	Three Rivers Center for Behavioral Health	01/14/02 - 01/22/02	42 - 53
6	Ross Fulcher, MD, RNCS	Florence Counseling Center	01/24/02 - 04/15/02	54 - 59
7	Eric Weinbaum, MD Renee Williams, LPC	McLeod Psychiatric Association	02/11/02 - 12/04/03	60 - 95
8		Vascular Diagnostics	03/05/02	96 - 101
9	R. Joseph Healy, MD	R. Joseph Healy, MD, PA	03/05/02 - 10/28/03	102 - 138
10		Seltzer Eye Associates, PC	03/12/02 - 07/09/03	139 - 145
11	Grant Breazeale, MD		03/20/02 - 04/26/02	146 - 148
12	Emergency Room Inpatient & MRI CT Scan Outpatient Inpatient	Carolinas Hospital System	04/05/02 04/09/02 - 04/12/02 05/24/02 10/17/02 04/07/03 - 04/10/03	149 - 157 158 - 161 162 163 - 164 165
13	Howard Farrell, MD	Florence ENT & Facial Plastics	05/20/02 - 11/13/02	166 - 171
14	Dora Windsorova, PhD		06/04/02 - 12/12/02	172 - 183
15	Timothy Malone, MD	Palmetto Baptist Medical Center	04/28/03 - 05/02/03	184 - 191
16	Correspondence from Steve Wukela, Jr. to R. Joseph Healy, MD		10/10/03	192 - 193
17	Correspondence from R. Joseph Healy, MD to Steve Wukela, Jr.		10/22/03	194
18	Photographs			195 - 196
19	Deposition of Scottie W. Floyd		12/18/03	

20	Deposition of R. Joseph Healy		01/05/03	
21	Income Summary and Records			197 - 206
22	Medical Summary			207 - 209
	APAs previously submitted at hearing of February 16, 2007			
23		Carolinas Hospital System Hospitalization Hospitalization Radiology - Lumbar MRI - Lumbar Spine MRI - Brain	 09/25/03 04/09/04 - 04/20/04 05/05/04 07/26/05 09/08/05	 210 211 - 222 223 - 224 225 - 226 227
24	Hospitalization	McLeod Regional Medical Center	07/16/04 - 07/21/04	228 - 276
25	ResCare Premier	(Notebook with 1700 pages front and back)	07/01/04 - 12/06/05 10/01/05 - 06/04/06	CD 277 - 296
26	J. Wesley Wallis, MD		03/04/06	297
27	Sasha Federer, PhD		05/05/06 - 02/01/07	298 - 354
28	Emergency Room	Carolinas Hospital System	11/03/06	355 - 370
29	Walter James Evans, MD	Comprehensive Neurological Services, PC	12/06/06	371 - 389
30	Deposition of R. Joseph Healy, MD		03/15/04	
31	Deposition of R. Joseph Healy, MD		04/24/06	
32	Deposition of Sasha Federer, PhD		02/02/07	
33	Deposition of Betty Joe Floyd		02/07/07	
34	Deposition of Scottie Floyd		02/07/07	
35	Rakesh P. Chokshi, MD	Pee Dee Orthopaedic Associates	01/24/07	390 - 393
	APAs to be submitted at hearing to be held on September 1, 2009			
36	R. Joseph Healy	R. Joseph Healy, PA	06/10/08 - 09/02/08	394 - 395
37	Forensic Autopsy Final Report - Medical University of SC		09/06/08	396 - 401
38	Toxicology Report - NMS Labs		09/16/08	402 - 406
39	Birth Certificate of Scottie Wayne Floyd		08/04/75	407
40	Obituary for Scottie Wayne Floyd		09/06/08	408
41	Funeral Announcement for Scottie Wayne Floyd		09/11/08	409

42	Certificate of Death of Scottie Wayne Floyd	10/02/08	410
43	Birth Certificate of Betty Jo Grainger, born 12/03/52	10/02/08	411
44	SC Driver's License issued to Betty Joe Floyd	12/15/03	412
45	Marriage License of Thomas Wayne Floyd and Betty Jo Grainger	05/30/69	413
46	Obituary of Tom Floyd	04/15/00	414
47	Deposition of Rakesh P. Chokshi, MD	03/12/07	
48	Deposition of Walter James Evans, MD	03/13/07	
49	Deposition of Betty Joe Floyd	07/24/09	
50	Deposition of Sasha Federer, MD	08/21/09	
51	Deposition of R. Joseph Healy, MD	08/25/09	

YOU ARE FURTHER NOTIFIED that you have the right of cross-examination; and, should you desire to exercise said right, you are to forthwith schedule the depositions of any of the physicians whose reports are submitted, for the purposes of cross-examination, or otherwise promptly submit opposing medical records into evidence.

YOU ARE FURTHER NOTIFIED that these records, or photocopies of the same, are being forwarded to the South Carolina Workers' Compensation Commission for insertion in their file and inclusion into evidence on behalf of the Claimant.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the Claimant: Betty Joe Floyd.

STEVE WUKELA, JR.
Attorney for Claimant
Wukela Law Firm
P. O. Box 13057
Florence, SC 29504-3057
(843) 669-5634

August 17, 2009

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715 *AMENDED*
(803) 737-5700

WCC File # 0123790
Carrier File # 251417003
Carrier Code # 00148
Employer FEIN 570858095

Scottie Floyd (Claimant's Name) _____ (SSN)

_____ (Address) _____ (City) _____ (State) _____ (Zip)

( ) _____ (Home Phone) (Work Phone)

Ken Baker Used Cars (Employer's Name)

2066 N. Hwy 501 Bypass, (Address) Marion, (City) S.C. (State) 29571 (Zip)

Legion Insurance in liquidation /SCPCIGA (Insurance Carrier)

Mark D. Cauthen, Esquire (Preparer's Name) P.O. Box 7217, Columbia, S.C. 29202 (Address) (803) 256-4645 (Phone #)

Provide the information requested in the space provided. Use an additional sheet, if necessary. Type or print all information.

☒ Injury by Accident ☐ Occupational Disease ☐ Both Injury by Accident and Disease ☐ Other

1. Date of accident 9/13/01 2. AWW: $375.36 Comp. Rate: $250.24

3. Type of injury and body part(s) Closed head injury.

4. Facts in controversy: Whether claimant has reached maximum medical improvement. Whether claimant is non-compliant with medical treatment and with Consent Order dated 6/27/06; whether hearing is premature in light of medical evidence indicating claimant is not at MMI; whether claimant is entitled to hearing on permanency where claimant is non-compliant with medical treatment. If so, extent of permanent disability; claimant's entitlement to additional medical treatment and associated care.

5. Legal issues involved See No. 4.

6. Unusual problems: Defendant's request postponement or adjournment of the hearing scheduled for 2/16/07 based on the consensus of the medical opinions that the claimant is not currently at maximum medical improvement. Alternatively, it is defendants position that claimant is not entitled to a hearing on permanency based on noncompliance with medical treatment and with the parties consent order dated 6/27/06. Additionally, claimant just began treatment for his back with Dr. Rakesh Chokshi and the parties are currently awaiting results of an MRI. Should the request for postponement be denied, defendants request the record be left open for depositions of Dr. Evans and Dr. Chokski.

7. Witnesses (designate if expert)* Cynthia Grimley, representative of the employer/carrier, claimant, any witnesses listed by the claimant. (The Defendants reserve the right to cross-examine any expert submitted by the claimant pursuant to 1-23-330 (3). The Defendants reserve the right to amend their Pre-hearing brief upon receipt of additional information.)

8. Exhibits: Deposition transcript of Dr. Alexandr Federer; Depositions of Scottie Floyd (2), Depositions of Betty Jo Floyd (2), Deposition of Walter James Evans (scheduled for 2/20/07); deposition transcripts of Dr. Joseph Healy (2) Progress Reports of Cynthia P. Grimley; Consent Order of 6/27/06.

9. Medical evidence: (Indicate report pursuant to R.67-612; deposition or appearance) See APA Submissions and Notice of Witnesses

10. Name, address, and specialty, if any, of the treating physician: Dr. Alexandr Federer; Dr. Joseph Healy, Dr. Walter James Evans, Dr. Rakesh Chokski

11. Impairment rating(s); body part(s); physician and date of opinion:

SIGNATURE Mark D. Cauthen
DATE 02/13/07

DATE OF HEARING: 02/16/07 TIME OF HEARING: 1:30 p.m.

On behalf of: ☐ Claimant ☒ Employer

File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports.
* Commissioners reserve the right to admit expert witnesses at hearings.

South Carolina Workers' Compensation Commission

P.O. Box 1715 · 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 0123790
Carrier File # 251-41-7003
Carrier Code #
Employer FEIN 57-0858095

Scottie Floyd
Claimant's Name SSN

Address City State Zip

( ) ( )
Home Phone # Work Phone #

Ken Baker Used Cars and Body Shop
Employer's Name

2066 N Hwy 501 Bypass Marion, SC 29571
Address City State Zip

Legion Insurance Co./CompFirst
Insurance Carrier

Steve Wukela, Jr. POBox 13057, Florence, SC 29504-3057 ((843) 669-5634
Preparer's Name Address Phone #

Provide the information requested in the space provided. Use an additional sheet, if necessary. Type or print all information.

☒ Injury by Accident ☐ Occupational Disease ☐ Both Injury by Accident and Disease ☐ Other

1. Date of accident September 13, 2001 2. AWW: $ 375.36 Comp. Rate: $ 250.24

3. Type of injury and body part(s) Head and Briain Injury, Mood swings, severe rages, headaches

4. Facts in controversy: This is an admitted case. The claimant is 28 years of age and has work experience as an automotive parts puller, pulling parts off cars. . . . Continued on page 2 of 3.

5. Legal issues involved: See attached Brief Statement dated 2/1/07

6. Unusual problems: See attached Brief Statement dated 2/1/07

7. Witnesses (designate if expert)* See attached Brief Statement dated 2/1/07

8. Exhibits: See attached APAs

9. Medical evidence: (Indicate report pursuant to R.67-612; deposition or appearance)
See attached APAs

10. Name, address, and specialty, if any, of the treating physician: R. Joseph Healy, MD
805 Pamlico Hwy, Suite 130-A Medical Mall, Florence, SC 29505
neurology, Dr. Sasha Federer, Neuro-psychologist, Dr. Walter Evans, neurologist

11. Impairment ratings body part(s); physician and date of opinion:

SIGNATURE 1 Feb 07

DATE OF HEARING: 02/16/07 TIME OF HEARING: 1:30 p.m.

On behalf of ☒ Claimant ☐ Employer

File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports.
* Commissioners reserve the right to admit expert witnesses at hearings.

Re: Scottie W. Floyd, Employer, vs. Ken Baker Used Cars and Body Shop, Employer
SCWCC File No. 0123790
Date of Accident: 9/13/01
Brief Statement dated: 12/19/03

. . . On September 13, 2001 while removing a control arm under tension off a Mercedes, it struck the claimant across the left forehead, nose, and cheek, breaking his nose and causing a closed head injury.

Claimant was taken to Marion Medical Center Emergency Room and received stitches in his forehead and cursory x-rays and was sent to Dr. Stewart, his family physician. Over the next four months Dr. Stewart treated claimant conservatively for concussion. Claimant was nauseated for approximately two weeks after the accident. Dr. Stewart then ordered a CT Scan on January 9, 2002, which detected "appearance consistent with infarct. . . . atypical post-traumatic fluid collection cannot be excluded." (APA 1, pg. 16) During that period of time claimant experienced severe headaches to the point wherein he took a pistol into the McLeod Regional Medical Center emergency room demanding help to stop the pain.

While at the McLeod Regional Medical Center emergency room a "CT Scan showed a decreased attenuation in the right frontal lobe and a fracture of the left frontoethmoidal complex." (APA 5, pg. 42) Claimant was sent to Three Rivers Center for Behavioral Health for psychological evaluation. When he returned from Columbia, claimant was referred to Dr. Healy, a neurologist who has been treating him conservatively for psychological and mood disorders and emotional outrages consistent with brain injury.

Claimant has severe headaches, photophobia, and uncontrolled emotional rages. Dr. Healy recommended claimant be referred to Tangram rehabilitation facility. The employer/carrier contested the referral to Tangram which resulted in a hearing before Commissioner Childs on January 7, 2004 and an Order dated June 10, 2004 which among other things found:

> **2. I find that the claimant sustained an injury to his brain, head, nose, and psyche on September 13, 2001 when while removing a control arm under tension off a Mercedes, a spring came loose and the control arm struck the claimant across the left forehead, nose and cheek, breaking his nose and causing a closed head injury.**
>
> * * *
>
> **3. I find claimant has not reached maximum medical improvement and is in need of additional psychological treatment and behavioral modification, specifically at Tangram Premier in Texas.**
>
> * * *
>
> **4. I find that based on the fact that the claimant has not reached maximum medical improvement and is in need of treatment in Tangram Premier that the issue of the extent of the claimant's disability is held in abeyance.**

Finally on July 27, 2004, the claimant was admitted to Tangram Premier in San Marco, Texas where he stayed from July 27, 2004 until June 1, 2006. Between the time of the hearing before Commissioner Childs of January 7, 2004 and the Order of June 10, 2004 the patient was admitted to McLeod Hospital as a result of severe epileptic seizures and renal failure resulting from his brain injury. As a result of these horrendous epileptic seizures the claimant sustained two compression fractures and injury to his spine which is a result of the brain injury. For whatever reason the carrier denies an injury to the spine. They have been providing medical treatment which is not an admission of compensability. In addition to the APAs 1-22 which have already been submitted at a prior hearing, the claimant is submitting in addition to the medical records from Tangram Premier, by virtue of a CD, (APA #25, consisting of 1700 pages) and APAs 23-34.

In any event, the claimant returned to South Carolina on a trial basis for a one week period in March 2006 where he was evaluated by Dr. Healy and returned to Tangram Premier. The deposition of Dr. Healy was taken March 15, 2004. As a result of the second deposition of Dr. Healy of April 24, 2006, the parties agreed to a Consent Order signed by Commissioner Bass on June 27, 2006 requiring the employer/carrier to provide continuing medical care for the claimant when he returned to Florence on June 1, 2006. Among other things provided for in the Order was a weekly allowance of $400.00 a week to be paid to the claimant's mother so that she could stay at home with the claimant as his care giver.

When the claimant returned he was significantly improved. However, over a period of a month or so his condition deteriorated and his episodes of violence increased. Dr. Healy refused to continue to treat the claimant because of his violence. Dr. Evans of Comprehensive Neurological Services, P.C. by agreement of the parties commenced treatment of the claimant. The claimant was unable to control his rage during this entire period of time. Now Dr. Evans is refusing to treat the claimant. Dr. Federer, a neuro-psychologist, undertook the continuing psychological treatment of the claimant and the claimant's condition has stabilized. Claimant still needs treatment for his back injuries by Dr. Chokshi, an orthopedic doctor, and for his brain injury by a neurologist.

Claimant asserts for the purposes of this hearing that his condition is permanent. That his brain injury has resulted in him being permanently totally disabled and that he will require close supervised medical attention and will need the continued use of a caregiver 24 hours a day. The claimant is informed and believes that he is entitled to lifetime disability benefits pursuant to 42-9-10 arising out of his physical brain damage and injury to his spine. He is also entitled to lifetime medical benefits.

MARION COUNTY MEDICAL CENTER
MARION, SOUTH CAROLINA
ADMISSION DATA & ASSESSMENT

FLOYD SCOTTIE 26

WILKINS MD V00000027436
WC 09/13/01

Name Scottie Floyd

ADMISSION HISTORY

Date	Time		Age	Sex	Last Tetanus	Triage Class	Immunizations
09-13-01	1412	☐ Amb ☐ Stretcher ☐ Arms ☒ W/C ☐ EMS ☐ POV	26	M	Unknown	☐ 1 ☐ 2 ☐ 3	☐ Up to Date in accordance with State Law ☐ Pneumonia ☐ Flu

Time	Temp	Pulse	Resp	B/P	Ht	Wt Stated / Actual
	97	111	20	155/86		

Source of Information: ☐ Other ☐ Patient ☐ Family ☐ Unable to Obtain

ALLERGIES: Food / Medications

☒ NKA ☐ Yes - below:

Type Reaction	Are you allergic to any of the following?	Yes	No
	Latex		✓
	Bananas / Avocados / Kiwi		✓
	IVP dye/ Seafood		✓

Previous Blood Transfusion ☐ No ☐ Yes

Reaction ☐ No ☐ Yes Describe:

Chief Complaint/ In Patient's Words
Laceration forehead @ L.O.C. now appears dysphoric - Bleeding

Developmental Status ☐ Appropriate for Age ☐ _____

LMP	G	P	A
N/A			

Head Circum cm | Visual Acuity od os ou

Tx PTA: ☐ EMS ☐ IV ☐ O2 ☐ Wound Care ☐ ACLS ☒ None ☐ Home ☐ Monitor

☐ Spinal Immobilization

Accident Date: _____ Time: _____ Agency Notified _____

MEDICAL HISTORY ☒ None

DISEASE	PT	FAMILY	DISEASE	PT	FAMILY
Anemia	☐	☐	Kidney Disease	☐	☐
Arthritis	☐	☐	Mental Illness	☐	☐
Asthma	☐	☐	Muscle / Bone Disorders	☐	☐
Bronchitis	☐	☐	Reproductive Disorders	☐	☐
Cancer	☐	☐	Seizures / Epilepsy	☐	☐
CVA	☐	☐	Skin Disorders	☐	☐
Diabetes	☐	☐	Stomach Disorders	☐	☐
Emphysema	☐	☐	Anesthesia Reactions	☐	☐
Glaucoma	☐	☐	Tobacco Use	☐	☐
Heart Disease	☐	☐	Alcohol / Drug Use	☐	☐
Hepatitis	☐	☐	Thyroid Problems	☐	☐
Hypertension	☐	☐	Other	☐	☐
Infectious Diseases	☐	☐	Other	☐	☐
Sensory Impairment	☐	☐	Other	☐	☐

PREVIOUS HOSPITALIZATIONS (Medical & Surgical)

Date	Reason

MEDICATION HISTORY (Include Vitamins / Herbs / Inhalers / Eye Drops / OTC) ☐ Unknown ☒ None

W/Pt	Medication	Dose	Frequency	Last Dose	W/Pt	Medication	Dose	Frequency	Last Dose

Initials	Signature / Title	Date / Time	Unit	Initials	Signature / Title
qc	Gwen Carson, LPN				

Marion County Medical Center

MARION, SOUTH CAROLINA

FLOYD, SCOTTIE 26

WILKINS MD V00000027436
WC 09/13/01

Page 2
EMERGENCY DEPARTMENT
DATA / ASSESSMENT TOOL

ASSESSMENT:

TIME TO RM: ROOM #:

		TIMES			
AIRWAY	SELF MAINTAINED	✓			
	ORAL/NASAL AIRWAY				
	INTUBATED				
BREATHING	NORMAL	✓			
	IRREGULAR				
	LABORED				
	ABSENT/APNEIC				
	ASSISTED/BAGGED				
CIRCULATION	PULSE PRESENT	✓			
	ABSENT				
SKIN	WARM				
	HOT				
	COOL				
	DRY				
	DIAPHORETIC	✓			
	NML/PINK				
	CYANOTIC				
	PALE				
	ASHEN				
DISABILITY	ALERT/ORIENTED X	3			
	RESPONDS VERBAL				
	RESPONDS PAIN				
	UNRESPONSIVE				
	CONFUSED				
	COMBATIVE				
HEAD (PERRL / SLUGGISH / NONREACTIVE / FIXED & DILATED)	R PUPIL REACTIVE	B			
	L PUPIL REACTIVE	B			
	SPEECH	Clear			
CHEST	ASYMMETRICAL				
	SYMMETRICAL				
	CLEAR				
	CONGESTED				
	WHEEZES				
	DECREASED				
PULSE	STRONG	✓			
	WEAK/THREADY				
	REGULAR				
	IRREGULAR				
ABDOMEN	SOFT	✓			
	FIRM/HARD				
	DISTENDED				
	TENDER				
	NONTENDER	✓			
	BOWEL SOUNDS PRESENT				
EXTREMITIES	NML CAP REFILL X	WNL			
	NML MOVEMENT X				
	NML SENSATION				
OTHER					

PAIN ASSESSMENT:

☐ NONE ☒ YES
LOCATION: face
INTENSITY (0-10): 10
CAUSED BY: Hit by heavy object
DURATION:
RELIEVED BY: nothing
TYPE: ☐ DULL ☐ SHARP ☐ PRESSURE
☐ RADIATING ☒ THROBBING
FAMILY NOTIFIED: ☐ Patient Declines ☐ N/A
TIME: WHO:

PSYCHOSOCIAL ASSESSMENT:

☐ N/A "ANY "YES" CONTACT CASE MANAGEMENT
☐ TRANSLATOR NEEDED
☐ SUSPECTED ABUSE/NEGLECT*
☐ NO SUPPORT SYSTEM*
☐ REQUESTS BLOODLESS SURGERY/MEDICINE
☐ OTHER CULTURAL PRACTICES
☐ FAMILY/PATIENT REQUESTS CHAPLAIN
☐ SPIRITUAL/CULTURAL DECLINED

PHYSICIANS

NAME	PAGED	ANSWERED	ARRIVED

VITAL SIGNS

TIME	B/P	PULSE / RESP	PRE PF / POST PF	O_2 SAT	TEMP
					☐ SEE TREND SHEET

TIME/INITIALS	TREATMENT/PROCEDURES		
	☐ ID BAND ☐ SIDE RAILS ↑ X 2 ☐ CALL LIGHT		
	O_2 L ____ VIA ____		
	EKG		
	MONITOR/RHYTHM ____		
	☐ NG ☐ OG TUBE Fr ____ ☐ PLACEMENT CHECKED		
	FOLEY Fr ____ IN & OUT CATH Fr ____		
	ETT ☐ NASAL ☐ ORAL Fr ____ ☐ END TIDAL CO_2		
TO / Portable	X-RAYS	FROM	VIA: ☐ AMB ☐ W/C ☐ STRETCHER
TO	CT SCAN	FROM	VIA: ☐ AMB ☐ W/C ☐ STRETCHER

Initials	Signature/Title	Date/Time	Unit
gc	Given Cannon, LPN		

9 8 7 6 5 4 3 2

Marion County Medical Center
MARION, SOUTH CAROLINA
Page 3
EMERGENCY DEPARTMENT
DATA / ASSESSMENT TOOL

FLOYD, SCOTTIE 26

WILKINS MD V00000027436
WC 09/13/01

NARRATIVE NOTES

1412- Brought by family c injury to face Placed T2 - Wound cleaned c N/S, Injection x 1 tzo — Gwen Cannon, LPN
1430 - TD given in LDM O.5mg — J.S.
1435 - Pt refused ice pack to head — J.S.
1450 Pt stated C/O of a little pain — L
1530 Pt takes more to remove blood clots -
1545 - TO X-ray by stretcher — 6/P 13/11 gc
1600 - Returns from X-ray & X-ray being done - vomited sup undigested food + Hd gc 1620 Pt goes back to X-ray — L
1633 Pt returned from X-ray — L ☐ See Additional Notes

IV SOLUTION & AMOUNT	PUMP	MEDICATION ADDED	SIZE	SITE	ML/HR	TIME START/INITIALS	TIME D/C/INITIALS	SITE AT DISCHARGE
Int	Yes No		20	HC		KC 1411	1700 gc	☒ No Redness, Pain, Swelling ☐ Other - See Nurses Notes
	Yes No							☐ No Redness, Pain, Swelling ☐ Other - See Nurses Notes
	Yes No							☐ No Redness, Pain, Swelling ☐ Other - See Nurses Notes

TIME	MEDICATION	DOSE	ROUTE	SITE	INITIALS	RESPONSE	INTAKE	OUTPUT
1420	MS04	5mg	IV		K	+ c pain - Stretcher		
1420	Phenergan	25mg	IV		K			
1425	TD	0.5ml	IM		L			
1500	MS04	5mg	IV		K			
1535	Reg. Symptoms	2 Ibuprofen				resolved		
							TOTAL	TOTAL

VALUABLES

☒ Not Inventoried ☐ Money Amt. ____
☐ Bracelet ☐ Earrings ☐ Clothes
☐ Necklace ☐ Rings ☐ Dentures
☐ Watch ☐ Purse ☐ Glasses
☐ Wallet ☐ Keys ☐ ID

With Whom/Where ____

Time 1707 Via:
☐ D/C Home ☐ LWT
☐ D/C ____
☐ AMA
☐ Transfer to:

DISPOSITION

☒ W/C ☐ Amb ☐ Stretcher ☐ Carried
☒ POV ☐ EMS/Ambulance
☒ Aftercare Instructions Given
To pt
☐ Transfer Form Completed
☐ POV ☐ EMS/Ambulance
Report to: ____
Time ____
Admitting M.D. ____
Monitor ☐ Yes ☐ No ☐ N/A
IV ☐ Yes ☐ No ☐ N/A
O_2 ☐ Yes ☐ No ☐ N/A

Initials	Signature	Title
gc	Gwen Cannon	LPN
KC	Kathie	R
JS	Jan T. Stanley	CMA

STATUS:
___ Improved
X Stable
___ Fair
___ Serious
___ Deceased

☐ Admitted to:
Room # ____
☐ Expired/Body to:
☐ SCOPA Notified

(MCMC-751 PAGE 3) (Revised 2/14/01)

1012

© 2000 T-System, Inc. Circle or check affirmatives, backslash (\) negatives.

03 Marion County Medical Center

EMERGENCY PHYSICIAN RECORD
Facial or Head Injury (4)

FLOYD SCOTTIE 26

WILKINS V00000027436
WC 09/13/01

TIME SEEN:_____ ROOM:_____ EMS Arrival

HISTORIAN: patient spouse paramedics

HX / EXAM LIMITED BY:

HPI chief complaint: injury to:
head face mouth / lip / chin / nose neck

occurred:
- just prior to arrival
- today
- yesterday
- ___ days PTA

where:
- home
- school
- neighbor's
- city park
- work
- street

context:
fell direct blow incised wound stab wound burn
Spring under car came loose

LOC? no dazed yes duration:
IF YES, remembers: injury coming to hospital

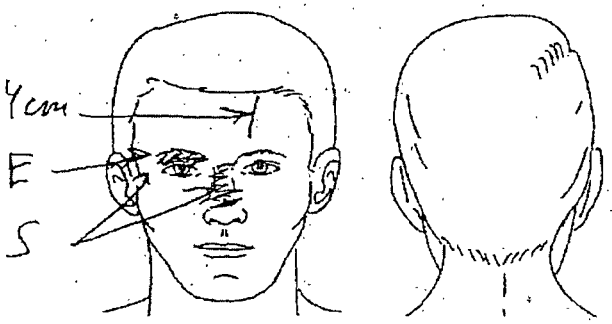
ROS vomiting headache neck pain

PAST HISTORY negative

Meds- none / see nurses note
Allergies- NKDA / see nurses note
Nurses note reviewed ☐ Tetanus immun. current ☐ Vital signs reviewed

PHYSICAL EXAM Alert Lethargic
Distress- NAD mild moderate severe
Other- c-collar (PTA / in ED) back-board IV splint

HEAD



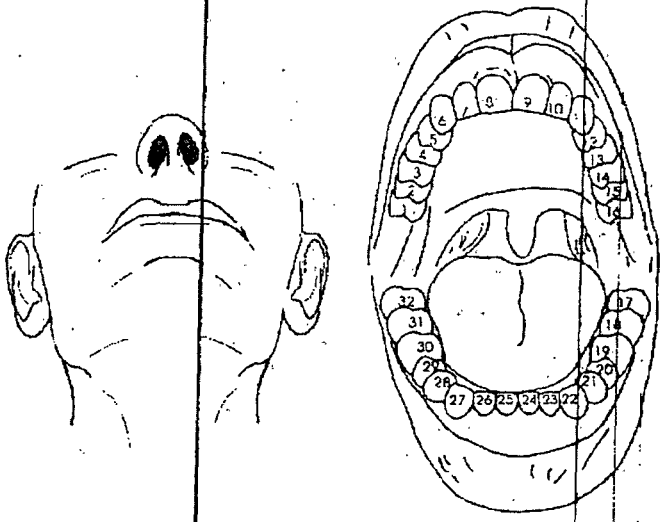
NECK
non-tender
painless ROM
see diagram
vertebral point-tenderness

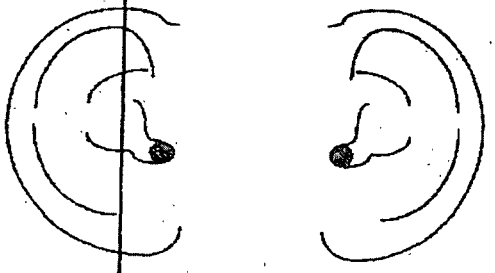
EYES
lids / conjunctivae normal
PERRL
EOMI

periorbital hematoma
subconjunctival hemorrhage
foreign body
corneal abrasion
hyphema
retinal detachment
unequal pupils
R pupil ___mm L pupil ___mm

ENT
normal external
pharynx nml
no injury to teeth lips or gums

hemotympanum
nasal septal hematoma
TM obscured by wax
clotted nasal blood
dental injury
dental malocclusion
poor dentition





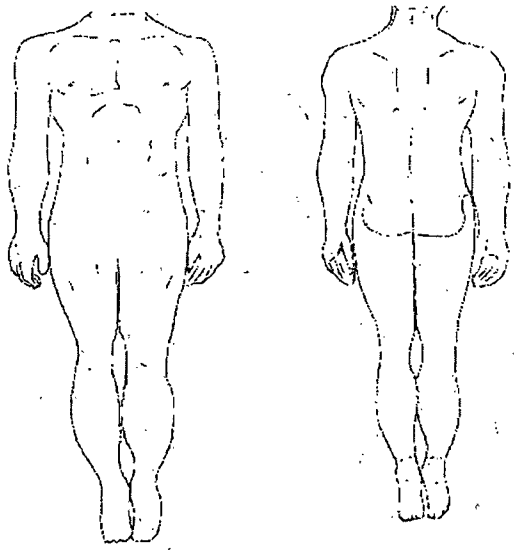
T=Tenderness PtT=Point Tenderness S=Swelling E=Ecchymosis B=Burn
C=Contusion Lac=Laceration A=Abrasion M=Muscle spasm
PW=puncture wound (Ø=without m=mild mod=moderate sv=severe)
Example- Tsv = Tenderness on palpation (severe)

NEURO/PSYCH
- ✓ oriented x3
- ✓ mood / affect nml
- ✓ no sensory / motor deficit
- ✓ CN's intact as tested
- __ slow / disoriented
- __ confused / obtunded
- __ weakness / sensory loss
- __ facial droop / EOM palsy / anisocoria
- __ abnormal gait
  antalgic ataxic

CHEST
- ✓ non tender

ABDOMEN
- ✓ non tender

EXTREMITIES
- ✓ non tender



Wound Description/Repair
length 4 cm location forehead
- __ superficial ✓ linear __ *stellate __ contused tissue
- __ SQ __ *irregular __ through-and-through
- __ muscle __ flap __ lip laceration
- ✓ clean __ contaminated *minimally / moderately / *heavily*

distal NV: ✓ neurovascular status intact

anesthesia: ✓ local __ LET / TAC ____ cc
✓ lidoc 1% 2% epi / bicarb __ marcaine .25% .5%

prep:
- __ Shur-Clens / Betadine / Hibiclens
- ✓ irrigated / washed with saline
  *minimal / mod. / *extensive*
- ✓ wound explored
- __ foreign material removed
  partially completely
  *minimal / mod. / *extensive*
- __ debrided
  *minimal / *mod. / *extensive*
- __ undermined
  *minimal / mod. / *extensive*
- __ *wound margins revised
- __ *vermilion border aligned
- __ *multiple flaps aligned

repair: *Wound closed with: wound adhesive / steri-strips*
SKIN- # 4 6 -0 ✓ nylon / prolene / staples
*SUBCU- # ____ ____ -0 vicryl / chromic

*may indicate intermediate repair *may indicate intermediate or complex repair

✓ Rx given Vicodin
__ Discussed with Dr.
will see patient in: office / ED / hospital

XRAYS ☐ Interp. by me ☐ Reviewed by me ☐ Discsd w/radiologist

C-Spine
- __ nml / NAD
- __ no fracture
- __ nml alignment
- __ soft tissues nml
- __ reversal / straightening of cerv. lordosis
- __ DJD / spondylosis / spurring

Facial Series
- ✓ nml / NAD
- __ no fracture
- __ soft tissues nml
- __ sinuses nml
- __ soft-tissue swelling
- __ max. sinus opacification / air-fluid level

Other ☐ See separate report

CT SCAN
__ normal

CLINICAL IMPRESSION:

Contusion	Laceration		Concussion
Hematoma			with LOC
head	✓ scalp	lip	without LOC
facial	forehead	buccal	
✓ nose	facial	chin	**Acute Cervical Myofascial Strain**
chin	periorbital	ear	
mouth	nose		

PROCEDURES and PROGRESS:

DISPOSITION- ☑ home ☐ admitted ☐ transferred
CONDITION- ☐ unchanged ☐ improved ☑ stable

PHYSICIAN SIGNATURE- [signature]

MARION COUNTY MEDICAL CENTER
2829 E. Hwy 76, P.O Box 1150
Marion, SC 29571

Patient: FLOYD.SCOTTIE

Birthdate:
MR#: M000041364
Location: ER

DIAGNOSTIC IMAGING REPORT

Admitting Dr:
Ordering Dr: THOMAS L WILKINS MD

Dept #: X000033798
Exam Date: 09/13/01

CHIEF COMPLAINT: Crush injury to nose

NASAL BONES:

No fracture or diastasis is seen. No other osseous or soft tissue abnormalities are noted.

IMPRESSION: 1. NEGATIVE STUDY.

***** Preliminary report if not electronically signed <signature on file> by radiologist****

<<Signature on File>>
Dictating Radiologist: _____
ARTURO E MACASINAG MD

Dict date: 09/13/01
Trans by: JARD
Trans date/time: 09/13/01 1649

Signed Status

Patient Location's copy

1442
8-4-75

MARION COUNTY MEDICAL CENTER

FLOYD, SCOTTIE 26

PHYSICIANS ORDERS AND WORKSHEET

WILKINS MD V00000027436
WC 09/13/01

E.R. M.D. Wilkins Date: 09-13-01

Patient Name: Scottie Floyd Private M.D. BSOA

INITIAL ASSESSMENT Date Time

CC T P R B/P

HPI W.T.

ALLERGY

PMHx: DM HTN CAD COPD PUD CA

Surg: APPY GB TONS HYST

Soc: ETOH MSDW SMOKE

FHx: DM HTN CAD COPD PUD CA

ROS: HEENT GI EXTREM CARD MS SKIN
RESP GU NEURO CHEST LYMPH PSYCH

EXAM SITE/TIME/INIT HOME MEDS

ADDRESSOGRAPH

PHYSICIAN ORDERS

- ☐ Old records ☐ Cardiac
- ☐ CBC ☐ Trauma
- ☐ Liver
- ☐ FSBS
- ☐ Basic Metabolic Profile
- ☐ CK-MB/-Troponin
- ☐ Amylase
- ☐ ETOH
- ☐ PT/PTT
- ☐ Type/Cross X unit or T&S
- ☐ Blood culture X
- ☐ Drug levels of
- ☐ UA void/cath
- ☐ Urine Culture
- ☐ HCG ☐ UCG
- ☐ GC/Chlamydia ☐ Wet Prep
- ☐ Urine drug screen

ASSESS Site/Time/Init

- ☐ CXR ☐ Port
- ☐ C-spine ☐ Port
- ☐ Pelvis ☐ Port
- ☐ Abd Series
- ☐ IVP ☐ LS spine
- ☐ Shoulder ☐ Right ☐ Left
- ☐ Wrist ☐ Right ☐ Left
- ☐ Ribs ☐ Right ☐ Left
- ☐ Hip ☐ Right ☐ Left
- ☐ Knee ☐ Right ☐ Left
- ☐ Ankle ☐ Right ☐ Left
- ☐ ECG ☐ ABG
- ☐ Monitor ☐ Pulse Ox
- ☐ O2
- ☐ IV @ Hl

ADDITIONAL ORDERS/MEDICATIONS Site/Time/Init

VO MSO4 5mg IVPC 1420
VO Phenergan 25mg IVPC 1420
Wells
VO MSO4 5mg IVPC 1510
Q Wells
Td 1/2cc IM @ 1425 given Renee, LPN

DIAGNOSIS/PROCEDURES

1. Lac
2. Contusion
3.
4.

DISPOSITION

☒ D/C ☐ Admit ☐ OBs Dr.

INSTRUCTIONS Ibuprofen

Sutures out in 5 days

Rx:

Condition at D/C: ☐ Improved ☒ Stable ☐ Fair ☐ Serious ☐ Decease

Follow up with: BSOA in 2 days if not improved

Otherwise recheck in ____ days

Signature D

Signature D

(MCMC-685) (Revised 5/4/00) WHITE - MEDICAL RECORDS • CANARY - ED COPY • PINK - PHYSICIAN • GOLDENROD - BILLIN

MARION COUNTY
MEDICAL CENTER

(MCMC-13 -- Front)

FLOYD 26

MARION
WILKINS V0000002743
WC 09/13/01

NURSES PROGRESS NOTE

DATE	TIME	Record: Admission, Pertinent Observations, Treatment and Discharge (Sign All Entries)
09-13-01	1700	INT dcd & needle removed intact - dry dsg over site ——— Gwen Carroll, LPN
	1707	Released home & verbalized understanding of epic & was also explained to friend - Taken out via W/C in stable condition To see PCP 5 days for suture removal ——— Gwen Carroll, LPN

MARION COUNTY MEDICAL CENTER
PHYSICIANS ORDERS AND WORKSHEET

E.R. M.D. Mock Date: 1-6-02

Patient Name: Scottie Floyd Private M.D. Keith

FLOYD, SCOTTIE 26

MOCK, JA V00000045268
CO 01/06/02

ADDRESSOGRAPH

PHYSICIAN ORDERS

					☐ Old records	☐ Cardiac
					☐ CBC	☐ Trauma
					☐ Liver	
					☐ FSBS	
PMHx:	DM	HTN	CAD	COPD	☐ Basic Metabolic Profile	
Surg:	APPY	GB	TONS	HYST	☐ CK-MB/-Troponin	
Soc:	ETOH	MSDW	SMOKE		☐ Amylase	
FHx:	DM	HTN	CAD	COPD	☐ ETOH	
ROS:	HEENT	GI	EXTREM	CARD	☐ PT/PTT	
	RESP	GU	NEURO	CHEST	☐ Type/Cross X	unit or T&S
EXAM:			SITU/TIME/INIT HOME MEDS:		☐ Blood culture X	
					☐ Drug levels of	
					☐ UA void/cath	
					☐ Urine Culture	
					☐ HCG	☐ UCG
					☐ GC/Chlamydia	☐ Wet Prep
					☐ Urine drug screen	

RESULTS Site/Time/Init

7840

☐ CXR	☐ Port	
☐ C-spine	☐ Port	
☐ Pelvis	☐ Port	
☐ Abd Series		
☐ IVP	☐ LS spine	
☐ Shoulder	☐ Right	☐ Left
☐ Wrist	☐ Right	☐ Left
☐ Ribs	☐ Right	☐ Left
☐ Hip	☐ Right	☐ Left
☐ Knee	☐ Right	☐ Left
☐ Ankle	☐ Right	☐ Left

ADDITIONAL ORDERS/MEDICATIONS Site/Time/Init

Percocet 5/325 mg #1 or
Percocet 5/325 mg #1

1710

Prescription instructions given

Frank Speight

0630

☐ ECG	☐ ABG	
☐ Monitor	☐ Pulse Ox	
☐ O2		
☐ IV	@	Hr.

DIAGNOSIS/PROCEDURES

Acute Cervical sprain

nature D 1/6/02

nature D

DISPOSITION Trans WOT LBA AMA Time

☐ D/C ☐ Admit ☐ OBs Dr.

INSTRUCTIONS Bedrest
Ice to neck PRN HA, neck, fever, pain

Rx:

Condition at D/C: ☒ Improved ☐ Stable ☐ Fair ☐ Serious ☐ Deceased

Follow up with: Keith in 2 days if not improved,

Otherwise recheck in _____ days

(C-685) (Revised 5/4/00) WHITE - MEDICAL RECORDS • CANARY - ED COPY • PINK - PHYSICIAN • GOLDENROD - BILLING

1018

Marion County Medical Center

MARION, SOUTH CAROLINA

EMERGENCY DEPARTMENT DATA / ASSESSMENT TOOL

FLOYD, SCOTTIE 26

MOCK, JA V00000045268
CO 01/06/02

NARRATIVE NOTES

0445 pt amb to ER 4 - Ct
0550 Dr Mock exams pt - Ct
0555 Meds given - Ct
0615 pt states relief rec'd from meds given c/5 - Ct
0630 pt d/c ambulatory, w/ RX given. pt verbalizes understanding
need to f/u prn - Ct

☐ See Additional Notes

IV SOLUTION & AMOUNT	PUMP	MEDICATION ADDED	SIZE	SITE	ML/HR	TIME START/INITIALS	TIME D/C/INITIALS	SITE AT DISCHARGE
	Yes No							☐ No Redness, Pain, Swelling ☐ Other - See Nurses Notes
	Yes No							☐ No Redness, Pain, Swelling ☐ Other - See Nurses Notes
	Yes No							☐ No Redness, Pain, Swelling ☐ Other - See Nurses Notes

TIME	MEDICATION	DOSE	ROUTE	SITE	INITIALS	RESPONSE	INTAKE	OUTPUT
0555	Demerol	50 mg	IM	Rt glut	CT			
	Phenergan	50 mg						
							TOTAL	TOTAL

VALUABLES

☑ Not Inventoried ☐ Money Amt. _____
☐ Bracelet ☐ Earrings ☐ Clothes
☐ Necklace ☐ Rings ☐ Dentures
☐ Watch ☐ Purse ☐ Glasses
☐ Wallet ☐ Keys ☐ ID

With Whom/Where _____

Initials	Signature	Title
CT	Carol Anderson	RN

STATUS:
✓ Improved
___ Stable
___ Fair
___ Serious
___ Deceased

DISPOSITION

Time 0630 Via: ☐ W/C ☐ Amb ☐ Stretcher ☐ Carried

☑ D/C Home ☐ LWT
☐ D/C _____
☐ AMA
☐ Transfer to:

☑ POV ☐ EMS/Ambulance
☑ Aftercare Instructions Given
To pt & pt's family
☐ Transfer Form Completed
☐ POV ☐ EMS/Ambulance

☐ Admitted to:
Room # _____
☐ Expired/Body to:
☐ SCOPA Notified

Report to: _____
Time _____
Admitting M.D. _____
Monitor ☐ Yes ☐ No ☐ N/A
IV ☐ Yes ☐ I
O_2 ☐ Yes ☐ No ☐ N/A

MARION COUNTY MEDICAL CENTER
MARION, SOUTH CAROLINA
ADMISSION DATA & ASSESSMENT

FLOYD, SCOTTIE 26

MOCK, JA V00000045268
CO 01/06/02

Name _____

ADMISSION HISTORY

Date	Time	Arrival	Age	Sex	Last Tetanus	Triage Class	Immunizations
1-6-01	0255	☐ Amb ☐ Stretcher ☐ Arms ☐ W/C ☐ EMS ☐ POV	26	M		☐ 1 ☐ 2 ☐ 3	☐ Up to Date in accordance with State Law ☐ Pneumonia ☐ Flu

Time	Temp	Pulse	Resp	B/P	Ht.	Wt: Stated / Actual
0255	96.8	65	18	134/66		

Source of Information: ☐ Other _____
☒ Patient ☐ Family ☐ Unable to Obtain

ALLERGIES: Food / Medications

☒ NKA ☐ Yes - below:

Type Reaction

Are you allergic to any of the following?	Yes	No
Latex		✓
Bananas / Avocados / Kiwi		✓
IVP dye/ Seafood		✓

Previous Blood Transfusion ☒ No ☐ Yes
Reaction ☐ No ☐ Yes Describe: _____

Chief Complaint/ In Patient's Words
had a concussion 3 mths ago, head is killing me, some place at concussion vomitted earlier, no BM in 2 days, was passed out IX from hyperventilation

Accident Date: 1-5 Time: 1pm Agency Notified _____

Developmental Status ☐ Appropriate for Age ☐ _____

LMP _____ G _____ P _____ A _____

Head Circum _____ cm

Visual Acuity od _____ os _____ ou _____

Tx PTA: ☐ EMS ☐ IV ☐ O2 ☐ Wound ☐ ACLS ☐ None ☐ Home ☐ Monitor Care

☐ Spinal Immobilization

MEDICAL HISTORY ☐ None

DISEASE	PT	FAMILY	DISEASE	PT	FAMILY
Anemia	☐	☐	Kidney Disease	☐	☐
Arthritis	☐	☑	Mental Illness anxiety	☐	☑
Asthma	☐	☐	Muscle / Bone Disorders	☐	☐
Bronchitis	☐	☑	Reproductive Disorders	☐	☐
Cancer	☐	☑	Seizures / Epilepsy	☐	☐
CVA	☐	☐	Skin Disorders	☐	☐
Diabetes	☐	☐	Stomach Disorders	☐	☐
Emphysema	☐	☑	Anesthesia Reactions	☐	☐
Glaucoma	☐	☐	Tobacco Use 3 pks	☑	☐
Heart Disease	☐	☐	Alcohol / Drug Use	☑	☐
Hepatitis	☐	☐	Thyroid Problems	☐	☐
Hypertension	☐	☐	Other	☐	☐
Infectious Diseases	☐	☐	Other	☐	☐
Sensory Impairment	☐	☐	Other	☐	☐

PREVIOUS HOSPITALIZATIONS (Medical & Surgical)

Date	Reason
	none

MEDICATION HISTORY (Include Vitamins / Herbs / Inhalers / Eye Drops / OTC) ☐ Unknown ☐ None

H/Pt	Medication	Dose	Frequency	Last Dose	W/Pt	Medication	Dose	Frequency	Last Dose
	Fioricet		1 qeh prn	10 p					
	Xyflo - Anxiety	50 mg	prn	2 days ago					

Initials	Signature / Title	Date / Time	Unit	Initials	Signature / Title	
	A Adams RN	0500 1-6-02	EF	CA	Carol Anderson RN	1 PETCT ED

Marion County Medical Center
MARION, SOUTH CAROLINA

Page 2
EMERGENCY DEPARTMENT
DATA / ASSESSMENT TOOL

FLOYD, SCOTTIE 26

MOCK, JA V00000045268
CO 01/06/02 08/04/1975

ASSESSMENT:

TIME TO RM: ROOM #:

		TIMES			
		0305			
AIRWAY	SELF MAINTAINED	✓			
	ORAL/NASAL AIRWAY				
	INTUBATED				
BREATHING	NORMAL	✓			
	IRREGULAR				
	LABORED				
	ABSENT/APNEIC				
	ASSISTED/BAGGED				
CIRCULATION	PULSE PRESENT	✓			
	ABSENT				
SKIN	WARM				
	HOT				
	COOL	✓			
	DRY				
	DIAPHORETIC				
	NML/PINK	✓			
	CYANOTIC				
	PALE				
	ASHEN				
DISABILITY	ALERT/ORIENTED X	✓			
	RESPONDS VERBAL				
	RESPONDS PAIN				
	UNRESPONSIVE				
	CONFUSED				
	COMBATIVE				
2° HEAD EARS: CLEAR, DRAINAGE; EYES: PERRLA, SLUGGISH, NONREACTIVE; MOUTH: CLEAR, DRAINAGE	R PUPIL REACTIVE				
	L PUPIL REACTIVE				
	SPEECH	✓			
CHEST	ASYMMETRICAL				
	SYMMETRICAL	✓			
	CLEAR	✓			
	CONGESTED				
	WHEEZES				
	DECREASED				
PULSE	STRONG	✓			
	WEAK/THREADY				
	REGULAR	✓			
	IRREGULAR				
ABDOMEN	SOFT	✓			
	FIRM/HARD				
	DISTENDED				
	TENDER				
	NONTENDER	✓			
	BOWEL SOUNDS PRESENT	✓			
EXTREMITIES	NML CAP REFILL X	✓			
	NML MOVEMENT X	✓			
	NML SENSATION	✓			
OTHER					

PAIN ASSESSMENT:

☐ NONE ☒ YES
LOCATION: down center of head
INTENSITY (0-10): 10
CAUSED BY: concussion
DURATION: intermittent
RELIEVED BY:
TYPE: ☐ DULL ☒ SHARP ☐ PRESSURE
☐ RADIATING ☐ THROBBING

FAMILY NOTIFIED: ☐ Patient Declines ☐ N/A
TIME: _____ WHO: _____

PSYCHOSOCIAL ASSESSMENT:

☐ N/A *"ANY YES" CONTACT CASE MANAGEMENT
☐ TRANSLATOR NEEDED
☐ SUSPECTED ABUSE/NEGLECT*
☐ NO SUPPORT SYSTEM*
☐ REQUESTS BLOODLESS SURGERY/MEDICINE
☐ OTHER CULTURAL PRACTICES
☐ FAMILY/PATIENT REQUESTS CHAPLAIN
☐ SPIRITUAL/CULTURAL DECLINED

PHYSICIANS

NAME	PAGED	ANSWERED	ARRIVED
Keith			

VITAL SIGNS

TIME	B/P	PULSE / RESP	PRE PF / POST PF	O_2 SAT	TEMP
					☐ SEE TREND SHEET

TIME/INITIALS	TREATMENT/PROCEDURES		
	☐ ID BAND ☐ SIDE RAILS ↑ X 2 ☐ CALL LIGHT		
	O_2 L _____ VIA _____		
	EKG		
	MONITOR/RHYTHM _____		
	☐ NG- ☐ OG TUBE Fr _____	☐ PLACEMENT CHECKED	
	FOLEY Fr _____ IN & OUT CATH Fr _____		
	ETT ☐ NASAL ☐ ORAL Fr _____	☐ END TIDAL CO_2	
TO / Portable	X-RAYS	FROM	VIA ☐ AMB ☐ W/C ☐ STRETCHER
TO	CT SCAN	FROM	VIA ☐ AMB ☐ W/C ☐ STRETCHER

Initials	Signature/Title	Date/Time	Unit
ch	[illegible]	1-6-02 0305	ER
CA	[illegible]	1/6/02	ER

9 8 7 6 5 4 3 2

(MCMC-751 PAGE 2) (Revised 2/14/01) White - HIM Canary - Pharmacy Pink - ED

1021

FLOYD, SCOTTIE 26

MOCK, JAMES V00000045268
CO 01/06/02

Marion County Medical Center

2829 East Highway 76 • P.O. Drawer 1150
Marion, South Carolina 29571-1150

Date 1/6/02

Mr. Floyd was seen by me today. He/she should be excused from work/school for:

24 hours 48 hours 72 hours

If an excuse is needed for longer than 72 hours, he/she will need to be reevaluated by a physician for.

M.D.

(MCMC-30) (Revised 3/10/99)

© 2000 T-System, Inc. Circle or check affirmatives, backslash (\) negatives.

26

Marion County Medical Center
EMERGENCY PHYSICIAN RECORD
Headache (5)

FLOYD, SCOTTIE 26

MOCK, JA V00000045268
CO 01/06/02

TIME SEEN: 540A ROOM: _____ EMS Arrival

HISTORIAN: (patient) (spouse) paramedics _____

__HX / __EXAM LIMITED BY: _____

HPI

chief complaint: (headache) facial pain fever *migraine hx*

started: 3 mo ago

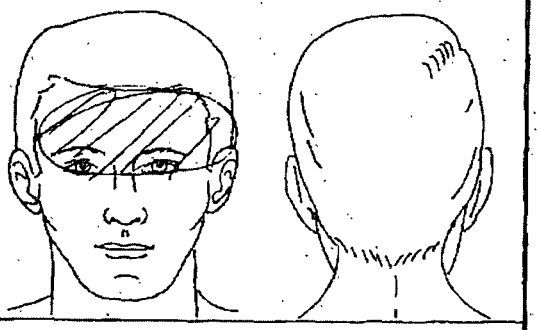
time course:
__abrupt / gradual onset
\still present __better
\gone now
lasted _____

__*intermittent episodes lasting* _____

__*worse/persistent since* _____

quality:
(similar to previous headaches)
"pain"
tightness
throbbing
sharp

location:



associated symptoms:
__preceding symptoms
visual disturbance scotoma
typical of prior aura(s)
__nausea
__vomiting
__power loss R/ L arm/leg
__tingling/numb sensation
\light bothers eyes (@ exc)
__blurred vision

severity:
maximum
(mild) moderate severe relieved by OTC meds
when seen in ED
gone (mild) moderate severe

(similar symptoms previously) c previous HA

__Recently seen/treated by doctor _____

ROS

CONST
__fever
\ *subjective / to* _____ °F
__muscle aches

ENT
__sore throat
__sinus pressure/drainage

For new, gradual-onset HA:
__CO exposure
__tick bite(s)
__head injury

PULMONARY &CVS
__chest pain
__cough
__sputum
__trouble breathing

GI and GU
__abdominal pain
__diarrhea
__pain on urination

Skin & Lymphatic & MS
__skin rash / swelling
__back pain

☑ all systems neg. except as marked

PAST HISTORY __negative
\chronic headaches
occasional frequent "migraine"
mild moderate severe
__high blood pressure
__sinus problems
__cancer history
__immunosuppressed
__glaucoma
__diabetes *insulin / oral / diet*
__asthma
__+HIV / AIDS
__other problems

Concern - s/p accident
3 mo ago HA since

Medications __none \see nurses note
__ASA __NSAID __acetaminophen

Allergies __NKDA
__see nurses note

SOCIAL HX (smoker) drugs
(alcohol *(recent / heavy / occasional)*)

FAMILY HX __cerebral aneurysm __migraine headaches
__stroke __HTN COPD, CA - Asthma

☑ Nursing Assessment Reviewed ☐ BP, HR, RR, Temp reviewed

PHYSICAL EXAM ✓Alert __Anxious

Distress: __NAD ✓mild __moderate __severe

HEENT
✓nml ENT inspection
✓pharynx nml
__purulent nasal discharge
__tender temporal artery
__pharyngeal erythema
__tonsillar exudate
__pain on percussion over sinuses
__abnormal TM
__pale conjunctivae
__narrow angle (ant. chambers)

NECK
✓nml inspection
✓supple
__thyromegaly
__lymphadenopathy (R / L)
__stiff neck / meningismus

RESPIRATORY
✓no resp. distress
✓breath sounds nml
__wheezing
__rales

CVS
✓reg. rate & rhythm
✓heart sounds nml
__heart murmur
__tachycardia / bradycardia
__decreased pulse(s)

ABDOMEN
✓non-tender
✓no organomegaly
__tenderness
__hepatomegaly / splenomegaly / mass

SKIN
✓color nml, no rash
✓warm, dry, nml palp.
__cyanosis / diaphoresis / pallor
__skin rash

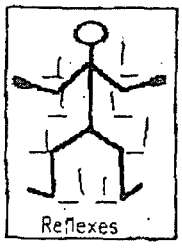
EXTREMITIES
✓non-tender
✓normal ROM
✓no pedal edema
__pedal edema
__calf tenderness

NEURO / PSYCH
higher functions
✓alert
✓oriented x3
✓mood / affect nml
__slow / confused / no response to commands
__disoriented
to: time / place / person

cranial nerves-
✓normal as tested
✓pupils equal, round, and reactive
__EOM palsy
__unequal pupils
R pupil ____mm L pupil ____mm
__facial palsy
__tongue deviation (to R / L)
__facial numbness
__abnormal fundi / papilledema / wide cups

cerebellar-
✓normal as tested
__abnormal Romberg test
__abnormal finger-nose-finger
__abnormal gait

sensorimotor-
✓no motor deficit
✓no sensory deficit
__weakness
__pronator drift (RUE / LUE)
__sensory loss
__abnormal reflexes


Reflexes

LABS, XRAYS, and PROGRESS

CBC		Chemistries	UA
normal except		*normal except*	*normal except*
WBC	segs	Na	WBC
Hgb	bands	K	RBC's
Hct	lymphs	Cl	bacteria
Platelets	monos	CO2	dip:
	eos	Gluc	
		BUN	
		Creat	

LP __discussed risks, benefits, alternatives; patient consents.
__(R / L) sitting
__betadine prep
__sterile technique
__L3-4
__L4-5
open press.=
fluid color RBC WBC
glucose polys lymph
protein monos gm stn

Head CT __*nml*

CXR ☐Interp. by me ☐Reviewed by me ☐Discsd w/radiologist
__*nml/NAD* __*no infiltrates* __*nml heart size* __*nml mediastinum*
not / changed from:

Time 1650 __unchanged ✓improved ✓re-examined
__pain relieved ✓pain almost fully relieved

Dr. Frank

__Discussed with Dr.
will see patient in: office / ED / hospital
✓Counseled patient / family regarding:
lab results diagnosis need for follow-up
✓Rx given __Admit orders written
__CRIT CARE- *30-74 min* *75-104 min* ____ min
__Prior records ordered
✓Additional history from: *family caretaker paramedic*

CLINICAL IMPRESSION:

Headache
acute severe hemiplegic vascular migraine cluster
Vomiting / Dehydration
Meningitis
Intracranial Hemorrhage
Subarachnoid Hemorrhage
Sinusitis
Viral Cephalgia

DISPOSITION- ☑home ☐admitted ☐transferred
CONDITION- ☐unchanged ☑improved ☐stable

PHYSICIAN SIGNATURE- Dr.

1024

MARION COUNTY MEDICAL CENTER
2829 E. Hwy 76, P.O Box 1150
Marion, SC 29571

Patient: FLOYD,SCOTTIE

Birthdate:

DIAGNOSTIC IMAGING REPORT

MR#: M000041364
Location: CT

Admitting Dr:
Ordering Dr: ROBERT G VYGE MD

Dept #: X000033798
Exam Date: 01/09/02

(ORDER SIGNED BY KEITH STEWART, PA-C)

CHIEF COMPLAINT: HIT IN HEAD TWO MONTHS AGO, SEVERE HEADACHES

(Omnipaque 300/75mL)

CRANIAL COMPUTED TOMOGRAPHY:

Multiple sections were obtained in the axial plane without and with contrast enhancement. The history of head trauma two months prior to this procedure is duly noted. A non-enhancing focus of low attenuation is seen in the right frontal region. It appears intraparenchymal rather than subdural in location. The pattern is more consistent with an infarct. No hemorrhage or mass lesion is seen. No abnormal extra-axial or intra-ventricular fluid collection is demonstrated. The remaining brain parenchyma, ventricles, cisterns and calvarium are normal.

IMPRESSION:

1. NON-ENHANCING FOCUS OF INTRAPARENCHYMAL LOW ATTENUATION IN THE LEFT FRONTAL REGION AS DESCRIBED ABOVE.
2. APPEARANCE CONSISTENT WITH AN INFARCT.
3. WITH THE GIVEN CLINICAL HISTORY AND THE PATIENT'S AGE, ATYPICAL POST-TRAUMATIC FLUID COLLECTION CANNOT BE EXCLUDED.
4. NO HEMORRHAGE OR MASS LESION.

***** Preliminary report if not electronically signed <signature on file> by radiologist*****

<<Signature on File>>
Dictating Radiologist: _____
ARTURO E MACASINAG MD

Dict date: 01/09/02
Trans by: AMARLOWE
Trans date/time: 01/09/02 1607

Signed Status

(MCMC-777 - Front)
(Revised 5/15/02)

Marion County Medical Center
Emergency Department Record

FLOYD, SCOTTIE 27

CARLSON, MD V0000012660
WC 05/09/03

Date 5/9/03 Arrival Time 0100 Triage Time 0100
Pt. Name Scottie Floyd Age 27 Race W (M) F
Ht. 5-9 Wt. 181 lbs. / kgs Last TD < 5 or > 5
LMP ____ G ____ P ____ A ____ Immunizations UTD / NUTD
Chief Complaint: Pediatric, Flu, Pneumonia

Severe HA

Source of Info: ☐ Pt. ☐ Family ☐ Other ____

ER Dr. Carlson
Family Dr. Healy
O / C Dr. ____
Mode of Arrival ☒ Car ☐ EMS ☐ Police ☐ Other ____
Tx PTA ☒ None ☐ EMS ____ IV ____ O2 ____ Wound
____ Splint ____ Monitor ____ ACLS
____ Spinal Immobilization
Visual acuity
OD ____ OS ____ OU ____ TD ____ Lot ____ Ex ____
FSBS ____ Triage Tylenol ____ mg ____
Meds Motrin ____ mg ____

VITALS
T 98.3 O / R / A / T P 71 R 20 BP 129/84
O2 Sat ____ RA / O2 ____ L

PAIN ASSESSMENT: See Wong Baker Scale
☐ None ☐ Yes
Intensity 6/10 Relief ____
Cause ____ Type: ☐ Dull ☐ Sharp ☐ Pressure
Duration ____ ☐ Radiating ☐ Throbbing

ALLERGIES: ☒ None ☐ PCN ☐ ASA ☐ Sulfa ☐ Latex ☐ IVP Dye ☐ Seafood
Other: ____

MED HISTORY

Keep	Med / Dose	Med / Dose
	Keppra 250 TBID	Clonazepam
	Prilosec 40 Tab	Img TBID
	Vicodin 5/500 1 tabs	2280
	Paxil CR 25 TBID	
	Carbatrol 200 TBID	

MEDICAL HISTORY
☐ Cardiac ☐ Cancer ☐ Smoker ____ pks / day
☐ HTN ☐ CVA ☐ ETOH Use
☐ Diabetes ☐ Seizure ☐ TB Screen ____ CXR ____ PPD
☐ Kidney ☐ Asthma ☐ Abuse Screen Y N ☐ Help Offered Y N
☐ Other Difficulty Swallowing Y N Slurred Speech Y N

PREVIOUS HOSPITALIZATIONS: Post Blindness Brain damage from accident
Rt Hemiparesis Brain surgery x1 - Rockmont

Triage Nurse ____

ADDITIONAL ORDERS / MEDICATIONS:

☐ OLD RECORDS

☐ MSE Done ☐ Refused ☐ Emerg Care ☐ Non-Emerg.

TSBD | H & P

done (Morphine 5mg IM
0130 hr (Phenergan 12.5mg IM

done - Morphine 5mg IM
0205 hr

LABS ORDERED
Time ____
☐ EKG ☐ Cardiac
☐ ABG ☐ Trauma
☐ CBC ☐ PT
☐ BMP ☐ PTT
☐ Lanoxin ☐ CK/MB
☐ Serum Pregnancy
☐ FSBS
☐ Hemocult
☐ Dilantin
☐ U / A
☐ UC / S ☐ UCG
☐ Bld cl ☐ Wet Prep
☐ Pulse Ox ☐ GC / Chlamydia
☐ Troponin

X-RAYS ORDERED
Time ____
☐ Chest ☐ CT Head
☐ Abd ☐ CT Abd
☐ C-Spine ☐ CT Pelvis
☐ L-Spine ☐ Pelvic U/S
☐ Skull
☐ Hip R L
☐ Femoral R L
☐ Pelvis
☐ Ribs R L
☐ Ankle R L
☐ Foot R L
☐ Shoulder R L
☐ Wrist R L
☐ Knee R L

D / C Instructions: Motrin 7 pm, Benadryl as needed

Condition on D/C: ☐ Improved ☒ Stable ☐ Unstable ☐ Deceased

Rx: Q W/E / S/E Follow-Up: Healy

Provisional Dx: HA Signature: ____

Dictated by ____ # ____ ☐ See Addendum T sheet ☐

1026

ASSESSMENT

LOC
Alert ✓
Oriented ✓
Confused
Drowsy
Arousable
Unresponsive
Smiling / Playful

BEHAVIOR
Appropriate
Agitated ✓
Flat
Depressed
Anxious
Crying

SKIN
Warm ✓
Dry ✓
Pale
Flushed
Cyanotic
Moist
Cool

RESPIRATORY
R L
✓ ✓ Clear
Rales
Wheezing
Decreased
Rhonci
Nasal Flaring
Retractions
Cough
Prod
Nonprod

CIRCULATION
Pulse Weak
Strong ✓
Regular ✓
Irregular
Cap Refill <2

ABDOMEN
BS Present ✓
Distended

TX / PROCEDURES
☐ ID Band
☐ Call Button
☐ SR ↑ x 2
☐ O_2 ____ L via ____
☐ EKG
☐ NG / OG ____ F
☐ Foley ____ F
☐ I / O Cath
☐ ETT ____ # ____
☐ FSBS
☐ Monitor
____ Rhythm
☐ Dressing / Splint

TIME	MEDS	ROUTE	RELIEF	INITIALS	IV	MEDS ADDED	SIZE / SITE	INITIALS	SITE @ D/
0130	Morphine 5mg	IM		QR					
0131	Phenergan 12.5mg	IM		QR					
0205	Morphine 5mg	IM		QR					

NSG NOTES Amb. TTR 0105 am / pm Room # FT6

0110 Dr Carlson in to see pt
0130 Meds given per order. Pt standing c c/o n/a stated. Family at bedside.
0131 Pain stated at 10/10
0200 Pt stated no relief from pain med
0205 Additional Morphine 5mg given IM for Pain.
0215 Pt comes to desk. Stated, "My pain went from a 10 to a 1/2 - I want to go home now". Rev VS. D/C'd amb. home c family. Family member to drive

VITAL SIGNS Joan Rine RN

Time	T	P	R	B / P	O_2 SAT	PAIN LEVEL
0215		72	16	122/80		

Coroner Notified ☐ Y ☐ N SCOPA Notified ☐ Y ☐ No Body to:

D / C DISPOSITION Time 0213
☐ Home ✓ epic given Pt. Verb. Understand
☐ AMA ☐ LBA ☐ LBTC
☐ Admit Room ____ Report to ____ Time ____
☐ Transfer ____ Report to ____ Time ____
VS on D / C T — P 72 R 16 B / P 122/80
Pain Level on D / C 2/10 D / C by KMcCracken
Mode of D / C ☐ AMB ☐ EMS ☐ W / C ☐ Carried

VALUABLES
☐ Not Inventoried
☐ Bracelet
☐ Necklace
☐ Watch
☐ Wallet ____ Amt
☐ ID
☐ Glasses
☐ Dentures
☐ Earrings
☐ Rings
☐ Purse
☐ Clothes
With Whom / Where:

© 2000 T-System, Inc. Circle or check affirmatives, backslash (\) negatives.

26

Marion County Medical Center

EMERGENCY PHYSICIAN RECORD
Headache (5)

FLOYD, SCOTTIE 27

CARLSON, MD V0000012660
WC 05/09/03

TIME SEEN: 0110 ROOM: 6 EMS Arrival

HISTORIAN: patient spouse paramedics

HX / EXAM LIMITED BY:

HPI

chief complaint: (headache) facial pain fever *migraine hx*

started: x " 2 years "
Gradual
Florida

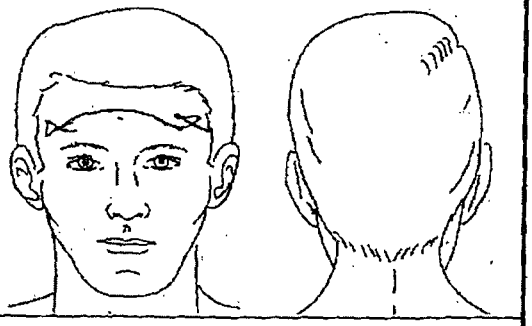
time course:
abrupt / gradual onset
still present better
gone now
lasted

intermittent episodes lasting

worse/persistent since

quality:
similar to previous headaches
"pain"
tightness
throbbing
sharp

location:



associated symptoms:
preceding symptoms
visual disturbance scotoma
typical of prior aura(s)
light bothers eyes
blurred vision
nausea
vomiting
power loss R/L arm/leg
tingling/numb sensation

severity:
maximum
mild (moderate) severe relieved by OTC meds
when seen in ED
gone mild (moderate) severe

Similar symptoms previously H/o Pregnant HAs

Recently seen/treated by doctor Baily

ROS

CONST
fever
subjective / to °F
muscle aches

ENT
sore throat
sinus pressure/drainage

For new, gradual-onset HA:
CO exposure
tick bite(s)
head injury

PULMONARY & CVS
chest pain
cough
sputum
trouble breathing

GI and GU
abdominal pain
diarrhea
pain on urination

Skin & Lymphatic & MS
skin rash / swelling
back pain

all systems neg. except as marked

PAST HISTORY negative
chronic headaches
occasional (frequent) "migraine"
mild moderate severe
high blood pressure
sinus problems
other problems Accident - brain injury
MVC

cancer history
immunosuppressed
glaucoma
diabetes *insulin / oral / diet*
asthma
+HIV / AIDS

Medications none see nurses note
ASA NSAID acetaminophen

Allergies NKDA
see nurses note

SOCIAL HX smoker drugs
alcohol *(recent / heavy / occasional)*

FAMILY HX cerebral aneurysm migraine headaches
stroke HTN

000019

1028

MARION COUNTY MEDICAL CENTER-EMERGENCY DEPARTMENT
2829 E Highway 76--PO Drawer 1150--Marion, SC 29571--(843)431-2150

INSTRUCTIONS FOR << FLOYD, SCOTTIE >>

Our doctors and staff appreciate your choosing us for your emergency medical care needs. Read these aftercare instructions carefully. Please call us if you have any questions about your medical problem. We are here to serve you.

NONSPECIFIC HEADACHE:

Your exam shows your headache does not have any specific cause. Headaches are caused by many different things including stress, tension, infections, and high blood pressure. Rarely headaches may be due to bleeding and tumors in the brain. Although your headache does not seem to have a serious cause, it is very important that you see your doctor for further evaluation if it is severe or does not get better in 1-2 days.

Headache treatment includes medicines for pain like ibuprofen. Rest, cold or hot packs on painful areas of the head and neck, and massage of the sore muscles may help. Call your doctor or return here right away if you have any of the following symptoms:

* A high fever, chills, or repeated vomiting.
* Passing out, difficulty with vision, unusual numbness or weakness.
* Severe pain despite medicine, confusion, or stiffness in the neck.

PRESCRIPTIONS:

Fill all the prescriptions ordered by your doctor and take them as directed. Generic medicines are as good as brand names, and often less expensive.

* If you have been given an antibiotic, be sure to take all of it.
* Keep your drugs out of the reach of children, in a cool, dry, dark place.
* Don't give your medicine to other people or use it for other illnesses.
* Stop your medicine and call us right away if you have drug allergy symptoms or bad side-effects. Call also if you vomit or cannot swallow the medicine.
* Bring your medicines with you any time you go to emergency for treatment.

Ask your doctor or pharmacist about drug or food interactions that may be important to know about when taking your prescription or herbal medicines.

NARCOTIC PAIN MEDICINE:

You have been prescribed a narcotic for pain relief. These drugs are usually combined with acetaminophen (Tylenol#3, Percocet, Darvocet, Anexsia, Vicodin) or aspirin (Empirin#3, Percodan, Synalgos-DC) for increased effect. Narcotics act on the central nervous system to reduce pain; they also impair mental alertness and physical abilities. We advise you not to drink alcohol, drive a car, or operate dangerous equipment when you are taking one of these drugs. Long term use of narcotic pain medications may be habit-forming.

You can lessen stomach irritation from your medicine by taking it with meals or a full glass of water. Common side effects of narcotics are: nausea and vomiting, heartburn, constipation, dizziness, sleepiness, and mood changes. If you have bothersome side effects or symptoms of an allergic reaction (itching, hives, rash), stop taking your medicine and call your doctor or the emergency room right away. Please keep your narcotic medicine well out of the reach of children.

ANTIEMETICS (MEDICINE FOR VOMITING):

Your doctor has prescribed medicine to control your nausea and vomiting. This type of medicine can be given orally, or by injection, or suppository.

Examples of these drugs include Compazine, Phenergan, Reglan, Tigan, Torecan, Vistaril, and Zofran. Most antiemetic medicine will cause you to be sleepy or dizzy. Do not drive a car or operate other dangerous equipment while you are taking one of these drugs. Avoid alcohol because it can upset your stomach more and cause greater sedation from your medicine.

Some of these medicines are not safe in pregnancy, and they should be used only occasionally in children under 2 years of age. You should contact your doctor or return here right away if you develop any of the following symptoms:

* Continued vomiting unrelieved by your medicine.
* Allergy symptoms (itching, rash, hives, breathing problems).
* Unusual muscle spasms or movements involving the neck, jaw, tongue, or other areas of the body.
* Blurred vision, severe dizziness, fainting, or seizures.

ADDITIONAL INSTRUCTIONS:
FOLLOW UP WITH DR HEALY
RETURN TO THE ER IF NEEDED

FOLLOW-UP CARE:
Your physician today has been DR. TODD CARLSON

For follow-up care you have been referred to the following doctor or clinic:

MENON Phone: (843)464-8244
511 N MAIN ST, MULLINS, SC

Please make an appointment for further treatment as needed or in _____ days. Tell your referral doctor or clinic that we have sent you, and bring your medicines and instructions to the office. If you had x-rays, an EKG, or lab tests today, they have been reviewed by your doctor. We will contact you at once if other important findings are noted after further review by our staff. If you do not continue to improve or if your condition worsens, please call your doctor or the emergency department right away so you can be examined.

I acknowledge receipt of these instructions. I understand that my condition may require more care and will arrange for further treatment as recommended.

RN
Staff Signature

Scottie D. Floyd
Patient or Representative Signature

Friday, May 09, 2003 - 01:33 AM

Betty Joe Floyd

(MCMC-777 - Front)
(Revised 5/15/02)

Marion County Medical Center
Emergency Department Record

FLOYD, SCOTTIE

SCHMITT, RI V00000126B00
WC 05/10/03

Date 05-10-03 Arrival Time _____ Triage Time 0921
Pt. Name Scottie Floyd Age 27 Race W (M) F
Ht. 5'9 Wt. 181 (lbs) kgs Last TD < 5 or > 5
LMP N/A G ___ P ___ A ___ Immunizations UTD / NUTD
Chief Complaint: Pediatric, Flu, Pneumonia
HA Onset 5.9.03 and then
not improved. Seen in ER
Then past for same complaint.

Source of Info: ☑ Pt. ☐ Family ☐ Other _____

ER Dr. Schmitt
Family Dr. ____
O / C Dr. Campbell
Mode of Arrival ☑ Car ☐ EMS ☐ Police ☐ Other _____
Tx PTA ☐ None ☐ EMS
___ IV ___ O2 ___ Wound
___ Splint ___ Monitor ___ ACLS
___ Spinal Immobilization
Visual acuity
OD ___ OS ___ OU ___ TD ___ Lot ___ Ex ___
FSBS ___ Triage Meds Tylenol ___ mg ___
None Motrin ___ mg ___

VITALS
T 98.3 (O) R / A / T P 78 R 20 BP 115/66
O2 Sat 97% (RA) O2 ___ L

PAIN ASSESSMENT: See Wong Baker Scale
☐ None ☑ Yes
Intensity 12/12 Relief ____
Cause ____ Type: ☐ Dull ☑ Sharp ☐ Pressure
Duration ____ ☐ Radiating ☐ Throbbing

ALLERGIES: ☑ None ☐ PCN ☐ ASA ☐ Sulfa ☐ Latex ☐ IVP Dye ☐ Seafood
Other: ____

MED HISTORY

Med / Dose	Med / Dose
Keppra 250mg 1 BID	Clonazepam 1mg 1 BID
Prilosec 40mg q day	
Vicodin 5/500 q 6hrs	
Pax 1 CR 25mg 1 BID	
Ambien CR 12.5mg 1 BID	

MEDICAL HISTORY
☐ Cardiac ☐ Cancer
☐ HTN ☐ CVA
☐ Diabetes ☐ Seizure
☐ Kidney ☐ Asthma
☐ Other

☑ Smoker 2 pks / day
☐ ETOH Use ☒
☐ TB Screen ____ CXR ____ PPD
☐ Abuse Screen Y N ☐ Help Offered Y N
Difficulty Swallowing Y N Slurred Speech Y N

PREVIOUS HOSPITALIZATIONS:
Rt hemiparesis Brain Surgery 2001
Part. Blind Rt Eye

Triage Nurse Alfredia Moore

ADDITIONAL ORDERS / MEDICATIONS:

☐ OLD RECORDS

1240

☐ MSE Done ☐ Refused ☐ Emerg Care ☐ Non-Emerg.

TSB 0940 H & P MS 10mg IM 10cc 1pm Phenergan 25mg

1240

NHA
NAR

D / C Instructions:

Condition on D/C: ☐ Improved ☑ Stable ☐ Unstable ☐ Deceased

Rx: Vicodin 10mg (#50) W/E / S/E Follow-Up: Dr. Healy 2d.

Provisional Dx: Typical Exac. of Chronic Cephalgia Signature: R. Schmitt

Dictated by # ☐ See Addendum T sheet ☒

LABS ORDERED
Time ____
☐ EKG ☐ Cardiac
☐ ABG ☐ Trauma
☐ CBC ☐ PT
☐ BMP ☐ PTT
☐ Lanoxin ☐ CK/MB
☐ Serum Pregnancy
☐ FSBS
☐ Hemocult
☐ Dilantin
☐ U / A
☐ UC / S ☐ UCG
☐ Bld cl ☐ Wet Prep
☐ Pulse Ox ☐ GC / Chlamydia
☐ Troponin

X-RAYS ORDERED
Time ____
☐ Chest ☐ CT Head
☐ Abd ☐ CT Abd
☐ C-Spine ☐ CT Pelvis
☐ L-Spine ☐ Pelvic U/S
☐ Skull
☐ Hip R L
☐ Femoral R L
☐ Pelvis
☐ Ribs R L
☐ Ankle R L
☐ Foot R L
☐ Shoulder R L
☐ ___ R L
☐ Wrist R L
☐ Knee R L

1031

ASSESSMENT

LOC
Alert ✓
Oriented ✓
Confused
Drowsy
Arousable
Unresponsive
Smiling / Playful

BEHAVIOR
Appropriate ✓
Agitated
Flat
Depressed
Anxious
Crying

SKIN
Warm ✓
Dry ✓
Pale
Flushed
Cyanotic
Moist
Cool

RESPIRATORY
R L
Clear
Rales
Wheezing
Decreased
Rhonci
Nasal Flaring
Retractions
Cough
Prod
Nonprod

CIRCULATION
Pulse Weak
Strong
Regular
Irregular
Cap Refill

ABDOMEN
B$ Present
Distended

TX / PROCEDURES
☐ ID Band
☐ Call Button
☐ SR ↑ x 2
☐ O_2 ____ L via ____
☐ EKG
☐ NG / OG ____ F
☐ Foley ____ F
☐ I / O Cath
☐ ETT ____ # ____
☐ FSBS
☐ Monitor
____ Rhythm
☐ Dressing / Splint

TIME	MEDS	ROUTE	RELIEF	INITIALS	IV	MEDS ADDED	SIZE / SITE	INITIALS	SITE @ D / C
1000	Morphine 10mg	IM		[illegible]					
1000	Phenergan 25mg	IM		[illegible]					

NSG NOTES TTR am / pm Room #

0935 - To Exam 4 Am RCTO HA - 10/10 Can Ocular
0940 Pt Admit in to Supt [illegible]
1000 IM meds Given [illegible]
1415 Pt states pain 8/10 non-[illegible] [illegible]
Meds
1420 RIC Given and understood pt left ER
Ambulating c Coniture Stable pt left to take
Meds as directed - Flu & Family pt [illegible]

VITAL SIGNS

Time		T	P	R	B / P	O_2 SAT	PAIN LEVEL

Coroner Notified ☐ Y ☐ N SCOPA Notified ☐ Y ☐ No Body to:

D / C DISPOSITION
Time 1021
☐ Home ____ epic given ____ Verb. Understand
☐ AMA ☐ LBA ☐ LBTC
☐ Admit Room ____ Report to ____ Time ____
☐ Transfer ____ Report to ____ Time ____
VS on D / C T ____ P ____ R ____ B / P ____
Pain Level on D / C ____ D / C by [signature]
Mode of D / C ☐ AMB ☐ EMS ☐ W / C ☐ Carried

VALUABLES
☐ Not Inventoried ☐ Glasses
☐ Bracelet ☐ Dentures
☐ Necklace ☐ Earrings
☐ Watch ☐ Rings
☐ Wallet ____ Amt ☐ Purse
☐ ID ☐ Keys
☐ Clothes 1032
With Whom / Where: [illegible]

© 2000 T-System, Inc. Circle or check affirmatives, backslash (\) negatives.

26

Marion County Medical Center

EMERGENCY PHYSICIAN RECORD

Headache (5)

FLOYD, SCOTTIE 27

SCHMITT RI SC V00000126800
WC 05/10/03

TIME SEEN: 0940 ROOM: 4 __ EMS Arrival

HISTORIAN: __patient __spouse __paramedics __

__HX / __EXAM LIMITED BY:

HPI

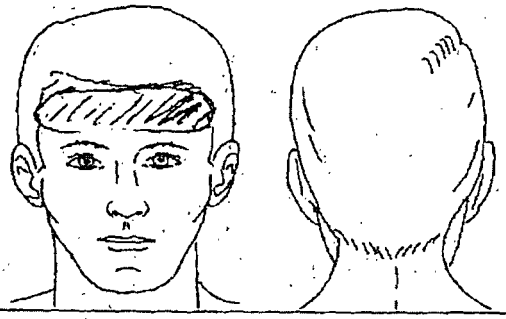
chief complaint: (headache) facial pain fever *migraine hx*

started: Gradual onset since about yesterday

time course:
__abrupt / (gradual onset)
__still present __better
__gone now
lasted
__*intermittent episodes lasting*
__*worse/persistent since*

quality:
(similar to previous headaches)
"pain"
tightness
throbbing
sharp

location:



associated symptoms:
__preceding symptoms
visual disturbance scotoma
typical of prior aura(s)
(light bothers eyes)
__blurred vision
__nausea
__vomiting
__power loss R/L arm/leg
__tingling/numb sensation

severity:
maximum
mild moderate (severe) relieved by OTC meds
when seen in ED
gone mild moderate (severe)

__Similar symptoms previously Daily 4/52

Recently seen/treated by doctor Seen yesterday ED 5 Dr. Joseph Kelly

ROS

CONST
__fever
subjective / to ___ F
__muscle aches

ENT
__sore throat
__sinus pressure/drainage

For new, gradual-onset HA
__CO exposure
__tick bite(s)
__head injury

PULMONARY & CVS
__chest pain
__cough
__sputum
__trouble breathing

GI and GU
__abdominal pain
__diarrhea
__pain on urination

Skin & Lymphatic & MS
__skin rash / swelling
__back pain

(all systems neg except as marked)

PAST HISTORY __negative

(chronic headaches)
occasional frequent "migraine"
mild moderate severe
__high blood pressure
__sinus problems

__cancer history
__immunosuppressed
__glaucoma
__diabetes *insulin / oral / diet*
__asthma
__+HIV / AIDS

__other problems
Rx of Jugular damage c
PE thrombosis

Medications __none (see nurses note
__ASA __NSAID __acetaminophen
new meds

Allergies (NKDA
__see nurses note

SOCIAL HX (smoker) drugs
alcohol *(recent / heavy / occasional)*

FAMILY HX cerebral aneurysm migraine headaches
__stroke __HTN

1033

☑ Nursing Assessment Reviewed ☑ BP, HR, RR, Temp reviewed

PHYSICAL EXAM Alert Anxious
Distress: NAD mild ✓moderate severe
Angry appearing male demanding meds.

HEENT
__nml ENT inspection
✓pharynx nml
__purulent nasal discharge
__tender temporal artery
__pharyngeal erythema
__tonsillar exudate
__pain on percussion over sinuses
__abnormal TM
__pale conjunctivae
__narrow angle (ant. chambers)
Rt. facial droop.

Refuses fundi exam on Rt (L) is nl.

NECK
✓nml inspection
✓supple
__thyromegaly
__lymphadenopathy (R / L)
__stiff neck / meningismus

RESPIRATORY
✓no resp. distress
✓breath sounds nml
__wheezing
__rales

CVS
✓reg. rate & rhythm
✓heart sounds nml
__heart murmur
__tachycardia / bradycardia
__decreased pulse(s)

ABDOMEN
✓non-tender
✓no organomegaly
__tenderness
__hepatomegaly / splenomegaly / mass

SKIN
✓color nml, no rash
__warm, dry, nml palp.
__cyanosis / diaphoresis / pallor
__skin rash

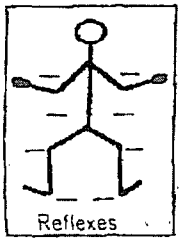
EXTREMITIES
✓non-tender
✓normal ROM
✓no pedal edema
__pedal edema
__calf tenderness

NEURO / PSYCH
higher functions
✓alert
✓oriented x3
__mood / affect nml
__slow / confused / no response to commands
__disoriented
to: time / place / person
angry (apparently chronic).

cranial nerves-
__normal as tested
__pupils equal, round, and reactive
__EOM palsy
__unequal pupils
R pupil ___mm L pupil ___mm
__facial palsy
__tongue deviation (to R / L)
__facial numbness
__abnormal fundi / papilledema / wide cups

cerebellar-
__normal as tested
__abnormal Romberg test
__abnormal finger-nose-finger
__abnormal gait

sensorimotor-
__no motor deficit
__no sensory deficit
__weakness Rt. sided.
__pronator drift (RUE / LUE)
__sensory loss
__abnormal reflexes



LABS, XRAYS, and PROGRESS

CBC		Chemistries	UA
normal except		*normal except*	*normal except*
WBC	segs	Na	WBC
Hgb	bands	K	RBC's
Hct	lymphs	Cl	bacteria
Platelets	monos	CO2	dip
	eos	Gluc	
		BUN	
		Creat	

LP __discussed risks, benefits, alternatives; patient consents
__(R / L) sitting open press. = ___
__betadine prep fluid color ___ RBC ___ WBC ___
__sterile technique glucose ___ polys ___ lymph ___
__L3-4 protein ___ monos ___ gm stn ___
__L4-5

Head CT __nml

CXR ☐ Interp. by me ☐ Reviewed by me ☐ Discsd w/radiologist
__nml/NAD __no infiltrates __nml heart size __nml mediastinum
not / changed from:

Time ___ __unchanged __improved __re-examined
__pain relieved __pain almost fully relieved

pt. c typical cephalgia. probable migraine constellation. All neuro findings are chronic. No new changes or focal findings.
Pt. upset trying to get a head CT but he has not on call and advised to come to ED.
MS 10mg/phenergan 25mg IM
Toradol 30mg

☐ Discussed with Dr. ___
will see patient in: office / ED / hospital
✓ Counseled patient / family regarding:
lab results diagnosis need for follow-up
✓ Rx given __Admit orders written

__CRIT CARE 30-74 min ___
75-104 min ___ min
__Prior records ordered
__Additional history from:
family caretaker paramedics

CLINICAL IMPRESSION:

Headache
acute severe hemiplegic
vascular migraine cluster
Vomiting / Dehydration
Meningitis
Intracranial Hemorrhage
Subarachnoid Hemorrhage
Sinusitis
Viral Cephalgia

DISPOSITION- ☑ home ☐ admitted ☐ transferred
CONDITION- ☐ unchanged ☑ improved ☑ stable

PHYSICIAN SIGNATURE R. Schmidt (F)

MARION COUNTY MEDICAL CENTER-EMERGENCY DEPARTMENT
2829 E Highway 76--PO Drawer 1150--Marion, SC 29571--(843)431-2150

INSTRUCTIONS FOR << FLOYD, SCOTTIE >>

Our doctors and staff appreciate your choosing us for your emergency medical care needs. Read these aftercare instructions carefully. Please call us if you have any questions about your medical problem. We are here to serve you.

NONSPECIFIC HEADACHE:

Your exam shows your headache does not have any specific cause. Headaches are caused by many different things including stress, tension, infections, and high blood pressure. Rarely headaches may be due to bleeding and tumors in the brain. Although your headache does not seem to have a serious cause, it is very important that you see your doctor for further evaluation if it is severe or does not get better in 1-2 days.

Headache treatment includes medicines for pain like ibuprofen. Rest, cold or hot packs on painful areas of the head and neck, and massage of the sore muscles may help. Call your doctor or return here right away if you have any of the following symptoms:

* A high fever, chills, or repeated vomiting.
* Passing out, difficulty with vision, unusual numbness or weakness.
* Severe pain despite medicine, confusion, or stiffness in the neck.

PRESCRIPTIONS:

Fill all the prescriptions ordered by your doctor and take them as directed. Generic medicines are as good as brand names, and often less expensive.

* If you have been given an antibiotic, be sure to take all of it.
* Keep your drugs out of the reach of children, in a cool, dry, dark place.
* Don't give your medicine to other people or use it for other illnesses.
* Stop your medicine and call us right away if you have drug allergy symptoms or bad side-effects. Call also if you vomit or cannot swallow the medicine.
* Bring your medicines with you any time you go to emergency for treatment.

Ask your doctor or pharmacist about drug or food interactions that may be important to know about when taking your prescription or herbal medicines.

NARCOTIC PAIN MEDICINE:

You have been prescribed a narcotic for pain relief. These drugs are usually combined with acetaminophen (Tylenol#3, Percocet, Darvocet, Anexsia, Vicodin) or aspirin (Empirin#3, Percodan, Synalgos-DC) for increased effect. Narcotics act on the central nervous system to reduce pain; they also impair mental alertness and physical abilities. We advise you not to drink alcohol, drive a car, or operate dangerous equipment when you are taking one of these drugs. Long term use of narcotic pain medications may be habit-forming.

You can lessen stomach irritation from your medicine by taking it with meals or a full glass of water. Common side effects of narcotics are: nausea and vomiting, heartburn, constipation, dizziness, sleepiness, and mood changes. If you have bothersome side effects or symptoms of an allergic reaction (itching, hives, rash), stop taking your medicine and call your doctor or the emergency room right away. Please keep your narcotic medicine well out of the reach of children.

ANTIEMETIC INJECTION:

You have been given an injection of medicine to help control nausea and vomiting. Examples of these medicines include: Compazine, P[illegible], Reglan,

Tigan, Torecan, and Vistaril. This medicine will make you drowsy, so you should stay in bed for the next 6 hours, and avoid driving or operating any dangerous equipment for the next 24 hours. You must also avoid drinking any alcohol until you are completely better. Please call your doctor or the emergency room right away if you have any of the following symptoms:

* Severe dehydration or continued vomiting unrelieved by your medicine.
* Allergy symptoms (itching, rash, hives, breathing problems).
* Unusual muscle spasms, especially around the neck or jaw.

ADDITIONAL INSTRUCTIONS:
TAKE MEDS AS DIRECTED
FOLLOW UP WITH FAMILY DOCTOR

FOLLOW-UP CARE:
Your physician today has been DR. RICHARD SCHMITT

For follow-up care you have been referred to the following doctor or clinic:

TREADWELL CAMPBELL Phone: (842)431-9882
MEDICAL PARK #1 HWY 76, MARION,SC 29571

Please make an appointment for further treatment as needed or in _____ days. Tell your referral doctor or clinic that we have sent you, and bring your medicines and instructions to the office. If you had x-rays, an EKG, or lab tests today, they have been reviewed by your doctor. We will contact you at once if other important findings are noted after further review by our staff. If you do not continue to improve or if your condition worsens, please call your doctor or the emergency department right away so you can be examined.

I acknowledge receipt of these instructions. I understand that my condition may require more care and will arrange for further treatment as recommended.

C F/N/D RN — Staff Signature

Scottie Floyd — Patient or Representative Signature

Saturday, May 10, 2003 - 10:09 AM

(MCMC-777 - Front)
(Revised 5/15/02)

Marion County Medical Center
Emergency Department Record

FLOYD, SCOTTIE 27
SC V0000012758
SCHMITT, RI
WC 05/14/03

Date 5/14/03 Arrival Time 2345 Triage Time 2345
Pt. Name Scottie W. Loyd Age 27 Race W (M) F
Ht. ____ Wt. ____ lbs. / kgs Last TD < 5 or > 5
LMP ____ G ____ P ____ A ____ Immunizations UTD / NUTD
Chief Complaint: Pediatric, Flu, Pneumonia
C/O Headache - Old head injury

Source of Info: ☑ Pt. ☐ Family ☐ Other ____

ER Dr. Schmitt
Family Dr. ____
O / C Dr. Gunner IV
Mode of Arrival ☐ Car ☐ EMS ☐ Police ☐ Other ____
Tx PTA ☐ None ☐ EMS ____ IV ____ O₂ ____ Wound
____ Splint ____ Monitor ____ ACLS
____ Spinal Immobilization

Visual acuity
OD ____ OS ____ OU ____ TD ____ Lot ____ Ex ____
FSBS ____ Triage Meds Tylenol ____ mg ____
Motrin ____ mg ____

VITALS
T 99.6 (O) R / A / T P 83 R 20 BP 134/77
O₂ Sat ____ RA / O₂ ____ L

PAIN ASSESSMENT: See Wong Baker Scale
☐ None ☐ Yes
Intensity ____ Relief ____
Cause ____ Type: ☐ Dull ☐ Sharp ☐ Pressure
Duration ____ ☐ Radiating ☐ Throbbing

ALLERGIES: ☒ None ☐ PCN ☐ ASA ☐ Sulfa ☐ Latex ☐ IVP Dye ☐ Seafood
Other: ____

MED HISTORY

Med / Dose	Med / Dose
Hydrocodone - 5/500 mg PRN	
~~Codeine~~ Xanax	

MEDICAL HISTORY
☐ Cardiac ☐ Cancer ☑ Smoker 2 3 PPD pks / day
☐ HTN ☐ CVA ☐ ETOH Use
☐ Diabetes ☐ Seizure ☐ TB Screen ____ CXR ____ PPD
☐ Kidney ☐ Asthma ☐ Abuse Screen Y N ☐ Help Offered Y N
☑ Other Headaches Difficulty Swallowing Y N Slurred Speech Y N

PREVIOUS HOSPITALIZATIONS:

Triage Nurse Dianne Lucy RN

ADDITIONAL ORDERS / MEDICATIONS: ☐ OLD RECORDS

☐ MSE Done ☐ Refused ☐ Emerg Care ☐ Non-Emerg.

TSBD | H & P

Morphine 10mg IM 0045 RC
Phenergan 25mg IM 0045 RC
Vicodin to go pack RC
1810

Pt needs to F/u w/ neurologist
RTER if S/S worse

LABS ORDERED
Time ____
☐ EKG ☐ Cardiac
☐ ABG ☐ Trauma
☐ CBC ☐ PT
☐ BMP ☐ PTT
☐ Lanoxin ☐ CK/MB
☐ Serum Pregnancy
☐ FSBS
☐ Hemoculi
☐ Dilantin
☐ U/A
☐ UC / S ☐ UCG
☐ Bld cl ☐ Wet Prep
☐ Pulse Ox ☐ GC /
☐ Troponin Chlamydia

X-RAYS ORDERED
Time ____
☐ Chest ☐ CT Head
☐ Abd ☐ CT Abd
☐ C-Spine ☐ CT Pelvis
☐ L-Spine ☐ Pelvic U/S
☐ Skull
☐ Hip R L
☐ Femoral R L
☐ Pelvis
☐ Ribs R L
☐ Ankle R L
☐ Foot R L
☐ Shoulder R L
R L
☐ Wrist R L
1037 R L

D / C Instructions:

Condition on D/C: ☐ Improved ☑ Stable ☐ Unstable ☐ Deceased

Rx: 2 W/E / S/E

Provisional Dx: Cephalgia

Dictated by ____ #

Follow Up: Healy Neurologist in Corydon

Signature: Dianne Schmitt

☐ See Addendum T sheet ☑

ASSESSMENT

LOC
Alert
Oriented ✓
Confused
Drowsy
Arousable
Unresponsive
Smiling / Playful

BEHAVIOR
Appropriate ✓
Agitated
Flat
Depressed
Anxious
Crying

SKIN
Warm ✓
Dry ✓
Pale
Flushed
Cyanotic
Moist
Cool

RESPIRATORY
R L
Clear
Rales
Wheezing
Decreased
Rhonci
Nasal Flaring
Retractions
Cough
Prod
Nonprod

CIRCULATION
Weak
Strong
Regular ✓
Irregular
p Refill <2sec

ABDOMEN
Present
tended

TX / PROCEDURES
D Hand
Call Button
:R ↑ x 2
L via
KG
IG / OG F
oley F
/ O Cath
IT #
SBS
oniter
Rhythm
essing/ Splint

TIME	MEDS	ROUTE	RELIEF	INITIALS	IV	MEDS ADDED	SIZE / SITE	INITIALS	SITE @ D / C
0043	Phenergan 25m	IM							
0045	morphine 10m	IM	10/10	3/15					

NSG NOTES TTR am / pm Room #

2355 - Ambulated to FTH3 - Diana Dwyer
0010 Exam per A. Smith PA-C. Ae
0045 Phenergan 25mg IM Gluteal - Ae
0045 Morphine 10mg IM Gluteal - Ae
0045 Nausea relieved. Pain ↓ manageable. Dr Schmidt in to talk c pt & family.
0120 Epic instruction to pt c verbal understanding. Rx c Epic & Rx to car. Discharge instructions reviewed. Ae

VITAL SIGNS

Time	T	P	R	B / P	O_2 SAT	PAIN LEVEL

Coroner Notified ☐ Y ☐ N SCOPA Notified ☐ Y ☐ No Body to:

D / C DISPOSITION Time 0115
☑ Home ✓ epic given ✓ Verb. Understand
☐ AMA ☐ LBA ☐ LBTC
☐ Admit Room ____ Report to ____ Time ____
☐ Transfer ____ Report to ____ Time ____
VS on D / C T____ P____ R____ B / P____
Pain Level on D / C ____ D / C by ____
Mode of D / C ☒ AMB ☐ EMS ☐ W / C ☐ Carried

VALUABLES
☐ Not Inventoried
☐ Bracelet
☐ Necklace
☐ Watch
☐ Wallet ____ Amt
☐ ID
☐ Glasses
☐ Dentures
☐ Earrings
☐ Rings
☐ Purse
☐ Keys
☐ Clothes
With Whom / Where:

1038

FLOYD, SCOTTIE 27
SC V00000127581
SCHMITT, RI
WC 05/14/03

© 2000 T-System, Inc. Circle or check affirmatives, backslash (/) negatives.

26

Marion County Medical Center

EMERGENCY PHYSICIAN RECORD

Headache (5)

TIME SEEN: 1210A ROOM: 3 __ EMS Arrival

HISTORIAN: (patient) __spouse __paramedics

__HX / __EXAM LIMITED BY:

HPI

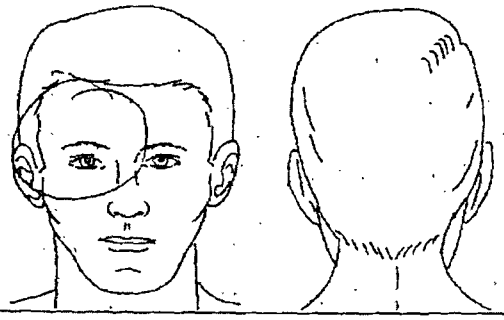
chief complaint: (headache) facial pain fever *migraine hx*

started:

time course:
__abrupt / (gradual onset)
__still present __better
__gone now
lasted
__*intermittent episodes lasting*
__*worse/persistent since*

quality:
similar to previous headaches
"pain"
tightness
throbbing
sharp

location:



associated symptoms:
(preceding symptoms)
visual disturbance scotoma
typical of prior aura(s)
(nausea)
__vomiting
__power loss R/L arm/leg
__tingling/numb sensation
(light bothers eyes)
__blurred vision

severity:
maximum
mild moderate severe relieved by OTC meds
when seen in ED
gone mild moderate severe

__Similar symptoms previously
seen last pm in ER

__Recently seen/treated by doctor
Neurologist for chronic Headache

Neuro.

ROS

CONST
__fever
subjective / to ____ °F
__muscle aches

ENT
__sore throat
__sinus pressure/drainage

For new, gradual-onset HA:
__CO exposure
__tick bite(s)
__head injury

PULMONARY & CVS
__chest pain
__cough
__sputum
__trouble breathing

GI and GU
__abdominal pain
__diarrhea
__pain on urination

Skin & Lymphatic & MS
__skin rash / swelling
__back pain

☐ all systems neg. except as marked

pt very talkative
knows what he wants
+ need.

PAST HISTORY

__negative

__chronic headaches
occasional frequent "migraine"
mild moderate severe
__high blood pressure
__sinus problems
__other problems
head injury
Chronic Headaches

__cancer history
__immunosuppressed
__glaucoma
__diabetes: *insulin / oral / diet*
__asthma
__+HIV / AIDS

Medications __none (see nurses note)
__ASA __NSAID __acetaminophen

Allergies __NKDA
__see nurses note

SOCIAL HX

(smoker) drugs
alcohol *(recent / heavy / occasional)*

FAMILY HX

__cerebral aneurysm __migraine headaches
__stroke __HTN

☑ Nursing Assessment Reviewed ☑ BP, HR, RR, Temp reviewed

PHYSICAL EXAM ✓Alert __Anxious

Distress: ✓NAD __mild __moderate __severe

HEENT
- ✓nml ENT inspection
- ✓pharynx nml
- __purulent nasal discharge
- __tender temporal artery
- __pharyngeal erythema
- __tonsillar exudate
- __pain on percussion over sinuses
- __abnormal TM
- __pale conjunctivae
- __narrow angle (ant. chambers)

NECK
- ✓nml inspection
- ✓supple
- __thyromegaly
- __lymphadenopathy (R / L)
- __stiff neck / meningismus

RESPIRATORY
- ✓no resp. distress
- ✓breath sounds nml
- __wheezing
- __rales

CVS
- ✓reg. rate & rhythm
- ✓heart sounds nml
- __heart murmur
- __tachycardia / bradycardia
- __decreased pulse(s)

ABDOMEN
- ✓non-tender
- ✓no organomegaly
- __tenderness
- __hepatomegaly / splenomegaly / mass

SKIN
- ✓color nml, no rash
- ✓warm, dry, nml palp.
- __cyanosis / diaphoresis / pallor
- __skin rash

EXTREMITIES
- ✓non-tender
- ✓normal ROM
- ✓no pedal edema
- __pedal edema
- __calf tenderness

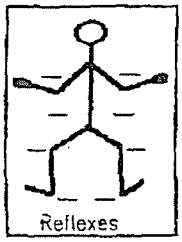
NEURO / PSYCH

higher functions
- ✓alert
- ✓oriented x3
- ✓mood / affect nml
- __slow / confused / no response to commands
- __disoriented to: *time / place / person*

cranial nerves-
- ✓normal as tested
- ✓pupils equal, round, and reactive
- __EOM palsy
- __unequal pupils — R pupil ___mm L pupil ___mm
- __facial palsy
- __tongue deviation (to R / L)
- __facial numbness
- __abnormal fundi / papilledema / wide cups

cerebellar-
- ✓normal as tested
- __abnormal Romberg test
- __abnormal finger-nose-finger
- __abnormal gait

sensorimotor-
- ✓no motor deficit
- ✓no sensory deficit
- __weakness
- __pronator drift (RUE / LUE)
- __sensory loss
- __abnormal reflexes



LABS, XRAYS, and PROGRESS

CBC		Chemistries	UA
normal except		*normal except*	*normal except*
WBC	segs	Na	WBC
Hgb	bands	K	RBC's
Hct	lymphs	Cl	bacteria
Platelets	monos	CO2	drip
	eos	Gluc	
		BUN	
		Creat	

LP __discussed risks, benefits, alternatives; patient consents

__(R / L) sitting — open press.=
__betadine prep — fluid color — RBC — WBC
__sterile technique — glucose — polys — lymph
__L3-4 — protein — monos — gm stn
__L4-5

Head CT __*nml*

CXR ☐ Interp. by me ☐ Reviewed by me ☐ Discsd w/radiologist
__*nml/NAD* __*no infiltrates* __*nml heart size* __*nml mediastinum*
not / changed from:

*Time*_____ __unchanged __improved __re-examined
__pain relieved __pain almost fully relieved

Morphine 10 mg IM
Phenergan 25 mg IM
Vicodin #30 po prn
Flu Rx Healy
Return in 3 days

☐ Discussed with Dr._____ CRIT CARE- *30-74 min* ____ *75-104 min* ____ *min*
will see patient in: office / ED / hospital
☐ Counseled patient / family regarding: ☐ Prior records ordered
lab results diagnosis need for follow-up
☐ Rx given ☐ Admit orders written ☐ Additional history from: *family caretaker paramedics*

CLINICAL IMPRESSION:

Headache	Intracranial Hemorrhage
acute severe hemiplegic	Subarachnoid Hemorrhage
vascular migraine cluster	Sinusitis
Vomiting / Dehydration	Viral Cephalgia
Meningitis	

DISPOSITION- ☑ home ☐ admitted ☐ transferred
CONDITION- ☐ unchanged ☑ improved ☐ stable

PHYSICIAN SIGNATURE- Thomas Schmitt

(MCMC-777 - Front)
(Revised 5/15/02)

Marion County Medical Center
Emergency Department Record

1400

FLOYD (SCOTTIE) 28

SC
NGUYEN, MAI V00000184322
WC 04/09/04

Date 4/9/04 Arrival Time 1318 Triage Time 1318
Pt. Name Floyd, Scotty Age 28 Race W (M)/F
Ht. unable to Wt. obtain lbs. Kgs. Last TD < 5 yr N/A 5
LMP NA G ___ P ___ A ___ Immunizations UTD / NTD
Chief Complaint: Pediatric, Flu, Pneumonia NA
40 new onset seizures 4hrs p.m.
Restless

Source of Info: ☐ Pt. ☒ Family ☐ Other

ER Dr.
Family Dr. Healy
O / C Dr.
Mode of Arrival ☐ Car ☑ EMS ☐ Police ☐ Other
Tx PTA ☐ None ☐ EMS ✓ IV ✓ O_2 ___ Wound
___ Splint ___ Monitor ___ ACLS
___ Spinal Immobilization

Visual acuity
OD ___ OS ___ OU ___ TD ___ Lot ___ Ex ___
FSBS ___ NA . Triage Tylenol ___ mg ___
Meds Motrin ___ mg ___

VITALS
T 99.2 O / R / A / T P 132 R 28 BP 138/76
O_2 Sat ___ RA / O_2 ___ L

PAIN ASSESSMENT: See Wong Baker Scale
☒ None ☐ Yes
Intensity ___ Relief ___
Cause ___ Type: ☐ Dull ☐ Sharp ☐ Pressure
Duration ___ ☐ Radiating ☐ Throbbing

ALLERGIES: ☒ None ☐ PCN ☐ ASA ☐ Sulfa ☐ Latex ☐ IVP Dye ☐ Seafood
Other: Coconut

MED HISTORY

Med / Dose	Med / Dose
See attached list	

MEDICAL HISTORY Brain injury 7 mo ago.
☐ Cardiac ☐ Cancer ☐ Smoker ___ pks / day
☐ HTN ☐ CVA ☐ ETOH Use
☐ Diabetes ☐ Seizure ☐ TB Screen ___ CXR ___ PPD
☐ Kidney ☐ Asthma ☐ Abuse Screen Y N ☐ Help Offered Y N
☐ Other Difficulty Swallowing Y N Slurred Speech Y N

PREVIOUS HOSPITALIZATIONS: 431
345.90.
342.90

Triage Nurse Nettie I Lowrimore RN.

ADDITIONAL ORDERS / MEDICATIONS: 907.0 E929.0 E849.5 288.8 305.20 ☐ OLD RECORDS

☐ MSE Done ☐ Refused ☐ Emerg Care ☐ Non-Emerg.

FSBD

H & P #1 LP @ 1350 1310.
Foley catheter Finger stick Bld chart
Ativan 2mg IV @ 1327 > 18 mg/dl @ 1327
Ativan 1mg IV @ 1335
Ativan 2mg IV - RC 1350
Ativan 2mg IVP Q15 min PRN Agitation. Repeat dose if necessary.
Ativan 1mg IV 1415
Ativan 1mg IV 1434
Repeat CXR ? intubation
Lidocaine 100mg IVP - 1500 Etomidate 20mg IV
Succinylcholine 100mg IV - 1504 1508 US
Rocephin 2g IV 1555 Cerebyx 1g IV 1556 ETT 1505
Vecuronium 10mg IV - 1530
Versed 5mg IV / hour - 1625 RC #20 R fa 1525
Depacon 2660 ~~1050~~ mg IV #20 R fa 1545
#10 Ota 1600

D/C Instructions:

Condition on D/C: ☐ Improved ☐ Stable ☐ Unstable ☐ Deceased

W/E / S/E Follow Up:

Provisional Dx: ICH, Seizure Signature:

Dictated by # ☐ See Addendum T sheet ☐

LABS ORDERED
Time ___
☐ EKG ☐ Cardiac
☒ ABG ☐ Trauma
☒ CBC ☐ PT
☒ BMP ☐ PTT
☐ Lanoxin ☐ CK/MB
☐ Serum Pregnancy
☐ FSBS
☐ Hemoccult
☐ Dilantin
☐ UA ☐ UCG
☐ UC/S ☐ Preg
☐ Blood ☐ Wet Prep
☐ Pulse Ox ☐ GC / Chlamydia
☐ Troponin

X-RAYS ORDERED
Time
☐ Chest ☒ CT Head
☐ Abd ☐ CT Abd
☐ C-Spine ☐ CT Pelvis
☐ L-Spine ☐ Pelvic U/S
☐ Skull
☐ Hip R L
☐ Femoral R L
☐ Pelvis
☐ Ribs R L
☐ Ankle R L
☐ Foot R L
☐ Shoulder R L
☐ Elbow R L
☐ Wrist R
☐ Knee R

104

1471

348

ASSESSMENT	TIME	MEDS	ROUTE	RELIEF	INITIALS	IV	MEDS ADDED	SIZE / SITE	INITIALS	SITE
LOC										
Alert combative										
Oriented										
Confused										
Drowsy										
Arousable										
Unresponsive										
Smiling / Playful										
BEHAVIOR										
Appropriate										
Agitated ✓										
Flat										
Depressed										
Anxious										
Crying										
SKIN										
Warm ✓										
Dry										
Pale										
Flushed										
Cyanotic										
Moist ✓										
Cool										
RESPIRATORY										
R L										
Clear										
Rales										
Wheezing										
Decreased										
Rhonci										
Nasal Flaring										
Retractions										
Cough										
Prod										
Nonprod										
CIRCULATION										
Pulse Weak										
Strong ✓										
Regular ✓										
Irregular										
Cap Refill										
ABDOMEN										
BS Present										
Distended										

NSG NOTES TTR 138 am / pm Room # CH 1

1338- Received to CH1 via stretcher by MCEMS. Pt. had seizure activity PTA. IV started (L) hand MCEMS. A&Ox3 @ RN bed. Pt was incont. of bowel & bladder. RC

1340- Seizure activity noted. Dr. Nguyen in room. Medication given RC

1342- Ativan 2 mg IVP given slowly. Seizure activity stopped RC

1347- Pt moving arms up toward head. no shaking noted. FSBS performed. 181 mg/dl RC

1350- Ativan 1 mg IVP given for restlessness RC

1340- Lab in to draw blood. RC, RN

1350 Heft Forgeath inserted by Earl Floyd ordered Ativan 2 mg IVP given for restlessness RC

1400- To X-ray dept for CT of head. Pt's arms still up head RC

1415- Ativan 1 mg IVP given for restlessness. Pt. still CT performed RC

1430- To X-ray room for CXR RC

1436- Returned to room. Cond unchanged. no seizure activity noted. 1 mg Ativan IVP ordered by Dr. Nguyen for restlessness RC

1434- Ativan 1 mg IVP given. NOA in pt status HR 137 bpm RC, RN

1445 Dr. Nguyen received CT report. Orders for admit to

VITAL SIGNS

Time	T	P	R	B / P	O_2 SAT	PAIN LEVEL

TX / PROCEDURES

- ☑ ID Band
- ☐ Call Button
- ☐ SR ↑ x 2
- ☐ O_2 ____ L via ____
- ☐ EKG
- ☐ NG / OG ____ F
- ☐ Foley ____ F
- ☐ I / O Cath
- ☐ ETT ____ #
- ☐ PSBS
- ☑ Monitor
- S. Tachy Rhythm
- ☐ Dressing / Splint

Coroner Notified ☐ Y ☐ N SCOPA Notified ☐ Y ☐ No Body to:

D / C DISPOSITION Time 1055

- ☐ Home ____ epic given ____ Verb. Understand
- ☐ AMA ☐ LBA ☐ LBTC
- ☐ Admit Room ____ Report to ____ Time ____
- ☑ Transfer Cardiology Report to Tim Bradham RN Time 1103
- VS on D / C T 98 P 99 R vent B / P 121/81
- Pain Level on D / C unknown D / C by ____
- Mode of D / C ☐ AMB ☑ EMS ☐ W / C ☐ Carried

VALUABLES

- ☐ Not Inventoried
- ☐ Bracelet
- ☐ Necklace
- ☐ Watch
- ☐ Wallet ____ Amt.
- ☐ ID
- ☐ Glasses
- ☐ Dentures
- ☐ Earrings
- ☐ Rings
- ☐ Purse
- ☐ Keys
- ☐ Clothes

With Whom / Where:

1042

MARION COUNTY
MEDICAL CENTER

(MCMC-13 – Front)

FLOYD, SCOTTIE 28
I
SC
NGUYEN, MAI V00000184322
SP 04/09/04

NURSES PROGRESS NOTES

DATE	TIME	Record: Admission, Pertinent Observations, Treatment and Discharge (Sign All Entries)
9/04	(cont.)	Intubation Ordered. → Robin Cannon RN
	1450	Dr. Nguyen talking c pt.'s mother. Mother informed. RSRN
	1500	Lidocaine 100mg IVP given by Judy Small RN. RSRN
	1502	Etomidate 20mg IVP given by Judy Small RN. RSRN
	1504	Succinylcholine 100mg IVP given by Judy Small, RN RSRN
	1505	#8.0 ETT inserted by Dr. Nguyen. Pt. tolerated c difficulty Placed on ventilator by resp. therapist. RSRN
	1520	Pt cleared. had small foul smelling bm. Gown placed on pt. RSRN
	1525	#20g IVI inserted (R) FA by J. Small RN KN
	1530	Vecuronium 10mg IVP given slowly. RSRN
	1535	Pt resting easily. No restlessness noted RSRN
	1538	Cerbyx 1gm IVPB started @ 100 cc/hr c/w pt. as per infusion Chart. NS@TKO RSRN
	1545	#20g IVI inserted (L) hand by Judy Small RN. Flushes easily RSRN
	1555	Rocephin 2gm IVPB started by Judy Small RN. Pt resting c agitation - Vent set by resp. Rocephin in @ Fa KSRN
	1558	Critical labs PT 22.4 INR 1.88, PTT 107.3 - read back by Emily

© 2000 T-System, Inc. Circle or check affirmatives, backslash (\) negatives.

FLOYD, SCOTTIE 28

SC
NGUYEN, MAI V00000184322
SP 04/09/04

49 Marion County Medical Center

EMERGENCY PHYSICIAN RECORD
Seizure (5)

TIME SEEN:_____ ROOM:_____ EMS Arrival

HISTORIAN: __patient __spouse __paramedics Hx by MD Rec + EMS

__HX / __EXAM LIMITED BY: _____

HPI

chief complaint: seizure ~~x1~~ ~~x2~~ x3 multiple 5 times today
hx of seizure disorder

occurred: __just prior to arrival _____

witnessed? __no Yes, by: EMS.

Pt has no family MD.
Followed by Dr Healy

character of seizure(s):

__lost consciousness
unresponsive
- completely partially unknown
did not regain between seizures

__motor activity
- generalized "shaking all over"
shaking in one area:

other:

__bowel incontinence
urinary incontinence
__stopped breathing
__lost pulse
__unknown

number and duration:

__unknown duration / number
__single isolated seizure
- duration:

__repeated seizures
- x2 x3 x4 multiple

__status epilepticus
__continued on arrival in ED
pt pop ictalin ER

post-ictal symptoms:

__none
confusion
__lost power/feeling
- arm / leg R / L

__speech difficulty
__visual disturbance
__headache

injury: head neck nose lip mouth bit tongue
chest abdomen back RUE RLE LUE LLE none
Ø known injury recently

preceding symptoms / cause of seizure: __none
__missed recent doses of seizure meds
__changed medication or dosage
__recent alcohol intake
__sleep deprivation
__recent illness / see ROS

Recently seen/treated by doctor

ROS

NEURO
__headache
__recent head injury None

CVS & PULMONARY
__chest pain
__palpitations
__cough
sputum
__trouble breathing

CONST
__fever
EYES & ENT
__trouble with vision
__sore throat
GI & GU
__abdominal pain
__nausea / vomiting
__diarrhea
__black/bloody stools
__painful / frequent urination
SKIN & LYMPH & MS
__skin rash / swelling
__joint pain

☐ all systems negative except as marked

PAST HISTORY __negative

__previous seizure / seizure disorder
recent onset / long-standing / since childhood
occasional / frequent / none for years last seizure:
2° to: idiopathic / head injury / prior stroke / ethanol abuse / cancer
craniotomy / cysticercosis / unsure

__stroke
__craniotomy

__HIV / AIDS
__brain tumor / cancer
known mets
__heart disease
__high blood pressure
__diabetes / insulin / oral / diet
__psychiatric disorder

__other problems
Pt had "brain surgery" 2001 for injury? Residual blindness (R) eye & (R) hemiparesis

Medications __none ✓see nurses note
__phenytoin
__phenobarbital
__carbamazepine
__valproic acid

Allergies __NKDA
see nurses note
"Coconut"

SOCIAL HX smoker drugs
alcohol (recent / heavy / occasional)

FAMILY HX

MARION COUNTY
MEDICAL CENTER

MCMC-13 – Back)

FLOYD, SCOTTIE 28

NGUYEN, MAI SC V000001R4322
SP 04/09/04

NURSES PROGRESS NOTES

DATE	TIME	Record: Admission, Pertinent Observations, Treatment and Discharge (Sign All Entries)
		Peggy Watson, lab tech done - Dr. Nguyen notified of labs RSW
9-04	1600	#20 g IM started in (L) fa by Judy Small, RN. - RSW
	1605	Depacon 1250 mg IV gtt. @ 113 cc/hr. infusing into (L) forearm - difficulty RSW
	1615	Pharmacist Bob called for Versed gtt. RSW
	1625	Versed gtt. 5mL/hr. infusing into (R) hand - difficulty RSW
	1630	Versed gtt. stopped. Pharmacist Bob states gtt. need not Versed in it. RSW
	1640	Versed resumed @ 5ml/hr per MD gtt. - Report to Tw Blackmon, RN @ CHS complete. EMS here to transport RSW
'04	1645	Cerebyx complete. Rocephin complete. SW ices were emptied RSW
	1655	From ER via stretcher to CHS ER via MICEMS Cond. stable RC, RN

RC, RN = Rum Cousins

Melissa D. Lawrence, RN

☐ Nursing Assessment Reviewed ☑ BP, HR, RR, Temp reviewed

PHYSICAL EXAM *Rx PTA-* __IV ✓

~~Distress~~ __NAD __Alert __convulsing ✓confused (post-ictal)

HEENT
__nml ENT inspection
✓no apparent trauma
__pharynx nml

__scleral icterus / pale conjunctivae
__nasal septal hematoma
__tongue abrasion / laceration
__hemotympanum
__TM obscured by cerumen (R/L)
__tenderness/swelling/ecchymosis
Dilated pupils ~~fixed~~ Reactive

NECK/BACK
✓neck supple
✓non-tender

__cerv. lymphadenopathy (R / L)
__meningismus
__vertebral tenderness
__carotid bruit

RESPIRATORY
__no resp. distress
__breath sounds nml

__rales
__rhonchi
__wheezing
Tachypneic.

CVS
__regular rate, rhythm
__heart sounds nml

__tachycardia / bradycardia
__irregularly irregular rhythm
__extrasystoles (occasional / frequent)
__murmur grade ___/6 sys / dias
__decreased pulse(s)

ABDOMEN
✓non-tender
✓no organomegaly

__tenderness
__hepatomegaly / splenomegaly

SKIN
__color nml, no rash
__warm, dry

__cyanosis / diaphoresis / pallor
skin rash petechiae from chest up.

EXTREMITIES
__non-tender
__normal ROM
__no pedal edema

✓pedal edema
__tenderness

OBSERVED SEIZURE ACTIVITY IN ED: ____ duration ____
focal / generalized awake / unresponsive
head turned R / L eyes deviated R / L

NEURO/PSYCH
higher functions
__alert
__oriented x3
__mood/affect nml

__slow / confused / combative
__disoriented to *time/place / person*
__aphasic *expressive / receptive*

cranial nerves-
__normal as tested
__pupils equal, round & reactive to light

__facial droop (R / L)
__tongue deviation (to R / L)
__abnormal accommodation
__pupils unequal
R pupil ___mm L pupil ___mm
__EOM palsy
__abnml fundi *papilledema / hemorrhages*
moving all 4 extrem.

cerebellar-
__normal as tested

__abnml Romberg / gait / finger-nose test
unable to test

sensorimotor-
__no motor deficit
__no sensory deficit
__reflexes nml, symmetrical

__weakness
__sensory deficit
__hyperreflexia / hyporeflexia
__abnormal reflexes / Babinski

izure-49

LABS, XRAYS, and PROGRESS

EKG MONITOR STRIP __NSR __Rate

EKG __NML ☐ Interp. by me ☐ Reviewed by me Rate
__NSR __nml intervals __nml axis __nml QRS __nml S/T
not / changed from:

CXR ☐ Interp. by me ☐ Reviewed by me ☐ Discuss w/radiologist
__nml/NAD __no infiltrates __nml heart size __nml mediastinum
not / changed from:

CBC
normal except
WBC 24
Hgb
Hct
Platelets

segs
bands
lymphs
monos
eos

Chemistries
normal except
Na
K
Cl
GO2

Gluc
BUN
Creat

Drug Levels
dilantin
phenobarb
tegretol

Toxicology
normal
neg except
acetamin

Aspirin ETOH
Triage® urine drug screen

Head CT __nml Old change Occipital Lobe

Pulse Ox ____% on RA / __L ____% at (time) 1 L/Nc

Time ____ __unchanged __improved __re-examined bleed

EMS gave 5 mg IV Valium. In ER, pt receives a total of 9 mg Ativan. Pt still agitated. Pt intubated for airway protection for transport for TCH. Pt's family insist on transfer to Carolinas Hospital. Spoke to Dr Kerst Dr Braga, Dr Gandy. Pt on Versed drip, Cerebyx drip and Depacon drip. Pt had a total of 6 seizures at home and 1 seizure in ER.
ABG on 60% O2/TV 700/RR 14
7.25 / 31 / 244

Discussed with Dr. ____ CRIT CARE: 30-74 min
will see patient in: office / ED / hospital 75-104 min ____ min
☐ Counseled patient / family regarding: ☐ Prior records ordered
lab results diagnosis need for follow-up ☐ Additional history from
☐ Rx given ☐ Admit orders written family consultant homemedics

CLINICAL IMPRESSION:

Seizure New-Onset Epileptic Status Epilepticus
Generalized Focal Grand Mal
Cardiac Dysrhythmia
Cerebrovascular Accident
Intracranial hemorrhage

DISPOSITION- ~~HOME~~ ☐ home ☐ admitted ☑ transferred to Carolinas
CONDITION- ☐ unchanged ☐ improved ☐ stable

PHYSICIAN SIGNATURE- A Guy

Marion County Medical Center

OUTPATIENT RECORD

DISCHARGE DATE | TIME

PATIENT I.D. NO. V00000184322	MED. RECORD NO. M000041364		NURSING STATION/ ROOM NO. / RATE
ADMISSION DATE 04/09/04	SERVICE CODE REG ER	ADMISSION TIME 1320	PHY. NGUYEN, MAI

PATIENT NAME: Last FLOYD, First SCOTTIE Middle Sex M

DATE OF BIRTH	AGE 28	RACE CA	RELIGION BAPTIST / SMOKING
MARITAL STATUS S	SS#	BIRTHPLACE / COUNTY	FINANCIAL CLASS SP

STREET 1 | STREET 2 | COUNTY

CITY | STATE | ZIP | TEL.

EMERGENCY CONTACT NAME: Last FLOYD, First BETTY M.I.

RELATION MO | Street | City

STATE SC ZIP CODE 29571 | TEL

PATIENT EMPLOYER Name KEN BAKER | TELEPHONE (843) 423-4836

EMPLOYER'S ADDRESS Street HWY 501 | City MARION | State SC | Zip 29571

NEAREST RELATIVE- FLOYD, BETTYJOE 05/09/03 | REL. ADDRESS: MARION, SC 29571

ADMITTING DR.: NGUYEN, MAI | REFERRING DR.:

ADMITTING DX.: WEAKNESS

CAUSE OF ADMIN: | ARRIVAL MODES: | DATE OF ONSET- 04/09/04

RESPONSIBLE PARTY NAME Last FLOYD, First SCOTTIE M.I.

STREET 1 | STREET 2

CITY | STATE SC | ZIP 29571 | TEL. (843)

RELATION TO PATIENT SP

	CARRIER 1	CARRIER 2	CARRIER 3
CARRIER NAME	SELF PAY INSURANCE		
CARRIER NO.			
PLAN NO.	1	2	
POLICY NO.			
GROUP INSURANCE			
GROUP MEMBER NAME	FLOYD, SCOTTIE		
LAST			
FIRST			
MIDDLE			
RELATIONSHIP			
BASIC DEDUCTIBLE			
ROOM BENEFITS			
MISC. BENEFITS			
VERIFIED BY			
PHONE NO.			
MAIL CLAIM TO:			

REMARKS:
1. COURTESY DISCHARGE? Y
2. CONSENT FORM SIGNED? N
3. PRIVACY NOTICE GIVEN? Y
DATE NOTICE GIVEN 05/09/2003

MEDICAL RECORDS

MARION COUNTY MEDICAL CENTER
EMERGENCY ROOM RECORD

[Floyd], Scottie VISIT # 184322

DATE OF SERVICE: 04/09/2004

CHIEF COMPLAINT: SEIZURE

HISTORY OF PRESENT ILLNESS: The patient is a 28-year-old white male who was brought by EMS for seizure at home. Patient has had a total of 5 seizures prior to arrival to the emergency department. Seizure was witnessed by EMS which was generalized tonic clonic. Patient received 5 mg Valium en route. In the emergency department the patient appears to be agitated and had 1 more episode of seizure with right-sided gaze deviation. The patient lives with his mother and has had traumatic brain injury in 2001 with surgery to his brain at that time. Patient has had a seizure disorder since the accident in 2001. He is taking Keppra and Tegretol.

MEDICATIONS: Multiple. Please see nursing note.

ALLERGIES: Coconut.

PAST MEDICAL HISTORY: Significant for prior brain injury in 2001 with residual blindness to right eye and right hemiparesis.

REVIEW OF SYSTEMS: Positive for incontinence, confusion, and seizure. Otherwise, there is no recent head injury, no fever, no chills per his mother. The rest of the review of systems is negative.

PHYSICAL EXAM:

VITAL SIGNS: Afebrile rectally. Heart rate 134, regular. Blood pressure stable.
APPEARANCE: Patient is a well-nourished male, appears to be combative and agitated on the bed.
HEENT: There is no apparent head trauma noted. There is no scleral icterus. Pupils are dilated, but briskly reactive bilaterally.
NECK: No midline tenderness. No meningismus. No cervical lymphadenopathy.
LUNGS: Patient is tachypneic, otherwise no rhonchi or wheezing noted.
HEART: Tachycardia.
ABDOMEN: Soft. Nontender.
SKIN: There is petechia from the chest up. Otherwise, no cyanosis, no diaphoresis, no other rash noted.
EXTREMITIES: No pedal edema noted.
NEUROLOGIC: Patient is combative and confused at this point. Cranial nerves: Patient is moving all 4 extremities. Otherwise, cranial nerves unable to be tested.

DIAGNOSTIC TESTING: White count 34 with left shift.

(continued)

MARION COUNTY MEDICAL CENTER
EMERGENCY ROOM RECORD

ED COURSE/MEDICAL DECISION MAKING: Patient was sedated with a total of 9 mg Ativan in the emergency department for his seizure. Patient had a head CT scan done in the emergency department and CAT scan as read by Dr. Max as subacute left posterior subdural 1 x 4 cm without any shift or evidence of hydrocephalus. Chest x-ray showed no evidence of infiltrate. Patient is subtherapeutic on his anticonvulsive medication. Patient was intubated in the ER by me for airway protection since the patient is going to be transferred to a tertiary facility for his intracranial bleed. Patient was given lidocaine, etomidate, succinylcholine for his intubation. Patient was intubated on first attempt with a 0.0 ET tube. Post intubation chest x-ray showed ET tube in place. Patient was also loaded with 1 gm Dilantin in the emergency department at 18 mg/kg. I spoke to Dr. Kent, who is covering for Dr. Healy who is the patient's neurologist, and Dr. Kent suggested giving the patient Depacon 18 mg/kg here in the emergency department. Patient was also given Rocephin 2 gm for his white count of 34,000. Patient was also started on a Versed drip for transport. I also spoke to Dr. James Brendon, who is the neurosurgeon at Carolinas Hospital, and also the ER physician at Carolinas Hospital was notified of the patient's transfer.

DIAGNOSIS:

1) Intracranial bleed.
2) Status epilepticus.
3) Leukocytosis.

Nguyen

Mai Nguyen, MD

DD: 04/09/2004
DT: 18:57
04/11/2004 00:09/EST/1433/1423b
Job #: 1387

MARION COUNTY MEDICAL CENTER
2829 E. Hwy 76, P.O Box 1150
Marion, SC 29571

Patient: FLOYD.SCOTTIE

Birthdate:
MR#: M000041364
Location: ER ( )
Visit #: V00000184322
Dept #: X000033798
Exam Date: 04/09/04

DIAGNOSTIC IMAGING REPORT

Primary Dr: JOSEPH R HEALY, MD
Ordering Dr: MAI T NGUYEN MD

CHIEF COMPLAINT: SEIZURE

PORTABLE CHEST:

Evaluation in a single frontal supine portable projection reveals the endotracheal tube in good position approximately 3.0 cm above the carina. The lung fields are clear. The heart, mediastinum and osseous structures are normal.

IMPRESSION:

1. ENDOTRACHEAL TUBE IN GOOD POSITION.
2. GROSSLY CLEAR LUNG FIELDS.

***** Preliminary report if not electronically signed by radiologist *****

ARTURO E MACASINAG MD
Dictating Radiologist

Dict date: 04/09/04
Trans by: AGASQUE
Trans date/time: 04/09/04 1615
Printed date/time: 4/9/04 4:44 PM

Signed Status
Patient Location's copy

MARION COUNTY MEDICAL CENTER
2829 E. Hwy 76, P.O Box 1150
Marion, SC 29571

Patient: FLOYD,SCOTTIE

Birthdate:

DIAGNOSTIC IMAGING REPORT

MR#: M000041364
Location: ER ( )
Visit #: V00000184322
Dept #: X000033798
Exam Date: 04/09/04

Primary Dr: JOSEPH R HEALY, MD
Ordering Dr: MAI T NGUYEN MD

CHIEF COMPLAINT: SEIZURE

(NO CONTRAST)

EXAM #: 3127
DISK #: 29B

CT OF THE HEAD:

Multiple sections were obtained in the axial plane without contrast enhancement. Abnormal extra-axial fluid collection is seen in the left cerebellar region, consistent with acute or subacute subdural hematoma. The exact duration or onset is unclear. Clinical correlation is suggested. Residual encephalomalacia is noted in the right frontal lobe, consistent with previous surgery as noted by clinical history. No evidence of acute infarction, hemorrhage or mass is seen. The remainder of the brain parenchyma, ventricles, cisterns and calvarium are normal.

IMPRESSION:

1. ABNORMAL EXTRA-AXIAL FLUID COLLECTION IN THE LEFT CEREBELLAR REGION, CONSISTENT WITH ACUTE OR SUBACUTE SUBDURAL HEMATOMA.
2. FOCAL ENCEPHALOMALACIA IN THE RIGHT FRONTAL LOBE, CONSISTENT WITH PREVIOUS SURGERY AS NOTED BY CLINICAL HISTORY.

PORTABLE CHEST:

A single frontal projection reveals the lung fields to be clear. The heart, mediastinum and osseous structures are normal.

IMPRESSION:

1. NEGATIVE STUDY.

***** Preliminary report if not electronically signed by radiologist *****

Demacosin MD

Signed Status
Patient Location's copy

ARTURO E MACASINAG MD
Dictating Radiologist

Dict date: 04/09/04
Trans by: AGASQUE
Trans date/time: 04/09/04 1447
Printed date/time: 4/9/04 4:41 PM

Signed Status
Patient Location's copy

MARION MEDICAL GROUP

1115 N. Main Street, Marion, South Carolina 29571

NAME: Callie Hazel

DATE & IMPRESSION	HISTORY & PHYSICAL	TREATMENT
9/18/01 KS	TEMP_____ PULSE _____ RESP_____ WT. _____ BP._____ Working on car & piece of car fell on face 9/13/01 - Rec'd since that afternoon - given Morphine IM ER - & Vicoprofen po by RA - Rec'd since accident - Lac of forhead sutures removed & complete lid subconjunctival hemorrhage & pupillary d's EOM I & neuro. deficit Raccoon eyes - & orbital tenderness still slight headache & dizziness F/U Thurs. Vicodin 750 #20	RETURN APPOINTMENT

MARION MEDICAL GROUP

1115 N. Main Street, Marion, South Carolina 29571

NAME: Sgt Scott Floyd

DATE & IMPRESSION	HISTORY & PHYSICAL	TREATMENT
7-20-01 KS	TEMP_____ PULSE _____ RESP_____ WT. 157 BP. 110/80 Follow-up-on accident see note 9-18 little a & progression of Sx & neuro sx still has mild vertigo will F/C a Tue. & work until F/C	RETURN APPOINTMENT Tues

MARION MEDICAL GROUP
1115 N. Main Street, Marion, South Carolina 29571

NAME: Scott Floyd

DATE & IMPRESSION | HISTORY & PHYSICAL | TREATMENT

9-25-01
KS

RETURN APPOINTMENT

TEMP_____ PULSE _____ RESP_____ WT. 151 BP. 110/78

FH- Felt like he was going to pass out Sunday - broke out in a cold sweat - Hasn't had episode like that since Sunday

Pt presents today for F/U ? concussion. Pt says he broke out in a cold sweat + had N/V on Sun. (9/23). He vomited ? a meal @ lunchtime + then had cold sweats later that pm. He has had ¢ other episodes since then. Pt admits to feelings of dizziness intermittently.

PE
Neuro - ⊕ nystagmus, pain ō eye movements + focussing/accomodation, CN 2-12 intact
Head - NC - raccoon eyes still present ; subconjunctival hemorrhages noted. Laceration on his right nose + ⊕ forehead areas have healed nicely. Eyes - PERRL, EOMI, ⊕ nystagmus, pain ō eye movements, significant subconj. hemorrhages ⊕ still present -
Neck - FRom, supple, ¢ JVD, ¢ lymph
Chest - CTAB⊕
CV - RRR, ¢ m/r/g, ¢ edema, 2+ peripheral pulses x 4 ext's.
MS - 5/5 strength, good ROM in all ext's.
General - 26 yo WM presenting in no acute distress. Skin - warm/dry.

A/P 1) ? concussion syndrome - pt. is to cont. Vioxx 25mg ¡ prn. ↓ inform us if sx get worse ¢ further testing indicated due to lack of neuro dx's. D/C naproxen per pt. Pt. believes this med to have caused his N/V episode.

- Gave pt. light duty order to return to work 9/26. WM re ✓ pt. in wk.

Began Tobra Pt-S.J.
J. Wallace

1055

MARION MEDICAL GROUP
1115 N. Main Street, Marion, South Carolina 29571

NAME: Scott Floyd

DATE & IMPRESSION	HISTORY & PHYSICAL	TREATMENT
10-02-01 SS	TEMP 98.4 PULSE 78 RESP 12 WT. ____ BP. 112/74 C/O. Severe Headache - Started Sat. Can't sleep or eat States "Vicks not working" S: Severe headache - as above Worsen if lies down & tries to go to sleep. O: EOMI, PERRLA Alert oriented Vision intact A/P: Severe Headache S/P - Head injury - CXR done in ER No CT Fioricet #20 Will return Thurs to recheck	RETURN APPOINTMENT Thurs

1056

MARION MEDICAL GROUP
1115 N. Main Street, Marion, South Carolina 29571

NAME: Scott Floyd

DATE & IMPRESSION	HISTORY & PHYSICAL	TREATMENT
10-04-01	TEMP____ PULSE____ RESP____ WT.____ BP. 127/70	RETURN APPOINTMENT
KS	W/C - Follow-up - States Headache a lot better pt better H.A. now behind ® eye only dentures resolving ↓ n/v/p subconjunctival hemorrhage 50% better ↓ visual Δ's neuro - stable pt concerned H.A. - injury pt ↓ work	
	P92 BP 116/70	
3/15/01	Gallacy head coping - has dull h/a Vision better - ↓ blurry	

S: Feeling better, c/o of dull intermittent H/A behind ® eye to his ® neck area. Still ⊕ photophobia, ↓ visual Δ's. ↓ N/V/↑ ↓ BP/BP, ↓ hematoma.

O: PERRLA
OTA®
neuro - ~~Angry~~. Pain in ® eye ↑ direct light. ~~PERRLA~~ CN 2-12 intact
MS - good strength x 4 extr.
HEENT - TM's clear. Eyes - nystagmus, EOMI, PERRLA - Subconjunctival hemorrhage almost completely.

A/P: ↓ concussive H/A - resolving.
Ekg ↓ ...

1057

MARION MEDICAL GROUP
1115 N. Main Street, Marion, South Carolina 29571

NAME: Scott Floyd

DATE & IMPRESSION	HISTORY & PHYSICAL	TREATMENT
1-19-01		RETURN APPOINTMENT
ICS	TEMP_____ PULSE _____ RESP_____ WT. 166 BP. 120/80	

f/u post concussion (?)
feeling better
still has dull H.A.
dizziness resolved
working OK
pt released w restrictions

PEARLA
& neuro deficit
affect appropriate
on & off table easily
& motor weakness
A&O x 4

A: post concussion H.A.
P: release & RTW w restrictions
F/C if H.A. worsen
discussed head injury precautions
use NSAIDS PRN H.A.

MARION MEDICAL GROUP
1115 N. Main Street, Marion, South Carolina 29571

NAME: Scott Floyd

DATE & IMPRESSION	HISTORY & PHYSICAL	TREATMENT
2-05-01 KS	TEMP____ PULSE ____ RESP____ WT. 159½ BP. 108/80	RETURN APPOINTMENT

C/O- unable to eat/sleep/unable to focus on job

Something is wrong with the cartilage in my nose deviated

CC. Anxiety kicking- can't sleep for 7-8 days could be longer. mind will not stop, can't concentrate. Constipation has set in

This happen 3-4 years ago. Anxiety Attacks They gave me something like Xanax.
all I want to do is sleep.
All this started after Accident at work where an axel fell on his head

O. Scott is a 2 days wm in NAD but seems very Anxious. Jittery moving around in chair unable to sit still.

HEENT perrla, EOMI, Nasal septum Deviated to Rt obsuring passage Lt open no exudate
op pink moist, cobblestone Appearance
neck soft supple ~ Adenopathy
chest - CTA all fields ~ (W)
RRR - RRR

A/P ① Deviated septum
② Anxiety ? PTSD - Zoloft 50 mg
Take ½ Tab for first week THE ↑ has QD

F/U 1 month

Timothy S Odell PA

1059

MARION MEDICAL GROUP
1115 N. Main Street, Marion, South Carolina 29571

NAME: Scott Floyd

DATE & IMPRESSION	HISTORY & PHYSICAL	TREATMENT
1-08-02		RETURN APPOINTMENT
K	TEMP_____ PULSE _____ RESP_____ WT. _____ BP: 130/80	

Severe HA

5x assoc. c headinjury 9-13.

see office note

pt has been bad to ER

he appears very anxious & present states something has to be done

unable to visualize fundus- pt refused

neck- supple

neuro - non-focal

PEARLA

50 Benerol

50 Phenergan

IM

A: post concussive H.A.

P: Benerol 50 / phenergan 50 IM, mother c pt c c of head L. McIntyre LPN for Dr. Vega

pt somewhat threatening - discussed c mother - he has been smoking marijuana lately & other drugs may need mental health eval.

1060

WV Jan Heath

MARION COUNTY MEDICAL CENTER
2829 E. Hwy 76, P.O Box 1150
Marion, SC 29571

Patient: FLOYD,SCOTTIE

Birthdate:

DIAGNOSTIC IMAGING REPORT

MR#: M000041364
Location: CT

Admitting Dr:
Ordering Dr: ROBERT G VYGE MD

Dept #: X000033798
Exam Date: 01/09/02

(ORDER SIGNED BY KEITH STEWART, PA-C)

CHIEF COMPLAINT: HIT IN HEAD TWO MONTHS AGO, SEVERE HEADACHES

(Omnipaque 300/75mL)

CRANIAL COMPUTED TOMOGRAPHY:

Multiple sections were obtained in the axial plane without and with contrast enhancement. The history of head trauma two months prior to this procedure is duly noted. A non-enhancing focus of low attenuation is seen in the right frontal region. It appears intraparenchymal rather than subdural in location. The pattern is more consistent with an infarct. No hemorrhage or mass lesion is seen. No abnormal extra-axial or intra-ventricular fluid collection is demonstrated. The remaining brain parenchyma, ventricles, cisterns and calvarium are normal.

IMPRESSION:

1. NON-ENHANCING FOCUS OF INTRAPARENCHYMAL LOW ATTENUATION IN THE LEFT FRONTAL REGION AS DESCRIBED ABOVE.
2. APPEARANCE CONSISTENT WITH AN INFARCT.
3. WITH THE GIVEN CLINICAL HISTORY AND THE PATIENT'S AGE, ATYPICAL POST-TRAUMATIC FLUID COLLECTION CANNOT BE EXCLUDED.
4. NO HEMORRHAGE OR MASS LESION.

***** Preliminary report if not electronically signed <signature on file> by radiologist*****

<<Signature on File>>
Dictating Radiologist: _____
ARTURO E MACASINAG MD

Dict date: 01/09/02
Trans by: AMARLOWE
Trans date/time: 01/09/02 1607

Neuro. eval.

Signed Status

JAN 10 200

MARION MEDICAL GROUP
1115 N. Main Street, Marion, South Carolina 29571

NAME: Scottie Hoyle

DATE & IMPRESSION	HISTORY & PHYSICAL	TREATMENT
		RETURN APPOINTMENT
	TEMP_____ PULSE _____ RESP_____WT. _____BP._____	
P-02		
	appt. Dr. Joseph Healy. Jan 15th 12:00 N Carolina's Hosp. Suit A-130- Dare's Riddick - W/C case manager - notified 919-875-0972 - needs clericals fax - 919-875-0890 MCo/K. Stewart CWS-48 - Tylenol #50 1 or 2 q 4h prn x 3	888-879-8494 ext 4009 Dr. 873-7475 2563
1/10/02 KS	Follow up W/C - H.A. - nasal pain → above Rx given sensitive abn. CT of head - RO infarct appt. c Dr Healy - 1-15 for eval.	Dr Healy Heather 1/14/02 prev 11 9:45
	- Nasal pain - edema of turbinates with tenderness c nasonex RQ	
	- Anxiety - pt very anxious / angry (+) family Hx of suicide pt wired / easily frustrated refer to mental health for eval. Mon. 9:45 Behind hospital	1062 Dr

McLeod
REGIONAL MEDICAL CENTER
555 East Cheves Street PO Box 100551
Florence, SC 29501-0551 (843) 777-2000

MEDICAL RECORDS ORIGINAL

Emergency Department

PATIENT NO.	PATIENT NAME	AGE	FC	DOB	REG DATE	REG TIME	MEDICAL RECORD NO.
101603116	FLOYD, SCOTTIE WAYNE	26	U		01/13/02	09:20	01-03-66-37

CONDITION ON ADMISSION: ☒ STABLE ☐ GUARDED ☐ CRITICAL
ER PHYS: 211128 REINHART, LARS
PRIV PHYS: 000000 SELF REFERRED
REL TO PT: M
BROUGHT BY: SELF CURRENT PH: NOTIFY: FLOYD, BETTY EMERGENCY PH: 843 423-4618

CHIEF COMPLAINT: HEADACHE/NAUSEA - Suicidal
CURRENT MEDICATIONS: Florect, Rhinocort
ALLERGIES: NKDA

LAST TETANUS	LMP	WT KG/LBS	TEMP ORAL/RECTAL	P	R	BP	RA/O2 SAT.	VISUAL ACUITY
			98.2	63	16	127/63	100 %	L R

TIME 1905 Pt between 2 sites SEVERITY 4 mo ago CONTEXT → CT time
HPI: Reports of H/A's + LOCATION Forhead. MODIFIERS Told had fluid on blood in brain DURATION 2 weeks ASSOCIATED Due TO Severe headache. Also QUALITY SUICIDAL CONSTIPTOMS TO ER & gun NAUSEA/VOMITING TIMING State will need medication Mom for ET.
(1920 Pt signed out @ 1920 dr. 13.02)
PMH: Depression, ↓ GI Anemia (chronic)
PSH: ↓ 3 PRBC; HX ETOH + Legs open
ROS: ↓ N/V, GE ↓ sleep
MDM:
PHYSICAL EXAM: Anal, Pacing, agitated um

HEAD		GI	S, NT, NB
EYES	anic L, PERRL	GU	
ENT		SKIN	Warm.
NECK	S	LYMPH	
RESP	C	NEURO	AAO, CN/M/S/C CS CNs
CARDIO	R	PSYCH	DAM qs TO self + others, agitated
MS	↓ C/C/T	CONST	

· MUSC Refused @ 2110.
· faxed to Bryan
· called Greenwood

1.42 | 108 | 9 | (WNL)
3.3 | 26 | 0.81

Psych TX; Neuro TX decided. Neuro will see Pt/c

Coltyg 6.5

Time Ordered	TREATMENTS	Nurse Initials	Time Done
	Haldol 5mg / Ativan 2mg >1M	Dne	1855
	KCL 20 mg PO / 2mg Ativan IVP	MMC	1920
	D #899		

5.8 | 15 | 44 | 1.65
X-RAY
CT REL abn Prebrain temporal

COMMUNICATIONS

PAGE TIME	MD	REPLY TIME
	D'Angelo	
1910	Lisa Campbell - ↓	

Time Ordered	ULTRASOUND	Time Entered
	Pelvic US	
	DX	
	RUQUS	
	DX	

☒ EMC Present ☐ EMC Absent
DIAGNOSIS #1: Psych, Danger to Self
DIAGNOSIS #2: ↓ TRAUMATIC HEAD Bleed Focal Fx
WORK EXCUSE:
DISCHARGE STATUS: ☐ IMPROVED ☐ UNCHANGED ☐ DECEASED ☐ YES ☐ NO
NO. OF DAYS
AFTER CARE INSTRUCTIONS FOR: ☐ HEAD INJURY ☐ CAST OR INJURED ☐ LACERATION REMOVE IN ___ DAYS ☐ STITCHES ☐ MEDICATION & DROWSINESS
SEPARATE SHEET GIVEN FOR: ☐ PEDIATRIC ☐ BURNS ☐ BACK CARE ☐ SEE BELOW ☐ COMPUTER DC INSTRUCTIONS GIVEN AND EXPLAINED
MUSC: 843-792-9888 → Page MD on Bryan:
Form faxed to private physician ☐
PHYSICIAN'S SIGNATURE _____ MD
DATE 1/13/02 TIME 1920 AM PM

The care you have received in the Emergency Department has been delivered on an emergency basis and must not be considered to be comprehensive medical care. I understand the instructions as given to me. Should I have any questions, I am to call (843)777-2027. For follow-up care you should: See Dr. _____ in ___ days.
PATIENT'S SIGNATURE: _____

DIAGNOSTICS

Time Ordered	Lab Test	Time Entered
	CBC	1045
1845	BMP	
	PT	
	PTT	
	Trop I	
	U/A	
	Urine C&S	
	U Preg	
	B-HCG (Quant)	
	Wet Prep	
	Chlamydia	
	GC	
	Blood CX I II	
	ABG	
	EKG	
	LFT's	
	Lipase	
	Amylase	
	Type/Screen	
	Type/Cross ___ U's PRBC	
	Other Labs	
1845	Coltyg 6	VOK

RADIOLOGY

Time Ordered	X-Ray CT	Time Entered
	CXR (PA/LAT)	
	CXR (Port)	
	Pelvis X-Ray	
	C-Spine Series	
	ABD Series	
1845	Head CT w/wo	1845
	DX	
	C-Spine CT	
	DX	
	ABD Pelvis CT w/wo	
	DX	
2045	NDS Staff	

Disposition	Time	Initials
Discharged Home		
TBA / EMRA		
Admit		
Room#		
MD Office		
Transfer (Y) N		
Corner		
Expired		
AMA		
LWBS (AMA)		
Other		

1063

Patient Hist / Data Base
Triage/Admission

McLeod Regional Medical Center — The Choice For Medical Excellence.

Pain/IV/INTERVENTIONS: EMER 101603116 01-03-66-37 01/13/02

26 M INT:____TIME:____

OH PMC PAC/FT 2 3 4 5

1 Pain 2 IV 3 Splint/Ace 4 Dressings [ ] Meds

Name: Floyd Scottie Age: 26 Date: 1-13-02 Triage Time: 920

Emergency Contact: _____ Phone Number: _____

Chief Complaint: Headache MD: Stewart

Brief Assessment: Alert - Antsy - NAD Masks

Pain Assessment: | | NA | X | Intensity 1 – 10 Scale 10 | | Sharp | | Achc | | Crushing

"10 X's worse than migraine"

Onset-Duration: 5 days Mode of Arrival: | | Ambulance | | W/C | X | Walk | | Carried

Health History	Pt	Fam		Pt	Fam
Diabetes			Infectious Dz.		
Hypertension			Sickle Cell		
CVA/TIA			Anemia/Bleeding		
GI Disorder			Kidney Dz.		
Cardiovascular Dz.			Psych. Disorders		
Pulmonary Dz.			Alcohol/Tobacco		NA
Seizures/Parkinsons			Illegal Drugs		NA
History of Abuse		NA	Sexually Transmit		NA
Pacemaker		NA	Immunizations:		
Cancer			Current		

Surgeries or Previous Hosp	Date
Injured Leg	4 months ago
Tonsillectomy	?

Cough Screen	Y	N
Cough > 2 Weeks (complete below)		
Hemoptysis		
Hx Pos PPD		
Fatigue / Weakness		
Fever		
Night Sweats		
Weight Loss		
Pt placed in isolation		
Time placed in isolation		

Allergies/ Reactions: Ø

Latex Allergy | | Y | X | N
Blood Transfusion | | Y | | N
Transfusion Reaction | | Y | X | N

Medications : None [ ] Listed Below [ ]

Name of Medication	Dose/Frequency	Date/Time of Last Dose	Name of Medication	Dose/Frequency	Date/Time of Last Dose
Fioricet	1 PO q 4°				
Rhinocort Aqua					

Did you bring your medication with you? Yes X No X Medication sent home with: (Name) _____

ER Vital Signs: Temp 98.6 Oral / Rectal P 63 R 16 BP 127/63 Sitting / Standing

Ht ____ [ ] Act [ ] Stated Wgt ____ [ ] Act [ ] Stated LMP ____ Pulse Ox 100% Visual Deficit L ____ R ____ Hearing Deficit L ____ R ____

Date of Last Tetanus: _____

Valuables [ ] Hearing Aid | | Cane/Crutches | | Purse/Wallet $ _____ / Credit Cards ____ | | Wheel Chair
[ ] Glasses/Contacts | | Dentures | | Clothes | | Jewelry | | Prosthesis | | X-Rays [ ] Walker

Description: Epic

[ ] Patient Locker [X] With Patient
[ ] Safe (Security) Officer's Name: _____ [X] Sent Home with (Name): _____
Patient / Family informed that hospital is not responsible for valuables. [X] Yes [ ] No

Are there any Religious/Cultural Practices that need to be part of your care? | | Yes | X | No (If yes document in Nurses Notes)
Are you in a relationship that could cause you to be afraid? | | Yes. | X | No

Signature

Signature

Seq. # 1923 Revised: 11/99; 1/00

ER NURSING ASSESSMENTS: Time: 10:05am Room Number: Uc89 [ ] LSB [ ] O2 [ ] C-Collar [ ] Splint _____

PHYSICAL ASSESSMENT

Respiratory	Circulatory	Neuro (GCS)		GI	GU
~~N/A~~	~~N/A~~	~~N/A~~	Verbal Response	N/A	~~N/A~~
Cough	Capillary Refill	V N 1.OC	5 Oriented	Vomiting	Flank Pain = L R
Prod Color:	Normal	Duration	4 Confused	Nausea	Diarrhea
Non Prod	Delayed	Unknown	3 Inappropriate Words	Diarrhea	Frequency
SOB	Heart Sounds	Weakness	2 Incomprehensible Sounds	Other	D/C Color
Normal	RRR	PERL	1 None	Bowel Sounds	GYN
Irregular	Irregular	HA 1 10	Motor Response	Absent	~~N/A~~
Shallow	Pain Scale 1 - 10	Eye Opening	6 Follows Commands	Present	Bleeding
Breath Sounds	Pulses	4 Spontaneous	5 Localizes Pain	Abdomen	# Pads in 1 hour
L R Clear	L R Radial	3 To Voice	4 Withdraws Pain	Soft	Discharge Color
L R Crackles	L R Pedal	2 To Pain	3 Flexes pain	Distended	G
L R Wheezing		1 None	2 Extends Pain	Guarding	P
L R Diminished			1 None	Rigid	A
Comments:	Comments:	Comments:		Tenderness	Pregnant / EDC
				Location:	FHT

SKIN/TRAUMA

~~N/A~~	Mucous Membranes
Warm	Moist
Cool	Dry
MAE	Trauma
Dry	~~N/A~~
Diaphoretic	Pain
Edema	Swelling
Absent	Deformity
Present	Numbness
Location:	Abrasion
Color	Laceration
Normal	Burn
Cyanotic	Confusion
Jaundice	Limited Movement
Ecchymosis	Location
Pale	Comments:
Mottled	
Redness	
Location	

PSYCHOSOCIAL/EDUCATION

Affect	
Normal	
Flat	
Behavior	
Cooperative	
Uncooperative	
Agitated	
Other	
Speech	
Normal	
Abnormal	
Support System	
Family/Significant Other	
Lives Alone	
Language Education	
Unable to read/write	
S/O can read/write	
Language other than English:	

FUNCTIONAL ASSESSMENT

ADL
Independent
Needs Assistance
Ambulation
Independent
Needs Assistance
Wheel Chair
Walker
Cane

PEDIATRIC ASSESSMENT

Birth
Full Term
Premature
Birth Weight
<5.5 # N/A
>5.5#

101603116 01-03-66-37 01/13/02
FLOYD, SCOTTIE WAYNE
26 M INT: TIME:

Time	Medication	Dose	Route/Site	Signature

Time	Temp	Pulse	Resp	B/P	Pulse Ox	Nurses Notes
10:05am						Asst complete Assess & Triage start PT
						Cooperative - but agitated. PT CO
						Discharge education & plan. States he
						Appointment w Dr Healy on Tues. Pain 7/4
						states "I need something but I'm
						pain". PT states 7/4 "I have the
						migraine". Tylenol @ bedside. PT states
						"I don't want to go to the ER I just
						want to listen me about my pain".
10:10						Security called - searched PT - found
						gun belt + also knife blades upon
						leaving. Many Security officers ——— so
10:20						Ready to DC 7 - Report to Alex Yarbrough RN

INTAKE/OUTPUT
Oral _____ NG _____
IV _____ Urine _____
Total _____

PATIENT OBSERVATION
Every 30 minutes
[ ] Yes [ ] No

DC STATUS
[ ] Good [ ] Improved [ ] Poor [ ] Deceased Admit Room No. _____
DC INSTRUCTIONS
[ ] Verbalized Understanding [ ] Computer D/C Instructions

cont 2nd page

Seq. # 1923 Revised: 11/99; 1/00

RAPID TRIAGE ASSESSMENT FORM

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

101603116 01-03-66-37 01/13/02
FLOYD ,SCOTTIE WAYNE
NAME LABEL 26 M INT:____ TIME:____

DATE: 1/13/02 TIME: 916
NAME: Scottie Floyd SEX: M
DOB: / / AGE: 26 SS#: c -

ZONE: ☐ MAIN ER ☑ URGENT CARE ☐ FAST TRACK
☐ WOMENS PAVILION ☐ OTHER:

☐ AIRWAY ☑ BREATHING ☑ CIRCULATION ☑ NO NEURO DEFICIT

PAIN 0 1 2 3 4 5 6 7 8 9 (10) ONSET: 8 days

PRIORITY LEVEL: [1 2] (3) 4 5

CHIEF COMPLAINT:
1. H/A - "middle of brain" ONSET: 8 days
2. nausea ONSET:
3. ONSET:

BRIEF ASSESSMENT: "concussion 4 months ago -" alert - oriented - states "fluid or blood building in brain" -

VITAL SIGNS: B/P / R
P 02 SAT
TEMP
DEFERRED ☑

TRIAGE RN: BRhoden

CARE ASSUMED BY:
(REQUIRED FOR LEVEL I OR II)

WHITE - ORIGINAL YELLOW - DIRECTOR PINK - REGISTRATION

7/2001

Ld

373130 1066

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

101603116 01-03-66-37 01/13/02
FLOYD ,SCOTTIE WAYNE
26 M INT:——TIME:——

NURSES' BEDSIDE RECORD

Page 2

DATE	HOUR	NOTES & TREATMENTS	SIGNATURE
	1050A	pt Medicated - Weather @ Bedside	
10/1/02 20-90	1125A	pt returned from CT - Calm & cooperative	
81/34-82	100p	pt resting quietly - No new c/o at this time	
18	210p	pt asleep - Door open	
	3:45pm	Family in room c pt. Wanting to smoke.	CEVANS RN
	3:52	Pt returned from smoking c Security.	CEVANS RN
	445	VS 110/62, 80, 20, 97.6. Pt ready to leave. Wants to go outside. Room door open.	CEVANS RN
	458	Security escorted pt out. Pt back in room	CEVANS RN
	510	Pee Dee Mental Health in c pt.	CEVANS RN
	600	Pt very agitated. Refused Ativan. Security @ door.	CEVANS RN
	620	Dr Lee in c pt. Pt agreed to take Ativan 2mg PO.	CEVANS RN
	624	Pt sitting on bed looking @ wall.	
	640	Pt eating. Family @ side.	CE... RN

Seq. #1185

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

101603116 01-03-66-37 01/13/02
FLOYD, SCOTTIE WAYNE
26 M INT:_____ TIME:_____

NURSES' BEDSIDE RECORD

Page 3

DATE	HOUR	NOTES & TREATMENTS	SIGNATURE
1-13-01	7[20] pm	VS 97, 20, 82, 119/62. Pt agreed to take Potassium 20mg. Med given. Pt cooperative @present. Very sleepy @present.	CEVANS RN
	845	Pt sleeping. Ø resp distress noted.	
	957	Pt opened eyes briefly. NAD Noted. Resp even unlabored.	CEVANS RN
	1030	VS 105/46, 60, 97.5, 18. Resp even unlabored. Pt cooperative.	CEVANS RN
	1120	Sleeping. NAD Noted. Report given to A Graham LPN -	CEVANS RN
	0300	Paper faxed to Bryan & report called. No bed available. Resting no S noted.	[illegible]
	0615	Breakfast tray ordered no evidence of c/o noted resting will awaken but goes back to sleep.	[illegible]
	700A	97.3 - 108/61 - 100 - 20 - Pt awakened - Calm cooperative - presents to smoke - Security aware - Pt Denies needs at 10-HR regular. Lungs clear -	

1068

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

101603116 01-03-66-37 01/13/02
FLOYD ,SCOTTIE WAYNE
26 M INT:_____TIME:_____

NURSES' BEDSIDE RECORD

DATE	HOUR	NOTES & TREATMENTS	SIGNATURE
	1220p	pt Medicated - report to 4/0 HD - pt Calmed & reassured	
	145p	pt accepted at 3 Livers - report given - pt leaving ambulatory & present. No new 4/0 Meds Calmitay given	

Seq. #1185

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

101603116 01-03-66-37 01/13/02
FLOYD ,SCOTTIE WAYNE
26 M PT:_____TIME:_____

NURSES' BEDSIDE RECORD

DATE	HOUR	NOTES & TREATMENTS	SIGNATURE
	900/A	pt escorted to 722 for am Care - Towels x2 - Wash x2 - tray - T brush + paste - soap provided - pt ant to use phone to call for clean Clothes No new Orders noted — (9)	
	945p	12/1/63-68-18- pt returned clean - feeling + appearing much improved D. Diet needs ordered @ present (9)	
	1020	Apohec admin @ 3 given info given - will assess for admit - will return call if bed available - a	
	1130	Phalec 3 given - info faxed as requested - bed pending will return our Call (9)	
	1150p	C.P called back will accept around 1pm - info given - pt Calm - back to room Gown making DIS 12/5/69 - 88-20 (9)	

Seq. #1185

1070

Scott Flor. -1

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

101603116 01-03-66-37 01/13/02
FLOYD ,SCOTTIE WAYNE
26 M INT:_____TIME:_____

PROGRESS RECORD

DATE	TIME	Note progress of case, complications, changes in diagnosis, condition on discharge, insructions to patient
1/13/02		Neurology Consult: 26 RH WM has chronic daily headaches since head injury 9/13/02. This has prevented him from working and the constancy of the headache has caused him to become exasperated. He has severe pain in head and tenderness over (R) supraciliary ridge. Prior to accident, which occurred at work, he had worked steadily for 2 years. On review of systems, has sleep apnea, clogged on severity of headache. He has light sensitivity (R) eye. He gets short of breath when stressed. He reports back pain. Smokes 3 ppd. He drank 16 oz alcoholic drink last night but not usually. Oriented, VSS. Tenderness (R) forehead. Neck supple. Moves all 4 limbs. Hypersonic. Full extraocular movements, symmetric facies, intact hearing, midline tongue protrusion. Moves all 4 limbs. Coordination and gait OK. Reflexes symmetric. CT head: (R) frontal-orbital encephalomalacia. Impression: post concussion syndrome with headache and dysfunction, closed head injury at work 9/13/02, pre-existing depression - now exacerbated by chronic daily headache, history of physical abuse by an alcoholic father who is now deceased. Plan: inpatient psychiatric evaluation and treatment Depakote 500 mg PO BID Neurontin 300 mg TID Toradol T-II q 6h PRN headache Continued (Marc D. Gunderman)

Seq. # 1201

Scott Floyd

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

101603116 01-03-66-37 01/13/02
FLOYD ,SCOTTIE WAYNE
26 M INT:——TIME:——

PROGRESS RECORD

DATE	TIME	Note progress of case, complications, changes in diagnosis, condition on discharge, insructions to patient
1/13/02 continued		Haldol 2-5mg IM or PO q8h PRN agitation neuropsychological testing EEG remove weapons from house neurology follow up after inpatient psychiatric evaluation and treatment while in psychiatric hospital, free T4, TSH, hepatic profile, Cortisol, sed rate MD Pringle MD
1/14/02	1430	EEG bedside —— M Bonhaus REET

Seq. # 1201

510
1-14-02

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

101603116 01-03-66-37 01/13/02
FLOYD, SCOTTIE WAYNE
26 M
INT: TIME:

CONSENT FOR TRANSFER TO ANOTHER FACILITY AND RELEASE OF MEDICAL INFORMATION

Patient's Name: Scottie Floyd

Diagnosis at Time of Transfer: S.F.

Referring MD (at McLeod Health): Hales

Accepting MD (at receiving facility): Heath Notified: Date/Time 1-14-02 @ 2pm

Receiving Facility: Sumter ☐ Acute ☐ Skilled ☒ Intermediate

Receiving Department: Intake Notified Date/Time: 1-14-02 Spoke to: B. Barnard

Mode of Transfer: ☐ Helicopter Ground Ambulance ☐ Private Vehicle ☒ Other FCSO

Accompanying Information: ☒ ER Record & Dictation ☒ Lab Results ☒ X-ray Results ☐ Films

☐ Hospital Chart (for inpatient transfers): ☐ H&P ☐ PT Registration Record ☐ Op Record ☐ DC Summary

☒ MD Progress Notes ☒ Record of Meds given today (Current MAR) ☒ Patient Transfer Form-Inter Agency Referral

Assessment At Time of Transfer

Pertinent History: (problem list or injury list) old Head Injury - S.F. - recurrent HA

Most Recent Vital Signs: Time 1200p BP 125/69 Pulse 88 Resp. 20 Temp. 98.2

Oxygen: ☒ NO ☐ YES — % Intubated: ☒ NO ☐ YES, — Tube Size

IV: ☒ NO ☐ YES, 1) Type — Rate — 2) Type — Rate —

Other: ☐ Chest Tube ☐ MAST ☐ Foley ☐ NG Tube ☐ C-Collar ☐ Spineboard
☐ Central Line ☐ Cardiac Monitor ☐ Restraints, type

Other Supports: O

Status at Transfer:
CARDIAC SYSTEM
Rate: 88
Rhythm: —

RESPIRATORY SYSTEM
Rate: 18
☒ Normal
☐ Labored
☐ Assisted vent bag

NERVOUS SYSTEM
☒ Alert
☒ Oriented
☐ Disoriented
☐ Drowsy
☐ Comatose
_____ Glascow Score

SKIN
☒ Normal ☐ Hot
☒ Dry ☒ Warm
☐ Moist ☐ Cool
☐ Diaphoretic

OTHER INFORMATION:
O

Nurses Signature:

Rev. 8/2001

Seq. #1073

Certificat of Need for Trai. :r - Side 2

Reason for Transfer (To be completed by referring MD)

I have examined Seattle Floyd this patient and based upon the reasonable risks and benefits described below, and upon the information available to me the medical benefits reasonably expected from the provisions of appropriate medical treatment at the receiving facility out weigh the risks associated with transfer

The **Medical Benefits** expected are (reason for transfer)

Availability of Burn Center

The Nursing Home Swing Bed, or Rehab Facility offers long term care and treatments not generally offered in acute care

Availability of Transplantation Services

X Availability of Extensive Psychiatric and/or substance abuse treatment services

Availability of ECMO Services for Neonates or other neonatal services. _____

Return to Level I or II nursery capable of meeting baby's needs _____

Availability of Complex Medical and Surgical Specialties not presently available at McLeod Health (MD must note specifics)

_____

Availability of a bed, a clinical resource or a diagnostic test not presently available at McLeod Health: (MD must note specifics)

_____

This patient (or the responsible person acting on his behalf) requests transfer to the receiving facility although the services needed are available at McLeod Health

Other _____

The Risks of Transfer: (To be completed by referring MD)

Transfer to another Medical Facility involves travel by air and/or motor vehicles including ambulances. While such travel typically carries the possible risks of highway or air accidents, delays due to traffic or mechanical malfunction, the medical risks of this patient's transfer are seen as:

X This patient's condition has been stabilized at McLeod Health such that, within reasonable medical probability, *no material deterioration of the patients condition is likely to result* from or during the transfer.

☐ The medical examination at McLeod Health indicates that further stabilization is necessary. Precautions and stabilizing actions (such as medications, and treatments, transfer by trained individuals, en-route monitoring and support) have been taken by the physicians and staff at McLeod Health. At this time, *the benefits of expediting the transfer to the receiving facility outweigh the risks* from being transferred, (such as a deterioration in condition, or death, or onset of new symptoms or change in level of pain while en-route.) Possible risks include: _____ (MD must note specifics)

☐ This patient has been examined and does not have an emergency medical condition and it is not expected that the absence of immediate medical attention could likely result in serious jeopardy to this patients health.

_____

Referring Physician's Signature

Authorization for Transfer: The patient named above and/or person acting on his/her behalf has been informed of the expected benefits and the risks associated with this transfer. The signature of the patient or person acting on his/her behalf indicates that the authorizing individual understands the reason for Transfer, the risks of the transfer. I understand the possible risks associated with refusal to consent to the transfer include the limitations of services unavailable at McLeod Health, such as examinations and treatments offered at the recommended facility. The authorizing individual hereby, consents to the transfer of the patient and the release of pertinent medical information from McLeod Health to the Receiving Facility and releases the recommending physician and the hospital from responsibility from any ill effects which may result from the transfer.

Authorizing Signature (Relationship) _____ Witness

Refusal for Transfer: I have been informed of the expected benefits of transfer to another facility and the risks associated with remaining at the current facility, including the limitations of services or unavailable services at McLeod Health. I am declining the recommended transfer and releasing the recommending physician and the hospital from responsibility from any ill effects which may result from declining the transfer.

_____ _____

Authorizing Signature (Relationship) Witness

Rev. 8/2001

Seq. #21074

PART I 101603116 PN
01 03 6637 MC
PAGE 1

APPLICATION FOR INVOLUNTARY EMERGENCY HOSPITALIZATION FOR MENTAL ILLNESS

FOR HOSPITAL USE ONLY
Date Admitted
Hospital Register No.
Approval of Hospital Official
Signature Date

(Complete in Triplicate)
STATE OF SOUTH CAROLINA)
COUNTY OF Marion)

IN THE MATTER OF:

Bettie Wright Floyd | M | | 26 | W | | |
Person alleged to be mentally ill | Sex | Birthdate | Age | Race | Marital Status

[illegible] | [illegible] | | | [illegible] | [illegible]
Street Address | City | State | Zip | Phone # | Length of Time Residing There

TO THE HOSPITAL DIRECTOR:

Application is hereby made for the INVOLUNTARY EMERGENCY ADMISSION of the aboved-named person to a SCDMH Psychiatric Hospital

or to _____
NAME OF NON-SCDMH HOSPITAL

for the following reasons:
That the undersigned believes that the above-named person is mentally ill, and because of this mental condition is likely to cause serious harm to self or others if not immediately hospitalized.

1. The specific type of serious harm thought probable is:
wom to self

2. That the applicant bases his/her belief on the following grounds:
came to ER w/ gun and threw knife, says he is no longer afraid to kill himself, agitation, Anxiety, feelings of hopelessness

3. That the applicant understands that for Involuntary Emergency Admission to occur that the said person must be examined and certified by at least one licensed physician (Part II, Certificate of Licensed Physician for Mental Illness) as required by Section 44-17-410, S.C. Code, 1976, as amended. If the said person has not been examined, listed below are the reasons:

4. That next-of-kin of allegedly mental ill person is Betty Joe Floyd "Goldie"
Name

Relation mother Whose address is _____ _____ _____ _____ _____
RFD or Street | City and State | Zip | Phone Number

In case of next-of-kin cannot be contacted, notify Virgie Hare

Friend _____ 843-423-6582
Relation | Address | City and State | Zip | Phone Number

SWORN to before me this
13 day of Jan, 19 2002

Brett Campbell, MSW
Notary Public for South Carolina or Probate Judge

My Commission Expires: 8-10-09

WHEREFORE, the undersigned requests that the person named above be admitted to a psychiatric hospital for treatment as authorized by law.

x Chasity EVANS RN
Applicant's Signature

Chasity Evans
Name of Applicant (typed or printed)

[illegible] Evans St. Florence, SC
Address of Applicant

[illegible]-2021
Telephone Number of Applicant

Nurse
Relation to Patient or Title, if any

(See reverse side which must be completed)

SCDMH FORM
APP 89 MI-130 pg. 1 of 2

1075

APPLICATION FOR INVOLUNTARY EMERGENCY HOSPITALIZATION FOR MENTAL ILLNESS

IMPORTANT NOTICE: All patients receiving treatment in a State Department of Mental Health facility will be charged the established fee as approved by the South Carolina Mental Health Commission.

PERTINENT FINANCIAL RESPONSIBILITY INFORMATION

Present Name	Full Name at Birth if Different From Present
Scotte Wayne Floyd	same

Education Level	Social Security Number	Occupation	Monthly Income
		mechanic	

Employer's Name	Address	If not employed, source of income: Retirement $	Public Assistance $	Other $
Ken Bates Used	MARION			

HOSPITALIZATION INSURANCE Coverage including group insurance, Medicare, Medicaid, military medical care, etc

Policy No. or HIB	Name of Insurance Co.	Address	If group insurance, name & address of firm
	Blue Cross		

MILITARY SERVICE

Branch	Service Number	Dates of Service	Type Discharge	Monthly Pension	VA Claim No.
NA					

FINANCIAL REPRESENTATIVE Please list the name, address and telephone numbers of the person to receive financial statements and other media related to the personal financial affairs on behalf of the patient.

Last Name	First Name	Middle Initial	Relation to Patient	Street Address or Rural Route & Box	Telephone
				City, State, Zip	Telephone

LIST OF SCDMH PSYCHIATRIC HOSPITALS

G. Werber Bryan Psychiatric Hospital 220 Faison Drive Columbia, S.C. 29203 For information and prior to all admissions call: 737-7143 - All Hours	South Carolina State Hospital 2100 Bull Street (P.O. Box 119) Columbia, S.C. 29202 For information and prior to all admissions call: 734-6560 - All Hours	William S. Hall Psychiatric Institute 1800 Colonial Drive (P.O. Box 202) Columbia, S.C. 29202
Patrick B. Harris Psychiatric Hospital P.O. Box 2907 Anderson, S.C. 29622 For information and prior to all admissions call: 231-2600 - All Hours	Crafts-Farrow State Hospital 7901 Farrow Road Columbia, S.C. 29203 For information and prior to all admissions call: 737-7922 - All Hours	Psychiatry Unit Forensic Unit Children's Unit For information and prior to all admissions call: 734-7038 - All Hours

NOTE: ADMINISTRATIVE PROCEDURE - FORMS:
"Application for Emergency Admission, Part I", and "Certificate of Licensed Physician, Part II", must be completed in triplicate and accompany the patient to the receiving hospital. The hospital must forward one copy to Judge of Probate of the county in accordance with 44-17-410(3) and retain one copy in the person's hospital record. ADMISSION MUST BE WITHIN SEVENTY-TWO HOURS OF THE DATE OF THE CERTIFICATION OF THE LICENSED PHYSICIAN. (PART II).

NOTE: TO LICENSED PHYSICIAN:
1. The licensed physician must consult with the local State Community Mental Health Center regarding the commitment/admission process and the available treatment options and alternatives in lieu of hospitalization at a state psychiatric facility. (Section 44-17-460, S.C. Code, 1976, as amended).
2. The licensed physician must also consult via telephone with the admitting physician of the receiving hospital regarding the appropriateness of admission and the persons mental and physical treatment needs.

NOTE: TO POLICE AND OTHER OFFICERS OF THE PEACE:
The certificate of a licensed physician authorizes and requires taking the proposed patient into custody. Section 44-17-440, South Carolina Code of Laws, 1976, as amended: "The certificate required by item 2 of Section 44-17-410 shall authorize and require any officer of the peace, preferably in civilian clothes, to take the individual into custody and transport him to the hospital designated by the certification. No person shall be taken into custody after the expiration of three days from the date of the certification. Any friend or relative may transport the individual to the mental health facility designated in the application, provided such friend or relative has read and signed a statement on the certificate which clearly states that it is the responsibility as an officer of the peace to provide timely transportation for the patient and that the friend or relative freely chooses to assume such responsibility. A friend or relative who chooses to transport the patient shall not be entitled to reimbursement from the State for the cost of such transportation. Any officer acting in accordance with the provisions of this article shall be immune from civil liability."

NOTE: TO FRIENDS AND RELATIVES:
It is the responsibility of an officer of the peace to provide timely transportation of the person alleged to be mentally ill to the designated mental health facility. However, by freely signing this statement, you can choose to assume that responsibility. Transportation must begin immediately. This form must be hand delivered by you to the admissions office of the designated mental health facility at the time of admission.

Date

Signature of Friend or Relative/Relationship

10160311 6 PN PAGE 1
01036637 mr

PART II
CERTIFICATE OF LICENSED PHYSICIAN
EXAMINATION FOR EMERGENCY ADMISSION

Scottie Floyd — NAME OF PERSON EXAMINED
25 — AGE
Marion — COUNTY OF RESIDENCE

MMH-ER — PLACE OF EXAMINATION
5:00 1-13-02 — HOUR AND DATE OF EXAMINATION

I, THE UNDERSIGNED LICENSED PHYSICIAN, have examined the above-named person and am of the opinion that the said individual:

☐ IS MENTALLY ILL AND because of this mental condition CURRENTLY POSES A SUBSTANTIAL RISK of physical harm to self and/or others to the extent that INVOLUNTARY EMERGENCY HOSPITALIZATION is recommended.

My recommendation for INVOLUNTARY EMERGENCY HOSPITALIZATION is based on the following symptoms and specific examples of behavior which indicate mental illness and probable risk of harm:

See of the SCOP

The person is therefore to be transported to _____ NAME OF SCDMH PSYCHIATRIC HOSPITAL

or to _____ NAME OF NON-SCDMH HOSPITAL for involuntary emergency admission.

For admission to SCDMH hospital, Physician must complete Part II, Page 2, over.

_____, M.D. — SIGNATURE OF LICENSED PHYSICIAN
17207 — S.C. LICENSE NUMBER

James D Lee, M.D. — TYPED OR PRINTED NAME
843-777-2037 — PHONE NUMBER

ADDRESS

All information MUST be typed or clearly printed.

SCDMH FORM
APR 89 (REV SEPT 93) M-131 Section 44-17-410(2)
MH-FCC-2

1077

PART II
CERTIFICATE OF LICENSED PHYSICIAN
EXAMINATION FOR EMERGENCY ADMISSION

Name of Patient	Sex	County of Residence	Date of Birth	Age
Floyd, Scotty G	M	Marion	- -	26

Are there prior admissions to SCDMH or other mental hospitals? ___ Yes ___ No	Where?	When?
Are there criminal charges? ___ Yes ✓ No	If yes, give details (include county, type of charge).	

Reasons for psychiatric admission (specify symptomatology) (Not necessary to repeat if completed on Page 1, over.)
agitation, anxiety, depression - suicidal. Request Haldol and Ativan to control anxiety for CT. (see below)

Medical Condition of patient
4 mo s/p head injury → severe headache + encephalomalacia on CT; seen by neuro here, suggest pain meds + Decadron +/- neurosurgery. K 3.3 Repleted (3.5 now) Co Hgb 6.5 [smokes heavily] stable.

Is patient medicated prior to transporting? ✓ Yes ___ No	If yes, give type, amount, route and when administered. Haldol 5 mg Ativan 2 mg IM 10:58

Medication - Maintenance Drugs

HEALTH OF PATIENT

Disease	Yes	No	Date(s)	Disease	Yes	No	Date(s)	Disease	Yes	No	Date(s)
Paralysis or Crippled Limbs		✓		Cancer		✓		Homicidal or Suicidal Tendency	✓		
Blindness or Eye Trouble		✓		TB or Lung Disease		✓		Mental Retardation or Dementia		✓	
Deafness or Ear Trouble		✓		Heart or Hi. Bl. Pressure		✓		Syphilis		✓	
Epilepsy or Seizures		✓		Tremors or Abnormal Movements		✓		HIV		✓	
Diabetes		✓		Hepatitis		✓		Alcohol Abuse H/O	✓		
Patient's Operations				Serious Allergies		✓		Drug Abuse Types Abused	✓		
				Head Injury	✓			Marijuana			

Name of treatment facility accepting admission	Name of treatment facility physician authorizing admission

ON THE BASIS OF MY PERSONAL EXAMINATION I BELIEVE THAT THE PERSON IS IN NEED OF INVOLUNTARY EMERGENCY PSYCHIATRIC HOSPITALIZATION. FURTHERMORE, THE PERSON HAS NO MEDICAL/SURGICAL CONDITIONS OR DISABILITIES THAT PRESENTLY REQUIRE A GENERAL HOSPITAL OR NURSING HOME LEVEL OF CARE AND IS MEDICALLY STABLE AND PHYSICALLY ABLE TO PARTICIPATE IN PSYCHIATRIC TREATMENT.

I have consulted with the Pee Dee Community Mental Health Center regarding Preadmission Screening. If not, state clinical reason ___

SIGNATURE OF LICENSED PHYSICIAN	, M.D.	17204 S.C. LICENSE NUMBER	ADMHC NAME OF CENTER
[illegible] TYPED OR PRINTED NAME	, M.D.	843-777-2037 PHONE NUMBER	[signature] 1-13-02 SIGNATURE OF FACE TO FACE SCREENER AND DATE
ADDRESS			Leesa Campbell, LMSW 327 PRINTED NAME OF SCREENER, TITLE AND ID #

McLeod REGIONAL MEDICAL CENTER
The Choice for Medical Excellence

101603116 01-03-66-37 01/13/02

FLOYD ,SCOTTIE WAYNE

26 M INT:_____TIME:_____

MEDICATION ADMINISTRATION RECORD

ALLERGIES

) MEDICATIONS ,TED IN YELLOW

DATE

DATE

START DATE		STOP DATE	
01/14	DEPAKOTE ENTERIC COATED EC TAB GVD DIVALPROEX SODIUM 250 MG/1 EC TAB GIVE 500 MG/2 EC TAB TWICE A DAY FLOYD, SCOTTIE WAYNE PT#:101603116 PMP#:1	R.Ph	PO INT
01/14	NEURONTIN UNIT DOSE CAP GVD GABAPENTIN 300 MG/1 CAP GIVE GIVE 300 MG/1 CAP THREE TIMES A DAY FLOYD, SCOTTIE WAYNE PT#:101603116 PMP#:2	R.Ph.	PO INT
01/14	HALOPERIDOL LIQ CONCENTR SYRING GVD HALOPERIDOL LACTATE 10 MG/5 ML GIVE GIVE 2.5 MG EVERY 8 HOURS AS NEEDED PRN AGITATION EQUIVALENT TO HALDOL FLOYD, SCOTTIE WAYNE PT#:101603116 PMP#:4	R.Ph	PO INT
01/14	HALDOL AMP GVD HALOPERIDOL LACTATE 5 MG/1 ML GIVE 2.5 MG EVERY 8 HOURS AS NEEDED PRN AGITATION EQUIVALENT TO HALDOL FLOYD, SCOTTIE WAYNE PT#:101603116 PMP#:5	R.Ph	IM INT
01/14	MIGRATINE CAP GVD ISOMETH/DICHLORAPH/APAP 1 CAP/1 CAP GIVE 2 CAP/2 CAP *** NOTE: INITIAL DOSE *** MAX 5 CAPS IN 24 HRS EQUIVALENT TO MIDRIN FLOYD, SCOTTIE WAYNE PT#:101603116 PMP#:3	R.Ph.	PO INT
01/14	MIGRATINE CAP GVD ISOMETH/DICHLORAPH/APAP 1 CAP/1 CAP GIVE GIVE 1 CAP/1 CAP EVERY 8 HOURS AS NEEDED MAX 5 CAPS IN 24 HRS EQUIVALENT TO MIDRIN FLOYD, SCOTTIE WAYNE PT#:101603116 PMP#:3	R.Ph	PO INT.
01/14	MIGRATINE CAP GVD ISOMETH/DICHLORAPH/APAP 1 CAP/1 CAP GIVE 1 CAP/1 CAP EVERY 8 HOURS AS NEEDED MAX 5 CAPS IN 24 HRS SUB FOR FIORICET EQUIVALENT TO MIDRIN FLOYD, SCOTTIE WAYNE PT#:101603116 PMP#:3	R.Ph	PO INT
	GIVE	R.Ph	
	GIVE	R.Ph	

SITE CODES		OMISSION CODES	SITE OF PAIN	SIGNATURE	INIT.	SIGNATURE	INIT.
1 - LT. DELTOID	7 - RT. LATERALIS	R - REFUSED	A				
2 - RT. DELTOID	8 - LT. LATERALIS	V - VOMITING/ NAUSEATED	B				
3 - RT. ARM	9 - LT. VENTROGLUTEAL	N - NPO	C				
4 - LT. ARM	10 - RT. VENTROGLUTEAL	O - OTHER					
5 - RT. GLUTEUS	11 - RT. ABDOMEN						
6 - LT. GLUTEUS	12 - LT. ABDOMEN						

F-1500706 (08/86) SMS

AGE SEX

McLeod Regional Medical Center
The Choice For Medical Excellence
555 East Cheves Street - PO Box 100551 - Florence, SC 29501-0551

MR: 01-03-66-37 **PN:** 101603116 **PT:** Floyd, Scottie Wayne
DATE SEEN: 01/13/2002 **ED PHYSICIAN:** JAMES D. LEE, MD

CC: HEADACHE, NAUSEA, SUICIDAL

HPI: The patient is a 26-year-old who was hit between the eyes 4 months ago with a piece of metal which caused both eyes to swell shut and be bloodshot for extended length of time. He was apparently not CT'd at that time. He went to his family physician several days ago and had an outpatient CT ordered due to severe headaches. He was told that there was something there and was set up to see neurology. He presents today because of severe headache and anxiety. He was told he had fluid or blood in his brain. He states that he has a severe headache to the point that he cannot stand it. It has aggravated his baseline anxiety and depression to the point that he is suicidal. He states he put the gun to his head multiple times last night and he actually came to the ER with a loaded gun and several knives. He denies any carbon monoxide exposure, cocaine, nausea, vomiting, or fever. He states he will need medications to calm him down for CT.

PMH: Depression, psychiatric problems. He saw a psychiatrist at 6 years old, none since then. He has been abused by his father prior to his father's death. He denies having glaucoma and states he has been checked for this.

SH: Positive for 3 packs per day of tobacco. History of alcohol in the past. None recently until the headaches got bad, and then he began again.

ROS: No nausea, vomiting, fever, abdominal pain.

PE: VITALS: Temp 98.2. Pulse 63. Respirations 16. Blood pressure 127/63. Pulse ox 100%. GENERAL: This is a tense, pacing, agitated white male. HEENT: Pupils equal, round, and reactive to light. Extraocular motion intact. No gross abnormality of the external ears or nose. NECK: Supple. LUNGS: Breath sounds equal bilaterally and clear to auscultation. HEART: He has a regular rate and rhythm. ABDOMEN: Bowel sounds positive. Abdomen soft and nontender. NEUROLOGICAL: He is warm and dry. Alert and oriented. Cranial nerves II-XII are intact. Motor 5/5 in all 4 extremities. Sensory grossly intact. Cerebellar function okay. Has no lacs or tracks to the extremities. Full range of motion. PSYCHIATRIC: He is tense, agitated, somewhat angry, and I feel he is a danger to himself and possibly others.

EDC: Patient was given Haldol 5 and Ativan 2 which did result in a dramatic change in his behavior and did allow us to get labs and to get a CT. CT shows a large area of encephalomalacia. Labs were fairly unexciting. Sodium 143, potassium 3.3 which we did replete. Chloride 108, CO2 26, BUN 9, creatinine 0.8, glucose 100.

(continued)

MR: 01-03-66-37 **PN:** 101603116 **PT:** Floyd, Scottie Wayne
DATE SEEN: 01/13/2002 **ED PHYSICIAN:** JAMES D. LEE, MD

White count 5.8, H&H 15 an 44. Platelets 165. Carboxyhemoglobin 6.5 probably attributable to his smoking. Neurology did see him. Dr. D'Angelo spent quite a bit of time talking to this gentleman. He feels that his continued headaches from this encephalomalacia may well have exacerbated his baseline problems and precipitated this event. The patient states that he has been having extreme difficulty getting proper evaluation and care for his injury. In fact it has been 4 months and he states the "only way I got a head CT at all was going to my doctor's office with a gun and showing my butt." The patient states that he was getting worse and felt that this was the only way to get care, and therefore, this is why he presented this way. He has actually been fairly cooperative. The patient was attempted to be admitted to Greenland Park; however, we have no beds. We are seeking a place to admit him for suicidal ideation and where he can be further cared for his posttraumatic headache.

MDM: The patient is much calmer after explanation of his pathology and validation of his headaches. He has also had another 2 mg of Ativan, which did not hurt either. He does seem to understand what is going on, appreciate the help that has been done, and feels somewhat better that he does have some knowledge of what is going on and that he will get care for this. Dr. D'Angelo's suggestion was that the patient be given narcotic pain control for several days at least while he is treated with Depakote +/- neurontin to deal with his neuropathic pain from this injury to his head. He also has a facial fracture which may need to be dealt with. The patient has marked deficit in his sense of smell, and this needs to be investigated further.

IMP: 1) Psychiatric evaluation, danger to self. 2) Posttraumatic headache. 3) Facial fracture.

DISP: The patient is committed and a search for a bed is underway. Dr. Dodaro is aware of the above and will assist with this as I am now off service.

James D. Lee, MD

DD: 01/13/2002 19:54
DT: 01/13/2002 20:01/ET/1216
JOB#: 0812

McLeod Regional Medical Center
The Choice For Medical Excellence
555 East Cheves Street - PO Box 100551 - Florence, SC 29501-0551

MR: 01-03-66-37 **PN:** 101603116 **PT:** Floyd, Scottie Wayne
DATE SEEN: 01/13/2002 **ED PHYSICIAN:** NICHOLAS DODARO, MD
TIME SIGNED OUT: 1920

CC: [_____]

NOTE: This is an addendum to the previously dictated note of Dr. James Lee on Scottie Floyd.

HPI: The patient was signed out to me at 1920 with Lisa Campbell of Pee Dee Mental Health evaluating the possibility of admission at MUSC. It turns out that MUSC, after a prolonged request for repeated extra labs, refused the patient at 2130 on the premise that the insurance carrier that the patient has did not cover admission to MUSC. I contacted Brian S. Hall via fax of the form, and I am waiting for possible evaluation and admission to that facility without the assistance of Lisa Campbell. I also contacted Greenland Park and spoke with Matt who said that he will be put on the waiting list and re-evaluated in the morning after any potential discharges tomorrow. At this point, there are no beds anywhere, and Lisa Campbell has said that she can no longer help me. She has offered to make no further phone calls to Brian or Greenland in an attempt to place this patient. I have made the phone calls and have not found placement. It seems that the patient will wait here in the ER overnight for Greenland Park to give us an answer in the morning. Matt of Greenland Park is aware of the patient, his history, presentation, evaluation, and treatment plan. The patient remains involuntarily committed with stable vital signs and, otherwise, having no complaints.

Nicholas Dodaro, MD

DD: 01/13/2002 22:00
DT: 01/14/2002 04:44/ET/1242
JOB#: 0899

RADIOLOGY REPORT

McLEOD REGIONAL MEDICAL CENTER

555 E. CHEVES STREET FLORENCE, SC 29506-2617
PHONE (843) 777-2087

PATIENT NAME:	**FLOYD, SCOTTIE**	**DISCHARGE DATE:**	{pt_dsch_dtime}
PT ACC #:	000101603116	MR/RAD #:	000001036637
DOB:	AGE: 26Y	SEX:	M RACE: {pt_race}
PHONE:		PT CLASS:	E FIN CLASS:
ADDRESS:		PT TYPE:	{pt_type} PT NS/ROOM:
ORD DR:	LEE, JAMES D		
ATTEND DR:			
COPY TO:			
DIAGNOSIS:	HA		

TRANSCRIBED D/T: Jan 14 2002 1:19A

HEAD (BRAIN)WO CON/CT / ORD #: 90001 CPT: 70450
COMMENTS:
ORDERED FOR: Jan 13 2002 10:41AM COMPLETED: Jan 13 2002 10:59AM
INDICATIONS: TRAUMA HIT ON HEAD 4 MONTHS AGO

RESULT:

INDICATION: 26 YEAR OLD MALE. TRAUMA HIT ON HEAD 4 MONTHS AGO.

PROCEDURE: Multiple contiguous 5.0 mm axial images were obtained through the posterior fossa with continuing 10.0 mm axial images through the vertex. There is a 3.0 x 4.0 cm focus of decreased attenuation in the right frontal lobe extending to the periphery which may be sequela from infarct or hemorrhage probably related to the trauma four months ago by history. There is no acute hemorrhage or infarct. The ventricles are normal in size and configuration. There is no significant mass effect. No extra-axial collections are identified. The paranasal sinuses, mastoid air cells are clear. There is no evidence of fracture through the nasal ethmoid or recess on the left side which may also be related to previous injury. There is no soft tissue swelling in that region.

CONCLUSION: 1) 3.0 X 4.0 CM FOCUS OF DECREASED ATTENUATION IN THE RIGHT FRONTAL LOBE LIKELY RELATED TO REMOTE TRAUMA.

2) FRACTURE OF THE LEFT FRONTOETHMOIDAL COMPLEX WHICH ALSO MAY BE RELATED TO THE TRAUMA 4 MONTHS AGO.

RADIOLOGIST: PAUL HAHN, MD
cb

January 14, 2002

1:25 am

Final Result
ELECTRONICALLY SIGNED BY:
PAUL Y **HAHN, M.D.

Printed: December 18, 2003 (8:56AM)

FLORENCE RADIOLOGICAL ASSOCIATES
If you have received this document by facsimile, the information contained in this transmission may contain medical record information and is privileged and confidential. It is intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone (collect) and return the original message to us at the address indicated via the US Postal Service.

THREE RIVERS CENTER FOR BEHAVIORAL HEALTH
2900 Sunset Blvd, West Columbia, SC 29169
(803) 796-9911 Fax (803) 791-7622

PATIENT NAME: FLOYD, SCOTTIE
MEDICAL RECORD#: 19136
ADMISSION DATE: 1-14-02
DISCHARGE DATE: 1-22-02
PHYSICIAN NAME: DR. HEATH, MD

DISCHARGE SUMMARY

CHIEF COMPLAINT:
"I need help."

INITIAL IMPRESSION:

AXIS I:	Organic mood disorder
	THC abuse
AXIS II:	Deferred
AXIS III:	Status-post head injury
	Headaches
AXIS IV:	Moderate
AXIS V:	30-40

CRITERIA FOR ADMISSION:

1. Danger to self
2. Emotional behavioral conditions and complications requiring 24 hour medical nursing care
3. Legally mandated
4. Impaired mood and depression
5. Cognitive impairment

HISTORY OF PRESENT ILLNESS:
This is a 26-year-old white male who sustained a closed-head injury at work 3-4 months ago. He had developed chronic headaches and complaints of anxiety. He presented at the local ER with a gun stating he needed help, or he intended to hurt self. CT scan showed a decreased attenuation in the right frontal lobe and a fracture of the left frontoethmoidal complex.

SUMMARY OF HISTORY AND PHYSICAL:
The history and physical exam was performed by the consulting internist with a completed report contained in the medical record. It was significant for the status-post head injury.

SUMMARY OF TREATMENT PLAN:
The patient's multidisciplinary treatment team met initially and subsequently throughout the course

of his hospitalization. The initial treatment plan included admission labs, history and physical, individual supportive interventions.

LABORATORY DATA:
A chemistry profile, UA and urine drug screen were performed. The urine drug screen was significant for positive barbiturates and marijuana. The chemistry profile and UA were unremarkable.

COURSE OF HOSPITALIZATION:
The patient was admitted to the Adult Unit and placed on a level consistent with his presenting history. We placed him on some Depakote and some Neurontin. I educated him as to the risks, benefits and side effects of these medications, and he did consent to same. During the course of hospitalization, I met with him daily for individual supportive interventions and overall medical management. We continued to educate him regarding his illness and regarding the need for medications. On 1-22-02, it was felt he had reached maximum benefit from his inpatient stay and could be managed in a less restrictive setting. He was discharged home for continued care.

RECOMMENDATIONS FOR FURTHER TREATMENT:
The patient's diet nor activity level were restricted. He was scheduled to follow-up with his neurologist. He is scheduled to follow-up with his psychiatrist in 7-10 days. He was scheduled to follow-up with his primary care physician for medical problems, abnormal labs, and routine care.

MEDICATIONS:
Ceftin 250 mg #16, 1 po bid
Fioricet tabs #30, 1-2 po q 8h prn headache
Neurontin 300 mg #90, 1 po tid
Depakote 500 mg #90, 1 po tid

CONDITION ON DISCHARGE:
His condition on discharge is stable. There is no evidence of overt psychosis. No current suicidal or homicidal ideations. Prognosis is fair.

FINAL DIAGNOSIS:

AXIS I:	Mood disorder, nos
	THC abuse
AXIS II:	Suspect organic personality disorder
AXIS III:	Status-post close-head injury
	History of headaches

	Sinusitis
AXIS IV:	Moderate
AXIS V:	45/30

CHARLES HEATH, MD

1/30/02
DATE

DICTATED BY RKB
RKB/CH/krh

D: 1-28-02
T: 1-29-02

THREE RIVERS CENTER
for BEHAVIORAL HEALTH

Patient Identification

INITIAL PSYCHIATRIC EVALUATION

HISTORY OF PRESENT ILLNESS AND SYMPTOMS (to support diagnosis and serverity of illness):

26 yo white male who sustained closed head injury at work 3-4 months ago. Has developed chronic HA, ↓ ego drive/activity. Presented at ER c gun stating he needed help or he intend to hurt self. Ed mildly consulted and CT scan - CT scan showed ↓ asymmetry in right frontal lobe c fracture of (R) frontal bone.

JUSTIFICATION FOR 24 HOUR CARE (check all that apply): Safety - Danger to self.

- [ ] Inability to meet basic life and health needs
- [x] Dangerous to self, others, or property with need for controlled environment
- [ ] Toxic effect of therapeutic psychotropic drugs
- [ ] Failure of treatment at lower level of care
- [ ] Needs treatment for acute intoxication or withdrawal
- [ ] Biomedical conditions and complications requiring 24 hour medical and nursing care
- [ ] Need for ECT, special drug therapy, or other specific therapeutic program requiring continuous hospitalization
- [x] Emotional or behavioral conditions and complications requiring 24 hour medical and nursing care
- [ ] High relapse potential due to inability to contorl substance abuse despite active participation in less restrictive care
- [ ] Recovery environment includes detrimental famiy
- [ ] Patient's occupation presents danger to public safety if they continue to use drugs or alcohol
- [ ] Failure of social or occupational functioning
- [ ] Legally mandated admission
- [x] Impaired mood, depression, mood swings, suicidal ideation
- [x] Psychosis, hallucinations, delusions, ideas of reference
- [x] Cognitive impairment, orientation, judgement, memory
- [ ] Other (Specify): _____

PAST PSYCHIATRIC HISTORY: Denies.

ETOH AND SUBSTANCE HISTORY: (+) THC as often as available - etoh but evasive as to quantity.

PAST MEDICAL HISTORY: Denies hx of head injury.

PERSONAL AND DEVELOPMENTAL HISTORY: Reports hx of trauma by alcoholic father.

THREE RIVERS CENTER FOR BEHAVIORAL HEALTH

INTERNAL MEDICINE HISTORY & PHYSICAL

 PATIENT IDENTIFICATION

DATE: 1/15/02

CHIEF COMPLAINT: he would hurt himself.

HPI (location, quality, severity, duration, timing, context, modifying factors and association by sxs.)
26 y/o c/o admitted on emergency commitment papers 2° to suicidal ideation. Several weeks' hx of (~ 3-4 months) headaches / fatigue / irritability / insomnia & progressively worse, severe. (Pt on antidepressant regimen reviewed)
① Hx head inj 9/13/01 → seen in ER → CT head unremarkable (c/o fracture / old inj
② Mental Hyg - Severe Neuro - Paranoid Delusional / Psychotic. pt would be
③ Psych/Soc Hx - Lives w/ mom & bro. No other psychiatric / outpatient f/u.
denies SI/HI/psychosis/substance use.

(Problem Pertinent =/- of 1 system / Extended =/- of 2-9 systems / Complete =/- of all symptoms)

ROS ☐ UNOBTAINABLE

CONSTITUTIONAL ☑ No F/C/R, weight loss, or change in appetite.
☐ Other

EYES ☑ No dipoplia, halos, floaters or vision changes.
☐ Other

ENT ☑ No change in hearing, nasal discharge or dysphagia.
☐ Other ringing (+) ear bilat.

C/V ☑ No CP, SOB, orthopnea or PND.
☐ Other

RESP. ☑ No cough, hemoptysis or expectorations.
☐ Other

GI ☑ No N/V, D/C, abdominal pain, melana, hematochezia, BRBPR or change in bowel habits.
☐ Other

GU ☑ No hematuria, dysuria, D/C or change in bladder habits.
☐ Other

M/S ☑ No myalgias, arthralgias, alterations of ROM or ambulation.
☐ Other

SKIN ☑ No rashes, excoriations, breakdown or pruritis.
☐ Other

NEURO ☑ No Sxs or TIA, CVA, seizure or sensory / motor changes.
☐ Other

(ALL 3 COMPONENTS, PMSH, FH AND SH MUST BE ADDRESSED)

PMSH ☐ Other Hx headaches (pt hearing) / All. Amoxicillin.

FH ☐ Unobtainable
☐ Other COPD / dem / intestinal.

SH ☐ Unobtainable
☐ Other ETOH / tob on nicotine w/ CAT.

ALL ☐ NKDA
☐ Other nkda

CURRENT MEDS: Clonidine / Depakote / Neurontin.

THREE RIVERS CENTER
FOR BEHAVIORAL HEALTH

INTERNAL MEDICINE HISTORY & PHYSICAL

 PATIENT IDENTIFICATION:

CRANIAL NERVES:

Olfactory	(✓)	Smells freshly burned match, fresh coffee, or alcohol swab.
Olfactory II	(✓)	Distinguishes number of fingers in central field. Distinguishes movements in peripheral field.
Oculas-Motor III Trochlear IV Abducens VI	(✓)	Gazes symmetrically up, down, sideways. No diplopia.
Trigern V	(✓)	~~Distinguishes 1 from 2 point touch symmetrically on forehead, cheek, and chin.~~ Chews symmetrically. Opens mouth symmetrically. Clenched teeth - force of contraction and bulk.
Facial VII	(✓)	Upper: frowns symmetrically. Lower: Smiles symmetrically. Both eyelids close on touching of comae.
Auditory VIII	(✓)	Hears fingers rubbing or snapping equally in both ears. ~~Hears watch ticking.~~ Hears whispered voice. ~~Hears tuning fork.~~
Glosso-Pharyngeal IX Vagus X	(✓)	Has gag reflex. Says "Ah" and palate pulls up symmetrically. Can make guttural sounds.
Accessory XI	(✓)	Shrugs shoulders symmetrically.
Hypoglossal XII	(✓)	Can stick tongue out straight without tremors or fasciculation.

MOTOR FUNCTIONS:

	(✓)	Gait and station are normal.
	(✓)	Romberg test is negative
	(✓)	Muscle tone is normal: no abnormal movements.
	(✓)	There is no limb weakness, atrophy or fasciculation seen.
	(✓)	Deep tndon reflexes are 2+ and symmetrical.
	(✓)	Plantar responses down going.
	(✓)	Finger-to-nose and heel-to-shin is normal.

SENSORY:

	(✓)	Sensory examination to ~~pinprick and vibration~~ is normal.

IMPRESSION & PLAN:

(1) [illegible] / dysphonia: Chr depressive d/t
? primary / ? intermittent cause / ? Psychiatric cause / ? substance
plan: Screening labs, No metabolic cause, likely psychiatric etiology - Rx accordingly.

Examiners Signature: _____ Date / Time: 1/15/02

Attending Physician Signature: _____ Date / Time: 1/16/02

A & P (cont'd)

(2.) Head injury :- CT findings normal
4 mrs ago - old fracture / old contusion
- acute findings

Clockwise headaches

- evaluated by Neurologist w.r.t → Persistent Depressive / Neurotic
- Begin Aloxa. MMS / Obs. / assessment by Neurologist as dic.

1/5/12

THREE RIVERS CENTER
FOR BEHAVIORAL HEALTH

INTERNAL MEDICINE HISTORY & PHYSICAL

PATIENT IDENTIFICATION

PHYSICAL EXAM

(Problems Focused / Expanded - 1 or more areas; Detailed - 6 or more areas; Complete - 9 or more areas)

Vital Signs ☐ Afebrile, Vital Signs Stable T 96.8 P 77 R 22 B/P 166/76

1. Gen ☑ WDWN
   ☐ Other _____
2. HEENT ☑ NC/AT, PERRL, Conjunctiva nonicteric, Fundi wnl, O/P clear, TMS clear.
   ☐ Other _____
3. Neck ☑ Supple w/o thyromegaly or lymphadenopathy; trachea midline.
   ☐ Other _____
4. Resp. ☑ CTA Bilaterally w/o rubs. Retractions, or use of accessory muscles or diaphragm.
   ☐ Other _____
5. Breast ☐ Symmetrical in size, w/o masses, retractions or nipple discharge.
   ☐ Other patient
6. C/V ☑ RRR w/o MGR, PMI nondispalaced and nl in size without thrills.
   ☐ Other _____
7. Abdomen ☑ Soft = BS, NT w/o HSM.
   ☐ Other _____
8. G/U ☐ (male) nl male genitalia, w/o scrotal masses, tenderness, hydrocele or spermatocele. nl prostate w/o tenderness or nodularity; heme neg. stool.
   ☐ (female)
   ☐ Other def hx 1° CVA resp and dl
9. Rectum Exam ☐
   ☐ Other _____
10. Lymphatics ☑ neck, axillae and groin w/o adenopathy.
    ☐ Other _____
11. M/S ☑ nl posture and gait; nl strength and tone w/o rigidity, flaccidity, atrophy, tenderness, misalignment, asymmetry, subluxation or effusion; FROM w/o limitations.
    ☐ Other _____
12. Skin ☑ nl w/o rashes, lesions, ulcers, induration or nodules.
    ☐ Other + atro/minimal hematoma on CAT. (scar frontal scalp region)
13. Neuro ☑ Cranial Nerves intact: DTRs 2+ bilateral and symmetric; Babinski absent.(See Page 3).
    ☐ Other _____
14. Psych ☑ Alert & Oriented X3; intact remote and recent memory: appropriate affect.
    ☐ Other _____

LABS / REPORTS:

MENTAL STATUS EXAMINATION:

A1043 Dysphoric. Tearful. Memory intact.
No overt psychosis. Denies present HI or SI.
No paranoid thought noted. Judgment impaired.
Generally good insight. Rather concrete in
understanding. Conc diminished.

PATIENT ASSETS: Good Health.

PATIENT LIABILITIES: Denies family support.

PROVISIONAL DIAGNOSIS:

AXIS I: Organic Mood Disorder THC Abuse

AXIS II: Defer.

AXIS III: SID Head Injury Headaches

AXIS IV: Moderate

AXIS V: 30-40

ESTIMATED LENGTH OF INPATIENT TREATMENT: 7-10

INITIAL DISCHARGE PLANS: ☒ HOME ☐ PLACEMENT
☐ OTHER:

INITIAL TREATMENT PLAN: Admit / Labs / Meds / Milieu
Pharmacologic Interv. Tx
includes this is disorder pt. Hx
Counseling.

I believe this patient requires Inpatient Hospitalization. I do not believe this patient could be adequately and appropriately treated in a less restrictive environment. My decision is based on the preceding clinical information.

PHYSICIAN'S SIGNATURE

1/15/02 10am
DATE/TIME

THREE RIVERS CENTER
FOR BEHAVIORAL HEALTH

CONTINUING CARE/ DISCHARGE PLANNING

1012022
FLOYD, SCOTTIE W.
191-16 HEATH
26 M W
PATIENT IDENTIFICATION NUMBER 2002

NAME:	AGE:	ADMISSION DATE:	DISCHARGE DATE:	CURRENT LEVEL OF CARE:
SCOTTIE FLOYD	26	14 JAN 02	22 JAN 02	LEVEL III

STREET ADDRESS:	THREE RIVERS PHYSICIAN:
CITY: ~~Loris, SC 29~~	DR. HEATH, MD
PATIENT TELEPHONE NUMBER:	PHYSICIAN TELEPHONE NUMBER: 1 866 796 9511

DISCHARGE TO:	TRANSFER TO:	DATE OF NEXT ATTENDANCE:
Home		

☑ ROUTINE ☐ AMA ☐ AT PATIENT'S OR FAMILY'S REQUEST ☐ OTHER (Explain):

TRANSPORTATION: ☐ PERSONAL CAR ☐ PARENT/RELATIVE ☐ PUBLIC ☐ SELF ☐ OTHER (Explain):

ACCOMPANIED BY: RELATIONSHIP:

FOLLOW-UP APPOINTMENTS

	NAME	ADDRESS	TELEPHONE NO.	DATE OF NEXT APPT.	TIME
Psychiatrist:	Dr Mark Wanbaum	901 E Cheves St Ste 460 Florence, SC 29506	1-843-679-7275 FAX 679-7285	2/11/02	1:30
Mental Health Center:					
Individual Therapist:	Ross Eul. Leg PhD	417 S. Dargan St. Florence, SC 29506	1-843 676 0200 FAX 1-843-676-0623	1/24/02	2PM
Marriage/Family:					
Primary Care Physician:	Dr. Robert Healy / LINDA BOLDUKE		1-843-664-9200	2/6/02	9:30 am
☐ Gp Home/RTC ☐ Continuing Care ☐ PHP ☐ IOP ☐ RTC					

MOM

Other treatment recommendations such as Support Groups, Specific Exercise Programs, AA/NA etc. Also address Social Services components such as appointment with State Disability, Social Security, Welfare, Home Health, Supportive Living, Etc.

	TIME	DAYS
		1

MARIE MARINA

THREE RIVERS CENTER
FOR BEHAVIORAL HEALTH

CONTINUING CARE/ DISCHARGE PLANNING

1012022 F

FLOYD, SCOTTIE W.
191-36 HEATH
26 M W
01 14 2002
IDENTIFICATION NUMBER

DISCHARGE MEDICATION(S)		AMT. PRESCRIBED	DOSAGE	FREQUENCY	ROUTE	REFILL Yes	REFILL No
DEPAKOTE	O	#90	500mg ÷	THREE TIMES DAILY	BY MOUTH		
CEFTIN		#16	250mg ÷	TWICE DAILY	" "		
[redacted]	X	#30	[redacted]	EVERY 8 HRS AS NEEDED	[redacted]		
NEURONTIN	O	#90	300mg ÷	THREE TIMES DAILY	" "		
PANLORSS	O	#30		1 OR 2 AS NEED	" "		✓

TALBIJAX
ED TO TAKE

PRESCRIPTIONS HAVE BEEN GIVEN TO THE PATIENT:
☒ YES ☐ NO ☐ N/A (If No) Explain why:

Medication Administration/Side Effects/Importance have been explained to my satisfaction and understanding.
Patient Initials: SWF

PRESCRIBED MEDICATIONS ARE INDEED AVAILABLE THROUGH INSURANCE, SELF-PAY, ETC.: ☐ YES ☐ NO ☐ N/A
IMPORTANCE OF MEDS DISCUSSED ☐ YES ☐ NO

SPECIAL INSTRUCTIONS / ADDITIONAL INFORMATION: Arrange follow up with Neurologist on O/C
RE: Chronic Headaches.

If you experience any problems go to the nearest emergency room, call 911 or call TCA Crisis at 746-9911

I understand and agree with the preceding instructions. Personal items and valuables have been returned.

X Scottie Floyd
PATIENT'S SIGNATURE

FAMILY / GUARDIAN (as appropriate)

NURSING STAFF SIGNATURE

1094

THREE RIVERS CENTER
FOR BEHAVIORAL HEALTH

CONTINUING CARE/ DISCHARGE PLANNING

1012022

FLOYD, SCOTTIE W.
191-36 HEATH
C 5 26 M W
3 01 14 2002
PATIENT IDENTIFICATION NUMBER

PATIENT DEMONSTRATES UNDERSTANDING AND KNOWLEDGE OF:

Patient's family involved in treatment ☐YES ☐ NO ☐ N/A Please explain: Mother & Paul Beth	When and how to seek further treatment ☐ YES ☐ NO ☐ N/A
Potential Drug-Food Interaction: ☐YES ☐ NO ☐ N/A	Family demonstrates ability to care for patient: ☐ YES ☐ NO ☐ N/A
Patient's care coordinated with primary care/ family physician ☐YES ☐ NO ☐ N/A Please explain:	Nutrition Intervention and/or Modified Diet: ☐ YES ☐ NO ☐ N/A

During treatment physical problems that were identified / treated:

Problem areas to be addressed in Continuing Care:

Three months' goals for Continuing Care:

FINANCIAL SUPPORT EDUCATION/ VOCATIONAL PLANS	SCHOOL	WORK	SPECIAL CONDITIONS
	☐ Part-time ☐ Full-time ☐ Other (Please explain)	☐ Part-time ☐ Full-time	

Brief Treatment Summary (i.e. reason for admission, interventions, response) and patient's condition on discharge:

PT said that family got rid of his firearms.

PT denies SI & HI

Social Services Signature: [signature] MSW, LPCT

DISCHARGE DIAGNOSIS:

AXIS I: Mood Disorder NOS
THC Abuse

AXIS II: Suspect Delusional Pers. Traits

AXIS III: S/P closed head injury
sinusitis
Hx of headaches

AXIS IV: moderate

AXIS V: 45 / 30
DISC - / ADM -

1095

FLORENCE COUNSELING SERVICES

Scotty Floyd January 24, 2002

Initial Psychotherapy Evaluation

This was first treatment session with this 27-year-old male client. He was referred my services by Three Rivers hospital in Columbia following his psychiatric admission there. A female friend accompanied him to the treatment session.

Client provided me with the following information pertinent to his admission treatment. Client stated that his present difficulties began when he was accidentally hit in the head with a suspension spring while working on an automobile. The blow was severe but did not require hospitalization. He stated that after the accident he had difficulty with short-term memory, working memory, irritability, and impulsivity. He also experienced severe headaches and is sensitive to bright light in his right eye, feels sound is distorted in his right ear, and reports no sense of smell in his right nostril. Client was able to work during October, November, and December but his work attendance was sporadic. He feels that he was getting inadequate medical care for his complaints. He made several visits to emergency rooms in January. He was also unsatisfied with the emergency room care and after emergency room visits on 1/6/02 and 1/8/02 he visited another emergency room on 1/13/02 with a loaded gun. He told emergency room staff that if he did not receive effective treatment that he would shoot himself outside of the emergency room. This led to his admission to Three Rivers Hospital in Columbia were he was treated as a psychiatric inpatient for eight days. Client stated that he was discharged on 1/22/01. Client stated that the most helpful part of the admission was the initiation of medical treatment addressing his complaints. In addition to seeing me he also has appointments scheduled with Dr. Marc Weinbaum, a psychiatrist, and Dr. Healy, a neurologist in the near future.

During the interview client's speech was somewhat pressured, rambling, and circumstantial. He acknowledged and displayed overt and severe problems with short-term memory. He frequently referred to notes and documents and asked for permission to tape record the treatment session. He was also conscientious about taking notes or writing things down that he felt he might need to remember. While his speech was somewhat pressured and intense he appeared to be making significant effort to not act or speak impulsively. He stated that he has to deliberately stop and think before speaking or acting. This was noted to occur numerous times during this session. A friend was present during the treatment session and he depended upon her numerous times for clarification or details while. Prior to his admission at Three Rivers Hospital client had very severe headaches. The headaches are still present but much more tolerable. The headaches, irritability, and impulsivity are significantly improved since the hospitalization. He attributes the improvement primarily to medication including Depakote 500 mg tid, Ceftin 200 mg bid, Fioricet tabs 1 or 2 tabs q8h prn, and Neurontin 300 mg tid. Client strongly denied any suicidal ideation or intent and stated that he was no longer possession of any firearms. When he was discharged from Three Rivers hospital he moved out of his own apartment and moved out in with his mother. He acknowledged a history substance abuse and stated that he has been using marijuana to cope with the headache pain. He agreed to abstain from use of non-prescription drugs or alcohol while in treatment. Problems with short-term memory, irritability, and impulsivity were overt during the treatment session. Client also acknowledges being sad for much of his life but stated that this has worsened since the accident. His memory problems interfered significantly with the interview and assessment of psychiatric symptoms and functioning will continue in future sessions.

In the next treatment session will assess psychiatric symptoms and functioning in greater detail. Will administer a Beck Depression Inventory and Beck Anxiety Inventory and if time allows will begin assessment of family history. Will also strongly encourage follow-up with the psychiatrist and the neurologist as appropriate medical treatment is crucial to his care.

ROSS FULCHER, MS, RNCS, P.A.

Ross Fulcher MS, RN, CS

FLORENCE COUNSELING SERVICES

Scotty Floyd January 29, 2002

INDIVIDUAL THERAPY

Client's mother was present for this treatment session. There's been no significant change since the last treatment session. His presentation was much like that noted in the initial session. He has abstained from any substance abuse. During this session continued assessment with administration of a Beck Depression Inventory and a Beck Anxiety Inventory and his scores were in the extremely severe range and mild-moderate range, 31 in 23 respectively. His scores were initially lower, however client acknowledged that he had been skimming through the test and only reading and selecting from the first items for each question, consequently this distorted his score. This impulsivity appears to be characteristic of his coping at present. While client was taking the depression and anxiety inventories I spoke with his mother and she describe changes in his functioning and cognitive performance consistent with that described in the last note. In particular she noted memory problems, difficulty with problem solving, difficulty tolerating frustration, difficulty with word finding and communication of concepts, increased irritability, and increased suspiciousness. She also noted that he makes a sincere effort to control his impulsiveness and to cope with the cognitive changes. Given client's deficits he does not appear to be a particularly appropriate candidate for psychotherapy at present. However he may benefit moderately from instruction in stress management and relaxation techniques as these may lower his stress level and assist with impulse control. We've scheduled one more session specifically to address basic stress management.

Ross Fulcher MS, RN, CS

FLORENCE COUNSELING SERVICES

Scotty Floyd February 5, 2002

INDIVIDUAL THERAPY

There's been no significant change since the last treatment session. Client has found that workers compensation will cover his treatment and found this to be quite a relief as his medical expenses and health-care needs are significant. Client has continued to abstain from marijuana use but states that he believes this has resulted in increased nightmares. He is scheduled to see Dr. Healy tomorrow and Dr. Weinbaum on February 11th. The primary focus of this treatment session was on introducing client to breathing/relaxation exercises and diaphragmatic breathing to provide him with a simple tool for stress management and impulse control. Client practiced this successfully during the treatment session and showed a surprising amount of skill with diaphragmatic breathing. He acknowledged that he has found this technique to be helpful with impulse control but has not used diaphragmatic breathing as a part of a meditation technique. We did not schedule additional sessions as evaluation and treatment by the neurologist and psychiatrist are probably more appropriate given client's presentation and the likely physiological causation of his distress and difficulties. I encouraged client to contact me to schedule additional sessions if he feels that this might be helpful.

Ross Fulcher MS, RN, CS

FLORENCE COUNSELING SERVICES

Scottie Floyd March 26, 2002

INDIVIDUAL THERAPY

This was the first session with this client since February 5th. He is presently under the care of Dr. Healey, a neurologist, and Dr. Weinbaum, a psychiatrist. He stated that Dr. Weinbaum had recommended he pursue counseling in addition to this medication management. Client status is much like that described in the previous notes and no overt change was apparent. Client stated that he believes his memory has improved only slightly but that the difficulties with headache, irritability, vision, and hearing remained unchanged. Client also expressed concern about flashbacks of family violence that occur when he is startled or experiences anger. These flashbacks exacerbate the anger when they occur. Client has found severe headaches, bad nightmares, and difficulty sleeping to be quite distressing. Over the last two weeks nightmares, headaches, and difficulty sleeping have been particularly severe. This is being addressed medically and he has made arrangements to work with Ms Renee Williams at McLeod Psychiatric Associates on a regular basis to coordinate his medical care. We agreed that we would not try to address physical and medical issues during the counseling sessions. He stated that the psychological problem most distressing at present is irritability and anger. Additional issues that may be addressed include acceptance of the physical and mental consequences of his head injury. He feels that he must constantly struggle to control his anger and recognizes that the irritability and anger are excessive and frequently inappropriate. We reviewed typical techniques for anger reduction, management, and control. Client was willing to listen but tended to focus on reasons why these approaches would not work. Despite his expressed doubts about cognitive and behavioral anger reduction techniques he stated he was willing to consider this approach. Given the possible organic factors contributing to client's chronic irritability and his difficulty with short-term memory the effectiveness of counseling will have to be judged by the actual outcome. Whenever possible treatment will be modified and adapted in consideration of clients specific needs and abilities.

Between now and the next treatment session client agreed to keep track of anger provoking situations and the associated thoughts and behaviors. We will begin to explore these specific situations to see how cognitive restructuring might be applicable.

Ross Fulcher MS, RN, CS

FLORENCE COUNSELING SERVICES

Scottie Floyd April 2, 2002

INDIVIDUAL THERAPY

Client status may have deteriorated slightly since the last treatment session. A friend of his, Ms. Beth Nesbit, was present during the treatment session at client's request and confirmed client's descriptions of his difficulties. He continues to have constant headache, upset stomach, significant difficulty with short-term memory, has slightly increased irritability, acknowledges increased suspicions of others, and stated that he has to work harder to control his irritability. He denies any specific suspicions of others but is quick to feel threatened by others for minor reasons such as feeling that others are staring at him. He stated that he is concerned that he might hurt someone while sleepwalking and has been locking his bedroom door so that he will have to wake up to leave his room. Client admits to carrying knives for self-defense. There have been no episodes of loss of control or threats to others, however client stated strongly that he would hurt someone else to protect itself. During this session his pupils were dilated. When this was pointed out he denied any recent substance abuse. He has decreased his use of prescribed medications due to the severe upset stomach. He recognizes that this may have an adverse effect on his status but stated that the GI distress is intolerable. He has used marijuana since last session and stated that this had a beneficial effect on his irritability, paranoia, and headache. He also stated that he sleeps better with decreased upsetting dreams when using marijuana. Cautioned client about the adverse effect this may have on his illness, medication management, and treatment.

Discussed and explored client's irritability and suspiciousness of others. He was initially reluctant to acknowledge that the suspicions that others might hurt him are exaggerated or admit that he might act impulsively because of his irritability and suspiciousness. He denied any plans or intention of hurting himself or anyone else. However when the risk to others due to suspicions or impulsivity was directly confronted he agreed to give all of his knives to his female friend, Ms. Beth Nesbit. He also acknowledged that he had been seeking this limit and had provided me with information about his suspiciousness and irritability with the belief that he would be directed to give his knives to someone else for safekeeping. Given his level of irritability and suspiciousness problem solving reference impulse control and allowing an opportunity for ventilation appeared to be the most appropriate interventions for this session. Exploring and restructuring thoughts that frequently contribute to anger was not deemed appropriate as client stated that almost everything is irritating at present.

Client is scheduled to see Ms. Renee Williams LPC for McLeod Psychiatric Associates on Thursday to address issues with medication management and coordination of medical treatment. He is scheduled to see his neurologist next Tuesday and his psychiatrist the following week.

Ross Fulcher MS, RN, CS

FLORENCE COUNSELING SERVICES

Scottie Floyd April 15, 2002

INDIVIDUAL THERAPY

Client's mother was present in this session. Client presentation and communication were basically unchanged over past sessions. He was seen in the emergency room on April 5th for headache and received 2 injections, he could not remember the medication used. He stated that he was hospitalized for neurological evaluation on April 9, 10, and 11. He denied any significant findings or changes in treatment as a consequence of this hospitalization. He expressed some anger that the neurologist, Dr. Healy, had told him that the headaches were "psychological." During the session he continued to be intense and angry but controlled his behavior appropriately with the exception of the intensity of communication. He continues to be quite frustrated with his lack of progress and with what he sees as ineffective medical interventions. Also expressed frustration about the quality and quantity of communication with his physician's. Client continues to honor his agreement to have someone else maintain possession of his knives and guns. He also stated that he is very aware of the consequences of impulsive or violent behavior. Reinforced his success in controlling his behavior since his hospitalization in January. Given the characteristics of client's illness and the heavy medical aspects of this treatment we agreed that his needs would best be served by seeing Ms. Renee Williams of McLeod Psychological Associates for counseling as she is better able to interface and coordinate care with his physician's, particularly his psychiatrist Dr. Weinbaum. Client is quite comfortable with this arrangement.

Ross Fulcher MS, RN, CS

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: SCOTTIE FLOYD Patient #: 4226

P1

DATE	PROGRESS
2-11-2002	SCOTTIE & HIS MOTHER ARE SEEN FOR A 60MIN PSYCH EVAL.
	NOTE DICTATED
	Dx: 293.83: DEPRESSION DUE TO TRAUMATIC BRAIN INJURY
	310.1: PERSONALITY CHANGE DUE TO TRAUMATIC BRAIN INJURY, COMBINED TYPE.
3-12-2002	DOESN'T THINK HE'S DOING BETTER, BUT APPETITE IS IMPROVING & HE IS LESS EMOTIONAL & SOCIALLY ISOLATED. NO ADVERSE SE TODAY. HE IS CHEERFUL & SPUNKY IN INTERVIEW. NO EVIDENCE OF THOUGHT DISORDER. HE IS UNCERTA ABOUT CONTINUING WITH INDIVIDUAL TRX, WHICH WAS DISCUSSED. DR HEALY D/C'D NEURONTIN 3WKS AG
	=> CONT. INDIVIDUAL TRX TO DEAL E Δ ING SELF CONCEPT & SELF ESTEEM ISSUES OVER TI
	=> 4 GOLOFT TO [illegible] PO QAM
	=> RTC 4WK
3-26-02	RTC Apr 4 @ 3:30 MMR

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Floyd Patient #: 4226

DATE	PROGRESS
3/26/02	60 min INDIVIDUAL C E+M Pt. reports decompensating. Feels meds not working. Unable to sleep / 3° @ most 4am - 7am, ↓ appetite, ↑ irritability / short tempered, feels ↑ rage - withdrawing from others so won't risk exploding, ↑ headaches - sinus / allergy related. Dr. Healey did confirm left hemisphere damage c prognosis of 6 mos - 12 mos recovery. Pt. had d/c ~~spr~~ Neurontin due to episodes of ringing in ears, seeing stars & feeling to knees c weakness. These episodes have continued off Neurontin. No S/H ideation. Discussed use of coping strategies & psychological impact of losses he has experienced since accident. Having nightmares. Won't go to sleep - fear nightmares. "Keep everything inside." Discussed using therapy, Ross Fulcher, to focus more on his issues, express self & explore coping. He will discuss c Ross today - 5p appt. Yc to Dr. Weinbaum. He requests this staff talk c Dr Healey re. episodes + ? of restarting Neurontin. Ringing of ears SE of Butalbital? Staffed c Dr. Heal. -- Pt. gave permission for release of info + in [illegible]

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Hoyt Patient #: 4226

DATE	PROGRESS
3/26/02	pt. have retrial of Neurontin. Ordered Neurontin 300mg T po QHS for 3 d then ↑ T po QBID for 3d then ↑ T po Q8°. Pt. agreeable. He has medication @ home does not need Rx. Wrote dosage out for pt & his mother. Pt. to call c any SE's / or problems. Pt. to F/U c this staff in 1 wk. will monitor status, case manage c MD's and tx needs. Pt. gave verbal permission for this staff to discuss case c R. Fulcher. Dc to Ross informed of today session. Ross to see today - will explore possibility of Scottie just F/U c this staff. Ross will inform this staff of outcome of session. Kimberlin LPC, CACII
pt's mom To call to provide allergy hx.	
3/29/02	Informed Dr. Healey that pt had med. Did not need Rx called in @

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Floyd Patient #: 4226

DATE	PROGRESS
4-4-02	RTC Apr 18 @ 3:30 MR
4/4/02	60Min Individual: Not doing well: dwindles jittery, muscles messed up, twitching, anal pain-fear hemmoroids, restless, edgy, twitching when does sleep. ↓ Depakote + Neurontin to take only once daily. States this helps bowel trouble + he plans to ↑ when bowel problems have cleared. Headache x 3 d. Meds not working. Nightmares, bad thoughts, paranoia, falling step out. Relinquished all weapons. None available. Brenda has them all. Denies S/H intent. Agrees to seek/utilize ER services if needed. Sees Dr. Healey + Dr Weinbaum next wk. -no marijuana in 4 days. Use as often as can. Controllable recall all morning. ↓ Appetite Lost 6 lb in 1½ wks. Staffed c Dr Weinbaum. Recommended ↑ meds back to original dose. Can take first once day: Depakote 1500 QHS + Neurontin 300 QHS (Never ↑) Pt agreeable. Will call c any problems. Discussed alternatives for agitation: walking when can, ice for HA - dark room, ER for injection if severe pain, avoiding people/places that ↑ agitation. Allowed barrier to walking discussed best KS walk. Shower afterwards to ↓ pain. Began discussion of guilt over loss fear letting out. Held in. Explored process of therapy + response to it. Will continue to provide services. Dx: 293.83 + 310.10 Renee Williams LPC, CACII
4/5/02 Phone Call	Out of Butalbital. (Has 5 pills) Dr Healey not in office - No coverage. Dr. Weinbaum agreeable to call ~~until appt c Dr Healey 4/9~~. Butalbital 50mg. 1 TID #16 a test

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Hoyt Patient #: 4226

DATE error @ Refer to previous page PROGRESS

4/4/02 60 min individual: Scottie reports not doing well. He states that his: jittery, missing missed sleep. Twitching. Anal pain. Only ↓ Depakote / Remeron after meds at bed x1 day. Take meds once a day to get levels out - ↓ dosage myself. w/up ↑ back up when feel better. Headache x 3 days. Meds not working. Bad thoughts - nightmares - paranoia, taking self out. Relinquished knives. NO weapons friend has all weapons. Denies SI/H. Dr Healey & Dr Hembree next week. Marijuana none 4 days as often as can. None available in 4 days. "Ell" all am. Everything makes irritable. Appetite poor. Lost 6 lb in wk + ½.

4.17.02 Tc.: MOTHER CALLED TO EXPRESS CONCERN OVER SCOTTIE. APPARENTLY, HIS H/A ARE MUCH WORSE, SINCE DR HEALY Δ HIS MEDICATION. HE IS ANGRY TO THE POINT SHE IS WALKING ON EGGSHELLS AROUND HIM, FEARING WHAT HE MIGHT DO.

SHE WAS ENCOURAGED TO GET SCOTTIE BACK Ō DR HEALY FOR THE PAIN. SHE WAS GIVEN INSTRUCTIONS ON HOW TO PURSUE IVC, IF NECESSARY

⇒ REEVAL AS SCHEDULED

1106

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Floyd Patient #: 4226

DATE	PROGRESS
4/18/02	Pt. mother called cancelled appt. for today. Re-scheduled with Dena for 4/23/02 @ 3:30 (Pat) MW
4/9/02	NOTE IS Out of order Phone call: staffed case c Dr. Healey. He is to see pt today updated on mental Status, medications + other tx. interventions. Will maintain contact c/w/ clinician LPC, CACII
4/23/02	60 min individual: Dr. Healey. Recommended Neuropsychological eval c Dora Winaswora. Adj. meds @ re. blood in stool, help relax + antibodic - sinus infection. HA little better. hurts only on nose Quitting smoking 3/4 ppd down to 1 ppd. Gained weight back. Sleep - 1-2° at time off + on throughout day. Still isolating. get out to go to MD + Walmart on those days Continues Marijuana use 3 times per day. Nightmares of childhood + accident everytime go to sleep. More open today in discussing anger, loss + past experiences - little insight on childhood (abuse, mothers screams) will diagnose

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Lloyd Patient #: 4226

DATE	PROGRESS
4/23/02	Subject. States will get there just need more time. Able to examine process of tx.
	Has knives back. Everything taken away. Need something. Lost control of everything. Denies any S/H intent. No thoughts of self harm or harm to others. Will relinquish knives should thought reoccur.
	Today mood brighter. More talkative. Quit meds 4 days last d/c. Restarted. Thought weren't working. tired of MD's. Discussed
4-23-02	RTC May 7 @ 3:30 MR
	importance of med compliance per max benefit. Several times of d/c meds or ↓ dose. Verbalizes understanding.
	RTC 1-2 wks. Lenea Willis LPC CACII
	Dx. 293.83 + 310.1 (I)
5/1/02	See med request sheet. Willis LPC, CACII
5/7/02	INDIVIDUAL: Scottie reports ↑ symptomatology. Has stopped all meds. Refuses to take. Not helping. SE's make worse. no marijuana either. Irritable. Wants to manage irritability. Discussed need for meds given head injury + mood/ personality disturbance 2° to. Discussed probability of cog-behavioral-interpersonal

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Bertie Floyd Patient #: 4226

DATE	PROGRESS
5/7/02	Discussed D/C 1 med @ time to determine cause of SE's. Pt. refuses to go back on any previous meds. Agreeable to new med. Staffed c Dr. Weinbaum. He Ordered Celexa 20mg ↑ QHS + Sonata 10 ↑ QHS for sleep - may repeat dose if 4° left to sleep. Rx given. Copies in chart. Discussed med compliance as well as alternative coping. Processed frustration c illness + loss of functioning. Continue to follow. Mood agitated. No S/H ideation. Aware of staff/ER availability if symptoms ↑. RTC 1 wk. Rx. 293.83 + 310.1 Cynthia LPC, CACII
5-7-02	RTC May 16 @ 2:30 MAR
5/16/02	INDIVIDUAL 60 MIN: Taking Celexa 20 mg. NO other meds except Sonata - Initially ↑ sleep to 4° - helps off & on. Past 3 nights not helping at all. Only taking ↑. Hasn't taken 2nd - system delicate little more low key. ↓ irritability appetite still fluctuates jaw pops, Right ~~Left~~ eye - impaired multi tasks - ↑ irritability. Trying - to... practice and implement new coping - planning ... MAR 5/16/02

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Bertie Floyd Patient #: 4226

DATE	PROGRESS
5/16/02 cont.	Self-breathing, eight weights. Frustrated over limitations which sound too extreme (told can't even feed the dog or pick up trash.) Discussed clarifying this c MD/lawyer. Should be able to do non strenuous tasks? Discuss @ next appt. c Dr Healey. Paranoid over what can do what can't. Don't want to reinjure self or jeopardize attorney case-to point of not even doing simple tasks-taking out trash. Discussed loss of functioning. grief. anger. boredom. More open in discussing losses today. Reinforced & provided support. Sonata Rx given c coupons. Will call NP. Casemanager to get Sonata approved. Utilize coupons until then. Pt. will call c #'s. Dx: 293.83 + 310.10 Lucille APC CACII
5/27/02	Pt. re-scheduled for 6/11/02 @ 3:30

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Hoyd Patient #:

DATE	PROGRESS
5/24/02	Phone Call: TC to Linda Bolduc / Anne Thompson to approve sleep medicine 919-781-3149 or 1-800-772-8914 Fax 910-842-9107
	They will approve meds need to fax RX. ? Wheter Sonata effective. Update on last appt. c Dr Healey: told Dr Healey Sonata not effective taking II-III (I QHS then repeating when awaken) Will reassess @ Nov. appt. v staff c Dr. Weinbaum. Pt. agreeable. Had "shot" for sleep 5/23 pm in ER. Fell off bed & hit head MRI in ER clear.
	Linda reported Dr Healey feels brain c healed. Headaches emotional. Injury in area of brain where pt. sustained injury can result in personality disturbance. Cleared for all activities. Able to drive. Unsure ? about returning to work - irritability / anger management. June 4th Dora Windsorova, Ph D- Neuro Ψ testing. Will await outcome before recommending return to work per Linda / Dr Healey. Will maintain contact c Linda Bolduc as needed
	Renee William LPC CAC II
5/29/02	Pt. unable to sleep. Missed last appt. Staffed c Dr Weinbaum. DC Sonata. Trial Ambien - I QHS, Rx in chart. Called in to CVS. Will fax Rx to Case Manager

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Hoyt Patient #: 4226

DATE	PROGRESS
5/30/02	Rx faxed to Linda Bolduc so she can facilitate payment to drug store through Workmans Comp. TC to Linda to inform of fax. Phillip LPC CACII
6/3/02	Appointment Reminder Call Made ~~Answering~~ Spoke with machine.
6/4/02	Pt did not show for apt. Sent ~~letter~~
6/11/02	Individual 60 min: Met c pt. + his mother. Pt. reports poor sleep still, headaches - sporadic Did not get Ambien - not approved yet. Will call to check on as should be approved Doing a little more in yard / around house but heat aggravates headaches. Continues to be frustrated c limitations. easily agitated. yl. Agitation + Depression some better c Celexa. Discussed behavioral strategies using to manage agitation and generated additional strategies: Discussed frustrations / losses since accident. Minimally processed Difficulty processing cognitively + easily agitated c "Suicidal" "Don't want to talk about." Neuropsych eval being done by Dora Windsorova Ph Should finish in next 2 wks. Needs Celexa refill - Sees Dr Weinbaum 1112 next

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Hoyt Patient #: 4226

DATE	PROGRESS
6/11/02	Samples issued:
conf.	TC to Linda Bolduc re: approval for Ambien
	left message:
	Continue F/U c this Staff. Dx 293.83 310.10
	Jennifer LPC, CACII
6/13/02	Phone Call: Ambien approved per Linda Bolduc.
	Call to pt mother. She will pick up Rx
	Jennifer LPC CACII
6/14/02	Appointment Reminder Call Made ~~Consulting~~ Spoke with machine. Mat
6-17-002	MED EVAL PT & MOTHER, BOTH AGREE HE IS
293.83	DOING BETTER SINCE D/C'ING HIS MEDS & STARTING
310.1	THE CELEXA. HE IS LESS IRRITABLE & SAYS
	HE IS ABLE TO KEEP A LID ON HIS ANGER, WHEN
	IT ~~ARISES~~ RISES. BOTH AGREE THAT, ALTHOUGH
	BETTER THAN HE WAS, HE IS NOT CONTINUING TO
	IMPROVE. NO SE.
	⇒ ↑ CELEXA TO 40MG PO QHS
	⇒ CONT AMBIEN 10MG QHS
	⇒ RTC 6-8 WKS AD
7/5/02	Appointment Reminder Call Made patient. Spoke w/ Renee Mat

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Floyd Patient #: 4226

DATE	PROGRESS
7/8/02	60 min INDIVIDUAL: Pt reports ending relationship ε girlfriend. Became agitated ε her- ↑ headache + irritability. She pushes buttons to see what will do. Warned not to - won't listen - Keeps on ×3 enough. ended relationship to avoid losing temper + if doesn't respect my requests don't need. Discussed patterns ε irritability. Past could hold back. now openness - agitation just comes out. If feel real bad / just lock self in room. During day when alone. do things to agitate self (set alarm to beep - hate sound) Want to build tolerance to irritability. Practice Managing. Discussed benefits + consequences of added tension. Few coping strategies. Still poor daily structure. Difficulty functioning - heat - ↑ headaches Processed emotional responses. Patterns: Brief. past abusive relationships as child. Relationship ε mother. More open + interactive. Able to express feelings to a degree. Examined process. Able to recognize benefits of IT. Motivation, improved mood. Reinforced progress today.

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Floyd Patient #: 4226

DATE	PROGRESS
7/8/02	Continuing to address emotional/interpersonal issues: Mood agitated. Affect restricted. NO S/H ideation. Continues marijuana use → provided education, explored positive intents, motivation to change. Feels med (Celexa) helpful. Continue it. RTC 2wks. DX: 293.93 / 310.10 Jennifer Millican LPC CACII
7/25/02 See next note Vivactil 10 mg 1 QD	Dr Healey d/c Amitriptyline. Started Trazadone 50mg i QHS 7d ii QHS 7d iii 7d. Sun/heat - headache Appt Dr Healey next wk 2 tests ~~EEG~~, B E

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scattie Hoyd Patient #: 4226

DATE	PROGRESS
7/25/02	60 min INDIVIDUAL. Scattie reports improvement c Celexa. ↓ depression but continues to struggle c agitation, obsessive thinking, temper control (continues to work on building frustration tolerance) Complains SE's sexual dysfunctio Staffed c Dr. Weinbaum. Ordered Viagra #6 samples issued. Ordered Risperdal .5mg ↑ QHS x 2 days then ↑ BID. If ↑ sedation may just take .5mg ↑ QHS. Pt. agrees. Risperdal .5 #28 samples issued. Will call c any problems. Dr. Healey d/c Ambien. Started Trazadone. Also, focused on daily structure, loss of functioning. grief work, interpersonal issues c mother. Open in expressing feelings/concerns. Reinforced ↑ openness. mood euthymic. More relaxed. no S/H ideation. Dx: 293.83 / 310.10 Dulcie Lee LPC CACII
8/7/02	~~Appointment Reminder Call~~ Spoke ~~Mother~~ Pat
8-8-02	RTC Aug 28 @ 3:30 pm ~~EJH 45~~

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Lloyd Patient #: 4226

DATE	PROGRESS
8/8/02	60 min INDividual Scottie reports doing better. Continues experience agitation · irritability · feels handling better · less volatile w/ mess meds can tell difference - ↑ agitation · feel meds are "excellent" Expect headaches Accepting less upset when occur · I/D + implementing alternative coping (plants, craft projects) ↑ daily structure as result · Feeling more productive · ↑ rapport ⊂ Dr Healey · Δ meds D/C Ambien · Change Celexa from HS to AM Trazadone 50 ½ QHS + ½ prn for severe insomnia Tramadol HCL 50 mg ½ BID prn Topamax 25 ½ QHS 7d then 1 QHS Risperdal .5 ½ BID · EEG - Frontal Lobe "slow" not sure what he meant. Requests consult ⊂ Dr. Healey. Wonders if call F/u ⊂ Dr Healey rather than Dr Weinbaum given ↑ appts · /transportation/ finances · will stay ⊂ both. Reinforced progress · Discussed interpersonal issues - GF/conflict able to problem solve · explore feelings + concerns · ↑ openness · Mood euthymic · neg S/H ideation · Med compliant · NC A/D this week · Dx 293.83 310.10

Initial/date CPC CACII

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Floyd Patient #: 4226

DATE	PROGRESS
8/8/02	Requests samples. Dr Weinbaum issued Celexa 20 mg # 56 1 QAM Risperdal .5 mg 1 BID # 35 Jill Gillian LPC, CACII
8/22/02	Stopped c Dr Weinbaum. Okay to F/U Dr Healey. Take Celexa QAM. Phone call to Dr Healey he is agreeable also. Phone call to Scottie to inform. Gillian LPC CACII
8/29/02	60 min individual. Pt. reports doing status quo. Couple episodes of agitation & ongoing headaches. able to process agitation after episodes & apologize when needed. Heat continues to exacerbate headaches. Having to stay indoors. & boredom & feeling unproductive. Continued grief over loss of functioning. able to process above. Open in sharing feelings & explaining ways to ↑ daily structure & self worth. Taking course work for HS diploma. Reinforced & encouraged. Several ideas generated for exploring as a hobby. Also processed getting tools from workplace & handling any "[illegible]." Doesn't have $ to pay off tools - will [illegible] 1118 [illegible] PTP 4 wks. moved

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Hoyd Patient #: 4226

DATE	PROGRESS
8/28/02	euthymic today. affect appropriate WO SI/HI ideation. Had DTs mod for 3 d due to severe headache. Dr. Healey started on Zantac(?) this helped. Plans to resume Ψ meds today. Dr Healey aware. Ruthellum LPC, CACII
8-28-02	RTC Sept 25 @ 3.30 MAR
9-25-02	RTC 10/9/02 3:30 pm
9/25/02	60 min individual: Scottie acknowledges experiencing a headache for 5 days. ? dosing of meds. tends to skip doses to allow "body to adjust." Pt to call Dr Healey 9/26/02. Today focus on agitation. Depression + anxiety → denies both. Reports ↑ agitation for past 2 wks. "Becoming addicted to anger." Enjoys power, rush, stimulation. Bored @ home - no activities - exciting to think of scenarios - acting out anger. Discussed pros/cons. Sees no pos. intents for not acting out. verbalizes consequences but feels no big deal - states actions consequence of harm injury. Discussed personality factors, [illegible]

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Floyd Patient #: 7226

DATE	PROGRESS
9/25/02	Consequences and make decisions. Verbalizes understanding + some agreement. Explored alternative to handling anger + underlying feelings. Explored daily structure purpose. Tendency to cys, but. mood euthymic. Affect appropriate. Denies S/H ideation. denies psychotic symptomatology. No evidence to suggest thought D/O. reports Med compliance - except only taking one Risperdal due to $ / supply of samples. Risperdal .5 T BID - #56 samples issued. Dx 293.83 ; 310.10 [signature] Phillip LPC, CACII
Voluntary admission	
10/8/02	Appointment Reminder Call Line answer. Spoke with machine. (Nat)
10/9/02	Pt. called cancelled appt. for today. Will call back to re-schedule. (Nat)
11/7/02	Pt's mother called resched. appt. for 11/11/02 @ 2:30. (Nat)
11/11/02	Pt. did not show for appt. w/Renee Sent Letter. (Nat)
12/2/02	Appointment Reminder Call Line answer. Spoke with machine. (Nat)
12/2/02	Pt did not show for appt. Nat Sent Letter

1120

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Estelle Floyd Patient #: 4226

DATE	PROGRESS
	Appointment Reminder Call Made 1/6/03 by _____ with pt. _____ (CB)(T
1/7/03	60 min INDividual: Trazadone 200 QHS ? Hydrocodiene 5/500 pain med 98° } Dr Healey
	Pt had:
Oct.	NOSE surgery - 1st month no HA after 2 mos (Dec.)
	HA came back.
	Stopped meds on own ~~before~~ surgery. When went back doing ok on sleep / pain no meds after surgery Still pain
Dr. Healey 1-22-03	now - nightmares returning - acting out in dreams. louder ~~temper~~ ok during day -
coping	holding on to it, let go, distract
	playstation sleep normalized for most part but spells. Sleep 2 days throw off. Random
	exercise ↑HA none since 10/02
	no interest - outdoors Workmans Comp RN - no longer welcome in session Sends records NOW
	getting along. ↑ now
	financial difficulty
	Appears to be more Marijuana - when can see - if difficulties
	depressed which has ↑ since D/C Celexa. Evidenced by loss of interest, irritability, withdrawal ↑, low energy. Pt. will discuss resuming Celexa c Dr Healey
	NO S/H ideation. Open in discussing frustrations,
1-14-03	RTC Healey @ 2:20 pm VRT

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Floyd Patient #: 4226

DATE	PROGRESS
1-7-03	loss of functioning and coping. Restricted participation. Explored process issues as well.
	Dx: 293.83, 310.10 Williams MS, LPC
	Appointment Reminder: Card Made 1/10/03. Spoke with Pt. KBB
1/21/03	RTC 2/7/03 @ 2:30 pm. KBB
1/21/03	60 min individual. Scottie reports struggling w interpersonal issues. Sister moved back in. ↓trust. Discussed situation around her marriage. Remarriage. pending divorce. Was basically extremely close to sister. LIVING with. She moved out to nanny's (NS) bestfriend. Felt betrayed. He was going to move to Mullins w girlfriend. Sister + husband sabotaged - lied. Estranged since ~2yrs. + Now she was to + emotional intimacy. gain support from Pt. He's still angry + hurt, no trust. Discussed feelings. Has been more irritable. passive aggressive. Discussed + assertiveness. dealing w more directly. Requires. She has to pass test of trust. Explored interpersonal issues, coping within house, + handling intensity of feelings. Feels managing anger okay. She fantasy of [illegible]

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Floyd Patient #: 4226

DATE	PROGRESS
1/21/03	fight on handling appropriately. Superficial c sister. Discussed barrier of passive-aggressive behaviors & impact on relationships. To see Dr Healey tomorrow. Wants to restart antidepressant. feels this helped irritability. Still bored during day. Again, explored options for improving daily structure. Pt sees no alternatives. (using PlayStation, sleep, magazines) Mood dysphoric. Affect appropriate. NO SI/H NO psychosis - some suspiciousness c sisters intentions (Hasn't told her about legalities & workmans comp). Dx 293.83 • 310.1 C Quillian MS, LPC
occ marijuana use with ETOH no	
	Appointment Reminder Call Made 2/6/03 . Spoke with Raquel RMA
2/7/03	30 min Individual: Dr. Healey started pt on: Paxil CR 12.5 mg 1 QS d the TT @ AM. Sleep schedule off - trouble falling asleep - going to sleep 6am. Some napping during day. ↑ fatigue / yawn. Go little no sleep couple days then sleep. Body sleeps when want to. c/o daily structure. Sit- [illegible] TV D.A. games. no physical activities.

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Sadie Lloyd Patient #: 4226

DATE	PROGRESS
2/7/03	Any activity gives headache. Stay inside to avoid headache. Discussed avoidance, inactivity / fatigue can exacerbate headache, discussed slowly building activity level. Pt. feels nothing can do. explored options. yes, but... Discussed pain management techniques. yes, but. more irritable today, less open / receptive. Ready to go after 30 min. Explored process issues. unreceptive ready to leave. Med compliant. occ. marijuana use. no S/H. more assertive c sister - Reinforced RTC 2-3 wks. Dx 293.83 + 310.10. P. Williams MS, LPC
3/7/03	INDIVIDUAL NO appetite - ? related ↑ pain med. 4 days had to ↑ pain med - 5d - 5 tab. q day Surgery - 17 sec. split down center of head - like cutting in half. Sharp pain. Shaved head. Don't want anything touch head Paxil CR 12.5 ↑ TTT QD Discussed pain management. Impact on mood. Coping. Will staff Dr Healey. Pt to Dr Healey office closed. Pt. go to ER. (for PTSD) P. Williams MS, LPC

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Floyd Patient #: 4226

DATE	PROGRESS
4/2/03	ID Outpatient therapy:
	Pt saw Dr. Healey 4/1/03 Med Δ:
Monday 4-1-03 ①	Lamictal Starter Kit - 1-2 wks 25mg IT QD
	3-4 wks 50 BID wk 5 100mg BID
②	Lorazepam 1mg 1/2 - 1 Q 8°
③	Stopped Hydrocodone ④ Continue Paxil CR
	Marijuana - Pt ↑ use per pt + Girlfriend (Beth) using all day everyday. Joint every 30 min. for 1 month. (
Before used marijuana regularly but not constantly during day	1 right seizures per pt. report
	Pt reports MRI/CT scan showing frontal lobe damage on both sides.
	Pt open in discussing changes in physical health - frustrations, limitations + coping.
	ER Monday - headaches & shots for pain - usually sleep but has been staying up this time. Tol body ↑ tolerance to injections.
	Pain has ↓ since injections + Med Δ
	heat - + outside temp. (pass out - lightheaded. (feel like
	Pt intoxicated. Smoked marijuana before appt. Hypomanic - speech pressured, tangential, excitable + mood euphoric.
	Pt's girlfriend to monitor mood if remains hypomanic or worsens to call this staff / Dr Healey. Pt gives permission for staff to consult Dr. Healey re to chart
3/7/03	RTC 3/28/03 @ 2:30pm KMA
3/28/03	Pt. re-scheduled for 4/2/03 @ 2:30 1125

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

lame: Sallie Floyd Patient #: 4226

DATE	PROGRESS
4/2/03	RTC 4/16/03 @ 3:30pm w/ Renee. ICMH
4/2/03	Status. NO anger or agitation. NO S/H ideation.
	Phone call to Dr. Healey informed of status, drug use and tx here.
	Dx: 293.83 & 310.10 & Marijuana dependence
	Phillips MS, LPC
4/8/03	Pt. in hospital, Carolinas. Due to seizure type activity & vomiting. Dr. Healey adv. NO.
	Phillips MS, LPC
4/16/03	Pt. did not show for appt. Tried R.
5/5/03	Wants appt. w/ Dr Weathers — Needs
Phone	meds. — Appt 5/15/03 @ 3p
Call	Phillips MS, LPC
5/20/03	60 min Individual: Pt. hospitalized @ Carolinas then hospitalized @ Baptist & on commitment. Had been told to go to ER by Dr Healey for test then was committed. MD's did not process tx or Mother reason why. Mom did not feel he was in that "bad shape". Headaches have been worse. Agitation @ times. Did destroy tire bumper. Punched in wall. (Prior to hospitalization)

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

ne: Scottie Floyd Patient #: 4226

DATE	PROGRESS
20/03	Meds A @ hospital. Don't think helpful. Have not taken consistently or @ all? in recds.
	Paxil CR 25 T QD
	Klonopin 1mg T BID
	Keppra 250 T BID
	Carbatrol 200 T BID
	Prilosec 20 TT QD
	Hydrocodone/APAP 5/500 T Q6°
	Has had 3 Mepheme Injections in past wk. for headaches. using marijuana as much as can. Only thing that helps.
error Q6hr ~~Ampicillin 500~~	
	Discussed marijuana use, med compliance & anger over hospitalization & way feet mistreated @ ER. able to process. mother present. States doing better since hospitalization. She also unhappy about ER visit. Discussed options for handling. May discuss c Dr Healey.
NO communication didn't understand comment about television review	Appt. Monday 5/26 c Dr Healey. Discussed coping strategies. Yes..but approach.
	Declines release for Workmans Comp Dr.
	Mood agitated. Under influence of Cannabis.
	NO SI H. Dx: 293.83 310.10 Cannabis Dependence
	Phillips MS, LPC
5/20/03	RTC. 6/12/03 @ 2:30 pm w/ Renee' KMA

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Floyd Patient #: 4226

DATE	PROGRESS
4/2/03	RTC 4/16/03 @ 3:30pm w/ Renee. ICBM
4/2/03	Status. NO anger or agitation. NO S/H ideation.
	Phone call to Dr. Healey. Informed of status, drug use and tx here.
	Dx: 293.83 & 304.10 x Marijuana dependence
	Phillianes MS, LPC
4/8/03	Pt. in hospital, Carolinas. Due to seizure type activity & vomiting. Dr. Healey adm. MD.
	Phillianes MS, LPC
4/16/03	Pt. did not show for appt (Not R.
5/5/03 phone call	Wants appt w/ Dr Weeraisuny — Needs meds. — Appt 5/15/03 @ 3:30
5/20/03	60 min Individual: Pt. hospitalized @ Carolinas then hospitalized @ Baptist & on Commitment. Had been told to go to ER by Dr Healey for test then was committed. MD's did not process Pt or Mother reason why. Mom did not feel he was in that "bad shape". Headaches have been worse. Agitation @ times. Did destroy tin bu[illegible] & Punched in wall. (Prior to hospitalization)

McLeod REGIONAL MEDICAL CENTER The Choice For Medical Excellence

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Hoyt Patient #: 4226

DATE	PROGRESS
5/20/03	meds Δ @ hospital. Didn't think helpful. Have not taken consistently w @ all? in 2wks.
	Paxil CR 25 T QD
	Klonopin 1mg T BID
	Keppra 250 T BID
	Carbatrol 200 T BID
	Prilosec 20 T QD
	Hydrocodone/APAP 5/500 T Q6°
	Has had 3 Nubaine Injections in past wk. for headaches. Using Marijuana as much as can. Only thing that helps.
error [illegible] 3rd [illegible]	Discussed marijuana use, med compliance & anger over hospitalization & way felt mistreated @ ER. able to process. mother present. States doing better since hospitalization She also unhappy about ER visit. Discussed options for handling. May discuss c Dr Healey.
NO communication Didn't understand comment about session room.	Appt. Monday 5/26 c Dr Healey. Discussed coping strategies. Yes..but. approach.
	Declines release for Workmans Comp DW.
	Mood agitated. Under influence of Cannabis.
	No SI H. Dx: 293.83 310.10 Cannabis Dependence
	Preliminary MS, LPC
5/20/03	RTC 6/12/03 @ 2:30pm w Renee'.

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Lloyd Patient #: 4226

DATE	PROGRESS
6/12/03	60 min Individual: Pt. reports continued struggle ε pain. Denies depression. Improved irritability. No anger/ outbursts A pain med but still headache all day stopped all other meds for 1 wk. to see what new med will do Plan resume all meds Sat, not taking 4 hours Discussed med compliance. Pt. focused on cannabis 1/2 marijuana per day. Unreceptive to ↓/ discussion of impact on mood ↓ irritable appropriate more ↓ agitated no feeling in Right hand - side ↑ acceptance of illness. Sister home 5 mos. better relationships ε sister 3 mos. open ε sister. band. helps diffuse irritability, more socialization ε sister. Still quits. he showed: ① get out more - ② improve daily structure. Able to id. ways to achieve both. Reinforced alternative coping. Mood euphoric. Under influence of marijuana. Unreceptive to discussion on marijuana. Denies S/H ideation. Dx: 293.83 310.10 Renee Williams MS, LPC
6/12/03	RTC 7/10/03 @ 2:30 pm w/ Renée. RWS

1130

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Floyd Patient #: 4226

DATE	PROGRESS
7/17/03	50 min individual: Pt. status the same. Headaches continue. Denies depression/anxiety. 2 episodes of anger/agitation since last visit 6/12/03. Punched shed / dryer, wore gloves. took outside to object not mom. Still cuts on elbow. Discussed triggers - ex-girlfriend pushing buttons. Tried handle assertively but she wouldn't stop. Able to process agitation. Has 4 daily goals/structure - Back to video games, reading game books, out & sister some, new friend fishing in AM if not too hot. Socializing little more per sister. Continues marijuana use but less due to finances. med. comp compliance. Takes every 3-4 days on average but none in couple wks. Discussed compliance & med effectiveness. Dx: 293.83 310.10 Guillermo MS, PA-C, CAC II
7/17/03	RTC 8/21/03 @ 3:30 pm. ICBA

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Lloyd Patient #: 4226

DATE	PROGRESS
8/21/03	RTC 9/22/03 @ 2:30 pm w/ Renee'. 10 mins
8/21/03	60 min Individual: Scottie acknowledges DIC marijuana for past 1½ days - trying to stop
8/13	Trazodone 7.5mg + Q8° prescribed by Dr.
20	Healey. Taking more than should with no
	effect. Wants med that will calm like
	marijuana. Discussed probability that other
	meds may not meet that need as well +
	other strategies for calming self. Discussed
	addictive & possibility of ↑ symptomatology
	as body adjusts to no marijuana as
	was using 1g. wants "nearly" every day.
	(nearly. if out $ may have to wait day/two to
	get) No S/H ideation. Feel easily
	agitated. Has old dryer can hit if need
	to. Mother gives permission for him to
	hit that. Pt. uses object to hit & OR wears
	gloves to protect self. Upset ex-girl.
	friend. Discussed relationship & letting go
	of past. Feels betrayed - "She pissed me off"
	She needs to pay. Tell parents stuff so they
	will intervene her won't be able to do
	anything. On sm. levels, feel he misses
	relationship but not "manly" to ack ... go.
	Unable to process feelings regarding relationship.

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Estelle Lloyd Patient #: 4226

DATE	PROGRESS
8/21/03	no intent to harm anyone physically. Keeping self out of circumstances where might get agitated. Using video games as distraction. Mother? What if he becomes agitated & uncontrollable Recognizes ↑ agitation without marijuana. Thinks he should continue to use Estelle recognizes consequences. Aware of behaviors. Can control. Discussed consequences + calling police if does get out of control. She agrees. ~~staff meds / file marijuana~~ Call to Dr Healey. Left message mother to call for earlier appt. Mood - pressured. Discussed med compliance not taking meds on regular basis or as prescribed. Agrees to do better. Dx: 293.83 310.10 Phillips MS LPC, CACII
8/29/03	Phone call: Pt. still not using marijuana. "Dogs are out" can't find any. Still cranky. But not aggressive, no outburst. Able to refill Trancene. This working better. Will continue to monitor progress. Phillips MS, LPC, CACII
8/29/03	Mother to call Dr Healey for earlier ~~appt~~ 1 Phillips MS, LPC

McLeod REGIONAL MEDICAL CENTER The Choice For Medical Excellence.

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Lloyd Patient #: 4226

DATE	PROGRESS
9/22/03	RTC 10/16/03 @ 3:30pm KBR
9/22/03	60 min individual: Scottie reports ↑ headaches & agitation. Doesn't feel meds are helpful. Has resumed marijuana use. Acknowledges daily headaches & joint pain in finger, wrist & elbow. Frustrated c legal process & no settlement as well as boredom (just plays PlayStation all day). Open in expressing frustrations. To see Dr Healey 9/23/03 -am. Did escalate & become threatening toward MD "if he doesn't D meds will punch out" "get physical" was able to explore frustrations/anger, responses, consequences & alternatives to violence. Denied any intent to harm MD. Did give permission for staff to call Dr Healey to inform of status.
* 9/22/03 Doubling Nardil due to relapse @	Discussed Anger mgmt & impact anger/tension has on headaches. Unreceptive initially but ultimately receptive to feedback. Taught tension release exercises. Angry @ therapist for making light over "what want for dinner" mother nags about this. Appropriately expressed anger & processed c staff. Reinforced. Not ~~[illegible]~~ked. NO S/H ideation - would consider SI but know would destroy mother so don't consider. Dx: 293.83 & V61.10

Renee Williams MS, LPC

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Sabrina Lloyd Patient #: 4226

DATE	PROGRESS (Pt asleep)
9/22/03	case staffed & Dr Healey call to mother to inform of staffing. Reminder mg LPC
10/28/03	RTC 11/19/03 @ 3:30 pm. w/ Renee. ICBE

McLeod REGIONAL MEDICAL CENTER The Choice For Medical Excellence

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Lloyd Patient #: 4226

DATE	PROGRESS
10/29/03	60 min Individual: Scottie continues to struggle ↑ agitation & anger management. Realizes that need to take responsibility for behaviors & managing temper. Trying to ↑ awareness of responses and id alternative ways to Enhance coping ↓ anger. Dr Healey rec anger man program in Texas. Planning to go - hopefully in next month. Had situation ↓ sister - she moved to VA ↓ boyfriend. Pt Anger @ decision as pt feels negatively toward boyfriend. Felt like handled anger well & recognized powerlessness. Continues to use marijuana daily. Reports med compliance as well Mood euthymic. No overt symptomatology Dx 293.83 & 310.10 Guidelines MS, CR, CACH
11-19-03	Patients mother called and Reschd to 12-1-03 2B
12/1/03	RTC 12/29/03 @ 3:30 pm w/ Rene. KMA

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Floyd Patient #: 4226

DATE	PROGRESS
12/1/03	60 min Individual. Scottie reports doing about same. Trying to do more during day. Definite limits ε heat and intensity of work. Taking frequent breaks. Feel better doing a little. Handling anger ε marijuana & trazodone. Better understanding alternatives to anger management yet dependent on cannabis. Wants abstain (error) cannabis yet - wants additional sedative. Abusing sedative - taking all @ once & up to VI @ time. Dr Healey wants to refer to Pain (Anger) management in Texas. Recognizes won't use addictive meds. IS agreeable to try alternatives ε structured help. Wants specialized program. Not agreeable to A/D tx. Wants "pain/impulse control" program. Will call ε Dr Healey's recommendation - name of program. Reinforced alternatives to substances & ↓ per substances. Discussed relationship issues - Doing better getting along ε others. Mother improving. Mood euthymic. Affect appropriate. No S/H ideation. DX: 293.83 + 310.10 Williams MS LPC, CACII

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

McLEOD PSYCHIATRIC ASSOCIATES
901 East Cheves Street, Suite 460
Florence, South Carolina 29506

Name: Scottie Hoyt Patient #: 4226

DATE	PROGRESS
1/13/04	50min Individual: Pt. reports continued headaches/ pain. Episodes of agitation when pain ↑. Denies any depression / anxiety. Handling agitation / pain ± marijuana. Also, taking meds from Dr Healey. Overusing trancene - running out early have space out or ↑ marijuana. Also, using video games. ↓ helping mother's friend ± household projects, no fishing or other activities. Discussed resuming these in small doses as were helping before. Considering Tanagram Rehab in Texas / Florida. Discussed tx facility. Researched info prior to appt. Reviewed ± pt. Discussed impact of marijuana on tx / progress & abstaining. Not ready to make any changes to this use. Discussed planning to use while in tx & sabotage of program. Reinforced having pos tx plan.
	Mood euthymic. Affect appropriate.
	Next 8TH. Dx: 293.83 & 310.1
	Rebecca Williams, MS, LPC, CACII

Vascular Diagnostics, LLC
500 Pamplico Highway-Suite G- Florence, S.C. 29505
Phone (843) 664-0882 • Fax (843) 317-1815

TRANSCRANIAL EVALUATION

Name MR. SCOTTIE W. FLOYD Age 26 Date 03-05-02

DOB _____ Physician HEALY

VASCULAR HISTORY

Smoker: Non___ Previous___ Current 3 ppd
Hypertension: — Diabetes —
Hyperlipidemia — Obese — Angina — MI — CVA —

PRESENTING CONDITION

Previous Vascular Surgery:

—

Vertigo ✓
Dysphasia Slurring
Syncope Vague
Memory Loss ✓
Headache Constant Frontal
Hemiplegia —
Amaurosis Fugax Right eye
TIA occas Tingling Right arm

NORMAL VALUES

	Velocity	*Depth*	*Direction*
OPHTHALMIC:	10-30 cm/sec	45-60mm	Toward
SIPHON:	38-62 cm/sec	60-75mm	Toward
MCA:	48-72 cm/sec	35-65mm	Toward
ACA:	38-62 cm/sec	60-75mm	Away
PCA:	30-50 cm/sec	60-75mm	Toward
VERTEBRAL:	30-50 cm/sec	65-75mm	Away
BASILAR:	30-50 cm/sec	85-120mm	Away

Technologist Dorian Knight, RVT
Physician _____

Form #107

Vascular Diagnostics, LLC
500-Pamplico Highway • Suite G • Florence, S.C. 29505
Ph. (843) 664-0882 • Fax (843) 317-1815

TRANSCRANIAL DOPPLER

For Vascular Diagnostics

DATE: 3/5/02

PATIENT: Scottie W. Floyd

AGE: 26

DOB:

REFERRED BY: Dr. Healy

26 Y/O patient of Dr. Healy's who is a 3 pack per day smoker who presents with vertigo, syncope, headache and TIA.

Routine protocol Transcranial Doppler done utilizing the Eden's Medical TranScan.

Increased velocity noted in the MCA bilaterally. Otherwise normal TCD and clinical correlation is necessary.

R. JOSEPH HEALY, MD
RJH/nb

VASCULAR DIAGNOSTIC, LLC.
500 Pamplico Hwy. Suite G
Florence SC 29505
843 664 0882
Fax 843 317 1815

EME Companion Patient Diagnostic Report

Patient:	FLOYD, SCOTTIE W.		
ID-Code:	HEALY	Birthdate:	
Filename:	FLYD	Date:	Mar 5, 2002
Technician:	DSK	Time:	13:54:37
Comments:			

Exam 1

Left	Depth	Vm	Vs	Vd	PI	RI	Right	Depth	Vm	Vs	Vd	PI	RI
2 MHz TEMPORAL (velocities in cm/s)													
MCA	64	75	134	49	1.14	0.63	MCA	64	71	126	45	1.14	0.65
		-18	-27	-11	0.80	0.59			-42	-76	-22	1.12	0.71
MCA	64	78	138	49	1.19	0.65	ACA	64	77	133	50	1.08	0.62
		-20	-30	-5	1.18	0.84			-56	-83	-34	0.83	0.59
ACA	64	24	52	11	1.73	0.79	MCA	64	77	128	47	1.10	0.63
		-51	-86	-32	1.03	0.63			-63	-94	-42	0.81	0.55
ACA	64	23	48	6	1.81	0.88	MCA-ACA	64	71	125	45	1.15	0.64
		-54	-97	-34	1.12	0.65			-57	-91	-40	0.86	0.56
PCA-P1	70	42	78	26	1.26	0.67	PCA-P1	70	47	84	31	1.13	0.63
		-38	-60	-23	0.91	0.61			-2	-10	-1	2.57	0.95
							PCA-P1	70	36	62	19	1.27	0.70
									-28	-52	-16	1.18	0.70
2 MHz Sub-occipital (velocities in cm/s)													
BA prox.	86	-34	-59	-22	1.01	0.62	VA	74	-40	-70	-26	1.03	0.63
BA dist.	94	-34	-36	-19	0.51	0.47							
BA dist.	94	-32	-45	-23	0.59	0.48							
VA	74	-35	-64	-21	1.13	0.67							
2 MHz Trans-Orbital (velocities in cm/s)													
Siphon	50	17	29	12	1.04	0.60	Siphon	70	52	94	36	1.12	0.62
		-13	-17	-11	0.34	0.37			-22	-52	-1	2.07	0.99
Siphon	70	56	90	38	0.92	0.57	Siphon	50	31	76	15	2.02	0.80
		-9	-21	-1	1.68	0.97			-26	-61	-16	1.55	0.74
Siphon	70	55	83	39	0.82	0.53	Siphon	50	23	54	9	2.03	0.83
		-8	-24	-1	1.93	0.97			-16	-38	-6	1.68	0.85

Vascular Diagnostics, LLC
500 Pamplico Highway-Suite G- Florence, S.C. 29505
Phone (843) 664-0882 • Fax (843) 317-1815

CAROTID EVALUATION

Name MR. SCOTTIE W. FLOYD Age 26 Date 03-05-02

DOB _____ Physician HEALY

VASCULAR HISTORY

Smoker: Non___ Previous___ Current 3 ppd
Hypertension: - Diabetes -
Hyperlipidemia - Obese - Angina - MI - CVA -

PRESENTING CONDITION

Previous Vascular Surgery:
-

Vertigo ✓
Dysphasia Slurring
Syncope Vague
Memory Loss ✓
Headache Constant frontal
Hemiplegia
Amaurosis Fugax - Right eye
TIA - occas Right arm tingling

Other Observations or Complaints:
6 Mo-Ago STRuck on forehead while @ work.

Technologist Dorian Knight, for RVT
Physician _____

Vascular Diagnostics, LLC
500-Pamplico Highway • Suite G • Florence, S.C. 29505
Ph. (843) 664-0882 • Fax (843) 317-1815

NON-INVASIVE CAROTID STUDY

For Vascular Diagnostics

DATE: 3/5/02

PATIENT: Scottie W. Floyd

AGE: 26

DOB:

REFRRED BY: Dr. Healy

26 Y/O patient of Dr. Healy's who is a 3 pack per smoker who presents with vertigo, syncope, headache and TIA.

Routine protocol Non-Invasive Carotid Study done utilizing the ATI Ultramark-9.

On the right no plaque seen with good vessel filling and normal Dopplers.

On the left no plaque seen with good vessel filling and normal Dopplers.

ICA/CCA ratio is 0.72 on the right and 0.71 on the left.

The vertebral flow is antegrade bilaterally.

IMPRESSION: No hemodynamically significant lesions noted bilaterally.

R. JOSEPH HEALY, MD
RJH/nb

Carotid Doppler Velocities

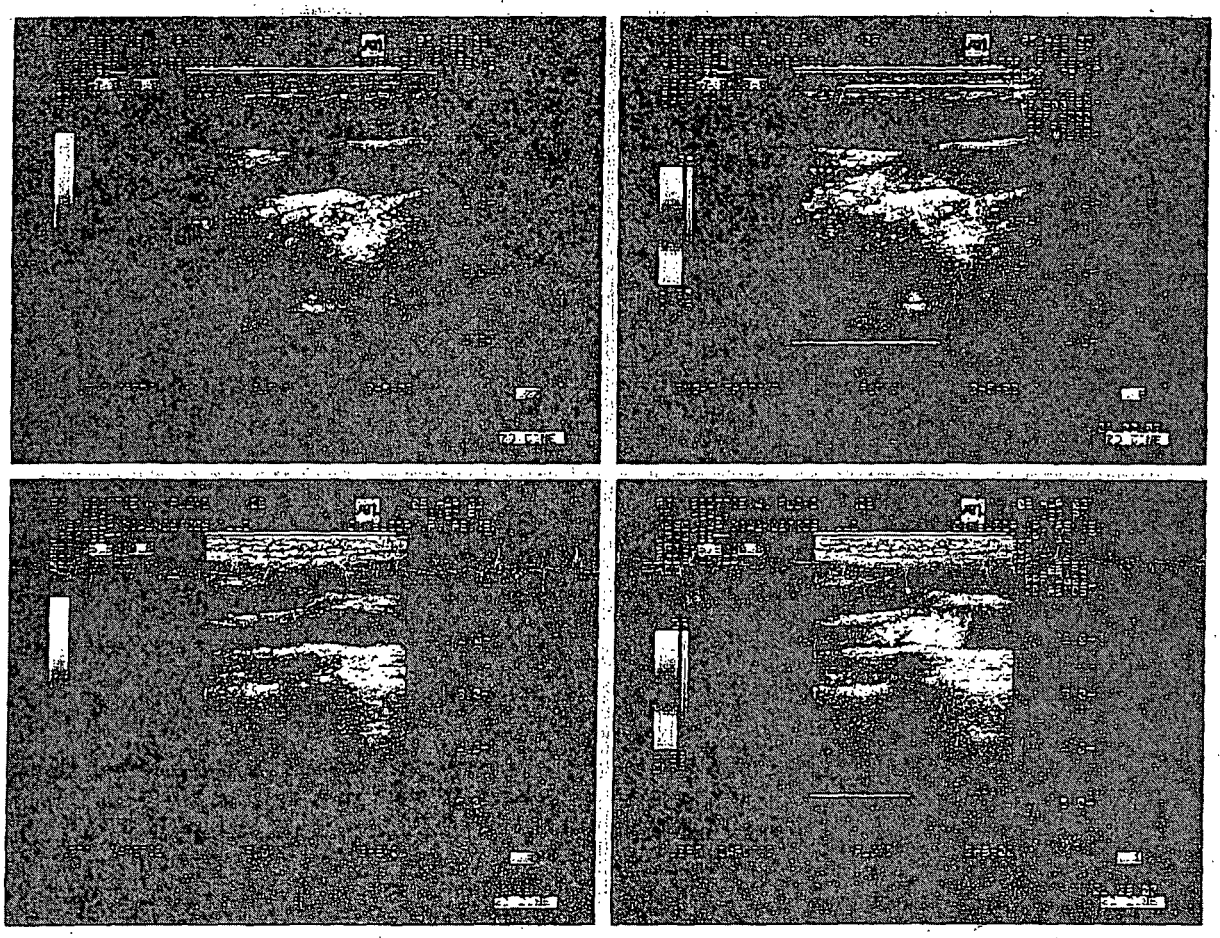
"Abnormal Velocities" are recorded at Proximal, Maximal and Distal Velocity in relation to the stenosis site
Normal Velocities are recorded at Maximal Velocity

RIGHT				LEFT		
Proximal	Maximal	Distal		Proximal	Maximal	Distal
	138		cm/sec		143		cm/sec
	117		cm/sec		139		cm/sec
	75		cm/sec		115		cm/sec
	81		cm/sec		91		cm/sec
	84		cm/sec		93		cm/sec
	100		cm/sec		102		cm/sec
	105		cm/sec		84		cm/sec
	51		cm/sec		65		cm/sec

PROXIMAL CCA
MID-CCA
BULB
PROXIMAL ICA
MID-ICA
DISTAL ICA
ECA
VERTEBRAL ARTERY

BP 160/70
ICA/CCA Ratio: .72

BP 110/70
ICA/CCA Ratio: .71



Patient Name MR. SCOTTIE W. FLOYD 03-05-02

OFFICE NOTE
March 5, 2002

RE: Scottie W. Floyd

Scottie Floyd returns today for a follow up. His MRI of the head shows contusion in the frontal lobe on the right. This is resolving somewhat but still is a large lesion. My impression is that he is on the mend at this point but he still has problems complaining about his vision and so I want to get formal visual fields checked to make sure that everything is OK. There has been no seizure activity and his headaches may be a little bit better. He has been seen by Dr. Weinbaum and also is getting some psychological counseling. At this point I think this is just going to take more time. Ultimately we will want to get neuropsychological testing done to see what type of organic problems may exist. We will continue Depakote ER 500 q 8 and Tenormin 25 p.o. q d and he is using Fiorinol as needed for headache and he is on Zoloft 100 p.o. q d.

R. JOSEPH HEALY, MD
RJH/nb

cc: Dr. Weinbaum

R. Joseph Healy, M.D., P.A.
P.O. BOX 3408
518-S. IRBY ST., SUITE 100
FLORENCE, SOUTH CAROLINA 29502
(803) 664-9200
(803) 664-9202 (FAX)

ADULT & PEDIATRIC NEUROLOGY

ELECTROPHYSIOLOGY

PRELIMINARY ELECTROPHYSIOLOGY REPORT

EMG/NCS _____

EEG 02-138

BAER/VER _____

OTHER _____

PATIENT NAME Floyd, Scottie

DATE 3/5/08

REFERRNG PHYSICIAN Heath

Low voltage

(L) frontal slowing

no epileptiform activity

no sleep

VJ

	Floyd Scottie
3.5.02	Test + IV
	VPA ER 500 q8h
	hydrocodone 5/500 q8h PRN
	Fioricet
	Zoloft 100
	Phenergan
	Atarax bid
	transfer from VPA
	off Neurontin now
	still intermittent HA
	developed bleeding hemorrhoid
	doing better now
	seeing Dr Wrenn-Gow
	Cont Rose Pulcher
4/8/02	Pt's mother cl Friday - son had HA - out of meds - cl family doctor - gave him enough medication to last until tomorrow 4/9/02 for his appt - Did NOT cl in prescription for pt - waiting for him to come in tomorrow - (NB)
4-9-02	Sch Admit Note

OFFICE NOTE
April 22, 2002

RE: Scottie W. Floyd

Scottie Floyd returns today for a follow up of his recent hospitalization. This patient was admitted to CHS 4/9/02. Please see admission note. His MRI of the head was repeated which showed abnormal signal in both frontal lobes right greater than left which looked like a post-traumatic injury. He also had a right mastoiditis. His headaches improved in the hospital and mainly because sleep improved and he wasn't smoking. He has gone back to smoking since he has been discharged although he states "not as much". I am going to give him a Z-pack to take for his right mastoiditis. His sleep is better but he is on Chlorohydrate at this point and I am going to increase it from 1500 to 2000 a day. He continues on Atenolol, Neurontin and Depakote. His hemorrhoids have been acting up and probably this is because of increasing problems with defecation due to pain medications. I have given him Colace to use twice a day and have recommended that he see Dr. Breazeale who is his primary care for this.

All in all I believe that we are making some progress at this point although the patient is reluctant to admit this but his mother seems to indicate that she thinks his headaches are doing better. I will see him in one month's time.

Ultimately, we are going to have to get neuropsychological testing done to see what type of functional loses there may be. I have explained that frontal lobe injuries can cause a lot of behavioral disturbances.

R. JOSEPH HEALY, MD
RJH/nb

cc: Grant Brazeale, MD
805 Pamplico Highway
Florence, SC 29505

Dr. Weinbaum

OFFICE NOTE
May 22, 2002

RE: Scottie W. Floyd

Scottie Floyd returns today for a follow up of his headaches and closed head injury. He actually looks better. We have cut a great deal of his medications I believe at Dr. Weinbaum's instruction that he is on Celexa 20 p.o. q a.m. and he is using Sonata at HS and tells me that he is taking as many as 3 10mg tablets and still doesn't sleep. His sleep hygiene is poor and he seems to have his days and nights backwards and I told him that he needs to try go to bed at 11:00 at night and get up at 7:00 in the morning. I believe his aggressive and combat of as well as oppositional behavior seems to be a little better. While he tells me he was mildly like this before I believe the head injury has caused amplification of his underlying basic personality. "Where he was a one he is now a ten" according to him. I have recommended that we get neuropsychological testing done and that if all is well that we try to get him back to work in a graduated and escalated fashion. I believe this would be therapeutic. While previously I was concerned about his impulsivity and whether or not this could heed to any anti-social type behavior I am a little less concerned at today's visit. I plan to talk with Dr. Weinbaum about this in the next several days.

Thank you for your kind referral.

R. JOSEPH HEALY, MD
RJH/nb

cc: Worker's Comp

Dr. Weinbaum

Grant Breazeale, MD
805 Pamplico Highway
Florence, SC 29505

Fax: 910-842-9127
Linda Baldwin

OFFICE NOTE
July 17, 2002

RE: Scottie W. Floyd

Scottie Floyd returns today for a follow up. He has had his neuropsychological testing done which predominately shows problems of the frontal area, which would be expected. He has some trouble with executive execution and he has trouble with behavioral problems. I believe this is all symptomatic of his head injury.

Headaches are still his biggest problem. He has not stopped smoking even though a number of people have recommended this and he still does not sleep well. Ambien has not worked for him so we will stop this and I am going to start him on Deseryl 50mg at HS and we will gradually increase slowly at 50mg increments. Depakote didn't work for him but I would like to try possibly Topamax. I am going to repeat his EEG and further recommendations will await the above.

Patient is doing better in the sense that he is calmer and his sense of humor is returning and his biggest problem seemed to be his anger relative to lack of a diagnosis and whether or not an earlier diagnosis would have helped him to do better. I share his concern and I feel that we are making progress however. His behavior has improved to the point where I don't feel that he is of much of a danger as he use to be from the standpoint of aggression.

I will see him back after the above studies. I have explained to him that his head injuries are permanent and that his brain injury is permanent and in that regard I am not sure what the future holds relative to employment etc.

R. Joseph Healy MD

R. JOSEPH HEALY, MD
RJH/nb

R. Joseph Healy, M.D., P.A.
P.O. BOX 3408
518-S. IRBY ST., SUITE 100
FLORENCE, SOUTH CAROLINA 29502
(803) 664-9200
(803) 664-9202 (FAX)

ADULT & PEDIATRIC NEUROLOGY

ELECTROPHYSIOLOGY

PRELIMINARY ELECTROPHYSIOLOGY REPORT

EMG/NCS _____

EEG 02-469

BAER/VER _____

OTHER _____

PATIENT NAME Floyd, Scottie

DATE 7/31/02

REFERRNG PHYSICIAN Heath

slowing c/f/central/temporally.
no epileptiform activity
background 10-11 Hz
no sleep
(+) photic stimulation
B/frontal slowing

OFFICE NOTE
August 7, 2002

RE: Scottie W. Floyd

Scottie W. Floyd returns today for a follow up. He seems to be a little calmer and his sentiment has improved. He tells me that he is sleeping a little better and that Deseryl seems to help. He has a 150mg at HS now. I believe his headaches are doing better although he still has them. He does have some headache free intervals. I am going to give him a trial of Topamax starting with 25mg once a day as a prophylaxis against the headache and Aleve doesn't seem to be helping him and so we will try Ultram for abortive therapy. His psychologist now has him on Risperidol and he takes 0.5mg in the evening and he can take one earlier in the day if necessary. His EEG shows bi-frontal slowing as expected. There is no evidence of epileptic form activity.

My impression at this point is that we are definitely dealing with a post-traumatic encephalopathy. There have been amplifications of his underlying baseline personality, which tended to be one with anxiety and occasional outburst if provoked premorbidly. This is certainly be amplified following his injuries although as I mentioned above I believe we are doing better.

He ultimately will be able to go back to some type of work but I think he will have to be placed in a different environment. I believe his previous work would serve only to trigger outburst and there is a very definite element of post-traumatic stress disorder here which would be adversely affected by returning to the environment of which he was injured.

I will see him back in one month's time and I have asked him not to drive.

R. JOSEPH HEALY, MD
RJH/nb

OFFICE NOTE
September 11, 2002

RE: Scottie W. Floyd

Scottie Floyd returns today for follow up. He looks good today and seems to be feeling better and I think this is because he is sleeping better. He is on Deseryl 200mg at HS. Topamax seems to help his headache in a prophylactic way and so I am going to increase him from 25mg to 50. He is using Ultram for abortive therapy. He continues on his Risperidol 0.5 in the evening.

He states that if he hears a loud noise or is startled that he seems to react to it violently which I think is consistent with post-traumatic stress disorder.

I believe the biggest problem at this point is trying to get him back to work. I have recommended that he go to Vocational Rehab, as he will need to be retrained in a different area and he needs to work in an environment is relatively safe. I believe going back to work would go a long way toward helping him to improve.

I will see him in a month's time.

Thank you for your very kind referral.

R. JOSEPH HEALY, MD
RJH/nb

cc: Dr. Weinbaum - done
Fax # 679-7285

Worker's Comp 910 8429127

OFFICE NOTE
October 8, 2002

RE: Scottie W. Floyd

Scottie Floyd returns today for a follow up of his headaches. He seems to be doing all right. The weather changes have caused him to have a little bit more in the way of headache. Apparently Dr. Farrell is going to go ahead and repair his septum in 10 days which I think is fine. His better breathing may well help his overall situation. He is presently on Deseryl 200 at HS, Topamax 50 and I am going to increase it to 75 and he continues on Risperidol 0.5 at HS and Ultram as needed for pain.

His worker's comp nurse has asked if he is ready for MMI and my answer is no. We should repeat his neuropsychological testing as per Dr. Windsorova recommendations. We will continue the above medications which are fine from the standpoint of his impending surgery.

Thank you for your kind referral.

R. JOSEPH HEALY, MD
RJH/nb

Fax to (919) 781-8593

cc: Howard Farrell, MD
1594 Freedom Blvd. Suite 206
Florence, SC 29505

1154 Ex 9/9/02

Lloyd Scotty

8.22.02 Per RJH he will do main follow up + meds for patient and Dr Weidman will see pt as needed

9.11.02 In the office

Left Note

9.16.02 Celexa 40mg QHS BEF 12SC 423-1021

10-8-02 I mem PTC

Left Note

Called in refill for 2 months of pulmicort per DSB

11/6/02 s/p septoplasty
doing well
pt has stopped all his meds x Desyrel/Zoloft
pt taking Lortab from Dr Parrell
for pain
req. refill + dc
will be overall
s/p CHT

Floyd. Scottie

12.2.02 Pt's mother called in wanting a refill on [illegible] - med was prescribed by another Dr. Per RPH: can't refill b/c he did order it.

12/3/02 Pt's mother cl - wanting refill on hydrocodone - told her RPH could not fill - moved appt from to 12/5/02@

12/05/02 - : nurse visit
headache persist intermittently
hydrocodone helps - told to use sporadically
sleep - has slept several nights but still has days + night mixed up.
nurses Ψ tint 12/12/02

Headache - PT
Hydrocodone 5/500

12.31.02 Pt's mother called in wanting refill on Hydrocodone - Per RPH # 40 8000

OFFICE NOTE
January 22, 2003

RE: Scottie W. Floyd
23201

Scottie Floyd returns today for a follow up. He has had his repeat neuropsychological testing. Essentially this shows that his cognitive functioning seems to be pretty good and has improved somewhat. Dr. Windsorova also thinks that there may be some continued improvement over the next year. The patient's biggest problem at this point is his mood instability and he gets agitated at time and I believe most of this comes from the frustration of his loss of livelihood and his headaches which prevent him from doing a number of usual daily activities. His sleep seems to be a little bit better. He does not get out of the house much mainly because he is frustrated that he may not be able to interact appropriately with others and that this may lead to rage reactions. Several medications have been tried in the past for this so I am going to go ahead and give him a trial of Paxil to see if this will help him. We will start with CR 12.5 1 p.o. q d and we will gradually increase upward as needed and tolerated. This may also help him with his headaches I told him.

I don't feel that he needs to be referred to pain management clinic since they typically send a lot of their headaches to me and I have not in my past referred a patient with headaches to a pain management clinic.

I do think efforts should be made to try and get him evaluated to see what type of vocational potentials he may have. I don't think he could go back to his old job because of post-traumatic stress problems although he does like this type of work. He has not reached MMI at this point.

R. JOSEPH HEALY, MD
RJH/nb

OFFICE NOTE
February 12, 2003

RE: Scottie W. Floyd
23201

Scottie Floyd returns today for a follow up. He seems to be doing a little better on Paxil and is on 25 of the CR variety q d and I am going to gradually increase him to 37 ½. I do think this helps his anxiety. We will also continue him on Hydrocodone which he takes for his headaches as needed and I have cautioned him about using too much. He seems to be a little calmer today and disposition is a little gentler and he seems to be sleeping OK. I will see him in 6 weeks.

R. JOSEPH HEALY, MD
RJH/nb

	Floyd, Scottie
1/28/03	6WK FU - Hydrocodone Trilysodone 200 See Note
1·30·03	too soon to fill Hydrocodone script Rsc
2·3·03	Hydrocodone 5/500 #50 1 po q 8hrs prn pain RF 2sc
2·12·03	2 WK RTC See Note
2·25·03	Prilosec 40 mg #30 1 po q day 3RF 2sc 423·1021 2 scripts
3-25-03	6 wk RTC Paxil CR 37.5 Hydrocodone Prilosec 40 See Note → Did not dictate waiting on EEG results

23201

OFFICE NOTE
March 25, 2003

RE: Scottie W. Floyd

Scottie Floyd returns today for a follow up. He is on Paxil CR 37.5, Hydrocodone and Prilosec 40. Apparently his girlfriend has noticed some involuntary motor activity nocturnally and I told the patient that this is a common time for seizure. He is not aware of this although he spoken up on several occasions with a lot of neck pain and it felt as though his "neck was stiff". I have been watching very closely all along for seizure activity since the frontal lobes are very epileptogenic. I am going to go ahead and get an EEG and recheck his CBC and CMP and further recommendations will await the above.

R. JOSEPH HEALY, MD
RJH/nb

R. Joseph Healy, M.D., P.A.
P.O. BOX 3408
518-S. IRBY ST., SUITE 100
FLORENCE, SOUTH CAROLINA 29502
(803) 664-9200
(803) 664-9202 (FAX)

LT & PEDIATRIC NEUROLOGY

ELECTROPHYSIOLOGY

PRELIMINARY ELECTROPHYSIOLOGY REPORT

EMG/NCS _____

EEG 03-184

BAER/VER _____

OTHER _____

PATIENT NAME Floyd, Scottie

DATE 3/25/03

REFERRNG PHYSICIAN Heath

frontal slowing - 5-6 Hz
background 10 Hz
no sleep

Abnormal
EEG

OFFICE NOTE
April 1, 2003

RE: Scottie Floyd
23201

Scottie Floyd returns today for a follow up. His EEG shows frontal slowing as expected. There is no definite epileptic form activity. Apparently he has had another episode awakening with a very stiff neck. Nobody has actually seen any definite seizure activity or either focal or frank. At this point I want to give him a trial of Lamictal and I have given him a starter pack to use for titration and this will cover the first five weeks of his treatment. Side effects have been explained. Yesterday he had to go to the ER for his headache. This is a headache that built over the day and I believe it was anticipation of coming to his appointment today and not be able to get a quicker appointment. I have told him that there is not much that the ER can do to help his headache. Hydrocodone does not seem to help and so I am going to switch to Ativan particularly since we are going to stop his Hydrocodone and at the rate he has been using it the possibility of some withdrawal is recognized and has been explained to he and his mother. I will start him on a milligram of Ativan p.o. q 8 hours and this may also help his headache since I believe there are chronic muscle contractions in etiology and secondary to a closed head injury and all of the social/domestic problems, which have followed it.

R. JOSEPH HEALY, MD
RJH/nb

OFFICE NOTE
April 28, 2003

RE: Scottie W. Floyd
23201

Scottie Floyd returns today for a follow up. He is becoming very aggressive and has rage reactions and apparently had one 4/14/03 and beat up the side of a building at home. His mother called here and we told her that if she was afraid or if he became threatening that she needed to call the Police but she didn't do that. He has stopped all of his medicines and the last time he was in the hospital his drug screen came back showing marijuana. I have had a long talk with him and have told him that this isn't going to help his situation but he states that it is the only thing that really helps his headache. This may actually be true. In the office today he is very frustrated and predominately this is with the worker's comp system. I have a letter from his rehab nurse saying that he needs to see Dr. James Brennan who is a neurosurgeon however the patient has no neurosurgical lesions. I don't believe that he needs to see a neurosurgeon. The nurse also states that she has been unable to get my records although there is no request in the chart for the records. She asked that the patient get his own records but according to my understanding that worker's compensation laws the patient is not suppose to have those records.

At this point I have asked Scottie to go and talk with his attorney. His mother and I have had a long talk today and if she feels threatened any point by his behavior she needs to take him to MRMC ER where he can get evaluated and get the proper psychiatric care. I do believe his behavior is becoming dangerous and that potentially he is a dangerous individual.

R. JOSEPH HEALY, MD
RJH/nb

OFFICE NOTE
May 8, 2003

RE: Scottie W. Floyd 23201

Scottie returns today for a follow up. Two weeks ago he was in the office and was very aggressive and he was taken to McLeod and apparently was transferred to Columbia. He returns today after being hospitalized at Baptist Hospital in Columbia and he is doing better. He is on Prilosec 40 p.o.q d, Klonopin 1mg p.o. b.i.d., Carbatrol 200 p.o. b.i.d., Paxil CR 25 p.o. b.i.d., Keppra 250 p.o. b.i.d. and Vicodan 5/500 1 p.o. b.i.d. p.r.n. pain.

He is much less aggressive and more polite. He still can escalate if he hears something he doesn't like. The patient complains of right arm pain and I believe is tender in the right innercubital fossa. I don't see any definite evidence of swelling but he is tender. I am curious as to whether or not there may be median nerve injury possibly from blood drawing. I am going to send him for some vascular studies and electrophysiological studies of the right arm. The pain radiates into the right 2nd, 3rd and 4th digits. We will treat it conservatively and I will give him a Medrol Dose pack and continue on the above medications.

He has an appointment with Renay Williams to follow up with counseling which is a good idea and I will see him back in two weeks time.

R. JOSEPH HEALY, MD
RJH/nb

R. Joseph Healy, M.D., P.A.
P.O. Box 3408
805 Pamplico Highway, Suite A130
Florence, S.C. 29505
P- (843) 664-9200
F-(843) 664-9202

ADULT & PEDIATRIC NEUROLOGY **ELECTROPHYSIOLOGY**

May 15, 2003

RE: Scottie Floyd

Scottie Floyd was seen in the Marion County Memorial Medical Center Emergency room last night with complaints of increasing headache. This was actually the third visit this week. I was called by Dr. Schmidt. Dr. Schmidt informed me that the patient isn't necessary behaving aggressively but that he was concerned about the patient returning to the ER on numerous occasions when he has been told that there isn't anything they can do to treat his headache. I informed Dr. Schmidt that the patient had told me verbally that he wanted to kill the emergency room doctor in the Marion County Memorial Emergency room who originally saw him and did not obtain a CT of his head. As a consequence I am concerned about the patient's behavior. It has been my opinion that his headaches are chronic tension headaches and that they are driven and exacerbated by his behavior and demeanor and that when he is upset they intensify. As a consequence I do believe that they are a measure of his aggressiveness or possibly a program to impulsive behavior. I have told Dr. Schmidt that I would be in contact with Scottie's family as of 7/15/03 and that I would notify Dr. Malone. There is nothing I can do at this point for his headaches but they do seem to improve with treatment of his mood and behavior. In view of his above threats in the past I still think that he is a danger to the public. His mother is aware of this.

I have tried to reach Dr. Malone this morning at two different phone numbers and he has not been available as yet and so I will fax the above letter to his office. Mrs. Floyd has already called to Columbia this morning to find out what to do and was told that they don't treat headaches. My own opinion is that the treatment of this headache is within the psychiatric realm.

R. JOSEPH HEALY, MD
RJH/nb

Fax to # (803) 779-7522

cc: Steve Wukela, Esquire
695150

	Min	Max	Mean
F-Latency	29.10ms	29.10ms	29.10ms
FWCV			

F-wave Study

Nerve	Median	Side	Right		
Stim. Site	Wrist	Rec. Site	APB	Distance	
M-Latency		M-Amplitude	0.00mV	F-Occurrence	1/1,100

	Min	Max	Mean
F-Latency	26.80ms	26.80ms	26.80ms
FWCV			

F-wave Study

Nerve	Ulnar	Side	Right		
Stim. Site	Wrist	Rec. Site	ADQ	Distance	
M-Latency		M-Amplitude	0.00mV	F-Occurrence	1/1,100

	Min	Max	Mean
F-Latency	24.95ms	24.95ms	24.95ms
FWCV			

Impression

(R) CTS

Date 5/26/2003

Signature

	Floyd, Scottie
-03	BTC per RJH
	See Note
4.16.03	Pt mother called stated patient is losing his temper and getting upset - per RJH if pt threatens her call the police/22e
4-28-03	BTC - 3 weeks ⇒ Paxil, Atarax, Lamictal > pt stopped meds & acting
	See Note
5-8-03	BTC
5-28-03	Tests
	See Note
5.27.03	Keppra 250mg 3RF 423-1021 / 22e
	Prilosec 25mg 3RF
	Klonopin 1mg 3RF
	Paxil CR 25mg 3RF
	Viccodan 5/500 3RF

OFFICE NOTE
May 26, 2003

RE: Scottie W. Floyd

Scottie Floyd returns today for a followup. His disposition seems to be a good bit better today and he's less angry and impulsive. He is concerned about his right arm. His exam suggests a median neuropathy and his EPS are confirmatory. I told him that we need to give this a month or two to see if it doesn't resolve. According to his history he was injured either with blood-drawing or with starting an IV while he was in Columbia. He has followed up with the Mental Health Center in Marion. I believe he is stable on his present medication regimen. In view of his persistent headaches I have recommended that we take a look at an MRA of the head. Further recommendations will await the above. Again, I don't believe there is any need for a neurosurgical referral unless this study shows that there is. I do not consider Scottie to be a surgical candidate at this point. I will see him back after his MRA of the head.

R. JOSEPH HEALY, M. D.

RJH:ec

	Floyd, Scottie
6-5-03	RTC.
	MRA head ⊖
	Hydrocodone won't work any longer
	10 g Valium didn't affect pt.
	Keppra
	Celebrex
	Qiaquapin
	Paxil CR 25 g
	Vicodan
	Trial Ultram 50 g PO q 6h prn
	PT Headache
7-30-03	Called CVS (423-1021) for 1 rf: Carbatrol 200mg probN / dfb
7-29-03	RTC. Headaches persist
	Keppra
	Celebrex
	Paxil CR 25mg
	very anxious
	Trileptal 7.5 g - PO q 8h Trial
	PT headache
8-6-03	Phoned in Carbatrol 200 mg. 1 BID 5 refills per RJH
	Loretta at 423102 1 (M3)

OFFICE NOTE
September 23, 2003

RE: Scottie W. Floyd
23201

Scottie Floyd returns today for a follow up. He is very agitated today because of left neck pain. He is tender over the left greater occipital nerve in the suboccipital region on the left and I believe has an occipital neuralgia. The main problem at this point is that it is aggravated his behavioral problems and he is very aggressive today and as a consequence I am recommending that he be admitted for behavioral control and I would like to get a left occipital nerve block done. Further recommendations will await the above.

R. JOSEPH HEALY, MD
RJH/nb

R. Joseph Healy, M.D., P.A.
P.O. Box 3408
805 Pamplico Highway, Suite A130
Florence, S.C. 29505
P- (843) 664-9200
F-(843) 664-9202

ADULT & PEDIATRIC NEUROLOGY

ELECTROPHYSIOLOGY

October 22, 2003

Steve Wukela, Jr. Esquire
Fax # 669-5150

Scottie W. Floyd

Dear Mr. Wukela:

I appreciate your letter of 10/10/03 concerning Scottie Floyd. I have been in contact with Kelly Dean who is Admissions Coordinator at Tangram in Texas. It sounds as though Scottie is exactly the kind of patient who they deal with routinely. I told her that this is a Worker's Compensation case and that we need to get all of the details worked out. Apparently Dr. Walter Harrell does not work there any longer and Dr. Wesley Wallace is the Medical Director.

A fax number for the facility is (512) 396-2024 and they are in need of some of Scottie's records. I told them I would do whatever was necessary to help facilitate the process but I do feel that this is exactly the type of program that Scottie would benefit from.

Thank you for your very kind inquiry and additional insight into Scottie's care.

Sincerely,

R. JOSEPH HEALY, MD
RJH/ab

117
2320

October 28, 2003

RE: Scottie W. Floyd
23201

Scottie returns today for a follow up. His recent hospitalization was helpful in some regards. Apparently the left occipital nerve block did help him. While he was hospitalized and under the influence of a great deal of Benzodiazepine and Morphine his behavior was great. I have had a long talk with him on several occasions about the fact that we cannot continue doing this. He tells me that he has watched "Dr. Phil" on TV and has gotten some insight in to how his behavior is adversely affecting his health. I have told him that behavior modification in my mind is the best way to approach his problem and I have recommended to him that we send him to a facility in Texas, which deals with his particular type of brain injury (specifically frontal lobe injuries with aggression and rage). I told him that I would make this recommendation and for the present time we will continue him on his Keppra, Prilosec, Paxil and I will increase his Tranxene to 15mg twice a day since Benzodiazepines do seem to help him a great deal.

In the office today his behavior seems to be a little better than it has been in the past and he attributes this to the fact that he is gaining some insight into his behavioral problems.

R. JOSEPH HEALY, MD
RJH/nb

Scott Lloyd

9/23/03 KTC

See Note

9.29.03 Tramxene 7.5 mg #90 St po q 8h PRN IRF. (PW)

CVS 423-1021 - CRYSTAL (DSH)

10-29-03 DSH

See Note

Tramxene 7.5 T.I.D

11-4-03 Faxed Rx to CVS/Maria for Tramadol 50mg. #3 Ref. SGo

12-9-03 RTC

See Note

Keppra 250/250
Ultram 50
Cordarone 200/200
Klonopin 1 mg BID
Paxil CR 25 mg BID
Pristiq 40 mg
Tramxene 7.5 = 8th

******* INSTANT BILL ******* ACCT: 23201 DATE: 12/15/03
R. JOSEPH HEALY, M. D., P. A.
885 PAMPLICO HWY, STE A-130 LAST PAYMENT YTD PAY
P.O. BOX 3408 ---------- -------
FLORENCE, SC 29505 11/19/03 $87.00 $2203.00

OFFICE PH:843-664-9200 HOME PH:843-206-1378 BUSINESS PH:843-432-4836 EXT:

	PAT	NAME	APPOINTMENT
MR. SCOTTIE M. FLOYD	SF	SCOTTIE M. FLOYD	

IAGNOSIS

54.00 CLOSED HEAD INJURY
11 DEPRESSION

DOCTOR	SSN#	TAX ID	MEDICAID	PROVIDER
R. JOSEPH HEALY, M.D.	170384330	57-0523239	111783	170384330

:	DR	PAT	DIAG	TCODE	MOD	DESCRIPTION	CHARGE	CREDIT	BALANCE
6/02	1	SF	12	99205	25	*NEW OFFICE VISIT-	250.00		250.00
6/02	1	SF	12	70460	26	*C T INTERPETAION	75.00		325.00
INS. FILED:02/07/02									
5/02	1	SF	1	95930		*VISUAL EVOKE TEST	275.00		600.00
5/02	1	SF	1	70551	26	*MRI BRAIN INTERP.	300.00		900.00
5/02	1	SF	1	95819		*EEG,TECHNOLOGICAL	250.00		1150.00
5/02	1	SF	1	92585		*BAER-TECHONOLOGIC	250.00		1400.00
5/02	1	SF	1	99224	25	*ESTAB. OFFICE VIS	75.00		1475.00
5/02	1	SF	1	93886	26	*TCD INTERPETATION	250.00		1725.00
5/02	1	SF	1	93880	26	*NICS INTERPETATIO	175.00		1900.00
INS. FILED:03/12/02									
9/02	1	SF		8		*WORKMENS COMP PAY		180.90	1719.10
APPLIES TO CHARGES ON: 02/06/02 CHK#:294655									
9/02-	1	SF		8C		*WORKMEN'S COMP.		69.10	1650.00
6/02									
9/02-	1	SF		8C		*WORKMEN'S COMP.		75.00	1575.00
6/02									
4/02	1	SF	1	1000		*MEDICAL RECORDS C	15.00		1590.00
4/02	1	SF		87		*8C VOCATIONAL REH		15.00	1575.00
APPLIES TO CHARGES ON: 04/04/02 CHK#:123569710									
9/02	1	SF		8		*WORKMENS COMP PAY		108.90	1466.10
APPLIES TO CHARGES ON: 03/05/02 CHK#:306709									
9/02-	1	SF		8C		*WORKMEN'S COMP.		191.10	1275.00

CONTINUED ON NEXT FORM

******* INSTANT BILL ******* ACCT: 23201 DATE: 12/15/03

R. JOSEPH HEALY, M. D., P. A.
805 PAMPLICO HWY, STE A-130
P.O. BOX 3408
FLORENCE, SC 29505

LAST PAYMENT		YTD PAY
11/19/03	$67.00	$2203.00

OFFICE PH:843-664-9200 HOME PH:843-006-1278 BUSINESS PH:843-423-4836 EXT:

MR. SCOTTIE W. FLOYD

PAT	NAME	APPOINTMENT
SF	SCOTTIE W. FLOYD	

IAGNOSIS

80.39 SEIZURES
84.0 HEADACHE/FACIAL PAIN

DOCTOR	SSN#	TAX ID	MEDICAID	PROVIDER
R. JOSEPH HEALY, M.D.	170384330	57-0823239	111783	170384330

E	DR	PAT	DIAG	TCODE	MOD	DESCRIPTION	CHARGE	CREDIT	BALANCE
5/02									
9/02	1	SF		8		*WORKMENS COMP PAY		478.20	796.50
PPLIES TO CHARGES ON: 03/05/02 CHK#:306709									
9/02-	1	SF		8C		*WORKMEN'S COMP.		371.80	425.00
5/02									
9/02	1	SF		8		*WORKMENS COMP PAY		118.80	306.20
PPLIES TO CHARGES ON: 03/05/02 CHK#:306709									
9/02-	1	SF		8C		*WORKMEN'S COMP.		306.20	0.00
5/02									
9/02	1	SF	1	99215	25	*ESTAB. OFFICE VIS	120.00		120.00
NS. FILED:04/10/02									
2/02	1	SF	2	99214	25	*ESTAB. OFFICE VIS	75.00		195.00
NS. FILED:04/22/02									
9/02-	1	SF	2	99223	25	*HOSPITAL ADMISSIO	165.00		360.00
9/02									
0/02-	1	SF	2	99231	25	*HOSPITAL F.U. DAY	120.00		480.00
1/02						(DAYS/UNITS = 2)			
0/02	1	SF	2	70551	26	*MRI BRAIN INTERP.	75.00		555.00
2/02-	1	SF	2	99238		*DISCHARGE DAY	75.00		630.00
2/02									
NS. FILED:05/09/02									
5/02	1	SF		8		*WORKMENS COMP PAY		75.00	555.00
PPLIES TO CHARGES ON: 04/22/02 CHK#:320012									

CONTINUED ON NEXT FORM

******* INSTANT BILL ******* ACCT: 83201 DATE: 12/15/03

R. JOSEPH HEALY, M. D., P. A.
865 PAMPLICO HWY, STE A-130
P.O. BOX 3408
FLORENCE, SC 29505

LAST PAYMENT		YTD PAY
11/19/03	$67.00	$2203.00

OFFICE PH:843-664-9200 HOME PH:843-206-1378 BUSINESS PH:843-423-4836 EXT:

	PAT	NAME	APPOINTMENT
MR. SCOTTIE W. FLOYD	SF	SCOTTIE W. FLOYD	

IAGNOSIS

54.00 CLOSED HEAD INJURY
80.39 SEIZURES
84.0 HEADACHE/FACIAL PAIN
49.3 ENCEPHALOPATHY

DOCTOR	SSN#	TAX ID	MEDICAID	PROVIDER
R. JOSEPH HEALY, M.D.	170384330	57-0923239	111783	170384330

	DR	PAT	DIAG	TCODE	MOD	DESCRIPTION	CHARGE	CREDIT	BALANCE
2/02	1	SF	1	99214	25	*ESTAB. OFFICE VIS	75.00		630.00
NS. FILED:05/27/02									
7/02	1	SF		8		*WORKMENS COMP PAY		120.00	510.00
PPLIES TO CHARGES ON: 04/09/02 CHK#:318862									
0/02	1	SF		8		*WORKMENS COMP PAY		291.30	218.70
PPLIES TO CHARGES ON: 04/12/02 CHK#:328533									
0/02-	1	SF		8C		*WORKMEN'S COMP.		68.70	150.00
2/02									
0/02	1	SF		8		*WORKMENS COMP PAY		75.00	75.00
PPLIES TO CHARGES ON: 04/10/02 CHK#:328533									
7/02	1	SF	1	99214	25	*ESTAB. OFFICE VIS	75.00		150.00
NS. FILED:07/18/02									
8/02	1	SF		8		*WORKMENS COMP PAY		75.00	75.00
PPLIES TO CHARGES ON: 05/22/02 CHK#:340722									
1/02	1	SF	123	95819		*EEG,TECHNOLOGICAL	250.00		325.00
1/02	1	SF	123	92585		*BAER-TECHONOLOGIC	250.00		575.00
NS. FILED:08/01/02									
7/02	1	SF	14	99214	25	*ESTAB. OFFICE VIS	75.00		650.00
NS. FILED:08/07/02									
7/02	1	SF		8		*WORKMENS COMP PAY		75.00	575.00
PPLIES TO CHARGES ON: 07/17/02 CHK#:355615									
3/02	1	SF		8		*WORKMENS COMP PAY		382.00	193.00
PPLIES TO CHARGES ON: 07/31/02 CHK#:361364									

CONTINUED ON NEXT FORM

******* INSTANT BILL ******* ACCT: 23201 DATE: 12/15/03

R. JOSEPH HEALY, M. D., P. A.
805 PAMPLICO HWY, STE A-130
P.O. BOX 3408
FLORENCE, SC 29505

LAST PAYMENT		YTD PAY
11/19/03	$87.00	$2303.00

OFFICE PH:843-664-9200 HOME PH:843-206-1378 BUSINESS PH:843-433-4836 EXT:

MR. SCOTTIE W. FLOYD

PAT	NAME	APPOINTMENT
SF	SCOTTIE W. FLOYD	

DIAGNOSIS

54.00 CLOSED HEAD INJURY
784.0 HEADACHE/FACIAL PAIN
349.3 ENCEPHALOPATHY

DOCTOR	SSN#	TAX ID	MEDICAID	PROVIDER
R. JOSEPH HEALY, M.D.	170384330	57-0823239	111783	170384330

E	DR	PAT	DIAG	TCODE	MOD	DESCRIPTION	CHARGE	CREDIT	BALANCE
10/02-31/02	1	SF		8C		#WORKMEN'S COMP.		118.00	75.00
11/02	1	SF	1	99214	25	#ESTAB. OFFICE VIS	75.00		150.00
INS. FILED:05/12/02									
12/02	1	SF		8		#WORKMENS COMP PAY		75.00	75.00
APPLIES TO CHARGES ON: 08/07/02 CHK#:362094									
08/02	1	SF	2	99214	25	#ESTAB. OFFICE VIS	75.00		150.00
INS. FILED:10/09/02									
14/02	1	SF		8		#WORKMENS COMP PAY		75.00	75.00
APPLIES TO CHARGES ON: 09/11/02 CHK#:373874									
06/02	1	SF	1	99214	25	#ESTAB. OFFICE VIS	75.00		150.00
INS. FILED:11/07/02									
21/02	1	SF		8		#WORKMENS COMP PAY		75.00	75.00
APPLIES TO CHARGES ON: 10/08/02 CHK#:387984									
05/02	1	SF	3	99214	25	#ESTAB. OFFICE VIS	75.00		150.00
INS. FILED:12/05/02									
18/02	1	SF		8		#WORKMENS COMP PAY		75.00	75.00
APPLIES TO CHARGES ON: 11/06/02 CHK#:394826									
27/02	1	SF		8		#WORKMENS COMP PAY		75.00	0.00
APPLIES TO CHARGES ON: 12/05/02 CHK#:398867									
22/03	1	SF	1	99214	25	#ESTAB. OFFICE VIS	75.00		75.00
INS. FILED:01/23/03									
03/03	1	SF		8		#WORKMENS COMP PAY		75.00	0.00

CONTINUED ON NEXT FORM

******* INSTANT BILL ******* ACCT: 23201 DATE: 12/15/03

R. JOSEPH HEALY, M. D., P. A.
805 PAMPLICO HWY, STE A-130
P.O. BOX 3403
FLORENCE, SC 29505

LAST PAYMENT		YTD PAY
11/19/03	$87.00	$2203.00

OFFICE PH:843-664-9200 HOME PH:843-206-1378 BUSINESS PH:843-423-4836 EXT:

MR. SCOTTIE W. FLOYD

PAT	NAME	APPOINTMENT
SF	SCOTTIE W. FLOYD	

IAGNOSIS

54.00 CLOSED HEAD INJURY
80.39 SEIZURES
48.3 ENCEPHALOPATHY
80.2 SYNCOPE

DOCTOR	SSN#	TAX ID	MEDICAID	PROVIDER
R. JOSEPH HEALY, M.D.	170384330	57-0823239	111783	170384330

	DR	PAT	DIAG	TCODE	MOD	DESCRIPTION	CHARGE	CREDIT	BALANCE
PPLIES TO CHARGES ON: 01/22/03 CHK#:415252									
6/03	1	SF	1	1000		*MEDICAL RECORDS C	15.00		15.00
6/03	1	SF		87		*SC VOCATIONAL REH		15.00	0.00
PPLIES TO CHARGES ON: 02/06/03 CHK#:124390330									
2/03	1	SF	1	99214	25	*ESTAB. OFFICE VIS	75.00		75.00
NS. FILED:02/13/03									
5/03	1	SF		8		*WORKMENS COMP PAY		75.00	0.00
PPLIES TO CHARGES ON: 02/12/03 CHK#:A00896									
6/03	1	SF	1	1000		*MEDICAL RECORDS C	25.00		25.00
6/03	1	SF		44		*ATTORNEY PAYMENT		25.00	0.00
PPLIES TO CHARGES ON: 02/26/03 CHK#:18730									
5/03	1	SF	123	95819		*EEG,TECHNOLOGICAL	250.00		250.00
5/03	1	SF	123	99215	25	*ESTAB. OFFICE VIS	120.00		370.00
NS. FILED:03/26/03									
1/03	1	SF	21	99214	25	*ESTAB. OFFICE VIS	75.00		445.00
NS. FILED:04/02/03									
7/03-7/03	1	SF	4	99223	25	*HOSPITAL ADMISSIO	165.00		610.00
8/03-9/03	1	SF	4	99231	25	*HOSPITAL F.U. DAY (DAYS/UNITS = 2)	120.00		730.00
0/03-0/03	1	SF	4	99238		*DISCHARGE DAY	75.00		805.00
3/03	1	SF	4	93886	26	*TCD INTERPETATION	250.00		1055.00

CONTINUED ON NEXT FORM

******* INSTANT BILL ******* ACCT: 22201 DATE: 12/15/03

R. JOSEPH HEALY, M. D., P. A.
865 PAMPLICO HWY, STE A-130
P.O. BOX 3408
FLORENCE, SC 29505

LAST PAYMENT		YTD PAY
11/19/03	$87.00	$2203.00

OFFICE PH:843-664-9200 HOME PH:843-206-1378 BUSINESS PH:843-423-4836 EXT:

	PAT	NAME	APPOINTMENT
MR. SCOTTIE W. FLOYD	SF	SCOTTIE W. FLOYD	

IAGNOSIS

80.2 SYNCOPE
54.00 CLOSED HEAD INJURY
48.3 ENCEPHALOPATHY

DOCTOR	SSN#	TAX ID	MEDICAID	PROVIDER
R. JOSEPH HEALY, M.D.	170384330	57-0823239	111763	170384330

E	DR	PAT	DIAG	TCODE	MOD	DESCRIPTION	CHARGE	CREDIT	BALANCE
09/03	1	SF	1	93890	26	*NICS INTERPETATIO	175.00		1230.00
09/03	1	SF	1	95819	26	*EEG, PROFESSIONAL	80.00		1310.00
INS. FILED:04/10/03									
22/03	1	SF		8		*WORKMENS COMP PAY		283.00	1027.00
APPLIES TO CHARGES ON: 03/25/03 CHK#:420919									
22/03-25/03	1	SF		8C		*WORKMEN'S COMP.		87.00	940.00
25/03	1	SF	2	99214	25	*ESTAB. OFFICE VIS	75.00		1015.00
INS. FILED:04/30/03									
29/03	1	SF		8		*WORKMENS COMP PAY		75.00	940.00
APPLIES TO CHARGES ON: 04/01/03 CHK#:422263									
29/03	1	SF		8		*WORKMENS COMP PAY		212.00	728.00
APPLIES TO CHARGES ON: 04/09/03 CHK#:422413									
29/03-09/03	1	SF		8C		*WORKMEN'S COMP.		293.00	435.00
29/03	1	SF		8		*WORKMENS COMP PAY		354.00	81.00
APPLIES TO CHARGES ON: 04/07/03 CHK#:422413									
29/03-07/03	1	SF		8C		*WORKMEN'S COMP.		6.00	75.00
28/03	1	SF	23	99214	25	*ESTAB. OFFICE VIS	75.00		150.00
INS. FILED:05/14/03									
19/03	1	SF		8		*WORKMENS COMP PAY		75.00	75.00
APPLIES TO CHARGES ON: 04/28/03 CHK#:426141									

CONTINUED ON NEXT FORM

******* INSTANT BILL ******* ACCT: 23201 DATE: 12/15/03

R. JOSEPH HEALY, M. D., P. A.
805 PAMPLICO HWY, STE A-130
P.O. BOX 3408
FLORENCE, SC 29503

LAST PAYMENT		YTD PAY
11/19/03	$87.00	$2203.00

OFFICE PH:843-664-6200 HOME PH:843-206-1378 BUSINESS PH:843-423-4836 EXT:

	PAT	NAME	APPOINTMENT
MR. SCOTTIE W. FLOYD	SF	SCOTTIE W. FLOYD	

AGNOSIS

4.00 CLOSED HEAD INJURY
A.0 HEADACHE/FACIAL PAIN
9.2 NEURALGIA

DOCTOR	SSN#	TAX ID	MEDICAID	PROVIDER
R. JOSEPH HEALY, M.D.	170384330	57-0823239	111793	170384330

	DR	PAT	DIAG	TCODE	MOD	DESCRIPTION	CHARGE	CREDIT	BALANCE
/03	1	SF		B		*WORKMENS COMP PAY		75.00	0.00
PLIES TO CHARGES ON: 05/08/03 CHK#:427412									
/03	1	SF	12	93903		*MOTOR WITH F WAVE (DAYS/UNITS = 4)	320.00		320.00
/03	1	SF	12	93904		*NERVE CONDUCTION (DAYS/UNITS = 4)	320.00		640.00
/03	1	SF	12	99214	25	*ESTAB. OFFICE VIS	75.00		715.00
B. FILED:05/28/03									
/03	1	SF	2	99214	25	*ESTAB. OFFICE VIS	75.00		790.00
3. FILED:06/10/03 REFILED:11/20/03									
/03	1	SF	2	70544	2626	*MRA-HEAD,WITHOUT	300.00		1090.00
3. FILED:06/10/03 REFILED:11/18/03									
03	1	SF		B		*WORKMENS COMP PAY		547.00	543.00
LIES TO CHARGES ON: 06/26/03 CHK#:431932									
03- 03	1	SF		BC		*WORKMEN'S COMP.		168.00	375.00
03	1	SF	2	99214	25	*ESTAB. OFFICE VIS	75.00		450.00
. FILED:07/30/03 REFILED:11/18/03									
03	1	SF	3	99215	25	*ESTAB. OFFICE VIS	120.00		570.00
. FILED:09/25/03 REFILED:11/19/03									
03- 03	1	SF	3	99223	25	*HOSPITAL ADMISSIO	165.00		735.00
03-	1	SF	3	99231	25	*HOSPITAL F.U. DAY	120.00		855.00

CONTINUED ON NEXT FORM

******* INSTANT BILL ******* ACCT: 23801 DATE: 12/15/03

R. JOSEPH HEALY, M. D., P. A.
805 PAMPLICO HWY, STE A-130
P.O. BOX 3408
FLORENCE, SC 29505

LAST PAYMENT
11/19/03 $87.00

YTD PAY
$2203.00

OFFICE PH:843-664-9200 HOME PH:843-206-1378 BUSINESS PH:843-423-4836 EXT:

PAT NAME		APPOINTMENT
MR. SCOTTIE W. FLOYD	SF	SCOTTIE W. FLOYD

IAGNOSIS

29.2 NEURALGIA
54.00 CLOSED HEAD INJURY
48.3 ENCEPHALOPATHY

DOCTOR	SSN#	TAX ID	MEDICAID	PROVIDER
R. JOSEPH HEALY, M.D.	170384330	57-0823239	111783	170384330

:	DR	PAT	DIAG	TCODE	MOD	DESCRIPTION	CHARGE	CREDIT	BALANCE
5/03						(DAYS/UNITS = 2)			
6/03-	1	SF	1	99238		#DISCHARGE DAY	75.00		930.00
6/03									
NS. FILED:10/02/03 REFILED:11/20/03									
3/03	1	SF	2	98960		MED/LEGAL FAMILY C	35.00		965.00
8/03	1	SF	3	99214	25	#ESTAB. OFFICE VIS	75.00		1040.00
NS. FILED:10/28/03 REFILED:11/18/03									
0/03	1	SF		44		ATTORNEY PAYMENT		35.00	1005.00
PPLIES TO CHARGES ON: 10/23/03 CHK#:20697									
9/03	1	SF		8		#WORKMENS COMP PAY		75.00	930.00
PPLIES TO CHARGES ON: 10/28/03 CHK#:337562136									
9/03	1	SF		8		#WORKMENS COMP PAY		120.00	810.00
PPLIES TO CHARGES ON: 09/23/03 CHK#:337562127									
9/03	1	SF		8		#WORKMENS COMP PAY		75.00	735.00
PPLIES TO CHARGES ON: 07/29/03 CHK#:337562118									
9/03	1	SF		8		#WORKMENS COMP PAY		87.00	648.00
PPLIES TO CHARGES ON: 06/05/03 CHK#:337562109									
9/03-	1	SF		80		#WORKMEN'S COMP.		213.00	435.00
5/03									
9/03	1	SF	22	99214	25	#ESTAB. OFFICE VIS	75.00		510.00
NS. FILED:12/10/03									

3EES

TOTAL: $510.00

OFFICE NOTE
December 9, 2003

RE: Scottie W. Floyd
23201

Scottie Floyd returns today for follow up of his frontal lobe injury. He actually seemed somewhat calmer today. In talking with he and his mother it seems that his mother has a new boyfriend and that the boyfriend is pretty active person and has been doing a lot of work around Scottie's house and Scottie has been helping him and in that regard he has been planting trees and clearing the brush off of some adjacent land all of which I think is good for him. I believe it argues very strongly for the fact that a vocationally structured program would be helpful in managing this patient's rage. I am going to go ahead and refill his Tranxene and I have told him that he could take 1 ½ or 2 as needed every 8 hours. We are trying to get his Worker's Comp carried to agree to allow him to go to a program for closed head injuries with organic CNS damage and behavioral problems. The main reason I want him to go to the Tangram facility in Texas is because of its track record. I have told Mr. Wukela that I would be glad to talk to the Worker's compensation Attorney who is Mr. Martin to explain my reasoning. The patient continues on his Keppra, Carbatrol and Paxil. He is still unable to work.

R. JOSEPH HEALY, MD
RJH/nb

OFFICE NOTE
December 17, 2003

RE: Scottie W. Floyd
23201

Scottie returns today for follow up. His EEG shows a great deal of muscle artifact as expected. There is frontal slowing but no epileptic form activity. I think based on a clinical description of his problems I am going to increase his Keppra from 250 q12 to 500. We will leave everything else the way that it is. Apparently his deposition is in the morning and I have asked him to try and maintain his behavior during this event.

R. JOSEPH HEALY, MD
RJH/nb

R. Joseph Healy, M.D., P.A.
P.O. BOX 3408
518-5, IRBY ST., SUITE 100
FLORENCE, SOUTH CAROLINA 29502
(803) 664-9200
(803) 664-9302 (FAX)

ADULT & PEDIATRIC NEUROLOGY

ELECTROPHYSIOLOGY

PRELIMINARY ELECTROPHYSIOLOGY REPORT

EMG/NCS _____

EEG 03-715

BAER/VER _____

OTHER _____

PATIENT NAME Floyd, Scottie

DATE 12-17-83

REFERRNG PHYSICIAN Heath

prominent muscle artifact
background 11-12 Hz
generalized slowing
no sleep

AB normal EEG

R. Joseph Healy, M.D.

ELECTRODIAGNOSTIC REPORT

Patient Information

ID	23201	In/Out Patient	In
Name	Floyd, Scottie W.	Refer. Dept.	Neurology
Date of Birth		Doctor	R. Joseph Healy, M.D
Age	28y4m		
Sex	Male	Examination Date	12/17/2003
Height		Examination No.	
Weight		Examiner	

ABR

Stim Side	Latency (msec)							Stim.	Interval (msec)			Amplitude (uV)	
	I	II	III	IV	V	A	B	dB	I-III	III-V	I-V	V-A	
Left	1.42	2.62	3.86	4.89	5.30	6.14		90dB	2.44	1.44	3.88	0.609	

ABR

Stim Side	Latency (msec)							Stim.	Interval (msec)			Amplitude (uV)	
	I	II	III	IV	V	A	B	dB	I-III	III-V	I-V	V-A	
Right	1.54	2.46	3.84	5.00	5.48	6.54		85dB	2.30	1.64	3.94		

Impression

Normal BAER

Date 12/17/2003 Signature

OFFICE NOTE
February 11, 2004

RE: Scottie Floyd
23201

Scottie Floyd returns today for a follow up. He seems to be fairly mannered today. His speech isn't necessary pressured and his language is not nearly as obscene as it usually is. He tells me this is because he has been smoking a lot of reefer to try and keep his rage his under control. He wants pain medicine but I told him I cannot write a prescription for pain medicine knowing that he uses illicit drugs. We are going to keep his Keppra and Carbatrol and his Tranxene and I have told him that I would like for him to go to the Tancrum facility in Texas because I am familiar with it and I have seen results from it. I believe this is the bottom line.

R. JOSEPH HEALY, MD
RJH/nb

F-66475130

OFFICE NOTE
March 24, 2004

RE: Scottie Floyd
23201

Scottie Floyd returns today for a follow up. He has been compliant with his Tranxene and Keppra. His headaches seem to be doing fairly well at the present time although his behavior is still bad and in the room today he punches a hole in the exam table trying to show me what he is going to do if somebody doesn't "do something about his headaches and behavioral problem". He is threatening as typically he does but they are not aimed at any particular individual. I told him that we had the deposition and that I thought that we will hear fairly soon whether Worker's Comp approves his stay at Tancrum. My main concern at this point is that something may happen in a violet way if we don't hurry up and get treatment soon. I have given him Darvocet to use as needed for his headaches and we will continue his Keppra and Tranxene.

R. JOSEPH HEALY, MD
RJH/nb

Fax to Attorney Steve Wukela

Floyd, Sadie

2-11-04 RTC

Set Note

Keppra 500 p100
Tramadol 715
Combivent 2 puff 200
Klonopin 1 mg BID
Ultram 50
Fluoxetine 25.
Omeprazole 20mg
2 po qd

3-24-04

Set Note

3/24/04 Workmans Comp cl Tantrum in Texas
only sees children ages 12-17 -
melody Harris - 803 772-9192 ext 13 w/c nurse

5-5-04 OOH

C/o both pain sleep better on VPA
? Compression fx Tramadol
need for x-ray
VPA ER 1500

Seizure
Comp fx

OFFICE NOTE
June 1, 2004

RE: Scottie W. Floyd
23201

Scottie returns today for a follow up. He is now 28 Y/O and has a frontal lobe injury from a closed head injury at work that happened several years ago. Because of this he has frontal lobe syndrome which causes rage and has also now caused seizures. The patient has not been able to intrograde back into society because of his rage problems and his Worker's Compensation people have not as of this date provided us with an acceptable treatment for his frontal lobe problems. He, as a consequence has had a number of social problems including carrying a weapon in the MRMC ER and having violent outburst at home to the point that his Mother is very afraid of him and he has damaged a number of pieces of property during these events. His own lawyers have witnessed him stabbing himself in his own hand.

After his most recent seizures he suffered compression fractures of the thoracic spine at several different levels which have caused him even more discomfort. Adequate pain management has been a problem for him and as a consequence he has resorted to marijuana to help control his rage and his pain.

From the standpoint of his functional and social abilities I believe that introgration back in society is going to be very difficult because of the behavioral problems. This poses a danger in the work place and unless we can make further progress with treatment of this condition which hasn't been made in the two years to date then I think this will be a permanent condition. I do think it is going to take at least two more years before we actually have the situation under control.

At this point I would consider him totally disabled from the standpoint of behavioral problems, which emanate from his organic brain syndrome and also because of the compression fractures of his thoracic spine and a seizure disorder.

I have given him Darvocet today to use for his pain and he continues on his Keppra and Depakote. I will see him in 6 weeks time.

R. JOSEPH HEALY, MD
RJH/nb

Fax to (843) 669-5150

OFFICE NOTE
March 23, 2006

RE: Scottie W. Floyd

Scottie Floyd returns today for a follow up. He has been a ResCare Premier in Texas. He has been there approximately 18 months now. His medications have changed to Keppra 750 p.o. q12, Flexaril 5 p.o. b.i.d., Effexor 150 p.o. qd, Depakote ER 500 p.o. q12 and Darvocet although he is using less and less all the time. He is accompanied by his therapist and Scottie has made a tremendous turn around. He is very calm and I don't really see signs of anger like he use to have. He is not impulsive any longer. He has gained a great deal of weight and seems to be functioning on a relatively independent schedule now living in his own home and actually taking care of another person who lives with him. He also does a great deal of lawn work and utility work on vehicles. He seems to be quite happy and pleased and has good insight into his improvement.

The next question becomes "can he live in the same manner here at home with his mother"? My impression would be that he can. I believe that he has a much better insight that he had before and the anger has for the most part disappeared. He seems to work out his problems now in a logical fashion rather than resorting the violence.

All in all I think they have done an excellent job.

We will continue the above medications and if I can be of further help please don't hesitate to contact me.

Sincerely,

R. JOSEPH HEALY, MD
RJH/nb

cc: Jane Stewart
Fax # (512) 396-2024 ✓

Steve Wukela, Esquire
Florence, SC —
6695150

OFFICE NOTE
July 11, 2006

RE: Scottie W. Floyd
23201

Scottie returns today for a follow up. He has been home now for 5 weeks from Texas. Apparently as soon as he got home his air conditioner broke and this caused a lot of stress but he apparently made it through that. He does say that his headaches are a little worse since he has been home. He looks like he has lost some weight and actually is down about 20 lbs to 251, which is good. He has had no seizures and has been compliant with his medications. He continues on Keppra 750 p.o. q12, Flexaril 5 p.o. q12, Depakote ER 1000 p.o. q12 and Darvocet p.r.n. headache. His mother states that he sleeps poorly and that he snores very badly and that he has apnea episodes. I believe this is predictable based on his weight gain. I have told him that the poor sleep is actually going to drive his headaches and I see treatment of his sleep disorder as treatment of not only his headache syndrome but also will help to prevent seizures since sleep deprivation is a potent stimulus to seizure. I told him I would check with Worker's Comp to see if we could get authorization for an NPSG.

I do want to repeat his EEG as he is asking about driving and I think the question probably depends upon his encephalopathy and chances of another seizure. It has been quite a while since he did have a seizure and he is compliant with his medications and I believe ultimately should be allowed to drive.

I see a little bit of regression today and that he is a little agitated although not anywhere near like what he was but certainly not as good as when he first came home. I am wondering about the stressors of his new living situation although he and his mom both say that things are doing well and he is being followed by Dr. Fetter which is important and I think vigilance at this point is very important.

His lab work will be checked too to make sure his medications are not a problem and further recommendations will await the above.

Thank you for your kind referral.

R. JOSEPH HEALY, MD
RJH/lb

cc: Worker's Comp
Jane Stewart
Fax # 512-396-2024

Steve Wukela
Fax # 669-5150

SELTZER EYE ASSOCIATES, P.C.

511 SOUTH DARGAN STREET, SUITE 3200 • FLORENCE, SC 29506 • (803) 664-9393

Name Hoyd, Scottie No 11643

Age: 26 Sex: M Race: W Date: 3.12.02

Present Hx

Pt c/o Sx's similar to migraine headaches c subsequent HA

Soc Hx

FMD

K's OD / OS

SC VA	SC N CC	Present Rx CC CL	Add	Pinhole CC / SC
OD 20/40 ?	OD	VA OD =	N OD	OD
OS 20/20	OS	VA OS =	N OS	OS

☐ Manifest ☐ Cycloplegic ☐ Retinoscopy

M OD = Add OD

OS = Add OS

Trop. 1.0% ☐ OD ☐ TIME:

NEO 2.5% ☐ OS ☐

CYC 1.0% ☐ OU ☐ INITIAL:

Color Vision	Pupils 8/8 2+/2+ NEG RAPD	AT OD 12 Time 4:00 OS 11 KC	OTHER
EOM Full c/s/e/p/e/f/ parallel	Cover Test ø/ø	VF See interpretation report attached	

OD OS

EXTERNAL

SLE

quiet	Conj
clear	K
d+q	AC
normal	I
clear	L

FUNDUS

Sharp c thin inf. rim - OU	Vit
0.8 deep	C/D 0.75+
	AV
untort	Mac - OU

INDIRECT

P —

No amsocoria

IMPRESSION / PLAN (1) Headache — Normal ocular exam — VFs unreliable — although OD VF shows severe constriction. 2nd Healy Ltr sent to Dr Heath for continued eval & W-up — ☐ HA ☐

DIAGNOSTIC TEST INTERPRETATION REPORT

NAME: Scottie Floyd CHART #: 11643 D.O.B.: _____

- ☑ Visual Field
- ☐ Fundus/ Disc Photos
- ☐ A-Scan
- ☐ B-Scan
- ☐ Scanning Laser
- ☐ Fluorescein Angiogram
- ☐ ICG
- ☐ Corneal Topography
- ☐ OD
- ☐ OS
- ☐ OU

Technician Comments:

Date Performed: 3/12/02 Performed by: TC

Reliability: _____

Patient Understanding & Cooperation: _____

Physician Interpretation:

TEST RESULTS: (Tonopen if applicable) Tp 12 @ 11 1130 Ap

(OD) Severe Constriction of VF c 10° x 10° Inf. Temporal Island & 10° x 10° sup Nasal Island.

High # FN's OD

OS & B.S. Inf. Nasal constriction —

IMPRESION/ PLAN:

① Headache & Visual Phenomenon Yet Migraine HA

② Hx of Head injury c subsegment damage to brain — ill defined & currently being evaluated by Dr. Healy.

Doctor's Signature

3-12-02

PATIENT INFORMATION

Name Floyd, Scottie Date MAR 12 2002
Age 26 DOB _____ Race W Chart No. 1164
Occupation _____
Chief Complaint Pt sts 16 months ago the ast hit between eyes & has had no problems since then, pt sts right side of face is numb & vision is slightly blurry.
Eye Doctor Dr _____ Medical Doctor Dr. Healy

OCULAR SYMPTOMS/DISEASE

- ___ Red Eyes
- ___ Irritation Eyes
- ___ Dryness
- ___ Double Vision
- ___ Flashes of Light
- ___ Floaters
- ___ Halos
- ___ Lazy Eye
- ___ Decrease Vision
- ___ Loss of Vision
- ✓ Glasses
  Date other
- ✓ Eye Injury Hit between eyes 16 months ago
- ___ Eye Surgery
  Surgeon _____
- ___ Eye Disease _____
- ___ Glaucoma
- 1 Other

Brain injury here eval by Dr Healy.

MEDICAL HISTORY

- ___ Hypertension
- ___ Heart Disease
- ___ Cancer
- ___ Asthma/Emphysema
- ___ Diabetes
  Age Diagnosed _____
- ___ Kidney Disease
- ___ TB/HIV
- ___ Fever/Weight Loss
- ___ Arthritis
- ___ Stomach Problems
- ___ Bleeding Disorders
- ___ Stroke
- ___ Migraine Headaches

Have you ever smoked? yes How much? _____
Have you ever used illicit drugs? no yes ____ no

Have you had surgery? ____ yes ____ no If yes what type _____

General Medications Depacote - Butabatal - Zoloft - Remeron - atenolol

Ocular Medications none

Allergies NKDA

FAMILY HISTORY

- ___ Hypertension
- ___ Cataracts
- ___ Retinal Detachment
- ___ Glaucoma
- ___ Heart Disease
- ___ Other _____
- ___ Blindness
- 1 Crossed Eyes
- ___ Diabetes
- ___ Lazy Eye

Floyd, Scottie
11643

Date: pt. R/S appt'- SEP 23 2002 | C/C: Pt. Rescheduled appt / No Shup / Patient keep appt | Drops/Meds: — | Dilation: Neo 2.5% Myd 1% Cyc 2%

scV ccV ccN | MR | T | OS OD OU

EOM | CT | VF | PUPILS

SLE	OD	SLE	OS
CONJ	W + Q	CONJ	W + Q
K	Cl	K	Cl
A/C	D + Q	A/C	D + Q
IRIS		IRIS	
LENS	Cl / CAP / Cl Op	LENS	Cl / CAP / Cl Op
FUNDUS	OD	FUNDUS	OS
DISC	Shp Nml C	DISC	Shp Nml C
C/D		C/D	
MAC	Intact	MAC	Intact
VASC	Intact	VASC	Intact
PERIPH	Flat 360	PERIPH	Flat 360

OTHER

IMP/P

Date: | C/C: | Drops/Meds: | Dilation: Neo 2.5% Myd 1% Cyc 2%

V ccV ccN | MR | T | OS OD OU

OM | CT | VF | PUPILS

SLE	OD	SLE	OS
CONJ	W + Q	CONJ	W + Q
K	Cl	K	Cl
A/C	D + Q	A/C	D + Q
IRIS		IRIS	
LENS	Cl / CAP / Cl Op	LENS	Cl / CAP / Cl Op
NDUS	OD	FUNDUS	OS
DISC	Shp Nml C	DISC	Shp Nml C
C/D		C/D	
MAC	Intact	MAC	Intact
VASC	Intact	VASC	Intact
ERIPH	Flat 360	PERIPH	Flat 360

HER

IP/P

11443
Flood, Scottie

12-2-02 pt needs refill hydrocodone
CVS Marion -423-1021 /p

12-2-02
called pt back N/A.
RC
5:15pm

June 09, 2003
N/A/sent post card.
SES
KW

Floyd, Scottie
11643

Pt. did not keep appt —— No Rx since original visit & c/o Headache

June 16, 2003.

+1.25 sph —— 20/60-2
+1.50 sph —— 20/20

20/60-2
20/20-1

Pt in today —
pt wants to have a CL for OD — to cover pupil. to decrease the amount of light in OD — & smaller implants often times light sensitivity.

Dr Hall

Discussed @ length the need to help c the light sensitivity.

Explore options c Cosmetic CL's OD — to ↓ light OD

or

Very dark shades.

Informed pt that we will do some research. I will discuss c Dr Hall

Very dark shades were given to the pt. to try. If sufficient, pt may not need CLs.

PATIENT INFORMATION

Name Floyd, Scottie Date June 09, 03
Age 27 DOB _____ Chart No: 11643
Occupation _____ Race (w)
Chief Complaint _____

Eye Doctor _____ Medical Doctor _____

OCULAR SYMPTOMS/DISEASE

_____Red Eyes
_____Irritation Eyes
_____Dryness
_____Double Vision
_____Flashes of Light
_____Floaters
_____Halos
_____Lazy Eye

_____Decrease Vision
_____Loss of Vision
_____Glasses
Date _____
_____Eye Injury _____
_____Eye Surgery
Surgeon _____
_____Eye Disease _____

_____Glaucoma
_____Other

MEDICAL HISTORY

_____Hypertension
_____Heart Disease
_____Cancer
_____Asthma/Emphysema
_____Diabetes
Age Diagnosed _____
_____Kidney Disease
_____TB/HIV

_____Fever/Weight Loss
_____Arthritis
_____Stomach Problems
_____Bleeding Disorders
_____Stroke
_____Migraine Headaches

Have you ever smoked? _____ How much? _____
Have you ever used illicit drugs? _____yes _____no

Have you had surgery? _____yes _____no If yes what type _____

General Medications _____ _____ _____
_____ _____ _____ _____

Ocular Medications _____ _____ _____

Allergies _____

FAMILY HISTORY

____Hypertension ____Glaucoma ____Blindness ____Diabetes
____Cataracts ____Heart Disease ____Crossed Eyes ____Lazy E
____Retinal Detachment ____Other _____

Clinical Care Flow Sheet

Problem:

Scott Lloyd

Ht. 5ft 8in (69) CALLED RX'S AC 34884

DATE / TIME	WT	T	B/P	P
3/20/02	171	97.2	100/70	84
4/25/02	177	96.2	110/70	70

MAR 20 2002

PATIENT Scottie Floyd AC34854 Date:

WT: 171 HT: TEMP: 97.2 BP: 100/70 RESP: PULSE: 84

APPEARANCE:

EYES	N	A
Conjunctiva/Lids		
Pupils/Irises		
Opthalmoscopic		
EARS, NOSE		
External Ears/Nose		
Otoscopic Exam		
Hearing Assmt.		
Nasal Mucosa		
Septum/Turbinates		
Oropharynx		
Lips/Gums		
Teeth/Dentures/Caries		
NECK		
Neck Exam		
Thyroid Exam		
RESPITORY		
Respitory Effort		
Percussion/Chest		
Palpation/Chest		
Asculation/Lungs		
CARDIOVASCULAR		
Palpation/Heart		
Ausculation/Heart		
Carotids		
Abdominal Aorta		
Femoral Arteries		
Pedal Pulses		
Edema/Varicosities		

CHEST	N	A
Breasts		
Breasts/Axillae		
GASTROINTESTAL		
Masses/Tenderness		
Liver/Spleen		
Hernia		
Anus/Perineum/Rectum		
Rectal Tone		
Hemorrhoids		
Occult Sample ____		
LYMPHATIC		
Neck		
Axillae		
Groin		
Other ____		
GENITOURINARY		
MALE		
Scrotal Contents		
Penis		
Digital Prostate Exam		
FEMALE		
External Genitalia		
Vagina		
Urethra		
Bladder		
Cervix		
Uterus		
Adnexa/Parametria		

MUSCULOSKELETAL	N	A
Gait/Station		
Nail/Digits		
Joints		
Bones		
Muscles		
ROM/Notation Pain		
Crepitation/Contracture		
Stability/Laxity		
Muscle Strength/Tone		
SKIN		
Tone		
Rash		
Lesion		
Abrasion		
Palpation Skin/Subq		
NEUROLOGIC		
Cranial Nerves II-XII		
DTR's		
Sensation: Arms		
Legs		
PSYCHIATRIC		
Judgement		
Insight		
Orientation		
Recent/Remote		
Memory		
Mood		
Affect		

IMPRESSION/PLAN:

CAD NKDA

Mod

REFERRAL:

HOSPITAL RECORDS REVIEWED:

PRE-OP DR:

RETURN TO WORK:

RETURN TO OFFICE:

PATIENT EDUCATION GIVEN:

Diet

Pathophysiology

Medication Counseling

Morbidity

Prognostication

Smoking/ETOH

PLANNED DIAGNOSTIC PROCEDURES:

lab

X-Ray

CT MRI

Treadmill: Reg Nuclear

Echo PFT Mammogram

1200

April 26, 2002

Scottie Floyd

This is a 26-year-old male, who comes in today with a complaint of rectal bleeding, mainly blood mixed with stool, no blood on the toilet paper.

He is still taking his same medications, Zoloft 200 mgs. daily, Fioricet 1 p.o. q. 4 hrs. p.r.n. for headache, Atenolol 25 mgs. daily, Phenergan 25 mgs. 1 q. 8 hrs. p.r.n. for nausea, vomiting. Depakote 500 mgs. 1 q. 8 hrs., Ativan 2 mgs. p.o. q. 8 hrs., Colace 100 mgs. b.i.d., Carafate 1 gr. q. a.c., Chloral Hydrate 500 mgs./5 ml, 3 teaspoons q.h.s. in a 400 cc. bottle.

PHYSICAL EXAM: Temp. 96.7, BP/110/70, P. 70, Wt. 177. Generally, no acute distress. HEENT: within normal limits. Lungs clear, heart regular. Abd. benign, good bowel sounds. Rectal exam, digitally has a resolving hemorrhoid, most likely the cause of his blood. Refer to Pee Dee G. I. for further evaluation. See him back in 3 months or p.r.n.

Grant Breazeale, M. D.
GB/md

CAROLINAS HOSPITAL SYSTEM — Registration Form

121 E. Cedar St.
P.O. Box 100550
Florence, S.C. 29501-0550

PATIENT NAME/ADDRESS	ACCOUNT NO.	TYPE	ROOM	UNIT NO./MED. REC. NO.
FLOYD, SCOTTIE W	H11280492	ER		H337978

BIRTHDATE	RELIGION	LOCATION/SERVICE
08/04/75	OTHER	ER

PHONE
SOC. SEC. NUM.
PATIENT EMPLOYER: KEN BAKER'S ORIGINALS

AGE	PERSON TO NOTIFY/ADDRESS	RELATIONSHIP
26	FLOYD, BETTY JO	M

PT. SEX	HOME PHONE	OTHER PHONE
M		

GUARANTOR/ADDRESS: FLOYD, SCOTTIE W

PT. RACE	NEXT OF KIN/ADDRESS	RELATIONSHIP
W	FLOYD, BETTY JO	M

PT. MAR. STAT.
S

PHONE 8 GUAR. REL. S

PT. FIN. CLASS	HOME PHONE	OTHER PHONE
A-NEIC	MRSA? NO *** VRE? NO *** PPD?	

GUARANTOR EMPLOYER: KEN BAKER'S ORIGINALS

INSURANCE CO. NAME	POLICY NO.	GROUP NO.	INSURED/SUBSCRIBER NAME

OCCURRENCE INFORMATION	REASON FOR VISIT
*ONSET OF SYMPTOMS/ILLNESS	HA*7 MO

OCCUR DATE/TIME	COMMENT	ARRIVAL MODE
04/05/02 20:07	CC/SO	CAR

ADMIT DATE/TIME	ADMITTING PHYSICIAN	ATTENDING PHYSICIAN	USER
04/05/02 :			ADMBCM

OTHER DOES PT HAVE ADVANCE DIRECTIVE? N
COPY W/CHART? N COPY REQUESTED? N
IS PT AN ORGAN DONOR? N

PATIENT DISPOSITION: HOME ☐ OMI ☐ SNF ☐ ICF ☐ H ☐ DIED ☐ AUTOPSY ☐ AMA ☐ OTHER ☐

DISCHARGE DATE/TIME

PRINCIPAL DIAGNOSIS (THE CONDITION ESTABLISHED AFTER STUDY TO BE CHIEFLY RESPONSIBLE FOR OCCASIONING THE PATIENTS ADMISSION)

SECONDARY DIAGNOSIS (COMPLICATIONS AND COMORBIDITIES: CONDITIONS WHICH DEVELOP AFTER ADMISSIONS OR EXISTS AT THE TIME OF ADMISSION AND EFFECT TREATMENT RECEIVED OR LOS.)

PRINCIPAL PROCEDURE/OPERATION (THE PROCEDURE MOST CLOSELY RELATED TO PRINCIPAL DIAGNOSIS)

SECONDARY PROCEDURES

DATE _____ ATTENDING PHYSICIAN SIGNATURE _____

CONSULTATIONS:	

1202

CAROLINAS HOSPITAL SYSTEM
FLORENCE, SOUTH CAROLINA

ADMISSION DATA & ASSESSMENT

FLORENCE H3372978
[illegible] 04/05/02
FLOYD, SCOTTIE W REG ER
CHANDLER, MICHAEL

Name: Healy M S A Floyd

ADMISSION HISTORY

Date	Time		Age	Sex	Last Tetanus	Triage Class	Acuity Class Change: Time:
4/5/02	1956	☐ Amb ☐ Stretcher ☐ Arms ☐ W/C ☐ EMS ☑ POV	26	M		☐ 1 ☐ 2 ☑ 3	☐ 1 ☐ 2 ☐ 3

Time	Temp	Pulse	Resp	B/P	Ht	Wt Stated / Actual
1954	98.3	79	20	129/57		

Immunizations ☐ Up to Date in accordance with State Law
☐ Flu Vaccine ☐ Pneumovax ☐ Hepatitis ☐ None
☐ Other

Source of Information: ☐ Other
☐ Patient ☐ Family ☐ Unable to Obtain

ALLERGIES: Food / Medications

☑ NKA ☐ Yes - below:

	Type Reaction

Are you allergic to any of the following?	Yes	No
Latex		✓
Bananas		✓
Avocados		✓
Kiwi		✓

Previous Blood Transfusion ☐ No ☐ Yes
Reaction ☐ No ☐ Yes Describe:

Chief Complaint / In Patient's Words
HA x 7 months

Developmental Status
☑ Appropriate for Age
☐

LMP	G	P	A

Head Circum: cm | Visual Acuity: od os ou

Tx PTA: ☐ EMS ☑ None ☐ Home
☐ IV ☐ O_2 ☐ Wound Care ☐ Monitor
Meds:

MEDICAL HISTORY ☐ None

DISEASE	PT	FAMILY	DISEASE	PT	FAMILY	DISEASE	PT	FAMILY
Anemia	☐		Hepatitis	☐		Stomach Disorders	☐	
Arthritis	☐	☐	Hypertension	☐	☐	Anesthesia Reactions	☐	
Asthma	☐	☐	Infectious Diseases	☐		Tobacco Use	☐	
Bronchitis	☐		Sensory Impairment	☐		Alcohol/Drug Use	☐	
Cancer	☐	☐	Kidney Disease	☐		Other	☐	
CVA	☐		Mental Illness	☐	☐	Other	☐	
Diabetes	☐	☐	Muscle/Bone Disorders	☐		Other	☐	
Emphysema	☐		Reproductive Disorders	☐		Other	☐	
Glaucoma	☐		Seizures/Epilepsy	☐		Other	☐	
Heart Disease	☐	☐	Skin Disorders	☐		Other	☐	

HOSPITALIZATIONS (medical & surgical): ☐ NO PREVIOUS HISTORY

Date	Reason	Date	Reason
	Head injury 7 months		

MEDICATION HISTORY (Include Vitamins, Herbs & Over the Counter) ☐ Unknown ☐ None

Medication (☐ With Patient ☐ Not Brought In ☐ Sent Home ☐ Sent to Pharmacy ☐ Instructed Not to Bring In)	Dose	Frequency	Last Dose	Medication (☐ With Patient ☐ Not Brought In ☐ Sent Home ☐ Sent to Pharmacy ☐ Instructed Not to Bring In)	Dose	Frequency	Last Dose
See	Chart						

Initials	Signature/Title	Initials	Signature
GM	Gene M Zamora		

1203

White - HIM Canary - Pharmacy Pink - ED

CAROLINAS HOSPITAL SYSTEM
FLORENCE, SOUTH CAROLINA

Page 2
EMERGENCY DEPARTMENT
DATA / ASSESSMENT TOOL

FLORENCE H337978
M1128604R2 04/05/02
FLOYD, SCOTTIE W REC ER
CHANDLER, MICHAEL
26 M S A-NEIC

ASSESSMENT: TIME TO RM: 2150 ROOM #: F1

		TIMES
AIRWAY	SELF MAINTAINED	
	ORAL/NASAL AIRWAY	
	INTUBATED	
BREATHING	NORMAL	
	IRREGULAR	
	LABORED	
	ABSENT/APNEIC	
	ASSISTED/BAGGED	
CIRCULATION	PULSE PRESENT	
	ABSENT	
	CPR	
SKIN	WARM	
	HOT	
	COOL	
	DRY	
	DIAPHORETIC	
	NML/PINK	
	CYANOTIC	
	PALE	
	ASHEN	
DISABILITY	ALERT/ORIENTED X	
	RESPONDS VERBAL	
	RESPONDS PAIN	
	UNRESPONSIVE	
	CONFUSED	
	LETHARGIC	
	COMBATIVE	
2° HEAD (BRISK / SLUGGISH / NONREACTIVE / CLEAR, SLURRED)	R PUPIL REACTIVE	
	L PUPIL REACTIVE	
	SPEECH	
CHEST	ASYMMETRICAL	
	SYMMETRICAL	
	CLEAR	
	CONGESTED	
	WHEEZES	
	DECREASED	
PULSE	STRONG	
	WEAK/THREADY	
	REGULAR	
	IRREGULAR	
ABDOMEN	SOFT	
	FIRM/HARD	
	DISTENDED	
	TENDER	
	NONTENDER	
	BOWEL SOUNDS PRESENT	
EXTREMITIES	NML CAP REFILL X	
	NML MOVEMENT X	
	NML SENSATION	
	STRONG RADIALS	
OTHER		

PAIN ASSESSMENT:
☐ NONE INITIALLY ☒ YES TIME:
LOCATION: headache
INTENSITY (0-10): 6
CAUSED BY: ? hit head in wreck
DURATION: 4 days - (2 mos)
RELIEVED BY: Ø
TYPE: ☐ DULL ☐ SHARP ☐ PRESSURE
☐ RADIATING ☐ THROBBING

FAMILY NOTIFIED: ☐ Patient Declines ☐ N/A
TIME: @ P— WHO: Fm

PSYCHOSOCIAL ASSESSMENT:
☒ N/A * ANY "YES" CONTACT CASE MANAGEMENT
☐ TRANSLATOR NEEDED
☐ SUSPECTED ABUSE/NEGLECT*
☐ NO SUPPORT SYSTEM*
☐ REQUESTS BLOODLESS SURGERY/MEDICINE
☐ OTHER CULTURAL PRACTICES
☐ FAMILY/PATIENT REQUESTS CHAPLAIN
☐ SPIRITUAL/CULTURAL DECLINED

PRIMARY CONSULTING PHYSICIANS

NAME	PAGED	ANSWERED	ARRIVED
Chandler			2156

VITAL SIGNS

TIME	B/P	PULSE	RESP	PRE PF	POST PF	O_2 SAT	TEMP
2200	112/60	76	18				
							☐ SEE TREND SHEET

TREATMENT/PROCEDURES

TIME/INITIALS	
2200	☒ ID BAND ☒ CALL LIGHT ☒ SIDE RAILS ↑ X2 ☐ N/A
	O_2 L ______ VIA ______
	EKG
	MONITOR/RHYTHM ______
	☐ NG ☐ OG TUBE Fr ______ ☐ PLACEMENT CHECKED
	FOLEY Fr ______ IN & OUT CATH Fr ______
	ETT ☐ NASAL ☐ ORAL Fr ______ ☐ END TIDAL CO_2
TO / Portable	X-RAYS — FROM — VIA: ☐ AMB ☐ W/C ☐ STRETCHER
TO	CT SCAN — FROM — VIA: ☐ AMB ☐ W/C ☐ STRETCHER
	SPLINT/LOCATION: ☐ POST APPLICATION - NEUROMUSCULAR INTACT ☐ OTHER-SEE NURSES NOTE

LABS

TIME/INITIALS		TIME/INITIALS		TIME/INITIALS	
	CBC		ABG		U/A
	BMP		Amy/Lipase		UCG
	PT/PTT		CP Protocol		T Screen
	Other:		Troponin		TXM
			Cultures		FSBS
					GYN Profile

9 8 7 6 5 4 3 2

1204

037390 Page 2 (8/01)

White - Original Yellow - Pharmacy Pink - E.D.

CAROLINAS HOSPITAL SYSTEM

FLORENCE, SOUTH CAROLINA

Page 3

EMERGENCY DEPARTMENT

DATA / ASSESSMENT TOOL

FLORENCE H337978
H1128C492 04/05/52
FLOYD, SCOTTIE W REG ER
CHANDLER, MICHAEL
26 S M S A-NSIC

NARRATIVE NOTES

2200 Pt. had head injury 3 months ago. H/A daily since - this one for past 4 days. Pt denies N/V or photophobia. 2220 Pt. relief of pain - no increased pain. Pt. pain remains very drowsy. Pain decrease 4/10 upon DC, with return of pain will be directed to ED. Pt. verbalizes understanding of home instructions for DC - Pt. ambulated to front desk with steady gait. ☐ See Additional Notes

IV SOLUTION & AMOUNT	PUMP	MEDICATION ADDED	SIZE	SITE	ML/HR	TIME START/INITIALS	TIME D/C/INITIALS	SITE AT DISCHARGE
	Yes No							☐ No Redness, Pain, Swelling ☐ Other - See Nurses Notes
	Yes No							☐ No Redness, Pain, Swelling ☐ Other - See Nurses Notes
	Yes No							☐ No Redness, Pain, Swelling ☐ Other - See Nurses Notes

TIME	MEDICATION	DOSE	ROUTE	SITE	INITIALS	RESPONSE/PAIN 0-10	INTAKE	OUTPUT
2200	Demerol	75mg	IM	(R)		No Adv 6/10	120	0
2200	Phenergan	25mg	IM	(R)		No Adv 6/10		
2330	Demerol	25mg	IM	Rt		4/10 No Adv Rxn		
							TOTAL 120	TOTAL 0

VALUABLES

☐ Not Inventoried ☐ Money Amt. _____
☐ Bracelet ☐ Earrings ☐ Clothes
☐ Necklace ☐ Rings ☐ Dentures
☐ Watch ☐ Purse ☐ Glasses
☐ Wallet ☐ Keys ☐ ID

With Whom/Where _____

Initials	Signature	Title
	[signature]	RN
	[signature]	

DISPOSITION

Time 2330 Via: ☐ W/C ☐ Amb ☐ Stretcher ☐ Carried

☐ D/C Home ☐ LWT ☒ POV ☐ EMS/Ambulance
☒ Aftercare Instructions Given
☐ D/C _____
☐ AMA To [illegible]

☐ Transfer to: ☐ Transfer Form Completed
☐ POV ☐ EMS/Ambulance

☐ Admitted to: Report to:
Room # _____ Time _____
☐ Expired/Body to: Admitting M.D.
Monitor ☐ Yes ☐ No ☐ N/A
IV ☐ Yes ☐ N/A
☐ SCOPA Notified O_2 ☐ Yes ☐ No ☐ N/A

☐ Nursing Assessment Reviewed ☐ BP, HR, RR, Temp reviewed

PHYSICAL EXAM Alert __Anxious
Distress __NAD __mild __moderate __severe

FLORENCE H3D797

HEENT
__nml ENT inspection
__pharynx nml

__purulent nasal discharge
__tender temporal artery
__pharyngeal erythema
__tonsillar exudate
__pain on percussion over sinuses
__abnormal TM
__pale conjunctivae
__narrow angle (ant. chambers)

NECK
__nml inspection
__supple

__thyromegaly
__lymphadenopathy (R / L)
__stiff neck / meningismus

RESPIRATORY
__no resp. distress
__breath sounds nml

__wheezing
__rales

CVS
__reg. rate & rhythm
__heart sounds nml

__heart murmur
__tachycardia / bradycardia
__decreased pulse(s)

ABDOMEN
__non-tender
__no organomegaly

__tenderness
__hepatomegaly / splenomegaly / mass

SKIN
__color nml, no rash
__warm, dry, nml palp.

__cyanosis / diaphoresis / pallor
__skin rash

EXTREMITIES
__non-tender
__normal ROM
__no pedal edema

__pedal edema
__calf tenderness

NEURO / PSYCH
higher functions
__alert
__oriented x3
__mood / affect nml

__slow / confused / no response to commands
__disoriented
to: *time / place / person*

cranial nerves-
__normal as tested
__pupils equal, round, and reactive

__EOM palsy
__unequal pupils
R pupil ____mm L pupil ____mm
__facial palsy
__tongue deviation (to R / L)
__facial numbness
__abnormal fundi / papilledema / wide cups

cerebellar-
__normal as tested

__abnormal Romberg test
__abnormal finger-nose-finger
__abnormal gait

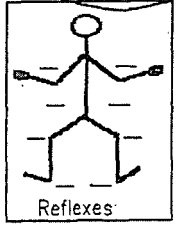
sensorimotor-
__no motor deficit
__no sensory deficit

__weakness

__pronator drift (RUE / LUE)

__sensory loss

__abnormal reflexes


Reflexes

LABS, XRAYS, and PROGRESS

CBC		Chemistries	UA
normal except		*normal except*	*normal except*
WBC	segs	Na	WBC
Hgb	bands	K	RBC's
Hct	lymphs	Cl	bacteria
Platelets	monos	CO2	dip:
	eos	Gluc	
		BUN	
		Creat	

LP __discussed risks, benefits, alternatives; patient consents
(R / L) sitting open press.=
betadine prep fluid color RBC WBC
sterile technique glucose polys lymph
L3-4 protein monos gm stn
L4-5

Head CT __*nml*

CXR ☐ Interp. by me ☐ Reviewed by me ☐ Discd w/radiologist
nml/NAD no infiltrates nml heart size nml mediastinum

not / changed from:

Time ____ __unchanged __improved __re-examined
__pain relieved __pain almost fully relieved

__Discussed with Dr. ____ CRIT CARE- *30-74 min*
will see patient in office / ED / hospital *75-104 min* *min*
Counseled patient / family regarding: Prior records ordered
lab results diagnosis need for follow-up Additional history from:
Rx given __Admit orders written *family caretaker paramedics*

CLINICAL IMPRESSION:

Headache
acute severe hemiplegic
vascular migraine cluster
Vomiting / Dehydration
Meningitis
Intracranial Hemorrhage
Subarachnoid Hemorrhage
Sinusitis
Viral Cephalgia

DISPOSITION- ☐ home ☐ admitted ☐ transferred
CONDITION- ☐ improved ☐ good ☐ fair ☐ poor ☐ expired
☐ stable ☐ unstable

☐ Emergency condition at discharge ☐ No emergency condition at discharge

PHYSICIAN SIGNATURE-

☐ Chart Completed ☐ Dictated Addendum

26 pg2

1206

☐ White - chart ☐ Canary - private MD ☐ Pink - ED copy

© 2000 T-System, Inc. Circle or check affirmatives, backslash (\) negatives.

26 Carolinas Hospital System
Florence, South Carolina

EMERGENCY PHYSICIAN RECORD
Headache (5)

FLORENCE H3377?9
H1128049? 02/03/12
FLOYD, SCOTTIE W REG ER
CHARLES MICHAEL 20 12/29/57
M S A M E I C

TIME SEEN: 9:55 __EMS Arrival

HISTORIAN: patient spouse paramedics
PRIVATE MD Healey

__HX / __EXAM LIMITED BY:

HPI

chief complaint: headache facial pain fever *migraine hx*

started: x4 days

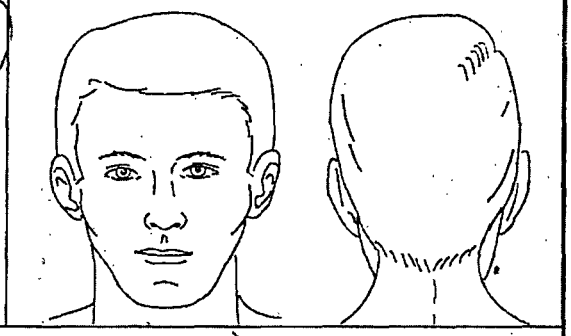
time course:
__abrupt / gradual onset
still present __better
__gone now
lasted

intermittent episodes lasting

worse/persistent since

quality:
similar to previous headaches
"pain"
tightness
throbbing
sharp

location:



associated symptoms:
__preceding symptoms
visual disturbance scotoma
typical of prior aura(s)

__light bothers eyes
__blurred vision

__nausea
__vomiting
__power loss R/L arm/leg
__tingling/numb sensation

severity:
maximum
mild moderate severe relieved by OTC meds

when seen in ED
gone mild moderate severe

Similar symptoms previously

Recently seen/treated by doctor

ROS

CONST
__fever
subjective / to ____ °F
__muscle aches

ENT
__sore throat
__sinus pressure/drainage

For new, gradual-onset HA
__CO exposure
__tick bite(s)
__head injury

PULMONARY & CVS
__chest pain
__cough
__sputum
__trouble breathing

GI and GU
__abdominal pain
__diarrhea
__pain on urination

Skin & Lymphatic & MS
__skin rash / swelling
__back pain

☐all systems neg except as marked

PAST HISTORY __negative

__chronic headaches
occasional frequent "migraine"
mild moderate severe
__high blood pressure
__sinus problems

__cancer history
__immunosuppressed
__glaucoma
__diabetes *insulin / oral / diet*
__asthma
__+HIV / AIDS

__other problems
Head Trauma

Medications __none __see nurses note
__ASA __NSAID __acetaminophen
See list

Allergies __NKDA
__see nurses note

SOCIAL HX smoker drugs
alcohol (recent: heavy / occasional)

FAMILY HX __cerebral aneurysm __migraine headaches
__stroke __HTN

☐White - chart ☐Canary - private MD ☐Pink - ED copy

CAROLINAS HOSPITAL SYSTEM

South Carolina

EMERGENCY DEPARTMENT PHYSICIAN'S ORDERS

Write or Imprint Patient Information Below

FLORENCE H3379782 04/05/02 REG ER
H1128C492 FLOYD, SCOTTIE W 26 CHANDLER, MICHAEL M S A-NEIC

DATE/TIME	ORDERS	ORDERS	ORDERS
	☐ CBC	☐ Spinal Fld Lab Protocol	☐ CT Scan
	☐ BMP	☐ ASA Lab Protocol	☐ Contrast ☐ IV Oral ☐ Trauma
	☐ U/A ☐ Cath ☐ Midstream ☐ C & S	☐ DPL Lab Protocol	☐ TD per Protocol
	☐ UCG	☑ Foley	☐ Solumedrol per Spinal Protocol
	☐ UDS	☐ EKG ☐ OLD EKG	☐ Tylenol 15 mg/kg po
	☐ Amylase/Lipase	☐ Monitor	☐ Ibuprofen 10 mg/kg po
	☐ Troponin	☐ O2 Via 2 L	☑ D/C Home
	☐ PT/PTT	☐ Pulse Ox	☐ Admit
	☐ CP Protocol	☐ IV	☑ Demerol 25 mg IM
	☐ Bld CX x 2, ☐ Sametime ☐ Diff. sites	☐ INT	☑ Phenergan 25 mg IM
	☐ Post Exposure Labs	☐ Eye Irrigation 9NS	☐
	☑ Trauma A Labs	☐ CXR ☐ Port ☐ PA/Lat	☐
	☐ Trauma B Labs	☐ AAS	☐
	☐ Gyn Lab Protocol	☐ Xray Other	MD Signature:

EMERGENCY DEPARTMENT PHYSICIAN'S ORDERS

FLORENCE H3379782 04/05/02 REG ER
H1128C492 FLOYD, SCOTTIE W 26 CHANDLER, MICHAEL M S A-NEIC

DATE/TIME	ORDERS	ORDERS	ORDERS
	☐ CBC	☐ Spinal Fld Lab Protocol	☐ CT Scan
	☐ BMP	☐ ASA Lab Protocol	☐ Contrast ☐ IV Oral ☐ Trauma
	☐ U/A ☐ Cath ☐ Midstream ☐ C & S	☐ DPL Lab Protocol	☐ TD per Protocol
	☐ UCG	☐ Foley	☐ Solumedrol per Spinal Protocol
	☐ UDS	☐ EKG ☐ OLD EKG	☐ Tylenol 15 mg/kg po
	☐ Amylase/Lipase	☐ Monitor	☐ Ibuprofen 10 mg/kg po
	☐ Troponin	☐ O2 Via 2 L	☐ D/C Home
	☐ PT/PTT	☐ Pulse Ox	☐ Admit
	☐ CP Protocol	☐ IV	☐ Demerol 25 mg IM
	☐ Bld CX x 2, ☐ Sametime ☐ Diff. sites	☐ INT	☐
	☐ Post Exposure Labs	☐ Eye Irrigation 9NS	☐
	☐ Trauma A Labs	☐ CXR ☐ Port ☐ PA/Lat	☐
	☐ Trauma B Labs	☐ AAS	☐
	☐ Gyn Lab Protocol	☐ Xray Other	MD Signature:

EMERGENCY DEPARTMENT PHYSICIAN'S ORDERS

FLORENCE H3379782 04/05/02 REG ER
H1128C492 FLOYD, SCOTTIE W 26 CHANDLER, MICHAEL M S A-NEIC

DATE/TIME	ORDERS	ORDERS	ORDERS
	☐ CBC	☐ Spinal Fld Lab Protocol	☐ CT Scan
	☐ BMP	☐ ASA Lab Protocol	☐ Contrast ☐ IV Oral ☐ Trauma
	☐ U/A ☐ Cath ☐ Midstream ☐ C & S	☐ DPL Lab Protocol	☐ TD per Protocol
	☐ UCG	☐ Foley	☐ Solumedrol per Spinal Protocol
	☐ UDS	☐ EKG ☐ OLD EKG	☐ Tylenol 15 mg/kg po
	☐ Amylase/Lipase	☐ Monitor	☐ Ibuprofen 10 mg/kg po
	☐ Troponin	☐ O2 Via	☐ D/C Home
	☐ PT/PTT	☐ Pulse Ox	☐ Admit
	☐ CP Protocol	☐ IV	☐
	☐ Bld CX x 2, ☐ Sametime ☐ Diff. sites	☐ INT	☐
	☐ Post Exposure Labs	☐ Eye Irrigation 9NS	☐
	☐ Trauma A Labs	☐ CXR ☐ Port ☐ PA/Lat	☐
	☐ Trauma B Labs	☐ AAS	☐
	☐ Gyn Lab Protocol	☐ Xray Other	MD Signature:

032503
REV. 2003
FN4

1208

CAROLINAS HOSPITAL SYSTEM
FLORENCE, SOUTH CAROLINA

FLORENCE H3379?8
0442 04/05/52
FLOYD, SCOTTIE W REG ER
CHANDLER MICHAEL
26 M S A-NEIC

Emergency Department
Medication Addendum

Medication	Dosage	Frequency
Neurontin	300mg	Q 8°
Depakote ER	500mg	Q 8°
Fioricet		Q 4° pm
Imitrex	25mg	QD
Phenergan	25mg	Q 8° prn
Zolpidem	100mg	2 tab QHS

CAROLINAS HOSPITAL SYSTEM

South

EMERGEN CARE

PLEASE CALL EXT. 2020 PRIOR TO PATIENT BEING DISCHARGED.

CLERENCE H337976
H1128042 04/05/02
FLOYD, SCOTTIE W REG ER
CHANDLER, MICHAEL
24 E M S A E I C

Emotional barriers: ☐ extr ☐ none identified
Level of knowledge about health ☐ high ☐ medium ☐ low ☐ other
Physical/cognitive/language limita ☐ visual ☐ physically impaired ☐ developmentally disabled
☐ aphasia ☐ language othe ☐ memory loss ☐ illiterate ☐ other ☐ none identified
Education Level:
Culture/language/religious/financial barriers affecting patient teaching/outcome:
☐ none identified

SPRAIN AND FRACTURE, SEVERE BRUISES

1. Elevate the injured part to lessen swelling. If pillows fasten, use chair cushions with pillows or blankets for comfort.
2. Ice packs also help prevent swelling, especially during the first 24-48 hours, then use heat. Please ice in plastic or rubber bag cloth cover.
3. If you have an elastic bandage, rewrap it if too tight or loose. Take off ace wrap for at least ½ hour every 24 hours.
4. If you have a splint keep it perfectly dry at all times.
5. If you have a splint wait 48 hours for the splint to become strong before you allow pressure or weight on any part of the splint.
6. Elevate splint at night and as often as possible in the day.
7. If the splinted or wrapped part swells in any way or gets cold, blue or numb, or if pain increases markedly, return to the clinic promptly.

BACK AND NECK INJURY INSTRUCTIONS

1. Use heat or cold on the injured area-whichever seems to help the most. Be careful not to burn yourself.
2. Rest as much as possible until you are improved. Used firm mattress.
3. Avoid positions and movements that make the pain worse.
4. If a cervical collar has been prescribed, it is not necessary to wear it continually-use it only as needed for comfort and support when upright.
5. No lifting or pushing.

URINARY TRACT INFECTION

1. Take the medicine regularly as directed. If the symptoms go away in a few days, DO NOT STOP TAKING YOUR MEDICINE. Continue to take the medicine until it is gone. If you develop a reaction to the medicine, call your doctor or the clinic.
2. DRINK LOTS OF FLUIDS. This is very important as it helps get the medication into your urinary system where it can work. It also helps flush out the urinary system. Lots of fluids means 1-2 quarts of water each 24 hours plus what you normally drink. It is best to avoid alcohol during your course of treatment.
3. Medication may change color of urine.

CARE OF HEAD INJURY

1. Avoid strenuous physical activities for at least 24 hours after injury.
2. Apply icebag to areas of swelling-continue for at least 24 hours after injury.
3. Tylenol for headache every four hours as needed (child's or adult as indicated).
4. Light diet for 24 hours after injury.
5. Arouse patient every 2 hours, day and night for at least 24 hours.

CALL CLINIC OR RETURN IMMEDIATELY IF:

1. Patient becomes confused, irrational, disoriented, talks out of head, doesn't know where he is.
2. Unable to arouse patient.
3. Patient continues to be nauseated and/or vomits more than once.
4. Patient has trouble with his balance.
5. Patient complains of double or blurred vision.
6. Headache persists, or if it becomes more intense 12 hours after the injury.

GENERAL INSTRUCTIONS

1. Follow up as needed with private physician.
2. Return to E.D. if condition worsens or fails to improve.
3. Take medications as directed.
4. Return if fever, nausea, vomiting, increased pain.
5. Return wound check in 2 days, suture removal _____ days

ABDOMINAL PAIN

1. Stay on a clear liquid diet for the next 24 hours. Gatorade is the best drink.
2. If vomiting, pain or fever becomes worse, check with the physician of your choice immediately.
3. Rest in bed with an ice bag placed over the spot that hurts the worst.
4. If you are better after 24 hours, you may stay on a light solid diet.
5. If you vomit blood, stool becomes black, pain or fever becomes worse, notify your physician or return to the E.D.

FEVER CONTROL

A fever does not necessarily indicate a dangerous infection. A child's temperature regulating mechanism is not well developed and thus, the fever is often higher than one would expect with relatively minor infection. The following instructions will help lower the temperature and avoid complications.

1. If feverish, take the temperature. (Normal temperature: Oral-98.6 degrees F. Rectal 99.8 degrees F.)
2. Only if the temperature is 101 degrees F. or above rectally, give Tylenol preparation every 4 hours as below:

1-6 months	0.4 cc. Tylenol drop
6 months-1 year	0.8 cc. Tylenol drops or ½ Tsp. Tylenol liquid
2 years	1 Tsp. Tylenol liquid
3-4 years	2 Tsp. Tylenol liquid
5 years	3 Tsp. Tylenol liquid

Note:
If temperature won't come down, you can alternate Ibuprofen and Tylenol every 2 hours.

3. If temperature is 104 degrees F. or more, do the following: Bathe the child for 15 minutes in lukewarm water in bathtub. DO NOT BATHE WITH ALCOHOL.
4. Follow the doctor's orders with regard to antibiotics and other medications.
5. Give plenty of fluids (Coke, 7-up, Sprite, Popsicles, Jello, iced tea, ice chips, etc.)
6. Return to the E.D. if: The child convulses or jerks.
   Spots or rash appear.

WOUND CARE (Cuts, Scrapes, Burns, etc.)

1. Keep dressing clean and dry.
2. Change dressing daily.
3. In the event that the dressing becomes wet, simply remove it, blot wound dry with a clean gauze and reapply a clean dressing.
4. Using Q-Tip and hydrogen peroxide, clean the suture line, then apply Neosporin Ointment sparingly.
5. Elevate the wound to help relieve soreness and speed healing.
6. If the wound becomes reddened, swollen, and has red streaks or pus, contact your doctor or return to the clinic.
7. It is important to have wounds checked and sutures removed on the date indicated. Wound checks and suture removals are done in the morning.
8. Return to the clinic for wound check _____
   suture removal _____
9. A booster injection of tetanus toxoid was given. Possible reactions:
   a. May be mild to moderate local inflammation or tenderness for a day.
   b. Rare occasions, fever and general discomfort occurs. Aspirin or Tylenol may be taken for this (if no allergies).
   c. If small bump forms at the site of the injection, it should disappear in a few days.
10. Tetanus immune globulin (human) was given and tetanus toxoid was given to begin active immunization. You should receive a second injection of tetanus toxoid in six weeks from your doctor.
11. Avoid direct sunlight to especially facial lacerations or abrasions for a minimum of 6 weeks. Protect area with either sun screen ointment or bandaid.
12. Other:

DIET FOR NAUSEA, VOMITING, DIARRHEA

First 24 hours	Second 24 hours	Third 24 hours
Kool Aid	Any foods on the "First 24 Hours" list	Progress to a regular diet as tolerated.
Gatorade, Sqwincher, Propps Plus	and the following:	Rice Cereal
Pedialyte	Mashed Potatoes	Plain grits
Seven-Up, Gingerale with bubbles shaken out	Mashed bananas	Dry toast
Hawaiian Punch, Hi-C	Rice	
Popsicles	Applesauce	
Jello	Babies: If on formula give half strength	

NO MILK
NO OTHER FOODS OR DRINKS
The patient may have as much of these drinks as they want, but feed them slowly.

INSTRUCTIONS TO PATIENT: FOOD AND DRUG INTERACTION PAMPHLET GIVEN TO PATIENT YES _____ NO _____

F/u PCP as already scheduled

THE CARE YOU HAVE RECEIVED IN THE EMERGENCY DEPARTMENT HAS BEEN DELIVERED ON AN EMERGENCY BASIS AND MUST NOT BE CONSIDERED TO BE COMPREHENSIVE MEDICAL CARE. YOUR PERSONAL PHYSICIAN WILL RECEIVE A COPY OF YOUR RECORDS. IT IS IMPORTANT THAT YOU REPORT ANY NEW OR REMAINING MEDICAL PROBLEMS TO YOUR PERSONAL PHYSICIAN.

FOR FOLLOW-UP CARE, YOU SHOULD SEE DR. _____ IN _____ DAYS, OR _____

X-RAYS OBTAINED AFTER NORMAL DUTY HOURS WILL BE LATER INTERPRETED BY A QUALIFIED RADIOLOGIST AND ANY DISCREPANCIES FOUND WILL BE COMMUNICATED TO YOUR PRIVATE PHYSICIAN. *I CERTIFY THAT I UNDERSTAND THE INSTRUCTIONS GIVEN ME. I CERTIFY THAT I HAVE RECEIVED WRITTEN AND VERBAL INSTRUCTIONS.*

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY X Beth Mashie DATE 4/5/02 TIME 2330

SERVICES PERFORMED	WORK/SCHOOL STATUS	MODIFIED WORK AS INDICATED
☐ INITIAL TREATMENT	☐ RETURN TO REGULAR DUTY	DURATION _____
☐ X-RAY ☐ LAB/DRUG SCREEN	_____ DATE	☐ 1. NO PROLONGED STANDING OR WALKING
☐ SUTURES	☐ RETURN TO MODIFIED DUTY	☐ 2. NO CLIMBING, BENDING OR STOOPING
☐ ADMITTED TO HOSPITAL	_____ DATE	☐ 3. LIMITED USE OF RIGHT / LEFT HAND
☐ FOLLOW-UP VISIT	☐ UNABLE TO RETURN	☐ 4. RIGHT / LEFT HANDED WORK ONLY
☐ DRESSING CARE ☐ PHYSICAL THERAPY	To my opinion this injury/illness ( ) is ( ) is not work related	☐ 5. NO WORK NEAR MOVING MACHINERY
☐ SUTURE REMOVAL		☐ 6. WEIGHT LIFTING RESTRICTIONS (LBS.) ☐ 0-15 ☐ 16-35 ☐ 36-50
		☐ 7. OTHER

M.D. Signature _____ RN Signature _____

Phone Call Made to Company . . . spoke with _____ Date: _____ Time 1210

PINK COPY - E.D.

F716 FLORENCE H337978
H1291150 04/09/02
FLOYD,SCOTTIE W ADM IN
HEALY,R. JOSEPH JR
26 M S A-NEIC

CAROLINAS HOSPITAL SYSTEM
South Carolina

HISTORY & PHYSICAL

NAME: _____ AGE: 26 MR#: _____

ATTENDING PHYSICIAN: Dr Ltf

CHIEF COMPLAINT: 26yo wf c hx of c/c and cerebral concussion 6 months ago. Chronic persistent headache

PRESENT ILLNESS: since which is unresponsive to medications. May co-morbid factors exist including poor sleep, tobacco abuse and personality disorder.

PAST MEDICAL HISTORY:

ALLERGIES: NKA

SOCIAL/FAMILY HISTORY: right Lost right pt had "bad smell + taste and then "fell out" and injured (R) arm. No Tongue bit

REVIEW OF SYSTEMS: no fever

CURRENT MEDICATIONS: Zoloft 200 q HS
VOA Nicotin

PHYSICAL EXAMINATION

VITAL SIGNS: T: 98 P: 64 R: 18 B/P: 103/70 WT: _____

GENERAL: wn, ws wf

HEART: RR S1S2 ± (m)

HEENT: no bruit

CHEST/LUNGS/BREASTS:

ABDOMEN:

GENITALIA/RECTAL:

EXTREMITIES:

NEURO:

IMPRESSION: - Chronic cephalgia
- Cerebral Contusion
- ? Seizures

PLAN:

admit

(DOCTOR'S SIGNATURE & DATE) 11 7 1241

FC-012496

RUN ON 06/04/2002-1435 PCI RADIOLOGY REPORT

H337978 - FLOYD,SCOTTIE W M 26 BETTY JO ACCT # H11291150
PATIENT STATUS: DIS IN LOC: F716 1

RE: 000497586 MRI/MRI- BRAIN W & W/O CONTRAST - F
EXAM DATE: 04/10/2002 ORDERED BY: HEAJO - HEALY,R. JOSEPH JR

REPORT STATUS: SIGNED REPORTED BY: 6CRE - STEVEN CREEDMAN MD

HX: CLOSED HEAD INJURY

T1 sagittal, T1 and T2 flair axial precontrast, T1 axial and coronal post contrast scanning performed. No previous brain imaging studies are available for comparison.

There is increased signal within the right mastoid air cells and sphenoid sinus. A triangular shaped area of abnormal signal was present in the right frontal lobe. This measures a maximum 3.9 x 3.5 x 1.7 cm. This is hypointense on T1 and hyperintense on T2 weighting, following CSF. Margins are well defined. No mass effect upon the right frontal horn. On post contrast images there is a small amount of peripheral enhancement at the posterior aspect of this lesion. No nodular enhancement. Smaller similar abnormal signal focus of approximately 1.3 x 2.2 cm in the adjacent anterior para sagittal left frontal lobe. With flair imaging, small amount of adjacent gliosis is suggested. No midline shift. Vascular flow voids are normal. Normal pituitary and cervicomedullary junction. No abnormal signal in the orbits.

There is history of closed head injury.

IMPRESSION:
1. ABNORMAL SIGNAL IN BOTH FRONTAL LOBES, RIGHT GREATER THAN LEFT. THIS MAY REPRESENT ENCEPALOMALACIA STATUS POST TRAUMATIC BRAIN INJURY/INFARCTION.
2. RIGHT MASTOIDITIS. MUCOINFLAMMATORY CHANGES IN THE SPHENOID SINUS.

d: 4/10/02; 14;53

CC: R JOSEPH HEALY JR MD

TECHNOLOGIST: MRI TECH
TRANSCRIBED DATE/TIME: 04/11/2002 (0835)
TRANSCRIPTIONIST: RADCM1

FOR EXAM: 000497586 MRI/MRI- BRAIN W & W/O CONTRAST

H337978 - FLOYD,SCOTTIE W M 26 BETTY JO ACCT # H11291150
PATIENT STATUS: DIS IN LOC: F716 1

RE: 000497586 MRI/MRI- BRAIN W & W/O CONTRAST - F
EXAM DATE: 04/10/2002 ORDERED BY: HEAJO - HEALY,R. JOSEPH JR

REPORT STATUS: SIGNED REPORTED BY: 6CRE - STEVEN CREEDMAN MD

HOW IS PATIENT TRANSPORTED? WCIV - WHEELCHAIR W/IV
ISOLATION/PRECAUTIONS: S - STANDARD
OTHER EXAM: N - NO OTHER EXAM TYPES
MONITORING NEEDS: 4 - FREQUENT OBSERVATION
DOES PT. HAVE PACEMAKER OR INTRACRANIAL ANEURYSM CLIPS? N
IS PT. COOPERATIVE? Y
REASON FOR MRI? CHECK FOR HEAD DAMAGE
COMMENTS: N

CAROLINAS HOSPITAL SYSTEM
805 Pamplico Highway
Florence, South Carolina 29505

DISCHARGE SUMMARY

NAME:	FLOYD,SCOTTIE W	**MED REC #:**	H337978
DOCTOR:	HEALY,R. JOSEPH JR	**PT ACCT #:**	H11291150
ADMIT DATE:	04/09/02	**PT STATUS:**	DIS IN
DISCHARGE DATE:	04/12/02		

==========

DIAGNOSIS: Chronic cephalgia.

Tobacco abuse.

Chronic anxiety state.

HOSPITAL COURSE: 26-year-old white male with history of closed head injury and frontal lobe contusion admitted with severe and persistent cephalgia. The patient admitted to neurology service and was placed at bedrest. Tobacco abuse and poor sleep hygiene had been driving this patient's headaches. Hemoglobin was 15 and electrolytes were normal and urinalysis was unremarkable. MRI of the head was repeated which showed abnormal signal in both frontal lobes, right greater than left consistent with previous traumatic brain injury. There was also a right mastoiditis. Medications were adjusted and attempts were made to improve the patient's sleep hygiene. The patient also "focuses" on "dead brain" and lesion was discussed with the patient which is old at this point and healing has taken place. Patient suffered from gastritis which is due to the numerous "pain medications" that he has been taking. He was counseled in proper sleep hygiene and by 4/12/02 had reached maximal hospital improvement and was discharged to home. He will continue on Ativan 2 mg p.o.q. 8 hours and chloral hydrate 500-1500 mg p.o. q.h.s. to improve sleep hygiene. The patient will follow up in my office in ten days' time.

Job # 2636

_____
Dr. R. JOSEPH HEALY, JR

HEAJO
/OS
D: 05/06/02
T: 05/06/02

CC:

(PCI:)

H337978 - FLOYD,SCOTTIE W M 27 BETTY JO Acct # H11443959
Patient Status: UNK Loc: UNK

Re: 000508261 CT/CT- BRAIN W/O IV CONTRAST - F
Exam Date: 05/24/2002 Ordered By: CHARA - CHARI,RAGHAVAN K.

Report Status: SIGNED Reported By: 12ALL - SCOTT H ALLEN MD

CT OF THE BRAIN WITHOUT CONTRAST 5/24/02

HISTORY: Headache.

Multiple axial images were obtained through the head without contrast. There are no prior CT exams. Comparison is made to a prior MRI from 4/10. The sinuses are clear. Intracranially, there is an area of decreased attenuation in the right frontal region as noted on prior MRI. The area in the left frontal region is not well demonstrated as it was on the MR. The ventricles are normal without mass effect or midline shift. No hemorrhage.

IMPRESSION: CHANGES FROM OLD INJURY IN THE FRONTAL LOBES GREATER ON THE RIGHT. NO ACUTE ABNORMALITY.

D: 5/24/02 @ 0701

#9074

Cc: RAGHAVAN K CHARI MD

Technologist: GARY SMITH, RT
Transcribed Date/Time: 05/24/2002 (0936)
Transcriptionist: HIMPT

For Exam: 000508261 CT/CT- BRAIN W/O IV CONTRAST
HOW IS PATIENT TRANSPORTED? WC - WHEELCHAIR
CLINICAL HISTORY: CHRONIC HEADACHE
OTHER EXAM: N - NO OTHER EXAM TYPES
MONITORING NEEDS: 1 - NO RISK
MD ORDER STATES/DIAG.? HEADACHE
Medical Necessity: NA
ICD-9:
ABN Status:

CAROLINAS HOSPITAL SYSTEM
805 Pamplico Highway
Florence, South Carolina 29505

OPERATIVE REPORT

NAME: FLOYD,SCOTTIE W **MED REC #:** H337978

PT ACCT #: H11925666 **ROOM #:**

SERVICE DATE: 10/17/02 **PT STATUS:** REG SDC

ATTENDING DR: FARRELL,HOWARD **LOCATION:** SDC

==========

DATE OF PROCEDURE: 10/17/02.

PREOP DIAGNOSIS: Nasal obstruction.

POSTOP DIAGNOSIS: Same.

OPERATIVE PROCEDURE: Septoplasty, bilateral inferior turbinate cautery.

OPERATIVE INDICTION: The patient has had problems with profound nasal obstruction after an accident where he was struck in the head getting closed head injury but also struck in the nose. The patient on exam has a profound septal deviation with bilateral nasal obstruction. The patient will undergo repair of his nasal septum today. The patient and family understand the risks and benefits of the above procedure.

OPERATIVE PROCEDURE: The patient was placed under general anesthesia. Left hemitransfixion incision was performed. Mucoperichondrial, mucoperiosteal flap was elevated. Profound deviation of the cartilaginous septum was corrected. Portion of the anterior cartilaginous septum was resected. Significant maxillary crest deviation was also corrected and with this portion of maxillary crest was resected and passed off as specimen. Perpendicular plate of ethmoid as well as vomer were also noted to be deviated. They were partially resected and passed off as specimen. Septal flaps were reapproximated. A septal stitch was performed. Anterior septal incision was closed with Chromic suture. The turbinates were end fractured. They were cauterized. Inferior turbinates on right and left side were cauterized with the bipolar cautery. The turbinates were then outfractured. ____ was put in place. Myragel was packed in the nose with packing. Intraoperatively no complications occurred. The patient tolerated the procedure without difficulty.

Job # tape

Dr. HOWARD FARRELL

FARHO
/ES
D: 10/17/02
T: 10/20/02

CC:

8057

PEE DEE PATHOLOGY ASSOCIATES, P.A.
805 Pamplico Hwy, Ste B-210, PO Box 6166
Florence, South Carolina 29505
843-664-4314

Patient: **FLOYD, SCOTTIE W**

Birthdate: [redacted] Age: 27 Sex: M

Location: CAROLINAS HOSP SYS/FLORENCE
Chart #: H337978
Room: SDC

SURGICAL PATHOLOGY REPORT

Physician(s): HOWARD FARRELL M.D.

Case Accession No: **S2002-021709**

Date of Procedure: 10 17 2002
Date Received: 10 17 2002

Clinical Information:
Pre-op: Septal deviation Post-op: Same

Specimen Source:
Source, TURBINATES

MICROSCOPIC DIAGNOSIS:
Labeled "turbinates": Portions of degenerating hyaline cartilage.

VCH/rt 10-18-02

(RGT)

Vera C. Hyman, M.D.

VERA C HYMAN, M.D./PATHOLOGIST
(Signed Out 10 18 2002)

Gross Description:
Container/Label: Scottie Floyd, turbinates
Pieces: two
Measurement: 1.3 x 0.8 x 0.2 cm. and 1.4 x 0.9 x 0.3 cm.
Section Summary: One cassette submitted for decalcification for approximately 30 minutes, 5n all used.
BD/kg 10-17-02

10/21/02

1217
HOWARD FARRELL M.D. copy

CAROLINAS HOSPITAL SYSTEM
805 Pamplico Highway
Florence, South Carolina 29505

DISCHARGE SUMMARY

NAME:	FLOYD,SCOTTIE W	**MED REC #:**	H337978
DOCTOR:	HEALY,R. JOSEPH JR.	**PT ACCT #:**	H12564514
ADMIT DATE:	04/07/03	**PT STATUS:**	DIS IN
DISCHARGE DATE:	04/10/03		

==========

DISCHARGE DIAGNOSIS: Syncope, substance abuse, history of closed head injury, frontal lobe syndrome with impulsitivity and rage.

27-year-old male admitted after he reportedly lost consciousness at home. No seizure activity was described and there was no tongue bite. The patient has severe headaches which are related to a closed head injury from 18 months ago. No evidence of arrhythmia was noted. EKG showed sinus rhythm with first degree AV block. EEG showed frontal slowing with no evidence of epileptiform activity. Noninvasive cerebrovascular exam was unremarkable. The patient admitted to using marijuana which he states is to control his headaches since "none of the medication works". During the hospitalization, he became agitated and threatened to leave the hospital against medical advise. The patient did leave the hospital without discharge orders on 04/10/03. He was told to continue on Paxil CR 12.5 3 tablets p.o. q.a.m., Ativan a mg p.o. q.8, Lamictal 50 mg p.o. q.day and Hydrocodone p.o. q.8h. p.r.n. headache. He was counselled with regards to his substance abuse and temper. The patient's frontal lobe syndrome is secondary to his closed head injury.

Job # 9839

_____
Dr. R. JOSEPH HEALY, JR.

HEAJO
/ES
D: 05/13/03
T: 05/20/03

CC:

Chart No. 4057

florence ent & facial plastics

Date 5.20.02

Name Scottie Floyd Age 26

Referring MD: K. Stewart, MD

CC: Head Ache

History: location, quality, severity, duration, timing, context, modifying factors, assoc. signs & sym.

S/p MVA between Cycles with Steel Loc Nose
Pain in Nose
Swell Lot
Injured Sept 13 Last yr
Nasal Bone Severity moderate

Review of symptoms

constitutional	nl ✓	abnl	
eyes	nl ✓	abnl	
ENT	nl	abnl ✓	headache
CV	nl ✓	abnl	
Resp	nl ✓	abnl	
Musculo/Skel	nl ✓	abnl	
GI	nl	abnl	
GU	nl ✓	abnl	
Integ	nl ✓	abnl	
nero	nl ✓	abnl	
psy	nl ✓	abnl	
endo	nl	abnl	
heme/lym	nl ✓	abnl	
aller/immuno	nl ✓	abnl	

Past/Family/Soc: Promethazine, Depakote, Butalbital

Current Meds: Sumatriptan, Zithromax, Zoloft, Lorazepam, Chloral Hydrate, Atenolol

Allergies: ✓

Prior illness: ✓

Prior Surg/Hosp: ✓

Health status relatives: ✓

Employment/occ hist: ✓

Etoh: ✓ Tobacco: ✓

Physical Exam:

pulse___ temp___ bp___ wt___ ht___

Constitutional:	General appearance	nl ✓	other
	Communication	nl ✓	other
Head/Face:	Inspection	nl ✓	other
	Facial Palp	nl ✓	other
	Salivary Glands	nl ✓	other
	facial strength	nl	other

Sign./date

Physical Exam: (cont.) Name _____

Eyes — occ mob/alignment — nl ✓ other _____

Ear — otoscopic — nl ✓ eac _____
TM (R) _____ mobility _____
TM (L) _____ mobility _____
hearing forks/speech — nl NT other _____

Skin — nl ✓ other _____
Nose — nl NT other _____
septum Septal Deviation (R) (L) turbinates _____
OMC WNL mucosa _____

Oral Cavity — lips/gum/teeth — nl ✓ other _____
Oral Pharynx — nl ✓ other _____

Pharynx (pharynx/pyriform sinus) — nl ✓ other _____
Larynx (mirror/flexible laryngoscopy) — nl ✓ other _____
supraglottis _____ epiglottis _____
false cords _____
glottis (cords/mobility) _____

nasopharynx — nl ✓ other _____
neck (masses, tracheal position) — nl ✓ other _____

Thyroid — nl ✓ other _____
respiratory — inspection — nl ✓ other _____
ascultation — nl ✓ other _____
cardio — ascultation — nl ✓ other _____
peripher vasc — nl ✓ other _____
nero/psy — orientation (ao x3) — nl ✓ other _____
cranial nerves (2-12) — nl ✓ other _____

Additional _____

IMPRESSION Headache etiology likely Post Traumatic
- Septal Deviation - likely post traumatic
- Loose of Smell likely via head injury

PLAN: Re-eval with PCP Healthy Plan

Sign./date _____

1220

Date: 9/20/02 ENT Follow up name Scotti Floyd chart # 8057

cc: Nasal Obst.

symptom: Nose Addr w/ Sx (R) pain w/ Nose 9/13/01 Sp Away Allen

duration: 1 wk severity: Severe location Nose

PMH, Complete review of systems unchanged from / / changed Tramadol Tramadol Topamax Celexa Prilosec

PE:

Constitutional: General appearance nl / other Skin nl / other

Ear /otoscopic nl / other

hearing/ forks/speech nl / other

Nose nl As other (R) Nasal Obst

septum OMC

Oral Cavity/lips/gum/teeth nl / other

Oral Pharynx nl / other

Pharynx(pharynx/pyriform sinus) nl / other

Larynx (mirror/ flexiblelaryngoscopy) nl other

nasopharynx nl other

neck (masses,tracheal position) nl / other

Thyroid nl / other

nero/psy/orientation(ao x3) nl other cranial nerves (2-12) nl / other

Additional

Studies:

Impression: Septal Deviation Pos found

Plan: Consider Septoplasty / CT Scan if ins 32

sign

Date: 10/8/02 ENT F/U

cc: Nasal Obst

symptom: Nasal Obst.

duration: 1 wks severity: Severe location Nose

PMH, Complete review of systems / unchanged from 5/20/02 changed

PE:

Constitutional: General appearance nl / other Skin nl / other

Ear /otoscopic nl other

hearing/ forks/speech nl Nr other

Nose nl As other

septum Septal Dev. (R) >(L) OMC

Oral Cavity/lips/gum/teeth nl / other

Oral Pharynx nl / other

Pharynx(pharynx/pyriform sinus) nl / other

Larynx (mirror/ flexiblelaryngoscopy) nl / other

nasopharynx nl / other

neck (masses,tracheal position) nl / other

Thyroid nl / other

nero/psy/orientation(ao x3) nl other cranial nerves (2-12) nl / other

Additional

Studies:

Impression: Septal Deviation

Plan Septoplasty Risks Benefits Alts

Date: 10/25/02 ENT Follow up name Scotty Boyd chart # 8057

cc: NASA (Sug

symptom: NASAL Surg Post op

duration: _____ severity: _____ location _____

PMH, Complete review of systems __ unchanged from / /

__changed _____

PE:

Constitutional: General appearance nl ✓ other _____ Skin nl ____ other _____

Ear /otoscopic nl ✓ other _____

hearing/ forks/speech nl NT other _____

Nose nl ✓ other _____

septum mid line OMC _____

Oral Cavity/lips/gum/teeth nl ✓ other _____

Oral Pharynx nl ✓ other _____

Pharynx(pharynx/pyriform sinus) nl ✓ other _____

Larynx (mirror/ flexiblelaryngoscopy) nl ✓ other _____

nasopharynx nl ✓ other _____

neck (masses, tracheal position) nl ✓ other _____

Thyroid nl ✓ other _____

nero/psy/orientation(ao x3) nl ✓ other _____ cranial nerves (2-12) nl ✓ other _____

Additional _____

Studies: _____

Impression: NASAL Surg / Septal Perfs

Plan: healing well Plan 2nd sign

Date: 11 / 11 / 02 Postoperative visit ENT F/U

cc: Post op

symptom: septum mid line

duration: two severity: not location Nose

PMH, Complete review of systems __ unchanged from 5/20 10

__changed _____

PE:

Constitutional: General appearance nl ✓ other _____ Skin nl ✓ other _____

Ear /otoscopic nl ✓ other _____

hearing/ forks/speech nl NT other _____

Nose nl ✓ other _____

septum mid line OMC _____

Oral Cavity/lips/gum/teeth nl ✓ other _____

Oral Pharynx nl ✓ other _____

Pharynx(pharynx/pyriform sinus) nl ✓ other _____

Larynx (mirror/ flexiblelaryngoscopy) nl ✓ other _____

nasopharynx nl ✓ other _____

neck (masses, tracheal position) nl ✓ other _____

Thyroid nl ✓ other _____

nero/psy/orientation(ao x3) nl ✓ other _____ cranial nerves (2-12) nl ✓ other _____

Additional _____

Studies: _____

Impression: Septoplasty Post op Plan well healed, Plan D/C

Date: 11 / 13 / 02 ENT Follow up name Scottie Floyd chart # 8057

cc: Septoplasty

symptom: Bloody Discharge

duration : _____ severity: _____ location _____

PMH ,Complete review of systems __ unchanged from / /

__changed _____

PE:

Constitutional: General appearance nl ✓ other _____ Skin nl ____ other _____

Ear /otoscopic nl ____ other _____

hearing/ forks/speech nl ____ other _____

Nose nl ✓ other _____

septum _____ OMC _____

Oral Cavity/lips/gum/teeth nl ✓ other _____

Oral Pharynx nl ✓ other _____

Pharynx(pharynx/pyriform sinus) nl ✓ other _____

Larynx (mirror/ flexiblelaryngoscopy) nl ✓ other _____

nasopharynx nl ✓ other _____

neck (masses,tracheal position) nl ✓ other _____

Thyroid nl ✓ other _____

nero/psy/orientation(ao x3) nl ✓ other _____ cranial nerves (2-12) nl ✓ other _____

Additional _____

Studies: _____

Impression: Nasal Surg well healed

Plan: _____

sign

Date: / / ENT F/U

cc: _____

symptom: _____

duration : _____ severity: _____ location _____

PMH ,Complete review of systems __ unchanged from / /

__changed _____

PE:

Constitutional: General appearance nl ____ other _____ Skin nl ____ other _____

Ear /otoscopic nl ____ other _____

hearing/ forks/speech nl ____ other _____

Nose nl ____ other _____

septum _____ OMC _____

Oral Cavity/lips/gum/teeth nl ____ other _____

Oral Pharynx nl ____ other _____

Pharynx(pharynx/pyriform sinus) nl ____ other _____

Larynx (mirror/ flexiblelaryngoscopy) nl ____ other _____

nasopharynx nl ____ other _____

neck (masses,tracheal position) nl ____ other _____

Thyroid nl ____ other _____

nero/psy/orientation(ao x3) nl ____ other _____ cranial nerves (2-12) nl ____ other _____

Additional _____

Studies: _____

Impression: _____

- INSTANT BILL ***-*** ACCT: 4557 DATE: 05/28/02

HOWARD S. FARRELL, M.D. & H.S.FARRELL,PC
1504 FREEDOM BLVD, STE. 256
FLORENCE, SC 29505-6846

LAST PAYMENT YTD PAY
01/28/03 60.00 9177.55

OFFICE PH:(843)665-2500 HOME PH:706-586-1575 BUSINESS PH:433-6332 EXT:

PAT NAME		APPOINTMENT
SCOTTIE M. FLOYD	SF	SCOTTIE M. FLOYD

DIAGNOSIS

1-J34.2 DEVIATED NASAL SEPTUM DSNO
2-J34.3 HYPERTROPHY OF NASAL TURBI

RELATION	GENN	TAX ID	MEDICAID	PROVIDER
4 HOWARD S. FARRELL, M.	106-62-9638	58-2367165	199109	58-2367165

DATE	LOC	PAT	DIAG	TOSVC	MOD	DESCRIPTION	CHARGE	CREDIT	BALANCE
05/28/02	4	SF	1	99242		CONSULT, OFFICE, E	165.00		165.00
** INS. FILED:05/28/02									
						FAXED CLAIM TO NURSE CASE MANAGER FOR STATUS			
05/28/02	4	SF	1	99213		EXPANDED, OV. ESTA	78.00		243.00
** INS. FILED:05/25/02									
10/08/02	4	SF	1	99213		EXPANDED, OV. ESTA	78.00		321.00
** INS. FILED:10/25/02									
10/17/02	4	SF	1	30520		SEPTOPLASTY	1600.00		1921.00
10/17/02	4	SF	2	30801	50%	CAUTERIZATION TURB	225.00		2146.00
** INS. FILED:10/30/02									
5/28/02	6	1		99080		Medical Records 5th			2151.00

CHARGES TOTAL: ~~2171.00~~ 2151.00

LATER SEND SEPARATE PAYMENTS FOR 8892 & 8893 CHARGES

CONFIDENTIAL
THIS REPORT IS STRICTLY CONFIDENTIAL AND IS PROVIDED ONLY FOR THE PERSON WHOM IT IS ADDRESSED. NO RESPONSIBILITY CAN BE ACCEPTED IF IT IS MADE AVAILABLE TO ANY OTHER PERSON, INCLUDING THE PATIENT.

Dora Windsorova, Ph.D., DABPS
Licensed Clinical Psychologist
417 South Dargan Street
Florence, SC 29506

Phone (843) 662-3330
Fax (843) 662-3315

Diplomate, American Board of Psychological Specialties, Forensic Neuropsychology

Clinical Psychology & Neuropsychology
Psychotherapy & Assessment

NEUROPSYCHOLOGICAL EVALUATION

NAME:	Scottie W. Floyd	**SS#:**	
DOB:		**EDUCATION:**	8 years
HANDEDNESS:	Right	**EVAL DATE:**	06-04, 08, 13, 17-02
REF. PHYSICIAN:	Joseph Healy, M.D.		

IDENTIFICATION AND REASON FOR REFERRAL: Mr. Floyd is a 26-year-old, single, Caucasian male who was involved in a work related accident on 9-13-01 suffering a closed head injury. He was referred for a neuropsychological evaluation by Dr. Healy in order to assess his current level of neuropsychological functioning, to identify any cognitive difficulties he may be experiencing as a result of his head injury, and to provide pertinent recommendations.

CURRENT COMPLAINTS AND PERTINENT HISTORY: The following history was obtained through an interview with Mr. Floyd and his mother, medical records provided by Dr. Healy, and from medical records that were provided to me per my request by Mr. Wukela, Mr. Floyd's attorney at law.

Mr. Floyd reported he was in good health working in an auto parts business for three years when he suffered a head injury on 9-13-01. Reportedly, he was breaking down auto parts when he released a bolt and when it happened a spring pushed the control, resulting in another part getting loose and the spring hitting him with force on his forehead. Mr. Floyd did not lose consciousness but immediately felt severe pain. He went to the emergency room where his forehead cut was sutured and his head was x-rayed. He was given pain medication and was discharged home. Mr. Floyd reported that the area around his eyes was dark with hematoma and swelled up to the point that he could not open his eyes for three weeks. He had severe nausea and blood in his vomitus for several days. His nausea and vomiting continued for 1½ months. He reported that this was only controlled with his medication. He also had nosebleeds. Mr. Floyd reported that he has had severe headaches. Mr. Floyd reported that he did not receive treatment for his headaches until he went to a doctor with a handgun, threatening to kill himself if he did not get some help for the headaches. He was examined at McLeod Emergency Room where he had a CT scan of the brain. Reportedly, he was told, "the front part of my brain was dead." He was medicated for pain and was sent to Three Rivers Psychiatric Hospital in Columbia where he was hospitalized for eight days with diagnosis of Mood Disorder, NOS. He was released home on January 22, 2002 with follow up by Dr. Mark Weinbaum and Mr. Ross Fulcher, RN, CNS. Currently, Mr. Floyd is treated by Dr. Weibaum and is in counseling with Ms. Rene Williams, LPC.

PERSONAL HISTORY: Mr. Floyd reported growing up with an alcoholic father who abused drugs, who was very physically abusive to his wife as well as to Mr. Floyd. His earliest memory relates to hearing his mother scream when his father beat her. He recalls an incident with he was 6 years old when his father cut his wrist and then held a gun to Mr. Floyd's head and demanded that he clean the blood. Eventually, Ms. Floyd separated from her husband and they divorced when Mr. Floyd was 7 years old. Mr. Floyd has a 3-year-younger sister with whom he has an estranged relationship.

Mr. Floyd repeated the 2nd grade at the time when his parents were divorcing and he was transferred to another school where he was held back. Mr. Floyd reported he quit school in the 9th grade because of having difficulty dealing with his English teacher. He reported he had difficulty in English but was good in Math. Mr. Floyd did hard labor work most of his life. He worked with heavy machinery, drove a truck, and worked in the landscape business. He stripped autos for an auto parts business for three years before he was involved in his accident. Mr. Floyd is single, currently not dating, and he has no children. His primary support is his mother.

ACTIVITIES OF DAILY LIVING: Mr. Floyd has lived with his mother since he was discharged from the psychiatric hospital at the end of January of this year. Before that, he was living independently taking independent care of his household. He spends most of his time at home, helping some with cleaning, cooking and yard work, and in his free time playing Play station, watching television, or listening to the stereo. He has one close friend with whom occasionally he does some outside activities. Mr. Floyd has not been driving his car since January of 2002 per his physician recommendation.

BEHAVIORAL OBSERVATION: Mr. Floyd was friendly and cooperative throughout the evaluation. During the initial session that was scheduled for a full day, he completed only the Clinical Interview as he complained of a headache and the session was rescheduled. The actual testing was done over two evaluation sessions, again to accommodate Mr. Floyd because of his headaches in order to facilitate his optimal performance. Mr. Floyd was quite intense discussing his difficulties as a result of his injury particularly his frustration about having continued headaches and resulting temper. He was alert and casually dressed, appearing his age. He was motivated to do well and appeared to put forth his best efforts on all tasks. Therefore, the following results are believed to be a valid representation of his current level of neuropsychological functioning.

TECHNIQUES UTILIZED:

Clinical Interview
Wechsler Adult Intelligence Scale - III (WAIS-III)
Wide Range Achievement Test - 3 (WRAT-3)
Halstead-Reitan Neuropsychological Test Battery (except for Category)

Wisconsin Card Sorting Test (WCST)
Controlled Oral Word Association Test
Wechsler Memory Scale – III (Logical Memory, Visual Reproduction)
California Verbal Learning Test – 2 (CVLT-2)
Beck Depression Inventory - 2 (BDI-2)

EVALUATION RESULTS:

Orientation: Mr. Floyd was alert and fully oriented to person, time, place, and situation.

Intellectual and Academic Abilities: On the WAIS-III, Mr. Floyd obtained a Verbal IQ of 90, a Performance IQ of 95, for a Full Scale IQ of 91. These results place his overall level of intellectual functioning within the Average range and at the 27th percentile when compared to same aged peers. There was no significant discrepancy between his verbal and performance scaled scores though some variability was noted within each domain. The age-corrected scaled scores for each subtest are as follows:

Verbal Subtest	Scaled Score	Performance Subtest	Scaled Score
Vocabulary	9	Picture Completion	11
Similarities	9	Digit Symbol	6
Arithmetic	10	Block Design	11
Digit Span	4	Matrix Reasoning	11
Information	10	Picture Arrangement	8
Comprehension	8		

Mr. Floyd's thought process was goal directed and intact on this structured test. In terms of his verbal abilities, his significant weakness was with his attention and concentration in repeating verbally presented digits. His other verbal scores were rather consistent and within average range. Mr. Floyd's performance on nonverbal subtests revealed significant weakness on a visual-motor task requiring hand-eye coordination and new learning. His relative weakness was in temporal sequencing of social stimuli. His other nonverbal scores were more consistent and within solid average range. Overall, the pattern of intellectual test results indicates long term average level of intellectual abilities without any significant decline though with notable difficulties with his attention and concentration and new learning at this time.

On the WRAT-3, Mr. Floyd obtained the following grade equivalents and standard scores: Reading – High School (96), Spelling – 5th grade (77), and Arithmetic – 7th grade (85). While Mr. Floyd's score in reading and spelling is consistent with his current level of intellectual functioning, his score in spelling is below and suggests him having learning disorder in spelling. Although his score in

arithmetic is somewhat lower, this score likely reflects his premorbid level of arithmetic ability rather than any decline.

Attention and Concentration: On intellectual testing, Mr. Floyd had significant difficulty with his attention and concentration on a task requiring repeating verbally presented digits. He was inconsistent in repeating four digits forwards and was able to repeat only three digits backwards. In contrast, his attention and concentration were above average on a slowly paced task requiring discrimination of subtle speech sounds and on a more rapidly paced task requiring discrimination of subtle rhythmic patterns. Overall, his performance indicates intact attention though with significant variability.

Flexibility of Thought, Abstract Reasoning, and Complex Problem Solving: On measures that are sensitive to generalized brain functioning, Mr. Floyd had mild difficulty with simple flexibility of thought though he had low average complex flexibility of thought and speed of mental processing. On a more complex measure of abstract reasoning and problem solving (WCST), Mr. Floyd performed very well completing 6 conceptual categories within the 85 trials administered. He was efficient in learning from provided feedback and shifting between cognitive sets though he had relative inefficiency in maintaining sets. Additionally, Mr. Floyd did well on complex psychomotor problem solving. Overall, these results indicate intact higher executive function though with slight inefficiency.

Language Function: Mr. Floyd's speech was fluent and without obvious difficulty in his receptive or expressive language. On a brief aphasia screening examination, except for some difficulty in his math, Mr. Floyd had intact basic language and communication function. Additionally, he had low average verbal fluency.

Visuospatial Ability: Mr. Floyd performed well on a complex psychomotor problem solving task that has a significant spatial component. He also had intact constructional praxis. Overall, he evidenced intact visual-spatial abilities.

Memory Function: In terms of his verbal memory, Mr. Floyd had mild difficulty with his immediate and 30-minute-delayed contextual verbal memory, scoring at the 8th and 7th percentile, respectively. On a more complex measure requiring learning and recalling of unorganized verbal information, Mr. Floyd had mild difficulty as well. His initial recall of the information was adequate and he learned sufficiently with additional practice trials. However, he had mild difficulty with his short-delay and 20-minute-delay recall though his recall was enhanced with verbal cueing. He was consistent in terms of items he recalled across the trials. His recognition was good on this task as he accurately recognized 15/16 words with adequate discriminability. His forced-choice recognition was adequate as well. His performance indicates a good encoding of the information with mild difficulty in free recall, but good recall with cueing and recognition.

In terms of his nonverbal memory, Mr. Floyd had good immediate and 30-minute-delayed figural memory, scoring at the 74th percentile. Additionally, he had above average incidental learning and memory on complex psychomotor problem solving. Overall, Mr. Floyd evidenced intact nonverbal memory though with some difficulties in his verbal memory.

Sensory-Perceptual Function: Mr. Floyd's finger tapping speed and grip strength were adequate bilaterally though his left hand finger tapping speed was somewhat slower than would be expected given his dominant right-handed speed. He had intact sensory-perceptual function. He had no problems on bilateral simultaneous tactile, auditory and visual stimulation, tactile finger recognition, tactile form recognition, and he evidenced full visual fields.

PSYCHOLOGICAL FUNCTIONING: Mr. Floyd has experienced depression since his accident requiring psychiatric hospitalization in January, 2002 when he had intense suicidal ideation and intent to shoot himself should he not have relief from his headaches. He was diagnosed with Mood Disorder NOS and discharged home on 1-22-02 after an eight day long hospitalization. He has been treated by Dr. Weinbaum since his discharge. He has been in psychotherapy as well. Currently Mr. Floyd continues to experience depression related to his headaches and limitations in his functioning. He continues to have occasional suicidal ideation without a plan and/or intent to act on his thoughts. However, he continues to be at risk as his headaches continue. Mr. Floyd's most pronounced depressive symptoms include irritability and agitation, which are intensified by neurobehavioral sequelae of his head injury including irritability, low frustration tolerance, and increased difficulty delaying and modulating his affective experiences. He continues to meet DSM IV diagnostic criteria for Depressive Disorder, NOS. He also meets criteria for Cannabis Abuse, currently in remission and Nicotine abuse.

SUMMARY AND RECOMMENDATIONS: The results of the current evaluation reveal Mr. Floyd to be intellectually functioning within the Average range with his overall IQ of 91. Academically, his reading is at high school level, spelling at the 5th grade level, and his arithmetic is at the 7th grade level. Overall, the pattern of results indicates these scores to reflect long term level of abilities without significant decline though with difficulties in Mr. Floyd's attention and concentration, new learning, and speed of processing at this time. His score in spelling also suggests a learning disorder in written expression.

The results of the neuropsychological evaluation reveal Mr. Floyd to have generally intact neuropsychological functioning except for mild difficulty and inefficiency in higher executive function and speed of processing, mild difficulty in his verbal memory, and slightly decreased left-hand motor speed. In contrast, he has good attention and concentration though with some variability, intact abstract reasoning and problem solving, complex psychomotor problem solving,

basic language and communication function, visual-spatial abilities, visual nonverbal memory, and generally intact sensory motor function. Additionally, Mr. Floyd is experiencing a number of behavioral symptoms related to his head injury including mood lability with difficulty modulating his affective experiences particularly his anger, increased irritability, and low frustration tolerance with difficulty to delay.

The pattern of Mr. Floyd's neuropsychological test results is consistent with very mild effects of head injury. Most pronounced is his variable attention and concentration, mild difficulty in verbal memory, and inefficiency in higher executive function as well as behavioral symptomatology related to his head injury. There is a psychiatric component contributing to his difficulties as well.

Given the level of his cognitive functioning alone, Mr. Floyd should not experience any significant difficulty in his day-to-day functioning. However, he will experience difficulty in situations requiring sustained attention and concentration, efficient memory, simultaneous processing, and working for prolonged periods of time. His ability to apply himself efficiently and consistently would be affected by the level of his headaches and his emotional/behavioral status.

Based on these results, the following recommendations are made:

1. It is recommended that Mr. Floyd continue to be treated psychiatrically both with medication and in psychotherapy to assist him to deal more effectively with his cognitive difficulties as well as with his mood lability with irritability, low frustration tolerance, and anger in order to optimize the level of his functioning.

2. It is strongly recommended that Mr. Floyd be evaluated for involvement in a pain management program to address his headaches and to promote optimal pain management.

3. It is also important that Mr. Floyd be encouraged to stop smoking.

4. Given that the current evaluation is conducted only nine months after Mr. Floyd's head injury, further recovery in his condition is expected. It is recommended that he be neuropsychologically reevaluated in six to nine months when he benefits from further recovery time, hopefully his headaches being under better control, and he is psychiatrically stable.

Dear Dr. Healy,

I met with Mr. Floyd and his mother to discuss with them the evaluation results and recommendations. Should you have any further questions regarding his current neuropsychological status or if I could be of any further assistance in his care, feel free to call me at 662-3330. Thank you for your kind referral.

Sincerely,

Dora Windsorova, Ph.D.
Licensed Clinical Psychologist

CONFIDENTIAL
THIS REPORT IS STRICTLY CONFIDENTIAL AND IS PROVIDED ONLY FOR THE PERSON WHOM IT IS ADDRESSED. NO RESPONSIBILITY CAN BE ACCEPTED IF IT IS MADE AVAILABLE TO ANY OTHER PERSON, INCLUDING THE PATIENT.

Dora Windsorova, Ph.D., DABPS
Licensed Clinical Psychologist
417 South Dargan Street
Florence, SC 29506

Phone (843) 662-3330
Fax (843) 662-3315

Diplomate, American Board of Psychological Specialties, Forensic Neuropsychology

Clinical Psychology & Neuropsychology
Psychotherapy & Assessment

NEUROPSYCHOLOGICAL EVALUATION

NAME:	Scottie W. Floyd	**SS#:**	
DOB:		**EDUCATION:**	8 years
HANDEDNESS:	Right	**EVAL DATE:**	12-12-02
REF. PHYSICIAN:	Joseph Healy, M.D.		

IDENTIFICATION AND REASON FOR REFERRAL: Mr. Floyd is a 27-year-old, single Caucasian male who was involved in a work related vehicle accident on 9-13-01 in which he suffered a closed head injury. He has experienced some cognitive difficulties as well as significant headaches and psychological difficulties since the accident. Mr. Floyd was neuropsychologically evaluated in June of 2001. He was referred for a neuropsychological reevaluation by Ms. Linda Bolduc, his Worker's Compensation case manager.

RESULTS OF PREVIOUS NEUROPSYCHOLOGICAL EVALUATION: On his initial evaluation on 6-02, Ms. Floyd's intellectual functioning was within the average range with his overall IQ of 91. Academically, his reading was at high school level, spelling at the 5th grade level, and his arithmetic at the 7th grade level. The overall pattern indicated long-term level of abilities without any significant decline though there were difficulties with Mr. Floyd's attention and concentration, new learning, and speed of processing at that time. His score in spelling suggested he might have learning disorder in written expression. The results of the neuropsychological evaluation revealed Mr. Floyd to have generally intact neuropsychological functioning except for mild difficulty and inefficiency in higher executive function and speed of processing, mild difficulty in his verbal memory, and slightly decreased left hand motor speed. In contrast, he had good attention and concentration though with some variability, intact abstract reasoning and problem solving, complex psychomotor problem solving, basic language and communication function, visual spatial abilities, visual nonverbal memory, and generally intact sensory-motor function. At that time, Mr. Floyd was experiencing a number of behavioral symptoms related to head injury including mood lability with difficulty modulating his affective experiences particularly his anger, increased irritability, and low frustration tolerance with difficulty to delay. The pattern of results indicated mild neuropsychological effects of head injury. It was noted there was a significant psychiatric component contributing to his difficulties as well.

CURRENT COMPLAINTS AND PERTINENT HISTORY: The following history was obtained through an interview with Mr. Floyd and his mother. Please refer to Mr. Floyd's previous neuropsychological evaluation for more detailed background history.

Mr. Floyd reported some improvement in his functioning since his last evaluation. Although he continues to have headaches, his headaches were better when he was on pain medication following his surgery to correct his nasal septum on 10-17-02. However, the medication is not as effective in managing his headaches as it used to be. His headache fluctuates in its intensity, sometimes still having severe headaches. At the time of the evaluation, he reported he has more intense headache rating his headache at 4 on a scale of 0 to 10 (0 = the worse ever, 10 = feeling comfortable). Mr. Floyd reported that his sense of smell has improved since his surgery and his hearing is better as well though he still continues to be sensitive to certain sounds. He reports his right eye vision is still somewhat "fuzzy with black spots" in the upper portion of his visual field. Mr. Floyd continues to be sensitive to light. He avoids sunlight as light still bothers him. He keeps his home lights lit low and cuts down the sharpness on his television. Mr. Floyd reported having significant sleep problems. At times he might sleep on and off for two days and sometimes he would stay up all night. Although he has concerns about his sleep schedule, he believes that he is doing his best to get needed rest.

In terms of his cognitive functioning, Ms. Floyd reported his short-term memory is "still somewhat off." He has some fluctuation in his concentration depending on the nature of the task. Psychologically, Mr. Floyd reported he is doing better than six months ago particularly having better "grip on my anger." Although he still gets upset "at a heartbeat" and has low frustration tolerance, he can better manage these feelings without "blowing my stack." Mr. Floyd reported he was on Celexa until mid November but approximately three weeks after his surgery, he discontinued the medication because he felt much better on pain pills. In fact, he has felt he is doing better being off Celexa. Mr. Floyd's current medication regimen includes Trazodone 100 mg 2 q. hs. and Hydrocodone / APAP 5/500 q. 8hr. as needed for pain.

Mr. Floyd reported he spends most of his time at home resting, playing with PlayStation or watching television. He spends time feeding his cats and sometimes he might do some chores around the house which is infrequent. He minimally socializes. He continues not to drive. Mr. Floyd lives with his mother who does most of the cleaning, cooking, washing, and grocery shopping. She also takes him to his appointments while she continues to work.

BEHAVIORAL OBSERVATION: Mr. Floyd was pleasant and cooperative throughout the evaluation. He was casually and neatly dressed. He was open during the Clinical Interview in discussing his progress over the last six months. Mr. Floyd expressed having more severe headache on the day of the evaluation and was not sure whether he would be able to participate more than an hour or two as a result. However, he reported being determined to do as much as he could and he was able to complete all testing during one session. As Mr. Floyd did well on a number of measures on his 06-02 evaluation. Only tasks on which he had difficulty were readministered. Mr. Floyd's affect was less intense than during his previous evaluation. He was motivated to do well and appeared to put forth his best efforts on all tasks. The following results are believed to be a valid representation of his current level of neuropsychological functioning.

ASSESSMENT TECHNIQUES UTILIZED:
Clinical Interview
Wechsler Adult Intelligence Scale – III (WAIS-III)
Wide Range Achievement Test – 3 (WRAT-3)
Trail Making Test A and B
Wechsler Memory Scale - 3 (Logical Memory, Visual Reproduction)
Beck Depression Inventory – 2 (BDI-2)

EVALUATION RESULTS:

Intellectual and Academic Abilities: On the WAIS-III, Mr. Floyd obtained a Verbal IQ of 92, a Performance IQ of 106, for a Full Scale IQ of 98. These results place his overall level of intellectual functioning within the Average range and at the 45th percentile when compared to same aged peers. There was significant discrepancy between his verbal and performance scaled scores with his verbal abilities being below his perceptual-motor skills. Some variability was noted within each domain. The age-corrected scaled scores for each subtest are as follows:

Verbal Subtest	Scaled Score	Performance Subtest	Scaled Score
Vocabulary	8	Picture Completion	13
Similarities	13	Digit Symbol	6
Arithmetic	9	Block Design	12
Digit Span	6	Matrix Reasoning	13
Information	9	Picture Arrangement	11
Comprehension	8		

Mr. Floyd's thought process was goal directed and intact on this structured test. In terms of his verbal abilities, his significant weakness was in repeating verbally presented digits. His significant strength was in verbal abstract reasoning. His other verbal scores were consistently within average range. His performance on nonverbal subtests revealed significant weakness on a visual-motor task requiring hand-eye coordination and new learning. His other performance scores were consistently within average to high average range. Compared to Mr. Floyd's previous evaluation, there is significant improvement in his perceptual-motor skills with his verbal abilities being consistent with previous results.

On the WRAT-3, Mr. Floyd obtained the following grade equivalents and standard scores: Reading – High School (93), Spelling - 7th grade (86), and Arithmetic - 8th grade (93). Mr. Floyd's score in reading and arithmetic is consistent with his current level of intellectual functioning though his score in spelling is significantly below and indicates him to have learning disorder in written expression. Compared to his previous evaluation, Mr. Floyd's spelling and math was slightly better at this time.

Flexibility of Thought: On measures that are sensitive to generalized brain functioning, Mr. Floyd had average simple flexibility of thought and speed of mental processing and low average complex flexibility of thought and speed of mental processing. Compared to his previous evaluation, there is slight improvement in his flexibility of thought and speed of processing.

Memory Function: In terms of his verbal memory, Mr. Floyd had adequate immediate and 30-minute-delayed contextual verbal memory, scoring at the 47th and 21st percentile, respectively. Compared to his previous evaluation there is notable improvement in his memory as he previously scored within the 8th and 7th percentile, respectively.

In terms of his nonverbal memory, Mr. Floyd performed adequately with his immediate and 30-minute-delayed figural memory, scoring within the 83rd and 51st percentile, respectively. The drop in his delayed memory mainly resulted from not recalling the simplest of four designs. Compared to his previous evaluation, these results are more or less consistent as previously he scored within the 74th percentile.

PSYCHOLOGICAL FUNCTIONING: During the Clinical Interview, Mr. Floyd reported some improvement in his anger management though he still gets easily irritable and frustrated. On the Beck Depression Inventory, his score fell within mild level of depressive symptomatology. He reported feeling sad much of the time, feeling discouraged about his future, feeling that he has failed more than he should have, not enjoying things as much as he used to, feeling guilty over many things he has done or should have done, feeling disappointed in himself, more critical of himself, and being more easily restless and irritable. He reported he lost most of his interest in other people or things, not considering himself as worthwhile and useful as he used to, and having more difficulty making decisions than usual. He acknowledged having less energy and no concentrating as well. He also reported some fluctuation in his appetite, having sleep disturbance, and somewhat decreased libido. He continues to meet DSM IV diagnostic criteria for Depressive Disorder, NOS.

SUMMARY AND RECOMMENDATIONS: The results of the current evaluation reveal Mr. Floyd to be intellectually functioning within the Average range with his overall IQ of 98. Compared to his previous evaluation, there is significant improvement in his perceptual-motor skills. Mr. Floyd continues to have some difficulty with his attention and processing speed. Academically, his reading is at high school level, spelling at the 7th grade level, and his arithmetic at 8th grade level. These results indicate long-term level of academic abilities with him having learning disorder in written expression.

The results of neuropsychological evaluation indicate Mr. Floyd to have low average-to-average flexibility of thought and speed of mental processing and intact verbal and nonverbal memory. Compared to his previous evaluation, there was slight improvement in his flexibility of thought and significant improvement in his verbal memory.

Given Mr. Floyd's good neuropsychological abilities noted on the previous evaluation, as well as noted improvement on this evaluation, Mr. Floyd should not experience difficulty in his day-to-day functioning and in returning to work considering his cognitive functioning alone. However, he continues to have significant headaches, sleep disturbance, irritability and low frustration tolerance, as well as depression. His headaches are a primary concern and the main contributor to Mr. Floyd not functioning effectively in his day-to-day life and not being able to return to work.

Based on these results, the following recommendations are made:

1. Although Mr. Floyd believes that he has been doing better without being on an antidepressant, it is recommended that he be still considered for the possibility of psychopharmacological intervention to address his mood lability with depression and sleep disturbance.

2. It is strongly recommended that Mr. Floyd be evaluated for involvement in a pain management program to promote optimal pain management as recommended previously. In my professional opinion, his level of functioning is contingent on effective pain management and so is his ability to return to work.

3. Given that the current evaluation is 15 months following his head injury, I would expect some further recovery in his cognition. Although Mr. Floyd is functioning well neuropsychologically, he still may benefit from neuropsychological reevaluation two years post his head injury at which point he would be believed to be at optimal baseline as most of the recovery would take place by that time.

Dear Dr. Healy,

Should you have any further questions regarding Mr. Floyd's current evaluation results or recommendations, or if I could be of any further assistance in his care feel free to call me at 662-3330. Thank you for your kind referral.

Sincerely,

Dora Windsorova, Ph.D.
Licensed Clinical Psychologist

Cc: Ms. Linda Bolduc

PALMETTO BAPTIST MEDICAL CENTER
Taylor @ Marion, Columbia, S.C. 29220

DISCHARGE SUMMARY

NAME: Floyd, Scott
HOSPITAL NO: 641108
DOCTOR: Timothy D. Malone, MD
ADMITTED: 04/28/03
DISCHARGED: 05/02/03
DICTATED: 05/14/03 7:45:00 pm
TRANSCRIBED: 05/21/03 10:23:27 am

ADMISSION DIAGNOSES:
AXIS I: Intermittent explosive disorder secondary to closed head trauma rule out depression, NOS. History of marijuana abuse versus depression.
AXIS II: Deferred.
AXIS III: Closed head trauma.
AXIS V: 25 upon admission and unable to determine pattern of function.

HISTORY OF PRESENT ILLNESS: This is a 27 year old white male who presented secondary to a closed head trauma in 2001. The patient now has persistent personality changes, he relates to damage to "both of his frontal lobe". The patient has become increasingly aggressive at home, reportedly struck walls at home, putting holes in the walls. The patient's mother is reportedly afraid of him. He has become increasingly violent in the home. He admits to daily use of marijuana and has been noncompliant with his psych medications.

HOSPITAL FINDINGS: A CBC was obtained along with the basic metabolic panel, thyroid profile, urinalysis and urine drug screen.

HOSPITAL COURSE: The patient was admitted to the adult psychiatric ward and placed under appropriate observation. He received routine labs and a physical examination by nurse practitioner. The multidisciplinary treatment team met initially and subsequently throughout the hospitalization and up dated his master treatment accordingly. He was enrolled in the full therapeutic module.

Upon the initial assessment by the attending physician the patient was with a constricted affect. He was able to contract for safety and was placed on his previous medications. A neurological consult was ordered to evaluate possible seizures, behavioral disturbance. He was started on Klonopin 1 mg b.i.d., Carbatrol 200 mg b.i.d. and Paxil CR 25 mg b.i.d. In addition, the neurologist did place him on Keppra 250 mg b.i.d. The patient thereafter, demonstrate much more appropriate behavior. He was not aggressive, he was not assaultive. He was quite pleasant and appropriate. His focus appeared to be largely on getting out of the hospital. He maintained that he had no thoughts of harm himself or his mother and was quite apologetic for his previous negative behavior. He continued to brighten and improve. He was subsequently discharged on

PALMETTO BAPTIST MEDICAL CENTER
Taylor @ Marion, Columbia, S.C. 29220

DISCHARGE SUMMARY

NAME: Floyd, Scott
HOSPITAL NO: 641108
DOCTOR: Timothy D. Malone, MD
ADMITTED: 04/28/03
DISCHARGED: 05/02/03
DICTATED: 05/14/03 7:45:00 pm
TRANSCRIBED: 05/21/03 10:23:27 am

continued - page 2

5/2/03.

CONDITION: His affect was bright and appropriate. He was denying homicidal and suicidal ideations, auditory and visual hallucinations or delusions.

FINAL DIAGNOSES:
AXIS I: Intermittent explosive disorder secondary to closed head trauma, depressive disorder. History of marijuana abuse versus dependency.
AXIS II: None.
AXIS III: Closed head trauma.
AXIS IV: Family discord.
AXIS V: 25 upon admission, 50 to 55 at discharge.

DIET: Regular diet.

ACTIVITY: Ad lib.

PROGNOSIS: Guarded.

Timothy D. Malone, MD
TDM :TL562
Job ID:858919

PALMETTO BAPTIST MEDICAL CENTER
Taylor @ Marion, Columbia, S.C. 29220

HISTORY AND PHYSICAL

652
GAE

NAME: Floyd, Scottie, W
HOSPITAL NO: 641108
DOCTOR: Timothy D. Malone, M.D.
DICTATED: 04/29/2003 1:01 P
TRANSCRIBED: 04/29/2003 1:18 P

ADMITTED: 04/28/2003
DISCHARGED:

cc: Timothy D. Malone, M.D.

IDENTIFYING INFORMATION: The patient is a 27-year-old single Caucasian male.

FAMILY HISTORY: Mother is alive in the mid-50s. His father died in his 60s. His mother has had cancer.

HABITS AND SOCIAL HISTORY: The patient smokes one pack of cigarettes a day and has done so for 13 years. He does not drink alcohol. He uses marijuana regularly.

MEDICATION ALLERGIES: None known.

MEDICATIONS PRIOR TO ADMISSION: Include Paxil, Prilosec, Ativan and Vicodin, although he has been noncompliant with these medications.

PAST MEDICAL HISTORY: He has had facial reconstruction due to a head injury. He has had previous psychiatric admissions.

REVIEW OF SYSTEMS: Is significant for headache, anxiety.

HISTORY OF PRESENT ILLNESS: The patient is admitted at this time due to increasing agitation and aggressiveness and medical noncompliance.

PHYSICAL EXAMINATION:
VITAL SIGNS: Height 69 inches, weight 187 pounds. Nutrition is adequate. Temperature is 98.7, pulse 72, respirations 20, blood pressure is 127/70.
HEENT: Is unremarkable.
NECK: Is supple.
RESPIRATORY: The lungs are clear.
CARDIOVASCULAR: Heart S1, S2. No rubs, gallops or murmurs.
ABDOMEN: Soft, nontender, without masses.
EXTREMITIES: Deep tendon reflexes are 2+. Peripheral pulses are 2+. The skin is warm and dry without evidence of clubbing, cyanosis, or edema.
NEUROLOGIC: Cranial nerves II-XII are grossly intact. The patient is a fair historian. He is somewhat agitated during the interview and examination.

PALMETTO BAPTIST MEDICAL CENTER
Taylor @ Marion, Columbia, S.C. 29220

HISTORY AND PHYSICAL

NAME: Floyd, Scottie, W
HOSPITAL NO: 641108
DOCTOR: Timothy D. Malone, M.D.
DICTATED: 04/29/2003 1:01 P
TRANSCRIBED: 04/29/2003 1:18 P

ADMITTED: 04/28/2003
DISCHARGED:

continued – page 2

ADMITTING DIAGNOSIS: Intermittent explosive disorder secondary to closed head injury.

PLAN: See admitting orders and treatment plan.

Timothy D. Malone, M.D.
Dictated by Jean A. Massey, RN, PhD, ANP
TM/ld
Job ID: 000849536

PALMETTO BAPTIST MEDICAL CENTER
Taylor @ Marion, Columbia, S.C. 29220

CONSULTATION

NAME: Floyd, Scottie, W
HOSPITAL NO: 641108 652A
DOCTOR: Mark Lencke, M.D.
DICTATED: 04/29/2003 6:37 P
TRANSCRIBED: 04/30/2003 9:03 A

ADMITTED: 04/28/2003
DISCHARGED:

cc: Mark Lencke, M.D.
Timothy D. Malone, M.D.

NEUROLOGIC CONSULTATION

The patient is a 28-year-old male admitted with explosive personality disorder and violent behavior. He is status post closed head injury in 09/01 according to the patient. He suffered some form of skull fracture and lost the vision in his right eye. Unfortunately, none of those records are available.

For his neurological difficulties following this closed head injury, he has been followed by Dr. Joseph Healy, according to the patient. Dr. Healy is a neurologist in Florence, South Carolina. The patient states that he has been on numerous medications for headache. He is being seen for this chronic headache which occurred since his accident. There is some question of seizures, although the patient denies them. He denies any history of loss of consciousness but states he gets "woozy" when he gets fatigued at some times. He has daily headache for which he has been taking Hydrocodone for some time, prescribed by Dr. Healy. He saw Dr. Healy as recently as yesterday, who apparently changed his pain medication but the patient could not remember the name of this medicine.

The patient is holocephalic, fairly constant and quite severe, according to the patient; rated 10/10 on the pain scale. He states that he has been on numerous medications for headache prevent, namely Depakote, Neurontin and possibly Topamax. He has apparently also been on antidepressants but states he has stopped many of these on his own accord due to some form of adverse side effects.

PAST MEDICAL HISTORY: As above.

CURRENT MEDICATIONS: Include Klonopin, Carbatrol, Ativan, Prilosec, Paxil, Vicodin and Haldol.

SOCIAL HISTORY: As per chart.

FAMILY HISTORY: As per chart.

REVIEW OF SYSTEMS: As per chart.

EXAMINATION: Examination of the head does reveal midline frontal surgical scar. The patient keeps his right eye closed and will not let me examine it. He is awake, alert and oriented to all spheres although his affect is in appropriate. His speech is clear; there is no dysarthria, apraxia or neglect. His mental status is grossly felt to be commensurate with his education level.

Cranial nerves II-XII are grossly intact, although he kept his right eye forcibly closed dur[illegible]ion.

CONSULTATION

NAME: Floyd, Scottie, W
HOSPITAL NO: 641108
DOCTOR: Mark Lencke, M.D.
DICTATED: 04/29/2003 6:37 P
TRANSCRIBED: 04/30/2003 9:03 A

ADMITTED: 04/28/2003
DISCHARGED:

continued- page 2

On motor testing there is no grip to the outstretched upper extremities, tone change or lateralizing sensory loss. He has no evidence of pathological or lateralizing reflexes.

IMPRESSION:

1. Chronic daily headache with analgesic rebound.
2. Status post closed head injury.
3. History of psychiatric difficulties as outlined per psychiatry admission history and physical.

RECOMMENDATIONS: I think his chance of an easily reversible cause of his headaches is essentially nil, especially in light of his daily narcotic use. I told the patient in no uncertain terms that as long as he continues to take these daily narcotics that there will be essentially nothing we have to offer. I have recommended a trial of Keppra 250 mg p.o. b.i.d. Once again, I have a very low index of suspicion that this will be helpful as long as he takes daily narcotics.

I have also told the patient that I think that this is a chronic problem that would best be addressed as an outpatient by his treating neurologist, Dr. Healy. I essentially told him that I have nothing else to offer. I think his prognosis quite poor in terms of getting rid of his analgesic rebound headaches. I do not plan to follow this patient on a regular basis but suggest that he follow-up with Dr. Healy once he is discharged.

The South Carolina Neurologic Clinic thanks Dr. Malone, et. al. for asking us to see this patient.

Mark Lencke, M.D.
ML/ajh
Job ID: 000849828

PALMETTO HEALTH BAPTIST

FLOYD,SCOTTIE W 652-01
0311800730
MR 000641108 MALONE,TIMOTHY D
27Y M

NURSING DISCHARGE SUMMARY

1. DISCHARGE: Date 5-2-03 Time 1930 Mode ambulatory
   Accompanied by: mother
   Discharge To: ☑ Home ☐ Nursing Home ☐ Other
2A. Home Health Referral: ☒ No ☐ Yes ☐ Form completed, signed by MD and sent to Home Health Coordinator
2B. Hospice Referral: ☐ No ☐ Yes ☐ Copy of Discharge Summary sent to Hospice
   ☐ Copy of H&P and Discharge Notes sent to Hospice
3. Follow-up Appointment(s) Renee Williams Tues, May 13, 2003, Dr Healy Thurs May 8, 2003 contact up appt & private primary MD, Tegretol level @ Carolina Hospital @ 12 30 s
4. Patients own Medications: ☐ Sent home on admission ☒ None Systems Thurs, May 8, 2003
   ☐ Return to patient/family at discharge ☐ Other
5. Supplies sent home: Pt refuses local ASD admission for substance abuse counseling

DISCHARGE INSTRUCTIONS

Keppra 250mg take 1 pill 2 X day

1 Patients Discharge Medications/Prescriptions: Prilosec 20mg take 2 pills every day
Klonopin 1mg take 1 pill 2X day Carbatrol 200mg take 1 pill 2 X day Paxil CR 25mg take 1 pill 2X day

2. Diet: Vicodin 5/500mg take 1 2 times a day as needed as tolerated

3. Activity Instructions/Limitations: as tolerated

4. Specific Instructions: 1) make apt f primary care MD
2) follow up with neurologist (Healy) as indicated above
3) follow with Renee Williams to follow up (psych)
4) report to Carolina hospital systems as indicated above for Tegretol level
5) take meds as ordered
6) no alcohol or street drugs
7) contact MD if problems arise

5. Given printed information on: D

6. Patient or Family Verbalized and/or Demonstrated Understanding of instructions: ☒ Yes ☐ No

Signature of patient/significant other

(Self)
Relationship

Nurses Signature Title Initials

Form 47
REV 12/95, 1/01, 10/02

PALMETTO BAPTIST MEDICAL CENTER

Taylor at Marion Street - Columbia, South Carolina 29220

Patient's Name Scottie Floyd Age 27

Address _____ Date 5/2/13

R
Prilosec 20mg tid po ac #60
Klonopin 1mg po BID #60
Carbatrol 200mg tpo BID #60
Paxil CR 25mg tpo BID #60
Keppra 250mg tpo BID #60
Vicodin 5/500mg tpo BID prn pain #20

☑ Unless Checked Label with Drug Name.

Refill 0 Times-No refills unless indicated

_____ M. D.
Dispense as written

_____ M. D.
Substitution Permitted

DEA # _____

Office Address _____

CAROLINAS HOSPITAL SYSTEM
805 Pamplico Highway
Florence, South Carolina 29505

DISCHARGE SUMMARY

NAME:	FLOYD,SCOTTIE W	MED REC #:	H337978
DOCTOR:	HEALY,R. JOSEPH JR.	PT ACCT #:	H13191382
ADMIT DATE:	09/25/03	PT STATUS:	DIS IN
DISCHARGE DATE:	09/26/03		

This is a 28-year-old, white male with frontal lobe injury and frontal lobe syndrome admitted with increasing aggression and complaints of pain. The patient was felt to have a left occipital neuralgia. He was admitted to neurology and treated with morphine sulfate 2 mg IV every 3 hours as needed and Ativan 2 mg p.o. q.6h. His behavior came under control although predominantly this was because of the morphine. Dr. Dove was consulted relative to his left occipital neuralgia and did a block on him 9/25/03. Following this, the patient was discharged to home. Once his pain medications were stopped, he became very agitated. The patient is in need of further behavioral modification treatment and will try and find a facility with experience in treating frontal lobe disorders. For the present time, I want him to receive physical therapy on an outpatient basis for his occipital neuralgia and he will resume his home medications which include Prilosec 40 mg p.o. q.d., Carbatrol 200 p.o. b.i.d., Klonopin 1 mg p.o. b.i.d., Paxil-CR 25 1 p.o. b.i.d., Keppra 250 p.o. b.i.d., and Tranxene 7.5 p.o. q.8h. p.r.n. anxiety.

job 3435

Dr. R. JOSEPH HEALY, JR.

HEAJO
/DCH
D: 10/27/03
T: 10/29/03

CC:

23201

Dictating Physician's copy

CAROLINAS HOSPITAL SYSTEM
805 Pamplico Highway
Florence, South Carolina 29505

DISCHARGE SUMMARY

NAME:	FLOYD,SCOTTIE W	**MED REC #:**	H337978
DOCTOR:	HEALY,R. JOSEPH JR.	**PT ACCT #:**	H13945365
ADMIT DATE:	04/09/04	**PT STATUS:**	DIS IN
DISCHARGE DATE:	04/20/04		

==========

DISCHARGE DIAGNOSIS
1. Status epilepticus.
2. Renal failure (contrast-induced).
3. Substance abuse.

This is a 28-year-old white male with history of closed head injury with frontal lobe syndrome. The patient was admitted by Dr. Kent, 04/09/2004, after multiple seizures. These appear to be due to him stopping his medications, which included Xanax and Keppra. The patient was admitted to neurology. BUN and creatinine upon admission were elevated at 23 and 3.5. This was felt to be due to probable muscle damage from multiple seizures. A CT of the head was obtained, which was done with contrast, and showed his previous frontal lobe injuries. Unfortunately, his BUN and creatinine continued to rise following this. Dr. Sitti was consulted. The patient was treated conservatively and renal function began to normalize. No seizures were noted during the hospitalization. EEG showed nonspecific encephalopathy with frontal lobe slowing.

By 04/20/2004, the patient reached maximal hospital benefit and was discharged home on Keppra 500 p.o. q.12h., Depakote ER 1500 at bedtime, Tranxene 7.5 p.o. q.8h. and Paxil CR 25 one p.o. q.d. He will follow up in my office in several weeks' time, and was told not to drive. His BUN and creatinine at the time of discharge were 8 and 1.2. CPK was also coming down.

DISCHARGE DIAGNOSIS
1. Seizure secondary to medication withdrawal.
2. Substance abuse.
3. Acute renal failure, resolving.
4. History of closed head injury and frontal lobe damage.

Job # 08403

Dr. R. JOSEPH HEALY, JR.

HEAJO
/JF
D: 05/31/04
T: 06/11/04

CC:

CAROLINAS HOSPITAL SYSTEM
805 Pamplico Highway
Florence, South Carolina 29505

CONSULTATION REPORT

NAME: FLOYD,SCOTTIE W. MED REC #: H337978

PT ACCT #: H13945365 ROOM #: SICU12

ATTENDING DR: HEALY,R. JOSEPH JR. PT STATUS: ADM IN

CONSULTANT: ORACHUN SITTI

DISCHARGE DT:

==========

DATE OF BIRTH:

Medical record number 337978

ADMITTING PHYSICIAN: Dr. Joseph Healy.

CONSULTING PHYSICIAN: Orachun Sitti

DATE OF CONSULTATION: April 9, '04

PHYSICIAN REQUESTING CONSULTATION: Dr. Ashley Kent.

REASON FOR CONSULTATION: Evaluation of severe leukocytosis. White blood cell count 34,800 with lymphocytosis and abnormal PT of 23.4 seconds with INR 1.88 and PTT of 107 seconds.

PRESENT ILLNESS: Patient is a 28-year-old white male who has history of frontal-lobe syndrome secondary to contusion a couple of years ago. September '03 he was admitted because of increasing aggression and complaining of the pain. Its contributed to the left occipital neuralgia. Discharged with Carbatrol 200 mg; Klonopin 1 mg b.i.d.; Keppra 250 mg b.i.d.; Tranxene 7.5 and Paxil CR along with Prilosec. Patient developed status epilepticus the day of admission, was transferred to Marion County Memorial Hospital. From Marion County Memorial Hospital to Carolinas Hospital and was admitted. Laboratory findings at Marion County Hospital drawn at 18:40 p.m. April 9 showed white blood count 34,800 with hemoglobin 17.5, hematocrit 57.5, MCV 101, platelets 202,000 and the differential showed neutrophils of 26, bands 7, lymphocytes of 53. His PT was prolonged at 22.8 seconds with INR 1.88 and PTT markedly prolonged at 107 seconds. Sodium was 151, potassium 4.2, chloride 105, CO2 less than 5, glucose 204, BUN of 9, creatinine 1.8, calcium 10.7. Alcohol was negative. Tegretol was less than 2, salicylate less than 5. His urine drug screen was positive for marijuana and positive for benzodiazepines. Because of the abnormal PT, PTT and leukocytosis I was asked to see the patient from hematology standpoint.

CURRENT MEDICATIONS supposed to be Keppra 500 b.i.d.; Carbatrol 200 mg b.i.d.; Klonipin 1 mg h.s.; Tranxene 7.5 mg one to two q. 8 hours; Paxil CR 25 mg q.d. and Prilosec 40 mg q.d.

PAST MEDICAL HISTORY: He has decreased hearing right ear and decreased vision in the right eye. Has history of chronic headache.

ALLERGIC HISTORY: **ALLERGIC TO COCONUT.**

FAMILY HISTORY: Mother had mini stroke at the age of 51, father died of alcohol and

drug abuse. One sister alive and well.

PERSONAL HISTORY: He does not smoke, doesn't drink.

REVIEW OF SYSTEMS: Unable to review. He was in post ictal and quite sedated.

PHYSICAL EXAMINATION

Vital signs at 5:30 p.m. showed temp 98.3, pulse about 99, respirations 14, B/P 140/76. GENERAL APPEARANCE reveals a young adult white male well developed, well nourished. He has venting mask in place. Post ictal. HEENT: Head was unremarkable. Closed his eyes. There is no facial drooling. There is petechiae over the face, neck and the trunk and lower legs. CHEST was clear to both percussion and auscultation. HEART: Regular rhythm, no murmur, no gallop was heard. NECK: There is no thyromegaly. Neck veins were flat. Carotid pulse strong, no carotid bruit. ABDOMEN: Soft, no abdominal mass. NEUROLOGICAL EXAM: He is sedated. He is moving all four extremities well. Please see details of neurologic exam by Dr. Kent.

We repeated the CBC at Carolinas Hospital drawn at 20:40. His PT is 12.1, INR of 1.0, PTT 28.9 and his repeat white blood count was 76,600, hemoglobin 16.2, hematocrit 46.8, MCV 89.6, platelets 133,000 with neutrophils 92%. Platelet function study - the platelet _____ to _____ was normal at 95.

On 4-10-04 his white blood count came down to 21,200, hemoglobin 15.5, platelets dropped to 112,000, 92% neutrophils. BUN did come up to 23, creatinine 3.5, sodium 140, potassium 4.3, chloride 106, CO2 was 20. He has abnormal LFT with total bilirubin 1.2, direct bilirubin 0.4, alkaline phos. of 123, SGOT 111, SGPT 51. Valproic acid level was 68.1 mg per ml.

IMPRESSION
1. Reactive glucocytosis secondary to stress and seizure.
2. Abnormal PT, PTT due to laboratory error.
3. Progressive thrombocytopenia. Need to rule out underlying DIC.
4. New onset abnormal BUN and creatinine.
5. Abnormal LFTs.

PLAN: Will repeat BMP today. Patient just has CT of the head with and without contrast. I'm wondering whether the increasing BUN and creatinine on 4-10-04 due to lab error or _____. He does have _____ decrease urine output for about three hours at _____ last night but now the urine output started picking up. Will continue with the Rocephin to cover any infection.

He does have positive urine drug screen for marijuana.

CAROLINAS HOSPITAL SYSTEM
805 Pamplico Highway
Florence, South Carolina 29505

CONSULTATION REPORT

NAME:	FLOYD,SCOTTIE W	**MED REC #:**	H337978
PT ACCT #:	H13945365	**ROOM #:**	SICU12
ATTENDING DR:	HEALY,R. JOSEPH JR.	**PT STATUS:**	ADM IN
CONSULTANT:	ORACHUN SITTI		
DISCHARGE DT:			

==========

Thank you very much for allowing me to see this patient.

Job # 8040

Dr. ORACHUN SITTI

SITOR
/NDP
D: 04/10/04
T: 04/10/04

CC: HEALY,R. JOSEPH JR.
KENT,ASHLEY DEANE

CAROLINAS HOSPITAL SYSTEM
805 Pamplico Highway
Florence, South Carolina 29505

CONSULTATION REPORT

NAME:	FLOYD,SCOTTIE W	**MED REC #:**	H337978
PT ACCT #:	H13945365	**ROOM #:**	F412
ATTENDING DR:	HEALY,R. JOSEPH JR.	**PT STATUS:**	ADM IN
CONSULTANT:	SARAWADEE S. SITTI		
DISCHARGE DT:			

==========

Medical record number 337978

DATE OF CONSULTATION: 4-10-04

REASON FOR CONSULTATION: Acute renal failure.

This 28-year-old white young man with history of brain injury post frontal lobe syndrome from contusion head injury several years ago. He was admitted to the hospital at this time with increasing seizures and apparently was noted to be in renal failure as well as receiving CT of the head without dye earlier this morning. Now renal consultation is being made.

HOME MEDICATIONS: Clonopin 1 mg at night; Tranxene _____ q.i.d.; Paxil CR 25 q.d.; Tegretol 200 b.i.d.; Prilosec 40 mg a day.

PAST MEDICAL HISTORY: Has history of decreased hearing right ear and decreased visual sight in the right eye and chronic headache and bursting of his aggressive behavior.

SOCIAL HISTORY: He doesn't smoke or drink.

ALLERGIC TO COCONUT.

No history of any substance abuse.

SYSTEMIC REVIEW is unobtainable. Patient is sedated at this time.

PAST SURGICAL HISTORY Has had no surgery and post traumatic brain injury and occipital neuralgia.

FAMILY HISTORY: Mother had a mini stroke at age 51. Father died of alcoholic and drug abuse. One sister living and well.

PHYSICAL EXAMINATION

His blood pressure was 130/70, heart rate 130, temperature was normal. Respirations of 28. He is sedated although arousable. NECK is not stiff, flat JVP. LUNGS are quite clear. ENT: Unremarkable. SKIN: Clean and clear. HEART: Regular rhythm, no gallop, no rub. ABDOMEN: Soft, no organomegaly. EXTREMITIES: No pitting edema, no calf tenderness, no swelling. NEURO: Somewhat sedated, was reported to be very combative at the time and limited examination at this time.

CAROLINAS HOSPITAL SYSTEM
805 Pamplico Highway
Florence, South Carolina 29505

CONSULTATION REPORT

NAME:	FLOYD,SCOTTIE W	**MED REC #:**	H337978
PT ACCT #:	H13945365	**ROOM #:**	F412
ATTENDING DR:	HEALY,R. JOSEPH JR.	**PT STATUS:**	ADM IN
CONSULTANT:	SARAWADEE S. SITTI		
DISCHARGE DT:			

==========

LABORATORY DATA: BUN of 23, creatinine of 3.5 done earlier 5 o'clock this morning and it has risen to 4.3 at 10 o'clock today already, glucose of 129. Abnormal liver function tests. Urinalysis showed dark urine clinically.

IMPRESSION: Acute renal failure in gentleman with previously normal renal function and recent onset of seizures. We obtained a CPK which came back over 8000 along with definite tea-colored, dark urine. Obviously this gentleman is suffering from acute rhabdomyolysis and myoglobinuria.

PLAN: Will go ahead with IV fluids and colonization and enhancing diuresis and watch renal electrolytes closely. Hopefully it is somewhat reversible as always.

Thank you once again for letting me participate in his care.

Job # 1012

Dr. SARAWADEE S. SITTI

SITSA
/NDP
D: 04/18/04
T: 04/18/04

CC: HEALY,R. JOSEPH JR.

CAROLINAS HOSPITAL SYSTEM
805 Pamplico Highway
Florence, South Carolina 29505

HISTORY & PHYSICAL

NAME: FLOYD,SCOTTIE W

DOCTOR: GANDY,EDWIN LAVERNE MED REC #: H337978

ROOM #: PT ACCT #: H13945365

PT STATUS: REG ER ADMIT DATE:

DISCHARGE DT:

==========

REFERRING PHYSICIAN: Dr. Healy.

HISTORY OF PRESENT ILLNESS: The patient is a 28-year-old nonhypertensive and nondiabetic male who couple of years ago was involved in an on-the-job injury where he was struck on the left forehead and developed frontal-lobe syndrome secondary to contusion over that area. No surgery was ever accomplished, and the patient has had several passing-out episodes in the past, hospitalized by Dr. Healy, and last admitted in October of 2003 with increase in aggression and complaints of pain, felt secondary to occipital neuralgia. The patient is noncompliant with medication, as manifested by the following medicine counts. On March 10th, his Keppra was refilled 60 pills. He had only taken 2 pills since that time. He is supposed to be on a b.i.d. dosing. Carbatrol filled February 13th, 54 pills, and 50 pills remain. Klonopin 1 mg 60 pills and 58 remaining. Tranxene 150 pills and 136 remaining from the 10th of March. Paxil 60 pills on the 10th of March with 58 remaining.

The patient usually sleeps a lot during the daytime and awoke this morning around noon and had a steak biscuit. He said that when he was going back to bed, his mother then heard a funny noise and went in and found vomitus all over him, and then he had some tonic seizures, very brief. He had 3 seizures before the arrival of the ambulance, and they noted him to be very cyanotic. He had 4 further seizures prior to arriving at the emergency room and 3 to 4 more in the hospital. Was given about 10 mg of Versed and loaded with a gram of Dilantin. He was orally intubated and placed on a Versed drip, and I was notified. The patient is a patient of Dr. Healy's. She described that situation. I suggested Depacon. However, the emergency room doctor apparently had given the Cerebyx 1 g. On the order sheet, there is a note for some Depacon, but I called back and they apparently only gave the Cerebyx. She described subdural hematoma on the patient, and I suggested they call neurosurgery. I called back, and the neurosurgeon wanted to assess the patient in the emergency room at Carolinas, and so therefore, Dr. Guinn transferred the care of Dr. Gandy. Dr. Gandy notified me that the patient had arrived and that he was breathing and waking up and thought that he could extubate the patient. I responded and came to the hospital and there met his mother. She describes a history that he had no pre-seizure illness; however, it was determined that the patient was noncompliant with medications.

MEDICATIONS: The patient's current medications included, although he was not taking them obviously, Keppra 500 p.o. b.i.d.; Carbatrol 200 mg p.o. b.i.d.; Klonopin 1 mg at bedtime; Tranxene 7.5 one to two q.8 h.; Paxil 1 p.o. q.d.; and an H2 blocker 1 p.o. q.d.

PAST MEDICAL HISTORY: The patient has had a nose surgery. He has significant posttraumatic brain injury with chronic headaches. He has had occipital neuralgia in the past. He has decreased hearing in the right ear, right visual problems, and

absent taste and smell.

ALLERGIES: To COCONUTS.

FAMILY HISTORY: Mother had a mini-stroke at 51 years of age. No hypertension. Father died of alcohol and drug abuse. One sister alive and well.

SOCIAL HISTORY: He does not smoke, and he does not drink.

REVIEW OF SYSTEMS: He has had no night sweats, fevers, or chills. No hemoptysis, hematemesis, melena, or hematochezia. He smokes marijuana for head pain and has been doing that for several years. He has had no melena, hematochezia, or hematemesis, although he had melena in the past. He has had no rheumatic fever, scarlet fever, fever, or nausea.

PHYSICAL EXAMINATION
GENERAL: He is a well-nourished, well-developed male, orally intubated and thrashing about.
VITAL SIGNS: Pulse 132, respirations 28, and blood pressure 138/76.
HEENT: Head is normocephalic and atraumatic, status post small trauma over the right forehead region. Eyes show clear disk margins. No hemorrhages or exudates. Ears are normal. Nose is normal. Mouth is normal. He had some petechiae of the skin. Ears, nose, and mouth within normal limits. Oral ET-tube in place.
NECK: Supple without JVD, HJR, thyromegaly, or bruits.
CHEST: Clear.
HEART: Regular rate and rhythm. S1 and S2.
ABDOMEN: Soft, nontender, and nondistended.
EXTREMITIES: No clubbing, cyanosis, or edema.
NEUROLOGIC: He is combative, writhing from side to side, trying to get the tube out, and trying to escape from the restraints. He will not follow any commands. He will not be comforted. Cranial nerve 2 showed intact spots to light. The 3rd, 4th, and 6th showed pupils to be equal, round, and reactive to light. Extraocular muscles were intact. The 5th cranial nerve showed equal _____ response. The 7th cranial nerve showed symmetric facies. The 8th cranial nerve was not testable. The 9th, 10th, and 11th showed positive gag, and sternocleidomastoid and trapezius muscle strengths were normal. The 12th cranial nerve showed tongue protruding in the midline. Motor exam showed full strength in all sites tested. Rapid reflexes were 2+ and symmetrical. Plantar responses were upgoing bilaterally. Coordination testing with finger-to-nose and heel-to-shin were not testable. Sensory examination responded to pain in 4 extremities.

LABORATORY: CAT scan of the head was reviewed with Dr. Sechtin, and he feels that there is no subdural hematoma and that this represents transverse sinuses. The

patient's PT was 22.4, and PTT was 107. Sodium of 151, potassium 4.2, chloride of 105, CO2 of less than 5, glucose 204, BUN of 9, creatinine of 1.8, and calcium 2.9. Alcohol less than 10. Carbamazepine less than 2. Salicylate less than 5. Benzodiazepines are positive. THC was positive. White cell count was 34.8, hemoglobin 17.5, hematocrit 57.5, MCV of 101.9, and platelet count 202,000. Urinalysis was positive for a large amount of blood, 3-4 white cells, and trace bacteria. In addition to the scan described above, there was old injury in the frontal lobes, right greater than left.

IMPRESSION
1. Status epilepticus secondary to posttraumatic brain injury.
2. Coagulopathy, lab error versus real findings.
3. Increased white cell count, stress reaction versus neoplastic process.
4. Petechiae, possibly secondary to seizure, however, with the above hematologic abnormalities.

RECOMMENDATIONS: We will admit him to the intensive care unit. Frequent neurochecks will be done. We will have the coagulopathy and increased white count assessed. He is going to be extubated in the emergency room. We will continue the Keppra 750 mg p.o. b.i.d. We will hold off on the Carbatrol until we get more information regarding his hematologic status. We will continue with Depacon 250 IV q.6 h., as it turns out he had received 1200 mg at Marion Memorial. They called back and notified me of this. We will check lab studies in the morning. We will obtain an MRI of the brain. Continue with Rocephin 1 g q.12 h. He was given 2 g in the emergency room.

Job #07986

Dr. ASHLEY DEANE KENT

KENAS
/ST
D: 04/09/04
T: 04/09/04

CC:

NAME			SEX	ACCOUNT NUMBER
FLOYD,SCOTTIE W			M	H13945365
ORDERING PHYSICIAN		PT. STATUS	LOCATION	MEDICAL RECORD NO.
GANDY,EDWIN LAVERNE		UNK	UNK	H337978
ATTENDING PHYSICIAN	DATE OF BIRTH	AGE	DATE OF EXAM	RADIOLOGY NO.
	(	30	04/09/2004	

EXAM# TYPE/EXAM RESULT

000686209 RAD/CHEST PORTABLE
HOW IS PATIENT TRANSPORTED? P - PORTABLE
ISOLATION/PRECAUTION: S - STANDARD
OTHER EXAM: N - NO OTHER EXAM TYPES
MONITORING NEEDS: 1 - NO RISK
IS PATIENT FOR SURGERY? N
REASON FOR EXAM? INTUBATION
IS X-RAY FOR PLACEMENT? N
COMMENTS: ER11

SUPINE CHEST X-RAY

HX: INTUBATION

Supine chest x-ray at 1830 hours was obtained portably for endotracheal tube placement.

Endotracheal tube appears to be satisfactorily positioned, 2.8 cm above the carina. The heart is not enlarged. The lungs are clear.

d: 04/10/04, 0815

Reported By: ALAN SECHTIN MD

CC: EDWIN L GANDY MD

Technologist: NEOSHAW MACK
Transcribed Date/Time: 04/10/2004 (1305)
Transcriptionist: RADCDV
Printed Date/Time: 01/24/2006 (0918)

NAME		SEX	ACCOUNT NUMBER
FLOYD,SCOTTIE W		M	H13945365
ORDERING PHYSICIAN	**PT. STATUS**	**LOCATION**	**MEDICAL RECORD NO.**
HEALY,R. JOSEPH JR.	UNK	UNK	H337978
ATTENDING PHYSICIAN / **DATE OF BIRTH**	**AGE**	**DATE OF EXAM**	**RADIOLOGY NO.**
	30	04/10/2004	

EXAM# TYPE/EXAM RESULT

000686237 RAD/CHEST PORTABLE
HOW IS PATIENT TRANSPORTED? P - PORTABLE
ISOLATION/PRECAUTION: S - STANDARD
OTHER EXAM: MRI - MRI
MONITORING NEEDS: 5 - CONSTANT OBSERVATION
IS PATIENT FOR SURGERY? N
REASON FOR EXAM? CONGESTION
IS X-RAY FOR PLACEMENT? N
COMMENTS: MRI OF BRAIN ALSO

PORTABLE CHEST - 04/10/04 - 0650 HOURS

HX: CONGESTION

The endotracheal tube has been removed. A nasogastric tube is seen. The tip projects below the hemidiaphragm, but is not included on the radiograph. The heart is not enlarged. The lungs are clear.

IMPRESSION: INTERVAL EXTUBATION WITH PLACEMENT OF NASOGASTRIC TUBE. THE LUNGS REMAIN CLEAR.

d: 04/10/04, 0816

Reported By: ALAN SECHTIN MD

CC: R JOSEPH HEALY JR MD

Technologist: UNKNOWN TECH
Transcribed Date/Time: 04/10/2004 (1309)
Transcriptionist: RADCDV
Printed Date/Time: 01/24/2006 (0918)

NAME		SEX	ACCOUNT NUMBER
FLOYD,SCOTTIE W		M	H13945365
ORDERING PHYSICIAN	PT. STATUS	LOCATION	MEDICAL RECORD NO.
KENT FANN FAASM,ASHLEY D	UNK	UNK	H337978
ATTENDING PHYSICIAN / DATE OF BIRTH	AGE	DATE OF EXAM	RADIOLOGY NO.
	30	04/10/2004	

EXAM# TYPE/EXAM RESULT

000686250 CT/CT- BRAIN W & W/O IV CONTRAS
HOW IS PATIENT TRANSPORTED? B - BED
CLINICAL HISTORY: SC
OTHER EXAM: N - NO OTHER EXAM TYPES
MONITORING NEEDS: 5 - CONSTANT OBSERVATION
PT'S RECENT BUN AND CREA. IF 50 YRS OR OLDER? N
ALLERGIES TO CONTRAST? NKA
MD ORDER STATES/DIAG.? CT OF HEAD WITH AND WITHOUT CONTRAST

CT SCAN OF THE BRAIN WITH AND WITHOUT CONTRAST

HX: SEIZURES

Axial images from the base of the skull to the vertex were obtained with and without intravenous contrast (100 mL of Isovue-300).

This study is compared with the previous study of 05/24/04.

As on the previous study, there is a large area of encephalomalacia in the frontal brain on the right. The basal cisterns, sulci, gyral pattern, and ventricular system are otherwise normal and stable. No mass, mass effect, or abnormal enhancement is seen.

IMPRESSION:
1. OLD AREA OF ENCEPHALOMALACIA, FRONTAL BRAIN ON RIGHT. NO ACUTE INTRACRANIAL ABNORMALITY.
2. MINIMAL MUCOSAL THICKENING IN THE MAXILLARY SINUS ON THE RIGHT WITH POSSIBLE TINY POLYP OR MUCOUS RETENTION CYST, MEASURING 9 MM.

The report was called to Dr. Kent.

d: 04/10/04, 0726

Reported By: ALAN SECHTIN MD

CC: ASHLEY DEAN KENT MD

Technologist: TAMMY NOLAN,RT
Transcribed Date/Time: 04/10/2004 (1256)
Transcriptionist: RADCDV
Printed Date/Time: 01/24/2006 (0918)

NAME			SEX	ACCOUNT NUMBER
FLOYD,SCOTTIE W			M	H14048318
ORDERING PHYSICIAN		PT. STATUS	LOCATION	MEDICAL RECORD NO.
HEALY,R. JOSEPH JR.		UNK	UNK	H337978
ATTENDING PHYSICIAN	DATE OF BIRTH	AGE	DATE OF EXAM	RADIOLOGY NO.
		30	05/05/2004	

EXAM# TYPE/EXAM RESULT

000693322 RAD/T-SPINE
HOW IS PATIENT TRANSPORTED? A - AMBULATORY
ISOLATION/PRECAUTION: S - STANDARD
OTHER EXAM: N - NO OTHER EXAM TYPES
MONITORING NEEDS: 1 - NO RISK
AREA OF INTEREST? SPINE T AND L
REASON FOR EXAM? SEIZURE DISORDER
000693323 RAD/L-SPINE
HOW IS PATIENT TRANSPORTED? A - AMBULATORY
ISOLATION/PRECAUTION: S - STANDARD
OTHER EXAM: N - NO OTHER EXAM TYPES
MONITORING NEEDS: 1 - NO RISK
AREA OF INTEREST? T SPINE AND L SPINE
REASON FOR EXAM? N
COMMENTS: IN ADM LOBBY

History: Seizure disorder.

LUMBAR SPINE: Five lumbar vertebral bodies are seen. The pedicles are intact. No spondylolisthesis or spondylolysis is seen. No acute fracture is seen.

IMPRESSION: NEGATIVE LUMBAR SPINE.

THORACIC SPINE: Twelve thoracic vertebral bodies are seen. Minimal curvature toward the right is present. There are compression fractures of T8 and T9 without displacement of the pedicles. There is approximately 40-50% loss of height of T8 and 20-30% loss of height of T9. More superiorly it is difficult to count the exact number, however, there appears to be compression deformity of what I am labeling at T3, superior end plate of T4, and T5. The bones are mildly osteopenic.

IMPRESSION: COMPRESSION DEFORMITIES IN MULTIPLE THORACIC VERTEBRAL BODIES AS ABOVE.

Report called to Dr. Healy's office at 1 p.m. and message was left for Dr. Healy to return my call with my beeper #.

D 5/5/04

NAME		SEX	ACCOUNT NUMBER
FLOYD,SCOTTIE W		M	H14048318
ORDERING PHYSICIAN	PT. STATUS	LOCATION	MEDICAL RECORD NO.
HEALY,R. JOSEPH JR.	UNK	UNK	H337978
ATTENDING PHYSICIAN	DATE OF BIRTH / AGE	DATE OF EXAM	RADIOLOGY NO.
	30	05/05/2004	

EXAM# TYPE/EXAM RESULT

000693322 RAD/T-SPINE
HOW IS PATIENT TRANSPORTED? A - AMBULATORY
ISOLATION/PRECAUTION: S - STANDARD
OTHER EXAM: N - NO OTHER EXAM TYPES
MONITORING NEEDS: 1 - NO RISK
AREA OF INTEREST? SPINE T AND L
REASON FOR EXAM? SEIZURE DISORDER
000693323 RAD/L-SPINE
HOW IS PATIENT TRANSPORTED? A - AMBULATORY
ISOLATION/PRECAUTION: S - STANDARD
OTHER EXAM: N - NO OTHER EXAM TYPES
MONITORING NEEDS: 1 - NO RISK
AREA OF INTEREST? T SPINE AND L SPINE
REASON FOR EXAM? N
COMMENTS: IN ADM LOBBY
<Continued>

T 1300
8030

Reported By: ALAN SECHTIN MD

CC: R JOSEPH HEALY JR MD

Technologist: TROY BYRD RT
Transcribed Date/Time: 05/05/2004 (1945)
Transcriptionist: XHIMCL
Printed Date/Time: 01/24/2006 (0917)

POLING,RONALD E			SEX: M	ACCOUNT NUMBER: H15883804
ORDERING PHYSICIAN: DAWSON,GEORGE R. III		PT. STATUS: UNK	LOCATION: UNK	MEDICAL RECORD NO.: H378856
ATTENDING PHYSICIAN	DATE OF BIRTH	AGE: 56	DATE OF EXAM: 07/26/2005	RADIOLOGY NO.

EXAM# TYPE/EXAM RESULT

000823468 MRI/MRI- LUMBAR SPINE W/O CONTR
HOW IS PATIENT TRANSPORTED? A - AMBULATORY
ISOLATION/PRECAUTIONS: S - STANDARD
OTHER EXAM: N - NO OTHER EXAM TYPES
MONITORING NEEDS: 1 - NO RISK
DOES PT. HAVE PACEMAKER OR INTRACRANIAL ANEURYSM CLIPS? N
IS PT. COOPERATIVE? Y
REASON FOR MRI LBP DDD
COMMENTS;

MRI- LUMBAR SPINE W/O CONTRAST

HISTORY: Low back pain.

Pain worse on the right than left at for 1-1/2 months. Sagittal T1, multiecho long TR images and axial T1 and fast spin echo T2-weighted images through L2-L3 disk space through L5-S1.

FINDINGS: There are areas of increased signal in multiple vertebral bodies on all imaging sequences most consistent with hemangiomas. The conus is in normal position and has normal signal. Vertebral body alignment is normal. There is disk dehydration at all levels from L2-L3 through L5-S1. Disk space narrowing at T11-T12 and T12-L1 is seen as well. At L2-L3, there is a diffuse broad-based bulging annulus and facet arthropathy, but no focal disk herniation or spinal stenosis. At L3-L4, there is bilateral facet arthropathy, a broad-based bulging annulus and an annular tear. The bulge is more prominent on the right than left effacing the fat in the inferior neural foramina. Small focal central protrusion is present, however, the AP diameter of the canal remains normal, although narrowed to 1.2 cm compared with 1.4 cm below this. At L4-L5, there is a small annular tear and a broad-based bulging annulus facet arthropathy and ligamentum flavum hypertrophy mildly narrowing the canal, but no sinal stenosis, as the dimension for the canal remain 1.2 x 1.7 cm. At L5-S1, no focal disk herniation seen. There is facet arthropathy.

IMPRESSION: MULTILEVEL DEGENERATIVE DISK DISEASE AND FACET ARTHROPATHY AS DESCRIBED ABOVE.

NAME		SEX	ACCOUNT NUMBER
POLING,RONALD E		M	H15883804
ORDERING PHYSICIAN	PT. STATUS	LOCATION	MEDICAL RECORD NO.
DAWSON,GEORGE R. III	UNK	UNK	H378856
ATTENDING PHYSICIAN	DATE OF BIRTH / AGE	DATE OF EXAM	RADIOLOGY NO.
	56	07/26/2005	

EXAM# TYPE/EXAM RESULT

000823468 MRI/MRI- LUMBAR SPINE W/O CONTR
HOW IS PATIENT TRANSPORTED? A - AMBULATORY
ISOLATION/PRECAUTIONS: S - STANDARD
OTHER EXAM: N - NO OTHER EXAM TYPES
MONITORING NEEDS: 1 - NO RISK
DOES PT. HAVE PACEMAKER OR INTRACRANIAL ANEURYSM CLIPS? N
IS PT. COOPERATIVE? Y
REASON FOR MRI LBP DDD
COMMENTS;
<Continued>

7/26/05 09:57
23719

Reported By: ALAN SECHTIN, M.D.

CC: GEORGE R. DAWSON III, M.D

Technologist: CATHY ERWIN RT(R)MR
Transcribed Date/Time: 07/26/2005 (1256)
Transcriptionist: XHIMRT
Printed Date/Time: 01/24/2006 (0918)

NAME		SEX	ACCOUNT NUMBER
SHULER,LINDA WOODLE		F	H16073298
ORDERING PHYSICIAN	PT. STATUS	LOCATION	MEDICAL RECORD NO.
BHAT,KRISHNA PRASAD	UNK	UNK	H392435
ATTENDING PHYSICIAN / DATE OF BIRTH	AGE	DATE OF EXAM	RADIOLOGY NO.
	51	09/08/2005	

EXAM# TYPE/EXAM RESULT

000836742 MRI/MRI- BRAIN W & W/O CONTRAST
HOW IS PATIENT TRANSPORTED? HV - HOSPITAL VAN
ISOLATION/PRECAUTION: S - STANDARD
OTHER EXAM: N - NO OTHER EXAM TYPES
MONITORING NEEDS: 4 - FREQUENT OBSERVATION
DOES PT. HAVE PACEMAKER OR INTRACRANIAL ANEURYSM CLIPS? N
IS PT. COOPERATIVE? Y
REASON FOR MRI? EVAL FOR BRAINSTEM (BASAL GANGLIIA CVA)
COMMENTS: CALL 661-3146, HOSP. VAN TO PICK WHEN READY FOR PATIENT.

MRI- BRAIN W & W/O CONTRAST 9/8/05

HISTORY: Left-sided weakness, slurred speech.

Routine pulse sequences were obtained before and after 22 cc of Magnevist. Brain volume and signal intensity are normal. The ventricles are normal in size. The cavum septum pellucidum and vergae are present. Vascular flow voids are normal. Normal pituitary and cervicomedullary junction. Attention to brain stem shows no abnormality. No abnormal enhancement following contrast. The patient appears to have had median antrostomies of both maxillary sinuses. Mild left maxillary sinus mucoinflammatory change. No abnormality in the orbits.

IMPRESSION: NEGATIVE BRAIN MRI.

9/8/05 14:31
12871

Reported By: STEVEN CREEDMAN, M.D.

CC: BHAT,KRISHNA PRASAD

Technologist: REBECCA HICKS, RT(R)MR
Transcribed Date/Time: 09/09/2005 (1047)
Transcriptionist: XHIMRT
Printed Date/Time: 01/24/2006 (0919)

McLeod
REGIONAL MEDICAL CENTER
Florence, SC 29501-0091 (843) 777-2000

Emergency Department

MEDICAL RECORDS ORIGINAL

803-750 23606

PATIENT NO.	PATIENT NAME	AGE	RC	DOB	REG DATE	REG TIME	MEDICAL RECORD NO.
106262694	FLOYD ,SCOTTIE WAYNE	29	S		07/16/04	17:10	01-03-66-37

CONDITION ON ADMISSION: ☒ STABLE ☐ GUARDED ☐ CRITICAL ER PHYS: 999979 ER, PHY UNASSI PRIVREF PHYS: 000000 SELF REFERRED

BROUGHT BY: LAW RELTOPT: M NOTIFY: FLOYD ,BETTY EMERGENCY PH:

CURRENT MEDICATIONS: Pill Depakote ER, 1 Lexapro Clonazepate

ALLERGIES: NKDA, Coconut ☐ HAND-WRITTEN ☐ DICTATED ☐ EM STATION

LAST TETANUS	LMP	WT KG/(LBS)	TEMP ORAL/RECTAL	P	R	BP	RA O2 SAT.	VISUAL ACUITY
Unknown	∅	80	98	84	20	119/76	%	∅.∅ R

TIME
HPI: Called Patient - started SEVERITY, LOCATION back brace, MODIFIERS
Called back. Need Rx to get brace DURATION, QUALITY, ASSOCIATED SYMPTOMS
getting ready to go to Virginia TIMING in Texas - Dr. Lemus-Has

PMH: Bipolar Mfg bad injury 1994-2000
PSH:
ROS: ∅ - lives w/ mother since 11
MDM:
PHYSICAL EXAM: - Call Progressive

HEAD		GI	bipolar disorder
EYES	2040: Punched wall	GU	- took old Rx
ENT	Determined by to	SKIN	Rx for by Hospital - Cash basis
NECK	(R) hand.	LYMPH	
RESP		NEURO	
CARDIO		PSYCH	
MS		CONST	

Time Ordered	TREATMENTS	Nurse Initials	Time Done
	5mg Haldol IM	MS	2032
	2mg Ativan IM		
	VO Dr. Dodard	MS	

RESULTS ++ (2040 Portable (R) hand X-ray done)
X-RAY
CT

COMMUNICATIONS

PAGE TIME	MD	REPLY TIME
1728 PM	Psychiatry on call Dr.	

Time Ordered	ULTRASOUND	Time Entered
	Pelvis LS	
	DX	
	RUQUS	
	DX	

☐ EMC Present ☐ EMC Absent

DIAGNOSIS #1: Impulsive behavior bipolar disorder DIAGNOSIS #2:

DISCHARGE STATUS: ☐ IMPROVED ☐ UNCHANGED ☐ DECEASED WORK EXCUSE: ☐ YES ☐ NO NO. OF DAYS

AFTER CARE INSTRUCTIONS FOR: ☐ HEAD INJURY ☐ CAST OR INJURED ☐ LACERATION & STITCHES REMOVE IN ____ DAYS ☐ MEDICATION & DROWSINESS

SEPARATE SHEET GIVEN FOR: ☐ PEDIATRIC ☐ BURNS ☐ BACK CARE ☐ SEE BELOW ☐ COMPUTER DC INSTRUCTIONS GIVEN AND EXPLAINED

ACCEPTED TO WAIT LIST @ BRYAN
7/16/04 10:15 PM DR. MAJOR

Form faxed to private physician. ☐

PHYSICIAN'S SIGNATURE: MD DATE TIME AM PM

The care you have received in the Emergency Department has been delivered on an emergency basis and must not be considered to be comprehensive medical care. I understand the instructions as given to me. Should I have any questions, I am to call (843)777-2027. For follow-up care you should: See Dr. _____ in ____ days.

PATIENT'S SIGNATURE: Floyd, Scottie Floyd

DIAGNOSTICS

Time Ordered	Lab Test	Time Entered
	CBC	
	BMP	
	PT	
	PTT	
	Trop I	
	U/A	
	Urine C&S	
	U Preg	
	B-HCG (Quant)	
	Wet Prep	
	Chlamydia	
	GC	
	Blood CX X2	
	ABG	
	EKG	
	LFT's	
	Lipase	
	Amylase	
	Type/Screen	
	Type/Cross ___ U's PRBC	
	Other Labs	

RADIOLOGY

Time Ordered	X-Ray CT	Time Entered
	CXR (PA/LAT)	
	CXR (Port)	
	Pelvis-X Ray	
	C-Spine Series	
	ABD Series	
	Head CT w/wo	
	DX	
	C-Spine CT	
	DX	
	ABD/Pelvis CT w/wo	
	DX	

Disposition	Time	Initials
Discharged Home	1315	SW
TBA / EMSA		
Admit		
Room#		
MD Office		
Transfer Y N		
Coroner		
Expired		
AMA		
LWBS (AMN)		
Other		

McLeod Health
Trust for Medical Excellence

106262694 01-03-66-37
FLOYD, SCOTTIE WAYNE
29 M
07/16/04

..atient History I ...sion

Room # 88

Primary Triage

Mode of Arrival: Ambulance W/C Walk Carried Stretcher
Accompanied by Police Family Member Other:

Date: 7-16-04 Time: 1705

Patient's Name: Scottie Floyd Age: 28 DOB: SS#

Emergency Contact/Relationship: Betty Floyd - m Phone #: 7 Primary Care MD: Healey

Treatment prior to arrival:

Have you been seen by a physician today?	☐Y ☐N	If yes, physician name:	
Were you referred by another physician to come to the ED?	☐Y ☐N	If yes, physician name:	
Is a McLeod Physician expecting you in the ED?	☐Y ☐N	If yes, physician name:	
Is your visit work related?	☐Y ☐N	If yes, employer name:	

Chief Complaint Onset
1. Psych eval per Dr. Healey

Initial Pain Score 0 - 10
0 1 2 3 4 5 6 7 8 9 10

Initial Priority Level: I II III IV V

Triage Interventions: ☐X-Ray ☐Labs ☐
Meds

Brief Assessment: also c/o headache seizures compressed Vertebrae. went to Dr. Healey office to see why back brace refused → states ø danger to anyone → told police would kill self now denies

Primary Triage RN: EXPOSURE RISK: ☐Y ☐N

SECONDARY TRIAGE Have you or anyone you have been in contact with traveled outside of the country? ☐Y ☐N

PAIN ASSESSMENT (REQUIRED ON ALL PATIENTS)
NONE CHEST EXTREMITY ABDOMEN HEADACHE BACKPAIN OTHER: LOCATION

ONSET: AM PM ☐Gradual ☐Sudden

QUALITY: DULL SHARP ACHING THROBBING BURNING STABBING OTHER:

INCREASES OR WORSE WITH: MOVEMENT DEEP BREATH HEAT COLD SITTING LYING WT. BEARING EATING PHYSICAL ACTIVITY OTHER:

IMPROVES WITH: HEAT COLD LYING DOWN RELAXATION MEDS OTHER:

Health History	Pt	Fam		Pt	Fam
Diabetes	N		Infectious Dz.	N	
Hypertension	N		Sickle Cell	N	
CVA/TIA	N		Anemia/Bleeding	N	
GI Disorder	N		Kidney Dz.	N	
Cardiovascular Dz.	N		Psych. Disorders	Y	
Pulmonary Dz.	Y		Alcohol/Tobacco	Y	NA
Seizures/Parkinsons	N		Illegal Drugs	Y	NA
History of Abuse	N	NA	Sexually Transmit		NA
Pacemaker	N	NA	Other		
Cancer	N		headaches		

Surgeries/Previous Hospitalization/ED Visits	Date
Knee injury	1-01

Immunizations:	Y	N	Date
Childhood UTD			
Tetanus			

Cough Screen	Y	N
Cough > 2 Weeks (complete below)		
Hemoptysis		
Hx Pos PPD		
Fatigue / Weakness		
Fever		
Night Sweats		
Weight Loss		
Pt placed in isolation		
Time placed in isolation		

Medications : None ☐ **Listed Below** ☐ **Do you take any Herbal/Vitamins or OTC Drugs?** ☐ Yes ☐ No

Name of Medication	Dose/Frequency	Date/Time of Last Dose	Name of Medication	Dose/Frequency	Date/Time of Last Dose
Depakote ER	500mg 3 PO qhs	7-15	Paxil CR	25mg	qDay
propoxy N-APAP	1-2 Q 6 hours	prn	Clorazepate	7.5mg	q8h
Keppra	500mg ½ Q 12 hours				

☐ See Medication Assessment form

Did you bring your medication with you? Yes ☐ No ☐ Medication sent home with: (Name)

Allergies/ Reactions: NKDA, coconut

Latex Allergy ☐Y ☒N
Blood Transfusion ☐Y ☐N
Transfusion Reaction ☐Y ☐N

ER Vital Signs: Temp Oral/Rectal P R BP Sitting Standing

Ht. 5'9 ☐Act. ☐Stated Wgt. 180# ☐kg ☐Act ☒lbs ☐Stated LMP (G.P.A) Pulse Ox BS Results

TRIAGE CONTINUATION ON BACK

1924 (4/04)

I06262694 01-03-66-37
FLOYD ,SCOTTIE WAYNE
29 M
07/16/04

PSYCHOSOCIAL ASSESSMENT:
Religious/Cultural Practices Relating to Care ☐ Yes ☒ No
Motor/Speech Deficit
Hearing Deficit ☐ Deaf ☐ HOH (R hearing) / WFS
Visual Deficit ☐ Blind ☐ Partial Blind ☐ Color Blindness ☐ Corrective Lenses
Primary Language English (L eye)
☐ Unable to read/write
☐ Significant other can read/write
Interpreter Notified ☐ Y ☐ N/A

Support System
☒ Family/Significant Other
☐ Lives alone

Any suspected or admitted abuse or neglect: ☐ Y ☒ N

DEVELOPMENTAL STATUS
Appropriate for age: ☐ Yes ☐ No
Head Circm (< 18 month) _____ cms
_____ wks
Birth Wt. (< 1 Yr) ____ lbs. ____ Ozs
_____ wks
Current Diet: _____ / _____

Full Term
Premature

AGE	HEAD CIRCUMFERENCE
YEAR/MONTH	CENTIMETERS
BIRTH	35
3 MONTHS	40.4
6 MONTHS	43.4
9 MONTHS	45.3
1 YEAR	46.6
18 MONTHS	47.9

Valuables ☐ Hearing Aid ☐ Cane/Crutches ☐ Purse/Wallet $ _____ / Credit Cards _____ ☐ Wheel Chair
☐ Glasses/Contacts ☐ Dentures ☐ Clothes ☐ Jewelry ☐ Prosthesis ☐ X-Rays ☐ Walker
Description: _____

☐ Patient Locker ☐ With Patient
☐ Safe (Security) Officer's Name: _____ ☐ Sent Home with (Name): _____
Patient / Family informed that hospital is not responsible for valuables. ☐ *Yes* ☐ *No*

NURSING COMMENTS/NOTES:

TIME	BP>2 YRS	PULSE			RESP	02 SAT	TEMP			PAIN	SCORE	INITIAL
								O	R			
								O	R			
								O	R			
								O	R			

POST TRIAGE CATEGORY: I II III IV V
UPGRADED ☐ Y ☐ N DOWNGRADED ☐ Y ☐ N (IF YES) REASON:
ED DATA COLLECTED BY: Laura Alexander RN
REVIEWED BY: _____ RN _____ RN @ _____ AM PM
Signature *Printed Name*

McLeod Health
The Choice for Medical Excellence.

106262694 01-03-66-37
FLOYD ,SCOTTIE WAYNE
29 M
07/16/04

Continued Emergency Department Nurses Notes **Change in pain must indicate intervention and follow up*

Time	Temp	Pulse	Resp	B/P	Pulse Ox	*Pain Score	Nurses Notes
1700						0/10	Off to recvd @ present to bathroom ambulatory - Neuro/vas wnl, remains @ hand lac, bandage intact & dressing noted — [illegible]
1800						2/10	@ cracked hand discomfort & distress noted - meds given see MAR — [illegible]
1830						1/10	Notes & pain @ present - resting in bed with [illegible] for continuous monitoring — [illegible]
1945							D/c to Hunt Burn. D.C from Dr. Hunt & given meds. results pending — [illegible]
2200							meds given & pain & hand. Stat seg & pulse. @ coop & staff. Is resting — [illegible]
2240	99.1	86	20	137/82		0/10	feeling better & meds & sandwich. @ done noted to @ thumb area from cast. 2x2 placed to area. @ rest & done & drainage & open area. encouraged to elevate arm. moves left & talking to staff. pt states he is to see psych doctor in am & decide if he can go home. @ coop. @ good BM & @ states feels better — N/Lee S/Nurse
							@ resting @ this time. & c/o. — S/Nurse
0400							resting & c/o. inc to hand — S
0550	97.1	64	20	130/74		2/10	ord. pt BSD to B&P c/o hand hurt & plast small bag noted. rec to area meds given @ coop & staff. Cont to monitor. — N/Lee S/Nurse
0650							c/o pain & wants more meds. pt have @ next pain meds. @ coop. states wants his shave. @ OOB to B&P. — N/Lee S/Nurse
0700						2/10	@ generalized discomfort - MAEW. A&Ox3 - Resp & clear & equal bilaterally noted calm & cooperative denies suicidal/homicidal ideation. Ord remains to @ hand encouraged to f extremity - bandage intact - voices @ personal needs @ present. Nurse call system active - safety remains in [illegible]
0900						1/10	Am care complete - Notes pain & @ present routine meds given see MAR - Denies A's & safety [illegible] active
0930						0/10	@ pt raced, watching TV @ present & cooperative & staff - @ distress noted - Safety remains [illegible] monitor
3:00							Vss @ pt is A&Ox3. It being explained @ pt of [illegible] papers made. It matter in her hand. Pt [illegible] examination. Pt home & mother and instructions and prescription mother and pt both understanding. AMS — [illegible]
3:15							

106262694 01-03-66-37
FLOYD, SCOTTIE WAYNE
29 M
07/16/04

McLeod Health
The Choice for Medical Excellence

Continued Emergency Department Nurses Notes *Change in pain must indicate intervention and follow up

Time	Temp	Pulse	Resp	B/P	Pulse Ox	*Pain Score	Nurses Notes
1715							Pt presents to ER c c/o needing Psych eval. PA was sent from Dr. Healey's office. Pt apparently got very angry c doctor Healey threatened to hit MD + staff. BMD called Security & Police. Police brought pt to ER for eval. pt brought to ER in cuffs. Pt very angry, states threatened & one. City Officer present. McLeod security notified @ present
1930							Pt searched by Security @ A'd into scrubs — MS
2000							Pt medicated c thioridazine. Staff. Pt moved to RM 67 — MS Pt became very volatile and hit wall c hand. MD aware orders recv'd. — MS
2130							Pt refused vital signs — MS Progressive Biomedics here to put for Black brace. Pt much calmer. — MS
2200							X-ray complete of hand. — MS ulna gutter splint on (R) hand as ordered. c 5 inch ACE wrap. Capref MS
2300							Pt resting eyes closed resp rate even non labored — MS Assumed Pt. care. Pt resting c eyes closed. Resp even & non-labored — KSM
000							Pt. cont to rest c eyes closed. Resp even and non-labored — KSM
130							Pt. cont to rest c eyes closed. Resp even and non-labored — KSM
300							Pt. cont. to rest c eyes closed. Resp. even and non-labored. 1:1 observation in progress — KSM
80							NAD noted. 1:1 observation in progress — KSM
0004	98.4	89	20	138/82			Pt. medicated per order. See MAR. Pt up to restroom. NAD noted. 1:1 observation in progress — KSM
0							Report given to K Springs, RN — KSM

106262694 01-03-66-37
FLOYD ,SCOTTIE WAYNE
29 M
07/16/04

McLeod Health
The Choice for Medical Excellence

7/16/04

Time	PO	NG	IV	Other	Time	Urine	NG	Emesis	Chest Tube	Other
300	—	—	3000ml	—						
TOTAL					TOTAL					

IV FLUIDS/BLOOD

Time	Bag #	Type	Amount	Site	Amount Infused	BY
1005	#3	#20 jelco	1000mL	(L) hand	1000mL	CLB/Started in RR
(D/C)						

Time	Medication: Drug	Dose	Route	Site	Response	Education Completed	Signature
	SEE					MAR	

Discharge Disposition Time:

☐ Home ☐ Other ___ Accompanied with ☐ Self ☐ Family ☐ EMS
Via ☐ W/C ☐ Ambulatory ☐ Stretcher ☐ Carried ☐ In Custody

☐ Pt/S.O. given and verbalized understanding of discharge instructions; document discharge instructions given

☐ Medication Education completed with patient ☐ Yes ☐ No
☐ Discharge vital signs: BP ___ P ___ R ___ T ___ Pain Score: ___

Resource Needs:
☐ None
☐ Spiritual Care
☐ Other ___
☐ Financial Counselor
☐ Pee Dee Coalition

☐ Case Manager Notified @ ___ AM PM
☐ Assistance with ADL's
☐ Assistance with medical equipment
☐ Assistance getting medications
☐ Assistance with referral: Type:

Safety
Bed in low position ☑ Yes ☐ No
Side rails up x2 ☑ Yes ☐ No
Call light within reach ☑ Yes ☐ No

Admit
Time report called: ___
Room # ___
Report to: ___
Time to floor: ___

Transported with:
☐ Monitor
☐ O2
☐ Pulse Ox
☐ RN

INITIALS	PRINTED NAME	SIGNATURE
LMS	Laura	Laura M Saunders RN
CLB	Carmen L. Birchmore, RN	Carmen L. Birchmore, RN
JT	Jaclette Tilley, CNA	Jaclette Tilley, CNA
EM	Erin S Mesa	

McLeod Health

The Choice for Medical Excellence.

106262694 01-03-66-37
FLOYD, SCOTTIE WAYNE
29 M
07/16/04

Emergency Services Nursing Assessment

Respiratory
Airway
- [X] Patent
- [ ] Intubated
- [ ] Oral/Nasal Airway
- [ ] Trach

Respirations
- [X] Normal
- [ ] Abnormal*

Breath Sounds
- L R Clear
- L R Wheezing
- L R Crackles
- L R Diminished

Cough
- [ ] Productive Color: _____
- [ ] Nonproductive

* See Additional N/N Above

Additional Notes: _____

Circulatory
Pulse
- L R Radial [X] Present [ ] Absent
- L R Radial [ ] Present [ ] Absent

Airway
- [X] Regular [ ] Irregular

Neck Veins
- [ ] Distended [X] Flat

Heart Sounds
- [X] Regular [ ] Irregular

Capillary Refill
- [X] Normal [ ] Delayed

[X] Shunt [ ] None
[X] Patent Thrill [ ] Yes [ ] No
[ ] Obstructed Bruit [ ] Yes [ ] No

Edema
- [X] Absent [ ] Present
- [ ] Pitting
- [ ] Location: _____

Additional Notes: _____

EKG Completed: _____ AM PM

EKG shown to Dr.: _____

Nurse/Tech Signature: _____

Neuro
LOC 3
- [ ] Alert/Oriented x _____
- [ ] Responds to verbal
- [ ] Unresponsive

Pupils
Right pupil reaction _____
- [ ] Brisk [ ] Sluggish
- [ ] Nonreactive

Left pupil reaction _____
- [ ] Brisk [ ] Sluggish
- [ ] Nonreactive

Extremities
- [X] Moves all extremities
- [ ] Deficit *see nurses notes

Speech
- [X] Clear [ ] Slurred
- [ ] Aphasia

[ ] For any abnormals start neuro flow sheet

Pediatric (18 mos & <)
LOC
- [ ] Alert/Oriented x _____
- [ ] Responds to verbal
- [ ] Lethargic
- [ ] Irritable
- [ ] Shrill Cry

Anterior Fontanel
- [ ] Soft [ ] Full
- [ ] Tense [ ] Sunken
- [ ] Bulging [ ] Closed
- [ ] Flat

2 3 4 5 6 7 8

Integumentary
Temp
- [X] Normal [ ] Cold
- [ ] Hot [ ] Diaphoretic

Color
- [X] Normal [ ] Jaundiced
- [ ] Cyanotic [ ] Pale
- [ ] Other: _____

Breakdown
- [ ] Present [X] Absent
- [ ] Location (Note on figure)

Trauma
Present [X] Absent
Location (Note on figure)

Mucous Membranes
- [X] Moist
- [ ] Dry
- [ ] Sticky

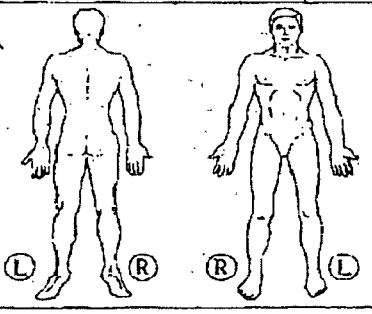


Figure Legend
(Include Size in Centimeters)
A = Abrasion
C = Contusion
L = Laceration
P = Decreased Pain
T = Tenderness
SW = Stab Wound
LS = Sutured
OPEN = Open Fracture
Amp = Amputation
GSW = Gunshot Wound
CFX = Closed Fracture
BS = Burns
BSA % = ___
PAR = Paralysis
S = Decreased Sensation

Mode of arrival: ambulated
Time in room: 1715
Room number: 88

Home Aids
- [ ] Pic Line
- [X] None
- [ ] Peg Tube
- [ ] Ventilator
- [ ] Colostomy
- [ ] Tenk-Off
- [ ] Ash/Split Cath
- [ ] Port-a-Cath
- [ ] Other: _____

GU
- [ ] Flank Pain
- [X] Denies Complaint
- [ ] Left
- [ ] Right
- [ ] Dysuria
- [ ] Frequency
- [ ] Urgency
- [ ] Hematuria
- [ ] Other: _____

Penile Discharge [ ] None
- [ ] Present
- Color: _____

GYN
Bleeding [ ] Denies Complaint
Number of Pads per hour: _____
Vaginal Discharge
Color _____
Odor [ ] Yes [ ] No
LMP N/A
Preg/Delivery Date: _____
FHT _____
G _____
P _____
A _____

Psychosocial
Affect
- [ ] Flat
- [ ] Normal

Behavior
- [ ] Cooperative
- [X] Uncooperative
- [ ] Other: _____

Additional Notes:
pt angry

GI
- [ ] Nausea
- [ ] Vomiting
- [ ] Diarrhea
- [ ] Loss of appetite denies
- [ ] Home diet: _____

Bowel Sounds
- [ ] Present
- [ ] Absent

Abdominal
- [ ] Normal [ ] Tenderness
- [ ] Distended
- [ ] Guarded (Location) _____
- [ ] Rigid
- [ ] Last BM _____

We are routinely screening for domestic violence. Have you been hit, kicked, verbally or sexually abused by a family member or significant other?
- [ ] Yes [X] No

Do you want help with this today?
- [ ] Yes [ ] No

If yes, contact DCP/SS

Pediatric:
- [ ] See Pediatric Developmental Age Assessment
- [X] Not Applicable 15 years or > use adult assessment form only

Psychiatric
Ideations [ ] None
- [ ] Harm to self
- [ ] Harm to others

Hallucinations [X] None
- [ ] Auditory
- [ ] Visual

Restraints/Seclusions
- [ ] Yes [X] No

If yes, see seclusion flowsheet

Forensic Restraints
- [ ] Yes [ ] No

If yes, police officer must be present

Security Notified
- [ ] Yes [ ] No

Patient searched
- [X] Yes [ ] No

If yes, searched by whom: Specialty tm

Initial Nurses Signature:

Shaunders RN

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

106262694 01-03-66-37
FLOYD, SCOTTIE WAYNE
29 M
07/16/04

PROGRESS RECORD

ADDRESSOGRAPH

DATE	TIME	Note Progress of case, complications, changes in diagnosis, condition on discharge, instructions to patient
7/21/04		15'
		Pt seen: He continues to do well. He has been cooperative w. staff and has not had any acting-out behaviors. He reports that he is willing to follow up c new med Zyprexa & that he plans to go to Jayram as scheduled. Pt states he expects his charges last week & that he is not going to hurt anyone. He was very pleasant & cooperative in our interaction. Will drop commitment. Jarvis Ellerson
7/22/04	12:15pm	Discussed w/ original Commitment papers placed in mail to Pinelotte County Manor CO & received/placed in mail discharged from Chris Nelson Melvin Ellerson, APRN, BC

Seq. #1201

McLeod Health
The Choice for Medical Excellence

106262694 01-03-66-37
FLOYD ,SCOTTIE WAYNE
29 M
07/16/04

Continued Emergency Department Nurses Notes *Change in pain must indicate intervention and follow up

Time	Temp	Pulse	Resp	B/P	Pulse Ox	*Pain Score	Nurses Notes
2000	99.3	66	16	127/77			Report received from Jacqui RN. Alert & oriented x 3 amb to BR. NAD noted. V/S assessment BP 127/77. Pulse R 66, T 99.3 ® cap refill less than 2 sec in fingers on ® hand, ® hand warm & edema to fingers denies pain in hand ® movement in fingers ® sensation to fingers in ® hand.
2100							C/O back pain. Pain med given. Sitter in place. Pt on phone & mother.
2315							Report to J. Ivey RN.
0015	on/color						Resting quietly, sleeping soundly but easily arousable. No c/o's noted or distress noted. Call light & in easy reach. Observation in progress.
0200							Resting & quietly sleeping & c/o's noted or distress noted. Call light & in easy reach. Observation continues.
0430							Sleeping & c/o's noted or distress noted. Observation continues. Call light & in easy reach.
0600							Continues to sleep & c/o's noted or distress noted. Call light & in easy reach. Observation in progress & all items at this shift.
0710						0/10	Awake - Alert & oriented x 3. MAEW - Cap refill to ® hand wnl - Manual cuffs noted - Behaviors noted reflect cooperative & staff. Speech clear - Lungs clear. Denies suicidal & homicidal ideation @ present - Voices & personal needs @ present - Call light & active - Sitter remains in continuous monitor
0800						3/10	@ headache - Meds given see MAR - Breakfast tray @ bedside. Cardiac D's noted
1000						7/10	Back pain & @ present - Request another med for pain & rest - See MAR & personal needs voiced & @ voiced last in bed. Each q voiced when spoken to - Call system active. Sitter remains in room
1130						9/10	
1215						0/10	Cardiac D's noted - MAEW - @ personal needs voiced - @ c/o voiced - A&Ox3 - remains cooperative & staff. Denies suicidal ideations
1515						0/10	Pt in room resting quietly in bed @ c/o voiced. Watching TV @ present time. Call system active. Sitter remains in continuous monitor

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

106262694 01-03-66-37
FLOYD ,SCOTTIE WAYNE
29 M
/16/04

NURSES' BEDSIDE RECORD

DATE	HOUR	NOTES & TREATMENTS	SIGNATURE
7/19/04	1505	Spoke c AB Green @ Tanger Pescara	
		Avenue Behavioral Center - Notes	
		acceptance pend insurance approval -	
		Referred to Melody Harris insurance	
		dept @ 803-772-9192 FAX (803) 750-2346	
		Attended to return call in ADM	
		for update - Chart copy faxed to	
		Columbia per release authorization	
		Pt compliant - Acute A's noted -	
	1700	Lest, NAD noted MAEw - continues	
		to ↑ RUE for edema - O2 varied	
		Call system active - bed remains	
		low monitor -	
	1800	Q 1 pm ↓ hard Meds given	
		see MAR - Voices & other ↓ present	
		Dr Tawa in for visit Pt Calm/Cooperative	
		Consent papers reviewed Pt updated	
		Acute A's noted -	
	1845	Bed, Acute A's Lest remains	
		low Continuous Monitor - Call	
		System active -	

Seq. #1185

McLeod Health
The Choice for Medical Excellence

106262694 01-03-66-37
FLOYD ,SCOTTIE WAYNE
29 M
07/16/04

Continued Emergency Department Nurses Notes **Change in pain must indicate intervention and follow up*

Time	Temp	Pulse	Resp	B/P	Pulse Ox	*Pain Score	Nurses Notes
07/16/04							Resting quietly c Mother @ bedside
2100							Requesting pain med for HA and pain
							in stomach. Willing to eat. VSS WNL
							Call light c in easy reach. Observation
							continues in progress. — Dewayne
2300							Sleeping soundly c @ comfort.
							Turn q hours. No c/o pain noted or
							distress noted. Call light c in easy
							reach. Observation continues q hr
							— Dewayne
0100							Sleeping soundly. Quiet at this
							time. Call light c in easy reach.
							Observation in progress. — Dewayne
0300							Resting quietly c eyes closed. No
							visible distress noted. VSS WNL. Comfort
							measures @ hand. Turn q hours. Call light
							c in easy reach. Observation
							continues in progress. — Dewayne
0345							Pain med given per request.
							C/o pain in back, head — @ hand.
0600							Resting quietly. Sleeping @ times.
							Comfort measures @ times. Call
							light c in easy reach. — Dewayne
0700						0/10	C/o pain @ present. Cap noted @ L hand.
							IV site @ R hand catheter intact - pressure applied
							to site. Dressing dry & intact. Resp even
							unlabored. Hemovac draining - Serosanguineous
							c/o. Staff - Behavior noted calm - Call light within
							site. Remains in bed. Safety measures
0900						0/0	in place. Complete Vascular Assessment noted @ hand
							upon admission. Skin warm, dry, pink. Capillary
							refill less than 3 sec. Instructed pt to report
							any pain, tingling, numbness, coldness. Verbalized
1100						0/0	understanding. Pupils PERRL - 3 mm c brisk reaction.
							Pt c/o HA. Eyes closed. Resp even, unlabored.
							Call light within reach. Safety measures in place.
1300						0/10	Pt remains in bed. Pupils PERRL - 3 mm c brisk
							reaction. Eyes closed. Resp even, unlabored.
							Call light within reach. Safety measures in place.
1500						1/0	Pt ambulated to BR c steady gait. Urine
							clear, yellow. Voided 300 cc. Returned to bed.
							Call light within reach. Safety measures in
1700						3/10	place. Pain @ present @ multiple sites -
							HA, back, abdomen, incision. Resp even,
							unlabored. Skin warm, dry, pink. Pupils
							PERRL - 3 mm c brisk reaction. Call light
							within reach. Safety measures in place.
							Continue to monitor.

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

106262694 01-03-66-37
FLOYD ,SCOTTIE WAYNE
29 M
07/16/04

NURSES' BEDSIDE RECORD

DATE	HOUR	NOTES & TREATMENTS	SIGNATURE
7/18/04	1505	100% of meal eaten. C/o pain (9/10). Meds given. Tol well.	Carmen J. Birchmore, RN
7/18/04	1600	VSS. BP 102/55, HR 64, Resp. 20, Temp. 97.0°. NAD noted.	Carmen J. Birchmore, RN
7/18/04	1610	Security in to wand search pt.	Carmen J. Birchmore, RN
7/18/04	1705	Called Bryan Psychiatric Hospital Spoke to Russell McLeod. Pt. on waiting list. Possible bed availability on ~~Fri. 7/2~~ (NB) Wed. 7/21/04	Carmen J. Birchmore, RN
7/18/04	1800	Meds given. Tol well.	Carmen J. Birchmore, RN
7/18/04	1600 Late Entry	Meds held due to AM med being delayed. Will administer at 1800	Carmen J. Birchmore, RN
7/18/04	1825	Report given to Janette Ivey, LPN	Carmen J. Birchmore, RN
07/18/04	1930	Resting Quietly Watching T.V. @ Intervals. No C/O's Voiced or Distress Noted. Call light & urn bell reach Observation in Progress	J. Dumpert

Seq. #1185

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

106262694 01-03-66-37
FLOYD ,SCOTTIE WAYNE
29 M
07/16/04

NURSES' BEDSIDE RECORD

DATE	HOUR	NOTES & TREATMENTS	SIGNATURE
7/18/04	0635	OR called to prep pt. meds given per order. CAOx3 & Coop. IVF d/c'd per order. Chart of prep meds. Ctd to mar.	Deb Stults
—	0636	BP 106/68 - HR 66 - R 16 - 98.0	—
7/18/04	0700	Report received from Deb Stults, RN.	Carmen G. Birchmore, RN
7/18/04	0715	To OR via stretcher. CAOx3. Security c pt.	Carmen G. Birchmore, RN
7/18/04	1005	Back in room CAOx3 VSS BP 109/58, HR 71, Resp. 20, Temp. 97.0°.	Carmen G. Birchmore, RN
7/18/04	1040	(R) Arm elevated on pillows. Ice to (R) arm. Apple juice given to pt. Tol well.	Carmen G. Birchmore, RN
7/18/04	1125	Security in to search pt.	Carmen G. Birchmore, RN
7/18/04	1200	Pt's mother took belongings home c pt's permission	Carmen G. Birchmore, RN
7/18/04	1100 late Entry	Dr. Woolery in to see pt.	Carmen G. Birchmore, RN
7/18/04	1215	VSS. BP 95/50, HR 52, Resp. 20, Temp. 97.6° NAD noted. CAOx3.	Carmen G. Birchmore, RN
7/18/04	1310	C/o pain (9/10). Meds given Tol well	Carmen G. Birchmore, RN

Seq. #1185

106262694 01-03-66-37
FLOYD ,SCOTTIE WAYNE
29 M
07/16/04

McLeod Health
The Choice for Medical Excellence

Continued Emergency Department Nurses Notes **Change in pain must indicate intervention and follow up*

Time	Temp	Pulse	Resp	B/P	Pulse Ox	*Pain Score	Nurses Notes
0720							pt ambulating to BR. Calm + cooperative NAD noted — RS
0820	97	65	20	102/64			Breakfast tray offered to pt. pt refused breakfast. Lying in room c lights off. NAD noted — RS
0905							Dr. Spohn here to see pt — RS
1000							pt sleeping in bed. Resp even + nonlabored. MD orders received + noted — RS
1100							Dr. Woolery here to see pt — RS
1100							Report received given to Tunstall RS
1200	98°	59	18	105/64		10/10	Alert, c/o back pain, brace. NAD noted. Mother in room. — (2)
1245							Pg ed Dr. Spohn regard OR consent. Sitter in place. — (2)
1300							Spoke Dr. Spohn regarding consent. Explained to pt + mother positioning 4th + 5th lumbar in Rhanol + pinning, mother signed consent. Pt gone to shower c security (2)
1400	97	57	18	108/57			Ruptured lumbar. Back brace on resting c eyes close, resp even + unlabored. No need to admit pt post-op per Penny, NP/PCS per Dr. Spohn. Sitter in place. — (2)
1600							Resting c eyes closed, resp even + unlabored. Sitter in place. — (2)
1800							Completed supper c difficulty. Lying down resting c eyes closed, resp even + unlabored. NAD noted — (2)
2000	97	61	20	103/64		9/10	c/o HA, MD aware, pain med ordered. Calm + cooperative. F20 6cm. Security search McClendon. Visitor in room. Sitter in place. — (2)
2100							Pt aware of MD, electrolytes ordered, nothing PO pt per MD. — (2)
2200							Reports HA gone. Instructed to lie down + rest. Sitter in place. — (2)
2300							Report to Deb Stutts RN. — (2)
0020		62	18	104/70		0/10	PT moved to Room 88. DVE started per orders. Pt, Corp c staff. 1:1 monitor cont. — (2)
0230							Back Brace on. Pt resting. DVE per orders — Cont to monitor — plus Steer
0400							VSS resting well — n/Steer

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

106262694 01-03-66-37
FLOYD ,SCOTTIE WAYNE
29 M
07/16/04

PHYSICIAN'S ORDER SHEET

Drug Sensitivity

1 NKDA	2 Coconut	3	Height: 5'9"
4	5	6	Weight: 180 lbs

Tuno 88

DATE: 7/20/04
TIME: 1500 AM (PM)
NRS. NOTED
TIME:
AM PM

- Apply Nicotine patch 21mg topically Q24°
V.O. Dr T. Lewis /LaDonna

DOCTOR SIGN & DATE HERE>

DATE: 7/20/04
TIME: 1950 AM PM
NRS. NOTED
TIME: 1950 7/20/04 AM PM

Maalox 30ml PO PRN
V.O. Dr Lewis /LPStuart

DOCTOR SIGN & DATE HERE>

DATE: 7/21/04

7/21/04, 10K to D/C per Orthopaedics
21 If patient does not go to Texas, Followup Next Tuesday W/ Dr Gohn

TIME:
AM PM
NRS. NOTED
TIME:
AM PM

DOCTOR SIGN & DATE HERE>

Seq#1198 Rev 11/02

Eric L Mellon 7-21-04 @ 12:00 pm

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

Scotty Floyd

106262694 01-03-66-37
FLOYD, SCOTTIE WAYNE
29 M
07/16/04

PHYSICIAN'S ORDER SHEET

Drug Sensitivity

1 NKDA	2 Coconut	3	Height: 5'9"
4	5	6	Weight: 180 lbs

DATE: 18 July 04

TIME: AM PM

1| D/C from RR back to ER 68

2| F/U Orthopaedics Texas x 2 weeks

DOCTOR SIGN & DATE HERE>

DATE:

TIME: AM PM

3(X Ray R Hand 2 Views

NRS NOTED

TIME: 1005

AM PM

< Noted 7/18/04 1005 Carmen J. Tomlinson RN

DOCTOR SIGN & DATE HERE>

DATE: 19 July 04

TIME: 1400 AM PM

- D/C Vicodol 30mg IV
- D/C saline lock
- Vicodol 60mg IM Q8° PRN Pain
V.O. Dr Lawell/Foster

NRS. NOTED

TIME.

AM PM

DOCTOR SIGN & DATE HERE>

Seq#1198 Rev 11/02

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

106262694 01-03-66-37
FLOYD ,SCOTTIE WAYNE
29 M
07/16/04

PHYSICIAN'S ORDER SHEET

Drug Sensitivity

1	2	3	Height:
4	5	6	Weight:

DATE: 7/17

Zyprexa 5 mg po TID.
Lopahrete level - 1144

TIME:
AM PM

NRS. NOTED

TIME:
AM PM

FAX TO PHARMACY 511

7/18/04 @ 0400

DOCTOR SIGN & DATE HERE>

DATE: 7/17/04

Zinacef 750 mg IV q8 hours PRN
V.O. Dr. Bedard / B Wyatt, RD

TIME: 2100
AM PM

FAX TO PHARMACY

NRS. NOTED

TIME: 2100
AM PM

DOCTOR SIGN & DATE HERE>

DATE:

TIME:
AM PM

NRS NOTED

TIME:
AM PM

DOCTOR SIGN & DATE HERE>

Seq#1198 Rev 11/02

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

106262694 01-03-66-37
FLOYD ,SCOTTIE WAYNE
29 M
07/16/04

PHYSICIAN'S ORDER SHEET

Drug Sensitivity

1	2	3	Height:
4	5	6	Weight:

DATE: 7/16/04

TIME: 2100 AM (PM)

NRS. NOTED

TIME:

AM PM

1) Ulnar Gutter Splint (R) hand - done
2) Orthopedic consult in a.m. - Reason: Fx 4th + 5th Metacarpal (R) Dr. Sporn By: Edwards spec Pain @ post OK 46
3) Haldol 5mg IM TID PRN agitation
4) Ativan 2mg IM TID PRN agitation

DOCTOR SIGN & DATE HERE> [signature]

FAX TO PHARMACY

DATE: 7/17/04

TIME:

AM PM

1) NPO after Midnight
2) After Midnight, IV NS @ 80cc/hr
3) May have Med c tiny sip H2O
4) Consent
Closed Reduction and Percutaneous Pinning R Hand 4th and 5th Metacarpal Base Fractures
5) Ancef 1gram IVPB on Call to OR

NRS. NOTED

TIME:

AM PM

DOCTOR SIGN & DATE HERE> [signature]

FAX TO PHARMACY

Seq#1198 Rev 11/02

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

106262694 01-03-66-37
FLOYD ,SCOTTIE WAYNE
29 M
07/16/04

PHYSICIAN'S ORDER SHEET

Drug Sensitivity

1	2	3	Height:
4	5	6	Weight:

Directions: 1. Mark through the item you do not wish to order
2. Indicate choice when options are available by placing a check (✓) in the parenthesis

Date/Time	ORDERS FOR INTERIM PSYCHIATRIC PATIENT — PAGE 1 OF 1
	(Patient waiting for admission to psychiatric inpatient unit)
	1. Urine drug screen 1950 dow
	2. Consult Psychiatric Nurse Liaison for needs assessment and individualization of treatment plan.
	3. Diet: Regular 1950
	( ) Disposable Tray
	4. Monitor Vital signs every 2 hours while awake. BP & Pulse 30 min after any PRN med.
	5. Activity: Per Nursing
	6. Patient ( ) may smoke
	(✓) may not smoke
	7. Continue following medications:
	See MAR
	8. Assess potential for drug or alcohol withdrawal and notify physician if prevention protocol may be indicated. Observation Status:
	(X) 1:1 Observation, Sitter needed
	( ) Special Observations, q 15 min. visualization and nurse to document q 2 hours
	( ) Routine Observations, q 30 min. visualization and nurse to document q 2 hours
	9. Initiate Interim Psychiatric Treatment Plan
	Consult Progressive Biomechanics 200 to get pt fitted for Northshelter cash brace which has a help kill back pain since T-spine fx (week ago (per Dr Healey)

Physician's Signature: _____ Date: _____

PPO-267
Created: 7/02

McLeod REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

ALLERGIES NO KNOWN ALLERGIES\

DISCONTINUED MEDICATIONS ARE HIGHLIGHTED IN YELLOW

DATE: 07/21/04 | DATE: 07/22/04

SCHEDULED MEDICATIONS ***

START DATE				STOP DATE	
07/16	TRANXENE UNIT DOSE	TAB	BFL	RPh	
	CLORAZEPATE DIPOTASSIUM	7.5 MG/1 TAB			PO
GIVE 7.5 MG = 1 TAB	EVERY EIGHT HOURS				
PT#: 0001062626894				ORD#: 4	

7A	8A	9A	10A	11A	12P	1P	2P	3P	4P	5P	6P
						00					
7P	8P	9P	10P	11P	12A	1A	2A	3A	4A	5A	6A
		00								00	

START DATE				STOP DATE	
07/16	DEPAKOTE ER TAB	SR TAB	BFL	RPh	
	DIVALPROEX SODIUM	500 MG/1 SR TAB			PO
GIVE 1500 MG = 3 SR TAB	AT BEDTIME DAILY				
PT#: 0001062626894				ORD#: 1	

7A	8A	9A	10A	11A	12P	1P	2P	3P	4P	5P	6P
7P	8P	9P	10P	11P	12A	1A	2A	3A	4A	5A	6A
		00									

START DATE				STOP DATE	
07/16	KEPPRA	TAB	BFL	RPh	
	LEVETIRACETAM	250 MG/1 TAB			PO
GIVE 750 MG = 3 TAB	EVERY 12 HOURS				
PT#: 0001062626894				ORD#: 4	

7A	8A	9A	10A	11A	12P	1P	2P	3P	4P	5P	6P
		00									
7P	8P	9P	10P	11P	12A	1A	2A	3A	4A	5A	6A
		00									

START DATE				STOP DATE	
07/20	HABITROL TDS	PATCH	DRW	RPh	
	NICOTINE	21 MG/24 HR			TOP
GIVE 21 MG = 24 HR	EACH DAY				
PT#: 0001062626894				ORD#: 17	

7A	8A	9A	10A	11A	12P	1P	2P	3P	4P	5P	6P
		00									
7P	8P	9P	10P	11P	12A	1A	2A	3A	4A	5A	6A
		00									

START DATE				STOP DATE	
07/17	ZYPREXA UNIT DOSE	TAB	JD2	RPh	
	OLANZAPINE	5 MG/1 TAB			PO
GIVE 5 MG = 1 TAB	THREE TIMES A DAY				
PT#: 0001062626894				ORD#: 8	

7A	8A	9A	10A	11A	12P	1P	2P	3P	4P	5P	6P
		00							00		
7P	8P	9P	10P	11P	12A	1A	2A	3A	4A	5A	6A
		00									

START DATE				STOP DATE	
07/16	PAXIL UNIT DOSE	TAB	BFL	RPh	
	PAROXETINE HCL	20 MG/1 TAB			PO
GIVE 20 MG = 1 TAB	EACH DAY				
	THERAPEUTIC SUBSTITUTION FOR PAXIL CR 25MG QD				
PT#: 0001062626894				ORD#: 5	

7A	8A	9A	10A	11A	12P	1P	2P	3P	4P	5P	6P
		00									
7P	8P	9P	10P	11P	12A	1A	2A	3A	4A	5A	6A

START DATE				STOP DATE	
				RPh	
GIVE					

7A	8A	9A	10A	11A	12P	1P	2P	3P	4P	5P	6P
7P	8P	9P	10P	11P	12A	1A	2A	3A	4A	5A	6A

PRN PAIN MEDICATIONS ***

START DATE				STOP DATE	
07/18	HALDOL	AMP	LBJ	RPh	
GIVE HALOPERIDOL LACTATE	5 MG/1 ML				IM
5 MG = 1 ML	3 TIMES DAILY AS NEEDED				
FOR AGITATION					
EQUIVALENT TO HALDOL					
PT#: 0001062626894				ORD#: 10	

7A	8A	9A	10A	11A	12P	1P	2P	3P	4P	5P	6P
7P	8P	9P	10P	11P	12A	1A	2A	3A	4A	5A	6A

START DATE				STOP DATE	
07/20	TORADOL	TUBEX	NN	07/25	
	KETOROLAC TROMETHAMINE	30 MG/1 ML		RPh	IM
30 MG = 1 ML	EVERY 6 HOURS AS NEEDED				
FOR SEVERE PAIN					
FOR PT DAS VG	RECOMM: DOSE IS 15 MG Q6H				
PT#: 0001062626894				ORD#: 15	

7A	8A	9A	10A	11A	12P	1P	2P	3P	4P	5P	6P
7P	8P	9P	10P	11P	12A	1A	2A	3A	4A	5A	6A

SITE CODES	
1 - LT. DELTOID	7 - RT. LATERALIS
2 - RT. DELTOID	8 - LT. LATERALIS
3 - RT. ARM	9 - LT. VENTROGLUTEAL
4 - LT. ARM	10 - RT. VENTROGLUTEAL
5 - RT. GLUTEUS	11 - RT. ABDOMEN
6 - LT. GLUTEUS	12 - LT. ABDOMEN

OMISSION CODES	SITE OF PAIN
R - REFUSED	A
V - VOMITING/ NAUSEATED	B
N - NPO	C
O - OTHER	

SIGNATURE | INIT. | SIGNATURE | INIT.

DF71500708 (08/98) BMS

PATIENT #: 0001062626894ROOM: IU8801MED RECORD #: 1038637
FLOYD, SCOTTIE WAYNE AGE 29Y SEX M PAGE 1 OF

eod

MEDICATION ADMINISTRATION RECORD

ALLERGIES NO KNOWN ALLERGIES

DISCONTINUED MEDICATIONS ARE HIGHLIGHTED IN YELLOW

DATE 07/21/06 | DATE: 07/22/06

START DATE	STOP DATE					
*** PRN MEDICATIONS ***						
07/19 ATIVAN		INJ	LBJ	RPh		
LORAZEPAM		2 MG/1 ML			IM	
Give 2 MG = 1 ML		3 TIMES DAILY AS NEEDED				
FOR AGITATION						
PT#: 000106826894					ORD#: 11	
07/20 MAALOX U/D		SUSP	DRP	RPh		
MAGNESIA-ALUMINA		30 ML/1 CUP			PO	
Give 30 ML = 1 CUP		@ AS NEEDED				
HOSPITAL ANTACID USED FOR MAALOX MYLANTA						
PT#: 000106826894					ORD#: 18	
07/18 PERCOCET 5/325 UNIT DOSETAB			DRW	RPh		
OXYCODONE/ACETAMINOPHEN 5 1 TAB/1 TAB					PO	
Give 1 TAB = 1 TAB		EVERY 4-6 HOURS AS NEEDED				
PERCOCET CONTAINS ACETAMINOPHEN - 325MG & OXYCODONE						
PT#: 000106826894					ORD#: 12	
07/19 PERCOCET 5/325 UNIT DOSETAB			DRW	RPh		
OXYCODONE/ACETAMINOPHEN 5 1 TAB/1 TAB					PO	
Give 2 TAB = 2 TAB		EVERY 4-6 HOURS AS NEEDED				
PERCOCET CONTAINS ACETAMINOPHEN - 325MG & OXYCODONE						
PT#: 000106826894					ORD#: 13	
07/16 PROPOXYPHENE NAPSYLATE/ATAB			BFL	RPh		
PROPOXYPHENE NAPSYLATE/AP 1 TAB/1 TAB					PO	
Give 1 TAB = 1 TAB		EVERY SIX HOURS AS NEEDED				
DARVOCET CONTAINS ACETAMINOPHEN 650MG & PROPOXYPHENE						
PT#: 000106826894					ORD#: 2	
07/16 PROPOXYPHENE NAPSYLATE/ATAB			BFL	RPh		
PROPOXYPHENE NAPSYLATE/AP 1 TAB/1 TAB					PO	
Give 2 TAB = 2 TAB		EVERY SIX HOURS AS NEEDED				
DARVOCET CONTAINS ACETAMINOPHEN 650MG & PROPOXYPHENE						
PT#: 000106826894					ORD#: 3	
				RPh		
Give						
				RPh		
Give						
				RPh		
Give						

SITE CODES	
1 - LT. DELTOID	7 - RT. LATERALIS
2 - RT. DELTOID	8 - LT. LATERALIS
3 - RT. ARM	9 - LT. VENTROGLUTEAL
4 - LT. ARM	10 - RT. VENTROGLUTEAL
5 - RT. GLUTEUS	11 - RT. ABDOMEN
6 - LT. GLUTEUS	12 - LT. ABDOMEN

OMISSION CODES	SITE OF PAIN	SIGNATURE	INIT.	SIGNATURE
R - REFUSED	A			
V - VOMITING/ NAUSEATED	B			
N - NPO	C	Ruby Shuster		
O - OTHER				

PATIENT #: 000106826894 ROOM: IUBB61 MED RECORD #: 1036637
FLOYD, SCOTTIE WAYNE AGE 29Y SEX M PAGE 2 O

DF71500708 (09/99) SWG

McLeod Regional Medical Center

MEDICATION ADMINISTRATION RECORD

ALLERGIES NO KNOWN ALLERGIES

DISCONTINUED MEDICATIONS ARE HIGHLIGHTED IN YELLOW

DATE: 07/20/04 | DATE: 07/21/04

*** SCHEDULED MEDICATIONS ***

07/16 TRANXENE UNIT DOSE TAB BFL RPh
CLORAZEPATE DIPOTASSIUM 7.5 MG/1 TAB PO
Give 7.5 MG = 1 TAB EVERY EIGHT HOURS
PT#: 0001062626974 ORD#: 6

07/16 DEPAKOTE ER TAB SR TAB BFL RPh
DIVALPROEX SODIUM 500 MG/1 SR TAB PO
Give 1500 MG = 3 SR TAB AT BEDTIME DAILY
PT#: 0001062626974 ORD#: 1

07/16 KEPPRA TAB BFL RPh
LEVETIRACETAM 250 MG/1 TAB PO
Give 750 MG = 3 TAB EVERY 12 HOURS
PT#: 0001062626974 ORD#: 4

07/17 ZYPREXA UNIT DOSE TAB JD2 RPh
OLANZAPINE 5 MG/1 TAB PO
Give 5 MG = 1 TAB THREE TIMES A DAY
PT#: 0001062626974 ORD#: 9

07/16 PAXIL UNIT DOSE TAB BFL RPh
PAROXETINE HCL 20 MG/1 TAB PO
Give 20 MG = 1 TAB EACH DAY
THERAPEUTIC SUBSTITUTION FOR PAXIL CR 25MG QD
PT#: 0001062626974 ORD#: 5

Toradol 60 mg IM Q8° PRN

*** PRN MEDICATIONS ***

07/18 HALDOL AMP LBJ RPh
Give HALOPERIDOL LACTATE 5 MG/1 ML IM
5 MG = 1 ML 3 TIMES DAILY AS NEEDED
FOR AGITATION
EQUIVALENT TO HALDOL
PT#: 0001062626974 ORD#: 10

07/18 TORADOL TUBEX LAH 07/24 RPh
Give KETOROLAC TROMETHAMINE 30 MG/1 ML IV
30 MG = 1 ML EVERY 6 HOURS AS NEEDED
FOR PT >65 YRS OR <50 KG MAXIMUM DOSE 15 MG EVERY 6H
PT#: 0001062626974 ORD#: 25

07/18 ATIVAN INJ LBJ RPh
Give LORAZEPAM 2 MG/1 ML IM
2 MG = 1 ML 3 TIMES DAILY AS NEEDED
FOR AGITATION
PT#: 0001062626974 ORD#: 11

SITE CODES	OMISSION CODES	SITE OF PAIN	SIGNATURE	INIT.
1 - LT. DELTOID, 2 - RT. DELTOID, 3 - RT. ARM, 4 - LT. ARM, 5 - RT. GLUTEUS, 6 - LT. GLUTEUS, 7 - RT. LATERALIS, 8 - LT. LATERALIS, 9 - LT. VENTROGLUTEAL, 10 - RT. VENTROGLUTEAL, 11 - RT. ABDOMEN, 12 - LT. ABDOMEN	R - REFUSED, V - VOMITING/NAUSEATED, N - NPO, O - OTHER	A, B, C		

PATIENT #: 0001062626974 ROOM: IUB MED RECORD #: 1036637
FLOYD, SCOTTIE WAYNE AGE 27Y SEX M PAGE 1 OF

DF71500705 (08/04) 6MS

McLeod REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

ALLERGIES NO KNOWN ALLERGIES\1

DISCONTINUED MEDICATIONS ARE HIGHLIGHTED IN YELLOW

DATE 07/20/04 | DATE 07/21/04

*** PRN MEDICATIONS ***

START DATE | STOP DATE | RPh | 7A 8A 9A 10A 11A 12P 1P 2P 3P 4P 5P 6P | 7P 8P 9P 10P 11P 12A 1A 2A 3A 4A 5A 6A

07/18 PERCOCET 5/325 UNIT DOSETAB DRW PO
OXYCODONE/ACETAMINOPHEN 5 1 TAB/1 TAB
Give 1 TAB = 1 TAB EVERY 4-6 HOURS AS NEEDED
PERCOCET CONTAINS ACETAMINOPHEN - 325MG & OXYCODONE
PT#: 000106262694 ORD#: 12

07/18 PERCOCET 5/325 UNIT DOSETAB DRW PO
OXYCODONE/ACETAMINOPHEN 5 1 TAB/1 TAB
Give 3 TAB = 2 TAB EVERY 4-6 HOURS AS NEEDED
PERCOCET CONTAINS ACETAMINOPHEN - 325MG & OXYCODONE
PT#: 000106262694 ORD#: 13

07/16 PROPOXYPHENE NAPSYLATE/ATAB BFL PO
PROPOXYPHENE NAPSYLATE/AP 1 TAB/1 TAB
Give 1 TAB = 1 TAB EVERY SIX HOURS AS NEEDED
DARVOCET CONTAINS ACETAMINOPHEN 650MG & PROPOXYPHENE
PT#: 000106262694 ORD#: 2

07/16 PROPOXYPHENE NAPSYLATE/ATAB BFL PO
PROPOXYPHENE NAPSYLATE/AP 1 TAB/1 TAB
Give 2 TAB = 2 TAB EVERY SIX HOURS AS NEEDED
DARVOCET CONTAINS ACETAMINOPHEN 650MG & PROPOXYPHENE
PT#: 000106262694 ORD#: 3

RPh

Give Maalox 30ml Po PRN

RPh

1/20/04 Nicotine Patch 21g Daily 024°

RPh

Give

RPh

Give

RPh

Give

SITE CODES: 1 - LT. DELTOID; 2 - RT. DELTOID; RT. ARM; LT. ARM; 5 - RT. GLUTEUS; 6 - LT. GLUTEUS; 7 - RT. LATERALIS; 8 - LT. LATERALIS; 9 - LT. VENTROGLUTEAL; 10 - RT. VENTROGLUTEAL; 11 - RT. ABDOMEN; 12 - LT. ABDOMEN

OMISSION CODES: R - REFUSED; V - VOMITING/NAUSEATED; N - NPO; O - OTHER

SITE OF PAIN: A; B; C

SIGNATURE | INIT. | SIGNATURE | INIT.

PATIENT #: 000106262694 ROOM: IU3801 MED RECORD #: 1036637
FLOYD, SCOTTIE WAYNE AGE 29Y SEX M PAGE 2 OF

F7135007/06 (08/98) GMS

McLeod REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

ALLERGIES: NO KNOWN ALLERGIES

DISCONTINUED MEDICATIONS ARE HIGHLIGHTED IN YELLOW

DATE 07/19/04 | DATE 07/20/04

*** SCHEDULED MEDICATIONS ***

07/19 07/16 TRANXENE UNIT DOSE TAB BFL RPh
CLORAZEPATE DIPOTASSIUM 7.5 MG/1 TAB PO
Give 7.5 MG = 1 TAB EVERY EIGHT HOURS
PT#: 000106262694 ORD#: 6

07/19 07/16 DEPAKOTE ER TAB SR TAB BFL RPh
DIVALPROEX SODIUM 500 MG/1 SR TAB PO
Give 1500 MG = 3 SR TAB AT BEDTIME DAILY
PT#: 000106262694 ORD#: 1

07/19 07/16 KEPPRA TAB BFL RPh
LEVETIRACETAM 250 MG/1 TAB PO
Give 750 MG = 3 TAB EVERY 12 HOURS
PT#: 000106262694 ORD#: 4

07/19 07/17 ZYPREXA UNIT DOSE TAB JOZ RPh
OLANZAPINE 5 MG/1 TAB PO
Give 5 MG = 1 TAB THREE TIMES A DAY
PT#: 000106262694 ORD#: 8

07/19 07/16 PAXIL UNIT DOSE TAB BFL RPh
PAROXETINE HCL 20 MG/1 TAB PO
Give 20 MG = 1 TAB EACH DAY
THERAPEUTIC SUBSTITUTION FOR PAXIL OR 25MG QD
PT#: 000106262694 ORD#: 5

RPh
Give

*** PRN MEDICATIONS ***

07/19 07/18 HALDOL AMP LBJ RPh
Give HALOPERIDOL LACTATE 5 MG/1 ML IM
5 MG = 1 ML 3 TIMES DAILY AS NEEDED
FOR AGITATION
EQUIVALENT TO HALDOL
PT#: 000106262694 ORD#: 10

07/19 07/17 TORADOL TUBEX LBJ 07/22 RPh
Give KETOROLAD TROMETHAMINE 30 MG/1 ML IV
30 MG = 1 ML EVERY 6 HOURS AS NEEDED
FOR PT >65 YO ~~MAXIMUM DOSE: 15 MG Q6H~~
PT#: 000106262694 ORD#: 9

07/19 07/18 ATIVAN INJ LBJ RPh
Give LORAZEPAM 2 MG/1 ML IM
2 MG = 1 ML 3 TIMES DAILY AS NEEDED
FOR AGITATION
PT#: 000106262694 ORD#: 11

SITE CODES: 1 - LT. DELTOID; 2 - RT. DELTOID; 3 - RT. ARM; LT. ARM; RT. GLUTEUS; 6 - LT. GLUTEUS; 7 - RT. LATERALIS; 8 - LT. LATERALIS; 9 - LT. VENTROGLUTEAL; 10 - RT. VENTROGLUTEAL; 11 - RT. ABDOMEN; 12 - LT. ABDOMEN

OMISSION CODES: R - REFUSED; V - VOMITING/NAUSEATED; N - NPO; O - OTHER

SITE OF PAIN: A; B; C

SIGNATURE / INIT.

PATIENT #: 000106262694 ROOM: TUBEX MED RECORD #: 1036637
FLOYD, SCOTTIE WAYNE AGE 29Y SEX M PAGE 1 OF

McLeod REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

ALLERGIES NO KNOWN ALLERGIES

DISCONTINUED MEDICATIONS ARE HIGHLIGHTED IN YELLOW

DATE: 07/17/04 | DATE: 07/20/04

7A	8A	9A	10A	11A	12P	1P	2P	3P	4P	5P	6P
7P	8P	9P	10P	11P	12A	1A	2A	3A	4A	5A	6A

START DATE 07/17/04 STOP DATE

07/18 PERCOCET 5/325 UNIT DOSETAB DRW RPh
OXYCODONE/ACETAMINOPHEN 5 1 TAB/1 TAB PO
GIVE 1 TAB = 1 TAB EVERY 4-6 HOURS AS NEEDED

PERCOCET CONTAINS ACETAMINOPHEN - 325MG & OXYCODONE
PT#: 0001062682694 ORD#: 12

START DATE 07/17/04 STOP DATE

07/18 PERCOCET 5/325 UNIT DOSETAB DRW RPh
OXYCODONE/ACETAMINOPHEN 5 1 TAB/1 TAB PO
GIVE 2 TAB = 2 TAB EVERY 4-6 HOURS AS NEEDED

PERCOCET CONTAINS ACETAMINOPHEN - 325MG & OXYCODONE
PT#: 0001062682694 ORD#: 13

START DATE 07/17/04 STOP DATE

07/18 PROPOXYPHENE NAPSYLATE/ATAB BFL RPh
PROPOXYPHENE NAPSYLATE/AP 1 TAB/1 TAB PO
GIVE 1 TAB = 1 TAB EVERY SIX HOURS AS NEEDED

DARVOCET CONTAINS ACETAMINOPHEN 650MG & PROPOXYPHENE
PT#: 0001062682694 ORD#: 2

START DATE 07/17/04 STOP DATE

07/18 PROPOXYPHENE NAPSYLATE/ATAB BFL RPh
PROPOXYPHENE NAPSYLATE/AP 1 TAB/1 TAB PO
GIVE 2 TAB = 2 TAB EVERY SIX HOURS AS NEEDED

DARVOCET CONTAINS ACETAMINOPHEN 650MG & PROPOXYPHENE
PT#: 0001062682694 ORD#: 3

START DATE 7/18/04 STOP DATE

Toradol 60mg IM Q8° PRN RPh

START DATE STOP DATE

GIVE RPh

START DATE STOP DATE

GIVE RPh

START DATE STOP DATE

GIVE RPh

START DATE STOP DATE

GIVE RPh

SITE CODES	
1 - LT. DELTOID	7 - RT. LATERALIS
2 - RT. DELTOID	8 - LT. LATERALIS
3 - RT. ARM	9 - LT. VENTROGLUTEAL
4 - LT. ARM	10 - RT. VENTROGLUTEAL
5 - RT. GLUTEUS	11 - RT. ABDOMEN
6 - LT. GLUTEUS	12 - LT. ABDOMEN

OMISSION CODES	SITE OF PAIN
R - REFUSED	A
V - VOMITING/ NAUSEATED	B
N - NPO	C
O - OTHER	

SIGNATURE | INIT. | SIGNATURE | INIT.

PATIENT #: 0001062682694 ROOM: IU804 MED RECORD #: 1036633
FLOYD, SCOTTIE WAYNE AGE 29Y SEX M PAGE 2 OF

DFT1500705 (08/98) SMS

McLeod MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

ALLERGIES NO KNOWN ALLERGIES\

DISCONTINUED MEDICATIONS ARE HIGHLIGHTED IN YELLOW

DATE 07/18/04 | DATE 07/19/04

START DATE — SCHEDULED MEDICATIONS *** — STOP DATE

07/16 TRANXENE UNIT DOSE TAB BFL RPh
CLORAZEPATE DIPOTASSIUM 7.5 MG/1 TAB
Give 7.5 MG = 1 TAB EVERY EIGHT HOURS PO
PT#: 000106262694 ORD#: 6

07/16 DEPAKOTE ER TAB SR TAB BFL RPh
DIVALPROEX SODIUM 500 MG/1 SR TAB
Give 1500 MG = 3 SR TAB AT BEDTIME DAILY PO
PT#: 000106262694 ORD#: 1

07/16 KEPPRA TAB BFL RPh
LEVETIRACETAM 250 MG/1 TAB
Give 750 MG = 3 TAB EVERY 12 HOURS PO
PT#: 000106262694 ORD#: 4

07/17 ZYPREKA UNIT DOSE TAB JDZ RPh
OLANZAPINE 5 MG/1 TAB
Give 5 MG = 1 TAB THREE TIMES A DAY PO
PT#: 000106262694 ORD#: 8

07/16 PAXIL UNIT DOSE TAB BFL RPh
PAROXETINE HCL 20 MG/1 TAB
20 MG = 1 TAB EACH DAY PO
THERAPEUTIC SUBSTITUTION FOR PAXIL CR 25MG QD
PT#: 000106262694 ORD#: 5

7/18/04 RPh
Give Percocet 1-2 tabs po q 4-6 hrs. PRN pain (CJB)

START DATE — PRN MEDICATIONS *** — STOP DATE

07/18 HALDOL AMP LBJ RPh
Give HALOPERIDOL LACTATE 5 MG/1 ML IM
5 MG = 1 ML 3 TIMES DAILY AS NEEDED
FOR AGITATION
EQUIVALENT TO HALDOL
PT#: 000106262694 ORD#: 10

07/17 TORADOL TUBEN LBJ RPh 07/22
Give KETOROLAC TROMETHAMINE 30 MG/1 ML IV
30 MG = 1 ML EVERY 8 HOURS AS NEEDED
FOR PT >65 YO RECOMM. DOSE IS 15 MG Q6H
PT#: 000106262694 ORD#: 9

07/18 ATIVAN INJ LBJ RPh
Give LORAZEPAM 2 MG/1 ML IM
2 MG = 1 ML 3 TIMES DAILY AS NEEDED
FOR AGITATION
PT#: 000106262694 ORD#: 11

SITE CODES	OMISSION CODES	SITE OF PAIN	SIGNATURE	INITIALS	SIGNATURE	INITIALS
1 - LT. DELTOID; RT. DELTOID; RT. ARM; 4 - LT. ARM; 5 - RT. GLUTEUS; 6 - LT. GLUTEUS; 7 - RT. LATERALIS; 8 - LT. LATERALIS; 9 - LT. VENTROGLUTEAL; 10 - RT. VENTROGLUTEAL; 11 - RT. ABDOMEN; 12 - LT. ABDOMEN	R - REFUSED; V - VOMITING/NAUSEATED; N - NPO; O - OTHER	A Arm; B Back; C Headache		CJB		

PATIENT #: 000106262694 ROOM: 108801 MED RECORD #: 1036437
FLOYD, SCOTTIE WAYNE AGE 29Y SEX M PAGE 1 OF

CF7150708 (08/88) SMS

McLeod REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

ALLERGIES NO KNOWN ALLERGIES\1

DISCONTINUED MEDICATIONS ARE HIGHLIGHTED IN YELLOW

DATE 07/13/04 | DATE: 07/19/04

START DATE	STOP DATE						7A	8A	9A	10A	11A	12P	1P	2P	3P	4P	5P	6P
							7P	8P	9P	10P	11P	12A	1A	2A	3A	4A	5A	6A

*** PRN MEDICATIONS ***

07/16 PROPOXYPHENE NAPSYLATE/ATAB BFL RPh
PROPOXYPHENE NAPSYLATE/AP 1 TAB/1 TAB PO
GIVE 1 TAB = 1 TAB EVERY SIX HOURS AS NEEDED

DARVOCET CONTAINS ACETAMINOPHEN 650MG & PROPOXYPHENE
PT#:0001062626974 ORD#: 2

START DATE	STOP DATE						7A	8A	9A	10A	11A	12P	1P	2P	3P	4P	5P	6P
							7P	8P	9P	10P	11P	12A	1A	2A	3A	4A	5A	6A

07/16 PROPOXYPHENE NAPSYLATE/ATAB BFL RPh
PROPOXYPHENE NAPSYLATE/AP 1 TAB/1 TAB PO
GIVE 2 TAB = 2 TAB EVERY SIX HOURS AS NEEDED

DARVOCET CONTAINS ACETAMINOPHEN 650MG & PROPOXYPHENE
PT#:0001062626974 ORD#: 3

START DATE	STOP DATE						7A	8A	9A	10A	11A	12P	1P	2P	3P	4P	5P	6P
							7P	8P	9P	10P	11P	12A	1A	2A	3A	4A	5A	6A

RPh
GIVE

START DATE	STOP DATE						7A	8A	9A	10A	11A	12P	1P	2P	3P	4P	5P	6P
							7P	8P	9P	10P	11P	12A	1A	2A	3A	4A	5A	6A

*** SCHEDULED IV'S ***

RPh
07/18 CEFAZOLIN 1 GM LAH 07/18
GIVE USE AS DIRECTED BY PHYSICIAN PB *SCHEDULED*
PREOP MED X 1 * ok call to or *
PT#:0001062626974*ORDER APPROACHING EXPIRATION* PMP#: 7

START DATE	STOP DATE						7A	8A	9A	10A	11A	12P	1P	2P	3P	4P	5P	6P
							7P	8P	9P	10P	11P	12A	1A	2A	3A	4A	5A	6A

RPh
GIVE

START DATE	STOP DATE						7A	8A	9A	10A	11A	12P	1P	2P	3P	4P	5P	6P
							7P	8P	9P	10P	11P	12A	1A	2A	3A	4A	5A	6A

RPh
GIVE

START DATE	STOP DATE						7A	8A	9A	10A	11A	12P	1P	2P	3P	4P	5P	6P
							7P	8P	9P	10P	11P	12A	1A	2A	3A	4A	5A	6A

RPh
GIVE

START DATE	STOP DATE						7A	8A	9A	10A	11A	12P	1P	2P	3P	4P	5P	6P
							7P	8P	9P	10P	11P	12A	1A	2A	3A	4A	5A	6A

RPh
GIVE

SITE CODES	
1 - LT. DELTOID	7 - RT. LATERALIS
2 - RT. DELTOID	8 - LT. LATERALIS
3 - RT. ARM	9 - LT. VENTROGLUTEAL
4 - LT. ARM	10 - RT. VENTROGLUTEAL
5 - RT. GLUTEUS	11 - RT. ABDOMEN
6 - LT. GLUTEUS	12 - LT. ABDOMEN

OMISSION CODES	SITE OF PAIN	SIGNATURE	INIT.	SIGNATURE	INIT.
R - REFUSED	A				
V - VOMITING/NAUSEATED	B				
N - NPO	C				
O - OTHER					

PATIENT #: 0001062626974 ROOM: IUS801 MED RECORD #: 1036637
FLOYD, SCOTTIE WAYNE AGE 29Y SEX M PAGE 2 OF

McLeod REGIONAL MEDICAL CENTER

MEDICATION ADMINISTRATION RECORD

ALLERGIES NO KNOWN ALLERGIES\

DISCONTINUED MEDICATIONS ARE HIGHLIGHTED IN YELLOW

DATE 07/17/04 | DATE 07/18/04

*** SCHEDULED MEDICATIONS ***

07/16 TRANXENE UNIT DOSE TAB BFL RPh
CLORAZEPATE DIPOTASSIUM 7.5 MG/1 TAB PO
Give 7.5 MG = 1 TAB EVERY EIGHT HOURS
PT#: 000106262694 ORD#: 6

07/16 DEPAKOTE ER TAB SR TAB BFL RPh
DIVALPROEX SODIUM 500 MG/1 SR TAB PO
Give 1500 MG = 3 SR TAB AT BEDTIME DAILY
PT#: 000106262694 ORD#: 1

07/16 KEPPRA TAB BFL RPh
LEVETIRACETAM 250 MG/1 TAB PO
Give 750 MG = 3 TAB EVERY 12 HOURS
PT#: 000106262694 ORD#: 4

07/16 PAXIL UNIT DOSE TAB BFL RPh
PAROXETINE HCL 20 MG/1 TAB PO
Give 20 MG = 1 TAB EACH DAY
THERAPEUTIC SUBSTITUTION FOR PAXIL CR 25MG QD
PT#: 000106262694 ORD#: 5

RPh
Give pre-op meds -

*** PRN MEDICATIONS ***

07/16 PROPOXYPHENE NAPSYLATE/ATAB BFL RPh
Give PROPOXYPHENE NAPSYLATE/AP 1 TAB/1 TAB PO
1 TAB = 1 TAB EVERY SIX HOURS AS NEEDED
DARVOCET CONTAINS ACETAMINOPHEN 650MG & PROPOXYPHENE
PT#: 000106262694 ORD#: 2

07/16 PROPOXYPHENE NAPSYLATE/ATAB BFL RPh
Give PROPOXYPHENE NAPSYLATE/AP 1 TAB/1 TAB PO
2 TAB = 2 TAB EVERY SIX HOURS AS NEEDED
DARVOCET CONTAINS ACETAMINOPHEN 650MG & PROPOXYPHENE
PT#: 000106262694 ORD#: 3

7/13/04 RPh
Give Zyprexa 5mg PO
TIA

7/13/04 RPh
Give Seroquel 50 mg IV
q 8 hrs PRN

SITE CODES			
1 - LT. DELTOID	7 - RT. LATERALIS	OMISSION CODES	SITE OF PAIN
2 - RT. DELTOID	8 - LT. LATERALIS	R - REFUSED	A
3 - RT. ARM	9 - LT. VENTROGLUTEAL	V - VOMITING/NAUSEATED	B
4 - LT. ARM	10 - RT. VENTROGLUTEAL	N - NPO	C
5 - RT GLUTEUS	11 - RT. ABDOMEN	O - OTHER	
6 - LT GLUTEUS	12 - LT. ABDOMEN		

SIGNATURE | INIT | SIGNATURE | #

PATIENT #: 000106262694 ROOM: I087 01 MED RECORD #: 1036637
FLOYD, SCOTTIE WAYNE AGE 29Y SEX M PAGE 1 OF

DF-7150708 (06/05) SMS

McLeod REGIONAL MEDICAL CENTER

106262694 01-03-66-37
FLOYD SCOTTIE WAYNE
29 M
07/16/04

MEDICATION ADMINISTRATION RECORD

ALLERGIES

DATE

START DATE	STOP DATE	GIVE	RPh	9A	10A	11A	12P	1P	2P	3P	4P	5P	6P	7P	8P	9P	10P	11P	12A	1A	2A	3A	4A	5A	6A
		Depakote ER 500mg 3 PO. Qhs														MS									
		Keppra 500m 1½ Q 12 hours PO.															MS								
		Paxil CR 25mg ÷ Q Day																							
		Clorazepate 7.5 mg ÷ Q 8 hours														MS								5A	
		Darvocet 1-2 PO. Q 6 hours prn																							
		Haldol 5mg IM TID prn agitation														MS									
		Ativan 2mg IM TID prn agitation														MC									

SITES			OMISSION CODES	SITE OF PAIN
	1 - LT. DELTOID	7 - RT. LATERALIS	R - REFUSED	A
	2 - RT. DELTOID	8 - LT. LATERALIS	V - VOMITING/NAUSEATED	B
	3 - RT. ARM	9 - LT. VENTROGLUTEAL	N - NPO	C
	4 - LT. ARM	10 - RT. VENTROGLUTEAL	O - OTHER	
	5 - RT. GLUTEUS	11 - RT. ABDOMEN		
	6 - LT. GLUTEUS	12 - LT. ABDOMEN		

SIGNATURE Laura Sanders RN
INIT. SIGNATURE Kamerunzi Ayson

AGE SEX PAGE OF

MCLEOD REGIONAL MEDICAL CENTER - RESULTS LISTING

106262694 FLOYD ,SCOTTIE WAYNE IURG IU8701 EMR
MR #: 000001036637 MRMC
---PAGE 1 ----------

	07/17/04		REFERENCE RANGE
THERA DRUGS	11:47		
VALPROIC ACD	53.8		50-100
	07/16/04		REFERENCE RANGE
DRUG SCREEN	19:51		
PCP	NEGATIVE		NEG
AMPHETAMINE	NEGATIVE		NEG
BARBITURATE	NEGATIVE		NEG
BENZODIAZEPN	POSITIVE*		NEG
OPIATES	NEGATIVE	T	NEG
CANNABINOID	POSITIVE*		NEG
COCAINE	NEGATIVE		NEG

==========END OF REPORT==========
14:31 07/17/04 FROM @01A,REPRTGF1

LQH92478

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

106262694 01-03-66-37
FLOYD ,SCOTTIE WAYNE
29 M
07/16/04

PROGRESS RECORD

ADDRESSOGRAPH

DATE	TIME	Note Progress of case, complications, changes in diagnosis, condition on discharge, instructions to patient
7/20/04	5:30 PM	Psychiatry — Pt. sent to Regional BIC room to get ready to transfer to Texas for long ongoing treatment program. Spoke to pt's mother who agreed to come on tonight + discuss her conditions for taking patient home. She states she agrees to go to Texas, agrees not to leave the home w/out her consent, and not to do anything to hurt herself or others. She states Pt. has NEVER had thoughts or engaged in this type of behavior. She denies intent to hurt Dr. Bailey + states he likes Dr. Bailey. Dr. Woolsey to re-evaluate tomorrow. Cecil Thomas Manigo
7/21/04		Order NO Major Change Cont Tramadol Ultram for a Relief for Pain May D/C per Order for Tuesday if Still in Florence

Seq. #1201

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

106262694 01-03-66-37
FLOYD,SCOTTIE WAYNE
29 M
07/16/04

PROGRESS RECORD

ADDRESSOGRAPH

DATE	TIME	Note Progress of case, complications, changes in diagnosis, condition on discharge, instructions to patient
20 July 04		O- Tue
		S/ No Complaints
		O/ Full ROM Fingers
		Hdd Swelling NVI
		Wet Cast
		NVI Intact
		No Neurotate
		A/ 2 day S/P Perc Pinning
		of 1 Rad + Ulna Metacarpal
		Base Fracture
		P/ Continue Elevate

Seq. #1201

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

106262694 01-03-66-37
FLOYD, SCOTTIE WAYNE
29 M
07/16/04

PROGRESS RECORD

ADDRESSOGRAPH

DATE	TIME	Note Progress of case, complications, changes in diagnosis, condition on discharge, instructions to patient
7/19/04	6:30 PM	Psychiatry - 251 Pt wanting to go home + began to escalate when I told him he would not be able to do so b/c he is on commitment. Pt talking very loudly and stating I was not listening to him. Denies ever threatening Dr Neely. "It was a misunderstanding." Pt is in pain from fracture @ hand. "The only reason I ever hurt is my temper." Cont Seroquel + Cont to facilitate transfer to Texas. Given pt's impulsivity pt is felt to be a danger to self or others. Commitment papers under Cecilia Jones mom was
7/20/04	1230	Progress Note S - Patient says he feels great. Requesting to go home to be with his mother. O - VSS A & P. 1. Aggressive behavior - Cont Keppra, Trazodone & Paxil. Dr Farina to see pt today. 2. Boxers fx - Cont NSAIDS PRN for pain PRN. Cont 1:1 observation Patient is stable for transport. B. Trask M.D.

Seq. #1201

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

106262694 01-03-66-37
FLOYD ,SCOTTIE WAYNE
29 M
07/16/04

PROGRESS RECORD

ADDRESSOGRAPH

DATE	TIME	Note Progress of case, complications, changes in diagnosis, condition on discharge, instructions to patient
7-19-04	10Hrs	talked to Betty Jo Floyd, pts mother who stated pt would be d/c'd to Tanglewood, Texas by Wed. She is to know definite today & will call & let us know. Melva LeBeau, APRN,C
7/20/04		D/C'd
		S/ Mild Swelling All Fingers
		O/ Mild Swelling Fingers
		Full ROM
		W/O Infxn
		A/ 1 day S/P Perc Pinning of R Hand Ring + Little Metacarpal bone
		D/C
		P/ Progressive Elevation Above Heart
		Move Fingers
		Roll Tuesday

Seq. #1201

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

106262694 01-03-66-37
FLOYD, SCOTTIE WAYNE
29 M
07/16/04

PROGRESS RECORD

ADDRESSOGRAPH

DATE	TIME	Note Progress of case, complications, changes in diagnosis, condition on discharge, instructions to patient
7/18		30" Psych Met c pt & his mother. Spoke c staff. He has been quiet & cooperative. He reports he slept like a baby." Has been compliant c meds here. Discussed case @ length c mother who is his legal guardian. Pt & mom feels he is much better. Scottie able to reflect on the events leading to ER visit. "I know I lost my temper." Recognizes his inappropriate behaviors. He denies any thoughts of wanting to hurt anyone. Pt is employed @ Pasolina and is easily irritated 2° to his organicity. Pt clearly needs transfer to Florence. It would be preferable to transition from ER directly to persons who are taking him to Florence. I would recommend this for his disposition. Staff denies no activity out of past 24°. Freddie Jones MD
7/18/04		Progress Note S: Back a head but feel better but head hurts O: Vitals Stable - Head injury below hospital - Dr - A/P ① Cognitive impairment currently secondary to head injury to be to Texas Med. ② Head pain 2° surgery + Dr will give Toradol. ③ Stable for Dc for. UR

Seq. #1201

Scottie Floyd

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

106262694 01-03-66-37
FLOYD, SCOTTIE WAYNE
29 M
07/16/04

PROGRESS RECORD

DATE	TIME	Note progress of case, complications, ... discharge, instructions to patient
18 July 04		OPERATIVE/PROCEDURE NOTE
		PRE-OP DIAGNOSIS R 4th-5th Metacarpal Base Fracture
		POST-OP DIAGNOSIS/FINDINGS Same
		PRIMARY SURGEON Dr. Spoon
		ASSISTANT(s)
		PROCEDURE Closed Rx c Manipulation & Perc Pinning of Fracture
		ESTIMATED BLOOD LOSS, as indicated
		SPECIMEN(s) None
		SURGEON'S SIGNATURE
		Brian D
		Hardware - 2 0.62" K wires
		Complications D

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

POST ANESTHESI PHYSICIANS ORDERS

FLOYD, SCOTTIE WAYNE
10626264 01-03-66-37
07/15/04 29 MRSA VRE
DODARO, NICHOLAS R
M W

PHYSICIAN'S ORDER SHEET

Drug Sensitivity

1	2	3	Height:
4	5	6	Weight:

ET

Directions: 1. Mark through the item you do not wish to order
2. Indicate choice when options are available by placing a check (✓) in the parenthesis

1. Routine PACU vital signs
2. Oxygen at 3 Liters per min via NC unless ordered otherwise per anesthesia provider
3. FSBS in PACU. Call MDA with results

Analgesia: To achieve pain score ≤ 3 on a pain scale 0 - 10

4. Morphine Sulfate 2-5 mg IV every 2-5 minutes
   Total maximum dose 30 mg
5. Meperedine (Demerol) _____ mg IV every _____ minutes
   Total maximum dose _____ mg
6. Fentanyl _____ mcg IV every _____ minutes
   Total maximum dose _____ mcg

7. Promethazine (Phenergan) _____ mg for nausea and/or vomiting
   May repeat x _____ doses
8. Dolasetron (Anzemet) 12.5 mg
   for nausea and/or vomiting
   May repeat x 1 doses
9. Toradol 30 mg IV x 1 dose Juse

10. _____ Patient may be discharged from PACU once the patient meets discharge criteria
11. _____ Call MDA for patient discharge
12. O_2 _____ L per minute via nasal cannula for room air oxygen saturation below _____% for
13. Additional Orders:

Physician's Signature: _____ **Date:** 7/18/04 **Time:** _____

PPO-103
Created: 3/02
Revised: 4/04
Reviewed:

noted A Quarrera 7/18/04 0910

ANESTHESIA RECORD

Cleo — NAL MEDICAL CENTER — The Choice For Medical Excellence

FLOYD, SCOTTIE WAYNE — 06252694 — 01-03-66-37 — 7/16/04 — 29 — M — RSA — VRE — DeCARO, NICHOLAS R

OR No. 3 | Machine No. 19139 | Page No. 1 of 2 | ASA 1 2 3 4 5 E

Date 7-18-04 | Anes. Time Start 0805 Finish 0912 | ASA

Diagnosis: (Post Op) Fracture of Right 4th + 5th metacarpals

Procedure Performed: Pinning of 4th + 5th Metacarpals

Surgeons: Spoho

Allergies: NKDA

"I have reviewed preoperative evaluation and VS immediately before induction and concur with plan" CRNA/MDA Karla Mathews CRNA MD

Age	Sex	Weight	Height	Hgb	Hct	BP	P	Tests	Time NPO
29	M	81 kg	69"			119/96	69	Op from ER Chipped, Ø	Poke prn

IV RA ☐ LA ☑ Size 20g Central Line ☐

Informed Consent ☑ Patient Identified ☑ Chart Reviewed ☐

Equipment Checked ET ☑ | Alarms Functional ☑

Monitors: EKG ☑ | Pulse Oximeter ☑ | ETCO2 ☑ | O2 Analyzer ☑ | NIABP RA ☑ LA ☐ RL ☐ LL ☐ | Arterial ☐ | PNS ☐ | Temperature ☑ | Stethoscopes

Airways: Esophageal ☐ | Pre-cordial ☐ | Pre-tracheal ☐ | Oral ☐ Nasal ☐ | Endotracheal Oral ☑ Nasal ☐ Size 7.5 Cuff ↑ Occlusion ☑ Smooth ☑ Difficult ☐ Secure @ 22 cm | BBSE ☑ EtCO2 ☑ | CPr ☐ | Eye Care CvL ☑ taped

Tourniquet: RA ☐ RL ☐ LA ☐ LL ☐ @ ↑

Patient Position: Supine + padded, left arm @ 90°

Warming Equipment: Art. Hose ☑ | Blanket lower ☑ | Fluids ☐

Regional Anesthesia: Epidural ☐ | Spinal ☐ | IV Regional ☐ | Other ☐

Drug | Site Needle @ | Technic HD ☐ LR ☐ | Approach MD ☐ LA ☐ | Difficulty none ☐ | HD ☐ CSF ☐ | Pricad ☐ | MAC T=91 ☐

Time	0805	0810	0815	0820	0825	0830	0835	0840	0845	0850	0855	0900	0905	0910	Totals
Agents: Lidocaine (mg)															
Propofol (mg)															
Versed mg															
Fentanyl mcg															
Desflurane	6.8	4.3													
N2O L/min	1	1													
O2 L/min	1	1													
Monitors: Fi O2	100%	100%													
SaO2	100	100	100												
ETCO2	39	39	39												
ECG	SR 138	SR 138	SR 138												
Temp ° C Nasal	36.1	36.1	36.1												
Fluid: LR (1000ml)															700
Blood Loss	8 tole														8
BP	119/96	119/96	119/96												
Pulse	69	69	69												
Start Anes	0805														
End Anes															
Start Op	0826														
End Op	0904														
Vent: Vt	760														
Rate	10														
PAP	20														
Resp: Spontaneous	T														
Assist	P&P														
Controlled	Paw														

Remarks: Spoke c pt/family in H/A. 0805 To OR. Pt moved self to OR table. → 0807 = Pre-O2 x 3 min. 0810 = Pt intubated. Smooth IV induction. Cards clear. ETT taped in place. 0906 Pt extubated. vent. TV = 400 ml. Suctioned orally. Pt awake, follows commands. Extubated. VSS. OR #7 = Pt moved self to stretcher. Awake, talking. To PACU. 0912 - Report given to RN.

Antibiotic	Time
Ancef 1gm IV @ 30 from floor	

Adjuvant Meds	Totals	IV Fluids	Absorbed
Anzemet 12.5mg 0845		LR 700 ml	
		Crystalloid	Blood Prod.
		Colloid	

PAR: A 0904 — BP 128/63 — P 89 — R 16 — %SAT 98% — Condition Stable — Report to: Amber, RN — EBL — Urine

Seq. No. 1644 Rev. 09/03

1300

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

Scottie Floyd
106262694 01-03-66-37
FLOYD, SCOTTIE WAYNE
29 M
07/16/04

PHYSICIAN'S ORDER SHEET

Drug Sensitivity

1 NKDA	2 Coconut	3	Height: 5'9"
4	5	6	Weight: 180 lbs.

DATE: 18 July 04

TIME:

AM PM

1) To RR Dr Spohn

2) DX - Closed Fracture of R Hand Meta Carpal Fractures

NRS. NOTED

TIME:

AM PM

3) Condition Good

FAX TO PHARMACY

DOCTOR SIGN & DATE HERE>

DATE:

4) VS Routine RR then q 8 hrs

TIME:

AM PM

5) Elevate R Arm Above Heart c Pillows

FAX TO PHARMACY

NRS NOTED

TIME:

AM PM

6) Ice to Hand PRN Swelling

7) NS dd 100ml then D/C when patient leaves RR

Done in E (CLB)

DOCTOR SIGN & DATE HERE>

DATE:

8) Advance to Regular Diet

TIME:

AM PM

9) Percocet 1-2 Tabs po q 4-6 hrs prn pain

CLB

NRS. NOTED

1005

TIME:

AM PM

FAX TO PHARMACY

(Noted 7/18/04 1005 Carmen L. Hitchcock, RN)

DOCTOR SIGN & DATE HERE>

Seq#1198 Rev 11/02

McLeod REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

OPERATIVE PROCEDURE RECORD

FLOYD, SCOTTIE WAYNE
13126294 01-03-66-37
7/11/04 29 YRS A VRE
DIAZ, NICHOLAS R
M U

Medical Rec. #	PTS Room	OP Room	DATE: MO.	DAY	YEAR
0108637	ER	3	07	18	04

Room Out	Anesthesia Stop	Operation Stop
0907	0912	0904
In 0805	Start 0805	Start 0826
Total	Total	Total

ANESTHESIA
General ☐ Epidural ☐ Local ☐ Spinal ☐ Block
☐ Standby ☐ Other

SURGEON	SURGEON
Lasher	
ASST SURGEON	ANESTHETIST
	X Matthews (CRNA)
ANAESTHESIOLOGIST	SCRUB
M Roe	
SCRUB	SCRUB
Williams (ST)	Rodriguez (ST)

CIRCULATOR	CIRCULATOR
K Hall	
CIRCULATOR	CIRCULATOR
SCRUB	SCRUB

ET

COUNT	CORRECT	INCORRECT
Sponges		
Instruments	NA	
Sharps		

SEE COUNT SHEET

PRE-OP ASSESSMENT
H&P ☐ LABS ☐ X-RAYS ☐ Permit ☐ H&P
Allergies NKA

SKIN CONDITION ☐ Flushed ☐ Dry
☐ Pale ☐ Cool ☐ Diaphoretic ☐ Warm

ADMISSION PATIENT STATUS
Alert ☐ Calm ☐ Sleepy ☐ Agitated
☐ Confused ☐ Apprehensive ☐ Not Responsive

SCRUB/PREP SOLUTION(S) ☐ NONE
Iodophor Scrub ☐ Iodophor Solution
Chlorhexidine Gluconate
☐ Other
Area Prepped (R) Hand/Arm

Shave Prep NA

PATIENT POSITIONED BY
KM, RW

Position: ☐ Supine ☐ Prone
☐ Sitting ☐ Lithotomy ☐ Jackknife
☐ Parkbench ☐ Rt. Lateral ☐ Lt. Lateral
☐ Elbow Pads ☐ Stirrups ☐ Mayfield Tongs
☐ K Thermal Blanket: Temp:
☐ Arm Side ☐ Rt. ☐ Lt.
☐ Arm Board ☐ Rt. ☐ Lt.
☐ Arm Chest ☐ Rt. ☐ Lt.
☐ Wilson Frame
☐ Codman Frame ☐ Head Rest Foam
☐ Bean Bag ☐ Foam Bolster

SPECIMENS
☐ To Lab ☐ With Patient ☐ Frozen
☐ With Doctor ____ # of Specimens
None ☐ Cultures ☐ Foreign Body
____ # of Cultures None
Site:

DRAINS AND PACKS
0

PROSTHESIS-GRAFT-IMPLANTS
Yes Amount 2 ☐ No
Type
Site (R) Hand
Serial/Lot No.
(2) .062 K-Wires

MONITORING Site identification verbalized and verified at time of incision
Tourniquet ____ mm Hg
Time On ____ Time Off ____
Time On ____ Time Off ____
Pressure Checked ☐ Yes
Tourniquet Placement Time

☐ X-Ray ☐ VCR ☐ Laser ☐ Biopsy ☐ Ultrasound
☐ C Arm Min 21 seconds
☐ Cautery
☐ Cut ☐ Coag 15
☐ Electrosurgical Pad (L) Thigh

Pre-Op Diagnosis Fractured 4th & 5th bone metacarpals bones (R)

Post-Op Diagnosis Same as Preop

Procedure (s) Percutaneous Pinning of (R) 4th & 5th Metacarpals

SERVICE
☐ EYE ☐ GYN
☐ ENT ☐ NEU
☐ DEN ☐ PLAS
☐ UROL ☐ THOR
☐ VASC ☐ O.H.
☐ POD ☐ GEN
ORTH

CASE TYPE
☐ MAJOR
☐ MINOR
☐ EMERGENCY
☐ SCHEDULED
Add-on

TRANSFUSION: ☐ YES NO
If yes, see Anesthesia Record

DRUGS & IRRIGATION
Bupivacaine

REMARKS/COMPLICATIONS
To OR 3 via stretcher SR's TXD. Warm blankets PRN. Pt transferred to OR table, belt applied over legs. Prepped & draped in usual sterile manner. Procedure began. Procedure completed. Sterile dressing & cast applied. Transferred to stretcher SR's TXD to PACU.

SEQ # 1240 REV. 12/2001

Signature: Richard D. Williams RN BA

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

PHYSICIAN'S ORDER SHEET

INTRAOPERATIVE ORTHOPEDICS ORDERS

FLOYD, SCOTTIE WAYNE
19626269 01-03-66-37
07/15/04 29 MRSA VRE
DODARO, NICHOLAS R
M W

Drug Sensitivity

1 NKDA	2	3	Height:	ET
4	5	6	Weight:	

Directions: 1. Mark through the item you do not wish to order
2. Indicate choice when options are available by placing a check (✓) [illegible]

Date/Time	INTRAOPERATIVE ORTHOPEDICS ORDERS FOR:	PAGE 1 OF 1
7/15/04	Drs. A.G. Dawson, G.R. Dawson, J.W. Dunlap Jr., P. Denton, R.W. Moore, P. Spohn, J.D. Morgan	
	1. Insert 16 fr. Foley catheter into bladder preop	[ ]yes [ ]no
	2. Apply Pneumatic TED Hose to unaffected leg preop	[ ]yes [ ]no
	3. Apply Pneumatic TED Hose to affected leg before transporting to PACU	[ ]yes [ ]no
	4. Kantrex ____ g in NaCl ____ cc for use with pulsavac machine intraop	[ ]yes [ ]no
	5. Kantrex 2 g in NaCl 500 cc on sterile field intra-op	[ ]yes [ ]no
	6. Lidocaine 1% with epinephrine 1:100,000 on sterile field intraop	[ ]yes [ ]no
	7. Lidocaine 1% plain on sterile field intra-op	[ ]yes [ ]no
	8. Marcaine 0.5% with epinephrine 1:200,000 on sterile field intraop	[ ]yes [ ]no
	9. Marcaine 0.5% plain on sterile field intraop	[ ]yes [ ]no
	10. Depo-medrol 40mg on sterile field intraop	[ ]yes [ ]no
	11. Astramorph 10mg/10ml on sterile field intraop	[ ]yes [ ]no
	12. Xerofoam gauze 5 x 9 for postop dressing	[ ]yes [ ]no
	13. Incorporate Hot/Ice pad into postop dressing	[ ]yes [ ]no
	14. Tobramycin 1.2g on sterile field intraop	[ ]yes [ ]no
	15. Knee immobilizer to affected knee postop	[ ]yes [ ]no
	16. Thrombin 5000 units mixed with calcium chloride 10% (abbojet) for use with symphony on sterile field	[ ]yes [ ]no
	17. Abduction pillow postop	[ ]yes [ ]no
	18. Apply shoulder immobilizer or arm sling to ____ arm	[ ]yes [ ]no
	19. Gelfoam 100 on sterile field intra-op	[ ]yes [ ]no
	20. Apply thigh high TED stocking to affected leg postop	[ ]yes [ ]no
	21. Apply Ice Man pad to affected ____ shoulder or ____ knee postop (please take cooler to PACU)	[ ]yes [ ]no
	22. Epinephrine 1cc of 1:1000 in NaCl 3000 cc bag x ____	[ ]yes [ ]no
	V.O. Dr. Spohn / Richard D. Williams, RN	

Physician's Signature: _____ **Date:** _____

PPO-142
Orig. Date: 11/96
Rev. 11/98, 12/98, 9/99, 1/00, 1/02, 7/02, 10/02, 9/03, 10/03

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence

106262694 01-03-66-37
FLOYD ,SCOTTIE WAYNE
29 M
07/16/04

PROGRESS RECORD

ADDRESSOGRAPH

DATE	TIME	Note Progress of case, complications, changes in diagnosis, condition on discharge, instructions to patient
		025 MM/S HR 86) mmHg 0 09:09
		7/16/04 [illegible] Floyd, Scottie

Seq. #1201

McLeod
REGIONAL MEDICAL CENTER
The Choice For Medical Excellence.

Addressograph

106262694 01-03-66-37
FLOYD ,SCOTTIE WAYNE
Z9 M
07/16/04

CONSENT FOR OPERATION AND/OR PROCEDURE

ACKNOWLEDGMENT:

I received explanation about the planned operation and/or procedure from my attending physician and/or the surgeon(s). No guarantees or assurances have been made or given by anyone as to the results that may be obtained. I understand:

* what will be performed
* the risks and complications that may occur
* the expected recovery period
* the likelihood of success
* the expected results
* possible benefits and drawbacks
* alternative methods of treatment
* possible results of not receiving treatment
* that anesthesia will be given by a person licensed by the State to give anesthesia; options, risks and alternatives have been explained to my understanding
* that there is a possibility that I could need transfusion of blood/blood products; options, risks and alternatives have been explained to my understanding

THIS PATIENT HAS AN ADVANCE DIRECTIVE, LIVING WILL AND/OR DO NOT RESUSCITATE ORDER.

I understand that it is the hospital policy to suspend any Advance Directive, Living Will and Do Not Resuscitate Order during the procedure and the recovery from anesthesia. I understand that I have the right to agree or disagree with this policy.

I understand and AGREE that any Advance Directive, Living Will and Do Not Resuscitate Order that I have WILL NOT BE IN EFFECT DURING THE PROCEDURE AND RECOVERY FROM ANESTHESIA.

Patient or Person Authorized to Consent for Patient

(Contact physician prior to completing acknowledgement if patient elects to NOT SUSPEND)

I understand that unexpected conditions may occur during the operation and/or procedure. In signing below, I give consent for additional or different procedures should the doctor(s) named below decide it is necessary or desirable.

Exception(s): none
(State exception(s) OR "none")

CONSENT:

I give consent for the following operation and/or procedure: closed reduction and percutaneous pinning right hand fourth and fifth metacarpal bone fractures

to be performed on Scottie Wayne Floyd, by doctor(s) P. Spohn, Dawson II, A. Dawson
(myself or name of patient)

Additionally, I give consent for the hospital to dispose of any tissue removed during the operation and/or procedure.

Tonya Wright, RN
(Witness)

Scottie Wayne Floyd
(Patient or Person Authorized to Consent for Patient)

1300 a.m. p.m.
Date)

mother
(Relationship to Patient)

CG 9 (JCAHO-RI.1.2, 1.2.1; TX.2.2; TX.5.2, 5.2.1; DHEC- 611 1)
Revised: 7-98; 1-02; 4-02; 6-02

FLORENCE ORTHOPAEDIC ASSOCIATES, P.A.

251 W. Palmetto Street
Florence, SC 29501-4490
Tel: (843) 662-7026
Fax: (843) 667-9594

OUTPATIENT SURGERY
LONG FORM - PRE-SURGICAL - HISTORY FORM

106262694 01-03-66-37
FLOYD, SCOTTIE WAYNE
29 M
07/16/04

Patient's Name: Scottie Floyd History No.:
Physician's Name: Peter J Spohn MD Date of Surgery: 18 July 04

I. History: Does the patient have any history of..... (Comment if history is positive.)

1. ☐ Cardiac Disease
2. ☐ Hypertension
3. ☐ Pulmonary Disease
4. ☐ Endocrine Disease
5. ☐ Allergic Disease or Condition
6. ☐ Blood Dyscrasia

26 Y.O. WM with Hx MCT Wall Yesterday Night, Seen ER Mcleod. L Hand 4th + 5th MC base fracture Needs Day Surgery for Reduction

Other Medical Conditions: 9/13/01 Closed Head Injury and Thoracic Spine Fx

Is the patient taking any medications? (List): Depakote, Keppra Trazodone, Paxil, Darvocet

I. Physical Exam: Temp:_____ P_____ R_____ B/P_____

1. ☐ HEENT - PERRLA, EOM Full, Pharynx Nml
2. ☐ Heart - (Describe) RRR S1 S2 Normal No Gallop
3. ☐ Lungs - (Describe) Clear
4. ☐ Extremities Pulses 2+ both upper extremities, NVI intact

II. Diagnosis: L Hand 4th + 5th Base Metacarpal Fracture

OPERATION PLANNED:
Closed Reduction and Percutaneous Pinning of both Fracture

ARE ANY SPECIAL ANESTHETIC TECHNIQUES NEEDED?
General

Physician's Signature

George R. Dawson, III, M.D.
Hand Surgery
Knee Surgery
General Orthopaedics
Joint Replacement
Arthroscopy

Alfred G. Dawson, M.D.
Knee Surgery
Joint Replacement
Sports Medicine
General Orthopaedics
Arthroscopy
Scoliosis

George R. Dawson, Jr., M.D.
Emeritus

R. Erskine Moore, Jr., M.D.
Emeritus

Peter J. Spohn, M.D.
Major Fracture Care
Joint Replacement
Arthroscopy/Sports Med.
Hand/Foot Surgery
General Orthopaedics
Certified Independent
Medical Examiner

MCLEOD REGIONAL MEDICAL CENTER
555 East Cheves Street
Florence, SC 29501

NAME: Floyd, Scottie Wayne
MED. REC. NO. : 01-03-66-37
ADMIT DATE: : 07/16/2004
DR. DICTATING : Leanna J. Thorn, MD

IURGIU8801

PATIENT #: 000106262694
PATIENT NUMBER: 000106262694

CHIEF COMPLAINT: This is a 29-year-old; complaint, homicidal actions, impulsive behavior.

HISTORY OF PRESENT ILLNESS: The patient has a history of psych illness and also organic brain injury from head trauma. He evidently was at his lawyer's office and was having back pain and began to threaten verbally Dr. Healy and his staff because he was unable to get a back brace fitted. Because he was threatening Dr. Healy's staff, he left the lawyer's office to go assault Dr. Healy and his staff. Luckily, the lawyer called Dr. Healy and gave him a warning. By the time the patient got there, there were police there and they had the doors locked. He was assaultive and abrasive there and very aggressive, threatening to kill the staff and Dr. Healy because they would not fit him for a back brace. Evidently, the patient is getting ready to go to a hospital in Texas for intensive therapy for the organic brain injury and aggressive behavior but he does not want to go without this back brace. He also has a back injury, thoracic spine injury. Dr. Healy said he could not get the brace in time for his departure on Wednesday and that he has been trying to get him to get this brace fitted for several months now but the patient has been noncompliant. The patient has a history of aggressive and impulsive behavior. Currently has no medical complaints. Chronic back pain is his only complaint.

REVIEW OF SYSTEMS: Negative except as in HPI.

PAST MEDICAL HISTORY: Past medical history of brain injury.

SOCIAL HISTORY: He has lived with his mother since his brain injury.

ALLERGIES: No drug allergies.

PHYSICAL EXAM: Temp 99; pulse 60; respirations 20; blood pressure 128/70. Awake, alert. Appears somewhat agitated and aggressive towards me. When I walked into the room, he told me that he had just asked security to find me and put a tazer to my butt to get me to his room faster. He thought this was funny and then laughed after he told me that. He says he does not remember threatening Dr. Healy but he is very mad at Dr. Healy for not getting his back brace. Pupils round. Neck is supple. Lungs: Clear to auscultation. Cardiac: S1, S2. Abdomen: Soft, nontender. Extremities are warm, 5/5 strength. He has a normal gait and does not appear to be in any pain in his back when he ambulates here in the department.

PLAN: I spoke with Dr. Healy. Dr. Healy is worried about himself and his staff because he was verbally threatened today by this gentleman, Mr. Floyd, and Dr. Healy knows he has an intensive history, very impulsive and aggressive. Dr. Healy thinks he needs to be in close supervision until he is able to go to Texas this Wednesday. On Wednesday, evidently somebody is going to come take him to Texas and they are supposed to be going on a train. They evidently came to pick him up yesterday but the attendant who is going to be traveling with him did not think he was safe for airplane travel. We are going to admit him to the hospital. He is being committed because of his homicidal behavior today, impulsive and aggressive behavior. We are going to get Progressive Biomechanics to come fit him for a CASH brace or a turtle-shell brace because of his fractures to see if that will help control his pain. We are going to continue his medications, including Depakote, Paxil, Keppra, clorazepate, and Percocet. He will be committed to the hospital. I am expecting that when I tell him this, he is going to be very irate and upset. His mother is here with him and also states that he is probably going to be not very happy when we tell him what is happening.

ORIGINAL

MCLEOD REGIONAL MEDICAL CENTER
555 East Cheves Street
Florence, SC 29501

DIAGNOSIS: Impulsive behavior, aggressive, homicidal.

Leanna J. Thorn, MD

meq
DD : 07/16/2004
DT : 07/17/2004 8:24 A
Job #: 000010446
cc: Nicholas R. Dodaro, M.D.
Leanna J. Thorn, MD

ORIGINAL

000106262694
MRMC LABORATORY
555 E CHEVES ST
FLORENCE, SC 29501
(843) 777-2078

LOC: EDREL

1309

NAME: FLOYD,SCOTTIE W
MRN : 01-03-66-37
PHYS: DODARO, NICHOLAS R.
COPY TO:

LABORATORY REPORT

COLLECTED: 07/17/2004 11:47 RECEIVED: 07/17/2004 11:53 SPECIMEN NUMBER: S48732
ORDERING PHYSICIAN: WOOLERY, JANET B

TEST		RESULT	REF RANGE	UNITS	
VALPROIC ACID	53.8	[50-100]	UG/ML		STAT

COLLECTED: 07/16/2004 19:51 RECEIVED: 07/16/2004 20:46 SPECIMEN NUMBER: F21812
ORDERING PHYSICIAN: THORN, LEANNA J

TEST		RESULT	REF RANGE	UNITS
URINE DRUG SCREEN				STAT
PCP URINE		NEGATIVE [NEG]		STAT
AMPHETAMINE		NEGATIVE [NEG]		STAT
BARBITURATE		NEGATIVE [NEG]		STAT
BENZODIAZEPINE	*	POSITIVE [NEG]		STAT
CANNABINOID	*	POSITIVE [NEG]		STAT
COCAINE		NEGATIVE [NEG]		STAT
OPIATES		NEGATIVE [NEG]		STAT

Screening test for medical evaluation only.
Not for legal purposes.

LOC: EDREL

MRN : 01-03-66-37
ACCT NO: 000106262694
PHYS: DODARO, NICHOLAS R.

NAME: FLOYD,SCOTTIE W
DOB SEX: M
SSN : 251-41-7003
FINAL

PRINTED: 07/22/2004
03:10
PAGE: 1
END OF REPORT

RADIOLOGY REPORT
McLEOD REGIONAL MEDICAL CENTER
555 E. CHEVES STREET FLORENCE, SC 29506-2617
PHONE (843) 777-2087

PATIENT NAME: FLOYD, SCOTTIE WAYNE DISCHARGE DATE:
PT ACCOUNT#: 00C106262694 MR/RAD #: 1036637

DOB: (AGE: 29Y SEX: M RACE: W
PHONE:) PT CLASS: E FIN CLASS: S
ADDRESS: PT TYPE: E PT NS/ROOM: IURG-IU8801

ORDER DR: NICHOLAS R DODARO M.D.
ATTEND DR: NICHOLAS R DODARO M.D.
COPY TO:
DIAGNOSIS: PSYCH EVAL
TRANSCRIBED D/T: Jul 20 2004 2:20AM
HAND-RT /3 VIEW MINIMUM / ORD #: 90001 CPT: 73130
ORDERED FOR: Jul 16 2004 8:43PM COMPLETED: Jul 16 2004 9:02PM
INDICATIONS/COMMENTS: INJURY

RESULT:

HISTORY: INJURY.

Three views obtained. There are fractures through the base of the fourth and fifth metacarpals. I believe there is also fracture to the base of the third metacarpal though this is only suggested on the oblique view. No dislocations.

CONCLUSION: METACARPAL FRACTURE AS ABOVE.

RADIOLOGIST: SCOTT H. ALLEN, MD
cb
July 20, 2004 2:19 AM

Final Result
ELECTRONICALLY SIGNED BY:
SCOTT H. ALLEN, M.D.

FLORENCE RADIOLOGICAL ASSOCIATES
If you have received this document by facsimile, the information contained in this transmission may contain medical record information and is privileged and confidential. It is intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone (collect) and return the original message to us at the address indicated via the US Postal Service.

RADIOLOGY REPORT
McLEOD REGIONAL MEDICAL CENTER
555 E. CHEVES STREET FLORENCE, SC 29506-2617
PHONE (843) 777-2087

PATIENT NAME: FLOYD, SCOTTIE WAYNE DISCHARGE DATE:
PT ACCOUNT#: 000106262694 MR/RAD #: 1036637

DOB: AGE: 29Y SEX: M RACE: W
PHONE: PT CLASS: E FIN CLASS: S
ADDRESS: PT TYPE: E 2T NS/ROOM: IURG-IU8801

ORDER DR: PETER SPOHN M.D.
ATTEND DR: NICHOLAS R DODARO M.D.
COPY TO:
DIAGNOSIS: PSYCH EVAL
TRANSCRIBED D/T: Jul 20 2004 1:02AM
HAND-RT /3 VIEW MINIMUM / ORD #: 90002 CPT: 73130
ORDERED FOR: Jul 18 2004 9:37AM COMPLETED: Jul 18 2004 9:46AM
INDICATIONS/COMMENTS: PER MD ORDER

RESULT:

Fractures of the base of the right fourth and fifth metacarpals and questionable fracture base of the third metacarpal. Two pins have been inserted and a cast has been applied. Fractures in good position.

CONCLUSION: SEE ABOVE.

RADIOLOGIST: CHENEY M. MEIERE JR., MD
cb
July 20, 2004 1:01 AM

Final Result
ELECTRONICALLY SIGNED BY:
CHENEY M MEIERE JR, M.D.

FLORENCE RADIOLOGICAL ASSOCIATES
If you have received this document by facsimile, the information contained in this transmission may contain medical record information and is privileged and confidential. It is intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone (collect) and return the original message to us at the address indicated via the US Postal Service.

ResCare Premier

220 W. Hutchison
San Marcos, Texas 78666

phone: 512.396.1200
fax: 512.396.2024
toll free: 1.800.28.BRAIN
email: admissions@rescarepremier.com
www.rescarepremier.com

ResCare Premier
Town Program
Outcome Goal Plan

Name: Scottie Floyd
Substitute Decision Maker:
Betty Joe Floyd
Diagnosis: Traumatic Brain Injury

Date: 10-01-05 to 12-31-05
Date of Admission: 7- 27-2004
Date of Injury/Event: 9-13- 2001
Re-Evaluation Date: December 2006

Involved Parties:
Betty Joe Floyd, mother/Substitute Decision Maker
Melody Harris, Case Manager
Steve Wukela, Attorney

Review of Substitute Decision Maker (SDM) Status:
Betty Joe Floyd currently is Scottie's SDM. The treatment team agrees that Scottie requires a legal SDM due to poor safety, decreased cognitive ability and poor judgment. This arrangement appears to be favorable.

Impairments:
Scottie was involved in a work related accident when a suspension spring hit him in the forehead and resulted in a closed head injury. He has experienced some cognitive difficulties as well as significant headaches and psychological difficulties since the accident. Scottie has severe headaches and back pain which, at times, lead to his agitation. He has limited vision in his right eye and wears sunglasses to prevent seeing bright lights. Scottie has limited to no feeling in his right arm and has magnified hearing in his right ear. Scottie suffers from severe migraine headaches as well.

Participant Strengths:
Independent Self-Care Medically Stable
Orientation Insight
Social Helpful
Enjoys outdoors Polite
Likes to go fishing Meal Preparation
Use of humor Family oriented

Activity Limitations:
Processing information Problem-solving
History of physical aggression Impulse control
Expression of emotion Judgment
Back pain Limited vision in right eye
Headaches Limited sensation in right arm
Initiation of daily activities Stamina

Participation Restrictions:
1. Unable to drive due to long-term deficits from TBI. Requires assistance for transportation. No valid driver's license.
2. Supervision to ensure safety.
3. Supervision of medication regimen.

Special Communication Needs:
Scottie currently has no special needs in the area of communication.

Characteristics of the Intended Discharge/Transition Environment:
It is intended that Scottie will reside in a supported living environment during the remainder of this quarter. Eventually, it is the goal of Scottie and his SDM for him to live at home with his mother in Marion, South Carolina. However, there are several limitations to the discharge environment which include: no public transportation, limited opportunity for routine activities outside the home (e.g., volunteer work).

Level of Supervision Required:
Level 6 Supervision: Reduced Supervision: Scottie requires reduced supervision while participating in activities at the program. He can be left unsupervised for thirty minutes in this setting. During times in his room and living room he can left unsupervised for one hour.

Level 7 Supervision: Remote Supervision: Scottie requires remote supervision during community-based activities and while at his volunteer position in the community. Scottie signs out in the participant log, which informs the treatment team of his whereabouts, time of departure from the program, and time of expected return to the program. Scottie has been approved to participate in outings to local theater, grocery store, and movie rental store independently. Scottie is approved to check out for one hour at a time or for the length of a movie when visiting the movie theatre.

Delegated Supervision-
Scottie receives delegated supervision when someone supervises him other than a ResCare Premier employee. The time frame for which supervision is delegated and the person to whom the supervision is delegated, usually a family member, friend, or employer, is documented on the Participant Leave form. Ms. Floyd must give consent before Scottie is to be supervised by someone other than a ResCare Premier staff member.

Overnight Staffing-
Scottie requires standard overnight staffing. This supervision is provided consistent with the licensing requirements. The Town Program has one awake overnight staff member that makes bed checks each hour.

Current Medications: (as of 12-31-05)
Keppra 500 mg 1 1/2 breakfast, 1 1/2 bed
Flexeril 5 mg 1 breakfast, 1 bed
Effexor 75 mg 1 breakfast, 2 bed
Depakote 500 mg 1 breakfast, 1 ln, 1 dinner
Claritin 10mg 1 breakfast (started on 10-27-05)
Darvocet N 100 mg 1 or 2 tabs x 6 hours for pain, as needed
Sudafed 12 hr 120 mg 1 breakfast, 1 bed, as needed for allergies

Medication Changes:
Zyprexa 5mg 1 dinner discontinued 12-14-05
Flexeril 5mg 1 dinner discontinued 12-21-05
Claritin 10mg 1 lunch started 11-16-05 and was discontinued 12-17-05

Allergies:
Coconut

Medical Issues:
On October 12th Wesley Wallis, MD met with Scottie and agreed to investigate alternative medications for his severe headaches.

On October 26th Dr. Wallis recommended Frovia 2.5 mg for Scottie to use for the severe headaches. He recommended that Scottie take one pill and could have another one in two hours as needed. Scottie reported that this medication did not help.

On October 27th Scottie had bloodwork drawn. He had a slightly elevated liver panel. A repeat lab draw will be in January.

On November 7th saw Larry Molenda, DDS to decide treatment plan for addressing Scottie's extensive dental issues. Scottie wants to pull all of his teeth and be fitted for dentures. A second opinion will also be sought.

On November 17th Dr. Wallis added an additional Claritin at lunch in an attempt to help with allergy related headaches. Scottie reported that the Claritin helped some. Later in the period, he reported that he believed the Claritin was making him sleepier, so he requested to use it as needed.

On December 12th saw J. Robert Donnelly, DDS for a second dental evaluation and cost analysis. The proposal is still pending at this time.

Training Provided Participant:
1. Functional Social Skills Training
2. Alternative Behavioral Strategies
3. Brain Injury Education
4. Relaxation Training

Training Provided Family:
1. Telephone updates on status
2. Community resource information
3. Brain injury education
4. Behavior Management

Communities of Choice:
1. Scottie's long-term goal is to return to South Carolina to live near/with his mother.
2. Recreation center
3. Library
4. Vendors/places of entertainment in the San Marcos area

Type of Services Needed: Supported Living Program
Duration: Re-Evaluation Date: December, 2006
Frequency (intensity): Daily
Responsible Party: Jane Stewart, Executive Program Director and the Town Program Treatment Team

Financial Resources Available:
Crawford & Company, Workers Compensation

Name of Person Coordinating Care:
Jane Stewart, Executive Program Director

Participant Expectations and Goals:
1. Anger management
2. Daily routine
3. Stop provoking people to challenge him
4. Return to work/volunteer
5. Be more independent

Family Expectations and Goals:
1. To help him however necessary

Funder Expectations and Goals:
1. Anger management
2. Vocational placement
3. Increase Judgment
4. Decrease headaches

Agreed Upon Outcome Goals

1. Scottie will plan and budget for personal purchases and expenses with minimal staff member support 85% of the time each quarter. **(Achieved)**
2. Scottie will reconcile his expenditures with no more than 3 mistakes per session. **(Achieved)**
3. Scottie will refrain from verbal aggression with no more than 12 incidents per quarter. **(Achieved)**
4. Scottie will refrain from physical aggression with no more than 1 incident per quarter, (to include property damage). **(Achieved)**
5. Scottie will increase the length of time he goes without pain medication (Darvocet N 100, Maxalt) to an average of 12 hours. **(Achieved)**
6. Scottie will remain drug-free 100% of time each quarter. **(Achieved)**
7. Scottie will prepare six meals per month with moderate assistance (3-5 cues per meal) from staff members. **(Achieved)**
8. Scottie will pack his medications (with minimal assistance from staff members) with no more than 6 mistakes for 90 days **(Achieved)**
9. Scottie will participate in structured activities 85% each quarter. **(Not Achieved)**
10. Scottie will maintain a clean and orderly living area 60% of the time with moderate assistance (3-5 cues). **(Achieved)**
11. Scottie will participate in a volunteer position for 5 hours a day for an average of 3 times a week for 12 weeks. **(Not achieved: Discontinued)**
12. Scottie will practice relaxation techniques an average of 2 times a week (for a minimum of 30 minutes) each for twelve weeks. **(Achieved)**

Outcome Goals for 4th Quarter 2005:

1. Scottie will participate in structured activities 85% of the time for the 90-day period. **(Not Achieved)**
2. Scottie will pack his medications (with minimal assistance from staff members) with no more than 2 mistakes per 90 days. **Achieved & maintain**
3. Scottie will participate in a volunteer position and average of 3 times per month. **(Achieved)**
4. Scottie will maintain a clean and orderly living area and bathroom, 70% of the time. **(Achieved with moderate assistance)**
5. Scottie will practice relaxation techniques and chart an average of 2 times per week for the quarter. **(Achieved)**
6. Scottie will plan and attend one individual outing in the community each week. **(Achieved)**
7. Scottie will cook two meals per month for the group with minimal assistance from staff members. **(Not Achieved)**

All Objectives are for a 90-day period. (10-01-05 to 12-31-05)

Scottie will cook two meals per month for the group with minimal assistance from staff.
Tie to Outcome Goal: # 7
Interventions: Staff members will:

- Provide Scottie with menu items for each meal.
- Provide stand-by assistance while in the kitchen.
- Encourage Scottie to plan and schedule meals in advance.
- Provide assistance as needed

Current Status: Not Achieved
Scottie accomplished this goal two out of the three months. In October, Scottie cooked two meals. In November he did not complete the objective, and in December Scottie cooked 4 meals. Scottie seems to enjoy cooking meals for the group.
Responsible Party: Town Program Treatment Team

Scottie will plan and attend one individual outing in the community each week.
Tied to Outcome Goal: # 6
Interventions: Staff members will:
- Provide Scottie with outing information.
- Assist and encourage Scottie to arrange outing.
- Provide transportation and support as needed while in the community.

Current Status: Achieved
Scottie accomplished his objective 10 out of 11 weeks. The last week of the quarter Scottie declined to participate in most activities but did agree to an outing to a restaurant.
Responsible Party: Town Program Treatment Team

Scottie will pack his medications (with minimal assistance from staff members) with no more than 2 mistakes for 90 days.
Tied to Outcome Goal: #2
Interventions: Staff members will:
- Prompt Scottie to pack his medications at the scheduled time each week
- Provide stand-by supervision while Scottie packs medications
- Provide stand-by supervision while Scottie orders medications
- Review medication note cards with Scottie to help him with medication packing
- Provide assistance as needed

Current Status: Achieved
Scottie packed his medications 13 of 13 times without any mistakes. The treatment team will evaluate having Scottie carry his medications on his person each day, requiring him to the check them out each morning and in each evening.
Responsible Party: Town Program Treatment Team

Scottie will participate in structured activities 85% of the time for 90 days.
Tied to Outcome Goal: #1
Interventions: Staff members will:
- Provide Scottie with a schedule of weekly activities
- Assist Scottie in arranging for all group and individual activities weekly
- Prompt Scottie to follow his schedule
- Provide positive reinforcement for participation

Current Status: Not achieved. Continue

Scottie participated in daily structured activities only 79% of the time during this quarter. Scottie was able to structure his time better by participating in PAC (participant advocacy committee) group and planning meeting weekly. Scottie was much more active this quarter compared to the third quarter. He began helping the staff members with projects around the house, such as grocery shopping and yard projects. He also began scheduling individual activities in the community, such as going to the coffee shop. Scottie was the only participant at the Townhouse Program that did not have a Christmas visit home. Although staff had planned numerous special outings during this time, Scottie chose not to participate in any activities. For about two weeks, Scottie refused to participate and often needed additional cues to get out of bed and to shower. The treatment team will monitor this area and consider an individual behavior plan if needed.
Responsible Party: Town Program Treatment Team

Scottie will participate in a volunteer position an average of 3 times per month for 90 days.
Tied to Outcome Goal: #3
Interventions: Staff members will:

- Assist Scottie in finding a volunteer position that he enjoys
- Provide Scottie with transportation to and from his volunteer position
- Obtain work evaluations from volunteer supervisor each week
- Review completed work evaluations with Scottie

Current Status: Achieved
Scottie accomplished his objective two out of three months. In November, a visit from his mother kept him occupied and he was only able to volunteer once that month. His absences from his volunteer position are considered excused, and the objective achieved. Scottie's volunteer position involved facility and vehicle maintenance and safety. Scottie goes with a staff member to other ResCare Premier programs and inspect the vehicles and buildings for repairs. He was very strict and took pride in giving feedback to the programs about any problem areas he found.
Responsible Party: Town Program Treatment Team

Scottie will maintain a clean and orderly living area and bathroom 70% of the time.
Tied to outcome goal: # 4
Interventions:

- Scottie will be given a daily schedule with time to clean his room.
- Staff members will prompt Scottie at the appropriate time to clean his room.
- Staff members will check his room and offer feedback about his room.
- Staff members will praise Scottie when his room is completed and clean.
- Scottie will be able to earn rewards for having a consistently clean living area.

Current Status: Achieved
Scottie maintained a clean and orderly living area 89% of the time with maximum cues from staff members. Scottie also required additional cues to wash his bed linens and clothes.
Responsible Party: Town Program Treatment Team

Scottie will practice relaxation techniques and chart an average of 2 times a week for the quarter.
Tied to outcome goal: # 5
Interventions:

- Staff members will practice techniques with Scottie
- Remind Scottie to complete the relaxation techniques at least twice a week
- Remind Scottie of relaxation techniques when he feels frustrated or angry
- Provide therapeutic relaxation materials

Current Status: Achieved
During last quarter, Scottie made a concerted effort to utilize his relaxation techniques and chart. During the first two weeks of this quarter he stated that he did not want to use the relaxation tapes and would apply relaxation strategies independently. It should be noted that Scottie went 15 days without having to take Darvocet N 100 for his headaches.
Responsible Party: Town Program Treatment Team

Maintenance Objectives:

Scottie will increase the length of time without pain medication (Darvacet) to an average of 10 hours.

- Praise Scottie for being able to function without pain medication.
- Encourage Scottie to only take medication when necessary.
- Encourage Scottie to take OTC pain medication.
- Teach relaxation skills.
- Provide low stimulus environment.

Current Status: Long Term Maintenance
Scott continued to monitor and control his use of Darvocet N 100 only taking twenty in the last 90 days. He last took Darvocet N 100 for a headache on 12-16-05 going the last fifteen days of the quarter with out taking a Darvocet N 100.
Responsible Party: Town Program Treatment Team

Scottie will refrain from verbal aggression with no more than 5 incidents per quarter.
Interventions: Staff members will:

- Encourage Scottie to have positive interactions with others on a daily basis.
- Commend Scottie each time he effectively has a positive interaction with others.
- Role-model positive interactions.
- Offer social skills training.
- Teach alternative behavioral strategies.
- Support with repetition and rehearsal of skills.

Current Status: Long Term Maintenance
There have been no reported incidents of verbal aggression during this quarter.
Responsible Party: Town Program Treatment Team

Scottie will remain drug free 100% of the time during this quarter.
Interventions: Staff members will:

- Provide opportunities for attendance at AA/NA meetings in the community
- Provide opportunities for informal and formal counseling if needed to address drug abuse issues
- Provide structured /scheduled activities of interest
- Encourage leisure activities that do not involve substance use

Current Status: Long Term Maintenance
Scottie has refrained from drug use 100% of the time during this quarter based on staff observation.
Responsible Party: Town Program Treatment Team

Scottie will refrain from physical aggression 100% of the time for 90 days, (to include property damage).
Interventions: Staff members will:

- Encourage Scottie to have positive interactions with others on a daily basis.
- Commend Scottie each time he effectively has a positive interaction with others.
- Role-model positive interactions.
- Have positive interactions with Scottie to encourage positive interactions with others.
- Provide social skills training.
- Teach alternative behavioral strategies.
- Support with repetition and rehearsal of skills.

Current Status: Long Term Maintenance
There have not been any incidents of physical aggression during this period.
Responsible Party: Town Program Treatment Team

Proposed Goals for 2006

Scottie will participate in structured activities 85% of the time during any one quarter.

Scottie will pack his medications (with minimal assistance from staff members) with no more than 2 mistakes per 90 days.

During a 6 month period, Scottie will have no more than one missed medication.

Scottie will participate in a volunteer position an average of 4 times per month.

Scottie will maintain a clean and orderly living area and bathroom 75% of the time with minimal support.

Scottie will plan, initiate and follow-up on individual activities in the community (unsupervised) a minimum of 2 times a month on average.

Scottie will cook two meals per month for the group with minimal assistance from staff members.

Objectives for First Quarter 2006:

Scottie will participate in structured activities 85% of the time.

Scottie will pack his medications (with minimal assistance from staff members) with no more than 3 mistakes for 90 days.

Scottie will participate in a volunteer position an average of once a week for 90 days.

Scottie will maintain a clean and orderly living area and bathroom, 80% of the time with moderate assistance.

Scottie will have no more than 3 missed medication, while carrying his medications this quarter.

Scottie will plan, initiate and follow through with an individual activity in the community (unsupervised) a minimum of 2 times per month on average.

Scottie will cook 1 meal a week for himself and a staff member with minimal assistance from staff.

Service Needs:

1. Contacts with his mother and case manager – Ongoing
2. Ongoing evaluation of dental issues.
3. Evaluate carrying medications each day.

Narrative:

Scottie achieved 2 out of 7 objectives this quarter. Scottie began the quarter off with a positive attitude, working with staff to remain productive throughout the day. This started with a decrease in his reliance on Darvocet to control his headaches.I In October he utilized the medication 11 times, then in November only required it 5 times, and finally only 4 times in December and for the last 15 days of the quarter didn't take any.

Scottie's mother came for a visit at the end of November. Scottie was focused positively on the visit from his mother, and continued to participate in the program activities and routine. He was able to make the arrangements and design a schedule for the week with staff member assistance. He seemed to take pride in being able to make the plans and spend time out of the program with his mother. While his mother was here, they cooked dinner for the group.

As explained earlier, the Christmas Holidays were difficult for Scottie. His problem behavior at the program carried over with his family in having negative telephone conversations or hardly talking at all. Scottie was encouraged to meet with the program psychologist, however, he refused. Within several days of the Christmas holiday,

Scottie's mood gradually improved and he showed more of an interest in program activities.

Scottie participated in numerous community activities, such as IMAX, museum, arcade, movies, half-priced books, Hastings, shopping with mother in Austin during visit and dinners out. In addition to community activities Scottie regularly attended a weekly coffee outing with a staff member, Thanksgiving luncheon, and holiday party with other programs. Scottie's willingness to participate in program outings was dependent, at least in part, on his providing input regarding the choice of activities during his regular planning and PAC meetings.

Thank you for allowing us the opportunity to participate in Scottie's rehabilitation. Please feel free to contact me with questions or concerns with his program at (512) 396-1305.

Jane Stewart

Jane Stewart
Executive Program Director

cc: Betty Joe Floyd- mother/SDM
Melody Harris- case manager
Steve Wukela- Attorney

ResCare Premier

220 W. Hutchison
San Marcos, Texas 78666

phone: 512.396.1200
fax: 512.396.2024
toll free: 1.800.28.BRAIN
www.rescarepremier.com

ResCare Premier
Town Program
Discharge Outcome Goal Plan

Name: Scottie Floyd
Substitute Decision Maker:
Betty Joe Floyd
Diagnosis: Traumatic Brain Injury

Date: 04-01-06 to 06-01-06
Date of Admission: 7- 27-2004
Date of Injury/Event: 9-13-2001
Discharge Date: 6-1-06

Involved Parties:
Betty Joe Floyd, mother/Substitute Decision Maker
Melody Harris, Case Manager
Steve Wukela, Attorney

Review of Substitute Decision Maker (SDM) Status:
Betty Joe Floyd currently is Scottie's SDM. The treatment team agrees that Scottie requires a legal SDM due to poor safety, decreased cognitive ability and poor judgment. This arrangement appears to be favorable.

Impairments:
Scottie was involved in a work related accident when a suspension spring hit him in the forehead and resulted in a closed head injury. He has experienced some cognitive difficulties as well as significant headaches and psychological difficulties since the accident. Scottie has severe headaches and back pain which, at times, lead to his agitation. He has limited vision in his right eye and wears sunglasses to prevent seeing bright lights. Scottie has limited to no feeling in his right arm and has magnified hearing in his right ear. Scottie suffers from severe migraine headaches as well.

Participant Strengths:
Independent Self-Care
Medically Stable
Orientation Insight
Social Helpful
Enjoys outdoors
Polite
Meal Preparation
Use of humor
Family oriented

Activity Limitations:
History of physical aggression Impulse control
Expression of emotion
Judgment
Limited vision in right eye
Headaches
Limited sensation in right arm
Stamina

Participation Restrictions:
1. Unable to drive due to long-term deficits from TBI. Requires assistance for transportation. No valid driver's license.
2. Supervision to ensure safety.

Special Communication Needs:
Scottie currently has no special needs in the area of communication.

Characteristics of the Intended Discharge/Transition Environment:
It is intended that Scottie will reside in a supported living environment during the remainder of this quarter. Eventually, it is the goal of Scottie and his SDM for him to live at home with his mother in Marion, South Carolina. However, there are several limitations to the discharge environment which include: no public transportation, limited opportunity for routine activities outside the home (e.g., volunteer work).

Level of Supervision Required Prior to Discharge:
Level 6 Supervision: Reduced Supervision: Scottie requires reduced supervision while participating in activities at the program. He can be left unsupervised for thirty minutes in this setting. During times in his room and living room he can left unsupervised for one hour.

Level 7 Supervision: Remote Supervision: Scottie requires remote supervision during community-based activities and while at his volunteer position in the community. Scottie signs out in the participant log, which informs the treatment team of his whereabouts, time of departure from the program, and time of expected return to the program. Scottie has been approved to participate in outings to local theater, grocery store, and movie rental store independently. Scottie is approved to check out for one hour at a time or for the length of a movie when visiting the movie theatre.

Delegated Supervision-
Scottie receives delegated supervision when someone supervises him other than a ResCare Premier employee. The time frame for which supervision is delegated and the person to whom the supervision is delegated, usually a family member, friend, or employer, is documented on the Participant Leave form. Ms. Floyd must give consent before Scottie is to be supervised by someone other than a ResCare Premier staff member.

Overnight Staffing-
Scottie requires standard overnight staffing. This supervision is provided consistent with the licensing requirements. The Town Program has one awake overnight staff member that makes bed checks each hour.

Medications: (as of 6-1-06)

Keppra 500mg 1 1/2 tabs @ BK, and BD
Depakote ER 500mg 1 tabs @ BK, and 2 @BD
Loratadine 10mg 1 tab @ BK
Flexeril 5mg 1 tab @ BK, and BD
Darvocet 100mg PRN

Allergies:
Coconut

Medical issues:

On April 5, Scottie saw Dr Wallis following his home visit. Dr. Wallis stated that since Scottie did so well on his home visit, he recommended stopping the Effexor.

On April 10, Scottie went to CPL for additional lab work on his liver function. His levels were elevated and Dr. Wallis asked for a repeat.

On May 3, Scottie seemed more on edge and anxious, but no medication changes noted.

On May 11, Scottie returned for a follow up liver function test. Later that day he went to Austin Radiology Associates for an ultrasound on his liver. The test results showed that Scotty has a fatty infiltration of the liver. No treatment needed at this time. Dr. Wallis recommended continuing periodic lab work to monitor.

On May 17, Scottie seemed more anxious and irritable. Dr. Wallis recommended Clorazepate 7.5 mg, twice a day as needed. He also prescribed Valium 5mg, 2, 2 hours before boarding the airplane.

On May 24, Dr. Wallis met with Scottie and reviewed his discharge questioner questionnaire and discussed his discharge plans.

Type of Services Needed: Supported Living Program
Duration: Discharge Date June 1, 2006
Frequency (intensity): Daily
Responsible Party: Jane Stewart, Executive Program Director and the Town Program Treatment Team

Financial Resources Available:
Crawford & Company, Workers Compensation

Name of Person Coordinating Care:
Jane Stewart, Executive Program Director

Training Provided Participant:
1. Functional Social Skills Training
2. Alternative Behavioral Strategies
3. Brain Injury Education
4. Relaxation Training

Training Provided Family:
1. Telephone updates on status
2. Community resource information
3. Brain injury education
4. Behavior Management

Communities of Choice:
1. Scottie's long-term goal is to return to South Carolina to live near/with his mother.
2. Recreation center
3. Library
4. Vendors/places of entertainment in the San Marcos area

Participant Expectations and Goals:
1. Anger management
2. Daily routine
3. Stop provoking people to challenge him
4. Be more independent

Family Expectations and Goals:
1. To help him however necessary

Funder Expectations and Goals:
1. Anger management
2. Vocational placement
3. Increase Judgment
4. Decrease headaches

Agreed Upon Goals for 2006

1. Scottie will participate in structured activities 85% of the time during any one quarter. **Achieved**

2. Scottie will pack his medications (with minimal assistance from staff members) with no more than 2 mistakes per 90 days. **Achieved**

3. During a 6 month period, Scottie will have no more than one missed medication. **Achieved**

4. Scottie will participate in a volunteer position an average of 4 times per month. **Not Achieved**

5. Scottie will maintain a clean and orderly living area and bathroom 75% of the time with minimal support. **Achieved**

6. Scottie will plan, initiate and follow-up on individual activities in the community (unsupervised) a minimum of 2 times a month on average. **Achieved**

7. Scottie will cook two meals per month for the group with minimal assistance from staff members. **Achieved**

Objectives for April 1 – June 1, 2006: The objectives for April-June remained the same as 1st quarter to ensure stability. As noted, Scottie achieved all the goals and objectives except one, this includes his long term maintenance objectives as well.

1. Scottie will cook 1 meal a week for himself and a staff member with minimal assistance from staff. **Achieved**

2. Scottie will plan, initiate and follow through with an individual activity in the community (unsupervised) a minimum of 2 times per month on average. **Achieved**

3. Scottie will pack his medications (with minimal assistance from staff members) with no more than 3 mistakes for 90 days. **Achieved**

4. Scottie will participate in structured activities 85% of the time for 90 days. **Achieved**

5. Scottie will participate in a volunteer position an average of once a week for 90 days. **Not Achieved**

6. Scottie will maintain a clean and orderly living area and bathroom 80% of the time. **Achieved**

7. Scottie will have no more than 3 missed medications, while carrying his medications this quarter. **Achieved**

Maintenance Objectives:

Scottie will increase the length of time without pain medication (Darvocet) to an average of 10 hours. **Achieved**

Scottie will refrain from verbal aggression with no more than 5 incidents per quarter. **Achieved**

Scottie will remain drug free 100% of the time during this quarter. **Achieved**

Scottie will refrain from physical aggression 100% of the time for 90 days, (to include property damage). **Achieved**

Narrative:

Scottie and the treatment team spent a great deal of time during since January planning and preparing for his discharge. With the assistance of his case manager, Cindy Grimley, a therapist was identified for Scottie post discharge. Scottie's mother was able to begin sessions with the therapist prior to Scottie's discharge to assist her in preparing for Scottie returning home. In addition, Scottie's previous doctor, Dr. Healy agreed to resume seeing Scottie upon his return home.

AsThe closer to the June 1, discharge date approached, Scottie became more anxious. He was able to express his anxiousness appropriately and would often discuss his feelings with the staff members. However, there were periods in which Scottie would sleep most of the day, stating it was easier to sleep than to think about all the changes that he was fixing to have in his lifeanticipating. With encouragement Scottie would resume participation in his program.

Scottie's mother came on May 25 and stayed until the date of discharge. Before her visit, Scottie expressed that he did not want to spend time with her at the hotel. But when she was here, he spent all but one night with her.

Scottie planned a camping trip with a staff member on May 25 and 26th. Scottie seemed to enjoy the outing away from the program.

Recommendation

Cognitive:

Scottie is able to express the things he likes and dislikes, activities he would like to complete, etc. His deficit in this area is with follow-through. On occasions, he will initiate and plan and activity, such as walking to town, breakfast out, or etc., but not always follow through on the plans.

- Encourage Scottie to make plans in the community

- Provide transportation when needed
- Utilize a schedule, planner for activities

Behavioral:

Scottie's behavior has improved dramatically during his rehabilitation at ResCare Premier. However, the potential for Scottie to become intimidating and angry seems to still be present. Scottie has accepted that he has to control his anger to function in society. When he becomes intimidating the staff members usually ignore the behavior and will leave the area, not giving Scottie any power. He has shown the intimidating behavior once in an 8 month period.

- Remind Scottie to keep anger under control
- Do not argue with Scottie or make him feel like he is in a corner
- Offer options when angry
- Leave the area when Scottie becomes angry, argumentative or intimidating

Activities of Daily Living/Functional Skills:

Scottie is very self sufficient with his activities of daily living. Because he has no sense of smell, staff members will have to cue him sometimes when his room smells, from sweaty clothes, or shoes, toor trash. Scottie is compliant when staff point out the odor. He acknowledges that the he cannot smell. Scottie is successful in maintaining his own banking. Scottie has limited sensation in his right arm, and occasionally he will reference the deficit when performing labor type of tasks, i.e. carrying something. Scottie is independent in cooking. He is able to cook a variety of items, not always well-balanced, but a variety.

- Cue when room smells
- Praise when his living space is clean and tidy
- Praise when he looks nice

Medical:

Scottie has decreased the amount of medication he is on tremendously since his admission. His use of Darvocet has decreased to the point that he generally tries to "work through" the pain and will use Darvocet as a last resort. Dr. Wallis, will provide a more detailed recommendation report regarding Scottie's medical needs.

Volunteer:

This area has fluctuated during his program at ResCare. Scottie tried volunteering at places like the food bank without success. The environment (other co-workers) and the lifting were areas of difficulty for him. He was able to volunteer at ResCare Premier in doing facility and vehicle safety inspections. He was able to follow a check list and report any infractions to the staff members. In developing a volunteer type program for Scottie we discovered that when he is given some authority and/or responsibility he takes the position much more serious. Scottie was not interested in finding other

volunteer work in the community, stating that when he was discharged there was no place to volunteer.

- Assist Scottie in locating a place to volunteer
- Encourage Scottie to participate in an activity to keep himself busy
- Provide Scottie with transportation to a volunteer position

Social/Leisure:

Scottie will participate in group activities that are of interest to him with other program participants and staff. He does not have any community social groups in which he is involved. On occasions when Scottie would go into town, he practiced safe walking habits, and returned each time without incident. Scottie expresses concern about returning home to his previous "social" group. We have discussed the importance of making changes with his peer group. He acknowledges that the previous groups are not a good influence. This appears to be an area of concern and anxiety for him.

- Encourage Scottie to develop new friends
- Praise Scottie for refraining from old friends and their behaviors
- Encourage Scottie to utilize the community for social activities

Driving:

Scottie is not eligible to drive at this time. His mother or others will need to provide transportation for him. He was encouraged to use the public transportation system in San Marcos. He denied such requests, stating that there was not such a system in Marion.

Drugs/Alcohol:

Scottie has remained drug and alcohol free at ResCare Premier for over a year. When he went on a home visit in March 2006, it was reported that he drank and smoked pot. Scottie talks openly about using pot occasionally upon discharge. He accepts that neither substance is good for someone with a brain injury, but believes alcohol is worse than pot. He has been non-compliant in attendingunwilling to attend AA or NA. He says he uses "recreationally" and is not addicted.

- Encourage Scottie to remain substance free
- Continue to educate Scottie on effects of substances on brain injury

In assisting Scottie with his rehabilitation, the treatment team found that developing a good relationship with Scottie enables the team to address behaviors and other deficit areas. Scottie is very adamant that he is not treated like a child or an imbecile. He responds well to options. Also, when asked to do a task, he responds better if he is given the task and a time frame in which the task might be completed. He responds well to, questions like, "what do you think?" i.e. What do you think might work for organizing this tool room?

Scottie has lots of interests and finding something in common goes a long way with him. If you approach him in a more peer like manner as opposed to a "professional vs. patient" his response is much better. When discussing his medication and possible changes, Scottie's responsiveness is much better when asked to try the change for a short period of time and if it does not work, then a reassessment will occur.

As indicated above, Scottie has made tremendous improvement since his admission to ResCare Premier, however, there continues to be some apprehension on the part of the treatment team asnd to Scottie's ability to be completely successful when living with minimal support, such as with his mother or independently. Scottie has been informed that if/when he needs additional support he may call or come back to ResCare Premier for assistance.

Thank you for allowing us the opportunity to participate in Scottie's rehabilitation. Please feel free to contact me with questions or concerns with his program at (512) 396-1305.

Jane Stewart
Executive Program Director

cc: Betty Joe Floyd- mother/SDM
Melody Harris- case manager
Steve Wukela- Attorney

ResCare Premier

220 W. Hutchison
San Marcos, Texas 78666

phone: 512.396.1200
fax: 512.396.2024
toll free: 1.800.28.BRAIN
www.rescarepremier.com

January 3, 2005

Steve Wukela, Attorney at Law
403 2nd Loop Road
P. O. Box 13057
Florence, SC 29504-3057

Re: Scottie Floyd

To Whom It May Concern:

Scottie Floyd is currently receiving rehabilitation services at ResCare Premier's 'Roca Vista' program. Mr. Floyd requires aid with interpersonal interactions, low frustration tolerance with intermittent explosive disorder, health and safety issues, transportation, and financial management secondary to the residual effects of his traumatic brain injury.

Mr. Floyd exhibits gross limitations in the area of social judgment, as well as emotional functioning. He has a tendency to be overly reactive and impulsive and has aggressive outbursts. When provoked (even as a result of minor misunderstandings) Mr. Floyd has become physically and verbally threatening. For example, after a misunderstanding at the Roca Vista program on December 19, Mr. Floyd exhibited the behavior described: he became physically and verbally threatening toward another participant in the program who happened to be of smaller stature than Mr. Floyd. He incited fear in the other participants living in the program, as well as staff members, and it was necessary to address ongoing verbal threats for approximately three hours before Mr. Floyd was able to calm down. This pattern of behavior was observed during the years since his injury while Mr. Floyd was living at home and prior to his admission to ResCare Premier (e.g., he had become aggressive in the home, frightening his mother; he punched holes in walls; he broke his hand by punching a tree; he had become threatening in public health settings, etc.)

While he has shown considerable improvement during the course of his treatment, this improvement is attributed, to a large extent, to the nature of the rehabilitation environment (highly structured, with clearly defined limits and expectations, with trained staff members, and in which environmental stressors can be controlled). Without this level of support, it is my opinion that Mr. Floyd would regress considerably, that this type of incident would occur more frequently, and that it would occur at the expense of the safety and well-being of Mr. Floyd, his family and members of the community.

Mr. Floyd requires regular supervision and monitoring of his health. Due to problems with judgment and impulsivity, without supervision he would have problems remembering to take his medication (including those that prevent seizures), taking it when it is not necessary or more often than prescribed, or being noncompliant with his prescribed medical regimen. He may take his medication and then demand to be taken to the emergency room if he does not see an immediate effect. This was a repeated pattern of behavior observed in the community prior to his admission.

Mr. Floyd does not cook independently nor has he shown any initiation in this area. He does not drive due to visual problems resulting from his injury and he has not exhibited the ability to be gainfully employed for any appreciable length of time (particulary due to his ongoing health problems which have included a recent diagnosis of multiple fractures in his back). Visual problems will also interfere with his ability to work in his previous occupation (mechanics). He requires oversight to manage his money and in the absence of such will most likely overspend, misappropriate funds, or fail to pay debts.

Mr. Floyd requires regular encouragement in order to be productive on a daily basis. Without this, he is non-productive, spending the majority of his day sleeping.

It is my clinical opinion and the opinion of his treatment team that he continue to have residential rehabilitation treatment and a guardian/substitute decision maker for a minimum of one year. In the absence of such, I would be concerned about his safety and the safety of the community in which he resides. I do not believe that the need for a guardian will diminish in the immediate future. While individuals with injuries similar to that of Mr. Floyd do make progress over time, deficits tend to be life-long and progress is typically made over the course of many years.

If I can be of further assistance, please contact me directly at 512-396-1200.

Sincerely,

Joanne M. McGee, Ph.D.
Licensed Neuropsychologist
Clinical Director, ResCare Premier
Texas Operations

Cindy C

J. Wesley Wallis, M.D.
2108 Hunter Road, Suite 116
San Marcos, Tx 78666
(512) 754-7700

03/14/2006

Fax to: Joseph Healy, M.D.
RE: Scottie Floyd

Dear Dr. Healy:

I've been following Mr. Floyd since August of 2004 and have made several medication alterations in the hope of helping impulsivity, anxiety, and anger. He originally came in on Keppra 500 mg 1½ b.i.d., clorazepate 7.5 mg t.i.d., and Zyprexa 5 mg t.i.d., Depakote 500 mg 3 at b.d. and Paxil CR 25 mg q.a.m. He was diagnosed with post traumatic headaches in addition to migraines and I did try at least Inderal 160 mg up to 320 mg for a period of time as well as Flexeril 5 mg t.i.d., Imitrex, Pamelor 25 mg at night. He did not have much response to many of the medication trials and I did refer him to a Michael Edmond (neurologist). He reviewed all of the different trials of medication and he recommended no additional medications. He felt the patient had already tried all known headache prophylaxis meds. He concurred with continue psychiatric management as it clearly served as the trigger and limitation of some of the environmental issues and I've included that report. I also tried him on Effexor up to the 225 mg dose which did seem to help some of his irritability, anger and impulsivity as well as headaches. We did try Imitrex, Maxalt, Amerge, Axert and Frova with minimal success. He did seem to have some benefit with the dose of Flexeril. He has recently been weaned down on the Effexor and we noted some increase in anxiety and being on edge. His Zyprexa was also decreased over 2005 to 5 mg at night by December 2005. My present plan has been to hold at the present medications until after his home visit. He has done fairly well over the past 6 months controlling his irritability, anxiety, anger and mood swings with less meds from 20004. He has had some trouble with motivation. He has cut his Darvocet use considerably over the past year. Several different medications have helped regarding the above problems; however, he does still have some headaches but of less intensity. The staff has asked me give you an update regarding his present meds. Let me know if you have any questions.

Sincerely,

J. Wesley Wallis, M.D.
JWW/sjs.drwords

CAROLINAS HOSPITAL SYSTEM

805 Pamplico Highway

. Box 100550

. .rence, S.C. 29501-0550

Registration Form

PATIENT NAME/ADDRESS	ACCOUNT NO.	TYPE	ROOM	UNIT NO./MED. REC. NO.
FLOYD, SCOTTIE W	H17135633	RCR		H337978

BIRTHDATE	RELIGION	LOCATION/SERVICE
	OTHER	CRFPT

PHONE / SOC. SEC. NUM.	AGE	PERSON TO NOTIFY/ADDRESS	RELATIONSHIP
PATIENT EMPLOYER: UNEMPLOYED	30	BIRD, KIMBERLY	SI
	PT. SEX: M		

GUARANTOR/ADDRESS	PT. RACE	HOME PHONE	OTHER PHONE	RELATIONSHIP
FLOYD, SCOTTIE W	W	NEXT OF KIN/ADDRESS: FLOYD, BETTY JO		M
PHONE GUAR. REL: S	PT. MAR. STAT.: S			
GUARANTOR EMPLOYER: UNEMPLOYED	PT. FIN. CLASS: W	HOME PHONE	OTHER PHONE	

MRSA? NO *** VRE? NO *** PPD? NEGATIVE

INSURANCE CO. NAME	POLICY NO.	GROUP NO.	INSURED/SUBSCRIBER NAME
S.C. GUARANTEE ASSOC	6482		

OCCURRENCE INFORMATION	REASON FOR VISIT
*ONSET OF SYMPTOMS/ILLNESS	CHI

OCCUR DATE/TIME	COMMENT	ARRIVAL MODE
09/13/01 :	SO/APPROVED PER CYNTHIA GRIMLEY	

ADMIT DATE/TIME	ADMITTING PHYSICIAN	ATTENDING PHYSICIAN	USER
05/05/06 :		HEALY, R. JOSEPH JR.	PTPBP

OTHER	PATIENT DISPOSITION	DISCHARGE DATE/TIME
	HOME ☐ OMI ☐ SNF ☐ ICF ☐ HH ☐ DIED ☐ AUTOPSY ☐ AMA ☐ OTHER ☐	

HIPAA: N

FLU VACCINE:

PNEUM VACCINE:

PRINCIPAL DIAGNOSIS (THE CONDITION ESTABLISHED AFTER STUDY TO BE CHIEFLY RESPONSIBLE FOR OCCASIONING THE PATIENTS ADMISSION)

SECONDARY DIAGNOSIS (COMPLICATIONS AND COMORBIDITIES: CONDITIONS WHICH DEVELOP AFTER ADMISSIONS OR EXISTS AT THE TIME OF ADMISSION AND EFFECT TREATMENT RECEIVED OR LOS.)

PRINCIPAL PROCEDURE/OPERATION (THE PROCEDURE MOST CLOSELY RELATED TO PRINCIPAL DIAGNOSIS)

SECONDARY PROCEDURES

1336

ATTENDING PHYSICIAN SIGNATURE DATE

ORIGINAL

NAME: FLOYD, SCOTTIE W

DOCTOR: HEALY, R. JOSEPH JR. MED REC #: H337978

ROOM #: PT ACCT #: H17135633

PT STATUS: DIS RCR ADMIT DATE:

==========

DATE OF BIRTH:

DATE OF ADMISSION: May 5, 2006

REASON FOR REFERRAL: Closed head injury.

REFERRING SOURCE: Worker's compensation.

CASE MANAGER: Cynthia Grimley.

BACKGROUND INFORMATION: Mr. Floyd is a 30-year-old white single male who on September 13, 2001 sustained closed head injury. Following his head injury, he experienced severe behavior problem and was hospitalized in Tangram, which is a premier behavior management program for head injuries in Texas. Prior to his placement in Rest Care Premier/ Tangram, he was seen by Dr. Healy and evaluated by Dr. Windsozarova. During his stay at Tangram, he became behaviorally stabilized and was able to return back to live with his mother. Prior to his return from Texas, I was able to interview with the case manager, treatment staff in Rest Care Treatment Facility and with client's mother. We have agreed that Scottie will require ongoing behavior management and also finished a new neuropsychological evaluation to assess his neurobehavior functioning at the present time. During the first interview, Mr. Scottie Floyd presented as cooperative, however, he is invested into his explosive moods, and it becomes important to him to express how dangerous he could become. However, he clearly learned behavior management techniques while in the previous treatment facility and in spite of his rough appearance, his actual behavior has improved significantly. We have agreed on starting the treatment by battery of neuropsychological tests and based on information from the treatment center in Texas and based on the results of the neuropsychological evaluations, we will develop a treatment plan based on those data.

CAROLINAS HOSPITAL SYSTEM
1925 Hoffmeyer Road
Florence, South Carolina 29501

NAME: FLOYD,SCOTTIE W

DOCTOR: HEALY,R. JOSEPH JR. **MED REC #:** H337978

ROOM #: **PT ACCT #:** H17135633

PT STATUS: DIS RCR **ADMIT DATE:**

==========

I would like to thank Ms. Cynthia Grimley for her kind referral of this gentleman. Expected frequency - once a week. Expected duration - 6 to 12 months.

Job #5334

Dr. SASHA FEDERER

FEDAL
/LC
D: 07/20/06
T: 07/20/06

CC:

REPORT #: 0720-0125

CAROLINAS HOSPITAL SYSTEM
1925 Hoffmeyer Road
Florence, South Carolina 29501

NAME: FLOYD,SCOTTIE W

DOCTOR: HEALY,R. JOSEPH JR. MED REC #: H337978

ROOM #: PT ACCT #: H17374380

PT STATUS: REG RCR ADMIT DATE:

==========

DOB:

DATE OF ADMISSION: 05/05/06

REFERRING SOURCE: Cynthia Grimley, Workers Compensation case manager.

DIAGNOSIS: Closed head injury.

TREATMENT PROGRESS NOTE
Mr. Floyd has been referred for evaluation and treatment by his Workers Compensation case manager. I initially met with Mrs. Grimley and then on 5/9 and 5/19 I have met with patient's mother. At that time he was still in a treatment facility in Texas. My first contact with Scottie was on June 5, 2006. Since then we have met on 6/9, 6/13, 6/21, and 6/30, 7/6, and 7/13.

Our initial consideration has been for establishing baseline of his neurocognitive status and battery of neuropsychologic tests was employed. Mr. Floyd has been tested before and has done well on Wechsler Adult Intelligence Scale, third edition. The testing procedures, however, goes somewhat slower than expected because of his frequent complaints of headaches. Apparently initially Mr. Floyd did not have air conditioning and the heightened temperature made him irritable with subsequent severe headaches. He missed a couple of the appointments because of his headaches were so severe that he was unable to leave home. During this period of time we had also been discussing his behavior status. Mr. Floyd is somewhat interested in being perceived as potentially explosive. He is most of the time dressed in military fatigues and his temper is much focus of his conversation. He is aware that his rage can be controlled, but we have discussed on a number of occasions the triggers for his loss of control and how to manage it. According to his mother since Mr. Floyd has returned back from Texas he has not exploded and has not had a behavior incident. During this period fo time we have also discussed possible future outcome and his most significant wish is to decrease the amount of headaches that he is experiencing and potentially return back to work. We have been able to develop a good therapeutic relationship and Mr. Floyd during his testing has been always cooperative and did not display any loss of control. During his sessions his mother is always present and he seems to relie on her for maintaining his emotional control.

CAROLINAS HOSPITAL SYSTEM
1925 Hoffmeyer Road
Florence, South Carolina 29501

NAME: FLOYD,SCOTTIE W

DOCTOR: HEALY,R. JOSEPH JR. **MED REC #:** H337978

ROOM #: **PT ACCT #:** H17374380

PT STATUS: REG RCR **ADMIT DATE:**

==========

Expected frequency once a week. Expected duration six to nine months. Continue with testing on neurobehavior battery and work on maintaining emotional and behavior equilibrium.

Sincerely.

Job 6864

Dr. SASHA FEDERER

FEDAL
/LC
D: 07/24/06
T: 07/24/06

CC:

REPORT #: 0724-0124

ORIGINAL

CAROLINAS HOSPITAL SYSTEM
1925 Hoffmeyer Road
Florence, South Carolina 29501

NAME: FLOYD,SCOTTIE W

DOCTOR: HEALY,R. JOSEPH JR. MED REC #: H337978

ROOM #: PT ACCT #: H17498874

PT STATUS: DIS RCR ADMIT DATE: 8/31/06

==========

DATE OF BIRTH:

DIAGNOSIS: Traumatic brain injury.

REFERRING PHYSICIAN: Dr. Joseph Healy.

30 DAYS TREATMENT NOTE: This note was dictated on 8/31/06 and covers the last 30 days. During this reporting period, Mr. Floyd was not seen in this office because of his reported headaches. As there are agreements with his mother and a case manager, I have seen Ms. Betty Floyd in his place 3 times. I have seen Ms. Floyd on 8/3, 8/11 and 8/25/06. She reports that her son still has severe headaches and at the time of appointment, he usually was still asleep. Apparently, when his headaches intensity he stays up for several days and nights, and then he falls asleep for a couple of days. She reports that her son had several episodes of becoming angry, however, he always managed to control his temper, never became physically aggressive and utilized some anger management techniques that he learned in inpatient rehabilitation center in Texas. There is an issue of not being able to complete the neuropsychological evaluation due to his nonattendance. I will continue to encourage him through his mother to come and participate in our outpatient evaluation and treatment. I would like to thank Dr. Healy for his kind referral of this most interesting patient.

Job 24141

Dr. SASHA FEDERER

FEDAL
/LW
D: 08/31/06
T: 08/31/06

CC:

REPORT #: 0831-0064

CAROLINAS HOSPITAL SYSTEM
1925 Hoffmeyer Road
Florence, South Carolina 29501

NAME: FLOYD,SCOTTIE W

DOCTOR: HEALY,R. JOSEPH JR. MED REC #: H337978

ROOM #: PT ACCT #: H17633835

PT STATUS: PRE RCR ADMIT DATE:

==========

DATE OF BIRTH:

DIAGNOSIS: Traumatic brain injury

REFERRING PHYSICIAN: Dr. Joseph Healy

Mr. Floyd came today, September 5, 2006, for a session attended with his mother and 16-month-old niece. Mr. Floyd stated that he has been threatened by his attorney and that he is going to retaliate. After the opening statement, we have discussed what happened. Apparently, Mr. Floyd's attorney, Mr. [illegible], contacted his mother on Friday and told her that if Mr. Floyd does not attend his appointments, since he missed three or four of my appointments, he may lose his benefits. Following that, apparently Mr. Floyd became very upset and today threatened to kill his attorney, caseworker and whoever was, as he stated, down the line. We have spent about 40 minutes going over his irrational way of thinking and trying to explain to him that the call was placed in order to assist him and to prevent him from losing benefits. Mr. Floyd became more agitated and, at some point, stated that the session was over, otherwise he may hurt me, as well. We have discontinued the session at that point.

Mr. Floyd has demonstrated similar out-of-control behaviors prior to the two years he has spent in a rehabilitation facility in Texas. Because of my duty to warn, I have contacted the attorney, Mr. [illegible], and also placed a call to Ms. Cynthia Grimley, the case manager who is supposed to see him today. I have not received, at the time of this dictation, a call from her yet. I will also contact Dr. Healy and discuss the situation that appears to be deteriorating. Mr. Floyd complains of increased frequency and intensity of headaches since he returned back to South Carolina, especially with the stormy weather. He reported that his headaches become unbearable and, at times, he does

not sleep for several days and then he sleeps for a couple of three days. Nevertheless, he was fairly irrational but made a number of death threats on members of his treatment team. We will have to convene and discuss what the next treatment step will be.

Sincerely

Job # 26016

Dr. SASHA FEDERER

FEDAL
/JH
D: 09/05/06
T: 09/05/06

CC:

REPORT #: 0905-0097

CAROLINAS HOSPITAL SYSTEM
805 Pamplico Highway
Florence, South Carolina 29505

CONSULTATION REPORT

NAME:	FLOYD,SCOTTIE W	**MED REC #:**	H337978
PT ACCT #:	H17633835	**ROOM #:**	
ATTENDING DR:	HEALY,R. JOSEPH JR.	**PT STATUS:**	REG RCR
CONSULTANT:	SASHA FEDERER		
DISCHARGE DT:			

==========

DATE OF BIRTH:

DIAGNOSES: Closed head injury.

FAMILY PRACTICE: Dr. Healy.

HISTORY: Today, Monday Sep 11, 2006, we have met at Dr. Healy's office to discuss treatment plan following the patient's outbursts and making homicidal threats. At this meeting, Ms. Cynthia Grimley, the case manager, Mr. Wukelia's client's attorney, another attorney who represented the insurance company, Dr. Healy, and myself were present. We have reviewed Mr. Floyd's progress since he returned in June from rehabilitation in Texas. Apparently, after the initial period where he did well, his level of activities have decreased significantly. He has missed 4 of my appointments and a couple of appointments for his sleep study. His mom claimed responsibility for 1 missed appointment of the sleep study and the other was due to his being asleep and she did not want to wake him up. After our meeting on Tuesday, when he threatened his attorney, case manager, and later me. We have discussed with all persons involved what would our next step be. Out of the discussion came a plan recommending that Mr. Floyd is to return back to inpatient rehabilitation for additional treatment. He is perceived as regressing in that his level of activity dropped significantly, number of headaches has increased and he has made homicidal threats. I have discussed the situation with Mrs. Floyd today, September 12, 2006. She stated that Scottie did feel regret; however, he has not contacted me. We will continue with planning and I recommend in summary Mr. Floyd is involved in the treatment plan if possible and/or selection of rehabilitation site.

CAROLINAS HOSPITAL SYSTEM
805 Pamplico Highway
Florence, South Carolina 29505

CONSULTATION REPORT

NAME:	FLOYD,SCOTTIE W	**MED REC #:**	H337978
PT ACCT #:	H17633835	**ROOM #:**	
ATTENDING DR:	HEALY,R. JOSEPH JR.	**PT STATUS:**	REG RCR
CONSULTANT:	SASHA FEDERER		
DISCHARGE DT:			

==========

Besides Texas, there is also is another possibility in North Carolina with learning services. The next meeting with Mr. Floyd and his mother is scheduled for this coming Friday.

Job # 29531

Dr. SASHA FEDERER

FEDAL
/LB
D: 09/12/06
T: 09/12/06

CC:

REPORT #: 0912-0189

CAROLINAS HOSPITAL SYSTEM
1925 Hoffmeyer Road
Florence, South Carolina 29501

NAME: FLOYD,SCOTTIE W

DOCTOR: HEALY,R. JOSEPH JR. **MED REC #:** H337978

ROOM #: **PT ACCT #:** H17899014

PT STATUS: REG RCR **ADMIT DATE:**

==========

DATE OF BIRTH:

DIAGNOSIS: Closed head injury.

MONTHLY PROGRESS NOTE: Mr. Floyd was seen in the last reporting period on October 20th, 27th, 31st, November 3rd and 9th. During this reporting period, Mr. Floyd attended all the scheduled therapy sessions. He was always on time and cooperative. Per the previous contact when he lost his temper and became threatening, Mr. Floyd has become much more cooperative, open and we have dealt during our sessions with the origin of his anger/rage, and it is a different experience. The focus has been on developing different coping styles that would allow him to remain more in control. His rage has been dating back to his childhood in living with extremely abusive and violent father who placed his family into poverty, substandard living and then he abandoned them. Mr. Floyd is dealing with issues of developing control over his rage and he has been able to verbally describe his thoughts and feelings in very cohesive way. During this period of time, I have been establishing much better therapeutic contact. Also, I was able to gain cooperation of the ER physician who prescribed medications for Mr. Floyd to tie him over until he saw Dr. James ~~Allen~~ Evans. During our visit in the emergency room, Mr. Floyd was very pleasant and cooperative with the physician. Mr. Floyd's mother also reported much improved temper control and there have not been any outbursts for the last 2 months.

PLAN: Complete neuropsychological testing. Continue with anger management and reality testing.

Job 26714

Dr. SASHA FEDERER

FEDAL
/LW
D: 11/09/06
T: 11/09/06

CC:

REPORT #: 1109-0150

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Scottie Floyd **Medical Record #:** _____

Date / Time	Narrative
5/5/06	I visited with C.M. Floyd, case manager and discussed pt's hx/dx, present situation and his future needs. A Thelen, PH

(

(1)

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Floyd Leathe **Medical Record #:** 332978

Date / Time	Narrative
5/9/06 3-4	Betty Long – meeting with Pt's mother Father ETOH abuse – plays always to mom + Leathe. Divorced 82 – 13 years of abuse Leathe can violent – dead now 6 years. Dad made promise + did not deliver. Stable pro technique of mom: Leathe hit dad (age 5) ~ metal pipe to protect mom. – Mom enabled ~ instructed mom kids instead ant – limit can't for 1 year Leathe started to come back for visit before the accident. Went home from hospital – from then until 13 01 ✓ till now in moms care

(3)

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Scott Floyd **Medical Record #:**

Date / Time	Narrative
5/19/06	Wants to discuss more about TBI.

A Hinds, PhD

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

(2)

Progress Note

Client Name: Sir Hit Floyd Medical Record #:

Date / Time	Narrative
5/9/00	Purchased Content — Joking, conning, cutting your dominance, TP, videogames — Rough at first. — Never failed to hurt her physically. Used to hit him blindly. Was When at home stayed at ~~Bond~~ room all the time Tends to be confrontational when people looked at him. Seth no longer exploding More talkative Takes more Cleans his room Mom promises not to bother him. Mom/Later Telegram — Jerk. Communication. She does not bother until Support. Scottie comes from Iffel-Tan ay yr. Jane Ms Jane Short 512-396-1005

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Sophie Floyd Progress Note

Client Name: Billy Joe Floyd Medical Record #: 337928

Date/Time	Narrative
5/19/08 1-2	Floyd on 25 of Otey County 1st of June. Sam arrives to get home. lost time based on court hearing - at home before Forgrave (called at D. Hedges office) Bill Hogan BJ Tonya Jane Stewart - 512-396-1305 cell 512-557-1020 Conducted Ms Stewart and discussed transfer to SC Catherine Graves on 2nd — Rec the mail call and from Texas Mom's cell phone 843 206-1379

1351

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Scott Flagg **Medical Record #:** 337978

Date / Time	Narrative
6/2/06 10-11	Medical record for p's attorney - M. Wilson present. Pt. was not present.
6/5/06 10-11	When went → PHA → more anger. Discharged for IP month. Tiwanna + HA. Goal ± 1) ↓ HA 2) Back to work - was car mechanic. Straining → HA Light + Noise → HA Head - dizziness, blurry. Upper ½ body - tremor called. Can't smell, taste or touch. Rehab. nurse asked for 4 more

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Floyd Scott **Medical Record #:**

Date / Time	Narrative
6/21/06	No arrangements ? HA.
11-12	Problem c tactile defensiveness
	Touching (any) → irritation
	Does not like affection - groan
	out of it.
	Problem c proper body heat
	More HA since he came home.
	Possible sleep apnea
	when up first.
	Will ask Dr Healy - billing slip on
	July 11th
	Information has to be short -
	STM is an issue.
	In talking needs instead of relying
	on answers - relies on intuitive /

A. Griffin Pt

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Scott Floyd **Medical Record #:**

Date / Time	Narrative
6/30/08 9-10	Skills to play game ai Play Station & Wii. Short to do small motor movement & thinking.

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Floyd Smith **Medical Record #:** _____

Date / Time	Narrative
7/6/06 10-11	Limited Dress. Pacing hall. Draw Self - ↑ impulsivity. Very hilarious in language. Can't stop when started. Now more able to converse out of the room more.

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Floyd Scott **Medical Record #:**

Date / Time	Narrative
7/13/06 9-10	Arrived having control over his legs, continues to be worried living alone & someone w/ the dangerous potential — Continued w/ Neuropsychological testing. Pt continued to complain of severe HA. Cooperative, used chalk & Family
7/20/06 10-11	Pt was in Shaw — mom called regarding his severe headache — Family

ORIGINAL

CAROLINAS HOSPITAL SYSTEM
1925 Hoffmeyer Road
Florence, South Carolina 29501

NAME: FLOYD,SCOTTIE W

DOCTOR: HEALY,R. JOSEPH JR. **MED REC #:** H337978

ROOM #: **PT ACCT #:** H17135633

PT STATUS: DIS RCR **ADMIT DATE:**

DATE OF BIRTH:

DATE OF ADMISSION: May 5, 2006

REASON FOR REFERRAL: Closed head injury.

REFERRING SOURCE: Worker's compensation.

CASE MANAGER: Cynthia Grimley.

BACKGROUND INFORMATION: Mr. Floyd is a 30-year-old white single male who on September 13, 2001 sustained closed head injury. Following his head injury, he experienced severe behavior problem and was hospitalized in Tangram, which is a premier behavior management program for head injuries in Texas. Prior to his placement in Rest Care Premier/ Tangram, he was seen by Dr. Healy and evaluated by Dr. Nenad Zarova. During his stay at Tangram, he became behaviorally stabilized and was able to return back to live with his mother. Prior to his return from Texas, I was able to interview with the case manager, treatment staff in Rest Care Treatment Facility and with client's mother. We have agreed that Scottie will require ongoing behavior management and also finished a new neuropsychological evaluation to assess his neurobehavior functioning at the present time. During the first interview, Mr. Scottie Floyd presented as cooperative, however, he is invested into his explosive moods, and it becomes important to him to express how dangerous he could become. However, he clearly learned behavior management techniques while in the previous treatment facility and in spite of his rough appearance, his actual behavior has improved significantly. We have agreed on starting the treatment by battery of neuropsychological tests and based on information from the treatment center in Texas and based on the results of the neuropsychological evaluations, we will develop a treatment plan based on those data.

CAROLINAS HOSPITAL SYSTEM
1925 Hoffmeyer Road
Florence, South Carolina 29501

NAME: FLOYD,SCOTTIE W

DOCTOR: HEALY,R. JOSEPH JR. MED REC #: H337978

ROOM #: PT ACCT #: H17135633

PT STATUS: DIS RCR ADMIT DATE:

I would like to thank Ms. Cynthia Grimley for her kind referral of this gentleman. Expected frequency - once a week. Expected duration - 6 to 12 months.

Job #5334

Dr. SASHA FEDERER

FEDAL
/LC
D: 07/20/06
T: 07/20/06

CC:

REPORT #: 0720-0125

CAROLINAS HOSPITAL SYSTEM
1925 Hoffmeyer Road
Florence, South Carolina 29501

NAME: FLOYD,SCOTTIE W

DOCTOR: HEALY,R. JOSEPH JR. MED REC #: H337978

ROOM #: PT ACCT #: H17374380

PT STATUS: REG RCR ADMIT DATE:

DOB:

DATE OF ADMISSION: 05/05/06

REFERRING SOURCE: Cynthia Grimley, Workers Compensation case manager.

DIAGNOSIS: Closed head injury.

TREATMENT PROGRESS NOTE
Mr. Floyd has been referred for evaluation and treatment by his Workers Compensation case manager. I initially met with Mrs. Grimley and then on 5/9 and 5/19 I have met with patient's mother. At that time he was still in a treatment facility in Texas. My first contact with Scottie was on June 5, 2006. Since then we have met on 6/9, 6/13, 6/21, and 6/30, 7/6, and 7/13.

Our initial consideration has been for establishing baseline of his neurocognitive status and battery of neuropsychologic tests was employed. Mr. Floyd has been tested before and has done well on Wechsler Adult Intelligence Scale, third edition. The testing procedures, however, goes somewhat slower than expected because of his frequent complaints of headaches. Apparently initially Mr. Floyd did not have air conditioning and the heightened temperature made him irritable with subsequent severe headaches. He missed a couple of the appointments because of his headaches were so severe that he was unable to leave home. During this period of time we had also been discussing his behavior status. Mr. Floyd is somewhat interested in being perceived as potentially explosive. He is most of the time dressed in military fatigues and his temper is much focus of his conversation. He is aware that his rage can be controlled, but we have discussed on a number of occasions the triggers for his loss of control and how to manage it. According to his mother since Mr. Floyd has returned back from Texas he has not exploded and has not had a behavior incident. During this period fo time we have also discussed possible future outcome and his most significant wish is to decrease the amount of headaches that he is experiencing and potentially return back to work. We have been able to develop a good therapeutic relationship and Mr. Floyd during his testing has been always cooperative and did not display any loss of control. During his sessions his mother is always present and he seems to relie on her for maintaining his emotional control.

CAROLINAS HOSPITAL SYSTEM
1925 Hoffmeyer Road
Florence, South Carolina 29501

NAME: FLOYD,SCOTTIE W

DOCTOR: HEALY,R. JOSEPH JR. MED REC #: H337978

ROOM #: PT ACCT #: H17374380

PT STATUS: REG RCR ADMIT DATE:

Expected frequency once a week. Expected duration six to nine months. Continue with testing on neurobehavior battery and work on maintaining emotional and behavior equilibrium.

Sincerely.

Job 6864

Dr. SASHA FEDERER

FEDAL
/LC
D: 07/24/06
T: 07/24/06

CC:

REPORT #: 0724-0124

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Scottie Floyd **Medical Record #:**

Date / Time	Narrative
7/25/06 9-10	Pt was c CO2 unconscious regarding treatment plan. Pt did not show 2° to headache. Plan: 1) Discuss c nurse concerning use of pain meds 2) Use of ETOH and Substance Use 3) When Scottie does not come to come about family session. 4) Confirm c Pt Nurse

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Sophie Floyd **Medical Record #:** 337978

Date / Time	Narrative
7/27/06 2-3	Meds were not called in because he depended on (illegible)
	Sophie was doing more herself. Was eating & family helping in room. Doing shower. Either oxygen can feel. Plays & his piece, pic picture of him.
	Sc. Wilco 10th of August for Physio Appmt
	Still does not go out very much. Seen had Thin C.V.A. before he left.
	Sophie hears only 1st part of sentence => Blows.
	Calling down Sister

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Sothie Floyd **Medical Record #:** 332978

Date / Time	Only known patient Narrative
8/3/06 9-10	Sothie Floyd up 48 hrs due to blood orders — now stays for 2 days. Stays all day yesterday after test is ordered. got angry Sothie explained block weekend — — her sister told him about conflict with her boyfriend. — Sister needs consultant financial help. In because of her friend there yelling all women's attention from Sothie 28
	He got angry but did not explode calm himself down. Able to demand control.
	Stay test on 16th of August. Sothie 3 day Tomorrow 31 Is aware that he can control his anger. So he does not have to leave home again.

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Leo the Loyal **Medical Record #:** 387949

Date / Time	Narrative
4/11/06	Only Betty To present
9-10	Leo thru Child hrs HA — sleeping upon till 4 am — often sleeping all day
	With pain + thunderstorm hrs HA goes
	4
	Leo thru mom tells hrs uncle am hrs own.
	Brothers school for no more secrets
	about mom's death
	Leo Lies as a young child
	Trouble w/ English teacher — quit in 9th
	grade.
	Tim Lewis is camouflage all hrs life —
	when he goes to HD's unit — always wearing
	camouflage.
	Becomes very close to hrs Son.
	Mom shall alter the bills Lies by change
	in Leo file — 3rd change

1364

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Floyd Lee Hite (Only mom) **Medical Record #:**

Date / Time	Narrative
8/25/06	Scottie did not make it more up 2 days / 2 nights - went in 3 hrs / EKG.
	— Had chest problem that may the child not come last Friday Scottie attached [illegible] to his [illegible] during his
	Scottie brought a used Jench. Discussed Scottie's ability to drive - child not appropriate today but. mom will be informed that Scottie will need go through DMV Driving test.
	Step just canceled because mom's chest pain.
	Hand Schedule - trying to stay up during Friday and sleep at night. Scottie still worried about his temper.

CAROLINAS HOSPITAL SYSTEM
1925 Hoffmeyer Road
Florence, South Carolina 29501

NAME: FLOYD,SCOTTIE W

DOCTOR: HEALY,R. JOSEPH JR. MED REC #: H337978

ROOM #: PT ACCT #: H17498874

PT STATUS: DIS RCR ADMIT DATE: 8/31/06

DATE OF BIRTH:

DIAGNOSIS: Traumatic brain injury.

REFERRING PHYSICIAN: Dr. Joseph Healy.

30 DAYS TREATMENT NOTE: This note was dictated on 8/31/06 and covers the last 30 days. During this reporting period, Mr. Floyd was not seen in this office because of his reported headaches. As there are agreements with his mother and a case manager, I have seen Ms. Betty Floyd in his place 3 times. I have seen Ms. Floyd on 8/3, 8/11 and 8/25/06. She reports that her son still has severe headaches and at the time of appointment, he usually was still asleep. Apparently, when his headaches intensity he stays up for several days and nights, and then he falls asleep for a couple of days. She reports that her son had several episodes of becoming angry, however, he always managed to control his temper, never became physically aggressive and utilized some anger management techniques that he learned in inpatient rehabilitation center in Texas. There is an issue of not being able to complete the neuropsychological evaluation due to his nonattendance. I will continue to encourage him through his mother to come and participate in our outpatient evaluation and treatment. I would like to thank Dr. Healy for his kind referral of this most interesting patient.

Job 24141

Dr. SASHA FEDERER

FEDAL
/LW
D: 08/31/06
T: 08/31/06

CC:

REPORT #: 0831-0064

CAROLINAS HOSPITAL SYSTEM
1925 Hoffmeyer Road
Florence, South Carolina 29501

NAME: FLOYD, SCOTTIE W

DOCTOR: HEALY, R. JOSEPH JR. MED REC #: H337978

ROOM #: PT ACCT #: H17633835

PT STATUS: PRE RCR ADMIT DATE:

DATE OF BIRTH:

DIAGNOSIS: Traumatic brain injury

REFERRING PHYSICIAN: Dr. Joseph Healy

Mr. Floyd came today, September 5, 2006, for a session attended with his mother and 16-month-old niece. Mr. Floyd stated that he has been threatened by his attorney and that he is going to retaliate. After the opening statement, we have discussed what happened. Apparently, Mr. Floyd's attorney, Mr. [redacted], contacted his mother on Friday and told her that if Mr. Floyd does not attend his appointments, since he missed three or four of my appointments, he may lose his benefits. Following that, apparently Mr. Floyd became very upset and today threatened to kill his attorney, caseworker and whoever was, as he stated, down the line. We have spent about 40 minutes going over his irrational way of thinking and trying to explain to him that the call was placed in order to assist him and to prevent him from losing benefits. Mr. Floyd became more agitated and, at some point, stated that the session was over, otherwise he may hurt me, as well. We have discontinued the session at that point.

Mr. Floyd has demonstrated similar out-of-control behaviors prior to the two years he has spent in a rehabilitation facility in Texas. Because of my duty to warn, I have contacted the attorney, Mr. [redacted], and also placed a call to Ms. Cynthia Grimley, the case manager who is supposed to see him today. I have not received, at the time of this dictation, a call from her yet. I will also contact Dr. Healy and discuss the situation that appears to be deteriorating. Mr. Floyd complains of increased frequency and intensity of headaches since he returned back to South Carolina, especially with the stormy weather. He reported that his headaches become unbearable and, at times, he does

CAROLINAS HOSPITAL SYSTEM
1925 Hoffmeyer Road
Florence, South Carolina 29501

NAME: FLOYD,SCOTTIE W

DOCTOR: HEALY,R. JOSEPH JR. MED REC #: H337978

ROOM #: PT ACCT #: H17633835

PT STATUS: PRE RCR ADMIT DATE:

not sleep for several days and then he sleeps for a couple of three days. Nevertheless, he was fairly irrational but made a number of death threats on members of his treatment team. We will have to convene and discuss what the next treatment step will be.

Sincerely

Job # 26016

Dr. SASHA FEDERER

FEDAL
/JH
D: 09/05/06
T: 09/05/06

CC:

REPORT #: 0905-0097

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Scottie Floyd **Medical Record #:**

Date / Time	Narrative
9/5/06	Before he went to Texas - S mirrored -
11-12	The attorney found that Scottie was not able to cooperate. - called Leo this - Leo that had had HA. Mom was offered that Leo this person would make them cooperate. back today - mom thought he moved wrist ok well
	N.A. Richard

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Cortly Floyd **Medical Record #:** 337 978

Date / Time	Narrative
9/12/06 10-11	Tamaryn 5 years ambulance of the accident + — only mom present Was living in a shelter home angry after parents divorced - fred # — Mom — called — Cookie would prefer that Cortlin get to the ER. Mom fill the pain also at 2 ½ from that point on an 0-10 I has a H/A. Pt's initial injury in Kenya - chest not found frontal lobe injury

1370

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Scottie Floyd **Medical Record #:** 337978

Date / Time	Narrative
10/12/06	bed 3 w/ hx w/ anger
9-10	Allyn first was canceled
	I think that we are against Jim
	Lmed meeting H1A more agreeing
	Can stay playing game 6 7 hx
	- Hx initiated good attention span,
	good speed of processing.
	OPI has more challenging with his
	psychological functioning - allyn suspicious
	of those around him, preoccupation with
	all things military and violence, perception
	of self as survivalist.
	I will try to contact D. Evans and
	D. Lant to see if they would like him
	on a DOT duty.

1371

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Sco the Floyd **Medical Record #:**

Date / Time	Narrative
10/20/06	Fear of being addicted, back from 6 months of Detox. When in Rage - feels no pain afterwards pain HA → 4
10/28/06	Tolerance. Smell + taste because the pain Focus in treatment Rage + Pain. Fear of being addicted → when the pain would come back ? → anxiety. Always fear of exploding

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Leo Hi Klay **Medical Record #:**

Date / Time	Narrative
10/3/06	Trial evaluation - clinician.
8-9a	Scottie is more open to discussing his
	image - feels that if he does not continue
	engagement the destructive part of him will
	take over and it would become a
	murderous rage. Fears that part of self.
	Focus on reinforcing the more loved part of
	himself (Graham PsyD)
11/3/06	
2:30-4:30	Tx approximately 2 hrs with Dr
	Evans to treat Scottie for DBT.
	I have contacted the case manager and ER
	physicians and set up an appointment for
	Scottie to get his meds filled by ER physicians
	I have met Scottie at ER to walk him
	through the process. He did well
	(Graham PsyD)

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Scottie Flagg Medical Record #:

Date / Time	Narrative
11/9/06	14-1 has head an abdomen => Dr.
8-10	HA.
	Neck + Shoulder are soft no course
	of LA Ade.
	How many sessions do we allowed
	Sessions ??
	Adele for Greg has cool, not
	getting angry.
11/14/06	Pt came today 15 min early and when I came
9-9:30	to be called to go home because of these symptoms.
	Very different behaviors from before when he
	just did not show up. He came today in spite
	of being sick — we have rescheduled for this
	Thursday.

CAROLINAS HOSPITAL SYSTEM
805 Pamplico Highway
Florence, South Carolina 29505

CONSULTATION REPORT

NAME:	FLOYD,SCOTTIE W	**MED REC #:**	H337978
PT ACCT #:	H17633835	**ROOM #:**	
ATTENDING DR:	HEALY,R. JOSEPH JR.	**PT STATUS:**	REG RCR
CONSULTANT:	SASHA FEDERER		
DISCHARGE DT:			

DATE OF BIRTH:

DIAGNOSES: Closed head injury.

FAMILY PRACTICE: Dr. Healy.

HISTORY: Today, Monday Sep 11, 2006, we have met at Dr. Healy's office to discuss treatment plan following the patient's outbursts and making homicidal threats. At this meeting, Ms. Cynthia Grimley, the case manager, Mr. Wukelia's client's attorney, another attorney who represented the insurance company, Dr. Healy, and myself were present. We have reviewed Mr. Floyd's progress since he returned in June from rehabilitation in Texas. Apparently, after the initial period where he did well, his level of activities have decreased significantly. He has missed 4 of my appointments and a couple of appointments for his sleep study. His mom claimed responsibility for 1 missed appointment of the sleep study and the other was due to his being asleep and she did not want to wake him up. After our meeting on Tuesday, when he threatened his attorney, case manager, and later me. We have discussed with all persons involved what would our next step be. Out of the discussion came a plan recommending that Mr. Floyd is to return back to inpatient rehabilitation for additional treatment. He is perceived as regressing in that his level of activity dropped significantly, number of headaches has increased and he has made homicidal threats. I have discussed the situation with Mrs. Floyd today, September 12, 2006. She stated that Scottie did feel regret; however, he has not contacted me. We will continue with planning and I recommend in summary Mr. Floyd is involved in the treatment plan if possible and/or selection of rehabilitation site.

CAROLINAS HOSPITAL SYSTEM
805 Pamplico Highway
Florence, South Carolina 29505

CONSULTATION REPORT

NAME:	FLOYD,SCOTTIE W	MED REC #:	H337978
PT ACCT #:	H17633835	ROOM #:	
ATTENDING DR:	HEALY,R. JOSEPH JR.	PT STATUS:	REG RCR
CONSULTANT:	SASHA FEDERER		
DISCHARGE DT:			

Besides Texas, there is also is another possibility in North Carolina with learning services. The next meeting with Mr. Floyd and his mother is scheduled for this coming Friday.

Job # 29531

Dr. SASHA FEDERER

FEDAL
/LB
D: 09/12/06
T: 09/12/06

CC:

REPORT #: 0912-0189

CAROLINAS HOSPITAL SYSTEM
1925 Hoffmeyer Road
Florence, South Carolina 29501

NAME: FLOYD,SCOTTIE W

DOCTOR: HEALY,R. JOSEPH JR. **MED REC #:** H337978

ROOM #: **PT ACCT #:** H17899014

PT STATUS: REG RCR **ADMIT DATE:**

==========

DATE OF BIRTH:

DIAGNOSIS: Closed head injury.

MONTHLY PROGRESS NOTE: Mr. Floyd was seen in the last reporting period on October 20th, 27th, 31st, November 3rd and 9th. During this reporting period, Mr. Floyd attended all the scheduled therapy sessions. He was always on time and cooperative. Per the previous contact when he lost his temper and became threatening, Mr. Floyd has become much more cooperative, open and we have dealt during our sessions with the origin of his anger/rage, and it is a different experience. The focus has been on developing different coping styles that would allow him to remain more in control. His rage has been dating back to his childhood in living with extremely abusive and violent father who placed his family into poverty, substandard living and then he abandoned them. Mr. Floyd is dealing with issues of developing control over his rage and he has been able to verbally describe his thoughts and feelings in very cohesive way. During this period of time, I have been establishing much better therapeutic contact. Also, I was able to gain cooperation of the ER physician who prescribed medications for Mr. Floyd to tie him over until he saw Dr. James ~~Allen~~ Elom. During our visit in the emergency room, Mr. Floyd was very pleasant and cooperative with the physician. Mr. Floyd's mother also reported much improved temper control and there have not been any outbursts for the last 2 months.

PLAN: Complete neuropsychological testing. Continue with anger management and reality testing.

Job 26714

Dr. SASHA FEDERER

FEDAL
/LW
D: 11/09/06
T: 11/09/06

CC:

REPORT #: 1109-0150

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Cathie Thorp Medical Record #:

Date / Time	Narrative
11/28/06	Chris Trent is moving in his head each visit. Last Thursday knee pain, did not eat for 3 days, had fever. When he does not eat he still drinks. At least down Pramlintide. Down daily. Always ready for insulin, feels Pramlintide to be skipped out. Is on the same dose long - just adjust the level after meal and breakfast. It also knocks him from the physician - help him not to take pain pills. Using his coupon for to found out more about his injury.

Cathie Thorp, PhD

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Kathy Floyd. Medical Record #: 337978

Date / Time	Narrative
11/29/06 9-10	Pt did not have consciousness when he woke up. Testing on Executive Function Tasks. Pt did well. See this along w/ reading, computer - utilizing cognitive skills. When conversation came to relationships - he relishes "the strange" in the world about him

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Sallie Floyd **Medical Record #:** 337978

Date / Time	Narrative
12/7/06 4-5	Had a good visit with Dr. Evans. New meds + sleep tests + back surg. Pain visit - can show - trial strong HA. Pain thunderstorm - it gets worse. Pt. was open and nothing to share about self.

A V Crawford

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Scottie F. Boyd **Medical Record #:** 337978

Date / Time	Narrative
12/12/06 9-10	On Tuesday Scottie got upset when he found out that he is on Hydrocodone - which he was on before - he then did not go. Jan told Scottie that the only pain is diarrhea. Scottie started to be more concentrate more please, thank you. Pt has a diagnosis which may be due meds to the — did not come Mother came alone.

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Smith Flory **Medical Record #:** 337978

Date / Time	Narrative
12/19/06 8-9	Pt. came with his mother today. Started with how routine works about an living on time diagram with Dr. to. It is Cecilia may to reestablishing contact. We went over his contract of things when he joined and that Dr. Evans would have Dr. Cochran - need that way on before and it did not work. Cecilia discuss instantly anger - did not check in to the door, smashed pills and went for Angry to go for days forth. Pt. reports feeling empty, lost his soul, no purpose for living. Feels

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Scottie Floyd **Medical Record #:**

Date / Time	Narrative
12/28/06	2. V. w chm - Injured c H.A. Scottie is in consistent pain Chr HA - up for 2 days - sleeps for 4 hrs - up for 2 days again Preparing self for changing next year. Plans more activities & stays exercise.
1/2/07 9-10	Scottie is sick - (mom came about - Planned birthday but not a good weekend Had I am bummed & picking the wrong wife. Long the conclusion Questions of Dating - Last Christmas - 04 2½ years ago. - Looks of indifference - Hates my food from a can #1) Goal - to hear off the medication

1/2/07 1383 L

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Scottie Floyd Medical Record #: 337978

Date / Time	Narrative
1/5/07 10:30-11	I have met with Scottie case manager and discussed the incident at Dr. Evans office. He is scheduled to be seen tonight for follow up study – I have given my phone # to the technician should the need arise. Scottie
1/9/07 8-10	Scottie later only ate some meal. He had Temazepin and chopped, fried Brioght bnt & chopped, fried Hydrocodone bnt & chopped. Given to him Dic 4th task only 1 Rechard and 3 thiogt. Most of Pt came alon Pt has been functioning without pain meds for last 2 wks

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Scottie Troy [illegible] **Medical Record #:** 337978

Date / Time	Narrative
1/16/07 9-10	At night hands and feet - does not believe he can tolerate CPap machine Wants to be left alone Better anger control CULT Administered — When not aroused, often involved Ps. does bother.

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Scottie Floyd **Medical Record #:**

Date / Time	Narrative
1/23/07	Scottie is starting to talk but has blood coming out of his mouth. Scottie not present - only was mother. Mom reports improvement in behavior - not as angry or grumpy. Does not get up as quick when loses a game. Laughs more at TV jokes more.

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Sadie Floyd Medical Record #: 337978

Date / Time	Narrative
1/25/07	Testing initiated
1-2	In Oct 2002 - within 2nd Trial std. His intellectual functioning remains in the same range as in 2002 - there is a very slight elevation - Possible due to an overlearning effect - this is Scottie's 3rd evaluation with this instrument + H. was not present.

1387

CAROLINAS HOSPITAL SYSTEM
805 Pamplico Highway
Florence, South Carolina 29505

CONSULTATION REPORT

NAME:	FLOYD,SCOTTIE W	**MED REC #:**	H337978
PT ACCT #:	H18281063	**ROOM #:**	
ATTENDING DR:	HEALY,R. JOSEPH JR.	**PT STATUS:**	PRE RCR
CONSULTANT:	SASHA FEDERER		

DISCHARGE DT:

==========

frontal lobe injury. Premorbidly Mr. Floyd has been exposed to very violent father and has in the past probably experienced symptoms of PTSD. With the frontal lobe injury he is able to manage judgment tasks that are affect free. However when he feels threatened, which is extremely easy for him, his judgment becomes severely impaired and he responds with threats of violence. Mr. Floyd described himself as constantly struggling to maintain his violent impulses under control. He continuously feels rage inside and is concerned that any mild provocation may bring the violent thoughts to be acted upon. He is still referring to the meeting in November when treatment team considered how to respond to his verbal threats of killing his attorney and anybody else involved in his case. Mr. Floyd continues to verbalize fear of being "snatched away" and his readiness to defend himself. Mr. Floyd also had difficulties with taking medications as prescribed. He claims that he has fear of being addicted to pain medication since he experienced addiction to Morphine. Also when he was prescribed medication he took before, he did not notice that the amount of medication was changed to meet his needs and in his emotional judgment refused to not only take the medication but also to continue to see Dr. Evans.

In summary, Mr. Floyd continues to make some mild improvements providing that the environment is conducive to him staying emotionally neutral. Mr. Floyd and I have developed a good therapeutic relationship and he appears to trust me. It may be partially due to my 25 years of experience of working with clients with head injury and consequent behavior problems. At this point I don't see Mr. Floyd being capable of functioning in an environment outside of his home or being introduced to strangers or demands on him. His violent thoughts are always potentiated by his ongoing headaches. The main task now will be for us to find a physician that will accept him into his practice. I have discussed with Mr. Floyd that I will not look for another physician but that it will be a joint venture and he would have to be co-responsible for finding a new physician, hoping that that will bring greater commitment on his part to cooperate. The treatment goal continued to be anger management, increased level of physical activities, improved cognitive and emotional flexibility and develop greater skills in cooperating with the outside world.

EXPECTED FREQUENCY: Once a week.

EXPECTED DURATION: Six to twelve months.

CAROLINAS HOSPITAL SYSTEM
PSYCHOLOGICAL SERVICES

Progress Note

Client Name: Sophie Floyd Medical Record #:

Date / Time	Narrative
1/30/07 9-10	Tom came alone - Sophie had HA with nurse. Pt. is paranoid about being taken away in the morning on dialysis. He still jumps to conclusions. Friend of S. lawyer, afraid of bothering others on self. Still does not want to tell anybody [illegible] Sophie

AL Vilm PhD

CAROLINAS HOSPITAL SYSTEM
805 Pamplico Highway
Florence, South Carolina 29505

CONSULTATION REPORT

NAME: FLOYD,SCOTTIE W MED REC #: H337978

PT ACCT #: H18281063 ROOM #:

ATTENDING DR: HEALY,R. JOSEPH JR. PT STATUS: PRE RCR

CONSULTANT: SASHA FEDERER

DISCHARGE DT:

DATE OF BIRTH:

REFERRING PHYSICIAN: Dr. Healy

REASON FOR REFERRAL: Closed head injury.

PROGRESS NOTE: Mr. Floyd has been seen in the month of December 2006 and January 2007. His attendance has been irregular, at times he did not come to the sessions due to headaches and nausea. During this reporting period there has been signs of gradual improvement as well as ongoing issues. The gradual improvement has been demonstrated in overall decreased level of anger. In his home his mother reports improved social graces and improved frustration tolerance. He still has ongoing issues with headaches and his sleep hygiene is poor. He has periods of time when he stays up at night and during the headache period he sleeps during the day or sometimes 20 hour period. Mr. Floyd is demonstrating improved behavior providing that he is in ideal conditions. Ideal at this point means that there are no stressors in his life involved and his mother is dedicated to providing an environment that is as stress free and demand free as possible. Basically Mr. Floyd is able to follow his own schedule and the only demands placed on him is to attend his doctor's appointments. When any conflicts come from his family or even simple situation of misunderstanding with a clerk in a store, he still becomes explosive. There also has been an instance when he reviewed his medication that he received from his new neurologist, Dr. Evans, and when he saw that he had been placed on the same medication he was on before he became extremely agitated and explosive. Some of his difficulties with his judgments are that whenever his judgment is affected by emotional content his behavior tends to deteriorate. During this period of time we also performed neuropsychological testing in order to establish his cognitive level of functioning. The result on Wechsler adult intelligence scale third edition was consistent with his previous testing in the year 2001 and 2002. The neuropsychological testing indicates that Mr. Floyd is still functioning within the average range of intellectual functioning, his full IQ being 100. There continues to be a significant discrepancy within his verbal and performance IQ. His verbal IQ is 94 and performance IQ is 109. His relative strength is his perceptive organization and items that do not require time limits. Again the structure of his intellectual functioning is consistent with his previous testing and there does not seem to be any signs of deterioration. However, it is known that intellectual measures itself do not accurately reflect the overall functioning level in persons with traumatic brain injury. On the test of new verbal learning Mr. Floyd's test results are somewhat lower than the one gained by Dr. [illegible]. He has difficulties initiating the task of learning words and gaining increase in the number of words memorized in five trials. As a matter of fact, his learning curve is ~~posteriorly~~ flat, however once Mr. Floyd learned the new material it did not deteriorate after 20 minute delay. Some of the fluctuation in results may also be due to his headache that he experienced during the testing. Mr. Floyd's speech is fluent, free of paraphrasic errors and he has good vocabulary and is able to express himself fairly well. It appears that the impact of his head injury is an unfortunate combination of premorbid personality and

CAROLINAS HOSPITAL SYSTEM
805 Pamplico Highway
Florence, South Carolina 29505

CONSULTATION REPORT

NAME:	FLOYD,SCOTTIE W	**MED REC #:**	H337978
PT ACCT #:	H18281063	**ROOM #:**	
ATTENDING DR:	HEALY,R. JOSEPH JR.	**PT STATUS:**	PRE RCR
CONSULTANT:	SASHA FEDERER		

DISCHARGE DT:

==========

frontal lobe injury. Premorbidly Mr. Floyd has been exposed to very violent father and has in the past probably experienced symptoms of PTSD. With the frontal lobe injury he is able to manage judgment tasks that are affect free. However when he feels threatened, which is extremely easy for him, his judgment becomes severely impaired and he responds with threats of violence. Mr. Floyd described himself as constantly struggling to maintain his violent impulses under control. He continuously feels rage inside and is concerned that any mild provocation may bring the violent thoughts to be acted upon. He is still referring to the meeting in November when treatment team considered how to respond to his verbal threats of killing his attorney and anybody else involved in his case. Mr. Floyd continues to verbalize fear of being "snatched away" and his readiness to defend himself. Mr. Floyd also had difficulties with taking medications as prescribed. He claims that he has fear of being addicted to pain medication since he experienced addiction to Morphine. Also when he was prescribed medication he took before, he did not notice that the amount of medication was changed to meet his needs and in his emotional judgment refused to not only take the medication but also to continue to see Dr. Evans.

In summary, Mr. Floyd continues to make some mild improvements providing that the environment is conducive to him staying emotionally neutral. Mr. Floyd and I have developed a good therapeutic relationship and he appears to trust me. It may be partially due to my 25 years of experience of working with clients with head injury and consequent behavior problems. At this point I don't see Mr. Floyd being capable of functioning in an environment outside of his home or being introduced to strangers or demands on him. His violent thoughts are always potentiated by his ongoing headaches. The main task now will be for us to find a physician that will accept him into his practice. I have discussed with Mr. Floyd that I will not look for another physician but that it will be a joint venture and he would have to be co-responsible for finding a new physician, hoping that that will bring greater commitment on his part to cooperate. The treatment goal continued to be anger management, increased level of physical activities, improved cognitive and emotional flexibility and develop greater skills in cooperating with the outside world.

EXPECTED FREQUENCY: Once a week.

EXPECTED DURATION: Six to twelve months.

CAROLINAS HOSPITAL SYSTEM
805 Pamplico Highway
Florence, South Carolina 29505

CONSULTATION REPORT

NAME: FLOYD,SCOTTIE W MED REC #: H337978

PT ACCT #: H18281063 ROOM #:

ATTENDING DR: HEALY,R. JOSEPH JR. PT STATUS: PRE RCR

CONSULTANT: SASHA FEDERER

DISCHARGE DT:

job 04146

DR. SASHA FEDERER

FEDAL
/BM
D: 02/01/07
T: 02/01/07

CC:

REPORT #: 0201-0030

CAROLINAS HOSPITAL SYSTEM
805 Pamplico Highway
P.O. Box 100550
Florence, S.C. 29501-0550

Registration Form

PATIENT NAME/ADDRESS	ACCOUNT NO.	TYPE	ROOM	UNIT NO./MED. REC. NO.
FLOYD, SCOTTIE W	H17915182	ER		H337978

BIRTHDATE	RELIGION	LOCATION/SERVICE
	OTHER	FSTRK

PHONE
SOC. SEC. NUM:
PATIENT EMPLOYER: UNEMPLOYED

AGE	PERSON TO NOTIFY/ADDRESS	RELATIONSHIP
31	BIRD, KIMBERLY	SI

PT. SEX: M

GUARANTOR/ADDRESS: FLOYD, SCOTTIE W

PT. RACE: W

HOME PHONE: 8 OTHER PHONE

NEXT OF KIN/ADDRESS: FLOYD, BETTY JO — RELATIONSHIP: M

PT. MAR. STAT.: S

PHONE GUAR. REL. S

PT. FIN. CLASS: W

GUARANTOR EMPLOYER: UNEMPLOYED

HOME PHONE 78 OTHER PHONE

MRSA? NO *** VRE? NO *** PPD? NEGATIVE

INSURANCE CO. NAME	POLICY NO.	GROUP NO.	INSURED/SUBSCRIBER NAME
[redacted]			

OCCURRENCE INFORMATION	REASON FOR VISIT
*ONSET OF SYMPTOMS/ILLNESS	HEADACHE

OCCUR DATE/TIME	COMMENT	ARRIVAL MODE
11/03/06 :	SP/SO/LYP	CAR

ADMIT DATE/TIME	ADMITTING PHYSICIAN	ATTENDING PHYSICIAN	USER
11/03/06 :		Gandy	ADMPLY

OTHER DOES PT HAVE ADVANCE DIRECTIVE? N
COPY W/CHART? N COPY REQUESTED? N
INFO GIVEN RE: FORMULATION OF ADV DIR?

PATIENT DISPOSITION

HOME	OMI	SNF	ICF	HH	DIED	AUTOPSY	AMA	OTHER
☐	☐	☐	☐	☐	☐	☐	☐	☐

DISCHARGE DATE/TIME

HIPAA
DIRECTORY? Y TELEPHONE CALL? Y ANSWERING MACHINE? Y FLU VACCINE:
CONFIDENTIAL COMMUNICATIONS? N IS PT AN ORGAN DONOR? N PNEUM VACCINE:
RESTRICTIONS? N

PRINCIPAL DIAGNOSIS (THE CONDITION ESTABLISHED AFTER STUDY TO BE CHIEFLY RESPONSIBLE FOR OCCASIONING THE PATIENTS ADMISSION)

SECONDARY DIAGNOSIS (COMPLICATIONS AND COMORBIDITIES: CONDITIONS WHICH DEVELOP AFTER ADMISSIONS OR EXISTS AT THE TIME OF ADMISSION AND EFFECT TREATMENT RECEIVED OR LOS.)

PRINCIPAL PROCEDURE/OPERATION (THE PROCEDURE MOST CLOSELY RELATED TO PRINCIPAL DIAGNOSIS)

SECONDARY PROCEDURES

ATTENDING PHYSICIAN SIGNATURE DATE

Name of Patient	Medical Record Number	Account Number	Date of Service
FLOYD, SCOTTIE W	H337978	H17915182	11/03/06

Consent to Medical and Surgical Procedures: I, the undersigned, consent to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include, but are not limited to, laboratory procedures, x-ray examinations, diagnostic procedures, medical, nursing or surgical treatments or procedures, anesthesia or hospital services rendered to me under the general and special instructions of the attending physician, his/her associates, partners, assistants or designee.

Medicare / Medicaid: I certify that the information I have given in applying for payment under Title V, XVIII and XIX of the Social Security Act is complete and correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed for this or any related Medicare/Medicaid Claim. I understand that the health care services paid for under Medicare, Medicaid and Maternal and Child Health Programs are subject to review by the Peer Review Organization.

Tricare / Medicare /Champus: I have received and understand the letters of information titled "An Important Message from "Tricare / Champus" and/or "Medicare" at the time of my admission. My signature only acknowledges my receipt of these messages from Carolinas Hospital System and does not waive any of my rights to request a review or make me liable for any payment. My signature also verifies my answers on the Medicare Secondary Payor Questions.

Assignment of Insurance / Liability Benefits: I hereby authorize payment directly to Carolinas Hospital System and all physicians involved in my treatment or diagnosis at Carolinas Hospital System by the group insurance, major medical insurance, hospital, surgical, medical and any other insurance payable to or on behalf of the undersigned. By virtue of hospitalization, I unconditionally assign any insurance benefits to Carolinas Hospital System and all physicians involved in my treatment. My authorization applies both to any surplus insurance benefits or any other payments received from any source, to the payment of other unpaid bills of the below recipient or of the undersigned of any individual who is financially responsible for the patient or guarantor. I understand that I am financially responsible to Carolinas Hospital System and physicians for charges not paid by insurance. If an unpaid balance is sent to a collection agency, I will be responsible for any legal fees and/or interest associated with collection of the debt.

Physician and Independent Contracts: I recognize that some or all physicians furnishing services to the patient are independent contractors. A separate billing will be rendered for these services.

Personal Valuables: I hereby release the hospital from any responsibility for valuables, money, personal or other possessions that are not deposited with the hospital for safekeeping.

Acknowledgement of Notice of Privacy Practices: I have been presented a copy of Carolinas Hospital System's Notice of Privacy Practices. I have been provided the opportunity to ask questions about Carolinas Hospital System's privacy practices. I have also been given information about requesting special handling / accommodations concerning privacy and use and disclosure of my protected health information.

If I have questions regarding the information set forth in Carolinas Hospital System's Notice of Privacy Practices I will contact Carolinas Hospital System's Privacy Officer at 843-661-3956.

PATIENT: Scottie Floyd 11-3-06
Signature Date

AUTHORITY TO SIGN IF NOT PATIENT: _____
Signature Date

RELATIONSHIP: _____

WITNESS: Ly Perry 11-3-06
Signature Date

99.0, 97, 16, D9/K

© 1996 - 2006 T-System, Inc. Circle or check affirmatives, backslash (\) negatives.

26

Carolinas Hospital System
Florence, South Carolina

EMERGENCY PHYSICIAN RECORD

Headache (5)

FLORENCE H337978
H17915182 11/03/06
FLOYD, SCOTTIE W REG ER
CANDY, EDWIN LAVERNE
31 M S W

Dottie Wayne Floyd

TIME SEEN: 1630 ☐ on arrival ___ EMS Arrival
HISTORIAN: patient spouse paramedics
PRIVATE MD Selina, Evans
__HX / __EXAM LIMITED BY:

HPI

chief complaint: headache facial pain fever *migraine hx*

started:

time course:
abrupt / thunderclap / gradual
onset ___ *hrs / days*
cannot pinpoint exact onset
still present better
gone now *lasted*

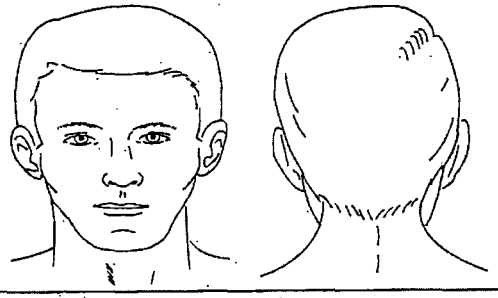
intermittent episodes lasting

worse / persistent since

severity:
maximum
mild moderate severe worst of life
when seen in ED
unchanged gone mild moderate severe

quality:
similar to previous headaches
"pain"
tightness
throbbing
sharp

location:



associated symptoms:
preceding symptoms
visual disturbance scotoma
typical of prior aura(s)
speech problems
light bothers eyes / blurred vision
confusion
nausea / vomiting
power loss (R / L) *arm leg*
trouble walking
tingling / numb sensation
neck pain / stiff neck
syncope
dizziness

exacerbated by: light noise movement position

Similar symptoms previously

Recently seen / treated by doctor

ROS

CONST
fever
subjective / to ___ °F
muscle aches

EENT
visual disturbances
sore throat
sinus pressure / drainage
difficulty swallowing

NEURO
dizziness
vertigo lightheadedness
For new, gradual-onset HA-
CO exposure
tick bite(s) / insect bite(s)
head injury

CVS / PULMONARY
chest pain
cough
sputum
trouble breathing

GI / GU
abdominal pain
diarrhea
pain on urination
incontinence

SKIN / LYMPH / MS
rash / swelling
back pain
skin lesions

☐ all systems neg except as marked

Dottie Wayne Floyd

PAST HX __negative

chronic headaches
occasional frequent "migraine"
mild moderate severe
high blood pressure
sinus problems
SAH risk factors:
1° relative
connective tissue disorder
Marfan's / Ehlers disease
cancer history
immunosuppressed
glaucoma
diabetes *Type 1 Type 2*
diet / oral / insulin
asthma
HIV / AIDS
prior CNS infection

Medications __none see nurses note
ASA NSAID acetaminophen
coumadin

Allergies __NKDA
see nurses note

SOCIAL HX

smoker ___ drug use / abuse *cocaine*
recent ETOH

FAMILY HX

cerebral aneurysm
stroke
pseudotumor
migraine headaches
HTN

1395

☐ White – chart ☐ Pink - ED copy

N17915182 N337978
FLOYD,SCOTTIE W 11/03/06
GANDY,EDWIN LAVERNE REG ER
31 M S W

☐ Nursing Assessment Reviewed ☐ Vitals Reviewed

PHYSICAL EXAM

General Appearance
__no acute distress
__alert
__mild / moderate / severe distress
__anxious / lethargic

EENT
__no facial swelling
__eyes nml inspection
__PERRLA
__tender temporal artery
__pain on percussion over sinuses
__pale conjunctivae
__narrow angle (anter. chambers)
__photophobia
__abnormal fundi / papilledema / wide cups
__EOM palsy
__unequal pupils *R pupil* ___ *mm L pupil* ___ *mm*
__nml ENT inspection
__pharynx nml
__purulent nasal discharge
__pharyngeal erythema
__tonsillar exudate
__abnormal TM

NECK
__nml inspection
__supple
__thyromegaly
__lymphadenopathy (R / L)
__stiff neck / meningismus
__carotid bruit
__Kernig's sign / Brudzinski's sign

RESPIRATORY
__no resp. distress
__breath sounds nml
__wheezes / rales / rhonchi

CVS
__reg. rate & rhythm
__heart sounds nml
__murmur *grade* ___ */6 sys / dias*
__tachycardia / bradycardia
__decreased pulse(s)

ABDOMEN
__non-tender
__no organomegaly
__tenderness
__hepatomegaly / splenomegaly / mass

SKIN
__color nml, no rash
__warm, dry, nml palp.
__cyanosis / diaphoresis / pallor / ecchymosis
__skin rash / embolic lesions

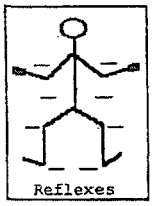
EXTREMITIES
__non-tender
__normal ROM
__no pedal edema
__joints nml
__pedal edema
__calf tenderness
__joint swelling
__Homan's sign

NEURO / PSYCH
higher functions
__alert
__oriented x3
__mood / affect nml
__nml speech
__slow / confused / no response to commands
__disoriented to *person / place / time*
__abnormal thought processes / cognition
__abnormal speech

cranial nerves-
__normal as tested
__facial palsy
__tongue deviation (to R / L)
__facial numbness

cerebellar-
__normal as tested
__abnormal Romberg test
__abnormal finger-nose-finger
__abnormal gait
__Babinski sign

sensorimotor-
__no motor deficit
__no sensory deficit
__weakness
__aphasia *expressive / receptive*
__pronator drift
__clonus
__sensory loss
__abnormal reflexes
__fasciculations


Reflexes

LABS & XRAYS

CBC		Chemistries	UA
normal except		*normal except*	*normal except*
WBC	segs	Na	WBC
Hgb	bands	K	RBC
Hct	lymphs	Cl	bacteria
Platelets	monos	CO2	dip:
	eos	Gluc	
		BUN	
		Creat	
		Ca	

LP __discussed risks, benefits, alternatives; patient consents.
sitting / lying (R / L) open press.=
betadine prep fluid color RBC WBC
sterile technique glucose polys lymph
L3-4 protein monos gm stn
L4-5

CXR ☐Interp. by me ☐Reviewed by me ☐Discsd w/ radiologist
__nml/NAD __no infiltrates __nml heart size __nml mediastinum
not / *changed from:*

HEAD CT
__normal

PROGRESS

Time ____ unchanged improved re-examined
pain relieved pain almost fully relieved

Discussed with Dr. ____ Additional history from:
will see patient in: ED / hospital / office *family caretaker paramedics*
Counseled patient / family regarding: __prior records ordered
lab / rad. results diagnosis need for follow-up __Rx given
CRIT CARE TIME *(excluding separately billable procedures)*
30-74 min 75-104 min ____ min

CLINICAL IMPRESSION

Headache *acute severe hemiplegic vascular migraine cluster*	Intracranial Hemorrhage
Vomiting / Dehydration	Subarachnoid Hemorrhage
Meningitis	Sinusitis
Cervical Strain / Sprain	Viral Cephalgia
TMJ Syndrome	Temporal Arteritis
	Pseudotumor (Intracranial HTN)

DISPOSITION- ☒home ☐admitted ☐transferred
CONDITION- ☐unchanged ☒improved ☐stable
☐ Emergency condition at discharge ☒No emergency condition at discharge

PHYSICIAN SIGNATURE-
☐ Chart Completed ☐Dictated Addendum

☐White – chart ☐Pink - ED copy

CAROLINAS HOSPITAL SYSTEM
Florence, South Carolina

EMERGENCY DEPARTMENT RECORD

NAME: FLOYD,SCOTTIE W

SERVICE DATE: 11/03/06 **MED REC #:** H337978

PT ACCT #: H17915182 **PATIENT STATUS:** REG ER

DISCHARGE DATE: **ROOM #:**

==========

This is a 31-year-old with a history of frontal lobe head injury. He is followed closely by Dr. Federer. He is basically running out of his medication since Friday. He has an appointment with a neurologist, Dr. Evans, next month. Dr. Federer has talked to me at length about his case and would ask that we refill his medications. He apparently is in-between neurologists at this time and will be following up with Dr. Evans but won't be until November.

The patient has no new complaints. He states that he always has chronic headaches, nothing has changed but mainly running out of several medications, which I have listed on the chart. He denies any change in symptomatology, no vomiting, there has been no new injury. He has had a little bit of sinus/nasal congestion but he takes Nasonex for that. He denies any ear pain, throat pain, chest pain, palpitations, abdominal pain, nausea or vomiting.

PHYSICAL EXAM: Well-nourished gentleman who is alert and cooperative. Vital signs - temperature is 99.0, pulse is 97, respiratory rate is 16, blood pressure is 129/75.
HEENT: He wears sunglasses; when they are removed, he has equal pupils. Fundi is benign. TMs are clear. Nasal mucosa is benign. Oropharynx is benign.
NECK: Supple.
LUNGS: Fields clear to bases anteriorly and posteriorly.
HEART: Tones are regular without murmur.
ABDOMEN: Soft, nontender.
NEUROLOGIC: He is alert, awake, follows commands. He is aware of person, place, time and situation.

HOSPITAL COURSE: We will refill his medications and he will follow up with Dr. Evans. Medications include Depakote, cyclobenzaprine, Keppra and Darvocet.

IMPRESSION
1. Chronic headaches
2. Frontal lobe injury

CAROLINAS HOSPITAL SYSTEM
Florence, South Carolina

EMERGENCY DEPARTMENT RECORD

NAME: FLOYD,SCOTTIE W

SERVICE DATE: 11/03/06 **MED REC #:** H337978

PT ACCT #: H17915182 **PATIENT STATUS:** REG ER

DISCHARGE DATE: **ROOM #:**

==========

He is discharged in stable condition.

I would like to thank Dr. Federer for his help in this case.

Job # 24432

Dr. EDWIN LAVERNE GANDY

GANED
/JH
D: 11/03/06
T: 11/04/06

CC: EVANS,W. JAMES
FEDERER,SASHA

REPORT # 1104-0001

990, 97, 76, 129/75 [redacted] [redacted] Date Stay

Carolinas Hospital System — Physician's Orders

Emergency Department Physician's Orders

FLORENCE H337970
M17915182 11/03/06
FLOYD,SCOTTIE M REG ER
GANDY,EDWIN LAVERNE
31 M S W
^ADDRESSOGRAPH^

Unapproved Abbreviations: U, IU, Q.D., Q.O.D., MS, MS04, MgS04, Trailing zero (X.0 mg), Lack of leading zero (.X mg)

Date

Time

____ AM

____ PM

☐ CBC ☐Auto Diff ☐Manual Diff	☐ Spinal Fluid Protocol	☐ TD 0.5ml IM
☐ BMP	☐ ASA Lab Protocol	☐ Tylenol_____ mg po
☐ FSBS	☐ Stroke Protocol	☐ Tylenol 15mg/kg po
☐ Flu Test	☐ Foley	☐ Ibuprofen_____ mg po
☐ BNP	☐ EKG ☐OLD EKG	☐ Ibuprofen 10 mg/kg po
☐ Mg	☐ Cardiac Monitor	☐ Maintain CSpine Precautions
☐ U/A ☐Cath ☐C&S ☐Midstream	☐ O2 VIA_____	☐ Remove CSpine Precautions
☐ UCG	☐ Pulse Ox	☐ D/C Home
☐ UDS	☐ IV_____	☐ Admit
☐ Amylase	☐ INT	☐
☐ Lipase	☐ CXR ☐Port ☐PA/LAT	☐
☐ Liver Profile	☐ AAS	☐
☐ Troponin	☐ Xray	☐
☐ PT/PTT	☐	☐
☐ CP Protocol	☐	☐
☐ BLD CX x2, Same Time Diff sites	☐	☐
☐ EEP Protocol	☐	☐
☐ Trauma A Protocol	☐ CT Scan	☐
☐ Trauma N Protocol	☐	☐
☐ ABG'S	☐	MD Signature:
☐ GYN Lab Protocol	☐	1

Date

Time

____ AM

____ PM

☐ CBC ☐Auto Diff ☐Manual Diff	☐ Spinal Fluid Protocol	☐ TD 0.5ml IM
☐ BMP	☐ ASA Lab Protocol	☐ Tylenol_____ mg po
☐ FSBS	☐ Stroke Protocol	☐ Tylenol 15mg/kg po
☐ Flu Test	☐ Foley	☐ Ibuprofen_____ mg po
☐ BNP	☐ EKG ☐OLD EKG	☐ Ibuprofen 10 mg/kg po
☐ Mg	☐ Cardiac Monitor	☐ Maintain CSpine Precautions
☐ U/A ☐Cath ☐C&S ☐Midstream	☐ O2 VIA_____	☐ Remove CSpine Precautions
☐ UCG	☐ Pulse Ox	☐ D/C Home
☐ UDS	☐ IV_____	☐ Admit
☐ Amylase	☐ INT	☐
☐ Lipase	☐ CXR ☐Port ☐PA/LAT	☐
☐ Liver Profile	☐ AAS	☐
☐ Troponin	☐ Xray	☐
☐ PT/PTT	☐	☐
☐ CP Protocol	☐	☐
☐ BLD CX x2, Same Time Diff sites	☐	☐
☐ EEP Protocol	☐	☐
☐ Trauma A Protocol	☐ CT Scan	☐
☐ Trauma N Protocol	☐	☐
☐ ABG'S	☐	MD Signature:
☐ GYN Lab Protocol	☐	

FLORENCE H337578
H17915182 11/03/06
FLOYD,SCOTTIE W REG ER
GANDY,EDWIN LAVERNE
31 / M S W

CAROLINAS HOSPITAL SYSTEM
FLORENCE, SOUTH CAROLINA

EMERGENCY DEPARTMENT ADMISSION DATA & ASSESSMENT

Name Dottie Wayne Floyd

ADMISSION HISTORY

Date	Time 1°	☐ Amb ☐ Stretcher ☐ Arms ☐ W/C ☐ EMS ☐ POV	Age	Sex	Last Tetanus	Triage Class ☐1 ☐2 ☐3 ☐4 ☐5	Acuity Class Change: Time: ☐1 ☐2 ☐3 ☐4 ☐5
11/3/06	1401		51	M			

Time 2°	Temp	Pulse	Resp	B/P	O2 Sat	Wt. Stated / Actual
	99.0 A R	97	16	129/75		

Immunizations ☐ Up to Date in accordance with State Law ☐ Other

Source of Information: ☐ Other Dr. Fedra ☐ Patient ☐ Family ☐ Unable to Obtain

Primary MD: Fedra

ALLERGIES: Food / Medications

☐ NKA ☐ Latex	Type Reaction

Developmental Status	LMP	G	P	A
☐ Appropriate for Age ☐	Head Circum cm	Visual Acuity od	os	ou

Tx PTA: ☐ EMS ☐ IV ☐ O2 ☐ Wound Care ☐ MD Office ☐ None ☐ Home ☐ Monitor

Meds:

Chief Complaint / In Patient's Words

HA -

MEDICAL HISTORY ☐ None

DISEASE	PT	DISEASE	PT	DISEASE	PT
Anemia	☐	Hepatitis	☐	Stomach Disorders	☐
Arthritis	☐	Hypertension	☐	Anesthesia Reactions	☐
Asthma	☐	Infectious Diseases	☐	Tobacco Use	☐
Bronchitis	☐	Sensory Impairment	☐	Alcohol/Drug Use	☐
Cancer	☐	Kidney Disease	☐	Other	☐
CVA	☐	Mental Illness	☐	Other	☐
Diabetes	☐	Muscle / Bone Disorders	☐	Other	☐
Emphysema	☐	Reproductive Disorders	☐	Other	☐
Glaucoma	☐	Seizures / Epilepsy	☐	Other	☐
Heart Disease	☐	Skin Disorders	☐	Other Head Injury	

TRAVEL

TRIGGER: FEVER, RESPIRATORY, OR CHEST RELATED ILLNESS

None ☐
International Travel ☐ Within 10 Days
Date
Where
Placed on Isolation ☐

TB SCREEN

*2 OR MORE RESP. ISOLATION

Cough > 2 Weeks	☐
Unexplained Weight Loss	☐
Unexplained Night Sweats	☐
Hemoptysis	☐
Unexplained Fever/Chills	☐
None	☐

Placed on Isolation ☐

PAIN ASSESSMENT ☐ None Initially

TIME	LOCATION	INTENSITY (0-10)	TYPE	CAUSED BY	DURATION	RELIEVED BY (Actions)
1402	HA	6/10	☐ Dull ☐ Sharp ☐ Pressure ☐ Radiating ☐ Throbbing	Chronic Head Inj		ED Visit
			☐ Dull ☐ Sharp ☐ Pressure ☐ Radiating ☐ Throbbing			
			☐ Dull ☐ Sharp ☐ Pressure ☐ Radiating ☐ Throbbing			

PSYCHOSOCIAL ASSESSMENT: ☐ N / A

☐ Mental Health Needs ____ Called.
☐ Suspected Abuse / Neglect ____ Contacted.
☐ No Support System. ☐ Case Management Contacted.
☐ Cultural Practice Request: ____

☐ Translation Needed ____
1° Language ____ Translator called.
☐ Spiritual Request ____
☐ Jehovah's Witness / Bloodless Surgery Request ____ Contacted.
☐ Other: ____

Initials	Signature / Title	Time Complete	Initials	Signature / Title	Time Complete
LB	Lin Bellamy				1400

CAROLINAS HOSPITAL SYSTEM
FLORENCE, SOUTH CAROLINA

FLORENCE H337976
11/03/06
H17915182 REG ER
FLOYD, SCOTTIE W
GANDY, EDWIN LAVERNE
31 M S W

Page 2

EMERGENCY DEPARTMENT DATA / ASSESSMENT TOOL

		TIME TO RM:	ROOM #:
ASSESSMENT:		1620	F6
	TIMES	1620	
AIRWAY	SELF MAINTAINED	✓	
	ORAL/NASAL AIRWAY		
	INTUBATED		
BREATHING	NORMAL	✓	
	IRREGULAR		
	LABORED		
	ABSENT/APNEIC		
	ASSISTED/BAGGED		
CIRCULATION	PULSE PRESENT	✓	
	ABSENT		
	CPR		
SKIN	WARM	✓	
	HOT		
	COOL		
	DRY	✓	
	DIAPHORETIC		
	NML/PINK	✓	
	CYANOTIC		
	PALE		
	ASHEN		
DISABILITY	ALERT/ORIENTED X	✓	
	RESPONDS VERBAL	✓	
	RESPONDS PAIN		
	UNRESPONSIVE		
	CONFUSED		
	LETHARGIC		
	COMBATIVE		
2° HEAD (BRISK / SLUGGISH / NONREACTIVE / CLEAR, SLURRED)	R PUPIL REACTIVE	✓	
	L PUPIL REACTIVE	✓	
	SPEECH	CL	
CHEST	ASYMMETRICAL		
	SYMMETRICAL	✓	
	CLEAR		
	CONGESTED		
	WHEEZES		
	DECREASED		
PULSE	STRONG	✓	
	WEAK/THREADY		
	REGULAR	✓	
	IRREGULAR		
ABDOMEN	SOFT	✓	
	FIRM/HARD		
	DISTENDED		
	TENDER		
	NONTENDER	✓	
	BOWEL SOUNDS PRESENT		
EXTREMITIES	NML CAP REFILL X		
	NML MOVEMENT X	✓	
	NML SENSATION	✓	
	STRONG RADIALS	✓	
OTHER			

SCREENS: (Within Past 7 Days)

FUNCTIONAL	☒ N / A ☐ Unexplained decline in mobility	If Yes ☐ Refer to Primary MD Unless otherwise ordered. ☐ Other:
NUTRITIONAL	☒ N / A ☐ Unexplained N / V or weight loss	

FAMILY NOTIFIED: ☐ Patient Declines ☐ N/A
TIME: 2 PT WHO: Mom

PRIMARY CONSULTING PHYSICIANS

NAME	PAGED	ANSWERED	ARRIVED

VITAL SIGNS

TIME	B/P	PULSE / RESP.	PRE PF / POST PF	O_2 SAT	TEMP
					☐ SEE TREND SHEET

TIME/INIT.	TREATMENT/PROCEDURES		
	☐ ID BAND ☐ CALL LIGHT ☐ SIDE RAILS ↑ X 2 ☐ NA		
	O_2 L _____ VIA _____		
	EKG		
	MONITOR RHYTHM _____		
	☐ NG ☐ OG TUBE Fr _____	☐ PLACEMENT CHECKED	
	FOLEY Fr _____	IN & OUT CATH Fr _____	
	ETT ☐ NASAL ☐ ORAL Fr _____	☐ END TIDAL CO_2	
TO: Portable	X-RAYS	FROM	VIA: ☐ AMB ☐ W/C ☐ STRETCHER
TO:	CT SCAN	FROM	VIA: ☐ AMB ☐ W/C ☐ STRETCHER
	SPLINT LOCATION:		☐ POST APPLICATION NEUROMUSCULAR INTACT ☐ OTHER-SEE NURSES NOTE

LABS

TIME/INITIALS		TIME/INITIALS		TIME/INITIALS	
	CBC		ABG		U/A
	BMP		Amy/Lipase		C&S
	PT/PTT		CP Protocol		UCG
	Liver Profile		Troponin		T Screen
	BNP		Cultures		TXM
	Mg		Flu Test		FSBS
					GYN Profile

Critical Value Received _____

1 2 3 4 5 6 7 8 9

Dr. _____
Notified. 1401

White - HIM Pink - ED

FLORENCE H337978
H17915182 11/03/06
FLOYD,SCOTTIE W REG ER
GANDY,EDWIN LAVERNE
31 M S W

CAROLINAS HOSPITAL SYSTEM

FLORENCE, SOUTH CAROLINA

Page 3

EMERGENCY DEPARTMENT

DATA / ASSESSMENT TOOL

NARRATIVE NOTES

K. Given PO Dr
Tylenol #3 1 tab PO Dr Gandy
10 acute distress and
Nurse (EB) K. Given (EB)

☐ See Additional Notes

SITE AT DISCHARGE
☐ No Redness, Pain, Swelling
☐ Other - See Nurses Notes
☐ No Redness, Pain, Swelling
☐ Other - See Nurses Notes
☐ No Redness, Pain, Swelling
☐ Other - See Nurses Notes

START	IV SOLUTION & AMOUNT	MEDICATION ADDED	SIZE	SITE	ML/HR	TIME D/C IV	TIME D/C Fld	TIME IV Cont'd	RESPONSE/PAIN 0-10

TIME	MEDICATION	DOSE	ROUTE	SITE	INITIALS	RESPONSE/PAIN 0-10	INTAKE	OUTPUT
							TOTAL	TOTAL

VALUABLES

☑ Not Inventoried ☐ Money Amt. _____
☐ Bracelet ☐ Earrings ☐ Clothes
☐ Necklace ☐ Rings ☐ Dentures
☐ Watch ☐ Purse ☐ Glasses
☐ Wallet ☐ Keys ☐ ID

With Whom/Where _____

Pain Scale at Discharge

Time: 1640

Pain Scale: 0/10

Initials	Signature	Title
EB	Elizabeth Ballard	RN

DISPOSITION

Time 1640 Via: ☐ W/C ☑ Amb ☐ Stretcher ☐ Carried

☑ D/C Home ☐ LWT
☐ D/C _____
☐ AMA ☐ Elopement
☐ Transfer to:

☐ POV ☐ EMS/Ambulance ☐ Law Enforcement
☑ Aftercare Instructions Given
To: Patient, Family
☑ Transfer Form Completed
☐ POV ☐ EMS/Ambulance

☐ Admitted to:
Room # _____
☐ Expired Body to:
☐ Lifepoint Notified

Report to: _____
Time _____
Admitting M.D. _____
Monitor ☐ Yes ☐ No ☐ N/A
IV ☐ Yes ☐ No ☐ N/A
O_2 ☐ Yes ☐ No ☐ N/A

1402

FLORENCE H33
11/03/
17915182 REG
FLOYD, SCOTTIE W
NDY, EDWIN LAVERNE
M S W

Chart Copy

Date: 11/3/06 Time: 4:35:39 PM

CAROLINAS HOSPITAL SYSTEM

Carolinas Hospital
805 Pamplico Highway

Patient Information	Treating Provider
FLOYD, SCOTTY	Edwin Gandy MD CHS ER - Florence Phone: 843-674-5100

1) Your Discharge Instructions	2) Your Prescriptions
HEADACHE #Document: 514 (English) NARCOTIC MEDICATION #Document: 548 (English)	Depakote Oral Tablet, enteric coated 500 Milligram 1 TABLET EVERY 8 HOURS # 90 TABLETS (0 Refills) Cyclobenzaprine HCl Oral Tablet 5 Milligram 1 T 3 TIMES DAILY # 90 MGS (0 Refills) Keppra Oral Tablet 500 Milligram 1 AND 1/2 TABLET TWICE DAILY # 81 TABLETS (0 Refills) Darvocet-N 100 Oral Tablet 100-650 Milligram 1 TABLET EVERY 6 HOURS AS NEEDED # 60 TABLETS (0 Refills)

3) You should Follow Up with:

Follow Up Physician	Follow Up Information
Carolinas Hospital 805 Pamplico Highway	

Food and Drug Interaction Pamphlet given to patient: ____ **Yes** ✓ **No**

I understand that the emergency care which I received is not intended to be complete and definitive medical care and treatment. I acknowledge that I have been instructed to contact the above physician immediately for continued and complete medical diagnosis, care and treatment. EKG's, X-rays, and lab studies will be reviewed by appropriate specialists and I will be notified of significant discrepancies. I also understand that my signature authorizes this Medical Center to release all or any part of my medical record (including, if applicable, information pertaining to AIDS and/or HIV testing, mental health records, and drug and/or alcohol treatment) to the referred physician listed above.

I have read and understand the above, received a copy of applicable instruction sheets, and will arrange for follow up care.

X Scottie Floyd — Signature: Patient/Parent/Guardian — Date/Time

Rachel Bullard RN — Signature: Instructed by — Date/Time

CONFIDENTIAL INFORMATION: The information contained in this fax is confidential. If you have received this fax in error, please notify the sender at once and destroy this document.

1403

Overhead Page Dr Federer on arrival

EY & ASSOCIATES

(803) 7
FAX: (
E-MAI

CYNTHIA P. GRIMLEY, MS, CRC, CCM, DABVE
REHABILITATION MANAGEMENT
VOCATIONAL EXPERT

SMISSION

DATE:

TO:

FROM: Cynthia Grimley

RE: Scottie Floyd

PAGES: 6 **FAX NUMBER:** 843-661-4365

COMMENTS:

Dr. Federer:

hat you will take Scottie to ER to have his medication
ıtment with Dr. Evans on December 6, 2006 at 1pm.

of the invoiced of the four medications he obtained right
-06)

ices for the medications from June, July and August
fill the Flexeril when he refilled all of his other
ut I think this was an error.

ne of the physician who actually writes the prescription
this goes through.

to Scottie's next appointment next week with you so I
at need to be filled out for Dr. Evans. I also need to
d out if she recalls where he had the MRI conducted.
the film.

Scotty Floyd for Sasha

f you have any questions. 803-446-9622.

Thanks for your help.

Cynthia

modern MEDICAL INCORPORATED
P.O.Box 549
Lewis Center, OH 43035
740-657-3330 * 800-547-3330
877-247-3330 toll-free fax
FED I.D. 31-1191553

PHARMACEUTICAL INVOICE

WORKERS' COMP

INVOICE NUMBER: 1303374
CUSTOMER CODE: SO3504
DATE: 06/02/2006
Patient No: 02207032

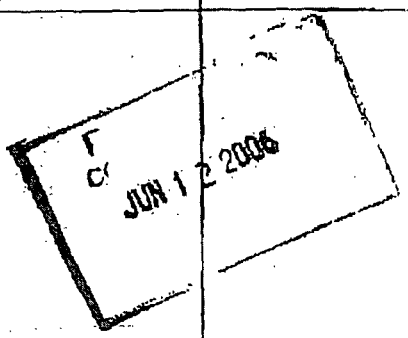
BILL TO
SOUTH CAROLINA P&C INS.
P.O. BOX 407
COLUMBIA, SC 29202
ATTN: BECKY MUSKOVIN

PATIENT INFO
SCOTTIE FLOYD
Claim Number:251417003
Date of Injury: 09/13/2001
Member No:
Adjuster: BECKY MUSKOVIN
Employer: KEN BAKER USED CARS
Dispensed By: B & J Pharmacy
205 Moore St
San Marcos TX 78666
NABP:4331249

REMIT TO MODERN MEDICAL, INC.

SSN/Member ID.	FILL DATE		SHIP VIA	TERMS
	05/30/2006		WALK IN	Due on Receipt

NDC	DESCRIPTION	QTY. ORD.	QTY. SHP.	UNIT PRICE	TOTAL AMOUNT
00074712653 B DAW = 0 Refill Prescription 1	DEPAKOTE ER TAB 500MG 30 DAYS RX: 0415100 DEA: AW3233260 Prescriber: WALLIS, JACK W MD	120	120	2.657	318.80
00603546828 G DAW = 0 Original Prescription	PROPO-N/APAP TAB 100-650 8 DAYS RX: 0417209 DEA: AW3233260 Prescriber: WALLIS, JACK W MD	30	30	0.731	21.93
50474059240 B DAW = 0 Refill Prescription 7	KEPPRA TAB 500MG 30 DAYS RX: 0401930 DEA: AW3233260 Prescriber: WALLIS, JACK W MD	90	90	2.912	262.08
00591325601 G DAW = 0 Refill Prescription 1	CYCLOBENZAPR TAB 5MG 30 DAYS RX: 0413922 DEA: AW3233260 Prescriber: WALLIS, JACK W MD	90	90	1.736	156.21



SOUTH CAROLINA P&C INS. saved $282.95 or 27.16% by using Modern Medical

Tomorrow's Medical Product Solutions Today

Invoice Summary
Suggested UCR = 1,041.97
Modern Medical Price = 759.02
SAVINGS = 282.95

INVOICE TOTAL **$ 759.02**

Carlisle Medical, Inc.

Post Office Box 9814
Mobile, AL 36691

(251) 344-7988

JUL 10 2006

DATE	INVOICE #
6/30/2006	43478

BILL TO	INSURED
South Carolina Property & Casualty P.O. Box 407 Columbia, SC 29202	

PATIENT NAME	DATE OF BIRTH	S.S.N.
Floyd, Scottie	6/30/2006	

SERVICE DATE	DRUG NAME - NDC	PHYSICIAN	QTY	AMOUNT
6/20/2006	Keppra 500mg/50474059240	Wallis	90	255.23
6/20/2006	Cyclobenzaprine 5mg 10147079001	Wallis	90	150.65
6/20/2006	Depakote 500mg/ 00074621513	Wallis	120	311.27
6/20/2006	Propo-N/APAP 100-650/00603546828	Wallis	30	19.04
		Total		$736.19

FEIN: 63-0890498
CMI USE: _____
Rev. 3/28/00

PRE-NEGOTIATED PRICING NOT SUBJECT FOR REVIEW

FOCUS CONTRACT ONLY FOR DURABLE MEDICAL EQUIPMENT

Carlisle Medical, Inc.

Post Office Box 9814
Mobile, AL 36691

(251) 344-7988

DATE	INVOICE #
7/31/2006	45019

BILL TO	INSURED
South Carolina Property & Casualty P.O. Box 407 Columbia, SC 29202	

PATIENT NAME	DATE OF BIRTH	S.S.N.
Floyd, Scottie	7/31/2006	

SERVICE DATE	DRUG NAME - NDC	PHYSICIAN	QTY	AMOUNT
7/26/2006	Propo-N/APAP100-650/00603546828	Healy	50	29.73
		Total		$29.73

PEIN: 63-0890498
CMI USE: _____
Rev. 3/28/00

PRE-NEGOTIATED PRICING NOT SUBJECT FOR REVIEW

FOCUS CONTRACT ONLY FOR DURABLE MEDICAL EQUIPMENT

SOURCECORP/ LEXICODE CORPORATION
EVALUATION & MANAGEMENT WORK SHEET
1995 E/M Documentation Guidelines

Patients Name: Floyd, D Date: 11/3 Physician: _____

HISTORY

⇨ Chief Complaint

HPI: Status of chronic conditions:

☐ 1 Condition ☐ 2 Conditions ☐ 3 or More Conditions

OR

⇨ HPI (history of present illness) elements:
Number of Locations (select HPI elements for each indevidual complaint or problem)

- ☐ Location (body location, diffuse/localize, unilateral/bilateral, fixed/migratory, radiate to
- ☐ Quality (sharp, dull, throbbing, stabbing, constant/intermittent, acute/chronic, stable, improving, worsening, well, better)
- ☐ Severity (pain scale of 1-10, nonverbal signals-lying still/ cont. moving, compare pain, cont. function/immobile)
- ☐ Associated signs & symptoms (additional sensations or feeling, pertinent (+) & (-), can overlap system w/ review)
- ☐ Timing (onset, nocturnal/diurnal/continuous, repetitive pattern)
- ☐ Context (where and what patient does a time of onset, rest/activity, recur with activity, situational stress)
- ☐ Duration (length of time of the system's existence)
- ☐ Modifying factors (what relieves or exacerbates a symptom, medication, heat, cold, eating)

⇨ ROS (review of system):

- ☐ Constitutional (wt loss, ect)
- ☐ Eyes
- ☐ Ear, nose mouth, throat
- ☐ Card/Vasc
- ☐ Resp
- ☐ GI
- ☐ GU
- ☐ Musculo
- ☐ Integumentary skin, breast)
- ☐ Neuro
- ☐ Psych
- ☐ Endo
- ☐ Hem/Lymph
- ☐ All/Immune

⇨ PFSH (past medical, family, social history) areas:

- ☐ Past history (the patients past experience with illnesses, operation,injuries and treatment)
- ☐ Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk)
- ☐ Social history (an age appropriate review of past and current activities)

** CompletePFSH: 2 areas: a) Estab. pts. office (outpt) care, domicillary care, home care; b) Emergency dept; c) Subsq. nursing facility care.
3 areas: a) New pts office (outpt) care, domicillary care, home care; b) Consultations; c) Initial hospital care; d) Hospital observation; e) Comp. nursing facility assessments.

⇨	☐ Status of 1-2 chronic condition	⇨	☐ Status of 3 or more chronic conditions
	Brief (1-2)		Extended (3 or more)
⇨ Brief (1-3)	☐ Brief (1-3)	⇨ Extended (4 or more)	☐ Extended (4 or more)
☐ None	☐ Pertinent to problem 1 system	☐ Extended 2-9 system	☐ Complete** =10 sys or 10 sy. w /+or- finding marked & stateme of all others negati
⇨ ☐ None	☐ None	☐ Pertinent 1 history area	☐ Complete ** 2-3 history areas
PROB FOCUSED	EXP PROB FOCUSED	DETAILED	COMPRE-HENSIVE

EXAM

⇨ Body Areas:

- ☐ Head inc. face
- ☐ Neck
- ☐ Chest, inc. breast & axillae
- ☐ Genitalia, Groin, buttocks
- ☐ Abdomen ☐ Back , inc. spine
- ☐ Each extremity

⇨ Organ systems:

- ☐ Constitutional (vitals)
- ☐ Eyes
- ☐ Ear, nose, mouth, throat
- ☐ Card/vasc
- ☐ Resp
- ☐ GI
- ☐ GU
- ☐ Musculo
- ☐ Skin
- ☐ Neuro
- ☐ Psych
- ☐ Hem/lymph/imm

☐	☐	☐	☐
Affected 1 BA/OS (Limited)	Affected 1 BA/OS and 2-7 OS (Limited)	Affected BA(s) and 2-7 OS (Extended)	8 or more OS or complete exam 1 OS (Complete)
PROB FOCUSED	EXP PROB FOCUSED	DETAILED	COMPRE-HENSIVE

MEDICAL DECISION MAKING

A - Number of Diagnoses or Treatment Options

A	B * X	C	= D
Problem(s) Status	Number	Points	Results
Self- limited or minor (stable, improved, or worsening)	Max = 2	1	
Est. problem; stable, improved	Any #	1	
New poblem; worsening	Any #	2	
New problem; no add workup planned	Max=1	3	
New problem add workup planned referral, consult, diagnostic test or advice sought)	Any #	4	
		TOTAL	3

B - Amount and/or Complexity of Data Reviewed

Revied Data	Points
Reviewed and/or order of clinical test	1
Reviewed and/or order of tests in the radiology section of CPT	1
Reviewed and/or order of tests in the medicine section of CPT	1
Decussion of test results w/ performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summartzation of old records and/or obtaining history from someone other than patient and/or dicussion of case with another health care provider	2
Independent visualization of image , tracing or specimen itself (not simply review of report)	2
TOTAL	A

C - Risk of complication and/or Morbidity or Mortality

Level of Risk	Minimal	Low	Moderate	High
Presenting problem(s)	☐	☐	☒	☐
Diagnostic procedure(s) ordered	☒	☐	☐	☐
Management options select	☐	☐	☒	☐
HIGHEST LEVEL	☐	☐	☒	☐

Final Results of Complexity (2)

		<=1	2	3	>=4
A	Number of diagnoses or treatment options	Minimal	Limited	Multiple	Extensive
B	Amount & complexity of data	<=1 Min or none	2. Limited	3 Moderate	>=4 Extensive
C	High risk	Minimal	Low	Moderate	HIGH
	Type of decision making	SF	LC	MC	HC

Est./New Pt E/R visit (3)	☐ 99281	☐ 99282	☒ 99283	☐ 99284	☐ 99285
HISTORY	PF	EPF ⇨	EPF	D	C
EXAM	PF	EPF ⇨	EPF	D	C
MDM	SF	LC	MC ⇨	MC	HC

TIME

Documentation may refer to prognosis, differential diagnosis, risks, benefits of treatment. Instructions, compliance, risk reduction or discussion with another health care provider.

Does documentation reveal total time?	Yes	No
Does documentation discribe the content of counseling or coordinating care?	Yes	No
Does documentation reveal that more than 50% of the time was counseling or coordinating care?	Yes	No

If all answers are "yes" select level based on time. Document total time:____min

Assigned E/M Level 3

450

COMPREHENSIVE NEUROLOGICAL SERVICES, P.C.

436 West Palmetto St., P.O. Box 7124, Florence, SC 29502 ✦ Telephone: (843) 669-2007 ✦ Facsimile: (843) 669-6677

Walter James Evans, MD
Board Certified, Neurology & Clinical Neurophysiology

Krishna Murthy, MD
Board Certified, Neurology & Pediatric Neurology

B. Floella Shupe, ACNP
Board Certified, Acute Care Nurse Practitioner

December 06, 2006

Dr. Sasha Federer
1925 Hoffmeyer Road
Florence, SC 29501

Re: Scott Floyd
Medical Record Number: 20592
Date of Birth:

Dear Dr. Federer:

On your kind referral, Mr. Scotty Floyd was seen for a comprehensive neurological evaluation regarding headaches and aggressive behavior following a work-related head injury on September 13, 2001. As you know, he is a thirty-one year old, right-handed, Caucasian male who was working as an automotive mechanic when he was struck on the left forehead by a piece of metal. He did not lose consciousness. However, he did fracture his nose and had a skin laceration. Because of headaches, he ultimately had a CT scan which showed frontal contusion. Subsequent MRI scan revealed that the damage was bilateral and that he had bilateral frontal lobe contusions with encephalomalacia. Since that time, he has suffered with headaches which have been associated with aggressive and agitated behavior with marked impulsivity. He has had extensive treatment of the headaches, both acutely and prophylactically. His course was also complicated by seizures including an admission for status epilepticus which was complicated by myoglobinuria. He was, ultimately, treated for inpatient behavior management at ResCare Premier in Texas for eighteen months. He did well there, probably because of the highly structured environment. He has now been at home for some time. He has difficulty maintaining physicians because he is not compliant with medications and does not keep visits. He becomes agitated very easily and makes threats including threatening to kill physicians and attorneys. He is now living with his mother and is doing somewhat better although his mother is afraid of him at times.

He describes his headaches as ongoing on a daily basis. They are disabling and can be severe. He has noted that weather, particularly heat and humidity, wind and thunderstorms can bring on the headaches. When he has headaches, his mood changes and he becomes agitated more readily. He has difficulty sleeping because of the headaches. It was recommended that he have a polysomnogram but he refused.

(Continued)

Past Medical History: He has been in good health save for the complications of his head injury, as described above. He had nasal reconstruction after his injury in 2002.

Current Medications: Depakote 500 mg b.i.d.; Keppra 750 mg b.i.d.; Flexeril 5 mg b.i.d.; Darvocet, two tablets PRN (this has been ineffective to control the pain).

Allergies: None.

Family History: Positive for heart disease, hypertension, arthritis, cancer, stroke and alcoholism in his father.

Social History: He is single and has an eleventh grade education. He does not use any alcohol. He smokes about one carton of cigarettes per week. In the past, he has worked as a mechanic, in landscaping and manual labor. He also regularly uses marijuana.

Review of Systems: He says that the upper half of his body is often overheated and that the lower half is underheated. His appetite has declined and he has lost about sixty pounds. The remainder of the Review of Systems is negative.

Physical Examination: Height, 5'10". Weight, 238 lbs. Blood pressure, 132/92. Pulse is 77 per minute.

Mental Status Examination: Speech is fluent. Concentration and attention span are intact. Affect is appropriate. Judgement and insight are intact.

Cranial Nerve Examination: Pupils are equal, round, and reactive to light and accommodation. Visual fields are intact to confrontation. Extraocular motion is intact without nystagmus. There is normal sensitivity to pin-prick over the face. The face is symmetrical. The soft palate elevates symmetrically on phonation and the tongue protruded in midline. Hearing is intact bilaterally.

Motor Examination: Muscle strength, tone and bulk are normal in all extremities. Gait is unremarkable. Tandem gait is performed well.

(Continued)

Sensory Examination: The patient claims normal sensitivity to light-touch and pin-prick in all extremities. Romberg Test is normal.

Reflex Examination: Reflexes are 2+ diffusely and symmetrical. No pathologic reflexes are elicited.

Review of Medical Records: Records of Marion Medical Group are reviewed. These include a number of handwritten notes from 1987 through 2002. There was also a typewritten note of November 6, 1995, indicating an automobile accident at 2300 hours on November 5, 1995. He was evaluated in the Emergency Room at Marion Medical Hospital by Dr. Cheezem for complaints of neck pain and vomiting. They note that "...X-rays of his cervical spine, lumbar spine and skull X-rays were made...The patient was on Highway 501 at Conway, turning into McDonald's when his car was struck from behind..." The diagnosis was of mild cervical and lumbosacral strain. X-rays were ordered. He was placed on Soma and Tylenol III for pain. These records include the report of a CT scan of the head on May 19, 1987 which was a negative study. A referral to Dr. Joseph Healy is noted on January 15, 2002. Numerous visits after the date of injury concern headaches.

CT scan of the head performed at McLeod Regional Medical Center was interpreted by Dr. Paul Hahn on January 13, 2002. This revealed "3 x 4 cm focus of decreased attenuation in the right frontal lobe, likely related to remote trauma; 2) fracture of the left frontoethmoidal complex which also may be related to trauma four months ago." The CT report accompanies the E.R. report by Dr. Leanna Thorn. He presented with complaints of headache. She describes his history and treatment. He was treated with Percocet and started on Pamelor and for follow-up by Dr. Healy.

(Continued)

Consultation by Dr. Mark D'Angelo is dated January 13, 2002 at McLeod Regional Medical Center. Dr. D'Angelo describes the history of injury and medical history and treatment. On examination, he was noted to be anxious but cooperative and pleasant. He did not describe any significant abnormalities. CAT scan revealed right orbitofrontal encephalomalacia. Dr. D'Angelo's impression was of "1) postconcussion syndrome with chronic daily headaches, agitation exacerbation with depression; 2) closed head injury at work on September 13, 2001 with preexisting depression exacerbated by chronic daily headaches; 4) history of physical abuse by his alcoholic father who is now deceased." Dr. D'Angelo recommended treatment with Depakote, Neurontin, Fioricet, Haldol. He also recommended neuropsychological testing, EEG and that all weapons be removed from the household. He recommended neurological follow-up after inpatient psychiatric evaluation.

Discharge Summary of Dr. Joseph Healy is dated April 12, 2002 and indicates "twenty-six year old, white male with history of closed head injury and frontal lobe contusion, admitted with severe and persistent cephalgia. The patient was admitted to Neurology Services and was placed at bed-rest. Tobacco abuse and poor sleep hygiene had been driving this patient's headaches. Hemoglobin was 15 and electrolytes were normal and urinalysis was unremarkable. MRI of the head was repeated which showed abnormal signal in both frontal lobes, right greater than left, consistent with previous traumatic brain injury. There was also right mastoiditis. Medications were adjusted and attempts were made to improve the patient's sleep hygiene."

Neuropsychological evaluation by Dr. Dora Windsorova is dated June 4th, 8th, 13th and 17th of 2002. Dr. Windsorova describes the injury in detail and she indicates that he "...suffered a head injury on 9/13/2001. Reportedly, he was breaking down auto parts when he released a bolt and when it happened, a spring pushed the control, resulting in another part getting loose and the spring hitting him with force on his forehead. Mr. Floyd did not lose consciousness but immediately felt severe pain. He went to the Emergency Room where his forehead cut was sutured and his head was X-rayed. He was given pain medication and was discharged home.

(Continued)

Mr. Floyd reported that the area around his eyes was dark with hematoma and swelled up to the point that he could not open his eyes for three weeks. He has severe nausea and blood in his vomitus for several days. His nausea and vomiting continued for 1 1/2 months. He reported that this was only controlled with his medication. He also had nosebleeds. Mr. Floyd reported that he had severe headaches. Mr. Floyd reported that he did not receive treatment for his headaches until he went to a doctor with a handgun, threatening to kill himself if he did not get some help for the headaches. He was examined at McLeod Emergency Room where he had a CT scan of the brain. Reportedly, he was told "the front part of my brain was dead". He was medicated for pain and was sent to Three Rivers Psychiatric Hospital in Columbia where he was hospitalized for eight days with the diagnosis of mood disorder and OS. He was released to home on January 22, 2002 with follow-up by Dr. Marc Weinbaum and Mr. Ross Fulcher..."

Dr. Windsorova also notes that "...Mr. Floyd reported growing up with an alcoholic father who abused drugs and was very physically abusive to his wife, as well as to Mr. Floyd. His earliest memory relates to hearing his mother scream when his father beat her. He recalls an incident when he was six years old when his father cut his wrist and then held a gun to Mr. Floyd's head and demanded that he clean the blood...Mr. Floyd repeated the second grade at the time when his parents were divorcing and he was transferred to another school where he was held back. Mr. Floyd reported he quit school in the ninth grade because of having difficulty dealing with his English teacher. He reported he had difficulty in English but was good in Math. Mr. Floyd did hard labor work most of his life. He worked with heavy machinery, drove a truck and worked in the landscape business. He stripped autos for an auto parts business for three years before he was involved in this accident. Mr. Floyd is single and currently not dating. He has no children. His primary support is his mother." She further notes that he has not driven his car since 2002. She notes that he was "...friendly and cooperative throughout the evaluation."

(Continued)

In describing the results of the WAIS III "...Mr. Floyd obtained a verbal I.Q. of 90, a performance I.Q. of 95, for a full-scale I.Q. of 91. These results place his overall level of intellectual functioning within the average range and at the twenty-seventh percentile when compared to same age peers." Subtest scaled scores included vocabulary = 9, similarities = 9, arithmetic = 10, digit span = 4, information = 10, comprehension = 8, picture completion = 11, digit symbol = 6, block design = 11, matrix reasoning = 11, and picture arrangement = 8. On the WRAT-III, he obtained the following grade equivalents: Reading was at high school level, spelling fifth grade level, arithmetic at seventh grade level. On tests of attention and concentration, he had "...significant difficulty with his attention and concentration on a task, repeating verbally presented digits..." On complex problem solving tasks, he had "...mild difficulty with simple flexibility of thought though he had low/average complex flexibility of thought and speed of mental processing...He was efficient in learning from provided feedback and shifting between cognitive sets though he had relative inefficiency in maintaining sets." Aphasia screening showed "...intact basic language and communication function." On tests of visual/spatial ability, he "...performed well on a complex psychomotor problem-solving task that has a significant spatial component." On tests of memory function, he had "...mild difficulty with his immediate and thirty minute delay contextual verbal memory, scoring at the eighth and seventh percentile, respectively..." For nonverbal memory, he "...had good immediate and thirty minute delayed figural memory, scoring at the seventy-fourth percentile..." Finger-tapping, speed and grip strength were thought to be adequate bilaterally.

Dr. Windsorova's Summary suggested "...Mr. Floyd to be intellectually functioning within the average range with his overall I.Q. of 91. Academically, his reading is at high school level, spelling at the fifth grade level and his arithmetic is at the seventh grade level.

(Continued)

Overall, the pattern of results indicates these scores to reflect long-term level of abilities without significant decline though with difficulties in Mr. Floyd's attention and concentration, new learning and speech of processing..." She thought that "The pattern of Mr. Floyd's neuropsychological test results is consistent with very mild effects of head injury. Most pronounced is his variable attention and concentration, mild difficulty in verbal memory and inefficiency in higher executive function, as well as behavioral symptomatology related to his head injury.", She recommended psychiatric treatment.

The Discharge Summary from Three Rivers Center for Behavioral Health in Columbia, South Carolina is dated January 22, 2002 with admission on January 14, 2002. Final Diagnosis was of Axis I mood disorder and THC abuse, axis II suspect organic personality disorder, axis III status post closed head injury and history of headaches and sinusitis, axis IV moderate, axis V 45/30. The criterion for admission were of "1) danger to self; 2) emotional behavioral conditions and complications requiring 24-hr medical nursing care; 3) legally mandated; 4) impaired mood and depression; 5) cognitive impairment." During the course of hospitalization, he was placed on Depakote and Neurontin and individual supportive interventions. He was discharged on Ceftin, Fioricet, Neurontin and Depakote, as per Dr. Charles Heath.

The initial psychotherapy evaluation of Dr. Ross Fulcher indicates that "...during the interview, client's speech was somewhat pressured, rambling and circumstantial." On his second treatment session on January 29, 2002, he thought that there was no significant change from the previous session. The patient scored in the extremely severe range of depression on the Beck Depression Inventory at 31 and in the mild to moderate range on the Beck Anxiety Inventory at 23. He showed signs of impulsivity during the test-taking and it was felt that he would benefit from instruction in stress management and relaxation techniques.

(Continued)

On Dr. Fulcher's third individual therapy session on February 5, 2002, he notes that the patient had abstained from marijuana but he thought it had resulted in increased nightmares. Breathing and relaxation exercises and diaphragmatic breathing exercises were reviewed. Dr. Fulcher also described sessions on March 26, 2002, April 2, 2002, and April 15, 2002. He thought that, overall, his condition had not changed between the sessions. On the last session, he describes "...He continued to be intense and angry but controlled his behavior appropriately with the exception of the intensity of communication. He continues to be quite frustrated with his lack of progress with what he sees as ineffective medical interventions."

Office note of March 5, 2002 indicates "...MRI of the head shows contusion in the frontal lobe on the right. This is resolving somewhat but still is a large lesion. My impression is that he is on the mend at this point..." He recommended formal visual field testing, as well as continued treatment with Depakote, Tenormin and Zoloft.

Noninvasive carotid study performed at Vascular Diagnostics on March 5, 2002 was interpreted by Dr. Healy as showing no hemodynamically significant lesions.

EEG performed by Dr. Healy on March 5, 2002 was interpreted as showing "...low voltage, left frontal slowing, no epileptiform activity, no sleep."

Technical report of transcranial Doppler performed at Vascular Diagnostics is reviewed. This is dated March 5, 2002. Dr. Healy's interpretation is provided in his records which indicate "increased velocity noted in the MCA bilaterally. Otherwise, normal TCD."

Ophthalmological evaluation at Seltzer Eye Associates of Florence on March 12, 2002 indicated normal ocular examination and visual fields.

(Continued)

Dr. Healy's office note of April 22, 2002 indicates that he was being seen for a follow-up of recent hospitalization on April 9, 2002. He states "...His MRI of the head was repeated which showed abnormal signal in both frontal lobes, right greater than left which looked like a posttraumatic injury. He also had a right mastoiditis." He was treated with Z-Pak, Chlorohydrate, Atenolol, Neurontin, Depakote and Colace for hemorrhoids.

Dr. Healy's office note of May 22, 2002 indicates that a number of medications have been cut at Dr. Weinbaum's instruction. The patient was currently on Celexa, Sonata but with poor sleep hygiene.

Follow-up note dated July 17, 2002 indicates "...headaches are still his biggest problem." He had not stopped smoking. Ambien did not help with sleep so he was started on Desyrel. Depakote didn't work for the headaches so a trial of Topamax was considered. He recommended repeating an EEG.

Office Note dated August 7, 2002 notes the patient to be calmer and sleeping better. He continued on Desyrel and Risperdal. Dr. Healy prescribed Topamax for prophylaxis of headache. Dr. Healy's impression was of "...posttraumatic encephalopathy. There have been amplifications of his underlying baseline personality which tended to be one with anxiety and occasional outbursts if provoked premorbidly."

Dr. Healy's office note of September 11, 2002 indicates that he was feeling better on Desyrel, Topamax, Ultram and Risperdal. He also describes "...If he hears a loud noise or is startled that he seems to react to it violently which I think is consistent with posttraumatic stress disorder." He recommended evaluation by Vocational Rehabilitation.

Dr. Healy's office note of October 8, 2002 indicates that the patient was doing better on Desyrel, Topamax, Risperdal and Ultram.

Operative report by Dr. Howard Farrell of Carolinas Hospital System is dated October 17, 2002. This is a report of a septoplasty and bilateral inferior turbinate cautery.

(Continued)

Dr. Healy's office note of January 22, 2003 reviews Dr. Windsorova's neuropsychological test results. He notes "...Dr. Windsorova also thinks that there may be some continued improvement over the next year." He was still having problems with agitation and frustration. He was started on Paxil and he did not recommend referral to Pain Management.

Follow-up note of February 12, 2003 indicates that he was doing better on Paxil and he recommended increasing the Paxil and continuing Hydrocodone.

Follow-up visit with Dr. Healy on March 25, 2003 indicates the patient was taking Paxil, Hydrocodone and Prilosec. His girlfriend had noted some "...involuntary motor activity nocturnally." Dr. Healy felt this was consistent with seizure. He further notes "I have been watching very closely all along for seizure activity since the frontal lobes are very epileptogenic." He recommended another EEG, as well as some blood-work.

Dr. Healy's office note of April 1, 2003 indicates "...His EEG shows frontal slowing as expected. There is no definite epileptiform activity." He started a trial of Lamictal. Hydrocodone was stopped and Ativan was started 1 mg q eight hours.

Dr. Healy's office note of April 28, 2003 indicates "...He is becoming very aggressive and has rage reactions and apparently had one 4/14/03 and beat up the side of a building at home. His mother called here and we told her that if she was afraid or if he became threatening that she needed to call the police but she didn't do that. He has stopped all of his medicines and the last time he was in the hospital, his drug screen came back showing marijuana." Dr. Healy advised him not to use marijuana. He did not think that he required neurosurgical evaluation.

(Continued)

December 06, 2006

Dr. Sasha Federer
Re: Scott Floyd
Medical Record Number: 20592
Date of Birth:
Page Eleven

Discharge Summary from Palmetto Baptist Medical Center is dated May 2, 2003 by Dr. Timothy D. Malone. His diagnosis was of "axis 1, intermittent explosive disorder secondary to closed head trauma, rule out depression...; history of marijuana abuse versus depression. The patient was admitted because of increasing aggression at home, reportedly striking the walls. The mother was afraid of him. He was treated with Klonopin, Carbatrol, Paxil, Keppra. He was observed to be pleasant and appropriate with his focus on getting out of the hospital."

Dr. Healy's note of May 8, 2003 indicates "...two weeks ago, he was in the office and was very aggressive and was taken to McLeod's. Apparently, he was transferred to Columbia. He returns today after being hospitalized at Baptist Hospital in Columbia and he is doing better." The patient was on Prilosec, Klonopin, Carbatrol, Paxil, Keppra, Vicodin at that time. He was described as being "...much less aggressive and more polite. He still can escalate if he hears something he doesn't like." He also recommended vascular and electrophysiological studies for pain radiating into the right second, third and fourth digits.

Dr. Healy's note of May 15, 2003 indicates the patient "had been seen at Marion County Medical Center Emergency Room the night before with headache" and that this was the third visit that week. The patient told Dr. Healy he wanted to kill the emergency room physician because he didn't order a CAT scan. Dr. Healy's opinion was that the headaches were chronic tension headaches "...that are driven and exacerbated by his behavior and demeanor and that when he is upset, they intensify...As a consequence, I do believe that they are a measure of his aggressiveness or possibly a program to impulsive behavior."

Dr. Healy's office note of May 26, 2003 indicates that he is less angry and less impulsive. The examination suggested a median neuropathy, confirmed by electrophysiological studies. He felt that he was stable on his current medication regimen. He recommended MRA of the head to further evaluate the headaches.

(Continued)

Venous Duplex Evaluation performed at Vascular Diagnostics on May 26, 2003 was negative for DVT or SVT.

Upper extremity arterial study performed at Vascular Diagnostics on May 26, 2003 showed normal study, according to the technician's interpretation.

Dr. Healy saw Mr. Floyd on September 23, 2003 for neck pain and occipital pain. He thought that his behavioral problems had been agitated and that he was "very aggressive".

Follow-up note by Dr. Healy is dated October 28, 2003 and indicates follow-up for recent hospitalization. He had a left occipital nerve block which helped with the headaches. He describes "...under the influence of a great deal of benzodiazepines and Morphine. His behavior was great." He recommended behavior modification and possible inpatient treatment in Texas. He recommended continued treatment with Keppra, Prilosec, Paxil, and Tranxene.

Office note of March 24, 2004 indicates "compliance with Tranxene and Keppra. The headaches were improved. He is still complaining of problems with headaches and behavioral problems."

The History and Physical by Dr. Ashley Kent of Carolinas Hospital System is dated April 9, 2004. He notes that the patient had "...several passing-out episodes in the past...admitted in October of 2003 with increase in aggression and complaints of pain felt secondary to occipital neuralgia. The patient is not compliant with medication, as manifested by the following medicine counts: (Dr. Kent then reviews pill counts in bottles exceeding the numbers expected)." Dr. Kent notes that "shortly after noon, the patients mother heard a funny noise and went in and found vomitus all over him and then, he had some tonic seizures, very brief. He had three seizures before the arrival of the ambulance and they noted him to be very cyanotic. He had four further seizures prior to arriving at the Emergency Room and three to four more in the hospital..." He was treated with Versed and Dilantin and orally intubated. He was given Cerebryx. Apparently, initial CT suggested a subdural hematoma but further review indicated that there was no subdural hematoma.

(Continued)

Alcohol level was less than 10. Carbamazepine level was less than 2. Salicylate level was less than 5. Benzodiazepines were positive and THC was positive. Dr. Kent treated him with Keppra and Depakon and held the Carbatrol due to hematological abnormalities. He was also given Rocephin.

The copy of an EMS Report is dated April 9, 2004 and is not legible. This apparently is regarding a hospital admission to Carolinas Hospital in April of 2004. History and Physical by Dr. Ashley Kent is dated April 9, 2004. Dr. Kent indicates "...involved in an on the job injury where he was struck on the left forehead and developed frontal lobe syndrome secondary to contusion over that area. No surgery was ever accomplished and the patient has had several passing-out episodes in the past, hospitalized by Dr. Healy and last admitted in October of 2003 with increase in aggression and complaints of pain, felt secondary to occipital neuralgia. The patient is noncompliant with medication, as manifested by the following medicine counts. On March 10th, his Keppra was refilled with sixty pills. He had only taken two pills since that time. He is supposed to be on a b.i.d. dosing. Carbatrol was filled on February 13th, fifty-four pills and fifty pills remain; Klonopin 1 mg, sixty pills and 58 remaining. Tranxene 150 pills and 136 remaining from the tenth of March. Paxil, 60 pills on the tenth of March with 58 remaining.... The patient usually sleeps a lot during the daytime, awoke this morning around noon and had a steak biscuit. He said that he was going back to bed. His mother then heard a funny noise and went in and found vomitus all over him and then, he had some tonic seizures, very brief. He had three seizures before the arrival of the ambulance and they noted him to be very cyanotic. He had four further seizures prior to arriving at the Emergency Room and three to four more in the hospital. He was given about 10 mg of Versed and loaded with a gram of Dilantin. He was orally intubated and placed on a Versed drip, and I was notified....I suggested Depakon. However, the Emergency Room doctor apparently had given the Cerebyx, one gram. On the order sheet, there is a note for some Depakon but I called back and the apparently only gave the Cerebyx. She described subdural hematoma on the patient and I suggested that they call Neurosurgery."

(Continued)

"I called back and the neurosurgeon wanted to assess the patient in the Emergency Room at Carolinas, and so therefore, Dr. Guinn transferred the care to Dr. Gandy. Dr. Gandy notified me that the patient had arrived and that he was breathing and waking up and thought that he could extubate the patient. I responded and came to the hospital and there, met his mother. She described a history that he had no pre-seizure illness. However, it was determined that the patient was not compliant with medications." He further describes review of the CAT scan with Dr. Sechtin and felt that there was no evidence of subdural hematoma, as initially thought at Marion Medical Center. Alcohol level was less than 10. Carbamazepine level was less than 2. Salicylate level was less than 5. Benzodiazepines are positive. THC was positive. White cell count was 34.8. Hemoglobin was 17.5 with hematocrit of 57.5 and MCV of 101.9 and platelet count of 202,000. Urinalysis was positive for a large amount of blood, three to four white cells and trace bacteria. He was admitted to the Intensive Care Unit. His BUN and Creatinine increased over the course of admission to a Creatinine of 3.5 and later to 4.3. Dr. Sarawadee S. Sitti was consulted. She diagnosed acute rhabdomyolysis and myoglobinuria."

CT scan of the brain performed at Carolinas Hospital System on April 10, 2004 was interpreted by Dr. Alan Sechtin as showing "1) Old area of encephalomalacia, frontal brain on right. No acute intracranial abnormality..."

The report of Dr. Sarawadee S. Sitti is dated April 18, 2004. Her diagnosis was of "acute renal failure in gentleman with previously normal renal function and recent onset of seizures. We obtained a CPK which came back over 8,000, along with definite tea-colored, dark urine. Obviously, this gentleman is suffering from acute rhabdomyolysis and myoglobinuria." Dr. Sitti recommended IV fluids and diuresis.

Dr. Healy's note of June 1, 2004 indicates frontal lobe syndrome with rage and seizures. He was having problems with violence and was carrying weapons. He damaged property. He stabbed himself in his hand. He suffered compression fracture of the thoracic spine due to the recent seizures. He felt that integration into society would be very difficult because of behavioral problems. He prescribed Darvocet in addition to Keppra and Depakote.

(Continued)

A letter to Dr. Steve Wukela from Dr. Joanne M. McGee is dated January 3, 2005. Dr. McGee is apparently a neuropsychologist and Clinical Director of ResCare Premier in San Marcos, Texas. She notes "Scotty Floyd is currently receiving rehabilitation service at ResCare Premier's 'Roca Vista' Program. Mr. Floyd requires aid with interpersonal interactions, low frustration tolerance with intermittent explosive disorder, health and safety issues, transportation and financial management secondary to the residual effects of his traumatic brain injury. Mr. Floyd exhibits gross limitations in the area of social judgement, as well as emotional functioning. He has a tendency to be overly reactive and impulsive and has aggressive outbursts. When provoked, even as a result of minor misunderstanding, Mr. Floyd has become physically and verbally threatening. For example, after a misunderstanding at the Roca Vista Program on December 19th, Mr. Floyd exhibited the behavior described: He became physically and verbally threatening toward another participant in the program who happened to be of smaller stature than Mr. Floyd. He incited fears in the other participating living in the program, as well as staff members and it was necessary to address ongoing verbal threats for approximately three hours before Mr. Floyd was able to calm down. This pattern of behavior was observed during the years since his injury while Mr. Floyd was living at home and prior to his admission to ResCare Premier...While he has shown considerable improvement during the course of his treatment, this improvement is attributed, to a large extent, to the nature of the rehabilitation environment (highly structures with clearly defined limits and expectations with trained staff members and in which environmental stressors can be controlled). Without this level of support, it is my opinion that Mr. Floyd would regress considerably and this type of incident would occur more frequently and would occur at the expense of the safety and well-being of Mr. Floyd, his family and members of the community." Dr. McGee recommended regular supervision and monitoring of his health, as well as assistance with medications, cooking, financial affairs, as well as regular encouragement on a daily basis. She thought that he would "...continue to have residential rehabilitation treatment and a guarding/substitute decision-maker for a minimum of one year."

(Continued)

December 06, 2006

Dr. Sasha Federer
Re: Scott Floyd
Medical Record Number: 20592
Date of Birth:
Page Sixteen

A neurological evaluation of Dr. Michael T. Edmond is dated June 2, 2005. Dr. Edmond describes Mr. Floyd's injuries and medical history. As a result of the injuries, he states "...He has developed a behavioral disorder with explosive personality, cognitive dysfunction with frontal lobe executive dysfunction, as well as chronic headaches." He describes daily headaches, bilateral frontal/temporal regions with frequent intensification, requiring narcotic analgesics. He notes treatment with Darvocet, Morphine, Demerol, Maxalt, Topamax, Lamictal, Depakote, Keppra, Clorazepate, Inderal, Flexeril, Pamelor, Ativan, Haldol, Celexa, Zoloft, Sonata, Desyrel, Risperdal, Tranxene, and Paxil. He notes in the Review of Systems that there was "partial visual loss of right eye. Increased hearing in right ear. Decreased smell. Normal taste. Poor oral hygiene with some difficulty chewing...some difficulty with concentration and attention...behavioral disorder with explosive personality with historical depression and some anxiety. Total loss of feeling in the right upper extremity..." Findings on examination included "...subjective anesthesia right upper extremity to all primary modalities with stereoagnosis although he is able to detect double simultaneous stimulation touching the right hand with the eyes closed..." His diagnoses were of "...1) closed head injury with bilateral frontal, possible temporal contusions with frontal encephalomalacia; 2) explosive behavior disorders with anxiety/depressive tendencies secondary to No. 1. 3) Seizure disorder secondary to No. 1; 4) chronic headaches with muscle tension component, vascular component and likely tied into psychogenic/psychiatric issues." Dr. Edmond thought that the headaches would be lifelong and revolve around the patient's psychiatric issues. He thought that there was no cure to be offered and that symptomatic management was appropriate. However, he thought that it would be reasonable to try other types of treatment such as biofeedback, stress management, relaxation techniques, occipital nerve blocks and even, BoTox.

Progress reports of Ms. Cynthia P. Grimley dated December 18, 2005 through November 3, 2006 are reviewed. She indicates in her note of October 3rd that "all parties met on September 11, 2006 to discuss this deteriorating situation. A more structured environment is recommended by Dr. Federer and Dr. Healy. Dr. Healy has indicated that he can no longer remain the primary treating physician due to the threats made by Mr. Floyd. Prior history indicates previous threats have been made by Mr. Floyd."

(Continued)

December 06, 2006

Dr. Sasha Federer
Re: Scott Floyd
Medical Record Number: 20592
Date of Birth:
Page Seventeen

Note of Dr. Healy's is dated March 23, 2006 and indicates that he had been at ResCare Premiere in Texas for eighteen months. Medications included Keppra, Flexeril, Effexor, Depakote and Darvocet. He believes that "...Scotty has made a tremendous turnaround. He is very calm and I don't really see signs of anger like he used to have. He is not impulsive any longer..." It was thought that the patient had much better insight and might be able to live at home.

Office note of July 11, 2006 indicates that "...He has been home now for five weeks from Texas." Dr. Healy indicates some stress related to a broken-down air-conditioner. He thought his headaches were worse. He reports loss of twenty pounds, no seizures and compliance on his medications include Keppra, Flexeril, Depakote ER and Darvocet PRN. Dr. Healy thought that possible sleep disorder was affecting his headaches and recommended polysomnography. He requested to repeat the EEG.

A number of other reports of Dr. Federer's are reviewed including August 31, 2006, July 24, 2006, July 20, 2006.

Dr. Federer's note of September 5, 2006 indicates that Mr. Floyd "...stated that he has been threatened by his attorney and that he is going to retaliate. After the opening statement, we have discussed what happened. Apparently, Mr. Floyd's attorney contacted his mother on Friday and told her that if Mr. Floyd does not attend his appointments, since he missed three or four of my appointments, he may lose his benefits. Following that, apparently Mr. Floyd became very upset and today, threatened to kill his attorney, caseworker and whoever was, as he stated, "down the line". We have spent about forty minutes going over his irrational way of thinking, trying to explain to him that the call was placed in order to assist him and to prevent him from losing benefits. Mr. Floyd became more agitated and some point, stated that the session was over - otherwise, he may hurt me as well. We had discontinued the session at that point...Mr. Floyd has demonstrated similar, out of control behaviors prior to the two years he had spent in a rehabilitation facility in Texas. Because of my duty to warn, I have contacted the attorney, Mr. Wukela, and also placed a call to Ms. Cynthia Grimley, case manager, who is supposed to see him today...I will also contact Dr. Healy and discuss the situation that appears to be deteriorating."

(Continued)

December 06, 2006

Dr. Sasha Federer
Re: Scott Floyd
Medical Record Number: 20592
Date of Birth:
Page Eighteen

"Mr. Floyd complains of increased frequency and intensity of headaches since he returned back to South Carolina, especially with the stormy weather. He reported that his headaches become unbearable and that, at times, he does not sleep for several days..."

The report of Dr. Edwin Gandy is dated November 3rd. He notes that Mr. Floyd was being followed closely by Dr. Federer and that he had an appointment with Dr. Evans in the following month. He agreed to refill his medications consisting of Depakote, Flexeril, Keppra and Darvocet.

The report of Dr. Sasha Federer is dated November 9, 2006. Dr. Federer indicates that Mr. Floyd was seen on October 20th, 27th, 31st, November 3rd and 9th. He attended all of the therapy sessions and was always on time and cooperative; that he had not had problems with aggression during these sessions and that his focus had been on "...developing different coping styles that would allow him to remain more in control."

Handwritten notes of McLeod Psychiatric Associates are reviewed.

Records of the Palmetto Oral and Maxillofacial Surgeons are also reviewed.

Impression:

1. Closed head injury with bilateral frontal contusions and subsequent encephalomalacia with headaches, impulse control, seizures.
2. Back pain due to thoracic compression fracture secondary to seizure.
3. Snoring with daytime drowsiness and difficulty initiating and maintaining sleep. Rule out obstructive sleep apnea.

Recommendations and Plan: I have taken the liberty of referring him to Dr. Rakesh Chokshi regarding pain due to multiple compression fractures.

(Continued)

December 06, 2006

Dr. Sasha Federer
Re: Scott Floyd
Medical Record Number: 20592
Date of Birth:
Page Nineteen

We will proceed with polysomnography. We will begin a trial of Aricept 5 mg q.h.s. for four weeks, increasing to 10 mg q.h.s. thereafter. Hopefully, this will improve some of the frontal lobe deficits including the impulsivity. He is to continue with the Depakote 500 mg b.i.d. and Keppra 750 mg b.i.d. and use Restoril 30 mg q.h.s. at night. We have entered into a Pain Management Agreement and I have agreed to begin a trial of Vicodin, one PO q six PRN (#120 x NRF). He is also to use Flexeril 5 mg, one PO q eight (#90 x 2 refills) for spasm.

I have explained to Mr. Floyd that compliance with medications, with the Pain Management Agreement and with all of the testing, and evaluation by other physicians is mandatory and a condition for his continued treatment here in this office. Furthermore, he must not display any aggressive behavior towards myself or my staff or any of the technologists of facilities to which he is referred as a condition of his continued treatment here at Comprehensive Neurological Services.

I will plan on seeing him again in four weeks. Thank you, once again, for your kind referral.

Sincerely,

W. JAMES EVANS, M.D.
Clinical Associate Professor of Neurology
Medical University of South Carolina

WJE/tb
cc: Dr. Rakesh Chokshi

Pee Dee Orthopaedic Associates, PA

Joseph W. Dunlap, Jr., M.D., FACS · W.S. "Bill" Edwards, Jr., M.D.
Rakesh Chokshi, M.D. · Patrick K. Denton, M.D. · Barry L. Clark, D.O.
Danny W. Nicholls, D.O. · Anthony W. Alexander, M.D.
Dewey Nelson Ervin, M.D. · A. Cecil Bozard, Jr., M.D.
Nigel A. R. Watt, M.D.

901 East Cheves Street, Suite 100 · Florence, SC 29506
(843) 662-5233 · Fax: (843) 678-9003 · www.pdoa.com

Date: January 24, 2007
Name: Scotty Floyd
Address:

Case #: 252-114
Age: 49 M
Ref By: James J. Evans, M.D.

FAMILY PHYSICIAN: James J. Evans, M.D.

CC: Mid-low back pain.

HPI: On 09/13/2001, he was at work with removing parts out a car when sprung back striking his head. He had a head injury at that time and developed a seizure disorder. In 2004, he had significant seizures, which caused thoracic back pain. He describes his pain as chronic to his thoracic back only, worsened with sitting, improved by physical therapy and medication. Denies any bowel or bladder complaints.

ROS: Review of systems form is reviewed with the patient.

PMH: Past medical history: Seizure disorder and headache. Surgeries: Facial reconstruction. Current medications: Vicodin 5 mg, Depakote, and Keppra. Allergies: No known drug allergies.

FH: Unremarkable.

SH: Currently unemployed. He has not worked since 09/13/2001. Does smoke one to two packs of cigarettes per day. Denies alcohol use.

PE: GENERAL: Height 5 feet 9 inches and weight 240 pounds. Mr. Floyd is a well-developed, well-nourished, 31-year-old male, alert and oriented x3. The patient in no acute distress. He does have tenderness on palpation to the thoracic spine, basically from T4-T10. He flexes without any difficulties. There is no excessive kyphotic deformity. He has 2+ patellar and Achilles deep tendon reflexes. No clonus. 5/5 motor strength to the lower extremities and normal sensation. 2+ dorsalis pedis pulses. Neurologically intact.

X-RAYS: Imaging studies AP and lateral of thoracic spine, questionable compressive deformities of the thoracic spine multiple levels include the T3, T4, and T5 of lateral lumbar spine and lumbar spondylosis. Otherwise, normal.

IMP: T-spine pain, possible compression fractures.

Con't ..... on Page Two (2)

Con't... from page one (1)

PLAN: Natural history was discussed with the patient regarding compression fractures. To determine the nature of these compression fractures, MRI of the thoracic spine will be needed. If these are acute fracture, vertebroplasty or bracing could be done. If these are chronic fractures, nonoperative care would to be to treat mutually. We have ordered MRI of the thoracic spine. We will have him return to the office following his MRI.

We would like to thank Dr. James Evans for this kind consultation and requesting to contact our office.

The patient was also seen and treated by Dr. Rakesh. P. Chokshi.

Thank you.

Rakesh. P. Chokshi, M.D./Daniel S Koele, PA-C.
Spine Surgeon
Pee Dee Spine Center (dictated but not read)

DK: sgk

cc: James J. Evans, M.D.

9/1/07 HCFA + update to SC Fns Duoraster + update faxed to 1-7 RB

Carolinas Hospital System 805 Pamplico Highway Florence, SC 29505 843-674-5000

NAME		SEX	ACCOUNT NUMBER
FLOYD,SCOTTIE W		M	H14048318
ORDERING PHYSICIAN	**PT. STATUS**	**LOCATION**	**MEDICAL RECORD NO.**
HEALY,R. JOSEPH JR.	UNK	UNK	H337978
ATTENDING PHYSICIAN / **DATE OF BIRTH**	**AGE**	**DATE OF EXAM**	**RADIOLOGY NO.**
	31	05/05/2004	

EXAM#	TYPE/EXAM	RESULT
000693322	RAD/T-SPINE	
000693323	RAD/L-SPINE	

History: Seizure disorder.

LUMBAR SPINE: Five lumbar vertebral bodies are seen. The pedicles are intact. No spondylolisthesis or spondylolysis is seen. No acute fracture is seen.

IMPRESSION: NEGATIVE LUMBAR SPINE.

THORACIC SPINE: Twelve thoracic vertebral bodies are seen. Minimal curvature toward the right is present. There are compression fractures of T8 and T9 without displacement of the pedicles. There is approximately 40-50% loss of height of T8 and 20-30% loss of height of T9. More superiorly it is difficult to count the exact number, however, there appears to be compression deformity of what I am labeling at T3, superior end plate of T4, and T5. The bones are mildly osteopenic.

IMPRESSION: COMPRESSION DEFORMITIES IN MULTIPLE THORACIC VERTEBRAL BODIES AS ABOVE.

Report called to Dr. Healy's office at 1 p.m. and message was left for Dr. Healy to return my call with my beeper #.

D 5/5/04
T 1300
8030

Reported By: ALAN SECHTIN MD

CC: R JOSEPH HEALY JR MD

Technologist: TROY BYRD-PACS ADMINISTRATOR
Transcribed Date/Time: 05/05/2004 (1945)
Transcriptionist: XHIMCL
Printed Date/Time: 01/22/2007 (1156)

******* INSTANT [illegible] ******* ACCT: 252114 DATE: 02/05/07

PEE DEE ORTHOPAED ASSOC., PA
901 E CHEVES ST. S E 100
FLORENCE, SC 29506

LAST PAYMENT

$0.00

YTD PAY

$0.00

OFFICE PH:843-662-5233 HOME PH:843-206-1379 BUSINESS PH:
EXT:

SCOTTY FLOYD
2

PAT NAME
--- ----
SF SCOTTY FLOYD

APPOINTMENT

02/07/07 3:45PM

DIAGNOSIS

724.1 PAIN THORACIC SPINE
V65.1 PERSON CONSULTING ON BEHAL
805.20 FX COMPRESSION/THORACIC/NO

M DOCTOR
---
2 RAKESH P. CHOKSHI,M.D

TAX ID

57-0518478

TE	DR	PAT	DIAG	TCODE	MOD	DESCRIPTION	CHARGE	CREDIT	BALANCE
'24/07	12	SF	1	99244		*OFFICE CONSULTATI	236.00		236.00
'24/07	12	SF	2	99361	25	*MEDICAL CONFERENC	50.00		286.00
'24/07	12	SF	1	72070		*X-RAY THORACIC SP	50.00		336.00
INS. FILED:01/29/07									
'25/07	12	SF	3	72146		*MRI;THORACIC WITH	758.00		1094.00

REF PHYS : EVANS,KENNETH TAX ID: 57-0705657
AGES REF STATE: SC LIC # : 10933 20 TOTAL: $1094.00

ACCEPT VISA/MASTERCARD, IN PERSON OR BY PHONE!

Scottie Floyd Chart #23705

6/10/08 RTC

33yo WD

SIP CAI ē formal Conclusions wt. ↓ to 208

Keppra 500/500 120/80

Depakote ER 500/500

Cohesion Letter - less impulsive

sleep is better

using marijuana

Darvocet N-100 #30 → pt taken it will last 60 days.

PT consult for physical Training

N

7/2/08 RTC in PT now

no urgies

VPA ER 500/500

Keppra 500/500

Darvocet - used 20 in 5 wks

wants to quit smoking

sleep is OK

Labs good 7/10/08

PT consult in progress

N

NAME → Scottie Lloyd Chart # 23201

9/2/08	RTC

sinus rhythm
using Chantix → not working enough → by Dr
no anxiety very little Darvocet + none
VIBAER 500/500
Keppra 500/500
Darvocet
PT very helpful
↓ U/A - dark urine
constipation

N

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

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

Patient: FLOYD, SCOTTY
Med Rec: FLOYDSCOTT
DOB: 1/1/1901
Male Race: Other
ACCESSION: FA-08-00603
Date Received: 9/6/2008
Date Collected: 9/6/2008

Forensic Autopsy Final Report

Autopsy Information

Date of Death: 9/5/08 **Time:** ~10:00 pm (pronounced)
Date of Autopsy: 9/6/08 **Time:** 11:00 am
County: Marion
Coroner: Jerry M. Richardson
Attending Pathologist: Cynthia A. Schandl, MD, PhD
Pathologist Assistant: Eowyn Corcrain
Autopsy Technician: Raymond Edwards
Prosector(s): Cynthia A. Schandl, MD, PhD

Reason for Autopsy: Found unresponsive in bed
(If Injury) How occurred: n/a
Date of Injury: n/a **Time:** n/a
Place of Injury: n/a **At Work:** No

Cause of Death

Complications of seizure disorder (due to)
Cerebral cavitary lesion (due to)
Remote blunt head trauma

Manner of Death

Accident

CASE HISTORY

According to the coroner, the decedent was a 33-year-old male who was found unresponsive in bed by his mother at approximately 9:30 pm on September 5, 2008. She stated that he went to bed at around 8:30 pm that night after eating dinner; he had no complaints at that time. Emergency medical personnel arrived to find no signs of life; and death was pronounced at 10:00 pm on September 5, 2008.

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

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

Forensic Autopsy Final Report

He has history of head trauma three years previous with subsequent seizure disorder for which he was prescribed Depakote and Keppra. He was also prescribed Darvocet.

GROSS DESCRIPTION

EXTERNAL EXAMINATION

The body is that of a well-developed, well-nourished, adult white male, who weighs approximately 213 pounds, is 70 inches in length, and appears compatible with the stated age of 33 years. The body is identified by the coroner. The body is clad in blue jeans shorts, blue boxer shorts and a braided belt in the belt loops of the shorts. The body is warm to the touch. Rigor is partially fixed (+2/4) in all extremities and jaw. Diffuse, blanchable pink-purple livor extends over the posterior surfaces of the body, except in areas exposed to pressure. Tardieu spots are of the anterior chest and shoulders; the head and neck are plethoric. The scalp hair is light brown and up to 0.2 inch in length over the crown. The irides are green; the pupils are bilaterally equal. The corneae are slightly clouded. The sclerae and conjunctivae are unremarkable. The nose and ears are not unusual; the left earlobe is pierced twice. The lips and gums are intact. The mouth is edentulous. The deceased has a beard and mustache. The neck is without masses, and the larynx is in the midline. The thorax is symmetrical with an anteroposterior/lateral ratio of about 1:2. The abdomen is flat. The penis is unremarkable; the testes are bilaterally descended within the scrotum. The anus and back are unremarkable. The upper and lower extremities are well-developed and symmetrical, without absence of digits. Identifying marks and scars consist of a 6 x 4 inch tattoo of a Confederate flag at the upper lateral right arm, a 1.5 inch faint scar of the left abdomen, a 3 x 2 inch region of irregular tattoo ink of the posterior left hand and wrist including a cross, and nondescript extremity scars up to 0.7 inch each. There is no evidence of emergency resuscitation and / or medical therapy.

INTERNAL EXAMINATION

BODY CAVITIES: No adhesions or abnormal collections of fluid are in any of the body cavities. All body organs are present in normal anatomical positions.

HEAD (CENTRAL NERVOUS SYSTEM): The brain weighs 1510 grams. The dura mater and falx cerebri are intact. The leptomeninges are thin and delicate. The cerebral hemispheres are asymmetrical; superficial inferior left frontal cavitation is noted as is a 3 x 2 x 1 inch cavitation of the inferior right frontal cerebrum. The structures at the base of the brain,

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

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

Patient: FLOYD, SCOTTY
Med Rec: FLOYDSCOTT
DOB: 1/1/1901
Male Race: Other
ACCESSION: FA-08-00603
Date Received: 9/6/2008
Date Collected: 9/6/2008

Forensic Autopsy Final Report

including cranial nerves and blood vessels, are intact and free of abnormality. Sections through the cerebral hemispheres reveal no additional lesions within the cortex, subcortical white matter, or deep parenchyma of either hemisphere. The basal ganglia, thalami, and hippocampi are unremarkable; the hippocampi appear symmetrical. The cerebral ventricles are normal caliber. Sections through the brainstem and cerebellum are unremarkable.

NECK: Examination of the soft tissues of the neck, including strap muscles, thyroid gland, and large vessels, reveals no abnormalities. The hyoid bone and larynx are intact. The lingual mucosa is intact; the underlying firm red-brown musculature is devoid of hemorrhage.

CARDIOVASCULAR SYSTEM: The heart weighs 410 grams. The pericardial and epicardial surfaces are smooth, glistening and remarkable for epicardial petechiae; the pericardial sac is free of significant fluid or adhesions. The coronary arteries arise normally, follow the usual distribution and are patent, without evidence of significant atherosclerosis or thrombosis. The chambers and valves bear the usual size-position relationships and are unremarkable. The valves have the following circumferences: tricuspid valve = 13.0 cm, pulmonic valve = 7.0 cm, mitral valve = 11.0 cm, and aortic valve = 6.0 cm. The myocardium is dark red-brown, firm, and unremarkable; the atrial and ventricular septa are intact. The left ventricular thickness = 1.0 cm, right ventricular thickness = 0.3 cm, and the interventricular septum = 1.0 cm. The aorta and its major branches arise normally, follow the usual course and are patent, free of significant atherosclerosis and other abnormality. The venae cavae and their major tributaries return to the heart in the usual distribution and are free of thrombi.

RESPIRATORY SYSTEM: The right and left lungs weigh 900 and 760 grams, respectively. The upper airway contains froth; the mucosal surfaces are smooth, yellow-tan and remarkable for petechiae. The pleural surfaces are smooth, glistening and unremarkable. Lobar divisions are of the usual configuration. The pulmonary parenchyma is dark red-purple, exuding moderate amounts of blood and frothy fluid; no focal lesions are noted. The pulmonary arteries are normally developed, patent, and without thrombus or embolus.

LIVER AND BILIARY SYSTEM: The liver weighs 1780 grams. The hepatic capsule is smooth, glistening and intact, covering red-brown parenchyma, with no focal lesions noted. The gallbladder contains three ml of red-brown, slightly mucoid bile; the mucosa is velvety and unremarkable. The extrahepatic biliary tree is patent, without evidence of calculi. The portal vein and its tributaries are unremarkable.

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

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

Patient: FLOYD, SCOTTY
Med Rec: FLOYDSCOTT
DOB: 1/1/1901
Male Race: Other
ACCESSION: FA-08-00603
Date Received: 9/6/2008
Date Collected: 9/6/2008

Forensic Autopsy Final Report

ALIMENTARY TRACT: The esophagus is lined by gray-white, smooth mucosa. The gastric mucosa is arranged in the usual rugal folds, and the lumen contains 600 ml of yellow partially digested food including meat, beans, and rice. No pills are identified within the gastrointestinal tract lumen. The small and large bowels are unremarkable. The appendix is present. The pancreas has a normal gray-white, lobulated appearance, and the ducts appear clear.

GENITOURINARY TRACT: The right and left kidneys weigh 150 and 160 grams, respectively. The renal capsules are smooth and thin, semi-transparent, and strip with ease from the underlying, smooth, red-brown, firm, cortical surfaces. The cortices are sharply delineated from the medullary pyramids, which are red-purple to tan and unremarkable. The calyces, pelves, and ureters are unremarkable. The relationships at the trigone are unremarkable. The urinary bladder contains scant cloudy yellow urine; the mucosa is gray-tan and smooth. The testes, prostate and seminal vesicles are unremarkable.

RETICULOENDOTHELIAL SYSTEM: The spleen weighs 140 grams and has a smooth, intact capsule covering red-purple, moderately soft parenchyma; the lymphoid follicles are unremarkable. The regional lymph nodes appear normal. The bone marrow is red-purple and homogeneous, without evidence of focal abnormality.

ENDOCRINE SYSTEM: The pituitary, thyroid, and adrenal glands are unremarkable.

MUSCULOSKELETAL SYSTEM: The bony framework, supporting musculature, and soft tissues are not unusual.

CASSETTE SUMMARY:
1. Cardiac apex, spleen, left kidney, left lung
2. Right lung, interventricular cardiac septum, pancreas, adrenal
3. Left cardiac ventricle, liver, cerebellum
4. Right cardiac ventricle, hippocampus (right), pituitary
5. Inferior right frontal cavitation

CAS:mtr
9/6/08

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

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

Patient: FLOYD, SCOTTY
Med Rec: FLOYDSCOTT
DOB: 1/1/1901
Male Race: Other
ACCESSION: FA-08-00603
Date Received: 9/6/2008
Date Collected: 9/6/2008

Forensic Autopsy Final Report

9/25/08

Cynthia A Schandl, M.D. Ph.D. (1-4382)/ MTR

CASE SUMMARY

A complete autopsy was performed on the body of 9/6/08 at the Medical University of South Carolina Autopsy Suite on Scotty Floyd. The postmortem examination began at 11:00 am. The prosector was Dr. Cynthia A. Schandl. The autopsy technician was Mr. Raymond Edwards. The autopsy was authorized by the Marion County Coroner, Mr. Jerry Richardson.

Significant findings at autopsy included heavy wet lungs (combined weight = 1660g), mild cardiomegaly (410g), pleural and epicardial petechiae, and cavitation of the inferior frontal cerebral lobe.

Microscopic examination of the lungs shows significant edema and regional hemorrhage as well as increased peri-bronchiolar pigmented macrophages. The inferior right frontal cerebral cavitation shows gliosis and pigmented phagocytes with regional tissue absence. Moderate macrovesicular steatosis affected 25-50% of hepatocytes and mild chronic triaditis are of the liver. Less than 5% glomerular senescence and associated chronic interstitial inflammation are of the kidney. Other than variable autolysis and congestion, sections of heart (apex, interventricular septum, left and right ventricle), spleen, pancreas, adrenal, cerebellum, hippocampus, and pituitary are noncontributory.

Peripheral blood was sent to National Medical Services, Inc. for toxicological analysis (control number 10922864). A blood screen for common drugs of abuse was presumptively positive for cannabinoids and propoxyphene. Toxicologic analysis of peripheral blood revealed the following: delta-9 tetrahydrocannabinol (THC) = 3.6 ng/ml, delta-9 carboxy THC = 15 ng/ml, propoxyphene = 0.14 mcg/ml, norpropoxyphene = 0.29 mcg/ml, nicotine, and cotinine (nicotine metabolite). Anticonvulsants Keppra (levetiracetam) and Depakote (valproic acid) were negative. Blood ethanol was negative. Results were reviewed by Demi Jones Garvin, PharmD, D-FTCB, Forensic Toxicologist.

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

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

Patient: FLOYD, SCOTTY
Med Rec: FLOYDSCOTT
DOB: 1/1/1901
Male Race: Other
ACCESSION: FA-08-00603
Date Received: 9/6/2008
Date Collected: 9/6/2008

Forensic Autopsy Final Report

Analysis of vitreous fluid reveals the following: sodium = 152 mmol/L, potassium = 10.4 mmol/L, chloride = 130 mmol/L, urea nitrogen = 7 mg/dl, creatinine = 0.5 mg/dl, glucose = 24.0 mg/dl, and acetone = negative.

In light of the historical, toxicological, vitreous chemistry, gross and microscopic autopsy findings, it is the opinion of the prosectors that the decedent died as the result of complications of seizure disorder that resulted from a cavitary lesion of the right frontal cerebrum due to remote blunt head trauma. Furthermore, the manner of death is best deemed accident. Of note, reportedly prescribed anticonvulsants, levetiracetam and valproic acid, were not present upon toxicological analysis.

FINAL DIAGNOSIS

- Pulmonary edema
- Pleural and epicardial petechiae
- Mild cardiomegaly (410g)
- Cerebral cavitation (inferior frontal)
- Hepatic steatohepatitis
- Respiratory bronchiolitis
- Peripheral blood toxicology: levetiracetam = negative, valproic acid = negative, delta-9 THC = 3.6 ng/ml, propoxyphene = 0.13 mcg/ml

CERTIFICATION

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

Cynthia A Schandl, M.D. Ph.D. (1-4382)
(Electronically signed by)
Verified: 09/25/2008 01:20
CAS/MTR

NMS LABS

NMS Labs
3701 Welsh Road, PO Box 433A, Willow Grove, PA 19090-0437
Phone: (215) 657-4900 Fax: (215) 657-2972
e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, DABFT, DABCC-TC, Laboratory Director

CONFIDENTIAL

Toxicology Report

Report Issued 09/16/2008 11:00

10161
The Forensic Science Network
PO Box 25469

Columbia, SC 29224

Patient Name FLOYD, SCOTTY
Patient ID FA08-603
Chain 10922864
Age 33 Y **Gender** M

Workorder 08267842

Received 09/09/2008 09:36

This analysis was performed under chain of custody. The chain of custody documentation is on file at NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date of this report.

Sample ID 08267842-001
Matrix Blood
Patient Name FLOYD, SCOTTY
Patient ID FA08-603
Container Type Gray Top Tube

Collect Dt/Tm 09/06/2008 11:30
Source Peripheral Blood

Approx Vol/Weight 8.75 mL

Receipt Notes None Entered

County MARION

Analysis and Comments	Result	Units	Reporting Limit	Notes
2505B Levetiracetam, Blood				
Analysis by High Performance Liquid Chromatography (HPLC)				
Levetiracetam	None Detected	mcg/mL	2.0	
Synonym(s): Keppra®				
Steady-state trough serum or plasma levels following doses of 1000 to 3000 mg/day: 3 - 37 mcg/mL. The same dosage regimen will typically result in peak levels of 10 - 60 mcg/mL, at approximately 1.5 hours post dose.				
4757B Valproic Acid, Blood				
Analysis by High Performance Liquid Chromatography (HPLC)				

Results for sample 08267842-001 are continued on next page.

VM

1440

NMS LABS
NMS Labs
3701 Welsh Road, PO Box 433A, Willow Grove, PA 19090-0437
Phone: (215) 657-4900 Fax: (215) 657-2972
e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, DABFT, DABCC-TC, Laboratory Director

CONFIDENTIAL

Sample ID 08267842-001
Matrix Blood
Patient Name FLOYD, SCOTTY
Patient ID FA08-603

Collect Dt/Tm 09/06/2008 11:30
Source Peripheral Blood

Analysis and Comments	Result	Units	Reporting Limit	Notes
Valproic Acid	None Detected	mcg/mL	1.0	
Synonym(s): Depakene®, Depakote®				
Normal anti-epileptic range. 50 - 100 mcg/mL. Higher levels are sometimes required in refractory epileptic patients. Therapeutic range for the treatment of manic episodes associated with bipolar disorder 50 - 125 mcg/mL.				
8095B Rapid Tox Panel II, Blood (Forensic)				
Analysis by Enzyme-Linked Immunosorbent Assay (ELISA)				
Opiates	None Detected	ng/mL	20	
Cocaine/Metabolites	None Detected	ng/mL	20	
Benzodiazepines	None Detected	ng/mL	100	
Cannabinoids	See Comment	ng/mL	10	
Comment: This screening result indicates that further testing is required. Refer to the confirmation test for the final result(s).				
Amphetamines	None Detected	ng/mL	20	
Barbiturates	None Detected	mcg/mL	0.040	
Phencyclidine	None Detected	ng/mL	10	
Methadone	None Detected	ng/mL	25	
Propoxyphene	See Comment	ng/mL	50	
Comment: This screening result indicates that further testing is required. Refer to the confirmation test for the final result(s).				
Analysis by Headspace Gas Chromatography (GC)				
Ethanol	None Detected	mg/dL	10	
Synonym(s): Ethyl Alcohol				
Methanol	None Detected	mg/dL	5.0	
Synonym(s): Methyl Alcohol				
Isopropanol	None Detected	mg/dL	1.0	
Synonym(s): Isopropyl Alcohol				
Acetone	None Detected	mg/dL	1.0	

Results for sample 08267842-001 are continued on next page

NMS LABS

NMS Labs
3701 Welsh Road, PO Box 433A, Willow Grove, PA 19090-0437
Phone: (215) 657-4900 Fax: (215) 657-2972
e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, DABFT, DABCC-TC, Laboratory Director

CONFIDENTIAL

Sample ID 08267842-001
Matrix Blood
Patient Name FLOYD, SCOTTY
Patient ID FA08-603

Collect Dt/Tm 09/08/2008 11:30
Source Peripheral Blood

Analysis and Comments	Result	Units	Reporting Limit	Notes
Analysis by Colorimetry (C)				
Salicylates	None Detected	mcg/mL	200	
Analysis by Colorimetry (C)				
Acetaminophen	None Detected	mcg/mL	5.0	
Analysis by Gas Chromatography (GC) and Gas Chromatography/Mass Spectrometry (GC/MS)				
GC and GC/MS Screen Findings	None Detected			
GC and GC/MS Incidental Findings	Positive			

Nicotine
Cotinine

The following is a general list of compounds included in the GC and GC/MS Screen.
Please note that not all known compounds included in each specified class or heading are included, and other compounds outside these classes are included in the scope of testing.
The detection of any particular compound is concentration-dependent.
For a detailed list of all compounds included in this screen, please contact NMS Labs.

Scope of Analysis:
Analgesics (Opioid and non-Opioid), Anesthetics, Antiasthmatic Agents, Anticholinergic Agents, Anticonvulsant Agents, Antidepressants, Antiemetic Agents, Antihistamines, Antiparkinsonian Agents, Antipsychotic Agents, Antitussive Agents, Anxiolytics (Benzodiazepines and others), Cardiovascular Agents (non-Digitalis), Hallucinogens, Hypnosedatives (Barbiturate and others), Muscle relaxants, non-Steroidal Anti-Inflammatory Agents (excluding Salicylate) and Stimulants (Amphetamine-like and others).

5280B Propoxyphene and Metabolite Quantitation/Confirmation, Blood (Forensic)

Analysis by Gas Chromatography/Mass Spectrometry (GC/MS)

Results for sample 08267842-001 are continued on next page

NMS LABS

NMS Labs
3701 Welsh Road, PO Box 433A, Willow Grove, PA 19090-0437
Phone: (215) 657-4900 Fax: (215) 657-2972
e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, DABFT, DABCC-TC, Laboratory Director

CONFIDENTIAL

Sample ID 08267842-001
Matrix Blood
Patient Name FLOYD, SCOTTY
Patient ID FA08-603

Collect Dt/Tm 09/06/2008 11:30
Source Peripheral Blood

Analysis and Comments	Result	Units	Reporting Limit	Notes
Propoxyphene	0.13	mcg/mL	0.10	
Synonym(s): Darvon®				
Average serum concentrations following a daily regimen of 195 mg Propoxyphene: 0.42 mcg Propoxyphene/mL.				
Norpropoxyphene	0.29	mcg/mL	0.10	
Synonym(s): Propoxyphene Metabolite				
Average serum concentrations following a daily regimen of 195 mg Propoxyphene: 1.45 mcg Norpropoxyphene/mL.				
5724B Cannabinoids Quantitation/Confirmation, Blood (Forensic)				
Analysis by Gas Chromatography/Mass Spectrometry (GC/MS)				
Delta-9 THC	3.6	ng/mL	1.0	
Synonym(s): Active ingredient of Marijuana				
The concentrations in Blood are usually about one-half of Serum/Plasma concentrations. Usual peak levels in Serum for 1.75% or 3.55% THC marijuana cigarettes: 50 - 270 ng/mL at 6 to 9 minutes after beginning smoking, decreasing to less than 5 ng/mL by 2 hours. Passive inhalation: Up to 2 ng/mL.				
Delta-9 Carboxy THC	15	ng/mL	5.0	
Synonym(s): Inactive Metabolite				
Usual peak levels in Serum for 1.75% or 3.55% THC marijuana cigarettes: 10 - 101 ng/mL about 32 to 240 minutes after beginning smoking, with a slow decline. Usually not detectable after passive inhalation.				
11-Hydroxy Delta-9 THC	None Detected	ng/mL	5.0	
Usual peak levels: Less than 10% of THC levels after smoking.				

NMS LABS

NMS Labs
3701 Welsh Road, PO Box 433A, Willow Grove, PA 19090-0437
Phone: (215) 657-4900 Fax: (215) 657-2972
e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, DABFT, DABCC-TC, Laboratory Director

CONFIDENTIAL

Sample ID 08267842-002
Matrix Blood
Patient Name FLOYD, SCOTTY
Patient ID FA08-603
Container Type Gray Top Tube

Collect Dt/Tm 09/06/2008 11:30
Source Peripheral Blood

Approx Vol/Weight 8.75 mL

Receipt Notes None Entered

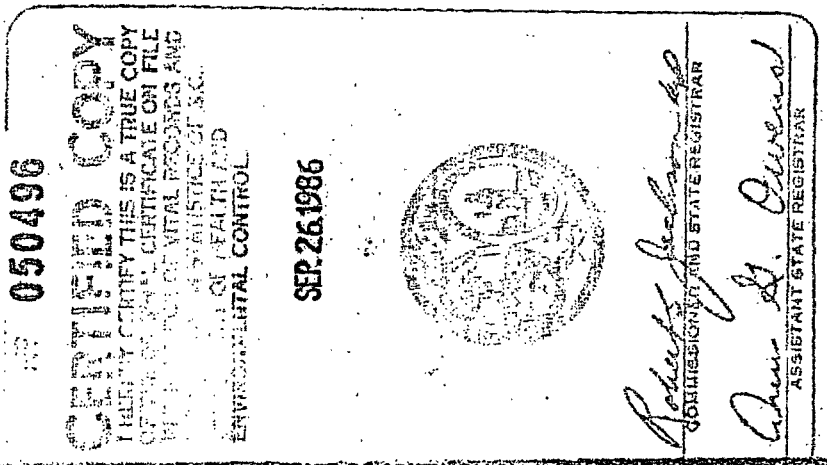
County: MARION

No testing performed on this sample.

Peripheral Blood-negative alcohols; toxicology findings indicate antemortem use of Cannabis; the postmortem propoxyphene concentration appears consistent with values reported during therapeutic administration (norproxyphene is the active metabolite); levetiracetam and valproic acid were not detected (note reporting limits)

Demi Garvin, Pharm.D., D-FTCB

Digitally signed by Demi Garvin, Pharm.D., D-FTCB
DN: cn=Demi Garvin, Pharm.D., D-FTCB, o=Forensic Science Network LLC, c=US
Date: 2008.09.23 20:16:39 -04'00'



Registration Dist. No. 32-A

Registrar's No.

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

CERTIFICATE OF LIVE BIRTH

75 027612

1. CHILD - NAME (First, Middle, Last): Scottie Wayne Floyd
2. SEX: Male
3. THIS BIRTH — SINGLE, TWIN, TRIPLET, ETC. (If not single birth — born first, second, third, etc.): Single
4. IF NOT SINGLE BIRTH — BORN FIRST, SECOND, THIRD, ETC.:
5. COUNTY OF BIRTH: Marion
6. CITY, TOWN, OR LOCATION OF BIRTH: Marion
7. INSIDE CITY LIMITS (Specify Yes or No): Yes
8. HOSPITAL — NAME (If not in hospital, give street and number): Palmetto General
9. DATE OF BIRTH (Month, Day, Year):
10. HOUR: 08 A.M.

11. MOTHER — MAIDEN NAME (First, Middle, Last): Betty Jo Grainger
12. AGE (At time of this birth): 22
13. STATE OF BIRTH (If not in U.S.A., name country): S.C.
14. RESIDENCE — STATE: S.C.
15. COUNTY: Dillon
16. CITY, TOWN, OR LOCATION: Nichols
17. INSIDE CITY LIMITS (Specify Yes or No): No
18. STREET AND NUMBER: Rt 1

19. FATHER — NAME (First, Middle, Last): Thomas Wayne Floyd
20. AGE (At time of this birth): 24
21. STATE OF BIRTH (If not in U.S.A., name country): S.C.

22. USUAL OCCUPATION: Carpenter
23. KIND OF BUSINESS OR INDUSTRY:
24. SIGNATURE OF MOTHER: Betty Jo Floyd
25. MAILING ADDRESS (If different from residence):
26. I certify that the above-named child was born alive at the place and on the date stated above.
    SIGNATURE: H. Dwight Tindall
27. DATE SIGNED (Month, Day, Year): 8-11-75
28. ATTENDANT — M.D., D.O., Midwife, Other (Specify): M.D.
29. CERTIFIER — NAME (Type or Print): Henry J. Fischl
30. MAILING ADDRESS (Street or R.F.D. No., City or Town, State, Zip): Marion, S.C. 29571
31. REGISTRAR — SIGNATURE: L. H. Blackmon M.D. KM
32. DATE RECEIVED BY LOCAL REGISTRAR (Month, Day, Year): 8-11-75

Scottie Wayne Floyd

MARION — Funeral services for Scottie Wayne Floyd, 33, will be Thursday, September 11, at 4:00 p.m. in the Chapel of Richardson Funeral Home. Mr. Floyd died on Friday, September 5, at his home.

Mr. Floyd was born in Marion, a son of Betty Joe (Cookie) Floyd Grainger. He was formerly employed with Ken Baker BMW Originals.

Surviving in addition to his mother of Marion, is a sister, Kimberly Diane Floyd of Marion and a niece, Amberlyn Nicole Smith.

Visitation will be held Thursday, September 11, 3:00-4:00 p.m. at Richardson Funeral Home.

Sign or read the guest book for this obituary at www.scnow.com.

IN MEMORY OF

SCOTTIE WAYNE FLOYD

BORN	**DIED**
	SEPTEMBER 5, 2008

SERVICES
4 :00 P.M.
THURSDAY, SEPTEMBER 11, 2008
RICHARDSON FUNERAL HOME

OFFICIATING
REV. MAXIE HARDEE

RICHARDSON FUNERAL HOME
MARION, SC

STATE OF SOUTH CAROLINA
CERTIFICATION OF VITAL RECORD

State of South Carolina
Department of Health and Environmental Control
CERTIFICATE OF DEATH

STATE BIRTH NUMBER

STATE FILE NUMBER 08-029044

NAME OF DECEDENT Scottie Wayne Floyd
For use by physician or institution

Items 1-23c To Be Completed/Verified By: FUNERAL DIRECTOR

1. DECEDENT'S LEGAL NAME (Include AKAs, if any) (First, Middle, Last): Scottie Wayne Floyd
2. SEX: Male
3. SOCIAL SECURITY NUMBER:
4a. AGE-Last Birthday (Years): 33
4b. UNDER 1 YEAR: Months / Days
4c. UNDER 1 DAY: Hours / Minutes
5. DATE OF BIRTH (MM/DD/YYYY):
6. BIRTHPLACE (City and State or Foreign Country): Marion, South Carolina
7a. RESIDENCE STATE: na
7b. COUNTY:
7c. CITY OR TOWN: n
7d. STREET AND NUMBER:
7e. APT. NO.
7f. ZIP CODE:
7g. INSIDE CITY LIMITS? ☐ Yes ☒ No
8. EVER IN US ARMED FORCES? ☐ Yes ☒ No
9. MARITAL STATUS AT TIME OF DEATH: ☐ Married ☐ Married, but separated ☐ Widowed ☐ Divorced ☒ Never Married ☐ Unknown
10. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage):
11. FATHER'S NAME (First, Middle, Last): Thomas Wayne Floyd
12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last): Betty Joe Grainger
13a. INFORMANT'S NAME: Betty Joe Floyd
13b. RELATIONSHIP TO DECEDENT: Mother
13c. MAILING ADDRESS (Street and Number, City, State, Zip Code): 71
14. PLACE OF DEATH (Check only one; see instructions)
IF DEATH OCCURRED IN A HOSPITAL: ☐ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival
IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Hospice facility ☐ Nursing home/Long term care facility ☒ Decedent's home ☐ Other (Specify)
15. FACILITY NAME (If not institution, give street and number):
16. CITY OR TOWN, STATE AND ZIP CODE:
17. COUNTY OF DEATH: 2
18. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal from state ☐ Other (Specify)
19. PLACE OF DISPOSITION (Name of cemetery, crematory, other place): Watson Funeral Home & Crematory
20. LOCATION-CITY, TOWN, AND STATE: Conway, South Carolina
21. NAME AND ADDRESS OF FUNERAL FACILITY: Richardson Funeral Home, Inc.
22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER AGENT
23. LICENSE NUMBER (Of Licensee): 1266
P.O. Box 697 Marion, South Carolina
23a. EMBALMER (Signature): not embalmed
23b. EMBALMER LICENSE NUMBER
23c. LICENSE NUMBER (Of Facility): 246

Items 24-49 To Be Completed By: MEDICAL CERTIFIER

ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH
24. DATE PRONOUNCED DEAD (MM/DD/YYYY):
25. TIME PRONOUNCED DEAD:
26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable)
27. LICENSE NUMBER:
28. DATE SIGNED (MM/DD/YYYY):
29. ACTUAL OR PRESUMED DATE OF DEATH (Spell Month): September 5, 2008
30. ACTUAL OR PRESUMED TIME OF DEATH: 10:00 p.m.
31. WAS CORONER OR MEDICAL EXAMINER CONTACTED? ☒ Yes ☐ No

CAUSE OF DEATH (See instructions and examples)

32. PART I. Enter the chain of events-diseases, injuries, or complications-that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

Approximate Interval: Onset to death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Complications of seizure disorder (due to)
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST
b. Cerebral cavitary lesion (due to)
Due to (or as a consequence of):
c. Remote blunt head trauma
Due to (or as a consequence of):
d.

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.

33. WAS AN AUTOPSY PERFORMED? ☒ Yes ☐ No
34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☒ Yes ☐ No

35. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☒ No ☐ Unknown
36. IF FEMALE: ☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to one year before death ☐ Unknown if pregnant within the past year
37. MANNER OF DEATH: ☐ Natural ☐ Homicide ☒ Accident ☐ Pending Investigation ☐ Suicide ☐ Could not be determined
38. DATE OF INJURY (Spell Month): September 13, 2001
39. TIME OF INJURY: App.3:00pm
40. PLACE OF INJURY (e.g., Decedent's home, construction site, restaurant, wooded area): Ken Baker Used Cars
41. INJURY AT WORK? ☒ Yes ☐ No
42. LOCATION OF INJURY: State: South Carolina City or Town: Marion County: Marion
Street & Number: 2066 N. hwy 501 by-pass Apartment Number: Zip Code: 29571
43. DESCRIBE HOW INJURY OCCURRED: Employee was removing a control arm from a car engine and a spring hit him in the forehead.
44. IF TRANSPORTATION INJURY, SPECIFY: ☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (Specify)
45. CERTIFIER (Check only one)
☐ Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated.
☐ Pronouncing and Certifying physician-To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
☒ Coroner/Medical Examiner-On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
Signature of certifier:
46. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 32): Jerry M. Richardson P.O. Box 697, Marion, South Carolina 29571
46a. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER:
47. TITLE OF CERTIFIER: Coroner
48. LICENSE NUMBER:
49. DATE CERTIFIED (MM/DD/YYYY): 09/29/2008
50. FOR REGISTRAR ONLY-DATE FILED (MM/DD/YYYY): OCT 02 2008

SC 00088250

ISSUED OCT 02 2008

This is a true certification of the facts on file in the Division of Vital Records, SC Department of Health and Environmental Control.

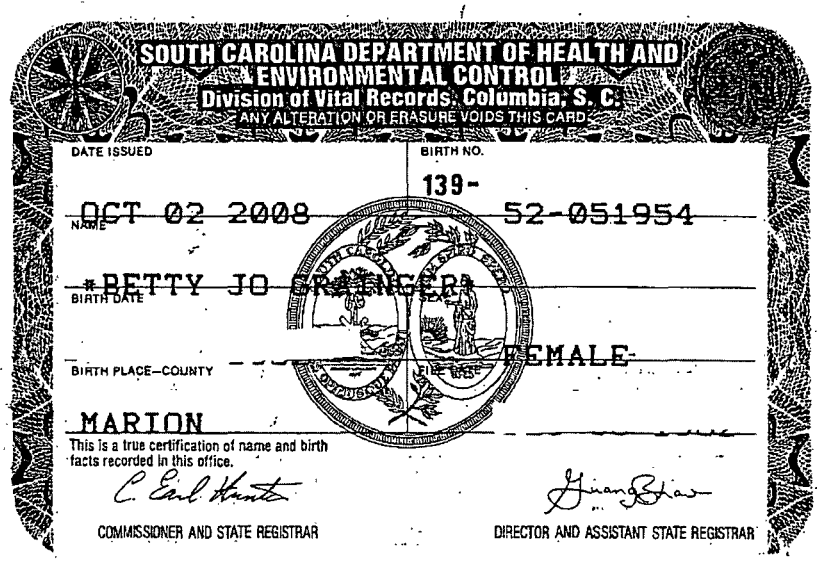
C. Earl Hunter
C. Earl Hunter
Commissioner and State Registrar

Guang Zhao
Guang Zhao
Assistant State Registrar

This copy is not valid unless prepared on an engraved border displaying the state seal and issuing agency logo.

Revision Date: 05/01/2008

DHEC PROMOTE PROTECT PROSPER
South Carolina Department of Health and Environmental Control



SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
Division of Vital Records, Columbia, S. C.
ANY ALTERATION OR ERASURE VOIDS THIS CARD

DATE ISSUED: OCT 02 2008

BIRTH NO.: 139- 52-051954

NAME: *BETTY JO CRAINGER

BIRTH DATE:

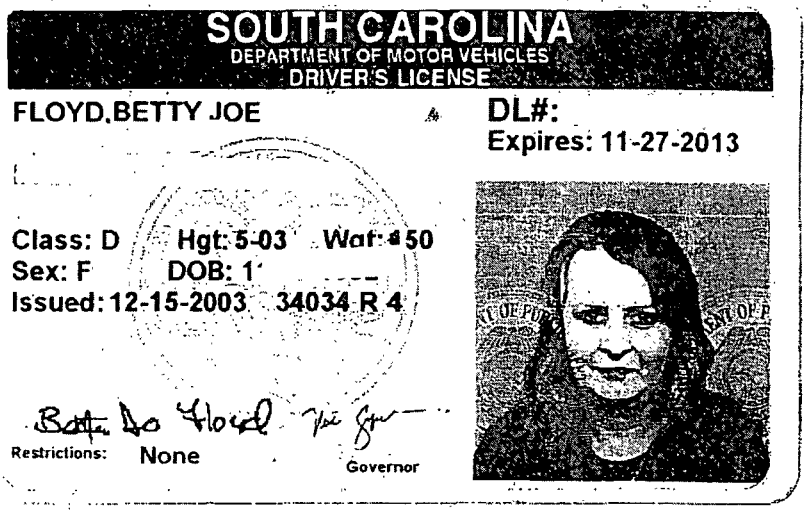
SEX: FEMALE

BIRTH PLACE—COUNTY: MARION

This is a true certification of name and birth facts recorded in this office.

C. Earl Hunter
COMMISSIONER AND STATE REGISTRAR

DIRECTOR AND ASSISTANT STATE REGISTRAR



SOUTH CAROLINA
DEPARTMENT OF MOTOR VEHICLES
DRIVER'S LICENSE

FLOYD,BETTY JOE

DL#:
Expires: 11-27-2013

Class: D Hgt: 5-03 Wgt: 150
Sex: F DOB: 1
Issued: 12-15-2003 34034 R 4

Restrictions: None

Governor

Marriage License

STATE OF SOUTH CAROLINA
County of Dillon

Whereas, It has been made to appear to me, Jasper D. Rogers, Probate Judge for Dillon County, upon oath,

that Thomas Wayne Floyd *of* Nichols, S. C.,

and Betty Jo Grainger *of* Nichols, S. C.

are legally capacitated to contract matrimony, and that their ages are respectively 20 *years and* ____ *months, and* 16 *years and* ____ *months; and their race is* White *and their nationality is American, and that application for a license was filed with this Court at* 2:30 P *M., on the* 29th *day of* May ____, 196 9.

These are, therefore, to authorize any person qualified to perfom marriage ceremonies to perform the marriage ceremony for the persons above named, and for the so doing this shall be sufficient warrant.

Given under my Hand and Seal at 2:30 P *M., this the* 30th *day of* May *A. D. 196* 9.

Jasper D Rogers

Probate Judge

Certificate

THIS IS TO CERTIFY, That I, Lucius Lamar King *did this day perform the marriage ceremony for the within named persons at* Lake View *South Carolina, this* 30 *day of* May *A. D. 196* 9.

Signatures of Contracting Parties

Betty Jo Grainger

Thomas Wayne Floyd

Lucius Lamar King Jr

Signature of person performing ceremony.

Minister
Bear Swamp Baptist Church

Dillon, South Carolina.

WALKER, EVANS & COGSWELL CO., CHARLESTON, S. C. 76155—0-57

Tom W. Floyd

ORRUM, N.C. — Mr. Tom W. Floyd, 51, died Saturday, April 15, 2000, at Southeastern Regional Medical Center in Lumberton, N.C., after an illness.

Memorial services will be at 11 a.m. Monday, April 17 from Cox-Collins Funeral Home Chapel in Mullins with the Rev. David McLellan officiating.

Mr. Floyd was born Sept. 21, 1948 in Marion County a son of Nettie Richardson Floyd. He was a retired carpenter.

Surviving in addition to his mother of Nichols are his wife, Joyce Callahan Floyd of the home; a son, Scottie Floyd of Marion; two daughters, Kimberly Diane Floyd of Marion and Danielle Floyd of the home; a brother, Bill Floyd of Nichols; and a sister, Barbara F. Jackson of Marion.

Visitation will be from 6 to 8 p.m. today at Cox-Collins Funeral Home in Mullins.

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM MARION COUNTY
South Carolina Workers' Compensation Commission

WCC Case Nos. 0123790 and 0824046

Betty Joe Floyd as Personal Representative of the Estate of Scottie Wayne Floyd and as dependent mother beneficiary of Scottie W. Floyd, deceased employee, ... Appellant,

v.

Ken Baker Used Cars, Employer, and Legion Insurance Company In liquidation c/o South Carolina Property & Casualty Insurance Guaranty Association and Amguard Insurance Company, Carriers, ... Respondents.

CERTIFICATE OF COUNSEL

The undersigned certifies that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

September 14, 2012

Steve Wukela, Jr.
Wukela Law Firm
Post Office Box 13057
Florence, South Carolina 29504
(843) 669-5634
Attorney for Appellant

THE STATE OF SOUTH CAROLINA

In The Court of Appeals

APPEAL FROM MARION COUNTY

South Carolina Workers' Compensation Commission

RECEIVED
SEP 17 2012
SC Court of Appeals

WCC Case No. 0123790 and 0824046

Betty Joe Floyd as Personal Representative of the Estate of Scottie Wayne Floyd and as dependent mother beneficiary of Scottie W. Floyd, deceased employee, ... Appellant,

v.

Ken Baker Used Cars, Employer, and Legion Insurance Company In liquidation c/o South Carolina Property & Casualty Insurance Guaranty Association and Amguard Insurance Company, Carriers, ... Respondents.

PROOF OF SERVICE

I certify that I have served the Record on Appeal of Appellant - Volumes, I, II and III, on the Employer, Ken Baker Used Cars, and the Carriers, Legion Insurance Company in Liquidation c/o South Carolina Property & Casualty Guaranty Association and Amguard Insurance Company, on September 17, 2012 via hand delivery to their attorneys of record, respectively, Mark D. Cauthen, Esquire and Peter P. Leventis, Esquire, of McKay, Cauthen, Settana & Stubley, P.A., 1303 Blanding Street, Columbia, SC 29201, and Edwin P. Martin, Jr., Esquire, Hedrick, Gardner, Kincheloe & Garofalo, LLP, 1301 Gervais Street – Suite 1900, Columbia, SC 29211.

September 17, 2012

Steve Wukela, Jr.
Wukela Law Firm
Post Office Box 13057
Florence, South Carolina 29504
(843) 669-5634
South Carolina Bar # 06244
Attorney for Appellant